Northern Inyo County Local Hospital District

Board of Directors Regular Meeting

Wednesday December 18, 2013; 5:30pm

Board Room
Birch Street Annex
2957 Birch Street, Bishop, CA

AGENDA

NORTHERN INYO COUNTY LOCAL HOSPITAL DISTRICT
BOARD OF DIRECTORS MEETING
December 18, 2013 at 5:30 P.M.

In the Northern Inyo Hospital Board Room at 2957 Birch Street, Bishop, CA

1. Call to Order (at 5:30 p.m.).
2. Opportunity for members of the public to comment on any items on this Agenda.

Consent Agenda

3. Approval of minutes of the December 2, 2013 Special Board meeting (*action item*).
4. Security report for October 2013 (*information item*).
5. Approval of the financial and statistical reports for September and October, 2013 (*action item*).
6. Renewal of EKG Services Agreement with James Richardson, M.D. (*action item*).
7. Renewal of Anesthesia Services Agreements with Curtis Schweizer, M.D., and Daniel Cowan, M.D. (*action items*).

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8. Administrator's Report; John Halfen.
   - A. Physician Recruiting Update
   - B. NRACO Update
   - C. Radiology update
   - D. NIH Auxiliary Boutique report
9. Chief of Staff Report; Thomas Boo, M.D.
   - A. Medical Staff reappointments and reprivileging, (*action items*):
     1. Alexander Adduci, M.D.
     2. Sandra Althaus, M.D.
     3. Clifford Beck, M.D.
     4. Theodore Berndt, M.D.
     5. Helena L. Black, M.D.
     6. Stacey L. Brown, M.D.
     7. Thomas Bryce, M.D.
     8. Nicholas J. Carlevato, M.D.
     9. Alice E. Casey, M.D.
     10. D. Scott Clark, M.D.
     11. Kristin Collins, D.O.
     12. Thomas Davee, M.D.
     13. John Erogul, M.D.
     14. Nickoline M. Hathaway, M.D.
     15. Andrew D. Hewchuck, D.P.M.
     16. Sudhir Kakarla, M.D.
     17. Asao Kamei, M.D.
     18. Sheldon M. Kop, M.D.
     19. David N. Landis, M.D.
     20. Doris Lin, M.D.
     21. Stephen J. Loos, M.D.
     22. Victor Lopez-Cuenca, M.D.
     23. Thomas O. McNamara, M.D.
     24. Michael W. Phillips, M.D.

25. Michael L. Dillon, M.D.
26. Thomas K. Reid, M.D.
27. James A. Richardson, M.D.
28. Curtis Schweizer, M.D.
29. Jennifer A. Scott, M.D.
30. Richard Seher, M.D.
31. Keith M. Shonnard, M.D.
32. Robert Swackhamer, M.D.
33. Leo M. Pisculli, M.D.
34. Amr H. Ramadan, M.D.
35. Gregory M. Taylor, M.D.
36. Carolyn J. Tiernan, M.D.
37. Rajesh Vaid, M.D.
38. Eva S. Wasef, M.D.
39. Taema F. Weiss, M.D.
40. Albert Douglas Will, M.D.
41. Natalia Zarzhevsky, M.D.

B. Allied Health Professional re-privileging, Robert Nalumaluhia, P.A. (*action item*).

C. Staff Category Advancement, Catherine Leja, M.D. (*action item*).

D. Staff Appointment/Privileges, Richard Meredick, M.D. (*action item*).

E. Policy and Procedure approvals (*action items*):

1. *Elective Delivery*
2. *Healthy Newborn Admission Protocol*
3. *NIH ED Triage Protocol*
4. *Breast Screening Exams – Self Referral*
5. *MPIRX: Myocardial Perfusion Imaging with Chemical Stress*
6. *Infant Oxygen Protocol*
7. *Liberation From Mechanical Ventilation – Weaning Protocol*
8. *Proportional Assist Ventilation (PAV) on PB 840 Ventilator*
9. *Adult Oxygen Protocol*
10. *Continuous Bronchodilator with MiniHeart Hi-Flow Continuous Nebulizer*
11. *Initial Ventilator Settings*
12. *BiPAP*
13. *Vapotherm*

10. Old Business

A. Chief Executive Officer Search Committee update (*information item*).

11. New Business

A. Exclusion of photography at District Board meetings (*discussion item*).

B. Election of Board Officers for 2014 calendar year (*action item*).

C. Ratification of purchase or orthopedic equipment (*action item*).

D. Approval of Health Plan Renewal Report for plan year 2014 (*action item*).

E. Capital Expenditure Request, purchase of additional backup tape library (*action item*).

F. Purchase of EEG machine (*action item*).

G. Approval of Hospital Wide Policy and Procedure, *Sanctions for Breach of Patient Privacy* (*action item*).

H. Approval of Hospital Wide Policy and Procedure, *Auditing of Employee Access to Patient Information* (*action item*).

I. Education for Board Members (*action item*).

J. Approval of Private Practice Physician Income Guarantee and Practice Management Agreement with Shawn Rosen, M.D. (*action item*).

12. Reports from Board members on items of interest.
13. Opportunity for members of the public to comment on any items on this Agenda, and/or on any items of interest.
14. Adjournment to closed session to:

A. Hear reports on the hospital quality assurance activities, and hear a report from the Medical Staff Executive Committee (Section 32155 of the Health and Safety Code, and Government Code Section 54962).

B. Confer with legal counsel regarding significant exposure of litigation (Subdivision (b) of Government Code Section 54956.9(b)(3)(A)).

C. Confer with legal counsel regarding a 2nd significant exposure of litigation (Subdivision (b) of Government Code Section 54956.9(b)(3)(A)).

D. Consider the employment of a public employee, to wit: Administrator/Chief Executive Officer (Government Code Section 54957).

E. Confer with legal counsel regarding a claim filed by Tami Matteson against Northern Inyo County Local Hospital District (Government Code Section 54956.9(a)).

F. Confer with legal counsel regarding a claim filed by Lauren and a claim filed by Nolan Nitschke against Northern Inyo County Local Hospital District (Government Code Section 54956.9(a)).

15. Return to open session, and report of any action taken in closed session.
16. Opportunity for members of the public to address the Board of Directors on items of interest.
17. Adjournment.

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CALL TO ORDER	The meeting was called to order at 6:30 p.m. by John Ungersma, M.D..
PRESENT	John Ungersma, M.D., President M.C. Hubbard, Vice President Denise Hayden, Secretary D. Scott Clark, M.D., Treasurer Peter Watercott, Member
ALSO PRESENT	Douglas Buchanan, District Legal Counsel
OPPORTUNITY FOR PUBLIC COMMENT	Doctor Ungersma asked if any members of the public wished to comment on any item listed on the Notice for this meeting. No comments were heard.

CONSENT AGENDA

Doctor Ungersma then called attention to the proposed consent agenda for this meeting, which contained the following items:

1. Approval of the minutes of the following special meetings:

- October 2, 2013	- October 14, 2014	- October 24, 2013
- October 8, 2013	- October 22, 2013	- November 11, 2013
- October 9, 2014	- October 23, 2013	- November 20, 2013

2. Approval of the minutes of the October 16, 2013 regular meeting

It was moved by Denise Hayden, seconded by D. Scott Clark, M.D. and passed to approve the proposed consent agenda as presented, with a typographical correction being made to the October 24 2013 special meeting minutes.

CLOSED SESSION

At 6:34p.m. Doctor Ungersma reported the meeting would adjourn to closed session to allow the Board of Directors to:

A. Discuss employment of a Public Employee (Government Code section 54957), title: District Chief Executive Officer. The Board will convene in closed session to conduct confidential interviews of a candidate for the position of District Chief Executive Officer.

RETURN TO OPEN SESSION AND REPORT OF ACTION TAKEN	At 7:55 p.m. the meeting returned to open session. Doctor Ungersma reported that the Board took no reportable action.
OPPORTUNITY FOR PUBLIC COMMENT	Doctor Ungersma again asked if any members of the public wished to comment on any items listed on the Notice for this meeting. No comments were heard.
ADJOURNMENT	The meeting was adjourned at 7:55 p.m..

Signed: ______________________________
John Ungersma, M.D., President

Attest: ______________________________
Denise Hayden, Secretary

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NORTHERN INYO HOSPITAL

SECURITY REPORT

OCTOBER 2013

FACILITY SECURITY

Access security revealed thirty six exterior doors found unsecured during those hours when doors were to be secured. Two interior doors were found unsecured during this same time period.

Old Building roof access was found unsecure on four occasions.

Three Hospital Vehicles were found unlocked this month.

ALARMS

On October 1st, a HUGS Alarm activated by error.

On October 7th, a HUGS Alarm activated as the result of a damaged tag.

On October 25th, a HUGS Alarm activated by error.

On October 27th, a HUGS Alarm activated by error.

On October 28th, a HUGS Alarm activated as the result of a loose tag.

HUMAN SECURITY

On October 6th, Security was called to ICU for a combative, detox patient.

On October 7th, Security Staff observed two male subjects loitering around vehicles in the east parking lot. Contact was made with one subject as the other ran from the area. This subject continued walking upon contact and continued west along W. Line Street. PD was contacted and the area and vehicles were checked.

On October 8th, Security Staff observed an occupied vehicle north of the Lab Building. Upon contact, it was determined that two subject were sleeping in the vehicle. These individuals had no need for medical attention and complied with a request to leave Campus.

On October 12th, Security Staff stood by with an extremely intoxicated patient in the ED.

On October 13th, EMS Personnel presented to the ED with a very drunk and obnoxious female patient. Security Staff stood by until discharge.

On October 15th, Security Staff stood by in the ED with an agitated and slightly aggressive 5150 patient.

On October 18th, Security Staff was called to ICU for an uncooperative and combative detox patient.

On October 22nd, Security Staff was called to the ICU for a disturbed patient.

On October 26th, Security Staff assisted Bishop Police and ICSO Personnel with a extremely combative 5150 patient in the ED. Security and ICSO Personnel provided 24/7 supervision of this patient for approximately 48 hours while treatment was provided in ICU.

On October 29th, Security Staff stood by with ICSO Personnel for an uncooperative, in-custody drunk presented for a Medical Clearance.

On October 30th, Security Staff was called to an office in the Pioneer Building for a subject found to be trespassing in the building. The subject left the area prior to the arrival of Security. Bishop Police were contacted, the area was checked and a report was taken.

Security Staff provided Law Enforcement assistance on seven occasions this month. Four were for Lab BAC's.

Security Staff provided 5150 supervision on five occasions this month.

Security Staff provided Patient assistance 40 times this month.

EOC REPORTING INFORMATION

	OCTOBER 2013	YEAR TO DATE
FIRE DOORS / OPEN OR PROPPED	0	0
TRESPASSING	3	11
VANDALISM	0	0
DISORDERLY CONDUCT		
BY PATIENT	7	56
BY OTHERS	0	3
SUSPICIOUS ACTIONS		
PERSONS	3	10
VEHICLES	1	1
PERSONAL PROPERTY		
DAMAGE	0	0
LOSS	0	1
HOSPITAL PROPERTY		
DAMAGE	0	0
LOSS	0	0

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Northern Inyo Hospital
Balance Sheet
For Period: 3-2014 (09/01/2013 - 09/30/2013)

	YTD Balance
Current Assets:	
Cash and Equivaliants	$946,539
Short-Term Investments	$5,398,474
Assets Limited as to Use	$0
Plant Replacement and Expansion Fund	$2
Other Investments	$1,111,764
Patient Receivable	$43,120,747
Less: Allowances	$-30,165,630
Other Receivables	$739,152
Inventories	$2,985,144
Prepaid Expenses	$1,158,883
Total Current Assets	$25,295,075
Internally Designated for Capital Acquistions	$951,705
Special Purpose Assets	$805,520
Revenue Bonds Held by a Trustee	$3,284,133
Less Amounts Required to Meet Current Obligations	$0
Assets Limited as to use	$5,041,358
Long Term Investments	$674,564
Property & equipment, net Accumulated Depreciation	$88,860,806
Unamortized Bond Costs	$710,397
Total Assets	$120,582,201

Northern Inyo Hospital
Balance Sheet
For Period: 3-2014 (09/01/2013 - 09/30/2013)

	YTD Balance
Liabilities and Net Assets	
Current Liabilities:	
Current Maturities of Long-Term Debt	$-2,009,160
Accounts Payable	$-1,383,141
Accured Salaries, Wages & Benefits	$-4,040,994
Accrued Interest and Sales Tax	$-978,174
Deferred Income	$-395,087
Due to 3rd Party Payors	$-1,891,874
Due to Specific Purpose Funds	$0
Total Current Liabilites	$-10,698,429
Long Term Debt, Net of Current Maturities	$-52,945,620
Bond Premium	$-1,390,201
Total Long Term Debt	$-54,335,820
Net Assets	
Unrestricted Net Assets	$-54,742,432
Temprorily Restricted	$-805,520
Net Income	
Total Net Assets	$-55,547,952
Total Liabilities and Net Assets	$-120,582,201

Statement of Operation
Monthly Statement of Operations
For Period: 3-2014 (09/01/2013 - 09/30/2013)

	September	MTD Budget	MTD Variance	Actual YTD	YTD Budget	YTD Variance
Unrestricted Revenues, Gains & Other Support						
Inpatient Service Revenue						
Ancillary	763,695	583,574	180,121	1,770,919	1,789,626	(18,707)
Routine	2,981,234	2,284,280	696,954	7,387,328	7,005,140	382,188
Total Inpatient Service Revenue	3,744,928	2,867,854	877,074	9,158,247	8,794,766	363,481
Outpatient Service Revenue	6,141,623	5,873,124	268,499	19,258,102	18,010,906	1,247,196
Gross Patient Service Revenue	9,886,551	8,740,978	1,145,573	28,416,349	26,805,672	1,610,677
Less Deductions from Revenue						
Patient Service Revenue Deductions	(346,805)	(201,228)	(145,577)	(954,404)	(617,096)	(337,308)
Contractual Adjustments	(3,787,408)	(3,163,770)	(623,638)	(10,885,198)	(9,702,226)	(1,182,972)
Prior Period Adjustments	9,603	122,093	(112,490)	28,683	374,417	(345,734)
Total Deductions from Patient Service Revenue	(4,124,610)	(3,242,905)	(881,705)	(11,810,920)	(9,944,905)	(1,866,015)
Net Patient Service Revenue	5,761,941	5,498,073	263,868	16,605,429	16,860,767	(255,338)
Other revenue	21,604	84,322	(62,718)	42,547	258,584	(216,037)
Transfers from Restricted Funds for Operating Exp	87,043	132,250	(45,207)	261,129	405,566	(144,437)
Total Other Revenue	108,647	216,572	(107,925)	303,676	664,150	(360,474)
Expenses:						
Salaries and Wages	1,763,706	1,818,949	(55,243)	5,347,154	5,578,105	(230,951)
Employee Benefits	1,371,562	1,125,241	246,321	3,502,725	3,450,735	51,990
Professional Fees	482,008	449,041	32,967	1,781,727	1,377,065	404,662
Supplies	553,257	492,114	61,143	1,650,050	1,509,144	140,906
Purchased Services	321,115	254,435	66,680	756,060	780,263	(24,203)
Depreciation	294,064	424,081	(130,017)	881,261	1,300,515	(419,254)
Interest Expense	201,862	212,450	(10,588)	600,799	651,512	(50,713)
Bad Debts	439,913	234,272	205,641	891,752	718,434	173,318
Other Expense	372,799	315,408	57,391	1,180,797	967,252	213,545
Total Expenses	5,800,287	5,325,991	474,296	16,592,326	16,333,025	259,301
Operating Income (Loss)	70,301	388,654	(318,353)	316,780	1,191,892	(875,112)
Other Income:						
District Tax Receipts	43,899	41,816	2,083	131,696	128,236	3,460
Partnership Investment Incomce		0	0		0	0
Grants and Other Contributions Unrestricted	7,800	5,996	1,804	62,700	18,388	44,312
Interest Income	10,718	944	9,774	31,649	2,894	28,755
Other Non-Operating Income	6,782	12,464	(5,682)	13,192	38,228	(25,036)
Net Medical Office Activity	(234,435)	(338,684)	104,249	(743,299)	(1,038,634)	295,335
340B Net Activity	55,287	50,718	4,569	161,428	155,534	5,894
Non-Operating Income/Loss	(109,949)	(226,746)	116,797	(342,635)	(695,354)	352,719
Net Income/Loss	(39,647)	161,908	(201,555)	(25,855)	496,538	(522,393)

Investments as of 9/30/2013

	Purchase Dt	Maturity Dt	Institution	Broker	Rate	Principal
1	9/2/2013	10/1/2013	LAIF (Walker Fund)	Northern Inyo Hospital	0.26%	322,006.64
2	9/2/2013	10/1/2013	Local Agency Investment Fund	Northern Inyo Hospital	0.26%	4,503,967.07
3	9/24/2013	10/1/2013	Multi-Bank Securities	Multi-Bank Service	0.01%	572,500.76
4	5/20/2010	5/20/2015	First Republic Bank-Div of BOFA	Financial Northeaster Corp.	3.10%	100,000.00
5	8/2/2013	10/15/2016	Wachovia Corp New Note	Multi-Bank Service	1.38%	566,205.00
			Total			**$6,064,679.47**

Northern Inyo Hospital
Monthly Report of Capital Expenditures
Fiscal Year Ending JUNE 30, 2013
As of September 30, 2013

MONTH APPROVED BY BOARD	DESCRIPTION OF APPROVED CAPITAL EXPENDITURES		AMOUNT	
FY 2011-12	Additional Coppper and Fiberoptic Cable		29,884	
	Paragon Physician Documentation Module		137,254	
FY 2012-13	Zimmer Orthopedic Power Equipment		44,115	
	Paragon Rules Engine/Meaningful Use Stage 2 QeM	Plus annual fees	60,360	
	Centricity Upgrade and Practice Management Purchase	Rural Health Clinic	30,762	
	Centricity EMR and Practice Management	Medical Office Practices	204,118	
	Platinum Scan Station and Somo Viewer Station	Radiology	193,700	*
	GE Logic E9 Ultrasound Machine	Ultrasound	158,706	*
	AMOUNT APPROVED BY THE BOARD IN THE PRIOR FISCAL YEARS TO BE EXPENDED IN THE CURRENT FISCAL YEAR		858,899	
FY 2013-14	Puritan Bennett 840 Ventilator	Respiratory Therapy	28,747	*
	AMOUNT APPROVED BY THE BOARD IN THE CURRENT FISCAL YEAR TO BE EXPENDED IN THE CURRENT FISCAL YEAR		28,747	

Amount Approved by the Board in Prior Fiscal Years to be Expended in the Current Fiscal Year	858,899	
Amount Approved by the Board in the Current Fiscal Year to be Expended in the Current Fiscal Year	28,747	
Year-to-Date Board-Approved Amount to be Expended	535,240	
Year-to-Date Administrator-Approved Amount	158,945	*
Actually Expended in Current Fiscal Year	381,153	*
Year-to-Date Completed Building Project Expenditures	338,366	*
TOTAL FUNDS APPROVED TO BE EXPENDED	1,075,339	
Total-to-Date Spent on Incomplete Board Approved Expenditures	0	

Northern Inyo Hospital
Monthly Report of Capital Expenditures
Fiscal Year Ending JUNE 30, 2013
As of September 30, 2013

MONTH APPROVED BY BOARD	DESCRIPTION OF APPROVED CAPITAL EXPENDITURES	AMOUNT
	Reconciling Totals:	
	Actually Capitalized in the Current Fiscal Year Total-to-Date	
	Plus: Lease Payments from a Previous Period	
	Less: Lease Payments Due in the Future	540,098
	Less: Funds Expended in a Previous Period	0
	Plus: Other Approved Expenditures	0
		0
	ACTUAL FUNDS APPROVED IN THE CURRENT FISCAL YEAR TOTAL-TO-DATE	535,240
		1,075,339
	Donations by Auxiliary	
	Donations by Hospice of the Owens Valley	
	+Tobacco Funds Used for Purchase	0
		0
		0
		0
	*Completed Purchase	0

(Note: The budgeted amount for capital expenditures for all priority requests for the fiscal year ending June 30, 2013, is $943,036 coming from existing hospital funds.)

**Completed in prior fiscal year

Northern Inyo Hospital
Monthly Report of Capital Expenditures
Fiscal Year Ending JUNE 30, 2013
As of September 30, 2013

Administrator-Approved Item(s)	Department	Amount	Month Total	Grand Total
Broselow Cart Premier	Surgery	1,629		
Prime 5th Wheel Stretcher	PACU	7,630		
Prime 5th Wheel Stretcher	PACU	7,630		
Office Furnishing	Nursing Administration	3,896		
Harmonic Scalpel Generator	Surgery	3,995		
EMG Neuromax 1002 CE	Ortho Clinic	9,000		
Conversion of Walk-IN Freezer to Cooler	Dietary	4,552		
MONTH ENDING SEPTEMBER 30, 2013			**38,332**	**158,945**

Northern Inyo Hospital
PLANT EXPANSION AND REPLACEMENT BUILDING PROJECTS
Fiscal Year Ending JUNE 30, 2013
As of September 30, 2013
(Completed and Occupied or Installed)

Item		Amount	Grand Total
Turner Construction-final payment	Building	338,366	
MONTH ENDING SEPTEMBER 30, 2013			**338,366**

Northern Inyo Hospital
Balance Sheet
For Period: 4-2014 (10/01/2013 - 10/31/2013)

	YTD Balance
Current Assets:	
Cash and Equivaliants	$260,310
Short-Term Investments	$6,916,075
Assets Limited as to Use	$0
Plant Replacement and Expansion Fund	$2
Other Investments	$1,111,764
Patient Receivable	$41,022,197
Less: Allowances	$-29,794,182
Other Receivables	$-81,036
Inventories	$2,990,596
Prepaid Expenses	$1,420,112
Total Current Assets	$23,845,838
Internally Designated for Capital Acquistions	$951,745
Special Purpose Assets	$54,846
Revenue Bonds Held by a Trustee	$3,285,860
Less Amounts Required to Meet Current Obligations	$0
Assets Limited as to use	$4,292,451
Long Term Investments	$666,205
Property & equipment, net Accumulated Depreciation	$88,790,344
Unamortized Bond Costs	$706,256
Total Assets	$118,301,094

Northern Inyo Hospital
Balance Sheet
For Period: 4-2014 (10/01/2013 - 10/31/2013)

	YTD Balance
Liabilities and Net Assets	
Current Liabilities:	
Current Maturities of Long-Term Debt	$-1,550,724
Accounts Payable	$-963,158
Accured Salaries, Wages & Benefits	$-4,283,483
Accrued Interest and Sales Tax	$-463,741
Deferred Income	$-351,188
Due to 3rd Party Payors	$-1,415,000
Due to Specific Purpose Funds	$0
Total Current Liabilites	$-9,027,294
Long Term Debt, Net of Current Maturities	$-52,945,620
Bond Premium	$-1,385,097
Total Long Term Debt	$-54,330,717
Net Assets	
Unrestricted Net Assets	$-54,888,238
Tempororily Restricted	$-54,846
Net Income	
Total Net Assets	$-54,943,083
Total Liabilities and Net Assets	$-118,301,094

Statement of Operation
Monthly Statement of Operations
For Period: 4-2014 (10/01/2013 - 10/31/2013)

	October	MTD Budget	MTD Variance	Actual YTD	YTD Budget	YTD Variance
Unrestricted Revenues, Gains & Other Support						
Inpatient Service Revenue						
Ancillary	572,332	603,026	(30,694)	2,343,251	2,392,652	(49,401)
Routine	1,978,984	2,360,430	(381,446)	9,366,312	9,365,570	742
Total Inpatient Service Revenue	2,551,317	2,963,456	(412,139)	11,709,563	11,758,222	(48,659)
Outpatient Service Revenue	6,527,012	6,068,891	458,121	25,785,114	24,079,797	1,705,317
Gross Patient Service Revenue	9,078,329	9,032,347	45,982	37,494,678	35,838,019	1,656,659
Less Deductions from Revenue						
Patient Service Revenue Deductions	(362,789)	(207,934)	(154,855)	(1,317,194)	(825,030)	(492,164)
Contractual Adjustments	(3,927,201)	(3,269,228)	(657,973)	(14,812,399)	(12,971,454)	(1,840,945)
Prior Period Adjustments	838,566	126,162	712,404	867,248	500,579	366,669
Total Deductions from Patient Service Revenue	(3,451,425)	(3,351,000)	(100,425)	(15,262,345)	(13,295,905)	(1,966,440)
Net Patient Service Revenue	5,626,904	5,681,347	(54,443)	22,232,333	22,542,114	(309,781)
Other revenue	13,914	87,131	(73,217)	56,461	345,715	(289,254)
Transfers from Restricted Funds for Operating Exp	87,043	136,658	(49,615)	348,172	542,224	(194,052)
Total Other Revenue	100,957	223,789	(122,832)	404,633	887,939	(483,306)
Expenses:						
Salaries and Wages	1,873,433	1,879,578	(6,145)	7,220,586	7,457,683	(237,097)
Employee Benefits	971,961	1,162,747	(190,786)	4,474,686	4,613,482	(138,796)
Professional Fees	652,272	464,012	188,260	2,433,999	1,841,077	592,922
Supplies	529,272	508,515	20,757	2,179,322	2,017,659	161,663
Purchased Services	289,814	262,914	26,900	1,045,874	1,043,177	2,697
Depreciation	269,147	438,217	(169,070)	1,150,408	1,738,732	(588,324)
Interest Expense	202,420	219,531	(17,111)	803,219	871,043	(67,824)
Bad Debts	237,389	242,081	(4,692)	1,129,141	960,515	168,626
Other Expense	273,173	325,922	(52,749)	1,453,970	1,293,174	160,796
Total Expenses	5,298,880	5,503,517	(204,637)	21,891,206	21,836,542	54,664
Operating Income (Loss)	428,980	401,619	27,361	745,760	1,593,511	(847,751)
Other Income:						
District Tax Receipts	43,899	43,210	689	175,594	171,446	4,148
Partnership Investment Incomce		0	0		0	0
Grants and Other Contributions Unrestricted		6,196	(6,196)	62,700	24,584	38,116
Interest Income	13,810	975	12,835	45,459	3,869	41,590
Other Non-Operating Income		12,882	(12,882)	13,192	51,110	(37,918)
Net Medical Office Activity	(336,496)	(349,975)	13,479	(1,079,795)	(1,388,609)	308,814
340B Net Activity	(4,428)	52,408	(56,836)	157,000	207,942	(50,942)
Non-Operating Income/Loss	(283,215)	(234,304)	(48,911)	(625,850)	(929,658)	303,808
Net Income/Loss	145,765	167,315	(21,550)	119,910	663,853	(543,943)

Northern Inyo Hospital

Investments as of 10/31/2013

	Purchase Dt	Maturity Dt	Institution	Rate	Principal
1	10/15/2013	11/1/2013	LAIF (Walker Fund)	0.27%	322,210.49
2	10/15/2013	11/1/2013	Local Agency Investment Fund	0.27%	6,007,292.65
3	10/16/2013	11/1/2013	Multi-Bank Securities	0.01%	586,572.35
4	5/20/2010	5/20/2015	First Republic Bank-Div of BOFA FNC	3.10%	100,000.00
5	8/2/2013	10/15/2016	Wachovia Corp New Note	1.38%	566,205.00
			Total		**$7,582,280.49**

Northern Inyo Hospital
Monthly Report of Capital Expenditures
Fiscal Year Ending JUNE 30, 2013
As of October 31, 2013

MONTH APPROVED BY BOARD	DESCRIPTION OF APPROVED CAPITAL EXPENDITURES		AMOUNT
FY 2011-12	Additional Coppper and Fiberoptic Cable		29,884
	Paragon Physician Documentation Module		137,254
FY 2012-13	Zimmer Orthopedic Power Equipment		44,115
	Paragon Rules Engine/Meaningful Use Stage 2 QeM	Plus annual fees	60,360
	Centricity Upgrade and Practice Management Purchase	Rural Health Clinic	30,762
	Centricity EMR and Practice Management	Medical Office Practices	204,118
	Platinum Scan Station and Somo Viewer Station	Radiology	193,700 *
	GE Logic E9 Ultrasound Machine	Ultrasound	158,706 *
	AMOUNT APPROVED BY THE BOARD IN THE PRIOR FISCAL YEARS TO BE EXPENDED IN THE CURRENT FISCAL YEAR		858,899
FY 2013-14	Puritan Bennett 840 Ventilator	Respiratory Therapy	28,747 *
	AMOUNT APPROVED BY THE BOARD IN THE CURRENT FISCAL YEAR TO BE EXPENDED IN THE CURRENT FISCAL YEAR		28,747

Amount Approved by the Board in Prior Fiscal Years to be Expended in the Current Fiscal Year	858,899
Amount Approved by the Board in the Current Fiscal Year to be Expended in the Current Fiscal Year	28,747
Year-to-Date Board-Approved Amount to be Expended	535,240
Year-to-Date Administrator-Approved Amount	158,945 *
Actually Expended in Current Fiscal Year	381,153 *
Year-to-Date Completed Building Project Expenditures	476,920 *
TOTAL FUNDS APPROVED TO BE EXPENDED	1,075,339

Total-to-Date Spent on Incomplete Board Approved Expenditures 0

Northern Inyo Hospital
Monthly Report of Capital Expenditures
Fiscal Year Ending JUNE 30, 2013
As of October 31, 2013

MONTH APPROVED BY BOARD	DESCRIPTION OF APPROVED CAPITAL EXPENDITURES	AMOUNT
Reconciling Totals:		
Actually Capitalized in the Current Fiscal Year Total-to-Date		
Plus: Lease Payments from a Previous Period		
Less: Lease Payments Due in the Future		540,098
Less: Funds Expended in a Previous Period		0
Plus: Other Approved Expenditures		0
		0
ACTUAL FUNDS APPROVED IN THE CURRENT FISCAL YEAR TOTAL-TO-DATE		535,240
		1,075,339
Donations by Auxiliary		
Donations by Hospice of the Owens Valley		
+Tobacco Funds Used for Purchase		0
		0
		0
		0
*Completed Purchase		0

(Note: The budgeted amount for capital expenditures for all priority requests for the fiscal year ending June 30, 2013, is $943,036 coming from existing hospital funds.)

