

March 20 2019 Regular Meeting

March 20 2019 Regular Meeting - March 20 2019 Regular Meeting

Agenda, March 20 2019 Regular Meeting

Agenda, March 20 2019 Regular Meeting	2
---	---

Chief of Staff Report

Medical Executive Committee report, March 2019	6
--	---

Medical Staff Policy and Procedure approvals, March 2019	8
--	---

Joint Commission Accreditation

Accreditation Data Update, Critical Access Hospitals	55
--	----

Joint Commission Survey Report	80
--------------------------------------	----

Community Health Needs Assessment

Community Health Needs Assessment information	119
---	-----

Pioneer Home Health Annual Budget

Pioneer Home Health annual budget	166
---	-----

Strategic and Fiscal Strategy Review

Strategic and Fiscal Strategy Review	175
--	-----

District Board Resolution 19-03

District Board Resolution 19-03	421
---------------------------------------	-----

Consent Agenda

Policy and Procedure annual approvals	422
---	-----

Minutes, January 28 Special Meeting	426
---	-----

Minutes, February 20 2019 Regular Meeting	427
---	-----

AGENDA

NORTHERN INYO HEALTHCARE DISTRICT BOARD OF DIRECTORS REGULAR MEETING

**March 20, 2019 at 5:30 p.m.
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. Chief of Staff Report; Allison Robinson MD:
 - A. Policy and Procedure approvals (*action items*):
 1. *Preoperative Medication Guidelines*
 2. *Newborn Screening Test*
 - B. Annual Reviews (*action items*):
 1. *Utilization Review Plan*
 2. *Utilization Review Critical Indicators 2019*
 3. *Radiology Critical Indicators 2019*
 4. *MRI Safety Policies*
 - i. *Diagnostic Imaging – MRI Safety – Magnet Room*
 - ii. *Diagnostic Imaging – MRI Safety Burn/Thermal Incident Reduction*
 - iii. *Diagnostic Imaging – MRI Safety, Ear Protection*
 5. *Radiation Safety Policies*
 - i. *Diagnostic Imaging – Handling of Radioactive Packages, Non-nuclear medicine personnel*
 - ii. *Diagnostic Imaging – Radioactive Material Hot Lab Security*
 - iii. *Diagnostic Imaging – Radioactive Materials Delivery After-hours*
 - iv. *Diagnostic Imaging – Radioactive Waste Storage and Disposal*
 - v. *Diagnostic Imaging – Disposal of Radioactive Sharps*
 - vi. *Diagnostic Imaging – Nuclear Medicine New Employee/Annual Orientation*
 - vii. *Diagnostic Imaging – Radioactive Material Spills*
 - viii. *ALARA Program*

ix. *Diagnostic Imaging – C-Arm (Flouroscope) Radiation Safety*

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

1. Anu Agarwal, MD (*Renown Cardiology*) – Telemedicine Staff
2. Abhilash Akinapelli, MD (*Renown Cardiology*) – Telemedicine Staff
3. Jack Ichino, MD (*Renown Cardiology*) – Telemedicine Staff
4. Thomas-Duythuc To, MD (*Renown Cardiology*) – Telemedicine Staff
5. Jeannie Pflum, DO (*Obstetrics & Gynecology*) – Consulting Staff

D. Temporary Privileges (*action items*):

1. Muhammad Gill, MD (*Internal Medicine*) – Locums/Temporary Staff
2. Joseph BenPerlas, MD (*Internal Medicine*) – Locums/Temporary Staff
3. Bonnie Rashid, MD (*Internal Medicine*) – Locums/Temporary Staff

E. Telemedicine Privileges – Credentialing by Proxy (*action item*):

As per the approved Telemedicine Physician Credentialing and Privileging Agreement, and as outlined and allowed by 42CFR 482.22, the Medical Staff has chosen to recommend the following practitioner for Telemedicine privileges relying upon Adventist Health’s credentialing and privileging decisions:

1. Arin Aboulian, MD (*Pulmonology*) – Glendale Adventist Telemedicine Staff

F. Reappointment to New Staff Category (*action item*):

1. Taema Weiss, MD (*Family Medicine*) – recommended Staff category change from Active Staff to Consulting Staff without clinical privileges

G. Advancement (*action item*):

The following Medical Staff member has satisfactorily completed their introductory focused professional practice evaluations and has been recommended to advance from Provisional Staff in the category listed

1. John Adam Hawkins, DO (*Emergency Medicine*) – advancement to Active Staff

H. Resignation (*action item*):

1. Sandra Althaus, MD (*Radiology*) – effective 1/14/19

I. Updated Core Privilege Forms (*action items*):

1. Family Medicine
2. Obstetrics and Gynecology

4. New Business

A. Strategic Plan update, Finance and Market Share Committee report (*information item*).

- B. Approval of NIHD Foundation Board members Tawny Thomson and Corrina Korpi (*action item*).
 - C. Joint Commission Accreditation report (*information item*).
 - D. Chief Executive Officer report (*information item*).
 - E. Community Health Needs Assessment update (*information item*).
 - F. Approval of Pioneer Home Health annual budget (*action item*).
 - G. Strategic and Fiscal Strategy Review (*information item*).
 - H. Chief Operating Officer report (*information item*).
 - I. Chief Nursing Officer report (*information item*).
 - J. Chief Financial Officer report (*information item*).
 - K. District Board Resolution 19-03, designation of Benefits and Compensation account representatives (*action item*).
 - L. Discuss dates for Strategic Planning session (*discussion item*).
 - M. Discussion of components for legal RFP process (*discussion item*).
5. Old Business
- A. Chief of Staff Job Description and stipend change approval (*action item*).
 - B. Chief Physician Quality Officer Job Description and stipend approval (*action item*).
 - C. Athena implementation update (*information item*).

Consent Agenda (action items)

- 6. Approval of minutes of the January 28 2019 special meeting
 - 7. Approval of minutes of the February 20 2019 regular meeting
 - 8. Policy and Procedure annual approvals
 - 9. Acceptance of Pioneer Home Health Designation of Affiliated Covered Entity
-
- 10. Reports from Board members (*information items*).
 - 11. Adjournment to closed session to/for:
 - A. Public employee performance evaluation, Chief Executive Officer (*pursuant to Government Code Section 54957*).
 - B. Conference with Legal Counsel regarding anticipated litigation or significant exposure to litigation (*pursuant to Government Code Section 54956.9(b)*), 2 potential cases.
 - C. Conference with Legal Counsel regarding existing litigation, Inyo County Local Agency

Formation Commission and Northern Inyo Healthcare District v. Southern Mono Healthcare District (*pursuant to Government Code Section 54956.9*).

- D. Discuss trade secrets, new programs and services (estimated public session date for discussion yet to be determined) (*Health and Safety Code Section 32106*).
- F. Conference with Labor Negotiators; Agency Designated Representative: Irma Moisa; Employee Organization: AFSCME Council 57 (*pursuant to Government Code Section 54957.6*).

12. Return to open session and report of any action taken in closed session.

13. 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.



TO: NIHD Board of Directors
FROM: Allison Robinson, MD, Chief of Medical Staff
DATE: March 5, 2019
RE: Medical Executive Committee Report

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

A. Policies and Procedures (*action items*)

1. *Preoperative Medication Guidelines*
2. *Newborn Screening Test*

B. Annual Reviews (*action items*)

1. Utilization Review Plan
2. Utilization Review Critical Indicators 2019
3. Radiology Critical Indicators 2019
4. MRI Safety Policies
 - i. Diagnostic Imaging – MRI Safety – Magnet Room
 - ii. Diagnostic Imaging – MRI Safety Burn/Thermal Incident Reduction
 - iii. Diagnostic Imaging – MRI Safety, Ear Protection
5. Radiation Safety Policies
 - i. Diagnostic Imaging – Handling of Radioactive Packages, Non-nuclear medicine personnel
 - ii. Diagnostic Imaging – Radioactive Material Hot Lab Security
 - iii. Diagnostic Imaging – Radioactive Materials Delivery After-hours
 - iv. Diagnostic Imaging – Radioactive Waste Storage and Disposal
 - v. Diagnostic Imaging – Disposal of Radioactive Sharps
 - vi. Diagnostic Imaging – Nuclear Medicine New Employee/Annual Orientation
 - vii. Diagnostic Imaging – Radioactive Material Spills
 - viii. ALARA Program
 - ix. Diagnostic Imaging – C-Arm (Fluoroscope) Radiation Safety

C. Medical Staff Appointments (*action items*)

1. Anu Agarwal, MD (*Renown Cardiology*) – Telemedicine Staff
2. Abhilash Akinapelli, MD (*Renown Cardiology*) – Telemedicine Staff
3. Jake Ichino, MD (*Renown Cardiology*) – Telemedicine Staff
4. Thomas-Duythuc To, MD (*Renown Cardiology*) – Telemedicine Staff
5. Jeannie Pflum, DO (*Obstetrics & Gynecology*) – Consulting Staff

D. Temporary Privileges (*action items*)

1. Muhammad Gill, MD (*Internal Medicine*) – Locums/Temporary Staff
2. Joseph BenPerlas, MD (*Internal Medicine*) – Locums/Temporary Staff
3. Bonnie Rashid, MD (*Internal Medicine*) – Locums/Temporary Staff

- E. Telemedicine Privileges – Credentialing by Proxy (*action item*)
As per the approved Telemedicine Physician Credentialing and Privileging Agreement, and as outlined and allowed by 42CFR 482.22, the Medical Staff have chosen to recommend the following practitioners for Telemedicine privileges relying upon Adventist Health’s credentialing and privileging decisions.
 - 1. Arin Aboulian, MD (*Pulmonology*) – Glendale Adventist Telemedicine Staff.

- F. Reappointment to New Staff Category (*action item*)
 - 1. Taema Weiss, MD (*Family Medicine*) – recommended staff category change from Active Staff to Consulting Staff without clinical privileges.

- G. Advancements (*action item*)
The following medical staff members have satisfactorily completed their introductory focused professional practice evaluations and have been recommended to advance from provisional staff in the category listed.
 - 1. John Adam Hawkins, DO (*Emergency Medicine*) – advancement to Active Staff

- H. Resignations (*action item*)
 - 1. Sandra Althaus, MD (*Radiology*) – effective 1/14/19

- I. Updated Core Privilege Forms (*action items*)
 - 1. Family Medicine
 - 2. Obstetrics and Gynecology

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Preoperative Medication Guidelines	
Scope: OP/PACU	Manual: Anesthesia, PACU, Surgery
Source: DON Perioperative Services	Effective Date: 2/98

This is a guideline for reference during the preoperative phone call and should not take the place of the critical conversation between the patient and the physician

Medications the patient should take the morning of surgery before coming to the hospital with a small sip of water:

- ❖ Heart or blood pressure medications that are not diuretics or combination diuretics that he/she normally takes in the morning (see below for exceptions)
- ❖ Anti-seizure or anti-psychotic medications that he/she normally takes in the morning
- ❖ Inhalers that he/she normally takes in the morning
- ❖ H2 receptor antagonists and proton pump inhibitors
- ❖ All medication patches should remain on the patient.
- ❖ **Medications considered necessary by the patient may be taken (i.e. thyroid medication) as long as it isn't contraindicated (i.e. insulin).**

Medications that should not be taken:

- ❖ Anti-hyperglycemics (oral or insulin)
- ❖ Anticoagulants or NSAIDs
- ❖ Diuretics or combination diuretic products
- ❖ Erectile dysfunction drugs (unless taken for pulmonary hypertension).
- ❖ ACE (Angiotensin Converting Enzyme) Inhibitors and ARBs (Angiotensin Receptor Blockers) for any patient that may receive a general anesthetic.
- ❖ Digoxin (not contraindicated but is unnecessary because it is long-lasting.)

Any questionable medication should be checked with the anesthesia provider

- ❖ Patients should be asked to bring a list of their usual medications to the hospital the morning of their surgery if they are unsure of their medications at the time of the preoperative interview.
- ❖ The patient can take his/her medication at home after discharge per physician discharge orders.

DOCUMENTATION: Complete the appropriate sections of the Preoperative Interview in the electronic health record and the Surgical Checklist

REFERENCES:

1. TJC Standards PC 02.03.01, PC 03.01.03, CA Code of Regulations
2. Title 22 Standard 70215 (c), (d)
3. ASPAN 2012-2014 Perianesthesia Nursing Standards, Practice Recommendations, and Interpretive Statements: Standard VI: Nursing Process

CROSS REFERENCE P&P: Preoperative Interview; Preoperative Preparation and Teaching

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Preoperative Medication Guidelines	
Scope: OP/PACU	Manual: Anesthesia, PACU, Surgery
Source: DON Perioperative Services	Effective Date: 2/98

Approval	Date
CCOC	7/16/18
STTA	1/23/19
Pharmacy & Therapeutics	2/21/19
MEC	3/5/19
Board of Directors	
Last Board of Directors Review	1/18/17

Developed:

Reviewed: 4/11 AW, 05/11AW, 9/12 AW

Revised: 1/98, 1/29/01, 9/08, 7/18, 1/19

Supersedes: Preoperative Medications

Index Listings: Medication Guidelines, Preoperative / Preoperative Medication Guidelines

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Newborn Screening Test	
Scope:	Manual: OB/Gyn
Source: OB Nurse Manager	Effective Date:

PURPOSE:

To screen all neonates for inborn errors of metabolism according to California State regulations.
To insure all results are obtained and placed in the medical record.

POLICY:

1. Newborn screening tests will be performed on all neonates according to the California Newborn Screening Program guidelines, and shall occur after 12 hours but no later than 48 hours of age. Screening is to be done prior to discharge or transfer of the newborn unless the newborn condition is life threatening and the collection cannot be safely done.
2. NIH staff will provide all patients with a current copy of the program pamphlet *“Important Information for Parents About the Newborn Screening Test”*
3. Newborn screening test will be collected before any red blood cell transfusion. In the event that a transfusion becomes necessary and the specimen is collected before 12 hours of life – collect a second specimen 24 hours after the end of the last PRBC transfusion and prior to 48 hours of life **if** the hemoglobin and hematocrit are \geq than 10 and 30, respectively. If the specimen was not collected before the transfusion collect a post transfusion specimen 24 hours after the end of the last PRBC transfusion **if** the hemoglobin and hematocrit are \geq than 10 and 30, respectively.
4. In cases of early discharge (before 12 hours of age) an initial test will be run and arrangements will be made to return for a second test before 48 hours of life. In addition, the nurse will fill out the “Newborn Screening for Babies Leaving the Hospital Prior to 12 Hours of Age” form.
5. Infants not tested or transferred to tertiary care center prior to newborn screening test being done must have documentation on the chart. The nursery nurse (or ward clerk) will be responsible for completing the “specimen not obtained” section on the Newborn Screen Test Request Form. Send completed form to the newborn screening lab for processing.
6. Newborn not born at the hospital: Collect NBS within 48 hours of admission.
7. Critically ill newborns should have testing postponed until the newborn is stable.
8. When parents refuse to have their newborn tested the nurse will:

- a. Have them read the newborn screening brochure and discuss the importance of early detection and treatment in prevention of disabilities.

If the parent continues to refuse the test, fill out the “specimen not obtained”: “parent refusal” section of the Newborn Screen Test Request form. Have parent sign the refusal signature. Send form to the Newborn Screening Lab.

- b. Notify the infant’s physician that the parents refused the Newborn Screening and signed the parental refusal.

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Newborn Screening Test	
Scope:	Manual: OB/Gyn
Source: OB Nurse Manager	Effective Date:

9. A newborn not born in hospital but admitted or transferred to the hospital within the first six days of age should have their newborn screen collected within 48 hours of admission.
10. When infant is born at home prior to admission to the hospital the form titled “Notification of Registration of Birth Which Occurred Out of a Licensed Health Facility(NBS-OH)” is filled out and sent to:

California Department of Health Services
Newborn Screening Section
850 Marina Bay Parkway, F175
Richmond, Ca. 94804

- a. Do the newborn screening test according to policy.
11. Designated personnel (unit clerk) will log in to the Online Specimen Tracking System at 7 days after newborns date of birth to verify that the specimen has been received. If specimen cannot be verified as having been received, unit clerk must notify the Newborn Screening Department
 12. Repeat test due to inadequate specimens will be done in the nursery at no charge to the patient

SPECIAL CONSIDERATIONS:

Physician order not required
 Procedure may be performed by: RN, LVN
 Special education required to perform procedure: **Yes**
 Age specific considerations: Inherent in procedure.

PRECAUTIONS:

1. California law (Title, XVII, California Administrative Code) states that all newborns must have a blood specimen taken before discharge from the newborn nursery. This test screens for specific diseases in the following groups: Metabolic, Endocrine, Hemoglobin and other genetic diseases. These are all required by law and performed on the same specimen.
2. The infant's heel should be warmed with a warm wet washcloth or diaper prior to testing.
3. The infant should be kept warm, by swaddling during the procedure. Infants should be removed from a radiant warmer during the procedure, as the artificial heat/drying effects of the warmer can alter test results.
4. Use the “tenderfoot” automated heel incisor to assure heel punctures no deeper than 1.0 mm in depth.
5. Avoid use of undue pressure that may cause excessive bruising.

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Newborn Screening Test	
Scope:	Manual: OB/Gyn
Source: OB Nurse Manager	Effective Date:

PROCEDURE:

1. Complete all information on the "Specimen Collection Form for Newborn Screening Tests".
2. If the mother doesn't have a social security number, fill in the social security number as 999-99-9999.
3. When appropriate, place the MediCal number, BIC (Benefits Identification Card, or PE (Presumptive Eligibility) number or sticker on the Newborn Screening Specimen Collection Form, located in the lower left hand corner of the form's Demographic page.
4. Place the goldenrod copy of the form on a lab report sheet in the infant's chart.
5. Cleanse the warmed heel with an alcohol wipe, wipe dry with a sterile dry gauze sponge and allow to air dry.
6. Gently grasp the infant's foot controlling the foot, but allowing adequate circulation.
7. Use the tenderfoot incision-making devise to puncture an outer aspect of the infant's heel. Use the dry sterile gauze sponge to wipe away the first drop of blood.
8. Coax a large drop of blood from the puncture site. Touch the blood drop, but not the heel to the newborn screening form circle center. Avoid excessive squeezing of the puncture site. Fill all five circles on the card completely from one side of the filter paper. Refer to "Neonatal Screening Blood Specimen Collection and Handling Procedure" for complete review and specific instructions as to location of puncture site and correct collection technique.
9. When procedure is complete, cover the puncture site with a spot Band-Aid and return the infant to the crib.
10. Place the specimen Collection Form in the drying rack for ~3 hours or until completely dry (blood has turned brown). Do not wait and batch specimens for mailing. All specimens should be sent within 12 hours of collecting when possible.
11. Complete the Transport Log sheet. Send the original log sheet and the tests done and dried in the provided envelope. The yellow copy of the Transport Log goes in the manila folder in the Nursery.
12. In the event of an inadequate specimen, NBS will notify us to redraw the specimen. They will fax the initial sheet to us with the stated problem. We should contact the patient to have them return to NIH for a repeat draw. This is done in the nursery as an outpatient procedure without an attached charge. The Attending MD is also notified so contact can be made.
13. At times results of testing require further blood work. This will be completed in the laboratory as outpatient testing.

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Newborn Screening Test	
Scope:	Manual: OB/Gyn
Source: OB Nurse Manager	Effective Date:

For any questions please call: **Newborn Screening - ASC 96
CHCC
Madera, California**

Phone: 559/353-6416

Fax: 559/353-6403

DOCUMENTATION:

1. As noted above in procedure.
2. All results will be sent to the Perinatal Unit Nurse Manager. The results will be entered in the Nursery Log and then forwarded to the Medical Records Department for posting in the infant's chart.
3. The infant should be charged for "NBS Draw/Handling" and "Newborn Screening" on the charge sheet.

Committee(s) approval needed: NO

Responsibility for review and maintenance: Perinatal Unit Nurse Manager

Index Listings: Newborn Screening Test

Revised: 6/92; 11/97; 06/01, 09/08, 11/08jk, 9/2010jk, 2/2012jk

Last Board of Director review 3/21/18

Approval	Date
CCOC	
Perinatal-Pediatrics Committee	2/15/19
Medical Executive Committee	3/5/19
Board of Directors	
Last Board of Directors Review	

Revised:

Reviewed:

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Utilization Review Plan*	
Scope: Hospital Wide	Manual: Case Management, Utilization Review
Source: DON Nursing Practice	Effective Date: 7/1/15

PURPOSE:

The purpose of this plan is to identify the elements of a comprehensive utilization review management plan which is necessary to satisfy Medicare Conditions of Participation. This plan is coordinated to support Northern Inyo Healthcare District (NIHD) mission and vision by collecting and reviewing data that assures the appropriate allocation of hospital resources and specifically monitoring the necessity for appropriateness of hospitalization extended length of stay and the quality of this interaction. This plan provides framework for addressing under and over utilization of resources as well as the review of treatment to determine that the care provided meets professionally recognized standards of care.

POLICY:

1. Northern Inyo Hospital’s (NIH’s) UR plan applies to all patients regardless of payment source and all admissions are reviewed in accordance with federal and state regulations governing Utilization review.
2. Findings and recommendations of the Utilization Review Committee are reported to the Medical Executive Committee. Additional issues can be referred to Billing Coding Compliance Committee.
3. The UR plan shall be reviewed and evaluated by the Utilization Review Committee and the Medical Executive Committee at least once a year and revised as needed.

DEFINITIONS:

1. **Utilization Management Plan** means the organizational plan that contains the essential requirements for the establishment and implementation of a utilization management process to ensure the quality, appropriateness and efficiency of care and resources furnished by the facility and medical staff. The purpose of this plan is to ensure that patients at Northern Inyo Hospital receive medically necessary and appropriate care at the appropriate time and in the appropriate setting.
2. **INTERQUAL Criteria** means clinical decision support guidelines licensed for use by hospitals to evaluate the appropriateness of medical interventions and level of care based on clinical criteria and standards.
3. **Secondary Review** means a clinical review performed by a physician member of the Utilization Review Committee or a Physician Advisor when INTERQUAL guidelines suggest a different patient status or level of care than that ordered by the patient’s Physician and/or a potential quality concern.

PROCEDURE:

Overview:

A developed plan that contains

- Delineation of responsibilities and authority of personnel for conducting internal utilization review.
- Establishes procedures to review the medical necessity of admissions, extended stays, and professional services, and appropriateness of settings.
- Establish procedures for coverage determinations, denials, appeals, and peer review within the organization.
- Establishes reporting, corrective action and documentation requirements for the utilization management process.

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Utilization Review Plan*	
Scope: Hospital Wide	Manual: Case Management, Utilization Review
Source: DON Nursing Practice	Effective Date: 7/1/15

Plan Requirements

- Commitment and cooperation from the hospital administration and Medical/Hospital staff.
- Objective Review Criteria
- Maintenance of appropriate data
- Integration of UR findings into quality improvement activities
- Patient record access appropriate for Utilization review

Composition – See *Medical Staff bylaws*

- The Utilization Review committee is a standing committee of the medical staff and is responsible to the Medical Staff Executive Committee. The committee shall be comprised of two or more physicians and other practitioners to perform the utilization management function. The other members may be any of the other types of practitioners specified in 482.12(c) (1). The Utilization Review and Medical Records Committee shall consist of at least 4 active staff members selected on a basis that will ensure insofar as feasible, representation of the services and the major clinical specialties which are routinely practiced by Practitioners at Northern Inyo Hospital.
 - The Quality Improvement Coordinator, the Utilization Review/Infection Control Coordinator, the Director of Nursing, Billing Department Supervisor, Director of Medical Records, DRG Coordinator, the Hospital’s Patient Representative, and Social Service Director shall serve as Ex Officio non-voting members.
- The UR committee may be supported by representatives from Case Management and Administration, but only physicians and other practitioners are members for regulatory purposes.
- No person with a direct financial interest may participate in reviews conducted by the Committee.

Meetings

- The UR committee shall meet as a separate and distinct committee with its own agenda and minutes. The committee shall meet as often as necessary to accomplish primary functions, but no fewer than quarterly.
- Committee minutes shall be maintained according to hospital policy and include the date/time of the meeting, attendees, standard reports, action item follow-up, focused reviews, audits, and action to be taken. The minutes shall exclude patient or physician names from charts reviews.

Standard Reports

- Length of Stay
- Avoidable Days
- Appeal Outcomes
- Denials
- INTERQUAL review results (Cases or number of days that do not satisfy criteria for admission, continued stay and/or level care, and secondary reviews results)
- # of Admission Hospital Issued Notice of Non-coverage (HINN) letters issued

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Utilization Review Plan*	
Scope: Hospital Wide	Manual: Case Management, Utilization Review
Source: DON Nursing Practice	Effective Date: 7/1/15

- Observation information, including the number of observation stays converted to inpatient, average length of stay (hours) and the number exceeding 48 hours.
- Condition Code 44

Authority and Responsibility

- **UR (Case Management) Committee Chair**
 - Assigns responsibility for medical necessity secondary review process
 - Evaluates the effectiveness of utilization management activities
 - Reports evaluation results and/or issues to appropriate committees.
- **Utilization Review Committee**
 - Provides oversight to assure that health care furnished at Northern Inyo Hospital is consistent with professionally recognized quality standards.
 - Provides oversight to assure consistently appropriate and medically necessary treatment for patients.
 - Evaluates and acts upon peer review information related to medical necessity, appropriateness of treatment and quality of care.
 - Provides for confidentiality of the peer review process and findings.
 - Provides focused review and reporting mechanisms or identified utilization management problems
 - Arrange for two or more appropriate practitioners to perform UR functions
 - Schedule meetings with appropriate minutes and committee activity.
 - Provides annual review, evaluation and approval of the plan by both the UR and Medical Executive Committee.
- **Duties:** The Utilization Review and Medical Records Committee shall perform the following functions:
 - Delineate the scope of utilization review provided within the hospital
 - Develop critical indicators to be used as screening devices in reviewing the utilization of Hospital Services.
 - Establish thresholds used to trigger physician review.
 - After cases have been isolated using the critical indicators, evaluate the quality and appropriateness of care administered and identify areas for improvement.
 - Review patient care services to ascertain if quality care within the standards of the Hospital and Medical Staff is being provided in the most cost-effective manner, address overutilization, underutilization, and inefficient scheduling of care and resources.
- **Case Management Staff**
 - **Director:** The Director of Case Management, under the direction of the Utilization Review Committee, has responsibility for the following activities:
 - Delegates responsibilities to appropriate personnel to ensure coverage for determining appropriate patient status.
 - Provides guidance to the medical staff and hospital personnel regarding medical necessity criteria and appropriate service determinations

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Utilization Review Plan*	
Scope: Hospital Wide	Manual: Case Management, Utilization Review
Source: DON Nursing Practice	Effective Date: 7/1/15

- The process of measuring and assessing the use of professional care, services, procedures, and facilities, including the medical necessity and appropriateness of:
 - ◆ Necessity of admission
 - ◆ Level of care
 - ◆ Appropriate utilization of resources
 - ◆ Continued stay
 - ◆ Discharge/post hospital referrals
 - ◆ Readmissions
 - ◆ Performance improvement team activities to improve systems and processes associated with inefficient or inappropriate delivery of care and services.
- **Case Manager:**
 - Reviews medical record documentation to obtain information necessary for UR determinations
 - Screens patients from time of admission for potential discharge and aftercare needs
 - Applies utilization review criteria objectively regarding level of care using INTERQUAL guidelines on all admissions and continued stays regardless of payer.
 - Reviews all continued stays and addresses all concerns with attending physician/hospitalist
 - If admission criteria are not satisfied, the reviewer shall contact the attending physician for additional information. If additional information is provided to support the admission satisfies admission criteria, the admission shall be approved.
 - ◆ If additional information is not provided or the case still fails to satisfy admission criteria, an alternate level of care (ALOC) shall be discussed with the attending physician. If the attending physician agrees that an ALOC is appropriate, the Case Manager shall facilitate the transfer. If the attending does not agree to transfer to an ALOC, the case shall be referred for secondary review.
- ◆ **Secondary Review Process**
 - When an admission or continued stay case is referred by the Case Manager to a member of the committee for secondary review, the reviewer shall review the case based on the documentation in the medical record and discussions with the attending physician in order to determine medical judgment. Secondary review determinations shall be documented and supported with clinical rationale.
 - If the physician member of the UR committee determines that an admission or a continued stay is not medically necessary, the Case Manager will be contacted and provided instructions on the appropriate level of care. Any determination to transfer a patient from the inpatient level of care to the observation level of care resulting from the secondary review process must involve a physician of the UR committee and must also comply with the requirements of Condition Code 44.
 - If the UR committee or designee decides that continued stay in the hospital is not medically necessary, the designee must give written notification to the hospital, the

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Utilization Review Plan*	
Scope: Hospital Wide	Manual: Case Management, Utilization Review
Source: DON Nursing Practice	Effective Date: 7/1/15

patient, and the practitioner responsible for the care no later than two (2) days after the determination. (*See Utilization Review Plan**)

REFERENCES:

1. A-0308
 - a. **§482.30 Condition of Participation: Utilization Review**
2. A-309
 - a. **§482.30(a) Standard: Applicability**
3. A-0310
 - a. **§482.30(b) Standard: Composition of Utilization Review Committee**
4. A-0311
 - a. **§482.30(c) Standard: Scope and Frequency of Review**
5. A-3012
 - a. **§482.30(d) Standard: Determination Regarding Admissions or Continued Stays**
6. A-0313
 - a. **§482.30(e) Standard: Extended Stay Review**
7. A-0314
 - a. **§482.30(f) Standard: Review of Professional Services**
8. TENET Utilization Management Plan

CROSS REFERENCE P&P:

1. Utilization Review Plan*
2. Discharge Planning

Approval	Date
UR Committee	2/28/19
MEC	3/5/19
Board of Directors	
Last Board of Director review	4/18/18

Developed: 2/15

Reviewed: 12/1/2017

Revised: 11/2016, 12/2016

Supersedes:

Index Listings:

Utilization Review Critical Indicators

2019

1. Discharge Disputes
2. Status Issues
3. Placement issues
4. Denials
 - a. Swing Bed Denials
 - b. Social Admission Denials
 - c. SNF Denials
5. Untimely Records Completions

Approvals:

UR Committee: 2/28/19

Medical Executive Committee: 3/5/19

Board of Directors:

Radiology Services Committee

Critical Indicators

2019

1. Death within 24 hours of invasive procedure.
2. Admission to ED within 24 hours of invasive procedure.
3. Severe contrast reaction.
4. Code Blue in the department
5. Patient called back for having wrong procedure performed.
6. Staff concerns with breach of protocols.

Approvals

Radiology Services Committee: 2/19/19

MEC: 3/5/19

BOD:

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: DI - MRI Safety - Magnet Room Safety*	
Scope: MRI	Manual: MRI
Source: Operations - Director of Diagnostic Services (DI & Lab)	Effective Date: 4/15/15

PURPOSE:

To provide guidance to employees for the safety screening of patients and care takers entering the magnet room of the MRI department.

POLICY:

All patients and caretakers entering the magnet room are required to fill out a clearance form prior to entering the magnet room.

PROCEDURE:

1. All patients, staff, family members, or others providing care or assistance must complete MRI screening forms prior to entering the magnet room
2. All patients, staff, family members, or others providing care or assistance screening forms must be cleared by the MRI technologist before entering the magnet room. This includes orbital x-rays when there is suspicion of metallic foreign bodies in the eye.
3. All available resources including PACS and HIS/RIS systems will be checked prior to any patient being imaged to evaluate for any contraindicative devices.
4. Any patient, staff, family members or other care providers who are found to have contraindicated devices will NOT be permitted to enter the magnet room.
5. There are NO exceptions to this policy. Contraindicated devices in the magnet room may be harmful or fatal for the patient or others in the magnet room.

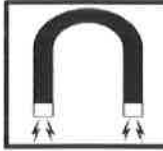
Approval	Date
Radiology Services Committee	2/17/2015
Medical Executive Committee	4/7/2015
Administration	2/17/2015
Board of Directors	4/15/2015
Last Board of Director review	4/19/17

Developed: 12/31/2014 DDI

Reviewed:

Revised:

MAGNETIC RESONANCE (MR) SCREENING FOR EMPLOYEES



The MR system has a very strong magnetic field that may be hazardous to individuals entering the MR environment or MR system room if they have certain metallic, electronic, magnetic, or mechanical implants, devices or objects. Therefore, **ALL** individuals are required to fill out this form **BEFORE** entering the MR environment or MR system room. Be advised, the MR system magnet is **ALWAYS** on.

Date: ____/____/____ Name: ____ Name: ____ Employee #: ____
month / day / year Last Name First M.I.

I have reviewed the lists below, and for personal reasons I have elected not to document my responses. I understand that I am required to remain outside the MR environment AT ALL TIMES in order to maintain a safe environment for myself and those around me.

Signature of Person Completing Form: _____

1. Have you ever worked with metal (grinding, fabricating, etc.) or ever had an injury to the eye involving a metallic object (e.g., metallic slivers, shavings, foreign body)? Yes No

If yes, please describe: _____

2. Are you pregnant or experiencing a late menstrual period? Yes No



WARNING: Certain implants, devices, or objects may be hazardous to you in the MR environment or MR system room. **Do not enter** the MR environment or MR system room if you have any question or concern regarding an implant, device, or object.

<input type="checkbox"/> Yes <input type="checkbox"/> No Cardiac pacemaker or Cardiac defibrillator	<input type="checkbox"/> Yes <input type="checkbox"/> No Any implant held in place with a magnet
<input type="checkbox"/> Yes <input type="checkbox"/> No Internal electrodes or pacing wires	<input type="checkbox"/> Yes <input type="checkbox"/> No IUD, Diaphragm or Pessary
<input type="checkbox"/> Yes <input type="checkbox"/> No Aneurysm clip(s)	<input type="checkbox"/> Yes <input type="checkbox"/> No Tattooed makeup (eyeliner, lips, etc.)
<input type="checkbox"/> Yes <input type="checkbox"/> No Neurostimulator or Deep brain stimulator	<input type="checkbox"/> Yes <input type="checkbox"/> No Body piercing(s)
<input type="checkbox"/> Yes <input type="checkbox"/> No Cochlear implant or other ear implant	<input type="checkbox"/> Yes <input type="checkbox"/> No Any metal fragments, bullets or shrapnel
<input type="checkbox"/> Yes <input type="checkbox"/> No Eye implant or Eyelid spring	<input type="checkbox"/> Yes <input type="checkbox"/> No Metal or wire mesh implants
<input type="checkbox"/> Yes <input type="checkbox"/> No Insulin pump or Drug infusion device	<input type="checkbox"/> Yes <input type="checkbox"/> No Wire sutures or surgical staples
<input type="checkbox"/> Yes <input type="checkbox"/> No Vascular access port or Swan-Ganz catheter	<input type="checkbox"/> Yes <input type="checkbox"/> No Harrington rods (spina) / spinal fusion rods
<input type="checkbox"/> Yes <input type="checkbox"/> No Medication skin patch (Nitro/Pain)	<input type="checkbox"/> Yes <input type="checkbox"/> No Joint replacement
<input type="checkbox"/> Yes <input type="checkbox"/> No Bone growth / fusion stimulator	<input type="checkbox"/> Yes <input type="checkbox"/> No Bone / joint pin, screw, nail, wire, plate
<input type="checkbox"/> Yes <input type="checkbox"/> No Carotid artery vascular clamp	<input type="checkbox"/> Yes <input type="checkbox"/> No Hearing aid (Remove before MRI)
<input type="checkbox"/> Yes <input type="checkbox"/> No Artificial heart valve or Aortic clip	<input type="checkbox"/> Yes <input type="checkbox"/> No Dentures (Remove before MRI)
<input type="checkbox"/> Yes <input type="checkbox"/> No Intravascular stents, filters or coils	Other: please explain: _____
<input type="checkbox"/> Yes <input type="checkbox"/> No IVC filter	_____
<input type="checkbox"/> Yes <input type="checkbox"/> No Shunt (spinal or intraventricular)	_____
<input type="checkbox"/> Yes <input type="checkbox"/> No Tissues expander or breast implants	_____
<input type="checkbox"/> Yes <input type="checkbox"/> No Penile implant	_____

Before entering the MRI Scan Room, please remove all metallic objects including hair pins, barrettes, jewelry, watches, safety pins, paperclips, money clip, keys, coins, pens, credit cards, beepers, and cellular phones.

I attest that the above information is correct to the best of my knowledge. I have read and understand the entire contents of this form and have had the opportunity to ask questions regarding the information on this form.

Signature of Person Completing Form: _____ Date/Time: _____

DO NOT WRITE BELOW THIS LINE... MRI STAFF ONLY.

MR SAFE It is safe for this individual to enter and remain inside the MR environment

MR UNSAFE It is **NOT** safe for this individual to enter and remain inside the MR environment

Reviewing MRI Technologist Name

Signature

Date

Time

Reviewing Radiologist

Signature

22

Date

Time



Northern Inyo Hospital
 150 Pioneer Lane
 Bishop, California 93514

MRI SAFETY SCREENING FORM FOR PATIENTS

Name: _____ D.O.B: _____
 Gender: _____ Age: _____ Weight: _____ Date: _____
 Referring Physician: _____

	<p>WARNING: Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MR procedure. Do Not Enter the MRI system room or MR environment if you have any questions or concern regarding an implant, device or object. Consult the MRI Technologist or Radiologist BEFORE entering the MR system room. We Strongly recommend using ear plugs or headphones for your MRI exam since some patients find the noise levels unacceptable.</p> <p style="text-align: center;"><i>The MR System magnet is ALWAYS on.</i></p>
--	--

1. Have you ever had surgery (operation, arthroscopy, endoscopy, biopsies, etc.) of any kind?

2. Have you ever experienced any problem related to a previous MRI examination procedure? Yes No

3. Have you had an injury to the eye involving a metallic object or fragment (metallic silvers, etc)? Yes No
 If yes, did you receive medical attention for the eye injury? Yes No

4. Have you ever been injured by a metallic object or foreign body (bullet, BB, shrapnel, etc.)? Yes No

5. Are you currently taking or have you recently taken any medication or drug? Yes No
 If yes, please list: _____

6. Do you have allergies? Yes No
 If yes, please list _____

* 1RAD *

7. Do you have:

- Renal or Kidney problems or disease? Yes No History of seizure disorder? Yes No
 Asthma or respiratory disease? Yes No History of cancer? Yes No
 Anemia or other blood disease? Yes No Do you have Diabetes? Yes No
 Are you on renal (kidney) dialysis? Yes No

For female patients:

8. Date of last menstrual period: «Last_Menstrual_Period_D Post Menopausal? Yes No

9. Are you pregnant or experiencing a late menstrual period? Yes No

10. Are you taking oral contraceptives or receiving hormonal treatment or hormone replacement therapy? Yes No

11. Are you taking any type of fertility medication or having fertility treatments? Yes No

If yes, please list: _____

12. Are you currently breastfeeding? Yes No

<input type="checkbox"/> Yes	<input type="checkbox"/> No	Aneurysm repair or clip(s) Circle: Brain Abdomen	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Implanted drug infusion device
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Cardiac Pacemaker or pacing wires	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Foley catheter with temperature sensor
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Implanted cardioverter defibrillator (ICD)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Any type of prosthesis (eye, penile implant, etc.)
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Electronic implant or device	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Pill Cam Capsule (endoscopy device)
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Magnetically-activated implant or device	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heart valve replacement or prosthesis
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Neurostimulation system (TENS unit)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Eyelid spring, wire, or eyelid weights
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Spinal cord stimulator	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Lens implant, IMT lens implant, retinal tack
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Internal electrodes or wires	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Artificial limb (prosthesis) List: _____
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Bone growth/bone fusion stimulator	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Stent, filter, or coil
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Cochlear, otologic, staples or any ear implant	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Shunt-spine or brain (intraventricular)

* 1RAD *

<input type="checkbox"/> Yes	<input type="checkbox"/> No	Vascular access port or catheter (porta-cath)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	IUD, diaphragm or pessary
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Radiation seeds or implants	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Dentures, partial plates
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Swan-Ganz or thermodilution catheter	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Magnetic dental implants
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Medication patch (nicotine, nitro, birth control)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tattoos or permanent cosmetics
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Any metal fragment or foreign body	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Body piercing, jewelry (Remove them)
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Wire mesh implant	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Body modification implants
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tissue expander (ie., breast)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hearing aid (Remove them)
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Surgical staples, clips or metallic sutures	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Sound Tec Direct Drive Hearing System
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Joint replacement (hip, Knee, etc.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Other implant:
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Bone or joint pin, screw nail, wire, plate, etc.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Breathing problems or tremors
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Acticoat silver wound dressing	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Claustrophobia
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Metal reinforced Endo Tracheal Tube	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is the patient on blood dialysis?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Rectal Probe Thermometer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, when is the next dialysis appointment?

IMPORTANT INSTRUCTIONS: Before entering the MR environment or MR system room, you must remove all metallic objects including hearing aid, keys, beeper, cell phone, hair pins, barrettes, jewelry, body piercing jewelry, watch, safety pins, paper clips, money clip, credit cards/magnetic strip cards, coins, pens, pocket knife, lighter, nail clipper, tools, dentures, clothing with metal or metallic threads. Please consult the MRI Technologist if you have any question or concern BEFORE you enter the MR scan room.

I attest that the above information is correct to the best of my knowledge. I have read and understand the contents of this form and had the opportunity to ask questions regarding the information on this form and regarding the MR procedure I am about to undergo. I hereby give my consent for the MRI examination.

Signature X: _____ Date: _____

Form completed by: Patient Relative Nurse _____

* 1RAD*



Northern Inyo Healthcare District
 150 Pioneer Lane
 Bishop, California 93514

Patient Label

MAGNETIC RESONANCE IMAGING (MRI) CONSENT FORM

I, the undersigned, voluntarily agree to the completion of an MRI. I have been informed of the following:

1. This procedure requires that I lie still on a padded table within the Magnetic Resonance Imager (MRI) for 30 to 60 minutes.
2. The inside of the MRI contains a large magnet.
3. The scanner has no moving parts and utilizes no x-ray radiation for image production.
4. There will be an associated sound of hammering as the radiowaves are transmitted during the scan. Earplugs or headphones will be provided to me.
5. While in the scanner, the MRI technologist will be able to communicate with me via a two-way intercom system.
6. I will be instructed to place all of my belongings into a locker, including watches, credit cards, bank cards, jewelry (including rings), dentures, wigs and hairpins.
7. I notified the technologist about any metal, surgeries or implanted medical devices that I might have.
8. Exposure to the magnetic field produces no known side effects. I will let the MRI technologist know if I experience any discomfort while I am being scanned.
9. If determined necessary by the Radiologist, I agree to the administration of a contrast media to be injected in my vein while I am having the scan. The contrast is FDA approved and used routinely for MRI exams. It contains a material called gadolinium. **The injection of contrast may cause discomfort, tingling or warmth in the lips, metallic taste in the mouth, tingling in the arm, nausea or headache. These symptoms are rare and usually go away quickly.**
10. People with kidney failure who receive gadolinium are at risk of developing Nephrogenic Systemic Fibrosis (NSF). NSF is a rare fibrosing condition of the skin and internal organs that may develop rapidly. NSF could be a serious progressive disease and in very rare cases may result in death. I have had the opportunity to discuss the risks and benefits of contrast use with the doctor. My questions have been answered. **For patients with no history of kidney failure, the risk of developing this condition is very small.**
11. There are no known risks associated with having MRI imaging without contrast during pregnancy; however, I will tell the technologist if I think there is any chance I could be pregnant.

Signature: _____ Date: _____ Time: _____

Witness: _____ Date: _____



**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: DI - MRI Safety Burn/Thermal Incident Reduction Policy*	
Scope: Departmental	Manual: MRI
Source: Operations - Director of Diagnostic Services (DI & Lab)	Effective Date: 3/21/16

PURPOSE:

To prevent excessive heating and possible burns associated with MR procedures

POLICY:

Complete and thorough screening, preparation, and monitoring of patients by appropriately licensed and trained MRI technologists shall be performed for every patient on every exam at every visit. Incidents of thermal incidents shall be reported, investigated, and reviewed at appropriate Safety and Medical Staff committee meetings.

PROCEDURE:

- 1) The patient should change into a gown or other appropriate attire that does not contain metallic material.
- 2) Prepare the patient for the MR procedure by ensuring that there are no unnecessary metallic objects contacting the patient's skin (e.g., drug delivery patches with metallic components, jewelry, necklaces, bracelets, key chains, etc.).
- 3) Prepare the patient for the MR procedure by using insulation material (i.e. appropriate padding) to prevent skin-to-skin contact points and the formation of "closed-loops" from touching body parts.
- 4) Insulating material (minimum recommended thickness, 1-cm) should be placed between the patient's skin and transmit RF coil that is used for the MR procedure (alternatively, the transmit RF coil itself should be padded). There should be no direct contact between the patient's skin and the transmit RF body coil of the MR system. This may be accomplished by having the patient place his/her arms over his/her head or by using elbow pads or foam padding between the patient's tissue and the transmit RF body coil of the MR system. This is especially important for MR examinations that use the transmit RF body coil or other large RF coils for transmission of RF energy.
- 5) Use only electrically conductive devices, equipment, accessories (e.g., ECG leads, electrodes, etc.), and materials that have been thoroughly tested and determined to be safe or otherwise acceptable for MR procedures.
- 6) Carefully follow specific MR safety or MR conditional criteria and recommendations for implants and devices made from electrically-conductive materials (e.g., bone fusion stimulators, neurostimulation systems, cardiac pacemakers, cochlear implants, intracranial pressure monitoring catheters, etc.).
- 7) Before using electrical equipment, check the integrity of the insulation and/or housing of all components including surface RF coils, monitoring leads, cables, and wires. Preventive maintenance should be practiced routinely for such equipment.

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: DI - MRI Safety Burn/Thermal Incident Reduction Policy*	
Scope: Departmental	Manual: MRI
Source: Operations - Director of Diagnostic Services (DI & Lab)	Effective Date: 3/21/16

Thermal incidents shall be documented on the patient log. The Diagnostic Imaging Manager or Director and radiologist shall be notified of the incident immediately. An incident report shall be completed and submitted for review.

REFERENCES:

1. Guidelines to Prevent Excessive Heating and Burns Associated with Magnetic Resonance Procedures, was developed by the Institute for Magnetic Resonance Safety, Education, and Research (IMRSER) and published with permission. Reviewed and updated 2015.

Approval	Date
Radiology Services Committee	2/16/2016
Medical Executive Committee	3/1/2016
Board of Directors	3/16/16
Last Board of Directors Review	

Developed: 2/5/2016 - PD

Reviewed: 2/15/17

Revised:

Supersedes:

Index Listings:

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: DI - MRI Safety, Ear Protection*	
Scope: Departmental	Manual: MRI
Source: Operations - Director of Diagnostic Services (DI & Lab)	Effective Date:

PURPOSE: To provide guidance for the technologist to ensure hearing protection is used properly in the MRI magnet room.

POLICY: All patients and persons entering the MRI magnet room must be provided with hearing protection when the magnet is in use.

PROCEDURE:

1. The patient will be properly screened and positioned for the MRI exam.
2. After all patient questions have been answered, the MRI technologist will provide foam or ear covering hearing protection for the duration of the scan.

Approval	Date
Radiology Services Committee	2/17/2015
Medical Executive Committee	4/7/2015
Administration	2/17/2015
Board of Directors	4/15/2015

Developed: 12/30/2014 - DDI

Reviewed:

Revised:

Supersedes:

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Diagnostic Imaging - Handling of Radioactive Packages, Non-nuclear medicine personnel	
Scope: Hospital Wide	Manual: Administrative, Nuclear Medicine
Source: Operations - Director of Diagnostic Services (DI & Lab)	Effective Date:01-01-2017

PURPOSE: provide guidelines and documentation of training of non-nuclear medicine personnel for the safe handling and delivery (to nuclear medicine department) of radioactive packages

POLICY:

All non-nuclear medicine personnel, i.e., security officer on duty or purchasing/materials management personnel, who may receive and/or deliver (to nuclear medicine) packages containing radioactive materials will be trained regarding proper handling and delivery of these packages.

PROCEDURE:

Appropriate personnel are instructed to follow the guidelines listed below upon receiving radioactive packages. A signed copy of this procedure will be kept in the Radiology Manager’s office to document training.

- Visually inspect the package, prior to handling. Notify Nuclear Medicine personnel immediately if package appears to be damaged or leaking. Do not handle a damaged or leaking package.
- Wear gloves when handling any radioactive package.
- Use cart or “dolly” to deliver radioactive packages. This maximizes distance between personnel and the package, minimizing radiation exposure rates.
- Promptly deliver all radioactive packages received to the Nuclear Medicine Department. If a nuclear medicine technologist is present, deliver package to them. If no nuclear medicine technologist is present, leave package at the hot lab door.
- Remove gloves immediately after delivery of package, dispose of the gloves in the Nuclear Medicine Imaging room trash.

If there are any questions regarding handling of radioactive packages, contact the Nuclear Medicine Department, ext. 2636; or the Director of Diagnostic Imaging, ext. 2634.

This document may be printed and used for documentation of annual training.

Trainee signature: _____

Nuclear Medicine Technologist – Trainer: _____

REFERENCES:

1. 10 CFR 20
2. 10 CFR 35
3. Guide for the Preparation of an Application for a Radioactive Materials License Authorizing Medical Use, Retrieved from: <http://www.cdph.ca.gov/pubsforms/Guidelines/Documents/RHB-MedicalGuide.pdf>,

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Diagnostic Imaging - Handling of Radioactive Packages, Non-nuclear medicine personnel	
Scope: Hospital Wide	Manual: Administrative, Nuclear Medicine
Source: Operations - Director of Diagnostic Services (DI & Lab)	Effective Date:01-01-2017

Committee Approval	Date
CCOC	12-18-17
Radiology Services Committee	11-21-17
Medical Executive Committee	12-05-17
Board of Directors	12-13-17

Revised: 11-21-17

Supersedes: Handling of Radioactive Packages, Non-nuclear medicine personnel, 2014

Responsibility for review and maintenance: DDI

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Diagnostic Imaging - Radioactive Material Hot Lab Security	
Scope: Hospital Wide	Manual: Nuclear Medicine
Source: Operations - Director of Diagnostic Services (DI & Lab)	Effective Date:01-01-2018

PURPOSE:

To define authorized entrance to the radioactive materials (RAM) hot lab.

POLICY:

1. The hot lab door shall remain locked at all times, unless authorized personnel are inside or supervising entrance to the hot lab.
2. Only authorized nuclear medicine personnel, Radiation Safety Officer and Medical Physicists may enter the hot lab unsupervised.
3. For after hours deliveries, contact the Nuclear Medicine Technologist, the Imaging Manager, or Director of Diagnostic Services for access to the hot lab for deliveries of RAM packages after –hours in accordance with the “Diagnostic Imaging - Radioactive Materials Delivery After-hours Policy/Procedure”

REFERENCES:

1. Guide for the Preparation of an Application for a Radioactive Materials License Authorizing Medical Use, Retrieved from: <http://www.cdph.ca.gov/pubsforms/Guidelines/Documents/RHB-MedicalGuide.pdf>,
2. 10 CFR 35

Cross Reference Policy

1. Diagnostic Imaging - Radioactive Materials Delivery After-hours Policy/Procedure

Committee Approval	Date
CCOC	12-18-17
Radiology Services Committee	11/21/17
Medical Executive Committee	12/05/17
Board of Directors	12-13-17

Supersedes: Hot Lab Security, 2014

Responsibility for review and maintenance: DDI

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Diagnostic Imaging - Radioactive Materials Delivery After-hours Policy/Procedure	
Scope: Departmental	Manual: Administrative, Nuclear Medicine
Source: Operations - Director of Diagnostic Services (DI & Lab)	Effective Date: 01-01-2018

PURPOSE: provides procedure for the safe receipt and handling of radioactive materials when nuclear medicine and trained purchasing/materials management personnel are not present to receive packages

POLICY:

1. If a courier arrives at the hospital after operating hours with radioactive packages, the courier will be directed to the Emergency entrance.
2. The Emergency Department clerk or any other emergency department personnel will call the Nursing Supervisor to sign for the package.
3. The Nursing Supervisor will contact:
 1. The Nuclear Medicine Technologist
 2. Manager of Diagnostic Imaging, or
 3. The Director of Diagnostic Services
4. The Nursing Supervisor will escort the courier to the Nuclear Medicine department to secure the radioactive packages in the Hot Lab (R132 in Nuclear Medicine).
5. The Nursing Supervisor will not handle the radioactive package at any time.
6. Should any problems or questions arise regarding this policy and procedure the Nuclear Medicine Technologist and/or the Radiation Safety Officer (RSO) will be called by the Nursing Supervisor. The numbers for the NMT and the RSO are posted on the hot lab door.

PROCEDURE:

1. Call the Nursing Supervisor to the Emergency entrance upon arrival of a courier making delivery of radioactive isotopes.
2. The Nursing Supervisor will sign for the package and escort the courier to the Nuclear Medicine Hot Lab and unlock the door with the punch key provided.
3. The courier will place the package in the Hot Lab on the floor to the left of the door and the Nursing Supervisor will make sure that the Hot Lab door is securely locked when he or she leaves.

REFERENCES:

1. Guide for the Preparation of an Application for a Radioactive Materials License Authorizing Medical Use, Retrieved from: <http://www.cdph.ca.gov/pubsforms/Guidelines/Documents/RHB-MedicalGuide.pdf>,
2. 10 CFR 35

Cross Reference Policy

1. Diagnostic Imaging - Radioactive Materials Delivery After-hours Policy/Procedure

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Diagnostic Imaging - Radioactive Materials Delivery After-hours Policy/Procedure	
Scope: Departmental	Manual: Administrative, Nuclear Medicine
Source: Operations - Director of Diagnostic Services (DI & Lab)	Effective Date: 01-01-2018

Committee Approval	Date
CCOC	12-18-17
Radiology Services Committee	11/21/17
Medical Executive Committee	12/05/17
Board of Directors	12-13-17

Supersedes: Nuclear Medicine after hours delivery - 2014

Responsibility for review and maintenance: DDI

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Diagnostic Imaging - Radioactive Waste Storage and Disposal	
Departments/Scope: Nuclear Medicine	
Source: Diagnostic Imaging Director	Effective Date: 01-01-2018

PURPOSE:

To ensure that radioactive waste is properly stored and handled until such time that it can be discarded following the general hospital waste procedures.

POLICY:

Radioactive waste shall be stored in the hot lab, or designated radioactive materials storage room, shielded, for a minimum of 10 half-lives and until it is indistinguishable from background radiation exposure levels, whichever is longer.

Human excreta is not considered radioactive waste. Human waste from patients undergoing diagnostic nuclear medicine procedures shall be handled according to hospital body fluid policy.

Radioactive materials are not disposed of into the sewage system, except wash water, which does NOT exceed allowable limits as stated in 10 CFR 20.

PROCEDURE:

- 1) Document all radioactive waste stored for decay on the "Waste Storage Log." If multiple isotopes are involved, always document the isotope with the longest half-life.
- 2) Store radioactive waste for 10 half-lives and until the radiation exposure levels, at the surface, are indistinguishable from background, whichever is longer.
- 3) Deface or destroy all radioactive labels.
- 4) Discard waste that is indistinguishable from background, and has been stored greater than 10 half-lives, following regular hospital waste guidelines.
- 5) Log discarded trash out on the "Waste Storage Log."

Reference

10 CFR 20.2

Committee Approval	Date
Committee Approval	Date
CCOC	12-18-17
Radiology Services Committee	11/21/17
Medical Executive Committee	12/05/17
Board of Directors	12-13-17

Supersedes: Radioactive waste storage and disposal, 11/2014
Responsibility for review and maintenance: DDI

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Diagnostic Imaging - Disposal of radioactive sharps	
Scope: Multidepartmental	Department: Diagnostic Imaging, Infection Control Blue Manual
Source: Radiology Director	Effective Date:

Purpose:

To prevent needle sticks and ensure safe disposal of radioactive sharps.

Policy:

1. Needles used with radioactive materials shall be recapped with a needle-capping device or one-handed recapping technique.
2. Needle/syringe shall be transported in a lead lined metal box.
3. Once the syringe and needle are returned to the Nuclear Medicine Hot Lab, they will be discarded in a sharps container.
4. The sharps container shall be stored in a lead shielded container or cabinet for decay at least 10 half-lives. The surface radiation survey of the container shall be indistinguishable from background prior to disposal.
5. Following radioactive decay in storage, all radiation labels shall be obliterated and sharps container shall be disposed of according to hospital policy.

Reference:

10 CFR 20.2
10 CFR 35.92

Committee Approval	Date
Radiology Services Committee	8/19/2014
Medical Executive Committee	9/2/2014
Administration	8/19/2014
Board of Directors	9/17/2014

Developed: 9/98;

Reviewed:

Revised: 10/2000; 6/2003; 10/2006 mw, 11/2010pd, 8/2011pd, BS 9/12, 11/13 PD, 7/2014 PD

Supersedes:

Responsibility for review and maintenance: DDI

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Diagnostic Imaging - Nuclear Medicine New Employee/Annual Orientation*	
Scope: Departmental	Manual: Nuclear Medicine
Source: Operations - Director of Diagnostic Services (DI & Lab)	Effective Date:

PURPOSE: The purpose of this guideline is to ensure that new Nuclear Medicine department employees are oriented to the practices, policies and equipment in the department. This guideline also documents annual review and re-orientation for all Nuclear Medicine department employees.

POLICY: Nuclear Medicine employees shall be oriented to the practices and policies in the nuclear medicine department.

PROCEDURE:

1. Each area on the list below shall be reviewed, in accordance with state and federal guidelines.
2. Employee shall review information and equipment listed below with the Radiation Safety Officer or Director of Diagnostic Imaging.
3. Employee shall sign this document and place in technologist’s binder. Provide a copy to the Human Resources department for employee personnel files.

Area of orientation or review	Tech initials	RSO/DDI initials
Proper operation and safety - GE Infinia Hawkeye and Xeleris workstation		
Proper operation and safety - Atomlab 500 and 100 plus dose calibrators		
Proper operation and safety – Ludlum Model 44-10 Gamma Scintillator Meter		
Proper operation and safety – Ludlum 14-C GM survey meter		
Proper operation and safety – Captus 3000 Uptake Probe and Well Counter		
Proper operation and safety – Mo99/Tc99m Generator		
Review Radiation Safety Program (ALARA Program)		
Review location of monthly Occupational Exposure Reports		
Review preparation and handling of radiopharmaceuticals		
Proper operation and safety of “Germfree” Radiopharmacy laminar flow hood		
Review quality control procedures for radiopharmaceuticals		
Review procedures for monitoring and storing radioactive waste		
Review procedures for shipping/receiving radioactive materials		
Review procedures for in-house transportation of radioactive materials		
Review procedures for injection of radioactive materials		
Review procedure for daily surveys for radioactive contamination		
Review procedure for weekly area survey and wipe tests for radioactive contamination		
Review procedure for Hot Lab security		
Review procedures for Nuclear Medicine patient examinations		
Signature:	Date	
RSO/DDI signature:	Date	

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Diagnostic Imaging - Nuclear Medicine New Employee/Annual Orientation*	
Scope: Departmental	Manual: Nuclear Medicine
Source: Operations - Director of Diagnostic Services (DI & Lab)	Effective Date:

REFERENCES:

1. Guide for the Preparation of an Application for a Radioactive Materials License Authorizing Medical Use. CA-DPH. 2010. Item 13 – Personnel Training Program

Approval	Date
Radiology Services Committee	12/16/2015
Medical Executive Committee	1/5/2016
Board of Directors	01/19/2016
Last Board of Director review	

Developed:

Reviewed: 11/01/2015

Revised: 9/26/14 DDI, 4/15/2015,

Supersedes: "Department Specific New/Annual Employee Orientation" 2009

Responsibility for review and maintenance: DDI

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Diagnostic Imaging - Ordering Radioactive Materials*	
Scope: Multi-departmental	Manual: Nuclear Medicine, Purchasing
Source: Operations - Director of Diagnostic Services (DI & Lab)	Effective Date:

PURPOSE: ensure that materials and quantities of radioactive materials (RAM) ordered are authorized by the license and that possession limits for RAM are not exceeded.

POLICY: The nuclear medicine technologist maintains written records that identify the authorized user or department, isotope, chemical form, activity, and supplier.

PROCEDURE:

1. For routinely and occasionally used materials, the Radiation Safety Officer or designee (nuclear medicine technologist) shall keep written records that identify the authorized user or department, isotope, chemical form, activity, and supplier.
2. The written records of order will be checked to confirm that the RAM received were ordered through proper channels.

REFERENCES:

1. Guide for the Preparation of an Application for a Radioactive Materials License Authorizing Medical Use, Retrieved from: <http://www.cdph.ca.gov/pubsforms/Guidelines/Documents/RHB-MedicalGuide.pdf>,
- 2.

CROSS REFERENCE P&P:

- 1.
- 2.
- 3.

Committee Approval	Date
Radiology Services Committee	2/17/2015
Medical Executive Committee	4/7/2015
Administration	2/17/2015
Board of Directors	4/15/2015

Developed:

Reviewed:

Revised:

Supercedes:

Responsibility for review and maintenance:

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Diagnostic Imaging - Ordering Radioactive Materials*	
Scope: Multi-departmental	Manual: Nuclear Medicine, Purchasing
Source: Operations - Director of Diagnostic Services (DI & Lab)	Effective Date:

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Diagnostic Imaging - Radioactive Material Spills Procedure	
Scope: Departmental	Manual: Nuclear Medicine
Source: Operations - Director of Diagnostic Services (DI & Lab)	Effective Date: 7/20/2014

PURPOSE: To define the duties of the nuclear medicine technologist in the event of major and minor spills in the hospital

PROCEDURE:

Major Spills

1. Clear the area. Notify all persons not involved to vacate the room.
2. Prevent the spread. Cover the spill with absorbent pads, but do not attempt to clean up. Confine the movement of all personnel potentially contaminated to prevent the spread
3. Shield the source. If possible, the spill should be shielded, but only if it can be done without further contamination or without significantly increasing personnel radiation exposure.
4. Close the room. Vacate and lock the room. Place appropriate radioactive materials sign on locked door.
5. Call for help. Notify the Radiation Safety Officer immediately.
 - a. Telephone number- EXT. 2636
 - b. Home number- 760-920-8630
6. Decontamination of personnel. Contaminated clothing should be removed and stored for further evaluation by the Radiation Safety Officer. If the spill is on the skin, flush with warm water thoroughly, wash with mild soap or Radiacwash.
7. Complete Radioactive Materials (RAM) Spills report. File in Nuclear Medicine office.
8. Complete Quality Review Report (QRR), send to QAPI.

Minor Spills

1. Notify persons in the area that a small spill has occurred.
2. Prevent the spread. Cover the spill with absorbent paper.
3. Carefully and quickly, clean the spill. Use absorbent pads and place in plastic bags. Dispose of bags in shielded radioactive waste container. Include all other contaminated materials such as disposable gloves, foot covers.
4. Survey the area with a GM survey meter. Check all areas at the surface of spill and also surrounding areas for possible contamination. The level of exposure must be indistinguishable from background exposure level, or the spill area must be shielded.
5. Wipe test the area of spill to check for removable contamination. Repeat cleaning of the area until the wipe test is less than 2000dpm/cm². If unable to clean sufficiently, cover with plastic backed absorbent paper. Place the absorbent side on the area of the spill, plastic up.
6. Report. Notify the Radiation Safety Officer of the incident.
7. Complete RAM Spills report. File in Nuclear Medicine office.
8. Complete Quality Review Report (QRR), send to QAPI.

REFERENCES:

1. 10 CFR 20
2. 10 CFR 35

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Diagnostic Imaging - Radioactive Material Spills Procedure	
Scope: Departmental	Manual: Nuclear Medicine
Source: Operations - Director of Diagnostic Services (DI & Lab)	Effective Date: 7/20/2014

3. Guide for the Preparation of an Application for a Radioactive Materials License Authorizing Medical Use, Retrieved from: <http://www.cdph.ca.gov/pubsforms/Guidelines/Documents/RHB-MedicalGuide.pdf>, Appendix K.

Committee Approval	Date
Radiology Services Committee	8/19/2014
Medical Executive Committee	9/2/2014
Administration	8/19/2014
Board of Directors	9/17/2014

Developed:

Reviewed:

Revised: 7/23/2014

Supersedes: Nuclear Medicine Spills Policy, 2004

Responsibility for review and maintenance: DDI, RSO

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: ALARA Program*	
Scope: Hospital Wide	Manual: Diagnostic Imaging
Source: Operations - Director of Diagnostic Services (DI & Lab)	Effective Date: 11/19/15

PURPOSE:

The purpose of establishing an ALARA (as low as reasonably achievable) Program is to incorporate practices, procedures and quality assurance checks to keep occupational and medical exposure to radiation as low as reasonably achievable.

Definitions:

ALARA – “as low as reasonably achievable,” acronym for the philosophy of keeping medical and occupational radiation exposure as low as reasonable achievable.

RSO – Radiation Safety Officer

RSC – Radiation Safety Committee

POLICY:

The term ALARA is an acronym for maintaining radiation exposures, and effluent releases of radioactive material in uncontrolled areas “as low as reasonably achievable” taking into account the available technology, economic costs in relation to benefits to the public health and safety, and other societal and socioeconomic considerations in their relationship with the utilization of radioactive materials and radiation – producing equipment in the public interest.

The ALARA philosophy extends to exposure to individuals in the performance of their duties (Occupational exposure) and to patients undergoing medical evaluations and treatments.

To achieve this goal, the management should address dose reduction for both workers and patients.

Although the program presented here is developed specifically for occupational exposure considerations, management should incorporate into their program those procedures, practices, and quality assurance checks that can eliminate unnecessary or extraneous radiation exposures to patients without compromising the quality of medical service. Such practices and checks include, but are not limited to:

- a) Use of appropriate and well-calibrated instrumentation and equipment.
- b) Use of appropriate digital imaging techniques
- c) Use of organ shields in diagnostic radiology.
- d) Staying with the well-established dosage limits unless deviation is absolutely essential in the judgment of the responsible physician.

1. Management Commitment

- a) We, the management of Northern Inyo Hospital, are committed to an efficient medical use of radioactive materials and radiation producing equipment by limiting their use to clinically indicated procedures, utilizing efficient exposure techniques, and optimally operated radiation equipment; limiting dosages to those recommended by the manufacturer unless otherwise necessary, using calibrated diagnostic and related instrumentation; and using appropriately trained personnel.

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: ALARA Program*	
Scope: Hospital Wide	Manual: Diagnostic Imaging
Source: Operations - Director of Diagnostic Services (DI & Lab)	Effective Date: 11/19/15

- b) We commit to the program described below for keeping occupational individual and collective doses ALARA. Toward this commitment, we hereby describe an administrative organization for radiation safety and will develop all necessary written policy, procedures, and instruction to foster the ALARA philosophy within our institution. The organization will include a Radiation Safety Committee (RSC) and a Radiation Safety Officer (RSO).
- c) We will perform a formal annual review of the radiation safety program, including ALARA considerations. The review will cover operating procedures and past dose records, inspections, and recommendations of the radiation safety staff or consultants.
- d) We will modify operating and maintenance procedures, equipment, and facilities if these modifications will reduce exposures and the cost is justified.

2. Radiation Safety Committee

a. Review of Proposed Users and Uses

- (1) The RSC will thoroughly review the qualifications of each applicant with respect to the types and quantities of radioactive materials and radiation-producing equipment and methods of use for which application has been made, to ensure that the applicant will be able to take appropriate measures to maintain exposure ALARA.
- (2) When considering a new use of radioactive material or radiation producing equipment, the RSC will review the efforts of the applicant to maintain exposure ALARA.
- (3) The RSC will ensure that the users justify their procedures and that individual and collective doses will be ALARA.

b. Delegation of Authority

(The judicious delegation of RSC authority is essential to the enforcement of an ALARA program.)

- (1) The RSC will delegate authority to the RSO for enforcement of the ALARA program.
- (2) The RSC will support the RSO when it is necessary for the RSO to assert authority. If the RSC has overruled the RSO, it will record the basis for its action in the minutes of the quarterly meeting.

c. Review of ALARA Program

- (1) The RSC will encourage all users to review current procedures and develop new procedures as appropriate to implement the ALARA concept.
- (2) The RSC will perform an annual review of occupational radiation exposure. A special meeting may be called for particular attention to instances in which the

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: ALARA Program*	
Scope: Hospital Wide	Manual: Diagnostic Imaging
Source: Operations - Director of Diagnostic Services (DI & Lab)	Effective Date: 11/19/15

investigational levels in Table 1 are exceeded. The principal purpose of this review is to assess trends in occupational exposure as an index of the ALARA program quality and to decide if action is warranted when investigational levels are exceeded (see Section 4 below for a discussion of investigational levels). Maximum legal limits of occupational exposure are listed in Table 2, for reference.

- (3) The RSC will evaluate the institution's overall efforts for maintaining doses ALARA on an annual basis. This review will include the efforts of the RSO, authorized users, and workers as well as those of management.

Table 1
Investigational Levels*

	Investigational Levels (mrems/calendar quarter)	
	Level I**	Level II**
1. Whole body; head and trunk; active blood-forming organs; or gonads, lens of eye	312	624
2. Lens of Eye	936	1872
3. Extremities	3125	6250
4. Skin of whole body	750	2250
5. Thyroid uptake	0.1 uCi	0.3 uCi

*Note that investigational levels in this program are not new dose limits but serve as checkpoints above which the results are considered sufficiently important to justify investigations. See Section 4 for further discussion.

**Investigational levels are as listed on Radiation Detection Company Dosimetry Report.

Table 2
Maximum Annual Levels*

	Maximum Annual Occupational Dose limits in mrem
1. Whole body	5,000
2. Extremities, Skin	50,000
3. Lens of the eyes	15,000
4. Fetus	500

*Legal limits for occupational radiation exposure, NCRP Report No. 116, Table 19.1

3. Radiation Safety Officer

a. Annual and Quarterly Review

- (1) *Annual review of the radiation safety program.* The RSO will perform an annual review of the radiation safety program for adherence to ALARA concepts. Reviews of specific methods of use may be conducted on a more frequent basis.

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: ALARA Program*	
Scope: Hospital Wide	Manual: Diagnostic Imaging
Source: Operations - Director of Diagnostic Services (DI & Lab)	Effective Date: 11/19/15

- (2) *Quarterly review of occupational exposures.* The RSO will review at least quarterly the radiation doses of authorized users and workers to determine that their doses are ALARA in accordance with the provisions of Section 5 of this program and will prepare a summary report for the RSC.
- (3) *Quarterly review of records of radiation surveys.* The RSO will review radiation surveys in unrestricted and restricted areas to determine that dose rates and amounts of contamination were at ALARA levels during the previous quarter and will prepare a summary report for the RSC.

b. Education Responsibilities for ALARA Program

The RSO (in cooperation with authorized user) will ensure that radiation workers and, as applicable, ancillary personnel are trained and educated in good health physics practices and procedures.

- (1) The RSO (or designee) will schedule briefings and educational sessions to inform workers of the ALARA program efforts.
- (2) The RSO (or designee) will ensure that authorized users, workers, and ancillary personnel who may be exposed to radiation will be instructed in the ALARA philosophy and informed that management, the RSC, and the RSO are committed to implementing the ALARA concept.

c. Cooperative Efforts for Development of ALARA Procedures

- (1) Radiation workers will be given opportunities to participate in formulating the procedures that they will be required to follow.
- (2) Radiation workers will be instructed in recourses that may be taken if they feel that ALARA is not being promoted in the workplace.

d. Reviewing Instances of Deviation from Good ALARA Practices

The RSO will investigate all know instances of deviation from good ALARA practices and, if possible, will determine the causes. When the cause is known, the RSO will implement changes in the program to maintain doses ALARA.

4. Authorized Users

a. New Methods of Use Involving Potential Radiation Doses

- (1) The authorized user will consult with the RSO and/or RSC during the planning stage before using radioactive materials and radiation-producing equipment to ensure that doses will be kept ALARA. Simulated trials runs may be helpful.
- (2) The authorized user will review each planned use of radioactive materials or radiation-producing equipment to ensure that doses will be kept ALARA. Simulated trial runs may be helpful.

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: ALARA Program*	
Scope: Hospital Wide	Manual: Diagnostic Imaging
Source: Operations - Director of Diagnostic Services (DI & Lab)	Effective Date: 11/19/15

5. Establishment of Investigational Levels in Order to Monitor Individual Occupational Radiation Doses (External and Internal)

This institution hereby establishes investigational levels for occupational radiation doses which, when exceeded, will initiate review or investigation by the RSC and/or the RSO. The investigational levels that we have adopted are listed in Table 1. These levels apply to the exposure of individual workers. The following actions will be taken at the investigational levels stated in Table 1.

a. Personnel Dose Less than Investigational Level I

Except when deemed appropriate by the RSO, no further action will be taken in those cases where an individual's dose is less than Table I values for the investigational Level I.

b. Personnel Dose Equal To or Greater Than Investigational Level I But Less Than Investigational Level II

The RSO will review the dose of each individual whose quarterly dose exceeds the investigational Level I and will report the results of the reviews at the first RSC meeting following the quarter when the dose was recorded. If the dose does not equal or exceed Investigational Level II, no specific action related to the exposure is required unless deemed appropriate by the Committee. The committee will, however, review each such dose in comparison with those of others performing similar tasks as an index of ALARA program quality and will record the review in the committee minutes.

c. Personnel Dose Equal to and Greater Than Investigational Level II

The RSO will investigate in a timely manner the causes of all personnel doses equaling or exceeding Investigational Level II and, if warranted, will take action. A notification letter will be sent to all personnel with doses equaling or exceeding Investigational Level II. A report of the investigation and any actions taken will be presented to the RSC at its first meeting following completion of the investigation. The details of these reports will be included in the RSC minutes.

d. Reestablishment of Investigational Levels to Level Above Those Listed in Table 1

In cases where a worker's or a group of workers' doses need to exceed an investigational level, a new, higher investigational level may be established for that individual or group on the basis that it is consistent with good ALARA practices. Justification for new investigational levels will be documented.

The RSC will review the justification for and must approve or disapprove all revisions of investigational levels.

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: ALARA Program*	
Scope: Hospital Wide	Manual: Diagnostic Imaging
Source: Operations - Director of Diagnostic Services (DI & Lab)	Effective Date: 11/19/15

REFERENCES:

1. CA Title 17
2. CA-RHB "Guide for the preparation of an application for a radioactive materials license authorizing medical use"
3. 10 CFR 35, 10 CFR 20
4. NCRP Report No. 116, Table 19.1
5. Radiation Detection Company Dosimetry Report

CROSS REFERENCE P&P:

1. Dosimetry Program - Occupational Radiation Exposure Monitoring Program

Approval	Date
Radiation Safety Committee	5/16/17
Radiology Services Committee	5/16/17
Medical Executive Committee	6/5/17
Board of Directors	6/21/17
Last Board of Director review	1/18/17

Developed:

Reviewed: 6/20/2018

Revised:

Supersedes:

Index Listings:

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Diagnostic Imaging - C-Arm (fluoroscope) Radiation Safety	
Scope: Departmental	Manual: Radiology
Source: Operations - Director of Diagnostic Services (DI & Lab)	Effective Date:

PURPOSE: Ensure mobile fluoroscopy equipment is operated in compliance with Title 17, 30307 and CA-DHS Radiation Safety Advisory 05-02.

POLICY:

1. The spacer cone shall remain mounted to the C-arm to prevent operation of the equipment with a source-skin distance of less than 30 cm (12 inches).
2. The spacer cone may be removed following instruction of a supervising physician (CA licensed "X-ray operator and supervisor), only if the cone is deemed a safety risk to the patient or sterile field.
3. Physicians and fluoroscopy personnel are granted an exemption to remove the spacer cones and operate at source-skin distances of not less than 20 centimeters for medical procedures in which the cone is contraindicated or compromises the procedure.
4. Manufacturer's published precautions for use of spacer cone shall be maintained.
5. The spacer cone shall be replaced upon completion of the exam for which removal was authorized.

REFERENCES:

1. California Code of Regulations, Title 17, Section 30307
2. CA-DHS Radiation Safety Advisory 05-02 (attached)

Committee Approval	Date
Radiology Services Committee	8/19/2014
Medical Executive Committee	9/2/2014
Administration	8/19/2014
Board of Directors	9/17/2014

Developed: 7/20/2014

Reviewed: 6/20/2018

Revised:

Supersedes: C-arm Fluoroscopy Radiation safety 10/31/2007

Responsibility for review and maintenance: DDI

Practitioner Name: _____ Date: _____
Please Print

FAMILY MEDICINE

Instructions: Please check box next to each core privilege/special privilege requested.

INITIAL CRITERIA

Education/Formal Training:

- Completed accredited residency training in family medicine.
- Board Certified/Board Eligible by the American Board of Family Medicine **OR** equivalent (AOA).

OUTPATIENT CORE PRIVILEGES

****Current BLS or ACLS required****

- Assess, evaluate, stabilize and/or provide treatment to patients of any age who present to the outpatient environment with any illness, condition or symptom.
- Evaluate, diagnose, perform H&P, consult, and provide non-surgical treatment to a patient of any age.

Primary Care

- Incision and drainage of abscess, excluding peri-rectal
- Allergy immunotherapy
- Anoscopy
- Arthrocentesis/joint injections
- Incision and drainage of Bartholin's cyst/abscess
- Bladder catheterization
- ~~Bone marrow aspiration/biopsy~~
- Burn management, 1st and 2nd degree
- Aspiration of breast cyst
- Application of cast/splint
- Cancer chemotherapy(in consultation with oncologist)
- Cerumen impaction removal
- Cervical dilation (mechanical)
- Removal of cervical polyps, simple
- Circumcision with clamp, pediatric only
- Colposcopy, with or without cervical biopsy
- Cryotherapy, skin
- Cryotherapy, cervix
- Dermoscopy
- Endometrial biopsy
- ~~Flexible sigmoidoscopy~~
- Foreign body removal (skin, superficial corneal/conjunctival, nose and ear)
- Ganglion cyst aspiration/injection
- Incision of thrombosed external hemorrhoid, simple
- Insertion/removal of implanted contraceptive device (eg, Nexplanon)
- Insertion/removal of intrauterine device (IUD)
- Laceration repair, simple
- Lumbar puncture

Primary Care (continued)

- Microscopic examination (urine, vaginal wet mount and skin preparations)
- ~~Myringotomy/tympanocentesis~~
- Nail removal
- Paracervical block
- Pessary placement
- Digital nerve/ring block anesthesia
- ~~Injection sclerotherapy (telangectases only)~~
- Skin biopsy (excisional, shave, or punch)
- Soft tissue injections/trigger point injections
- Drainage of subungual hematoma
- Tonometry
- Tympanometry
- Application of Unna paste boot
- Vasectomy
- Uncomplicated wound debridement

Obstetrics/Gynecology

- Endocervical curettage
- Vulvar/vaginal biopsy
- Abdominal/transvaginal OB/GYN ultrasonography
- Saline infusion hysterosonography

Physical Examinations

- Pre-employment physicals
- Commercial driving medical exams (DOT Medical Examiner's Certificate required)
- Disability evaluations
- Independent medical evaluations (Workman's Compensation)
- Return to work evaluations

ADULT INPATIENT CORE PRIVILEGES

Requires inpatient experience within the last 2 years, current ACLS certification, and recommendation by Hospitalist Director.

- Admit, evaluate, diagnose, perform H&P, consult and provide nonsurgical treatment to adult patients presenting with general medical problems.
- Admit, evaluate, diagnose, perform H&P, consult and provide nonsurgical treatment to adult patients presenting with critical illnesses, needing ICU care.
- Ventilator management.



