Northern Inyo County Local Hospital District

Board of Directors Regular Meeting

Wednesday October 16, 2013; 5:30pm

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

DRAFT AGENDA

NORTHERN INYO COUNTY LOCAL HOSPITAL DISTRICT
BOARD OF DIRECTORS MEETING
October 16, 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 the minutes of the September 18, 2013 regular meeting (*action item*)
4. Approval of the following financial and statistical reports: (*action item*)
   - Capital Expenditures/Investments as of June 30, 2013
   - Financial and statistical reports for the month of July, 2013
   - Financial and statistical reports for the month of August, 2013
5. Security report for July and August 2013 (*information item*).

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6. Administrator's Report; John Halfen.
   A. Physician Recruiting Update
   B. NRACO Update
   C. High Performing Hospitals
7. Chief of Staff Report; Thomas Boo, M.D.
   A. Policy and Procedure approvals (*action items*):
      1. *Injury and Illness Prevention Program*
      2. *Monitoring and Documentation of Weekly Fluoroscopic QC*
   B. NIH Privilege for Radiologists: *Radiofrequency Ablation* (*action item*).
   C. Voluntary Resignation of Privileges: Natalia Zarzhevsky, M.D. (*action item*).
   D. Changes to Medical Executive Committee Leadership (*information item*)
8. Old Business
   A. Chief Executive Officer Search Committee update (*information item*).
   B. Tahoe Carson Radiology contract change (*action item*).
   C. Tahoe Carson Radiology request for additional credentialing of physicians (*action item*).
   D. Hospitalwide Policy and Procedure approval, *Communicating Protected Health Information Via Electronic Mail (Email)* (*action item*).
   E. Approval of revised Private Practice Physician Income Guarantee and Practice Management

Agreement with Richard Meredick, M.D. (*action item*).

F. Approval of changes made to District Personnel Policy regarding Job Protected Leave (*action item*).

9. New Business
   - A. Policy and Procedure manual annual approval, Biomedical Services (*action item*).
   - B. Approval of changes to Private Practice Physician Income Guarantee and Practice Management Agreement with Mark Robinson, M.D., Medical Director of Orthopedic Services (*action item*).
10. Reports from Board members on items of interest.
11. Opportunity for members of the public to comment on any items on this Agenda, and/or on any items of interest.
12. Adjournment to closed session to:
    - A. Confer with legal counsel regarding pending litigation based on stop notice filed by Strocal, Inc. (Government Code Sections 910 et seq., 54956.9).
    - 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 (pursuant to Government Code Section 54957).
    - E. Confer with legal counsel regarding a claim filed by Tami Matteson against Northern Inyo County Local Hospital District. This portion of the closed session is authorized by Government Code Section 54956.9(a).
13. Return to open session, and report of any action taken in closed session.
14. Opportunity for members of the public to address the Board of Directors on items of interest.
15. Adjournment.

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CALL TO ORDER	The meeting was called to order at 5:30 pm by John Ungersma, M.D., President.
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	John Halfen, Hospital Administrator Douglas Buchanan, District Legal Counsel Sandy Blumberg, Executive Assistant
OPPORTUNITY FOR PUBLIC COMMENT	Doctor Ungersma asked if any members of the public wished to comment on any items listed on the agenda for this meeting, or on any items of interest. No comments were heard.
CLOSED SESSION	At 5:32 p.m. Doctor Ungersma reported the meeting would adjourn to closed session to allow the Board of Directors to 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).
RETURN TO OPEN SESSION AND REPORT OF ACTION TAKEN	At 6:14 p.m. the meeting returned to open session. Doctor Ungersma reported that the Board took no reportable action.
AFFILIATION AGREEMENT WITH RENOWN HOSPITAL	Mr. Halfen called attention to a proposed Affiliation Agreement with Renown Hospital in Reno Nevada. He explained that with Accountable Care Organization (ACO) development and healthcare reform looming in our immediate future, it is in the Hospital's best interest to develop a stronger relationship with our nearest major medical facility for resource and referral purposes. Mr. Halfen additionally stated that regardless of whether or not the National Rural Accountable Care Organization (NRACO) we are affiliated with at this time is successful, some of our Medicare beneficiaries will drop out of the system and go to Renown for services. Mr. Halfen also stated that establishing affiliation agreements is common practice, and in the future it will be important for Northern Inyo Hospital (NIH) to align itself with a larger facility in a mutual effort to provide quality care for our patients. He additionally stated that he will request two changes be made to the proposed Affiliation Agreement, the first being that the stipend NIH will pay to Renown is reduced from $5,000 per month to $2,500 until such time as we determine the degree to which we will rely on Renown for services. The second change he will request is to add compliance referral to the list of services available to NIH through Renown. Bill Gordon with Renown Hospital was present in order to answer questions, and he stated that those two changes will be

acceptable to Renown. Mr. Halfen also stated that NIH already has a good working relationship with Renown, citing their practice of allowing our patients to be transferred to their facility for care before proof of ability to pay has been established. He also noted that Renown has provided us with a temporary OB physician in the past, when we found ourselves in need of additional coverage. The new affiliation agreement will strengthen our existing relationship and provide additional support services including borrowing medical equipment when necessary. Mr. Gordon also noted that the agreement contains no requirement for NIH to refer patients to Renown, and the proposed agreement is easy to terminate if we wish to do so in the future. Following review of the agreement provided it was moved by D. Scott Clark, M.D., seconded by M.C. Hubbard, and (unanimously) passed to approve the proposed Affiliation Agreement with Renown Hospital as requested, including the two changes suggested by Mr. Halfen.

CONSENT AGENDA

The proposed consent agenda for this meeting contained the following items:

1. Annual Policy and Procedure manual approval (35 manuals) (*action item*)
2. Approval of the minutes of the July 17, 2013 regular meeting (*action item*)
3. Security report for June 2013 (*information item*)
4. Approval of Hospitalist Agreement with Mark McDowell, M.D. (*action item*)
5. Approval of Hospitalist Agreement with Shawn Rosen, M.D. (*action item*)
6. Hospitalist Director Agreement with Tom Boo, M.D. (*action item*)

It was moved by Ms. Hubbard, seconded by Denise Hayden, and passed to approve the proposed consent agenda items as presented.

ADMINISTRATORS REPORT

NRACO UPDATE

Mr. Halfen reported that the NRACO has been accepted as a functioning ACO, and he will attend the first meeting of the Board of Directors in two weeks. He additionally reported that the District will be working with two Health Information Exchanges (HIE's) in order to provide services.

PHYSICIAN RECRUITING UPDATE

Mr. Halfen also reported that Shawn Rosen, M.D. is now working in the practice of Doctors Kamei, Hathaway, and Englesby on a trial basis. Orthopedic surgeon Richard Meredick M.D. also plans to relocate to this area in the next couple of months, and we are currently working with him to prepare for the equipment requirements of his practice.

BETA HEALTHCARE CREDIT

Mr. Halfen additionally stated that the District recently received a $2,500 payment from Beta Healthcare for the Performance Improvement efforts of the NIH Emergency Department.

CHIEF OF STAFF REPORT

Immediate Past Chief of Staff Robbin Cromer-Tyler M.D. reported that following careful review and consideration by the appropriate Committees, the Medical Executive Committee recommends the appointment and privileging of the following physicians:

A. Sierra Bourne, M.D., Emergency Medicine
B. Joy Engblade, M.D., Internal Medicine/Hospitalist
C. Anne Gasior, M.D. Family Medicine/Hospitalist
D. Kristina Jong, M.D., Radiologist/Breast Imaging Sub-Specialist
E. Shawn Rosen, M.D., Internal Medicine/Hospitalist

Doctor Cromer-Tyler also stated that the Medical Executive Committee recommends approval of Ellen Roza, P.A. to function under the approved NIH protocol *Physician Assistant in the Operating Room* and according to the *Delegations of Services Agreement* with supervising physician Mark K. Robinson, M.D.. She additionally stated that the Committee recommends acceptance of the resignation of Shiva Shabnam, M.D. from the NIH Medical Staff, and that they also recommend approval of the following hospital wide policies and procedures:

1. *Reporting Vaccine Adverse Events*
2. *Cytology Workload*
3. *Haloperidol Usage*
4. *Timing of Medication Administration*
5. *Intravenous Medication Policy*

Following review of the information provided it was moved by Ms. Hayden, seconded by Peter Watercott, and passed to approve all four Medical Staff agenda items as requested.

OLD BUSINESS

CEO SEARCH COMMITTEE REPORT

The District's Chief Executive Officer (CEO) recruiter, Mr. Don Whiteside was present to provide an update on the current CEO search. He reported that the CEO Search Committee has met to review a list of 10 possible candidates for the job, a group that has been narrowed down from an original applicant pool of nearly 40 candidates. The CEO Search Committee has selected 5 (or possibly 6) candidates who will come on site for a first interview. Mr. Whiteside commented that our recruitment efforts have attracted a solid group of candidates who are highly qualified individuals, and he feels confident that at least one of them will meet our expectations for the next Hospital CEO.

NEW BUSINESS

NO SMOKING SIGNS FOR THE HEALING GARDEN

NIH Marketing Director Angie Aukee called attention to proposed "No Smoking" signs for the Hospital's Healing Garden. She also called attention to a proposed sign that informs the public that the Healing Garden was created as a result of the fundraising efforts of the NIH Foundation, race director Marie Boyd, and from proceeds donated from the Bishop High Sierra Ultramarathon. Smoking in the Healing Garden, which is located within 50 feet of the Hospital building, has recently become an issue, prompting requests to post 'no smoking' signage. District Legal Counsel Doug Buchanan stated that the wording regarding smoking being "prohibited" cannot be stated on the signs. Following

brief discussion it was moved by Mr. Watercott, seconded by Ms. Hayden, and passed to approve the signs for the NIH Healing Garden, minus the wording that smoking in the area is "prohibited".

VENTILATOR PURCHASE FOR RESPIRATORY THERAPY

Mr. Halfen called attention to a request for ratification of the purchase of a Puritan Bennett 840 Ventilator for the Respiratory Therapy (R.T.) Department. R.T. Director Kevin Christensen stated that one of the ventilators currently in use in the department is 26 years old, and its' manufacturer is no longer supporting repairs for that equipment. It was moved by Ms. Hayden, seconded by Mr. Watercott, and passed to ratify the purchase of the Puritan Bennett 840 Ventilator for use in the RT Department as requested.

AGREEMENTS FOR JOY ENGBLADE M.D. AND SHAWN ROSEN M.D.

Mr. Halfen also called attention to proposed *Private Practice Income Guarantee and Practice Management Agreements* for Doctors Joy Engblade and Shawn Rosen, as well as a *Relocation Expense Agreement* for Dr. Engblade. Doctors Engblade and Rosen will join the practice of Doctors Kamei, Hathaway, and Englesby, and will also assist with NIH hospitalist rotations. It was moved by Doctor Clark, seconded by Ms. Hubbard and passed to approve all three agreements as requested.

EMPLOYEE DISCOUNT POLICY

Controller Carrie Petersen called attention to a proposed employee discount policy that would allow NIH employees covered under the hospital's medical benefit plan (and their covered beneficiaries) to be entitled to a 50 percent discount off the "covered" out-of-pocket medical expense for services received at Northern Inyo Hospital. Following brief discussion it was moved by Ms. Hubbard, seconded by Dr. Clark, and passed to approve the proposed employee discount for covered hospital employees, with Ms. Hayden and Mr. Watercott abstaining from the vote.

DONATION PLAQUE FOR THE HOSPITAL LOBBY

Mr. Halfen called attention to a proposed donation plaque dedicating the new NIH hospital lobby in recognition of Kathy Sherry and John Hawes with Turner Construction. The plaque recognizes their efforts and countless hours of dedication to the successful completion of the hospital rebuild project. It was moved by Doctor Clark, seconded by Mr. Watercott, and passed to approve the dedication plaque for the new hospital lobby as requested.

TAHOE CARSON RADIOLOGY

Members of the Tahoe Carson Radiology (TCR) group were present to discuss why they believe their current contract with NIH should remain intact. Dr. David Landis spoke to the fact that TCR has a history of providing satisfactory radiology coverage for the hospital, stating that until recently the group was unaware of the NIH Medical Executive Committee's level of dissatisfaction with their services. Discussion followed, including comments from physicians and management of TCR, as well as some input from NIH physicians who were unaware that we are considering termination of TCR's services. Several people spoke on

behalf of TCR Radiologist Natalia Zarzchevsky, and comments were also heard regarding the opinion that most of the problems with the group might be considered to be largely administrative in nature. Discussion also included a review of the services TCR provides, including the Saturday clinic and procedures performed by Dr. Thomas McNamara. At the end of discussion on this topic, Doctor Ungersma announced that action on this agenda item will be tabled to the open session that will follow the 2nd closed session of this meeting.

REVIEW OF JOB PROTECTED LEAVE RECOMMENDATIONS OF THE PPAC COMMITTEE

NIH Surgery Tech Nita Eddy addressed the Personnel Payroll Advisory Committee's (PPAC) recommendations to the Board of Directors on the subject of employee Job Protected Leave. Ms. Eddy explained the tremendous amount of work the PPAC committee has done in an effort to reach an agreement between Administration and hospital employees on this subject, and she reviewed the process the PPAC committee has used to gather employee input on this topic. A cost analysis on the suggestions being made by PPAC has been done, and everyone involved understands the importance of the financial considerations involved in this decision. Ms. Eddy stated that the key issues for the employees are: having an adequate amount of job protected leave; employees maintaining health insurance coverage at a reasonable rate while on leave; and recognition of the value of long term employees when considering their amount of allowed job protected leave (JPL). PPAC proposes a sliding scale of up to 28 weeks of leave, depending on the years of service of the employee. Mr. Halfen suggested the possibility of guaranteeing employees on leave "a job" rather than their previous job if they return to work following more than a 16 week absence. He explained that especially in the case of licensed positions, it is difficult for managers to operate and still keep a position open for an employee who is on an extended leave of absence. Radiology Director Patty Dickson, the management representative on the PPAC committee, stated she would like to present Mr. Halfen's proposed change to the group of people she represents prior to the vote on this subject. Following further discussion it was decided that a Special Meeting of the Board of Directors will be convened for the purpose of making a decision on this issue, to allow PPAC representatives time to convey Mr. Halfen's new proposal to the employees they represent and obtain their feedback. The Board commended the PPAC committee on the countless hours of time they have spent on this issue, in the interest of their fellow NIH employees.

PERSONNEL POLICY AMENDMENT REGARDING EMPLOYEE ASSISTANCE

Human Resources Director Georgan Stottlemyre called attention to proposed changes to the Employee Assistance portion of the NIH Personnel Policy, which would update the policy to actual on the subject of employee advocacy. It was moved by Ms, Hubbard, seconded by Doctor Clark, and passed to approve the Employee Assistance section of the Personnel Policy as requested, with Ms. Hayden and Mr. Watercott abstaining from the vote.

