

# Board Meeting

## Board Meeting - June 17, 2026

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### **Mission**

Northern Inyo Healthcare District provides health care services to improve the quality of life and health for all we serve

### **Vision**

Northern Inyo Healthcare District will be known throughout the Eastern Sierra Region for providing high quality, compassionate, comprehensive care in coordination with regional partners.

## **AGENDA**

### NORTHERN INYO HEALTHCARE DISTRICT BOARD OF DIRECTORS REGULAR MEETING

June 17, 2026, 4:15 pm

**Open Session scheduled to begin at 5:00 pm**

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

TO CONNECT VIA ZOOM: (A link is also available on the NIHD Website)

<https://us06web.zoom.us/j/86114057527>

Webinar ID: 861 1405 7527

Passcode: 898843

#### PHONE CONNECTION:

(669) 444-9171

(719) 359-4580

Webinar ID: 861 1405 7527

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1. Call to order at 4:15 pm
2. Public comment on closed session items
3. Adjournment to closed session for:
  - a. Conference with legal counsel - Anticipated litigation  
Significant exposure to litigation pursuant to Government Code § 54956.9(d)(2)  
Potential Case(s): One Case (1)  
**Open Session Scheduled to begin at 5:00 pm**
4. Return to open session and report on any actions taken in closed session.
5. 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.

6. 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 May 20, 2026 Regular Board Meeting
  - b. Approval of Policies and Procedures
    - i. Capitalization of Assets
    - ii. Code White
    - iii. IT Hardware Lifecycle Policy
    - iv. Sterilization Recall
    - v. Use of Human Donor Breastmilk/Storage of Breastmilk
7. Consideration of Credentialing Actions recommended by the Medical Executive Committee – Action Item
  - a. Medical Staff Initial Appointments 2026-2027
8. Medical Staff Bylaws – Action Item
9. Chief Executive Officer Report
  - a. Auxiliary Report – Information Item
  - b. Foundation Report – Information Item
  - c. NIHD Workforce Housing Needs – Information Item
  - d. Bishop Commons Worker Housing Memorandum of Understanding – Action item
  - e. Strategic Growth, Wipfli / WOLD Update – Information Item
  - f. Opening Meeting Routine – Action Item
10. Chief Human Resources Officer Report
  - a. Retirement Accounts – Information Item
11. Chief Financial Officer Report
  - a. Financial and Statistical Report – Action Item
12. General Information from Board Members
13. 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 before the meeting.*

CALL TO ORDER Northern Inyo Healthcare District (NIHD) Board Chair Best-Baker called the meeting to order at 3:30 pm.

PRESENT  
Melissa Best-Baker, Chair  
David Lent, Vice-Chair  
Maggie Egan, Secretary  
Laura Smith, Treasurer  
Jean Turner, Member at Large  
  
Christian Wallis, Chief Executive Officer  
Allison Partridge, Chief Operations Officer / Chief Nursing Officer  
Alison Murray, Chief Human Resources Officer, Chief Business Development Officer  
Andrea Mossman, Chief Financial Officer

ABSENT Adam Hawkins, Chief Medical Officer

TELECONFERENCING Notice has been posted, and a quorum participated from locations within the jurisdiction.

PUBLIC COMMENT ON CLOSED SESSION ITEMS Chair Best-Baker reported that at this time, audience members may speak only on closed session agenda items.  
  
**Public Comment:** None

ADJOURN TO CLOSED SESSION Adjourn to closed session at 3:31 pm.

RETURN TO OPEN SESSION Return to open session at 5:38 pm.

REPORT OUT FROM CLOSED SESSION Report out: The Board of Directors voted to reject the request to file a late claim.

PUBLIC COMMENT Chair Best-Baker reported that at this time, audience members may speak on any items not on the agenda that are within the jurisdiction of the Board.  
  
**Public Comment:**  
Lopez and Morgan of HealthTrust Workforce Solutions introduced themselves to the Board and shared that they were in Bishop conducting a benchmarking assessment for the District at the request of the Board and administration. They stated they had been gathering information during their visit and anticipated providing a report to the Board and administration within approximately 45 days.  
  
A speaker commented that holding lengthy closed session discussions immediately before the regular meeting created long wait times for members of the public and suggested considering separate timing for certain closed session

items. A request was also made for the District to help the community understand how upcoming county, state, and federal elections could affect District funding and to discuss the topic publicly at a future meeting. Board leadership explained that the topic could be discussed publicly only if brought forward as a future agenda item.

Public comment included concerns regarding the community perception of Northern Inyo Healthcare District and reports that local residents frequently seek healthcare services outside the area, including in Carson City. A speaker encouraged the District to examine factors affecting public trust and utilization of local healthcare services.

A community member also discussed reviving a former local health-focused television program to help improve public understanding of hospital services, staff, and healthcare processes. The speaker suggested featuring physicians, nurses, administrators, and departments through recorded interview sessions distributed through television, YouTube, and social media platforms to strengthen community engagement and address misinformation regarding healthcare and insurance processes.

CONSENT AGENDA

**Public Comment:** None

**Board Discussion:** None

**Motion by** Smith to approve the consent agenda.

**2<sup>nd</sup>:** Lent

**Pass:** 5-0

CONSIDERATION OF  
CREDENTIALING  
ACTIONS  
RECOMMENDED BY THE  
MEDICAL EXECUTIVE  
COMMITTEE

**Public Comment:** None

**Board Discussion:** None

**Motion by** Egan to approve the credentialing actions recommended by the Medical Executive Committee

**2<sup>nd</sup>:** Turner

**Pass:** 5-0

CEO REPORT

**AB 2561 (McKinnor): Local public employees: vacant positions**

Human Resources Manager Routt presented the annual AB 2561 Local Public Employee Vacant Positions Report, which provides a high-level review of District vacancies, recruitment trends, and retention efforts. She reported that Northern Inyo Healthcare District currently had 18 active vacancies, including 14 represented positions consisting primarily of registered nurses and technicians, along with four non-represented positions. She also stated that an additional 18 vacancies were on hold due to candidates currently being selected or completing pre-employment onboarding processes.

She explained that the District had successfully closed 95 requisitions during the fiscal year through a combination of internal promotions, external

recruitment, rehires, and conversion of contracted staff into permanent employees. She noted significant internal movement within the organization, including employees entering through entry-level positions and later advancing into other roles through career growth opportunities.

She identified several difficult-to-fill positions, including physical therapy, speech-language pathology, clinical laboratory scientist, radiology technician, perinatal RN, and surgery RN positions. Routt stated that the District continues to utilize multiple staffing agencies for both temporary and permanent recruitment efforts and has expanded employee engagement and retention initiatives through recognition programs, Hospital Week activities, career ladder programs, and planned negotiations with union partners regarding the development of an LVN career ladder program.

**Public Comment:** None

**Board Discussion:** None

**Motion by Smith** to accept the AB 2561 report  
**2<sup>nd</sup>:** Turner  
**Pass:** 5-0

### **Bishop Commons**

CEO Wallis introduced representatives from Foothill Partners, including Wiele and Oliverio, to present a proposed workforce housing redevelopment project for the former Kmart property in Bishop. The presenters explained that the project would demolish the long-vacant Kmart building and replace it with approximately 100 modular studio and one-bedroom workforce housing units intended primarily for single workers and couples. The presenters described the project as an effort to address regional workforce housing shortages affecting healthcare, retail, government, and tourism employers. They stated that investment groups are interested in financing the project but have requested evidence of local demand through preliminary leasing commitments from major employers and agencies. The presentation also included discussion regarding modular construction methods, projected rental rates around \$1,800 per month, potential future restaurant and retail uses on the property frontage, and a proposed timeline of approximately 18 months to two years before occupancy.

### **Public Comment:**

A community member expressed support for additional housing opportunities but emphasized the importance of holding public meetings to gather input regarding affordability and whether the proposed rental rates would realistically meet local workforce needs. The speaker stated that public participation would be important to ensure the project serves the intended population and reflects the realities of the Bishop housing market.

### **Board Discussion:**

Board members discussed ongoing challenges associated with recruiting and retaining employees due to limited housing availability in the Bishop area.

Board members asked questions regarding the proposed memorandum of understanding and potential future leasing commitments associated with the project. Discussion also focused on current rental market conditions, the need for one-bedroom units for temporary and traveling healthcare workers, the broader regional housing shortage, and how freeing up larger homes from temporary workforce occupancy could improve housing availability for families. The presenters also described plans to retain and renovate portions of the existing adjacent retail building for food and beverage uses and discussed the potential economic benefit of reducing workforce occupancy in local motels. The Board generally expressed interest in the concept and acknowledged the significant workforce housing needs facing the District and the region.

### **Strategic Growth, Wipfli/WOLD Update**

CEO Wallis introduced representatives from Wipfli and WOLD to provide an update regarding the District's Strategic Growth and Facility Master Plan process. Representatives from Wipfli reviewed findings from the initial phases of the assessment process, including evaluation of regional population trends, healthcare utilization, provider access, market share, service demand, and facility conditions. The presenters stated that Northern Inyo Healthcare District serves a broad regional population extending beyond Bishop and noted strong utilization of District services, particularly in primary care. The presentation identified opportunities to expand specialty care services, improve provider recruitment, and address space limitations within existing clinic facilities. WOLD representatives summarized the April strategic planning and Lean planning sessions involving leadership, staff, and consultants. The planning exercises focused on long-term campus sustainability, future facility needs, workflow improvements, outpatient clinic consolidation, parking access, and modernization of aging facilities. Preliminary concepts discussed included construction of a new multi-story outpatient services building, continued use of newer hospital infrastructure, and phased replacement or decommissioning of older facilities across the campus.

**Public Comment:** None

### **Board Discussion:**

Discussion included the importance of balancing long-term campus sustainability with financial feasibility, improving outpatient clinic space and patient access, and supporting future specialty service expansion. The presenters explained that planning teams were developing a hybrid recommendation utilizing existing campus investments while modernizing areas identified as outdated or undersized. Discussion also addressed the collaborative planning process involving leadership, staff, consultants, and community-focused healthcare planning considerations.

### **Opening meeting routine**

**Public Comment:** None

**Board Discussion:**

Board members discussed the possibility of incorporating the Mission Statement, Vision Statement, organizational values, and the Pledge of Allegiance into the opening of Board meetings in order to keep the purpose and responsibilities of the Board at the forefront of governance discussions and decision-making. Discussion included whether the Mission and Vision statements should be read aloud during meetings or printed within meeting agendas and materials. Additional discussion addressed the historical purpose of the Pledge of Allegiance as a civic tradition promoting accountability, unity, public service, and civic-minded decision-making within governmental meetings. Board discussion reflected support for continuing to include the Mission and Vision statements in printed form on meeting agendas and materials rather than incorporating them as a verbal portion of the meeting opening.

**Motion by Smith** to include the Pledge of Allegiance in the meeting routine  
**2<sup>nd</sup>: None**

**Motion did not carry**

Following the failed motion, a board member asked whether any members wished to comment on why they would not support or second the motion to include the Pledge of Allegiance before meetings. No additional comments were made by the Board.

FINANCE COMMITTEE

**Benchmarking Update**

CEO Wallis provided an update regarding the benchmarking assessment being conducted by HealthTrust. He explained that the consultants were onsite, conducting interviews with managers and directors throughout the organization as part of a benchmarking and operational assessment process. He stated that the consultants were conducting detailed 30- and 50-minute interviews across multiple departments and leadership areas. He also noted that the organization had provided a substantial amount of operational and organizational data for review as part of the assessment process.

**Public Comment:** None

**Board Discussion:** None

**Banking Recommendations**

**Transfer Funds/Establish Business Sweep Account**

CFO Mossman presented banking recommendations related to the District's operating cash and investment management strategy. The presentation included a recommendation to transfer approximately \$1.4 million from a low-interest account previously used as collateral for a line of credit into a higher-yield account at Five Star Bank. She also presented a recommendation to establish a Business Interest Sweep account designed to maintain a target operating balance while automatically transferring excess funds into higher-interest earning accounts. Discussion included projected interest earnings, current

banking structure, liquidity considerations, and opportunities to improve investment returns on District funds while maintaining operational flexibility.

**Public Comment:** None

**Board Discussion:** Finance Committee Vice-Chair Best-Baker noted that Sharp from Eastern Sierra Community Bank attended the finance committee meeting and helped make these recommendations.

**Motion by** Turner to approve the transfer of funds

**2<sup>nd</sup>:** Lent

**Pass:** 5-0

**Motion by** Turner to approve the establishment of a business sweep account

**2<sup>nd</sup>:** Egan

**Pass:** 5-0

### **Cash Flow Action Plan**

Revenue Cycle Director Lind presented the District's Cash Flow Action Plan update and reviewed progress made by the Cash Flow Action Team since the implementation of Jorie began approximately one year prior. Lind explained that the team utilizes a dashboard to monitor operational and revenue cycle performance metrics and highlighted significant improvements in charges, payments, average daily revenue, accounts receivable (AR) days, and claims management processes. She also reported that AR days had decreased from 81 days to 63 days, which she stated was the lowest level achieved during the current monitoring period and reflected faster reimbursement turnaround and improved collection efficiency. Additional metrics reviewed included reductions in accounts receivable over 90 days, improvements in discharged-not-final-billed (DNFB) days, increases in clean claim rates, and reductions in denial rates. She attributed the improvements to stronger interdepartmental collaboration, operational workflow changes, and focused efforts to resolve issues more efficiently across departments.

**Public Comment:** None

### **Board Discussion:**

Board members discussed the improvements in AR days and revenue cycle performance metrics and acknowledged the operational and financial impact of improved collection turnaround times. Discussion included the relationship between faster collections, lower cost-to-collect expenses, improved operational efficiency, and overall financial stability for the District. Board members commended staff for the sustained improvement efforts and ongoing collaboration across departments.

### **NIH Operational Budget 26/27**

CFO Mossman presented the proposed FY 2026–2027 operational budget and reviewed the revised budget development process used for the upcoming fiscal year. She stated that department leaders and executive leadership began the

budgeting process earlier than in prior years and worked collaboratively to review departmental needs, operational trends, staffing, expenses, and growth strategies. She thanked department leaders and staff for their increased engagement and collaboration throughout the budgeting process and stated that the proposed budget reflected a more realistic and transparent operational plan than in prior years. The presentation included discussion regarding projected operating losses, anticipated revenue growth, improved revenue cycle performance, reductions in contract labor expenses, operational investments, and ongoing financial strategies intended to improve cash flow and long-term financial stability. Discussion also addressed uncertainty related to potential federal healthcare funding changes and the District's decision not to incorporate speculative Medicaid reductions into the proposed budget assumptions at this time.

**Public Comment:** None

**Board Discussion:**

Board members commended staff for the clarity, transparency, and detail provided within the proposed budget materials and discussed the improved budget development process and organizational engagement. The Board approved the FY 2026–2027 operational budget by unanimous vote.

**Motion by** Turner to approve the NIH Operational Budget 26/27  
**2<sup>nd</sup>:** Lent  
**Pass:** 5-0

**NIH Capital Budget 26/27**

CFO Mossman presented the proposed FY 2026–2027 capital budget and reviewed the District's new collaborative capital planning process, which included the use of an electronic capital request and prioritization tool developed by staff. Department leaders submitted and prioritized multi-year capital requests based on patient safety, regulatory compliance, strategic growth opportunities, and end-of-life equipment replacement needs. The proposed capital budget included approximately \$2.1 million for the replacement of the District's MRI machine, along with additional projects related to parking lot improvements, weapons detection equipment required under new California law, facility improvements, and specialty service expansion support. CFO Mossman stated that the proposed capital budget totaled approximately \$4 million, including contingency funding, and reflected the District's improved financial position and commitment to investing in infrastructure, patient care, and long-term operational needs.

CEO Wallis and CFO Mossman expressed appreciation to Neil Lynch and Lynda Vance for the development of the new electronic capital planning and prioritization tool that supported the revised capital budgeting process.

**Public Comment:** None

**Board Discussion:**

Board members discussed the importance of addressing deferred maintenance and aging equipment needs, maintaining contingency funding for unexpected facility issues, and continuing long-range capital planning efforts. Discussion also highlighted the value of the new electronic capital planning tool and the collaborative prioritization process used by department leaders and staff. Board members expressed support for investing in infrastructure, patient safety, equipment modernization, and future service line growth rather than continuing to delay needed capital projects.

**Motion by** Lent to approve the NIH Capital Budget 26/27

**2<sup>nd</sup>:** Turner

**Pass:** 5-0

### **Financial and Statistical Report**

CFO Mossman presented the March 2026 Financial and Statistical Report and reviewed the third-quarter financial performance and operational results. She reported that the District exceeded its March budget projections by approximately \$1.3 million, largely driven by strong orthopedic and surgical volumes, improved payer mix, higher inpatient acuity, and continued revenue cycle improvements. The presentation highlighted that a positive operating income was achieved for the quarter for the first time since 2024 and reported continued improvements in accounts receivable days, debt service coverage ratios, days cash on hand, and unrestricted cash reserves. She reported that cash balances had increased by approximately \$3.8 million since the beginning of the fiscal year and stated that it is one of the strongest financial positions in recent years. Additional discussion included ongoing cash flow initiatives, improved investment earnings through Five Star Bank and LAIF accounts, and continued operational improvement efforts related to orthopedics, benchmarking, and space planning initiatives.

**Public Comment:** None

**Board Discussion:** None

**Motion by** Lent to accept the Financial and Statistical Report

**2<sup>nd</sup>:** Turner

**Pass:** 5-0

### GOVERNANCE COMMITTEE

#### **Advocacy Update**

CEO Wallis introduced legislative consultant Madden to provide an advocacy and legislative update following the Board's recent direction to formalize the District's advocacy tracking and review process. Madden provided an overview of the California legislative process, including bill introduction deadlines, policy and appropriations committee review, movement between the Assembly and Senate, and final gubernatorial action. Madden explained that the legislative calendar operates on strict deadlines and that bills must progress through multiple review stages in order to advance through the legislative process.

Madden and CEO Wallis then reviewed several priority one healthcare-related bills identified for District monitoring:

- **AB 1923** – Legislation sponsored by the California Hospital Association to provide an additional \$300 million in funding for the Distressed Hospital Loan Program and create a clearer pathway for certain loans to potentially convert into grants for financially struggling hospitals.
- **AB 2353** – Legislation intended to require analysis and reporting of financial impacts to hospitals when new healthcare-related mandates are proposed by the Legislature, including operational and compliance costs associated with new requirements.
- **AB 2208** – Legislation related to Medi-Cal retroactive eligibility and potential impacts associated with HR1 federal Medicaid changes. The bill would preserve three months of retroactive Medi-Cal coverage at state expense despite reductions in federal reimbursement support.
- **AB 1607** – Legislation extending the sunset date associated with portions of the Maddy Emergency Medical Services Fund program, which provides reimbursement support for hospitals and physicians treating uninsured patients and supports local EMS funding allocations.
- **Federal School-Based Healthcare Grant Legislation** – Discussion regarding potential future federal grant opportunities that could support school-based healthcare clinic operations, staffing, equipment, and services, including the District’s Panther Clinic and Bronco Clinic programs.

**Public Comment:** None

**Board Discussion:**

Board members discussed several of the proposed priority bills, including healthcare mandate costs, EMS funding distribution, Medi-Cal impacts, and school-based healthcare grant opportunities. A board member also raised interest in legislation related to physical therapy scope of practice, identified as AB 2497, and requested that the bill be added to the District’s legislative tracking list for future Governance Committee review. Board members expressed appreciation for the legislative tracking and advocacy support process.

**Values and Taglines**

CEO Wallis presented a discussion regarding the District’s Mission, Vision, Values, and tagline alignment efforts. He explained that multiple versions of organizational values were currently being used throughout the District and stated that leadership wanted to establish a single, aligned set of values for the organization. He recommended the adoption of the “CARES” values developed during the executive team’s strategic planning process, representing Compassion, Accountability, Respect, Excellence, and Stewardship. Discussion also included retaining the District’s existing tagline, “One Team, One Goal, Your Health,” due to its current use in marketing materials and organizational branding.

**Public Comment:** None

**Board Discussion:**

Board members discussed removing outdated value statements currently displayed within the organization.

**Motion by** Turner to approve the values: Compassion, Accountability, Respect, Excellence, Stewardship

**2<sup>nd</sup>:** Lent

**Pass:** 5-0

QUALITY COMMITTEE

**Grievance Committee**

Quality Manager Feinberg presented an update regarding the District's newly established Grievance Committee. Feinberg explained that the committee was created to improve coordination, communication, and resolution of patient grievances, including concerns related to patient care, financial disputes, and other complaints submitted to the District. She stated that the committee meets every two weeks or more frequently as needed and includes representation from physicians, nursing, finance, quality, and risk management to allow collaborative review and resolution of grievances. The presentation also highlighted the implementation of a dedicated staff contact responsible for reaching out to patients immediately upon receipt of a grievance and maintaining communication with patients throughout the resolution process. She stated the committee's approach aligned with the District's broader efforts to improve transparency, patient communication, and resolution timelines.

**Public Comment:** None

**Board Discussion:**

Board members discussed the benefits of the collaborative grievance review process and the importance of improving communication and follow-up with patients during grievance resolution efforts. Discussion included comments regarding prior limitations of department-specific grievance responses and appreciation for the committee's multidisciplinary approach to resolving patient concerns more efficiently and collaboratively. Board members expressed support for the new process and ongoing improvements related to patient communication and resolution efforts.

**Quality Dashboard**

Quality Manager Feinberg presented the quarterly Quality Dashboard and reviewed key quality, patient safety, patient satisfaction, operational, and workforce metrics for the District. Feinberg reported zero central line-associated bloodstream infections (CLABSIs), zero catheter-associated urinary tract infections (CAUTIs), zero inpatient falls with injury, and zero sentinel events during the reporting period. Additional quality metrics reviewed included low medical transfer rates, 30-day readmission rates well below benchmark, mortality rates below benchmark, emergency department wait times below established standards, and patient satisfaction scores that generally met or approached benchmark targets across multiple service areas. Feinberg

also reviewed workforce and operational measures, including employee engagement survey response rates, employee turnover, workers’ compensation claims, and reportable workforce incidents. Feinberg stated that a shortened public-facing version of the Quality Dashboard would be developed for publication on the District website with additional explanation of quality measures for community education purposes. She stated that staff would be working with the Marketing Department to develop and publish a shortened public-facing quality dashboard on the District website with additional explanation of quality measures for community viewing and education purposes.

**Public Comment:** None

**Board Discussion:**

**Motion by** Turner to accept the quality dashboard

**2<sup>nd</sup>:** Egan

**Pass:** 5-0

**GENERAL INFORMATION  
FROM BOARD MEMBERS**

Board members provided general informational comments and updates. Discussion included updates regarding the upcoming Association of California Healthcare Districts annual conference scheduled in October in Monterey, including conference themes, governance training information, and future conference planning. Board members also encouraged community participation in the upcoming Board election cycle and discussed the importance of attracting a strong pool of candidates for the District Board of Directors. Additional comments recognized the District’s employee awards presentation, including recognition of long-term employees and acknowledgment of nurse Laura Partridge for the development of a maternal mental health program that received recognition at the federal level. Board members further expressed appreciation to CEO Wallis and District staff for ongoing financial improvement efforts, leadership, public outreach presentations to local government agencies, and Hospital Week employee recognition activities and events.

**ADJOURNMENT**

Adjournment at 8:20 pm.

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

Attest: \_\_\_\_\_  
Maggie Egan  
Northern Inyo Healthcare District  
Secretary



**NORTHERN INYO HEALTHCARE DISTRICT  
NON-CLINICAL POLICY**

Title: Capitalization of Assets		
Owner: Chief Financial Officer	Department: Fiscal Services	
Scope: Districtwide		
Date Last Modified: 06/10/2026	Last Review Date: No Last Periodic Review Date Set	Version: 5
Final Approval by: NIHD Board of Directors	Original Approval Date: 08/18/2004	

**PURPOSE:**

To define minimum criteria dollar amount for capitalizing assets.

**POLICY:**

This policy outlines in general terms the distinction between capitalized and non-capitalized plant and equipment acquisitions. Property and plant is divided into three categories (land, buildings and improvements other than buildings). Equipment is categorized as either movable or fixed. Each category will be defined below along with the respective capitalization method.

**Capitalized Expenditures**

**A. Land**

1. Capitalize new acquisitions of land at cost.
2. Establish land donated value by an appraisal. The value is the fair market value as of the date of the gift.
3. Land does not depreciate.

**B. Buildings**

1. Treat buildings as a single asset without separating the "shell" from other building components.
2. Building additions that add square footage to a building are capitalized and componentized.
3. Certain major replacements or renovations of a building, which extend the original life of the building or enhance the value, may be capitalized.

**C. Improvements other than Buildings**

1. This category consists of land improvements outside the periphery of the building. Examples include parking lots, sidewalks, electric lines, telephone lines, etc.
2. Improvements have the same capitalization criteria as buildings.
3. Costs incurred must meet threshold of \$25,000 and be in the same building section.

**D. Movable Equipment**

1. Capitalize items of equipment or furnishings that have an acquisition cost of ~~\$3,000~~ \$5,000 or more and a life expectancy of greater than one year. This includes the cost of any modifications and attachments or accessories necessary for the equipment's intended purpose upon initial purchase.

Delivery, installation, taxes, and initial equipment calibration are also included in the total equipment cost.

2. Expenditures for the restoration or betterment of equipment may be capitalized if the expenditure restores the item to like new condition and extends the useful life or increases the item's book value. The item will be capitalized at the restoration cost, provided the item meets the capital threshold requirements. This capitalized cost should not exceed the present fair market value of the item.
3. Accessories purchased after the first year of an item's acquisition must meet the movable equipment capitalization threshold and will be capitalized separately. Accessories are non-disposable items.
4. Group or mass purchases of furnishings, computers, or similar items, which individually are less than the capitalization threshold, are capitalized and depreciated over the average useful life of the items.
5. Software purchases processed on a separate purchase order will be capitalized and issued a property tag as long as the unit cost is ~~\$3,000~~ \$5,000 or more.
6. Equipment gifted are recorded at the lower of fair market value or purchase price, if new.

#### E. Fixed Equipment

1. Fixed equipment has the same capitalization threshold as movable equipment. These assets are stationary and are attached to another structure, such as a wall or floor. Examples of fixed equipment include biosafety cabinets, audiovisual systems, cubicle walls, time clock machines, and fume hoods.

#### **Expenditures of costs considered capital expenditures include:**

1. Demolition costs and preparing the site for construction
2. Cost of building materials
3. Contractor and construction costs
4. Architect and consultant fees
5. Building permit fees
6. Subcontract fees
7. Payment for rented equipment to complete the construction
8. Operating and maintenance costs for work performed in building the asset
9. Cost of supplies consumed in the construction

Fixed assets will be transferred from construction in progress and depreciation will begin to be recognized once the construction project cost is completed and the asset has been put into service for the intended use.

#### **Expenditures that should not be capitalized as plant and equipment**

1. Expenditures for repairs, maintenance, or replacement of component parts which do not extend the unit's original life or increase the net book value. Examples of these include carpet installations, paint and patching of walls, and pothole repairs.
2. Expenditures for moving partitions in an existing building or renovations that do not add value to the buildings that are not part of an overall renovation.
3. Expenditures incurred in connection with the rearrangement, transfer, or moving of capitalized items from one location to another.
4. Expenditures made to maintain fixed assets in normal operating condition or to restore fixed assets to normal operating condition.

**Depreciation**

Depreciation is calculated using the straight-line method over the useful life of the asset ranging up to forty years. Land is not subject to depreciation. Assets are depreciated over their useful lives as presented in the American Hospital Association's *Estimated Useful Lives of Depreciable Hospital Assets*.

**Disposition**

Movable equipment should be disposed of through trade-in, retirement, sale, or disposal. Finance will review and approve the disposal once the disposal is requested. (See attachment – Asset Disposition Form)

**REFERENCE:**

AHA: Estimated Useful Lives of Depreciable Hospital Assets

**RECORD RETENTION AND DESTRUCTION:**

1. Indefinitely

**CROSS REFERENCE POLICIES AND PROCEDURES:**

1. Asset Management
2. Asset Control

Supersedes: v.4 Capitalization of Assets
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**NORTHERN INYO HEALTHCARE DISTRICT  
CLINICAL POLICY AND PROCEDURE**

Title: Code White Procedure – Code White Team		
Owner: DON Outpatient Services	Department: MedSurg, ED, ICU, PACU, OB, OR	
Scope: District Wide		
Date Last Modified:	Last Review Date:	Version:
Final Approval by: NIHD Board of Directors	Original Approval Date:	

**PURPOSE:**

The primary goal of the Code White Team is the immediate and appropriate treatment of any pediatric patient (infant to age 18) in cardiac or respiratory arrest. This team responds to an announced Code White that occurs anywhere in the hospital building. The Code White Team shall consist of the Emergency Department (ED) physician, Respiratory Therapist, and four members of the nursing staff selected by the Nursing Supervisor at the beginning of each shift.

**POLICY:**

1. The Emergency Department physician shall be the Code White team leader.
2. Any cardiac arrests in the operating room will follow the Cardiac Arrest in the OR Policy. The House Supervisor will be notified of cardiac arrests in the Operating Room (OR).
3. A Code Blue Critique will be completed after every Code Blue by the RN Leader and House Supervisor.
4. All codes will be peer reviewed as a critical indicator for the ED physicians.
5. All codes will be reviewed by the Resuscitation Committee.
6. Advanced Directives and Physician Orders for Life Sustaining Treatment (POLST) will be reviewed and communicated to the Code White Team Leader as soon as possible.
7. The Code Team will be posted daily and changed as needed on the hospital intranet by the House Supervisors.
8. The Pediatric Crash Cart and Broselow Tape will be checked at the beginning of each shift by designated staff and maintained according to hospital policy.

**PROCEDURE:**

**RN CODE LEADER:**

RN Code Leader will be filled by the ED RN. Qualifications: ED or ICU RN with current Advanced Cardiac Life Support (ACLS) and Pediatric Advanced Life Support (PALS) certification.

Performs or delegates the following:

1. Coordinates team members and treatment. Ascertains physician in charge and receives orders directly from that physician.
2. Ensures that all Basic Life Support (BLS) and Pediatric Advanced Life Support (PALS) is delivered per latest American Heart Association (AHA) pediatric standards, including proper rate and depth of compressions, adequate changes in compressor role, and quick resumption of cardiopulmonary resuscitation (CPR) after interventions or pulse checks.

3. Follows PALS algorithms for pediatric cardiac and respiratory arrest, performs cardioversion, pacing, or defibrillation as ordered, and ensures correct age- and weight-based dosing of all medications. All procedures, treatments, and medications will be communicated to the recorder to insure complete and timely documentation.
4. Ensures that noise and unnecessary conversations are kept to a minimum.
5. Communicates all interventions, medications, and procedures to the recorder for complete documentation.
6. Work with House Supervisor during resuscitation to release staff that are not needed.
7. Ensures timely notification of family, and that a Social Worker, Case Manager, or designated support staff is assigned to assist families during the event.

**CODE ASSIST RN:**

1. Positions bed and removes head board.
2. Brings crash cart and Broselow cart to the bedside. Broselow carts are located in ED 7 and the Med/Surg floor. Crash Carts are located in ED room 1, ED room 7, Med/Surg, ICU, OB, PACU, OR, Cardiopulmonary, Infusion, and CT.
3. Applies monitor leads and defibrillator **pads** appropriate to patient size (using Broselow color zones). Runs initial monitor strip.
4. Assist with any additional procedures as needed.
5. Assists with IV/IO access, NG or Foley insertion as delegated. Insert Foley catheter or delegate to another staff member.
6. Prepares and labels all medications per weight-based dosing chart.
7. Ensures that vital signs are obtained and recorded every 5 minutes if BP and pulse are present.

**CODE COMPRESSIONS: 2 Staff Members**

Qualifications: Current BLS card with no medical restrictions for performing CPR.

1. Places backboard under patient. This can be found on the back of the crash cart.
2. Takes over cardiac compressions. This requires frequent changes with no person performing compression for longer than 2 minutes at a time. This is to insure good quality compressions are maintained and to avoid fatiguing staff.
3. Ensures AED or manual defibrillator is connected and ready.

**CODE RECORDER:**

Recorder may be the House Supervisor, ED RN, or ICU RN. No staff will be assigned to this position if they do not maintain a current ACLS and PALS certification.

1. Recorder - records all information during code on code sheet
2. Accurately times start of Code and all treatments.
3. Charts VS Q 5 min. when BP and pulse present or insures that an electronic record of vital signs is maintained.
4. Prompts Code Leader for appropriate PALS protocols.
5. Ensures that a copy of Code White record and Code Critique are completed and submitted to the ED Manager or DON of outpatient services.

**RESPIRATORY THERAPIST:**

1. Provides oxygenation and ventilation **support** using age-appropriate equipment. Manages and secures endotracheal tube.
2. Manages and secures endotracheal tube or airway adjuncts.
3. Monitor SpO2 and ETCO2 on all patients in a resuscitation.
4. Assist with transport for procedures or transfer.

**REFERENCES:**

1. American Heart Association: Pediatric Advanced Life Support (PALS) Guidelines
2. American Heart Association: Basic Life Support (BLS) for Healthcare Providers
3. American Heart Association: Advanced Cardiac Life Support (ACLS) Guidelines

**CROSS REFERENCE POLICIES AND PROCEDURES:**

1. Code Blue Documentation

**RECORD RETENTION AND DESTRUCTION: N/A**

**CROSS REFERENCE POLICIES AND PROCEDURES:**

Supersedes: Not Set
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## NORTHERN INYO HEALTHCARE DISTRICT NON-CLINICAL POLICY

Title: IT Hardware Lifecycle Policy		
Owner: Director of IT	Department: Information Technology	
Scope: Districtwide		
Date Last Modified: 04/01/2026	Last Review Date: No Last Periodic Review Date Set	Version: 1
Final Approval by: NIHD Board of Directors	Original Approval Date:	

**PURPOSE:**

This policy establishes practical and cost-effective procedures for the acquisition, deployment, maintenance, and retirement of IT (Information Technology) hardware within Northern Inyo Healthcare District (NIHD). The objectives are to:

- Maintain safe and reliable clinical and administrative operations
- Protect patient information in compliance with HIPAA (Health Insurance Portability and Accountability Act) and HITECH (Health Information Technology for Economic and Clinical Health)
- Maximize useful life of IT assets while minimizing financial risk
- Support regulatory audits with clear, documented controls

This policy is designed to balance patient safety, security, and fiscal responsibility consistent with the needs of a Critical Access Hospital.

**POLICY:**

**Hardware Lifecycle Stages**

**Procurement**

- All hardware purchases must be approved by IT leadership or designee.
- Preference will be given to:
  - o Existing standardized models
  - o Multi-year warranties or support contracts
- Vendors must:
  - o Support healthcare compliance requirements
  - o Disclose end-of-life (EOL) and end-of-support (EOS) timelines
- Purchasing decisions will prioritize:
  - o Clinical impact, if any
  - o Total cost of ownership
  - o Vendor reliability and support availability

**Deployment**

- All devices must be configured by IT prior to use.
- Standard configurations include:
  - o NIHD-approved operating system
  - o Security baseline (anti-malware, firewall, logging)
  - o Encryption for devices handling PHI (Protected Health Information)

- Asset tagging and inventory tracking will be maintained using a centralized inventory.
- Deployment timelines may vary based on staffing and clinical priorities.

### **Maintenance**

- IT will perform routine maintenance based on available resources and risk level.
- Maintenance activities include:
  - Operating system and security patching
  - Firmware updates where feasible
  - Hardware health checks for critical systems
- Patch prioritization:
  - Critical security patches applied as soon as operationally feasible
  - Non-critical updates applied during scheduled maintenance windows
- Support is provided through internal IT and approved third-party vendors as needed.

### **Review & Refresh**

- Hardware will be reviewed annually to assess:
  - Performance
  - Security risk
  - Supportability
  - Clinical impact of failure
- Target replacement cycles:

<b>Asset Type</b>	<b>Target Lifecycle</b>
Workstations	3-5 years
Servers	3-5 years
Networking equipment	5-7 years
Mobile devices	2-3 years

- Equipment may remain in service beyond these targets if:
  - It remains supported and secure
  - Risk is documented and accepted by IT leadership
  - Mitigating controls are in place

### **Decommissioning**

- Hardware containing NIHD data must be securely wiped prior to disposal.
- Data destruction will follow NIST (National Institute of Standards and Technology) 800-88 guidelines or vendor-certified equivalents.
- Decommissioned assets will be:
  - Recycled through certified e-waste vendors when available
  - Donated or repurposed only after data destruction
- Disposal and wipe records will be retained for audit purposes.