Northern Inyo Hospital Medical Staff
Clinical Privilege Request Form

Appointment cycle _____
(Office use only)

Practitioner Name: _____ Date: _____

Please Print

SPECIAL PRIVILEGES	
<i>All require experience within last 2 years</i>	
<input type="checkbox"/> Well newborn care/admit to nursery (NRP required, STABLE preferred; approval by Chief of Pediatrics) <input type="checkbox"/> Pediatric consultation and admission (advanced experience managing peds/newborns; PALS & NRP required; approval by Chief of Pediatrics) <input type="checkbox"/> Conscious sedation (requires tutorial and current ACLS certificate per Procedural Sedation policy) <input type="checkbox"/> Surgical first assist (requires experience in last 2 years and recommendation by Chief of Surgery)	Special Privileges in Obstetrics: require experience in last 2 years and recommendation by Chief of OB/GYN <input type="checkbox"/> Vaginal delivery; spontaneous <input type="checkbox"/> Vacuum-assisted vaginal delivery <input type="checkbox"/> Episiotomy and repair of vaginal lacerations (1 st and 2 nd degree only; 3 rd /4 th degree must consult OB) <input type="checkbox"/> Manual extraction of the placenta <input type="checkbox"/> FSE application/IUPC insertion <input type="checkbox"/> Induction of labor/cervical ripening

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

APPROVALS

COMMENTS/MODIFICATIONS TO REQUESTED PRIVILEGES:

RHC/Outpatient Clinic Medical Director Date

Chief of Medicine Date

Chief of Pediatrics Date

Chief of Surgery Date

Chief of Obstetrics Date

Hospitalist Director Date

<i>Approvals</i>	<i>Committee Date</i>
Credentials Committee	
Medical Executive Committee	
Board of Directors	

(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:	
<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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
<input type="checkbox"/>	
OUTPATIENT CORE PRIVILEGES	
Current BLS or ACLS required	
Request	<ul style="list-style-type: none"> • 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.
<input type="checkbox"/>	
SPECIAL PRIVILEGES	
(requires experience within the last 2 years)	
<input type="checkbox"/> Circumcision with clamp, pediatric only <input type="checkbox"/> Robotic Surgery (per Robotic credentialing policy) <input type="checkbox"/> Complex robotic gyn procedures (sacrocolpopexy)	<input type="checkbox"/> Insertion/removal of implanted contraceptive device (e.g. Nexplanon) <input type="checkbox"/> Cervical cerclage
CONSULTING PRIVILEGES	
(for Consulting Staff only)	
Request	<ul style="list-style-type: none"> • 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.
<input type="checkbox"/>	

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

APPROVALS

COMMENTS/MODIFICATIONS TO REQUESTED PRIVILEGES:

Chief of Obstetrics _____
Date

Chief of Surgery _____
Date

<i>Approvals</i>	<i>Committee Date</i>
Credentials Committee	
Medical Executive Committee	
Board of Directors	

(Office use only)

Accreditation Data Update: Critical Access Hospital Program

June 2018



Introduction



- ❑ This **critical access hospital program** data update will be provided on a regular basis to all accredited hospitals.
- ❑ This initial report includes results from onsite critical access hospital surveys that were conducted between the timeframe of **6/1/17 through 5/31/18**.
 - These surveys include **initial and re-accreditation surveys only**, and exclude any mid-cycle surveys such as extension, CMS follow-up, and/or complaint surveys.
- ❑ Accreditation programs are reviewed for non-compliance by surveyors for each element of performance (EP). This report focuses on the **most frequently cited Standards and EPs** for the critical access hospital program, and includes **examples of non-compliance**. This report also includes **SAFER™** distributions.

SAFER™

Survey Analysis for Evaluating Risk™ (SAFER™)



- ❑ A transformative approach for identifying and communicating risk levels associated with deficiencies cited during surveys
- ❑ Helps organizations prioritize and focus corrective actions
- ❑ Provides one, comprehensive visual representation of survey findings
- ❑ **Implemented: January 2017**

Aggregate SAFER Data



Critical Access Hospital Requirement for Improvement(RFI) Distribution For Full and Initial survey from 06/01/2017 through 05/31/2018 (n=139)

		Immediate Threat to Life 0.34%			
		LIMITED	PATTERN	WIDESPREAD	
Likelihood to Harm a Patient/Staff/Visitor	HIGH	1.51%	1.23%	1.54%	4.28%
	MODERATE	14.19%	11.30%	4.74%	30.22%
	LOW	47.09%	14.62%	3.45%	65.16%
		62.79%	27.15%	9.73%	
		LIMITED	PATTERN	WIDESPREAD	
		Scope			

Average Number of Requirements for Improvements (RFIs)

**06/01/2017 – 05/31/2018 Average number of RFIs
For Critical Access Hospital Programs (n=139)**

23.37

Most Frequently Cited Elements of Performance (EPs)

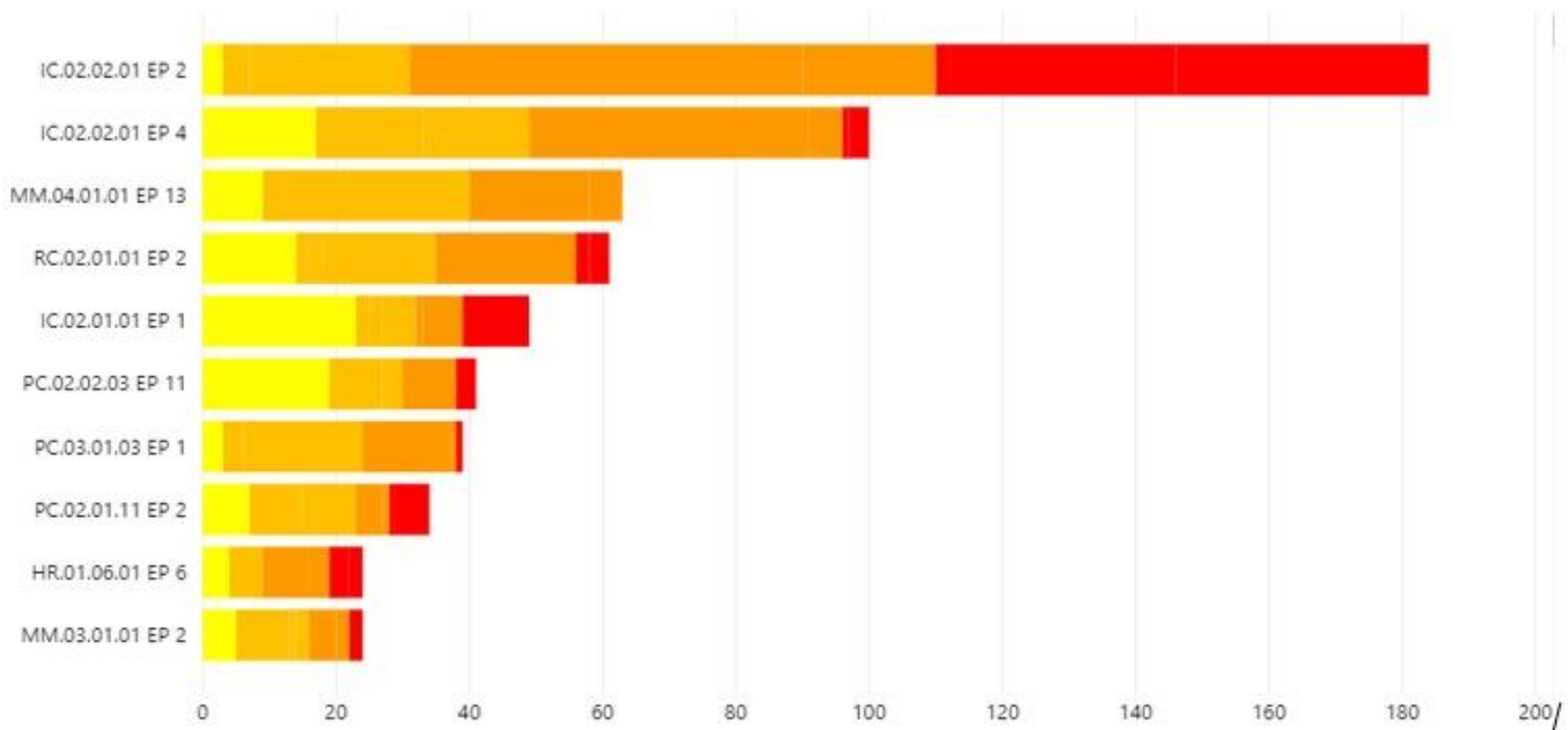
Most Frequently Cited Clinical* Elements of Performance (EPs)



Top 10 Most Frequently Cited *Clinical Standards and Elements of Performance

Full and Initial Critical Access Hospital surveys from 06/01/2017 through 05/31/2018
(N=139)

NUMBER OF EP-LEVEL RFIS AND SAFER PLACEMENT



*Clinical EPs include all chapters in the Critical Access Hospital Accreditation manual except for the Environment of Care and Life Safety Code Chapters.

Most Frequently Cited Clinical EPs: Example Observations* (cont.)



IC.02.02.01, EP 2 - The critical access hospital implements infection prevention and control activities when doing the following: Performing intermediate and high-level disinfection and sterilization of medical equipment, devices, and supplies.

- ❑ Instruments soaking in a sink used for hand hygiene
- ❑ Staff not following process for high-level disinfection
- ❑ Reusable and disposable Laryngeal Masks being used. The reusable LMA's have a limited 40 uses or 1 year reprocessing limit according to the manufacturer Laryngeal Mask Company. Staff were unaware of the manufacturer's recommendation and were not monitoring the reprocessing of the LMA's.
- ❑ Scope Buddy used in the cleaning process for endoscopes was not being cleaned at the end of the day per manufacturers recommendations

Most Frequently Cited Clinical EPs:

Example Observations* (cont.)



IC.02.02.01, EP 4 - The critical access hospital implements infection prevention and control activities when doing the following: Storing medical equipment, devices, and supplies.

- ❑ There was no temperature and/or humidity monitoring in the sub-sterile room, which contained sterile instrument trays
- ❑ OB delivery room had a mounted vaginal probe that was uncovered during storage
- ❑ Airway bags that are stored in the hospital owned ambulances contained six laryngoscope blades of various sizes and a McGill forceps, which were unwrapped and not protected from recontamination
- ❑ During a tour of the sterile storage room, it was noted that a rack with sterile instruments was stored less than two inches from an external wall. This is not consistent with AAMI guidelines, which the organization has adopted.
- ❑ Bronchoscopes were observed hanging bent and the ends upward which did not allow proper drying in the cabinet

Most Frequently Cited EPs – Clinical:

Example Observations*



MM.04.01.01 EP 13 - The critical access hospital implements its policies for medication orders.

- ❑ With PRN medication prescribed, there was no indication for use included with the order in accordance with hospital policy
- ❑ Therapeutic duplication of drugs for nausea and drugs for pain was made; however, there were no instructions by the physician when to give which medication
- ❑ Written titration order in the record of care did not include a documented desired goal or adjustment increments per hospital's policy
- ❑ In review of the record of care it was noted that the patient was ordered two different PRN medications for the indication of pain. There was no differentiation of when to give each of the medications, which did not meet the hospital's policy.

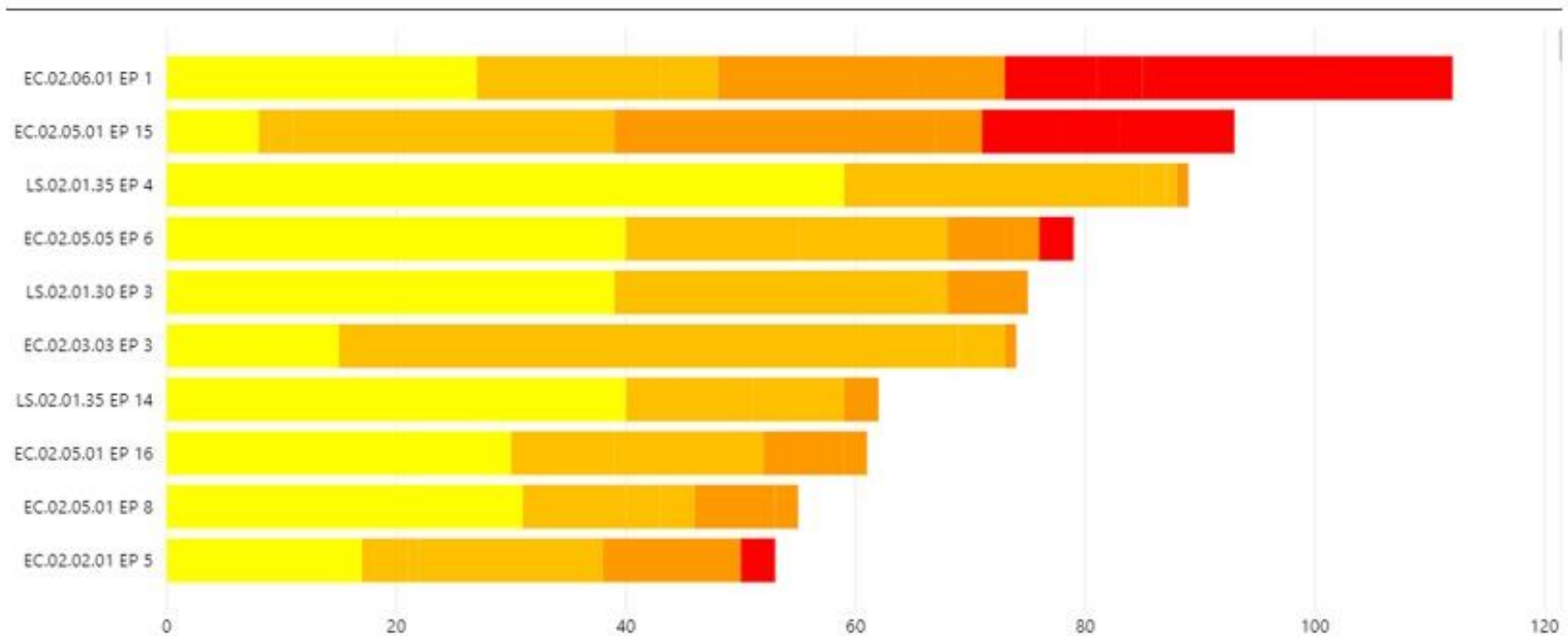
Most Frequently Cited Environment of Care (EC) and Life Safety (LS) Code* EPs



Top 10 Most Frequently Cited *Environment of Care (EC) and Life Safety (LS) Code EPs

Full and Initial Critical Access Hospital surveys from 06/01/2017 through 05/31/2018 (N=139)

NUMBER OF EP-LEVEL RFIS AND SAFER PLACEMENT



*Environment of Care and Life Safety Code chapters addresses General life safety design, building construction, and the physical environment.

Most Frequently Cited EC/LS EPs: Example Observations* (cont.)

EC.02.06.01, EP 1 - Interior spaces meet the needs of the patient population and are safe and suitable to the care, treatment, and services provided

- ❑ The nurse call cord was less than 4 inches from the floor; there was no nurse call cord in room
- ❑ In patient room there was a stained ceiling tile and a fluorescent light fixture which appeared to have dried leaked material in it
- ❑ Behavioral health patients were kept in the Emergency Department where there are stretchers with side-rails that had bars which were a strangulation risk

Most Frequently Cited EC/LS EPs: Example Observations* (cont.)



EC.02.05.01, EP 15 - In critical care areas designed to control airborne contaminants (such as biological agents, gases, fumes, dust), the ventilation system provides appropriate pressure relationships, air-exchange rates, filtration efficiencies, and temperature and humidity.

- ❑ The airflow from the OR bio-hazard storage room was positive to the OR corridor
- ❑ In the sterile processing area and the surgery sterile storage area, there were sterile packs stored, and there was no monitoring of temperature or humidity in these locations
- ❑ Pharmacy had a negative air pressure relationship to the hospital corridor

Most Frequently Cited EC/LS EPs: Example Observations* (cont.)



LS.02.1.35, EP 4 - Approved automatic sprinkler systems piping is not used to support any other item.

- ❑ A wire was found using the sprinkler pipe as support
- ❑ There was low voltage wiring and/or metal flex conduit lying on the fire sprinkler piping
- ❑ On the ceiling in front of the 2nd floor electrical closet there were cables and flexible conduit on the fire main sprinkler pipe
- ❑ During ceiling inspection, conduit was observed using the sprinkler pipe for support. Outside nursing station in acute care, 3 wires were observed using the sprinkler pipe as support.

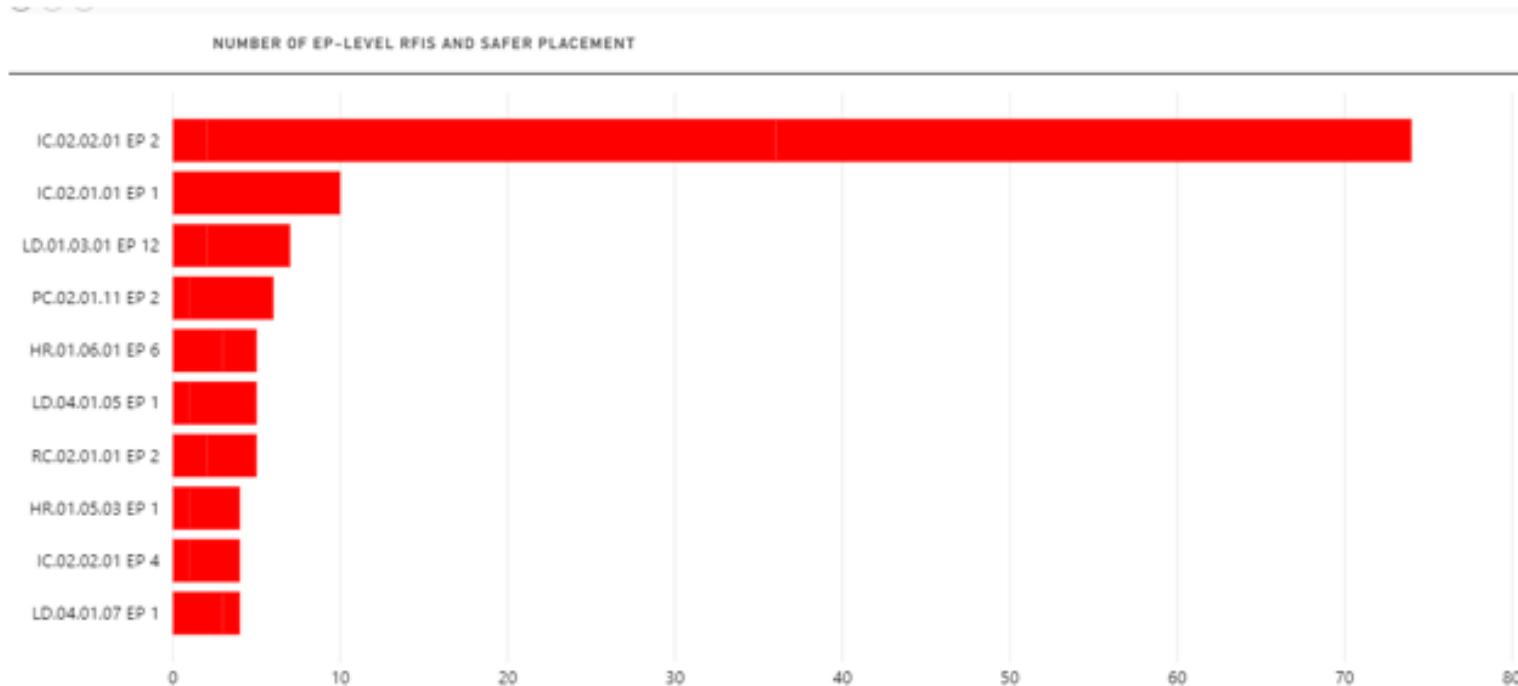
Most Frequently Cited High Likelihood to Harm Elements of Performance (EPs)

Most Frequently Cited High Likelihood to Harm* Clinical** EPs



Top 10 *High-Risk Most Frequently Cited Clinical Elements of Performance

Full and Initial Critical Access Hospital surveys from 06/01/2017 through 05/31/2018 (N=139)



*High Likelihood to harm on the SAFER Matrix is defined as harm could happen at any time. The deficient practice could directly lead to harm without the need for other significant circumstances or failures. If the deficiency continues, it would be likely that harm could happen at any time to any patient (or did actually happen).

**Clinical EPs include all chapters in the Critical Access Hospital Accreditation manual except for the Environment of Care and Life Safety Code Chapters.

Most Frequently Cited High Likelihood to Harm Clinical EPs: Example Observations* (cont.)



IC.02.02.01, EP 2 - The critical access hospital implements infection prevention and control activities when doing the following: Performing intermediate and high-level disinfection and sterilization of medical equipment, devices, and supplies.

- ❑ There was an Ultrasound machine with mounted cavity probe located in the OB department delivery room. Personnel stated the unit was wiped with "Cavi Wipes", a low-level disinfectant in between patient use. The device required high-level disinfection and there were no procedures in place to perform HLD.
- ❑ In the rural clinics it was noticed that the process for pre-cleaning instruments used in the clinic did not follow the AAMI guidelines, which the organization adopted. The instruments were being taken from the room to the soiled utility room in a paper towel and were then immersed in a mixture of detergent which was not mixed according to manufacturer guidelines.

Most Frequently Cited High Likelihood to Harm

Clinical EPs: Example Observations* (cont.)

IC.02.01.01, EP 1 -The critical access hospital implements its infection prevention and control activities, including surveillance, to minimize, reduce, or eliminate the risk of infection.

- ❑ Ear Nose and Throat clinic had not been involved in the infection control surveillance activities related to process for performing high level disinfection
- ❑ The facility was using sanitizer in the final rinse cycle of the dishwasher to provide disinfection. The sanitizer level was only being checked once daily and not at each time the dishwasher was drained and refilled for a different meal time washing per manufacture's instructions.

Most Frequently Cited High Likelihood to Harm

Clinical EPs: Example Observations*



LD.01.03.01, EP 12 -The critical access hospital has a governing body that assumes full legal responsibility for the operation of the critical access hospital.

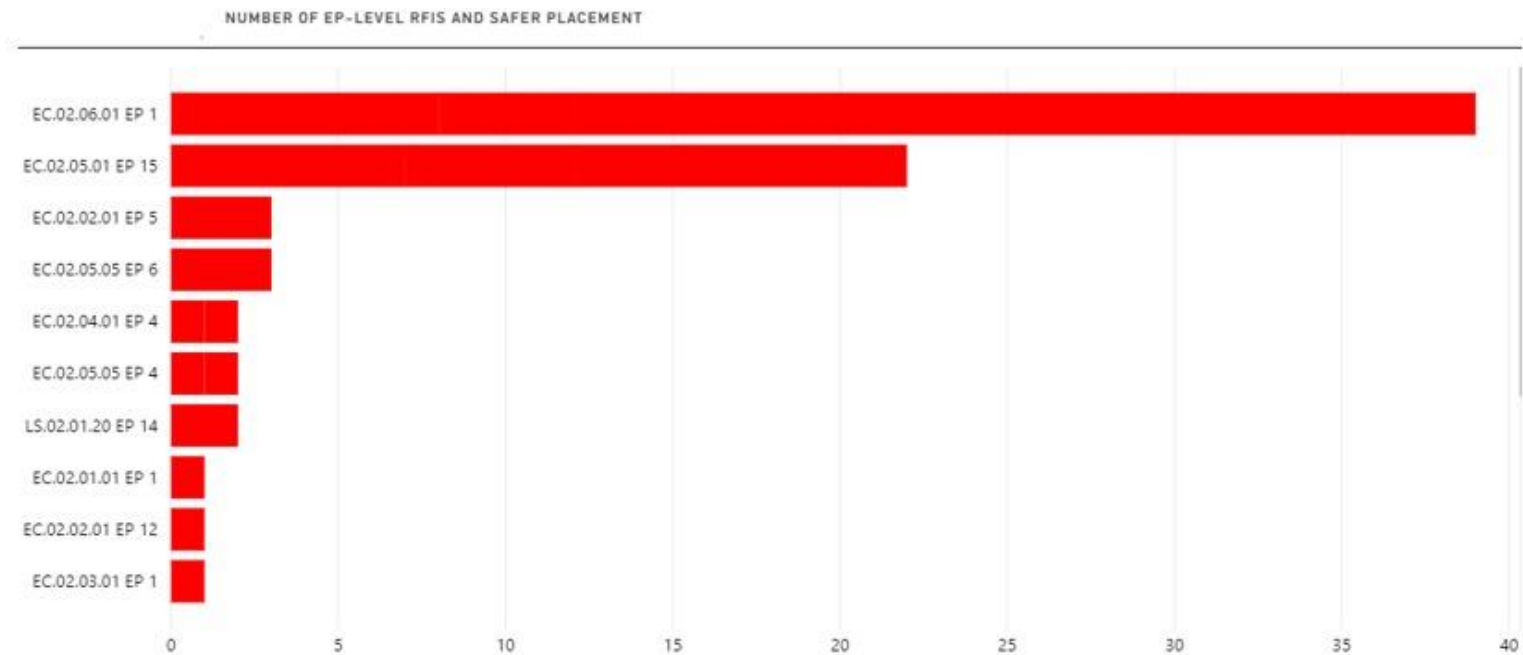
- ❑ The governing body/leadership did not ensure that the following Conditions of Participation were met as determined through observations, documentation, and staff interviews:
 - ✓ 485.623 Condition of Participation: Physical Plant and Environment; 412.27 Excluded psychiatric units: Additional requirements; 485.635; Condition of Participation: Provision of Services; 485.639 Condition of Participation: Surgical Services; 485.627(a) Standard: Governing Body or Responsible Individual; 485.635 Condition of Participation: Provision of Services

Most Frequently Cited High Likelihood to Harm* Environment of Care and Life Safety Code** EPs



Top 10 ***High-Risk** Most Frequently Cited *Environment of Care (EC) and
Life Safety (LS) Code Elements of Performance

For Full and Initial Critical Access Hospital surveys from 06/01/2017 through 05/31/2018 (N=139)



*High Likelihood to harm on the SAFER Matrix is defined as *harm could happen at any time*. The deficient practice could directly lead to harm without the need for other significant circumstances or failures. If the deficiency continues, it would be likely that harm could happen at any time to any patient (or did actually happen).

** The Environment of Care and Life Safety Code chapters address general life safety design, building construction, and the physical environment.

Most Frequently Cited High Likelihood to Harm EC and LS EPs: Example Observations* (cont.)



EC.02.06.01, EP 1 - Interior spaces meet the needs of the patient population and are safe and suitable to the care, treatment, and services provided.

- ❑ Identified in the hospital's risk assessment but had not been replaced or ordered, which can pose as a ligature risk: door knobs in the patient rooms and patient restrooms were not of a ligature resistant type; metal chain type pull cords used to adjust the window blinds; door hinges in the patient rooms and patient restrooms were not of a ligature resistant three hinge type; electric light fixtures above the patient beds were standard hospital type.
- ❑ Inpatient patient rooms contained heater vents, furniture, closet doors, window blind knobs and bathroom sink faucets that were not ligature resistant.
- ❑ In the Endoscopy room, it was noted the scope reprocessing room was small and did not allow for a conducive dirty-to-clean workflow. There was only one sink in the area to clean the scopes.

Most Frequently Cited EC and LS EPs: Example Observations* (cont.)

EC.02.05.01, EP 15 - In critical care areas designed to control airborne contaminants (such as biological agents, gases, fumes, dust), the ventilation system provides appropriate pressure relationships, air-exchange rates, filtration efficiencies, and temperature and humidity

- ❑ In 2 of the 3 operating rooms the temperature and humidity logs were reviewed they ranged from 62% to 75%, with no corrective actions recorded. The acceptable limit was 60%.
- ❑ It was determined that a CACI was utilized for compounding hazardous medication. The organization could not provide evidence that the room maintained negative pressure or had 12 air exchanges per hour.

Most Frequently Cited EC and LS EPs: Example Observations*

EC.02.02.01, EP 5 - The critical access hospital minimizes risks associated with selecting, handling, storing, transporting, using, and disposing of hazardous chemicals.

- ❑ Corrosive Chemicals (Floor Stripper pH>13) are being used in a janitor's closet without a readily available eyewash station.
- ❑ Eyewash station did not provide tepid water (between 60-100 degrees)
- ❑ Eye wash station was behind locked doors.

Thank you!!



Final Accreditation Report

**Northern Inyo Healthcare District
150 Pioneer Lane
Bishop, CA 93514**

**Organization Identification Number: 9762
Unannounced Full Event: 2/19/2019 - 2/21/2019**

**Program Surveyed
Critical Access Hospital**

The Joint Commission Table of Contents

<u>Executive Summary</u>	<u>3</u>
<u>What's Next - Follow-up Activity</u>	<u>4</u>
<u>Critical Access Hospital</u>	<u>7</u>
• SAFER™ Matrix	7
• The Centers for Medicaid and Medicare Services (CMS) Summary	9
• Requirements for Improvement (RFI)	11
<u>Appendix</u>	<u>26</u>
• The Centers for Medicaid and Medicare Services (CMS) Conditions of Participation (CoP)	26
• Standards/Elements of Performance (EP) Language	28
• Report Section Descriptions	37
• Clarification Instructions	39

The Joint Commission Executive Summary

Program	Survey Dates	Event Outcome	Follow-up Activity	Follow-up Time Frame or Submission Due Date
Critical Access Hospital	02/19/2019 - 02/21/2019	Requirements for Improvement	Clarification (Optional)	Submit within 10 Business Days from the final posted report date
			Evidence of Standards Compliance (ESC)	Submit within 60 Calendar Days from the final posted report date

The Joint Commission What's Next - Follow-up Activity

Program: Critical Access Hospital

Standard	EP	SAFER™ Placement	CoP	Tag	Included in the Evidence of Standard Compliance (within 60 calendar days)
EC.02.01.01	1	Moderate / Pattern	§485.623 (a)	C-0221	✓
EC.02.02.01	12	Low / Pattern	§485.623 (b)(2)	C-0223	✓
	19	Low / Limited	§485.623 (b)(2)	C-0223	✓
	5	Low / Limited	§485.623 (b)(2)	C-0223	✓
EC.02.03.03	2	Low / Widespread			✓
	3	Low / Widespread	§485.623 (c)(1)(i)	C-----	✓
EC.02.03.05	19	Moderate / Widespread	§485.623 (b)(1)	C-0222	✓
	28	Low / Limited	§485.623 (c)(1)(i)	C-----	✓
	3	Low / Limited	§485.623 (b)(1)	C-0222	✓
	4	Low / Limited	§485.623 (b)(1)	C-0222	✓
	5	Low / Limited	§485.623 (b)(1)	C-0222	✓
EC.02.05.01	15	Moderate / Limited	§485.623 (b)(1)	C-0222	✓
	16	Low / Pattern			✓
	9	Low / Limited			✓
EC.02.05.03	1	Low / Limited			✓

The Joint Commission

Standard	EP	SAFER™ Placement	CoP	Tag	Included in the Evidence of Standard Compliance (within 60 calendar days)
	11	Low / Limited			✓
EC.02.05.05	4	Moderate / Pattern	§485.623 (b)(1)	C-0222	✓
	6	Low / Limited	§485.623 (a)	C-0221	✓
EC.02.05.07	8	Low / Limited	§485.625 (e)(2)	E-0041	✓
	9	Low / Limited	§485.623 (b)(1)	C-0222	✓
EC.02.05.09	11	Low / Limited	§485.623 (b)(1)	C-0222	✓
	12	Low / Limited			✓
EM.02.01.01	14	Low / Limited	§485.625 (b)(8)	E-0026	✓
EM.03.01.03	2	Low / Limited	§485.625 (d)(2)(ii) (A)	E-0039	✓
HR.01.01.01	2	Low / Limited	§485.608 (d)	C-0154	✓
LS.02.01.10	11	Low / Limited	§485.623 (c)(1)(i)	C-----	✓
LS.02.01.20	13	Low / Limited			✓
LS.02.01.34	10	Low / Limited	§485.623 (c)(1)(i)	C-----	✓
	9	Low / Limited			✓
LS.02.01.35	14	Low / Limited	§485.623 (c)(1)(i)	C-----	✓
	6	Low / Limited	§485.623 (c)(1)(i)	C-----	✓

The Joint Commission

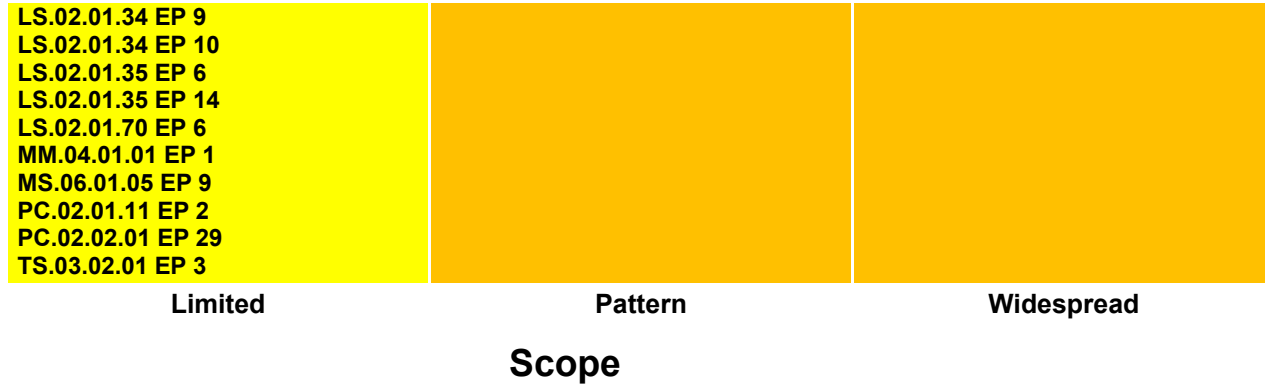
Standard	EP	SAFER™ Placement	CoP	Tag	Included in the Evidence of Standard Compliance (within 60 calendar days)
LS.02.01.70	6	Low / Limited	§485.623 (b)(2)	C-0223	✓
MM.04.01.01	1	Low / Limited			✓
MM.05.01.01	4	Moderate / Limited			✓
MS.06.01.05	9	Low / Limited			✓
PC.02.01.11	2	Low / Limited			✓
PC.02.02.01	29	Low / Limited	§483.55 (b)(4)	C----	✓
RC.02.01.01	2	Low / Pattern	§485.638 (a)(4)(iii)	C-0306	✓
TS.03.02.01	3	Low / Limited			✓

**The Joint Commission
SAFER™ Matrix
Program: Critical Access Hospital**

Likelihood to harm a Patient / Visitor / Staff

ITL			
High			
Moderate	EC.02.05.01 EP 15 MM.05.01.01 EP 4	EC.02.01.01 EP 1 EC.02.05.05 EP 4	EC.02.03.05 EP 19
Low	EC.02.02.01 EP 5 EC.02.02.01 EP 19 EC.02.03.05 EP 3 EC.02.03.05 EP 4 EC.02.03.05 EP 5 EC.02.03.05 EP 28 EC.02.05.01 EP 9 EC.02.05.03 EP 1 EC.02.05.03 EP 11 EC.02.05.05 EP 6 EC.02.05.07 EP 8 EC.02.05.07 EP 9 EC.02.05.09 EP 11 EC.02.05.09 EP 12 EM.02.01.01 EP 14 EM.03.01.03 EP 2 HR.01.01.01 EP 2 LS.02.01.10 EP 11 LS.02.01.20 EP 13	EC.02.02.01 EP 12 EC.02.05.01 EP 16 RC.02.01.01 EP 2	EC.02.03.03 EP 2 EC.02.03.03 EP 3

The Joint Commission



The Joint Commission The Centers for Medicaid and Medicare Services (CMS) Summary

Program: Critical Access Hospital

CoP(s)	Tag	CoP Score	Corresponds to:
§485.608	C-0150	Standard	
§485.608(d)	C-0154	Standard	CAH/HR.01.01.01/EP2
§485.623	C-0220	Standard	
§485.623(a)	C-0221	Standard	CAH/EC.02.01.01/EP1 CAH/EC.02.05.05/EP6
§485.623(b)(1)	C-0222	Standard	CAH/EC.02.03.05/EP3 CAH/EC.02.03.05/EP4 CAH/EC.02.03.05/EP5 CAH/EC.02.03.05/EP19 CAH/EC.02.05.01/EP15 CAH/EC.02.05.05/EP4 CAH/EC.02.05.07/EP9 CAH/EC.02.05.09/EP11
§485.623(b)(2)	C-0223	Standard	CAH/EC.02.02.01/EP5 CAH/EC.02.02.01/EP12 CAH/EC.02.02.01/EP19 CAH/LS.02.01.70/EP6
§485.623(c)(1)(i)	C-----	Standard	CAH/EC.02.03.03/EP3 CAH/EC.02.03.05/EP28 CAH/LS.02.01.10/EP11 CAH/LS.02.01.34/EP10 CAH/LS.02.01.35/EP6 CAH/LS.02.01.35/EP14
§485.638	C-0300	Standard	
§485.638(a)(4)(iii)	C-0306	Standard	CAH/RC.02.01.01/EP2
§485.645	C-0350	Standard	
§483.55	C----	Standard	
§483.55(b)(4)	C----	Standard	CAH/PC.02.02.01/EP29
§485.625	E-0001	Standard	
§485.625(b)(8)	E-0026	Standard	CAH/EM.02.01.01/EP14

The Joint Commission

CoP(s)	Tag	CoP Score	Corresponds to:
§485.625(d)(2)(ii)(A)	E-0039	Standard	CAH/EM.03.01.03/EP2
§485.625(e)(2)	E-0041	Standard	CAH/EC.02.05.07/EP8

The Joint Commission Requirements for Improvement

Program: Critical Access Hospital

Standard	EP	SAFER™ Placement	EP Text	Observation	CoP	CoP Score
EC.02.01.01	1	Moderate Pattern	The critical access hospital implements its process to identify safety and security risks associated with the environment of care that could affect patients, staff, and other people coming to the critical access hospital's facilities. Note: Risks are identified from internal sources such as ongoing monitoring of the environment, results of root cause analyses, results of proactive risk assessments of high-risk processes, and from credible external sources such as Sentinel Event Alerts.	1). Observed in Tracer Activities at Northern Inyo Healthcare District (150 Pioneer Lane, Bishop, CA) site . During review of relative humidity recordings in the operating rooms, it was noted that for all 3 ORs, the number of readings in January in which the humidity was below 20% was 56 times out of 2232 total humidity readings. The hospital is functioning under a CMS waiver permitting using the operating room at a relative humidity of 20% or more. There have been no instances of performing surgery with the relative humidity under 20%. However, the organization is doing procedures when the humidity is between 20%-30%. The organization has not conducted a risk assessment in making its determination to perform surgery at such levels of humidity, although hospital staff have been given guidance on conducting a risk assessment and have begun the process.	§485.623(a)	Standard
EC.02.02.01	5	Low Limited	The critical access hospital minimizes risks associated with selecting, handling, storing, transporting, using, and disposing of hazardous chemicals.	1). Observed in Building Tour at Northern Inyo Healthcare District (150 Pioneer Lane, Bishop, CA) site . The emergency generators 1,2 and 3 have non-sealed lead acid batteries and there was no emergency eyewash in the vicinity.	§485.623(b)(2)	Standard
				2). Observed in Building Tour at Northern Inyo Healthcare District (150 Pioneer Lane, Bishop, CA) site . The surgical suite where specimen jars containing formalin and soiled sterile processing areas did not have a plumbed energy eyewash station.	§485.623(b)(2)	Standard
EC.02.02.01	12	Low Pattern	The critical access hospital labels hazardous materials and waste. Labels identify the contents and hazard warnings. * (See also IC.02.01.01, EP 6) Footnote *: The Occupational Safety and Health Administration's (OSHA) Bloodborne Pathogens and Hazard Communications Standards and the National Fire Protection Association (NFPA) provide details on labeling requirements.	1). Observed in Building Tour at Northern Inyo Healthcare District (150 Pioneer Lane, Bishop, CA) site . The fuel tank for generator 1 and 2 was not labeled for contents of diesel fuel. A label was ordered during survey.	§485.623(b)(2)	Standard

The Joint Commission

Standard	EP	SAFER™ Placement	EP Text	Observation	CoP	CoP Score
				2). Observed in Building Tour at Northern Inyo Healthcare District (150 Pioneer Lane, Bishop, CA) site . The sub deck fuel tank for generator 3 was not labeled for contents of diesel fuel. A label was ordered during survey.	§485.623(b)(2)	Standard
				3). Observed in Individual Tracer at Northern Inyo Healthcare District (150 Pioneer Lane, Bishop, CA) site . During tracer activities in the operating room and sterile processing areas, the process for cleaning endoscopes was discussed and reviewed. It was noted that the containers used for bringing dirty scopes into the decontamination area do not have a biohazard label on them. Further discussion revealed that containers for bringing surgical instruments from the OR down the hallway into the decontamination area are covered with drapes before being transported via a cart to the decontamination area, and there is no biohazard marking on this container.	§485.623(b)(2)	Standard
EC.02.02.01	19	Low Limited	The critical access hospital has procedures for the proper routine storage and prompt disposal of trash.	1). Observed in Building Tour at Northern Inyo Healthcare District (150 Pioneer Lane, Bishop, CA) site . The med surge electrical room H2061 had used fluorescent bulbs which are universal waste stored in an open unlabeled box. Used bulbs need to be kept in a closed box that labeled for used or spent bulbs. Corrected on survey.	§485.623(b)(2)	Standard
EC.02.03.03	2	Low Widespread	The critical access hospital conducts fire drills every 12 months from the date of the last drill in all freestanding buildings classified as business occupancies and in which patients are seen or treated. Note: In leased or rented facilities, drills need be conducted only in areas of the building that the critical access hospital occupies.	1). Observed in Document Review at Northern Inyo Healthcare District (150 Pioneer Lane, Bishop, CA) site . The fire response drills were not conducted on a quarterly interval of 3 months +/- 10 days for the following: 1) 2018 first shift – fourth quarter drill not conducted 2) third shift – third quarter drill not conducted. 3) 2017 first shift April 28th and August 30th exceeded time interval 4) 2017 second shift-May 31st and September 27th exceeded time interval. 5) 2017 Second Shift – fourth quarter drill not conducted. 6) 2017 third shift – June 14th and July 19th less than an interval of 3 months +/- 10 days.		
EC.02.03.03	3	Low	When quarterly fire drills are required, they are	1). Observed in Document Review at Northern Inyo	§485.623(c)(1)(i)	Standard

The Joint Commission

Standard	EP	SAFER™ Placement	EP Text	Observation	CoP	CoP Score
		Widespread	unannounced and held at unexpected times and under varying conditions. Fire drills include transmission of fire alarm signal and simulation of emergency fire conditions. Note 1: When drills are conducted between 9:00 P.M. and 6:00 A.M., the critical access hospital may use alternative methods to notify staff instead of activating audible alarms. Note 2: For full text, refer to NFPA 101-2012: 18/19: 7.1.7; 7.1; 7.2; 7.3.	Healthcare District (150 Pioneer Lane, Bishop, CA) site . The fire response drills were less than 1-hour variance per shift and therefore not at unexpected times for the following. 1) 2018 first shift Jan 26th at 2:45 p.m., April 27th at 2:00 p.m. 2) 2018 second shift February 26th at 3:10 p.m., May 30th at 3:10 p.m., and August 30th at 3:10 p.m. 3) 2018 third shift – June 27th at 5:00 p.m. October 19th at 5:15 p.m. and December 17th at 5:30 p.m. 4) 2017 first shift – April 28th at 2:00 p.m. and August 30th at 1:45 p.m. 5) 2017 second shift Feb 27th at 3:10 p.m. , May 31st at 3:15 p.m., and September 27th at 3:07 p.m. 6) 2017 third shift – March 24th at 5:00 a.m., June 14th at 5:25 a.m., and July 19th at 6:00 a.m..		
EC.02.03.05	3	Low Limited	Every 12 months, the critical access hospital tests duct detectors, heat detectors, manual fire alarm boxes, and smoke detectors on the inventory. The results and completion dates are documented. Note: For additional guidance on performing tests, see NFPA 72-2010: Table 14.4.5; 17.14.	1). Observed in Document Review at Northern Inyo Healthcare District (150 Pioneer Lane, Bishop, CA) site . The annual testing of smoke, heat and duct detectors for the support building exceeded the annual testing interval of one year +/- one month with June 27, 2017 and November 9, 2017 inspections.	§485.623(b)(1)	Standard
EC.02.03.05	4	Low Limited	Every 12 months, the critical access hospital tests visual and audible fire alarms, including speakers and door-releasing devices on the inventory. The results and completion dates are documented. Note: For additional guidance on performing tests, see NFPA 72-2010: Table 14.4.5.	1). Observed in Document Review at Northern Inyo Healthcare District (150 Pioneer Lane, Bishop, CA) site . The annual testing of audible and visuals notification devices or the support building exceeded the annual testing interval of one year +/- one month with June 27, 2017 and November 9, 2017 inspections.	§485.623(b)(1)	Standard
EC.02.03.05	5	Low Limited	Every 12 months, the critical access hospital tests fire alarm equipment on the inventory for notifying off-site fire responders. The results and completion dates are documented. Note: For additional guidance on performing tests, see NFPA 72-2010: Table 14.4.5.	1). Observed in Data Session at Northern Inyo Healthcare District (150 Pioneer Lane, Bishop, CA) site . The annual testing of offsite emergency notification of the fire alarm system for the support building exceeded the annual testing interval of one year +/- one month with June 27, 2017 and November 9, 2017 inspections.	§485.623(b)(1)	Standard
EC.02.03.05	19	Moderate Widespread	Every 12 months, the critical access hospital tests automatic smoke-detection shutdown devices for air-handling equipment. The results and completion dates are documented. Note: For additional guidance on performing tests,	1). Observed in Document Review at Northern Inyo Healthcare District (150 Pioneer Lane, Bishop, CA) site . The organization did not provide documentation for HVAC shutdown from smoke detector activation for 2017 and 2018.	§485.623(b)(1)	Standard

The Joint Commission

Standard	EP	SAFER™ Placement	EP Text	Observation	CoP	CoP Score
			see NFPA 90A-2012: 6.4.1.			
EC.02.03.05	28	Low Limited	<p>Documentation of maintenance, testing, and inspection activities for Standard EC.02.03.05, EPs 1–20, 25 (including fire alarm and fire protection features) includes the following:</p> <ul style="list-style-type: none"> - Name of the activity - Date of the activity - Inventory of devices, equipment, or other items - Required frequency of the activity - Name and contact information, including affiliation, of the person who performed the activity - NFPA standard(s) referenced for the activity - Results of the activity <p>Note: For additional guidance on documenting activities, see NFPA 25-2011: 4.3; 4.4; NFPA 72-2010: 14.2.1; 14.2.2; 14.2.3; 14.2.4; NFPA 101-2012: 18/19.7.2.1.5.10.1; 7.2.1.5.11.</p>	1). Observed in Document Review at Northern Inyo Healthcare District (150 Pioneer Lane, Bishop, CA) site . In review of the EC 02.03.05 EP2 the NFPA reference was missing on the documentation for the flow and tamper switches for 2017 and 2018 documents.	§485.623(c)(1)(i)	Standard
EC.02.05.01	9	Low Limited	<p>The critical access hospital labels utility system controls to facilitate partial or complete emergency shutdowns.</p> <p>Note 1: Examples of utility system controls that should be labeled are utility source valves, utility system main switches and valves, and individual circuits in an electrical distribution panel.</p> <p>Note 2: For example, the fire alarm system's circuit is clearly labeled as Fire Alarm Circuit; the disconnect method (that is, the circuit breaker) is marked in red; and access is restricted to authorized personnel. Information regarding the dedicated branch circuit for the fire alarm panel is located in the control unit. For additional guidance, see NFPA 101-2012: 18/19.3.4.1; 9.6.1.3; NFPA 72-2010: 10.5.5.2.</p>	1). Observed in Building Tour at Northern Inyo Healthcare District (150 Pioneer Lane, Bishop, CA) site . The electrical disconnect for the main fire alarm in panel HZL beaker # 34 needs to be colored red. Reference NFPA 72 - 2010 10.5.5.2.3. Corrected on survey.		
EC.02.05.01	15	Moderate Limited	<p>In critical care areas designed to control airborne contaminants (such as biological agents, gases, fumes, dust), the ventilation system provides appropriate pressure relationships, air-exchange rates, filtration efficiencies, and temperature and humidity.</p> <p>Note: For more information about areas designed for control of airborne contaminants, the basis for</p>	1). Observed in Building Tour at Northern Inyo Healthcare District (150 Pioneer Lane, Bishop, CA) site . The clean surgical sterile processing had a negative pressure relationship relative to the soiled side of sterile processing and a negative pressure relationship relative to the corridor. Corrected on survey.	§485.623(b)(1)	Standard

The Joint Commission

Standard	EP	SAFER™ Placement	EP Text	Observation	CoP	CoP Score
			design compliance is the Guidelines for Design and Construction of Health Care Facilities, based on the edition used at the time of design (if available).			
EC.02.05.01	16	Low Pattern	In non-critical care areas, the ventilation system provides required pressure relationships, temperature, and humidity. Note: Examples of non-critical care areas are general care nursing units; clean and soiled utility rooms in acute care areas; laboratories, pharmacies, diagnostic and treatment areas, food preparation areas, and other support departments.	1). Observed in Building Tour at Northern Inyo Healthcare District (150 Pioneer Lane, Bishop, CA) site . The OR Clean supply room H1064 had a negative pressure relationship relative to the corridor. Corrected on survey.		
				2). Observed in Building Tour at Northern Inyo Healthcare District (150 Pioneer Lane, Bishop, CA) site . The L&D clean supply H2066 clean supply had negative pressure relationship relative to the corridor. Corrected on survey.		
				3). Observed in Building Tour at Northern Inyo Healthcare District (150 Pioneer Lane, Bishop, CA) site . The ICU clean supply clean supply had negative pressure relationship relative to the corridor. Corrected on survey.		
				4). Observed in Building Tour at Northern Inyo Healthcare District (150 Pioneer Lane, Bishop, CA) site . The PACU clean utility room H1096 had a negative pressure relationship relative to the corridor. Corrected on survey.		
EC.02.05.03	1	Low Limited	For facilities that were constructed, or had a change in occupancy type, or have undergone an electrical system upgrade since 1983, the critical access hospital has a Type 1 or Type 3 essential electrical system in accordance with NFPA 99, 2012 edition. This essential electrical system must be divided into three branches, including the life safety branch, critical branch, and equipment branch. Both the life safety branch and the critical branch are kept independent of all other wiring and equipment, and they transfer within 10 seconds of electrical interruption. Each branch has at least one automatic transfer switch. For additional guidance, see NFPA 99-2012: 6.4.2.2.	1). Observed in Building Tour at Northern Inyo Healthcare District (150 Pioneer Lane, Bishop, CA) site . The electrical disconnect for the main fire alarm in panel HZL beaker # 34 needs to be on the life safety branch. The fire alarm breaker was on a panel that had breakers to equipment and non-life safety items.		

The Joint Commission

Standard	EP	SAFER™ Placement	EP Text	Observation	CoP	CoP Score
EC.02.05.03	11	Low Limited	<p>The critical access hospital provides emergency power within 10 seconds for the following: Emergency lighting at emergency generator locations. The critical access hospital's emergency power system (EPS) has a remote manual stop station (with identifying label) to prevent inadvertent or unintentional operation. A remote annunciator (powered by storage battery) is located outside the EPS location.</p> <p>Note: For guidance in establishing a reliable emergency power system (that is, an essential electrical distribution system), refer to NFPA 99-2012: 6.4.1.1.6; 6.4.1.1.17; 6.4.2.2; NFPA 110-2010: 5.6.5.6; 7.3.1.</p>	1). Observed in Building Tour at Northern Inyo Healthcare District (150 Pioneer Lane, Bishop, CA) site . Generator 1 and 2 need an emergency stop button outside of the room enclosure.		
EC.02.05.05	4	Moderate Pattern	<p>The critical access hospital inspects, tests, and maintains the following: High-risk utility system components on the inventory. The completion date and the results of the activities are documented.</p> <p>Note 1: A high-risk utility system includes components for which there is a risk of serious injury or even death to a patient or staff member should it fail, which includes life-support equipment.</p> <p>Note 2: Required activities and associated frequencies for maintaining, inspecting, and testing of utility systems components that are completed in accordance with manufacturers' recommendations must have a 100% completion rate.</p> <p>Note 3: Scheduled maintenance activities for high-risk utility systems components in an alternative equipment maintenance (AEM) program inventory must have a 100% completion rate.</p>	1). Observed in Document Review at Northern Inyo Healthcare District (150 Pioneer Lane, Bishop, CA) site . In review of the fire damper inspection report for EC 02.03. 05/ EP18 from May 4, 2017 there 3 dampers that failed. The dampers were not readily accessible and there was no risk assessment follow up until the dampers can be repaired.	§485.623(b)(1)	Standard
EC.02.05.05	6	Low Limited	<p>The critical access hospital inspects, tests, and maintains the following: Non-high-risk utility system components on the inventory. The completion date and the results of the activities are documented.</p> <p>Note: Scheduled maintenance activities for non-high-risk utility systems components in an alternative equipment maintenance (AEM) program inventory must have a 100% completion rate. AEM frequency is determined by the critical access hospital AEM program.</p>	1). Observed in Building Tour at Northern Inyo Healthcare District (150 Pioneer Lane, Bishop, CA) site . The electrical room containing the main fire alarm panel had multiple items with less than 3 feet clearance in storage blocking access to electrical panels. Corrected on survey.	§485.623(a)	Standard

The Joint Commission

Standard	EP	SAFER™ Placement	EP Text	Observation	CoP	CoP Score
				2). Observed in Building Tour at Northern Inyo Healthcare District (150 Pioneer Lane, Bishop, CA) site . The med surge electrical room H2061 had storage within 3 feet of electrical panels. Corrected on survey.	§485.623(a)	Standard
				3). Observed in Building Tour at Northern Inyo Healthcare District (150 Pioneer Lane, Bishop, CA) site . In the boiler room the control panel for the on demand hot water system were removed. Correct on survey.	§485.623(a)	Standard
EC.02.05.07	8	Low Limited	At least annually, the critical access hospital tests the fuel quality to ASTM standards. The test results and completion dates are documented. Note: For additional guidance, see NFPA 110-2010: 8.3.8.	1). Observed in Document Review at Northern Inyo Healthcare District (150 Pioneer Lane, Bishop, CA) site . The organization did not provide documentation of a fuel test of the diesel for the emergency generators.	§485.625(e)(2)	Standard
EC.02.05.07	9	Low Limited	At least once every 36 months, critical access hospitals with a generator providing emergency power test each emergency generator for a minimum of 4 continuous hours. The test results and completion dates are documented. Note: For additional guidance, see NFPA 110-2010, Chapter 8.	1). Observed in Document Review at Northern Inyo Healthcare District (150 Pioneer Lane, Bishop, CA) site . The triennial 30% load run for emergency generators 1 and 2 on June 11th and 12th 2016 did not clearly differentiate the load of each generator or show the run times for each of the generators though the total run time exceeded 4 hours required for each generator.	§485.623(b)(1)	Standard
EC.02.05.09	11	Low Limited	The critical access hospital makes main supply valves and area shutoff valves for piped medical gas and vacuum systems accessible and clearly identifies what the valves control. Piping is labeled by stencil or adhesive markers identifying the gas or vacuum system, including the name of system or chemical symbol, color code (see NFPA 99-2012: Table 5.1.11), and operating pressure if other than standard. Labels are at intervals of 20 feet or less and are in every room, at both sides of wall penetrations, and on every story traversed by riser. Piping is not painted. Shutoff valves are identified with the name or chemical symbol of the gas or vacuum system, room or area served, and caution to not use the valve except in emergency. (For full text, refer to NFPA 99-2012: 5.1.4; 5.1.11.1; 5.1.11.2; 5.1.14.3; 5.2.11; 5.3.13.3; 5.3.11)	1). Observed in Building Tour at Northern Inyo Healthcare District (150 Pioneer Lane, Bishop, CA) site . In the bulk oxygen tank the mains source shut off valve was not labeled. A label was ordered during survey.	§485.623(b)(1)	Standard

The Joint Commission

Standard	EP	SAFER™ Placement	EP Text	Observation	CoP	CoP Score
EC.02.05.09	12	Low Limited	<p>The critical access hospital implements a policy on all cylinders within the critical access hospital that includes the following:</p> <ul style="list-style-type: none"> - Labeling, handling, and transporting (for example, in carts, attached to equipment, on racks) in accordance with NFPA 99-2012: 11.5.3.1 and 11.6.2 - Physically segregating full and empty cylinders from each other in order to assist staff in selecting the proper cylinder - Adaptors or conversion fittings are prohibited - Oxygen cylinders, containers, and associated equipment are protected from contamination, damage, and contact with oil and grease - Cylinders are kept away from heat and flammable materials and do not exceed a temperature of 130°F - Nitrous oxide and carbon dioxide cylinders do not reach temperatures lower than manufacturer recommendations or -20°F - Valve protection caps (if supplied) are secured in place when cylinder is not in use - Labeling empty cylinders - Prohibiting transfilling in any compartment with patient care <p>(For full text, refer to NFPA 99-2012: 11.6.1; 11.6.2; 11.6.5; 11.7.3)</p>	1). Observed in Building Tour at Northern Inyo Healthcare District (150 Pioneer Lane, Bishop, CA) site . In the maintenance shop there was an unsecured helium compressed gas tank. Corrected on survey.		
				2). Observed in Building Tour at Northern Inyo Healthcare District (150 Pioneer Lane, Bishop, CA) site . The PACU equipment room H1082 had empty and half full oxygen cylinders comingled with full oxygen cylinders.		
				3). Observed in Building Tour at Northern Inyo Healthcare District (150 Pioneer Lane, Bishop, CA) site . The med surge med room had an unlabeled rack of comingled full, half full e- size oxygen cylinders.		
EM.02.01.01	14	Low Limited	<p>The critical access hospital has a procedure for requesting an 1135 waiver for care and treatment at an alternative care site.</p> <p>Note: During disasters, organizations may need to request 1135 waivers to address care and treatment at an alternate care site identified by emergency</p>	1). Observed in Document Review at Northern Inyo Healthcare District (150 Pioneer Lane, Bishop, CA) site . The organization did not provide documentation for a procedure for requesting an 1135 waiver for care and treatment at an alternative care site.	§485.625(b)(8)	Standard

The Joint Commission

Standard	EP	SAFER™ Placement	EP Text	Observation	CoP	CoP Score
			management officials. The 1135 waivers are granted by the federal government during declared public health emergencies; these waivers authorize modification of certain federal regulatory requirements (for example, Medicare, Medicaid, Children’s Health Insurance Program, Health Insurance Portability and Accountability Act) for a defined time period during response and recovery.			
EM.03.01.03	2	Low Limited	For each site of the critical access hospital that offers emergency services or is a community-designated disaster receiving station, at least one of the critical access hospital’s two emergency response exercises includes an influx of simulated patients. Note 1: Tabletop sessions, though useful, cannot serve for this portion of the exercise. Note 2: This portion of the emergency response exercise can be conducted separately or in conjunction with EM.03.01.03, EPs 3 and 4.	1). Observed in Document Review at Northern Inyo Healthcare District (150 Pioneer Lane, Bishop, CA) site . Of the disaster drills in 2018 the reviewed , the evacuation and lock down to an external active shooter, neither drill involved influx of simulated patients into the hospital.	§485.625(d)(2)(ii)(A)	Standard
HR.01.01.01	2	Low Limited	The critical access hospital verifies and documents the following: - Credentials of care providers using the primary source when licensure, certification, or registration is required by law and regulation to practice their profession. This is done at the time of hire and at the time credentials are renewed. - Credentials of care providers (primary source not required) when licensure, certification, or registration is not required by law and regulation. This is done at the time of hire and at the time credentials are renewed. Note 1: It is acceptable to verify current licensure, certification, or registration with the primary source via a secure electronic communication or by telephone, if this verification is documented. Note 2: A primary verification source may designate another agency to communicate credentials information. The designated agency can then be used as a primary source. Note 3: An external organization (for example, a credentials verification organization [CVO]) may be	1). Observed in Competency Session at Northern Inyo Healthcare District (150 Pioneer Lane, Bishop, CA) site . In 2 of 10 HR files reviewed, it was noted that there was no primary source verification prior to expiration of the previous license in one pharmacist file and no primary source verification of registration required by the State of California in one dietitian’s file. In both instances, primary source verification on the date of survey confirmed licensure or registration.	§485.608(d)	Standard

The Joint Commission

Standard	EP	SAFER™ Placement	EP Text	Observation	CoP	CoP Score
			used to verify credentials information. A CVO must meet the CVO guidelines identified in the Glossary.			
LS.02.01.10	11	Low Limited	Fire-rated doors within walls and floors have functioning hardware, including positive latching devices and self-closing or automatic-closing devices (either kept closed or activated by release device complying with NFPA 101- 2012:7.2.1.8.2). Gaps between meeting edges of door pairs are no more than 1/8 of an inch wide, and undercuts are no larger than 3/4 of an inch. Fire-rated doors within walls do not have unapproved protective plates greater than 16 inches from the bottom of the door. Blocking or wedging open fire-rated doors is prohibited. (For full text, refer to NFPA 101-2012: 8.3.3.1; 7.2.1.8.2; NFPA 80-2010: 4.8.4.1; 5.2.13.3; 6.3.1.7; 6.4.5)	1). Observed in Building Tour at Northern Inyo Healthcare District (150 Pioneer Lane, Bishop, CA) site . The cross corridor double 1 1/2 hour rated doors located by the dining room did not latch upon closure.This finding was observed during survey activity, but corrected onsite prior to the surveyor's departure. The corrective action taken needs to be included in the organization's Evidence of Standards Compliance submission	§485.623(c)(1)(i)	Standard
LS.02.01.20	13	Low Limited	An exit enclosure is not used for any purpose that has the potential to interfere with its use as an exit and, if so designated, as an area of refuge. Open space within the exit enclosure is not used for any purpose that has the potential to interfere with egress. (For full text, refer to NFPA 101-2012: 18/19.2.2.3; 7.1.3.2.3; 7.2.2.5.3.1)	1). Observed in Building Tour at Northern Inyo Healthcare District (150 Pioneer Lane, Bishop, CA) site . The north stairwell on the second floor landing had storage of medical evacuation sled.The surveyor discussed the Life Safety deficiency with the organization, and it was determined that the following ILSMs will be implemented until the deficiency has been resolved and according to the organization's ILSM policy: Conduct education promoting awareness of deficiencies(EP-13)		
LS.02.01.34	9	Low Limited	The ceiling membrane is installed and maintained in a manner that permits activation of the smoke detection system. (For full text, refer to NFPA 101-2012: 18/19.3.4.1)	1). Observed in Building Tour at Northern Inyo Healthcare District (150 Pioneer Lane, Bishop, CA) site . In the corridor by the infusion area with smoke detection there were two ceiling tiles missing creating a gap in the ceiling smoke membraneThis finding was observed during survey activity, but corrected onsite prior to the surveyor's departure. The corrective action taken needs to be included in the organization's Evidence of Standards Compliance submission		
LS.02.01.34	10	Low Limited	The critical access hospital meets all other Life Safety Code fire alarm requirements related to NFPA 101-2012: 18/19.3.4.	1). Observed in Building Tour at Northern Inyo Healthcare District (150 Pioneer Lane, Bishop, CA) site . The pull station in the electrical room containing the main fire alarm panel was obstructed	§485.623(c)(1)(i)	Standard

The Joint Commission

Standard	EP	SAFER™ Placement	EP Text	Observation	CoP	CoP Score
				by items in storage. This finding was observed during survey activity, but corrected onsite prior to the surveyor's departure. The corrective action taken needs to be included in the organization's Evidence of Standards Compliance submission		
				2). Observed in Building Tour at Northern Inyo Healthcare District (150 Pioneer Lane, Bishop, CA) site . In the back side of clean sterile storage there was a fire response pull station obstructed by a trash can near the emergency exit. This finding was observed during survey activity, but corrected onsite prior to the surveyor's departure. The corrective action taken needs to be included in the organization's Evidence of Standards Compliance submission	§485.623(c)(1)(i)	Standard
LS.02.01.35	6	Low Limited	There are 18 inches or more of open space maintained below the sprinkler deflector to the top of storage. Note: Perimeter wall and stack shelving may extend up to the ceiling when not located directly below a sprinkler head. (For full text, refer to NFPA 101-2012: 18.3.5.1; 19.3.5.3; 9.7.1.1; NFPA 13-2010: 8.5.5.2; 8.5.5.2.1; 8.5.5.3)	1). Observed in Building Tour at Northern Inyo Healthcare District (150 Pioneer Lane, Bishop, CA) site . In sterile storage the center shelves had items on the top shelf with less than 18 inch clearance below the fire sprinkler heads. This finding was observed during survey activity, but corrected onsite prior to the surveyor's departure. The corrective action taken needs to be included in the organization's Evidence of Standards Compliance submission	§485.623(c)(1)(i)	Standard
LS.02.01.35	14	Low Limited	The critical access hospital meets all other Life Safety Code automatic extinguishing requirements related to NFPA 101-2012: 18/19.3.5.	1). Observed in Building Tour at Northern Inyo Healthcare District (150 Pioneer Lane, Bishop, CA) site . In OR # 2 there was a fire extinguisher blocked by storage of step stool. This finding was observed during survey activity, but corrected onsite prior to the surveyor's departure. The corrective action taken needs to be included in the organization's Evidence of Standards Compliance submission	§485.623(c)(1)(i)	Standard
LS.02.01.70	6	Low Limited	Soiled linen and trash receptacles larger than 32 gallons are stored in a room protected as a hazardous area. (For full text, refer to NFPA 101-2012: 18/19.7.5.7) Note: Containers that are 96 gallons or less and are labeled and listed as meeting the requirements of	1). Observed in Building Tour at Northern Inyo Healthcare District (150 Pioneer Lane, Bishop, CA) site . The PACU had a large trash can greater than 32 gallon capacity stored adjacent to a soiled linen hamper. Reference NFPA 101 -2012 19.7.5.7.1 (2). This finding was observed during survey activity,	§485.623(b)(2)	Standard

The Joint Commission

Standard	EP	SAFER™ Placement	EP Text	Observation	CoP	CoP Score
			FM Approval Standard 6921 (or equivalent) and are used solely for recycling clean waste (including patient records awaiting destruction) are permitted in an unprotected area. Those containers that are greater than 96 gallons are stored in a hazardous storage area.	but corrected onsite prior to the surveyor's departure. The corrective action taken needs to be included in the organization's Evidence of Standards Compliance submission		
MM.04.01.01	1	Low Limited	<p>The critical access hospital follows a written policy that identifies the specific types of medication orders that it deems acceptable for use.</p> <p>Note: There are several different types of medication orders. Medication orders commonly used include the following:</p> <ul style="list-style-type: none"> - As needed (PRN) orders: Orders acted on based on the occurrence of a specific indication or symptom - Standing orders: A prewritten medication order and specific instructions from the licensed independent practitioner to administer a medication to a person in clearly defined circumstances - Automatic stop orders: Orders that include a date or time to discontinue a medication - Titrating orders: Orders in which the dose is either progressively increased or decreased in response to the patient's status - Taper orders: Orders in which the dose is decreased by a particular amount with each dosing interval - Range orders: Orders in which the dose or dosing interval varies over a prescribed range, depending on the situation or patient's status - Signed and held orders: New prewritten (held) medication orders and specific instructions from a licensed independent practitioner to administer medication(s) to a patient in clearly defined circumstances that become active upon the release of the orders on a specific date(s) and time(s) - Orders for compounded drugs or drug mixtures not commercially available - Orders for medication-related devices (for example, nebulizers, catheters) - Orders for investigational medications 	1). Observed in Individual Tracer at Northern Inyo Healthcare District (150 Pioneer Lane, Bishop, CA) site . During an individual tracer in the PACU, it was noted that there were several medications ordered for pain, and they were ranked in order of choice with Fentanyl ranked first. There was also another order for Meperidine IVP prn pain or shaking, although the Meperidine was not given a rank. The patient was noted to have a pain level of 7, and Fentanyl 25 micrograms was given. However, the Meperidine was omitted. which was not consistent with the orders. The patient's record subsequently documented a pain score level of 6, and Fentanyl 25 micrograms was again given, although at a pain score level of 6, the order indicated 12.5 micrograms of Fentanyl was to be given.		

The Joint Commission

Standard	EP	SAFER™ Placement	EP Text	Observation	CoP	CoP Score
			<ul style="list-style-type: none"> - Orders for herbal products - Orders for medications at discharge or transfer 			
MM.05.01.01	4	Moderate Limited	<p>All medication orders are reviewed for the following:</p> <ul style="list-style-type: none"> - Patient allergies or potential sensitivities - Existing or potential interactions between the medication ordered and food and medications the patient is currently taking - The appropriateness of the medication, dose, frequency, and route of administration - Current or potential impact as indicated by laboratory values - Therapeutic duplication - Other contraindications 	<p>1). Observed in Individual Tracer at Northern Inyo Healthcare District (150 Pioneer Lane, Bishop, CA) site . During individual patient tracer of a postoperative orthopedic patient, it was noted that Dilaudid 0.2 mg IV prn pain level 7-10 and Oxycodone 10 mg prn pain level 7-10 were ordered. The oxycodone order indicated that PO medication was to be used first, but the Dilaudid order did not have any limitations. There was no documentation of clarification of this order by the pharmacist.</p>		
MS.06.01.05	9	Low Limited	<p>Before recommending privileges, the organized medical staff also evaluates the following:</p> <ul style="list-style-type: none"> - Challenges to any licensure or registration - Voluntary and involuntary relinquishment of any license or registration - Voluntary and involuntary termination of medical staff membership - Voluntary and involuntary limitation, reduction, or loss of clinical privileges - Any evidence of an unusual pattern or an excessive number of professional liability actions resulting in a final judgment against the applicant - Documentation as to the applicant's health status - Relevant practitioner-specific data as compared to aggregate data, when available - Morbidity and mortality data, when available 	<p>1). Observed in Credentialing and Privileging at Northern Inyo Healthcare District (150 Pioneer Lane, Bishop, CA) site . During review of a rural clinic's provider's file in which the reappointment application had a summary of peer review, proctoring, data and outcome review, it was noted that the actual information that was reviewed was not sent to the medical staff office. That information was not available to the medical staff leaders responsible for recommending renewal of privileges. Evaluation of the data in another provider's file showed demonstration that 3% of the provider's patients were offered influenza immunization and 22% had appropriate colorectal screening while the summary report indicated that the provider's performance was satisfactory based on a thorough and comprehensive review.</p>		
PC.02.01.11	2	Low Limited	<p>Resuscitation equipment is available for use based on the needs of the population served. Note: For example, if the critical access hospital has a pediatric population, pediatric resuscitation equipment should be available. (See also EC.02.04.03, EP 2)</p>	<p>1). Observed in Tracer Visit at Northern Inyo Healthcare District (150 Pioneer Lane, Bishop, CA) site . During tracer activities in the Operating Room, it was noted that a locked lipid emulsion resuscitation kit used for emergency reversal of local anesthetic toxicity was being checked weekly, but that the lock number was not recorded as part of the check. This meant that there was no way to determine that everything inside the locked kit was, in fact, the complete requirements for managing the local anesthetic toxicity emergency.</p>		

The Joint Commission

Standard	EP	SAFER™ Placement	EP Text	Observation	CoP	CoP Score
				2). Observed in Tracer Activities at Northern Inyo Healthcare District (150 Pioneer Lane, Bishop, CA) site . During tracer activities in the Emergency Department, it was noted that daily checks of the Broselow bag does not include the lock number.		
PC.02.02.01	29	Low Limited	For critical access hospitals with swing beds: The critical access hospital follows its policy identifying circumstances when loss of or damage to a resident's dentures is the critical access hospital's responsibility and it may not charge a resident for the loss or damage of dentures.	1). Observed in Document Review at Northern Inyo Healthcare District (150 Pioneer Lane, Bishop, CA) site . The hospital currently does not have a policy related to identifying circumstances when loss of or damage to a resident's dentures is the hospital's responsibility and when it may not charge a resident for the loss or damage of dentures. A draft policy has been developed and is awaiting approval by the medical staff and governing body.	§483.55(b)(4)	Standard
				2). Observed in Document Review at Northern Inyo Healthcare District (150 Pioneer Lane, Bishop, CA) site . The hospital currently does not have a policy related to identifying circumstances when loss of or damage to a resident's dentures is the hospital's responsibility and when it may not charge a resident for the loss or damage of dentures. A draft policy has been developed and is awaiting approval by the medical staff and governing body.	§483.55(b)(4)	Standard
RC.02.01.01	2	Low Pattern	The medical record contains the following clinical information: - The reason(s) for admission for care, treatment, and services - The patient's initial diagnosis, diagnostic impression(s), or condition(s) - Any findings of assessments and reassessments (See also PC.01.02.01, EP 1; PC.03.01.03, EPs 1 and 8) - Any allergies to food - Any allergies to medications - Any conclusions or impressions drawn from the patient's medical history and physical examination - Any diagnoses or conditions established during the patient's course of care, treatment, and services (including complications and hospital-acquired infections). For psychiatric distinct part units in critical access hospitals: The diagnosis includes	1). Observed in Record Review at Northern Inyo Healthcare District (150 Pioneer Lane, Bishop, CA) site . During review of a swing bed patient whose prior admission was on the medical surgical unit, it was noted that some orders, such as oxycodone 10 mg po prn pain level 7-10, were continued from the prior admission.	§485.638(a)(4)(iii)	Standard

The Joint Commission

Standard	EP	SAFER™ Placement	EP Text	Observation	CoP	CoP Score
			<p>intercurrent diseases (diseases that occur during the course of another disease; for example, a patient with AIDS may develop an intercurrent bout of pneumonia) and the psychiatric diagnoses.</p> <ul style="list-style-type: none"> - Any consultation reports - Any observations relevant to care, treatment, and services - The patient's response to care, treatment, and services - Any emergency care, treatment, and services provided to the patient before his or her arrival - Any progress notes - All orders - Any medications ordered or prescribed - Any medications administered, including the strength, dose, route, date and time of administration - Any access site for medication, administration devices used, and rate of administration - Any adverse drug reactions - Treatment goals, plan of care, and revisions to the plan of care (See also PC.01.03.01, EP 23) - Results of diagnostic and therapeutic tests and procedures - Any medications dispensed or prescribed on discharge - Discharge diagnosis - Discharge plan and discharge planning evaluation (See also PC.01.02.03, EP 6) 			
TS.03.02.01	3	Low Limited	The critical access hospital documents the dates, times, and staff involved when tissue is accepted, prepared, and issued. (See also TS.03.01.01, EP 6)	1). Observed in Tracer Visit at Northern Inyo Healthcare District (150 Pioneer Lane, Bishop, CA) site . During review of the tissue tracking log, it was noted that the documentation of the individual receiving the tissue was not documented in 3 of 67 tissues received that were noted in the tracking log.		

The Joint Commission
Appendix
Conditions of Participation Text

Program: Critical Access Hospital

CoP	Tag	CoP Standard text
§485.608 Compliance With Federal, State, and Local Laws and Regulations	C-0150	§485.608 Condition of Participation: Compliance With Federal, State, and Local Laws and Regulations The CAH and its staff are in compliance with applicable Federal, State and local laws and regulations.
§485.608(d) Licensure, Certification or Registration of Personnel	C-0154	§485.608(d) Standard: Licensure, Certification or Registration of Personnel Staff of the CAH are licensed, certified, or registered in accordance with applicable Federal, State, and local laws and regulations.
§485.623 Physical Plant and Environment	C-0220	§485.623 Condition of Participation: Physical Plant and Environment
§485.623(a) Construction	C-0221	§485.623(a) Standard: Construction The CAH is constructed, arranged, and maintained to ensure access to and safety of patients, and provides adequate space for the provision of services.
§485.623(b)(1) Maintenance	C-0222	(1) All essential mechanical, electrical, and patient-care equipment is maintained in safe operating condition;
§485.623(b)(2) Maintenance	C-0223	(2) There is proper routine storage and prompt disposal of trash;
§485.623(c)(1)(i)	C-----	(i) The CAH must meet the applicable provisions and must proceed in accordance with the Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4.)
§485.638 Clinical Records	C-0300	§485.638 Condition of Participation: Clinical Records
§485.638(a)(4)(iii) Records System	C-0306	(iii) All orders of doctors of medicine or osteopathy or other practitioners, reports of treatments and medications, nursing notes and documentation of complications, and other pertinent information necessary to monitor the patient's progress, such as temperature graphics, progress notes describing the patient's response to treatment; and
§485.645	C-0350	§485.645 Special Requirements for CAH Providers of Long-Term Care Services ("Swing-Beds") A CAH must meet the following requirements in order to be granted an approval from CMS to provide post-CAH SNF care, as specified in §409.30 of this chapter, and to be paid for SNF-level services, in accordance with paragraph (c) of this section.
§483.55	C-----	§483.55 Dental services. The facility must assist residents in obtaining routine and 24-hour emergency dental care.

The Joint Commission

CoP	Tag	CoP Standard text
§483.55(b)(4)	C----	(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and
§485.625 Establishment of the Emergency Program (EP)	E-0001	<p>§485.625 Condition of Participation: Emergency Preparedness</p> <p>The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. The emergency preparedness plan must include, but not be limited to, the following elements:</p>
§485.625(b)(8) Roles under a Waiver Declared by Secretary	E-0026	(8) The role of the CAH under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials.
§485.625(d)(2)(ii)(A) Emergency Prep Testing Requirements	E-0039	(A) A second full-scale exercise that is community-based or individual, facility-based.
§485.625(e)(2) Hospital CAH and LTC Emergency Power	E-0041	(2) Emergency generator inspection and testing. The CAH must implement emergency power system inspection and testing requirements found in the Health Care Facilities Code, NFPA 110, and the Life Safety Code.

