Northern Inyo Healthcare District

Board Meetings

December 20, 2023 Regular Board Meeting

NORTHERN INYO HEALTHCARE DISTRICT
One Team. One Goal. Your Health.

AGENDA
NORTHERN INYO HEALTHCARE DISTRICT
BOARD OF DIRECTORS REGULAR MEETING

December 20, 2023 at 5:30 p.m.
Northern Inyo Healthcare District invites you to join this meeting:

TO CONNECT VIA **ZOOM**: (*A link is also available on the NIHD Website*)
https://zoom.us/j/213497015?pwd=TDlIWXRuWjE4T1Y2YVFWbnF2aGk5UT09
Meeting ID: 213 497 015
Password: 608092

PHONE CONNECTION:
888 475 4499 US Toll-free
877 853 5257 US Toll-free
Meeting ID: 213 497 015

The Board is again meeting in person at 2957 Birch Street Bishop, CA 93514. Members of the public will be allowed to attend in person or via zoom. Public comments can be made in person or via zoom.

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1. Call to Order (at 5:30 pm).
2. ***Public Comment***: The purpose of public comment is to allow members of the public to address the Board of Directors. Public comments shall be received at the beginning of the meeting and are **limited to three (3) minutes per speaker**, with a total time limit of thirty (30) minutes for all public comment unless otherwise modified by the Chair. Speaking time may not be granted and/or loaned to another individual for purposes of extending available speaking time unless arrangements have been made in advance for a large group of speakers to have a spokesperson speak on their behalf. Comments must be kept brief and non-repetitive. The general Public Comment portion of the meeting allows the public to address any item within the jurisdiction of the Board of Directors on matters not appearing on the agenda. Public comments on agenda items should be made at the time each item is considered.
3. Reports from Board Members
   A. Governance (Jean Turner)

B. Human Resources (Mary Mae Kilpatrick)

C. Finance (Melissa Best-Baker)

4. New Business:

A. Election of Board Officers for Calendar Year 2024 (*Board will appoint Officers for calendar year 2024*)

B. Chief Executive Officer Report *(Board will receive this report)*

a. Ridgecrest

b. CFO Search

c. Leadership Training

C. Chief Financial Officer Report

a. Financial & Statistical Reports *(Board will consider the approval of these reports*)

b. Clifton Larson Allen LLP Charge Capture – Statement of Work *(Board will consider the approval of this agreement)*

c. Mid-Year Projection *(Board will receive this information)*

D. District Board Resolution 23-08 *(Board will consider approval of District Board Resolution 23-08)*

E. Cerner Work Queue Monitor (*Board will consider the approval of this agreement)*

F. Board of Director Bylaws (*Board will consider the approval of these Bylaws)*

G. Bronco Clinic Presentation *(Board will receive this report)*

H. Chief of Staff Report, Sierra Bourne MD:

a. Medical Staff Appointments *(Board will consider the approval of these Medical Staff Appointments)*

1. Neil Bhathela, DO (Neurology) – Telemedicine Staff

2. Atalanta Olito, DO (Anesthesiology) – Active Staff

3. Luis Esparza, MD (Anethesiology) – Active Staff

b. Medical Staff Reappointments 2024-2025 *(Board will consider the approval of these Medical Staff Reappointments)*

	Last Name	**First Name**	**Title**	**Specialty**	**Category**
1.	Ahmed	Farres	MD	Interventional Radiology	Active
2.	Al Danaf	Jad	MD	Cardiovascular Disease	Telehealth - FPPE
3.	Alim	Muhammad	MD	Pulmonary Disease	Telehealth
4.	Brieske	Timothy	MD	Family Medicine	Active
5.	Brown	Stacey	MD	Family Medicine	Active

6.	Burnier	Andre	MD	Emergency Medicine	Courtesy - FPPE
7.	Ebner	Benjamin	MD	Cardiovascular Disease	Telehealth
8.	Erogul	John	MD	Diagnostic Radiology	Courtesy
9.	Farooki	Aamer	MD	Diagnostic Radiology	Telehealth
10.	Figueroa	Jennifer	PAC	Physician Assistant	APP
11.	Garg	Shilpi	MD	Pediatric Cardiology	Telehealth
12.	Gaskin	Gregory	MD	Emergency Medicine	Active
13.	Hathaway	Nickoline	MD	Internal Medicine	Active
14.	Hawkins	John	DO	Emergency Medicine	Active
15.	Hewchuck	Andrew	DPM	Podiatry	Active
16.	Hosseini	Alireza	MD	Endocrinology	Telehealth
17.	Irons	Matthew	PAC	Physician Assistant	APP - FPPE
18.	Jesionek	Adam	MD	Family Medicine	Active
19.	Kamei	Asao	MD	Internal Medicine	Active
20.	Khine	Htet	MD	Cardiovascular Disease	Telehealth
21.	Kim	Paul	MD	Anesthesiology	Active
22.	Kim	Martha	MD	Obstetrics and Gynecology	Active
23.	Klabacha	Rita	PAC	Physician Assistant	APP
24.	Levy	Justin	MD	Internal Medicine	Courtesy - FPPE
25.	Lizcano	Jennifer	DO	Internal Medicine	Active
26.	Loos	Stephen	MD	Diagnostic Radiology	Active
27.	Ma	Ruhong	DO	Internal Medicine	Active
28.	Majlessi	Azadeh	MD	Rheumatology	Telehealth
29.	Maki	Erik	MD	Interventional Radiology	Courtesy
30.	Malloy	Sarah	FNP	Nurse Practitioner, Family	APP
31.	Marvin	Shawn	MD	Diagnostic Radiology	Telehealth - FPPE
32.	McEnany	Michael	MD	Emergency Medicine	Active - FPPE
33.	Meredick	Richard	MD	Orthopaedic Surgery	Active
34.	Meredick	Kristin	MD	Pediatrics	Active
35.	Norris	Jennifer	CNM	Certified Nurse Midwife	APP
36.	O'Neill	Tammy	PAC	Physician Assistant	APP
37.	Page	Nolan	DO	Emergency Medicine	Courtesy - FPPE
38.	Peterson	Snow	DO	Sleep Medicine	Telehealth
39.	Pflum	Jeannie	DO	Obstetrics and Gynecology	Courtesy
40.	Plank	David	MD	Plastic Surgery	Courtesy
41.	Pomeranz	David	MD	Emergency Medicine	Active
42.	Quach	Truong	MD	Family Medicine	Active
43.	Redelman	Ryan	MD	Diagnostic Radiology	Courtesy - FPPE
44.	Reid	Thomas	MD	Ophthalmology	Active
45.	Ricci	Lindsey	MD	Pediatrics	Active

46.	Robinson	Chelsea	MD	Emergency Medicine	Active - FPPE
47.	Rowan	Christopher	MD	Cardiovascular Disease	Telehealth
48.	Swackhamer	Robert	MD	Cardiovascular Disease	Telehealth
49.	Tiernan	Carolyn	MD	Emergency Medicine	Courtesy
50.	Tseng	Ian	MD	Diagnostic Radiology	Telehealth
51.	Turner	Gary	MD	Diagnostic Radiology	Courtesy
52.	Wakamiya	Anne	MD	Internal Medicine	Active
53.	Wasef	Eva	MD	Pathology	Active
54.	Wilson	Christopher	MD	Cardiovascular Disease	Telehealth

c. Privileges Expiring 12/31/2023 *(information item)*

1. Scott Brown, MD (Urology) – Reappointment Application not submitted
2. Daniel Firer, MD (Family Medicine/Emergency Medicine) – Reappointment Application not submitted

d. Privilege Form Update *(Board will consider the approval of this Form)*

1. Certified Nurse Midwife

e. Policies (*Board will consider the approval of these Policies and Procedures*)

1. Medical Waste Management Plan

f. Medical Executive Committee Report *(Board will receive this report)*

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5. **Consent Agenda -** *All matters listed under the consent agenda are considered routine and will be enacted by one motion unless any member of the Board wishes to remove an item for discussion.*

A. Approval of minutes of the October 18, 2023 Regular Board Meeting *(Board will consider the approval of these minutes)*

B. Approval of minutes of the November 15, 2023 Regular Board Meeting *(Board will consider the approval of these minutes)*

C. Department Reports *(Board will consider the approval of these reports)*

D. Approval of Policies and Procedures (*Board will consider the approval of these Policies and Procedures)*

a. Workforce Access to His or Her own Protected Health Information
b. Nursing Services Competency Plan
c. Orientation/Cross Training Time Frames
d. Nursing Students Requesting Clinical Preceptorship Rotation
e. Business Associate Agreements Execution and Management

f. Governmental Agent Services
g. Financial Assistance Policy
h. DI Venipuncture by Radiologic Technologists
i. ALARA Program
j. DI – Posting Requirements for Radiology
k. DI – Repeat Rate and Analysis
l. DI NM General Rules for the Safe Use of Radioactive Materials
m. Diagnostic Imaging – C-Arm (fluoroscope) Radiation Safety
n. Diagnostic Imaging – Disposal of radioactive sharps
o. Diagnostic Imaging – Guidelines for use of radiology equipment in other areas
p. Diagnostic Imaging – Handling of Radioactive Packages, Non-nuclear medicine personnel
q. Diagnostic Imaging – Imaging Equipment Quality Control
r. Diagnostic Imaging – Maintenance of Diagnostic Imaging Equipment
s. Diagnostic Imaging – Monitoring and Documentation of Fluoroscopic Quality Control
t. Diagnostic Imaging – Nuclear Medicine New Employee/Annual Orientation
u. Diagnostic Imaging – Ordering Privilege and Procedure
v. Diagnostic Imaging – Ordering Radioactive Materials
w. Diagnostic Imaging – Radioactive Material Hot Lab Security
x. Diagnostic Imaging – Radioactive Materials Deliver After-hours Procedure
y. Diagnostic Imaging – Radioactive Waste Storage and Disposal
z. Dosimetry Program – Occupational Radiation Exposure Monitoring Program
aa. Mammography Medical Audit Procedure
bb. Radiation Safety Committee Charter
cc. Radiology Services Pregnant Personnel

E. General Information from Board Members (*Board will provide this information*)
F. Public comments on closed session items.
G. Adjournment to Closed Session to/for:
    a. Medical Staff Report *(pursuant to Government Code Section 32155)*
H. Adjournment

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

Northern Inyo Healthcare District
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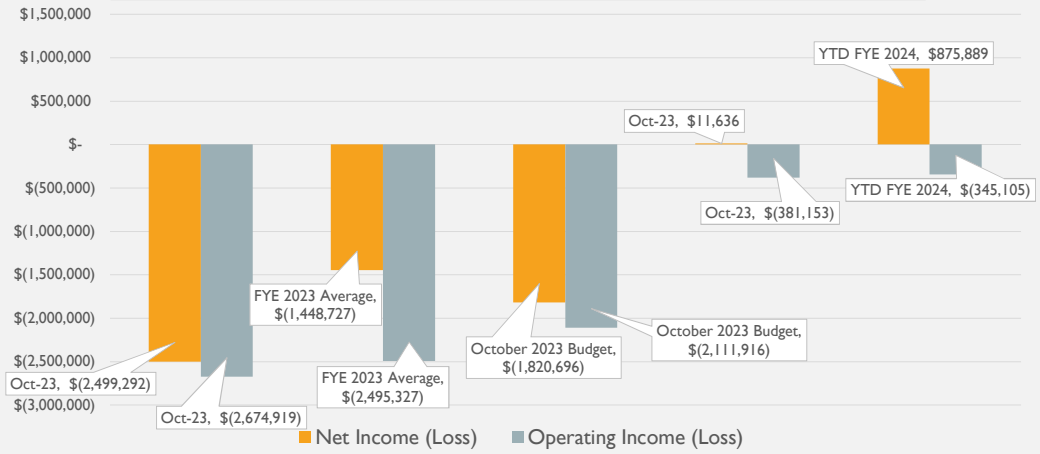
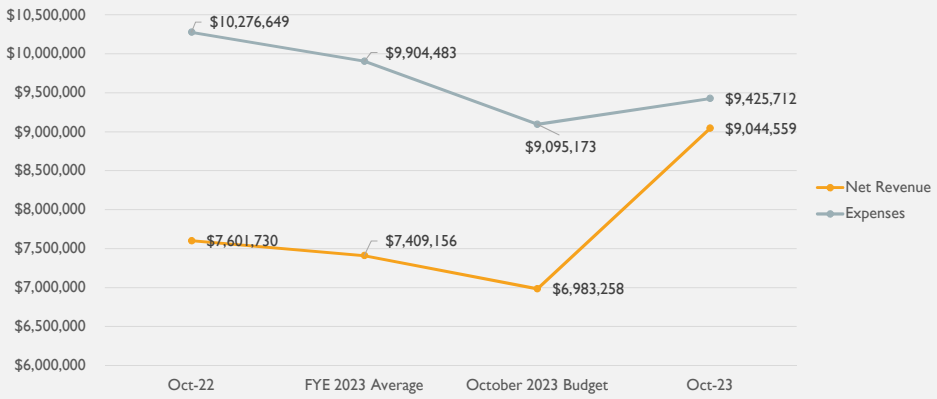
NIHD FINANCIAL UPDATE

October 2023

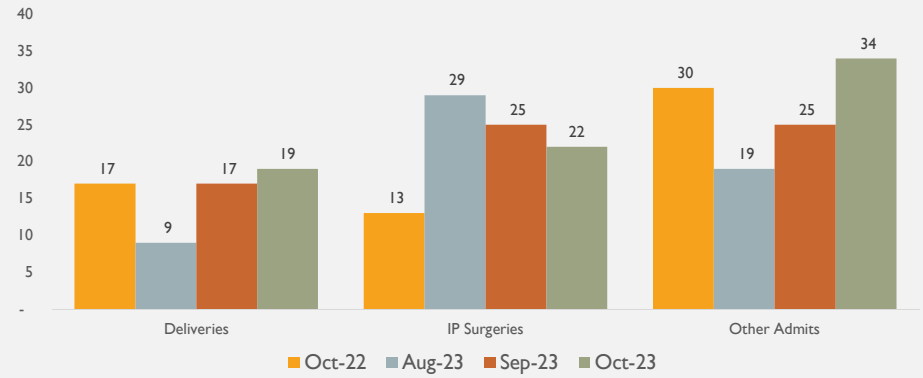
OCTOBER 2023 FINANCIAL PERFORMANCE



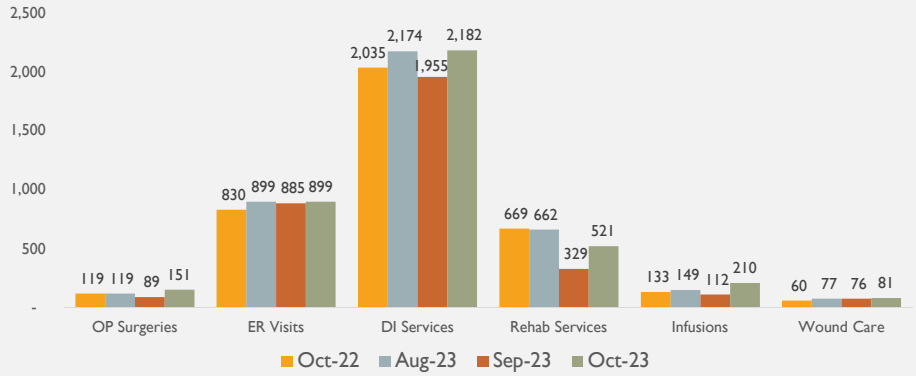
OCTOBER 2023 OPERATING INCOME (LOSS) PERFORMANCE



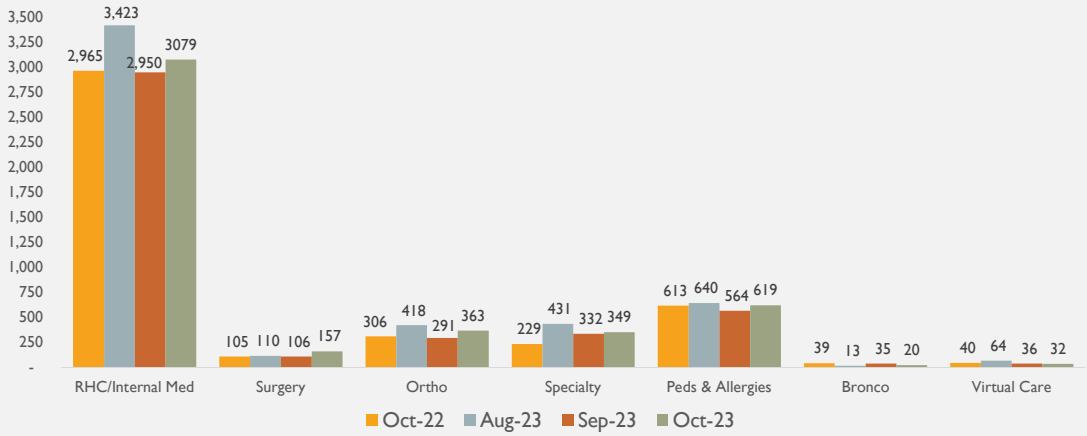
OCTOBER 2023 INPATIENT VOLUME PERFORMANCE



OCTOBER 2023 OUTPATIENT VOLUME PERFORMANCE



OCTOBER 2023 CLINIC VOLUME PERFORMANCE



KEY PERFORMANCE INDICATORS

CASH

Metric	October 2022	October 2023	% Change
Average Daily Expenses	$316,166	$323,315	2%
Unrestricted Funds	$26,063,196	$16,841,267	-35%
Average Daily Cash (includes grants, IGT, and tax appropriations)	$363,506	$286,692	-21%
Average Daily Net Cash	$47,340	-$36,623	-177%

WAGE COSTS

Metric	FYE 2023 Average	October 2023	% Change
Total Paid FTEs	425	353	-7%
Salaries, Wages, Benefits (SWB) per Adjusted Patient Day (APD)	$5,935	$4,771	-36%
Employed Average Hourly Rate	$48.51	$51.98	24%
Benefits % of Wages	59%	60%	1%

AUDIT UPDATE

- Still wrapping up the audit

Northern Inyo Healthcare District
Income Statement
Fiscal Year 2024

	7/31/2023	7/31/2022	8/31/2023	8/31/2022	9/30/2023	9/30/2022	10/31/2023	10/31/2022	2024 YTD	2023 YTD	YOY Change
Gross Patient Service Revenue											
Inpatient Patient Revenue	3,306,704	3,986,305	3,728,137	3,395,933	3,530,592	1,938,350	3,277,300	2,813,064	13,842,733	12,133,651	464,236
Outpatient Revenue	13,693,264	11,474,649	14,800,302	12,619,549	12,209,645	11,643,340	14,790,086	12,337,627	55,493,297	48,075,165	2,452,459
Clinic Revenue	1,274,341	1,112,050	1,721,328	1,281,637	1,455,030	1,298,041	1,599,317	1,312,937	6,050,015	5,004,664	286,380
Gross Patient Service Revenue	18,274,309	16,573,004	20,249,767	17,297,119	17,195,267	14,879,730	19,666,703	16,463,628	75,386,045	65,213,480	3,203,075
Deductions from Revenue											-
Contractual Adjustments	(8,174,338)	(6,172,708)	(9,375,676)	(7,321,120)	(4,068,387)	(6,082,559)	(9,911,289)	(9,137,803)	(31,529,690)	(28,714,191)	(773,485)
Bad Debt	(1,040,036)	(1,834,762)	(917,527)	(831,081)	(625,969)	(1,268,812)	(421,557)	589,809	(3,005,089)	(3,344,846)	(1,011,366)
A/R Writeoffs	(330,815)	(378,045)	(718,732)	(717,468)	(784,171)	(739,907)	(289,298)	(325,216)	(2,123,016)	(2,160,635)	35,918
Other Deductions from Revenue	-	497,912	-	(67,000)	-	-	-	950	-	431,862	(950)
Deductions from Revenue	(9,545,189)	(7,887,603)	(11,011,935)	(8,936,670)	(5,478,527)	(8,091,278)	(10,622,143)	(8,872,259)	(36,657,794)	(33,787,810)	(1,749,884)
Other Patient Revenue											-
Incentive Income	-	-	-	-	-	-	-	-	-	-	-
Other Oper Rev - Rehab Thera Serv	1,387	5,303	-	4,367	-	4,346	-	10,361	1,387	24,376	(10,361)
Medical Office Net Revenue	-	-	-	-	-	-	-	-	-	-	-
Other Patient Revenue	1,387	5,303	-	4,367	-	4,346	-	10,361	1,387	24,376	(10,361)
Net Patient Service Revenue	**8,730,507**	**8,690,703**	**9,237,833**	**8,364,816**	**11,716,740**	**6,792,798**	**9,044,559**	**7,601,730**	**38,729,638**	**31,450,047**	**1,442,830**
CNR%	**48%**	**52%**	**46%**	**48%**	**68%**	**46%**	**46%**	**46%**	**51%**	**48%**	**0%**
Cost of Services - Direct											-
Salaries and Wages	2,446,627	2,175,027	2,580,857	2,269,022	3,511,439	2,195,439	2,804,438	2,179,142	11,343,360	8,818,629	625,296
Benefits	1,776,636	2,008,070	1,244,252	1,759,698	1,284,353	1,801,034	1,679,949	1,669,695	5,985,190	7,238,497	10,254
Professional Fees	1,751,172	1,381,538	1,919,787	1,438,889	1,825,852	1,650,775	1,442,077	1,797,498	6,938,888	6,268,700	(355,422)
Contract Labor	225,464	655,016	572,961	622,813	657,327	1,451,288	278,108	1,024,423	1,733,859	3,753,539	(746,315)
Pharmacy	392,685	211,326	655,955	671,932	379,562	54,166	283,643	136,557	1,711,845	1,073,980	147,087
Medical Supplies	393,315	315,752	608,302	290,221	375,431	578,033	690,604	366,356	2,067,653	1,550,362	324,248
Hospice Operations	-	-	-	-	-	-	-	-	-	-	-
EHR System Expense	136,392	107,979	129,805	230,353	8,890	220,408	273,794	183,047	548,880	741,786	90,748
Other Direct Expenses	620,496	546,374	659,948	667,228	569,841	808,934	664,293	572,765	2,514,578	2,595,302	91,528
Total Cost of Services - Direct	7,742,787	7,401,082	8,371,866	7,950,156	8,612,694	8,760,076	8,116,905	7,929,482	32,844,253	32,040,796	187,423
											-
General and Administrative Overhead											-
Salaries and Wages	441,653	360,265	419,843	365,276	541,249	370,478	445,153	381,872	1,847,897	1,477,891	63,281
Benefits	320,415	356,264	178,697	312,157	226,122	316,570	275,400	1,160,994	1,000,633	2,145,984	(885,594)
Professional Fees	243,596	535,217	233,758	190,076	667,309	318,029	(5,392)	265,196	1,139,270	1,308,518	(270,588)
Contract Labor	72,918	30,218	56,818	52,224	43,254	92,958	93,075	57,021	266,065	232,421	36,054
Depreciation and Amortization	324,565	318,087	324,565	332,153	326,475	334,828	324,565	362,317	1,300,170	1,347,386	(37,752)
Other Administative Expenses	175,162	79,314	196,334	164,310	128,953	199,538	176,006	119,767	676,455	562,929	56,239
Total General and Administrative Overhead	1,578,308	1,679,363	1,410,015	1,416,196	1,933,362	1,632,402	1,308,807	2,347,167	6,230,491	7,075,128	(1,038,360)
Total Expenses	**9,321,095**	**9,080,446**	**9,781,881**	**9,366,352**	**10,546,056**	**10,392,477**	**9,425,712**	**10,276,649**	**39,074,744**	**39,115,924**	**(850,937)**
											-
Financing Expense	180,370	183,196	178,594	182,350	177,359	180,796	179,095	182,190	715,417	728,532	(3,095)
Financing Income	228,125	64,203	228,125	431,229	228,125	247,716	228,125	247,716	912,498	990,863	(19,591)
Investment Income	60,924	74,115	52,333	23,389	61,899	(18,154)	158,200	99,582	333,357	178,933	58,618
Miscellaneous Income	140,406	484,508	292,643	(364,949)	72,221	146,486	185,286	10,519	690,556	276,564	174,767
Net Income (Change is Financial Position)	**(341,503)**	**49,888**	**(149,542)**	**(1,094,218)**	**1,355,571**	**(3,404,427)**	**11,363**	**(2,499,292)**	**875,889**	**(6,948,049)**	**2,510,655**
Operating Income	(590,588)	(389,742)	(544,049)	(1,001,537)	1,170,684	(3,599,679)	(381,153)	(2,674,919)	(345,105)	(7,665,877)	2,293,766
Net Profit Margin	-3.9%	0.6%	-1.6%	-13.1%	11.6%	-50.1%	0.1%	-32.9%	2.3%	-22.1%	33.0%
Operating Margin	-6.8%	-4.5%	-5.9%	-12.0%	10.0%	-53.0%	-4.2%	-35.2%	-0.9%	-24.4%	31.0%

Northern Inyo Healthcare District
Balance Sheet
Fiscal Year 2024

	PY Balances	7/31/2023	7/31/2022	8/31/2023	8/31/2022	9/30/2023	9/30/2022	10/31/2023	10/31/2022	YOY Change
Assets										
Current Assets										
Cash and Liquid Capital	17,525,946	19,768,284	8,260,905	18,008,863	9,033,146	18,771,541	7,095,805	15,130,616	8,362,653	6,767,963
Short Term Investments	10,497,077	10,513,789	24,254,218	10,555,533	24,248,339	10,555,533	21,741,818	10,658,191	21,873,055	(11,214,864)
PMA Partnership	-	-	-	-	-	-	-	-	-	-
Accounts Receivable, Net of Allowance	15,430,119	13,605,084	22,573,731	13,668,526	22,319,458	15,119,591	22,244,291	18,412,645	19,941,094	(1,528,449)
Other Receivables	307,876	66,067	3,628,324	321,629	3,799,364	794,581	4,862,660	1,149,410	5,032,262	(3,882,852)
Inventory	5,159,474	5,120,179	3,116,641	5,099,597	3,111,028	5,155,489	3,075,988	5,210,947	3,071,145	2,139,802
Prepaid Expenses	1,960,680	2,321,465	1,466,831	2,821,462	1,431,968	2,326,052	1,332,692	2,377,751	1,027,946	1,349,805
Total Current Assets	**50,881,172**	**51,394,868**	**63,300,650**	**50,475,610**	**63,943,304**	**52,722,787**	**60,353,254**	**52,939,560**	**59,308,155**	**(6,368,595)**
Assets Limited as to Use										
Internally Designated for Capital Acquisitions	-	-	-	-	-	-	-	-	-	-
Short Term - Restricted	1,466,355	1,466,418	2,044,212	1,466,541	2,044,299	1,466,663	2,044,383	1,466,789	1,327,387	139,402
Limited Use Assets										-
LAIF - DC Pension Board Restricted	798,218	870,163	747,613	828,419	753,493	828,419	760,014	828,417	714,585	113,832
Other Patient Revenue	13,076,830	13,076,830	19,296,858	13,076,830	19,296,858	13,076,830	19,296,858	13,076,830	19,296,858	(6,220,028)
PEPRA - Deferred Outflows	-	-	-	-	-	-	-	-	-	-
PEPRA Pension	-	-	-	-	-	-	-	-	-	-
Total Limited Use Assets	13,875,048	13,946,993	20,044,471	13,905,249	20,050,351	13,905,249	20,056,872	13,905,247	20,011,443	(6,106,196)
Revenue Bonds Held by a Trustee	923,902	918,195	1,105,984	912,490	1,100,247	752,501	1,090,633	746,796	1,085,089	(338,293)
Total Assets Limited as to Use	**16,265,305**	**16,331,607**	**23,194,667**	**16,284,281**	**23,194,897**	**16,124,414**	**23,191,888**	**16,118,832**	**22,423,918**	**(6,305,086)**
Long Term Assets										
Long Term Investment	2,767,655	2,776,508	2,274,959	2,783,284	2,777,201	2,790,423	2,741,517	2,797,561	2,731,432	66,130
Fixed Assets, Net of Depreciation	77,707,415	77,207,398	76,799,479	77,751,338	76,624,374	77,428,005	76,931,213	77,676,251	76,624,362	1,051,889
Total Long Term Assets	**80,475,070**	**79,983,907**	**79,074,438**	**80,534,623**	**79,401,575**	**80,218,428**	**79,672,730**	**80,473,812**	**79,355,794**	**1,118,019**
Total Assets	**147,621,547**	**147,710,381**	**165,569,755**	**147,294,513**	**166,539,776**	**149,065,629**	**163,217,871**	**149,532,205**	**161,087,867**	**(11,555,662)**
Liabilities										
Current Liabilities										
Current Maturities of Long-Term Debt	732,605	825,158	2,575,534	798,370	2,549,958	801,314	2,524,301	655,101	2,053,565	(1,398,464)
Accounts Payable	6,906,962	7,062,903	5,058,837	6,750,705	6,469,871	6,935,344	6,569,826	6,819,778	6,512,022	307,756
Accrued Payroll and Related	11,218,818	11,742,012	6,269,082	11,656,151	7,183,582	12,664,513	6,976,334	12,669,463	7,087,285	5,582,178
Accrued Interest and Sales Tax	85,509	169,971	145,639	244,123	252,061	96,606	321,777	166,957	126,986	39,971
Notes Payable	1,633,708	1,633,708	2,133,708	1,633,708	2,133,708	1,633,708	2,133,708	1,633,708	2,133,708	(500,000)
Unearned Revenue	(4,542)	(4,542)	1,160,535	(4,542)	468,063	(4,542)	468,063	(4,542)	468,063	(472,605)
Due to 3rd Party Payors	693,247	693,247	693,247	693,247	693,247	693,247	693,247	693,247	693,247	-
Due to Specific Purpose Funds	-	-	-	-	-	-	-	-	-	-
Other Deferred Credits - Pension	1,873,995	1,873,995	2,146,080	1,873,995	2,146,080	1,873,995	2,146,080	1,873,995	2,146,080	(272,085)
Total Current Liabilities	**23,140,302**	**23,996,452**	**20,182,661**	**23,645,757**	**21,896,570**	**24,694,185**	**21,833,337**	**24,507,707**	**21,220,955**	**3,286,752**
Long Term Liabilities										
Long Term Debt	33,455,530	33,455,530	33,455,947	33,455,530	33,455,947	32,730,530	33,455,947	32,730,530	33,455,947	(725,417)
Bond Premium	203,263	200,126	237,771	196,989	234,634	193,852	231,497	190,715	228,359	(37,645)
Accreted Interest	17,123,745	17,218,877	16,820,264	17,314,009	16,915,399	17,409,141	17,010,533	17,504,273	17,105,668	398,605
Other Non-Current Liability - Pension	47,257,663	47,257,663	47,950,740	47,257,663	47,950,740	47,257,663	47,950,740	47,257,663	48,813,068	(1,555,405)
Total Long Term Liabilities	**98,040,201**	**98,132,196**	**98,464,722**	**98,224,191**	**98,556,720**	**97,591,186**	**98,648,717**	**97,683,181**	**99,603,043**	**(1,919,862)**
Suspense Liabilities	-	-	-	-	-	-	-	-	-	-
Uncategorized Liabilities	44,693	44,693	451,476	36,944	709,722	36,944	763,396	68,644	790,738	(722,093)
Total Liabilities	**121,225,197**	**122,173,341**	**119,098,859**	**121,906,892**	**121,163,011**	**122,322,315**	**121,245,449**	**122,259,532**	**121,614,735**	**644,797**
Fund Balance										
Fund Balance	43,831,306	23,268,194	43,831,306	23,268,194	43,831,306	23,268,194	43,831,306	23,786,064	43,831,306	(20,045,242)
Temporarily Restricted	2,610,286	2,610,349	2,589,701	2,610,472	2,589,789	2,610,594	2,589,873	2,610,720	2,589,875	20,845
Net Income	(20,045,242)	(341,503)	49,888	(491,045)	(1,044,330)	864,526	(4,448,757)	875,889	(6,948,049)	7,823,938
Total Fund Balance	**26,396,350**	**25,537,040**	**46,470,896**	**25,387,621**	**45,376,765**	**26,743,313**	**41,972,422**	**27,272,672**	**39,473,131**	**(12,200,459)**
Liabilities + Fund Balance	**147,621,547**	**147,710,381**	**165,569,755**	**147,294,513**	**166,539,776**	**149,065,629**	**163,217,871**	**149,532,205**	**161,087,867**	**(11,555,662)**
(Decline)/Gain		88,834	(1,743,492)	(415,868)	970,022	1,771,115	(3,321,905)	466,576	(2,130,005)	2,596,581
	-	-	-	-	-	-	-	-	-	-

Northern Inyo Healthcare District
Statement of Cash Flows
Fiscal Year 2024

Operating Activities		
Receipts from and on behalf of patients (per bank account)	$	32,917,903
Payments to suppliers, contractors, and employees	$	(41,227,284)
Other receipts and payments, net	$	690,556
Net Cash from Operating Activities	**$**	**(7,618,825)**
Noncapital Financing Activities		
Noncapital contributions (and grants)	$	-
Property taxes received	$	912,498
Reduction of CMS advance	$	-
Other	$	-
Net Cash from Noncapital Financing Activities	**$**	**912,498**
Capital and Capital Related Financing Activities		
Principal payments on long-term debt	$	(763,062)
Interest Paid	$	(715,417)
Purchase and construction of capital assets	$	31,164
Property Taxes Received	$	-
Net Cash used for Capital and Capital Related Financing Activities	**$**	**(1,447,315)**
Investing Activities		
Investment income	$	333,357
Net Cash from Investing Activities	**$**	**333,357**
Net Change in Cash and Cash Equivalents	**$**	**(7,820,285)**
Cash and Cash Equivalents, Beginning of Year	$	27,622,763
Cash and Cash Equivalents, YTD 2024	**$**	**19,802,478**

Northern Inyo Healthcare District
Long-Term Debt Service Coverage Ratio
FYE 2024

Calculation method agrees to SECOND and THIRD SUPPLEMENTAL INDENTURE OF TRUST 2021 Bonds Indenture

Long-Term Debt Service Coverage Ratio Calculation

Numerator:	HOSPITAL FUND ONLY
Excess of revenues over expense	$ (36,609)
+ Depreciation Expense	1,300,170
+ Interest Expense	715,417
Less GO Property Tax revenue	912,498
Less GO Interest Expense	176,693
2013 and 2021 Indenture)	**$ 3,068,169**

Other Patient Revenue

Denominator:	
3rd Supplemental Indenture of Trust)	
2021A Revenue Bonds	$ 112,700
2021B Revenue Bonds	905,057
2009 GO Bonds (Fully Accreted Value)	
2016 GO Bonds	
Financed purchases and other loans	1,704,252
Total **Maximum Annual Debt Service**	**$ 2,722,009**
Ratio: (numerator / denominator)	**1.13**
Required Debt Service Coverage Ratio:	1.10
In Compliance? (Y/N)	**No**

Unrestricted Funds and Days Cash on Hand

	HOSPITAL FUND ONLY
Cash and Investments-current	$ 19,802,478
Cash and Investments-non current	2,797,561
Sub-total	22,600,039
Less - Restricted:	
PRF and grants (Unearned Revenue)	-
Held with bond fiscal agent	(746,796)
Building and Nursing Fund	(1,466,789)
Total Unrestricted Funds	**$ 20,386,454**
Total Operating Expenses	$ 39,074,744
Less Depreciation	1,300,170
Net Expenses	37,774,574
Average Daily Operating Expense	$ 410,593
Days Cash on Hand	**50**

Northern Inyo Healthcare District
Oct 2023 – Financial Summary

	CY MONTH	PY MONTH	BUDGET	PY Variance	Budget Variance	YTD	PY YTD	BUDGET	PY Variance	Budget Variance	MOM % Variance	YOY % Variance	YTD Budget % Variance
Net Income (Loss)	11,636	(2,499,292)	(1,820,696)	2,510,928	1,832,332	875,889	(6,948,049)	(8,113,965)	7,823,938	8,989,854	-100%	-113%	-111%
Operating Income (Loss)	(381,153)	(2,674,919)	(2,111,916)	2,293,766	1,730,763	(345,105)	(7,665,877)	(9,270,832)	7,320,772	8,925,727	-86%	-95%	-96%

Income is favorable to prior year for October and YTD due to an increase in net revenue caused by an increase in volumes and a decrease in expenses.

IP Gross Revenue	3,277,300	2,813,064	2,827,654	464,236	449,646	13,842,733	12,133,651	11,538,237	1,709,081	2,304,496	17%	14%	20%
OP Gross Revenue	14,790,086	12,337,627	12,451,160	2,452,459	2,338,926	55,493,297	48,075,165	49,470,318	7,418,133	6,022,979	20%	15%	12%
Clinic Gross Revenue	1,599,317	1,312,937	1,318,779	286,380	280,538	6,050,015	5,004,664	4,724,779	1,045,351	1,325,236	22%	21%	28%
Net Patient Revenue	9,044,559	7,601,730	6,983,258	1,442,830	2,061,301	38,729,638	31,450,047	27,652,718	7,279,592	11,076,920	19%	23%	40%
Cash Net Revenue % of Gross	46%	46%	42%	0%	4%	51%	48%	42%	3%	9%			22%

Revenue is higher than last year and budget due to an increase in volume across inpatient and outpatient services.

