Northern Inyo Hospital

May 13 2015 Regular Meeting

May 13 2015 Regular Meeting - May 13 2015 Regular Meeting

AGENDA

NORTHERN INYO COUNTY LOCAL HEALTHCARE DISTRICT
BOARD OF DIRECTORS REGULAR MEETING

May 13, 2015 at 5:30 p.m.

In the Northern Inyo Hospital Board Room at 2957 Birch Street, Bishop, CA

1. Call to Order (at 5:30 p.m.).
2. At this time persons in the audience may speak on any items not on the agenda on any matter within the jurisdiction of the District Board. (*Members of the audience will have an opportunity to address the Board on every item on the agenda. Speakers are limited to a maximum of two minutes each.)*

Consent Agenda (action items)

3. Approval of minutes of the April 7 2015 special meeting
4. Approval of minutes of the April 15 2015 regular meeting
5. Approval of financial and statistical reports for the month of March, 2015

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6. Chief Executive Officer's Report; Victoria Alexander-Lane.
   - A. Physician Recruitment update
   - B. LAFCO update
   - C. Foundation update
   - D. Radiology Department ACR Accreditation
   - E. Stop Loss – 10 in last year
   - F. Contracts in progress
7. Chief of Staff Report; Mark Robinson, M.D.
   - A. Approval of Policies/ Procedures/Protocols/Order Sets (*action items*):
     1. Cardiopulmonary – *Stress ECHO Procedure*
     2. Cardiopulmonary – *Stress Echo*
   - B. Advancement of Colleen McEvoy's proctoring period based upon Doctors Collins and Helvie's reviews of Colleen McEvoy's charts (*action item*).
   - C. Proposed Telemedicine Bylaws Amendment (*action item*).
8. Chief Nursing Officer Report (*information item*).
9. Chief Performance Excellence Officer Report (*information item*).
10. New Business
    - A. Amendments (2) to the District Defined Benefit Retirement Plan (*action item*).

B. Purchase of Dragon Software Licenses and Training (*action item*).

C. Emergency purchase of Tissue Processor, $80,054 (*action item*).

11. Reports from Board members (*information items*).
12. Adjournment to closed session to/for:

A. Hear reports on the hospital quality assurance activities from the responsible department head and the Medical Staff Executive Committee (*Section 32155 of the Health and Safety Code, and Section 54962 of the Government Code*).

B. Discussion of potential litigation *(Government Code section 54956(d)(2)*).

13. Return to open session, and report of any action taken in closed session.
14. 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.

CALL TO ORDER	The meeting was called to order at 11:00 am by M.C. Hubbard, President.
PRESENT	M.C. Hubbard, President Denise Hayden, Vice President D. Scott Clark, M.D., Secretary Peter Watercott, Treasurer John Ungersma, M.D., Member at Large
OPPORTUNITY FOR PUBLIC COMMENT	Ms. Hubbard asked if any persons in the audience wished to speak on items listed on the agenda for this meeting. No comments were heard.
ADJOURNMENT TO CLOSED SESSION	At 11:03am, Ms. Hubbard announced that the meeting would adjourn to closed session to allow the Board of Directors to: A. Commence Annual CEO Performance Evaluation (*Government Code Section 54957*).
RETURN TO OPEN SESSION AND REPORT OF ACTION TAK	At 12:31pm the meeting returned to open session. Ms. Hubbard reported the Board took no reportable action.
ADJOURNMENT	The meeting was adjourned at 12:32 pm.

_____
M.C. Hubbard, President

Attest:

