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AGENDA

NORTHERN INYO HEALTHCARE DISTRICT
BOARD OF DIRECTORS REGULAR MEETING

April 17, 2019 at 5:00 p.m.

2957 Birch Street, Bishop, CA

1. Call to Order (at 5:00 pm).
2. Adjournment to Closed Session to/for:
   A. Conference with Labor Negotiators; Agency Designated Representative: Irma Moisa; Employee Organization: AFSCME Council 57 (*pursuant to Government Code Section 54957.6*).
3. Return to Open Session and report of any action taken in Closed Session.
4. At this time persons in the audience may speak on any items not on the agenda on any matter within the jurisdiction of the District Board (*Members of the audience will have an opportunity to address the Board on every item on the agenda. Speakers are limited to a maximum of three minutes each).*
5. Strategic Plan update, Workforce Experience Committee report (*information item*).
6. Chief of Staff Report; Allison Robinson MD:
   A. Policy and Procedure approvals (*action items*):
      1. *Preoperative Monitoring of Storage Devices and Units*
      2. *Crash Cart and Defibrillator Check Policy*
      3. *Newborn and Pediatric Abduction Prevention Safety and Security*
      4. *Responsibilities of Nursing Students and Hospital Staff*
      5. *Standardized Procedures for Medical Functions in the Emergency Department*
      6. *Diet Texture Ordering Protocol*
      7. *Laboratory Home Collections*
      8. *Lymphedema Treatment*
      9. *Standards of Care for the Swing Bed Resident*
7. New Business
   A. Medication-Assisted Treatment program report (*information item*).
   B. Robotic Equipment update (*action item*).
   C. Medical Staff Services Pillars of Excellence, quarterly report (*information item*).
   D. Pharmacy update (*information item*).

E. Financial report as of December 31, 2018 (*information item*).

F. Policy and Procedure approval, *Resuscitation Quality Improvement* (*RQI*) (*action item*).

Consent Agenda (action items)

8. Approval of minutes of the March 13 2019 special meeting
9. Approval of minutes of the March 20 2019 regular meeting
10. Policy and Procedure annual approvals
11. Approval of new Chief of Staff job description
12. Northern Inyo Healthcare District Auxiliary bylaws annual approval

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13. Reports from Board members (*information items*).
14. Adjournment to closed session to/for:
    A. Discuss trade secrets, new programs and services (estimated public session date for discussion yet to be determined) (*Health and Safety Code Section 32106*).
    B. Public employee performance evaluation, Chief Executive Officer (*pursuant to Government Code Section 54957*).
15. Return to open session and report of any action taken in closed session.
16. Adjournment.

In compliance with the Americans with Disabilities Act, if you require special accommodations to participate in a District Board meeting, please contact administration at (760) 873-2838 at least 48 hours prior to the meeting.

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

Medical Staff Office
(760) 873-2136 voice
(760) 873-2130 fax

TO: NIHD Board of Directors
FROM: Allison Robinson, MD, Chief of Medical Staff
DATE: April 2, 2019
RE: Medical Executive Committee Report

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

A. Policies and Procedures (*action items*)
   1. *Preoperative Monitoring of Storage Devices and Units*
   2. *Crash Cart and Defibrillator Check Policy*
   3. *Newborn and Pediatric Abduction Prevention Safety and Security*
   4. *Responsibilities of Nursing Students and Hospital Staff*
   5. *Standardized Procedures for Medical Functions in the Emergency Department*
   6. *Diet Texture Ordering Protocol*
   7. *Laboratory Home Collections*
   8. *Lymphedema Treatment*
   9. *Standards of Care for the Swing Bed Resident*

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Temperature Monitoring of Storage Devices and Units	
Scope: Anesthesia, Biomedical Engineering, Diagnostic Imaging, Environmental Services, ICU/CCU, Infusion Center, Laboratory, Maintenance, Medical Staff, Nursing Administration, PACU, Perinatal, Pharmacy, Plant Services, Purchasing, Rehabilitation Services, Respiratory, Rural Health Clinic, Safety, Sterile Processing, Surgery	Manual: Operations' Policy Manual, Clinical Practice Manual
Source: Chief Operating Officer	Effective Date:

PURPOSE:
To ensure that units and devices storing temperature-dependent items are monitored in accordance with applicable state and federal regulations and that such monitoring results in temperature corrections that keep stored contents within allowable legal and safe temperatures.

POLICY:
1. Storage devices such as refrigerators, freezers, and warmers will be continuously temperature monitored via real-time electronic monitoring equipment.

2. Such electronic monitoring equipment shall be capable of notifying specific personnel when temperatures fluctuate above or below set parameters.

3. Responsibility for the monitoring of temperature-dependent storage devices shall be assigned to departments in accordance the contents of the device as defined by state law and regulation regardless of the location of the devices:

    a. All drugs (agents bearing the federal legend "Rx Only") requiring storage in temperature-dependent devices shall be assigned to the Pharmacy Department.
    b. All food and beverages requiring storage in temperature-dependent devices shall be assigned to the Dietary Department.
    c. All reagents, blood, blood derivatives and human derived samples requiring storage in temperature-dependent devices shall be assigned to the Laboratory Department.
    d. All tissue and bone used in surgical procedures requiring storage in temperature-dependent devices shall be assigned to the Surgery Department.
    e. All substances used in diagnostic imaging which are not drugs and are under the legal purview of Radiological Services as defined in California Administrative Codes shall be assigned to the Diagnostic Imaging Department.
    f. All other rehab procedures requiring temperature-dependent storage shall be assigned to the Rehabilitation Services Department.
    g. All blanket warmers used in the nursing departments will be assigned to the Nursing Department.
    h. All breastmilk refrigerators used in the perinatal department and for lactating staff members will be assigned to the Nursing Department.

4. Each department assigned responsibility for monitoring and responding to fluctuations outside of established temperature settings will establish standards for responding to temperature fluctuations in accordance with industry standards.

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Temperature Monitoring of Storage Devices and Units	
Scope: Anesthesia, Biomedical Engineering, Diagnostic Imaging, Environmental Services, ICU/CCU, Infusion Center, Laboratory, Maintenance, Medical Staff, Nursing Administration, PACU, Perinatal, Pharmacy, Plant Services, Purchasing, Rehabilitation Services, Respiratory, Rural Health Clinic, Safety, Sterile Processing, Surgery	Manual: Operations' Policy Manual, Clinical Practice Manual
Source: Chief Operating Officer	Effective Date:

5. Each department assigned responsibility for monitoring and responding to fluctuations outside of established temperature settings will identify individuals who will perform the following functions:

    a. Respond to notifications by the monitoring system of fluctuations outside of established temperature settings in accordance with individual department standards.
    b. Electronic documentation of the response taken
    c. Provision of temperature log(s) when requested by hospital management, regulatory inspectors or surveyors.

6. All departments with temperature monitoring responsibility shall be trained in use of the electronic temperature monitoring system and in the policy and procedures as established.
7. Standardized training on temperature monitoring system will be provided and available to all designated staff.

CROSS REFERENCE P&P:
1. Drug Storage and Inspections of Medication Areas
2. Laboratory Department Temperature Monitoring
3. Bone Graft Tissue Bank
4. Dietary Department Refrigerator and Freezer Alarms
~~1. Temperature Monitoring of Storage Devices and Units~~
~~2. Temperature Monitoring of Storage Devices and Units~~
~~Drug Storage and Inspections of Medication Areas~~
~~3. Laboratory Department Temperature Monitoring~~
~~3. Bone Graft Tissue Bank~~
~~3. Dietary Department Refrigerator and Freezer Alarms~~

REFERENCES:

1. CAMCAH 2016 of TJC, Standard EC 04.01.01- EP 1
2. California Regulatory Code 22CCR§70263(q)(6) 22CCR§70273(k)(3)

Approval	Date
Infection Control Committee	**2/26/19**
CCOC	**2/25/19**
Medical Executive Committee	**4/2/19**
Board of Directors	
Board of Directors Last Review	

Developed: 12/2013
Reviewed: 1/18/2017

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Temperature Monitoring of Storage Devices and Units	
Scope: Anesthesia, Biomedical Engineering, Diagnostic Imaging, Environmental Services, ICU/CCU, Infusion Center, Laboratory, Maintenance, Medical Staff, Nursing Administration, PACU, Perinatal, Pharmacy, Plant Services, Purchasing, Rehabilitation Services, Respiratory, Rural Health Clinic, Safety, Sterile Processing, Surgery	Manual: Operations' Policy Manual, Clinical Practice Manual
Source: Chief Operating Officer	Effective Date:

Revised: **10/17/2018kh**
Responsibility for review and maintenance: Chief Operating Officer
Index Listings:

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NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Crash Cart and Defibrillator Check Policy	
Scope: NIHD	Manual: Cardiovascular, Circulation (OXC), CPM - Respiratory, Oxygen
Source: Manager of Emergency Services	Effective Date: 6/30/16

PURPOSE:

To ensure availability of all drugs, equipment, and supplies necessary to initiate advanced life-support measures and ensure uniformity of emergency carts throughout Northern Inyo Hospital.

POLICY:

1. Ensuring that crash cart contents are complete, not outdated, or damaged will be the responsibility of each department.
   a. A staff member will check the crash cart a minimum of once per day while the unit is open. If the unit is closed, the staff member will write closed under the day with no check Upon reopening of the unit the crash cart will be checked
   b. The crash cart expiration spreadsheet will be checked monthly. All drawers and contents must be visually inspected annually.
   c. A QRR will be completed anytime outdated supplies are found.