The Joint Commission

Appendix

Standard and EP Text

Program: Critical Access Hospital

Standard	EP	Standard Text	EP Text
EC.02.01.01	1	The critical access hospital manages safety and security risks.	The critical access hospital implements its process to identify safety and security risks associated with the environment of care that could affect patients, staff, and other people coming to the critical access hospital's facilities. Note: Risks are identified from internal sources such as ongoing monitoring of the environment, results of root cause analyses, results of proactive risk assessments of high-risk processes, and from credible external sources such as Sentinel Event Alerts.
EC.02.02.01	5	The critical access hospital manages risks related to hazardous materials and waste.	The critical access hospital minimizes risks associated with selecting, handling, storing, transporting, using, and disposing of hazardous chemicals.
EC.02.02.01	12	The critical access hospital manages risks related to hazardous materials and waste.	The critical access hospital labels hazardous materials and waste. Labels identify the contents and hazard warnings. * (See also IC.02.01.01, EP 6) Footnote *: The Occupational Safety and Health Administration's (OSHA) Bloodborne Pathogens and Hazard Communications Standards and the National Fire Protection Association (NFPA) provide details on labeling requirements.
EC.02.02.01	19	The critical access hospital manages risks related to hazardous materials and waste.	The critical access hospital has procedures for the proper routine storage and prompt disposal of trash.
EC.02.03.03	2	The critical access hospital conducts fire drills.	The critical access hospital conducts fire drills every 12 months from the date of the last drill in all freestanding buildings classified as business occupancies and in which patients are seen or treated. Note: In leased or rented facilities, drills need be conducted only in areas of the building that the critical access hospital occupies.
EC.02.03.03	3	The critical access hospital conducts fire drills.	When quarterly fire drills are required, they are unannounced and held at unexpected times and under varying conditions. Fire drills include transmission of fire alarm signal and simulation of emergency fire conditions. Note 1: When drills are conducted between 9:00 P.M. and 6:00 A.M., the critical access hospital may use alternative methods to notify staff instead of activating audible alarms. Note 2: For full text, refer to NFPA 101-2012: 18/19: 7.1.7; 7.1; 7.2; 7.3.
EC.02.03.05	3	The critical access hospital maintains fire safety equipment and fire safety	Every 12 months, the critical access hospital tests duct detectors, heat

The Joint Commission

Standard	EP	Standard Text	EP Text
		building features. Note: This standard does not require critical access hospitals to have the types of fire safety equipment and building features described below. However, if these types of equipment or features exist within the building, then the following maintenance, testing, and inspection requirements apply.	detectors, manual fire alarm boxes, and smoke detectors on the inventory. The results and completion dates are documented. Note: For additional guidance on performing tests, see NFPA 72-2010: Table 14.4.5; 17.14.
EC.02.03.05	4	The critical access hospital maintains fire safety equipment and fire safety building features. Note: This standard does not require critical access hospitals to have the types of fire safety equipment and building features described below. However, if these types of equipment or features exist within the building, then the following maintenance, testing, and inspection requirements apply.	Every 12 months, the critical access hospital tests visual and audible fire alarms, including speakers and door-releasing devices on the inventory. The results and completion dates are documented. Note: For additional guidance on performing tests, see NFPA 72-2010: Table 14.4.5.
EC.02.03.05	5	The critical access hospital maintains fire safety equipment and fire safety building features. Note: This standard does not require critical access hospitals to have the types of fire safety equipment and building features described below. However, if these types of equipment or features exist within the building, then the following maintenance, testing, and inspection requirements apply.	Every 12 months, the critical access hospital tests fire alarm equipment on the inventory for notifying off-site fire responders. The results and completion dates are documented. Note: For additional guidance on performing tests, see NFPA 72-2010: Table 14.4.5.
EC.02.03.05	19	The critical access hospital maintains fire safety equipment and fire safety building features. Note: This standard does not require critical access hospitals to have the types of fire safety equipment and building features described below. However, if these types of equipment or features exist within the building, then the following maintenance, testing, and inspection requirements apply.	Every 12 months, the critical access hospital tests automatic smoke-detection shutdown devices for air-handling equipment. The results and completion dates are documented. Note: For additional guidance on performing tests, see NFPA 90A-2012: 6.4.1.
EC.02.03.05	28	The critical access hospital maintains fire safety equipment and fire safety building features. Note: This standard does not require critical access hospitals to have the types of fire safety equipment and building features described below. However, if these types of equipment or features exist within the building, then the following maintenance, testing, and inspection requirements apply.	Documentation of maintenance, testing, and inspection activities for Standard EC.02.03.05, EPs 1–20, 25 (including fire alarm and fire protection features) includes the following: - Name of the activity - Date of the activity - Inventory of devices, equipment, or other items - Required frequency of the activity - Name and contact information, including affiliation, of the person who performed the activity - NFPA standard(s) referenced for the activity - Results of the activity Note: For additional guidance on documenting activities, see NFPA 25-2011: 4.3; 4.4; NFPA 72-2010: 14.2.1; 14.2.2; 14.2.3; 14.2.4; NFPA 101-2012: 18/19.7.2.1.5.10.1; 7.2.1.5.11.
EC.02.05.01	9	The critical access hospital manages risks associated with its utility systems.	The critical access hospital labels utility system controls to facilitate partial or complete emergency shutdowns. Note 1: Examples of utility system controls that should be labeled are utility source valves, utility system main switches and valves, and

The Joint Commission

Standard	EP	Standard Text	EP Text
			individual circuits in an electrical distribution panel. Note 2: For example, the fire alarm system's circuit is clearly labeled as Fire Alarm Circuit; the disconnect method (that is, the circuit breaker) is marked in red; and access is restricted to authorized personnel. Information regarding the dedicated branch circuit for the fire alarm panel is located in the control unit. For additional guidance, see NFPA 101-2012: 18/19.3.4.1; 9.6.1.3; NFPA 72-2010: 10.5.5.2.
EC.02.05.01	15	The critical access hospital manages risks associated with its utility systems.	In critical care areas designed to control airborne contaminants (such as biological agents, gases, fumes, dust), the ventilation system provides appropriate pressure relationships, air-exchange rates, filtration efficiencies, and temperature and humidity. Note: For more information about areas designed for control of airborne contaminants, the basis for design compliance is the Guidelines for Design and Construction of Health Care Facilities, based on the edition used at the time of design (if available).
EC.02.05.01	16	The critical access hospital manages risks associated with its utility systems.	In non-critical care areas, the ventilation system provides required pressure relationships, temperature, and humidity. Note: Examples of non-critical care areas are general care nursing units; clean and soiled utility rooms in acute care areas; laboratories, pharmacies, diagnostic and treatment areas, food preparation areas, and other support departments.
EC.02.05.03	1	The critical access hospital has a reliable emergency electrical power source.	For facilities that were constructed, or had a change in occupancy type, or have undergone an electrical system upgrade since 1983, the critical access hospital has a Type 1 or Type 3 essential electrical system in accordance with NFPA 99, 2012 edition. This essential electrical system must be divided into three branches, including the life safety branch, critical branch, and equipment branch. Both the life safety branch and the critical branch are kept independent of all other wiring and equipment, and they transfer within 10 seconds of electrical interruption. Each branch has at least one automatic transfer switch. For additional guidance, see NFPA 99-2012: 6.4.2.2.
EC.02.05.03	11	The critical access hospital has a reliable emergency electrical power source.	The critical access hospital provides emergency power within 10 seconds for the following: Emergency lighting at emergency generator locations. The critical access hospital's emergency power system (EPS) has a remote manual stop station (with identifying label) to prevent inadvertent or unintentional operation. A remote annunciator (powered by storage battery) is located outside the EPS location. Note: For guidance in establishing a reliable emergency power system (that is, an essential electrical distribution system), refer to NFPA 99-2012: 6.4.1.1.6; 6.4.1.1.17; 6.4.2.2; NFPA 110-2010: 5.6.5.6; 7.3.1.
EC.02.05.05	4	The critical access hospital inspects, tests, and maintains utility systems.	The critical access hospital inspects, tests, and maintains the following:

The Joint Commission

Standard	EP	Standard Text	EP Text
		Note: At times, maintenance is performed by an external service. In these cases, critical access hospitals are not required to possess maintenance documentation but must have access to such documentation during survey and as needed.	High-risk utility system components on the inventory. The completion date and the results of the activities are documented. Note 1: A high-risk utility system includes components for which there is a risk of serious injury or even death to a patient or staff member should it fail, which includes life-support equipment. Note 2: Required activities and associated frequencies for maintaining, inspecting, and testing of utility systems components that are completed in accordance with manufacturers' recommendations must have a 100% completion rate. Note 3: Scheduled maintenance activities for high-risk utility systems components in an alternative equipment maintenance (AEM) program inventory must have a 100% completion rate.
EC.02.05.05	6	The critical access hospital inspects, tests, and maintains utility systems. Note: At times, maintenance is performed by an external service. In these cases, critical access hospitals are not required to possess maintenance documentation but must have access to such documentation during survey and as needed.	The critical access hospital inspects, tests, and maintains the following: Non-high-risk utility system components on the inventory. The completion date and the results of the activities are documented. Note: Scheduled maintenance activities for non-high-risk utility systems components in an alternative equipment maintenance (AEM) program inventory must have a 100% completion rate. AEM frequency is determined by the critical access hospital AEM program.
EC.02.05.07	8	The critical access hospital inspects, tests, and maintains emergency power systems. Note: This standard does not require critical access hospitals to have the types of emergency power equipment discussed below. However, if these types of equipment exist within the building, then the following maintenance, testing, and inspection requirements apply.	At least annually, the critical access hospital tests the fuel quality to ASTM standards. The test results and completion dates are documented. Note: For additional guidance, see NFPA 110-2010: 8.3.8.
EC.02.05.07	9	The critical access hospital inspects, tests, and maintains emergency power systems. Note: This standard does not require critical access hospitals to have the types of emergency power equipment discussed below. However, if these types of equipment exist within the building, then the following maintenance, testing, and inspection requirements apply.	At least once every 36 months, critical access hospitals with a generator providing emergency power test each emergency generator for a minimum of 4 continuous hours. The test results and completion dates are documented. Note: For additional guidance, see NFPA 110-2010, Chapter 8.
EC.02.05.09	11	The critical access hospital inspects, tests, and maintains medical gas and vacuum systems. Note: This standard does not require critical access hospitals to have the medical gas and vacuum systems discussed below. However, if a critical access hospital has these types of systems, then the following inspection, testing, and maintenance requirements apply.	The critical access hospital makes main supply valves and area shutoff valves for piped medical gas and vacuum systems accessible and clearly identifies what the valves control. Piping is labeled by stencil or adhesive markers identifying the gas or vacuum system, including the name of system or chemical symbol, color code (see NFPA 99-2012: Table 5.1.11), and operating pressure if other than standard. Labels are at intervals of 20 feet or less and are in every room, at both sides of wall penetrations, and on every story traversed by riser. Piping is not painted. Shutoff valves are identified with the name or chemical symbol of the gas or vacuum system, room or area served, and caution to not use the valve except in

The Joint Commission

Standard	EP	Standard Text	EP Text
			emergency. (For full text, refer to NFPA 99-2012: 5.1.4; 5.1.11.1; 5.1.11.2; 5.1.14.3; 5.2.11; 5.3.13.3; 5.3.11)
EC.02.05.09	12	<p>The critical access hospital inspects, tests, and maintains medical gas and vacuum systems.</p> <p>Note: This standard does not require critical access hospitals to have the medical gas and vacuum systems discussed below. However, if a critical access hospital has these types of systems, then the following inspection, testing, and maintenance requirements apply.</p>	<p>The critical access hospital implements a policy on all cylinders within the critical access hospital that includes the following:</p> <ul style="list-style-type: none"> - Labeling, handling, and transporting (for example, in carts, attached to equipment, on racks) in accordance with NFPA 99-2012: 11.5.3.1 and 11.6.2 - Physically segregating full and empty cylinders from each other in order to assist staff in selecting the proper cylinder - Adaptors or conversion fittings are prohibited - Oxygen cylinders, containers, and associated equipment are protected from contamination, damage, and contact with oil and grease - Cylinders are kept away from heat and flammable materials and do not exceed a temperature of 130°F - Nitrous oxide and carbon dioxide cylinders do not reach temperatures lower than manufacturer recommendations or -20°F - Valve protection caps (if supplied) are secured in place when cylinder is not in use - Labeling empty cylinders - Prohibiting transfilling in any compartment with patient care <p>(For full text, refer to NFPA 99-2012: 11.6.1; 11.6.2; 11.6.5; 11.7.3)</p>
EM.02.01.01	14	<p>The critical access hospital has an Emergency Operations Plan.</p> <p>Note: The critical access hospital's Emergency Operations Plan (EOP) is designed to coordinate its communications, resources and assets, safety and security, staff responsibilities, utilities, and patient clinical and support activities during an emergency (refer to Standards EM.02.02.01, EM.02.02.03, EM.02.02.05, EM.02.02.07, EM.02.02.09, and EM.02.02.11). Although emergencies have many causes, the effects on these areas of the organization and the required response effort may be similar. This "all hazards" approach supports a general response capability that is sufficiently nimble to address a range of emergencies of different duration, scale, and cause. For this reason, the plan's response procedures address the prioritized emergencies but are also adaptable to other emergencies that the organization may experience.</p>	<p>The critical access hospital has a procedure for requesting an 1135 waiver for care and treatment at an alternative care site.</p> <p>Note: During disasters, organizations may need to request 1135 waivers to address care and treatment at an alternate care site identified by emergency management officials. The 1135 waivers are granted by the federal government during declared public health emergencies; these waivers authorize modification of certain federal regulatory requirements (for example, Medicare, Medicaid, Children's Health Insurance Program, Health Insurance Portability and Accountability Act) for a defined time period during response and recovery.</p>
EM.03.01.03	2	<p>The critical access hospital evaluates the effectiveness of its Emergency Operations Plan.</p>	<p>For each site of the critical access hospital that offers emergency services or is a community-designated disaster receiving station, at least one of the critical access hospital's two emergency response exercises includes an influx of simulated patients.</p> <p>Note 1: Tabletop sessions, though useful, cannot serve for this portion of the exercise.</p> <p>Note 2: This portion of the emergency response exercise can be</p>

The Joint Commission

Standard	EP	Standard Text	EP Text
			conducted separately or in conjunction with EM.03.01.03, EPs 3 and 4.
HR.01.01.01	2	The critical access hospital defines and verifies staff qualifications.	<p>The critical access hospital verifies and documents the following:</p> <ul style="list-style-type: none"> - Credentials of care providers using the primary source when licensure, certification, or registration is required by law and regulation to practice their profession. This is done at the time of hire and at the time credentials are renewed. - Credentials of care providers (primary source not required) when licensure, certification, or registration is not required by law and regulation. This is done at the time of hire and at the time credentials are renewed. <p>Note 1: It is acceptable to verify current licensure, certification, or registration with the primary source via a secure electronic communication or by telephone, if this verification is documented.</p> <p>Note 2: A primary verification source may designate another agency to communicate credentials information. The designated agency can then be used as a primary source.</p> <p>Note 3: An external organization (for example, a credentials verification organization [CVO]) may be used to verify credentials information. A CVO must meet the CVO guidelines identified in the Glossary.</p>
LS.02.01.10	11	Building and fire protection features are designed and maintained to minimize the effects of fire, smoke, and heat.	Fire-rated doors within walls and floors have functioning hardware, including positive latching devices and self-closing or automatic-closing devices (either kept closed or activated by release device complying with NFPA 101- 2012:7.2.1.8.2). Gaps between meeting edges of door pairs are no more than 1/8 of an inch wide, and undercuts are no larger than 3/4 of an inch. Fire-rated doors within walls do not have unapproved protective plates greater than 16 inches from the bottom of the door. Blocking or wedging open fire-rated doors is prohibited. (For full text, refer to NFPA 101-2012: 8.3.3.1; 7.2.1.8.2; NFPA 80-2010: 4.8.4.1; 5.2.13.3; 6.3.1.7; 6.4.5)
LS.02.01.20	13	The critical access hospital maintains the integrity of the means of egress.	An exit enclosure is not used for any purpose that has the potential to interfere with its use as an exit and, if so designated, as an area of refuge. Open space within the exit enclosure is not used for any purpose that has the potential to interfere with egress. (For full text, refer to NFPA 101-2012: 18/19.2.2.3; 7.1.3.2.3; 7.2.2.5.3.1)
LS.02.01.34	9	The critical access hospital provides and maintains fire alarm systems.	The ceiling membrane is installed and maintained in a manner that permits activation of the smoke detection system. (For full text, refer to NFPA 101-2012: 18/19.3.4.1)
LS.02.01.34	10	The critical access hospital provides and maintains fire alarm systems.	The critical access hospital meets all other Life Safety Code fire alarm requirements related to NFPA 101-2012: 18/19.3.4.
LS.02.01.35	6	The critical access hospital provides and maintains systems for extinguishing fires.	There are 18 inches or more of open space maintained below the sprinkler deflector to the top of storage.

The Joint Commission

Standard	EP	Standard Text	EP Text
			Note: Perimeter wall and stack shelving may extend up to the ceiling when not located directly below a sprinkler head. (For full text, refer to NFPA 101-2012: 18.3.5.1; 19.3.5.3; 9.7.1.1; NFPA 13-2010: 8.5.5.2; 8.5.5.2.1; 8.5.5.3)
LS.02.01.35	14	The critical access hospital provides and maintains systems for extinguishing fires.	The critical access hospital meets all other Life Safety Code automatic extinguishing requirements related to NFPA 101-2012: 18/19.3.5.
LS.02.01.70	6	The critical access hospital provides and maintains operating features that conform to fire and smoke prevention requirements.	Soiled linen and trash receptacles larger than 32 gallons are stored in a room protected as a hazardous area. (For full text, refer to NFPA 101-2012: 18/19.7.5.7) Note: Containers that are 96 gallons or less and are labeled and listed as meeting the requirements of FM Approval Standard 6921 (or equivalent) and are used solely for recycling clean waste (including patient records awaiting destruction) are permitted in an unprotected area. Those containers that are greater than 96 gallons are stored in a hazardous storage area.
MM.04.01.01	1	Medication orders are clear and accurate.	The critical access hospital follows a written policy that identifies the specific types of medication orders that it deems acceptable for use. Note: There are several different types of medication orders. Medication orders commonly used include the following: - As needed (PRN) orders: Orders acted on based on the occurrence of a specific indication or symptom - Standing orders: A prewritten medication order and specific instructions from the licensed independent practitioner to administer a medication to a person in clearly defined circumstances - Automatic stop orders: Orders that include a date or time to discontinue a medication - Titrating orders: Orders in which the dose is either progressively increased or decreased in response to the patient's status - Taper orders: Orders in which the dose is decreased by a particular amount with each dosing interval - Range orders: Orders in which the dose or dosing interval varies over a prescribed range, depending on the situation or patient's status - Signed and held orders: New prewritten (held) medication orders and specific instructions from a licensed independent practitioner to administer medication(s) to a patient in clearly defined circumstances that become active upon the release of the orders on a specific date(s) and time(s) - Orders for compounded drugs or drug mixtures not commercially available - Orders for medication-related devices (for example, nebulizers, catheters) - Orders for investigational medications

The Joint Commission

Standard	EP	Standard Text	EP Text
			<ul style="list-style-type: none"> - Orders for herbal products - Orders for medications at discharge or transfer
MM.05.01.01	4	A pharmacist reviews the appropriateness of all medication orders for medications to be dispensed in the critical access hospital.	<p>All medication orders are reviewed for the following:</p> <ul style="list-style-type: none"> - Patient allergies or potential sensitivities - Existing or potential interactions between the medication ordered and food and medications the patient is currently taking - The appropriateness of the medication, dose, frequency, and route of administration - Current or potential impact as indicated by laboratory values - Therapeutic duplication - Other contraindications
MS.06.01.05	9	The decision to grant or deny a privilege(s), and/or to renew an existing privilege(s), is an objective, evidence-based process.	<p>Before recommending privileges, the organized medical staff also evaluates the following:</p> <ul style="list-style-type: none"> - Challenges to any licensure or registration - Voluntary and involuntary relinquishment of any license or registration - Voluntary and involuntary termination of medical staff membership - Voluntary and involuntary limitation, reduction, or loss of clinical privileges - Any evidence of an unusual pattern or an excessive number of professional liability actions resulting in a final judgment against the applicant - Documentation as to the applicant's health status - Relevant practitioner-specific data as compared to aggregate data, when available - Morbidity and mortality data, when available
PC.02.01.11	2	Resuscitation services are available throughout the critical access hospital.	<p>Resuscitation equipment is available for use based on the needs of the population served.</p> <p>Note: For example, if the critical access hospital has a pediatric population, pediatric resuscitation equipment should be available. (See also EC.02.04.03, EP 2)</p>
PC.02.02.01	29	The critical access hospital coordinates the patient's care, treatment, and services based on the patient's needs.	<p>For critical access hospitals with swing beds: The critical access hospital follows its policy identifying circumstances when loss of or damage to a resident's dentures is the critical access hospital's responsibility and it may not charge a resident for the loss or damage of dentures.</p>
RC.02.01.01	2	The medical record contains information that reflects the patient's care, treatment, and services.	<p>The medical record contains the following clinical information:</p> <ul style="list-style-type: none"> - The reason(s) for admission for care, treatment, and services - The patient's initial diagnosis, diagnostic impression(s), or condition(s) - Any findings of assessments and reassessments (See also PC.01.02.01, EP 1; PC.03.01.03, EPs 1 and 8) - Any allergies to food - Any allergies to medications

The Joint Commission

Standard	EP	Standard Text	EP Text
			<ul style="list-style-type: none"> - Any conclusions or impressions drawn from the patient's medical history and physical examination - Any diagnoses or conditions established during the patient's course of care, treatment, and services (including complications and hospital-acquired infections). For psychiatric distinct part units in critical access hospitals: The diagnosis includes intercurrent diseases (diseases that occur during the course of another disease; for example, a patient with AIDS may develop an intercurrent bout of pneumonia) and the psychiatric diagnoses. - Any consultation reports - Any observations relevant to care, treatment, and services - The patient's response to care, treatment, and services - Any emergency care, treatment, and services provided to the patient before his or her arrival - Any progress notes - All orders - Any medications ordered or prescribed - Any medications administered, including the strength, dose, route, date and time of administration - Any access site for medication, administration devices used, and rate of administration - Any adverse drug reactions - Treatment goals, plan of care, and revisions to the plan of care (See also PC.01.03.01, EP 23) - Results of diagnostic and therapeutic tests and procedures - Any medications dispensed or prescribed on discharge - Discharge diagnosis - Discharge plan and discharge planning evaluation (See also PC.01.02.03, EP 6)
TS.03.02.01	3	The critical access hospital traces all tissues bi-directionally.	The critical access hospital documents the dates, times, and staff involved when tissue is accepted, prepared, and issued. (See also TS.03.01.01, EP 6)

The Joint Commission

Appendix

Report Section Information

SAFER™ Matrix Description

All Requirements for Improvement (RFIs) are plotted on the SAFER matrix according to the likelihood the issue could cause harm to patient(s), staff, and/or visitor(s), and the scope at which the RFI is observed. Combined, these characteristics identify a risk level for each RFI, which in turn will determine the level of required post-survey follow up. As the risk level of an RFI increases, the placement of the standard and Element of Performance moves from the bottom left corner to the upper right. The definitions for the Likelihood to Harm a Patient/Staff/Visitor and Scope are as follows:

Likelihood to Harm a Patient/Staff/Visitor:

- Low: harm could happen, but would be rare
- Moderate: harm could happen occasionally
- High: harm could happen any time

Scope:

- Limited: unique occurrence that is not representative of routine/regular practice
- Pattern: multiple occurrences with potential to impact few/some patients, staff, visitors and/or settings
- Widespread: multiple occurrences with potential to impact most/all patients, staff, visitors and/or settings

The Evidence of Standards Compliance (ESC) or Plan of Correction (POC) forms with findings of a higher risk will require two additional fields within the ESC or POC. The organization will provide a more detailed description of Leadership Involvement and Preventive Analysis to assist in sustainment of the compliance plan. Additionally, these higher risk findings will be provided to surveyors for possible review or onsite validation during any subsequent onsite surveys, up until the next full triennial survey occurs. The below legend illustrates the follow-up activity associated with each level of risk.

SAFER™ Matrix Placement	Required Follow-Up Activity
HIGH/LIMITED HIGH/PATTERN HIGH/WIDESPREAD	<ul style="list-style-type: none"> Two additional areas surrounding Leadership Involvement and Preventive Analysis will be included in the ESC or POC Finding will be highlighted for potential review by surveyors on subsequent onsite surveys up to and including the next full survey or review
MODERATE/PATTERN MODERATE/WIDESPREAD	
MODERATE/LIMITED LOW/PATTERN LOW/WIDESPREAD	<ul style="list-style-type: none"> ESC or POC will not include Leadership Involvement and Preventive Analysis
LOW/LIMITED	

The Joint Commission

Appendix

Report Section Information

CMS Summary Description

For organizations that utilize The Joint Commission for deeming purposes, observations noted within the Requirements for Improvement (RFI) section that are crosswalked to a CMS Condition of Participation (CoP)/Condition for Coverage (CfC) are highlighted in this section. The table included within this section incorporates, from a Centers for Medicare and Medicaid Services (CMS) perspective, the CoPs/CfCs that were noted as noncompliant during the survey, the Joint Commission standard and element of performance the CoP/CfC is associated with, the CMS score (either Standard or Condition Level), and if the standard and EP will be included in an upcoming Medicare Deficiency Survey (MEDDEF) if applicable.

Requirements for Improvement Description

Observations noted within the Requirements for Improvement (RFI) section require follow-up through the Evidence of Standards Compliance (ESC) process. The identified timeframes for submission for each observation are found in the Executive Summary section of the Final Report. If a follow-up survey is required, the unannounced visit will focus on the requirements for improvement although other areas, if observed, could still become findings. The time frame to perform the unannounced follow-up visit is dependent on the scope and severity of the issue identified within Requirements for Improvement.

The Joint Commission

Appendix

Report Section Information

Clarification Instructions

Documents not available at the time of survey

Any required documents that are not available at the time of survey will no longer be eligible for the clarification process. These RFIs will become action items in the post-survey ESC process.

Clerical Errors

Clerical errors in the report will no longer be eligible for the clarification process. The Joint Commission will work with the organization to correct the clerical error, so that the report is accurate. The corrected RFIs will become action items in the post-survey process.

Audit Option

There will no longer be an audit option as part of the clarification process. With the implementation of the SAFER™ matrix, the "C" Element of Performance (EP) category is eliminated. The "C" EPs were the subject of Clarification Audits.

The clarification process provides an organization the opportunity to demonstrate compliance with standards that were scored "not compliant" at the time of the survey. The organization has 10 business days from the date the report is published on the extranet site to submit the clarification. *The Evidence of Standards Compliance (ESC) due dates will remain the same whether or not the organization submits a clarification and/or is successful in the clarification process.*

Clarifications may take either of the following forms:

- An organization believes it had adequate evidence available to the surveyor(s) and was in compliance **at the time of the survey**. (Please note that actions taken during or immediately after the survey will not be considered.) The organization must use the clarification form to support their contention.
- The organization has detailed evidence that was not immediately available **at the time of the survey**. The clarification must include an explanation as to why the surveyor(s) did not have access to the information or why it was not provided to the surveyor(s) at the time of the survey. However, any required documents that are not available at the time of survey are not eligible for the Clarification Process. These RFIs will become action items in the post-survey ESC process.
- Please do not submit supplemental documentation unless requested by The Joint Commission. If additional information is requested, the organization will be required to highlight the relevance to the standards in the documentation.



Northern Inyo Hospital

2018 Outmigration Assessment

January 17, 2018

WIPFLi
CPAs and Consultants

HEALTH CARE PRACTICE



Agenda

Demographic Trends

Hospital Market Analysis

Physician and Behavioral Health Demand

Home Health and DME Demand

Community Health Indicators

Demographic Trends



Service Area Definition




- Service area provided by Northern Inyo's Leadership team
 - When possible, data was separated into three service areas for more focused analysis

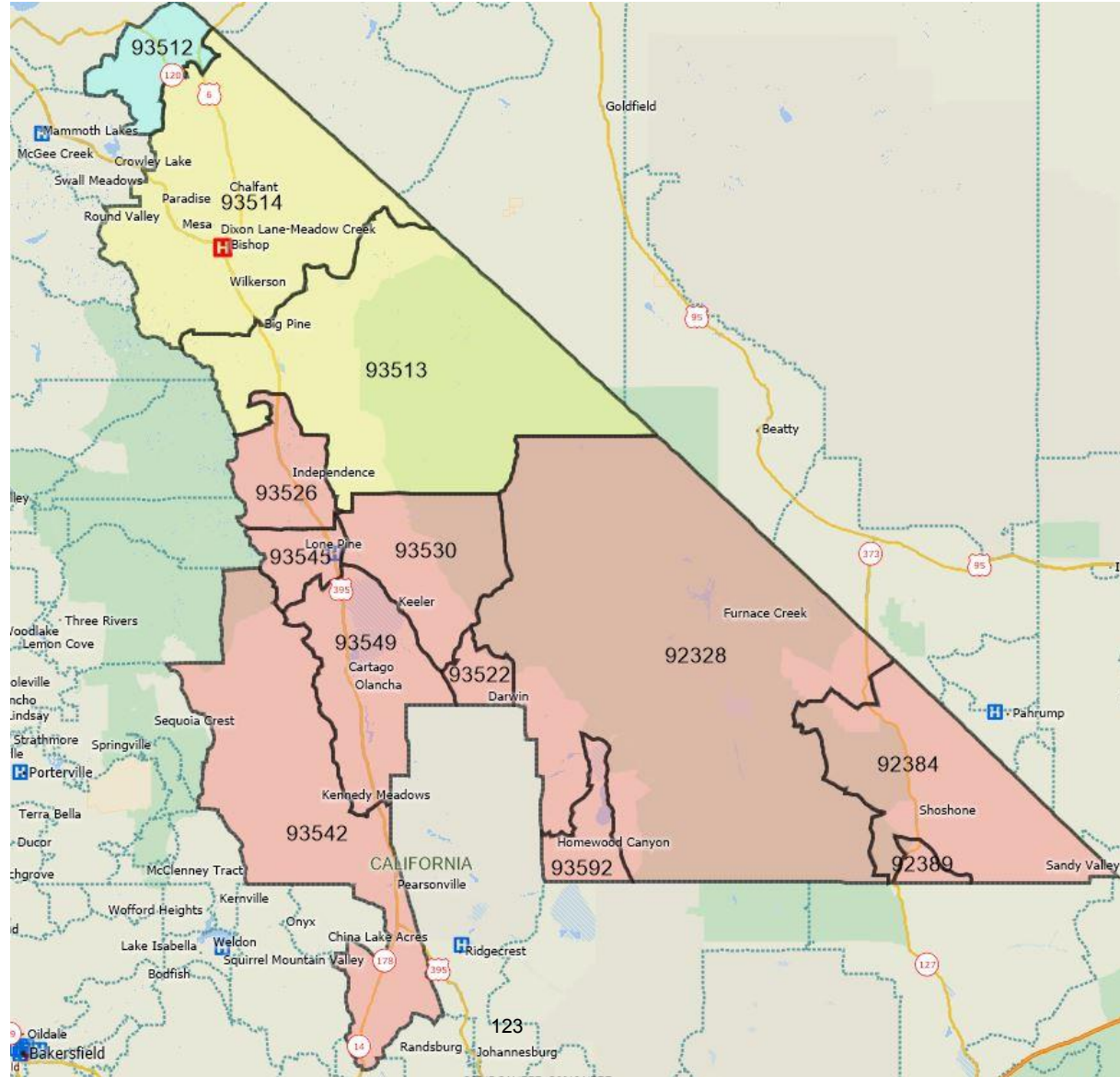
Northern Service Area	
93513 - Big Pine	93514 - Bishop

Southern Service Area	
92328 - Death Valley	93526 - Independence
92384 - Shoshone	93542 - Little Lake
92389 - Tecopa	93545 - Lone Pine
93522 - Darwin	93549 - Olancho

Non Tax Payer Service Area	
93512 - Benton	

Service Area Definition

-  = Northern
-  = Southern
-  = Non Tax Payer



Population

- Northern Service Area (“NSA”) anticipated to decrease by 1% over the next five years, another .4% out to 2028
 - Translates to roughly 262 fewer people in the NSA over the next 10 years
- Southern Service Area (“SSA”) anticipated to decrease at a slightly higher rate
- Non Tax Payer Service Area anticipated to increase slightly

	2010	2018	2023	2028	2018-2023 Change	2018-2023 Percent Change	2018-2023 Raw Change	2023-2028 Percent Change	2023-2028 Raw Change	2018-2023 Compound Annual Growth
Northern Service Area	15,688	15,725	15,527	15,463	-198	-1%	-198	0%	-64	99.8%
Southern Service Area	3,990	3,880	3,780	3,714	-100	-3%	-100	-2%	-66	99.6%
Total Service Area	19,678	19,605	19,307	19,178	-298	-2%	-298	-1%	-129	99.7%
Non Tax Payer Service Area	275	283	286	295	3	1%	3	3%	9	100.2%
California	37,253,956	39,806,791	41,456,909	43,328,648	1,650,118	4%	1,650,118	5%	1,871,739	100.7%
United States	308,745,538	330,088,686	343,954,683	359,888,576	13,865,997	4%	13,865,997	5%	15,933,893	100.7%

Population

- Population will continue to age, with 65-74 and 75-84 age cohorts expanding significantly in both the NSA and SSA
 - Important for future service mix but also rising mix of Medicare

Area	2010	2018	2023	2028	Percent Change 18-23	Percent of Total		Growth in Population 18-23
						2018	2023	
Northern Service Area								
Ages 0-19	3,675	3,417	3,374	3,332	-1.3%	21.7%	21.7%	0.0%
Ages 20-44	4,078	4,183	4,081	3,981	-2.4%	26.6%	26.3%	-0.3%
Ages 45-64	5,008	4,606	4,078	3,611	-11.5%	29.3%	26.3%	-3.0%
Ages 65-74	1,499	1,963	2,287	2,664	16.5%	12.5%	14.7%	2.2%
Ages 75-84	1,014	1,081	1,215	1,366	12.4%	6.9%	7.8%	1.0%
Ages 85+	414	475	492	510	3.6%	3.0%	3.2%	0.1%
Total	15,688	15,725	15,527	15,463	-1.3%			
Females 15-44	2,466	2,457	2,366	2,278	-3.7%	15.6%	15.2%	-0.4%
Southern Service Area								
Ages 0-19	836	747	746	745	-0.1%	19.3%	19.7%	0.5%
Ages 18-44	1,029	993	959	926	-3.4%	25.6%	25.4%	-0.2%
Ages 45-64	1,347	1,222	1,067	932	-12.7%	31.5%	28.2%	-3.3%
Ages 65-74	430	555	603	655	8.6%	14.3%	16.0%	1.6%
Ages 75-84	228	240	287	343	19.6%	6.2%	7.6%	1.4%
Ages 85+	120	123	118	113	-4.1%	3.2%	3.1%	0.0%
Total	3,990	3,880	3,780	3,714	-2.6%			
Females 15-44	580	552	531	511	-3.8%	14.2%	14.0%	-0.2%
Non Tax Payer Service Area								
Ages 0-19	63	59	56	53	-5.1%	1.5%	1.5%	0.0%
Ages 18-44	64	64	64	64	0.0%	1.6%	1.7%	0.0%
Ages 45-64	106	105	95	86	-9.5%	2.7%	2.5%	-0.2%
Ages 65-74	28	37	47	60	27.0%	1.0%	1.2%	0.3%
Ages 75-84	11	14	20	29	42.9%	0.4%	0.5%	0.2%
Ages 85+	3	4	4	4	0.0%	0.1%	0.1%	0.0%
Total	275	283	286	295	1.1%			
Females 15-44	39	39	41	43	5.1%	1.0%	1.1%	0.1%

Source: ESRI

Hospital Market Analysis



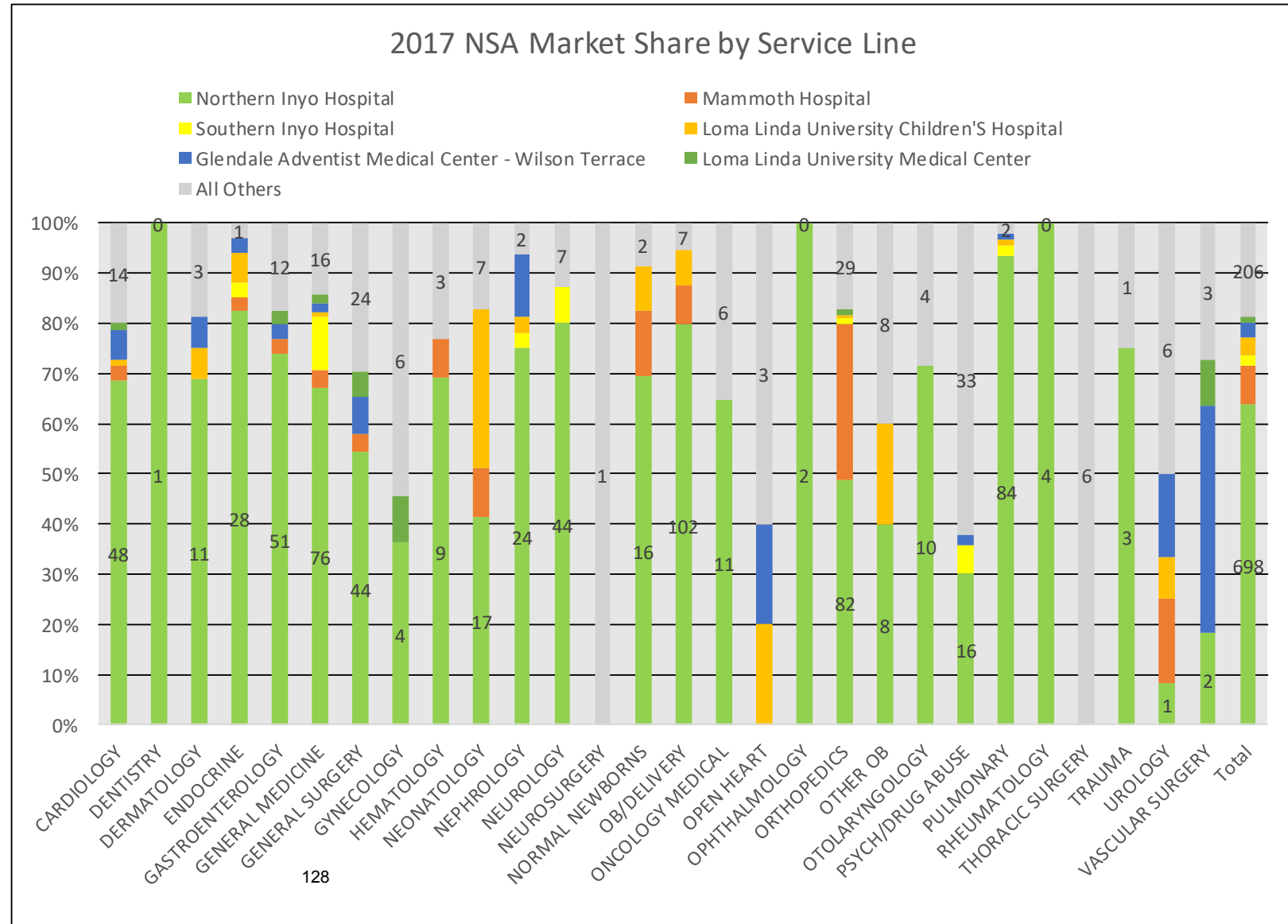
Inpatient Market Share

- Market share in NSA dropped by 4% in 2017
- Overall market in NSA increased slightly
- Market share in SSA dropped from 43% in 2016 to 35% in 2017
- Non Tax service area market share of 61%

Inpatient Market Share	2015	2016	2017	Change	2015	2016	2017	Change
Northern Service Area								
Northern Inyo Hospital	733	701	698	(35)	68%	68%	64%	-4%
Mammoth Hospital	84	57	84	0	8%	6%	8%	0%
Glendale Adventist Medical Center - Wilson Terrace	21	33	30	9	2%	3%	3%	1%
Loma Linda University Children'S Hospital	26	16	38	12	2%	2%	3%	1%
Children's Hospital of Los Angeles	15	17	9	(6)	1%	2%	1%	-1%
Loma Linda University Medical Center	14	14	13	(1)	1%	1%	1%	0%
Southern Inyo Hospital	7	5	25	18	1%	0%	2%	2%
All Others	180	184	197	17	17%	18%	18%	1%
Total	1,080	1,027	1,094	14				
Southern Service Area								
Northern Inyo Hospital	125	88	89	(36)	42%	43%	35%	-7%
Mammoth Hospital	7	17	15	8	2%	8%	6%	3%
Glendale Adventist Medical Center - Wilson Terrace	6	2	1	(5)	2%	1%	0%	-2%
Loma Linda University Children'S Hospital	11	3	8	(3)	4%	1%	3%	-1%
Children's Hospital of Los Angeles		3	1	1	0%	1%	0%	0%
Loma Linda University Medical Center	5		13	8	2%	0%	5%	3%
Southern Inyo Hospital	41	11	27	(14)	14%	5%	11%	-3%
All Others	101	83	102	1	34%	40%	40%	6%
Total	296	207	256	(40)				
Non Tax Service Area								
Northern Inyo Hospital	11	23	20	9	65%	79%	61%	-4%
Mammoth Hospital	2	3	6	4	12%	10%	18%	6%
Glendale Adventist Medical Center - Wilson Terrace			5	5	0%	0%	15%	15%
Loma Linda University Children'S Hospital			1	1	0%	0%	3%	3%
Children's Hospital of Los Angeles				0	0%	0%	0%	0%
Loma Linda University Medical Center	1	1		(1)	6%	3%	0%	-6%
Southern Inyo Hospital	1			(1)	6%	0%	0%	-6%
All Others	2	2	1	(1)	12%	7%	3%	-9%
Total	17	29	33	16				

2017 Inpatient Market Share by Service Line

- Opportunity to increase cases in orthopedics (current market share is under 50%)
- Majority of Psych and Substance abuse services currently leaving community



Physician and Behavioral Health Demand



Physician Supply vs. Demand

- Shortage in total service area in primary care of 5.1 FTEs based on current supply
- Lack of medical subspecialties, particularly in cardiology, oncology, and neurology
- General surgery demand appears to be met by current supply
- While orthopedics shows adequate supply, lack of surgical focus translates to shortage and lower subsequent market share in orthopedics compared to other specialty areas

Physician Demand by Specialty						
Specialty	Northern	Southern	Non-Tax	Total	Supply	Net Coverage / (Shortage)
Primary Care						
Obstetrics/Gynecology	1.9	0.5	0.0	2.5	2.0	(0.5)
Family Practice	5.3	1.3	0.1	6.6	7.5	0.9
Internal Medicine	4.7	1.2	0.1	6.0	2.0	(4.0)
Pediatrics	2.0	0.5	0.0	2.6	1.1	(1.5)
Sub-Total	14.0	3.5	0.3	17.7	12.6	(5.1)
Medical Subspecialties						
Audiology	0.7	0.2	0.0	0.8		(0.8)
Allergy	0.2	0.1	0.0	0.3		(0.3)
Cardiology	0.8	0.2	0.0	1.0	0.2	(0.8)
Dermatology	0.5	0.1	0.0	0.6		(0.6)
Endocrinology	0.2	0.0	0.0	0.2		(0.2)
Gastroenterology	0.5	0.1	0.0	0.6		(0.6)
Hematology/Oncology	0.5	0.1	0.0	0.6		(0.6)
Infectious Disease	0.2	0.0	0.0	0.2		(0.2)
Nephrology	0.2	0.1	0.0	0.3		(0.3)
Neurology	0.5	0.1	0.0	0.6		(0.6)
Pulmonary Medicine	0.3	0.1	0.0	0.4		(0.4)
Rheumatology	0.2	0.0	0.0	0.2		(0.2)
Surgical Subspecialties						
General Surgery	1.7	0.4	0.0	2.2	2.0	(0.2)
Neurosurgery	0.2	0.1	0.0	0.3		(0.3)
Ophthalmology	0.9	0.2	0.0	1.2	1.0	(0.2)
Orthopedics / Podiatry	1.2	0.3	0.0	1.5	2.8	1.3
Otolaryngology	0.5	0.1	0.0	0.7		(0.7)
Plastic Surgery	0.2	0.1	0.0	0.3		(0.3)
Thoracic Surgery	0.2	0.0	0.0	0.2		(0.2)
Urology	0.6	0.1	0.0	0.7		(0.7)

Behavioral Health

- Psychiatrist shortage based on current supply of 1.7
- Psychologist demand in total service area appears to be met with current supply, however significant shortage appears in counseling/social work/therapy

	Demand																				Supply
	Northern Inyo					Southern Inyo					Non Tax					Total Service Area					
	Wipfli	RHRC (US)	HRSA (US)	RHRC (Non-Metro)	Median	Wipfli	RHRC (US)	HRSA (US)	RHRC (Non-Metro)	Median	Wipfli	RHRC (US)	HRSA (US)	RHRC (Non-Metro)	Median	Wipfli	RHRC (US)	HRSA (US)	RHRC (Non-Metro)	Median	
Psychiatrist	1.9	2.5	2.8	0.9	2.2	0.5	0.6	0.7	0.2	0.6	0.0	0.0	0.1	0.0	0.0	2.4	3.1	3.6	1.2	2.8	1.7
Behavioral Health NP		0.3	0.5	0.3	0.3		0.1	0.1	0.1	0.1		0.0	0.0	0.0	0.0		0.4	0.6	0.3	0.4	
Psychologists		4.7	11.6	2.2	4.7		1.2	2.9	0.5	1.2		0.1	0.2	0.0	0.1		6.0	14.7	2.7	6.0	8.0
Counselors/Social Workers/Therapists		27.3	21.6	19.8	21.6		6.7	5.7	4.9	5.7		0.5	0.4	0.4	0.4		34.5	27.7	25.0	27.7	14.0
<i>Counselors/Social Workers/Therapists</i>																					
<i>Substance Abuse Counselors</i>			5.3					1.4					0.1					6.8			
<i>Mental Health Social Workers</i>		9.7	6.9	6.1			2.4	1.8	1.5			0.2	0.1	0.1			12.2	8.9	7.7		
<i>Mental Health Counselors</i>		17.6	7.5	13.6			4.3	2.0	3.4			0.3	0.1	0.2			22.3	9.6	17.2		
<i>Marriage and Family Therapists</i>			1.9					0.5					0.0					2.4			

Home Health and DME Demand



Home Health Agency

- Based on home health visits per 1,000, and average frequency of 9,062 visits per agency, need for roughly 1.2 agencies in total service area
 - Current supply of 1 agency results in shortage of .2, or around 1,800 visits

Home Health Agency Demand	Service Area			Total
	Northern	Southern	Non-Tax Payer	
Home Health Visits Per 1,000 in CA				
Under 71 Years				175
Over 71 Years				2,950
Anticipated Visits				
Under 71 Years	2,398	595	45	3,038
Over 71 Years	5,974	1,410	77	7,461
Total	8,372	2,005	122	10,499
<i>Average Visits Per Agency</i>				9,062
Agencies Required				1.2
Supply of Agencies				1
Agency Overage/(Shortage)	133			(0.2)

Durable Medical Equipment (“DME”)

- Current supply based on review of existing providers of 7.4 DME providers (RX, medical supply, optometry, podiatry and orthotist)
- Based on current demand, there appears to be a shortage in orthotist-related DME providers in the total service area

	Service Area			Total
	Northern Inyo	Southern Inyo	Non-Tax Payer	
Supply				
Pharmacy				4.0
Medical Supply Company				1.0
Optometry/Optician				2.0
Podiatry				0.4
Individual Certified Prosthetist/Orthotist				
Total				7.4
Demand				
Pharmacy	2.5	0.6	0.0	3.1
Medical Supply Company	0.5	0.1	0.0	0.7
Optometry/Optician	0.4	0.1	0.0	0.5
Podiatry	0.3	0.1	0.0	0.3
Individual Certified Prosthetist/Orthotist	0.1	0.0	0.0	0.2
Total	3.8	0.9	0.1	4.7
Overage/(Shortage)				
Pharmacy				0.9
Medical Supply Company				0.3
Optometry				1.5
Podiatry				0.1
Individual Certified Prosthetist/Orthotist				(0.2)






















Community Health Indicators



Community Health Indicators

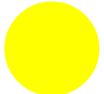

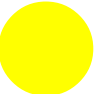
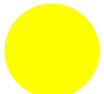
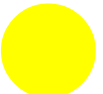
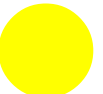
- Inyo County was compared to California and national benchmarks across many key community health, environmental, healthcare, economic and behavioral health indicators
- Detailed graphs are provided in the appendix; summary charts provide at-a-glance comparisons

Community Health Indicators

Community Health Indicators	2017-2018 Change	Compared to California	Compared to National Benchmark
Premature Death			
Low birthweight			
Poor or fair health			
HIV prevalence			
Diabetes prevalence			
Poor physical health days			
Frequent physical distress			






























Mental Health Indicators

Mental Health	2017-2018 Change	Compared to California	Compared to National Benchmark
Poor mental health days			
Frequent mental distress			












Healthy Behaviors

Healthy Behaviors	2017-2018 Change	Compared to California	Compared to National Benchmark
Drug overdose deaths			
Motor vehicle crash deaths			
Excessive drinking			
Insufficient sleep			
Adult obesity			
Physical inactivity			
Alcohol-impaired driving deaths			
Adult smoking			
Sexually transmitted infections			
























Economic Health Indicators

Economy	2017-2018 Change	Compared to California	Compared to National Benchmark
Uninsured children			
Uninsured adults			
Children in poverty			
















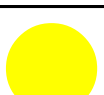
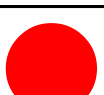
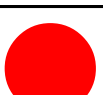
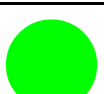
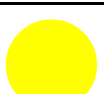
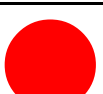


Better	Similar	Worse
		

Healthcare Indicators

Healthcare System	2017-2018 Change	Compared to California	Compared to National Benchmark
Dentists			
Diabetic screening			
Mammography screening			
Primary care physicians			
Mental health providers			
Other primary care providers			
Preventable hospital stays			



Environmental Health Indicators

Environment	2017-2018 Change	Compared to California	Compared to National Benchmark
Injury deaths			
Firearm fatalities			
Access to exercise opportunities			
Limited access to healthy foods			
Food environment index			
Violent crime Rate			
Food insecurity			
Health care costs			



WIPEFLI

CPAs and Consultants

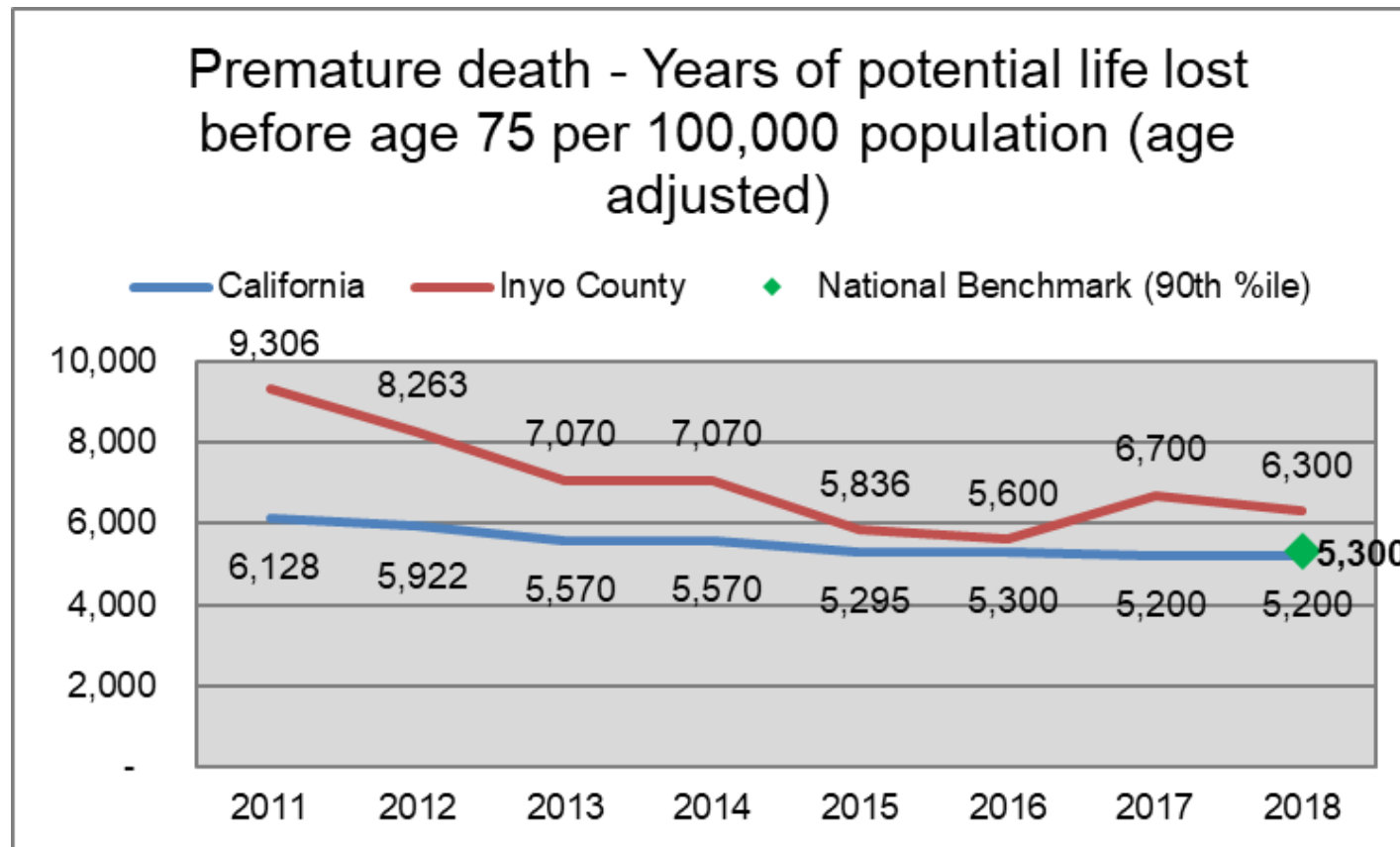
HEALTH CARE PRACTICE

wipfli.com/healthcare

APPENDIX

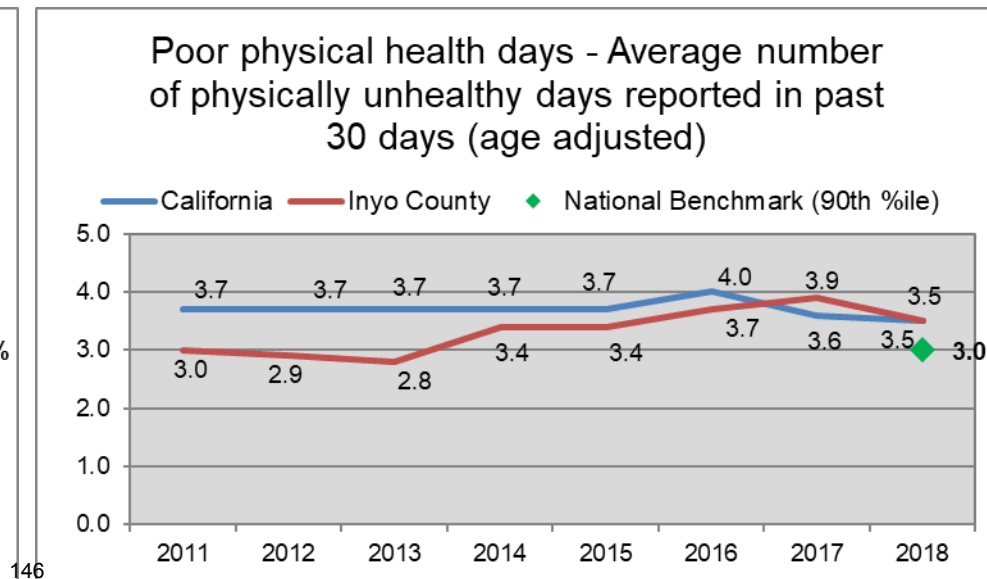
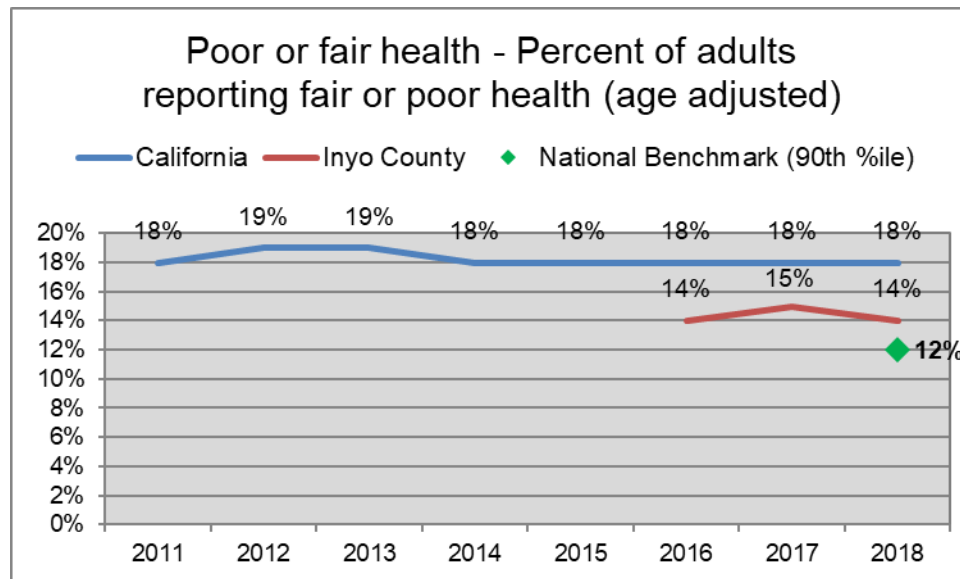
Length of Life

- Inyo premature deaths per 100,000 higher than California, which aligns with national benchmark



Quality of Life

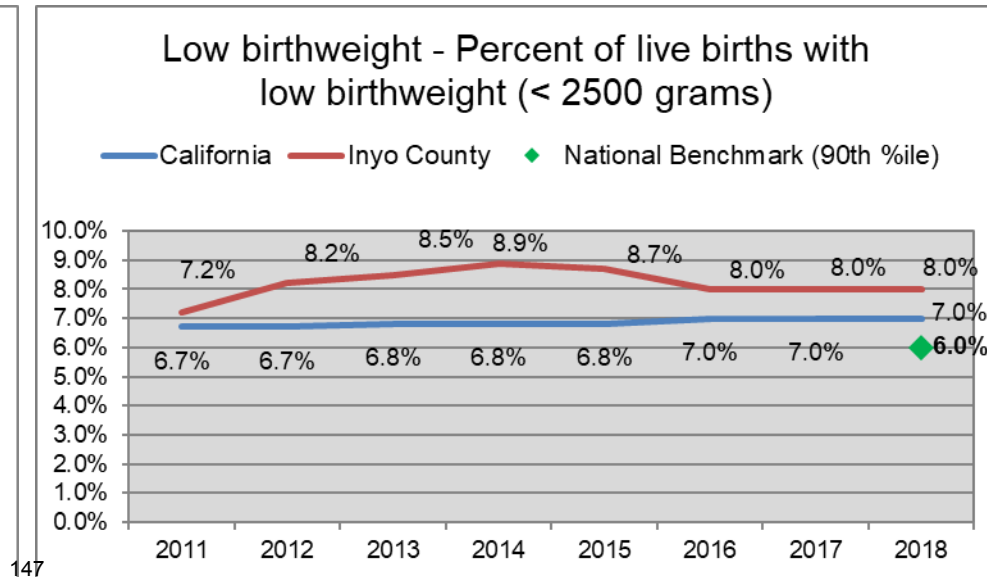
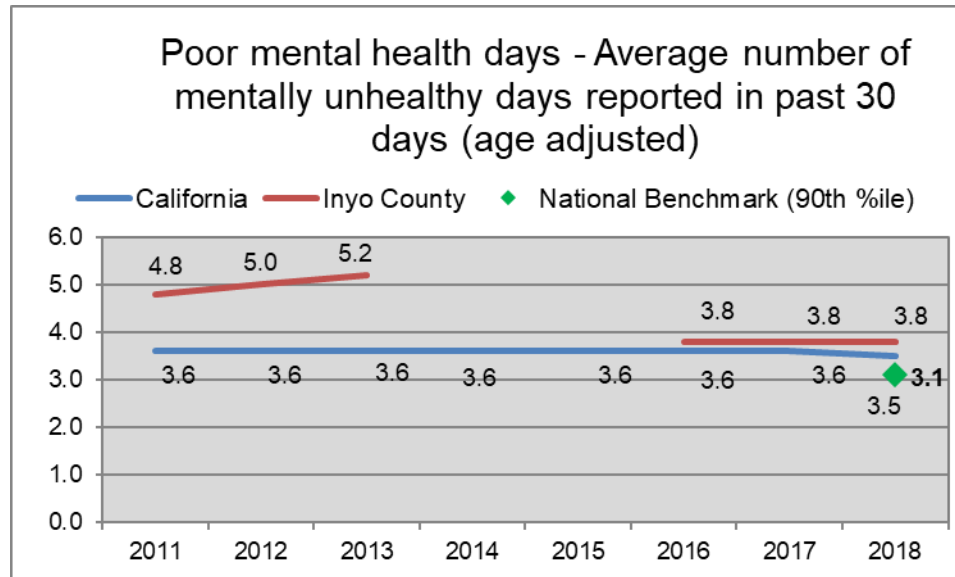
- Inyo County % of population in poor or fair health is slightly higher than national benchmark, but better than California
- Poor physical health days in line with CA, slightly above national benchmark



Source: County Health Rankings

Quality of Life

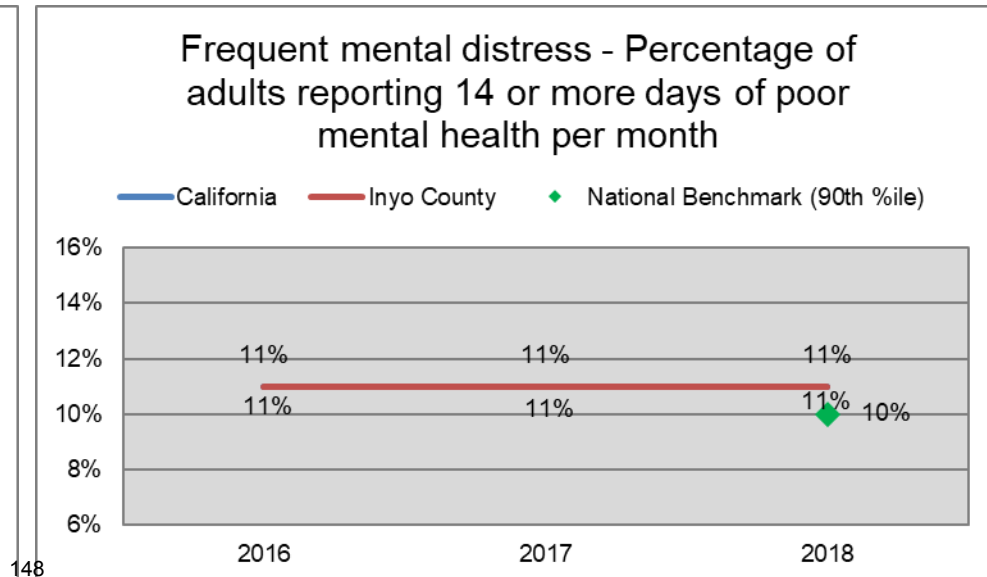
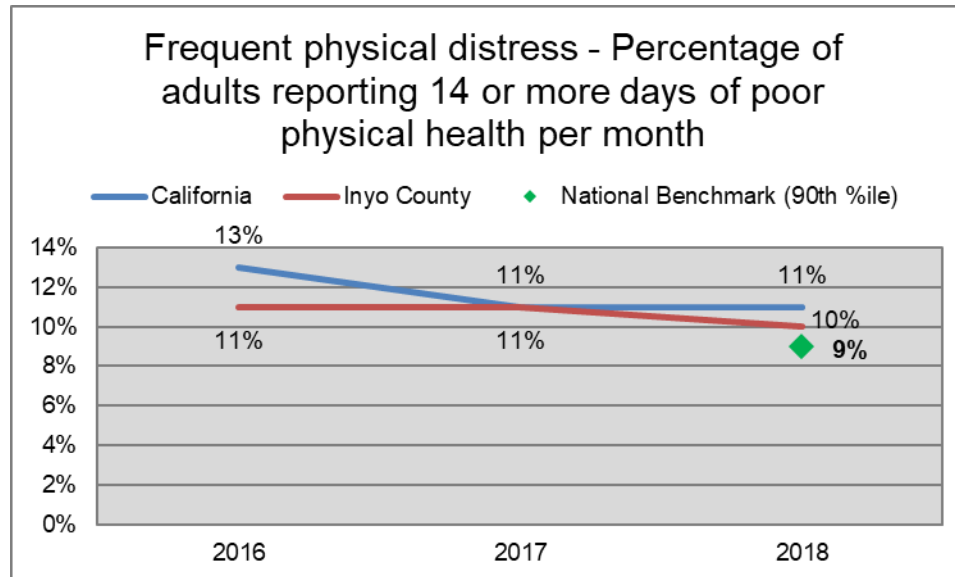
- Poor mental health days in Inyo County slightly above CA
- Low birthweight % in Inyo County is higher than CA, national benchmark



Source: County Health Rankings

Additional Health Outcomes

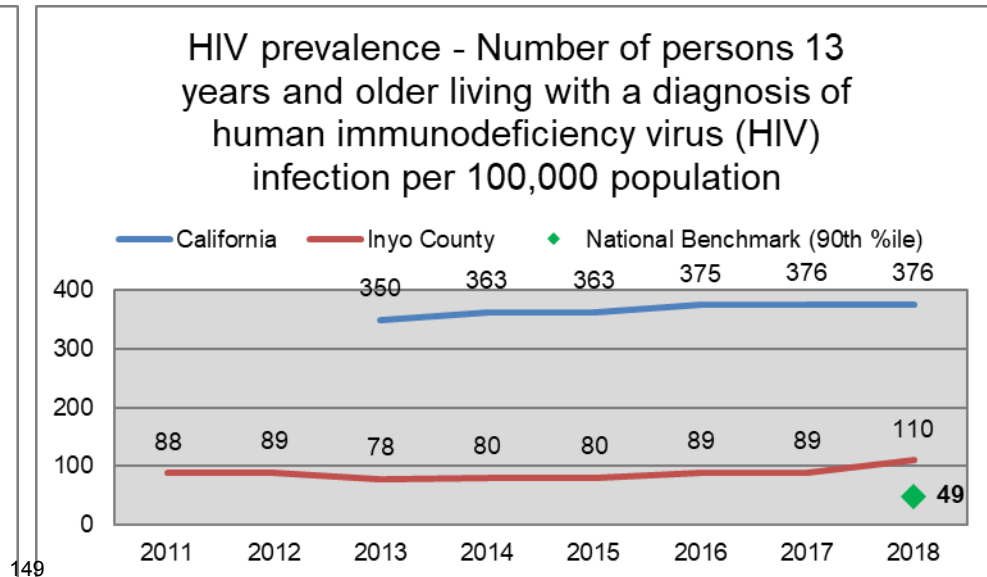
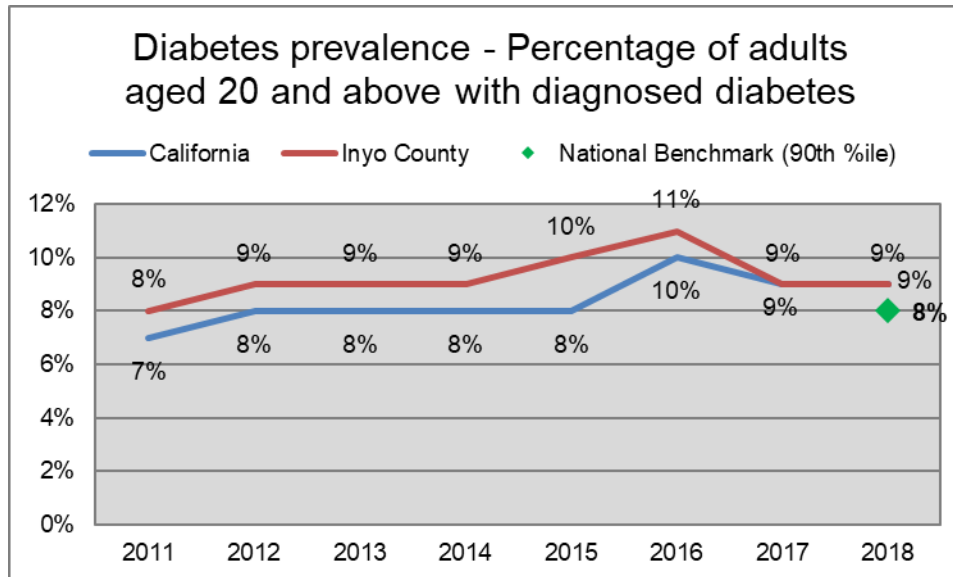
- Inyo rate of frequent physical distress is lower than CA, slightly above national benchmark
- Rate of frequent mental distress is in line with CA, but above national benchmark



Source: County Health Rankings

Additional Health Outcomes

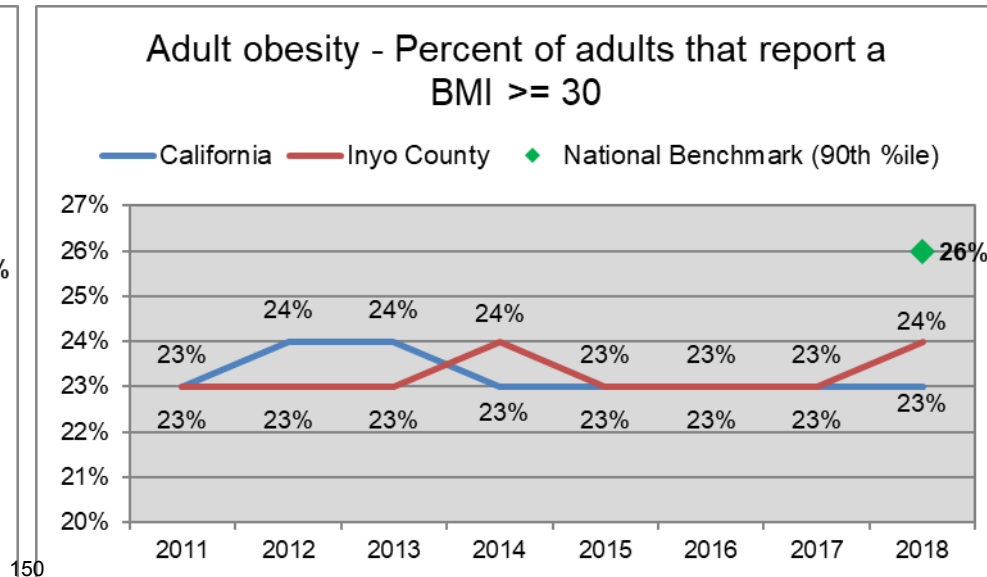
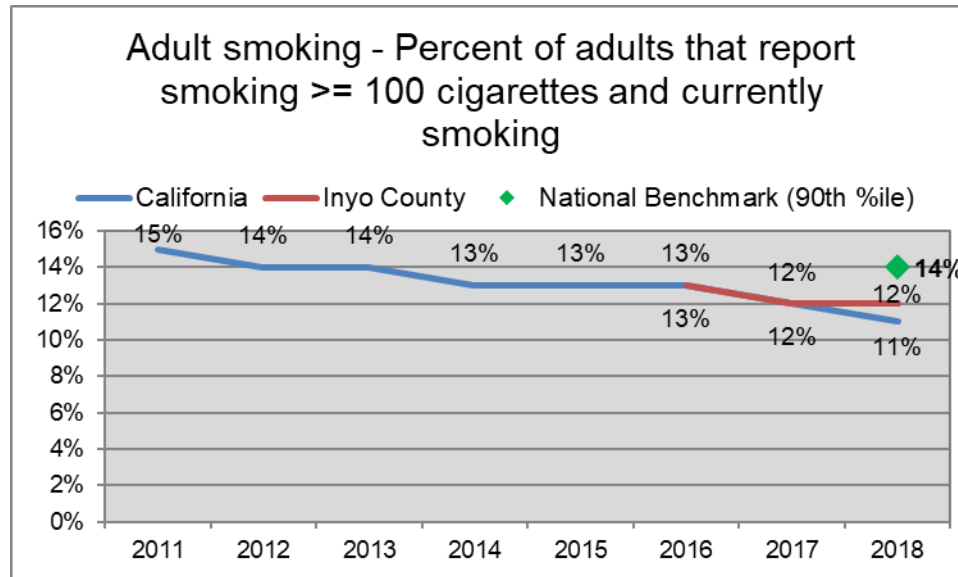
- Prevalence of diabetes in Inyo County has declined for the last two years, in line with California, but slightly above national benchmark
- HIV prevalence significantly below CA, slightly above national benchmark



Source: County Health Rankings

Health Behaviors

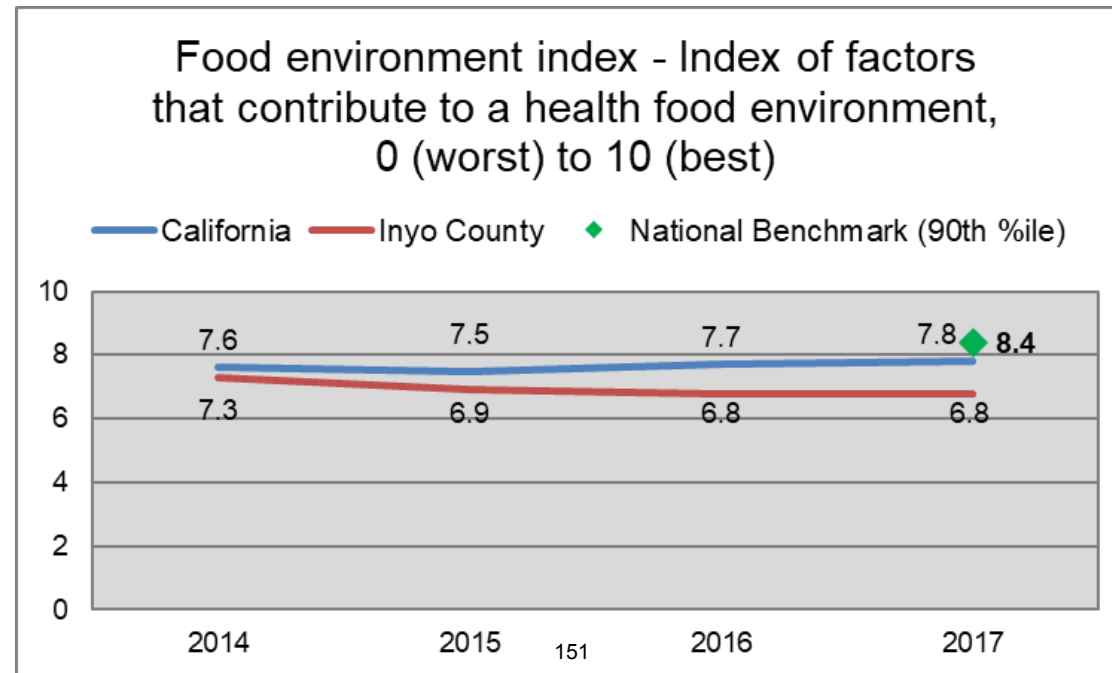
- Rate of adult smoking in Inyo County is below national benchmarks
- Rate of adult obesity in Inyo County (24%) is below the national benchmark of 26%
 - Inyo County rates did rise slightly from 2017



Source: County Health Rankings

Health Behaviors

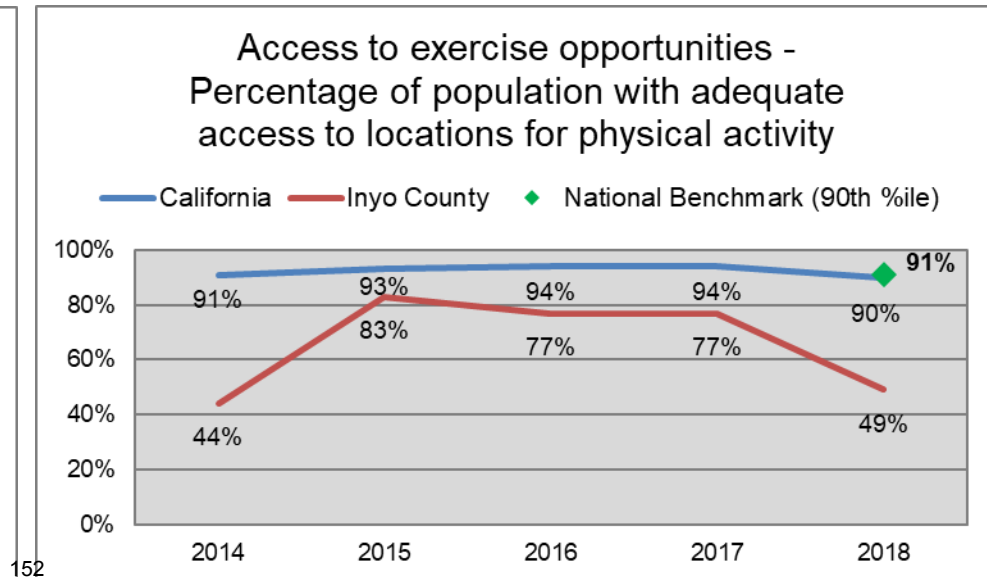
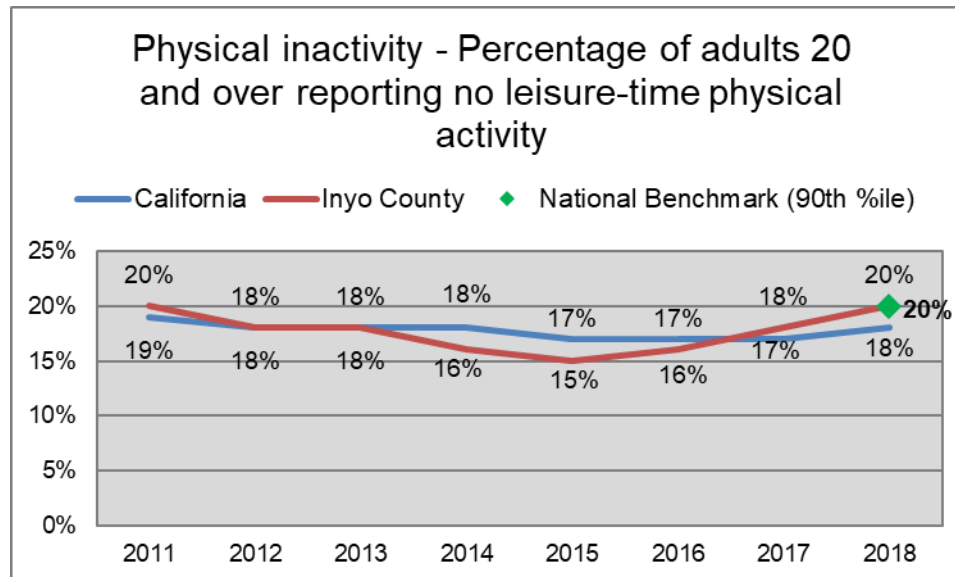
- Inyo County food environment index is lower than CA, and below the national benchmark
- Rate has been declining steadily since 2014



