Northern Inyo County Local Hospital District

Board of Directors Regular Meeting

Wednesday February 18, 2009 5:30pm

Board Room
Northern Inyo Hospital

AGENDA

NORTHERN INYO COUNTY LOCAL HOSPITAL DISTRICT
BOARD OF DIRECTORS MEETING

February 18, 2009 at 5:30 P.M.

In the Board Room at Northern Inyo Hospital

1. Call to Order (at 5:30 P.M.).
2. Opportunity for members of the public to comment on any items on this Agenda.
3. Approval of minutes of the January 21, 2009 regular meeting.
4. Financial and Statistical Reports for the month of December 2008; John Halfen.
5. Administrator's Report; John Halfen.

   A. Building Update

   B. Bonds

   C. F.Y.I. Section

   - Legislation update from AHA

   D. Other

6. Chief of Staff Report – Richard Nicholson, M.D..
   A. Hospital wide Policies / Procedures (*action items*):
      1. Drugs of Abuse Maternal and Infant
      2. Implantation of Medical Devices
      3. Exposure Evaluation
      4. Sputum Induction
      5. Liberation from Mechanical Ventilator
   B. Proctoring extension (*action item*)
   C. Provisional Obstetrical privileges grant (*action item*).
   D. Temporary privileges granted.
   E. Other
7. Old Business
   A. Reaffirmation of John Halfen as negotiator regarding potential acquisition of real property at 2957 Birch Street, Bishop, California. Negotiation will be with the designee(s) of Southern Mono County Healthcare District (*action item*).
8. New Business
   A. Advance payroll check policy (*action item*).
   B. Capital purchase, Lab Coagulation analyzer, $30,520 (*action item*).
9. Reports from Board members on items of interest.

10. Opportunity for members of the public to comment on any items on this Agenda, and/or on any items of interest.
11. Adjournment to closed session to:
    A. Hear reports on the hospital quality assurance activities, and hear a report from the Medical Staff Executive Committee (Section 32155 of the Health and Safety Code, and Government Code Section 54962).
    B. Instruct negotiator regarding price and terms of payment for the purchase, sale, exchange, or lease of a real property (Government Code Section 54956.8).
    C. Confer with legal counsel regarding pending litigation against the District by an employee (Government Code Section 54956.9(a)).
    D. Conduct CEO Annual Performance Evaluation and compensation (Government Code Section 54957).
12. Return to open session, and report of any action taken in closed session.
13. Possible discussion of, possible cancellation of Radiology Medical Director contract. (*action item*).
14. Opportunity for members of the public to address the Board of Directors on items of interest.
15. Adjournment.

THIS SHEET

INTENTIONALLY

LEFT BLANK

CALL TO ORDER	The meeting was called to order at 5:35 p.m. by Peter Watercott, President.
PRESENT	Peter Watercott, President John Ungersma, M.D., Vice President M. C. Hubbard, Secretary D. Scott Clark, M.D., Director
ALSO PRESENT	John Halfen, Administrator Richard Nicholson, M.D., Chief of Staff Douglas Buchanan, Esq., District Legal Counsel Sandy Blumberg, Administrative Secretary
ABSENT	Michael Phillips, M.D., Treasurer
PUBLIC COMMENTS ON AGENDA	Mr. Watercott asked if any members of the public wished to address the Board on any items listed on the agenda for this meeting. No comments were heard.
MINUTES	The minutes of the October 15, 2008 and December 3, 2008 regular meetings; and the minutes of the December 3, 2008 special meeting were approved.
ADMINISTRATOR'S REPORT	
FINANCIAL AND STATISTICAL REPORTS	John Halfen, Chief Financial Officer reviewed with the Board the financial and statistical reports for the month of November 2008. Mr. Halfen noted the statement of operations shows a bottom line excess of revenues over expenses of $7,984. Mr. Halfen called attention to the following: *–Inpatient and outpatient service revenue were both under budget* *–Total expenses were slightly under budget* *–Salaries and wages were over budget* *–Professional fees expense was over budget* *–The Balance Sheet showed no significant change* *–Year-to-date net income is $1,717,777* Mr. Halfen noted it is not surprising for revenue to be down during the months of November and December. He also reviewed the status Hospital investments, including cash and cash equivalent assets that will be needed to help fund the Hospital rebuild project. Mr. Halfen also reported he has moved most of Northern Inyo Hospital (NIH)'s money out of the Local Agency Investment Fund (LAIF). He reviewed a new monthly report detailing revenue earned per hospital department, which also compares this year's totals to prior year totals. It was moved by M.C. Hubbard, seconded by John Ungersma, M.D. and passed to approve the

financial and statistical reports for the month of November 2008 as presented.

ADVANCE BENEFICIARY NOTICE

FYI SECTION

Mr. Halfen reported the Hospital Laboratory Department has developed a method to deal with Advance Beneficiary Notices for Medicare patients, which advises those patients prior to tests being done if Medicare is not likely to approve payment for those services.

22,443

Mr. Halfen informed the group that 22,443 is the number of cookies the Dietary Department produced in the kitchen during the 2008 calendar year.

EMPLOYMENT APPLICATIONS

Mr. Halfen referred to an article about Starbucks Corporation, which reports that employers may no longer ask prospective employees about their history of conviction of certain types of felonies.

ECONOMY UPDATE

Mr. Halfen also called attention to information regarding current economic conditions, and reported that unemployment in Inyo County has reached 11%. It is expected that the current recession may effect the hospital in several ways, including fewer patients coming in for non-emergent services; an increase in bad debt and collections issues; and the possibility that the State of California may issue warrants (instead of checks) for payment to hospitals for services.

FOUNDATION DONATION, DR. REID

Mr. Halfen reported that Tom Reid, M.D. has donated $2,500 of Everest Challenge bike race proceeds to the Northern Inyo Hospital Foundation. The Board expressed its gratitude to Dr. Reid for his generosity.

OTHER

Mr. Halfen also reported the Hospital is in the process of changing the appearance and content of patient billing statements, in order to make them easier for patients to read and understand.

CHIEF OF STAFF REPORT

Chief of Staff Richard Nicholson, M.D. reported the Medical Staff Executive Committee recommends the appointment and privileging of radiologist Leon S. Jackson, M.D. to the NIH Active Medical Staff It was moved by Ms. Hubbard, seconded by D. Scott Clark, and passed to approve the appointment of Doctor Jackson as recommended. Doctor Nicholson also reported the resignation of Staff physician Catherine Leja, M.D., who recently moved out of the area. It was moved by John Ungersma, M.D. seconded by Doctor Clark, and passed to (regretfully) accept the resignation of Doctor Leja as requested.

Doctor Nicholson also reported the Medical Staff and appropriate Committees recommend Board approval of the following policies and procedures:

1. Muscle Biopsy

2. Use of Fentanyl Patches
3. Ventilators in the Emergency Room
4. Versa Med I-Vent
5. Drawing of Arterial Blood Gases
6. Nasotracheal Suctioning
7. Back-Feeding Oxygen
8. Patient-Ventilator System Checks
9. Contact Precautions
10. Multidrug Resistant Organism (MDRO) Control Plan

It was moved by Doctor Ungersma, seconded by Doctor Clark, and passed to approve all 10 policies and procedures as recommended.

OLD BUSINESS

REAFFIRMATION OF NEGOTIATOR

Mr. Halfen asked for reaffirmation of himself as negotiator regarding the potential acquisition of real property at 2957 Birch Street, Bishop, California. Negotiation will be with the designee(s) of Southern Mono County Healthcare District. It was moved by Ms. Hubbard, seconded by Doctor Ungersma, and passed to approve the reaffirmation as requested.

COST OF LIVING ADJUSTMENT

Mr. Halfen also requested approval of a 1.1 percent Cost of Living Adjustment (COLA) for Hospital employees, which was tabled at the January District Board meeting due to the lack of a quorum. Mr. Halfen stated the Consumer Price Index (CPI) suggests justification of such an increase, and with the increase salaries would still remain within budget. It was moved by Doctor Ungersma, seconded by Doctor Clark, and passed to approve the Cost of Living Adjustment as recommended, to become effective as of the first full pay period in February. Mr. Watercott abstained from the vote.

NEW BUSINESS

PURCHASE OF EXISTING MODULAR BULDING AND BOARD RESOLUTION 09-02

Mr. Halfen referred to proposed Board Resolution 09-02, which establishes the need for purchasing a previously leased modular building located on Hospital property. The building currently houses Community Relations and Employee Health, and Administration has determined that the modular is only building that can meet the present need of Northern Inyo County Local Hospital District (NICLHD). It was moved by Doctor Ungersma, seconded by Ms. Hubbard, and passed to approve Resolution 09-02 establishing the need to purchase the modular building. It was then moved by Ms. Hubbard, seconded by Doctor Ungersma, and passed to approve the purchase of said building from ModSpace Corporation, at a cost of $31,114.

BOARD RESOLUTION 09-02

Mr. Halfen also called attention to proposed Board Resolution 09-01 which establishes that it is in the best interest of the public health of the communities served by the District to recruit and retain qualified licensed physicians and surgeons to this area, and to enter into agreements with those physicians in order to retain them. The Resolution also establishes that the Board has done reasonable and due diligence in regard to

physician recruitment and retention. It was moved by Doctor Ungersma, seconded by Ms. Hubbard, and passed to approve Resolution 09-02 as presented.

PRACTICE MANAGEMENT AGREEMENTS

Mr. Halfen also referred to proposed agreements with the following physicians, which would help to retain those physicians in this area:

- Alice Casey, M.D.
- Charlotte Helvie, M.D.
- Clifford Beck, M.D.
- David L. Greene, M.D.
- Amr Ramadan, M.D.

The agreements with Doctors Beck and Casey allow for the Hospital taking over management of their practice in exchange for part of the proceeds of the practice. It was moved by Doctor Ungersma, seconded by Ms. Hubbard, and passed to approve the practice management agreements with Doctors Beck and Casey as presented. The agreement with Doctor Helvie allows for the Hospital establishing an income guarantee for the Doctor in order to help insure that she continues to practice in this area. It was moved by Ms. Hubbard, seconded by Doctor Ungersma, and passed to approve the agreement with Dr. Helvie as presented. The agreements with Doctors Greene and Ramadan are practice management agreements, which allow for the Hospital incurring some of the costs of the practice as an inducement for the physicians to stay in this area. It was moved by Doctor Ungersma, seconded by Ms, Hubbard, and passed to approve the practice management agreements with Doctors Greene and Ramadan as presented.

LAPRASCOPIC VIDEO EQUIPMENT PURCHASE

Surgery Unit Nurse Manager Barbara Stuhaan, R.N. presented information on a proposed purchase of laparoscopic video equipment for a total cost of $254,000. Ms. Stuhaan noted the equipment currently in use at NIH was purchased in 1995, and changes in technology have improved high definition video equipment to a very high quality. NIH surgeons have used the equipment proposed for purchase and found it to be exceptional, and if purchased the new equipment is expected to last for approximately 7 years. Following discussion it was moved by Ms. Hubbard, seconded by Doctor Ungersma, and passed to approve purchase of the laparoscopic video equipment as requested.