2. Each unit will be responsible to provide all items not under the responsibility of Pharmacy or Cardiopulmonary Department. Pharmacy supplies will be in a sealed tray with the earliest expiration date marked on the outside of the package. Two sealed trays will be stored for quick restocking of a crash cart after use. Respiratory supplies will be checked by respiratory staff.

3. Pharmacy shall be responsible for maintaining all pharmaceuticals in the crash cart. This will include drawers one and two and part of drawer five. Pharmacy will have the contents of drawer one and two placed in four locked drawer inserts with the earliest outdate marked. Drawer five contains a sealed tray with IV fluids with the earliest expiration marked on the outside of the package.

4. Respiratory Therapy (RT) will be responsible for all items located in drawer six of the crash cart. This will include a locked intubation roll for pediatric and adult patients. RT will also be the responsible to ensure all intubation equipment is in good working order.

5. All crash carts will be checked as per the following:
   a. The defibrillator and cardiac monitor shall be checked and appropriately documented for performance on both battery and electrical current once daily while the unit is open. The defibrillator will remain plugged into an emergency power electrical outlet at all times, except during battery testing or use.
   b. The crash cart lock will be checked once daily while units are open. The last three numbers on the lock will be written into the crash cart checklist. If the locks are changed, the new number will be placed on the checklist.
   c. When crash cart is opened it will be restocked by the unit staff and a yellow securement device will be applied. Pharmacy will be notified to check cart and apply a red lock.

6. Request for change in crash cart contents, shall be reviewed by the Resuscitation Committee.

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NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Crash Cart and Defibrillator Check Policy	
Scope: NIHD	Manual: Cardiovascular, Circulation (OXC), CPM - Respiratory, Oxygen
Source: Manager of Emergency Services	Effective Date: 6/30/16

REFERENCE:
TJC (2016) Comprehensive Accreditation Manual for Critical Access Hospitals.
Standard PC 02.01.09 and Standard PC 02.01.1. Joint Commission Resources. Oakbrook, Illinois.

CROSS REFERENCE P&P:

Approval	**Date**
CCOC	9/24/18
Resuscitation Committee	02/08/19
ER Medical Services	03/06/19
MEC	04/02/19
Board	06/2016
Last Board of Director review	6/21/17

Developed: 04/2013 AS
Reviewed: 5/17 la
Revised: 05/2016 AS, 9/18gr

draft

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Newborn & Pediatric Abduction Prevention Safety and Security	
Scope: Pediatric & Perinatal	Manual: CPM - Patient Safety (PS), Safety
Source: Manager of Perinatal Department	Effective Date: 12/14/16

PURPOSE:

1. To provide for the security and safety of all newborns in the Perinatal Department and pediatric patients in the Acute Sub Acute Department.
2. To prevent newborn and pediatric abduction and to provide guidelines in the case of such an occurrence. For clarification:
   Neonate (Newborn) = Birth to 27 days of age
   Pediatric= 28 days of age until 13th Birthday

POLICY:

1. All newborns in the Perinatal Department will be under the direct observation of a member of the nursing staff and/or direct care giver at all times. Under no circumstances will a newborn be left unattended.
2. All newborns and pediatric patients in the Acute Sub Acute Department will be under the supervision of a member of the nursing staff and/or direct care giver at all times.
3. All newborn/pediatric patients will be banded with a security tag on admission or at birth. This tag will be activated as stated in the HUGS/PEDZ policy.
4. The primary care giver of the patient will be informed of security precautions at the time of admission or as soon as they are available.
5. Nursing staff will document patient and family education of newborn/pediatric security on the nursing admission assessment form.
6. In the Perinatal Department, all newborns will be identified in the following manner:
   a. All mother-baby couples will have matching ID bands placed on them either in the birthing room or O.R., prior to separating mother and infant. However, if an emergency exists, the infant will be properly banded as soon after admission to the nursery as possible.
7. All pediatric patients will be identified in the following manner:
   a. All newborn and pediatric patients and their designated legal guardian will have matching ID bands placed on them at the time of admission.
8. Hospital staff will notify and work closely with law enforcement agencies, if an abduction occurs.

PROCEDURE:

A. Security Measures:

1. At Northern Inyo Hospital (NIH) an electronic surveillance system by HUGS is utilized for all infant and pediatric patients. Refer to HUGS/PEDZ policy
2. Infant-Mother ID bands will be placed on each mother-baby as soon after delivery as possible. Indicate to the parents verbally and visually that the name bands are matching. Document the band number and time bands were applied on the Labor and Delivery Record. The mother will have one wristband, and the baby will have two bands – one applied to a wrist, and the other to an ankle. These bands must be verified as matching and include the following information:

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   a. Mom's First Name, BABY (Sex of infant), Mom's Last Name Example: "Jane BABY GIRL Smith".
   b. Date and Time of infant's birth
3. Infant bar code scanning tag will be added once the infant has been registered and infant labels are available. Apply an infant label to the designated tag and attach it directly to the Mother-Baby band that is on the infant's ankle. Verify that all patient identification indicators are identical. This tag will be used for scanning purposes.
4. All Perinatal Department nurses wear pink accented photo ID badges.
5. Pediatric patients will utilize the HUGS system in addition to the regular hospital wristband. A regular hospital ID band with the patient identification label will be placed on the legal parent/guardian at the time of admission.
6. Inform mothers of security procedures which include but are not limited to:
   a. Check for proper identification before giving the baby to anyone
   b. Never leave the baby alone or unsupervised in the room
   c. Place the baby's bassinet on the side of the bed that is away from the door.
   d. All infants should remain in their cribs during transport i.e. from nursery to mother's room, thus family members and staff should not be carrying infant in hallways or outside the Perinatal Department. Each crib will have a crib card with infant's name, birth date and physician.
   e. Instruct patients and family members to observe the visiting hours and rules and **NOT** to open the main security door to permit access to other visitors.
   f. Only staff members should allow access to visitors according to patient privacy laws.

B. **In the event of an abduction:**
1. Follow the CODE AMBER abduction procedure outlined in the Emergency Preparedness Procedure chart. AKA "Rainbow chart".
2. In the event of an abduction, the downtime Code Amber form will be completed and a copy provided to law enforcement.
3. House Supervisors, Directors of Nursing, Nurse Managers, or Administration:
   a. Consider moving the primary care giver of the abducted child to a private room off the Department and assign a staff member (preferably the nurse assigned to the mother, House Supervisor or nurse manager) to accompany them at all times protecting them from stressful contact with the media and other interference.
   b. If the incident occurred at shift change, hold the shift scheduled to leave until excused by law enforcement.
   c. The House Supervisor or nurse manager should brief all involved staff. In turn, nurses should then explain the situation to other patients in the unit (preferably while the mother and her infant are together).

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Title: Newborn & Pediatric Abduction Prevention Safety and Security	
Scope: Pediatric & Perinatal	Manual: CPM - Patient Safety (PS), Safety
Source: Manager of Perinatal Department	Effective Date: 12/14/16

d. Nursing Administration should be sensitive to the fact that the staff may suffer post trauma stress as a result of the abduction.
e. Protect the crime scene (area where the abduction occurred) in order to preserve the subsequent collection of any forensic evidence by law enforcement.
f. Coordinate with the police department by involving the media search for the infant if indicated.
g. Coordinate with the police department in notifying the Center for Missing and Exploited Children (NCMEC) at 1-800-843-5678 for technical assistance in handling on-going crisis management indicated.
h. Any facility providing care to infants and pediatric patients in the surrounding area such as but not limited to Hospitals, physician offices, Clinics, should be notified about the incident and provided with a full description of the patient and the abductor.

REFERENCES:

1. National Center for Missing and Exploited Children; January, 2016, "For Healthcare Professionals: Guidelines on Prevention of and Response to Infant Abductions"

CROSS REFERENCE P&P:

1. HUGS/PEDZ policy

Approval	**Date**
Safety Committee	11/9/16
CCOC	3/25/19
MEC	4/2/19
Board of Directors	12/14/16
Last Board of Director review	12/19/18

Developed: 10/16 la
Reviewed:
Revised: 11/18ap
Supersedes: Child/Infant Abduction Policy, Infant Security Policy, Safety and Security Infant/Pediatric Abduction Prevention

draft

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Responsibilities of Nursing Students and Hospital Staff	
Scope: Clinical Departments	Manual: Nursing Administration
Source: Chief Nursing Officer	Effective Date:

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

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

REFERENCES:

1. CAMCAH 2019; HR.01.02.07 – EP 5.
2. CAMCAH 2019; IC.01.04.01 – EP 1.
3. CAMCAH 2019; LD.03.06.01 – EP 2.
4. CAMCAH 2019; NR.02.03.01 – EP 5.

CROSS REFERENCE P&P:
1. Guideline for licensed nurses & nursing students giving medications
2. Nursing Students requesting clinical preceptorship rotation
3. Observation in the operating room

Approval	Date
CCOC	3/25/19
MEC	4/2/19
Board of Directors	
Last Board of Directors Review	

Developed:
Reviewed:
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Title: Responsibilities of Nursing Students and Hospital Staff	
Scope: Clinical Departments	Manual: Nursing Administration
Source: Chief Nursing Officer	Effective Date:

Revised: 3/19ta
Supersedes:

draft

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Standardized Procedures For Medical Functions In The Emergency Department	
Scope: Emergency Department	Manual: Emergency Department
Source: Emergency Department Manager	Effective Date:

PURPOSE:

The purpose of the policy is to define designated medical functions that may be performed by the RN as a standardized procedure in the ED.