### **Lifecycle Performance Targets**

#### **Procurement**

- Majority of purchases aligned with approved standards where feasible
- Warranty coverage appropriate to asset criticality
- Cost justification documented for major purchases

#### **Deployment**

- All devices:

- o Properly configured before use
  - o Logged in inventory
- Deployment timelines may vary based on staffing and clinical urgency

### **Maintenance**

- Critical vulnerabilities addressed promptly based on risk
- Preventive maintenance for servers and network equipment at least annually
- Clinical systems prioritized for uptime and support

### **Decommissioning**

- 100% of retired devices containing PHI securely wiped
- Records will be disposed of according to District Record Retention and Disposal Policy

### **Vendor and Contract Considerations**

- Vendor contracts should prioritize:
  - o Reliability over premium features
  - o Clear support escalation paths
  - o Predictable costs
- SLAs (Service Level Agreements) should be reasonable and cost-effective:
  - o Best-effort same or next business day for critical systems
  - o Extended response times acceptable for non-clinical systems
- Bulk purchasing and cooperative contracts (e.g., GPO (Group Purchasing Organization) agreements) are preferred

### **Security & Compliance**

- All hardware must support HIPAA and HITECH safeguards.
- Devices storing or accessing PHI must:
  - o Use encryption where technically feasible
  - o Require authenticated access
- Centralized access controls (e.g., Active Directory, MDM (Mobile Device Management) where available) will be used to the extent resources allow.
- Hardware-related security incidents must be reported according to NIHD's incident response procedures.

### **Roles & Responsibilities**

#### **IT Department**

- Manage hardware lifecycle activities
- Maintain inventory and documentation
- Assess and document risks related to aging equipment

#### **Department Managers**

- Ensure appropriate use of hardware
- Notify IT of failures, losses, or unusual behavior

#### **Compliance / Privacy Officer**

- Monitor adherence to regulatory requirements
- Participate in periodic reviews and audits

**End Users**

- Use equipment responsibly
- Report issues, damage, or loss promptly

**REFERENCES:**

- NIST Special Publication 800-53 Rev. 5 – Security and Privacy Controls for Information Systems and Organizations
- NIST Special Publication 800-88 Rev. 1 – Guidelines for Media Sanitization
- NIST Special Publication 800-37 Rev. 2 – Risk Management Framework for Information Systems and Organizations
- HIPAA Security Rule – 45 CFR Part 164, Subparts C and D
- NIST Cybersecurity Framework (CSF) 2.0

**RECORD RETENTION AND DESTRUCTION:****CROSS REFERENCES:**

Supersedes: Not Set
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**NORTHERN INYO HEALTHCARE DISTRICT  
CLINICAL POLICY AND PROCEDURE**

Title: Sterilization Recall Policy		
Owner: Perioperative Manager	Department: Surgery	
Scope: Sterile Processing, Surgery Scrub Tech		
Date Last Modified: 02/13/2026	Last Review Date: No Last Periodic Review Date Set	Version: 6
Final Approval by: NIHD Board of Directors	Original Approval Date: 02/01/2001	

**PURPOSE:**

To ensure that all items available for patient care are properly sterilized. Should failure of sterilization process occur, all items processed may be retrieved by sterile processing personnel.

To ensure sterilization, the sterilization date is applied to all sterilized items and packaging is considered sterile unless the integrity of the packaging has been compromised.

**POLICY:**

Sterilizers are checked daily for proper functioning by use of live spore cultures. The biological System is incubated and monitored in sterile processing and read within 24 hours per manufacturer literature.

Sterilization records are kept in the sterile processing unit. If during culture period growth of any kind takes place, the Perioperative Director of Nurses and Operating Room Coordinator are notified. The attending physician is notified when applicable.

Sterilizing in the affected autoclave is discontinued until the biomedical engineer and/or sterilizer service provider has serviced the sterilizer to correct any problem.

All items sterilized in that autoclave from the time of the last negative culture are recalled and reprocessed per procedure.

**PROCEDURE:**

**RETRIEVAL PROCESS:**

- Every item sterilized in the sterile processing area is marked with internal indicators sensitive to time and temperature, as well as, external autoclave sensitive tape. Each item sterilized is marked with sterilization date and is considered sterile until its integrity is compromised.
- Each item is marked with date, autoclave letter and load number and is recorded on Ver Doc Steamload Release System (load envelope) for that load when sterilized.
- If failure of sterilization cycle is indicated either by graph indicator or internal or external pack indicators, all items from that autoclave cycle are retrieved per record of Ver Doc Steamload Release System (load envelope). Previous loads are spot-checked for sterilization.
- Biomedical engineer is notified and autoclave is not used until fault is identified and repaired.
- Sterilized supplies in all units are checked for integrity prior to use.

- Any item where the packaging integrity has been compromised will be returned to sterile processing for reprocessing.

### **DEFINITIONS:**

Sterilization may be defined as the established and approved process by which all forms of microorganisms are destroyed. There are effective ways to obtain sterilization. They are:

1. Saturated steam under pressure.
2. Ethylene oxide gas
3. Dry Heat
4. V Pro processed instruments
5. Steris processed instruments

Ethylene oxide gas is not utilized at this institution.

Dry Heat is not a method utilized at this institution.

### **Sterilization life of packages:**

The sterilized packages are considered sterile until outdate unless the integrity of the packaging has been compromised.

### **DOCUMENTATION:**

All positive biological cultures that indicate recall of product are documented in log book in sterile processing and also in the quality assurance log book including possible causes of failure and maintenance/service representative findings.

The positive biological culture should be sent to the laboratory for sub culturing (**the recall should not be delayed during this testing**).

### **REFERENCE:**

1. IAHCMM Central Supply Training Manual
2. TJC: IC.02.02.01
3. Title 22: 70833
4. AORN RP Sterilization
5. ANSI/AAMI ST79

Supersedes: v.5 Sterilization Recall Policy*
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**NORTHERN INYO HEALTHCARE DISTRICT  
CLINICAL POLICY AND PROCEDURE**

Title: Use of Human Donor Breastmilk/Storage of Breastmilk		
Owner: : Perinatal Manager	Department: Perinatal	
Scope: Perinatal, Women’s Clinic, Pediatric Clinic, MedSurg		
Date Last Modified:	Last Review Date:	Version:
Final Approval by: NIHD Board of Directors	Original Approval Date:	

**PURPOSE:**

To support patients in providing exclusive breastmilk nutrition to their babies and to provide optimum nutrition for infants and neonates that require supplementation for medical indications

**SUPPORTIVE DATA:**

**POLICY:**

Human donor breastmilk (HDBM) will be provided, per provider order, to breastfed infants being cared for at NIHD or their affiliated clinic when short-term supplementation is indicated.

**PROCEDURE:**

1. Human Donor Breastmilk will be obtained from a member bank of the Human Milk Bank Association of North America (HMBANA), which complies with the guidelines for the establishment and operation of a donor human milk bank.
2. An order/prescription for HDBM supplementation will be obtained from the provider.
3. An informational handout discussing the risks and benefits will be provided to the parents/caregiver, and a consent will be signed prior to giving HDBM.
4. HDBM will be stored in designated breast milk freezers. The freezer temperatures will be set at -20 degrees Celsius/-4 degrees Fahrenheit or below, and temperatures will be checked and logged daily. Freezer alarms will be set and monitored.
5. Thawed HDBM/pumped breastmilk will be refrigerated and used within 48 hours or discarded.
6. Prior to feeding, HDBM will be checked with the second RN, utilizing two patient identifiers, and the lot number and expiration date will be documented in the EMR.
7. Receiving and Logging HDBM:

Upon receipt of a shipment of HDBM, the Perinatal Nurse or their designee will:

- a. Verify that dry ice is still present
- b. Ensure milk is frozen, and bottles are intact.
- c. Match the shipping receipt expiration dates and lot numbers. If there are discrepancies, notify the milk bank for instructions on discarding or returning the HDBM.
- d. Log each bottle in the designated HDBM log.
- e. Prior to feeding, the RN will record the following in the Human Donor Milk log: Date and time, RN initials, patient label, donor milk lot number and expiration date, and amount of milk dispensed to patient.
- f. The HDBM will be labeled with the patient sticker and the date and time the milk is thawed. The thawed milk will be refrigerated for 4 hours after thawing and discarded 24 hours after thawing.

- g. HDBM will be defrosted and warmed in a breast milk warmer prior to feeding. Individual liners are to be kept on the infant’s crib in a clean bag. The warmer is to be cleaned with food-grade wipes after each patient use.
- h. Parent/guardian coming from the clinic will pay for the donor human milk at the registration desk.
- i. Parent/guardian will pick up the HDBM on the Perinatal Unit and will provide a receipt of purchase and a prescription from a clinic provider.

**REFERENCES:**

- 1. Human Milk Banking Association of California (2024). HMBANA Standards for Donor Human Milk Banking: An Overview
- 2. Kilpatrick, S. J., Papile, L.-A., & Macones, G. A. (Eds.). (2017). Guidelines for perinatal care (8th ed.). American Academy of Pediatrics.

**RECORD RETENTION AND DESTRUCTION: N/A**

**CROSS REFERENCE POLICIES AND PROCEDURES:**

Supersedes: Not Set
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**NORTHERN INYO HOSPITAL**  
 Northern Inyo Healthcare District  
 150 Pioneer Lane, Bishop, California 93514

TO: NIHD Board of Directors  
 FROM: Samantha Jeppsen, MD, Chief of Medical Staff  
 DATE: June 2, 2026  
 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 2026-2027 (*action item*)
  1. Nirav Patel , MD (*diagnostic radiology*) - Telemedicine Staff (GTR)
  2. Shahroz Aziz, MD (*diagnostic radiology*) - Telemedicine Staff (GTR)
  3. Aela Paiz, DO (*obstetrics & gynecology*) - Courtesy Staff

B. Amendments to Northern Inyo Healthcare District Medical Staff Bylaws (*action item*)

The Active Medical Staff has voted to approve the following amendments to the Medical Staff Bylaws and submits them to the District Board for approval. These amendments allow the Medical Staff to carry out its responsibilities in self-governance and in ensuring the quality of care provided by members of the Medical Staff.

<b>Amendment</b>	
1	Moving <b>Infection Control Committee</b> from a Medical Staff Committee to Hospital Committee. Medical staff participation and representation on this committee will remain intact as per law.
2	Moving <b>Pharmacy and Therapeutics Committee</b> from a Medical Staff Committee to Hospital Committee. Medical staff participation and representation on this committee will remain intact as per law.
3	Extending Medical Executive Committee membership to <b>Chief of Anesthesia, Chief of Orthopedics and Chief of Surgery.</b>
4	Creation of a multidisciplinary <b>Peer Review Committee</b> to promote quality patient care and bring a standardized framework for assessing practitioner competency and providing practitioner feedback.

The Medical Executive Committee has additionally approved the following technical and editorial amendments and submits them to the District Board for approval. Technical and editorial amendments provide clarity in areas where bylaws language is ambiguous.

<b>Technical/Editorial Amendment</b>	
5	Clearly specify the required limits for professional liability insurance are \$1M/\$3M instead of referring to other documents for this information.

6	Remove duplicative notifications to the Chief of Staff when applications are requested and received.
7	Clarify that applicant disclosures of “filed” professional liability cases includes cases that are dismissed.
8	Specify the Board must be informed of corrective actions at their <i>next</i> regularly scheduled meeting following notification to the practitioner.
9	Clarify that the parties notified of a corrective action are the same parties notified of a hearing request.
10	Simplified language to add clarity that an amendment must be approved by a majority of the voting Medical Staff, regardless of whether the vote took place by mail, in person, or electronically.



**NORTHERN INYO HEALTHCARE DISTRICT  
BYLAWS**

Title: Northern Inyo Healthcare District Medical Staff Bylaws		
Owner: Medical Staff Director	Department: Medical Staff	
Scope: Medical Staff Practitioners		
Date Last Modified: 05/31/2026	Last Review Date: 05/31/2026	Version: 4
Final Approval by: NIHD Board of Directors	Original Approval Date: 02/17/2021	

# Northern Inyo Healthcare District Medical Staff Bylaws

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## ARTICLE I: PURPOSE AND TERMS

### I.1 PURPOSE OF THE BYLAWS

- (a) These Bylaws are adopted in recognition of the mutual accountability, interdependence and responsibility of the Medical Staff and the Northern Inyo Healthcare District Board of Directors in protecting the quality of medical care provided at Northern Inyo Healthcare District and assuring the competency of the District's Medical Staff. These Bylaws provide a framework for the self-governance of the Medical Staff, which is a collegial and democratic body with extensive knowledge in medical care. These Bylaws assure an organization of the Medical Staff that permits the Medical Staff to discharge its responsibilities in matters involving the quality of medical care, to govern the orderly resolution of issues and the conduct of Medical Staff functions supportive of those purposes, and to account to the Board of Directors for the effective performance of Medical Staff responsibilities. These Bylaws provide the professional and legal structure for Medical Staff operations, organized Medical Staff relations with the Board of Directors, and relations with applicants to and members of the Medical Staff.
- (b) These Bylaws address the Medical Staff's responsibility to establish criteria and standards for Medical Staff membership and privileges, and to enforce those criteria and standards. They establish clinical criteria and standards for quality assurance, utilization review, and other Medical Staff activities including, but not limited to, periodic meetings of the Medical Staff, its committees and departments, and review and analysis of patient medical records. They describe the standards and procedures for selecting and removing Medical Staff Officers, and they address the respective rights and responsibilities of the Medical Staff.
- (c) The Medical Staff acknowledges that the Board of Directors, in exercising its responsibility to protect the quality of medical care provided by and the competency of the Medical Staff and to ensure the responsible governance of the hospital, possesses administrative oversight authority of the Medical Staff. In exercising its administrative authority, the Board of Directors acknowledges and commits to respecting the rights and functions of a self-governing Medical Staff, as established by statute and through the Medical Staff Bylaws. The Medical Staff commits to exercising its rights and responsibilities with diligence and good faith, and acknowledges that if it does not do so, the Board of Directors may act, as delineated in these Bylaws, to fulfill the specific responsibility that the Medical Staff has failed to perform.

### I.2 NAME

The name of this organization is the Medical Staff of Northern Inyo Hospital, a 501(c)(6) recognized organization.

### I.3 PURPOSES AND RESPONSIBILITIES OF THE MEDICAL STAFF

The Medical Staff's purposes are:

- (a) To assure that all patients admitted or treated in any of the Northern Inyo Healthcare District services receive a uniform standard of quality patient care, treatment and efficiency consistent with generally accepted standards attainable within the District's means and circumstances.
- (b) To support professional education and community health education.
- (c) To initiate and maintain rules for the Medical Staff to carry out its responsibilities for the professional work performed in Northern Inyo Healthcare District.
- (d) To provide an avenue for the Medical Staff, Board of Directors, and administration to discuss issues of mutual concern.

- (e) To exercise its rights and responsibilities in a manner that does not jeopardize the District's license, Medicare and Medi-Cal provider status, accreditation, and other credentialed statuses.

The Medical Staff's responsibilities are:

- (a) To provide quality patient care.
- (b) To assure for the benefit of the public, and also to account to the Board of Directors for, the quality of patient care provided by all members authorized to practice in Northern Inyo Healthcare District through the following measures:
  - (1) Review and evaluation of the quality of patient care provided through valid and reliable patient care evaluation procedures;
  - (2) A credentials program, including mechanisms of appointment, reappointment and the matching of clinical privileges to be exercised or specified services to be performed with the verified credentials and current demonstrated performance of the applicant;
  - (3) Participating in a utilization review program to provide for the appropriate use of all medical services.
- (c) To establish and enforce professional standards related to the delivery of healthcare within Northern Inyo Healthcare District.
- (d) To initiate and pursue corrective action with respect to members where warranted.
- (e) To cooperate with other community health facilities and/or educational institutions or efforts that strive to improve the quality of patient care within Northern Inyo Healthcare District.
- (f) To establish and amend as needed Medical Staff Bylaws and policies.
- (g) To select and remove Medical Staff Officers.
- (h) To assess and utilize Medical Staff dues as appropriate for the purposes of the Medical Staff.

#### I.4 DEFINITIONS

**ACTIVE STAFF** means the category of Medical Staff members who regularly provide care at Northern Inyo Healthcare District and meet the qualifications and prerogatives as listed in these Bylaws.

**AD HOC COMMITTEE** means a committee created for a particular purpose for a finite amount of time, as necessary.

**ADVERSE ACTION** means an action which is reportable under Business and Professions Code 805.

**ADMINISTRATOR or CHIEF EXECUTIVE OFFICER** means the person appointed by the Board of Directors to serve in an administrative capacity in the overall management of the District.

**ADVANCED PRACTICE PROVIDER or APP** means an individual, other than a licensed physician, dentist, or podiatrist, who exercises independent judgement within the areas of his or her professional competence and the limits established by the Board of Directors, the Medical Staff, and the applicable State Practice Act, who is qualified to render direct or indirect medical care under the supervision or direction of a Medical Staff member (with the exception of certified registered nurse anesthetists, who are APPs that practice under an independent license as per current California regulations).

**AUTHORIZED REPRESENTATIVE** means the individual(s) designated by the District and approved by the Medical Executive Committee to provide information to and request information from the National Practitioner Data Bank according to the terms of these Bylaws.

**BOARD OF DIRECTORS** means the governing body of Northern Inyo Healthcare District.

**CHAIR** means the individual practitioner elected to preside over a committee or meeting.

**CHIEF EXECUTIVE OFFICER** see ADMINISTRATOR.

**CHIEF MEDICAL OFFICER** means an active member of the Medical Staff appointed by the Administrator to provide administrative support for the Medical Staff, communicate the views of the hospital administration to the Medical Staff, and serve as a liaison between the Medical Staff and the administration. The Chief Medical Officer shall serve on Medical Staff committees without vote unless otherwise specified at the time of appointment.

**CHIEF OF STAFF** means the chief officer or president of the Medical Staff elected by members of the Medical Staff.

**CONTRACT PRACTITIONER** means a practitioner who is party to a clinical services agreement with the District.

**CONSULTING STAFF** means the category of Medical Staff members who treat and otherwise care for patients at Northern Inyo Healthcare District and meet the qualifications and prerogatives as listed in these Bylaws.

**COURTESY STAFF** means the category of Medical Staff members who do not utilize Northern Inyo Healthcare District as the principle location of their practice but are given privileges and meet the qualifications and prerogatives as listed in these Bylaws.

**CURRENT COMPETENCE** means a combination of observable and measurable knowledge, skills, abilities and personal attributes that constitute a practitioner's performance within the last twenty-four (24) months.

**DATE OF RECEIPT** means the date any notice, special notice, or other communication was delivered personally; or if such notice was sent by mail, it shall mean seventy-two (72) hours after the notice, special notice, or communication was deposited postage prepaid, in the United States mail.

**DAYS** means calendar days, unless otherwise specified.

**DEPARTMENT or CLINICAL DEPARTMENT** is a group of practitioners holding privileges in a designated clinical practice area.

**DEPARTMENT CHIEF** is the individual practitioner who is the elected leader of the designated clinical department.

**DISTRICT** means Northern Inyo Healthcare District (NIHD) and includes all inpatient and outpatient services operated by Northern Inyo Healthcare District.

**EX-OFFICIO** means service by virtue of office or position held. An ex-officio appointment is without vote unless otherwise specified.

**HONORARY STAFF** means those former Medical Staff members or other physicians, dentists or podiatrists who do not actively practice at Northern Inyo Healthcare District but are deemed deserving of membership as described in these Bylaws.

**IN GOOD STANDING** means a member has unrestricted clinical privileges, is currently not under suspension or serving with any limitation of voting or other prerogatives imposed by operation of the Bylaws or policy of the Medical Staff.

**INVESTIGATION** means a process specifically instigated to determine the validity, if any, to a concern or complaint raised against a practitioner, and does not include activity of the physician wellness committee.

**LEAD APP** means the elected representative of the Advanced Practice Providers (APPs).

**LIMITED LICENSE PRACTITIONER** means a practitioner who is not a physician or an APP, but who practices under a license such as a dentist or podiatrist.

**MEDICAL EXECUTIVE COMMITTEE** means the executive committee of the Medical Staff.

**MEDICAL DIRECTOR** means the administratively-appointed physician leader of the medical or District department(s) or group(s).

**MEDICAL STAFF** means those Northern Inyo Healthcare District physicians (MD or DO), dentists, and podiatrists who have been granted recognition as members pursuant to the terms of these Bylaws.

**MEDICAL STAFF YEAR** means the twelve-month period beginning July 1 through the subsequent June 30.

**MEMBER** means any physician, dentist, or podiatrist who has been appointed to the Medical Staff.

**NOTICE** means a written communication delivered personally to the addressee or sent by United States mail, first-class postage prepaid, addressed to the addressee at the last address as it appears in the official records of the Medical Staff or the District.

**PHYSICIAN** means an individual with an MD or DO degree who is currently licensed to practice medicine.

**PRACTITIONER** means, unless otherwise expressly limited, any currently licensed physician (MD or DO), limited license practitioner, or Advanced Practice Provider.

**PREROGATIVES** means the specific governance rights to which a member or APP may be entitled, depending upon the practitioner's category, including without limitation, rights to vote on Medical Staff and Medical Staff committee matters, hold Medical Staff Office, or serve on Medical Staff committees.

**PRIVILEGES or CLINICAL PRIVILEGES** means the permission granted to a Medical Staff member or APP to render specific patient services.

**PROCEDURAL RIGHTS** means rights to a hearing and appeal in accordance with Article VII to which a practitioner becomes entitled to as the result of adverse actions taken or recommended which constitute grounds for a hearing.

**TELEMEDICINE or TELEHEALTH** means the remote diagnosis and treatment of patients by means of telecommunications technology.

**UNFAVORABLE ACTION** means an action which adversely affects the practitioner but, unlike an adverse action, is not reportable as defined under Business and Professions Code 805.

## ARTICLE II: MEMBERSHIP

### II.1 NATURE OF MEMBERSHIP

No practitioner, including those in a medical-administrative position by virtue of a contract with the District, shall admit or provide medical or health-related services to patients of Northern Inyo Healthcare District unless the practitioner is a member of the Medical Staff or advanced practice provider with corresponding privileges or has been granted temporary, telemedicine or disaster privileges in accordance with the procedures set forth in these Bylaws. Appointment to the Medical Staff shall confer only such clinical privileges and rights as have been granted by the Board of Directors in accordance with these Bylaws. Privileges shall be granted and maintained only if the requested privileges are within Northern Inyo Healthcare District's patient care needs.

### II.2 QUALIFICATIONS FOR MEMBERSHIP

#### II.2-1 GENERAL QUALIFICATIONS

Membership and privileges shall be extended only to practitioners who are professionally competent and continuously meet the qualifications, standards, and requirements as described in this article.

#### II.2-2 BASIC QUALIFICATIONS

A practitioner must demonstrate compliance with all basic standards set forth in this Section in order to have an application for Medical Staff membership or privileges accepted for review, except in the instance of appointment to honorary staff. The practitioner must:

- (a) Qualify to practice in California as follows:
  - (1) Physicians must hold an MD or DO degree or their equivalent and a valid and unrestricted license to practice medicine issued by the Medical Board of California or the California Board of Osteopathic Examiners. For purposes of this Section, "or their equivalent" shall mean any degree (i.e., foreign) recognized by the Medical Board of California or the California Board of Osteopathic Examiner;
  - (2) Podiatrists must hold a DPM degree and a valid and unrestricted certificate to practice podiatry issued by the Medical Board of California;
  - (3) Dentists must hold a DDS or equivalent degree and a valid and unrestricted license to practice dentistry issued by the California Board of Dental Examiners;
- (b) Where applicable to their practice, have a valid and unrestricted federal Drug Enforcement Administration (DEA) certificate.
- (c) Have professional liability insurance in not less than \$1M per claim/\$3M aggregate.
- (d) Be board certified or board eligible as determined by the individual service and in the criteria for privileging.
- (e) Be eligible to receive payments from the federal Medicare and state Medicaid (Medi-Cal) programs.
- (f) If requesting privileges only in departments operated under an exclusive contract, be a member, employee, or subcontractor of the group or person that has the contract.

- (g) Not have been convicted of, or plead guilty or no contest to, a felony related directly to his/her professional practice, or patient relationships, or involving moral turpitude, within the past seven (7) years.

A practitioner who does not meet these basic standards is ineligible to apply for Medical Staff membership or privileges, and the application shall not be accepted for review, except that the honorary Medical Staff do not need to comply with any of the basic standards. If it is determined during processing that an applicant does not meet all of the basic qualifications, the review of the application shall be discontinued. An applicant who does not meet the basic standards is not entitled to the procedural rights set forth in these Bylaws.

### **II.2-3 ADDITIONAL QUALIFICATIONS FOR MEMBERSHIP**

In addition to meeting the basic standards, the practitioner must, through the credentialing and privileging processes:

- (a) Demonstrate his or her:
  - (1) Adequate education, training and experience in the requested privileges;
  - (2) Current professional competence;
  - (3) Good judgment; and
  - (4) Adequate physical and mental health status to demonstrate to the satisfaction of the Medical Staff that he or she is professionally and ethically competent so that patients can reasonably expect to receive the generally recognized professional level of quality of care.
- (b) Be determined to:
  - (1) Adhere to the lawful ethics of his or her profession;
  - (2) Work cooperatively with others in the District setting so as to not adversely affect patient care or District operations, as well as abide by the policy on professional conduct and prohibition of disruptive or discriminatory behavior;
  - (3) Keep as confidential, as required by law, all information or records received in the physician-patient relationship; and
  - (4) Participate in and properly discharge Medical Staff responsibilities.

### **II.3 EFFECT OF OTHER AFFILIATIONS**

No person shall be entitled to membership or privileges in the Medical Staff merely because that person holds a certain degree, is licensed to practice in this or in any other state, is a member of any professional organization, is certified by any clinical board, or because such person had, or presently has, staff membership or privileges at another health care facility. Medical staff membership or clinical privileges shall not be conditioned or determined on the basis of an individual's participation or non-participation in a particular medical group, IPA, PPO, PHO, hospital-sponsored foundation, or other organization or in contracts with a third party which contracts with this District.

### **II.4 NONDISCRIMINATION**

No aspect of Medical Staff membership or particular clinical privileges shall be denied on the basis of sex, race, age, creed, color, national origin, physical or mental impairment, or sexual orientation if it does not pose a threat to the quality and safety of patient care.

## II.5 BASIC RESPONSIBILITIES OF MEDICAL STAFF MEMBERSHIP

Except for honorary staff, the ongoing responsibilities of each practitioner shall include:

- (a) providing patients with the quality of care meeting the professional standards of the Medical Staff of this District;
- (b) abiding by the Medical Staff Bylaws, applicable Joint Commission (or other applicable accrediting body) standards, and applicable Medical Staff and District policies and procedures, including those related to the security of electronic health records;
- (c) discharging in a responsible and cooperative manner such reasonable responsibilities and assignments imposed upon the member by virtue of Medical Staff membership or privileges, including committee assignments, serving as a proctor, or performing peer review;
- (d) preparing and completing in timely fashion medical records for all the patients to whom the practitioner provides care in the District;
- (e) abiding by the ethical principles of the appropriate state medical or other professional association(s);
- (f) working cooperatively with members, nurses, District administration and others so as not to adversely affect patient care, as well as complying with Medical Staff policy on professional conduct;
- (g) making appropriate arrangements for coverage of that member's patients;
- (h) refusing to engage in improper inducements for patient referral;
- (i) participating in and documenting continuing education programs as determined by the Medical Staff for maintenance of privileges;
- (j) discharging such other reasonable staff obligations as may be lawfully established from time to time by the Medical Staff or Medical Executive Committee;
- (k) performing and documenting, if granted the requisite privileges, or arranging for the performance of, a history and physical on every patient he/she admits. As further detailed in Medical Staff policy, a medical history and physical examination shall be completed no more than thirty (30) days before, or twenty-four (24) hours after, admission or registration, but prior to surgery or a procedure requiring anesthesia services. When the medical history and physical examination is completed within thirty (30) days before admission or registration, the physician must complete and document an updated examination of the patient within twenty-four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The history and physical must be completed and documented by a practitioner in accordance with state law and Medical Staff policy.
- (l) paying applicable dues and/or fees, if required; and
- (m) promptly notifying the Medical Staff Office in writing as soon as reasonably possible, but within 30 days:
  - (1) the initiation of formal proceedings by a medical licensing authority or the DEA to suspend, revoke, restrict or place on probation a license or DEA certificate;
  - (2) an action by the Medical Staff executive committee or the governing body of another hospital or health care entity to suspend, revoke, restrict, or deny clinical privileges for reasons related to professional competence or conduct;

- (3) the practitioner's exclusion from participation in Medicare, Medi-Cal or any federal health care program or conviction of a criminal offense related to the provision of health care items or services;
- (4) any formal allegations of fraud or abuse or illegal activity relating to the practitioner's professional practice or conduct made by any State or Federal government agency;
- (5) any report filed with the National Practitioner Data Bank or Healthcare Integrity and Protection Data Bank,
- (6) any injury, disability, or illness that would significantly interfere with his/her medical practice;
- (7) the filing of any malpractice claim or action in which the practitioner is a named defendant; or
- (8) any other action that could affect his/her Medical Staff standing and/or clinical privileges at the healthcare District.

Failure to abide by the above-listed duties may result in adverse action.

## **II.6 CONTRACT PRACTITIONERS**

### **II.6-1 MEMBERSHIP AND PRIVILEGES REQUIRED**

A contract practitioner may provide services authorized pursuant to the applicable specified clinical services contract only if the specified clinical services are within the scope of privileges which the contract practitioner has been granted in accordance with these Bylaws. Also, a practitioner who is an employee or subcontractor of a contract practitioner or a medical group or other professional entity which is a party to a contract at the District may be granted temporary privileges to serve as locum tenens for a contract practitioner, provided the practitioner otherwise meets applicable Bylaws requirements for the granting and exercise of such temporary privileges.

### **II.6-2 EFFECT OF SPECIFIED CLINICAL SERVICES CONTRACT TERMINATION**

The termination or expiration of the applicable specified clinical services contract shall automatically terminate only the practitioner's rights to provide services on such basis as specified in the contract, and

- (a) Expressly shall not, of itself, affect the Medical Staff membership or privileges granted to the practitioner, and
- (b) Accordingly, shall not entitle the contract practitioner to procedural rights unless otherwise required by law or expressly provided in the applicable specified clinical services contract.

The affected individual who wishes to maintain Medical Staff membership or privileges after termination of a contract must continue to comply with and adhere to the requirements set forth in these Bylaws. Failure to comply will be deemed a voluntary resignation from Medical Staff membership and privileges. Such deemed resignation shall not entitle the practitioner to procedural rights.

### **II.6-3 MEDICAL STAFF ROLE IN SPECIFIED CLINICAL SERVICES CONTRACTING**

Prior to approving, renewing, or modifying and, to the extent reasonably practical, prior to terminating, a specified clinical services contract, the Board of Directors, Administrator, or Chief Medical Officer shall give notice of the planned action to the Medical Staff by transmitting the notice to the Medical Executive Committee. The Medical Staff and/or the Medical Executive Committee may review and make recommendations to the Board of Directors regarding quality of care issues related to specified clinical services contractual arrangements for physician and/or professional services, prior to the District Board taking final action in the matter.

## **II.7 ADMINISTRATIVE PRACTITIONERS**

Members may be assigned duties by the District Board which are solely administrative in nature, provided that such duties are reasonably related to the member's official Medical Staff responsibilities. The District Board, in its sole discretion, may terminate such assignment at any time. Unless otherwise required by law, such purely administrative service assignment and termination is independent of, and shall have no effect on, the member's membership or privileges, shall not entitle the member to procedural rights, and records of such assignment or termination shall not be deemed part of the member's credentials files or any other Medical Staff records.

## ARTICLE III: CATEGORIES OF MEMBERSHIP

### III.1 CATEGORIES

The categories of the Medical Staff shall include the following: active, courtesy, consulting, and honorary. At appointment and each time of reappointment, the member's staff category shall be determined.

There are several groups of practitioners who, due to the nature of their practice, do not require assignment to a Medical Staff category. The scope and extent of these practitioners' relationships with the healthcare District can be found in Article IV of these Bylaws.

### III.2 MODIFICATION OF MEMBERSHIP

On its own, upon recommendation of the Credentials Committee, or pursuant to a request by a member under Section 5.6-1(b), or upon direction of the Board of Directors as set forth in Section 6.2-6, the Medical Executive Committee may recommend a change in the Medical Staff category of a member consistent with the requirements of these Bylaws.

### III.3 ACTIVE STAFF

#### III.3-1 QUALIFICATIONS

The active staff shall consist of members who:

- (a) meet the qualifications for membership set forth in Section 2.2;
- (b) when on duty, are located close enough to the healthcare District to provide appropriate quality care, as per the policies of the specific department; and
- (c) are regularly involved in patient care in this healthcare District and regularly involved in Medical Staff functions, as determined by the Medical Staff.

#### III.3-2 RIGHTS AND RESPONSIBILITIES (PREROGATIVES)

Except as otherwise provided, the rights and responsibilities of an active member shall be to:

- (a) exercise such clinical privileges as are granted pursuant to these Bylaws;
- (b) attend and vote on matters presented at general and special meetings of the Medical Staff and of the department and committees to which the member is duly appointed;
- (c) hold staff or department office and serve as a voting member of committees to which the member is duly appointed or elected by the Medical Staff or duly authorized representative thereof, so long as the activities required by the position fall within the member's scope of practice;
- (d) pay Medical Staff membership dues and application fees in the amount as determined by the Medical Executive Committee; and
- (e) exercise other such rights and responsibilities at outlined in Table 3.8.

#### III.3-3 TRANSFER OF ACTIVE STAFF MEMBER

After two consecutive ongoing professional practice evaluation (OPPE) cycles as per policy in which a member of the active staff fails to regularly care for patients in this healthcare District or be regularly involved in Medical Staff functions as determined by the Medical Staff, that member shall be referred to the Credentials Committee to determine the appropriate category, if any, for which the member is qualified.

### **III.4 COURTESY STAFF**

#### **III.4-1 QUALIFICATIONS**

The courtesy staff shall consist of members who:

- (a) meet the general qualifications set forth in Section 2.2;
- (b) when on duty, are located close enough to the healthcare District to provide appropriate quality care, as per the policies of the specific department;
- (c) do not utilize this healthcare District as the principle location in their practice and are not regularly involved in Medical Staff functions; and
- (d) are members in good standing of the active Medical Staff of another licensed hospital, and at the time of appointment and reappointment, are able to provide proof of continued membership and privileges at the primary hospital. Exceptions to this requirement may be made by the Medical Executive Committee for good cause.

#### **III.4-2 RIGHTS AND RESPONSIBILITIES (PREROGATIVES)**

Except as otherwise provided, the rights and responsibilities of the courtesy staff shall be to:

- (a) care for patients of the healthcare District and exercise such clinical privileges as are granted pursuant to these Bylaws;
- (b) attend meetings of the Medical Staff and the department of which that person is a member, including open committee meetings and educational programs, when available. Courtesy staff have no right to vote at such meetings, except within committees when the right to vote is specified at the time of appointment;
- (c) provide patient activity and quality review information from his or her primary facility as may be requested at the time of appointment and reappointment;
- (d) pay Medical Staff membership dues and application fees, as determined by the Medical Executive Committee; and
- (e) exercise other such rights and responsibilities at outlined in Table 3.8.

Courtesy staff members shall not be eligible to hold office in the Medical Staff.

#### **III.4-3 LIMITATIONS**

Courtesy staff members who regularly admit patients or regularly care for patients at the District shall, upon review of the Credentials Committee and Medical Executive Committee, be obligated to seek appointment to the appropriate staff category.

Courtesy staff members who do not maintain active staff membership at another licensed hospital shall be referred to the Credentials Committee to determine the appropriate category, if any, for which the member is qualified.

### **III.5 CONSULTING STAFF**

#### **III.5-1 QUALIFICATIONS**

Any member of the Medical Staff in good standing may consult in that member's area of expertise; however, the consulting Medical Staff shall consist of such practitioners who:

- (a) meet the qualifications set forth in Section 2.2 and are not otherwise members of the Medical Staff;
- (b) possess adequate clinical and professional expertise;
- (c) are called upon periodically by a practitioner at Northern Inyo Healthcare District to render care to patients treated at or admitted to this facility.

### **III.5-2 RIGHTS AND RESPONSIBILITIES (PREROGATIVES)**

The rights and responsibilities of the consulting staff shall be to:

- (a) treat and otherwise care for patients at this facility on request of the patient's practitioner;
- (b) exercise such additional clinical privileges as are granted pursuant to these Bylaws;
- (c) attend meetings of the Medical Staff and the department of which that person is a member, including open committee meetings and educational programs, when available. Consulting staff have no right to vote at such meetings, except within committees when the right to vote is specified at the time of appointment;
- (d) pay application fees, as determined by the Medical Executive Committee; and
- (e) exercise other such rights and responsibilities at outlined in Table 3.8.

Consulting staff members shall not be eligible to hold office in the Medical Staff.

## **III.6 HONORARY STAFF**

### **III.6-1 QUALIFICATIONS**

The honorary staff shall consist of physicians, dentists, or podiatrists who do not actively practice at the District but are deemed deserving of membership by virtue of their outstanding reputation, noteworthy contributions to the health and medical sciences, or their previous long-standing service to the District, and who continue to exemplify high standards of professional and ethical conduct. Members who have retired from active practice and, at the time of their retirement, were members in good standing of the Medical Staff, and who continue to adhere to appropriate professional and ethical standards, shall also be eligible for appointment to honorary staff upon recommendation of the Medical Executive Committee.