**Completed in prior fiscal year

Northern Inyo Hospital
Monthly Report of Capital Expenditures
Fiscal Year Ending JUNE 30, 2013
As of October 31, 2013

Administrator-Approved Item(s)	Department	Amount	Month Total	Grand Total
Captus 3000 Thyroid Uptake System	Nuclear Medicine	20,352		
Office Furnishing	Nursing Supervision	4,491		
Ergotron SV42 w/Pivot 1 Drawer Life	Information Tech	5,355		
Simpad System	Staff Development	11,369		
McKesson Compliance Advisor Upgrade	Information Tech	11,766		
MONTH ENDING OCTOBER 31, 2013			**53,333**	**212,278**

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AGREEMENT FOR SERVICES TO THE
NORTHERN INYO HOSPITAL
ELECTROCARDIOGRAPHIC DEPARTMENT

THIS AGREEMENT MADE AND ENTERED INTO this 1st day of December, 2013, by and between NORTHERN INYO COUNTY LOCAL HOSPITAL DISTRICT (hereinafter "Hospital") and James Richardson, M.D. (hereinafter "Physician").

I
RECITALS

A. Hospital is located at 150 Pioneer Lane, Bishop, California, and operates therein a service designated as the Electrocardiography Department (hereinafter "EKG Department").

B. Physician is a sole practitioner licensed to practice medicine in the State of California, and a diplomate of the American Board of Internal Medicine. Physician has represented and does represent, to the Hospital that, on the basis of his or her training or experience, he or she is knowledgeable in the interpretation of electrocardiographs (hereinafter "EKGs") and is readily available to interpret EKGs.

C. Hospital desires to contract with Physician to provide professional interpretation of EKGs done on patients at the Hospital.

D. The parties desire to enter this Agreement to provide a complete statement of their respective duties and obligations.

E. The term "EKG" shall mean all products of the EKG Department, including but without limitation, electrocardiographs, rhythm strips, stress tests, event recorders, and telemetry strips.

NOW, THEREFORE, in consideration of the covenants and agreements set forth below, the parties agree as follows:

II
COVENANTS OF PHYSICIAN

1. Physician shall perform the follow services:

a. Be available to provide interpretation of all full and partial cardiac function studies performed by the EKG Department on Physician's patients. Said interpretations are to be done within 24 hours of the time the EKG studies are performed. Physician shall have no exclusive right to read studies hereunder, and acknowledges that EKG and treadmill studies may be read by any other physician deemed qualified to do so by the Medical Staff Executive Committee.

b. Physician acknowledges that Hospital has retained the services of Asao Kamei, M.D. (hereinafter "Dr. Kamei"), to serve as Chief of the EKG Department and agrees that, should Physician fail to read and interpret any EKG which he or she is obligated to read within 24 hours of its creation, or should Physician fail to read and interpret any EKG done in preparation for any surgery, whether emergency or elective, if said EKG has not been read within a reasonable time prior to the time scheduled for said surgery, said EKG will be read and interpreted by Dr. Kamei, and he shall receive compensation from the Hospital for such service. Physician acknowledges and agrees that in such event, Physician will not be compensated by the Hospital, but nonetheless may read and interpret the relevant EKG as may be required for the care of his or her own patients. In regard to the circumstances set forth in this sub-paragraph (b), Physician further acknowledges and agrees that Dr. Kamei may designate another qualified physician (who must also be a Diplomate of the American Board of Internal Medicine) to perform such services for him in the event of his or her absence or inability to perform such services.

c. Physician acknowledges and agrees that Dr. Kamei, acting in his role as Chief of the EKG Department, may read any EKG done in the Hospital.

d. Participate in retrospective evaluation of care provided in the EKG Department.

e. Be available to provide interpretation of EKGs for patients under the care of Physician who were seen in the Hospital's Emergency Room Department whether or not said patient was seen by the Physician in the Emergency Room.

f. Be available to provide interpretation of EKGs for emergent pre-operative patients under the care of the Physician.

2. Physician shall at all times comply with the policies, rules and regulations of the Hospital, subject to State and federal statutes covering his or her practice. No part of the Hospital premises shall be used, at any time, by Physician for the general practice of medicine except during the exercise of privileges granted Physician as a member of the Hospital Active Medical Staff.

3. Physician agrees to maintain books, records, documents, and other evidence pertaining to all costs and expenses incurred, and revenue acquired, pursuant to this

agreement to the extent, and in such detail, as will properly reflect all net costs, direct and indirect, of labor, materials, equipment, supplies and services, and other costs and expenses of whatever nature, for which he or she may claim payment or reimbursement from the Hospital. Physician acknowledges and agrees that any federal office authorized by law shall have access, for the purpose of audit and examination, to any books, documents, papers, and records of Physician which are relevant to this Agreement, at all reasonable times for a period of four (4) years following the termination of this Agreement, during which period Physician shall preserve and maintain said books, documents, papers and records. Physician further agrees to transfer to the Hospital, upon termination of this Agreement, any books, documents, papers or records which possess long-term (i.e., more than four (4) years) value to the Hospital. Physician shall include a clause providing similar access in any subcontract he or she may enter with a value of more than $10,000, or for more than a 12-month period, when said sub-contract is with a related organization.

4. Physician acknowledges, covenants, and agrees that Hospital shall have no obligation to compensate him or her for EKGs read in the following cases:

   a. Where a patient seen in the Emergency Room is not identified as being in the care of Physician and the EKG is subsequently read by the Chief;
   b. Where a patient first seen in the Emergency Room and who has not previously been under the care of Physician, is admitted to the Hospital to the care of Physician after the patient's EKG has been read by the Chief;
   c. Where any member of the Hospital Medical Staff requests Physician to consult on a patient after the patient's EKG is read by the Chief;
   d. Where Physician has not been identified as the primary physician of a patient at the time a patient's pre-operative EKG is read by the Chief;
   e. For any EKG not read within 24 hours of its creation.

III
COVENANTS OF THE HOSPITAL

1. Hospital shall furnish, for the use of Physician in rendering services hereunder:

   a. Sufficient space in the Hospital to enable him or her to perform his or her duties under this Agreement; and,

   b. Ordinary janitorial and in-house messenger service, and such electricity for light and power, gas, water, and heat as may be required by him or her to perform his or her duties under this Agreement.

2. Hospital shall pay Physician in accordance with Exhibit A for all interpretation rendered by the Physician. Said sums are payable on the twentieth (20th) day of the calendar month immediately following the service performed. Payments made pursuant to this Paragraph 2 shall be deemed Physician's full, complete, and reasonable compensation for services under this Agreement.

3. Hospital shall allow any member of the Hospital Medical Staff to designate, in writing, any physician who is (a) also a member of the Hospital Active Medical Staff and (b) a diplomate of the American Board of Internal Medicine, as the physician who shall be entitled to read EKGs for any patient admitted to the Hospital to the care of said physician, and Hospital shall compensate said physician for the services thereafter rendered provided that (c) said physician has executed an agreement with Hospital identical to this Agreement and (d) the written designation described in this subdivision is renewed, in writing, annually.

4. Hospital will attempt, insofar as is reasonably possible in the circumstances, to identify and notify the primary physician of any patient treated in the Hospital's Emergency Room Department and/or Surgery Department.

IV
GENERAL PROVISIONS

1. Services to be performed by Physician under this Agreement may be performed by other physicians who are approved in writing (which approval is revocable) by Hospital and who shall be members of the Hospital Active Medical Staff. If Physician is absent, services required to be performed by Physician under this Agreement shall be performed by Dr. Kamei or his designee. Notwithstanding anything to the contrary contained herein, Physician shall not have the right to assign this agreement, or any rights or obligations thereunder, without the written consent of Hospital first had and obtained.

2. In the performance of his or her duties and obligations under this Agreement, it is further mutually understood and agreed that:

    a. Physician is at all times acting and performing as an independent contractor, that Hospital shall neither have nor exercise any control or direction over the methods by which he or she shall perform his or her work and functions (except that Physician shall do so at all times in strict compliance with currently approved methods and practices of internal medicine and cardiology, and in accord with the Hospital's Bylaws and with the Hospital Medical Staff Bylaws and Rules and Regulations), and that the sole interest of Hospital is to assure that the services of Physician shall be performed and rendered, and the EKG Department shall be

operated, in a competent, efficient, and satisfactory manner in accord with the highest medical standards possible.

b. No act, commission, or omission of Physician pursuant to the terms and conditions of this Agreement shall be construed to make or render Physician an agent, employee, or servant of the Hospital.

c. It is the intent of the parties that Physician be an independent contractor, and not an employee, in the performance of his or her duties under this Agreement. In order to protect the Hospital from liability, Physician shall defend, indemnify, and hold harmless the Hospital from liability for any and all claims arising out of the performance of his or her duties under this Agreement.

3. Physician shall, at all relevant times, be a member of the Hospital Active Medical Staff.

4. Each party shall comply with all applicable requirements of law relating to licensure and regulation of both physicians and hospitals.

5. This is the entire agreement of the parties, and supersedes any and all prior oral and/or written agreements. It may be modified only by a written instrument signed by both parties.

6. Whenever, under the terms of this Agreement, written notice is required or permitted to be given, such notice shall be deemed given when deposited in the United States mail, first class postage prepaid, addressed as follows:

HOSPITAL: Administrator
Northern Inyo Hospital
150 Pioneer Lane
Bishop, California 93514

PHYSICIAN: James Richardson, M.D.
307 Academy
Bishop, California 93514

or to such other address as either party may notify the other, in writing.

7. The term of this Agreement is one (1) year, commencing on December 1, 2013 and ending at midnight on November 30, 2014.

8. Notwithstanding the aforesaid term, Hospital may terminate this Agreement immediately upon the occurrence of any of the following events:

a. Physician's death, loss of Hospital Active Medical Staff membership, loss of license to practice medicine, or loss of Active Medical Staff privileges required to render services under this Agreement;

b. Physician's inability to render services hereunder;

c. The appointment of a receiver of the assets of Physician, an assignment by him or her for the benefit of his or her creditors, or any action taken or suffered by him or her (with respect to him or her) under any bankruptcy or insolvency law;

d. Closure of the Hospital;

e. Sixty (60) days after written notice of termination without cause is given by Hospital to Physician.

However, the parties understand and acknowledge that termination of this Agreement shall not affect Physician's membership on the Hospital Medical Staff.

9. Originals of medical records of the EKG Department are the property of the Hospital and shall be retained on Hospital premises. Physician shall have access to, and may photocopy, such documents and records as may be required for the care of his or her patients or to perform his or her duties under this Agreement, provided only that he or she gives reasonable notice. Physician shall complete all reports required of him or her by Hospital, for the performance of his or her duties under this Agreement, within 24 hours of the time the EKG is performed. Physician acknowledges that, should he or she remove an original EKG from the custody of the EKG Department, he or she shall return it to the custody of the EKG Department within the 24-hour period required for reading as set forth in Article II, section 1(a) above. "Custody" includes, but is not limited to, the physical premises occupied by the EKG Department and any EKG machines, carts, or collection or storage vehicles located within the Hospital but outside the EKG Department physical premises. Physician shall not destroy or mutilate originals of medical records or EKGs.

10. This Agreement is for the personal services of Physician and Physician may not assign his or her rights, duties, obligations or responsibilities thereunder.

11. Subject to the restrictions against transfer or assignment set forth above, the provisions of this Agreement shall inure to the benefit, and be binding upon, the heirs, successors, assigns, agents, personal representatives, conservators, executors and administrators of the parties.

12. Use of the masculine, feminine or neuter gender, and/or of the singular or plural number, shall include the other when the context shall indicate.

This agreement may be executed in counterparts, each of which shall be an original but all of which shall constitute one and the same agreement.

IN WITNESS WHEREOF, the parties have executed this Agreement at Bishop, California on the day, month and year first above written.

NORTHERN INYO COUNTY
LOCAL HOSPITAL DISTRICT

By ______________________________
John Ungersma, M.D. President
Board of Directors

____
James Richardson, M.D.
307 Academy
Bishop, California 93514

EXHIBIT A
EKG INTERPRETATION RATES

1.	EKG Interpretation	$ 20.50
2.	Rhythm Strip	$ 17.00
3.	Tele Strip	$ 20.00
4.	Cardiac event recorder	$ 36.45
5.	Treadmill Study	$107.10
6.	Cardiac Nuclear	$133.75
7.	Adenosine Nuclear	$157.50

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NORTHERN INYO HOSPITAL
GENERAL ANESTHESIA CO-MEDICAL DIRECTOR AND
PROFESSIONAL SERVICES AGREEMENT

(COWAN AND SCHWEIZER AGREEMENTS ARE IDENTICAL)

This Co-Medical Director and Professional Services Agreement ("Agreement") dated this 1st day of January, 2014, is entered into by and between Northern Inyo County Local Hospital District ("Hospital") and Curt Schweizer, M.D. (Physician).

RECITALS

A. Hospital operates a general acute care hospital, which, among other things, operates inpatient and outpatient major and minor surgery suites, offering a variety of surgical procedures, located at 150 Pioneer Lane, Bishop, California.

B. Physician are individuals duly licensed to practice medicine in the State of California, specializing in general anesthesia, are Board Certified in anesthesia, and are members of the Northern Inyo Hospital Active Medical Staff with privileges sufficient to practice general anesthesia.

C. Hospital desires to obtain administrative and professional medical services from Physician for the patients of Hospital, and Physician desire to furnish such services upon the terms and conditions set forth in this Agreement.

D. Hospital believes that high standards of patient care can be achieved if Physician assumes the responsibilities set out further in this Agreement.

IN WITNESS WHEREOF, ALL PARTIES AGREE AS FOLLOWS:

I.

RESPONSIBILITIES OF THE PHYSICIAN.

1.01. **Professional Services**. Physician shall provide the following services, consistent with the Hospital's policies and procedures, to the Hospital and Hospital patients, provided that Physician's obligations hereunder are limited to the provision of services within his professional capabilities:

a) Medical Services. In cooperation with the Hospital, arrange for appropriate coverage for the provision of professional anesthesia services to Hospital patients.

Physician shall cooperate in Hospital's participation in the Medicare and Medi-Cal programs. Physician shall provide services to Medicare and Medi-Cal beneficiaries in a nondiscriminatory manner.

Anesthesiologists will be solely responsible for developing a mechanism for scheduling surgical assignments between and amongst themselves for scheduled cases at the Hospital, which will cover not less that one operating room per day, five days a week, excluding Hospital holidays, for the first room, and not less than 120 days per year for a second

operating room. The protocol for scheduling the second room will be determined and agreed to jointly between the anesthesiologists and memorialized in a written memorandum after acceptance by Administration. Physician shall not be required to provide more than 90 days of second room coverage per year.

b) On-Call Coverage. Anesthesiologists shall provide on-call anesthesia coverage for the Hospital twenty-four hours per day, seven days per week, and 365 days per year. Anesthesiologists are specifically required to communicate with each other sufficiently to ensure continuous and non-interrupted call coverage. In the event that Physician is unable to provide said coverage he is specifically required to provide an equally qualified locums tenens or the equivalent at his own expense. Physician shall not be required to provide more than 26 weeks per year of call coverage on an annualized basis.

c) Administrative Services. As Co-Medical Directors, Physician will assist the Hospital in meeting all State and Federal legal and regulatory requirements, including but not limited to those found in Title XXII and Medicare's "Conditions of Participation" as well as those of any accreditation agency the Hospital may be participating with. These functions may include, but will not be limited to, review, creation, and revision of policies and procedures as they relate to anesthesia.

Additionally the Co-Medical Directors will be called upon to help promote the Hospital in regards to procedures offered at the Hospital and will take an active role in insuring that the Hospital is keeping up to date technologically and medically. Co-Medical Directors will provide the services described in Exhibit "A" as well as assist Hospital personnel in providing educational programs to Medical Staff, employees, and others.

1.02. Medical Director and Administrative Services. Physician shall act as Co-Medical Director of the Hospital's anesthesia service.

a) Time Commitment. Physician shall not be required to devote more than four (4) hours per month to the administrative services described in this Agreement.

b) Physician Time Reports. Physician shall maintain weekly time reports, which provide accurate accountings of time spent, on a daily basis, providing administrative services to the Hospital. Such reports shall be substantially in the form attached as Exhibit B, or as otherwise required by Hospital, and shall document Physician's actual provision of administrative services. All time reports shall be submitted to Hospital no later than the 10th day of the calendar month following the month in which the services were performed.

1.03. Personal Services. This Agreement is entered into by Hospital in reliance on the professional and administrative skills of Physician. Physician shall continue to be primarily responsible for fulfilling the terms of the Agreement, except as specifically set forth in this Agreement. . The physician will be specifically permitted to arrange for any other anesthesiologist to substitute his/her services in the stead of the contracting physician so long as the substituting physician is an active member of the Medical Staff.

1.04. Absences. In the event Physician is unable to perform the obligations under this Agreement due to illness, continuing education responsibilities, leave or other justifiable cause, Hospital shall designate a qualified replacement. The person who provides services on behalf of Physician in Physician's absence shall be bound by all terms of this Agreement. Hospital shall

have the right to approve the length of Physician's absence, and any unapproved absence shall constitute a breach of this Agreement.

1.05. Non-Exclusive Arrangement. Physician shall provide professional services to and for the benefit of the Hospital. All revenues associated with Hospital activities (non professional fee, typically part A) belong to the Hospital. Physician shall bill and retain all billings associated with professional anesthesia services.

This is not an exclusive arrangement with the Hospital. Physician therefore is free to seek supplemental income arrangements elsewhere; however they will give first priority to performing all Hospital activities consistent with the terms of this Agreement. Physician shall not undertake non-Hospital activities to the extent that such undertaking would interfere with his obligations under this Agreement.

1.07. Limitation on Use of Space. No part of the Hospital's premises shall be used at any time by Physician as an office for the private practice of medicine or to see patients other than Hospital patients.

II.

HOSPITAL RESPONSIBILITIES.

2.01. Hospital Services.

a) Space. Hospital shall make available for Physician reasonably necessary facilities for the successful provision of anesthesia services. This may include a hospital approved Pain Management Service,

b) Equipment. In consultation with Physician, Hospital shall make all decisions regarding the acquisition of all equipment as may be reasonably necessary for the proper operation and conduct of Hospital. Hospital shall repair, replace or supplement such equipment and maintain it in good working order.

III.

COMPENSATION AND INCOME GUARANTEE.

3.01. Compensation. Hospital shall pay each anesthesiologist $2000.00 per month for administrative services during the term of this Agreement. In addition, Hospital shall guarantee a surgical case volume such that Physician receives payments from private billings, net of all billing expense, contractual adjustments, discounts and refunds, in the amount of $631,736.28 annually on a pro-rated basis. Said pro-ration shall be the physicians share of first call taken. This compensation will be adjusted annually by a factor of 1.05 plus the employee COLA.

3.02.1 Compensation Methodology . Within ten working days of the end of each quarter and the receipt of billings report(s) from the Physician billing service, the Hospital will calculate the pro-rated receipts for Physician. In the event that this yields an amount less than the pro-rated share indicated in 3.01 the Hospital will fund the difference to the Physician. In the event this amount is in excess, the Hospital will credit that amount against future payments. At he the end

of each calendar year the Hospital will fund any credits to the physician.
A full accounting will be provided for each quarter's transactions by the hospital.

Should this agreement terminate under section 4.02 of this agreement, Physician shall be entitled to 100% of the uncollected billings

3.03 **Second Room Compensation.** In those quarters when the Physician is scheduled for the second room in excess of 8.0 days per quarter, on an annualized basis (30 days per year), he shall be compensated $400 per day.

3.04 **Additional Compensation.** Compensation will be adjusted by the same amount as the Cost Of Living Adjustments received by the NIH employees in the same amount at the same time

IV.

TERM AND TERMINATION.

4.01. **Term**. The term of this Agreement shall be for a period of twenty four months beginning on the first day of January, 2014 and ending on the 31st day of December, 2015.

4.02. **Termination**. Notwithstanding the provisions of section 4.01 of this Agreement, this Agreement may be terminated:

a) By either party at any time, without cause or penalty, upon 90 days' prior written notice to the other party;

b) Immediately by Hospital in its sole discretion if Physician fails to maintain the professional standards described in this Agreement;

c) Immediately upon closure of the Hospital;

d) By either party upon written notice to the other party in the event that any federal, state or local government or agency passes, issues or promulgates any law, rule, regulation, standard or interpretation at any time while this Agreement is in effect that prohibits, restricts, limits or in any way substantially changes the arrangement contemplated herein or which otherwise significantly affects either party's rights or obligations under this Agreement; provided that in such event, Hospital must give notice to Physician equal to that provided to Hospital by the relevant federal, state or local government or agency. If this Agreement can be amended to the satisfaction of both parties to compensate for any such prohibition, restriction, limitation or change, this clause shall not be interpreted to prevent such amendment; or

e) By either party in the event of a material breach by the other party, and in such event, the non-breaching party shall have the right to terminate this Agreement after providing thirty (30) days' written notice to the breaching party, unless such breach is cured to the satisfaction of the non-breaching party within the thirty (30) days.

f) Automatically with ninety (90) days' notice, at such time as the Medical Staff approves privileges for a third qualified, practicing anesthesiologist.

g) Immediately upon death or disability such that Physician is physically unable to perform the duties required under this agreement.

4.03. Rights Upon Termination. Upon any termination or expiration of this Agreement, all rights and obligations of the parties shall cease except those rights and obligations that have accrued or expressly survive termination.

V.

PROFESSIONAL STANDARDS.

5.01. Medical Staff Standing. Prior to performing services pursuant to this Agreement, Physician must obtain full Active or Provisional Medical Staff membership privileges on the Medical Staff of Hospital with appropriate clinical privileges, and maintain such membership throughout the term of this Agreement. Such membership shall be subject to all of the privileges and responsibilities of Medical Staff membership.

5.02. Licensure and Standards. Physician shall:

a) At all times be licensed to practice medicine in the State of California;

b) Comply with all policies, bylaws, rules and regulations of Hospital and Hospital Medical Staff, including those related to documenting all advice to patients and proper sign-off of lab and X-ray reports;

c) Be a member, in good standing, of the Active Medical Staff of the Hospital;

d) Maintain professional liability coverage in an amount required for membership on the Active Medical Staff of the Hospital;

e) Participate in continuing education as necessary to maintain licensure and the current standard of practice;

f) Comply with all applicable laws, rules and regulations of any and all governmental authorities, and applicable standards and recommendations of the Joint Commission on Accreditation of Healthcare Organizations.

g) Maintain a professional image to the public, the Medical Staff and the Hospital employees. Said professional image would not include public intoxication, drug abuse of any kind, failure to respond to reasonable requests of the Medical Staff, or failure to perform the duties required by the Medical Staff, the District Board and this Agreement.

h) The physician specifically agrees to abide by the Professional Conduct Prohibition of Disruptive or Discriminatory Behavior Policy attached hereto.

VI.

RELATIONSHIP BETWEEN THE PARTIES.

6.01. Professional Relations.

a) Independent Contractor. No relationship of employer and employee is created by this Agreement. In the performance of Physician's work and duties, Physician are at all times acting and performing as independent contractors, practicing the profession of medicine.

Hospital shall neither have nor exercise control or direction over the methods by which Physician perform professional services pursuant to this Agreement; provided, however, that Physician agree that all work performed pursuant to this Agreement shall be in strict accordance with currently approved methods and practices in Physician' professional specialty and in accordance with the standards set forth in this Agreement. The sole interest of Hospital is to insure that such services are performed and rendered in a competent and cost effective manner.

b) Benefits. Except as specifically set forth in this Agreement, it is understood and agreed that Physician shall have no claims under this Agreement or otherwise against Hospital for social security benefits, worker's compensation benefits, disability benefits, unemployment benefits, sick leave, or any other employee benefits of any kind. In addition, Hospital shall have no obligation to reimburse Physician for any costs or expenses associated with Physician' compliance with continuing medical education requirements.