POLICY:

It is the policy of Northern Inyo Healthcare District (NIHD) that only standardized procedure functions based on defined circumstances as outlined in this document may be performed by a Registered Nurse (RN) in the Emergency Department (ED) without previous written authorization of the Emergency Department Physician or Licensed Independent Practitioner (LIP).

PROCEDURE:

1. Competency Requirements
    a. To be eligible to perform this standardized procedure in the ED, the RN must:
        i. Hold a current CA RN License
        ii. Complete an initial training course specific to the elements of the standardized procedure outlined in this policy.
        iii. Competency is demonstrated annually and documented in the employee's competency assessment files.
        iv. A list of RN's competent to perform this standardized procedure is maintained with the Chief Nursing Officer and is updated annually.
        v. Standardized procedures are reviewed and approved annually by the Interdisciplinary Practice Committee.
2. Abdominal Pain
    a. Circumstances under which the procedure maybe performed:
        i. Any patient in the ED 18 years of age and older presenting with complaint of Abdominal Pain with a documented Emergency Severity Index (ESI) level 2-5.
    b. Circumstances under which the Physician or LIP must be contacted:
        i. Any patient classified as an ESI Level 1.
        ii. Any patient classified as an ESI level 2 will require notification within 10 minutes.
        iii. Any significant change in patient condition
    c. Standardized procedure:
        i. Upon presentation to the ED with complaint of Abdominal Pain and assigned an ESI level 2-5, if the physician or LIP cannot immediately evaluate the patient, the EDRN will place the following orders prior to the patient being seen by the ED Physician or LIP.
            1. Saline Lock

2. NPO
3. CBC with automated differential
4. Comprehensive Metabolic Panel
5. Urine Dip and Hold Urine
6. Urinalysis, culture and sensitivity if urine dip shows leukesterase or nitrates
7. Female 10 years of age to 60 years of age:
    a. Pregnancy Test Urine Qualitative
8. For Upper Abdominal Pain:
    a. Lipase
    b. EKG if age >35
9. If nausea present:
    a. Ondansetron (Zofran) 4 mg IV X1
10. If vomiting present:
    If no medical history of Chronic Renal disease or heart failure, Normal Saline Bolus 1000ml

d. Complications:
    i. Immediate Physician or LIP notification of abnormal Vital Signs and or change in status to higher priority category.

e. Documentation:
    i. Patient specific information obtained for ED nursing documentation includes subjective data, objective data, and record of any actions taken per standardized procedure.

3. Chest Pain 35 years of age and older
    a. Circumstances under which the procedure maybe performed:
        i. Any patient in the ED 35 years of age and older presenting with complaint of Chest Pain with a documented ESI level 2-5.
    b. Circumstances under which the Physician or LIP must be contacted:
        i. Any patient classified as an ESI Level 1.
        ii. Any patient classified as an ESI level 2 will require notification within 10 minutes.
        iii. Any significant change in patient condition
    c. Standardized procedure:
        i. Upon presentation to the ED with complaint of Chest Pain and assigned an ESI level 2-5, if the physician or LIP cannot immediately evaluate the patient, the EDRN will place the following orders prior to the patient being seen by the ED Physician or LIP.
            1. STAT EKG
            2. Continuous Pulse Oximetry

3. Continuous Cardiac Monitoring
4. Saline Lock
5. Chest X-ray 2 views, if able to stand. If unable to stand 1 view portable
6. CBC with automated differential
7. Comprehensive Metabolic Panel
8. Troponin I
9. If patient takes Coumadin:
    a. Prothrombin Time (PT) and INR
    b. Partial Thromboplastin Time
10. Oxygen via nasal cannula to keep oxygen saturation >95%
11. Aspirin 325mg PO Stat if not taken prior to arrival, or equivalent to equal 325mg if partial dose taken prior to arrival, and no contraindications to aspirin

d. Complications:
    i. Immediate Physician or LIP notification of abnormal Vital Signs and or change in status to higher priority category.

e. Documentation:
    i. Patient specific information obtained for ED nursing documentation includes subjective data, objective data, and record of any actions taken per standardized procedure.

4. Chest Pain 16 years of age to 34 years of age
    a. Circumstances under which the procedure maybe performed:
        i. Any patient in the ED 16 years of age to 34 years of age presenting with complaint of Chest Pain with a documented ESI level 2-5.
    b. Circumstances under which the Physician or LIP must be contacted:
        i. Any patient classified as an ESI Level 1.
        ii. Any patient classified as an ESI level 2 will require notification within 10 minutes.
        iii. Any significant change in patient condition
    c. Standardized procedure:
        i. Upon presentation to the ED with complaint of Chest Pain and assigned an ESI level 2-5, if the physician or LIP cannot immediately evaluate the patient, the EDRN will place the following orders prior to the patient being seen by the ED Physician or LIP.
            1. STAT EKG
            2. Chest X-ray 2 views, if able to stand. If unable to stand 1 view portable
    d. Complications:

i. Immediate Physician or LIP notification of abnormal Vital Signs and or change in status to higher priority category.

e. Documentation:

i. Patient specific information obtained for ED nursing documentation includes subjective data, objective data, and record of any actions taken per standardized procedure.

5. Dysuria

a. Circumstances under which the procedure maybe performed:

i. Any patient presenting to the ED with complaint of Dysuria with a documented ESI level 2-5.

b. Circumstances under which the Physician or LIP must be contacted:

i. Any patient classified as an ESI Level 1.

ii. Any patient classified as an ESI level 2 will require notification within 10 minutes.

iii. Any significant change in patient condition

c. Standardized procedure:

i. Upon presentation to the ED with complaint of Dysuria and assigned an ESI level 2-5, if the physician or LIP cannot immediately evaluate the patient, the EDRN will place the following orders prior to the patient being seen by the ED Physician or LIP.

1. Urine Dip and Hold Urine
2. Urinalysis, culture and sensitivity if urine dip shows leukesterase or nitrates
3. Female 10 years of age to 60 years of age:
    a. Pregnancy Test Urine Qualitative

d. Complications:

i. Immediate Physician or LIP notification of abnormal Vital Signs and or change in status to higher priority category.

e. Documentation:

i. Patient specific information obtained for ED nursing documentation includes subjective data, objective data, and record of any actions taken per standardized procedure.

6. Fever 16 years of age and older

a. Circumstances under which the procedure maybe performed:

i. Any patient in the ED 16 years of age and older presenting with complaint of fever with a documented ESI level 2-5.

b. Circumstances under which the Physician or LIP must be contacted:

i. Any patient classified as an ESI Level 1.

ii. Any patient classified as an ESI level 2 will require notification within 10 minutes.
iii. Any significant change in patient condition

c. Standardized procedure:
    i. Upon presentation to the ED with complaint of fever and assigned an ESI level 2-5, if the physician or LIP cannot immediately evaluate the patient, the EDRN will place the following orders prior to the patient being seen by the ED Physician or LIP.
        1. Acetaminophen 650mg PO X1 for temperature >100.5 Fahrenheit if unable to swallow may order PR.
        2. If Acetaminophen has been administered in the last 6 hours, and Ibuprofen has not been administered in last 6 hours, order will be placed for Ibuprofen 600mg PO X1.

d. Complications:
    i. Immediate Physician or LIP notification of abnormal Vital Signs and or change in status to higher priority category.

e. Documentation:
    i. Patient specific information obtained for ED nursing documentation includes subjective data, objective data, and record of any actions taken per standardized procedure.

7. Fever 3 months of age to 15 years of age
    a. Circumstances under which the procedure maybe performed:
        i. Any patient in the ED 3 months to 15years of age presenting with complaint of fever with a documented ESI level 2-5.
    b. Circumstances under which the Physician or LIP must be contacted:
        i. Any patient classified as an ESI Level 1.
        ii. Any patient classified as an ESI level 2 will require notification within 10 minutes.
        iii. Any significant change in patient condition
    c. Standardized procedure:
        i. Upon presentation to the ED with complaint of fever and assigned an ESI level 2-5, if the physician or LIP cannot immediately evaluate the patient, the EDRN will place the following orders prior to the patient being seen by the ED Physician or LIP.
            1. Acetaminophen Suspension 15mg/kg PO X1 (maximum dose 1000mg) for temperature >100.5 Fahrenheit if unable to swallow notify ED Physician or LIP. If patient is greater than 6 months of age and Acetaminophen has already been administered in last 6hours and Ibuprofen has not been administered in last 6 hours,

order will be placed for Ibuprofen 10mg/kg PO X1 (maximum dose 600mg) for temperature greater than 100.5 Fahrenheit.

d. Complications:
   i. Immediate Physician or LIP notification of abnormal Vital Signs and or change in status to higher priority category.
e. Documentation:
   i. Patient specific information obtained for ED nursing documentation includes subjective data, objective data, and record of any actions taken per standardized procedure.

8. Extremity Deformity or pain from trauma
   a. Circumstances under which the procedure maybe performed:
      i. Any patient in the ED 5 years of age and older presenting with extremity deformity or pain from trauma with a documented ESI level 2-5, and assessed to have normal circulation, movement, and sensation in the distal extremity.
   b. Circumstances under which the Physician or LIP must be contacted:
      i. Any patient classified as an ESI Level 1.
      ii. Any patient classified as an ESI level 2 will require notification within 10 minutes.
      iii. Any significant change in patient condition
   c. Standardized procedure:
      i. Upon presentation to the ED with extremity deformity or pain from trauma assigned an ESI level 2-5, if the physician or LIP cannot immediately evaluate the patient, the EDRN will place the following orders prior to the patient being seen by the ED Physician or LIP.
         1. If Ibuprofen has not been administered in the last 6 hours order will be placed for Ibuprofen 10mg/kg max dose of 600mg PO X1, if no NSAIDS have been taken in the last 6 hours.
         2. Contact ED Physician or LIP for pain medication order if needed
         3. Obtain Radiology: X-ray of the affected extremity
         4. Ice Therapy
         5. Elevate affected extremity
   d. Complications:
      i. Immediate Physician or LIP notification of abnormal Vital Signs and or change in status to higher priority category.
   e. Documentation:
      i. Patient specific information obtained for ED nursing documentation includes subjective data, objective data, and record of any actions taken per standardized procedure.