### **III.6-2 RIGHTS AND RESPONSIBILITIES (PREROGATIVES)**

Honorary members are not eligible to admit patients to the hospital or to exercise clinical privileges in the District, or to vote or hold office in this Medical Staff organization, but they may serve upon committees without vote at the discretion of the Medical Executive Committee. They may attend staff and department meetings, including open committee meetings and educational programs. Appointment to honorary staff shall be indefinite, unless otherwise requested by the member.

## **III.7 GENERAL EXCEPTIONS TO PREROGATIVES**

Regardless of the category of membership in the Medical Staff, limited license members (i.e., podiatrists and dentists):

- (a) shall only have the right to vote on matters within the scope of their licensure. In the event of a dispute over voting rights, that issue shall be determined by the Chair of the meeting, subject to final decision by the Medical Executive Committee; and

(b) shall exercise clinical privileges only within the scope of their licensure and as set forth in Section 4.7.

**III.8 TABLE OF PREROGATIVES BY MEDICAL STAFF CATEGORY**

	<b>Active</b>	<b>Courtesy</b>	<b>Consulting</b>	<b>Honorary</b>
<b>Exercise privileges</b>	Yes	Yes	Yes	No
<b>General voting rights</b>	Yes	No	No	No
<b>Attendance at general Medical Staff meeting required</b>	Yes	No	No	No
<b>May be committee member</b>	Yes	Yes	Yes	Yes
<b>Vote in committee</b>	Yes	No, unless specified at time of appointment to committee	No, unless specified at time of appointment to committee	No
<b>May hold Medical Staff Office</b>	Yes	No	No	No
<b>May be committee Chair</b>	Yes	No	No	No
<b>May be Department Chief</b>	Yes	No	No	No
<b>Pay dues</b>	Yes	Yes	No	No
<b>Pay reappointment application fee</b>	No	Yes	Yes	No
<b>Must have malpractice insurance</b>	Yes	Yes	Yes	No
<b>Must file for reappointment</b>	Yes	Yes	Yes	No

## **ARTICLE IV: APPLICATION PROCEDURES FOR PRIVILEGES**

### **IV.1 GENERAL**

Except as otherwise specified herein, no person (including persons engaged by Northern Inyo Healthcare District in administratively responsible positions) shall exercise clinical privileges in the District or via telemedicine link unless and until that person applies for and receives approval to exercise clinical privileges as set forth in these Bylaws, or, with respect to advanced practice providers, has been granted a service authorization or privileges under applicable Medical Staff policies.

By applying to the Medical Staff for privileges (or, in the case of members of the honorary staff, by accepting an appointment to that category), the applicant acknowledges responsibility to first review these Bylaws and policies, and agrees to comply with the responsibilities of Medical Staff membership and with the Bylaws and policies of the Medical Staff as they exist and as they may be modified from time to time.

### **IV.2 BURDEN OF PRODUCING INFORMATION**

In connection with all applications for appointment, reappointment, privileges, or transfer of staff category, the applicant shall have the burden of producing information for an adequate evaluation of the applicant's current competence, character, ethics, and other qualifications and suitability for the clinical privileges and staff category requested, of resolving any reasonable doubts about these matters, and of satisfying requests for information. The applicant's failure to sustain this burden shall be grounds for the Medical Staff's refusal to take action on the application, which shall not be subject to appeal or review under Article VII of these Bylaws. To the extent consistent with law, this burden may include submission to a medical or psychological examination as per relevant credentialing policy, at the applicant's expense, if deemed appropriate by the Medical Executive Committee, which may select the examining physician. If current competency cannot be demonstrated, an applicant may be eligible for re-entry per the current policy.

### **IV.3 APPOINTMENT AND AUTHORITY**

The Medical Staff shall make recommendations to the Board of Directors for appointments, denials and revocations of appointments to the Medical Staff as set forth in these Bylaws.

### **IV.4 DURATION OF APPOINTMENT AND REAPPOINTMENT**

Initial appointments and reappointments to the Medical Staff shall be for a period of up to two (2) years. Any recommendation for appointment or reappointment of less than two (2) years is at the sole discretion of the Medical Executive Committee and is not subject to rights of appeal as set forth in Article VII.

### **IV.5 APPLICATION FOR INITIAL APPOINTMENT, REAPPOINTMENT, AND PRIVILEGES**

#### **IV.5-1 APPLICATION FORM**

An application form shall be developed by the District and the Medical Staff. The form shall require detailed information which shall include, but not be limited to, information concerning:

- (a) the applicant's qualification, including, but not limited to, professional education, training and experience, current licensure, current DEA registration (if applicable), and continuing medical education information related to the clinical privileges to be exercised by the applicant;
- (b) peer references familiar with the applicant's current professional competence and ethical character;
- (c) requests for membership categories, departments, and clinical privileges;

- (d) past or pending professional disciplinary action, voluntary or involuntary denial, revocation, suspension, reduction or relinquishment of Medical Staff membership or privileges or any licensure or registration, and related matters;
- (e) any past or pending arrests, indictments, criminal charges, or convictions brought against the applicant;
- (f) current physical and mental health status, to the extent necessary to determine the applicant's ability to perform obligations or requested privileges, or as otherwise permitted by law;
- (g) final judgments, settlements, or arbitration awards made against the applicant in professional liability cases, and any filed and served cases pending or dismissed;
- (h) professional liability insurance coverage, in not less \$1M per claim/\$3M aggregate; and
- (i) any past, pending or current exclusion of suspension from a state or federal health care program, or any investigation or disciplinary action by any governmental agency relating to the applicant's professional license or practice.

Each application shall be in writing, or electronically submitted on the prescribed form with all provisions completed (or accompanied by an explanation of why answers are unavailable), and signed by the applicant. When an applicant requests an application form, that person shall be given a copy of these Bylaws and, as deemed appropriate by the Medical Executive Committee, copies or summaries of any other applicable Medical Staff and District policies relating to clinical practice in the District. Failure to disclose the information requested in the application, or knowingly providing false or misleading information may result in disciplinary action, including suspension or termination of membership and/or privileges, or in a decision that the application does not qualify for credentialing consideration.

#### **IV.5-2 EFFECT OF APPLICATION**

In addition to the matters set forth in Section 5.1, by submitting an application for privileges, each applicant:

- (a) signifies willingness to appear for interviews in regard to the application;
- (b) authorizes consultation with others who have been associated with the applicant and who may have information bearing on the applicant's competence, qualifications and performance, and authorizes such individuals and organizations to candidly provide all such information;
- (c) consents to inspection of records and documents that may be material to an evaluation of the applicant's qualifications and ability to carry out clinical privileges requested, and authorizes all individuals and organizations in custody of such records and documents to permit such inspection and copying;
- (d) releases from any liability, to the fullest extent provided by law, all persons for their acts performed in connection with investigating and evaluating the applicant;
- (e) releases from any liability, to the fullest extent provided by law, all individuals and organizations who provide information regarding the applicant, including otherwise confidential information;
- (f) consents to the disclosure to other hospitals, medical associations, licensing boards, and to other similar organizations as required by law, any information regarding the applicant's professional or ethical standing that the District or Medical Staff may have, and releases the Medical Staff and District from liability for so doing to the fullest extent permitted by law;

- (g) if a requirement then exists for Medical Staff dues, acknowledges responsibility for timely payment;
- (h) agrees to provide quality care for patients;
- (i) pledges to maintain an ethical practice, including refraining from illegal inducements for patient referral, providing for the care of the applicant's patients, seeking consultation whenever indicated, refraining from providing illusory or unnecessary surgical or medical services, and refraining from delegating patient care responsibility to non-qualified or inadequately supervised practitioners;
- (j) pledges to be bound by the Medical Staff Bylaws and policies, as well as applicable District policies; and
- (k) agrees that if membership and/or privileges are granted, and for the duration of Medical Staff membership and/or privileges, the applicant has an ongoing and continuous duty to report to the Medical Staff Office as soon as reasonably possible, but within thirty (30) days, any and all information that would otherwise correct, change, modify or add to any information provided in the application or most recent reapplication.

#### **IV.5-3 VERIFICATION OF INFORMATION**

The applicant shall deliver a completely filled-in, signed, and dated application and supporting documents to the Medical Staff Office and an advance payment of non-refundable Medical Staff dues or fees, if any is required. The Medical Staff Office shall expeditiously seek to collect or verify the references, licensure status, and other evidence submitted in support of the application. The District's authorized representative shall query the National Practitioner Data Bank regarding the applicant or member and submit any resulting information to the Credentials Committee for inclusion in the applicant's or member's credentials file. The applicant shall be notified of any problems in obtaining the information required, and it shall be the applicant's obligation to obtain any reasonably requested information. Failure to provide any requested information within thirty (30) days of a request, or an otherwise agreed to timeframe, shall be deemed a voluntary withdrawal of the application and no further action will be taken with respect to the application. When collection and verification of information is accomplished, all such information shall be transmitted to the Credentials Committee and the appropriate department(s). No final action on an application may be taken until receipt of the Data Bank report.

#### **IV.5-4 DETERMINE IF APPLICATION IS COMPLETE**

The application will be deemed complete when all required information has been submitted by the applicant and all necessary verifications have been obtained. An application will become incomplete if the need arises for new, additional, or clarifying information at any time prior to final determination by the Board. Notwithstanding any other provision of these Bylaws, an application that is determined to be incomplete shall not qualify for privileging recommendations, regardless of any assessment or determination that may have been made as to its completeness at an earlier stage in the process. Should the applicant fail to make the application complete after thirty (30) days of a request, or an otherwise agreed-to timeframe, the credentialing and privileging process will be terminated. An incomplete application will not be processed. Termination of the credentialing and privileging process under this provision shall not entitle the applicant to any hearing or appeal under Article VII.

#### **IV.5-5 DEPARTMENT ACTION**

After receipt of the application, the Chief of each department to which the application is submitted shall review the application and supporting documentation, may seek additional information, and may conduct a personal

interview with the applicant at the Chief's discretion. The Chief shall evaluate all matters deemed relevant to a recommendation, including information concerning the applicant's provision of services within the scope of privileges requested, his/her clinical and technical skills, any relevant data available from District performance improvement activities, and the applicant's participation in relevant continuing education. The Chief shall transmit to the Credentials Committee his or her recommendations and, if appointment is recommended, recommendations as to membership category, department affiliation, clinical privileges to be granted, and any special conditions to be attached to the appointment. The Chief may also defer action on the application in the event that additional information is needed. In this case, the applicant will be notified and the application will be considered incomplete as described in Section 5.5-4.

#### **IV.5-6 CREDENTIALS COMMITTEE ACTION**

The Credentials Committee shall review the application, evaluate and verify the supporting documentation, the Department Chief's recommendations, and other relevant information. The Credentials Committee may elect to interview the applicant and seek additional information. As soon as practicable, the Credentials Committee shall transmit to the Medical Executive Committee a written report with its recommendations and, if appointment is recommended, recommendations as to membership category, department affiliation, clinical privileges to be granted, and any special conditions to be attached to the appointment. The Credentials Committee may also defer action on the application in the event that additional information is needed. In this case, the applicant will be notified and the application will be considered incomplete as described in Section 5.5-4.

#### **IV.5-7 MEDICAL EXECUTIVE COMMITTEE ACTION**

At its next regular meeting after receipt of the Credentials Committee report and recommendation, or as soon thereafter as is practicable, the Medical Executive Committee shall consider the report and any other relevant information. The Medical Executive Committee may request additional information, return the matter to the Credentials Committee for further investigation, and/or elect to interview the applicant. The Medical Executive Committee shall immediately forward to the Administrator, for prompt transmittal to the Board of Directors, a written report with its recommendations and, if appointment is recommended, recommendations as to membership category, department affiliation, clinical privileges to be granted, and any special conditions to be attached to the appointment. The Medical Executive Committee may also defer action on the application in the event that additional information is needed. In this case, the applicant will be notified and the application will be considered incomplete as described in Section 5.5-4.

#### **IV.5-8 EFFECT OF MEDICAL EXECUTIVE COMMITTEE ACTION**

- (a) Favorable recommendation: When the recommendation of the Medical Executive Committee is favorable to the applicant, it shall be immediately forwarded to the Board of Directors and the supporting documentation shall be made available upon request.
- (b) Unfavorable recommendation: When the recommendation of the Medical Executive Committee is an unfavorable action, in whole or in part, the Board of Directors and the applicant shall be promptly informed by written notice. The applicant shall not be entitled to procedural rights as provided in Article VII.
- (c) Adverse recommendation: When a final recommendation of the Medical Executive Committee is an adverse action, in whole or in part, the Board of Directors and the applicant shall be promptly informed by written notice. The applicant shall be entitled to procedural rights as provided in Article VII. The Board of Directors shall not take action on the pending adverse recommendation until the applicant has exhausted or waived his/her procedural rights.

#### **IV.5-9 BOARD OF DIRECTORS ACTION**

On favorable recommendation of the Medical Executive Committee:

- (a) A decision of the Board to adopt a favorable recommendation of the Medical Executive Committee shall be deemed as final action.
- (b) If the Board is inclined to reject or modify a favorable recommendation, the Board shall refer the matter to the joint conference committee.
- (c) If the Board's resolution constitutes grounds for a hearing under Article VII of the Bylaws, the Administrator shall promptly inform the applicant and the Chief of Staff, and the applicant shall be entitled to the procedural rights as provided in that Article. Once the applicant has exhausted or waived his/her procedural rights, the Board may then take final action.

On adverse recommendation of the Medical Executive Committee:

- (a) Once the applicant has exhausted or waived his or her procedural rights, the Board may take final action in the matter or refer the matter to the joint conference committee.

#### **IV.5-10 NOTICE OF FINAL DECISION**

- (a) Notice of the final decision shall be given to the applicant, the Chief of Staff, the Chief of each department concerned, and the Administrator if not previously informed.
- (b) A decision and notice to appoint or reappoint shall include, if applicable: (1) the staff category to which the applicant is appointed; (2) the department to which that person is assigned; (3) the clinical privileges granted; and (4) any special conditions attached to the appointment.

#### **IV.5-11 REAPPLICATION AFTER ADVERSE OR UNFAVORABLE ACTION**

An applicant who has received a final adverse action, as defined in these Bylaws, regarding an application for appointment, reappointment, or privileges shall not be eligible to reapply to the Medical Staff for a period of three (3) years. Any such reapplication shall be processed as an initial application, and the applicant shall submit such additional information as may be required to demonstrate that the basis for the earlier adverse action no longer exists.

An applicant who has received an unfavorable action, as defined in these Bylaws, is eligible to reapply once the deficiency has been corrected. The waiting period shall not apply.

#### **IV.5-12 TIMELY PROCESSING OF APPLICATIONS**

Once an application is deemed complete, it is expected to be processed within one hundred twenty (120) days, unless it becomes incomplete at any point during processing as described in these Bylaws. This time period is provided to assist in the processing of the application and not to create rights for applicants to have their applications processed within this specific time period.

### **IV.6 REAPPOINTMENT AND REQUESTS FOR MODIFICATIONS OF STAFF STATUS OR PRIVILEGES**

Applicants for reappointment, renewal of privileges, and requests for modifications of staff status or privileges shall be subject to all of the general application provisions of these Bylaws, subject only the following additional provisions:

#### **IV.6-1 REAPPLICATION DEADLINE AND CONTENT**

- (a) At least one hundred fifty (150) days prior to the expiration date of the current staff appointment or expiration of privileges for privileges-only practitioners (for example, telemedicine), a reapplication form shall be submitted to the member or privileged practitioner. At least one hundred twenty (120) days prior to the expiration date, each applicant shall submit to the Medical Staff Office the completed application form for renewal of appointment to the staff and for renewal or modification of clinical privileges. The reapplication form shall include all information necessary to update and evaluate the qualifications of the applicant. However, an applicant for reappointment shall not be required to repeat information which has been provided and verified in a prior application and in which there has been no change during the period since the application submitted the prior application. For such information, in response to each relevant portion of the application form, the applicant shall indicate that the information is unchanged.
- (b) A Medical Staff member or privileged practitioner who seeks a change in Medical Staff status or modification of clinical privileges may submit such a request at any time.
- (c) The timely processing of reapplications from receipt of the application to final action shall be one hundred twenty (120) days.

#### **IV.6-2 FAILURE TO FILE REAPPOINTMENT APPLICATION**

If an application for reappointment is not received at least one hundred twenty (120) days prior to the expiration date, written notice shall be promptly sent to the applicant advising that the application has not been received. The applicant may submit a request for extension to the Medical Executive Committee for consideration.

If an applicant fails, without good cause, to submit the required application by the deadline, but submits it prior to the expiration date of the applicant's privileges, and no final decision has been rendered by the expiration date due to the delays caused by the applicant's failure to timely submit the complete application, the applicant's privileges and prerogatives shall be deemed to be automatically suspended upon the expiration date unless otherwise extended by the Medical Executive Committee with the approval of the Board of Directors. The automatic suspension shall remain in effect until the District Board makes a final decision on the application.

If an applicant fails, without good cause, to submit the required reappointment application by the expiration date of the applicant's privileges, or to provide information requested to complete the application after receiving a notice of incomplete application, the applicant shall be deemed to have voluntarily resigned from membership and relinquished all privileges, effective as of the expiration date of the applicant's term of appointment and/or privileges.

In the event membership terminates and/or privileges lapse for the reasons set forth herein, the procedures set forth in Article VII shall not apply.

#### **IV.7 LEAVE OF ABSENCE**

A practitioner taking any of the following leaves of absence for a duration exceeding ninety (90) days must notify the Medical Staff Office prior to the start of leave, stating the approximate period of leave desired, which may not exceed one (1) year. Absence for longer than one (1) year shall result in automatic expiration of Medical Staff appointment and

clinical privileges, unless an extension is requested in writing at least forty-five (45) days prior to the one-year date and granted by the Medical Executive Committee. Reinstatement from any leave shall be subject to the provisions listed in Section 5.7-5.

#### **IV.7-1 ROUTINE LEAVE OF ABSENCE**

A practitioner may take a routine leave of absence, giving consideration to his/her contractual obligations. The Medical Executive Committee shall be notified of the leave.

#### **IV.7-2 MEDICAL LEAVE OF ABSENCE**

A practitioner may take a medical leave of absence to accommodate treatment for, or recovery from, a behavioral health or physical health condition affecting his or her fitness to practice safely. The approximate period of leave needed shall be specified, and as reasonable during the leave, the Medical Executive Committee shall be kept informed of changes to the projected date of return. The practitioner may be required to submit a letter of release from the treating physician as part of the reinstatement process confirming that his or her health is free from any impairment prior to exercising any patient care. The Medical Executive Committee may, at its discretion, require a fit for duty evaluation be performed by a provider of its choosing and at the practitioner's cost.

#### **IV.7-3 MILITARY LEAVE OF ABSENCE**

A practitioner may request a leave of absence to fulfill military service obligations. Such request shall be granted upon notice and review by the Medical Executive Committee.

#### **IV.7-4 OBLIGATION UNDER LEAVE OF ABSENCE**

During the period of the leave, the practitioner shall not exercise clinical privileges at Northern Inyo Healthcare District, and membership rights and responsibilities shall be inactive, but the obligation to pay dues, if any, shall continue, unless waived by the Medical Executive Committee.

Before any routine leave of absence may begin, all medical records must be completed and dues must be current, unless such dues are excused by the Medical Executive Committee. Meeting attendance requirements will be waived during the period of leave.

#### **IV.7-5 REQUEST FOR REINSTATEMENT**

At least forty-five (45) days prior to the termination of the leave of absence or as soon as reasonably known, the practitioner may request reinstatement of privileges by submitting a written notice to the Medical Executive Committee (and in the case of an advanced practice provider, written notice to the interdisciplinary practice committee in addition to the Medical Executive Committee). The Medical Executive Committee shall make a recommendation concerning the reinstatement of the practitioner's privileges and prerogatives, which may take into consideration a summary of the practitioner's activities during the leave. Reinstatement may be granted subject to focused professional practice monitoring and/or evaluation as determined by the Medical Executive Committee. A recommendation that a practitioner be denied reinstatement shall be considered a denial of privileges and may be appealed as such pursuant to these Bylaws.

#### **IV.7-6 FAILURE TO REQUEST REINSTATEMENT**

Failure, without good cause, to request reinstatement shall be deemed a voluntary resignation from the Medical Staff or advanced practice provider staff and shall result in automatic expiration of membership, privileges, and prerogatives. A practitioner whose membership and/or privileges automatically expires under this provision may contest this action to the Medical Executive Committee by submitting a written statement or request a meeting

before the committee. The Medical Executive Committee's decision on the matter shall be final. A request for membership and/or privileges subsequently received from a member terminated under this provision shall be submitted and processed in the manner specified in these Bylaws for initial appointments.

#### **IV.7-7 EXPIRATION OF APPOINTMENT WHILE ON LEAVE**

If a practitioner's term of appointment is scheduled to expire during the period for which a leave is requested, the practitioner may:

- (a) Seek and obtain reappointment prior to going on leave, which would result in an adjustment of the practitioner's subsequent term of appointment to reflect the new date of reappointment. The Medical Staff may require that supplemental information be produced to confirm current competence upon reinstatement; or
- (b) Apply for reappointment at the scheduled time while on leave. The Medical Staff may require that supplemental information be produced to confirm current competence upon reinstatement; or
- (c) Permit the current term of appointment to expire and reapply for membership and/or privileges as an initial applicant once the leave of absence has ended.

## **ARTICLE V: CLINICAL PRIVILEGES**

### **V.1 EXERCISE OF PRIVILEGES**

Except as otherwise provided in these Bylaws, a practitioner providing clinical services at this healthcare District shall be entitled to exercise only those clinical privileges specifically granted. Said privileges and services must be within the scope of any license, certificate or other legal credential authorizing practice in this state and consistent with any restrictions thereon, and shall be subject to applicable policies and the authority of the Department Chief. Medical staff privileges may be granted or continued by the Board of Directors only upon recommendation of the Medical Staff and following the procedures outlined in these Bylaws. Medical staff privileges may be modified or terminated by the mechanisms as outlined in these Medical Staff Bylaws.

### **V.2 PRIVILEGE REQUESTS**

Each application for privileges must contain a request for the specific clinical privileges desired by the applicant. A request for a modification of clinical privileges may be made at any time, but such requests must be supported by documentation of training and/or experience supportive of the request.

### **V.3 LAPSE OF APPLICATION**

If a practitioner requesting initial or additional clinical privileges fails to furnish the information necessary to evaluate the request within thirty (30) days (or as otherwise agreed upon), the application shall be regarded as incomplete and lapse as detailed in Section 5.5-4, and the applicant shall not be entitled to a hearing.

### **V.4 BASIS FOR PRIVILEGE DETERMINATION**

Requests for clinical privileges shall be evaluated on the basis of the practitioner's education, training, experience, current demonstrated professional competence and judgment, clinical performance, physical and mental health affecting the ability to perform duties, and the documented results of patient care and other quality review and monitoring as per ongoing and focused professional practice evaluations (OPPE and FPPE). If current competency cannot be demonstrated, an applicant may be eligible for re-entry per the current policy. Privilege determinations may also be based on pertinent information concerning clinical performance obtained from other sources, especially other institutions and health care settings where a member exercises clinical privileges. The decision to grant or deny a privilege and/or to renew an existing privilege shall include peer recommendations which address the applicant's:

1. Patient care
2. Medical/clinical knowledge
3. Practice-based learning and improvement
4. Interpersonal and communication skills
5. Professionalism
6. Systems-based practice

Privileges shall be granted and maintained only if the requested privileges are within the District's patient care needs. Furthermore, no specific privilege may be granted to a practitioner if the task, procedure or activity constituting the privilege is not available within the District despite the practitioner's qualifications or ability to perform the requested privilege, except as provided for under emergency privileges Section 4.11.

## **V.5 CRITERIA FOR “CROSS-SPECIALTY” OR NEW PRIVILEGES WITHIN THE DISTRICT**

Any request for clinical privileges that are new to the District shall initially be reviewed by the appropriate departments and administration in order to establish the need for, and appropriateness of, the new procedure or services. Any request for new clinical privileges that overlap more than one department shall initially be reviewed by the appropriate departments in order to address criteria for the procedure. The Medical Executive Committee shall facilitate the establishment of District-wide credentialing criteria for new or trans-specialty procedures, with the input of all appropriate departments, with a mechanism designed to ensure that quality patient care is provided for by all individuals with such clinical privileges. In establishing the criteria for such clinical privileges, the Medical Executive Committee may establish an ad hoc committee with representation from all appropriate departments.

Further details regarding the development and approval process for new privileges or new services can be found in applicable policy.

## **V.6 FOCUSED PROFESSIONAL PRACTICE EVALUATION (FPPE)**

### **V.6-1 FPPE FOR INITIAL PRIVILEGES**

#### **(a) General Provisions:**

- (1) All initial appointees to the Medical Staff and all practitioners granted new clinical privileges shall be subject to a period of initial review and evaluation as further described in the Medical Staff’s Focused and Ongoing Professional Practice Evaluation (FPPE and OPPE) policy.
- (2) Until an initial appointee has been evaluated for core privileges and released from FPPE for these core privileges, he or she cannot be considered for a Medical Staff leadership position and cannot vote on any Medical Staff issues.

#### **(b) Failure to Complete FPPE:**

- (1) If FPPE for core privileges is not completed due to an insufficient amount of clinical activity as per the FPPE and OPPE policy, the practitioner’s membership and privileges will automatically expire, unless otherwise recommended by the Credentials Committee and Medical Executive Committee. Such expiration shall not entitle the practitioner to procedural rights.
- (2) If FPPE for special privileges is not completed due to an insufficient amount of clinical activity, FPPE can be extended as recommended by the proctor(s), the Credentials Committee, and the Medical Executive Committee. In this instance, the practitioner’s core privileges and eligibility for reappointment shall not be affected. Additionally, such extension of FPPE shall not be considered a limitation or restriction of privileges entitling the practitioner to procedural rights.
- (3) If FPPE for any privilege (core or special) is not completed satisfactorily due to competency or quality of care concerns, the relevant privilege, and the membership if the privileges under question are core privileges, may be terminated and/or revoked. In this instance, the practitioner shall be entitled to the procedural rights outlined in these Bylaws.

### **V.6-2 FPPE ARISING FROM CONCERNS**

FPPE may also be initiated when the performance or outcomes of a practitioner are questionable, which may become evident with the occurrence of a single or sentinel event and/or patterns or trends indicating potentially

unsafe patient care. The initiation of FPPE arising from concerns differs from FPPE for new privileges described under Section 4.6-1. Practitioners subject to FPPE arising from concerns may be entitled to procedural rights if such action is a reportable action.

## **V.7 CONDITIONS FOR PRIVILEGES OF PRACTITIONERS**

### **V.7-1 ADMISSIONS**

- (a) The following categories of practitioners are eligible to independently admit patients to the hospital:
  - (1) Physicians (MDs or DOs)
- (b) The following categories of practitioners are eligible to co-admit patients to the hospital:
  - (1) Dentists (non-MD)
  - (2) Podiatrists
  - (3) Certified Nurse Midwives
- (c) Additionally, the following categories of APPs with admitting privileges (as per relevant standardized procedures/protocols) may admit patients upon order of a member of the Medical Staff who has admitting privileges and who maintains responsibility for the overall care of the patient:
  - (1) Physician Assistants
  - (2) Nurse Practitioners

### **V.7-2 RESPONSIBILITY FOR CARE OF PATIENTS**

- (a) The admitting practitioner shall establish at the time of admission, the patient's condition and provisional diagnosis.
- (b) For patients admitted by or upon order of a limited license practitioner, a physician with appropriate privileges must assume responsibility for the care of the patient's medical or psychiatric problems that are present at the time of admission or which may arise during hospitalization which are outside of the limited license practitioner's lawful scope of practice.
- (c) Where a dispute exists regarding proposed treatment between a physician member and a practitioner with co-admitting privileges, the physician member's treatment plan shall be the recognized treatment plan.

### **V.7-3 SURGERY**

Surgical procedures performed by limited license practitioners shall be under the overall supervision of the Chief of the department of surgery or his or her designee.

## **V.8 TEMPORARY CLINICAL PRIVILEGES**

Temporary privileges shall not exceed one hundred twenty (120) consecutive days, unless the Medical Executive Committee recommends and the Board of Directors approves a longer period for good cause, and are allowed under two circumstances only: (1) to address a patient care need and (2) to permit patient care to be provided while an application is pending.

### **V.8-1 PATIENT CARE NEEDS**

#### **(a) Care of Specific Patient**

Temporary clinical privileges may be granted to a practitioner where good cause exists to provide care to a specific patient or group of patients.

#### **(b) Locum Tenens**

Temporary clinical privileges may be granted to a practitioner serving as a locum tenens for a current member of the Medical Staff to meet the care needs of that member's patients or duties in his/her absence.

#### **(c) Other Important Patient Care Needs**

Temporary clinical privileges may be granted to allow a practitioner to fulfill an important patient care, treatment, or service need.

### **V.8-2 PENDING APPLICATION FOR MEDICAL STAFF MEMBERSHIP OR PRIVILEGES**

Temporary clinical privileges may be granted to an applicant while his or her application for Medical Staff membership and/or privileges is completed and awaiting review and approval of the Credentials Committee, the Medical Executive Committee or the Board of Directors.

### **V.8-3 PROCESS FOR GRANTING TEMPORARY CLINICAL PRIVILEGES**

Applicants who have qualifications, ability, and judgment consistent with Section 2.2 can qualify to be granted temporary clinical privileges for patient care needs or to permit patient care while an application is pending, provided that:

- (a) The Medical Executive Committee has not made a final recommendation that is adverse or with limitation.
- (b) The applicant has no current or previously successful challenge to professional licensure or registration.
- (c) The application has no involuntary termination of Medical Staff membership at any other organization, and no involuntary limitation, reduction, denial or loss of clinical privileges.
- (d) The applicant has no unusual pattern of, or an excessive number of, professional liability actions resulting in a final judgment adverse to the applicant.
- (e) The following has been completed:
  - (1) Verification of current California licensure;
  - (2) Verification of the National Practitioner Data Bank report;
  - (3) Verification of relevant training and experience;
  - (4) Verification of current competence and ability to perform the privileges requested.

A decision to grant temporary privileges to an applicant under this Section shall not be binding or conclusive with respect to an applicant's pending request for appointment to the Medical Staff. No practitioner has any right to be granted temporary privileges.

The Administrator is given authority to grant temporary privileges to an applicant. Such action, however, shall be on the recommendation of the following Medical Staff members:

- (1) The applicable clinical Department Chief;
- (2) The Credentials Committee Chairperson; and
- (3) The Chief of Staff.

#### **V.8-4 GENERAL CONDITIONS OF TEMPORARY PRIVILEGES**

- (a) If granted temporary privileges, the applicant shall act under the supervision of the Department Chief (or designee) to which the applicant has been assigned.
- (b) Temporary privileges shall automatically terminate at the end of the designated period, unless earlier terminated or suspended under Articles VI and/or VII of these Bylaws or unless affirmatively renewed. A Medical Staff applicant's temporary privileges shall automatically terminate if the applicant's initial application is withdrawn.
- (c) Notwithstanding any other provision of these Bylaws to the contrary, an applicant shall not be entitled to procedural rights if the applicant's request for temporary privileges is refused, or if all or any portion of the applicant's temporary privileges are suspended, unless such action is a reportable action.
- (d) All persons receiving temporary privileges shall be bound by the Medical Staff Bylaws and policies, and all applicable District policies.

#### **V.9 TELEMEDICINE PRIVILEGES**

Practitioners who wish to provide approved types of telehealth services will be credentialed and privileged according with this Section but, unless they separately qualify, apply, and are approved for membership in a staff category described in Article III of these Bylaws, will not be appointed to the Medical Staff in any membership category.

##### **V.9-1 TELEMEDICINE CREDENTIALING**

- (a) In processing a request for telemedicine privileges, the Medical Staff may follow the normal credentialing process described in Article V of these Bylaws, including but not limited to the collection of information from primary sources. Alternatively, the Medical Staff may elect to rely upon the credentialing and privileging decisions made by distant-site hospitals and telemedicine entities when making recommendations on privileges for individual distant-site practitioners, subject to meeting the conditions required by law and those specified in these Bylaws.
- (b) Telemedicine privileges shall be for a period not to exceed two (2) years, and shall be subject to re-evaluation and renewal pursuant to the same principles and process described in these Bylaws for the renewal of clinical privileges held by Medical Staff members.
- (c) The direct care or interpretive services provided by the distant-site practitioner must meet the professional standards of the District and its Medical Staff at all times. Distant-site practitioners holding telemedicine privileges shall be obligated to meet all of the basic responsibilities that must be met by members of the Medical Staff, as described in these Bylaws, modified only to take into account their distance from the hospital and the need to pay dues.

- (d) Telemedicine privileges may be denied, restricted, suspended or revoked at the discretion of the Medical Executive Committee or the Chief of Staff acting on its behalf, without hearing rights as described in Article VII of these Bylaws, except as required by law.
- (e) Recognizing that telemedicine physicians may be privileged at many healthcare facilities and entities, the District shall conduct the primary verification procedures for an adequate number of hospitals, health care organizations and/or practice settings with whom the telemedicine physician is or has previously been affiliated in order to ensure current competency. In order to assist in this credentialing and privileging process, the District may request information from the telemedicine physician's primary practice site to assist in evaluation of current competency. The District may also accept primary source verification of credentialing information from the physician's primary practice site or the telemedicine entity to supplement its own primary source verification.

#### **V.9-2 RELIANCE ON DISTANT-SITE ENTITIES**

The Medical Staff may rely upon the credentialing and privileging decisions made by a distant-site hospital or distant-site telemedicine entity if the District Board ensures through a written agreement with the distant-site hospital or entity that all of the following provisions are met:

- (a) The distant-site entity acknowledges that it is a contractor of services to this District and, in accordance with 42 CFR §485.635(c)(4)(ii), furnishes services in a manner that permits Northern Inyo Healthcare District to be in compliance with the Medicare Conditions of Participation and appropriate accreditation agencies.
- (b) The distant-site entity is either a Medicare-participating hospital or a lawful provider of the telemedicine services in question, and it confirms that its credentialing and privileging processes and standards for practitioners meet the standards described in the Medicare Conditions of Participation 42 CFR §485.616(c).
- (c) The distant-site entity acknowledges, or the District confirms, that the distant-site entity has a process that is consistent with the credentialing and privileging requirements of the Joint Commission standards for critical access hospitals.
- (d) The individual distant-site practitioner holds privileges at the distant-site entity to provide the services involved, and the distant-site entity provides the District with a current list of the distant-site practitioner's privileges at the distant-site entity.
- (e) The individual distant-site practitioner is licensed in California, or is otherwise authorized by California law, to provide the services at issue, and is covered by professional liability insurance meeting the standards that apply to Medical Staff members at this District as described in these Bylaws.
- (f) The Medical Staff of Northern Inyo Healthcare District performs, and maintains evidence of, peer review of the distant-site practitioners' performance as it relates to District patients and sends the distant-site telemedicine entity such performance information for use in the periodic appraisal of the individual distant-site practitioners. At a minimum, the information this District will provide must include all adverse events that result from the telemedicine services provided by the distant-site practitioners to this District's patients and all complaints this District has received about the distant-site practitioners.

When the District is not a party to a written agreement with a distant-site Medicare participating hospital or distant-site entity containing all of the requirements of the CMS Hospital Conditions of related to distant-site telemedicine credentialing, the telemedicine physician must be credentialed and privileged pursuant to the general credentialing and privileging procedures described in Article V of these Bylaws.

#### **V.10 ADVANCED PRACTICE PROVIDERS**

Advanced Practice Providers (APPs) are not eligible for Medical Staff membership, as per California law. They may be granted practice privileges if they hold a license, certificate, or other legal credential in a category of APPs that the Board of Directors (after securing Medical Executive Committee recommendations) has identified as eligible to apply for practice privileges as set forth in Article VIII.

#### **V.11 EMERGENCY PRIVILEGES**

In the case of an emergency involving a particular patient, any practitioner with clinical privileges, to the degree permitted by the scope of the applicant's license and regardless of department, staff status, or clinical privileges, shall be permitted to do everything reasonably possible to save the life of the patient or to save the patient from serious harm provided that the care provided is within the scope of the individual's license or training. Once the emergency has passed or assistance has been made available, further care of the patient shall be assumed by a practitioner of the appropriate department.

#### **V.12 DISASTER PRIVILEGES**

In the case of a disaster in which the disaster plan has been activated and the District is unable to handle the immediate patient needs, the following may grant disaster privileges to volunteer practitioners in accordance with the process outlined in the applicable Medical Staff policy:

- (a) the Chief of Staff;
- (b) any physician member of the Medical Executive Committee;
- (c) any Department Chief;
- (d) any active Medical Staff member; or
- (e) designee of any of the above.

