November 15 2017 Regular Meeting

November 15 2017 Regular Meeting - November 15 2017

AGENDA

NORTHERN INYO HEALTHCARE DISTRICT
BOARD OF DIRECTORS REGULAR MEETING

November 15, 2017 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 pm).
2. At this time persons in the audience may speak on any items not on the agenda on any matter within the jurisdiction of the District Board (*Members of the audience will have an opportunity to address the Board on every item on the agenda. Speakers are limited to a maximum of three minutes each.).*
3. New Business
   A. Audit Report for 2016/2017 Fiscal Year, Wipfli LLP (*action item*).
   B. Policy and Procedure approval, *Sanctions for Breach of Patient Privacy* (*action item*).
   C. Policy and Procedure approval, *Sending Protected Health Information by Fax* (*action item*).
   D. Policy and Procedure approval, *Disclosures of PHI over the Telephone* (*action item*).
   E. Policy and Procedure approval, *Patient's Rights* (*action item*).
   F. Policy and Procedure approval, *Employee Recognition* (*action item*).
   G. Policy and Procedure approval, *Inyo Mono Advocates for Community Action* (*action item*).
   H. Policy and Procedure approval, *Nursing Services Jobs and Titles* (*action item*).
   I. Nursing Committee Charter approvals (*action items*):
      1. *Clinical Consistency Oversight Committee*
      2. *Professional Practice Council*
      3. *Safe Patient Handling Subcommittee*
      4. *Staffing Issues Advisory Committee*
   J. Hospital wide Pillars of Excellence, July 1 2017 through June 30 2018 (*information item*).
   K. Establish Board candidate interview committee (*action item*).
4. Old Business
   A. School Clinic update (*information item*).
   B. Compounding Pharmacy update (*information item*).

Consent Agenda (action items)

5. Approval of minutes of the October 2, 2017 special meeting

6. Approval of minutes of the October 18 2017 regular meeting
7. Financial and Statistical Reports as of September 30 2017
8. 2013 CMS Validation Survey Monitoring, November 2017

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9. Patient Experience Committee report (*information item*).
10. Workforce Experience Committee report (*information item*).
11. Chief of Staff Report; Richard Meredick, MD:

A. Policies/Procedures/Protocols/Order Sets approvals (*action items*):

- *Universal Protocol*
- *Airway Management*
- *Child Abuse and Neglect*
- *Admission, Discharge, Transfer of Patients: Continuum of Care*
- *Nursing Care of Outpatient Interventional Radiology Patient*
- *Contrast Use with Patients on Metformin*
- *Order Set Approval and Archiving*
- *Cosyntropin Stimulation Test*
- *Nursing Services Standing Committee Structure and Hospital Committee Participation*
- *EMTALA*
- *Medical Screening Examination of the Obstetrical Patient*
- *Blood Bank – Emergency Requests for Blood Components*
- *Medication Dosing in Renal Failure*

B. Core Privilege Form (*action item*):

- Obstetrics and Gynecology

C. Medical Staff Appointments/Privileges (*action items*):

- William I. Feske, MD (Radiology – Provisional Active Staff) – Dr. Feske was approved for a 90-day introductory period under temporary privileges in August 2017. The Bishop Radiology Group will continue to work with Dr. Feske. Dr. Feske is being recommended for provisional active staff membership.
- Irin Pansawira, OD (UC Berkeley Optometry – telemedicine staff) (*credentialing by proxy per bylaws section 3.6.1*).

D. Temporary Locum Tenens Privileges (*information item*):

- Zunaira Islam, MD (Hospitalist – locum tenens) – Dr. Islam underwent the expedited approval and credentialing process as designated in the Medical Staff Bylaws to meet an urgent patient care need for a maximum of 60 days in the 2017-2018 calendar year. Start Date: 11/3/2017.

12. Reports from Board members (*information items*).
13. Adjournment to closed session to/for:
    A. Hear reports on the hospital quality assurance activities from the responsible department head and the Medical Staff Executive Committee (*Section 32155 of the Health and Safety Code, and Section 54962 of the Government Code*).
    B. Discuss trade secrets, new programs and services (estimated public session date for discussion yet to be determined) (*Health and Safety Code Section 32106*).
    C. Discussion of a personnel matter (*pursuant to Government Code Section 54957*).
14. Return to open session and report of any action taken in closed session.
15. Adjournment.

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

Northern Inyo Healthcare District

Bishop, California

Financial Statements and Supplementary Information

Years Ended June 30, 2017 and 2016

WIPFLi LLP
CPAs and Consultants

Northern Inyo Healthcare District

Financial Statements and Supplementary Information

Years Ended June 30, 2017 and 2016

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WIPFLI LLP

Independent Auditor's Report

Board of Directors
Northern Inyo Healthcare District
Bishop, California

Report on the Financial Statements

We have audited the accompanying financial statements of Northern Inyo Healthcare District, its discretely presented component unit, and the aggregate remaining fund information, as of and for the years ended June 30, 2017 and 2016, and the related notes to the financial statements, which collectively comprise the Northern Inyo Healthcare District basic financial statements as listed in the table of contents.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with accounting principles generally accepted in the United States; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audit. We conducted our audit in accordance with auditing standards generally accepted in the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of the District as of June 30, 2017 and 2016, and the changes in financial position and cash flows thereof, for the year then ended in accordance with accounting principles generally accepted in the United States.

Required Supplementary Information

Accounting principles generally accepted in the United States require the schedule of changes in the net pension liability and related ratios and contributions on pages 51 through 54 be presented to supplement the basic financial statements. Such information, although not a part of the basic financial statements, is required by the Governmental Accounting Standards Board, who considers it to be an essential part of financial reporting for placing the basic financial statements in an appropriate operational, economic, or historical context. We have applied certain limited procedures to the required supplementary information in accordance with auditing standards generally accepted in the United States, which consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the basic financial statements, and other knowledge we obtained during our audit of the basic financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

Management has omitted the management's discussion and analysis that accounting principles generally accepted in the United States require to be presented to supplement the basic financial statements. Such missing information, although not a part of the basic financial statements, is required by the Governmental Accounting Standards Board, who considers it to be an essential part of financial reporting for placing the basic financial statements in an appropriate operational, economic, or historical context. Our opinion on the basic financial statements is not affected by this missing information.

Supplementary Information

Our audit was conducted for the purpose of forming opinions on the financial statements that collectively comprise the Northern Inyo Healthcare District's financial statements as a whole. The combining financial statements and statistical section are presented for purposes of additional analysis and are not a required part of the financial statements. The combining financial statements are the responsibility of management and were derived from and relate directly to the underlying accounting and other records used to prepare the financial statements.

Such information has been subjected to the auditing procedures applied in the audit of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States. In our opinion, the combining financial statements are fairly stated in all material respects in relation to the financial statements as a whole.

The statistical information has not been subjected to the auditing procedures applied in the audit of the basic financial statements and, accordingly, we do not express an opinion or provided any assurance on it.

Wipfli LLP

November XX, 2017
Spokane, Washington

Northern Inyo Healthcare District

Statements of Net Position

June 30, 2017 and 2016

Assets and Deferred Outflows of Resources	2017 Hospital	2017 Pioneer Medical Associates	2016 Hospital	2016 Pioneer Medical Associates
Current assets:				
Cash and equivalents	$ 3,700,497	$ 63,810	$ 3,616,253	$ 110,082
Current portion of assets limited as to use	2,084,955	-	1,598,000	-
Receivables:				
Patient - Net	13,692,932	-	12,050,254	-
Other	35,924	-	537,695	-
Inventory	3,996,558	-	3,151,882	-
Prepaid expenses and deposits	1,355,285	-	1,012,979	-
Total current assets	24,866,151	63,810	21,967,063	110,082
Other assets:				
Noncurrent assets limited as to use	18,315,044	-	20,346,263	-
Investment in PMA	512,810	-	264,441	-
Goodwill in PMA	581,219	-	581,219	-
Net pension asset	3,847	-	-	-
Total other assets	19,412,920	-	21,191,923	-
Capital assets				
Nondepreciable capital assets	961,144	341,260	959,015	341,260
Depreciable capital assets - Net	78,826,238	209,938	82,118,750	225,468
Capital assets - Net	79,787,382	551,198	83,077,765	566,728
Deferred outflows of resources	13,365,385	-	14,144,525	-
TOTAL ASSETS AND DEFERRED OUTFLOWS OF RESOURCES	$ 137,431,838	$ 615,008	$ 140,381,276	$ 676,810

See accompanying notes to financial statements.

Northern Inyo Healthcare District

Statements of Net Position

June 30, 2017 and 2016

Liabilities, Deferred Inflows of Resources, and Net Position	2017 Hospital	2017 Pioneer Medical Associates	2016 Hospital	2016 Pioneer Medical Associates
Current liabilities:				
Current maturities of long-term liabilities:				
Bonds payable	$ 1,902,000	$ -	$ 1,598,000	$ -
Capital lease obligation	146,310	-	943,981	-
Accounts payable	1,806,069	-	2,136,881	-
Accrued interest and sales tax	150,903	-	181,492	-
Accrued payroll and related liabilities	4,265,677	-	5,035,994	-
Estimated third-party payor settlements	987,319	-	1,621,328	-
Unearned revenue	77,427	-	-	-
Total current liabilities	9,335,705	-	11,517,676	-
Long-term liabilities:				
Bonds payable	44,553,401	-	46,567,830	-
Accreted interest	10,867,094	-	9,540,509	-
Capital lease obligation	-	-	146,220	-
Net pension liability	30,487,532	-	33,492,468	-
Total long-term liabilities	85,908,027	-	89,747,027	-
Total liabilities	95,243,732	-	101,264,703	-
Deferred inflows of resources	4,507,730	-	1,427,520	-
Net position:				
Net investment in capital assets	33,042,009	-	33,643,543	-
Restricted for debt service	4,142,192	-	3,677,623	-
Restricted for programs	133,140	409,141	31,371	450,255
Restricted for pension benefits	2,933	-	-	-
Unrestricted	360,102	205,867	336,516	226,555
Total net position	37,680,376	615,008	37,689,053	676,810
TOTAL LIABILITIES, DEFERRED INFLOWS OF RESOURCES, AND NET POSITION	$ 137,431,838	$ 615,008	$ 140,381,276	$ 676,810

See accompanying notes to financial statements.

Northern Inyo Healthcare District

Statements of Revenue, Expenses, and Changes in Net Position

Years Ended June 30, 2017 and 2016

	2017		2016	
	Hospital	Pioneer Medical Associates	Hospital	Pioneer Medical Associates
Operating revenue:				
Net patient service revenue	$ 75,170,833	$ -	$ 74,146,031	$ -
Other operating revenue	438,963	192,779	692,616	192,779
Total revenue	75,609,796	192,779	74,838,647	192,779
Operating expenses:				
Salaries and wages	23,374,755	-	21,661,553	-
Employee benefits	17,527,645	-	15,742,060	-
Professional fees	10,897,303	1,290	11,278,187	1,280
Supplies	7,299,715	-	7,199,940	-
Purchased services	3,588,642	-	3,835,670	-
Depreciation	5,028,943	15,530	5,167,287	16,799
Other operating expenses	4,153,247	37,796	4,465,672	39,512
Total operating expenses	71,870,250	54,616	69,350,369	57,591
Income from operations	3,739,546	138,163	5,488,278	135,188
Nonoperating revenue (expenses):				
Tax revenue for operations	583,731	-	537,369	-
Tax revenue for debt services	1,304,781	-	1,496,646	-
Interest income	628,397	35	212,234	38
Interest expense	(2,959,007)	-	(3,299,568)	-
Loss on sale of asset	(4,605)	-	(10,542)	-
Noncapital grants and contributions	252,515	-	661,882	-
Medical office building - Net	(4,081,762)	-	(4,000,230)	-
Total nonoperating revenue (expenses)	(4,275,950)	35	(4,402,209)	38
Excess (deficit) of revenue over expenses	(536,404)	138,198	1,086,069	135,226
Capital grants and contributions	527,727	-	105,788	-
Distributions to PMA investors	-	(200,000)	-	(100,000)
Increase (decrease) in net position	(8,677)	(61,802)	1,191,857	35,226
Net position at beginning	37,689,053	676,810	36,497,196	641,584
Net position at end	$ 37,680,376	$ 615,008	$ 37,689,053	$ 676,810

See accompanying notes to financial statements.

Northern Inyo Healthcare District

Statements of Cash Flows

Years Ended June 30, 2017 and 2016

	2017		2016	
	Hospital	Pioneer Medical Associates	Hospital	Pioneer Medical Associates
Increase (decrease) in cash and cash equivalents:				
Cash flows from operating activities:				
Receipts from and on behalf of patients and third-party payors	$ 72,894,146	$ -	$ 70,965,309	$ -
Receipts from other operating revenue	946,024	192,779	188,278	192,779
Payments to employees	(40,822,150)	-	(36,334,184)	-
Payments to suppliers, contractors, and others	(27,456,701)	(39,086)	(25,948,758)	(40,792)
Net cash provided by operating activities	5,561,319	153,693	8,870,645	151,987
Cash flows from noncapital financing activities:				
District tax revenue for operations	583,731	-	537,369	-
Medical office building, net	(4,081,762)	-	(4,000,230)	-
Other nonoperating revenue	252,515	-	661,882	-
Net cash used in noncapital financing activities	(3,245,516)	-	(2,800,979)	-
Cash flows from capital and related financing activities:				
District tax revenue for debt services	1,382,208	-	1,496,646	-
Capital grants and contributions	527,727	-	105,788	-
Received for sale of asset	-	-	62,434	-
Proceeds from issuance of long-term debt	-	-	17,557,000	-
Principal paid on long-term debt	(1,598,000)	-	(1,098,818)	-
Long-term debt in escrow	-	-	(17,281,182)	-
Principal paid on capital lease obligations	(943,891)	-	(1,007,859)	-
Interest paid	(1,775,440)	-	(2,451,319)	-
Payments for purchase of property and equipment	(2,001,016)	-	(1,199,703)	-
Net cash used in capital and related financing activities	(4,408,412)	-	(3,817,013)	-

Northern Inyo Healthcare District

Statements of Cash Flows (Continued)

Years Ended June 30, 2017 and 2016

	2017		2016	
	Hospital	Pioneer Medical Associates	Hospital	Pioneer Medical Associates
Cash flows from investing activities:				
Interest received	$ 623,107	$ 35	$ 206,944	$ 38
Net sales (purchases) of assets limited as to use	1,544,264	-	(4,693,027)	-
Partnership distributions/contributions	(248,369)	(200,000)	133,052	(100,000)
Net cash provided by (used in) investing activities	1,919,002	(199,965)	(4,353,031)	(99,962)
Net increase (decrease) in cash and cash equivalents	(173,607)	(46,272)	(2,100,378)	52,025
Cash and cash equivalents at beginning	3,616,253	110,082	5,716,631	58,057
Cash and cash equivalents at end	$ 3,442,646	$ 63,810	$ 3,616,253	$ 110,082

Northern Inyo Healthcare District

Statements of Cash Flows (Continued)

Years Ended June 30, 2017 and 2016

	2017		2016	
	Hospital	Pioneer Medical Associates	Hospital	Pioneer Medical Associates
Reconciliation of income from operations to net provided by operating activities:				
Income from operations	$ 3,739,546	$ 138,163	$ 5,488,278	$ 135,188
Adjustments to reconcile income from operations to net cash provided by operating activities:				
Depreciation and amortization	5,028,943	15,530	5,167,287	16,799
Provision for bad debts	3,221,888	-	2,213,693	-
Changes in operating assets and liabilities:				
Receivables:				
Patient - Net	(4,864,566)	-	(3,518,747)	-
Other	507,061	-	(504,338)	-
Inventory	(844,676)	-	(120,841)	-
Prepaid expenses and deposits	(342,306)	-	336,349	-
Accounts payable	(330,812)	-	615,203	-
Accrued payroll and related liabilities	(770,317)	-	(253,394)	-
Estimated third-party payor settlements	(1,134,009)	-	(1,875,668)	-
Net pension asset/liability and related deferred inflows/outflows	850,567	-	1,322,823	-
Total adjustments	1,321,773	15,530	3,382,367	16,799
Net cash provided by operating activities	$ 5,061,319	$ 153,693	$ 8,870,645	$ 151,987
Noncash capital and investing activities:				
Prior year capital expenditures charged to operations during current year	$ 257,853	$ -	$ -	$ -

See accompanying notes to financial statements.

Northern Inyo Healthcare District

Statements of Net Position of Pension Trust Fund - Plan

December 31, 2016

Assets	
Assets:	
Fixed dollar account	$ 14,594,640
Indexed bond fund	10,774,446
TOTAL ASSETS	$ 25,369,086
Net Position	
Net position held in trust for pension benefits	$ 25,369,086
TOTAL NET POSITION	$ 25,369,086

See accompanying notes to financial statements.

Northern Inyo Healthcare District

Statements of Changes in Net Position of Pension Trust Fund - Plan

Years Ended December 31, 2016

Additions:	
Employer contributions	$ 4,500,000
Return on plan assets	131,859
Total additions	4,631,859
Deductions:	
Benefits paid	7,959,656
Total deductions	7,959,656
Change in net position	(3,327,797)
Net position at beginning	28,696,833
Net position at end	$ 25,369,036

See accompanying notes to financial statements.

Northern Inyo Healthcare District

Statement of Net Position of Pension Trust Fund - PEPRA Plan

December 31, 2016

Assets	
Assets:	
Cash	$ 23,330
TOTAL ASSETS	$ 23,330
Net Position	
Net position held in trust for pension benefits	23,330
TOTAL NET POSITION	$ 23,330

See accompanying notes to financial statements.

Northern Inyo Healthcare District

Statement of Changes in Net Position of Pension Trust Fund - PEPRA Plan

Year Ended December 31, 2016

Additions:		
Employee contributions	$	9,380
Employer contributions		13,950
Total additions		23,330
Change in net position		23,330
Net position at beginning		-
Net position at end	$	23,330

See accompanying notes to financial statements.

Northern Inyo Healthcare District

Notes to Financial Statements

Note 1: Summary of Significant Accounting Policies

Reporting Entity

Northern Inyo Healthcare District (the "District"), was organized in 1946 under the terms of the Local Health Care District Law and is operated and governed by an elected Board of Directors. The District includes a 25-bed acute care facility that provides inpatient, outpatient, emergency care services, and a rural health clinic in Bishop, California, and it's surrounding area.

Northern Inyo Hospital Foundation, Inc. (the "Foundation") is a legally separate 501(c)(3) tax-exempt nonprofit public benefit corporation. The Foundation acts primarily as a fundraising organization to supplement the resources that are available to the District. Although the District does not control the timing or amount of receipts from the Foundation, the majority of the resources, or income thereon that the Foundation holds and invests, are restricted to the activities of the District by the Foundation's bylaws. The Foundation's Board of Directors may also restrict the use of such funds for capital asset replacement, expansion, or other specific purposes. The District shall appoint the Board of Directors for the Foundation per the Foundation's bylaws, and for this reason it is a blended component unit of the District.

Northern Inyo Hospital Auxiliary, Inc. (the "Auxiliary") is also a legally separate 501(c)(3) tax-exempt public benefit corporation. The Auxiliary's actions are subject to the approval of the District, and for this reason it is a blended component unit of the District.

Discretely Presented Component Unit

The Pioneer Medical Associates (PMA) is a partnership established by a group of physicians and practitioners in 1986 within the District campus at 152 Pioneer Lane. In an effort to support the continued recruitment for physicians and services, it has been the practice of the District to work with the PMA partners when appropriate and directed by the Board of Directors to purchase practices of individuals or groups who are leaving the area or retiring. The District currently owns a 66.67% interest in the partnership through acquisitions. PMA is reported in a separate column in the accompanying financial statements to emphasize that it is legally separate from the District. Separate financial statements for the component unit are not available.

Basis of Presentation

The financial statements have been prepared in accordance with the accounting principles generally accepted in the United States (GAAP) as prescribed by Governmental Accounting Standards Board (GASB).

Note 1: Summary of Significant Accounting Policies (Continued)

Use of Estimates in Preparation of Financial Statements

The preparation of the accompanying financial statements in conformity with GAAP requires management to make certain estimates and assumptions that directly affect the reported amounts of assets and liabilities and disclosure contingent assets and liabilities at the date of the financial statements. Estimates also affect the reported amounts of revenue and expenses during the reporting period. Actual results may differ from these estimates.

The District considers critical accounting estimates to be those that require more significant judgments and include the valuation of accounts receivable, including contractual allowances and provision for uncollectible accounts, estimated third-party payor settlements, and an estimate for claims incurred, but not reported under a self-funded health insurance plan.

Cash and Cash Equivalents

The District considers all highly liquid debt instruments with an original maturity of three months or less to be cash equivalents, excluding assets limited as to use.

The District is authorized under California Government Code to make direct investments in local agency bonds, notes, or warrants within the state; U.S. Treasury instruments; registered state warrants or treasury notes; securities of the U.S. government or its agencies; bankers' acceptances; commercial paper; certificates of deposit placed with commercial banks and/or savings and loan companies; repurchase or reverse repurchase agreements; medium-term corporate notes; shares of beneficial interest issued by diversified management companies, certificates of participation, and obligations with first-priority security; and collateralized mortgage obligations.

All investments are stated at fair value. Investment gain (loss) includes changes in fair value of investments, interest, and realized gains and losses.

Patient Receivables and Credit Policy

Patient receivables are uncollateralized patient obligations that are stated at the amount management expects to collect from outstanding balances. These obligations are primarily from local residents, most of whom are insured under third-party payor agreements. The District bills third-party payors on the patients' behalf, or if a patient is uninsured, the patient is billed directly. Once claims are settled with the primary payor, any secondary insurance is billed, and patients are billed for copay and deductible amounts that are the patient's responsibility. Payments on patient receivables are applied to the specific claim identified on the remittance advice or statement. The District does not have a policy to charge interest on past due accounts.

Northern Inyo Healthcare District

Notes to Financial Statements

Note 1: Summary of Significant Accounting Policies (Continued)

Patient Receivables and Credit Policy (Continued)

The carrying amounts of patient receivables are reduced by allowances that reflect management's best estimate of the amounts that will not be collected. Management provides for contractual adjustments under terms of third-party reimbursement agreements through a reduction of gross revenue and a credit to patient receivables. In addition, management provides for probable uncollectible amounts, primarily for uninsured patients and amounts patients are personally responsible for, through a reduction of gross revenue and a credit to the allowance for uncollectible accounts based on its assessment of historical collection experience and the current status of individual accounts. Balances that are still outstanding after management has used reasonable collection efforts are written off through a charge to the allowance for uncollectible accounts and a credit to patient receivables.

Patient receivables are recorded in the accompanying statements of net position net of contractual adjustments and an allowance for uncollectible accounts.

The District has a discount policy established for residents of the district. The amount of charges foregone for services and supplies furnished under the District's discount policy aggregated approximately $326,000 and $439,00 for the years ended June 30, 2017 and 2016, respectively.

Investment in PMA

Investment in a partnership is carried at the District's equity in the partnership's net assets. The partnership was organized to provide real estate for PMA. Ownership of the partnership consists of the District and local physicians.

Goodwill in PMA

Goodwill represents the excess of purchase price of an acquired business over the identifiable intangible assets acquired and liabilities assumed in connection with the acquisition of practices in PMA. The District reviews for impairment of goodwill on an annual basis, and this is amortized when a change in the expected duration of the intangible asset has occurred. No goodwill impairment was recognized in 2017 and 2016.

Inventory

Inventory is valued at the average unit cost, determined using the average of cost per unit extended by inventory quantity.

Assets Limited as to Use

Assets limited as to use include assets held under indenture agreements, assets held to service debt under the bond issue, and designated assets set aside by the Board of Directors for future capital improvements, over which the Board retains control and may at its discretion subsequently use for other purposes.

Note 1: Summary of Significant Accounting Policies (Continued)

Fair Value Measurement

Fair value is the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. A three-tier hierarchy prioritizes the inputs used in measuring fair value. These tiers include Level 1, defined as quoted market prices in active markets for identical assets or liabilities; Level 2, defined as inputs other than quoted market prices in active markets that are either directly or indirectly observable; and Level 3, defined as unobservable inputs therefore, requiring an entity to develop its own assumptions. The asset's or liability's fair value measurement within the hierarchy is based on techniques that maximize the use of relevant observable inputs and minimizes the use of unobservable inputs.

Assets or liabilities measured and reported at fair value are classified and disclosed in one of the three following categories:

Level 1 - Inputs to the valuation methodology are unadjusted quoted priced for identical assets or liabilities in active markets that the District has the ability to access.

Level 2 - Inputs to the valuation methodology include:

- Quoted prices for similar assets or liabilities in active markets.
- Quoted prices for identical or similar assets or liabilities in inactive markets.
- Inputs, other than quoted prices, those are observable for the asset or liability.
- Inputs that are derived principally from or corroborated by observable market data by correlation or other means.

If the asset or liability has a specified contractual term, the Level 2 input must be observable for substantially the full term of the asset or liability.

Level 3 - Inputs to the valuation methodology are unobservable and significant to the fair value measurement.

The asset's or liability's fair value measurement level within the fair value hierarchy is based on the lowest level of any input that is significant to the fair value measurement. Valuation techniques used need to maximize the use of observable inputs and minimize the use of unobservable inputs.

Capital Assets and Depreciation

Capital assets are recorded at cost if purchased or fair value at date received if contributed. The District maintains a threshold level of a unit or group cost of $5,000 or more for capitalizing capital assets. Depreciation is provided over the estimated useful life of each class of depreciable asset and is computed using the straight-line method.

Estimated useful lives range from 2 to 25 years for land improvements, buildings and improvements, leasehold improvements, and fixed equipment and from 3 to 20 years for equipment.

Note 1: Summary of Significant Accounting Policies (Continued)

Accreted Interest

Interest expense on capital appreciation bonds is being accreted on the straight line basis to maturity of the individual bonds.

Asset Impairment

Capital assets are reviewed for impairment when events or changes in circumstances suggest that the service utility of the capital asset may have significantly and unexpectedly declined. Capital assets are considered impaired if both the decline in service utility of the capital asset is large in magnitude and the event or change in circumstance is outside the normal life cycle of the capital asset. Such events or changes in circumstances that may be indicative of impairment include evidence of physical damage, enactment, or approval of laws or regulations or other changes in environmental factors; technological changes or evidence of obsolescence; changes in the manner or duration of use of a capital asset; and construction stoppage. The determination of the impairment loss is dependent on the event or circumstance in which the impairment occurred. Impairment losses, if any, are recorded in the statements of revenue, expenses, and changes in net position. There were no impairment losses recorded in the years ended June 30, 2017 and 2016.

Compensated Absences

The District accrues all leave time for employees as paid time-off (PTO) in the financial statements. In addition, employees hired prior to January 1, 2003, might have accumulated additional sick leave for major medical health problems. Usage of the additional sick leave must be approved by management.

The total potential liability of the District's accumulated sick leave for major medical is approximately $198,000 and $452,000 for the years ended June 30, 2017 and 2016, respectively. Such benefits do not vest; therefore, no liability has been accrued.

Retirement Plan

For purposes of measuring the net pension liability and deferred outflows/inflows of resources related to pensions, and pension expense, information about the pension net position of the Northern Inyo Healthcare District Retirement Plan ("the Plan") and Northern Inyo Healthcare District PEPRA Retirement Plan ("the PEPRA Plan") and additions to/deductions from the plans' pension net position have been determined on the same basis as they are reported by the Plan and PEPRA Plan. For this purpose, benefit payments (including refunds of employee contributions) are recognized when due and payable in accordance with the benefit terms. Investments are reported at fair value.

Northern Inyo Healthcare District

Notes to Financial Statements

Note 1: Summary of Significant Accounting Policies (Continued)

Unearned Revenue

Unearned revenue consists of tax collections the District received from the local tax agency. Amounts expected to be recognized in revenue within one year have been reclassified to current liabilities in the accompanying statements of net position.

Net Position

Net position of the District is classified in four components. Net investment in capital assets consists of capital assets net of accumulated depreciation and reduced by the current balances of any outstanding borrowings used to finance the purchase or construction of those assets. Restricted for debt service is cash that must be used for payments toward debt service. Restricted for programs is cash that must be used for nursing scholarships, as specified by contributors external to the District. Restricted nonexpendable net position is the minority interest of the partnership's net position. Unrestricted is remaining net position that does not meet the definitions above.

Net Patient Service Revenue

Net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payors, and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payors. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and are adjusted in future periods as final settlements are determined.

Charity Care

The District provides care to patients who meet certain criteria under its charity care policy without charge or at amounts less than its established rates. The District maintains records to identify the amount of charges forgone for services and supplies furnished under the charity care policy. Because the District does not pursue collection of amounts determined to qualify as charity care, they are not reported as net patient service revenue.

Operating Revenue and Expenses

The District's statements of revenue, expenses, and changes in net position distinguish between operating and nonoperating revenue and expenses. Operating revenue results from exchange transactions associated with providing health care services. Nonexchange revenue, including taxes, investment gain, grants, contributions received for purposes other than capital asset acquisition, and certain other revenue, is reported as nonoperating revenue. Operating expenses are all expenses incurred to provide health care services, other than financing costs.

Note 1: Summary of Significant Accounting Policies (Continued)

District Property Tax Revenue

The District has the authority to impose taxes on property within the boundaries of the health care district. Taxes are received from Inyo County (the "County"), which bills and collects the taxes for the District. Secured property taxes attach as an enforceable lien on property as of January 1 and are payable in two installments on November 1 and February 1.

Grants and Contributions

The District receives grants as well as contributions from individuals and private organizations. Revenue from grants and contributions (including contributions of capital assets) is recognized when all eligibility requirements, including time requirements, are met. Grants and contributions may be restricted for either specific operating purposes or capital purposes. Amounts that are unrestricted or are restricted to a specific operating purpose are reported as nonoperating revenue. Amounts restricted to capital acquisitions are reported after nonoperating revenue (expenses).

Advertising Costs

Advertising costs are expensed as incurred. Advertising expense totaled approximately $41,000 and $67,000 in 2017 and 2016, respectively.

Tax Status

The District is is a local agency of the State of California within the meaning of Section 56054 of the California Government Code. Accordingly, the District is exempt from federal income and state income, property, and franchise taxes. The District is not exempt for California Sales Tax and pays sales tax as required based on the type of product and or service purchased.

Unemployment Compensation

The District is a part of a pooled unemployment insurance group through California Association of Hospital and Healthcare Systems (CAHHS) for unemployment insurance and does not pay state unemployment tax.

Subsequent Events

Subsequent events have been evaluated through November XX, 2017, which is the date the financial statements were available to be issued.

Note 2: Reimbursement Arrangements With Third-Party Payors

The District has agreements with third-party payers that provide for reimbursement to the District at amounts that vary from its established rates. A summary of the basis of reimbursement with major third-party payers follows:

Hospital

Medicare – The Medicare program has designated the District as a critical access hospital (CAH) for Medicare reimbursement purposes. Under this designation, District inpatient, outpatient, and swing bed services rendered to Medicare program beneficiaries are paid based on a cost-reimbursement methodology, with the exception of certain lab and mammography services, which are reimbursed based on fee schedules. The cost based payments are reduced by a two percent mandatory reduction called sequestration. Sequestration reductions for Medicare hospital services were approximately $373,000 and $385,000 for 2017 and 2016, respectively.

Medi-Cal – Under CAH designation, the District inpatient and swing bed services rendered to Medi-Cal program beneficiaries were paid on a cost based reimbursement methodology through June 30, 2015. As of July 1, 2015, the State of California established rates are based on the most recently audited cost report for the District. There are no settlements for cost based methods after June 30, 2015. The reimbursement for outpatient services is based on a fee schedule. Starting in 2014, the State of California expanded the provision of coverage to managed care organization in rural California. The District applied for and received supplemental reimbursements for its inpatient and outpatient services during 2017 and 2016. The managed care organizations are included in the supplemental reimbursement in fiscal 2017, during the year the net Inter-Governmental Transfers (IGT) related to health claims during the California fiscal year 2015 was $1,205,451 after $59,476 in fees paid to the health plans. The supplemental reimbursements are based on a cost based reimbursement method. This method does not guarantee that all cost are recovered after the Federal match and administrative fees are paid.

Physician and Professional Services in Rural Health Clinics

Certain physician and professional services rendered to Medicare and Medi-Cal beneficiaries qualify for reimbursement as Medicare-approved rural health clinic services. Qualifying services are reimbursed based on a cost-reimbursement methodology. The cost based reimbursement payments from Medicare are reduced by a two percent mandatory reduction called sequestration. The sequestration reductions for the Rural Health Clinic services was approximately $23,000 and $22,000 for 207 and 2016, respectively.

Hospital Based and Free Standing Physicians and Professional Services

The District has entered into payment agreements with certain commercial insurance carriers, health maintenance organizations, and preferred provider organizations. The basis for payment to the District under these agreements includes discounts from established charges and prospectively determined daily rates.

Note 2: Reimbursement Arrangements With Third-Party Payors (Continued)

Accounting for Contractual Arrangements

The District is reimbursed for certain cost-reimbursable items at an interim rate, with final settlements determined after an audit of the District's related annual cost reports by the respective Medicare fiscal intermediaries. Estimated provisions to approximate the final expected settlements after review by the intermediaries are included in the accompanying financial statements. The cost reports for the District have been audited by Medicare and Medi-Cal through June 30, 2015 and 2014.

Compliance

The health care industry is subject to numerous laws and regulations of federal, state, and local governments. Compliance with these laws and regulations, particularly those relating to the Medicare and Medi-Cal programs, can be subject to government review and interpretation, as well as regulatory actions unknown and unasserted at this time. Violation of these laws and regulations could result in the imposition of fines and penalties, as well as repayments of previously billed and collected revenue from patient services. Management believes the District is in substantial compliance with current laws and regulations.

CMS uses recovery audit contractors (RAC) to search for potentially inaccurate Medicare payments that might have been made to health care providers and that were not detected through existing CMS program integrity efforts. Once the RAC identifies a claim it believes is inaccurate, the RAC makes a deduction from or addition to the provider's Medicare reimbursement in an amount estimated to equal the overpayment or underpayment. As of June 30, 2017, the District has not been notified by the RAC of any potential significant reimbursement adjustments.

Note 3: Cash and Cash Equivalents

Deposits

Custodial Credit Risk - Custodial credit risk is the risk that, in the event of a bank failure, the District's deposits may not be returned. The District does not have a deposit policy for custodial credit risk.

The California Government Code requires that a financial institution secure deposits made by state or local governmental units by pledging securities in an undivided collateral pool held by a depository regulated under state law (unless so waived by the governmental unit). The market value of the pledged securities in the collateral pool must equal at least 110% of the total amount deposited by the public agencies. California law also allows financial institutions to secure public deposits by pledging first trust deed mortgage notes having a value of 150% of the secured public deposits and letters of credit issued by the Federal Home Loan Bank of San Francisco having a value of 105% of the secured deposits.

At June 30, 2016, the net carrying amount of deposits was $5,262,273, and the bank balance was $6,576,430. Of the bank balance, $250,000 was covered by federal deposit insurance, and $6,326,430 was collateralized (i.e., collateralized with securities held by the pledging financial institutions of at least 110% of the District's cash deposits, in accordance with the California Government Code).

Note 3: Cash and Cash Equivalents (Continued)

Investments

Interest Rate Risk – As a means of limiting its exposure to fair value losses arising from rising interest rates, the District's investment policy includes its investment portfolio to the Local Agency Investment Guidelines promulgated by the California Debt & Investment Advisory Commission.

The District is a participant in the Local Agency Investment Fund (LAIF), which is regulated by California Government Code Section 16429 under the oversight of the Treasurer of the State of California. The fair value of the District's investment in this pool is reported in the accompanying financial statements at amounts based on the District's pro rata share of the fair value provided by LAIF for the entire LAIF portfolio (in relation to the amortized cost of that portfolio). The balance available for withdrawal is based on the accounting records maintained by LAIF, which are recorded on an amortized cost basis. The LAIF investment portfolio consists primarily of treasury bills, notes, and certificates of deposit.

Investments included in assets limited as of use consisted of the following at June 30:

		Remaining Maturity (in Years)			
	Fair Value	0-1	1-5	5-10	More Than 10
2017					
Certificates of deposit	$ 1,005,607	$ -	$ 1,005,607	$ -	$ -
LAIF	13,019,163	13,019,163	-	-	-
Totals	$ 14,024,770	$ 13,019,163	$ 1,005,607	$ -	$ -
2016					
Certificates of deposit	$ 1,020,246	$ 153,105	$ 867,141	$ -	$ -
LAIF	15,570,215	15,570,215	-	-	-
Totals	$ 16,590,461	$ 15,723,320	$ 867,141	$ -	$ -

Following is a description of the valuation methodologies used for assets measured at fair value.

Certificates of deposit are valued at quoted market prices, which represent the net asset value (NAV) of shares held by the District at year-end.

Fixed-income securities are valued at cost, which approximates fair value.

The methods described may produce a fair value calculation that may not be indicative of net realizable value or reflective of future values. Furthermore, while the District believes its valuation methods are appropriate and consistent with other market participants, the use of different methodologies or assumptions to determine fair value of certain financial instruments could result in a different fair value measurement at the reporting date.

Northern Inyo Healthcare District

Notes to Financial Statements

Note 3: Cash and Cash Equivalents (Continued)

Investments (Continued)

The following tables set forth by level, within the fair value hierarchy, the District's assets at fair value at June 30:

2017

	Fair Value Measurements Using			Total Assets at Fair Value
	Level 1	Level 2	Level 3	
Assets:				
Fixed income securities	$ 974,905	$ -	$ -	$ 974,905
Certificates of deposit	-	1,005,607	-	1,005,607
Totals	$ 974,905	$ 1,005,607	$ -	$ 1,980,512

2016

	Fair Value Measurements Using			Total Assets at Fair Value
	Level 1	Level 2	Level 3	
Assets:				
Fixed income securities	$ -	$ 520,378	$ -	$ 520,378
Certificates of deposit	-	1,020,246	-	1,020,246
Totals	$ -	$ 1,540,624	$ -	$ 1,540,624

Employees' Retirement System - The District's governing body has the responsibility and authority to oversee the investment portfolio. Various professional investment managers are contracted to assist in managing the District's investments; all investment decisions are subject to California law and the investment policy established by the governing body. The District's investments are held by an independent trust company.

The District's retirement system investments are stated at NAV and fair value. The fixed dollar fund is stated at NAV, which is determined based on the total value of all investments in its portfolio minus the value of liabilities. The index bond fund is stated at fair value, using a level one measurement (Level 1), which is determined as follows: (a) short-term investments are reported at cost, which approximates fair value; (b) securities traded on a national or international exchange are valued at the last reported sales price at current exchange rates; (c) investments for which market quotations are not readily available are valued at their fair values as determined by the custodian under the direction of the District's governing body, with the assistance of a valuation service; and (d) cash deposits are reported at carrying amounts, which reasonably approximate fair value.

Note 3: Cash and Cash Equivalents (Continued)

Investments (Continued)

Following is a summary of the District's investments as of June 30:

	2017	2016
Fixed dollar fund	$ 14,594,640	$ 18,150,549
Indexed bond fund	10,774,446	10,546,334
Totals	$ 25,369,086	$ 28,696,883

Credit Risk - Credit risk is the risk that an issuer of an investment will not fulfill its obligation to the holder of the investment. This is measured by assignment of a rating by a nationally recognized statistical rating organization. The District has an investment policy that limits its investment choices by credit rating. LAIF is not rated.

Concentration of Credit Risk - The California Government Code limits the purchase of certain investments to defined percentages of the investment portfolio.

Custodial Credit Risk - For an investment, custodial credit risk is the risk that, in the event of the failure of the counter party (e.g., broker-dealer) to the transaction, the District will not be able to recover the value of its investment or collateral securities that are in the possession of another party. The District's investment policy does not limit the exposure to custodial credit risk for investments. All investments are held by the District's agent in the District's name and, therefore, are not exposed to custodial risk.

Northern Inyo Healthcare District

Notes to Financial Statements

Note 4: Assets Limited as to Use

Assets limited as to use that are required for obligations classified as current liabilities are reported in current assets.

Assets limited as to use consisted of the following at June 30:

	2017	2016
LAIF investments:		
Board designated - Capital improvements	$ 12,594,786	$ 15,036,629
Internal designated - Pension plan	424,377	533,586
Total LAIF investments	13,019,163	15,570,215
Cash and other investments		
External restrictions:		
Bond payment funds - Under indenture agreement	2,720,239	2,693,403
Nursing scholarship fund	133,140	31,371
Bonds and interest	1,421,953	984,220
Board designations:		
Internally designated for capital acquisitions	1,124,992	1,124,430
Fixed-income, corporate bonds - Future operations	974,905	520,378
Certificates of deposit - Future operations	1,005,607	1,020,246
Total cash and other investments	7,380,836	6,374,048
Total assets limited as to use	20,399,999	21,944,263
Less - Current portion	2,084,955	1,598,000
Noncurrent assets limited as to use	$ 18,315,044	$ 20,346,263

Northern Inyo Healthcare District

Notes to Financial Statements

Note 5: Patient Receivables - Net

Patient receivables - net consisted of the following at June 30:

	2017	2016
Patient receivables	$ 28,190,581	$ 22,427,240
Less:		
Contractual adjustments	12,648,649	9,144,986
Allowance for uncollectible accounts	1,849,000	1,232,000
Patient receivable - Net	$ 13,692,932	$ 12,050,254

The District gross days in accounts receivables was 79.42 and 64.14 for 2017 and 2016, respectively.

