Northern Inyo Healthcare District

Board Meetings

Board Meeting - July 16, 2025

Agenda

Consent Agenda

Chief of Staff Report

Chief Human Resources Officer / Chief Business Development Officer

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

July 16, 2025, 5:00 pm
Northern Inyo Healthcare District invites you to join this meeting

Connect via Zoom: *(A link is also available on the NIHD Website)*
https://zoom.us/j/213497015?pwd=TDlIWXRuWjE4T1Y2YVFWbnF2aGk5UT09
Meeting ID: 213 497 015
Password: 608092

Phone Connection:
888 475 4499 US Toll-free
877 853 5257 US Toll-free
Meeting ID: 213 497 015

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

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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 June 18, 2025, Special Board Meeting
    b. Approval of minutes for June 18, 2025, Regular Board Meeting
    c. Approval of minutes for June 26, 2025, Special Board Meeting
    d. Approval of Policies and Procedures
        i. Age Related and Population Specific Care
        ii. Benefits – Employee Recognition
        iii. Cleaning the Pharmacy Sterile IV Preparation Area (Clean Room)
        iv. Dilation and Curettage in the Emergency Department
        v. Emergency Department telephone Advice information
        vi. Emergency Management Plan
        vii. Licensure of Nursing Personnel
        viii. Medical Staff Department Policy - Pediatrics
        ix. Pathways for Development Review and Revision of Nursing Standards
        x. Responsibilities of Nursing Students and District Staff
        xi. Standardized Procedure - Certified Nurse Midwife
        xii. Standardized Procedure for Admission of the Well Newborn
        xiii. Standardized Protocol for the Orthopedic Physician Assistant
        xiv. Sterile Compounding Environmental Monitoring

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4. New Business:
    a. Chief Executive Officer Report
        i. Mammoth Orthopedic Institute Partnership Update – *Information Item*
        ii. The Joint Commission Survey Update – *Information Item*
        iii. Capital Equipment Purchase – *Action Item*
            1. Spider Shoulder Positioner - $29,200
            2. Hana Table - $150,000
    b. Chief of Staff Report, Samantha Jeppsen MD
        i. Medical Staff Initial Appointments 2025-2026 – *Action Item*
        ii. Medical Staff Initial Appointments 2025-2026 – Proxy Credentialing – *Action Item*
        iii. Medical Executive Committee Meeting Report – *Information item*

c. Chief Human Resources Officer / Chief Business Development Officer
    i. Business Development Update – *Information Item*
    ii. Human Resources Plan – *Information Item*
    iii. Marketing Plan – *Information item*
d. Chief Financial Officer Report
    i. Financial & Statistical Reports (*Board will consider the approval of these reports)*

5. General Information from Board Members (*Board will provide this information)*
6. 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 2:00 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 Officer, Chief Business Development 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 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 2:04 pm for public employee appointment and discussion pursuant to Government Code §54957(b)(1), Title: Chief Executive Officer Candidate.
RETURN TO OPEN SESSION	Called back to open session at 4:44 pm Chair Turner stated there were no reportable actions from the closed session
ADJOURNMENT	Adjournment at 4:44 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
Adam Hawkins, DO, Chief Medical Officer
Alison Murray, Chief Human Resources Officer, Chief Business Development Officer
Allison Partridge, Chief Operations Officer / Chief Nursing Officer
Andrea Mossman, Chief Financial Officer
Sierra Bourne, MD, Chief of Staff

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.

There were no comments from the public.

CONSENT AGENDA

Chair Turner called attention to the Consent Agenda.

The following item was removed from the Consent Agenda for further discussion:

- Approval of May 21, 2025 Regular Board Meeting Minutes

Motion to approve the remainder of the Consent Agenda: Smith
2nd: Best-Baker
Passed: 5-0

The Board then reviewed the Meeting Minutes from May 21, 2025. The following corrections were noted:

- Correction to the physician name on page 4 to Dr. Adam Jesionek
- Correction to reflect Director Barrett's vote as "yes" on page 4

Motion to approve May 21, 2025 Meeting Minutes with corrections: Best-Baker
2nd: Smith
Passed: 5-0

CHIEF EXECUTIVE OFFICER REPORT

Chair Turner called attention to the Chief Executive Office Report

Chief Executive Officer Christian presented a recommendation to restructure the Board's standing committees to improve efficiency and align with governance best practices. He proposed a three-month pilot to:

- Realign the committee schedule so meetings occur prior to regular board meetings,
- Transition each committee to include two designated board members rather than full board participation,
- Allow Committee Chairs to report action items to the full Board, and
- Evaluate the structure after three months before making permanent changes via bylaw amendment.

Board members discussed the proposal and agreed to move forward with the realignment on a trial basis.

Board Committee Appointments under the new structure:

- Finance Committee: David McCoy Barrett and Melissa Best-Baker
- Quality Committee: David Lent and Laura Smith
- Governance Committee: Jean Turner and David Lent

Motion to approve the realignment of board committees on a three-month trial basis and appoint committee members as proposed: Smith
2nd: Melissa Best-Baker
Passed: 5-0

CHIEF OF STAFF REPORT

Chair Turner called attention to the Chief of Staff Report.

Dr. Rasoumoff
Dr. Rasoumoff provided an informational update to the Board regarding the peer review process and medical staff accountability. He emphasized the importance of peer review in maintaining clinical standards and shared a recent case example that underscored the process's value in supporting provider improvement and patient safety.

Key points included:

- The peer review process is intended to support—not punish—physicians while ensuring quality of care.
- A case was highlighted in which the provider accepted feedback and showed growth following the peer review.
- Dr. Rasoumoff encouraged continued support for the Medical Executive Committee and its role in maintaining a culture of excellence.

Motion to approve Medical Staff Initial Appointments 2025-2026: Best-Baker
2nd: Lent
Passed: 5-0

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

Motion to approve Additional Privileges: Best-Baker
2nd: Lent
Passed: 5-0

The Ortho Physician Assistant Privilege Form was removed from the agenda

Medical Executive Committee (MEC) report.
Dr. Bourne shared that several physicians are beginning to explore the use of artificial intelligence (AI) tools to assist with clinical documentation. The MEC is monitoring this closely to ensure documentation quality is maintained. Any notes created using AI are currently flagged with a disclaimer in the medical record, and the Committee may develop guidelines around AI use in the future.

Dr. Bourne also announced upcoming leadership transitions:

- Dr. Sam Jeppsen will begin serving as Chief of Staff in July. She is an emergency physician with prior service as Emergency Department Chair and as a long-standing MEC member.
- Dr. Chelsea Robinson, also an emergency physician, will join the MEC as a new member-at-large.
- Dr. Connor Wiles will continue serving on the committee to help ensure leadership continuity.

Dr. Bourne reflected on her four-year tenure as Chief of Staff and expressed gratitude to the Board and District leadership for their ongoing support.

CHIEF FINANCIAL OFFICER REPORT

Chair Turner called attention to the Chief Financial Officer Report

Cash-Flow Report

Wallis presented an overview of the District's cash flow cycle. A Cash Flow Action Team was assembled to map the full patient-to-payment process and identify areas contributing to delays in revenue.

The team examined each stage of the cycle, including scheduling, registration, insurance authorization, provider documentation, coding, billing, and collections. Wallis described how breakdowns at any point in the process—such as incomplete orders, missing documentation, or delayed coding—can result in claims being held, denied, or returned for correction, ultimately impacting cash flow.

The team developed a detailed action plan to address these issues. The plan includes specific tasks, assigned roles, and target due dates to ensure accountability and track progress. Wallis explained that while financial

improvements will appear gradually in metrics like cash on hand and accounts receivable, these action steps serve as early indicators of sustained operational change. The plan will be monitored through regular updates to the Finance Committee.

Wallis invited members of the Cash Flow Action Team to share their insights. Lawrence, Director of Outpatient Clinics, shared that participating in the workgroup gave her a more complete understanding of the full billing process and how each team's work is interconnected. She found it valuable to see how decisions and actions in one area can affect outcomes across the entire revenue cycle. While her team has been managing high-volume claim reconciliation lists, she expressed optimism that the new action plan will help prevent many issues from occurring in the first place.

Mossman noted that the project fostered stronger alignment across departments by clearly defining roles and responsibilities. She emphasized that assigning ownership to each stage of the revenue cycle has improved clarity, communication, and coordination—allowing teams to collaborate more effectively and take proactive steps toward resolution.

Public Comment:
A member of the public asked whether the District plans to bring on a Cerner trainer to support provider documentation improvements. Wallis and Mossman responded that the idea is under active development and may include broader coding and documentation training beyond Cerner-specific tools. Mossman added that the District's outsourced coding vendor already provides targeted audits and training and that a 90- to 120-day documentation review for new providers may be added as part of the onboarding process.

There was collective appreciation for the collaborative approach and the shift from discussion to measurable action. Improvements in cash flow processes were recognized as essential to both the District's financial stability and the patient experience.

Fiscal 2026 Budget

Mossman presented the proposed budget for Fiscal Year 2026. The presentation focused on improving the District's operating margin, enhancing cash flow, and addressing known cost pressures through strategic planning.

Revenue Highlights:

- Net revenue is projected to grow by 4.8%, reflecting expected volume increases across service lines, including a rebound in surgical volumes following provider transitions.
- The District's payer mix includes a substantial proportion of government payers, with 40% of revenue from Medicare and 26% from Medicaid. These programs reimburse at lower rates than commercial insurers, such as Blue Cross, which continues to provide higher

payment levels. Accurate management and optimization of all payer categories remain essential to the District's financial strategy.
- A recent 4% reduction in Medicare reimbursement was noted as a factor influencing projected revenue. The budget anticipates that future growth will be driven by increased patient volumes and continued improvements in operational efficiency.

Expense Planning:

- Expenses are projected to grow 2.1% year-over-year, with supply costs impacted by inflation and tariffs.
- A targeted reduction in contract labor and overtime costs is planned, favoring in-house staffing wherever possible.
- Salaries and benefits, which represent 55% of total operating expenses, will see a modest 2% increase. Ongoing monitoring of premium pay and benefit cost savings opportunities was noted.
- Capital spending is estimated at $2 million, with a "wait-and-see" approach pending clarity on state and federal reimbursement changes.

Cash and Operating Margin:

- The budget projects $7 million in net income, a 73% improvement over FY25 projections.
- Cash flow planning incorporates debt obligations and capital purchases, with a goal to increase available cash by $1.3 million.
- The District aims to reduce its operating loss by 25% in FY26 and continue improving in subsequent years.

Motion to approve the Fiscal 2026 Budget with "unknowns": Best-Baker
2nd: Lent
Passed: 5-0

Policy Clarifications – Financial Assistance and Charity Care Policy

During budget discussion, questions were raised about recent changes to the District's Financial Assistance and Charity Care Policy. Staff clarified that the updates were required to comply with new state regulations from HCAI, which mandate that only 100% discounts be labeled as "charity care," while partial discounts must be referred to as "discounted care."

Financial and Statistical Reports – April 2025

The report reflected a net loss of $3.7 million for April, driven by lower patient volumes and a $3.2 million Medicare repayment and rate adjustment. Despite a $500,000 reduction in expenses, the District's year-to-date operating loss grew to $7.3 million, with a projected year-end net loss of $10 million.

Average daily expenses held steady at $320,000, while net revenue varied significantly—averaging $292,000 but dropping to $180,000 in April. Year-to-

date volumes improved in several areas, including behavioral health (+26%) and women's health (+11%), though surgical services remained below target.

Accounts receivable performance showed progress, with a $7 million reduction in aged AR over 270 days and the lowest AR >90 days rate on record (36%). Days cash on hand increased to 92, and the debt service coverage ratio reached 4.2, reflecting bond compliance.

Wages and benefits now represent 55% of operating expenses, down from 70% in FY22. Upfront patient cash collections more than doubled since January.

Board members engaged in a robust discussion about declining ER visit numbers, expressing interest in better understanding patient experience and community perceptions around emergency services. They requested further analysis, including historical volume trends, Press Ganey scores, and diagnostic data, to determine whether the decline is seasonal, service-related, or part of a broader shift. Directors emphasized the importance of understanding and improving both care experiences and public confidence in the District's services.

Motion to approve the Financial and Statistical Reports: Lent
2nd: Smith
Passed: 5-0

CHIEF MEDICAL OFFICER REPORT

Chair Turner called attention to the Chief Medical Officer Report

Beta Heart Score

An overview was provided on the Beta HEART initiative, a multi-year program aimed at cultivating a culture of safety, transparency, empathy, accountability, and trust across the organization. Beta HEART is supported by Beta Healthcare Group, the District's provider of liability and malpractice coverage.

The initiative began with an external gap analysis, after which NIHD was advised to start its journey with the domain of "Culture of Safety." This includes promoting physical and emotional safety for staff, encouraging error reporting without fear of retaliation, and fostering a learning culture that supports continuous improvement.

As part of this work, the District implemented the SCORE survey in March 2025. SCORE measures staff perceptions in areas such as safety climate, leadership, emotional well-being, and engagement. Key hospital-wide findings included:

- Strengths: Work-life balance, resilience to burnout, and job stability.
- Challenges: Emotional recovery, perceptions of local leadership, DEI belonging, and workforce safety.

- Mixed results: Teamwork and safety climate scored just below benchmark targets; staff reported moderate growth opportunities and workload strain.

Department-level results were also compiled and are being used to support unit-specific improvement efforts. The Quality Team is leading this next phase by conducting a structured debrief process with each department. This includes meeting first with managers to review department-specific data, then with frontline staff in confidential sessions to identify themes and inform action plans. These plans will be revisited and refined throughout the year, with another round of SCORE surveying planned for March 2026.

Board members expressed appreciation for the staff's participation in the survey and commended the Quality Team for coordinating more than 60 meetings to support this effort. The initiative was seen as a strong foundation for enhancing both the employee experience and patient care culture across the District.

Service Line Update
Women's Health

The District expressed heartfelt appreciation to Dr. Janine Arndal for her 18 years of exceptional service and leadership. As one of the first robotic-assisted surgeons at NIHD, Dr. Arndal played a foundational role in expanding women's health services and held key leadership positions including Chief of Obstetrics, Vice Chief of Staff, and Chair of STTA. Her dedication to patients and the community has left a lasting legacy, and she departs with the District's sincere gratitude and best wishes.

Her departure, while deeply felt, comes at a time when rural obstetric programs across the state are facing pressures related to reimbursement and provider availability.

In response, the District has reaffirmed its strong commitment to sustaining and strengthening women's health services. Active recruitment efforts are underway, and leadership has begun weekly check-ins with the department to offer support, reduce workload where possible, and ensure continued high-quality care for patients and families.

Orthopedics

The District continues to prioritize the development of its orthopedic service line, with focused efforts over the past 6 to 8 months on evaluating workflows, identifying opportunities for improvement, and aligning services with community needs. The importance of orthopedics as a core offering was emphasized, along with appreciation for the extensive collaboration and planning that has taken place across departments.

Leadership expressed strong optimism about the future of the service line and thanked the teams involved for their dedication and thoughtful contributions. Continued planning is underway to ensure the orthopedic program evolves to meet growing demand and deliver high-quality care to the region.

Cardiology

Cardiology services continue to grow in response to high patient demand and strong provider engagement. Echocardiogram volumes reached a record high last year—300 above previous years—and are already on pace to exceed that in the current year. The recent addition of a nurse practitioner has expanded access to routine care and advanced diagnostic imaging, helping to reduce patient wait times.

Recognizing the continued strain on appointment availability, leadership is working closely with the cardiologist to explore options for expanding provider coverage and enhancing service offerings. A thoughtful business planning process is underway, focused on increasing access, strengthening diagnostic capabilities, and supporting long-term growth. Board and community members expressed deep appreciation for the quality of care being provided and the cardiology team's contributions to improving health outcomes across the region.

Behavioral Health

Psychiatric nurse practitioner Talia Luc will soon be departing after serving as a key provider under the supervision of Dr. Akalin. Her contributions to patient care were appreciated, and leadership expressed gratitude for her service.

A replacement provider has been identified, and transition planning has been underway for several months to ensure continuity of care. Additional behavioral health support remains available through Eastern Sierra Counseling, Inyo County, and Toiyabe Indian Health Project.

Quality

The District was recognized with a Quality Improvement Program (QIP) Top Performance Award from the California Department of Health Care Services, marking the second consecutive year it has achieved all program metrics. This recognition reflects the collective efforts of the Quality Department and the many clinical teams involved in meeting quality improvement goals. Leadership acknowledged the work behind the achievement and expressed appreciation for the cross-departmental collaboration that made it possible.

Rehabilitation Services

A full-time, local occupational therapist joined the team this month and will support both outpatient care and patient engagement rounding. Leadership also

acknowledged Monica Jones for her dedication in maintaining inpatient and outpatient services over the past several months.

CHIEF NURSING OFFICER / CHIEF OPERATING OFFICER REPORT

Chair Turner called attention to the COO / CNO report

Incident Command Events
Telephone System Outage

On May 27, a severed fiber optic cable near Adelanto caused a complete landline outage across the District. Incident Command was activated due to the duration of the disruption. Cell phones were distributed to key departments, and alternative contact numbers from the Artera appointment system were shared to maintain communication with patients. The outage lasted three days and ended on May 30. Staff worked collaboratively to ensure continuity of care, and the workflows developed during the response have strengthened the District's preparedness for future incidents.

Pharmacy Infusion Projection Update

Final construction activities for the pharmacy are nearly complete, with a few remaining items—such as door coordination, temperature controls, and minor finishing work—being resolved. All required documentation has been submitted to the California Department of Public Health (CDPH), and the District is actively working with the assigned pharmacy surveyor in preparation for the final inspection.

Once infection control sign-off is complete, the pharmacy will be secured and stocked as required for inspection. For the infusion area, application materials have also been submitted to CDPH, and the District is awaiting surveyor assignment.

Leaders expressed appreciation for the cross-departmental teamwork that has carried this complex, multi-year project to its final phase.

GENERAL INFORMATION FROM BOARD MEMBERS

Board members discussed the upcoming Association of California Healthcare Districts (ACHD) Annual Meeting, highlighting the value of participating in the ethics training and the opportunity to network with peers across the state. Directors were encouraged to consider joining ACHD committees, which offer valuable insights into common challenges and innovative solutions shared by other districts. Staff were reminded to coordinate registration and hotel arrangements with the Board Clerk.

PUBLIC COMMENT ON CLOSED SESSION ITEMS

There were no public comments on closed session items.

ADJOURNMENT TO CLOSED SESSION

Adjournment to closed session at 7:33 pm under Government Code § 54957.6 for a conference with the District's designated labor negotiator regarding employee organization AFSCME Council 57. A second closed session item was withdrawn.

RETURN TO OPEN SESSION	Return to open session at 8:04 pm Chair Turner stated there were no reportable actions from the closed session.
ADJOURNMENT	Adjournment at 8:04 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 Special 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
Adam Hawkins, DO, Chief Medical Officer
Alison Murray, Chief Human Resources Officer, Chief Business Development Officer
Allison Partridge, Chief Operations Officer / Chief Nursing 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

Chair Turner called attention to the Orthopedic Service Line Contract

The Executive Team and staff presented the proposed partnership with Mammoth Orthopedic Institute (MOI) to re-establish and enhance orthopedic services at NIHD.

- The team expressed deep appreciation to Director David McCoy Barrett and Dr. Karch for their foresight and leadership in initiating the partnership, and also thanked Dr. Hawkins, Diane Picken, Allison, Christian, Tom Parker (CEO of Mammoth Hospital), and the executive team, acknowledging the many individuals whose hard work, collaboration, and persistence made the project possible.
- Dr. Hawkins outlined the strategic goals of the partnership: providing world-class, dependable, local orthopedic care and increasing access for the community.
- Andrea Mossman reviewed the financial projections, explaining the productivity-based contract and its anticipated positive revenue impact over the next several years.

Motion to approve Orthopedic Service Line Contract: Lent
2nd: Smith
Passed: 5-0

Capital Equipment

- Hana Table ($150,000): An orthopedic-specific surgical table that supports all orthopedic procedures, with particular benefits for total hip replacements. The Hana Table enables both anterior and posterior approaches, unlike the

current fracture table which supports only a posterior approach, and is designed to position the body for optimal access during surgery.

- Spider Shoulder Positioner ($29,200): A specialized attachment used in shoulder procedures, particularly total shoulder replacements, to correctly position the extremity during surgery. It also has attachments that support arthroscopic and other partial shoulder procedures.

Motion to purchase capital equipment: Smith
2nd: Barrett
Passed: 5-0

Motion to approve Medical Staff Appointments 2025-2026: Best-Baker
2nd: Lent
Passed: 5-0

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 5:17 pm for public employee appointment and discussion pursuant to Government Code §54957(b)(1), Title: Chief Executive Officer Selection
RETURN TO OPEN SESSION	Called back to open session at 6:36 pm Chair Turner stated there were no reportable actions from the closed session
ADJOURNMENT	Adjournment at 6:37 pm.

_____
Jean Turner
Northern Inyo Healthcare District
Chair

Attest: _____
David Lent
Northern Inyo Healthcare District
Secretary

NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL POLICY AND PROCEDURE

Title: Age Related and Population Specific Care		
Owner: Interim CEO, COO, CNO	Department: Nursing Administration	
Scope: Nursing Department		
Date Last Modified: 07/29/2022	Last Review Date: 07/02/2025	Version: 2
Final Approval by: NIHD Board of Directors	Original Approval Date: 07/01/2014	

PURPOSE:

To provide age related population specific care to patients served at Northern Inyo Healthcare District (NIHD), across the life span, from neonates to the older adult.

POLICY:

1. Staff will be trained and competent to provide effective care, treatment and services to several groups according to the following distinctions.
    - Age, ranging from neonates to the older adult
    - Particular disease or condition
    - Point of wellness – illness spectrum, including conditions considered urgent, acute or chronic
    - Level of physical and mental ability
    - Availability of family and social support
2. Ages and population specific care are identified in each job description.

DEFINITION:

The population specific age groups at NIHD are defined as:

Neonatal: Birth to 27 days of age
Pediatric: 28 days to 13 years of age
Adult: 14 years of age to 65 years of age
Older Adult: Over 65 years of age

PROCEDURE:

1. Nursing Leaders will assure staff competency (through policy and procedure; job descriptions, and practice standards) for the ages and populations served in the departments. Developmental ages are identified according to physical, motor/sensory adaptation, cognitive, psychological characteristics and appropriate interventions. The attached charts serve as a guideline.
2. The physical environment for persons of all ages and population specific need will be safe and comfortable.
3. The social environment will be compatible with the activities appropriate to the age group served, developmental age (peer group) and population specific need. Furniture and equipment will be provided appropriate to age, size, developmental and condition specific needs of the population.
4. Nursing Leaders, in collaboration with District Education Services, are responsible to maintain a process to ensure that all staff responsible for the assessment, treatment, and care of patients is trained and competent to care for the age groups and specific populations identified in the department job descriptions including:

- Ability to obtain information and interpret information in terms of patient needs (assessment)
- Demonstrate knowledge of growth and development including interventions
- Understand the range of treatments and care requirements for populations served such as bariatric, diabetic, limited English proficiency, pain, end of life care, etc.

5. Training and competency are achieved by orientation, ongoing competency, performance feedback and ongoing performance improvement.

REFERENCES:

1. The Joint Commission (Jan 2022) Comprehensive Accreditation Manual for Critical Access Hospitals, Functional Chapter Human Resources HR.01.05.03, Number 5. Oakbrook, IL: Joint Commission

CROSS REFERENCED POLICIES AND PROCEDURES:

1. Standards of Patient Care in the Perinatal Unit
2. Standards of Care RHC
3. Standards of Care in the Perioperative Unit
4. Standards of Care in the Perioperative Unit Pediatric Patients
5. Standards of Care in the Outpatient Infusion Unit
6. Standards of Care in ICU
7. Standards of Care for the Emergency Department
8. Standards of Care- Acute- sub acute services- Adult patient
9. Standards of Care- Swing Bed Resident
10. Pediatric Standards of Care in the OPD/PACU
11. Pediatric Standards of Care and Routines
12. DI – Standards of Care
13. Standards of Care in the Respiratory Care Department

RECORD RETENTION AND DESTRUCTION:

Documentation related to patient care is entered into the patient's medical record, which is maintained by the NIHD Medical Records Department.

Supersedes: v.1 Age Related and Population Specific Care

Title: Benefits - Employee Recognition		
Owner: Chief Human Resources Officer	Department: Human Resources	
Scope: District Wide		
Date Last Modified: 06/12/2025	Last Review Date: No Review Date	Version: 3
Final Approval by: NIHD Board of Directors	Original Approval Date:	

POLICY:
We are proud of the contribution made by our long-term employees; therefore, the hospital recognizes these employees for continued, loyal, and devoted service. Service awards are presented to employees by the

Administration after five years of service and following each additional five years of regular employment. In addition, certificates are presented to these employees entitling them to additional Paid Time Off hours or pay based on the following schedule:

- An employee who was in a full-time status as of their anniversary date ~~last pay period of the prior year~~ will be given 8 hours of Paid Time Off;
- An employee who was in a regular part-time status as of their anniversary date ~~the last pay period of the prior year~~ will be given 6.4 hours of Paid Time Off;
- An employee who was in a per diem status as of their anniversary date ~~the last pay period of the prior year~~ will be paid $100.00 gross pay.