TURNER CONTRACT APPROVAL

Mr. Halfen called attention to a Guaranteed Maximum Price (GMP) contract with Turner Construction for the remainder of the hospital rebuild project, at a total cost of $42,600,000. The bidding process for Phase II is well under way and construction managers are pleased with the results so far. It was noted that the changes made to the foundation of the building by the Office of Statewide Healthcare Planning and Development (OSHPD) increased the cost of the project by 3.6 million dollars. Mr. Halfen requested Board approval a total GMP of $43,000,000 for Phase II, to include a small amount of fluctuation for change orders. It was moved by Ms. Hubbard, seconded by Doctor

Ungersma, and passed to approve the Guaranteed Maximum Price of $43,000,000 for the remainder of the building project as requested. Mr. Halfen also reviewed projected cash flow for the project in order to illustrate how the balance of the project would be paid for. He noted that $14,500,000 of the funding is still forthcoming, in the form of the second general obligation bond issue.

IT PLANNING CONSULTANTS

Information Technology (IT) Director Adam Taylor referred to a proposal to hire IT Planning Consultants to prepare for future technology needs, in particular for planning ahead for low voltage equipment. Following review of the proposal it was moved by Doctor Ungersma, seconded by Ms. Hubbard, and passed to approve the agreement with PlanNet Consulting as recommended, at a total cost of $76,350.

IT SERVICE AGREEMENTS

Mr. Taylor also referred to a proposal from Zones Corporation to purchase Cisco service agreements for existing IT equipment at a cost of $15,189. Following brief discussion it was moved by Doctor Ungersma seconded by Ms. Hubbard and passed to approve the purchase of service agreements as requested.

POSSIBLE DISCUSSION OF A PATIENT COMPLAINT

Mr. Halfen stated the Board recently received a patient complaint from a patient who requested the matter be reviewed by the District Board. Following careful consideration it was determined the matter dealt with a misunderstanding between a physician's private practice and a patient, and that the matter should appropriately be resolved between the two. The Board will compose a letter expressing their concern for the patient's well being, and will suggest the matter might be resolved by contacting the physician.in question.

LANGUAGE SERVICES QUARTERLY REPORT

Language Services Manager Jose Garcia presented the Language Services quarterly report for the fourth quarter of 2008. He reported a 60% increase in the delivery of language services and noted this is partially due to improved documentation of interpreting sessions. It was moved by Doctor Ungersma, seconded by Ms. Hubbard, and passed to accept the Language Services quarterly report for the fourth quarter of 2008.

BOARD MEMBER REPORTS

Mr. Watercott asked if any member of the Board of Directors wished to report on any items of interest. Mr. Watercott then noted the NIH Foundation fundraiser "Groundhog A-Go-Go" will be held January 31 at the Tri-County Fairgrounds.

OPPORTUNITY FOR PUBLIC COMMENT

In keeping with the Brown Act, Mr. Watercott again asked if any members of the public wished to address the Board of Directors on any items on this agenda, and/or on any items of interest. Tomi Bortolazzo, M.D. stated the patient complaint previously discussed involved her

practice, and she has spoken to the patient in an attempt to reach an understanding or resolution to the problem.

CLOSED SESSION

At 7:11p.m. Mr. Watercott announced the meeting was being adjourned to closed session to allow the Board of Directors to:

A. Hear reports on the hospital quality assurance activities, and hear a report from the Medical Staff Executive Committee (Section 32155 of the Health and Safety Code, and Government Code Section 54962)
B. Instruct negotiator regarding price and terms of payment for the purchase, sale, exchange, or lease of a real property (Government Code Section 54956.8).
C. Confer with legal counsel regarding pending litigation against the District by an employee (Government Code Section 54956.9(a)).
D. Conduct CEO Annual Performance Evaluation (Government Code Section 54957).
E. Discussion of a patient complaint.

RETURN TO OPEN SESSION

At 7:27 p.m. the meeting was returned to open session. Mr. Watercott reported the Board approved the Hospital quality assurance report during closed session.

OPPORTUNITY FOR PUBLIC COMMENT

Mr. Watercott again asked if any members of the public wished to comment on any items listed on the agenda for this meeting, or on any items of interest. No comments were heard.

ADJOURNMENT

The meeting was adjourned at 7:35 p.m.

_____
Peter Watercott, President

Attest: _____
M.C. Hubbard, Secretary

THIS SHEET

INTENTIONALLY

LEFT BLANK

BUDGET VARIANCE ANALYSIS

Dec-08 PERIOD ENDING PRIOR TO AUDIT

In the month, NIH was

	12%	over budget in IP days;
(	0.1%)	over in IP Ancillary Revenue and
(	2.2%)	over in OP Revenue resulting in
$ 230,708 (	3.5%)	over in gross patient revenue from budget &
$ 253,408 (	6.5%)	over in net patient revenue from budget

Total Expenses were:

$ 46,246 (	1.2%)	under budget. Wages and Salaries were
$ (4,182) (	-0.3%)	under budget and Employee Benefits
$ (27,595) (	-3.3%)	under budget.
$ 161,575		of other income resulted in a net income of
$ 476,102	$ 249,649	over budget.

The following expense areas were over budget for the month:

$ 44,941	16%	Professional Fees; registry staff & Physicians
$ 30,033	15%	Supplies Expense
$ 8,367	4%	Depreciation Expense
		Interest Expense due to 2005 General Obligation Bond Interest payments no longer being
$ 64,914	142%	Capitalized
$ 34,565	21%	Bad Debt Expense

Other Information:

41.93%	Contractual Percentages for month
42.25%	Contractual Percentages for Year
$ 2,193,879	Year-to-date Net Revenue

Special Notes for Month:

Interest Expense will remain high for year due to first Phase of Building Project being completed and the interest payments for the first issue of the 2005 General Obligation Bond will no longer be capitalized as it was during the construction.
The depreciation expense was under estimated during the budget process and will be over budget all year.
We have added a new line on the Income Statement to show the amount of 3rd party contractuals being reduced monthly. Auditors feel we have too high of an amount booked for Medicare and Medi-Cal Cost Report settlements.

NORTHERN INYO HOSPITAL

Balance Sheet

December 31, 2008

Assets	*Current Month*	*Prior Month*	*FYE 2008*
Current assets:			
Cash and cash equivalents	3,355,355	2,455,168	2,434,216
Short-term investments	15,757,705	15,682,904	15,199,287
Assets limited as to use	555,022	698,098	49,003
Plant Expansion and Replacement Cash	883	491,658	1,941,239
Other Investments (Partnership)	961,824	961,824	352,361
Patient receivable, less allowance for doubtful accounts $497,848	7,774,946	7,854,118	8,273,347
Other receivables (Includes GE Financing Funds)	505,817	812,902	571,376
Inventories	2,175,489	2,195,611	2,177,577
Prepaid expenses	713,496	634,393	602,851
Total current assets	31,800,536	31,786,676	31,601,257
Assets limited as to use:			
Internally designated for capital acquisitions	547,914	547,359	558,237
Specific purpose assets	568,532	101,240	520,160
	1,116,447	648,598	1,078,397
Revenue bond construction funds held by trustee	682,553	1,000,949	782,802
Less amounts required to meet current obligations	555,022	698,098	49,003
Net Assets limited as to use:	1,243,978	951,449	1,812,196
Long-term investments	8,914,638	8,914,638	8,914,638
Property and equipment, net of accumulated depreciation and amortization	31,358,507	31,118,006	29,541,929
Unamortized bond costs	299,661	301,148	308,583
Total assets	73,617,321	73,071,916	72,178,602

NORTHERN INYO HOSPITAL

Balance Sheet

December 31, 2008

Liabilities and net assets	*Current Month*	*Current Month*	*FYE 2008*
Current liabilities:			
Current maturities of long-term debt	341,440	548,941	683,626
Accounts payable	811,713	828,580	1,140,966
Accrued salaries, wages and benefits	2,799,399	2,762,094	2,600,516
Accrued interest and sales tax	163,401	251,978	172,391
Deferred income	285,908	333,558	-
Due to third-party payors	3,302,458	3,377,458	3,940,301
Due to specific purpose funds	-	-	-
Total current liabilities	7,704,318	8,102,609	8,537,799
Long-term debt, less current maturities	25,270,196	25,270,196	25,270,196
Bond Premium	384,570	385,776	391,804
Total long-term debt	25,654,767	25,655,972	25,662,000
Net assets:			
Unrestricted	39,689,704	39,212,096	37,458,642
Temporarily restricted	568,532	101,240	520,160
Total net assets	40,258,236	39,313,335	37,978,803
Total liabilities and net assets	73,617,321	73,071,916	72,178,602