Admits (excl. Nursery)	75	60	15	263	255	8	25%	3%					
IP Days	234	170	64	824	762	62	38%	8%					
IP Days (excl. Nursery)	212	148	64	735	676	59	43%	9%					
Average Daily Census	6.84	4.77	2.07	7.99	7.35	1	43%	9%					
ALOS	2.83	2.47	0.36	2.79	2.65	0	15%	5%					
Deliveries	19	17	2	64	58	6	12%	10%					
OP Visits	3,559	3,737	(178)	13,889	14,677	(788)	-5%	-5%					
RHC Visits	3,079	2,708	371	11,812	9,950	1,862	14%	19%					
NIA Clinic Visits	1,540	1,689	(149)	6,095	6,498	(403)	-9%	-6%					
Bronco Clinic Visits	20	39	(19)	69	83	(14)	-49%	-17%					
Internal Medicine Clinic Visits	-	357	(357)	201	1,540	(1,339)	-100%	-87%					
Orthopedic Clinic Visits	363	306	57	1,434	1,275	159	19%	12%					
Pediatric & Allergy Clinic Visits	619	613	6	2,367	2,125	242	1%	11%					
Specialty Clinic Visits	349	229	120	1,375	972	403	52%	41%					
Surgery Clinic Visits	157	105	52	474	353	121	50%	34%					
Virtual Care Clinic Visits	32	40	(8)	175	150	25	-20%	17%					
Surgeries IP	22	13	9	88	78	10	69%	13%					
Surgeries OP	151	119	32	481	395	86	27%	22%					
Total Surgeries	173	132	41	569	473	96	31%	20%					
Diagnostic Imaging	2,182	2,035	147	8,419	8,199	220	7%	3%					
Emergency Visits	899	830	69	3,608	3,275	333	8%	10%					
ED Admits	50	46	4	177	196	(19)	9%	-10%					
ED Amits % of ED Visits	5.6%	5.5%	0.1%	4.9%	6.0%	-1%	2%	-18%					
Rehab	521	669	(148)	2,173	2,857	(684)	-22%	-24%					
Nursing Visits	352	245	107	1,141	1,049	92	44%	9%					
Observation Hours	1,794	1,793	1	7,069	7,153	(84)	0%	-1%					

Admissions increase due to an increase in deliveries, surgeries and ER admits. RHC increased for the month due to merger with Internal Medicine which occured in late July along with an increase in volume but for the year volume is up overall. We are seeing strong volumes in all of our clinics due to efficiencies and new providers. Outpatient Surgeries increased due to ner urology and general surgeon. DI services and ER visits continue to be strong.

Payor mix													
Blue Cross	19.20%	23.50%		-4.30%		17.40%	23.20%		-5.80%				
Commercial	2.60%	0.60%		2.00%		2.80%	4.60%		-1.80%				
Medicaid	26.90%	26.50%		0.40%		22.60%	26.50%		-3.90%				
Medicare	50.40%	44.10%		6.30%		52.80%	42.90%		9.90%				
Self-pay	0.90%	5.30%		-4.40%		3.80%	2.80%		1.00%				
Workers' Comp	0.00%	0.00%		0.00%		0.60%	0.00%		0.60%				
DEDUCTIONS													
Contract Adjust	9,911,289	9,137,803	8,957,851	773,485	953,438	31,529,690	28,714,191	35,480,400	2,815,498	(3,950,710)	8%	10%	-11%
Bad Debt	421,557	589,809	328,242	(168,253)	93,315	3,005,089	3,344,846	1,300,108	(339,757)	1,704,981	-29%	-10%	131%
Write-off	289,298	325,216	328,242	(35,918)	(38,944)	2,123,016	2,160,635	1,300,108	(37,619)	822,908	-11%	-2%	63%
Other	-	950	-	(950)	-	-	431,862	-	(431,862)	-	-100%	\	

Payor mix has shifted from Blue Cross to Medicare. As a CAH, we are reimbursed at cost by Medicare. Net revenue remains consistent with prior year at 46% of gross revenue but has increased due to an increase in volume/gross revenue

DENIALS

Denials $500k less than 6-month average and $2.5M less than December 2022 (baseline for RSM revenue cycle project)

CHARITY

Charity discounts were minimal (less than $2k)

BAD DEBT

Bad debt write offs were $701k.

Northern Inyo Healthcare District
Oct 2023 – Financial Summary

	CY MONTH	PY MONTH	BUDGET	PY Variance	Budget Variance	YTD	PY YTD	BUDGET	PY Variance	Budget Variance	MOM % Variance	YOY % Variance	YTD Budget % Variance
CASH													
Cash deficit for October was -$1.1MM or $-36k/day.													
CENSUS													
Patient Days	234	170		64		824	762		62		38%	8%	
Adjusted Days	1,404	995		409		4,487	4,095		392		41%	10%	
Employed Paid FTE	353	380		(27)		357	390		(33)		-7%	-9%	
Contract Paid FTE	22	50		(28)		26	49		(24)		-55%	-48%	
Total Paid FTE	375	430		(55)		383	440		(57)		-13%	-13%	
EPOB (Employee per Occupied Bed)	1.58	2.65		(1.07)		1.37	1.70		(0.33)		-40%	-19%	
Adjusted EPOB	0.26	0.45		(0.2)		0.25	0.32		(0)		-42%	-22%	
Decline in contract FTEs and total FTEs due to RIFFs and staffing management.													
SALARIES													
Per Adjust Bed Day	$ 2,315	$ 2,574		$ (259)		$ 2,940	$ 2,514		$ 425		-10%	17%	
Total Salaries	$ 3,249,591	$ 2,561,013	$ 3,236,547	$ 688,578	13,044	$ 13,191,257	$ 10,296,520	$ 12,909,072	$ 2,894,737	282,185	27%	28%	2%
Normalized Salaries (incl PTO used)	$ 3,249,591	$ 2,802,008	$ 3,236,547	$ 447,583		$ 13,191,257	$ 11,687,945	$ 12,909,072	$ 1,503,312	282,185	16%	13%	2%
Average Hourly Rate	$ 51.98	$ 41.59		$ 10.39		$ 52.59	$ 42.63		$ 9.96		25%	23%	
Employed Paid FTEs	352.89	380.32		(27.43)		356.85	390.06		(33.21)				
Salaries are up for the month and the year compared to prior year due to merit increases. Total paid employed FTEs are down due to RIFFs that occurred during April and July													
BENEFITS													
Per Adjust Bed Day	$ 1,393	$ 2,845		$ (1,452)		$ 1,557	$ 2,292		$ (735)		-51%	-32%	
Total Benefits	$ 1,955,349	$ 2,830,689	$ 1,987,649	$ (875,340)	(32,300)	$ 6,985,823	$ 9,384,482	$ 7,871,924	$ (2,398,659)	(886,101)	-31%	-26%	-11%
Benefits % of Wages	60%	111%	61%	-50%		53%	91%				-46%	0%	
Pension Expense	$ 393,873	$ 1,717,832	$ 790,381	$ (1,323,959)	(396,508)	$ 1,789,393	$ 4,357,413	$ 3,102,998	$ (2,568,020)	(1,313,605)	-77%	-59%	-42%
MDV Expense	$ 1,256,181	$ 648,121	$ 547,117	$ 608,060	709,064	$ 4,004,359	$ 2,718,864	$ 2,169,887	$ 1,285,495	1,834,472	94%	47%	85%
Payroll Taxes & WC insurance	$ 255,739	$ 193,645		$ 62,094		$ 1,233,086	$ 1,177,921	Unavailable	$ 55,165		32%	5%	
PTO Incurred	$ -	$ 240,995		$ (240,995)		$ -	$ 1,391,425	Unavailable	$ (1,391,425)		-100%	-100%	
PTO Accrued	$ 49,556	$ 30,096		$ 19,460		$ (41,015)	$ (261,141)	Unavailable	$ 220,126		65%	-84%	
Normalized Benefits	$ 1,955,349	$ 2,589,694	$ 1,987,649	$ (634,345)		$ 6,985,823	$ 7,993,057		$ (1,007,234)		-24%	-13%	
Normalized Benefits % of Wages	60%	92%	61%	-32%		53%	68%						
Benefits at a % of Wages are down due to reduced pension now that employees are matching pension contributions. MDV increased due to higher volume of usage/claims.													
Salaries, Wages & Benefits	$ 5,204,940	$ 5,391,702	$ 5,224,197	$ (186,762)	(19,257)	$ 20,177,080	$ 19,681,002	$ 20,780,996	$ 496,078	(603,916)	-3%	3%	-3%
SWB/APD	$ 3,707.22	$ 5,419		$ (1,712)		$ 4,497	$ 4,806		$ (309)		-32%	-6%	
Total YTD SWB is up 3% compared to prior year due to merits. However, it is -3% under budget.													
PROFESSIONAL FEES													
Per Adjust Bed Day	$ 1,288	$ 3,160		$ (1,872)	1,288	$ 2,246	$ 2,824		$ (578)	$ 2,824	-59%	-20%	
Total Physician Fee	$ 1,432,267	$ 1,603,952	$ 1,085,223	$ (171,685)	347,044	$ 5,762,924	$ 5,433,825	$ 4,335,343	$ 329,099	$ 1,098,482	-11%	6%	25%
Total Contract Labor	$ 371,183	$ 1,081,444	$ 418,094	$ (710,261)	(46,911)	$ 1,999,924	$ 3,985,960	$ 1,757,786	$ (1,986,036)	$ 2,228,174	-66%	-50%	127%
Total Other Pro-Fees	$ 4,418	$ 458,743	$ 511,645	$ (454,325)	(507,227)	$ 2,315,234	$ 2,143,392	$ 2,202,421	$ 171,842	$ (59,029)	-99%	8%	-3%
Total Professional Fees	$ 1,807,868	$ 3,144,139	$ 2,014,962	$ (1,336,271)	(207,094)	$ 10,078,082	$ 11,563,177	$ 8,295,550	$ (1,485,095)	$ 3,267,627	-43%	-13%	39%
Contract Paid FTEs	22.35	50.02		(27.67)		24.88	49.49		(24.61)		-55%	-50%	
Physician expense increase due to anesthesia expenses, adding a general surgeon, and urology. However, this is contributing to higher volumes and revenue. Contract labor reductions have occurred and is being limited to essential personnel.													
PHARMACY													
Per Adjust Bed Day	$ 202	$ 137		$ 65		$ 382	$ 262		$ 119		47%	45%	
Total Rx Expense	$ 283,643	$ 136,557	$ 369,521	$ 147,086	(85,878)	$ 1,711,845	$ 1,073,980	$ 1,451,432	$ 637,865	260,413	108%	59%	18%
Supplies are higher due to volume increases along with prior year being under-accrued due to accounting not completing full month end trend accruals. YTD is also higher than prior year for the same reason.													
MEDICAL SUPPLIES													
Per Adjust Bed Day	$ 492	$ 368		$ 124		$ 461	$ 379		$ 82		34%	22%	
Total Medical Supplies	$ 690,604	$ 366,356	$ 372,419	$ 324,248	318,185	$ 2,067,653	$ 1,550,362	$ 1,478,467	$ 517,291	589,186	89%	33%	40%
Supplies are higher due to volume increases along with prior year being under-accrued due to accounting not completing full month end trend accruals. YTD is also higher than prior year for the same reason.													

Northern Inyo Healthcare District
Oct 2023 – Financial Summary

	CY MONTH	PY MONTH	BUDGET	PY Variance	Budget Variance	YTD	PY YTD	BUDGET	PY Variance	Budget Variance	MOM % Variance	YOY % Variance	YTD Budget % Variance
EHR SYSTEM													
Per Adjust Bed Day	$ 195	$ 184		$ 11		$ 122	$ 181		$ (59)		6%	-32%	
Total EHR Expense	$ 273,794	$ 183,047	$ 151,595	$ 90,747	122,199	$ 548,880	$ 741,786	$ 606,380	$ (192,906)	(57,500)	50%	-26%	-9%
Added modules and services increased cost this month alon with prior year being under-accrued due to inproper accounting. YTD, balance sheet cleanup caused credits in expense.													
OTHER EXPENSE													
Per Adjust Bed Day	$ 572	$ 696		$ (124)		$ 711	$ 771		$ (60)		-18%	-8%	
Total Other	$ 802,546	$ 692,533	$ 593,390	$ 110,013	209,156	$ 3,191,034	$ 3,158,231	$ 2,834,371	$ 32,803	356,663	16%	1%	13%
Utilities and insurance increased compared to last October. YTD expenses are fairly flat compared to prior year													
DEPRECIATION AND AMORTIZATION													
Per Adjust Bed Day	$ 258	$ 326		$ (68)		$ 290	$ 329		$ (39)		-21%	-12%	
Total Depreciation and Amortization	$ 362,317	$ 324,565	$ 369,089	$ 37,752	(6,772)	$ 1,300,170	$ 1,347,386	$ 1,476,354	$ (47,216)	(176,184)	12%	-4%	-12%
Total dollar consistent with run-rate.													
Total Expenses	$ 9,425,712	$ 10,238,899	$ 9,095,173	$ (813,187)		$ 39,074,744	$ 39,115,924	$ 36,923,550	$ (41,180)	2,151,194	-8%	0%	6%
For the month, expenses are down due to less professional fees including contract labor. Ytd expenses are slightly under prior year													

Key Financial Performance Indicators	Industry Benchmark	Oct-22	FYE 2023 Average	Jul-23	Aug-23	Sep-23	Oct-23	Variance to Prior Month	Variance to FYE 2023 Average	Variance to Prior Year Month	Variance to Benchmark	Reduction Target	Comment
Volume													
Admits	41	60	68	64	57	67	75	8	7	15	34		Mammoth monthly average in 2022 per HCAI
Adjusted Patient Days	n/a	866	984	951	945	862	1,169	307	185	303	n/a		
Total Surgeries	153	132	120	134	148	114	173	59	53	41	20		Mammoth monthly average in 2022 per HCAI
ER Visits	659	830	810	925	899	885	899	14	89	69	240		Mammoth monthly average in 2022 per HCAI
RHC and Clinic Visits	n/a	4,397	4,353	3,875	5,099	4,314	4,619	305	266	222	n/a		
Diagnostic Imaging Services	n/a	2,035	2,020	2,108	2,174	1,955	2,182	227	162	147	n/a		
Rehab Services	n/a	669	762	661	662	329	521	192	(241)	(148)	n/a		
AR & Income													
Gross AR (Cerner only)	n/a	$ 51,620,313	$ 53,638,580	$ 51,928,721	$ 50,613,728	$ 51,259,303	$ 53,295,391	$ 2,036,088	$ (343,188)	$ 1,675,078	n/a		
AR > 90 Days	$ 7,688,895.45	$ 23,532,351	$ 23,440,542	$ 23,660,417	$ 23,784,037	$ 23,867,624	$ 23,888,672	$ 21,048	$ 448,130	$ 356,321	$ 16,199,777	(16,199,777)	15% of gross AR is benchmark
AR % > 90 Days	15%	45.6%	45.3%	45.84%	46.59%	46.19%	44.50%	-1.7%	-0.8%	-1.1%	29.5%		Industry average
AR Days	45.00		91.35	90.52	85.93	84.50	86.92	2.42	(4.43)	$ 87	41.92		Industry average
Net AR	n/a	$ 19,941,094	$ 17,800,084	$ 11,299,207	$ 11,379,597	$ 15,434,810	$ 16,443,565	$ 1,008,755	$ (1,356,519)	$ (3,497,529)	n/a		
Net AR % of Gross	n/a	38.6%	33.1%	21.8%	22.5%	30.1%	30.9%	0.7%	-2.2%	-7.8%	n/a		
Gross Patient Revenue/Calendar Day	n/a	$ 531,085	$ 546,652	$ 589,494	$ 653,218	$ 573,176	$ 554,686	$ (18,490)	$ 8,034	$ 23,601	n/a		
Net Patient Revenue/Calendar Day	n/a	$ 245,217	$ 243,317	$ 281,629	$ 297,995	$ 390,558	$ 291,760	$ (98,798)	$ 48,443	$ 46,543	n/a		
Net Patient Revenue/APD	n/a	$ 8,778	$ 7,622	$ 9,180	$ 9,775	$ 13,593	$ 7,739	$ (5,854)	$ 117	$ (1,039)	n/a		
Wages													
Wages	n/a	$ 2,814,461	$ 3,281,173	$ 3,246,211	$ 3,393,123	$ 4,052,687	$ 3,249,591	$ (803,096)	$ (31,582)	$ 435,130	n/a		
Employed paid FTEs	n/a	380.32	384.63	365.27	357.51	351.58	352.89	1.30	(31.74)	(27.43)	n/a	-7%	
Employed Average Hourly Rate	$ 38.00	$ 41.78	$ 48.51	$ 50.17	$ 53.58	$ 67.24	$ 51.98	$ (15.26)	$ 3.47	$ 10.21	$ 13.98		According to California Hospital Association data
Benefits	n/a	$ 2,577,241	$ 1,907,194	$ 1,782,070	$ 1,030,526	$ 1,510,474	$ 1,955,349	$ 444,875	$ 48,155	$ (621,892)	n/a		
Benefits % of Wages	30%	91.6%	58.7%	54.9%	30.4%	37.3%	60.2%	22.9%	1.5%	-31.4%	30.2%	(589,971)	Industry average
Contract Labor	n/a	$ 1,081,444	$ 808,284	$ 493,990	$ 629,779	$ 700,581	$ 371,183	$ (329,398)	$ (437,101)	$ (710,261)	n/a		
Contract Labor Paid FTEs	n/a	50.02	40.27	31.42	24.01	24.82	22.35	(2.47)	(17.92)	(27.67)	n/a		
Total Paid FTEs	n/a	430.34	424.90	396.69	381.53	376.40	375.24	(1.16)	(49.66)	(55.10)	n/a		
Contract Labor Average Hourly Rate	$ 81.04	$ 122.05	$ 112.84	$ 88.75	$ 148.05	$ 164.66	$ 93.74	$ (70.92)	$ (19.10)	$ (28.31)	$ 12.70	$ (50,286)	Per zip recruiter as of August 2023 for California, higher range is benchmark
Total Salaries, Wages, & Benefits	n/a	$ 6,473,146	$ 5,996,651	$ 5,522,271	$ 5,053,428	$ 6,263,742	$ 5,576,123	$ (687,619)	$ (420,528)	$ (897,023)	n/a		
SWB% of NR	50%	85.2%	79.8%	63.3%	54.7%	53.5%	61.7%	8.2%	-18.1%	-23.5%	$ 0	$ 282,247	Per Becker Healthcare, max should be 50%
SWB/APD	2,903	$ 7,475	$ 5,935	$ 5,807	$ 5,348	$ 7,267	$ 4,771	$ (2,495)	$ (1,164)	$ (2,704)	n/a		Industry average
SWB % of total expenses		71.3%	66.0%	58.7%	51.7%	59.4%	59.2%	-0.2%	-6.9%	-12.1%	n/a		
Physician Spend													
Physician Expenses	n/a	$ 1,606,452	$ 1,400,634	$ 1,369,822	$ 1,536,036	$ 1,424,804	$ 1,436,684	$ 11,880	$ 36,050	$ (169,768)	n/a		
Physician expenses/APD	n/a	$ 1,855	$ 1,451	$ 1,440	$ 1,625	$ 1,653	$ 1,229	$ (424)	$ (222)	$ (626)	n/a		
Supplies													
Supply Expenses	n/a	$ 502,912	$ 544,557	$ 786,000	$ 1,264,257	$ 754,993	$ 974,247	$ 219,254	$ 429,690	$ 471,335	n/a		
Supply expenses/APD		$ 581	$ 579	$ 826	$ 1,338	$ 876	$ 834	$ (42)	$ 255	$ 253	n/a		
Other Expenses													
Other Expenses	n/a	$ 497,936	$ 1,138,604	$ 1,724,605	$ 1,928,160	$ 2,102,517	$ 1,438,658	$ (663,859)	$ 300,054	$ 940,722	n/a		
Other Expenses/APD	n/a	$ 575	$ 1,178	$ 1,813	$ 2,040	$ 2,439	$ 1,231	$ (1,208)	$ 53	$ 656	n/a		
Margin													
Net Income	n/a	$ (2,499,292)	$ (1,448,727)	$ (341,503)	$ (149,542)	$ 1,355,571	$ 11,363	$ (1,344,208)	$ 1,460,090	$ 2,510,655	n/a		
Net Profit Margin	n/a	-32.9%	-20.8%	-3.9%	-1.6%	11.6%	0.1%	-11.5%	20.9%	33.0%	n/a		
Operating Income	n/a	$ (2,674,919)	$ (2,495,327)	$ (590,588)	$ (544,049)	$ 1,170,684	$ (381,153)	$ (1,551,837)	$ 2,114,174	$ 2,293,766	n/a		
Operating Margin	2.9%	-35.2%	-33.0%	-6.8%	-5.9%	10.0%	-4.2%	-14.2%	28.8%	31.0%	-7.1%		Per Kaufman Hall September Natitonal Hospital Flash
Cash													
Avg Daily Expenses	n/a	$ 316,166	$ 363,636	$ 294,580	$ 494,001	$ 308,431	$ 323,315	$ 14,884	$ (40,320)	$ 7,149	n/a	$ (36,623)	2%
Unrestricted Funds	n/a	$ 26,063,196	$ 25,069,144	$ 26,823,700	$ 20,017,212	$ 17,873,934	$ 16,841,267	$ (1,032,666)	$ (8,227,877)	$ (9,221,928)	n/a		-35%
Average Daily Cash Collections	n/a	$ 363,506	$ 340,919	$ 265,554	$ 306,137	$ 251,797	$ 286,692	$ 34,895	$ (54,227)	$ (76,814)	n/a	$ 36,623	-21%
Average Daily Net Cash		$ 47,340	$ (22,716)	$ (29,026)	$ (187,864)	$ (56,634)	$ (36,623)	$ 20,011	$ (13,907)	$ (83,963)	n/a	$ 36,623	-177%

CliftonLarsonAllen LLP
https://www.claconnect.com

November 6, 2023

We are pleased to submit this engagement letter to provide Mid-Revenue Cycle consulting assistance; specifically addressing Charge Description Master (CDM) and Charge Capture services, which CliftonLarsonAllen LLP ("CLA," "we," "us," and "our") would provide for Northern Inyo Healthcare District ("NIHD" or "the organization"). Based upon our discussion with you, we have prepared this statement of work (SOW), which outlines the objectives, approach, deliverables, timing, and related fees for the professional services to be provided by CLA to NIHD related to this consulting evaluation.

Project Objectives, Scope, and Approach
From our recent conversation, you are interested in CLA's consulting assistance to evaluate the Mid-Revenue Cycle core functions that include, CDM, Charge Capture, and a review of clinical documentation and coding outpatient encounters. This SOW outlines a customized service approach focused on optimizing net revenue in key areas of your CDM, charge capture, and coding workflow processes.

We will perform the engagement in accordance with the Statement on Standards for Consulting Services issued by the American Institute of Certified Public Accountants.

Charge Description Master (CDM), Charge Capture and Revenue Integrity Operational Evaluation
Consulting assistance for the CDM and Charge Capture operations will include the following activities:

Step 1: Project Initiation & Data Analytics
To begin the assessment, CLA will provide a data request to NIHD outlining the pertinent information for data analyses to support the CDM line-item and targeted charge capture operational review. Data required is listed below, but not limited to the following:

- Revenue Usage for both Hospital and Professional billing by Payer, By Department, By Charge Line with CPT, Revenue Code, and Patient Type detail (Inpatient/Outpatient) for each of the three fiscal year-end time periods ending June 30 of 2021, 2022, and 2023.

- Chargemaster by charge number with CPT, Modifier, Pricing, Revenue Code, and other detail for the most recent version.

- Revenue cycle performance metrics for calendar year 2022 and year-to-date 2023, which addresses the below:
    - Charge capture, including lag days for charge posting and charge entry backlogs.
    - Days in Total Discharge Not Final Billed (DNFB) to include coding DNFB holds by account

type (inpatient, ambulatory surgery, and outpatient).
  - Overall Late Charges as a Percentage of Total Charges.
  - Late Charges per Clinical Department as a Percentage of Total Charges.
  - Net Days in Charge Audit Lag.

Step 2: Strategic Chargemaster Evaluation
CLA will conduct an evaluation of the chargemaster, service capture, and maintenance processes. The key activities are as follows:

Activity A: Review of Line-Item Detail - we will perform an evaluation of line-item detail of the departmental charge master.

- Validate UB☒ 04 revenue code assignments for inpatient and outpatient services and evaluate the crosswalk of these codes to your Medicare cost report to assure proper reporting and reimbursement.
- Verify accuracy and consistency of line☒ item descriptions for inpatient and outpatient services.
- Assess consistency of pricing across departments.
- Validate accuracy of modifier assignment.
- Assess the accuracy of and recommend appropriate revisions to CPT☒ 4/HCPCS codes assigned for those line items requiring such code assignments and use of supplies; including but not limited to:
  - **Radiology Services:** Including diagnostic radiology, CT, MRI, ultrasound, nuclear medicine, radiation oncology, and other special radiological procedures (70000 – 79999 CPT☒ 4 code series).
  - **Laboratory Services**: Including chemistry, hematology, immunology, microbiology, and pathology (80000 – 89999 CPT☒ 4 code series).
  - **Clinic Services:** Including rural health clinics, general clinics, and specialty clinics.
  - **Other Therapeutic Services**: Including physical therapy, occupational therapy, respiratory therapy, speech therapy, infusion therapy, chemotherapy, and outpatient mental health therapy (90000 ☒ 99999 CPT☒ 4 code series).
  - **Other Diagnostic Services**: Including neurology, echocardiography, cardiography, and cardiac catheterization (90000 ☒ 99999 CPT☒ 4 code series).
  - **Emergency Department Services**: Including levels of Evaluation and Management services, procedures, pharmaceuticals, and supplies.
  - **Pharmacy:** Including pharmaceuticals requiring detailed coding, and identification of billable dose units.
    · Identify valid CPT/HCPCS codes to be utilized for services performed in the hospital.
    · Identify line items that have not been used during recent fiscal years that may be considered for inactivation.
    · Identify pharmacy drug waste protocol, procedures, and potential impact, if waste is not properly processed for coding and billing compliance.

Activity B: Billable vs. Non-Billable Supply Investigation- All line items assigned to revenue code

series 27X will be evaluated to determine if they are separately billable under Medicare guidelines. Line items that are specifically listed by Medicare as not separately billable will be flagged as such. Items that could be interpreted to not be billable based on other Medicare definitions and criteria, but are not specifically listed, will also be flagged in a manner so they can be addressed by facility personnel. Potential routine supplies will be quantified for potential bundling into procedure codes to optimize third party payments.

Activity C: Chargemaster and Charge Capture Interviews - Operational interviews will be conducted with select department leaders and staff involved in the chargemaster and service capture process. The purpose of these interviews will be to clarify key chargemaster line items and to evaluate the service capture and chargemaster maintenance processes currently in place to identify opportunities for improvement.

Step 3: Conduct Clinical Documentation/Coding & Claims - perform remote review of approximately thirty (30) medical records and claims of various service types to aid in the charge capture process. These claims will be selected from departments which we typically have located significant reporting and charge capture opportunities.

Step 4: Follow-up and Implementation Assistance

Upon completion of the above process, CLA will work with management to design an action register to utilize to address recommended changes. CLA and management will then assess the available resources at your organization and/or CLA that will be needed to complete the necessary changes in a time effective manner. CLA will provide additional resources as agreed upon at that time to successfully implement the recommendations.

Deliverables

We will maintain ongoing communication with the liaison assigned to collaborate closely with us and will meet with management leaders, as requested, regarding the status of our progress throughout this engagement. In addition, we will deliver a final report, in a PowerPoint® and Excel® format that will summarize our findings, observations, and any recommendations.

NIHD Responsibilities

To ensure timely and efficient execution of the project, we have made certain assumptions around NIHD key stakeholder responsibilities. Our experience in serving clients has taught us the best outcomes are the result of collaborative execution by both CLA and our clients. Listed below are the typical responsibilities we see clients fulfill for this type of engagement, and what we have structured this SOW for NIHD around:

- Assignment of executive sponsors from the Finance, CDM and Charge Capture operational areas to set the tone relative to the importance of this initiative to approve communications, to direct resources, and to assist in resolving issues.
- Provision of some form of administrative support to assist with timely response for data requests.
- To ensure the project advances efficiently, NIHD personnel should plan to be available on a timely basis for individual discussions. The duration of the project may vary based on NIHD's ability to

provide requested data, schedule, and attend operational interviews. CLA and NIHD agree to work together to define mutually agreeable timing for all data request, meetings.

- Information discovered or provided by NIHD will be considered accurate. CLA is not responsible for the validity of information provided by NIHD regarding the CDM business operations, and/or processes, and NIHD will provide relevant data and information requested, on a timely basis.

- For all non☒ attest services, we may provide to you, including these consulting services, management agrees to assume all management responsibilities; oversee the services by designating an individual, preferably within senior management, who possesses suitable skill, knowledge, and/or experience to understand and oversee the services; evaluate the adequacy and results of the services; and accept responsibility for the results of the services.

Timing
This engagement shall begin with a mutually agreed starting date following our receipt of the signed agreement letter. The project would be initiated with a data request for information.

Personnel
Adam Roth, Principal will serve as the overall relationship leader, and he will be supported by Sheila Hill who will be responsible for ensuring quality and timely completion of engagement. There will also be other consultants assigned with technical experience in mid-revenue cycle areas such as: CDM, charge capture, and clinical documentation/coding.

Fees
Our fees for these services will be based on the time involved and the degree of responsibility and skills required, plus expenses including internal and administrative charges. We will also bill for expenses (including internal and administrative charges) plus a technology and client support fee of five percent (5%) of all professional fees billed. This project will be conducted remotely; however, if there were project-related expenses to include travel and other out-of-pocket expenses (where applicable) would be limited to no more than 15% of project fees. Our invoices, including applicable state and local taxes, will be rendered throughout the project as work progresses and are payable on presentation.

Fees and reimbursements will be due and payable throughout the project, following the organization's receipt of an invoice from CLA. Compensation for services is due within thirty (30) days of the mailing of our bill. Finance charges of one and one☒ quarter percent (1.25%) per month will be added to any past due amounts. CLA has the right to immediately terminate our services if payment for our fees or costs is not made to us in a timely manner. If any collection action is required to collect unpaid balances due us, reasonable attorney fees and expenses shall be recoverable.

In accordance with our firm policies, work may be suspended if your account becomes 60 days or more overdue and will not be resumed until your account is paid in full. If we elect to terminate our services for nonpayment, our engagement will be deemed to have been completed even if we have not issued our report. You will be obligated to compensate us for all time expended and related fees and to reimburse us for all out☒ of☒ pocket expenditures through the date of termination.

The estimated professional fees are as follows:

Professional Services	Start Date	Estimated Fees	Services Selected
Step 1 & 2: Data Analytics, CDM & Charge Capture Evaluation	To Be Determined	**$34,500***	
Step 3: Clinical Documentation/Coding Review	To Be Determined	**$6,000**	
Step 4: Follow-up & Implementation Assistance	To Be Determined	To Be Determined	
Other: Client Technology & Support Fee	To Be Determined	**$2,025**	

*Fees based on remote review. If performed on-site, incremental travel time and out of pocket costs will be added as incurred.

Fee quote includes all services described in this proposal plus one conference call to discuss the final draft of the report and follow up questions up to 1 month after receipt of the final report. Questions requiring extensive research or received later than one month after receipt of the report would be billed at our standard hourly rates.

Other services requested would be at the appropriate hourly rate.

Consultant	Rate
Principals	$350 - $590
Engagement directors and senior consultants	$180 - $385
Managers	$160 - $365
Seniors	$120 - $210
Associates	$80 - $215
Client service assistants	$90 - $150

You also agree to compensate us for any time and expenses, including time and expenses of legal counsel, we may incur in responding to discovery requests or participating as a witness or otherwise in any legal, regulatory, or other proceedings that we are asked to respond to on your behalf.

Legal compliance

The entity agrees to assume sole responsibility for full compliance with all applicable federal and state laws, rules or regulations, and reporting obligations that apply to the entity or the entity's business, including the accuracy and lawfulness of any reports the entity submits to any government regulator, authority, or entity, except that CLA is responsible for its own compliance with HIPAA as set forth in the BAA. The entity also agrees to be solely responsible for providing legally sufficient substantiation, evidence, or support for any

reports or information supplied by the entity to any governmental or regulatory body, or for any insurance reimbursement in the event that the entity is requested to do so by any lawful authority. CLA, its successors, affiliates, officers, and employees do not assume or undertake any duty to perform or to be responsible in any way for any such duties, requirements, or obligations.

Record retention

Our working papers, including any copies of your records that we chose to make, are our property and will be retained by us in accordance with our established records retention policy. This policy states, in general, that we will retain our working papers for a period of seven years. After this period expires, our working papers and files will be destroyed. Furthermore, physical deterioration or catastrophic events may shorten the time our records are available. The working papers and files of our firm are not a substitute for the entity's records.

In accordance with Section 1861(v)(1) of the Social Security Act, the Secretary and Comptroller General have access, upon request, to the contract and to the books, documents, and records of CLA that are necessary to verify the nature and extent of the costs of services furnished under this contract. This will remain applicable until the expiration of four years after the services furnished under this contract.

Agreement

CLA appreciates the opportunity to assist the entity and believes that this SOW accurately summarizes the terms of our engagement. This letter constitutes the entire agreement regarding these services and supersedes all prior agreements (whether oral or written), understandings, negotiations, and discussions between you and CLA. If you have any questions, please contact us.

If the entity agrees with the terms of this engagement as described in this SOW, please sign and date and return it to us. By returning this SOW, the entity is authorizing us to commence our services.

Sincerely,

CliftonLarsonAllen LLP

CLA

Clifton Larson Allen, LLP

Sheila Hill, Principal

SIGNED 11/9/2023, 5:35:59 PM EST

CLA

Adam Roth, Principal

SIGNED 11/9/2023, 5:37:21 PM EST

Client

Northern Inyo Healthcare District

SIGN:

Stephen DelRossi, Interim CEO/CFO

DATE:

NORTHERN INYO HEALTHCARE DISTRICT
One Team. One Goal. Your Health.

Northern Inyo Healthcare District

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

NORTHERN INYO HEALTHCARE DISTRICT
RECOMMENDATION TO THE BOARD OF DIRECTORS
FOR ACTION

Date: December 20, 2023

Title: **APPROVAL OF BOARD RESOLUTION 23-08**

Synopsis: Board Resolution 23-08 authorizes the Chief Executive Officer to complete and submit the Multi-Bank Securities, Inc., ACH Authorization Agreement and Standing Instructions Letter of Authorization for the effective management of District investments with this company. Further, 23-08 authorizes the Chief Executive Officer to sign investment documents, as appropriate. It is recommended that Board Resolution 23-08 be approved and adopted. If approved, this resolution would be effective Wednesday, December 20, 2023 upon the Board's approval.

Prepared by: Katie Manuelito, Board Secretary

Approved by: Stephen DelRossi, Chief Executive Officer

RESOLUTION NO. 23-08

RESOLUTION OF THE BOARD OF DIRECTORS OF THE NORTHERN INYO HEALTHCARE DISTRICT APPROVING THE DEPOSIT AND INVESTMENT OF FUNDS TO ELIGIBLE CERTIFICATES OF DEPOSIT AND THE LOCAL AGENCY INVESTMENT FUND

WHEREAS, the Legislature of the State of California has declared that the deposit and investment of public funds by local officials and local agencies is an issue of statewide concern (California Government Code Sections 53600.6 and 53630.1); and

WHEREAS, the Board of Directors (the "Board") of the Northern Inyo Healthcare District (the "District") may invest surplus monies not required for the immediate necessities of the District in accordance with the provisions of California Government Code Section 53600 *et seq*.; and

WHEREAS, the District may also deposit its moneys with an eligible state or national bank, savings association or federal association, and state or federal credit union located in California, as provided in Government Code Section 53630 *et seq*.; and

WHEREAS, the District now wishes to approve the deposit and/or investment of surplus District moneys in eligible certificates of deposit and with the Local Agency Investment Fund ("LAIF"), in accordance with the law and as provided herein.

NOW, THEREFORE, BE IT RESOLVED, DETERMINED, AND ORDERED by the Board of Directors of the Northern Inyo Healthcare District as follows:

1. The above recitals are true and correct, and the Board of the District so finds and determines.

2. All deposits and/or investments of District funds shall be done in compliance with law and the limitations applicable to public agencies, including pursuant to Government Code Sections 53600 *et seq*. and 53630 *et seq*.

3. The Board hereby approves the deposit and investment of moneys not required for the immediate needs of the District in the LAIF, in compliance with the California Government Code Section 16429.1.

4. The Board hereby approves the deposit of moneys not required for the immediate needs of the District in non-negotiable certificates of deposit with eligible financial institutions and securities, for a term not to exceed 5 years in compliance with the California Government Code.

5. The Board hereby delegates the authority to manage and authorize the deposits and investments of funds in eligible certificates of deposit and LAIF to its Chief Financial Officer. The Chief Financial Officer shall confirm that any deposit of funds into a certificate of deposit is done with an eligible financial institution that can hold public funds, in compliance

with the limitations and requirements of the California Government Code, including with respect to limitations on securities and required collateral described in California Government Code Section 53652.