INFORMATION TECHNOLOGY POLICY AND PROCEDURE APPROVALS

Information Technology (IT) Director Adam Taylor called attention to the following proposed policies and procedures regarding computer security:

- *Password Policy*
- *Device Encryption Policy*
- *Communicating Protected Health Information Via Electronic Mail (Email)*

Following discussion of these three policies, it was decided that clarification is needed on two of the policies; however the *Device Encryption Policy* is acceptable as presented. It was moved by Mr. Watercott, seconded by Ms. Hayden and passed to approve the *Device Encryption Policy* as presented. Approval of the policies titled *Password Policy* and *Communicating Protected Health Information Via Electronic Mail (Email)* will be tabled to a future meeting of the District Board.

PENSION PLAN FOR NEW EMPLOYEES

Mr. Halfen called attention to a correspondence from pension attorneys Best Best & Krieger regarding establishment of a Section 401(a) retirement plan for hospital employees hired January 1, 2013 or later. Mr. Halfen explained that passage of the Public Employees Pension Reform Act (PEPRA) requires that any defined benefit plan involve an employee contribution of up to 50% of the benefit of the plan. The hospital is required to alter its existing employee pension plan for employees hired on or after January 1 2013 to include a defined benefit contribution plan, the details of which are spelled-out in this correspondence. The proposed plan will not do away with or nullify Social Security benefits for hospital employees, and an attempt is being made to change the existing pension plan as little as possible in order to bring it into compliance with the new federal regulations. Following review of the information provided, it was moved by Doctor Clark, seconded by Ms. Hubbard, and passed to approve the proposed revised pension plan for employees hired January 1 2013 and later, as requested.

BOARD MEMBER REPORTS

Doctor Ungersma asked if any members of the Board of Directors wished to report on any items of interest. No reports were heard.

OPPORTUNITY FOR PUBLIC COMMENT

Doctor Ungersma again asked if any members of the public wished to comment on any items on this Agenda, or on any items of interest. TCR Radiologist Thomas McNamara, M.D. spoke on behalf of the Tahoe Carson Radiology group, stating that it is a privilege for the group to practice here. He additionally stated his belief that the TCR group is made up of an unusually high quality group of physicians, which is very hard to come by. He suggested that if problems exist in the relationship between TCR and NIH, those problems should be worked on rather than simply terminating the agreement. He additionally stated his impression that most of the NIH Medical Staff was unaware of the movement to terminate the TCR contract. Dr. McNamara suggests that TCR and NIH work on resolving their differences for a period of at least one month.

CLOSED SESSION

At 8:17 p.m. Doctor Ungersma reported the meeting would adjourn to closed session to allow the Board of Directors to:

A. Confer with legal counsel regarding pending litigation based on stop notice filed by Strocal, Inc. (Government Code section 910 et seq., 54956.9).
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 (pursuant to Government Code Section 54957).
E. Confer with legal counsel regarding a claim filed by Tami Matteson against Northern Inyo County Local Hospital District. This portion of the closed session is authorized by Government Code section 54956.9(a).

RETURN TO OPEN SESSION AND REPORT OF ACTION TAKEN

At 9:40 p.m. the meeting returned to open session. Doctor Ungersma reported that the Board took the following (2) reportable actions:

- A proposed settlement with Turner Construction and Strocal Inc. has been approved
- At the request of the claimant, discussion of the claim filed by Tami Matteson will be tabled to the October regular meeting of the District Board.

TAHOE CARSON RADIOLOGY AGENDA ITEMS

Doctor Ungersma then recommended that the Tahoe Carson Radiology agenda items be tabled to the October meeting of the District Board. It was moved by Ms. Hubbard, seconded by Ms. Hayden, and passed to table the TCR agenda items to the October regular meeting of the District Board.

OPPORTUNITY FOR PUBLIC COMMENT

Doctor Ungersma again asked if any members of the public wished to comment on any items listed on the agenda for this meeting. TCR Radiologist Natalia Zarzhevsky M.D. thanked the Board for tabling the TCR matter to the next meeting, and asked if TCR is free to meet with the Medical Executive Committee prior to the next Board meeting. Doctor Ungersma responded that the radiology group is welcome to approach the Medical Executive Committee on this matter.

The meeting was adjourned at 9:49 p.m..

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John Ungersma, M.D., President — Denise Hayden, Secretary

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

MONTH APPROVED BY BOARD	DESCRIPTION OF APPROVED CAPITAL EXPENDITURES		AMOUNT
FY 2011-12	Transport Monitor for PACU to be purchased by NIH Auxillary Donation		15,000 *
	Additional Coppper and Fiberoptic Cable		29,884
	Paragon Physician Documentation Module		137,254
	Ultrasound Machine		165,694 *
	AMOUNT APPROVED BY THE BOARD IN THE PRIOR FISCAL YEARS TO BE EXPENDED IN THE CURRENT FISCAL YEAR		347,832
FY 2012-13	Breast Ultrasound	GE Capital Lease	200,000
	Digital Radiography Upgrade to Radiology Room 2		108,000 *
	Zimmer Orthopedic Power Equipment		44,115
	Invivo HD 8ch Foot/Ankle Coil for MRI		41,600 *
	Magnitude Outdoor Walk-in Freezer		48,256 *
	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
	GE Logic E9 Ultrasound Machine		159,122
	AMOUNT APPROVED BY THE BOARD IN THE CURRENT FISCAL YEAR TO BE EXPENDED IN THE CURRENT FISCAL YEAR		896,333

Amount Approved by the Board in Prior Fiscal Years to be Expended in the Current Fiscal Year	347,832
Amount Approved by the Board in the Current Fiscal Year to be Expended in the Current Fiscal Year	896,333
Year-to-Date Board-Approved Amount to be Expended	1,244,165
Year-to-Date Administrator-Approved Amount	1,286,376 *

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

MONTH APPROVED BY BOARD	DESCRIPTION OF APPROVED CAPITAL EXPENDITURES	AMOUNT
	Actually Expended in Current Fiscal Year	197,856 *
	Year-to-Date Completed Building Project Expenditures	0 *
	TOTAL FUNDS APPROVED TO BE EXPENDED	2,728,396
	Total-to-Date Spent on Incomplete Board Approved Expenditures	0

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	1,484,232
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	1,244,165
	2,728,396

Donations by Auxiliary	For 2012 Asset receive 2013	
Donations by Hospice of the Owens Valley		
+Tobacco Funds Used for Purchase		60,000
		0
		0
		0
		60,000

*Completed Purchase

(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 June 30, 2013

Administrator-Approved Item(s)	Department	Amount	Month Total	Grand Total
Cannon Image Runner C7260	IT	22,035		
Cannon Image Runner 6265	IT	13,030		
Braco CD Publisher	RADIOLOGY	3,645		
Ergotron WOW Cart	IT	8,564		
MONTH ENDING JUNE 30, 2013			47,274	**1,286,376**

Investments as of 6/30/2013

	Purchase Dt	Maturity Dt	Institution	Broker	Rate	Principal
1	6/2/2013	7/1/2013	LAIF (Walker Fund)	Northern Inyo Hospital	0.24%	321,871.51
2	6/2/2013	7/1/2013	Local Agency Investment Fund	Northern Inyo Hospital	0.24%	5,500,886.67
3	6/2/2013	7/1/2013	Multi-Bank Securities	Multi-Bank Service	0.01%	2,572,436.62
4	5/20/2010	5/20/2015	First Republic Bank-Div of BOFA	Financial Northeaster Corp.	3.10%	100,000.00
			Total			**$8,495,194.80**

Northern Inyo Hospital
Balance Sheet
For Period: 1-2014 (07/01/2013 - 07/31/2013)

	YTD Balance
Current Assets:	
Cash and Equivaliants	$1,589,827
Short-Term Investments	$8,398,431
Assets Limited as to Use	$0
Plant Replacement and Expansion Fund	$2
Other Investments	$1,178,290
Patient Receivable	$39,387,739
Less: Allowances	$-28,307,068
Other Receivables	$744,818
Inventories	$2,988,124
Prepaid Expenses	$1,204,951
Total Current Assets	$27,185,114
Internally Designated for Capital Acquistions	$951,626
Special Purpose Assets	$758,961
Revenue Bonds Held by a Trustee	$2,944,778
Less Amounts Required to Meet Current Obligations	$0
Assets Limited as to use	$4,655,366
Long Term Investments	$100,000
Property & equipment, net Accumulated Depreciation	$88,985,633
Unamortized Bond Costs	$718,680
Total Assets	$121,644,792

Northern Inyo Hospital
Balance Sheet
For Period: 1-2014 (07/01/2013 - 07/31/2013)

	YTD Balance
Liabilities and Net Assets	
Current Liabilities:	
Current Maturities of Long-Term Debt	$-2,270,286
Accounts Payable	$-1,937,833
Accured Salaries, Wages & Benefits	$-4,624,525
Accrued Interest and Sales Tax	$-615,965
Deferred Income	$-482,884
Due to 3rd Party Payors	$-1,891,874
Due to Specific Purpose Funds	$-58,539
Total Current Liabilites	$-11,881,906
Long Term Debt, Net of Current Maturities	$-52,945,620
Bond Premium	$-1,400,407
Total Long Term Debt	$-54,346,027
Net Assets	
Unrestricted Net Assets	$-54,657,898
Tempororily Restricted	$-758,961
Net Income	
Total Net Assets	$-55,416,859
Total Liabilities and Net Assets	$-121,644,792

Statement of Operation
Monthly Statement of Operations
For Period: 1-2014 (07/01/2013 - 07/31/2013)

	July	MTD Budget	MTD Variance	Actual YTD	YTD Budget	YTD Variance
Unrestricted Revenues, Gains & Other Support						
Inpatient Service Revenue						
Ancillary	401,739	603,026	(201,287)	401,739	603,026	(201,287)
Routine	1,873,807	2,360,430	(486,623)	1,873,807	2,360,430	(486,623)
Total Inpatient Service Revenue	2,275,546	2,963,456	(687,910)	2,275,546	2,963,456	(687,910)
Outpatient Service Revenue	6,513,777	6,068,891	444,886	6,513,777	6,068,891	444,886
Gross Patient Service Revenue	8,789,323	9,032,347	(243,024)	8,789,323	9,032,347	(243,024)
Less Deductions from Revenue						
Patient Service Revenue Deductions	(265,581)	(207,934)	(57,647)	(265,581)	(207,934)	(57,647)
Contractual Adjustments	(3,031,746)	(3,269,228)	237,482	(3,031,746)	(3,269,228)	237,482
Prior Period Adjustments	4	126,162	(126,158)	4	126,162	(126,158)
Total Deductions from Patient Service Revenue	(3,297,323)	(3,351,000)	53,677	(3,297,323)	(3,351,000)	53,677
Net Patient Service Revenue	5,492,000	5,681,347	(189,347)	5,492,000	5,681,347	(189,347)
Other revenue	5,811	87,131	(81,320)	5,811	87,131	(81,320)
Transfers from Restricted Funds for Operating Exp	87,043	136,658	(49,615)	87,043	136,658	(49,615)
Total Other Revenue	92,854	223,789	(130,935)	92,854	223,789	(130,935)
Expenses:						
Salaries and Wages	1,732,805	1,879,578	(146,773)	1,732,805	1,879,578	(146,773)
Employee Benefits	1,108,927	1,162,747	(53,820)	1,108,927	1,162,747	(53,820)
Professional Fees	765,298	464,012	301,286	765,298	464,012	301,286
Supplies	609,382	508,515	100,867	609,382	508,515	100,867
Purchased Services	81,147	262,914	(181,767)	81,147	262,914	(181,767)
Depreciation	293,555	438,217	(144,662)	293,555	438,217	(144,662)
Interest Expense	196,417	219,531	(23,114)	196,417	219,531	(23,114)
Bad Debts	397,682	242,081	155,601	397,682	242,081	155,601
Other Expense	360,198	325,922	34,276	360,198	325,922	34,276
Total Expenses	5,545,411	5,503,517	41,894	5,545,411	5,503,517	41,894
Operating Income (Loss)	39,443	401,619	(362,176)	39,443	401,619	(362,176)
Other Income:						
District Tax Receipts	43,899	43,210	689	43,899	43,210	689
Partnership Investment Incomce		0	0		0	0
Grants and Other Contributions Unrestricted		6,196	(6,196)		6,196	(6,196)
Interest Income	10,625	975	9,650	10,625	975	9,650
Other Non-Operating Income	5,326	12,882	(7,556)	5,326	12,882	(7,556)
Net Medical Office Activity	(235,365)	(349,975)	114,610	(235,365)	(349,975)	114,610
340B Net Activity	37,762	52,408	(14,646)	37,762	52,408	(14,646)
Non-Operating Income/Loss	(137,753)	(234,304)	96,551	(137,753)	(234,304)	96,551
Net Income/Loss	(98,311)	167,315	(265,626)	(98,311)	167,315	(265,626)

Northern Inyo Hospital
Monthly Report of Capital Expenditures
Fiscal Year Ending JUNE 30, 2013
As of July 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	158,020 *
	AMOUNT APPROVED BY THE BOARD IN THE PRIOR FISCAL YEARS TO BE EXPENDED IN THE CURRENT FISCAL YEAR		858,213
FY 2013-14			
	AMOUNT APPROVED BY THE BOARD IN THE CURRENT FISCAL YEAR TO BE EXPENDED IN THE CURRENT FISCAL YEAR		0
	Amount Approved by the Board in Prior Fiscal Years to be Expended in the Current Fiscal Year		858,213
	Amount Approved by the Board in the Current Fiscal Year to be Expended in the Current Fiscal Year		0
	Year-to-Date Board-Approved Amount to be Expended		506,493
	Year-to-Date Administrator-Approved Amount		36,106 *
	Actually Expended in Current Fiscal Year		351,720 *
	Year-to-Date Completed Building Project Expenditures		0 *
	TOTAL FUNDS APPROVED TO BE EXPENDED		894,319
	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 July 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		387,826
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		506,493
		894,319
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 July 30, 2013

Administrator-Approved Item(s)	Department	Amount	Month Total	Grand Total
3M Codefinder Software	Medical Records	4,796		
3M Coding Reference Software	Medical Records	2,865		
3M Coding Reference Software Plus	Medical Records	2,824		
3M APCfinder Software	Medical Records	2,637		
3M DRGFinder Software	Medical Records	1,679		
3M HCPCS/CPTfinder Software	Medical Records	2,398		
3MClinical Analyzer Software	Medical Records	3,021		
Foldable Tube f170/f260	Surgery	14,586		
National 430 Food Machine	Dietary	1,300		
MONTH ENDING JULY 31, 2013			**36,106**	**36,106**

Northern Inyo Hospital
Balance Sheet
For Period: 2-2014 (08/01/2013 - 08/31/2013)