NORTHERN INYO HOSPITAL

Statement of Operations

As of December 31, 2008

	MTD Actual	MTD Budget	MTD Variance $	MTD Variance %	YTD Actual	YTD Budget	YTD Variance $	YTD Variance %	Prior YTD
Unrestricted revenues, gains and other support:									
In-patient service revenue:									
Routine	673,286	607,596	65,690	10.8	3,655,005	3,645,576	9,429	0.3	1,959,439
Ancillary	2,108,079	2,028,606	79,473	3.9	11,680,400	12,171,636	(491,236)	(4.0)	6,342,843
Total in-patient service revenue	2,781,365	2,636,202	145,163	5.5%	15,335,405	15,817,212	(481,807)	-3.0%	8,302,282
Out-patient service revenue	4,034,292	3,948,747	85,545	2.2	24,714,301	23,692,482	1,021,819	4.3	11,346,822
Gross patient service revenue	6,815,657	6,584,949	230,708	3.50	40,049,707	39,509,694	540,013	1.4	19,649,104
Less deductions from patient service revenue:									
Patient service revenue adjustments	166,640	142,545	(24,095)	(16.9)	1,451,334	855,270	(596,064)	(69.7)	405,095
Contractual adjustments	2,606,866	2,535,204	(71,662)	(2.8)	15,393,010	15,211,224	(181,786)	(1.2)	8,444,707
Prior Period Adjustments	(118,456)	-	118,456	100.0	(695,807)	-	695,807	100.0	(41,889)
Total deductions from patient service revenue	2,655,050	2,677,749	22,699	0.9	16,148,536	16,066,494	(82,042)	(0.5)	8,807,914
Net patient service revenue	4,160,608	3,907,200	253,408	6%	23,901,170	23,443,200	457,970	2%	10,841,190
Other revenue	26,733	28,005	(1,272)	(4.5)	259,819	168,030	91,789	54.6	81,422
Transfers from Restricted Funds for Other Operating Expenses	65,541	65,541	-	-	393,246	393,246	-	0.0	-
Total Other revenue	92,274	93,546	(1,272)	(1.4)	653,065	561,276	91,789	16.4	81,422
Total revenue, gains and other support	4,252,882	4,000,746	252,136	(1.3)	24,554,236	24,004,476	549,760	16.4	10,922,613
Expenses:									
Salaries and wages	1,403,244	1,407,426	4,182	0.3	8,279,964	8,444,556	164,592	2.0	3,831,559
Employee benefits	811,375	838,970	27,595	3.3	5,013,161	5,033,820	20,659	0.4	2,119,417
Professional fees	326,472	281,531	(44,941)	(16.0)	2,009,055	1,689,186	(319,869)	(18.9)	832,154
Supplies	472,469	474,570	2,101	0.4	2,861,896	2,847,420	(14,476)	(0.5)	1,310,138
Purchased services	224,866	194,833	(30,033)	(15.4)	1,162,852	1,168,998	6,146	0.5	459,146
Depreciation	217,517	209,150	(8,367)	(4.0)	1,282,112	1,254,900	(27,212)	(2.2)	370,096
Interest	110,750	45,836	(64,914)	(141.6)	654,843	275,016	(379,827)	(138.1)	96,812
Bad debts	202,587	168,022	(34,565)	(20.6)	772,979	1,008,132	235,153	23.3	459,178
Other	138,840	241,537	102,697	42.5	1,247,157	1,449,222	202,065	13.9	557,114
Total expenses	3,908,121	3,861,875	(46,246)	(1.2)	23,284,019	23,171,250	(112,769)	(0.5)	10,035,614
Operating income (loss)	344,761	138,871	205,890	(0.1)	1,270,217	833,226	436,991	16.9	886,998
Other income:									
District tax receipts	47,650	37,013	10,637	28.7	285,900	222,078	63,822	28.7	111,039
Interest	63,769	60,000	3,769	6.3	556,402	360,000	196,402	54.6	265,680
Other	50,156	8,333	41,823	501.9	208,823	49,998	158,825	317.7	18,839
Grants and Other Non-Restricted Contributions	-	3,333	(3,333)	(100.0)	9,105	19,998	(10,893)	(54.5)	10,000
Partnership Investment Income	-	-	-	-	-	-	-	-	-
Total other income, net	161,575	108,679	52,896	49	1,060,230	652,074	408,156	62.6	405,559
Non-Operating Expense									
Medical Office Expense	20,570	13,408	(7,162)	(53.4)	86,903	80,448	(6,455)	(8.0)	31,239
Urology Office	9,663	7,689	(1,974)	(25.7)	49,664	46,134	(3,530)	(7.7)	43,252
Pediatric Office	-	-	-	N/A	-	-	-	N/A	-
OB-GYN Office	-	-	-	N/A	-	-	-	N/A	-
Total Non-Operating Expense	30,234	21,097	(9,137)	(43.3)	136,567	126,582	(9,985)	(7.9)	74,491
Excess (deficiency) of revenues over expenses	476,102	226,453	249,649	110.2	2,193,879	1,358,718	835,161	61.5	1,218,066

NORTHERN INYO HOSPITAL

Statement of Operations--Statistics

As of December 31, 2008

	Month Actual	Month Budget	Month Variance	Variance Percentage	YTD Actual	YTD Budget	Year Variance	Year Percentage
Operating statistics:								
Beds	25.00	25.00	N/A	N/A	25.00	25.00	N/A	N/A
Patient days	297.00	265.00	32.00	1.12	1,732.00	1,590.00	142.00	1.09
Maximum days per bed capacity	775.00	750.00	N/A	N/A	4,600.00	4,500.00	N/A	N/A
Percentage of occupancy	38.32	35.33	2.99	1.08	37.65	35.33	2.32	1.07
Average daily census	9.58	8.83	0.75	1.08	9.41	8.83	0.58	1.07
Average length of stay	3.26	3.01	0.25	1.08	3.15	3.01	0.14	1.05
Discharges	91.00	88.00	3.00	1.03	550.00	528.00	22.00	1.04
Admissions	91.00	87.00	4.00	1.05	550.00	522.00	28.00	1.05
Gross profit-revenue depts.	4,525,301.77	4,321,007.00	204,294.77	1.05	26,431,047.60	25,926,042.00	505,005.60	1.02
Percent to gross patient service revenue:								
Deductions from patient service revenue and bad debts	41.93	43.22	(1.29)	0.97	42.25	43.22	(0.97)	0.98
Salaries and employee benefits	32.20	34.08	(1.88)	0.94	33.02	34.08	(1.06)	0.97
Occupancy expenses	4.89	4.38	0.51	1.12	5.34	4.38	0.96	1.22
General service departments	5.56	6.28	(0.72)	0.89	6.02	6.28	(0.26)	0.96
Fiscal services department	4.46	4.74	(0.28)	0.94	4.77	4.74	0.03	1.01
Administrative departments	4.84	5.37	(0.53)	0.90	5.03	5.37	(0.34)	0.94
Operating income (loss)	4.61	1.84	2.77	2.51	2.85	1.84	1.01	1.55
Excess (deficiency) of revenues over expenses	6.99	3.44	3.55	2.03	5.48	3.44	2.04	1.59
Payroll statistics:								
Average hourly rate (salaries and benefits)	39.30	43.24	(3.93)	0.91	40.91	43.24	(2.33)	0.95
Worked hours	47,217.15	47,276.00	(58.85)	1.00	282,191.27	283,656.00	(1,464.73)	0.99
Paid hours	55,830.10	51,895.00	3,935.10	1.08	323,209.57	311,370.00	11,839.57	1.04
Full time equivalents (worked)	268.28	273.27	(4.99)	0.98	269.27	273.27	(4.01)	0.99
Full time equivalents (paid)	317.22	299.97	17.25	1.06	308.41	299.97	8.43	1.03

NORTHERN INYO HOSPITAL

Statements of Cash Flows

As of December 31, 2008

	Month-to-date	Year-to-date
Cash flows from operating activities:		
Increase (decrease) in net assets	944,900.94	2,279,433.35
Adjustments to reconcile excess of revenues	-	-
over expenses to net cash provided by		
operating activities: (correcting debt payment)	-	-
Depreciation	217,516.93	1,282,112.46
Provision for bad debts	202,587.38	772,978.75
Loss (gain) on disposal of equipment	-	11,229.70
(Increase) decrease in:		
Patient and other receivables	183,670.92	(209,017.79)
Other current assets	(58,981.04)	(108,556.63)
Plant Expansion and Replacement Cash	490,774.96	1,940,356.30
Increase (decrease) in:		
Accounts payable and accrued expenses	(115,789.40)	146,547.40
Third-party payors	(75,000.00)	(637,843.00)
Net cash provided (used) by operating activities	1,789,680.69	5,477,240.54
Cash flows from investing activities:		
Purchase of property and equipment	(458,018.82)	(3,098,691.22)
Purchase of investments	(74,801.23)	(1,167,881.20)
Proceeds from disposal of equipment	-	(11,229.70)
Net cash provided (used) in investing activities	(532,820.05)	(4,277,802.12)
Cash flows from financing activities:		
Long-term debt	(208,707.30)	(349,419.32)
Issuance of revenue bonds	318,395.31	100,248.37
Unamortized bond costs	1,486.95	8,921.70
Increase (decrease) in donor-restricted funds, net	(467,848.28)	(38,049.73)
Net cash provided by (used in) financing activities	(356,673.32)	(278,298.98)
Increase (decrease) in cash and cash equivalents	900,187.32	921,139.44
Cash and cash equivalents, beginning of period	2,455,167.67	2,434,215.55
Cash and cash equivalents, end of period	3,355,354.99	3,355,354.99

NORTHERN INYO HOSPITAL

Statements of Changes in Net Assets

As of December 31, 2008

	Month-to-date	Year-to-date
Unrestricted net assets:		
Excess (deficiency) of revenues over expenses	476,101.74	2,193,878.95
Net Assets due/to transferred from unrestricted	-	12,178.75
Net assets released from restrictions used for operations	950.92	35,325.92
Net assets released from restrictions used for payment of long-term debt	(65,541.00)	(393,246.00)
Contributions and interest income	555.50	(10,322.10)
Increase in unrestricted net assets	412,067.16	1,837,815.52
Temporarily restricted net assets:		
District tax allocation	468,193.35	550,811.01
Net assets released from restrictions	(950.92)	(502,623.88)
Restricted contributions	-	-
Interest income	50.35	184.70
Net Assets for Long-Term Debt due from County	65,541.00	393,246.00
Increase (decrease) in temporarily restricted net assets	532,833.78	441,617.83
Increase (decrease) in net assets	944,900.94	2,279,433.35
Net assets, beginning of period	39,313,335.24	37,978,802.83
Net assets, end of period	40,258,236.18	40,258,236.18

Northern Inyo Hospital
Summary of Cash and Investment Balances
Calendar Year 2008

	Operations Checking Account					Time Deposit Month-End Balances							
Month	Balance at Beginning of Month	Deposits	Disbursements	Balance at End of Month	Investment Operations Fund	Bond and Interest Fund (2)	Equipment Donations Fund	Childrens Fund	Scholarship Fund	Tobacco Settlement Fund	Total Revenue Bond Fund (1)	Project Revenue Bond Fund (1)	General Obligation Bond Fund
January	799,688	3,470,821	3,178,334	1,092,175	20,699,869	533,220	25,185	3,034	5,854	432,993	729,781	18,154	4,996,062
February	1,092,175	3,784,341	3,845,492	1,031,024	21,348,607	533,220	25,185	3,034	5,854	433,239	773,502	18,193	3,693,002
March	1,031,024	8,396,549	9,206,848	220,726	22,761,607	533,397	25,192	3,035	5,855	433,438	817,192	18,221	2,905,472
April	220,726	5,565,892	5,070,387	716,230	21,993,157	533,397	25,192	3,035	5,855	532,756	904,546	18,258	2,706,314
May	716,230	4,861,035	4,171,128	1,406,138	22,583,401	505,947	25,192	3,035	20,855	532,894	934,534	18,258	2,318,199
June	1,406,138	3,979,790	4,241,108	1,144,820	24,112,234	506,089	25,199	3,036	10,960	533,038	782,802	18,278	1,941,042
July	1,144,820	3,591,736	4,304,179	432,378	25,157,206	473,714	25,799	3,036	10,960	533,181	826,431	18,297	1,896,555
August	432,378	3,928,525	4,052,898	308,005	24,668,222	539,232	25,799	3,036	10,960	533,315	870,108	18,316	1,802,362
September	308,005	6,941,975	5,021,257	2,228,723	23,464,535	539,363	25,805	3,037	8,963	533,463	913,829	18,335	488,249
October	2,228,723	3,669,458	5,409,330	488,851	24,438,919	72,065	25,805	3,037	8,963	521,427	957,490	18,349	490,613
November	488,851	3,294,047	3,600,921	181,977	24,595,851	89,165	25,805	3,037	8,963	521,554	1,000,949	18,350	491,657
December	181,977	4,947,737	4,219,311	910,403	24,670,653	557,358	26,222	3,037	8,014	521,703	682,553	18,350	882

Notes:

(1) The difference between the Total and Project Revenue Bond Funds represents amounts held by the trustee to make payments on the District's behalf and about $575,000 to cover the Bond Reserve Account Requirement with respect to the Series 1998 Bonds. The Project amount represents the balance available to spend on the building project; however, the district accumulates invoices and only requests reimbursement quarterly.