Note 6: Net Patient Service Revenue

Net patient service revenue consisted of the following for the years ended June 30:

	2017	2016
Gross patient service revenue:		
Inpatient services	$ 38,151,155	$ 41,322,656
Outpatient services	91,391,838	86,647,836
Totals	129,542,993	127,970,492
Less:		
Contractual adjustments	51,150,272	51,610,768
Provision for uncollectible accounts	3,221,888	2,213,693
Net patient service revenue	$ 75,170,833	$ 74,146,031

Note 6: Net Patient Service Revenue (Continued)

The following table reflects the percentage of gross patient service revenue by payor source for the years ended June 30:

	2017	2016
Medicare	42 %	42 %
Medi-Cal	23 %	21 %
Other third-party payors	30 %	33 %
Patients	5 %	4 %
Patient service revenue (net of contractual allowances and discounts)	100 %	100 %

Note 7: Charity Care

The District provides health care services and other financial support through various programs that are designed, among other matters, to enhance the health of the community including the health of low-income patients. Consistent with the mission of the District, care is provided to patients regardless of their ability to pay, including providing services to those persons who cannot afford health insurance because of inadequate resources.

Patients who meet certain criteria for charity care, generally based on federal poverty guidelines, are provided care based on criteria defined in the District's charity care policy. The District maintains records to identify and monitor the level of charity care it provides. The amount of charges foregone for services and supplies furnished under the District's charity care policy aggregated approximately $1,792,964 and $1,204,081 for the years ended June 30, 2017 and 2016, respectively.

The estimated cost of providing care to patients under the District's charity care policy aggregated approximately $953,000 and $640,000 in 2017 and 2016, respectively. The cost was calculated by multiplying the ratio of cost to gross charges for the District times the gross uncompensated charges associated with providing charity care.

Northern Inyo Healthcare District

Notes to Financial Statements

Note 8: Capital Assets

The District's capital assets activity consisted of the following for the years ended June 30:

	2017				
	Balance July 1, 2016	Additions	Transfers and Adjustments	Deletions	Balance June 30, 2017
Nondepreciable capital assets:					
Land	$ 735,330	$ -	$ -	$ -	$ 735,330
Construction in progress	223,685	828,075	(692,741)	(133,205)	225,814
Total nondepreciable capital assets	959,015	828,075	(692,741)	(133,205)	961,144
Depreciable capital assets:					
Land improvements	863,585	3,500	-	-	867,085
Buildings	87,803,771	5,446	-	-	87,809,217
Equipment	29,946,881	1,163,997	692,741	(377,054)	31,426,565
Total depreciable capital assets	118,614,237	1,172,943	692,741	(377,054)	120,102,867
Less - Accumulated depreciation	36,495,487	5,028,943	-	(247,801)	41,276,629
Net depreciable capital assets	82,118,750	(3,856,000)	692,741	(129,253)	78,826,238
Totals	$ 83,077,765	$(3,027,925)	$ -	$ (262,458)	$ 79,787,382

At June 30, 2017, construction in progress consisted of e-prescribing of controlled substances, pharmacy clean room, and ortho clinic move. The e-prescribing and pharmacy clean room projects are expected to be completed during fiscal year 2018; the ortho clinic move is expected to be completed by June 2020. The estimated completion costs of the projects are approximately less than $1,325,000. The District intends to fund the projects through the use of internal funds.

Northern Inyo Healthcare District

Notes to Financial Statements

Note 8: Capital Assets (Continued)

	2016				
	Balance July 1, 2015	Additions	Transfers and Adjustments	Deletions	Balance June 30, 2016
Nondepreciable capital assets:					
Land	$ 735,330	$ -	$ -	$ -	$ 735,330
Construction in progress	292,122	308,470	(376,907)	-	223,685
Total nondepreciable capital assets	1,027,452	308,470	(376,907)	-	959,015
Depreciable capital assets:					
Land improvements	863,585	-	-	-	863,585
Buildings	88,116,384	191,886	34,651	(539,150)	87,803,771
Equipment	29,759,606	699,347	342,256	(854,328)	29,946,881
Total depreciable capital assets	118,739,575	891,233	376,907	(1,393,478)	118,614,237
Less - Accumulated depreciation	32,648,702	5,167,287	-	(1,320,502)	36,495,487
Net depreciable capital assets	86,090,873	(4,276,054)	376,907	(72,976)	82,118,750
Totals	$ 87,118,325	$ (3,967,584)	$ -	$ (72,976)	$ 83,077,765

Northern Inyo Healthcare District

Notes to Financial Statements

Note 8: Capital Assets (Continued)

The PMA's capital assets activity consisted of the following for the years ended June 30:

	2017			
	Balance July 1, 2016	Additions	Deletions	Balance June 30, 2017
Nondepreciable capital assets:				
Land	$ 341,260	$ -	$ -	$ 341,260
Total nondepreciable capital assets	341,260	-	-	341,260
Depreciable capital assets - Buildings	1,043,214	-	-	1,043,214
Less - Accumulated depreciation	817,746	15,530	-	833,276
Net depreciable capital assets	225,468	(15,530)	-	209,938
Totals	$ 566,728	$ (15,530)	$ -	$ 551,198

	2016			
	Balance July 1, 2015	Additions	Deletions	Balance June 30, 2016
Nondepreciable capital assets:				
Land	$ 341,260	$ -	$ -	$ 341,260
Total nondepreciable capital assets	341,260	-	-	341,260
Depreciable capital assets - Buildings	1,043,214	-	-	1,043,214
Less - Accumulated depreciation	800,947	16,799	-	817,746
Net depreciable capital assets	242,267	(16,799)	-	225,468
Totals	$ 583,527	$ (16,799)	$ -	$ 566,728

Northern Inyo Healthcare District

Notes to Financial Statements

Note 9: Long-Term Debt and Capital Lease Obligations

Long-term debt and capital lease obligations activity for the years ended June 30 was as follows:

	2016	Additions	Reductions	2017	Current Due
Bonds payable:					
2016 General Obligation Refunding Bond	$ 17,557,000	$ -	$ (278,000)	$ 17,279,000	$ 282,000
General Obligation Bonds, 2009 Series:					
Current Interest Bonds	2,535,000	-	(350,000)	2,185,000	595,000
Capital Appreciation Bonds	8,144,947	-	-	8,144,947	-
Revenue Bonds, 2010 Series	8,780,000	-	(660,000)	8,120,000	700,000
Revenue Bonds, 2013 Series	10,415,000	-	(310,000)	10,105,000	325,000
Subtotal bonds payable	47,431,947	-	(1,598,000)	45,833,947	1,902,000
Bond premiums:					
General Obligation Bonds:					
2009 Series	560,770	-	(97,376)	463,394	-
Revenue Bonds, 2013 Series	173,113	-	(15,053)	158,060	-
Total bonds payable	48,165,830	-	(1,710,429)	46,455,401	1,902,000
Accreted Interest - General Obligation Bonds, 2009 Series, Capital Appreciation Bonds	9,540,509	1,326,585	-	10,867,094	-
Capital lease obligations:					
Bank of the West-Trinity McKesson Paragon	380,892	-	(380,892)	-	-
Bank of the West-Taycor Turner Log Hospital Equipment	100,628	-	(100,628)	-	-
Bank of the West-Trinity Hospital Equipment	297,030	-	(253,779)	43,251	43,251
GE Financing 2	199,188	-	(148,543)	50,645	50,645
GE Financing 3	112,463	-	(60,049)	52,414	52,414
Total capital leases payable	1,090,201	-	(943,891)	146,310	146,310
Totals	$ 58,796,540	$ 1,326,585	$ (2,654,320)	$ 57,468,805	$ 2,048,310

Northern Inyo Healthcare District

Notes to Financial Statements

Note 9: Long-Term Debt and Capital Lease Obligations (Continued)

	2015	Additions	Reductions	2016	Current Due
Bonds payable:					
2016 General Obligation Refunding Bond	$ -	$ 17,557,000	$ -	$ 17,557,000	$ 278,000
General Obligation Bonds, 2005 Series	14,035,000	-	(14,035,000)	-	-
General Obligation Bonds, 2009 Series:					
Current Interest Bonds	5,950,000	-	(3,415,000)	2,535,000	350,000
Capital Appreciation Bonds	8,144,947	-	-	8,144,947	-
Revenue Bonds, 2010 Series	9,400,000	-	(620,000)	8,780,000	660,000
Revenue Bonds, 2013 Series	10,725,000	-	(310,000)	10,415,000	310,000
Subtotal bonds payable	48,254,947	17,557,000	(18,380,000)	47,431,947	1,598,000
Bond premiums:					
General Obligation Bonds:					
2005 Series	290,538	-	(290,538)	-	-
2009 Series	653,497	-	(92,727)	560,770	-
Revenue Bonds, 2013 Series	188,167	-	(15,054)	173,113	-
Total bonds payable	49,387,149	17,557,000	(18,778,319)	48,165,830	1,598,000
Accreted Interest - General Obligation Bonds, 2009 Series, Capital Appreciation Bonds	8,213,924	1,326,585	-	9,540,509	-
Capital lease obligations:					
Bank of the West-Trinity McKesson Paragon	817,459	-	(436,567)	380,892	380,892
Bank of the West-Taycor Turner Log Hospital Equipment	229,577	-	(128,949)	100,628	100,628
Bank of the West-Trinity Hospital Equipment	537,819	-	(240,789)	297,030	253,489
GE Financing 2	344,573	-	(145,385)	199,188	148,543
GE Financing 3	168,632	-	(56,169)	112,463	60,429
Total capital leases payable	2,098,060	-	(1,007,859)	1,090,201	943,981
Total	$ 59,699,133	$ 18,883,585	$ (19,786,178)	$ 58,796,540	$ 2,541,981

Note 9: Long-Term Debt and Capital Lease Obligations (Continued)

The terms and due dates of the District's long-term debt and capital lease obligations at June 30, 2017, follow.

Long-Term Debt

General Obligation Bonds, 2005 Series

On September 28, 2005, the District issued $15,035,000 in General Obligation Bonds, 2005 Election, 2005 Series to finance the expanding, equipping, and upgrading of hospital facilities. The 2005 Bonds consist of two types of bonds, Current Interest Serial Bonds and Current Interest Term Bonds, issued in the amounts of $7,845,000 and $7,190,000, respectively.

Interest on the Current Interest Serial Bonds is payable semiannually on May 1 and November 1 at rates of 4.25% to 6.00%. The Current Interest Serial Bonds mature annually commencing on November 1, 2006, through November 1, 2030, in amounts ranging from $25,000 to $995,000. Interest on the Current Interest Term Bonds is payable semiannually at 5.60%. The Current Interest Term Bonds mature annually commencing on November 1, 2031, through August 1, 2035, in amounts ranging from $1,100,000 to $1,790,000.

The Current Interest Serial Bonds maturing on or after November 1, 2016, may be called by the District on or after November 1, 2015. The bond debt was extinguished in 2016 using proceeds from the issuance of the 2016 General Obligation Refunding Bond.

General Obligation Bonds, 2009 Series

On April 21, 2009, the District issued $14,464,947 in General Obligation Bonds, 2005 Election, 2009 Series to finance the construction and equipping of an expansion and renovation of the Hospital. The 2009 Bonds consist of two types of bonds, Current Interest Bonds and Capital Appreciation Bonds, issued in the amounts of $6,320,000 and $8,144,947, respectively.

Interest on the Current Interest Bonds is payable semiannually on May 1 and November 1 at 5.75%. Current Interest Bonds mature annually commencing on November 1, 2012, through November 1 2019, in amounts ranging from $60,000 to $865,000, as well as a bond maturing on November 1, 2038, for $3,150,000. Interest on the Capital Appreciation Bonds is accreted annually and paid at maturity. The Capital Appreciation Bonds mature annually commencing on November 1, 2020, through November 1, 2038, in amounts ranging from $1,020,000 to $3,420,000, inclusive of interest accreted through such maturity dates.

The Current Interest Bonds maturing on November 1, 2038, may be called by the District beginning November 1, 2017. The Capital Appreciation Bonds are not subject to redemption prior to their fixed maturity dates. The Current Interest Bond debt was partially extinguished in 2016 using proceeds from the issuance of the 2016 General Obligation Refunding Bond.

Note 9: Long-Term Debt and Capital Lease Obligations (Continued)

Revenue Bonds, 2010 Series

On April 14, 2010, the District issued $11,600,000 in Revenue Bonds, 2010 Series to finance the replacement hospital, finance the bond reserve account, and pay certain costs of issuance related to the 2010 Bonds.

Interest on the 2010 Bonds is payable semiannually on June 1 and December 1 at rates ranging from 5.000% to 6.375%. Mandatory sinking fund deposits to retire the bonds on their term maturity dates, ranging from $510,000 to $1,145,000, are due annually through December 2025.

The 2010 Bonds maturing on December 1, 2021, may be called by the District beginning December 1, 2016.

The District is required to maintain certain covenants and provide various reporting under the agreement. Management believes the District is in compliance with all covenants at June 30, 2016.

Revenue Bonds, 2013 Series

On January 17, 2013, the District issued $11,335,000 in Revenue Bonds, 2013 Series to finance the replacement hospital, finance the bond reserve account, and pay certain costs of issuance related to the 2013 Bonds.

Interest on the 2013 Bonds is payable annually on December 1 at rates ranging from 3.875% to 5.000%. Mandatory sinking fund deposits to retire the bonds on their term maturity dates, ranging from $295,000 to $1,805,000, are due annually through December 2029.

The 2013 Bonds maturing on December 1, 2027, may be called, without premium, by the District on December 1, 2013, through December 1, 2015.

2016 General Obligation Refunding Bond

On May 12, 2016, the District issued $17,550,000 in a 2016 General Obligation Refunding Bond, to refinance the General Obligation Bonds, 2005 Series in whole and to pay a portion of General Obligation Bonds, 2009.

Interest on the 2016 bond is payable semiannually on November 1 and May 1 at a rate of 3.450%. Mandatory sinking fund deposits to retire the bonds on their term maturity dates, ranging from $278,000 to $1,874,000, are due annually through December 2035.

Note 9: Long-Term Debt and Capital Lease Obligations (Continued)

Capital Lease Obligations

A lease obligation to Bank of the West Taycor is due in monthly installments of $11,394 in 2012 through 2017, including interest at 4.548%, collateralized by equipment at a cost of $612,754 and related accumulated amortization of $310,122. Lease was paid off during 2017.

The District has two Bank of the West Trinity leases due in total monthly installments of $60,877 in March 2012 through 2018, including interest at 4.995% and 4.857%, collateralized by equipment at a cost of $2,839,609 and related accumulated amortization of $2,305,056.

Lease obligations to GE Government Finance Inc. (No. 2) are due in total monthly installments of $5,289 in March 2013 through 2018, including interest at 3.580%, collateralized by equipment at a cost of $290,000 and related accumulated amortization of $203,000.

Lease obligations to GE Government Finance Inc. (No. 3) are due in total monthly installments of $12,754 in September 2012 through 2017, including interest at 3.500%, collateralized by equipment at a cost of $700,719 and related accumulated amortization of $365,060.

Advanced Refunding

The District issued $17,557,000 in General Obligation Refunding Bonds ("2016 GOR Bond") with interest rates of 3.45% in November 2016. The proceeds were used to advance refund $3,150,000 of outstanding General Obligation Bonds Election of 2005, Series 2009 ("2009 GO Bond"), which had interest rates of 5.75% and General Obligation Bonds Election of 2005, Series 2005 ("2005 GO Bond"), which had varying interest rates of 6.00% to 4.25%. Net proceeds of $17,281,182 were derived from the issuance of the 2016 GOR bonds at par, including a $9,103 premium, and after payment of $275,818 in underwriting fees. Of the net proceeds, $17,281,182 was deposited in an irrevocable trust with an escrow agent to provide funds for the future debt service payment on the 2005 GO Bond and 2009 GO Bond, and $276,071 was used for issuance and other costs. As a result, the 2005 GO Bond and 2009 GO Bonds are considered defeased, and the liability for those bonds has been removed from the statements of net position. The District advance refunded bonds to reduce its total debt service payments and obtain an economic gain (difference between the present values of the old and new debt service payments) of $30,996. On June 30, 2017, $3,150,000 of bonds outstanding are considered defeased.

Note 9: Long-Term Debt and Capital Lease Obligations (Continued)

Scheduled principal and interest repayments on long-term obligations are as follows as of June 30, 2017:

	Long-Term Debt		Capital Lease Obligations	
	Principal	Interest	Principal	Interest
2018	$ 1,902,000	$ 1,590,233	$ 146,310	$ 1,508
2019	2,178,681	1,497,933	-	-
2020	2,379,681	1,397,010	-	-
2021	1,998,759	1,909,063	-	-
2022	2,113,988	1,913,015	-	-
2023-2027	13,070,676	8,875,032	-	-
2028-2032	12,859,723	9,057,094	-	-
2033-2037	9,015,597	11,125,367	-	-
Thereafter	936,296	5,628,704	-	-
Totals	$ 46,455,401	$ 42,993,451	$ 146,310	$ 1,508

Note 10: Leases

The District leases office space in a medical office building under a noncancelable operating lease as an agreement with PMA that expires in 2018.

The future minimum required payments by year and in the aggregate under the noncancelable operating lease, as of June 30, 2017, are as follows:

	2017
2018	$ 194,672
2019	292,008
2020	292,008
2021	292,008
2022 and beyond	97,336
Total	$ 1,168,032

Total building rent expense for the years ended June 30, 2017 and 2016, was $940,667 and $1,087,126, respectively.

Note 11: Pledged Revenues

The District has pledged future revenues to repay $11,600,000 million in District revenue bonds issued in March 2010. Proceeds from the bonds are to provide a portion of the funding for its replacement hospital project. The bonds are payable solely from revenues through 2025. The total principal and interest remaining to be paid on the bonds is $10,623,219. Principal and interest paid for the current year and revenues were $1,182,638 and $71,823,552, respectively.

The District has pledged future revenue to repay $11,335,000 in District revenue bonds issued in January 2013. Proceeds from the bonds are to provide a portion of the funding for its remodeling, expansion, improvement, and equipping of the facility. The bonds are payable solely from revenues through 2029. The total principal and interest remaining to be paid on the bonds is $14,981,803. Principal and interest paid for the current year and revenues were $63,938 and $71,823,552, respectively.

Note 12: Retirement Plans

Defined Benefit Plan - The Plan

The District sponsors a defined benefit pension plan, a single-employer defined benefit plan for employees over age 21 with at least one year of service. The plan is governed by the Board of Directors, which may amend benefits and other plan provisions and which is responsible for the management of plan assets. The primary factors affecting the benefits earned by participants in the pension plan are employees' years of service and compensation levels.

The District provides service retirement and pre-retirement death benefits to plan members, who must be District employees and beneficiaries. Benefits are based on years of credited service, equal to one year of full-time employment. Members with five years of total service are eligible to retire at age 55 with statutorily reduced benefits. All members are eligible for pre-retirement death benefits after five years of service. The benefit vesting schedule is 50% vesting after five years, increasing 10% per year to 100% vested after 10 years of service.

Active participants automatically become 100% vested upon attainment of normal retirement age or if they become totally and permanently disabled.

Note 12: Retirement Plans (Continued)

The Plan's provisions and benefits in effect at June 30, 2017, are summarized as follows:

	"The Plan"
Hire date	Prior to January 1, 2013
Benefit Payments	Life Annuity
Retirement Age	65-70
Monthly benefits, as a % of eligible compensation	2.50%, not less than $600
Required employer contribution rates	22.1% of applicable payroll

Employees covered at January 1, 2017, by the benefit terms for the Plan are as follows:

Inactive employees or beneficiaries currently receiving benefits	77
Active employees	195
Total	272

The employer contribution rates are determined on an annual basis by the actuary and shall be effective on July 1 following notice of a change in the rate. Funding contributions for the Plan are determined annually on an actuarial basis as of January 1 by the Plan. The actuarially determined rate is the estimated amount necessary to finance the costs of benefits earned by employees during the year, with an additional amount to finance any unfunded accrued liability.

The District's net pension liability for the Plan is measured as the total pension liability, less the pension plan's fiduciary net position. The net pension liability of the Plan is measured as of June 30, 2017, using an annual actuarial valuation as of January 1, 2017, rolled forward to June 30, 2017, using standard update procedures. A summary of principal assumptions and methods used to determine the net pension liability is shown on the next page.

Note 12: Retirement Plans (Continued)

The total pension liabilities in the January 1, 2017, actuarial valuations were determined using the following actuarial assumptions:

	"The Plan"
Valuation date (actuarial valuation date)	January 1, 2017
Measurement date (net pension liability measured)	June 30, 2017
Actuarial cost method	Entry-Age Normal Cost Method
Actuarial assumptions	
Discount rate	5.00%
Projected salary increase	4.00%
Investment rate of return	5.00%
Mortality: Pre-retirement	RP-2014 Healthy Mortality w/ generational projection from 2006, base year using scale MP-2016.
Mortality: Post-retirement (annuity elected)	RP-2014 Healthy Mortality w/ generational projection from 2006, base year using scale MP-2016.
Mortality: Post-retirement (lump sum elected)	Based on date of participation DOP before 7/1/2009: 1984 UP, Mortality table set back four years. DOP on/after 7/1/2009: RP-2000. Table for males set back four years.

The table below reflects the long-term expected real rate of return by asset class. The rate of return was calculated using the capital market assumptions applied to determine the discount rate and asset allocation. These rates of return are net of administrative expenses.

Asset Class	Target Asset Allocation	Long-Term Expected Real Rate of Return
Cash	1.15 %	2.72 %
U.S. fixed income	42.47 %	3.69 %
U.S. governmental bonds	8.63 %	3.17 %
U.S. credit bonds	13.81 %	4.72 %
U.S. mortgages	9.78 %	3.31 %
U.S. bank/leveraged loans	16.68 %	5.38 %
U.S. high yield bonds	3.45 %	6.98 %
Private equity	3.45 %	11.32 %
Hedge funds - Multi-strategy	0.58 %	5.91 %
Totals	100.00 %	

Note 12: Retirement Plans (Continued)

The changes in the net pension liability of the Plan are as follows:

	Total Pension Liability	Plan Net Position	Net Pension Liability (Asset)
	$ 61,998,249	$ 28,505,781	$ 33,492,468
Changes for the year:			
Service cost incurred	2,812,178	-	2,812,178
Interest on total pension liability	3,053,437	-	3,053,437
Differences between actual and expected experience	(3,295,677)	-	(3,295,677)
Changes in assumptions	(417,283)	-	(417,283)
Benefit payments	(7,575,753)	(7,575,753)	-
Contributions - Employer	-	5,340,000	(5,340,000)
Net investment income	-	(126,769)	126,769
Administrative expense	-	(55,640)	55,640
Totals	$ 56,575,151	$ 26,087,619	$ 30,487,532

The following presents the net pension liability of the District's Plan, calculated using the discount rate, as well as what the District's net pension liability would be if it were calculated using a discount rate that is one-percentage point lower or one-percentage point higher than the current rate:

	"The Plan"
1% decrease	4.00%
Net pension liability	$37,492,708
Current discount rate	5.00%
Net pension liability	$33,492,468
1% increase	6.00%
Net pension liability	$24,533,726

Note 12: Retirement Plans (Continued)

The District recognized pension expense of $6,193,500 and $5,222,823 in 2017 and 2016, respectively. At June 30, 2017, the District reported deferred outflows of resources and deferred inflows of resources related to pensions from the following sources:

	Deferred Outflows of Resources	Deferred Inflows of Resources
Differences between actual and expected experience	$ 1,149,465	$ 2,916,864
Changes in assumptions	10,085,332	1,589,952
Net differences between projected and actual earning on plan investments	2,130,588	-
Totals	$ 13,365,385	$ 4,506,816

Other amounts reported as deferred outflows of resources and deferred inflows of resources related to pensions will be recognized as pension expense as follows:

Year Ended June 30	Increase in Pension Expense
2018	$ 1,640,948
2019	1,640,946
2020	1,469,252
2021	1,272,314
2022	973,218
Thereafter	1,861,891
Total	$ 8,858,569

Defined Benefit Plan - The PEPRA Plan

The District sponsors a defined benefit pension plan ("PEPRA Plan"), a single-employer defined benefit plan for the Chief Executive Officer (CEO). The plan is governed by the Board of Directors, which may amend benefits and other plan provisions and which is responsible for the management of plan assets. The primary factors affecting the benefits earned by participants in the pension plan are employees' years of service and compensation levels.

Northern Inyo Healthcare District

Notes to Financial Statements

Note 12: Retirement Plans (Continued)

The District provides service retirement and pre-retirement death benefits to plan members, who must be District employee holding the position of Chief Executive Officer and beneficiaries. Benefits are based on years of credited service, equal to one year of full-time employment. Members with five years of total service are eligible to retire at age 62 with statutorily reduced benefits. All members are eligible for early retirement benefits at age 52 with atleast 5 years of credited services with reduced benefits. The benefit vesting schedule is 100% vesting after five years of credited service, or upon total and permanent disability.

The PEPRA Plan's provisions and benefits in effect at June 30, 2017, are summarized as follows:

	"The PEPRA Plan"
Hire date	Beginning January 1, 2016
Benefit Payments	Life Annuity
Retirement Age	62 or 5th anniversary of participant
Monthly benefits, as a % of eligible compensation	2% of Average Annual Compensation multiplied by years of Credited Service
Required employee contribution rates	12% of applicable payroll
Required employer contribution rates	11.50% of applicable payroll

Employees covered at January 1, 2017, by the benefit terms for the PEPRA Plan are as follows:

Inactive employees or beneficiaries currently receiving benefits	-
Active employees	1
Total	1

The employer contribution rates are determined on an annual basis by the actuary and shall be effective on July 1 following notice of a change in the rate. Funding contributions for the PEPRA Plan are determined annually on an actuarial basis as of January 1 by the PEPRA Plan. The actuarially determined rate is the estimated amount necessary to finance the costs of benefits earned by employees during the year, with an additional amount to finance any unfunded accrued liability.

The District's net pension liability for the PEPRA Plan is measured as the total pension liability, less the pension plan's fiduciary net position. The net pension liability of the PEPRA Plan is measured as of June 30, 2017, using an annual actuarial valuation as of January 1, 2017, rolled forward to June 30, 2017, using standard update procedures. A summary of principal assumptions and methods used to determine the net pension liability is shown on the next page.

Note 12: Retirement Plans (Continued)

The total pension liabilities in the January 1, 2017, actuarial valuations were determined using the following actuarial assumptions:

	"The PEPRA Plan"
Valuation date (actuarial valuation date)	January 1, 2017
Measurement date (net pension liability measured)	June 30, 2017
Actuarial cost method	Entry-Age Normal Cost Method
Actuarial assumptions	
Discount rate	5.00%
Investment rate of return	5.00%
Mortality: Pre-retirement	RP-2014 Healthy Mortality w/ generational projection from 2006, base year using scale MP-2016.
Mortality: Post-retirement (annuity elected)	RP-2014 Healthy Mortality w/generational projection from 2006, base year using scale MP-2016.

The table below reflects the long-term expected real rate of return by asset class. The rate of return was calculated using the capital market assumptions applied to determine the discount rate and asset allocation. These rates of return are net of administrative expenses.

Asset Class	Target Asset Allocation	Long-Term Expected Real Rate of Return
U.S. fixed income	60.00 %	3.69 %
Global equity	40.00 %	7.89 %
Totals	100.00 %	

Note 12: Retirement Plans (Continued)

The changes in the net pension liability of the PEPRA Plan are as follows:

	Total Pension Liability	Plan Net Position	Net Pension Liability (Asset)
Balance as of June 30, 2016	$ -	$ -	$ -
Changes for the year:			
Changes in assumptions	42,389	-	42,389
Contributions - Employee	-	23,072	(23,072)
Contributions - Employer	-	23,164	(23,164)
Current-year net changes	42,389	46,236	(3,847)
Totals	$ 42,389	$ 46,236	$ (3,847)

The following presents the net pension liability of the District's PEPRA Plan, calculated using the discount rate, as well as what the District's net pension liability would be if it were calculated using a discount rate that is one-percentage point lower or one-percentage point higher than the current rate:

	"The PEPRA Plan"
1% decrease	4.00%
Net pension liability	$3,575
Current discount rate	5.00%
Net pension liability	$(3,847)
1% increase	6.00%
Net pension liability	$(10,199)

Note 12: Retirement Plans (Continued)

The District recognized pension expense of $18,711 in 2017. At June 30, 2017, the District reported deferred outflows of resources and deferred inflows of resources related to pensions from the following sources:

	Deferred Outflows of Resources	Deferred Inflows of Resources
Net differences between projected and actual earning on plan investments	$ -	$ 914

Other amounts reported as deferred outflows of resources and deferred inflows of resources related to pensions will be recognized as pension expense as follows:

Year Ended June 30	Increase in Pension Expense
2018	$ 228
2019	228
2020	228
2021	230
2022	-
Thereafter	-
Total	$ 914

Defined Contribution Plan

The District sponsors and contributes to the Northern Inyo County Local Hospital District 401(a) Retirement Plan (NICLHD), a defined contribution pension plan, for its employees. The plan covers its employees who have attained the age of 21 years and were not a participant in the District's defined benefit plan prior to January 1, 2013, and completed of one year of service. NICLHD is administered by the District.

Benefit terms, including contribution requirements, for NICLHD are established and may be amended by the District's Board of Directors. For each employee in the pension plan, the District is required to contribute 7% as a percent of annual salary, exclusive of overtime pay, to an individual employee account. Employees are not permitted to make contributions to the pension plan. For the year ended June 30, 2017 and 2016, the District recognized pension expense of $415,453 and $316,613, respectively.

Note 12: Retirement Plans (Continued)

Each participant shall have a nonforfeitable and vested right to his or her account for each year of service completed while an employee of the employer, in accordance with the following schedule:

Years	Nonforfeitable Percentage
5	50.0 %
6	60.0 %
7	70.0 %
8	80.0 %
9	90.0 %
10 or more	100.0 %

Nonvested District contributions are forfeited upon termination of employment. Such forfeitures are used to cover a portion of the pension plan's administrative expenses. There have been no forfeitures to date.

Note 13: Medical Office Building, Net

The District has a number of Board-approved management practice arrangements with physicians to provide services for primary care and specialty services in the district. These managed contracts are nonoperating activities of the District and are listed in the nonoperating revenue (expenses) on the statements of revenue, expenses, and changes in net position. The hospital provides an income guarantee against net revenue while also providing all services for operating of the physician practices. The District has practice management agreements for the following physician practices: Pediatrics, Internal Medicine, Orthopedic Surgery, and General Surgery. The net cost of this activity is included in medical office building, net in the accompanying statements of revenue, expenses, and changes in net position for the years ended June 30, 2017 and 2016.

Note 14: Risk Management

The District is exposed to various risks of loss related to medical malpractice; torts; theft of, damage to, and destruction of assets; errors and omissions; injuries of employees; and natural disasters.

TheDistrict's comprehensive general liability insurance covers losses of up to $20,000,000 per claim with $30,000,000 annual aggregate for occurrence basis during a policy year regardless of when the claim was filed (occurrence-based coverage). The District's professional liability insurance covers losses up to $5,000,000 per claim with $5,000,000 annual aggregate for claims reported during a policy year (claims-made coverage). Under a claims-made policy, the risk for claims and incidents not asserted within the policy period remains with the District.

Although there exists the possibility of claims arising from services provided to patients through June 30, 2017, which have not yet been asserted, the District is unable to determine the ultimate cost, if any, of such possible claims, and accordingly no provision has been made for them. Settled claims have not exceeded commercial coverage in any of the three preceding years.

The District is a participant in the Association of California Healthcare Districts' ALPHA Fund, which administers a self-insured workers' compensation plan for participating member hospitals and their employees. The District pays a premium to the ALPHA Fund; the premium is adjusted annually. If participation in the ALPHA Fund were terminated by the District, the District would be liable for its share of any additional premiums necessary for final disposition of all claims and losses covered by the ALPHA Fund.

Note 15: Self-Funded Insurance

The District has a self-funded health care plan that provides medical and dental benefits to employees and their dependents. Employees share in the cost of health benefits. Health care expense is based on actual claims paid, reinsurance premiums, administration fees, and unpaid claims at year-end. The District buys reinsurance to cover catastrophic individual claims over $90,000. The District records a liability for claims incurred but not reported that is recorded in accrued liabilities in the accompanying statements of net position. The following represents the health plan activity for the District and estimated claims outstanding at June 30:

	Beginning of Fiscal Year Liability	Current-Year Claims and Changes in Estimates	Claim Payments	Balance at Fiscal Year-End
2017	$ 1,322,825	$ 5,305,722	$ 5,314,951	$ 1,313,596
2016	$ 1,700,804	$ 4,893,297	$ 5,271,276	$ 1,322,825

Northern Inyo Healthcare District

Notes to Financial Statements

Note 16: Functional Expenses

The District provides general health care services to residents within its geographic area. Expenses, including interest expense, related to providing these services consisted of the following for the following for the years ended June 30:

	2017	2016
Health care service	$ 62,686,431	$ 60,002,820
Management and administration	12,021,650	12,647,117
Total expenses	$ 74,708,081	$ 72,649,937

Note 17: Concentration of Credit Risk

Financial instruments that potentially subject the District to credit risk consist principally of patient receivables.

Patient receivables consist of amounts due from patients, their insurers, or governmental agencies (primarily Medicare and Medi-Cal) for health care provided to the patients. The majority of the District's patients are from Lake Arrowhead, California, and the surrounding area.

The mix of receivables from patients and third-party payors was as follows at June 30:

	2017	2016
Medicare	35 %	34 %
Medi-cal, including CMSP	26 %	25 %
Other third-party payors	32 %	35 %
Patients	7 %	6 %
Totals	100 %	100 %

Note 18: Commitments and Contingencies

Litigation

The District may from time to time be involved in litigation and regulatory investigations that arise in the normal course of doing business. After consultation with legal counsel, management estimates that matters, if applicable, existing as of June 30, 2017, will be resolved without material adverse effect on the District's future financial position, results from operations, or cash flows.

Pollution Remediation Obligations

Pollution remediation obligations are triggered by an obligating event. An obligating event is when a government is compelled to take action to protect the public from pollution; has violated a pollution permit, license, or law; has or will be named in a lawsuit; or voluntarily engages in a cleanup. Management has considered this guidance specifically as it relates to its legal obligations related to asbestos removal on its existing properties. Management of the District believes there has not been an obligating event, and if there had been, the amount of the potential liability could not be reasonably estimated. Therefore, no obligations have been recorded for pollution remediation as of June 30, 2017 and 2016.

Required Supplementary Information

Northern Inyo Healthcare District

Schedule of Changes in the Net Pension Liability and Related Ratios and Contributions - Plan

Last Ten Fiscal Years (If Available)

Total Pension Liability	2017	2016	2015
Service cost incurred	$ 2,812,178	$ 2,219,985	$ 2,683,298
Interest in total pension liability	3,053,437	3,047,939	3,356,235
Difference between actual and expected	(3,295,677)	1,385,608	108,261
Change in assumption	(417,283)	12,966,856	(1,841,294)
Benefit payments	(7,575,753)	(8,213,871)	(9,321,200)
Net change in total pension liability	(5,423,098)	11,406,517	(5,014,700)
Total pension liability - Beginning	61,998,269	50,591,752	55,606,452
Total pension liability - Ending (a)	56,575,171	61,998,269	50,591,752
Plan net position:			
Contribution - Employer	5,340,000	3,900,000	4,320,000
Net investment income	(126,769)	880,376	1,223,136
Administrative expense	(55,640)	(51,336)	-
Benefit payments	(7,575,753)	(8,213,871)	(9,321,200)
Net change in plan net position	(2,418,162)	(3,484,831)	(3,778,064)
Plan net position - Beginning	28,505,801	31,990,632	35,768,696
Plan net position - Ending (b)	26,087,639	28,505,801	31,990,632
Net pension liability - Ending (a)-(b)	$ 30,487,532	$ 33,492,468	18,601,120
Plan fiduciary net position as a percentage of the total pension liability	46.11 %	45.98 %	63.23 %
Covered-employee payroll	$ 15,892,425	$ 17,664,833	$ 19,429,331
Net pension liability as percentage of covered employee payroll	225.34 %	210.74 %	105.30 %

Notes to Schedule:

Changes in assumptions: In 2017, amounts reported as changes in assumptions resulted primarily from adjustments to expected form of, discount rate, payment election, and mortality assumptions.

Northern Inyo Healthcare District

Schedule of Changes in the Net Pension Liability and Related Ratios and Contributions - Plan (Continued)

Last Ten Fiscal Years (If Available)

SCHEDULE OF CONTRIBUTIONS	2017	2016	2015
Actuarially determined contribution	$ 5,340,000	$ 3,900,000	$ 4,320,000
Contributions in relation to the actuarially determined contributions	5,340,000	3,900,000	4,320,000
Contribution deficiency	$ -	$ -	$ -
Covered-employee payroll	$ 15,892,425	$ 17,664,833	$ 19,429,331
Contributions as a percentage of covered employee payroll	33.60 %	22.08 %	22.23 %

Notes to Schedule

Valuation date:	January 1, 2017
Methods and assumptions used to determine contribution rates:	
Single-employer plan	Entry Age Normal Cost Method
Amortization method	Level percentage of payroll, closed
Remaining amortization period	17 years
Asset valuation method	Market value
Inflation	2.3%
Salary increases	4%, including inflation
Investment rate of return	5.00%
Retirement age	65, or 70 *
Mortality: Pre-retirement	**
Mortality: Postretirement (annuity elected)	***
Mortality: Postretirement (lump sum elected)	****

** RP-2014 Healthy Mortality w/generational projection from 2006, Base Year using Scale MP-2016.
*** RP-2014 Healthy Mortality w/generational projection from 2006, Base Year using Scale MP-2016.
**** DOP before 7/1/2009: 1984 UP, Mortality Table set back four years. DOP On/After 7/1/2009: RP-2000 Table for Males set back four years.

SCHEDULE OF INVESTMENT RETURNS	2017	2016	2015
Annual money-weighted rate of return, net of investment expense	(0.48)%	3.11 %	3.86 %

Northern Inyo Healthcare District

Schedule of Changes in the Net Pension Liability and Related Ratios and Contributions - PEPRA Plan

Last Ten Fiscal Years (If Available)

Total Pension Liability		2017
Changes of benefit terms	$	42,389
Net change in total pension liability		42,389
Total pension liability - Beginning		-
Total pension liability - Ending (a)		42,389
Plan net position:		
Contribution - Employer		23,072
Contribution - Employee		23,164
Net change in plan net position		46,236
Plan set position - Beginning		-
Plan net position - Ending (b)		46,236
Net pension liability (asset) - Ending (a)-(b)	$	(3,847)
Plan fiduciary net position as a percentage of the total pension liability		109.08 %
Covered-employee payroll	$	117,020
Net pension liability (asset) as percentage of covered employee payroll		(3.29)%

Northern Inyo Healthcare District

Schedule of Changes in the Net Pension Liability and Related Ratios and Contributions - PEPRA Plan (Continued)

Last Ten Fiscal Years (If Available)

SCHEDULE OF CONTRIBUTIONS		2017
Actuarially determined contribution	$	13,950
Contributions in relation to the actuarially determined contributions		13,950
Contribution deficiency	$	-
Covered-employee payroll	$	117,020
Contributions as a percentage of covered employee payroll		11.92 %

Notes to Schedule

Valuation date:	January 1, 2017
Methods and assumptions used to determine contribution rates:	
Single-employer plan	Entry Age Normal Cost Method
Amortization method	Level percentage of payroll, closed
Remaining amortization period	17 years
Asset valuation method	Market value
Inflation	2.5%
Salary increases	4%, including inflation
Investment rate of return	5.00%
Retirement age	65
Mortality: Pre-retirement	**
Mortality: Postretirement (annuity elected)	***

** RP-2014 Healthy Mortality w/generational projection from 2006, Base Year using Scale MP-2016.
*** RP-2014 Healthy Mortality w/generational projection from 2006, Base Year using Scale MP-2016.