	YTD Balance
Current Assets:	
Cash and Equivaliants	$-723,988
Short-Term Investments	$7,398,453
Assets Limited as to Use	$0
Plant Replacement and Expansion Fund	$2
Other Investments	$1,178,290
Patient Receivable	$41,601,761
Less: Allowances	$-29,396,619
Other Receivables	$711,314
Inventories	$2,992,459
Prepaid Expenses	$1,140,854
Total Current Assets	$24,902,526
Internally Designated for Capital Acquistions	$951,665
Special Purpose Assets	$817,500
Revenue Bonds Held by a Trustee	$3,114,455
Less Amounts Required to Meet Current Obligations	$0
Assets Limited as to use	$4,883,620
Long Term Investments	$674,564
Property & equipment, net Accumulated Depreciation	$88,765,306
Unamortized Bond Costs	$714,539
Total Assets	$119,940,555

Northern Inyo Hospital
Balance Sheet
For Period: 2-2014 (08/01/2013 - 08/31/2013)

	YTD Balance
Liabilities and Net Assets	
Current Liabilities:	
Current Maturities of Long-Term Debt	$-2,145,869
Accounts Payable	$-827,339
Accured Salaries, Wages & Benefits	$-3,904,170
Accrued Interest and Sales Tax	$-798,618
Deferred Income	$-438,985
Due to 3rd Party Payors	$-1,891,874
Due to Specific Purpose Funds	$0
Total Current Liabllites	$-10,006,855
Long Term Debt, Net of Current Maturities	$-52,945,620
Bond Premium	$-1,395,304
Total Long Term Debt	$-54,340,923
Net Assets	
Unrestricted Net Assets	$-54,775,276
Tempororily Restricted	$-817,500
Net Income	
Total Net Assets	$-55,592,776
Total Liabilities and Net Assets	$-119,940,555

Statement of Operation
Monthly Statement of Operations
For Period: 2-2014 (08/01/2013 - 08/31/2013)

	August	MTD Budget	MTD Variance	Actual YTD	YTD Budget	YTD Variance
Unrestricted Revenues, Gains & Other Support						
Inpatient Service Revenue						
Ancillary	605,485	603,026	2,459	1,007,224	1,206,052	(198,828)
Routine	2,532,287	2,360,430	171,857	4,406,094	4,720,860	(314,766)
Total Inpatient Service Revenue	3,137,772	2,963,456	174,316	5,413,318	5,926,912	(513,594)
Outpatient Service Revenue	6,602,703	6,068,891	533,812	13,116,480	12,137,782	978,698
Gross Patient Service Revenue	9,740,475	9,032,347	708,128	18,529,798	18,064,694	465,104
Less Deductions from Revenue						
Patient Service Revenue Deductions	(342,018)	(207,934)	(134,084)	(607,599)	(415,868)	(191,731)
Contractual Adjustments	(4,066,044)	(3,269,228)	(796,816)	(7,097,790)	(6,538,456)	(559,334)
Prior Period Adjustments	19,076	126,162	(107,086)	19,080	252,324	(233,244)
Total Deductions from Patient Service Revenue	(4,388,987)	(3,351,000)	(1,037,987)	(7,686,310)	(6,702,000)	(984,310)
Net Patient Service Revenue	5,351,488	5,681,347	(329,859)	10,843,488	11,362,694	(519,206)
Other revenue	15,132	87,131	(71,999)	20,943	174,262	(153,319)
Transfers from Restricted Funds for Operating Exp	87,043	136,658	(49,615)	174,086	273,316	(99,230)
Total Other Revenue	102,175	223,789	(121,614)	195,029	447,578	(252,549)
Expenses:						
Salaries and Wages	1,850,643	1,879,578	(28,935)	3,583,448	3,759,156	(175,708)
Employee Benefits	1,022,235	1,162,747	(140,512)	2,131,162	2,325,494	(194,332)
Professional Fees	534,421	464,012	70,409	1,299,719	928,024	371,695
Supplies	487,411	508,515	(21,104)	1,096,793	1,017,030	79,763
Purchased Services	348,561	262,914	85,647	429,708	525,828	(96,120)
Depreciation	293,641	438,217	(144,576)	587,197	876,434	(289,237)
Interest Expense	202,520	219,531	(17,011)	398,937	439,062	(40,125)
Bad Debts	54,157	242,081	(187,924)	451,839	484,162	(32,323)
Other Expense	447,800	325,922	121,878	807,998	651,844	156,154
Total Expenses	5,241,390	5,503,517	(262,127)	10,786,802	11,007,034	(220,232)
Operating Income (Loss)	212,272	401,619	(189,347)	251,715	803,238	(551,523)
Other Income:						
District Tax Receipts	43,899	43,210	689	87,797	86,420	1,377
Partnership Investment Incomce		0	0		0	0
Grants and Other Contributions Unrestricted	54,900	6,196	48,704	54,900	12,392	42,508
Interest Income	10,306	975	9,331	20,931	1,950	18,981
Other Non-Operating Income	1,083	12,882	(11,799)	6,409	25,764	(19,355)
Net Medical Office Activity	(273,500)	(349,975)	76,475	(508,865)	(699,950)	191,085
340B Net Activity	68,379	52,408	15,971	106,141	104,816	1,325
Non-Operating Income/Loss	(94,933)	(234,304)	139,371	(232,686)	(468,608)	235,922
Net Income/Loss	117,339	167,315	(49,976)	19,029	334,630	(315,601)

Investments as of 8/31/2013

	Purchase Dt	Maturity Dt	Institution	Broker	Rate	Principal
1	8/2/2013	9/1/2013	LAIF (Walker Fund)	Northern Inyo Hospital	0.27%	322,006.64
2	8/28/2013	9/1/2013	Local Agency Investment Fund	Northern Inyo Hospital	0.27%	4,503,967.07
3	8/2/2013	9/1/2013	Multi-Bank Securities	Multi-Bank Service	0.01%	2,572,478.91
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			**$8,064,657.62**

Northern Inyo Hospital
Monthly Report of Capital Expenditures
Fiscal Year Ending JUNE 30, 2013
As of August 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	120,613 *
Actually Expended in Current Fiscal Year	381,153 *
Year-to-Date Completed Building Project Expenditures	0 *
TOTAL FUNDS APPROVED TO BE EXPENDED	1,037,007

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 August 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		501,767
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
		1,037,007

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

Administrator-Approved Item(s)	Department	Amount	Month Total	Grand Total
Armstrong-Hunt Heating Coil	Maintenance	2,144		
Data Pathway-New EKG Area	EKG	3,485		
Freezer Med Grade	Pharmacy	2,995		
HPProliant DL380p	IT	6,000		
HP-E5-2680 2.70GHz-20MB	IT	7,422		
HP-E5-2680 2.70GHz-20MB 8C	IT	7,422		
Staxi Medical Transport Chair	Radiology	1,544		
Staxi Medical Transport Chair	Community Relations	1,274		
Nuance Management Server & Console	UR	10,000		
Dragon Medical 360	UR	2,199		
Dragon Medical 360	UR	2,199		
Dragon Medical 360	UR	2,199		
Dragon Medical 360	UR	2,199		
Nuance PowerMic 11	UR	914		
MONTH ENDING AUGUST 31, 2013			**51,996**	**120,613**

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NORTHERN INYO HOSPITAL

SECURITY REPORT

JULY 2013

FACILITY SECURITY

Access security during this period revealed twenty one exterior doors found unsecure during those hours when doors were to be secured. Three interior doors were found unsecure during this same period.

ALARMS

On July 13th, three HUGS Alarms were activated as errors.

On July 14th, a HUGS Alarm activated as the result of an error.

On July 21st, a HUGS Alarm activated as the result of a bad tag.

On July 22nd, two HUGS Alarms activated as the result of errors.

On July 31st, two HUGS Alarms activated as the result of a loose tag.

HUMAN SECURITY

On July 6th, an injured, drunk, person was brought to the ED for treatment by several drunken friends. Upon discharge, the patient and others were picked up by a sober family member.

On July 20th, EMS presented at the ED with an agitated patient who had attempted suicide. Security stood by with this patient until calm.

On July 23rd, ED Staff requested Security Staff for an intoxicated, uncooperative patient. Security Staff stayed with this patient until discharge.

On July 24th, the Bishop Care Center called the ED to report one of their residents had gone AWOL while waiting to be accompanied to the ED. Security Staff checked the Campus and was unable to locate this person. Care Center Staff arrived a short time later with this patient.

On July 27th, Security Staff stood by while a drunken patient was treated in the ED.

Security Staff provided Law Enforcement standby on twelve occasions this month.

Security Staff provided assistance with two suspected 5150's this month.

Security Staff provided thirty five patient assists this month.

EOC REPORTING INFORMATION

	JULY 2013	YEAR TO DATE
FIRE DOORS / OPEN OR PROPPED	0	0
TRESPASSING	0	7
VANDALISM	0	0
DISORDERLY CONDUCT		
BY PATIENT	2	35
BY OTHERS	0	0
SUSPICIOUS ACTIONS		
PERSONS	0	6
VEHICLES	0	0
PERSONAL PROPERTY		
DAMAGE	0	0
LOSS	0	1
HOSPITAL PROPERTY		
DAMAGE	0	0
LOSS	0	0

NORTHERN INYO HOSPITAL

SECURITY REPORT

AUGUST 2013

FACILITY SECURITY

Access security during this period revealed twenty three exterior doors found unsecured during those hours when doors were to be secured. Four interior doors were found unsecured during this same period.

Old Building roof access was found unsecured on four occasions this month.

One Hospital vehicle was found unsecured with the keys present during this period.

ALARMS

On August 4th, a HUGS Alarm was falsely activated.

On August 9th, a HUGS Alarm was falsely activated.

On August 10th, a HUGS Alarm was falsely activated.

On August 29th, a HUGS Alarm was activated as an error.

HUMAN SECURITY

On August 3rd, an ED Patient became combative and assaulted and battered two ED Staff members, resulting injuries to Staff. Bishop Police responded and assisted in controlling the patient who was treated and later discharged.

On August 4th, Security Staff stood by with an uncooperative ED Patient until a transfer was made to another facility.

On August 4th, an ED Patient was being treated, when for unknown reasons the Patient eloped. Security Staff checked the Campus and was unable to locate the patient.

On August 10th, EMS presented to the ED with a patient that was combative and restrained to the gurney. Security Staff was called to the ED and stood by with this patient until discharged.

On August 16th, Security Staff stood by in the ED while an intoxicated and uncooperative female juvenile was treated. This patient was discharged to parents.

On August 16th, EMS presented to the ED with an intoxicated and uncooperative, assault victim. Security Staff stood by during treatment and Law Enforcement responded for reporting purposes.

On August 18th, Security Staff and Law Enforcement stood by with family members of an ED patient being treated as the result of a suicide attempt.

On August 18th, Security Staff was called to the ICU for a combative Patient. This Patient was restrained, medicated and transferred to another facility.

On August 28th, Security Staff stood by with a suspected 5150 until transfer to another facility.

On August 29th, EMS presented to the ED with an intoxicated and uncooperative Patient. Security stood by with this patient until discharge.

On August 30th, an employee was separated from employment with the Hospital. A short time later Hospital Staff was notified by a third party that the separated employee had communicated his dissatisfaction and related a comment that was interpreted by the third party as a possible threat toward Staff. Law Enforcement and Security were notified of the circumstances and the Hospital was Locked Down. Law Enforcement made contact with the separated employee and was able to take specific measures to mitigate the possibility of any adverse actions by this individual. Security measures remained in effect throughout the evening and the Lock Down was lifted the next day.

On August 31st, Security Staff was called to the ED for an uncooperative and intoxicated, Patient.

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

Security Staff provided 5150 assistance in four instances this month.

Security Staff provided assistance to Patients on forty one occasions this month.

EOC REPORTING INFORMATION

	AUGUST 2013	YEAR TO DATE
FIRE DOORS / PROPPED OR OPEN	0	0
TRESPASSING	0	7
VANDALISM	0	0
DISORDERLY CONDUCT		
BY PATIENT	8	43
BY OTHERS	1	1
SUSPICIOUS ACTIONS		
PERSONS	0	6
VEHICLES	0	0
PERSONAL PROPERTY		
DAMAGE	0	0
LOSS	0	1
HOSPITAL PROPERTY		
DAMAGE	0	0
LOSS	0	0

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Highlight High Performing Hospitals

- Large Number of Hospitals have achieved a 5 Ranking in the Level of Progress Report
- This is a dynamic achievement and can change whenever data submitted changes meeting the 40%/20% goal on each harm topic.

ADE	CAUTI	CLABSI	EED	Falls	OB	PrU	Read	SSI	VAP	VTE
5	66	98	51	56	8	82	50	48	51	10

- Mentor Hospitals Designated by CMS

Hospital Names	
Barton Memorial Hospital	John Muir Medical Center, Concord
Coalinga Regional Medical Center	Los Alamitos Medical Center
Doctors Hospital of Manteca	Marshall Medical Center
Goleta Valley Cottage Hospital	Northern Inyo Hospital
Hi-Desert Medical Center	San Ramon Regional Medical Center
Hoag Memorial Hospital Presbyterian	

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NORTHERN INYO HOSPITAL
INJURY AND ILLNESS PREVENTION PROGRAM

1. RESPONSIBILITY

The Injury and Illness Prevention Program (IIP Program) Administrator:
Risk Management

The Program Administrator has the authority and responsibility for implementing the provisions of this program for: all regular NIH employees, temporary agency employees, contract employees, volunteers, students.

All managers and supervisors are responsible for implementing and maintaining the IIP Program in their work areas and for answering employees' questions about the IIP Program. A copy of this IIP Program is available from each manager and supervisor and can be found in policy manager.

2. COMPLIANCE

NIH Management is responsible for ensuring that all safety and health policies, procedures, regulations, and standards are clearly communicated and understood by all employees. Managers and supervisors are expected to enforce the rules fairly and uniformly.
All employees are responsible for using safe work practices. Such practices include following all directives, policies and procedures, and assisting in maintaining a safe work environment.
Our system of ensuring that all employees comply with the rules and maintain a safe work environment includes:

a. Informing employees of the provisions of our IIP Program;
b. Evaluating the safety performance of all employees;
c. Recognizing employees who perform safe and healthful work practices. This recognition is accomplished by: Annual Evaluations and individual departmental processes.
d. Providing training to employees whose safety performance is deficient.
e. Disciplining employees for failure to comply with safe and healthful work practices as delineated by Human Resources and NIH policies and procedures.
f. Other means that we use to ensure employee compliance with safe and healthful work practices include:
    Annual Hospital Wide Medcom Training
    Departmental Competency Training

3. COMMUNICATION

We recognize that open, two-way communication between management and employees on health and safety issues is essential to an injury-free, productive workplace. The following system of communication is designed to facilitate a continuous flow of safety and health information between management and employees in a form that is readily understandable and consists of one or more of the following items:

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a. New employee's orientation including a discussion of safety and health policies and procedures. This orientation monitors the completion of Medcom Safety modules.
b. Review of our IIP Policy
c. Workplace safety and health training programs. This includes annual and as needed training- specific to each department. Our Employee Wellness Program and exercise classes will be explained in the orientation.
d. Regularly scheduled safety meetings. These meetings will include the Human Resource's report on employee injuries and illnesses.
e. Effective communication of safety and health concerns between employees and supervisors, including translation where appropriate.
f. Posted or distributed safety information.
g. A system for employees to anonymously inform management about workplace hazards. This is accomplished by the:
    i. Quality Review Reporting System: QI reports
    ii. Letters can also be left anonymously in the Performance Improvement mail.
    iii. Phone line dedicated to anonymous safety/complaint issues.
    Safety Report Line: 760.873.2806
    iv. No employee will be subject to reprisals for reporting hazards or potential hazards.
h. A labor/management safety/health committee- Our "Safety Committee" meets regularly, prepares written records of the safety and health committees meetings, reviews results of the periodic scheduled inspections, reviews the dosimeter reports for radiology staff, reviews investigations of accidents and exposures and makes suggestions to management for the prevention of future incidents, reviews investigations of alleged hazardous conditions, and submits recommendations to assist in the evaluation of employee safety suggestion.