Source: County Health Rankings

Health Behaviors

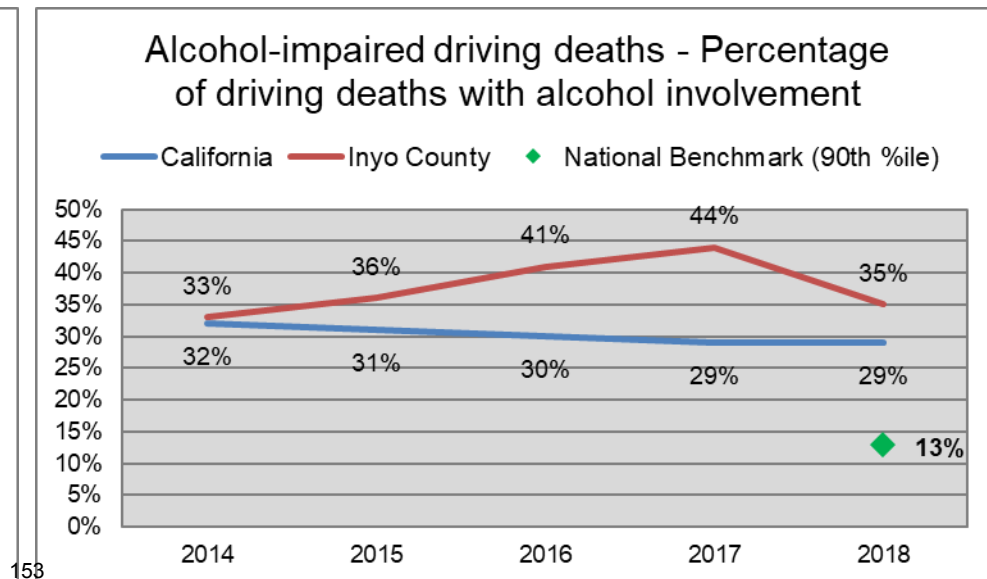
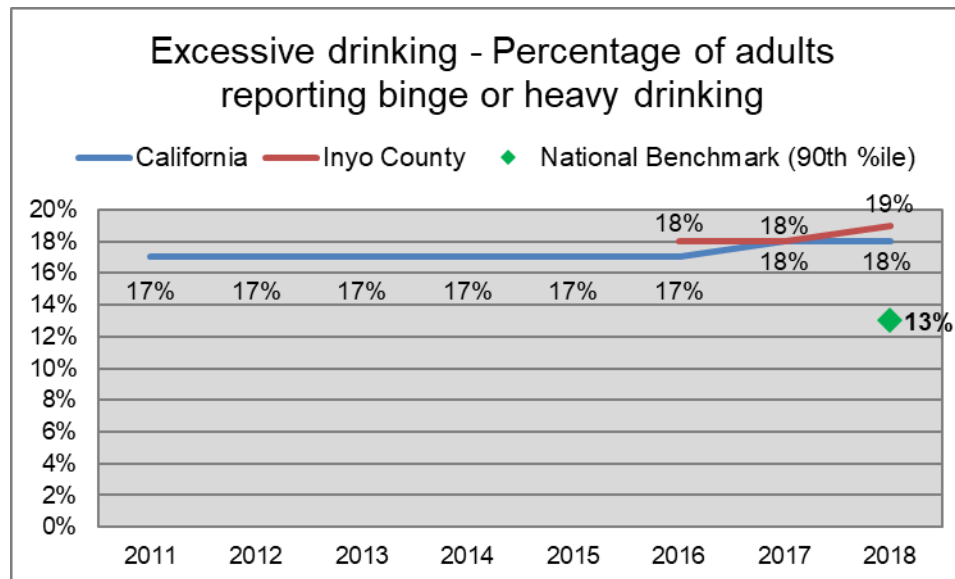
- Rates of physical inactivity in Inyo County are in line with national benchmark, but higher than CA
 - Rates have been rising since 2015 when they were lower than CA
- Access to exercise opportunities in Inyo County are significantly below CA and national benchmarks



Source: County Health Rankings

Health Behaviors

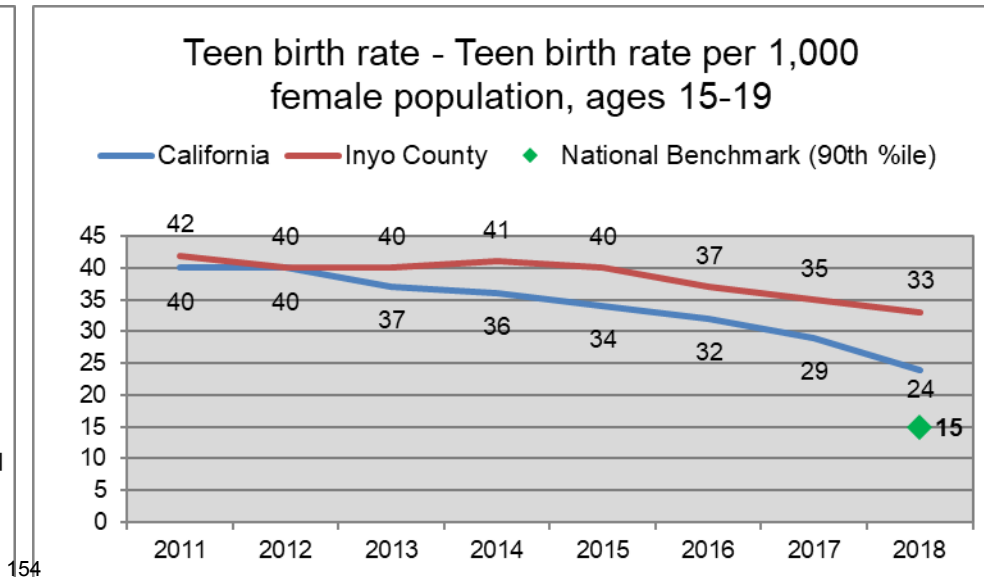
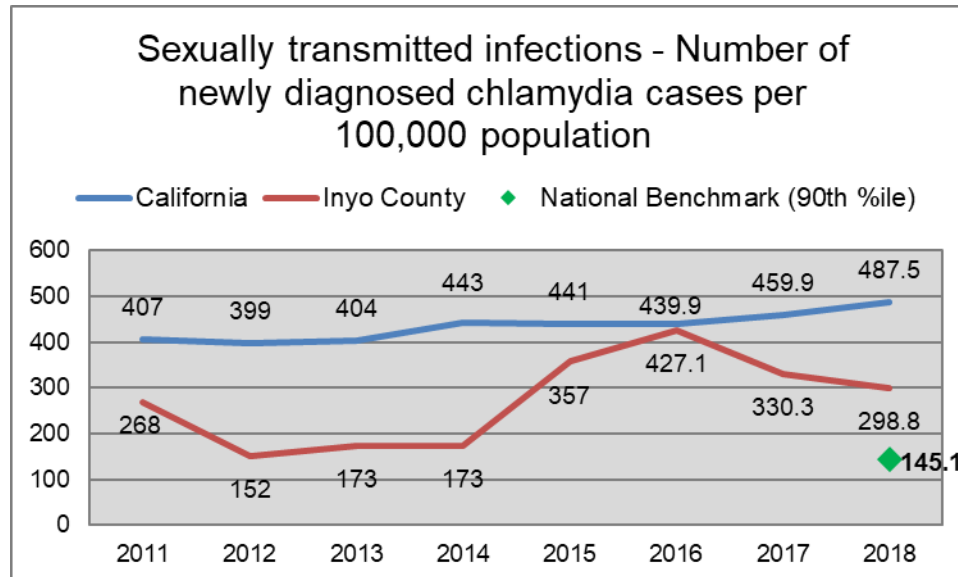
- Rates of excessive drinking in Inyo County are higher than CA, and significantly above national benchmarks
- Alcohol-impaired driving deaths in Inyo County are above CA and national benchmarks, although they have declined from a high in 2017



Source: County Health Rankings

Health Behaviors

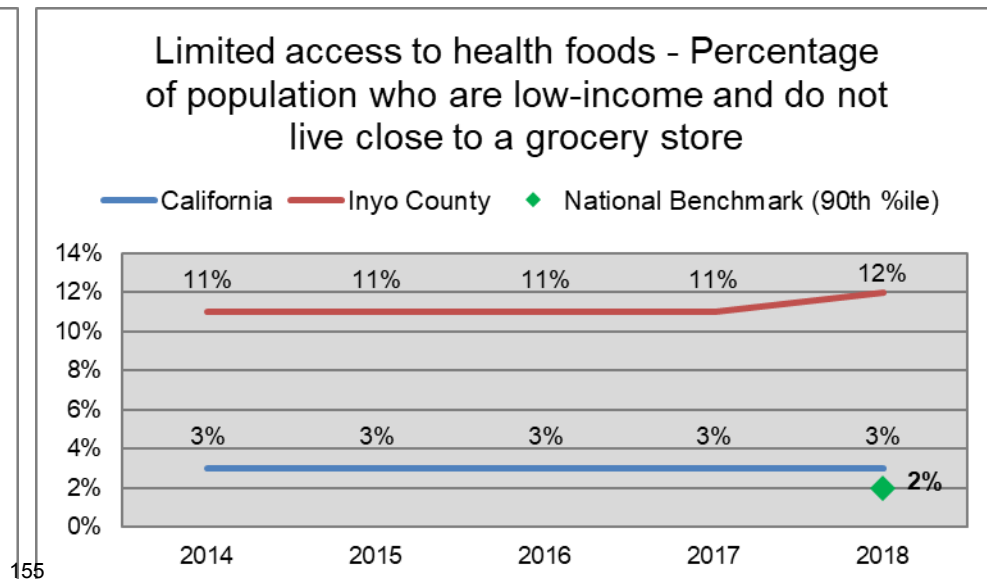
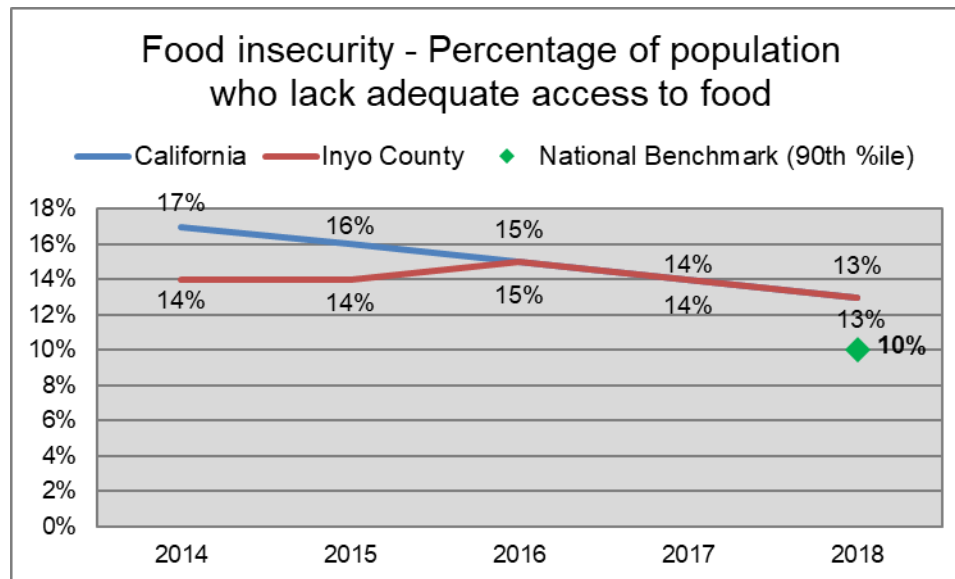
- STI rates in Inyo county are above the national benchmark but below CA
 - Rates have been declining from a high in 2016
- Teen birth rates in Inyo County are above CA and national benchmarks, however they have been falling steadily from 2011



Source: County Health Rankings

Additional Health Behaviors

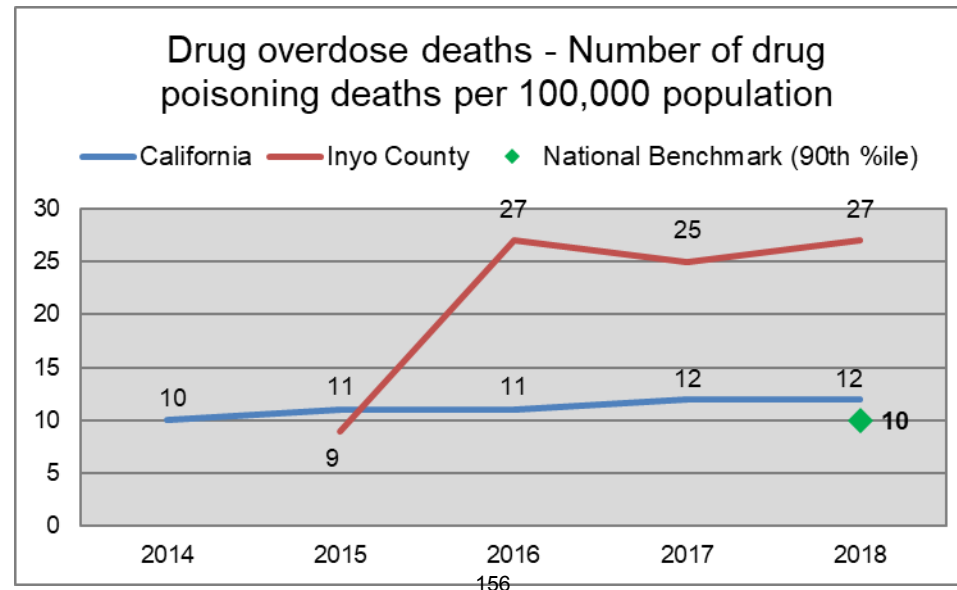
- Rates of food insecurity in Inyo County are in line with CA, and slightly above national benchmarks
- Access to health foods is significantly more limited in Inyo County compared with CA and national benchmarks



Source: County Health Rankings

Additional Health Behaviors

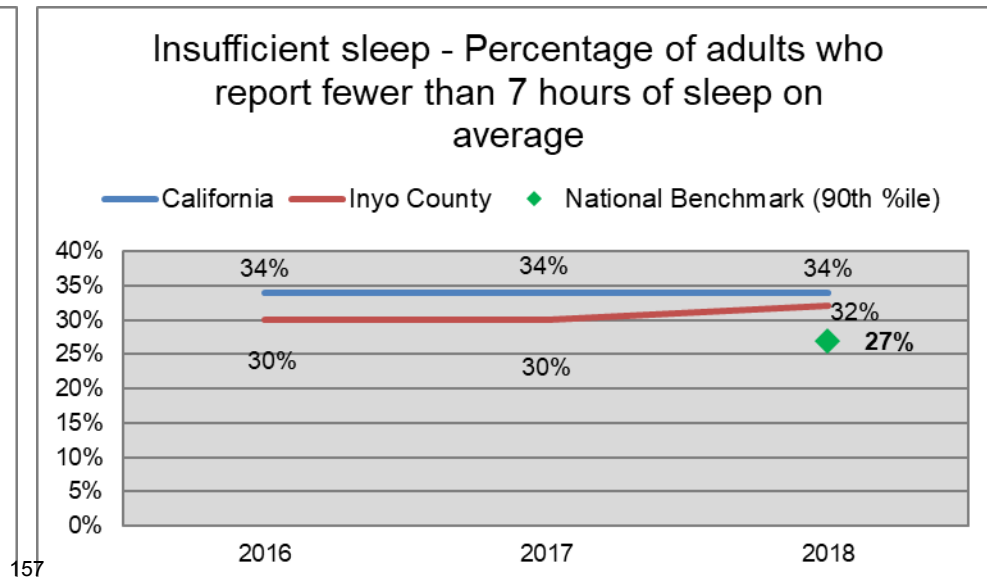
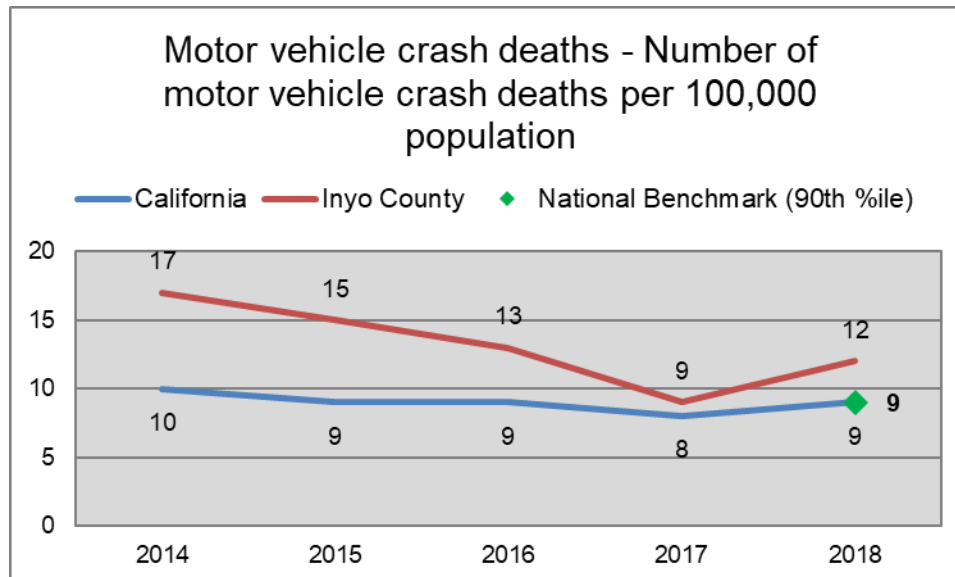
- Rate of drug overdose deaths in Inyo County are over double CA and the national benchmark



Source: County Health Rankings

Additional Health Behaviors

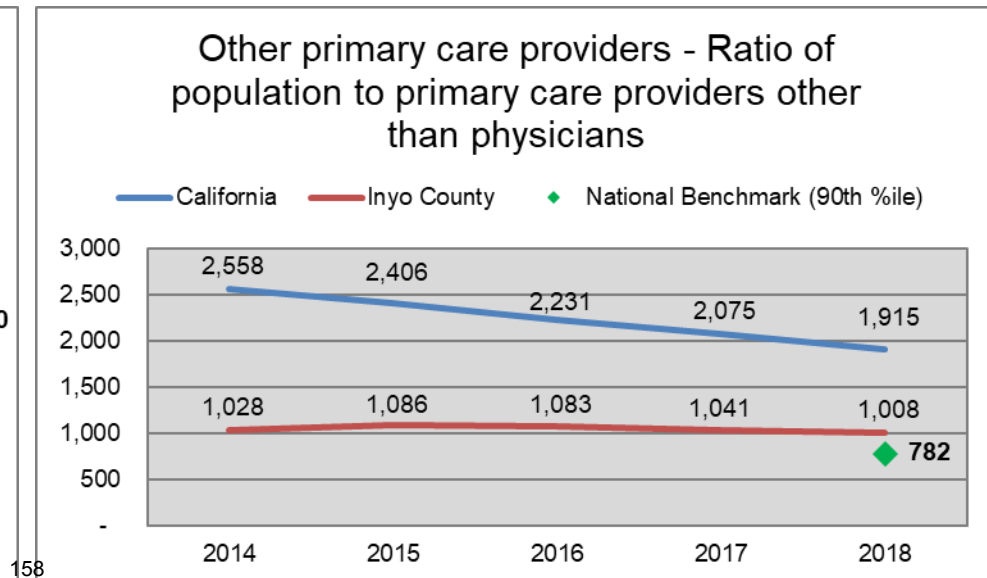
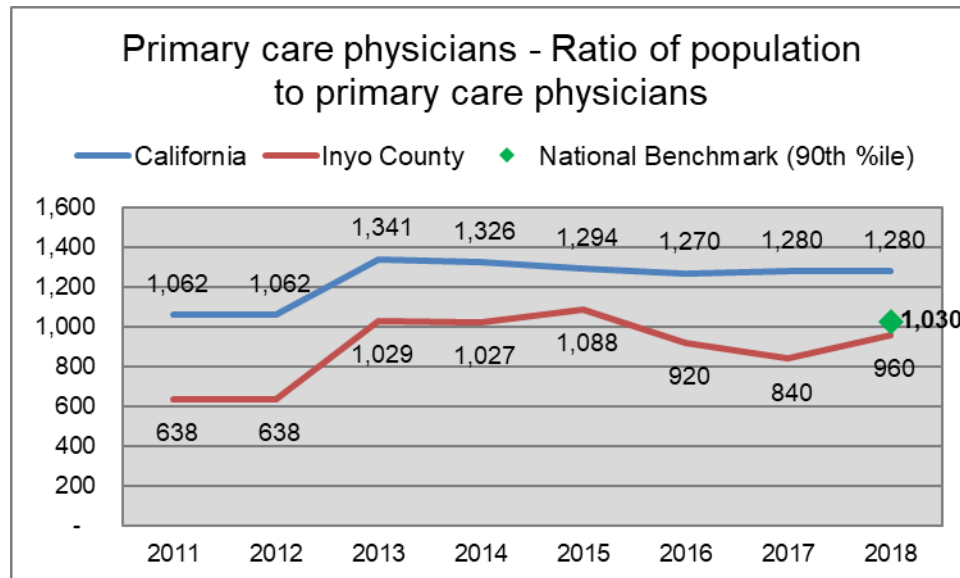
- Rates of motor vehicle crash deaths are slightly higher than CA and national benchmarks
 - Rates have increased in 2018 after a steady decline from 2014
- Rates of insufficient sleep are lower in Inyo County compared to CA but slightly higher than the national benchmark



Source: County Health Rankings

Clinical Care

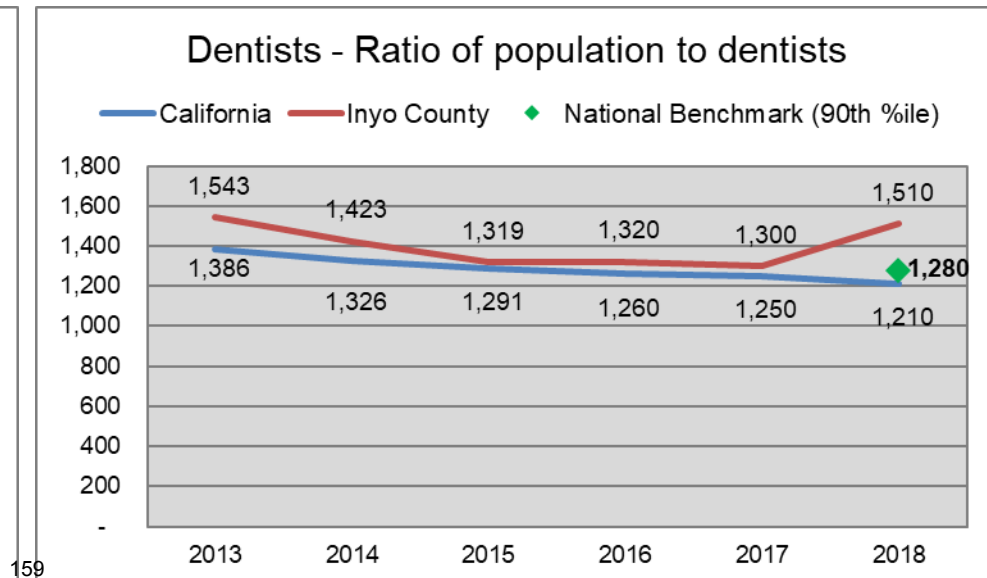
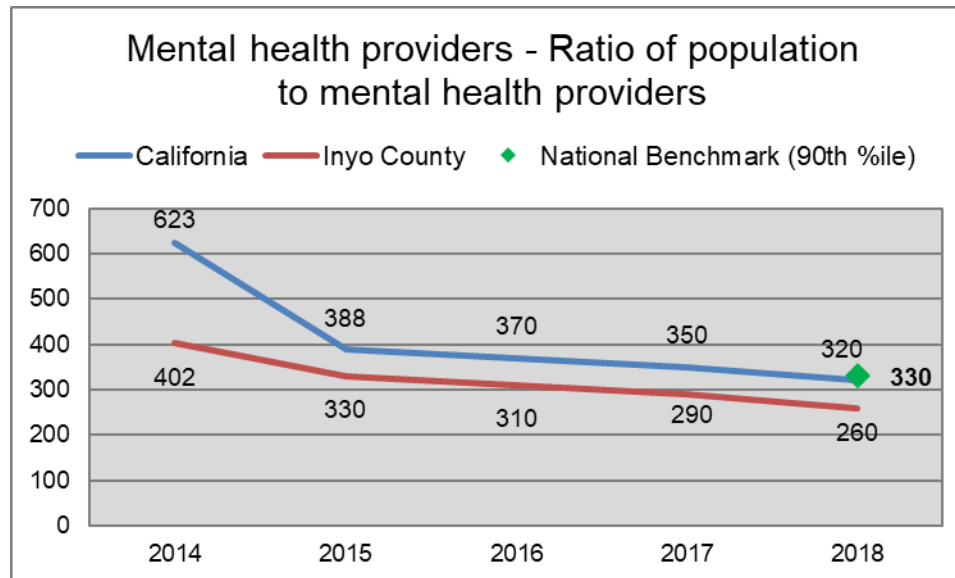
- Ratio of population to primary care physicians (lower is better) in Inyo County is lower than CA and national benchmarks
- Ratio of population to primary care providers (non-physician) is also lower than CA and only slightly higher than national benchmarks



Source: County Health Rankings

Clinical Care

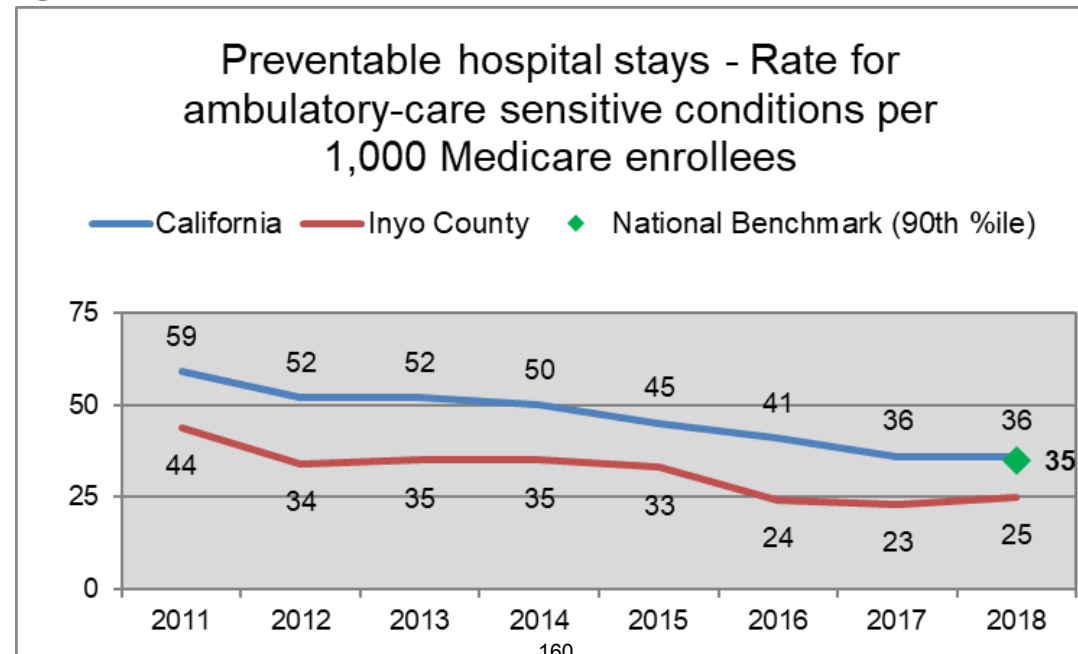
- Ratio of population to mental health providers is lower in Inyo County than CA and national benchmarks
- Ratio of population to dentists is higher (worse) in Inyo County compared to CA and national benchmarks
 - Ratio went up significantly in 2018



Source: County Health Rankings

Clinical Care

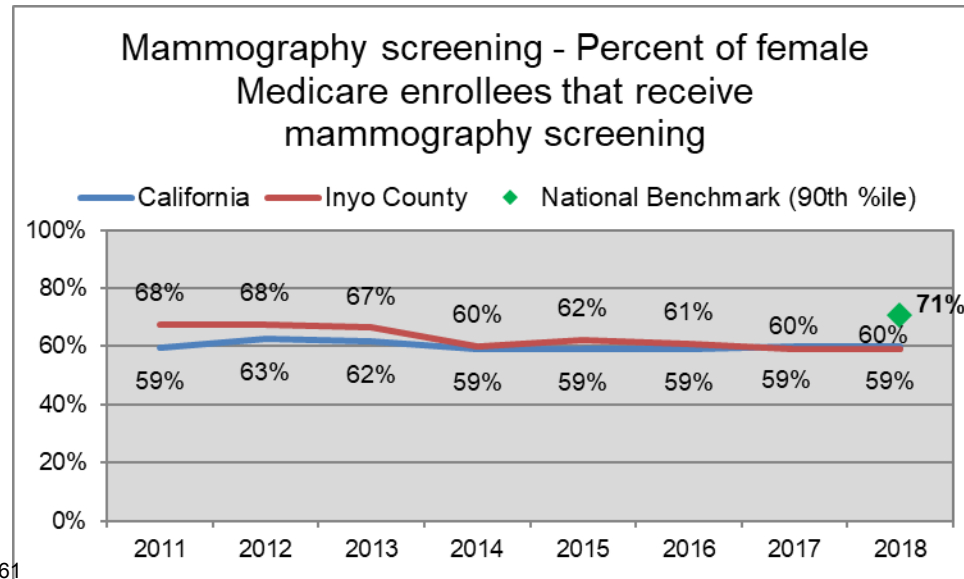
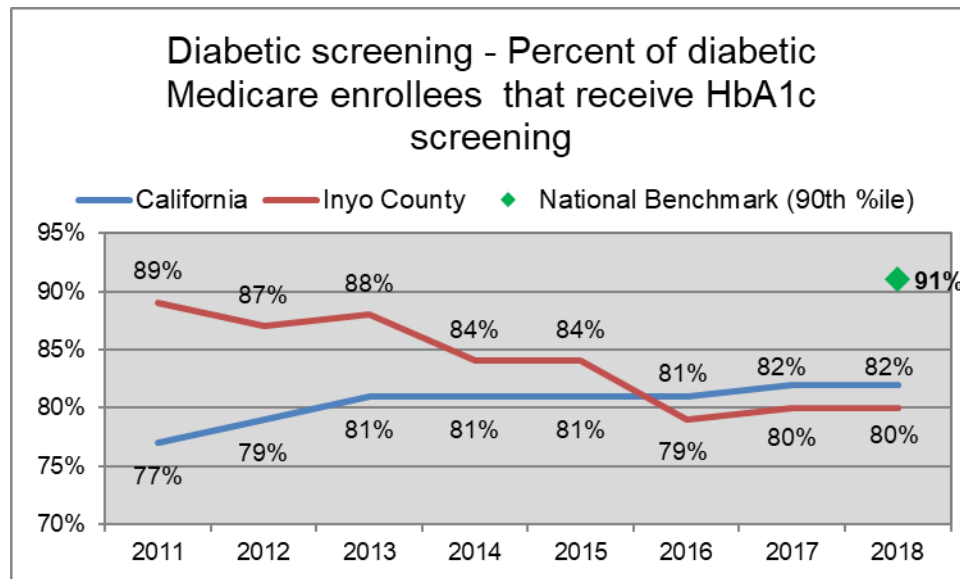
- Rate of Medicare preventable hospital stays for ambulatory-care sensitive conditions in Inyo County is lower than CA and national benchmark
 - Rate has been steadily decreasing since 2011 however it has risen slightly in 2018



Source: County Health Rankings

Clinical Care

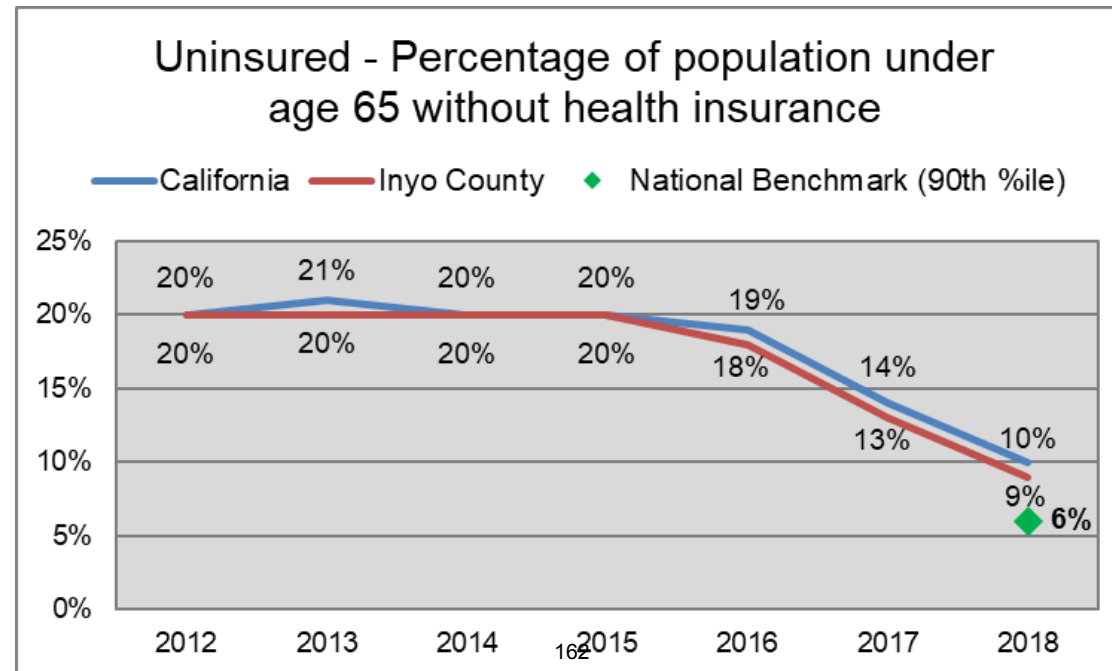
- Rate of diabetic screening in Inyo County is below CA and significantly below national benchmark
 - Rate has been dropping since 2011, although in 2017 and 2018 the rate increased slightly
- Rate of mammography screening in Inyo County is in line with CA but significantly below national benchmarks



Source: County Health Rankings

Additional Clinical Care

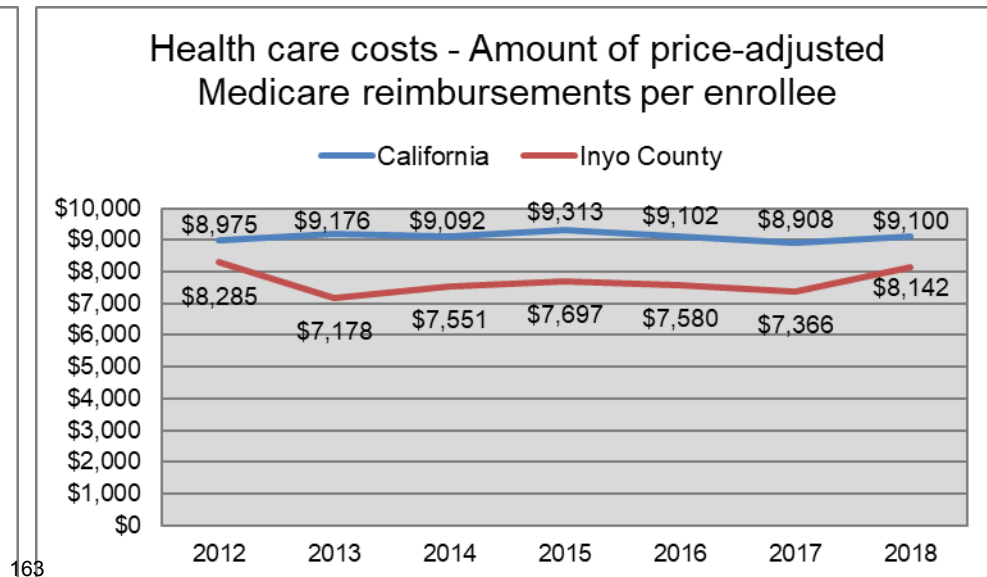
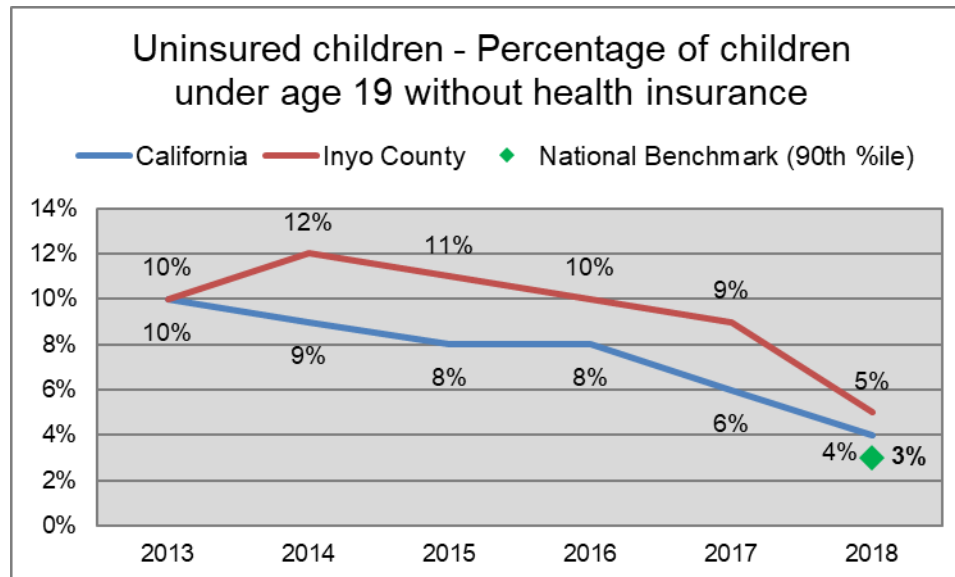
- Uninsured rate in Inyo County is slightly below CA, but above the national benchmark of 6%
 - Uninsured rate has been declining steadily since a high of 20% in 2015



Source: County Health Rankings

Additional Clinical Care

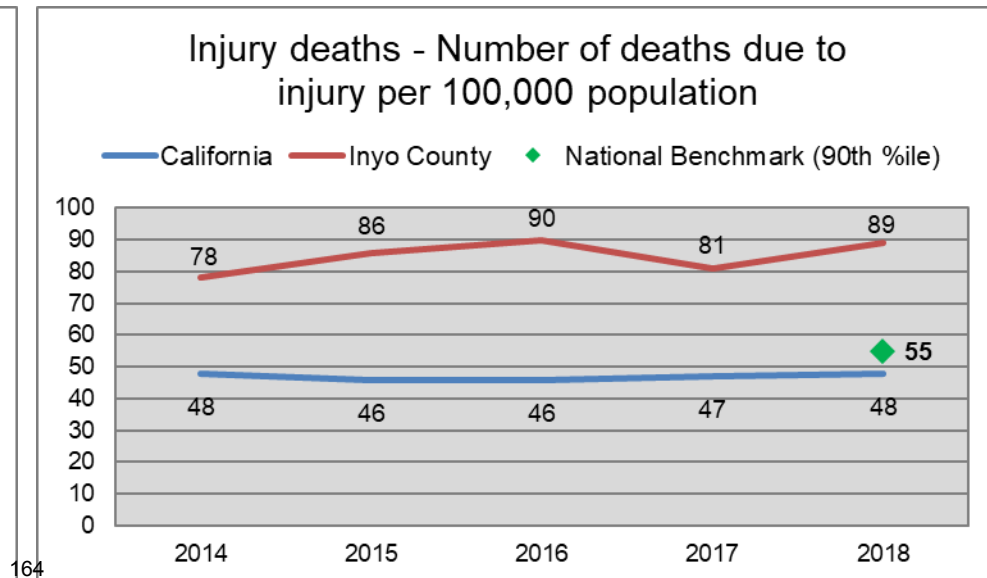
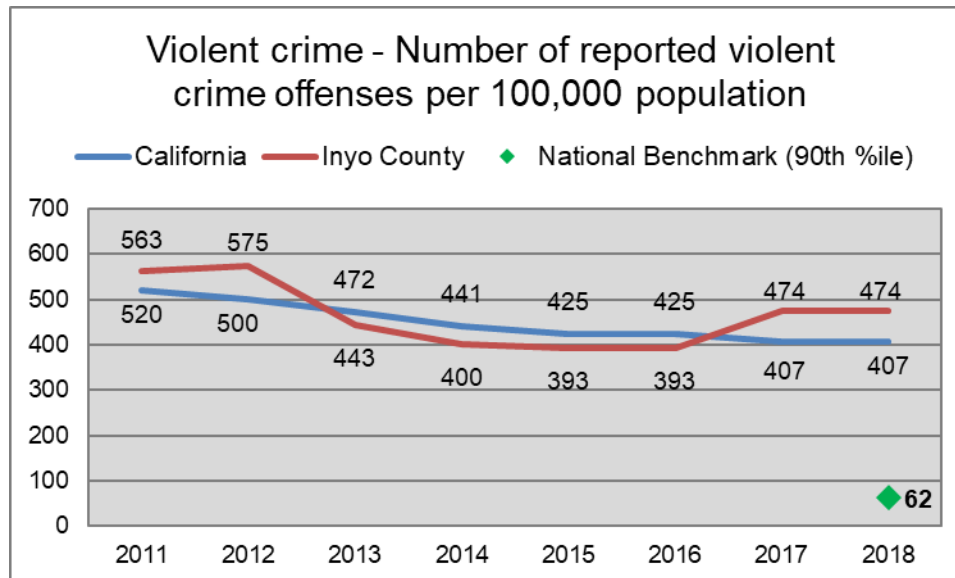
- Rate of uninsured children in Inyo County is higher than CA, and higher than national benchmark of 3%
- Health care costs (price-adjusted Medicare reimbursement) per enrollee in Inyo County is below CA



Source: County Health Rankings

Social & Economic Factors

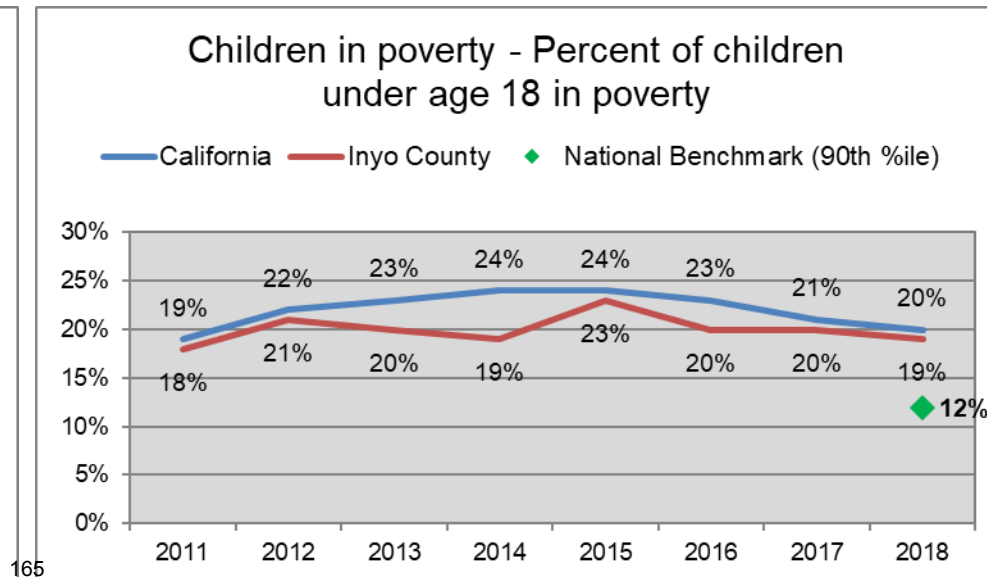
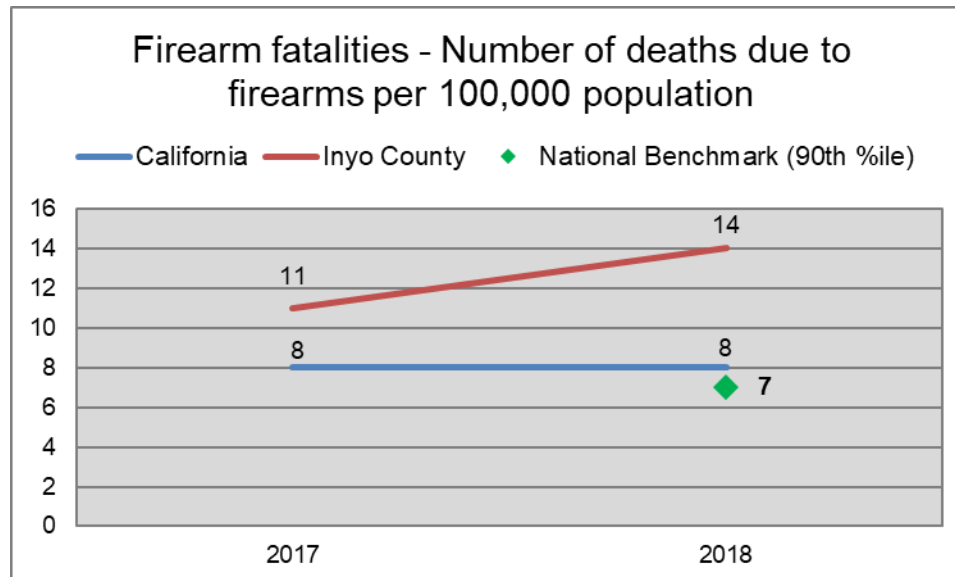
- Rates of violent crime in Inyo County are above CA, and significantly above national benchmark
 - Rates have been increasing since 2016
- Injury related death rates in Inyo County are almost double CA, and significantly above national benchmarks



Source: County Health Rankings

Social & Economic Factors

- Firearm fatality rates in Inyo County are double the national benchmark and CA
- Rates of children in poverty (19%) are slightly below CA but above national benchmarks of 12%



Source: County Health Rankings

**Pioneer Home Health Care, Inc.
Projected Budget For 2019**

Acct #	Account Description	PHHC	PCP	Hospice	2019		2018
					PROJECTED		Actual YTD
4010	Salaries - RN	242,486.00	-	-	242,486.00		166,562.29
4030	Salaries - PT	72,320.00	-	-	72,320.00		15,283.33
4040	Salaries - OT	-	-	-			0.00
4050	Salaries - ST	-	-	-			0.00
4060	Salaries - MSW	-	-	-			5,384.32
4070	Salaries - CHHA	2,800.00	-	-	2,800.00		313.28
4015	Salaries - HOS RN	-	-	80,829.00	80,829.00		37,577.55
4016	Salaries - HOS RN cont care	-	-	-	-		0.00
4035	Salaries - HOS PT	-	-	-	-		0.00
4035	Salaries - HOS OT	-	-	-	-		-
4065	Salaries - HOS MSW	-	-	-	-		8,256.19
4075	Salaries - HOS Aide	-	-	7,000.00	7,000.00		7,729.16
4076	Salaries - HOS Aide cont care	-	-	-	-		0.00
4085	Salaries - HOS Chaplain	-	-	4,112.00	4,112.00		3,702.25
4090	Salaries - All NLK	1,200.00	-	-	1,200.00		1,202.97
4097	Salaries - PCP Direct	-	404,320.00	-	404,320.00		328,410.65
		318,806.00	404,320.00	91,941.00			
						815,067.00	574,421.99
4110	Payroll Taxes - RN	18,671.42	-	-	18,671.42		12,826.88

Pioneer Home Health Care, Inc.
Projected Budget For 2019

Acct #	Account Description				2019	2018	
		PHHC	PCP	Hospice	PROJECTED	Actual YTD	
4130	Payroll Taxes - PT	4,339.20	-	-	4,339.20		1,657.91
4140	Payroll Taxes - OT	-	-	-	-		0.00
4160	Payroll Taxes - MSW	-	-	-	-		524.31
4170	Payroll Taxes - CHHA	168.00	-	-	168.00		19.74
4115	Payroll Txs - HOS RN	-	-	6,223.83	6,223.83		3,004.14
4116	Payroll Taxes - HOS RN cont a	-	-	-	-		-
4135	Payroll Taxes - HOS PT	-	-	-	-		-
4165	Payroll Taxes - HOS MSW	-	-	-	-		796.08
4175	Payroll Taxes - HOS Aide	-	-	420.00	420.00		582.08
4176	Pyll Taxes - HOS Aide cont ca	-	-	-	-		0.00
4185	Payroll Taxes - HOS Chaplain	-	-	123.36	123.36		402.81
4190	Payroll Taxes - All NLK	92.40	-	-	92.40		40.17
4197	Payroll Taxes - PCP Direct	-	36,388.80	-	36,388.80		29,787.90
		<u>23,271.02</u>	<u>36,388.80</u>	<u>6,767.19</u>			
						66,427.02	49,642.02
4210	Benefits - RN	28,701.93	-	-	28,701.93		18,449.12
4230	Benefits - PT	3,829.34	-	-	3,829.34		899.07
4240	Benefits - OT	-	-	-	-		0.00
4260	Benefits - MSW	-	-	-	-		24.11

Pioneer Home Health Care, Inc.
Projected Budget For 2019

Acct #	Account Description	PHHC	PCP	Hospice	2019		2018
					PROJECTED		Actual YTD
4270	Benefits - CHHA	582.06		-	582.06		58.79
4215	Benefits - HOS RN	-	-	9,563.31	9,563.31		4,695.62
4216	Benefits - HOS RN cont are	-	-	-	-		-
4265	Benefits - HOS MSW	-	-	-	-		38.06
4275	Benefits - HOS Aide	-	-	2,134.22	2,134.22		1,833.88
4276	Benefits - HOS Aide cont care		-	-	-		0.00
4285	Benefits - HOS Chaplain	-	19.08	-	19.08		23.85
4290	Benefits - All NLK	24.00	-	-	24.00		68.32
4297	Benefits - PCP Direct	-	47,083.53	-	47,083.53		35,493.74
		<u>33,137.33</u>	<u>47,102.61</u>	<u>11,697.53</u>			
						91,937.47	61,584.56
	@ .50 cents per mile						
4310	Transportation - RN	10,559.82	-	-	10,559.82		8,399.00
4330	Transportation - PT	10,559.81	-	-	10,559.81		2,020.50
4340	Transportation - OT	-	-	-	-		-
4360	Transportation - MSW	-	-	-	-		110.00
4370	Transportation - CHHA	125.72	-	-	125.72		43.00
4315	Transpotation - HOS RN	-	-	3,519.94	3,519.94		2,111.00
4316	Transp - HOS RN cont are	-	-	-	-		-
4335	Transp - HOS PT	-	-	-	-		-

168

**Pioneer Home Health Care, Inc.
Projected Budget For 2019**

Acct #	Account Description	PHHC	PCP	Hospice	2019		2018
					PROJECTED		Actual YTD
4345	Transp - HOS OT	-	-	-	-		-
4365	Transp - HOS MSW		-	-	-		562.50
4375	Transp - HOS Aide	-	-	377.14	377.14		1,388.50
4376	Transp - HOS Aide cont care		-	-	-		-
4384	Transp - HOS Chaplain	-	-	524.00	524.00		594.00
4390	Transportation - All NLK	-	-	-	-		2.00
4397	Transportation - PCP Direct	-	2,000.00	-	2,000.00		1,945.80
		21,245.35	2,000.00	4,421.08			
						27,666.43	17,176.30
4405	Contract Serv - HOS Med Dir	-	-	-	-		-
4408	Contract Serv - HOS Dietitian	-	-	-	-		-
4409	Contract Serv - Interpreter	-	-	-	-		-
4410	Contract Services - SN	-	-	-	-		-
4430	Contract Services - PT	22,750.00	-	-	22,750.00		52,108.90
4440	Contract Services - OT	5,000.00	-	-	5,000.00		406.25
4450	Contract Services - ST	3,250.00	-	-	3,250.00		1,495.50
4460	Contract Services - MSW	-	-	6,000.00	6,000.00		
		31,000.00	-	6,000.00			
						37,000.00	

Pioneer Home Health Care, Inc.
Projected Budget For 2019

Acct #	Account Description	PHHC	PCP	Hospice	2019	2018
					PROJECTED	Actual YTD
4500	Billable Medical Supplies	1,000.00	-	-	1,000.00	1,569.50
4600	Billable Client Expenses	-	-	-	-	9.80
		1,000.00	-	-		
					1,000.00	55,589.95
5009	Salaries - QA	45,904.32	-	-	45,904.32	2,224.64
5010	Salaries - Clin Sup	-	-	-	-	-
5011	Salaries - Clerical	133,136.64	-	-	133,136.64	143,468.34
5012	Salaries - Administrator	151,233.64	-	-	151,233.64	123,472.19
5017	Salaries - PCP Indirect	-	55,623.36	-	55,623.36	48,507.46
5018	Salaries - HOS Indirect Other	-	-	59,024.88	59,024.88	4,076.34
5020	Salaries - HOS Ind Clinical	-	-	-	-	13,286.66
5025	Salaries - HOS Ind Admin	-	-	37,808.41	37,808.41	17,465.39
		330,274.60	55,623.36	96,833.29		
					482,731.25	352,501.02
5109	Pyrl Taxes - QA	3,213.30	-	-	3,213.30	946.11
5110	Pyrl Taxes - Clin Sup	-	-	-	-	-
5111	Pyrl Taxes - Clerical	9,585.84	-	-	9,585.84	10,341.81
5112	Pyrl Taxes - Administrator	11,493.76	-	-	11,493.76	9,421.06
5117	Pyrl Taxes - PCP Indirect	-	4,839.23	-	4,839.23	4,231.75
5118	Pyrl Taxes - HOS Indirect Othe	-	-	4,603.94	4,603.94	320.30

Pioneer Home Health Care, Inc.
Projected Budget For 2019

Acct #	Account Description	PHHC	PCP	Hospice	2019 PROJECTED	2018 Actual YTD
5120	Pyrl Taxes - HOS Ind Clinical	-	-	-	-	956.13
5125	Pyrl Taxes - HOS Ind Admin	-	-	2,873.44	2,873.44	1,231.13
		24,292.90	4,839.23	7,477.38		
					36,609.51	27,448.29
5209	Benefits - QA	17.45	-	-	17.45	31.96
5210	Benefits - Clin Sup	-	-	-	-	-
5211	Benefits - Clerical	19,171.77	-	-	19,171.77	18,630.04
5212	Benefits - Administrator	3,723.32	-	-	3,723.32	3,628.17
5217	Benefits - PCP Indirect	-	1,369.42	-	1,369.42	3,723.09
5218	Benefits - HOS Indirect Other	-	-	6,847.05	6,847.05	792.92
5220	Benefits - HOS Ind Clinical	-	-	-	-	1,457.58
5225	Benefits - HOS Ind Admin	-	-	930.83	930.83	528.86
		22,912.54	1,369.42	7,777.88		
					32,059.84	28,792.62
5300	Transp - Non Visit Related	656.25			656.25	663.00
5307	Transp - PCP indirect	-	375.00	-	375.00	346.50
5308	Transp - HOS Indirect Other	-	-	218.75	218.75	291.00
5320	Transp - HOS Ind Clinical	-	-	-	-	-
5325	Transp - HOS Ind Admin	-	-	-	-	-

Pioneer Home Health Care, Inc.
Projected Budget For 2019

Acct #	Account Description	PHHC	PCP	Hospice	2019	2018	
					PROJECTED	Actual YTD	
		656.25	375.00	218.75			
						1,250.00	1,300.50
5500	401K Plan	10,427.48	4,576.17	3,947.78	18,951.43		
5510	Accounting	14,000.00	-	4,400.00	18,400.00		18,630.00
5520	Bad Debt	-	-	-	-		213.24
5530	Bank Charges	-	-	-	-		25.00
5535	Building Costs	-	-	5,000.00	5,000.00		2,121.93
5536	Collection Fees	-	-	-	-		-
5540	Community Education	450.00	450.00	500.00	1,400.00		1,251.93
5550	Computer Costs	25,761.34	4,263.33	4,053.33	34,078.00		61,858.79
5560	Consultant Services	-	-	600.00	600.00		-
5580	Dues & Subscriptions	2,568.34	743.33	1,818.33	5,130.00		5,219.00
5590	Employee Education	2,000.00	400.00	1,000.00	3,400.00		3,263.02
5600	Employee Welfare	284.00	324.00	118.00	726.00		620.14
5610	Equipment Rental	863.34	863.33	863.33	2,590.00		1,830.92
5620	Insurance - Gen/Prof/D&O	7,299.90	5,677.70	3,244.40	16,222.00		15,227.00
5630	Interest	-	-	-	-		2,234.96
5635	Interest - Mortgage	6,444.65	3,222.32	3,759.38	13,426.35		13,650.77
5640	Janitorial	1,389.00	627.00	784.00	2,800.00		2,800.00

Pioneer Home Health Care, Inc.
Projected Budget For 2019

Acct #	Account Description	PHHC	PCP	Hospice	2019 PROJECTED	2018 Actual YTD
5650	Legal	-	-	-	-	4,405.00
5660	Licenses, Taxes & Fees	11,986.00	1,632.00	4,254.00	17,872.00	14,507.63
5670	Maintenance & Repairs/Equip	-	-	-	-	-
5680	Maintenance & Repairs/Prop	3,636.00	1,818.00	2,121.00	7,575.00	9,711.27
5685	Marketing	-	2,232.00	-	2,232.00	718.04
5690	Medical Waste	-	-	-	-	-
5700	Meetings - Staff/UR/Adv Brd	200.00	50.00	200.00	450.00	219.25
5710	Minor Equipment	600.00	500.00	500.00	1,600.00	33.21
5720	Non-Billable Med Supplies	250.00	110.00	40.00	400.00	355.97
5730	Office Expense/Supplies	5,000.00	1,000.00	1,000.00	7,000.00	10,139.81
5740	Rent	-	-	340.00	340.00	1,105.00
5750	Patient Education	500.00	-	450.00	950.00	817.91
5760	Postage	850.00	550.00	100.00	1,500.00	2,695.35
5770	Printing & Stationary	1,800.00	820.00	1,050.00	3,670.00	3,863.01
5780	Prof Conf/Committees/Meeting	1,844.00	563.00	883.00	3,290.00	138.00
5790	Recruiting/Hiring	15,710.00	4,714.00	5,785.00	26,209.00	6,070.48
5800	Telephone/Communication Sy	4,788.00	2,856.00	756.00	8,400.00	8,075.98
5810	Utilities	3,554.00	1,776.00	2,070.00	7,400.00	7,332.26
6000	HOS Bereavement Prog Servs	-	-	260.00	260.00	93.33

Pioneer Home Health Care, Inc.
Projected Budget For 2019

Acct #	Account Description				2019		2018	
		PHHC	PCP	Hospice	PROJECTED		Actual YTD	
6005	HOS Charity Care	-	-	-	-		-	
6010	HOS DME / 02	-	-	5,000.00	5,000.00		4,327.94	
6015	HOS Fundraising Costs	-	-	500.00	500.00		338.87	
6020	HOS Inpatient General Care	-	-	-	-		-	
6025	HOS Inpatient Respite Care	-	-	-	-		-	
6035	HOS Medical Supplies	-	-	1,800.00	1,800.00		1,020.00	
6110	HOS Pharmaceuticals	-	-	5,500.00	5,500.00		3,949.39	
6115	HOS Patient Transportation	-	-	-	-		-	
6130	HOS Room & Board Expense	-	-	-	-		-	
6135	HOS Volunteer Prog Costs	-	-	250.00	250.00		1,131.96	
6450	HOS Start-Up Amortization	-	-	82,660.80	82,660.80		82,660.80	
		122,206.05	39,768.18	145,608.35	307,582.58			
						307,582.58		292,657.16
								1,461,114.41
						*	*	
	Total Expenses	928,802.04	591,786.60	378,742.45		1,899,331.09	1,461,114.41	
	Mortgage Loan Principle	2,213.21	1,106.61	1,291.03		4,610.85		
		931,015.25	592,893.21	380,033.48		1,903,941.94		
	Projected Income	812,200.00	566,930.00	497,637.00		\$ 1,876,767.00		
	Projected Net	(118,815.25)	(25,963.21)	117,603.52		\$ (27,174.94)		

Strategy Review 2019

Current Strategy

- Patient Experience
- Workforce Experience
- Quality
- Finance & Market Share

Then & Now

- Then

- Exec Team
- Dedicated meeting

- Now

- Expanded Leadership Team
- Dedicated meeting and Resources

Patient Experience

- Survey
 - Press Ganey
 - Focused NIHD developed

Workforce Experience

- Recruitment/Hiring/Retention
- Survey
 - Third year Starts Feb 25th
- Developed Department Leader led response/improvements
- Clarity on leadership expectations/accountabilities
- Clarity on workforce performance/accountabilities

Quality

- Flu vaccination as an example of leadership focused on a goal
- Defining Value for the District
- Process towards continuous improvement
- Safety Coach

Finance & Market Share

- Training for Leaders on budget understanding and management
- Subcommittee on Market Share reaching out to physicians for participation

Next Step

- Where are we
- Where do we see ourselves going
- How will we get there
- How far along

Where Are We

- Set the foundation for understanding
- Set the foundation for solid leadership
- Set the foundation for building
- Redefined who we are as a local healthcare provider
- Community Health Needs Assessment
 - Demographic & Insurance data mining
 - Community data collection

Where Do We See Ourselves Going

- Now in position to define tomorrow
- Expanding outpatient services (providers & space)
- Expanding access (providers & space)
- Partnerships
 - Local
 - Regional/Statewide
- Behavioral Health
- Offer Continuum of Services

How Will We Get There

- Strategy driven!
- Informed Decision Making!
- Collaboration!
- From a position of strength
- New models
- Use of technology
- Integrate with social service providers
- Comprehensive Health System

How Far Along Are We

- Step 1- Solid Foundation
- Step 2- Assess potential partners & collaborators
- Step 3- Develop relationships
- Step 4- Assess impact
- Step 5- Reassess

Things to Review

- Mission-Vision-Values
 - Board
 - District
- Strategy
 - Operational
 - Fiscal
- Job Description
- Interview process
- Conflict of Interest
 - Externally

DISCUSSION

Northern Inyo Hospital

Strategic Financial Planning

WIPFLi LLP
CPAs and Consultants
HEALTH CARE PRACTICE

June 3, 2016



Today's Objectives

- Review current state at NIH and market future
- Review the status quo financials for next 5 yrs
- Review the potential impact of several strategic scenarios
- Review the key initiatives for NIH from last meeting
- Agree upon strategic direction and priorities
- Understand and commit to a process for next steps

8:30-9:30 AM

WHERE ARE WE TODAY?

Market/Performance

Physicians/Providers

RHC



THE MARKET

Service Area Definition

The service area for the market analysis is defined as:

Primary Service Area

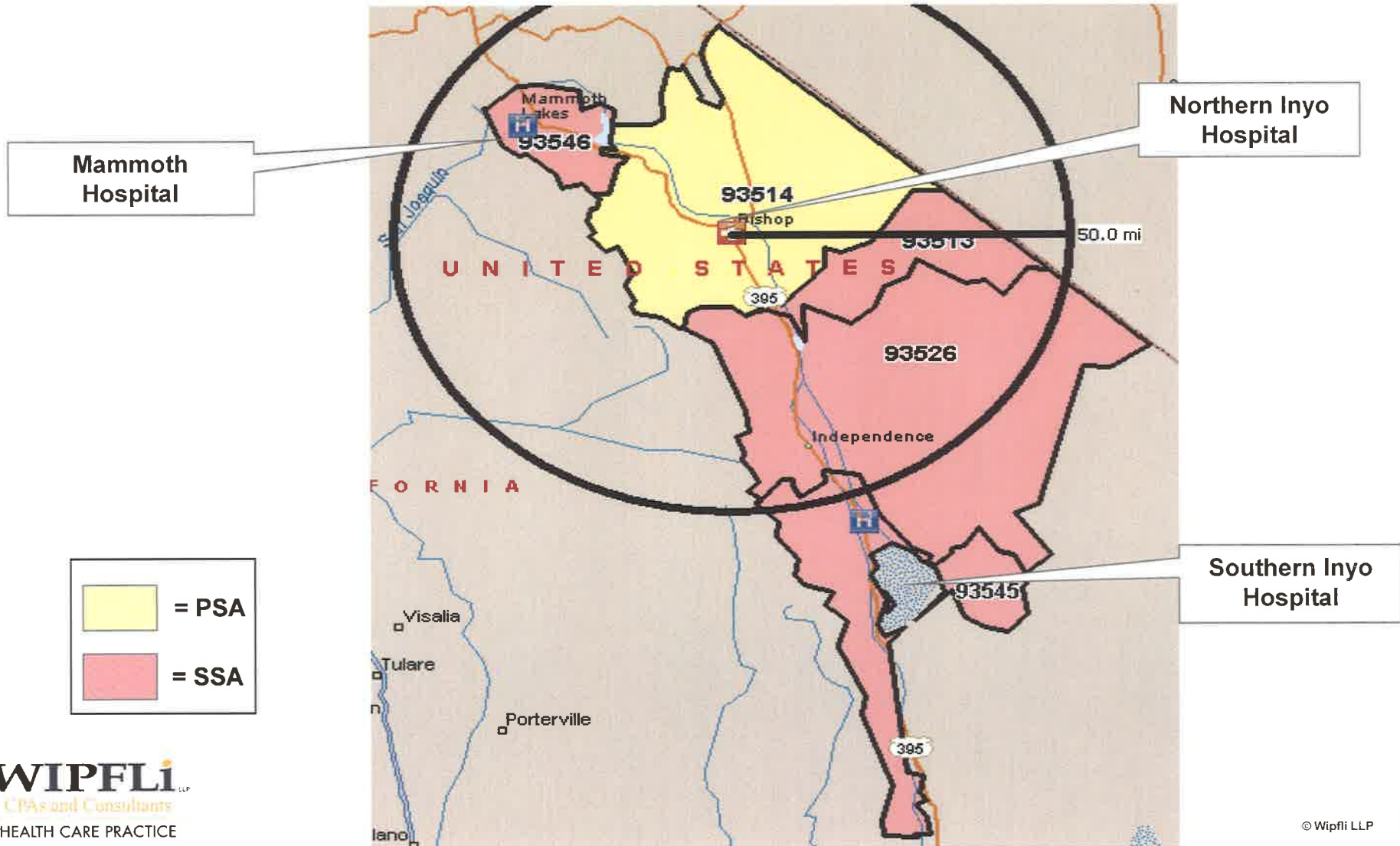
Primary Service Area
93514 - Bishop

Secondary Service Area

Secondary Service Area	
93513 - Big Pine	93526 - Independence
93545 - Lone Pine	93546 - Mammoth Lakes

Service Area Map and Area Hospitals

Northern Inyo Hospital service area and nearest competitors



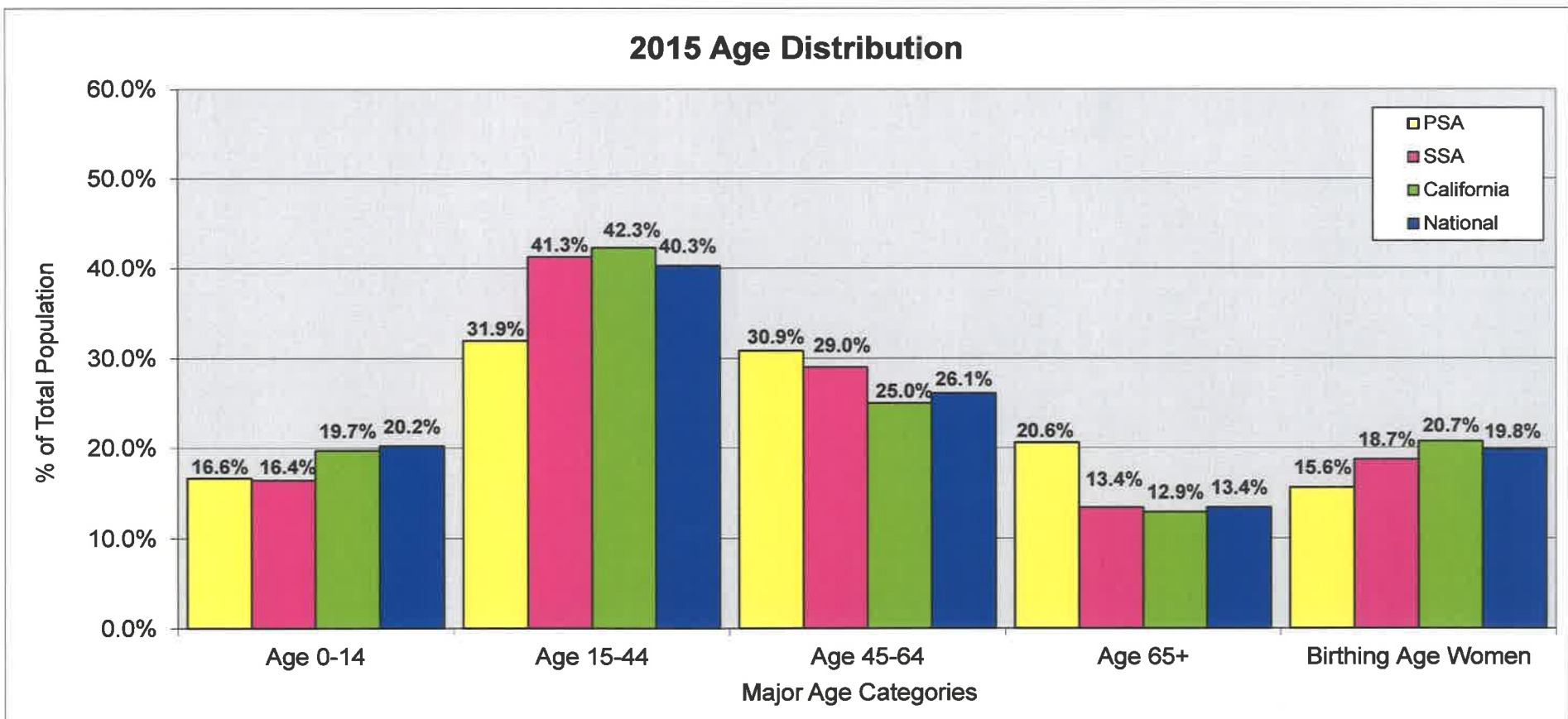
Demographics: Population Today and 2025

- PSA population is expected to grow only slightly over the next ten years, by +200
- The SSA population is expected to decline however; If financially prudent, continued outreach and enhanced relations with the SSA communities is advised

	2005	2015	% Change (2005-2015)	Change (2005-2015)	2025 Estimated Population	Projected Change (2015-2025)	Variance (2015-2025)
Primary Service Area (PSA)							
93514 - Bishop	13,563	13,936	2.8%	373	14,144	1.5%	208
PSA Total	13,563	13,936	2.8%	402	14,144	1.5%	208
Secondary Service Area (SSA)							
93513 - Big Pine	1,809	1,919	6.1%	111	2,093	9.1%	174
93526 - Independence	746	761	2.0%	15	763	0.3%	2
93545 - Lone Pine	2,137	2,358	10.3%	221	2,316	-1.8%	-42
93546 - Mammoth Lakes	8,880	9,472	6.7%	592	9,134	-3.6%	-338
SSA Total	13,571	14,510	6.9%	939	14,306	-1.4%	-204
Total Service Area	27,134	28,446	4.8%	1,341	28,450	0.0%	4

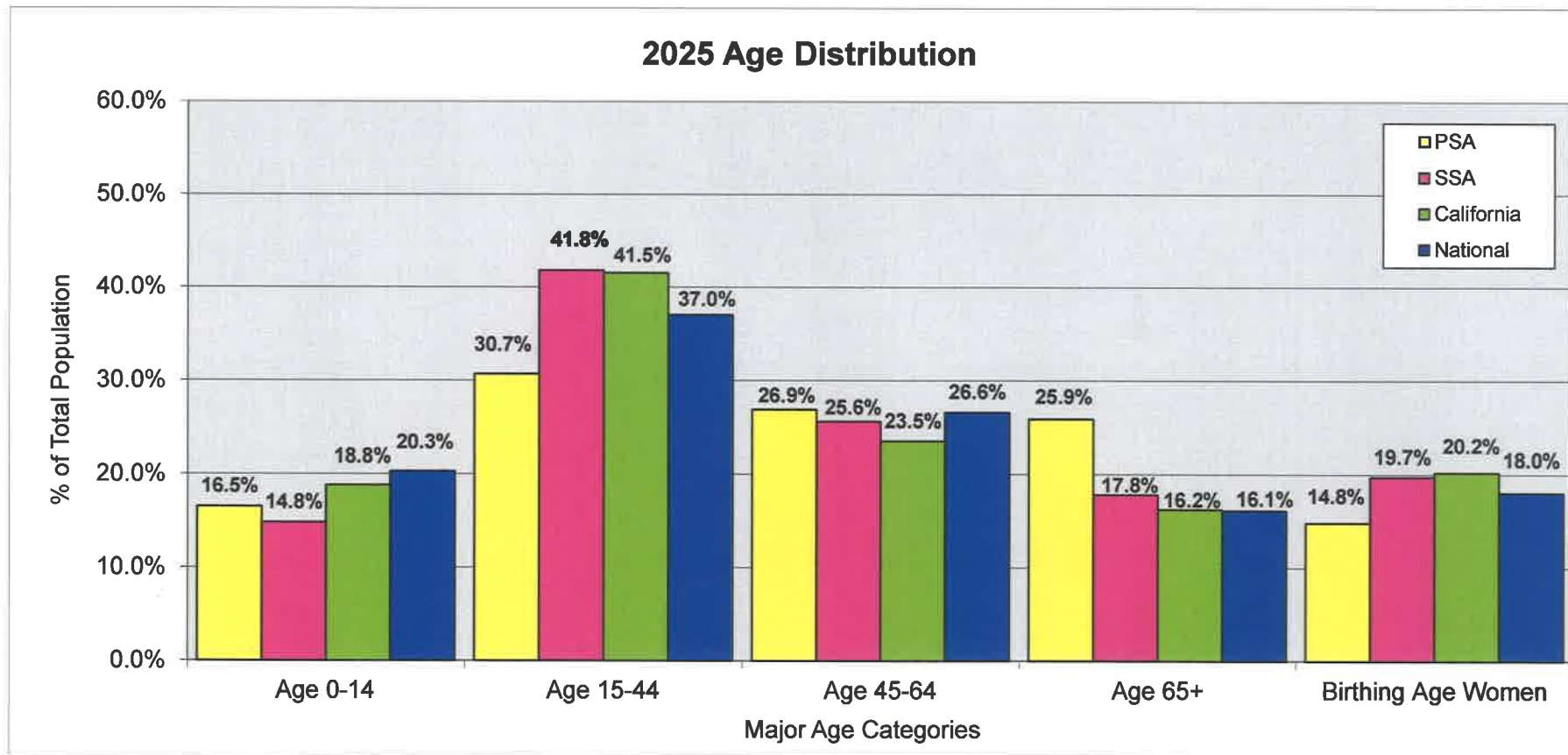
Demographics: Population Distribution Today

- PSA has a significantly older population compared to California and USA
- SSA population is significantly younger than the PSA and aligns closer to State and national averages



Demographics: Age Distribution 2025

- PSA population is expected to continue aging over the next ten years which should drive increased healthcare utilization; however, healthcare reform will have a competing impact – in particularly for inpatient



Utilization Trends: Inpatient Statistics

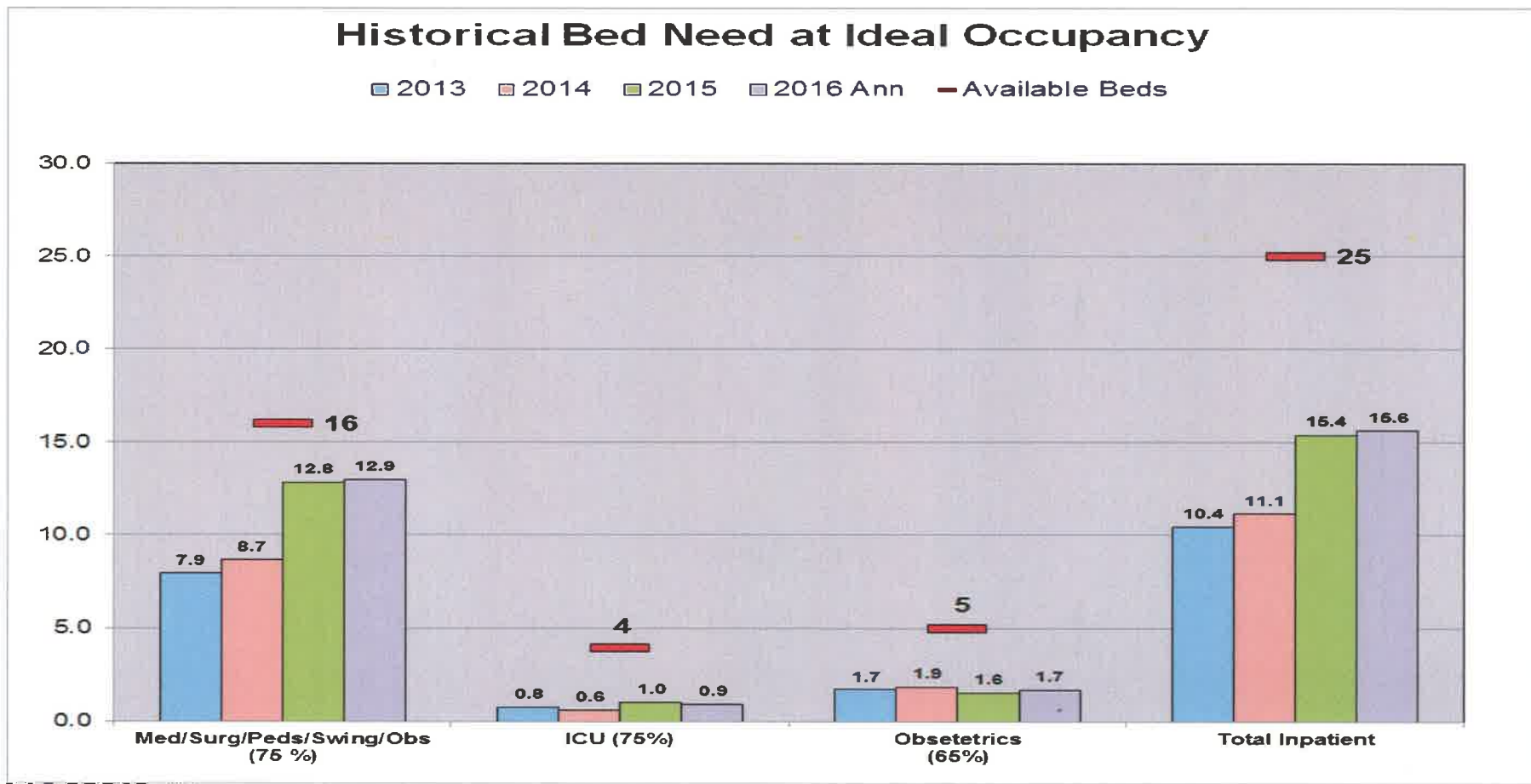
Inpatient discharges and days have increased significantly over the past 3 years

- ALOS has remained relatively flat overall; increased in ICU but reduced in OB and Peds
- Observation cases have declined significantly since 2013; this is unusual compared to the rise in observation cases Wipfli has seen at other hospitals
 - Could reflect more appropriate admitting protocols vs. other CAHs that have seen lower admits due to insufficient hospital inpatient coverage

Discharges	2013	2014	2015	2016 Ann	13 to '16 Variance	13 to '16 % Change
Med/Surg	547	557	686	741	194	35.4%
ICU	42	29	46	41	(1)	-2.0%
Pediatrics	44	62	41	63	19	44.2%
Obstetrics	182	234	193	230	48	26.2%
GRAND TOTAL DISCHARGES	815	882	966	1,075	260	31.9%
Observation	480	336	358	281	(199)	-41.4%
Swing	3	27	103	122	119	3957.1%
Patient Days	2013	2014	2015	2016 Ann	Variance	%Change
Med/Surg	1,574	1,741	2,193	2,321	747	47.5%
ICU	211	171	285	257	46	21.9%
Pediatrics	94	118	88	110	16	16.7%
Obstetrics	413	439	369	411	(2)	-0.4%
GRAND TOTAL PATIENT DAYS	2,292	2,469	2,935	3,099	807	35.2%
Observation	480	336	358	281	(199)	-41.4%
Swing	22	173	862	830	808	3671.4%
Average Length of Stay	2013	2014	2015	2016 Ann	Variance	% Change
Med/Surg	2.9	3.1	3.2	3.1	0.3	8.9%
ICU	5.0	5.9	6.2	6.3	1.2	24.4%
Pediatrics	2.1	1.9	2.1	1.7	(0.4)	-19.0%
Obstetrics	2.3	1.9	1.9	1.8	(0.5)	-21.1%
GRAND TOTAL ALOS	2.8	2.8	3.0	2.9	0.1	2.5%
Observation	1.0	1.0	1.0	1.0	0.0	0.0%
Swing	7.3	6.4	8.4	6.8	(0.5)	-7.0%

Inpatient Bed Need

- Historical acute care bed need of 15-16 beds at ideal occupancy rates, OB need of 2 beds and ICU of roughly 1 bed