SCHEDULE OF INVESTMENT RETURNS	2017
Annual money-weighted rate of return, net of investment expense	- %

Supplementary Information

Northern Inyo Healthcare District

Combining Statement of Net Position of the District and Component Units

June 30, 2017 (Auxiliary May 31, 2017)

Assets and Deferred Outflows of Resources	Inyo Hospital	Hospital Foundation	Hospital Auxiliary	Elimination	Total
Current assets:					
Cash and cash equivalents	$ 3,247,148	$ 396,118	$ 57,231	$ -	$ 3,700,497
Current portion of assets limited as to use	2,084,955	-	-	-	2,084,955
Receivable:					
Patient-Net	13,692,932	-	-	-	13,692,932
Other	35,924	-	-	-	35,924
Inventory	3,996,558	-	-	-	3,996,558
Prepaid expenses and deposits	1,355,285	-	-	-	1,355,285
Total current assets	24,412,802	396,118	57,231	-	24,866,151
Other assets:					
Noncurrent assets limited as to use	18,315,044	-	-	-	18,315,044
Investment in PMA	512,810	-	-	-	512,810
Goodwill in PMA	581,219	-	-	-	581,219
Net pension asset	3,847	-	-	-	3,847
Total other assets	19,412,920	-	-	-	19,412,920
Capital assets:					
Nondepreciable capital assets	961,144	-	-	-	961,144
Depreciable capital assets - Net	78,826,238	-	-	-	78,826,238
Capital assets - Net	79,787,382	-	-	-	79,787,382
Deferred outflows of resources	13,365,385	-	-	-	13,365,385
TOTAL ASSETS AND DEFERRED OUTFLOWS OF RESOURCES	$ 136,978,489	$ 396,118	$ 57,231	$ -	$ 137,431,838

Northern Inyo Healthcare District

Combining Statement of Net Position of the District and Component Units

(Continued)

June 30, 2017 (Auxiliary May 31, 2017)

Liabilities, Deferred Inflows of Resources, and Net Position	Inyo Hospital	Hospital Foundation	Hospital Auxiliary	Elimination	Total
Current liabilities:					
Current maturities of long-term liabilities:					
Bonds payable	$ 1,902,000	$ -	$ -	$ -	$ 1,902,000
Capital lease obligation	146,310	-	-	-	146,310
Accounts payable	1,806,069	-	-	-	1,806,069
Accrued interest and sales tax	150,903	-	-	-	150,903
Accrued payroll and related liabilities	4,265,677	-	-	-	4,265,677
Estimated third-party payor settlements	987,319	-	-	-	987,319
Unearned revenue	77,427	-	-	-	77,427
Total current liabilities	9,335,705	-	-	-	9,335,705
Long-term liabilities:					
Bonds payable	44,553,401	-	-	-	44,553,401
Accreted interest	10,867,094	-	-	-	10,867,094
Net pension liability	30,487,532	-	-	-	30,487,532
Total long-term liabilities	85,908,027	-	-	-	85,908,027
Total liabilities	95,243,732	-	-	-	95,243,732
Deferred inflows of resources	4,507,730	-	-	-	4,507,730
Net position:					
Net investment in capital assets	33,042,009	-	-	-	33,042,009
Restricted for debt service	4,142,192	-	-	-	4,142,192
Restricted for programs	133,140	-	-	-	133,140
Restricted for pension benefits	2,933	-	-	-	2,933
Unrestricted	(93,247)	396,118	57,231	-	360,102
Total net position	37,227,027	396,118	57,231	-	37,680,376
TOTAL LIABILITIES, DEFERRED INFLOWS OF RESOURCES, AND NET POSITION	$ 136,978,489	$ 396,118	$ 57,231	$ -	$ 137,431,838

Northern Inyo Healthcare District

Combining Statement of Net Position of the District and Component Units

(Continued)

June 30, 2016 (Auxiliary May 31, 2016)

Assets and Deferred Outflows of Resources	Inyo Hospital	Hospital Foundation	Hospital Auxiliary	Elimination	Total
Current assets:					
Cash and cash equivalents	$ 3,184,094	$ 378,724	$ 53,435	$ -	$ 3,616,253
Current portion of assets limited as to use	1,598,000	-	-	-	1,598,000
Receivable:					
Patient-Net	12,050,254	-	-	-	12,050,254
Other	537,695	-	-	-	537,695
Inventory	3,151,882	-	-	-	3,151,882
Prepaid expenses and deposits	1,012,979	-	-	-	1,012,979
Total current assets	21,534,904	378,724	53,435	-	21,967,063
Other assets:					
Noncurrent assets limited as to use	20,346,263	-	-	-	20,346,263
Investment in PMA	264,441	-	-	-	264,441
Goodwill in PMA	581,219	-	-	-	581,219
Total other assets	21,191,923	-	-	-	21,191,923
Capital assets:					
Nondepreciable capital assets	959,015	-	-	-	959,015
Depreciable capital assets - Net	82,118,750	-	-	-	82,118,750
Capital assets - Net	83,077,765	-	-	-	83,077,765
Deferred outflows of resources	14,144,525	-	-	-	14,144,525
TOTAL ASSETS AND DEFERRED OUTFLOWS OF RESOURCES	$ 139,949,117	$ 378,724	$ 53,435	$ -	$ 140,381,276

Northern Inyo Healthcare District

Combining Statement of Net Position of the District and Component Units

(Continued)

June 30, 2016 (Auxiliary May 31, 2016)

Liabilities, Deferred Inflows of Resources, and Net Position	Inyo Hospital	Hospital Foundation	Hospital Auxiliary	Elimination	Total
Current liabilities:					
Current maturities of long-term liabilities:					
Bonds payable	$ 1,598,000	$ -	$ -	$ -	$ 1,598,000
Capital lease obligation	943,981	-	-	-	943,981
Accounts payable	2,136,881	-	-	-	2,136,881
Accrued interest and sales tax	181,492	-	-	-	181,492
Accrued payroll and related liabilities	5,035,994	-	-	-	5,035,994
Estimated third-party payor settlements	1,621,328	-	-	-	1,621,328
Total current liabilities	11,517,676	-	-	-	11,517,676
Long-term liabilities:					
Bonds payable	46,567,830	-	-	-	46,567,830
Accreted interest	9,540,509	-	-	-	9,540,509
Capital lease obligation	146,220	-	-	-	146,220
Net pension liability	33,492,468	-	-	-	33,492,468
Total long-term liabilities	89,747,027	-	-	-	89,747,027
Total liabilities	101,264,703	-	-	-	101,264,703
Deferred inflows of resources	1,427,520	-	-	-	1,427,520
Net position:					
Net investment in capital assets	33,643,543	-	-	-	33,643,543
Restricted for debt service	3,677,623	-	-	-	3,677,623
Restricted for programs	31,371	-	-	-	31,371
Unrestricted	(95,643)	378,724	53,435	-	336,516
Total net position	37,256,894	378,724	53,435	-	37,689,053
TOTAL LIABILITIES, DEFERRED INFLOWS OF RESOURCES, AND NET POSITION	$ 139,949,117	$ 378,724	$ 53,435	$ -	$ 140,381,276

Northern Inyo Healthcare District

Combining Statement of Revenue, Expenses, and Changes in Net Position of the District and Component Units

June 30, 2017 (Auxiliary May 31, 2017)

	Inyo Hospital	Hospital Foundation	Hospital Auxiliary	Elimination	Total
Revenue:					
Net patient service revenue	$ 75,170,833	$ -	$ -	$ -	$ 75,170,833
Other operating revenue	409,776	-	29,187	-	438,963
Total revenue	75,580,609	-	29,187	-	75,609,796
Operating expenses:					
Salaries and wages	23,374,755	-	-	-	23,374,755
Employee benefits	17,527,645	-	-	-	17,527,645
Professional fees	10,896,393	910	-	-	10,897,303
Supplies	7,297,227	2,488	-	-	7,299,715
Purchased services	3,588,642	-	-	-	3,588,642
Depreciation	5,028,943	-	-	-	5,028,943
Other operating expenses	4,122,331	30,916	-	-	4,153,247
Total operating expenses	71,835,936	34,314	-	-	71,870,250
Income (loss) from operations	3,744,673	(34,314)	29,187	-	3,739,546
Nonoperating revenue (expense):					
Tax revenue for operations	583,731	-	-	-	583,731
Tax revenue for debt services	1,304,781	-	-	-	1,304,781
Interest income	628,397	-	-	-	628,397
Interest expense	(2,959,007)	-	-	-	(2,959,007)
Loss on sale of asset	(4,605)	-	-	-	(4,605)
Noncapital grants and contributions	195,606	51,708	5,201	-	252,515
Medical office building - Net	(4,081,762)	-	-	-	(4,081,762)
Total nonoperating revenue (expenses)	(4,332,859)	51,708	5,201	-	(4,275,950)
Excess (deficit) of revenue over expenses	(588,186)	17,394	34,388	-	(536,404)
Capital grants and contributions	558,319	-	(30,592)	-	527,727
Increase in net position	(29,867)	17,394	3,796	-	(8,677)
Net position at beginning	37,256,894	378,724	53,435	-	37,689,053
Net position at end	$ 37,227,027	$ 396,118	$ 57,231	$ -	$ 37,680,376

Northern Inyo Healthcare District

Combining Statement of Revenue, Expenses, and Changes in Net Position of the District and Component Units (Continued)

June 30, 2016 (Auxiliary May 31, 2016)

	Inyo Hospital	Hospital Foundation	Hospital Auxiliary	Elimination	Total
Revenue:					
Net patient service revenue	$ 74,146,031	$ -	$ -	$ -	$ 74,146,031
Other operating revenue	669,664	-	22,952	-	692,616
Total revenue	74,815,695	-	22,952	-	74,838,647
Operating expenses:					
Salaries and wages	21,661,553	-	-	-	21,661,553
Employee benefits	15,742,060	-	-	-	15,742,060
Professional fees	11,277,197	990	-	-	11,278,187
Supplies	7,198,683	1,257	-	-	7,199,940
Purchased services	3,835,670	-	-	-	3,835,670
Depreciation	5,167,287	-	-	-	5,167,287
Other operating expenses	4,463,810	1,862	-	-	4,465,672
Total operating expenses	69,346,260	4,109	-	-	69,350,369
Income (loss) from operations	5,469,435	(4,109)	22,952	-	5,488,278
Nonoperating revenue (expense):					
Tax revenue for operations	537,369	-	-	-	537,369
Tax revenue for debt services	1,496,646	-	-	-	1,496,646
Interest income	212,234	-	-	-	212,234
Interest expense	(3,299,568)	-	-	-	(3,299,568)
Loss on sale of asset	(10,542)	-	-	-	(10,542)
Noncapital grants and contributions	433,112	223,636	5,134	-	661,882
Medical office building, net	(4,000,230)	-	-	-	(4,000,230)
Total nonoperating revenue (expenses)	(4,630,979)	223,636	5,134	-	(4,402,209)
Excess of revenue over expenses	838,456	219,527	28,086	-	1,086,069
Capital grants and contributions	128,799	-	(23,011)	-	105,788
Increase in net position	967,255	219,527	5,075	-	1,191,857
Net position at beginning	36,289,639	159,197	48,360	-	36,497,196
Net position at end	$ 37,256,894	$ 378,724	$ 53,435	$ -	$ 37,689,053

Northern Inyo Healthcare District

Statistical Information

Year Ended June 30, 2017

Bed Complement

	2017	2016	2015	2014	2013
Medical/surgical	11	11	11	11	11
Prenatal/obstetrics	6	6	6	6	6
Pediatric	4	4	4	4	4
Intensive care	4	4	4	4	4
Total licensed bed capacity	25	25	25	25	25

Utilization

	2017	2016	2015	2014	2013
License beds	25	25	25	25	25
Patient days	3,914	3,777	3,804	3,070	2,737
Discharges	1,090	1,136	1,069	1,145	1,031
Occupancy	35 %	41 %	42 %	34 %	25 %
Average stay (days)	3.0	3.3	3.3	2.7	2.8
Emergency room visits	8,959	8,764	7,948	8,191	8,658
Outpatient visits	38,829	38,454	37,684	38,545	37,368

Medical Staff

	2017	2016	2015	2014	2013
Active	50	44	36	36	37
Consulting	23	30	30	30	27
Honorary	10	10	9	9	7
AHP	9	8	8	6	5
Total practitioners	92	92	83	81	76

Employees

	2017	2016	2015	2014	2013
Full-time	322	296	290	273	284
Part-time and per diem	106	98	105	116	106
Total employees	428	394	395	389	390
Full-time equivalents	298.00	298.00	321.37	297.51	279.57

Northern Inyo Healthcare District

Statistical Information (Continued)

Year Ended June 30, 2017

Bond Debt Service Coverage

	2017	2016	2015	2014	2013
Excess (deficit) of revenue over expenses	$ (536)	$ 1,086	$ 1,100	$ 1,075	$ 625
Add:					
Depreciation and amortization expenses	5,029	5,167	4,956	5,274	3,523
Interest expense	2,959	3,299	3,530	3,626	3,731
Available to meet debt service	$ 7,452	$ 9,552	$ 9,586	$ 9,975	$ 7,879
Actual debt service:					
2005 General obligation bonds	$ -	$ -	$ 899	$ 884	$ 884
2009 General obligation bonds	852	625	487	423	423
2010 Revenue bonds	1,182	1,182	1,178	1,182	1,182
2013 Revenue bonds	767	764	788	788	804
2016 Revenue bonds	873	860	-	-	-
Totals	$ 3,674	$ 3,431	$ 3,352	$ 3,277	$ 3,293
Historical debt service coverage ratio	2.03	2.78	2.86	3.04	2.39

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: **Sanctions for Breach of Patient Privacy Policies**	
Scope: District Wide	Manual: **Compliance**
Source: Compliance Officer	Effective Date: 12/1/2017

PURPOSE:

To comply with 45 CFR 164.530(e)(1) which requires "a covered entity must have and apply appropriate sanctions against members of its workforce who fail to comply with the privacy policies and procedures of the covered entity"

POLICY:

Definitions:

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

"Workforce" means persons whose conduct, in the performance of their work for NIHD, is under the direct control of NIHD or have an executed agreement with NIHD, whether or not NIHD pays them. The Workforce includes employees, NIHD contracted and subcontracted staff, NIHD clinically privileged Physicians and Allied Health Professionals (AHPs), and other NIHD health care providers involved in the provision of care of NIHD's patients.

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

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

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

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

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

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

Breach Levels by Incident

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

Title: **Sanctions for Breach of Patient Privacy Policies**	
Scope: District Wide	Manual: **Compliance**
Source: Compliance Officer	Effective Date: 12/1/2017

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

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

Whistleblower Protection

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

Disciplinary Action

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

ATTACHMENT A

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: **Sanctions for Breach of Patient Privacy Policies**	
Scope: District Wide	Manual: **Compliance**
Source: Compliance Officer	Effective Date: 12/1/2017

Sanctions for Breach of Patient Privacy – Incident Severity Scale

Guidelines with recommended corrective actions, once an incident and individual are identified.

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

Action Level:

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

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: **Sanctions for Breach of Patient Privacy Policies**	
Scope: District Wide	Manual: **Compliance**
Source: Compliance Officer	Effective Date: 12/1/2017

Action Level Modification:

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

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

References

1. 45 CFR 164.530(e)(1)
2. California Health and Safety Code Sec. 2 1280.15
3. Civil Code 56.36
4. California Health and Safety Code 130200

Approval	Date
Compliance Committee	10/24/2017
Administration	
Board of Directors	
Last Board of Directors Review	

Developed:
Revised 12/2013 KH, 10/20/2017 PD
Reviewed 12/16/15
Supersedes

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: **Sending Protected Health Information by Fax**	
Scope: **District Wide**	Manual: **Compliance**
Source: Compliance Officer	Effective Date: 12/1/2017

PURPOSE:
To provide guidance for sending protected health information (PHI) by fax to prevent the occurrence of a breach of patient information.

POLICY:

1. PHI may only be faxed by NIHD personnel who have been trained in this policy.

2. Preprogrammed fax machines shall undergo a fax number verification prior to being released for use by staff. Requests for a programmed fax number shall be submitted through the IT Helpdesk ticket system.

    a. A verification request fax will be sent to each requested fax number for any machine by the Compliance department prior to release to staff.
    b. The verification request fax will contain at least the following statement or words of similar import: "This fax verification is intended for _____. If the intended party has received this fax, check here and fax back to _____. If someone other than the intended party has received this fax, check here and fax back to _____."
    c. Once verified, the fax number verification form will be sent to the IT department for programming. IT will program and send visual verification to the Compliance Department.
    d. The preprogrammed fax machine will not be released for staff use until all preprogrammed fax numbers have been verified in accordance with this section.
    e. Compliance will notify of completion of programming and availability of programmed fax button for use.

3. The Compliance Department will be responsible for determining that a preprogrammed fax machine can be released to staff in accordance with this policy.

4. Multi-use fax machines are defined as capable of copying as well as receiving and sending faxes. Multi-use fax machines may only be put in service if an alarm is set to notify operators of a fax being received.

5. Prior to faxing PHI, NIHD personnel must either:
    a. Verify the fax number as being accurate and correct for the intended recipient, or
    b. Utilize a preprogrammed fax number by accessing the number memory of the fax machine or faxing program.

6. Verification of a fax number must be done through one of the following means:
    a. Contacting the intended recipient (or the recipient's office personnel) and reading back the number to that individual; or
    b. Sending a test fax asking for the recipient to send a verification fax back.

7. NIHD personnel performing fax verification must document
    a. Who verified the recipient's fax number for the recipient; and
    b. Which NIHD person performed the verification; and
    c. The date and time of verification.

Title: **Sending Protected Health Information by Fax**	
Scope: **District Wide**	Manual: **Compliance**
Source: Compliance Officer	Effective Date: 12/1/2017

FAXING TO AN UNINTENDED RECIPIENT

8. NIHD personnel who send faxes of PHI in accordance with this policy, but through human error still send a fax to an unintended recipient, must report the mistake to the NIHD Compliance Officer via phone or via email **as soon as the mistake is recognized** and also must complete a PHI Breach Notification Form. The PHI Breach Notification Form is available on the Hospital Intranet. Note: The report to CDPH requires that the violator be named in the report.

9. NIHD personnel who are notified by an unintended recipient that they received a fax containing PHI must report to the Compliance Officer by phone or email, as soon as possible, but not later than the end of their shift. The employee who receives this notification from the unintended recipient must report the following:
    a. The name and telephone number of the unintended recipient.
    b. The time and date of the notification by the unintended recipient.
    c. A description of the PHI that was received including the patients name and the general type of PHI (doctors' orders, test results, etc.).
    d. The disposition of the PHI (e.g. the recipient will send the document(s) back to us, the recipient will deliver the document(s) to the hospital, the recipient will shred the document(s)).

10. If the unintended recipient is a hospital, medical or dental practice or facility, NIHD employees receiving notification from those offices may instruct the offices to shred the documents or send them to the NIHD Compliance Officer.

11. If the unintended recipient is other than a hospital, medical or dental practice or facility, then the NIHD employee **must** ask the recipient to send the documents to the NIHD Compliance Officer. Shredding is not to be recommended.

REFERENCES

1. CA Health and Safety Code 1280.15
2. 42 USC Section 17939

Committee Approval	**Date**
Compliance Committee	**10/24/2017**
Administration	
Board of Directors	
Last Board of Directors Review	

Revised: 2-14-12, 10/4/2017
Reviewed: 1/18/17, 10/17/2017
Supersedes:

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: **Sending Protected Health Information by Fax**	
Scope: **District Wide**	Manual: **Compliance**
Source: Compliance Officer	Effective Date: 12/1/2017

Responsibility for review and maintenance: Compliance Officer
Index Listings: Fax, Faxing, PHI
Initiated: 4-9-2010

NORTHERN INYO HEALTHCARE DISTRICT
COMPLIANCE
POLICY AND PROCEDURE

Title: Disclosures of Protected Health Information Over the Telephone	
Scope: District Wide	Manual:
Source:	Effective Date: 12/1/2017

PURPOSE: In certain instances, using the telephone to communicate with a patient or to respond to requests for a patient's protected health information (PHI) is necessary or more convenient for the patient than communicating via mail or e-mail, or having to come to Northern Inyo Healthcare District (NIHD) in person. In order to do so while maintaining patient privacy and minimizing workforce disclosures to incorrect parties, NIHD has certain rules in place which must be followed.

POLICY: Workforce members should attempt to limit, to the extent practical, PHI communicated over the phone. When necessary to disclose PHI over the telephone, NIHD has procedures that must be followed.

PROCEDURES:

1. **Requests from or disclosures to a caller stating he/she is a patient**
   If a caller states he/she is a patient and he/she is requesting PHI about himself/herself, the workforce member will provide the PHI when they have confirmed the caller is the patient, using two patient identifiers.
   a. The workforce member will, prior to disclosing PHI, ask specific questions that could only be answered by the patient. For example, the patient's date of birth, address, father's name, or mother's name.
   b. If the workforce member knows the patient and the patient's voice, and recognizes the voice on the telephone as being that of the patient, verification with two identifiers shall be used to ensure the workforce member is in the correct record.
   c. The workforce member may elect to place a return call to the patient using the telephone number documented in the patient's record rather than immediately disclosing the patient's PHI to a caller initiating the telephone conversation.

2. **Requests from or disclosures to a caller who is not the patient**
   If the caller states he/she is an immediate family member (e.g. father, mother, child, or sibling) of the patient, the workforce member will refer to the patient's record for documentation (Authorization for Release of Information) to determine what information may be provided to this individual.
   d. If the caller states he/she is a friend, relative, or acquaintance of the patient or if the caller is unrelated to the patient (e.g. the patient's employer, law enforcement, or a reporter) the workforce member will:
      i. Not disclose PHI without the patient's permission; or
      ii. Provide only directory information about the patient. Directory information is defined as:
         1. The patient's name
         2. The patient's location

3. The patient's condition described in general terms that do not communicate specific PHI about the patient ("good", "stable", "critical", etc.)

3. Calls to a patient's home

Workforce members may not leave messages regarding treatments or diagnostic testing information on a patient's answering machine. Individuals leaving appointment reminders may only provide the name of the provider, the office phone number, the date and time of appointment, and/or the location.

4. Documenting disclosures made over the telephone

If PHI is disclosed to a caller, the workforce member will document the disclosure in the patient's medical record.

Questions

Questions about disclosure of a patient's PHI over the telephone should be directed to the workforce member's supervisor or the HIPAA Privacy Officer.

Approval	Date
Compliance Committee	**10/24/2017**
Administrator	
Board of Directors	
Last Board of Directors Review	

Developed: July 2013
Revised:10/20/2017
Reviewed: 12/16/15

NORTHERN INYO Healthcare District
POLICY AND PROCEDURE

Title: Patient's Rights	
Scope:	**Department:** Administration
Source: CEO	**Effective Date:**

NORTHERN INYO HEALTHCARE DISTRICT POLICY ON PATIENTS' RIGHTS, PATIENTS' RESPONSIBILITIES, AND PROCESS FOR RESOLUTION OF PATIENT GRIEVANCES OR COMPLAINTS

The following rights and responsibilities apply to adult patients and the parents and/or guardians of neonate, child and adolescent patients:

Rights

In accordance with Section 70707 of Title 22, California Code of Regulations and Medicare Conditions of Participation, the Northern Inyo Healthcare District and its Medical Staff have adopted the following patient rights:

1. The patient shall have the right to exercise theses rights without regard to sex, economic status, educational background, race, color, religion, ancestry, national origin, sexual orientation, marital status, or the source of payment for care.
2. The patient shall have the right to be treated with respect, consideration and dignity, and to be made comfortable. The patient has the right to have his or her personal values and beliefs respected.
3. The patient shall have personal privacy respected. Patient has the right to have visitors be asked to leave prior to an examination and when treatment issues are being discussed. Privacy curtains will be used in semi-private rooms.
4. The patient shall have knowledge of the name of the physician who has the primary responsibility for coordinating the care and the names and professional relationships or other physicians and non-physicians who will see the patient.
5. The patient has the right to be informed of his or her health status, and prospects for recovery and outcomes of care (including unanticipated outcomes) in terms that the patient can understand.
6. The patient has the right to make decisions regarding medical care, and receive as much information about any proposed treatment or procedure as the patient may need in order to give informed consent or to refuse this course of treatment. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved in the treatment, alternate courses of treatment or non-treatment and the risks involved in each and to know the name of the person who will carry out the procedure or treatment.
7. The patient has the right to participate in the development and implementation of the patient's plan of care and make decisions regarding that care. The patient has the right to ethical questions that arise in the course of his or her care, including issues of conflict resolution, withholding resuscitative services, and forgoing or withdrawing life-sustaining treatment.
8. The patient has the right to participate actively in decisions regarding medical care. To the extent permitted by law, this includes the right to refuse treatment.
9. The patient has the right to appropriate assessment and management of his or her pain, information about pain, pain relief measures and to participate in pain management decisions. If the patient suffers from severe chronic intractable pain, the patient has the option to request or reject the use of any or all modalities to relieve pain, including opiate medication. The patient's doctor may refuse to prescribe opiate medication, but if so, must inform the patient that there are physicians who specialize in the treatment of severe chronic intractable pain with methods that include the use of opiates.

10. The patient has the right to have a family member (or representative of the patient's choice) and the patient's own physician notified promptly of the patient's admission to the hospital.
11. The patient has the right to full consideration of confidentiality and personal privacy during patient care at the hospital. Case discussion, consultation, examination and treatment are confidential and should be conducted discreetly. The patient has the right to be advised of and consent to the presence of any individual.
12. The patient has the right to confidential treatment of all communications and records pertaining to the care and the stay in the hospital. Basic information may be released to the public, unless specifically prohibited in writing by the patient. Written permission shall be obtained before medical records can be made available to anyone not directly concerned with the care of the patient except as my otherwise be required or permitted by law.
13. The patient has the right to reasonable responses to any reasonable requests he or she may make for service.
14. The patient has the right to leave the hospital even against the advice of physicians, to the extent permitted by law.
15. The patient has the right to reasonable continuity of care and to know in advance the time and location of appointments as well as the identity of persons providing the care.
16. The patient has the right to be advised if hospital/personal physician proposes to engage in or perform human experimentation affecting care or treatment. The patient has the right to refuse to participate in such research projects.
17. The patient has the right to be free from seclusion, and form physical restraints and drugs that are used as a restraint that are not medically necessary or are used as a means or coercion, discipline, convenience, or retaliation by staff.
18. The patient has the right to be informed by the physician, or a delegate of the physician, of continuing health care requirements following discharge from the hospital. Upon the request of the patient, a friend or family member may be provided with this information also.
19. The patient has the right to examine and receive and explanation of the bill regardless of source of payment.
20. The patient has the right to know which hospital rules and policies apply to the patient's conduct while a patient.
21. The patient has the right to formulate advance directives and have hospital staff and practitioners who provide care in the hospital comply with these directives. This includes designating a decision maker if he or she becomes incapable of understanding a proposed treatment or becomes unable to communicate his or her wishes regarding care. Hospital staff and practitioners who provide care at Northern Inyo Hospital shall comply with these directives.
22. The patient has the right to request or refuse treatments. However, the patient does not have the right to demand treatment or services deemed medically unnecessary or inappropriate.
23. The patient has the right to have all his or her rights apply to the person who may have legal responsibility to make decisions regarding medical care on behalf of the patient.
24. The patient has the right to file a grievance. To file a grievance with this Healthcare District, the patient may do so by writing or by calling the Northern Inyo Hospital Quality Assurance & Performance Improvement office, Northern Inyo Hospital, 150 Pioneer Lane, Bishop, CA 93514, (760) 873-2100. The Hospital Quality Assurance staff will review each grievance and provide the patient with response in accordance with the Grievance Policy. The written response will contain the name of a person to contact at the Healthcare District, the steps taken to investigate the grievance, the results of the

grievance process, and the date of completion of the grievance process. Concerns regarding quality of care or premature discharge will also be referred to the appropriate utilization and Quality Control Peer Review Organization (PRO).

25. The patient has the right to file a complaint with the State Department of Health Services regardless of whether the Healthcare District's grievance process is used or not. The State Department of Health Service's phone number and address is: California Department of Health Services, Licensing and Certification, San Bernardino District Office, 464 West 4th Street, Suite 529, San Bernardino, Ca 92401, phone 909-383-4777 or 800-344-2896.
26. The patient has the right to designate visitors or his or her choosing, if the patient has decision making capacity, whether or not the visitor is related by blood or marriage, unless:
    a. No visitors are allowed.
    b. The Healthcare District reasonably determines that the presence of a particular visitor would endanger the health or safety of a patient, a member of the Healthcare District staff, or other visitor to the Healthcare District campus, or would significantly disrupt the operations of the Healthcare District.
    c. The patient has indicated to the Healthcare District staff that the patient no longer wants this person to visit.
27. The patient has the right to have his or her wishes considered for purposes of determining who may visit if the patient lacks decision-making capacity and to have the method of that consideration disclosed in the Healthcare District policy on visitation. At a minimum, the Healthcare District shall include any person living in the household.
28. These patient rights may not be construed to prohibit the Healthcare District from otherwise establishing restrictions on visitation, including restrictions upon the hours of visitations and number of visitors.
29. The patient has the right to be provided with free interpreter services if the patient, or his or her legal representative, cannot communicate with the physician because of language or communication barriers.
30. For many patients, pastoral counseling and other spiritual services are an integral part of healthcare and daily life. The hospital will provide pastoral counseling services for patients who request them.
31. The patient has the right to receive care in a safe setting, free from verbal or physical abuse or harassment. The patient has the right to access protective services including notifying government agencies of neglect or abuse.
32. The patient has the right to access information contained in his or her records within a reasonable time frame, except in certain circumstances specified by law.

Restrictions of Patient's Rights:

1. Any restrictions of communication are fully explained to the patient, family or significant other and are determined with their participation.
2. When the Healthcare District restricts a patient's visitors, mail, telephone, or other forms of communications, the restrictions are evaluated for their therapeutic effectiveness.
3. Generally, patients have the right to expect unrestricted access to communication. Sometimes, however, it may be necessary to restrict visitors, mail, telephone calls, or other forms of communication as a component of a patient's care (for example, to prevent injury or deterioration in the patient, damage to the environment, or infringement on the rights of others). The patient is included in any such decision.

4. Communication restrictions are explained in a language the patient understands. For an unemancipated minor or patient under guardianship, applicable law determines who is legally entrusted to act in the patient's best interest. Clinical justification of such restrictions is documented in the medical record.

Responsibilities

Patients are responsible for the following items:

1. The patient shall provide complete and accurate information regarding his or her medical history to those involved with his or her care.
2. The patient shall inform the physician or nurse of any changes in his or her health.
3. The patient shall inform the attending physician and the nurse of any pain he or she has and results of pain control measures.
4. The patient shall make it known whether he or she clearly understands the course of action and what is expected of him or her.
5. The patient shall make it know to appropriate Healthcare District staff and/or his or her physician that he or she is in need of interpreter services or other assistance because of language or communication barriers.
6. The patient shall work collaboratively with his or her physician and the hospital's patient care staff in developing and carrying out agreed upon treatment plans.
7. The patient shall follow Healthcare District rules and regulations affecting patient care and conduct.
8. The patient shall assure that the financial rules and obligations of his or her health care are fulfilled as promptly as possible.
9. The patient shall be considerate of the rights or other patients and Healthcare District personnel.
10. The patient shall take responsibility for maximizing health habits, such as exercising, not smoking, and eating a healthy diet.
11. The patient shall avoid knowingly spreading disease.
12. The patient shall recognize the reality of risks and limits of the science of medical care, and the human fallibility of the health care professional.
13. The patient shall be aware of a health care provider's obligation to be reasonably efficient and equitable in providing care to other patients and the community.
14. The patient shall report wrongdoing and fraud to appropriate resources or legal authorities.

Process for Resolution of Patient Grievances or Complaints

Should there be a conflict between the care expectations of the patient (or the care expectations of the parents and/or guardians of neonate, child or adolescent patients), the patient (or patient's representative) should request from their physician or head nurse that a patient care conference be held to attempt to resolve the conflict. The conference should involve the patient and/or the patient's representative, and Healthcare District staff members involved in the conflict, and should be conducted within 24 hours of the request for the conference.

If the conflict cannot be resolved by those attending the patient care conference, then the patient and/or the patient's representative should file a grievance verbally or in writing. The patient may do so by writing or by calling the Northern Inyo Healthcare District Quality Department, Northern Inyo Hospital, 150 Pioneer

NORTHERN INYO Healthcare District
POLICY AND PROCEDURE

Title: Patient's Rights	
Scope:	**Department:** Administration
Source: CEO	**Effective Date:**

Lane, Bishop, CA 93514, (760) 873-2100. The Quality Department will review each grievance and provide the patient with a response. The written response will contain the name of a person to contact at the Healthcare District, the steps taken to investigate the grievance, the results of the grievance process, and the date of completion of the grievance process. If the patient (or the patient's representative) is not satisfied with the Quality Department's response, an appeal may be submitted to the Northern Inyo Healthcare District Administrator.
Presentation of a grievance or complaint will not compromise a patient's access to care.

Any patient or patient's representative who alleges this Healthcare District has been in non-compliance with advance directives or alleges patient abuse, neglect or misappropriation of patient property in this facility may file a complaint with California Department of Health Services, Licensing and Certification, San Bernardino District Office, 464 West 4th Street, Suite 529, San Bernardino, CA 92401, phone 909-383-4777 or 800-344-2896.

Approval	**Date**
Administrator	
Chief of Staff	
Board of Directors	
Last Board of Directors Review	

Committee(s) approval needed: ___ No _X_ Yes (Board of Directors)
Responsibility for review and maintenance: Administrator
Index Listing: Patient's Rights; Rights, Patient
Initiated: 01/2001;
Revised 11/7/02; 11/8/2017
Reviewed:

NORTHERN INYO HEALTHCARE DISTRICT
EMPLOYEE HANDBOOK – PERSONNEL POLICY

Title: EMPLOYEE RECOGNITION	
Scope: District Wide	Department: Human Resources – Employee Handbook
Source: Human Resources	Effective Date:

PURPOSE:

The purpose of this policy is to establish a District-wide recognition program for Northern Inyo Healthcare District ("District") employees.

POLICY:

The District believes the quality of the District's employees will determine the quality of the care, treatment and services the District provides. Therefore, as part of enhancing employee engagement through promoting recognition for its employees, it is the District's policy to establish an employee recognition program based on the quality of the work done by its employees.

PROCEDURE:

1. Recognition for On the Spot Awards

   Recognition for On-the-Spot Awards is done at any time. Employees and/or customers can submit a One Team/One Goal/Your Health card directly to the employee who is recognized describing the reason(s) why the recognized employee deserves an On-the-Spot Award. Criteria for this award is an immediate observable on the spot display by that employee of the work done that is aligned with the mission, vision and/or values of the District. The recognized employee shall take the card to Human Resources who will exchange the card for a nominal reward. Employees will be recognized throughout the District for their On-the-Spot awards. Cards are generally available throughout the District including in Community Relations, Human Resources and the Cafeteria.

2. Recognition as Employee of the Month.

   Recognition of at least one (1) Employee-of-the-Month occurs monthly. The Employee-of-the-Month Recognition program awards at least one (1) employee each month who is nominated by an employee from within or outside the nominated employee's department. The selection criteria for this award is based on the nominated employee's work that consistently demonstrates work aligned with the mission, vision, and/or values of the District. Nominations shall be made on the approved form. A sub-committee of the Workforce Council, the Employee Recognition Subcommittee (ERS), shall review and select each month's Employee of the Month. The ERS shall be chaired by the Community Relations representative of the Workforce Council and further consist of at least one (1) employee appointed yearly to the ERS by each Chief as well as the current winner of the Employee-of-the-Year award.

Title: EMPLOYEE RECOGNITION	
Scope: District Wide	Department: Human Resources – Employee Handbook
Source: Human Resources	Effective Date:

3. Recognition as Employee of the Year

Recognition as the Employee-of-the-Year occurs annually. The Employee-of-the-Year recognition program awards one (1) employee per year from the winners of the Employee-of-the-Month award from the prior twelve (12) months and from other nominees that are received. The Executive Leadership Team shall select an employee whose work throughout the prior twelve (12) months adds significant value to the mission, vision and/or values of the District. Additional criteria can be used to include work by the nominee around The 7 Habits of Highly Effective People (i.e., a proactive person, a person who begins with the end in mind, a person who puts first things first, a person who thinks win-win, a person who seeks first to understand, and then to be understood, a person who can synergize and a person who creates growth and self-renewal). The Employee of the Year shall be recognized at the Northern Inyo Hospital (NIH) Foundation's Annual Avenue of Excellence Award Dinner, shall serve a one (1) year term on the ERS, and be otherwise recognized through other means available to the District.

REFERENCES:

Covey, S. (1989). *The 7 Habits of Highly Effective People: Powerful Lessons in Personal Change.* New York, NY: Simon & Schuster.

Approval	**Date**
Human Resources	11/2/2017
Executive Leadership	11/5/2017
Board of Directors	

Developed:
Reviewed:
Revised:
Supersedes:
Index Listings:

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Inyo Mono Advocates for Community Action (IMACA)	
Scope:	Manual: Social Services
Source: Chief Nursing Officer	Effective Date:

Inyo-Mono Advocates for Community Action (IMACA)
PO Box 845
224 South Main Street
Bishop, California 93514
(760) 873-8557 voice
(760) 873-8192 FAX

http://www.imaca.net/

PURPOSE:

It is the mission of Inyo Mono Advocates for Community Action, Inc. (IMACA) to empower low-income people, to advocate for their needs, and to find and maintain a healthy lifestyle by breaking the cycle of poverty.

IMACA's Mission is to break the cycle of poverty by:

- Advocating for low-income residents of Inyo and Mono Counties by making their needs known to policy makers.
- Informing and involving residents of our communities in social planning and policy making.
- Creating permanent advancement in the abilities of individuals, groups, snd communities affected by poverty.
- Empowering low-income citizens in our communities by providing education and assistance in order that these residents achieve economic self-sufficiency and become fully participating, responsible adults.

POLICY:

This agency is the designated community action agency for Inyo and Mono County.

Services provided by IMACA include:

- Advocacy
- Affordable Housing
- Assistive Devices for the Disabled
- Child Care in Mono County
- Commodities Distribution
- Economic Development
- Emergency Food and Shelter
- Energy Assistance
- Energy Conservation Education
- Head Start and State Preschool
- Holiday Food and Gifts
- Home Weatherization

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Inyo Mono Advocates for Community Action (IMACA)	
Scope:	Manual: Social Services
Source: Chief Nursing Officer	Effective Date:

- Information and Referrals
- Rental Assistance

The Social worker will, when appropriate, refer patients and families to this agency for assistance including emergency shelter, temporary food assistance, energy crisis intervention (when power is going to be shut off). The social worker may also assist the patient and or family with the application process as requested.

This agency also manages the Sunrise Mobile Home Park, a seniors only trailer park in Bishop set up for low income seniors and Clarke Street Senior apartments, studio apartments for low income seniors.

Approval	**Date**
NEC	10/18/17
Board of Directors	
Last Board of Directors Review	

Revised:
Reviewed: 10/17ta
Supersedes:
Index Listings:

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Nursing Services Jobs and Titles	
Scope: Nursing Department	Manual: 1. NAM - Administration/Organization of Nursing Services
Source: Chief Nursing Officer	Effective Date:

PURPOSE: To identify the organization of Nursing Services by job classification and titles.

POLICY:

1. Positions in Nursing Services have been classified under the following categories:
   a. Administrative Management
   b. Clinical Support Management
   c. Provider Support
   d. Direct Care Coordinator
   e. Patient Care Support Position
   f. Administrative Support

2. A Job Description is available, in writing, for each position that staff are hired. The positions of Nursing Services are:
   a. Administrative Management Positions
      i. Chief Nursing Officer (CNO)

      ii. Director of Nursing (DON)
         1. Director of Nursing Perioperative Services
         2. Director of Emergency and Inpatient Services

      iii. Nurse Manager
         1. Manager of Quality/Informatics/Infection Preventionist
         2. Manager of Emergency and Disaster Planning
         3. Manager of ICU & Acute/Subacute
         4. Manager of Perinatal
         5. Manager of Perioperative Services/PACU/Infusion

      iv. Assistant Nurse Manager
         1. Assistant Manager Emergency and Disaster Planning
         2. Assistant Manager ICU & Acute/Subacute
         3. Assistant Manager Perinatal

   b. Clinical Support Management Positions
      i. House Supervisor

      ii. Coordinator
         1. Surgery/CSP Coordinator
         2. District Education Coordinator

      iii. Clinical Informatics Nurse Specialist

      iv. Case Manager

      v. Social Worker (LCSW)

Title: Nursing Services Jobs and Titles	
Scope: Nursing Department	Manual: 1. NAM - Administration/Organization of Nursing Services
Source: Chief Nursing Officer	Effective Date:

c. Registered Nurse First Assistant (RNFA)

d. Direct Care Coordinator Positions
   i. Registered Nurse (RN)

e. Patient Care Support Positions
   i. Department Clerk/LVN/Monitor Tech ICU
   ii. Department Clerk/Licensed Vocational Nurse Perinatal
   iii. Department Clerk/ Monitor Tech ED
   iv. Department Clerk/Monitor Tech (EMT/CNA)
   v. Department Clerk/Certified Nursing Assistant Acute/Subacute
   vi. Department Clerk Acute/Subacute
   vii. Scrub Tech
   viii. Central Sterile Processing Tech
   ix. Perioperative Clerk
   x. Outpatient Clerk

f. Administrative Support
   i. Administrative Assistant
   ii. Staffing Coordinator
   iii. Clinical Application Specialist
   iv. Surgery Inventory Management Clerk

3. Performance Standards are in place for positions that assume additional duties in addition to the main job hired.
   a. Clinical Staff Educator
      i. Acute/Subacute
      ii. ICU
      iii. ED
      iv. Surgery
      v. PACU/Infusion/Outpatient
   b. Shift Charge*
   c. Pre-hospital Liaison Nurse

4. Skills checklist are developed for the RN Job Description based on the Clinical Department Competency requirements.

5. Nursing Services job descriptions, performance standards and skills checklist will be reviewed every three years of more often.