RECORD RETENTION AND DESTRUCTION:

CROSS REFERENCED POLICIES AND PROCEDURES:

Supersedes: v.2 Benefits - Employee Recognition
Legal Review: Atkinson, Andelson, Loya, Ruud & Romo 10/30/2020

NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL POLICY AND PROCEDURE

Title: Cleaning the Pharmacy Sterile IV Preparation Area. (Clean Room)		
Owner: Manager Employee Health & Infection Control	Department: Infection Prevention	
Scope: Pharmacy, Environmental Services, Infection Prevention		
Date Last Modified: 07/02/2025	Last Review Date: No Review Date	Version: 4
Final Approval by: NIHD Board of Directors	Original Approval Date: 03/21/2018	

PURPOSE:

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

POLICY:

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

DEFINTIONS:

1. Anteroom: An International Organization for Standardization (ISO) Class 8 or cleaner room with fixed walls and doors where personnel hand hygiene, garbing procedures, and other activities that generate

high particulate levels may be performed. The anteroom is the transition room between the unclassified area of the facility and the buffer room
2. Primary Engineering Control (PEC): A device or zone that provides an International Organization for Standardization (ISO) Class 5 air quality environment for sterile compounding
3. Secondary Engineering Control (SEC): The area where the PEC is placed (e.g., a cleanroom suite or an SCA). It incorporates specific design and operation parameters to minimize the risk of contamination within the compounding area.

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

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

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

Site	Cleaning	Disinfecting	Sterile Sporicidal Disinfectant
Pass-through chamber	**Daily** on days compounding occurs	**Daily** on days compounding occurs	• **Monthly** if compounding Category 1 and/or Category 2 Compounding sterile preparations (CSPs) •
PEC, work surfaces, and equipment inside PEC PEC & SEC	**Daily** on days compounding occurs	**Daily** on days compounding occurs	
Work surfaces outside	**Daily** on days compounding occurs	**Daily** on days compounding occurs	
Floors	**Daily** on days compounding occurs	**Daily** on days compounding occurs	
Walls, doors, and door frames	**Monthly**	**Monthly**	**Monthly**
Ceilings			
Storage shelving and bins			
PEC and Equipment outside PEC			

PROCEDURE:

1. Perform Hand Hygiene
2. Don Proper Personal Protective Equipment prior to entering clean room (Gown, mask, gloves, hairnet, booties, and eye protection). Remove and discard PPE when exiting.

3. Disposable soap containers must be replaced they are not to be refilled or topped off.
4. Daily: clean- wipe all horizontal surfaces, mop the floor with a designated mop.
5. Monthly cleaning: Walls, doorframes, ceilings, storage shelving and s, tables, stools, and all other items and surfaces in the Pharmacy Clean Room using approved sporicidal/germicidal product; after cleaning repeat with 70% sterile alcohol using new disposable mop pad.
6. No sweeping, dusting or spraying will be done while in Pharmacy Clean Room.
7. Daily: Empty all trash containers. The outside of the waste containers shall be wiped out with the approved germicidal cleaning and disinfecting solutions.
8. Monthly: Cleaning of the inside and outside of trash containers with approved sporicidal agent.
9. All waste containers will be properly disposed of when at fill line. Replacements must be wiped down with 70% sterile alcohol before placed in sterile compounding areas.
10. Complete daily and monthly log.

REFERENCES:

1. Association for Professionals in Infection Control and Epidemiology (APIC). August 2023. Ten Key Points the Infection Preventionist Needs to Know about (USP) >797>: Pharmaceutical Compounding-Sterile Preparations. Retrieved from https://apic.org/wp-content/uploads/2023/08/APIC_PGC_Ten-Key-Points-the-Infection-Preventionist-Needs-to-Know.pdf
2. California Hospital Association. (2018). Record and Data Retention Schedule. Retrieved from file:///H:/Public/CHA/CHA%20Record%20and%20Data%20Retention%20Schedule%202018.pdf
3. The Joint Commission Infection Prevention and Control IC.02.02.01. (2017). IC.02.02.01: The critical access hospital reduces the risk of infections associated with medical equipment, devices, and supplies. Retrieved from https://e-dition.jcrinc.com/MainContent.aspx
4. The Joint Commission Infection Prevention and Control IC.02.02.01. (2017). IC.02.02.01: The critical access hospital reduces the risk of infections associated with medical equipment, devices, and supplies. Retrieved from https://e-dition.jcrinc.com/MainContent.aspx
5. The Joint Commission Medication Management MM.05.01.07 The Critical Access Hospital safely prepares medications. Retrieved from https://e-dition.jcrinc.com/ASearch.aspx
6. United States Pharmacopeia (USP). 11/1/23. <797> Faqs. Retrieved from https://go.usp.org/USP_GC_797_FAQs
7. United States Pharmacopeia (USP). 11/22. <797> Pharmaceutical Compounding-Sterile Preparations. Retrieved from https://online.uspnf.com/uspnf/document/1_GUID-A4CAAA8B-6F02-4AB8-8628-09E102CBD703_7_en-US
8. United States Pharmacopeia (USP). 2017. USP General Chapter <800> Hazardous Drugs-Handling in Healthcare Settings. Retrieved from www.usp.org

RECORD RETENTION AND DESTRUCTION:

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

CROSS-REFERENCE P&P:

1. MEDICAL WASTE MANAGEMENT PLAN
2. Pharmacy Sterile Products: Compounding Quality Assurance Program
3. Pharmacy Sterile Compounding: Training Requirements, General Conduct, and Aseptic Compounding

Supersedes: v.3 Cleaning the Pharmacy Sterile IV Preparation Area. (Clean Room)

NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL POLICY AND PROCEDURE

Title: Dilation and Curettage in the Emergency Department		
Owner: Manager of ED and Disaster Planning	Department: Emergency Department	
Scope: Emergency Department, Surgery		
Date Last Modified: 07/02/2025	Last Review Date: 07/02/2025	Version: 2
Final Approval by: NIHD Board of Directors	Original Approval Date: 06/17/2021	

PURPOSE: To establish appropriate guidelines regarding initiation of a Dilation and Curettage (D&C) or a modified suction curettage procedure in the Emergency Department (ED).

POLICY:

1. Dilation and Curettage or modified suction curettage procedures are to be scheduled and performed in an outpatient ambulatory clinic or in the Operating Room (OR).

2. A Dilation and Curettage or modified suction curettage procedure will **NOT** be performed in the Emergency Department unless the procedure is deemed emergent and a collaborative conversation has taken place to ensure adequate resources are available to safely support the procedure in the ED.

PROCEDURE:

1. The OB/GYN physician will be notified immediately by the ED physician of any hemodynamically unstable patients in the ED that may be in need of a D&C or modified suction curettage procedure.
2. Every attempt will be made to transfer the patient to the OR.
3. If the patient is unable to transfer to the OR and the OB/GYN physician deems the D&C or modified suction curettage emergent, the OB/GYN will perform the D&C or modified suction curettage in the ED.
4. A collaborative conversation will occur between the ED physician, OB/GYN physician, and the House Supervisor to meet the following needs:
    1. Staffing – An OR RN/Scrub Tech or an ED RN may assist the OB/GYN physician during the procedure only if staffing allows and a plan is in place to accommodate emergencies that may arrive to the ED or OR.
    2. Equipment – All necessary equipment will be obtained by the OB/GYN physician or House Supervisor prior to start of procedure.
    3. If procedural sedation is required, policies related to procedural sedation administration must be followed.

5. If an ED RN is utilized during the procedure, the House Supervisor will be made aware and on standby in case the ED volume increases or critical patients arrive needing assistance.

REFERENCES:

1. Lippincott Procedures

CROSS REFERENCED POLICIES AND PROCEDURES:

1. Evaluation and Screening of Patients Presenting to Emergency Department.

RECORD RETENTION AND DESTRUCTION:

Supersedes: v.1 Dilation and Curettage in the Emergency Department

NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL POLICY AND PROCEDURE

Title: Emergency Department Telephone Advice Information		
Owner: Manager of ED and Disaster Planning	Department: Emergency Department	
Scope: Emergency Department RN, House Supervisors		
Date Last Modified: 12/02/2021	Last Review Date: 07/02/2025	Version: 4
Final Approval by: NIHD Board of Directors	Original Approval Date:	

PURPOSE:

To define the parameters of advice or information that may be given to a person calling the Emergency Department staff seeking advice or medical information.

POLICY:

It is the policy of Northern Inyo Healthcare District (NIHD) that any person that calls the Emergency Department (ED) for telephone advice or information shall be informed that we do not give advice to persons that were not recent ED patients. It is our policy to only give information to patients calling for clarification of their discharge instructions or to relay or discuss their test results. It is our policy to give advice to emergency type of calls (911) that are put through to us by law enforcement or other EMS dispatch.

PROCEDURE:

1. Any person that calls and asks to be connected to the ED (and not the clerk) should be asked if they are calling for advice. If they are calling for advice they should be asked if they are calling about a recent ER visit. If they are calling about a recent visit they should be transferred to the ED.

2. Recent ED patients calling for advice, clarification of instructions or test results will receive advice and /or results specific to their diagnosis and current symptoms or concerns. The Registered Nurse (RN) or Qualified Medical provider (QMP) will review the chart and the appropriate advice will be given. If at any time it is unclear as to what the concern or question is, or if the patient feels their condition is worsening they will be advised to call their doctor, return to the ED or call 911.

3. 911 Call patched through to the Emergency Department:

In a life-threatening situation, while waiting for medical help to arrive, law enforcement may put a call through to the ED via phone from a person that needs immediate medical assistance and information. In this case the most appropriate QMP or ED RN may give advice over the phone.

4. Emergency Services (EMS) radio or telephone patched through to the ED:

If further advice or orders are needed after initial EMS protocols are initiated on scene, the QMP may give further orders to EMS providers.

5. When a caller that is asking for advice is not asking about a recent ED visit, they should be transferred to extension 3111. They will then be given the following message.

You have been connected to the ER telephone advice line.

Our policy does not allow us to give telephone advice to people that we have not seen.

Hang up and dial 911 if you have a medical emergency.

If you need to see a doctor, you may come to the ER. You can be seen and treated even if you cannot pay.

If you have a medical question your doctor may be able to help you

If you need poison control advice, that number is 1-800-876-4766.

If you have a question about a recent ER visit, discharge instructions or test results please call back and tell the operator you need to talk to an ER doctor or nurse about your ER visit.

Documentation:

1. A brief note about the call and any further action will be documented as an addendum in the patient's original visit chart.

2. Any advice given over the phone or base station radio to EMS must be documented in the ambulance run sheet.

REFERENCE:

RECORD RETENTION AND DESTRUCTION: Documentation in medical record is maintained per the medical records department at NIHD.

CROSS REFERENCED POLICIES AND PROCEDURES:

1. Emergency Department Telephone Advice Information
2. Pre- Hospital Policy
3. MICN Policy

Supersedes: v.3 Emergency Department Telephone Advice Information

NORTHERN INYO HEALTHCARE DISTRICT

PLAN

Title: Emergency Management Plan		
Owner: Manager of ED and Disaster Planning	Department: Emergency Department	
Scope: District Wide		
Date Last Modified: 07/02/2025	Last Review Date: 04/21/2022	Version: 6
Final Approval by: NIHD Board of Directors	Original Approval Date: 08/01/2008	

PURPOSE:

Northern Inyo Healthcare District Emergency Management Plan follows the Hospital Incident Command System (HICS) format and is the foundation for the all hazards Emergency Preparedness Program. The Emergency Preparedness Program is comprised of 3 basic elements: 1) An all-hazards risk assessment, 2) Emergency Operations Plan (EOP); and 3) a training exercise program.

The Emergency management Plan is designed to outline the basic infrastructure and operating procedures utilized to mitigate, prepare for, respond to, and recover from emergency situations that tax the routine operating capabilities of the healthcare district. Coordination of planning and response with other healthcare organizations, public health, and local emergency management will be included. The plan also addresses proper plan maintenance, communications, resource and assets management, patient care, continuity of operations, management of staff, evacuations, reunification and contingency planning for utilities failure.

The plan will undergo an annual review process to ensure any plan deficiencies are identified and addressed. An improvement plan will be instituted and maintained to ensure lessons learned and action items identified from exercises and real events are properly addressed and documented.

An emergency incident is defined as natural or manmade events which cause major disruption in the environment of care such as damage to the organization's buildings and grounds due to severe wind storms, tornadoes, hurricanes, earthquakes, fires, floods, explosions or the impact on patient care and treatment activities due to such things as; the loss of utilities (power, water, and telephones), riots, accidents or emergencies within the organization or in the surrounding community that disrupt the organization's ability to provide care.

Northern Inyo Healthcare District (NIHD) will manage all emergency incidents, exercises and preplanned (reoccurring/special) events in accordance with the Incident Command System (ICS) design of HICS. HICS has defined organization and job action sheets to accommodate as many positions as needed, depending on the disaster. In the event of a communitywide emergency, the agency's incident command structure will be integrated into and be consistent with the community command structure. Staff shall receive Incident Command System training appropriate to their level of response and assigned roles and responsibilities to ensure they are prepared to meet the needs of patients in an emergency.

NIHD has established mutual-aid agreements with Mammoth Hospital, Southern Inyo Healthcare District and Toiyabe Indian Health Clinic. In addition, NIHD works in conjunction with hazardous materials response teams, local fire department, local law enforcement, area pharmacies and medical supply vendors.

SCOPE:

The Emergency Operations Plan is designed to guide planning and response to a variety of hazards that could threaten the environment of the NIHD campus or the safety of patients, staff, visitors, or adversely impact the ability of the organization to provide healthcare services to the community. The plan is also designed to assure compliance with applicable codes and regulations. This plan covers all healthcare district facilities (main building, all outbuildings and clinics) and its implementation is the responsibility of all personnel.

Authority for activating the plan will rest with the designated administrator at the time of any incident in need of plan activation**.** Activation of the plan will be conducted in conjunction with agency command staff as well as local emergency management and public health personnel, when appropriate.

The Emergency Plan consists of the Emergency Operations Plan (EOP) and supporting documents. The EOP is the all hazards response overview, includes concept of operations, and organizational structure. The supporting documents provide more detail on the initial response to priority hazards, threats, and events and operational planning. In addition, this plan will define specific goals and objectives, describe preparedness activities, expand the definitions and roles of the Hospital Command Center, and outline response and recovery strategies to be implemented during an emergency event.

SITUATION OVERVIEW:

Hazard Vulnerability Analysis (HVA)

The Disaster Management Committee with the assistance of other pertinent personnel will conduct an HVA of the operations and environment of NIHD. This assessment process helps to identify the hospitals highest vulnerabilities to natural and man-made hazards so that effective preventive measures can be taken and a coordinated response plan can be developed. The results of the HVA will be reviewed with the Inyo Mono Healthcare Coalition (MIHCC) and other emergency management partners. The HVA is completed annually and results will be shared with the Disaster Management Committee, Senior Leadership, and the NIHD Board of Directors.

The critical access hospital's HVA includes the following:

- Natural hazards (such as flooding, wild fire)
- Human-caused hazards (such as bomb threats or cyber/information technology crimes)
- Technological hazards (such as utility or information technology outages)
- Hazardous materials (such as radiological, nuclear, chemical)
- Emerging infectious diseases (such as the Ebola, Zika, or SARS-CoV-2 viruses)

The top identified hazards for this facility are found below**.** These top five hazards have been shared at the community and regional level for partner awareness.

Rank	Hazard
1	Wild Fire
2	IT Systems Failure
3	MCI
4	Chemical Exposure
5	Earthquake

PLANNING ASSUMPTIONS

The following set of assumptions governs the parameters by which this plan was developed.

- Emergencies can happen at any time.
- Emergencies will differ in type, size, scope, and duration.
- NIHD is ultimately responsible for the safety of its patients and staff. External resources may or may not be available in emergency situations. NIHD must understand how we are incorporated into local, regional, and state plans and coordination efforts to participate in available resource request processes.
- Local, state, and federal departments and other healthcare facilities may provide assistance necessary to protect lives and property, however, these resources may not be available and NIHD will plan to manage the incident ourselves, at least for a period of time.
- While this plan outlines actions that should be taken during emergency situations, staff will need to adapt their actions as appropriate for the specifics of the situation.
- No emergency plan can cover all possible contingencies, this plan should be used as a guide and a planning tool to prepare staff and the organization for the most likely hazards that could occur as based on the Hazard Vulnerability Analysis.
- The plan must be implemented in a flexible manner to be successful.
- Staff will be familiar with the plan and their expected responsibilities.
- Staff will execute their responsibilities as outlined in this plan during the emergency event.
- Proper execution of this EOP will save lives and reduce damage from the emergency event.

CONCEPTS OF OPERATIONS

Incident Management

Incident management activities are divided into four phases: mitigation, planning, response and recovery. The job action sheet of HICS includes sections addressing each phase. The four phases are described below:

Mitigation: Mitigation activities describes the actions taken to reduce or eliminate the severity of an emergency. NIHD's strategies for mitigation are to assess and prioritize specific hazards and identify means to reduce those hazards as the organization's ability allows.

Planning: Describes the training, supplies, and equipment required to initiate full effective response at the time of an emergency. NIHD's planning activities include developing emergency operations plans and procedures, conducting training for personnel in those procedures, and conducting exercises with staff to ensure they are capable of implementing response procedures when necessary.

Response: Response includes those actions that are taken when a disruption or emergency occurs. It encompasses the activities that address the short-term, direct effects of an incident. Response activities for NIHD can include activating the incident command center and emergency plans, triaging and treating patients, staff, and visitors who have been affected by an incident, and providing support to other community emergency

response agencies when needed.

Recovery: Describes the processes for restoring operations to a normal or improved state of affairs by both short and long term efforts. Recovery activities for NIHD may include the restoration of interrupted utility services, non-vital functions, replacement of damaged equipment, facility repairs, organized return of patients into the facility, and reconstitution of patient records and other vital information systems. Another key consideration in the recovery and response phases of an incident is the tracking of staff hours, expenses, and damages incurred as a result of the emergency. Detailed records will be maintained throughout an emergency to document expenses and damages for possible reimbursement or to properly file insurance claims.

Plan Activation
The Emergency Operations Plan will be activated in response to internal or external threats to the facility. Internal threats could include fire, workplace violence, and loss of power/other utility or other incidents that threaten the well-being of patients, staff, and/or the facility itself. External threats include incidents that may not affect the facility directly but have the potential to overwhelm NIHD resources or put the facility on alert.

Persons Responsible for Plan Activation
Once a threat has been confirmed, the employee obtaining the information must notify their unit supervisor or the House Supervisor immediately. Employees can use the Emergency Preparedness Procedures Quick Reference flip chart, also known as the Rainbow Chart, which is found in all areas of the hospital for immediate step by step instructions for several emergency situations.

The administrator or administrator on call, and the nursing supervisor on duty, have authority to activate the Incident Command Center (ICC) and initiate all or portions of the emergency operations plan whenever a defined emergency exists. The person activating the emergency plan or Emergency Operating Center (EOC), serves as the Incident Commander until relieved by a senior administrator, or relinquishes responsibility to another individual for breaks or rest periods. It is better to activate the EOC early, and close it soon thereafter, then to delay activation and try to catch up with rapidly moving events.

Position Responsible for Emergency Operations Plan Activation

Position/Title	Contact Number
Primary: Administrator or AOC House Supervisor	See call sheet for AOC cell 760-920-3392 (Sup cell)

The healthcare district may receive three principle notifications: Advisory, Alert and or Activation.

- **Advisory** is given when no system response is needed but the potential for a response exists.
- **Alert** is given when a response is likely or imminent and should prompt an elevated level of response preparedness.
- **Activation** is given when a response is required.

The local Public Health Department or local emergency management office will usually receive these notifications at which time NIHD will be informed.

Important information to obtain as soon as possible should include but is not limited to:

- Type of incident, including specific hazard/agent, if known
- Location of incident
- Number and types of injuries
- Special actions being taken (e.g., decontamination, transporting persons)
- Estimated time of arrival of first-arriving Emergency Medical Service units.

Alerting Staff (On and Off Duty)
To notify staff that the EOP has been activated, those within the facility will be contacted first through the internal communication systems, if functioning, such as overhead paging, radios, and email.

Staff away from the facility at the time of activation will be contacted via the simplified texting alert system, and phone trees. The individuals responsible for contacting staff include the House Supervisor and individual department directors or managers.

Alerting Response Partners
NIHD works closely with several external partners. The IC or Disaster Manager will be the individual(s) responsible for contacting these external agencies to notify them that the EOP has been activated.

ORGANIZATION & ASSIGNMENT OF RESPONSIBILITIES

During an event, specific roles and responsibilities will be assigned to individual positions/titles as well as facility departments.

Essential Services
The table below identifies the department roles and responsibilities during plan activation.

Roles and Responsibilities

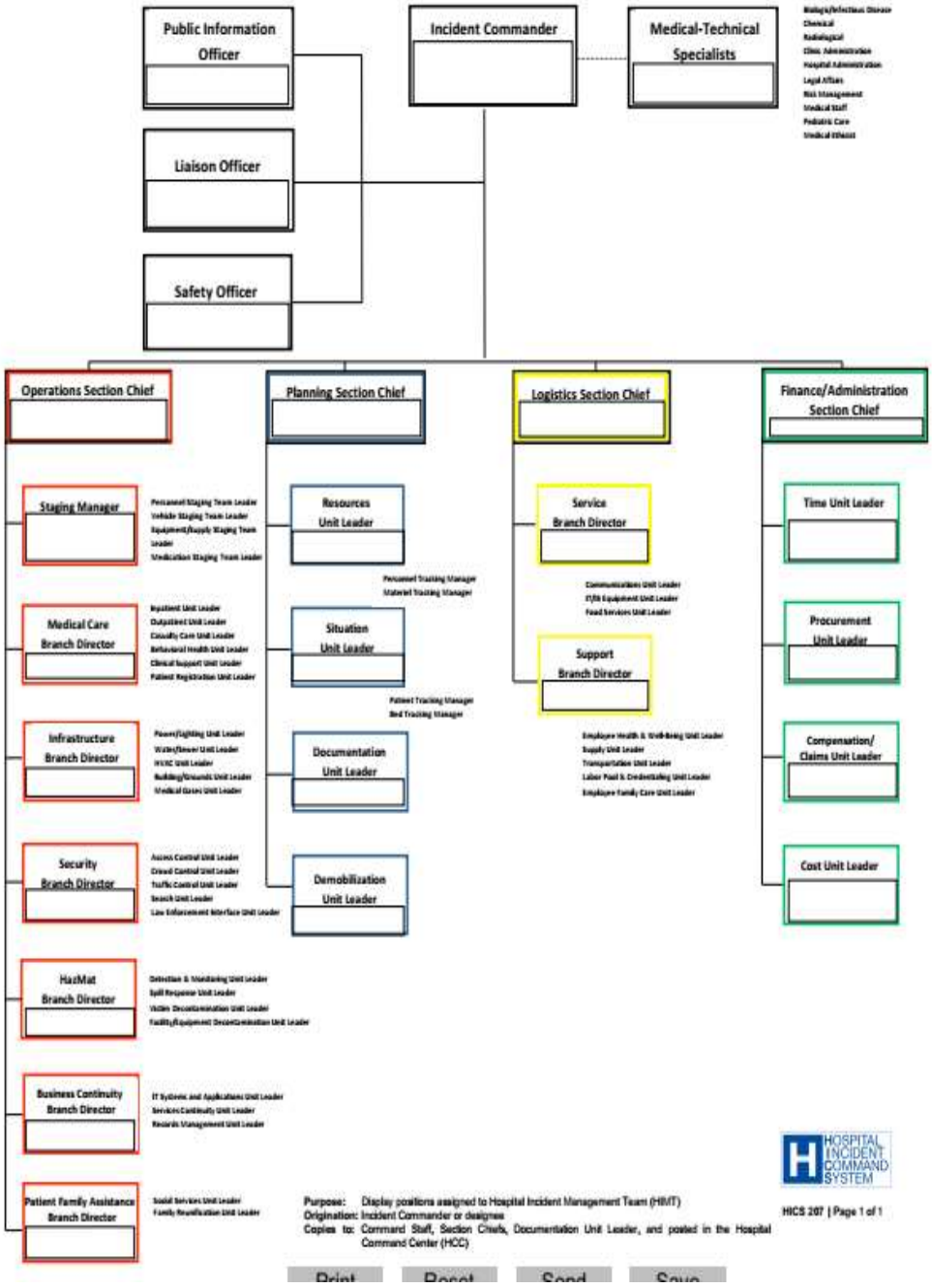
Essential Services	Roles and Responsibilities	Point of Contact by Position	Secondary Point of Contact
Administration	Incident Command	Chief Executive Officer	Chief Operations Officer
Medical Staff	Direction of Medical Staff Services	Chief of Emergency Medicine	Chief Medical Officer/Chief of Staff
Dietary	Emergency Food Provisions	Dietary Manager	Dietician
Housekeeping	Preparation and distribution of EVS related supplies.	Manager of EVS	EVS/Laundry Assistant Manager
Maintenance	Facilities Management & Utilities Operations	Director of Facilities	Maintenance Manager
Nursing	Patient Care Operations	Chief Nursing Officer	Inpatient/Outpatient Director of Nursing
Pharmacy	Emergency disposition of medications.	Pharmacy Director	Staff Pharmacist
Safety & Security	Maintain safe and secure facilities to operate under emergent situations.	Director of Facilities	Maintenance Manager
Materials Management/Supplies	Provide additional supplies as needed.	Director of Purchasing	Designated Administrator

Positions
Identifying and assigning personnel in the HICS system depends a great deal on the size and complexity of the incident. The HICS is designed to be flexible enough so that the number of staff needed to respond to an incident can be easily expanded or contracted. HICS Form 203 is used to document and assign staff to HICS specifics positions.

DIRECTION, CONTROL, AND COORDINATION

NIHD will coordinate emergency operations from the facility command center. The primary hospital command center will be located in the Second Floor Conference Room (H2063). Should an alternative location be needed off campus, NIHD can utilize one of their off-site locations (Birch Street, Joseph House, etc.) or any of alternative evacuation sites as described in the evacuation section of this document.