Ancillary Statistics

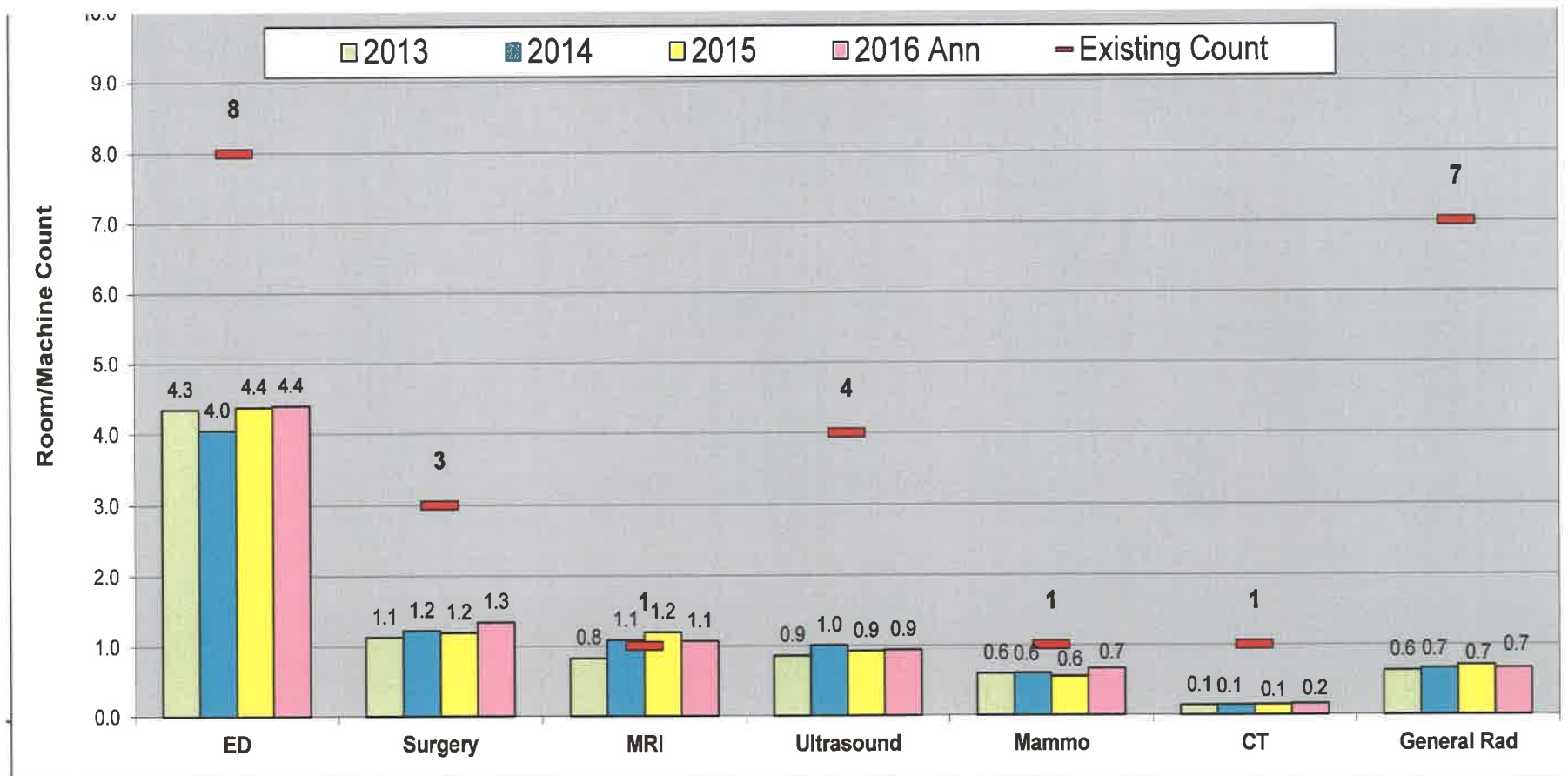
- Virtually all key ancillary volumes have increased since 2013; only decline occurred with Medical outpatient which saw a big increase in 2015 but dropped in 2016
- MRI and Physical Therapy saw the biggest increases since 2013
- Surgery volume has been trending upwards; a financial 'engine' of most CAHs

	2013	2014	2015	2016 Ann	'13-'16 Variance	'13-'16 % Change
ED	8,689	8,097	8,755	8,798	109	1.3%
Surgery	1,243	1,344	1,313	1,478	235	18.9%
MRI	4,984	6,506	7,193	6,427	1,443	28.9%
Ultrasound	2,915	3,421	3,137	3,187	272	9.3%
Mammo	4,481	4,544	4,189	5,019	538	12.0%
CT	1,313	1,348	1,405	1,515	202	15.4%
General Rad	6,333	6,677	7,118	6,660	327	5.2%
Lab	111,090	115,875	116,177	119,355	8,265	7.4%
Physical Therapy	11,396	17,443	20,362	18,398	7,002	61.4%
Medical Outpatient	2,161	2,270	2,825	1,982	(179)	-8.3%

Ancillary Room and Diagnostic Need

Some capacity issues in existing ancillary modalities

- ED, MRI and Ultrasound are reaching existing room capacities
- ED can have very large peak periods; overflow rooms are likely often needed



Competitive Position: PSA

- PSA inpatient market has grown slightly since 2014;
- NIH market share in the PSA has increased almost 2% since 2012;

Primary Service Area	2012	2013	2014	Change
Northern Inyo Hospital	615	579	722	107
Mammoth Hospital	72	62	80	8
Loma Linda University Medical Center	38	40	42	4
Southern Inyo Hospital	4	12	4	0
Ronald Reagan UCLA Medical Center	9	14	18	9
City of Hope Helford Clinical Research Hospital	10	6	11	1
Antelope Valley Hospital	11	10	5	(6)
Glendale Adventist Medical Center	2	6	17	15
Cedars Sinai Medical Center	11	13	8	(3)
All Others	144	138	141	(3)
Total	916	880	1,048	132

Primary Service Area	2012	2013	2014	% Change
Northern Inyo Hospital	67.1%	65.8%	68.9%	1.8%
Mammoth Hospital	7.9%	7.0%	7.6%	-0.2%
Loma Linda University Medical Center	4.1%	4.5%	4.0%	-0.1%
Southern Inyo Hospital	0.4%	1.4%	0.4%	-0.1%
Ronald Reagan UCLA Medical Center	1.0%	1.6%	1.7%	0.7%
City of Hope Helford Clinical Research Hospital	1.1%	0.7%	1.0%	0.0%
Antelope Valley Hospital	1.2%	1.1%	0.5%	-0.7%
Glendale Adventist Medical Center	0.2%	0.7%	1.6%	1.4%
Cedars Sinai Medical Center	1.2%	1.5%	0.8%	-0.4%
All Others	15.7%	15.7%	13.5%	-2.3%
Total	100%	100%	100%	14.4%

Competitive Position: SSA

- SSA inpatient market size is not growing; remained flat over the past few years
- SSA market share for NIH has increased over 4% in the same time period

Secondary Service Area	2012	2013	2014	Change
Northern Inyo Hospital	154	147	187	33
Mammoth Hospital	307	336	314	7
Loma Linda University Medical Center	39	44	35	(4)
Southern Inyo Hospital	73	51	37	(36)
Ronald Reagan UCLA Medical Center	9	17	10	1
City of Hope Helford Clinical Research Hospital	9	5	3	(6)
Antelope Valley Hospital	15	5	14	(1)
Glendale Adventist Medical Center	4	5	6	2
Cedars Sinai Medical Center	13	17	13	0
All Others	188	175	179	(9)
Total	811	802	798	(13)

Secondary Service Area	2012	2013	2014	% Change
Northern Inyo Hospital	19.0%	18.3%	23.4%	4.4%
Mammoth Hospital	37.9%	41.9%	39.3%	1.5%
Loma Linda University Medical Center	4.8%	5.5%	4.4%	-0.4%
Southern Inyo Hospital	9.0%	6.4%	4.6%	-4.4%
Ronald Reagan UCLA Medical Center	1.1%	2.1%	1.3%	0.1%
City of Hope Helford Clinical Research Hospital	1.1%	0.6%	0.4%	-0.7%
Antelope Valley Hospital	1.8%	0.6%	1.8%	-0.1%
Glendale Adventist Medical Center	0.5%	0.6%	0.8%	0.3%
Cedars Sinai Medical Center	1.6%	2.1%	1.6%	0.0%
All Others	23.2%	21.8%	22.4%	-0.8%
Total	100%	100%	100%	-1.6%

Market/Demand Assessment

Population Served Calculation



Population served estimates were developed based on future market share and immigration assumptions

Future population served projections were calculated using future 2021 estimated market share under three scenarios of market share growth

- **Low scenario** reflects “current state”
- **Medium scenario** reflects growth in overall population served based on market share growth, provider recruitment plan and subsequent population growth estimates
- **High scenario** reflects more aggressive growth estimates based on more aggressive scenario for market capture (retention); high scenario also reflects a ‘pressure test’ of future physical capacity under a more aggressive growth estimate over the next five years

Market/Demand Assessment

Population served expected to remain flat under the medium scenario and could grow by 1,462 under the high scenario over the next 5 years

	2012	2013	2014	2015	2021 Estimated Population		
					Low	Medium	High
Inpatient Population Served							
Total PSA Population (X)	13,867	13,890	13,913	13,936	13,642	14,064	14,486
NIH PSA Market Share (=)	67.1%	65.8%	68.9%	68.9%	67.1%	69.6%	72.0%
(A) NIH PSA Population Served	9,310	9,139	9,585	9,601	9,159	9,784	10,430
Total SSA Population (X)	14,503	14,505	14,507	14,510	13,954	14,386	14,818
NIH SSA Market Share (=)	19.0%	18.3%	23.4%	23.4%	20.0%	22.5%	25.0%
(B) NIH SSA Population Served	2,754	2,659	3,400	3,400	2,791	3,237	3,704
C = Total NIH Service Area Pop. Served (X)	12,064	11,798	12,985	13,001	11,950	13,021	14,134
In-migration Allowance (=)	10.9%	8.3%	5.8%	8.3%	7.0%	8.5%	10.0%
(D) In-migration Total	1,317	985	750	1,085	837	1,107	1,413
(C+D) Total NIH Population Served	13,382	12,782	13,734	14,086	12,787	14,128	15,548
Discharges per 1,000 Population							
NIH Primary Service Area	66.1	63.4	75.3	75.3			
NIH Secondary Service Area	55.9	55.3	55.0	55.0			
NIH Total Service Area	60.9	59.2	65.0	65.0			
California	86.9	84.9	82.1				
Oregon	86.3	85.8	83.1	NA			
Nevada	94.5	91.0	90.2				

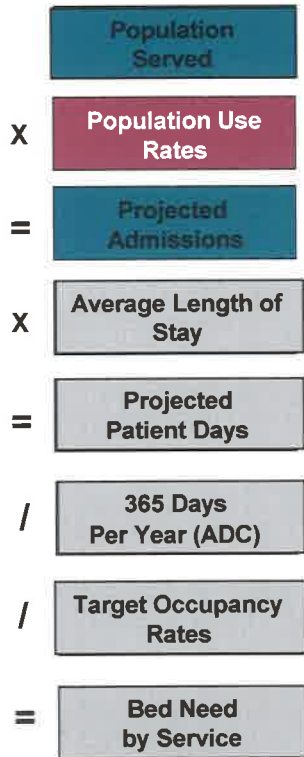
Inpatient Volumes-Bed Need Calculation

- Future use rates were adjusted for each service line/bed type
 - Research suggests that inpatient utilization *should* continue to remain steady or decline, despite expanding insurance

Inpatient Admissions	Estimated 2021						
	2013	2014	2015	2016 Ann	Low	Medium	High
Total Population Served	12,782	13,734	14,086	14,086	12,787	14,128	15,548
Acute Care Admissions							
Medical/Surgical	547	557	686	741	486	643	824
<i>Pop. Served Admissions per 1,000</i>	42.8	40.6	48.7	52.6	38.0	45.5	53.0
ICU	42	29	46	41	28	39	51
<i>Pop. Served Admissions per 1,000</i>	3.3	2.1	3.3	2.9	2.2	2.8	3.3
Pediatrics	44	62	41	63	37	52	70
<i>Pop. Served Admissions per 1,000</i>	3.4	4.5	2.9	4.5	2.9	3.7	4.5
Obstetrics	182	234	193	230	166	205	249
<i>Pop. Served Admissions per 1,000</i>	14.2	17.0	13.7	16.3	13.0	14.5	16.0
Total Acute Care Admissions	815	882	966	1,075	717	939	1,194
<i>Pop. Served Admissions per 1,000</i>	63.8	64.2	68.6	76.3	56.1	66.4	76.8
California Inpatient Utilization Rate	84.9	82.1	-	-			

Inpatient Volumes-Bed Need Calculation (continued)

Historical and Projected Utilization



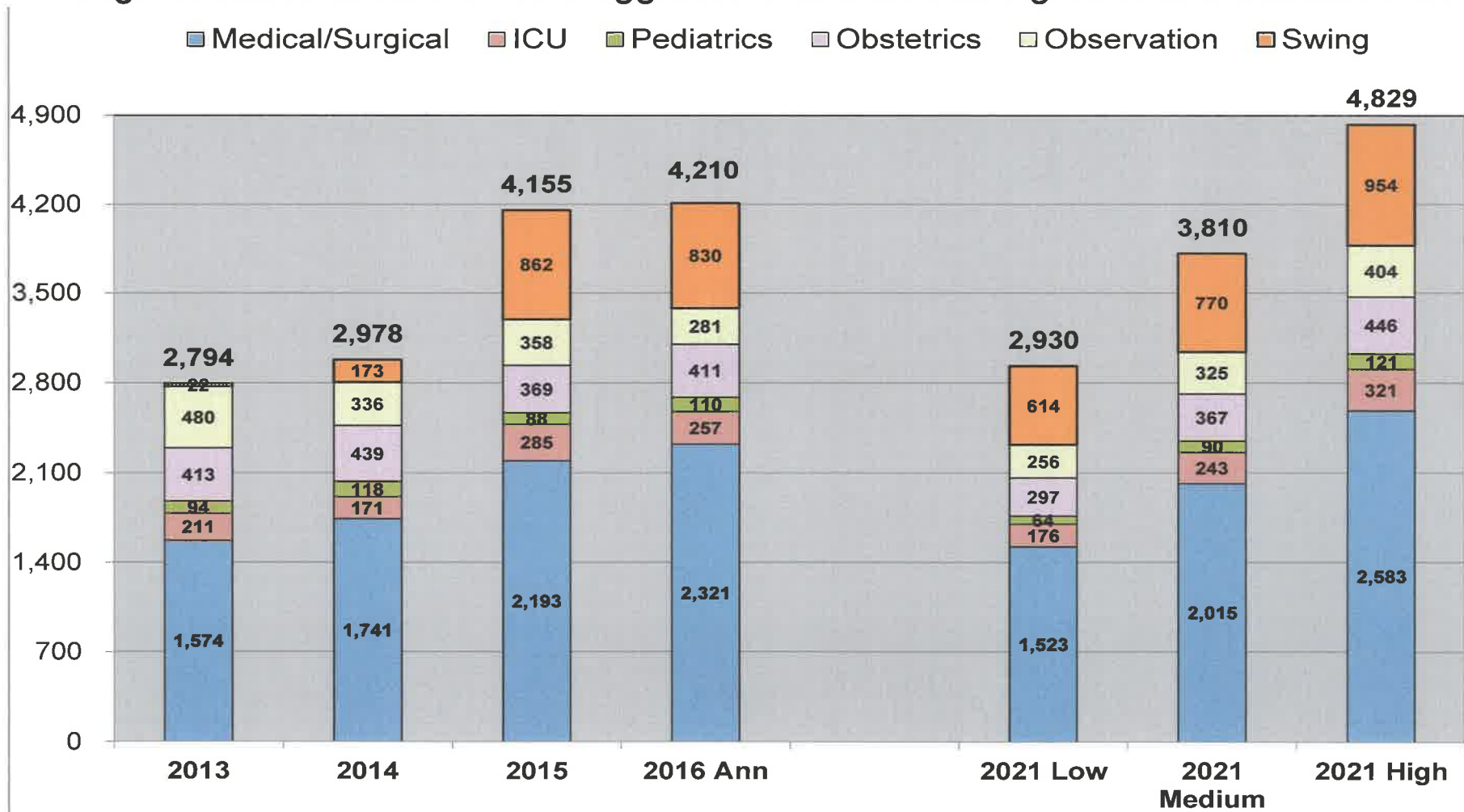
Observation and Swing admissions were also projected out to 2021

- Medium and high scenarios reflect expected rise in utilization in observation and swing

Inpatient Admissions					Estimated 2021		
	2013	2014	2015	2016 Ann	Low	Medium	High
Observation	480	336	358	281	256	325	404
<i>Pop. Served Admissions per 1,000</i>	37.6	24.5	25.4	20.0	20.0	23.0	26.0
Swing-bed	3	27	103	122	90	113	140
<i>Pop. Served Admissions per 1,000</i>	0.2	2.0	7.3	8.6	7.0	8.0	9.0

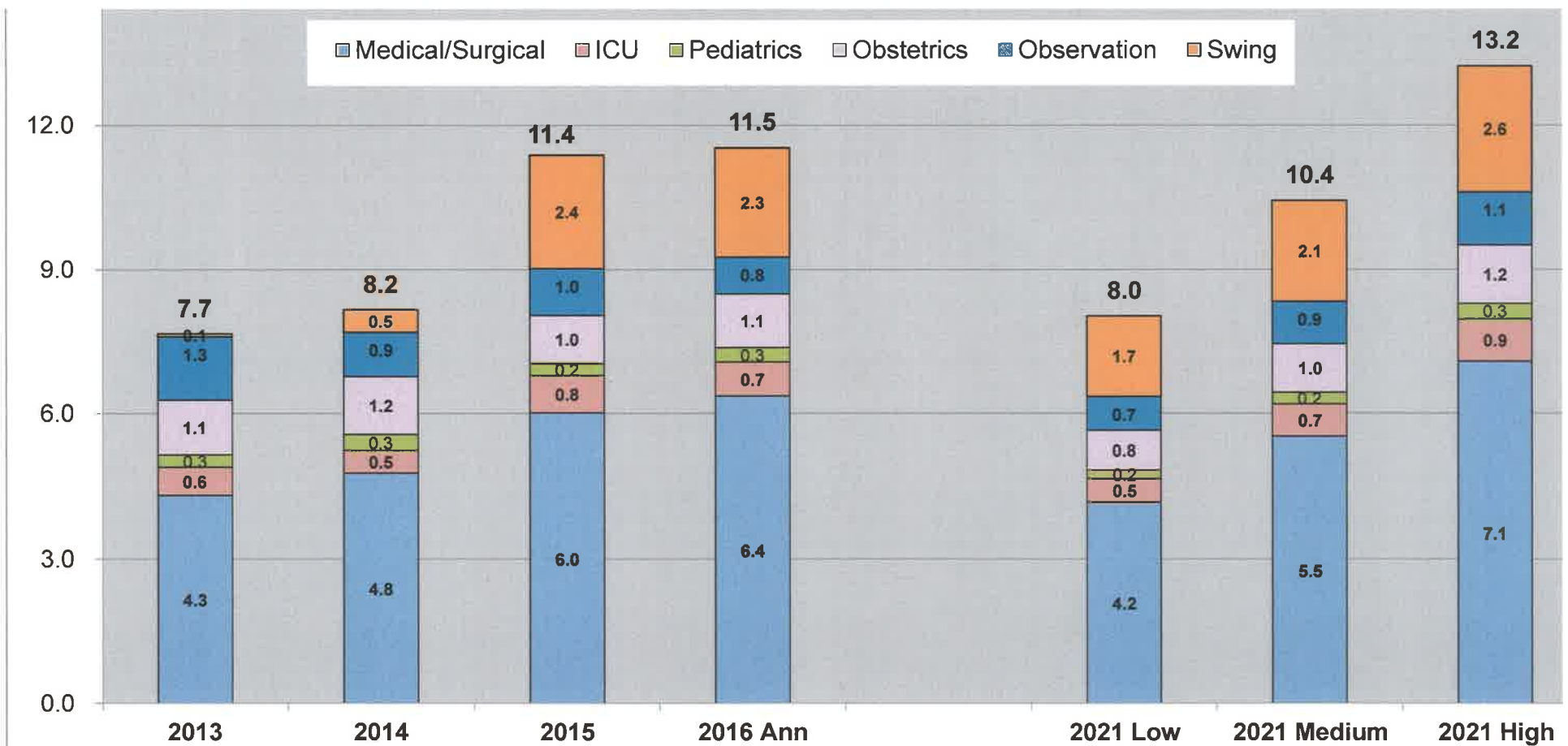
Inpatient Days

- Inpatient days are expected to decline under low and medium scenarios due to downward pressure driven by health reform and other policy changes
- High scenario assumes more aggressive market share growth and utilization rates



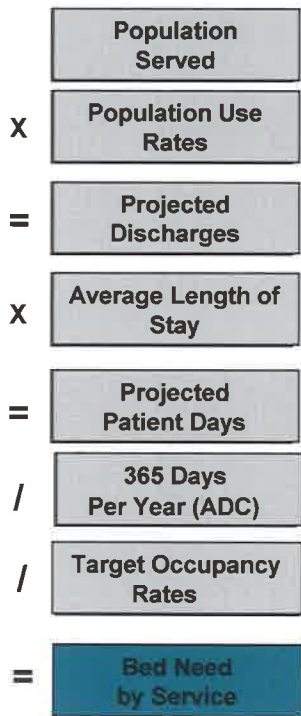
Average Daily Census (ADC)

- Average daily census expected to reach 11 beds under the medium scenario; under the high scenario ADC could grow to 13



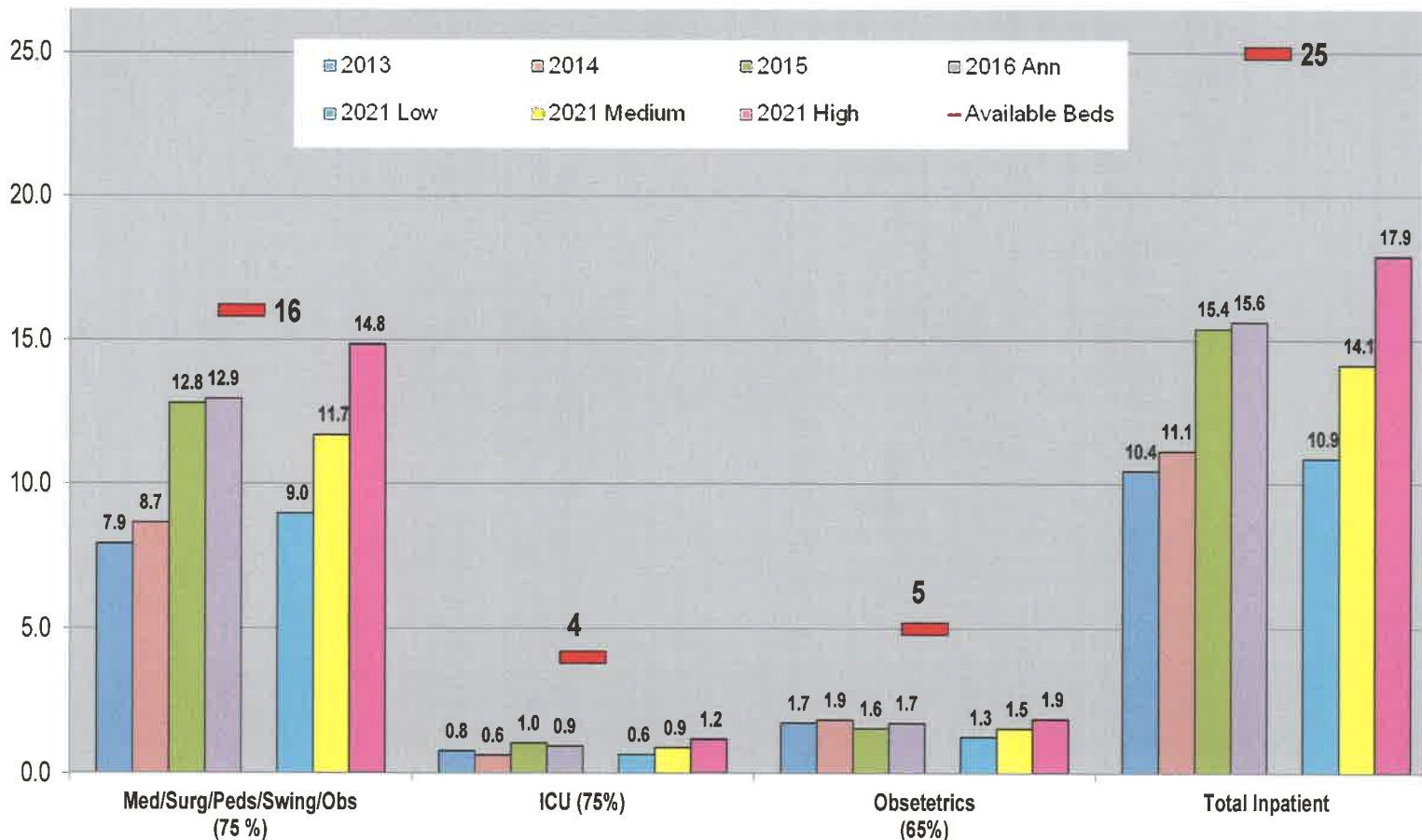
Inpatient Bed Need Calculation

Inpatient Bed Need Summary



Bed Need Summary (adjusted for ideal occupancy)

- Bed need not expected to exceed 25 beds even under the high scenario
- NIH should operate an all-private bed model if rooms are available



Ancillary Services Calculation

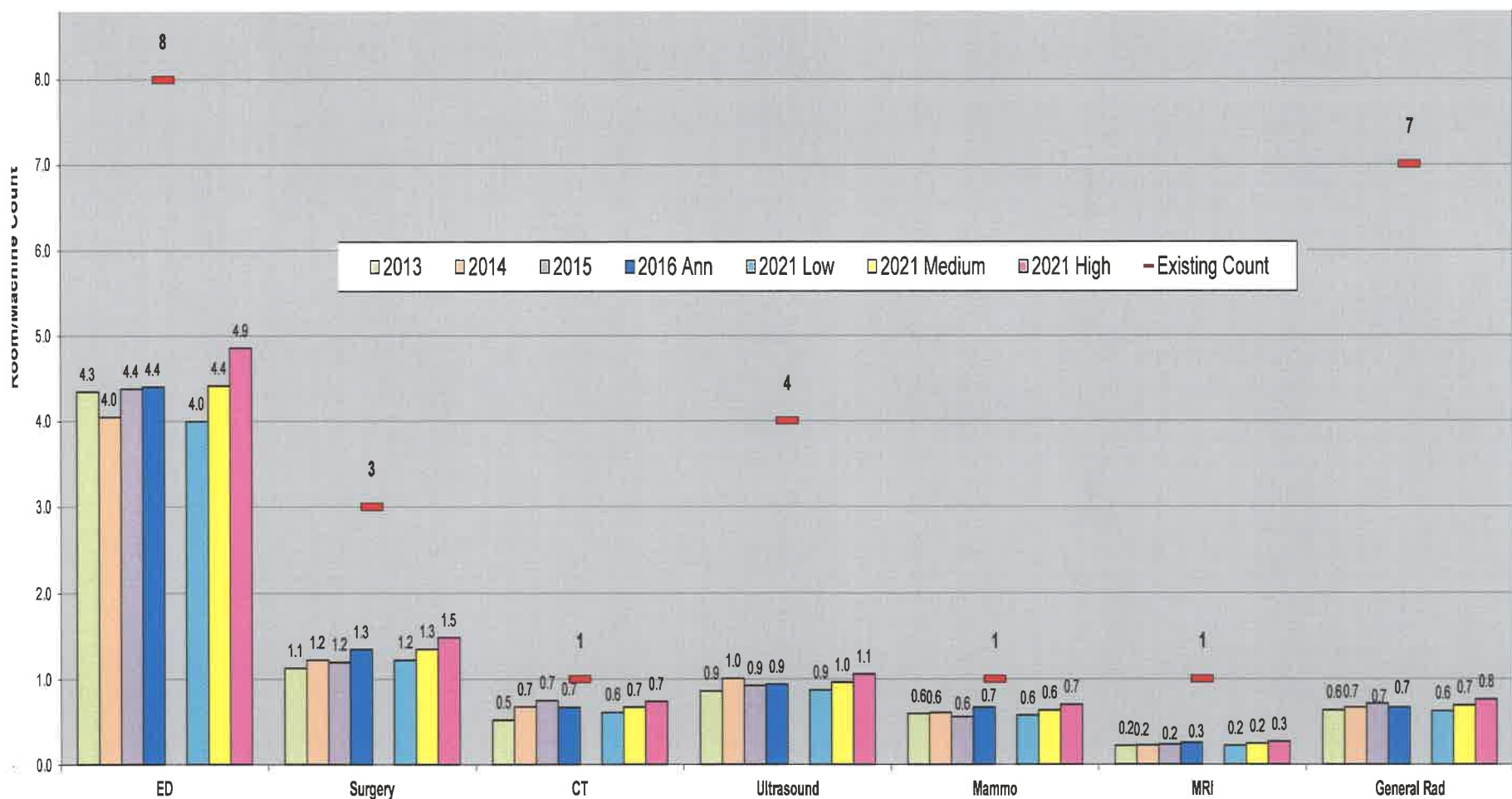
Utilization rates created using cases per 1,000 pop. served or per 1,000 ER visits

- Example: ER (based on per 1,000 pop. served) and Diag. Imaging (based on per 1,000 ER visits)

	2013	2014	2015	2016 Ann	Estimated 2021		
					Low	Medium	High
<i>Population Served</i>	12,782	13,734	14,086	14,086	12,787	14,128	15,548
Emergency Room							
Inpatient	214	445	854	629	571	631	694
Outpatient	8,475	7,652	7,901	8,169	7,415	8,193	9,016
Total Visits	8,689	8,097	8,755	8,798	7,986	8,824	9,710
% Inpatient	2.5%	5.5%	9.8%	7.2%	7.2%	7.2%	7.2%
% Outpatient	97.5%	94.5%	90.2%	92.8%	92.8%	92.8%	92.8%
Total Visits Per 1,000 Pop. Served	680	590	622	625	625	625	625
Surgical Procedures							
Inpatient Surgeries	313	294	270	276	228	252	277
Outpatient Surgeries	930	1,050	1,043	1,202	1,114	1,230	1,354
Total Surgeries	1,243	1,344	1,313	1,478	1,343	1,482	1,631
% Outpatient	74.8%	78.1%	79.4%	81.3%	83.0%	83.0%	83.0%
Total Surgeries Per 1,000 Pop. Served	97	98	93	105	105	105	105
Diagnostic Radiology							
Inpatient Scans	1,021	1,122	1,337	1,226	1,172	1,268	1,424
Outpatient Scans	5,312	5,555	5,781	5,434	5,066	5,623	6,159
Total Scans	6,333	6,677	7,118	6,660	6,237	6,891	7,584
% Outpatient	83.9%	83.2%	81.2%	81.6%	81.2%	81.6%	81.2%
Total Scans Per 1,000 ER Visits	729	825	813	757	781	781	781

Ancillary Services Calculation

Under all scenarios in 2021, all ancillary service modalities are expected to have sufficient capacity over the next 10 years





PHYSICIAN/PROVIDER ANALYSIS

Physician Demand Projections

Wipfli has developed a population-based, age-adjusted model to estimate current and future physician FTE requirements in a given geographical area for the selected physician specialties. The Wipfli model is one of the most comprehensive in the industry, as it has been built and refined over time to include a number of nationally recognized physician demand models and provides the ability to adjust demand based on factors such as age and acuity.

Because of variation in demand models, Wipfli utilized a “blended” approach involving six models.

Blending provides a conservative approach to estimating demand.

Physician Demand Results

- Supply numbers indicate a shortage in the primary service area
- NIH should continue to pursue recruitment in primary care; additional room for capacity is consistent with qualitative reports of access to care

Primary + Secondary Service Area

SPECIALTY	2015	2015	Variance	2020	2020	Variance
	SUPPLY	DEMAND		SUPPLY	DEMAND	
Primary Care						
Obstetrics/Gynecology	3.0	2.1	0.9	3.0	2.2	0.8
Family Practice	6.0	5.7	0.3	6.0	5.9	0.1
Internal Medicine	0.0	5.2	(5.2)	0.0	5.3	(5.3)
Pediatrics	0.2	2.2	(2.1)	0.2	2.2	(2.1)
Sub-Total	9.2	15.2	(6.0)	9.2	15.6	(6.4)

Providers: Rural Health Clinic Benchmarking - CA

Category/Indicator	2014'		
	Mean		
	CA	Western	Nation
Number of Facilities	147	383	1,917
Productivity Indicators:			
Encounters per FTE:			
Physicians	5,065	4,155	4,107
Physician Assistants	3,385	3,276	3,041
Nurse Practitioners	2,905	2,884	2,897
Clinical Psychologist/Social Worker	1,265	1,280	1,254
Total Healthcare Staff Costs per Provider	159,926	121,250	87,249
Injection Cost:			
Cost per Pneumococcal Injection	236.93	184.14	192.40
Cost per Influenza Injection	67.42	62.68	62.80

Providers: Rural Health Clinic Benchmarking

NORTHERN INYO RURAL HEALTH CLINIC
 150 PIONEER LANE
 BISHOP, CA 93514



Category/Indicator	6/30/2013				6/30/2014			
	RHC	Mean			RHC	Mean		
	NIH	CA	Western	Nation	NIH	CA	Western	Nation
Number of Facilities	1	139	381	1,881	1	147	383	1,917
Clinic Cost per Encounter:								
Total Direct Costs of Medical Services	144.23	↓ 95.39	104.86	95.22	138.45	↓ 101.41	108.45	97.74
Total Allowable Cost per Actual Encounter	247.08	↓ 180.14	193.85	174.69	232.05	→ 188.69	199.51	180.25
Total Allowable Cost per Adjusted Encounter	247.08	↑ 177.13	187.13	166.09	232.05	↑ 184.03	192.30	172.09
Average Medicare Encounters	5,362	2,034	2,335	2,489	5,933	1,741	2,399	2,540
Medicare Percent of Visits	30.51%	14.00%	20.56%	25.47%	29.07%	13.04%	20.22%	25.22%

- NIH is able to capture all of the costs per encounter for the RHC
- There has been a significant increase in Medicare encounters since 2013 and NIH sees almost 2.5x the number of Medicare patients than the average California RHC

Capital Needs

- Cash preservation was identified as a top 5 focus for NIH as it allows for the ability to invest in resources and facilities in support of key strategic initiatives
- The importance of cash was identified as follows:
 - Expanding primary care infrastructure
 - Physical Plant investment – improved efficiencies
 - IT/Informatics
 - Weathering potential reimbursement changes



FINANCIAL SCENARIOS

What's Important in Determining Credit Strength

<p><u>Total Margin (%)</u> Reflects your profitability from active patient care and related operations, tax support and other donations</p>	<p>↑ = Good</p>
<p><u>Modified Earnings Before Depreciation & Amortization Margin (%)*</u> How much cash you made before accounting for noncash item capital expenses (depreciation) divided by revenues including net clinic impact</p>	<p>↑ = Good</p>
<p><u>Days Cash on Hand – All Sources (Number)</u> Gauges liquidity by measuring the number of days of cash operating expenses you could support if your revenue stream were to be reduced or eliminated</p>	<p>↑ = Good</p>
<p><u>Debt-to-Capitalization</u> What you owe (long term) versus what you own</p>	<p>↓ = Good</p>
<p><u>Debt Service Coverage (Ratio)</u> Measures your ability to cover the maximum debt payment of the debt (interest and principal payment)</p>	<p>↑ = Good</p>

Key Assumptions for Future “Status Quo”

ALL FINANCIAL SCENARIOS ARE FOR PLANNING PURPOSES ONLY AND SHOULD BE INTERPRETED AS ACTUAL PERFORMANCE

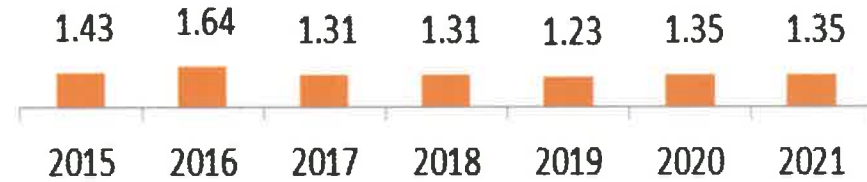
- Growth in gross revenue of Inpatient 1%; continued 4% growth of Outpatient and Clinic annually over 5 year period
- Bad debt is approximately 2% of gross revenues based on historical
- Payor mix stays constant
- Additional \$1MM of salaries for union contract added into 2017 and associated cost-based reimbursement
- Inflationary growth in other salaries, expenses and benefits
- Continued costs for traveling (temporary) positions as recruitment continues to be a challenge
- Annual investments of \$650,000 for routine capital replacement
- Investments grow at modest 3% annually

Status Quo Scenario

Total Margin



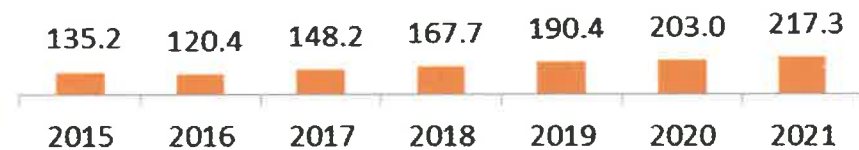
Debt Service Coverage



EBIDA Ratio*



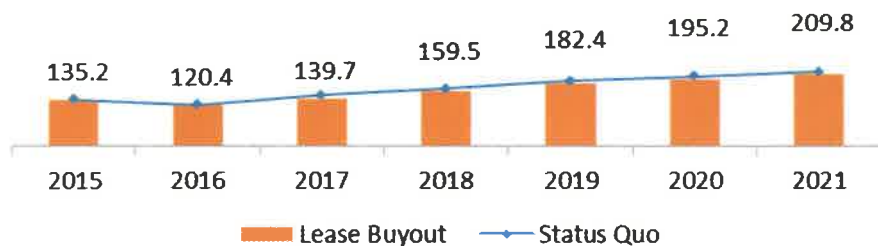
Days Cash on Hand



- Under the status quo scenario financial performance will be steady but eroding operations will have to be supported by other sources (donations, investment income, etc.)
- Cash will increase because of investment returns
- Financial ratios are “average”

Payoff of Celtic Lease Scenario

Days Cash on Hand



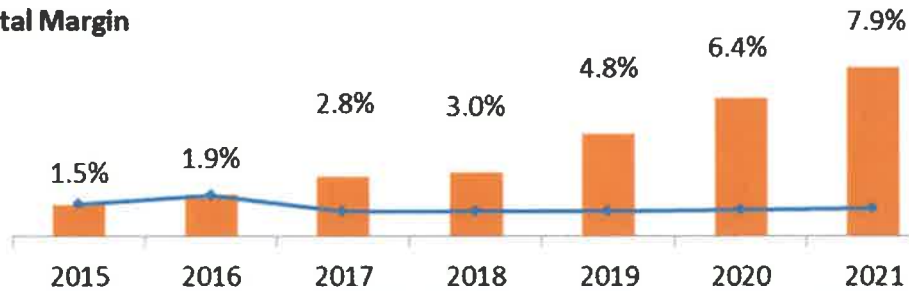
Total Margin



- Assume a worst case scenario that NIH pays off the Celtic lease for \$750K (being negotiated could be less) as a onetime operating expense and purchases \$750 in new equipment in 2017
- One “Day of Cash on Hand” is equal to approximately \$185,000
 - If you paid \$1.5 MM the difference is 139.7 DCOH in 2017 vs. 148.4 DCOH
- Cash will quickly recover; the total margin will be improved by the \$59,000 per month in lease payments or \$708,000 savings annually from status quo

Transition to 80% Outpatient Revenues Scenario

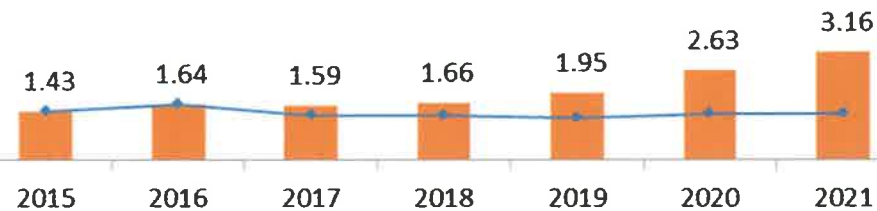
Total Margin



EBIDA Ratio*



Debt Service Coverage



Debt to Capitalization



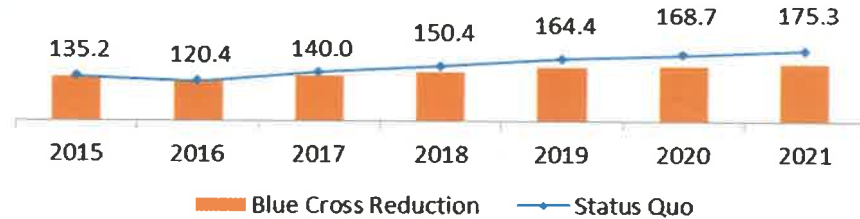
- Outpatient revenues as a %age of total revenues are increased from current 66%age to 80% in 2021
- The cost report was utilized to estimate the cost to charge ratios for ancillary services to account for additional expenses associated with increased OP revenues
- Improvement in financials is reflective of profitability of OP vs. IP business

Blue Cross Contract Reduction Scenario

Total Margin



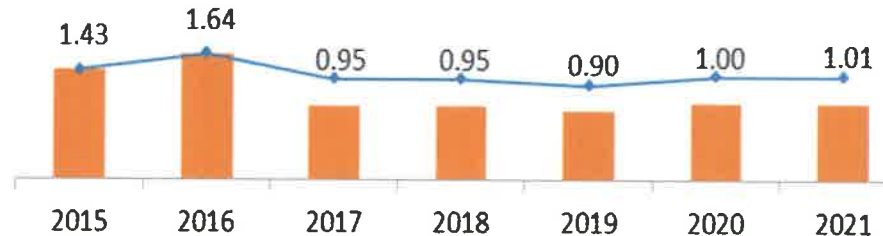
Days Cash on Hand



EBIDA Ratio*



Debt Service Coverage



- NIH receives about 28% of their gross revenues from Blue Cross
- If Blue Cross reduced reimbursement by 5% in 2017 then the financial impact is about \$2MM less in net revenues on average per year
- Illustrates the importance of commercial contracts to the overall financials

Financial Scenarios: Determining Debt Capacity

- Basis for developing the maximum amount of debt that can be supported by the hospital's operations at a given point in time.
- High-level assumptions at revenue and expense level.
- Looks forward over the next five years, but doesn't assume significant changes in operations or reimbursement
- Provides information to board and management around \$ size of project that is affordable and within reason.
- Incorporates Medicare reimbursement for interest and depreciation

Financial Scenarios: Access to Capital

Community Facilities Program

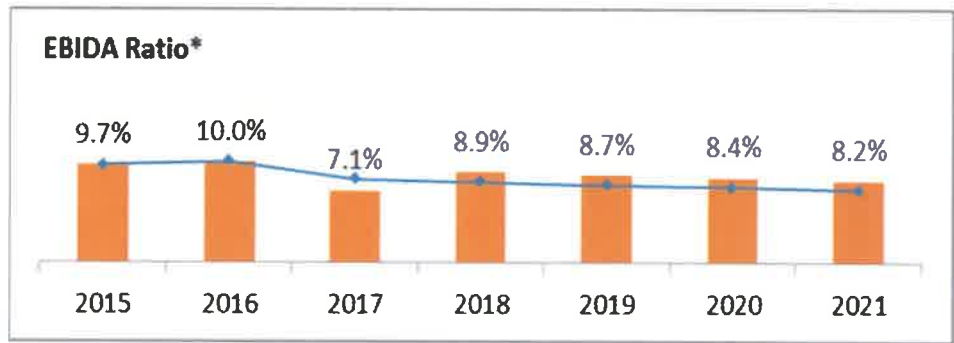
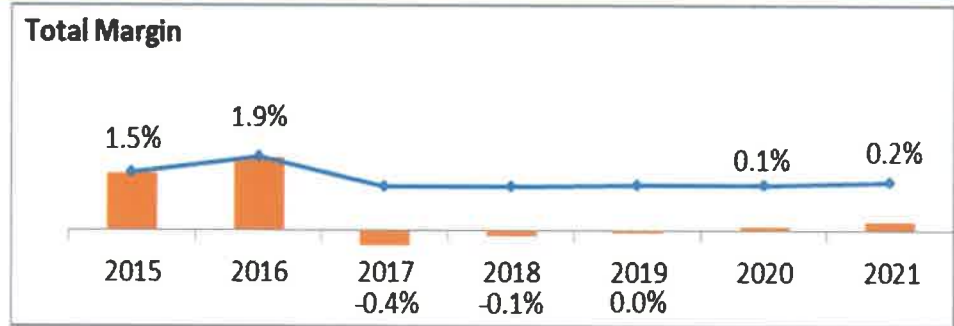
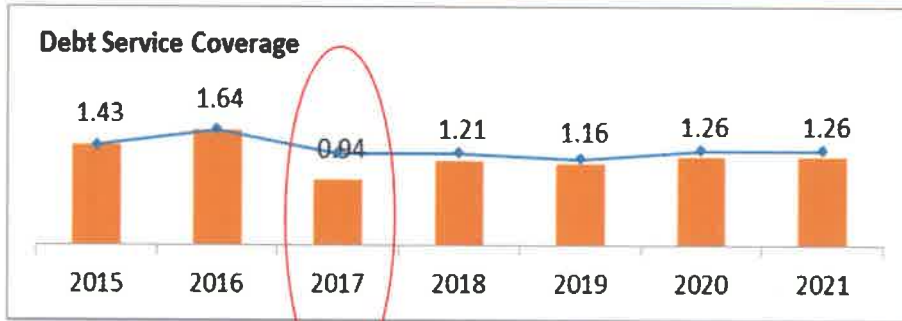


Larger projects are public /private debt

Direct Loan

- USDA makes loans directly to the District
- Current rate is 2.875% fixed for up to 40 years
- Money allocated for FY2016 budget is + \$2.2B
- No fees paid to placement agent are allowed
- Features/requirements
 - Standard documents
 - No tax-exempt opinion
 - No covenants
 - No application fees
 - Examined financial forecast prepared by outside CPA firm part of the application

\$20MM Project Scenario



- Not modeled here, but potential to refinance up to \$19.99 MM in existing debt at through USDA which could also improve
- \$20MM Ratios above would meet USDA standards; EBIDA is slightly better because of increased reimbursement

Key Strategic Initiatives

Providing the Right Services	Enhanced Community Focus	<u>Incorporate Data & Information into Culture</u>
Short Term		
Understand demand and profitability of key services	Planned collaboration with local vendors (examples: "Walk with A Doc")	Acknowledge different areas are more advanced than others; build on their successes
Invest in profitable growth of outpatient services	Active educational outreach (example: Healthy Living Lectures)	Plan for future resource needs (e.g., expertise, equipment, software, training, etc.)
Work to ensure provider engagement in growth area/new models of care	Continue to build positive perceptions of NIH & its leadership (i.e., Board members open house)	Work toward data confidence; ensuring validity and completeness of information
Divest in those services that don't meet quality/volume/profitability requirements		
Longer Term		
Growth in areas to enhance wellness	Promote Benefits of Patient Experience / focus citizens – Example: "CPR Town"	Plan for consumer expectations (i.e., PT portal; access info/visits etc.)
Coordinate with other providers in community	Ensure employees are focused on customer/community service	Address the integration of data across the organization in expectation of population health
Evaluate opportunities to incorporate alternative medicine		Implement processes for data management/data validation/basic analysis across NIH

Finalizing Strategic Initiatives

To be completed on site

Wrap Up / Next Steps

- Summarize Results from Strategic Retreat
- Build out of tactics in support of key initiatives
- Establish monitoring process for progress on initiatives

Critical Access Hospital Finance 101

Updated June 2017



NATIONAL RURAL HEALTH RESOURCE CENTER

525 South Lake Avenue, Suite 320 | Duluth, Minnesota 55802
(218) 727-9390 | info@ruralcenter.org
Get to know us better: www.ruralcenter.org



This project is/was supported by the Health Resources and Services Administration (HRSA) of the US Department of Health and Human Services (HHS) under grant number UB1RH24206, Information Services to Rural Hospital Flexibility Program Grantees, \$957,510 (0% financed with nongovernmental sources). This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the US Government.

TABLE OF CONTENTS

Purpose	3
Government Insurance Programs	3
What is Medicare?	3
What is Medicaid?	5
What is Children’s Health Insurance Program (CHIP)?	6
Government Health Care Reimbursement	7
What is the prospective payment system?	7
What is the Medicare swing bed program?	8
What is CAH cost-based reimbursement?	9
What is CAH Medicare ambulance reimbursement?	9
What are allowable costs for 101 percent cost-based reimbursement from Medicare?	9
What is the difference between PPS and cost-based reimbursement?	10
What is Optional (Method II) Billing?	10
What is a Medicare Administrative Contractor (MAC)?	12
If CAHs are reimbursed at 101 percent, why might they not make a profit?	12
What is a hospital cost report?	13
If a CAH has an RHC attached, how do they bill for those services and file their expenses?	14
CAH Finances	15
What are the most important CAH financial indicators?	15
Days in Net Accounts Receivable	16
Days in Gross Accounts Receivable	17
Days Cash on Hand	17
Total Margin	18
Operating Margin	19
Debt Service Coverage Ratio	19
Salaries to Net Patient Revenue	20

Payor Mix Percentage	21
Inpatient Payor Mix	21
Outpatient Payor Mix	21
Average Age of Plant	21
Long Term Debt to Capitalization	22
Is there a model for predicting CAH financial distress?	22
Where can I find information about the financial performance of CAHs in my state?	25
Improving CAH Financial Performance	26
What interventions can CAHs use to improve financial performance?	26
Why is a review of the cost report important?	26
What is a charge master and how often should it be reviewed?	27
What are strategic, financial and operational assessments?	27
What is revenue cycle management?	27
Why are physician practice management assessments useful?	28
What is Lean and how can it impact CAH finances?	28
Why is education on finances important for CAH department managers and Board members?	28
Why is collaboration important for improving finances in CAHs?	29
Appendix	30
Example Critical Access Hospital – Balance Sheet	30
Example Critical Access Hospital – Statement of Operations	31
Example Critical Access Hospital – Statement of Cash Flows	32

PURPOSE

This manual was developed for use by state Medicare Rural Hospital Flexibility (Flex) Program personnel as well as staff and boards of critical access hospitals (CAHs). The content is designed to be as non-technical as possible and to provide answers to frequently asked questions regarding CAH finance and financial performance.

GOVERNMENT INSURANCE PROGRAMS

What is Medicare?

The Medicare program, an amendment to Social Security legislation known as Title XVIII, provides medical coverage to all Americans 65 years of age and older. The bill was signed into law by President Lyndon B. Johnson in 1965 and took effect in July, 1966. The enactment of the Medicare program was significant because it was the beginning of the federal government's role as a major financer of health care. In 2010, there were 46.6 million enrollees in the Medicare program, or approximately 15 percent of the total US population. Approximately 21 percent of Medicare beneficiaries live in rural counties, meaning rural hospitals tend to have a higher percentage of Medicare recipients than their urban counterparts.

Medicare is health insurance for people 65 or older, people under 65 with certain disabilities and people of any age with End-Stage Renal Disease. Medicare is funded by both Social Security payroll taxes and insurance premiums, with coverage categories divided into "Parts." Medicare Part A is the hospital insurance portion of the program and includes acute hospital inpatient care and inpatient skilled nursing care. Medicare Part B is the medical insurance component and includes coverage for doctor visits and outpatient care. Medicare Part C, known as Medicare Advantage, covers both Part A and Part B options. And, Medicare Part D is the prescription drug coverage component of the program, which went into effect on January 1, 2006.

Medicare Part A (Hospital Insurance)

- Helps cover inpatient care in hospitals, skilled nursing facilities, hospice and home health care
- Most people do not have to pay a premium for Medicare Part A because they, or a spouse, paid Medicare taxes while working in the United States. If they do not automatically get premium-free Part A, they may still be able to enroll and pay a premium

Medicare Part B (Medical Insurance)

- Helps cover doctors' and other health care providers' services, outpatient care, durable medical equipment and home health care
- Helps cover some preventive services
- Most people pay up to the standard monthly Medicare Part B premium
- Some Medicare recipients buy coverage that fills gaps in Medicare coverage, such as Medicare Supplemental Insurance (Medigap)

Medicare Part C (also known as Medicare Advantage)

- Offers health plan options run by Medicare-approved private insurance companies. Medicare Advantage Plans are a way to get the benefits and services covered under Part A and Part B
- Most Medicare Advantage Plans cover Medicare prescription drug coverage (Part D)
- Some Medicare Advantage Plans may include additional benefits for an additional cost

Medicare Part D (Medicare Prescription Drug Coverage)

- Helps cover the cost of prescription drugs
- May help lower your prescription drug costs and help protect against higher costs
- Run by Medicare-approved private insurance companies
- Costs and benefits vary by plan

What is Medicaid?

Medicaid is health coverage available to people and families who have limited income and resources. It is funded both by the federal government and state governments, but is managed at the state level. The program was enacted in 1965 as Title XIX of the Social Security Act. The funding of Medicaid is a major component of state spending, on average comprising 25 percent of the total state budget. Nationally, 60 percent of Medicaid spending goes toward acute care services and over a third goes toward long-term care services.

Medicaid recipients who are disabled or elderly may also receive coverage for services such as nursing home care or home and community-based services. Depending on the state's rules, individuals may also be asked to pay a small part of the cost (copayment) for some medical services. If an individual qualifies for both Medicare and Medicaid, most of their health care costs will be covered, including prescription drug coverage.

Frequently, nursing home residents run out of financial resources during their stay, at which point they become eligible for Medicaid coverage. States attempt to control the costs by ensuring that those receiving Medicaid benefits are truly eligible and at times adopt payment methodologies of the Medicare program. Because Medicaid programs are managed at the state level, there is state-to-state variation in eligibility requirements, coverage and reimbursement.

Medicaid reimbursement, in general, is lower than both Medicare and private insurance reimbursement. Thus, the proportion of Medicaid business for any health care organization is particularly relevant to its financial performance. Moreover, because Medicaid programs place stress on state budgets, state regulators often carry out cost containment measures to reduce Medicaid spending. State cost containment activities include the reduction of payments to providers, reduction in covered services and reduced pharmacy benefits. Over half of CAHs receive cost based reimbursement from their state Medicaid program. For information on state-specific Medicaid reimbursement rates for CAHs, please visit

<https://www.ruralcenter.org/tasc/resources/states%E2%80%99-use-cost-based-reimbursement-medicaid-services-critical-access-hospitals-cahs>

What is Children's Health Insurance Program (CHIP)?

The Children's Health Insurance Program (CHIP) provides access to low cost health insurance coverage for children in families who earn too much to qualify for Medicaid but not enough to be able to buy private health insurance. These families are eligible for free or low-cost health insurance that pays for doctor and dental visits as well as prescription drugs, hospitalizations and more.

GOVERNMENT HEALTH CARE REIMBURSEMENT

What is the prospective payment system?

In 1983, the payment methodology for inpatient acute hospital care (Medicare Part A) changed from cost-based reimbursement to a prospective payment system (PPS). In this new payment system, all the various clinical diagnoses are classified into groups, called "Diagnosis Related Groups" or DRGs. With the establishment of DRG categories, of which there are more than 500, hospitals are paid a fixed amount to treat each patient based on age, sex, International Classification of Diseases (ICD) diagnoses, procedures, discharge status and the presence of comorbidities or complications. Upon admission, each patient is assigned a DRG based on his or her primary diagnosis, for example, "pneumonia". The hospital is then paid a specific dollar amount for that pneumonia patient, based on the DRG code assigned. Some patients need more anticipated services to treat their specific ailment(s), while other cases require fewer services. Regardless, the hospital is still paid the same amount for that DRG code. Naturally, some diagnoses, and their corresponding DRGs, have very high levels of complexity and thus are more costly to treat. For example, a heart transplant is vastly more complicated and requires more resources than a normal newborn birth. Consequently, DRG reimbursement for heart transplants is higher than for the normal newborn DRG.

Base DRG rates can be adjusted for several reasons, including a hospital's location. Just as the cost of living in the United States varies by location, the cost of providing health care varies by location as well. A heart transplant performed in San Francisco, California, would likely cost more than one performed in Omaha, Nebraska, due to wage differences, supply costs differences, etc. The DRG system adjusts for this by varying DRG payments according to market forces across the country.

Inherent in the DRG reimbursement system is the incentive for hospitals to treat and discharge patients as quickly as possible. Because this reimbursement program pays hospitals on a "per patient" basis, there is a financial incentive for hospitals to treat as many patients as possible, as efficiently as possible. By discharging patients in a timely manner, it frees more bed space which can be used to treat more incoming patients. Additionally, the reduced number of days spent in the hospital for a given patient reduces the required resources and associated costs of caring for

that patient. In this way, for any DRG, a shorter length of stay is more profitable for the hospital than a longer length of stay. Because of this direct impact on profitability, the "Average Length of Stay" metric is used by hospitals to assess the efficiency of their organization.

What is the Medicare Swing Bed program?

As discussed earlier, hospitals are reimbursed on a DRG basis for inpatient acute care. Often, patients who require acute inpatient services require inpatient rehabilitative aftercare or skilled nursing care. DRG acute payment rates are set based upon the resources required to treat the acute condition only, and not those expended on the subsequent rehabilitation. Therefore, the Medicare program created a separate reimbursement system to compensate providers for the extended care service they provide. The amount of extended care required by patients for any condition is highly variable because of differences in age, overall health and other factors that determine the speed of recovery. Due to this length of stay variation, hospitals receive reimbursement based on the overall assessed condition of the patient, the amount of which is determined by the assigned Resource Utilization Group (RUG).

The RUG system classifies patients into one of 66 RUG levels, based on the expected amount of provider resources to be expended. RUG payments are larger for most severe conditions that require a great deal of attention and service. In cases in which extended care is required, PPS hospitals receive two payments for a patient: DRG payment for the treatment of the acute condition and the RUG payment for care offered to patients after the acute treatment.

The Medicare swing bed program allows hospitals with 100 beds or less to provide both acute care treatment and skilled nursing treatment to patients without having to physically move the patient to another bed. The hospital receives both forms of reimbursement described above, simply by discharging patients from acute care beds and admitting them to skilled nursing beds when the patient meets the coverage guidelines for skilled care. The skilled nursing bed is sometimes referred to as a "swing" bed, because the hospital swings a bed from an acute care designation to a skilled nursing designation. Patients must be in the medically necessary acute care bed for at least 72 hours before they can be discharged to a swing bed.

What is CAH cost-based reimbursement?

During the 1980s and 1990s, almost 400 hospitals closed across the US because of financial losses from the PPS system. In 1997, the Balanced Budget Act created the Medicare Rural Hospital Flexibility (Flex) Program and CAH provider type.

Medicare pays for the same services from CAHs as for other acute care hospitals (e.g., inpatient stays, outpatient visits, laboratory tests and post-acute skilled nursing days). However, CAH payments are based on each CAH's costs and the share of those costs that are allocated to Medicare patients.

CAHs receive cost based reimbursement for inpatient and outpatient services provided to Medicare patients (and Medicaid patients depending on policy of the state in which they are located). Cost based reimbursement provides significant financial advantage to CAHs by allowing them to get paid at 101 percent of costs on all of their hospital Medicare business. The cost of treating Medicare patients is estimated using cost accounting data from Medicare cost reports.

What is CAH Medicare ambulance reimbursement?

Under Medicare ambulance reimbursement, if a CAH or an entity that is owned and operated by the CAH is the only provider or supplier of ambulance service located within a 35-mile drive of that CAH, the CAH or the CAH-owned and operated entity is paid 101 percent of the reasonable costs of the CAH or entity in furnishing ambulance services. Additionally, if there is no other provider or supplier of ambulance services within a 35-mile drive of the CAH but there is a CAH-owned and operated entity furnishing ambulance services that is more than a 35-mile drive from the CAH, that CAH-owned and operated entity can be paid 101 percent of reasonable costs for its ambulance services as long as it is the closest provider or supplier of ambulance services to the CAH.

What are allowable costs for 101 percent cost-based reimbursement from Medicare?

Medicare pays CAHs for most inpatient, outpatient and swing bed services to Medicare beneficiaries on the basis of reasonable cost. Reasonable cost is the cost that was actually incurred in order to provide a medical service, to the extent the cost is necessary in order to efficiently deliver that service.

Expenses must be prudent and reasonable, as well as related to patient care. For a condensed list of allowable vs. non-allowable expenses, please refer to Table A below.

Table A. Allowable Costs in CAH

Type of Expense	Allowable or Not Allowable
Public education	Allowable
Employee recruitment	Allowable
Taxes based on income	Not Allowable
Sales tax	Allowable
Property taxes	Allowable
Entertainment	Not Allowable
Civic organizations	Allowable
Legal fees	Depends on activity
Collection agency fees	Allowable
Political/lobbying costs	Not Allowable

What is the difference between PPS and cost-based reimbursement?

PPS is a system where payment levels are set ahead of time or “prospectively” before health care services are delivered, as opposed to after the diagnosis and treatment. Because rates are set prior to services, each service has a pre-determined rate associated with it. These rates are based on estimates of the resources that must be expended for any particular service, e.g. physician time and effort, supplies, etc. In this way, this reimbursement system attempts to appropriately match payments to the acuity of patient illnesses. For example, hospitals are paid a fixed amount for performing a hip replacement and a different fixed amount for treating a patient with heart failure. This type of reimbursement methodology controls for costs because providers are paid a fixed rate per service, regardless of the costs they incur.

What is Optional (Method II) Billing?

A CAH may elect the Optional (Method II) Payment Method under which it bills the fiscal intermediary (FI) or Medicare Administrative Contractor (MAC) for both facility services and professional services to its outpatients on a single claim. Eligible medical professionals affiliated with CAHs can elect the Optional (Method II) Payment Method whereby the CAH bills on behalf of

these professionals for their outpatient services. These services include when a CAH physician reassigns outpatient billing services to the CAH, for example in pathology, radiology, emergency room, outpatient surgery and outpatient clinics. This payment does not include services provided at a rural health clinic (RHC) and only applies to the CAH outpatient services.

It is important to note that Optional (Method II) Payment Method billing is setting-specific, not provider-specific. If a provider works in an RHC, they cannot use Optional (Method II) Payment Method for those clinic services. However, if that same provider also provides outpatient services in the CAH, that provider could use Optional (Method II) Payment Method for those outpatient CAH services under the Optional (Method II) Payment Method based on the sum of:

- For facility services: 101 percent of reasonable costs, after applicable deductions, regardless of whether the physician or practitioner has reassigned his or her billing rights to the CAH; and
- For physician professional services: 115 percent of the allowable amount, after applicable deductions, under the Medicare Physician Fee Schedule. Payment for non-physician practitioner services is 115 percent of the amount that otherwise would be paid for the practitioner's professional services under the Medicare Physician Fee Schedule

Physicians reassign their billing to the hospital and the hospital must do the billing. All providers of the CAH do not need to use Optional (Method II) Payment Method, but can individually elect to do so. Overall, it is beneficial for the CAH to elect the Optional (Method II) Payment Method, as it results in higher reimbursement.

In the past, if a CAH chose to be paid under the Optional (Method II) Payment Method, it was required to make that election on an annual basis. However, in the Fiscal Year (FY) 2011 Inpatient Prospective Payment System (IPPS) Final Rule, CMS changed the regulations for the optional method election. Effective for cost reporting periods beginning on or after October 1, 2010:

- If a CAH elects the optional method in its most recent cost reporting period beginning before October 1, 2010, that election remains in place until the CAH submits a termination request to its FI/MAC. CAHs will no longer be required to make an annual election

- If a CAH chooses to make a change or terminate its optional method election, the CAH will need to notify its FI/MAC in writing at least 30 days prior to the start of the next cost reporting period

What is a Medicare Administrative Contractor (MAC)?

Section 911 of the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) established Medicare Contracting Reform (MCR). This statute required the Department of Health and Human Services (HHS) to replace Medicare's 48 carriers and fiscal intermediaries who process Medicare Part A and B Fee for Service claims with the new Medicare Administrative Contractor (MAC) authority. The primary reasons for instituting this change were to increase the contractor's efficiency in the receipt, processing and payment of Fee-For-Service claims. For more information on the MACs, please visit

<https://www.cms.gov/Medicare/Medicare-Contracting/Medicare-Administrative-Contractors/MedicareAdministrativeContractors.html>

If CAHs are reimbursed at 101 percent, why might they not make a profit?

Some CAH expenses, such as recruiting and bad debts, are not included in the cost-based reimbursement formula. Therefore, CAHs generally earn less than 101 percent of cost for care of their Medicare patients. Consequently, profitability of CAHs is dependent on private insurance business, for both inpatient and, increasingly, outpatient services. Private insurance payors do not reimburse CAHs on a cost basis, but rather follow a PPS system or reimburse on a percent of charges. In fact, the profitability of commercial business is enhanced because of the cost based reimbursement received for Medicare/Medicaid business.

Suppose a CAH administrator decides to purchase and install a CT scanner for \$1 million and assume 40 percent of patient care at the CAH in the CT department is Medicare business. The CAH will receive \$400,000 in cost reimbursement over the useful life of the scanner ($\$1 \text{ million} * 40 \text{ percent} = \$400,000$) from Medicare for their portion of this scanner used to serve patients. This reduces the hospital's remaining costs for the CT scanner to \$600,000. The use of the scanner from other patients would need to be available in order to offset the remaining costs based on overall demand.

It is often the challenge of rural health care providers to operate profitably with a patient population that is comprised of more Medicare and Medicaid business than urban providers. When performing financial assessments of CAHs, it is essential to evaluate both the proportion of private insurance business as well as the DRG rates negotiated with the private payor.

What is a hospital cost report?

The Medicare Cost Report is a financial document filed annually by all Medicare providers participating in the program, including: hospitals, skilled nursing facilities, home health agencies, RHCs, federally qualified health centers (FQHC), hospice, renal and home office. The Medicare Cost Report is submitted annually to CMS for settlement of costs relating to health care services rendered to Medicare beneficiaries. The Medicare Cost Report records: each institution's total costs and charges associated with providing services to all patients; the portion of those costs and charges allocated to Medicare patients; and the Medicare payments received.

The Medicare Cost Report must be filed with the FI/MAC within five months of fiscal year end of the CAH to achieve settlement of costs for health care services. Final settlement will equal the total reimbursable costs incurred by or on behalf of the CAH for furnishing covered care to the CAH's Medicare enrollees (less applicable deductible and coinsurance). Throughout the course of the year, the hospital receives interim payments from Medicare for its services. These payments are based on historical costs as claims are processed. At the end of the hospital's fiscal year, if the final settlement determination is greater than payments already made to the CAH through interim settlement, an underpayment will be declared and CMS will make a lump-sum payment to the CAH. Conversely, if the final settlement determination is less than the total payment made, the CAH has been overpaid and CMS must recover the overpayment. This is like the filling of individual taxes each year, where it is likely a person will either owe tax money to or be paid a refund from the state or federal government based on estimated tax payments throughout the previous year. The above payment methodology illustrates the importance of up-to-date charges, billing and coding methodologies for the hospital to ensure accuracy and maximize allowable payment.

If a CAH has an RHC attached, how do they bill for those services and file their expenses?

The primary benefit of RHC status is enhanced reimbursement from Medicare and Medicaid. Medicare reimburses RHCs based on allowable and reasonable costs. There are two types of RHCs: independent RHCs and provider based RHCs. Provider based RHCs work as a department of another provider, such as a CAH, providing health care services to the same population. Independent RHCs, on the other hand, are not affiliated with other providers. There can be significant reimbursement implications associated with each type of designation; for example, independent RHCs are subject to a payment cap, whereas provider based RHCs are not subject to a payment cap if the parent entity is a hospital with fewer than 50 available acute care beds (not licensed beds). Provider based RHCs are reported on the main provider's cost report as a department of that provider. As a result, overhead is allocated to the RHC through the step-down overhead allocation process in the same manner that impacts all of the provider's patient care service departments.

CAH FINANCES

What are the most important CAH financial indicators?

Financial indicators closely aligned with financial strength can be used to determine the financial status of a CAH. Financial indicators, often ratios, combine line items from the balance sheet, statement of operations and/or statement of cash flows in a meaningful way to help interpret strengths or weaknesses in operations or financing activities. Examining these ratios over time can help determine an organization's future trajectory or momentum.

In June 2012, a group of CAH financial experts met in Minneapolis, Minnesota at a CAH Financial Leadership Summit. Of the many identified financial ratios proven useful for assessing organizations' financial conditions, the Summit participants identified the 10 most important indicators for evaluating CAH financial performance. Table B displays each of these 10 indicators with the 2015 CAH US medians as listed in the *CAH Financial Indicators Report: Summary of 2015 Medians by State* updated by the Flex Monitoring Team in March 2017. Each indicator also notes if favorable values are trending above or below the median.

Table B. CAH Financial Indicator Medians, 2015

CAH Financial Indicator	2015 US Median	Favorable Trending
Days in Accounts Receivable	52.46	Down
Days Cash on Hand	76.26	Up
Total Margin	3.09%	Up
Operating Margin	1.79%	Up
Debt Service Coverage	2.89	Up
Salaries to Net Patient Revenue	44.68%	Down
Medicare Inpatient Payer Mix*	73.24%	Down
Average Age of Plant (years)	10.18	Down
Long Term Debt to Capitalization	27.72%	Down

* Summit participants agreed Overall Payer Mix was a more comprehensive indicator of financial performance than Medicare Inpatient Payer Mix alone.

Source: Flex Monitoring Team CAH Financial Indicators Reports Primer and Calculator Resources, Template for Presentation of CAHFIR Data, March 2017.

A definition, formula and benchmarks for each of the 10 most important indicators of CAH financial performance is provided below. Each indicator also includes an example data table, which is meant to be used as a

reference when calculating these ratios for a specific CAH. Sample data corresponds with the financial statements in the Appendix, including a balance sheet, statement of operations and statement of cash flows. Many of the line items on the financial statements have a letter designation under the column titled "Row". These letters are referenced in the descriptions of the indicator calculations.

Days in Net Accounts Receivable

Days in Net Accounts Receivable measures the number of days it takes an organization to collect its payments.

How values are calculated:

- Net Accounts Receivable: [Row B] – [Row C]
- Net Patient Revenue: [Row Q]
- Days in Net Accounts Receivable: $([Row B]-[Row C]) \div ([Row Q] \div 365)$

Example data:

	2014	2015	2016
Net Accounts Receivable	771,000	802,000	778,000
Net Patient Revenue	5,195,000	5,330,000	5,388,000
Days in Net Accounts Receivable	54.17	54.92	52.70

High values reflect a long collection period and indicate problems in the organization's business office with regards to billing or collecting payments. The ability to collect payments for services is increasingly difficult, but extremely important. Improvement in days in accounts receivable can mean hundreds of thousands of dollars in improvement in cash on hand. Common problems include out of date charge masters, poor registration processes and bad communication. "Days in Accounts Receivable" is a good measure of how the billing process is working and efficiency, but it does not indicate the overall financial strength of the hospital. Favorable values are **below** the median and the 2015 CAH US Median = **52.46 days**. Reductions to accounts receivable will improve cash on hand.

Days in Gross Accounts Receivable

Days in Gross Accounts Receivable tests the net days in accounts receivable with a goal of being the same amount of time as net days in accounts receivable.

How values are calculated:

- Gross Accounts Receivable: [Row B]
- Gross Revenue: [Row P]
- Days in Gross Accounts Receivable: $[\text{Row B}] \div ([\text{Row P}] \div 365)$

Example data:

	2014	2015	2016
Gross Accounts Receivable	1,001,000	1,012,000	993,000
Gross Revenue	6,395,000	6,460,000	6,503,000
Days in Gross Accounts Receivable	57.13	57.18	55.74

Days in Gross Accounts Receivable is important to track and compare to net accounts receivable to assess the revenue cycle performance. Gross and net days are close in value in highly functioning business offices. Gross accounts receivable does not include any accounting adjustments which makes it a good measure of overall performance when compared to net days in accounts receivable. For example, if gross days are higher than net days, the organization's allowances (e.g. write offs) may require further analysis. Favorable values are **below** the median and the 2015 CAH US Median = **50.37 days**.

Days Cash on Hand

Days Cash on Hand measures the number of days an organization could operate if no additional cash was collected or received. This reflects the organization's "safety net" relative to the size of the hospital's expenses.

How values are calculated:

- Cash and Temporary Investments: [Row A]
- Total Expenses: [Row X]
- Depreciation and Amortization: [Row U]
- Provision for Doubtful Accounts/Bad Debt: [Row W]
- Days Cash on Hand: $[\text{Row A}] \div (([\text{Row X}] - [\text{Row U}] - [\text{Row W}]) \div 365)$

Note: Provision for Doubtful Accounts/Bad Debt is only included in this equation if classified as an operating expense on the Income Statement.

Example data:

	2014	2015	2016
Cash and Temporary Investments	1,120,000	1,280,000	1,831,000
Total Expenses	5,688,000	5,747,000	5,817,000
Depreciation and Amortization	229,000	218,000	211,000
Bad Debt	102,000	107,000	126,000
Days Cash on Hand	76.31	86.17	121.96

Lending organizations view this ratio as critical in the assessment of a project's feasibility, as it represents the amount of dollars readily available to meet short term obligations and make debt payments should an organization experience short term financial distress. Favorable values are **above** the median and the 2015 CAH US Median = **76.26 days**.

Total Margin

Total Margin measures the control of expenses relative to revenues.

How values are calculated:

- Change in Net Assets: [Row Z]
- Total Revenue: [Row S]
- Total Margin: [Row Z] ÷ [Row S]

Example data:

	2014	2015	2016
Change in Net Assets	64,000	87,000	159,000
Total Revenue	5,752,000	5,834,000	5,976,000
Total Margin	1.11%	1.49%	2.66%

Total Margin indicates the organization's overall profit. It is important to note that organizations need at least a small measure of profit to reinvest in their facilities, staff and infrastructure. Consistently negative total margins may eventually lead to hospital closure. While Total Margin is a good indicator of financial strength, it is important to look at operating margin as well. An organization might have a high Total Margin ratio if, for example, it is the recipient of non-operating sources of revenue, such as a county subsidy to provide quality health care to indigent residents. Margin driven by supplemental funding sources may be at risk with more pressure on local and county governmental budgets, for example. Favorable values are **above** the median and the 2015 CAH US Median = **3.09 percent**.

Operating Margin

Operating Margin measures the control of operating expenses relative to operating revenues related to patient care. Operating expenses are all expenses incurred from the hospital in delivering services. Examples are salaries and benefits, purchased services, depreciation and amortization, supplies, interest expense, professional fees and bad debt expense.

How values are calculated:

- Net Operating Income: [Row R] – [Row X]
- Total Operating Income: [Row R]
- Operating Margin: $([Row R] - [Row X]) \div [Row R]$

Example data:

	2014	2015	2016
Net Operating Income	-7,000	10,000	63,000
Total Operating Income	5,681,000	5,757,000	5,880,000
Operating Margin	-0.12%	0.17%	1.07%

This measure reflects the overall performance on the CAH's core business: providing patient care. It is important to note that it takes into account the deductions from revenue, such as contractual allowances, bad debt and charity care. Favorable values are **above** the median and the 2015 CAH US Median = **1.79 percent**.

Debt Service Coverage Ratio

Debt Service Coverage Ratio measures the ability to pay obligations related to long-term debt.

How values are calculated:

- Change in Net Assets: [Row Z]
- Interest: [Row V]
- Depreciation and Amortization: [Row U]
- Repayment of Debt (Principal Payments): [Row AA]
- Interest Paid on Long Term Debt (Interest Payments): [Row BB]
- Debt Service Coverage Ratio: $([Row Z] + [Row V] + [Row U]) \div ([Row AA] + [Row BB])$

Example data:

	2014	2015	2016
Change in Net Assets	64,000	87,000	159,000
Interest	28,000	17,000	13,000
Depreciation and Amortization	229,000	218,000	211,000
Principal Payments	169,000	145,000	90,000
Interest Payments	28,000	17,000	10,000
Debt Service Coverage Ratio	1.63	1.99	3.83

The measure reflects the availability of capital after debt obligations have been satisfied. The debt service coverage represents a key ratio in determining the ability of an organization to take on additional debt, whether for information technology (IT), equipment or a building project. The higher the value of the debt service coverage ratio, the greater the "cushion" to repay outstanding debt or take on additional obligations. Favorable values are **above** the median and the 2015 CAH US Median = **2.89**.

Salaries to Net Patient Revenue

Salaries to Net Patient Revenue measures labor costs relative to the generation of operating revenue from patient care.

How values are calculated:

- Salaries: [Row T]
- Net Patient Revenue: [Row Q]
- Salaries to Net Patient Revenue: [Row T] ÷ [Row Q]

Example data:

	2014	2015	2016
Salaries	2,895,000	2,908,000	2,958,000
Net Patient Revenue	5,195,000	5,330,000	5,388,000
Salaries to Net Patient Revenue	55.73%	54.56%	54.90%

Salaries are a major part of the expense structure and require close management. Reviewing the costs can help a CAH assess its staffing efficiency. Overstaffing can reduce overall hospital profitability. Closely monitoring salaries to net patient revenue and improving efficiencies can improve financial performance. Favorable values are **below** the median and the 2015 CAH US Median = **44.68 percent**.

Payer Mix Percentage

Payer Mix Percentage is the proportion of patients represented by each payer type. As displayed below, inpatient and outpatient payer mix are calculated differently.

Inpatient Payer Mix measures the percentage of total inpatient days that are provided to patients of each payer type. The 2015 CAH US Median for Medicare inpatient payer mix was **73.24 percent**. Favorable values are **below** the median.

$$\frac{\text{Inpatient Days for Payer}}{\text{Total Inpatient Days} - \text{Nursery Bed Days} - \text{Nursing Facility Swing Days}}$$

Outpatient Payer Mix measures the percentage of total outpatient charges that are for patients of each payer type.

$$\frac{\text{Outpatient Charges for Payer}}{\text{Total Outpatient Charges}}$$

Payer mix percentages are particularly important in estimating provider revenue, because the final reimbursement amount for any patient ultimately depends on the payment source. For CAHs, reimbursement for Medicare is 101 percent of costs. Real costs for Medicare patients are already below 100 percent since some cost, such as physician recruiting, are not reimbursed by Medicare (See Table A - "Allowable Costs in CAH"). The only alternative source of profits is providing services to privately insured patients. It is often the challenge of rural health care providers to operate profitably with a patient population that is comprised of more Medicare and Medicaid business than urban providers.

Average Age of Plant

Average Age of Plant measures the average age in years of the buildings and equipment of an organization.

How values are calculated:

- Accumulated Depreciation: [Row E]
- Depreciation and Amortization: [Row U]
- Salaries to Net Patient Revenue: [Row E] ÷ [Row U]

Example data:

	2014	2015	2016
Accumulated Depreciation	1,874,000	1,755,000	1,896,000
Depreciation Expense	229,000	218,000	211,000
Average Age of Plant	8.18	8.05	8.99

CAHs often fail to improve or rebuild their facilities. The status of newer facilities has been shown to have a positive effect on financial performance and on the recruitment and retention of physicians and staff. Average age of plant is a good indicator of distress with older hospitals having greater problems. Lower, decreasing values indicate a newer facility or more frequent reinvestments in buildings or equipment over time. Favorable values are **below** the median and the 2015 CAH US Median = **10.18 years**.