☐ Other:

____

____

____

____

4. HAZARD ASSESSMENT

Periodic inspections to identify and evaluate workplace hazards shall be performed by the competent observer(s) in all areas of our workplace:

Periodic inspections are performed according to the following schedule:

a. Quarterly and reported to the Safety Committee.
b. When new substances, processes, procedures or equipment which present potential new hazards are introduced into our workplace;
c. When new, previously unidentified hazards are recognized;
d. When occupational injuries and illnesses occur;
e. When we hire and/or reassign permanent or intermittent employees to tasks for which a

DRAFT

hazard evaluation has not been previously conducted;

f. Whenever workplace hazardous conditions, or potentially hazardous conditions, are reported by any employee.

Periodic inspections consist of identification and evaluation of workplace hazards utilizing applicable sections of the attached Hazard Assessment Checklist and any other effective methods to identify and evaluate workplace hazards.

5. ACCIDENT/EXPOSURE INVESTIGATIONS

Investigation of workplace accidents, hazardous substance exposures and near-accidents is always done. The employee's direct supervisor and/or department head should always be notified as soon as the event occurs. Employee Health will take part in the investigation when there is an employee injury. if the injured employee's supervisor/department manager has not previously been notified, Employee Health will do that as soon as possible. Safety will also have a role when the QR Report indicates a safety/environmental issue.

"Supervisor's Report of Employee Incident":

a. The initial form to be done by the employee's direct supervisor and/or department manager.
b. The shift supervisor may also complete this form, but input from the department manager is always preferred. The department manager may not have been in-house at the time of the incident, but is usually the better person to know how the incident fits into patterns of the specific unit or specific individual.

The investigation will include:

a. Visiting the accident scene as soon as possible;
b. Interviewing injured employees and witnesses;
c. Examining the workplace for factors associated with the accident/exposure;
d. Determining the cause of the accident/exposure;
e. Taking corrective action to prevent the accident/exposure from reoccurring; and
f. Recording the findings and corrective actions taken.

6. HAZARD CORRECTION

Unsafe or unhealthy work conditions, practices or procedures shall be corrected in a timely manner based on the severity of the hazards. Hazards shall be corrected according to the following procedures:

a. When observed or discovered;
b. When an imminent hazard exists which cannot be immediately abated without endangering employee(s) and/or property, we will remove all exposed employees from the area except those necessary to correct the existing condition. Employees necessary to correct the hazardous condition shall be provided with the necessary protection. The Immediate Threat policy is in the Safety Manual.
c. All such actions taken and dates they are completed shall be documented on the appropriate forms. There is a Departmental Risk Assessment Form, found in the Safety Manual, which is completed annually be department heads.

7. TRAINING AND INSTRUCTION

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All employees, including managers and supervisors, shall have training and instruction on general and job-specific safety and health practices. Training and instruction shall be provided as follows:

a. When the IIP Program is first established;
b. To all new employees within 60 days of hire.
c. To all employees given new job assignments for which training has not previously provided;
d. Whenever new substances, processes, procedures or equipment are introduced to the workplace and represent a new hazard;
e. Whenever the employer is made aware of a new or previously unrecognized hazard;
f. To supervisors to familiarize them with the safety and health hazards to which employees under their immediate direction and control may be exposed; and
g. To all employees with respect to hazards specific to each employee's job assignment.

Workplace safety and health practices for Northern Inyo Hospital include, but are not limited to, the following:

a. Explanation of the employer's IIP Program, emergency action plan and fire prevention plan, and measures for reporting any unsafe conditions, work practices, injuries and when additional instruction is needed.
b. Use of appropriate clothing, including gloves, footwear, and personal protective equipment.
c. Information about chemical hazards to which employees could be exposed and other hazard communication program information.
d. Availability of eye wash stations.
e. Proper food and beverage storage to prevent them from becoming contaminated. There is no eating or drinking in patient care areas.
f. Provisions for medical services and first aid through the Emergency Department for any employee injury, hospital acquired illness, or hospital exposure.
g. Proper housekeeping, such as keeping stairways and isles clear, work areas neat and orderly, and promptly cleaning up spills.
h. Proper storage to prevent:
    i. stacking goods in an unsafe manner
    ii. storing materials and equipment against doors, exits, fire extinguishing equipment and electrical panels.
i. Prevention of musculoskeletal disorders
    i. including proper lifting techniques;
    ii. safe patient handling;
    iii. knowledgeable use of all lifting equipment.
j. The Safe Patient Handling Program policy addresses NIH's commitment to
    i. minimal manual patient lifting;
    ii. providing adequate lift equipment;
    iii. instruction on the use of the lift equipment;
k. Development of a culture of safety utilizing lift teams when appropriate
l. Illness Prevention, which includes

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i. NIH's Vaccination Program;
ii. N-95 Fit Test Program for appropriate departments as listed in the Aerosolized Transmissible Disease Policy, and as determined by Infection Control;
iii. hand hygiene program, including education, training and observation, and the use of required signage in all bathrooms;
iv. extensive availability of alcohol based hand rub stations throughout NIH.

In addition, we provide specific instructions to all employees regarding hazards unique to their job assignment, to the extent that such information was not already covered in other training.

8. SCHEDULED AND PERIODIC INSPECTIONS

NORTHERN INYO HOSPITAL has the following procedures for identifying and evaluating workplace hazards, including scheduled periodic inspections to identify unsafe conditions and work practices. Supervisors are responsible for seeing that periodic inspections are conducted. The Program Administrator may assist supervisors to develop self-inspection forms and checklists and guides for inspection and record keeping. On request, the Program Administrator will also conduct or arrange for third parties to conduct periodic surveys to assist the supervisors in identifying and correcting potential hazards.

a. Inspections are conducted according the following schedule:
   i. Upon initial establishment of the IIPP
   ii. When new substances, processes, procedures, or equipment which present potential new hazards are introduced
   iii. When new, previously unrecognized hazards are identified
   iv. When occupational injuries or illnesses occur
   v. Periodically as determined by the nature of the exposure
b. Outside Agencies

Several agencies conduct random, regular, or periodic inspections at to assist NIH in achieving some of its inspection responsibilities. These include:
   i. ALPHA Fund
   ii. Fire Marshal's Office
   iii. Fire Department
   iv. County Environmental Health Department
   v. Cal/OSHA
   vi. California Department of Public Health

9. RECORD KEEPING of SCHEDULED AND PERIODIC INSPECTIONS

a. Records of scheduled and periodic inspections to identify unsafe conditions and work practices **shall** be maintained for a minimum of three years. The records **shall** include:
   i. the name(s) of the person(s) conducting the inspection,
   ii. any descriptions of the unsafe conditions and work practices,
   iii. the actions taken to correct the identified unsafe conditions and work practices
b. The Department Manager is responsible for maintaining these records and providing a

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copy to the Program Administrator.

c. Documentation of safety and health training for each employees, including the employees' names or other identifier, training dates, type(s) of training, and training providers are recorded on a employees training and instruction form. These records are kept by either the Department Head and/or by Human Resources.
d. Inspection records and training documentation will be maintained according to the following schedule:
   i. for one year,
   ii. training records of employees who have worked for less than one year which are provided to the employees upon termination of employment.
   iii. Quality Review Reports are kept for 7 years.

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Committee Approval	Date
Safety Committee	2/27/13
Medical Executive Committee	
Administration	
Board of Directors	

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Monitoring and Documentation of Weekly Fluoroscopic QC	
Scope: Department	Department: Radiology
Source: Title 17, Section 30307(b)	Effective Date: March 12, 2013
Radiology Manager:	Date signed:
Radiation Safety Officer:	Date signed:

PURPOSE:

Ensures that fluoroscopic quality control (QC) is completed and documented weekly, in accordance with State regulation

POLICY:

Monitoring of fluoroscopic tube current (mA) and potential (kVp) weekly shall be recorded in the Fluoroscopy QC binders and maintained in the Imaging department manager's office.

PROCEDURE:

1. There shall be a rotating group of technologists with fluoroscopy licenses assigned to weekly QC. **All QC shall be performed on Monday or Tuesday of each week.**
2. There shall be a calendar posted in the break room, easily visible, to ensure that the technologist responsible for the quality control has a visible reminder. Upon completion of the QC, the technologist shall initial on the calendar and **bring the binders to the imaging department manager, or designee, for immediate review.**
3. All technologists shall check the calendar to ensure that the QC has been completed. It is every technologist's responsibility to ensure completion of this monitoring and proper documentation.
4. Every radiologic technologist with a fluoroscopy license shall have the ability to perform the QC.
5. The records of the weekly monitoring shall be maintained for at least three years, as required by the regulation listed above.
6. An audit of the QC records shall be conducted quarterly by the RSO, or designee, and submitted to the Radiation Safety Committee.

Revised 3/13/2013
Reviewed
Supercedes 3/12/2010

Proposal: Add radiofrequency ablation for pain management @ Northern Inyo Hospital.

Background:

1. Spine related pain is a major cause of disability, limitation of physical activity (promoting obesity, diabetes, hypertension, vascular disease), need for medications (with associated costs, and risk of dependency/abuse), increased use of medical resources (physicians offices, hospitals, physical therapies), special equipment (canes, walkers, wheelchairs, beds), and surgical procedures.
2. Recent recommendations from national leaders has discouraged the use of surgery, especially spinal fusions, due to high costs, complications, morbidity, and high incidence of recurrent pain.
3. Instead, non-surgical treatments are being increasingly encouraged. These include interventional treatments with injections of steroids + anesthetics into epidural space, facet joints, medial nerves, SI joints, piriformis muscles, greater trochanteric bursa & trigger points. These have a high success rate, and are currently performed @ NIH.
4. In the patient with suboptimal response to these methods a more durable method of reducing pain is to use radiofrequency ablation to block the transmission of pain from the facet joints (lumbar & cervical), SI joints. In the patients with advanced spine degeneration, including spinal canal stenosis, the facet joints are the major source of pain (arthritis), and disability.
5. The radiofrequency ablation procedure is performed on an outpatient basis, and does not require general anesthesia.
6. It is performed with visualization utilizing fluoroscopy, usually a C-arm, which is in place @ NIH.
7. It is a standard procedure that is covered by Medicare, and other carriers. Relative to other procedures the reimbursement to the facility is generous.

Equipment:

1. Fluoroscopy. Usually a C-arm. Currently available @ NIH.
2. Source of radiofrequency energy. Range = $8-12,000.
3. Radiofrequency needles. 4-6 required. $400 each. Reusable.

Personnel:

1. One radiology technologist capable of operating fluoroscopy, virtually all of them.
2. One nurse, if performing the procedure with conscious sedation.
3. Access to a radiology room with a C-arm.

Anticipated Use:

1. 4-10 patients per month. This is based on my own experience seeing patients only 1 ½ days a month in the Rural Health Clinic. I anticipate increasing my availability to see patients requiring pain management. The addition of this capability would make that more reasonable.
2. The number of treatments can be expected to increase as the word spreads to patients, and physicians that this is available.
3. The service can be expected to draw patients from surrounding areas.
4. Currently, to receive this treatment, patients must now travel to Carson/Reno or to LA area. It is difficult for back pain patients to make these trips. Also, many are older & have limited access to transportation. The distances, weather, and food/lodging costs prevent many patients from obtaining this care.

Operators:

1. Usually interventional radiologist or anesthesiologist.
2. Occasionally a physiatrist, orthopedist, neurologist.

Training:

1. Training, experience, and privileges in fluoroscopy, spinal injections, conscious sedation.
2. Additional training in radiofrequency ablation (1 day).
    a. On-site or off-site.

Proctoring:

1. Either on-site or off-site.
2. 2 cases.
3. Observed by experienced operator with privileges to perform the procedure.

Complications:

1. Bleeding & infection can occur with any invasive procedure.
2. Post-procedure neuritis.
3. Ablation of motor nerve.

Rural Setting:

1. Facility, personnel, medical staff available for support are adequate.
2. Low-risk procedure.
3. Liklihood of need for emergency treatment of a complication is remote.

Maggie Egan

From: mcnamaramodesto@aol.com
Sent: Thursday, August 29, 2013 4:53 PM
To: Maggie Egan; dscott.clark@verizon.net; Alexis Safarik; john.halfin@nih.org; Patty Dickson; mcnamaramodesto@aol.com; mcnamara@tcrad.com
Subject: Fwd: RFA
Attachments: RF_Proposal.docx

Categories: Red Category

Maggie, Scott,

Dr. Jim Barnett was very generous with his time, and put together this very informative email citing his extensive experience with radiofrequency ablations, and providing a reference article. I request that this be part of the submission.

Please acknowledge receipt so I can be sure that you got it. Thank you.

mcnamaramodesto@aol.com

-----Original Message-----
From: Tom McNamara <mcnamara@tcrad.com>
To: Jim Barnett <surfinmd@gmail.com>
Cc: mcnamaramodesto <mcnamaramodesto@aol.com>; Tom McNamara <mcnamara@tcrad.com>
Sent: Thu, Aug 29, 2013 4:06 pm
Subject: RE: RFA

Jim,

This is excellent. I have put together a Proposal. I am sending it to you for correction(s). It will be helpful if you could answer some specific questions having to do with reimbursement.
(1) What are CPT, and ICD-9 codes? (2) Range of $$ reimbursements for hospitals? (3) Cost of needles?