9. Vomiting 18 years of age and older
    a. Circumstances under which the procedure maybe performed:
        i. Any patient in the ED 18 years of age and older presenting with complaint of vomiting with a documented ESI level 2-5.
    b. Circumstances under which the Physician or LIP must be contacted:
        i. Any patient classified as an ESI Level 1.
        ii. Any patient classified as an ESI level 2 will require notification within 10 minutes.
        iii. Any significant change in patient condition
    c. Standardized procedure:
        i. Upon presentation to the ED with complaint of vomiting and assigned an ESI level 2-5, if the physician or LIP cannot immediately evaluate the patient, the EDRN will place the following orders prior to the patient being seen by the ED Physician or LIP.
            1. Place Saline Lock
            2. If no medical history of Chronic Renal disease or heart failure, Normal Saline Bolus 1000ml
            3. Ondansetron (Zofran) 4mg IV X1
    d. Complications:
        i. Immediate Physician or LIP notification of abnormal Vital Signs and or change in status to higher priority category.
    e. Documentation:
        i. Patient specific information obtained for ED nursing documentation includes subjective data, objective data, and record of any actions taken per standardized procedure.
10. Vomiting 6 months of age to 17 years of age
    a. Circumstances under which the procedure maybe performed:
        i. Any patient in the ED 6 months to 17 years of age presenting with complaint of vomiting with a documented ESI level 2-5.
    b. Circumstances under which the Physician or LIP must be contacted:
        i. Any patient classified as an ESI Level 1.
        ii. Any patient classified as an ESI level 2 will require notification within 10 minutes.
        iii. Any significant change in patient condition
    c. Standardized procedure:
        i. Upon presentation to the ED with complaint of vomiting and assigned an ESI level 2-5, if the physician or LIP cannot immediately evaluate the patient, the EDRN will place the following orders prior to the patient being seen by the ED Physician or LIP.

1. Ondansetron (Zofran) 0.5mg/kg Oral Disintegrating Tab (ODT), max dose 4mg.

d. Complications:
   i. Immediate Physician or LIP notification of abnormal Vital Signs and or change in status to higher priority category.

e. Documentation:
   i. Patient specific information obtained for ED nursing documentation includes subjective data, objective data, and record of any actions taken per standardized procedure.

11. Shortness of Breath WITH history of Asthma
   a. Circumstances under which the procedure maybe performed:
      i. Any patient presenting to the ED with complaint of Shortness of Breath with history of Asthma and with a documented ESI level 2-5.
   b. Circumstances under which the Physician or LIP must be contacted:
      i. Any patient classified as an ESI Level 1.
      ii. Any patient classified as an ESI level 2 will require notification within 10 minutes.
      iii. Any significant change in patient condition
   c. Standardized procedure:
      i. Upon presentation to the ED with complaint of Shortness of Breath with history of Asthma and assigned an ESI level 2-5, if the physician or LIP cannot immediately evaluate the patient, the EDRN will place the following orders prior to the patient being seen by the ED Physician or LIP.
         1. Continuous pulse oximetry
         2. Oxygen administration titrate to keep saturation >90%
         3. Duoneb x1
   d. Complications:
      i. Immediate Physician or LIP notification of abnormal Vital Signs and or change in status to higher priority category.
   e. Documentation:
      i. Patient specific information obtained for ED nursing documentation includes subjective data, objective data, and record of any actions taken per standardized procedure.

12. Shortness of Breath 18 years of age and older without history of Asthma
   a. Circumstances under which the procedure maybe performed:

i. Any patient presenting to the ED 18 years of age and older with complaint of Shortness of Breath without history of Asthma with a documented ESI level 2-5.

b. Circumstances under which the Physician or LIP must be contacted:
   i. Any patient classified as an ESI Level 1.
   ii. Any patient classified as an ESI level 2 will require notification within 10 minutes.
   iii. Any significant change in patient condition

c. Standardized procedure:
   i. Upon presentation to the ED with complaint of Shortness of Breath without history of Asthma and assigned an ESI level 2-5, if the physician or LIP cannot immediately evaluate the patient, the EDRN will place the following orders prior to the patient being seen by the ED Physician or LIP.
      1. Saline Lock
      2. Continuous pulse oximetry
      3. Continuous cardiac monitoring
      4. Chest X-ray 2 views, if able to stand. If unable to stand 1 view portable
      5. EKG if patient >35 years of age
      6. Oxygen administration titrate to keep saturation >90%
      7. If wheezes are present:
         a. Duoneb x1

d. Complications:
   i. Immediate Physician or LIP notification of abnormal Vital Signs and or change in status to higher priority category.

e. Documentation:
   i. Patient specific information obtained for ED nursing documentation includes subjective data, objective data, and record of any actions taken per standardized procedure.

13. Shortness of Breath 17 years of age and younger without history of Asthma
   a. Circumstances under which the procedure maybe performed:
      i. Any patient presenting to the ED 17 years of age and younger with complaint of Shortness of Breath without history of Asthma with a documented ESI level 2-5.
   b. Circumstances under which the Physician or LIP must be contacted:
      i. Any patient classified as an ESI Level 1.

ii. Any patient classified as an ESI level 2 will require notification within 10 minutes.

iii. Any significant change in patient condition

c. Standardized procedure:

i. Upon presentation to the ED with complaint of Shortness of Breath without history of Asthma and assigned an ESI level 2-5, if the physician or LIP cannot immediately evaluate the patient, the EDRN will place the following orders prior to the patient being seen by the ED Physician or LIP.

1. Continuous pulse oximetry
2. Chest X-ray 2 views, if able to stand. If unable to stand 1 view portable
3. Oxygen administration titrate to keep saturation >90%
4. If wheezes are present:
    a. Albuterol 2.5mg via hand held nebulizer x1

d. Complications:

i. Immediate Physician or LIP notification of abnormal Vital Signs and or change in status to higher priority category.

e. Documentation:

i. Patient specific information obtained for ED nursing documentation includes subjective data, objective data, and record of any actions taken per standardized procedure.

REFERENCES:

1. **California State and Consumer Services Agency, Board of Registered Nursing. (2011). "*An explanation of the scope of RN practice including standardized procedures*". Retrieved from www.rn/gov Section 2725 of California Nurse Practice Act.**
2. **Emergency Severity Index (ESI) Implementation Handbook, 2012 Edition. Retrieved from www.ahrg.gov/researdh/esi/esi7.htm.**

Approval	**Date**
Emergency Services Committee	3/6/19
Pharmacy and Therapeutics Committee	2/21/19
Radiology Committee	2/19/19
Interdisciplinary Committee	2/13/19
MEC	4/2/19

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Standardized Procedures For Medical Functions In The Emergency Department	
Scope: Emergency Department	Manual: Emergency Department
Source: Emergency Department Manager	Effective Date:

Board of Directors	
Last Board of Directors Review	

Developed: 1/9/2019
Reviewed:
Revised:
Supersedes:
Index Listings:

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Diet Texture Ordering Protocol	
Scope: Speech, Dietary, Nursing	Manual: Clinical Practice Manual - GNT
Source: Director of Rehab Services	Effective Date:

PURPOSE:

To give the discipline of Speech-Language Pathologist (SLP) privileges to adjust a patient's diet orders and swallow strategies to ensure safe swallowing.

POLICY:

1. The SLP will follow the adopted hospital diet texture manual for dietary options.

2. Upon completion of the evaluation by the SLP, the diet may be adjusted or changed with downgrades and advancements of textures including solids and liquids.

3. A. Diet modifications will be placed into the Electronic Medical Record (EMR) by the SLP and then sent over for the physician's signature as confirmation of the diet texture. SLP diet texture order changes need to take effect immediately with notification to physician, nursing staff, and dietary staff.
   B. All SLP dietary order changes will need physician e-signature as co-signing/confirmation within 24 hours. (SLP student interns may document in EMR, but they will not have diet management privileges or enter an SLP plan of care order).

4. Each patient within the facility will need to have a diet order whether it is NPO, clear liquids, or full PO intake as outlined in the diet texture manual.

PROCEDURE:

1. Physician enters initial diet order on admission. All diet orders and changes are entered via the Computer Physician Order Entry system (CPOE).
2. Subsequent diet order changes may be made at the discretion of the physician.
3. Upon evaluation or re-evaluation of a patient, the SLP may adjust diet orders via a Speech/Swallow Plan of Care and in CPOE in the following scenarios:
   A. Downgrade a diet consistency (liquids and/or solids). E-signature by physician is required (i.e., changing diet from Regular consistency to Dysphagia Ground).
   B. Upgrades a diet consistency (liquids and/or solids). E-signature by physician is required (i.e., changing from Dysphagia Puree and Honey thick liquids to a Dysphagia Ground and Nectar thick liquids).
   C. Modifications in the delivery of the solids, liquids, or medications to ensure safe swallowing strategies. E-signature by physician is required (i.e., Changing diet from Dysphagia Advanced with thin liquids to Dysphagia Advanced with thin liquids, but utilizing a small sip by cup with chin tuck and crushing the medications in applesauce).
4. Diet advancement off of NPO requires an order directly from the physician.
5. Diet upgrades or downgrades will not progress off of "Clear liquids only" (to a full liquid or Solid consistencies) or onto "Clear liquids only", as the "Clear liquids only" diet needs to be ordered or discontinued directly by a physician. However, the SLP may modify the "Clear liquid" diet with the liquid consistencies of "Thin, Nectar, or Honey thick" to reduce aspiration risk.
6. Changing a patient from a PO diet to an NPO diet also requires an order directly from the physician.