The volunteer practitioner shall be required to submit identification and other such required documentation for verification as further detailed in policy. The Medical Staff shall oversee the performance of all volunteer practitioners. Once the care of disaster victims can be adequately assumed by the members of the regular Medical Staff, then disaster privileges of the volunteer will be terminated as further detailed in policy.

## **ARTICLE VI: PEER REVIEW AND CORRECTIVE ACTION**

### **VI.1 MONITORING AND PEER REVIEW**

Medical staff departments and committees are responsible for carrying out delegated peer review and quality assessment functions as per applicable peer review and quality policies. They may counsel, educate, issue letters of warning or censure, or initiate focused review or retrospective or concurrent monitoring (so long as the practitioner is only required to provide reasonable notice of admission and procedures) without initiating an investigation or formal corrective action. Comments, suggestions, and warnings may be issued orally or in writing. Informal actions, focused review, monitoring or counseling shall be documented in the practitioner's file and reviewed as part of their ongoing professional practice evaluation. Medical executive committee approval is not required for such actions, but the Medical Executive Committee shall be notified if trends or concerns are noted. Such routine peer review and quality assessment functions shall not constitute an investigation and shall not constitute a restriction of privileges or grounds for any formal hearing or appeal rights as described in Article VII of these Bylaws.

### **VI.2 CORRECTIVE ACTION**

Corrective action is separate from routine monitoring and peer review and can be initiated at any time as outlined in this Section. A practitioner is not required to have exhausted all monitoring and peer review activities prior to initiation of a corrective action. It is recommended that Medical Staff legal counsel be consulted in corrective action proceedings.

#### **VI.2-1 CRITERIA FOR INITIATION**

Any person may provide information to the Medical Staff Office or officer of the Medical Staff about the conduct, performance, or competence of its members and practitioners, who will then take this information to the Department Chief, the Chief of Staff or Medical Executive Committee. When reliable information indicates a practitioner may have exhibited acts, demeanor, or conduct reasonably likely to be (1) detrimental to patient safety or to the delivery of quality patient care within the District; (2) unethical; (3) contrary to the Medical Staff Bylaws; or (4) below applicable professional standards, an investigation or request for action may be initiated.

#### **VI.2-2 INITIATION**

A request for an investigation or action against such practitioner may be initiated by the Chief of Staff or the Medical Executive Committee. The request must be submitted to the Medical Executive Committee, and supported by reference to specific activities or conduct alleged. If the Medical Executive Committee initiates the request, it shall make an appropriate recording of the reasons in the minutes.

#### **VI.2-3 INVESTIGATION**

If the Medical Executive Committee concludes an investigation is warranted, it shall direct an investigation to be undertaken. The Medical Executive Committee may conduct the investigation itself, or may assign the task to an ad hoc committee of the Medical Staff. If an ad hoc committee is formed, the Chief of Staff shall appoint the members of the ad hoc committee with the recommendation of the Medical Executive Committee. If the investigation is delegated to an officer or committee other than the Medical Executive Committee, such officer or committee shall proceed with the investigation in a prompt manner and shall forward a written report of the investigation to the Medical Executive Committee as soon as practicable. The report may include recommendations for appropriate corrective action. The affected practitioner shall be promptly notified by the Chief of Staff that an investigation is being conducted and shall be given an opportunity to provide information in a manner and upon such terms as the investigating body deems appropriate. The body investigating the matter may, but is not obligated to:

- (a) conduct interviews with persons involved; however, such investigation shall not constitute a “hearing” as that term is used in Article VII, nor shall the procedural rules with respect to hearings or appeals apply; and
- (b) review the practitioner’s file.

Despite the status of any investigation, at all times the Medical Executive Committee shall retain authority and discretion to take whatever action may be warranted by the circumstances, including summary suspension, termination of the investigative process, or other action.

**VI.2-4 EXECUTIVE COMMITTEE ACTION**

As soon as practicable after the conclusion of the investigation, the Medical Executive Committee shall take action which may include, without limitation:

- (a) determining no corrective action be taken and, if the Medical Executive Committee determines there was no credible evidence for the complaint in the first instance, removing any adverse information from the practitioner’s file;
- (b) referring the practitioner to the Physician Wellness Committee for evaluation and follow-up as appropriate;
- (c) deferring action for a reasonable time where circumstances warrant;
- (d) issuing letters of admonition, censure, reprimand, or warning, although nothing herein shall be deemed to preclude committees or departments or their Chiefs from issuing informal written or oral warnings outside of the mechanism for corrective action. In the event such letters are issued, the affected practitioner may make a written response which shall be placed in his or her file;
- (e) recommending the imposition of terms of probation or special limitation upon continued Medical Staff membership or exercise of clinical privileges, including, without limitation, requirements for co-admission, mandatory consultation, or monitoring;
- (f) recommending reduction, modification, suspension or revocation of clinical privileges;
- (g) recommending reductions of membership status or limitation of any prerogatives directly related to the practitioner’s delivery of patient care;
- (h) recommending suspension, revocation or probation of Medical Staff membership; and
- (i) taking other actions deemed appropriate under the circumstances.

**VI.2-5 SUBSEQUENT ACTION**

If the Medical Executive Committee has imposed or recommended corrective action as to which the affected practitioner may request a hearing, the Board of Directors shall be advised of the action at the next regularly scheduled meeting after notification to the practitioner.

**VI.2-6 INITIATION BY BOARD OF DIRECTORS**

If the Medical Executive Committee fails to investigate or take disciplinary action in response to information about a practitioner’s competence, performance, or conduct that is provided in accordance with the provisions of this Article, and if the Board of Directors determines that the Medical Executive Committee’s failure to proceed is contrary to the weight of the evidence, the Board of Directors may direct the Medical Executive

Committee to initiate investigation or disciplinary action. The Board's request for Medical Staff action shall be in writing and shall set forth the basis for the request.

If the Medical Executive Committee fails to take action in response to such direction from the Board of Directors, then the Board may initiate the dispute resolution process as described in the Joint Conference Committee of these Bylaws (unless immediate action is required to protect the health or safety or any individual, in which event the procedures for summary suspension shall apply). If the dispute resolution process does not result in action by the Medical Executive Committee, and the Board of Directors still believes action is necessary, then the Board of Directors may initiate an investigation or corrective action after written notice to the Medical Executive Committee, and shall fully comply with Articles VI and VII of these Medical Staff Bylaws.

### **VI.3 SUMMARY RESTRICTION OR SUSPENSION**

#### **VI.3-1 CRITERIA FOR INITIATION**

Whenever a practitioner's conduct is such that failure to take action may result in an imminent danger to the health of any individual, including but not limited to current or future patients, the Chief of Staff, the Medical Executive Committee, or the Chief of the department in which the practitioner holds privileges may summarily restrict or suspend the Medical Staff membership or clinical privileges of such practitioner. Unless otherwise stated, such summary restriction or suspension shall become effective immediately upon imposition, and the person or body responsible shall promptly give written notice to the Board of Directors, the Medical Executive Committee, the Medical Staff Office, the Chief Medical Officer and the Administrator. In addition, the affected practitioner shall be provided with a written notice of the action that fully complies with the requirements of Section 6.3-2 below. The summary restriction or suspension may be limited in duration and shall remain in effect for the period stated or, if none, until resolved as set forth herein. Unless otherwise indicated by the terms of the summary restriction or suspension, the practitioner's patients shall be promptly assigned to another practitioner by the Department Chief or by the Chief of Staff, considering where feasible, the wishes of the patient in the choice of a substitute practitioner. Summary suspension or restriction shall automatically constitute a request for investigation pursuant to this Article.

#### **VI.3-2 NOTICE OF SUMMARY SUSPENSION**

The affected practitioner shall be promptly provided with written notice of such suspension within two (2) business days. This initial written notice shall generally describe the reasons for the action, the extent of the action, and the effective date and time of the action. Oral notice of summary suspension may be provided immediately to the affected practitioner and prior to the written notice if needed in order to assure patient safety.

This initial notice shall not substitute for, but is in addition to, the notice required under Section 7.3-1 (which applies in all cases where the Medical Executive Committee does not immediately terminate the summary suspension). The notice under Section 7.3-1 may supplement the initial notice provided under this Section, by including any additional relevant facts supporting the need for summary suspension or other corrective action.

#### **VI.3-3 MEDICAL EXECUTIVE COMMITTEE ACTION**

As soon as reasonably possible under all circumstances after such summary restriction or suspension has been imposed, a meeting of the Medical Executive Committee shall be convened to review and consider the action. Upon request, the affected practitioner may attend and make a statement concerning the issues under investigation, on such terms and conditions as the Medical Executive Committee may impose, although in no event shall any meeting of the Medical Executive Committee, with or without the practitioner, constitute a "hearing" within the meaning of Article VII, nor shall any procedural rules apply. The Medical Executive Committee may modify, continue, or terminate the summary restriction or suspension, but in any event it shall

furnish the practitioner with notice of its decision within two (2) working days of the meeting. A copy of the notice shall be given to the Administrator, the Chief Medical Officer, the District Board, and the relevant Department Chief.

#### **VI.3-4 PROCEDURAL RIGHTS**

Unless the Medical Executive Committee promptly terminates the summary restriction or suspension, it shall remain in effect during the pendency of the corrective action, hearing and appeal process, and the practitioner shall be entitled to the procedural rights afforded by Article VII.

#### **VI.3-5 INITIATION BY BOARD OF DIRECTORS**

If the Chief of Staff, members of the Medical Executive Committee and the Chief of the department in which the practitioner holds privileges are not available to summarily restrict or suspend the practitioner's membership or clinical privileges, the Board of Directors (or the Administrator on-call, as designee) may immediately suspend a practitioner's privileges if a failure to suspend those privileges is likely to result in an imminent danger to the health of any person, provided that the Board of Directors (or Administrator on-call) made reasonable attempts to contact the Chief of Staff, members of the Medical Executive Committee and the Chief of the department before the suspension.

A suspension under this Section is subject to ratification by the Medical Executive Committee. If the Medical Executive Committee does not ratify such a summary suspension within two (2) business days, the summary suspension shall terminate automatically. If the Medical Executive Committee does ratify the summary suspension, all other provisions under Section 6.3 of these Bylaws will apply. In this event, the date of imposition of the summary suspension shall be considered to be the date of ratification by the Medical Executive Committee for purposes of compliance with notice and hearing requirements.

#### **VI.4 AUTOMATIC SUSPENSION OR LIMITATION**

In the following instances, the practitioner's privileges or membership may be suspended or limited as described, with no right to hearing unless reportable by law to the Medical Board of California. However, the practitioner may appear before the Medical Executive Committee or submit a written statement addressing the question of whether grounds exist for the special action as set forth below. A practitioner may be eligible to reapply for reinstatement of privileges if the cause for such automatic action has been resolved.

##### **VI.4-1 LICENSURE**

- (a) Revocation and Suspension: Whenever a practitioner's license or other legal credential authorizing practice in this state is revoked or suspended, Medical Staff membership and clinical privileges shall be automatically revoked as of the date such action becomes effective.
- (b) Restriction: Whenever a practitioner's license or other legal credential authorizing practice in this state is limited or restricted by the applicable licensing or certifying authority, any clinical privileges which the practitioner has been granted which are within the scope of said limitation or restriction shall be automatically limited or restricted in a similar manner, as of the date such action becomes effective and throughout its term.
- (c) Probation: Whenever a practitioner is placed on probation by the applicable licensing or certifying authority, membership status and clinical privileges shall automatically become subject to the same terms and conditions of the probation as of the date such action becomes effective and throughout its term.

- (d) Expiration: Whenever a practitioner's license is expired or evidence of renewal has not been received, the practitioner shall be automatically suspended until such time as evidence of current licensure has been received. Failure to reinstate such license or other legal credential within thirty (30) days of such lapse or expiration shall result in automatic termination of Medical Staff membership and/or clinical privileges.

#### **VI.4-2 DRUG ENFORCEMENT ADMINISTRATION (DEA) CERTIFICATE**

- (a) Whenever a practitioner's DEA certificate is revoked, limited, expired, or suspended, the practitioner shall automatically and correspondingly be divested of the right to prescribe medications covered by the certificate, as of the date such action becomes effective and throughout its term.
- (b) Probation: Whenever a practitioner's DEA certificate is subject to probation, the practitioner's right to prescribe such medications shall automatically become subject to the same terms of the probation, as of the date such action becomes effective and throughout its term.

#### **VI.4-3 MEDICAL RECORDS**

Members of the Medical Staff and other clinically privileged practitioners are required to complete medical records within such reasonable time as may be prescribed by the District and the Medical Staff. A limited suspension in the form of withdrawal of admitting and other related privileges until medical records are completed may be imposed by the Chief of Staff after notice of delinquency for failure to complete medical records within such period has been given to the practitioner. For the purpose of this Section, "related privileges" means voluntary on-call service for the emergency room, scheduling surgery, assisting in surgery, consulting on hospital cases, and providing professional services within Northern Inyo Healthcare District. Bona fide leave may constitute an excuse subject to approval by the Medical Executive Committee. Practitioners whose privileges have been suspended for delinquent records may admit patients only in life-threatening situations. The suspension shall continue until lifted by the Chief of Staff or his or her designee. If within ninety (90) days after implementation of suspension the practitioner has not completed the delinquent records, the practitioner's membership and privileges shall be automatically terminated without right to a hearing unless reportable by law.

#### **VI.4-4 PROFESSIONAL LIABILITY INSURANCE**

Failure to maintain professional liability insurance in the amounts indicated shall result in an automatic suspension of a practitioner's clinical privileges, and if within ninety (90) days after written warning of the delinquency the practitioner does not provide evidence of required professional liability insurance and evidence of coverage for the interim, the practitioner's membership and privileges shall be automatically terminated without right to a hearing unless reportable by law.

#### **VI.4-5 FAILURE TO PROVIDE INFORMATION OR SATISFY SPECIAL ATTENDANCE REQUIREMENT**

Failure without good cause to provide information or appear when requested by a Medical Staff committee or department as described in these Bylaws shall result in the referral to the Medical Executive Committee for action, which may include automatic suspension of all privileges. The automatic suspension shall remain in effect until the practitioner has provided the requested information and/or satisfied the special attendance requirement.

#### **VI.4-6 FELONY CONVICTION OR PLEA**

A practitioner who has been convicted of, or who has pleaded guilty or no contest to, a felony shall not be eligible for privileges or initial appointment to the Medical Staff unless the Medical Executive Committee determines, in its sole discretion, the felony was not directly related to the practitioner's professional practice or patient relationships,.

If a practitioner of the Medical Staff is convicted of, or pleads guilty or no contest to a felony, the practitioner's Medical Staff membership and privileges shall be automatically suspended pending review by the Medical Executive Committee. If the Medical Executive Committee, in its sole discretion, confirms that the felony was directly related to the practitioner's professional practice or patient relationships or involving moral turpitude, the practitioner's staff membership and privileges shall terminate without right to a hearing. If the Medical Executive Committee determines, in its sole discretion, the felony was not directly related to the practitioner's professional practice or patient relationships, the practitioner shall be permitted to request reinstatement as an initial applicant.

#### **VI.4-7 EXCLUSION FROM GOVERNMENTAL PROGRAM**

A practitioner who is excluded as a provider from any governmental health care program (including but not limited to Medicare and Medi-Cal) may not apply for initial appointment to the Medical Staff. If a privileged practitioner is excluded as a provider from such governmental program during their appointment, the practitioner's Medical Staff membership and privileges shall be automatically terminated without right to a hearing.

#### **VI.4-8 NOTICE OF AUTOMATIC ACTION**

No notice shall be required for an automatic action to become effective. However, as soon as reasonably practical after the automatic action becomes effective, written notice shall be provided to the affected practitioner, the Administrator, the Chief Medical Officer, the Department Chief, and the Chief of Staff.

#### **VI.4-9 MEDICAL EXECUTIVE COMMITTEE DELIBERATION**

As soon as practicable after automatic action is taken or warranted, the Medical Executive Committee shall convene to review and consider the facts, and may recommend any further corrective action as it may deem appropriate in accordance with these Bylaws.

## **ARTICLE VII: HEARINGS AND APPELLATE REVIEWS**

### **VII.1 GENERAL PROVISIONS**

#### **VII.1-1 PROCESS TO CHALLENGE ADVERSE ACTIONS REPORTABLE UNDER BUSINESS AND PROFESSIONS CODE SECTION 805**

The notice, hearing and appeal provisions available to a practitioner to contest an action or final recommended action which must be reported to the Medical Board of California under Business and Professions Code Section 805 shall be governed by the provisions of this Article commencing with Section 7.2 below.

#### **VII.1-2 PROCESS TO CHALLENGE UNFAVORABLE ACTIONS NOT REPORTABLE UNDER BUSINESS AND PROFESSIONS CODE SECTION 805**

A practitioner who is adversely and significantly affected by an unfavorable action or recommended action for which a review process is not otherwise provided in these Bylaws or in or policies, and which is not reportable under Business and Professions Code Section 805, may contest such actions or recommended actions by delivering a written request for review to the Medical Executive Committee. In no event shall any meeting of the Medical Executive Committee, with or without the practitioner, constitute a hearing within the meaning of Article VII, nor shall any procedural hearing rights apply. If the action or recommended action was made by the Board of Directors, the practitioner may contest the matter by providing written request for review to the Board of Directors. Any such request for review must be delivered within thirty (30) days from the practitioner's receipt of notice of the action or recommendation.

Examples of matters reviewable under this Section include, without limitation, restriction of clinical privileges for less than thirty (30) days in a twelve (12) month period; summary suspension of clinical privileges for fourteen (14) days or less; and termination, denial or restriction of privileges or membership rights for reasons other than medical disciplinary cause as defined in Business and Professions Code Section 805.

#### **VII.1-3 DUTY TO EXHAUST INTERNAL REMEDIES**

All practitioners and applicants are obligated to exhaust all remedies provided in this Article or elsewhere in Medical Staff Bylaws before initiating legal action. Any practitioner who fails to exhaust the remedies (including all hearing and appeal remedies) provided in these Bylaws before initiating legal action, shall be liable to pay the full costs, including legal fees, required to respond to such legal action.

#### **VII.1-4 TIMELY COMPLETION OF PROCESS**

The hearing and appeal process shall be completed within a reasonable time.

#### **VII.1-5 FINAL ACTION**

Recommended adverse actions described in Section 7.2 shall become final only after the hearing and appellate rights set forth in these Bylaws have either been exhausted or waived, and only upon being adopted as final actions by the Board of Directors.

### **VII.2 GROUNDS FOR HEARING**

Except as otherwise specified in these Bylaws, any one or more of the following adverse actions shall constitute grounds to request a hearing:

- (a) denial of initial Medical Staff appointment or requested reappointment to the Medical Staff, based on professional competence or conduct which is reasonably likely to be detrimental to patient safety or to the delivery of patient care;
- (b) denial of requested clinical privileges based on professional competence or conduct which is reasonably likely to be detrimental to patient safety or to the delivery of patient care;
- (c) summary suspension of staff membership or staff privileges for greater than fourteen (14) days;
- (d) termination or revocation of Medical Staff membership or clinical privileges based on professional competence or conduct which is reasonably likely to be detrimental to patient safety or to the delivery of patient care;
- (e) involuntary reduction or restriction of clinical privileges or membership for thirty (30) days or more in any twelve (12) month period; or
- (f) any other disciplinary action or recommendation that must be reported, by law, to the practitioner's California licensing authority under Business and Professions Code Section 805.

### **VII.3 REQUESTS FOR HEARING**

#### **VII.3-1 NOTICE OF ACTION OR PROPOSED ACTION**

In all cases in which action has been taken or a recommendation made as set forth in Section 7.2, the practitioner shall be given prompt written notice of:

- (a) the recommendation or final proposed action and that such action, if adopted, shall be taken and reported to the Medical Board of California and/or to the National Practitioner Data Bank, if required;
- (b) a brief description of the reasons for the proposed action;
- (c) the right to request a hearing pursuant to Section 7.3-3, and that such hearing must be requested in writing within thirty (30) days; and
- (d) a summary of the rights granted in the hearing pursuant to the Medical Staff Bylaws.

#### **VII.3-2 HEARINGS PROMPTED BY BOARD OF DIRECTORS ACTION**

If the hearing is based upon an adverse decision or recommendation of the Board of Directors, the Board of Directors or its designee shall fulfill the duties assigned to the Medical Executive Committee or the Chief of Staff when the Medical Executive Committee is the body whose decision prompted the hearing. This shall include, but not be limited to, preparing the notice of adverse action or recommended action and right to a hearing, scheduling the hearing, providing the notice of hearing and statement of charges, and designating the judicial review committee, presenter and witnesses.

#### **VII.3-3 REQUEST FOR HEARING**

The practitioner shall have thirty (30) days following receipt of notice of such action to request a hearing. The request shall be in writing addressed to the Chief of Staff with a copy to the Medical Executive Committee, Administrator, Chief Medical Officer, and Board of Directors. Any such request shall include the practitioner's intent with regard to representation. In the event the practitioner does not request a hearing within the time and in the manner described, the practitioner shall be deemed to have waived any right to a hearing and accepted the recommendation or action involved.

#### **VII.3-4 TIME AND PLACE FOR HEARING**

Upon receipt of a request for hearing, the Medical Executive Committee has thirty (30) days to schedule a hearing. The Medical Executive Committee will give notice to the practitioner of the time, place and date of the hearing. The date of the commencement of the hearing shall be not be more than sixty (60) days from the date of receipt of the request by the Medical Executive Committee for a hearing, so long as the practitioner has at least thirty (30) days from the date of notice to prepare for the hearing, or both parties mutually agree to an earlier date. When the request is received from a practitioner who is under summary suspension the hearing shall be held as soon as the arrangements may reasonably be made.

#### **VII.3-5 NOTICE OF HEARING AND NOTICE OF REASONS OR CHARGES**

Together with the notice stating the place, time and date of the hearing, the Chief of Staff or designee on behalf of the Medical Executive Committee shall provide the reasons for the recommended action, including the acts or omissions with which the practitioner is charged and a list of the charts in question, where applicable.

#### **VII.3-6 JUDICIAL REVIEW COMMITTEE**

When a hearing is granted, the Medical Executive Committee shall recommend a judicial review committee. The judicial review committee shall be composed of not less than three (3) members of the active Medical Staff. The judicial review committee members shall be unbiased, shall gain no direct financial benefit from the outcome, and shall not have acted as accusers, investigators, fact finders, initial decision-makers or otherwise have not actively participated in the consideration of the matter leading up to the recommendation or action. Knowledge of the matter involved shall not preclude a member of the Medical Staff from serving as a member of the judicial review committee. In the event that it is not feasible to appoint a judicial review committee from the active Medical Staff, the Medical Executive Committee may appoint members from other staff categories or practitioners who are not members of the Medical Staff. Such appointment shall include designation of the Chair. The judicial review committee shall consist of one member who shall have the same healing arts licensure as the accused, and where feasible, include an individual practicing the same specialty as the practitioner. All other judicial review committee members shall have MD or DO degrees or equivalent license.

#### **VII.3-7 FAILURE TO APPEAR OR PROCEED**

Failure without good cause of the practitioner to personally attend and proceed at such a hearing in an efficient and orderly manner shall be grounds for termination of the hearing and shall be deemed to constitute voluntary acceptance of the recommendations or actions involved.

#### **VII.3-8 POSTPONEMENTS AND EXTENSIONS**

Once a request for hearing is initiated, postponements and extensions of time beyond the times permitted in these Bylaws may be permitted by the officer presiding over the hearing on a showing of good cause, or upon agreement of the parties.

### **VII.4 HEARING PROCEDURE**

#### **VII.4-1 PREHEARING PROCEDURE**

- (a) Not less than fifteen (15) days prior to the hearing, each party shall furnish to the other a written list of the names and addresses of the individuals, so far as is then reasonably known or anticipated, who are expected to give testimony or evidence in support of that party at the hearing. Nothing in the foregoing shall preclude the testimony of additional witnesses whose possible participation was not reasonably anticipated. The parties shall notify each other as soon as they become aware of the possible participation of such additional witnesses. Failure to provide the name of any witness at

least ten (10) days prior to the hearing date at which the witness is to appear shall constitute good cause for a continuance.

- (b) The practitioner may inspect and copy, at their expense, any documentary information relevant to the charges that the Medical Executive Committee has in its possession or under its control. The Medical Executive Committee may inspect and copy, at its expense, any documentary information relevant to the charges that the practitioner has in their possession or under their control. Requests for discovery shall be met as soon as practicable. Failure to comply with reasonable discovery requests at least thirty (30) days prior to the hearing shall be good cause for a continuance of the hearing. The right to inspect and copy by either party does not extend to confidential information referring solely to individually identifiable practitioners, other than the practitioner under review.
- (c) The practitioner and the Medical Executive Committee shall exchange all evidence which will be made available to the judicial review committee and introduced at the hearing. Failure to produce copies of all documents expected to be produced at least ten (10) days before the commencement of the hearing shall constitute good cause for a continuance.
- (d) The hearing officer (see Section 7.4-3) shall consider and rule upon any request for access to information and may impose any safeguards the protection of the peer review process and justice requires. In so doing, the hearing officer shall consider:
  - (1) whether the information sought may be introduced to support or defend the charges;
  - (2) the exculpatory or inculpatory nature of the information sought, if any;
  - (3) the burden imposed on the party in possession of the information sought, if access is granted; and
  - (4) any previous requests for access to information submitted or resisted by the parties to the same proceeding.
- (e) The practitioner shall be entitled to a reasonable opportunity to question and challenge the impartiality of judicial review committee members and the hearing officer. Challenges to the impartiality of any judicial review committee member shall be ruled on by the hearing officer. Challenges to the impartiality of the hearing officer shall be ruled on by the hearing officer.
- (f) It shall be the duty of the practitioner and the Medical Executive Committee or its designee to exercise reasonable diligence in notifying the Chair of the judicial review committee of any pending or anticipated procedural disputes as far in advance of the scheduled hearing as possible, in order that decisions concerning such matters may be made in advance of the hearing. Objections to any prehearing decisions may be succinctly made at the hearing.

#### **VII.4-2 REPRESENTATION**

The hearings provided for in these Bylaws are for the purpose of intraprofessional resolution of matters bearing on professional conduct, professional competency, or character. The parties may be represented by legal counsel.

In all instances, the Chief of Staff or another physician designated by the Medical Executive Committee shall have the authority to:

- (a) be present during all phases of the hearing process;

- (b) to make decisions regarding the detailed contents of the notice of reasons or charges;
- (c) to make decisions regarding the presentation of testimony and exhibits;
- (d) to direct the activities of the Medical Executive Committee's attorney, if any;
- (e) to consult with prospective and designated witnesses for the Medical Executive Committee; and
- (f) to amend the notice of reasons or charges as he or she seems warranted during the course of the proceedings, subject to the practitioner's procedural rights.

However, the Medical Executive Committee's representative shall not have the authority to modify the nature of the Medical Executive Committee's action or recommendation without the Medical Executive Committee's approval.

#### **VII.4-3 THE HEARING OFFICER**

The Medical Executive Committee shall recommend a hearing officer to preside at the hearing. The hearing officer shall be an attorney-at-law qualified to preside over a quasi-judicial hearing, but attorneys from a firm regularly utilized by the District, the Medical Staff or the involved practitioner or applicant for membership, for legal advice regarding their affairs and activities shall not be eligible to serve as hearing officer. The hearing officer shall gain no direct financial benefit from the outcome and must not act as a prosecuting officer or as an advocate. The hearing officer shall endeavor to assure that all participants in the hearing have a reasonable opportunity to be heard and to present relevant oral and documentary evidence in an efficient and expeditious manner, and that proper decorum is maintained. The hearing officer shall be entitled to determine the order of or procedure for presenting evidence and argument during the hearing and shall have the authority and discretion to make all rulings on questions which pertain to matters of law, procedure or the admissibility of evidence. If the hearing officer determines that either side in a hearing is not proceeding in an efficient and expeditious manner, the hearing officer may take such discretionary action as seems warranted by the circumstances, in accordance with California law. If requested by the judicial review committee, the hearing officer may participate in the deliberations of such committee and be a legal advisor to it, but the hearing officer shall not be entitled to vote.

#### **VII.4-4 RECORD OF THE HEARING**

A court reporter shall be present to make a thorough and accurate record of the hearing proceedings, and the prehearing proceedings, if deemed appropriate by the hearing officer. The cost of attendance of the recorder shall be borne by the District, but the cost of the transcript, if any, shall be borne by the party requesting it. The judicial review committee may, but shall not be required to, order that oral evidence shall be taken only on oath administered by a person lawfully authorized to administer such oath.

#### **VII.4-5 RIGHTS OF THE PARTIES**

Within reasonable limitations, both sides at the hearing may call and examine witnesses for relevant testimony, introduce relevant exhibits or other documents, cross-examine or impeach witnesses who shall have testified orally on any matter relevant to the issues, and otherwise rebut evidence, as long as these rights are exercised in an efficient and expeditious manner. The practitioner may be called by the Medical Executive Committee (or its designee) and examined as if under cross-examination.

#### **VII.4-6 MISCELLANEOUS RULES**

Judicial rules of evidence and procedure relating to the conduct of the hearing, examination of witnesses, and presentation of evidence shall not apply to a hearing conducted under this Article. Any relevant evidence,

including hearsay, shall be admitted if it is the sort of evidence on which responsible persons are accustomed to rely on in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law. The judicial review committee may interrogate the witnesses or call additional witnesses if it deems such action appropriate. At its discretion, the judicial review committee may request both sides to file written arguments. The hearing process shall be completed within a reasonable time after the notice of the action is received, unless the hearing officer issues a written decision that the practitioner or the Medical Executive Committee failed to provide information in a reasonable time or consented to the delay.

#### **VII.4-7 BURDENS OF PRESENTING EVIDENCE AND PROOF**

- (a) At the hearing the Medical Executive Committee shall have the initial duty to present evidence for each case or issue in support of its action or recommendation. The practitioner may present evidence in response.
- (b) An applicant shall bear the burden of persuading the judicial review committee, by a preponderance of the evidence, of the applicant's qualifications by producing information which allows for adequate evaluation and resolution of reasonable doubts concerning the applicant's current qualifications for membership and privileges. An applicant shall not be permitted to introduce information requested by the Medical Staff but not produced during the application process or corrective action proceedings, unless the applicant establishes that the information could not have been produced previously in the exercise of reasonable diligence.
- (c) Except as provided above for applicants, throughout the hearing, the Medical Executive Committee shall bear the burden of persuading the judicial review committee, by a preponderance of the evidence, that its action or recommendation is reasonable and warranted.

#### **VII.4-8 ADJOURNMENT AND CONCLUSION**

After consultation with the Chair of the judicial review committee, the hearing officer may adjourn the hearing and reconvene the same without special notice at such times and intervals as may be reasonable and warranted, with due consideration for reaching an expeditious conclusion to the hearing. Both the Medical Executive Committee and the practitioner may submit a written statement at the close of the hearing. Upon conclusion of the presentation of oral and written evidence, or the receipt of closing written arguments, if submitted, the hearing shall be closed.

#### **VII.4-9 BASIS FOR DECISION**

The decision of the judicial review committee shall be based on the evidence introduced at the hearing, including all logical and reasonable inferences from the evidence and the testimony. The decision of the judicial review committee shall be subject to such rights of appeal as described in these Bylaws.

#### **VII.4-10 DECISION OF THE JUDICIAL REVIEW COMMITTEE**

Within thirty (30) days after final adjournment of the hearing, the judicial review committee shall render a decision which shall be accompanied by a report in writing and shall be delivered to the Medical Executive Committee. If the practitioner is currently under suspension, however, the time for the decision and report shall be fifteen (15) days. A copy of said decision also shall be forwarded to the Administrator, the Chief Medical Officer, the Board of Directors, and to the practitioner. The report shall contain a concise statement of the reasons in support of the decision including findings of fact and a conclusion articulating the connection between the evidence produced at the hearing and the conclusion reached. Both the practitioner and the Medical Executive Committee shall be provided a written explanation of the procedure for appealing the

decision. The decision of the judicial review committee shall be subject to such rights of appeal or review as described in these Bylaws.

## **VII.5 APPEAL**

### **VII.5-1 TIME FOR APPEAL**

Within ten (10) days after receipt of the decision of the judicial review committee, either the practitioner or the Medical Executive Committee may request an appellate review. A written request for such review shall be delivered to the Chief of Staff, the Administrator, the Chief Medical Officer, the other party in the hearing, and a copy provided to the Board of Directors. If a request for appellate review is not requested within such period, that action or recommendation shall thereupon become the final action of the Medical Staff.

### **VII.5-2 GROUNDS FOR APPEAL**

A written request for an appeal shall include an identification of the grounds for appeal and a clear and concise statement of the facts in support of the appeal. The grounds for appeal from the hearing shall be:

- (a) substantial non-compliance with the procedures required by these Bylaws or applicable law which has created demonstrable prejudice;
- (b) the decision was not supported by substantial evidence based upon the hearing record or such additional information as may be permitted pursuant to Section 7.5-5; or
- (c) the judicial review committee failed to sustain an action or recommendation from the Medical Executive Committee that, based on the evidence in the hearing record was reasonable and warranted.

### **VII.5-3 APPEAL BOARD**

The Board of Directors may sit as the appeal board, or it may delegate that function to an appeal board which shall be composed of not less than three (3) individuals designated by the Board of Directors. Knowledge of the matter involved shall not preclude any person from serving as a member of the appeal board, so long as that person did not take part in a prior hearing on the same matter. The appeal board may select an attorney to assist it in the proceeding, but that attorney shall not be entitled to vote with respect to the appeal. The attorney firm selected by the Board of Directors shall be neither the attorney firm that represented either party at the hearing before the judicial review committee nor the attorney who assisted the hearing panel or served as hearing officer.

### **VII.5-4 TIME, PLACE AND NOTICE**

The appeal board shall, within thirty (30) days after receipt of request for appellate review, schedule a review date and cause each side to be given notice of the time, place and date of the appellate review. The appellate review shall commence within sixty (60) days from the date of such request for appellate review, provided however, that when a request for appellate review concerns a practitioner who is under suspension which is then in effect, the appellate review should commence within forty-five (45) days from the date of receipt of the request for appellate review. The time for appellate review may be extended by the appeal board for good cause.

### **VII.5-5 APPEAL PROCEDURE**

The proceeding by the appeal board shall be in the nature of an appellate hearing based upon the record of the hearing before the judicial review committee, provided that the appeal board may accept additional oral or written evidence, subject to a foundational showing that such evidence could not have been made available to

the judicial review committee in the exercise of reasonable diligence and subject to the same rights of cross-examination or confrontation provided at the judicial review hearing; or the appeal board may remand the matter to the judicial review committee for the taking of further evidence and for decision. Each party shall have the right to be represented by legal counsel, or any other representative designated by that party in connection with the appeal, to present a written statement in support of that party's position on appeal, and to personally appear and make oral argument. The appeal board may thereupon conduct, at a time convenient to itself, deliberations outside the presence of the appellant and respondent and their representatives. The appeal board shall present to the Board of Directors its written recommendations as to whether the Board of Directors should affirm, modify, or reverse the judicial review committee decision consistent with the standard set forth in Section 7.5-6, or remand the matter to the judicial review committee for further review and decision.

#### **VII.5-6 DECISION**

- (a) Except as provided in Section 7.5-6(b), within thirty (30) days after the conclusion of the appellate review proceedings, the Board of Directors shall render a final decision. The Board of Directors may affirm, modify, reverse the decision or remand the matter for further review by the judicial review committee or any other body designated by the Board of Directors for reconsideration stating the purpose for the referral. The Board of Directors shall give great weight to the judicial review committee findings and shall not act arbitrarily or capriciously. The Board of Directors may, however, exercise its independent judgment in determining whether a practitioner was afforded a fair hearing, whether the decision was reasonable and warranted, and whether any bylaw or policy relied upon by the judicial review committee is unreasonable and unwarranted. The decision shall be in writing, shall specify the reasons for the action taken, and shall provide findings of fact and conclusions articulating the connection between the evidence produced at the hearing and the appeal (if any), and the decision reached, if such findings and conclusions differ from those of the judicial review committee. If the Board of Directors determines that the practitioner was not afforded a fair hearing in compliance with the Bylaws, the Board of Directors shall remand the matter.
- (b) If the matter is remanded to the judicial review committee or other body designated by the Board of Directors for further review and recommendation, the committee shall promptly conduct its review and make its recommendations to the Board of Directors. This further review and the time required to report back shall not exceed thirty (30) days in duration except as the parties may otherwise agree or for good cause as jointly determined by the Chair of the Board of Directors and the judicial review committee.
- (c) The appeal board's decision shall constitute the final decision of the District. Any recommendation affirmed by the appeal board shall become effective immediately. The decision reached shall be forwarded to the Chief of Staff, the medical executive and Credentials Committees, the subject of the hearing, the Chief Medical Officer and the Administrator.