Command Structure
Command will be organized according to the ICS model to help manage the implementation of emergency responses and to integrate the facility response with the community and other health care providers. The ICS model plan is developed to manage emergency responses that have unpredictable elements. These are determined as part of the HVA and priority analysis. Plans that stand alone are designed to allow immediately available staff to effect instant activation and to manage the consequences. Most others are designed to use the ICS for emergency management.


Public Information Officer
Incident Commander
Medical-Technical Specialists
Liaison Officer
Safety Officer
Operations Section Chief
Planning Section Chief
Logistics Section Chief
Finance/Administration Section Chief
Staging Manager
Medical Care Branch Director
Infrastructure Branch Director
Security Branch Director
HazMat Branch Director
Business Continuity Branch Director
Patient Family Assistance Branch Director
Resources Unit Leader
Situation Unit Leader
Documentation Unit Leader
Demobilization Unit Leader
Service Branch Director
Support Branch Director
Time Unit Leader
Procurement Unit Leader
Compensation/ Claims Unit Leader
Cost Unit Leader
Purpose: Display positions assigned to Hospital Incident Management Team (HIMT)
Origination: Incident Commander or designee
Copies to: Command Staff, Section Chiefs, Documentation Unit Leader, and posted in the Hospital Command Center (HCC)
HOSPITAL INCIDENT COMMAND SYSTEM
HICS 207 | Page 1 of 1
Print
Reset
Send
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HICS Positions with Possible Hospital Staffing Position Candidates

HICS Position	Hospital Position
Incident Commander	Chief Executive Officer Administrator On Call Nursing Supervisor Chief Operating Officer Chief Medical Officer Director of Emergency Medicine
Public Information Officer (PIO)	Chief Executive Officer Administrator Manager of Marketing
Safety Officer	Facilities Manager Maintenance Manager DON Infection Prevention
Liaison Officer	Chief Executive Officer Manager of ED/Disaster Administrator
Operations Section Chief	Chief Nursing Officer Chief Operating Officer DON Inpatient or Outpatient Services Administrator
Medical-Technical Specialist(s)	Chief of Staff DON Infection Prevention Information Technologies

Orders of Succession

Orders of succession ensure leadership is maintained throughout the facility during an event when key personnel are unavailable. Succession will follow facility policies for key facility personnel and leadership.

Key HICS Position Assignments and Orders of Succession

Command and Control	Primary	Successor 1	Successor 2
Shift 1			
NIHD Representative	CEO	COO	CFO
Incident Commander	COO	CEO	CMO
Public Information Officer	Director of Marketing	CEO	COO
Safety Officer	Director of Facilities	Maintenance Manager	Designated Administrator
Liaison	Manager of ED/Disaster	Designated Administrator	Designated Administrator
Operations Section Chief	CMO	CNO	DON
Planning Section Chief	CNO	CMO	COO
Logistics Section Chief	Purchasing Director	Manager of ED/Disaster	Manger of Clinical Engineering
Finance/Administration Section Chief	CFO	Controller	Designated Administrator
Shift 2			
NIHD Representative	DON	House Sup	CNO
Incident Commander	House Sup	Clinical Manager	Designated Administrator
Public Information Officer	Designated Administrator	Director of Marketing	CEO
Safety Officer	Maintenance Manager	Quality Manager	Director of Facilities
Liaison	Quality Admin	HR Director	HR Manager
Operations Section Chief	Clinical Manager	DON	ED/Disaster Manager
Planning Section Chief	Clinical Manager	Designated Administrator	Quality Manager
Logistics Section Chief	Designated Administrator	Designated Administrator	Designated Administrator
Finance/Administration Section Chief	Controller	Designated Administrator	Designated Administrator

Delegation of Authority

Delegation of authority specify who is authorized to make decisions or act on behalf of NIHD leadership and personnel if they are away or unavailable during an emergency. Delegation of authority planning involves the following:

- Identifying which authorities can and should be delegated.
- Describing the circumstances under which the delegation would be exercised and including when it would become effective and terminate.
- Identifying limitations of the delegation.
- Documenting to whom authority should be delegated.
- Ensuring designees are trained to perform the emergency duties.

Emergency Authority Delegation

Authority	Type of Authority	Position Holding Authority	Triggering Conditions
Activate Facility Command Center	Emergency Authority	Administrator on call (AOC)/House Sup.	Immediate Threat, Operations Interruptions
Activate Emergency Annexes and the Emergency Operations Plan	Emergency Authority	Administrator on call (AOC)/House Sup.	Specific Incidents i.e. Power Outage, Active Shooter, etc.
Close facility	Emergency Authority	CEO/COO	Remaining in the facility is unsafe.
Represent facility when engaging Govt. Officials	Administrative Authority	CEO, COO, Compliance Officer	Unannounced Survey, local or national emergency.
Activate facility memorandum of understanding/mutual aid agreements	Administrative Authority	Senior Leadership	Additional resources necessary to operate.

Community-wide Response Involvement
Inyo County is part of the Mutual Aid Region VI (6) of the Southern District of the California Office of Emergency Services (Cal OES). The local emergency response group works with local, county and state planning agencies under Cal OES to define the role each provider will play during an emergency. The anticipated role of NIHD is to function as an acute medical care facility capable of effectively treating many levels of injury/illness. This role might be reduced if environmental circumstances affect the integrity of the campus or the utility systems essential to providing care.

Regional Healthcare Coalition Coordination
NIHD is a member of the Inyo County Unified Command and the Mono Inyo Healthcare Coalition. NIHD participates in regular planning meetings, exercises, and incident review/debriefings.

Both groups are made up of representatives of community emergency response agencies, health care organizations, and other organizations interested in developing coordinated regional emergency response plans. These crucial discussions between key community stakeholders guide the development of the NIHD Emergency Operations Plan and aid in general disaster planning. These groups meet on a regular basis.

INFORMATION COLLECTION, ANALYSIS, AND DISSEMINATION

Information is vital to making good decisions during a crisis. The needed information must be collected in a timely manner, analyzed and disseminated to "need to know" parties to enable them to determine their most appropriate course of action during the incident.

Information is collected and disseminated by various systems which may include:

- Inyo Mono Healthcare Coalition, Inyo County Unified Command, and the California Health Alert Network (CAHAN)
- Local/regional dispatch center
- Local emergency operations centers
- State Public Health Emergency Response Center/State Emergency Operations Center

Essential elements of information contain situational awareness details that are critical to the initial and ongoing response and recovery operations. The elements listed below may not apply to every event, may not be all-inclusive, and may be modified as needed and adjusted per operational period. NIHD is prepared to share this information during a disaster or emergency event with relevant partners:

- Facility operating status
- Facility structural integrity
- Status of evacuations/shelter in-place operations
- Status of critical medical services (e.g., trauma, critical care)
- Critical service/infrastructure status (e.g., electric, water, sanitation, heating, ventilation, and air conditioning)
- Bed or patient status

- Equipment/supplies/medications/vaccine status or needs
- Staffing status
- Emergency Medical Services (EMS) status
- Epidemiological, surveillance or lab data (e.g., test results, case counts, deaths)
- Point of Dispensing (POD)/mass vaccination sites data (e.g., throughput, open/set-up status, etc.)

COMMUNICATIONS

Day to day internal communications are carried out by emails, landline telephones, cell phones, handheld radios, and the internal overhead paging system. Back up communication means include handheld radios and cell phones should landlines and overhead paging systems fail. Internal code alert systems, internal networks, and the overhead paging system are considered vital to the lifesaving functions of the facility and will be considered an emergency if they fail.

External communications are carried out by landline telephones, emails, and cell phones. In the event of a failure of these systems, backup systems such as HAM Radios and Satellite phones, will be utilized.

NIHD has established common equipment, communications and data interoperability resources with emergency medical services (EMS), public health, and emergency management that will be used during incident response. This element will be part of the annual evaluation of NIMS compliance.

NIHD will establish common language that is consistent with language to be used by local emergency management, law enforcement, emergency medical services, fire department, and public health personnel. Plain language will be used in training and tested during drill exercises.

Notification of Civil Authority
Whenever a situation adversely affects NIHD's ability to provide services to the community, the healthcare district notifies appropriate authorities and city-county agencies and coordinates mutual aid and other response activities through the county Emergency Operations Center (EOC), if appropriate, or directly with receiving hospitals.

Several local agencies may play a role in managing an emergency. NIHD maintains a current list of these agencies and key contacts for various kinds of emergency situations. Contacts on the list include police, fire, Emergency Medical Services, local emergency management offices, utility companies and the Red Cross. The Incident Commander, or designee, notifies agencies as appropriate as soon as possible after an emergency response is initiated.

California Department of Health Services requires that all emergency/disaster related occurrences, which threaten the welfare, safety, or health of patients, must be reported to the Department of Health Services, Licensing and Certification Program.

Release of Information
Release of information to the news media follows procedures developed by the Public Information Officer (PIO) who act as spokesperson for the organization. The Incident Commander will release information as appropriate to the situation. In larger incidents, the assigned PIO for Inyo County EOC may act as spokesperson for the overall emergency event and report healthcare related information on behalf of the District.

Staff Notification
As previously noted, staff is notified of EOP implementation in several ways: overhead page, landline telephone, cellular phones, CAHAN notification, text message, or runners in the healthcare district. Off duty staff, physicians, and other licensed practitioners will be contacted via departmental call trees, e-mail notification, or mass notification system.

NIHD maintains an updated employee directory as well as a communication binder with all relevant authorities contact information.

In the event of an emergency or evacuation, the emergency response plan include a method for sharing and/or releasing location information and medical documentation for patients under the hospital's care to the following individuals or entities, in accordance with law and regulation:

- Patient's family, representative, or others involved in the care of the patient
- Disaster relief organizations and relevant authorities
- Other healthcare providers

Pertinent medical information is transported with each patient as a hard-copy (HICS-260) form.

MANAGEMENT OF PATIENT CARE ACTIVITY

NIHD has a specific plan that addresses management of patient care activities. The plans include procedures for discontinuation of elective treatment, evaluation of patients for movement to other units, release to home or transfer to other facilities as space is needed, management of information about incoming patients and current patients for planning, patient management, and informing relatives and others; and for transport of patients.

Victims will be admitted through the Emergency Department for initial triage and disposition to appropriate area as their condition warrants. Outpatient and elective procedures may need to be canceled and rescheduled, depending on resource allocation and facility status (i.e. condition of department, availability of staff & supplies) as a result of the emergency. Inpatients will be assessed on admission and placed in the following categories for discharge or transfer:

- **Very High Risk** – could only be cared for in an acute facility
- **High Risk** – could be transferred to an acute care facility
- **Moderate Risk** – would be transferred to another facility
- **Low Risk** – could be transferred home
- **Minimum Risk** – could be discharged immediately

Emergency Locations for Patient Care
All patients will enter through Emergency Department, after triage outside, as appropriate.
Patient Treatment Areas will be assigned as follows unless otherwise stated at the time of Code Triage.

- **Triage Area** – Emergency parking lot adjacent to the Emergency Department
- **Immediate Care Area** - Emergency Department
- **Delayed Care Area** – Rural Health Clinic
- **Minor Care Area** – Pioneer Medical Building
- **Morgue** – To be determined at the time of emergency

Pre-assigned locations of various functions (if activated) are as follows unless otherwise stated at the time of the Code Triage:

- **Healthcare District Command Center** – 2nd Floor Conference Room
- **Labor Pool** – Main Lobby
- **Family Center/Human Services Center** – Rehabilitation Building
- **Press Center** – Administration Meeting Room
- **Dependent Adult/Child Care Center/Pediatric-Safe Area (PSA)** – Rehabilitation Building

Patient Populations
NIHD intends to serve all populations that seek healthcare during emergencies including at-risk populations. NIHD may be forced to curtail or consolidate services offered depending on damage to facilities. Services may be transferred to undamaged areas of the hospital or other area hospitals. At-risk or vulnerable populations may have additional needs to be addressed during an emergency or disaster incident, such as medical care, communication, transportation, supervision, and maintaining independence. As needed based on the situation, NIHD would coordinate with the appropriate jurisdiction to request resources from regional, state, or federal assets to augment/increase care when needed and or available.

Evacuation
A facility evacuation plan is in place and can be implemented in phases. Relocation of staff away from the area of emergency may be undertaken by staff on the spot, moving to areas in adjacent zones. A full evacuation would be implemented if the impact of an emergency renders the healthcare district inoperable or unsafe for occupancy, and would be implemented with the involvement of the Administrator on Call in conjunction with senior leadership.

Shelter in Place
If NIHD administration, along with internal safety and public safety officials, determines that sheltering in place is the safest course of action for patients, staff, and volunteers, the command center will be activated to ensure patient care and staff needs are met. The command center will plan for and ensure care and sustenance needs are met along with ensuring a safe environment.

Chemical and Radioactive Isolation and Decontamination
The management of situations involving nuclear, biological, or chemical contamination is a joint effort between national, state, and local officials and the health care community. NIHD is prepared to manage a limited number of individuals contaminated with hazardous materials and to meet the care needs of others who have been decontaminated by other agencies.

If the facility is contaminated, a contractor experienced in the isolation and decontamination process will be contacted by the Incident Command staff. The Safety Officer, with Public Safety assistance, will assure isolation of the affected area until it is declared safe by appropriate experts.

Reunification
In the event of pediatric surge, mass casualty incident, or a disaster that requires activation of a surge/reunification plan, NIHD will work in conjunction with County Unified Command and other pertinent county partners to activate the Concept of Operations (CONOPS) of the Mono & Inyo Healthcare Coalition Pediatric Surge Plan. This plan outlines reunification in detail. Included in the plan is a pediatric identification and tracking system for both accompanied and unaccompanied children, rapid survey protocol to identify unaccompanied or displaced children, and defined Pediatric Safe Area (PSA) where uninjured, displaced or discharged children can be held until released to a caregiver. All forms, tools and documents are located in the CONOPS document found in the Disaster Planning Binder.

ESSENTIAL NEEDS FOR STAFF AND PATIENTS

Vulnerable Populations: Clinical activities for vulnerable patient populations including pediatric, geriatric, disabled, or have serious chronic conditions will be provided in the customary way but additional emphasis will be placed on security, safety, and mobility in terms of evacuation should it become necessary during an emergency. NIHD plans for the possibility of a surge in patients. Transportation of patients and supplies will be handled by several means, including but not limited to: NIHD care shuttles, local and county EMS, Inyo-Mono Transit Authority, local law enforcement, and local EMS air support.

Food and Other Nutritional Supplies: The Logistics Section will ensure that supplies in-stock, on campus are sufficient. Food service vendors will be notified and updated to provide for essential needs. The Dietary Department handles all food and water acquisition and delivery.

Medications and Related Supplies: Pharmacy handles both the acquisition and delivery of supplies. Pharmacy also has strategic inventory which contains counter measures for organic phosphates, nerve agents, and pesticides.

Medical/Surgical Supplies (including PPE): The Logistics Section in conjunction with the Purchasing Department handles the acquisition of supplies through its vendors and transport via its delivery personnel.

Medical Oxygen and Supplies: NIHD can provide bottles of gases supplied by normal vendors or disaster response contractors, or by a state resource request. NIHD has an emergency plan for medical gas failure.

Potable or Bottled Water: The Dietary Department handles food and water acquisition and delivery. The Dietary Department maintains an inventory of bottled water on campus for emergency use. NIHD can request local and state support for additional potable water as needed.

Personal Hygiene and Sanitary Needs: Personal hygiene and sanitary needs of patients during emergencies will be provided by NIHD. In addition, when water intended for hand washing is not available, the hospital utilizes waterless alcohol-based hand rub, which is maintained in ample supply at the hospital. The alternative means to personal hygiene can be baby wipes, personal wipes, or alcohol-based rubs. The alternative means to sanitation, if toilets are inoperable, is kitty litter, red bags in toilets, or positioning of water barrels and waste collection barrels. Limit changes of bed linen to those patients who have gross soiling. Environmental Services use of daily water will be curtailed as designated by the Manager of Environmental Services.

Management of Behavior Health Patients: During an emergency, NIHD will arrange for mental health consultation to patients through prearranged county services. The NIHD social worker should be made available to attend to the emotional needs of patients while awaiting county services in the event of a disaster. If necessary, patients should be transferred to a specialized behavioral health setting. If transfer of patients is not possible, then staff should be assigned to monitor patients accordingly to NIHD policy.

Surge and Alternative Care Sites

NIHD plans for the possibility of a surge in patients. The surge tent may be utilized for alternate care site. Other care sites may include Jill Kinmont Boothe School; Bishop City Hall, Pine Street School Gym, and the Tri County Fairgrounds. Transportation of patients and supplies will be handled by several means, including but not limited to: NIHD care shuttles, local and county EMS, Inyo-Mono Transit Authority, local law enforcement, and local EMS air support.

The Incident Command Center works with Operations, Planning and Logistics Chiefs to coordinate appropriate staff to assure required equipment, medication, medical records, staffing communications and transportation are mobilized to support relocation and management of patients at remote sites.

Patient Tracking
NIHD tracks the location of patients on site during an emergency using wristbands, bed assignment, and electronic management systems. HICS 254-Disaster Victim Patient Tracking Form will be utilized.
In the event that the computer system is down, the registration staff will coordinate the use of the Disaster Victim Patient Tracking Form with the START Triage system, both are maintained on paper. NIHD will ensure that all patient identification wristbands (or equivalent identification) is intact on all patients. If patients are evacuated, the HICS 260 - Patient Evacuation Tracking Form will be used. When more than two patients are being evacuated, the HICS 255 - Master Patient Evacuation Tracking Form should be used to gain a master copy of all those that were evacuated. Information on forms should include, but is not limited to: patient/resident name, date of birth, Medicare/Medicaid number, if minor (accompanied or not), evacuation site location, date of evacuation, arrival time at evacuation site, date of return to facility (if known), and comments/notes.

In addition, NIHD will utilize third-party information such as local emergency response agencies and the Red Cross as appropriate to assist families in locating patients.

Staff Tracking
The management chain of command as well as incident command resource management principles will be used to track the location of on-duty staff.

NIHD uses staff identification badges to identify caregivers and other employees during mass casualty or major environmental disasters. All staff presenting to the facility will need to have a visible NIHD ID in order to enter. Staff without ID's must report to the Labor pool, be positively identified, and receive a temporary badge or other approved alternate. Key members of the Incident Command team are issued a vest with the ICS Command Title visible to identify their role in the response. These vests move with the job title as more senior staff become available, and during longer incidents where jobs are handed from staff to staff. The Liaison Officer from the Incident Command team is assigned to work with law enforcement, fire services, emergency management agencies, contractors, the media, and volunteer responders to issue NIHD emergency identification or to determine what form of identification will be required for each responding group.

SAFETY AND SECURITY

NIHD completes security assessments to address vulnerabilities campus wide. The Director of Facilities in conjunction with the in-house Security Team is responsible for the overall planning of the Security Services response in day-to-day operations and during emergency events. If insufficient security staff exists to cope with the emergency, a request for assistance from local law enforcement agencies shall be completed.

NIHD requires the facility to establish a command center, a staging or assembly area, and a perimeter with controlled or monitored access points. The on-duty Security Officer or Incident Commander shall direct other responsibilities as deemed necessary. NIHD security and local law enforcement will maintain access, crowd and traffic control. Volunteers from the labor pool would be used to expand the security force if needed.

The restriction of visitors and guests during critical incidents is a necessary procedure to maintain order, safety, and security for patients, staff and visitors. Upon the notification or realization that an imminent threat to the clinical environment exists, a decision to initiate limited facility access shall be considered through the collaboration of the Administrator on Call, Incident Commander, House Supervisor and the on-duty Security Officer.

The extent of the limited access and entry shall be determined through careful examination of the threat and impact on facility operations.
There are 6 levels of lockdown with varying degrees of access, entry and exit. See Lockdown Policy.

CYBER SECURITY

NIHD has a Cyber Security Incident Response Manual (CSIRM) and Disaster Recovery and Planning (DRP) in place. The purpose of the plan is to have established procedures for managing cyber security incidents that may affect the hospital's information technology systems, staff, patients and visitors. The plan outlines the roles and responsibilities of hospital staff, communication protocols, and incident response procedures.

ALTERNATE SOURCES OF UTILITY SYSTEMS

Alternate emergency plans for supply of utilities for patient care are maintained for these contingencies. Plans include use of emergency power, backup systems for water, HVAC, and medical gas failure. Managers and staff in all departments affected by the plans are trained as part of organizational wide and department specific education. The plans are tested from time to time as part of the regularly scheduled drills of the EOP and actual outages of utility systems.

LOGISTICS

Resources and Assets

Acquiring and Replenishing Food, Water, Medications and Supplies

The amounts and locations of current food, water, pharmaceuticals, medical and non-medical supplies, are evaluated to determine how many hours the facility can sustain itself before needing re-supply. This gives the facility a par value on supplies and aids in the projection of sustainability before terminating services or evacuating if needed supplies are unable to reach the facility. Supplying NIHD in an emergency will be initially satisfied by pulling from local resources. As replenishment becomes necessary, resources will be requested from vendors.

If NIHD is unable to acquire sufficient resources through outside vendors and pre-positioned arrangements to meet the healthcare needs of the community, the Logistics Chief and/or Director of Purchasing will communicate these need to the county and utilize the Medical Health Operation Area Coordination (MHOAC) to help locate resources and replenishments at the state level. If sufficient supplies cannot be acquired through regional or state medical supply, the county emergency management team will provide assistance with coordinating the transfer of patient's to other facilities upon request.

Monitoring Quantities of Resources and Assets

The Logistics Chief and/or assigned staff is responsible for monitoring quantities of assets and resources during an emergency. A Resource Accounting Record form (HICS Form 257) should be used when resources and assets are tracked during an emergency.

96 Hour Sustainability

Establishing the sustainability of resources is crucial to determining if services can be rendered during a disaster for three days, based on the facility's hazard vulnerability analysis (HVA). Resource inventory is currently maintained to provide for approximately 96 hours. If this cannot be sustained through current inventory, agreements are in place with suppliers and vendors for the remaining days. If supplies cannot be obtained, policies and procedures are in place in the event the facility may need to evacuate or temporarily close.

Management and Assignment of Staff

Following a disaster, facility personnel must be accounted for. Their location and status should be ensured by unit supervisors, along with the status and location of all patients. They will be tracked during the emergency plan activation to ensure safety and accountability.

Facility personnel may not be assigned to their regular duties or their normal supervisor during emergency plan activation. They may be asked to perform various jobs that are vital to the operation but may not be their normal day to day duties. The Labor Pool is the designated reporting location for reassignment of available staff and volunteers and will be located in the NIHD main lobby. Staff will be assigned as needed and provided information outlining their job responsibilities and who they report to during the event.

If necessary and appropriate, staff may be reassigned to another campus location. Furthermore, staff may be needed to accompany evacuating patients. Staffing assistance from state agencies can be utilized if needed. In the case that NIHD has the need to use volunteers, NIHD has a plan in place to grant emergency privileges to providers. NIHD may use temporary staffing services or travelers to address staffing needs as well.

The Emergency Department physician on duty at the time of the emergency will be responsible for providing medical services for the "Immediate Care" area. Additional physicians may be called in depending on the number of casualties and the nature of their injuries. If "Delayed Care" and/or "Minor Care" areas are established, a physician will be asked to coordinate medical efforts for these functions. The medical staff reviews the EOP at the Medical Executive Committee annually.

Volunteers are responsible for knowing the overhead page, CODE TRIAGE, for the activation of the emergency preparedness plan. Those volunteers assigned to specific departments are responsible to return to their assigned department, unless released to the labor pool. All other volunteers are responsible for reporting to the labor pool, if activated.

Managing Staff Support Needs

All NIHD personnel are considered essential during emergency response situations. The healthcare district recognizes its responsibility to provide meals, rest periods, housing, and psychological support to staff. In addition, the healthcare district recognizes that providing support such as communication services and dependent care to employees' families during emergency situations allows employees to respond in support of the essential functions of the healthcare district. The Operations Chief, working through the Human Service Director and his/her unit leaders will initiate support programs and activities, based on the demands of the specific emergency including but not limited to:

- Emergency lodging and meals
- Emergency transportation
- Emergency child care
- Psychological and bereavement counseling
- Staff prophylaxis or immunizations

Procedures are in place to address the transportation and housing of staff that may not be able to get to or from the facility during an emergency. In addition, a procedure is in place for incident stress debriefing. Staff who are involved in emergency operations are offered an opportunity to address incident related issues with qualified behavioral health professionals.

Finance

Expenditures will be tracked from the beginning of the disaster to include personnel time, supplies, equipment use, rental of equipment, etc. A designated cost center may be assigned given the duration of the disaster. The Finance Section will have processes in place to ensure the needed tracking occurs. Forms that may be used for

expense tracking include HICS 252: Section Personnel Time Sheet, HICS 253: Volunteer Registration, HICS 256: Procurement Summary Report, and HICS 257: Resource Accounting Record.

RECOVERY

NIHD has recovery plans to return operations to normal functions after most emergencies. The recovery plans are activated near the completion of the Emergency Operations Plan (HICS). The Incident Commander will determine the degree of activity required. Preset activity that is activated by the "all clear" includes action by medical records to capture the records of emergency services, capture of costs by patient billing, and return of facilities to their original and normal use. The plans also call for resetting and recovering emergency equipment and supplies, and documentation of the findings of the after the event debriefing. If substantial damage has been done to the facility, plans for reconstruction and renovation will be developed at that point. Documentation of current assets (buildings, equipment, etc.) has been recorded for baseline.

Documentation for FEMA assistance will be based on pictures of damages and repairs, documentation and notes on damages and repairs, newspaper reports and stories, video footage from television stations, and records of all expenditures, receipts, and invoices. Short- term recovery frequently overlaps with response.