6. Certain job positions in nursing may be a combination of positions under one job description such as Department Clerk/Certified Nursing Assistant.

*This title may be rotated among RN's for the assigned shifts; usually not in place if the Coordinator is working

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Nursing Services Jobs and Titles	
Scope: Nursing Department	Manual: 1. NAM - Administration/Organization of Nursing Services
Source: Chief Nursing Officer	Effective Date:

PROCEDURE:

1. Interview questions will be developed for position categories job titles and used by the interview team at the time of application to determine if the applicant can meet the minimum requirements of the job description for which the applicant has applied.

   a. The HR process for hiring, orientation, and job description will be followed

2. During orientation, each employee will receive a copy of the job description for the position hired and sign a copy of the job description for the HR Employee file.

   a. Any change in the job description will require a copy to be signed by the employee and placed in the HR Employee file

3. Nursing Services department orientation will be based on the job description; skills check list and any applicable performance standards.

4. Annual feedback will be provided to each employee per HR policy.

REFERENCES:

1. TJC (January 2016) CAMCAH. Chapter Human Resources Standard HR 01.02.01, The critical access hospital defines staff qualification; EP 1,12., 13, Standard HR 01.02.07 The critical access hospital determines how well staff function within the organization, EP 2, Standard HR 01.02.07 The critical access hospital provides orientation to staff, EP1-6,

CROSS REFERENCE P&P:

1. Nursing Services Organizational Charts
2. HR Hiring Process

Approval	**Date**
NEC	10/18/17
Board of Directors	
Last Board of Director review	3/15/17

Developed: 1/2/15
Reviewed:
Revised: 8/15, 10/2017ta
Supercedes:

Northern Inyo Hospital
Nursing Services
Clinical Consistency Oversight Committee (CCOC)

Reports to: Chief Nursing Officer (CNO)

Membership: Nursing Educator, DON's, Nurse Managers, Assistant Nurse Managers, Administrative Assistant, Clinical Informatics Quality Nurse Specialist, and Interdisciplinary Team Management as needed

Convenes: Monthly for 2.5 hours and as needed

Purpose:

To oversee the development, review and revision of clinical practice standards (P&P's) to ensure national and regional standards of practice, evidence based practice, and community standards are met.

To refer P&P's that involve more than one discipline to the Medical Staff Committee(s) for discussion and approval.

To involve the Interdisciplinary Team Management as appropriate with CCOC discussion and approval of P&P's that involve the managers departments of oversight.

Developed: 11/2014
Reviewed: 10/2017ta
Revised:

NIH
Professional Practice Council

Reports to: Indirectly to Chief Nursing Officer

Membership Mix: ED RN, ICU RN, MS/Peds/Swing RN, OR/CSP RN, PAT/SDS/PACU/Infusion RN, Perinatal RN, CNO on invitation and at least quarterly Interdisciplinary Team Representatives as needed by invitation

Meeting Structure: Monthly 2 hour meeting

Purpose:

1. Assessment, review, response to problems, concerns, issues and other related activities which impact clinical care outcomes.
2. Review of Evidence Based Practice and regulations that impact the delivery of care.
   a. Determination and dissemination of needed changes in practice, coordination of information/opportunities
3. Identification of clinical QA/PI goals for area of specialty
4. The function of the Central Council is to provide oversight for:
   a. Determining and standardizing nursing practice at NIH
   b. Review trends and issues/make recommendations/evaluate effectiveness of actions
   c. Act as a resource to enhance professionalism and promote current standards of care and practice
   d. To ensure interdisciplinary and nursing policies remain compliant with the California Board of Nursing State Practice Act, Scope of Practice Guidelines and other regulatory agencies
   e. Benchmark practice
5. The Central Council shall address issues in the following order:
   a. Improve patient care. Those issues involving patient safety will have the highest priority
   b. Improve employee/patient satisfaction
   c. Reduce cost via best practice implementation

Council Chairperson:

- Elected by Council peers
- Runs the Central Council meeting (term 1 year)
- Sets the agenda with CNO assistance
- Acts for the group; speaks for the group when not in session
- Assigns group tasks/functions/goals to other committees
- Handles council disputes

Recorder/Reporter:

- Takes minutes/posts minutes on intranet

Council Members:

- Elected by department staff (union-eligible) for 2 years
- Rotate half the members off one year and the other half off the second year
- Members speak on behalf of those services when decisions have to be made
- Work may be assigned to members to be done in the meeting or to be taken back to the department and completed there. Reports on progress and tasks are given at each meeting

Alternate Council Members

- As members rotate off the Council, the member becomes an alternate member
- Attends the meeting in the absence of the department member
- Supports and coaches the department Council Representative

Dev. 7/13
Rev. 12/13, 3/14, 1/15, 10/2017ta
Last Board of Director Review: 3/15/17

Northern Inyo Hospital
Nursing Services
Safe Patient Handling Subcommittee

Lead by: Employee Health Specialist
Reports to: Chief Nursing Officer (CNO)
Information flowed to Safety Committee

Membership: Employee Health Specialist, CNO, HR Benefit/LOA Specialist, Staff members form DI, RHC, ED, ICU, Medical/Surgical, DON ED & Inpatient Services, District Education Coordinator and Nurse Managers as alternates when needed

Convenes: Bi-Monthly

Purpose:

1. To review the California requirements of the Safe Patient Handling regulations.

2. Develop and oversee plans and P&P's that support Safe Patient Handling:
   a. Musculoskeletal Injury Prevention Plan
   b. Safe Patient Handling P&P
   c. Injury and Illness Prevention Program

3. Review and discuss any Safe Patient Handling events to prevent future occurrence.

4. Proactively round to observe and identify risk situations and receive staff feedback.

5. To support the development of safe patient handling goals for each district clinical care unit.

Developed: 2/2015
Reviewed:
Revised: 10/2017ta
Last Board of Director review: 3/15/17

Staffing Issues Advisory Committee
(SIAC)

Reports to: Chief Nursing Officer
Chief of human Resources

Membership: Nurse Manager
House Supervisor
Staffing Coordinator
Union-eligible Representative for:
Surgery/PACU/Infusion
Medical-Surgical
ICU
ED
RHC
Perinatal

Convenes: Monthly

Purpose:
* To evaluate the ability of NIH to meet department specific Staffing Management Plans.
* To develop structure (Policy and Procedure) for staffing and scheduling practices to ensure the right staff with the right skills are working in the right department on the right shift to meet patient needs, (includes deployment, work schedule preparation, low census and floating of staff).
* To address any staff concerns with staffing practices submitted to the committee for review.
* To address retention and recruitment issues.
* To monitor TJC Functional Chapter Standards.
* To participate in selection and annual validation of staffing acuity system.

Developed: 12/13
Reviewed:
Revised: 1/2015, 10/2017ta
Last Board of Director review: 3/15/17

NORTHERN INYO HEALTHCARE DISTRICT

Hospital-Wide Pillars of Excellence: FY July 1, 2017-June 30, 2018

Indicator	Baseline	Goal	J-S Q1	O-D Q2	J-M Q3	A-J Q4	YTD
Service							
1. Patient satisfaction							
a. RHC- Overall score % Top Box	**73.0 Below Average[1]**	**85.0 Better Than Most**	**78.0 Below Average[1]**				**78.0**
b. Emergency Department-Overall score % Top Box	**71.7 Below Average[2]**	**85.0 Better Than Most**	**70.4 Below Average[2]**				**70.4**
c. HCAHPS Perinatal-Overall score % Top Box	**75.4 Above Average[3]**	**85.0 Better Than Most**	**92.5 Best in Class[3]**				**92.5**
d. HCAHPS MedSurg-Overall score % Top Box	**66.4 Below Average[4]**	**85.0 Better Than Most**	**67.3 Below Average[4]**				**67.3**
Note: Baseline was calculated on data from Q2, Q3 and Q4 due to transition to Press Ganey. 1. Peer Comparison = All PG Medical Practice Groups. 2. Peer Comparison= Hospitals with 10,000 or less visits/year. 3. Peer Comparison= Hospitals with 20-30 Beds. 4. Peer Comparison= Hospitals with 20-30 Beds.							
Quality							
1. Adverse Drug Events-Anticoagulants*	**1/22 (4.5%)**	**0**	**0/11 (0%)**				**0**
2. Surgical Site Infections*,[1]	**9/1420 (0.63%)**	**0**	**1/377 (0%)**				**0**
3. Central Line Associated Bloodstream Infections (CLABSI) CLABSI/Line Days (Per 1000 Line Days)*	**0/205 (0.0)**	**0**	**0/88 (0)**				**0**
4. Catheter Associated Urinary Tract Infections (CAUTI) CAUTI/Catheter Days (Per 1000 Catheter Days)*	**1/711 (0.14)**	**0**	**0/207 (0)**				**0**
5. Ventilator Associated Events*	**0/23 (0%)**	**0**	**0/12 (0%)**				**0**
6. Falls With Injuries (Per 1000 Patient Days)*	**2/2454 (0.81)**	**0**	**4/813 (4.9)**				**4.9**
7. 30 Day Readmission Rate (Inpatient)*	**29/1168 (2.4%)**	**<15%**	**8/274 (2.9%)**				**2.9**
*Note: Baseline period for these metrics is FY 16-17. 1. SSI National average is about 2.0%. 2. Correction was made in denominator for this data.							
People							
1. Overall Turnover Rate, 3		**<15%**	**5.70%**				**5.7**
a. Active			**429**				**429**
b. Leave Of Absence			**18**				**18**
c. Terminated			**27**				**27**
2. Total Recordable Incident Rate (OSHA) per 100 employees-Modified**		**0**	**12/444 (2.68%)**				**2.68**
Benchmark data for these metrics only available per annum and since the number of incidents accumulates, but number of employees is relatively constant, it is most appropriate to compare only per annum data to the goal. To compute YTD prior to year end, an average of the quarterly metric denominator will be used. **OSHA metric is per 100 FTE; NIH proxy measure is per 100 employees. National average for hospitals is 6.2. (Reference available in PEX office)							
Finance							
1. Current Ratio	**3.12**	**>2.0**	**2.45**				**2.45**
2. Days Cash on Hand-Short Term Sources	**78**	**>75**	**53.95**				**64.35**
3. Debt Service Coverage Ratio	**2.26**	**>1.5-2.0**	**2.79**				**2.66**
4. A/R Days (Inpatient & Outpatient)	**79**	**<60**	**82.05**				**79.20**

LEGEND	
	Best-in-Class Performance, Exceeds Goal
	Above Average, Meets Goal
	About Average, Does Not Meet Goal
	Below Average, Does Not Meet Goal

Important General Notes:

1. Goals in Blue are stretch goals and may follow a 'zero defects' approach outlined in the Hospital-Wide Quality Assurance and Performance Improvement (QAPI) plan. On some metrics, we have set the bold goal of zero defects (best-in-class). For the metrics with a goal of zero, either we are best-in-class and get a blue color code or not best-in-class and get a red code. It is important to note that a code of red in the 'Quality' category of indicators for metrics with goals of zero does not necessarily indicate poor performance, just that we have not met our goal of zero Patient Satisfaction/Patient Experience-For each department the Top Box Percentile Rank for the chosen Peer Comparison groups was used to classify the performance category based on the following cut points; 90-100 Best in Class (Blue), 75-89 Above Average (Green), 50-74 About Average (Yellow), ≤49 Below Average (Red). It is recommended that specific performance dimensions be further assessed by area leadership to identify specific opportunities for improvement.

Rev. 11/6/17 krb

CALL TO ORDER	The meeting was called to order at 5:30 pm by Peter Watercott, President.
PRESENT	Peter Watercott, President John Ungersma MD, Vice President M.C. Hubbard, Secretary Mary Mae Kilpatrick, Treasurer Kevin S. Flanigan, MD, MBA, Chief Executive Officer Kelli Huntsinger, Chief Operating Officer John Tremble, Chief Financial Officer Tracy Aspel RN, Chief Nursing Officer Evelyn Campos Diaz, Chief Human Resources Officer Sandy Blumberg, Executive Assistant
ABSENT	Richard Meredick MD, Chief of Staff Phil Hartz, Member at Large
OPPORTUNITY FOR PUBLIC COMMENT	Mr. Watercott announced at this time persons in the audience may speak only on items listed on the Notice for this meeting, and speakers will be limited to a maximum of three minutes each. No comments were heard.
BUDGET AND FINANCIAL STRATEGY WORKSHOP	A budget and financial strategy workshop was held for the purpose of strategizing to improve the District's financial standing in light of the fact that a significant loss was realized for the 2016/2017 fiscal year. The following topics were discussed as part of this workshop: - Components of healthcare spending - National healthcare spending trends - Review of healthcare services provided by Northern Inyo Healthcare District (NIHD) - Review of services not available within the District - Patient service volume trends within the District - Data collected from consumer surveys - District payor trends and payment methods - Review of District debt and capital status - District revenues, expenditures, and trends - Healthcare market and operational challenges - Ideas for additional patient services the District may be able to provide It was noted that District leadership will focus on strategic financial planning moving forward, and that additional workshops will be held in order to continue monitoring of current market trends and District performance.

CLOSED SESSION	At 7:26 pm Mr. Watercott announced the Board would adjourn to closed session for discussion of Labor Relations (*pursuant to Government Code Section 454957.6*).
RETURN TO OPEN SESSION AND REPORT OF ACTION TAKEN	At 8:29 pm the meeting returned to open session. Mr. Watercott announced the Board took no reportable action.
ADJOURNMENT	The meeting was adjourned at 8:30 pm.

_____
Peter Watercott, President

Attest: _____
M.C. Hubbard, Secretary

CALL TO ORDER	The meeting was called to order at 5:30 pm by Peter Watercott, President.
PRESENT	Peter Watercott, President John Ungersma MD, Vice President M.C. Hubbard, Secretary Mary Mae Kilpatrick, Treasurer Kevin S. Flanigan, MD, MBA, Chief Executive Officer John Tremble, Chief Financial Officer Tracy Aspel RN, Chief Nursing Officer Evelyn Campos Diaz, Chief Human Resources Officer Richard Meredick MD, Chief of Staff Sandy Blumberg, Executive Assistant
ABSENT	Phil Hartz, Member at Large Kelli Huntsinger, Chief Operating Officer
OPPORTUNITY FOR PUBLIC COMMENT	Mr. Watercott announced at this time persons in the audience may speak on any items not on the agenda on any matter within the jurisdiction of the District Board. Speakers will be limited to a maximum of three minutes each. No comments were heard.
CHILDHOOD OBESITY PROGRAM PRESENTATION	Serena Johnson, Director of Inyo County First 5 gave a presentation on *Team Inyo for Healthy Kids,* a program that promotes active lifestyles, balanced nutrition, and healthy choices for youth.
MEDICAL STAFF SERVICES PILLARS OF EXCELLENCE	Chief Executive Officer Kevin S. Flanigan, MD, MBA reviewed the Medical Staff Services Pillars of Excellence report for July 1 2017 through September 30 2017.
2013 CMS SURVEY MONITORING	Doctor Flanigan called attention to the District's 2013 CMS Validation Survey monitoring reports as of September 2017, which include performance statistics on the following: - Advance Directives Assessment Compliance - Dietary Consults Performed When Ordered - Percentage of Care Plans Individualized - Pain Reassessment Non-Compliance, Perinatal - Pain Reassessment Non-Compliance, Medical Surgical, ICU, and ED Departments - Restraint chart monitoring for legal orders
NIHD FOUNDATION BOARD NOMINATION	Doctor Flanigan requested approval of the appointment of Ms. Heidi Dougherty to the Northern Inyo Healthcare District (NIHD) Foundation Board of Directors. It was moved by Mary Mae Kilpatrick, seconded by John Ungersma MD, and unanimously passed to approve the appointment of Heidi Dougherty to the NIHD Foundation Board as requested.

COMPOUNDING PHARMACY UPDATE

Doctor Flanigan provided an update on progress made toward bringing the NIHD compounding pharmacy into compliance with new regulations. The District has applied for a waiver to continue providing services until such time as upgrades can be made to the compounding room, and the next step in the process will be to move forward with an interim fix that is expected to take 8 months to complete.

SCHOOL CLINIC UPDATE

The Bishop Union High School on-campus student health clinic will open in the next couple of months. NIHD Nurse Practitioner Colleen McEvoy RN will be on site on Tuesdays to provide services for students.

ATHENAHEALTH IMPLEMENTATION

Information Technology Director Robin Cassidy provided an update on progress made toward implementation of the Athenahealth Health Information System, which is scheduled to go live on September 25 2018. An overview of the vendors involved in the project and a project timeline were also provided.

CONSENT AGENDA

Mr. Watercott called attention to the Consent Agenda for this meeting, which contained the following items:

- Approval of minutes of the August 23 2017 special meeting
- Approval of minutes of the September 20 2017 regular meeting
- Policy and Procedure annual approvals (Attachment A to Agenda)

It was moved by Dr. Ungersma, seconded by M.C. Hubbard, and unanimously passed to approve all three Consent Agenda items as presented.

DATA AND INFORMATION COMMITTEE REPORT

Doctor Flanigan provided a Data and Information Committee report which included an overview of Information Technology projects in progress, some of which have been moved to a lower priority until after implementation of the Athenahealth system next September.

CHIEF EXECUTIVE OFFICER REPORT

Doctor Flanigan also provided a Chief Executive Officer report which included the following:

- The NIHD Foundation's annual physician and employee-of- the-year recognition event will take place on November 11
- Doctor Flanigan recognized NIHD employees Jeff Tatum, Debbie Noyes, and Lynda Vance for educational achievements
- Glendale Adventist has issued a letter of intent to partner with NIHD to provide telehealth services, including weekend orthopedic coverage and cardiology
- The Robbin Cromer-Tyler MD Inc. physician group has expanded to include an increasing number of NIHD physicians

CHIEF OPERATING OFFICER REPORT

On behalf of Chief Operating Officer Kelli Huntsinger, Doctor Flanigan reported the following:

- The NIHD Pharmacy recently underwent a survey by the California Departmentn of Public Health, and no deficiencies of

significance were noted
- The NIHD Moonlight Mammograms event was extremely successful, and 21 women attended in order to obtain breast health services
- A second Moonlight Mammograms event has been scheduled for October 25, and translators will be on site to provide language services for anyone who needs them
- A Rehabilitation Services open house highlighting pediatric services has been scheduled for October 27
- NIHD will renew its participation in the 340B pharmacy program in partnership with Dwayne's Pharmacy

CHIEF FINANCIAL OFFICER'S REPORT

Chief Financial Officer John Tremble reviewed the financial and statistical reports for the period ending August 31 2017, noting the following:
- Net revenues were $295,000 better than budget
- Expenses were $289,000 over budget
- Inpatient and outpatient volumes were good
- Net income for the month was $433,327, due to a positive prior year settlement and good patient volume
- Year-to-date net income as of August 31 2017 was $527,192

Mr. Tremble also noted that total net assets on the Balance Sheet have decreased, and the District continues to work on its billing and coding issues and on decreasing the number of days that accounts are in receivables. It was moved by Doctor Ungersma, seconded by Ms. Kilpatrick, and unanimously passed to approve the financial and statistical reports as of August 31 2017 as presented.

CHIEF HUMAN RESOURCES OFFICER'S REPORT

Chief Human Resources Officer Evelyn Campos Diaz provided a Human Resources Department update which included updates on leadership development programs; improvements being made to the employee orientation process; TeamSTEPPS and 7 Habits trainings for employees; and upcoming employee relations trainings for leaders. She additionally noted that Flexcare communications trainings (for flexing personal communication styles) are being considered, and the next Employee Engagement Survey will take place in January of 2018.

CHIEF NURSING OFFICER'S REPORT

Chief Nursing Officer Tracy Aspel RN provided a Nursing Department report which included the following:
- 95 robotic surgeries were performed in the first year of the program. This number far exceeds our original expectations.
- RQI program carts (including pediatric advanced life support training materials) are being used for staff education
- The Nursing Department restructure has decreased the number of nursing Directors to 2, and has increased the number of nursing managers and assistant managers on staff
- Nursing Department projects currently in progress involve pain audits; falls risk; and live audits intended to catch stop time

- errors
- RN's recently hired at NIHD as new graduates have proven to be exemplary nurses, and have been wonderful additions to the nursing team

CHIEF OF STAFF REPORT

Chief of Staff Richard Meredick MD reported following careful review, consideration, and approval by the appropriate Committees the Medical Executive Committee recommends approval of the following hospital wide policies, procedures, protocols, and order sets:

POLICIES, PROCEDURES, PROTOCOLS, ORDER SETS

- *Patient Food From Non-Hospital Sources*
- *MICN Guidelines*
- *Rapid Response Team*
- *Pre-Hospital Care*

It was moved by Ms. Hubbard, seconded by Doctor Ungersma, and unanimously passed to approve all four policies, procedures, protocols, and order sets as presented.

MEDICAL STAFF APPOINTMENTS AND PRIVILEGING

Doctor Meredick also reported following careful review and consideration the Medical Executive Committee recommends approval of the following Medical Staff appointments and privileging:

- Uttama Sharma, MD (RHC Family Practice - provisional active staff)
- Jayson Morgan, MD (Renown Cardiology - telemedicine staff)
- Eric Wallace, MD (Bishop Radiology Group - provisional consulting staff)
- Jacqueline Theis, OD (UC Berkeley Optometry - telemedicine staff), credentialing by proxy per bylaws section 3.6.1

It was moved by Doctor Ungersma, seconded by Ms. Kilpatrick, and unanimously passed to approve all Medical Staff appointments and privileging as recommended.

TEMPORARY LOCUM TENENS PRIVILEGES

Doctor Meredick additionally reported the Medical Executive Committee recommends approval of temporary Locum Tenens privileges for the following:

- Erica Rotondo, DO (family practice) - locum tenens assignment in the Internal Medicine clinic from 10/30/2017-5/4/2018
- Kristin Irmiter, MD (pediatrics) - locum tenens assignment at RHC, Bishop Pediatrics and Allergy Clinic, and newborn care from 10/30/2017-4/27/2018

It was moved by Doctor Ungersma, seconded by Ms. Kilpatrick, and unanimously passed to approve both Locum Tenens privileges as requested.

CORE PRIVILEGE FORM

Dr. Meredick also called attention to approval of a Core Privilege form for Emergency Medicine. It was moved by Ms. Kilpatrick, seconded by Ms. Hubbard, and unanimously passed to approve the Core Privilege form for Emergency Medicine as presented.

BOARD MEMBER REPORTS	Mr. Watercott asked if any members of the Board of Directors wished to report on any items of interest. Director Ungersma stated he was recently a patient in the NIHD Emergency Department and that he received excellent care from David Pomeranz, MD and the entire Emergency Department staff.
ADJOURNMENT TO CLOSED SESSION	At 7:16pm Mr. Watercott announced the meeting would adjourn to closed session to allow the Board of Directors to: A. Hear reports on the hospital quality assurance activities from the responsible department head and the Medical Staff Executive Committee (*Section 32155 of the Health and Safety Code, and Section 54962 of the Government Code*). B. Confer with Legal Counsel regarding pending and threatened litigation, existing litigation and significant exposure to litigation, 1 matter pending (*pursuant to Government Code Section 54956.9*). C. Discuss trade secrets, new programs and services (estimated public session date for discussion yet to be determined)(*Health and Safety Code Section 32106*). D. For Discussion of a personnel matter (*pursuant to Government Code Section 54957*). E. To conduct Chief Executive Officer performance evaluation (*pursuant to Government Code Section 54957*).
RETURN TO OPEN SESSION AND REPORT OF ACTION TAKEN	At 8:54 pm the meeting returned to open session. Mr. Watercott reported the Board took no reportable action.
ADJOURNMENT	The meeting adjourned at 8:55 pm.

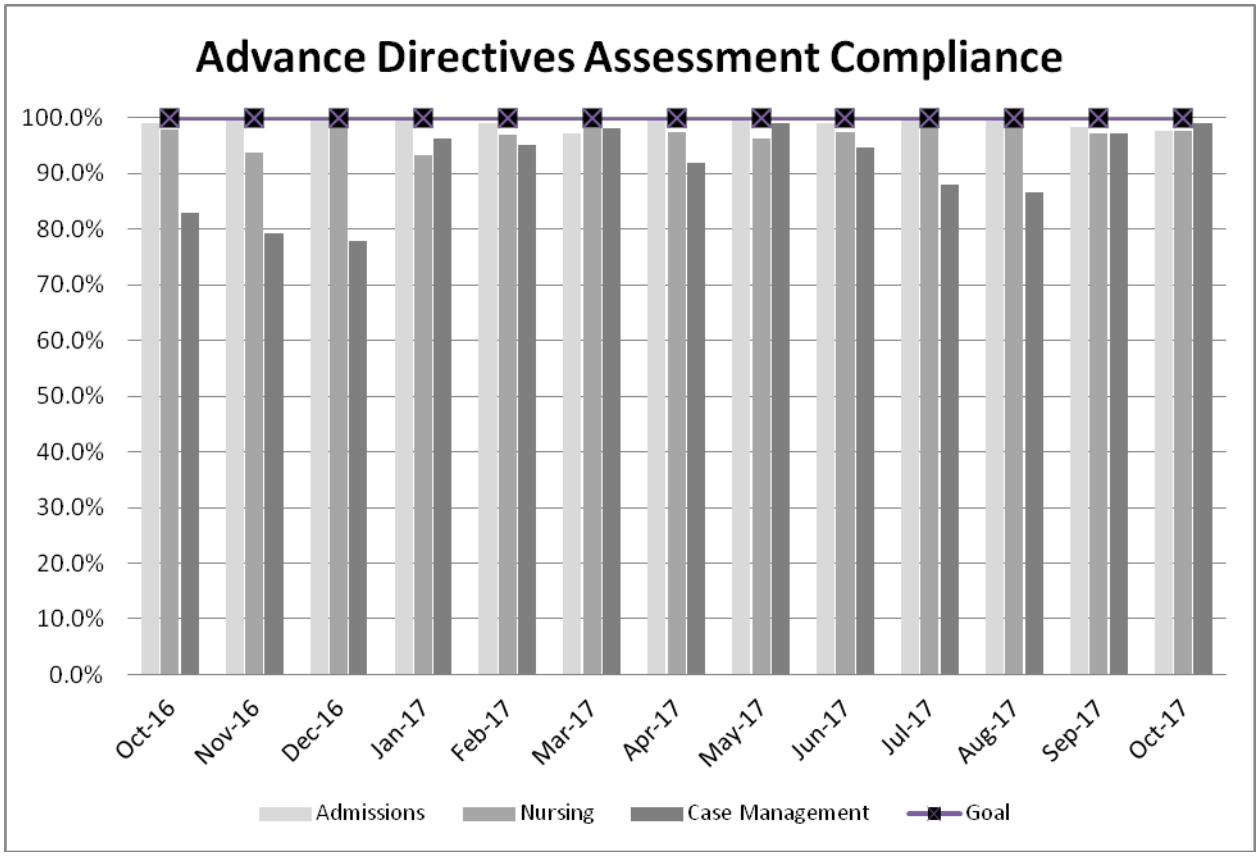
_____
Peter Watercott, President

Attest: _____
M.C. Hubbard, Secretary

2013 CMS Validation Survey Monitoring-November 2017

1. QAPI continues to receive and monitor data related to the previous CMS Validation Survey, including but not limited to, restraints, dietary process measures, case management, pain re-assessment, as follows:

    a. Advance Directives Monitoring.

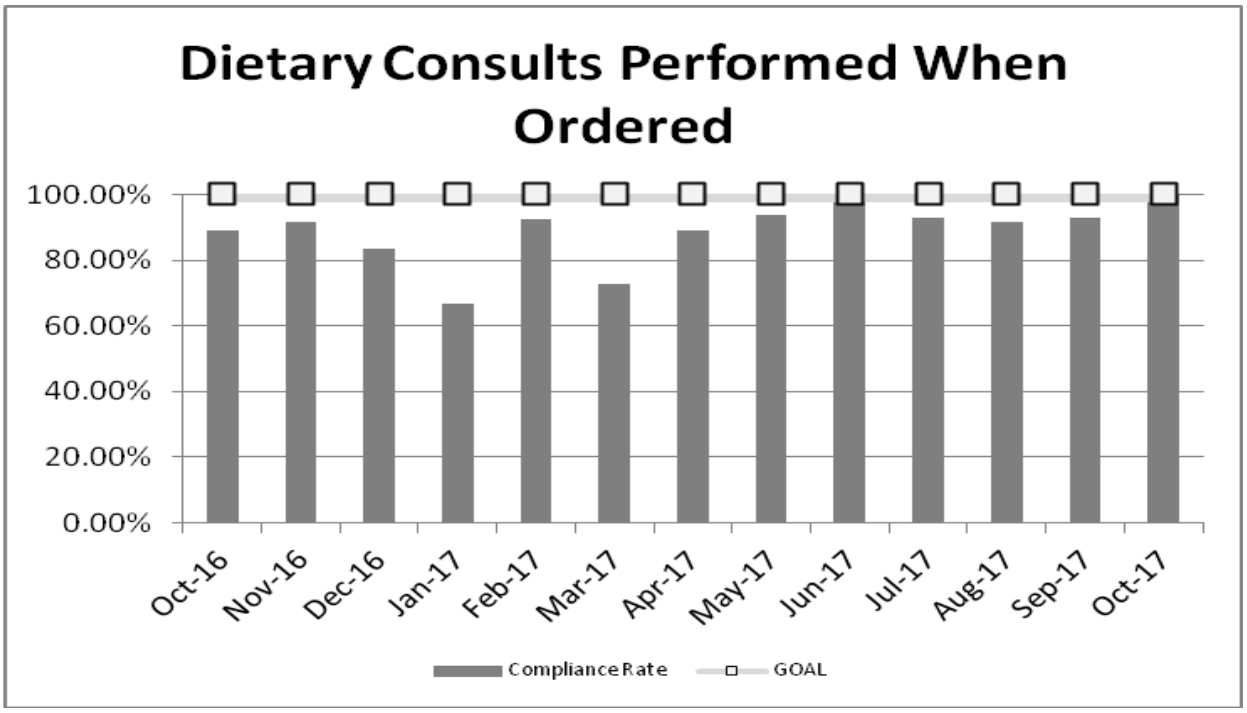


    b. Positive Lab Cultures are being routed to Infection Prevention and each positive is being investigated as to source. Monitoring has been ongoing and reported through Infection Control Committee. QAPI receives data.

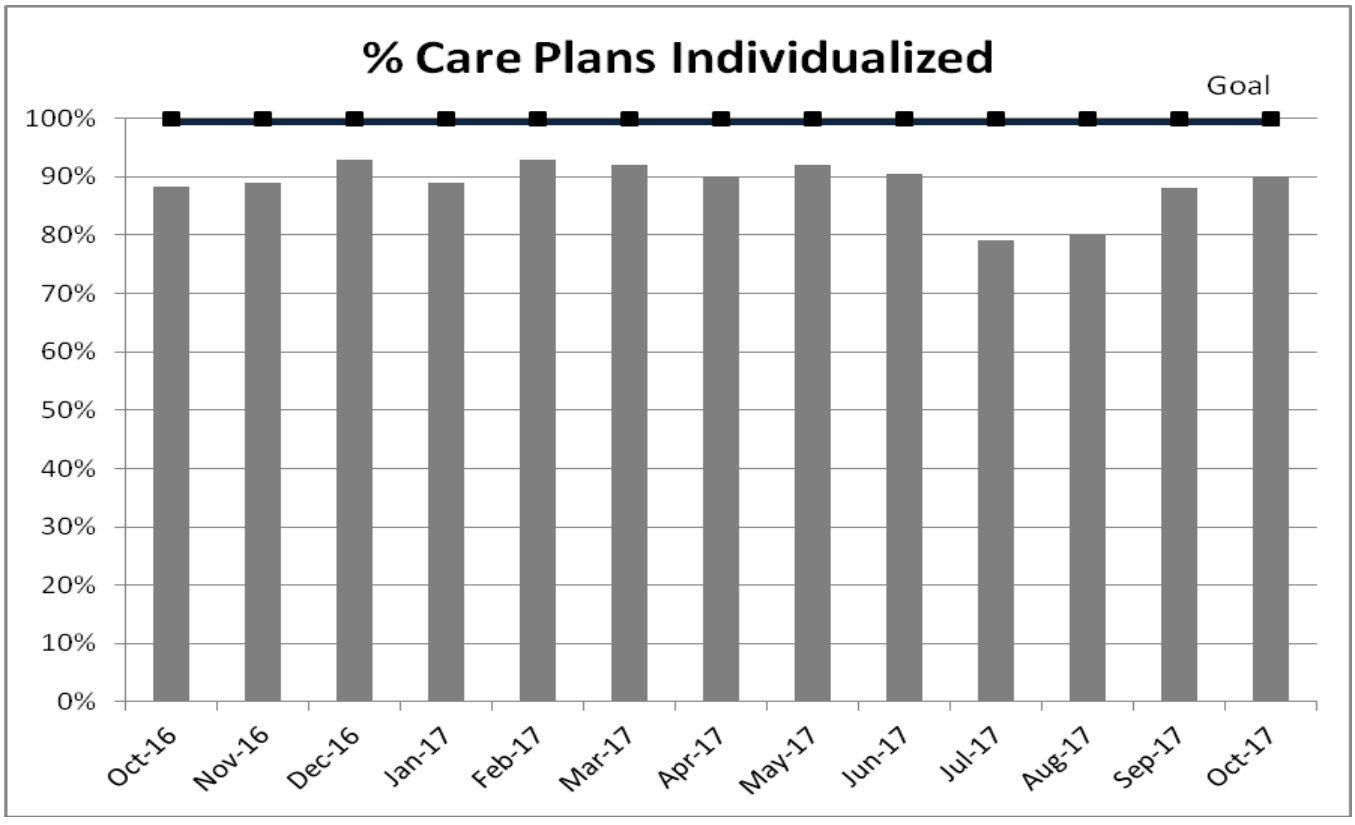
    c. Safe Food cooling monitored for compliance with approved policy and procedure. 100% compliance since May 6, 2013.

    d. Dietary hand washing logs have been reported and are at 100% compliance since May 6, 2013.

e. QAPI continues to monitor dietary referrals and the number of consults completed within 24 hours.

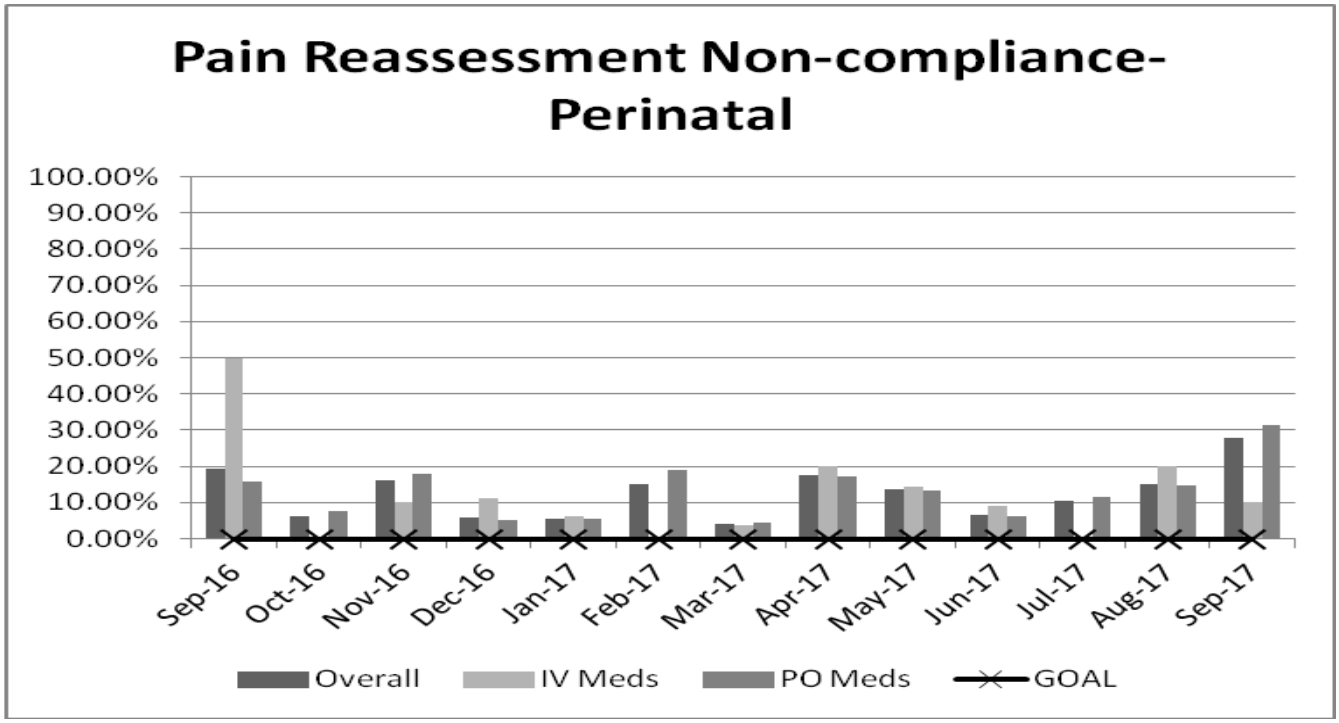


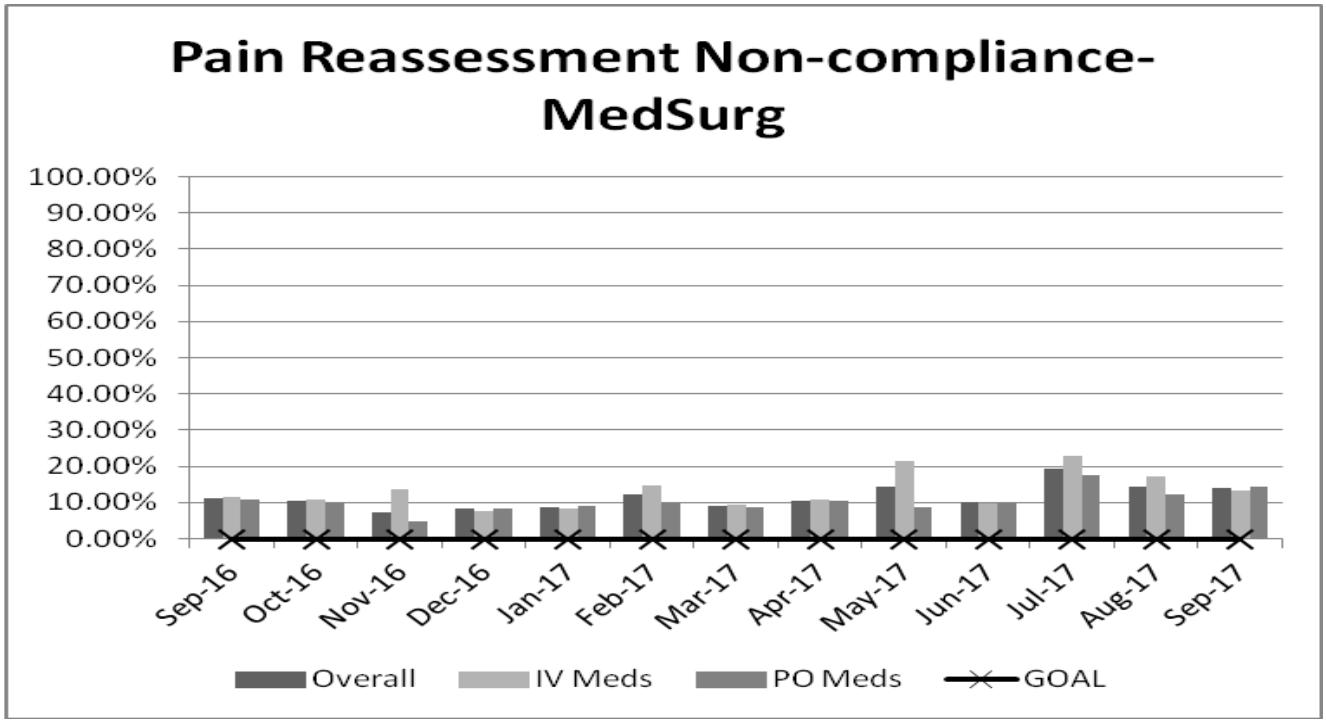
f. Care plans reviewed by Case Management and interventions made to produce care plans. Progress has been made in developing individualized care plans.