Best regards,

T. O. McNamara, M.D.

From: Jim Barnett [surfinmd@gmail.com]
Sent: Thursday, August 29, 2013 2:42 PM
To: Tom McNamara
Subject: RFA

Re: Radiofrequency Ablation of Medial Branch Nerves, Spinal Facet Joints
Indication: Facet Syndrome, secondary to chronic Arthropathy, Chronic Axial spine pain

As it pertains to a rural hospital such as yours:

This is a safe procedure developed in Europe 40 years ago. It has been mainstream treatment for the most common cause of Axial Back pain in the US for at least 25 years. I have performed at least 5000 cases in 13 years. The typical idea is to develop accurate diagnoses of Facet (Zygapophaseal joint) pain by performing medial branch nerve blocks. All insurance companies have their criteria but in short: Xray guided placement of a 25 gauge spinal to the location of the Medial Branch nerve, placing 0.2-0.4 ml of concentrated local

anesthetic, without sedation or superficial local thus isolating the diagnostic block to the medial branch that innervated the Facet joint and capsule. If the patient gets greater than 50% benefit for several hours, with increased ability to extend and rotate the spinal segment tested, they may be a candidate for a Rhizotomy. Some criteria require initial then confirmatory block separated by one week and often using a different local anesthetic. I typically, for example block L3,4,5 bilaterally and tell the patient to try to reproduce their pain. Go swing a golf club or the like. If the patient gets greater than 50% benefit they are a candidate. I strive for 70% and I inject only 0.2ml to make the injection much more specific.

Although most injections require normal hemostasis, I have injected hundreds of anticoagulated low back facets without stopping Plavix or other products that change bleeding.

The machine and probes are available for 20 to 35K. they are durable, and if enough cases are performed often the machine is less expensive as the vendors want the disposables.

I test both sides, I RF only one side at a time. This limits steroid exposure, and time on the table for this usually older population. Medicare pays office based fees, surgicenter rates or hospital codes, It never loses money. It is extremely safe. Other than occasional neuritis causing transient discomfort, I have seen no issues. 5000 cases, one hospitalization post for a hematoma and discomfort misinterpreted by a rural hospital nearby as a possible abcess.

I do 10 cases per week in a mature pain practice, the benefits are usually one year in neck or thorax, two years low back in my hands.

The procedure can be extended to treat Sacroiliac joint pain, ablating the Lateral Branch Nerves.

I have taught injection techniques in days to weeks, My opinion is that Dr Mcnamara could start today.

I'm more than happy to come over, supply the equipment and demonstrate on a few of your patients at any time.

Jim Barnett, MD

Common treatise on Procedure:

Spine (Phila Pa 1976).<http://www.ncbi.nlm.nih.gov/pubmed/15507813##> 2004 Nov 1;29(21):2471-3.
Effectiveness of repeated radiofrequency neurotomy for lumbar facet pain.
Schofferman J<http://www.ncbi.nlm.nih.gov/pubmed?term=Schofferman%20J%5BAuthor%5D&cauthor=true&cauthor_uid=15507813>,
Kine G<http://www.ncbi.nlm.nih.gov/pubmed?term=Kine%20G%5BAuthor%5D&cauthor=true&cauthor_uid=15507813>.
Source

SpineCare Medical Group, San Francisco Spine Institute, Daly City, California, USA. jschofferman@spinecare.com<mailto:jschofferman@spinecare.com>

Abstract
STUDY DESIGN:

Retrospective chart review.

OBJECTIVES:

To determine the success rate and duration of relief of repeat radiofrequency neurotomy for lumbar facet joint pain.

SUMMARY OF BACKGROUND DATA:

Radiofrequency neurotomy is an effective but temporary management of lumbar facet pain. When pain recurs, radiofrequency neurotomy is usually repeated, but the outcome and duration of relief for repeat radiofrequency neurotomies are unknown.

METHODS:

Record review of consecutive patients who had an initial successful radiofrequency neurotomy, subsequent recurrence of pain, and then repeat radiofrequency neurotomy. Responses of repeat radiofrequency neurotomies were compared with initial radiofrequency neurotomy for success rates and duration of relief.

RESULTS:

There were 16 women and 4 men. Mean age was 48 years (range, 26-63). Radiofrequency neurotomy denervated one segment in two patients, two segments in 16 patients, and three or more in two patients. There were 10 bilateral and 10 unilateral radiofrequency neurotomies. Mean duration of relief after initial radiofrequency neurotomy was 10.5 months (range, 4-19). To date, two patients had a series of two radiofrequency neurotomies performed, six had three, five had four, three had five, and four had seven or more. Twenty patients had a second radiofrequency neurotomy, which was successful in 17 (85%) but unsuccessful in two. The mean duration of relief in 16 of these 17 patients was 11.6 months (range, 6-19), and relief is continuing in one. Sixteen patients had a third radiofrequency neurotomy, of which 15 were successful and one was unsuccessful. The mean duration of relief in nine of the 15 was 11.2 months (range, 5-23), and relief is continuing in the other six. Eight patients had a fourth radiofrequency neurotomy, which was successful in seven but unsuccessful in one. The mean duration of relief was 9 months (range, 5-14) in three patients, and relief is continuing in the other four. None of these differences is significant. The frequency of success and durations of relief remained consistent after each subsequent radiofrequency neurotomy.

CONCLUSIONS:

Repeated radiofrequency neurotomies are an effective long-term palliative management of lumbar facet pain. Each radiofrequency neurotomy had a mean duration of relief of 10.5 months and was successful more than 85% of the time.
PMID:
15507813
[PubMed - indexed for MEDLINE]

Procedure	Volume (1 year)	Repeat patients (IN 1 YEAR)
CT GDD EPIDURAL INJ - LUMBAR/SACRAL	2	0
CT GDD EPIDURAL INJ CERVICAL/THORACIC	1	0
XR GDD EPIDURAL INJ LUMBAR/SACRAL	178	41
XR GDD EPIDURAL INJ CERVICAL/THORACIC, EA ADDL	2	0
XR GDD EPIDURAL INJ CERVICAL/THORACIC, 1ST LEVEL	16	1
CT GDD FACET INJ LUMBAR/SACRAL, 1ST LEVEL	3	0
CT GDD FACET INJ LUMBAR/SACRAL, EA ADDL LEVEL	5	0
XR GDD FACET INJ LUMBAR/SACRAL, 1ST LEVEL	7	0
XR GDD FACET INJ LUMBAR/SACRAL, EA ADDL LEVEL	1	0
XR GDD FACET INJ CERVICAL/THORACIC, 1ST LEVEL	1	0
XR GDD FACET INJ CERVICAL/THORACIC, EA ADDL LEVEL	1	0
XR GDD TRANSFORAMINAL EPIDURAL, LUMBAR	2	0
XR GDD TRIGGER POINT INJ, 1 OR 2 MUSCLES	2	0
XR GDD SI JOINT/PIRIFORMIS/GREATER TROCH BURSA	52	11
XR GDD SI JOINT INJ UNILATERAL	4	0
XR GDD SI JOINT INJ BILATERAL	5	1
XR GDD NERVE ROOT BLOCK	8	1
TOTAL	290	55

GDD = Guided

updated 9/17/13 per feedback from Dr. McNamara

Procedure	Repeat patients (IN 1 YEAR)	Pts for RFA would have 3 levels each		MC RFA APC	MC $
		1st level	Addl Level		
CT GDD EPIDURAL INJ - LUMBAR/SACRAL	0			$ 856.68	$ -
CT GDD EPIDURAL INJ CERVICAL/THORACIC	0			$ 565.75	$ -
XR GDD EPIDURAL INJ LUMBAR/SACRAL	41	41	82	$ 856.68	$ 81,515.38
XR GDD EPIDURAL INJ CERVICAL/THORACIC, EA ADDL	0			$ 182.61	$ -
XR GDD EPIDURAL INJ CERVICAL/THORACIC, 1ST LEVEL	1	1	2	$ 565.75	$ 930.97
CT GDD FACET INJ LUMBAR/SACRAL, 1ST LEVEL	0			$ 856.68	$ -
CT GDD FACET INJ LUMBAR/SACRAL, EA ADDL LEVEL	0			$ 565.75	$ -
XR GDD FACET INJ LUMBAR/SACRAL, 1ST LEVEL	0			$ 856.68	$ -
XR GDD FACET INJ LUMBAR/SACRAL, EA ADDL LEVEL	0			$ 565.75	$ -
XR GDD FACET INJ CERVICAL/THORACIC, 1ST LEVEL	0			$ 565.75	$ -
XR GDD FACET INJ CERVICAL/THORACIC, EA ADDL LEVEL	0			$ 182.61	$ -
XR GDD TRANSFORAMINAL EPIDURAL, LUMBAR	0			$ 856.75	$ -
XR GDD TRIGGER POINT INJ, 1 OR 2 MUSCLES	0			$ 565.75	$ -
XR GDD SI JOINT/PIRIFORMIS/GREATER TROCH BURSA	11	11	22	$ 565.75	$ 6,427.86
XR GDD SI JOINT INJ UNILATERAL	0			$ 565.75	$ -
XR GDD SI JOINT INJ BILATERAL	1	1	2	$ 565.75	$ 930.97
XR GDD NERVE ROOT BLOCK	1	1	2	$ 565.75	
(projected) ANNUAL TOTAL	55				$ 89,805.18

GDD = Guided

		CODE	DESCRIPTION		CODE
		723.5	TORTICOLLIS		722.1
		723.8	C-FACET SYNDROME		724.1
SIA		738.2	C-SPONDYLOLISTHESIS-AQ		724.0
AIN			LUMBAR SPINE		847.
		721.3	L- SPONDY W/O MYELOPAT		353.(
		722.10	HNP LUMBAR SPINE		
		722.52	LUMBAR DEGEN DISC DISE		729.
		722.83	POSTLAMINECT SYND LUM		729.
		724.02	SPINAL STENOSIS LUMBAR		733.8
		724.2	LOW BACK PAIN		733.1
		724.3	SCIATICA		
E		724.4	T OR L RADICULOPATHY		786.5
		738.4	L-SPONDYLOLISTHESIS-AQ		353.
		737.30	SCOLIOSIS-AQUIRED		786.5
		754.2	SCOLIOSIS CONGENITAL		053.
		720.0	ALKYLO SPONDYLITIS C OR		225.
		322.9	ARACHNOIDITIS		625.
THY		847.2	LUMBAR STRAIN/SPRAIN		728.
SE		722.93	LUMBAR DISCITIS		332.
VIC		344.6	CAUDA EQUINA SYNDROM		928.
ICA		727.40	SYNOVIAL CYST-EXTRADU		789.
		720.2	SACROILITIS		356
		724.8	FACET SYNDROME- LUMBE		724.
			[illegible] ACIC SPINE		344
		[illegible]	T-DEG DIS DISEASE		344

B 10/16/1972

M

HM PHONE: (209) 652-7110

COPAY: $0.00 / $0.0

PATIENT BALANCE:

Procedure Co

	CODE	DESCRIPTION	MOD
	62319	CONT L- EPIDURAL	
	64483	L- TRANS EPIDURAL	
	64484	2ND LEVEL LESI	
	62273	EPIDURAL PATCH	
	64479	C- TRANS EPIDURAL	
		RADIOFREQUENCY	
	64633	C/T RF 1ST LEVEL	
	64634	C/T RF- ADD LEVELS	
	64635	L-RF 1ST LEVEL	
	64636	L-RF ADD LEVELS	
		MUSCLE/ JOINT INJECTIONS	
	20600	FINGER/TOES	
	20605	ELBOW, WRIST, ANKL	
	20610	KNEE, SHLD, HIP JT	
	20552	TP/PIRI INJ	
	20550	TPS /PIRI W/C	
	27096	SI JT INJ	
	64440	SI JT/COCCYX INJ W/	
		OTHER PROCEDURES	

CODE	DESCRIPTION
337.21	RSD-UL TYPE 1
64445	SCIATIC N[illegible]
	SYMPATHETIC BLOCK
64530	CELIAC PELUS
64510	STELLATE GANGLION
64520	L OR T SYMPATHETIC
	FACET/ MEDIAL BRANCH BLOCK
64493	L-FACETS/ SNRB
64494	L-FACET/SNRB-2ND L
64495	L-FACET/SNRB- 3RD L
64490	C/T-FACET/SNRB 1ST
64491	C/T- FACET/SNRB- 2N
64492	C/T-FACET/SNRB- 3R
62275	C/T FACET W/C
62275	51-C/T ADD LEVEL W
64442	L-FACET 1ST W/C
64443	-51 L/ ADD LEVEL W/
64440	SNRB SINGLE W/C
64441	SNRB- MULTIPLE-W/C

Reimbursement

Code	64633 - DESTROY CERV/THOR FACET JNT
Date Of Service	2013-07-01
Wage Index	1.00000

Status Indicator - T

Significant Procedure, Multiple Procedure Reduction Applies. Paid under OPPS; Separate APC payment.

Status Indicator

APC Status Indicator	T - Significant Procedure, Multiple Procedure Reduction Applies. Paid under OPPS; Separate APC payment.
APC	00207 - Level III Nerve Injections

Wage Adjusted APC Payment	**$ 565.75**
Relative Weight	7.9333
National Payment Rate	$ 565.75
National Unadjusted Coinsurance	$ 0.00
Minimum Unadjusted Coinsurance	$ 113.15

Reimbursement

Code	64634 - DESTROY C/TH FACET JNT ADDL
Date Of Service	2013-07-01
Wage Index	1.00000

Status Indicator - T

Significant Procedure, Multiple Procedure Reduction Applies. Paid under OPPS; Separate APC payment.

Status Indicator

APC Status Indicator	T - Significant Procedure, Multiple Procedure Reduction Applies. Paid under OPPS; Separate APC payment.
APC	00204 - Level I Nerve Injections

Wage Adjusted APC Payment	**$ 182.61**
Relative Weight	2.5607
National Payment Rate	$ 182.61
National Unadjusted Coinsurance	$ 0.00
Minimum Unadjusted Coinsurance	$ 36.53

Reimbursement

Code	64635 - DESTROY LUMB/SAC FACET JNT
Date Of Service	2013-07-01
Wage Index	1.00000

Status Indicator - T

Significant Procedure, Multiple Procedure Reduction Applies. Paid under OPPS; Separate APC payment.

Status Indicator

APC Status Indicator	T - Significant Procedure, Multiple Procedure Reduction Applies. Paid under OPPS; Separate APC payment.
APC	00203 - Level IV Nerve Injections

Wage Adjusted APC Payment	**$ 856.68**
Relative Weight	12.0130
National Payment Rate	$ 856.68
National Unadjusted Coinsurance	$ 0.00
Minimum Unadjusted Coinsurance	$ 171.34

Reimbursement

Code	64636 - DESTROY L/S FACET JNT ADDL
Date Of Service	2013-07-01
Wage Index	1.00000

Status Indicator - T

Significant Procedure, Multiple Procedure Reduction Applies. Paid under OPPS; Separate APC payment.

Status Indicator

APC Status Indicator	T - Significant Procedure, Multiple Procedure Reduction Applies. Paid under OPPS; Separate APC payment.
APC	00207 - Level III Nerve Injections

Wage Adjusted APC Payment	**$ 565.75**
Relative Weight	7.9333
National Payment Rate	$ 565.75
National Unadjusted Coinsurance	$ 0.00
Minimum Unadjusted Coinsurance	$ 113.15

Reimbursement

Code	64640 - INJECTION TREATMENT OF NERVE
Date Of Service	2013-07-01
Wage Index	1.00000

Status Indicator - T

Significant Procedure, Multiple Procedure Reduction Applies. Paid under OPPS; Separate APC payment.