Draft

Title: Diet Texture Ordering Protocol	
Scope: Speech, Dietary, Nursing	Manual: Clinical Practice Manual - GNT
Source: Director of Rehab Services	Effective Date:

7. The SLP cannot directly order NPO or take a patient off NPO. However, the SLP may make the recommendations to do so in the Speech/Swallow Plan of Care.

REFERENCES:

1. Lippincott Procedures; "Impaired swallowing and aspiration precautions."
2. American Speech-Language-Hearing Association. (1986). *Autonomy of speech-language pathology and audiology* [Relevant Paper]. Available from www.asha.org/policy.
3. The Joint Commission; 2019 CAMCAH; PC.01.03.01

CROSS REFERENCE P&P:

1. **Physician's Diet Orders**
2. **Scope of Care Rehabilitation Services**

Approval	**Date**
CCOC	12/17/2019
Med Services/ICU	3/28/19
Medical Executive Committee	4/2/19
Board of Directors	
Last Board of Directors Review	

Developed: 11/01/2018
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Revised:
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Index Listings:

draft

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Laboratory Home Collections	
Scope:	Manual: Lab- General Laboratory Procedures, Lab- Laboratory Administration, Lab- Phlebotomy
Source: Operations - Director of Diagnostic Services (DI & Lab)	Effective Date:

PURPOSE: To ensure that home bound patients have an opportunity to receive laboratory services from NIHD and to maintain a safe and ergonomic environment for laboratory personnel providing home collection services.

POLICY:

NIHD Laboratory services will go to patient's homes to collect specimens for patients who meet specific criteria, as defined below, and for whom laboratory tests were ordered by credentialed NIHD providers.

PATIENT CRITERIA FOR HOME BOUND SERVICES:

Patient must meet at least one of the following requirements of Medicare's definition of "home bound patients":

- Patient cannot leave home without considerable and taxing physical effort
- Patient must have injury or illness that keeps them from leaving their home
- Patient must have symptoms of a disease process that worsen when leaving their home
- Patient infrequently leaves home for non-medical services and does so only for short durations

NOTE: Lack of transportation does not qualify a patient for home collection services. Patients who have transport needs should coordinate transport services with NIHD transportation services or other local transportation service.

HOME COLLECTION SERVICE AREA:

Home collection services will be provided only to patients who live within the 30 minutes driving time of hospital AND reside within Northern Inyo Healthcare District boundaries.

PROCEDURE:

1. NIHD provider will order lab tests AND order home draw services on patients who live within the defined boundaries outlined in this policy and whom meet criteria for home collection services as defined in this policy.

2. Lab will contact the patient or caregiver by phone the day prior to the date home collection services are scheduled in order to:
   a. Verify the patient will be home and prepared for service
   b. Remind fasting patients that they must not eat or drink anything except water prior to collection
   c. Remind that bed bound or non-ambulatory patients will have a caregiver present to allow entry into the residence
   d. Assure that the environment is safe including but not limited to:
      i. All animals will be confined or restrained during visit
      ii. Individuals at the residence are not under the influence of non-prescribed drugs or alcohol
      iii. There are no unsanitary conditions within the home or on the property
      iv. The patient will be prepared for collection, i.e. in a position that allows for ergonomic collection of specimen

3. Documentation will be made on the home draw list indicating that the patient had been reached or a message was left. Home collection services will not be provided unless the patient or the caregiver is contacted on the day prior to the collection and that the requirements within section 2 are confirmed.

<table>
<tr><td colspan="2">Title: Laboratory Home Collections</td></tr>
<tr><td>Scope:</td><td>Manual: Lab- General Laboratory Procedures, Lab- Laboratory Administration, Lab- Phlebotomy</td></tr>
<tr><td>Source: Operations - Director of Diagnostic Services (DI & Lab)</td><td>Effective Date:</td></tr>
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4. One qualified lab assistant and one additional NIHD employee will be required to be present for all home collection services. Under no circumstances will NIHD staff enter a premise without the patient or caregiver physically providing access to the residence.

5. Fasting patients will be collected prior to non-fasting patients whenever possible. Non-fasting patients will be prioritized to facilitate travel efficiency and to accommodate patient special requests.

6. A Condition of Admission (COA) will be provided with each order and must be signed by the patient or caregiver prior to obtaining a specimen. The Lab Assistant will sign and date as the witness.

7. Lab staff will follow all procedures to ensure specimen integrity and processing in a manner that will preserve the specimen as necessary for accurate testing.

WITHDRAWAL OF HOME DRAW SERVICES

1. If both the lab staff and the chaperoning NIHD staff agree that services cannot be provided in a safe, ergonomic, and sanitary method, home collection services will be discontinued immediately and the following will occur:
    a. the ordering provider and Director of Diagnostic services will be notified of the immediate withdrawal of services and the cause(s) of the withdrawal of services.
    b. The Director of Diagnostic Services will be responsible for notifying the appropriate authorities of unsafe / hazardous conditions as required by law.
2. The ordering provider may re-order home collection services once the provider is confident that the cause(s) of the withdrawal of services have been remedied.
3. Any patient that has home collection services withdrawn on three separate occasions will not be eligible for future home collection services without documented changes in patient's living conditions that are reviewed and approved by Director of Diagnostic Services.

REFERENCES:

1. US Dept. of Health and Human Services "Clarifying the definition of Homebound and Medical Necessity using OASIS DATA; Final Report, 2001.

CROSS REFERENCE P&P:

1. Rejected Specimens Acceptability and Rejection

Approval	**Date**
CCOC	02/25/2019
Medical Services / ICU	3/28/19
MEC	4/2/19
Board of Directors	
Last Board of Directors Review	

Developed: 02/2019
Reviewed:
Revised:
Supersedes:

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Lymphedema Treatment	
Scope: Only Certified Lymphedema Therapists (CLT)	Manual: Occupational Therapy, Physical Therapy, Rehabilitation Services
Source: Chief Nursing Officer	Effective Date:

PURPOSE: To establish and describe the medical necessity guidelines of Certified Lymphedema Therapists (CLT) for managing lymphedema, lipedema, chronic venous insufficiency, and other contributing diagnoses for the development of lymphedema in both adult and pediatric patients based upon its clinical severity using the gold-standard method of Complete Decongestive Therapy (CDT). Lymphedema is an accumulation of protein-rich fluid in the interstitial spaces that leads to swelling, decreased mobility, increased risk of infection, psychosocial concerns, limited function, and impaired self-care. Lymphedema may be primary, due to a genetic anomaly of the lymphatic system; or secondary, due to a removal of lymph nodes, radiation treatment, infection, surgery, trauma, or other contributing health issues.

POLICY:

1. Certified Lymphedema Therapists (CLT) will adhere to the treatment standard of CDT when diagnosing and treating swelling conditions. As edema is simply a *symptom* of a disease process, proper diagnosis is essential when utilizing treatments as outlined in the CDT procedure. CLT's are specifically trained in diagnosis of various edema-related conditions.
2. The treatment standard of CDT includes:
    1. Skin care.
    2. Manual Lymphatic Drainage (MLD) involving massage to redirect lymph fluid toward functioning lymph systems.
    3. Compression bandaging/fitting for compression garments for preventing re-accumulation of fluid.
    4. Remedial exercises for enhancing lymphatic flow from peripheral to central drainage components.
    5. Development and implementation of a home program, which continues to address the above, with the patient's understanding that lymphedema is a chronic, life-long condition demanding independent and consistent management.
3. CDT is medically necessary when it is anticipated that the patient and/or caregiver will show compliance following the instructions associated with the CDT for any of the following indications:
    1. There is a documented diagnosis of lymphedema from a physician (MD, DO), advanced practice registered nurse (NP), or physician assistant (PA-C).
    2. Intractable lymphedema of the extremities, unrelieved by conservative therapy.
    3. One or more previous hospital admissions to treat complications of intractable lymphedema.
    4. Evidence of ulceration due to lymphedema.
    5. Post-mastectomy lymphedema syndrome.
    6. Hereditary edema.
    7. Truncal edema.
    8. Genital edema.
    9. Head and neck edema.
    10. And there are not documented contraindications for lymphedema management, including acute infection of the body part, venous or arterial obstruction, or confirmed/suspected local disease or active malignancy.