#### **VII.5-7 RIGHT TO ONE HEARING**

Except in circumstances where a new hearing is ordered by the Board of Directors or a court because of procedural irregularities or otherwise for reasons not the fault of the practitioner, no practitioner shall be entitled to more than one evidentiary hearing and one appellate review on any matter which shall have been the subject of adverse action or recommendation.

#### **VII.6 EXCEPTION TO HEARING RIGHTS**

## VII.6-1 AUTOMATIC ACTION BASED UPON ACTIONS TAKEN BY ANOTHER PEER REVIEW BODY

(a) The Medical Executive Committee shall be empowered to:

- (1) use as a basis for disqualification from membership and/or privileges, or
- (2) automatically impose

any adverse action that has been taken within the preceding thirty-six (36) months by another peer review body (as that term is used in the federal or California laws) after that action is considered final and the action was taken in conformance with California Business & Professions Code section 809 et seq. For purposes of this Section, an action shall be considered final when the practitioner has completed the hearing, appeal and judicial proceedings related to the action.

(b) The practitioner shall not be entitled to any hearing or appeal unless the Medical Executive Committee takes an action that is more restrictive than the final action taken by the original peer review body. Any hearing and appeal that is requested by the practitioner shall not address the merits of the action taken by the original peer review body, which were already reviewed at the original peer review body's hearing, and shall be limited to only the question of whether the automatic action is more restrictive than the original peer review body's action.

(c) Nothing in this Section shall preclude the Medical Staff or Board of Directors from taking a more restrictive action than another peer review body based upon the same facts or circumstances.

## ARTICLE VIII: ADVANCED PRACTICE PROVIDERS

### VIII.1 QUALIFICATIONS OF ADVANCED PRACTICE PROVIDERS

Advanced Practice Providers (APPs) are non-physician practitioners who are eligible to apply for privileges at Northern Inyo Healthcare District. APPs are not eligible for Medical Staff membership as described in California state law. They may be granted practice privileges if they hold a license, certificate or other credentials in a category of APPs that the Board of Directors (after securing Medical Executive Committee recommendation) has identified as eligible to apply for practice privileges, and only if the APPs are professionally competent and continuously meet the qualifications, standards, and requirements set forth in the Medical Staff Bylaws as demonstrated by the Medical Staff ongoing and focused professional practice evaluation process.

### VIII.2 CATEGORIES

The Board of Directors may determine, based upon recommendation of the Medical Executive Committee and such other information as it has before it, those categories of APPs that shall be eligible to exercise privileges at Northern Inyo Healthcare District. Such APPs shall be subject to the supervision requirements developed and approved by the interdisciplinary practice committee, the Medical Executive Committee, and the Board of Directors.

### VIII.3 PRIVILEGES

- (a) APPs may exercise only those setting-specific privileges granted to them by the Board of Directors. The range of privileges for which each APP may apply, and any special limitations or conditions to the exercise of such privileges, shall be based on recommendations of the interdisciplinary practice committee, subject to approval by the Credentials Committee, the Medical Executive Committee and the Board of Directors.
- (b) An APP must apply and qualify for practice privileges. Applications for initial granting of practice privileges and biennial renewal thereof shall be submitted and processed in a similar manner to that provided for Medical Staff members, unless otherwise specified in Medical Staff policies.
- (c) Each APP shall be subject to terms and conditions similar to those specified for Medical Staff members as they may logically be applied to APPs and appropriately tailored to the particular APP.

### VIII.4 RIGHTS AND RESPONSIBILITIES (PREROGATIVES)

The prerogatives which may be extended to an APP shall be defined in Medical Staff and/or District policies. Such prerogatives may include:

- (a) Provision of specified patient care services; which services may be provided independently or under the supervision or direction of a Medical Staff member and consistent with the practice privileges granted to the APP and within the scope of the APP's licensure or certification.
- (b) Participation in the open session of general meetings of the Medical Staff in a non-voting role.
- (c) Being a voting participant at departmental committees appropriate to their specialty, which vote shall be limited to the following:
  - (1) Departmental policies, procedures, or other matters specific to the APP's line of practice; and
  - (2) Election of Department Chief.
- (d) Attendance at District and Medical Staff education programs.

Additionally, each APP shall:

- (a) Meet those responsibilities required by applicable policies and as specified in the Bylaws, Section 2.5, and as they may be logically applied to reflect the scope of practice of the APP.
- (b) Retain appropriate responsibility within the APPs area of professional competence for the care and supervision of each patient in the District for whom the APP is providing services.
- (c) Participate in peer review of other APPs as appropriate, participate in quality improvement and discharge such other functions as may be required from time to time.

## **VIII.5 PROCEDURAL RIGHTS OF ADVANCED PRACTICE PROVIDERS**

### **VIII.5-1 GRIEVANCE RIGHTS AFTER ADVERSE ACTIONS**

Except as otherwise provided in this Section with respect to automatic termination or other matters, an APP shall have the right to utilize the grievance hearing process set forth in this Section in order to challenge any action that, if taken against a Medical Staff member, would be an adverse action constituting grounds for a procedural rights hearing pursuant to these Bylaws. However, nothing contained in these Bylaws shall be interpreted to entitle an APP to procedural rights, including, but not limited to, a procedural rights hearing or appellate review to which a Medical Staff member may be entitled.

An APP may challenge such adverse action by filing a written grievance with the Medical Executive Committee no later than fifteen (15) days after such action. Upon receipt of such a grievance, the Medical Executive Committee or its designee shall conduct an investigation that shall afford the APP an opportunity for an interview concerning the grievance. Any such interview shall not constitute a "hearing" pursuant to the Bylaws and shall not be conducted according to the procedural rules applicable to such hearings as set forth in Article VII. Before the interview, the APP shall be informed of the general nature and circumstances giving rise to the action, and the APP may present information relevant thereto at the interview. A record of the interview shall be made. The Medical Executive Committee or its designee shall make a decision and recommendation for final action based on the interview and all other information available to it, and shall submit a written report of its recommendation, decision, and statement of basis for it to the Board of Directors. After receipt of the Medical Executive Committee report, the Board of Directors shall take final action on the matter.

### **VIII.5-2 EMPLOYMENT BY THE DISTRICT**

If the APP is an employee of Northern Inyo Healthcare District, disciplinary actions related to the terms and conditions of employment of the APP shall be governed by applicable human resources policies.

### **VIII.5-3 AUTOMATIC TERMINATION**

- (a) Notwithstanding the provisions of Section 8.5-1, an APP's privileges shall automatically terminate without review if the APP's certification or license expires, is revoked, or is suspended.
- (b) Notwithstanding the provisions of Section 8.5-1, an APP's privileges may be subject to termination following review by the interdisciplinary practice committee and Medical Executive Committee if no appropriate supervising practitioner is available because:
  - (1) The Medical Staff membership of the supervising practitioner is terminated, whether such termination is voluntary or involuntary and no other member is able or willing to function as the supervising practitioner; or

(2) The supervising practitioner no longer agrees to act as the supervising practitioner for any reason, or the relationship between the APP and the supervising practitioner is otherwise terminated, regardless of the reason thereof and no other member is able or willing to function as the supervising practitioner.

(c) Additionally, APPs are subject to the automatic action provisions of Section 6.4 of these Bylaws.

#### **VIII.5-4 REVIEW OF CATEGORY DECISIONS**

The grievance rights afforded by this Section shall not apply to any decision regarding whether a category of APP shall or shall not be eligible for practice privileges and the terms, prerogatives, or conditions of such decision. Those questions shall be submitted for consideration to the Board of Directors, which has the discretion to decline to review the request or to review it using any procedure the Board of Directors deems appropriate.

## ARTICLE IX: OFFICERS

### IX.1 OFFICERS OF THE MEDICAL STAFF

#### IX.1-1 IDENTIFICATION

The officers of the Medical Staff shall be the Chief of Staff, Vice Chief of Staff, Immediate Past Chief of Staff, and member(s)-at-large. In addition, the Medical Staff's Department Chiefs shall be deemed Medical Staff Officers within the meaning of California law.

#### IX.1-2 QUALIFICATIONS

Officers must be members of the active Medical Staff at the time of their nomination and election, and must remain members in good standing during their term of office. Failure to maintain such status shall create a vacancy in the office involved.

The Chief Medical Officer will not be eligible to hold Medical Staff Office during employment by the District. Should a Medical Staff Officer accept a position as Chief Medical Officer they will resign from their Medical Staff position and a replacement shall be determined per the process outlined in these Bylaws. The Chief Medical Officer will retain voting privileges to which they are eligible to participate based on their rights as an active Medical Staff member.

Additionally, if possible, the Chief of Staff must have previously served on the Medical Executive Committee in some capacity for at least one term.

#### IX.1-3 NOMINATIONS

- (a) Elections for Chief of Staff shall be every two years. Elections for member(s)-at-large shall be every year.
- (b) The Medical Executive Committee shall nominate one or more nominees for the office of Chief of Staff and may nominate one or more nominees for member-at-large to be filled at the time of elections. The Medical Executive Committee shall give notice of the nominations to members eligible to vote on the officers no later than thirty (30) days prior to the election.
- (c) Nominations may also be made by any member entitled to vote by submitting a written nomination to the Medical Staff Office. A member may also nominate him- or herself, provided that he or she qualifies for such office.
- (d) All nominees for election shall disclose in writing to the Medical Staff those current or impending personal, professional, or financial affiliations or relationships of which they are reasonably aware, including contractual, employment or other relationships with the District, which could foreseeably result in a conflict of interest with their activities or responsibilities on behalf of the Medical Staff.

#### IX.1-4 ELECTIONS

The Chief of Staff and member(s)-at-large shall be elected by written ballot sent to eligible members prior to the end of the Medical Staff year during which an election is held. Whenever feasible, the election shall be held three (3) to six (6) months prior to the end of the Medical Staff year so as to give the newly elected officer the opportunity to begin transitioning into the role. Voting shall be by written ballot submitted to the Medical Staff Office or via electronic vote.

A nominee for Chief of Staff shall be elected upon receiving a majority of the valid votes cast. If no candidate for the office receives a majority vote on the first ballot, a run-off election shall be held promptly between the two candidates receiving the highest number of votes. In the case of a tie on the second ballot, the majority vote of the Medical Executive Committee shall decide the election by written ballot at its next meeting or a special meeting called for that purpose.

In the election for member-at-large where there are two or more nominees, the two nominees receiving the highest numbers of votes shall be elected to each serve in the role of member-at-large. If there are not two or more nominees on the ballot, only one position of member-at-large need be filled.

#### **IX.1-5 TERM OF ELECTED OFFICE**

The Chief of Staff shall serve a two (2) year term, commencing on the first day of the Medical Staff year following the election. The Chief of Staff shall be eligible to serve consecutive terms.

The Vice Chief of Staff, Immediate Past Chief of Staff, and member(s)-at-large shall serve a one (1) year term. The Vice Chief of Staff and member(s)-at-large shall be eligible to serve consecutive terms.

Each officer shall serve until the end of that officer's term, unless that officer resigns or is removed from office.

#### **IX.1-6 RECALL OF OFFICERS**

Any Medical Staff Officer may be removed from office for valid cause, including, but not limited to, gross neglect or misfeasance in office, or serious acts of moral turpitude. Recall of a Medical Staff Officer may be initiated by the Medical Executive Committee or by a petition signed by at least one-third of the members of the active Medical Staff presented to the Medical Executive Committee or Chief of Staff. Recall shall require a majority vote of the Medical Executive Committee. A special meeting may be called for this purpose.

At least ten (10) days prior to the initiation of any removal action, the individual shall be given written notice of the date of the meeting at which action is to be considered. The individual shall be afforded an opportunity to speak to the Medical Executive Committee prior to a vote on removal. This provision does not include actions such as summary suspension where such timeline may not be feasible.

#### **IX.1-7 VACANCIES IN ELECTED OFFICE**

Vacancies in office occur upon the death or disability, resignation, or removal of the officer, or such officer's loss of membership in the Medical Staff. Vacancies shall be filled by appointment by the Chief of Staff with consultation with the Medical Executive Committee until the next regular election, except for the member-at-large, which may remain vacant.

### **IX.2 DUTIES OF OFFICERS**

#### **IX.2-1 CHIEF OF STAFF**

The Chief of Staff shall serve as the chief officer of the Medical Staff. With the assistance of the Medical Executive Committee where appropriate, the duties required of the Chief of Staff (or designee, as allowed by the Bylaws) shall include, but not be limited to:

- (a) enforcing the Medical Staff Bylaws and policies, implementing sanctions where indicated in consultation with the Medical Executive Committee, and promoting compliance with procedural safeguards where corrective action has been requested or initiated;
- (b) calling, presiding at, and being responsible for the agenda of all general meetings of the Medical Staff;

- (c) serving as Chair of the Medical Executive Committee and calling, presiding at, and being responsible for the agenda of all meetings thereof;
- (d) in the interim between Medical Executive Committee meetings, performing those responsibilities of the committee that, in the Chief of Staff's opinion, must be performed prior to the next regular or special meeting of the committee;
- (e) serving as an ex-officio member of all other staff committees without vote, unless Chief of Staff membership in a particular committee is required by these Bylaws;
- (f) interacting with the Administrator, Chief Medical Officer and Board of Directors in all matters of mutual concern within the District;
- (g) representing the views and policies of the Medical Staff to the Board of Directors, the Administrator or designee, and Chairing the joint conference committee as indicated in these Bylaws;
- (h) regularly reporting to the Board of Directors on the performance of Medical Staff functions and communicating to the Medical Staff any concerns expressed by the District Board;
- (i) being a spokesperson for the Medical Staff in external professional and public relations;
- (j) serving on liaison committees with the Board of Directors and administration, as well as outside licensing or accreditation agencies;
- (k) performing such other functions as may be assigned to the Chief of Staff by the Bylaws, the Medical Staff, or the Medical Executive Committee.

#### **IX.2-2 VICE CHIEF OF STAFF**

The Vice Chief of Staff shall serve a one (1) year term and is selected from among the current members serving on the Medical Executive Committee. The Vice Chief of Staff shall assume all duties and authority of the Chief of Staff in the absence of the Chief of Staff and shall perform such other duties as may be assigned.

#### **IX.2-3 IMMEDIATE PAST CHIEF OF STAFF**

The Immediate Past Chief of Staff will remain a member of the Medical Executive Committee for one (1) year, and shall attend at least the first three (3) consecutive months of their term to assure a smooth transition with the change in leadership and longer as deemed necessary. The Immediate Past Chief of Staff shall perform such other duties as may be assigned.

#### **IX.2-4 MEMBER-AT-LARGE**

There may be one or two officers with the title member-at-large. The member(s)-at-large shall be members of the Medical Executive Committee and shall perform duties as may be assigned.

## ARTICLE X: CLINICAL DEPARTMENTS

### X.1 ORGANIZATION OF CLINICAL DEPARTMENTS

The active Medical Staff shall be organized into clinical departments. Each department shall be organized as a separate component of the Medical Staff and shall have a Chief selected and entrusted with the authority, duties, and responsibilities specified in this Article. When appropriate, or at the recommendation of the departmental committee, the Medical Executive Committee may approve the creation, elimination, modification, or combination of departments.

Department committees, as described in Article XI, may represent a single clinical department or a combination of clinical departments as appropriate.

Additional medical or surgical specialties not currently listed as a department will be assigned to an existing department through the credentialing and privileging process.

### X.2 DEPARTMENTS

The clinical departments under these Bylaws are:

- (a) Anesthesia
- (b) Emergency Medicine
- (c) Surgery (including Pathology)
- (d) Inpatient Medicine
- (e) Obstetrics & Gynecology
- (f) Orthopedic Surgery (including Podiatry)
- (g) Outpatient Medicine
- (h) Pediatrics
- (i) Radiology

### X.3 ASSIGNMENT TO DEPARTMENTS

Each privileged practitioner shall be assigned membership based on specialty or board certification in at least one department, but may also be granted membership and/or clinical privileges in other departments consistent with practice privileges granted.

### X.4 FUNCTIONS OF DEPARTMENTS

The general functions of each department shall include:

- (a) Conducting patient care reviews for the purpose of analyzing and evaluating the quality and appropriateness of care and treatment provided to patients within the department, as per the Medical Staff's policy on ongoing and focused professional practice evaluation.
- (b) Recommending to the Medical Executive Committee guidelines for the granting of clinical privileges and the performance of specified services within the department.

- (c) Evaluating and making appropriate recommendations to the Credentials Committee and the Medical Executive Committee regarding the qualifications of applicants seeking appointment or reappointment and clinical privileges within that department.
- (d) Reviewing and evaluating departmental adherence to: (1) Medical Staff and District policies and procedures, (2) sound principles of clinical practice, and (3) quality improvement.
- (e) Coordinating with nursing and ancillary staff in regards to patient care provided by the department's members with nursing and ancillary patient care services.
- (f) Reporting to the departmental committee concerning: (1) the activities of the department, and (2) recommendations for maintaining and improving the quality of care provided in the department and the District.
- (g) Meeting regularly for the purpose of considering patient care review findings and the results of the department's other review and evaluation activities, as well as reports on other department and staff functions.
- (h) Taking appropriate action when problems in patient care and clinical performance or opportunities to improve care are identified.
- (i) Formulating departmental policies/procedures as reasonably necessary for the proper discharge of its responsibilities subject to the approval by the Medical Executive Committee.

## **X.5 DEPARTMENT CHIEFS**

### **X.5-1 QUALIFICATIONS**

Each department shall have a Chief who shall be a member of the active staff and shall be qualified by licensure, training, experience and demonstrated ability in at least one of the clinical areas covered by the department. If required by applicable California regulations or other law, the Department Chief must be certified by an appropriate specialty board or eligible for certification by an appropriate specialty board. Otherwise, the Department Chief shall possess comparable competence as affirmatively established through the peer review process.

### **X.5-2 SELECTION**

The Department Chief shall be elected by the voting members of their department. In the event of a tie vote, the Chief will be appointed by vote of the Medical Executive Committee. Departments with a single member will automatically have the single member designated as Chief. Vacancies due to any reason shall be filled for the unexpired term through special election by the respective department with such mechanisms as that department may adopt.

### **X.5-3 TERM OF OFFICE**

Each Department Chief shall serve a one (1) year term which coincides with the Medical Staff year or until his or her successor is chosen, unless he or she shall sooner resign, be removed from office, or lose his or her Medical Staff membership or clinical privileges in that department. Department Chiefs shall be eligible to serve consecutive terms.

#### **X.5-4 REMOVAL**

Removal of Department Chiefs from office may occur for cause by a two-thirds vote of the department members. The Medical Executive Committee may remove Department Chiefs in the course of a corrective action proceeding as indicated.

#### **X.5-5 DUTIES**

Each Chief shall have the following authority, duties and responsibilities, and shall otherwise perform such duties as may be assigned:

- (a) oversee the quality of patient care, professional performance and behaviors rendered by practitioners with clinical privileges in the department and designate proctors as necessary;
  - (b) assign a member of the Medical Staff to assume responsibility for duties and/or the care of another member's patients in the event the member is unable to fulfill their obligations due to termination of privileges, illness, or similar extenuating circumstances;
  - (c) enforce the Medical Staff Bylaws and Medical Staff and District policies within the department;
  - (d) implement within the department appropriate actions taken by the Medical Executive Committee;
  - (e) coordinate with District administration, department Medical Director (if any), and nursing services in matters relevant to the department;
  - (f) perform such other duties commensurate with the office as may from time to time be reasonably requested by the Chief of Staff or the Medical Executive Committee.
- (a)

## ARTICLE XI: COMMITTEES

### XI.1 DESIGNATION

The Medical Executive Committee and the other committees described in these Bylaws shall be the standing committees of the Medical Staff. Special or ad hoc committees may be created by the Medical Executive Committee or the Chief of Staff to perform specified tasks. Any committee that is carrying out all or any portion of a function or activity required by these Bylaws is deemed a duly-appointed and authorized committee of the Medical Staff.

### XI.2 GENERAL PROVISIONS

#### XI.2-1 APPOINTMENT OF COMMITTEE MEMBERS AND CHAIRS

The chair and members of committees shall be designated as per the Bylaws. If not specified in the Bylaws, the chair and members of committees shall be appointed by and may be removed by the Chief of Staff, subject to consultation with the Medical Executive Committee. Medical staff committees shall be responsible to the Medical Executive Committee. Each committee chair or other authorized person chairing a meeting has the right to discuss and to vote on issues presented to the committee.

The Administrator, or his or her designee, shall appoint any non-Medical Staff committee members who are not otherwise designated by title in the provision or resolution creating the committee.

The removal of any committee member who is automatically assigned to a committee because he or she is a general officer or other official shall be governed by the provisions pertaining to removal of such officer or official.

#### XI.2-2 COMMITTEE COMPOSITION

Except as otherwise provided in the Bylaws, committees established to perform Medical Staff functions required by these Bylaws may include any category of: Medical Staff members; advanced practice providers; representatives from District services such as administration, nursing services, or medical records; representatives of the community; and persons with special expertise, depending upon the functions to be discharged. Each active Medical Staff member and advanced practice provider who serves on a committee participates with vote unless the statement of committee composition provides for designation of the position as non-voting.

#### XI.2-3 REPRESENTATION ON DISTRICT COMMITTEES AND PARTICIPATION IN DELIBERATIONS

The Medical Staff may discharge its duties relating to medical records, utilization review, infection control, pharmacy and therapeutics, accreditation, licensure, certification, disaster planning, facility and services planning, financial management, and physical plant safety by providing Medical Staff representation on District committees established to perform such functions. The Medical Executive Committee or Chief of Staff will be responsible for appointing a Medical Staff or APP representative on District committees when requested. Reports of activities and recommendations relating to infection control, medical records, utilization review, and pharmacy and therapeutics shall be made to the Medical Executive Committee at least quarterly.

#### XI.2-4 EX-OFFICIO MEMBERS

The Chief of Staff and the Administrator or designee are ex-officio members of all standing and special committees of the Medical Staff. They and all other persons designated to serve as ex-officio committee members shall serve without vote unless provided otherwise in the provision or resolution creating the committee.

#### **XI.2-5 ACTION THROUGH SUBCOMMITTEES**

Any Medical Staff standing committee may establish subcommittees to assist in carrying out its duties, in addition to any such subcommittees established by the Medical Executive Committee or expressly designated in the Bylaws. A subcommittee shall be composed of one or more voting members of the standing committee. The Medical Executive Committee shall be informed when a subcommittee is established. The committee Chair may also appoint individuals to serve as non-voting subcommittee members, after consulting with, and subject to the approval of, the Chief of Staff regarding Medical Staff members, and the Administrator or designee regarding District personnel. An ad hoc committee is not considered a subcommittee.

#### **XI.2-6 TERM OF COMMITTEE MEMBERS**

The term of committee members shall be as designated in the Bylaws. If not specified, a committee member shall be appointed for a term of one year, subject to unlimited renewal, and shall serve until the end of this period and until his or her successor is appointed, unless he or she shall sooner resign or be removed from the committee.

#### **XI.2-7 COMMITTEE VACANCIES**

Unless otherwise specified, vacancies on any committee shall be filled in the same manner in which an original appointment to such committee is made.

#### **XI.2-8 LIMITATION OF ATTENDANCE AT COMMITTEE MEETINGS**

Unless otherwise specified in the Bylaws, any privileged practitioner who is in good standing may be permitted to attend any portion of a Medical Staff committee's meeting dealing with a matter of importance to that practitioner even though the practitioner is not a member of the committee. However, the committee Chair or the Chief of Staff shall have the discretion to deny entry to the meeting to such practitioner, or to request any nonmember to leave the meeting. Any such nonmember who attends shall abide by all Bylaws applicable to that committee.

In addition, during any portion of a committee meeting when the committee is in closed session or conducting peer review and chart review functions with respect to specific Medical Staff members, applicants, or other practitioners or advanced practice providers, attendance at the committee's meeting shall be restricted to (a) privileged practitioners who are members of the committee through assignment or election by the Medical Staff, and (b) any Medical Staff member or other person whom the committee has invited or requested to attend to assist in the functions (but only for the portion of the meeting designated by the committee or the committee Chair).

The committee Chair, after consulting with the Chief of Staff and Administrator, may call on outside consultants or other special advisors to assist the committee in fulfilling its duties and allow such special advisors to attend committee meetings related to the assistance they are providing, but such advisors shall not be deemed members of the committee.

Any nonmember who attends a committee meeting shall be deemed to have agreed, by his or her presence at the meeting, to maintain the confidentiality of and to refrain from any unauthorized disclosure to other persons of the committee's records, deliberations, and proceedings.

#### **XI.2-9 ACCOUNTABILITY**

All Medical Staff committees shall be accountable to the Medical Executive Committee.

## **XI.3 MEDICAL EXECUTIVE COMMITTEE**

### **XI.3-1 COMPOSITION**

The Medical Executive Committee shall be composed of the Chief of Staff, Vice Chief of Staff, Immediate Past Chief of Staff, Department Committee Chairs, Chief of Anesthesia, Chief of Surgery, Chief of Orthopedics, and up to two members-at-large, if elected. The Chief of Staff shall Chair and preside over the Medical Executive Committee. The Administrator or designee and the Chief Nursing Officer shall be a non-voting ex-officio members.

### **XI.3-2 DUTIES**

With the assistance of the Chief of Staff and/or the use of ad hoc committees as appropriate, the Medical Executive Committee shall:

- (a) represent and act on behalf of the Medical Staff, subject to such limitations as may be imposed by these Bylaws;
- (b) ensure the Medical Staff fulfills its responsibilities to the District Board as per the District Bylaws;
- (c) monitor, evaluate, and supervise the performance of all Medical Staff functions, including conducting an annual review of Medical Staff policies;
- (d) review, evaluate, or take other appropriate action for matters related to the competence and other qualifications of privileged practitioners or practitioners applying for privileges;
- (e) taking reasonable steps to promote ethical conduct and competent clinical performance on the part of all privileged practitioners and when indicated, initiate and/or pursue disciplinary or corrective actions affecting privileged practitioners, as provided in the Bylaws;
- (f) ensure Medical Staff's knowledge of and compliance with the Medical Staff Bylaws and policies; the District's Bylaws, rules, and policies; state and federal laws and regulations; and other accreditation requirements;
- (g) oversee the development of Medical Staff policies, approve (or disapprove) all such policies, and oversee the dissemination and implementation of all such policies following their approval by the Medical Staff;
- (h) implement, as they relate to the Medical Staff, the approved policies, procedures, standards, and rules of the District, including, without limitation, the Compliance program (which program relates to Medicare and Medi-Cal fraud and abuse matters); the District confidentiality policies and procedures related to compliance with applicable law, including but not limited to the federal Health Insurance Portability and Accountability Act ("HIPAA") and the California Medical Information Act; and the District medical error reporting program, including without limitation, applicable disclosure and reporting protocols.
- (i) provide liaison between the Medical Staff, the Administrator and the District Board by regularly reporting to the District Board and to the Medical Staff;
- (j) make recommendations to the District Board regarding Medical Staff structure, membership and privileges requirements, application, disciplinary, and hearing procedures, peer review and quality

assessment and improvement activities, and other aspects of Medical Staff affairs addressed in the Medical Staff Bylaws;

- (k) make recommendations to administration in the selection of and assignment of responsibilities to department Medical Directors, the Chief Medical Officer, or other practitioners contracted by the District to provide administrative services;
- (l) review and make recommendations to the Chief Medical Officer regarding quality of care issues related to specified clinical services contract arrangements for professional medical services;
- (m) participate and provide information when requested in District proceedings involved with making specified clinical services contracting decisions;
- (n) in collaboration with the District, oversee the development and implementation of a District-wide quality improvement plan and recommend revisions as needed;
- (o) review quality improvement reports from Department Chiefs, committees, and other Medical Staff patient care review activities;
- (p) establish, as needed, such ad hoc committees that will fulfill particular functions for a limited time and will report directly to the Medical Executive Committee;
- (q) appoint committee members for all standing committees, all special Medical Staff, liaison, or multi-disciplinary committees, and designating the Chairs of these committees, except where otherwise provided by these Bylaws; and
- (r) recommend the amount of annual dues for each Medical Staff membership category, subject to Medical Staff approval, and recommend the manner of expenditure of dues funds, subject to the committee's acknowledgment that such expenditures must be consistent with applicable law regarding such expenditures.

### **XI.3-3 MEETINGS**

The Medical Executive Committee should be scheduled to meet on a monthly basis and shall meet at least ten (10) times during the Medical Staff year.

## **XI.4 BYLAWS COMMITTEE**

### **XI.4-1 COMPOSITION**

The Bylaws Committee shall be composed of at least three (3) active staff members.

### **XI.4-2 DUTIES**

The Bylaws Committee shall make reasonable efforts to assure that the Medical Staff Bylaws and policies adequately and accurately reflect the current structure and practices of the Medical Staff and comply with applicable legal requirements by:

- (a) conducting an annual review of the Bylaws;
- (b) developing and submitting proposals for Bylaws changes to the Medical Executive Committee and to the Medical Staff in accordance with Bylaws procedures;
- (c) receiving, evaluating, and making recommendations with respect to Bylaws or policies proposals made by the executive committee, Department Chiefs, member petition or other sources; and

- (d) engaging in such other activities as reasonably appropriate for fulfilling these and other functions as specified in the Bylaws or policies.

#### **XI.4-3 MEETINGS AND REPORTS**

The Bylaws Committee will meet at least annually and otherwise as requested by the Bylaws Committee Chair or Chief of Staff. The committee shall report its activities and recommendations at least annually to the Medical Executive Committee.

### **XI.5 CREDENTIALS COMMITTEE**

#### **XI.5-1 COMPOSITION**

The Credentials Committee shall be composed of at least five (5) active staff members, selected on a basis that will ensure insofar as feasible, representation of the clinical departments and the major clinical specialties which are routinely practiced by privileged practitioners at Northern Inyo Healthcare District.

#### **XI.5-2 DUTIES**

The Credentials Committee shall evaluate and make recommendations with respect to the qualifications of all applicants for Medical Staff appointment, reappointment, privileges, and changes in staff categories, and fulfill other functions as specified in the Bylaws or policies.

#### **XI.5-3 MEETINGS AND REPORTS**

The Credentials Committee shall meet at least quarterly, or as often as necessary as determined and called by the committee Chair, the Chief of Staff, or the Medical Staff Office. The committee shall report its activities and recommendations with respect to applicants as specified in the Bylaws and shall otherwise report the status of pending applications and its activities to the Medical Executive Committee.

### **XI.6 INTERDISCIPLINARY PRACTICE COMMITTEE**

#### **XI.6-1 COMPOSITION**

The interdisciplinary practice committee (IDPC) shall be composed of:

- (a) an equal number of Medical Staff members who are physicians and nursing staff who are registered nurses;
- (b) the lead advanced practice provider;
- (c) the Chief Nursing Officer; and
- (d) the Administrator (or the Administrator's designee, who may not be a registered nurse or a physician Medical Staff member).

The Medical Executive Committee shall appoint the physician members and designate one of them as the Chairperson. The Chief Nursing Officer shall appoint the nursing staff members. In addition, representatives in the categories of advanced practice providers granted privileges in the District may serve as consultants on an as-needed basis, and shall participate, when requested and feasible, in the committee proceedings when a member of the same APP category is applying for privileges.

#### **XI.6-2 DUTIES**

The IDPC functions to establish, implement, monitor, and evaluate policies and procedures for interdisciplinary medical practice pursuant to Title 22, California Code of Regulations, Sections 70706 and 70706.2, other

applicable law, and the Bylaws. IDPC duties shall include, but not necessarily be limited to, the standardized procedures and credentialing duties as set forth below in this Section.

**(a) STANDARDIZED PROCEDURE DUTIES:**

- (1) The IDPC shall develop and review standardized procedures that apply to nurses or APPs, identify functions that are appropriate for standardized procedures, initiate such procedures, and review and approve standardized procedures in accordance with applicable licensure regulations, such as Title 22, California Code of Regulations, Sections 70706 and 70706.2, other applicable law, and the Bylaws.
- (2) Request for development of standardized procedures may be initiated by the Administrator, the Chief Medical Officer, the Chief Nursing Officer, the Medical Executive Committee, the Chief of Staff, the appropriate Department Chiefs, the affected registered nurses or APPs, or supervising practitioners.
- (3) Prior to approval of new or amended standardized procedures, the IDPC shall obtain consultation and recommendations from the Department Chief(s), other appropriate Medical Staff members, and non-Medical Staff members who practice in the clinical field or medical or nursing specialties under review as subject of the proposed standardized procedures.
- (4) Standardized procedures shall be reviewed and approved by the IDPC, the Medical Executive Committee, the Administrator, and the Board of Directors in order to become effective.
- (5) The IDPC may approve standardized procedures only by affirmative vote of the following IDPC members: the Administrator (or the Administrator's designee), a majority of the physician members, and a majority of the registered nurse members (including the Chief Nursing Officer).
- (6) The IDPC is responsible for assuring that standardized procedures are a collaborative effort among Administrators and health professionals, including physicians and nurses. Each standardized procedure shall:
  - i. Be in writing and show the date or dates of each required approval, including approval by the IDPC;
  - ii. Specify which standardized procedure functions which registered nurses are authorize to perform and under what circumstances;
  - iii. State any specific requirements which are to be followed by registered nurses in performing all or part of the functions covered by the particular standardized procedure;
  - iv. Specify any experience, training, and/or special education requirements for performance of the standardized procedure functions;
  - v. Establish a method for initial and continuing evaluation of the competence of those registered nurses authorized to perform the standardized procedure functions;
  - vi. Provide for a method of maintaining a written record of those persons authorized to perform the standardized procedure functions;

- vii. Specify the nature and scope of review and/or supervision required for performance of the standardized procedure functions. For example, if the function is to be performed only under the immediate supervision of a physician, that limitation must be clearly stated. If physician supervision is not required, that fact should be clearly stated;
- viii. Set forth any specialized circumstances under which the registered nurse is to communicate immediately with a patient's physician concerning the patient's condition;
- ix. State the limitations on settings or departments within the facility where the standardized procedure functions may be performed;
- x. Specify any special requirements for procedures relating to patient recordkeeping; and
- xi. Provide for a method of periodic review of the standardized procedure.

**(b) CREDENTIALING ADVANCED PRACTICE PROVIDERS DUTIES:**

- (1) Upon request by the Medical Executive Committee or the Board of Directors, or at its own initiative, the IDPC shall make recommendations regarding APP category eligibility, delineation of APP practice privileges, supervision requirements, and other such matters related to APP practice at the District.
- (2) The IDPC shall review and evaluate APP applications and requests for privileges and forward its written report and recommendations to the appropriate Department Chief or Credentials Committee.
- (3) The IDPC shall serve as liaison between APPs and the Medical Staff.

**XI.6-3 MEETINGS**

The IDPC shall meet as often as needed, but at least annually. The committee shall report its activities and recommendations with respect to applicants as specified in the Bylaws to the Credentials Committee.

**XI.7 JOINT CONFERENCE COMMITTEE**

**XI.7-1 COMPOSITION**

The joint conference committee is an ad hoc committee composed of two (2) members of the Board of Directors and two (2) members of the Medical Executive Committee, one (1) of which shall be the Chief of Staff, and the other which shall be appointed by the Medical Executive Committee. The Administrator, or designee, shall be a non-voting, ex-officio member. The Chair of the committee should alternate yearly between the Board of Directors and the Medical Staff; odd-numbered years will be the Board of Directors, and even-numbered years will be the Medical Staff.

**XI.7-2 DUTIES**

The function of the joint conference committee is to serve as a liaison between members of the Board of Directors, the District administration, and the Medical Staff on an ad hoc basis. The joint conference committee shall act in an advisory function and provide a forum for:

- (a) maintenance of effective communications to keep the Board, Medical Staff, and the Administrator cognizant of any pertinent actions taken or contemplated;
- (b) planning for growth and development of the District and the Medical Staff;
- (c) discussion of matters of District and Medical Staff policy, practice, and planning not related to peer review; and
- (d) interaction between the Board of Directors and the Medical Staff on such matters as may be referred by the Medical Executive Committee or the Board of Directors.

The joint conference committee may also meet on an ad hoc basis to act as a deliberative body as described below for:

- (a) the resolution of conflicts or disputes between the Medical Staff and the Board of Directors or administration; and
- (b) the resolution of any dispute related to the Medical Staff's rights or self-governance or discharge of Medical Staff responsibilities.

### **XI.7-3 DISPUTE RESOLUTION PROCESS**

All disputes between administration or the Board of Directors and the Medical Staff that have not been resolved by prior informal meetings and discussions shall be addressed to and mediated by the joint conference committee.

- (a) Following written notice of a dispute needing mediation, the committee shall convene within fourteen (14) days after the next regularly scheduled District Board meeting.
- (b) The committee shall meet and confer in good faith to formulate a recommendation for mediation of the dispute.
- (c) If the committee cannot reach a consensus, the committee may appoint an outside professional mediator as a member of the committee, and the mediator shall serve as the Chair of the committee but shall have no vote. The parties shall cooperate to select the mediator from a list of candidates provided by services such as the Judicial Arbitration and Mediation Service or the American Arbitration Association. The cost of the mediator shall be covered by the District.