Initiation and Recovery
The decision to enter into the recovery stage of an event is made by the CEO/Designated Administrator. In this stage, the hospital will undertake recovery procedures to return the facility to normal operations.

Recovery Protocol
In order to efficiently recover from an event, protocols must be followed. Listed below are protocols important to recovery operations.

Recovery protocols:

- Prioritize health care service, delivery, and recovery objectives by organizational essential functions.
- Maintain, modify, and demobilize healthcare workforce according to the needs of the facility.
- Work with local emergency management, service providers, and contractors to ensure priority restoration and reconstruction of critical building systems.
- Maintain and replenish pre-incident levels of medical and non-medical supplies.
- Work with local, regional, and state emergency medical system providers, patient transportation providers, and non-medical transportation providers to restore pre-incident transportation capability and capacity.
- Work with local emergency management, service providers, and contractors to restore information technology and communication systems.
- Prepare after-action reports, corrective action reports, and improvement plans.

Restoration of Services
The CEO/Designated Administrator will coordinate the restoration of services after an emergency situation affecting the hospital.

Staff/Patient Re-Entry
The CEO/Designated Administrator will work with the California Department of Public Health Licensing & Certification Unit to give approval for the return of staff and patients to the facility.

Staff Debriefing
A debriefing will be conducted within 30 days of the incident to collect lessons learned from the incident or exercise. These lessons learned will be used to revise and update the plan. The ED/Disaster Manager or designee will be responsible for coordinating the debriefing.

After-Action Report
After any real incident or exercise where the emergency operations plan is activated, an after-action report (AAR) will be written. The purpose of the AAR is to document the overall performance of the organization during the exercise or real event. It will contain a summary of the scenario or events, staff actions, strengths, issues, opportunities for improvement, and best practices.

The purpose of the after-action report is to ensure issues and opportunities for improvement are adequately addressed to improve response capabilities to future events. If necessary, an improvement plan will be developed to include a list of issues to be addressed, tasks that will be performed to address them, individuals responsible for completing the tasks, and a timeline for completion.

The ED/Disaster Manager will be responsible for coordinating the development of the after-action report and will ensure identified improvements are completed within the targeted timeframes.

Request for 1135 Wavier
The 1135 waiver allows reimbursement during an emergency or disaster even if providers can't comply with certain requirements that would under normal circumstances bar Medicare, Medicaid or Children's Health insurance program (CHIP). The waiver applies to federal requirements only and not state licensures. Waiver requests can be made by sending an email to the CMS Regional Office in California. Information of the facility and justification for requesting the waiver is required.

PLAN DEVELOPMENT AND MAINTENANCE

The ED/Disaster Manager is the qualified individual to lead the Emergency Management Program and works under the general direction of the Chief Nursing Officer (CNO), the Chief Medical Officer (CMO) and the Chief Executive Officer (CEO). The ED/Disaster Manager in collaboration with the Disaster Management Committee, is responsible for managing all aspects of the Emergency Management Program. The Disaster Management Committee advises senior leadership regarding emergency management issues which may necessitate changes in policies and procedures, orientation or education of personnel and/or purchase of equipment.

The Disaster Management Committee is responsible for the following:

- Oversees the emergency management program
- Provides input and assists in the coordination of the preparation, development, implementation, evaluation, and maintenance of emergency management program.
- Meets quarterly
- Includes multidisciplinary representatives (senior leadership, nursing services, medical staff, pharmacy services, infection prevention, facilities engineering, security, and information technology)

In addition, senior leadership provides direct oversight and support of the Emergency Management Program through the Disaster Management Committee. Senior leadership reviews all after action reports (AAR) and improvement plans related to the emergency management program.

Annual Program Evaluation

The Disaster Management Committee is responsible for performing the annual evaluation of the EOP. The annual evaluation examines the objectives, scope, performance, and effectiveness of the EOP and the HVA. The annual evaluation uses a variety of information sources including reports from internal policy and procedure review, after action reports, and summaries of other activities. In addition, findings by outside agencies, such as accrediting or licensing bodies or qualified consultants, are used. The findings of the annual evaluation lead to changes/improvements in the emergency management plan. The annual evaluation is presented to the Disaster Committee and to senior leadership via the Executive Committee. The emergency management plan is required reading for all NIHD workforce.

Training Program

Each new staff member of NIHD participates in a general orientation that includes information related to the EOP. Examples of such information include; emergency preparedness procedures, job-specific roles, emergency communication plans, Rainbow Chart, and location of emergency supplies and equipment.

The Human Resources Department conducts the general orientation program and is responsible for scheduling, managing and documenting staff completion.

New staff members also receive a department-specific orientation. Each department manager or Clinical Staff Educator (CSE) provides new staff members with a department-specific orientation to their role in the Emergency Management Program. Information specific to the Emergency Management Program is included in the continuing education program. The ED/Disaster Manager in coordination with the Disaster Committee, collaborates with individual department heads to develop content and supporting materials for general and department-specific orientation and continuing education programs.

Exercise Program

NIHD will test its plan and operational readiness at least twice per year, utilizing high hazard scenarios per the HVA. NIHD will participate in a community full scale exercise at least annually; if such exercise opportunity is accessible. If not accessible, the hospital will conduct a full scale exercise. NIHD will also conduct one additional exercise of any type at least annually.

All exercises and real events will be documented using the AAR template. This report shall be completed within 60 days of the exercise or real event. The ED/Disaster Manager will be responsible for coordinating the exercises, after action reporting, and improvement planning. The AAR or improvement plan will be incorporated into the emergency plan as soon as it is feasible. All improvement items will be tracked.

All exercises will incorporate elements of the National Incident Management System and Hospital Incident Command System. Future exercises should be planned and conducted to reflect anticipated hazards, incorporating gaps and improvement action items identified during previous exercises and real events.

Independent Study (IS) IS-100, IS-200, IS-700 and IS-800 are available to all healthcare district personnel likely to have a leadership role in emergency preparedness, incident management, and or emergency response during an incident.

DEFINITIONS

a. **Hospital Incident Command System (HICS)** – The "All Hazards" plan used to manage emergencies. This describes a management method that may be adapted to most emergency situations, both internal and external.
b. **Emergency Operations Plan (EOP)** – The program to identify, plan for, prepare for, drill, recover from, and evaluate the response to the drills and actual emergencies, and to identify processes and elements that may be improved with better planning, equipment, or training.
c. **Emergency -** Emergencies are defined as natural or manmade events which cause major disruption in the environment of care such as damage to the organization's buildings and grounds due to severe wind storms, tornadoes, hurricanes, earthquakes, fires, floods, explosions; or, the impact on patient care and treatment activities due to such things as the loss of utilities (power, water, and telephones), riots, accidents or emergencies within the organization or in the surrounding community that disrupt the organization's ability to provide care.
d. **Hazard Vulnerability Analysis (HVA):** a structured process to evaluate the potential for conditions or events that are likely to have a significant adverse impact on the health and safety of the patients, staff, and visitors of NIH or on the ability of NIH to conduct normal patient care and business activities.

REFERENCES:

1. California Office of Emergency Services (CALOES), (2023) https://www.caloes.ca.gov/

2. Federal Emergency Management Agency (FEMA), ICS-100: Introduction to Incident Command System, (2023) https://www.fema.gov/national-incident-management-system

3. Joint Commission Resources, (2023) Emergency Management in Healthcare: An All Hazards Approach. https://www.jointcommission.org/resources/patient-safety-topics/emergency-management

4. Comprehensive Accreditation Manual for Critical Access Hospitals (CAMCAH), (2023) Emergency Management Reference Guide https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_w_cah.pdf

5. Centers for Medicare Services (2023) 1135 Waivers Emergency Preparedness https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/1135Waivers

CROSS REFERENCED POLICIES AND PROCEDURES:

1. HICS Organization Chart
2. Credentialing Health Care Practitioners in the Event of a Disaster
3. Emergency Room Overcrowding
5. Capacity Management: Patient Surge
6. Evacuation Policy
7. Emergency Response Plan-Medical Gas Failure
8. Emergency Response Plan-HVAC Failure
9. Lockdown Plan

10. Active Shooter
11. Disaster Management Committee
12. Disaster Plan Perioperative Unit
13. Sterile Processing Disaster Plan
14. Triage of Patients Suspected of Ebola
15. Cyber Security Incident Response Manual

RECORD RETENTION AND DESTRUCTION: Emergency Operation Plan documents need to be retained for 15 years.

Supersedes: v.5 Emergency Management Plan

NORTHERN INYO HEALTHCARE DISTRICT
NON-CLINICAL POLICY AND PROCEDURE

Title: Licensure of Nursing Personnel		
Owner: Interim CEO, COO, CNO	Department: Nursing Administration	
Scope: Registered Nurses, Licensed Vocational Nurses		
Date Last Modified: 07/02/2025	Last Review Date: No Review Date	Version: 6
Final Approval by: NIHD Board of Directors	Original Approval Date: 08/01/2011	

PURPOSE:

To ensure that all Northern Inyo Healthcare District (NIHD) Registered Nurses (RN) and Licensed Vocational Nurses (LVN) who practice nursing have a current active California license to practice nursing before starting work and thereafter.

POLICY:

1. RN and LVN whose job descriptions meet the requirements for nursing practice in the State of California will maintain a current license to practice as a RN or LVN.
    a. RN license granted from California Board of Registered Nurses.
    b. LVN license granted from California Board of Vocational Nurses and Psychiatric technician examinees.
2. According to California law, RN's or LVN's may be granted temporary permit licenses.
3. RN and LVN staff that does not have an active current license will not be allowed to practice nursing.
4. All licenses including temporary licenses must be renewed on or before the expiration date.
5. Graduate nurses who possess an interim Permit from the California Board of Nursing may practice professional nursing at NIHD under the supervision of an RN.
6. The Human Resources Department verifies licensure with the Board of Registered Nursing and the California Board of Vocational Nurses and Psychiatric technician examinees via the primary verification.
7. The Human Resources Department monitors and verifies RN and LVN licensure prior to expiration of Licensure.
8. Nurses are responsible for obtaining their own license and renewal.
9. Advanced Practice Nurse Licensure as an RN and Advanced Practice Nurse shall be maintained by the Medical Staff Office.
10. An RN or LVN with an Interim Permit who fails the examination or does not receive licensure prior to the Interim Permit Expiration, will no longer practice as a nurse.
    a. Staff failing boards may apply for any open position to which they are eligible.

PROCEDURE:

1. Upon hire or on the RN or LVN first day of employment, the RN or LVN license, Temporary license, or Interim Permit shall be viewed by the Human Resources Department and the number and expiration date documented on the Licensure Tracking form (see attached) kept in the Employee's HR file.

a. Record of Interim Permit shall be kept in the same manner as the licenses. If the nurse passes the examination, the Interim Permit remains in effect until a regular license is issued or until the Interim Permit expiration date. If the nurse fails the examination, the Interim Permit shall be terminated upon notice by mail, or if the nurse fails to receive the notice, upon the date specified on the Interim Permit.

2. Each month the RN and LVN license file will be reviewed by the Human Resources Department for next month expirations.
    a. Notice of need for renewal will be sent to the employee and manager via e-mail.
3. Employees who have not renewed their license by the expiration date will:
    a. Be suspended pending license verification. The employee may choose to use PTO.
    b. The RN or LVN will not be allowed to work in another position during the lapsed licensure period.
    c. The RN or LVN has four weeks to complete the requirements for licensure renewal. If licensure is not completed within the four-week time frame, the employee will be terminated for employment at Northern Inyo Healthcare District.

REFERENCES:

1. The Joint Commission (CAMCAH Manual) (Jan 1, 2022) HR 01.02.05 EP1.
2. Scope of Regulation Excerpt from Business and Professions Code Division 2, Chapter 6. Article 2 Section 2725.
3. California Board of Registered Nursing - https://www.rn.ca.gov/

RECORD RETENTION AND DESTRUCTION:

Licenses are maintained in the employee personnel file by the Human Resources Department. These will be maintained for the duration of the employment, plus 6 years.

CROSS REFERENCED POLICIES AND PROCEDURES:

1. Licensure of Nursing Personnel
2. Licenses and Registrations
3. Termination
4. Termination Benefits

Supersedes: v.5 Licensure of Nursing Personnel

NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL POLICY AND PROCEDURE

Title: Medical Staff Department Policy - Pediatrics		
Owner: Medical Staff Director	Department: Medical Staff	
Scope: Practitioners Privileged in Pediatrics		
Date Last Modified: 07/02/2025	Last Review Date: No Review Date	Version: 4
Final Approval by: NIHD Board of Directors	Original Approval Date: 07/21/2021	

PURPOSE: To delineate clear expectations for practitioners in the department of pediatrics at Northern Inyo Healthcare District (NIHD).

POLICY: All practitioners granted privileges in the department of pediatrics will adhere to the following protocols.

PROTOCOL:

1. Call:
    a. Practitioners participating in call coverage shall return phone calls as soon as possible and within 10 minutes and be at bedside as soon as possible and within 30 minutes if needed in an emergency. Non-emergent consults will be completed within 24 hours and within a reasonable amount of time as agreed upon by the pediatric practitioner and the practitioner requesting consult.
        i. **Exception**: Practitioners whose home residence is in Mammoth Lakes, CA have the option to take call from their home if patient care allows. These practitioners shall be at the bedside within 45 minutes if needed in an emergency. The practitioner has the responsibility to ensure adherence to this policy and shall not take call from Mammoth Lakes, CA in the event that travel time is expected to be longer than 45 minutes, such as due to weather conditions. At all times, the Chief of Pediatrics, the Chief of Staff, and/or the Medical Executive Committee reserve the right to require a practitioner stay within a 30-minute radius if it is reasonably believed that a longer response time may compromise the delivery of safe patient care.
    b. All pediatrics patients admitted will be rounded on in the hospital within 24 hours of admission and everyday thereafter.
        i. Healthy term newborns born before 5pm will be examined before the end of the day.
        ii. Healthy newborns born after 5pm may be examined the next day unless nursing or OB provider request sooner assessment.
        iii. Newborns with complications will be examined as soon as reasonably possible or as agreed upon by the pediatric practitioner and the staff member identifying the concern.
        iv. Pediatric patients will have orders placed at the time of admission and be examined prior to admission in the clinic or emergency department.
2. Meeting attendance:
    a. Attend monthly pediatric provider meetings and monthly pediatric team meetings.
    b. Attend additional meetings per medical staff bylaws requirements or assignment to committees.
    c. Advanced Practice Providers (APPs) can vote at pediatric department meetings and vote for department Chief.

3. Credentialing:
    a. Physician practitioners in the department of pediatrics must be board certified or board eligible by the American Board of Pediatrics and are strongly encouraged to be members of the American Academy of Pediatrics.
4. Focused Professional Practice Evaluation (FPPE):
    a. Practitioners new to NIHD will be expected to complete FPPE as per policy. For clinic work FPPE is expected to include at least eight days of chart review of all patients seen. Inpatient work will include chart review of at least the first eight newborn admissions and eight inpatient pediatric admissions.
5. Ongoing Professional Practice Evaluation (OPPE):
    a. Practitioners will be expected to participate in all requirements of OPPE as per medical staff policy. Providers must average eight neonatal encounters and four pediatrics encounters every six months over the OPPE cycle. If this average has not been met at re-credentialing, additional proctoring may be assigned in order to maintain admitting privileges.
6. Peer Review:
    a. Inpatient charts identified by critical indicators will all be subject to peer review as per the peer review policy.
    b. This will include ongoing peer review of 10 outpatient encounter charts each month.
7. Re-Entry:
    a. Pediatric practitioners may be eligible for re-entry as per policy.

REFERENCES:

1. None

RECORD RETENTION AND DESTRUCTION:

1. Life of policy, plus 6 years

CROSS REFERENCE POLICIES AND PROCEDURES:

1. Northern Inyo Healthcare District Medical Staff Bylaws
2. Medical Staff Peer Review and Professional Practice Evaluations
3. Practitioner Re-Entry Policy

Supersedes: v.3 Medical Staff Department Policy - Pediatrics

NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL POLICY AND PROCEDURE

Title: Pathways for Development, Review and Revision of Nursing Standards		
Owner: Interim CEO, COO, CNO	Department: Nursing Administration	
Scope: Nursing Department		
Date Last Modified: 06/10/2025	Last Review Date: No Review Date	Version: 3
Final Approval by: NIHD Board of Directors	Original Approval Date: 08/2013	

PURPOSE:

1. Development of nursing standards describe and guide how the nursing care needs of patients and/or patient population are assessed, evaluated and met including the competency of the staff.
2. This policy and procedure addresses the systematic process, including the Chief Nursing Officer (CNO) accountability and responsibility for nursing standard development, review, revision, approval and implementation.

DEFINITIONS:

1. Structure Standards: Define the foundation for all the conditions and mechanisms needed to operate a nursing system.
   a. Generic Nursing Structure Standards are written plans, policies and/or procedures and are located in the Nursing Administration section of the policy manual application.
   b. Department Specific Structure Standards are written plans, policies and/or procedures and are located in the Department Specific area within the policy manual application.
2. Process Standards: Define the actions, knowledge, and skills needed by nursing in the delivery of care and what constitutes that care. Process standards have been categorized into five formats:
   a. Policy and Procedures (P&Ps);
   b. Forms;
   c. Standards of Care;
   d. Standards of Practice; and
   e. Job Descriptions

POLICY:

1. The CNO has ultimate authority for the oversight of Nursing Standards.
2. The CNO in collaboration with the Director's/Managers of Nursing, District Education Coordinator, House Supervisors, Clinical Informatics, develops the structure standards located in the Nursing Administration Manual (NAM).
3. The Directors of Nursing have been delegated the authority to lead the process for the review of direct patient care process standards including Policies and Procedures (P&P), Forms, and Standards of Practice (delegated and independent). Prior to implementation assurance of consistency with the NIHD Mission, Vision, Values and Goals, evidence based practice, legal and ethical considerations and responsiveness to performance improvement and other evaluation mechanisms is required.
4. The Clinical Consistency Committee is responsible for assuring collaboration and involvement with other disciplines and seeking Medical Staff Committee approval where necessary (follow NIHD Hospital Policy and Procedure)

5. The DON/Manager is responsible for developing, reviewing and revising Nursing Standards of Care (what the patient/family can expect) for their department or patient population. Other standards of Care may be developed for patient populations that may be care for in greater than one department i.e. Care of the Dying.
6. Nursing Standards of Practice describe activities that define nursing expectations that nursing staff perform to provide the realms of nursing practice (delegated, independent and interdependent) to patients and their significant others.
    a. The care plans developed for the patient's clinical diagnosis reflect delegated and independent realms of nursing practice.
    b. Disease Specific Order Sets reflect the interdependent realms of practice.
7. Interdisciplinary P&P's (assure one level of care and apply to more than one department) serve as the procedure guideline to provide patient care based on the standards of care/practice and designated by the scope of who can perform the P&P.
8. Department and/or Service Line specific P&P's (assure one level of care and apply to one department only or a service line) and are located in the Departments (Structures/Process Standards) Manual within the electronic policy application found on the NIHD intranet.
9. The Hospital Policy and Procedure format is the template utilized for developing all P&P's. The Policy Steering Committee has oversight of format development utilized within the NIHD policy application.
10. A Nursing Services Overall Position Skills Checklist (based on job description, licensure, practice, procedures, certification, and training) is utilized upon hire of all new personnel.
11. Up to Date is the reference for all nursing units and specialties in addition to American Nursing Association Scope and Standards of Practice for each specialty area. Additionally, The Joint Commission Standards, including elements of performance, are followed.
12. Job Descriptions reflect broad competency statements of what the employee must know in the performance of the employee's job.
    a. Performance standards specify what the employee must be able to demonstrate to meet the competency statement.
    b. A Job Description Clinical Skills Checklist, utilized for competency validation, exists for each position responsible for direct patient care.
13. Forms (to use during downtime) will be developed reflective of the electronic medical record (EMR) that support the nursing process (delivery of care) for the specific patient population.
14. Required review or revision of Structures and Process Standards no less than every two years.
    a. Changes in practice based on research, new technology, changing populations, performance improvement, risk reduction / safety information will direct the review and modification of structures / process standards.
15. New Process Standards that involve multiple disciplines require collaboration for development.
16. Structure and Process Standards will be available on the NIHD intranet Policy Manual application. *OneSOURCE* is a reference for clinical equipment. It can be located via the NIHD Intranet.

PROCEDURE:

1. Staff may request a Process Standard Development review or revision working with nursing leadership.
2. Lippincott Procedure Manual may be utilized in lieu of development of procedures. Critical notes applicable to NIHD practice will be included as necessary.
3. Use of approved clinical reference manuals for nursing procedures not described in the NIHD policy manual application is acceptable.
    a. All NIHD info-bases will supersede information given in the reference manuals.
    b. Approved Reference Manuals will be located in all nursing departments.
4. The Clinical Consistency Oversight Committee (CCOC) will oversee the approval of Nursing Policy and Procedure. Anyone developing a draft Policy and Procedure will send the document to the CCOC

Chair for member oversight. The CCOC member or designee will request additional feedback from risk management, compliance officer and/or other committees for approval.
    a. See charter of CCOC listed in policy manual application
5. The department/ or job specific clinical staff educator will ensure that competency check off is completed via one of the list below:
    a. Use Competency Validation Form to validate skills completion;
    b. Policy Manager Review;
    c. Learning Management System review and testing process
6. After staff education, the effective date on the Policy Procedure will indicate the Policy and Procedure goes into effect. Until that time, the policy remains in draft.

REFERENCES:

1. CAMCAH (January 2023), TJC Nursing Functional Chapter, NR 02.01.01 and NR 02.03.01

RECORD RETENTION AND DESTRUCTION:

CROSS REFERENCE POLICIES AND PROCEDURES:

1. Development, Review and Revision of Policies and Procedures
2. Nursing Quality Assurance/Performance Improvement (QAPI)
3. Plan for the Provision of Nursing Care

Supersedes: v.2 Pathways for Development, Review and Revision of Nursing Standards

NORTHERN INYO HEALTHCARE DISTRICT
NON-CLINICAL POLICY

Title: Responsibilities of Nursing Students and District Staff		
Owner: Interim CEO, COO, CNO	Department: Nursing Administration	
Scope: Nursing Leadership, Human Resources, Infection Control, Human Resources, District Education		
Date Last Modified: 06/10/2025	Last Review Date: 06/12/2025	Version: 5
Final Approval by: NIHD Board of Directors	Original Approval Date: 07/06/2006	

PURPOSE:

To define guidelines for student expectations while at the District during nursing program clinical rotations.

POLICY:

1. All students will show documents to demonstrate meeting the employee health requirements prior to beginning clinical rotations at the District. Clearance will be done by the NIHD Employee Health Specialist RN. Student health records will be retained by the college/university.
2. Students will be required to complete compliance and infection control training modules, assigned via the District Education Department and be cleared by the Human Resources department prior to beginning clinical rotations at the District.
3. The School/University is responsible for assuring the physical fitness of students. The instructor will make sure appropriate precautions are followed if a student has an infectious disease.
4. Students will wear appropriate uniforms and name badge, with clear identification of student role, while in the District facilities.
5. Students are subject to all District policies and procedures while in the facility.
6. The instructor is ultimately responsible for the training and education provided for the student.
7. The NIHD licensed personnel is responsible for the care given to the patient by the student.
8. There needs to be effective communication and coordination of care between the NIHD licensed personnel and clinical instructor.
9. Students will not be included in the District staffing requirements.

REFERENCES:

1. CAMCAH 2022; HR.01.02.07 – EP 5.
2. CAMCAH 2022; IC.01.04.01 – EP 1.
3. CAMCAH 2022; LD.03.06.01 – EP 2.
4. CAMCAH 2022; NR.02.03.01 – EP 5.

CROSS REFERENCE P&P:

1. Nursing Students Medication Administration/Supervision
2. Nursing Students Requesting Clinical Preceptorship Rotation
3. Observation in the Operating Room

RECORD RETENTION AND DESTRUCTION:

The university or college is responsible for the maintenance of the student records, including health records.

Supersedes: v.4 Responsibilities of Nursing Students and Hospital Staff

NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL STANDARDIZED PROCEDURE

Title: Standardized Procedure - Certified Nurse Midwife		
Owner: Medical Staff Director	Department: Medical Staff	
Scope: Certified Nurse Midwife		
Date Last Modified: 07/02/2025	Last Review Date: No Review Date	Version: 5
Final Approval by: NIHD Board of Directors	Original Approval Date: 07/15/2020	

PURPOSE:
The nurse midwife, by virtue of added knowledge and skill gained through an organized program of study and clinical experience recognized by the American College of Nurse-Midwives, practices in the area of management of care of pregnant women, so long as progress meets the criteria accepted as normal. Nurse-Midwives are educationally prepared to recognize the deviations from normal at a time when medical care can be instituted to safeguard the well-being of the patient and baby. The practice of nurse-midwifery is recognized as an extended role for specially trained nurses under the Nursing Practice Act, as used in the following policies and protocols.

DEFINITIONS:
1. **Nurse-midwife** means a registered nurse certified to practice nurse-midwifery pursuant to the Nursing Practice Act (Art. 2.5, Ch 6, Div. 2 Secs 2746-2746.51, business and professional Code and related to regulations (Sections 1460-1466 Title 16 California Adm. Code)).
2. **Supervising Physician** means a physician who is an active member of the medical staff at Northern Inyo Hospital and who has current obstetrical privileges. This individual must contract with the practicing nurse-midwife to supervise normal obstetrical patient care.
3. **"Normal delivery"** means vertex presentation, vaginal birth of a child, completed by the natural efforts of the mother. Criteria and Exclusions: refer to addendum A attached.