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Lymphedema Treatment	
Scope: Only Certified Lymphedema Therapists (CLT)	Manual: Occupational Therapy, Physical Therapy, Rehabilitation Services
Source: Chief Nursing Officer	Effective Date:

PROCEDURE:

1. Following a referral from a MD, NP, or PA-C, the CLT performs a full evaluation of the patient. The evaluation includes:
    1. Medical history.
    2. Prior level of function.
    3. Medical and treatment diagnoses.
    4. Contraindications to any part of the CDT protocol.
    5. Skin inspection and assessment.
    6. Circumferential measurements of affected and non-affected areas.
    7. Problem list and summary.
    8. Plan of care.
    9. Short-term and long-term goals.
    10. Facilitative factors and barriers to progress.
    11. Rehabilitation potential.
    12. Frequency and duration.
    13. Education.
    14. Certification dates.
    15. Discharge plan.
2. Based on the evaluation findings, a Plan of Care (POC) is established for initiating CDT, or some modification therein, as needed for the specific edema-related condition. The treatment protocol for full CDT is defined above, and is broken into two stages:
    1. The intensive or decongestive phase.
    2. The self-management phase.
3. The Intensive Phase of CDT involves:
    1. 3-5x/week sessions over a 2 to 8-week period, focusing on overall decongestion of the affected body area.
    2. Skin care, including application of low pH lotions to the affected limb prior to bandaging and instruction in proper cleansing and moisturizing techniques for maintaining the health and integrity of the skin and to prevent infections.
    3. Manual lymph drainage (MLD) application between 30-60 minutes, starting with stimulation of the patent lymphatic system areas, resulting in a "suction effect" on the protein-rich lymph fluid in the congested area, and then moving to the affected areas or limbs.
    4. Compression therapy, including the application of short-stretch bandages in combination with appropriate padding materials, and patient instruction to not remove the bandages at home. Instruction of the patient and a caregiver/family member in self-application of the bandages occurs at this stage.
    5. Decongestive exercises performed by the patient twice daily for 10-15minutes while wearing the compression bandages for improving lymph circulation and maximize functional ability.
4. The Self-Management Phase of CDT involves:
    1. Skin and nail care, including application of appropriate skin moisturizers twice daily.
    2. Self-manual lymph drainage.
    3. Compression therapy, including the use of bandages/foam and garments as appropriate.
    4. Decongestive exercises.

Title: Lymphedema Treatment	
Scope: Only Certified Lymphedema Therapists (CLT)	Manual: Occupational Therapy, Physical Therapy, Rehabilitation Services
Source: Chief Nursing Officer	Effective Date:

5. Reassessments will occur at least once a week during the session with the CLT, where circumferential measurements will be taken and recorded to ensure maintenance or progression of gains from treatment.
6. The CLT recommends appropriate compressive garments as needed for the edema condition, body area, and affected lymph systems.

REFERENCES:

1. Zuther, Joachim E., and Steve Norton. *Lymphedema Management: the Comprehensive Guide for Practitioners*. Thieme, 2018.
2. International Society of Lymphology. The diagnosis and treatment of peripheral lymphedema. Consensus document of the International Society of Lymphology. 2013. Available at: http://www.u.arizona.edu/~witte/ISL.htm
3. Letellier ME, Towers A, Shimony A, et al. Breast Cancer-Related Lymphedema: A Randomized Controlled Pilot and Feasibility Study. Am J Phys Med Rehabil. 2014 Apr 16.
4. Position Statement of the National Lymphedema Network. Lymphedema Treatment. August 2006. updated February 2011.Available at: http://www.lymphnet.org/pdfDocs/nlntreatment.pdf
5. Tambour M, Tange B, Christensen R, et al. Effect of physical therapy on breast cancer related lymphedema: protocol for a multicenter, randomized, single-blind, equivalence trial. BMC Cancer. 2014 Apr 3;14:239.
6. Women's Health and Cancer Rights Act (WHCRA). CMS.gov. 1998. Available at: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/whcra_factsheet.html
7. Harris SR, Hugi MR, Olivotto IA, Levine M, for the Steering Committee for Clinical Practice Guidelines for the Care and Treatment of Breast Cancer. Clinical practice guidelines for the care and treatment of breast cancer: 11. Lymphedema CMAJ 2001; 164:191-9.
8. Holtgrefe K. Twice-Weekly Complete Decongestive Physical Therapy in the management of Secondary Lymphedema of the Lower Extremities. Physical Therapy. 2006; 86; 1128-1136.
9. Kligman l, Wong R, Johnston M, Laetsch N, and members of the Supportive Care Guidelines Group. The Treatment of Lymphedema Related to Breast Cancer – Evidence Summary Report #13-1

CROSS REFERENCE P&P:

1.
2.
3.

Approval	**Date**
CCOC	2/25/19
Medical Services/ICU Committee	3/28/19
Medical Executive Committee	4/2/19
Board of Directors	
Last Board of Directors Review	

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Lymphedema Treatment	
Scope: Only Certified Lymphedema Therapists (CLT)	Manual: Occupational Therapy, Physical Therapy, Rehabilitation Services
Source: Chief Nursing Officer	Effective Date:

Developed: 10/2018
Reviewed:
Revised:
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Index Listings:

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Standards of Care for the Swing Bed Resident	
Scope: Swing	Manual: Standards of Care (S of C)
Source: Manager – ICU Acute/Subacute	Effective Date: 7/1/2014

POLICY STATEMENT:

1. Subacute nursing is provided using an interdisciplinary team approach based on a holistic assessment of patient needs, problems, capabilities, limitations, interventions, and patient response.
2. Patient expectations as defined will be met for each patient.
3. The patient age specific population served is:
   a. Adult 13 years old to 65
   b. Older adult 65+

PROCEDURE:

The Subacute Swing patient can expect:

1. **ON ADMISSION/TRANSFER INTO DEPARTMENT:**
   a. To be greeted immediately upon arrival to the unit including:
      1) Clean resident room with appropriate supplies and equipment.
      2) Introduction of team members
      3) Explanation of what to expect within the next hour.
      4) Assessing level of assistance required in transferring from cart or wheelchair to the bed, ambulating, feeding self, changing into a gown, and supporting patient level of assistance identified.
      5) Oriented to room including call light use, phone and bed operation, bathroom location, TV, and unit routine.
      6) Pain, potty, position addressed.
      7) Addressing additional comfort needs such as fluids, blankets, IV site, traction, safety devices, and communication devices.
      8) Conducting an environmental assessment (trash can, Kleenex, etc.) within reach and patient personal equipment checked prior to usage.

   b. To have his/her admitting or transfer condition assessed (quick check) within 30 minutes of arrival.
   c. To receive information about the patient/family's Speak Up Patient Safety Program, Patient Safety, Swing Patient Rights, Advance Directives, Infection Control, Rapid Response, Patient Advocate, and Swing Bed Resident.
   d. To have initial nursing assessment initiated within 4 hours of admission (completed within 12 hours of admission) to the unit including:
      1) Review of Medical Staff orders
      2) Interdisciplinary referral based on functional screens within the nursing assessment
      3) Medication history (list of current medications and purpose).

   e. To have Medical Staff Practitioner admitting orders to Subacute received and reviewed with the resident and initiated within 4 hours of admission:
      1) To review medical staff plan of care as written

   f. In addition to the initial nursing assessment and the patient profile, the RN will conduct an initial and periodic comprehensive, accurate assessment of each resident's functional capacity. The periodic assessment will be repeated within 14 days after a significant change in the resident's physical or mental condition and not less often than once every 12 months.
   g. To have resident discharge needs initiated at time of admission and throughout the stay including:
      1) Patient goals for hospitalization (what can we help you with while you are here?)

2) Referral to the interdisciplinary team based on clinical screens for dietary, social work, rehabilitation services, and pharmacy.

h. To have the nursing assessment including plan of care reviewed/updated within 12 hours of admission/transfer to the unit including:
   1) Physician orders obtained for transfer
   2) Medication reconciliation

i. To have pharmacy review the medication list for appropriateness including medication reason specified within 24 hours of admission/transfer

2. THROUGHOUT STAY:

a. To be treated in accordance to resident rights.

b. To be kept informed of and encouraged to take part in development of the plan of care including discharge needs, medications and procedures.

c. To have his/her health status monitored and reassessed by an RN a minimum of every shift and as the patient's condition warrants.

d. To keep the Physician(s) updated and informed of response to care and/or significant changes as demonstrated by:
   1) Abnormal or worsening critical signs specific to patient baseline.
   2) Abnormal or critical lab values.
   3) Significant or worsening change in physical assessment.
   4) Significant change in level of mental status.
   5) Significant change or imbalance in I & O.
   6) Any adverse drug and/or blood reaction.
   7) Inability to control or obtain pain relief or untoward change as a response of treatment.
   8) Any untoward occurrence/event occurring in the hospital.

e. To receive prompt identification and intervention for potential and/or actual complications/side effects, including rapid response team initiation.

f. To have pain reassessed and managed in a systematic way to achieve optimal pain relief.

g. To have care delivered based on standards of practice for the diagnosis identified.

h. To have hourly rounding 0800 to 2400 and every 2 hour rounding 2400 to 0800 for:
   1) Pain, potty, position
   2) Comfort needs addressed
   3) Environment assessment

i. Safety measures to be identified specific to each patient including:
   1) A fall risk assessment every 24 hours and with change of condition.
      a) Interventions in place specific to the patient
      b) High risk patient to be awoken at agreed upon time for toileting
   2) Skin assessment every 24 hours
      a) Interventions to be in place specific to patient
   3) Identification bracelet in place in addition to usage of two methods of patient identification.
   4) Time out as appropriate for identified invasive procedures.
   5) 5 rights of medication administration practiced.
   6) Smoke free environment.
   7) To achieve a restraint free environment emphasizing alternatives to restraint such as use of restorative programs, resident orientation techniques etc. Restraints only used if less

restrictive measures have not succeeded or are clearly not likely to succeed in preventing injury to the patient (see P&P)

8) To be assessed for suicidal risk.

j. To be supported throughout the admission with information and education including:
   1) Understanding of health status.
   2) Self care in relation to health status – an explanation of the plan for care treatment services.
   3) Medications being administered and purpose.
   4) Usage of any equipment during stay and equipment usage after discharge.
   5) Basic health practices and safety including hour to communicate concerns about safety issues before, during and after care is received.
   6) Nutrition interventions.
   7) Discussion of pain, the risk for pain, and methods for pain management
   8) Information on oral health.
   9) Habitation or rehabilitation techniques to help patient reach maximum independence.
   10) Fall reduction strategies.

k. To have continuity of care maintained between caregivers and departments through appropriate sharing of information (SBAR-QC).

l. To have preventative measures followed for resident infections, pneumonia, clots.

m. To have an Attending Physician oversee care with site visit every 24 hours.

n. To have Medical Staff consultations completed within 48 hours of referral.

o. To have social and recreational activities provided according to resident abilities and interest.

p. To have services that support family time, social work, nursing care, dental care, rehabilitation and discharge needs.

q. To have good and nutrition products that meet the resident's special diet, cultural, religious or ethnic preferences.

r. If a patient has dentures that are lost or damaged by staff, the hospital will consume the responsibility for the cost of replacement. The case manager or house supervisor will facilitate referral to dental services within three days from the incident. If the referral is unable to be completed, it will be documented as to what interventions were offered to ensure the resident is able to eat and drink adequately.