6. This Resolution shall take effect immediately after its adoption on the date hereof.

PASSED, APPROVED, AND ADOPTED by the Northern Inyo Healthcare District this 20th day of December 2023, by the following vote:

AYES: _____

NOES: _____

ABSTAIN: _____

ABSENT: _____

By:_____
Chair of the Board
Northern Inyo Healthcare District

ATTEST:

By:_____
Clerk of the Board
Northern Inyo Healthcare District

NORTHERN INYO HEALTHCARE DISTRICT
SUBMISSION TO THE BOARD OF DIRECTORS
FOR APPROVAL

Date: December 11, 2023

Title: **Cerner Work Queue Monitor**

Presenter(s): Bryan Harper, ITS Director
Amanda Santana, Informatics Lead

Synopsis: This software will allow NIHD to use the Cerner system as designed to store orders for future use, rather than storing those orders on the District servers. This will improve workflow for employees and patients. It will also eliminate one of the major risks that the annual penetration testing (for Cyber security) documents.

It is recommended that the Board of Directors approve the purchase of this software.

Prepared by: Bryan Harper, ITS Director

Reviewed by: _____
Name
Title Compliance Officer

Approved by: _____, 12/11/23
Name
Title

ORACLE

Ordering Document

CPQ-3204843

Northern Inyo Healthcare District
150 Pioneer Ln
Bishop CA, 93514
US

Contact
Amanda Santana
(760) 873-5811
amanda.santana@nih.org

Oracle America, Inc.
500 Oracle Parkway
Redwood Shores, CA
94065

Fee Summary

Fee Description	Net Fees	Monthly Fees	Annual Fees
Recurring Services	--	1,445.50	--
Professional Services -- Fixed Price	41,175.00	--	--
Professional Services -- Estimated Expenses	6,500.00	--	--
Total Fees	**47,675.00**	**1,445.50**	**0.00**

Billing Frequency

Description	% of Total Due	Payment Due
Recurring Services	100%	Annually in advance, beginning when access issued
Professional Services - Fixed Price	100%	Upon order execution
Professional Services - Estimated Expenses	100%	Monthly in arrears

Ordered Items

Recurring Services

Part Number	Description	Term	Pass-Through Code	Quantity	Unit Net Price	Extended Monthly Fees
B100110	Work Queue Management - Providers	76 mo	--	59	24.50	1,445.50
					Subtotal	1,445.50

Professional Services

Professional Services -- Fixed Price

Part Number	Description	Service Descriptions	Pass-Through Code	Net Fees
B103914	Work Queue Management for Ambulatory (CommunityWorks)	Attached	--	41,175.00
			Subtotal	41,175.00

Professional Services -- Estimated Expenses

Part Number	Description	Estimated Fees
B102173	Oracle Health Travel and Expenses for Commercial Estimate - Each	6,500.00
	Subtotal	6,500.00

Permitted Facilities

Name	Street Address	City
Northern Inyo Healthcare District	150 Pioneer Ln	Bishop, CA, 93514 US

A. Terms of Your Order

1. Applicable Agreement

a. This order incorporates by reference the terms of the Cerner Business Agreement LA-0000012761 and all amendments and addenda thereto (the "Agreement"). The defined terms in the Agreement shall have the same meaning in this order unless otherwise specified herein.

Oracle America, Inc. is acting as ordering and invoicing agent for Cerner Corporation. Your order remains between You and Cerner Corporation. All references to "Oracle", "we", "us", or "our" shall refer to Cerner Corporation. We may refer to Client as "You".

2. Fees and Payments

a. Listed above is a summary of net fees due under this order. All fees on this order are in US Dollars.

b. Fees will be invoiced in accordance with the Billing Frequency table above.

c. Oracle may increase the monthly fee for each Ordered Item identified as Licensed Software Support, Equipment support, Sublicensed Software support, Recurring Services, Transaction Services, Professional Services -- Recurring, Application Management Services, and Managed Services in the table(s) above any time following the initial 12 month term after such recurring service fees begin (but not more frequently than once in any 12 month period) by giving You 60 days prior notice of the price increase. The amount of such annual increase will equal 8%. Oracle may also increase the fees at any time during the term if an Oracle third party increases the fees to be paid by Oracle, with such increase being limited to the amount of increase in Oracle's fee to the third party.

d. You agree to pay any sales, value-added or other similar taxes imposed by applicable law that Oracle must pay based on the items You ordered, except for taxes based on Oracle's income.

e. Once placed, Your order shall be non-cancelable and the sums paid nonrefundable, except as provided in the Agreement and this order.

3. Terms Applicable to Ordered Items

a. **Scope of Use.**

You will use the Ordered Items in this order in accordance with the Documentation and subject to the quantity of the item specified in the Ordered Items table(s) above. This order incorporates by reference the scope of use metric, definition, and any rules applicable to the Ordered Item as described in the Oracle Health Definitions and Rules Booklet v100123 which may be viewed at http://www.oracle.com/contracts on the Oracle Health tab.

If the quantity of an Ordered Item is exceeded, You agree to execute a new order setting forth the additional quantity of the item.

Where applicable, scope of use will be measured periodically by Oracle's system tools, or, for metrics that cannot be measured by system tools or obtained through industry available reporting sources (e.g., FTEs or locations), You will provide the relevant information (including records to verify the information) to Oracle at least once per year. You agree that if an event occurs that will affect Your scope of use (such as the acquisition of a new hospital or other new facility), You will notify Oracle in writing of such event no later than 30 days following the effective date of such event so that Your scope of use can be reviewed. Any additional fees due under this section will be payable within 30 days following Your receipt of an invoice for such fees. Any additional monthly fees will begin on the date the limit was exceeded and shall be paid annually (pro-rated for any partial month).

b. **Solution Descriptions.**

Solution Descriptions applicable to each Ordered Item identified as Licensed Software, Recurring Services or Transaction Services in the table(s) above are available on http://www.oracle.com/contracts on the Oracle Health tab. The Solution Description is identifiable by the Part Number in the table(s) above. These Solution Descriptions are incorporated into this order by reference.

c. **Shared Computing Services.**

You understand that Oracle may deliver the products and services on this order in a Shared Computing Services model. The policies that govern the Shared Computing Services model are available at http://www.oracle.com/contracts on the Oracle Health tab and are incorporated into this order by reference.

d. **Permitted Facilities.**

The Ordered Items in this order are for use by the facilities listed in the Permitted Facilities table(s) above. You may add or substitute Permitted Facilities by amending this order.

4. Recurring Services

a. Unless otherwise set forth herein, all Ordered Items identified as Recurring Services in the table(s) above begin on the date that You are issued access that enables You to activate Your Service.

5. Professional Services

a. **Oracle Health Professional Services Delivery Policies.**

The Oracle Health Professional Services Delivery Policies ("Health PSDP") available at http://oracle.com/contracts on the Oracle Health tab apply to and are incorporated into this order.

b. **Service Descriptions.**

Service Descriptions applicable to each Ordered Item identified as Professional Services in the table(s) above may be found (i) at http://www.oracle.com/contracts on the Oracle Health Tab (where identified as "Online" in the Professional Services table(s)), or (ii) as an attachment to this order (where identified as "Attached" in the Professional Services table(s)). These Service Descriptions are incorporated into this order by reference.

c. **Estimated Fees.**

Fees for Professional Services identified in this order as "Professional Services -- Time and Materials" and "Professional Services -- Estimated Expenses" are estimates intended only to be for Your budgeting and Oracle's resource scheduling purposes and may exceed the estimated totals; these estimates do not include taxes. For Professional Services performed on a time and materials (T&M) basis, You shall pay Oracle for all of the time spent performing such services at the rate specified in the Items Ordered table(s) above, plus materials, taxes and expenses. Actual expenses shall be invoiced as incurred, in accordance with the Billing Frequency table. Once fees for Professional Services reach the estimate and upon amendment to this order, Oracle will cooperate with You to provide continuing Professional Services on a T&M basis.

d. As required by U.S. Department of Labor regulations (20 CRF 655.734), You will allow Oracle to post a notice regarding Oracle H-1B employee(s) at the work site prior to the employee's arrival on site.

6. Order of Precedence

a. In the event of inconsistencies between the terms contained in this order and the Agreement, this order shall take precedence. This order will control over the terms contained in any purchase order.

7. Effective Date

a. If accepting this order electronically, the effective date of this order is the date You click to accept the order. If accepting this order via E-sign, the effective date of this order is the date You adopt and sign. If accepting this order via Download and Sign, the effective date is the date You return the document to Oracle. Otherwise, the effective date is the last signed date stated below.

8. Offer Validity

a. This offer is valid through 29-Feb-2024 and shall become binding upon execution by You and acceptance by Oracle.

Northern Inyo Healthcare District	
Signature	_____
Name	_____
Title	_____
Signature Date	_____

Oracle America, Inc.	
Signature	Jessica King
Name	Jessica King
Title	Senior Director, Americas SSC, Deal Management
Signature Date	15-Dec-2023 06:40 AM PST

Work Queue Management for Ambulatory (CommunityWorks)

Part #: B103914
Cerner Legacy Part #: CTS-WQM-AMB-CWX-IMP

Description of Services	Oracle will provide the following Services:
	• Conduct design sessions; topics will include:
	  o Project planning
	  o Imaging process and workflow
	  o Work queue processing
	• Integration with existing fax infrastructure or network-based scanners (based off of licensure included/owned)
	• Conduct up to two (2) rounds of integration testing
	  o Lead first round of testing and use second round to train Your superusers
	• Work Queue Management installed and configured as outlined in this scope
	• Knowledge transfer for maintenance purposes
	• Superuser training for the as-built system

Your Cooperation / Obligations	You are responsible for the following obligations: • Conduct end-user training and create training documentation
Assumptions	• Number of domains: One (1) non-production and one (1) production domain • Number of clinics: Up to ten (10) clinics • Oracle Health Document Imaging is currently installed and working or being implemented in Your production environment. • Application and project management duration will be the length of the project, approximately six (6) months, if implemented independently. If implemented in conjunction with other projects, duration will adjust to overall project timeline.

Bill To / Ship To Contact Information

Bill To Contact

Customer Name	Customer Address	Contact Name / Phone / Email
Northern Inyo Healthcare District	150 Pioneer Ln Bishop, CA, US 93514	Amanda Santana (760) 873-5811 amanda.santana@nih.org

Ship To Contact

Customer Name	Customer Address	Contact Name / Phone / Email
Northern Inyo Healthcare District	150 Pioneer Ln Bishop, CA, US 93514	Amanda Santana (760) 873-5811 amanda.santana@nih.org

NORTHERN INYO HEALTHCARE DISTRICT

BYLAWS

ADOPTED BY THE BOARD OF DIRECTORS

NORTHERN INYO HEALTHCARE DISTRICT

REVISED AND ADOPTED IN CONFORMANCE WITH DIVISION 23, SECTION 32000 ET SEQ. OF THE CALIFORNIA HEALTH AND SAFETY CODE ON DECEMBER 20, 2023

NORTHERN INYO HEALTHCARE DISTRICT

BYLAWS

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NORTHERN INYO HEALTHCARE DISTRICT

BYLAWS

ARTICLE I

NAME, AUTHORITY AND OFFICES

Section 1. NAME

The name of this non-profit health care district organization shall be the Northern Inyo Healthcare District, hereinafter "the District".

Section 2. AUTHORITY

a) This District, having been established January 11, 1946, by vote of the residents of the District under the provisions of Division 23, Section 32000 et seq, of the Health and Safety Code of the State of California, otherwise known and referred to herein as "The Local Health Care District Law," and ever since said time having been operated thereunder, these bylaws are adopted in conformance therewith, and subject to the provisions thereof.

b) In the event of any conflict between these bylaws and "The Local Health Care District Law," the latter shall prevail. To the extent they are not in conflict with these bylaws, the proceedings of the District Board shall be guided by the most recent edition of Robert's Rules of Order.

Section 3. OFFICES

The principal office for the transaction of business of the District is hereby fixed within the boundaries of the District as determined by the Board of Directors.

Section 4. TITLE OF PROPERTY

The title to all property of the District shall be vested in the District, and the signature of the Chair and/or Secretary**,** or any officer designated by the Directors, as authorized at any meeting of the Directors, shall constitute the proper authority for the purchase or sale of property, or for the investment or other disposal of funds which are subject to the control of the District.

NORTHERN INYO HEALTHCARE DISTRICT

BYLAWS

ARTICLE II

PURPOSES AND SCOPE

Section 1. PURPOSES

The purposes of the Northern Inyo Healthcare District shall include, but not be limited to the following:

a) Within available resources, to provide facilities and health services for quality acute and continued care of the injured and ill, inducing health maintenance and education, regardless of sex, race, creed, cultural or national origin.

b) To coordinate, wherever possible and feasible, the activities of the District with health agencies and other health facilities providing specialized as well as comprehensive care.

c) To conduct educational and research activities essential to the attainment of its purposes.

d) To do any and all other acts necessary to carry out the provisions of the Health Care District Act.

Section 2. SCOPE OF BYLAWS

a) These bylaws shall govern the Northern Inyo Healthcare District, its Board of Directors and its relationship to affiliated or subordinate organizations. The primary purpose of these bylaws is to provide rules for the self-governance of the District and the Board of Directors, to provide a structure for the Board of Directors to fulfill its functions and responsibilities with respect to an organized self-governing Medical Staff, and to provide a structure for Administration of the licensed healthcare inpatient and outpatient facilities operated by the District (specifically Northern Inyo Hospital, 1206 D and 1206 B clinics).

b) The Board of Directors may delegate certain powers to the Authority of the Board's committees, the Medical Staff, and to other affiliated and subordinate organizations and groups governed by the District, such powers to be exercised in accordance with the respective bylaws or guidelines of such groups. All powers and functions not expressly delegated to such affiliated or subordinate organizations or groups are to be considered residual powers vested in the Board of Directors of this District.

c) The Bylaws, Rules and Regulations of the Medical Staff and other affiliated and subordinate organizations and groups governed by the District, and any amendments to such bylaws, shall not be effective until the same are approved by the Board of Directors of the Northern Inyo Healthcare District. The provisions of these District bylaws shall be construed to be consistent with the Medical Staff's bylaws. Except that these Bylaws shall not conflict with the bylaws of the Medical Staff as approved by the Board of Directors, the Board of Directors may review these Bylaws and revise them as it deems appropriate.

Section 3. NOT FOR PROFIT STATUS

There shall be no contemplation of profit or pecuniary gain, and no distribution of profits to any individual, under any guise whatsoever; nor shall there by any distribution of assets or surpluses to any individual on the dissolution of this District.

Section 4. DISPOSITION OF SURPLUS

Should the operation of the District result in a surplus of revenue over expenses during any particular period, such surplus may be used and dealt with by the Directors for charitable District purposes or for improvements hospital's facilities for the care of the sick, injured, or disabled, or for other purposes not inconsistent with the Local Health Care District Act, or these bylaws. The Board of Directors may authorize the disposition of any surplus property of the District by any method determined appropriate by the Board.

Section 5. INDEMNIFICATION

a) Any person made or threatened to be made a party to any action or proceeding, whether civil or criminal, administrative or investigative, by reason of the fact that he/she, his/her estate, or his/her personal representative is or was a Director, officer or employee of the District, or an individual (including a medical staff appointee) acting as an agent of the District, or serves or served any other corporation or other entity or organization in any capacity at the request of the District while acting as a Director, officer, employee or agent of the District shall be and hereby is indemnified by the District, as provided in Sections 825 *et.seq.* of the California Government Code.

b) Indemnification shall be against all judgments, fines, amounts paid in settlement and reasonable expenses, including attorney's fees actually and necessarily incurred, as a result of any such action or proceeding, or any appeal therein, to the fullest extent permitted and in the manner prescribed by the laws of the State of California, as they may be amended from time to time, or such other law or laws as may be applicable to the extent such other law or laws is not inconsistent with the law of California, including Sections 825 *et.seq.* of the California Government Code.

c) Nothing contained herein shall be construed as providing indemnification to any person

in any malpractice action or proceeding arising out of or in any way connected with such person's practice of his or her profession.

Section 6. FISCAL YEAR

The fiscal year of the District shall commence on the first day of July and each year shall end on the last day of June of each year.

Section 6 Annual Audit removed see section see VI Section, 2, b.

NORTHERN INYO HEALTHCARE DISTRICT

BYLAWS

ARTICLE III

BOARD OF DIRECTORS

Section 1. ELECTION

The Board of Directors shall be elected as provided in "The Local Healthcare District Law," which shall also govern eligibility for election to the Board of Directors.

Section 2. POWERS

The Board of Directors shall have and exercise all the powers of a Healthcare District as set forth in the Healthcare District Act. Specifically, the Board of Directors shall be empowered as follows:

a) To control and be responsible for the overall governance of the District, including the provision of management and planning.

b) To make and enforce all rules and regulations necessary for the administration, government, protection and maintenance of hospitals and other facilities under District jurisdiction and to ensure compliance with all applicable laws.

c) To appoint a Chief Executive Officer and to define the powers and duties of such appointee, and to delegate to such person overall responsibility for operations of the District, the Hospital, and affiliated entities as specified herein and consistent with Board of Directors' Policies. The Board shall also retain legal counsel and independent auditors as needed for District and Hospital operations.

d) To authorize the formation of other affiliated or subordinate organizations which they may deem necessary to carry out the purposes of the District.

e) To periodically review and develop a strategic plan for the District and the Hospital.

f) To determine policies and approve procedures for the overall operation and affairs of this District and its facilities according to the best interests of the public health and to assure the maintenance of quality patient care.

g) To enter into Joint Powers Agreements with other public entities, and to carry out the District's responsibilities in regard to such Joint Powers Authority as prescribed by law.

h) To evaluate the performance of the Hospital in relation to its vision, mission and goals.

i) To provide for coordination and integration among the Hospital's leaders to establish policy, maintain quality care and patient safety, and provide for necessary resources.

j) To be ultimately accountable for the safety and quality of care, treatment and services.

k) All powers of the Board of Directors, which are not restricted by statute, may be delegated by an employment agreement, policies, and by direction of the Board to the Chief Executive Officer or to others employed by or with responsibilities to the District, to be exercised in accordance with that delegation.

l) In the event of a vacancy in any Board office established by Article V of these Bylaws (Chair, Vice Chair, etc.), the Board of Directors shall select someone to fill such vacancy and to serve until the next regular election of officers, unless such person earlier resigns or is removed in accordance with said Article.

m) To do any and all other act and things necessary to carry out the provisions of these bylaws or of the provisions of the Local Healthcare District Law.

Section 3. COMPENSATION

The Board of Directors shall serve without compensation except that the Board of Directors, by a majority vote of the members of the Board, may authorize payment not to exceed one hundred dollars ($100) per meeting, or for each committee meeting or other meeting authorized by Board or Chair of the Board, and not to exceed five (5) meetings a month as compensation to each member of the Board of Directors, in accordance with Section 32103 of the California Health and Safety Code, as amended.

Each member of the Board of Directors shall be allowed his/her necessary traveling and incidental expenses incurred in the performance of official business of the District pursuant to the Board's policy.

A budget for the Board of Directors educational expenses is developed each year. At least annually, the entire Board will review their travel and incidental expenses.

Section 4. VACANCIES

Any vacancy upon the Board of Directors shall be filled by the methods prescribed in Section 1780 of the Government Code.

NORTHERN INYO HEALTHCARE DISTRICT

BYLAWS

ARTICLE IV

MEETINGS OF DIRECTORS

Section 1. REGULAR MEETINGS

The regular meetings of the Board of Directors of the Northern Inyo Healthcare District shall be held monthly, or as periodically determined by the Board, on such day and at such time as the Board of Directors shall from time-to-time establish by resolution and/or motion.

Section 2. SPECIAL MEETINGS

Special meetings of the Board of Directors may be called by the Chair or three (3) Directors, and notice of the holding thereof shall be received by each member of the Board of Directors at least twenty-four hours (24) before said meeting.

Section 3. QUORUM

A majority of the members of the Board of Directors shall constitute a quorum for the transaction of business, and motions and resolutions shall be passed if affirmatively voted upon by a majority of those voting at the time the vote is taken. If a member has a conflict of interest and may not vote they may not be counted towards a quorum.

Section 4. ADJOURNMENT

A quorum of the Board of Directors may adjourn any Directors' meeting to meet again at a stated day and hour; provided, however, that in the absence of a quorum, a majority of the Directors present at any Directors' meeting, either regular or special, may adjourn until the time fixed for the next regular meeting of the Board of Directors. An adjourned meeting can consider only the business of the meeting which was adjourned. An adjourned meeting must be completed prior to the convening of a new meeting.

Section 5. PUBLIC MEETINGS

All meetings of the Board of Directors whether regular, special or adjourned, shall be open to the public in accordance with Government Code Sections 54950 through 54961, commonly known as the Ralph M. Brown Act provided, however, that the foregoing shall not be construed to prevent the Board of Directors from holding executive sessions to consider the appointment,

employment, promotion, demotion or dismissal of an employee or public officer, as the term is defined by law, or to hear complaints or charges brought against such officer or employee, to discuss labor negotiations, or to consult with legal counsel concerning litigation to which the District is a party, and prospective and probably litigation, as provided in Sections 54956.7 through 54957 of the Government Code. In addition, closed sessions may be held to discuss trade secrets as defined in Government Code Section 54956.7, and provided in Section 32106 of the Health and Safety Code. To the extent not in violation with the Ralph M. Brown Act or the California Public Records Act, and California Health and Safety Code Section 32155, any information and reports protected from discovery by California Evidence Code Section 1157 that are provided to the Board of Directors by the Medical Staff shall be presented and discussed in closed sessions, maintained as confidential and not released except as required by applicable laws.

Section 6. MINUTES

A book of minutes of all public meetings of the Board of Directors shall be kept at the principal office of the District and shall be open for public inspection upon request.

Section 7. SCOPE OF MOTIONS AND RESOLUTIONS

The decisions of the Board establishing general rules or procedures of the District and/or procedures affecting the Directors shall be by motion or resolution. All motions or resolutions become effective at the time voted upon affirmatively by a majority of the Directors voting at the time the vote is taken.

NORTHERN INYO HEALTHCARE DISTRICT

BYLAWS

ARTICLE V

OFFICERS AND THEIR DUTIES

Section 1. OFFICERS

The officers of the Board of Directors of the Northern Inyo Healthcare District shall be a Chair, Vice Chair and a Secretary, a Treasurer, and "Member at Large".

Section 2. ELECTION OF OFFICERS

a) The officers of the Board of Directors shall be chosen every year by the Board of Directors at the December meeting of every calendar year; and each officer shall hold office for one year, or until a successor shall be elected and qualified, or until the officer is otherwise disqualified to serve.

b) If an officer of the Board, other than the Chair, is unable to act, the Board may appoint some other member of the Board of Directors to do so, and such person shall be vested temporarily with all the functions and duties of the office.

c) Any officer on the Board of Directors may resign at any time or be removed as a Board officer by the majority vote of the other Directors then in office at any regular or special meeting of the Board of Directors. In the event of a resignation or removal of an officer, the Board of Directors shall elect a successor to serve for the balance of that officer's unexpired term.

Section 3. DUTIES

a) Chair: The Board of Directors shall elect one of their members to act as Chair. If at any time the Chair shall be unable to act, the Vice Chair shall assume office and perform the duties of the office. If the Vice Chair shall also be unable to act, then the Secretary/Treasurer shall assume the office and shall immediately conduct a Board election to appoint a Chair, and such person shall be vested temporarily with all the functions and duties of the Chair.

The Chair, or member of the Board of Directors acting as such, as above provided:

(1) Shall preside over all meetings of the Board of Directors, and shall review all requested agenda items submitted to the Chair and the Chair & Chief Executive Officer pursuant to the Board's written policies;

(2) Shall sign as Chair on behalf of the District all instruments in writing that the Chair has been specifically authorized by the Board to sign;

(3) Shall act as the main liaison between the Board and management for communications and oversight purposes. It is expected that the Chair will discuss District business with the Chief Executive Officer and Vice Chair on a regular basis;

(4) Shall appoint or remove members of committees subject to approval by the Board of Directors.

(5) Shall have, subject to the advice and control of the Board of Directors, general responsibility for the affairs of the District and generally shall discharge all other duties which shall be required of the Chair by the Bylaws of the District.

b) Vice Chair: The Vice Chair shall, in the event of death, absence, or other inability of the Chair, exercise all the powers and perform all the duties herein given to the Chair. It is expected that the Vice Chair will participate in regular discussions with the Chair and Chief Executive Officer regarding District business.

c) Secretary:

(1) The member of the Board who is elected to the position of Secretary shall act in this capacity for both the District and the Board of Directors;

(2) Shall be responsible for seeing that records of all actions, proceedings and minutes of meetings of the Board of Directors are properly kept and are maintained at the District offices;

(3) Shall serve, or cause to be served, all notices required either by law or these bylaws, and in the event of absence, inability, refusal or neglect to do so, such notices may be served by any person thereunto directed by the Chair of the Board of Directors of this District;

(4) Shall be responsible for seeing that the seal of this District is in safekeeping at the District and shall use it under the direction of the Board of Directors;

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(5) Shall perform such other duties as pertains to the office and as are prescribed by the Board of Directors. The Secretary may delegate his or her duties to appropriate

management personnel.

d) Member at Large: The Member at Large shall have all the powers and duties of the Secretary in the absence of the Secretary, and shall perform such other duties as may from time to time be prescribed by the Board of Directors.

e) Treasurer:

(1) Shall have the responsibility for the safekeeping and disbursal of funds in the treasury of the District in accordance with the provisions of the "Local Healthcare District Law" and in accordance with resolutions, procedures and directions as the Board of Directors may adopt;

(2) Shall receive monthly reports from management with respect to the financial condition of the District and shall present such reports to the Board of Directors as directed by the Board of Directors;

(3) Shall perform such other duties as they pertain to this office and as prescribed by the Board of Directors. The Treasurer may delegate his or her duties to appropriate management personnel.

NORTHERN INYO HEALTHCARE DISTRICT

BYLAWS

ARTICLE VI

COMMITTEES

Section 1. COMMITTEES

a) The Board of Directors may sit as a Committee of the Whole on any and all matters, or may create such Standing Committees, ad hoc Committees, or task force Committees as are deemed appropriate.

b) The duties of these committees shall be to develop and make policy recommendations to the Board and to perform such other functions as shall be stated in these bylaws or in the resolution or motion creating the committee. Each Standing Committee will include two Board members, one of whom shall act as Chair of the Standing Committee. The Chair and Board members of each Standing Committee shall be appointed by the Chair of the Board and approved by the Board at the earliest possible time at the beginning of each calendar year and shall serve for one year, or until a successor has been appointed and approved. Other members of each standing committee are automatically members with one year terms, or until a successor has been appointed and approved. The two Board members shall be the only voting members of each Standing Committee, unless otherwise provided for in these Bylaws.

c) Special or ad hoc committees may be appointed by the Chair with the approval of the Board of Directors for such specific tasks as circumstances warrant. Special committees may consist only of Board members, or they may include individuals not on the Board. Voting rights on special committees shall be specified by the Board of Directors at the time the committee is created. No committee so appointed shall have any power or authority to commit the Board of Directors or the District in any manner; however, the Board may direct the particular committee to act for and on its behalf, by special vote.

d) All committees shall keep minutes of each meeting and shall maintain their minutes at the District offices and shall submit reports to the Board as requested.

e) Aside from committees upon which the Chair is appointed as a voting member, the Chair of the Board shall be an ex officio member of each committee, without being a voting member. The Chair shall be notified of all committee meetings.

Section 2. STANDING COMMITTTEES

Governance Committee: Members of this standing committee shall include two representatives from the Board of Directors and the Chief Executive Officer. The two members of the Board of Directors shall be the only members of the Committee with voting privileges. The function of this Committee is to recommend amendments or changes to the District bylaws and Board policies. This Committee shall commence an on-going review of the Bylaws to ensure that the Bylaws are maintained current and consistent with the Board's and the District's functions and operations. This Committee shall also review the Board Policy Manual, at least every four years, and make recommendations to the Board on any additions or deletions of policies. The Committee shall also be responsible for development of a format for the evaluation of the Chief Executive Officer, and for the conduct of a periodic evaluation. This Committee shall also be responsible for developing a format and administering the Board of Directors' periodic self-evaluations. Such Board evaluation shall include an annual assessment of resolution of safety and quality issues and initiatives.

Section 3. AD HOC COMMITTEES

As needed, and from time to time, the Board shall create the following ad hoc committees as follows:

a) Quality and Safety Committee: Two members of the Board shall comprise the Quality and Safety Committee, being advised by the Chief Executive Officer, the Medical Executive Committee, the Chief of Staff, and Medical Staff members from time to time. The Quality and Safety Committee shall:

(1) Analyze data regarding safety and quality of care, treatment and services and establish priorities for performance improvement.

(2) Oversee the Medical staff's fulfillment of its responsibilities in accordance with the Medical Staff Bylaws, applicable law and regulation, and accreditation standards.

(3) Ensure that recommendations from the Medical Executive Committee and Medical Staff are made in accordance with the standards and requirements of the Medical Staff Bylaws, Rules and Regulations with regard to:

- completed applications for initial staff appointment, initial staff category assignment, initial department/divisional affiliation, membership prerogatives and initial clinical privileges;
- completed applications for reappointment of medical staff, staff category, clinical privileges;
- establishment of categories of Allied Health Professionals permitted to practice at the hospital, the appointment and reappointment of Allied Health Professionals and privileges granted to Allied Health Professionals.

(4) Provide a system for resolving conflicts that could adversely affect safety or quality of care among individuals working within the hospital environment.

(5) Ensure that adequate resources are allocated for maintaining safety and quality care, treatment and services.

(6) Analyze findings and recommendations from the Hospital's administrative review and evaluation activities, including system or process failures and actions taken to improve safety, both proactively and in response to actual occurrences.

(7) Assess the effectiveness and results of the quality review, utilization review, performance improvement, and risk management programs.

(8) Perform such other duties concerning safety and quality of care matters as may be necessary.

b) Finance Committee: Two members of the Board shall comprise the Finance Committee. The Finance Committee in consultation with the Chief Executive Officer shall be responsible for reviewing and monitoring the annual budget and, as appropriate, its long term capital expenditure plan. The Finance Committee shall oversee retention of auditors and approve audits, and business plans pursuant to subsidiary organizations.

c) Community Benefit Committee: The members of this Committee shall be two members of the Board of Directors. The Committee shall be assisted, as needed, by the Chief Executive Officer and the Director of Community and Government Affairs, along with any other staff or representatives designated by the Committee. The two members of the Board of Directors shall be the only members of the Committee with voting privileges. This Committee shall have general responsibility for development and implementation of an achievable Community Benefit Initiative, including identification of a process by which the initiative can be pursued, achieved, and sustained. The Committee will assess and marshal resources available to the District to advance the Initiative in a manner responsive to community health needs, prioritized based on a balance of need and outcome attainability, and, where helpful, in partnership with District and community stakeholders.

NORTHERN INYO HEALTHCARE DISTRICT

BYLAWS

ARTICLE VII

CHIEF EXECUTIVE OFFICER

Section 1 GENERAL PROVISIONS

The Board of Directors shall have the authority to employ and discharge the Chief Executive Officer and shall specify the terms and conditions of the person's employment. The performance of the Chief Executive Officer will be evaluated on an annual basis by the Board of Directors based on performance criteria established from time to time by the Board of Directors.

The Chief Executive Officer shall be responsible for the overall management of the Hospital and District, and has the necessary and full authority to effect this responsibility subject to the Board's oversight, any policies and directives issued by the Board, and as called upon pursuant to the JPA Agreement. Chief Executive Officer is directly responsible to the Board of Directors and the Authority, for the management of the Hospital and all of its departments and activities.

Section 2. QUALIFICATIONS, DUTIES AND RESPONSIBILITIES

Qualifications, specific duties and responsibilities of the Chief Executive Officer shall be set forth in the appropriate section of the Policy Manual and any employment agreement with the Chief Executive Officer.

NORTHERN INYO HEALTHCARE DISTRICT

BYLAWS

ARTICLE VIII

MEDICAL ADMINISTRATION IN THE HOSPITAL

Section 1. ESTABLISHMENT OF A MEDICAL STAFF

There shall be a Medical Staff for the Hospital established in accordance with the requirements of the Local Healthcare District Law (H. & Safety Code 32000, *et.seq*.), whose membership shall be comprised of all physicians, dentists and podiatrists who are duly licensed and privileged to admit and care for patients in the Hospital. The Board of Directors shall appoint the Medical Staff, which shall be an integral part of the Hospital. The Medical Staff derives its authority from the Board of Directors and shall function in accordance with the Medical Staff Bylaws, Rules and Regulations and Policies that have been approved by the Medical Staff and by the Board.

The Medical Staff shall be represented before the Board of Directors by the Chief of Staff or his/her designee and shall be afforded full access to the Board through the Board's regular meetings and committees as described herein. The Medical Staff, through its officers, department chiefs, and committees, shall be responsible and accountable to the Board of Directors for the discharge of those duties and responsibilities set forth in the Medical Staff's Bylaws, Rules and Regulations, and Policies, and as delegated by the Board of Directors from time to time.

Section 2. BYLAWS, RULES AND REGULATIONS

The Medical Staff is responsible for the development, adoption, and periodic review of the Medical Staff Bylaws and Rules and Regulations, consistent with these District Bylaws, applicable laws, government regulation, and accreditation standards. The Medical Staff Bylaws, Rules and Regulations and all amendments thereto, shall become effective upon approval by the Medical Staff and the Board of Directors.

Section 3. BOARD ACTION ON MEMBERSHIP AND CLINICAL PRIVILEGES

(a) Medical Staff Responsibilities: The Medical Staff is responsible to the Board of Directors for the quality of care, treatment and services rendered to patients in the Hospital. The Board of Directors shall delegate to the Medical Staff the responsibility and authority to investigate and evaluate all matters relating to Medical Staff membership status, clinical privileges, and corrective action, except as

provided in Section 3(d). The Medical Staff adopt and forward to the Board or committee of the Board specific written recommendations, with appropriate supporting documentation, that will allow the Board of Directors to take informed action. When the Board of Directors does not concur with a Medical Staff recommendation, the matter shall be processed in accordance with the Medical Staff Bylaws and applicable law before the Board renders a final decision. The Board of Directors shall act on recommendations of the Medical Staff within the period of time specified in the Medical Staff Bylaws or Rules and Regulations, or if no time is specified, then within a reasonable period of time. However, at all times the final authority for appointment to membership on the Medical Staff of the Hospital remains the sole responsibility and authority of the Board of Directors.

(b) Criteria for Board Action: The process and criteria for acting on matters affecting Medical Staff membership status and clinical privileges shall be as specified in the Medical Staff Bylaws.

(c) Terms and Conditions of Staff Membership and Clinical Privileges: The terms and conditions of membership status in the Medical Staff, and the scope and exercise of clinical privileges, shall be as specified in the Medical Staff bylaws unless otherwise specified in the notice of individual appointment following a determination in accordance with the Medical Staff Bylaws.

(d) Initiation of Corrective Action and Suspension: Where in the best interests of patient safety, quality of care, or the Hospital staff, and after consultation with the Chief of Staff, the Board of Directors shall have the authority to take any action that it deems appropriate with respect to any individual applying for or appointed to the Medical Staff or who is seeking or exercising clinical privileges or the right to practice in the Hospital. Action taken by the Board of Directors in such matters shall follow the procedures for corrective action outlined in the Medical Staff Bylaws, Rules and Regulations. The Board shall notify the Executive Committee immediately of any such action.

Chief Executive Officer may summarily suspend or restrict clinical privileges of any Medical Staff member where failure to take action may result in imminent danger to the health of any individual and when no person authorized to take such action by the Medical Staff is available, provided that the Chief Executive Officer has made reasonable documented attempts to contact the person or persons so authorized. A suspension by the Chief Executive Officer that has not been ratified by the Medical Executive Committee within two working days, excluding weekends and holidays, shall terminate automatically.

(e) Fair Hearing and Appellate Procedures: The Medical Staff Bylaws shall establish fair hearing and appellate review mechanisms in connection with Staff recommendations for the denial of Staff appointments, as well as denial of reappointments, or the curtailment suspension or revocation of privileges. The

hearing and appellate procedures employed by the Board of Directors upon referral of such matters shall be consistent with the Local Healthcare District Law at Section 32150 *et. seq*. of the Health & Safety Code, and those specified in the Medical Staff Bylaws, Rules and Regulations to the extent not inconsistent therewith. Any doctor or other practitioner who feels aggrieved by any adverse recommendation or deprivation of Medical Staff status or clinical privileges shall be required, as a condition to exercising his or her right of appeal to the Board, to pursue his or her appeal through orderly channels of appeal and at the proper time and in the manner prescribed by the Bylaws and procedures of the Medical Staff of this hospital. When the Medical Staff has made its final ruling and decision concerning the appeal of any aggrieved doctor or practitioner in accordance with the Bylaws of the Medical Staff, and such doctor or practitioner then desires to appeal to the Board, he or she shall give notice in writing to the Hospital Administrator within ten (10) days next following the date of the entry of the final order of the Medical Staff. Said notices must state in substance the grievance made and complained of, and must be given in the time and manner herein specified, or the Board shall not take cognizance thereof except at its discretion. If said notice is so given within said time, then it shall be the duty of the Board to then consider such grievance in its entirety and render the decision of the Board in writing, and deliver a copy of its decision and findings to the aggrieved doctor or practitioner. Such decision shall be final.