_____
D. Scott Clark, M.D., Secretary

CALL TO ORDER	The meeting was called to order at 5:30 pm by Denise Hayden, Vice President.
PRESENT	Denise Hayden, Vice President D. Scott Clark, MD, Secretary Peter Watercott, Treasurer John Ungersma, MD, Member at Large
ABSENT	M.C. Hubbard, President
ALSO PRESENT	Victoria Alexander-Lane, Chief Executive Officer Mark Robinson MD, Chief of Staff Sandy Blumberg, Executive Assistant
NIH AUXILIARY QUARTERLY REPORT	Northern Inyo Hospital (NIH) Auxiliary President Judy Fratella provided a quarterly report on Auxiliary activities. Ms. Fratella included mention of: - Purchase of a Vidas Analyzer for the Hospital Laboratory - A sales report from the Hospital gift shop - The NIH Auxiliary recently received the *Citizens of the Quarter* award from the City of Bishop. Stuart Souders MD and NIH Director of Diagnostic Imaging Patty Dickson presented Ms. Fratella and Auxiliary Treasurer Sharon Moore with a plaque memorializing the Auxiliary's donation of the Hospital's Automated Breast Ultrasound machine, which has already been instrumental in saving lives in this community.
OPPORTUNITY FOR PUBLIC COMMENT	Ms. Hayden stated at this time persons in the audience may speak on any items not on the agenda on any matter within the jurisdiction of the District Board. She additionally noted that members of the audience will have the opportunity to address the Board on every item on the agenda, and that speakers will be limited to a maximum speaking time of two minutes each. The following persons spoke during public comment: - Martha Reynolds, Northern Inyo Hospital R.N. - Devin Riley, NIH Information Technology Technical Services Manager
CONSENT AGENDA	Ms. Hayden called attention to the consent agenda for this meeting, which included approval of the minutes of the March 18 2015 regular meeting. It was moved by John Ungersma, MD, seconded by Peter Watercott, and unanimously passed to approve the proposed consent agenda item as presented.
REVISED PERFORMANCE IMPROVEMENT AND PROGRESSIVE DISCIPLINE POLICY	Chief Executive Officer (CEO) Victoria Alexander-Lane called attention to a revised policy titled *Performance Improvement and Progressive*

Discipline Policy and Procedure, which has recently been re-worded. The revised policy was presented as an information item for members of the Board.

POLICY AND PROCEDURE APPROVAL, EMPLOYEE COMPLAINTS AND THE GRIEVANCE PROCESS

Ms. Alexander-Lane then called attention to approval of a proposed policy titled *Employee Complaints and the Grievance Process*. It was moved by D. Scott Clark, MD, seconded by Doctor Ungersma, and unanimously passed to approve the *Employee Complaints and the Grievance Process* policy and procedure as presented. William Wolfson MD also spoke publicly on this agenda item.

CHIEF EXECUTIVE OFFICER'S REPORT

Ms. Alexander-Lane reported the following in regard to physician recruitment:

PHYSICIAN RECRUITMENT UPDATE

- General surgeon Allison Robinson, MD will begin practicing at NIH during the month of July
- Pediatrician Louisa Salisbury, MD and OB/Gyn physician Martha Kim, MD will both begin practicing at NIH during the month of June
- Physician Assistant Sunny Sawyer will begin seeing patients at the Rural Health Clinic (RHC) for same day visits at the start of May

JOINT COMMISSION SURVEY OF THE LAB

Ms. Alexander-Lane introduced NIH Laboratory Director Fran Yuschak, who reported the Lab recently underwent an unannounced survey by the Joint Commission, and passed the inspection with no citations of significance being noted.

LAFCO UPDATE

Ms. Lane additionally reported that Hospital Administration will meet with the Inyo County Local Agency Formation Commission (LAFCO) in the next week, in order to discuss Southern Mono Healthcare District's current and proposed operations within the boundaries of the Northern Inyo County Local Healthcare District.

EMPLOYEE RECOGNITION EVENT

Ms. Alexander-Lane additionally reported that the Hospital's Long-Term Employee Recognition Event will be held on April 17, 2015.

LEGAL EXPENSES FOR UNION

Ms. Alexander-Lane also reported that the Healthcare District has already spent over $48,000 in legal expenses for work done regarding formation of the nurses' union, and that the union start-up process is expected to be very long and to become much more expensive.

CHIEF OF STAFF REPORT

Chief of Staff Mark Robinson, MD reported that following careful review and consideration the Medical Staff Executive Committee recommends Board approval of the following:

PRIVILEGING AND CREDTNTIALING

1. Approval of appointment to the NIH Provisional Consulting Medical Staff of Board-certified Radiology Physician Edmund Pillsbury, M.D. according to the approved privileges as requested through December 31, 2016. This recommendation is made consequent to careful review of the applicant's application and

supporting documentation.