Long Term Debt to Capitalization

Long Term Debt to Capitalization measures the percentage of net assets (or equity) that is debt.

How values are calculated:

- Long Term Debt, Net of Current Portion: [Row K]
- Net Assets - Accumulated Earnings (Deficit): [Row M]
- Long Term Debt to Capitalization: [Row K] ÷ ([Row K] + [Row M])

Example data:

	2014	2015	2016
Long Term Debt	186,000	183,000	178,000
Net Assets	1,835,000	2,173,000	2,694,000
Long Term Debt to Capitalization	9.20%	7.77%	6.20%

This ratio measures the amount of capital that is financed with debt, which is important to lenders for long term viability. Higher values signify a riskier situation and indicate that a hospital may have a harder time sustaining debt payments in the future and/or getting financing from lenders. Favorable values are **below** the median and the 2015 CAH US Median = **27.72 percent**.

Is there a model for predicting CAH financial distress?

The Financial Distress Index was developed by researchers from the North Carolina Rural Health Research and Policy Analysis Center at University of North Carolina at Chapel Hill. A well-functioning prediction model, such as

this, can be used as an early warning system to identify hospitals at increased risk of facing financial distress. State Flex Programs, CAH CEOs and boards reviewing the model could identify areas of particular distress and develop strategies, or interventions, to improve financial performance. To view more information about the prediction of financial distress among rural hospitals, please visit

<https://www.ruralhealthresearch.org/publications/998>.

Today's characteristics (recent financial performance and measures of a market in which a hospital operates) are used to assign CAHs to one of four "risk levels" that predict whether a CAH will be in financial distress two years later. Many financial performance and market characteristics were considered for inclusion. The final model was selected due to its ability to predict performance in a straightforward manner. Variables used in the model are noted below in Tables C, D, E and F.

The model separates hospitals into risk of financial distress categories. Financial distress events include:

- Unprofitability
- Equity decline
- Insolvency
- Closure

Accurate assignment of hospitals to categories that reflect low, mid-low, mid-high and high risk of financial distress can provide an effective early warning system to CAHs, allowing CAH Administrators and state Medicare Flex Program Coordinators to target efforts to those at higher risk.

Table C. Descriptive Measures of Variables Included in Prediction of Financial Distress among Rural Hospitals, Financial Performance

Variable	Description
Profitability	Total margin; two-year change in total margin
Reinvestment	Retained earnings as a percent of total assets
Benchmark performance	Percent of benchmarks met over two years

Table D. Descriptive Measures of Variables Included in Prediction of Financial Distress among Rural Hospitals, Government Reimbursement

Variable	Description
Medicare	CAH status
Medicaid	Medicaid to Medicare fee index

Table E. Descriptive Measures of Variables Included in Prediction of Financial Distress among Rural Hospitals, Hospital Characteristics

Variable	Description
Ownership	Government/not-for-profit, for-profit
Size	Net patient revenue (millions)

Table F. Descriptive Measures of Variables Included in Prediction of Financial Distress among Rural Hospitals, Market Characteristics

Variable	Description
Competition	Log of miles to nearest hospital more than 100 beds; market share (<25%)
Economic Condition	Log of poverty rate in the market area
Market Size	Log of population in the market area

Where can I find information about the financial performance of CAHs in my state?

The Flex Monitoring Team has created a login protected online tool called the *Critical Access Hospital Measurement and Performance Assessment System* (CAHMPAS). CAHMPAS is available to CAH executives, state Flex Programs and federal staff to explore the financial, quality and community-benefit performance of CAHs. CAHMPAS provides graphs and data, which allows comparison of CAH performance for various measures across user-defined groups: by location, net patient revenue or other factors. CAHMPAS includes a variety of metrics and allows CAHs to compare their financial performance to peer facilities. For more information visit

<http://www.flexmonitoring.org/cahmpas/>

The Flex Monitoring Team has also released primers, a presentation template and a calculator spreadsheet to support communication of the CAH financial data. The primer documents explain the measure calculations and offer insights regarding the roles each measure plays in assessing a hospital's financial health. The presentation temple is an editable PowerPoint file for CAHs to use in presenting their own CAH financial data to others. The calculator spreadsheet is an Excel file that enables CAHs to verify the Flex Monitoring Team's calculations and calculate more recent financial indicators using data on hand. For more information visit

<http://www.flexmonitoring.org/publications/cahfir-resources/>

IMPROVING CAH FINANCIAL PERFORMANCE

What interventions can CAHs use to improve their financial performance?

The 2012 CAH Financial Leadership Summit identified several important financial interventions that historically have been associated with improved financial performance. They include:

- Cost report review and strategy
- Strategic, financial and operational assessments
- Revenue cycle management
- Physician practice management assessments
- Lean process improvement training
- Financial education for CAH department managers
- Financial education for CAH boards
- Pooling Small Rural Hospital Improvement Program (SHIP) dollars
- Developing chief financial officer (CFO) networks
- Benchmarking financial indicators

A subsequent CAH Financial Leadership Summit was held in 2016 to build upon the knowledge gained from the 2012 Summit. The resulting report, *2016 Financial Leadership Summit Report: Strategies for Rural Hospitals Transitioning to Value-based Purchasing and Population Health*, is designed to help rural hospitals leaders meet existing challenges by describing market forces impacting rural hospitals and providing key operational strategies that providers may deploy to overcome these challenges and be successful in alternative payment models. The report highlights success stories and lessons learned that were shared by the panelists during the summit. To view the Summit findings and recommendations, please visit

<https://www.ruralcenter.org/srht/resources/2016-financial-leadership-summit-report-strategies-rural-hospitals-transitioning>.

Why is a review of the cost report important?

A review of the cost report can be completed by an outside party to look for common errors in preparation. Because it drives Medicare payments, errors on the cost report directly affect the bottom line, sometimes as much as hundreds of thousands of dollars. Errors include incorrect allocations of expenses and inaccurate statistics, for example. Most cost reports are “outsourced,” but understanding direct and indirect costs and how cost

reports work is a critical input to making sound decisions for chief executive officers (CEOs), CFOs and board members.

What is a charge master and how often should it be reviewed?

The Charge Description Master (CDM) is primarily a list of services and procedures, room accommodations, supplies, drugs/biologics and/or radiopharmaceuticals that may be billed to a patient registered as an inpatient or outpatient on a claim. It is integral to the CAH's revenue cycle and provides many of the necessary data elements for compliant claims submission for reimbursement. It is recommended to have an outside source perform a comprehensive charge master and revenue cycle review annually. Ongoing education is also crucial to having business office staff remain current with information necessary to appropriately bill for services rendered. Code changes and description changes must be communicated to the departments who will be generating the charges and may need to be altered or added to the system. Similarly, charge tickets may need to be updated. Billing and coding workshops are available in many locations throughout the country.

What are strategic, financial and operational assessments?

Strategic, financial and operational assessments provide a broad-based analysis of hospital performance and help identify specific opportunities for CAH improvement. These studies provide an objective review of the areas where many CAHs need help, including:

- Matching services to community needs
- Staffing to benchmarks
- Clinic management
- Medical staff planning
- Organizational culture

Assessments are recommended periodically to determine areas of focus for follow-up improvement work.

What is revenue cycle management?

Revenue cycle management is a means to improve hospital revenue and reimbursement by streamlining workflow, processes and education throughout all financial components of the hospital. A holistic revenue cycle

management includes a multi-disciplinary approach focusing on culture change with comprehensive, dramatic and permanent results. Specific areas of focus may include:

- Comprehensive charge master and revenue cycle review
- Business office and patient financial services review
- Development of training protocols for revenue capture
- Implementation of an effective revenue control process
- Pricing analysis
- Recovery audit contractor (RAC) preparedness and revenue cycle process improvement
- Revenue process capture audits

These assessments should result in identifying opportunities for improvement and specific, actionable recommendations.

Why are physician practice management assessments useful?

As more and more physicians align and become employees of CAHs, it is critically important to contract with physicians and operate clinics according to best practices. A practice management assessment looks at physician and mid-level provider productivity, scheduling, staffing, billing and collection practices. These assessments should result in specific recommendations and action plans that have the potential to bring in additional revenue and improve clinic efficiency.

What is Lean and how can it impact CAH finances?

Lean focuses on increasing efficiency and eliminating waste. This creates greater value for customers and uses fewer resources. In the health care setting, Lean processes can result in substantial cost savings, fewer delays and increased patient and staff satisfaction. Lean education, Lean networks and shared Lean expertise have all been successfully used by individual CAHs and networks of rural hospitals.

Why is education on finances important for CAH department managers and Board members?

Financial education for CAH department managers can enhance budgeting, planning and financial skills in department heads, whose background may be clinical rather than business or administrative. CAH Board members similarly

lack basic CAH financial knowledge. Financial education for CAH Boards provides a fundamental grounding on cost-based reimbursement and CAH financial strategies. Hospital financial management is complex and rural hospital boards need a basic understanding of CAH finances to provide needed oversight. This type of education has been done successfully with rural hospitals using both on-site workshops and web-based presentations, which are often stored and accessible online.

Why is collaboration important for improving finances in CAHs?

Two minds are better than one. Collaboration allows CAH staff to share ideas, lessons learned, best practices and funds with one another. Many state Flex Programs have provided support to develop CFO networks. CFO networks have proven to be a popular method of education, peer learning and peer support. In more than a dozen states, rural hospital CFOs meet periodically, either in person or virtually, to discuss common issues, gain new skills and share experiences and techniques.

Benchmarking financial outcomes among groups of hospitals is a common means of measuring performance and comparing results. By collaboratively comparing results, CAHs identify areas of strengths and weaknesses and measure progress toward strategic goals. This collective benchmarking also provides an opportunity for the hospitals to share common issues, best practices and lessons learned. The University of North Carolina-Chapel Hill's distribution of annually updated financial indicator data through CAHMPAS is a useful source for benchmarking, but other information sources are also available.

Aside from the value of bringing collective minds together, using various funding sources to achieve an end goal can be strategic. Pooling SHIP dollars among a group of CAHs has provided an effective means of providing financial or Lean education to hospital staff and boards. Economies of scale, shared expertise, access to speakers and resources, peer learning and support have all been reported as benefits of pooling resources.

APPENDIX

Example Critical Access Hospital - Balance Sheet

[Row]		2014	2015	2016
	ASSETS			
	Current Assets:			
A	Cash and Temporary Investments	1,120,000	1,280,000	1,831,000
B	Patient Accounts Receivable, Gross	1,001,000	1,012,000	993,000
C	Less: Provision for Doubtful Accounts	-230,000	-210,000	-215,000
	Other Accounts Receivable	-	24,000	24,000
	Supplies	162,000	169,000	169,000
	Other Current Assets	68,000	57,000	57,000
D	Total Current Assets	2,121,000	2,332,000	2,859,000
	Property, Plant & Equipment:	2,663,000	2,612,000	2,712,000
E	Less: Accumulated Depreciation	-1,874,000	-1,755,000	-1,896,000
	Net Fixed Assets	789,000	857,000	816,000
F	TOTAL ASSETS	2,910,000	3,189,000	3,675,000
	LIABILITIES & NET ASSETS			
	Current Liabilities:			
G	Current Portion of Long Term Debt	144,000	89,000	49,000
H	Accounts Payable & Accrued Liabilities	115,000	148,000	158,000
	Estimated Amounts Due to Third Party	260,000	226,000	226,000
I	Other Current Liabilities	370,000	370,000	370,000
J	Total Current Liabilities	889,000	833,000	803,000
K	Long Term Debt, Net of Current Portion	186,000	183,000	178,000
L	TOTAL LIABILITIES	1,075,000	1,016,000	981,000
	NET ASSETS			
M	Accumulated Earnings (Deficit)	1,835,000	2,173,000	2,694,000
	TOTAL LIABILITIES & NET ASSETS	2,910,000	3,189,000	3,675,000

Example Critical Access Hospital - Statement of Operations

[Row]		2014	2015	2016
	REVENUE			
N	Total Inpatient Revenue	2,402,000	2,445,000	2,471,000
O	Total Outpatient Revenue	3,993,000	4,015,000	4,032,000
P	Total Gross Revenue	6,395,000	6,460,000	6,503,000
	Less: Contractual Allowances	-1,200,000	-1,130,000	-1,115,000
Q	Net Patient Revenue	5,195,000	5,330,000	5,388,000
	Other Operating Revenue	486,000	427,000	492,000
R	Total Operating Revenue	5,681,000	5,757,000	5,880,000
	Gain (Loss) on PP&E Disposal	-2,000	-3,000	-
	Contributions/Grants	65,000	69,000	77,000
	Investment Income	8,000	11,000	19,000
S	Total Revenue	5,752,000	5,834,000	5,976,000
	EXPENSES			
T	Salaries	2,895,000	2,908,000	2,958,000
	Benefits, Supplies & Other	2,434,000	2,497,000	2,509,000
U	Depreciation & Amortization	229,000	218,000	211,000
V	Interest	28,000	17,000	13,000
W	Provision for Doubtful Accounts/Bad Debt	102,000	107,000	126,000
X	Total Expenses	5,688,000	5,747,000	5,817,000
Y	EXCESS OF REVENUES OVER EXPENSES	64,000	87,000	159,000
	Restricted Contributions	-	-	-
Z	CHANGE IN NET ASSETS	64,000	87,000	159,000

Example Critical Access Hospital - Statement of Cash Flows

[Row]		2014	2015	2016
	CASH FLOWS FROM OPERATING ACTIVITIES			
	Change in Net Assets	522,000	547,000	542,000
	Adjustments to reconcile change in net cash provided by operating activities:			
	Purchase of Other Assets	246,000	459,000	-210,000
	Other Current Liabilities	-3,000	-6,000	-
		34,000	-	-
	Net Cash Provided by Operating Activities	799,000	1,000,000	332,000
	CASH FLOWS FROM FINANCING ACTIVITIES			
AA	Repayment of Debt	-169,000	-145,000	-90,000
	Purchase of PP&E	-63,000	-189,000	-100,000
BB	Interest Paid on Long Term Debt	-28,000	-17,000	-10,000
	Gifts to Purchase Capital Assets	46,000	-	-
	Net Cash Used by Investing Activities	-214,000	-351,000	-200,000
	CASH FLOWS FROM INVESTING ACTIVITIES			
	Interest and Dividends on Investments	8,000	11,000	19,000
	Net Cash Used by Investing Activities	8,000	11,000	19,000
	NET INCREASE (DECREASE) IN CASH	593,000	660,000	151,000
	CASH, BEGINNING OF YEAR	527,000	1,120,000	1,178,000
	CASH, END OF YEAR	1,120,000	1,780,000	1,931,000

WIPFLI^{LLP}

CPAs and Consultants

HEALTH CARE PRACTICE

Critical Access Hospital and Rural Health Clinic Conference

A Deep Dive:
Your CAH Medicare
Cost Report From A-M

September 13, 2016



Introduction to Health Care Reimbursement

If a non-health care business charges
\$100 for a good or service it provides,
how much does it get paid?



Gas Station



Grocery Store



Plumber



Restaurant



Garbage Service



Clothing Store

WIPFLI
HEALTH CARE PRACTICE

© 2016 WIPFLI 1

Introduction to Health Care Reimbursement



WIPFLI

HEALTH CARE REIMBURSEMENT

2

Introduction to Health Care Reimbursement

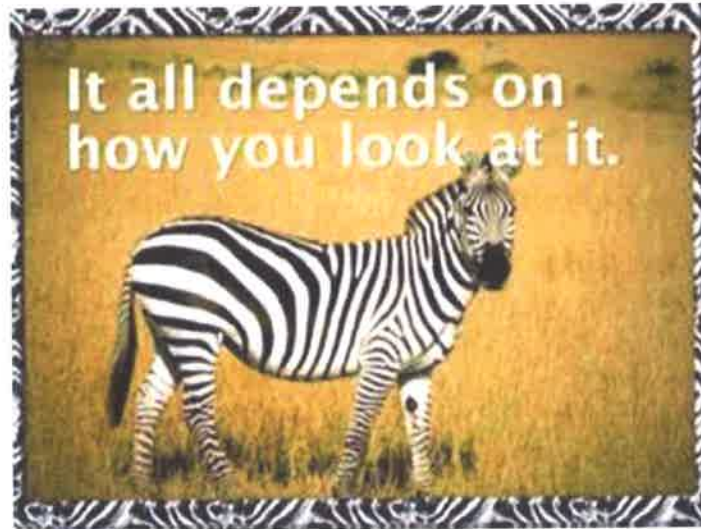
If a health care provider charges \$100 for a service it provides, how much does it get paid?

WIPFLI

HEALTH CARE REIMBURSEMENT

3

Introduction to Health Care Reimbursement



WIPFLI
HEALTH CARE PRACTICE

© 2014 WIPFLI 4

267

Introduction to Health Care Reimbursement

Examples of Possible Payments for Health Care Services

Private pay	\$ 100
Private pay	-
Medicare	60
Medicaid	55
Insurance #1	90
Insurance #2	85
Insurance #3	80
Etc.	?

To determine the estimated amount a health care provider will be paid, three important pieces of information must be known:

1. Payor type
2. Patient type
3. Specific type of service

WIPFLI
HEALTH CARE PRACTICE

© 2014 WIPFLI 5

Introduction to Health Care Reimbursement

Sample Methods of Reimbursement Currently in Use in the Health Care Industry

Hospital	Nursing Home	Psych/Acute Rehab Services	Home Health/Hospice	Clinics
<ul style="list-style-type: none"> Medicare <ul style="list-style-type: none"> "Allowable" cost Diagnosis related groups (DRGs) Fee schedules Add-on payments Amputation procedure codes (APCs) Medicaid <ul style="list-style-type: none"> Cost-based rates Access payments Fee schedules Enhanced ambulatory procedure groups Commercial insurance <ul style="list-style-type: none"> Contracted payors <ul style="list-style-type: none"> Negotiated discounts Rates per visit Fee schedules Noncontracted payors <ul style="list-style-type: none"> Standard charges Self-pay patients <ul style="list-style-type: none"> Standard charges Discounts as required under "Patient Protection Act" or state specific legislation Charity care Bad debts 	<ul style="list-style-type: none"> Medicare <ul style="list-style-type: none"> Resident Utilization Groups (RUGs) Fee schedules (therapy) "Allowable" cost for vaccines Medicaid <ul style="list-style-type: none"> Blended cost and equity-based rates Fee schedules (therapy) Commercial insurance <ul style="list-style-type: none"> Contracted payors <ul style="list-style-type: none"> Standard charges Negotiated rates Self-pay patients <ul style="list-style-type: none"> Standard charges 	<ul style="list-style-type: none"> Medicare <ul style="list-style-type: none"> Diagnosis-related groups (inpatient) "Allowable" cost Fee schedules Medicaid <ul style="list-style-type: none"> Cost-based rate per discharge (inpatient) Fee schedules Commercial insurance <ul style="list-style-type: none"> Contracted payors <ul style="list-style-type: none"> Negotiated discounts Rates per visit Fee schedules Noncontracted payors <ul style="list-style-type: none"> Standard charges Self-pay patients <ul style="list-style-type: none"> Standard charges Discounts as required under "Patient Protection Act" or state specific legislation Charity care Bad debts 	<ul style="list-style-type: none"> Medicare <ul style="list-style-type: none"> Rates per episode of care or length of stay Medicaid <ul style="list-style-type: none"> Rates per episode of care or length of stay Commercial insurance <ul style="list-style-type: none"> Contracted payors <ul style="list-style-type: none"> Standard charges Negotiated rates Self-pay patients <ul style="list-style-type: none"> Standard charges 	<ul style="list-style-type: none"> Medicare <ul style="list-style-type: none"> Fee schedules "Allowance" cost for rural health clinics Medicaid <ul style="list-style-type: none"> Fee schedules "Allowance" cost or per diem rates for rural health clinics Commercial insurance <ul style="list-style-type: none"> Contracted payors <ul style="list-style-type: none"> Negotiated discounts Rates per visit Fee schedules Noncontracted payors <ul style="list-style-type: none"> Standard charges Self-pay patients <ul style="list-style-type: none"> Standard charges Discounts as required under "Patient Protection Act" or other state specific legislation Charity care Bad debts

WIPFLI
HEALTH CARE PRACTICE

©2017 WIPFLI 6

208

Medicare Reimbursement

There are two primary types of hospital reimbursement methodologies for Medicare

- Prospective Payment System (PPS)
- Cost-Based System

WIPFLI
HEALTH CARE PRACTICE

©2017 WIPFLI 7

Prospective Payment System - Hospital Services

Medicare

- Inpatient and Outpatient
 - Paid at prospectively determined rates based on a patient classification system
 - ~ Inpatient => MS DRG
 - ~ Outpatient => APCs
 - Payment calculation: Base rate x weight
 - Example: Chest pain, DRG 143, relative weight .5391 (per Federal Register)
$$\$5,000 \times .5391 = \$2,695$$

Cost-Based System - Hospital Services

Medicare

- Inpatient, Outpatient, and Swing Bed
 - Generally, paid for services based on (retrospective) cost reimbursement methods.
 - Although certain types of laboratory services, ambulance services, and professional services may be carved out and reimbursed using a prospectively determined fee schedule.

Medicare Payment Overview

Type of Service	PPS Hospital	CAH
Inpatient	DRG	101% of Allowable Cost
Outpatient Procedures (surgery, radiology, etc.)	APC	101% of Allowable Cost
Lab	Fee Schedule	101% of Allowable Cost (except for reference lab)
Therapies	Fee Schedule	101% of Allowable Cost
Swing Bed	RUG	101% of Allowable Cost
Ambulance Service	Fee Schedule	Fee Schedule (unless only one within 35 miles, then 101% of cost)

Medicare Payment Overview

Type of Service	PPS Hospital	CAH
O/P Clinics (facility component)	APC	101% of Allowable Cost
O/P Clinics (professional component)	Fee Schedule (reduced for site of service)	Fee Schedule Plus 15% for CAHs Electing Method II Billing (reduced for site of service)
CRNA Services	Fee Schedule (unless elect cost if less than 800 procedures/year)	Fee Schedule (unless elect cost if less than 800 procedures/year and 1 FTE/year)
Other Professional Services	Fee Schedule – Except for professional services in a rural health clinic, then generally based on allowable cost	Fee Schedule Plus 15% for CAHs Electing Method II Billing (except for professional services in a rural health clinic setting then generally based on allowable cost)
Outlier Payments	Cost – generally insignificant for rural providers	N/A

Medicare Payment Overview

Type of Service	PPS Hospital	CAH
Disproportionate Share Hospital (DSH)	Add-on to DRG payments	N/A
Graduate Medical Education (GME)/ Indirect Medical Education (IME)	Add-on to DRG payment	If approved, included in 101% of allowable cost
Exempt Units	Rehab Unit – PPS Psych Units – PPS	Limited to 10 exempt unit beds (Same reimbursement as PPS)

WIPFLI

© WIPFLI 12

Medicare Payment Overview

Type of Service	PPS Hospital	CAH
Skilled Nursing Facility	RUGs	RUGs
Home Health Agency	HHRGs	HHRGs
Hospice	Prospective rate	Prospective rate
Dialysis	Prospective rate	Prospective rate, except inpatient dialysis is 101% of allowable cost

WIPFLI

© WIPFLI 13

Acronyms

PPS	-	Prospective Payment System
CAH	-	Critical Access Hospital
DRG	-	Diagnostic Related Group
APC	-	Ambulatory Payment Classification
MDS	-	Minimum Data Set
RUGs	-	Resource Utilization Groups
HHRG	-	Home Health Resource Group

272

Introduction to Health Care Reimbursement

Sample Methods of Reimbursement Currently in Use in the Health Care Industry

Hospital	Nursing Home	Psych/Adult Rehab Services	Home Health/Hospice	Clinics
<ul style="list-style-type: none"> • Medicare <ul style="list-style-type: none"> - "Allowable" cost - Diagnosis related groups (DRGs) - Fee schedules - Add on payments - Ambulatory procedure codes (APCs) • Medicaid <ul style="list-style-type: none"> - Cost based rates - Access payments - Fee schedules - Enhanced ambulatory procedure groups • Commercial insurance <ul style="list-style-type: none"> - Contracted payors <ul style="list-style-type: none"> ▪ Negotiated discounts ▪ Rates per visit ▪ Fee schedules - Noncontracted payors <ul style="list-style-type: none"> ▪ Standard charges • Self-pay patients <ul style="list-style-type: none"> - Standard charges - Discounts as required under "Patient Protection Act" or state specific legislation - Charity care - Bed debts 	<ul style="list-style-type: none"> • Medicare <ul style="list-style-type: none"> - Resident Utilization Groups (RUGs) - Fee schedules (therapy) - "Allowable" cost for vaccines • Medicaid <ul style="list-style-type: none"> - Blended cost and acuity-based rates - Fee schedules (therapy) • Commercial insurance <ul style="list-style-type: none"> - Standard charges - Negotiated rates • Self-pay patients <ul style="list-style-type: none"> - Standard charges 	<ul style="list-style-type: none"> • Medicare <ul style="list-style-type: none"> - Diagnosis-related groups (inpatient) - "Allowable" cost - Fee schedules • Medicaid <ul style="list-style-type: none"> - Cost based rate per discharge (inpatient) - Fee schedules • Commercial insurance <ul style="list-style-type: none"> - Contracted payors <ul style="list-style-type: none"> ▪ Negotiated discounts ▪ Rates per visit ▪ Fee schedules - Noncontracted payors <ul style="list-style-type: none"> ▪ Standard charges • Self-pay patients <ul style="list-style-type: none"> - Standard charges - Discounts as required under "Patient Protection Act" or state specific legislation - Charity care - Bed debts 	<ul style="list-style-type: none"> • Medicare <ul style="list-style-type: none"> - Rates per episode of care or length of stay • Medicaid <ul style="list-style-type: none"> - Rates per episode of care or length of stay • Commercial insurance <ul style="list-style-type: none"> - Standard charges - Negotiated rates • Self-pay patients <ul style="list-style-type: none"> - Standard charges 	<ul style="list-style-type: none"> • Medicare <ul style="list-style-type: none"> - Fee schedules - "Allowance" cost for rural health clinics • Medicaid <ul style="list-style-type: none"> - Fee schedules - "Allowance" cost or per diem rates for rural health clinics • Commercial insurance <ul style="list-style-type: none"> - Contracted payors <ul style="list-style-type: none"> ▪ Negotiated discounts ▪ Rates per visit ▪ Fee schedules - Noncontracted payors <ul style="list-style-type: none"> ▪ Standard charges • Self-pay patients <ul style="list-style-type: none"> - Standard charges - Discounts as required under "Patient Protection Act" or other state specific legislation - Charity care - Bed debts

Medicare Cost-Based Reimbursement

Medicare reimbursement =
101% of Medicare allowable cost

Effective April 1, 2013, there is also a governmental budget sequestration adjustment of a 2% reduction in reimbursement after determining deductible and coinsurance amounts applicable to all Medicare claims. (Currently, the sequestration adjustment is projected to continue through 2023.)

Currently, there is legislative discussion by CMS to reduce reimbursement from the current 101% to 100% of Medicare allowable cost before sequestration.

Medicare Cost-Based Reimbursement Overview

What is "allowable" cost?

- Necessary and proper in providing services
- Must be related to patient care (includes personnel costs, administrative costs, laundry, housekeeping, dietary, etc.)
- Adequate cost data and cost finding support
- Must be "reasonable"; i.e., must follow the *"prudent buyer"* principle

Medicare Cost-Based Reimbursement Overview

What is the prudent buyer principle?

- The prudent and cost-conscious buyer not only refuses to pay more than the going (market) price for an item or service, he/she also seeks to economize by minimizing cost.
- This is especially so when the buyer is an institution or organization that makes bulk purchases and can, therefore, often gain discounts because of the size of its purchases.
- Another way to minimize cost is to obtain free replacements or reduced charges under warranties for medical devices.
- Any alert and cost-conscious buyer seeks such advantages, and it is expected that Medicare providers of services will also seek them.

Medicare Cost-Based Reimbursement Overview

Computation of "allowable" costs:

- Allowable cost = Total expense minus costs not supported by Medicare minus cost offsets.
- Examples of costs not supported by Medicare: some forms of advertising expense, bad debt expense, lobbying dues, etc.
- Examples of cost offsets: some forms of investment income, other operating revenue such as vending machine income, medical records fees, etc.

Allowable Cost Summary Based on Year End, 20XX, Medicare Cost Report

Sample Hospital FYE XX/XX/20XX Cost Report Information:

Total expenses		\$ 46,000,000
Add: Related party add-on	\$ 2,500,000	
Less: Medicare nonallowable expenses:		
Provider-based physicians	(2,400,000)	
Investment income	(10,000)	
Cafeteria	(165,000)	
Unnecessary borrowing - Nonallowable interest expense	(500,000)	
Electronic health records system depreciation	(175,000)	
Other miscellaneous revenue	(250,000)	
Subtotal		(1,000,000)
Allowable expenses		45,000,000
Less: Noncost reimbursed expenses:		
Nursing home and assisted living	(6,000,000)	
Marketing	(800,000)	
Specialty clinic	(1,200,000)	
Subtotal		(8,000,000)
Total cost reimbursed expenses		\$ 37,000,000

WIPFLI
HEALTH CARE PRACTICES

© WIPFLI LLP 20

High Level View Computation of Medicare Cost-Based Reimbursement

Inpatient and Swing Bed

- Nursing services costs component
 - Total allowable department costs *times* percent Medicare utilization
plus
- Ancillary costs component (computed for each department)
 - Total allowable department costs times percent Medicare utilization

Outpatient

- Ancillary costs component (computed for each department)
 - Total allowable department costs times percent Medicare utilization

WIPFLI
HEALTH CARE PRACTICES

© WIPFLI LLP 21

High Level Understanding of Dollar Impact on Reimbursement

Patient-Related Expense Example:

Adults and Pediatrics Medicare Utilization	75%
Increase Adults and Pediatrics Allowable Expense by	\$ 100,000
Dollar Impact on Medicare Reimbursement	<u>\$ 75,000</u>
Expenses to be paid from sources other than Medicare	<u>\$ 25,000</u>

Overhead Expense Example:

Increase Laundry Expense by	\$ 100,000
Percent of Total Cost That is Cost Reimbursed	<u>72%</u>
Estimated Medicare Allowable Expense	\$ 72,000
Average Medicare Utilization	<u>44%</u>
Dollar Impact on Medicare Reimbursement	<u>\$ 31,680</u>
Expenses to be paid from sources other than Medicare	<u>\$ 68,320</u>

WIPFLI

HEALTH CARE PRACTICE

WIPFLI 22

276

Common Myths About CAH Status

CAH Myths:

All costs will get paid...

All Medicare allowable costs for Medicare enrollees will get paid...

We're a critical access hospital; therefore, we should a/ways "break even"...



WIPFLI

HEALTH CARE PRACTICE

WIPFLI 23

Common Fact About CAH Status

CAH Fact:

You can't make a profit from Medicare.

CONFIRMED

277

Where do we go from here?



Cost Report Layout

Worksheet number is at top right-hand corner of each worksheet.

Worksheet Series	
S	Settlement, Organization, and Patient Statistical Information
A	Expense Assignment
B	Allocation of Overhead Costs
C	Patient Care Revenue and Cost-to-Charge Ratio
D	Determination of Medicare's Costs
E	Medicare Settlement and Payment Information
G	Financial Statements
H	Home Health
I	Renal Dialysis
K	Hospice
M	Rural Health Clinic

WIPFLI

WIPFLI 26

278

Basic CAH Medicare Cost Report Mechanics

Worksheet S	Worksheet A	Worksheet B	Worksheet C	Worksheet D	Worksheet E
Informational Questions	Expenses	Overhead expense allocation	Charges	Medicare/Medicaid Charges	Medicare/Medicaid Settlement
S, S-2, S-3, S-4, S-5, S-7, S-8, S-9, S-10	A, A-6, A-8, A-8-1, A-8-2, A-8-3	B Part I, B-1	C	D Part V, D-3, D-1 Parts I, II, III	E Part B, E-1, E-2 E-3 Part V
Hospital information, patient days, and other statistics	Costs reclassified, added, and subtracted	Overhead allocated to revenue-producing departments	+ Dept. revenues = Cost-to-charge ratios	X Dept. Medicare charges = Medicare cost	Compared to Medicare Payments = Settlement

WIPFLI

WIPFLI 27

Worksheet S-2

Worksheet S-2, Part I

- Series of informational questions that provide the cost report "reader" with a wealth of knowledge about the hospital.
 - Provider type and payment system
 - Debt and lease agreements
 - Provider-based physician services
 - Statistical basis
 - Contract therapy
 - Reimbursable bad debts
 - Provider summary report data
- Important to ensure all responses are accurate because they can directly impact the settlement (i.e., data may not flow to a worksheet if the response on worksheet S-2 is not accurate, which may directly impact the final cost report settlement).

Worksheet S-2, Part I

Key lines for CAHs include:

26	Geographic location
90-97	Title V and Title XIX
105	Critical access hospital
106	Elected all-inclusive for O/P services (Method II)
108	CRNA pass-through (rural election only)
109	Purchased PT, OT, ST & RT

		Y	N		
		1.00	2.00		
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & M training programs? Enter "Y" for yes or "N" for no in column 1. (See instructions) If yes, the GME elimination would not be on worksheet B, Part 1, column D5 and the program would be cost reimbursed. If yes complete worksheet D-2, Part 12, column 2. If this facility is a CAH, do SAs in an approved medical education program train in the CAH's excluded IPR and/or DRG unit? Enter "Y" for yes or "N" for no in column 2. (See instructions)	M		107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR section 482.133(c). Enter "Y" for yes or "N" for no.	Y		108.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.			109.00	
		Physical	Occupational	Speech	Respiratory
		1.00	2.00	3.00	4.00
		N	Y	Y	N

WIPFLI

HEALTH CARE PRACTICE

32

281

Worksheet S-2, Part I

Key lines for CAHs include:

118	Malpractice policy type & amounts
140	Related-party activity
144	Provider-based physicians
146	Change in allocation method
167-170	HIT meaningful use

		1.00	
167.00	Health Information Technology (HIT) Incentive in the American Recovery and Reinvestment Act	Y	10
168.00	Is this provider a meaningful user under section 1344(n)? Enter "Y" for yes or "N" for no.	450.00	104
169.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0.00	104
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (See instructions)		
		Beginning	Ending
		1.00	2.00
170.00	Enter in columns 1 and 2 the FIM beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	05/15/2013	08/13/2013
			174

WIPFLI

HEALTH CARE PRACTICE

33

Elections - All-Inclusive/Method II Billing

- Worksheet S-2 Part 1 Line 106

If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services?

Elections - All-Inclusive/Method II Billing

- What is Method II Billing?
 - Combined billing on an 851 claim form that includes both facility and outpatient professional service charges
 - ~ Facility payment continues to be 101% costs (subject to sequestration)
 - ~ Payment for professional services at 115% of Medicare fee schedule after Part B deductible and coinsurance (Note: CPT/HCPCS code required)

Elections - All-inclusive/Method II Billing

- How to make the all-inclusive/Method II billing election:
 - One-time election must be made in writing to Medicare contractor
 - Election stays in effect until hospital withdraws
 - Must be filed 30 days before beginning of cost report year
 - Applies to physician services in outpatient space, where physician reassigns billing to CAH, in a provider-based department, other than a provider-based rural health clinic, for example:
 - ~ Pathology
 - ~ Emergency room
 - ~ Outpatient clinics
 - ~ Radiology
 - ~ Outpatient surgery

Elections - All-inclusive/Method II Billing

- Does not include rural health clinic services or inpatient professional services (does include outpatient observation services)
- Cannot elect mid-year for new physicians that are outside of the departments for which you did elect Method II
- Can elect all-inclusive/Method II billing for CRNA services (usually not advisable if already receiving CRNA pass through)

Elections - Additional Bonuses Available

- The following bonuses are available for physician billing:
 - Additional payment for HPSA Bonus (10%)
 - Additional incentive payment for primary care practitioners (10%) (per ACA)
 - Additional incentive payment for rural surgeons (10%) (per ACA)
 - Telemedicine add-on for eligible site of origination of visit for qualifying telemedicine services (approximately \$25 per service/visit)

Election - CRNA Pass Through

- Worksheet S-2, Line 108

Is this a rural hospital qualifying for an exception to the CRNA fee schedule?

Election - CRNA Pass Through

- What is the CRNA Pass Through (i.e., exception to fee schedule)?
 - Cost-based reimbursement for anesthesiology services provided by a CRNA, if you are a low volume provider

WIPFLI

HEALTH CARE PRACTICE

© WIPFLI LLP 40

Elections - CRNA Pass Through

Criteria for qualification:

- Perform less than 800 surgeries per calendar year requiring anesthesia
- CRNA has less than 2,080 hours of worked time
- Qualifying criteria determined by annualizing procedures and hours through September 30
- Must be in rural county
- Hospital must have been in existence in calendar year 1987 and procedures in that year did not exceed 250 procedures performed by the CRNA
- Annual calendar year election
- Must make a written request between October 1 and November 30 of each calendar year

WIPFLI

HEALTH CARE PRACTICE

© WIPFLI LLP 41

Worksheet S-3

Worksheet S-3, Part I

Reporting of statistical data:

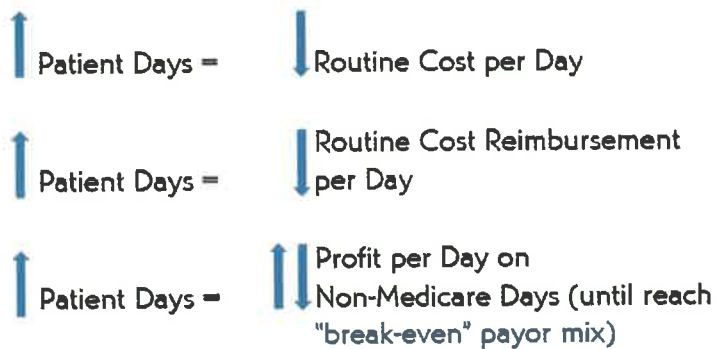
- Number of beds
- CAH hours for I/P care, excluding swing bed, nursing home, and observation
 - Critical data along with discharges used to calculate average length of stay for 96-hour rule compliance
 - Important to track hours and not merely use days times 24 hours
- Patient days
 - Report by payor type – Medicare and Medicaid
 - Report total days
- FTEs
- Discharges

Worksheet S-3, Part I

- Observation days (be sure to track where observation is occurring in the hospital and maintain logs)
- Discharges (no impact on settlement)

Worksheet S-3, Part I: Patient Days and Discharges

Assuming cost remains constant



Cost Reporting Strategies

- Accurate patient days are critical for a CAH for proper cost-based reimbursement and also for cost report optimization due to several cost reporting rules and regulations.

- Formula for routine costs and cost reimbursement calculation for inpatient services:

$$\begin{array}{rcccl}
 \text{IP Routine Direct} & & \text{Adjustments and} & & \text{Overhead} \\
 \text{Costs} & + / - & \text{Reclassifications} & + & \text{Allocated} \\
 \hline
 \text{Adults \& Peds} & + & \text{Swing Bed-SNF Days} & + & \text{Observation Days} \\
 \text{Days} & & & & \text{Equivalent} \\
 & & & & = \\
 & & & & \text{Routine} \\
 & & & & \text{Cost Per} \\
 & & & & \text{Day}
 \end{array}$$

- Medicare Inpatient Routine Reimbursement Calculated as:

$$\begin{array}{rcccl}
 \text{Routine Cost Per} & \times & \text{101\% (CAH} & \times & \text{98\% (Sequestration} \\
 \text{Day} & & \text{Reimbursement rate)} & & \text{after factoring} \\
 & & & & \text{deductible and} \\
 & & & & \text{coinsurance} \\
 & & & & \text{amounts)} \\
 & & & & = \\
 & & & & \text{Medicare CAH} \\
 & & & & \text{Inpatient Routine} \\
 & & & & \text{Reimbursement} \\
 & & & & \text{Per Day}
 \end{array}$$

WIPFLI
HEALTH CARE PRACTICES

© Wipfli LLP 46

288

Cost Reporting Strategies

Question: How Difficult is It to Count Patient Days for Cost Reporting Purposes?



Answer: It can be difficult due to many variables and to ensure proper cost calculations in the cost report.

Guiding Principle: Medicare reimbursement for inpatient and swing bed services is based on allowable costs in the inpatient nursing unit divided by number of "acute inpatient days."

WIPFLI
HEALTH CARE PRACTICES

© Wipfli LLP 47

Cost Reporting Strategies

Worksheet S-3 Part I: Patient Days and Discharges

To ensure accuracy of patient days:

- Eliminate labor and delivery days
- Count SNF and NF swing bed days separately
 - Per cost report instructions, SNF swing bed days are defined as traditional swing bed days plus HMO swing bed days
- Hospice days - If the CAH has a contractual relationship for hospice services:
 - Do not include contracted hospice days on Worksheet S-3
 - Do not include contracted hospice charges on Worksheet C
 - Offset contracted hospice revenue via Worksheet A-8 adjustment to the cost center which includes the expenses for providing the contract hospice services
- Other days – Ensure that adults & pediatrics days do not include days such as respite care or “bed and breakfast” days where acute care services are not being provided (Consider reporting these as NF days)

Cost Reporting Strategies

To ensure accuracy of patient days (Continued):

- How do we gather information for observation days?
 - Ensure observation days are based on hours of service divided by 24
 - Always round up to the next whole observation day when calculating observation day equivalents

Patient Days Exercise		
Worksheet S-3, Part I, Column 8		
		<u>Total All Patients</u>
Line 1	Hospital Adults & Peds	1,320
Line 5	Hospital Adults & Peds - Swing Bed SNF	200
Line 28	Observation Bed Days	<u>80</u>
	Total Days	<u>1,600</u>

WIPFLI HEALTH CARE PRACTICE 50

Patient Days Exercise		
Worksheet S-3, Part I, Column 8		
		<u>Total All Patients</u>
Med Surg Days	850	Line 1 Hospital Adults & Peds
Obstetric Days	365	Line 5 Hospital Adults & Peds - Swing Bed :
Labor & Delivery Days	35	Line 6 Hospital Adults & Peds - Swing Bed :
Hospice Days	50	Line 28 Observation Bed Days
Respite Days	<u>20</u>	Line 32 Labor & Delivery Days
Total Hospital Adults & Peds	1,320 A	
Swing Bed SNF	120	
Swing Bed NF	<u>80</u>	
Total Hospital Adults & Peds - Swing	200 A	
Observation Units	80 A	
Observations Days	25	
Total Days	<u>1,600</u> Sum of A	

WIPFLI HEALTH CARE PRACTICE 51

Tips on Where to Focus Efforts

Example of estimated impact of change in patient days:

Adults & Peds		
Medicare adults & peds plus SNF swing-bed days	750	750
Total adults & peds plus SNF swing-bed plus observations days	1,600	1,360
Medicare Utilization	46.9%	55.1%
Adults & Peds reimbursable costs	\$ 2,000,000	\$ 2,000,000
Medicare reimbursable costs	\$ 938,000	\$ 1,102,000
Change in Medicare reimbursable costs		\$ 164,000

WIPFLI

HEALTH CARE PRACTICE

© WIPFLI 52

Other S Worksheets

S-3, Part II-V	Wages and hours (CAHs generally exempt from reporting unless required by state Medicaid program)
S-4	Home health data
S-5	Renal dialysis data
S-7	SNF RUG data
S-8	RHC data
S-9	Hospice data
S-10	Hospital Uncompensated and Indigent Care Worksheet

WIPFLI

HEALTH CARE PRACTICE

© WIPFLI 53

Worksheet A

Worksheet A Columns

Column 1	Salaries
Column 2	Other expenses
Column 4	Reclassifications flow from Worksheet A-6
Column 6	Adjustments flow from Worksheet A-8
Column 7	Net allowable costs (to Worksheet B)

Worksheet A Lines

WIPFLI FINANCIAL SYSTEMS WIPFLI HEALTHCARE PERIOD: 01/01/2018 TO 12/31/2018 WORKSHEET A

RECLASSIFICATION AND ADJUSTMENTS OF FISCAL BALANCE OF DEPARTMENT FROM 01/01/2018 TO 12/31/2018 DEPARTMENT AND FISCAL BALANCE PER 01/01/2018 TO 12/31/2018

DEPT (ENTER DESCRIPTION)	Fiscal Year				Adjustments	Net Expense		Total
	2018	2019	2020	2021		Line A-01	Per Allocation	
GENERAL SERVICE COST CENTERS								
1.00 INPATIENT CASE MGMT W/OUT W/PCO		1,495,000	1,495,000	155,000	1,210,000	121,000	1,331,000	1.00
2.00 INPATIENT CASE MGMT W/OUT W/PCO		0	0	0	0	19,000	19,000	2.00
4.00 INPATIENT BENEFITS DEPARTMENT		0	2,000,000	2,000,000	0	2,000,000	2,000,000	4.00
6.00 INPATIENT ADMINISTRATION & GENERAL		3,130,000	3,130,000	2,200,000	0	2,200,000	5,460,000	6.00
7.00 INPATIENT MEDICATIONS		222,000	500,000	700,000	0	700,000	1,422,000	7.00
8.00 INPATIENT LABORATORY & IMAGING SERVICES		70,000	50,000	50,000	0	50,000	170,000	8.00
9.00 INPATIENT HOUSEKEEPING		270,000	80,000	310,000	0	310,000	660,000	9.00
20.00 OUTPATIENT		400,000	430,000	430,000	0	430,000	1,260,000	20.00
21.00 OUTPATIENT		0	0	0	0	0	0	21.00
30.00 OUTPATIENT ROUTINE SERVICE COST CENTERS		540,000	110,000	110,000	0	110,000	760,000	30.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00 INPATIENT ROUTINE SERVICE COST CENTERS		540,000	110,000	110,000	0	110,000	760,000	30.00
40.00 INPATIENT ROUTINE SERVICE COST CENTERS		1,500,000	100,000	1,400,000	0	1,400,000	2,900,000	40.00
45.00 INPATIENT ROUTINE SERVICE COST CENTERS		0	0	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS								
50.00 INPATIENT OPERATING ROOM		300,000	400,000	600,000	0	600,000	1,300,000	50.00
54.00 INPATIENT LABORATORY		300,000	300,000	300,000	0	300,000	900,000	54.00
55.00 INPATIENT RADIOLOGY		300,000	300,000	300,000	0	300,000	900,000	55.00
60.00 INPATIENT MEDICAL PHARMACY		300,000	300,000	300,000	0	300,000	900,000	60.00
70.00 INPATIENT MEDICAL SUPPLIES AWARDED TO PATIENTS		40,000	100,000	140,000	0	140,000	280,000	70.00
75.00 INPATIENT MEDICAL SUPPLIES AWARDED TO PATIENTS		0	0	0	0	0	0	75.00
OUTPATIENT SERVICE COST CENTERS								
20.00 OUTPATIENT SERVICE COST CENTERS		400,000	430,000	430,000	0	430,000	1,260,000	20.00
30.00 OUTPATIENT SERVICE COST CENTERS		1,400,000	100,000	1,400,000	0	1,400,000	2,900,000	30.00
40.00 OUTPATIENT SERVICE COST CENTERS		1,100,000	100,000	1,000,000	0	1,000,000	2,100,000	40.00
SPECIAL PURPOSE COST CENTERS								
105.00 SPECIAL PURPOSE COST CENTERS		1,100,000	1,100,000	1,100,000	0	1,100,000	3,300,000	105.00
106.00 SPECIAL PURPOSE COST CENTERS		1,100,000	1,100,000	1,100,000	0	1,100,000	3,300,000	106.00
107.00 SPECIAL PURPOSE COST CENTERS		1,100,000	1,100,000	1,100,000	0	1,100,000	3,300,000	107.00
NON-REIMBURSABLE COST CENTERS								
190.00 NON-REIMBURSABLE COST CENTERS		1,100,000	1,100,000	1,100,000	0	1,100,000	3,300,000	190.00
191.00 NON-REIMBURSABLE COST CENTERS		1,100,000	1,100,000	1,100,000	0	1,100,000	3,300,000	191.00
192.00 NON-REIMBURSABLE COST CENTERS		1,100,000	1,100,000	1,100,000	0	1,100,000	3,300,000	192.00

WIPFLI

HEALTHCARE SERVICES

© WIPFLI 56

203

Worksheet A Lines

Departments organized by:

- General service cost centers (Lines 1 to 23) - *Administration, plant, administration, housekeeping, etc.*
- Inpatient routine service cost centers (Lines 30 to 46) - *Adults and pediatrics, SNFs, etc.*
- Ancillary service cost centers (Lines 50 to 76) - *Laboratory, radiology, pharmacy, etc.*
- Outpatient service cost centers (Lines 88 to 93) - *Provider-based clinics, emergency room (ER), observation*
- Other reimbursable cost centers (Lines 94 to 101) - *Dialysis, DME, ambulance, home health*
- Special purpose cost centers (Lines 105 to 117) - *ASC and hospice*
- Non-reimbursable cost centers (Lines 190 to 194) - *Gift shop, adult day care, medical office building, free standing clinic, research, etc.*

WIPFLI

HEALTHCARE SERVICES

© WIPFLI 57

Cost Reporting Strategies

Worksheet A

- Expenses by department reconciled to internal and/or audited financial statements
- Prescribed cost centers, but opportunity to expand or collapse cost centers/departments (i.e., therapies)
- Review non-reimbursable cost centers/departments to determine if expenses can be directly assigned or reduced
- Compare expense by department to prior year – explain changes to ensure expenses properly recorded in each cost center/department

Worksheet A-6

Worksheet A-6

- Worksheet A-6 – provides opportunity to reclass expenses between cost centers/departments to provide for proper matching of expenses with revenue
- Could result in converting hospital expense groupings to Medicare groupings
- Common reclassifications:
 - Interest expense
 - Depreciation expense
 - Nursing salaries
 - Physician activities (i.e., benefits, rounding)

WIPFLI
HEALTH CARE PRACTICE

© Wipfl LLP 80

205

Worksheet A-6 - Common Reclassifications

- Try to keep number of reclassifications to a minimum

Health Financial Systems		SIMPLO CAR HOSPITAL				In lieu of Form 990-2012-10	
420140371047006		Provider ID: X3170				Period: Worksheet A-6 From 01/01/2014 To 12/31/2014 Submission Frequency: 12/31/2014 9:48 AM	
Cost Center	Description	Debit				Credit	Net
		Line #	Salary	Other	Ref.		
1.00	A - TO RECLASSIFY INTEREST						
	REV CAP REL COSTS-BLND & FINT	1.00	0	719,000			1.00
	TOTALS			719,000			
1.00	B - RECLASSIFY DEPRECIATION						
	REV CAP REL COSTS-BLND & FINT	1.00	0	600,000			1.00
	TOTALS			600,000			
Health Financial Systems		SIMPLO CAR HOSPITAL				In lieu of Form 990-2012-10	
4#(reclassifications)		Provider ID: X3170				Period: Worksheet A-6 From 01/01/2014 To 12/31/2014 Submission Frequency: 12/31/2014 9:48 AM	
Cost Center	Description	Debit				Credit	Net
		Line #	Salary	Other	Ref.		
1.00	A - TO RECLASSIFY INTEREST						
	INTEREST EXPENSE	1.00	0	719,000	11		1.00
	TOTALS			719,000			
1.00	B - RECLASSIFY DEPRECIATION						
	REV CAP REL COSTS-BLND & FINT	1.00	0	600,000	9		1.00
	TOTALS			600,000			
500.00 Grand Total: Debit				1,319,000			500.00

WIPFLI
HEALTH CARE PRACTICE

© Wipfl LLP 81

Cost Reporting Strategies

Worksheet A-6 (Reclassifications)

- Where do we want to reclass expense if possible?

Cost centers/departments with high Medicare utilization

Cost Reporting Strategies

Determine \$150,000 of expenses were incorrectly coded to RAD (Medicare utilization 30%) and should have been recorded in PT (Medicare utilization 50%).

What do you think the estimated reimbursement impact is?

- A. \$30,000
- B. \$45,000
- C. \$75,000

Cost Reporting Strategies

Determine \$150,000 of expenses were incorrectly coded to RAD (Medicare utilization 30%) and should have been recorded in PT (Medicare utilization 50%).

Reimbursement impact at least \$30,000 based on increase in utilization.

- Increase in Medicare utilization 20% (50% - 30%) times \$150,000

Worksheet A-8

Worksheet A-8: Adjustments to Expenses

- This worksheet provides for adjustments to remove unallowable expenses and offset nonpatient care revenue
- Adjustments increase or decrease reimbursable costs
- Medicare assumes that nonpatient service revenue is equal to the cost of the service provided
- Review all nonpatient income to determine if an offset to expense is required

Line Item	Description	Amount	Adjustment
1.00	Unallowable expenses - net of offset	1.00	-1.00
2.00	Unallowable expenses - net of offset	1.00	-1.00
3.00	Unallowable expenses - net of offset	1.00	-1.00
4.00	Unallowable expenses - net of offset	1.00	-1.00
5.00	Unallowable expenses - net of offset	1.00	-1.00
6.00	Unallowable expenses - net of offset	1.00	-1.00
7.00	Unallowable expenses - net of offset	1.00	-1.00
8.00	Unallowable expenses - net of offset	1.00	-1.00
9.00	Unallowable expenses - net of offset	1.00	-1.00
10.00	Unallowable expenses - net of offset	1.00	-1.00
11.00	Unallowable expenses - net of offset	1.00	-1.00
12.00	Unallowable expenses - net of offset	1.00	-1.00
13.00	Unallowable expenses - net of offset	1.00	-1.00
14.00	Unallowable expenses - net of offset	1.00	-1.00
15.00	Unallowable expenses - net of offset	1.00	-1.00
16.00	Unallowable expenses - net of offset	1.00	-1.00
17.00	Unallowable expenses - net of offset	1.00	-1.00
18.00	Unallowable expenses - net of offset	1.00	-1.00
19.00	Unallowable expenses - net of offset	1.00	-1.00
20.00	Unallowable expenses - net of offset	1.00	-1.00
21.00	Unallowable expenses - net of offset	1.00	-1.00
22.00	Unallowable expenses - net of offset	1.00	-1.00
23.00	Unallowable expenses - net of offset	1.00	-1.00
24.00	Unallowable expenses - net of offset	1.00	-1.00
25.00	Unallowable expenses - net of offset	1.00	-1.00
26.00	Unallowable expenses - net of offset	1.00	-1.00
27.00	Unallowable expenses - net of offset	1.00	-1.00
28.00	Unallowable expenses - net of offset	1.00	-1.00
29.00	Unallowable expenses - net of offset	1.00	-1.00
30.00	Unallowable expenses - net of offset	1.00	-1.00
31.00	Unallowable expenses - net of offset	1.00	-1.00
32.00	Unallowable expenses - net of offset	1.00	-1.00
33.00	Unallowable expenses - net of offset	1.00	-1.00
34.00	Unallowable expenses - net of offset	1.00	-1.00
35.00	Unallowable expenses - net of offset	1.00	-1.00
36.00	Unallowable expenses - net of offset	1.00	-1.00
37.00	Unallowable expenses - net of offset	1.00	-1.00
38.00	Unallowable expenses - net of offset	1.00	-1.00
39.00	Unallowable expenses - net of offset	1.00	-1.00
40.00	Unallowable expenses - net of offset	1.00	-1.00
41.00	Unallowable expenses - net of offset	1.00	-1.00
42.00	Unallowable expenses - net of offset	1.00	-1.00
43.00	Unallowable expenses - net of offset	1.00	-1.00
44.00	Unallowable expenses - net of offset	1.00	-1.00
45.00	Unallowable expenses - net of offset	1.00	-1.00
46.00	Unallowable expenses - net of offset	1.00	-1.00
47.00	Unallowable expenses - net of offset	1.00	-1.00
48.00	Unallowable expenses - net of offset	1.00	-1.00
49.00	Unallowable expenses - net of offset	1.00	-1.00
50.00	Unallowable expenses - net of offset	1.00	-1.00
51.00	Unallowable expenses - net of offset	1.00	-1.00
52.00	Unallowable expenses - net of offset	1.00	-1.00
53.00	Unallowable expenses - net of offset	1.00	-1.00
54.00	Unallowable expenses - net of offset	1.00	-1.00
55.00	Unallowable expenses - net of offset	1.00	-1.00
56.00	Unallowable expenses - net of offset	1.00	-1.00
57.00	Unallowable expenses - net of offset	1.00	-1.00
58.00	Unallowable expenses - net of offset	1.00	-1.00
59.00	Unallowable expenses - net of offset	1.00	-1.00
60.00	Unallowable expenses - net of offset	1.00	-1.00
61.00	Unallowable expenses - net of offset	1.00	-1.00
62.00	Unallowable expenses - net of offset	1.00	-1.00
63.00	Unallowable expenses - net of offset	1.00	-1.00
64.00	Unallowable expenses - net of offset	1.00	-1.00
65.00	Unallowable expenses - net of offset	1.00	-1.00
66.00	Unallowable expenses - net of offset	1.00	-1.00
67.00	Unallowable expenses - net of offset	1.00	-1.00
68.00	Unallowable expenses - net of offset	1.00	-1.00
69.00	Unallowable expenses - net of offset	1.00	-1.00
70.00	Unallowable expenses - net of offset	1.00	-1.00
71.00	Unallowable expenses - net of offset	1.00	-1.00
72.00	Unallowable expenses - net of offset	1.00	-1.00
73.00	Unallowable expenses - net of offset	1.00	-1.00
74.00	Unallowable expenses - net of offset	1.00	-1.00
75.00	Unallowable expenses - net of offset	1.00	-1.00
76.00	Unallowable expenses - net of offset	1.00	-1.00
77.00	Unallowable expenses - net of offset	1.00	-1.00
78.00	Unallowable expenses - net of offset	1.00	-1.00
79.00	Unallowable expenses - net of offset	1.00	-1.00
80.00	Unallowable expenses - net of offset	1.00	-1.00
81.00	Unallowable expenses - net of offset	1.00	-1.00
82.00	Unallowable expenses - net of offset	1.00	-1.00
83.00	Unallowable expenses - net of offset	1.00	-1.00
84.00	Unallowable expenses - net of offset	1.00	-1.00
85.00	Unallowable expenses - net of offset	1.00	-1.00
86.00	Unallowable expenses - net of offset	1.00	-1.00
87.00	Unallowable expenses - net of offset	1.00	-1.00
88.00	Unallowable expenses - net of offset	1.00	-1.00
89.00	Unallowable expenses - net of offset	1.00	-1.00
90.00	Unallowable expenses - net of offset	1.00	-1.00
91.00	Unallowable expenses - net of offset	1.00	-1.00
92.00	Unallowable expenses - net of offset	1.00	-1.00
93.00	Unallowable expenses - net of offset	1.00	-1.00
94.00	Unallowable expenses - net of offset	1.00	-1.00
95.00	Unallowable expenses - net of offset	1.00	-1.00
96.00	Unallowable expenses - net of offset	1.00	-1.00
97.00	Unallowable expenses - net of offset	1.00	-1.00
98.00	Unallowable expenses - net of offset	1.00	-1.00
99.00	Unallowable expenses - net of offset	1.00	-1.00
100.00	Unallowable expenses - net of offset	1.00	-1.00

WIPFLI

HEALTH CARE PRACTICE

8/2008 11.0 66

298

Worksheet A-8 - Adjustments

Potential A-8 revenue offsets:

Realized Investment Income to extent of interest expense (except interest on funded depreciation)

Cafeteria revenue

Rebates

Hospital assessments

Medical Record fees

Miscellaneous income

Donations received

Potential A-8 expense offsets:

Interest expense (unnecessary borrowing)

Refinancing costs

Patient phones and cable TV

Lobbying costs (portion of association dues)

Nonphysician anesthetist (unless qualify for exception to CRNA fee schedule)

Hospital assessments

Donations made to other organizations

CAH HIT adjustment for depreciation and interest

Advertising

WIPFLI

HEALTH CARE PRACTICE

8/2008 11.0 67

Cost Reporting Strategies

Worksheet A-8 Advertising Adjustment Analysis

	Allowable	Nonallowable	Don't Know???
Fund-raising			
Recruiting medical, paramedical, administrative, and clerical personnel			
Informational listing (yellow pages)			
Informational materials about the provider's operation			
TV advertisement for new service			
General public ads which seek to increase patient utilization of services			
General ads designed to invite physicians to utilize a provider's facility			
Presentation of good public image and related to patient care			
Rural health clinic advertising (special exception)			

WIPFLI
HEALTH CARE PRACTICE

© WIPFLI 88

Cost Reporting Strategies

Required to offset interest income to the extent of interest expense except for . . .

Funded Depreciation and Non-Comingled Contributions

WIPFLI
HEALTH CARE PRACTICE

© WIPFLI 89

Cost Reporting Strategies

Funded Depreciation Worksheet S-2 Part II Line 29

- Funds set aside for the acquisition of depreciable assets used to render patient care or for other capital purposes related to patient care
- Accounts designated as funded depreciation **MUST** be approved by the Board of Directors and documented in the Board minutes
- Document withdrawals from funded depreciation accounts to support acquisitions of depreciable assets
- Deposits must be held for six months prior to being withdrawn for capital acquisitions

WIPFLI

HEALTH-CARE PRACTICE

© WIPFLI 70

Cost Reporting Strategies

Unnecessary Borrowing

Funded depreciation must be used before additional dollars are borrowed; otherwise, interest expense on that portion of the borrowing is disallowed on Worksheet A-8.

WIPFLI

HEALTH-CARE PRACTICE

© WIPFLI 71

Worksheet A-8-1

Worksheet A-8-1 - Related Organizations

Related parties included on worksheet A-8-1 are organizations related to a hospital by common ownership or control.

The types of cost include:

- Services
- Facilities
- Supplies

The actual cost is reported on worksheet A-8-1.

Worksheet A-8-2

Worksheet A-8-2 - Physician Cost

Worksheet A-8-2 calculates allowable provider-based physician costs.

- Total remuneration (salaries, certain benefits, contracted services) is split into two components:
 1. Professional component – services provided directly to patients
 2. Provider component – services provided to support patients such as availability/on-call, directorships, etc.

Worksheet A-8-2 - Physician Cost

- Report total remuneration (salaries, benefits*, contracted services) in column 3
- Report professional component in column 4
- Report provider administrative costs and ER availability in column 5

HEALTH FINANCIAL SYSTEMS		SUNSHINE HOSPITAL		In Line of Work Code: 0001-00				
PROVIDER BASED PHYSICIAN ADJUSTMENT		Physician (Contract)		Period: From 01/01/2014 To 12/31/2014				
WIPFLI A Line #	WIPFLI B Line #	WIPFLI C Line #	Total Remuneration	Professional Component	Proprietary Component	WCS Amount	Physician/Physician Hour Component	Physician/Physician Hour Component
1.00	01.00 EMERGENCY	2.00	1,000,000	300,000	500,000	0	7.00	0
2.00	02.00 ADULTS & PEDIATRICS		100,000	100,000	0	0		2.00
3.00	0.00		0	0	0	0		3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			1,100,000	400,000	600,000	0		200.00

WIPFLI A Line #	WIPFLI B Line #	WIPFLI C Line #	Adjusted Rate	Percentage of Adjusted Rate	Cost of Memberships & Continuing Education	Provider Ownership Share of est. %	Physician Cost of Malpractice Insurance
1.00	01.00 EMERGENCY	2.00	8.00	9.00	13.00	25.00	14.00
2.00	02.00 ADULTS & PEDIATRICS		0	0	0	0	0
3.00	0.00		0	0	0	0	0
4.00	0.00		0	0	0	0	0
5.00	0.00		0	0	0	0	0
6.00	0.00		0	0	0	0	0
7.00	0.00		0	0	0	0	0
8.00	0.00		0	0	0	0	0
9.00	0.00		0	0	0	0	0
10.00	0.00		0	0	0	0	0
200.00			8.00	9.00	13.00	25.00	14.00

*Are certain benefits of employed physicians not required to be offset?

WIPFLI

76

Worksheet A-8-2 - ED Availability Requirements

- Emergency department (ED) logs or time study
- Contract language addressing non-patient related time
- 30-minute physician response time to emergency departments (do not need to be on premises)

WIPFLI

77

Cost Reporting Strategies

- Worksheet A-8-2: Reporting provider-based physician costs
- Professional expenses reimbursed on a fee schedule must be removed from the cost report, except for professional expenses in a non-reimbursable cost center, such as a free standing clinic.
 - Have all professional fees been properly identified such as ER, OR, EKG, radiology, lab, etc.?
 - A portion of professional fees may be allowable for standby time and/or on-call time with proper documentation. This portion of time is referred to as "provider" time.
 - The most common "provider" time is related to standby time for ER.
 - Is the hospital putting forth extra effort to properly capture the split of ER time between "professional" time and "provider" time?
 - If you pay for on-call OR coverage, this time may also be allowable as "provider" time depending on circumstances and MAC.
 - Medicare contractor will require documentation to support "provider" time identified on cost report worksheet A-8-2.

Cost Reporting Strategies

Proper documentation of "provider component" time:

- Time study requirements from the Provider Reimbursement Manual are as follows:
 - Must submit written plan to intermediary no later than 90 days prior to start of cost reporting period
 - One full work week each month of the year
 - Must use alternating weeks (i.e., Week 1 in 1st month, Week 2 in 2nd month, etc.)
 - Time study must be signed by the physician

Cost Reporting Strategies

Emergency Room Physician Time Study
SAMPLE

Physician Name: _____ Date: _____

Physician Signature: _____

To complete, place an "X" in the appropriate box for each 15-minute increment to identify the activities performed.

Part A - Provider Component					Part B - Professional Component	
Supervision	Committee Work	Administration of Department	Quality Control	Emergency Room Availability	Patient Services	Documentation
0:00	0:15					
0:15	0:30					
0:30	0:45					
0:45	1:00					
1:00	1:15					
1:15	1:30					
1:30	1:45					
1:45	2:00					

a. Emergency Room Availability. For CAHs, this includes on call time not on site at the facility. Individual must not be performing any health care services at another location at the same time.

WIPFLI
P.L.L.C.
HEALTH CARE PRACTICE

© 2011 WIPFLI 80

Cost Reporting Strategies

Alternatives to required time study:

- Time study consisting of two, two-week time studies for physicians (alternating weeks) and one week per month for midlevel practitioners
- Time study consisting of one week per quarter, alternating weeks
- ER Log

Approval from your Medicare contractor **REQUIRED**

Cost Reporting Strategies

Recommended List of Items to Maintain

- Signed contract including ER on-call or availability with provider or provider group.
- Evidence that hospital evaluated alternative methods for ER coverage before selecting current method.
- Signed allocation agreement - Exhibit 1 of CMS 339.

(Source: PRM 2109)

WIPFLI
HEALTH CARE PRACTICE

© Wipfli LLP 82

Cost Reporting Strategies

- Calculating professional ER provider component on Worksheet A-8-2 of Medicare cost report:

$$\frac{\text{Professional Component (column 4)}}{\text{Total Remuneration (column 3)}}$$

What is your percent?



WIPFLI
HEALTH CARE PRACTICE

© Wipfli LLP 83

Cost Reporting Strategies

What would happen if some of these percentages changed?

307

Cost Reporting Strategies

- Example of decreasing professional component percentage

Professional/Provider Components	50/50	49/51	45/55	40/60
Total ER provider costs	\$ 2,000,000	\$ 2,000,000	\$ 2,000,000	\$ 2,000,000
Professional component	\$ 1,000,000	\$ 980,000	\$ 900,000	\$ 800,000
Provider component	\$ 1,000,000	\$ 1,020,000	\$ 1,100,000	\$ 1,200,000
Impact of change from 50/50 split - additional reimbursement	\$ -	\$ 4,200	\$ 20,900	\$ 41,700

As the provider component goes up, the cost-to-charge ratio increases.

Impact will vary depending on Medicare volumes in the emergency room and in the hospital.



Medicare utilization of this emergency room is 20.8%.

Worksheet A-8-3

Worksheet A-8-3 - Purchased PT, OT, ST, RT

- Report only contracted PT, OT, ST, and RT
- Employed therapists are exempt from reasonable cost limits
- Reasonable costs is determined based on hourly limits and other factors
- Costs in excess of limits are eliminated on worksheet A-8

Worksheet A Series - Summary

Worksheet A Lines

WIPFLI HEALTH CARE PRACTICE
 Provider: CCM 001018
 Period: 01/01/2014 to 12/31/2014
 Worksheet: A
 Date of Print: 01/01/2015



Cost Center Description	Salaries		Other		Total (Col. 3+4)	Line Allocation (Col. 5-6)	Total Balance (Col. 7+8)	Adjustments (Col. 9-10)	Net Balance (Col. 11)	
	1.00	2.00	3.00	4.00						
GENERAL SERVICE COST CENTERS										
1.00 OFFICE SUPPLIES		1,400,000		1,400,000	1,400,000		1,400,000		1,400,000	1.00
2.00 RECEIVING - SUPPLIES										2.00
3.00 JANITORY SERVICES										3.00
4.00 JANITORY SUPPLIES										4.00
5.00 OFFICE OPERATIONS & GENERAL	2,188,900	4,100,000		2,000,000	6,288,900		6,288,900		6,288,900	5.00
6.00 OFFICE LABORATORY	200,000	500,000		700,000	700,000		700,000		700,000	6.00
7.00 OFFICE LABORATORY & SUPPLIES	273,000	40,000		313,000	313,000		313,000		313,000	7.00
8.00 OFFICE LABORATORY										8.00
9.00 OFFICE LABORATORY										9.00
10.00 OFFICE LABORATORY										10.00
11.00 OFFICE LABORATORY										11.00
12.00 OFFICE LABORATORY										12.00
13.00 OFFICE LABORATORY										13.00
14.00 OFFICE LABORATORY										14.00
EMERGENCY SERVICE CENTER COST CENTERS										
50.00 OFFICE LABORATORY	100,000	100,000		200,000	200,000		200,000		200,000	50.00
60.00 OFFICE LABORATORY										60.00
70.00 OFFICE LABORATORY										70.00
80.00 OFFICE LABORATORY										80.00
90.00 OFFICE LABORATORY										90.00
100.00 OFFICE LABORATORY										100.00
LABORATORY SERVICE COST CENTERS										
50.00 LABORATORY	200,000	400,000		600,000	600,000		600,000		600,000	50.00
60.00 LABORATORY	200,000	400,000		600,000	600,000		600,000		600,000	60.00
70.00 LABORATORY	200,000	400,000		600,000	600,000		600,000		600,000	70.00
80.00 LABORATORY	200,000	400,000		600,000	600,000		600,000		600,000	80.00
90.00 LABORATORY	200,000	400,000		600,000	600,000		600,000		600,000	90.00
100.00 LABORATORY	200,000	400,000		600,000	600,000		600,000		600,000	100.00
SPECIAL PROGRAM COST CENTERS										
110.00 SPECIAL PROGRAM	1,000,000	1,000,000		2,000,000	2,000,000		2,000,000		2,000,000	110.00
120.00 SPECIAL PROGRAM	1,000,000	1,000,000		2,000,000	2,000,000		2,000,000		2,000,000	120.00
130.00 SPECIAL PROGRAM	1,000,000	1,000,000		2,000,000	2,000,000		2,000,000		2,000,000	130.00
140.00 SPECIAL PROGRAM	1,000,000	1,000,000		2,000,000	2,000,000		2,000,000		2,000,000	140.00
150.00 SPECIAL PROGRAM	1,000,000	1,000,000		2,000,000	2,000,000		2,000,000		2,000,000	150.00
NON-REIMBURSABLE COST CENTERS										
200.00 NON-REIMBURSABLE	1,000,000	1,000,000		2,000,000	2,000,000		2,000,000		2,000,000	200.00
210.00 NON-REIMBURSABLE	1,000,000	1,000,000		2,000,000	2,000,000		2,000,000		2,000,000	210.00
220.00 NON-REIMBURSABLE	1,000,000	1,000,000		2,000,000	2,000,000		2,000,000		2,000,000	220.00
230.00 NON-REIMBURSABLE	1,000,000	1,000,000		2,000,000	2,000,000		2,000,000		2,000,000	230.00
240.00 NON-REIMBURSABLE	1,000,000	1,000,000		2,000,000	2,000,000		2,000,000		2,000,000	240.00

Overhead Cost Centers

Revenue Producing Cost Centers

Non-reimbursable Cost Centers

Expense Elimination

Worksheet A - Summary of Column 7 Costs

Information from Sample CAH Hospital Medicare cost report:

	<u>Cost Report</u>	<u>Percent</u>
Overhead cost centers	\$ 8,540,000	49%
Revenue-producing cost centers:		
Cost-reimbursed cost centers	7,300,000	42%
PPS-reimbursed cost centers	1,400,000	8%
Non-reimbursable cost centers	<u>30,000</u>	<u>1%</u>
	<u>\$ 17,270,000</u>	<u>100%</u>

Worksheet B Part I

Worksheet B - Allocation of Overhead Costs

- Allocation of overhead costs to revenue-producing and non-reimbursable cost centers/departments using statistics.
- Overhead departments include:
 - Capital-related costs – Depreciation and interest expense
 - Employee benefits
 - Administration and general
 - Plant and maintenance
 - Laundry
 - Housekeeping
 - Dietary
 - Cafeteria
 - Nurse administration
 - Medical records

Worksheet B, Part I - Allocation of All Costs

- Column 0 equals Worksheet A Column 7
- Column 26 equals Column 0 in total with no costs reported on Lines 1 through 23

The image shows two side-by-side spreadsheets from Wipfl's software. The left spreadsheet is titled 'Worksheet B - Allocation of Overhead Costs' and the right is 'Worksheet B, Part I - Allocation of All Costs'. Both contain multiple columns of data, including department names, costs, and allocation statistics. A red arrow at the bottom indicates a relationship between the two sheets, specifically pointing from the bottom of the left sheet to the bottom of the right sheet.

Worksheet B-1

Cost Reporting Strategies

Examination of Conscience



When was the last time the statistics were updated in the cost report?

- Every year?
- Every other year?
- When my cost report preparer makes me?
- Never?

Cost Reporting Strategies

- Verify that each department included in an overhead department's statistic actually provides support services to that department
- What are common questions to ask when reviewing Worksheet B-1 (examples):
 - Does housekeeping clean the gift shop or the ambulance garage?
 - Is the nursery receiving an allocation from dietary?
 - How are physician benefits allocated?
 - Does central supply/purchasing order for all departments or do some departments do their own ordering (i.e., lab, pharmacy, etc.)?
 - Does maintenance provide services to leased buildings?
- Consider directly assigning housekeeping or maintenance costs to off-site nonallowable department (i.e., medical office building) only with a proper trail and support for Medicare

WIPFLI

HEALTH CARE PRACTICE

© WIPFLI LLP 66

Cost Reporting Strategies

Statistic Considerations

Square Feet:

- Update annually based on square footage changes
 - Should be weighted based on date of change
- Did you know there are two square footage statistics?
 - Gross square footage includes hallways and common areas
 - Net square footage excludes hallways and common areas
 - Consider evaluating both methods
- Do not use gross square footage for part of the building and net square footage for other parts of the building. Maintain consistency.