The Medical Staff shall have the right to be heard, through its Chief of Staff or designee at meetings of the Board.

Section 4. ACCOUNTABILITY TO THE BOARD

The Medical Staff shall conduct and be accountable to the Board for conducting activities that contribute to the preservation and improvement of quality patient care and safety in the Hospital.

Section 5. DOCUMENTATION

The Board shall receive and act upon the findings and recommendations emanating from the activities required by Section 4. All such findings and recommendations shall be in writing and supported and accompanied by appropriate documentation upon which the Board can take appropriate action.

Section 6. COMPENSATED MEDICAL DIRECTOR POSITIONS

Compensated Medical Director positions shall be responsible to the Chief Executive Officer and the Medical Staff for documentation of activities related to their assignment. Compensated Medical Directors shall be approved by the Chief Executive Officer and for fit and compensation amount. Medical Staff may appoint Service Directors, the slate of Service Directors must be approved by the Board of Directors.

NORTHERN INYO HEALTHCARE DISTRICT

BYLAWS

ARTICLE IX

AMENDMENT

These Bylaws may be amended by affirmative vote of a majority of the total number of members of the Board of Directors at any regular or special meeting of the Board of Directors, provided a full statement of such proposed amendment shall have been sent to each Board member not less than forty-eight (48) hours prior to the meeting.

Affirmative action may be taken to amend these Bylaws by unanimous vote of the entire Board membership at any regular or special meeting of the Board of Directors, in which event the provision for forty-eight (48) hours notice shall not apply.

Chair, Board of Directors
June 15, 2022

Bronco Clinic Update

Colleen McEvoy PNP

Stacey Brown MD

The Bronco Clinic: A School-Based Health Center (SBHC) at Bishop Union High Started January 2019

What is a School-Based Health Center (SBHC)?

- A clinic at a school
- Almost 300 SBHC's in the state of California and the number is growing
- About 2,500 SBHC's nationwide
- They are located at elementary schools, middle schools and high schools
- Offer a wide range of services: reproductive health, medical, vision, dental, behavioral health, youth engagement programs and more

Services Provided at the Bronco Clinic

- NEW: Pre-Participation Physical Exams: Sports PE's
- Treatment of minor illness or injuries in collaboration with the health clerk (school employee)
- Over the counter medications: pain medications, tums, allergy medications, cough drops- helps keeps students at school
- Diagnosis and treatment of illnesses and injuries Examples: Strep tests, cold symptoms, concussion follow-ups, acne treatment, injuries, chronic abdominal pain, asthma management etc.
- Treatment and referrals for depression, anxiety and other behavioral health issues
- Reproductive health related services (full range of birth control, condoms, pregnancy tests), STD screening and treatment (minor consent)
- In class education on birth control, family planning and other health topics

Benefits of SBHC's

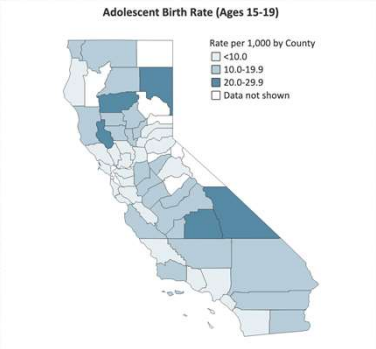
- Research shows that SBHC's:
- Have a positive impact on health and education outcomes
- Increase the use of cost-effective preventive care- decreases emergency room visits
- Help health care agencies improve clinical quality scores by meeting quality metrics
- Increase a lead agency's base of patients/clients
- Allows pediatric providers to more closely communicate with school staff and teachers

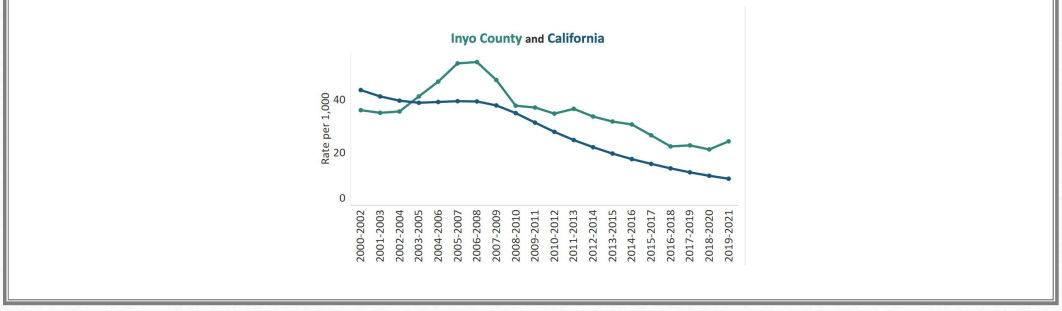
Benefits of SBHC's

- Provides confidential reproductive health services for adolescents- can decrease the adolescent birth rate and rates of sexually transmitted infections
- Parents can stay at work and students can stay at school- parents are VERY happy about this
- Improved school attendance which benefits everyone- hard to show change the last few years
- Of Note: The current policy environment in California is very supportive of the development, expansion and improvement of SBHC's

California Adolescent Birth Rate 2021

https://www.cdph.ca.gov/Programs/CFH/DMCAH/surveillance/Pages/adolescent-births.aspx





Adolescent Birth Rate Inyo County 2019-2021
24.4 per 1,000

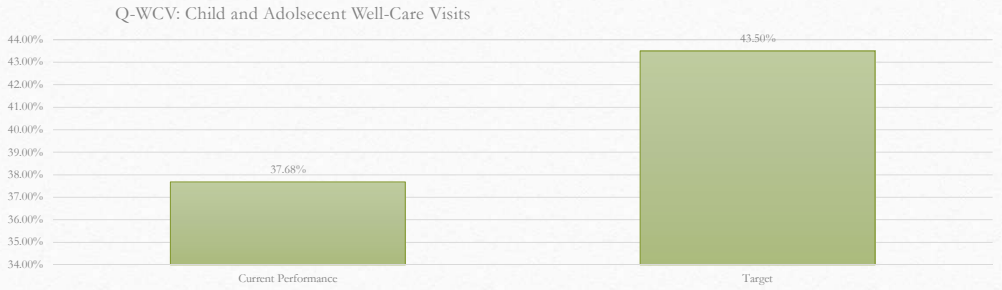
Benefits for NIHD-Quality Metrics

- Being at Bishop Union High School (BUHS) can help us reach several quality metrics
- If we reach one metric, we can receive up to $250,000
- At the Bronco Clinic we are bringing adolescents into care who were not getting healthcare
- We can more easily test and treat adolescents for sexually transmitted infections (STI's)

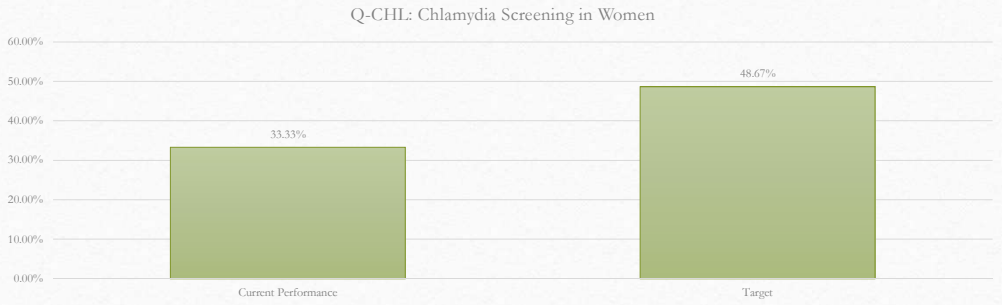
Quality Incentive Pool Measures: Adolescents

Child and Adolescent Well-Care Visits

Description: The percentage of individuals 3-21 years of age who have had at least one comprehensive well-care visit with a PCP or OB/GYN during the measurement year

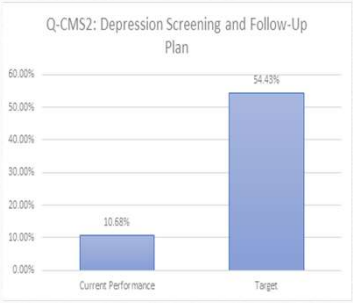


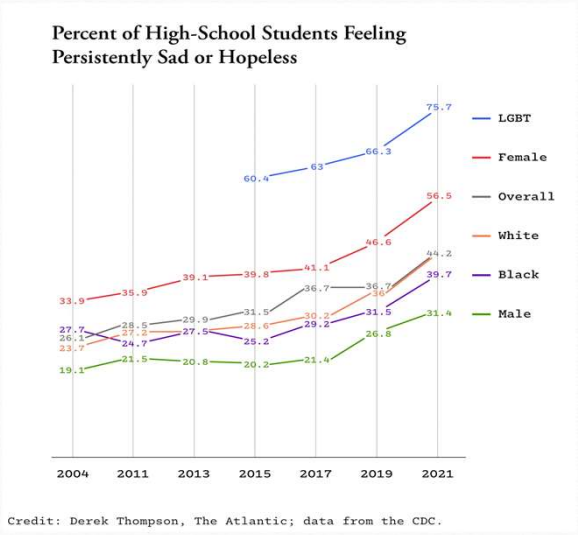
Quality Incentive Pool: The percentage of women 16-24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.



Quality Incentive Pool: Preventive care and Screening: Screening for Depression and Follow-Up Plan

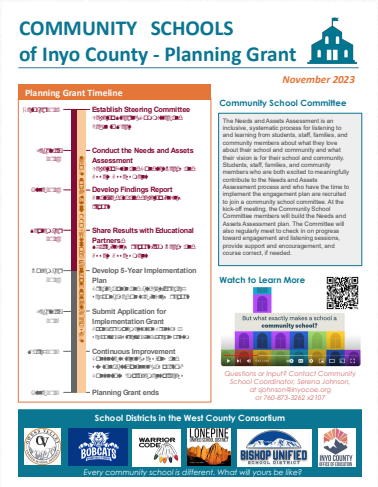
Description: Percentage of patients aged 12 years and older screened for depression on the date of the encounter or up to 14 days prior to the date of encounter using an age-appropriate standardized depression screening tool (we use PHQ-9) and if positive, a follow-up plan is documented on the date or up to two days after the date of the qualifying encounter





Community Schools

- Bishop Unified is working on making their schools – community schools with support from a state grant
- Community Schools are public schools that partner with stakeholders to create the conditions students need to thrive
- Community schools have 4 pillars- one of which involves mental/physical health supports



Schedule 2023-2024

- Shortened hours this year to reduce cost to NIHD
- Tuesday and Thursday mornings – Colleen McEvoy PNP
- Every other Thursday afternoon Stacey Brown MD
- If we get busy can expand hours with approval of the executive team

Visit Number and Types

- 2022-2023 school year about 400 visits
- Should be more visits 2023-24 year
- Most ½ days see 6-10 patients
- Reproductive health about 25% of visits
- A lot of mental health visits 25%?
- The rest: sick visits/ injuries/ physicals

Sustainability

- Billing private insurance and Medi-Cal for appointments requiring parental consent:
  - Sports PE's
  - Sick visits
  - Injuries
- Billing Family PACT and Medi-Cal for consent from the minor. Family PACT is a state program that pays for reproductive health based on income .
- No charge visits: over the counter medications
- Researching Grants: more available in last few years

Health Office- Run by BUHS open 5 days/week


Bronco Clinic


IN the basement in Main Building
DETECTO

Resources

- California School-Based Health Alliance: https://www.schoolhealthcenters.org/
- National School-Based Health Alliance: https://www.sbh4all.org
- Bishop Community Schools: https://inyocoe.org/community-schools/

CALIFORNIA SCHOOL-BASED HEALTH ALLIANCE

Putting Health Care Where Kids Are

Navigating the Promise of School-Based Health Centers

A Guide for Health Care Leaders

Introduction

The purpose of this document is to help leaders in the health care field who operate or are considering operating school-based health centers (SBHCs) make decisions wisely and with complete information. The California School-Based Health Alliance (CSHA) is a strong proponent of SBHCs: a unique, strategic and indispensable model for increasing health and education equity, especially in underserved schools and communities. We also know that there are very real challenges when more traditional health care agencies (i.e. hospitals, community clinics) operate SBHCs. This document will help to differentiate SBHCs from these other practices and models and equip practitioners, staff, agency leaders and other stakeholders with a deeper understanding on the SBHC model of care.

Thanks to those who requested and suggested this document – Kalila Banks of Clinica Sierra Vista and CSHA Board member Jessica Saint-Paul, among others. Thanks also to our generous funder, the California Health Care Foundation, and to reviewers Kalila Banks, Saun-Toy Trotter, and Sang Leng Trieu. The primary author and architect was Tracy Mendez, SBHC champion and forever friend of CSHA.

CSHA wants to support the development of thriving SBHCs in the right conditions. This is a resource to understand and deliver integrated health care through the innovative and collaborative school-based health model. Please reach out to us if we can support you in your journey.

> ***"Now is the time to invest in what we know works. School-based health centers, especially those that focus on both physical and mental health, are a proven path to better health outcomes for students, and we know that translates into better education outcomes."***
>
> *Tony Thurmond, State Superintendent for Public Instruction*

What Are School-Based Health Centers?

SBHCs are student-focused health centers or clinics that are located on or near a school campus, are organized through school, community, and health provider relationships, and provide age-appropriate, clinical health care services onsite by qualified health professionals. SBHCs provide primary medical care, behavioral health services, or dental care services onsite or through mobile health or telehealth. They can be considered part of the primary care safety net, like a neighborhood pediatrician or an outpatient Children's Hospital clinic.

In California, about half of SBHCs are operated by community health centers such as federally qualified health centers (FQHCs); about one fourth are directly operated by school districts; and the remainder by a combination of local hospitals, public health departments, and other entities such as community-based mental health organizations and medical groups. Often, SBHCs are run by a combination of organizations such as these – see the text box below for an example.

Since the 1970s, SBHCs have grown throughout California and the United States. The original SBHCs were often focused on teen pregnancy prevention as well as creating access to primary care for uninsured and low-income children in underserved, mostly urban, regions of the state and country. Newer health centers are more likely to include dental services and a wider array of behavioral health care ranging from social emotional wellness promotion to individual and family psychotherapy and support groups. With the COVID pandemic and heightened awareness of structural racism in the U.S., public sentiment and the policy environment have become more supportive of public health and mental health services and supports for children and youth.

The James Morehouse Project (JMP) at El Cerrito High School (ECHS) was started by a teacher in 1998. Today the JMP is a beautiful and comprehensive SBHC that is an anchor of school culture and climate at ECHS. The director is a school district employee; medical services are provided by Contra Costa Health Services; all other JMP staff are employed by the community mental health agency Bay Area Community Resources. Other community-based partners come onsite to lead groups or partner with JMP staff and interns on youth development projects. The partners work together closely to ensure center services feel seamless to youth.

Today there are over 300 SBHCs spanning most California counties and all age groups, with many more in the planning and development phases. SBHCs are heralded because they allow students to stay in school and schools to focus on education while helping young people learn how to advocate for their own health needs and navigate the health care system in a way that is safe and accessible.

Why Operate School-Based Health Centers?

There are many reasons a lead agency such as an FQHC, other health care provider, or school district might consider opening and operating a SBHC. These range from mission-focused values to smart business practice. We outline a few key ones below.

Research and experience demonstrate that SBHCs have a positive impact on health and education outcomes and equity. They increase attendance, and in a recent study of SBHCs in Los Angeles Unified School District, this pattern is most pronounced among students who use mental health services at their SBHC. SBHCs can also increase students' connectedness to caring adults and their school, which is a protective factor against multiple health and education risks. Utilizing SBHCs reduces high-risk behaviors, especially among marginalized populations such as LGBTQ+ youth and young men of color.

One young woman referred to her SBHC as "the beating heart" of her high school. It was the first place she and many students received any mental health services, and also helped support a positive school culture and climate.

SBHCs increase the use of cost-effective preventive care such as immunizations, family planning, well-child visits, and behavioral health care. Children and youth covered by Medi-Cal – especially those over age 5 – receive less than half of the preventive services recommended by pediatricians, and therefore important opportunities for identifying trauma, developmental delays, and a range of chronic health conditions are missed. Adolescents, and especially low-income adolescents of color, are not always well served by the existing health care system but benefit from many health care touchpoints given the rapid physical, socio-emotional, behavioral, and developmental changes that occur during this time period. By providing care in a familiar, trusted location, like a school-based health center, young people receive more screening, prevention, and earlier intervention for concerns that, if left untreated, may have lasting consequences. In fact, most care in SBHCs is focused on prevention and wellness, which involves ample time for screening, counseling, and anticipatory guidance. This is especially important given recent increases in the incidence of COVID-19, depression, anxiety, suicide, overdose, obesity, and sexually-transmitted infections. SBHCs also decrease utilization of emergency room services for students with asthma and other chronic conditions.[1]

Related to the above, **SBHCs can help health care agencies improve clinical quality scores** in areas like well-child visits, immunizations, chlamydia screening, depression screening and follow-up, and asthma control. This can help with pay-per-performance and value-based care, accreditation, primary care health home status, and reporting for HEDIS, UDS, and other measures.

SBHCs increase health equity. Access to culturally competent, high-quality, first-contact primary care through SBHCs is an effective, research-based strategy to reduce health inequities and improve health outcomes for LGBTQ+ youth, low-income youth, and youth of color. SBHCs assure equal opportunities for all children to access needed health care services.

SBHCs focus on health care services for children and youth with Medi-Cal coverage. SBHCs leverage the fact that fewer children than adults are uninsured and almost half are covered by Medi-Cal. Youth in California have access to the program regardless of documentation status and with higher family-income thresholds than adults.

More generally, **SBHCs help increase a lead agency's base of patients/clients.** They provide outreach to a wide cross-section of the community and a way to generate a steady flow of young people and families that need medical, dental and behavioral health care without a costly or complex marketing campaign. As community health centers have struggled to retain patient numbers in the face of widespread gentrification in many California cities, SBHCs can also serve broader communities in need.

[1] 5. Key JD, Washington EC, Hulsey TC, Reduced emergency department utilization associated with SBHC enrollment, J Adol Health 2002; 30:273- 278; 9. Santelli J, Kouzis A, et al. SBHCs and adolescent use of primary care and hospital care. J Adol Health 1996; 19: 267-275.

Satisfied SBHC patients can become promoters of lead agencies for their friends and families well past graduation.

SBHCs offer lead agencies deeper connections to the communities they serve and positive visibility with a range of stakeholders. They are a health care model built on authentically listening to and engaging with the target population. The impact of this model has gained attention of funders at the federal level, as evidenced by several recent rounds of grants from the Health Resources and Services Administration (HRSA) focused exclusively on SBHCs.

SBHCs allow health care providers to more easily collaborate with the other important players that impact child health and development. In traditional health settings it is difficult for a pediatrician to participate in a special education meeting, or for a psychologist to have easy access to a student's teachers. Most primary care providers can't easily coordinate with school nurses around daily medications or blood sugar levels. SBHCs promote this integration and support much smoother coordination of care, ultimately improving health and education outcomes.

SBHCs support workforce development. Many health care providers and other staff welcome the opportunity to work in this novel setting delivering relationship-based "upstream" preventive care to young people. This can help with workforce recruitment and retention at a time when this has never been more challenging. In addition, SBHCs mentor young people to enter health careers, helping build a diverse health care pipeline that better reflects California demographics and promotes graduation/career pathways.

The current policy environment is very supportive of the development, expansion and improvement of SBHCs. A variety of current state initiatives recognize the importance of child and adolescent trauma, behavioral health care, collaboration between health and social services, and community school partnerships. Although California continues to be one of the few large states that does not *directly* fund SBHCs, the broader conditions in the Golden State are generally favorable. For example, most low-income children and youth now qualify for Medi-Cal; Family PACT covers family planning services for most adolescents; and multiple state initiatives support adolescent and school mental health services.

For much more information on SBHCs and their benefits, see schoolhealthcenters.org.

How the Model Is Unique

This section addresses some of the many ways SBHCs differ from other pediatric and teen health care settings:

SBHCs are smaller than typical community-based health centers. Most SBHCs are physically small (1-3 exam rooms) and have less than one full-time medical practitioner working in them. (This ranges from 0.2 FTE to 2.0 or more medical providers.)

The service mix varies. For example, in a typical community health center, there might be one behavioral health clinician for every four medical providers, whereas SBHCs might have more behavioral health than primary care FTE. In general, school communities find that it is beneficial to maximize behavioral health services availability, and maintain at least a 1:1 ratio of behavioral health to medical provider time. While the medical needs of a population of 1,000+ adolescents can usually be addressed by a 1.0 FTE nurse practitioner or physician assistant[2], behavioral health needs are much more time-intensive. It is also recommended to have a high ratio of health education staff given the many opportunities for health promotion, counseling, teaching, and motivational interviewing.

SBHCs address many social determinants of health and education. Going back to their origins, SBHCs have always supported young people in ways that were holistic, not strictly clinical, acknowledging the ways that factors like hunger, school failure, and dating violence impacted student health and well-being. SBHCs operate peer health education programs, conduct classroom education, and connect students to employment services and youth development programs in their communities that support social connection. Some SBHCs host school supply giveaways and food distribution, many operate peer mentorship or peer health education programs, others host medical legal partnerships, and still others offer groups for new immigrants, young men of color, and/or girls' empowerment. Because of both proximity and collaboration with school, students often walk into their school-based health centers seeking support they might be reluctant to request from a community-based medical center or mental health program. SBHC staff accept this challenge and go “outside the clinic walls” to support adolescent autonomy, health, and well-being. SBHCs also help promote developmental assets (positive supports and strengths that young people need to succeed) such as a caring school environment, positive adult relationships, and demonstrating that the community values youth.[3]

Staffing needs vary. Because SBHCs are small, their staff care teams are often less specialized than those working in larger health centers. For example, larger community-based clinics may employ medical records personnel, referrals staff, a call center, and/or billers, not to mention dedicated nurse case managers that support a number of primary care providers. SBHCs are more likely to have a few

[2] Another difference is that SBHCs usually employ fewer physicians than other outpatient clinic sites, and more advanced practice providers (APPs) like nurse practitioners and physician assistants. A common ratio is 4:1 or 5:1 APP to MD time, and in some cases physicians are only engaged in a consultative/supervisory capacity. This staffing pattern is cost effective, especially since reimbursement is generally high for these two categories, and acknowledges that the *medical* complexity of patient care in SBHCs is often low but the need for medical practitioner, behavioral health and health education *time* is high.

[3] The Developmental Assets Framework - Search Institute (search-institute.org)

staff who play multiple roles – e.g., a medical assistant that also handles referrals and medical records, and a receptionist/clerk who does billing and insurance enrollment.

There are more collaborative relationships to navigate. At a minimum, SBHC operators – assuming they are not run by the school district itself – will need to work in close collaboration with the host school and school district. Schools often have many other service providers on campus, so those entities are also important partners – this includes after-school programs, Family Resource Centers, and other mental health providers working with special populations. (See more on coordinating services below.)

During the COVID pandemic, one SBHC had staff going to students' homes to help with Wi-Fi hot spots for students and families. This gave them critical access to their online education and also telehealth appointments with SBHC clinicians and others.

In part because of the relationships described above, **SBHCs typically require a higher ratio of management to provider FTE than other centers.** SBHCs lack the assembly line efficiencies or economies of scale, are intrinsically complex, and benefit from an administrator who is very skilled at nurturing trusted relationships for the school and parent community.

Parents and guardians are often not present for their children's care. The beauty of the model is that caregivers can authorize consent at the beginning of a school year or enrollment and then children can independently access the care for which consent was provided. This means less transportation burdens and interference with work for families and caregivers. This facilitates easy access but can also complicate some aspects of the care. For example, children and youth often cannot give a thorough medical history; discussions about vaccines, specialty referrals and other decisions or follow-up take coordination with parents/caregivers through collateral visits by phone, video and sometimes in person.

Lack of a clearly defined model. Unlike some other provider types (such as FQHCs, free clinics, and/or tribal clinics), there are no statutes in California governing SBHCs. SBHCs therefore follow various licensing and regulatory rules depending on their lead agency and other factors such as how many hours per week they operate. Unlike other states, SBHCs are not required to submit any consistent data that is centered on the model or the needs of children and youth. Site visits to ensure quality are not consistently performed and therefore there is abundant variation and diversity across sites.[4] In addition, related concepts like "school wellness center" (see text box at right) can introduce more complexity and

The term "wellness center" has become popular in recent years but is used inconsistently across California. Most often it is used to refer to a center run by an LEA (local educational agency) with a primary focus on behavioral health and no onsite physical health services.

[4] Some variation between SBHCs is appropriate in order to allow services to address local context and needs, drawing on community strengths and assets.

variation, and sometimes centers that appear to be SBHCs are opened with non-SBHC names. It is difficult in this context to promote clarity and understanding about SBHCs in California.

It's hard to control an SBHC's payer mix. The SBHC model works best with an open door policy that allows **all** students to access services. This is in contrast to other settings that are often focused on patients with a particular health insurance/payer – e.g., a closed system like Kaiser Permanente or clinics that have members assigned by Medi-Cal managed care plans. While this approach is a deliberate way to encourage children and teens to utilize the primary and preventive care services, it can mean there are many services provided without a payer source – e.g., when a student with Kaiser coverage chooses to use their SBHC for a comprehensive sports physical. (One promising future development will be the state's development of a Statewide School-linked Fee Schedule for all payers, due to be implemented by 2024.)

Limited hours of operation. For budgetary reasons and because client volume is limited by the school size, some SBHCs operate for as little as one day each week. Many are closed during school breaks and summers, making arrangements for continuity of care via their lead agency or other community partners.

Less predictable operating schedules. School environments are quite different from health care settings. SBHC operations are interrupted by events like assemblies, fire drills, exams and state testing, school lockdowns[5], pep rallies, field trips, and professional development days. These disruptions are common and can disable the SBHC for hours or days at a time. With a small number of providers, an entire clinic shift can be impacted by the nurse practitioner responding to a medical emergency on the football field or in the classroom, or the social worker coordinating a 5150 psychiatric hold and consult.

At La Clínica de La Raza, a large FQHC based in Oakland that operates 8 SBHCs, productivity standards are approached differently than in other primary care clinics. Providers working at La Clínica's non-SBHC sites are given 20% follow-up time to complete charting, coordination of care, quality improvement, and other patient care related duties. SBHC providers are expected to include their follow-up time in their regular shift s but see fewer patients in each scheduled hour. This pace, and the frequency of no-shows and unexpected interruptions, amounts to a similar overall number of patients per FTE per year as FQHC national standards: 2,100 for non-physician practitioners (NP, PA and CNM) and 4,200 for physicians.

[5] A school lockdown is issued when there is a threat to students and school staff. Schools protect students by responding cautiously to violence in the community and other potential threats to school safety.

Standard measures of provider productivity are likely to be lower than in other settings. Most outpatient health practices operate based on underlying principles of how many clients/patients can be seen throughout a clinical shift in order to balance operating revenue, access, and clinical quality. These standards should be based on reasonable expectations that allow good relationship-building, respect, and clinical quality, even if hurried clinicians sometimes feel otherwise. However, standards set for good outpatient practices do not always translate well to SBHCs because of: (1) a less predictable operating environment (see above); (2) constant turnover of patient population; (3) caregivers not present (see above); and (4) most care focused on prevention and wellness, which involves ample screening, counseling, anticipatory guidance, and conversation, with very few procedures or "expedited" visits. SBHC providers may need to spend relatively more of their total work time building trust and relationships, not just with student clients but also with families and school staff.
While no formal standards exist at a state or national level, CSHA suggests the following based on best practices collected from SBHCs over the years:

- medical providers can see about 2 patients per hour at most in an SBHC setting
- behavioral health clinicians can see an average of 4-6 clients per day
- dental providers/teams can see 15-18 patients per day

As a result of many of the factors described above – low productivity, frequent closures, more management time, and few economies of scale - **health insurance reimbursement alone is often insufficient to cover the full costs of providing high-quality SBHC care.** In addition, most SBHCs do not charge patients/families for non-reimbursable care. And in general, staff spend a higher proportion of their time in non-reimbursable activities such as group education, outreach, crisis management, etc.

Incomplete local control. SBHCs are "guests" on a school campus, which means lead agencies are subject to at least some of the school's policies and procedures. This means staff need to be respectful of school rules like hall passes, visitor policies, and being intentional about how and when to pull students from class. Many SBHCs wanted to keep their doors open during the early months of the COVID pandemic, but had to follow district closures.

Venice Family Clinic, which operates three SBHCs in the Los Angeles area, has found that doing facilities work such as implementing a data network for EHR access has been challenging. Lead agencies need to know who owns the equipment at the SBHC, where to go for repairs, and know that the timeline for making these kinds of changes might be very different than what they expect. This is often learned when planning and constructing a new SBHC where multiple players can slow the process significantly.

There can be controversies. In California, there are laws to support a young person accessing confidential and/or sensitive services, known as California Minor Consent and Confidentiality Laws. Even with this law, concerns may surface about

children and teens independently accessing health care services – especially ones like family planning, mental health, or even immunizations.

Schools and the education sector have different rules about information-sharing than health care providers. Schools are governed by a federal law called FERPA (Family Educational Rights and Privacy Act) that differs quite significantly from HIPAA (Health Insurance Portability and Accountability Act) and other health care laws. In California, minors are legally permitted to access a variety of health care services during the school day without parent/guardian consent; however, schools are responsible for what happens to students on the school campus[6] and are accustomed to knowing everything about what happens to students while there. Accustomed to operating with full information about students, administrators can become frustrated when they are not informed of things like mental health emergencies, child abuse reports, pregnancies, and/or students using substances on campus. These issues can be challenging in any setting serving adolescents but can be particularly thorny in SBHCs. The next section includes suggestions for how to increase clarity, partnership and collaboration to address these very challenges.

Recommendations & Lessons Learned

Although not exhaustive, this section offers a few suggestions for how SBHC staff and lead agencies can be most successful operating in this unique environment so that expectations are clear and aligned for all parties.

Budget realistically and appropriately. This includes setting realistic productivity standards that may differ from other sites operated by the lead agency; building in non-productive time for outreach, coordination, shorter school days, and more frequent service interruptions. In the absence of good historical data, consider reducing by at least 20-30% the service volume you would expect in a different setting. There also may be good reasons to evaluate an SBHC's budget and financials without allocating the lead agency's full indirect overhead. This can be especially true when the lead agency is a hospital or academic medical center with research, teaching, and training costs, as well as ancillary departments less frequently used by SBHCs (e.g., radiology, pharmacy, etc.).

Secure some base funding that is not reliant on third party reimbursement. Unfortunately, California does not yet have state grants for SBHCs, but other SBHCs have gained this contribution and commitment from a variety of sources that include: county allocations, Mental Health Services Act (MHSA) grants, private donors, foundation grants, fundraising events, and/or in-kind support from their lead agencies.

[6] *In loco parentis* implies strong central authority of educational institutions, stating that schools take the role of parents when the students are placed under their care.

Negotiate a clear MOU that specifies roles and responsibilities. CSHA recommends that all SBHCs have Memoranda of Understanding (MOUs) or other documentation with their school hosts and any other close partners (e.g., other agencies with which you will share space), and Business Associate Agreements (BAAs) as needed with agencies that will be sharing patient health information. The MOU should specify roles, responsibilities, data governance/data sharing expectations, and scope of services, as well as any financial agreements. If possible, lead agencies should protect their ability to provide all care within the normal scope of their agency and clinical licensure – for example, not allowing the school or district to impose restrictions on family planning, behavioral health or substance use counseling.

The Alameda County Health Care Services Agency provides base funding of $110,000 per year to 28 SBHCs. This funding is sourced through Tobacco Master Settlement Fund and local sales tax revenue.

Venice Family Clinic provides base funding to its SBHCs through private donations, fundraising and school district contributions.

Hire for success. Beyond any technical or licensure requirements, providers and other care team members should love children and youth, understand the unique SBHC model, and thrive when working flexibly in a small, low-resource environment under a range of circumstances. Staff continuity is important for building trust with the school community, so rotating staff through the SBHC is not recommended. Students need to feel comfortable with the front desk, medical assistant, providers, and others. Employers also need to be very explicit about schedules and other arrangements: e.g., if the SBHC is closed for the summer, what happens to employees? Are they guaranteed employment at another location? Are they expected to take paid time off? Are they 10- or 11-month employees and if so what happens to their health insurance coverage and other benefits? Finally, management staff need to be emotionally intelligent and skilled at negotiating effectively with school administrators, families, and other partners. Some of the most effective SBHCs in California are led by experienced, seasoned professionals that blend advocacy and assertiveness with lived experience and cultural humility; others are newer to the field and exhibit all these essential skills! All are comfortable going outside established protocols, deferring and consulting when needed, being self-reflective, managing through crisis and change, and never losing sight of their mission or why they are there.

Establish strong relationships with key players on the school campus. Ideally, SBHC staff will meet regularly with the school principal or other key administrators. If this is not possible, which is common, they should find ways to share general information about the health center and be a visible presence at most school events and integrated into school culture, including staff meetings, back-to-school night, family orientation, fairs, and PTSA meetings. Be sure to communicate SBHC closures outside of school

closures, and try to determine what is most valuable to the school about the SBHC, highlighting these services - whether back-to-school physicals, vaccines, crisis intervention, or periodic consultations for school staff. Keep communication as open and simple as possible, and submit reports at least a few times each year to let school stakeholders know how many students are using the services and other key metrics or stories. Staff should share what they can with school partners – e.g., let them know an emergency vehicle is coming, but not why or for whom. Any new SBHC planning should involve, at minimum, school nurse(s) from the site or district level, and ideally ongoing collaboration with nursing staff. Be aware and sensitive to the fact that some school staff may be less welcoming of the clinic presence, fearing they may lose their unique role or connection to students. It is always advisable to find influential allies such as vice principals, counselors, coaches, teachers, nurses, and/or Community Schools Managers. Also, remember that school staff turnover can be high and that introductions, overviews and tours are needed every school year, even if the SBHC has been on campus for decades!

Beyond this general collaboration, **the SBHC should be integrated within the web of on-campus service providers** and participate in Coordination of Service Team (COST) meetings or the equivalent. SBHC staff should be regular members of COST, there should be clear referral pathways and processes for students who might benefit from SBHC services, and service providers should share information based on clear parameters and agreements shaped by their professional laws and regulations. More information about the COST process can be found here: Coordination of Services Team**.**

One SBHC provided an annual School Staff Recognition Day with lunch and other goodies. Several provide TB tests for teachers on campus so they don't have to visit their providers, and one SBHC in East Oakland operates a wellness room focused on wellness and support for school staff as well as students. These touches can make a big difference!

Educate school personnel. SBHC leadership should be proactive in sharing the SBHC mission, services and other key facts with school leadership and families both to improve SBHC efficiency and to avoid unnecessary misunderstandings and controversies. They should also *listen* to those same stakeholders to understand their concerns. Some examples: (1) Ensure secondary school staff understand that minors 12 and over (and in some cases even younger) can consent to some of their own health care such as family planning and mental health services. Let stakeholders know that SBHCs follow the same minor consent and confidentiality rules applicable in any other health care settings such as a community pediatrician. Armed with this information they can help respond to caregivers with questions or concerns. This video offers some helpful examples of how schools and SBHCs can better work together within their mutual laws and regulations. (2) School staff should understand the scope of services, since some misinformed voices have spread rumors that SBHCs provide abortion services or gender reassignment surgery. (They do not.) (3) SBHC providers can be inundated with non-revenue generating tasks such as basic first aid or consultations with teachers. Although some of these activities are valuable, it may help to educate school and district personnel up front about providers' scope of

practice and the SBHC revenue model so they become your partners and use your team to the highest level. Collaborating with front office staff, school nurses, and administrators - as well as classroom teachers - can really make a difference for maximizing the skills of all those involved.

Conclusion & Resources

CSHA strongly encourages organizations that care about the health and well-being of children and youth to consider opening and operating SBHCs. They are a tremendous way to increase access to care that we know helps improve health, well-being, school success, and health equity. They support families and can help schools focus on education.

We also know the most successful SBHCs are ones where the leaders have their eyes wide open about these issues, set achievable goals, and support the onsite staff without expecting replicas of other ambulatory sites.

The following resources are available to support you and your teams as you plan, operate, evaluate and improve SBHCs. Please don't hesitate to reach out to CSHA at info@schoolhealthcenters.org – and sign up for our mailing list here to learn about our many webinars, trainings, and annual conference. We are here to help you build and sustain the best SBHC for your school community!

- **Vision to Reality Guide to Planning a SBHC:** www.schoolhealthcenters.org/vision-to-reality
- **Alameda County Coordination of Services Team Toolkit:** https://achealthyschools.org/wp-content/uploads/2020/05/149_01_COST_Guide_email.pdf
- **Consent & Confidentiality: A California Guide to Sharing Student Health & Education Information:** www.schoolhealthcenters.org/hipaaferpa
- **Sustaining & Growing Behavioral Health Services at SBHCs:** www.schoolhealthcenters.org/sustaining-behavioral-health
- **SBHCs Maximizing Third Party Reimbursement:** www.schoolhealthcenters.org/third-party-reimbursement
- **Braiding New Funding to Support California SBHCs:** www.schoolhealthcenters.org/funding/sbhcs
- **Student Confidentiality and Consent:** www.schoolhealthcenters.org/resources/sbhc-operations/student-records-consent-and-confidentiality/consent/
- **Student Health Index:** www.schoolhealthcenters.org/student-health-index

About the California School-Based Health Alliance

The California School-Based Health Alliance (CSHA) is the statewide nonprofit organization helping to put more sustainable health care services in schools to improve the health and academic success of children and youth while reducing health and education disparities.