### **XI.7-4 MEETINGS AND REPORTS**

The committee shall meet as needed on an ad-hoc basis as described above. The Chief of Staff, or designee, shall report the committee's activities or discussions to the Medical Executive Committee and to the Medical Staff via email or at the next regularly scheduled meetings, as appropriate for the subject matter. Minutes shall be kept during meetings as appropriate and a copy maintained in the Medical Staff Office.

## **XI.8 PEER REVIEW COMMITTEE**

### **XI.8-1 COMPOSITION**

The Peer Review committee shall be composed of at least three (3) Medical Staff members selected on a basis that will ensure insofar as feasible, representation from various specialties. Members shall not participate in the review of cases in which they have a conflict of interest.

### **XI.8-2 DUTIES**

The Peer Review Committee shall:

- (a) Promote high standards of professional practice, behavior and patient care.
- (b) Evaluate the quality, appropriateness, and efficiency of care rendered by privileged practitioners. The committee may also recommend external peer review when indicated.
- (c) Identify opportunities for improvement in clinical performance and/or professional conduct and ensure that privileged practitioners practice within accepted standards of care and in accordance with the Medical Staff's professional conduct policy.
- (d) Oversee and support the Medical Staff's Focused Professional Practice Evaluation (FPPE) and Ongoing Professional Practice Evaluation (OPPE) processes including reviewing practitioner-specific performance data and trends and identifying practitioners requiring further review, monitoring, or intervention.
- (e) Identify system issues impacting quality of care and collaborate with hospital quality programs to improve clinical outcomes.
- (f) Request specialty-specific review from non-members, as needed, to perform a thorough review, and allow the practitioner under review to provide a response. The practitioner's response shall be either in writing or in-person, as determined by the committee.
- (g) Issue recommendations to practitioners on areas of education, monitoring, or feedback.
- (h) Make recommendations to the Medical Executive Committee regarding practitioner performance concerns, including but not limited to, request for corrective action, privilege modification, limitation or revocation.

### **XI.8-3 MEETINGS, REPORTS AND MINUTES**

The Peer Review Committee shall meet as often as necessary, but at least quarterly. It shall maintain only such records of its proceedings as it deems advisable and consistent with confidentiality concerns, and all records shall be confidential and protected the fullest extent permitted by law. The committee shall routinely report on its activities to the Medical Executive Committee.

## **XI.9 PHYSICIAN WELLNESS COMMITTEE**

### **XI.9-1 COMPOSITION**

The physician wellness committee shall be composed of at least three (3) Medical Staff members, one (1) of whom should be a psychiatrist whenever feasible. Insofar as feasible, members of this committee shall not actively participate on other peer review or corrective action ad hoc committees while serving on this committee.

Additionally, in order to facilitate open communication about provider wellness, meetings of the physician wellness committee will be limited to the Medical Staff members of that committee and other participants will be included by invitation of the Chair of the committee only.

### **XI.9-2 DUTIES**

The committee shall:

- (a) Consider general matters related to the health and well-being of Medical Staff members and, with the approval of the Medical Executive Committee or Chief of Staff, develop educational programs or staff events for promoting well-being.

- (b) Educate staff on illness and impairment recognition issues specific to physicians.
- (c) Review, evaluate, and make recommendations as appropriate or otherwise required by the Bylaws:
  - (1) Voluntary disclosures to the committee by members or other practitioners regarding their health status;
  - (2) Health status referrals or reports from the Chief of Staff or other Medical Staff Officer or committee regarding a member; and
  - (3) Responses from applicants concerning physical or mental disabilities.
- (d) Investigate any applicant, member, or other practitioner who has or may have physical or mental disability that may affect the practitioner's capability to exercise the privileges applied for and/or held by the practitioner in a manner that meets the patient care quality standards of the District and the Medical Staff. An investigation may include any or all of the following steps:
  - (1) Ascertain the health status of the practitioner through committee interview;
  - (2) Medical examination by an appropriate healthcare professional to evaluate whether the practitioner has a physical or mental disability or other health problem that may affect patient care;
  - (3) Evaluate the effects of the health status on the practitioner's capability to exercise privileges applied for or held by the practitioner, and when relevant with respect to a qualified physical or mental disability under applicable law, assess if and how reasonable accommodations can be made;
  - (4) Provide advice, counseling, or referrals as appropriate.

The activities of the physician wellness committee shall be confidential. However, if the committee receives information that demonstrates that the health or impairment of a practitioner may pose a risk of harm to patients, self or others, that information shall be referred to the Chief of Staff or the Medical Executive Committee. This committee is not disciplinary in nature and does not preclude other review mechanisms as set forth in these Bylaws.

### **XI.9-3 MEETINGS, REPORTING AND MINUTES**

The physician wellness committee shall meet as often as necessary, but at least quarterly. It shall maintain only such records of its proceedings as it deems advisable and consistent with confidentiality concerns, and shall routinely report on its activities to the Medical Executive Committee.

## **XI.10 UTILIZATION REVIEW AND MEDICAL RECORDS COMMITTEE**

### **XI.10-1 COMPOSITION**

The utilization review and medical records committee shall consist of at least three (3) Medical Staff members. Representatives from quality, utilization review, nursing, billing, medical records, and social services shall be invited as non-voting members.

### **XI.10-2 DUTIES**

The utilization review and medical records committee shall perform the following functions:

- (a) Delineate the scope of utilization review provided within the District;

- (b) Develop critical indicators to be used as screening devices in reviewing the utilization of District services;
- (c) After cases have been isolated using the critical indicators, evaluate utilization of services administered and identify areas for improvement, if necessary;
- (d) Review patient care services to ascertain if utilization of services within the standards of the District and Medical Staff are being provided in the most cost-effective manner, address overutilization, underutilization, and inefficient scheduling of care and resources;
- (e) Review diagnoses, problems, procedures and the practices of practitioners that appear to have utilization-related problems, and examine relevant quality assurance findings and interface with the practitioners as deemed necessary or appropriate;
- (f) Determine appropriate action to be taken with respect to identified utilization and other patient care problems, and report such matters to the Medical Executive Committee;
- (g) Refer problems which cannot reasonably be resolved at the committee level to the appropriate committee;
- (h) Develop, implement, and maintain such Utilization Review Plan as approved by the Medical Executive Committee and District Board; and
- (i) Comply with applicable federal and state regulations.

### **XI.10-3 MEETINGS**

The utilization review and medical records committee shall meet at least quarterly. The committee shall report a summary of its activities or findings to the Medical Executive Committee on a regular basis. The committee shall also give notification to the Medical Executive Committee promptly after the committee receives notice of any matter for which a practitioner is required to give notice to the Medical Staff pursuant to these Bylaws, if not already reported.

## **XI.11 DEPARTMENTAL COMMITTEES**

### **XI.11-1 COMPOSITION**

The departmental committees can represent a single clinical department or a combination of clinical departments. The departmental committees shall be composed of the practitioners assigned to the represented departments.

Members have the duty to attend all meetings of the department, unless excused for good reason by the Chair of the committee.

Additional committee members may be assigned as needed to represent all disciplines of the department at regularly scheduled meetings.

#### **(a) Emergency Services Committee**

The Emergency Services Committee shall represent all medical services provided in the emergency department. In addition, the emergency department nurse manager and the Administrator (or designee) shall be ex-officio non-voting members. Other departments may participate as needed by invitation. As available, the Administrator shall designate a District quality representative to this committee in a non-voting capacity.

(b) Inpatient Medicine Committee

The Inpatient Medicine Committee represents the adult medical services provided in the medical/surgical and intensive care unit departments. Whenever possible, the cardiopulmonary Medical Director and an outpatient medicine committee representative shall serve on the committee. The medical/surgical nurse manager and the Administrator (or designee), as well as representatives from the respiratory therapy, physical therapy, dietary, and pharmacy departments shall be non-voting ex-officio members. Other departments may participate as needed by invitation. As available, the Administrator shall designate a District quality representative to this committee in a non-voting capacity.

(c) Outpatient Medicine Committee

The Outpatient Medicine Committee represents the outpatient services including family medicine, internal medicine, outpatient infusion department, and other outpatient medicine departments not represented by other committees. Whenever possible, the cardiopulmonary Medical Director and an inpatient medicine committee representative shall serve on the committee. The clinical nurse manager, a representative from the outpatient infusion department, and the Administrator (or designee) shall be non-voting ex-officio members. Other departments may participate as needed by invitation. As available, the Administrator shall designate a District quality representative to this committee in a non-voting capacity.

(d) Perinatal/Pediatrics Committee

The Perinatal/Pediatrics Committee shall represent the pediatric and obstetrical departments. The nurse managers of the perinatal and pediatrics units and the Administrator (or designee) shall be ex-officio non-voting members. Other departments may participate as needed by invitation. As available, the Administrator shall designate a District quality representative to this committee in a non-voting capacity.

(e) Radiology Services Committee

The Radiology Services Committee represents the radiology services. The director of diagnostic services and the Administrator (or designee) shall be non-voting ex officio members. Other departments may participate as needed by invitation. As available, the Administrator shall designate a District quality representative to this committee in a non-voting capacity.

(f) Surgery/Tissue/Transfusion/Anesthesia Committee

The Surgery/Tissue/Transfusion/Anesthesia (STTA) Committee represents all surgical, anesthesia, and pathology services. The director of perioperative nursing and the Administrator (or designee) shall serve as ex-officio non-voting members. Other departments may participate as needed by invitation. As available, the Administrator shall designate a District quality representative to this committee in a non-voting capacity.

## **XI.11-2 DUTIES**

The Medical Staff departmental committees listed in Section 11.12-1 are responsible for overseeing the quality and appropriateness of patient care rendered in the department by, without limitation:

- (a) Using critical indicators to conduct concurrent and retrospective peer review of medical records with referral for committee review as indicated;

- (b) Monitoring and evaluating clinical performance of all privileged practitioners attending patients or administering care in the department;
- (c) Periodically reviewing and evaluating the medical services provided;
- (d) Making recommendations concerning matters for which the committee is responsible to the Medical Executive Committee and the Administrator or Chief Medical Officer as appropriate;
- (e) Reviewing applicants for privileges when requested by the Department Chief;
- (f) Electing annually the departmental committee Chair, who presides over the meetings and attends the Medical Executive Committee meetings. This departmental committee Chair may or may not be the Chief of the department; and
- (g) Receiving reports from other committees as appropriate.

#### **XI.11-3 MEETINGS AND REPORTS**

The Medical Staff departmental committees shall meet at least quarterly. The committees shall report a summary of their activities or findings to the Medical Executive Committee on a regular basis. The committees shall also give notification to the Medical Executive Committee promptly after the committees receive notice of any matter for which a practitioner is required to give notice to the Medical Staff pursuant to these Bylaws, if not already reported.

## ARTICLE XII: MEETINGS

### XII.1 GENERAL MEDICAL STAFF MEETINGS

#### XII.1-1 REGULAR MEETINGS

Regular meetings of the Medical Staff members shall be held at least quarterly. The date, place and time of the regular meetings shall be determined by the Medical Executive Committee or the Chief of Staff, and adequate notice shall be given to the members.

#### XII.1-2 AGENDA

The order of business at a meeting of the Medical Staff shall be determined by the Chief of Staff and Medical Executive Committee. The agenda shall include, as applicable:

- (a) reading and acceptance of the minutes of the last regular and all special meetings held since the last regular meeting;
- (b) administrative reports from the Chief of Staff, departments, committees, , and the Administrator or designee;
- (c) election of officers when required by these Bylaws;
- (d) old business; and
- (e) new business.

#### XII.1-3 SPECIAL MEETINGS

Special meetings of the Medical Staff may be called at any time by the Chief of Staff or the Medical Executive Committee, or shall be called upon the written request of ten percent (10%) of the members of the active Medical Staff. The person calling or requesting the special meeting shall state the purpose of such meeting in writing. The meeting shall be scheduled as soon as reasonably possible, but within thirty (30) days after receipt of such request. Notice shall be given to the members of the staff with as much advance notice as possible, which includes the stated purpose of the meeting. No business shall be transacted at any special meeting except that stated in the notice calling the meeting.

### XII.2 COMMITTEE AND DEPARTMENT MEETINGS

#### XII.2-1 REGULAR MEETINGS

Except as otherwise specified in these Bylaws, the Chairs of Medical Staff and departmental committees may establish the times for the holding of regular meetings. The Chairs shall make every reasonable effort to ensure the meeting dates are disseminated to the members with adequate notice.

#### XII.2-2 SPECIAL MEETINGS

A special meeting of any Medical Staff committee or department may be called by the Chair thereof, the Medical Executive Committee, or the Chief of Staff.

### XII.3 QUORUM

#### XII.3-1 GENERAL MEDICAL STAFF MEETINGS

The presence of fifty percent (50%) of the total members of the active Medical Staff at any regular or special meeting in person or through written (electronic) ballot shall constitute a quorum for the purpose of the election or removal of Medical Staff Officers, or other special votes as determined by the Chief of Staff. The presence of twenty-five percent (25%) of members shall constitute a quorum for all other actions.

#### **XII.3-2 DEPARTMENT MEETINGS**

For department committees, a quorum shall consist of two physicians.

#### **XII.3-3 MEDICAL STAFF COMMITTEE MEETINGS**

A quorum of fifty percent (50%) of the voting members shall be required for medical executive meetings. For other Medical Staff committee meetings (e.g., utilization review, pharmacy and therapeutics), the presence of two (2) committee voting members shall constitute a quorum, unless otherwise specified in the committee composition.

### **XII.4 VOTING AND MANNER OF ACTION**

#### **XII.4-1 VOTING**

Unless otherwise specified in these Bylaws, only members of the active Medical Staff may vote in Medical Staff general meetings and elections. All members of the Medical Staff and APP staff are entitled to vote at committee and department meetings appropriate to their specialty as described at time of appointment.

#### **XII.4-2 MANNER OF ACTION**

Except as otherwise specified, the action of a majority of the members present and voting at a meeting at which a quorum is present shall be the action of the group. A meeting at which a quorum is initially present may continue to transact business notwithstanding the withdrawal of members, if any action taken is approved by at least a majority of the required quorum for such meeting, or such greater number as may be specifically required by these Bylaws. A meeting in which a quorum is not initially present may be started, though no action may be taken until a quorum is present. Committee and Medical Staff action may be conducted by telephone conference or other electronic communication. Votes collected by electronic means require a majority vote to be valid.

### **XII.5 MINUTES**

Except as otherwise specified herein, minutes of meetings shall be prepared and retained. They shall include, at a minimum, a record of the attendance of members and the vote taken on significant matters.

### **XII.6 ATTENDANCE REQUIREMENTS**

#### **XII.6-1 REGULAR ATTENDANCE**

Members are expected to attend all meetings of the Medical Staff and of the department or committee to which assigned. Attendance via telephone conference or other electronic communication shall be accepted. Each member of the consulting or courtesy staff shall be required to attend such meetings as may be determined by the Medical Executive Committee.

#### **XII.6-2 ABSENCE FROM MEETINGS**

Any member who is compelled to be absent from any Medical Staff, department, or committee meeting shall promptly provide to the regular presiding officer thereof the reason for such absence. Unless excused for good cause by the presiding officer of the department or committee, or the Medical Staff Office for Medical Staff meetings, failure to attend may be included in the practitioner's ongoing professional practice evaluation,

reviewed by the Medical Executive Committee, and may be grounds for removal from such committee or for corrective action.

### **XII.6-3 SPECIAL ATTENDANCE**

At the discretion of the Chair or presiding officer, when a member's practice or conduct is scheduled for discussion at a regular department or committee meeting, the member may be requested to attend. If a suspected deviation from standard clinical practice is involved, the notice shall be given at least seven (7) days prior to the meeting and shall include the time and place of the meeting and a general indication of the issue involved. Failure of a member to appear at any meeting to which notice was given, unless excused by the Medical Executive Committee upon a showing of good cause, shall be a basis for corrective action.

## **XII.7 CONDUCT OF MEETINGS**

Unless otherwise specified, meetings shall be conducted according to Robert's Rules of Order; however, technical or non-substantive departures from such rules shall not invalidate action taken at such a meeting.

## **XII.8 EXECUTIVE SESSION**

The Chairperson of any standing, special, or ad hoc committee of the Medical Staff, including departments, may call an executive session meeting. Only members of the active Medical Staff holding voting privileges on the committee shall attend the executive session meeting. The Chairperson, at his or her discretion, may request other individuals to attend the meeting in an informational capacity. Executive session may be called to discuss peer review issues, personnel issues, or any other sensitive issues requiring confidentiality.

## **ARTICLE XIII: CONFIDENTIALITY, IMMUNITY AND RELEASES**

### **XIII.1 AUTHORIZATION AND CONDITIONS**

By applying for or exercising clinical privileges within Northern Inyo Healthcare District, an applicant:

- (a) authorizes representatives of the District and the Medical Staff to solicit, provide, and act upon information bearing upon, or reasonably believed to bear upon, the applicant's professional ability and qualifications;
- (b) authorizes persons and organizations to provide information concerning such practitioner to the Medical Staff;
- (c) agrees to be bound by the provisions of this Article and to waive all legal claims against any representative of the Medical Staff or the District who would be immune from liability under Section 13.3 of this Article; and
- (d) acknowledges that the provisions of this Article are express conditions to an application for Medical Staff membership, the continuation of such membership, and to the exercise of clinical privileges at this District.

### **XIII.2 CONFIDENTIALITY OF INFORMATION**

#### **XIII.2-1 GENERAL**

The minutes, files, records and proceedings of the Medical Staff and all departments and standing or ad hoc committees, including information regarding any applicant, member or other individual exercising clinical privileges or practice privileges, shall be considered Medical Staff minutes or records and, to the fullest extent permitted by law, shall be confidential and protected from discovery pursuant to California Evidence Code Section 1157 and any other applicable peer review or other policy or privilege. This information shall become part of the Medical Staff committee files and shall not become part of any patient files, general District records, or any member's personal or office files.

Dissemination of such information and records shall only be made where expressly required by law, as authorized by these Bylaws, or pursuant to officially adopted policies of the Medical Staff or, where no officially adopted policy exists, only with the express approval of the Chief of Staff and the Administrator.

#### **XIII.2-2 BREACH OF CONFIDENTIALITY**

As effective peer review and consideration of the qualifications of Medical Staff members and applicants to perform specific procedures must be based on free and candid discussions, any breach of confidentiality of the discussions or deliberations of Medical Staff departments or committees, except in conjunction with other hospital, professional society, or licensing authority, is outside appropriate standards of conduct for this Medical Staff, violates the Medical Staff Bylaws, and will be deemed disruptive to the operations of the District. If it is determined that such a breach has occurred, the Medical Executive Committee may undertake such corrective action as it deems appropriate.

#### **XIII.2-3 ACCESS TO AND RELEASE OF CONFIDENTIAL INFORMATION**

All requests for access to Medical Staff records, including confidential committee records and credential files, shall be presented to an authorized representative. Authorized representatives include the authorized Medical Staff Office personnel and Medical Staff Officers.

- (a) Access for Official Purposes

- (1) The following individuals may access Medical Staff records, including confidential committee records and credentials files, to the extent described:
  - i. Committee members and their authorized representatives, for the purpose of conducting authorized committee functions.
  - ii. Medical staff and department officials, and their authorized representatives, for the purpose of fulfilling any authorized function of such official.
  - iii. The Administrator, the Board of Directors, and their authorized representatives, for the purpose of enabling them to discharge their lawful obligations and responsibilities. Information which is disclosed to the Board of Directors or its appointed representatives shall be maintained as confidential.
  - iv. Consultants or attorneys engaged by the District may be granted access to credential files that are necessary to enable them to perform their functions, if an authorized Medical Staff representative agrees.
  - v. Representatives of licensure agencies, accreditation agencies, or auditors from Medicare or Medicaid, if an authorized representative is with them.
- (2) All subpoenas pertaining to Medical Staff records, including confidential committee records and credentials files, shall be referred to the Medical Staff Office, who shall first consult with the Administrator, the Chief of Staff, and legal counsel regarding appropriate response.

(b) Limits on Access to Practitioner's Credentials File

- (1) A practitioner can view the contents of his or her credentials file, as described below, during normal business hours upon reasonable prior request to the Chief of Staff or Medical Staff Officer. The individual only has the right to review and receive a copy of documents provided by or addressed personally to the individual practitioner. The Medical Staff has discretion to disclose other documents to a member, but in no case shall copies of confidential letters of reference, hospital verifications or other confidential correspondence be disclosed. An individual practitioner may review the above identified parts of his or her credentials file under the following circumstances:
  - i. Review of the credentials file is accomplished in the presence of one of the following: authorized Medical Staff Office personnel, officer of the Medical Staff, a member of the Credentials Committee, or Department Chief.
  - ii. The practitioner understands that he or she may not remove any items from the credentials file.
  - iii. The practitioner understand that, subject to review by the Chief of Staff, he or she may add an explanatory note or other document to the file.
  - iv. The practitioner understands that he or she may not review confidential letters of reference, hospital verifications or other confidential correspondence received by the District or the Medical Staff.
  - v. Documents provided by the practitioner for inclusion in the credentials file (e.g., Curriculum Vitae, licenses, insurance policy, continuing medical education) may be

photocopied. No other items may be photocopied without the express permission of the credentials Chair.

(c) Medical Staff Committee Files and Minutes

- (1) Any member shall be allowed access to minutes or other Medical Staff records which describe meetings or activities of the Medical Staff committees that they were entitled to attend (e.g. their department committees of which they are members). This does not include minutes or records of meeting or activities from which the practitioner was specifically excluded.

### **XIII.3 IMMUNITY FROM LIABILITY**

#### **XIII.3-1 FOR ACTION TAKEN**

Each representative of the Medical Staff and District shall be immune, to the fullest extent provided by law, from liability to an applicant or member for damages or other relief for any action taken or statements or recommendations made within the scope of duties exercised as a representative of the Medical Staff or District.

#### **XIII.3-2 FOR PROVIDING INFORMATION**

Each representative of the Medical Staff and District and all third parties shall be immune, to the fullest extent provided by law, from liability to an applicant or member for damages or other relief by reason of providing information to a representative of the Medical Staff or District concerning such person who is, or has been, an applicant to or member of the staff or who did, or does, exercise clinical privileges or provide services at this District.

### **XIII.4 ACTIVITIES AND INFORMATION COVERED**

The confidentiality and immunity provided by this Article shall apply to all acts, communications, reports, recommendations or disclosures performed or made in connection with this or any other healthcare facility's or organization's activities concerning, but not limited to:

- (a) application for appointment, reappointment, or clinical privileges;
- (b) corrective action;
- (c) hearings and appellate reviews;
- (d) utilization reviews;
- (e) other department, committee or Medical Staff activities related to monitoring and maintaining quality patient care and appropriate professional conduct; and
- (f) queries and reports concerning the National Practitioner Data Bank, peer review organization, the Medical Board of California, and similar queries and reports.

### **XIII.5 RELEASES**

Each applicant or member shall, upon request of the Medical Staff or District, execute general and specific releases in accordance with the express provisions and general intent of this Article. Execution of such releases shall not be deemed a prerequisite to the effectiveness of this Article.

### **XIII.6 INDEMNIFICATION**

Northern Inyo Healthcare District shall indemnify, defend and hold harmless the Medical Staff, its individual members, and its appointed representatives (e.g. expert witnesses, lay committee members, hearing officers) from and against losses and expenses (including attorneys' fees, judgments, settlements, and all other costs, direct or indirect) incurred or suffered by reason of or based upon any threatened, pending or completed action, suit, proceeding, investigation, or other dispute relating or pertaining to any alleged act or failure to act within the scope of peer review, quality assessment, or activities related to establishing standards, policies and/or procedures pursuant to the self-governing Medical Staff provisions, including, but not limited to:

- (a) as a member of or witness for a Medical Staff department, service, committee or hearing panel;
- (b) as a member of or witness for the District Board or any District task force, group, or committee, and;
- (c) as a person providing information to any Medical Staff or hospital group, officer, Board member or employee for the purpose of aiding in the evaluation of the qualifications, fitness or character of a Medical Staff member or applicant.

The Medical Staff or member may seek indemnification for such losses and expenses under this Bylaws provision, statutory and case law, any available liability insurance or otherwise as the Medical Staff or member sees fit, and concurrently or in such sequence as the Medical Staff or member may choose. Payment of any losses or expenses by the Medical Staff or member is not a condition precedent to the District's indemnification obligations hereunder. In no event will the District indemnify an indemnitee for acts or omissions taken in bad faith or in pursuit of the indemnitee's private economic interests.

## ARTICLE XIV: GENERAL PROVISIONS

### XIV.1 DUES OR ASSESSMENTS

The Medical Executive Committee shall have the power to recommend the amount of annual dues or assessments, if any, for each category of Medical Staff membership, subject to the approval of the Medical Staff, and to determine the manner of expenditure of such funds received.

Failure of a member to pay dues or assessments, without good cause as determined by the Medical Executive Committee, will be included in the member's ongoing professional practice evaluation and may be grounds for corrective action.

### XIV.2 AUTHORITY TO ACT

Any member or members who act in the name of this Medical Staff without proper authority shall be subject to such disciplinary action as the Medical Executive Committee may deem appropriate.

### XIV.3 DIVISION OF FEES

Any division of fees by members of the Medical Staff is forbidden and any such division of fees shall be cause for exclusion or expulsion from the Medical Staff.

### XIV.4 NOTICES

Except where specific notice provisions are otherwise provided in these Bylaws, any and all notices, demands, requests required or permitted to be mailed shall be in writing properly sealed, and shall be sent through United States Postal Service. An alternative delivery mechanism may be used if it is reliable, as expeditious, and if evidence of its use is obtained. Notice to the Medical Staff or officers or committees thereof, shall be addressed as follows:

Name and proper title of addressee  
Name of department or committee  
*[c/o Medical Staff Office, Chief of Staff]*  
Hospital name  
Street address  
City, State, Zip code

Mailed notices to a member, applicant or other party shall be to the addressee at the address as it last appears in the official records of the Medical Staff or District.

### XIV.5 DISCLOSURE OF INTEREST

All nominees for election or appointment to Medical Staff Offices, Department Chief, or the Medical Executive Committee shall, at least twenty (20) days prior to the date of election or appointment, disclose in writing to the Medical Executive Committee those personal, professional, or financial affiliations or relationships of which they are reasonably aware which could foreseeably result in a conflict of interest with their activities or responsibilities on behalf of the Medical Staff. Further information on conflict of interest may be found in Northern Inyo Healthcare District's compliance program.

### XIV.6 RETALIATION PROHIBITED

Neither the Medical Staff, its members, committees or department heads, the Board of Directors, its Chief Executive Officer, or any other employee or agent of the District or Medical Staff, may engage in any punitive or retaliatory action

against any member of the Medical Staff because that member claims a right or privilege afforded by, or seeks implementation of any provision of, these Medical Staff Bylaws.

## ARTICLE XV: ADOPTION AND AMENDMENT OF BYLAWS AND POLICIES

### XV.1 BYLAWS

#### XV.1-1 PROCEDURE FOR PROPOSALS

Proposals to adopt, amend or repeal the Bylaws may be initiated by either of the following methods:

- (a) The Medical Executive Committee, with the recommendation of the Bylaws Committee, or on its own motion, may recommend adoption, amendment or repeal of the Bylaws to the voting members of the Medical Staff as provided in this Article.
- (b) The members of the active staff, by a written petition signed by at least twenty percent (20%) of the active staff members, may petition the Medical Executive Committee to initiate a proposal to adopt, amend or repeal the Bylaws. Such petition shall identify exact language to be added, changed or deleted. If the Medical Executive Committee agrees with the proposed change, it may recommend the change as provided in subsection (a), above.

#### XV.1-2 APPROVAL BY THE ACTIVE STAFF

If a proposal is initiated as provided above, the Chief of Staff shall inform the members of the active staff of the proposed change by mail, by electronic means, or at a meeting of the Medical Staff. Voting on proposals shall take place not less than thirty (30) days and not more than ninety (90) days from the date of such notice.

To be adopted, a proposed change must be approved by a majority of the members of the active staff.

#### XV.1-3 APPROVAL BY THE DISTRICT BOARD

Upon action by the active staff as provided above, the proposed change shall be submitted to the Board of Directors for approval. The Board of Directors may not unreasonably withhold its approval from the active staff's recommended change. If the Board of Directors votes to disapprove any part of the recommended change, the Board of Directors shall give the Chief of Staff written notice of the reasons for non-approval within ten (10) business days from the Board of Directors' action. At the request of the Medical Executive Committee, the Board of Directors' disapproval shall be submitted to the Joint Conference Committee for resolution.

### XV.2 MEDICAL STAFF POLICIES

#### XV.2-1 PROCEDURE FOR PROPOSALS

Proposals to adopt, amend or repeal the Medical Staff policies may be initiated by any active Medical Staff member or Medical Staff committee.

#### XV.2-2 APPROVAL

- (a) Approval by the appropriate Medical Staff committee(s), as applicable;
- (b) Approval by the Medical Executive Committee;
- (c) Approval by the active Medical Staff; and
- (d) Submission to the Board of Directors for approval. If the Board of Directors disapproves the policy, it will be referred back to the appropriate committee(s).

### XV.3 TECHNICAL AND EDITORIAL AMENDMENTS

Notwithstanding any other provision of the Bylaws to the contrary, the Medical Executive Committee shall have authority on behalf of the Medical Staff to approve such amendments to the Bylaws or policies as the Medical Executive Committee deems to be necessary or appropriate to correct or clarify punctuation, spelling, grammatical or expression errors or ambiguities; cross references; numbering or organization; names or titles of committees, officers, practitioner categories, or other such identifiers. The Medical Executive Committee shall give notice of such amendments to the Medical Staff members, the Administrator, and the District Board. Such amendments shall become effective upon approval by the District Board.

#### **XV.4 DISTRIBUTION OF APPROVED PROPOSALS**

Promptly after approval, and if reasonably practical, prior to the proposal's effective date, a copy of an approved proposal for Bylaws or policies changes shall be distributed to all members, applicants, and other privileged practitioners and APPs who hold any type of privileges pursuant to the Bylaws.

The Northern Inyo Healthcare District Medical Staff Bylaws are:

ADOPTED by the Medical Staff on

\_\_\_\_\_, 20\_\_\_\_  
Date

\_\_\_\_\_  
Chief of Staff

\_\_\_\_\_  
Vice Chief of Staff

APPROVED by the Board of Directors on

\_\_\_\_\_, 20\_\_\_\_  
Date

\_\_\_\_\_  
Board Chair

\_\_\_\_\_  
Board Secretary



DATE: June 2026  
TO: Board of Directors, Northern Inyo Healthcare District  
FROM: Alison Murray, CHRO  
RE: NIHD Workforce Housing Needs

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## MEMORANDUM

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### **Background**

Northern Inyo Healthcare District recruits healthcare professionals from both within and outside the Eastern Sierra region. For employees relocating to the area, housing is often a significant factor in their decision to accept employment and can impact the onboarding process.

### **Discussion**

The District's workforce housing needs include travelers, locum providers, contract staff, and employees relocating to the community for permanent positions.

Travelers and contract staff generally require furnished, move-in-ready housing for assignments lasting a minimum of thirteen weeks. These accommodations typically include furnishings, utilities, internet service, and other basic household items. Because travelers often arrive with only personal belongings, readily available housing is important to ensure a smooth transition into their assignment.

Employees relocating for permanent positions may need short-term housing while securing permanent accommodations or may seek long-term housing options within the community. Housing needs vary based on household size, pets, and individual family circumstances. Depending on the employee's needs, both furnished and unfurnished housing options may be utilized.

Human Resources staff regularly assist prospective and newly hired employees with identifying available housing resources. Limited housing availability can create challenges during recruitment and onboarding, particularly for candidates relocating from outside the area.

Access to additional workforce housing opportunities would provide more reliable housing options for travelers, contractors, and relocating employees. It would also support recruitment and retention efforts, reduce delays in filling critical positions, and help establish a more consistent source of workforce housing within the local community.

### **Recommendation**

Consider the District's current and future workforce housing needs and review the proposed Memorandum of Understanding related to potential workforce housing opportunities at Bishop Commons.



DATE: June 2026  
TO: Board of Directors, Northern Inyo Healthcare District  
FROM: Christian Wallis, CEO  
RE: Bishop Commons Worker Housing Memorandum of Understanding

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## MEMORANDUM

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### **Background**

At the May 20, 2026 Board meeting, Foothill Partners presented the proposed Bishop Commons development project for the former Kmart property in Bishop. The project includes approximately 104 workforce housing units, redevelopment of the existing retail center, and additional commercial development, with anticipated completion in early 2028.

Foothill Partners has requested that major employers and public agencies execute a Memorandum of Understanding (MOU) expressing interest in potentially leasing workforce housing units upon project completion. The developer intends to use these expressions of interest to demonstrate community demand and support ongoing project planning and financing efforts. The proposed MOU is non-binding and does not obligate the District to lease units, commit funds, or enter into a future lease agreement.

### **Discussion**

Workforce housing remains a challenge for healthcare recruitment and retention throughout the Eastern Sierra. Northern Inyo Healthcare District currently assists some employees with housing placement and continues to experience challenges recruiting employees relocating to the area. Additional workforce housing opportunities may support future recruitment and retention efforts.

According to information provided by Foothill Partners, Bishop Unified School District has executed an MOU. The developer has also indicated that Mammoth Hospital, Mammoth Resorts, Albertsons/Vons, and other employers are evaluating participation. Foothill Partners further reported that some public agencies have determined they do not currently have a workforce housing need or available resources to support participation at this time.

Current draft terms include monthly rent of \$1,800 per unit, annual rent increases of 3%, utilities paid separately, and a three-year lease term. Any future lease commitment would be subject to separate evaluation and approval by the District.

### **Recommendation**

Authorize the Chief Executive Officer to execute the non-binding Bishop Commons Worker Housing Memorandum of Understanding on behalf of Northern Inyo Healthcare District.



January 1, 2026 Pension Valuation Review

# Northern Inyo County Local Hospital District Retirement Plan

USI Consulting Group  
May 1, 2026



# Purpose of the Valuation

- The ultimate cost of a pension plan is based primarily on the level of benefits promised by the plan. The pension fund's investment earnings serve to reduce the cost of plan benefits and expenses. Thus,

<i>Hospital's Ultimate Cost</i>	=	<i>Benefits Paid</i>	+	<i>Expenses Incurred</i>	-	<i>Investment Return</i>	-	<i>Employee Contributions</i>
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- Actuarial Valuation utilizes an actuarial cost method to assign a portion of this “ultimate cost” to the budget year. The valuation does not determine the cost of the plan but is a tool used to determine the appropriate level of Hospital contributions.
- Actuarially Determined Employer Contribution (ADEC) developed from the valuation is comprised of two components: amortization of the unfunded liability & normal cost (assignment of benefits “earned” for the budget year).