6.02. Responsibility for Own Acts. Each party will be responsible for its own acts or omissions and all claims, liabilities, injuries, suits, demands and expenses of all kinds which may result or arise out of any malfeasance or neglect, caused or alleged to have been caused by either party, their employees or representatives, in the performance or omission of any act or responsibility of either party under this contract. In the event that a claim is made against both parties, it is the intent of both parties to cooperate in the defense of said claim and to cause their insurers to do likewise. However, both parties shall have the right to take any and all actions they believe necessary to protect their interest.

VII.

GENERAL PROVISIONS.

7.01. No Solicitation. Physician agrees that he will not, either directly or indirectly, during and after the term of this Agreement, call on, solicit or take away, or attempt to call on, solicit or take away any patients or patient groups with whom Physician dealt or became aware of as a result of Physician' past, present or future affiliation with Hospital.

7.02. Access to Records. To the extent required by Section 1861(v)(i)(I) of the Social Security Act, as amended, and by valid regulation which is directly applicable to that Section, Physician agree to make available upon valid written request from the Secretary of HHS, the Comptroller General, or any other duly authorized representatives, this Agreement and the books, documents and records of Physician to the extent that such books, documents and records are necessary to certify the nature and extent of Hospital's costs for services provided by Physician.

Physician shall also make available such subcontract and the books, documents, and records of any subcontractor if that subcontractor performs any of the Physician' duties under this Agreement at a cost of $10,000 or more over a twelve-month period, and if that subcontractor is organizationally related to Physician.

Such books, documents, and records shall be preserved and available for four (4) years after the

furnishing of services by Physician pursuant to this Agreement. If Physician is requested to disclose books, documents or records pursuant to this subsection for purposes of an audit, Physician shall notify Hospital of the nature and scope of such request, and Physician shall make available, upon written request of Hospital, all such books, documents or records. Physician shall indemnify and hold harmless Hospital in the event that any amount of reimbursement is denied or disallowed because of the failure of Physician or any subcontractor to comply with their obligations to maintain and make available books, documents, or records pursuant to this subsection. Such indemnity shall include, but not be limited to the amount of reimbursement denied, plus any interest, penalties and legal costs.

This section is intended to assure compliance with Section 1861 of the Social Security Act, as amended, and regulations directly pertinent to that Act. The obligations of Physician under this section are strictly limited to compliance with those provisions, and shall be given effect only to the extent necessary to insure compliance with those provisions. In the event that the requirements or those provisions are reduced or eliminated, the obligations of the parties under this section shall likewise be reduced or eliminated.

7.03. **Amendment**. This Agreement may be amended at any time by mutual agreement of the parties, but any such amendment must be in writing, dated, and signed by all parties.

7.04. **Assignment**. Except as provided in section 1.01 b) above, Physician shall not assign, sell, transfer or delegate any of the Physician' rights or duties, including by hiring or otherwise retaining additional Physician to perform services pursuant to this Agreement, without the prior written consent of Hospital.

7.05. **Attorneys' Fees**. If any legal action or other proceeding is commenced by either party, to enforce rights, duties, and/or responsibilities under this Agreement, the prevailing party shall be entitled to recover reasonable attorney's fees and costs. As used in this Section 7.05, the term "prevailing party" shall have the meaning assigned by Section 1032(a)(4) of the California Code of Civil Procedure.

7.06. **Choice of Law**. This Agreement shall be construed in accordance with, and governed by, the laws of the State of California.

7.07. **Exhibits**. All Exhibits attached and referred to herein are fully incorporated by this reference.

7.08. **Notices**. All notices or other communications under this Agreement shall be sent to the parties at the addresses set forth below:

Hospital: Administrator
Northern Inyo Hospital
150 Pioneer Lane
Bishop, CA 93514

Physician: Curt Schweizer, M.D.
398 Vista Road
Bishop, CA 93514

7.09. **Records**. All files, charts and records, medical or otherwise, generated by Physician in connection with services furnished during the term of this Agreement are the property of Hospital. Physician agrees to maintain medical records according to Hospital policies and procedures and in accordance with community standards. Each party agrees to maintain the confidentiality of all records and materials in accordance with all applicable state and federal laws. Hospital agrees to permit Physician to have access during or after the term of the Agreement to medical records generated by Physician if necessary in connection with claims, litigation, investigations, or treatment of patients.

7.10. **Prior Agreements**. This Agreement represents the entire understanding and agreement of the parties as to those matters contained in it. No prior oral or written understanding shall be of any force or effect with respect to the matters contained in this Agreement. Any modification of this Agreement must be in writing and signed by the parties.

7.11. **Referrals**. This Agreement does not impose any obligation or requirement that Hospital shall make any referral of patients to Physician or that Physician shall make any referral of patients to Hospital. The payment of compensation pursuant to section 3.01 is not based in any way on referrals of patients to Hospital.

7.12. **Severability**. If any provision of this Agreement is determined to be illegal or unenforceable, that provision shall be severed from this Agreement, and the remaining provisions shall remain enforceable between the parties.

7.13. **Waiver**. The failure of either party to exercise any right under this Agreement shall not operate as a waiver of that right.

7.14. **Gender and Number**. Use of the masculine gender shall mean the feminine or neuter, and the plural number the singular, and vice versa, as the context shall indicate.

7.15. **Authority and Executive**. By their signature below, each of the parties represent that they have the authority to execute this Agreement and do hereby bind the party on whose behalf their execution is made.

7.16. **Mutual Construction**. This agreement has been prepared by all the parties thereto, and shall be so construed.

NORTHERN INYO COUNTY LOCAL HOSPITAL DISTRICT	PHYSICIAN
By: _________________________	By: _________________________
John Ungersma, M.D. President Board of Directors	Curt Schweizer, M.D. Physician

Attachment A

ADMINISTRATIVE SERVICES TO BE PROVIDED

Physician shall:

- Provide general administration of the day-to-day operations of the Hospital's anesthesia service.
- Implement Hospital's policies and procedures.
- Assure Physician' coverage of Hospital, in cooperation with Hospital.
- Provide medical consultation to the NIH Medical Staff, the Hospital staff, and Hospital administration in the area of the Physician's specialty as needed.
- Coordinate and consult with Hospital and Hospital Medical Staff regarding the efficiency and effectiveness of Hospital, and make recommendations and analyses as needed for Hospital to reduce costs and improve services provided in Hospital.
- Develop, review, and provide training programs to Physician and other medical personnel providing services to Hospital.
- Participate in Hospital, and Hospital Medical Staff committees upon request.
- Participate in the development and presentation of programs related to the marketing of Hospital's services and enhancing Hospital/community relations, provided, however, that Physician shall not be required to participate in any advertising related to Hospital's services.
- Advise and assist in the development of protocols and policies for Hospital.
- Upon request by Hospital, be available at all times to respond/consult in the event of urgent or emergent situations. Cooperate in all litigation matters affecting Physician and/or Hospital.

ATTACHMENT B

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Professional Conduct. Prohibition of Disruptive or Discriminatory Behavior	
Scope: Hospital wide	Department: Medical Staff
Source: Medical Staff	Effective Date: 12/5/07

POLICY

All Medical Staff members shall conduct themselves at all times while on Hospital premises in a courteous, professional, respectful, collegial, and cooperative manner. This applies to interactions and communications with or relating to Medical Staff colleagues, AHPs, nursing and technical personnel, other caregivers, other Hospital personnel, patients, patients' family members and friends, visitors, and others. Such conduct is necessary to promote high quality patient care and to maintain a safe work environment. Disruptive, discriminatory, or harassing behavior, as defined below, are prohibited and will not be tolerated.

Definitions

A. "Disruptive Behavior" is marked by disrespectful behavior manifested through personal interaction with practitioners, Hospital personnel, patients, family members, or others, which:

1. Interferes, or tends to interfere with high quality patient care or the orderly administration of the Hospital or the Medical Staff; or

2. Creates a hostile work environment; or

3. Is directed at a specific person or persons, would reasonably be expected to cause substantial emotional distress, and serves no constructive purpose in advancing the goals of health care.

B. "Discrimination" is conduct directed against any individual (e.g., against another Medical Staff member, AHP, Hospital employee, or patient) that deprives the individual of full and equal accommodations, advantages, facilities, privileges, or services, based on the individual's race, religion, color, national origin, ancestry, physical disability, mental disability, medical disability, marital status, sex, gender, or sexual orientation.

C. "Sexual harassment" is unwelcome verbal or physical conduct of a sexual nature, which may include verbal harassment (such as epithets, derogatory comments or slurs), physical harassment (such as unwelcome touching, assault, or interference with movement or work), and visual harassment (such as the display of derogatory or sexual-themed cartoons, drawings or posters). Sexual harassment includes unwelcome advances, requests for sexual favors, and any other verbal, visual, or physical conduct of a sexual nature when (1) submission to or rejection of this conduct by an individual is used as a factor in decisions affecting hiring, evaluation, retention, promotion, or other aspects of employment; or (2) this conduct substantially interferes with the individual's employment or creates an intimidating, hostile, or offensive work environment. Sexual harassment also includes conduct indicating that employment and/or employment benefits are conditioned upon acquiescence in sexual activities.

Examples of Prohibited Conduct

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

A. Any striking, pushing, or inappropriate touching of Hospital Staff or others;

B. Any conduct that would violate Medical Staff and/or Hospital policies relating to discrimination and/or sexual harassment;

C. Forcefully throwing, hitting, pushing, or slamming objects in an expression of anger or frustration;

D. Yelling, screaming, or using an unduly loud voice directed at patients, Hospital employees, other practitioners, or others;

E. Refusing to respond to a request by any caregiver for orders, instructions, or assistance with the care of a patient, including, but not limited to, repeated failure to respond to calls or pages;

F. Use of racial, ethnic, epithetic, or derogatory comments, or profanity, directed at Hospital employees or others;

G. Criticism which is unreasonable and unprofessional of Hospital or Medical Staff personnel (including other practitioners), policies or equipment, or other negative comments that undermine patient trust in the Hospital or Medical Staff in the presence or hearing of patients, patients' family members, and/or visitors;

H. Use of medical record entries to criticize Hospital or Medical Staff personnel, policies, or equipment, other practitioners, or others;

I. Unauthorized use and/or disclosure of confidential or personal information related to any employee, patient, practitioner, or other person;

J. Use of threatening or offensive gestures;

K. Intentional filing of false complaints or accusations;

L. Any form of retaliation against a person who has filed a complaint against a practitioner alleging violation of the above standard of conduct;

M. Use of physical or verbal threats to Hospital employees, other practitioners, or others, including, without limitation, threats to get an employee fired or disciplined;

N. Persisting to criticize, or to discuss performance or quality concerns with particular Hospital employees or others after being asked to direct such comments exclusively through other channels;

O. Persisting in contacting a Hospital employee or other person to discuss personal or performance matters after that person or a supervisory person, the Chief Executive Officer ("CEO"), or designee, or Medical Staff leader, has requested that such contacts be discontinued [NOTE: MEDICAL STAFF MEMBERS ARE ENCOURAGED TO PROVIDE COMMENTS, SUGGESTIONS AND RECOMMENDATIONS RELATING TO HOSPITAL EMPLOYEES, SERVICES OR FACILITIES; WHERE SUCH INFORMATION IS PROVIDED THROUGH APPROPRIATE ADMINISTRATIVE OR SUPERVISORY CHANNELS];

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

PROCEDURE

Hospital Staff Response to Disruptive or Discriminatory Behavior or Sexual Harassment ("Walk Away Rule")

Any Hospital employee ("Caregiver") who believes that he or she is being subjected to disruptive or discriminatory behavior or sexual harassment within the meaning of this Policy by a Medical Staff member is authorized and directed to take the following actions:

A. Promptly contact the Caregiver's immediate supervisor to report the situation and to arrange for the transition of patient care as necessary in order to permit the Caregiver to avoid conversing or interacting with the Practitioner;

B. Discontinue all conversation or interaction with the Practitioner except to the extent necessary to transition patient care responsibility safely and promptly from the Caregiver to another qualified person as directed by the Caregiver's supervisor;

C. Continue work or patient care activity elsewhere as directed; and

D. Consult with supervisory personnel or with the Director of Human Resources about filing a written report of the alleged incident.

Enforcement

A. Allegations

1. All allegations of disruptive behavior, discrimination, or sexual harassment, as defined above, by a Practitioner involving a patient or involving another member of the Medical or AHP staff shall be forwarded, in writing, to Medical Staff Administration. If the Chief of Staff determines that the allegations are supported by reliable evidence, the Chief of Staff shall forward the allegation to the Medical Executive Committee ("MEC") for action consistent with the Medical Staff Bylaws. Pursuant to Section 7.1.2.5.2 of these Bylaws, the Chief of Staff shall also consult with the Administrator.

2. Allegations of disruptive behavior, discrimination, or sexual harassment, as defined above, by a Practitioner, directed toward hospital employees or persons other than patients and Medical Staff members, will be immediately forwarded to the Chief of Staff. The Chief of Staff, or designee, shall

promptly conduct an initial evaluation. If the Chief of Staff or designee determines that the complaint may be valid, she or he shall inform the Hospital Administrator and shall then proceed as provided herein.

3. If the allegations involve the Chief of Staff, the Vice Chief of Staff shall take over the responsibilities of the Chief of Staff under this section. If the allegations involve a member of the Medical Executive Committee, that member shall not participate or be present during the Medical Executive Committee's consideration of the matter.

4. Initial complaints of disruptive behavior, discrimination, or sexual harassment by a Practitioner shall be documented on an incident reporting form and shall be maintained in the Medical Staff Office. Where possible, reports should include:

   a. Name(s) of individual(s) involved;
   b. Date, time and place of incident;
   c. A factual description and detailing of the incident;
   d. All witnesses to the incident including any patient or patient's family member or visitor;
   e. The immediate effects or consequences of the incident; and
   f. Any action taken by anyone to intervene or remedy the incident.

B. Initial Investigation and Mediation

1. The Chief of Staff shall promptly establish an Ad Hoc Committee to investigate the complaint. If the complaining party is a Hospital employee, the Ad Hoc Committee shall include: the Chief of Staff or designee, the Chair of the practitioner's Clinical Department or designee, the complaining employee's immediate supervisor, and the Hospital Administrator or designee. The Ad Hoc Committee shall take written statements from the complaining party, any witnesses, and the accused. The complaining party shall be informed of the process to investigate and respond to such allegations and shall be informed that retaliation for making such allegations will not be tolerated. The complaining party shall also be informed that if he or she makes a written statement, the statement may be made available to the Practitioner who is the subject of the allegations.

2. All witness statements and investigation documents shall be maintained in the Medical Staff Office as confidential, peer review documents.

3. If the complaint appears to be supported by reliable evidence, the Ad Hoc Committee shall meet with the

Practitioner who is the subject of the complaint and advise the Practitioner of his or her obligations under this policy; that a complaint has been made; and that no retaliation against any complaining person, witness or investigator will be tolerated. The Chair of the Ad Hoc Committee shall provide the Practitioner with sufficient information to understand and respond to the allegations made by the complaining party. The Practitioner shall be permitted to respond orally or in writing to the allegations. Any written statement provided by the Practitioner and all documentation of the investigation created by the Chief of Staff or designee, or by the Ad Hoc Committee, shall be maintained as confidential Medical Staff documents. The Ad Hoc Committee meeting with the Practitioner shall not constitute a hearing and the Practitioner shall not be entitled to legal counsel or other representation during the meeting. The Practitioner may, of course, seek legal counsel outside the meeting process.

4. The Chief of Staff or designee shall advise the Hospital Administrator of the complaint and the status of the investigation. Although legal counsel are not permitted to be present during interviews or meetings provided for in these provisions, the Chief of Staff or designee are encouraged to consult with Medical Staff legal counsel and the Practitioner, at his or her own expense, may consult legal counsel outside the investigation and meeting process.

5. The Chief of Staff or designee and Hospital Administrator shall take appropriate steps to assure that employees, witnesses and others are protected from discrimination, harassment, or retaliation pending the resolution of the complaint.

6. The Ad Hoc Committee shall attempt, if feasible and appropriate, to persuade the parties to agree to a resolution of the complaint, which would be produced in written form and signed by both parties.

7. If the Practitioner is determined to be at fault, the Ad Hoc Committee may enter into a voluntary conduct agreement with the Practitioner; may refer the Practitioner to the Medical Staff Assistance Committee; may refer the Practitioner for counseling or evaluation; or may coordinate other steps to reach an effective voluntary resolution of the issue.

C. Formal Action

1. If the Ad Hoc Committee, or its Chair, concludes that the matter cannot be resolved through voluntary actions and

agreements, the Chair shall refer the matter to the MEC with a request for formal corrective action in accordance with Article 8 of the Bylaws. In the event of such referral, any member of the Medical Executive Committee who is the subject of the investigation shall not participate or be present during the Medical Executive Committee's consideration of the matter, except as is provided in subparagraph 2 or 3, below.

2. If immediate action must be taken in response to an imminent risk to the health or safety of any person, any person authorized under Section 7.1 to request corrective action may summarily suspend the Practitioner's Medical Staff membership and privileges in accordance with Section 7.2 of the Bylaws. In that event, the Practitioner shall be entitled to request an interview with the MEC to review the suspension within five (5) days of the suspension. The provisions of the Bylaws shall be followed for review of summary suspensions.

3. If the MEC initiates a corrective action investigation of the complaint, it shall, where feasible, assure that the investigation, although not constituting a hearing, shall include the following elements:

   a. The Practitioner shall be entitled to review, but not retain, copies of statements made by complaining parties and witnesses. The Practitioner shall also be entitled to receive a summary of other adverse information considered relevant to the investigation.

   b. The Practitioner shall be entitled to respond to the adverse statements and information and to submit oral or written information in response, subject to such conditions and limitations as the MEC may determine.

   c. If the MEC determines that there is substantial evidence that a violation of this policy has occurred, it may do any one or more of the following:

      1) Issue a written or oral reprimand. If a written or oral reprimand is issued, the Practitioner shall be entitled to reply orally or in writing to the MEC. A copy of any written reprimand and any written reply shall be maintained in the Practitioner's credentials file. A written reprimand shall not be considered medical disciplinary action, shall not be reported to the Medial Board of California or the National Practitioner Data Bank, and shall not entitle the Practitioner to a hearing or appeal under Article 8 of the Bylaws.

      2) Recommend that the Practitioner undertake

psychoanalysis, therapy, counseling, or training.

3) Recommend other corrective action in accordance with Article 8 of the Bylaws.

4) If the MEC recommends action, which would entitle the Practitioner to request a Medical Staff hearing, special notice to the Practitioner shall be given in accordance with Section 8.6.2 of the Bylaws.

D. Action by the District Board or Designee

If the District Board determines that the MEC's action is inadequate, or if the MEC takes no action after the investigation, the District Board, after complying with applicable law, may do or recommend any one or more of the actions listed in Section C.4) above.

E. If either the MEC or the District Board recommends corrective action, which, if adopted, would require a report to the Medical Board of California or the National Practitioner Data Bank, the Practitioner shall be notified of the proposed action and of his or her right to request a hearing in accordance with the Bylaws.

Committee	Approved
Medical Executive Committee	12/04/07
Administration	
Board of Directors	12/05/07

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BOUTIQUE REPORT 2013

EXPENSES	
Workshop supplies	$124.73
Boutique expenses	2,214.55
TOTAL EXPENSES	$2,662.78
INCOME	
Boutique tickets	$5,181.00
Boutique sales (day of boutique)	2,214.55
(hall sale)	849.00
(fairground)	214.00
Baked goods (day of boutique)	482.00
(hall sale)	107.50
Mini drawing (day of boutique)	301.00
Deposit seed money	200.00
INCOME	$9,549.05
MINUS EXPENSES	- 2,662.78
TOTAL INCOME BOUTIQUE 2013	$6,886.27

Sharon Moore
Treasurer &
Boutique Chairman

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NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Elective Delivery	
Scope: Perinatal Unit	Department: Perinatal
Source: Perinatal Nurse Manager	Effective Date: 10/2013

PURPOSE:

To establish a written policy of criteria to allow for safe delivery of obstetric care when elective delivery of a pregnancy is considered by means of an elective induction or an elective cesarean delivery

POLICY:
Elective delivery is generally considered when the benefits to expedite delivery outweigh the risks of continuing a pregnancy. The OB practitioner may opt for elective delivery of a pregnancy based upon any of the following: maternal and fetal conditions, gestational age, antepartum testing results, cervical and membrane status and logistical factors. This will be documented in the MD progress notes.

Elective induction and /or elective cesarean (primary or repeat) without medical indication prior to 39 weeks are strongly discouraged without evidence to confirm fetal maturity.

Means to determine maturity confirmation from historical criteria include:
- Ultrasound measurement at less than 20 weeks of gestation supports gestational age of 39 weeks or greater
- Fetal heart tones have been documented as present for 30 weeks by Doppler ultrasonography
- It has been 36 weeks since a positive serum or urine human chorionic gonadotropin pregnancy test results.

PROCEDURE:

All inductions of labor will be reviewed by the perinatal nurse manager. Results of these audits will be given to the Obstetrical Chief of service and reviewed at the Perinatal-Pediatric Committee meeting.

References:
American College of Obstetrics and Gynecologists (2009). Induction of Labor (Practice Bulletin No. 107). Washington, Dc Author

Committee Approval	**Date**
Peri Peds	10/15/13

Revised
Reviewed
Supercedes

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Healthy Newborn Admission Protocol	
Scope: Perinatal Unit	Department: Nursery
Source: Perinatal Manager	Effective Date: 10/2013

PURPOSE:

Standard Protocol for admitting a healthy newborn when the pediatrician or family medicine physician is not in attendance.

POLICY:

Nursing will initiate this protocol to admit a healthy newborn to the nursery.

PROCEDURE:

1. Admit to newborn nursery – with diagnosis of healthy newborn
2. Vital signs every hour times 2 then every shift or PRN
3. Umbilical cord care per protocol
4. Breastfeed on demand or at least every 4 hours
5. Bottle-feed with 20 KCAL/oz milk based formula if not breastfeeding
6. Cord blood to lab for group, Rh, and Coombs test if mother is Rh negative or group O
7. Blood glucose monitoring per protocol
8. Oximeter check per protocol

Committee Approval	Date
Peri Peds Committee	10/15/13
Pharmacy and Therapeutics Committee	
Medical Executive Committee	

Responsibility for review and maintenance:
Index Listings:
Developed: 10/2013
Revised:
Reviewed:

ED Protocol Checklists

Fever

For pediatric patients under 14 years old and based on prior antipyretic given
- ☐ Tylenol 15mg/kg PO or PR Q4hrs
- ☐ Motrin 10mg/kg PO Q6hrs (for patients 6 months old or greater)

For adult patients
- ☐ Tylenol 650mg PO or PR Q6hrs

Gastrointestinal Bleeding
- ☐ Saline Lock IV
- ☐ Cardiac Monitor
- ☐ Labs – CBC, CMP, PT/PTT, Type & Screen

Seizure
- ☐ Oxygen saturation and Cardiac Monitor
- ☐ Saline Lock IV
- ☐ Accucheck
- ☐ Dextrose for BS <60 – D50 25gm IVP for adults and D25 1mg/kg for peds
- ☐ For active seizures notify physician immediately then Ativan 2mg IVP for adults and 0.05mg/kg IVP for peds, may repeat x1 prn

Shortness of Breath
- ☐ Oxygen saturation and Cardiac Monitor
- ☐ Saline Lock IV
- ☐ Titrate oxygen to keep sats >90%
- ☐ Labs – draw and hold
- ☐ 2 view CXR
  - I view portable if patient unstable
- ☐ Albuterol 2.5mg/3cc NS nebulized, may repeat x1
- ☐ ECG for patients >40yo

Shock/Sepsis
- ☐ Oxygen saturation and Cardiac Monitor
- ☐ Large-bore IV
- ☐ Titrate oxygen to keep sats >90%
- ☐ Fluid bolus NS in 500ml increments for SBP<90
  - Pediatric patients – NS 20mg/kg for AMS or SBP<70
- ☐ Labs – CBC, CMP, Trop, MB, Lactate, Blood Cx x2, UA
- ☐ 1 view portable CXR

____________________ _______________ _______________

Emergency Physician Date Time

ED Protocol Checklists

Neurologic Symptoms (possible Stroke)

- ☐ Oxygen saturation and Cardiac Monitor
- ☐ Saline Lock IV
- ☐ Accucheck
- ☐ CT Head w/o contrast
- ☐ CBC, CMP, PT/PTT
- ☐ ECG

Syncope

- ☐ Oxygen saturation and Cardiac Monitor
- ☐ Saline Lock IV
- ☐ Orthostatic vital signs
    - Supine for 5 minutes then check BP & HR, stand for 2-5 minutes then check BP & HR
    - Considered positive with decrease SBP by 20mmHG, decrease DBP by 10, increase HR by 30bpm or symptoms of cerebral hypoperfusion
- ☐ ECG
- ☐ Accucheck

Vomiting

- ☐ Saline Lock IV
- ☐ Labs – draw and hold
- ☐ For adults without a history of CHF or Chronic Renal Failure, 1L NS Bolus
- ☐ Zofran 8mg PO or 4mg IV for >16kg and 2mg PO for <16kg

Trauma Order Sets

Eye Problems

- ☐ Visual acuity with corrective eyewear
- ☐ Proparacaine and fluorescein strips to bedside
    - May instill 1-2 gtts Proparacaine q30min to affected eye
- ☐ For chemical injuries, irrigate affected eye with 1L NS through Morgan lens. Start immediately in triage before checking visual acuity

Laceration

- ☐ For adults with tetanus immunization >10 years or unknown, give Tdap 0.5ml IM
- ☐ For pediatric patients, apply LET topical anesthetic to wound for 20-30min
- ☐ Irrigate wound as tolerated

____________________ ______________ ______________

Emergency Physician Date Time

ED Protocol Checklists

Orthopedic Injuries

The ED physician should be notified immediately for open fractures, dislocations or injuries with vascular compromise.

- ☐ Ice, elevate and stabilize
- ☐ Urine or serum HCG as needed
- ☐ Saline Lock IV for moderate to severe pain or obvious deformities
- ☐ Examine extremity and document neurovascular status, deformity, instability, crepitus, bony tenderness, ecchymosis, or swelling

  Always examine joints above and below as well for associated injuries

  Order appropriate Xrays – special considerations:
  - o Ankle, Foot, Toes, Heel
    - ☐ Xray entire foot for toe injuries
    - ☐ Add calcaneal views for heel tenderness or fall from height
    - ☐ Add knee xrays for tenderness over proximal fibula
  - ☐ Elbow, Forearm, Wrist, Fingers
    - ☐ Xray wrist for distal forearm tenderness
    - ☐ Add navicular view for snuffbox tenderness

      No xrays for peds <6yo with arm pain or loss of function and no obvious deformity
  - ☐ Shoulder, Clavicle
    - ▪ Notify physician immediately for SOB or low sats
  - ☐ Chest (Ribs)

☐ Order 1vw upright CXR

Pain control

For acute orthopedic injuries only. Patients with chronic pain issues must be seen by the ED physician prior to medication.