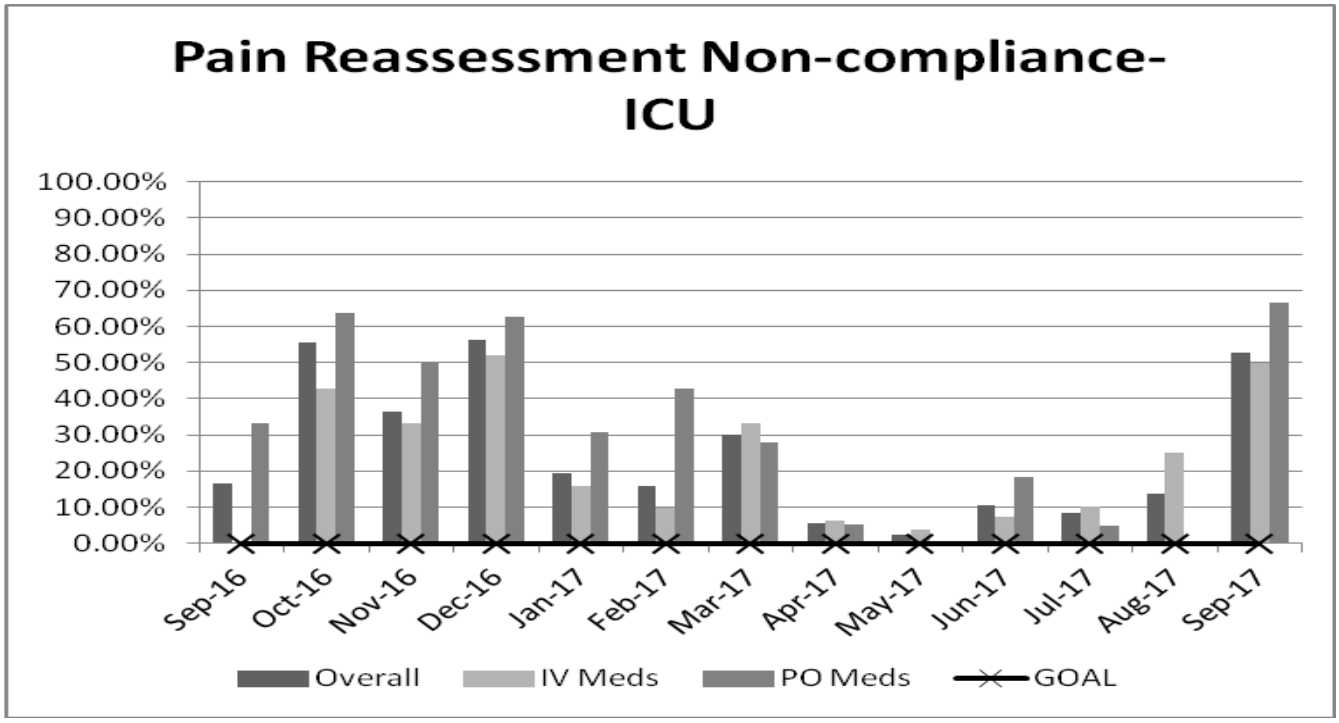


g. Fire drill date, times, attendance and outcomes, smoke detector tests, and fire extinguisher test grids have been approved. All fire drills were complete and compliant from May 6, through present.

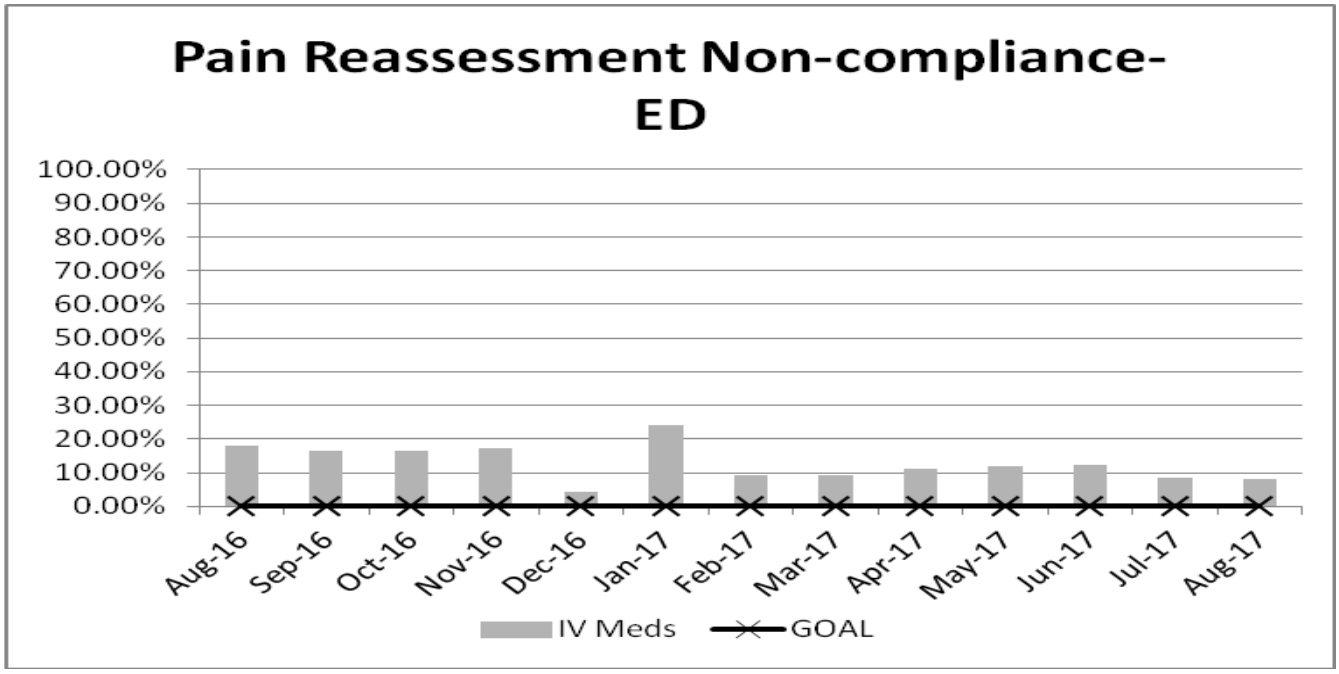
h. Pain Re-Assessment. NIH conducts pain re-assessment after administering pain medications and uses a 1-10 scale.







Note: Due to small sample sizes in the ICU, results should be interpreted with caution for this unit.



- Pain assessment data not received from ED for September

Table 6. Restraint chart monitoring for legal orders.

	March 2017	***April 2017****	***May 2017***	***June 2017***	***July 2017***	***Aug 2017***	***Sept 2017***	***Oct 2017***	***Goal***
Restraint verbal/written order obtained within 1 hour of restraints	1/1 (100%)		2/2 (100%)	2/2 (100%)	3/3 (100%)	3/3 (100%)	2/2 (100%)	3/3 (100%)	100%
Physician signed order within 24 hours	0/1 (0%)		2/2 (100%)	2/2 (100%)	3/3 (100%)	2/3 (66%)	1/2 (50%)	2/3 (66%)	100%
Physician Initial Order Completed (all areas completed and form/time/date noted/signed by MD and RN)	0/1 (0%)		2/2 (100%)	1/2 (50%)	3/3 (100%)	1/3 (33%)	0/2 (0%)	2/3 (66%)	100%
Physician Re-Order Completed (all areas completed and form time/date/noted/signed by MD and RN)	0/1 (0%)		0/1 (0%)	3/3 (100%)	2/5 (40%)	2/8 (25%)	0/2 (0%)	1/2 (50%)	100%
Orders are for 24 hours	2/2 (100%)		3/3 (100%)	5/5 (100%)	8/8 (100%)	11/11 (100%)	4/4 (100%)	5/5 (100%)	100%
Is this a PRN (as needed) Order	0/2 (0%)		0/3 (0%)	0/5 (0%)	0/8 (0%)	0/11 (0%)	0/4 (0%)	0/5 (0%)	0%

*No restraint orders for this time interval

NORTHERN INYO HEALTHCARE DISTRICT
PRELIMINARY STATEMENT OF OPERATIONS
for period ending September 30, 2017

	ACT MTD	BUD MTD	VARIANCE	ACT YTD	BUD YTD	VARIANCE
Unrestricted Revenues, Gains & Other Support						
Inpatient Service Revenue						
Routine	948,877	778,471	170,406	2,701,305	2,387,317	313,988
Ancillary	2,876,302	2,700,381	175,921	8,496,829	8,281,161	215,668
Total Inpatient Service Revenue	3,825,178	3,478,852	346,326	11,198,134	10,668,478	529,656
Outpatient Service	8,014,957	7,857,438	157,519	25,077,923	24,096,162	981,761
Gross Patient Service Revenue	**11,840,135**	**11,336,290**	**503,845**	**36,276,057**	**34,764,640**	**1,511,417**
Less Deductions from Revenue						
Patient Service Revenue Deductions	96,615	227,153	(130,538)	479,056	696,599	(217,543)
Contractual Adjustments	4,872,097	4,348,068	524,029	14,910,158	13,334,076	1,576,082
Prior Period Adjustments	(51,621)	(12,967)	(38,654)	(690,608)	(39,767)	(650,841)
Total Deductions from Patient Service Revenue	**4,917,091**	**4,562,254**	**354,837**	**14,698,605**	**13,990,908**	**707,697**
Net Patient Service Revenue	**6,923,044**	**6,774,036**	**149,008**	**21,577,452**	**20,773,732**	**803,720**
Other revenue	52,553	74,342	(21,789)	144,979	227,980	(83,001)
Total Other Revenue	**52,553**	**74,342**	**(21,789)**	**144,979**	**227,980**	**(83,001)**
Expenses:						
Salaries and Wages	2,128,840	2,253,618	(124,778)	6,500,997	6,911,096	(410,099)
Employee Benefits	1,456,227	1,538,619	(82,392)	4,438,384	4,718,435	(280,051)
Professional Fees	884,609	701,142	183,467	3,007,871	2,150,160	857,711
Supplies	687,928	627,567	60,361	2,213,413	1,924,543	288,870
Purchased Services	313,925	348,470	(34,545)	782,263	1,068,642	(286,379)
Depreciation	408,807	428,731	(19,924)	1,222,851	1,314,777	(91,926)
Bad Debts	265,693	234,952	30,741	709,972	720,520	(10,548)
Other Expense	446,695	341,327	105,368	1,210,498	1,046,727	163,771
Total Expenses	**6,592,724**	**6,474,426**	**118,298**	**20,086,248**	**19,854,900**	**231,348**
Operating Income (Loss)	**382,873**	**373,952**	**8,921**	**1,636,183**	**1,146,812**	**489,371**
Other Income:						
District Tax Receipts	43,955	47,513	(3,558)	131,865	145,705	(13,840)
Tax Revenue for Debt	128,647	160,148	(31,501)	385,940	491,122	(105,182)
Partnership Investment Income	-	-	-	66,526	-	66,526
***Grants and Other Contributions**	16,705	41,096	(24,391)	36,035	126,028	(89,993)
Interest Income	25,116	16,302	8,814	82,140	49,992	32,148
Interest Expense	(243,934)	(252,142)	8,208	(732,240)	(773,236)	40,996
Other Non-Operating Income	8,651	2,344	6,307	14,017	7,188	6,829
Net Medical Office	(302,256)	(383,901)	81,645	(1,034,449)	(1,177,293)	142,844
340B Net Activity	-	16,439	(16,439)	932	50,413	(49,481)
Non-Operating Income/Loss	**(323,115)**	**(352,201)**	**29,086**	**(1,049,233)**	**(1,080,081)**	**30,848**
Net Income/Loss	**59,758**	**21,751**	**38,007**	**586,950**	**66,731**	**520,219**

NORTHERN INYO HEALTHCARE DISTRICT

Preliminary BUDGET VARIANCE ANALYSIS

Sep-17 *Fiscal Year Ending June 30, 2018*

Year to date for the month ending July 31, 2017

	-89	or	-9%	more IP days than in the prior fiscal year
$	529,656	or	4.96%	over budget in Total IP Revenue and
$	981,761	or	4.1%	over budget in OP Revenue resulting in
$	1,511,417	or	4.3%	over budget in gross patient revenue &
$	803,720	or	3.9%	over budget in net patient revenue

Year-to-date Net Revenue was			$	21,577,452
Total Operating Expenses were:			$	20,086,248
				for the fiscal year to date
$	231,348	or	1.2%	over budget. Salaries and Wages were
$	(410,099)	or	-5.9%	under budget and Employee Benefits
$	(280,051)	or	-5.9%	under budget
			68%	Employee Benefits Percentage of Wages

The following expense areas were also over budget for the year for reasons listed:

$	857,711	or	39.9%	Professional Fees are over budget due to contract labor budgeted as employees
$	163,771	or	15.6%	Other Expenses are over budget due to timing difference on Annual Directors & Officers Liability

Other Information:

$	1,636,183			Operating Income, less
$	(1,049,233)			loss in non-operating activities resulted in a Net
$	586,950	$	520,219	over budget.
			40.52%	Contractual Percentages for Year and
			40.24%	Budgeted Contractual Percentages including
$	690,608	in prior year cost report favorable settlement activity for Medicare & Medi-Cal		

Non-Operating activities included:

$	(1,034,449) loss	$	142,844	favorable to budget in Medical Office Activities
$	36,035	$	(89,993)	unfavorable to budget in Grants and Other

Northern Inyo Healthcare District
Preliminary Balance Sheet
Period Ending September 30, 2017

Assets:	Current Month	Prior Month	Change
Current Assets			
Cash and Equivalents	2,429,075	3,410,441	(981,367)
Short-Term Investments	9,350,190	9,485,957	(135,767)
Assets Limited as to Use	-	-	-
Plant Replacement and Expansion Fund	-	-	-
Other Investments	1,311,342	1,311,342	-
Patient Receivable	61,477,794	60,104,945	1,372,848
Less: Allowances	(45,638,925)	(45,191,772)	(447,153)
Other Receivables	4,269,253	3,941,232	328,021
Inventories	4,001,771	4,052,092	(50,321)
Prepaid Expenses	1,739,941	1,795,949	(56,008)
Total Current Assets	**38,940,439**	**38,910,187**	**30,253**
Internally Designated for Capital Acquisitions	1,125,132	1,125,087	45
Special Purpose Assets	1,049,858	1,629,870	(580,012)
Limited Use Asset; Defined Contribution Pension	729,521	593,754	135,767
Limited Use Assets Defined Benefit Plan	13,365,385	13,365,385	-
Limited Use Asset Defined Benefit Plan 003	-	-	-
Revenue Bonds Held by a Trustee	3,202,755	3,041,773	160,982
Less Amounts Required to Meet Current Obligations	-	-	-
Assets Limited as to use	**19,472,650**	**19,755,869**	**(283,218)**
Long Term Investments	1,750,000	1,750,000	-
			-
Property & equipment, net of Accumulated Depreciation	78,839,213	79,174,659	(335,445)
Unamortized Bond Costs	-	-	-
Total Assets	**139,002,303**	**139,590,714**	**(588,411)**

Northern Inyo Healthcare District
Preliminary Balance Sheet
Period Ending September 30, 2017

Liabilities and Net Assets	Current Month	Prior Month	Change
Current Liabilities:			
Current Maturities of Long-Term Debt	1,951,402	1,969,246	(17,844)
Accounts Payable	1,986,850	2,566,677	(579,827)
Accrued Salaries, Wages & Benefits	5,285,942	4,985,247	300,695
Accrued Interest and Sales Tax	549,965	413,537	136,428
Deferred Income	473,024	516,979	(43,955)
Due to 3rd Party Payors	1,155,302	1,122,302	33,000
Due to Specific Purpose Funds	-	-	-
Other Deferred Credits; Pension	4,506,816	4,506,816	-
Total Current Liabilities	**15,909,300**	**16,080,803**	**(171,504)**
Long Term Debt, Net of Current Maturities	43,931,947	43,931,947	-
Bond Premium	599,714	606,960	(7,247)
Accreted Interest	11,198,740	11,088,192	110,549
Other Non-Current Liabilities; Pension	30,487,532	30,487,532	-
Total Long Term Debt	**86,217,933**	**86,114,631**	**103,302**
Net Assets			
Unrestricted Net Assets less Income	35,825,212	35,765,409	59,803
Temporarily Restricted	1,049,858	1,629,870	(580,012)
Net Income (Income Clearing)	(586,949)	(527,191)	(59,758)
Total Net Assets	**36,875,070**	**37,395,279**	**(579,967)**
Total Liabilities and Net Assets	**139,002,303**	**139,590,714**	**(648,169)**

NORTHERN INYO HEALTHCARE DISTRICT

Preliminary OPERATING STATISTICS

for period ending September 30, 2017

		FYE 2018	FYE 2017		Variance %
	Month to Date	Year-to-Date	Year-to-Date	Variance from PY	
Licensed Beds	25	25	25		
Total Patient Days with NB	301	912	1,001	(89)	-9%
Total Patient Days without NB	275	825	910	(85)	-9%
Swing Bed Days	18	71	166	(95)	-57%
Discharges without NB	90	275	291	(16)	-5%
Swing Discharges	-	8	22	(14)	-64%
Days in Month	31	31	31		
Occupancy without NB	8.87	26.61	29.35	(2.7)	-9%
Average Stay (days) without NB	3.06	3.00	3.13	(0.1)	-4%
Average LOS without NB/Swing	2.86	2.82	2.77	0.1	2%
Hours of Observation	124	2,241	2,119	122	6%
Observation Adj Days	5	93	88	5	6%
ER Visits All Visits	1,082	2,823	2,571	252	10%
RHC Visits	2,839	9,258	6,052	3,206	53%
Outpatient Visits	3,774	11,517	10,108	1,409	14%
IP Surgeries	25	74	73	1	1%
OP Surgery	96	311	300	11	4%
Worked FTE's	369.07	344.12	319.64	24	8%
Paid FTE's	393.42	394.25	357.51	37	10%
Hours Worked to Hours Paid%	93.8%	87.3%	89.4%	-2.1%	-2%
Payor %					
Medicare		45%	41%	5%	
Medi-Cal		23%	23%	0%	
Insurance, HMO & PPO		29%	33%	-4%	
Indigent (Charity Care)		0.3%	1.2%	-0.9%	
All Other		2%	2%	0%	
Total		100%	100%		

Northern Inyo Healthcare District

Preliminary Financial Indicators as of September 30, 2017

	Target	Sep-17	Aug-17	Jul-17	Jun-17	May-17	Apr-17	Mar-17	Feb-17	Jan-17	Dec-16	Nov-16	Oct-16	Sep-16
Current Ratio	>1.5-2.0	2.45	2.42	2.49	3.39	3.83	3.51	3.41	3.45	3.53	3.69	2.85	2.95	2.60
Quick Ratio	>1.33-1.5	1.82	1.81	2.05	2.84	3.23	2.96	2.88	2.90	2.93	2.92	2.46	2.41	2.20
Days Cash on Hand prior method	>75	140.47	142.06	160.31	154.70	160.60	159.55	160.80	157.10	151.40	140.37	160.86	145.43	157.98
Days Cash on Hand Short Term	>75	53.95	59.26	79.93	79.37	75.71	76.12	77.66	79.99	71.85	62.90	85.97	67.02	77.60
Debt Service Coverage	>1.5-2.0	2.79	2.87	2.34	1.81	1.96	1.91	2.07	2.23	2.17	2.13	2.46	2.30	2.80
Operating Margin		7.49	8.45	6.67	4.71	6.18	6.06	6.01	6.83	6.30	5.59	7.48	6.43	8.37
Outpatient Revenue % of Total		69.13	69.83	66.58	69.86	69.96	69.76	69.43	69.11	69.10	69.28	68.11	67.48	67.03
Cash flow (CF) margin (EBIDA to revenue)		4.82	5.62	3.68	2.48	2.84	2.59	3.41	4.27	3.94	3.71	5.43	4.53	7.01
Days in Patient Accounts Receivable	<60 Days	92.50	81.40	74.10	78.90	89.00	86.00	85.10	76.70	80.80	77.70	75.60	75.00	77.80

Debt Service Coverage as outlined in 2010 and 2013 Revenue Bonds require that the district has a debt service coverage ratio of 1.50 to 1 (can be 1:25 to 1 with 75 days cash on hand)

Debt Service Coverage is calculated as Net Income (Profit/Loss) from the Income Statement PLUS Depreciation & Interest Expense added back divided by the Current Interest & Principle for TOTAL DEBT from the Debt Information divided by number of closed fiscal periods

Current Ratio Equals (from Balance Sheet) Current Assets divided by Current Liabilities

Quick Ratio Equals (from Balance Sheet) Current Assets;Cash and Equivalents through Net Patient Accounts Receivlable Only divided by Current Liabilities

Updated Days Cash on hand Short Term = current cash & short term investments / by total operating expenses year-to-date / by days in fiscal year

Operating Margin Equals (from Income Statement) Year-to-date Operating Income /(Year-to-date Net Patient Service Revenue+Other Operating Revenue+District Tax Receipts) *100

Outpatient Revenue % of Total Revenue Equal (from Income Statement) Gross Outpatient/Total Gross Patient Revenue

Cash Flow (CF) margin (EBIDA to revenue) Equals (from Income Statement) [Net Income+Interest+Depreciation+Amoritization(if any)/Total Revenue] x 100

Accounts Receivable Days are pulled from the AR Aging report

NORTHERN INYO HEALTHCARE DISTRICT

Investments as of September 30, 2017

ID	Purchase Date	Maturity Dat	Institution	Broker	Rate		Principal Invested
2	31-Aug-17	01-Sep-17	Local Agency Investment Fund	Northern Inyo Hospital	1.11%		9,100,189.90
3	13-Jun-14	13-Jun-18	Synchrony Bank Retail-FNC	Financial Northeaster Corp.	1.60%		250,000.00
				Short Term Investments			9,350,189.90
4	28-Nov-14	28-Nov-18	American Express Centurion Bank	Financial Northeaster Corp.	2.00%		150,000.00
5	02-Jul-14	02-Jul-19	Barclays Bank	Financial Northeaster Corp.	2.05%		250,000.00
6	02-Jul-14	02-Jul-19	Goldman SachsBank USA NY CD	Financial Northeaster Corp.	2.05%		250,000.00
7	20-May-15	20-May-20	American Express Centurion Bank	Financial Northeaster Corp.	2.05%		100,000.00
8	26-Sep-16	27-Sep-21	Comenity Capital Bank	Multi-Bank Service	1.70%		250,000.00
9	02-Sep-16	28-Sep-21	Capital One Bank	Multi-Bank Service	1.70%		250,000.00
10	28-Sep-16	28-Sep-21	Capital One National Assn	Multi-Bank Service	1.70%		250,000.00
11	28-Sep-16	28-Sep-21	Wells Fargo Bank NA	Multi-Bank Service	1.70%		250,000.00
				Long Term Investments		$	1,750,000.00
				Total Investments		$	11,100,189.90
1	8/31/2017	9/1/2017	LAIF Defined Cont Plan	Northern Inyo Hospital	1.11%	$	729,521.00
				LAIF PENSION INVESTMENTS		$	729,521.00

NORTHERN INYO HEALTHCARE DISTRICT

Restricted and Specific Purpose Fund Balances

for period ending September 30, 2017

	Current Month	Prior Month	Change
Board Designated Funds:	September		
Tobacco Fund Savings Account	$ 1,098,406	$ 1,098,362	44
Equipment Fund Savings Account	$ 26,725	$ 26,725	-
Total Board Designated Funds:	**$ 1,125,131**	**$ 1,125,087**	**$ 44**
Specific Purpose Funds:			
* Bond and Interest Savings Account	$ 916,704	$ 1,496,729	$ (580,025)
Nursing Scholarship Savings Account	$ 33,038	$ 33,037	$ 1
Medical Education Savings Account	$ 75	$ 75	$ -
Joint NIHD/Physician Group Savings Account	$ 100,041	$ 100,028	$ 13
Total Specific Purpose Funds:	**$ 1,049,859**	**$ 1,629,870**	**$ (580,012)**
Grand Total Restricted and Specific Purposes Funds:	**$ 2,174,989**	**$ 2,754,957**	**$ (579,968)**

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

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

TO: NIHD Board of Directors
FROM: Richard Meredick, MD, Chief of Medical Staff
DATE: November 7, 2017
RE: Medical Executive Committee Report

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

A. Policy/Procedure/Protocols/Order Sets (action items)

1. *Universal Protocol*
2. *Airway Management*
3. *Child Abuse and Neglect*
4. *Admission, Discharge, Transfer of Patients: Continuum of Care*
5. *Nursing Care of Outpatient Interventional Radiology Patient*
6. *Contrast Use with Patients on Metformin*
7. *Order Set Approval and Archiving*
8. *Cosyntropin Stimulation Test*
9. *Nursing Services Standing Committee Structure and Hospital Committee Participation*
10. *EMTALA*
11. *Medical Screening Examination of the Obstetrical Patient*
12. *Blood Bank – Emergency Requests for Blood Components*
13. *Medication Dosing in Renal Failure*

B. Core Privilege Form (action item)

1. Obstetrics & Gynecology

C. Medical Staff Appointment/Privileges (action item)

1. William I. Feske, MD (Radiology – Provisional Active Staff) – Dr. Feske was approved for a 90-day introductory period under temporary privileges in August 2017. The Bishop Radiology Group will continue to work with Dr. Feske. Dr. Feske is being recommended for provisional active staff membership.

2. Irin Pansawira, OD (UC Berkeley Optometry – telemedicine staff)*

   **credentialing by proxy per bylaws section 3.6.1*

D. Temporary Locum Tenens Privileges (information item)

1. Zunaira Islam, MD (Hospitalist – locum tenens) – Dr. Islam underwent the expedited approval and credentialing process as designated in the Medical Staff Bylaws to meet an urgent patient care need for a maximum of 60 days in the 2017-2018 calendar year. Start Date: 11/3/2017.

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Universal Protocol	
Scope: Northern Inyo Hospital	Manual: CPM - Operative, Invasive Procedures, PACU, Preparation and Post Op (OOP)
Source: DON Perioperative Services	Effective Date: 12/1/15

PURPOSE:
To provide steps to assist in minimizing avoidable risks during invasive or surgical procedures. The expected outcome is that the patient's procedure is performed on the correct site, side, and level.

POLICY:
1. It is the policy of Northern Inyo Hospital that the following steps must be completed before every invasive or surgical procedure~~, unless noted on the exception list~~. This policy shall be followed for all invasive or surgical procedures throughout the facility.
   a. In the pre-procedure/preoperative area, a confirmation of the correct site, procedure, and patient shall occur.
   b. In the pre-procedure/preoperative area, the patient shall be involved whenever possible. If the patient is unable to participate, a designated caregiver shall participate.
   c. All patients who undergo an invasive or surgical procedure involving laterality, multiple structures (e.g.; fingers and toes), or multiple levels (e.g.; spinal surgery) must have their surgical / procedural site marked.
   d. If a patient refuses site marking, the patient's physician will review the rationale for site marking and the implications for refusing site marking.
   e. A licensed independent practitioner or other provider who is privileged or permitted to perform the intended invasive or surgical procedure will mark the procedure/surgical site before the patient enters the procedure/operating room. ~~unless the anatomical site is exempt per policy guidelines. See "k" below for bedside procedures.~~
   f. A discrepancy at any point in time must be resolved before continuing the procedure. All team members and the patient, if possible, must agree on resolution of the identified discrepancy.
   g. A time out will be performed for all cases, including those not requiring site marking.
   h. Two patient identifiers (full name, date of birth) will be used to verify a patient's identity. A patient room number should not be used as an identifier.
   i. If a treatment (e.g.; anesthesia block) or medication administration (e.g.; eye drops) must be performed before the site has been marked (in the holding area), the patient verification process as outlined above must be followed.
   j. Site marking may be waived in a life-threatening emergency at the discretion of the operating physician, but a time out should be conducted unless there is more risk than benefit for the patient.

PROCEDURE:
Procedure Interventions:

1. Scheduling and preadmission testing:
Obtain the following information when scheduling an invasive or surgical procedure:
Write out fully on the procedure/operating room schedule and on all relevant documentation (e.g.; consents) the words right, left, or bilateral for scheduled procedures that involve anatomical sites that have laterality.
   a. The correct spelling of the patient's full name
   b. Date of birth
   c. Procedure to be performed
   d. Physician's name
   e. Implants required, if applicable
   f. Facility-required booking data.

2. Preprocedure/preoperative verification:

The registered nurse or other health care provider (e.g., radiographer, phlebotomist, and respiratory therapist) should:

a. Verify the patient's identity using at least two identifiers (full name, date of birth).
b. Verify the scheduled invasive or surgical procedure as stated by the patient and compare to the posted schedule, consents, radiographic films, site mark (if applicable), and any other pertinent information in the medical record.
c. Involve the patient in the process, to the fullest extent possible, with verbal and visual responses (e.g.; stating name and pointing to correct site location).
d. Use a designated caregiver if the patient is a minor, incompetent, sedated, has a language barrier, or is a trauma/emergency victim, to complete the identifiers and verify the site mark.
e. Clarify any discrepancies in data with the physician.

3. Marking the surgical site:

a. Use a marker that is sufficiently permanent to remain visible after completion of the skin prep and draping.
b. The mark is to be placed on the day of the invasive or surgical procedure by the licensed independent practitioner who is performing the procedure.
c. Before marking the site, verify the patient's identity, consent, medical record data, and any other information, including radiographs and history and physical, as applicable, to confirm accuracy.
d. Ask the patient or designated caregiver to state the procedure and site and side of surgery and have the patient provide visual clues, if appropriate, such as pointing.
e. The licensed independent practitioner will mark the site at or adjacent to the incision site at a location that will be visible after the patient is prepped and draped.
f. The person marking the site will use his or her initials for the mark.
g. Spine surgery requires a two-stage marking process.
    - Preoperatively, the person doing the marking does so on the patient's skin at the level of the procedure (e.g., cervical, thoracic, lumbar). The skin mark indicates anterior vs. posterior and right vs. left.
    - Intraoperatively, x-rays with immovable markers will be used to determine exact location and level of surgery. The operating physician will review the x-rays for confirmation.
h. For procedures involving laterality of organs where the incision or approach may be from the mid-line or from a natural orifice, the site is marked and the laterality noted using one of the alternative methods listed below. The person doing the marking should not:
    - Place the skin mark on an open wound or lesion or
    - Mark non-operative sites unless medically indicated (e.g., pedal pulse markings, no blood pressure cuff).
i. If the patient refuses site marking, the patient's physician will review with the patient the rationale for site marking and the implications for refusing site marking. If the patient still refuses site marking, the person responsible for marking the site should use an alternative method before the case proceeds.
j. For sites that cannot be easily marked - e.g.; mucosal surfaces, perineum, teeth extractions, eyes and infants (infants should not be marked as site marking can cause permanent tattooing) alternative methods may include:
    - A temporary, unique wrist band on the side of the procedure that contains the patient's name and a second identifier for the intended procedure and site for cases that are impossible or impractical to mark (e.g., interventional procedures such as cardiac catheterization, pacemaker insertion)
    - A mark at or near the insertion site that will remain visible after completion of the skin prep and sterile draping (e.g.; minimal access procedures intended to treat a lateralized internal organ).

- Documentation, dental radiographs, or dental diagrams that indicate the name and number of the operative tooth.
- For ophthalmology – a mark will be placed in the eyebrow by the ophthalmologist.

4. **Taking a time out:**
Time outs will be performed before all surgical or invasive procedures. Time outs will:
   a. Cause all other activities to be suspended (unless there is a threat to patient safety) during the time out.
   b. Be initiated by a designated team member (RN circulator).
   c. Involve all members of the surgical/ procedural team.
   d. Address the following standard information.
      - Correct patient identity
      - Correct side and site are marked for lateralized sites
      - Consent form is present and accurate
      - Agreement on the procedure to be done
      - Correct patient position
      - Confirm that relevant images and results are properly labeled and appropriately displayed
      - Confirm that antibiotics have been administered, if ordered
      - Confirm that the skin prep has dried
      - Implant/Prosthetic/Special Equipment is present, if applicable
   e. Be performed in the location of the procedure and after the patient is prepped and draped
   f. Be performed before each procedure if two procedures are being performed on the same patient
   g. Reconcile problems if the responses among team members differ. Missing information or discrepancies will be addressed and reconciled before starting the procedure
   h. **For Clinical Units:** On the clinical units the staff is instructed to use the "Time Out" stamp. The stamp is placed in a progress note and this note is taken to the bedside and completed at time of procedure. The progress note is then placed into the patient's chart. If using the stamp, the initials of the MD and the RN /clinical unit Tech must be documented as well as the time and date of procedure.

5. **The Debriefing:** The debriefing after the procedure while the surgeon/physician is still in the room will include:
   a. Counts correct including sponge, needle and others.
   b. Confirmation of correct specimen handling including correct patient identification on requisition and label(s), specimen(s) correctly identified, and special instructions for the pathologist complete and accurate as applicable.
   c. Agreement on name of the procedure completed and changed in electronic record if needed.
   d. If special patient specific post-procedure needs are identified, follow-up is planned.
   e. If other concerns/issues/opportunities for improvement identified, follow-up is planned.

DEFINTIONS:

Time out: The Time Out is a collective verbal verification by all members of the surgical/procedural team and takes place immediately before the procedure begins. The time out will include a pause in patient care activity conducted by the surgical/procedural team immediately before starting the procedure to conduct a final confirmation that the correct patient, correct procedure, site/side is marked and visible, correct positioning, pre-op antibiotics have been infused within 60 minutes and relevant images match patient ID and match site/side are displayed if applicable and as applicable, all relevant information, and necessary equipment are available.

DOCUMENTATION:

1. A quality review report should be completed if the time out does not occur and the site is not marked ~~(if required).~~.

Title: Universal Protocol	
Scope: Northern Inyo Hospital	Manual: CPM - Operative, Invasive Procedures, PACU, Preparation and Post Op (OOP)
Source: DON Perioperative Services	Effective Date: 12/1/15

2. The nurse/technician will document the patient's inability and/or refusal to allow documentation and the alternative method used to mark the site.
3. Record, at a minimum, the following items:
   a. Who marked the site, date of surgery/procedure and time is documented on surgical safety checklist in the operating room or designated form in other patient care areas.
   b. The time of pause (names are not required because it is assumed that all people listed on the operative record at the start of the procedure were present). In other patient care areas, the names of the team members present should be documented.
   c. Any other items required by the facility

COMPETENCY:
The registered nurse / clinical unit technician assisting with the operative / invasive procedure should be clinically competent and possess the skills necessary to verify the correct site, correct procedure, and correct patient for invasive or surgical procedures. The competencies include the ability to:
   a. Assess the patient
   b. Verify the correct site, correct patient, and correct procedure
   c. Verify the surgical/procedural site has been marked by the surgeon/physician.
   d. Initiate the time-out
   e. Document the process

REFERENCES:
Petersen C, ed. *Perioperative Nursing Data Set*. 3rd ed. Denver, CO: AORN, Inc; 2010. In press.
AORN Recommended Practices 2014 Edition
World Health Organization Implementation Manual WHO Surgical Safety Checklist 2009
National Patient Safety Goals 2014. Joint Commission. http://www.jointcommission.org/Patient Safety/NationalPatientSafetyGoals

CROSS REFERENCE P&P:
1. Surgical/ Invasive Procedure Checklist
2. Informed Consent

Approval	**Date**
CCOC	4/17
STC	10/25/17
MEC	11/7/17
Board of Directors	11/15/17
Last Board of Director review	1/18/17

Developed: New version approved at Surgery Tissue Committee 10-21-2104
Reviewed: 7/9/2012 PM
Revised: 1-04, 10-20-14 AW, (2nd version) 10/2015BS- AW, 2/2017AW
Supersedes: Surgical Procedural Site Identification
Index Listings: Universal Protocol, Time Out Procedure, Site Identification,

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Airway Management	
Scope: PACU	Manual: Cardiovascular, Circulation (OXC), Oxygen, PACU - Respiratory
Source: PACU Nurse Manager	Effective Date:

PURPOSE:
The first responsibility a Recovery Room nurse has is to ensure a patent airway on each patient. This should be checked the moment the patient is brought into the PACU. It is important to feel for air exchange as well as to watch for chest expansion/decompression. The easiest way to feel for air exchange is to place the back of your hand 2-3 inches above the patient's mouth. If an adequate flow of air is felt on expiration, then oxygen should be applied and patient care should continue. The anesthesiologist will order the amount and route of oxygen administration (usually via a mask or nasal cannula.)

POLICY:
The PACU nurses will follow the airway management techniques/guidelines established by the American Heart Association in the most recent ACLS textbook.

It is mandatory for all PACU nurses to have successfully completed the ACLS course.
An ACLS manual is located in the reference material cupboard in the PACU.

EQUIPMENT: Assorted sizes of nasal and oral airways are kept above each PACU gurney. The supply of these airways should be assured by the PACU nurse before the arrival of patients from the Operating Room. After use, the nasal and oral airways are to be soaked in water and washed thoroughly with a brush. They are then cleaned as per procedure.

There is also an Ambu bag (self inflating bag and a non-rebreathing valve) with an adult mask located at each PACU bay. A pediatric bag and masks are located in the cupboard P shelf 01-03 in the PACU.

There is suction at each PACU bay.

PRECAUTIONS: Check that suction supplies are available (and working) at each PACU bay before a PACU admission.

PROCEDURE:
<u>Head Tilt</u>
If the patient's airway is not patent, i.e. poor air exchange, the PACU nurse should immediately reposition the patient's head. Tilt the head back by placing one hand under the patient's neck and the other hand on the patient's forehead. This will lift the base of the tongue away from the posterior pharyngeal wall. A small pillow or towel roll under the patient's shoulders may help to maintain this position. Recheck airway.

<u>Jaw Lift</u>
If there is still poor air exchange, then a forward displacement, of the mandible should be performed. Lift up on the chin or place your fingers behind the mandible on each side of the jaw and gently lift. Again, check airway.

Suction, if necessary. Listen for sounds of loose secretions and use a nasal suction catheter for the throat (suction through the nares or the mouth) or a Yankauer suction tip for the mouth.

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Airway Management	
Scope: PACU	Manual: Cardiovascular, Circulation (OXC), Oxygen, PACU - Respiratory
Source: PACU Nurse Manager	Effective Date:

Nasal Airway

A nasal airway is made of soft rubber and is generally better tolerated by the patient than an oral airway. Quickly choose an airway that measures about from the opening of the nares to the bottom of the Jaw. Lubricate the nasal airway with Lidocaine jelly, K-Y jelly. Insert while tilting the patient's head back. Check for air exchange. Maintain head tilt/Jaw lift as necessary and apply oxygen.

Qral Airway

An oropharyngeal airway may be inserted, instead of, or in adjunct to a nasal airway. Quickly select one that is large enough to extend from the teeth to the base of the tongue but not so large as to obstruct the airway by impacting the epiglottis or cause irritation to the throat and induce vomiting.

1. Extend patient's head by placing one hand beneath the neck close to the occiput and gently lifting the neck while tilting the head backward by pressure on the forehead with the other hand.
2. Insert the airway upside down and rotate through 180 degrees as airway is introduced over the tongue to the pharynx.

OR

3. Insert from side of mouth and rotate into position.

Again, recheck airway and continue head tilt/jaw lift as necessary and apply 02.

If an airway has been established but there is lack of spontaneous respiration by the patient, then the ambu bag should be used to assist in ventilating the patient. Narcan should be considered for use if narcotics had been used during surgery or in the PACU. The anesthesiologist should be notified as quickly as possible of the patient's condition. Intubation supplies should be ready for use if re-intubation is a consideration.

Maintenance of an adequate airway (head tilt/jaw lift and nasal or oral airways) must be continued until the patient is breathing spontaneously and exchanging a good amount of air without assistance.