WIPFLI

HEALTH CARE PRACTICE

© WIPFLI LLP 67

Cost Reporting Strategies

Statistic Considerations

Depreciation Expense:

- Tie to trial balance
- Depreciation expense:
 - Include interest and insurance expense related to equipment

Time Study:

- Update annually to match operations
- Meet time study requirements as previously discussed

Cost Reporting Strategies

Statistic Considerations

Gross Salaries:

- Tie to trial balance and:
 - Include all A-6 reclassifications that affect salaries
 - Do not include the salary statistic for any department where employee benefits are directly assigned

Cost Reporting Strategies

Statistic Considerations

FTEs (Including Nursing FTEs):

- Agree to annual payroll records
- Challenge whether the FTE uses the department
- Review reasonableness of FTEs per department (i.e., Nursing Admin)

Accumulated Costs:

- Calculated by cost report software

Cost Reporting Strategies

Statistic Considerations

Laundry Pounds:

- Accumulate annually so that statistic represents current year operations
- If using a third party, make sure you get pounds, not pieces

Meals:

- Accumulate annually so that statistic represents current year operations
- Statistic should not exceed patient days times three meals a day

Cost Reporting Strategies

Statistic Considerations

Patient Days:

- Agree to annual records
- Exclude nursery days

Costed Requisitions:

- Tie to internal records

Gross Patient Revenue:

- Typically includes professional revenue so it will not tie to Worksheet C

WIPFLI

HEALTH CARE PRACTICE

WIPFLI 102

316

Cost Reporting Strategies

Statistic Bases

<u>Cost Center/Department</u>	<u>Simplified Method</u>	<u>Standard Recommendation</u>
Building and Fixtures	Square Feet	Square Feet
Movable Equipment	Square Feet	Depreciation Expense or Square Feet
Maintenance & Repairs	Square Feet	Square Feet
Operation of Plant	Square Feet	Square Feet
Housekeeping	Square Feet	Square Feet or Time Study
Employee Benefits	Salaries	Gross Salaries
Cafeteria	Salaries	FTEs
Administrative and General	Accumulated Costs	Accumulated Costs
Laundry and Linen	Patient Days	Laundry Pounds
Dietary	Patient Days	Meals
Social Service	Patient Days	Time Study or Patient Days
Nursing Administration	Nursing Salaries	Nursing FTEs
Central Services	Costed Requisitions	Costed Requisitions
Pharmacy	Costed Requisitions	Costed Requisitions
Medical Records	Gross Patient Revenue	Gross Patient Revenue or Time Study

WIPFLI

HEALTH CARE PRACTICE

WIPFLI 103

Cost Reporting Strategies

Simplified cost method:

- ✓ Uses standard cost centers and prescribed statistics (no changes allowed)
- ✓ Less time and cost to accumulate statistics
- ✓ Prior approval must be received (90 days prior to the end of the cost reporting period), unless first year (period) as a CAH
- ✓ Once elected, must continue to use simplified method for no less than three years, unless a change of ownership occurs

Cost Reporting Strategies

Analyze financial impact of fragmented cost centers:

- Certain cost centers can be fragmented to allow for more accurate cost allocation:
 - ✓ Prior approval is needed from intermediary
 - ✓ Must submit 90 days prior to end of cost reporting period
 - ✓ Eliminates allocation of costs to areas not benefited
 - ~ Fragmenting certain administrative functions can result in less cost allocation to the non-cost-reimbursed and non-reimbursable cost centers

Cost Reporting Strategies

Fragmented Cost Centers:

- Buildings and fixtures to separately identify new building additions
- Administrative and general

Cost Center

- ✓ Communications
- ✓ Data processing
- ✓ Business office
- ✓ Other A & G

Allocation Statistic

- ✓ Number of phones
- ✓ Computers/processing time
- ✓ Patient service revenue
- ✓ Accumulated cost

Worksheet B Series - Summary

Fully Allocated Costs - Worksheet B, Part I

Line #	Dept	Wkst. A, Col 7	Allocations from General Service Cost Centers	Total Fully Allocated Costs, Wkst. B, Part I, Col 26	% of Costs Allocated
General Service Cost Centers					
1	New Capital Bldg & Fix	1,530,000	(1,530,000)	-	
2	New Capital Equip	525,000	(525,000)	-	
4	Employee Benefits	2,000,000	(2,000,000)	-	
5	Administrative & General	2,135,000	(2,135,000)	-	
7	Operation of Plant	700,000	(700,000)	-	
8	Laundry & Linen Service	85,000	(85,000)	-	
9	Housekeeping	335,000	(335,000)	-	
10	Dietary	600,000	(600,000)	-	
16	Medical Records & Library	630,000	(630,000)	-	
Inpatient Routine Service Cost Centers					
30	Adults & Pediatrics	920,000	1,037,700	1,957,700	53%
44	Skilled Nursing Facility	1,400,000	2,173,600	3,573,600	61%
Auxiliary Service Cost Centers					
50	Operating room	600,000	527,700	1,127,700	47%
54	Radiology-Diagnostic	960,000	657,100	1,617,100	41%
60	Laboratory	780,000	512,000	1,292,000	40%
66	Physical Therapy	400,000	470,900	870,900	54%
71	Medical Supplies Charged to Patients	140,000	62,800	202,800	31%
73	Drugs Charged to Patients	1,000,000	493,900	1,493,900	33%
Outpatient Service Cost Centers					
68	Rural Health Clinic	1,600,000	1,452,300	3,052,300	48%
91	Emergency	900,000	1,137,200	2,037,200	56%
Nonreimbursable Cost Centers					
	Subtotal	17,240,000	(14,600)	17,225,400	
190	Gift, Flower, Coffee Shop & Canteen	30,000	14,600	44,600	33%
	Total	17,270,000	-	17,270,000	

WIPFLI

HEALTH CARE PRACTICE

WIPFLI 108

Worksheet C

WIPFLI

HEALTH CARE PRACTICE

WIPFLI 109

Worksheet C - Cost-to-Charge Ratio

Worksheet C reports gross patient service revenue by cost center/department:

- Cost-to-charge ratio is calculated
- Cost-to-charge ratio used for ancillary reimbursement
- **Key concept: Matching of revenue and expenses**

Health Financial Systems SSMC ZUM HOSPITAL To: State of Penn 201-2532-22

COMPUTATION OF RATIO OF COSTS TO CHARGES Physician: UNAVAILABLE From: 01/01/2014 Worksheet C
 To: 12/31/2014 Part 2 Date/Time Prepared: 12/18/2014 9:48 am

Cost Center Description	Total Cost (from Wkst. B Part 2, col. 2)	Therapy Level Adj.	Total Costs	CHS DRG Reimburse	Total Costs
1.00	7.00		7.00	4.00	9.00
INPATIENT NURSING SERVICE COST CENTERS					
10.00 02000 NURSES & PHYSICIAN	1,987,664		1,987,664	0	1,987,664 80.00
44.00 04000 SKILLED NURSING FACILITY	1,571,817		1,571,817	0	1,571,817 60.00
45.00 04100 NURSING FACILITY				0	0 45.00
ANCILLARY SERVICE COST CENTERS					
50.00 05200 OPERATING ROOM	1,127,701		1,127,701	0	1,127,701 50.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	1,817,100		1,817,100	0	1,817,100 50.00
60.00 06000 LABORATORY	1,291,187		1,291,187	0	1,291,187 60.00
66.00 06600 PHYSICAL THERAPY	870,944		870,944	0	870,944 60.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	202,773		202,773	0	202,773 71.00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0		0	0	0 72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	1,491,952		1,491,952	0	1,491,952 73.00
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC	1,052,144		1,052,144	0	1,052,144 88.00
93.00 09300 EMERGENCY	2,037,188		2,037,188	0	2,037,188 93.00
94.00 09400 OBSERVATION BEDS (NON-RESTRICTED RWTS)	241,711		241,711	0	241,711 94.00
SPECIAL PURPOSE COST CENTERS					
113.00 11300 INTEREST EXPENSE					113.00
200.00 Subtotal (see instructions)	17,460,133		17,460,133	0	17,460,133 200.00
201.00 Less: Observation Beds	241,711		241,711		241,711 201.00
202.00 Total (see instructions)	17,218,422		17,218,422	0	17,218,422 202.00

WIPFLI
HEALTH CARE REACTOR

© Wipfl LLP 110

320

Cost Reporting Strategies

- All professional services reimbursed on a fee schedule must be eliminated on Worksheet C
 - Emergency room physicians
 - Anesthetist/CRNA (if not cost reimbursed)
 - Provider-based clinic physicians
 - Radiologist
 - Etc.
- Grouping of revenue must match grouping of expense

WIPFLI
HEALTH CARE REACTOR

© Wipfl LLP 111

Cost Reporting Strategies

Department	Sample Cost-to-Charge Ratio
Operating room	.678414
Radiology - Diagnostic	.358009
Laboratory	.700380
Respiratory therapy	.657865
Physical therapy	.834908
Medical supplies charged to patients	.313127
Implants charged to patients	.300117
Drugs charged to patients	.376038
Clinic	1.137843
Emergency	.911530
Observation beds (nondistinct part)	.301296

- Cost-to-charge ratio over 1.0 means costs exceed charges.
- Cost-to-charge ratios greater than 1.0 or a change of greater than 10% compared to the prior year may be questioned by the Medicare contractor.
- Cost-to-charge ratio near zero means charges greatly exceed cost.
- Cost-to-charge ratios should be comparable to the prior filed cost report or an explanation of the change should be available.

WIPFLI
HEALTH CARE PRACTICE

Note: Total charges on Worksheet C exclude professional fees

© Wipfli LLP 112

Cost Reporting Strategies

Typical Departments With Cost-to-Charge Ratio Over 1.0:

- 1 Low volume departments such as labor and delivery or speech therapy
- 2 High cost departments such as emergency room, clinic, and observation
- 3 Cost report preparation errors such as:
 - Anesthesia – Calculation of professional component costs
 - Medical supplies – Expense reported in medical supply department while charges reported in department utilizing the supply
 - Laboratory – Lab gross-up not completed
- 4 Start-up departments such as operating room with a new surgeon

WIPFLI
HEALTH CARE PRACTICE

© Wipfli LLP 113

Worksheet C - Cost-to-Charge Ratio

- Column 6 and 7 equal the hospital's inpatient and outpatient service revenue per the general ledger, less any revenue billed for professional services
- Column 8 total must be reconciled to internal or audited financial statements
- Cost-to-charge ratios are computed for ancillary departments (Column 9)

WIPFLI Financial Systems SAMPLE CASH HOSPITAL In Lieu of Form 990-2551-JE

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider: CMC-NALLEN Period: From 01/01/2014 Part I Worksheet C
 To 12/31/2014 Part II Worksheet C
 01/01/2014 01/01/2014 01/01/2014 01/01/2014

Cost Center Description	Charges		Total (Col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio
	Inpatient	Outpatient			
INPATIENT ROUTINE SERVICE COST CENTERS					
00.00 01000 ADULT & PEDIATRICS	1,400,000		1,400,000		30.00
44.00 04400 SKILLED NURSING FACILITY	1,900,000		1,900,000		44.00
45.00 04500 NURSING FACILITY	0		0		45.00
ANCILLARY SERVICE COST CENTERS					
50.00 01000 OPERATING ROOM	710,000	2,900,000	3,610,000	0.139122	0.000000
54.00 01400 RADIOLOGY-DIAGNOSTIC	400,000	1,300,000	1,700,000	0.287792	0.000000
60.00 01000 LABORATORY	400,000	1,300,000	1,700,000	0.196188	0.000000
66.00 02000 PHYSICAL THERAPY	425,000	1,100,000	1,525,000	0.104931	0.000000
71.00 01200 MEDICAL SUPPLIES CHARGED TO PATIENTS	180,000	220,000	400,000	0.190311	0.000000
72.00 01200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0.000000	0.000000
71.00 01200 DRUGS CHARGED TO PATIENTS	500,000	2,800,000	3,300,000	0.133538	0.000000
OUTPATIENT SERVICE COST CENTERS					
84.00 02800 RURAL HEALTH CLINIC	0	1,100,000	1,100,000		84.00
91.00 02100 EMERGENCY	50,000	1,400,000	1,450,000	1.236899	0.000000
92.00 02200 OBSERVATION BEDS (NON-OUTPATIENT PART)	100,000	800,000	900,000	0.148119	0.000000
SPECIAL PURPOSE COST CENTERS					
111.00 11000 INTEREST EXPENSE					111.00
200.00 20000 Subtotal (See Instructions)	8,205,000	18,620,000	26,825,000		200.00
201.00 20100 Less Overpayment Beds					201.00
202.00 20200 Total (See Instructions)	8,205,000	18,620,000	26,825,000		202.00

WIPFLI

HEALTHCARE PRACTICE

WIPFLI 114

322

Worksheet D & E

WIPFLI

HEALTHCARE PRACTICE

WIPFLI 115

Worksheet D Series - Determines Medicare's Costs

- Worksheet D Series calculates Medicare's cost for services provided to Medicare patients
- Applies cost-to-charge ratio by department to Medicare charges to estimate the Medicare cost
- Medicare patient days, charges, payments, and other processed claims information is provided by Medicare on the provider statistical and reimbursement (PS&R) report
- Group PS&R revenue by revenue code to match cost centers where related revenue and expenses recognized on Worksheet A series and Worksheet C series

Medicare PS&R

- Suggestions for running PS&R:
 - Attempt to run reports well in advance (at least 45 days) to ensure you can access data needed for your cost report
 - For cost report PS&R, we suggest you use a paid-through date that is as close as possible to the due date of your cost report (be sure to review that claim billing is not behind or the final settlement could change significantly)
 - Passwords in the online PS&R system expire every 60 days

Medicare PS&R

Cost Report Worksheet	Related PS&R Schedule
	<u>Statistical Data</u>
S-3	Reports 110, 118, 180, 210, 399, 710
	<u>Charges</u>
D-3 Hospital	Report 110 – Inpatient Part A (Charges)
D-3 SNF	Report 210 – SNF - Inpatient Part A (Charges)
D-3 S/B SNF	Report 180 – Swing bed SNF (Charges)
D Part V	Report 850 – Outpatient (Charges)
S-4	Report 399 – Home health

WIPFLI

HEALTH CARE PRACTICE

WIPFLI 118

324

Medicare PS&R

Cost Report Worksheet	Related PS&R Schedule
	<u>Payments</u>
E-1, Hospital, Col 2	Report 110 – Inpatient Part A (net reimbursement)
E-1, Hospital, Col 4	Report 850 – Outpatient (net reimbursement)
E-1, SNF, Col 2	Report 210 – Inpatient Part A (net reimbursement)
E-1, S/B - SNF, Col 2	Report 180 – Swing bed SNF (net reimbursement)
M-5	Report 710 – Rural health clinic (net reimbursement)
H-4	Report 399 – Home health

WIPFLI

HEALTH CARE PRACTICE

WIPFLI 119

Worksheet D Part V (outpatient) Worksheet D-3 (inpatient, SNF, swing bed)

Ancillary Hospital Costs Allocated to Medicare Services

- Cost-to-charge ratio from Worksheet C
- Outpatient Medicare charges from PS&R
- Ratio times charge equals Medicare cost

WIPFLI Hospital System - SUMMIT HOSPITAL - 31 State St. Columbus, OH 43215
 Department of Medicare, Other Health Services and Ancillary Costs - Provider: 000-00000 - Period: 01/01/2014 - 12/31/2014
 Worksheet D - Form: WIPFLI0014 - Date: 12/29/2014 9:49 AM

Cost Center Description	CHRG		CHRG		CHRG		CHRG		CHRG	
	Cost to Charge Ratio	Charge	Medicare	Non-Medicare	Medicare	Non-Medicare	Medicare	Non-Medicare	Medicare	Non-Medicare
ANCILLARY SERVICE COST CENTERS										
44.00 RADIO PRACTICE ROOM	0.12412	0	261,500	0	0	0	0	0	0	0
44.00 RADIO LABORATORY	0.12412	0	2,000,000	0	0	0	0	0	0	0
44.00 RADIO LABORATORY	0.12412	0	2,000,000	0	0	0	0	0	0	0
71.00 ST200 MEDICAL SUPPLIES (CHARGED TO PATIENT)	0.00000	0	0	0	0	0	0	0	0	0
72.00 ST200 MEDICAL SUPPLIES (CHARGED TO PATIENT)	0.00000	0	0	0	0	0	0	0	0	0
73.00 ST200 MEDICAL SUPPLIES (CHARGED TO PATIENT)	0.37526	0	400,000	0	0	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS										
44.00 RADIO PRACTICE ROOM (LINE)	0.12412	0	261,500	0	0	0	0	0	0	0
44.00 RADIO LABORATORY (LINE)	0.12412	0	2,000,000	0	0	0	0	0	0	0
71.00 ST200 MEDICAL SUPPLIES (CHARGED TO PATIENT)	0.00000	0	0	0	0	0	0	0	0	0
72.00 ST200 MEDICAL SUPPLIES (CHARGED TO PATIENT)	0.00000	0	0	0	0	0	0	0	0	0
TOTAL			5,000,000	0	0	0	0	0	0	0

WIPFLI
HEALTH CARE PRACTICE

Medicare PS&R

- Department Report by Revenue Code
 - Assists the cost report preparer in identifying which department the charges on the PS&R are related to
 - The report matches revenue to the appropriate revenue codes and departments
 - Using a department report by revenue code can increase the accuracy of the cost report

Cost Reporting Strategies

- How to determine Routine Medicare Utilization?

	Total Days	Medicare Days	Medicare Utilization
Routine	3,377	2,729	81%

Total days include:

A & P	Worksheet S-3, Part I, Line 1, Col 8
Swing bed SNF	Worksheet S-3, Part I, Line 5, Col 8
Observation	Worksheet S-3, Part I, Line 28, Col 8

Medicare days include:

A & P	Worksheet S-3, Part I, Line 1, Col 6
Swing bed SNF	Worksheet S-3, Part I, Line 5, Col 6

WIPFLI
HEALTH CARE PRACTICES

© Wipfli LLP 124

327

Cost Reporting Strategies

- How to determine Ancillary Medicare Utilization?

Ancillary Department	Wks C Total Charges	Wks D, V				Wks C Total	Medicare Utilization	Wks C Cost-to-Charge Ratio
		OP	I/P	Swing Bed	Total			
50 Operating room	\$ 1,368,900	\$ 427,400	\$ 230,000	\$ -	\$ 657,400	48%	0.5074	
53 Anesthesiology	531,300	177,000	105,000	-	282,000	53%	0.6516	
54 Radiology	2,236,400	951,000	247,000	27,000	1,225,000	55%	0.3867	
60 Laboratory	2,369,500	1,041,000	536,000	25,000	1,602,000	67%	0.3086	
60.01 Blood	122,700	34,000	30,000	4,000	68,000	56%	0.2048	
65 Respiratory therapy	579,100	123,000	241,000	31,000	395,000	68%	0.2178	
66 Physical therapy	995,500	157,000	62,000	79,000	298,000	30%	0.4968	
67 Occupational therapy	264,000	17,000	37,000	63,000	117,000	44%	0.3853	
68 Speech therapy	73,800	11,000	4,000	1,500	16,500	22%	0.3039	
69 Electrocardiology	418,000	76,000	82,000	700	158,700	38%	0.2209	
71 Medical supplies to patients	1,712,800	332,000	733,000	109,000	1,174,000	69%	0.3477	
73 Drugs charged to patients	60,800	11,000	31,000	4,300	46,300	76%	0.2310	
91 Emergency	1,846,000	780,000	162,000	1,000	923,000	50%	0.4853	
92 Observation beds	235,000	103,000	-	-	103,000	44%	0.4168	
95 Ambulance	530,200	243,000	-	-	243,000	46%	0.4465	
Totals	\$ 13,371,800	\$ 4,463,400	\$ 2,500,000	\$ 345,500	\$ 7,308,900	55%		

WIPFLI
HEALTH CARE PRACTICES

© Wipfli LLP 125

Cost Reporting Strategies

- If you had the ability to record expenses in any department on the previous slide, which one would you select?

WIPFLI
HEALTH CARE PRACTICES

© Wipfli LLP 126

Worksheet E Series - Medicare Settlements

Medicare settlements:
 101% of costs (routine and ancillary)
 Less:
 ○ Deductible
 ○ Coinsurance
 Plus + Medicare bad debts
 Less – Sequestration adjustment (2% of net of above lines)

= Total Medicare reimbursable cost
 Less – Payments received (see E-1)

= Medicare settlement

WIPFLI
HEALTH CARE PRACTICES

© Wipfli LLP 127

Medicare Bad Debts

Bad debts are allowable if:

- Amount pertains to uncollectible Medicare deductible and coinsurance amounts
- Does not relate to physician professional services
- Only for Medicare bad debts (do not include Medicare HMO beneficiaries)
- Unless patient has been determined to be indigent, write-off should not be less than 120 days after first billing to beneficiary
- Amount written off within cost reporting period and considered worthless when returned from collection agency (if sent to a collection agency)
- Collection efforts must be the same for all payor types
- Any recoveries of bad debts claimed in prior years are offset against amounts claimed in current year

WIPFLI
A Division of
HEALTH CARE PRACTICE

© Wipfli LLP 128

Medicare Bad Debts

May be claimed without collection effort if:

- Medicare/Medicaid crossover claim, except Medicare has a must bill policy—therefore, if you claim a Medicare bad debt, it must be billed to the State even if you know it will not be paid
- Indigent patients with supporting proof of indigence
- Bankrupt patients with supporting proof of bankruptcy

WIPFLI
A Division of
HEALTH CARE PRACTICE

© Wipfli LLP 129

Medicare Bad Debts

Documentation required to support claimed amounts may include:

- Medicare remittance advice
- Medicaid remittance advice
- Supplementary insurance remittance advice
- Copy of UB
- Patient history information
- Copies of bills sent to patients
- Documentation supporting collection efforts (i.e., considered worthless when returned from collection agency)
- Electronic listing of bad debts claimed that includes patient name, Medicare number, dates of service, indigence, write-off date, amounts, etc.

Worksheet G

Financial Statements

G	Balance sheet
G-1	Fund balance
G-2	Patient revenues
G-3	Revenue & expense

Clinic Services

Clinic Services

Types of Clinics

- Free standing clinic
- Free standing rural health clinic
- Provider-based clinic
- Provider-based rural health clinic

Clinic Services

Free Standing vs Provider-Based

Free Standing Clinic – A medical clinic operating as its own entity. A free standing clinic may be owned by another entity such as a hospital or by a group of physicians.

Provider-Based Clinic – A clinic owned and operated as an "outpatient department" of the hospital similar to other hospital departments such as x-ray, laboratory, ER, etc.

How Does a Provider-Based Clinic Work?

Provider-Based Clinic - Key Concepts

There are four general criteria that apply to all sites seeking provider-based status:

- **Common licensure**— meaning the operations of the department are operating as a department of the hospital it is considered a part of.
- **Clinical integration**— meaning the clinic records and activities are integrated as with any other hospital department with reporting responsibility of the department directly to hospital leadership.
- **Financial integration**— meaning the financial and billing activities of the provider-based department are included in the activities of the hospital.
- **Public awareness**— meaning the provider-based department is presented to the public as a department of the hospital.

How Does Provider-Based Billing Work?

- Financial and billing example for CPT 99213, a common midlevel evaluation and management code:
 - Patients, other than Medicare patients, are billed on CMS Form 1500 as a global service as a free standing clinic.
 - Medicare patients are billed differently:
 - ~ The professional service is billed as site-of-service facility with a Medicare reimbursement rate of \$49.87 compared to the free standing clinic rate of \$70.46.
 - ~ PPS Hospital: The technical service is billed and reimbursed separately as an ambulatory procedure code (APC) payment in the amount of \$85.98.
 - ~ CAH Hospital: The technical service is billed and reimbursed separately based on available cost.

How Does Provider-Based Billing Work?

Medicare Reimbursement Example for Provider-Based Clinic vs. Freestanding Clinic

PPS Hospital Sample

Sample Service (CPT 99213)	9913 Professional	APC G0463 Facility	99213 Global (or Total)
Freestanding clinic			70.46
Provider based department of PPS hospital	49.87	85.98	135.85
Net increase in reimbursement			65.39

CAH Hospital Sample

Sample Service (CPT 99213)	9913 Professional	CCR of Clinic Dept. Facility	99213 Global (or Total)
Freestanding clinic			70.46
Provider based department of CAH hospital	49.87	87.50	137.37
Net increase in reimbursement			66.91

This example reflects the difference in Medicare reimbursement between a free standing clinic and a provider-based department of a hospital for both a PPS and CAH hospital.

How Does a Provider-Based Rural Health Clinic Work?

Provider-Based RHC - Key Concepts

In general, the requirements are as follows:

- Located in a "rural" and "underserved" community.
- Must employ at least one nurse practitioner (NP) or physician assistant (PA).
- Required to be staffed by NP or PA or certified nurse midwife (CNM) who must be on site to see patients at least 50% of the time clinic is open.
- Other staff may work under contract.
- A physician must supervise each NP, PA, or CNM consistent with state and federal law.
- Capable of delivering outpatient primary care services (direct services, basic lab services, emergency services).
- Maintain a patient health record system and deliver health care services under the guidance of written policies and procedures.

How Does RHC Billing Work?

- Medicare reimbursement (and in some states Medicaid as well) in a provider-based RHC, for both the professional and technical services, is based on allowable costs.
- On an interim basis, a visit-based reimbursement rate is established, with final settlement based on the filing and review of Medicare and, if applicable, Medicaid cost reports.
- Medicare has established annual minimum productivity thresholds for midlevel providers and physicians. If providers do not meet minimum visit thresholds, the allowable costs are divided by the minimum productivity thresholds, thus reducing reimbursable cost to the extent productivity standards are not met.
- The billing process for payors other than Medicare is consistent with a free standing clinic.

How Does Provider-Based RHC Billing Work?

Medicare Reimbursement Example for Provider-Based Clinic or Provider-Based RHC vs. Free Standing Clinic

Sample Service (CPT 99213)	9913 Professional	APC G0463 Facility	99213 Global (or Total)
Free standing clinic visit			70.46
Provider based clinic - PPS hospital	49.87	85.98	135.85
Provider based clinic - CAH hospital	49.87	87.50	137.37
Provider based rural health clinic			222.35

This example reflects the difference in Medicare reimbursement between a free standing clinic and a provider-based department of a hospital.

Clinic Services

Medicare Reimbursement – Summary:

- Free Standing Clinic: Fee schedule reimbursement
- Provider-Based Clinic (treat as a hospital department):
 - Professional Component: Fee schedule reimbursement
 - Facility Component: Cost-based reimbursement (CAH)/APC (PPS)
- Rural Health Clinic (RHC): Cost-based reimbursement
 - Independent RHC: Cost-based up to annual per encounter limit
 - Provider-Based RHC: Cost-based without per encounter limit, if hospital the RHC is provider-based to is less than 50 beds
 - Both types of RHCs are subject to a provider productivity standard to receive full cost reimbursement or rate per encounter

Worksheet M Series

Worksheet M Series

RHC Cost Report Components

- Trial Balance of Expenses
- Reclassification and Adjustment of Trial Balance of Expenses
 - Reclassifications
 - Adjustments
 - Related-party adjustments
- RHC Provider Statistics
- Flu/PPV Vaccine Costs
- Visits
- Overhead
- Determination of Medicare Reimbursement and Payments

Worksheet M Series

Cost Report Requires Separation of Staff Costs

- Health Care Staff Costs:
 - Physician
 - Physician Assistant
 - Nurse Practitioner
 - Visiting Nurse
 - Other Nurse
 - Clinical Psychologist
 - Clinical Social Worker
- Facility Overhead Costs:
 - Office Staff
- Cost Other Than RHC Services:
 - Laboratory
 - Radiology
 - Hospital Services
 - Other

Worksheet M Series

Cost Report Example

	COMPEN- SATION	OTHER COSTS	TOTAL	RECLASS- IFICATIONS	NET EXPENSES FOR ALLOCATION
	1	2	3	4	7
FACILITY HEALTH CARE STAFF COSTS					
1 Physician	850,000	150,000	1,000,000		1,000,000
2 Physician Assistant	120,000	40,000	160,000		160,000
3 Nurse Practitioner					
4 Visiting Nurse					
5 Other Nurse	175,000		175,000		175,000
6 Clinical Psychologist					
7 Clinical Social Worker					
8					
9 Other Facility Health Care Staff Costs					
10 Subtotal (sum of lines 1-9)	1,145,000	190,000	1,335,000	-	1,335,000

Worksheet M Series

Identify Costs of Non-RHC Services

- Laboratory services
- Diagnostic radiology
- Hospital patients (inpatient/ER/ASC)
- Medical directorships
- Mammography
- DME

Worksheet M Series

Cost Report Requires Separation of FTEs and Visits

- Health Care Provider FTEs and Visits:
 - *Physician*
 - *Physician Assistant*
 - *Nurse Practitioner*
 - *Visiting Nurse*
 - *Clinical Psychologist*
 - *Clinical Social Worker*

Worksheet M Series

Common Mistakes Calculating FTEs:

DO record FTE for clinic time only:

- *Time spent in the clinic*
- *Time with SNF patients*
- *Time with swing bed patients*

DO NOT include non-clinic time for FTE:

- *Hospital time (inpatient or outpatient)*
- *Administrative time*
- *Committee time*

WIPFLI

HEALTHCARE PRACTICE

WORKSHEET 150

340

Worksheet M Series

Sample Reconciliation of Provider FTE:

Clinical FTE	0.70
Administrative FTE	0.05
Hospital FTE	0.20
Medical Director FTE	<u>0.05</u>
Total FTE	1.00

WIPFLI

HEALTHCARE PRACTICE

WORKSHEET 151

Worksheet M Series

RHC Encounters/Visits

"The term 'visit' is defined as a face-to-face encounter between the patient and a physician, physician assistant, nurse practitioner, nurse midwife, specialized nurse practitioner, visiting nurse, clinical psychologist, or clinical social worker during which an RHC service is rendered."

RHC Manual, Ch.504

Worksheet M Series

Common Mistakes Calculating RHC Visits:

- DO include all "visits" that:
 - Take place in the RHC during hours of operation,
 - Home visits, and
 - SNF visits for all payors.
 - Swing bed visits for all payors.
- DO NOT include the following "visits":
 - Hospital visits (either inpatient or outpatient visits) or
 - "Nurse-only" visits in the RHC setting.

Worksheet M Series

RHC Visits

- Counting of "visits" is easier said than done.
- Do not include the following in your visit count:
 - Units of service instead of visits
 - Non-visits (e.g., nurse-only 99211)
 - Non-RHC visits (e.g., hospital visits)
 - Non-billable visits (e.g., cash only)
- Remember: higher visits = lower cost per visit = lower rate!

WIPFLI

HEALTH CARE PRACTICE

WIPFLI 154

Worksheet M Series

Productivity Standards:

- *Physician 4,200 visits annually for 1.0 FTE*
- *Midlevel 2,100 visits annually for 1.0 FTE*

Total visits used in calculation of cost per visit is the greater of the actual visits or minimum allowed (FTEs x Productivity Standard).

An exemption to the productivity standards may be requested on an annual basis; however, exemption requirements are vague and may be difficult to obtain. Need to show a unique circumstance as to why the standard should be reduced.

WIPFLI

HEALTH CARE PRACTICE

WIPFLI 155

Medicare Cost Report – Sample Worksheet M-2

Visits and Productivity Position	Number of FTEs	Total Visits	Productivity Standard	Minimum Visits	Greater of Total Visits or Minimum Visits
1 Physician	1.00	2,000	4,200	4,200	
2 Physician Assistant	-	-	2,100	-	
3 Nurse Practitioner	1.30	3,200	2,100	2,730	
4 Subtotal	2.30	5,200		6,930	6,930

Visits and Productivity Position	Number of FTEs	Total Visits	Productivity Standard	Minimum Visits	Greater of Total Visits or Minimum Visits
1 Physician	0.70	2,000	4,200	2,940	
2 Physician Assistant	-	-	2,100	-	
3 Nurse Practitioner	1.30	3,200	2,100	2,730	
4 Subtotal	2.00	5,200		5,670	5,670

WIPFLI

HEALTH CARE PRACTICE

© Wipfli LLP 156

Worksheet M Series

RHC Payment Rate Calculation

$$\frac{\text{Allowable RHC Costs}}{\text{Greater of Total Visits or Minimum Visits}} =$$

RHC Cost Per
Encounter

WIPFLI

HEALTH CARE PRACTICE

© Wipfli LLP 157

Worksheet M Series

Allowable RHC Costs	<u>\$ 750,000</u>	<u>\$ 750,000</u>
Greater of Total Visits or Minimum Visits	<u>6,930</u>	<u>5,670</u>
RHC Cost per Encounter	<u>\$ 108</u>	<u>\$ 132</u>
Difference		<u>\$ 24</u>
Medicare visits		<u>3,000</u>
Increase in reimbursement		<u>\$ 72,000</u>

WIPFLI
HEALTH CARE PRACTICE

Worksheet 158

Worksheet M Series

How many of you have Rural Health Clinics currently not meeting the RHC productivity standards?

WIPFLI
HEALTH CARE PRACTICE

Worksheet 159

Other Cost Report Worksheets

- H Series = Home Health
- K Series = Hospice
- I Series = Dialysis
- Subproviders = Psych, Acute Rehab, SNF
 - May require additional D and E Series worksheets

Useful Information

- Cost-to-charge ratios W/S C
- Cost per day W/S D-1
- Cost per visit (RHC) W/S M-3
- Cost per visit (HHA) W/S H-3
- Charges I/P & O/P W/S C
- Patient days W/S S-3
- FTEs W/S S-3
- Direct cost by department W/S A
- Allocated cost W/S B, Part 1
- Statistical data W/S B-1
- Medicare inpatient cost W/S D-1
W/S D-3
- Medicare outpatient cost W/S D, Part V

Recommended Questions for Review of Cost Report

- Do worksheets A and C reconcile to our internal or audited financial statements?
- Have we reviewed all miscellaneous revenue and expense accounts for any necessary A-8 cost adjustments?
- Have we captured all allowable costs from related parties (if any)?
- Have we summarized time studies for physicians or other departments in the current year?
- Do patient days reconcile to internal statistics or revenue reports?
- Have statistics on B-1 been reviewed for reasonableness?
- Are costs assigned or allocated to non-reimbursable cost centers appropriate (including cost centers such as nursery, labor and delivery, nursing home, etc.)?
- Are cost-to-charge ratios consistent and reasonable between years?
- Have professional fees been properly excluded from worksheet C?
- Have we reviewed FTEs and minimum visits in the rural health clinics (if applicable)?

Questions?

Thank you!

WIPFLI
CPAs and Consultants
HEALTH CARE PRACTICE

WIPFLI 104

Today's Presenters:



Kathy LaBrake
Partner, Health Care Practice
715.843.8351
klabrake@wipfli.com



Holly Pokrandt
Partner, Health Care Practice
715.858.6627
hpokrandt@wipfli.com

WIPFLI
CPAs and Consultants
HEALTH CARE PRACTICE

wipfli.com/healthcare



WIPFLI^{LLP}

CPAs and Consultants

HEALTH CARE PRACTICE

wipfli.com/healthcare

Northern Inyo Hospital

Bishop, California

Fiscal Strategic
Planning
April 21, 2016



WIPFLI^{LLP}
CPAs and Consultants
HEALTH CARE PRACTICE

Today's Agenda

- 2:00 - 2:15 Introductions/Overview of the Day
- 2:15 - 3:00 The Future of Rural Healthcare
- 3:00 – 3:45 Key Success Factors for Critical Access Hospitals
- 3:45 - 4:00 Break
- 4:00 - 4:15 Orientation to Strategic Planning
- 4:15 - 5:00 Exercise: Strengths, Weaknesses, Opportunities and Threats
- 5:00 - 5:45 Discussion of Future Direction and Prioritization
- 5:45 - 6:00 Wrap up and next steps



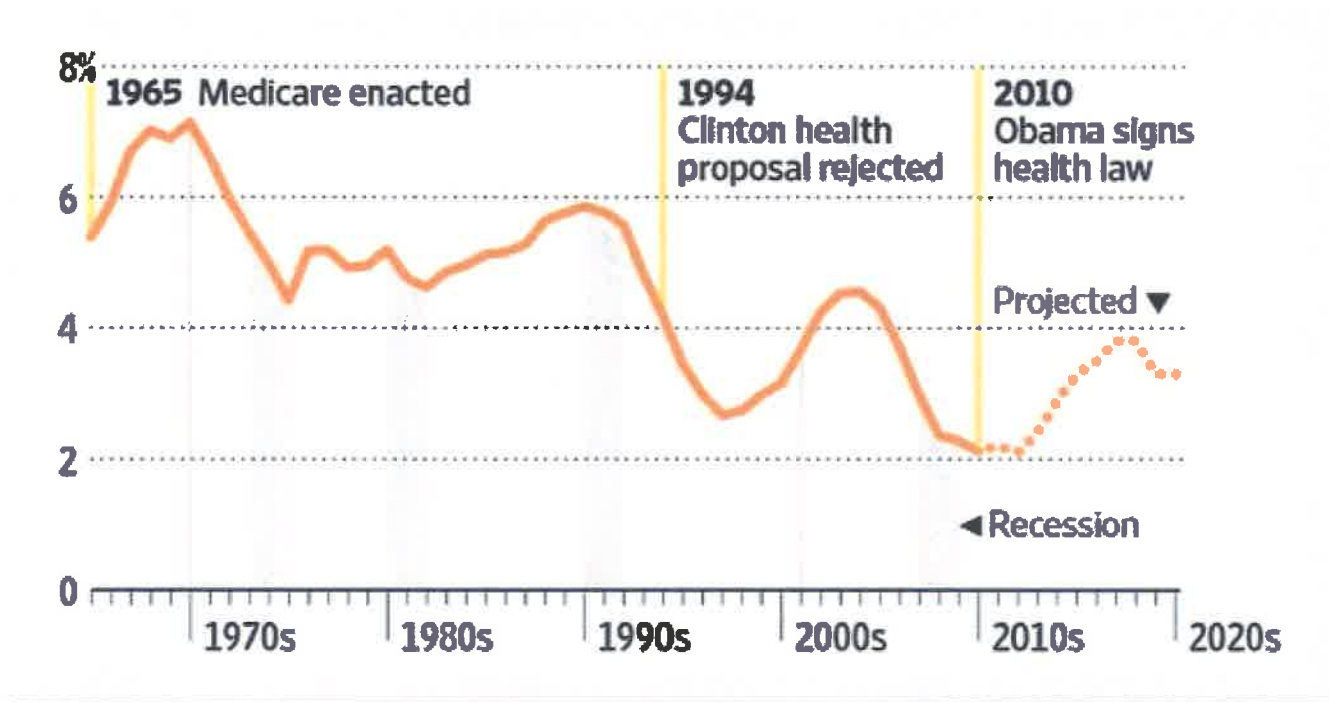
Today's Environment

WIPFLI^{LLP}
CPAs and Consultants
HEALTH CARE PRACTICE

A New Era for Healthcare



Healthcare cost *inflation* has been tracking to a historic low

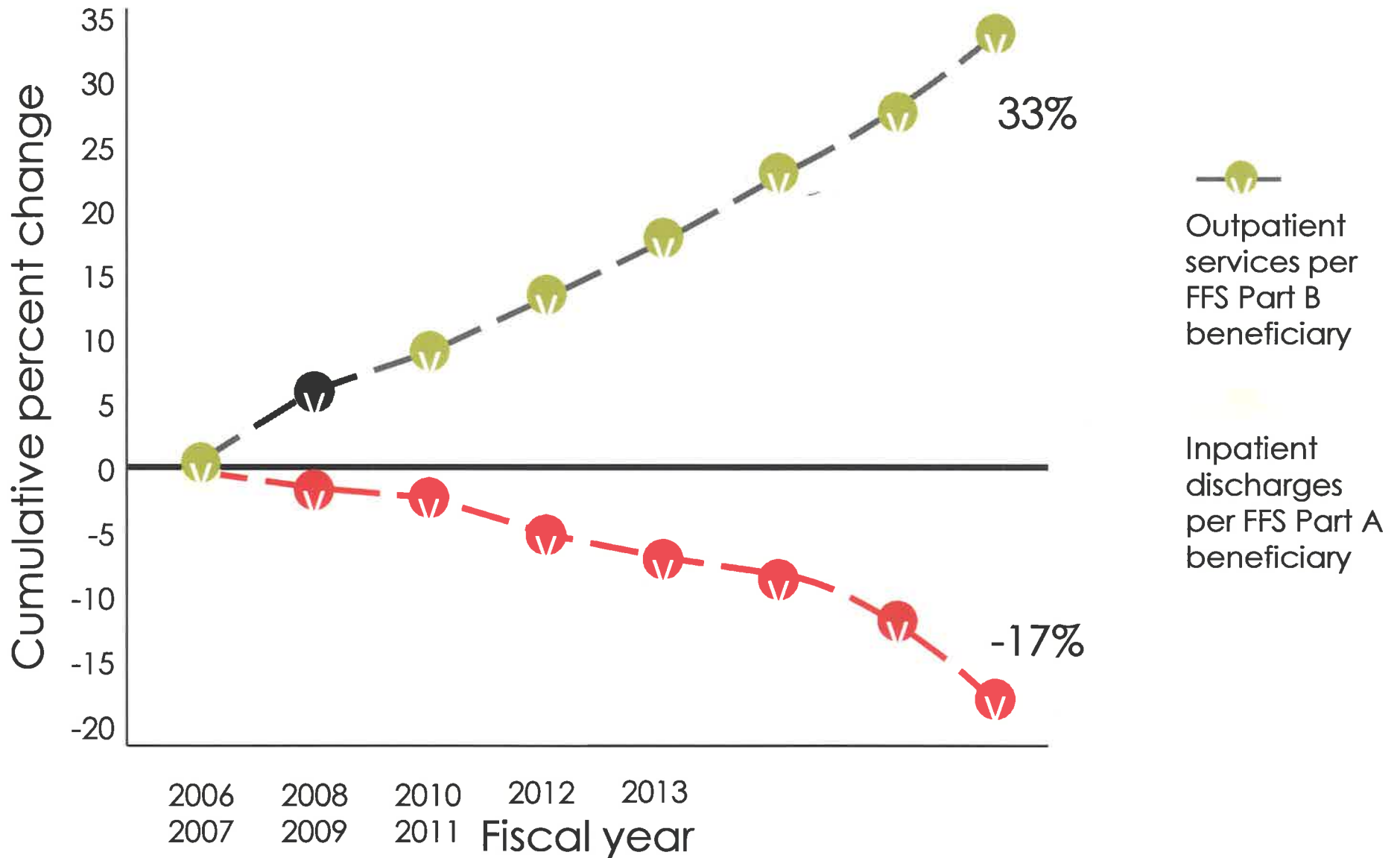


“Personal health care costs rose in the 12 months ending in May at the **slowest rate in the last 50 years**, as spending on hospital and nursing home services declined.”

–USA Today, July 29, 2013

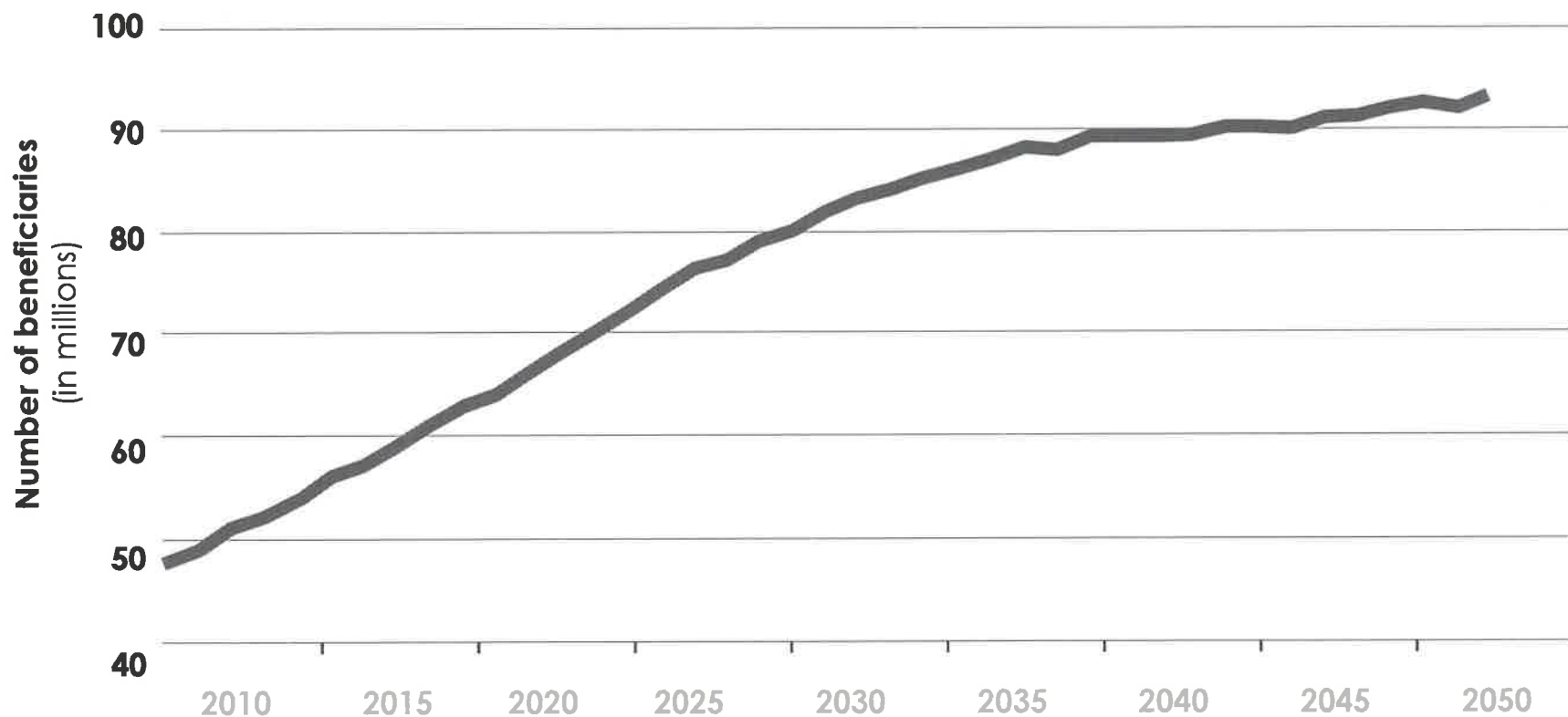
Source: CMS, WSJ

Care is moving out of the hospital while outpatient visits continue to rise



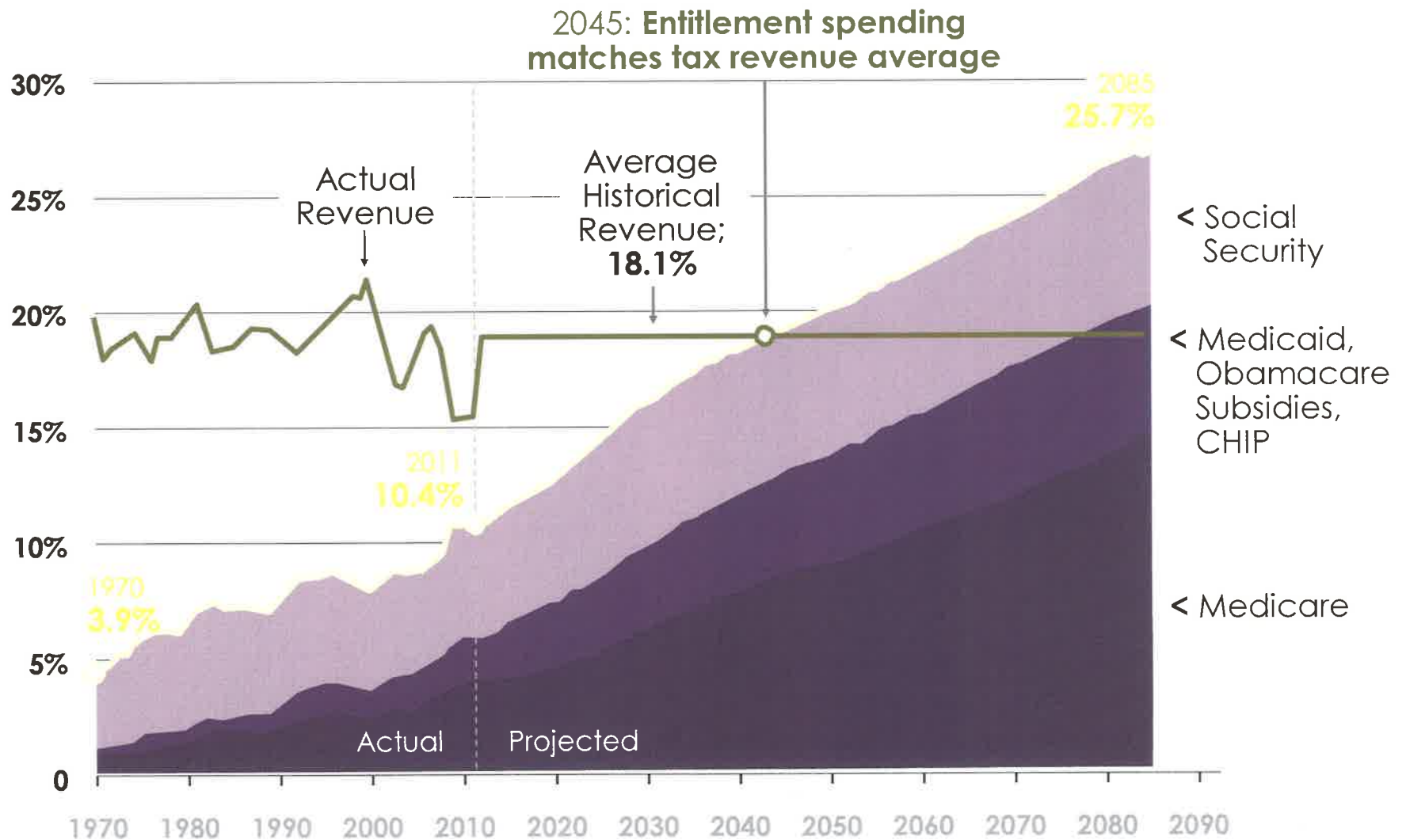
10,000 people will enter Medicare every day for the next 15 years

Medicare enrollment project to grow rapidly as members of the baby-boom generation age into the program



Source: 2014 annual report of the Boards of Trustees of the Medicare trust funds, <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/downloads/tr2014.pdf>.

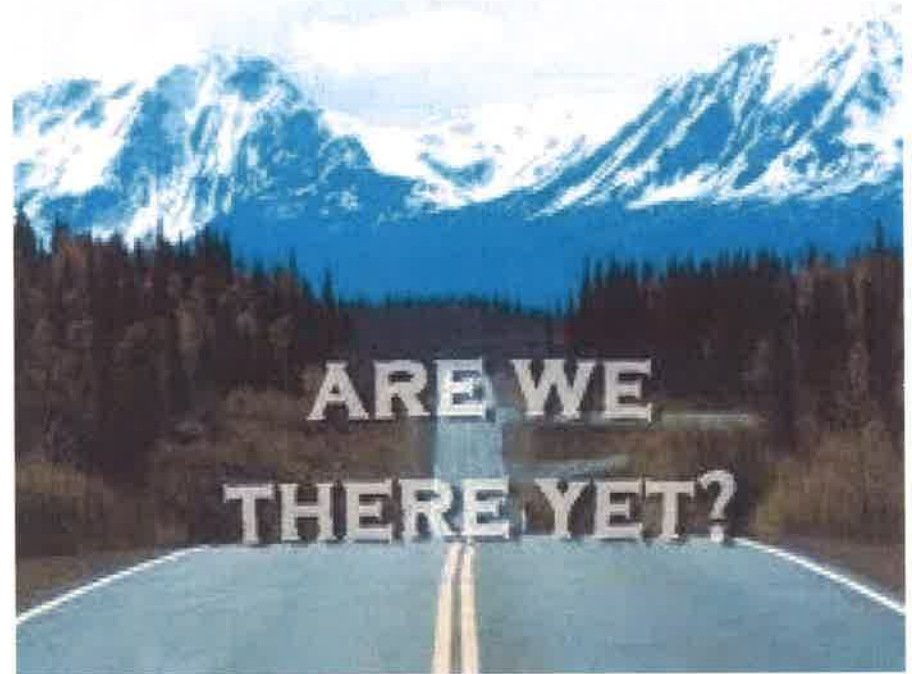
And overall, we're still on pace to bankrupt the U.S.



Source: <http://www.realclearpolicy.com/blog/2012/05/>

Change is Here

- Outcome-based reimbursement
- Integrated provider networks
- Coordinated care across the care continuum
- Electronic health records (EHRs)
- Quality and outcome metrics tracking
- Development of ACOs
- Health Information exchanges



Rapid consolidation in the industry to achieve economies of scale and hedge against reimbursement risk

Health Systems: New Focus

2006

Today

Key success factors for system growth

- Expand market share, strengthen service lines, exert pricing leverage, solidify referrals, secure physicians and increase utilization

- Expand covered lives, compete on outcomes, minimize total cost, assemble networks, offer convenience, and expand access

Performance metrics

- Discharges, service line share, fee-for-service revenue, pricing growth, occupancy rate, process quality

- Share of lives, geographic reach, risk-based revenue, share of wallet, outcomes quality, total cost of care

Infrastructure

- Inpatient capacity, outpatient imaging centers, ambulatory surgery centers, and clinical technology

- Primary care capacity, care management staff and systems, health IT analytics, and a post-acute care network

Health Systems: New Focus

2006

Today

Key success factors for system growth

- Expand market share, strengthen service lines, exert pricing leverage, solidify referrals, secure physicians and increase utilization

- Expand covered lives, compete on outcomes, minimize total cost, assemble networks, offer convenience, and expand access

Performance metrics

- Discharges, service line share, fee-for-service revenue, pricing growth, occupancy rate, process quality

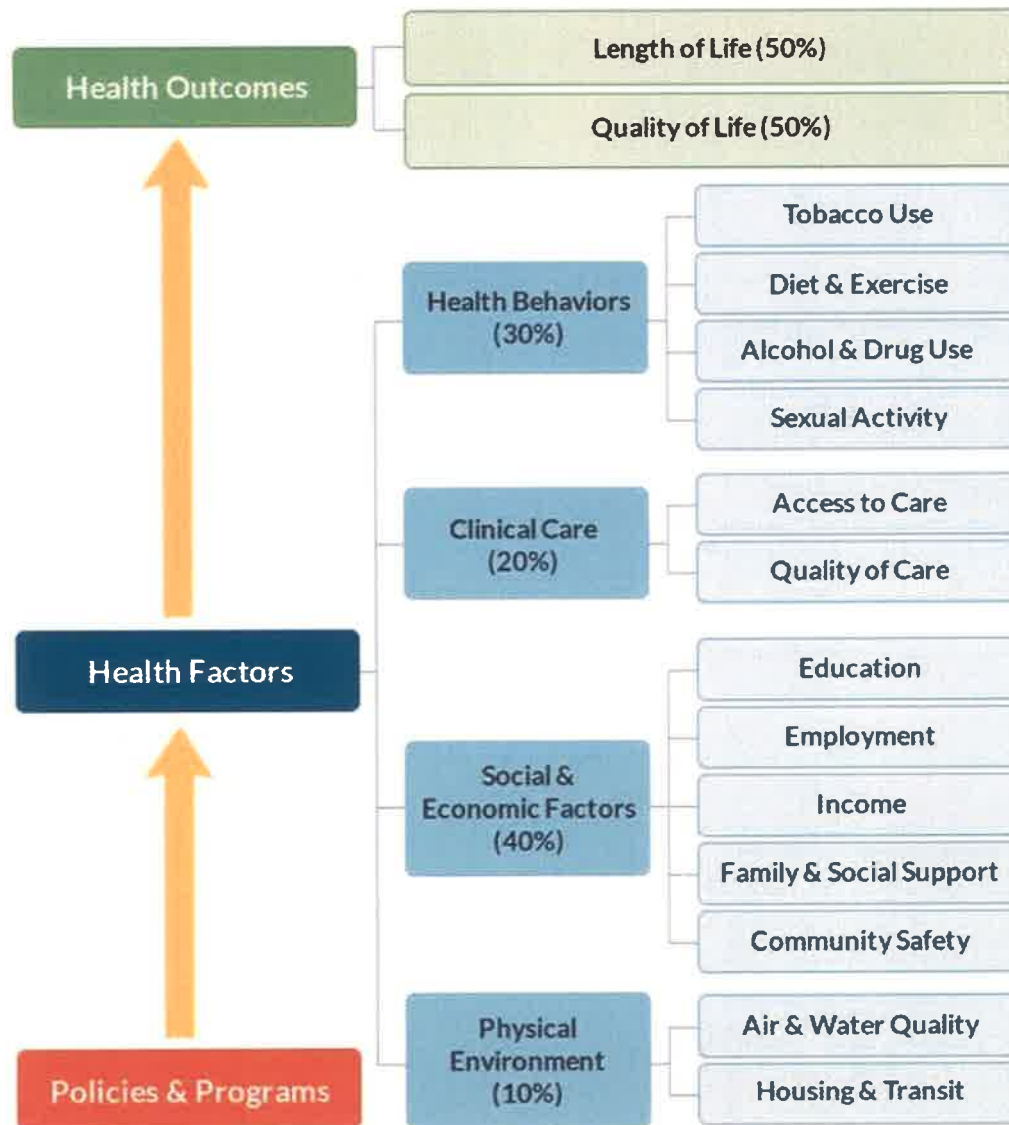
- Share of lives, geographic reach, risk-based revenue, share of wallet, outcomes quality, total cost of care

Infrastructure

- Inpatient capacity, outpatient imaging centers, ambulatory surgery centers, and clinical technology

- Primary care capacity, care management staff and systems, health IT analytics, and a post-acute care network

80% of health is generated outside the walls of the health system



County Health Rankings model © 2014 UWPHI

Incentives are increasing
for better health

The incentives are
working

A goal for relevancy is to
double the impact of the
rural health delivery
system

New Care Delivery Models

Opportunities for Health Care Cost Reduction

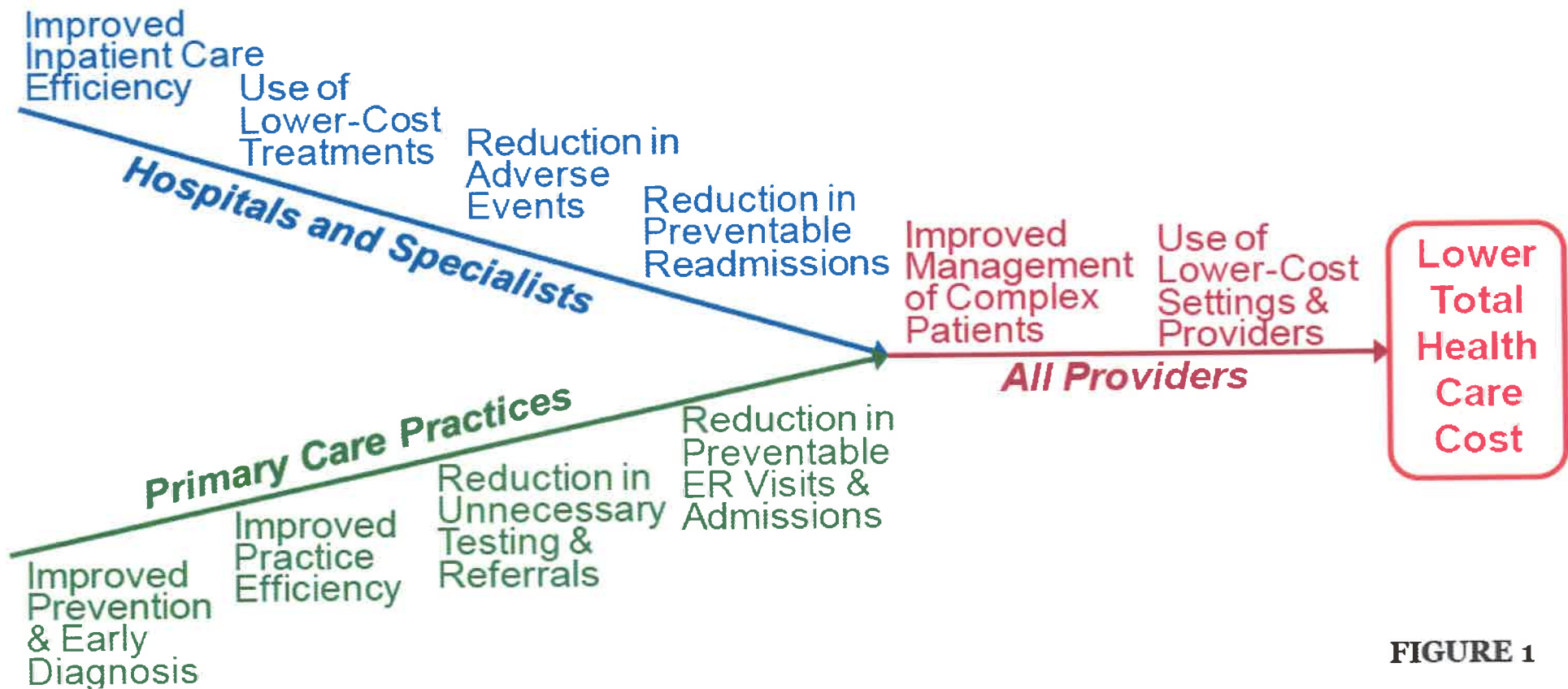
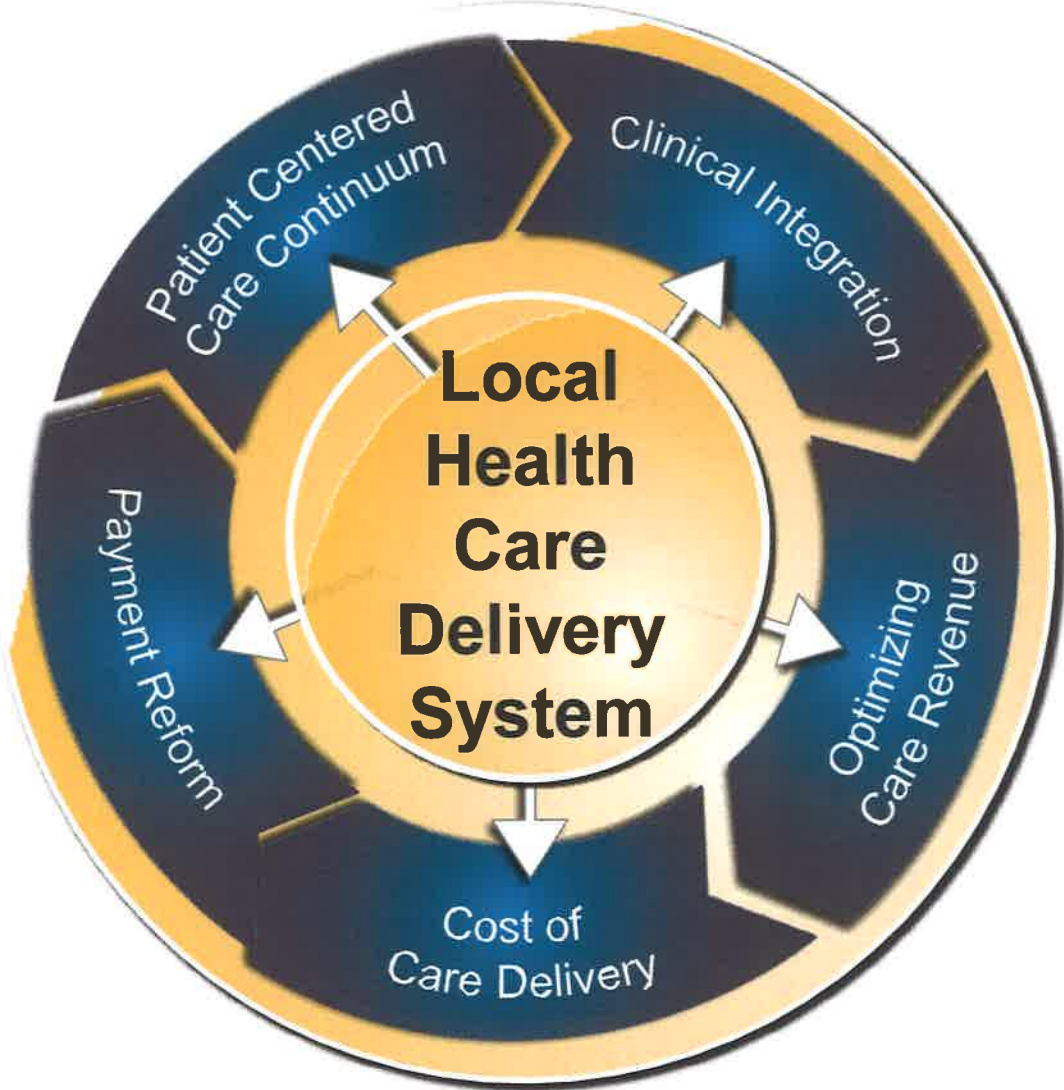


FIGURE 1

Source: "How to Create Accountable Care Organization, First Edition, September 7, 2009; 2009, Center for Healthcare Quality and Payment

Rural Hospitals Will be Part of the Larger Continuum of Care



Key Factors Influencing Rural Health

Structural change in healthcare driven by unsustainable economics

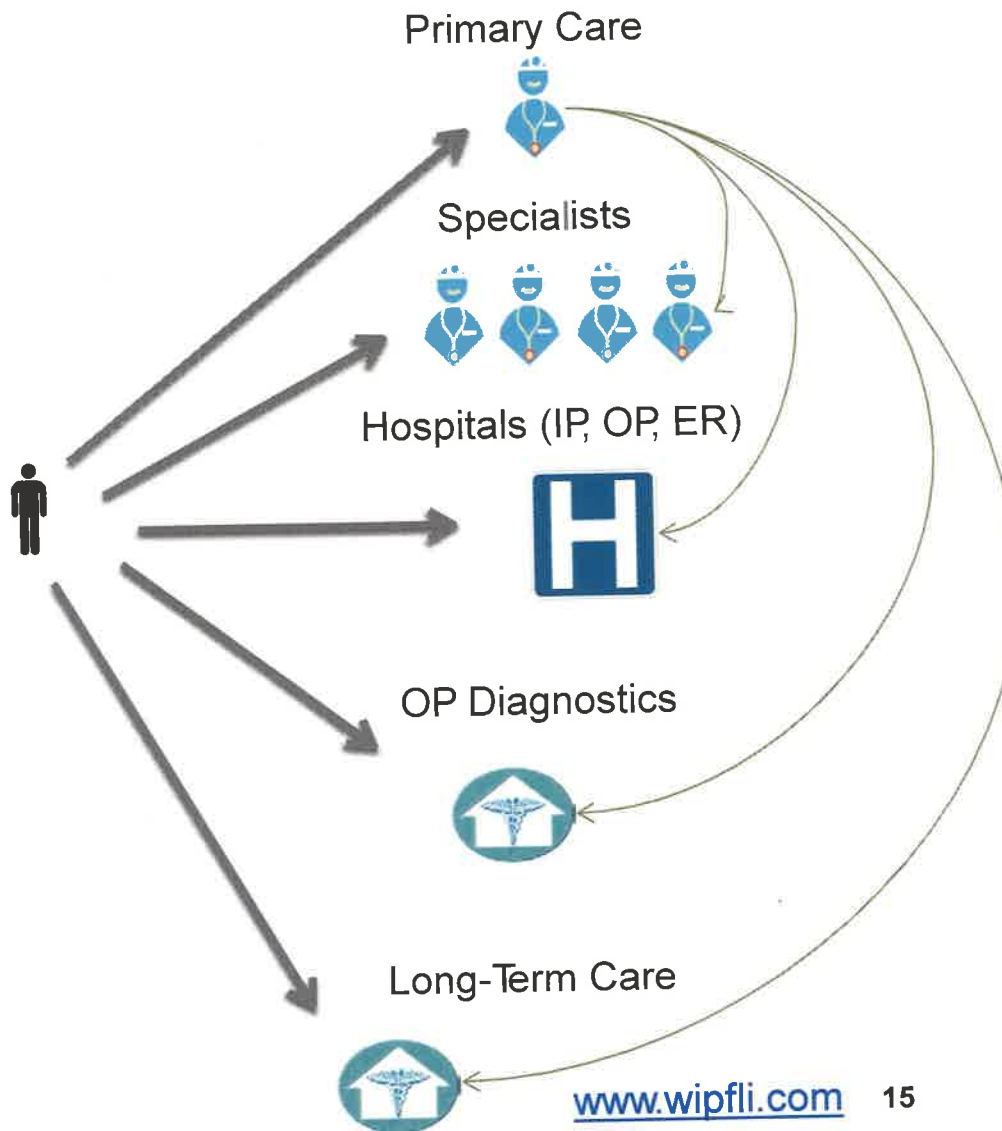
- Happening in both the public and private markets

Changes in payment are leading to changes in delivery

- Immediate emphasis on efficiency and quality
- Increasing importance of primary care
- Rationalization of system (“what is delivered where”)

Sustainability (feasibility) is how well providers respond

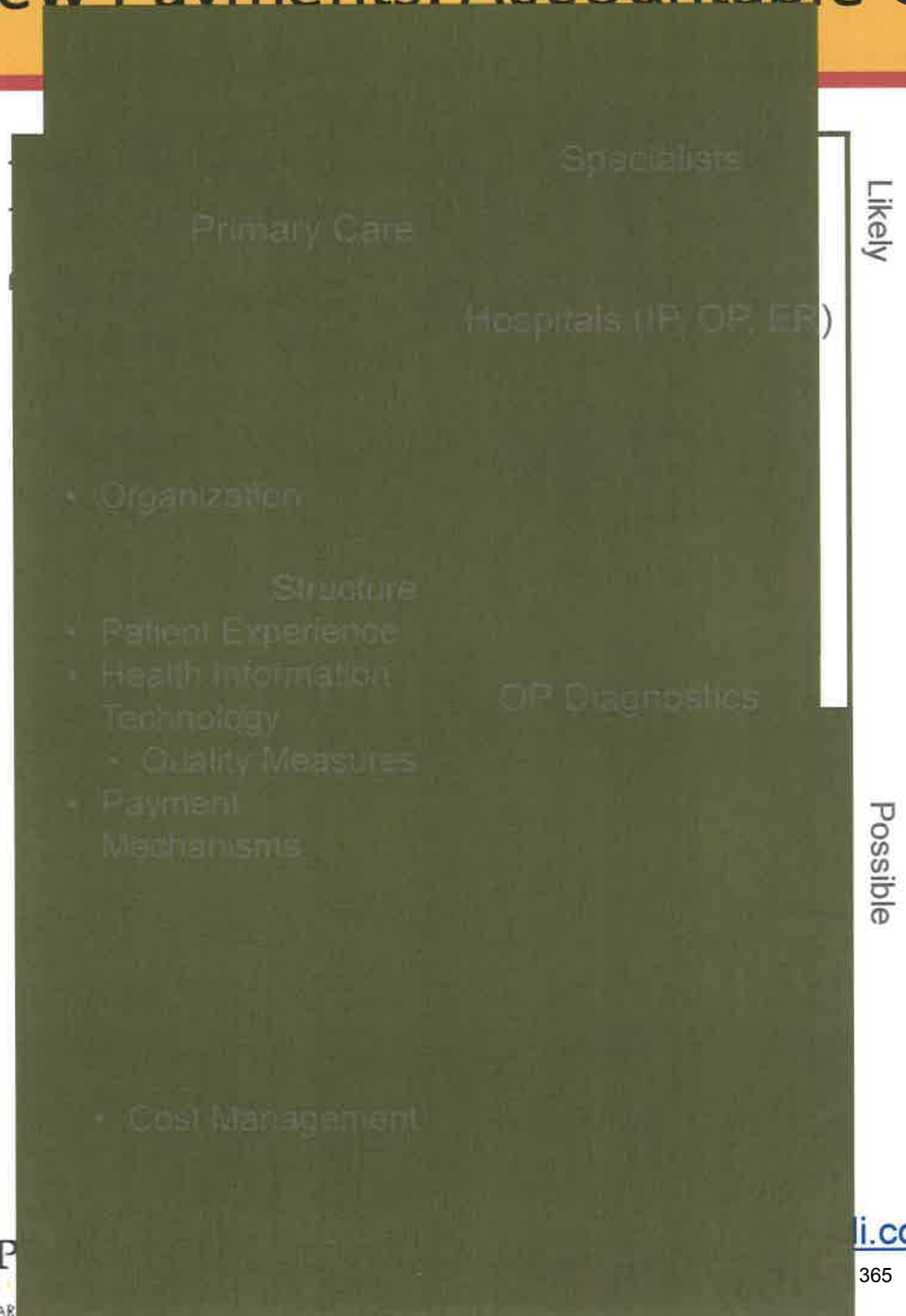
Current Payment



Each unit of service is paid without constraint:

- Coordination may not exist
- Poor quality can be rewarded
- Incentives do not exist to reduce utilization or find optimal care location
- Prevention not emphasized
- Variation based on insurance coverage
- Reform begins to introduce quality into equation

New Payments: Accountable Care Organizations



Cost and quality are primary outcomes:

- Primary care coordinates population care
- Health care managed to optimize outcomes
- Prevention and patient self-management emphasized
- Many options for payment including:
 - Shared savings
 - Partial per person fee
 - Global fee

Rural Hospitals Have An Important Role

“Rural Relevance under Healthcare Reform Study”

Perform as well as or better than urban hospitals in primary care on:

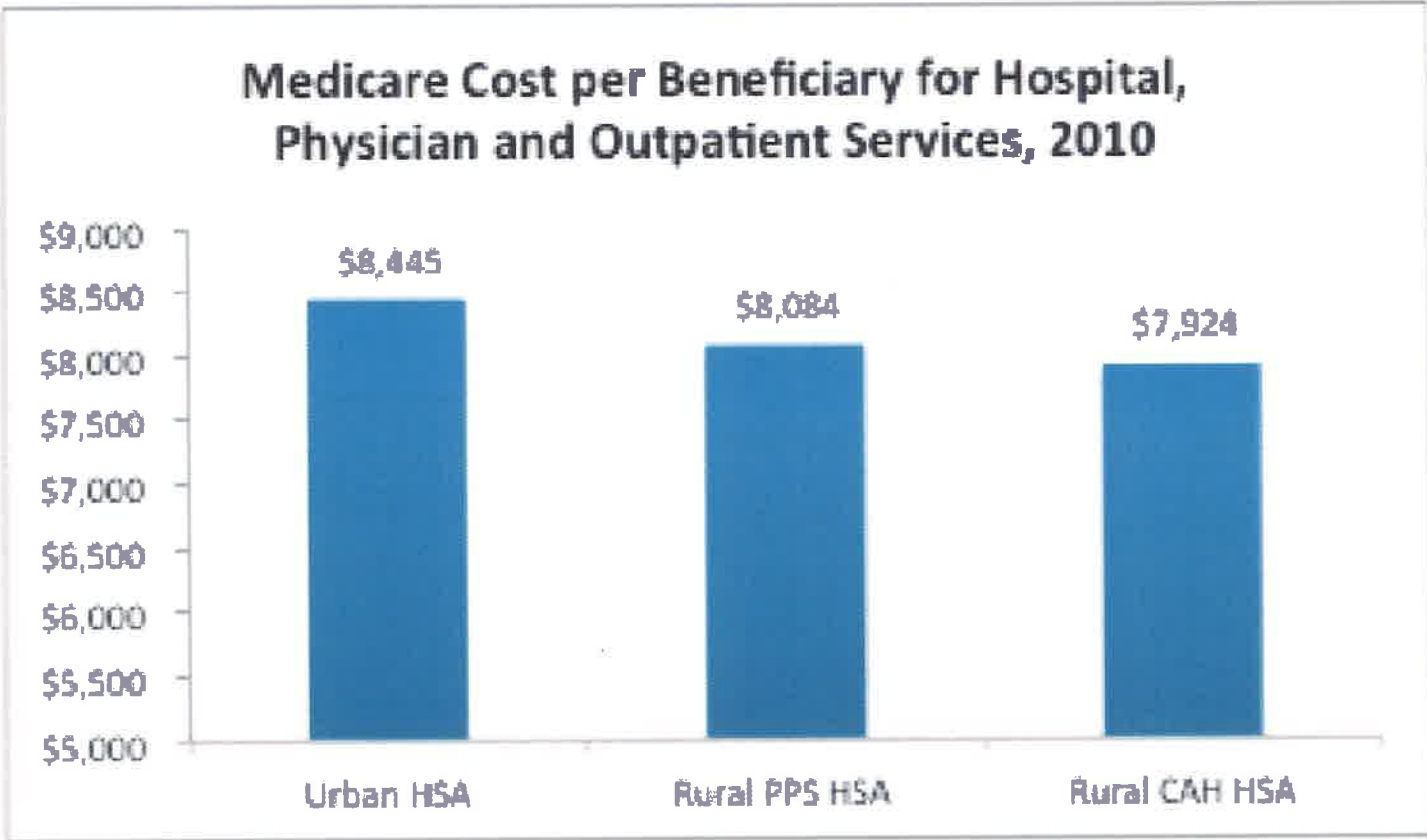
- ✓ Quality
- ✓ Patient satisfaction
- ✓ Operational efficiency

Appropriately referred to tertiary care centers for care they could not provide



58 hospitals closed in past decade: 283 are reportedly on the brink

Lower Rural Costs Per Person



Beneficiaries (millions)	
Urban HSA	20.02
Rural PPS HSA	3.72
Rural CAH HSA	1.71

Source: Dartmouth Atlas of Healthcare, 2010 Medicare reimbursements per enrollee (Parts A and B) for hospital, physician, and outpatient services Price, age, sex & race-adjusted. Hospital service areas (HSA) divided into urban and rural based on 2010 Census data. Areas with a Prospective Payment System (PPS) general acute or a Critical Access Hospital (CAH) were assigned accordingly.

Challenges For Rural Hospitals

- Aging and shrinking population; higher percentage of government payers (Medicare, Medicaid)
- Patient outmigration to larger population centers
- Defining and developing role within an “accountable care environment”
- Difficulty recruiting providers and staff
- Inability to reduce cost structure further
- Growing cost of technology (EHR, Quality, Pop. Health management, etc.)
- Aging plant; significant capital needs



Consolidation or Affiliation

Strategic affiliations, partnerships, and joint ventures?

- Spectrum of relationships
- Both short and long-term strategic consequences
- Can involve varying degrees of joint governance
- Various degrees of risk and reward involved

Typically, the greater the \$ invested, the greater control required and the greater the difficulty in the formation

Remember: There is no exchange of cash between non-profit organizations

What Smaller Hospitals Want From Affiliation

2006

- Clinical Expertise
- Cash infusion
- Increased access to specialists
- Broader scope of services
- Access to Capital

Today

- Expertise; clinical, operational, technology, data management
- Bargaining power
- Protection from irrelevance/guarantee of acute care presence in the community
- Support for quality programs and new models of care



Transformation

A **rural health system** for offering coordinated emergency, primary care, diagnostic testing and community wellness services within a system of care that reduces costs, improves quality and transforms population health.

Key Success Factors for CAHs



WIPFLI^{LLP}
CPAs and Consultants
HEALTH CARE PRACTICE

How Can We Remain Successful?

New Revenue Streams
Reduce Costs

FY 2013 VCHO
Solid Waste & Recycling Expense



HIT?