IV narcotics require initial review by the ED physician

For adults
- ☐ Mild to moderate pain – Motrin 600mg PO
- ☐ Moderate pain – Percocet-5 1 tab PO
- ☐ Severe pain – Fentanyl 50ucg IVP q5min prn, max 200 ucg

For pediatrics >2 years old
- ☐ Mild to moderate pain – Motrin 10mg/kg PO
- ☐ Moderate pain – Lortab (hydrocodone/acetaminophen) elixir 0.1mg/kg hydrocodone PO
- ☐ Severe pain – Fentanyl 1ucg/kg intranasal, may repeat 0.5ucg after 5 minutes

________________________ __________________ __________________

Emergency Physician Date Time

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Breast Screening Exams - Self Referral**	
Scope:	Department: **Radiology**
Source: Radiology Director	Effective Date: '

PURPOSE: The purpose of this policy is to serve the patients in this community that need a mammogram/screening whole breast ultrasound but do not have a referring physician or do not have an order from their primary care physician.

Definitions:

Self-referrals – patients requesting a screening mammogram/screening whole breast ultrasound who do not have a referring physician

Self-requests – patients referring themselves for a screening mammogram/screening whole breast ultrasound who do have a primary care physician

Screening Mammogram- mammogram on a patient who is asymptomatic and has not had previous breast cancer.

Screening Whole Breast Ultrasound – Automated Breast Ultrasound (ABUS) on a patient who is asymptomatic and has not had previous breast cancer.

POLICY:

1. Self-referrals will be scheduled for screening mammography/screening whole breast ultrasound.
   a. Self-referrals may have a screening mammogram/screening whole breast ultrasound once a year.
   b. If the patient has any complaints or diagnoses other than screening, they need to see a healthcare provider.
2. Self-requests will be scheduled for screening mammography/screening whole breast ultrasound.
   a. Self-requests may have a screening mammogram/screening whole breast ultrasound once a year.
   b. If the patient has any complaints or diagnoses other than screening, they need to see their healthcare provider.
3. Self-referrals shall receive the mammography/screening whole breast ultrasound report, in addition to the summary of report written in lay terms.
4. Self-requests shall have the mammography/screening whole breast ultrasound report sent to their primary care physician. A summary of the written report in lay terms shall be sent to the patient.
   a. In the event that the healthcare provider declines to accept the mammography/screening whole breast ultrasound report then we will treat the patient as a self-referred.
5. Self-referrals with abnormal results will be referred to the physician or group of physicians that has agreed to provide medical care to these patients. A list of physicians who have agreed to accept these patients is on file and may be provided upon request.
6. Follow-up contact will be made to self-referrals with abnormal results (BIRADS 0, 3, 4, 5) to determine that they have consulted a healthcare provider for follow-up care.
7. In the event that a self-referred or a self-requested patient is having a screening mammogram/screening whole breast ultrasound when the interpreting radiologist is onsite and determines a need for additional workup, the imaging department will contact either the healthcare provider who has agreed to accept the patient or primary healthcare provider provided by the patient to obtain an order for additional diagnostic workup.

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Breast Screening Exams - Self Referral**	
Scope:	Department: **Radiology**
Source: Radiology Director	Effective Date:

Committee Approval	Date
Radiology Services Committee	11/19/13
Medical Executive Committee	
Administration	
Board of Directors	

Responsibility for review and maintenance:
Index Listings:
Initiated:
Revised/Reviewed:
Supercedes:

ED Protocol Checklists

Medical Order Sets

Abdominal/Flank Pain

- ☐ Saline Lock IV
- ☐ NPO
- ☐ Labs – CBC, CMP
- ☐ UA – dip and hold
- ☐ For females of child-bearing age, add serum qual HCG
- ☐ For upper abdominal pain, add serum lipase and amylase
- ☐ For upper abdominal pain and >40yo, add EKG

Allergic Reaction

Notify physician immediately for any respiratory distress.

- ☐ Oxygen saturation and Cardiac Monitor
- ☐ IV NS or saline lock
- ☐ Epinephrine (1:1000) 0.3mg IM for adults and 0.01mg/kg IM for peds

For any patient with wheezing, difficulty breathing, difficulty swallowing, swollen tongue or history of prior severe allergic reaction.

- ☐ Benadryl 50mg IVP for adults and 1mg/kg IVP for peds
- ☐ Albuterol 2.5mg/3cc NS nebulized, may repeat x1

Altered Level of Consciousness

Notify physician immediately for any unstable vital signs or respiratory distress.

- ☐ Oxygen saturation and Cardiac Monitor
- ☐ Accucheck
- ☐ Saline lock IV with bloods to hold
- ☐ Dextrose for BS <60 – D50 25gm IVP for adults and D25 1mg/kg for peds

Chest Pain – Adult

- ☐ Oxygen saturation – O_2 via Nasal Cannula for sats < 95%
- ☐ Cardiac Monitor
- ☐ Saline lock IV, Antecubital 18g if possible
- ☐ ECG
- ☐ Labs – CBC, CMP, Trop, MB
  - ☐ Add PT/PTT if on Coumadin
- ☐ 1 view portable CXR
- ☐ Aspirin 162 mg PO chew tab
- ☐ NTG SL 0.4mg q5min prn, may repeat x 2

Contraindicated for patients who have recently taken phosphodiesterase inhibitors (i.e. Viagra)
Hold for SBP < 100, HR <50 or >100, evidence of RV infarct on ECG

Dysuria

- ☐ UA w/culture if indicated
  - ☐ For females of child-bearing age, add urine qual HCG

____________________ ________________ ________________

Emergency Physician | Date | Time

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **MPIRX: Myocardial Perfusion Imaging with chemical stress**	
Scope:	Department: **EKG, Outpatient, Pharmacy, Radiology**
Source: SNM, ASNC, ACC, Astellas	Effective Date:

PURPOSE: To provide personnel with guidelines for the performance of chemical stress testing for the purposes of stress myocardial perfusion imaging.

DEFINITIONS:

MPI – Myocardial perfusion imaging

ALARA – As Low As Reasonably Achievable – federally mandated hospital radiation safety and protection program.

POLICY:

1. MPI orders will be received by the Central Registration Dept for authorization. Central Registration will forward the order to EKG and Nuclear Medicine (via scan to email) following authorization.
2. The EKG department will contact the patient and schedule the stress test. EKG will notify Nuclear Medicine, Pharmacy and OP Nursing appropriately.
3. Nuclear Medicine will select the proper imaging protocol for the exam, based on patient's clinical history and prior exams. If the proper imaging protocol necessitates a scheduling time change, Nuclear Medicine will notify EKG.
4. The supervising physician, an EKG technician, an RN and a Nuclear Medicine technologist will be present for the duration of the stress test.
5. Under direct physician supervision, an RN will administer regadenoson.
6. Following administration of regadenoson, the Nuclear Medicine technologist will administer 99mTc Sestamibi.
7. Upon completion of the stress test, the Nuclear Medicine Technologist will coordinate the appropriate post-stress imaging procedures.
8. All personnel involved with patient care during procedures involving radioactive materials shall wear an occupational exposure monitoring badge ("film badge").

PRECAUTIONS FOR PERSONNEL: Procedures utilizing radioactive materials should be performed by non-pregnant personnel, if possible. All personnel involved in the procedure should keep radiation exposure ALARA by decreasing time in close proximity to the patient and increasing distance between the patient and themselves.

INDICATIONS:

Regadenoson (injection) is a pharmacologic stress agent indicated for radionuclide myocardial perfusion imaging in patients unable to undergo adequate exercise stress, more specifically in the presence of the following conditions: Inability to perform adequate exercise due to non-cardiac physical limitations (pulmonary, peripheral vascular, musculoskeletal, or mental conditions) or due to lack of motivation.

Preview

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **MPIRX: Myocardial Perfusion Imaging with chemical stress**	
Scope:	Department: **EKG, Outpatient, Pharmacy, Radiology**
Source: SNM, ASNC, ACC, Astellas	Effective Date:

CONTRAINDICATIONS:

1. Patients with second or third degree AV block or sinus node dysfunction unless these patients have a functioning artificial pacemaker.
2. Patients with acute bronchospasm.
3. Systolic blood pressure <90 mm Hg.
4. Use of dipyridamole, dipyridamole-containing medications in last 48 hours.
5. Use of aminophylline in last 24 hours.
6. Ingestion of caffeinated foods (e.g., chocolate) or beverages (e.g., coffee, tea, and sodas) within the last 12 hours.
7. All the contraindications for a standard exercise stress test:
    1. Acute myocardial infarction
    2. Unstable angina
    3. Life-threatening arrhythmia
    4. Acute cardiac inflammation
    5. Critical aortic stenosis
    6. Congestive heart failure
    7. Pulmonary emboli
    8. Significant uncontrolled hypertension
    9. Serious non-cardiac diseases
    10. Unwilling patient or patient unable to give informed consent
    11. Allergy to medications used in testing

EQUIPMENT AND SUPPLIES:

1. IV start supplies including Luer-lock with 2 claves (Y-connector saline lock) (preferred)
2. Bed
3. Oximeter, sphygmomanometer
4. ECG Exercise Testing System (12-lead), ECG electrodes
5. Medication for adverse reaction
    a. Aminophylline may be administered in doses ranging from 50 to 250 mg by slow intravenous injection (50-100 mg over 30-60 seconds) to attenuate severe and/or persistent adverse reactions to regadenoson.
    b. Nitroglycerin tablet, sublingual, 0.4 mg (1/150 grain),
    c. Albuterol inhaler (MDI)
6. Oxygen and cannula or mask
7. Crash cart and suction
8. Dual-Head Gamma Camera with integrated gating device

MEDICATIONS USED IN THIS TEST:

1. Regadenoson (Lexiscan), 5 mL containing 0.4 mg (standard dose)
    a. Special populations
        i. Nursing mothers need clearance from their attending physician to undergo the test using Regadenoson. Nursing mothers will need to consult with the Nuclear

Preview

Medicine technologist, prior to being scheduled, for information regarding breastfeeding following the administration of radioactive material administration.

ii. No dose adjustment is needed in patients with renal impairment
iii. No dose adjustment is needed in patients with hepatic impairment
iv. No dose adjustment is needed in geriatric patients

2. Technetium (Tc99m) Sestamibi (Tc99m Cardiolite ™)
3. Normal saline for IV line flush

PATIENT INFORMATION AND INSTRUCTIONS:

1. Patients should avoid consumption of any products containing methylxanthines, including caffeinated and decaffeinated coffee, tea or other beverages, foods (e.g. chocolate), caffeine-containing drug products, and theophylline for at least 12 hours prior to stress test. Patients will be advised to hold caffeine for 24 hours. Patients that have consumed caffeine within 12 hours will be rescheduled. Patients who have consumed caffeine 12-24 hours prior to the exam will be reviewed by the supervising physician (and/or pharmacist) to determine suitability for chemical stress.
2. Dipyridamole should be withheld for 48 hours prior to regadenoson administration. Patients will be asked to contact their physician for instructions if they are on dipyridamole.
3. Patients on theophylline or dipyridamole will be informed to consult with their ordering physician for medication instructions.
4. It is recommended that out-patients and scheduled patients be NPO for 4 hours prior to imaging. If the patient has not been NPO for 4 hours, exams should not be automatically cancelled; consult Nuclear Medicine technologist on per case basis if the patient has not been NPO for 4 hours.
5. Insulin dependent diabetic patients will be asked to hold pre-meal insulin for 4 hours during the fasting period prior to the Nuclear Medicine procedure. Insulin dependent diabetics who, for low blood sugar reasons have not been NPO for 4 hours will be assessed and processed by the Nuclear Medicine Technologist on a case by case basis.
6. Preferably the patient should wear comfortable 2-piece clothing (pants/shirt). The patient should wear comfortable walking shoes.
7. The scheduler will give out-patients the pre-test instructions and obtain allergy history.
8. An RN will call the patient at least one day prior to the scheduled test to verify allergies, and routine medications and dosages with the patient and reinforce instructions. The RN shall enter allergy and medication information into the "Patient Profile" section of Paragon.

PRETEST PROCEDURE:

1. The EKG technician will send the patient's name and encounter number to the pharmacy.
2. The EKG technician will obtain informed procedure consent.
3. The EKG technician will prep the patient for a stress test in the standard manner.
4. An RN or Nuclear Medicine Technologist will start a peripheral IV using a 22-gauge or larger catheter.

Preview

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: MPIRX: Myocardial Perfusion Imaging with chemical stress	
Scope:	Department: EKG, Outpatient, Pharmacy, Radiology
Source: SNM, ASNC, ACC, Astellas	Effective Date:

5. The patient shall remain supine or semi-upright for the test.
6. Once the patient is prepared, the supervising physician will be notified. The supervising physician shall be present during the stress test including the recovery phase.
7. The pharmacy will deliver the pre-packaged regadenoson and a rescue kit with all the rescue/reversal medications and rescue policy to the EKG department.
8. The administering RN will verify the dose of 5 mL (0.4 mg regadenoson) and expiration date.

TESTING PROCEDURE:

1. ECG monitoring should be continuous during the stress test.
2. A 12-lead electrocardiogram will be recorded every minute during the test.
3. Blood pressure should be monitored every minute during the test and 3-5 minutes into recovery.
4. Regadenoson (5 mL containing 0.4 mg of regadenoson) should be given as 10 to 15 second injection into the established peripheral IV.
5. Administer a 5-mL saline flush immediately after the injection of regadenoson.
6. Wait 10-20 seconds.
7. Administer the 99mTc Sestamibi followed by a 2-5 ml saline flush. The radionuclide may be injected directly into the same catheter port as regadenoson.
8. Indications for reversal of regadenoson include:
    1) Severe hypotension (systolic blood pressure <80 mm Hg).
    2) Development of symptomatic, persistent second degree or complete heart block.
    3) Wheezing.
    4) Severe chest pain associated with ST depression of 2 mm or greater.
    5) Signs of poor perfusion (pallor, cyanosis, and cold skin).
    6) Technical problems with the monitoring equipment.
    7) Patient's request to stop.
9. The patient should rest until symptoms are resolved.
10. Monitoring will be terminated at 5 minutes or by the supervising physician, whichever is longer. This completes the stress test/recovery portion of the MPIRX procedure.
11. The supervising physician's stress report shall be provided to the Nuclear Medicine department by the EKG department upon completion of the report.
12. The patient will be escorted to the cafeteria for a light meal.
13. The Nuclear Medicine technologist will image the patient as appropriate.
14. The Nuclear Medicine technologist will discontinue the IV.
15. The Nuclear Medicine technologist, in conjunction with the radiologist, will determine the status of a resting MPI and schedule as needed.

TREATMENT OF SIDE EFFECTS:

1. The most common reactions to administration of regadenoson during MPI are shortness of breath, headache, and flushing.
2. Less common reactions are chest discomfort, angina pectoris or ST-segment depression, dizziness, chest pain, nausea, abdominal discomfort, dysgeusia, and feeling hot.

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: MPIRX: Myocardial Perfusion Imaging with chemical stress	
Scope:	Department: EKG, Outpatient, Pharmacy, Radiology
Source: SNM, ASNC, ACC, Astellas	Effective Date:

3. Most adverse reactions begin soon after dosing and generally resolve within approximately 15 minutes, except for headache which resolves in most patients within 30 minutes.
4. Aminophylline may be administered in doses ranging from 50 to 250 mg by slow IV injection (50 to 100 mg over 30-60 seconds) to attenuate severe and/or persistent adverse reactions to regadenoson.

ADVERSE REACTIONS TO REGADENOSON: (PARTIAL LIST/ MOST COMMON)

1. Dyspnea 28%
2. Headache 26%
3. Flushing 16%
4. Chest discomfort 13%
5. Angina Pectoris or ST segment depression 12%
6. Dizziness 8%
7. Chest pain 7%
8. Nausea 6%
9. Abdominal discomfort 5%
10. Dysgeusia 5%

CARDIAC REACTIONS TO REGADENOSON: (PARTIAL LIST/ MOST COMMON)

Arrhythmia 26%

1. PACs 7%
2. PVCs 14%
3. 1st Degree AV block 3%
4. 2nd Degree AV block 0.1%

The attending physician will assess and treat the patient as needed.

DOCUMENTATION:

A "Stress Test History Questionnaire" is completed by the EKG technician. The IV and drug administration shall be documented on the "MPI Stress – Drug Administration Record" and shall be completed by the RN and Nuclear Medicine technologist.

Preview

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **MPIRX: Myocardial Perfusion Imaging with chemical stress**	
Scope:	Department: **EKG, Outpatient, Pharmacy, Radiology**
Source: SNM, ASNC, ACC, Astellas	Effective Date:

In review

References (attached):

Exercise Standards for Testing and Training, American Heart Association/AHA, http://circ.ahajournals.org, pp 873-882
Lexiscan Product Monograph, Astellas
Lexiscan Package insert
Stress protocols and tracers, American Society of Nuclear Cardiology Imaging Guidelines for Nuclear Cardiology Procedures
Procedure Guideline for Myocardial Perfusion Imaging 3.3, Society of Nuclear Medicine, 2008
Patient-centered Imaging, American Society of Nuclear Cardiology, 2012

Committee Approval **Date**

Pharmacy and Therapeutics
Policy and Procedure
10/31/13 Medical Services Committee
11/19/13 Radiology Committee
Medical Executive Committee
Administration
Revised
Reviewed
Supercedes

Maggie Egan

From: Patty Dickson
Sent: Monday, November 04, 2013 9:24 AM
To: Maggie Egan
Subject: RE: MPIRX

Summary of changes to the MPIRX policy:

1. Changed #2 in *Contraindications* from bronchospasm to ACUTE BRONCHOSPASM.
2. Adjusted *Medications section 1.a.i.* to include that Nursing mothers will need clearance from their attending physician to undergo Regadenoson testing and consult with Nuclear Medicine regarding receiving radioactive materials prior to scheduling.
3. Clarified *Patient Information and instructions section 1* to advise caffeine hold for 24 hours, reschedule exams on patients who have consumed caffeine in less than 12 hours and verify with supervising physician -if caffeine has been consumed in 12-24 hours prior to the test.
4. Changed *Testing procedure # 4* to state 10-15 second injection (of 5ml Regadenoson).

From: Maggie Egan
Sent: Saturday, November 02, 2013 5:30 PM
To: Patty Dickson
Subject: RE: MPIRX

I will send it by email attachment to the Rad Serv Comm – can you give me a breakdown of the changes that were made since that Comm met & recommended its approval? Also, if it doesn't happen by this MEC mtg, there is another before the next Board mtg in Dec (remember, no Board mtg in Nov). Thx, maggie

DRAFT

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Infant Oxygen Protocol	
Scope: Hospital-Wide	Department:
Source: Director of Respiratory Care	Effective Date:

PURPOSE:

To provide protocol driven respiratory therapy for the administration of oxygen at concentrations greater than that in ambient air, with the intent of treating or preventing the symptoms and manifestations of hypoxia.

POLICY:

1. The Infant Oxygen Protocol will be initiated on patients, 0-1 year of age by a CPOE or written order from the physician for any type of oxygen therapy. The Infant Oxygen Protocol may be ordered as Infant Oxygen Protocol

2. In addition, the Oxygen Protocol may be ordered in forms other than specified by this protocol by entering an order that specifies:
    a. The type of oxygen delivery device.
    b. Liter flow or FIO_2.

3. Registered Nurses may also set up oxygen. If oxygen is started by an RN, the RN must follow this protocol, obtain an order and inform Respiratory Care that the patient is on oxygen.

4. Respiratory Therapists and Registered Nurses will assess the patients as follows:
    a. Upon receipt of the physician order, place patient on a continuous pulse oximeter and evaluate the patient, which will include a room air SpO_2, RR, HR, breath sounds and any signs of, grunting, nasal flaring, or retractions.

5. If it is determined that the infant needs oxygen, the infant will be place on one of the below interfaces with an oxygen blender:
    a. Vapotherm Hi-flow nasal cannula, an FDA approved device designed to comfortably deliver flow of 1-6 LPM of heated, humidified oxygen through a nasal cannula interface.
    b. Traditional nasal cannula with a bubble humidifier attached, flow rates ½ to 2 LPM (this system does not deliver heated humidified oxygen).
    c. Oxygen hood, humidified with an immersion heater.

6. Titrate the FIO_2 to keep the $SpO_2 \geq 88$ and < 93%, or within the physician specified limits. The RCP will contact the MD to initiate a CBG if condition indicates.

7. When the patient is on the Vapotherm, start by weaning the FIO_2 first, and then wean flow.

8. After birth, infants may initially need to have blow-by oxygen via flow-inflating bag with mask, blow-by oxygen via extension tubing with cupped hand or simple mask.

9. If the patient has been on room air for 48 hours, SpO_2 checks will be discontinued.

Title: Infant Oxygen Protocol	
Scope: Hospital-Wide	Department:
Source: Director of Respiratory Care	Effective Date:

10. All documentation will be done in the Clinical CareStation under Respiratory Assess, Resp. Birth and Group Notes or Progress Notes.

GUIDELINES AND WARNINGS

1. The responsible physician and R.N. will be contacted:
   a. If the RCP is unable to determine appropriate care upon evaluation
   b. If the patient demonstrates an increase in oxygen requirement (increases of ≥ 3 L/min. or increases in oxygen of 10% after the Vapotherm high flow system has been set-up.
   c. If the FIO_2 requirements are greater than 50%.
   d. Notify the physician if the SpO_2 is < 88% or if the patient is demonstrating an increase in O2 requirement.

REFERENCES:

1. AARC Clinical Practice Guideline "Selection of an Oxygen Delivery Device for Neonatal and Pediatric Patients".

Committee Approval	Date
Respiratory Care	
Pharmacy and Therapeutics Committee	
Medical Executive Committee	
Board of Directors	
Perinatal-Pediatrics Comm	10/15/13

Revised
Reviewed
Supercedes

Changes are underlined and italicized

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Liberation From Mechanical Ventilation-Weaning Protocol	
Scope: Respiratory Therapists, ICU RN	Department: Respiratory Care, ICU
Source: Director of Respiratory Care	Effective Date: January, 2009

To guide Respiratory Therapist and Nurses in successfully liberating patients receiving mechanical ventilator support. Upon the physician ordering "*Weaning Protocol" or "Weaning*" the RCP will follow the procedure described below to facilitate a safe and timely removal of the endotracheal tube at the earliest appropriate time.

As the conditions that warranted placing the patient on the ventilator stabilize and begin to resolve, attention should be placed on removing the ventilator as quickly as possible. Unnecessary delays in this discontinuation process increase the complication rate from mechanical ventilation (e.g., pneumonia, airway trauma) as well as the cost.

In general, patients being considered for removal from ventilatory support fall into two categories: (1) those for whom removal is quick and routine, i.e., OD, status asthmaticus, pulmonary edema, recovering from postoperative anesthesia, etc. (2) those who need a more systematic approach for discontinuing ventilatory support, i.e., COPD, prolonged mechanical ventilation (> 1-2 weeks) etc.

The primary phase in any ventilator weaning is a Daily Screening for readiness to wean.

This should start in the early morning with the Respiratory Therapist and ICU RN discussing the plan of action. **If the physician has written an order for "*Weaning Protocol" or "Weaning* in AM", then the patient should be given a "Sedation Vacation" early enough so the patient can be assessed for Daily Screening at 7 AM.** Gastric feeding should be held to allow time for stomach emptying in case a successful spontaneous breathing trial leads to extubation.

PROCEDURE:

I. DAILY SCREENING PATIENT ASSESSMENT:

1. Some reversal of the underlying cause of the respiratory failure
2. Minute ventilation < 15L/min
3. PEEP <= 5-8 cm H2O
4. Pa02/Fi02 > 150- 200 or Fio2 < 40
5. Adequate cough during suctioning
6. No continuous infusion of vasopressor agents or sedatives, (dopamine can be given in doses not exceeding 5 ug/kg body weight/min, and intermittent bolus dosing of sedatives is allowed).
7. Spontaneous respiratory effort
8. Hemodynamic stability
9. Afebrile
10. Patient can follow commands, lifting head up, etc.

A. Exclusions:

11. Dopamine > 8 mcg/kg/min
12. Excessive level of sedation

If the patient meets the above Daily Screening then the following Weaning Parameters will be done:

II. MEASURABLE CRITERIA

A. RCPs should perform weaning parameters daily in the AM and PRN.

Change mode to Spontaneous with a Pressure Support of 5cm/H2o. Observe patients VT for 5-10 minutes. Have patient perform VC maneuver. Do three MIP. Record all information on flow sheet.

1. Tidal Volume (VT)..........................> 5 ml/kg
2. Vital Capacity................................> 10 ml/kg of body weight
3. Maximal inspiratory pressure............. –20 to-30 cm H_2O or better
4. RR...<30-35 breaths/min
5. Spo2 > 90 may increase Fio2 by 5%

It patient passes, then proceed to next step, Spontaneous Breathing Trials

If patient does not pass, go to **Section III.**

Spontaneous Breathing Trials

Place ventilator in Spontaneous Mode with Pressure Support 0-7 cm/H20, observe patients respiratory status for 30 minutes to 120 minutes. Following this SBT, if the patient meets or exceeds the criteria below;

1. Tidal Volume (VT)..........................> 5
2. Vital Capacity................................> 10 ml/kg of body weight
3. Maximal Inspiratory Pressure..............- 25 cm H20
6. Rapid shallow breathing index (f/vt).......< 105 after 30 minutes
7. Minute Ventilation..........................<15 L/min
8. Fio2 .... <= 40 – 50 %

Patient should then be considered for extubation. Consider ABG's.

The decision to use these criteria must be individualized. Some patients not satisfying all of the above criteria may be ready for attempts at discontinuation of mechanical ventilation.

B. **Signs of Poor Clinical Tolerance.** Patients exhibiting a number of the following signs are not tolerating the weaning process and should be returned to the previous level of support.

1. Breathing frequency above 35 bpm for 5 minutes or longer.
2. Spo2 < 90 for more than 30 seconds
3. Heart rate > 140 beats/min. Sustained changes in the heart rate of 20% in either directions
4. Systolic BP > 180 or < 90 mmHg..
5. RSBI > 105
6. Increased anxiety.
7. Agitation.
8. Decreased mental status.
9. Diaphoresis.
10. The onset of arrhythmias.