DOCUMENTATION:

Approval	**Date**
NEC	9/20/17
Surgery Tissue	10/25/17
MEC	11/7/17
Board of Directors	11/15/17
Last Board of Directors Review	1/18/17

Developed: 1/90 AW
Reviewed: 4/98 AW, 02/01 AW, 07/10 AW, 05/11AW, 9/12AW
Revised:
Supersedes:
Index Listing: Airway Management, PACU

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Child Abuse Neglect Policy	
Scope: NIHD	Manual: Social Services
Source: Social Worker	Effective Date:

I. PURPOSE:

A. To define the policy and procedure for reporting victims of suspected child abuse, neglect, and/or exploitation who present as an outpatient or inpatient to Northern Inyo Healthcare District.
B. To identify and assist suspected victims of child abuse, neglect, and/or exploitation and to help the victim's caregivers as well.
C. To comply with California child abuse, neglect, and exploitation reporting requirements, which require the screening, detection, and reporting of child abuse, neglect, and exploitation. [Penal Code Section 11165 et seq.]
D. To ensure system-wide recognition of child abuse, neglect and exploitation and specific reporting procedures.

II. DEFINITIONS:

A. **Health Practitioner** (Mandated Reporter) includes a physician; surgeon; psychiatrist; resident; intern; registered nurse; licensed clinical social worker or associate clinical social worker; or any other person who is currently licensed under Business and Professions Code Section 500 [Welfare and Institutions Code Section 15610.37].
B. **Reasonable suspicion** means an objectively reasonable suspicion that a person would entertain, based upon facts drawing when appropriate upon his or her training and experience, to suspect abuse [Welfare and Institutions Code Section 15610.65].
C. **Child** in California is defined as any person under 18 years of age [Penal Code S11165 (a)].
D. **Child Abuse, Neglect, and Exploitation** definition encompasses multiple categories of acts or omissions: non-accidental physical injury, sexual abuse, neglect, exploitation, victimization, illegal or use of a child for another's profit or advantage, willful cruelty or unjustifiable punishment, corporal punishment or injury, abuse in and out of home care.

III. POLICY:

A. Any employee who is engaged in patient care activities shall sign a statement acknowledging his/her awareness of the child abuse, neglect, and/or exploitation reporting requirements and his/her agreement to comply with the law, as a prerequisite to employment. This statement shall be retained in the employee's personnel file. Every employee will sign this statement during the new hiring process before New Employee Orientation.
B. Health Practitioners have **mandatory** reporting responsibilities: When a child presents to Northern Inyo Healthcare District as an outpatient or inpatient, the health practitioner will report any observed incident that reasonably appears to be child abuse/neglect; such as a physical injury where the nature of the injury, its location on the body, or repetition of injuries indicates physical and/or sexual abuser obvious signs of neglect, such as failure to thrive. The health practitioner is also mandated to report any verbal accounts by the child that he/she has experienced behavior constituting abuse (see Attachment I, Indicators of Child Abuse, Neglect and Exploitation).

C. Any health practitioner who has knowledge of abuse, neglect, and/or exploitation or any health practitioner who observes in their professional capacity or in the scope of their employment, a patient whom they reasonably suspect is a victim of child abuse, neglect, and/or exploitation, shall immediately, or as soon as practically possible report to the appropriate authorities (Inyo County Child Protective Services or the local Law Enforcement Agency. See IV below)
D. Indicators of Child Abuse, Neglect and Exploitation are listed (see Attachment I).
E. The identity of all persons who make child abuse reports is confidential and may be disclosed only among the agencies receiving or investigating mandated reports
F. A health practitioner who makes a required report does not incur civil or criminal liability, and may not be discharged or disciplined for making the report.
G. A health practitioner who knowingly fails to report an instance of child abuse, neglect or exploitation is guilty of a misdemeanor punishable by imprisonment, fine, or both and may be discharged or disciplined for not making the report [Penal Code Section 11166(c)].
H. In the hospital or clinic, when two or more mandated reporter may become jointly aware of the same instance of reportable child abuse, neglect, and/or exploitation, (Penal Code Section 11166(h)) allows the team to select, by mutual agreement a single member who will be responsible for making the report. However, if one of these persons knows that the designated person has failed to report, that person must thereafter make the report.
I. The statute allows the hospital to create internal procedures to facilitate reporting, ensure confidentiality and apprise supervisors and administrators of reports. These procedures must make clear that reporting duties are individual, that no supervisor or administrator may impede or inhibit child abuse reporting, and that employees must not be subject to sanctions for making a report [Penal Code 11166(i)(1)]. Any administrative procedures implemented must also maintain the confidentiality of the report.
J. Each department manager is responsible for the education of appropriate medical office and hospital staff regarding criteria for handling patients whose injuries or illnesses are suspected attributable to child abuse, neglect, and/or exploitation.

IV. PROCEDURE:

A. For **suspected** child abuse, neglect, and/or exploitation the health practitioner will: (See Attachment I, Indicators of Child Abuse/Neglect/Exploitation).

1. Provide a private, safe, non-judgmental environment for assessment.
2. REPORT:
    a. An initial telephone report must be made immediately or as soon as is practically possible after receiving the information concerning the incident [Penal Code Section 11166(a)].
        i. Monday thru Friday 8:00 to 5:00 - **Inyo County Child Protective Services** at **760-872-1727.** After hours, weekends, and holidays - **Inyo County Sheriff's Department** at **760-873-7887.**

ii. Complete a **Suspected Child Abuse Report** form (SS 8572) (located on the Intranet under Forms>Departmental>Nursing Multi-Unit>Suspected Child Abuse Report).
iii. Once completed; print copy, and fax a written report (form SS 8572) to **Inyo County Child Protective Services** at **760-872-1749.** Written reports should be faxed within 36 hours of the receiving the information concerning the incident.
iv. The original form (SS 8572) is to be sealed in a manila envelope marked **confidential** for delivery to Medical Records.
v. For Inpatient and Emergency Department, a copy of the form (SS 8572) is to be given to the social worker; second floor **Clinical Coordinators Office H2096**. After hours, weekends, and holidays place in mail box outside of clinical coordinators office.
vi. For Outpatient, a copy of the form (SS 8572) is to be given to case management for follow up.

B. The California Department of Justice has adopted "Suspected Child Abuse Report," form SS 8572, which must be used for the written report. The form may be obtained from the local social services department, child protection services or at www.ccfmtc.org.

The SS 8572 form shall include the following information:
1. The name, business address and telephone number of the mandated reporter.
2. The information that gave rise to the reasonable suspicion of child abuse or neglect and the source or sources of that information.
3. The child's name, address and present location, and, if applicable, the child's school, grade and class.
4. The names, addresses and telephone numbers of the child's parents or guardians.
5. The name, address, telephone number and other relevant information about the person or persons who might have abused or neglected the child.
6. The mandated reporter shall make a repost even if some of this information is not known or is uncertain to him or her.

[Penal Code Section 11167]

C. **When sexual abuse is evident**, refer to Emergency Department Sexual Assault Exam Policy. For sexual assault victims and suspect exams, a SART (Sexual Assault Response Team) nurse will be contacted by the examining nurse.
D. Document in the medical record anything that may be attributed to or evidence of suspected child abuse/neglect/exploitation, such as:
1. Comments by the victim regarding past abuse/neglect/exploitation.
2. A map of the victim's body showing and identifying injuries and bruises at the time the care is provided.
3. Photographs of the victim's injuries. Parental consent is not required or recommended.

E. For **maternal substance abuse** the law specifies that a positive toxicology screen during pregnancy or at the time of an infant's delivery is not in and of itself a sufficient basis for reporting child abuse or neglect. However, if other factors are present that indicate risk to the child, then a child abuse report must be made [Penal Code Section 11165.13].
F. IN SUMMARY - **Failure to report is a crime and there are strong penalties for anyone who fails to report** [Penal Code Section 11166(c)].

REFERENCES:

1. CHA Consent Manual 2016 Edition, Chapter 19 Assault and Abuse Reporting Requirements; Child Abuse and Neglect (19.8 – 19.18).
2. North Bay Healthcare Administrative Manual. Child Abuse, Neglect and Exploitation; Policy #310.

CROSS REFERENCE P&P:

1. Case Management Manual
2. Clinical Practice Manual
3. Emergency Department Manual
4. ICU Manual
5. Perinatal Services Manual

Approval	**Date**
Clinical Consistency Committee	7/17/17
PeriPeds	10/20/17
Utilization Review	8/24/17
MEC	11/7/17
Board of Directors	11/15/17
Last Board of Director Review	

Developed: 7/17
Reviewed:
Revised:
Supersedes:
Index Listings:

Attachment I: Indicators of Child Abuse/Neglect/Exploitation

Child abuse/neglect/exploitation is defined as a physical injury which is inflicted by other than accidental means on a child by another person. It also includes emotional abuse, sexual abuse, exploitation, neglect or abuse in or out of home care. The following are signs and/or symptoms that may indicate child abuse, neglect and/or exploitation. Patients who present with these signs and/or symptoms require further evaluation, even if an acute problem is not apparent. Evaluation will be provided by the health practitioner.

There are four basic areas in which abuse/neglect/exploitation may be revealed:

1. Environmental Problems
2. Parental Clues
3. Physical Indicators in the Child
4. Behavioral Indicators in the Child

I. Environmental Problems

A. Hazardous conditions in the home (broken windows, faulty electrical fixtures)
B. Health risks (presence of rats, no electricity, no running water) or unsanitary conditions
C. Extreme dirt or filth affecting health

II. Parental or Caregiver Clues

The Parent or Caregiver -

A. Is unable or unwilling to meet child's basic needs and provide a safe environment.
B. Tells you of homicidal thoughts or feelings toward child
C. Tells you of use of objects (belt, whip, spoon, or clothes hanger) to discipline the child
D. Is unable to describe positive characteristics of child
E. Has unrealistic expectation of child (example – toilet training a 6 mo old)
F. Uses "out of control" discipline
G. Is unduly harsh and rigid about childrearing
H. Singles out one child as "bad", "evil", or "beyond control"
I. Berates, humiliates, or belittles child constantly
J. Turns to child to have his/her own needs met
K. Is impulsive, unable to use internal controls
L. Cannot see child realistically, attributes badness to child, or misinterprets child's normal behavior

III. Physical Indicators in the Child

A. Physical Abuse
    1. Fractures, lacerations, bruises that cannot be explained, or explanations which are improbable given the extent of the injury
    2. Burns (cigarette, rope, scalding water, iron, radiator)
    3. Facial injuries (black eyes, broken jaw, broken nose, bloody or swollen lips) with implausible or nonexistent explanations
    4. Subdural hematomas, long bone fractures, fractures in different states of healing
    5. Pattern of bruising (parallel or circular bruises) or bruises in different stages of discoloration, indicating repeated trauma over time
    6. Excessive bruising in an area other than usual traumatic contact (over soft surfaces such as face, abdomen, buttocks, etc.)

B. Neglect
1. Failure to thrive – a child's failure to gain weight at the expected rate for a normal child
2. Malnutrition or poorly balanced diet (bloated stomach, extremely thin, dry, flaking skin, pale, fainting)
3. Inappropriate dress for weather
4. Dirty, unkempt
5. Unattended medical conditions (infected minor burns, impetigo)

C. Sexual Abuse
1. Bruising around genital area
2. Swelling or discharge from vagina/penis
3. Tearing around genital area, including rectum
4. Visible lesions around mouth or genitals
5. Complaint of lower abdominal pain
6. Painful urination, defecation
7. Difficulty in walking or sitting due to genital or anal pain
8. Sexually transmitted diseases in infant, toddler, pre-school, and school age child.
9. Any female minor under the age of 16 who is pregnant by a male over the age of 21 whether consensual or not
10. Any female minor under the age of 14 with a male over the age of 14 whether consensual or not

IV. Behavioral Indicators in the Child

(The presence of any of these indicators does not prove the child is being abused, but should serve as a warning signal to investigate further.)

A. Physical Abuse
1. Hostile or aggressive behavior toward others
2. Extreme fear or withdrawn behavior around others
3. Self-destructive (self mutilating, bangs head, etc.)
4. Destructive (breaks windows, sets fires, etc.)
5. Verbally abusive to others
6. Out of control behavior (seems angry, panics, easily agitated)

B. Sexual Abuse/Exploitation
1. Sexualized behavior (has precocious knowledge of explicit sexual behavior and engages self or others in overt or repetitive sexual behavior)
2. Hostile or aggressive
3. Fearful or withdrawn
4. Self-destructive (self-mutilates)
5. Pseudo-mature (seems mature beyond chronological age)
6. Eating disorders
7. Alcoholism/drug abuse
8. Running away
9. Promiscuous behavior

C. Neglect/Exploitation
1. Clingy or indiscriminate attachment

2. Isolates self
3. Seems depressed or passive

D. Emotional Abuse/Exploitation
   1. Lacks self-esteem; puts self down constantly
   2. Seeks approval to an extreme
   3. Seems unable to be autonomous (makes few choices, fears rejection)
   4. Hostile, verbally abusive, provocative

"The California Child Abuse and Neglect Reporting Law: Issues and Answers for Health Practitioners", State Department of Social Services, Office of Child Abuse Prevention, 2012.

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Admission, Discharge, Transfer of Patients: Continuum of Care	
Scope: NIH	Manual: Nursing Administration Manual (NAM)
Source: CNO	Effective Date:

PURPOSE:
To ensure appropriate patient placement based upon the balance of intensity of services required and the unique needs of the individual patient with staff who have demonstrated the skills and competencies necessary to provide care in an appropriate healing environment. These guidelines will:

1. Provide a consistent process of admission, transfer and discharge of patients.

2. Describe the continuum for patient care.

POLICY:
This policy applies to all patients presenting to any of the hospital-based services at Northern Inyo Hospital.

A. **Continuum Provisions**

1. Patients are admitted, discharged and transferred by physician's order only. Admissions are coordinated by physicians, nurses, case managers and other support disciplines as appropriate. Patients enter the hospital by direct admission, transfer/referral from another healthcare institution, scheduled surgeries or outpatient procedures and emergency admissions.

2. The House Supervisor monitors and evaluates capability and capacity (current staffing, census, admissions, discharges and transfers) in order to coordinate patient placement for admissions and transfers in.

3. Patients who have stable psychiatric concerns and require medical, surgical and/or maternal-child care will be admitted to the appropriate unit to meet their current health care needs. Patients assessed as having unstable medical and psychiatric concerns (potential to harm self and/or others) will be admitted to the appropriate level of care and be provided with continuous observation (per the Patient Safety Attendant or 1:1 Staffing Guidelines Policy) until a mental health evaluation can be performed to determine the appropriate observation required. Once these patients are medically stabilized, they will be evaluated for transfer to the proper facility or treatment service for their psychiatric issues.

4. After an initial medical screening examination, the ED physician may determine the patient requires the services of an on-call physician such as but not limited to a surgeon or hospitalist. The on-call physician will provide further evaluation and/or treatment to stabilize the patient with an emergency medical condition.

5. After completion of a medical screening exam and/or medical evaluation with medical stabilization (See Policy Evaluation and Medical Screening of patients presenting to the Emergency Department), a physician may determine that the patient

requires transfer to another healthcare facility for ongoing treatment and/or tertiary care.

B. **Admissions**

1. Patients are admitted to Northern Inyo Hospital for care and treatment, in accordance with the requirements of applicable laws, regulations and accreditation standards. Patients are accepted regardless of race, ethnicity creed or ability to pay. Patients with a primary diagnosis of alcoholism or drug abuse are not candidates for admission except for provision of medical stabilization and appropriate consultations and referrals.

    a. Medical Staff members shall be responsible for the medical care and treatment of patients in the hospitals.

    b. Within 24 hours after admission or immediately before, every patient shall have a complete history and physical examination completed consistent with the medical staff bylaws.

2. House Supervisor (HS) will assign the bed once an admission order is placed by the physician.

3. All patients admitted to the hospital will have identification wristbands applied.

4. Patients will receive, upon admission or as soon thereafter as reasonably practical, written information regarding:

    a. Active participation in decisions regarding medical care

    b. appropriate pain assessment and treatment

    c. being informed or if the patient so authorizes allowing a friend or family/caretaker be provided information about the patients continuing health care requirements following discharge from the hospital

5. Types of admissions include: direct, pre-scheduled, emergent, inter-facility and unplanned from surgery.

6. The admission order must identify the admitting physician and diagnosis, the admission status, and the intensity of service (ICU, Medical etc.) before the patient will be admitted.

7. Based on bed availability, patients are assigned to a unit specific bed placement based on diagnosis, condition, age, needs of the patient, medical necessity and unit admission criteria. Once a bed assignment has been made, the goal is to move the

patient to that bed within 60 minutes. The patient hand-off process is documented in the EHR.

8. Patients are registered to the assigned unit and specific bed under a patient status classification: Out-Patient Observation (OPO), Inpatient, or Out Patient Procedure.

C. **Observation:**

Observation services begin and end with an order by a physician or other qualified licensed practitioner of NIH. Observation services provides for evaluation and treatment of patients who do not meet admitting criteria. Observation provides time for a physician to evaluate a patient's condition and determine the medical necessity for inpatient admission, usually within a 48 hour period. The order for observation services must be written prior to initiation of the service, as documented by a dated and timed order in the patient's medical record. The order may not be backdated. Orders should be clear for the level of care intended, such as "admit to inpatient" or "place in observation." (Admit to observation may also be used)

1. Observation should be considered if the patient is hemodynamically stable and does not meet acute inpatient care criteria. Observation care is a well-defined set of specific, clinically appropriate services that include;

    a. Ongoing short-term treatment, assessment, and reassessment, that are provided before a decision can be made regarding whether a patient will require further treatment as an inpatient, or may be safely discharged.

    b. Observation status is commonly assigned to patients with unexpectedly prolonged recovery after outpatient surgery

    c. Patients who present to the emergency department and who then require a significant period of treatment or monitoring before a clinical decision is made concerning their next placement. Once there is sufficient information to render this clinical decision, the patient should be expeditiously admitted, appropriately transferred, or discharged.

2. Observation services are not appropriate:
    a. As a substitute for an inpatient admission;

    b. For continuous monitoring;

    c. For medically stable patients who need diagnostic testing or outpatient procedures (e.g., blood transfusion, chemotherapy,) that are routinely provided in an outpatient setting;

    d. For patients awaiting nursing home placement;

e. To be used as a convenience to the patient, his or her family, NIH or NIH staff;

f. For routine prep or recovery prior to or following diagnostic or surgical services; or

g. As a routine stop between the emergency department and an inpatient admission

D. Discharges

1. When it is determined by a patient's attending physician that the patient biophysically no longer requires an acute level of care the patient will be discharged.

2. Patients and their families are provided interdisciplinary discharge planning services throughout the continuum of care. This process is initiated prior to or at the time of admission in a consistent manner, reflecting each patient's special needs related to age, disability, cultural, spiritual, psychosocial and medical condition and continues until the day of discharge to the appropriate setting.

3. A minor shall be discharged only to the custody of his/her parent or to his/her legal guardian or custodian, unless such parent or guardian shall otherwise direct in writing.

4. Patients are discharged from Northern Inyo Hospital to a variety of different settings each requiring information about the discharge needs of the patient.

5. Patients are informed in a timely manner of the need to plan for discharge. Planning for discharge or transfer involves the patient, physicians, staff, family and significant others involved in the patient's care, treatment and services.

6. Patients are discharged or transferred with information explaining why they are being discharged and will be provided written information about:

   a. their diagnosis

   b. follow up information

   c. medication regime they are to be following, and

   d. diagnosis specific education describing the ongoing care needs upon discharge

7. The patient discharge instructions will include information on when to seek follow-up care for emergent or ongoing medical needs and smoking cessation as appropriate.

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Patients may be discharged from the hospital to:

8. Discharge to Home

    a. Patients being discharged to home will have the discharge process completed prior to discharge based upon physician's orders and clinical documentation.

    b. Physicians will perform Discharge Medication Reconciliation prior to patient discharge.

    c. Nursing staff will review the content of the discharge, instructions and education with the patient and/or family/significant other.

    d. Nursing staff will have the patient or designee sign the patient instructions and education acknowledging understanding of the information.

    e. Nursing staff will place the original signed form in the medical record and provide the patient or designee with a copy inclusive of the discharge instructions and education.

9. Discharge to Home with Home Care

    a. The nursing staff will complete all steps as outlined in section D/6.

    b. The Case Manager or Social Worker who is responsible for arranging the home care will provide the Home Care agency with copies of pertinent information from the medical record including the printed discharge summary inclusive of the discharge instruction content indicated above. Printing of information may be delegated to other team members of the department.

    c. If the Case Manager or Social Worker is not available, the RN designated staff member discharging the patient will send all pertinent information to the home care agency.

10. Discharge to skilled Nursing Facility, Board or Assisted Living

    a. The discharging physician must determine the appropriateness of discharge to these levels of care based on the patient's medical condition and continuing care needs.

    b. The Case Manager or Social Worker will provide the patient or designee with contact information for at least one public or non-profit agency or organization dedicated to providing information or referral services relating to community based long term care options in the patient’s county of residence and appropriate to the needs and characteristics of the patient. This

information should include contact information for the local area agency on aging and local independent living centers. (CHS code section1262.5)

c. When a patient has an accepting facility and the physician has cleared them for discharge, nursing staff will give the patient for transfers to an Assisted Living facility, the Residential Care Facility Admission Form (known as a 602 form) will be filled out with all pertinent continued health care information.

d. Prior to the patient leaving acute care, the RN will call report to the receiving facility.

e. When possible, the patient's family or representative will tour the local SNF or Assisted Living facility and will prioritize to which facility referrals will be made.

f. The hospital physician will provide the receiving facility with a Discharge (Transfer) Summary containing relevant medical information to ensure the continuum of care for the patient at the receiving facility. Relevant information may include:

1.Patient's diagnosis

2.Hospital course

3.Pain management and treatment

4.Medications

5.Treatments

6.Dietary requirements

7.Rehabilitative potential

8.Known allergies, and

9.Discharge treatment plan.

g. A copy of the Discharge Instructions and Transfer (Discharge) Summary will be given to the patient or the patient's legal representative, if any, prior to transfer to a skilled nursing facility or intermediate care facility. (State Standards HSC 1262.5).

h. The Nurse will give the patient or patient's legal representative, information about each medication the patient is currently on.

i. If the discharging physician will not be following the patient at the SNF, the physician will be responsible for finding a receiving physician who will follow the patient. The Case Manager or Social Worker will assist in this process and confirm an accepting physician has been secured at the time of discharge.

j. The discharging physician will determine the appropriate mode of transportation and enter the appropriate order in the EHR.

k. Case Management will arrange transportation to the accepting facility as ordered by the physician.

11. Discharge to jail with law enforcement

a. Nursing staff will complete the appropriate patient documentation, select the appropriate diagnosis specific education content, then sign and print the discharge summary to provide the patient with discharge instruction for the patient as outlined in Section b. Additional required paperwork will be completed by the physician.

b. Upon discharge, the nurse will provide the patient with the diagnosis specific education content. The patient discharge summary inclusive of the patient's diagnosis, follow-up information, medication regime and discharge education will be given to the forensic staff member accompanying the patient.

E. Transfer, Inter-facility

Transfers to another acute care or psychiatric facility require a physician/qualified medical provider order.

1. When it is determined that the patient has an emergency medical condition and Northern Inyo Hospital (NIH) does not have capability or capacity to provide care, NIH shall:

   a. stabilize the patient, within the capability and capacity of the hospital-based services; or

   b. provide, if applicable, for the appropriate transfer of the patient to another medical facility in accordance with these procedures.

2. If a patient has an emergency medical condition that has not been stabilized, the patient may be transferred only if the transfer is carried out in accordance with the procedures set forth below:

a. The patient may be transferred if the patient or the legally responsible person acting on the patient's behalf is first fully informed of the risks of the transfer, the alternatives (if any) to the transfer and of the Hospital's obligations to provide either further examination and treatment sufficient to stabilize the patient's emergency medical condition, or an appropriate transfer. Then the transfer may occur if the patient or legally responsible person:

   i. makes a request for transfer to another medical facility, stating the reasons for the request; and

   ii. acknowledges the request and his or her awareness of the risks and benefits of the transfer by signing the Physicians Certification Form; or

   iii. the patient has been notified or attempts over a 24 hour period have been made and a responsible person cannot be reached.

b. The patient may be transferred if a physician/advanced practice provider, in consultation with a responsible physician has documented, on the Physician Certification Form that the expected medical benefits from transfer outweigh the risks. A Physicians Certification Form per verbal order shall be countersigned by the qualified medical provider. In the event a consulting physician has assumed care of the patient, that physician shall determine that the benefits outweigh the risks of the transfer for the patient and shall document such in the patient's medical record.

3. The hospital-based service shall send the receiving facility copies of all pertinent medical records available at time of transfer, including but not limited to:

   a. Facesheet

   b. Physician orders

   c. Physician transfer summary or transfer form

   d. History

   e. records related to the patient's emergency medical condition

   f. observations of signs or symptoms

   g. preliminary diagnosis

   h. results of diagnostic studies or telephone reports of the studies

   i. treatment provided

j. results of any tests

k. a copy of the medication reconciliation or a medical history list if for an Emergency Department patient; and

l. a copy of the informed written request or certification and consent to transfer called the Physicians Certification Form. If an on-call physician has refused or failed to appear within a reasonable time after being requested to provide necessary stabilizing treatment, the hospital-based service shall provide the name and address of that physician to the receiving facility.

4. When transfer teams from the receiving facility are utilized, they assume responsibility for the patient on their arrival, as long as the patient's condition remains unchanged.

5. If the individual is transferred for non-medical reasons, the transferring physician will document that the transfer will not create deterioration or jeopardize the medical condition of the individual or unborn child.

6. When air or ground ACLS transport is required, physician orders for enroute transfer must be completed and signed by M.D. on appropriate forms.

7. Report by the RN responsible for the patient will be called to the RN receiving the patient at the accepting facility. This will include all hand off information (SBAR) and will include any current isolation procedures being followed.

8. The following must occur and be documented in the medical record:

   a. The physician or another qualified medical person informs the patient of the reason for transfer.

   b. The physician certifies the transfer including the risks, benefits and alternatives of the transfer.

   c. The patient, or a legal responsible person acting on the patient's behalf, consents to transfer.

   d. An Emergent Transfer Form shall be filled out if the patient is transferred to another facility.

   e. The transferring physician must obtain agreement to the transfer from the receiving facility and from the physician who will assume responsibility for the patient at the receiving facility (the "receiving physician"). This includes confirmation that the receiving facility has capability and capacity to care for the patient.

f. The transferring physician will provide appropriate orders for the transfer that will include mode of transport, level of care required during transport, additional equipment and medical orders during transport.

g. The Case Manager, House Supervisor, RN, or designee will arrange for and document appropriate transportation, staffing and expected time of transfer.

9. Documentation by Nursing:

   a. Completion of emergent or non-emergent transfer form.

   b. NIH staff needs to document procedures done, IV infusions started, and/or medications given prior to transfer team handoff. In addition the RN should document any medications, IV infusions or supplies sent with the transport team.

   c. Notation in nursing record of:

      a. Time and method of transfer

      b. Patient's condition on transfer including current V/S and cardiac rhythm when applicable

      c. Disposition of belongings

      d. Notification of family member if possible

BOARD & CARE: (Sterling Heights is our local facility)

1. Physician's Report - State of California Form completed by MD needed for first time admission to facility only (Social Service has copies or the facility will provide)

2. Physician Discharge Instructions

3. Copy of Current MAR (this will be a record of last dose of medication given prior to discharge)

4. Copy of Facesheet

5. Copy of Power of Attorney/Living Will (if available)

6. New residents only---Current negative TB clearance or documented negative for TB chest X-ray.

SKILLED NURSING FACILITY (SNF):

Title: Admission, Discharge, Transfer of Patients: Continuum of Care	
Scope: NIH	Manual: Nursing Administration Manual (NAM)
Source: CNO	Effective Date:

I. Non Emergent Transfer Form

II. PAS-PASARR - Document is completed by Social Services when appropriate (may be completed by Nursing Supervisor if SS not available). Required for all transfers to Nevada Nursing Homes, regardless of insurance source.

III. Copy of Power of Attorney/Living Will (if available).

IV. Discharge/ Transfer Summary completed and if possible sent with patient at time of transfer (May need to fax if transfer completed prior to summary completion). Bishop Care center requires, prior to receiving the patient, discharge/transfer summary completed or completion of their Physician orders for skilled nursing forms.

V. Medical Record Chart Copies including but not limited to:

a. Copy of Current MAR (this will be a record of last dose given and what medications patient has been on during hospitalization).

b. Nutritional Screening

c. History and physical

d. Consultations

e. Current labs

f. X-ray Reports (film copies not necessary unless requested)

g. Operative Report

h. Copy of Face Sheet

VI. Skin Assessment - needed only if there is a skin breakdown, wound, or bruise. Include pictures of these wounds if taken on admit and also those taken at discharge

VII. TB Clearance: Clear Chest X-ray or Neg PPD is required unless patient is returning to SNF (Nevada requires report to read "Clear for TB". California does not.)

10. Patients Who Have An Emergency Medical Condition But Refuse To Consent To Treatment Or To Transfer:

a. The hospital-based service may discharge or transfer a patient with an emergency medical condition before the condition is stabilized only if the patient or legally responsible person has signed a request for transfer or the physician has signed a certification or;

1) If the patient refuses examination or treatment: If the hospital offers such examination and treatment and informs the patient or legally responsible person of the risks and benefits to the patient of the examination and/or treatment, but the patient or legally responsible person refuses to consent to the examination and/or treatment, the hospital shall take all reasonable steps to have the patient or legally responsible person sign a "Refusal of Treatment".

2) In addition, the medical record shall contain a description of the examination, treatment, or both if applicable, that was refused by or on behalf of the individual.

3) A patient who has refused further medical examination and treatment may nevertheless be transferred in accordance with the procedures set forth in this policy.

4) If the patient is a minor and the parents refuse advised medical treatment, the parent(s) would sign the "Refusal of Treatment" form and, depending on the severity of the illness, a CPS Report may be completed.

5) If the patient refuses transfer: The hospital may discharge a patient who has an emergency medical condition if, after the hospital offers to transfer the patient to another medical facility, and after the hospital informs the patient or legally responsible person of the risks and benefits to the patient of the transfer, the patient or legally responsible person refuses to be transferred. The Hospital shall take all reasonable steps to have the patient or legally responsible person sign the "Refusal of Treatment" form. In addition, the medical record shall contain a description of the proposed transfer that was refused by or on behalf of the individual.

11. Hospital Administration, Compliance, and Quality Improvement shall be advised when a patient who has an emergency medical condition refuses to consent to further examination and treatment or to an appropriate transfer.

12. Patients Who do not have an Emergency Condition

    a. When the patient is determined as a result of a medical screening examination not to have an emergency medical condition, the patient may be transferred to another health care facility (if in need of further care) or discharged (if not in need of further care).

F. Transfer, Intra-facility: Procedural Transfers

1. Transfers for Invasive Procedures

a. When transferring a patient, the assigned staff of the sending unit is responsible for the management of the patient until completion of report and placement of the patient in the receiving department.

b. Patients transferring to a monitored bed in ICU or Telemetry must be accompanied by an ACLS certified healthcare provider.

c. Patients receiving monitored medication must be accompanied by an RN.

d. The Procedural Consent form if needed may be obtained at either transferring or receiving department but must be documented on the consent form specific to the location of the procedure.

e. The patient's original chart will be sent with the patient to the receiving department to ensure the surgical checklist as well as pre-procedural physician orders are completed.

f. Verbal report is given between the transferring staff and the receiving staff

g. Nursing transfer note will consist of the following:

1) A quick check will occur immediately prior to transfer

2) Documentation of the SBAR handoff

3) Communication will be inclusive of:

- Report given to
- Transfer to Location
- Transfer From location
- Transfer mode
- Patient family notified

h. Nursing documentation of the patient care handoff will be documented by the receiving RN. The content documented will consist of the following:

1) Name of transferring RN providing report

2) Quick check

G. Record Keeping

1. The hospital-based services, whether transferring or receiving patients, must maintain the following:

    a. Medical and other records related to patients transferred to or from the hospital-based services for a period of seven (7) years from the date of the transfer

    b. A list of physicians who are on call for duty after the initial examination to provide treatment necessary to stabilize a patient with an emergency medical condition; and

    c. Information on each patient who comes to the emergency department seeking assistance and whether he or she refused treatment, was refused treatment, or whether he or she was transferred, admitted and treated, stabilized and transferred, or discharged can be found in the EHR.

H. Reporting

1. The Hospital must file with the California Department of Public Health quarterly the Emergency Department Transfer Communication (EDTC) report that shall describe the aggregate number of transfers made including but not limited to the reasons for transfer.

2. The Hospital's Medical Staff members and employees have the following reporting obligations:

    a. The Hospital's Medical Staff members and employees who know of an apparent violation of the patient transfer laws on the part of the Hospital in its capacity as a receiving facility shall immediately report such violation to Hospital Administration, and Hospital Administration shall be responsible to report the violation to the Regional CMS office within one week of the suspect transfer.

    b. The Hospital's Medical Staff members and employees who know of an apparent violation of the patient transfer laws on the part of the Hospital in its capacity as a transferring hospital shall immediately report such violation to Hospital Administration.

    c. The Hospital's Medical Staff members and employees shall be provided with a copy of this Policy and advised that all hospitals are required to comply with federal and state laws regarding emergency transfers, as set forth in this policy. Risk Management and the Performance Improvement departments shall immediately investigate any suspect transfer, whether to or from the Hospital.

    d. The Hospital shall not retaliate, penalize, or take adverse action against any Hospital Medical Staff member or employee for reporting violations of federal state transfer laws to the proper authorities.

I. Posting Signs

1. The Hospital shall post conspicuously, signs stating whether or not the Hospital participates in the Medi-Cal program.

2. The Hospital shall post conspicuously, in the emergency department, signs specifying rights of patients under law with respect to examination and treatment for emergency medical conditions and of women who are pregnant and are having contractions.

J. Requirements for Receiving Facilities Special Units

1. Regional referral centers or hospitals that have specialized capabilities or facilities, such as a burn unit, a shock-trauma unit or a neonatal intensive care unit, may not refuse to accept from a referring hospital an appropriate transfer of a patient who requires such specialized capabilities or facilities if the receiving facility has the capacity to treat the individual.

SERVICE DEFINITIONS AND ADT CRITERIA

A. Outpatient Services

The provision of emergent and/or non-emergent health care services to patients who require less than 24 hours of care with the appropriate staff equipment, space, and supplies.

1. Emergency Department

a. Definition: Patients of any age or condition presenting for emergency care will be provided a medical screening exam, stabilizing care, discharged with a plan of care, admitted for further treatment or transferred according to the guidelines of this policy.(See Policy: Evaluation and Medical Screening of Patients Presenting to the Emergency Department)

b. Exclusions: Non-emergent elective patient procedures i.e. elective transfusions, bronchoscopy, endoscopy, general anesthesia, prolonged monitoring or procedures requiring operating room techniques except in trauma resuscitation.

1) At Northern Inyo Hospital, patients with an OB related complaint, caring a fetus above the gestational age of 20 weeks, who present to the ED with a non-life threatening emergency, will be sent to the Labor and Delivery department for medical screening.

c. Demand beyond capacity: the Emergency Department may divert non-emergent ambulances only if the diverting facility is on internal disaster.

2. Surgical Patients / Outpatient Procedures

a. Definition: Provide individualized patient care to patients requiring therapeutic procedures, elective and urgent OP surgical elective, IP surgical (pre operatively), diagnostic procedures (i.e., liver and kidney biopsy, patients).

b. Exclusions: Neonates less than 28 days of age. Patients requiring monitoring and or constant observation or assistance.

c. Demand beyond capacity: Patients will be assessed for appropriate nursing unit for direct admit or transfer. Elective procedures may be evaluated for rescheduling. Pre op appointments may be rescheduled. Surgical patients may be held in PACU pending bed availability.

3. Infusion Center

a. Definition: Provide outpatient infusion services for adult and pediatric patients
b. > 27 days. Patients requiring treatment; provide nursing care related to venous access devices; provide other (limited) outpatient infusion or injection services. Provides outpatient services for adults requiring medical oncology and/or hematology services.

c. Exclusions: TPN, continuous heparin, infusions exceeding 8 hours,

d. Demand beyond capacity: If census exceeds capacity or if patient needs services started late in the day with treatment period exceeding clinic hours; refer to approved home care agency for injection or infusion services if allowed for patient comfort and for capacity issues. Patients are prioritized according to medical needs or first available appointment.

4. Rehabilitation, Inpatient Services

a. Definition: Provide physical therapy, occupational therapy and speech-language pathology services to patients of all ages in inpatient settings.

b. Exclusions: Patients requiring therapy services in a home setting are referred to the home health agency.

c. Demand beyond capacity: Patients are triaged according to severity of needs.

B. Inpatient Services

The provision of acute inpatient care that is medically necessary for the required treatment of the patient's illness/diagnosis.

If demand exceeds capacity of the appropriate unit, consider the following:

- Place the patient at a higher level of care as an overflow patient
- Provide the appropriate level of care by assigning additional, appropriately skilled staff in an alternative setting until the appropriate level of care is available.
- The patient's physician will be responsible for making decisions for the disposition of the patient in the event both physical and staffing capacity is exceeded.

1. Medical-Surgical and/or Acute Care Unit:

   A. Definition: Acute medical or surgical condition requiring nursing intervention at least every 4-8 hours for medical/surgical level of care. Telemetry monitoring is available for adult patients. Care is also provided to pediatric patients presenting with a wide range of medical and/or surgical problems. Patients younger than 28 days of age may be admitted if both physician and unit manager are in agreement as to the appropriateness of the admission to the medical/surgical unit.

   B. Exclusions: Adult patients requiring intervention and assessment that exceeds the unit standard including but not limited to: invasive monitoring, ventilator management, medication titration. Pediatric patients that should be transferred to a tertiary pediatric care center include but are not limited to:

      a. Inadequate medical and/or nursing support to care for a sick infant/child either in numbers of staff available or experience level of staff.

      b. An infant/child who requires assisted ventilation.

      c. An infant/child with a congenital malformation or other condition requiring pediatric surgery that is beyond our capability.

      d. An infant/child with unstable heart disease requiring intensive monitoring and follow-up.

      e. An infant/child with multi-system trauma or multi-system failure.

      f. An infant/child with complex problems requiring subspecialty consultation not available at NIH

2. Intensive Care Unit (ICU)

    a. Definition: Acute cardiac, medical or surgical condition requiring nursing interventions at least every 1-2 hours, invasive hemodynamic monitoring, mechanical ventilation, cardiac monitoring in patients 13 years and older.

    b. Exclusions: Pediatric patients unless extenuating circumstances are present and agreed upon by the Medical Director of the ICU and CEO of NIHD; Patients who do not meet intensity criteria.

3. Labor & Delivery

    a. Definition: Comprehensive and individualized nursing care to pregnant women requiring antepartum management for pregnancy induced medical problems; intrapartum management for low risk obstetrical patients; and for women and their babies requiring management during the immediate post delivery recovery phase of pregnancy.

    b. Exclusions: High Risk Pregnant patients including but not limited to those requiring cardiac monitoring intracardiac invasive monitoring, ventilation, titrated cardiac/antiarrythmic medications or recovering from multi - system trauma.

4. Mother-Baby

    a. Definition: Provide individualized, family-centered care to postpartum women and their newborn infants, low-risk antepartum patients not in labor such as patients with pyelonephritis or patients requiring diabetic education.

    b. Exclusions: Postpartum patients with medical conditions requiring invasive monitoring, critical care services and/or telemetry. Patients with active TB will remain in the Labor & Delivery room in isolation with a HEPA filter throughout hospitalization.

5. Nursery

    a. Definition: Provide care to the newborn transitioning from the birth process requiring observation and stabilization for 1-2 hours post delivery; provide observation and interventions for newborns with hypoglycemia and/or Group B Strep exposure not to exceed12 hours; and provide routine newborn care for all well newborns until discharge.

    b. Exclusions: Any newborn demonstrating signs of instability post delivery, prematurity, or congenital anomalies requiring special observation and intervention will be transferred to another facility.