(2) The Bond and Interest Fund now contains the Debt Service amount from the County for both the original Bond and the 2005 Bond.

Investments as of 12/31/08

ID	Purchase Date	Maturity Date	Institution	Certificate ID	Rate	Principal Invested
1	02-Dec-08	01-Jan-09	Local Agency Investment Fund	20-14-002	2.35%	1,717,772
2	12-Dec-08	01-Jan-09	Prudential Instl Liquiditiy	7455350-10-9	1.38%	100,000
3	31-Dec-08	01-Jan-09	Union Bank-Money Market	2740028807	1.75%	10,772,046
4	02-Dec-08	02-Jan-09	Local Agency Investment Fund	20-14-002 Walker	2.35%	307,290
5	04-Jan-05	05-Jan-09	Mututal Bank	9N01836	4.36%	99,000
6	04-Aug-08	17-Feb-09	Wachovia Corp Senior Note	929903AD4	5.00%	1,985,580
7	17-Jun-08	16-Mar-09	Fedl National Mtg Asso-Wachovia	31359MUQ4	3.13%	100,626
8	21-Sep-07	01-Apr-09	Citigroup Med Term Note	125581AJ7	3.38%	239,293
9	07-Aug-08	15-Jun-09	World Savings Bank Note	98153BAE4	5.17%	1,105,773
10	12-Jun-08	19-Jun-09	Federal Home Loan Bank-Wachovia	3133XFVF0	5.25%	102,703
			Current Fiscal Year Totals			**16,530,082**
11	03-Jun-08	01-Jul-09	International Lease Finance Corp	459745FM2	4.75%	1,005,500
12	10-Oct-08	09-Oct-09	Amboy Bank	023305CF0	3.75%	250,000
13	15-Oct-08	15-Oct-09	Colonial Bank, N.A.	195554PG9	3.65%	250,000
14	15-Oct-08	15-Oct-09	Comerica Bank	200339CT4	3.65%	250,000
15	15-Oct-08	15-Oct-09	Morgan Stanley Bank	61747MPB1	3.65%	250,000
16	17-Oct-08	16-Oct-09	Bank of Michigan	06424TCW9	3.60%	250,000
17	17-Oct-08	16-Oct-09	Firstbank of Puerto Rico	337629B32	3.70%	250,000
18	17-Oct-08	16-Oct-09	GMAC Bank	36185AXP8	3.65%	250,000
19	16-Oct-08	16-Oct-09	Westernbank Puerto Rico	95989QKL0	3.75%	250,000
20	21-Sep-07	01-Nov-09	Citigroup Med Term Note	12560PCL3	6.88%	702,987
21	15-Dec-08	01-Nov-09	Federal Home Loan Mtg Corp-MBS	31282VBY0	4.50%	73,191
22	22-Feb-08	07-Dec-09	Bear Stearns Co Note	073902BR8	4.58%	933,927
23	12-Dec-08	12-Dec-09	1st Financial Bank USA (FNC CD)	5X42582	3.55%	249,000
24	12-Dec-08	12-Dec-09	Discover Bank (FNC CD)	5x42584	3.15%	250,000
25	12-Dec-08	12-Dec-09	M&T Bank N.A. (FNC CD)	5X42577	3.15%	250,000
26	12-Dec-08	12-Dec-09	Texas Community Bank (FNC CD)	5X42597	3.40%	250,000
27	18-Aug-08	15-Dec-09	World Savings Bank Note	9515GAA3	5.24%	492,950
28	30-Dec-04	30-Dec-09	Capital City Bank and Trust	9N01713	4.75%	99,000
29	11-Dec-08	15-Jan-10	Berkshire Hathaway Fin Corp GRD Sr Not	084664AR2	2.49%	203,510
30	11-Dec-08	22-Feb-10	Citigroup Inc	172967CU3	6.49%	97,308
31	25-Jul-08	01-Mar-10	Schwab Medium Term Note	80851QCX0	4.33%	528,440
32	11-Dec-08	15-Apr-10	Greater Bay Bancorp Sr Note	391648AT9	3.82%	101,688
33	22-Apr-05	22-Apr-10	Bank of Waukegan	065563AR9	4.75%	99,000
34	11-Dec-08	28-Apr-10	Toyota Motor Credit Corp Note	829233PV60	2.79%	200,164
35	24-Apr-08	15-May-10	American General Finance Corp Note	02635PSV6	4.47%	503,905
			Fiscal Year 2010			**8,040,570**
36	18-Dec-08	18-Dec-10	Worlds Foremost Bank (FNC CD)	5X42688	4.40%	100,000
			Fiscal Year 2011			**100,000**
			TOTAL INVESTMENTS			**24,670,653**

Financial Indicators

	Target	Dec-08	Nov-08	Oct-08	Sep-08	Aug-08	Jul-08	Jun-08	May-08	Apr-08	Mar-08	Feb-08	Jan-08
Current Ratio	>1.5-2.0	4.13	3.92	3.90	3.31	3.68	3.64	3.70	4.28	4.09	3.85	4.22	4.42
Quick Ratio	>1.33-1.5	3.69	3.47	3.44	2.89	3.22	3.18	3.31	3.85	3.64	3.40	3.44	3.63
Days Cash on Hand	>75	223.53	223.62	218.15	229.56	229.67	222.74	233.39	239.70	254.30	229.19	274.52	258.26

Northern Inyo Hospital
Monthly Report of Capital Expenditures
Fiscal Year Ending JUNE 30, 2008
As of December 31, 2008

MONTH APPROVED BY BOARD	DESCRIPTION OF APPROVED CAPITAL EXPENDITURES	AMOUNT
FY 2006-07	NovaRad RIS (part of original NovaRad PACS System)	208,426 *
FY 2007-08	Seimens Patient Monitor SC 9000XL	7,799
	3-D FOR M.E.P.	45,000
	OMNICELL COLOR TOUCH	55,419 *
	Access II Immunoassay System (Approved 4-08 with Reagent Agreement)	64,724 *
	AMOUNT APPROVED BY THE BOARD IN PRIOR FISCAL YEARS TO BE EXPENDED IN THE CURRENT FISCAL YEAR	381,368
FY 2008-09	Beckman Coulter AcT10	9,600
	Modular Building Purchase-Quality Improvement	21,785 *
	AMOUNT APPROVED BY THE BOARD IN THE CURRENT FISCAL YEAR TO BE EXPENDED IN THE CURRENT FISCAL YEAR	31,385
	Amount Approved by the Board in Prior Fiscal Years to be Expended in the Current Fiscal Year	381,368
	Amount Approved by the Board in the Current Fiscal Year to be Expended in the Current Fiscal Year	31,385
	Year-to-Date Board-Approved Amount to be Expended	62,399
	Year-to-Date Administrator-Approved Amount	408,691 *
	Actually Expended in Current Fiscal Year	350,355 *
	Year-to-Date Completed Building Project Expenditures	0 *
	TOTAL FUNDS APPROVED TO BE EXPENDED	821,445
	Total-to-Date Spent on Incomplete Board Approved Expenditures	0

Northern Inyo Hospital
Monthly Report of Capital Expenditures
Fiscal Year Ending JUNE 30, 2008
As of December 31, 2008

MONTH APPROVED BY BOARD	DESCRIPTION OF APPROVED CAPITAL EXPENDITURES	AMOUNT
	Reconciling Totals:	
	Actually Capitalized in the Current Fiscal Year Total-to-Date	759,046
	Plus: Lease Payments from a Previous Period	0
	Less: Lease Payments Due in the Future	0
	Less: Funds Expended in a Previous Period	0
	Plus: Other Approved Expenditures	62,399
	ACTUAL FUNDS APPROVED IN THE CURRENT FISCAL YEAR TOTAL-TO-DATE	821,445
	Donations by Auxiliary	0
	Donations by Hospice of the Owens Valley	0
	+Tobacco Funds Used for Purchase	12,179
		0
		12,179

*Completed Purchase
(Note: The budgeted amount for capital expenditures for the fiscal year ending June 30, 2006, is $3,600,000 coming from existing hospital funds.)

**Completed in prior fiscal year

Northern Inyo Hospital
Monthly Report of Capital Expenditures
Fiscal Year Ending JUNE 30, 2008
As of December 31, 2008

MONTH APPROVED BY BOARD	DESCRIPTION OF APPROVED CAPITAL EXPENDITURES	AMOUNT
Board Approved Construction and Remodel amounts to be Reimburse from Revenue Bonds:		
FY 1996-97	Central Plant and Emergency Power Generator	3,000,884 **
FY 1997-98	Administration/Office Building (Includes Furniture and Landscaping)	1,617,772 **
FY 2000-01	New Water Line Construction	89,962 **
FY 2001-02	Siemens ICU Patient Monitoring Equipment	170,245 **
	Central Plant and Emergency Power Generator OSHPD Fee	18464.5 **
FY 2003-04	Emergency Room Remodel (Included in New Building & Remodel)	0
FY 2004-05	Emergency Room Remodel (add to $500,000) (In New Building & Remodel)	0
FY 2005-06	Hospital Building and Remodel	39,500,000
FY 2005-06	Construction Cost Overrun Approval	15,250,000
FY 2008-09	Phase II-Bid 1 (Bid Approvals-part of above original numbers)	17,580,971
	Total-To-Date Board Approved Construction Amounts to be reimbursed from Revenue Bonds & General Obligation Bond	77,228,299
	Total-To-Date Spent on Construction In Progress from Rev Bonds for Incomplete Projects (Includes Architect Fees for Future Phases)	

*Completed Purchase

Northern Inyo Hospital
Monthly Report of Capital Expenditures
Fiscal Year Ending JUNE 30, 2008
As of December 31, 2008

Administrator-Approved Item(s)	Department	Amount	Month Total	Grand Total
Alarm System for Rental House	Employee Housing	1,800		
Dell 2008WFP 30" Flat Panel Monitor	Radiology	2,162		
RF9 Novasure Controller	SURGERY	25,321		
OLYMPUS MICROSCOPE BX41	LAB	9,850		
XX TPAD X200T	RHC	1,910		
PILATES REFORMER	PHYSICAL THERAPY	1,940		
BROOKWALTER RETRACTOR SET	SURGERY	26,104		
POLAROID P4000 DUAL-SIDED PRINTER	HUMAN RESOURCES	2,133		
CANNON iR 1023iF Printer	MED/SURG	2,618		
HEAVY-DUTY POWER LIFTER	MED/SURG	4,083		
HEAVY-DUTY POWER LIFTER W/SCALE	MED/SURG	4,478		
TELESCOPE 70 DEGREES 4MM	SURGERY	3,752		
BARIATRIC WHEELCHAIR	MED/SURG	1,501		
Month Ending December 31, 2008			**87,653**	**408,691**