Section III:

Patients, who do not meet the aforementioned SBT criteria, should have the cause for the failed SBT determined. Once reversible causes for failure are corrected, and if the patient still meets the above criteria, subsequent SBTs should be preformed every 24 hours. It may be necessary to start with Pressure Support of 10 –15cm/H20 or a targeted VT 100cc less than what the patient was on, then slowly, decreasing Pressure Support, with a target of 5cm/H20. SBT should last no longer than 2 hours, following that time, place patient back on starting settings and rest for 2 hours. Then repeat SBT. SBT may continue until 20:00, after that time the patient should be placed back on previous setting until 07:00, and SBT begin again.

Reported re-intubation rates range from 4% to 23% for different intensive care units populations. Although the optimal rate of re-intubation is not known, it would seem likely to rest between 5% and 15%.

Proportional Assist Ventilation (PAV):

PAV may be a useful ventilation adjunct in patients who have substantial asynchrony, increased WOB and who have failed multiple SBT. See Policy and Procedure "PAV on Puritan Bennett 840 Ventilator" on setting this mode.

Changes are underlined and italicized

Title: Liberation From Mechanical Ventilation-Weaning Protocol	
Scope: Respiratory Therapists, ICU RN	Department: Respiratory Care, ICU
Source: Director of Respiratory Care	Effective Date: January, 2009

NIPPV

Noninvasive facemask positive-pressure ventilation may prevent the need for re-intubation in those who appear to be failing immediately after extubation

There are hazards and complication in removing the endotracheal tube See: "Removal of Endotracheal Tube (Extubation)" policy.

References:

Determining the Best Threshold of Rapid Shallow Breathing Index in a Therapist-Implemented Patient-Specific Weaning Protocol
Respiratory Care February 2007

Discontinuing Ventilatory Support, Chapter 47
Egan's Fundamentals of Respiratory Care, ninth Edition

Evidence-Based Guidelines for Weaning and Discontinuing Ventilatory Support
Respiratory Care January 2002

Ventilator Modes Used in Weaning
Chest 2001

Liberation From Mechanical Ventilation: A decade of Progress
Chest 1998

Committee Approval	**Date**
Respiratory Care	1-14-09
Medical Services Committee	1-29-09
ICU Committee	1-29-09
Board of Directors	2-18-09

Revised
Reviewed
Supercedes

DRAFT

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Proportional Assist Ventilation (PAV) on PB 840 Ventilator	
Scope: Respiratory Therapist	Department: Respiratory Care
Source:	Effective Date:

POLICY STATEMENT:
Proportional Assist Ventilation (PAV) mode of ventilation is a support mode that may be useful in assisting patients in increased ventilator comfort and decreased time to extubation. The PAV mode is intended for use in spontaneously breathing adult patients whose ventilator ideal body weight (IBW) setting is at least 25 kg. Patients must be intubated with either endotracheal tube or tracheostomy tubes of internal diameter 6.0 mm to 10.0 mm. Patients must have stable, sustainable inspiratory drive.

PROCEDURE:

1. Verify MD order
2. Set up correct IBW, endotracheal tube or tracheostomy tube size, and maximum airway pressure (40 cmH_2O) on PB 840 ventilator.
3. Initial setting of PEEP and FiO2 as per usual criteria. Initial PEEP should be $\geq$ 5 cmH_2O. With PAV, compliance may be used to titrate PEEP, see below.
4. Initial assist setting at 70%.
5. Follow decision tree provided by Puritan Bennett/Covidien clinical resource to titrating assist and PEEP settings. See attachment.

CONSIDERATIONS:

1. Immediate response following a change to PAV varies considerable depending on whether the patient was over-assisted, and whether there was non-synchrony on the previous mode. See attached decision tree.
2. Breathing may be quite variable on PAV. Vt may be quite low (i.e. 3-4 ml/Kg). to the extent that respiratory rate does not increase concurrently and there are no other signs of distress, low Vt is not an indication to change assist level.
3. A high respiratory rate (even up to 50/min) need not by itself indicate distress. Other signs of distress should be present (e.g. sustained change in heart rate or blood pressure, accessory muscle use, sweating).
4. PaCO2 may rise after switching to PAV. Be concerned only if PH decreases below normal (< 7.35).
5. Distressed at 70% assist is uncommon and is usually due to delay triggering because of sever dynamic hyperinflation and weak muscles (i.e. COPD). Alternatively, it may be due to very low compliance at low lung volume (i.e. obesity, abdominal pathology, ALI/ARDS, etc.) and usually these patients exhibit hypoxemia. Either condition may be improved by increasing PEEP.
6. Very few patients continue to have distress at 70% assist after adjusting PEEP. In these patients, increase % assist in steps of 5% up to 90%. Wait 15-20 breaths between steps and observe for stretched out breaths (delayed cycling off). If stretched out breaths appear, decrease the assist to previous level. Usually these are patients in who trigger delay is excessive and cannot be improved by increasing PEEP and % assist. Usually these patients are not candidates for fast weaning. % assist and/or PEEP should be reduced slowly (over several hours or days, depending on the individual patient).

DRAFT

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Proportional Assist Ventilation (PAV) on PB 840 Ventilator	
Scope: Respiratory Therapist	Department: Respiratory Care
Source:	Effective Date:

CAUTIONS:

1. The PAV mode is intended for use in spontaneously breathing adult patients.
2. Definition of respiratory distress in relation to PAV (at least 2 of the following):
   a. Heart rate > 120% of the usual rate for > 5 min and/or systolic BP. 180 or < 190 mmHg and/or BP changes > 20% of the previous value for > 5min.
   b. Respiratory rate > 40 b/m for > 5 min.
   c. Marked use of accessory muscles.
   d. Diaphoresis.
   e. Abdominal paradox.
   f. Marked complaint of dyspnea

DOCUMENTATION

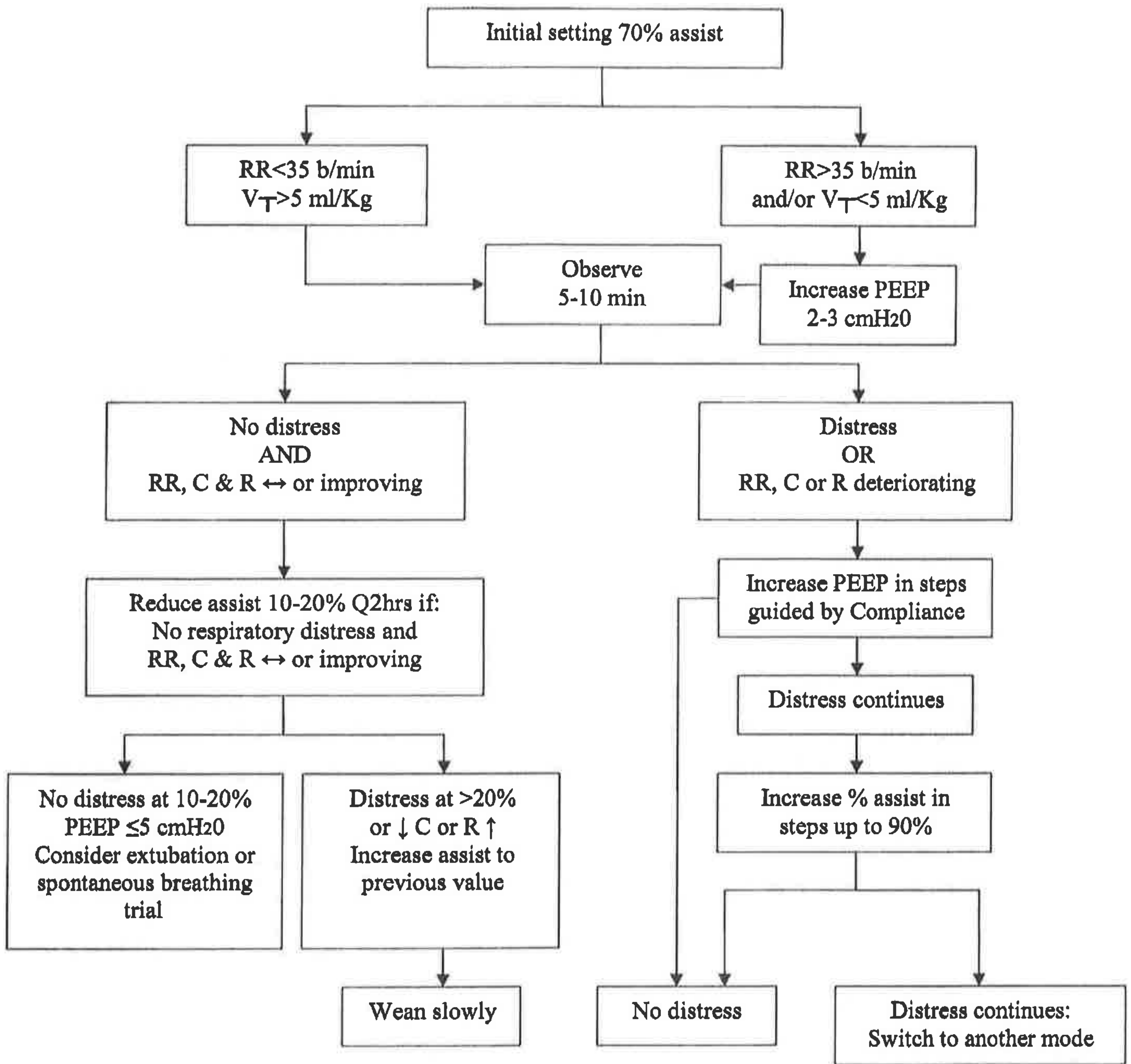
1. Document pertinent observation not detailed in the Clinical CareStation with progress notes.

REFERENCE/RESOURCES:

1. Puritan Bennett/Covidien resources.

Committee Approval	Date

Revised
Reviewed
Supercedes



Initial setting 70% assist
RR<35 b/min
V_T>5 ml/Kg
RR>35 b/min
and/or V_T<5 ml/Kg
Observe
5-10 min
Increase PEEP
2-3 cmH20
No distress
AND
RR, C & R ↔ or improving
Distress
OR
RR, C or R deteriorating
Reduce assist 10-20% Q2hrs if:
No respiratory distress and
RR, C & R ↔ or improving
Increase PEEP in steps
guided by Compliance
Distress continues
Increase % assist in
steps up to 90%
No distress at 10-20%
PEEP ≤5 cmH20
Consider extubation or
spontaneous breathing
trial
Distress at >20%
or ↓ C or R ↑
Increase assist to
previous value
Wean slowly
No distress
Distress continues:
Switch to another mode

DRAFT

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Adult Oxygen Protocol --REVISED	
Scope: Hospital-Wide	Department:
Source: Director of Respiratory Care	Effective Date:

PURPOSE:

To provide protocol driven respiratory therapy for the administration of oxygen at concentrations greater than that in ambient air, with the intent of treating or preventing the symptoms and manifestations of hypoxia.

POLICY:

1. The Oxygen Protocol will be initiated on patients by a CPOE or written order from the physician for any type of oxygen therapy, including Ventilators, BiPAP, CPAP, Vapotherm High Flow Nasal Cannula, and Heated / Cool Aerosol. The Oxygen Protocol may be ordered as Oxygen Protocol.

2. In addition, the Oxygen Protocol may be ordered in forms other than specified by this protocol by entering an order that specifies:
    a) The type of oxygen delivery device.
    b) Liter flow or FIO_2.

3. Registered Nurses may also set up oxygen. If oxygen is started by an RN, the RN must follow this protocol, obtain an order and inform Respiratory Care that the patient is on oxygen.

4. After the physician has entered an order, the RCP will:
    a) Evaluate the patient upon receipt of the physician order.
    b) Place a high or low flow system on the patient depending upon the assessment criteria.
    c) Titrate the FIO_2 to keep the $SpO_2 \geq 92\%$ or within the physician specified limits. The RCP will contact the MD to initiate an ABG if condition indicates.
    d) Notify the physician whenever a patient goes from a Low Flow system to a High Flow system.
    e) Notify the physician if the SpO_2 is $< 92\%$ on Oxygen, or if the patient is demonstrating an increase in O2 requirement as described under guidelines and warnings.

OVERVIEW:

The Oxygen Protocol will be initiated for patients in the following situations:

1. Documented hypoxemia defined as a decreased PaO_2 in the blood below normal range, PaO_2 of < 60 torr or SpO_2 of < 90 in patients' breathing room air.

2. An acute care situation in which hypoxemia is suspected. Substantiation of hypoxemia is required following initiation of therapy.
    a) Severe trauma
    b) Acute Myocardial infarction.

DRAFT

Title: Adult Oxygen Protocol --REVISED	
Scope: Hospital-Wide	Department:
Source: Director of Respiratory Care	Effective Date:

3. For comfort measures as ordered by a physician. This is written for patients that have DNR orders and are usually near death. The goal of comfort measures is to wean from a High Flow system to a Low Flow system, keeping the patient and family members comfortable. It is important that the RCP communicate with both the patient's doctor and nurse as to what is going to be a proper liter flow for the patient's "comfort". SpO_2 checks are not documented unless ordered.

4. The patient will be placed on a Low Flow system if the requirement is determined to be 6 liters of oxygen or less, a respiratory rate of less than 25, and a regular and consistent ventilator pattern.

5. The patient will be placed on a High Flow system if the requirement is determined to be more than 6 liters. The respiratory rate > 25, room air $PaO_2 < 60$, or unable to meet the ordered SpO_2.

6. If the patient is ordered on a CPAP device and needs oxygen, 1-6 LPM may be bled-in.

7. Notify the physician if a patient has been set-up on a high flow system, or anytime the FIO_2 is increased by 10%, for a sustained amount of time, > one hour. Document that the physician has been notified, noting any change in orders.

8. After the initial evaluation, (which will include a room air SpO_2, RR, HR, breath sounds) the RCP will place the patient on a nasal cannula or Oxi-Mask at 1 L/min and titrate the oxygen liter flow to maintain a $SpO_2 \geq 92\%$ or within physicians ordered goals. Patient will be place on a continuous SpO_2 monitor, and the oxygen liter flow will be increased 1 L/min Q5 minutes until the ordered SpO_2 range is met.

9. If greater than 6 L/min is needed to maintain the ordered SpO_2, and a high flow system is indicated, the physician will need to be notified. Oxygen therapy via traditional nasal cannula should not be used at flows higher than 6 LPM. Adequate humidification is required to maintain ciliary activity, prevent squamous epithelial changes, prevent dehydration and thickening of secretions, minimize atelectasis and tracheitis and decrease heat loss.

10. When a Low Flow system is indicated, the RCP will place the patient on one of the following:

    a. Traditional nasal cannula at 1-6 LPM
    b. Oxi-Mask at 1-6 LPM

Title: Adult Oxygen Protocol --REVISED	
Scope: Hospital-Wide	Department:
Source: Director of Respiratory Care	Effective Date:

11. When a High Flow system is indicated, the RCP will place the patient on one of the following:
    a) Simple mask.
    b) Venturi mask.
    c) Aerosol mask, tracheostomy collars, t-tube adapters, face tents and large bore generator, Heated or Cool depending on application.
    d) Non-rebreather mask.
    e) Oxi-Mask.
    f) Vapotherm Hi-flow nasal cannula, an FDA approved device designed to comfortably deliver flow of 1-40 LPM for Adults and 1-6 LPM for Infants, of heated, humidified oxygen through a nasal cannula interface.

12. When a patient has been ordered to be on a BiPAP or a Ventilator, the FIO_2 will initially be set at 100%. Once the patient is stable the FIO_2 will be weaned to maintain the ordered SpO_2. During suctioning and other events that cause the SpO_2 to drop lower than the ordered SpO_2, the FIO_2 will be adjusted (increased) to maintain the ordered SpO_2. If unable to return to the previous FIO_2 after the event, > one hour, the physician will be notified.

GUIDELINES AND WARNINGS

1. The responsible physician and R.N. will be contacted:
    a. If the RCP is unable to determine appropriate care upon evaluation
    b. If the patient demonstrates an increase in oxygen requirement (increases in oxygen of 10% after the high flow system has been set-up or increases of ≥ 3 L/min on traditional nasal cannula or Oxi-Mask when the patient has been set-up on a low flow system.
    c. If the patient demonstrates an increase in CO2 (e.g., disoriented, somnolence, or stupor).
    d. If the SpO_2 of ≥ 92% or the physician's specified limits cannot be maintained.

2. The PaCO2 of chronically hypercapnic patients with COPD often does rise acutely after these patients are given oxygen. But it is important to note that the diagnosis of COPD on a patient's medical record does not automatically mean the patient has a chronically high PaCO2 or that administration will induce hypercapnia. In order to prevent hypoxia but avoid hypoventilation in these patients, we should aim for an arterial PO2 between 50 and 60 torr, or a SpO_2 of 80-90%.

3. In any event, O2 should never be withheld from acutely hypoxemic patients with COPD for fear of inducing hypoventilation and hypercapnia. Tissue oxygenation is an overriding priority; oxygen must never be withheld from exacerbated, hypoxemic patients with COPD for any reason. This means the clinician must be prepared to mechanically support ventilation if O2 administration induces severe hypoventilation.

4. Consider obtaining ABG's if the patient exhibits signs of increased disorientation, somnolence, or stupor.

Title: Adult Oxygen Protocol --REVISED	
Scope: Hospital-Wide	Department:
Source: Director of Respiratory Care	Effective Date:

WEANING OF OXYGEN:

1. When a patient has been ordered on Oxygen with a SpO_2 order, the RCP will do a room air SpO_2 check Q AM and PRN to see if a patient can be left on room air.
   a. First assess the patient on oxygen.
   b. Place a continuous SpO_2 monitor on the patient, document liter flow, SpO_2.
   c. Remove the nasal cannula and observe the patient to see if they de-sat below the ordered SpO_2. When determining room air SpO_2, the patient must be off oxygen for at least 15 minutes prior to obtaining reading.

2. When the patient's oxygen is <= 6 L/min, the oxygen will be titrated by 1 L/min, every 5 minutes, keeping the SpO_2 >= 92% or within the physician specified limits, until the patient is on room air.

3. Oxygen will also be weaned PRN, 1 LPM to keep the SpO_2, 2-3% above the ordered SpO_2.

4. When the patient is on a high flow system, the oxygen will be titrated by 5 L/min, every 5 minutes, keeping the SpO_2 >= 92% or within the physician specified limits, until the patient can be weaned to a nasal cannula or Oxi-Mask at 6 L/min or less.

5. When the patient is on the Vapotherm, start by weaning the FIO_2 to 50% first, then wean flow.

6. If a patient in ICU or Medical Surgical units has been on room air for 48 hours, SpO_2 checks will be changed to Q Shift unless otherwise ordered by the Physician.

7. In the OB department, if the mom has been on room air for 24 hours, SpO_2 will be discontinued.

Title: Adult Oxygen Protocol --REVISED	
Scope: Hospital-Wide	Department:
Source: Director of Respiratory Care	Effective Date:

DOCUMENTATION:

1. All documentation will be done in the Clinical CareStation under Respiratory RT, and Group Notes or Progress Notes.
2. All discussions regarding the patient with physicians and nurses need to be documented.
3. All telephone orders must be documented per policy "Verbal Orders"

Committee Approval		Date
Respiratory Care		October 1, 2013
Peri-Peds Committee		October 15, 2013
Medical Services – ICU Committee	Pending	October 31, 2013
Medical Executive Committee	Pending	November 5, 2013
Pharmacy and Therapeutics Committee	Pending	November 21, 2013
Board of Directors	Pending	December 11, 2013

Revised
Reviewed
Supercedes

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Continuous Bronchodilator with MiniHeart Hi-Flow Continuous Nebulizer	
Scope: Respiratory Therapists	Department: Respiratory Care
Source: Director of Respiratory Care	Effective Date: May 17, 2012

PURPOSE:
To outline steps that will be taken by Respiratory Care Practitioners (RCPs) to continuously nebulize bronchodilators in the adult or pediatric population.

POLICY:
Respiratory Care Practitioners will administer inhaled medications only with a physician's order.
Full time nebulization is to be done in the Emergency Department or ICU.
In an emergency situation continuous nebulization can be implemented on the Medical Surgical Floor with the physician present.
This treatment may also be used as therapy for hyperkalemia in high doses (10 mg) in conjunction with other modalities of treatment.

INDICATIONS:

1. Patients with severe bronchospastic disease who require intermittent therapy of inhaled $beta_2$ agonists every hour or more and/or have initial peak flow rates < 50% of known best or predicted peak flow value.
2. Patients in impending or acute respiratory failure secondary to an acute reversible airway disease.
3. Patients with hyperkalemia.

CONTRAINDICATIONS:
Known hypersensitivity to the medication being delivered.

PRECAUTIONS:

1. Refer to medication resources for information on the specific medication used.
2. Continuous nebulizer therapy with $beta_2$agonists is contraindicated on patients with complicated medical illness such as:
   a. Pneumonia
   b. Diabetes
   c. Hypokalemia (potassium <3.0 mmol/L) NOTE: Albuterol can cause acute Hypokalemia. It has a potentially toxic effect on the heart, especially against the background of hypoxia, acidosis, increased adrenergic drive, and dysrhythmia, which can be associated with the disease or its treatment. Serum potassium levels should be obtained, when feasible, before starting therapy. If serum potassium is <3.0 mmol/L, do not start therapy. If the potassium is 3.5 to 5.0 mmol/L, begin therapy and repeat potassium assessment every four hours that therapy is continued.
   d. Chest pain and/or frequent arrhythmias
   e. Pulmonary edema
   f. Unstable coronary artery disease
   g. Severe tachycardia (>200/minute)

PRECAUTIONS: continued

3. Airway obstruction may occur due to swelling or excessive liquefaction of secretions.
4. Hypoxemia from inadequate supplemental oxygen delivery during therapy may occur.
5. Pregnancy

EQUIPMENT:

1. MiniHeart Hi-Flow Continuous Nebulizer Kit (includes aerosol mask and tubing)
2. Oxygen Flowmeter and Nipple
3. Medication:
   a. Albuterol multi-dose bottle 5% solution (5mg/ml)
   b. Albuterol unit doses
   c. Atrovent unit doses
   d. NaCl 15-18ml
4. 25cc Syringe
5. Peak Flow Meter
6. Cardiac Monitor
7. Pulse Oximeter

ORDERING:
This modality will be instituted upon written or verbal order from a physician. The order should specify **Continuous Bronchodilator Therapy (CBT)**. Order should include cardio-respiratory monitor and continuous pulse oximetry.

There are two standard dosing selections for the MiniHeart Hi-Flow Continuous Nebulizer.

- **Low Dose Albuterol--7.5 mg Albuterol / Treatment**
- **High Dose Albuterol--15 mg Albuterol / Treatment**

The dosage should be determined by the patient's clinical condition and by the amount of beta agonists the patient has already received. It is recommended that the total dosage of beta agonists should not exceed 20 mg/hour unless otherwise directed by the physician.
The Low Dose is recommended for pediatric patients 12 years of age and younger, and for any patient weighing less than 100 pounds.

NOTE: Dosages of up to 40 mg/hour have been reported in the literature without significant side effects.

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Scope: Respiratory Therapists	Department: Respiratory Care
Source: Director of Respiratory Care	Effective Date: May 17, 2012

Multidose Albuterol 5% solution (5mg/ml)

Low Dose Albuterol **7.5 mg** Albuterol	1.5 ml Albuterol Solution + 18 ml NaCl = 1 hour T/x
High dose Albuterol **15 mg** Albuterol	3 ml Albuterol Solution + 18 ml NaCl = 1 hour Tx
Low Dose Albuterol + **Pre-Pack Atrovent** 7.5 mg Albuterol & 500 mcg Atrovent	1.5 ml Albuterol Solution + 1 Pre-Pack Atrovent + 15 ml NaCl = 1 hour T/x
High Dose Albuterol + **Pre-Pack Atrovent** 15 mg Albuterol & 500 mcg Atrovent	3 ml Albuterol Solution + 1 Pre-Pack Atrovent + 15 ml NaCl = 1 hour T/x

Pre-Pack Albuterol

Low Dose Albuterol **7.5 mg** Albuterol	3 unit doses Albuterol + 12 ml NaCl = 1 hour T/x
High dose Albuterol **15 mg** Albuterol	6 unit doses Albuterol + 3ml NaCl = 1 hour Tx
Low Dose Albuterol + **Pre-Pack Atrovent** 7.5 mg Albuterol & 500 mcg Atrovent	3 unit doses Albuterol + 1 unit dose Atrovent + 9 ml NaCl = 1 hour T/x
High Dose Albuterol + **Atrovent** 15 mg Albuterol & 500 mcg Atrovent	6 unit doses Albuterol + 1 unit dose Atrovent = 1 hour T/x

Title: Continuous Bronchodilator with MiniHeart Hi-Flow Continuous Nebulizer	
Scope: Respiratory Therapists	Department: Respiratory Care
Source: Director of Respiratory Care	Effective Date: May 17, 2012

PROCEDURE:

1. Review the chart
2. Follow Standard Precautions
3. Introduce yourself to the patient
4. Patient identification must be confirmed using the **two-identifier** system prior to conducting any healthcare procedures. See policy.
5. Wash hands
6. Assemble MiniHeart nebulizer
7. Explain the procedure to the patient and reassure him/her as necessary
8. Record baseline parameters (HR, RR, Breath sounds, SpO_2, PEFR)
9. Inject appropriate medications into the nebulizer. .
10. Adjust flow rate 8 lpm. Observe system for adequate nebulization.
11. Monitor patient continuously in the acute phase when CBT is initiated and as often as necessary in the critical care area. The practitioner should be nearby and monitor patient closely while CBT is being administered.

ADVERSE EFFECTS:

1. Tachycardia
2. Tremors
3. Nausea and/or vomiting
4. Hypoxemia
5. Worsening of airflow limitation
6. Arrhythmias; S T segment depression
7. Hypokalemia

Note: If any of the above adverse effects occur during CBT, the patient should be assessed for discontinuing the treatment. The physician should be contacted prior to termination or reduction of the treatment regime.

ASSESSMENT OF OUTCOME:

1. Patients who show signs of improvement should be gradually weaned from CBT and assessed frequently. The RCP may suggest to the physician to wean patients by either:
   a. Changing to a lower dose of Albuterol
   b. Removing the mask for short trial periods and beginning intermittent HHN every one hour for the first four hours and then every two hours if patient remains stable.