Status Indicator

APC Status Indicator	T - Significant Procedure, Multiple Procedure Reduction Applies. Paid under OPPS; Separate APC payment.
APC	00207 - Level III Nerve Injections

Wage Adjusted APC Payment	**$ 565.75**
Relative Weight	7.9333
National Payment Rate	$ 565.75
National Unadjusted Coinsurance	$ 0.00
Minimum Unadjusted Coinsurance	$ 113.15

National Charge Percentiles from SAF 2011 claims - 3752 procedures.

10th Percentile	$ 439.05
25th Percentile	$ 843.00
50th Percentile	$ 1305.46
75th Percentile	$ 2328.75
90th Percentile	$ 3943.75

Dear Medical Executive Committee,

I would like voluntarily remove the previously requested privileges including:

Pancreatic biopsy

Needle localization

Renal biopsy

Renal cyst aspiration

Retroperitoneal biopsy

Also I would like to remove the “US guided cyst puncture & aspiration” from my proctoring list as it is a duplicate line with already proctored “US guided aspiration”

Thank you very much for your consideration.

Natalia Zarzhevsky, MD

09/26/2013

THIS SHEET INTENTIONALLY LEFT BLANK

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Communicating Protected Health Information Via Electronic Mail (Email)**	
Scope: **Hospital Wide**	Manual: **Compliance**
Source: **Medical Records Director**	Effective Date:

PURPOSE: To describe the procedures governing an individual's use of a Northern Inyo Hospital (NIH) electronic mail (email) system. It also defines the steps that must be taken by NIH patients who wish to engage in email with an NIH workforce member.

POLICY: NIH does not permit the email of unencrypted Protected Health Information (PHI).

PROCEDURE:

1. **Communicating PHI via Email Internally** (Internal email is defined as being sent from and delivered to the nih.org domain (both sender and recipient's email addresses end with "@nih.org")

   Email of PHI will be permitted at NIH if the following safeguards are implemented:
   a. NIH shall use the following safeguards when communicating PHI in or attached to an email message:
      (1) Email communications containing PHI about NIH patients will be transmitted only on NIH email system and **is not to be forwarded to an email account outside NIH.**
      (2) PHI should not be transmitted in the subject line of the email message. This includes the name of the patient or a medical record number. It is acceptable to have PHI in the body of the email as necessary for identification purposes for the reader.
      (3) If a message has an attachment that contains PHI, the subject line of the email message will not include the name of the patient.
      (4) If a document that contains PHI is attached to the message, the User should verify before transmitting the email message that he/she has attached the proper attachment.
      (5) Before transmitting the email message, Users should double-check the message and any attachments to verify that no unintended information is included.
      (6) Users who communicate PHI via email will comply with all other NIH policies and procedures including, but not limited to, the Minimum Necessary Policy.

   b. Any user who is unsure whether an email message or attachment contains PHI should contact his/her supervisor or the HIPAA Privacy Officer before initiating the email communication.

2. **Communicating PHI with Patients**
   a. Patients have the right to request that NIH communicate with them via email.
   b. If a patient requests email communications containing their PHI, the individual receiving the request must obtain a completed **Patient Request for Email Communication** form from the patient AND provide the patient with the **Important Information About Provider/Patient Email** form prior to processing the patient's request

      Both forms are available as an attachment to this policy and on the NIH Intranet. The forms are located under Forms>HIPAA.

   c. NIH workforce members reserve the right to deny a patient's request to communicate with him/her via email.
   d. All completed Request for Communications forms will be forwarded to the Medical Records Department for processing and will be maintained for a minimum of six (6) years. Approved

Requests are valid regardless of the time period as long is maintained or the signed form is scanned into the patient's electronic medical record.

e. An approved Request for Email Communication will be effective for only the health care provider identified on the Request. The patient must complete a separate Request for each health care provider with whom he/she wants to communicate via email, and must revoke each Request to discontinue email communications.

f. PHI sent to patients shall meet all criteria listed in Section 3, Communicating PHI Via Email Externally.

3. **Communicating PHI via Email Externally**
   a. PHI shall not be sent to email systems located outside of NIH, hereby defined as 'external destinations' without meeting HIPAA encryption standards.
   b. All email that contains PHI sent to external destinations shall be encrypted prior to delivery, in a manner adherent to NIH Information Technology (I.T.) Department requirements. (See "Steps to Encrypt PHI Email" attached to this policy).
   c. All automatic forwarding, redirection, or other automated delivery or pickup of NIH email, to external destinations is explicitly prohibited.
   d. The email message will include the following confidentiality notice:
   e. **"This electronic message is intended for the use of the named recipient and may contain confidential and/or privileged information. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or use of the contents of this message is strictly prohibited. If you have received this message in error or are not the named recipient, please notify us immediately by contacting the sender at the electronic mail address noted above with a copy to hipaa.compliance@nih.org and destroy this message".**

      Note: This confidentiality notice is automatically added to all external emails and does not require sender interaction.

4. **Ownership of Electronic Mail**
   a. The email systems at NIH belong to Northern Inyo Hospital.
   b. NIH reserves the right to override individual passwords and access the email system at any time for valid business purposes such as PHI security investigations at the request of Human Resources.

APPLICABILITY: NIH WORKFORCE

RESPONSIBILITY: HIPAA Privacy Officer, Information Security Officer

Committee Approval	Date
Administrator	
Board of Directors	

In review

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Communicating Protected Health Information Via Electronic Mail (Email)**	
Scope: **Hospital Wide**	Manual: **Compliance**
Source: **Medical Records Director**	Effective Date:

Responsibility for review and maintenance: Medical Records Director, Information Security Officer
Developed: **July 2013**
Revised: **September 2013**
Reviewed:

in review

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NORTHERN INYO HOSPITAL
PRIVATE PRACTICE PHYSICIAN
INCOME GUARANTEE AND PRACTICE MANAGEMENT AGREEMENT

This Agreement is made and entered into on this 6th day of January 2014 by and between Northern Inyo County Local Hospital District ("District") and Richard Meredick, M.D. ("Physician").

RECITALS

A. District, which is organized and exists under the California Local Health Care District Law, *Health & Safety Code section 32000, et seq.*, operates Northern Inyo Hospital ("Hospital"), a critical access hospital serving northern Inyo County, California, including the communities of Bishop and Big Pine.

B. The District Board of Directors has found, by Resolution No. 09-01, that it will be in the best interests of the public health of the aforesaid communities to obtain a licensed physician and surgeon who is a board-certified/specialist in the practice of Orthopedics, to practice in said communities, on the terms and conditions set forth below.

C. Physician is a physician and surgeon, engaged in the private practice of medicine, licensed to practice medicine in the State of California, and a member of the American College of Orthopedic Surgeons. Physician desires to locate his practice ("Practice") to Bishop, California, and practice Orthopedics in the aforesaid communities.

IN WITNESS WHEREOF, THE PARTIES AGREE AS FOLLOWS:

I.
COVENANTS OF PHYSICIAN

Physician shall locate his Practice to medical offices ("Offices") provided by District at a place to be mutually agreed upon in Bishop, California and shall, for the term of this Agreement, do the following:

1.01. __Services__. Physician shall:

(a) Provide Hospital with the benefit of his expertise and experience in direct patient care and render those services necessary to enable the Hospital to achieve its goals and objectives for the provision of Orthopedics Services. Said services shall include, but not be limited to, those described on Exhibit "A and B" attached hereto and, by this reference, incorporated herein.

(b) Provide Hospital with patient medical record documentation for all direct patient services rendered pursuant to this Agreement. Such documentation shall be submitted to Hospital on an ongoing basis, and shall be in the form, and contain the information, required by the Hospital to the end that a complete medical record can be assembled for each patient and appropriate billing completed.

1.02. **Limitation on Use of Space**. No part of any offices provided by the District either by lease or other arrangement shall be used at any time by Physician as anything other than the private practice of Orthopedic medicine unless specifically agreed to, in writing, by the parties.

1.03. **Medical Staff Membership and Service**: Physician shall:

a) Maintain Provisional or Active Medical Staff ("Medical Staff") membership with surgical privileges sufficient to support a full orthopedic practice.

b) Provide on-call coverage to the Hospital's Emergency Services within the scope of privileges granted to him by Hospital and as required by the NIH Medical Staff by-laws.

c) Assist NIH in securing, providing, and retaining services of one other physician, credentialed by the Medical Staff with sufficient skills to provide relief coverage for Physician and to provide for a reasonably full scope of orthopedic services for NIH's service area.

d) 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, services, and other costs and expenses of whatever nature, for which he may claim payment or reimbursement from the District. 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 District, 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 sub-contract he may enter with a value of more than Ten Thousand Dollars ($10,000) or for more than a twelve (12) month period, when said sub-contract is with a related organization.

e) At all times comply with all relevant policies, rules and regulations of the Hospital, subject to California and federal statutes governing the practice of medicine.

f) District expressly agrees that said services might be performed by such other qualified physicians as the Physician may employ or otherwise provide so long as each such physician has received proper training, is properly licensed, has been granted privileges by the Hospital Medical Staff, and has received approval in writing from the Hospital.

g) Provide Emergency Department call as required by the Medical Staff By-laws.

II.
COVENANTS OF THE DISTRICT

2.01. Hospital Services.

a) Space. Hospital shall make the Offices available for the operation of Physician's Practice either through a direct let at no cost to Physician or through an arrangement with a landlord, also at no cost to the Physician, other than the fees retained by the hospital (3.05).
b) Equipment. In consultation with Physician, Hospital shall provide all equipment as may be reasonably necessary for the proper operation and conduct of Physician's practice. Hospital shall repair, replace or supplement such equipment and maintain it in good working order.

2.02. General Services. District shall furnish ordinary janitorial services, maintenance services, and utilities, including telephone service, as may be required for the proper operation and conduct of Physician's Practice.

2.03. a. Supplies. District shall purchase and provide all supplies as may be reasonably required for the proper treatment of Physician's Practice patients. Physician shall inform Hospital of supply needs in a timely manner and shall manage the use of supplies in an efficient and reasonable manner that promotes quality and cost-effective patient care.

b. Equipment. District shall purchase and provide all supplies as may be reasonably required for the proper treatment of Physician's Practice patients, and specifically include the items in Exhibit C.

2.04. Personnel. District shall determine the initial number and types of employees and place them in the Practice initially. Physician and Hospital will mutually agree to subsequent staffing requirements. Physician shall not be required to maintain any personnel that he does not feel are appropriate for the Practice.

2.05. Business Operations. District shall be responsible for all business operations related to operation of the Practice, including personnel management, billing and payroll functions. Physician will provide the appropriate billing codes, which will be used unless changed by mutual consent of the Physician and Hospital. Hospital will incur and pay all operating expenses of the Practice.

2.06. Hospital Performance. The responsibilities of District under this Article shall be subject to District's reasonable discretion and its usual purchasing practices, budget limitations and applicable laws and regulations.

2.07. Practice Hours. The District desires, and Physician agrees, that Physician's Practice shall operate on a full-time basis, maintaining hours of operation in keeping with the full time practice of one Orthopedic surgeon while permitting a surgery schedule sufficient to service the patients of the Practice. Specific shifts will be scheduled according to normal operating procedures of the Practice and will be mutually agreed upon with Physician.

2.08. **Time Off.** Physician may take up to 12 weeks per year off provided he is able to secure the services of another physician to assume his responsibilities.

III.
COMPENSATION

3.01. **Compensation**. During the term of this agreement, District shall guarantee Physician a minimum annual income of $600,000, ("Minimum Guaranteed Income"). Professional fees will be payable to Physician at the rate of $23,076.92 every two (2) weeks. Physician shall be entitled to receive fifty (50%) percent of fees collected for services rendered to Physician as described in this Agreement, however, the Minimum Guaranteed Income shall be deducted from such fifty (50%) of such fees collected. The parties shall semi-annually the first year then at least quarterly review this collection and determine if the biweekly payment to Physician as described should be increased, but not decreased to reflect the collections performance. All payments shall be made on the same date as the District normally pays its employees.

Additionally, Physician will receive $15,000.00 semi-annually for each 180 consecutive calendar days this contract is in force, excluding any notice period. Notice period exclusion requirement will be waived if 180 day notice is given.

3.02. **Billing for Professional Services**. Subject to section 2.05 above, Physician assigns to District all claims, demands and rights of Physician to bill and collect for all professional services rendered to Practice patients, for all billings for orthopedic services, and for all billings for consulting performed or provided by Physician. Physician acknowledges that Hospital shall be solely responsible for billing and collecting for all professional services provided by Physician to Practice patients and for all orthopedic services performed at the Hospital, and for managing all Practice receivables and payables, including those related to Medicare and MediCal beneficiaries. Physician shall not bill or collect for any services rendered to Practice patients or Hospital patients, and all Practice receivables and billings shall be the sole and exclusive property of Practice. In particular, any payments made pursuant to a payer agreement (including co-payments made by patients) shall constitute revenue of the Practice. In the event payments are made to Physician pursuant to any payer agreement, Physician shall promptly remit the payments directly to Hospital. Hospital shall provide quarterly written reports to Physicians as to the collections and receivables.

3.03. **Retention**. Hospital will retain 50% of all fees collected from the activities of physician/practice in exchange for the services rendered in II above up to the guarantee amount.

3.04. **Malpractice Insurance.** Physician agrees to secure his own malpractice insurance with limits and coverage's appropriate for Physician to provide services under this Agreement. Hospital agrees to promptly reimburse to Physician 80% of malpractice premiums paid by Physician.

3.05. **Recruiting Expense.** Physician will be reimbursed all expenses associated with the preapproved expenses of recruiting another physician to the Staff.

3.06. Additional consideration. Physician will be provided Medical, Dental, and Vision insurance by admittance to the NIH self funded group. Physician will also receive 250,000 in life Insurance coverage.

IV.
TERMS AND TERMINATION

4.01. Term. The term of this Agreement shall be for three (3) years beginning on January 6, 2014 and ending January 5, 2017. The Agreement may be renewed, by written instrument signed by both parties, no later than 120 days before its expiration date.

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

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

b) Immediately upon closure of the Hospital or Practice;

c) 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

d) 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' reasonable written notice to the breaching party, explaining the breach, unless such breach is cured to the reasonable satisfaction of the non-breaching party within the thirty (30) days.

e) By either party with 90 days prior written notice.

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.

4.04. Accounts Receivable. Physician shall have no claim to the accounts receivable but shall only have his claim to the compensation set forth in Section 3.01.

4.05 Professional Services Rendered Outside the District. Any professional services provided outside the District by Physician must be agreed to in advance, in writing, by the District, which agreement District shall not unreasonably withhold. Hospital may not require Physician to work outside the District.