POLICY:
1. Experience, training and/or education criteria for Nurse Midwives
   Applicants for membership and privileges as a nurse-midwife shall meet the following criteria:
   a. Licenses: Possession of a valid California license as a registered nurse. Possession of a valid California license as a certified nurse midwife.
   b. Board Certification: Board certified as a Certified Nurse Midwife (CNM) by the American Midwifery Certification Board (AMCB) within one year of graduation from an accredited school of nurse-midwifery.
   c. Education: Graduation from an accredited certified nurse midwife program.
   d. Experience:
      i. New Graduates: Completion of a post graduate internship in a university-affiliated setting or in a setting approved by the Chief of Obstetric services.

ii. Experienced CNM: In lieu of the required internship, an experienced CNM may furnish documentation of 1-2 years of recent hospital based intrapartum management experience in either a university setting or in affiliation with a board certified obstetrician/gynecologist or family practice physician.
iii. For a CNM that cannot demonstrate current competence (experience in last 24 months) refer to applicable practitioner re-entry policy.

e. Maintain American Midwifery Certification Board Continuing Competency and Assessment (CCA).
f. Departmental and/or perinatal meeting attendance as determined by the Chief of Obstetric Services.
g. CNMs who request privileges to assist at Cesarean Section deliveries must meet the following educational and performance criteria:
    i. Successful completion of a course in CNM First Assisting for Cesarean Sections through an accredited college or a program approved by the American College of Nurse-Midwives (ACNM) or Chief of Obstetrical Services, that incorporates didactic and clinical performance sections.
    ii. The CNM will be proctored for minimum of 2 second assists and 3 first assists for Cesarean Sections and/or for a minimum of 3 months, at which time the Chief of Obstetric Services will recommend either an extension of the proctoring period or approval for Cesarean Section First Assistant privileges.
    iii. Continued competency will be reviewed by the Chief of Obstetrical Services on an ongoing basis .
    iv. Refer to Appendix B for complete description of CNMFA scope and qualifications.
h. Application requirements for staff privileges, in addition to the above, will include
    i. The certified nurse-midwife will be required to carry liability insurance
    ii. The certified nurse-midwife will agree not to participate in out-of-hospital births
i. Successful completion of BLS is required; successful completion of ACLS is preferred.

2. Probationary/Proctoring period
    a. The period of observation will be no less than 3 months and will be used for evaluation of midwifery skills. A new graduate will be required to have a total of 10 supervised deliveries by a designated proctor to receive hospital privileges. A midwife with greater than 2 years of documented experience will be required to have 5 supervised deliveries.
    b. Observation will be performed by: supervising physician, other CNMs with current staff privileges, chart review, as well as assessment of staff obstetrician/gynecologists.
    c. CNM Cesarean Section First Assistant: proctoring period as described under Section 1 above
3. Nurse-midwife functions:
    a. Function as member of the obstetrical team under supervision and guidance of a supervising physician. Arrange for alternate consultation if supervising physician not available
    b. Manage labor, delivery and postpartum course of normal obstetrical patients and/or deliver care to normal newborn under the auspices of supervising physician and may co-manage exclusions with physician present
    c. Function in the role as First Assistant for Cesarean Sections when requested by an obstetrician. See complete description under Appendix B.

PROCEDURE:

1. Intrapartum care by nurse midwife:
    a. A Certified Nurse Midwife may function under the confines of their own "Scope of Practice" as defined by the American Midwifery Certification Board. All of the above functions are to be performed within the parameters of normal criteria. If problems arise, the supervising physician is to be notified immediately, as well as the pediatrician, if indicated.
    b. Medication orders are to be signed by the supervising physician unless prescribed under the approved medication listed (see formulary list).
2. Resuscitation of newborn:
    a. Routine stabilization/care of the newborn at delivery following the guidelines of the American Heart Association/Academy of Pediatrics Neonatal Resuscitation Program.
    b. The CNM will communicate with the on-call pediatrician about any newborn needing additional assistance after delivery and as needed.
    c. Newborn Care: The nurse-midwife may perform and enter the initial physical examination and discharge exam on the newborn record and write admission orders. Complications or abnormalities will be promptly reported to the supervising physician. The supervising physician must countersign medications orders (unless prescribed under the approved medications listed) and will examine infant(s) when requested to do so by CNM or at the physician's discretion.
3. Records:
    a. Documentation shall be sufficiently complete to include: an appropriate database, differential diagnosis, management plans and final disposition of the patient. Information shall be recorded on the patient record, which is centrally filed and available to all care providers.
4. Formulary of approved medications:
    a. Any medication in an approved Obstetrics order set.
    b. Any medication that the patient was routinely taking at home to be continued in the hospital.
    c. Other medications within the scope of services of a CNM with co-signature by the physician.

REFERENCES:

1. California Code of Regulations. Title 16, Sections 1460-1466.

RECORD RETENTION AND DESTRUCTION:

1. Life of policy, plus 6 years

Supersedes: v.4 Standardized Procedure - Certified Nurse Midwife

APPENDIX A

CRITERIA FOR CO-MANAGEMENT, COLLABORATION, EXCLUSIONS AND MEDICAL MANAGEMENT.

1. Criteria for Certified Nurse Midwife delivery will include:
    a. Gestational age > 36 to < 42 weeks
    b. EFW > 2500 - <4000 grams
    c. Normal prenatal care and low risk factors, gestational diabetes diet-controlled
2. Exclusions
    a. Any patient that does not meet the criteria above will be co-managed with the Attending Physician.
3. Medical management of the patient may be transferred to the Physician during the course of the hospitalization by agreement between the CNM and physician.

APPENDIX B

CERTIFIED NURSE MIDWIFE FIRST ASSISTANT (CNMFA)

POLICY:

1. The Certified Nurse Midwife First Assistant (CNMFA) assists the attending obstetrician during a Cesarean Section by providing aid in exposure and other technical functions, which will help the surgeon, carry out a safe operation with optimal results for the patient.
2. Only a CNM currently licensed in California, who meets all the criteria specified within this procedure may perform as a CNMFA.
3. The CNMFA may function under this standardized procedure when the attending obstetrician has determined that the CNMFA can provide the type of assistance needed during the specific surgery.

PROTOCOL:

1. The CNMFA may assist with the positioning and draping of the patient, or perform these actions independently, if so directed by the physician.
2. The CNMFA will provide retraction by:
    a. closely observing the operative field at all times
    b. managing all instruments in the operative field to prevent obstruction of the surgeon's view
    c. anticipating retraction needs with knowledge of the surgeon's preferences and anatomical structures
3. The CNMFA may provide hemostasis by:
    a. sponging and utilizing pressure as necessary
    b. utilizing suctioning techniques
    c. applying clamps on superficial vessels and tying or electro-coagulation of them as directed by the physician
4. The CNMFA may perform knot tying by using basic techniques of knot tying to include two-handed tie, one-handed tie and instrument tie.
5. The CNMFA may provide closure of layers by approximating tissue layers under the direct supervision of the physician.
6. The CNMFA will assist the physician at the completion of the surgical procedure by:
    a. affixing and stabilizing all drains
    b. cleaning the wound and applying the dressing

QUALIFICATIONS:

1. A CNM who is approved as a CNMFA at NIHD may function as first assistant if all the following conditions exist:
    a. currently licensed as a CNM in California
    b. successful completion of a course in CNM First Assisting as noted in the above procedure- refer to section B-5 (a copy of the certificate of completion will be placed in the CNMFA's credentialing file)
    c. demonstrated knowledge and skill in applying principles of asepsis and infection control and demonstrated skill in behaviors that are unique to functioning as a CNMFA
    d. demonstrated knowledge of surgical anatomy, physiology and operative procedures encountered in a Cesarean delivery
    e. demonstrated ability to function effectively and harmoniously as a team member
    f. able to perform BLS, completion of ACLS preferred
    g. able to perform effectively in stressful and emergency situations

APPENDIX C

APPROVALS

The following CNM's who have been approved to function as Certified Nurse Midwives under this standardized procedure are:

Name:	Approval Date:
_____	_____
_____	_____

The following CNM's who have been approved to function as a CNMFA under this standardized procedure are:

Name:	Approval Date:
_____	_____
_____	_____

This standardized procedure has been approved for use at Northern Inyo Healthcare District by:

_____ _____

Chair, Interdisciplinary Practice Committee Date

_____ _____

Administrator Date

_____ _____

Chief of Staff Date

_____ _____

President, Board of Directors Date

NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL STANDARDIZED PROCEDURE

Title: Standardized Procedure for Admission of the Well Newborn		
Owner: Interim Perinatal Manager	Department: Perinatal	
Scope: Perinatal RN		
Date Last Modified: 06/05/2025	Last Review Date: No Review Date	Version: 4
Final Approval by: NIHD Board of Directors	Original Approval Date: 4/21/2021	

PURPOSE:

To ensure well newborns receive immediate and short-term ongoing assessment, care, and timely administration of prophylactic ophthalmic erythromycin to prevent opthalmia neonatorum, intramuscular Hepatitis B vaccine for perinatal Hepatitis B prevention, and intramuscular Vitamin K to prevent Vitamin K deficient bleeding (VKDB), pending notification of the pediatrician and receipt of physician orders for continuing care.

POLICY

It is the policy of Northern Inyo Healthcare District (NIHD) that all well newborns will be assessed and provided care upon admission under the direction of a Registered Nurse (RN) with annual documented competencies following this Standardized Procedure. All well newborns will receive prophylactic administration of erythromycin ophthalmic ointment, Hepatitis B vaccine, and Vitamin K by an RN/LVN, unless there is a documented refusal by the parent, under this Standardized Procedure.

PROCEDURE

1. Experience, Training, and/or Education Requirements of the RN
    a. Current California RN licensure
    b. Current Neonatal Resuscitation Program (NRP) card
    c. Successful completion of orientation to newborn care at NIHD
2. Method of Initial and Continued Evaluation of Competence
    a. Initial evaluation: successful completion and demonstration of competency and clinical decision making in assessment of the newborn, as documented in the unit-specific clinical competency orientation checklist.
    b. Ongoing evaluation: annual completion of competency validation of the newborn assessment and administrations of prophylactic medications to a neonate.
3. Maintenance of Records of those authorized in Standardized Procedure
    a. A list of RNs competent to perform this standardized procedure is maintained with the Chief Nursing Officer and is updated annually.
4. Settings where Standardized Procedure may be performed
    a. Admission of a well newborn and administration of prophylactic medications may take place in the Perinatal unit at the mother's bedside, newborn nursery, or in the Post Anesthesia Care Unit.

5. Standardized Procedure
    a. Circumstance under which Standardized Procedure may be performed:
        i. Well newborn delivered at NIHD
    b. Procedure
        i. The RN will perform an admission assessment according to policy
        ii. The RN will initiate the Newborn Admission Orders:
            - Code Status:
                - Full Code
            - When to call Pediatrician:
                - Call Pediatrician Between 0630-0730 to inform them of any delivery after 5pm the previous day.
                - If born before 5pm, call Pediatrician ASAP
            - Please call Pediatrician immediately**, at any hour,** in the event of:
                - Infant requiring resuscitation efforts following birth
                - Maternal Chorioamnionitis
                - Maternal GBS positive without adequate maternal antibiotic coverage if infant is <37 weeks or ROM ≥18 hours' even if otherwise well
                - Immediately for infant fever ≥100.4°F
                - For sustained HR abnormalities, >5 minutes when infant calm, HR >180 and or < 100
                - Respiratory Rate >60
                - Immediately for other concerns that cannot wait until normal rounding time
                - If indicated per Pulse Ox Screening, Hyperbilirubinemia, or Hypoglycemia policies
            - Vital signs every 30 minutes x4 and PRN
            - Vital signs every 8 hours for the term, uncomplicated infant born via vaginal birth
            - Vital signs every 4 hours x24 hours, then every 8 hours for infants born via cesarean-section
            - Vital signs every 4 hours for infants <37 weeks' gestation
            - Infant diet: Breastfeed only unless maternal refusal or medical need per policy
                - Breastfeed on demand
            - Oximetry per protocol
            - Drugs of Abuse Screen:
                - If mother's DOA positive for THC only:
                    i. Advise patient that continuing use of marijuana/THC containing products while breastfeeding is not advised
                - If a mother's DOA positive for drugs other than THC: -RN to file CPS report
                    i. Consult to social worker
                    ii. Cord Segment to be sent
                    iii. Newborn urine drug screen

- Newborn Hearing Screening before discharge
- Newborn Screening Test before discharge
- Bili scan at 24 hours or earlier, then daily until discharge
- Bili Scan PRN for worsening jaundice or any jaundice prior to 24 hours of age
- Congenital Heart Disease Screen at 24 hours
- Sweet Ease for pain control only
- Pacifier use for pain control only unless requested by parent and pacifier use education provided
- Collect cord blood workup specimen
- Heel Stick Blood Sugar per *Newborn Blood Sugar Monitoring Policy*
- Inform Provider of any medication refusal by family, during normal office hours
- Erythromycin Ophthalmic Ointment 0.5 %, 1 application within 2 hours of delivery
- Phytonadione IM (Vitamin K) Give 1 mg. Give within 2 hours of delivery
- Hepatitis B Vaccine IM 0.5 mL within 24 hours if mother is Hepatitis B negative. Give as soon as possible within 12 hours of age if mother is Hepatitis B positive or unknown.
    - Notify Pediatric Provider on call if the mother is Hepatitis B positive
- Cholecalciferol Oral Drops 400 unit every day. Start day of discharge
    - 400 IU = 1 DROP Q day to start on the day of discharge.

6. Review of Standardized Procedure
    a. Standardized procedures are reviewed and approved annually by the Interdisciplinary Practice Committee.

REFERENCES:

1. AWHONN (2021) Perinatal Nursing (*5th Ed.*) Wolters Kluwer.
2. American Academy of Pediatrics & College of Obstetricians and Gynecologist (2017*). Guidelines for Perinatal Care (8th Ed.).* Elk Grove Village, IL: Author
3. California State and Consumer Services Agency, Board of Registered Nursing. (2011). "*An explanation of the scope of RN practice including standardized procedures*". Retrieved from www.rn/gov Section 2725 of California Nurse Practice Act.

CROSS-REFERENCED POLICIES AND PROCEDURES:

1. Admission, Care, Discharge and Transfer of the Newborn
2. Drugs of Abuse Maternal and Infant
3. Transcutaneous Bilirubin Testing (Bili Scan)
4. Infant Feeding Policy
5. Newborn Pulse Oximetry Screen
6. Newborn Hearing Screening Program
7. Newborn Blood Glucose Monitoring
8. Lippincott: Newborn assessment: https://procedures.lww.com/lnp/view.do?pId=7149440&hits=neonatal,newborn,neonate,neonates&a=false&ad=false&q=newborn

RECORD RETENTION AND DESTRUCTION:
Documentation is maintained within the patient and medical record, which is managed by the NIHD Medical Records Department.

Supersedes: v.3 Standardized Procedure for Admission of the Well Newborn

NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL STANDARDIZED PROTOCOL

Title: Standardized Protocol for the Orthopedic Physician Assistant		
Owner: Medical Staff Director	Department: Medical Staff	
Scope: Orthopedic Physician Assistants		
Date Last Modified: 07/02/2025	Last Review Date: No Review Date	Version: 1
Final Approval by: NIHD Board of Directors	Original Approval Date:	

PURPOSE:
This standardized protocol defines the scope of clinical services the Physician Assistant (PA) may provide in both inpatient and emergency department settings under the supervision of an orthopedic surgeon. This protocol ensures compliance with the California Physician Assistant Practice Act and relevant institutional policies.

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:
        i. Pediatric and adult patients
    b. Setting:
        i. Inpatient hospital units
        ii. Preoperative and postoperative care units
        iii. Emergency department
        iv. On-call orthopedic coverage
    c. Supervision:
        i. Physician consultation is available at all times, either on-site, by phone, or by electronic means.

PROTOCOL:
The Physician Assistant is authorized to perform the following orthopedic-related duties under the supervision and delegation of the supervising orthopedic surgeon:

1. Inpatient Rounds
    a. Conduct daily evaluations of hospitalized orthopedic patients
    b. Document assessments, progress notes, and care plans
    c. Communicate significant findings to the supervising surgeon
2. Admission of Patients
    a. Perform comprehensive admission history and physical exams
    b. Initiate diagnostic and therapeutic orders
    c. Coordinate care with multidisciplinary teams
3. Discharge of Patients

   a. Assess discharge readiness
   b. Complete discharge summaries and patient instructions
   c. Prescribe discharge medications per scope and protocol
4. Preoperative Evaluations
   a. Perform detailed preoperative assessments
   b. Order and interpret pre-op labs and imaging
   c. Educate patients on the surgical process in collaboration with the supervising surgeon
5. Postoperative Management
   a. Monitor post-op recovery and incision sites
   b. Identify and manage common post-op complications
   c. Modify medications and wound care based on surgeon-directed protocols
6. On-Call Coverage
   a. Respond to urgent orthopedic issues during scheduled call shifts
   b. Perform orthopedic evaluations and minor procedures as indicated
   c. Coordinate directly with the orthopedic surgeon for complex cases
7. Emergency Department Coverage
   a. Evaluate and treat patients in the emergency department as directed by the supervising orthopedic surgeon
   b. Perform orthopedic assessments for acute injuries
   c. Conduct fracture reductions and management of dislocated joints
   d. Apply splints, braces, or casts as indicated
   e. Perform preoperative evaluations in collaboration with the orthopedic surgeon when surgical intervention is indicated

REFERENCES:

1. Physician Assistant Practice Act. California Business and Professions Code, Division 2, Chapter 7.7.

RECORD RETENTION AND DESTRUCTION:

1. Life of policy, plus 6 years.

SIGNATURES:

Physician Assistant: _____

Name: _____ Date: _____

Supervising Physician: _____

Name: _____ Date: _____

Supersedes: Not Set

NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL STANDARDIZED PROTOCOL

Title: Sterile Compounding Environmental Monitoring		
Owner: PHARMACY DIRECTOR	Department: Pharmacy	
Scope:		
Date Last Modified: 07/02/2025	Last Review Date: No Review Date	Version: 1
Final Approval by: NIHD Board of Directors	Original Approval Date:	

PURPOSE: To define the process for microbial bioburden sampling within Northern Inyo Hospital's Sterile Compounding Environment.

PROCEDURE:

1. **Surface Viable Bioburden Sampling**
    a. Surface sampling shall occur on a monthly basis for all International Organization for Standardization (ISO) classified areas during dynamic conditions that simulate actual production
    b. Surfaces shall NOT be disinfected immediately prior to sampling
    c. ISO-5 Areas:
        i. Inside the laminar air flow workbench (LAFW) and Biological Safety Cabinet (BSC)
    d. ISO-7 Areas:
        i. "High touch" areas that are commonly touched on a routine basis within the ISO classified area (e.g. phone, counters, shelving etc.)
    e. Surface Contact Sampling :
        i. Open the plate and place onto surface, ensuring full contact is made with the surface
        ii. Label each Plate with the sample number and date (MM/DD/YYYY) per table 1
        iii. Surface tested is to be cleaned with suitable EPA-Registered One-Step Cleaner Disinfectant (e.g. TB1-3300) followed by Sterile 70% Isopropyl Alcohol after testing
        iv. Repeat Steps i-iii. For all surfaces SS-1 through SS-2 per table 1
        v. Log media paddles in the Environmental Monitoring Log
        vi. Incubate the paddles containing TSA at 30-35C for 48-72 hours followed by 20-25C for minimum 5 days.
        vii. Log results in the Environmental Monitoring Log
        viii. If sampling exceeds action limits of Table 3 for any ISO classified area, follow step 3 below
        ix. Monthly tests will be compared to the established baseline value over time. An increasing trend over baseline warrants a prompt re-evaluation of the adequacy of cleaning procedures, operational procedures, and air filtration efficiency.
2. **Sampling that Exceeds Action Limits**
    a. If action limits are exceeded the hood / area in question is to be thoroughly cleaned and re-tested.
        i. The colonies on the original agar plate are to be evaluated and identified to the genus level by TSS Environmental Laboratories

ii. The Hospital Infection Control must be notified and consulted for further evaluation
iii. If a highly pathogenic microorganisms (e.g., gram-negative rods, coagulase positive staphylococcus, molds and yeasts) is identified, the situation must be immediately remedied through terminal cleaning with sporicidal and disinfection of the area, regardless of CFU count.

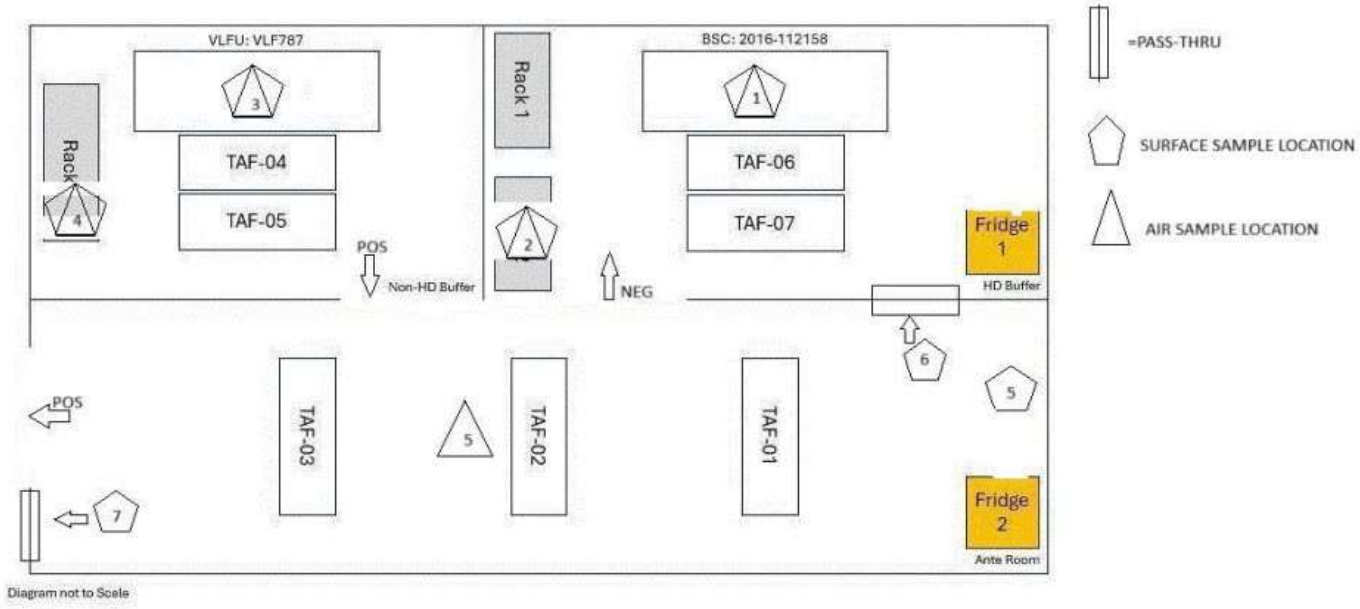
Table 1. Surface Bioburden Sampling Locations

Sample No.	Area
SS-1	Biological Safety Cabinet
SS-2	Negative pressure room Shelf
SS-3	Laminar Flow Hood
SS-4	Positive pressure room shelf
SS-5	Ante room shelf
SS-6	Negative pressure pass through window
SS-7	Ante room pass through window

Table 3. Baseline and Action Limit Colony Forming Unit Values

Room and Sample	Location Site	Baseline (Ideal)	Action Limit (CFU)
Hoods (ISO 5)	Air	0	>1
	Surface	0	>3
Buffer Zone/Clean Room (ISO 7)	Air	0	>10
	Surface	0	> 5

Environmental Monitoring Sampling Map



REFERENCES:

United States Pharmacopeia Convention. (2023). *USP General Chapter <797> Pharmaceutical Compounding – Sterile Preparations*.

United States Pharmacopeia Convention. (2023). *USP General Chapter <800> Hazardous Drugs – Handling in Healthcare Settings*.

RECORD RETENTION AND DESTRUCTION: records will be retained for 3 calendar years

Supersedes: Not Set

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

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

TO: NIHD Board of Directors
FROM: Samantha Jeppsen, MD, Chief of Medical Staff
DATE: July 1, 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. Grace Kim, MD (pediatrics) – Courtesy Staff
    2. Peter Reim, MD (emergency medicine) – Active Staff
    3. Ryan Roleson, MD (emergency medicine) – Active Staff
    4. Tyler Williamson, MD (orthopedic surgery) – Active 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. Donna Newsome, MD (teleneurology) – Telemedicine Staff (Sevaro)
    2. Lauren Crawford, MD (teleneurology) – Telemedicine Staff (Sevaro)

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

BUSINESS DEVELOPMENT UPDATE

- COMMUNITY ENGAGEMENT UPDATE
  - LOCAL PARTNERS:
    - TOIYABE INDIAN HEALTH PROJECT
    - BISHOP CHAMBER OF COMMERCE
    - BISHOP MULE DAYS CELEBRATION
- GRANTS UPDATE:
  - CALIFORNIA HOSPITAL ASSOCIATION – FLEX GRANT
  - CALIFORNIA DEPARTMENT OF HEALTH CARE ACCESS AND INFORMATION – SHIP GRANT
- GOVERNMENT UPDATE

HUMAN RESOURCES PLAN

THE EMPLOYEE EXPERIENCE

- RECRUITMENT AND TALENT ACQUISITION
  - COMMUNITY AND SOCIAL MEDIA
- HRIS AND ANALYTICS
- ONBOARDING AND ORIENTATION
  - ONBOARDING EXPERIENCE
  - NEW HIRE FEEDBACK AND ROUNDING

EVENTS AND ENGAGEMENT

TRAINING AND DEVELOPMENT

- POLICY AND PROCEDURE
  - IT STARTS WITH US
- TEAM DEVELOPMENT
- LEADERSHIP TRAINING

STRATEGIC COMMUNICATIONS UPDATE

MARKETING	COMMUNICATIONS	STRATEGY
▪ ANNUAL FOCUS ▪ TRADITIONAL ▪ DIGITAL ▪ SPECIAL PROJECTS	▪ INTERNAL ▪ EXTERNAL ▪ NIHD FOUNDATION & AUXILIARY	▪ OPPORTUNITIES ▪ OUTREACH ▪ TEAM SUPPORT

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

DATE: June 2025

TO: Board of Directors, Northern Inyo Healthcare District

FROM: Andrea Mossman, Chief Financial Officer

RE: Financial Summary and Operation Insights as of May 2025

Financial Summary

1. Net Income: May's net loss was $(2.1M), which was $(2.1M) lower than last May. This was due to slow surgical and clinic volumes along with a shift in payor mix from Blue Cross to Medicare. Additionally, our Medicare outpatient rate was reduced by 12.7% compared to last May. This affected our revenue an additional $1.2M for a total negative impact of $(3M). For the year, net income was at $2.83M, which was $(989k) lower than last year-to-date. This was due to lower net revenue due to less surgical volume and rate cuts in Medicare, which were partially offset by reduced expenses.
2. Operating Income: May's operating loss was $(2.5M), which was $(2.1M) lower than last May due to lower revenue as mentioned above. For the year, operating loss was $(9.8M) which was $(1.2M) due to lower surgical volume and reimbursement as mentioned above.
3. EBIDA: May's EBIDA was $(1.7M), which was $(2.1M) lower than last May due to the revenue impact mentioned above. For the year, EBIDA was $(1.45M) lower than last year due to revenue concerns mentioned above.
4. Revenue Breakdown: May's gross revenue was unfavorable to last May by $(2.1M) due to a decline in volume in clinics and surgeries. For the year, gross revenue was higher by 2% due to increased volumes in most areas excluding surgeries. Net revenue was lower by $(2.4M) due to less surgical volumes which are reimbursed at a higher rate along with rate cuts from Medicare.