The physician should be notified of any treatment failure. Treatment failure may include, but is not limited to the following:

1. Failure to significantly improve
2. Decreasing aeration over time or increased wheezing without a simultaneous increase in aeration
3. Worsening blood gases
4. Decreasing SpO_2 readings or an increasing need for oxygen to maintain the same saturations
5. Decreasing level of consciousness or decreased ability to awaken the patient
6. Increased work of breathing
7. Increasing signs of respiratory failure
8. Significant arrhythmias, excessive tachycardia (25% increase in heart rate from baseline value, with a maximum of 200 in the pediatric patient).
9. Chest pain

SPECIAL INSTRUCTIONS:

1. An RCP must be available and ready to respond at all times during CBT, and the patients must be on continuous pulse oximetry and ECG monitor. Frequent vitals must be taken as described in this procedure.
2. CBT should not be interrupted if at all possible.
3. Intolerance to bronchodilator administration is based on hazards listed in this procedure. However, this modality has been demonstrated to be effective in reversing status asthmaticus. Therefore, when considering discontinuance of CBT, tachycardia will be defined as a 25% increase above baseline level.
4. Once the emergent episode of status asthmaticus subsides, weaning from CBT will be tailored to each patient, depending on individual response.
5. Consider obtaining ABG's to monitor PCo2

DOCUMENTATION:

1. Initial treatment time started
2. Medication dose and diluent
3. Baseline parameters:
    a. Heart rate
    b. Respiratory rate
    c. Peak expiratory flow rate (if obtainable)
    d. Breath sounds
    e. Oxygen saturation
    f. Adverse reactions (bronchospasm, coughing, etc)

Title: Continuous Bronchodilator with MiniHeart Hi-Flow Continuous Nebulizer	
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Source: Director of Respiratory Care	Effective Date: May 17, 2012

4. Document every 15 minutes x 2 then every 30 minutes, or more frequently if the patient's clinical condition warrants. Monitor the patient for the following:
    a. Tremor
    b. Irritability
    c. Alterations in blood pressure
    d. Recurrent arrhythmias
    e. Tachycardia
    f. Untreated Hypokalemia

5. If the above signs or symptoms are seen, stop the therapy immediately and notify the physician

REFERENCES

AARC Clinical Practice Guideline: Delivery of Aerosol to the Upper Airway

AARC Clinical Practice Guideline: Selection of a Device for Delivery of Aerosol to the Lung Parenchyma

Rose, BD. Clinical Manifestations and Treatment of Hyperkalemia. Accessed from Up to Date 3-20-2012 www.uptodate.com

Westmed MiniHeart Hi-Flow Continuous Nebulizer Product Literature Sheet

Committee Approval	**Date**	**Date**
Respiratory Care	4-11-12	10-1-2013
Pharmacy & Therapeutics	5-17-12	
Medical Executive Committee		
Board of Directors		

Revised
Reviewed
Supercedes

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Initial Ventilator Settings	
Scope: Respiratory Therapists	Department: Respiratory Care
Source: Director of Respiratory Care	Effective Date: 4-26-2012

PURPOSE:

To provide a starting point when placing an Adult or Pediatric Patient >= 45 kilograms on a Mechanical Ventilator.

PROCEDURE:

Whenever a patient is placed on a mechanical ventilator the following parameters will serve as the **<u>Initial Settings</u>** until the physician writes orders.

1. **Initial Ventilator Settings**

   A. Assist Control
   a. Volume Ventilation may be used for the majority of patients.
   b. Pressure Ventilation should be considered if peak pressures rise over 40 cm H2O or plateau pressures rise >= 30 cm H2O.

   B. Tidal Volume
   a. Volume Control—Target 6-8 ml/Kg IBW
   b. Pressure Control—Target 4-6 ml/Kg IBW

   C. Respiratory Rate
   a. Start at a rate of 8-26 breaths / minute. Adjust to achieve optimum total cycle time and maintain desired minute ventilation, while maintaining plateau pressure <= 30 cm H2O

   D. Peep of 3-5 cm H2O

   E. FIO2: Initial setting of 60-100% until results from arterial blood gases (ABG) can be obtained and the setting adjusted.
   a. Initial ABG should be obtained 20-60 minutes from start of ventilation.
   b. Pulse oximetry should be correlated with initial ABG and the patient subsequently monitored with continuous pulse oximetry to maintain SpO_2 at patient's normal or > 90%.
   c. ETCO2 should be correlated with initial ABG and the patient subsequently monitored with continuous ETCO2 monitor.

   F. Peak inspiratory flow rate.

   The peak inspiratory flow rate determines how fast each breath will be delivered to the patient and is therefore a determinant of inspiratory time. The faster the flow rate, the shorter the inspiratory time, and the more breaths that can be delivered per minute. Optimal inspiratory flow time is between 0.5 and 1.5 seconds and is usually achieved with a **peak inspiratory flow rate between 40 and 70 L/min.**

Title: Initial Ventilator Settings	
Scope: Respiratory Therapists	Department: Respiratory Care
Source: Director of Respiratory Care	Effective Date: 4-26-2012

The above settings may need to be adjusted to meet the ventilatory and oxygenation needs of some patients. All patients will be started on Volume Ventilation. However, the RCP may switch to Pressure Ventilation whenever the patient is setup on a ventilator and the resultant plateau pressures are consistently greater than 30 cm H2O.

1. Ventilation Targets
    a. ABG (Arterial Blood Gas) ranges.
        i. Unless otherwise ordered, the following chart summarizes the arterial blood gas targets for a mechanically ventilated patients:

Patient Category	pH	PaCO2	PaO2	SaO2
Normal	7.35 – 7.45	35-45 mmHg	Greater than or equal to 80 mmHg	92-97%
Chronic Lung Disease	7.30 – 7.45	45-60 mmHg or adjust to pH range	55-75 mmHg	Greater than or equal to 89%
ARDS	7.25 – 7.45	Adjust to pH range	Greater than or equal to 60 mmHg	88-95%

1. Oxygenation Strategies and Tools
    a. Indication and Application
        i. Nearly all mechanically ventilated patients will require the application of additional inspired oxygen to meet their targeted oxygen parameters or PaO2.
    b. Adjustments
        i. As a general rule when it becomes necessary to increase the inspired oxygen amount to greater than 50% in order to meet the patient's oxygen parameters, you may need to consider the additional application of PEEP.
    c. Weaning
        i. Oxygen is a drug, therefore when a patient has met their oxygen parameters, the weaning of oxygen should take precedence over the weaning of any level of PEEP.
        ii. As a general rule, when oxygen is less than or equal to 50% inspired, the subsequent weaning of PEEP may take place.

2. PEEP
    a. Indications and Application
        i. PEEP is used for improving oxygenation in patients with refractory hypoxemia.
        ii. For the mechanically ventilated patient it is common to apply a minimum of 5 cmH2O of PEEP since the artificial airway bypasses the patients use of physiologic PEEP.
        iii. Some expected outcomes of the application of PEEP.
            1. Restored FRC and alveolar recruitment
            2. Decreased shunt
            3. Increased lung compliance
            4. Decreased work of breathing
            5. Increased PaO2 for a given FiO2
    b. Contraindications
        i. Some contraindications for the application of PEEP are:
            1. Unmanaged bronchopleural fistula
            2. Untreated pneumothorax
            3. Severe unilateral lung disease
            4. Elevated ICP
            5. Severe bullous lung disease
        ii. Some contraindications are relative at moderate or low levels of PEEP, therefore, the MD should be consulted when these indicators are noted or foreseen
    c. Adjustments
        i. Adjustments to the level of PEEP can be based on ABG results, or clinical observation.
    d. Signs of intolerance
        i. Can be seen with increased application of PEEP or at times during weaning of PEEP:
            1. Increased WOB
            2. Decrease in cardiac output (or decrease in monitored end-tidal carbon dioxide
            3. Decrease in blood pressure
            4. Decrease in oxygenation and saturation
    e. Weaning
        i. The weaning of levels of PEEP should be done judiciously, in increments of 2-3 cm H2O over a period of time, while monitoring for signs of intolerance.
        ii. The weaning of PEEP usually does not take precedence over the weaning of inspired oxygen.

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Initial Ventilator Settings	
Scope: Respiratory Therapists	Department: Respiratory Care
Source: Director of Respiratory Care	Effective Date: 4-26-2012

Committee Approval	**Date**
Respiratory Care	4-11-2012
ICU Medical Surgical Committee	4-26-2012
Medical Executive Committee	
Board of Directors	

Revised
Reviewed
Supercedes

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: BiPAP	
Scope: Hospital Wide	Department: Respiratory Care
Source: Director of Respiratory Care	Effective Date: 12-21-2005

PURPOSE:

To codify indications, contraindications, initial settings and conditions of admission for bi-level positive airway pressure (BiPAP) V 60 or Vision Ventilatory Support System

POLICY:

1. All patients admitted to the hospital for acute respiratory exacerbation or other serious medical condition and requiring BiPAP, will be admitted to the ICU due to the required higher level of care.

2. *Patients that are ordered for BiPAP or CPAP, and* ***Do Not Use These Devices At Home*** *will be admitted to the ICU for careful observation.*

3. Patients, who use BiPAP or CPAP at home and are stable, may be admitted to the Medical / Surgical Floor. Patients that are stable can transfer from the ICU to the Medical / Surgical floor. Unless otherwise ordered by admitting / attending physician, patients will be housed in a closely observed room, if the physician orders regular floor care for the patient.

Indications:

1. Acute Respiratory Insufficiency or Failure:
    a. Medically unacceptable or worsening alveolar hypoventilation, as reflected by an elevated or rising $PaCO_2$
    b. Ventilatory muscle dysfunction or muscle fatigue - clinical signs include tachypnea, dyspnea, and use of accessory muscles, reduced tidal volume, and subjective patient complaints
    c. Refractory hypoxemia ($PaO_2 < 55$ on FiO_2 .50 or more)
    d. Patients who develop post-extubation difficulty in whom avoidance of re-intubation is desired
2. A patient with upper airway obstruction due to such conditions as laryngeal or glottic edema, for whom it is desirable to avoid endotracheal intubation until more definitive, permanent therapy, becomes effective.
3. Obstructive Sleep Apnea
4. Terminal patients who desire comfort measures

Contraindications and Relative Contraindications:

1. Patients incapable of maintaining life-sustaining ventilation in the event of malposition of the mask.
2. Uncooperative or agitated patients.
3. Patients with facial or nasal trauma.
4. Patients with or susceptible to pneumothorax or pneumomediastinum should be monitored closely when applying positive pressure. (Pre-existing bullous lung disease may represent a relative contraindication).
5. Patient's inability to maintain a patient airway or adequately clear secretions.
6. Severe respiratory failure where intubation is immediately necessary.

7. Hypotension induced by positive pressure ventilation.
8. Epistaxis causing pulmonary aspiration of blood.
9. Patients at risk for aspiration of gastric contents.
10. Acute sinusitis or otitis media.

Equipment: BiPAP V-60 Ventilator or BiPAP Vision Ventilator with Circuit.
Humidifier if indicated.
Various size masks and headgear.

PROCEDURE:

Obtain baseline clinical assessment including the following:
Systemic blood pressure. Also, check with nurse regarding pulsus paradoxus
Pulse and respiratory rate
Use of accessory muscles
Skin color (cyanosis).
Auscultation

Obtain laboratory data including:
ABG
Chest X-ray
Oxyhemoglobin saturation by oximetry (SpO_2)

Initial application of the BiPAP system:

1. Therapist should explain the use of the BiPAP system to the healthcare personnel managing the patient's care.
2. Therapist should take care in trying to explain to the patient exactly what to expect from the BiPAP system and that there will be a time period of adjusting to both the pressure and the mask. When appropriate, let them know in a caring way what the alternative is. I.e. intubation. Reassure the patient that you will be at the bedside until they are comfortable with the therapy. Continue to monitor them on a regular basis.
3. Carefully fit the BiPAP mask:
    a. Select the smallest size mask to comfortably fit the patient.
    b. Note: A properly fitted mask should come close to but not touch the nose in three places: the bridge of the nose, on the sides of both nares, and just below the lowest point of the nose, above the lip.
    c. If using treatment mask with anesthesia strap, therapist must remain in the room at all times. This is for initial set-up only.
4. Be careful not to over stress the anxious patient with attempts to place a mask. Try using the mask of the Ambu bag first to see if patient will tolerate having something over their face. If not initially tolerated and the patient is continuing to fail, another mode of support should be considered.
5. *Patient needs to be NPO initially when placed on the BiPAP unit. If there is an order for dietary, call the physician to see if he would like to Discontinue or Hold Dietary.*

Title: BiPAP	
Scope: Hospital Wide	Department: Respiratory Care
Source: Director of Respiratory Care	Effective Date: 12-21-2005

Suggested Initial Settings:

IPAP – 10 - 15 cmH20

EPAP- 4.0 – 7 cmH2O (The difference between IPAP and EPAP is Pressure Support. In this case, PS of 6 cmH2O)

Adjustments of the BiPAP System:

1. IPAP- Increase IPAP in increments of 2.0 cmH2O to increase pressure support. Increase pressure support to augment ventilation. Note: When you increase IPAP, you will increase tidal volume. Check Vt at the bottom of the screen.
2. EPAP- Increase EPAP by 2 cmH2O increments to increase Functional Residual Capacity (FRC). Note: When you increase EPAP, increase the IPAP by the same amount to maintain the pressure support level.
3. Timed Insp.- This can be set from 0.5 seconds to 3.0 seconds. This adjustment increases or decreases the amount of time it takes to deliver a breath. It should be adjusted for patient comfort. Initially, start small. Your patient may become more anxious if he feels air hunger and it's taking 2.0 seconds or more to get a breath. Note: This adjustment will change automatically with rate changes, so as to not inverse the I:E ratio.
4. IPAP Rise Time- This is another one of those patient comfort adjustments. It changes the flow pattern from a square wave, on the lowest setting (0.05sec.), to the highest setting (0.4 sec.), which is more like a bell waveform. You'll just have to see what works for your patient.

Continued Monitoring:

1. Once your patient is on the BiPAP system, continue to monitor the following:
    a. Physical examination
    b. Blood pressure
    c. Pulse and respiratory rate
    d. Skin color, temperature, and perfusion
    e. Use of accessory muscles
    f. Paradoxical movement of the chest wall
    g. Auscultation

2. Laboratory data
    a. ABG
    b. Chest X-ray
    c. Oximetry

3. Assess therapy Based on clinical and physiological outcomes.
    a. Adjust control settings as necessary
    b. Mask- Assess leak, skin condition (apply skin barrier if necessary).
    c. Note any patient discomfort and re-evaluate.

Title: BiPAP	
Scope: Hospital Wide	Department: Respiratory Care
Source: Director of Respiratory Care	Effective Date: 12-21-2005

If a satisfactory degree of patient comfort is not achieved or the patient's medical management is not adequate, BiPAP administration should be discontinued and alternative therapy instituted as required.

Committee Approval	Date	Date
Policy and Procedure	8/15/2005	10-1-2013
Medical Services - ICU Committee	10/27/2005	10-31-2013
Pharmacy Therapeutic Committee		
Medical Executive Committee	12/7/2005	
Administration	12/7/2005	
Board of Directors	12/21/2005	

Revised 10-1-2013
Reviewed 10-31-2013
Supercedes 7/10/2002

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Vapotherm	
Scope: Respiratory Therapists	Department: Respiratory Care
Source: Director of Respiratory Care	Effective Date: August 4, 2011

PURPOSE:

The Vapotherm system is used to add warm moisture to breathing gases for administration to patients, including infant, pediatrics and adults, at flow rates from 1 to 40 liters per minute via nasal cannulas.

POLICY:

Heat and humidity prevents airway water-loss, airway cooling, thickened secretions, nasal irritation and bleeding. The high flow nasal cannula delivery system has been designed to safely provide optimal humidity to both infants and adult patients who require higher humidity and FiO2 levels than a traditional cannula can provide.

INDICATIONS:

1. Documented hypoxemia
    a. Adults: defined as a decreased PaO2 in the blood below normal range , PaO2 < 60 mmHg or SaO2 of < 90% while breathing room air.
    b. Pediatric: defined as a decreased PaO2 in the blood below normal range, PaO2 of < 65 mmHg or SaO2 of < 92 while breathing room air.
    c. PaO2 and / or SaO2 below desirable range for specific clinical situation.
2. An acute care situation in which hypoxemia is suspected.
3. Severe trauma.
4. Acute myocardial infarction.
5. Short-term therapy or surgical intervention (e.g., post-anesthesia recovery hip surgery, etc.)

CONTRAINDICATIONS:

No specific contraindications to oxygen therapy exist when indications are judged to be present. Specific to nasal cannula: Patients with occluded or defective nares should not use the system.

WARNINGS AND CAUTIONS:

1. The cartridge, disposable water path and delivery tube are labeled as single patient use only and must be replaced after 30 days use on a single patient.
2. Never connect the unit to a patient until it reaches set point temperature (temperature display stops flashing). Allow the unit to warm-up to purge condensate and prevent patient discomfort due to cold or partly humidified gas.
3. The Precision Flow is not MRI compatible.
4. The back-up battery is designed for temporary use only, when AC power to the unit has been interrupted.

5. Clamp water supply when not in use, including Standby mode, to prevent damage by water ingress.
6. The oxygen sensor should be replaced after 1 year.
7. The sensor windows in the docking station must not be scratched or damaged. If necessary, clean them only with alcohol wipes (70-90 % isopropyl alcohol).
8. The transparent sensor ports in the docking station must be clean. The unit will not operate if the sensors do not receive a clear signal, see Operating Instruction Manual.

PRECAUTIONS AND / OR POSSIBLE COMLICATIONS:

a. With PaO2 >= 60 torr, ventilatory depression may occur in spontaneously breathing patients with chronic elevated PaCo2.

b. With FiO2 >= 0.5 absorption atelectasis, oxygen toxicity, and / or depression of ciliary function may occur.

c. Supplemental oxygen should be administered with caution to patients suffering from paraquat poisoning and to patients receiving bleomycin.

d. Fire hazard is increased in the presence of increased oxygen concentrations.

LIMITATIONS OF PROCEDURE:

Oxygen therapy has only limited benefit for the treatment of hypoxia due to anemia, and benefit may be limited with circulatory disturbances. Oxygen therapy should not be used in lieu of but in addition to mechanical ventilation when ventilatory support is indicated.

ASSESSMENT OF NEED:

Need is determined by measurement of inadequate oxygen tensions and / or saturations, by invasive or noninvasive methods, and / or the presence of clinical indicators as previously described. Supplemental oxygen flow should be titrated to maintain adequate oxygen saturation as indicated by pulse oximetry SpO2 or appropriate arterial blood gas values.

PROCEDURE:

1. Verify physician orders.
2. Review chart for relevant information.
3. Follow standard precautions.
4. Introduce yourself to the patient.
5. Verify the patient's identify using two identifiers.
6. Explain procedure to the patient and reassure him/her as necessary.

Title: Vapotherm	
Scope: Respiratory Therapists	Department: Respiratory Care
Source: Director of Respiratory Care	Effective Date: August 4, 2011

Inserting disposable patient circuit

1. Install a high or low-flow vapor transfer cartridge in disposable water path. The cartridge may be inserted either way up. Align the cartridge ports with the disposable water path openings and press firmly into place.
    a. If a HIGH-FLOW cartridge is installed the flow cannot be set below 5 lpm.
    b. If a LOW-FLOW cartridge is installed the flow cannot be set above 8 lpm.
2. Fit the delivery tube to the disposable water path. Press firmly into place, both latches must click shut.
3. Open door by sliding it forward to expose the docking station
4. Hold disposable patient circuit by its handle, with the delivery tube downward.
5. Slide disposable patient circuit downward into the docking station until it stops.
6. Press down firmly to ensure correct seating.
7. Close door by sliding it backwards until it stops. If the sliding door does not close easily, check that the cartridge is installed correctly and the disposable water path is fully inserted into the docking station.
8. Plug in power cord, and check that all the display indicators light. The Precision Flow then performs a self-test:
    a. All icons and numeric displays light up for a few seconds
    b. Internal sensors and control systems are checked
    c. If no faults are detected the unit enters STANDBY mode
    d. "water out" icon indicates there is no water in the disposable water path
    e. Status LED is amber.
9. Push or rotate the control setting knob in either direction to light up the display in STANDBY mode.
10. To connect the sterile water, remove spike cap and wipe spike with 70- 90% isopropyl alcohol. Firmly insert spike into spike port or the sterile water, avoiding direct hand contact. Unclamp the water inlet tube so that water flow into the disposable water path and the "Water Out" alarm cancels/
11. Press Run/Stan-by button to start gas flow, pump and heater. Press twice if the display is initially blank.
12. Wait for desired set temperature to be reached before placing the cannula on the end of the patient delivery tube. The flashing green status LED becomes steady when the set temperature is reached.
13. Size cannula to patient by ensuring that nasal prongs do not fit tightly into nares (1/2 the diameter of the nares).

Title: Vapotherm	
Scope: Respiratory Therapists	Department: Respiratory Care
Source: Director of Respiratory Care	Effective Date: August 4, 2011

14. Adjust temperature on Vapotherm unit according to required flow rate.

Flow Rate	1-3	4-6	6-8	9 or more
Gas Temperature	33-34 C	34-35 C	35-36 C	36-37 C

REFERENCES:

1. AARC Clinical Practice Guideline "Oxygen Therapy for Adults".
2. Vapotherm www.vtherm.com/products/precision

Committee Approval	**Date**
Respiratory Care Committee	8-4-2011
ICU / Medical Surgical Committee	4-26-2012

Revised
Reviewed
Supercedes

THIS SHEET

INTENTIONALLY

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NORTHERN
INYO HOSPITAL
Northern Inyo County Local Hospital District

People you know,
caring for people you love

150 Pioneer Lane
Bishop, California 93514
(760) 873-5811 voice
(760) 872-2768 fax

December 11, 2013

To: Northern Inyo County Local Hospital
District Board of Directors

From: Kathy Bowersox-Miess MHA, BSN RN

Topic: Orthopedic Capital Equipment Approval FY 2014

Richard Meredick MD has entered into an Orthopedic Practice Management agreement effective 1/6/2014 with NIH. As part of the Orthopedic Practice Management Agreement, NIH has agreed to purchase equipment and supplies for the treatment of orthopedic patients. The attached list is a breakout of capital instrumentation, equipment, and implants/disposables required.

Cost breakdown as follows:

- Instrumentation $57,612
- Implants and disposables $21,003
- Equipment $5,200

Additional quotes for trauma and total joint instrumentation, implants, and disposables will be forth coming.

ARTHREX QUOTE TOTALS

CAPITAL INSTRUMENTATION		QUOTE TOTAL	
SUPPLIMENTAL SHOULDER INSTRUMENTS		$	8,098.00
COMPLETE SHOULDER TRAY		$	19,259.00
ACL TRAY		$	12,841.00
ARTHROSCOPY INSTRUMENTS		$	17,414.10
TOTAL CAPITAL INSTRUMENTATION		**$**	**57,612.10**

IMPLANTS AND DISPOSABLES		QUOTE TOTAL	
STaR SLEEVES FOR SHOULDER TRACTION		$	2,400.00
SHOULDER IMPLANTS AND DISPOABLES		$	14,752.00
ACL IMPLANTS AND DISPOSABLES		$	3,851.00
ARTHROSCOPY PUMP		$	2,440.00
SHAVER SYSTEM		$	2,760.00
TOTAL IMPLANTS AND DISPOSABLES		**$**	**26,203.00**

ARTHREX QUOTE TOTAL		**$**	**83,815.10**

Arthrex Shoulder Equipment

Part #	Description	Qty	List	Cost	Total
AR12540	Looped Suture Grasper	1	$ 1,465.00	$ 1,025.00	$ 1,025.00
AR1305	Single Hole Knot Pusher	1	$ 643.00	$ 450.00	$ 450.00
AR1342-15	Arthroscopic Tissue Elevator, 15 Degree	1	$ 443.00	$ 310.00	$ 310.00
AR1342-30	Arthroscopic Tissue Elevator, 30 Degree	1	$ 443.00	$ 310.00	$ 310.00
AR21020	Ring Curette	1	$ 540.00	$ 378.00	$ 378.00
AR4130	Ball Rasp	1	$ 488.00	$ 341.00	$ 341.00
AR1312	Glennoid Rasp	1	$ 493.00	$ 345.00	$ 345.00
AR1312-90	Bankart Rasp	1	$ 493.00	$ 345.00	$ 345.00
AR5008	Arthroscopic Shoulder Probe	1	$ 143.00	$ 100.00	$ 100.00
AR6531	Gold Obturator for AR6530 Cannula	1	$ 536.00	$ 375.00	$ 375.00
AR6541	Blue Obturator for AR6540 Cannula	1	$ 536.00	$ 375.00	$ 375.00
AR6549	Purple Obturator for AR6570 Cannula	1	$ 536.00	$ 375.00	$ 375.00
AR1927PB	Anchor Punch	1	$ 272.00	$ 190.00	$ 190.00
AR1927CTB	FT Bio-Corkscrew Tap	1	$ 707.00	$ 495.00	$ 495.00
AR1922P	4.5MM Punch	1	$ 272.00	$ 190.00	$ 190.00
AR2324PTB	4.75MM Punch/Tap	1	$ 708.00	$ 495.00	$ 495.00
AR13970SR	King Fisher Grasper	1	$ 2,136.00	$ 1,495.00	$ 1,495.00
AR13975SR	FiberWire Suture Grasper	1	$ 2,136.00	$ 1,495.00	$ 1,495.00
AR1934R	2.9 & 3.0 Offset Guide	1	$ 529.00	$ 370.00	$ 370.00
AR8402C	Sterilization case	1	$ 1,500.00	$ 1,050.00	$ 1,050.00
AR3025	Wissinger Rod, 4.0 mm	1	$ 143.00	$ 100.00	$ 100.00
AR3026	Extra Long Switching Stick, 4.0 mm	2	$ 186.00	$ 130.00	$ 260.00
AR11890	BirdBeak Suture Passer, 22 degree	1	$ 1,500.00	$ 1,050.00	$ 1,050.00
AR11800	BirdBeak Suture Passer, 45 degree	1	$ 1,500.00	$ 1,050.00	$ 1,050.00
AR2167-2	Penetrator Suture Passer	1	$ 1,643.00	$ 1,150.00	$ 1,150.00
AR-12140	Scissor, Serrated	1	$ 1,422.00	$ 995.00	$ 995.00
AR12250	Suture Cutter	1	$ 1,500.00	$ 1,050.00	$ 1,050.00
AR11794L	Flush Cutter Suture Cutter	1	$ 1,500.00	$ 1,050.00	$ 1,050.00
AR13250	FiberTape Cutter	1	$ 1,500.00	$ 1,050.00	$ 1,050.00
AR13960SR	Rotator Cuff Grasper	1	$ 1,422.00	$ 995.00	$ 995.00
	Total				$ 19,259.00