CSHA:

- **H**elps schools and communities start SBHCs
- **E**nsures high-quality SBHCs through education and training
- **A**dvocates for public policies to support SBHCs
- **R**aises the visibility of SBHCs so they are valued by the public
- **S**upports youth engagement and healthy youth development

Learn more about our work and find additional resources for school-based health on our website: https://www.schoolhealthcenters.org.

1203 Preservation Park Way, Suite 302, Oakland, CA 94612
510-268-1260
info@schoolhealthcenters.org

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

Medical Staff Office
(760) 873-2174 voice
(760) 873-2130 fax

TO: NIHD Board of Directors
FROM: Sierra Bourne, MD, Chief of Medical Staff
DATE: December 6, 2023
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. Medical Staff Appointments (*action item*)
   1. Neil Bhathela, DO (*neurology*) – Telemedicine Staff
   2. Atalanta Olito, DO (*anesthesiology*) – Active Staff
   3. Luis Esparza, MD (*anesthesiology*) – Active Staff

B. Medical Staff Reappointments 2024-2025 (*action item*)
   The following 54 reappointment applications were received, processed, and recommended for renewal of privileges for a period of two years (January 1, 2024 – December 31, 2026) by the Medical Staff with privileges as requested.

	Last Name	First Name	Title	Specialty	Category
1	Ahmed	Farres	MD	Interventional Radiology	Active
2	Al Danaf	Jad	MD	Cardiovascular Disease	Telehealth - FPPE
3	Alim	Muhammad	MD	Pulmonary Disease	Telehealth
4	Brieske	Timothy	MD	Family Medicine	Active
5	Brown	Stacey	MD	Family Medicine	Active
6	Burnier	Andre	MD	Emergency Medicine	Courtesy - FPPE
7	Ebner	Benjamin	MD	Cardiovascular Disease	Telehealth
8	Erogul	John	MD	Diagnostic Radiology	Courtesy
9	Farooki	Aamer	MD	Diagnostic Radiology	Telehealth
10	Figueroa	Jennifer	PAC	Physician Assistant	APP
11	Garg	Shilpi	MD	Pediatric Cardiology	Telehealth
12	Gaskin	Gregory	MD	Emergency Medicine	Active
13	Hathaway	Nickoline	MD	Internal Medicine	Active
14	Hawkins	John	DO	Emergency Medicine	Active
15	Hewchuck	Andrew	DPM	Podiatry	Active
16	Hosseini	Alireza	MD	Endocrinology	Telehealth
17	Irons	Matthew	PAC	Physician Assistant	APP - FPPE
18	Jesionek	Adam	MD	Family Medicine	Active
19	Kamei	Asao	MD	Internal Medicine	Active
20	Khine	Htet	MD	Cardiovascular Disease	Telehealth
21	Kim	Paul	MD	Anesthesiology	Active
22	Kim	Martha	MD	Obstetrics and Gynecology	Active
23	Klabacha	Rita	PAC	Physician Assistant	APP
24	Levy	Justin	MD	Internal Medicine	Courtesy - FPPE

25	Lizcano	Jennifer	DO	Internal Medicine	Active
26	Loos	Stephen	MD	Diagnostic Radiology	Active
27	Ma	Ruhong	DO	Internal Medicine	Active
28	Majlessi	Azadeh	MD	Rheumatology	Telehealth
29	Maki	Erik	MD	Interventional Radiology	Courtesy
30	Malloy	Sarah	FNP	Nurse Practitioner, Family	APP
31	Marvin	Shawn	MD	Diagnostic Radiology	Telehealth - FPPE
32	McEnany	Michael	MD	Emergency Medicine	Active - FPPE
33	Meredick	Richard	MD	Orthopaedic Surgery	Active
34	Meredick	Kristin	MD	Pediatrics	Active
35	Norris	Jennifer	CNM	Certified Nurse Midwife	APP
36	O'Neill	Tammy	PAC	Physician Assistant	APP
37	Page	Nolan	DO	Emergency Medicine	Courtesy - FPPE
38	Peterson	Snow	DO	Sleep Medicine	Telehealth
39	Pflum	Jeannie	DO	Obstetrics and Gynecology	Courtesy
40	Plank	David	MD	Plastic Surgery	Courtesy
41	Pomeranz	David	MD	Emergency Medicine	Active
42	Quach	Truong	MD	Family Medicine	Active
43	Redelman	Ryan	MD	Diagnostic Radiology	Courtesy - FPPE
44	Reid	Thomas	MD	Ophthalmology	Active
45	Ricci	Lindsey	MD	Pediatrics	Active
46	Robinson	Chelsea	MD	Emergency Medicine	Active - FPPE
47	Rowan	Christopher	MD	Cardiovascular Disease	Telehealth
48	Swackhamer	Robert	MD	Cardiovascular Disease	Telehealth
49	Tiernan	Carolyn	MD	Emergency Medicine	Courtesy
50	Tseng	Ian	MD	Diagnostic Radiology	Telehealth
51	Turner	Gary	MD	Diagnostic Radiology	Courtesy
52	Wakamiya	Anne	MD	Internal Medicine	Active
53	Wasef	Eva	MD	Pathology	Active
54	Wilson	Christopher	MD	Cardiovascular Disease	Telehealth

C. Reappointment Applications Not Submitted (*information item*)
    1. Scott Brown, MD (*urology*) – privileges to expire on 12/31/2023
    2. Daniel Firer, MD (*family med/emergency med*) – privileges to expire on 12/31/2023

D. Privilege Form Update (*action item*)
    1. Certified Nurse Midwife

E. Policies (*action item*)
    1. *Medical Waste Management Plan*

F. Medical Executive Committee Meeting Report (*information item*)

Certified Nurse Midwife

Delineation of Privileges

Applicant's Name: ,

Instructions:

1. Click the Request checkbox at the top of a group to request all privileges in that group.
2. Uncheck any privileges you do not want to request in that group.
3. Sign form electronically and submit with any required documentation.

Facilities
☑ **NIHD**

Required Qualifications	
Education/Training	Completion of a program leading to licensure as a registered nurse. **AND** Completion of a nurse-midwifery education program accredited by the Accreditation Commission for Midwifery Education (ACME) or predecessor organization acceptable to The American Midwifery Certification Board (AMCB).
Certification	Current certification as a Certified Nurse Midwife from the American Midwifery Certification Board (AMCB)
Clinical Experience (Initial)	Applicant must provide documentation of provision of clinical services in the specific privileges requested during the previous 24 months (waived for applicants who completed training within the past year).
Clinical Experience (Reappointment)	Applicant must provide documentation of provision of clinical services in the specific privileges requested during the previous 24 months.
Additional Qualifications	Applicant must have a supervising or collaborating physician. **AND** Current California furnishing certificate and DEA Registration with schedules 2, 2N, 3, 3N, 4 and 5. **AND** Current BLS and NRP certification required. **AND** The CNM must abide by the applicable Northern Inyo Healthcare District Standardized Procedures.

Core Privileges in Certified Nurse Midwife	
Description: Midwifery practice as conducted by certified nurse-midwives (CNMs) is centered on women's health care, focusing particularly on pregnancy, childbirth, the post partum period, and the family planning and gynecologic needs of women.	
Request	Check the Request checkbox to select all privileges listed below. Uncheck any privileges you do not wish to request in the group. ☐ - Currently Granted privileges
☐	Perform history and physical examination

☐	Manage the perinatal health care of patients (mothers and newborns) where a normal vertex vaginal delivery is the expected outcome including diagnostic testing and patient education.
☐	Management of women's health needs related to family planning, oral contraception, health screenings and diagnosis/treatment of sexually transmitted diseases
☐	Perform, order and interpret preventive and non-invasive diagnostic tests
☐	Furnish/order appropriate pharmacologic and nonpharmacologic interventions
☐	Third trimester limited fetal ultrasound
	Procedures
☐	Management of single spontaneous vertex vaginal delivery and fetal monitoring including administration of local and pudendal blocks and augmentation of labor
☐	Evaluation of complaint of labor or ruptured membranes at 36 weeks or greater
☐	Perform episiotomy and repair of minor (up to 2nd degree) vaginal lacerations
☐	Manual removal of placenta, post-delivery
☐	Oxytocin challenge test
☐	I & D abscess
☐	Pap smear and endocervical culture
☐	Biopsy of cervix, endometrium
☐	Excision/biopsy of vulvar lesions
☐	IUD placement and removal
☐	Insertion/removal of implanted contraceptive device (e.g., Nexplanon)

FPPE (Department Chief to select)	
☐	Concurrent evaluation of the first 10 deliveries by the collaborating physician for new CNM graduates.
☐	Concurrent evaluation of the first 5 deliveries by the collaborating physician for CNMs with greater than 2 years of experience.
☐	Retrospective evaluation of 5 deliveries
☐	Evaluation from OB Head Nurse/Supervisor

Certified Nurse Midwife Surgical First Assist Privileges

Description: The Certified Nurse Midwife First Assistant assists the attending obstetrician during a Cesarean Section by providing aid in exposure and other technical functions, which will help the surgeon carry out a safe operation with optimal results for the patient

Qualifications

Education/Training - Other	Completion of a course in Certified Nurse Midwife First Assisting (certificate to be provided)

Request	
	Check the Request checkbox to select all privileges listed below. Uncheck any privileges you do not wish to request in the group. ☐ - Currently Granted privileges
☐	Act as surgical first assist for C-Section and tubal ligation

FPPE (Department Chief to select)	
☐	Concurrent evaluation of 2 second assists and 3 first assists
☐	Evaluation from collaborating surgeon

Point of Service Provider Performed Microscopy

Description: Microscopic exam of fluids at the point of service by a non-pathologist.

Qualifications

Clinical Experience (Initial)	For practitioners new to NIHD or newly requesting PPM privileges, successful initial competency testing must be completed and followed by a 6-month and 12-month evaluation. After the first year, all practitioners will be evaluated annually or as needed. Initial competency testing includes: (1) successful completion of an online module for each type of test and (2) completion of observed assessment by an observer holding PPM privileges.
Clinical Experience (Reappointment)	Documentation of successful completion of organization sponsored annual training and skills validation in provider performed microscopy as per policy.

Request	Check the Request checkbox to select all privileges listed below. Uncheck any privileges you do not wish to request in the group. ☐ - Currently Granted privileges
☐	Urine Sediment (Rural Health Clinic only)
☐	KOH (potassium hydroxide) preparation
☐	Direct Wet Mount
☐	Fern Test (Women's Clinic only)

FPPE (Department Chief to select)	
☐	Concurrent review (over-reading) of 1 PPM in each type of exam by a practitioner with unrestricted privileges in this area or lab personnel as outlined in policy.

Acknowledgment of Applicant

I have requested only those privileges for which by education, training, health status, current experience, and demonstrated competency I believe that I am competent to perform and that I wish to exercise at Northern Inyo Healthcare District and I understand that:

A. In exercising any clinical privileges granted, I am constrained by applicable Hospital and Medical Staff policies and rules applicable generally and any applicable to the particular situation.

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's Signature NIHD

Department Chief Recommendation - Privileges	
I have reviewed the requested clinical privileges and supporting documentation and my recommendation is based upon the review of supporting documentation and/or my personal knowledge regarding the applicant's performance of the privileges requested:	
Privilege	Condition/Modification/Deletion/Explanation

NORTHERN INYO HEALTHCARE DISTRICT

PLAN

Title: MEDICAL WASTE MANAGEMENT PLAN		
Owner: Interim Maintenance Assistant Manager.	Department: Maintenance	
Scope: District Wide		
Date Last Modified: 11/08/2023	Last Review Date: No Review Date	Version: 4
Final Approval by: NIHD Board of Directors	Original Approval Date: 08/01/2005	

PURPOSE: The purpose of this document is to outline and define safe and appropriate handling of medical waste, and to designate responsibilities of medical waste handling at this facility. It is also to assure compliance with all regulatory agencies and to provide a set of accepted definitions (if required.)

POLICY:

Medical Waste will be handled, stored, treated and disposed of in accordance with regulations as stated in the "Medical Waste Management Act" of the California Health and Safety Code. All human body parts and human tissue waste are stored in a multi-freezer (DAA) designated accumulation area. All other hazardous waste will undergo onsite treatment through the sterilization process. Chemo waste and Pharmaceutical waste are picked up Monthly by a medical waste transporter "

The Medical Waste Management Plan will be reviewed annually by the:

- Director of Facilities
- Maintenance leadership
- Maintenance team member
- Environmental Services leadership
- Director of Pharmacy
- Infection Preventionist Manager

The changes and review will be documented within policy management system via track changes and notes.

TYPES OF MEDICAL WASTE:

- Laboratory
- Blood and other potentially infectious materials (OPIM)
- Chemo Waste
- Contaminated Sharps
- Human Tissue Waste (Pathology)
- Recognizable Human Anatomical Parts
- Pharmaceutical
- Radioactive Waste (

- Biohazard waste from Small Quantity Generators (none at this time)
- Non-infectious waste

TYPE OF GENERATOR:

- Large Quantity Generator (greater than 600 lbs. per month)

TYPE OF ON-SITE TREATMENT:

- Steam Sterilization/Autoclave
  - This facility complies with the Medical Waste Management Act (MWMA) Treatment Permit Conditions.
  - Training for Operators will be conducted on an annual basis and documentation will be retained for a minimum of two years.
  - Monthly testing using a biological indicator (b.i.) will be performed and the results will be kept in the Maintenance office located in the Spore Testing Binder.

Autoclave/Steam Sterilizer Monthly Testing Protocol

Once per month, per HSC Section 118215(a)(2)(D), the biological indicator Geobacillus Stearothermophilus shall be placed at the center of a load processed under standard operating conditions to confirm the attainment of adequate sterilization conditions, (Temp. 275 degrees, 45 lbs. pressure psi, 45 minutes duration) and the results are maintained in the Maintenance Dept. for a minimum of two years.

- Test Vial 1262 for Steam Sterilization must be inserted into a retrievable vessel, in the center of a medical waste load.
- Run the autoclave at operating parameters and then retrieve the test vial in a safe manner
- Snap the vial like you are activating a glow stick (you will feel and hear a distinctive crack)
- Place the test vial in a 1262 incubator and take a fresh vial and snap it the same as above
- Place the **C**ontrol vial or (fresh cracked vial) in the incubator next to the cooked vial (place a **C** on the fresh vial)
- Run incubator and check results in 48 hours.
- If fresh vial changes to yellow that means the box of test vials is good and the incubator is at the right temperature. (No color change means bad box of vials or malfunctioning incubator)
- If the cooked vial stays purple, then the autoclave is operating properly and all microbes were killed. (Yellow vial indicates not fully sterilizing the waste indicating live microbes changing the color to yellow)
- Document the results of both vials along with the date and initials of person conducting testing.

Annual Training for the Operators

- Annual training for the Operators shall be documented and be retained in the Maintenance Office for a minimum of two years.

MEDICAL WASTE MANAGEMENT ACT DEFINITIONS:

- **See attached**

I. CONTAINMENT, TRANSPORT, STORAGE:

- Medical waste is segregated and contained from other hospital waste at its point of origin.
- Sharps are disposed of into sharps containers for disposal.
- All biohazardous waste is red bagged, and when full bags are tied tightly.
- Radioactive waste will be handled in accordance with radioactive waste policy and regulations.
- Medical wastes are sterilized as specified in this policy.
- Medical waste will not be stored for longer than 7 days. (At room temperature,)
- All medical waste is transported daily in a covered transport cart to a locked storage dumpster. Once a month medical waste transporter picks up Medical & Pharmaceutical Waste.
- Bags of medical waste will not be placed on floors, in rooms, or corridors; bags are to be placed directly in transport carts
- Items such as broken glass, laboratory slides and sharps or pointed objects, which could puncture a plastic bag, will be placed in sharps containers.
- Bags of normal waste, soiled linens or other materials will not be placed in the transport cart used for transport of Biohazardous waste.
- Environmental Services employees will check the transport cart routinely to ensure it is in good condition, clean, and labeled properly. (Biohazardous Waste or the work Biohazard and the biohazard international symbol.)
- The transport cart must be leak proof, secured tightly with a cover, be labeled on sides and top “Biohazard” and Biohazard symbols.
- Appropriate P.P.E. is worn at all times for collecting and transporting.

II. MEDICAL/BIOHAZARDOUS WASTE AT THIS FACILITY MEANS ANY OF THE FOLLOWING:

- Items that are caked with dried blood or OPIM and are capable of releasing these materials.
- Waste compromised of human tissue, which has been fixed in formaldehyde or other fixatives.
- Waste contaminated with trace amounts of chemo agents.
- All contaminated sharps i.e.: needles, scalpel blades, glass pipettes.
- Any liquid or semi liquid blood or OPIM.
- A container, or inner liner removed from a container, which previously contained

a Chemotherapeutic agent, is empty if the container or inner liner removed from the container has been emptied by the generator as much as possible, using methods commonly employed to remove waste or material from containers or liners, so that the following conditions are met:

A. If the material which the container or inner liner held is pourable, no material can be poured or drained from the container or inner liner when held in any orientation, including, but not limited to, when tilted or inverted.

B. If the material which the container or inner liner held is not pourable, no material or waste remains in the container or inner- liner that can feasibly be removed by scraping.

PHARMACEUTICAL WASTE PROCEDURE:
Refer to Safe Handling and Disposal of Occupationally Hazardous Drugs and Environmentally Hazardous Drugs in Policy Manager.

HANDLING AND DISPOSING OF SHARPS WASTE PROCEDURE:
Refer to Bloodborne Pathogen Exposure Plan

EDUCATION AND TRAINING:

- All employees who come in contact with blood and OPIM will receive initial and annual training on handling of biohazardous/medical waste as it pertains to job responsibilities. The education can be provided by the Infection Prevention team, Employee Health team or by online learning management system
- Maintenance leadership is responsible to ascertain safe and appropriate operation of sterilizer by qualified operators.

III. BIOHAZARDOUS WASTE DISPOSAL FROM SMALL QUANTITY GENERATOR (S.Q.G.) COMMUNITY CENTERS:
To assist medical offices in the disposal of medical (infectious) waste in order to:

- Comply with stringent federal and state regulations.
- Assure safety to hospital and office personnel.
- Prevent access by outside persons or animals.
- Reduce the amount of infectious waste generated.

POLICY:

- Infectious waste must be in red plastic bags and must be labeled “biohazardous” in writing or biohazard label.
- Bags must be labeled with office name.
- Bags must not be overfilled and must be tied securely to enable picking up by tied top.
- Double bagging is not necessary except for strength or if outside of bag is soiled.
- Used needles, syringes and sharps must be in biohazard sharps containers and will be sealed with puncture proof lid.
- Infectious waste must be delivered to the hospital maintenance building between the hours of 7:00 AM and 3:30 PM on weekdays only.
- Infectious waste **MUST NOT** be left outside the maintenance building, in the parking lot or the fenced off area near maintenance building.

• Offices must fill in the Medical Waste Treatment Record form located inside the maintenance building, medical waste container.

IV. CONTAMINATED SHARPS FROM THE COMMUNITY:

- Northern Inyo Healthcare District will accept contaminated needles from the community for disposal.
- Refer questions and persons with needles to the Manger of Infection Prevention/Employee Health or Maintenance; ***USED NEEDLES OR NEEDLE CONTAINERS*** must not be accepted by anyone else.
- NIHD will accept contaminated needles from the community for disposal in the Red Kiosk located at the front entrance of the Main Hospital.
- Needle containers may not be supplied to patients or other individuals, for home use.
- All efforts are made to assure appropriate containers are used and will not be accepted otherwise.

V. CLEANING UP BLOOD SPILLS OR OTHER POTENTIALLY INFECTIOUS MATERIAL (OPIM):

- Blood spills are cleaned up as quickly as possible.
- Blood spills are cleaned up in a manner to prevent exposure to any person.
    1. Use hospital disinfectant or bleach solution.
    2. Wear gloves
    3. Use disposable rag, paper towel or mop.
    4. To avoid aero-soling, do not spray into spill.
    5. Dampen rag with cleaning solution, wipe up.
    6. Re-clean area with clean rag and solution.
    7. As an alternative, sprinkle spill with jelling powder, seep up with dustpan and broom.
    8. Red bag granules.
    9. Clean dustpan and broom by swishing in cleaning solution on cleaning cart or with rag.
    10. Wipe up as in steps 5 and 6.
    11. Blood spill kits are available

VI. BIOHAZARDOUS WASTE CARTS AND CLEANING:

- Large rigid, wheeled carts are used to transport biohazardous waste from the hospital units to locked storage dumpster.
- Environmental Services will check that carts are clean and in good condition at all times.
- Carts are lined with red bags; this bag is disposed of with biohazardous waste.
- Carts are cleaned on a regular basis.

VII. STEAM STERILIZER/COMPACTOR *Maintenance of Equipment:*

The steam sterilizer and compactor are maintained and inspected to ensure safe and proper

operation and that infectious materials are fully sterilized in compliance with State and Federal regulations.

PROCEDURE/STERILIZER:

Daily:
Walk around the unit, check for damaged hoses and leaks. Remove any litter that may have accumulated around the sterilizer.
Open the sterilizer door and check the seal for damage and debris.
Clean drain screens (parts #41 and #45 on drawing #100A06.) Remove screens by lifting from the drain hole and check for the presence of debris and sediment that might restrict the flow of condensate (water.) Use a wire brush to loosen the debris, rinse thoroughly, and replace in the drain hole.
Clean "Y" strainers (Parts #6 and #39) with a crescent wrench (adjustable open end wrench) remove the large nut from the strainer. Carefully remove the internal strainer screen, clean and rinse the screen and replace, this should be done weekly.
Check the sterilizer carts for plastic residue or other debris and remove. Use a scraper if necessary.
Check the sterilizer door for alignment by slowly closing the door. If you hear scraping noises that might indicate misalignment, repair it immediately.

Weekly:
Clean wire strainers.
Recorder chart: Open the cover of the recorder with your fingers, unscrew the round knob in the center of chart. Replace with new chart. Release the pen holder; swing the arm out of the way. Gently pull the pen holder about ¼" away from the paper chart. Then remove the chart. Replace with a new chart. Release the pen holder, swing the arm back in place and gently tighten the center knob. (**Do not over tighten the knob.)**
Check the Roto-Wedge door.

a. Remove any debris from the wedges and gasket.
b. Lubricate the face of the wedges with high temperature grease.
c. Lubricate hinges and bearings, grease fittings are provided on the hinge and bearing housings.
d. Lubricate the gasket. Wipe off the gasket and the door with a clean rag to remove any debris. Spray a thin layer of high temperature Teflon based lubricant such as "Tri-Flow" on the gasket.
e. Check hydraulic hose fittings for damage and tighten the fittings if required.

f. The exterior of the sterilizer is thoroughly cleaned, primed and painted with a premium coating; however, rust may develop in certain areas due to the high moisture environment and frequent washing. Minor rust may develop due to scratches or other breaks in the coating. When rust develops, thoroughly dry the area, wire brush to remove any loose coating, and apply a
recommended primer. Primed areas can then be touched up with finish coating.
Check hydraulic oil level and top off with approved hydraulic oil if necessary.

Monthly:

Perform biological indicator test monthly to confirm the attainment of adequate sterilization conditions.

Yearly:
Even though the hydraulic system is used on a limited basis (only when opening and closing the door), it is recommended that the hydraulic fluid be drained and replaced annually.

Thermometers are checked annually for calibration and records of the calibration checks are maintained as part of the maintenance files and records for a period of three years.

PROCEDURE/COMPACTOR:
Prior to performing any maintenance on the compactor or power unit, shut off the power at the disconnect switch and lock this switch in the "off" position. See power lockout procedure on page 3. Do not service the machine if it is possible for someone to start the machine while it is being serviced.

The self-contained compactor has grease zerts on the four cylinder pins, the four container wheels, and the container door hinges. These zerts must be greased monthly or more often depending on usage. Grease the cylinder pins until grease can be seen between the pin and pin plate.

Take the rear cover off the compactor, check for trash build up in the cylinder area, and clean when necessary.

The power units use a permanent type oil filter which may be reused after each cleaning. To keep down time at a minimum while cleaning the dirty filter, replace it with a spare clean filter. The dirty filter may then be cleaned as follows:

a. Soak the filter in kerosene or other solvent to loosen the contaminant.
b. Lightly scrub the filter with a soft bristle paint brush. **DO NOT USE A WIRE BRUSH.**
c. Remove embedded contaminants with clean, dry shop air. Direct the flow of air against the side of the filter with a perforated support.
d. Again, wash the filter in a solvent and blow with shop air, then inspect for damage. Holes in the filter cloth will leak dirt into the pump and valve which may cause malfunctions in the hydraulic system.

See chart below for recommended filter change frequency.
USAGE FILTER CHANGE OR CLEAN FREQUENCY

USAGE	FILTER CHANGE OR

	CLEAN FREQUENCY
Heavy: 6 hrs. per day	Initial change after 2 weeks, thereafter every 3 months
Medium: 2-6 hrs. per day	Initial change after 3 weeks, thereafter every 6 months
Light: up to 2 hrs. per day	Initial change after 4 weeks, thereafter every 12 months

INITIAL MAINTENANCE CHECK PROCEDURE:

1. The first maintenance check should take place with the first filter change and include the following:

a. Check and tighten all electrical and hydraulic connections on the power unit, control head, and cylinder.

b. Check and tighten all mechanical fasteners, nuts, bolts, set screws, etc.

c. Drain some hydraulic fluid from the bottom of the reservoir by removing the ¾" plug from the half coupling under the oil level gauge. Inspect the fluid for the presence of water. Drain all water.

d. Check the wear guide shoes, or Nylatron guide blocks, located on the rear of the ram, for looseness and unreasonable wear. Call a factory authorized representative if wear seems excessive or uneven.

Under normal conditions the fluid can be used for an indefinite time. If you suspect that the fluid has been contaminated or has otherwise lost its usefulness, drain off some of the fluid, take it to an oil distributor and have it analyzed.

The bottom of the reservoir should be inspected every 12 to 18 months for sludge deposits. If there is a detectable layer of sludge, the reservoir should be drained, flushed with kerosene or another suitable solvent, and then refilled with clean hydraulic fluid. Recommended oil may be used for all but extremely cold temperatures. An immersion oil heater is recommended for an area where temperatures are expected to frequently reach 0 degrees F or below.

Note: All records pertaining to onsite treatment shall be maintained for a period of not less than three years.

PROCEDURE/STERILIZER:

1. Put on Personal Protective Clothing, (i.e. gloves, eye protection, cover gown.) Any questions
regarding P.P.C. refer to your Infection Control Manual.
2. Safety door latch: Place handle in the open position.
3. Push **door open** button on control panel.

4. Lower loading ramp and remove sterilizer cart, place liner into sterilizer cart, and cut a few
holes in the liner to allow moisture to escape.
5. Push cart to Infectious Waste Bin and begin placing Red Bags and Sharp containers into the
cart, (this should be about 15-20 bags) do not load bags too high in the cart as the load should
be able to be placed into the sterilizer without any bags touching the inside of the vessel, using autoclave tape, tape the bag shut as much as possible. (does not require a tight seal.)
6. Close sterilizer door, push **door close** button on the control panel, place safety T handle into
the locked position.
7. Visually look around the sterilizer, steam lines, water lines, and drains, making sure these
areas are clear.
8. Turn water valve on.
9. Push **cycle start** button.
10. Check to assure sterilizer read out time is set for 45 minutes.
11. Cycle light on control panel will go off when load is done.
12. It is recommended to let vessel temperature drop to approximately 200 degrees before opening the door.
13. Be sure to put on welding gloves before opening door and unloading the cart, as the load will
be **hot**.
14. Before placing sterilized waste into compactor, be sure the chart on the control panel indicated 275 degrees' temperature for 45 minutes was achieved and the autoclave tape has turned brown. If the chart does not read 275 or the tape has not change color, re-run the load. If the second load fails, mark the load as not sterile, remedy the problem with the equipment and re-run the load.
15. Put cart on Compactor ram and dump the sterilized waste into the compactor (see procedure
for compactor.)
16. Place cart back into sterilizer; close the door, push **door closed** button until door locks, turn
water valve off.

PROCEDURE/COMPACTOR:

1. Assure that compactor ram is in the retracted position.
2. Place dumping container in dumper and secure.
3. Pull red "**Emergency Stop**" button to outer most position.
4. Set Compactor / Dumper switch to Dumper.
5. **Turn and hold** keyed "Start" switch to start position. (deadman operation) The dumper **will not** function unless the keyed switch is held in the start position.
6. Turn "**Up/Down**" switch to "**UP**" until dumper stops at the end of the dumper stroke.
7. When all refuse has emptied from container, turn and hold "**Up/Down**" switch to the "**Down**" position until dumper comes to rest in starting position and release key.

8. After the above process has been completed, set the "**Compactor/dumper**" switch to "**Compactor**".
9.. Assure that the red "**Emergency Stop**" button is pulled out to the outer most position.
10. Turn the "**Keyed Start**" switch to "**Start**" and release.
The compactor will cycle the pre-determined number of cycles and shut off automatically.
The process is now complete and ready to be repeated.
Caution: Make sure all personnel are clear of dumper before operation.
Make sure that all safety gates are closed and all inter-lock switches are functioning properly.
Do not switch to dumper operation until compactor has completed cycling and power unit shuts down.

Note: All records pertaining to onsite treatment shall be maintained for a period of not less than three years.

CLOSURE PLAN:
Should NIHD ever experience a termination of this treatment facility, we would have to hire an out of the area vendor to haul away our Medical Waste. The treatment facility would then be disassembled and disposed of properly.

TABLE 1: WASTE ITEMS AND APPROPRIATE DISPOSAL CONTAINERS

DESIGNATED CONTAINER				
WASTE ITEM	**Sharps Box**	**Red Bag**	**Regular Bag**	**Other Designated Containers**
Needles/syringes	**X**			
Lancets	**X**			
Any other sharps	**X**			
Lab and microbiology used specimen tubes or media plates	**X**			
Broken glass	**X**			
Gloves, gowns, masks (dripping with blood)		**X**		
Any Dressings or Chucks (saturated with blood or other drainage)		**X**		
Foley catheters/bags with blood		**X**		
Any drainage receptacle with large amount of blood		**X**		
Any drainage tubes with large amount of		**X**		

Blood bags		**X**		
Peripads or tampons		**X**	**X**	
IV lines and bags (with blood)		**X**		
IV catheters			**X**	
IV lines and bags (no blood)			**X**	
Bedpans, urinals, emesis basins			**X**	
Ventilator tubing			**X**	
Foley catheters and bags			**X**	
Any dressings or chucks (minimal blood)			**X**	
Diapers			**X**	
ET tubes and suction catheters/Ng tubes			**X**	
Gloves, gowns, aprons, masks (no blood or slightly stained with blood)			**X**	
Tissues and paper towels			**X**	
Guiac and Gastro-occult cards			**X**	
Chemotherapy items Trace				**Yellow rigid container: chemo bucket**
Pharmaceutical Waste: Hazardous Drugs and Bulk Chemotherapy				**Black Bin**
Pharmaceutical Waste: General				**Blue and White Container**
Pharmaceutical Waste: Controlled Substance				**Opaque Green Bin**

Note: The general pharmaceutical waste, trace chemotherapy waste, and controlled substance will be picked up by a medical waste transporter vendor to be incinerated. These items will be stored in EVS storage room until packaged and mailed out. When packaged the waste containers will be sent to Purchasing to be officially mailed out.

REFERENCES:

1. Association for Professionals in Infection Control and Epidemiology (APIC). (2023).

Waste Management. Retrieved from https://text.apic.org/toc/infection-prevention-for-support-services-and-the-care-environment/waste-management#book_section_683912. California
2. Department of Public Health (2017). Medical Waste Management Plan Checklist. Retrieved from https://www.cdph.ca.gov/CDPH%20Document%20Library/ControlledForms/cdph8661.pdf
3. California Department of Public Health. (2022). Medical Waste Management Program. Retrieved from https://www.cdph.ca.gov/Programs/CEH/DRSEM/Pages/EMB/MedicalWaste/MedicalWaste.aspx
4. Occupational Safety & Health Administration) (accessed 11/6/2023). Standard Number 1910.1030 Feminine Products. Retrieved from https://www.osha.gov/laws-regs/standardinterpretations/1992-06-01

CROSS REFERENCE P&P:

1. Bloodborne Pathogen Exposure Control Plan
2. Hazardous Materials & Waste Management Plan
3. Hazardous Materials & Waste Inventory EC.02.02.01EP1
4. Opioids Waste Policy
5. Safe Handling and Disposal of Occupationally Hazardous Drugs and Environmentally Hazardous Drugs*
6. Hazardous Materials & Waste Management Plan
7. Lippincott Procedures Personal Protective equipment (PPE), putting on
8 Lippincott Procedures Personal Protective equipment (PPE), removal
9. Hazardous Spill & Exposure EC.02.02.01EP3-4
10.. Reporting Hazardous Materials & Waste Incident EC.04.01.01EP8
11. Management of Hazardous Chemicals EC.02.02.01EP5
12. Labeling Hazardous Material &Waste EC.02.02.01EP12
13. Hazardous Materials & Waste Management Plan
14. Formaldehyde EC.02.02.01EP9
15. Disposal of Radioactive Waste. Diagnostic Imaging - Radioactive Waste Storage and Disposal
16. Diagnostic Imaging - Disposal of radioactive sharps
17. InQuiseek – Medical Waste Handling and Disposal

Supersedes: v.1 MEDICAL WASTE MANAGEMENT PLAN

CALL TO ORDER	Northern Inyo Healthcare District (NIHD) Board Chair Mary Mae Kilpatrick called the meeting to order at 5:30 p.m.
PRESENT	Mary Mae Kilpatrick, Chair Melissa Best-Baker, Vice Chair Jean Turner, Secretary Ted Gardner, Treasurer Stephen DelRossi, MSA, Chief Financial Officer / Interim Chief Executive Officer Allison Partridge RN, MSN, Chief Nursing Officer / Interim Chief Operations Officer Alison Murray, Chief Human Resources Officer Sierra Bourne, MD, Chief of Staff
ABSENT	Adam Hawkins, DO, Chief Medical Officer
OPPORTUNITY FOR PUBLIC COMMENT	Chair Kilpatrick reported that at this time, members of the audience may speak on any items not on the agenda on any matter within the jurisdiction of the District Board. Public comments shall be received at the beginning of the meeting and are limited to three minutes per speaker, with a total time limit of thirty minutes for all public comment unless otherwise modified by the Chair. The general Public Comment portion of the meeting allows the public to address any item within the jurisdiction of the Board of Directors on matters not appearing on the agenda. Public comments on agenda items should be made at the time each item is considered. There were no comments from the public.

NEW BUSINESS

AD HOC COMMITTEE REPORTS

Chair Kilpatrick called attention to Ad Hoc Committee reports.

Governance Committee: Secretary Turner reported the following:

- Governance Documents for Discussion – Secretary Turner presented documents.

- Governance versus Management Matrix of Responsibilities – Secretary Turner highlighted these tools for the Board and Board Chair to use. Secretary Turner asked for questions, comments, or changes. There were no questions, comments, or changes.

- Board Members Code of Conduct – Secretary Turner explained that this document from ACHD requires review and signatures by all Board members annually. Secretary Turner asked for questions or comments. There were no questions or comments.

- Calendar of Time Sensitive Business – Secretary Turner reported that some items are required to happen during specific months, others are tasks to be reviewed annually. Secretary Turner asked for questions or comments. There were no questions or comments.

It was motioned by Vice Chair Best-Baker to approve the documents as presented, seconded by Treasurer Gardner, and passed 4-0 vote.

HR Committee: Chair Kilpatrick reported she has spoken and received an update from Human Resources.

Finance Committee: Vice Chair Best-Baker reported the finance committee met the previous week. Vice Chair Best-Baker referred to Interim CEO DelRossi to discuss changes and updates in his following report. Chair Kilpatrick asked if there were any questions or comments. There were no questions or comments.

APPOINTMENT OF THE ZONE 1 BOARD VACANCY

Chair Kilpatrick called attention to the appointment of the Zone 1 NIHD Board vacancy. Vice Chair Best-Baker reported she and Treasurer Gardner interviewed a lot of great candidates.

The committee reported their recommendation is to appoint applicant David McCoy Barrett.

Discussion ensued.

It was motioned by Treasurer Gardner to appoint David McCoy Barrett to the vacant seat of Zone I, seconded by Vice Chair Best-Baker, and passed 4-0 vote.

Secretary Turner wanted to highlight the fact that a total of six candidates were interested and applied for the vacant seat of Zone I, and thanked everyone who applied and who were willing to serve the community.