NORTHERN INYO HOSPITAL
STATISTICS

12 MONTHS	SURGERIES									BIRTHS			ER						OP			ADMITS			PT DAYS			PT DAYS			DISCH		
	IP			OP			TOTAL						ADMITS			VISITS			REFERRALS			(W/NB)			(W/O NB)			(W/NB)			(W/NB)		
2008	06	07	08	06	07	08	06	07	08	06	07	08	06	07	08	06	07	08	06	07	08	06	07	08	06	07	08	06	07	08	06	07	08
JANUARY	40	38	33	72	73	106	112	111	139	19	17	16	60	47	48	563	510	573	3135	3331	3237	126	111	107	370	299	329	410	350	364	124	106	96
FEBRUARY	29	24	17	62	59	81	91	83	98	20	19	14	44	14	39	467	521	545	3100	2991	3165	106	107	86	255	251	241	303	291	274	113	105	96
MARCH	50	25	32	101	53	82	151	78	114	26	17	13	63	49	43	543	460	506	3387	3079	3285	152	117	108	333	286	318	399	322	349	149	116	102
APRIL	31	31	35	81	59	120	112	90	155	18	17	14	54	48	61	474	525	558	3145	3251	3611	114	105	112	310	245	307	346	276	338	116	112	118
MAY	31	38	41	73	95	110	104	133	151	20	19	27	53	40	68	564	580	594	3313	3343	3406	111	112	128	345	299	316	381	342	376	106	103	126
JUNE	49	27	33	76	70	83	125	97	116	16	12	18	44	41	38	552	511	580	3235	3186	3388	107	104	112	307	297	258	342	323	294	97	107	108
JULY	31	41	22	59	85	110	90	126	132	30	24	21	36	49	44	619	624	676	3012	3109	3307	129	132	99	313	388	274	371	445	317	126	127	105
AUGUST	40	35	33	117	115	114	157	150	147	26	26	20	54	46	52	580	565	642	3401	3402	3145	138	126	114	350	353	305	408	421	345	134	140	113
SEPTEMBER	35	36	25	86	90	78	121	126	103	14	18	26	42	55	33	470	515	576	2952	2897	3299	110	118	119	289	283	274	320	326	330	118	109	115
OCTOBER	26	37	39	62	94	125	88	131	164	16	15	21	43	30	73	523	560	564	3290	3378	3527	108	87	132	269	263	330	301	296	372	97	93	135
NOVEMBER	39	38	30	82	103	73	121	141	103	21	15	21	14	29	36	494	452	394	2991	3178	2868	100	100	103	323	284	252	369	320	291	103	98	100
DECEMBER	29	27	29	78	92	123	107	119	152	12	17	22	20	42	44	454	510	584	2792	2900	3215	109	87	113	304	251	297	329	286	338	117	92	113
CALENDAR YEAR	430	397	369	949	988	1,205	1379	1,385	1574	238	216	233	527	490	579	6303	6333	6792	37753	38045	39453	1410	1306	1333	3768	3499	3501	4279	3998	3988	1400	1308	1327
MONTHLY AVERAGE	36	33	31	79	82	100	115	115	131	20	18	19	44	41	48	525	528	566	3,146	3,170	3,288	118	109	111	314	292	292	357	333	332	117	109	111

NORTHERN INYO HOSPITAL
DEPARTMENTAL NON-EMERGENCY OUTPATIENT VISITS

12 MONTHS 2008	* DIAGNOSTIC RADIOLOGY 06 / 07 / 08	* MAMMOGRAPHY 06 / 07 / 08	* NUCLEAR MEDICINE 06 / 07 / 08	* ULTRASOUND 06 / 07 / 08	* CT SCANNING 06 / 07 / 08	* MRI 06 / 07 / 08	LABORATORY 06 / 07 / 08	E K G / E E G 06 / 07 / 08	PHYSICAL THERAPY 06 / 07 / 08	RESPIRATORY THERAPY 06 / 07 / 08	RURAL HEALTH CLINIC 06 / 07 / 08	TOTALS 06 / 07 / 08
JANUARY	312 / 308 / 544	229 / 198 / 193	29 / 36 / 71	107 / 166 / 205	123 / 112 / 170	85 / 86 / 89	1686 / 1621 / 1809	103 / 139 / 103	302 / 335 / 335	12 / 19 / 10	1029 / 941 / 1057	4017 / 3961 / 4586
FEBRUARY	250 / 263 / 593	211 / 194 / 193	60 / 38 / 63	135 / 157 / 205	111 / 102 / 217	92 / 71 / 85	1633 / 1662 / 1744	82 / 84 / 113	361 / 302 / 364	19 / 19 / 11	970 / 965 / 1150	3924 / 3857 / 4738
MARCH	329 / 269 / 529	83 / 122 / 311	52 / 29 / 133	133 / 144 / 223	126 / 95 / 233	105 / 76 / 403	1853 / 1734 / 1774	132 / 100 / 149	425 / 340 / 346	14 / 16 / 12	1099 / 1095 / 1211	4351 / 4020 / 5324
APRIL	254 / 258 / 697	237 / 246 / 199	35 / 46 / 183	109 / 139 / 196	107 / 123 / 264	84 / 105 / 453	1984 / 1767 / 1984	84 / 85 / 121	397 / 300 / 410	21 / 14 / 14	915 / 883 / 1318	4227 / 3966 / 5839
MAY	263 / 262 / 613	241 / 230 / 479	41 / 85 / 167	122 / 150 / 213	110 / 131 / 230	88 / 100 / 424	1741 / 1743 / 1758	95 / 112 / 137	374 / 295 / 349	18 / 18 / 9	958 / 1007 / 1308	4051 / 4133 / 5687
JUNE	257 / 264 / 616	220 / 243 / 486	32 / 37 / 118	128 / 149 / 186	119 / 128 / 156	111 / 101 / 542	1828 / 2203 / 1752	104 / 90 / 123	370 / 260 / 314	10 / 7 / 19	859 / 864 / 1247	4038 / 4346 / 5559
JULY	228 / 275 / 604	134 / 192 / 477	35 / 46 / 71	126 / 155 / 196	121 / 109 / 157	71 / 113 / 443	1615 / 1618 / 1716	93 / 94 / 142	379 / 276 / 357	13 / 17 / 15	946 / 887 / 1190	3761 / 3782 / 5368
AUGUST	269 / 256 / 561	275 / 256 / 402	47 / 59 / 86	135 / 149 / 190	120 / 126 / 150	97 / 130 / 542	1741 / 1850 / 1647	132 / 115 / 145	408 / 289 / 325	14 / 17 / 11	1020 / 1064 / 1294	4258 / 4311 / 5353
SEPTEMBER	251 / 224 / 567	229 / 218 / 464	45 / 75 / 70	126 / 149 / 191	99 / 101 / 157	78 / 55 / 502	1542 / 1667 / 1822	111 / 83 / 131	355 / 254 / 322	11 / 9 / 13	917 / 1047 / 1288	3764 / 3882 / 5527
OCTOBER	265 / 287 / 639	233 / 223 / 511	44 / 58 / 82	116 / 173 / 210	123 / 101 / 167	79 / 92 / 464	1757 / 1877 / 1793	102 / 116 / 118	345 / 284 / 367	27 / 12 / 15	923 / 1129 / 1422	4014 / 4352 / 5788
NOVEMBER	230 / 234 / 541	236 / 250 / 398	35 / 39 / 62	146 / 160 / 168	118 / 69 / 161	87 / 102 / 378	1594 / 1668 / 1449	93 / 93 / 86	269 / 350 / 311	17 / 6 / 9	991 / 992 / 1249	3816 / 3963 / 4812
DECEMBER	234 / 205 / 597	194 / 227 / 411	31 / 26 / 60	120 / 130 / 196	117 / 75 / 137	72 / 80 / 447	1573 / 1556 / 1704	98 / 69 / 92	242 / 365 / 278	14 / 6 / 14	930 / 937 / 1311	3553 / 3596 / 4800
CALENDAR YEAR	3142 / 3105 / 7101	2522 / 2599 / 4524	486 / 574 / 1166	1503 / 1821 / 2379	1394 / 1272 / 2199	1049 / 1111 / 4772	20547 / 20966 / 20952	1229 / 1180 / 1460	4227 / 3650 / 4078	190 / 160 / 152	11557 / 11811 / 15045	47774 / 48169 / 63381
MONTHLY AVERAGES	262 / 259 / 592	210 / 217 / 377	41 / 48 / 97	125 / 152 / 198	116 / 106 / 183	87 / 93 / 398	1712 / 1747 / 1746	102 / 98 / 122	352 / 304 / 340	16 / 13 / 13	963 / 984 / 1254	3981 / 4014 / 5282

*Radiology has changed their methodology for capturing statistics and feel these are more accurate. They are much higher than previously reported.

THIS SHEET

INTENTIONALLY

LEFT BLANK

American Hospital Association

Legislative Advisory

Friday, January 30, 2009

HEALTH LEGISLATION MOVING IN CONGRESS INCLUDES KEY HOSPITAL ISSUES – WHERE WE STAND

This "roadmap" highlights the legislation of interest to hospitals that is moving on several fronts this week: SCHIP, and the Economic Recovery package. As action progresses, we'll send out AHA Advocacy Action Alerts with specific messages and suggestions on how you can help advance our agenda. In addition, look for much more extensive descriptions and analysis of key provisions as these bills move to the next stage of the legislative process.

Children's Health Insurance Program Reauthorization Act

The House and Senate both have passed bills to reauthorize and extend SCHIP coverage.

Key hospital concern	House bill	Senate bill
SCHIP reauthorization and expansion	Continues coverage for 7 million children currently covered, expands to another 4 million, funded primarily with increased tobacco tax	Same as House
Physician self-referral	Prospective ban included with limits on future growth; provides additional savings to finance SCHIP	No ban included

Critical Next Steps

Differences between the House and Senate bills may be ironed out among congressional committee chairs and leaders but at this point, it is uncertain whether there will be a formal House-Senate conference. We are pushing for a conference on the SCHIP legislation that would include the self-referral ban.

American Recovery and Reinvestment Act
(The "economic stimulus" bill)

The $819 billion House-passed economic recovery bill contains several AHA-backed provisions. The Senate next week is expected to debate a similar version costing $887 billion. Here are the key issues for hospitals as they now stand.

Key hospital concern	House bill	Senate bill
Medicaid support	$89.5 billion in additional FMAP funds for each state, plus a 2.5% increase in DSH payments through Dec. 2010; no maintenance of effort for provider payments	Similar provisions; no DSH increase
Health IT	$20 billion for health IT, mostly through Medicare and Medicaid payments to physicians and hospitals; CAH, inpatient rehab, psychiatric and long-term care hospitals not included	$17.9 billion for same purpose; CAHs included, but not inpatient rehab, psychiatric or long-term care hospitals
Regulatory reversals	Extends until June a moratorium on CMS enforcement of six Medicaid rules that cut billions in hospital payments; expands moratorium to hospital outpatient rule that cuts payments $2 billion over five years; reinstitutes through September Medicare IME adjustment for teaching hospitals' capital costs, blocking $200 million cut	Like House, eliminates cuts to Medicare capital IME payments for fiscal year 2009; does not extend current moratorium on Medicaid rules nor extend moratorium to Medicaid outpatient regulation
Access to capital	Expands incentives for banks to purchase hospitals' tax-exempt bonds	Similar to House

Critical Next Steps

Medicaid support: We will push Congress to couple additional FMAP funding with a requirement that states maintain their 2009 level of eligibility and services for Medicaid beneficiaries, and protect current provider payment levels. We will advocate for the Senate bill to adopt the DSH provision.