# FY 26/27 Contribution (ADEC)

	January 1, 2026	January 1, 2025
<b>Number of members</b>		
Active employees	67	71
Terminated vested members	60	64
Retired, disabled and beneficiaries	26	21
Total	153	156
<b>Covered employee payroll</b>	8,034,274	8,545,281
<b>Average plan salary</b>	119,915	120,356
<b>Actuarial present value of future benefits</b>	55,512,747	53,640,408
<b>Actuarial accrued liability</b>	51,598,818	49,271,433
<b>Plan assets</b>		
Market value of assets	23,465,847	17,397,175
Actuarial value of assets	23,465,847	17,397,175
<b>Unfunded accrued liability</b>	28,132,971	31,874,258
<b>Funded ratio</b>	45.5%	35.3%
<b>Actuarially determined employer contribution (ADEC)</b>		
Fiscal year ending	2027	2026
ADEC	3,143,067	3,452,654

# Contribution Analysis

## Liability Gains and Losses

- Liability gains and losses occur when actual experience does not perfectly match the expectation in the assumptions. For example, pay is higher/lower than expected or there are more/fewer deaths or terminations than anticipated.
- The difference in liability between expected and actual is studied each year to ensure that the assumptions being used are appropriate.
- For the January 1, 2026 valuation, actual liabilities were about 1.1% lower than expected. The primary reasons for this were:
  - Lower than expected salary increases on average for active employees. Many active employees had slightly lower earnings in 2025 than in 2024.
  - The above gain was partially offset by new retiree losses (new retirees electing annuity over lump sum which is less costly)

# Contribution Analysis

## Asset Gains and Losses

- Assets were expected to return 6.25% during 2025 which is the long term investment rate of return assumption
- Actual return on the Market Value of Assets was 16.8%, which was greater than the expectation
- The asset gain relative the expectation of 6.25% was about \$1.96 million, representing a reduction in contribution of approximately \$186,000
- The plan is well funded enough that might consider a change next year to use an Actuarial Value of Assets in determining contributions rather than the straight market value
- The Actuarial Value of Assets is designed to smooth gains or losses in the market over a 4 or 5 year period. The result is more contribution stability year over year as the market can be unpredictable
- Can revisit next year whether a change to using an Actuarial Value of Assets makes sense

# Asset Reconciliation

Summary of Fund Activity	
<b>1. Beginning market value of assets January 1, 2025</b>	
Trust assets	\$17,397,175
<b>2. Contributions</b>	
Hospital contributions during year	3,503,427
Employee contributions during year	311,894
Total for plan year	3,815,321
<b>3. Disbursements</b>	
Benefit payments during year	889,316
Administrative expenses during year	7,988
Total for plan year	897,304
<b>4. Net investment return</b>	
Interest and dividends	540,543
Realized and unrealized gain / (loss)	2,610,112
Investment-related expenses	0
Total for plan year	3,150,655
<b>5. Ending market value of assets January 1, 2026</b>	
Trust assets: (1) + (2) - (3) + (4)	23,465,847
<b>6. Approximate rate of return</b>	
	16.8%

# Contribution Calculation

- **Actuarially Determined Employer Contribution (ADEC)** is the sum of two components: 1) Amortization of Unfunded Liability + 2) Normal Cost.
- The **unfunded liability (Liability less Market Value of Assets)** is amortized over a 16 year period. The 16 years reduces by one each year to an ultimate period of 15. Unfunded liability as of January 1, 2026: \$28.1 million (was \$31.9 million in 2024). Reduction due to higher than expected asset returns and lower than expected liability.
- The **Normal Cost** represents the value of benefits that are allocated to the upcoming fiscal year under the actuarial cost method (i.e. the value your active employees are accruing due to additional service and salary increases).
- The Hospital's Contribution is calculated as follows:

Payment on the Unfunded Liability	\$2,665,000
Normal Cost	\$574,000
Expected Employee Contributions	(\$281,000)
Adjustment for Interest	<u>\$185,000</u>
<b>Total Hospital Contribution</b>	<b>\$3,143,000</b>

# Contribution Payments

- The Hospital's policy has been to contribute the contribution in monthly installments from July through June. Continuing this policy would calculate to a monthly contribution from July 1, 2026 to June 30, 2027 of \$261,923
- The monthly contribution from 2025 to 2026 is \$287,721
- To date the Hospital has made the following contributions:

<u>Date</u>	<u>Employer</u>
7/22/2025	290,000.00
8/19/2025	290,000.00
9/23/2025	290,000.00
10/21/2025	290,000.00
11/20/2025	290,000.00
12/30/2025	290,000.00
1/20/2026	290,000.00
2/24/2026	290,000.00
3/17/2026	290,000.00



# Questions



This information is provided solely for educational purposes and is not to be construed as investment, legal or tax advice. Prior to acting on this information, we recommend that you seek independent advice specific to your situation from a qualified investment/legal/tax professional.

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DATE: June 2026  
TO: Board of Directors, Northern Inyo Healthcare District  
FROM: Andrea Mossman, Chief Financial Officer  
RE: Financial Summary and Operation Insights April 2026

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## Financial Performance

April closed with a net loss of \$1.0 million, which was \$486,000 unfavorable to budget. Operating loss for the month was \$1.9 million, or \$1.1 million below budget.

The primary driver of the variance was a one-time correcting entry recorded in April to reverse a duplicate revenue interface transaction that was originally posted in January. The adjustment reduced April net patient revenue by approximately \$1.0 million. While the correction negatively impacted April results, it does not affect year-to-date performance, and year-to-date revenue is now accurately stated.

**Key Takeaway:** April results were significantly impacted by a one-time \$1.0 million revenue correction related to a duplicate January interface transaction. Following this adjustment, year-to-date financial results accurately reflect hospital operations.

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## Volume and Operational Metrics

Patient activity remained strong during April, with several key volume indicators exceeding budget:

- Admissions exceeded budget by 21 cases.
- Inpatient days (excluding nursery) exceeded budget by 82 days, an increase of 55%.
- Average Daily Census was 55% above budget.
- Diagnostic Imaging volumes exceeded budget by 11%.

Areas below budget included:

- Surgeries were 11 cases below budget (-7%). Orthopedic and general surgery volumes increased, offset by lower ophthalmology volumes following a physician retirement.
- Emergency Department visits were 3% below budget.
- Rehabilitation visits were 19% below budget.
- Rural Health Clinic visits were 14% below budget.

**Key Takeaway:** Inpatient demand remained strong and exceeded expectations; however, outpatient activity, including clinic visits, rehabilitation services, emergency department visits, and surgical volumes, continued to lag budget.

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## Revenue and Deductions

Gross patient revenue exceeded budget by \$1.8 million, driven by stronger-than-expected patient volumes and an unbudgeted rate increase. These favorable factors were partially offset by the \$1.0 million revenue correction recorded during the month.

Contractual deductions and allowances exceeded budget by \$1.7 million, reflecting both the higher gross revenue levels and the January revenue correction. As a result, net revenue yield was approximately 3% below budget for the month.

Despite the April adjustment, year-to-date net patient revenue remains favorable to budget by \$3.5 million, or 4%.

**Key Takeaway:** Underlying revenue performance remains positive, supported by higher patient volumes and improved reimbursement rates. The April variance reflects a one-time accounting correction rather than a deterioration in revenue trends.

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## Expense Performance

Total operating expenses exceeded budget by \$1.4 million (14%) during April. Key drivers included:

- Salaries and wages were 16% above budget, primarily due to compensation adjustments not included in the original budget.
- Supply expense exceeded budget by \$337,000, consistent with higher patient volumes.
- Professional fees exceeded budget by \$484,000, reflecting increased physician-related expenses and revenue cycle investments that are supporting improved collections performance.

Despite these pressures, salary, wage, and benefit expense per adjusted patient day remained 24% below budget, demonstrating improved productivity and effective leverage of higher patient volumes.

**Key Takeaway:** Expense pressures continue, particularly in labor and professional services; however, productivity metrics remain favorable and partially offset the impact of rising costs.

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## Labor and Workforce

Labor management remains a key operational focus.

- Contract labor expense exceeded budget by \$73,000.
- Contract labor full-time equivalents were approximately 2% below budget.
- Agency labor rates remained elevated, particularly within Labor and Delivery staffing.
- Salary, wage, and benefit expense represented 52% of total operating expenses, compared to the organizational target of 50% or less.

**Key Takeaway:** The organization continues to reduce dependence on contract labor while maintaining staffing levels necessary to support patient care. Workforce optimization efforts remain ongoing.

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## Cash and Liquidity

Liquidity and cash flow indicators continued to strengthen during April.

- Days Cash on Hand was 103 days, supported in part by a one-time Employee Retention Credit (ERC) receipt of approximately \$4.0 million.
- Unrestricted cash totaled \$34.0 million, an increase of \$19.6 million compared to the prior year.
- Revenue cycle performance continued to improve:
  - o Accounts receivable days decreased by 19 days year over year.
  - o Bad debt and write-offs were \$330,000 below budget.
  - o Accounts receivable balances greater than 90 days declined by \$2.8 million year over year.

**Key Takeaway:** The hospital's liquidity position remains strong. Continued improvements in revenue cycle performance are accelerating cash collections and strengthening overall financial stability.

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## Overall Assessment

Operational performance remained solid during April, with inpatient volumes continuing to outperform budget and year-to-date net revenue exceeding expectations. While April's reported loss was impacted by a one-time \$1.0 million revenue correction, the adjustment ensures that year-to-date financial results are accurate and reliable. The organization continues to make progress in revenue cycle performance, liquidity, and workforce stabilization, while closely managing ongoing labor and operating cost pressures.

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### Strategic Focus / Action Plan

- Continue **growth in orthopedic and general surgery volumes**
  - Improve **OR and clinic scheduling efficiency**
  - Advance **revenue cycle optimization** (denials, coding, collections)
  - Maintain focus on **labor productivity and cost control**
  - Expand **orthopedic program outreach**, including Ridgecrest market
- 

### **Overall Summary**

April results reflect **lower than budget due to correcting entry of \$1M from January**. However, April was driven by strong volumes and early success in revenue cycle initiatives. While **expense pressures persist**, particularly in labor and benefits, **cash flow and margin trends are moving in a positive direction**.

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### Northern Inyo Healthcare District April 2026 – Financial Summary

	Current Month				Prior MTD			Year to Date				Prior YTD		
	Actual	Budget	Variance	Variance %	Actual	Change	Change %	Actual	Budget	Variance	Variance %	Actual	Change	Change %
** Variances are B / (W)														
<b>Net Income (Loss)</b>	(1,013,007)	(527,473)	(485,534)	92%	(3,722,346)	2,709,339	73%	4,431,616	4,953,593	(521,977)	11%	4,965,178	(533,561)	(11%)
<b>Operating Income (Loss)</b>	(1,892,040)	(778,786)	(1,113,254)	143%	(4,558,891)	2,666,851	58%	(11,324,447)	(7,831,817)	(3,492,630)	(45%)	(7,280,385)	(4,044,062)	56%
<b>EBIDA (Loss)</b>	(514,664)	(110,319)	(404,344)	367%	(3,313,182)	2,798,519	84%	9,073,620	9,125,132	(51,512)	1%	9,152,696	(79,077)	(1%)
IP Gross Revenue	3,901,381	3,596,335	305,046	8%	3,003,097	898,284	30%	40,677,762	36,442,862	4,234,900	12%	37,402,197	3,275,565	9%
OP Gross Revenue	15,480,289	14,221,947	1,258,342	9%	13,297,993	2,182,296	16%	146,837,382	143,838,598	2,998,785	2%	139,411,989	7,425,393	5%
Clinic Gross Revenue	1,939,954	1,727,250	212,704	12%	1,891,743	48,211	3%	19,756,097	17,566,564	2,189,532	12%	17,612,381	2,143,715	12%
<b>Total Gross Revenue</b>	<b>21,321,624</b>	<b>19,545,532</b>	<b>1,776,092</b>	<b>9%</b>	<b>18,192,833</b>	<b>3,128,791</b>	<b>17%</b>	<b>207,271,241</b>	<b>197,848,024</b>	<b>9,423,217</b>	<b>5%</b>	<b>194,426,567</b>	<b>12,844,674</b>	<b>7%</b>
<b>Net Patient Revenue</b>	<b>9,166,983</b>	<b>8,925,676</b>	<b>241,307</b>	<b>3%</b>	<b>5,398,149</b>	<b>3,768,833</b>	<b>70%</b>	<b>93,767,496</b>	<b>90,233,479</b>	<b>3,534,017</b>	<b>4%</b>	<b>88,385,178</b>	<b>5,382,318</b>	<b>6%</b>
<i>Cash Net Revenue % of Gross</i>	<i>43%</i>	<i>46%</i>	<i>(3%)</i>	<i>(6%)</i>	<i>30%</i>	<i>13%</i>	<i>45%</i>	<i>45%</i>	<i>46%</i>	<i>(0%)</i>	<i>(1%)</i>	<i>45%</i>	<i>(0%)</i>	<i>(0%)</i>
<b>Admits (excl. Nursery)</b>	72	51	21	41%	51	21	41%	722	697	25	4%	697	25	4%
<b>IP Days</b>	257	171	85	50%	171	85	50%	2,393	2,393	1	0%	2,393	1	0%
<b>IP Days (excl. Nursery)</b>	232	150	82	55%	150	82	55%	2,058	2,060	(2)	(0%)	2,060	(2)	(0%)
<b>Average Daily Census</b>	7.7	5.0	2.7	55%	5.0	2.7	55%	6.8	6.8	(0.0)	(0%)	6.8	(0.0)	(0%)
<b>ALOS</b>	3.2	2.9	0.3	10%	2.9	0.3	10%	2.9	3.0	(0.1)	(4%)	3.0	(0.1)	(4%)
<b>Deliveries</b>	12	8	4	50%	8	4	50%	165	168	(3)	(2%)	168	(3)	(2%)
<b>OP Visits</b>	4,519	4,577	(58)	(1%)	4,577	(58)	(1%)	40,751	39,765	986	2%	39,765	986	2%
Rural Health Clinic Visits	2,258	2,587	(329)	(13%)	2,587	(329)	(13%)	23,243	23,122	121	1%	23,122	121	1%
Rural Health Women Visits	570	582	(12)	(2%)	582	(12)	(2%)	5,443	5,211	232	4%	5,211	232	4%
Rural Health Behavioral Visits	108	236	(128)	(54%)	236	(128)	(54%)	1,150	2,036	(886)	(44%)	2,036	(886)	(44%)
<b>Total RHC Visits</b>	<b>2,936</b>	<b>3,405</b>	<b>(469)</b>	<b>(14%)</b>	<b>3,405</b>	<b>(469)</b>	<b>(14%)</b>	<b>29,836</b>	<b>30,369</b>	<b>(533)</b>	<b>(2%)</b>	<b>30,369</b>	<b>(533)</b>	<b>(2%)</b>
Bronco Clinic Visits	40	22	18	82%	22	18	82%	367	374	(7)	(2%)	374	(7)	(2%)
Internal Medicine Clinic Visits	-	-	-	-%	-	-	-%	-	-	-	-%	-	-	-%
Orthopedic Clinic Visits	350	342	8	2%	342	8	2%	3,328	3,500	(172)	(5%)	3,500	(172)	(5%)
Pediatric Clinic Visits	546	562	(16)	(3%)	562	(16)	(3%)	5,825	5,977	(152)	(3%)	5,977	(152)	(3%)
Specialty Clinic Visits	774	643	131	20%	643	131	20%	6,768	5,469	1,299	24%	5,469	1,299	24%
Surgery Clinic Visits	177	163	14	9%	163	14	9%	1,477	1,559	(82)	(5%)	1,559	(82)	(5%)
Virtual Care Clinic Visits	-	56	(56)	(100%)	56	(56)	(100%)	309	576	(267)	(46%)	576	(267)	(46%)
<b>Total NIA Clinic Visits</b>	<b>1,887</b>	<b>1,788</b>	<b>99</b>	<b>6%</b>	<b>1,788</b>	<b>99</b>	<b>6%</b>	<b>18,074</b>	<b>17,455</b>	<b>619</b>	<b>4%</b>	<b>17,455</b>	<b>619</b>	<b>4%</b>
IP Surgeries	14	20	(6)	(30%)	20	(6)	(30%)	115	116	(1)	(1%)	116	(1)	(1%)
OP Surgeries	132	137	(5)	(4%)	137	(5)	(4%)	1,251	1,294	(43)	(3%)	1,294	(43)	(3%)
<b>Total Surgeries</b>	<b>146</b>	<b>157</b>	<b>(11)</b>	<b>(7%)</b>	<b>157</b>	<b>(11)</b>	<b>(7%)</b>	<b>1,366</b>	<b>1,410</b>	<b>(44)</b>	<b>(3%)</b>	<b>1,410</b>	<b>(44)</b>	<b>(3%)</b>
Cardiology	6	-	6	-%	-	6	100%	26	4	22	550%	4	22	550%
General	86	71	15	21%	71	15	21%	796	707	89	13%	707	89	13%
Gynecology & Obstetrics	12	16	(4)	(25%)	16	(4)	(25%)	109	118	(9)	(8%)	118	(9)	(8%)
Ophthalmology	-	45	(45)	(100%)	45	(45)	(100%)	68	250	(182)	(73%)	250	(182)	(73%)
Orthopedic	29	8	21	263%	8	21	263%	220	196	24	12%	196	24	12%
Pediatric	-	-	-	-%	-	-	-%	-	1	(1)	(100%)	1	(1)	(100%)
Plastics	-	1	(1)	(100%)	1	(1)	(100%)	2	2	-	-%	2	-	-%
Podiatry	-	-	-	-%	-	-	-%	3	6	(3)	(50%)	6	(3)	(50%)
Urology	13	16	(3)	(19%)	16	(3)	(19%)	142	123	19	15%	123	19	15%
<b>Diagnostic Image Exams</b>	2,311	2,081	230	11%	2,081	230	11%	22,228	20,872	1,356	6%	20,872	1,356	6%
<b>Emergency Visits</b>	767	794	(27)	(3%)	794	(27)	(3%)	8,432	8,431	1	0%	8,431	1	0%
<b>ED Admits</b>	46	23	23	100%	23	23	100%	442	413	29	7%	413	29	7%
<b>ED Admits % of ED Visits</b>	6%	3%	3%	107%	3%	3%	107%	5%	5%	0%	7%	5%	0%	7%
<b>Rehab Visits</b>	944	1,161	(217)	(19%)	1,161	(217)	(19%)	8,098	8,580	(482)	(6%)	8,580	(482)	(6%)
<b>OP Infusion/Wound Care Visits</b>	932	646	286	44%	646	286	44%	6,574	5,645	929	16%	5,645	929	16%
<b>Observation Hours</b>	1,333	1,304	29	2%	1,304	29	2%	12,279	14,963	(2,684)	(18%)	14,963	(2,684)	(18%)

**Northern Inyo Healthcare District**  
**April 2026 – Financial Summary**

\*\* Variances are B / (W)

**PAYOR MIX (Patient Days)**

	Current Month				Prior MTD			Year to Date				Prior YTD		
	Actual	Budget	Variance	Variance %	Actual	Change	Change %	Actual	Budget	Variance	Variance %	Actual	Change	Change %
Blue Cross	14.4%	25.3%	(10.9%)	(43.2%)	25.3%	(10.9%)	(43.2%)	23.0%	23.9%	(0.9%)	(3.7%)	23.9%	(0.9%)	(3.7%)
Commercial	10.2%	13.9%	(3.6%)	(26.1%)	13.9%	(3.6%)	(26.1%)	6.5%	7.7%	(1.2%)	(15.1%)	7.7%	(1.2%)	(15.1%)
Medicaid	18.7%	14.4%	4.3%	29.8%	14.4%	4.3%	29.8%	22.1%	27.2%	(5.1%)	(18.7%)	27.2%	(5.1%)	(18.7%)
Medicare	52.8%	43.8%	9.1%	20.7%	43.8%	9.1%	20.7%	46.2%	38.8%	7.4%	19.1%	38.8%	7.4%	19.1%
Self-pay	2.5%	2.7%	(0.3%)	(9.4%)	2.7%	(0.3%)	(9.4%)	2.0%	2.0%	0.0%	1.6%	2.0%	0.0%	1.6%
Worker's Comp	1.4%	-%	1.4%	-%	-%	1.4%	-%	0.1%	0.4%	(0.2%)	(62.9%)	0.4%	(0.2%)	(62.9%)
Other	-%	-%	-%	-%	-%	-%	-%	-%	0.0%	(0.0%)	(100.0%)	0.0%	(0.0%)	(100.0%)

**PAYOR MIX (Gross Revenue)**

Blue Cross	28.1%	27.6%	0.5%	2.0%	27.6%	0.5%	2.0%	28.3%	26.7%	1.6%	5.9%	26.7%	1.6%	5.9%
Commercial	7.7%	6.9%	0.8%	12.0%	6.9%	0.8%	12.0%	6.5%	7.0%	(0.6%)	(8.0%)	7.0%	(0.6%)	(8.0%)
Medicaid	16.0%	17.0%	(1.0%)	(6.0%)	17.0%	(1.0%)	(6.0%)	17.7%	19.4%	(1.7%)	(8.8%)	19.4%	(1.7%)	(8.8%)
Medicare	45.0%	46.3%	(1.3%)	(2.8%)	46.3%	(1.3%)	(2.8%)	44.6%	43.3%	1.3%	3.1%	43.3%	1.3%	3.1%
Self-pay	2.0%	1.2%	0.8%	62.5%	1.2%	0.8%	62.5%	1.9%	2.2%	(0.4%)	(16.3%)	2.2%	(0.4%)	(16.3%)
Worker's Comp	1.1%	0.9%	0.2%	21.5%	0.9%	0.2%	21.5%	0.8%	1.1%	(0.3%)	(26.4%)	1.1%	(0.3%)	(26.4%)
Other	0.2%	0.2%	0.0%	9.2%	0.2%	0.0%	9.2%	0.2%	0.2%	0.0%	11.4%	0.2%	0.0%	11.4%

**DEDUCTIONS**

Contract Adjust	(11,804,084)	(9,622,417)	(2,181,667)	23%	(8,841,205)	(2,962,879)	34%	(106,793,268)	(97,507,156)	(9,286,112)	10%	(93,650,705)	(13,142,563)	14%
Bad Debt	26,871	(115,868)	142,739	(123%)	(3,774,465)	3,801,335	(101%)	(3,749,228)	(1,174,129)	(2,575,099)	219%	(4,133,621)	384,393	(9%)
Write-off	(377,429)	(707,802)	330,374	(47%)	(179,014)	(198,415)	111%	(4,270,979)	(7,172,395)	2,901,415	(40%)	(8,108,881)	3,837,902	(47%)

**CENSUS**

Patient Days	232	150	82	55%	150	82	55%	2,058	2,060	(2)	(0%)	2,060	(2)	(0%)
Adjusted ADC	42	28	15	53%	28	15	53%	35	35	(0)	(0%)	35	(0)	(0%)
Adjusted Days	1,266	907	359	40%	907	359	40%	10,488	10,708	(220)	(2%)	10,708	(220)	(2%)
Employed FTE	387.4	383.0	4.3	1%	383.0	4.3	1%	379.7	369.2	10.5	3%	369.2	10.5	3%
Contract Labor FTE	20.8	21.3	(0.5)	(2%)	21.3	(0.5)	(2%)	19.7	24.7	(5.0)	(20%)	24.7	(5.0)	(20%)
Total Paid FTE	408.1	404.3	3.8	1%	404.3	3.8	1%	399.4	393.8	5.6	1%	393.8	5.6	1%
EPOB (Employee per Occupied Bed)	1.8	2.7	(0.9)	(35%)	2.7	(0.9)	(35%)	2.0	1.9	0.0	1%	1.9	0.0	1%
EPOC (Employee per Occupied Case)	0.3	0.5	(0.2)	(34%)	0.5	(0.2)	(34%)	0.0	0.0	0.0	2%	0.0	0.0	2%
Adjusted EPOB	9.6	16.4	(6.7)	(41%)	16.4	(6.7)	(41%)	10.0	10.1	(0.1)	(1%)	10.1	(0.1)	(1%)
Adjusted EPOC	1.8	3.0	(1.2)	(40%)	3.0	(1.2)	(40%)	0.2	0.2	(0.0)	(0%)	0.2	(0.0)	(0%)

**SALARIES**

Per Adjust Bed Day	3,042	3,668	(626)	(17%)	4,194	(1,152)	(27%)	3,529	3,123	406	13%	3,068	461	15%
Total Salaries	3,851,445	3,326,869	524,576	16%	3,803,369	48,077	1%	37,012,727	33,446,626	3,566,100	11%	32,848,488	4,164,239	13%
Average Hourly Rate	58.00	50.67	7.33	14%	57.92	0.08	0%	56.11	52.15	3.96	8%	51.22	4.89	10%
Employed Paid FTEs	387.4	383.0	4.3	378.7	383.0	4.3	379.7	369.2	10.5	3%	369.2	10.5	3%	

**BENEFITS**

Per Adjust Bed Day	1,005	1,642	(638)	(39%)	1,561	(556)	(36%)	1,384	1,407	(22)	(2%)	1,407	(23)	(2%)
Total Benefits	1,271,979	1,489,410	(217,431)	(15%)	1,415,779	(143,800)	(10%)	14,518,099	15,061,429	(543,330)	(4%)	15,071,027	(552,928)	(4%)
Benefits % of Wages	33%	45%	(12%)	(26%)	37%	(4%)	(11%)	39%	45%	(6%)	(13%)	46%	(7%)	(15%)
Pension Expense	358,955	381,274	(22,319)	(6%)	377,313	(18,358)	(5%)	3,574,922	3,864,945	(290,023)	(8%)	3,936,545	(361,623)	(9%)
MDV Expense	634,768	756,922	(122,155)	(16%)	743,662	(108,894)	(15%)	7,685,918	7,670,147	15,772	0%	7,834,990	(149,071)	(2%)
Taxes, PTO accrued, Other	278,257	351,214	(72,957)	(21%)	294,805	(16,548)	(6%)	3,257,259	3,526,338	(269,079)	(8%)	3,299,492	(42,233)	(1%)
<b>Salaries, Wages &amp; Benefits</b>	<b>5,123,424</b>	<b>4,816,279</b>	<b>307,146</b>	<b>6%</b>	<b>5,219,148</b>	<b>(95,723)</b>	<b>(2%)</b>	<b>51,530,826</b>	<b>48,508,055</b>	<b>3,022,770</b>	<b>6%</b>	<b>47,919,515</b>	<b>3,611,311</b>	<b>8%</b>
<b>SWB/APD</b>	<b>4,046</b>	<b>5,310</b>	<b>(1,264)</b>	<b>(24%)</b>	<b>5,755</b>	<b>(1,708)</b>	<b>(30%)</b>	<b>4,913</b>	<b>4,530</b>	<b>383</b>	<b>8%</b>	<b>4,475</b>	<b>438</b>	<b>10%</b>
<b>SWB % of Total Expenses</b>	<b>46%</b>	<b>50%</b>	<b>(3%)</b>	<b>(7%)</b>	<b>52%</b>	<b>(6%)</b>	<b>(12%)</b>	<b>49%</b>	<b>49%</b>	<b>(0%)</b>	<b>(1%)</b>	<b>50%</b>	<b>(1%)</b>	<b>(2%)</b>

**Northern Inyo Healthcare District**  
**April 2026 – Financial Summary**

\*\* Variances are B / (W)

**PROFESSIONAL FEES**

Per Adjust Bed Day  
 Total Physician Fee  
 Total Contract Labor  
 Total Other Pro-Fees  
 Total Professional Fees  
 Contract AHR  
 Contract Paid FTEs  
 Physician Fee per Adjust Bed Day

**PHARMACY**

Per Adjust Bed Day  
 Total Rx Expense

**MEDICAL SUPPLIES**

Per Adjust Bed Day  
 Total Medical Supplies

**EHR SYSTEM**

Per Adjust Bed Day  
 Total EHR Expense

**OTHER EXPENSE**

Per Adjust Bed Day  
 Total Other

**DEPRECIATION AND AMORTIZATION**

Per Adjust Bed Day  
 Total Depreciation and Amortization

**TOTAL EXPENSES**

Per Adjust Bed Day  
 Per Calendar Day

	Current Month				Prior MTD			Year to Date				Prior YTD		
	Actual	Budget	Variance	Variance %	Actual	Change	Change %	Actual	Budget	Variance	Variance %	Actual	Change	Change %
Per Adjust Bed Day	2,522	2,987	(465)	(16%)	3,074	(553)	(18%)	2,819	2,578	242	9%	2,409	411	17%
Total Physician Fee	2,127,062	1,698,925	428,137	25%	1,656,184	470,878	28%	18,041,459	17,088,308	953,151	6%	15,849,948	2,191,512	14%
Total Contract Labor	426,165	353,063	73,103	21%	452,748	(26,583)	(6%)	3,454,732	3,925,560	(470,828)	(12%)	4,439,600	(984,868)	(22%)
Total Other Pro-Fees	639,487	657,063	(17,577)	(3%)	679,353	(39,866)	(6%)	8,073,288	6,587,810	1,485,478	23%	5,503,662	2,569,627	47%
Total Professional Fees	3,192,714	2,709,051	483,663	18%	2,788,285	404,429	15%	29,569,479	27,601,678	1,967,802	7%	25,793,209	3,776,270	15%
Contract AHR	119.58	96.73	22.85	24%	124.04	(4.46)	(4%)	101.10	91.65	9.44	10%	103.65	(2.56)	(2%)
Contract Paid FTEs	20.8	21.3	(0.5)	(2%)	21.3	(0.5)	(2%)	19.7	24.7	(5.0)	(20%)	24.7	(5.0)	(20%)
Physician Fee per Adjust Bed Day	1,680	1,873	(193)	(10%)	1,826	(146)	(8%)	1,720	1,596	124	8%	1,480	240	16%
Per Adjust Bed Day	451	482	(31)	(6%)	361	90	25%	417	414	3	1%	363	54	15%
Total Rx Expense	571,051	437,010	134,041	31%	327,061	243,989	75%	4,371,360	4,428,366	(57,006)	(1%)	3,884,311	487,050	13%
Per Adjust Bed Day	498	472	27	6%	319	180	56%	492	405	87	22%	423	69	16%
Total Medical Supplies	630,877	427,637	203,240	48%	289,061	341,816	118%	5,162,454	4,334,760	827,694	19%	4,532,514	629,940	14%
Per Adjust Bed Day	28	35	(8)	(22%)	49	(22)	(44%)	35	30	5	16%	32	3	10%
Total EHR Expense	34,915	32,115	2,801	9%	44,592	(9,677)	(22%)	364,527	321,148	43,380	14%	338,689	25,839	8%
Per Adjust Bed Day	796	954	(158)	(17%)	970	(174)	(18%)	901	812	89	11%	841	60	7%
Total Other	1,007,697	865,217	142,481	16%	879,730	127,968	15%	9,451,292	8,699,750	751,542	9%	9,009,806	441,486	5%
Per Adjust Bed Day	394	460	(66)	(14%)	451	(58)	(13%)	443	390	53	14%	391	52	13%
Total Depreciation and Amortization	498,344	417,154	81,190	19%	409,164	89,180	22%	4,642,004	4,171,539	470,465	11%	4,187,519	454,485	11%
Per Adjust Bed Day	11,059,023	9,704,462	1,354,561	14%	9,957,041	1,101,982	11%	105,091,943	98,065,296	7,026,647	7%	95,665,563	9,426,380	10%
Per Adjust Bed Day	8,734	10,700	(1,966)	(18%)	10,979	(2,244)	(20%)	10,020	9,158	862	9%	8,934	1,086	12%
Per Calendar Day	368,634	323,482	45,152	14%	331,901	36,733	11%	345,697	322,583	23,114	7%	314,689	31,008	10%

Key Financial Performance Indicators	Industry Benchmark	FYE 2024			FYE 2025			Jan-26	Feb-26	Mar-26	Apr-26	Variance to PM	Variance to FYE 2025 Average	Variance to PYM
		Apr-24	Average	Apr-25	Average	Apr-25	Average							
<b>Volume</b>														
Admits	41	63	69	51	71	73	76	92	72	(20)	1	21		
Deliveries	n/a	15	17	8	17	14	11	18	12	(6)	(5)	4		
Adjusted Patient Days	n/a	1,156	977	907	1,125	1,317	903	1,001	1,266	265	141	359		
Total Surgeries	153	148	146	157	140	115	127	151	146	(5)	6	(11)		
ER Visits	659	856	826	794	852	876	838	893	767	(126)	(85)	(27)		
RHC and Clinic Visits	n/a	4,819	4,607	5,193	4,772	5,001	4,448	4,936	4,823	(113)	51	(370)		
Diagnostic Imaging Services	n/a	2,250	2,069	2,081	2,129	2,304	2,070	2,368	2,311	(57)	182	230		
Rehab Services	n/a	835	662	1,161	838	796	867	917	944	27	106	(217)		
<b>AR &amp; Income</b>														
Gross AR (Cerner only)	n/a	\$ 52,118,365	\$ 52,823,707	\$ 51,510,454	\$ 50,813,697	\$ 42,782,472	\$ 45,756,586	\$ 48,086,679	\$ 46,907,846	\$ (1,178,834)	\$ (3,905,852)	\$ (4,602,608)		
AR > 90 Days	\$ 6,599,901.18	\$ 21,921,549	\$ 23,112,391	\$ 18,527,180	\$ 20,669,422	\$ 13,540,953	\$ 13,901,792	\$ 15,208,624	\$ 15,741,875	\$ 533,252	\$ (4,927,547)	\$ (2,785,305)		
AR % > 90 Days	15%	42.77%	44.2%	36.0%	40.6%	31.7%	30.4%	31.6%	33.6%	1.9%	-7.0%	-2.4%		
Gross AR Days (per financial statements)	60	76	85	85	80	61	60	62	66	4	(14)	(19)		
Net AR Days (per financial statements)	30	52	58	103	71	63	35	40	52	11	(19)	(51)		
Net AR	n/a	\$ 17,119,074	\$ 16,938,200	\$ 12,663,338	\$ 19,370,868	\$ 21,330,628	\$ 26,841,775	\$ 27,435,133	\$ 30,351,013	\$ 2,915,880	\$ 10,980,146	\$ 17,687,675		
Net AR % of Gross	n/a	32.8%	31.9%	24.6%	38.5%	49.9%	58.7%	57.1%	64.7%	7.6%	26.2%	40.1%		
Gross Patient Revenue/Calendar Day	n/a	\$ 687,640	\$ 619,457	\$ 606,428	\$ 634,418	\$ 707,068	\$ 758,932	\$ 770,059	\$ 710,721	\$ (59,338)	\$ 76,302	\$ 104,293		
Net Patient Revenue/Calendar Day	n/a	\$ 331,651	\$ 292,759	\$ 179,938	\$ 273,563	\$ 340,613	\$ 397,320	\$ 378,447	\$ 305,566	\$ (72,881)	\$ 32,003	\$ 125,628		
Net Patient Revenue/APD	n/a	\$ 8,607	\$ 8,757	\$ 5,952	\$ 8,088	\$ 8,018	\$ 12,326	\$ 11,720	\$ 7,240	\$ (4,480)	\$ (848)	\$ 1,288		
<b>Wages</b>														
Wages	n/a	\$ 3,340,105	\$ 3,285,431	\$ 3,803,369	\$ 3,661,965	\$ 3,714,863	\$ 3,442,161	\$ 3,839,305	\$ 3,851,445	\$ 12,140	\$ 189,480	\$ 48,077		
Employed paid FTEs	n/a	367.13	353.69	383.03	370.77	373.41	374.44	388.32	387.36	(0.97)	16.59	4.33		
Employed Average Hourly Rate	\$55.50	\$ 53.07	\$ 53.49	\$ 58.08	\$ 56.89	\$ 56.32	\$ 57.61	\$ 55.97	\$ 58.16	\$ 2.19	\$ 1.27	\$ 0.08		
Benefits	n/a	\$ 2,493,560	\$ 1,640,216	\$ 1,415,779	\$ 1,401,858	\$ 997,381	\$ 1,489,133	\$ 2,111,276	\$ 1,271,979	\$ (839,297)	\$ (129,879)	\$ (143,800)		
Benefits % of Wages	30%	74.7%	48.8%	37.2%	39.8%	26.8%	43.3%	55.0%	33.0%	-22.0%	-6.7%	-4.2%		
Contract Labor	n/a	\$ 320,113	\$ 518,351	\$ 452,748	\$ 447,445	\$ 318,690	\$ 256,756	\$ 280,557	\$ 426,165	\$ 145,608	\$ (21,279)	\$ (26,583)		
Contract Labor Paid FTEs	n/a	21.07	23.49	21.29	23.89	18.71	19.44	19.83	20.79	0.95	(3.10)	(0.50)		
Total Paid FTEs	n/a	388.20	377.18	404.32	394.65	392.12	393.87	408.16	408.15	(0.01)	13.49	3.83		
Contract Labor Average Hourly Rate	\$ 81.04	\$ 88.62	\$ 123.22	\$ 124.38	\$ 120.98	\$ 96.42	\$ 82.79	\$ 80.07	\$ 119.91	\$ 39.84	\$ (1.07)	\$ (4.47)		
Total Salaries, Wages, & Benefits	n/a	\$ 6,153,778	\$ 5,443,998	\$ 5,671,896	\$ 5,511,268	\$ 5,030,934	\$ 5,188,050	\$ 6,231,139	\$ 5,549,590	\$ (681,549)	\$ 38,322	\$ (122,306)		
SWB% of NR	50%	61.8%	62.1%	105.1%	72.0%	47.6%	46.6%	53.1%	60.5%	7.4%	-11.5%	-44.5%		
SWB/APD	2,204	\$ 5,323	\$ 5,104	\$ 6,254	\$ 5,284	\$ 3,820	\$ 5,748	\$ 6,225	\$ 4,383	\$ (1,842)	\$ (901)	\$ (1,871)		
SWB % of total expenses	50%	58.8%	55.4%	57.0%	55.6%	49.4%	51.7%	52.9%	50.2%	-2.7%	-5.5%	-6.8%		