3. ON TRANSFER WITHIN NIH:

a. Transfer tab completed by transferring RN.
b. Assessment completed by receiving RN.
c. Transferring RN provides report of patient condition (SBAR-QC P&P) to receiving RN.
d. Patient/family kept updated on reason for transfer, location moved, and change in plan of care.
e. To be transferred with all belongings.
f. Medications/orders to be reconciled upon transfer by receiving RN/ Pharmacy.

4. ON DISCHARGE/TRANSFER TO ANOTHER FACILITY:

a. Discharge transfer orders to be reviewed with patient/family member.
b. Discharge Transfer assessment to be completed by RN and report called to receiving facility RN.
c. Transportation to be arranged including:
   1) Care level during transport (orders)
   2) IV/Medication maintenance as appropriate.
   3) Medical condition

4) Record of care (chart copy per policy)

d. Discharging Transfer RN to give report to transport team RN/MD/Paramedic/EMT as appropriate.

e. Patient to be transferred with all personal belongings and medications.

f. Patient will be notified in writing and verbally of their discharge/transfer. A copy of the written discharge/transfer notice will then be faxed to the state's long-term care ombudsman.

5. ON DISCHARGE:

a. Discharge assessment completed by RN.

b. Discharging RN to provide written discharge instructions to patient/family member/significant other as per policy.

c. Discharging RN to clarify discharge instruction with patient/family member/significant other on discharge instructions including:

1) Who to call for questions
2) Nature of medical condition and what symptoms to report to MD.
3) Medications to take.
4) Follow up appointment or when to make it; including outpatient diagnostic test and lab work completion instruction.
5) At home equipment, usage and vendor to call for assistance.
6) Home Health/Hospice/Meals on Wheels contact information as ordered.
7) Activity level and return to work.

d. To be discharged with all belongings and medications.

e. Hospital follow-up call.

6. ON EXPIRATION:

a. Family member/significant other/Power of Attorney/health care surrogate, nursing home, and Organ Procurement agency to be notified of impending death.

b. All Medical Staff assigned to the case, nursing home, family member/significant other/Power of Attorney/Health Care Surrogate, and organ procurement agency to be notified of death (see Organ/Tissue/Eye Donation*).

c. All belongings to be returned to family or sent with body to funeral home.

d. Post mortem care to be completed and body released to funeral home, medical examiner, or donation university.

REFERENCES:

1. ANA (2004) Nursing Scope and Standards of Practice. Silver Spring: Nurses Books
2. Smith, Duell, & Martin (2008) Clinical Nursing Skills. New Jersey; Prentice Hall.
3. Definition of Nursing Practice
4. The Joint Commission CAMCAH, PC.02.02.01 & RI01.06.03

CROSS REFERENCE HOSPITAL P&P:

1. Rights of Swing Bed Patients*
2. Organ/Tissue/Eye Donation

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Standards of Care for the Swing Bed Resident	
Scope: Swing	Manual: Standards of Care (S of C)
Source: Manager – ICU Acute/Subacute	Effective Date: 7/1/2014

Approval	**Date**
Nurse Executive Committee	7/26/18
Medical Services/ICU Committee	3/28/19
Medical Executive Committee (MEC)	4/2/19
Board of Directors	12/14
Last Board of Director review	4/19/17

Developed: 5/10/2013
Reviewed: 6/16, 2/17 la
Revised: 10/14, 03/18 JN
Supercedes:

Medical Staff Services

Department: Medical Staff Administration
Pillars of Excellence: FY July 1, 2018-June 30, 2019
(current quarter with past 3 quarters of data)

Indicator	Baseline	Goal	Apr-Jun 2018 Q4	Jul-Sep 2018 Q1	Oct-Dec 2018 Q2	Jan-Mar 2019 Q3	YTD
Service							
1. Customer satisfaction							
a. Average Credentialing TAT (from receipt of complete application)	12 days	<21 days	11 d	7 d	16 d	12 d	11 d
b. Average Privileging TAT (from receipt of complete application)	30 days	<60 days	44 d	25 d	35 d	39 d	37 d
c. Percent on-time start	95%	100%	93%	100%	86%	46%	80%
2. Application times							
a. Average time for any application materials to be returned	18 days	<14 days	23 d	24 d	17 d	19 d	21 d
b. Average time for complete application to be returned	37 days	<45 days	46 d	43 d	23 d	28 d	36 d
Quality							
1. Credentialing/Privileging							
a. Percent processed within time frame specified in bylaws	100%	100%	100%	100%	100%	91%	98%
b. Percent of applicants granted temporary/expedited privileges	39%	<33%	36%	25%	57%	36%	38%
People							
1. Active Staff	41	N/A	41	39	39	42	
2. All Medical Staff Members and Allied Health Professionals (+ tele)	106	N/A	106	108	105	109	
3. Locums/Temporary Staff	4	N/A	4	5	6	9	
4. Resignations	13	N/A	1	7	4	4	
Finance							
1. Total initial applications processed	62/year	N/A	14	8	7	11	40
2. Number of locum tenens applications	19/year	N/A	4	2	3	5	14
3. Number of applications abandoned/discontinued	5/year	N/A	0	2	2	1	5

LEGEND	
(blue)	Exceeds goal; 100%
(green)	Meets goal
(yellow)	Close to goal
(red)	Does not meet goal

Dev. 2/17

Medical Staff Services

FY 2019
Q3: January – March 2019

Narrative Notes:

1. Drop in "Percent on-time start" under the pillar of Customer Satisfaction – **46%**
    a. This metric measures how many practitioners privileged during the quarter started on a date that was expected and/or planned (labeled as "on-time start"). During this quarter, the percent on-time start reached an all-time low of 46%. This was primarily due to the medical staff office's prioritization of the hospitalist service over other services, which resulted in our office postponing the start date of four cardiologists providing remote interpretations and one surgeon. There was one additional applicant that was also delayed due to difficulties in completing necessary verifications of the person's education.

2. Drop in "Percent processed within time specified in the bylaws" under the pillar of Quality – **91%**
    a. For eight quarters in a row, the medical staff office has processed 100% of applications within the timeframe specified in the medical staff bylaws. This quarter, one of the eleven applications exceeded the 45-day review period designated in the bylaws to extend from the time the application is completed to the time the application is first verified by the credentials committee. This delay was caused by the decision to postpone the surgeon's application in order to prioritize the hospitalist applications.

3. New metric titled "Resignations" added to the pillar of People
    a. This quarter, the metric of "Resignations" has been added for tracking. The baseline was established by taking the total number of medical staff resignations approved at the board of directors during fiscal year 2018. This metric does not necessarily track the departure of temporary practitioners who do not become medical staff members.

Dianne Picken, M.S.
Medical Staff Support Manager
4/2/19

Dev. 2/17

Northern Inyo Healthcare District

Financial Narrative for the Six Months Ended December 31, 2018

Revenues:
Acute inpatient utilization was lower than in 2017 at 8.065 average acute daily census versus 9.049. Gross inpatient revenues are (11.2%) lower than in 2017. A (3%) reduction in inpatient surgical cases and a (18%) reduction in ICU days being contributing factors.

Observation hours also dropped by (10.1%) to an average daily census value of 1.19. Swing bed improved to an average census of 1.625 from .973. Overall bed utilization was 10.88 versus 11.34.

Outpatient revenues were up 8.9%. Half of this was due to our 4.0% price increase. There was growth in imaging, lab, infusion and other diagnostic services. RHC visits are down period over period due to decreased volumes during the Athena ramp up and moving Pediatrics to NIA.

The change in accounting practices to no longer include any special payments to NIHD (District support from the State, IGTs for Medicaid, etc.) has seen discounts go up to the extent that Other operating revenues have grown. These special payments were outlined in the Budget and are on track.

Operating Expenses:
Salary and benefit expenses have grown as overall FTEs have increase by 26.4 year over year. The impact of Phase III salary increases also represents a significant part of the change. Temporary labor costs (Contract Services) continue to be greater than budget and prior year. The cost of extra labor associated with Athena implementation is estimated at $540,000. Pharmacy price increases are the source of supply cost increases for the year. Both July and August were $40,000 more a month more expensive in electric utilization in 2018 than in 2017.

Non-Operating:
The Prime Grant of $1,930,000 in December had the impact to turn the year to date positive. This Grant drops by ($400,000) next year. NIA Clinic net revenues are both worse than budget and prior year. The Athena implementation significantly impacted patient visit totals. The 340B Retail pharmacy program with Dwayne's is on track for the year and an improved source of revenue for this year.