Title: Admission, Discharge, Transfer of Patients: Continuum of Care	
Scope: NIH	Manual: Nursing Administration Manual (NAM)
Source: CNO	Effective Date:

REFERENCES:

1. Council of the Society of Critical Care Medicine, Society of Critical Care Medicine. Guidelines on Admission and Discharge for Adult Intermediate Care Units. Critical Care Medicine 1998; 26(3):607-610.
2. Humbreet, D. & Reilly, T. A nurse managed remote telemetry model. Critical Care Nurse 2007; 27 (3):22-32.
3. Barclays official California Code of Regulations Title 22. Division 5. Licensing and Certification of Health Facilities, Home Health Agencies, Clinics, and Referral Agencies. 2013
4. California Health and Safety code sections 1262.5, 1262.6
5. State Operations Manual Appendix W. Survey protocol, Regulations and Interpretive Guidelines for Critical Access Hospitals (CAHs)and Swing beds in CAHs 165, 12-16-16

CROSS REFERENCE P&P:

1. Admission, Discharge, Transfer of Patients
2. Capacity Management Plan
3. Patient Admission Procedure to ICU
4. Newborn Discharge procedure
5. Admission Procedure of the Pediatric patient
6. Admission Procedure to the Acute/Sub Acute Department
7. Admission Procedure of the Hospice Patient
8. Admission Assessment of the Obstetrical Patient
9. Admission Procedure and Care of the Newborn
10. Patient Placement Policy
11. PACU Discharge Criteria
12. Preoperative Preparation and Teaching
13. Opening and Closing ICU and Acute/Sub Acute Departments
14. Discharge Planning for the Hospitalized Patient
15. Admission Procedure of the Emergency Room Patient to the Hospital
16. Transfer to Other Medical Facilities Maternal and Infant
17. Admission, Documentation, Assessment, Discharge, and Transfer of Swing Bed Patients

Approval	**Date**
CCOC	7/17/17
Med Services / ICU	7/27/17
Peri Peds	10/20/17
MEC	11/7/17
Board of Directors	11/15/17
Last Board of Directors Review	

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Admission, Discharge, Transfer of Patients: Continuum of Care	
Scope: NIH	Manual: Nursing Administration Manual (NAM)
Source: CNO	Effective Date:

Developed: 6/17la
Reviewed:
Revised:
Supersedes: Patient Discharge, Admission of a patient to Northern Inyo Hospital, Patient transfer/Discharge to Another Facility, Outpatient Observation (OPO) Policy, Patient Transfer Accepting a

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Nursing Care of Outpatient Interventional Radiology Patient	
Scope: OPD Nursing and Radiology	Manual: OP/PACU
Source: OPD Nurse Manager	Effective Date:

PURPOSE:
This general nursing policy outlines the procedures for monitoring, observing, assisting, medicating and supplies needed for nursing care of patients having interventional radiology procedures. The Procedural Sedation policy will be followed for any patient receiving sedation during the procedure. Each patient will receive the teaching needed to undergo the procedure, the care ordered by the Radiologist, and discharge instructions will be reviewed with and given to the patient prior to discharge.

The patient will be under the care of the Radiologist and will be monitored and cared for by an RN competent in:

- Basic arrhythmia recognition
- Airway management
- Cardiopulmonary resuscitation
- Clinical pharmacology sedative/analgesic medication used and their antagonists.
- Knowledge of the equipment utilized for patient monitoring
- ACLS certified

PRE-PROCEDURE PHONE CALL / ASSESSMENT

- Patients scheduled for an RFA or Vertebroplasty will be called by an RN to obtain information for the patient profile (including allergies and regular medications), and to give the patient information re: upcoming procedures including arrival time, check in area, and to ensure the patient has arranged for a ride home with a responsible adult after the procedure.
- Check orders to ensure any pre-procedure testing has been completed and if sedation is ordered – that Pharmacy receives a copy of the orders.
- Verify that lab results (PT, PTT, bleeding time, and any other ordered lab work) are on the chart and any abnormal values have been reported to the ordering physician

PRIOR TO PROCEDURE:

- Verify that a signed consent is on the chart
- Patient will change into a gown and a set of vital signs and a brief patient assessment should be completed by one of the Outpatient nurses when patient arrives for the procedure.
- IV catheter 22g or greater will be placed for all sedation patients.

ASSESSMENT:
The RN should complete a pre-procedure assessment with documentation on a checklist to include:

- Patient identified using 2 patient identifiers (Name and DOB)
- Physical assessment
- Allergies
- Current medications
- Baseline vital signs, including oxygen saturation and pre-procedure Aldrete Score

- Level of Consciousness, age, and weight
- Current medical problems
- Patient education needs, abilities, preferences and readiness to learn
- Pregnancy status
- Verification that a responsible adult is available to transport the outpatient home.

DOCUMENTATION:
Nursing care should be documented in the EHR. The sedation (medication administered, vital signs and assessment during the procedure) should be charted on the Outpatient Procedure/Local Anesthesia Record.

Care Guidelines for the following procedures are included below:

- **RFA**
- **Vertebroplasty**
- **Observation of the Lung or Liver Biopsy**
- **Observation Following a Myelogram**
- **Monitoring the Patient in the MRI Unit**
- **Anxiolysis in the MRI Unit**
- **VCUG: Assisting with a Voiding Cystourethrogram**

RFA: RADIOFREQUENCY ABLATION (OF MEDIAL BRANCH NERVE(S)):

These patients generally receive procedural sedation

CONTRAINDICATIONS:

1. Absolute
    - Bacterial infection: systemic or localized at the injection site
2. Relative
    - Allergy to injectants
    - NSAIDs, aspirin, or other antiplatelet agents (ex. Plavix, Coumadin, Lovenox, Gingko Biloba)
    - Hyperglycemia, adrenal suppression, immune compromise, congestive heart failure
    - Pregnancy
    - Bleeding diathesis: due to anticoagulants or hematologic disease

COMPLICATIONS: include, but not limited to:

1. Infection (cellulitis, osteomyelitis)
2. Bleeding
3. Cardiovascular (dysrhythmias, congestive heart failure, vasovagal reaction)
4. Respiratory
5. Urologic
6. Neurologic Injury (neuritis)

7. Adverse local anesthetic drug reaction
8. Adverse steroid reaction
9. Allergic reaction to non-ionic contrast

Potential post-procedural complaints include, but are not limited to:

1. Vasovagal reaction
2. Pain (injection site, radicular, corticosteroid flare)
3. Headache
4. Numbness or weakness
5. Burning/tingling in distribution of nerves adjacent to treatment area

PRE-PROCEDURE SCREENING

1. Identify food and drug allergies at the time of scheduling procedure.
2. Identify medications and compounds affecting clotting mechanisms, coordinate medication hold with referring or prescribing physician.

Medication or compound	**Days to hold before procedure**, at radiologist's discretion
Non-steroidal anti-inflammatory drugs	3 days
Coumadin (warfarin)	6 days
Ticlid	14 days
Plavix	10 days
Pletal and Trental	2 days
Persantine and Aggrenox	7 days
Heparin, Lovenox, Innohep, Fragmin, Normiflo	12 hours

PROCEDURE:

1. Radiologist to explain the procedure to the patient and answer any questions.
2. Patient signs consent form for procedure.
3. Prior to the start of a procedure, a time out should be performed (see Universal Protocol).
4. Assess the patient's pain level.
5. Place the patient prone on the c-arm table with a pillow under the pelvis, if desired. Radiologist performs the procedure.

POST PROCEDURE:

1. After the procedure assess the patient carefully when helping them off the table, observing for extremity numbness or other complications.
2. OP observation for 1 - 1.5 hours.

Title: Nursing Care of Outpatient Interventional Radiology Patient	
Scope: OPD Nursing and Radiology	Manual: OP/PACU
Source: OPD Nurse Manager	Effective Date:

VERTEBROPLASTY:

The percutaneous application of an acrylic based cement to the vertebral body for the purpose of stabilizing a fracture or other disruption of the vertebral body. These patients generally receive procedural sedation.

INDICATIONS: Acute compression fracture related to osteopenia or neoplastic replacement, ie pathologic fracture

CONTRAINDICATIONS: Spinal stenosis, traumatic fracture in young patient, very displaced fracture fragments

PATIENT PREPARATION:

1. The patient will be instructed to arrive one hour prior to the scheduled time of the procedure.
2. Following admission, the patient will go to outpatient nursing for assessment and IV insertion.
3. Medical history to include current medications, allergies and concurrent conditions will be reviewed or obtained. Lab results will be reviewed by nursing. Any lab results outside of the expected range will be reviewed with the radiologist.
4. Nursing will complete a basic physical assessment to include heart and lung status and vital signs including blood pressure, pulse, respirations and O2 saturation on room air.
5. Informed consent shall be obtained.
6. An IV will be started by nursing. An IV solution will be ordered by the radiologist and will be run at a TKO rate
7. Review of procedure and post procedure routines will be reviewed with patient. Post-procedure teaching to include recovery positioning.

PROCEDURE:

1. Patient will be taken to the restroom immediately prior to procedure.
2. Patient will be taken into prepared procedure room.
3. O2 nasal cannula will be placed on patient prior to positioning on the imaging table.
4. Technologist will position patient prone on procedure table.
5. NIBP, O2 saturation monitoring will be established by nurse.
6. Once entire procedure team is in the room, TIMEOUT shall take place. TIMEOUT will be documented per hospital policy (Universal Protocol).
7. The nurse will begin sedation as directed by radiologist in compliance with the hospital Procedural Sedation policy. Vital signs will be monitored at a minimum of every 5 minutes throughout procedure.

POST PROCEDURE:

1. Sterile dressing and Tegaderm® (or equivalent product) will be applied to bilateral needle puncture sites.
2. Patient to remain in prone position on procedure table for a minimum of 15 minutes before transfer back to recovery gurney.

3. Patient to be transferred to supine position on recovery gurney. Pillows may be placed beneath knees as needed for comfort. Patient to remain in supine position for 2 hours.
4. Vital signs to be monitored per Procedural Sedation policy then every 30 minutes X 2.
5. Patient may begin oral fluids once fully awake.
6. Head of Bed may be elevated after 2 hours as tolerated. Patient may ambulate as tolerated.
7. Patient may be discharged once 2 hours time has elapsed and patient is stable.
8. Discharge instructions to include removal of dressing, ice instead of heat and follow up appointment with radiologist in 2 weeks.
9. If vital signs are significantly different than baseline or if there is excessive drainage on dressings, notify radiologist prior to discharge.

OBSERVATION OF THE OUTPATIENT LUNG OR LIVER BIOPSY

The "Procedural Sedation" policy will be followed if sedation is needed during the biopsy.

EQUIPMENT: Patient monitor.

PRECAUTIONS:

1. Potential for pneumothorax with a lung biopsy.
2. Potential for bleeding with a liver biopsy, although risk is lower with use of CT imaging.
3. Patient may have diet as ordered.
4. Observe patient for signs/symptoms pneumothorax (shortness of breath, tachypnea, pain, low SPO_2) or bleeding (hypotension, tachycardia, weakness, dizziness).
5. Patients may be up to the bathroom if stable after the 1st hour of observation (unless otherwise ordered by the Radiologist).
6. Patients may be discharged per the radiologist's order.

OBSERVATION FOLLOWING A MYELOGRAM:

To establish observation guidelines for patients who have had a myelogram in radiology. These patients do not usually require procedural sedation.

EQUIPMENT: Equipment to monitor vital signs and fluids for the patient to drink (after the procedure) should be available.

PRECAUTIONS:

- Headache, agitation, change in mental acuity, and seizure activity should be reported to the radiologist immediately.
- The patient should have head up upon arrival to the OPD, and throughout observation as ordered by the radiologist.
- The patient should start drinking fluids on arrival through the observation and after discharge (at home). This helps to dilute the contrast medium and decrease the likelihood of seizure activity.

Post-Procedure:

1. After the myelogram the patient will be brought to the Outpatient Unit via stretcher by a Radiology Technician. The Outpatient nurse should position the patient with the head of bed or gurney up 45 degrees or as ordered by the radiologist.
2. The patient should start drinking fluids. Check with the patient for preferences. A lunch may be ordered for the patient if okay with the Radiologist.
3. Vital signs should be taken on arrival and every hour unless needed more frequently.
4. Observe patient for CNS changes (headache, agitation, change in mental acuity, and seizure activity).
5. Patient can get up to the bathroom after one hour.
6. The Radiologist should be called if the patient needs an analgesic (or any other medication).
7. Patient can be discharged per the radiologist's order.

MONITORING THE PATIENT IN THE MRI UNIT:

All patients that receive IV sedation will be monitored in accordance with the "Procedural Sedation" policy; this policy establishes frequency and type of patient information that must be monitored and documented. In addition the Radiologist or attending physician may ask that a patient be monitored during an MRI due to patient condition.

SPECIALTY EQUIPMENT:

1. MRI compatible monitor (kept in MRI unit)
2. Abrasive prep gel and 4x4 gauze, razor if necessary
3. Quadtrode EKG lead
4. Cannula (divided between prongs for monitoring end tidal CO2 and administering O2 if needed). The monitor ascertains a respiratory rate from the end tidal CO2; this is the only means of obtaining a respiratory rate on this monitor.
5. Medication as ordered for sedation and /or analgesia, syringes, alcohol swabs
6. Oxygen is in the MRI unit – check tank for level
7. Ambu bag is kept in the MRI unit – check before starting procedure
8. Crash Cart (CT room)

PROCEDURE:

1. Check physician orders for sedation / analgesia.
2. Gather supplies and medications. Check with MRI Tech to ensure oxygen tank and patient monitor as well as any other equipment / supplies needed in the actual room with the magnet are MRI compatible (non-ferrous)
3. Check all emergency supplies before starting procedure (as mentioned above): oxygen, ambu bag, reversal agents etc..
4. Alert nursing supervisor that a scan with sedation will be started. The Radiology crash cart (located in the CT hallway) must be available.
5. Explain the procedure to the patient. Make sure the patient has signed a consent for the sedation and a questionnaire for the MRI.

6. Make sure that all NPO instructions have been followed for any elective sedation procedure (see the "Procedural Sedation" policy).
7. If the patient is an outpatient make sure the patient has a responsible adult available to drive the patient home; the patient should know that he/she is not to drive for 24 hours after sedation.
8. Check that all old EKG leads and any other metal object has been removed from the patient; there is a place in the control room for patient valuables.
9. Establish IV access if needed. (This can be done before the patient enters the magnet room.)
10. Prep skin and apply EKG lead:
    - Shave area above heart if needed - about 4 inches high and wide
    - Apply skin prep gel and rub into skin briskly
    - Wipe off excess with a gauze pad
11. Apply Quadtrode EKG electrode pad as shown on package.
12. Connect electrode impedence monitor with the standard 3 leads (white- right arm, red- left leg and black- left arm). Check level of impedence. A green light means a safe level; anything 6K or less is a safe level. If not check that the EKG electrode pad is firmly adhered to the skin. A pad that has dried out will not have sufficient gel to reduce impedence; reprep skin and attach new electrode checking that the gel pad is still moist. Recheck with the impedence monitor.
13. Make sure that EKG cable extends down through the patients' legs and that there are no loops in the cable. For a scan in which the patient will enter the bore of the magnet feet first, put the leads on upside down and have the cable extend over the shoulder. Make sure that the patient is protected from cable heat by a layer of material under the cable.
14. Apply appropriately sized NIBP cuff.
15. Apply nasal cannula; this is necessary to obtain a respiratory rate as the respiratory rate is not obtained off of the EKG leads as it is on other monitors.
16. Apply SPO2 probe.
17. Apply oxygen if needed from the non-ferrous O2 cylinder in the magnet room.
18. Ensure the patient's comfort and establish mechanism for the patient to signal if he/she needs anything during the scanning. There is a microphone into the magnet room so the radiology tech., nurse, or doctor can communicate with the patient.
19. Set up parameters on the display monitor at the control room desk. Select a pre-programmed "monitoring package" or select individual options with the touch pads and dial.
20. Follow the "Procedural Sedation" policy for monitoring guidelines.

ANXIOLYSIS IN THE MRI UNIT:

Minimal Sedation (anxiolysis) in the MRI in order that the patient can tolerate being in the MRI machine.Adult patients may receive Versed 0.5mg IV over one minute, repeated every 2 minutes as needed for relaxation to a MAXIMUM dose of 4mg as ordered by the Radiologist.

If a patient needs pain medication in order to complete the testing, the Radiologist may order pain medication addition to the anxiolytic after assessing the patient. The pain will be assessed /

documented using a valid pain scale and treatment of the pain will be addressed thoroughly as an issue separate from the need for anxiolysis.

PROCEDURE:
IV Access: saline lock or running IV will be started prior to the patient entering the MRI unit.

Equipment / Supplies

- Equipment available which includes: crash cart with defibrillator, oxygen, suction, bag-valve mask, cardiac monitor, pulse oximetry, B/P monitor.
- Medication: Versed as ordered and saline for flushing IV.
- Reversal agents romazicon (Flumazenil) and naloxone (Narcan) should be available.
- Monitoring: Use the MRI compatible monitor (kept in the MRI unit).

During the MRI, the RN will monitor the patient for:

- SpO2
- Respiratory rate
- Heart rate
- Blood Pressure
- EKG if patient has a significant cardiac history or at the discretion of the radiologist or monitoring RN

The Radiologist will be notified if the patient has:

- Respiratory rate <10
- SpO2 <90%
- Heart rate or blood pressure change of 20% from baseline heart rate or blood pressure

Discharge:
The patient may be discharged home 45 minutes after the last Versed dose was administered, as long as the discharge criteria from the Procedural Sedation policy has been met, and the patient has a responsible adult to drive him/her home.

VCUG: ASSISTING WITH A VOIDING CYSTOURETHROGRAM

The nurse inserts the catheter for this procedure. If sedation is required follow Procedural Sedation policy.

EQUIPMENT:

1. VCUG tray: Obtain from the outpatient department. Ensure the normal saline is not outdated and that the proper size catheter is in the tray (you may need to use a small feeding tube depending on the size of the child).
2. Prep solution (iodine povidine or Techni-Care)

PRECAUTIONS:

Title: Nursing Care of Outpatient Interventional Radiology Patient	
Scope: OPD Nursing and Radiology	Manual: OP/PACU
Source: OPD Nurse Manager	Effective Date:

1. Chlorhexidine has not been approved for mucous membrane prep. Use an iodine povidine (Betadine) solution; if there is an allergy use a Techni-Care solution.
2. Consider explaining procedure to parents before entering the radiology room so the parent can be supportive once the procedure has started. Also consider the use of a doll for teaching a child that is between the ages of 3 - 7, and / or distracting child with a toy – a donated stuffed animal from the ER supply might be used.

PROCEDURE:

1. Gather equipment (see above) and take it to Radiology when called that the patient is ready to be catheterized.
2. Explain procedure to patient (parent if applicable). Obtain written consent from patient or parent and check for patient allergies.
3. Wash perineal area per catheterization policy and catheterize patient using aseptic technique, if patient >1yr of age: fill balloon on catheter for patients < 1 yr. of age – consider taping catheter to hold in place instead of inflating balloon.
4. Connect catheter to contrast fluid tubing and infuse contrast material.
5. Stop infusion when patient begins to wiggle their feet and legs which indicates bladder is full enough. X-ray technician will obtain x-ray to confirm a full bladder and take X-Rays while the patient empties his/her bladder.
6. Deflate catheter balloon with a syringe if applicable and remove catheter. The X-ray technician then resumes responsibility for patient.

REFERENCE:

1. Procedural Sedation policy

Approval	**Date**
CCOC	7/17/17
Radiology	10/20/17
MEC	11/7/17
Board of Directors	11/15/17
Last Board of Directors Review	

Developed: 7/17
Reviewed:
Revised:
Supersedes: Observation Following a Myelogram, Observation of the Lung or Liver Biopsy Outpatient, Monitoring the Patient in the MRI Unit, Anxiolysis in the MRI Unit,
VCUG: Assisting with a Voiding Cystourethrogram
Index Listings: Nursing Care of the Outpatient Interventional Radiology Patient, Radiofrequency Ablation, Vertebroplasty, Observation of the Lung or Liver Biopsy, Observation Following a Myelogram, Monitoring the Patient in the MRI Unit, Anxiolysis in the MRI Unit, VCUG: Assisting with a Voiding Cystourethrogram

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Contrast Use with Patients on Metformin	
Scope: Diagnostic Imaging	Manual: Diagnostic Imaging
Source: Operations – Director of Diagnostic Services (DI & Lab)	Effective Date:

PURPOSE: To establish criteria for appropriate use of contrast material for patients currently being prescribed Metformin.

POLICY:
Guidelines regarding iodinated IV contrast and Metformin:

1. Patients with normal renal function can recieve full dose contrast.

2. In patients with **no evidence of AKI and with eGFR ≥30** there is no need to discontinue metformin either prior to or following the intravenous administration of iodinated contrast media, nor is there an obligatory need to reassess the patient's renal function following the test or procedure.

3. In patients taking metformin who are known to have acute kidney injury or severe chronic kidney disease (stage IV or stage V; i.e., eGFR< 30), or are undergoing arterial catheter studies that might result in emboli (atheromatous or other) to the renal arteries, metformin should be temporarily discontinued at the time of or prior to the procedure, and withheld for 48 hours subsequent to the procedure and reinstituted only after renal function has been re-evaluated and found to be normal.

Guidelines regarding Gadolinium based contrast and Metformin:

1. No need to discontinue metformin prior to contrast medium administration when the amount of gadolinium-based contrast material administered is in the usual dose range of 0.1 to 0.3 mmol per kg of body weight.

REFERENCES:
1. Adopted from ACR Manual on Contrast Media– Version 10.3 / May 31, 2017

CROSS REFERENCE P&P:

Approval	**Date**
Department of Radiology	9/12/17
Pharmacy and Therapeutics Committee	10/19/17
Medical Executive Committee	11/7/17
Board of Directors	11/15/17
Last Board of Directors Review	

Developed: 8/17
Reviewed:
Revised:
Supersedes:
Index Listings:

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Order Set Approval*	
Scope: Medical Staff, Clinical Informatics	Manual: Medical Staff
Source: Chief of Staff	Effective Date: ~~12/1/16~~

PURPOSE:

The purpose of this policy is to define the process in which hospital order sets are requested, defined, created, ~~and~~ approved for use, and archived when no longer in use.

POLICY:

1. Before an order set can be created and implemented for use in Computerized Physician Order Entry (CPOE) and as a ~~paper~~ paper-based downtime form, it must be approved by Medical Staff in conjunction with Pharmacy and Nursing.
~~1.~~2. In order to provide the best care and standards of practice for our patients, it is imperative that prescribing physicians have a framework that is consistent with nationally recognized and evidence-based guidelines. The framework should allow for consensus among prescribing physicians within a group, yet maintain options that can be tailored to the individual needs of each patient.
~~2.~~3. Order set champions drive the process of order set approval, but should:
    a. Seek the input of the prescribing physicians for order content;
    b. Consult with pharmacy to ensure all medications comply with dosing recommendations based on current ~~evidenced~~ evidence-based guidelines; and
    c. Consult with nursing leadership for related nursing care and order communication as appropriate.
4. Order sets may receive approval by proxy or by the associated medical group's committee.
~~3.~~5. Order sets may be archived when it is identified as no longer relevant or in use.

DEFINITIONS:

1. *Order set*: a list of individually selectable interventions that an ordering practitioner may choose from. For the purpose of this policy, the term "order set" encompasses any physician order set, standing order, or protocol. Standing orders are orders that may be initiated without an initial order if certain criteria are met; and protocols are initiated if certain criteria are met, but there must be an order to initiate.

2. *Order set champion* – The physician, pharmacist, or nurse who is responsible for facilitating the review by the end-user of order set content and ensures the order set flows through the appropriate procedure for approval and implementation. The order set champion will also need to ensure that substantiating documentation has been included (e.g. clinical trial data, national guidelines, and professional/regulatory/accreditation standards, etc.) with the proposed content and is available to end-user reviewers and/or associated medical committees.

PROCEDURE:

1. Need for new order set or change to existing order set is identified.
    a. Identify an order set champion who will be responsible for ensuring that the order set/change requests follows procedure and that substantiating documentation has been collected and is readily available.
    b. Clinical Informatics may be contacted to research content and provide examples of evidenced based diagnosis or symptoms specific order sets. Clinical Informatics can also compile prescriber recommendations and/or evidence based orders into a draft on request.

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NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Order Set Approval*	
Scope: Medical Staff, Clinical Informatics	Manual: Medical Staff
Source: Chief of Staff	Effective Date: ~~12/1/16~~

c. Consensus will be needed for any additions or changes by the end-user group of prescribers. Reviewer comments and approval may be done by proxy. Representatives from Pharmacy, Nursing, and Ancillary departments should be consulted, as appropriate, to provide the necessary feedback. Alternatively, ~~Order~~ order sets may be reviewed/approved by the associated medical staff committee.
d. Order set content may then be released to Clinical Informatics for final development and implementation, including any required end-user education.
e. The Pharmacy and Therapeutics Committee will review order sets annually and will identify order set champion(s) and provide substantiating documentation, as needed, to facilitate any proposed changes following content review.

2. Need for archiving an order set is identified.
   a. When an order set is identified as no longer relevant or in use after consultation with the potentially affected parties, the proposal for archiving an order set will be reviewed and approved by the Pharmacy and Therapeutics Committee.

~~1.~~

REFERENCES:

1. Institute for Safe Medication Practices. (2010). *Guidelines for Safe Medication Practices.* Retrieved September 28, 2016 from http://www.ismp.org/tools/guidelines/standardordersets.pdf
2. Calloway, Sue Dill RN, Esq., CPHRM, CCMSCP . (2015). PowerPoint Presentation: *CMS Hospital CoPs on Standing Orders, Protocols, Order Sets, & Preprinted Orders: What Hospitals Need to Know*. November 9, 2015.

Approval	Date
Pharmacy and Therapeutics Committee	10/19/2017
Medical Executive Committee	11/07/2017
Board of Directors	11/15/2017
Last Board of Directors Review	08/20/2017

Developed: 09/2016
Reviewed:
Revised: 10/2017 dp
~~Supercedes~~Supersedes: Orderset Approval Policy
Index Listings: order set approval, order set archiving

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Cosyntropin Stimulation Test	
Scope: Laboratory, Outpatient Nursing	Manual: CPM - Diagnostic Test and Lab Test (DLT)
Source: DON Perioperative Services	Effective Date: 07/27/05

PURPOSE: To outline a policy and procedure that nursing can follow to complete a test for an ACTH stimulating test (cosyntropin stimulation test for primary adrenal insufficiency).

- The physician will need to order the ACTH stimulating test on an Outpatient order form or other physician orders as this is a nursing procedure, not simply a lab test.
- Standard ACTH involves testing for Cortisol. Aldosterone is not typically included. If the physician wants Aldosterone levels measured at the same time, it must be ordered in addition to the ACTH stimulating test.
- Blood may be drawn from the saline lock (see policy/procedure ~~on this~~for blood draw through saline lock) but there is risk for the sample to be hemol~~y~~ized so it is best to have the phlebotomist draw the samples via venapuncture.

EQUIPMENT:
- Saline lock supplies
- Normal saline (several 10ml PFNS prefilled syringes)
- Cosyntropin – from Pharmacy
- Syringes

PROCEDURE:
1. Patient should be fasting for 4 hours (water is ok) prior to the test.
2. Notify lab.
3. Complete brief nursing assessment in the Ambulatory Nursing tab in Paragon.
4. Start saline lock.
5. Direct Laboratory phlebotomist to draw baseline Cortisol.
6. Reconstitute Cosyntropin with ~~2-5ml~~1mL NS. Administer 250mcg of cosyntropin IV over 2 minutes. Flush saline lock with NS.
7. Laboratory phlebotomist should draw for Cortisol at 60 minutes after the administration of the Cosyntropin or as ordered by the physician.
8. Discontinue saline lock when test is complete.
9. Discharge patient to home when vital signs are stable.

ADVERSE REACTIONS: Adverse reaction may include: formation of wheal or erythema at injection site, bradycardia, tachycardia, hypertension, peripheral edema, or rash, or rarely – anaphylactic reaction

REFERENCES: LabCorp test: 140761

APPROVED	**DATE**
CCOC	5/22/17
Medical Services/ICU Committee	10/26/17
MEC	11/7/17
Board of Directors	
Last Board of Director review	

Initiated: 3/95
Revised: 7/28/05. 4/26/06, 6/1/06, 4/10, 5/10, 10/10 AW, 5/17AW
Reviewed: 05/11AW, 09/12 AW, 6/16 AW

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Cosyntropin Stimulation Test	
Scope: Laboratory, Outpatient Nursing	Manual: CPM - Diagnostic Test and Lab Test (DLT)
Source: DON Perioperative Services	Effective Date: 07/27/05

Index Listings: Cosyntropin Stimulation Test; ACTH Stimulation Test; Cortrosyn Test; Adrenal Insufficiency Test

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Nursing Services Standing Committee Structure and Hospital Committee Participation	
Scope: Nursing Services	Manual: 1. NAM - Administration/Organization of Nursing Services
Source: CNO	Effective Date:

PURPOSE:

1. Standing committees are permanently established within Nursing Services to make decisions or handle problems related to a specific function. Concerns addressed by standing committee are those that need continual monitoring over the life time of the hospital.

POLICY:

1. Members of Nursing Service hold positions in a variety of standing committees including Hospital Administration, Medical Staff, ancillary Services, Nursing Services, Support Services and the Community.
2. Nursing Services participates in a variety of non-routine meetings that include Task Force and PI Teams.
3. Monthly meetings are held by Nursing Management in each department with staff (direct reports).
4. Nursing Services committees are evaluated for structure and function via review of the following questions:
    a. Does the committee fill a vital need that is not within the scope of any other committee? Does the committee continue to meet the purpose for existing? Are committee goals set for accomplishment?
    b. Are there adequate (too few or too many) committees to enable Nursing Services to reach its goals? Are there any obvious omissions? Is staff involved in committee decision-making when appropriate?
    c. Are the purpose statements of the committee consistent with the Mission/Vision Philosophy of Nursing Services?
    d. Is the total number of committees and membership logical for the size of Nursing Services and the established objectives of annual goals?

PROCEDURE:

1. Nursing Services members actively participate in the following Nursing Services, Hospital Administration, Medical Staff, Ancillary Services, Support Services, and Community Committees.
    a. Nursing Services Committees (see attached purpose, etc)
        i. Nursing Executive Committee
        ii. Shared Governance Central Council
            1. Orientation Competency Committee
            2. Staffing Issues Advisory Committee
            3. Professional Practice Committee
            4. Clerk/Tech Council
        iii. Safe Patient Handling
        iv. Clinical Consistency Oversight Committee
        v. Staffing Huddle
    b. Hospital Administration
        i. Senior Leadership
        ii. Department Heads Committee
        iii. Resuscitation Committee/Emergency Management/End of Life Committee
        iv. Safety Committee
        v. Data Integrity Meeting
        vi. Workforce Experience Committee
        vii. Patient Experience Committee
    c. Medical Staff Committees
        i. Medical Executive Committee
        ii. Quality Improvement and Library/Medical Education Committee
        iii. Pharmacy & Therapeutics Committee
        iv. Infection Control Committee

Title: Nursing Services Standing Committee Structure and Hospital Committee Participation	
Scope: Nursing Services	Manual: 1. NAM - Administration/Organization of Nursing Services
Source: CNO	Effective Date:

v. Emergency Services Committee
vi. Perinatal/Pediatrics Committee
vii. Medical Services/ICU Committee
viii. Utilization Review and Medical Records Committee
ix. Interdisciplinary Practice Meeting
x. Surgery, Tissue, Transfusion and Anesthesia Committee

d. Ancillary Services
   i. Radiation Safety Committee
   ii. Medication (MAIC)

Nursing Services Staff participation on committees must be approved by the person's manager.

REFERENCES:

1. CAMCAH 2016 of TJC Standard NR.01.01.01- EP #4.

CROSS REFERENCE P&P:

1. Medical Staff Rules & Regulations

Approval	**Date**
NEC	**10/18/17**
MEC	**11/7/17**
Board	**11/15/17**

Developed: 6/2013
Reviewed:
Revised: 1/15, 2/2017ta
Supercedes:

Responsibility for review and maintenance:
Index Listings:

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: EMTALA Policy	
Scope: ED & Perinatal	Manual: CPM – Admission, Discharge, Transfer (ADT)
Source: ED & Disaster Nurse Manager	Effective Date:

PURPOSE:
To establish guidelines for providing appropriate medical screening examinations ("MSE") and any necessary stabilizing treatment or an appropriate transfer for the individual as required by EMTALA, 42 U.S.C. § 1395dd, and all Federal regulations and interpretive guidelines promulgated thereunder.

POLICY:
An EMTALA obligation is triggered when an individual comes to a dedicated emergency department ("DED") and:

1. the individual or a representative acting on the individual's behalf requests an examination or treatment for a medical condition; or
2. a prudent layperson observer would conclude from the individual's appearance or behavior that the individual needs an examination or treatment of a medical condition.

Such obligation is further extended to those individuals presenting elsewhere on hospital property requesting examination or treatment for an emergency medical condition ("EMC"). Further, if a prudent layperson observer would believe that the individual is experiencing an EMC, then an appropriate MSE, within the capabilities of the hospital's DED (including ancillary services routinely available and the availability of on-call physicians), shall be performed. The MSE must be completed by an individual (i) qualified to perform such an examination to determine whether an EMC exists, or (ii) with respect to a pregnant woman having contractions, whether the woman is in labor and whether the treatment requested is explicitly for an EMC. If an EMC is determined to exist, the individual will be provided necessary stabilizing treatment, within the capacity and capability of the facility, or an appropriate transfer as defined by and required by EMTALA. Stabilization treatment shall be applied in a non-discriminatory manner (*e.g.*, no different level of care because of an individual's race, color, ethnicity, religion, ancestry, national origin, citizenship, age, sex, marital status, sexual orientation (including gender identification), genetic information, preexisting medical condition, physical or mental disability, insurance status, economic status, ability to pay for medical services or any other category protected by law, except to the extent that a circumstance such as age, sex, preexisting medical condition, or physical or mental disability is medically significant to the provision of appropriate medical care to the patient).

PROCEDURE:
1. **When an MSE is Required**

   A hospital must provide an appropriate MSE within the capability of the hospital's emergency department, including ancillary services routinely available to the DED, to determine whether or not an EMC exists: (i) to any individual, including a pregnant woman having contractions, who requests such an examination; (ii) an individual who has such a request made on his or her behalf; or (iii) an individual whom a prudent layperson observer would conclude from the individual's appearance or behavior needs an MSE. An MSE shall be provided to determine whether or not the individual is experiencing an EMC or a pregnant woman is in labor. An MSE is required when:

a. The individual ***comes to a DED*** of a hospital and a request is made by the individual or on the individual's behalf for examination or treatment for a medical condition, including where:
   i. The individual requests medication to resolve or provide stabilizing treatment for a medical condition.
   ii. The individual arrives as a transfer from another hospital or health care facility. Upon arrival of a transfer, a physician or qualified medical person ("QMP") must perform an appropriate MSE. The physician or QMP shall provide any additional screening and treatment required to stabilize the EMC. The MSE of the individual must be documented. This type of screening cannot be performed by the triage nurse. If an EMC is determined to exist and the hospital admits the individual as an inpatient for further treatment, the hospital's obligation under EMTALA ceases.

   Note: The MSE and other emergency services need not be provided in a location specifically identified as a DED. The hospital may use areas to deliver emergency services that are also used for other inpatient or outpatient services. MSEs or stabilization may require ancillary services available only in areas or facilities of the hospital outside of the DED.

b. The individual arrives on the ***hospital property other than a DED*** and makes a request or another makes a request on the individual's behalf for examination or treatment for an EMC.
   i. Screening where the individual presented: If an individual is initially screened in a department or location on-campus other than the DED, the individual may be moved to another hospital department or facility on-campus to receive further screening or stabilizing treatment without such movement being a transfer. The hospital shall not move the individual to an off-campus facility or department (such as an urgent care center or satellite clinic) for an MSE.
   ii. Transporting to the DED: The hospital may determine that movement of an individual to the hospital's DED may be necessary for screening. However, common sense and individual judgment should prevail. When determining how best to transport the individual to the DED (means of transport, accompanying qualified personnel, equipment, etc.), the following factors should be taken into account but shall not be determinative:
      - *Whether the hospital DED has the personnel and resources necessary to render adequate medical treatment to all existing patients in the DED,*
      - *Whether responding to the emergency could send hospital personnel into harm's way or unreasonably endanger or jeopardize the lives or health of such personnel, and*
      - *Whether non-hospital paramedics, emergency medical technicians, or other qualified personnel are more appropriate to respond.*
   iii. Transporting to other hospital property: The facility may direct individuals to other hospital-based facilities that are on hospital property and operated under the hospital's provider number. However, the hospital should not move an individual to a hospital-based facility located off-campus, such as a rural health clinic or physician

office, for an MSE or other emergency services. Individuals should only be moved to the hospital-based on-campus facility when the following conditions are met:

- all persons with the same medical condition are moved to this location regardless of their ability to pay for treatment,
- there is a bona fide medical reason to move the individual, and
- QMP accompany the individual.

Note: Unless outpatient testing is associated with an individual presenting to the DED with a request for an emergency medical screening, it should not be performed in the emergency department. Individuals presenting for outpatient testing should be registered as outpatients and not as emergency patients.

Note: Anyone may make the request for an MSE or treatment described in both a. and b. above. Specifically,

- A minor (child) can request an examination or treatment for an EMC. Hospital personnel should not delay the MSE by waiting for parental consent. If, after screening the minor, it is determined that no EMC is present, the staff may wait for parental consent before proceeding with further examination and treatment. **Note:** For additional information regarding treatment of minors, please consult your operations counsel.
- Emergency Medical Services (EMS) personnel may request an evaluation or treatment on an individual's behalf.

  Example: If an individual is on a gurney or stretcher or in an ambulance or on a helipad at the hospital and EMS personnel, the individual, or a legally responsible person acting on the individual's behalf, requests examination or treatment of an EMC from hospital staff, an MSE must be provided.

c. The individual arrives ***on the hospital property***, either in the DED or property other than the DED, ***and no request is made*** for evaluation or treatment, but the appearance or behavior of the individual would cause a prudent layperson observer to believe that the individual needed such examination or treatment.

d. An individual is in a ***ground or air ambulance*** for purposes of examination and treatment for a medical condition at a hospital's DED, and the ambulance is either:
   i. *owned and operated by the hospital*, even if the ambulance is not on hospital grounds, or
   ii. neither owned nor operated by the hospital, but *on hospital property*.

e. A ***community-wide plan*** exists for specific hospitals to treat certain EMCs (*e.g.*, psychiatric, trauma, physical or sexual abuse). Prior to transferring the individual to the community plan hospital, an MSE must be performed and any necessary stabilizing treatment rendered.

f. If a ***law enforcement official*** requests hospital emergency personnel to provide ***medical clearance*** for incarceration, the Hospital has an EMTALA obligation to provide an MSE

to determine if an EMC exists. If an EMC is found to exist and is stabilized, the Hospital has met its EMTALA obligations and additional requests for assessment or testing are not required. All facilities must remain in compliance with federal and state HIPAA regulations.

g. If a ***law enforcement official*** brings a person who is exhibiting behavior that suggests that he or she is intoxicated to the DED for ***drawing of the blood alcohol*** and asks for an MSE, or if a prudent layperson observer would believe that the individual needed examination or treatment for a possible EMC, then an MSE must be performed. This is required because some medical conditions could present behaviors similar to those of an inebriated individual.

h. If an individual presents to a facility which does not have the capability to perform a rape kit when one is needed, the hospital's obligation is to provide an appropriate MSE without disturbing the evidence and transfer the individual to a hospital that has the capability to gather the evidence. Transfer must occur only in compliance with hospital policies and procedures that are Medicare Hospital Conditions of Participation (CoP) and licensure compliant.

i. ***Born Alive Infant***. When an infant is born alive in the DED, if a request is made on the infant's behalf for screening for a medical condition or if a prudent layperson would conclude based on the infant's appearance or behavior that the infant needed examination or treatment for a medical condition, the hospital and physician must provide an MSE. If the infant is born alive elsewhere on the hospital's campus and a prudent layperson observer would conclude based on the born alive infant's appearance or behavior that the infant was suffering from an EMC, the hospital and medical staff must perform an MSE to determine whether or not an EMC exists. If an EMC exists, the hospital must provide for stabilizing treatment or an appropriate transfer.

iii. The individual requests medication to resolve or provide stabilizing treatment for a medical condition.
iv. The individual arrives as a transfer from another hospital or health care facility. Upon arrival of a transfer, a physician or qualified medical person ("QMP") must perform an appropriate MSE. The physician or QMP shall provide any additional screening and treatment required to stabilize the EMC. The MSE of the individual must be documented. This type of screening cannot be performed by the triage nurse. If an EMC is determined to exist and the hospital admits the individual as an inpatient for further treatment, the hospital's obligation under EMTALA ceases.

Note: The MSE and other emergency services need not be provided in a location specifically identified as a DED. The hospital may use areas to deliver emergency services that are also used for other inpatient or outpatient services. MSEs or stabilization may require ancillary services available only in areas or facilities of the hospital outside of the DED.