Shoulder Implants and Disposables

Part #	Description	Qty Each	Qty in Boxes	List Price	Stocking Price	Stocking Total
AR-1680BC	8X12 TENODESIS SCREW	2	2	$ 450.00	$ 315.00	$ 630.00
AR6530	8.25 x 7 Twist-in Cannula, bx/5	5	1	$ 36.00	$ 25.00	$ 125.00
AR6540	8.25 x 9 Twist-in Cannula, bx/5	5	1	$ 36.00	$ 25.00	$ 125.00
AR6548	5 x 7 Low Profile Cannula	5	1	$ 36.00	$ 25.00	$ 125.00
AR6570	7 x 7 Twist-in Cannula, bx/5	5	1	$ 36.00	$ 25.00	$ 125.00
AR6592-08-20	8 X 20 MM PASSPORT, 5 BOX	5	1	$ 46.00	$ 32.00	$ 160.00
AR6592-08-30	8 X 30 MM PASSPORT, 5/BOX	5	1	$ 46.00	$ 32.00	$ 160.00
AR6592-08-40	8 X 40 MM PASSPORT, 5/BOX	5	1	$ 46.00	$ 32.00	$ 160.00
AR4068-25TR	Suture Lasso, 25 Tight Curve, Right	2	2	$ 200.00	$ 140.00	$ 280.00
AR4068-25TL	Suture Lasso, 25 Tight Curve, Left	2	2	$ 200.00	$ 140.00	$ 280.00
AR4068-45L	Suture Lasso, 45 Curve, L Curved, SD	2	2	$ 200.00	$ 140.00	$ 280.00
AR4068-45R	Suture Lasso, 45 Curve, R Curved, SD	2	2	$ 200.00	$ 140.00	$ 280.00
AR4068-90R	Suture Lasso, 90 degree R Curved, SD	2	2	$ 200.00	$ 140.00	$ 280.00
AR4068-90L	Suture Lasso, 90 degree L Curved, SD	2	2	$ 200.00	$ 140.00	$ 280.00
AR4068C	Crescent Suture Lasso	2	2	$ 200.00	$ 140.00	$ 280.00
AR1934BCFT-2	Bio-SutureTak 3.0 mm, Double Loaded, 5/bx	5	1	$ 486.00	$ 340.00	$ 1,700.00
AR1934DS-2	Bio-SutureTak Disposable Kit	5	5	$ 229.00	$ 160.00	$ 800.00
AR1934PI-30	Percutaeous Kit for 3.0 SutureTak	1	1	$ 279.00	$ 195.00	$ 195.00
AR1927BCF-3	5.5 mm FT BioComposite Corkscrew Triple Play, 5/bx	5	1	$ 486.00	$ 340.00	$ 1,700.00
AR1927BCF	5.5 mm FT BioComposite Corkscrew, 5/bx	5	1	$ 465.00	$ 325.00	$ 1,625.00
AR2323BCC	5.5 mm BioComposite SwivelLock 5/bx	5	1	$ 543.00	$ 380.00	$ 1,900.00
AR2324BCC	4.75 mm BioComposite SwivelLock 5/bx	5	1	$ 543.00	$ 380.00	$ 1,900.00
AR7200	FiberWire w/ Tapered Needle	12	1	$ 26.50	$ 18.50	$ 222.00
AR7235	Fiber Link, 12/bx	12	1	$ 71.50	$ 50.00	$ 600.00
AR7237-7	FiberTape, 6/bx	6	1	$ 64.60	$ 45.00	$ 270.00
AR7237-7T	TigerTape, 6/bx	6	1	$ 64.50	$ 45.00	$ 270.00
	Total					$ 14,752.00

ARTHREX LATERAL SHOULDER DISTRACTION UNIT (AKA: FISHINF POLE)

Part #	Description	Qty Each	Qty in Boxes	List Price	Stocking Price	Stocking Total
AR-1606V	STaR SLEEVE, 6/BOX	24	4	$ 143.00	$ 100.00	$ 2,400.00

AR-1600M	3-POINT LATERAL DISTRACTION UNIT	1	1		$ 4,200.00	N/C
	(FREE WITH PURCHSE OF 4BX STaR SLEEVES)					

Arthrex RetroConstruction ACL/PCL System

Part #	Description	Qty.	List	Unit	Ext Price
AR-1510H	ACL FRAME GUIDE ASSEMBLY	1	$ 643.00	$ 450.00	$ 450.00
AR-1778R-24	RETROCONSTRUCTION GUIDE GRADUATED DRILL SLEEVE, 2.4 MM	1	$ 393.00	$ 275.00	$ 275.00
AR-1204FDS	3.5MM DRILL SLEEVE FOR FLIP CUTTER, STEPPED	1	$ 198.00	$ 138.00	$ 138.00
AR-1778-30	3.0MM DRILL SLEEVE FOR RETRO DRILL	1	$ 393.00	$ 275.00	$ 275.00
AR-1510FR	CONTOURED FOOTPRINT FEMORAL ACL GUIDE, RIGHT	1	$ 780.00	$ 546.00	$ 546.00
AR-1510FL	CONTOURED FOOTPRINT FEMORAL ACL GUIDE, LEFT	1	$ 780.00	$ 546.00	$ 546.00
AR-1510T	TIBIAL ARM, FLIPCUTTER GUIDE	1	$ 523.00	$ 366.00	$ 366.00
AR-1510M	MULTI USE, HOOK ARM	1	$ 593.00	$ 415.00	$ 415.00
AR-1510PTR	TIBIAL PCL, HOOK ARM Right	1	$ 942.00	$ 659.00	$ 659.00
AR-1510PTL	TIBIAL PCL, HOOK ARM Left	1	$ 942.00	$ 659.00	$ 659.00
AR-1510R	RETRO DRILL MARKING HOOK	1	$ 1,122.00	$ 785.00	$ 785.00
AR-1510C	RETROCONSTRUCTION DRILL GUIDE SYSTEM INSTR CASE	1	$ 999.00	$ 699.00	$ 699.00
AR1278L	Hamstring Graft Harvester, Closed	1	$ 713.00	$ 713.00	$ 713.00
AR-1278PL	Hamstring Graft Harvester, Open	1	$ 850.00	$ 595.00	$ 595.00
AR1800-04	TransPortal Femoral Guide, 4 mm	1	$ 1,250.00	$ 875.00	$ 875.00
AR1800-05	TransPortal Femoral Guide, 5 mm	1	$ 1,250.00	$ 875.00	$ 875.00
AR1800-06	TransPortal Femoral Guide, 6 mm	1	$ 1,250.00	$ 875.00	$ 875.00
AR1800-07	TransPortal Femoral Guide, 7 mm	1	$ 1,250.00	$ 875.00	$ 875.00
AR1997CT-07	7mm Tap	1	$ 429.00	$ 300.00	$ 300.00
AR1997CT-08	8mm Tap	1	$ 429.00	$ 300.00	$ 300.00
AR1997CT-09	9mm Tap	1	$ 429.00	$ 300.00	$ 300.00
AR1997CT-10	10mm Tap	1	$ 429.00	$ 300.00	$ 300.00
AR1843BT	RetroScrew Notcher	1	$ 743.00	$ 520.00	$ 520.00
AR-1996CD-1	BioComposite Interf Screw Screwdriver Tip	1	$ 715.00	$ 500.00	$ 500.00
	Total				$12,841.00

ACL IMPLANTS AND DISPOSABLES

Part #	Description	Qty.	List Price	Stocking Price	Price
AR1249	Bio-Screw Guide Wire, 6ea.	6	$ 30.00	$ 21.00	$ 126.00
AR6565	Shoehorn Cannula, 5/bx	5	$ 36.00	$ 25.00	$ 125.00
AR1380	Interference Screw, 8x20	1	$ 136.00	$ 95.00	$ 95.00
AR1381	Interference Screw, 8x25	1	$ 136.00	$ 95.00	$ 95.00
AR1390	Interference Screw, 9x20	1	$ 136.00	$ 95.00	$ 95.00
AR1391	Interference Screw, 9x25	1	$ 136.00	$ 95.00	$ 95.00
AR1400	Interference Screw, 10x20	1	$ 136.00	$ 95.00	$ 95.00
AR1401	Interference Screw, 10x25	1	$ 136.00	$ 95.00	$ 95.00
AR-1595T	ACL TightRope Dill Pin II	2	$ 140.00	$ 115.00	$ 230.00
AR-1588T	ACL TightRope	2	$ 393.00	$ 275.00	$ 550.00
AR-1370C	7 x 23 BioComposite Screw	1	$ 322.00	$ 225.00	$ 225.00
AR-1380C	8 x 23 BioComposite Screw	1	$ 322.00	$ 225.00	$ 225.00
AR-1390C	9 x 23 BioComposite Screw	1	$ 322.00	$ 225.00	$ 225.00
AR-1400C	10 x 23 BioComposite Screw	1	$ 322.00	$ 225.00	$ 225.00
AR-1370TC	7 x 28 BioComposite Screw	1	$ 322.00	$ 225.00	$ 225.00
AR-5028C-08	8 x 28 BioComposite Delta Screw	1	$ 322.00	$ 225.00	$ 225.00
AR-5028C-09	9 x 28 BioComposite Delta Screw	1	$ 322.00	$ 225.00	$ 225.00
AR-5028C-10	10 x 28 BioComposite Delt Screw	1	$ 322.00	$ 225.00	$ 225.00
AR-5028C-11	11 x 28 BioComposite Delta Screw	1	$ 322.00	$ 225.00	$ 225.00
AR-1404TC	12 X 28 BioComposite Scew	1	$ 322.00	$ 225.00	$ 225.00
	Total				$ 3,851.00

Arthrex Arthroscopy Instruments

Part #	Description	Qty	List Price	Unit Price	Ext. Price
AR-11000	STANDARD PUNCH, STR, 2.75	2	$ 1,422.00	$ 782.10	$ 1,564.20
AR-12300	MED PUNCH, STR, 3.4	2	$ 1,422.00	$ 782.10	$ 1,564.20
AR-11500NR	SMALL GRASPER	2	$ 1,422.00	$ 782.10	$ 1,564.20
AR-12600NR	MED TOOTHED GRASPER	2	$ 1,422.00	$ 782.10	$ 1,564.20
AR-11040	WideBiter Punch 2.75 mm Straight Shaft, Straight Tip	2	$ 1,422.00	$ 782.10	$ 1,564.20
AR-11041	WideBiter Punch 2.75 mm 15° Up Curved Shaft, Straight Tip	2	$ 1,422.00	$ 782.10	$ 1,564.20
AR-11042	WideBiter Punch 2.75 mm 30° Right Curved Shaft, Straight Tip	2	$ 1,422.00	$ 782.10	$ 1,564.20
AR-11043	WideBiter Punch 2.75 mm 30° Left Curved Shaft, Straight Tip	2	$ 1,422.00	$ 782.10	$ 1,564.20
AR-11240	WideBiter Punch 2.75 mm Straight Shaft, 15° Up Tip	2	$ 1,422.00	$ 782.10	$ 1,564.20
AR-11912	Rotary WideBiter Punch 2.75 mm Straight Shaft, 90° Right Tip	1	$ 1,422.00	$ 782.10	$ 782.10
AR-11913	Rotary WideBiter Punch 2.75 mm Straight Shaft, 90° Left Tip	1	$ 1,422.00	$ 782.10	$ 782.10
AR-12530	BACKBITER	1	$ 1,422.00	$ 782.10	$ 782.10
AR-2180	16 SLOT STERILIZATION CASE	2	$ 708.00	$ 495.00	$ 990.00
	Total				$ 17,414.10

Arthrex Arthroscopy Pump

With the purchase of the qualifying tubing order below, Arthrex will provide TWO Pumps at no c
(Contract included in this email)

Part #	Description	Qty	List Price	Unit Price
AR-6410	One Piece Arthroscopy Pump Tubing Set, 10/Box	40	$ 87.50	$ 61.00
	Total			

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Ext. Price
$ 2,440.00
$ 2,440.00

Arthrex Shaver System

For the qualifying purchase of the Shaver Blades listed below, Arthrex will provide the follow
(Contract included with this email)

No Charge Capital Equipment:

Part #	Description	Qty	List Price	Ext List Price
AR-8300	APS II Shaver Control Console	1	$ 6,179.00	$ 6,179.00
AR-8310	APS II Shaver Foot Switch	1	$ 2,429.00	$ 2,429.00
AR-8330H	APS II Shaver Handpiece, Hand Control	3	$ 10,708.00	$ 32,124.00

Shaver Blades and Burrs:

Part #	Description	Qty	List Price Ea	Ext List Price
AR-8400ST	4.0 Saber, BX/5	10	$ 85.00	$ 850.00
AR-8400CST	4.0 Curved Saber, BX/5	5	$ 95.00	$ 475.00
AR-8400EX	4.0 Excaliber, BX/5	10	$ 85.00	$ 850.00
AR-8400BC	4.0 Bone Cutter, BX/5	5	$ 95.00	$ 475.00
AR-8550EX	5.5 Excaliber, BX/5	5	$ 85.00	$ 425.00
AR-8550BC	5.5 Bone Cutter, BX/5	10	$ 95.00	$ 950.00
AR-8550OBT	5.5 12 Flute Oval Burr, BX/5	10	$ 85.00	$ 850.00
AR-8400RBE	4.0 8 Flute Round Burr, BX/5	5	$ 85.00	$ 425.00
	Total			

'ing at no charge:

Unit Price	Ext. Price
No Charge	No Charge
No Charge	No Charge
No Charge	No Charge

Unit Price	Ext. Price
$ 44.25	$ 442.50
$ 49.50	$ 247.50
$ 44.25	$ 442.50
$ 49.50	$ 247.50
$ 44.25	$ 221.25
$ 49.50	$ 495.00
$ 44.25	$ 442.50
$ 44.25	$ 221.25
	$ 2,760.00

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Barry G. Miller & Associates, Inc.
3450 Palmer Drive, Suite 4-278
Cameron Park, CA 95682
(916) 745-4533

October 29, 2013

Mr. John Halfen
Ms. Georgan Stottlemyre
Ms. Carrie Petersen
Northern Inyo Hospital
150 Pioneer Lane
Bishop, CA 93514-2599

Dear John, Georgan & Carrie:

I have attached your health plan renewal report for plan year 2014. This health plan report includes:

- Annual financial totals;
- Claims rates year by year dating back to when we started working with you in 1996;
- Large claims reports;
- Current and renewal rate options;
- Pinnacle Claims Management's administration renewal letter and agreement (requiring signature);
- Sun Life's renewal proposal (requiring signature).

This year, our actual paid claims through September are $2,365,910 vs. an aggregate ceiling of $4,526,123 resulting in an overall 40% savings of $2,160,213. There were 11 large claims, i.e. those exceeding $45,000, or approximately half our $90,000 deductible, representing 49.3% of total claims through September 30th. Of these 11 claims, five exceeded $90,000. There are 21 claimants in utilization review with 20 remaining active. We have received $230,775 (reinsurance reimbursements) to date with an additional $49,361 pending. Just in the last two plan years, we received $885,737 in specific reimbursements.

Note your overall claims to date this year decreased to $898.90 per employee per month vs. last year's $1,032.59 per employee per month, a decrease of 13%.

Through a series of back and forth negotiations, we were able to lower the current reinsurer's (Sun Life) rates down from an initial 20% increase on the specific stop-loss to a 15% increase for the current specific deductible of $90,000, as shown on page 6. Sun Life also showed higher deductible options of $95,000 which would reduce the increase to 12% and $100,000 which would reduce the increase to 10% over the current plan year. Each year, along with negotiating with your current reinsurer, we search a variety of the competitive outside reinsurers. This year, we had five stop-loss companies decline to quote due to the inability to show competitive rates and the overall large number of high dollar claimants. One carrier provided us with a proposal, but it was 40% higher than current.

This year, all of our stop-loss companies have allowed for medical trend and market conditions as well as the current economical conditions. I would suggest choosing one of the higher specific deductibles (i.e. $95,000 or $100,000) for the new plan year to help offset the increase in premium. Please choose a specific deductible on Sun Life's renewal proposal, sign on pages 16 and 18 and return to me for processing along with the signed Pinnacle Claims Management administration agreement.

If you have questions after reviewing our report, please call. We're looking forward to working with you again this year.

Regards,

Barry

Barry Miller

Terri

Terri Zinchiak

BGM:tz
Attachments

Northern Inyo Hospital Health Plan
Renewal Report

Barry G. Miller & Associates
License #0B20769
October 29, 2013

NORTHERN INYO HOSPITAL
RENEWAL REPORT
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NORTHERN INYO HOSPITAL
Current Year-to-Date Totals
Plan Year 2013
January 1, 2013 – September 30, 2013

	Current Maximum Liability	Actual Costs	Percentage of Total
Claims:	**$4,526,123**	**$2,365,910**	**84.7%**
Stop-Loss Premiums:	**$ 19,325**	**$ 19,325**	**.4%**
Individual Stop-Loss:	**$ 670,749**	**$ 670,749**	**12.6%**
Administration:	**$ 107,237**	**$ 107,237**	**2.0%**
ASO Fees:	**$ 17,766**	**$ 17,766**	**.3%**
TOTALS	**$5,341,200**	**$3,180,987**	**100%**
Dollar Savings (Nine Months)		**$2,160,213**	
Percentage Savings			**40%**

Assumptions:

Current Worst Case aggregate claims liability was calculated using the actual aggregate for the first nine months.

Actual paid claims were calculated using nine months of claims minus specific reimbursements of $230,775.

Stop-loss and individual stop-loss premiums were based on actual premiums paid over nine months and assumes counts of 1,348 single employees and 1,616 families for the months of January through September 2013.

Administration was based on actual employee counts for nine months of 1,348 singles and 1,616 families.

NORTHERN INYO HOSPITAL

Claims Comparison by Plan Year

Plan Year	Total Annual Claims	Average Monthly Claims	Average Claims Per Employee
1996-97	$ 715,755	$ 62,239	$ 327.57
1997-98 (Jan.-Dec.)	$ 697,224	$ 73,392	$ 365.13
1998-99 (Jan. 98-March 99)	$ 849,624	$ 70,802	$ 317.50
1999-00 (Jan. 99 -March 00)	$1,080,348	$ 99,029	$ 444.08
2000-01 (Jan. 00 – March 01)	$1,363,511	$113,626	$ 465.68
2001-02 (Jan. 01 – Mar. 02)	$1,500,462	$125,039	$ 529.83 +14%
2002-03 (Jan. 02 – Mar. 03)	$2,037,981	$169,832	$ 696.03 +31%
2003-04 (Jan. 03 – Mar. 04)	$1,829,263	$154,239	$ 621.93 - 11%
2004-05 (Jan. 04 – Mar. 05)	$2,622,830	$218,569	$ 827.91 + 33%
2005-06 (Jan. 05 – Mar. 06)	$2,257,946	$188,162	$ 704.73 – 15%
2006-07 (Jan. 06 – Mar. 07)	$2,453,238	$204,437	$ 759.99 + 7.8%
2007-08 (Jan. 07 – Mar. 08)	$2,486,818	$207,235	$ 790.97 + 4%
2008-09 (Jan. 08 – Mar. 09)	$2,929,998	$244,167	$ 894.38 + 13%
2009-10 (Jan. 09 – Mar. 10)	$3,522,642	$293,554	$1,001.89 +12%
2010-11 (Jan. 10 – Mar. 11)	$3,426,479	$285,540	$ 964.66 - 4%
2011-12 (Jan. 11 – Mar. 12)	$3,642,654	$303,555	$1,018.64 + 6.3%
2012-13 (Jan. 12 – Mar. 13)	$3,828,835	$319,070	$1,032.59 + 1.4%
2012-14 (Jan. 13 – Sept. 13)	$2,365,910	$295,739	$ 898.90 - 13%

* Numbers based on actual claims experience and employee counts. Current year is calculated based on eight months of mature claims (12/15 contract).

Specific Reinsurance Summary

Employer Northern Inyo Hospital
Reinsurance Carrier Sun Life Assurance Company of Canada
Stop Loss Retention $90,000.00
Date Revised 10/03/13

Policy Period Jan-2013-Dec 2013
Benefit Type Med, Rx
Contract Type I-12; P-15 Gapless

Claimant Name	Claimant ID Number	Group Number	Prognosis	Total Paid Claims	Advanced Funding	Total Paid Domestic	Less 20% Paid Domestic	Total Submitted Less Spec Ded	Not Covered	Total Reimbursed	Balance Due	Comment
	W00312527-00	02491	Guarded	$ 219,336.83	$ -	$ 210,932.24	$ 42,186.45	$ 87,150.38	$ -	$ 87,150.52	$ -	50%/Initial/S
	W00223690-00	02491	Fair	$ 118,775.02	$ -	$ 2,119.68	$ 423.94	$ 28,351.08	$ -	$28,209.71	$ 141.36	50% & Initi
	W00243845-00	02491	Good	$ 61,976.93	$ -	$ 56,843.08	$ 11,368.62	$ -	$ -	$ -	$ -	50% Notifica
	W00250220-00	02491	Fair	$ 94,689.16	$ -	$ 89,213.18	$ 17,842.64	$ -	$ -	$ -	$ -	50% Notifica
	W00012372-00	02491	Guarded	$ 264,555.16	$ -	$ 209,249.80	$ 41,849.96	$ 132,705.20	$ -	$ 83,485.08	$ 49,220.12	50%/Initial/S
	W00092564-51	02491	Good	$ 53,858.44	$ -	$ 50,233.48	$ 10,046.70	$ -	$ -	$ -	$ -	Under 50
	W00066768-00	02491	Good	$ 72,543.79	$ -	$ 69,932.91	$ 13,986.59	$ -	$ -	$ -	$ -	50% Notifica
	W00066962-40	02491	Stable	$ 122,412.44	$ -	$ 2,417.53	$ 483.51	$ 31,928.93	$ -	$ 31,929.54	$ -	50% & Init
	W00058237-40	02491	Fair	$ 45,694.86	$ -	$ 1,876.76	$ 375.36	$ -	$ -	$ -	$ -	50% Notifica
	W00085074-51	02491	Stable	$ 63,769.98	$ -	$ 5,510.94	$ 1,102.19	$ -	$ -	$ -	$ -	50% Notifica
	W00067930-00	02491	Stable	$ 49,814.71	$ -	$ 1,043.97	$ 208.80	$ -	$ -	$ -	$ -	50% Notifica
Grand Totals				$ 1,167,427.32	$ -	$ 699,373.57	$ 139,874.76	$ 280,135.59	$ -	$ 230,774.85	$ 49,361.48	

Northern Inyo Hospital

Aggregate Summary 01/01/13 thru 12/31/13

Month	Medical, Rx Family	Dental Family	Monthly Agg Deductible	Cumulative Agg Deductible	Medical Foreign	Medical Domestic	Medical 80% Domestic	Dental	Rx	Total Paid Claims	Specific Reimbursement	Net Claims
Jan-13	320	339	$488,170.00	$488,170.00	$3,620.41	$13,708.86	$10,967.09	$12,300.70	$8,036.98	$34,925.18	$0.00	$34,925.18
Feb-13	326	346	$497,394.00	$985,564.00	$20,105.97	$123,758.18	$99,006.54	$11,271.05	$18,581.54	$148,965.10	$0.00	$183,890.28
Mar-13	330	350	$503,470.00	$1,489,034.00	$155,534.91	$249,901.47	$199,921.18	$23,367.25	$13,059.64	$391,882.98	$0.00	$575,773.26
Apr-13	331	351	$504,989.00	$1,994,023.00	$123,437.94	$340,613.11	$272,490.49	$29,358.65	$15,159.87	$440,446.95	$86,046.56	$930,173.65
May-13	330	350	$503,470.00	$2,497,493.00	$153,140.86	$217,427.23	$173,941.78	$21,469.00	$12,921.95	$361,473.59	$0.00	$1,291,647.24
Jun-13	332	351	$506,398.00	$3,003,891.00	$118,465.17	$59,520.89	$47,616.71	$15,700.30	$13,608.52	$195,390.70	$33,033.50	$1,454,004.44
Jul-13	330	349	$503,360.00	$3,507,251.00	$152,179.78	$121,633.21	$97,306.57	$21,861.95	$11,932.49	$283,280.79	$24,772.05	$1,712,513.18
Aug-13	334	353	$509,436.00	$4,016,687.00	$128,640.87	$160,183.00	$128,146.40	$19,506.49	$9,144.42	$285,438.18	$28,209.71	$1,969,741.65
Sep-13	334	353	$509,436.00	$4,526,123.00	$164,482.69	$325,342.86	$260,274.29	$18,882.85	$11,241.17	$454,881.00	$58,712.99	$2,365,909.66
Oct-13			$0.00	$4,526,123.00			$0.00			$0.00		$2,365,909.66
Nov-13			$0.00	$4,526,123.00			$0.00			$0.00		$2,365,909.66
Dec-13			$0.00	$4,526,123.00			$0.00			$0.00		$2,365,909.66
Jan-14	RunOut						$0.00			$0.00		$2,365,909.66
Feb-14							$0.00			$0.00		$2,365,909.66
Mar-14							$0.00			$0.00		$2,365,909.66
					$1,019,608.60	$1,612,088.81	$1,289,671.05	$173,718.24	$113,686.58	$2,596,684.47	$230,774.81	

Coverage Effective	January 1, 2013

Aggregate Claim Factors

Factors Include:	Medical, Dental & Rx	
Contract Basis:	I-12/ P-15	
Med & Rx Family	$	1,409.00
Dental Family	$	110.00

$90,000 Individual Excess Loss Rates

Factors Include:	Medical, Rx	
Contract Basis:	I-12/ P-15	
Single	$	133.94
Family	$	303.34

Average Number of Medical Employees	330
Average Number of Dental Employees	349

Total Paid Claims	$ 2,596,684.47
Less Payments Outside the Aggregate Contract	$ -
Less Specific Reimbursement	$ 230,774.81
Less Final Reimbursements Due	$ -
Net Claims	$ 2,365,909.66

Annual Aggregate Deductible	$ 451,674.85
Cumulative Aggregate Deductible	$ 4,526,123.00
Net Claims less greater Deductible	**$ (2,160,213.34)**

Enrollment changes will cause fluctuations on the life count reported.
Life count and claims paid dollars on this report reflects totals as of run date and is subject to change.