Deductions Summary

1. Contractual Adjustments: For the year, contractual discounts are lower by 2% due to a shift in payor mix from Medicare to Blue Cross and Commercial, which reimburse at a higher rate. Net revenue as a % of gross revenue is at 45% for the year, which is (2%) lower than last year-to-date due to Medicare rate cuts.

2. Bad Debt: For the year, bad debt increased $5.3M due to aged AR cleanup.
3. Write-offs: Other write-offs were higher than prior year and budget due to continued aged AR cleanup.

Salaries

1. Per Adjusted Patient Day / Adjusted Employee per Occupied Bed (Adjusted EPOB): For the month of May, wages per patient was 3% higher due to merits. For the year, wages per patient were (4%) lower due to increased volume in most areas.
2. Total Salaries: For year-to-date, wages was up 2% due to annual merit increases.
3. Average Hourly Rate: For the year, average hourly rate was 1% higher than last year due to merits.

Benefits

1. Total Benefits: For May and year-to-date, benefits were lower than prior year due to pension and medical expenses.
2. Benefits % of Wages: For the year, we were at 45% of wages, which was lower than prior year by (9%).

Total Salaries, Wages and Benefits (SWB)

1. Salaries, Wages and Benefits (SWB) / Adjusted Patient Day: For the year, we were (19%) under budget and (9%) 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 May, we were under budget by (9%). For the year, we were lower than prior year by (2%). This was due to benefits being lower. For the year, we were at 50% of total expenses, which is our goal. However, when you include contract labor, we are at 52%.

Contract Labor

1. Contract Labor Expense: For the year, contract labor was (8%) 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 40% and higher than prior year by 4%. We will continue to evaluation and negotiate rates based on market.
3. Contract Labor Full-Time Equivalents (FTEs): For the year, contract labor was (11%) lower than prior year.

Other Expenses

1. Physician Expense / Adjusted Patient Day: For the year, physician expenses per patient were 4% over budget yet (2%) under prior year-to-date.
2. Supplies: For the year, supplies were lower than prior year-to-date due to lower pharmacy costs and less surgical supply costs.
3. Total Expenses: For the year, expenses were under budget by (4%) and under prior year by (1%). This was due to lower benefits and supplies.

Stats Summary

1. Admits (excluding Nursery): For May, admits were 1% higher due to higher medical admits from the ER. For the year, admits were relatively flat to prior year.
2. Inpatient Days (excluding Nursery): For May, inpatient days were 9% higher. For the year, inpatient days increased 10%.
3. Average Daily Census: Average census increased 11% compared to last year-to-date.
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 5% higher than last year.
6. Surgical Procedures: For May, surgeries were (12%) lower than last May due to due to a strong month for Ophthalmology. For the year, surgical procedures were (3%) lower with decreases in ophthalmology, orthopedics, and gynecology.
7. Emergency Department (ED) Visits: Emergency visits were relatively flat to last May yet 1% higher year-to-date.
8. Diagnostic Imaging (DI) Exams: For the month, DI exams were (4%) lower than last May due to orthopedics. For the year-to-date, DI exams were relatively flat compare to last year-to-date. Approximately 25% of volume in this cost center comes from orthopedic clinic.
9. Rehab Visits: For May, rehab visits were lower by (11%) yet they were up 30% for the year. Approximately 36% of volume in this cost center comes from orthopedic clinic.
10. Outpatient Infusion / Injections / Wound Care Visits: These visits were higher by 70% compared to last year-to-date.
11. Observation Hours: Observations hours were down (22%) 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 May, RHC was up 4% and was up 2% compared to last year-to-date.
13. Other Clinics: For May, 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.

Cash Summary

1. Days Cash on Hand: As of May, days cash on hand was at 92 days. Our bond requirement is 75 days.
2. Estimated Days until Depletion (excluding supplement/IGT): As of May, days until depletion (excluding IGT) is 676 days or nearly 2 years. This excludes supplement money such as grants and IGT. When considering those funds, we are only depleting by $1,500 per day. It is estimated that we have approximately $3-5M in IGT at risk due to federal Medicaid cuts.
3. Unrestricted Cash: Unrestricted cash balance is now $27.9M. While this is higher than where we ended FYE 2024, we have depleted cash $28M since July 1, 2021. During FYE 2023 and FYE 2024, we averaged a depletion of $6M annually in cash.

Northern Inyo Healthcare District

May 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)	(2,134,682)	(808,998)	(1,325,684)	164%	(36,142)	(2,098,540)	(5,806%)	2,830,496	349,884	2,480,612	(709%)	3,819,593	(989,098)	(26%)
Operating Income (Loss)	(2,485,229)	(1,101,419)	(1,383,810)	126%	(352,524)	(2,132,705)	(605%)	(9,765,614)	(12,543,031)	2,777,417	22%	(8,594,067)	(1,171,547)	14%
EBIDA (Loss)	(1,725,518)	(445,420)	(1,280,098)	287%	411,699	(2,137,217)	519%	7,427,178	4,349,242	3,077,936	(71%)	8,878,036	(1,450,858)	(16%)
IP Gross Revenue	3,371,624	3,526,682	(155,058)	(4%)	3,646,287	(274,663)	(8%)	40,773,821	39,012,746	1,761,075	5%	38,554,203	2,219,618	6%
OP Gross Revenue	13,103,211	14,185,079	(1,081,867)	(8%)	14,890,447	(1,787,235)	(12%)	152,515,200	156,714,079	(4,198,878)	(3%)	152,183,966	331,234	0%
Clinic Gross Revenue	1,810,472	1,587,112	223,360	14%	1,822,994	(12,522)	(1%)	19,422,853	18,067,321	1,355,532	8%	17,723,375	1,699,478	10%
Total Gross Revenue	**18,285,307**	**19,298,872**	**(1,013,565)**	**(5%)**	**20,359,728**	**(2,074,421)**	**(10%)**	**212,711,874**	**213,794,146**	**(1,082,272)**	**(1%)**	**208,461,544**	**4,250,330**	**2%**
Net Patient Revenue	**7,772,831**	**8,966,222**	**(1,193,391)**	**(13%)**	**9,651,912**	**(1,879,081)**	**(19%)**	**96,158,009**	**98,202,696**	**(2,044,687)**	**(2%)**	**98,586,335**	**(2,428,326)**	**(2%)**
Cash Net Revenue % of Gross	*43%*	*46%*	*(4%)*	*(9%)*	*47%*	*(5%)*	*(10%)*	*45%*	*46%*	*(1%)*	*(2%)*	*47%*	*(2%)*	*(4%)*
Admits (excl. Nursery)	87	86	1	1%	86	1	1%	783	785	(2)	(0%)	785	(2)	(0%)
IP Days	296	266	30	11%	266	30	11%	2,683	2,339	344	15%	2,339	344	15%
IP Days (excl. Nursery)	258	237	21	9%	237	21	9%	2,284	2,073	212	10%	2,073	212	10%
Average Daily Census	8.3	7.6	0.7	9%	7.6	0.7	9%	6.8	6.2	0.7	11%	6.2	0.7	11%
ALOS	3.0	2.8	0.2	8%	2.8	0.2	8%	2.9	2.6	0.3	10%	2.6	0.3	10%
Deliveries	19	22	(3)	(14%)	22	(3)	(14%)	187	178	9	5%	178	9	5%
OP Visits	4,178	3,894	284	7%	3,894	284	7%	43,943	39,145	4,798	12%	39,145	4,798	12%
Rural Health Clinic Visits	2,439	2,462	(23)	(1%)	2,462	(23)	(1%)	25,561	25,988	(427)	(2%)	25,988	(427)	(2%)
Rural Health Women Visits	566	536	30	6%	536	30	6%	5,777	5,233	544	10%	5,233	544	10%
Rural Health Behavioral Visits	257	145	112	77%	145	112	77%	2,293	1,767	526	30%	1,767	526	30%
Total RHC Visits	**3,262**	**3,143**	**119**	**4%**	**3,143**	**119**	**4%**	**33,631**	**32,988**	**643**	**2%**	**32,988**	**643**	**2%**
Bronco Clinic Visits	20	63	(43)	(68%)	63	(43)	(68%)	394	390	4	1%	390	4	1%
Internal Medicine Clinic Visits	-	-	-	-%	-	-	-%	-	201	(201)	(100%)	201	(201)	(100%)
Orthopedic Clinic Visits	300	415	(115)	(28%)	415	(115)	(28%)	3,800	3,825	(25)	(1%)	3,825	(25)	(1%)
Pediatric Clinic Visits	478	630	(152)	(24%)	630	(152)	(24%)	6,455	6,805	(350)	(5%)	6,805	(350)	(5%)
Specialty Clinic Visits	668	559	109	19%	559	109	19%	6,137	4,512	1,625	36%	4,512	1,625	36%
Surgery Clinic Visits	132	129	3	2%	129	3	2%	1,691	1,434	257	18%	1,434	257	18%
Virtual Care Clinic Visits	51	60	(9)	(15%)	60	(9)	(15%)	627	575	52	9%	575	52	9%
Total NIA Clinic Visits	**1,649**	**1,856**	**(207)**	**(11%)**	**1,856**	**(207)**	**(11%)**	**19,104**	**17,742**	**1,362**	**8%**	**17,742**	**1,362**	**8%**
IP Surgeries	10	15	(5)	(33%)	15	(5)	(33%)	126	218	(92)	(42%)	218	(92)	(42%)
OP Surgeries	113	125	(12)	(10%)	125	(12)	(10%)	1,407	1,382	25	2%	1,382	25	2%
Total Surgeries	**123**	**140**	**(17)**	**(12%)**	**140**	**(17)**	**(12%)**	**1,533**	**1,600**	**(67)**	**(4%)**	**1,600**	**(67)**	**(4%)**
Cardiology	3	1	2	200%	1	2	200%	7	2	5	250%	2	5	250%
General	71	68	3	4%	68	3	4%	778	783	(5)	(1%)	783	(5)	(1%)
Gynecology & Obstetrics	10	17	(7)	(41%)	17	(7)	(41%)	128	172	(44)	(26%)	172	(44)	(26%)
Ophthalmology	15	18	(3)	(17%)	18	(3)	(17%)	265	246	19	8%	246	19	8%
Orthopedic	9	23	(14)	(61%)	23	(14)	(61%)	205	275	(70)	(25%)	275	(70)	(25%)
Pediatric	-	-	-	-%	-	-	-%	1	-	1	-%	-	1	-%
Plastics	-	-	-	-%	-	-	-%	2	-	2	-%	-	2	-%
Podiatry	-	-	-	-%	-	-	-%	6	1	5	500%	1	5	500%
Urology	15	13	2	15%	13	2	15%	138	121	17	14%	121	17	14%
Diagnostic Image Exams	2,210	2,293	(83)	(4%)	2,293	(83)	(4%)	23,082	23,011	71	0%	23,011	71	0%
Emergency Visits	899	896	3	0%	896	3	0%	9,330	9,201	129	1%	9,201	129	1%
ED Admits	58	49	9	18%	49	9	18%	470	389	81	21%	389	81	21%
ED Admits % of ED Visits	6%	5%	1%	18%	5%	1%	18%	5%	4%	1%	19%	4%	1%	19%
Rehab Visits	865	970	(105)	(11%)	970	(105)	(11%)	9,445	7,271	2,174	30%	7,271	2,174	30%
OP Infusion/Wound Care Visits	686	780	(94)	(12%)	780	(94)	(12%)	6,331	3,716	2,615	70%	3,716	2,615	70%
Observation Hours	1,309	1,225	84	7%	1,225	84	7%	16,272	20,742	(4,470)	(22%)	20,742	(4,470)	(22%)

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

Northern Inyo Healthcare District
May 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	17.5%	20.9%	(3.3%)	(16.1%)	20.9%	(3.3%)	(16.1%)	23.4%	18.7%	4.7%	25.2%	18.7%	4.7%	25.2%
Commercial	6.3%	2.9%	3.3%	113.8%	2.9%	3.3%	113.8%	7.4%	3.8%	3.6%	94.3%	3.8%	3.6%	94.3%
Medicaid	19.5%	24.4%	(4.9%)	(20.0%)	24.4%	(4.9%)	(20.0%)	26.6%	24.6%	2.0%	8.3%	24.6%	2.0%	8.3%
Medicare	54.7%	42.4%	12.3%	29.0%	42.4%	12.3%	29.0%	40.3%	48.3%	(8.0%)	(16.6%)	48.3%	(8.0%)	(16.6%)
Self-pay	2.0%	3.5%	(1.5%)	(43.3%)	3.5%	(1.5%)	(43.3%)	2.0%	3.6%	(1.6%)	(44.7%)	3.6%	(1.6%)	(44.7%)
Worker's Comp	-%	-%	-%	-%	-%	-%	-%	0.4%	0.5%	(0.1%)	(25.2%)	0.5%	(0.1%)	(25.2%)
Other	-%	5.9%	(5.9%)	(100.0%)	5.9%	(5.9%)	(100.0%)	-%	0.6%	(0.6%)	(100.0%)	0.6%	(0.6%)	(100.0%)
DEDUCTIONS														
Contract Adjust	(7,499,521)	(9,183,956)	1,684,435	(18%)	(9,761,982)	2,262,461	(23%)	(101,150,225)	(102,007,691)	857,465	(1%)	(103,077,386)	1,927,161	(2%)
Bad Debt	(2,837,626)	(582,161)	(2,255,465)	387%	(538,525)	(2,299,101)	427%	(6,971,246)	(7,224,768)	253,521	(4%)	(1,663,671)	(5,307,576)	319%
Write-off	(177,633)	(566,533)	388,900	(69%)	(410,472)	232,838	(57%)	(8,286,515)	(6,358,992)	(1,927,523)	30%	(5,141,184)	(3,145,331)	61%
CENSUS														
Patient Days	258	237	21	9%	237	21	9%	2,284	2,073	212	10%	2,073	212	10%
Adjusted ADC	39	43	(4)	(9%)	43	(4)	(9%)	37	33	4	11%	33	4	11%
Adjusted Days	1,399	1,322	77	6%	1,322	77	6%	11,918	11,207	710	6%	11,207	710	6%
Employed FTE	381.5	366.1	15.5	4%	366.1	15.5	4%	364.2	356.9	7.2	2%	356.9	7.2	2%
Contract Labor FTE	19.6	26.5	(6.8)	(26%)	26.5	(6.8)	(26%)	24.7	27.7	(3.0)	(11%)	27.7	(3.0)	(11%)
Total Paid FTE	401.2	392.5	8.6	2%	392.5	8.6	2%	388.8	384.6	4.2	1%	384.6	4.2	1%
EPOB (Employee per Occupied Bed)	1.6	1.7	(0.1)	(6%)	1.7	(0.1)	(6%)	1.8	2.0	(0.2)	(9%)	2.0	(0.2)	(9%)
EPOC (Employee per Occupied Case)	0.3	0.3	0.0	12%	0.3	0.0	12%	0.0	0.0	(0.0)	(9%)	0.0	(0.0)	(9%)
Adjusted EPOB	8.4	9.3	(0.8)	(9%)	9.3	(0.8)	(9%)	9.6	10.9	(1.3)	(12%)	10.9	(1.3)	(12%)
Adjusted EPOC	1.8	1.7	0.1	9%	1.7	0.1	9%	0.2	0.2	(0.0)	(12%)	0.2	(0.0)	(12%)
SALARIES														
Per Adjust Bed Day	2,573	2,675	(102)	(4%)	2,505	69	3%	3,058	3,435	(376)	(11%)	3,180	(122)	(4%)
Total Salaries	3,599,495	3,536,678	62,817	2%	3,311,797	287,698	9%	36,447,982	38,493,323	(2,045,341)	(5%)	35,641,334	806,649	2%
Average Hourly Rate	53.26	54.54	(1.28)	(2%)	51.07	2.18	4%	52.29	56.34	(4.05)	(7%)	52.01	0.28	1%
Employed Paid FTEs	381.5	366.1	15.5	350.6	366.1	15.5	4%	364.2	356.9	7.2	2%	356.9	7.2	2%
BENEFITS														
Per Adjust Bed Day	826	1,567	(741)	(47%)	1,189	(363)	(31%)	1,362	2,044	(683)	(33%)	1,689	(328)	(19%)
Total Benefits	1,155,616	2,072,172	(916,556)	(44%)	1,571,990	(416,373)	(26%)	16,226,643	22,910,026	(6,683,382)	(29%)	18,933,716	(2,707,073)	(14%)
Benefits % of Wages	32%	59%	(26%)	(45%)	47%	-15%	(32%)	45%	60%	(15%)	(25%)	53%	(9%)	(16%)
Pension Expense	407,004	498,151	(91,146)	(18%)	290,559	116,445	40%	4,343,550	5,476,984	(1,133,434)	(21%)	5,017,323	(673,773)	(13%)
MDV Expense	444,654	748,612	(303,958)	(41%)	840,375	(395,722)	(47%)	8,279,643	8,234,732	44,911	1%	10,413,001	(2,133,358)	(20%)
Taxes, PTO accrued, Other	303,958	825,410	(521,451)	(63%)	441,055	(137,097)	(31%)	3,603,450	9,198,310	(5,594,859)	(61%)	3,503,392	100,058	3%
Salaries, Wages & Benefits	4,755,111	5,608,850	(853,739)	(15%)	4,883,787	(128,676)	(3%)	52,674,626	61,403,349	(8,728,723)	(14%)	54,575,050	(1,900,424)	(3%)
SWB/APD	3,400	4,242	(843)	(20%)	3,694	(294)	(8%)	4,420	5,479	(1,059)	(19%)	4,870	(450)	(9%)
SWB % of Total Expenses	46%	56%	(9%)	(17%)	49%	(2%)	(5%)	50%	55%	(6%)	(10%)	51%	(1%)	(2%)

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

Northern Inyo Healthcare District

May 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	2,461	1,690	771	46%	2,398	63	3%	2,453	2,193	260	12%	2,472	(19)	(1%)
Total Physician Fee	1,878,965	1,463,822	415,143	28%	1,780,354	98,611	6%	17,728,913	16,100,445	1,628,468	10%	16,929,994	798,919	5%
Total Contract Labor	392,345	349,333	43,012	12%	968,946	(576,601)	(60%)	4,831,945	3,865,431	966,514	25%	5,250,341	(418,397)	(8%)
Total Other Pro-Fees	1,170,777	420,773	750,004	178%	421,564	749,213	178%	6,674,439	4,614,583	2,059,856	45%	5,529,807	1,144,632	21%
Total Professional Fees	3,442,088	2,233,928	1,208,159	54%	3,170,864	271,223	9%	29,235,297	24,580,459	4,654,838	19%	27,710,142	1,525,154	6%
Contract AHR	112.79	74.46	38.32	51%	206.54	(93.76)	(45%)	102.32	72.92	29.41	40%	98.75	3.58	4%
Contract Paid FTEs	19.6	26.5	(6.8)	(26%)	26.5	(6.8)	(26%)	24.7	27.7	(3.0)	(11%)	27.7	(3.0)	(11%)
Physician Fee per Adjust Bed Day	1,343	1,107	236	21%	1,347	(3)	(0%)	1,488	1,437	51	4%	1,511	(23)	(2%)
PHARMACY														
Per Adjust Bed Day	237	349	(112)	(32%)	303	(66)	(22%)	354	453	(99)	(22%)	443	(89)	(20%)
Total Rx Expense	331,813	461,460	(129,647)	(28%)	400,601	(68,788)	(17%)	4,216,124	5,076,056	(859,932)	(17%)	4,963,691	(747,568)	(15%)
MEDICAL SUPPLIES														
Per Adjust Bed Day	177	325	(148)	(46%)	261	(84)	(32%)	401	421	(20)	(5%)	462	(61)	(13%)
Total Medical Supplies	247,645	430,271	(182,626)	(42%)	345,474	(97,829)	(28%)	4,780,159	4,718,712	61,447	1%	5,174,423	(394,264)	(8%)
EHR SYSTEM														
Per Adjust Bed Day	35	102	(67)	(66%)	13	22	160%	33	133	(100)	(75%)	23	10	41%
Total EHR Expense	49,037	135,000	(85,963)	(64%)	17,826	31,211	175%	387,726	1,485,000	(1,097,274)	(74%)	258,114	129,612	50%
OTHER EXPENSE														
Per Adjust Bed Day	732	631	100	16%	558	173	31%	842	846	(4)	(1%)	842	(0)	(0%)
Total Other	1,023,203	834,554	188,649	23%	738,044	285,158	39%	10,033,009	9,482,793	550,216	6%	9,440,538	592,471	6%
DEPRECIATION AND AMORTIZATION														
Per Adjust Bed Day	293	275	18	6%	339	(46)	(14%)	386	357	29	8%	451	(66)	(15%)
Total Depreciation and Amortization	409,164	363,578	45,586	13%	447,841	(38,677)	(9%)	4,596,683	3,999,358	597,325	15%	5,058,443	(461,761)	(9%)
TOTAL EXPENSES	10,258,060	10,067,641	190,419	2%	10,004,437	253,623	3%	105,923,623	110,745,727	(4,822,104)	(4%)	107,180,402	(1,256,780)	(1%)
Per Adjust Bed Day	7,334	7,615	(281)	(4%)	7,567	(233)	(3%)	8,888	9,881	(993)	(10%)	9,563	(675)	(7%)
Per Calendar Day	330,905	324,763	6,143	2%	322,724	8,181	3%	316,190	330,584	(14,394)	(4%)	318,989	(2,799)	(1%)