V.
PROFESSIONAL STANDARDS

5.01. Medical Staff Membership. It is a condition of this Agreement that Physician maintain Provisional or Active Medical Staff membership on the Hospital Medical Staff with appropriate clinical privileges and maintains such membership and privileges throughout the term of this Agreement.

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, Hospital Medical Staff, and Practice, 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 Provisional or Active Medical Staff of Hospital;

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

g) At all times conduct himself, professionally and publicly, in accordance with the standards of the medical profession, the American College of Orthopaedic Surgeons, the Hospital Medical Staff, and the District. Further, he shall not violate any California law which prohibits (1) driving a motor vehicle under the influence of alcohol or prescription drugs or the combined influence of such substances, (2) unlawful use of controlled substances, (3) being intoxicated in a public place in such a condition as to be a danger to himself or others, and/or (4) conduct justifying imposition of an injunction prohibiting harassment of Hospital employees in their workplace. Entry of any injunction, judgment, or order against Physician based upon facts, which constitute the above offenses, shall be a material breach of this Agreement.

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 is at all times acting and performing as an independent contractor, practicing the profession of medicine. District shall neither have nor exercise control or direction over the methods by which Physician performs professional services pursuant to this Agreement; provided, however, that Physician agrees that all work performed pursuant to this Agreement shall be in strict accordance with currently approved methods and practices in Physician's professional specialty and in accordance with the standards set forth in this Agreement.

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, or any other employee benefit of any kind. In addition, Hospital shall have no obligation to reimburse Physician for any costs or expenses associated with Physician's 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 for 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 for (1) year after the termination or expiration of this Agreement, solicit, or attempt to solicit any patients or patient groups with whom Physician dealt or became aware of as a result of Physician's past, present or future affiliation with Hospital and Practice. Such prohibition shall not preclude Physician from treating or continuing to treat patients who seek his services after the termination or expiration of this Agreement.

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 agrees 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 Physician's duties under this Agreement at a cost of $10,000.00 or more over a twelve (12) 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 its 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 both parties.

7.04. **No Referral Fees**. No payment or other consideration shall be made under this Agreement for the referral of patients, by Physician, to Hospital or to any nonprofit corporation affiliated with District.

7.05. **Repayment of Inducement**. The parties stipulate and agree that the income guaranteed to Physician under this Agreement, and the covenants of the District to provide office space, personal, equipment, and certain other benefits, are the minimum required to enable Physician to relocate himself to Bishop, California; that he is not able to repay such inducement, and no such repayment shall be required.

7.06. **Assignment**. Physician shall not assign, sell, transfer or delegate any of the Physician's rights or duties, including by hiring or otherwise retaining additional physicians to perform services pursuant to this Agreement, without the prior written consent of Hospital, which consent shall not be unreasonably withheld.

7.07. **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.

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

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

7.10. **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: Richard Meredick, M.D.
152 Pioneer Lane, Suite A
Bishop, CA 93514

Notice may be given either personally or by first-class mail, postage prepaid, addressed to the party designated above at the address designated above, or an address subsequently specified in writing by the relevant party. If given by mail, notice shall be deemed given two (2) days after the date of the postmark on the envelope containing such notice.

7.11. 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 Practice. Physician agrees to maintain medical records according to Practice 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.

7.12. 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. This Agreement may be modified only by a writing signed by each party or his/its lawful agent.

7.13. 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.

7.14. 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.

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

7.16. 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.

7.17. 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.

7.18. Construction. This Agreement has been negotiated and prepared by both parties and it shall be assumed, in the interpretation of any uncertainty, that both parties caused it to exist.

NORTHERN INYO COUNTY
LOCAL HOSPITAL DISTRICT

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

PHYSICIAN

By ______________________________
Richard Meredick, M.D.

APPROVED AS TO FORM:

____
Douglas Buchanan
District Legal Counsel

EXHIBIT A

SCOPE OF DUTIES OF PHYSICIAN

POSITION SUMMARY
Physician is a Member of the Northern Inyo Hospital Active Medical Staff with privileges commensurate with a private practice in orthopedic medicine. Physician will be available to provide direct orthopedic diagnosis and treatment to Practice and Hospital patients. The Physician will provide orthopedic services commensurate with the needs of the District. It is generally thought that the District's needs require the services of about 1.6 full time equivalent orthopedic physicians. All time off will be coordinated with Call coverage such that scheduled time off will not conflict with the Physician's call requirement.

Specifically, Physician will:

1. Provide high quality orthopedic medical care services.
2. Be responsible to provide the clinical, surgical, and ER orthopedic coverage for the District and/or to provide other physician(s) to do the same as may be required by the NIH Medical staff and/or this Agreement.
3. Direct on-going educational programs that serve the patient and the NIH Medical Staff.
4. Evaluate and develop treatment plans to facilitate the individual healthcare needs of each orthopedic patient.
5. Work with all Practice personnel to meet the healthcare needs of all orthopedic patients.
6. Assess, evaluate, and monitor on-going health care and medication of Practice patients.
7. Manage surgical orthopedic emergencies.
8. Participate in professional development activities and maintain professional affiliations.
9. Participate with Hospital to meet all federal and state regulations.
10. Accept emergency call as provided herein.
11. Actively participate in Medical Staff governance by serving on committees as required by Medical Staff Bylaws, Rules and Policies, and accepting the appointments to chairs, Chiefs of service and other designation as requested by the Medical Staff.
12. Abide by any behavioral agreement currently in force by the Medical Staff.
13. Perform the surgical procedures in Exhibit B.
14. Perform "return to work" or other physical assessments on employees that are requested by the Hospital and are within the scope of Physicians' Practice.
15. Physician will coordinate the relationship(s) of other orthopedic related sub-specialties.

EXHIBIT B

Physician agrees to, is privileged and is capable of performing the following procedures:

1. Joint repair, including but not limited to total hip and knee replacement.
2. Sports medicine management.
3. Arthroscopy.
4. Fracture reduction and fixation.

EXHIBIT C

Minimum Equipment

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People you know, caring for people you love

NORTHERN INYO HOSPITAL

Northern Inyo County Local Hospital District

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

October 7, 2013

To: John Halfen, Administrator (CEO/CFO)
Carrie Petersen, Chief of Fiscal Services

From: Georgan Stottlemyre, Human Resources Director

RE: Leave of Absence Policies

The Board of Directors further considered the Personnel/Payroll Advisory Committee (PPAC) recommendations to the Administrator and Board of Directors regarding the Leave of Absence Policies at a Special Meeting on October 2, 2013. The Board approved keeping the current Leave Policy with consideration for employees' leave hours – Paid Leave (PDLV), Old Sick (SICKO), New Sick (SICKN) and other specifications.

We met today to review the updated and amended policies based on the Boards approval at their October 2, 2013 Special meeting. Attached are drafts of updated policies to replace the Personnel Policy titled 14-02 FAMILY MEDICAL LEAVE OF ABSENCE, as we discussed. The titles of the attached updated policy drafts are: 1) Leaves of Absence - NORTHERN INYO HOSPITAL (NIH) JOB PROTECTED LEAVE (JPL) (14-02); 2) Leaves of Absence - FAMILY AND MEDICAL LEAVE ACT (FMLA) / CALIFORNIA FAMILY RIGHTS ACT (CFRA); and 3) Leaves of Absence – LEAVE DONATION.

The Leaves of Absence - FAMILY AND MEDICAL LEAVE ACT (FMLA) / CALIFORNIA FAMILY RIGHTS ACT (CFRA) policy draft is based on a sample policy in a 2013 Business and Legal Reports (BLR) California Employer Resources publication. The publication indicates that the sample policy complies with the provisions of the federal Family and Medical Leave Act (FMLA) and the California Family Rights Act (CFRA).

The Leaves of Absence - NORTHERN INYO HOSPITAL (NIH) JOB PROTECTED LEAVE (JPL) (14-02) policy draft addresses the additional JPL time currently provided by NIH and the additional considerations and specification approved by the Board. This draft adds how PTO may also be used.

The Leaves of Absence – LEAVE DONATION policy draft addresses this topic previously approved by the Board in the form of the "PTO or Paid Leave Transfer" form making additional clarifications about leave donation/transfer conditions.

There are additional matters related Leaves of Absence that will need to be addressed in policy at a later time.

Please consider seeking legal counsel review of the Leaves of Absence policies.

NORTHERN INYO HOSPITAL
EMPLOYEE HANDBOOK – PERSONNEL POLICY

Title: 14-02 FAMILY MEDICAL LEAVE OF ABSENCE	
Scope: Hospital Wide	Department: **Human resources – Employee Handbook**
Source: Human Resources	Effective Date:

POLICY:

The hospital provides non-introductory full-time, regular part-time and per diem employees with up to four months of unpaid leave during any twelve-month period to allow the employee to:

A. Care for his, or her, own illness or injury.

B. Care for an ill or injured child, parent or spouse.

C. Give birth to a child, adopt a child, or care for a child placed with the employee for foster care.

Employees off longer than 30 calendar days without pay will receive a new anniversary date upon return to work. The hospital will reinstate employees taking family leaves to the same or similar position if they return to their jobs within this four-month period.

Employees do not accrue Paid Time Off (PTO) benefits while on an unpaid Family Medical Leave of Absence. The hospital will pay for medical, dental, and vision, insurance for full-time and regular part-time employees while they are on Family Medical Leave. Employees are responsible for paying for disability and life insurance coverage they wish to maintain on themselves during the time they are on a Family Medical Leave of Absence. While on Family Medical Leave of Absence, employees are responsible for paying for any medical, dental, vision, disability or life insurance coverage they may have on their eligible dependents through the hospital group plan.

If the employee elects not to return to work as a full-time or regular part-time employee for the hospital at the end of his or her four-month unpaid Family Medical Leave of Absence, the employee will be required to reimburse the hospital for premiums paid by the hospital for the employee's medical, dental, and vision insurance while the employee was on Family and Medical Leave of Absence.

Committee Approval	**Date**
Personnel/Payroll Advisory Committee	
Human Resources	
Administration	
Board of Directors	11/20/2002

NORTHERN INYO HOSPITAL
EMPLOYEE HANDBOOK – PERSONNEL POLICY

Title: Leaves of Absence - NORTHERN INYO HOSPITAL (NIH) JOB PROTECTED LEAVE (JPL) (14-02)	
Scope: Hospital Wide	Department: **Human resources – Employee Handbook**
Source: Human Resources	Effective Date:

POLICY:

If you are eligible for job protected leave (JPL) under federal or state law as described in Northern Inyo Hospital's (NIH) Leaves of Absence policies following the same criteria (eligibility, reasons, certification, etc.), NIH provides for concurrent job protected leave of up to four months (16 weeks; 640 full-time hours). NIH JPL is used concurrently at the same time as legally provided leaves of absence including but not limited to Pregnancy Disability Leave (PDL), Family Medical Leave Act (FMLA), California Family Rights Act (CFRA).

Essentially, NIH Job Protected Leave may lengthen the time an employee may be out on job protected leave in some circumstances. Example 1. Employee on job protected medical leave for own serious health condition (non-pregnancy related) is not released and is unable to return to work after legally provided 12 weeks. Employee has up to 4 additional weeks of job protected leave time. Example 2. Employee on Pregnancy Disability for the maximum of 4 months and then on California Family Rights Act for baby bonding for 12 weeks will have no additional time available from NIH JPL since the 16 weeks runs concurrently and has been exhausted in this example. Example 3. Employee requires additional time beyond legally provided 12 weeks as an accommodation for disability. Employee has up to 4 additional weeks of job protected leave time.

Paid Time Off (PTO) may accrue, although possibly at a reduce level, while on job protected leaves of absence while you are coordinating benefits. If an employee on NIH JPL is no longer receiving a paycheck from NIH to coordinate benefits, no PTO accrues.

Healthcare benefits continue to be available at the applicable payroll deduction rate while on NIH JPL. If an employee on NIH JPL is no longer receiving a paycheck from NIH such that the applicable payroll deductions cannot be withheld, then the employee will be billed by NIH for the amount of the payroll deduction.

Other employees may donate PTO during this four-month part of the NIH JPL.

Employees off longer than 30 calendar days without pay will receive a new anniversary date upon return to work. The hospital will reinstate employees taking family leaves to the same or similar position if they return to their jobs within this four-month period.

Title: Leaves of Absence - NORTHERN INYO HOSPITAL (NIH) JOB PROTECTED LEAVE (JPL) (14-02)	
Scope: Hospital Wide	Department: **Human resources – Employee Handbook**
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If after the four-month job protected leave described above is exhausted, an employee has remaining leave hours available, leave may be extended according to the following:

- The same leave criteria as described in Northern Inyo Hospital's (NIH) Leaves of Absence policies apply.
- Entire balance of any available Paid Leave (PDLV), Old Sick Leave (SICKO), New Sick Leave (SICKN) may be used – employee will be paid at the level of their status (e.g. full-time employee will be paid 40 hours per week; part-time employee will be paid 32 hours per week) until all balances are exhausted or employee is released to return to work whichever occurs first. Employee is responsible for appropriately informing any income replacement resource, such that the integration of wage-replacement with full pay does not result in employee inappropriately receiving more than 100 percent of their salary.
- All of the employee's available Paid Time Off (PTO) may be used – employee will be paid at the level of their status (e.g. full-time employee will be paid 40 hours per week; part-time employee will be paid 32 hours per week) until the balance is exhausted or they are released to return to work whichever occurs first. Other employees may only donate PTO during the first four month part of the NIH JPL.
- Paid Time Off (PTO) will no longer accrue.
- Healthcare benefits continue to be available at full COBRA rates according to the plan document. There is a maximum length of time that COBRA is available.
- Employee will receive a new anniversary date.
- Employee will return to an available job for which they are qualified at the pay rate and other specifications for that job.

If employee is still unavailable to return to work after the above options are exhausted, the employee will be separated from employment with Northern Inyo Hospital.

Approval	**Date**
Human Resources	
Administration	
Board of Directors	

NORTHERN INYO HOSPITAL
EMPLOYEE HANDBOOK – PERSONNEL POLICY

Title: Leaves of Absence - FAMILY AND MEDICAL LEAVE ACT (FMLA) / CALIFORNIA FAMILY RIGHTS ACT (CFRA)	
Scope: Hospital Wide	Department: **Human resources – Employee Handbook**
Source: Human Resources	Effective Date:

POLICY:

Northern Inyo Hospital (NIH) provides family and medical leave benefits in accordance with the federal Family and Medical Leave Act (FMLA) and the California Family Rights Act (CFRA). If your absence qualifies as family and medical leave under both state and federal laws, you will use your entitlement under each law at the same time, to the extent permitted by law. If one law's provisions provide a greater benefit, you will receive the greater benefit. These leave benefits are described below.

Eligibility

To be eligible for family/medical leave, you must have worked for NIH for at least 12 months and for at least 1,250 hours in the 12 calendar months immediately preceding the commencement of your leave. (You must also work at a worksite with at least 50 employees on site or within a 75-mile radius.)