	Industry Benchmark	FYE 2024			FYE 2025			Apr-26	Variance to PM	Variance to 2025 Average	Variance to PYM	
		Apr-24	Average	Apr-25	Average	Jan-26	Feb-26					Mar-26
<b>Physician Spend</b>												
Physician Expenses	n/a	\$ 1,656,184	\$ 1,613,172	\$ 1,591,311	\$ 1,507,510	\$ 1,942,693	\$ 1,737,862	\$ 1,937,506	\$ 2,127,062	\$ 189,556	\$ 619,552	\$ 535,751
Physician expenses/APD	n/a	\$ 1,826	\$ 1,565	\$ 1,755	\$ 1,476	\$ 1,475	\$ 1,925	\$ 1,935	\$ 1,680	\$ (256)	\$ 204	\$ (75)
<b>Supplies</b>												
Supply Expenses	n/a	\$ 616,123	\$ 832,644	\$ 1,009,496	\$ 776,504	\$ 995,550	\$ 900,674	\$ 930,897	\$ 1,201,928	\$ 271,031	\$ 425,425	\$ 192,432
Supply expenses/APD		\$ 679	\$ 822	\$ 1,113	\$ 744	\$ 756	\$ 998	\$ 930	\$ 949	\$ 19	\$ 205	\$ (164)
<b>Other Expenses</b>												
Other Expenses	n/a	\$ 2,012,839	\$ 1,939,040	\$ 2,186,301	\$ 1,824,207	\$ 2,204,650	\$ 2,212,109	\$ 2,672,831	\$ 2,180,443	\$ (492,388)	\$ 356,236	\$ (5,858)
Other Expenses/APD	n/a	\$ 2,219	\$ 1,861	\$ 2,411	\$ 1,787	\$ 1,674	\$ 2,451	\$ 2,670	\$ 1,722	\$ (948)	\$ (65)	\$ (689)
<b>Margin</b>												
Net Income	n/a	\$ (3,722,346)	\$ 253,100	\$ (192,661)	\$ 383,722	\$ 1,879,313	\$ 6,301,475	\$ 486,988	\$ (1,013,007)	\$ (1,499,995)	\$ (1,396,729)	\$ (820,346)
Net Profit Margin	n/a	-69.0%	3.7%	-1.9%	3.0%	17.8%	56.6%	4.2%	-11.1%	-15.2%	-14.0%	-9.1%
Operating Income	n/a	\$ (4,558,891)	\$ (1,557,761)	\$ (509,466)	\$ (686,444)	\$ 385,170	\$ 1,086,276	\$ (40,522)	\$ (1,892,040)	\$ (1,851,518)	\$ (1,205,596)	\$ (1,382,574)
Operating Margin	2.9%	-84.5%	-26.1%	-5.1%	-10.9%	3.6%	9.8%	-0.3%	-20.6%	-20.3%	-9.7%	-15.5%
EBITDA	n/a	\$ (3,313,182)	\$ 676,999	\$ 245,536	\$ 841,891	\$ 2,303,607	\$ 6,944,209	\$ 980,998	\$ (514,664)	\$ (1,495,662)	\$ (1,356,554)	\$ (760,200)
EBITDA Margin	12.7%	-61.4%	9.4%	2.5%	8.7%	21.8%	62.4%	8.4%	-5.6%	-14.0%	-14.4%	-8.1%
Debt Service Coverage Ratio	3.70	419.8%	3.9	3.8	3.3	0.4	4.7	3.5	3.2	(0.3)	(0.1)	(0.6)
<b>Cash</b>												
Avg Daily Disbursements (excl. IGT)	n/a	\$ 321,662	\$ 350,828	\$ 382,730	\$ 355,328	\$ 354,878	\$ 388,193	\$ 363,206	\$ 624,096	\$ 260,890	\$ 268,768	\$ 241,365
Average Daily Cash Collections (excl. IGT)	n/a	\$ 391,697	\$ 340,919	\$ 352,222	\$ 299,110	\$ 289,881	\$ 313,515	\$ 328,025	\$ 384,546	\$ 56,521	\$ 85,435	\$ 32,323
Average Daily Net Cash		\$ 70,035	\$ (9,908)	\$ (30,508)	\$ (56,218)	\$ (64,996)	\$ (74,679)	\$ (35,181)	\$ (239,550)	\$ (204,369)	\$ (183,332)	\$ (209,042)
Upfront Cash Collections		\$ 71,226	\$ 54,286	\$ 32,329	\$ 36,146	\$ 62,345	\$ 67,508	\$ 88,629	\$ 74,703	\$ (13,926)	\$ 38,557	\$ 42,374
Upfront Cash % of Gross Charges	1%	0.4%	0.3%	0.2%	0.2%	0.3%	0.3%	0.4%	0.4%	0.0%	0.2%	0.2%
Unrestricted Funds	n/a	\$ 27,688,938	\$ 23,774,285	\$ 14,442,406	\$ 23,536,438	\$ 23,124,630	\$ 23,811,084	\$ 32,334,262	\$ 34,024,342	\$ 1,690,081	\$ 10,487,904	\$ 19,581,936
Change of cash per balance sheet	n/a	\$ 3,770,050	\$ 321,485	\$ (4,672,727)	\$ (321,485)	\$ 2,095,753	\$ 686,454	\$ 8,523,178	\$ 1,690,081	\$ (6,833,097)	\$ 2,011,566	\$ 6,362,808
Days Cash on Hand (assume no more cash is collected)	196	92	73	46	72	72	74	99	103	4	30	57
Estimated Days Until Depleted (operating cash only)		610	2,399	247	406	416	411	583	461	(122)	55	214
Years Until Cash Depletion (operating cash only)		1.67	6.57	0.68	1.11	1.14	1.12	1.60	1.26	(0.34)	0.15	0.59

# NIHD Financial Update

Chief Financial Officer

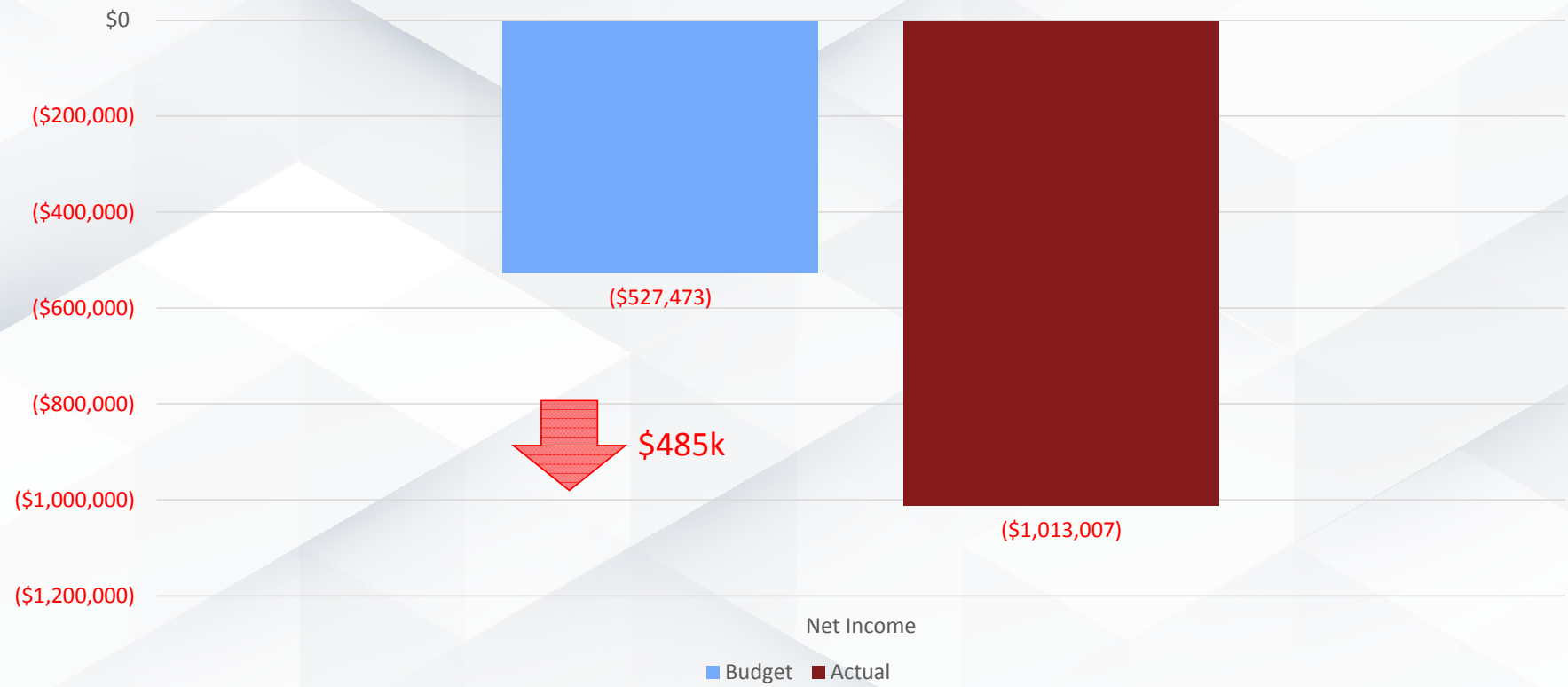
April 2026



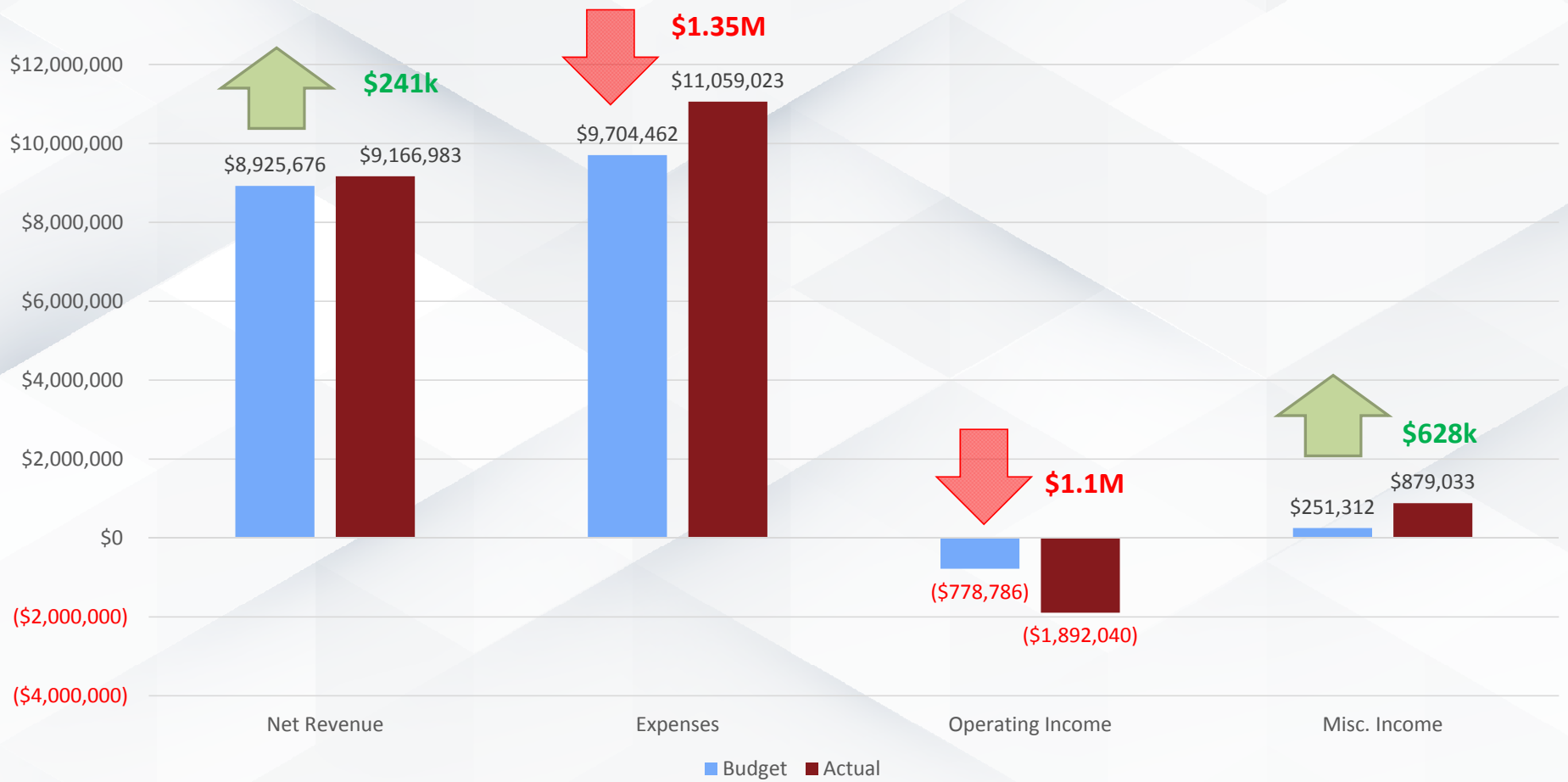
 **NORTHERN INYO HEALTHCARE DISTRICT**

# INCOME PERFORMANCE

# Net Income



# Income to Budget



## VOLUME & Income Action plan

- The Mammoth Orthopedic Institute began orthopedic surgeries in July. Their surgical volume has steadily increased. Orthopedic surgeries exceeded their budget. Additionally general surgeries are also exceeding budget.
- We are working on reviewing operational efficiency including OR utilization and space utilization reviews to maximize patient flow and care.
- We are being more deliberate in our service line strategy.
- We are working on a staff benchmarking analysis to determine if we are appropriately staffing by skill mix in all departments.
- Leaders are doing a great job of managing their expenses and helping build budgets for the next fiscal year.

## Cash Performance

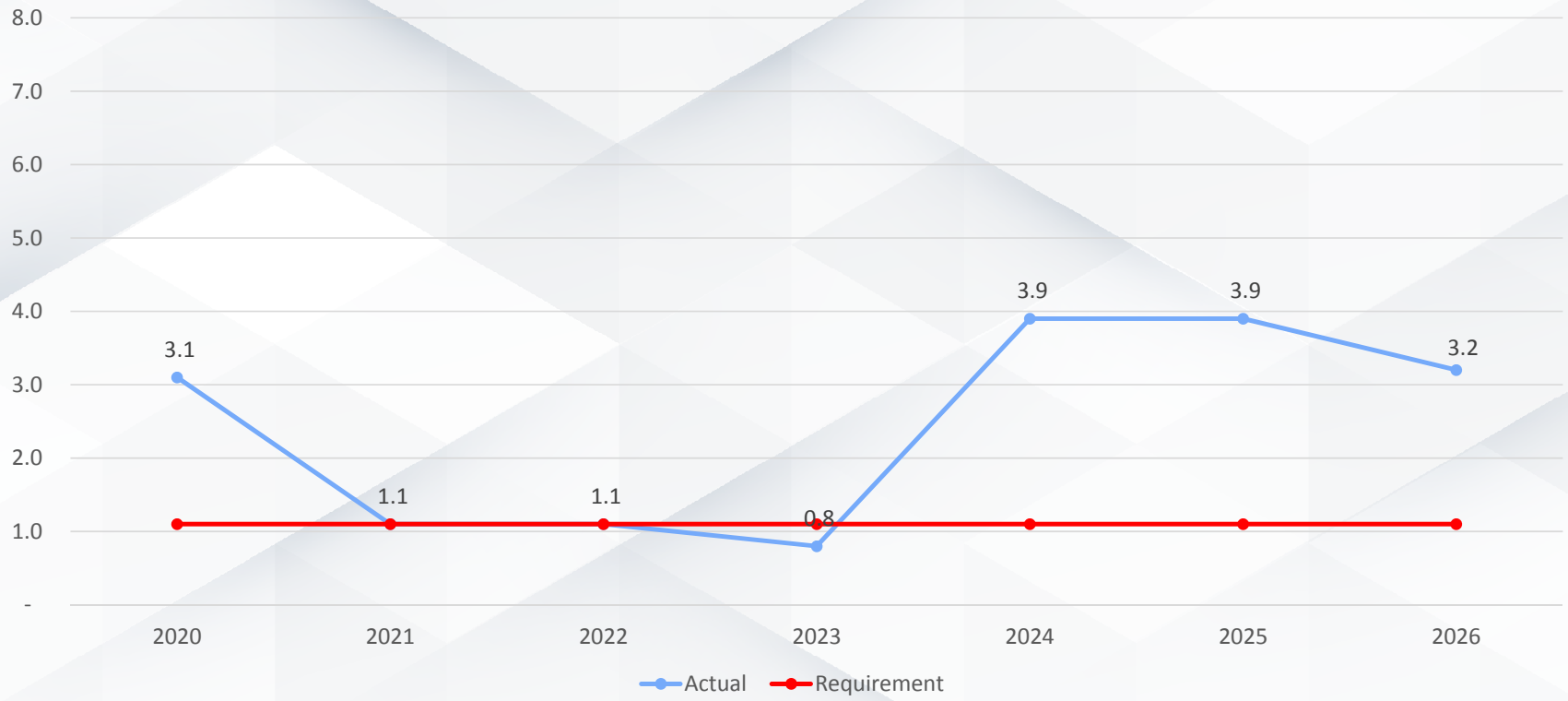
## Income to Cash

	FYE 2026
<b>Net Income (loss)</b>	<b>\$4,431,616</b>
Principal Payments on Long-Term Debt (balance sheet only)	\$(1,942,891)
Other Debt (long-term leases & subscriptions – balance sheet only)	\$(909,321)
Capital purchases (balance sheet only)	\$(2,317,970)
Timing of accruals vs cash (accrued in FYE 2025 and received in FYE 2026)	\$4,077,011
<b>Impact to Cash</b>	<b>\$(1,093,171)</b>
<b>Adjusted Net Income (cash basis)</b>	<b>5,524,787</b>

## Gross AR Days



# Debt Service Coverage Ratio



# Days Cash on Hand



# Unrestricted Funds



## Cash action plan

- The cash flow action team is working to improve processes in all aspects of billing and collections.
- We have hired a new AI-based billing company, Jorie, and have hit record cash collections the past few months. The automation is now live in several areas.
- We have moved \$22M in cash to Five Star Bank to earn better returns on our cash.
- We have another \$11M in the LAIF Earning over 4% interest.
- AR days are at a record low for the organization.

**Northern Inyo Healthcare District  
Income Statement  
Fiscal Year 2026**

	2/28/2026	Feb Budget	2/28/2025	3/31/2026	Mar Budget	3/31/2025	4/30/2026	Apr Budget	4/30/2025	2026 YTD	Budget Variance	PYM Change
<b>Gross Patient Service Revenue</b>												
Inpatient Patient Revenue	5,180,099	3,355,879	2,845,791	5,985,858	3,643,136	6,901,902	3,901,381	3,596,335	3,003,097	40,677,762	305,046	898,284
Outpatient Revenue	14,213,119	13,070,432	12,402,184	15,833,078	14,386,230	13,051,580	15,480,289	14,221,947	13,297,993	146,837,382	1,258,342	2,182,296
Clinic Revenue	1,856,889	1,706,899	1,689,999	2,052,895	1,735,007	1,718,306	1,939,954	1,727,250	1,891,743	19,756,097	212,704	48,211
<b>Gross Patient Service Revenue</b>	<b>21,250,107</b>	<b>18,133,209</b>	<b>16,937,974</b>	<b>23,871,832</b>	<b>19,764,372</b>	<b>21,671,787</b>	<b>21,321,624</b>	<b>19,545,532</b>	<b>18,192,833</b>	<b>207,271,241</b>	<b>1,776,092</b>	<b>3,128,791</b>
<b>Deductions from Revenue</b>												
Contractual Adjustments	(9,511,723)	(8,980,922)	(8,529,361)	(11,883,671)	(9,943,164)	(10,138,614)	(11,804,084)	(9,622,417)	(8,841,205)	(106,793,268)	(2,181,667)	(2,962,879)
Bad Debt	(324,918)	(108,143)	(194,637)	(1,107,080)	(119,730)	(370,446)	26,871	(115,868)	(3,774,465)	(3,749,228)	142,739	3,801,335
A/R Writeoffs	(288,495)	(660,615)	(844,459)	(458,960)	(731,396)	(176,044)	(377,429)	(707,802)	(179,014)	(4,270,979)	330,374	(198,415)
Other Deductions from Revenue	-	(162,185)	-	1,309,730	(179,562)	-	-	(173,770)	-	1,309,730	173,770	-
Deductions from Revenue	(10,125,136)	(9,911,866)	(9,568,457)	(12,139,981)	(10,973,852)	(10,685,103)	(12,154,642)	(10,619,856)	(12,794,684)	(113,503,745)	(1,534,785)	640,042
<b>Other Patient Revenue</b>												
Incentive Income	-	-	-	-	-	-	-	-	-	-	-	-
Other Oper Rev - Rehab Thera Serv	-	-	-	-	-	-	-	-	-	-	-	-
Medical Office Net Revenue	-	-	-	-	-	-	-	-	-	-	-	-
Other Patient Revenue	-	-	-	-	-	-	-	-	-	-	-	-
<b>Net Patient Service Revenue</b>	<b>11,124,971</b>	<b>8,221,343</b>	<b>7,369,517</b>	<b>11,731,850</b>	<b>8,790,521</b>	<b>10,986,684</b>	<b>9,166,983</b>	<b>8,925,676</b>	<b>5,398,149</b>	<b>93,767,496</b>	<b>241,307</b>	<b>3,768,833</b>
<b>CNR%</b>	<b>52.4%</b>	<b>45.3%</b>	<b>43.5%</b>	<b>49.1%</b>	<b>44.5%</b>	<b>50.7%</b>	<b>43.0%</b>	<b>45.7%</b>	<b>29.7%</b>	<b>45.2%</b>	<b>-2.7%</b>	<b>13.3%</b>
<b>Cost of Services - Direct</b>												
Salaries and Wages	2,929,179	3,109,178	2,430,386	3,271,550	3,435,715	2,997,295	3,241,797	3,326,869	3,078,978	31,446,917	(85,072)	162,820
Benefits	1,351,414	1,407,463	1,184,125	1,776,950	1,512,150	1,425,501	1,118,914	1,489,410	1,277,083	12,416,255	(370,496)	(158,168)
Professional Fees	1,947,795	2,314,639	1,772,635	2,104,413	2,396,473	2,013,306	2,354,887	2,355,988	1,903,652	20,098,089	(1,101)	451,235
Contract Labor	216,406	335,595	377,408	243,243	361,796	187,691	281,325	353,063	355,281	2,623,676	(71,738)	(73,956)
Pharmacy	336,237	407,876	207,210	529,919	451,577	755,356	571,051	437,010	327,061	4,371,360	134,041	243,989
Medical Supplies	564,437	398,630	357,873	400,978	442,517	303,803	630,877	427,637	289,061	5,162,454	203,240	341,816
Hospice Operations	-	-	-	-	-	-	-	-	-	-	-	-
EHR System Expense	39,971	32,115	32,417	31,525	32,115	20,415	34,915	32,115	44,592	364,527	2,801	(9,677)
Other Direct Expenses	604,322	841,786	615,234	756,649	876,969	585,010	750,237	865,217	602,461	6,994,556	(114,980)	147,776
<b>Total Cost of Services - Direct</b>	<b>7,989,762</b>	<b>8,847,281</b>	<b>6,977,287</b>	<b>9,115,227</b>	<b>9,509,311</b>	<b>8,288,377</b>	<b>8,984,004</b>	<b>9,287,308</b>	<b>7,878,169</b>	<b>83,477,835</b>	<b>(303,304)</b>	<b>1,105,835</b>
<b>General and Administrative Overhead</b>												
Salaries and Wages	512,982	-	402,119	567,755	-	514,529	609,648	-	724,391	5,565,809	609,648	(114,743)
Benefits	137,719	-	219,418	334,327	-	241,966	153,065	-	138,697	2,101,844	153,065	14,368
Professional Fees	485,303	-	428,917	916,493	-	494,527	411,662	-	431,885	6,016,658	411,662	(20,223)
Contract Labor	40,350	-	(10,102)	37,315	-	95,330	144,840	-	97,467	831,056	144,840	47,373
Depreciation and Amortization	642,734	417,154	409,164	494,010	417,154	409,164	498,344	417,154	409,164	4,642,004	81,190	89,180
Other Administrative Expenses	229,845	-	253,138	307,245	-	251,163	257,460	-	277,268	2,456,737	257,460	(19,808)
<b>Total General and Administrative Overhead</b>	<b>2,048,934</b>	<b>417,154</b>	<b>1,702,654</b>	<b>2,657,146</b>	<b>417,154</b>	<b>2,006,679</b>	<b>2,075,019</b>	<b>417,154</b>	<b>2,078,872</b>	<b>21,614,108</b>	<b>1,657,865</b>	<b>(3,853)</b>
<b>Total Expenses</b>	<b>10,038,695</b>	<b>9,264,435</b>	<b>8,679,941</b>	<b>11,772,372</b>	<b>9,926,465</b>	<b>10,295,056</b>	<b>11,059,023</b>	<b>9,704,462</b>	<b>9,957,041</b>	<b>105,091,943</b>	<b>1,354,561</b>	<b>1,101,982</b>
Financing Expense	164,468	196,180	195,369	170,574	196,180	201,224	162,781	196,180	194,928	1,754,632	(33,399)	(32,147)
Financing Income	(260,102)	78,984	78,984	381,929	78,984	78,984	414,751	190,806	903,825	3,489,578	223,945	(489,074)
Investment Income	67,568	47,322	37,373	82,241	47,322	49,720	339,523	47,322	58,156	1,221,423	292,201	281,367
Miscellaneous Income	5,572,201	213,075	170,566	233,914	397,786	145,639	287,539	209,364	69,492	12,799,695	78,175	218,047
<b>Net Income (Change in Financial Position)</b>	<b>6,301,475</b>	<b>(899,890)</b>	<b>(1,218,870)</b>	<b>486,988</b>	<b>(808,032)</b>	<b>764,746</b>	<b>(1,013,007)</b>	<b>(527,473)</b>	<b>(3,722,346)</b>	<b>4,431,616</b>	<b>(485,534)</b>	<b>2,709,339</b>
Operating Income	1,086,276	(1,043,092)	(1,310,424)	(40,522)	(1,135,945)	691,628	(1,892,040)	(778,786)	(4,558,891)	(11,324,447)	(1,113,254)	2,666,851
EBIDA	6,944,209	(482,737)	(809,707)	980,998	(390,879)	1,173,910	(514,664)	(110,319)	(3,313,182)	9,073,620	(404,344)	2,798,519
Net Profit Margin	56.6%	-10.9%	-16.5%	4.2%	-9.2%	7.0%	-11.1%	-5.9%	-69.0%	4.7%	-5.1%	70.7%
Operating Margin	9.8%	-12.7%	-17.8%	-0.3%	-12.9%	6.3%	-20.6%	-8.7%	-84.5%	-12.1%	-11.9%	84.0%
EBIDA Margin	62.4%	-5.9%	-11.0%	8.4%	-4.4%	10.7%	-5.6%	-1.2%	-61.4%	9.7%	-4.4%	67.0%

**Northern Inyo Healthcare District  
Balance Sheet  
Fiscal Year 2026**

	PY Balances	2/28/2026	2/28/2025	3/31/2026	3/31/2025	4/30/2026	4/30/2025	PM Change	PY Change
<b>Assets</b>									
<b>Current Assets</b>									
Cash and Liquid Capital	20,757,956	17,484,375	17,437,514	21,007,812	18,774,677	22,886,679	19,449,093	1,878,867	3,437,586
Short Term Investments	7,741,599	6,076,527	7,419,400	11,076,390	7,253,236	11,137,664	7,742,770	61,274	3,394,893
PMA Partnership	-	-	-	-	-	-	-	-	-
Accounts Receivable, Net of Allowance	16,645,748	26,841,775	17,511,087	27,435,133	18,641,177	30,351,013	12,663,338	2,915,880	17,687,675
Other Receivables	9,238,007	12,744,646	10,409,887	4,811,775	9,013,770	(1,058,088)	9,700,579	(5,869,863)	(10,758,667)
Inventory	5,334,241	5,343,895	6,125,219	5,359,679	7,049,031	5,345,142	7,043,517	(14,537)	(1,698,375)
Prepaid Expenses	1,106,127	1,892,288	810,066	1,870,160	1,195,648	1,741,924	1,277,412	(128,235)	464,513
<b>Total Current Assets</b>	<b>60,823,678</b>	<b>70,383,505</b>	<b>59,713,172</b>	<b>71,560,949</b>	<b>61,927,539</b>	<b>70,404,334</b>	<b>57,876,709</b>	<b>(1,156,615)</b>	<b>12,527,625</b>
<b>Assets Limited as to Use</b>									
Internally Designated for Capital Acquisition:	-	-	-	-	-	-	-	-	-
Short Term - Restricted	1,469,292	(711,179)	1,468,789	(711,051)	1,468,917	129,810	1,469,040	840,861	(1,339,230)
Limited Use Assets	-	-	-	-	-	-	-	-	-
LAIF - DC Pension Board Restricted	-	-	-	-	-	-	-	-	-
LAIF - DB Pension Board Restricted	9,393,030	9,393,030	10,346,490	9,393,030	13,882,457	9,393,030	13,882,457	-	(4,489,427)
PEPRA - Deferred Outflows	-	-	-	-	-	-	-	-	-
PEPRA Pension	-	-	-	-	-	-	-	-	-
Deferred Outflow - Excess Acquisition	573,097	573,097	573,097	573,097	573,097	573,097	573,097	-	-
Total Limited Use Assets	9,966,127	9,966,127	10,919,587	9,966,127	14,455,554	9,966,127	14,455,554	-	(4,489,427)
Revenue Bonds Held by a Trustee	297,382	251,962	330,616	246,484	324,871	241,007	319,127	(5,477)	(78,120)
<b>Total Assets Limited as to Use</b>	<b>11,732,801</b>	<b>9,506,909</b>	<b>12,718,991</b>	<b>9,501,560</b>	<b>16,249,342</b>	<b>10,336,944</b>	<b>16,243,722</b>	<b>835,384</b>	<b>(5,906,777)</b>
<b>Long Term Assets</b>									
Long Term Investment	497,086	250,182	748,360	250,060	(597,117)	-	497,075	(250,060)	(497,075)
Fixed Assets, Net of Depreciation	81,644,252	79,236,372	83,122,430	78,707,951	83,170,782	78,315,524	82,773,362	(392,427)	(4,457,838)
<b>Total Long Term Assets</b>	<b>82,141,338</b>	<b>79,486,555</b>	<b>83,870,790</b>	<b>78,958,011</b>	<b>82,573,665</b>	<b>78,315,524</b>	<b>83,270,437</b>	<b>(642,487)</b>	<b>(4,954,913)</b>
<b>Total Assets</b>	<b>154,697,817</b>	<b>159,376,969</b>	<b>156,302,954</b>	<b>160,020,520</b>	<b>160,750,547</b>	<b>159,056,802</b>	<b>157,390,868</b>	<b>(963,718)</b>	<b>1,665,934</b>
<b>Liabilities</b>									
<b>Current Liabilities</b>									
Current Maturities of Long-Term Debt	3,599,764	3,827,808	4,586,959	3,561,107	4,312,667	3,556,887	4,300,283	(4,220)	(743,397)
Accounts Payable	4,413,297	5,397,508	4,086,194	5,456,295	3,592,092	5,174,270	3,663,678	(282,025)	1,510,592
Accrued Payroll and Related	3,525,333	4,726,435	2,991,863	5,021,515	3,268,949	5,366,893	3,524,904	345,378	1,841,989
Accrued Interest and Sales Tax	83,538	200,396	424,010	265,033	144,235	102,872	220,309	(162,161)	(117,437)
Notes Payable	339,892	339,892	446,860	339,892	446,860	339,892	446,860	-	(106,968)
Unearned Revenue	-	-	(4,542)	-	(4,542)	-	(4,542)	-	4,542
Due to 3rd Party Payors	3,324,903	4,331,882	693,247	4,331,882	1,637,684	4,331,882	1,637,684	-	2,694,198
Due to Specific Purpose Funds	-	-	-	-	-	-	-	-	-
Other Deferred Credits - Pension & Leases	8,758,790	8,742,233	12,583,266	8,740,163	12,581,197	8,740,163	12,579,127	-	(3,838,964)
<b>Total Current Liabilities</b>	<b>24,045,518</b>	<b>27,566,154</b>	<b>25,807,857</b>	<b>27,715,888</b>	<b>25,979,142</b>	<b>27,612,860</b>	<b>26,368,305</b>	<b>(103,028)</b>	<b>1,244,555</b>
<b>Long Term Liabilities</b>									
Long Term Debt	33,367,666	30,483,481	33,732,107	30,376,414	33,749,977	30,283,079	33,648,895	(93,335)	(3,365,816)
Bond Premium	127,973	102,877	140,522	99,740	137,384	96,603	134,247	(3,137)	(37,645)
Accreted Interest	17,272,679	17,046,315	16,920,864	17,130,702	17,009,899	17,215,090	17,094,610	84,388	120,480
Other Non-Current Liability - Pension	31,874,258	31,874,258	32,946,355	31,874,258	32,946,355	31,874,258	32,946,355	-	(1,072,097)
<b>Total Long Term Liabilities</b>	<b>82,642,576</b>	<b>79,506,931</b>	<b>83,739,848</b>	<b>79,481,114</b>	<b>83,843,615</b>	<b>79,469,030</b>	<b>83,824,107</b>	<b>(12,084)</b>	<b>(4,355,077)</b>
Suspense Liabilities	-	-	-	-	-	-	-	-	-
Uncategorized Liabilities (grants)	61,310	94,957	127,821	114,957	139,321	114,957	139,321	-	(24,364)
<b>Total Liabilities</b>	<b>106,749,404</b>	<b>107,168,041</b>	<b>109,675,526</b>	<b>107,311,959</b>	<b>109,962,078</b>	<b>107,196,846</b>	<b>110,331,732</b>	<b>(115,113)</b>	<b>(3,134,886)</b>
<b>Fund Balance</b>									
Fund Balance	40,722,935	45,780,996	37,235,861	45,793,513	40,632,146	45,957,791	40,624,917	164,278	5,332,874
Temporarily Restricted	1,469,292	1,470,296	1,468,789	1,470,424	1,468,799	1,470,548	1,469,040	124	1,508
Net Income	5,756,186	4,957,636	7,922,778	5,444,624	8,687,524	4,431,616	4,965,178	(1,013,007)	(533,561)
<b>Total Fund Balance</b>	<b>47,948,412</b>	<b>52,208,928</b>	<b>46,627,427</b>	<b>52,708,561</b>	<b>50,788,469</b>	<b>51,859,956</b>	<b>47,059,136</b>	<b>(848,605)</b>	<b>4,800,820</b>
<b>Liabilities + Fund Balance</b>	<b>154,697,817</b>	<b>159,376,969</b>	<b>156,302,954</b>	<b>160,020,520</b>	<b>160,750,547</b>	<b>159,056,802</b>	<b>157,390,868</b>	<b>(963,718)</b>	<b>1,665,934</b>
(Decline)/Gain	-	5,750,804	(1,593,545)	643,551	4,447,593	(963,718)	(3,359,679)	(1,607,269)	2,395,961

Northern Inyo Healthcare District  
 Long-Term Debt Service Coverage Ratio  
 FYE 2026

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	\$ 4,431,616
+ Depreciation Expense	4,642,004
+ Interest Expense	1,754,632
Less GO Property Tax revenue	2,442,704
Less GO Interest Expense	384,153
<b>"Income available for debt service"</b>	<b>\$ 8,001,395</b>

Denominator:	
<b>Maximum "Annual Debt Service"</b>	
2021A Revenue Bonds	\$ 112,700
2021B Revenue Bonds	892,400
2009 GO Bonds (Fully Accreted Value)	
2016 GO Bonds	
Financed purchases and other loans	1,506,725
<b>Total Maximum Annual Debt Service</b>	<b>\$ 2,511,825</b>

Ratio: (numerator / denominator) **3.19**

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	\$ 34,024,342
Cash and Investments-non current	-
Sub-total	34,024,342
Less - Restricted:	
PRF and grants (Unearned Revenue)	-
Held with bond fiscal agent	-
Building and Nursing Fund	-
<b>Total Unrestricted Funds</b>	<b>\$ 34,024,342</b>

Total Operating Expenses	\$ 105,091,943
Less Depreciation	4,642,004
Net Expenses	100,449,939
Average Daily Operating Expense	\$ 330,427

Days Cash on Hand **103**

**Northern Inyo Healthcare District**  
**Statement of Cash Flows**  
**Fiscal Year 2026**

**CASH FLOWS FROM OPERATING ACTIVITIES**

Receipts from and on Behalf of Patients	93,807,194
Payments to Suppliers and Contractors	(39,837,932)
Payments to and on Behalf of Employees	(54,985,558)
Other Receipts and Payments, Net	<u>4,125,728</u>
Net Cash Provided (Used) by Operating Activities	3,109,433

**CASH FLOWS FROM NONCAPITAL FINANCING ACTIVITIES**

Noncapital Contributions and Grants	6,217,230
Property Taxes Received	<u>1,046,873</u>
Net Cash Provided (Used) by Noncapital Financing Activities	7,264,103

**CASH FLOWS FROM CAPITAL AND CAPITAL RELATED FINANCING ACTIVITIES**

Principal Payments on Long-Term Debt	(1,942,891)
Proceeds from the Issuance of Refunding Revenue Bonds	-
Payment to Defease Revenue Bonds	-
Interest Paid	(1,754,632)
Purchase and Construction of Capital Assets	(2,317,970)
Payments on Lease Liability	(87,732)
Payments on Subscription Liability	(821,589)
Property Taxes Received	796,680
Net Cash Provided (Used) by Capital and Capital Related Financing Activities	<u>(6,128,135)</u>

**CASH FLOWS FROM INVESTING ACTIVITIES**

Investment Income	1,221,423
Rental Income	<u>57,964</u>
Net Cash Provided (Used) by Investing Activities	<u>1,279,386</u>

**NET CHANGE IN CASH AND CASH EQUIVALENTS**

5,524,788

Cash and Cash Equivalents - Beginning of Year

28,499,555

**CASH AND CASH EQUIVALENTS - END OF YEAR**

34,024,342