Health IT: We will advocate for all hospitals to be eligible for IT funding incentives, and to ensure that privacy provisions in the bills do not present barriers to the provision of care.

Regulatory reversals: We will advocate for all of the CMS rules to be blocked by moratoria in the final bill.

Access to capital: We will call on Congress to broaden the economic recovery legislation to help financially strapped hospitals access capital. We will call for improvements to the FHA Section 242 Hospital Mortgage Insurance construction loan program, and urge Congress to create a new construction grant and credit subsidy program within FHA and take other steps to support hospital capital financing.

THIS SHEET

INTENTIONALLY

LEFT BLANK

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Drugs of Abuse Maternal and Infant**	
Scope: Multi-Department	Department: **Laboratory, OB/Gyn**
Source: Kneip, Jan	Effective Date: 10/16/2007

PURPOSE:

To comply with Health & Safety Code Section 123605, and Penal Code Section 11165.3 and to help protect infants who have been exposed to drugs or alcohol prenatally and thus who may be at risk for withdrawal or parental neglect.

POLICY:

1. NIH will arrange for a Needs Assessment by the Inyo County Child Protective Services (hereafter CPS) Social Worker or other qualified Health Care Provider, (hospital social worker/physician/nurse) for all infants with a history of passive exposure to drugs and alcohol.
2. Arrangements will be made for appropriate follow-up services prior to the infant's discharge.

The attending physician will order The Drugs of Abuse Screen (detecting amphetamines, cannabis (hereafter THC), cocaine, opiates, benzodiazepines, phencyclidines, barbiturates and tricyclic antidepressants) when indicated. If alcohol is to be tested for it requires a blood sample and is a separate test. The urine test provides only a preliminary result. A more specific alternate chemical method must be used in order to obtain a confirmed analytical result. The physician should order the confirmatory testing as soon as possible as turn around times may be less than optimal.

Maternal High Risk Factors:

a. Late prenatal care (hereafter PNC) (<4visits), or no PNC
b. History of substance use (in the last 4 years)
c. Suspicion of substance use based on physician or nursing observations (e.g., tracks, signs of intoxication or withdrawal, etc.)
d. Actively undergoing treatment in a substance abuse program
e. Home deliveries
f. Suspected or confirmed placental abruption
g. Pre-term labor
h. Low birth weight infant
i. Past births of substance-exposed newborns

3. The physician will order testing on any mother who is suspected (i.e., per Maternal High Risk Factors listed below) or self-reports using alcohol or illicit drugs. A urine drug screen will be obtained to establish the presence of drug metabolite. These mothers will be questioned as to any history of alcohol or drug use and will be informed that it is hospital policy that any mother with any risk factors will be tested for Drugs Of Abuse, as will their infants (It should be explained that these substances may have significant effects on their baby, which may influence the care they need).

4. Upon admission of a mother who meets the above criteria, the labor nurse will consult the attending physician and if ordered will obtain the mother's urine sample (minimum of 10ml) before she receives any analgesia or sedation, and send the sample ASAP to the lab for a Drugs of Abuse Screen. When the labor nurse is collecting the urine sample, the mother is to be notified of the following:
   a. We are going to screen her urine for drugs of abuse.
   b. We may be collecting and screening the baby's first urine.

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Drugs of Abuse Maternal and Infant**	
Scope: Multi-Department	Department: **Laboratory, OB/Gyn**
Source: Kneip, Jan	Effective Date: 10/16/2007

5. The nurse's notes are to reflect that all of the above was communicated to the mother and that she understood. The nurse must also carefully chart all of the signs and symptoms of the mother's suspected or self-reported substance abuse. If the patient refuses a drug screen, the nurse must document in her nurses notes and report incident to physician.

6. Any infant who is questionably symptomatic for withdrawal, i.e., showing clinical signs associated with withdrawal from alcohol or drugs, including jitteriness, irritability, seizures, hyper or hypo-tonia, apnea, tachypnea, abnormal cry, sleep and feeding patterns, microcephaly, among others, will have a urine bag placed. Their urine will be obtained and held until an order can be obtained from the Pediatrician.

7. Collection of urine for Drugs of Abuse Screen specimen and completion of Laboratory Requisition slip:
   a. Verify the identification of the individual to be tested using the arm band and compare identification to the addressograph on the request slip and specimen container.
   b. If possible, have the mother urinate directly into the correctly labeled specimen container.
   c. Close the lid on the specimen container, and identify specimen.
   d. On Laboratory Requisition slip write: "Urine for Drugs of Abuse Screen."
   e. Verify correct addressograph information on the lab slip to the information on the specimen.
   f. Send specimen to the Lab immediately.

8. Chart in nurses notes that specimen was obtained and taken to the Lab.

9. Notify Social Services of admission of "at-risk" mom and baby. The hospital social worker will:
   a. Perform a routine assessment to determine any patient immediate need.
   b. Work with Attending Physician and assist per request.
   c. Consider making a Community Health Nurse/service referral on mothers who have a history of substance use, or meet any other high-risk criteria. If there is concern warranting a visit immediately following discharge, the service will be notified by phone. This will be done with an order from the attending physician.
   d. Make a referral to Child Protective Services in writing based on the Health & Safety Code Section 123605, and Penal Code Section 11165.3. The physicians caring for both mother and infant must be notified prior to this report.

10. If the hospital social worker is not available, and if another qualified staff member, including a registered nurse, cannot accomplish these tasks, the physician should be notified.

Committee Approval	**Date**
Peri-Peds Committee	01/20/2009
Medical Executive Committee	
NICLHD Board of Directors	

Revised	10/07 jk, 1/09 jk
Reviewed	
Supercedes	

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Implantation of Medical Devices	
Departments/Scope: Surgery	
Source: Surgery	Effective Date: 7-23-2008

POLICY:

All medical implant devices are accurately identified and sterility is assured prior to implantation and is appropriately documented during implantation.

Verification of the patient will be completed on all patients prior to initiation of the surgical procedure and will be documented on the Intra-Operative Record.

An "Implant Time Out" will be performed prior to opening implants for all surgical procedures requiring implants and this will be documented on the Intra-Operative Record.

PURPOSE:
To decrease the risk to the patient of infection, use of an incorrect implant or other related complications.
To insure that the identification of an implant is checked prior to implantation and this implant information is document during the surgical procedure.

To ensure the verification of the patient is completed prior to initiation of the surgical procedure.

SCOPE OF IMPLANT:

1. Joint Arthroplasty
2. Internal Fixation Hardware
3. Intraocular Implants
4. Pacemakers
5. Central Line Access
6. Vascular Grafts
7. Implantation of Mesh

IMPLEMENTATION:
Definition (Food and Drug Administration)

A. In-hospital sterilization guidelines:

    1. Flash sterilization of implant items is inappropriate.

2. Flash sterilization of implants is done only in an emergency situation where there is no other alternative and delay in surgery will adversely affect surgical outcome or compromise patient safety.
    - In the event that results of biological monitoring are unknown prior to implantation, the circulating nurse shall notify the surgeon
    - Accurate documentation of load contents shall be noted in the flash sterilization log. The information is necessary for tracking for infection control
3. In-hospital sterilized implants are processed in sterilizers that are concurrently biologically monitored.
4. Whenever feasible, in-hospital sterilized items are not implanted until such time as results of biological monitoring are known.

B. Resterilization of implants:

1. Only those implant items for which the manufacturer has provided specific instructions for resterilization may be resterilized.
2. Resterilization of mechanically stressed, such as screws or dropped implant items is not to be done.

PATIENT VERIFICATION:

- Prior to the patient coming to the surgical suite, the circulating nurse performs verification of the patient, surgeon, side/site, X-Rays, available implants, and prophylactic antibiotics if appropriate.

- In the surgical suite, prior to initiation of the surgical procedure, verification of the patient, surgeon, side/site, and antibiotic given is completed with the surgical team consisting of Surgeon, Anesthesiologist, Scrub Person and Circulating Nurse. This is documented in the Intra Operative Record under Patient Identification "Time Out".

RESPONSIBILITY OF SURGICAL TEAM:

B. Prior to delivery of implants to sterile field, the surgical team verifies the identity of the implant both visually and verbally. The surgical team includes the Operating Surgeon, Scrub person, and Circulating Nurse.

- All surgical procedures requiring implants will have an "Implant Time Out" confirmed with the surgical team both visually and verbally prior to the opening of the implants. This is documented on the Intra-Operative Record under Patient Identification.

    - Total Joint Procedures will have two circulating nurses assigned to that procedure and they are to relieve each other for breaks if necessary, or can

have an additional nurse for relief. One of the primary circulators for that procedure must be present at all times during the procedure.

- On all surgical procedures requiring implants, the surgeon will choose the desired implant and it will be available for implantation.

- There is a grease board in the surgical suite where the date, patient name, the operative side/site is designated. As the surgeon determines the type and size /side of the different implants, they are immediately added to the board for review by the circulating nurse.

- On Orthopedic Procedures the surgeon chooses the implants verbally as he determines which implants he needs, and the circulating nurse writes them on the grease board during the procedure. When all implants have been chosen, the circulating nurse will go to the cart and pick the implants off the cart.

- On the Orthopedic Carts with side specific implants, the side specific implants will be placed in colored containers such as RED for Right Implants and BLUE for Left Implants to differentiate the side specific implants.

- When bringing the specific cart with implants to the surgical area, the circulating nurse prior to arrival in the surgical area will remove the non-specified side implants. Such as the Total Knee Cart and the procedure is for a Right Knee Replacement, the Left Knee specific implants will be removed from cart.

- On Ophthalmologic procedures, the Intra Ocular Lens will be verified with the surgical team visually and verbally including reference to the Lens Information Sheet from the Ophthalmologist office prior to opening.

- Only implants verified as having been subject to the sterilization process are implanted. Factory –packaged sterile implants must be checked for package integrity and expiration date. In –hospital sterilized implants must be checked for package integrity, expiration date, and process indicator results.
- After the procedure is completed, the circulating nurse assigned to the procedure will reorder the implants used.

SURGICAL PROCEDURES REQUIRING IMPLANTS INCLUDE BUT NOT LIMITED TO:

- Surgical procedures requiring orthopedic hardware.
- Pacemakers

- Insertion of Invasive Lines (groshong catheter, vascular ports, any other line for IV therapy that will be longterm.)
- Procedures requiring mesh (such as hernia repairs, TVT etc.)
- Procedures requiring Vascular Grafts.