Operations Versus Budget:
The process of loading the detailed budget into Intacct is still not complete. After Six Months Net Revenues are at $45,219,062 and with Bond Support at $716,647 resulting in Net Operating Revenues of $45,935,709 versus a budget of $46,258,380, ($322,751) behind plan.

Salary expenses are $15,547,841 versus a budget of $15,080,894; ($466,947) behind plan.
Total Operating Expenses are $45,266,315 versus a budget of $45,542,028; $275,713 ahead of plan.
Operating Income (Loss) is ($47,253) versus a budget of $715,352.

Interest Income is ahead of plan at $335,113 versus the budget of $211,726; ahead of plan $123,387
Medical Office Building (net) is behind plan with a loss of ($3,445,683) versus a budget of ($2,490,490).
Overall Net Income is at $198,943 versus a budget of $1,272,588 when the budget is adjusted to reflect the receipt of the Prime Grant in December, 2018.

Northern Inyo Healthcare District
Preliminary Income Statement - Detail
As of December 31, 2018

	Month To Date 12/31/2018	Month To Date 11/30/2018	Year To Date 12/31/2018	Year To Date 12/31/2017
Inpatient Revenue	2,742,456	3,605,529	19,586,134	22,071,015
Outpatient Revenue	8,128,750	8,633,604	54,218,328	50,868,453
Clinic (RHC) Revenue	522,842	428,393	1,184,319	0
Total Gross Patient Service Revenue	11,394,049	12,667,526	74,988,780	72,939,467
Deductions from Revenue	(5,831,072)	(6,207,004)	(37,753,788)	(33,427,594)
Total Net Patient Revenue	5,562,977	6,460,523	37,234,992	39,511,873
Medicare Settlement Income/Expense	329,140	329,140	658,280	1,218,763
Disproportionate Share Income/Loss	0	0	2,471,502	1,715,636
Other Operating Revenue	984,592	1,327,124	4,854,288	207,499
Gross Operating Revenue	6,876,709	8,116,787	45,219,062	42,653,770
Operating Expenses				
Salary	3,173,378	2,770,191	15,547,841	12,773,366
Benefits	1,326,891	1,702,217	10,163,348	9,563,825
Non-Benefit Expenses	16,037	13,369	89,329	98,493
Professional Fees	738,879	723,504	6,036,046	6,144,967
Supplies	519,841	689,072	4,460,703	4,316,151
Contract Services	583,092	428,657	2,498,168	768,182
Other Department Expenses	92,968	70,761	493,764	353,022
Hospital Insurance Expenses	33,687	33,687	272,654	178,578
Utilities	118,397	105,693	802,027	685,949
Depreciation and Amortization	343,692	343,699	2,052,388	2,451,230
Repairs and Maintenance	13,802	29,540	296,927	999,774
Leases and Rental Expenses	67,640	42,594	417,211	492,083
Other Fees	50,833	122,921	726,012	635,992
Interest Expense - Operating	231,952	232,777	1,409,897	1,507,816
Total Operating Expenses	7,311,089	7,308,683	45,266,315	40,969,427
Total Net Operating Profit (Loss)	(434,380)	808,104	(47,253)	1,684,343
Non-Operating Revenue				
Other Income				
Tax Payer General Support	48,743	48,743	292,458	262,768
Bond/ Tax Payer Bond Support	112,498	137,596	716,647	771,881
Interpreter Services Revenue	0	17,827	17,827	0
Fin Chgs-Pt Ar - Int Incm-Payors	118	408	8,771	35,905
Interest Income	59,151	50,952	335,113	143,292
Total Other Income	220,511	255,526	1,370,816	1,213,846
Grant Revenue	1,980,000	0	2,035,716	1,224,328
Other Non-Operating Income	7,364	1,960	19,628	9,888
Net Medical Office Activity	(696,836)	(486,635)	(3,445,683)	(2,038,939)
340b Net Activity	11,896	162,854	241,345	(3,251)
Donations	0	0	3,300	0
Rental Income	4,303	0	15,995	27,035
Gain/Loss on Sale of Assets	2,142	(619)	5,081	0
Total Non-Operating Revenue	1,529,379	(66,914)	246,196	432,908
Total Net Income	1,094,999	741,227	198,943	2,117,251

Northern Inyo Healthcare District
Preliminary Balance Sheet
As of December 31, 2018

	Month Ending 12/31/2018 Actual
Assets	
Current Assets	
Cash and Liquid Capital	4,093,204.77
Short Term Investments	10,750,151.03
PMA Partnership	379,758.00
Accounts Receivable, Net of Allowance	
Accounts Receivable	71,256,344.23
Allowances against Receivables	52,868,725.69
NIA Accrued Allowances	
NIA Accrued Allowances	298,874.84
Total NIA Accrued Allowances	298,874.84
Total Accounts Receivable, Net of Allowance	18,088,743.70
Other Receivables	4,745,380.06
Short Term Notes Receivable	(6.00)
Inventory	3,759,004.65
Prepaid Expenses	1,973,715.44
Total Current Assets	43,789,951.65
Assets Limited as to Use	
Internally Designated for Capital Acquisitions	1,098,765.26
Short Term - Restricted	1,585,470.45
Limited Use Assets	
DC Pension	2,189,400.49
DB Pension	13,547,735.00
PEPRA	2,967.70
Total Limited Use Assets	15,740,103.19
Revenue Bonds Held by a Trustee	3,736,309.16
Total Assets Limited as to Use	22,160,648.06
Long Term Assets	
Long Term Investment	1,054,166.52
Fixed Assets, Net of Depreciation	
Fixed Assets	124,556,671.63
Accumulated Depreciation	47,785,716.13
Construction in Progress	972,229.75
Total Fixed Assets, Net of Depreciation	77,743,185.25
Total Long Term Assets	78,797,351.77
Total Assets	144,747,951.48
Liabilities	
Current Liabilities	
Current Maturities of Long-Term Debt	811,088.92
Accounts Payable	1,581,007.41
Accrued Payroll and Related	8,502,839.88
Accrued Interest and Sales Tax	276,002.69
Unearned Revenue	362,345.64
Due to 3rd Party Payors	1,239,094.96
Due to Specific Purpose Funds	108,883.52
Other Deferred Credits - Pension	4,059,539.70
Total Current Liabilities	16,940,802.72
Long Term Liabilities	
Long Term Debt	41,839,947.15
Bond Premium	508,144.74
Accreted Interest	12,856,971.50
Other Non-Current Liability - Pension	31,778,171.00
Total Long Term Liabilities	86,983,234.39
Suspense Liabilities	1,644,212.49
Total Liabilities	105,568,249.60
Fund Balance	
Fund Balance	36,499,232.23
Temporarily Restricted	1,585,470.45
Net Income	1,094,999.20
Total Fund Balance	39,179,701.88
Liabilities + Fund Balance	144,747,951.48

Northern Inyo Hospital District
Cash Flow Statement
As of December 31, 2018

	Month To Date 12/31/2018 Actual	Year To Date 12/31/2018 Actual
Changes in Cash from Operating Activities		
Operations		
Net Income Less Items not Requiring Cash	1,436,549.70	2,261,933.70
Total Operations	1,436,549.70	2,261,933.70
Accounts Receivable	(3,032,667.00)	(10,676,656.07)
Allowances against Receivable	1,875,184.01	6,501,246.26
Other Receivables	614,566.85	(1,209,556.29)
Employee Advances	0.00	6.00
Inventory	(225,221.69)	(508,603.70)
Accounts Payable	(814,133.99)	(1,313,989.58)
Accrued Payroll and Related	(75,074.94)	2,351,487.83
Other Accrued Liabilities	696,699.34	2,007,456.95
Total Changes in Cash from Operating Activities	475,902.28	(586,674.90)
Changes in Cash from Investing Activities		
Short Term Investments		
ST Investment - LAIF	3,109,692.83	5,109,177.22
Total Short Term Investments	3,109,692.83	5,109,177.22
Construction in Progress	(6,452.99)	(243,376.48)
Purchase of Fixed Assets	(620.76)	(2,148,968.65)
Items Not Requiring Cash in Current Period	(341,550.50)	(2,047,307.14)
Accumulated Depreciation and Amortization	343,692.00	2,052,387.64
Uncategorized Assets		
DC Pension	(109,411.33)	(648,327.77)
Equipment Interest	0.00	(95.00)
LT Investments - LT Portion	(2,423.00)	493,455.00
Rev Bond - Reserve Account	(370.75)	(1,316.61)
Rev Bond - Revenue Fund	(62,923.46)	(373,842.06)
2010 Rev Bond - Reserve Account	(1,364.96)	(6,150.08)
2010 Rev Bond - Revenue Fund	(99,267.85)	(609,174.80)
2013 Rev Bond - Bond Premium	(1,254.44)	(7,526.64)
05 Bond 09 Issue - Bond Premium	(3,137.07)	(18,822.42)
Total Uncategorized Assets	(280,152.86)	(1,171,800.38)
Total Changes in Cash from Investing Activities	2,824,607.72	1,550,112.21
Changes in Cash from Financing Activities		
Short Term Notes Payable	122,657.92	(438,064.97)
Long Term Notes Payable	110,548.75	(61,707.50)
Total Changes in Cash from Financing Activities	233,206.67	(499,772.47)
Increase (Decrease) in Cash	3,533,716.67	463,664.84
Cash, Beginning Period	559,488.10	3,629,539.93
Cash, Ending Period	4,093,204.77	4,093,204.77