Successful Rural Hospitals - Top 10 Characteristics

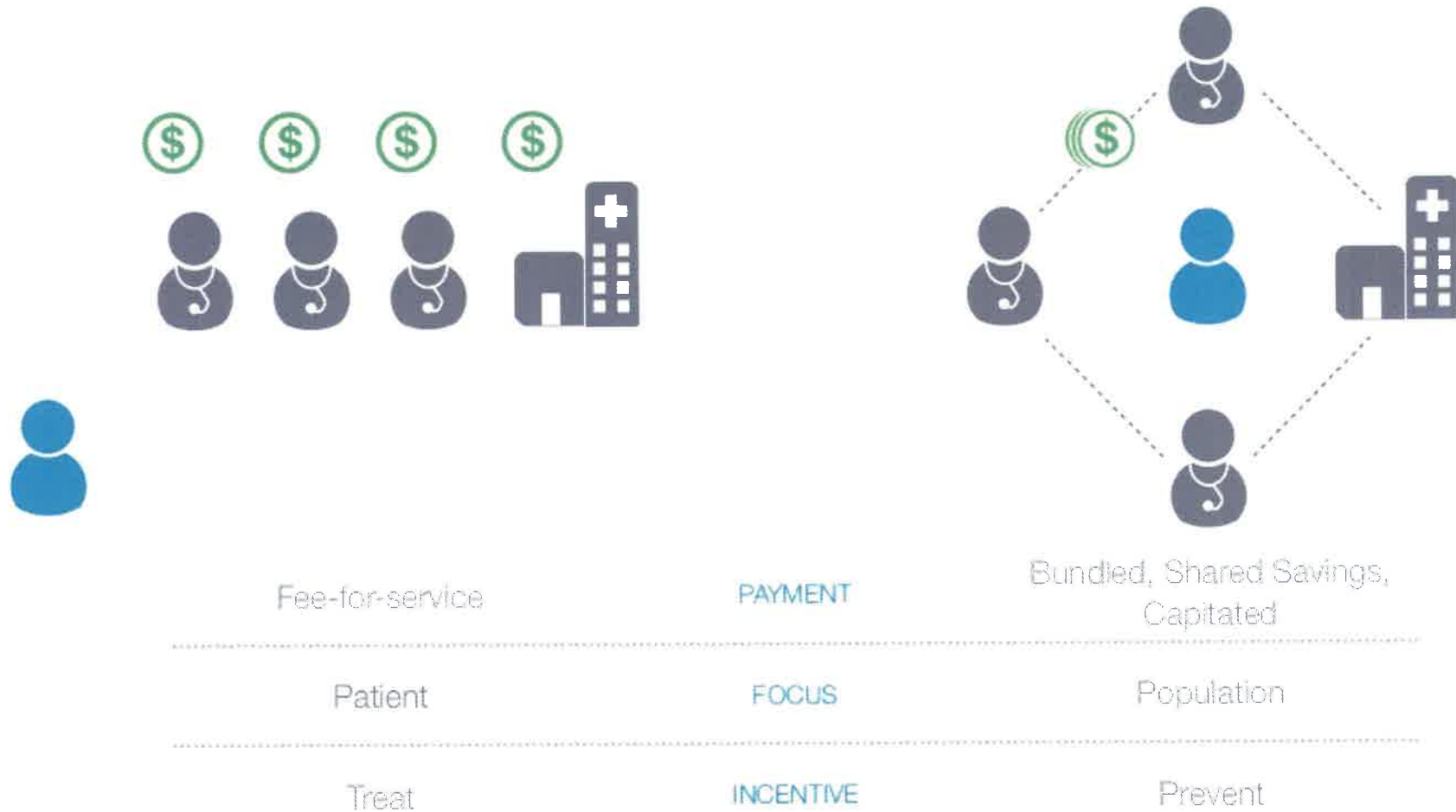
1. Leadership - Clear Vision of Future
2. Strategies are Implemented
3. Partnerships are a Priority
4. Focus on the Community
5. Engages Providers in Hospital Business
6. “Right” Complement of Services
7. Regular Financial Monitoring
8. Embraces Data and Information Systems
9. Foundation and/or Other Cash Reserves
10. Aware of Policies Affecting Future

No. 1: Leadership and Clear Vision

SHIFT FROM VOLUME TO VALUE

3

VALUE

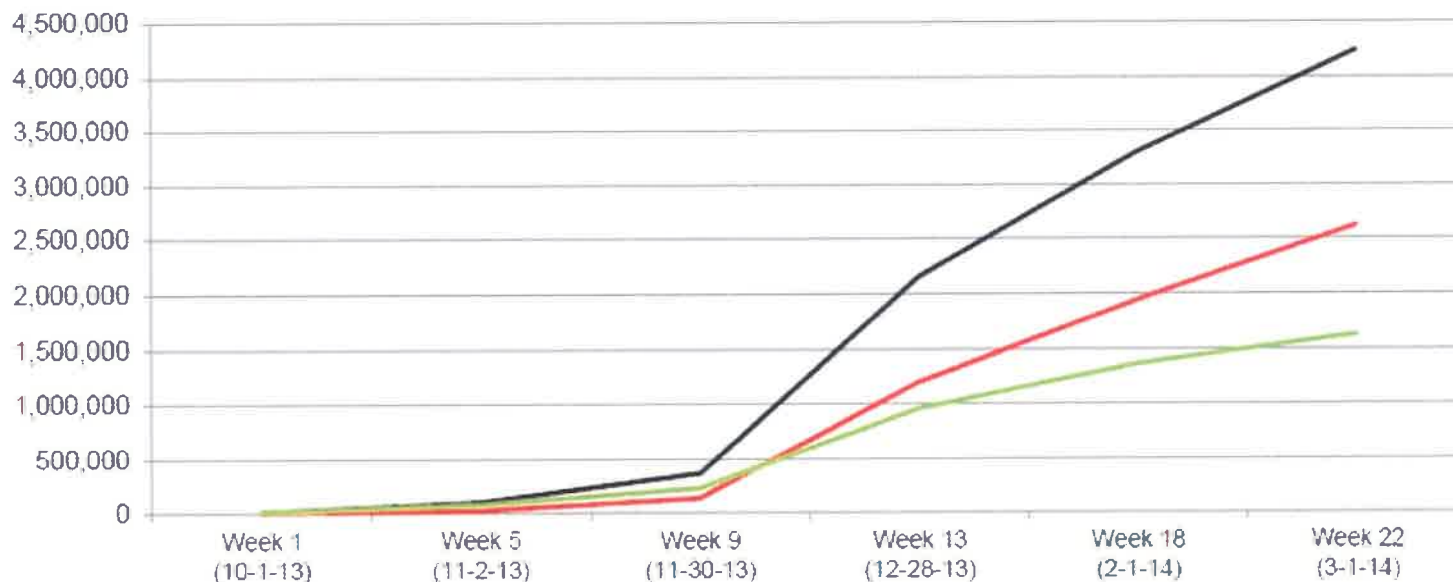


Presentation © 2013 Brook Health

No. 1: Leadership and Clear Vision

Trends in the Cumulative Number of Individuals Who Have Selected a Marketplace Plan, 10-1-13 to 3-1-14

Over 4.2 million people have selected a Marketplace plan since October 1st, including 2.6 million who have selected a plan through the FFM

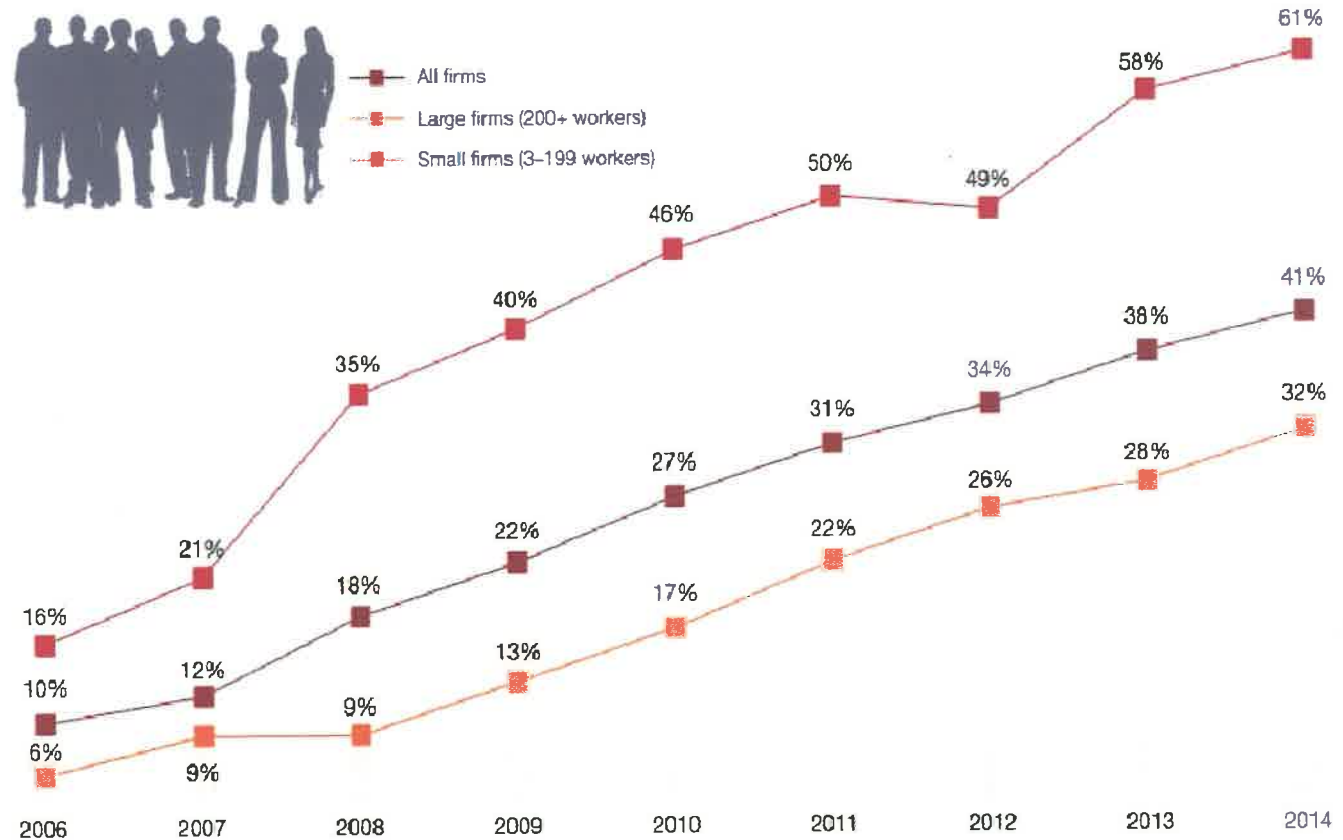


- New users of healthcare will be emerging
- The cumulative number of young adults (18 - 34) selecting a marketplace plan increased 33%

No. 1: Leadership and Clear Vision

- Increasing consumer out of pocket
- More collected from individuals
- Internal opportunities to lower costs and improve benefits

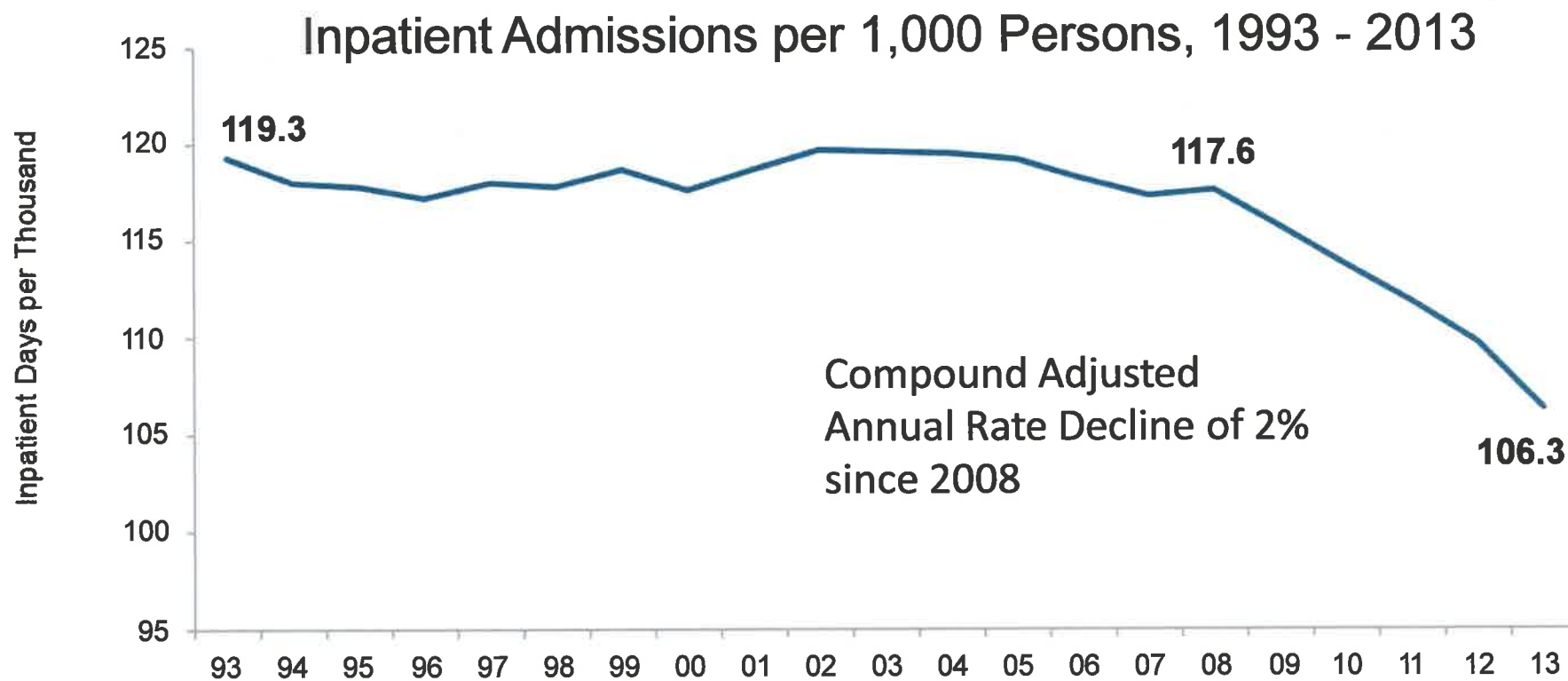
Percentage of High Deductible Health Plans



Source: Kaiser Family Foundation—2014 Employer Health Benefits Survey

No. 1: Leadership and Clear Vision

Expect lower inpatient use...

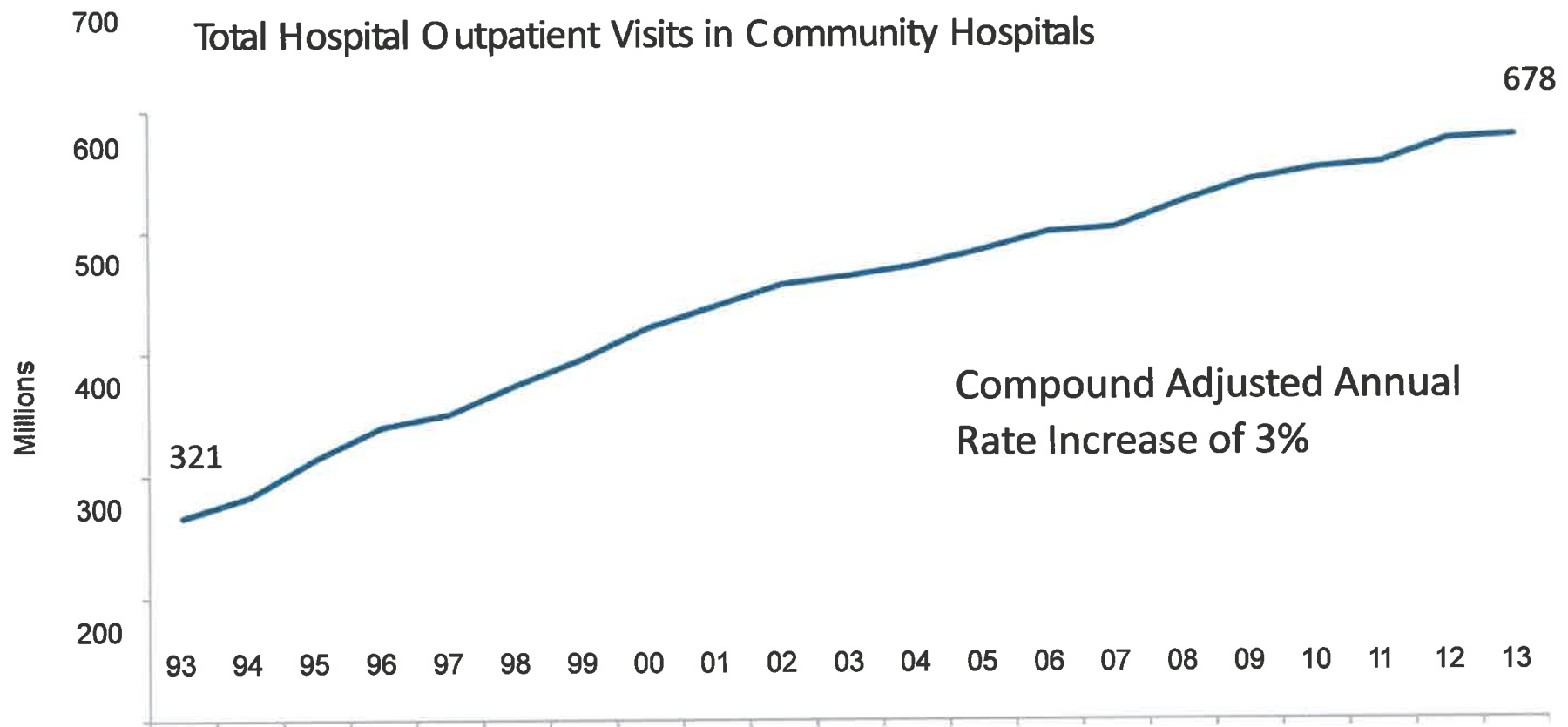


Source: Avalere Health analysis of American Hospital Association Annual Survey data, 2013, for community hospitals. US Census Bureau: National and State Population Estimates, July 1, 2013.

Link: <http://www.census.gov/popest/data/state/totals/2011/index.html>.

No. 1: Leadership and Clear Vision

And higher outpatient use



Source: Avalere Health analysis of American Hospital Association Annual Survey data, 2011, for community hospitals.

Options for Success

“Dual Approach”

Maintain strategies and tactics for success in “current” environment

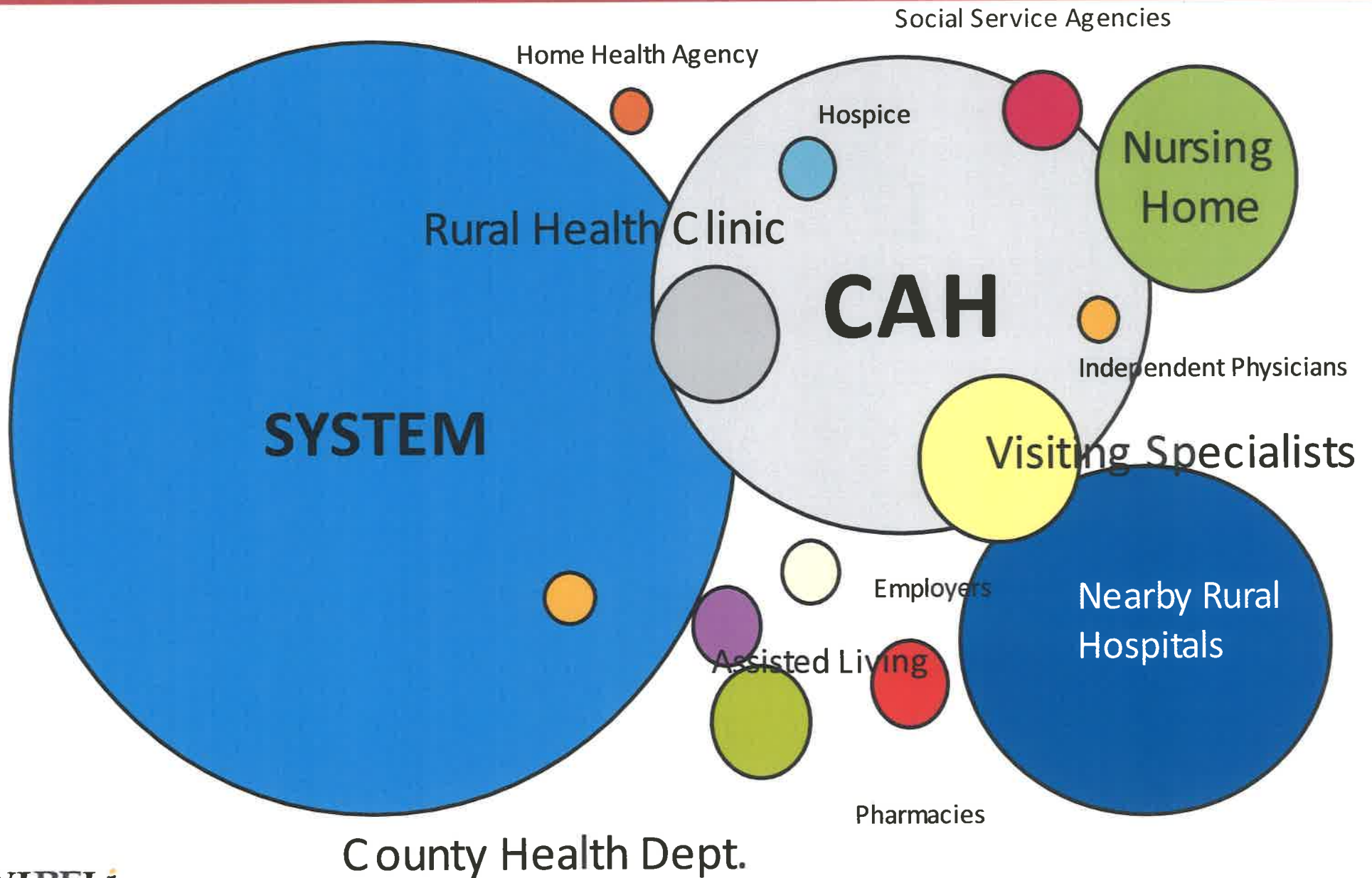
Proactively position organization for the “anticipated” future environment

No. 2: Strategies are Implemented

- Does meaningful strategic planning at least annually
- Evaluates strategic progress regularly
- Communicates the plan organization-wide in easy-to-understand language
- Supports plan with clear tactics, responsibilities, and time frame for completion



No. 3: Partnerships are a Priority



No. 3: Partners are a Priority

Creating the Case for Joint Strategies

- Develop a business case for need/resource requests
- Data-driven
- Input from physicians/providers
- Thinks about solutions to the geography given scarce resources
- Evaluate financial implications



No. 3: Partnerships are a Priority

Service Line: Orthopedics

Market opportunity	Inpatient				Outpatient		Total
	PSA	SSA	TSA	Total	PSA	Total	Total
Market Size	417	273	156	846			
Current Market Share	54.4%	21.3%	14.1%	36.3%			
% Unavailable	1.4%	5.5%	4.5%	3.3%			
Top Competition	CD - 16.2%, BMC - 13.8%						

Note that share info is from 2008 and does not reflect the loss of Dr. X- 09 Volumes are down 30%

Profitability

Net Revenue		1,546,378	902,813	2,449,191
Expense		951,655	526,535	1,478,190
Margin		<u>594,723</u>	<u>376,278</u>	<u>971,001</u>

Physician Supply/Need (All Service Areas - 100% Market Share)

Physician supply (CH)	2
Mkt Share Physician need	<u>2.7</u>
Net Need/(Oversupply)	<u>0.7</u>

Note that there are 2.4 total market FTEs and a market demand of 4.8 - net market undersupply is 2.4

Physician Leadership

Dr. X accounts for the majority of cases - he has indicated that he plans to retire in 2-4 years

Call issues have arisen due to loss of Dr. Y

Capacity/facility Issues

OR capacity had been issue with three physician

Service Line Risks

Hospital 1 and Hospital 2 expanding presence at local CAHs - filling void left by Dr. X

No. 4: Focus On Community

- Community Health Needs Assessment (CHNA) mandates focus on the community
- Reporting and data transparency
- Critical access hospitals (CAHs) are the engine of the community

We need to engage the community in a way that they truly feel they add value.

It is easy to get feedback from our patients, we need input from our *community*.

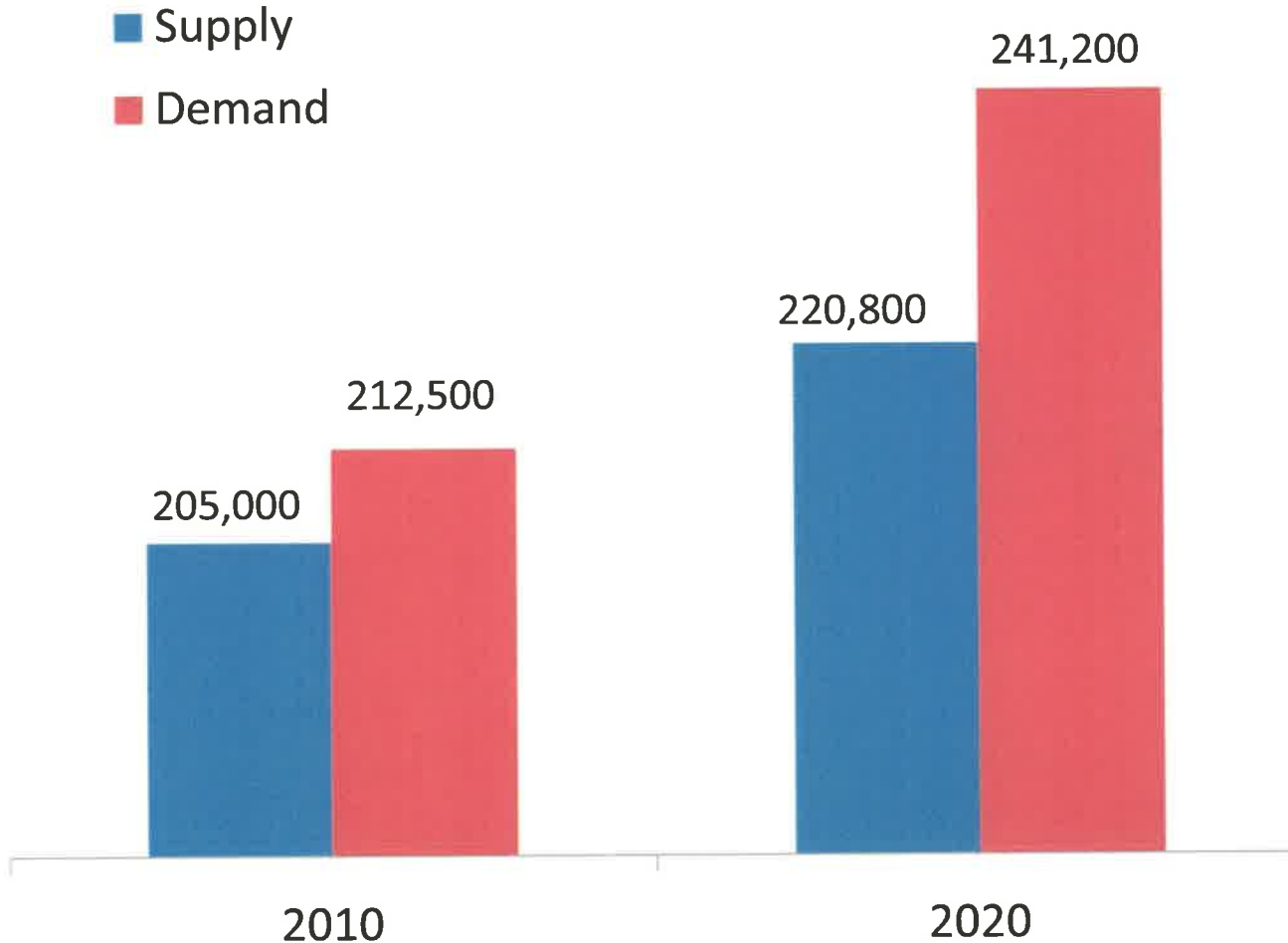
Start small - focus on employee health improvement, or one primary issue in your community

We need to turn stakeholders into partners.



No. 5: Engages Providers in Hospital Business

Projected Primary Care Shortages



Challenge for rural providers

Modern facilities help recruitment

Practice approach and lifestyle

Opportunity with population health

Source: <http://bhpr.hrsa.gov/healthworkforce/supplydemand/usworkforce/primarycare/>

No. 6: “Right” Complement of Services

Community View

Based on
Community
Needs

Market Share
Assessment

Organizational View

What are your
current
volumes?

Are you really
good at this
service?

Patient View

Is the patient
experience
standardized?

What would the
patient (and
family) say?

No. 6: “Right” Complement of Services

Know Vulnerability of Volumes - Ambulatory-Sensitive Conditions

- Angina
- Asthma
- Bacterial pneumonia
- Cellulitis
- Chronic obstructive pulmonary disease (COPD)
- Congestive heart failure
- Convulsions
- Dehydration
- Diabetes
- Gastroenteritis
- Hypertension
- Kidney/urinary infections

Medicare is scrutinizing admissions for “ambulatory-sensitive conditions” to challenge whether these conditions could be treated effectively on an outpatient basis.

Volumes Related to Ambulatory-Sensitive Conditions

DRG	Service Line	Days of	%
Total Days of Care		1,048	
194 SIMPLE PNEUMONIA & PLEURISY W CC	Pulmonology	77	5%
690 KIDNEY & URINARY TRACT INFECTIONS W/O MCC	Urology	53	3%
392 ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS	Gastroenterology/ID	44	3%
865 VIRAL ILLNESS W MCC	Infectious Disease	41	3%
192 CHRONIC OBSTRUCTIVE PULMONARY DISEASE	Pulmonology	38	3%
948 SIGNS & SYMPTOMS W/O MCC	Neurology/Cancer/Genl Med	37	2%
775 VAGINAL DELIVERY W/O COMPLICATING DIAGNOSES	Women's Health	35	2%
195 SIMPLE PNEUMONIA & PLEURISY W/O CC/MCC	Pulmonology	33	2%
603 CELLULITIS W/O MCC	General Medicine	15	1%
641 MISC DISORDERS OF NUTRITION,METABOLISM	General Medicine	13	1%
203 BRONCHITIS & ASTHMA W/O CC/MCC	Pulmonology	4	0%

- Of the top DRG s at, the disease states in blue are those that CMS has targeted for potential treatment on an outpatient basis vs. inpatient
- The DRG s could be nursing home patients with common ailments, complicated by multiple health issues and meeting current criteria for inpatient stays

No. 6: “Right” Complement of Services

Inpatient services cover indirect costs

Outpatient services drive profitability and ability to subsidize other necessary services/loss leaders

Typical CAH Annual Profitability by Patient Setting

	Charges	Reimbursement	Direct Costs	Contribution Margin	Indirect Costs	Total Margin
IP	\$8,200,531	\$4,991,532	\$2,494,534	\$2,496,998	\$2,429,492	\$65,042
OP	\$35,669,064	\$18,985,684	\$8,951,055	\$10,034,629	\$6,654,660	\$2,296,395
Swing	\$1,856,571	\$2,072,537	\$1,008,686	\$1,063,851	\$1,022,918	(\$14,232)
	\$45,726,167	\$26,049,753	\$12,454,275	\$13,595,478	\$10,107,070	\$2,347,205

Currently 66% Charges at NIH are OP

No. 6: “Right” Complement of Services

- Typically, 90% of rural outpatient volume is distributed into four service lines,

- ✓ Gastrointestinal
- ✓ General surgery
- ✓ Ophthalmology
- ✓ Orthopedics

Top Procedures	% of Volumes	% of Charges
COLONOSCOPY	23%	13%
OTHER EXTRACAPSULAR EXTRACTION LENS	14%	17%
CLOS [ENDO] BX LARGE INTESTINE	9%	6%
EGD W/CLOS BX	8%	6%
ENDO POLYPECTOMY LARGE INTESTINE	8%	6%
ENDO DESTRUC OTH LES/TISS LG INTEST	5%	3%
LAPAROSCOPIC CHOLECYSTECTOMY	3%	8%
UNILATERAL REPAIR ING HERNIA NOS	3%	5%
OTHER UNILAT REPAIR INGUINAL HERNIA	3%	5%
REPAIR OF HERNIA	3%	5%

No. 7: Regular Financial Monitoring

<p><u>Operating Margin (%)</u></p> <p>Reflects your profitability from active patient care and related operations</p>	<p>↑ = Good</p>
<p><u>Earnings Before Depreciation & Amortization Margin (%)</u></p> <p>How actual cash you made before accounting for non-cash item capital expenses (depreciation) divided by revenues</p>	<p>↑ = Good</p>
<p><u>Days Cash on Hand – All Sources (Number)</u></p> <p>The number of days you could operate and pay expenses if your revenue stream were to be reduced or eliminated</p>	<p>↑ = Good</p>
<p><u>Debt Service Coverage (Ratio)</u></p> <p>Measures your ability to cover your current year interest and principal payment</p>	<p>↑ = Good</p>
<p><u>Debt-to-Capitalization</u></p> <p>What you owe (long term) versus what you own</p>	<p>↓ = Good</p>

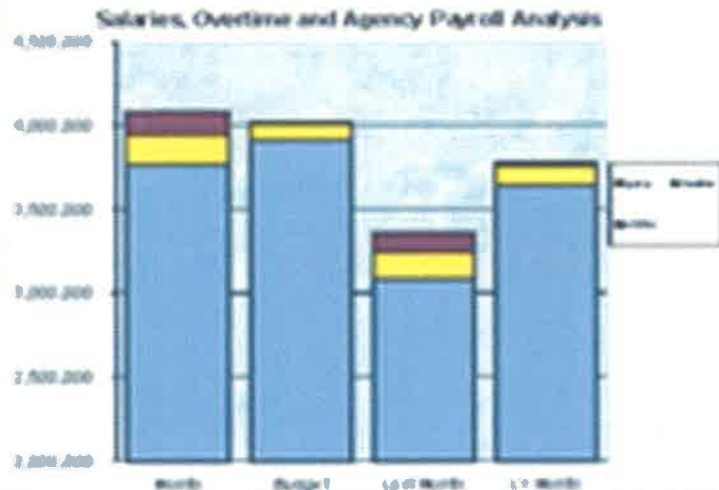
No. 7: Regular Financial Monitoring

- Essential to have appropriate financial and operational indicators
- Financial ratios for CAHs are determined by:
 - Size of CAH
 - Service mix
 - Position in the capital cycle
- Interim Medicare cost reports can help mitigate cash flow issues
- Use monitoring to identify “issues” early



What's Your Handicap?
What Course Are You Playing?

STATEMENT OF REVENUE AND EXPENSES - YTD		
	ACTUAL	BUDGET
Revenue:		
Gross Patient Revenues	\$143,809,698	\$158,202,547
Assessment Tax Revenue	8,998,578	8,998,578
Deductions From Revenue	(100,571,871)	(112,167,886)
Net Patient Revenues	52,236,405	55,033,239
Other Operating Revenue	2,282,855	997,947
Total Operating Revenues	54,519,260	56,031,186
Expenses:		
Salaries, Benefits & Contract Labor	26,659,830	28,000,897
Purchased Services & Physician Fees	6,097,761	5,571,562
Supply Expenses	4,839,582	5,204,743
Assessment Tax	3,216,522	3,216,522
Other Operating Expenses	6,950,346	6,935,975
Bad Debt Expense	6,292,236	6,375,517
Depreciation & Interest Expense	2,662,336	2,758,124
Total Expenses	56,718,613	58,063,140
NET OPERATING SURPLUS	(2,199,353)	(2,031,954)
Non-Operating Revenue/(Expenses)	55,008	317,442
TOTAL NET SURPLUS	(12,843,345)	(17,714,512)
KEY STATISTICS AND RATIOS - YTD		
	ACTUAL	BUDGET
Total Adult Patient Days	19,381	20,829
Average Adult Daily Census	106.5	114.4
Average Adult Acute Length of Stay	4.18	3.77
Total Emergency Room Visits	11,225	10,050
Referred Total Outpatient Visits	33,864	36,904
Total Surgeries	1,584	1,800
Inpatient Gross Rev. as a % of Total	60.5%	60.7%
Outpatient Gross Rev. as a % of Total	39.5%	39.3%
Contractual Allowance %	63.7%	65.2%
Total Worked FTE's	667.4	680.4
Total Paid FTE's	739.2	765.0
Paid FTE's per Adjusted Occupied Bed	5.9	5.1
Salary and Benefits as a % of Net Rev	58.4%	59.5%
EBITDA - YTD	1.0%	1.3%



Blue	Net Hospital
Light Blue	Other
Red	Per FTE per Bed
Green	Per FTE per Bed

No. 8: Embraces Data and Information Systems

- Necessary to have significantly more staff in finance and IT
- The “new” capital need
- Whole host of new compliance/confidentiality issues

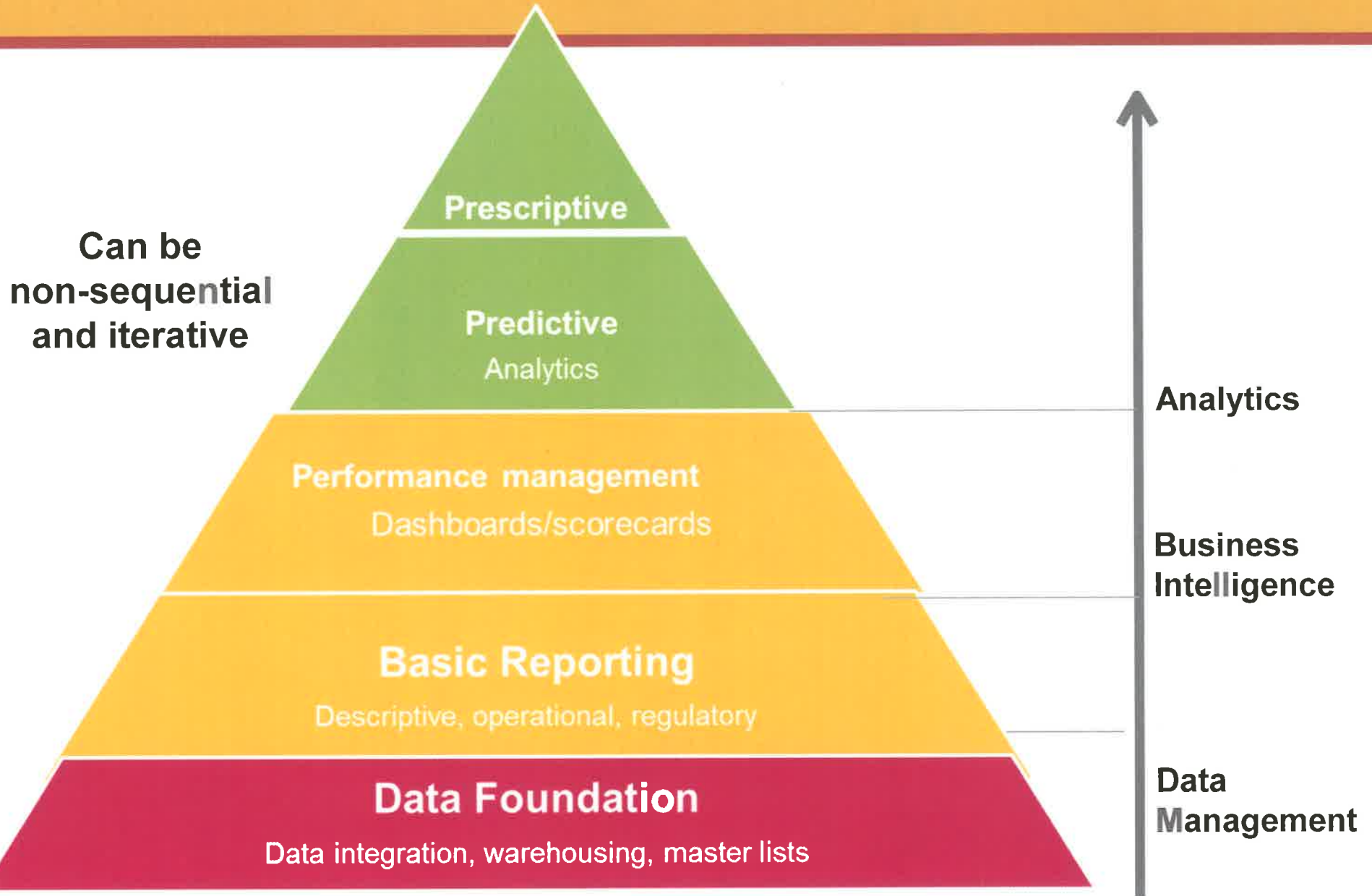
Many CAHs are overwhelmed with reporting requirements, it is hard to address *internal* data gathering that supports your goals and operations.

Measurement takes the politics out of management and drives performance.



Until we have supportive systems that allow us to embrace and support change, it is not going to happen.

No. 8: Embraces Data and Information Systems



No. 8: Embraces Data and Information Systems

Business Intelligence = Meaningful, Actionable Information

- ✓ Easy, fun and fast to use
- ✓ Self-reliance – no calls to IT
- ✓ Flexibility
- ✓ Exportable
- ✓ Confidence in data
- ✓ Not too expensive



No. 9: Financial Position and Cash Reserves

The Power of Cash Flow

- Positive cash flow (profit) fuels a hospital's ability to meet routine capital and expenditures



Cash Flow Is King

Why is Cash Important?

- War chest to pursue strategic opportunities
- Cushion to absorb reimbursement changes
- Endowment for future health care in the community and to support mission-critical services

Cash Is Queen



Building Cash: Medicare/Medi-Cal Reimbursement

Two primary types of hospital reimbursement methodologies for Medicare and Medi-Cal

- Prospective Payment System (PPS) ... similar to Medi-Cal
- Cost-Based System (CAH) ...
 - **101% Medicare allowable costs** for inpatient, swing bed, and outpatient services, but not for
 - professional services done in a hospital setting, certain lab services, screening mammography services, and some minor medications and supplies.
 - Applies a 2% reduction in reimbursement - until 2025.
 - Medicare bad debt is reimbursed at 65% (previously 100%).

Building Cash: Medicare/Medi-Cal Reimbursement

	Part A Cost	Part B Cost	Part B MFFS	Total
Sample CAH (2010)	5,000,000	10,000,000	2,000,000	17,000,000
Sequestration (2% Net Reim)	(100,000)	(200,000)	(40,000)	(340,000)
Bad Debt (From 100% to 65%)	(52,500)	(105,000)		(157,500)
Meaningful Use (1%IP & 1+MFFS)	(50,000)		(20,000)	(70,000)
PQRS (2% MFFS)			(40,000)	(40,000)
VBM (2%-4% MFFS)			(80,000)	(80,000)
Sample CAH (2017)	4,797,500	9,695,000	1,820,000	16,312,500
Total Reduction	(202,500)	(305,000)	(180,000)	(687,500)

Potential Medicare Reimbursement Impact

Opportunity	Estimated Impact	Period
Implementation of Separate Capital Cost Center (IP/ER area)	\$50,000	Annually
Bad Debt Policy Revision	\$500,000	One-time
RHC Flu & Pneumo Cost (do not bill Medicare)	TBD	Annually
Reclassified of Skilled Nursing Facility Days	\$43,000	2015
Immediate total impact	\$593,000	

- Ensure collection efforts per policy are the same for all payor types, and any recoveries of bad debts claimed in prior years are offset against amounts claimed in current year
- Cost-based reimbursement is two to three times standard payment levels for Pneumonia and flu immunizations; do NOT bill Medicare log only
- Count SNF and NF swing bed days separately

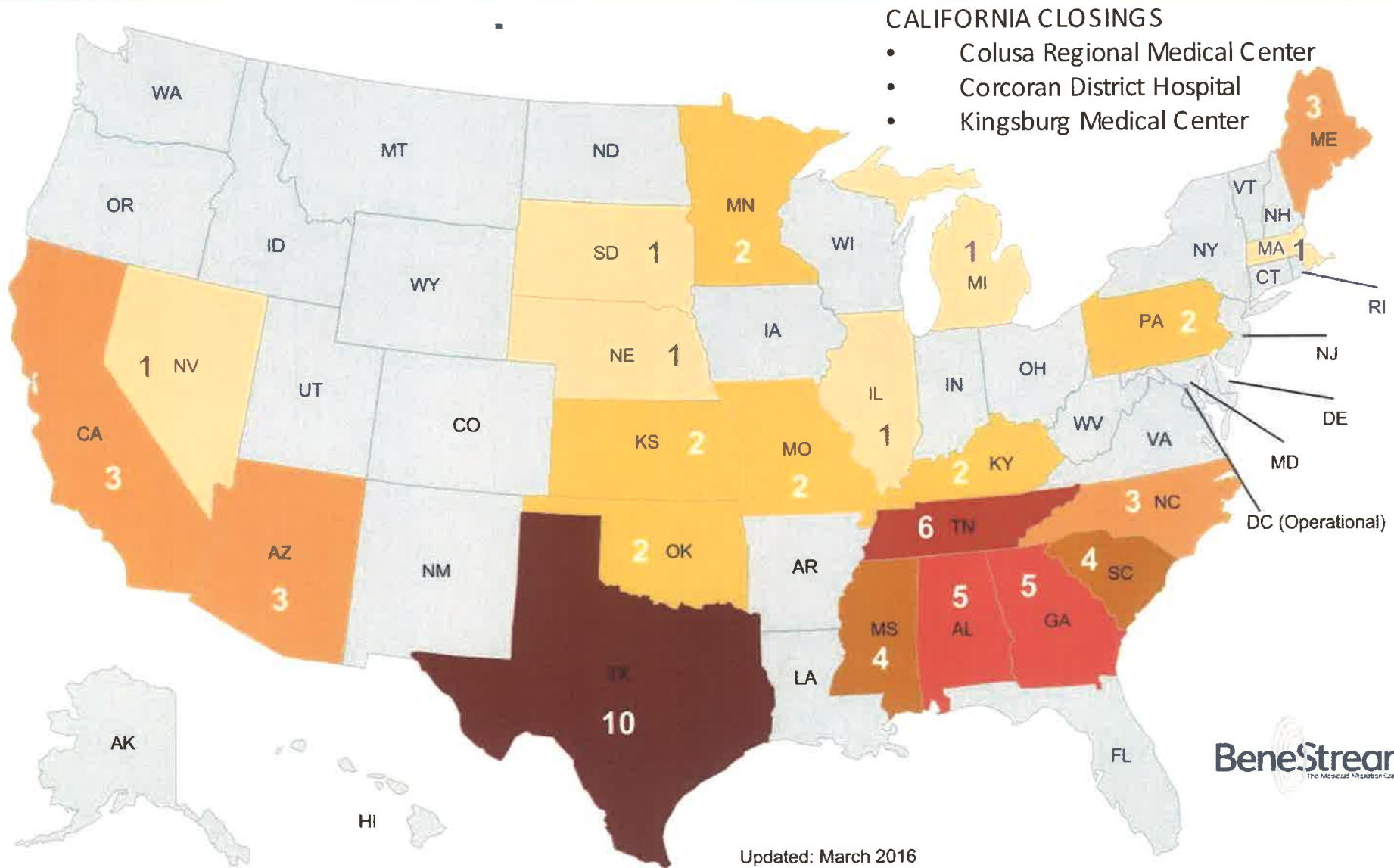
No. 10: Aware of Policies Affecting Future

CAH facilities represent . . .

- 25% of all community hospitals
- 60% of all rural hospitals
- Less than 5% of Medicare expenditures
- 1,300+ essential access points



Rural Hospital Closures: 2010 – March 2016



Updated: March 2016
 Source: University of North Carolina Rural Health Research Program



No. 10: Aware of Policies Affecting Future

- Communicate that investing in rural health care is needed for both:
 - Rural community
 - Rural patient (and maintaining access to care)
- Demonstrate cost effectiveness of providing care in rural America



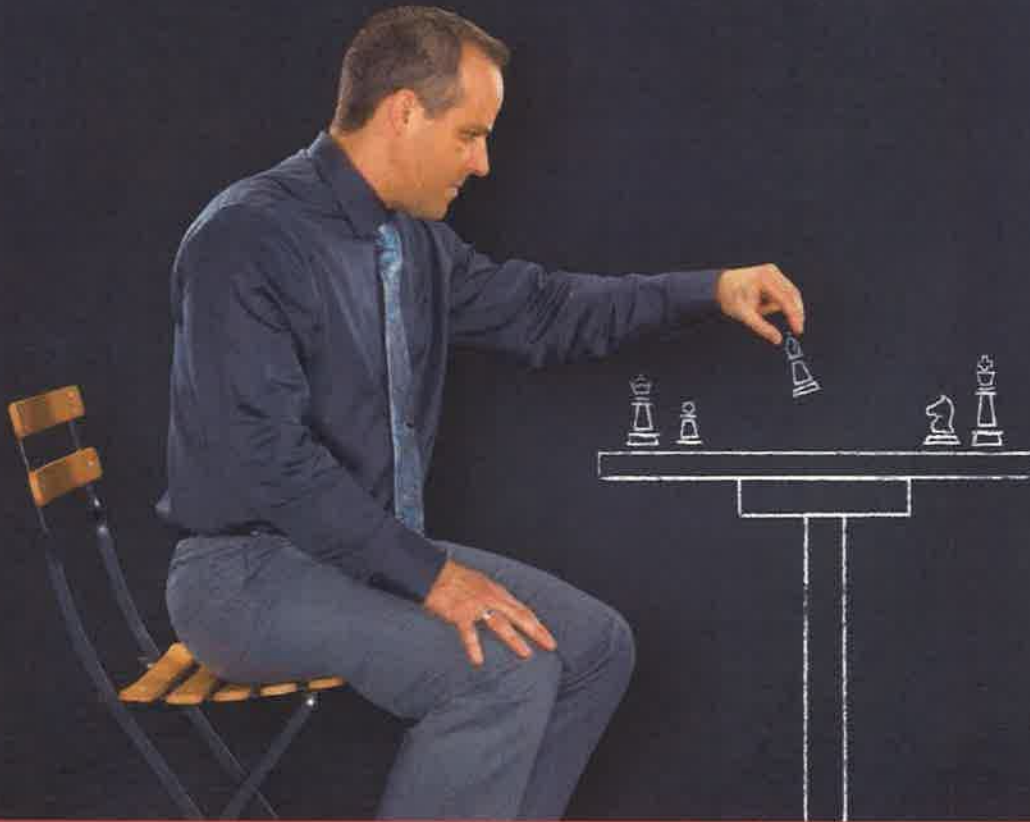
Rural Hospitals Have a Lot to be Proud of...



- Rural hospital performance on CMS Process of Care measures is on par with urban hospitals
- Rural hospital performance on CMS outcome measures is better than urban hospitals
- Medicare spent \$2.2 billion less on rural beneficiaries or -3.7% than on urban beneficiaries

Source: "Rural Relevance Under Healthcare Reform"(based on Medicare Shared Savings Data Files) 1/23/12
<http://www.ivantagehealth.com/>

Focus on NIH



WIPFLi^{LLP}
CPAs and Consultants
HEALTH CARE PRACTICE





Benchmarking: NIH Volumes

Northern Inyo Healthcare District

Fiscal Year

6/30/15



- Bottom performance group 
- Below average performance group 
- Above average performance group 
- Best performance group 

Indicator	Hospital Values		Mean	Min.	25th Quartile	50th Quartile (Median)	75th Quartile	Max.
Total Surgeries	1,313		742	84	285	541	994	3,032
ER Visits	8,831		5,874	1,215	3,246	4,552	7,975	21,405
Births	198		142	1	47	155	215	359
Lab Tests	115,335		77,838	18,258	41,145	61,219	87,884	373,409
Radiology Tests	12,224		8,096	1,272	4,007	6,544	11,873	26,986
CT Tests	1,405		2,796	488	1,058	1,489	2,743	33,175
Ultrasound Tests	2,137		1,894	343	773	1,082	1,585	17,693
MRI Tests	7,193		763	65	276	367	850	7,193
Respiratory Therapies	50,686		11,787	828	3,728	9,018	14,745	66,902
Physical Therapies	20,362		15,036	353	6,013	12,922	19,888	56,448
Pharmacy Units	255,434		115,668	0	63,773	89,328	179,251	355,880





Benchmarking: NIH Costs











Northern Inyo Healthcare District

Fiscal Year

6/30/15



- Bottom performance group 
- Below average performance group 
- Above average performance group 
- Best performance group 

Indicator	Hospital Values	Mean	Min.	25th Quartile	50th Quartile (Median)	75th Quartile	Max.
Labor Hours	700,960 	416,110	140,816	247,718	333,476	535,933	1,108,744
Hours per APD	58.44 	28.00	7.23	20.16	26.45	33.54	62.99
Outpatient Revenue %	66.7% 	78.1%	48.2%	73.8%	78.2%	84.7%	92.5%
ER \$ per Visit	\$545.12 	\$379.48	\$115.77	\$261.12	\$373.60	\$475.64	\$945.73
Nursing Expense per APD	\$254.16 	\$156.74	\$50.43	\$92.31	\$133.66	\$190.86	\$633.64
ICU Expense per Day	\$4,894.88 	\$1,958.08	\$448.59	\$985.94	\$1,731.41	\$2,136.14	\$5,256.00
Surgery Expense per Surgery	\$3,199.73 	\$1,783.59	\$249.36	\$937.54	\$1,417.22	\$2,142.25	\$5,431.27
\$ per Lab Test	\$41.57 	\$20.57	\$1.38	\$15.63	\$18.94	\$22.39	\$58.48
\$ per Radiology Test	\$423.74 	\$153.46	\$41.77	\$98.78	\$138.95	\$167.34	\$464.32
\$ per Physical Therapies	\$58.56 	\$46.93	\$6.78	\$27.88	\$39.46	\$46.12	\$207.39





Benchmarking: Overhead/General Costs


Northern Inyo Healthcare District

Fiscal Year

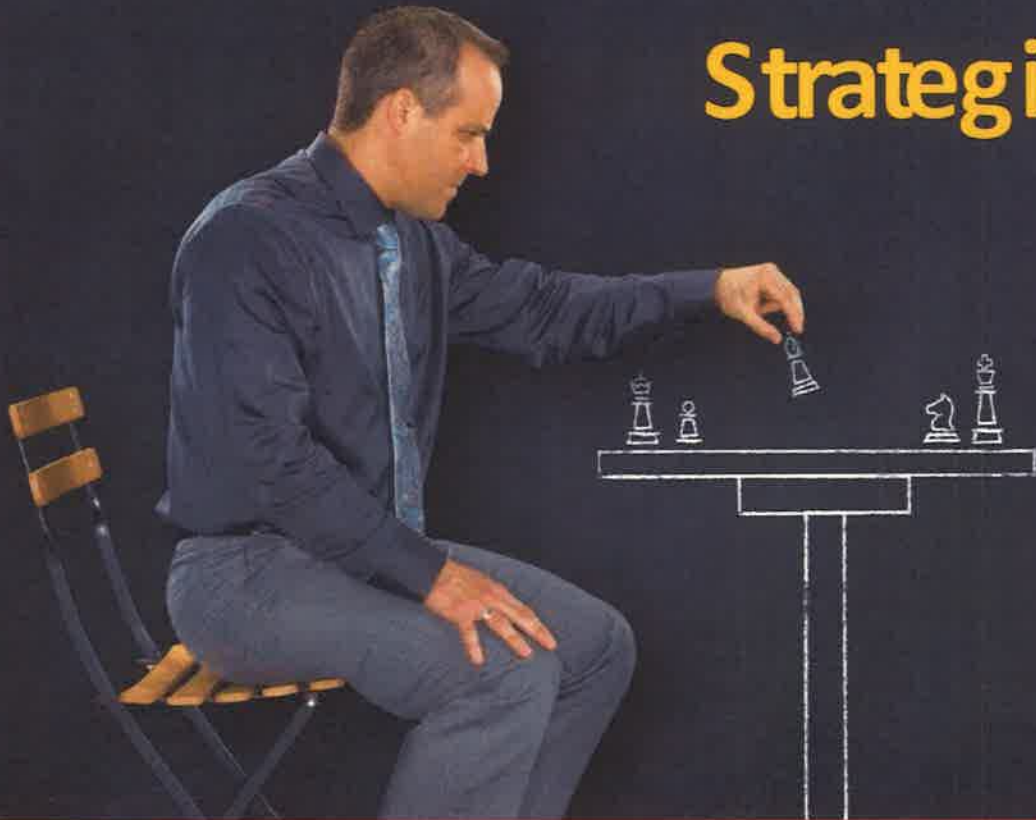
6/30/15



- Bottom performance group 
- Below average performance group 
- Above average performance group 
- Best performance group 

Indicator	Hospital Values	Mean	Min.	25th Quartile	50th Quartile (Median)	75th Quartile	Max.
Cost (Salaries/Benefits) per Hour	\$54.80 	\$37.18	\$21.28	\$31.17	\$36.99	\$41.69	\$54.80
Hours per APD	58.44 	28.00	7.23	20.16	26.45	33.54	62.99
Maintenance \$ per Square Foot	\$14.46 	\$9.96	\$2.48	\$6.77	\$9.40	\$11.94	\$36.77
Housekeeping \$ per Square Foot	\$10.04 	\$4.49	\$1.09	\$2.66	\$3.39	\$5.41	\$18.23
Medical Records \$ per Acute APD	\$81.96 	\$28.77	\$3.97	\$17.00	\$23.93	\$37.93	\$109.17
Human Resources \$ per All APD	\$39.90 	\$23.13	\$2.17	\$7.39	\$15.37	\$26.41	\$189.18
Finance \$ per All APD	\$62.93 	\$24.87	\$0.00	\$9.84	\$20.07	\$33.09	\$98.22

Future Direction and Strategic Prioritization



WIPFLi
CPAs and Consultants
HEALTH CARE PRACTICE

It Used to be Simpler. . .

- Medicine was genuinely simpler, requiring less in the way of expensive equipment and specialized technical personnel
- Care was relatively cheap and structures of reimbursement were rudimentary (frequently involving patient self-payment)

**The Hospital was more
charity than business**

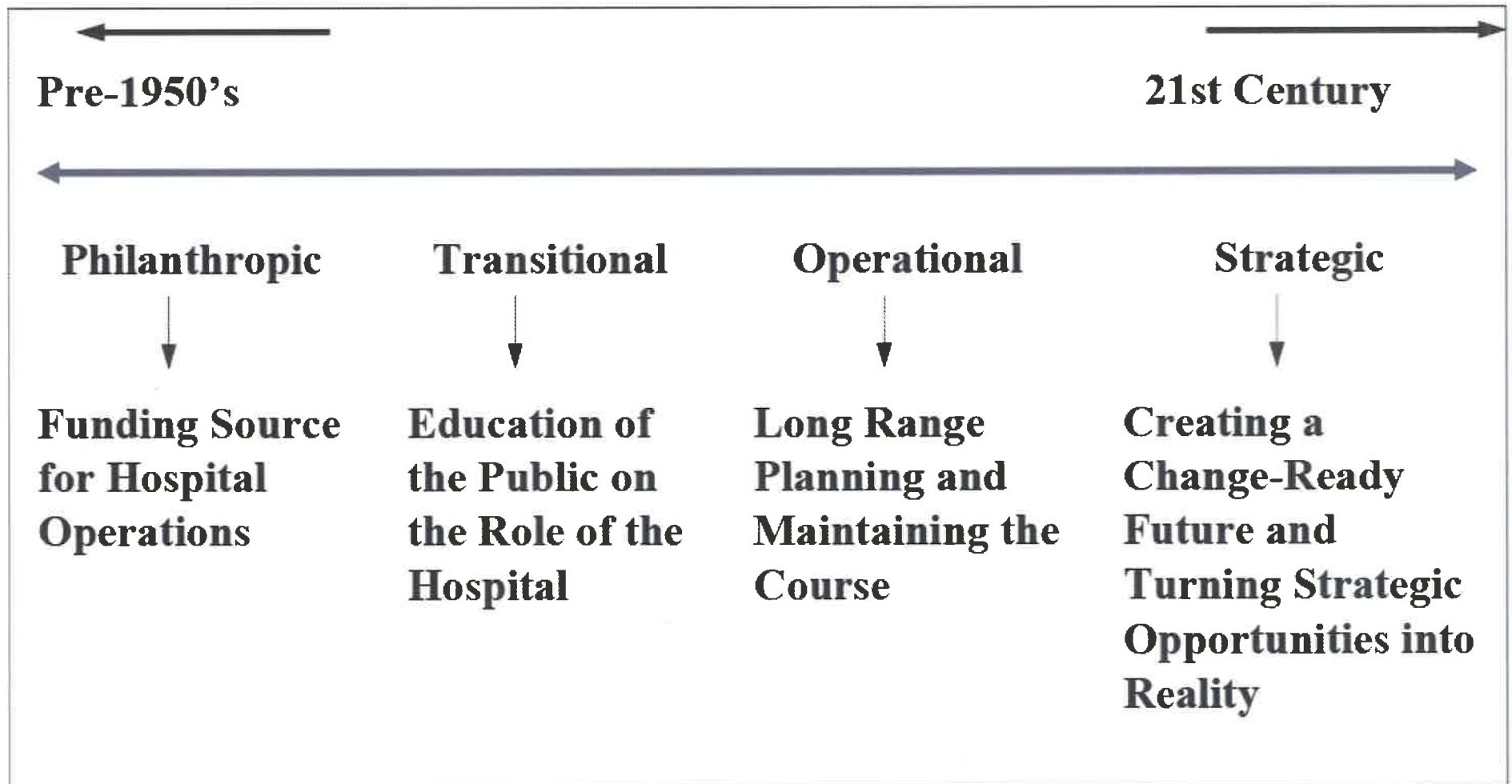
Traditional Role of Hospital Board

- Comprised of local business people & professionals
- Directors raised charitable donations (no Foundation Board)
- Encouraged volunteer participation in hospital life
- Light oversight of management that was lean and uncomplicated by today's standards

TO DAY

Boards have not only the fiscal responsibility of the hospital, but also responsibility for the quality and cost of care.

Evolution of Role of Hospital Boards



Overview of Strategic Financial Planning

Strategic Initiatives

- Identify key elements to carry forward in strategic planning
- Defining what you will do

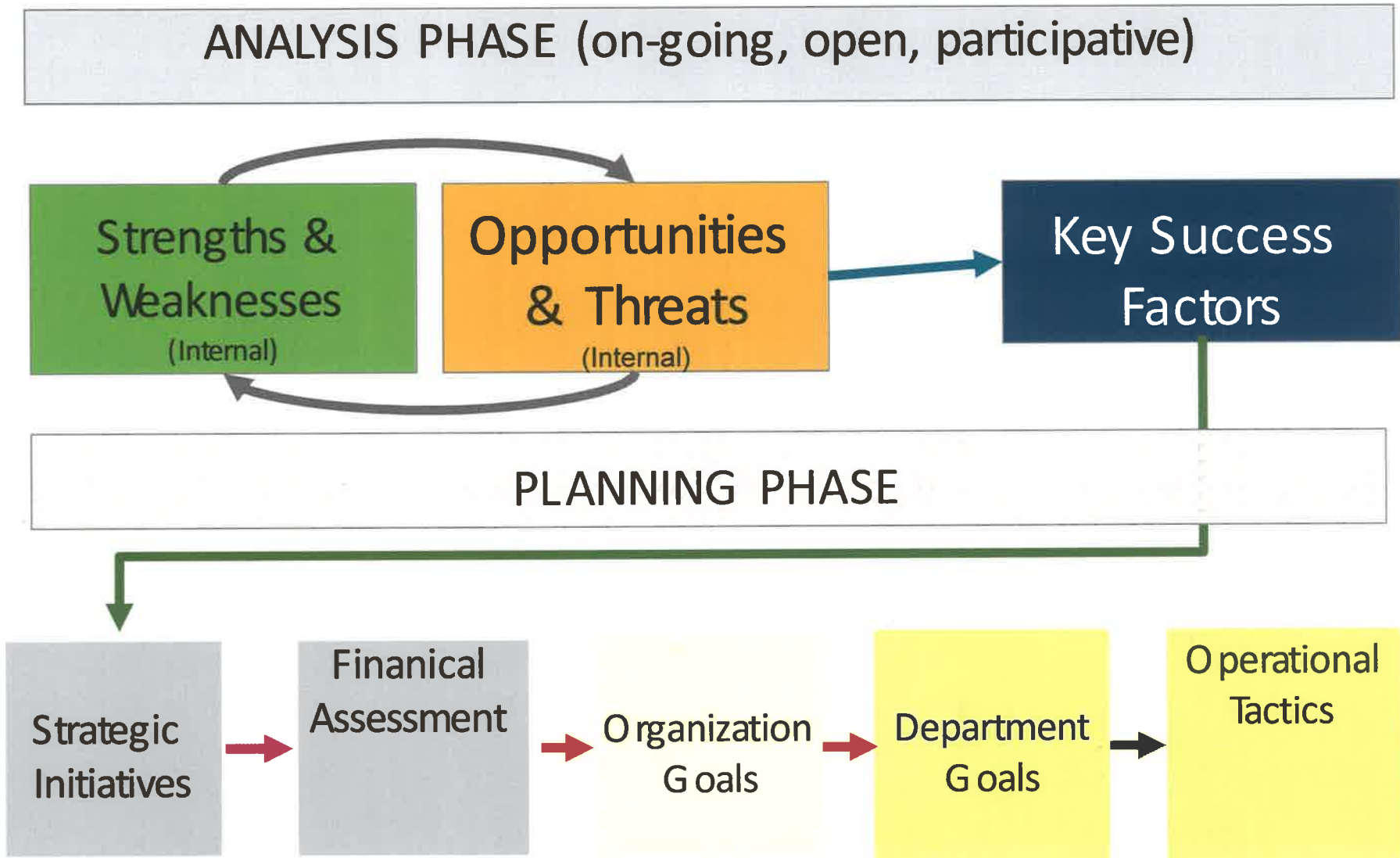
Prioritize & Quantify

- Translates potential impact of initiatives on financial position
- Revisit and agree upon priorities for strategic initiatives

Tactics

- Specifying exactly how you will proceed (i.e., what tasks)
- Assign team to develop tactics to achieve strategic initiatives

Strategic Planning Process



Your Role Today

Board

Senior Management &

Medical Staff

Management

Supervisor

Strategic

Operational

Tactical



For Discussion– Key Strategic Questions

- What issues are most relevant to NIH today, in the future?
- Are we doing all we can to maximize how we are paid today?
- Is there a need for additional management or clinical expertise?
- How are we preparing our community for changes in healthcare and the role of the hospital?
- Are we properly aligning our primary care practices with the quality and cost-effectiveness goals of tomorrow?
- Will there be access to capital for improvements and for transformation into a consumer-facing organization?
- Which initiatives should be the primary focus?

Priorities for NIH

- To be Completed on Site
- Short term
- Longer term

These initiatives will be supported by tactics to achieve in documented strategic plan.

Next Steps

Session #2

- Present quantitative information on current and future state “status quo”
- Model two or three key initiatives identified today to project high-level cost estimates and impact on financials
- Refine strategic options and project impact onto financial situation as necessary

WIPEFLi LLP

CPAs and Consultants

HEALTH CARE PRACTICE

wipfli.com/healthcare

NORTHERN INYO HEALTHCARE DISTRICT

DISTRICT BOARD RESOLUTION 19-03

WHEREAS, pursuant to Chapter 932 of the statutes of 1933 was added to the California Government Code to create Health Care Districts; and

WHEREAS, the Board of Directors of the Northern Inyo Healthcare District does hereby finds that the deposit and withdrawal of money, the creation and maintenance of accounts for the benefits and compensation of the employees, payment of vendors and suppliers of the Health Care District and its business entities as outlined in Section 1, Division 23, Article 2; of the Statute and,

NOW THEREFORE, BE IT RESOLVED, that the Board of Directors of the Northern Inyo Healthcare District does hereby authorize the creation and maintenance of accounts the deposit of monies and withdrawal of monies of Northern Inyo Healthcare District for the purpose of operating the business entities of the District and,

BE IT FURTHER RESOLVED by the Northern Inyo Healthcare District Board of Directors, meeting in regular session this 20th day of March, 2019 that the Chief Executive Officer; Kevin S. Flanigan, MD, MBA; Chief Operating Officer, Kelli Davis; Chief Nursing Officer, Tracy Aspel, and the Chief Financial Officer; John Tremble, or their successors in office, shall be authorized to operate all financial accounts of the organization and to create additional accounts as needed to meet the business needs of the Healthcare District in accordance with Section 1, Division 23, Article 2 of the California Chapter 932 Statute.

BE IT FURTHER RESOLVED that this Resolution be made a part of the minutes of this meeting.

Mary Mae Kilpatrick, President _____
Northern Inyo Healthcare District Date

Attest: _____
Robert Sharp, Secretary _____
Northern Inyo Healthcare District Date

DIAGNOSTIC IMAGING
POLICY AND PROCEDURE ANNUAL APPROVAL

1. CT Dose Documentation

Med/Surg Policies

For BOD Review March, 2019

Title
Admission Procedure to the Acute Sub Acute Department*
Chart Check Guidelines
Cylinder Safety and Handling
Discharge Planning for Homeless Patients
eMAR Downtime Procedure
Emergency Medication and Code Blue Crash Cart Policy
FUNCTIONAL RISK ASSESSMENT CRITERIA FOR THERAPY REFERRAL*
ICU Acuties
Interfacility Transfer Guidelines
Intubation Tray Adult/Pediatric
Intubation Tray Infant
Iron Dextran (Imferon) Administration
MIG (Intravenous Immune Globulin)
Latex Precautions
Leaving Hospital Against Medical Advice Refusal of Treatment or Transfer
Lidocaine Anesthetic For Local Infiltration Prior To Peripheral Catheter Placement
Medication Reconciliation
Myocardial Perfusion Stress Test: Nuclear
Neupogen / Procrit Administration
Nourishment - Patient Request
NPO Guidelines
Nursing Care of Outpatient Interventional Radiology Patient
Nutritional IV
OmniCell Automated Dispensing Unit (ADU)
Ordering Dietary Supplements
ORTHOPEDIC HARDWARE
PAPR Respirator Inspection Record
Patient Nutritional Care
Patient Warmer (Warm Air Hyperthermia System)
Physician Certification Form
Physician Request for Consult
Poison and Drug Overdose Information
Portacath Vascular Access System
Potassium Intravenous Administration
Radiation Policy for Management of Patients with Excessive Exposure
Recommendation for Prophylaxis After Occupational Exposure to HIV
Responding to Ventilator, BiPAP, Vapotherm, EtCO2 and SpO2 Alarms
Saline Lock For Blood Draw
Scope of Service Acute/Subacute*
Self Help Utensils

Med/Surg Policies

For BOD Review March, 2019

SUBMISSION OF BIOPSY (TISSUE) SPECIMENS (NOT FLUID)

Surgical Drains Care of

Transfer & Transportation for Patients

Warfarin Monitoring Protocol

Warming Cabinet for Blankets/Solutions

Wound Vac - Vacuum Assisted Closure System ATS

Nursing Administration Policies

For BOD Review March, 2019

Title
Blood Product Replacement During Obstetric Hemorrhage
Discharge Planning for Homeless Patients
Entries in the Medical Record
Guide to Release of Patient Information to the Media
Guidelines for Employee Transportation of Patients
Guidelines for Licensed Nurses Nursing Students Giving Medications
Kronos Timekeeping System
Leaving Hospital Against Medical Advice Refusal of Treatment or Transfer
Legal Blood Alcohol Intake Form Completion of the
Med Occurrence/Med Errors Scoring and QI Form
Medication Occurrence Report
Medication Reconciliation
Nursing Care of Outpatient Interventional Radiology Patient
Nursing Department Dress Code
Nursing Instructor Policy
OmniCell Automated Dispensing Unit (ADU)
Patient Visitation Rights
Plan for the Provision of Nursing Care
Procedures Requiring Informed Consents
Recommendation for Prophylaxis After Occupational Exposure to HIV
Release of Patient Information to News Media and Patient's Right to Confidentiality
Responsibilities of Nursing Students and Hospital Staff
Safe Injection Practices
Withholding Resuscitative Measures

- CALL TO ORDER** The meeting was called to order at 10:00 am by Mary Mae Kilpatrick, President, in the Northern Inyo Healthcare District (NIHD) Board Room at 2957 Birch Street, Bishop California.
- PRESENT** Mary Mae Kilpatrick, President
Jean Turner, Vice President
Robert Sharp, Secretary
Peter Tracy, Treasurer
M.C. Hubbard, Member at Large
Kevin S. Flanigan, MD, MBA, Chief Executive Officer
John Tremble, Chief Financial Officer
- OPPORTUNITY FOR PUBLIC COMMENT** Ms. Kilpatrick 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.
- LEADERSHIP STRUCTURE PRESENTATION** Chief Executive Officer Kevin S. Flanigan, MD, MBA provided a presentation on Leadership Structure Evolution at the Healthcare District, which included the following:
- Definitions and role expectations for NIHD Chiefs; Directors; Managers; Assistant Managers; and Coordinators
 - Impact of the nurses' union Memorandum of Understanding (MOU) on District management
 - Leadership comparison, September 2015 to present
- BOARD EDUCATION BROWN ACT; COMPLIANCE; ETHICS; AND GOVERNANCE** District Legal Counsel Colin Coffey then provided Board education session on the following topics:
- Fiduciary compliance responsibility
 - Transparency, ethics, and governance
 - Conflicts of interest
 - The Brown Act
 - Key excerpts from Local Healthcare District Law
 -
- He additionally distributed orientation materials for newly elected officials, and tips for Chief Executive and staff success.
- ADJOURNMENT** The meeting was adjourned at 1:37 pm.

Mary Mae Kilpatrick, President

Attest:

Robert Sharp, Secretary

- CALL TO ORDER** The meeting was called to order at 5:30 pm by Mary Mae Kilpatrick, President.
- PRESENT** Mary Mae Kilpatrick, President
Jean Turner, Vice President
Robert Sharp, Secretary
Peter Tracy, Treasurer
M.C. Hubbard, Member at Large
Allison Robinson MD, Chief of Staff
Kevin S. Flanigan MD, MBA, Chief Executive Officer
Kelli Davis, Chief Operating Officer
John Tremble, Chief Financial Officer
Tracy Aspel RN, Chief Nursing Officer
- OPPORTUNITY FOR PUBLIC COMMENT** Ms. Kilpatrick announced at this time persons in the audience may speak on any items not on the agenda for this meeting on any matter within the jurisdiction of the District Board, and speakers will be limited to a maximum of three minutes each. Comments were heard from Robbin Cromer-Tyler MD, who informed the Board that Allison Robinson MD has been appointed to the American Board of Surgeons' Board of Directors as on June 2019.
- CHIEF OF STAFF REPORT** Chief of Staff Allison Robinson, MD reported following careful review, consideration, and approval by the appropriate Committees, the Medical Executive Committee recommends approval of the following hospital-wide Policies and Procedures:
- POLICY AND PROCEDURE APPROVALS** *1. Bone Graft Tissue Bank*
2. Preoperative Interview
3. Scheduling of Nursing Personnel
It was moved by M.C. Hubbard, seconded by Peter Tracy, and unanimously passed to approve Policies and Procedures 1 through 3 as presented.
- ANNUAL REVIEWS APPROVALS** Doctor Robinson also reported the Medical Executive Committee recommends approval of the following Annual Reviews:
1. *Plan to Eliminate or Substantially Reduce Medication-Related Errors 2018-2019*
 2. *Critical Indicators 2019*
 - i. *Emergency Department Critical Indicators*
 - ii. *Surgical Critical Indicators*
 - iii. *Anesthesia Critical Indicators*
 - iv. *Neonatal Critical Indicators*
 - v. *Pediatric Critical Indicators*
 - vi. *Perinatal Critical Indicators*
 - vii. *ICU Critical Indicators*
 - viii. *Medical Services Critical Indicators*

ix. RHC Critical Indicators

It was moved by Mr. Tracy, seconded by Jean Turner, and unanimously passed to approve all Annual Reviews as presented.

STANDARDIZED
PROCEDURES FOR THE
NURSE PRACTITIONER
OR CERTIFIED NURSE
MIDWIFE

Doctor Robinson additionally reported the Medical Executive Committee recommends approval of the following Standardized Procedures for the Nurse Practitioner or Certified Nurse Midwife:

- i. General Policy for the Nurse Practitioner or Certified Nurse Midwife*
- ii. Certified Nurse Midwife and Certified Nurse Midwife First Assistant*
- iii. Adult Health Maintenance*
- iv. Emergency Care Policy*
- v. Furnishing Medications/Devices Policy*
- vi. Laboratory & Diagnostic Testing*
- vii. Management of Acute Illness*
- viii. Management of Chronic Illness*
- ix. Management of Minor Trauma*
- x. Minor Surgical Procedure*
- xi. Well Child Care*

It was moved by Ms. Hubbard, seconded by Robert Sharp, and unanimously passed to approve Standardized Procedures for the Nurse Practitioner or Certified Nurse Midwife 1 through 11 as presented.

STANDARDIZED
PROTOCOLS FOR THE
PHYSICIAN ASSISTANT

Doctor Robinson also reported the Medical Executive Committee recommends approval of the following Standardized Protocols for the Physician Assistant:

- i. General Policy for the Physician Assistant*
- ii. Medical Screening Examination for the Emergency Department Physician Assistant*
- iii. Physician Assistant in the Operating Room*
- iv. Adult Health Maintenance*
- v. Emergency Care Policy*
- vi. Laboratory and Diagnostic Testing*
- vii. Management of Acute Illness*
- viii. Management of Chronic Illness*
- ix. Management of Minor Trauma*
- x. Medication/Device Policy*
- xi. Minor Surgical Policy*
- xii. Well Child Care Policy*

It was moved by Ms. Hubbard, seconded by Mr. Sharp, and unanimously passed to approve Standardized Protocols for the Physician Assistant 1 through 12 as presented.

PROPOSAL OF
EXPANDED CHIEF OF
STAFF POSITION

Doctor Robinson also presented a proposal for an expanded Chief of Staff Role as recommended by the Medical Executive Committee. The proposal included an overview of the recommended responsibilities for the Chief of Staff, and a financial analysis of the costs involved.

Following discussion of this agenda item Ms. Kilpatrick stated a decision on this topic will be tabled to a future meeting of the District Board, in order to allow for a deeper analysis of all aspects involved.

STRATEGIC PLAN
UPDATE, QUALITY
AND PERFORMANCE
COMMITTEE REPORT

Stacey Brown MD provided an update on the activities of the Northern Inyo Healthcare District (NIHD) Quality Improvement Operational Team, established for the purpose of helping to achieve the quality and performance-related goals of the District's Strategic Plan. The group's current metric includes assessment of the NIHD employee flu vaccination rate, as well as quarterly infection prevention education for District staff. The District has achieved a year-to-date employee flu vaccination rate of 98%; and a year-to-date infection prevention education rate of 100%. The group is also focused on enhancing a culture of safety District wide, which includes implementation of an employee Safety Coach program at NIHD.

RURAL HEALTH
CLINIC ANNUAL
REPORT

Doctor Brown also provided an annual NIHD Rural Health Clinic update, which included information on the following:

- History and evolution of the Rural Health Clinic (RHC) from 2001 to present
- Current Clinic status regarding staffing and care coordination
- Innovations implemented at the Clinic including telemedicine; specialty services, and a Same Day Service line
- Report on the future direction of the Clinic including preventative medicine; chronic care management; transitional care management; after hours provider team contact; coordination with new geriatric/memory services; and an expansion of services to the Bishop Care Center

QUARTERLY
COMPLIANCE REPORT

Compliance Officer Patty Dickson provided a quarterly Compliance Department report which included the following:

- Comprehensive Compliance Program review
- Summary of Personal Health Information breaches for Calendar Year 2018
- Review of compliance issues and inquiries
- Overview of audits performed; California Public Records Act requests; the Compliance Work plan; Licensing Survey response monitoring; and Conflicts of Interest questionnaires

It was moved by Mr. Sharp, seconded by Ms. Hubbard, and unanimously passed to accept the Compliance Department quarterly report as presented.

DISTRICT WIDE
POLICY AND
PROCEDURE
APPROVALS

Chief Nursing Officer Tracy Aspel called attention to the following (proposed) District wide Policies and Procedures:

- *Authorization of Hours Worked Beyond Regularly Scheduled Shift (Including Overtime Request).*
- *Guidelines for Licensed Nurses Nursing Students Giving Medications*

- *Thrombolytic Therapy for Acute Myocardial Infarction*

It was moved by Ms. Hubbard, seconded by Ms. Turner, and unanimously passed to approve all three Policies and Procedures as presented.

CHARGE CAPTURE
POLICY

Chief Financial Officer John Tremble called attention to a proposed Policy and Procedure titled *Charge Capture Policy*. It was moved by Mr. Sharp, seconded by Ms. Hubbard, and unanimously passed to approve the proposed *Charge Capture Policy* as presented.

BOARD DISCUSSION
ON RESPONSE TO
EMAILS AND LETTERS

Discussion took place on the topic of Board of Directors response to emails and letters received. At the conclusion of discussion it was determined that receipt of correspondences by the Board can and should be acknowledged (any number of Board members may respond independently), then responsibility and determination of further action needed will be handled by the Chief Executive Officer (CEO). The CEO will later provide feedback to the Board of Directors as appropriate.

STRATEGIC PLAN
STATUS REPORT AND
NEXT STEPS

Doctor Flanigan provided a status report on progress made toward achieving the goals of the District's Strategic Plan, including an overview of leadership's current strategies in the areas of patient experience; the workforce experience; quality; and finance and market share. He also provided a look forward at upcoming initiatives and proposed expansion of services, as well as future leadership strategies.

PHASE II RESPONSE TO
BUDGET

Doctor Flanigan also provided an update on Phase II of the District's response to a projected budget deficit for the second half of the current fiscal year. He reviewed cost reduction efforts to date, and stated that Phase II will include looking at consolidation of responsibilities; pulling two positions from the budget; changing staffing models; and an expected expansion of the Chief of Staff role. He additionally noted that Phase III of the District's response to budget will take place during the fourth quarter of this fiscal year.

BRIDGE GRANT
AWARD

Doctor Flanigan also reported that NIHD has been selected to participate in the California Bridge Program, an accelerated training program for healthcare providers to facilitate treatment of substance use disorders. The amount of NIHD's Bridge grant award is \$175,000, which will fund an 18-month program developed in response to the opioid crisis.

OFFICE SPACE MOVES

Doctor Flanigan additionally stated there is some level of concern in the community regarding the many office space moves and relocations of staff that are currently in progress within the District. He explained that reason for the moves is to consolidate departments into one area, in particular Finance staff which is currently spread out in several different locations within the facility.

CONSENT AGENDA

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

- *Approval of minutes of the January 16 2019 regular meeting*
- *Approval of minutes of the February 6 special meeting*
- *Policy and Procedure annual approvals*

It was moved by Mr. Tracy, seconded by Ms. Turner, and unanimously passed to approve all three Consent Agenda items as presented.

BOARD MEMBER
REPORTS

Ms. Kilpatrick asked if any members of the Board of Directors wished to report on any items of interest. Director Turner expressed appreciation of the Association of California Healthcare Districts (ACHD) Legislative Day, which was recently attended by the full Board and the Chief Executive Officer. Director Sharp commented that he has received positive feedback from employees regarding District leadership, and Director Hubbard reminded everyone that the Blue Ribbon Run/Walk/Ride event will take place on Saturday, March 9. No other comments were heard.

ADJOURNMENT TO
CLOSED SESSION

At 8:00pm Ms. Kilpatrick announced the meeting would adjourn to Closed Session to allow the Board of Directors to:

- A. Confer with Legal Counsel regarding potential litigation, 1 matter pending (*pursuant to Government Code Section 54956.9(d)(2)*).

RETURN TO OPEN
SESSION AND REPORT
OF ACTION TAKEN

At 8:15 pm the meeting returned to Open Session. Ms. Kilpatrick reported the Board took no reportable action.

ADJOURNMENT

The meeting was adjourned at 8:16 pm.

Mary Mae Kilpatrick, President

Attest:

Robert Sharp, Secretary