DOCUMENTATION:

A. One of the registered professional nurses in the circulating role is responsible for the documentation of implanted devices. On Total Joint Procedures, where there are two circulating nurses, one of the circulating nurses will be responsible for the documentation of implanted devices.
B. All implants must be documented in the Intra Operative Patient Record under "Implants", including:
    - Name of device (implant)
    - Manufacturer
    - Lot number
    - Model number
    - Size and Side
    - Location of implant
    - Expiration date

SPECIAL CONSIDERATIONS:

Physician order required: ___X_ Yes _____ No
Procedure may be performed by: X__RN

Committee Approval	**Date**
Surgery Tissue Committee	7-23-08
Medical Executive Committee	
Administration	
Board of Directors	

Maggie Egan

Subject: FW: Policy Revision_Exposure Evaluation_for ED Committee Review

-----Original Message-----
From: Kathryn Erickson
Sent: Friday, January 09, 2009 2:39 PM
To: Maggie Egan
Subject: Policy Revision_Exposure Evaluation_for ED Committee Review

Hi, Maggie,

At the August Infection Committee meeting I was asked to consolidate all of the existing Exposure policies, and at the November Infection Committee meeting the policy was referred to the ED Committee for approval. I have attached the draft, and the original memo. The changes were as follows:

a. **Exposure Evaluation** - revised as requested at August IC meeting:
   1. Exposure Reporting Policy - DELETED
   2. Recommendations for Prophylaxis after Occupational Exposure to HIV - DELETED
   3. HIV Testing without Consent - DELETED (consolidated with Initial Evaluation of Exposure Incident)
   4. AIDS/HIV Testing and Orders - Remove from All-Unit policies; keep in Infection Prevention Department Policies for reference regarding synopsis of California Laws; will also be readily available via Policy Manager
   5. Initial Evaluation of Exposure Incident Policy - Revised with detail regarding physician responsibility as defined by Cal-OSHA law.
   6. Name of policy changed to EXPOSURE EVALUATION.

Please let me know whether they review it or NOT.

Thank you!

Exposure ıluation_10-08_DRA

Policy revision memo to IC doc...

Kathryn Erickson, RN
Staff Development/Infection Prevention
Northern Inyo Hospital
150 Pioneer Lane
Bishop, California 93514
760-873-2138 Staff Development
760-872-5838 FAX

NORTHERN INYO HOSPITAL
Nursing Services - Infection Control

DRAFT

EXPOSURE EVALUATION

POLICY

1. Any NIH employee who has experienced an exposure to potentially infectious materials while rendering occupational or health care related services will be evaluated in a timely manner and post-exposure prophylaxis offered as indicated at the hospital's expense. In most cases, a nurse's first report shall be all that is required, but an employee may preferentially request a physician evaluation.

CONSIDERATIONS:

Definition of Exposure:

1. An injury which exposed the Health Care Worker (HCW) to another person's blood or other potentially infected material (OPIM) via:
2. A percutaneous injury with a contaminated needle or sharp object.
3. Contact with the surface of the eye or mucous membrane of the nose or mouth.
4. Contact with non-intact skin or when skin is chapped, abraded, or inflicted with dermatitis or if contact is prolonged or involves extensive areas.
5. Other infectious disease exposures (i.e., bacterial transmission or viral respiratory illness) will be reported to the Employee Health (EH) nurse and appropriate evaluation and follow-up will be instituted by EH.

Body fluids considered potentially infectious:

1. Blood, semen, vaginal secretions, and other body fluids contaminated with visible blood.
2. Cerebrospinal, synovial, pleural, peritoneal, pericardial, and amniotic fluids.
3. Tissue and laboratory specimens that contain blood or other potentially infectious material (OPIM).

IMMEDIATE MANAGEMENT:

1. **Wash** puncture wounds and other cutaneous injures with soap and water or antiseptic soap.
2. **Decontaminate** exposed oral and nasal mucous membranes by vigorous flushing with water.
3. **Irrigate** eyes with clean water, saline, or specific sterile irrigants per ER.
4. **Report** exposures to ER as soon as possible.

RESPONSIBILITY:

1. Emergency Department Staff

a. Assure initial steps for immediate management of injury are implemented.

a. **Evaluation and Certification of Exposure –** A physician must evaluate and certify the significance of the exposure, including its nature and extent.

   i. Certification must be in writing.

   ii. Certification must be within 72 hours of the request.

   iii. Exposed individuals, including physicians, may not verify their own exposure as significant, but employing physicians may certify the exposure of their employees.

   iv. Within 72 hours of certifying the exposure as significant, the certifying physician must provide written certification to the attending physician of the source patient that a significant exposure has occurred.

   v. The certifying physician must also request information on whether the source patient has tested positive or negative for a communicable disease and the availability of blood or other patient sample.

b. **Response** – the source patient's attending physician must respond to the certifying physician's request for information within three working days.

c. **Release of Known Communicable Disease Positive Status** – If the source patient is already known to be positive for a communicable disease, the attending physician must attempt to get the source patient's consent to release his or her communicable disease status to the exposed individual.
   i. If the source patient refuses or cannot be contacted, an attending physician of the source patient may advise the exposed individual of the source patient's communicable disease status as soon as possible after certification of the exposure as significant.
   ii. Consent for release is not required where the exposed individual is a treating health care provider or an employee or agent of the treating health care provider who provides direct patient care and treatment.

d. **Testing where Source Patient's Communicable Disease Status is Unknown** – If the source patient's communicable disease status is not known and blood or other patient samples are available, and if the exposed individual has tested negative on a baseline test for communicable disease, then the source patient must be given the opportunity to consent to a test for communicable diseases as follows: Within 72 hours after receiving written certification of a significant exposure, an attending physician of the source patient must do all of the following:
   i. **Notice to Source Patient**. The attending physician must make a good faith effort to notify the source patient, or the patient's authorized legal representative, of the significant exposure. This effort includes, but is not limited to, an effort to locate the patient by telephone or by certified first class mail. The efforts to contact the source patient, and the results of these efforts, must be documented in the source patient's medical record.
      (1) If the source patient or the legal representative cannot be contacted after a good faith effort, it may be treated as if the source patient has refused to be tested (see c below).

v. **Counseling and Referral** – The attending physician must provide the source patient with medically appropriate pretest counseling and refer the source patient to appropriate post test counseling and follow-up if necessary. This must be done whether or not the source patient consents to testing.

e. **Informing the Exposed Individual** – If an exposed individual is informed of the status of a source patient with regard to a communicable disease, by law the exposed individual must be informed that he or she is subject to existing confidentiality protections for any identifying information about the test results.

i. This includes informing the exposed individual about the need to keep the test results and the identity of the source patient confidential and the penalties for violating the law.

(1) The law does not permit the identity of the source patient to be disclosed to the exposed individual.

(2) In many, if not most, instances, the exposed individual will already know who the source patient is.

(3) However, the health care provider should not reveal or confirm the identity of the source patient.

DEFINITIONS

A. "**Attending physician of the source patient**" is any physician who provides health care services to the source patient and includes any of the following:

1. The private physician of the source patient;
2. The physician primarily responsible for the patient who is undergoing inpatient treatment in a hospital; or
3. A registered nurse or licensed nurse practitioner who has been designated by the attending physician of the source patient.

(1) For purposes of follow-up of Healthcare Worker (HCW) exposure incidents, references to "attending physician of the source patient" shall include the Northern Inyo Hospital Infection Surveillance Nurse (or designee), Nursing Supervisor, or Nurse Manager; any of whom may be charged with the initial post-exposure evaluation and follow-up of a hospital employee.

B. "**Available blood or patient sample**" means blood or other tissue or material that was legally obtained in the course of providing health care provider of the source patient ***prior to*** the exposure incident.

C. "**Certifying physician**" means any physician consulted by the exposed individual for the exposure incident. A certifying physician must have demonstrated competency and understanding of the applicable guidelines or standards of the California Division of Occupational Safety and Health (CAL-0OSHA). (**Note:** The law does not specify how this competency may be demonstrated).

D. "**Communicable disease**" is any disease transferable through the exposure incident, as determined by the certifying physician.

http://www.guideline.gov/summary/summary.aspx?doc_id=8131&nbr=004532&string=Management+AND+occupational+AND+exposure

3. California Department of Health Services, April, 2007 – A Brief Guide to California's HIV/AIDS Laws, 2006 http://www.cdph.ca.gov/programs/AIDS/Documents/RPT2007-06-14-2849-2006AIDSLAWS.pdf
4. University of California, San Francisco, National HIV/AIDS Clinicians Consultation Center, http://www.ucsf.edu/hivcntr/
5. http://hivinsite.ucsf.edu/InSite?page=kbr-07-02-06#S6X
6. "HIV Testing in Health Care Settings;" California Department of Public Health, January 18, 2008. http://www.cdph.ca.gov/programs/AIDS/Documents/PERILTRGenAB682Policy2008-01-18.pdf
7. California Department of Public Health, Office of AIDS; www.dhs.ca.gov/AIDS
8. California Consent Manual, California Hospital Association, 2007

Index Listing: Exposure, Exposure Evaluation, Initial Evaluation of Exposure Incident
Reviewed/Revised: 2/2006, 4/2007, 9/2007, 6/2008, 10/2008

HIV

- ☐ **Obtain** "Patient Packet" for source patient (*small envelope inside Exposure Packet*)
  - ☐ **Provide source patient with HIV Test Information Sheet,** after ICP or supervisor has informed patient of need for exposure follow-up *(if ICP or Sup not available, ED RN should explain that an exposure has occurred, and our procedure is to obtain baseline lab tests for HIV and HCV on the source patient)*
  - ☐ **Contact lab** to draw HIV and HCV ASAP from source patient, if no previously drawn specimen available
    - ☐ Use **Infection Surveillance lab requisition** found in Patient Packet
  - ☐ **Write order** on **Physician Order Sheet** and any comments on **Progress Notes** contained in packet
    "HIV antibody (per needle stick protocol)"
    "HCV antibody (per needle stick protocol)"
- ☐ **If source patient refuses to be tested, proceed according to "HIV Testing Without Consent" process described in this policy**
- ☐ Keep all patient information in the Patient Packet and keep the packet together with the patient chart
- ☐ **Provide HCW with Exposure Information Sheets.**
- ☐ **Provide** HCW with Infection Surveillance lab requisition for HIV and HCV antibody test and instruct to proceed to lab for draw
- ☐ Inform the HCW that the baseline test can be performed during regular lab business hours – STAT not necessary.

HBV

- ☐ **Determine** HCW's HBV vaccine / immunity status (*in general, all NIH patient care staff have completed the series or are immune; ascertain if the HCW was one of our few non-responders*)
- ☐ **If HCW is immune, no further workup on either patient or HCW is necessary**
- ☐ If HCW is not immune, **order** HB surface antigen on patient; ask lab to run ASAP
- ☐ If HCW HBV status is unknown (i.e.; vaccine series not completed, **order**:
  - ☐ HB_s Antigen on HCW
  - ☐ HB_s Antibody on HCW
  - ☐ HB_s Antigen on source patient
- ☐ If indicated by above HB_s results – **follow NIH policy**, "Hepatitis Prophylaxis / Needle Stick Policy"

HCV

- ☐ **Order** baseline HCV antibody test on both HCW and source patient

Consent is not necessary

Prophylaxis is not indicated

Draft

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Sputum Induction	
Scope: Respiratory Therapist	Department: Respiratory Care
Source:	Effective Date:

PURPOSE:

To obtain sputum via induction with a hypertonic saline solution via hand held nebulizer when a patient cannot voluntary cough up a sample.