CHIEF EXECUTIVE OFFICER REPORT

Chair Kilpatrick introduced the Chief Executive Officer Report. Before reporting CFO/Interim CEO DelRossi introduced Katie Manuelito, NIHD's new Board of Directors Clerk. Mr. DelRossi reported the following:

- Becker's Conference – Mr. DelRossi attended the 5 day Becker Healthcare CISO conference and reported the following:
  - Invited as a panelist on multiple boards.
  - Invited to join in a four panel Humanity Board focused on Revenue Cycle.
  - Invited to attend a special meeting for rare diseases.
  - Networked with various companies about AI. AI will soon be a driving force in healthcare districts across the U.S.
  - Spent time making contacts with individuals who can help

our District.

- FY 2024 Strategic Plan – A strategic planning meeting is scheduled for 12/9/2023. Mr. DelRossi also added that a new community needs assessment must be done for next year.

CHIEF FINANCIAL OFFICER REPORT

Chair Kilpatrick introduced the Chief Financial Officer report.

- Mr. DelRossi reported the following Financial & Statistical Reports:
  - August was a good month; net change in financial position was negative $150,000, this has been the best operation numbers since Mr. DelRossi has started.
  - Revenue was over 20 Million gross, with a 2.1 Million dollar increase since July. There has been an increase in Outpatient and RHC visits; combined visits are up 10% from last year.
  - 148 surgeries in August, surgery volume is up 17%.
  - ER visits up roughly 12%.
  - The Rehabilitation Department is looking to recruit 3 physical therapists, volume is down 10% due to recent resignations.
  - Payor mix- down shift in Blue Cross to 9%; this will be continuously monitored.
  - Full Time Employee's (FTE) - last year NIHD had 459 FTE's, and now we currently have 388 FTE's with a total of 71 decrease in FTE's.
  - We have given significant raises over year, but cost per adjusted bed day is down $468. Professional fees are up per adjusted bed days due to using Locums anesthesiologist. This should decrease as we recruit permanent physicians.

- FY 2022 Audit Deficiencies follow up:

NIHD had four items we are looking at related to unreconciled balance sheets.

  - Fallen short on 2 accounts; those accounts should be balanced in the next 3-4 months.
  - Pension Administration – previous auditors noted we were deficient in documentation. After follow-up, we found that the auditors were incorrect and we are in compliance with documentation.
  - Pension accounting deficiency – Auditors have sent a template to assist in resolution.
  - We have resolved contractual allowances with a third party payor that had issues.

- NIHD has found two potential new findings with our fixed assets – Last year's roll over was never compared to the general ledger and

was missing the value of donated land in the year 1946.

- Grants – 14 grants have been reviewed, 12 have been closed out and 2 are currently being worked on.

Vice Chair Best-Baker asked about first item of unreconciled balance sheets and how many there were. Mr. DelRossi reported 150 – 200 have been reviewed and balanced.

- Birch Street Property Status:
    - Purchase price of $799,000. Current condition retail value of $899,000. If sold we would have $100,000 pickup minus the commission. If sold, we have to find or build a climate controlled storage facility. Mr. DelRossi concluded that, with all the factors it is not in our best interest to sell the property.

Discussion ensued.

- Revenue Cycle Update:

RSM continues to help NIHD maintain systems, particularly when we find "breaks," and lend technical expertise on an hourly basis. Jordan Fuller our main point of contact who is the technical expert in Cerner. Mr. Fuller is also working with our ITS team to help create SR tickets to help us track progress of repair with issues found.

- RSM recently assisted us in creating a cash balance in methodology using three way matching to confirm accuracy, before NIHD was only using a two way method. This method has helped us identify issues related to charge capture in laboratory and therapy departments.

Gloria Sacco, Revenue Cycle Director, added that Jordan Fuller used to work for Cerner and his knowledge and expertise has increased our response time on SR tickets. He helps us evaluate issues, and helps us with the appropriate language to use on SR Tickets.

- OS – Biller, OS is not responsible for Medicaid or self-pay. Their portion of >90 days AR is 19%, we've given them a goal of 15%.

- Novus – Medicaid and Medical processer. NIHD has given them 47,000 accounts dating back to year 2019 to analyzing what is collectible.

- MedPlan – Group that collects payments after insurance - self pay, and balances after insurance. We have found issues with the way data flows back and forth, NIHD has submitted an SR ticket to correct data flow.

- Hauge – Bad debt collector. We recently sent 3 million dollars of accounts; they are currently in process of sending 3,000 accounts to be collected.

- Athena – We currently have about 1 million dollars in credits with Athena, but not all true credits.

It was motioned by Secretary Turner to approve the report as presented, seconded by Treasurer Gardner, and passed 4-0 vote.

DISTRICT BOARD RESOLUTION 23-06

Chair Kilpatrick introduced District Board Resolution 23-06 Credit Card Change.

CFO/Interim CEO DelRossi noted that Union Bank recently became US Bank, and in return NIHD lost all control of our credit card statements. NIHD has not had access to credit card data to verify credit card activity for the past 5 months. Mr. DelRossi also added that he reached out to Robert Sharp, representative at Eastern Sierra Community Bank (ESCB) who have primary custody of our accounts. In conclusion, Mr. DelRossi proposes we open credit cards with ESCB, close out credit card accounts with US Bank.

Discussion ensued.

Chair Kilpatrick read Resolution 23-06 aloud.

It was motioned by Treasurer Gardener to approve District Board Resolution 23-06 Credit Card Change as presented, seconded by Vice Chair Best-Baker, and passed 4-0 vote.

TAX – EXEMPT

Chair Kilpatrick introduced the Tax-Exempt Conversion of the NIHD 2021B Taxable Refunding Revenue Bonds.

Mr. DelRossi stated we have until 11/02/2023 to decide to move forward, and proposes we payoff accrued interest of $90,000, and transition those instruments to non-taxable, in return this will save the district about 1.25 percentage points of interest.

It was motioned by Secretary Turner to approve Tax-Exempt Conversion of the NIHD 2021B Taxable Refunding Revenue Bonds, seconded by Treasurer Gardner, and passed 4-0 vote

CHIEF OF STAFF REPORT

Chair Kilpatrick called attention to the Chief of Staff report.

Dr. Bourne presented the Medical Executive Committee (MEC) report.

POLICIES

Dr. Bourne provided an overview of the policies and procedures for approval.

- Policies
  - Aerosolized Transmissible Disease Exposure Plan Respiratory Protection Program
  - Deployment of Nursing Staff at Department Level and Patient Care Assignments
  - Diagnostic Imaging – Communication of Mammography Results to the Healthcare Provider
  - Health Care Worker (HCW) Influenza Vaccination
  - Patient and or Visitor Exposure to Blood or Body Fluids
  - Qualifications to Insert Peripherally Inserted Central-Catheters and Midlines

Chair Kilpatrick asked several questions about how many nurses have gone through and completed the PICC line training and validation. Discussion ensued.

Vice Chair Best-Baker had a question/update to the wording in the HCW Influenza Vaccination Policy. Board ensued discussion.

It was motioned by Vice Chair Best-Baker to approve the policies with change to wording on the HCW Influenza Vaccination policy, seconded by Treasurer Gardner, and passed 4-0 vote.

MEDICAL EXECUTIVE COMMITTEE REPORT

Dr. Bourne provided the following report from the Medical Executive Committee meeting.

- Welcomed the following new physicians:
  Dr. Amy Do – Emergency Department
  Dr. James Tur & Dr. Ramirez – (2) Hospitalists
  Dr. Rowan – Cardiology.

Dr. Bourne also added that Dr. Clayton Davis spoke eloquently at fundraiser and is one who is rapidly winning the heart and minds of our community.

Report from O.B. – Labor & Deliver at Mammoth Hospital has no plans to reopen, and NIHD has had a 25% - 30% delivery volume increase.

Report from Laboratory – Decrease in O negative blood use. NIHD's year over year usage of O negative blood has improved drastically since implementation of new Emergency Release Policy. In 2021 we used 22% O negative per population, and in 2023 we are down to 5.9% which is well below the benchmark.

UASI Coding audits – Emergency Department is currently being audited and is undergoing one on one training this month.

Wellness Committee – planning a provider Christmas party.

CONSENT AGENDA

Chair Kilpatrick called attention to the consent agenda that contained the following items.

- *Approval of minutes of the August 30, 2023 Special Board Meeting*
- *Approval of minutes of the September 20, 2023 Regular Board Meeting*
- *Approval of minutes of the September 27, 2023 Special Board Meeting*
- *Chief Human Resources Officer Report*
- *Department Reports*
- *Approval of Policies and Procedures*
    - *i. Discharge Planning for the Hospital patient*
    - *ii. Opening and Closing Nursing Departments*

Secretary Turner asked for a one word correction to the September 20th Regular meeting minutes. Page 95, "…civility in Board members" should read "…civility in Board meetings"

Discussion ensued.

It was motioned by Treasurer Gardener to approve the consent agenda with the change to the wording in the September 20th Regular meeting minutes, seconded by Vice Chair Best-Baker, and passed 4-0 vote.

REPORTS FROM BOARD MEMBERS

Chair Kilpatrick opened up Reports from Board Members.

Treasurer Gardener attended NIHD foundation fundraising dinner, and reported it was very well planned and executed event in a great location.

Secretary Turner echoed Treasurer Gardner, that the foundation fundraiser was a well-done event with great speeches. Secretary Turner also added that her role on the Education Committee for ACHD has its first meeting next week to collecting ideas for educational topics for board and CEO conference next year.

Chair Kilpatrick reported the following:

- Attended hour-long meeting with auditors that went very well. The auditors are expected to visit onsite twice a year, but offered to come more often if NIHD needs.
- Attended Quality Council and Medical Surgical meeting.
- Attended NIH Foundation meet and greet.
- Attended Dr. Ungersma services.
- Attended Inyo Associates meeting with CFO/Interim CEO DelRossi

PUBLIC COMMENTS ON CLOSED SESSION ITEMS

Chair Kilpatrick announced that any person in the audience may now speak on items only listed on the Closed Session portion of this meeting.

There were no public comments. Chair Kilpatrick announced there would be no report out.

ADJOURNMENT TO CLOSED SESSION

At 6:53 pm, Chair Kilpatrick announced the meeting would adjourn to Closed Session to allow the District Board of Directors to discuss the following:

a. Public Employee Performance Evaluation pursuant to Government Code Section 54957(b)(1). Title: Interim CEO
b. Conference with Labor Negotiators pursuant to Government Code Section 54957.6 Agency Designated Representatives: HR/Board Chair. Unrepresented employee: Interim CEO

ADJOURNMENT

Adjournment at 6:55 p.m.

_____
Mary Mae Kilpatrick,
Northern Inyo Healthcare District, Chair

Attest: _____
Jean Turner,
Northern Inyo Healthcare District, Secretary

CALL TO ORDER	Northern Inyo Healthcare District (NIHD) Board Chair Mary Mae Kilpatrick called the meeting to order at 5:30 p.m.
PRESENT	Mary Mae Kilpatrick, Chair Melissa Best-Baker, Vice Chair Jean Turner, Secretary Ted Gardner, Treasurer David McCoy Barrett, Member at Large Stephen DelRossi, MSA, Chief Financial Officer / Interim Chief Executive Officer (present via zoom) Allison Partridge RN, MSN, Chief Nursing Officer / Interim Chief Operations Officer Adam Hawkins, DO, Chief Medical Officer Alison Murray, Chief Human Resources Officer (present via zoom)
ABSENT	Sierra Bourne, MD, Chief of Staff
OPPORTUNITY FOR PUBLIC COMMENT	Chair Kilpatrick reported that at this time, members of the audience may speak on any items not on the agenda on any matter within the jurisdiction of the District Board. Public comments shall be received at the beginning of the meeting and are limited to three minutes per speaker, with a total time limit of thirty minutes for all public comment unless otherwise modified by the Chair. The general Public Comment portion of the meeting allows the public to address any item within the jurisdiction of the Board of Directors on matters not appearing on the agenda. Public comments on agenda items should be made at the time each item is considered. There were no comments from the public.
SWEARING IN OF NEWLY APPOINTED BOARD MEMBER	Chair Kilpatrick announced that newly appointed Board member, David McCoy Barrett would be sworn in. CNO/Interim COO, Allison Partridge swore in David McCoy Barrett to the vacant Board of Directors seat of Zone I. Mr. McCoy Barrett repeated his Oath of Office aloud.

NEW BUSINESS

AD HOC COMMITTEE REPORTS	Chair Kilpatrick called attention to Ad Hoc Committee reports. **Governance Committee**: Secretary Turner acknowledged Compliance Officer, Patty Dickson for her assistance and support with policy work and updates.

APPROVAL OF CONTRACT FOR PERMANENT CEO

Chair Kilpatrick called attention to the approval of the CEO Permanent contract. CHRO Alison Murray presented the contract and called attention to the agreement term, salary, severance, and scope.

Discussion ensued.

CHRO Murray also called special attention to Section 9.1, three sentences down, and proposed the removal of the language specifying returning to CFO position if Mr. DelRossi is terminated as CEO. Discussion ensued and the Board agreed that the specific language does not apply at this time.

It was motioned by Secretary Turner to approve the contract as amended, seconded by Treasurer Gardener, and passed 5-0 vote.

CHIEF EXECUTIVE OFFICER REPORT

Chair Kilpatrick called attention to the Chief Executive Officer Report. Mr. DelRossi reported the following:

- Surgeons – NIHD has welcomed a new Surgeon, Urologist, and Cardiologist. The new services provided by our new physicians are directly responsible for helping drive a 14% year over year increase, Mr. DelRossi is very pleased with the new surgeons, services, and positive feedback from staff and patients.

- Blue Shield, Blue Cross, and Aetna – working through augmenting/mitigating contracts.

CHIEF FINANCIAL OFFICER REPORT

Chair Kilpatrick introduced the Chief Financial Officer report.

- Financial & Statistical Reports:

Controller Andrea Mossman presented the financial and statistical report, and reported that September 2023 was a great month for NIHD. Expenses were relatively flat, in conclusion NIHD had a total of 1.4 million dollar net income, which is substantially better than the last few years. Discussion ensued.

It was motioned by Secretary Turner to approve the Financial & Statistical Report as presented, seconded by Vice Chair Best-Baker, passed 5-0 vote.

- Revenue Cycle Update:

Mr. DelRossi presented the following revenue cycle update. The Revenue Cycle team is still finding issues, but sees light at the end of the tunnel. We have recently been able to exert more pressure on 3rd party vendors/billers to hold them accountable for their time and work. Mr. DelRossi also added that 3,000 accounts were sent to bad debt on 10/31/2023. Finally, Mr. DelRossi reported that Gloria Sacco, Revenue Cycle Director, has agreed to stay on for an indefinite amount of time to work with our Revenue Cycle team.

Vice Chair Best-Baker requested for presentation/documentation similar to what the Board received in the past, Mr. DelRossi replied that he will

bring PowerPoint slides back to highlight each small project.

Secretary Turner also added that she has recently received positive feedback from the community on patient visits and the current billing processes.

- Cost Report and Audit Update:

Controller Andrea Mossman presented the following cost report and audit update. Cost reports are filed annually, and must be filed by November 30, 2023 to be filed in a timely manner. NIHD is making good progress and will have a draft Cost Report ready for Medicare to review over the Thanksgiving Holiday week. We currently send the draft Cost Report to Medicare for review before filing to assure NIHD receives full reimbursement. The cost report goes hand in hand with our Audit, which is also going well, and NIHD expects to have the audit completed in December.

Ms. Mossman also added that Siemens, our bondholders, are very happy with our initiatives and has offered extensions if needed, and also they are very happy with the recent financial progress NIHD has made.

- Automation and AI:

Mr. DelRossi reported that the same discussion on automation and AI in healthcare has carried from the last conference he attended. He also added that in the past, NIHD was used as a test subject with Athena, and that in the future NIHD will move cautiously toward the new AI models.

DISTRICT BOARD RESOLUTION 23-07 DISSOLUTION OF NORTHERN INYO HEALTH NON-PROFIT

Chair Kilpatrick introduced District Board Resolution 23-07 Dissolution of Northern Inyo Health Non-Profit

Chair Kilpatrick read Resolution 23-07 aloud.

Discussion ensued.

It was motioned by Secretary Turner to approve District Board Resolution 23-07 Dissolution of Northern Inyo Health Non-Profit as presented, seconded by Treasurer Gardner, and passed 5-0 vote.

CHIEF OF STAFF REPORT

Chair Kilpatrick called attention to the Chief of Staff report.

Dr. Adam Hawkins presented the Medical Executive Committee (MEC) report.

MEDICAL STAFF APPOINTMENTS AND REAPPOINTMENTS 2023-2024

Dr. Hawkins introduced the Medical Staff appointments and reappointments.

Discussion ensued.

It was motioned by Vice Chair Best-Baker to approve the appointment and reappointments as presented, second by Secretary Turner, and passed 5-0 vote.

ADDITIONAL PRIVILEGES AND CHANGE IN STAFF CATEGORY

Dr. Hawkins introduced the additional privileges and change in staff category.

Discussion ensued.

It was motioned by Treasurer Gardener to approve the additional privileges and change in staff category as presented, seconded by Vice Chair Best-Baker, and passed 5-0 vote.

POLICIES

Dr. Hawkins provided an overview of the policies and procedures for approval.

- Policies
  - Administrative Closure of the Medical Record
  - Medical Staff Department Policy – Pediatrics

Discussion ensued.

It was motioned by Vice Chair Best-Baker to approve the policies as presented, seconded by Treasurer Gardener, and passed 5-0 vote.

MEDICAL EXECUTIVE COMMITTEE REPORT

Dr. Hawkins provided the Medical Executive Committee meeting report.

Discussion ensued.

CONSENT AGENDA

Chair Kilpatrick called attention to the consent agenda that contained the following items.

- *Chief Nursing Officer/Interim Chief Operating Officer Report*
- *Chief Medical Officer Report*
- *Compliance Department Quarterly Report*
- *Department Reports*
- *Board of Director Bylaws*
- *Approval of Policies and Procedures*
  i. *Medicare Outpatient Observation Notice*
  ii. *Processing Returned Mail*
  iii. *Processing United States Postal Service Mail*
  iv. *Grant Program Activities*
  v. *Funding Requests for NIH Foundation*
  vi. *Subpoena and Legal Summons for Workforce*

Discussion ensued. Chair Kilpatrick noticed the consent agenda item, Board of Director Bylaws needed some edits and pulled the item.

It was motioned by Vice Chair Best-Baker to approve the consent agenda

as presented, with the exception of the Board of Director Bylaws, seconded by Treasurer Gardener, and passed 5-0 vote.

REPORTS FROM BOARD MEMBERS

Chair Kilpatrick called for Reports from Board Members.

Secretary Turner wanted to highlight, for new Board Member David McCoy Barret, that the upcoming 2024 ACHD annual conference is a conference that all the Board members attend and that the conference will provide mandatory trainings to look forward to. Secretary Turner also added that she is a Board member on the ACHD governance committee and at their last meeting they reviewed applications for new ACHD Board members and also discussed the planning details for next year's conference.

Treasurer Gardner voiced his appreciation for Vice Chair Best-Baker's help to find and fill the vacant Board position with Mr. McCoy Barrett and reminded the public that a few seats are up for re-election during the next general election in November 2024.

Chair Kilpatrick reported that she accompanied Mr. DelRossi to the City Council meeting and acknowledged the work Stephen has done to represent NIHD at various public meetings, and thanked not only Mr. DelRossi but all the leadership team.

ADJOURNMENT

Adjournment at 6:52 p.m.

_____
Mary Mae Kilpatrick, Northern Inyo Healthcare District, Chair

Attest: _____
Jean Turner, Northern Inyo Healthcare District, Secretary

NORTHERN INYO HEALTHCARE DISTRICT
One Team. One Goal. Your Health.

150 Pioneer Lane
Bishop, California 93514
(760) 873-5811

DATE: December 2023

TO: Board of Directors
Northern Inyo Healthcare District

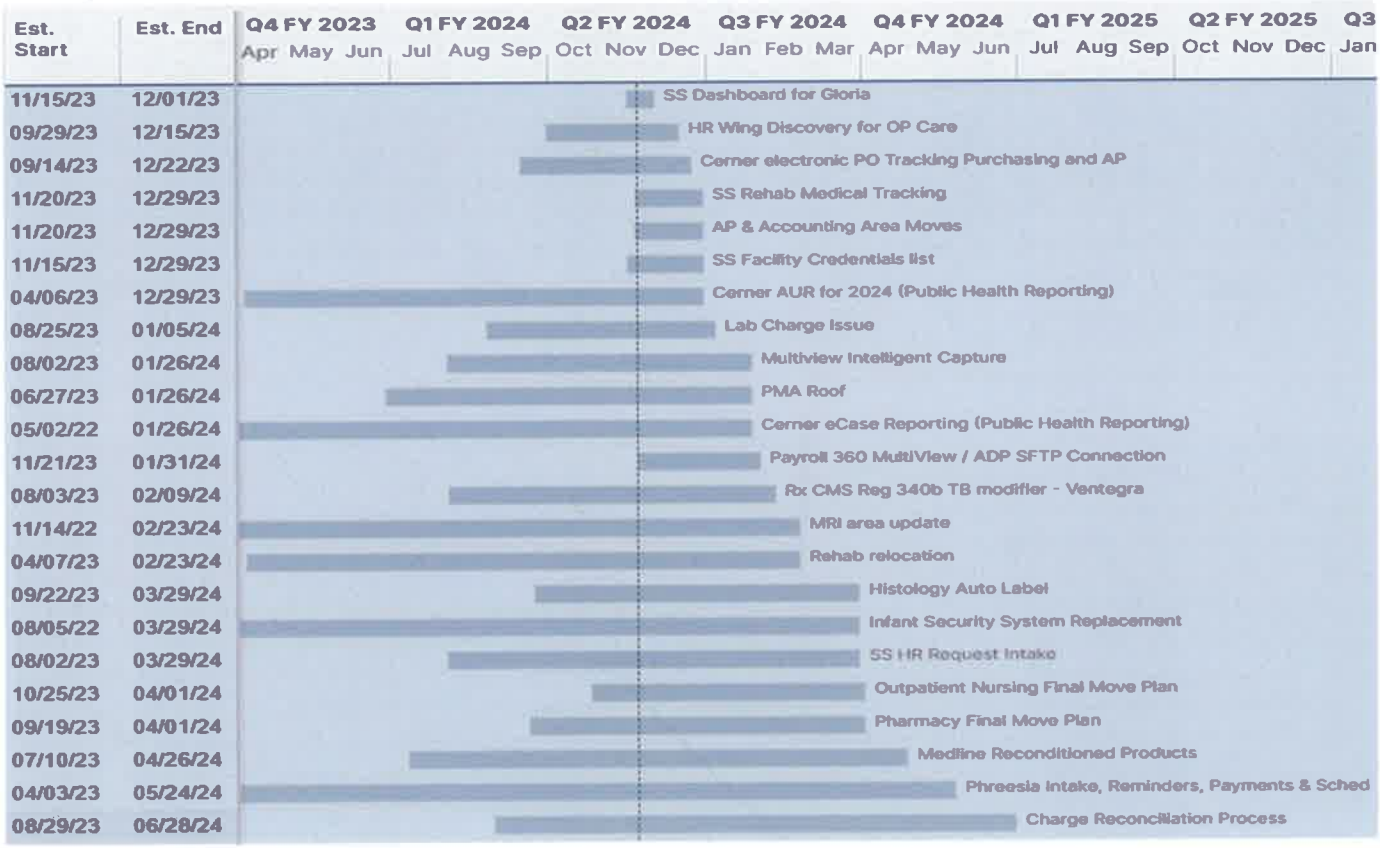
FROM: Stephen DelRossi, CEO
Lynda Vance, Manager of Project Management

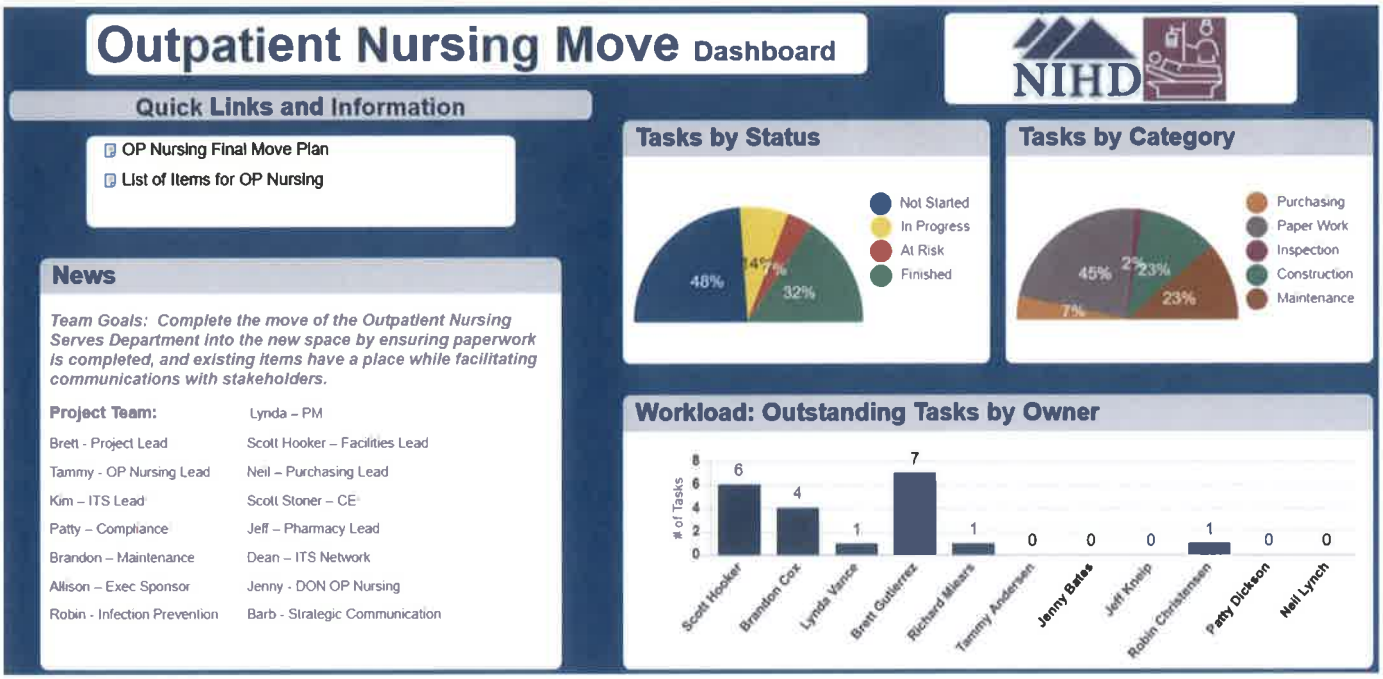
RE: Department Update for Project Management Office (PMO)

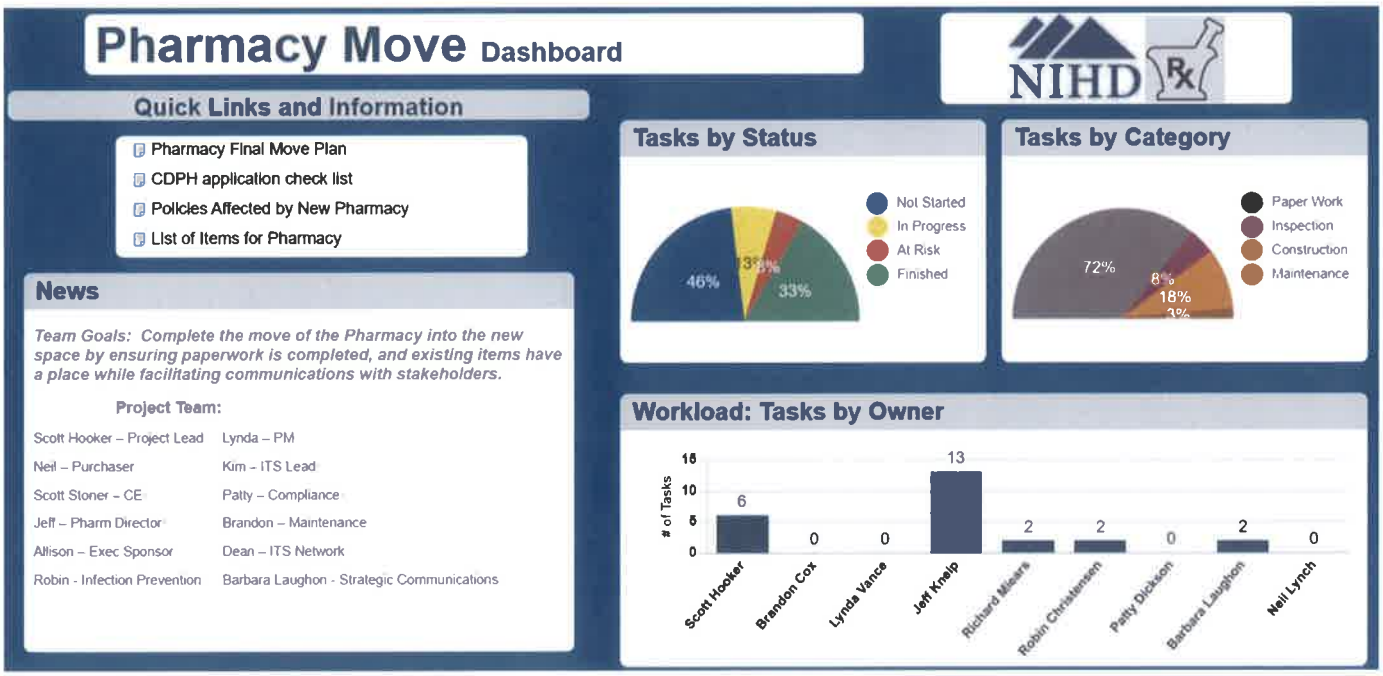
REPORT DETAIL

NEW BUSINESS

Happy Holidays! I have switched up the format for my report to give you a visual of the projects and their timelines. Below is a Gantt view of active projects, a snip of the SmartSheet dashboards for the Pharmacy and Outpatient Nursing moves, and a list of projects on hold. I hope these updates to my report give you a better understanding of project management at NIHD.







On Hold Projects - 11 (SmartSheet(SS) Rehab Medical Hours Tracking, Hauge/Cerner Name update, HIE HealthNet Grant, Cerner Insurance Contract Management, SmartSheet(SS) TB Questionnaire EH, Phone Standard Message Part 2, Urology new service line pieces, SmartSheet upgrade for PHI Compliance, RevSpring Reminders & Payments, Provider AI Assistance, HealthTrust Productivity)

OLD BUSINESS

The InfoShare team meets bi-weekly to review moves and other interdependent projects. Weekly Change meetings inform leaders about workflow changes, the EHR, and ITS functions. I continue to support projects and discoveries for efficiencies to decrease costs and increase revenue.

NORTHERN INYO HEALTHCARE DISTRICT

Improving our communities, one life at a time.
One Team, One Goal, Your Health!

150 Pioneer Lane
Bishop, California 93514

(760) 873-5811

DATE: December 2023

TO: Board of Directors
Northern Inyo Healthcare District

FROM: Stephen DelRossi, CEO
Marnie Davis, HIM Manager

RE: Department Update for HIM

REPORT DETAIL

NEW BUSINESS

HIM has been working with several departments and clinical staff within NIHD for a more efficient and effective workflow to produce clean and complete charts. The outcome will be that coding and billing will be able to have faster productivity, and NIHD will have quicker reimbursements.

We are hiring a new HIM Specialist after a long period of being short-staffed. We look forward to the help and adding a new team member to the HIM family.

OLD BUSINESS

None

NORTHERN INYO HEALTHCARE DISTRICT

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150 Pioneer Lane
Bishop,California 93514
(760) 873-5811

DATE: December 2023

TO: Board of Directors
Northern Inyo Healthcare District

FROM: Stephen DelRossi, CEO
Fabiola Esparza, Business Office Manager

RE: Department Update for Business Office

REPORT DETAIL

NEW BUSINESS

- We hired a part time employee, Alejandra Ruiz (AR Tech), to help cover the previous AR Tech that moved to PRN status, to ensure we get payments posted in a timely manner. Alejandra is doing very well.

- We are down to 2 staff members in the Business Office. One staff member is on LOA until the first week of January. This means we have one staff member taking calls, responding to emails, & assisting patients at the front window (with management covering lunches when needed).

- Charge Reconciliation Process- We have been working closely with all revenue generating department leads to develop a good daily reconciliation process so that all revenue is captured. We have all learned quite a bit while working together to develop a good process.

- The 340B Pharmacy is in the works and should be ready to go live 1/1/24. We have had to make a few adjustments to the naming conventions for our Misc Medicaid plans in order for the Ventegra team to distinguish which encounter qualifies for the re-pricing.

- We are working closely with our early out vendor, Med-Plan to address the issues we have:
  - All timeline notes aren't coming over into Cerner
  - Payment & adjustment SFTP files not loading into Cerner

OLD BUSINESS

None

NORTHERN INYO HEALTHCARE DISTRICT
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150 Pioneer Lane
Bishop, California 93514
(760) 873-5811

DATE: December 2023

TO: Board of Directors
Northern Inyo Healthcare District

FROM: Stephen DelRossi, CEO
Bryan Harper, Director of ITS/CISO

RE: Department Update for ITS/CISO

REPORT DETAIL

NEW BUSINESS

CE

- Continue to Negotiate contracts with Purchasing; Millipore (20% savings over prior contract) (Lab Water), Microtome Pathology(20% Savings over prior contract), Alcon (Dr Reid, Surgery).Installed new Ultrasound for Urologist in Surgery for a new procedure.
- Build/Install new SPYGlassDS video system for common bile duct stone removal.
- Install Lithovue, lithotripsy for stones in the common bile duct.
- Install Flushing Pump for OR
- Reinforce medication storage in Pediatric department, Identify areas for improvement, recommend, reconfigure equipment.
- Joined the Water Management Team
- Oct-Nov 480 Total work orders. 297 were scheduled preventative maintenance, 183 were unscheduled work orders that were user reported.

ITS

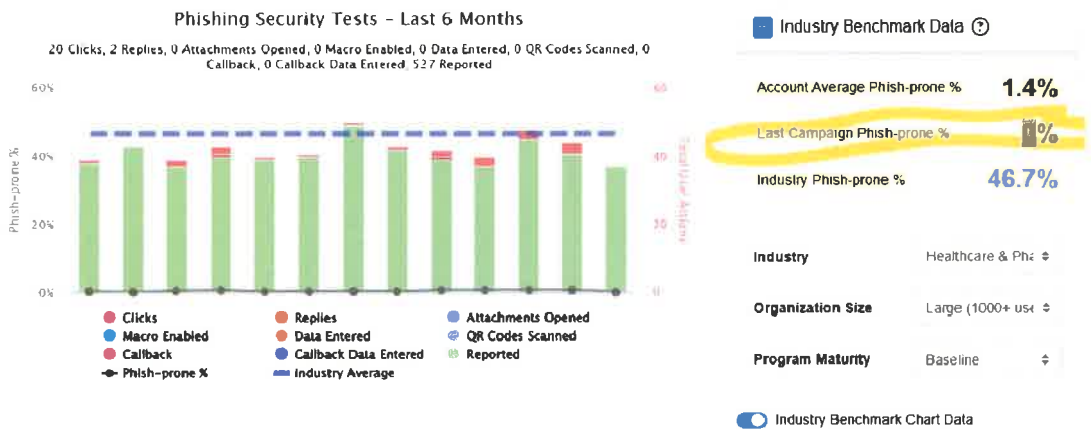
- New SIP trunk lines for moving our phone lines to digital which has cost savings.
- Working on commvault server overhaul and backup
- Critical patch upgrade for citrix. Known exploit
- Replace batteries and Clean up Admin NOC
- DI Network battery replacement
- New CHC Data Workflow for Purchasing
- Omnicell Duplications in Cerner Orders
- Qtr Stryker data export reports automated
- Demo with work "Q" for cerner that will streamline outside orders.
- Centricity old EMR data clean up ready for import to OneContent.

- Athena data cleanup started and contact made with Hyland for data migration. (initial phase)
- The switch over from Verizon to ATT, now that it has been a year. We saved the district over $21,000
- Removed over 60+ windows 10 computers and replaced with updated windows 11.

Security

- For the 1st time since starting security training 2018 we have had 0% in phish prone.

Phishing



- Trained over 40 staff members
- Continued patching of servers & workstations
- Resolving items found in pentesting report and CISA report.
- New Security Defense Servers/Lab completed

OLD BUSINESS

CE

- Installed new Anesthesia Machines and interfaced to Cerner.
- Installed new Ultrasound for Urologist in Surgery for a new procedure.
- Help Facilitate rollout of Comfort Glide and new style blood pressure cuffs.

ITS

- Printer reduction project – operational savings for the district
- Commvault upgrade (backup servers)
- Upgrade citrix (external users)
- Update NetScalers (citrix and OneContent) (load balance servers)
- 3M Updates (coding)
- Shasta data pull for data Exchange w/Cerner (call to prep for CA law)
- Omnicell Duplications in Cerner Orders (pharmacy)

Security

- New Security Defense Servers/Lab
- USB Drive Detection Alerts
- ITS/ Security - Continued patching of servers & workstations
- Continued security awareness trainings
- Ongoing testing and compliance of the NIHD network weekly.