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

Key Financial Performance Indicators	Industry Benchmark	May-23	FYE 2023 Average	May-24	FYE 2024 Average	Feb-25	Mar-25	Apr-25	May-25	Variance to Prior Month	Variance to FYE 2024 Average	Variance to Prior Year Month
Volume												
Admits	41	78	68	86	71	61	60	51	87	36	16	1
Deliveries	n/a	19	17	22	17	15	14	8	19	11	2	(3)
Adjusted Patient Days	n/a	1,190	977	1,321	1,035	969	511	907	1,399	492	364	78
Total Surgeries	153	123	120	140	146	137	117	157	123	(34)	(23)	(17)
ER Visits	659	815	810	896	840	787	825	794	899	105	59	3
RHC and Clinic Visits	n/a	4,557	4,353	4,999	4,607	4,531	4,734	5,193	4,911	(282)	304	(88)
Diagnostic Imaging Services	n/a	2,191	2,020	2,293	2,069	1,919	2,057	2,081	2,210	129	141	(83)
Rehab Services	n/a	949	762	970	662	635	860	1,161	865	(296)	203	(105)
AR & Income												
Gross AR (Cerner only)	n/a	$ 50,856,137	$ 53,638,580	$ 53,102,112	$ 52,823,707	$ 49,708,783	$ 48,628,722	$ 51,510,454	$ 49,751,818	$ (1,758,636)	$ (3,071,890)	$ (3,350,295)
AR > 90 Days	$ 7,001,767.65	$ 26,738,034	$ 23,387,686	$ 22,672,126	$ 24,488,432	$ 17,112,621	$ 16,111,701	$ 18,527,180	$ 20,779,018	$ 2,251,838	$ (3,709,414)	$ (1,893,108)
AR % > 90 Days	15%	51.45%	45.3%	43.4%	46.7%	34.4%	33.1%	36.0%	41.8%	5.8%	-4.9%	-1.6%
Gross AR Days (per financial statements)	60	87	98	81	85	82	70	85	84	(1)	(1)	3
Net AR Days (per financial statements)	30	36	73	43	58	65	45	103	83	(20)	25	39
Net AR	n/a	$ 9,681,108	$ 17,800,084	$ 13,540,975	$ 16,938,200	$ 17,511,087	$ 18,641,177	$ 12,663,338	$ 24,454,016	$ 11,790,678	$ 7,515,816	$ 10,913,041
Net AR % of Gross	n/a	19.0%	33.1%	25.5%	31.9%	35.2%	38.3%	24.6%	49.2%	24.6%	17.2%	23.7%
Gross Patient Revenue/Calendar Day	n/a	$ 585,271	$ 546,652	$ 656,765	$ 619,457	$ 604,928	$ 699,090	$ 606,428	$ 589,849	$ (16,579)	$ (29,608)	$ (66,917)
Net Patient Revenue/Calendar Day	n/a	$ 269,771	$ 243,317	$ 311,352	$ 292,759	$ 263,197	$ 354,409	$ 179,938	$ 250,736	$ 70,798	$ (42,022)	$ (60,616)
Net Patient Revenue/APD	n/a	$ 7,028	$ 7,622	$ 7,307	$ 8,757	$ 7,603	$ 21,500	$ 5,952	$ 5,557	$ (395)	$ (3,200)	$ (1,749)
Wages												
Wages	n/a	$ 3,154,215	$ 3,281,173	$ 3,311,797	$ 3,285,431	$ 2,832,505	$ 3,511,824	$ 3,803,369	$ 3,599,495	$ (203,874)	$ 314,064	$ 287,698
Employed paid FTEs	n/a	364.62	384.63	357.91	353.69	359.66	363.01	385.47	381.54	(3.93)	27.85	23.63
Employed Average Hourly Rate	$55.50	$ 48.83	$ 49.86	$ 52.24	$ 53.32	$ 49.22	$ 54.61	$ 57.56	$ 53.26	$ (4.30)	$ (0.06)	$ 1.02
Benefits	n/a	$ 1,819,896	$ 1,907,194	$ 1,571,990	$ 1,640,216	$ 1,403,544	$ 1,667,467	$ 1,415,779	$ 1,155,616	$ (260,163)	$ (484,600)	$ (416,373)
Benefits % of Wages	30%	57.7%	58.7%	47.5%	50.3%	49.6%	47.5%	37.2%	32.1%	-5.1%	-18.2%	-15.4%
Contract Labor	n/a	$ 821,563	$ 808,284	$ 968,946	$ 518,351	$ 367,306	$ 283,021	$ 452,748	$ 392,345	$ (60,403)	$ (126,006)	$ (576,601)
Contract Labor Paid FTEs	n/a	37.94	40.27	29.72	23.49	27.74	21.69	20.80	19.64	(1.16)	(3.86)	(10.08)
Total Paid FTEs	n/a	402.56	424.90	387.63	377.18	387.39	384.70	406.26	401.18	(5.09)	24.00	13.54
Contract Labor Average Hourly Rate	$ 81.04	$ 122.24	$ 112.84	$ 184.04	$ 126.74	$ 82.77	$ 73.66	$ 126.99	$ 112.79	$ (14.20)	$ (13.95)	$ (71.26)
Total Salaries, Wages, & Benefits	n/a	$ 5,795,674	$ 5,996,651	$ 5,852,733	$ 5,443,998	$ 4,603,354	$ 5,462,313	$ 5,671,896	$ 5,147,456	$ (524,440)	$ (296,542)	$ (705,277)
SWB% of NR	50%	69.3%	79.8%	60.6%	63.2%	62.5%	49.7%	105.1%	66.2%	-38.8%	3.1%	5.6%
SWB/APD	2,572	$ 4,870	$ 5,909	$ 4,431	$ 5,346	$ 4,749	$ 10,689	$ 6,254	$ 3,680	$ (2,574)	$ (1,666)	$ (750)
SWB % of total expenses	50%	63.8%	66.0%	58.5%	56.7%	53.0%	53.1%	57.0%	50.2%	-6.8%	-6.5%	-8.3%

Physician Spend	Industry Benchmark	May-23	FYE 2023 Average	May-24	FYE 2024 Average	Feb-25	Mar-25	Apr-25	May-25	Variance to Prior Month	Variance to FYE 2024 Average	Variance to Prior Year Month
Physician Expenses	n/a	$ 1,229,279	$ 1,400,634	$ 1,780,354	$ 1,507,510	$ 1,524,202	$ 1,809,889	$ 1,656,184	$ 1,878,965	$ 222,781	$ 371,455	$ 98,611
Physician expenses/APD	n/a	$ 1,033	$ 1,451	$ 1,348	$ 1,478	$ 1,572	$ 3,542	$ 1,826	$ 1,343	$ (483)	$ (135)	$ (4)
Supplies												
Supply Expenses	n/a	$ 227,784	$ 544,557	$ 746,075	$ 776,504	$ 564,895	$ 1,059,159	$ 616,123	$ 579,458	$ (36,665)	$ (197,046)	$ (166,617)
Supply expenses/APD		$ 191	$ 579	$ 565	$ 780	$ 583	$ 2,073	$ 679	$ 414	$ (265)	$ (366)	$ (151)
Other Expenses												
Other Expenses	n/a	$ 1,827,709	$ 1,138,604	$ 1,625,275	$ 1,891,477	$ 1,987,302	$ 1,963,696	$ 2,012,839	$ 2,652,181	$ 639,343	$ 760,704	$ 1,026,906
Other Expenses/APD	n/a	$ 1,536	$ 1,178	$ 1,230	$ 1,878	$ 2,050	$ 3,843	$ 2,219	$ 1,896	$ (323)	$ 18	$ 666
Margin												
Net Income	n/a	$ (915,356)	$ (1,448,727)	$ (36,142)	$ 383,722	$ (1,218,683)	$ 764,746	$ (3,722,346)	$ (2,134,682)	$ 1,587,664	$ (2,518,404)	$ (2,098,540)
Net Profit Margin	n/a	-10.9%	-20.8%	-0.4%	3.0%	-16.5%	7.0%	-69.0%	-27.5%	41.5%	-30.4%	-27.1%
Operating Income	n/a	$ (1,173,331)	$ (2,495,327)	$ (352,524)	$ (686,444)	$ (1,310,237)	$ 691,628	$ (4,558,891)	$ (2,485,229)	$ 2,073,662	$ (1,798,785)	$ (2,132,705)
Operating Margin	2.9%	-14.0%	-33.0%	-3.7%	-10.9%	-17.8%	6.3%	-84.5%	-32.0%	52.5%	-21.1%	-28.3%
EBITDA	n/a	$ (1,259,806)	$ (1,789,289)	$ 411,699	$ 841,891	$ (809,519)	$ 1,173,910	$ (3,313,182)	$ (1,725,518)	$ 1,587,664	$ (2,567,409)	$ (2,137,217)
EBITDA Margin	12.7%	-15.1%	-22.6%	4.3%	8.7%	-11.0%	10.7%	-61.4%	-22.2%	39.2%	-30.9%	-26.5%
Debt Service Coverage Ratio	3.70		(5.8)	3.6	3.3	6.9	6.6	4.2	3.1	(1.1)	(0.2)	(0.5)
Cash												
Avg Daily Disbursements (excl. IGT)	n/a	$ 363,468	$ 363,636	$ 342,362	$ 355,328	$ 413,756	$ 314,837	$ 321,662	$ 359,335	$ 37,673	$ 4,007	$ 16,973
Average Daily Cash Collections (excl. IGT)	n/a	$ 423,206	$ 340,919	$ 294,096	$ 299,110	$ 271,384	$ 363,569	$ 391,697	$ 359,285	$ (32,412)	$ 60,174	$ 65,188
Average Daily Net Cash		$ 59,738	$ (22,716)	$ (48,265)	$ (56,218)	$ (142,373)	$ 48,733	$ 70,035	$ (50)	$ (70,085)	$ 56,168	$ 48,215
Upfront Cash Collections				$ 34,412	$ 36,146	$ 83,209	$ 78,395	$ 71,226	$ 81,100	$ 9,874	$ 44,954	$ 46,688
Upfront Cash % of Gross Charges	1%	0.0%	0.0%	0.2%	0.2%	0.5%	0.4%	0.4%	0.4%	$ 0	$ 0	$ 0
Unrestricted Funds	n/a	$ 26,740,594	$ 25,185,410	$ 27,788,508	$ 23,536,438	$ 23,805,870	$ 23,918,889	$ 27,688,938	$ 27,908,135	$ 219,197	$ 4,371,697	$ 119,627
Change of cash per balance sheet	n/a	$ 1,851,890	$ 204,360	$ 13,346,102	$ (541,459)	$ 1,061,144	$ 113,019	$ 3,770,050	$ 219,197	$ (3,550,853)	$ 760,655	$ (13,126,905)
Days Cash on Hand (assume no more cash is collected)	196	91	83	90	72	86	80	92	92	-	20	2
Estimated Days Until Depleted (operating cash only)		-	1,109	482	406	332	411	610	676	66	270	194
Years Until Cash Depletion (operating cash only)		-	3.04	1.32	1.11	0.91	1.13	1.67	1.85	0.18	0.74	0.53

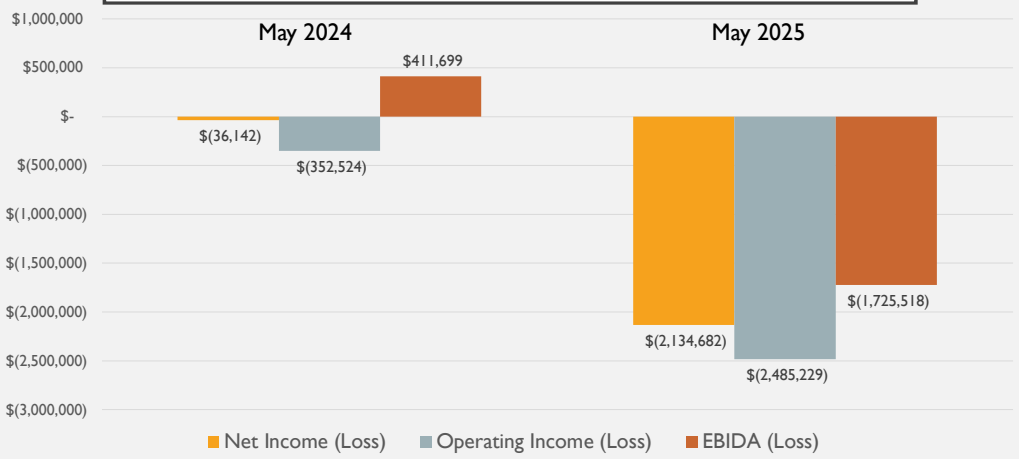
NORTHERN INYO HEALTHCARE DISTRICT
One Team. One Goal. Your Health.