Types of absences covered – reasons for leave

You may take up to 12 weeks of unpaid job-protected family/medical leave within a 12-month period for any of the following reasons:

1. The birth of a child and to bond with or provide care for such child;
2. The placement of a child with you for adoption or foster care and to bond with or care for such child;
3. To care for a parent, child, spouse, or domestic partner who has a serious health condition;
4. For your own serious health condition that renders you unable to perform the functions of your position; or
5. For a qualifying exigency, as described below.
    a. Eligible employees with a spouse, son, daughter, or parent on active duty in the regular Armed Forces or called to active duty status in the National Guard or reserves may use their 12-week FMLA leave entitlement to address certain qualifying exigencies Arising out of the fact that the employee's spouse, son, daughter, or parent is on (or has been notified of an impending call to) "covered active duty" in the Regular Armed Forces, National Guard, or reserves, i.e., deployment in a foreign country, or is a qualified veteran with a serious injury or illness.

    "Covered active duty" for members of a regular component of the armed forces means duty during deployment of these members with the armed

forces to a foreign country. "Covered active duty" for members of the reserve components of the Armed Forces (members of the U.S. National Guard and reserves) means duty during deployment of these members with the armed forces to a foreign country under a call or order to active duty in a contingency operation.

Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings. (Leave for this reason is referred to in this policy as "qualifying exigency leave" and is not covered under the leave provisions of the CFRA.)

6. Eligible employees may take up to 26 weeks of FMLA leave to care for a covered servicemember with a serious injury or illness during any single 12-month period. (Leave for this reason is referred to in this policy as "military caregiver leave" and is not covered under the leave provisions of the CFRA.) A covered servicemember includes:
   a. A current member of the Armed Forces, including a member of the National Guard or Reserves, with an injury or illness that the member incurred in the line of duty on active duty in the armed forces (or existed before the beginning of the member's active duty and was aggravated by service in line of duty on active duty in the Armed Forces) and that may render the servicemember medically unfit to perform his or her office, grade, rank, or rating.
   b. Veterans, that is, those discharged or released under conditions other than dishonorable at any time during the 5-year period before the first date the eligible employee takes FMLA leave to care for him or her while her or she undergoes medical treatment, recuperation, or therapy for a serious injury or illness.

For the purposes of leave taken under reasons #3 and #4 above, a "serious health condition" is an illness, injury, impairment, or physical or mental condition that involves either inpatient care (i.e., an overnight stay in a medical care facility) or continuing treatment by a healthcare provider, and that renders the employee unable to perform the essential functions of his or her position, or a covered family member with a serious health condition needing the employee's care.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than three consecutive calendar days combined with at least

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two visits to a health care provider; one visit and a regimen of continuing treatment; or incapacity due to pregnancy; or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

Leave for either of the first two reasons listed above must be completed within the 12-month period beginning on the date of birth or placement of the child. In cases in which NIH employs both parents, they may take a maximum combined total of 12 weeks leave during any 12-month period for the first two reasons.

When NIH employs both husband and wife, they may take a maximum combined total of 26 weeks in a single 12-month period for military caregiver leave or a combination of qualifying exigency leave and military caregiver leave. For only qualifying exigency leave, the husband and wife may take a maximum combined total of 12 weeks.

Calculating the 12-month period

NIH uses a rolling 12-month period method to calculate the 12-month period during which eligible employees may take 12 weeks of family/medical leave.

Note that military caregiver leave is a one-time FMLA benefit, and as such, the 26 weeks are only available during a single 12-month period. However, an employee may be entitled to more than one period of military caregiver leave if the leave is to care for a different covered servicemember or to care for the same servicemember with a subsequent serious injury or illness, except that no more than 26 workweeks of leave may be taken within any single 12-month period. NIH will begin counting the 12-month period on the first day of leave taken to care for the injured or ill servicemember. During the 12-month period when military caregiver leave is used, an employee is limited to a combined total of 26 weeks of FMLA leave for any reason.

Pregnancy, childbirth, related conditions

While pregnancy and prenatal care are included in the definition of "serious health condition" under the FMLA, they are not covered under the leave provisions of the CFRA. If you take leave for pregnancy disability (up to 4 months, as certified by your healthcare provider) and are also eligible for family/medical leave, your FMLA-protected family/medical leave will run concurrently with your pregnancy disability leave. Once you are no longer disabled by pregnancy/childbirth, you may apply for up to 12 weeks of leave under the CFRA to bond with your newborn.

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Notice of leave

If your need for family/medical leave is foreseeable, you must give NIH at least 30 days prior written notice. If this is not possible, you must give notice as soon as practicable (generally the same day or next business day after you learn of the need for leave, depending on the circumstances), and you must comply with NIH's usual and customary notice and procedural requirements for requesting leave (such as call-in procedures), absent unusual circumstances. Failure to provide such notice may be grounds for delay of leave. Additionally, if you are planning a medical treatment, you must consult with your supervisor regarding the dates of such treatment to minimize disruption to NIH's operations.

For foreseeable leave due to a qualifying exigency, notice must be provided as soon as practicable, regardless of how far in advance such leave is foreseeable.

When providing notice, you must include sufficient information for NIH to determine if the leave may qualify for FMLA/CFRA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee's serious health condition renders the employee unable to perform the essential functions of his or her position, a family member is unable to perform daily activities because of a serious health condition, the need for hospitalization or continuing treatment by a healthcare provider, or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA/CFRA leave was previously taken or certified.

NIH has Request for Family/Medical Leave forms available from the human resources department. You should use these forms when requesting leave.

Certification

NIH requires requests for family/medical leave to be supported by a medical or other certification, as described below. You may obtain approved certification forms from the human resources department. When you request a leave, NIH will notify you of the requirement for certification and when it is due (no fewer than 15 calendar days after you request leave). If you are unable to obtain the certification due to reasons beyond your control, notify the human resources department as soon as possible. Failure to provide requested certification in a timely manner may result in delay of leave until required documentation is provided.

Serious health condition

A request for family/medical leave because of your own serious health condition or to care for a family member with a serious health condition must be supported by a medical certification from a healthcare provider. The medical certification must include the following information:

1. The name, address, telephone number, and fax number of the healthcare provider and type of medical practice/specialization;
2. The approximate date on which the serious health condition commenced and its probable duration;
3. The healthcare provider's statement documenting the need for leave (but excluding any reference to a specific diagnosis);
4. If you are the patient, a statement from the healthcare provider establishing that you are unable to work at all or perform one or more of the essential functions of your position due to the serious health condition; *and*
5. If the patient is a covered family member with a serious health condition, confirmation the family member is in need of care.

NIH, at its expense, may require an examination by a second healthcare provider designated by NIH if it has a question about the validity of the medical certification you initially provide. If the second healthcare provider's opinion conflicts with the original medical certification, NIH, at its expense, may require a third, mutually agreed on, healthcare provider to conduct an examination and provide a final and binding opinion.

NIH may require updated medical certification for additional leave, even if taken for the same medical condition. Failure to provide requested certification within 15 days, except where it is not practical under the circumstance, may result in delay of further leave until the certification is provided.

Qualifying exigency (military) leave

If you request qualifying exigency leave, you must provide NIH with a copy of the military member's active duty orders or other documentation issued by the military that indicates that the covered military member is on (or has been notified of an impending call to) "covered active duty" in the armed forces, and the dates of the covered military member's active duty service.

You must also provide a certification that includes the following information:

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1. A statement or description, signed by you, of appropriate facts regarding the qualifying exigency for which FMLA leave is requested, accompanied by any available documentation that supports the request.
2. The approximate date on which the qualifying exigency commenced or will commence;
3. The beginning and end dates for the absence;
4. If the leave will be taken on intermittent or reduced-schedule basis, an estimate of the frequency and duration of the qualifying exigency; *and*
5. If the qualifying exigency involves meeting with a third party, appropriate contact information for that individual or entity and a brief description of the purpose of the meeting. (This description should be limited to how the meeting relates to one of the bases for exigency leave and should not include any description of the topics discussed in the meeting.)

Military caregiver leave

Leave requested to care for a covered servicemember with a serious injury or illness must be supported by a certification, including a medical certification of the servicemember's need for care.

Leave is generally unpaid

Family/medical leave is generally unpaid. However, accrued vacation and other personal paid time off (except sick leave) may be substituted for unpaid leave for any type of family/medical leave. In addition, accrued sick leave may be substituted for unpaid leave when the family/medical leave is for your own serious health condition, and you may elect to substitute paid sick leave for the care of a family member, for military caregiver leave, or for any other situation for which paid sick leave is normally available under NIH policies and procedures or as required by state or federal law. The term "substitute" means that the paid leave will run concurrently with the unpaid FMLA leave.

The use of paid leave for family/medical leaves is, in all circumstances, subject to the terms and conditions contained in NIH's usual policies and procedures and restrictions applicable to that type of paid leave.

Depending on the circumstances, you may be eligible for other wage-replacement benefits, including short- or long-term disability insurance payments, workers' compensation benefits, State Disability Insurance benefits, or Paid Family Leave benefits. Eligible employees participating in the Paid Family Leave program may receive up to 6 weeks of partial wage replacement when taking leave from work to bond with a

new child or to care for a seriously ill parent, child, spouse, or domestic partner. You will be required to use up to 2 weeks of accrued, unused vacation time before receiving Paid Family Leave benefits, one of which shall run concurrently with the 1-week waiting period.

Note that neither the substitution of paid leave nor the integration of other wage-replacement benefits for unpaid leave shall extend the maximum family/medical leave period or result in your receiving more than 100 percent of your salary.

Medical and other benefits

During an approved family/medical leave, NIH will maintain your health benefits as if you continued to be actively employed. If paid leave is substituted for unpaid family/medical leave, NIH will deduct your portion of the health plan premium as a regular payroll deduction. If your leave is unpaid, you must pay your portion of the premium by paying invoices from NIH for your portion of the health plan premium. Your healthcare coverage will cease if your premium payment is more than 30 days late. If your payment is more than 15 days late, we will send you a letter to this effect. If we do not receive your copayment within 15 days after the date of this letter, your coverage may cease. If you elect not to return to work for at least 30 calendar days at the end of the leave period, you will be required to reimburse NIH for the cost of the premiums paid by NIH for maintaining coverage during your unpaid leave, unless you cannot return to work because of a serious health condition or other circumstances beyond your control.

During family/medical leave, you will accrue benefits, such as sick and vacation days, only when paid leave is substituted for unpaid leave and only if you would otherwise be entitled to continue accruing benefits. The use of family/medical leave cannot result in the loss of any employment benefit that accrued before the start of an employee's leave.

Intermittent and reduced-schedule leave

Leave because of a serious health condition or military caregiver leave may be taken intermittently (in separate blocks of time due to a single health condition) or on a reduced-leave schedule (reducing the usual number of hours you work per workweek or workday) if medically necessary. Qualifying exigency leave may also be taken intermittently or on a reduced-leave schedule.

Leave for bonding or the care of a new child generally must be taken in blocks of at least two weeks, but you are allowed to take two leaves of increments shorter than 2 weeks with the approval of your manager or human resources.

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If leave is unpaid, NIH will reduce your salary based on the amount of time actually worked. In addition, while you are on an intermittent or reduced-schedule leave, NIH may temporarily transfer you to an available alternative position that you are qualified for that better accommodates your recurring leave and that has equivalent pay and benefits.

Reinstatement

Employees returning from family/medical leave will be restored to the original or an equivalent position (with equivalent pay, benefits, and other employment terms). However, NIH reserves the right to deny reinstatement of "key employees" whose salary is among the top 10 percent of employees within 75 miles of the worksite if it would cause substantial and grievous economic injury to the operation of NIH.

As a condition of restoring an employee whose FMLA leave was occasioned by the employee's own serious health condition that made the employee unable to perform the employee's job, NIH requires the employee to obtain and present certification from the employee's healthcare provider that the employee is able to resume work.

Employer responsibilities

NIH is required to inform employees requesting leave whether they are eligible for family/medical leave. If they are, the notice must specify any additional information required as well as the employees' rights and responsibilities. If they are not eligible, the notice must provide a reason for the ineligibility.

NIH must inform employee if leave will be designated as FMLA/CFRA-protected and the amount of leave counted against the employee's leave entitlement. If the employer determines that the leave is not FMLA/CFRA-protected, the employer must notify the employee.

Unlawful Acts by Employers

It is unlawful for any employer to:

- Interfere with, restrain, or deny the exercise of any right provided under the FMLA and the CFRA.
- Discharge or discriminate against any person for opposing any practice made unlawful by the FMLA and the CFRA or for involvement in any proceeding under or relating to the FMLA or CFRA.

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Enforcement

An employee may file a complaint with the U.S. Department of Labor or the California Department of Fair Employment and Housing or may bring a private lawsuit against an employer alleging unlawful acts listed above. The FMLA and the CFRA do not affect any federal or state law prohibiting discrimination or supersede any state or local law or collective bargaining agreement that provides gender family or medical leave rights.

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EMPLOYEE HANDBOOK – PERSONNEL POLICY

Title: Leaves of Absence - LEAVE DONATION	
Scope: Hospital Wide	Department: **Human resources – Employee Handbook**
Source: Human Resources	Effective Date:

POLICY:

It is the policy of Northern Inyo Hospital (NIH) to allow employees to donate/transfer their paid leave (PDLV) or paid time off (PTO) (hereinafter "leave") to another employee who is experiencing a family emergency or personal crisis that creates a need for additional time off beyond that individual's available leave. Such donations are strictly voluntary, may occur during the first 16 weeks of a Northern Inyo Hospital (NIH) Job Protected Leave (JPL), and require the Administrator's approval.

PROCEDURES:

To be eligible to donate leave, you must have been employed with NIH for at least one year preceding the leave donation.

If you wish to donate leave, you must complete a "PTO or Paid Leave Transfer" form and provide it to the Administrator for approval.

The minimum donation is 8.00 hours and the maximum donation is 40.00 hours in one pay period, as long as you retain a minimum of 40.00 hours in your own PTO account.

Donated/transferred hours may be from an employee at the same or a higher rate of pay to an employee at the same or lower rate of pay on an hour for hour basis. Otherwise, only the equivalent value of hours may be donated. (Example 1. If donating employee makes $10/hour and receiving employee makes $5/hour, if all other requirements are met, donating employee may donate/transfer 40.00 hours. Example 2. If donating employee makes $5/hour and the receiving employee makes $10/hour, if all requirements are met, donating employee may donate/transfer 40.00 hours x $5 = $200 / $10 = 20.00 hours to the receiving employee. In this case, the hours will be rounded down to the nearest whole hour.)

Donated/transferred hours will not be returned to you.

You may only donate whole hours (i.e. 20.0 not 20.25).

You cannot borrow against future leave to donate. If you are currently on leave, you cannot donate leave.

You may donate/transfer leave to another employee during their first 16 weeks of a Northern Inyo Hospital (NIH) Job Protected Leave (JPL).

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Additional Information

Employees on extended leave, past their first 16 weeks of an NIH JPL, may no longer receive PTO donations/transfers.

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