NORTHERN INYO HEALTHCARE DISTRICT
NON-CLINICAL POLICY AND PROCEDURE

Title: Workforce Access to His or Her Own Protected Health Information		
Owner: Compliance Officer	Department: Compliance	
Scope:		
Date Last Modified: 08/14/2023	Last Review Date: No Review Date	Version: 5
Final Approval by: NIHD Board of Directors	Original Approval Date: 12/16/2015	

PURPOSE:
To provide all Northern Inyo Healthcare District patients with the same access to their protected health information.

POLICY:
Northern Inyo Healthcare District maintains protected health information on each patient in either historical paper or electronic medical record format. Workforce member access to his or her own protected health information is treated in the same manner as that of every patient.

DEFINITIONS:
"Medical Record" means any item, collection, or grouping of information that includes protect health information and is maintained, collected, used, or disseminated by or for a covered entity.

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

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

"Health Insurance Portability and Accountability Act" (HIPAA) means the Standards for Privacy of Individually Identifiable Health Information. This rule includes standards to protect the privacy of individually identifiable health information.

PROCEDURE:
1. In order to access his or her own protected health information, a workforce member must follow the regular procedure of the facility. A workforce member is not permitted to access his or her own information by use of clinical information systems or any other paper or electronic system.

2. A workforce member may obtain a copy of his or her own medical record in the Health Information Management (HIM) Department following facility policies and procedures.

3. Workforce member records will be subject to random HIPAA privacy and security audits for inappropriate access.

4. Inappropriate access to a workforce member's own PHI may result in disciplinary action up to and including termination.

REFERENCES:
45 C. F. R. §§160 - 164.524 et seq. (HIPAA)

California Confidentiality of Medical Information Act –

Civil Code § 56-56.16 California Health and Safety Code §§ 123110 - 123130

Title 22 C.C.R; California Code Regulation §§ 70751(b) and 71551(b)

RECORD RETENTION AND DESTRUCTION:

CROSS REFERENCE POLICIES AND PROCEDURES:

Supersedes: v.4 Workforce Access to His or Her Own Protected Health Information

NORTHERN INYO HEALTHCARE DISTRICT
NON-CLINICAL POLICY AND PROCEDURE

Title: Nursing Services Competency Plan		
Owner: Chief Nursing Officer-Interim COO	Department: Nursing Administration	
Scope: Nursing Department		
Date Last Modified: 12/30/2022	Last Review Date: No Review Date	Version: 4
Final Approval by: NIHD Board of Directors	Original Approval Date: 10/2014	

PURPOSE:

To ensure the quality of patient care, all members of the Nursing Services staff will successfully complete job description competency validation upon hire and throughout employment in order to fulfill their job responsibilities.

Resuscitation Quality Improvement (RQI) is the preferred method for competency recertification of Cardio-Pulmonary Resuscitation (CPR) skills as evidenced by 'Best Practice' recommendations through the American Heart Association and Laerdal.

POLICY:

1. Competency is assured through the following validations:
   a. On-going validation of licensure and/or required certifications based on the job description;
   b. Demonstration of competent performance during the orientation period;
   c. Annual performance feedback using the job description performance standards; and
   d. On-going competency evaluation of a prioritized focus of the job description performance standards (annual job specific competency plan) based on best practice standards.
2. The Nursing Competency Plan consists of an assessment of each nursing staff member's competency using a Competency Based Orientation Evaluation (CBOE) tool at the time of employment/transfer (pre-assessment); at the completion of orientation prior to assuming independent assignments, and annually throughout the staff member's employment with the hospital.
3. Successful completion of a competency based orientation, annual competency based feedback (evaluation) and on-going competency assessment (annual competency plan) is intended to evaluate the employee's ability to perform independently and to seek assistance as needed.
4. The annual department and/or job based competency plans (see attached format) will be developed for each department position by the Department Manager in collaboration with the Department Clinical Staff Educator (CSE) and approval by the CNO prior to the start of each calendar year.
   a. Those staff completing orientation within the Annual Competency Plan year will not complete the Annual Competency Plan because those competencies identified in the Annual Competency Plan will be covered in the orientation.
   b. Additional education mandated outside the Annual Competency Plan will be required by the orientee.
5. Standardization of generic competencies between departments will be the responsibility of the Manager/CSE/District Staff Development Specialist in consultation with the CNO.

6. An orientee may be released from orientation without being able to independently perform all the skills identified on the skills checklist.
    a. A list of skills requiring additional support prior to independent staff performance will be developed by the manager/CSE based on the CBOE.
    b. Those skills the orientee is not competent to perform independently will be shared with the House Supervisor for scheduling purposes.
    c. The staff member is required to ask for assistance in performing any skill that the staff member has not been scored competent until such time as they have completed competency demonstration.
    d. Prior to the next evaluation, those skills requiring additional support may be checked off by a preceptor.
7. Inability or failure to demonstrate competence in a routine skill will necessitate an individualized enhancement plan developed by the Nurse Manager, in collaboration with Human Resources, to help the employee meet the identified deficiencies.
    a. Continued inability to meet routine competencies within an identified time frame will necessitate further action.
8. Staff who fail to complete the annual competency plan or allow the required job license/ certification to expire will not be allowed to work.

DEFINITIONS:

1. Competency: Defined as the knowledge, skills, and ability necessary to meet the performance standards defined in the job description.
2. Clinical Staff Educator: Nursing manager and/or staff person designated with the lead preceptor role who support the completion of the department annual competency plan.
3. Performance Standard: Actions and/or skills required to meet the competency.

PROCEDURE:

1. Prior to employment, verification of initial competency by the hiring manager and/or HR will include:
    a. Completion of an interview reflective of the position being hired;
    b. License or certification verification;
    c. Job training requirements attained such as BLS, ACLS etc. or agreed upon plan to complete during orientation;
2. Each department will have a job description that has competency statements and performance standards for each position title hired.
    a. Clinical jobs will have a skills checklist with competency statement for performance standards that reflect the patient population and ages served.
3. Initial Orientation Period
    a. Nursing Staff will complete criteria during the Initial Orientation process in order to complete the 90-day initial employment period
    b. Documentation of competency will consist of the following:
        i. Current licensure/certification, if required on the job description qualifications
        ii. American Heart Training Center Certification such as BLS, ACLS, PALS if required outlined in the job description qualification, followed by quarterly competency session.
        iii. General Hospital Wide Orientation
        iv. Generic Nursing Orientation (GNO)
        v. Department Specific Orientation (DSO)
        vi. Includes a signed job description, and if applicable, skills checklist and minimal competency based orientation check off.

vii. Computer Training to be determined
viii. Successful completion of medication administration (using bar coding and Omni cell), documentation and knowledge assessment if applicable
ix. Performance feedback throughout, and
x. Knowledge assessment at the end of orientation
xi. Goals for focus to be reviewed at the annual evaluation

4. Annual competency based feedback (Evaluation) consists of:
    a. Review of Teamwork essential job functions identified on the job description (Mission, vision, Behavioral standards)
    b. Review of the Organizational Support job functions identified on the job description (HR, Code Response P&P)
    c. Review of role Job Functions from the Job Description (Nursing Process, Patient Education)
    d. Review of Skill Checklist from the Job Description
    e. Review of previous goals and additional goals for development
5. On-going Competency Plan
    a. An annual needs assessment by position is distributed to develop an on-going competency plan based on but not limited to:
        i. Needs assessment
        ii. High risk, problem prone, low/high volume, high costs processes
        iii. QA/PI findings
        iv. Population and/or age related knowledge needs
        v. New developments/updates and/or regulatory changes
        vi. New services and/or equipment
    b. Records for each staff members on-going competency will be maintained by the employee (Competency Notebook) with oversight by the employee's direct supervisor
6. Staff competency determination may include a combination of the following methods:
    a. Peer evaluation
    b. Direct observation
    c. Test completion (written or verbal)
    d. Question/answer (problem solving; case study)
    e. Skills lab including simulation and drills
    f. Didactic instruction (class attendance)
    g. Documentation review/QA-PI
    h. Computer based video/Learning Management System Software
    i. Other
7. The following actions will be taken when job certification and/or mandatory training is not completed:
    a. Licensure, certification and/or job training
        i. If licensure and/or certification are expired, the employee will be suspended without pay until licensure and/or certification is provided (may result in termination if expiration period exceeds 4 weeks)
        ii. If job training requirements such as BLS, ACLS, PALS etc. are not met on or expired, the employee will be suspended without pay until training is achieved (may result in termination if job training is not completed in 4 weeks).
        iii. Exceptions for job training may be made in accordance to HR P&P to accommodate ADA. Scheduling needs to be reflective of any accommodations made for job training requirements.
        iv. The employee may not work in another job classification because the employee did not achieve the required job training, licensure and/or certification
    b. Mandatory Training

i. If staffs are not able to attend the scheduled training, the manager is to be notified. If the Manager approves no attendance or the staff member is on a leave etc., the staff member may need to complete the check-off with the Department Designated Lead Educator prior to returning to work or taking a patient care assignment

c. Annual Competency Plan
   i. If staffs are unable to complete training for the annual competency plan by the end of the calendar year, the staff member will be suspended without pay (may result in termination if job training is not complete in 4 weeks)
   ii. The staff member cannot work until the competency plan requirements are completed

8. Each situation where staffs are unable to complete mandatory training, licensure, certification and/or job training will be reviewed by the Manager and CNO in collaboration with Human Resources prior to termination

REFERENCES:

1. TJC (January 2022) CAMCAH. Functional Chapter Human Resources, Standards HR.01.05.03, HR 01.06.01. Joint Commission Resources, Oakbrook Terrance, Illinois
2. TJC (January 2022) CAMCAH Functional Chapter Nursing, Standard NR 02.03.01. Joint Commission Resources, Oakbrook Terrance, Illinois.

CROSS REFERENCED POLICIES AND PROCEDURES:

1. Competency Plan
2. Floating Nursing Workforce
3. Hiring – background screening
4. Orientation
5. Cross Training Nursing Staff (under development)
6. Orientation to Nursing Departments
7. Orientation/Cross Training Time Frames
8. Competency Notebook

RECORD RETENTION AND DESTRUCTION:

Orientation and Competency training documentation are maintained within the Competency Notebook for the Nursing Departments for 3 years. Annually the records are sent to the Human Resources (HR) Department to be maintained within the Employee's HR file. HR maintains responsibility for storage and destruction of HR files for the duration of employment + six (6) years.

Supersedes:

NORTHERN INYO HEALTHCARE DISTRICT
NON-CLINICAL POLICY AND PROCEDURE

Title: Orientation/Cross Training Time Frames		
Owner: Chief Nursing Officer-Interim COO	Department: Nursing Administration	
Scope:		
Date Last Modified: 12/30/2022	Last Review Date: No Review Date	Version: 2
Final Approval by: NIHD Board of Directors	Original Approval Date:	

PURPOSE:
To set a time frame on the number of hours paid to each orientee to become competent in a job position hired or cross trained.

DEFINITIONS:
Orientation: The process of assisting new and/or transferring personnel in gaining the knowledge and skills (competency verification/validation) to function in a particular position at Northern Inyo Healthcare District (NIHD).

Cross Training: The process of assisting an employee who has completed orientation in one department to gain knowledge and skills (competency verification/validation) to function in another department and/or position. Cross Training only occurs after the employee is competent to function in their hired role.

Float Training: The process of assisting an employee to gain knowledge of shift activity with the support of a resource RN. Staff will function within the competencies of their Job Description.

POLICY:
1. Established time frames are a guide for orientation/cross training to positions within Nursing Services.
2. The manager of the department where the employee is hired must approve exceptions to the established time frames.
3. Each department will track/monitor the orientation /cross training time frames of all non-exempt direct care staff including but not limited to: Registered Nurse (RN), Licensed Vocational Nurse (LVN), Certified Nursing Assistants (CNA), and Department Clerks.
4. Cross Training requires the staff member to complete annual competency validations for the department in order to maintain cross-trained status. Minimum hour requirements must be met. (See Union Contract for RN union eligible nurses.) Annual performance appraisals for the cross-trained position are required and will be performed by the manager/director of the department to which they are cross-trained.
5. RN Staff floating to a department who are not cross-trained will be given a float orientation to the department including an RN resource.

PROCEDURE:
1. The following time frames are to be used as a guideline by the Manager to complete the orientation process.

Category of employee	Time Frame
a. Employee with experience in clinical area	2-3 weeks
b. Experienced employee entering new clinical area	3-6 weeks
c. Recently graduated nurse (less than one year experience as an RN/LVN)	7 weeks
d. Department Clerk with experience	2 weeks
e. Certified Nursing Assistant/Tech/Dept. Clerk	3-4 weeks
f. Nursing Assistant/ERT/CSP Tech with experience	2-3 weeks
g. Coordinator/Manager/Director	90 days
h. House Supervisor without management experience	2-3 weeks
i. House Supervisor without management experience new to NIH	3-4 weeks
j. House Supervisor with management experience	2-3 shifts
k. Surgery RN/ST without experience	6-9 months
l. Surgery RN/ST with experience	6-8 weeks
m. OB RN without experience	6-9 months
n. OB RN with experience	2-3 weeks

REFERENCES:

1. TJC (January 2023) CAMCAH Human Resources Chapter. Standard HR.01.04.01 EP 1 & 3, Joint Commission Resources, Oakbrook, Illinois.

RECORD RETENTION AND DESTRUCTION:

Maintain competency validations for duration of employment, plus six (6) years.

CROSS REFERENCE POLICIES AND PROCEDURES:

1. Orientation to nursing departments
2. 02-03 Orientation

Supersedes: v.1 Orientation/Cross Training Time Frames*

NORTHERN INYO HEALTHCARE DISTRICT
NON-CLINICAL POLICY AND PROCEDURE

Title: Nursing Students Requesting Clinical Preceptorship Rotation		
Owner: Chief Nursing Officer-Interim COO	Department: Nursing Administration	
Scope: Nursing, HR, Employee Health, Infection Prevention		
Date Last Modified: 12/30/2022	Last Review Date: No Review Date	Version: 2
Final Approval by: NIHD Board of Directors	Original Approval Date: 04/20/2016	

PURPOSE:
To define requirements for allowing students to precept with Northern Inyo Healthcare District (NIHD) Nursing Staff.

POLICY:
1. Preceptorship rotations for nursing students at NIHD may be established through collaboration with the CNO and/or Manager of Nursing Unit where the rotation is to occur.
2. A written agreement between the academic institution and NIHD must be on file prior to student participation in patient care.
   a. The Instructor will make contact with the Chief Nursing Officer (CNO).
   b. CNO will review with the Nursing Unit Manager to determine acceptability of providing preceptorship based on current staffing and other various challenges.
   c. Preceptor options will be identified by Nurse Manager and opportunities presented to candidate(s).
   d. Preceptor commitment must be obtained in order to accept student rotation at NIHD.
3. NIHD Preceptor student's requisites (see attached checklist) must be completed prior to the start of the preceptor rotation.
4. The student will be under the direct supervision of the assigned preceptor at all times. The Preceptor shall supervise the nursing student when the student provides patient care, treatment, or services as part of their training. The Registered Nurse Preceptor has responsibility for the care of assigned patients.

DEFINITION:
1. Preceptor: An experienced staff nurse who generally has extensive work experience and knowledge of the clinical department. The Preceptor should be dedicated to helping other nurses or students advance in their careers; provides feedback on Preceptee strengths and weaknesses and offers suggestions for improvement in tasks and behaviors.

PROCEDURE:
I. NIHD Clinical Site Requirements oversight by Nursing Management (CNO and Nurse Manager):
   1. CNO supports clinical site selected for rotation.
   2. CNO provides management and preceptor contact information for the College/University.
   3. CNO assure contract/agreement is complete and current between College/University and NIHD.
   4. Manager oversees orientation to NIHD.
   5. Manager supports Preceptee involvement in daily nursing staff activities as appropriate for level and objectives.

II. Procedure Student Requirements:

1. See attached Role of a Student Preceptee.
2. Students will be required to complete compliance and infection control training modules, assigned via the District Education Department and be cleared by the Human Resources department prior to beginning clinical rotations at the District.
3. Share your objectives/skills sign off with your preceptor.
4. Review your competency achievements on a regular basis (weekly) with your preceptor and your clinical faculty liaison.

III. Procedure Instructor/Liaison:

1. Seek opportunity by contacting CNO at NIHD to establish need and participate in contract process.
2. Seek feedback from student and the NIHD preceptor on progress and developments.
3. Provide feedback to student and NIHD/preceptor on progress and development.
4. Be available for questions, problem identification and resolution.
5. Supports process where the health screening records are maintained and made available upon request for the student. Understands the student must be in good health to participate in clinical preceptee rotation at NIHD.

IV. Procedure Role of the Preceptor:

1. Participate in identification of learning needs of the nursing Preceptee.
2. Set goals with the Preceptee in collaboration with the faculty and curriculum.
3. Act as role model.
4. Recognize that the student needs an environment of support, feedback and inquiry.
5. Provide patient care in accordance with established, evidence based nursing practice standards.
6. Fulfill nursing duties according to Job Policies & Procedures and Standards of Care.
7. Demonstrate leadership skills in problem solving, decision making, priority setting delegation of responsibility and in being accountable.
8. Recognize nursing role elements may be new to the student.
9. All documentation by the preceptee must be co-signed by the preceptor.
10. Facilitate the student's professional socialization into the new role and with other staff.
11. Provide student with feedback on his/her progress, based on preceptor's observation of clinical performance, assessment of achievement of clinical competencies and patient care documentation.
12. Plan learning experiences and assignments to help the student meet weekly professional and clinical goals.
13. Consult with clinical faculty as necessary
14. Consult with Manager on any problems/issues that arise.
15. Participate in on-going student evaluation and ability to meet goals and skills check list.

REFERENCES:

1. The Joint Commission (CAMCAH Manual) July 1, 2022; Standards: NR.02.01.01 and NR.02.02.01
2. The Joint Commission (CAMCAH Manual) July 1, 2022; Standards: HR.01.02.07 EP 5.
3. The Joint Commission (CAMCAH Manual) July 1, 2022; Standards: IC.01.04.01 EP 1.

RECORD RETENTION AND DESTRUCTION:

Records are maintained by the College or University on Nursing Students, including health records, performance feedback documentation.

CROSS REFERENCED POLICIES AND PROCEDURES:

1. Nursing Student Medication Administration/Supervision
2. Responsibilities of Nursing Students and District Staff

Supersedes: v.1 Nursing Students Requesting Clinical Preceptorship Rotation*

NORTHERN INYO HEALTHCARE DISTRICT
NON-CLINICAL POLICY AND PROCEDURE

Title: Business Associate Agreements Execution and Management		
Owner: Compliance Officer	Department: Compliance	
Scope: District Wide		
Date Last Modified: 08/09/2023	Last Review Date: No Review Date	Version: 4
Final Approval by: NIHD Board of Directors	Original Approval Date: 12/16/2015	

PURPOSE

To establish guidelines for Northern Inyo Healthcare District to identify those relationships which meet the HIPAA definition of a "business associate" and provide direction on the process by which a business associates agreement will be established.

DEFINITIONS:

Business Associate (BA): an individual or entity, who is not a member of Northern Inyo Healthcare District's workforce, who performs functions or activities on behalf of, or provides services to, NIHD that involve access by the business associate to PHI

Business Associate Agreement (BAA): a written contract with the business associate that establishes specifically what the business associate has been engaged to do and requires the business associate to comply with the HIPAA Privacy and Security Rules' requirements to protect the privacy and security of protected health information

Covered Entity (CE): health plans, providers of health services, and clearinghouses that transmit any health information in electric form; for the purposes of this policy NIHD is a "provider" CE

Protected Health Information (PHI): information about health status, provision of health care, or payment for health care that is created or collected by a Covered Entity and can be linked to an individual (also called Individually Identifiable Health Information)

POLICY:

1. Business Associate Agreements will be established with all Business Associates who create, receive, maintain, or transmit PHI on behalf of Northern Inyo Healthcare District.
2. BAAs will meet the applicable requirements of 45 CFR § 164.504(e).
3. BAAs will be revised and re-signed as laws and regulations governing BAAs are updated and implemented by the Federal Government.
4. Departments currently receiving services from the Business Associate will, in collaboration with the Privacy Officer, identify Business Associates.
5. The Privacy Officer or Chief Executive Officer may execute Business Associate Agreements.

PROCEDURE:

1. For any new contractual agreements to be entered into by the District, District administration will ensure that the Compliance Department is notified to assess the need for a BAA. This may be done by entering a ticket into the contract lifecycle management software or emailing the Compliance team for assistance.
2. The Compliance Department will send the BAA to the correct contact for the BA.

3. Once completed, the fully executed BAA will be maintained in the contract lifecycle management software by the Compliance Department.

REFERENCES:

1. 45 CFR § 164 Subpart E
2. 45 CFR § 164.502(e)(1)

RECORD RETENTION AND DESTRUCTION:

CROSS REFERENCED POLICIES AND PROCEDURES:

1. Vendor Credentialing

Supersedes: v.3 Business Associate Agreements Execution and Management

NORTHERN INYO HEALTHCARE DISTRICT
NON-CLINICAL PROCEDURE

Title: Governmental Agent Services		
Owner: Compliance Officer	Department: Compliance	
Scope: District Wide		
Date Last Modified: 12/05/2023	Last Review Date: No Review Date	Version: 4
Final Approval by: Executive Committee	Original Approval Date: 05/20/2014	

PURPOSE:
To set forth hospital policy governing the conditions and terms allowed for service provided by outside governmental agents to patients at Northern Inyo Healthcare District (NIHD) and for the identification of regulatory agency personnel.

POLICY:
1. Governmental agents (Agent) from governmental agencies including but not limited to:
    a. Inyo County Mental Health/Behavioral Health
    b. Inyo County Child Protective Services
    c. Inyo County Adult Protective Services
    d. CDPH Facility Evaluator

    Agents may be summoned to provide services at NIHD only by nursing supervisors and law enforcement personnel.
2. An Agent will be allowed to perform services for a patient only after meeting with the nursing supervisor on duty.
3. The nursing supervisor will verify that the Agent is wearing an identification badge. If the agent is not wearing an identification badge, the Agents identity will be verified by contacting the agency's home office, and validating name/title/badge number. Inyo County Agent identification can be confirmed against the Inyo County personnel list available on the hospital Intranet.
4. Nursing Supervisor or designee will escort the Agent to the Patient's location.
5. Upon completion of the Agent's service evaluation of the patient, the Agent may be given temporary work space designated by NIHD Management. Such work space will be isolated from areas where Protected Health Information is accessible. No NIHD employee may give an Agent access to the NIHD information system or computer network.
6. If an Agent needs Internet access for their personal laptop, the Nursing Supervisor may assist the Agent by providing the "Guest Password" for the NIHD Internet access.
7. Only Agents whose credentials have been verified will be allowed to enter patient care areas. Agent credentials may be verified by contacting the agency's home office and confirming name/title/badge number.

PROCEDURE:

If any person or persons identifying themselves as Inyo County staff is encountered, immediately escort the person(s) to a nursing supervisor.

If any person or persons identifying themselves as regulatory surveyors (e.g. from The Joint Commission (TJC), California Department of Public Health (CDPH) or Office of Civil Rights (OCR) is encountered, immediately escort the person(s) to one of the following (in order of preference):
1. Chief Executive Officer

2. Administrator-on-call
3. Chief Nursing Officer
4. Chief of Operations
5. Compliance Officer
6. Chief Human Resources Officer
7. Nursing Supervisor

Administrative personnel will:

1. Make a photocopy of the identification of the surveyor or write down relevant information for verification purposes. This includes name, title, and badge number.
2. CDPH – Call the agency to verify the legitimacy at **909-383-4777**
3. TJC – Validate that the survey is legitimate by accessing your Joint Commission extranet site.
    a. Access the Joint Commission's website at www.jointcommission.org
    b. Click on "the Joint Commission Connect" logo
    c. Enter a login and password

    Your organization's extranet site contains the following information (posted by 7:30 a.m. on the morning of your survey):
    - Notification of scheduled Joint Commission event authorizing the surveyor's presence for the unannounced survey
    - Surveyor name(s), picture and biographical sketch
    - Scheduled survey dates
4. Assign a hospital employee to accompany the surveyor(s) during their survey

In the event that the surveyor(s) refuse to allow their identification to be documented for verification or if the administration suspects that the surveyor is an imposter:

1. Call the local **Police – 873-5866**

Go to The Joint Commission (TJC) website and fill out the Homeland Security Incident Report (even if the imposters claim to be from another agency)

CROSS REFERENCES POLICIES AND PROCEDURES:

Supersedes: v.3 Governmental Agent Services

NORTHERN INYO HEALTHCARE DISTRICT
NON-CLINICAL POLICY

Title: Financial Assistance Policy		
Owner: Chief Executive Officer	Department: Fiscal Services	
Scope: District Wide		
Date Last Modified: 12/06/2023	Last Review Date: No Review Date	Version: 3
Final Approval by: NIHD Board of Directors	Original Approval Date: 02/15/2017	

PURPOSE:

To define the parameters of eligibility, amount of aid possible, and the process of access to the Financial Assistance Program mandated by California **Health and Safety Code Section** (CA HSC) **127400-127446.**

DEFINITIONS:

CA HSC 127400: As used in this article, the following terms have the following meanings:

(a) "Allowance for financially qualified patient," means, with respect to services rendered to a financially qualified patient, an allowance that is applied after the District's charges are imposed on the patient, due to the patient's determined financial inability to pay the charges.

(b) "Federal poverty level (FPL)" means the poverty guidelines updated periodically in the Federal Register by the United States Department of Health and Human Services under authority of subsection (2) of Section 9902 of Title 42 of the United States Code.

(c) "Financially qualified patient" means a patient who is both of the following:

(1) A patient who is a self-pay patient, as defined in subdivision (f), or a patient with high medical costs, as defined in subdivision (g).

(2) A patient who has a family income that does not exceed 400 percent of the federal poverty level.

(d) "Hospital" means a facility that is required to be licensed under subdivision (a), (b), or (f) of Section 1250, except a facility operated by the State Department of State Hospitals or the Department of Corrections and Rehabilitation. Northern Inyo Healthcare District includes a hospital and clinics, referred to as "the District".

(e) "Department" means the Department of Health Care Access and Information.

(f) "Self-pay patient" means a patient who does not have third-party coverage from a health insurer, health care service plan, Medicare or Medicaid, and whose injury is not a compensable injury for purposes of workers' compensation, automobile insurance, or other insurance as determined and documented by the hospital"

(g) "A patient with high medical costs" means a person whose family income does not exceed 400 percent of the federal poverty level, as defined in subdivision (b). For these purposes, "high medical costs" means any of the following:

(1) Annual out-of-pocket costs incurred by the individual at the Healthcare District that exceed the lesser of 10 percent of the patient's current family income or family income in the prior 12 months.

(2) Annual out-of-pocket expenses that exceed 10 percent of the patient's family income, if the patient provides documentation of the patient's medical expenses paid by the patient or the patient's family in the prior 12 months.

(3) A lower level determined by NIHD in accordance with the District's Financial Assistance policy.

(h) "Patient's family" means the following:

(1) For persons 18 years of age and older, spouse, domestic partner, as defined in Section 297 of the Family Code, and dependent children under 21 years of age, whether living at home or not.

(2) For persons under 18 years of age, parent, caretaker relatives, and other children under 21 years of age of the parent or caretaker relative.

(i) "Reasonable payment plan" means monthly payments that are not more than 10 percent of a patient's family income for a month, excluding deductions for essential living expenses. "Essential living expenses" means, for purposes of this subdivision, expenses for any of the following: rent or house payment and maintenance, food and household supplies, utilities and telephone, clothing, medical and dental payments, insurance, school or child care, child or spousal support, transportation and auto expenses, including insurance, gas, and repairs, installment payments, laundry and cleaning, and other extraordinary expenses.

POLICY:

Northern Inyo Healthcare District (NIHD) will provide healthcare access to individuals who are uninsured, under insured, or who have high medical costs. This is available for medically necessary service/care. Federal Poverty Level Guidelines (FPL) for income will be the basis of eligibility for NIHD's Financial Assistance Program. The Notice of Available Charity and Discount Services included in this policy will be updated annually when FPL is released; using 400 percent of the government poverty income level for free, discounted, or financed care. NIHD will offer financing arrangements to ease the burden of healthcare costs. The following criteria will be followed for determining the level and type of assistance:

1. Eligibility criteria will be the applicant's, applicant's family, or entire household gross income, including alimony, child support, financial support of absent parent, and all other income from whatever source derived, coupled with household size.
2. Income from whatever source derived will be used to consider the applicant's level of responsibility. The following indicates the amount and type of assistance available:
    a. When the total income is at or below 100% of the FPL, NIHD will offer free care through the Financial Assistance application and approval process;
    b. When the total income is above 100% and equal to or lower than 200%, NIHD will offer a 25% discount and long-term financing through the Financial Assistance application and approval process;
    c. When the total income is above 200% and equal to or lower than 250%, NIHD will offer a 20% discount and long-term financing through the Financial Assistance application and approval process;
    d. When the total income is above 250% and equal to or lower than 300%, NIHD will offer a 15% discount and long-term financing through the Financial Assistance application and approval process;
    e. When the total income is above 300% and equal to or lower than 350%, NIHD will offer a 10% discount and long-term financing through the Financial Assistance application and approval process;
    f. When the income is above 350% and equal to or lower than 400%, NIHD will offer a 5% discount and long-term financing through the Financial Assistance application and approval process;

    g. When the total income is above 400%, NIHD will offer long-term financing through the Financial Assistance application and approval process;
3. Monetary assets will be considered in the determination of eligibility. For purposes of this determination, monetary assets shall not include retirement or deferred compensation plans qualified under the Internal Revenue Code, or nonqualified deferred compensation plans. Furthermore, the first ten thousand dollars ($10,000) of a patient's monetary assets shall not be counted in determining eligibility, nor shall 50 percent of a patient's monetary assets over the first ten thousand dollars ($10,000) be counted in determining eligibility.
4. Verification of the patient's household income may consist of, but not limited to, the following applicable documents:
    a. Paycheck stubs for current three months;
    b. Unemployment payment stubs;
    c. Disability payment stubs;
    d. Bank statements for current three months;
    e. Copy of current or previous year income tax return;
    f. Copy of currently approved letter or denied letter from the local social service assistance program (Medi-Cal).
5. Should the applicant have no source of income, inquiry will be made as to how the patients supports him or herself**.**
6. All other resources of coverage will first be sought. This includes, but is not limited to, any available local social service assistance program such as Medi-Cal and CCS (California Children's Services); Medicare; Insurance; employer provided or offered health plan; Inyo County Medical Services Program (CMSP); other available third party sources; participation in the Affordable Care Act.
    a. Individuals without insurance will be assisted in following the Affordable Care Act, participating in "Open" Enrollment.
    b. Written denial is required for applicants not eligible for assistance through their local department of social services or Medicaid programs.
    c. Should an applicant be eligible for Medi-Cal or other State's Medicaid programs with a Share of Cost, the applicant may NOT be entitled to the Financial Assistance Program to assist with meeting Share of Cost responsibilities. Once their Share of Cost is satisfied, the applicant's Medi-Cal will be accepted as payment for covered services.
    d. Failure to comply with timely application, (60 days from discharge date) for local social service assistance programs, or failure to complete the application for available local social service assistance programs may be a basis for denial of the NIHD Financial Assistance Program.
7. To sustain eligibility, NIHD Financial Assistance recipients will be required to submit a new Financial Assistance application every twelve months, including new application to available local social service assistance programs.
8. If any information given proves to be untrue, NIHD reserves the right to re-evaluate the application and take whatever action becomes appropriate up to disqualification and revocation of financial assistance.
9. Efforts to identify patient's qualification for NIHD Financial Assistance Program will be initiated upon receipt of the completed application and ALL supporting documents not to exceed (6) Six months from self-pay balance first statement.
10. Conditional qualification may be made in cases where eligibility for other available assistance programs has not yet been determined.
11. Individuals who do not respond to notices of Charity or Discount services, who do not respond to billing and collection efforts, and their accounts are subsequently assigned to Bad Debt and an outside collection agency will not be eligible for NIHD's Financial Assistance program adjustments.

12. Financial Assistance denials for patients based upon their income may become subsequently approved should their income change following their original determination based on additional supplied information. Subsequent determinations will not result in a refund of prior payments.
13. Effect of the determination of eligibility will not be open-ended. Charity status may be reviewed at any time during the covered time period, not to exceed one year.
14. Included in the initial billing (patient statement) of the uninsured individuals, will be the NORTHERN INYO HEALTHCARE DISTRICT REQUEST FOR HEALTH COVERAGE INFORMATION / NORTHERN INYO HEALTHCARE DISTRICT NOTICE OF OTHER COVERAGE PROGRAMS / and FINANCIAL ASSISTANCE SERVICES (included in this policy).
15. Post notices of NIHD's Financial Assistance & Discount Payment Program in all patient care areas, waiting rooms and reception areas as well as the Credit (payment) and Billing Information Office. This will include the Rural Health Clinic and all Northern Inyo Associates Offices.
16. Applications for the NIHD Financial Assistance Services will be available through Northern Inyo Healthcare District Administration, Social Services Department, and the Credit and Billing Information Office.
    a. The application will include the patient's or applicant's complete name; address; telephone number; social security number; employer; family size; income as described above; service rendered/requested; date of service; applicant's signature; and space for eligibility determination.
17. The Credit & Billing Information Staff will process complete applications within ten (10) business days.
18. Send the applicant a final determination by the US mail.
19. https://healthconsumer.org for additional assistance.

REFERENCE:

1. California Health and Safety Code Section 127400-127446.
2. CA AB 1020

RECORD RETENTION AND DESTRUCTION:

Maintain all patient accounting files for fifteen (15) years.

CROSS REFERENCE POLICIES AND PROCEDURES:

1. Billing and Collections
2. Price Transparency
3. Credit Balance Refund Processing
4. Prompt Pay Discounts
5. InQuiseek - #600 Financial Policies

Supersedes: v.2 Charity Care Program

REQUEST FOR HEALTH COVERAGE INFORMATION

NOTICE OF OTHER COVERAGE PROGRAMS

OF AVAILABLE FINANCIAL ASSISTANCE

When you presented for your recent services, it appeared that you may not have health insurance or other coverage. If this is incorrect, please contact our Credit and Billing Information office at (760) 873-2097 at your earliest convenience to provide us with your coverage information.

If you do not have health insurance coverage, or other coverage, you may be eligible for Medicare, MediCal, CMSP, or CCS.

You may contact our Credit and Billing Information office at (760) 873-2190 or your local Social Services office for an application for MediCal.

You may obtain information from the Social Security Office regarding Medicare benefits or your local county Health Department regarding CMSP, CCS benefits.

It is the policy of the Northern Inyo Healthcare District to provide a reasonable amount of care without, or below charge to people who are uninsured, under insured, or with high medical costs. Individuals within the annual income requirements established below may be eligible to receive free or discounted medical care based upon income level and family size.

2023 POVERTY GUIDELINES FOR THE 48 CONTIGUOUS STATES AND THE DISTRICT OF COLUMBIA	
Persons in family/household	**Poverty guideline**
1	$14,580
2	$19,720
3	$24,860

2023 POVERTY GUIDELINES FOR THE 48 CONTIGUOUS STATES AND THE DISTRICT OF COLUMBIA	
Persons in family/household	**Poverty guideline**
4	$30,000
5	$35,140
6	$40,280
7	$45,420
8	$50,560
For families/households with more than 8 persons, add $5,140 for each additional person.	

If you believe, you may be eligible, or if you would like more information or an application, contact the Credit and Billing Information Office, Monday – Friday 8:30a.m. - 4:30p.m. Telephone: (760) 873-2097.

NORTHERN INYO HEALTHCARE DISTRICT

CLINICAL POLICY

Title: DI Venipuncture by Radiologic Technologists		
Owner: Manager of Diagnostic Imaging Services	Department: Radiology	
Scope: Diagnostic Imaging Technologists		
Date Last Modified: 12/16/2021	Last Review Date: 12/05/2023	Version: 2
Final Approval by: NIHD Board of Directors	Original Approval Date: 05/29/2018	

PURPOSE:

To insure that radiology technologists can safely perform venipuncture for the purpose of administering medications within the scope of their practice.

POLICY:

1. A Certified Radiologic Technologist (CRT) may, under the general supervision of a licensed physician and surgeon, perform venipuncture in an upper extremity to administer contrast materials, manually or by utilizing a mechanical injector only if the radiologic technologist has been issued a certificate pursuant to California Health and Safety Code 106985(b). Only contrast materials or pharmaceuticals approved by the United States Food and Drug Administration may be used and that use shall be in accordance with the manufacturer's labeling.

2. The CRT must have completed at least the following:
    a. Received a total of ten hours of instruction, including all of the following:
        i. Anatomy and physiology of venipuncture sites.
        ii. Venipuncture instruments, intravenous solutions, and related equipment.
        iii. Puncture techniques.
        iv. Techniques of intravenous line establishment.
        v. Hazards and complications of venipuncture.
        vi. Post-puncture care.
        vii. Composition and purpose of anti-anaphylaxis tray.
        viii. 10 initial venipunctures, either on live person or mannequin venipuncture arm
        ix. First aid and basic cardiopulmonary resuscitation.

    b. Performed ten observed venipunctures under supervision of a physician, licensed nurse, or a licensed nuclear medicine technologist with venipuncture specified on their California nuclear medicine certificate.