PRECAUTIONS:

1. Use of hypertonic saline may produce bronchospasm in patients with hyperreactive airways. Patients should be monitored for signs of intolerance and respiratory distress.

2. Excessive coughing in susceptible patients may precipitate vomiting.

3. **Standard Droplet Precautions** should be taken, see "Infection Control Policy and Procedure Manual" located in the Respiratory Department. **Airborne Precautions** should be taken on all sputum inductions done to R/O TB, or patients diagnosed with Pulmonary Tuberculosis.

POLICY:

Non-Invasive Procedures

EQUIPMENT NEEDED:

1. Sputum cup, Small Bio Hazard bag
2. Hand Held Nebulizer
3. 15ml 10% Hypertonic saline, located in the Omni-Cell
4. Personal Protective Equipment
5. Paperwork

PROCEDURE:

1. Verify orders, obtain lab slip and other paper work from ward clerk or receptionist.
2. Wash hands, verify patient and introduce yourself.
3. Explain the need and the procedure to the patient.
4. Instruct the patient to remove dentures and to rinse or gargle their mouth with water.
5. First ask the patient to cough, to see if they can produce a sample, if unable then:
6. Listen to breath sounds, if patient is wheezing call physician and ask for an order for bronchodilator of choice. Give bronchodilator first, check to see if patient can cough up sample, if not.
7. Nebulize Hypertonic solution for 10-20 minutes or until sample is obtained.
8. Instruct the patient to breath normally through the mouth and take occasional deep breaths.
9. Explain to the patient that coughing is normal and a desired effect of the procedure.
10. Instruct the patient to cough forcefully and expectorate into the specimen container.
11. Monitor patient and breath sounds, if increase wheezing or bronchoconstriction occurs, stop hypertonic saline, call physician for bronchodilator.
12. If patient is unable to produce a specimen, notify the physician.
13. Label the specimen cup with patients name, date and time of collection. Place in a biohazard bag and with the lab slip completely filled out take to bacteriology. Place the biohazard bag with the sputum cup under the hood and notify personnel. If Laboratory personal are not in house, the RCP will need to follow "Laboratory Manual for Respiratory Care".
14. Dispose of equipment and wash hands.
15. Chart and bill procedure.

Invasive Procedure:

See Nasotracheal Suctioning

Revised 1-14-2009 with AARC guidelines and "Respiratory Care A Guide to Clinical Practice"

Committee Approval	Date
Respiratory Care	
Medicine/Intensive Care Committee	
Executive Committee	
Administration	
Hospital District Board of Directors	

Supercedes 3--23-2000

DRAFT

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title Liberation From Mechanical Ventilator	
Scope: Respiratory Therapist, ICU RN	Department: Respiratory Care, ICU
Source: Kevin Christensen	Effective Date:

PURPOSE:
To guide Respiratory Therapist and Nurses in successfully liberating patients receiving mechanical ventilator support. Upon the physician ordering "Weaning Protocol" the RCP will follow the procedure described below to facilitate a safe and timely removal of the endotracheal tube at the earliest appropriate time.

As the conditions that warranted placing the patient on the ventilator stabilize and begin to resolve, attention should be placed on removing the ventilator as quickly as possible. Unnecessary delays in this discontinuation process increase the complication rate from mechanical ventilation (e.g., pneumonia, airway trauma) as well as the cost.

In general, patients being considered for removal from ventilatory support fall into two categories: (1) those for whom removal is quick and routine, i.e., OD, status asthmaticus, pulmonary edema, recovering from postoperative anesthesia, etc. (2) those who need a more systematic approach for discontinuing ventilatory support, i.e., COPD, prolonged mechanical ventilation (> 1-2 weeks) etc.

The primary phase in any ventilator weaning is a Daily Screening for readiness to wean.

This should start in the early morning with the Respiratory Therapist and ICU RN discussing the plan of action. **If the physician has written an order for weaning in the AM then the patient should be given a "Sedation Vacation" early enough so the patient can be assessed for Daily Screening at 7 AM.** Gastric feeding should be held to allow time for stomach emptying in case a successful spontaneous breathing trial leads to extubation.

PROCEDURE:

I. DAILY SCREENING PATIENT ASSESSMENT:

1. Some reversal of the underlying cause of the respiratory failure
2. Minute ventilation < 15L/min
3. PEEP <= 5-8 cm H2O
4. Pa02/Fi02 > 150- 200 or Fio2 < 40
5. Adequate cough during suctioning
6. No continuous infusion of vasopressor agents or sedatives, (dopamine can be given in doses not exceeding 5 ug/kg body weight/min, and intermittent bolus dosing of sedatives is allowed).

7. Spontaneous respiratory effort
8. Hemodynamic stability
9. Afebrile
10. Patient can follow commands, lifting head up, etc.

A. Exclusions:

11. Dopamine > 8 mcg/kg/min
12. Excessive level of sedation

If the patient meets the above Daily Screening then the following Weaning Parameters will be done:

II. MEASURABLE CRITERIA

A. **RCPs should perform weaning parameters daily in the AM and PRN.**

Change mode to Spontaneous with a Pressure Support of 5cm/H2o. Observe patients VT for 5-10 minutes. Have patient perform VC maneuver. Do three MIP. Record all information on flow sheet.

1. Tidal Volume (VT).....> 5 ml/kg
2. Vital Capacity.....> 10 ml/kg of body weight
3. Maximal inspiratory pressure..... –20 to-30 cm H2O or better
4. RR.....<30-35 breaths/min
5. Spo2 > 90 may increase Fio2 by 5%

It patient passes, then proceed to next step, Spontaneous Breathing Trials

If patient does not pass, go to **Section III.**

Spontaneous Breathing Trials

Place ventilator in Spontaneous Mode with Pressure Support 0-7 cm/H20, observe patients respiratory status for 30 minutes to 120 minutes. Following this SBT, if the patient meets or exceeds the criteria below;

1. Tidal Volume (VT).....> 5
2. Vital Capacity.....> 10 ml/kg of body weight
3. Maximal Inspiratory Pressure.....- 25 cm H20
6. Rapid shallow breathing index (f/vt).....< 105 after 30 minutes
7. Minute Ventilation.....<15 L/min
8. Fio2 ..... <= 40 – 50 %

Patient should then be considered for extubation. Consider ABG's.

The decision to use these criteria must be individualized. Some patients not satisfying all of the above criteria may be ready for attempts at discontinuation of mechanical ventilation.

B. **Signs of Poor Clinical Tolerance.** Patients exhibiting a number of the following signs are not tolerating the weaning process and should be returned to the previous level of support.

1. Breathing frequency above 35 bpm for 5 minutes or longer.
2. Spo2 < 90 for more than 30 seconds
3. Heart rate > 140 beats/min. Sustained changes in the heart rate of 20% in either directions
4. Systolic BP > 180 or < 90 mmHg..
5. RSBI > 105
6. Increased anxiety.
7. Agitation.
8. Decreased mental status.
9. Diaphoresis.
10. The onset of arrhythmias.

Section III:

Patients who do not meet the aforementioned SBT criteria, should have the cause for the failed SBT determined. Once reversible causes for failure are corrected, and if the patient still meets the above criteria, subsequent SBTs should be preformed every 24 hours. It may be necessary to start with Pressure Support of 10 –15cm/H20 or a targeted VT 100cc less than what the patient was on. Then slowly, decreasing Pressure Support, with a target of 5cm/H20. SBT should last no longer than 2 hours, following that time, place patient back on starting settings and rest for 2 hours. Then repeat SBT. SBT may continue until 20:00, after that time the patient should be placed back on previous setting until 07:00, and SBT begin again.

Reported reintubation rates range from 4% to 23% for different intensive care units populations. Although the optimal rate of reintubation is not known, it would seem likely to rest between 5% and 15%.

NIPPV

Noninvasive facemask positive-pressure ventilation may prevent the need for re-intubation in those who appear to be failing immediately after extubation

There are hazards and complication in removing the endotracheal tube See: "Removal of Endotracheal Tube (Extubation)" policy.

References:

Determining the Best Threshold of Rapid Shallow Breathing Index in a Therapist-Implemented Patient-Specific Weaning Protocol
Respiratory Care February 2007

Discontinuing Ventilatory Support, Chapter 47
Egan's Fundamentals of Respiratory Care, ninth Edition

Evidence-Based Guidelines for Weaning and Discontinuing Ventilatory Support
Respiratory Care January 2002

Ventilator Modes Used in Weaning
Chest 2001

Liberation From Mechanical Ventilation: A decade of Progress
Chest 1998

Committee Approval	**Date**
Respiratory Care	1-14-09
Policy and Procedure	
Medical Services Committee	
ICU Committee	
Medical Executive	
Administration	
Board of Directors	

Revised
Reviewed

THIS SHEET

INTENTIONALLY

LEFT BLANK

Information Regarding PAYROLL Check Advances

The process for requesting advances on payroll checks seems to be an area of confusion and uncertainty among many of the hospital employees. Following are the guidelines and procedures for requesting an advance on your payroll check. This will hopefully clarify when and how to request such a check.

Advances are given ONLY in the following circumstances:

a. ADVANCES on next scheduled payroll check will be paid WITHOUT NOTICE ONLY in cases of extreme emergency (i.e., death in employee's family).
b. NON-EMERGENCY VACATION LEAVE ADVANCES WILL BE PAID IF REQUESTED TWO OR MORE WEEKS IN ADVANCE OF THE FIRST DAY OF ACTUAL VACATION.

Early PAYROLL Checks will be issued in the following circumstances:

a. Two or more weeks advance written notice is requested in the event of a resignation.
b. Dismissed employees will receive their final paychecks immediately upon dismissal.

For all employees, except dismissed or resigning employees, the following Check Request Advance must be completed by the employee requesting the advance and approved by the employee's department head prior to forwarding the request to the Hospital Administrator. Due to Director Deposit related problems with Payroll Checks being issued in advance UP TO 80% of an employee's normal take home pay will be paid from the Accounts Payable System. The advance amount will be taken from the employee's next scheduled payroll check with the remainder going by Direct Deposit as normal into the designated bank account.

Check Advance Request

Employee's Name:	Department:	Date and Time Check Needed:

Explanation of need (include payroll date to be paid in this advance):	Today's Date:

Amount Requested: $_____
(Up to 80% of prior take home pay)

Employee's Signature/Date:	Department Head's Signature/Date:
Administrator's Signature/Date:	**Accounting Approval/Date:**

___ **Your Check Request Advance has been approved. Please pick up your check in the Human Resources & Education Department on the date/time you requested it.**

END