NIHD FINANCIAL UPDATE

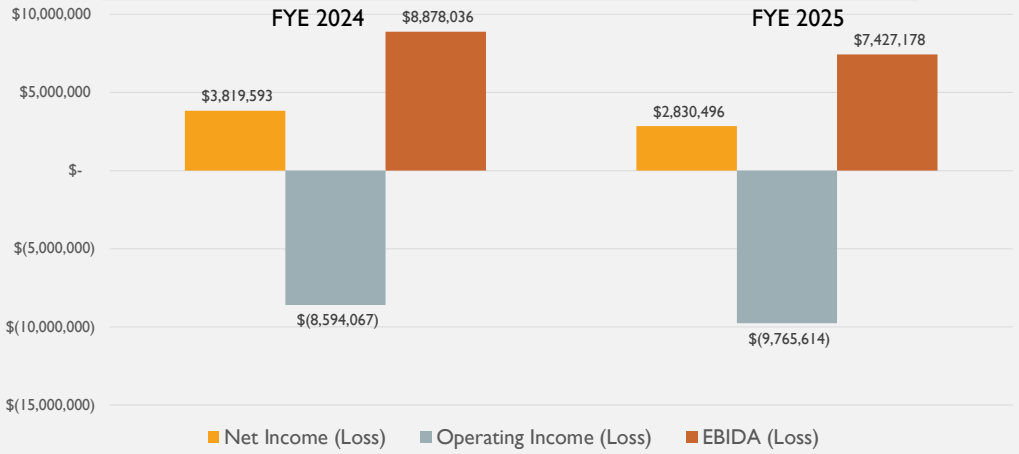
May 2025

INCOME

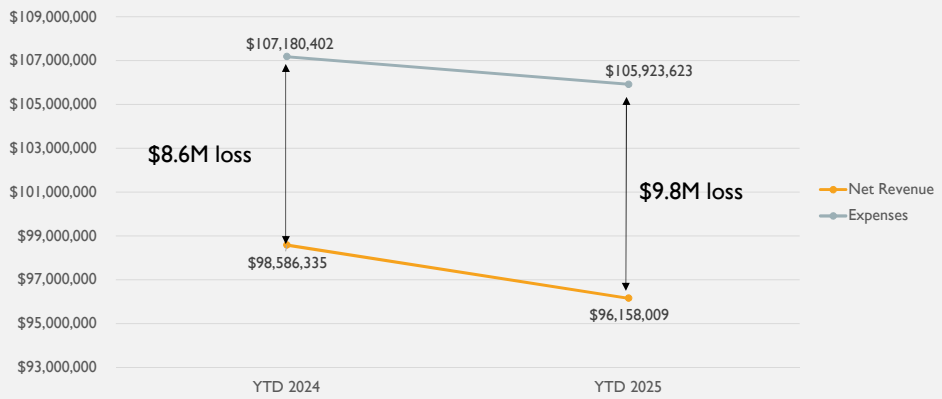
MAY 2025 FINANCIAL PERFORMANCE



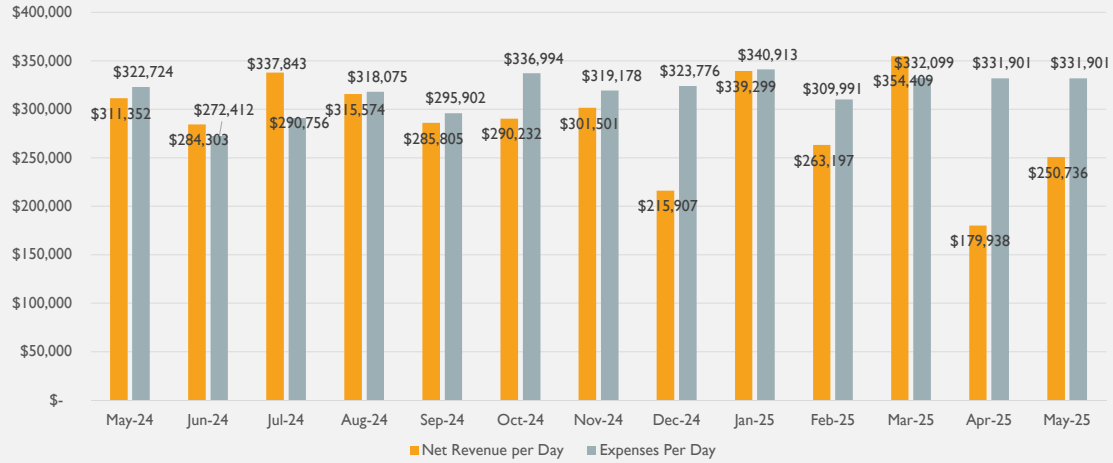
FYE 2025 FINANCIAL PERFORMANCE



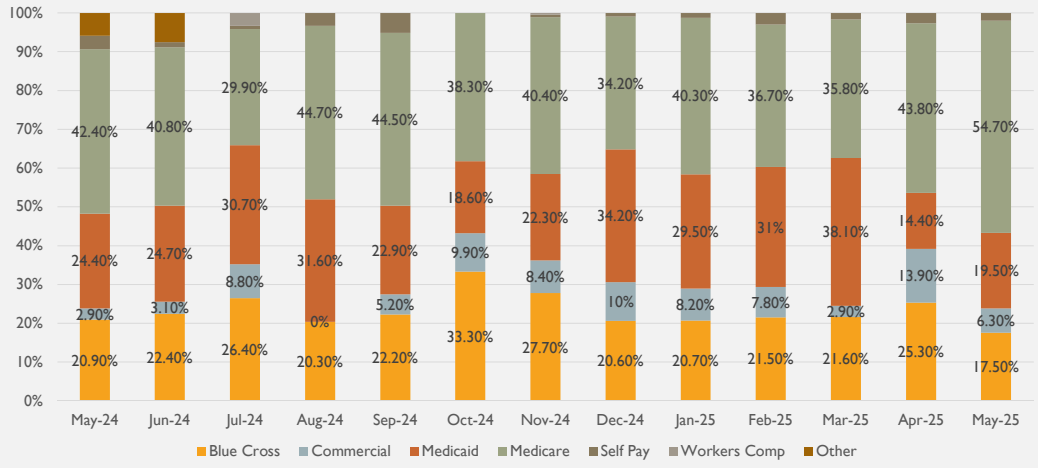
YTD OPERATING INCOME (LOSS) PERFORMANCE



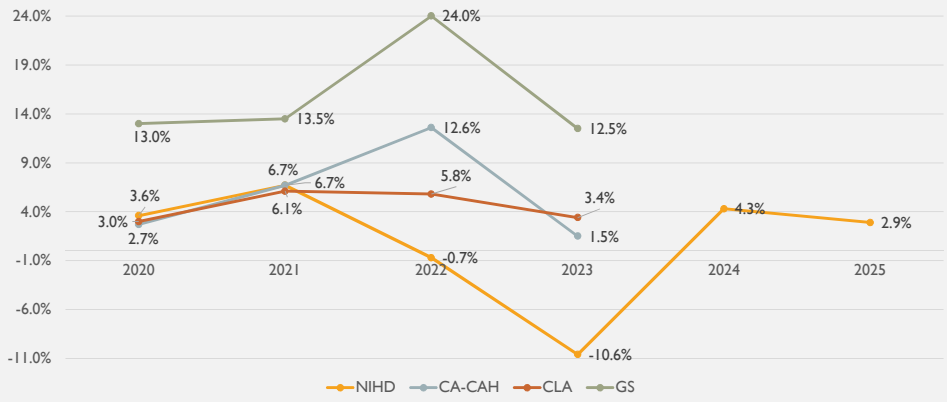
TREND PER CALENDAR DAY



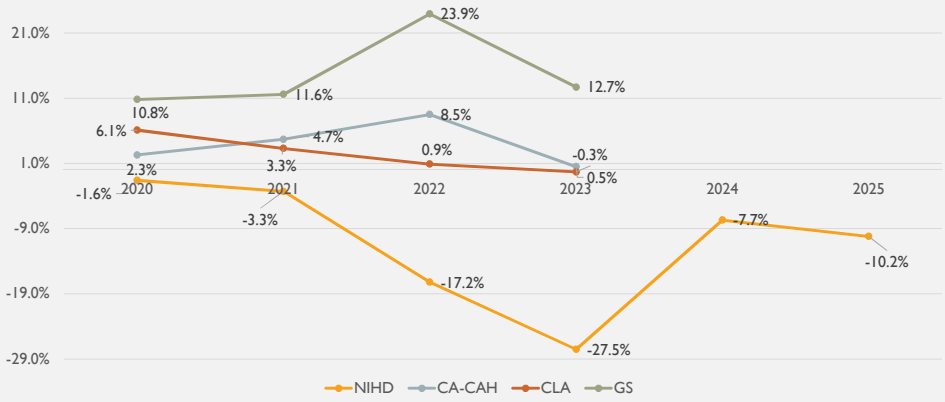
PAYOR MIX TREND



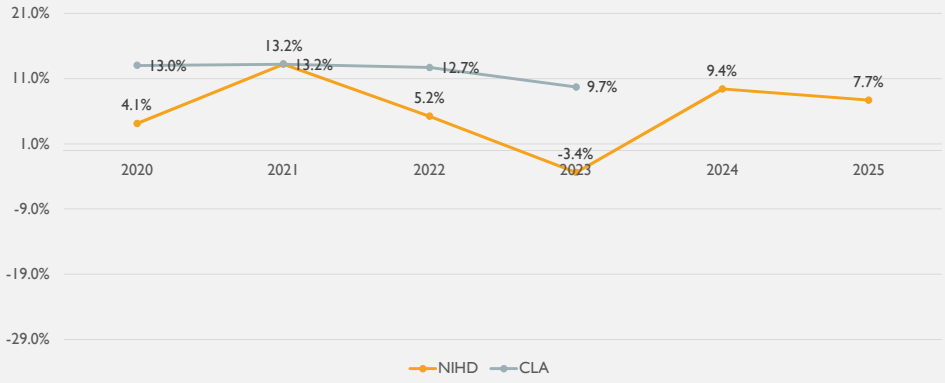
NET PROFIT MARGIN



OPERATING MARGIN

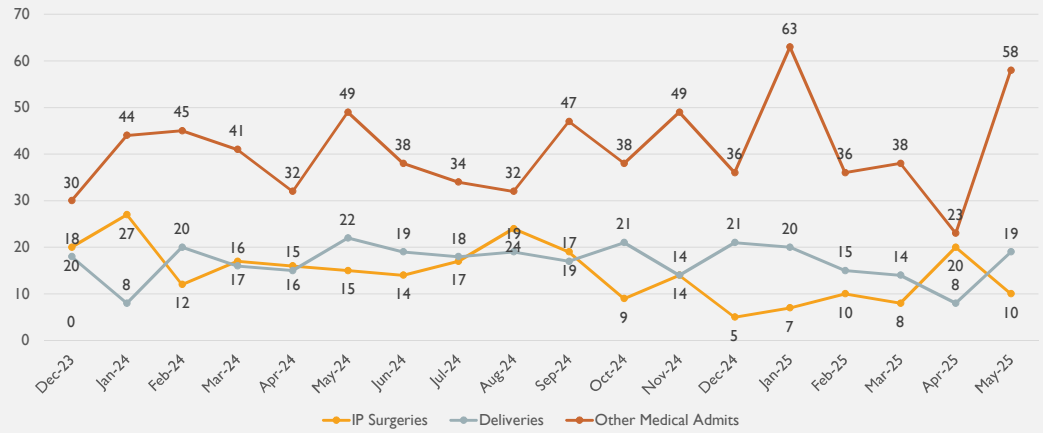


EBIDA MARGIN

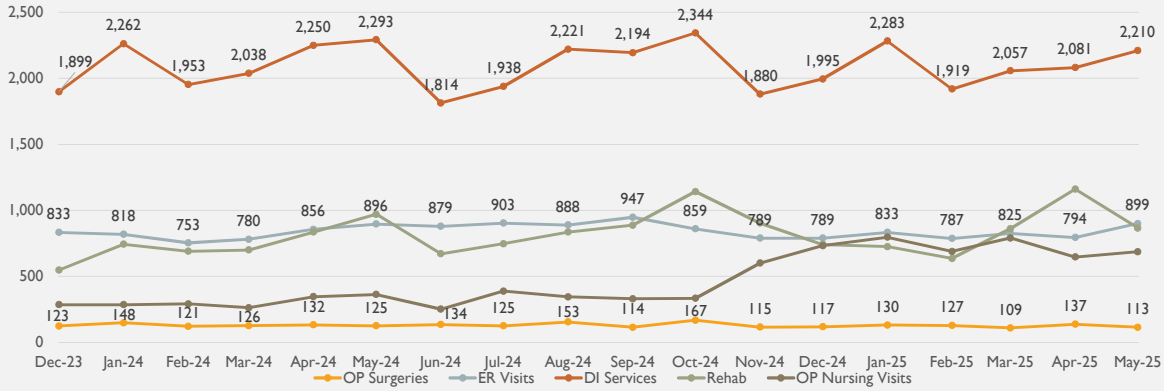


VOLUMES

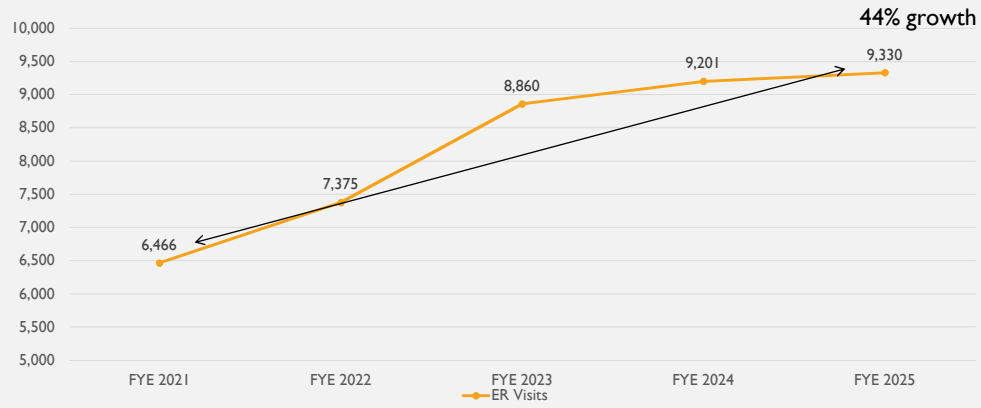
INPATIENT VOLUME PERFORMANCE



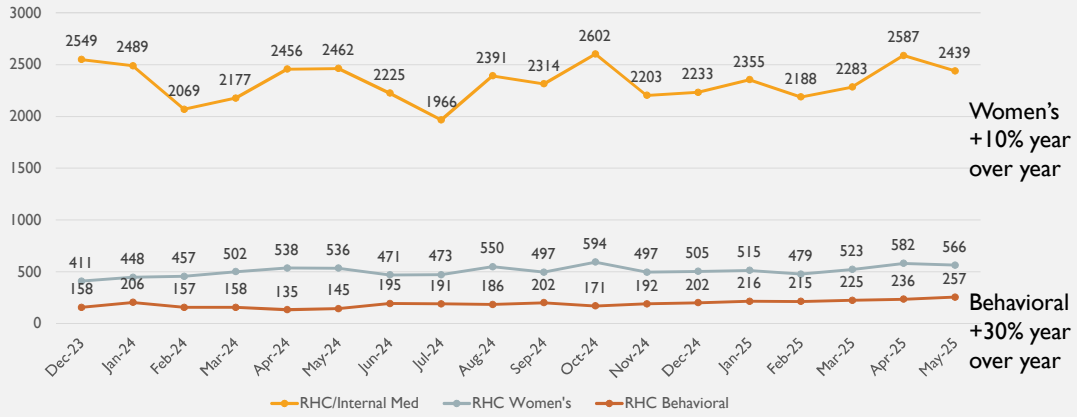
OUTPATIENT VOLUME PERFORMANCE



ER VISITS



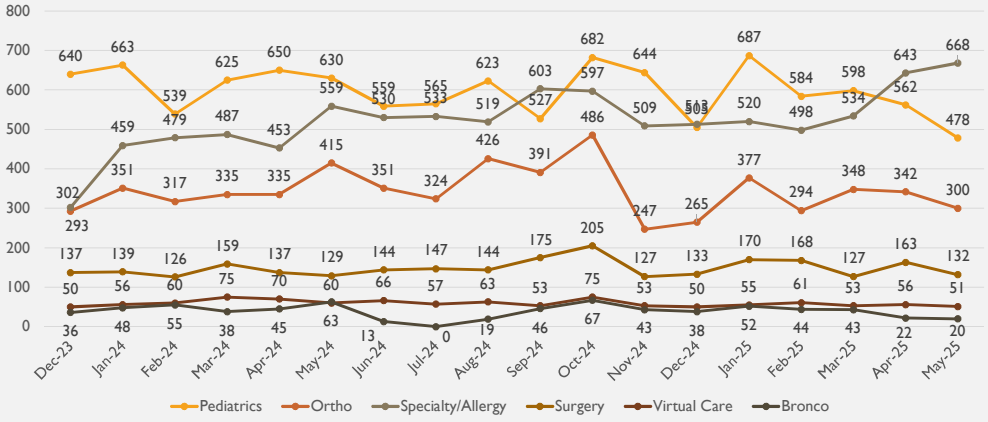
RHC VOLUME PERFORMANCE



Women's +10% year over year

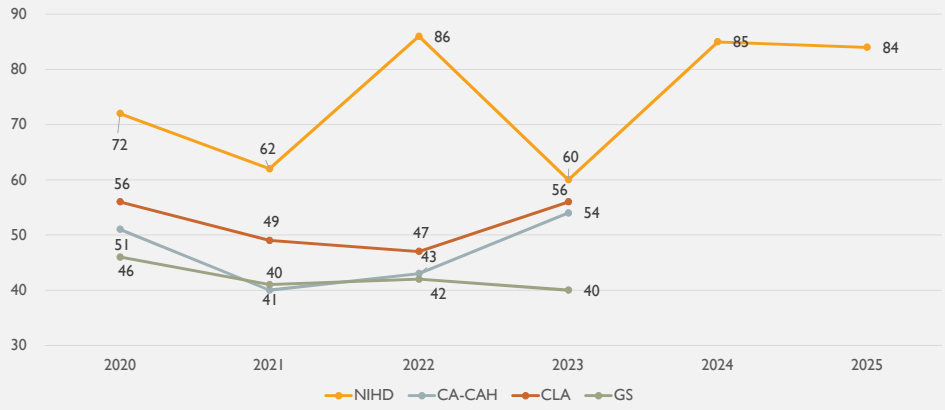
Behavioral +30% year over year

CLINIC VOLUME PERFORMANCE

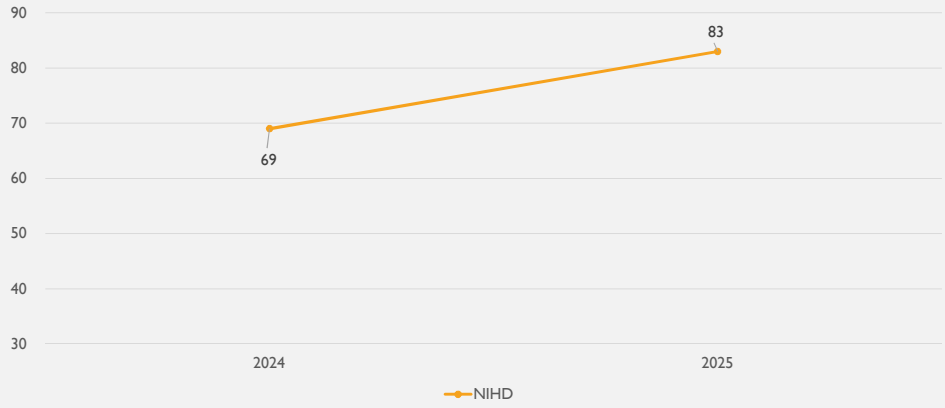


KEY PERFORMANCE INDICATORS

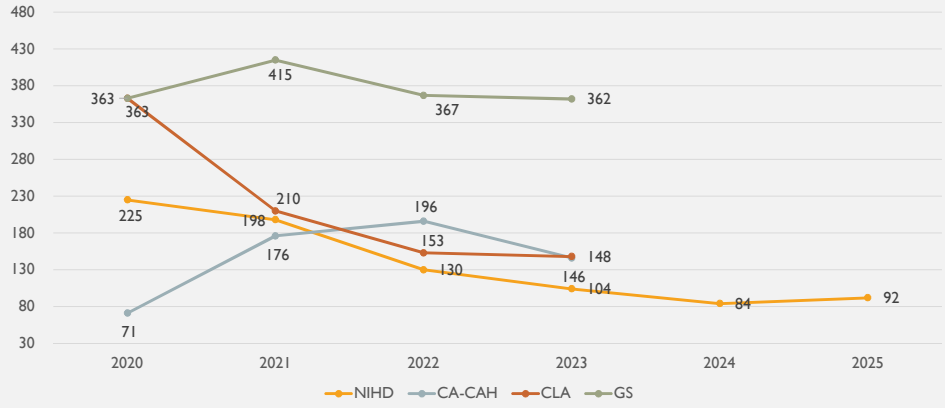
GROSS AR DAYS



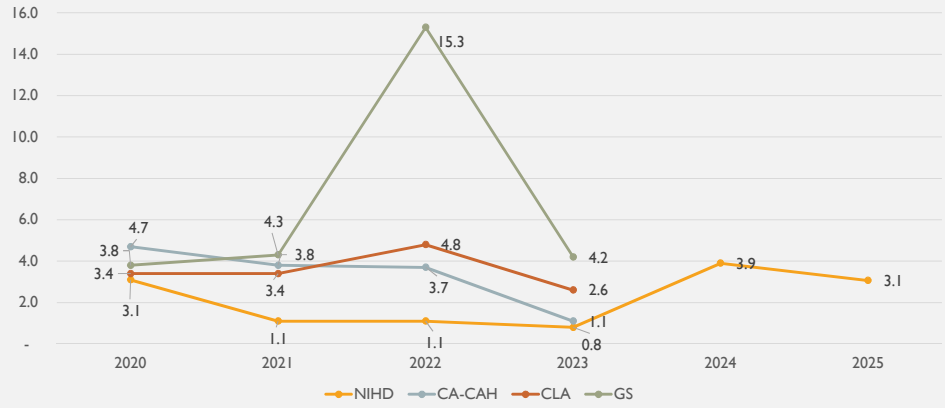
NET AR DAYS



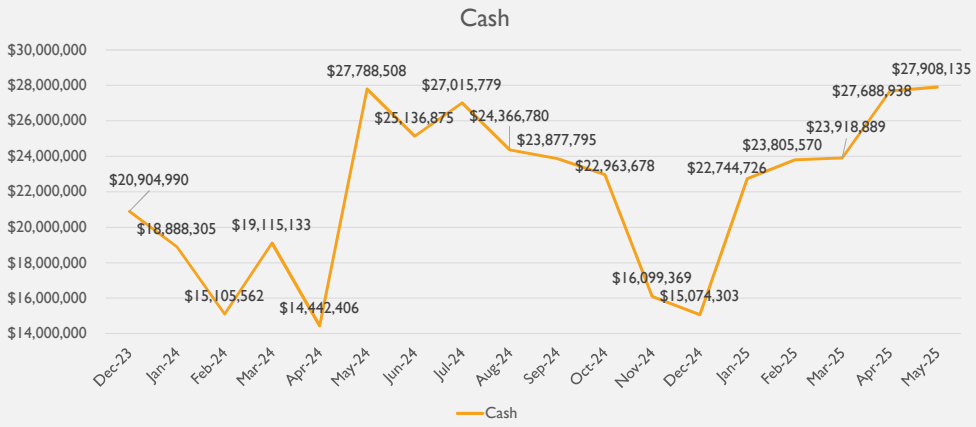
DAYS CASH ON HAND



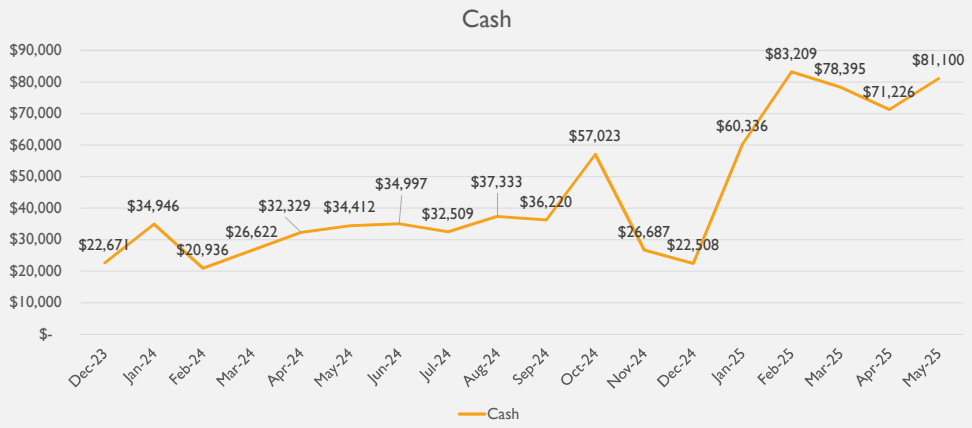
DEBT SERVICE COVERAGE RATIO



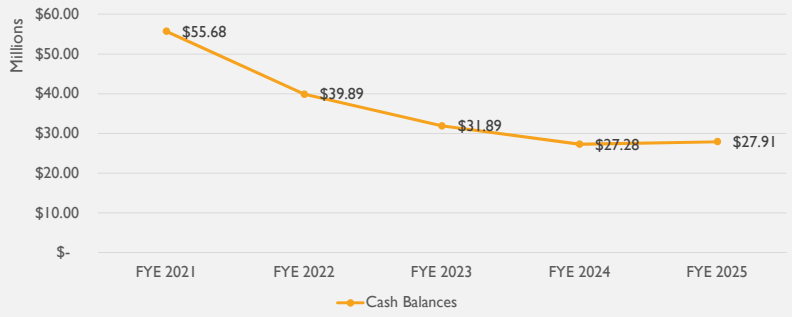
UNRESTRICTED FUNDS



UPFRONT CASH COLLECTIONS



CASH BALANCE TREND



WAGE COSTS

	YTD 2024	YTD 2025
Total Paid FTEs	385	389
Salaries, Wages, Benefits (SWB) Expense (incl. contract labor)	$59,825,391	$57,506,571
SWB % of total expenses (including contract labor)	56%	54%
Employed Average Hourly Rate	$52.01	$52.29
Benefits % of Wages	53%	45%

Northern Inyo Healthcare District
Income Statement
Fiscal Year 2025

	2/29/2025	Feb Budget	2/28/2024	3/31/2025	Mar Budget	3/31/2024	4/30/2025	Apr Budget	4/30/2024	5/31/2025	May Budget	5/31/2024	2025 YTD	2024 YTD	Budget Variance	PYM Change	PYTD Change
Gross Patient Service Revenue																	
Inpatient Patient Revenue	2,845,791	3,478,230	3,063,000	6,901,902	3,536,492	3,740,981	3,003,097	3,168,714	3,215,615	3,371,624	3,526,682	3,646,287	40,773,821	38,554,203	(155,058)	(274,663)	2,219,618
Outpatient Revenue	12,402,184	14,066,268	12,719,309	13,051,580	13,918,914	11,921,652	13,297,993	13,441,623	15,650,478	13,103,211	14,185,079	14,890,447	152,515,200	152,183,966	(1,081,867)	(1,787,235)	331,234
Clinic Revenue	1,689,999	1,599,414	1,500,716	1,718,306	1,594,299	1,601,821	1,891,743	1,579,674	1,763,094	1,810,472	1,587,112	1,822,994	19,422,853	17,723,375	223,360	(12,522)	1,699,478
Gross Patient Service Revenue	16,937,974	19,143,911	17,283,024	21,671,787	19,049,705	17,264,454	18,192,833	18,190,012	20,629,186	18,285,307	19,298,872	20,359,728	212,711,874	208,461,544	(1,013,565)	(2,074,421)	4,250,330
Deductions from Revenue															-		-
Contractual Adjustments	(8,529,361)	(8,800,983)	(9,066,535)	(10,138,614)	(8,800,983)	(15,144,877)	(8,841,205)	(8,800,983)	(10,525,952)	(7,499,521)	(9,183,956)	(9,761,982)	(101,150,225)	(103,077,386)	1,684,435	2,262,461	1,927,161
Bad Debt	(194,637)	(627,905)	(285,977)	(370,446)	(612,905)	4,239,262	(3,774,465)	(597,905)	131,776	(2,837,626)	(582,161)	(538,525)	(6,971,246)	(1,663,671)	(2,255,465)	(2,299,101)	(5,307,576)
A/R Writeoffs	(844,459)	(542,909)	(567,860)	(176,044)	(542,909)	(706,178)	(179,014)	(542,909)	(285,526)	(177,633)	(566,533)	(410,472)	(8,286,515)	(5,141,184)	388,900	232,838	(3,145,331)
Other Deductions from Revenue	-	-	-	-	-	-	-	-	-	-	-	-	(152,618)	-	-	-	(152,618)
Deductions from Revenue	(9,568,457)	(9,971,797)	(9,920,372)	(10,685,103)	(9,956,797)	(11,611,793)	(12,794,684)	(9,941,797)	(10,679,701)	(10,514,779)	(10,332,650)	(10,710,978)	(116,560,604)	(109,882,241)	(182,129)	196,199	(6,678,363)
Other Patient Revenue																	-
Incentive Income	-	-	-	-	-	-	-	-	-	2,304	-	-	4,304	-	2,304	2,304	4,304
Other Oper Rev - Rehab Thera Serv	-	-	862	-	-	-	-	-	-	-	-	3,163	2,435	6,979	-	(3,163)	(4,544)
Medical Office Net Revenue	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Other Patient Revenue	-	-	862	-	-	-	-	-	-	2,304	-	3,163	6,738	6,979	2,304	(859)	(240)
Net Patient Service Revenue	**7,369,517**	**9,172,114**	**7,363,514**	**10,986,684**	**9,092,908**	**5,652,661**	**5,398,149**	**8,248,215**	**9,949,485**	**7,772,831**	**8,966,222**	**9,651,912**	**96,158,009**	**98,586,282**	**(1,193,391)**	**(1,879,081)**	**(2,428,273)**
CNR%	**43.5%**	**47.9%**	**42.6%**	**50.7%**	**47.7%**	**32.7%**	**29.7%**	**45.3%**	**48.2%**	**42.5%**	**46.5%**	**47.4%**	**45.2%**	**47.3%**	**-4.0%**	**-4.9%**	**-2.1%**
Cost of Services - Direct																	-
Salaries and Wages	2,430,386	3,309,193	2,516,276	2,997,295	3,540,655	2,677,613	3,078,978	3,453,964	2,792,227	3,089,016	3,536,678	2,867,100	30,887,479	30,485,898	(447,662)	221,916	401,582
Benefits	1,184,125	2,021,621	1,537,835	1,425,501	2,234,956	1,490,439	1,277,083	2,065,622	2,146,672	935,894	2,072,172	1,340,313	13,851,078	16,200,544	(1,136,278)	(404,419)	(2,349,466)
Professional Fees	1,772,635	1,883,219	1,623,461	2,013,306	1,888,549	1,976,553	1,903,652	1,880,084	1,780,229	2,159,742	1,884,595	1,979,333	20,335,121	19,746,332	275,146	180,409	588,789
Contract Labor	377,408	340,148	405,743	187,691	386,404	364,547	355,281	343,860	205,329	292,586	349,333	952,538	3,984,100	4,727,868	(56,747)	(659,952)	(743,768)
Pharmacy	207,210	461,460	474,631	755,356	461,460	442,678	327,061	461,460	656,870	331,813	461,460	400,601	4,216,124	4,963,691	(129,647)	(68,788)	(747,568)
Medical Supplies	357,873	430,271	218,356	303,803	429,135	642,449	289,061	427,518	352,626	247,645	430,271	345,474	4,780,159	5,174,423	(182,626)	(97,829)	(394,264)
Hospice Operations	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
EHR System Expense	32,417	135,000	126,094	20,415	135,000	(768,589)	44,592	135,000	16,399	49,037	135,000	17,826	387,726	258,114	(85,963)	31,211	129,612
Other Direct Expenses	615,234	842,560	696,431	585,010	863,658	834,238	602,461	869,498	571,418	737,203	834,554	562,883	7,278,176	7,300,101	(97,350)	174,321	(21,924)
Total Cost of Services - Direct	6,977,287	9,423,470	7,598,828	8,288,377	9,939,816	7,659,929	7,878,169	9,637,006	8,521,770	7,842,936	9,704,063	8,466,067	85,719,963	88,856,971	(1,861,127)	(623,131)	(3,137,008)
General and Administrative Overhead																	
Salaries and Wages	402,119	-	427,743	514,529	-	494,737	724,391	-	547,877	510,479	-	444,697	5,560,503	5,155,436	510,479	65,782	405,067
Benefits	219,418	-	264,414	241,966	-	284,918	138,697	-	346,888	219,722	-	231,676	2,375,566	2,733,172	219,722	(11,955)	(357,606)
Professional Fees	428,917	-	344,426	494,527	-	451,329	431,885	-	153,271	890,001	-	222,585	4,068,230	2,713,469	890,001	667,416	1,354,761
Contract Labor	(10,102)	-	24,000	95,330	-	63,611	97,467	-	114,784	99,759	-	16,409	847,845	522,474	99,759	83,351	325,372
Depreciation and Amortization	409,164	363,578	386,783	409,164	363,578	1,264,318	409,164	363,578	438,198	409,164	363,578	447,841	4,596,683	5,058,443	45,586	(38,677)	(461,761)
Other Administative Expenses	253,138	-	142,398	251,163	-	258,954	277,268	-	336,216	285,999	-	175,162	2,754,833	2,140,437	285,999	110,838	614,395
Total General and Administrative Overhead	1,702,654	363,578	1,589,765	2,006,679	363,578	2,817,866	2,078,872	363,578	1,937,234	2,415,124	363,578	1,538,370	20,203,659	18,323,431	2,051,546	876,755	1,880,228
Total Expenses	**8,679,941**	**9,787,048**	**9,188,592**	**10,295,056**	**10,303,394**	**10,477,795**	**9,957,041**	**10,000,584**	**10,459,004**	**10,258,060**	**10,067,641**	**10,004,437**	**105,923,623**	**107,180,402**	**190,419**	**253,623**	**(1,256,780)**
Financing Expense	195,369	179,044	184,336	201,224	183,367	345,952	194,928	183,367	197,249	198,265	183,367	209,254	2,198,284	2,195,815	14,898	(10,989)	2,469
Financing Income	78,984	238,960	228,125	78,984	498,443	228,125	903,825	238,960	228,125	250,741	259,482	228,125	2,897,257	2,509,370	(8,741)	22,616	387,887
Investment Income	37,373	46,181	(105,802)	49,720	133,181	39,189	58,156	46,181	164,066	54,996	46,181	46,777	531,982	675,063	8,815	8,220	(143,081)
Miscellaneous Income	170,566	9,550,168	9,178,896	145,639	173,534	342,474	69,492	177,387	121,862	243,074	170,125	250,735	11,365,155	11,425,043	72,950	(7,661)	(59,888)
Net Income (Change in Financial Position)	**(1,218,870)**	**9,041,331**	**7,291,804**	**764,746**	**(588,696)**	**(4,561,299)**	**(3,722,346)**	**(1,473,208)**	**(192,715)**	**(2,134,682)**	**(808,998)**	**(36,142)**	**2,830,496**	**3,819,540**	**(1,325,684)**	**(2,098,540)**	**(989,045)**
Operating Income	(1,310,424)	(614,934)	(1,825,078)	691,628	(1,210,486)	(4,825,134)	(4,558,891)	(1,752,369)	(509,519)	(2,485,229)	(1,101,419)	(352,524)	(9,765,614)	(8,594,120)	(1,383,810)	(2,132,705)	(1,171,493)
EBIDA	(809,707)	9,404,909	7,678,588	1,173,910	(225,118)	(3,296,981)	(3,313,182)	(1,109,630)	245,483	(1,725,518)	(445,420)	411,699	7,427,178	8,877,983	(1,280,098)	(2,137,217)	(1,450,805)
Net Profit Margin	-16.5%	98.6%	99.0%	7.0%	-6.5%	-80.7%	-69.0%	-17.9%	-1.9%	-27.5%	-9.0%	-0.4%	2.9%	3.9%	-18.4%	-27.1%	-0.9%
Operating Margin	-17.8%	-6.7%	-24.8%	6.3%	-13.3%	-85.4%	-84.5%	-21.2%	-5.1%	-32.0%	-12.3%	-3.7%	-10.2%	-8.7%	-19.7%	-28.3%	-1.4%
EBIDA Margin	-11.0%	102.5%	104.3%	10.7%	-2.5%	-58.3%	-61.4%	-13.5%	2.5%	-22.2%	-5.0%	4.3%	7.7%	9.0%	-17.2%	-26.5%	-1.3%

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	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	220,905	(1,704,166)
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	(1,398)	1,327,029
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	11,790,678	10,913,041
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	(11,235,366)	(9,066,308)
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	(8,661)	1,831,588
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	(376,847)	(291,615)
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**	**389,311**	**3,009,569**
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	128	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	-	(1,802,389)
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	-	-
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	-	(1,802,389)
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	(5,744)	(643,730)
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**	**(5,616)**	**(2,444,613)**
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	(311)	(1,343,879)
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	(264,823)	(2,054,262)
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**	**(265,134)**	**(3,398,140)**
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**	**118,561**	**(2,833,184)**
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	90,782	223,429
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	728,849	(336,206)
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	416,398	(3,275,185)
Accrued Interest and Sales Tax	109,159	424,010	238,080	144,235	314,125	220,309	140,964	141,308	39,126	(79,001)	102,182
Notes Payable	446,860	446,860	1,035,689	446,860	931,738	446,860	931,738	339,892	446,860	(106,968)	(106,968)
Unearned Revenue	(4,542)	(4,542)	(4,542)	(4,542)	(4,542)	(4,542)	(1,812)	(4,542)	662	-	(5,204)
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	(1,971,000)	(1,026,563)
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	(2,070)	10,657,531
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**	**(923,008)**	**6,233,016**
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	(101,342)	(2,835,350)
Bond Premium	165,618	140,522	178,166	137,384	175,029	134,247	171,892	131,110	168,755	(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	89,034	285,937
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	-	(14,311,308)
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**	**(15,445)**	**(16,898,366)**
Suspense Liabilities	-	-	-	-	-	-	-	-	-	-	-
Uncategorized Liabilities (grants)	31,506	127,821	124,918	139,321	123,693	139,321	124,093	139,321	122,993	-	16,328
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**	**(938,453)**	**(10,649,022)**
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	3,191,569	8,803,429
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	128	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	(2,134,682)	(989,098)
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**	**1,057,014**	**7,815,838**
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**	**118,561**	**(2,833,184)**
(Decline)/Gain		(1,593,545)	7,268,230	4,447,593	(4,128,674)	(3,359,679)	(1,350,778)	118,561	12,156	3,478,240	106,405

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	$ 2,830,496
+ Depreciation Expense	4,596,683
+ Interest Expense	2,198,284
Less GO Property Tax revenue	1,988,207
Less GO Interest Expense	447,235
"Income available for debt service"	**$ 7,190,020**
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**
	2,340,924
Ratio: (numerator / denominator)	**3.07**
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	$ 27,411,370
Cash and Investments-non current	496,765
Sub-total	27,908,135
Less - Restricted:	
PRF and grants (Unearned Revenue)	-
Held with bond fiscal agent	-
Building and Nursing Fund	-
Total Unrestricted Funds	**$ 27,908,135**
Total Operating Expenses	$ 105,923,623
Less Depreciation	4,596,683
Net Expenses	101,326,940
Average Daily Operating Expense	$ 303,374
Days Cash on Hand	**92**

Northern Inyo Healthcare District
Statement of Cash Flows
Fiscal Year 2025

CASH FLOWS FROM OPERATING ACTIVITIES	
Receipts from and on Behalf of Patients	96,205,954
Payments to Suppliers and Contractors	(44,591,093)
Payments to and on Behalf of Employees	(57,506,571)
Other Receipts and Payments, Net	(449,507)
Net Cash Provided (Used) by Operating Activities	(6,341,216)
CASH FLOWS FROM NONCAPITAL FINANCING ACTIVITIES	
Noncapital Contributions and Grants	9,059,829
Property Taxes Received	909,049
Other	2,897,257
Net Cash Provided (Used) by Noncapital Financing Activities	12,866,135
CASH FLOWS FROM CAPITAL AND CAPITAL RELATED FINANCING ACTIVITIES	
Principal Payments on Long-Term Debt	(1,861,947)
Proceeds from the Issuance of Refunding Revenue Bonds	-
Payment to Defease Revenue Bonds	-
Interest Paid	(2,198,284)
Purchase and Construction of Capital Assets	(696,318)
Payments on Lease Liability	(667,393)
Payments on Subscription Liability	(598,622)
Property Taxes Received	954,410
Net Cash Provided (Used) by Capital and Capital Related Financing Activities	(5,068,154)
CASH FLOWS FROM INVESTING ACTIVITIES	
Investment Income	531,982
Rental Income	66,251
Net Cash Provided (Used) by Investing Activities	598,233
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