Northern Inyo Hospital

Aggregate Summary 01/01/12 thru 12/31/12

Month	Medical, Rx Family	Dental Family	Monthly Agg Deductible	Cumulative Agg Deductible	Medical Foreign	Medical Domestic	Medical 80% Domestic	Dental	Rx	Total Paid Claims	Specific Reimbursement	Net Claims
Jan-12	303	324	$465,294.00	$465,294.00	$4,268.27	$2,090.94	$1,672.75	$9,701.40	$11,420.72	$27,063.14	$0.00	$27,063.14
Feb-12	304	326	$466,932.00	$932,226.00	$36,981.89	$21,281.07	$17,024.86	$25,333.94	$21,397.55	$100,738.24	$0.00	$127,801.38
Mar-12	304	327	$467,042.00	$1,399,268.00	$152,752.82	$101,504.31	$81,203.45	$32,791.60	$17,166.60	$283,914.47	$0.00	$411,715.85
Apr-12	302	326	$464,096.00	$1,863,364.00	$54,206.18	$192,893.56	$154,314.85	$24,249.52	$14,893.91	$247,664.46	$0.00	$659,380.30
May-12	303	327	$465,624.00	$2,328,988.00	$112,123.63	$239,082.00	$191,265.60	$25,015.64	$20,714.47	$349,119.34	$0.00	$1,008,499.64
Jun-12	304	328	$467,152.00	$2,796,140.00	$143,877.71	$62,956.83	$50,365.46	$16,932.11	$14,640.34	$225,815.62	$0.00	$1,234,315.27
Jul-12	305	329	$468,680.00	$3,264,820.00	$109,477.52	$198,228.29	$158,582.63	$24,680.70	$12,059.60	$304,800.45	$0.00	$1,539,115.72
Aug-12	310	334	$476,320.00	$3,741,140.00	$134,463.60	$130,545.03	$104,436.02	$19,030.16	$12,928.04	$270,857.82	$0.00	$1,809,973.54
Sep-12	314	337	$482,322.00	$4,223,462.00	$113,036.81	$157,249.92	$125,799.94	$15,547.70	$12,679.54	$267,063.99	$9,907.69	$2,067,129.84
Oct-12	313	336	$480,794.00	$4,704,256.00	$164,728.65	$132,562.68	$106,050.14	$31,819.93	$14,644.69	$317,243.41	$21,141.82	$2,363,231.43
Nov-12	317	340	$486,906.00	$5,191,162.00	$393,909.41	$203,851.74	$163,081.39	$15,455.30	$14,804.87	$587,250.97	$285.57	$2,950,196.84
Dec-12	319	342	$489,962.00	$5,681,124.00	$483,865.08	$212,932.81	$170,346.25	$19,574.20	$15,206.82	$688,992.35	$281,009.83	$3,358,179.35
Jan-13	RunOut				$ 272,111.55	$ 120,564.69	$96,451.75	$10,742.90	$9,348.84	$388,655.04	$0.00	$3,746,834.40
Feb-13					$ 143,634.09	$ 56,441.38	$45,153.10	$655.80	$0.00	$189,442.99	$264,599.42	$3,671,677.97
Mar-13					$ 40,539.60	$ 239,530.81	$191,624.65	$3,009.90	$0.00	$235,174.15	$78,017.20	$3,828,834.92
					$2,359,976.81	$2,071,716.06	$1,657,372.85	$274,540.80	$191,905.99	$4,483,796.45	$654,961.53	

Coverage Effective January 1, 2012

Aggregate Claim Factors

Factors Include:	Medical, Dental & Rx	
Contract Basis:	I-12/ P-15	
Med & Rx Family		$ 1,418.00
Dental Family		$ 110.00

$90,000 Individual Excess Loss Rates

Factors Include:	Medical, Rx	
Contract Basis:	I-12/ P-15	
Single		$ 99.21
Family		$ 224.69

Average Number of Medical Employees	306
Average Number of Dental Employees	331

Total Paid Claims	$ 4,483,796.45
Less Payments Outside the Aggregate Contract	$ -
Less Specific Reimbursement	$ 654,961.53
Less Final Reimbursements Due	$ 4,508.73
Net Claims	$ 3,824,326.19
Annual Aggregate Deductible	$ 5,201,090.00
Cumulative Aggregate Deductible	$ 5,681,124.00
Net Claims less greater Deductible	**$ (1,856,797.81)**

Enrollment changes will cause fluctuations on the life count reported.

Life count and claims paid dollars on this report reflects totals as of run date and is subject to change.

NORTHERN INYO HOSPITAL

Reinsurance Renewal

12/15 Contract effective January 1, 2014

		Current $90,000 Specific	Negotiated $90,000 Renewal	Optional $ 95,000 Renewal	Optional $100,000 Specific
Individual Stop-Loss:					
Individual Stop-Loss Rates **	Single	$ 133.94	$ 154.06	$ 150.04	$ 147.36
	Family	$ 303.34	$ 348.90	$ 339.80	$ 333.74
Annual Premium		$ 896,306	$1,030,932	$1,004,040	$986,126
Contract Basis (Gapless/No Laser)		12/15	12/15	12/15	12/15
Administration: (claims processing)***					
	Employee Composite	$ 36.18	$ 37.02	$ 37.02	$ 37.02
Annual		$ 143,273	$ 146,599	$ 146,599	$ 146,599
Aggregate Premium:					
	Employee Composite	$ 6.52	$ 6.52	$ 6.52	$ 6.52
Annual		$ 25,819	$ 25,819	$ 25,819	$ 25,819
ASO Fees: Annual**		$ 23,688	$ 23,688	$ 23,688	$ 23,688
Claims:					
Aggregate Claims Rate	Medical	$1,234.00	$1,370.00	$1,378.00	$1,386.00
	RX	$ 175.00	$ 85.00	$ 85.00	$ 85.00
	Dental	$ 100.00	$ 110.00	$ 110.00	$ 110.00
Contract Basis		12/15	12/15	12/15	12/15
Annual Claims Maximum**		$6,015,240	$6,197,400	$6,229,080	$6,260,760

* Renewal shown on an incurred and paid (24/12) contract basis.

** Current and renewal annual premium based on 150 single employees and 180 family units. Specific coverage includes prescription drugs. ASO fee remains the same as last five plan years. Specific stop-loss contract is on a 12/15 gapless coverage basis with no lasers on any individuals. The original stop-loss increase, before negotiations, was 20%.

*** Medical, dental and RX administration.

Renewal Costs (Reinsurance, Administration and Claims Costs)
Annual Totals
Sun Life Insurance Company
Reinsurance Renewal
12/15 Contract

	Current $90,000 Specific	Negotiated $90,000 Renewal	Optional $ 95,000 Renewal	Optional $100,000 Specific
Individual Stop-Loss:	$ 896,306	$1,030,932	$1,004,040	$ 986,126
Administration:	$ 143,273	$ 146,599	$ 146,599	$ 146,599
Aggregate Premium:	$ 25,819	$ 25,819	$ 25,819	$ 25,819
ASO Fees:	$ 23,688	$ 23,688	$ 23,688	$ 23,688
Annualized Current Claims:	$3,154,547	$3,154,547	$3,154,547	$3,154,547
FIXED COSTS TOTAL	$1,089,086	$1,227,038	$1,200,146	$1,182,232
% Difference from Current Rates		+12.7%	+10.2%	+8.6%
"Worst Case" Claims Liability:	$6,015,240	$6,197,400	$6,229,080	$6,260,760
"Worst Case" Total Costs:	$7,104,326	$7,424,438	$7,429,226	$7,442,992
TOTAL COSTS (If claims equal this plan year – $3,154,547 – 12 mo. mature claims)	$4,243,633	$4,381,585	$4,354,693	$4,336,779
% Difference from Current		+3.3%	+2.6%	+2.2%

Sun Life's Proposal Qualifications and Contingencies

Renewal acceptance is subject to possible revision based upon receipt and review of the following items:

Paid claims experience through 10/31/13 including monthly enrollment figures (received).

Updated shock loss information through 10/31/13. Shock loss information should include injuries, illnesses, diseases, diagnoses or other losses of the type which are reasonably likely to result in a significant medical expense claim or disability, regardless of current claim dollar amount.

Proposal assumes that benefits will be administered by Pinnacle Claims Management and that the Blue Cross Prudent Buyer network will be utilized.

Renewal rates assume the underlying plan was brought into compliance with the mandated health care reform (Affordable Care Act – ACA) including, but not limited to no lifetime maximums and dependent age provisions.

Rates include the cost of increasing the annual maximum from $2,000,000 to unlimited per the Affordable Care Act.

Health Plans Surveyed

Insurance Company	Response
Sun Life Assurance Company	Shown in proposal
Cairnstone re	Declined to quote – not competitive
Optum Health Unimerica	Declined to quote – rates 40% higher than current
Zurich America	Declined to quote
Best re	Declined to quote – not competitive
Munich Health	Declined to quote
HCC Life	Declined to quote

Summary

- Total worst case liability for the first nine months of this year (January through September) is $4,526,123. Actual costs, due to favorable claims experience (i.e. actual paid claims that are less than maximums), are $2,365,910 total dollars. Thus, your costs are $2,160,213 under your aggregate ceiling.

- Claims consume approximately 85% of total costs.

- Stop-loss premium expenses represent 12½% of total costs.

- Administration costs are 2% of total costs, much lower than if we were fully insured where administration would be more like 15-19%.

- Thus the majority of your plan costs are returned in benefits to your employees as opposed to "overhead" such as administration and reinsurance costs.

- Medical/dental/RX claims per employee per month for nine months of this year are $898.90 which is 13% lower than last year. Last year's claims were 1.4% over the prior year. Your highest claims year was last year's at $1,032 per employee per month with this year's claims well under that figure.

- The large claims report identifies eleven claimants. Remember, you are responsible for claims up to $90,000; the reinsurance company, Sun Life, pays amounts above that. (We have asked Pinnacle to identify any claim once it hits 50% of the $90,000 deductible so we can keep an eye on it.) Thus, we have five claims this year that has exceeded $90,000 which, as of September 30th, was by $230,775 with another $49,361 pending. The highest claimant is currently at $264,555 with the next highest at $219,337. Note there is another six months of claims to consider as this is a 12/15 specific contract.

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CAPITAL EXPENDITURE BUDGET REQUEST

Department: *IT*
Requested by: *Adam Taylor*

Budget year: *2013/2014*
Estimated cost: *$20,000.00*
Requested Priority: *1*

GENERAL INFORMATION:

Item description:
Additional backup tape library

Purpose:
Current library is reaching capacity.

Is this item required or recommended by third-party or regulatory agencies?
Yes ☐ No ☐ N/A ☐
If yes, please explain:

Is this item a replacement item?
Yes ☐ No ☐ N/A ☐
If yes, please explain:

Describe any associated installation costs, site preparation, construction costs, additional equipment or supply costs or additional staffing requirements:

Additional comments:
Significant increase in number of systems supported over the past several years requires increased capacity for backups. This will also reduce weekly labor cost by $250.
Original request was for $20K, but we need to increase to $36.8K.

Department Head Signature: ______________________ Date:

03/2012

CDWG.com | 800.594.4239

OE400SPS

SALES QUOTATION

QUOTE NO.	ACCOUNT NO.	DATE
DTDH094	9130691	10/10/2013

BILL TO:
NORTHERN INYO HOSPITAL
150 PIONEER LN

Accounts Payable
BISHOP , CA 93514-2599

Customer Phone #760.873.5811

SHIP TO:
NORTHERN INYO HOSPITAL
Attention To: RYAN MCVEITTY
150 PIONEER LN

BISHOP , CA 93514-2599
Contact: JUSTIN
NORCROSS 760.873.2841

Customer P.O. # I80 BUNDLE QUOTE

ACCOUNT MANAGER	SHIPPING METHOD	TERMS	EXEMPTION CERTIFICATE
RYAN STULTS 877.554.5521	AIT - Deferred, 3-5 Days	Net 30 Days-Healthcare	

QTY	ITEM NO.	DESCRIPTION	UNIT PRICE	EXTENDED PRICE
1	3016380	QUANTUM SCALAR I80 LTO-6 8G FC BUN Mfg#: LSC18-CH6J-250H Contract: MARKET	16,040.00	16,040.00
1	1994168	QUANTUM PHONE-BASED INSTALL/TRAINING Mfg#: SSC1S-NSYT-PB00 Contract: MARKET Electronic distribution - NO MEDIA	449.30	449.30
1	1976369	QUANTUM 1YR NBD GOLD SUP UPL F/ I80 Mfg#: SSC18-LS00-GN11 Contract: MARKET Electronic distribution - NO MEDIA	1,224.11	1,224.11
2	2944535	QUANTUM SCALAR I40/I80 TAPE DRV MOD Mfg#: LSC1S-UTDJ-L6HA Contract: MARKET	7,205.00	14,410.00
4	2529901	QUANTUM 2M OPTICAL MULTIMODE CABLE Mfg#: 3-03891-05 Contract: MARKET	85.00	340.00
1	1897826	CISCO MDS 9124 8X4G FC SW SFP-W/8PT Mfg#: M9124PL8-4G-AP= Contract: MARKET	1,417.50	1,417.50
		SUBTOTAL		33,880.91
		FREIGHT		375.87
		TAX		2,576.60

US Currency

TOTAL 36,833.38

Please remit payment to:
CDW Government
75 Remittance Drive
Suite 1515
Chicago, IL 60675-1515

CDW Government
230 North Milwaukee Ave.
Vernon Hills, IL 60061

Fax: 312.705.9298

'his quote is subject to CDW's Terms and Conditions of Sales and Service Projects at
ıttp://www.cdw.com/content/terms-conditions/product-sales.asp
'or more information, contact a CDW account manager

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Northern Inyo County Local Hospital District

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

To: Board of Directors

From: Leon Freis, COO

Date: 12-5-2013

RE: REPLACEMENT OF EEG EQUIPMENT

Current Nicolet EEG Machine purchased 2005. Not capable of interface or remote reading.

Proposed replacement:

Caldwell Easy III with accessories and licenses per quote attached: NOT TO EXCEED $50,916.60

Benefits:

1. During the past 12 months 41 EEG's were done generating $22,728 in revenue. There are no cost of goods sold and other personnel costs are sunk costs. The rate of reimbursement for the revenue generated is not directly known, but at contractual allowances of 50%, cost recovery would be accomplished in approximately 4.5 years.
2. The new equipment would be readable remotely which would decrease our turnaround time for reading.

CADWELL LABORATORIES, INC
Phone: (800) 245 3001 or (509) 735 6481 Fax: (509) 783 6503

909 North Kellogg Street, Kennewick, WA 99336

Customer #:
Quote No. Northern Inyo Hospital_120213_E3+QVMAMbPersyst

Date: 12/02/13

Name: Northern Inyo Hospital
Address: 150 Pioneer Ln
City, State, ZIP: Bishop CA 93514

Method of Payment: N30

Phone:
Fax:

Sales Representative: Jim Murri
Prepared by: Betty Cooper

Attn:
Email:

Cadwell Flex Ambulatory EEG 32 CH Recorder Q-Video Mobile Package for Current Easy III Customers
Includes: Amb Recorder & pouch w/small & large waist belts, Amb EEG amplifier & pouch, small, med, & large chest straps, EasyNet Cables 5"-180", batteries, battery case, battery cable, RJ 45 cable, flash card, microphone stockinette, small & large limb strap, electrode kit, 08/23/13

Cadwell Easy III EEG
Includes: Amplifier, Photic Stimulator (flash rate 1-60), Satellite View, Power Com Module, & electrode kit

Qty	Description		Tier 2
-	**Customer is responsible for pulling all cables and installing any non-cart based cameras, prior to installation of systems.**		
-			**Amerinet Price**
1	**EASY III 46 Channels (32 channel amplifier, 12 Easy Net channels, 1 ambient IR light channel and 1 ambient light ch**		**$12,691.00**
1	Easy II or Easy III 10-20 pattern color coded remote input headbox		$329.00
1	20' Cable for remote input box		$188.00
1	Amplifier Cable 2 meter		incl
1	2 Meter Cable for Easy III Photic Stimulator		incl
1	Patch Cable, 7'		$18.80
1	Microsoft Office 2010		$173.90
1	Easy III License for Citrix Server — **Allows users to read w/o reading license**		$5,000.00
1	Persyst ICU Continuous Monitoring (CPA) — **Single Site License** — On-line seizure detection & continuous EEG trending		$5,640.00
1	Dell Small Form Factor Optiplex 7010 (Core i7, 64 bit, 3.4 GHz, 8 GB, 500 GB HD, Windows 7 Professional) 3 Yr warranty		$1,146.80
1	Cisco USB Ethernet Adapter		$32.90
1	StarTech USB Ethernet Adaptor		$32.90
1	Flat Panel Widescreen LCD Color Monitor 24"		$328.06
1	Q-Video, MPEG4, 30 frames per second		$1,465.10
1	Sony Camera when mounted on trolley cart		$1,597.06
1	Narrow Trolley includes amp arm (Assembled)		$1,043.40
1	Keyboard & Mouse Tray		incl
1	Drawer , Narrow Trolley		$204.92
1	Accessory Bag for POC cart & trolleys		$46.06
1	Arm Easy III Photic w/o bracket		$141.00
1	Angled Arm Mount		incl
3	Cable Wrap		incl
1	Isolation Transformer 800VA 110V/220V (6 inputs)		$423.00
1	Easy III Operator Manual		$47.00
1	Easy III Technical Manual		$141.00
1	**AMBULATORY 32 CH SYSTEM W/2 GB COMPACT FLASH CARD & D BATTERIES**		**$17,225.00**
1	Q-Video Mobile Camera CE and QVM software		incl
1	Upgrade Above to 4 GB compact flash Card		incl
1	Tripod for camera		incl
1	A B Switch		$45.00
	Sub Total	$58,390.00	$47,959.90
	Combo Discount — **Expires December 31, 2013**		($814.90)
	Shipping & Handling N/C per Amerinet contract #VQ10076		$0.00
	Sub Total		$47,145.00
	Prepayment discount	0.00%	$0.00
	Sub Total		$47,145.00
	Sales Tax — Tax will apply unless exempt	0.00%	$0.00
	Grand Total		$47,145.00

Options not included in above price		
Infrared Illuminator 7' cable		$352.50
Persyst ICU Continuous Monitoring (CPA)	On-line seizure detection & continuous EEG trending	$5,640.00
Persyst Ambulatory Pack	Routine and Ambulatory Review	$2,000.00

You can lease this equipment, OAC, for $1,051.60 per month for 60 months. NO prepayment penalty!!!
Call Sageland Financial at 509-845-6161 If tax was not added to the quotation applicable tax will be added to the monthly payment

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NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Sanctions for Breach of Patient Privacy**	
Scope: Hospital Wide	Department: **Compliance**
Source: Compliance Officer	Effective Date:

PURPOSE:

To comply with 45CRF164.530(e)(1) which requires "a covered entity must have and apply appropriate sanctions against members of its workforce who fail to comply with the privacy policies and procedures of the covered entity"

POLICY:

Definitions:

"Sanction" means training with documentation in the employee record, disciplinary action or termination.

"Workforce" means an employee, student or volunteer of the hospital.

"Inadvertent Violation" means an error that results in a breach of privacy made while following hospital policies and procedures.

"Negligent Violation" means a breach of privacy made while incorrectly following or not following hospital policies and procedures.

"Deliberate Violation" means a breach of privacy made while willfully not following hospital policy.

"Protected Health Information" or "PHI" means any individually identifiable health information regarding a patient's medical or physical condition or treatment in any form created or collected as a consequence of the provision of health care, in any format including verbal communication.

"Unauthorized" means the inappropriate acquisition, access of, use or disclosure of protected health information without a direct need to know for medical diagnosis, treatment, or lawful use as permitted the California Medical Information Act or any other statute or regulation governing the lawful access, use, or disclosure of medical information. (California Health and Safety Code Sec. 2 § 1280.15)

"Malicious" means with intent to harm or with intent to gain personally.

Breach Levels by Incident

1. **Minor breach**
   A Minor Breach is inadvertent and non-malicious in nature.
   Examples include but are not limited to: distributing, emailing or faxing protected health information to the wrong individual unintentionally.

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Title: **Sanctions for Breach of Patient Privacy**	
Scope: Hospital Wide	Department: **Compliance**
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2. **Moderate breach**
   A moderate breach is negligent in nature. The intent of the violation is unclear and the evidence cannot be clearly substantiated as to malicious intent.
   Examples include but are not limited to failing to log off computer systems, failing to check a guarantor or insurance provider when registering a patient, failing to check that the provider selected for an outpatient order matches the written order presented by the patient, faxing protected health information to an unverified fax number, or a pattern of minor violations.

3. **Major/severe breach**
   A major/severe breach is a deliberate violation that purposefully or maliciously violates a patient's privacy or disregards Northern Inyo Hospital policy.
   Examples include but are not limited to: releasing or using data for personal gain, destroying or altering data, purposefully accessing or attempting to gain access to patient information to which in which the employee has no work related need to access, maliciously attacking or hacking hospital information systems, releasing patient data with the intent to harm an individual or the hospital, or a pattern of repeated moderate violations.

Levels of Sanctions for Physicians
Unlawful access, use or disclosure made by physicians and reported to the hospital by whistleblowers, discovered through complaints or discovered by audit, shall be reported immediately to the Chief of the Medical Staff or to the Vice-Chief of the Medical Staff if the alleged act is by the Chief of the Medical Staff.

Whistleblower Protection

a. Neither the hospital nor any employee of the hospital may intimidate, threaten, coerce, discriminate against, or take other retaliatory action against any individual who reports any conduct that is unlawful or otherwise violates professional or clinical standards including, but not limited to the reporting of conduct that results in the breach of privacy of any patient of Northern Inyo Hospital.
b. Proven violation of this section will result in Immediate Loss of Employment.

Disciplinary Action
Disciplinary action, up to and including termination, based on recommended corrective actions in **Attachment A "Sanctions for Breach of Patient Privacy – Incident Severity Scale**", will be taken for any workforce member for a violation of privacy and security policies and procedures. Northern Inyo Hospital prohibits the use of hospital property for illegal purposes and for purposes not in support of Civil Code 56.36/Health and Safety Code 130200 and 1280.15.

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NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Sanctions for Breach of Patient Privacy**	
Scope: Hospital Wide	Department: **Compliance**
Source: Compliance Officer	Effective Date:

ATTACHMENT A

Sanctions for Breach of Patient Privacy – Incident Severity Scale
Guidelines with recommended corrective actions, once an incident and individual are identified.

		Action Level		
Level	**Intention of the Individual** Responsible for the privacy breach	**Minor**	**Moderate**	**Major/Severe**
1	**Inadvertent** • Inadvertent mistake	1	1	2
2	**Negligent/Unintentional** • Carelessness or negligence • No known or believed intent	2	3	3-4
3	**Intentional** • Due to curiosity or concern	2	3	3-4
4	**Intentional** • Malicious intent, including accessing or use of information in a domestic dispute • Personal financial gain • Willful or reckless disregard of policies, procedures or law	4	4	4

Action Level:

1. Re-training and/or counseling memo
2. Counseling memo, verbal warning, warning letter, or suspension (length to be determined by circumstance)
3. Suspension, or written warning indicating that any further conduct resulting in a breach of privacy will result in termination
4. Termination

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NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Sanctions for Breach of Patient Privacy**	
Scope: Hospital Wide	Department: **Compliance**
Source: Compliance Officer	Effective Date:

Action Level Modification:

Action level may be modified by the consensus of the Privacy Officer, Human Resources Director, and the employee's manager by considering the following:

1. Previous history or corrective action (level of action may increase based on repeat offenses)
2. Whether or not the individual caused an inadvertent violation based upon a situation or operation that the individual did not know caused the breach.

Approval	**Date**
Compliance Committee	3/18/2011
Administration	4/20/2011
Board of Directors	4/20/2011

Responsibility for Review and Maintenance: Compliance Officer, Privacy Officer
Developed:
Revised
Reviewed
Supersedes

draft

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NORTHERN INYO HOSPITAL
MEDICAL RECORDS
POLICY AND PROCEDURE

Title: **Auditing of Employee Access to Patient Information**	
Scope: **Hospital Wide**	Manual: **Compliance**
Source: Compliance Officer	Effective Date:

PURPOSE: Establishes requirements for auditing access to confidential information including protected health information in accordance with Northern Inyo Hospital policy and state and federal regulations.

Definitions:

"Workforce" means an employee, student or volunteer of the hospital.

"Confidential Information" means protected health information and information related to patients, workforce, providers, financial data, information protected by law and other information pertaining to Northern Inyo Hospital unless otherwise specified.

"Minimum Necessary" means that a covered entity must make reasonable efforts to limit protected health information to the minimum necessary to accomplish the intended purpose of the use, disclosure, or request.

"Need-to-Know" means workforce should have access to only the data he or she needs to perform a particular function (role based access).

"Protected Health Information" (PHI) means individually identifiable health information that is transmitted or maintained in any form or medium, including electronic PHI.

"Breach" means the unauthorized acquisition, access, use or disclosure of PHI which compromises the security or privacy of the PHI.

POLICY:
Access to hospital information systems is granted on a need-to-know basis.

Audits will be performed which evaluate whether information accessed was based on "minimum necessary" and "need-to-know" principles and standards.

AUDIT TYPES:

1. **Routine Audits** – Routine audits can include but are not limited to:

Title: **Auditing of Employee Access to Patient Information**	
Scope: **Hospital Wide**	Manual: **Compliance**
Source: Compliance Officer	Effective Date:

Audit	Description
Same Last Name	Workforce who access the record of a patient with the same last name
Same Department	Workforce who access the record of a co-worker who works in the same department
Workforce Hospital Admission	When a Northern Inyo Hospital employee is admitted to the hospital as a patient
Confidential Document	Workforce who access "confidential" patient documents
New Workforce Member	All access made by new workforce members are audited prior to the end of their 90 day introductory period
High Profile Individual	The patient is a newsworthy individual

2. **Audits for Specific Cause –** A request to audit for cause may come from various sources including but not limited to:
   a. Administration
   b. Human Resources
   c. Department Director/Manager
   d. Board of Directors
   e. Security Officer
   f. Patient or representative
   g. Community member

Audits for specific cause are conducted in all systems applicable to services provided to the patient.

Causes or reasons for specific audits include but are not limited to:

Audit	Description
Internal Concern	Concern is expressed by a co-worker, Administration, Department Manager, Security Officer or other user
Patient Complaint	Patients request an audit of access to their medical record
Employee Family Member Admission	When a Northern Inyo Hospital employee's family member is admitted as a patient
Restricted Information Patients	Users who accesses a patients record who requests restricted access

Follow-Up	Additional auditing may be required for previous problematic audits
Disciplined Workforce	Workforce who have been disciplined for accessing records inappropriately

3. **Random Audits –** Random audits may be performed on clinical systems and may be done to determine clean-up of inactive users.

Audits Investigated and Evaluated

1. The Privacy Officer will review the audit results for possible breaches of patient privacy based on "minimum necessary" and "need-to-know" principles. When questionable access is discovered on the audit report:

    a. The Privacy Officer will meet with the workforce member requesting information and an explanation for accessing the patient information. If further information is required based on the information received, meetings with additional workforce may occur.

    b. If the audit findings reveal activity that appears to constitute a breach of confidentiality, audit and investigation results for disciplinary determination will be reported to the following but not limited to:

        i. Administration, Human Resources and/or the workforce members' department manager/supervisor.
        ii. State and/or Federal agencies, in accordance with current law.

Audit Record Disposition and Retention

1. Audit reports are confidential Northern Inyo Hospital documents. Copies of audit reports will be shared internally with Administration and management as necessary, and disclosed as required by law or for other business operations.

2. Audit for specific cause outcomes may be communicated to the requestor via mail or telephone, as determined by the Privacy Officer.

3. Audit results will be saved and stored according to state and federal regulations.

NORTHERN INYO HOSPITAL
MEDICAL RECORDS
POLICY AND PROCEDURE

Title: **Auditing of Employee Access to Patient Information**	
Scope: **Hospital Wide**	Manual: **Compliance**
Source: Compliance Officer	Effective Date:

Committee Approval	**Date**
Compliance Committee	12-10-13
Administration	
Board of Directors	

Responsibility for Review and Maintenance: Compliance Officer, Privacy Officer
Developed: 12-10-2013
Revised:
Reviewed:
Supersedes:

END