REFERENCES:

1. California Health and Safety Code Section 106895

RECORD RETENTION AND DESTRUCTION:

- Duration of Employment + 6 years

CROSS REFERENCED POLICIES AND PROCEDURES:

- Diagnostic Imaging Department Orientation and Competency

Supersedes: v.1 DI Venipuncture by Radiologic Technologists

NORTHERN INYO HEALTHCARE DISTRICT

PLAN

Title: ALARA Program		
Owner: Manager of Diagnostic Imaging Services	Department: Radiology	
Scope: Diagnostic Imaging, Hospital Clinical Staff		
Date Last Modified: 12/07/2022	Last Review Date: 06/22/2023	Version: 3
Final Approval by: NIHD Board of Directors	Original Approval Date: 06/20/2017	

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) 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 Healthcare District, 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.
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 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 (mRem/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.

(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,

(1) Ancillary personnel are trained and educated in good health physics practices and procedures.

(2) The RSO (or designee) will schedule briefings and educational sessions to inform workers of the ALARA program efforts.

(3) 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

(1) 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.

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
   (1) 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
   (1) 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
   (1) 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
   (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.
   (2) The RSC will review the justification for and must approve or disapprove all revisions of investigational levels.

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

RECORD RETENTION AND DESTRUCTION:

- Dosimetry reports will be kept for duration of employment + 30 years
- Patient dose records will be maintained in interpretive report as part of the medical record

CROSS REFERENCE P&P:

1. Dosimetry Program - Occupational Radiation Exposure Monitoring Program
2. CHA records retention recommendations

Supersedes: v.2 ALARA Program*

NORTHERN INYO HEALTHCARE DISTRICT

CLINICAL GUIDLINES

Title: DI - Posting Requirements for Radiology		
Owner: Manager of Diagnostic Imaging Services	Department: Radiology	
Scope: Radiology Services		
Date Last Modified: 01/04/2023	Last Review Date: 12/04/2023	Version: 2
Final Approval by: Medical Executive Committee	Original Approval Date: 06-15-2016	

PURPOSE:

To articulate signs that shall be posted in the Radiology department in accordance with state and federal radiation regulations.

GENERAL GUIDELINES:

Required signs shall be displayed in a conspicuous manner. These postings include, but are not limited to the following:

1. "Radiation Area," "X-ray in Use," "Radioactive Materials," and intrusion prevention signs
2. RH2634 "Notice to Employees"
3. Inspection reports and responses
4. Emergency procedures for radiation accidents
5. Sign with the location of a current copy of regulations
6. Technologists and Physician licenses and permits, or a sign with the location of permits
7. Technique charts shall be posted at each x-ray control operator station
8. Signs stating "Inform the technologist if you are or think you may be pregnant."
9. Occupational exposure reports or a sign noting the location of reports
10. Facility registration
11. Radioactive Material License

REFERENCES: California Code of Regulations, Title 17

CROSS REFERENCED POLICIES AND PROCEDURES: N/A

Supersedes: v.1 DI - Posting Requirements for Radiology

NORTHERN INYO HEALTHCARE DISTRICT
RADIATION SAFETY PROCEDURE

Title: DI - Repeat Rate and Analysis		
Owner: Manager of Diagnostic Imaging Services	Department: Radiology	
Scope: Radiology Technologists		
Date Last Modified: 01/04/2023	Last Review Date: 12/04/2023	Version: 1
Final Approval by: Medical Executive Committee	Original Approval Date:	

PURPOSE: Ensures rejected images are analyzed for cause, for technologist performance improvement and overall reduction of patient radiation exposure.

PROCEDURE:

1. Technologist will review images for quality. Images not demonstrating adequate quality are repeated.
2. Repeat images are entered into the RIS in the repeat image tracking field.
3. Reason for repeat should be completed for each repeat image.
4. Radiologist will inform technologist and imaging leadership of quality issues with exams and provide critique of unacceptable exams sent for interpretation.
5. Repeat rate will be tracked per technologist, quarterly.
6. Departmental repeat rate should be maintained under 4% on a semi-annual basis
7. Quarterly repeat rates will be reported at the radiation safety Committee meeting.
8. A corrective action plan will be created and implemented for any employee that exceeds the 4% acceptable threshold for any two consecutive quarters.
9. If departmental repeat rate exceeds 4% over a 6-month period, Departmental corrective action planning must be presented and approved by Radiology Services Committee.

REFERENCES:

1. AHRA Radiology Policy & Procedure Manual: Third Edition. 2012. The Association for Medical Imaging Management. Sudbury, MA.
2. American College of Radiology (ACR) – American Association of Physicists in Medicine (AAPM) Radiation Safety Officer Resources, 2018.

CROSS REFERENCE POLICY AND PROCEDURES:

1. ALARA Program
2. Mammography QA - Repeat Rate Analysis
3. DI Radiation Protection for the patient

RETENTION AND DESTRUCTION OF RECORDS:

Until next inspection + six (6) years.

Supersedes: Not Set

NORTHERN INYO HEALTHCARE DISTRICT
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NORTHERN INYO HEALTHCARE DISTRICT
RADIATION SAFETY PROCEDURE

Title: DI NM General Rules for the Safe Use of Radioactive Materials		
Owner: Manager of Diagnostic Imaging Services	Department: Radiology	
Scope: Nuclear Medicine		
Date Last Modified: 12/03/2021	Last Review Date: 12/04/2023	Version: 3
Final Approval by: Medical Executive Committee	Original Approval Date: 2004	

Purpose:
The purpose of this guideline is to provide general rules for the safe use of radioactive materials.

Procedure:
The general rules listed below shall be followed at all times in the nuclear medicine department.

1. Wear laboratory coats or other protective clothing at all times in areas where radioactive materials are used.
2. Wear disposable gloves at all times while handling radioactive materials.
3. Monitor hands and clothing for contamination before leaving the area.
4. Use syringe shields for preparation of patient doses and administration to patients except in circumstances such as pediatric cases when their use would compromise the patient's well being.
5. Do not eat, drink, smoke, or apply cosmetics in any area where radioactive material is stored or used.
6. Do not store food, drink or personal items in areas where radioactive material is stored or used.
7. Wear personnel monitoring devices at all times while in areas where radioactive materials are used or stored. These devices should be worn at chest level or at waist level when device is not shielded by workbenches, etc.
8. Wear TLD finger badges during elution of generator and preparation, assay, and injection of radiopharmaceuticals.
9. Dispose of radioactive waste only in specifically designated receptacles.
10. Never pipette by mouth.
11. Survey generator, kit preparation, and injection areas for contamination at the end of the day. Decontaminate in necessary.
12. Confine radioactive solutions in covered containers plainly identified and labeled with the name of the compound, radionuclide, date, activity, and radiation level, if applicable.
13. Always label syringes to indicate the radiopharmaceutical, activity, type of study and name of patient.
14. Assay each patient dose in the dose calibrator prior to administration. Do not use any doses that differ from the prescribed dose by more than 10%.
15. Do not use radiopharmaceutical containing more than 0.15 microcurie of Mo-99 per 1.0 millicurie of Tc99m.
16. Always transport radioactive material in shielded containers.

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 AND PROCEDURES:

1. Diagnostic Imaging – Radioactive Materials Hot Lab Security
2. Diagnostic Imaging – Radioactive Materials Delivery After-Hours Procedure
3. Dosimetry Program – Occupational Radiation Exposure Monitoring Program

RETENTION AND DESTRUCTION OF RECORDS:

1. Dosimetry records – life of employment +30 years
2. Receipt and disposition of radiopharmaceuticals – 10 years

Supersedes: v.2 DI NM General Rules for the Safe Use of Radioactive Materials

NORTHERN INYO HEALTHCARE DISTRICT
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NORTHERN INYO HEALTHCARE DISTRICT
RADIATION SAFETY PROCEDURE

Title: Diagnostic Imaging - C-Arm (fluoroscope) Radiation Safety		
Owner: Manager of Diagnostic Imaging Services	Department: Radiology	
Scope: Radiology Technologist		
Date Last Modified: 12/01/2021	Last Review Date: 12/04/2023	Version: 2
Final Approval by: Medical Executive Committee	Original Approval Date: 09/14/2014	

PURPOSE: To establish procedure that maintains safety for workforce and is compliant with regulations.

PROCEDURE:

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)

RECORD RETENTION AND DESTRUCTION: Q/C records kept for 6 years

CROSS REFERENCED POLICIES AND PROCEDURES:

- Radiation Safety Committee Charter
- ALARA Program
- Diagnostic Imaging – Imaging Equipment Quality Control

Supersedes: v.1 Diagnostic Imaging - C-Arm (fluoroscope) Radiation Safety

NORTHERN INYO HEALTHCARE DISTRICT
RADIATION SAFETY PROCEDURE

Title: Diagnostic Imaging - Disposal of radioactive sharps		
Owner: Manager of Diagnostic Imaging Services	Department: Radiology	
Scope: Nuclear Medicine Technologist		
Date Last Modified: 12/06/2022	Last Review Date: 12/04/2023	Version: 4
Final Approval by: Medical Executive Committee	Original Approval Date: 09/17/2014	

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:

1. 10 CFR 20.2
2. 10 CFR 35.92

CROSS REFERENCE POLICY AND PROCEDURES:

1. Disposal of Radioactive Materials
2. Diagnostic Imaging – Radioactive Waste Storage and Disposal

RETENTION AND DESTRUCTION OF RECORDS: N/A

Supersedes: v.3 Diagnostic Imaging - Disposal of radioactive sharps

NORTHERN INYO HEALTHCARE DISTRICT

CLINICAL GUIDLINES

Title: Diagnostic Imaging - Guidelines for use of radiology equipment in other areas		
Owner: Manager of Diagnostic Imaging Services	Department: Radiology	
Scope: Hospital Wide		
Date Last Modified: 01/04/2023	Last Review Date: 12/04/2023	Version: 3
Final Approval by: Medical Executive Committee	Original Approval Date: 07/20/2014	

PURPOSE:

Provides guidance for safe and compliant operation of radiation producing machines outside of the imaging department.

GENERAL GUIDELINES:

1. The Imaging department will perform radiographic examinations outside of the imaging department upon receipt of an appropriate order for a "portable" service.
2. The portable examination shall be performed under the direction of a trained, registered and licensed radiologic technologist.
3. Appropriate radiation protection measures shall be employed in obtaining the desired study, under the direction of a trained, registered and licensed radiologic technologist.
4. Portable radiographic equipment shall be operated only by authorized personnel, under the direction of a trained, registered and licensed radiologic technologist.
5. The mobile fluoroscopic equipment (C-arm) shall always be operated by CA licensed fluoroscopy technologists, under the supervision of a licensed physician "X-ray Operator and Supervisor" or by the licensed physician "X-ray Operator and Supervisor.
6. Technologists and physicians using fluoroscopy equipment shall monitor and document the following:
    1. Radiation exposure fluoroscopy time
    2. Proper technique
    3. Use of lead apron or other appropriate radiation protection measures
7. Occupational exposure badges shall be worn at all times when there is the opportunity for occupational exposure.

REFERENCES:

1. AHRA Radiology Policy & Procedure Manual: Third Edition. 2012. The Association for Medical Imaging Management. Sudbury, MA.

CROSS REFERENCED POLICIES AND PROCEDURES:

- Diagnostic Imaging – C-Arm (fluoroscope) Radiation Safety
- Radiation Safety Committee Charter

Supersedes: v.2 Diagnostic Imaging - Guidelines for use of radiology equipment in other areas*

NORTHERN INYO HEALTHCARE DISTRICT
NON-CLINICAL POLICY AND PROCEDURE

Title: Diagnostic Imaging - Handling of Radioactive Packages, Non-nuclear medicine personnel		
Owner: Manager of Diagnostic Imaging Services	Department: Radiology	
Scope: Purchasing, Security, and Nuclear Medicine		
Date Last Modified: 11/19/2021	Last Review Date: 12/04/2023	Version: 3
Final Approval by: NIHD Board of Directors	Original Approval Date: 2014	

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 Services at ext. 2002.

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,

RECORD RETENTION AND DESTRUCTION: Training documentation to be kept 6 years after date of training

CROSS REFERENCED POLICIES AND PROCEDURES:

- DI NM radioactive package receipt
- DI NM General Rules for the Safe Use of Radioactive materials
- Diagnostic Imaging Radioactive Material Hot Lab Security

Supersedes: v.2 Diagnostic Imaging - Handling of Radioactive Packages, Non-nuclear medicine personnel

NORTHERN INYO HEALTHCARE DISTRICT

CLINICAL POLICY

Title: Diagnostic Imaging - Imaging Equipment Quality Control		
Owner: Manager of Diagnostic Imaging Services	Department: Radiology	
Scope:		
Date Last Modified: 12/06/2022	Last Review Date: 06/22/2023	Version: 2
Final Approval by: NIHD Board of Directors	Original Approval Date:	

PURPOSE:

Ensures Imaging Services equipment is operating in a manner that is safe and compliant with state and federal regulations

POLICY:

1. The imaging department technologist shall perform quality control on all imaging equipment following manufacturer recommendations located in equipment manuals.
2. Quality control limits are set by manufacturer, manufacturer's field service engineer (FSE), or the medical physicist.
3. Equipment not performing within the designated specifications shall be removed from service immediately.
4. The Director of Diagnostic Services (DDS) and radiologist shall be notified of deficiency or malfunction.
5. The DDS or designee shall contact the appropriate manufacturer or FSE, or biomedical engineer.
6. Following correction or repair, appropriate quality control shall be repeated.
7. After passing quality control standards, equipment shall be placed back into service.

REFERENCES:

- National Council on radiation protection and measurements (NCRP) Report No. 99
- California Code of Regulations – Title 17

RECORD RETENTION AND DESTRUCTION:

- Until next Inspection + 6years

CROSS REFERENCED POLICIES AND PROCEDURES:

- DI – Monitoring and Documentation of Fluoroscopic Quality Control
- Mammography Quality Control

Supersedes: v.1 Diagnostic Imaging - Imaging Equipment Quality Control*

NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL PROCEDURE

Title: Diagnostic Imaging - Maintenance of Diagnostic Imaging Equipment		
Owner: Manager of Diagnostic Imaging Services	Department: Radiology	
Scope: Radiology		
Date Last Modified: 12/13/2022	Last Review Date: 07/11/2023	Version: 2
Final Approval by: Medical Executive Committee	Original Approval Date: 12/16/2015	

PURPOSE:
To ensure the safest possible daily operation and function of diagnostic equipment at Northern Inyo Healthcare District (NIHD) for our patients and workforce; resulting in excellent diagnostic images.

PROCEDURE:

1. The hospital identifies quality control and maintenance activities to maintain the quality of diagnostic imaging equipment that include X-Ray machines, fluoroscopic equipment, Computed Tomography (CT), Magnetic Resonance Imaging (MRI), mammography, and nuclear medicine (NM) equipment images produced. The organization identifies how often these activities should be conducted.

2. The hospital maintains the quality of the diagnostic images produced.

3. Quality Control is the techniques to monitor and maintain the technical elements of the diagnostic systems to produce quality images.

4. The types of tests can consist of:

    a. Acceptance/Initial Testing - is performed on new equipment or equipment that has undergone major repairs. It is to demonstrate that is performing within the manufacturer's specifications and criteria, to detect any defects that may exist and to establish the baseline performance that may be used as a reference point in future testing.
    b. Routine performance evaluations - are specific test performed on the equipment in use after a certain period of time to verify that the equipment is performing within the previously accepted standards and to diagnose any changes in performance before becoming radiographic apparent.
    c. Error correction tests - are tests performed on malfunctioning equipment to evaluate the equipment and to verify the correct cause of the malfunction so that proper repair can be made.

5. The continuous quality improvement concept should continue to the staff member performing the functions with the equipment by being actively involved in the quality of the diagnostic image given to the medical staff.

6. The maintenance activities for each equipment producing a diagnostic image, such as computed tomography (CT), nuclear medicine (NM), or magnetic resonance imaging (MRI), should be determined through risk-based criteria as discussed in Policy on Maintaining, Testing & Inspecting Med Equipment (ME-EC.02.04.01EP4a) and the manufacturer's specifications.

REFERENCES:

1. CCR, Title 17.1.5.4 and 4.5

RECORD RETENTION AND DESTRUCTION:

1. Life of equipment plus 6 years

CROSS REFERENCED POLICIES AND PROCEDURES:

1. Equipment and Supplies preventative maintenance program
2. Inspection, Testing and Maintenance of new medical equipment

Supersedes: v.1 Diagnostic Images

NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL PROCEDURE

Title: Diagnostic Imaging - Monitoring and Documentation of Fluoroscopic Quality Control		
Owner: Manager of Diagnostic Imaging Services	Department: Radiology	
Scope: Diagnostic Technologists		
Date Last Modified: 10/28/2021	Last Review Date: 12/04/2023	Version: 3
Final Approval by: Medical Executive Committee	Original Approval Date: 04/15/2015	

PURPOSE:
Ensures that fluoroscopic quality control is completed and documented weekly, in accordance with Title 17, Section 30307

PROCEDURE:
1. Monitoring fluoroscopic tube current (mA) and potential (kVp) shall be performed and documented weekly on quality control logs provided by the medical physicist.
2. Any technologists with a fluoroscopic license may be responsible for performing the weekly quality control.
3. Responsibility and accountability for performance of weekly fluoroscopic quality control shall be assigned and maintained by Diagnostic Imaging Coordinator.

REFERENCES:
- California Code of Regulations – Title 17

RECORD RETENTION AND DESTRUCTION:
- Until next inspection + 6 years

CROSS REFERENCED POLICIES AND PROCEDURES:
- Diagnostic Imaging – Imaging equipment quality control
- Mammography Quality Control

Supersedes: v.2 Diagnostic Imaging - Monitoring and Documentation of Fluoroscopic Quality Control*

NORTHERN INYO HEALTHCARE DISTRICT
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NORTHERN INYO HEALTHCARE DISTRICT
RADIATION SAFETY PROCEDURE

Title: Diagnostic Imaging - Nuclear Medicine New Employee/Annual Orientation		
Owner: Manager of Diagnostic Imaging Services	Department: Radiology	
Scope: Nuclear Medicine Technologist		
Date Last Modified: 12/03/2021	Last Review Date: 12/04/2023	Version: 4
Final Approval by: Medical Executive Committee	Original Approval Date: 01/19/2016	

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.

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
4. 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 quarterly 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	

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

CROSS REFERENCE POLICY AND PROCEDURES:

- Diagnostic Imaging Department Orientation and Competency
- Competency Plan - district

RETENTION AND DESTRUCTION OF RECORDS:

Duration of employment + 6 years

Supersedes: v.3 Diagnostic Imaging - Nuclear Medicine New Employee/Annual Orientation*

NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL PROCEDURE

Title: Diagnostic Imaging - Ordering Privilege and Procedure		
Owner: Manager of Diagnostic Imaging Services	Department: Radiology	
Scope: Diagnostic Imaging Department		
Date Last Modified: 10/28/2021	Last Review Date: 12/04/2023	Version: 2
Final Approval by: Medical Executive Committee	Original Approval Date: 04/15/2015	

PURPOSE:

To clarify who and how diagnostic imaging orders may be placed.

PROCEDURE:

1. Orders for diagnostic imaging procedure may be accepted from any provider as outlined in the Medical Staff Bylaws) at Northern Inyo Healthcare District (NIHD).
2. Orders are submitted electronically, hand-written, or faxed to the Diagnostic Imaging Department. Verbal orders are permitted in urgent or emergent situations. Licensed professionals may take verbal orders within the scope of their practice. Verbal orders must be documented according to the NIHD Verbal Orders Policy.
3. Orders will be reviewed and the patient's exam will be performed or scheduled.
4. Technologists performing the exam shall review the order prior to performing the exam. If there are questions or concerns the technologist will consult the radiologist.
5. The radiologist, referring physician, or designee, may determine the appropriate protocol for exams.
6. If the ordered test is considered clinically inappropriate or suboptimal, the radiologist or designee will attempt to contact the ordering provider to obtain additional clinical information or request an order modification. In an urgent or emergent situation, or for patient convenience, the radiologist will modify the test if unable to contact the referring provider.
7. No diagnostic imaging exams may be performed without a provider order.
8. The Food and Drug Administration (FDA) has approved the use of "self-referral" for certain screening exams. These may be performed without a provider order when the patient meets the criteria for the screening exam.
9. During the acquisition of the ordered study, additional views, sequences, slices or images may be acquired at the request of the interpreting physician.

REFERENCES:

- **Hos**pital Condition of Participation – 42 CFR 482.26

RECORD RETENTION AND DESTRUCTION:

- Interpretive reports from exam performed will be stored in Patient Medical Record per NIHD Medical Records policies

CROSS REFERENCED POLICIES AND PROCEDURES:

1. Verbal and/or Phone Medical Practitioner Orders
2. Self-referral for Breast Screening Exams
3. DI – Standards of Care

Supersedes: v.1 Diagnostic Imaging - Ordering Privilege and Procedure*

NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL POLICY AND PROCEDURE

Title: Diagnostic Imaging - Ordering Radioactive Materials		
Owner: Manager of Diagnostic Imaging Services	Department: Radiology	
Scope: Nuclear Medicine Department		
Date Last Modified: 11/19/2021	Last Review Date: 06/22/2023	Version: 2
Final Approval by: NIHD Board of Directors	Original Approval Date: 04/15/2015	

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,

RECORD RETENTION AND DESTRUCTION: Records will be kept for 10 years

CROSS REFERENCED POLICIES AND PROCEDURES:

- DI NM General rules of the safe use of radioactive materials
- DI NM Radioactive package receipt

Supersedes: v.1 Diagnostic Imaging - Ordering Radioactive Materials*

NORTHERN INYO HEALTHCARE DISTRICT

CLINICAL POLICY

Title: Diagnostic Imaging - Radioactive Material Hot Lab Security		
Owner: Manager of Diagnostic Imaging Services	Department: Radiology	
Scope: Nuclear Medicine, Diagnostic Imaging, House Supervisors		
Date Last Modified: 12/06/2022	Last Review Date: 06/22/2023	Version: 3
Final Approval by: NIHD Board of Directors	Original Approval Date: 2014	

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, Diagnostic Imaging Departmental Leadership, House Supervisors, Radiation Safety Officer and Medical Physicists may enter the hot lab unsupervised.
3. For afterhours deliveries, please refer to the "Diagnostic Imaging - Radioactive Materials Delivery After-hours 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

RECORD RETENTION AND DESTRUCTION: N/A

CROSS REFERENCED POLICIES AND PROCEDURES:
1. Diagnostic Imaging – Radioactive Materials Delivery After-Hours procedure
2. DI NM General Rules for the safe use of Radioactive Materials

Supersedes: v.2 Diagnostic Imaging - Radioactive Material Hot Lab Security

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NORTHERN INYO HEALTHCARE DISTRICT
RADIATION SAFETY PROCEDURE

Title: Diagnostic Imaging - Radioactive Materials Delivery After-hours Procedure		
Owner: Manager of Diagnostic Imaging Services	Department: Radiology	
Scope: Nuclear Medicine		
Date Last Modified: 12/03/2021	Last Review Date: 12/04/2023	Version: 3
Final Approval by: Medical Executive Committee	Original Approval Date: 2014	

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

PROCEDURE:

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 ED clerk or other ED employee will call the Nursing Supervisor to the Emergency entrance upon arrival of a courier making delivery of radioactive isotopes.
3. The Nursing Supervisor will sign for the package and escort the courier to the Nuclear Medicine Hot Lab and unlock the door (R123 in Nuclear Medicine)
4. 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.
5. Should any problems or questions arise during the delivery, 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.
6. The house supervisor is not to handle the radioactive package at any time during the delivery process.

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. Radioactive Material Hot Lab Security
2. Radioactive Waste Storage and Disposal
3. DI NM Radioactive Package Receipt

RETENTION AND DESTRUCTION OF RECORDS: receipt records are kept for 10 years.

Supersedes: v.2 Diagnostic Imaging - Radioactive Materials Delivery After-hours Policy/Procedure

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RADIATION SAFETY PROCEDURE

Title: Diagnostic Imaging - Radioactive Waste Storage and Disposal		
Owner: Manager of Diagnostic Imaging Services	Department: Radiology	
Scope: Nuclear Medicine		
Date Last Modified: 12/03/2021	Last Review Date: 12/04/2023	Version: 3
Final Approval by: Medical Executive Committee	Original Approval Date: 09/17/2014	

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.

PROCEDURE:

1. 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.
2. Radioactive waste shall be stored in the hot lab, or designated radioactive materials storage room
3. 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.
4. Store radioactive waste for 10 half-lives and until the radiation exposure levels, at the surface, are indistinguishable from background, whichever is longer.
5. Deface or destroy all radioactive labels.
6. Discard waste that is indistinguishable from background, and has been stored greater than 10 half-lives, following regular hospital waste guidelines.
7. Log discarded trash out on the "Waste Storage Log."
8. Human excreta is not considered radioactive waste. Human waste from patients undergoing diagnostic nuclear medicine procedures shall be handled according to hospital Infectious / Non-Infections Waste Disposal Procedure.

Reference
1. 10 CFR 20.2

CROSS REFERENCE POLICY AND PROCEDURES:

1. Hazardous Materials & Waste Inventory
2. Hazardous Materials & Waste Management Plan
3. Infectious/Non-Infectious Waste Disposal Procedure

RETENTION AND DESTRUCTION OF RECORDS: 10 years

Supersedes: v.2 Diagnostic Imaging - Radioactive Waste Storage and Disposal

NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL POLICY AND PROCEDURE

Title: Dosimetry Program - Occupational Radiation Exposure Monitoring Program		
Owner: Manager of Diagnostic Imaging Services	Department: Radiology	
Scope: Diagnostic Imaging Technologists, Surgery RN and Scrub Tech		
Date Last Modified: 10/28/2021	Last Review Date: 12/16/2021	Version: 3
Final Approval by: NIHD Board of Directors	Original Approval Date: 11/18/2015	

PURPOSE:
To establish guidelines for monitoring occupational radiation exposure and ensure that radiation worker's exposure and monitoring complies with "As Low As Reasonably Achievable" (ALARA) principles.

POLICY:
In order to detect and evaluate occupational exposure to external radiation, individual monitoring devices will be issued to individuals who are likely to receive, in one year from sources external to the body, a dose in excess of 10 percent of the legal limit as defined in the ALARA Program. It is Northern Inyo Healthcare District (NIHD) policy that all Imaging technologists wear their personal radiation dosimetry badge at all times when on duty, as required by 10 CFR 20, 20.1101.

PROCEDURE:
Radiation Monitoring Badges:

1. Supervisors / Managers of employees that work in areas with potential for radiation exposure shall have a radiation ("film") badge ordered for and delivered to all employees that work within those areas.
2. NIH provide "TLD" (thermoluminescent dosimeters) badges and rings to monitor radiation exposure.
3. Employees shall wear their badge at all times while working within the defined areas where there is potential to exceed the 10% dose threshold outlined in the policy statement.
4. The badge shall be worn at collar (thyroid) level outside of lead.
5. If two (2) dosimetry badges are issued (either because of high dosimetry levels or fetal monitoring), the second badge shall be worn at waist level under lead.
6. If a finger badge is issued, this shall be worn on the hand most likely to receive the most exposure.
7. At no time will any employee deliberately tamper with a dosimetry badge, as this is ground for disciplinary action.
8. The Radiation Safety Officer shall review the records quarterly, and all employees shall have access to their records at any time.
9. A record that does not contain sensitive information shall be posted at the employee information board in the Imaging Department.
10. All original records shall be kept for the duration of licensure of the hospital as required by the state and/or the NRC.
11. Review of staff dosimetry monitoring shall be conducted at least every quarter by the Radiation Safety Officer, Diagnostic Medical Physicist or Health Physicist. The review shall assess if the staff

radiation exposure levels are within ALARA levels set by the US Nuclear Regulatory Commission's 10 CFR 20 Standards for Protection Against Radiation regulation.

12. Occupational workers approaching maximum allowable exposure shall be counseled. A physicist shall review exposures for accuracy and explanation.
13. NRC regulations prohibit the occupational worker who reaches maximum allowable radiation exposure from additional exposure to occupational sources of radiation for the duration of the period (quarter/annual). NIHD shall ensure the occupational worker receives no additional occupational radiation from registered or licensed sources.
14. Area exposure badges are used to measure background radiation within the DI department and are placed and removed from the bulletin board in the DI employee hallway coinciding with employee dosimetry badge distribution. Area monitoring reports will be reviewed by RSO in conjunction with employee dosimetry report review.
15. Control badges shall be kept in an area free from radiation exposure. At NIHD, control badges will be stored in the diagnostic Imaging break room. Control badges are used by the radiation badge company to monitor background radiation at the facility. Control badges are used to accurately calculate occupational exposure.

ATTACHMENTS:

1. U.S. Nuclear Regulatory Commission Regulatory Guide 8.13, Rev. 3, June 1999
2. Declaration of Pregnancy Form Letter

REFERENCES:

1. US Nuclear Regulatory Commission (USNRC), NRC Library, Document Collections, NRC Regulations (10 CFR), *Part 20 - Standards for Protection Against Radiation,*, http://www.nrc.gov/reading-rm/doc-collections/cfr/part020/
2. 10 CFR 20→ Subpart C → §20.1201
3. U.S. Nuclear Regulatory Commission Regulatory Guide 8.13, Rev. 3, June 1999

RECORD RETENTION AND DESTRUCTION:

- Duration of Employment +30 years

CROSS REFERENCED POLICIES AND PROCEDURES:

1. ALARA Program
2. CT Radiation Safety Policy
3. Radiology Services Pregnant Personnel

Supersedes: v.2 Dosimetry Program - Occupational Radiation Exposure Monitoring Program*

NORTHERN INYO HEALTHCARE DISTRICT
DIAGNOSTIC IMAGING PROCEDURE

Title: Mammography Medical Audit Procedure		
Owner: Manager of Diagnostic Imaging Services	Department: Radiology	
Scope: Medical Staff OPPE		
Date Last Modified: 12/03/2021	Last Review Date:	Version: 2
Final Approval by: Medical Executive Committee	Original Approval Date: 02-2012	

PURPOSE:

To define how Northern Inyo Healthcare District collects and reviews outcome data for all mammograms performed within the district.

PROCEDURE:

1. Northern Inyo Healthcare District collects mammography outcome data in a Mammography Information System (MIS)
2. Outcome data will be required by all providers providing interpretive reports on Mammography exams and such reports will include, at a minimum:
    a. Follow up on the disposition of all positive mammograms.
    b. Correlation of pathology results
3. Quarterly, the summary outcome data reports will be submitted for review to the Radiology Services Committee and the medical staff office as a component of On-going Professional Practice Evaluation (OPPE) and Focused Professional Practice Evaluation (FPPE).

REFERENCES: CCR Title 17 Section 30317.30

CROSS REFERENCE POLICY AND PROCEDURES:

1. Diagnostic Imaging – Mammography Compliance Requirements

RETENTION AND DESTRUCTION OF RECORDS:

1. Length of practitioner's career at NIHD + 6 years

Supersedes: v.1 Mammography Medical Audit Policy

NORTHERN INYO HEALTHCARE DISTRICT
COMMITTEE CHARTER

Title: Radiation Safety Committee Charter		
Owner: Manager of Diagnostic Imaging Services	Department: Radiology	
Scope: Diagnostic Imaging Team		
Date Last Modified: 11/01/2021	Last Review Date: 12/04/2023	Version: 2
Final Approval by: Executive Committee	Original Approval Date: 08/16/2005	

COMMITTEE PURPOSE:

This guideline is to establish a Radiation Safety Committee (RSC) to review and/or establish radiation safety policies and procedures in accordance with California Title 17 regulations.

COMMITTEE MEMBERSHIP

The Northern Inyo Healthcare District RSC shall consist of at least:

1. A physician specializing in nuclear medicine or diagnostic radiology who is an authorized user on the Radioactive Materials License
2. An additional provider or employee who is particularly knowledgeable about radioactive materials and/or radiation producing machines use for diagnosis, therapy, or research.
3. A representative of the hospital's management
4. A representative of the nursing service

FREQUENCY OF MEETINGS:

The RSC shall meet at least annually per regulation.
Minutes of all such meetings shall be maintained for review and inspection.

COMMITTEE GOALS AND RESPONSIBILITIES:

1. Be familiar with all pertinent California regulations, the terms of the license, and information submitted in support of the request for the license and its amendments.
2. Review the Northern Inyo Healthcare District's ALARA program annually.
3. Review the training and experience of any individual who uses radioactive material or radiation machines (including physicians, physicists, and pharmacists) and determine that the qualifications are sufficient to enable them to perform their duties safely and in accordance with California regulations and the conditions of the license.
4. Establish a program to ensure that all individuals whose duties may require them to work in the vicinity of radioactive material or radiation machines (e.g., nursing, security, and environmental services workers) are properly instructed as required by section 30280.
5. Review and approve all requests for use of radioactive material within the institution prior to forwarding the request to the Department.
6. Prescribe special conditions that will be required during a proposed use of radioactive material or radiation machines such as requirements for bioassays, physical examinations of users, and special monitoring procedures.

7. Review and approve or disapprove, with advice and consent of the Radiation Safety Officer (RSO) and the management representative, minor changes in radiation safety procedures.
8. Review quarterly, with the assistance of the RSO, a summary of all radiation dose records and all incidents involving radioactive materials and radiation-producing equipment with respect to cause and corrective actions.
9. Establish a table of investigational levels of individual occupation radiation exposures.
10. Review the entire radiation safety program at least annually to determine that all activities are being conducted safely and in accordance with California regulations and the conditions of the license. The review shall include shall include an examination of all records, reports from the RSO, results of California inspections, written safety procedures, and management control system.
11. Recommend remedial action to correct any deficiencies identified in the radiation safety program.
12. Maintain written records of all committee meetings, actions, recommendations, and decisions.

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. United States Nuclear Regulatory Commission; Subpart B

RECORD RETENTION AND DESTRUCTION:

Supersedes: v.1 Radiation Safety Committee*

NORTHERN INYO HEALTHCARE DISTRICT

CLINICAL POLICY

Title: Radiology Services Pregnant Personnel		
Owner: Manager of Diagnostic Imaging Services	Department: Radiology	
Scope: Radiology Technologist		
Date Last Modified: 10/28/2021	Last Review Date: 12/04/2023	Version: 3
Final Approval by: NIHD Board of Directors	Original Approval Date:	

Purpose: Teratogenic effects of ionizing radiation in the first trimester of pregnancy have long been known. Although the reported epidemiological association of excess risk in childhood cancer with prenatal radiation exposure of 1 to 10 Rem to the embryo, or fetus, is still uncertain, it is conservative radiation protection philosophy to assume that such a risk may exist. This policy will define Northern Inyo Healthcare District's (NIHD) response to this condition.

Policy:

NIHD will take all necessary steps to reduce the exposure of pregnant personnel to as low as reasonably achievable.

Although not required, as soon as a radiology technologist believes that she is pregnant, it is highly recommended that she notify Diagnostic Imaging leadership.

The following specific technical assignments will be allowed:

1. General radiography and fluoroscopy in the department
2. Computed Tomography, mammography, MRI and ultrasound
3. Surgery and portable radiography.

Under no circumstances will pregnant technologists be allowed to hold patients.

Management will notify all appropriate personnel of the pregnancy so that all staff may make every reasonable attempt to ensure that pregnant technologists and technologists in general perform examinations prior to the administration of radionuclides from nuclear medicine.

A second body dosimetry badge shall be acquired for pregnant personnel. It shall be worn at the midsection. When a lead apron is worn, it shall be a wrap-around, and the badge shall be worn under the apron. The dosimetry company shall be informed of the badge's purpose for proper record keeping.

The Radiation Safety Officer shall be notified so that potential radiation exposure to the pregnant individual can be evaluated.

1. The occupational exposure of the expectant mother shall not exceed 500 mRem during the full gestational period. (Source: National Council on Radiation Protection and Measurements)
2. Pregnant personnel shall read the pregnancy advisory literature (Appendices A and B, 8.13-3 through 8.13-7, see attachments on left sidebar) and document that fact on the Declaration of Pregnancy form.

REFERENCES:

- National Council on Radiation Protection and Measurements
- American College of Radiology

RECORD RETENTION AND DESTRUCTION:

- Duration of Employment plus 30 years

CROSS REFERENCED POLICIES AND PROCEDURES:

- Pregnant Personnel in the Perioperative Unit*
- Dosimetry Program – Occupational Radiation Exposure Monitoring Program”

Supersedes: v.2 Radiology Services Pregnant Personnel

Declaration of Pregnancy

To: _____, Radiology Department Manager

In accordance with the NRC's regulations at 10 CFR 20.1208, "Dose to an Embryo/Fetus," I am declaring that I am pregnant. I believe I became pregnant in _____ (only the month and year need to be provided).

I understand the radiation dose to my embryo/fetus during my entire pregnancy will not be allowed to exceed 500 mrem (millirem) (unless that dose has already been exceeded between the time of conception and submitting this letter). I also understand that meeting the lower dose limit may require a change in job or job responsibilities during my pregnancy.

I have received and read Appendices A and B, "Effects on the Embryo/Fetus of Exposure to Radiation and Other Environmental Hazards" and "Pregnant Worker' Guide.

_____

Your Signature

_____

Your printed name

_____

Date