2. **Extent of the MSE**

   a. **Determine if an EMC exists.** The hospital must perform an MSE to determine if an EMC exists. It is not appropriate to merely "log in" or triage an individual with a medical condition and not provide an MSE. Triage is not equivalent to an MSE. Triage entails the clinical assessment of the individual's presenting signs and symptoms at the time of arrival at the hospital in order to prioritize when the individual will be screened by a physician or other QMP.

   b. **Definition of MSE.** An MSE is the process required to reach, with reasonable clinical confidence, the point at which it can be determined whether the individual has an EMC or not. It is not an isolated event. The MSE must be appropriate to the individual's presenting signs and symptoms and the capability and capacity of the hospital.

   c. **An on-going process.** The individual shall be continuously monitored according to the individual's needs until it is determined whether or not the individual has an EMC, and if he or she does, until he or she is stabilized or appropriately admitted or transferred. The medical record shall reflect the amount and extent of monitoring that was provided prior to the completion of the MSE and until discharge or transfer.

   d. **Judgment of physician or QMP.** The extent of the necessary examination to determine whether an EMC exists is generally within the judgment and discretion of the physician or other QMP performing the examination function according to algorithms or protocols established and approved by the medical staff and governing board.

   e. **Extent of MSE varies by presenting symptoms.** The MSE may vary depending on the individual's signs and symptoms:
      i. Depending on the individual's presenting symptoms, an appropriate MSE can involve a wide spectrum of actions, ranging from a simple process involving only a brief history and physical examination to a complex process that also involves performing ancillary studies and procedures such as (but not limited to) lumbar punctures, clinical laboratory tests, CT scans and other diagnostic tests and procedures.
      ii. *Pregnant Women:* The medical records should show evidence that the screening examination includes, at a minimum, ~~on-going~~ evaluation of fetal heart tones, regularity and duration of uterine contractions, fetal position and station, cervical dilation, and status of membranes (*i.e.*, ruptured, leaking and intact), to document whether or not the woman is in labor. A woman experiencing contractions is in true labor unless a physician, certified nurse-midwife or other QMP acting within his or her scope of practice as defined by the hospital's medical staff bylaws and State medical practice acts, certifies ~~in writing~~ that after a reasonable time of observation, the woman is ~~in false labor~~not in labor. The recommended timeframe for such physician certification of the QMP's determination of false labor should be within 24 hours of the MSE, however, the medical staff bylaws, rules and regulations can provide guidance on the timeframe.

iii. *Individuals with psychiatric or behavioral symptoms:* The medical records should indicate both medical and psychiatric or behavioral components of the MSE. The MSE for psychiatric purposes is to determine if the psychiatric symptoms have a physiologic etiology. The psychiatric MSE includes an assessment of suicidal or homicidal thoughts or gestures that indicates danger to self or others, and, as applicable, an assessment of the patient's inability to provide or utilize food, shelter, or clothing due to a mental disorder.

Non-discrimination. The hospital must provide an MSE and necessary stabilizing treatment to any individual regardless of an individual's race, color, ethnicity, religion, ancestry, national origin, citizenship, age, sex, marital status, sexual orientation (including gender identification), genetic information, preexisting medical condition, physical or mental disability, insurance status, economic status, ability to pay for medical services or any other category protected by law, except to the extent that a circumstance such as age, sex, preexisting medical condition, or physical or mental disability is medically significant to the provision of appropriate medical care to the patient.

3. **Who May Perform the MSE**

a. Only the following individuals may perform an MSE:
   i. A qualified physician with appropriate privileges;
   ii. Other qualified licensed independent practitioner (LIP) with appropriate competencies and privileges; or
   iii. A qualified staff member who:
      - is qualified to conduct such an examination through appropriate privileging and demonstrated competencies;
      - is functioning within the scope of his or her license and in compliance with state law and applicable practice acts (*e.g.*, Medical or Nurse Practice Acts);
      - is performing the screening examination based on medical staff approved guidelines, protocols or algorithms; and
      - is approved by the facility's governing board as set forth in a document such as the hospital bylaws or medical staff rules and regulations, which document has been approved by the facility's governing body and medical staff. It is not acceptable for the facility to allow informal personnel appointments that could change frequently.

b. **Qualified Medical Personnel.** QMPs may perform an MSE if licensed and certified, operating under the supervision of a physician, approved by the hospital's governing board through the hospital's by-laws, and only if the scope of the EMC is within the individual's scope of practice.

   i. The designation of QMP is set forth in a document approved by the governing body of the hospital. Each individual QMP approved to provide an MSE under EMTALA must be appropriately credentialed and must meet the requirements for annual evaluations set forth in the protocol agreements with physicians and the State's

medical practice act, nurse practice act or other similar practice acts established to govern health care practitioners. Only appropriately credentialed APRNs, PAs and physicians may perform MSEs in the DED.

ii. **Psychiatric QMP.** The ED physician shall consult the QMP providing the behavioral assessment for psychiatric purposes but shall remain the primary decision-maker with regard to transfer and discharge of the individual presenting to the DED with psychiatric or behavioral emergencies. Should an individual with a psychiatric or behavioral emergency present to a behavioral department of a hospital that meets the requirements of a DED, that department is responsible for ensuring that the individual has the appropriate MSE, including any behavioral examination, and providing necessary stabilizing treatment.

iii. **Labor and Delivery QMP.** QMPs in the labor and delivery DED may be appropriately-approved RNs and must communicate their findings as to whether or not a woman is in labor to the obstetrician, CNM, or other MD on call~~, the laborist;,~~ or the ED physician.

iv. **Limitations.** The hospital has established a process to ensure that:
   a) a physician examines all individuals whose conditions or symptoms require physician examination;
   b) an ED physician on duty is responsible for the general care of all individuals presenting themselves to the emergency department; and
   c) the responsibility remains with the ED physician until the individual's private physician or an on-call specialist assumes that responsibility, or the individual is discharged.

4. **No Delay in Medical Screening or Examination**

a. **Reasonable Registration Process.** An MSE, stabilizing treatment, or appropriate transfer will not be delayed to inquire about the individual's method of payment or insurance status, or conditioned on an individual's completion of a financial responsibility form, an advance beneficiary notification form, or payment of a co-payment for any services rendered. The facility must render emergency services and care without first questioning the patient or any other person as to his or her ability to pay therefor. The patient or his/her legally responsible relative or guardian are required to provide insurance or credit information, or sign an agreement to pay, promptly after the services are rendered. The hospital may seek non-payment information from the individual's health plan about the individual, such as medical history. In the case of an individual with an EMC, once the hospital has conducted the MSE and has initiated stabilizing treatment, it may seek authorization for all services from the plan as long as doing so does not delay completion of the stabilizing treatment.

b. **Managed Care.** For individuals who are enrolled in a managed care plan, prior authorization from the plan shall NOT be required or requested before providing an

appropriate MSE and initiating any further medical examination and necessary stabilizing treatment.

c. **EMS.** A hospital has an obligation to see the individual once the individual presents to the DED whether by EMS or otherwise. A hospital that delays the MSE or stabilizing treatment of any individual who arrives via transfer from another facility, by not allowing EMS to leave the individual, could be in violation EMTALA and the Hospital CoP for Emergency Services. Even if the hospital cannot immediately complete an appropriate MSE, the hospital must assess the individual's condition upon arrival of the EMS service to ensure that the individual is appropriately prioritized based on his or her presenting signs and symptoms to be seen for completion of the MSE.

d. **Contacting the individual's physician.** An ED physician or non-physician practitioner may contact the individual's personal physician at any time to seek advice regarding the individual's medical history and needs that may be relevant to medical treatment and screening of the individual, so long as this consultation does not inappropriately delay services.

e. **Financial Responsibility Forms.** The performance of the MSE and the provision of stabilizing treatment will NOT be conditioned on an individual's completion of a financial responsibility form, an advance beneficiary notification form, or payment of a co-payment for any services rendered.

f. **Financial Inquiries.** Individuals who inquire about financial responsibility for emergency care should receive a response by a staff member who has been well trained to provide information regarding potential financial liability. The staff member who provides information on potential financial liability should clearly inform the individual that the hospital will provide an MSE and any necessary stabilizing treatment, regardless of his or her ability to pay. Individuals who believe that they have an EMC should be encouraged to remain for the MSE.

Note: There is no delay in the provision of an MSE or stabilizing treatment if: (i) there is not an open bed in the DED; (ii) there are not sufficient caregivers present to render the MSE and/or stabilizing treatment; and (iii) the individual's condition does not warrant immediate screening and treatment by a physician or QMP.

5. **Refusal to Consent to Treatment**

a. **Written Refusal – Partial Refusal of Care or Against Medical Advice.** If a physician or QMP has begun the MSE or any stabilizing treatment and an individual refuses to consent to a test, examination or treatment or refuses any further care and is determined to leave against medical advice, after being informed of the risks and benefits and the hospital's obligations under EMTALA, reasonable attempts shall be made to obtain a written refusal to consent to examination or treatment using the form provided for that purpose or document the individuals refusal to sign the Against Medical Advice Form

(see Against Medical Advice Form). The medical record must contain a description of the screening and the examination, treatment, or both if applicable, that was refused by or on behalf of the individual.

b. **Waiver of Right to Medical Screening Examination.** If an individual refuses to consent to examination or treatment and indicates his or her intention to leave prior to triage or prior to receiving an MSE or if the individual withdrew the initial request for an MSE, facility personnel must document the patient's reason for leaving. Documentation should reflect that the hospital offered to provide screening and treatment before patient's refusal.

c. **Documentation of Information.** The physician or nurse must document that the individual has been informed of the risks and benefits of the examination and/or treatment but refused to sign the form.

d. **Documentation of Unannounced Leave.** If an individual leaves the facility without notifying facility personnel, this must be documented upon discovery. The documentation must reflect that the individual had been at the facility and the time the individual was discovered to have left the premises. Triage notes and additional records must be retained. If the individual leaves prior to transfer or leaves prior to an MSE, the information should be documented on the individual's medical record. If an individual has not completed a Sign-In Sheet, an ED staff member should complete a sheet and if the individual's name is not known a description of the individual leaving should be entered on the form. All individuals presenting for evaluation or treatment must be entered into the Central Log.

6. **Stabilizing Treatment Within Hospital Capability**

The determination of whether an individual is stable is not based on the clinical outcome of the individual's medical condition. An individual has been provided sufficient stabilizing treatment when the physician treating the individual in the DED has determined, within reasonable clinical confidence, that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility, or with respect to an EMC of a woman in labor, that the woman has delivered the child and placenta; or in the case of an individual with a psychiatric or behavioral condition, that the individual is protected and prevented from injuring himself/ herself or others. For those individuals who are administered chemical or physical restraints for purposes of transfer from one facility to another, stabilization may occur for a period of time and remove the immediate EMC, but the underlying medical condition may persist and, if not treated for longevity, the individual may experience exacerbation of the EMC. Therefore, the treating physician should use great care when determining if the EMC is in fact stable after administering chemical or physical restraints.

a. **Stable.** The physician or QMP providing the medical screening and treating the emergency has determined within reasonable clinical confidence, that the EMC that caused the individual to seek care in the DED has been resolved although the underlying medical condition may persist. Once the individual is stable, EMTALA no

longer applies. (The individual may still be transferred; however, the "appropriate transfer" requirement under EMTALA does not apply.)

b. **Stabilizing Treatment Within Hospital Capability and Transfer.** Once the hospital has provided an appropriate MSE and stabilizing treatment within its capability, an appropriate transfer may be effected by following the appropriate transfer provisions. (See Transfer Policy.) If there is a disagreement between the physician providing emergency care and an off-site physician (*e.g.*, a physician at the receiving facility or the individual's primary care physician if not physically present at the first facility) about whether the individual has been provided sufficient stabilized treatment to effect a transfer, the medical judgment of the transferring physician takes precedence over that of the off-site physician.

Refer to the hospital's Transfer Policy for additional directions regarding transfers of those individuals who are not medically stable. If a hospital has exhausted all its capabilities and is unable to stabilize an individual, an appropriate transfer should be implemented by the transferring physician.

c. **Stabilizing Treatment and Individuals Whose EMCs Are Resolved.** An individual is considered stable and ready for discharge when, within reasonable clinical confidence, it is determined that the individual has reached the point where his or her continued care, including diagnostic work-up and/or treatment, could reasonably be performed as an outpatient or later as an inpatient, provided the individual is given a plan for appropriate follow-up care with the discharge instructions. The EMC that caused the individual to present to the DED must be resolved, but the underlying medical condition may persist. Hospitals are expected within reason to assist/provide discharged individuals the necessary information to secure follow-up care to prevent relapse or worsening of the medical condition upon release from the hospital.

7. **When EMTALA Obligations End**

The hospital's EMTALA obligation ends when a physician or QMP has made a decision:

a. That no EMC exists (even though the underlying medical condition may persist);
b. That an EMC exists and the individual is appropriately transferred to another facility; or
c. That an EMC exists and the individual is admitted to the hospital for further stabilizing treatment; or
d. That an EMC exists and the individual is stabilized and discharged.

Note: A hospital's EMTALA obligation ends when the individual has been admitted in good faith as an inpatient, whether or not the individual has been stabilized. An individual is considered to be an inpatient when the individual is formally admitted to the hospital by a physician's order. A hospital continues to have a responsibility to meet the patient's emergency needs in accordance with hospital CoPs. A patient in observation status is not considered admitted as an inpatient, therefore, EMTALA obligations continue.

j. ***EMTALA Waivers and Requirements During Pandemics and Other Declared Emergencies.***

a. Alternative Screening Sites on Campus for Screening during a Pandemic (No Waiver Required.) For the screening of influenza like illnesses, the hospital may establish an alternative screening site(s) on campus. Individuals may be redirected to these sites AFTER being logged in. The redirection and logging can take place outside the entrance to the DED. However, the person doing the directing must be qualified (*e.g.*, an RN or QMP) to recognize individuals who are obviously in need of immediate treatment in the DED. The MSEs must be conducted by qualified personnel.

b. Alternative Screening Site Off-Campus (No Waiver Required.) The hospital may encourage the public to go to an off-campus hospital-controlled site <u>for the screening of influenza like illness</u>. However, the hospital may NOT tell an individual who has already come to the DED to go to the off-site location for the MSE. The off-campus site for influenza like illnesses should not be held out to the public as a place that provides care for EMCs in general on an urgent, unscheduled basis.

c. EMTALA Waivers.

i. A hospital operating under an EMTALA waiver will not be sanctioned for an inappropriate transfer or for directing or relocating an individual who comes to the DED to an alternative off-campus site, for the MSE if the following conditions are met:

1. The transfer is necessitated by the circumstances of the declared emergency in the emergency area during the emergency period (as those terms are defined in the hospital's EMTALA Transfer Policy);
2. The direction or relocation of an individual to receive medical screening at an alternate location is pursuant to an appropriate State emergency preparedness plan or, in the case of a public health emergency that involves a pandemic infectious disease, pursuant to a State pandemic preparedness plan;
3. The hospital does not discriminate on the basis of an individual's source of payment or ability to pay;
4. The hospital is located in an emergency area during an emergency period; and
5. There has been a determination that a waiver of sanctions is necessary.

ii. An EMTALA waiver can be issued for a hospital only if:

1. The President has declared an emergency or disaster under the Stafford Act or the National Emergencies Act; and
2. The Secretary of HHS has declared a Public Health Emergency (PHE); and
3. The Secretary invokes his or her waiver authority including notifying Congress at least 48 hours in advance; and
4. The waiver includes waiver of EMTALA requirements and the hospital is covered by the waiver.

c. In the absence of CMS notification of area-wide applications of the waiver, the hospital must contact CMS and request that the waiver provisions be applicable to the hospital.
d. In addition, in order for an EMTALA waiver to apply to the hospital and for sanctions not to apply, (i) the hospital must activate its disaster protocol, and (ii) the State must have activated an emergency preparedness plan or pandemic preparedness plan in the emergency area, and any redirection of individuals for an MSE must be consistent with such plan.
e. Even when a waiver is in effect, there is still the expectation that everyone who comes to the DED will receive an appropriate MSE, if not in the DED, then at the alternate care site to which they are redirected or relocated.

Except in the case of waivers related to pandemic infectious disease, an EMTALA waiver is limited in duration to 72 hours beginning upon activation of the hospital's disaster protocol. In the case of a PHE involving pandemic infectious disease, the general EMTALA waiver authority will continue in effect until the termination of the declaration of the PHE. However, the waiver may be limited to a date prior to the termination of the PHE declaration, as determined by CMS. If a State emergency/pandemic preparedness plan is deactivated in the area where the hospital is located prior to the termination of the PHE, the hospital no longer meets the conditions for an EMTALA waiver and the hospital waiver would cease to be in effect as of the deactivation date. Likewise, if the hospital deactivates its disaster protocol prior to the termination of the PHE, the hospital no longer meets the conditions for an EMTALA waiver and the hospital waiver would cease to be in effect as of the deactivation date.

REFERENCES:

1. EMTALA: A Guide to Patient Anti Dumping Laws. (2009)

CROSS REFERENCE P&P:

1. Emergency Medical Screening of Patients on Hospital Property.
2. Evaluation and Screening of Patients Presenting to Emergency Department.
3. Medical screening Exam for the Obstetrical patient- Standardized Procedure.

Approval	**Date**
CCOC	8/28/17
Peri-Peds Committee	10/20/17
Emergency Services Committee	9/13/17
Medical Executive Committee	11/7/17
Board of Directors	11/15/17
Last Board of Directors Review	

Developed:
Reviewed:
Revised:
Supersedes:

Title: EMTALA Policy	
Scope: ED & Perinatal	Manual: CPM – Admission, Discharge, Transfer (ADT)
Source: ED & Disaster Nurse Manager	Effective Date:

Index Listings:

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Medical Screening Examination of the Obstetrical Patient	
Scope: Perinatal	Manual: Perinatal
Source: RN Manager Perinatal Services	Effective Date:

PURPOSE
To outline the methodology for the medical screening examination of the obstetric patient by the RN.

POLICY
I. Procedure to be performed
   A. Standardized procedure for medical screening examination for the obstetrical patient performed by a registered nurse (RN) who is determined qualified by the Hospital's Medical Staff Bylaws, Rules and Regulations and approved by the Hospital's Governing Board, in compliance with the provisions of the Emergency Medical Treatment and Labor Act (EMTALA) 42 U.S.C., Section 1395, Tag A406.

II. Responsible Party
   A. A physician or Certified Nurse Midwife (hereafter, "provider") on the hospital medical staff is available for consultation to certify the labor evaluation.

   B. A medical screening examination may be performed by a Perinatal RN certified to perform medical screening examinations following this standardized procedure.

   C. The RN must successfully complete an initial competency validation involving two validations that are signed either by a provider or a qualified nurse preceptor (who has completed 5 validations). Original documentation is to be kept on file.

III. Contraindications to performing this procedure: Patient Refusal.
IV. Conditions for Provider Consultation and Orders
   A. All pregnant women presenting to the obstetrical department for care will receive a Medical Screening Examination and Assessment of Labor when requested without discrimination and regardless of their ability to pay.

   B. Following examination and assessment of the patient, the RN will communicate with the provider to apprise him/her of the findings. Based thereon, the provider will either concur with the assessment of the RN, or will present to the hospital to further evaluate the patient themselves.

   C. If the RN determines that a woman is not in labor, a provider must certify the diagnosis either through telephone consultation or physical examination of the patient. If telephone consultation is the means utilized to satisfy this requirement, documentation within the patient charts must be in accordance with the hospital Conditions of Participation (CoP) at 42 CFR §482.24(c)(1).

   D. A provider must be notified immediately if:
      a. Delivery is imminent. Preparations should be made for immediate delivery.

b. Complications or abnormal assessments arise during the patient' assessment. Such problems include:
   i. Fever, signs of infection
   ii. Excessive vaginal bleeding (more than spotting)
   iii. Elevated blood pressure
   iv. Hyperreflexia
   v. Non-vertex presentation
   vi. Tetanic contraction pattern
   vii. Non-reactive NST, Category 3 or worsening Category 2 strip
   viii. Premature gestation presenting in labor
   ix. Ruptured membranes

IV. Review Process
A. Quality improvement monitoring of this standardized procedure is ongoing.
B. Quality indicators developed and applied to all obstetrical patients, and chart audits will be performed for the following:
   Births occurring outside of a hospital facility, following a Medical Screening Exam by a RN

PROCEDURE

I. Who can perform this procedure?
A. Only Northern Inyo Hospital certified Perinatal RN's or providers may perform this standardized procedure.

II. Equipment
A. Sterile gloves
B. Lubricant
C. Electronic Fetal Monitor
D. BP cuff
E. Thermometer
F. Reflex hammer
G. Slides/microscope for fern testing

III. Validate appropriate patient selection criteria:
A. Patient must be an obstetric patient presenting for rule-out labor
B. Patient must give consent.
C. Patient must have absence of complications as listed under Policy III. D.b.

IV. Explain procedure to patient

V. If delivery is imminent, CALL THE PROVIDER and prepare for immediate delivery.

VI. If delivery is not imminent, continue assessment which will include but is not limited to:
A. Gravida, parity, EDC
B. Chief compliant/reason for visit
C. Review of prenatal record if available, obstetric history, and risk factors

D. Fetal movement
E. Evaluation of fetal heart rate and patterns appropriate for gestational age
F. Uterine contraction patterns
G. Labor status:
    a. Cervical dilation, effacement, and fetal station (unless contraindicated)
    b. Presenting part
    c. Status of membranes
H. Evaluation of urine for protein
I. Any other associated information

VII. Continue examination to assess, labor progress, and fetal wellbeing.

VIII. Maternal Infection
A. If temperature is 100.4 or above:
    a. Suspect infection – CALL PROVIDER
    b. Assess for other abnormal findings such as elevated blood pressure or excessive bleeding. If present – CALL PROVIDER.
    c. Determine proteinuria and check reflexes. If abnormal – CALL PROVIDER.
B. If temperature is normal, include this information with report to provider when total assessment is completed.

IX. Assessment of Labor Progress
A. Abdominal palpation and EFM monitoring
B. Assess uterine contraction pattern noting:
    a. Frequency
    b. Duration
    c. Intensity
    d. Resting tone
C. If normal, include this information with report to provider when total assessment is completed.
D. Potential complications may include but are not limited to:
    a. Preterm gestation
    b. Tetanic contraction pattern.
E. If potential complications are present – CALL PROVIDER
F. Vaginal examination:
    a. Determine the membrane status
        i. Intact or ruptured
        ii. Color, odor, or amount
        iii. Include this information with report to provider when total assessment is completed.
        iv. Digital cervical examination should not be performed in patients less than 36.0 weeks gestation, in cases of known or suspected placenta previa,

active vaginal bleeding, or with rupture of membranes, prior to receiving an order to do so by the provider

b. Determine presenting part
   i. If cephalic, include this information with report to provider when total assessment is completed.
   ii. If abnormal, CALLPROVIDER
c. Determine the state of the cervix:
   i. Effacement
   ii. Dilation
   iii. Station
d. If normal, include this information with report to provider when total assessment is completed
e. If abnormal, CALL PROVIDER

G. Assess bleeding:
   a. CALL PROVIDER if bleeding is more than spotting
   b. If normal, include this information with report to provider when total assessment is completed.

H. Assessment of fetal wellbeing
   a. Identify fetal heart rate pattern with application of an electronic fetal monitoring system or Doppler, if indicated.
   b. (2)Utilizing NICHD criteria and nomenclature assess NST reactivity or strip Category.
   c. If NST is non-reactive or if strip is Category 3 or worsening Category 2, CALL PROVIDER

I. At the completion of the medical screening examination, the RN will report to the patient's provider, by phone or in person, the findings of the examination and any other pertinent information before any further procedures are performed. Regardless of the assessment, any patient meeting the following criteria will be examined, in person, by a provider prior to discharge home:
   a. No prenatal care
   b. Maternal temperature ≥~~100.5~~100.4(F), of uncertain etiology
   c. Altered level of consciousness
   d. Active vaginal bleeding
   e. Rupture of membranes
   f. Category 3 or worsening Category 2 strip
   g. Major maternal trauma.

J. In regards to a patient who is determined to not be in labor but needs additional evaluation to rule out an emergency condition: This patient will be seen in the Emergency Department and be provided with a medical screening examination to rule out other medical conditions prior to being discharged home. Prior to transfer back to the

Emergency Department, the L&D RN will report to the on-call provider, the findings of the labor examination and any other pertinent information. This RN will also call report to the Emergency Department RN and/or the Emergency Department Attending provider to inform them of the patient's impending return to the Emergency Department.

X. Documentation
   A. Patient assessment, including fetal assessment, will be documented in the EHR according to department policy.

REQUIREMENTS FOR MEDICAL SCREENING EXAMINATION FOR THE OBSTETRICAL PATIENT

XI. Minimal Education/Training
   A. Selected RNs will have successfully completed the hospital competency for performing Medical Screening Examination of the Obstetric Patient.

XII. Expertise
   A. Selected RNs will posses:
      a. Current California Registered Nurse (RN) license
      b. Current NRP and BLS certifications
      c. Experience in direct patient care with laboring patients as a RN
      d. Successful completion of annual antepartum and intrapartum continuing education per department requirements
      e. Completion of electronic fetal monitoring program (Intermediate or Advanced Fetal Monitoring) every two years.

XIII. Initial Evaluation
   A. Successfully complete the Northern Inyo Hospital Medical Screening Exam test with 85% accuracy.
   B. Successfully complete at least two (2) different obstetric patient medical screening examinations under the observation of the provider preceptor or a qualified nurse preceptor.
      a. A qualified "nurse preceptor" is a RN who may validate the competency of another RN to perform this procedure. A nurse preceptor must have completed at least five (5) obstetric patient medical screening examinations.
      b. Determined competency must be documented on the Medical Screening
      c. Examination of Obstetric Patient Competency Validation Tool.

XIV. Ongoing Evaluation
   A. Annual competency validation to be performed.

Approval	**Date**
Perinatal Pediatrics Committee	10/20/17
Medical Executive Committee	11/7/17
Board of Directors	11/15/17

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Medical Screening Examination of the Obstetrical Patient	
Scope: Perinatal	Manual: Perinatal
Source: RN Manager Perinatal Services	Effective Date:

Last Board of Directors Review	

Developed:
Reviewed:
Revised:
Supersedes:
Index Listings:

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Medical Screening Exam for the Obstetrical Patient - Standardized Procedure	
Scope:	Manual: OB/Gyn
Source: OB Nurse Manager	Effective Date:

MEDICAL SCREENING EXAMINATION FOR THE OBSTETRICAL PATIENT PERFORMED BY THE REGISTERED NURSE

NAME/TITLE: _____ DATE: _____

Measurement of Competency	Meets Requirements Date	Needs Additional Assistance	Comments
1) Describes patient selection criteria and instances of provider notification.			
a) Imminent delivery			
b) Fever, signs of infection			
c) Excessive vaginal bleeding			
d) Elevated blood pressure			
e) Hyperreflexia			
f) Non-vertex presentation			
g) Tetanic contraction pattern			
h) Non-reactive NST			
i) Category 3 strip			
j) Worsening Category 2 strip			
k) Premature gestation presenting in labor			
l) Ruptured membranes regardless of gestational age.			
2) Explains procedure to patient			
3) Assembles equipment			
4) Performs assessment in systematic format			
a) Chief complaint			
b) Obstetric history			
c) Labor status and progress			
d) Fetal wellbeing			
5) Communicates findings of examination and any other pertinent information to provider.			
6) Documents appropriately in the EHR			

_____ _____

Employee Signature Provider/Qualified RN Preceptor Signature

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Medical Screening Exam for the Obstetrical Patient - Standardized Procedure	
Scope:	Manual: OB/Gyn
Source: OB Nurse Manager	Effective Date:

MEDICAL SCREENING EXAMINATION FOR THE OBSTETRICAL PATIENT
PERFORMED BY REGISTERED NURSE

QUALITY IMPROVEMENT DATA

MEDICAL RECORD #_____

C.C.: _____

DATE: _____

1. Patient Selection
   - ❑ Meets criteria
   - ❑ Does not meet criteria. Describe: _____
2. Maternal Assessment
   - ❑ All systems WNL
   - ❑ Presence of complications
3. Fetal Assessment
   - ❑ Reassuring FHR
   - ❑ Non-reassuring tracing

   Describe: _____
4. Documentation
   - ❑ Electronic Medical Record
5. Provider Contacted:
   - ❑ Yes Who: _____
   - ❑ No Why not: _____
6. Outcome
   - ❑ Birth Outside of Hospital
   - ❑ Maternal complications Describe: _____
   - ❑ Neonatal complications Describe: _____
   - ❑ Admission for labor
   - ❑ Discharged
   - ❑ Other:_____

PATIENT CARE SERVICES DIVISION

NAME/TITLE: _____DATE: _____

COMPETENCY: Medical Screening Examination for the Obstetrical Patient Performed by the Registered Nurse

*Evaluation Method Codes: O=Observation; M=Module; T=Test; RD=Return Demonstration; C-Computer

Measurement of Competency	Meets Requirements Date	Needs Additional Assistance	*Evaluation Methods/ Comments
1. Successfully completes module and post-test with 100% accuracy.			
2. Describes patient selection criteria and instances			

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Medical Screening Exam for the Obstetrical Patient - Standardized Procedure	
Scope:	Manual: OB/Gyn
Source: OB Nurse Manager	Effective Date:

Measurement of Competency	**Meets Requirements Date**	**Needs Additional Assistance**	***Evaluation Methods/ Comments**
of physician notification.			
a. Imminent delivery			
b. Fever, signs of infection			
c. Excessive vaginal bleeding			
d. Elevated blood pressure			
e. Abnormal deep tendon reflexes			
f. Non-vertex presentation			
g. Uterine hyperstimulation			
h. Lack of uterine activity			
i. Tetanic contraction			
j. Non-reassuring fetal heart rate			
k. Premature gestation			
l. Ruptured membranes regardless of gestational age.			
3. Explains procedure to patient			
4. Assembles equipment			
5. Performs assessment in systematic format			
a. Chief complaint			
b. Obstetric history			
c. Labor status and progress			
d. Maternal hydration			
e. Fetal wellbeing			
6. Communicates findings of examination and any other pertinent information to physician.			
7. Documents appropriately on the Birthing Center Log Book and on the Obstetrical Assessment Record.			

_____

Employee Signature Instructors Signature

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Medical Screening Exam for the Obstetrical Patient - Standardized Procedure	
Scope:	Manual: OB/Gyn
Source: OB Nurse Manager	Effective Date:

MEDICAL SCREENING EXAMINATION FOR THE OBSTETRICAL PATIENT
PERFORMED BY REGISTERED NURSE

QUALITY IMPROVEMENT DATA

MEDICAL RECORD #_____

AGE: _____

C.C.: _____

DATE: _____

1. Patient Selection
   - ❑ Meets criteria
   - ❑ Does not meet criteria. Describe: _____
2. Maternal Assessment
   - ❑ All systems WNL
   - ❑ Presence of complications
3. Fetal Assessment
   - ❑ Reassuring FHR
   - ❑ Non-reassuring tracing

   Describe: _____
4. Documentation
   - ❑ Log Book ❑ Medical Record
5. Physician Contacted:
   - ❑ Yes Who: _____
   - ❑ No Why not: _____
6. Outcome
   - ❑ Birth Outside of Hospital
   - ❑ Maternal complications Describe: _____
   - ❑ Neonatal complications Describe: _____

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Medical Screening Exam for the Obstetrical Patient - Standardized Procedure	
Scope:	Manual: OB/Gyn
Source: OB Nurse Manager	Effective Date:

NOT A PART OF PERMANENT MEDICAL RECORD
APPROVAL

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

_____ _____
Chairman, Perinatal/Pediatrics Committee Date

_____ _____
Chairman, Interdisciplinary Practice Committee Date

_____ _____
Chief of Staff Date

_____ _____
Administrator Date

_____ _____
President, Board of Directors Date

Registered Nurses who have been approved to perform this standardized procedure are:

_____ _____
Date

_____ _____
Date

_____ _____
Date

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Medical Screening Exam for the Obstetrical Patient - Standardized Procedure	
Scope:	Manual: OB/Gyn
Source: OB Nurse Manager	Effective Date:

_____ _____
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NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Blood Bank—Emergency Requests for Blood Components~~Blood Bank – Emergency Requests – Crash Blood~~	
Scope: Hospital Wide	Manual: CPM - Fluid, Electrolytes and Blood Products (F&B), Lab- Blood Bank
Source: Coordinator of Immunology CLS	Effective Date:

PURPOSE:
This policy and procedure describes how to request and obtain blood components ~~uncrossmatched O negative blood~~ for emergencies ~~and the time required to crossmatch units~~.

POLICY:

1. During emergencies, patients needing immediate blood transfusions will be given uncrossmatched O negative pRBCs~~blood~~.

2. The emergency department or House Supervisor will call the laboratory when a patient needing immediate transfusion arrives or is expected to arrive in the emergency room

3. An operating room nurse will call the laboratory if a patient needing immediate transfusion arrives in surgery.

4. The ~~nursing supervisor~~ House Supervisor or designated staff member (ward clerk, RN) will call the laboratory if a patient needing immediate transfusion is in OB, ICU or MedSurg.

5. When a request for emergency uncrossmatched O negative pRBCs ~~blood~~ is received, laboratory personnel will transport to the requesting department four units of uncrossmatched O negative pRBCs ~~blood packed~~ in a transport box.

~~6. If the need for transfusion is immediate and there is no time to pack the units in a validated container, the four units will be transported to the patient in a basket labeled "Crash Blood". If these units are not used and are out of the blood bank refrigerator for more than 30 minutes, they will be discarded.~~

~~7.~~6. The transport box will remain with the patient until the physician determines that the patient ~~will~~ no longer needs the units, when 4 hours has passed, or when the units are replaced with type specific crossmatched blood.

~~8.~~7. At the end of 4 hours, if the units are still needed, laboratory personnel will repack the same O negative units in a new transport box with fresh ice packs.

~~9.~~8. If the patient's blood type is known, uncrossmatched type specific blood will be supplied in order to conserve the O negative units.

~~10.~~9. The physician will be required to sign for uncrossmatched units. This can be done after the emergency.

~~11.~~10. The time involved in providing uncrossmatched or crossmatched blood is as follows:

a. Uncrossmatched O negative blood _____less than 10 minutes
b. Uncrossmatched type-specific units _____15 to 20 minutes
c. Crossmatched type-specific units, no antibody screen _____ 20 to 30 minutes

Title: Blood Bank—Emergency Requests for Blood Components~~Blood Bank--Emergency Requests--Crash Blood~~	
Scope: Hospital Wide	Manual: CPM - Fluid, Electrolytes and Blood Products (F&B), Lab- Blood Bank
Source: Coordinator of Immunology CLS	Effective Date:

d. Crossmatched type-specific units, antibody screen _____45 to 60 minutes

~~12.~~11. The blood products in stock at Northern Inyo Hospital is:

O positive_____ 14 units
O negative_____8 units
A positive_____12units
A negative_____4 units
AB positive_____2 units
B positive_____4 units
FFP (AB~~ Pos~~)_____106~~ units~~
Cryoprecipitate_____2 units pooled
~~Cryoprecipitate_____5 units, pooled~~

PROCEDURE:

1. Call the laboratory with a verbal order for emergency uncrossmatched O negative units. Inform the laboratory how many units and how soon the units are needed.

~~2. The person accepting the container with the blood will be required to initial the blood bank issue log. This can be done after the emergency.~~

~~3.~~2. When the transport box with the units is received, keep the box with the patient until the physician determines the blood is no longer needed.

~~4.~~3. After removing a unit, ~~replace the insulated top and~~ close the container to keep the temperature of the units below 10C.

~~5.~~4. Call the laboratory to return the blood container as soon as it is not needed. The container must be returned to the blood bank within 4 hours.

~~6.~~5. If the container is needed more than 4 hours, call the laboratory.

Approval	**Date**
Laboratory Director	
Medical Executive Committee	
Board of Directors	
Last Board of Directors Review	

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

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Medication Dosing in Renal Failure	
Scope: Hospital Wide	Manual: Pharmacy
Source: Pharmacy Director	Effective Date:

PURPOSE:

To reduce medication related toxicity and adverse effects in patients with renal insufficiency/failure by making appropriate dose adjustment on renally cleared medications.

POLICY:

1. Pharmacists are authorized by the medical staff to adjust the dosages of renally eliminated medications based upon creatinine clearance rates calculated for each patient. This will apply to all medications besides chemotherapy medications which will be handled in a different manner.

PROCEDURE:

1. Upon receipt of an order for a medication that is eligible for dose adjustment, the pharmacist will determine if the ordered dose and frequency is appropriate based on estimated creatinine clearance.
2. The pharmacist will use the creatinine clearance that is provided by the computer system to determine renal function. The computer system uses appropriate renal function estimators for the population that the patient fits in. Majority of patient's renal function is determined by the Cockcroft-Gault equation. If the pharmacist determines another estimate for creatinine clearance is more appropriate they will use that estimate for the dose adjustment.
3. Appropriate dosing of the medication will be determined based on the renal dose adjustment section of product package insert or most up to date version of Lexicomp.
4. If the ordered dose of the medication is not appropriate, the pharmacist is allowed to discontinue the current order and reorder the medication at the dose defined by the above references.
5. If the medication is contraindicated based on renal function, the pharmacist is responsible for contacting the provider to suggest alternatives.
6. If the original ordered dose is not appropriate for the indication, the pharmacist must contact the provider to recommend alternative dosing.
7. The pharmacist will monitor renal function throughout patients stay in the hospital. If renal function changes throughout the stay, appropriate recommendations will be made to physician for changes in renally cleared medications.

REFERENCES:

1. Dowling, T.C., Matzke, G.R., Murphy, J.E., & Burckart, G. J. (2010). Evaluation of renal drug dosing: prescribing information and clinical pharmacist approaches. *Pharmacotherapy* (30): 776-86. (LOE 8)

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Medication Dosing in Renal Failure	
Scope: Hospital Wide	Manual: Pharmacy
Source: Pharmacy Director	Effective Date:

Approval	**Date**
Pharmacy & Therapeutics Committee	10/19/2017
Medical Executive Committee	11/7/2017
Board of Directors	11/15/2017
Last Board of Directors Review	

Developed: 8/24/17
Reviewed:
Revised:
Supersedes:
Index Listings:

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

Northern Inyo Hospital Medical Staff
Clinical Privilege Request Form

Appointment cycle _____
(Office use only)

Practitioner Name: _____ Date: _____
Please Print

OBSTETRICS & GYNECOLOGY

Instructions: Please check box next to each core privilege/special privilege requested.
Draw a line through and initial next to any core privilege NOT requested.

INITIAL CRITERIA

Education/Formal Training:

- Completed accredited residency training in Obstetrics and Gynecology.
- Board Certified/Board Eligible by the American Board of Obstetrics and Gynecology or equivalent.
- All practitioners requesting privileges to manage and attend births in Labor and Deliver at Northern Inyo Hospital will complete the appropriate BETA (Quest for Zero: Excellence in OB) requirements and will comply with NICHD terminology in the OB setting.

INPATIENT CORE PRIVILEGES

Request	
☐	• Admit, evaluate, diagnose, consult, perform H&P, and manage the care of female patients in any condition or stage of pregnancy who present to the hospital or Emergency Department. • Admit, evaluate, diagnose, consult, perform H&P, and provide pre-operative, intra-operative and post-operative care for management of female patients presenting with illness, injury, disorders of the gynecologic or genitourinary system. • Vaginal delivery • Hysterectomy • Cesarean section • Cesarean hysterectomy • Diagnostic cystoscopy • Diagnostic and operative hysteroscopy • Diagnostic and operative laparoscopy • Diagnostic and operative laparotomy • Adnexal surgery • Ultrasound • Suburethral slings

OUTPATIENT CORE PRIVILEGES

Request	
☐	• Assess, evaluate, diagnose, consult, perform H&P, and manage the care of female patients in any condition or stage of pregnancy or with illness, injury, or disorders of the gynecologic or genitourinary system who present to the outpatient clinic.

SPECIAL PRIVILEGES

☐ Circumcision with clamp, pediatric only ☐ Robotics (see separate list)	☐ Insertion/removal of implanted contraceptive device (e.g. Nexplanon)

CONSULTING PRIVILEGES
(for Consulting Staff only)

Request	
☐	• Provide consultation, order, interpret, and evaluate diagnostic tests to identify and assess patients' clinical problems and health care needs on request from Active or Provisional Staff members or Temporary Privileges Practitioners.

Please sign acknowledgment on next page.

Northern Inyo Hospital Medical Staff
Clinical Privilege Request Form

Appointment cycle _____
(Office use only)

Practitioner Name: _____ Date: _____
Please Print

Acknowledgment of Practitioner:
I have requested only those privileges for which by education, training, health status, current experience and demonstrated performance I am qualified to perform and for which I wish to exercise and I understand that:

(a) In exercising any clinical privileges granted, I am constrained by any Medical Staff Bylaws, Rules and Regulations, and policies and procedures applicable.
(b) Any restriction on the clinical privileges granted to me is waived in an emergency situation and in such situation my actions are governed by the applicable section of the Medical Staff Bylaws or related documents.

_____ _____
Practitioner Signature *Date*

_____ _____
Chief of Obstetrics *Date*

_____ _____
Chief of Surgery *Date*

_____ _____
Chief of Staff *Date*

_____ _____
President, Board of Directors *Date*

Approvals	*Committee Date*
Credentials Committee	
Medical Executive Committee	
Board of Directors	

(Office use only)