2. Privileging of Sunny Sawyer, PA-C to function according to the approved NIH Physician Assistant Protocols as requested through December 31, 2016. This recommendation is made pursuant to careful review of the Physician Assistant Certified application and supporting documentation by majority vote.
3. Advancement from Provisional Consulting Staff of Jeanette Schneider, MD to Consulting Staff with clinical privileges as requested. This recommendation is made consequent to careful review of the applicant's applications and supporting documentation
4. Granting of additional privileges as requested commensurate with their current practice to the following:
   - Thomas McNamara, MD, Radiology
   - Joy Engblade, MD, Hospitalist

POLICY/PROCEDURES/ PROTOCOLS APPROVAL

5. Approval of the following policies/procedures, which have been reviewed and recommended by the appropriate Medical Staff Committees:
   A. Policies/Procedures/Protocols:
      1. Diagnostic Imaging - Imaging Equipment Quality Control
      2. Diagnostic Imaging - Monitoring and Documentation of Fluoroscopic Quality Control
      3. Diagnostic Imaging - Ordering Privilege and Procedure
      4. Diagnostic Imaging - Guidelines for the use of radiology equipment in other areas
      5. Diagnostic Imaging - Self-Referral for Breast Screening Exams
      6. DI - Standards of Care
      7. Diagnostic Imaging - Nuclear Medicine New Employee/Annual Orientation
      8. Diagnostic Imaging - Ordering Radioactive Materials
      9. Diagnostic Imaging - MRI Safety, Ear Protection
      10. Diagnostic Imaging - Premedication for Radiographic Contrast Sensitivity
      11. Diagnostic Imaging - MRI Safety - Magnet Room Safety
      12. Diagnostic Imaging - CT Dose Documentation
      13. Diagnostic Imaging - Patient Priority
      14. Diagnostic Imaging - Teleradiology Services
      15. Patient Requiring Psychiatric Evaluation and Treatment

It was moved by Doctor Clark, seconded by Doctor Ungersma, and unanimously passed to approve items 1 through 4 as presented. It was then moved by Mr. Watercott, seconded by Doctor Clark, and passed unanimously to approve policies/procedures/and protocols 1 through 15 as presented.

CHIEF NURSING OFFICER REPORT	Chief Nursing Officer Kathy Decker, RN provided a monthly nursing department report which included an update on performance excellence projects; a flu season update; and a nursing education update.
PERFORMANCE EXCELLENCE REPORT	Chief Performance Excellence Officer Maria Sirois provided a monthly update on hospital Performance Excellence projects and activities, including introduction of the Baldridge Model of performance excellence and discipline, and the Hospital's implementation of Lean Six Sigma training.
NEW BUSINESS	
FINANCIAL REPORT	Chief of Fiscal Services Carrie Petersen provided a review of the NIH Financial and Statistical and Reports as of February 28, 2015. Ms. Petersen called attention to statistics of importance including patient revenue; accounts receivables; investments; long term debt; expenses; and review of the Balance Sheet as of February 28 2015. Regarding the Statement of Operations she additionally noted that revenue is running 8% over budget for the year; inpatient days are 44 percent higher than the previous year; and the excess of revenues over expenses for the fiscal year- to-date is $503,756. Following review of the information provided it was moved by Mr. Watercott, seconded by Doctor Ungersma, and unanimously passed to approve the Financial and Statistical Reports as of February 28 2015 as presented.
AUXILIARY BYLAWS APPROVAL	Ms. Alexander-Lane called attention to annual approval of the NIH Auxiliary Bylaws, which have undergone no significant changes. It was moved by Mr. Watercott, seconded by Doctor Clark and unanimously passed to approve the NIH Auxiliary Bylaws as updated.
B CLINICS SLIDING SCALE DISCOUNT FEE POLICY	Chief of Fiscal Services Carrie Petersen called attention to a proposed Sliding Scale Discount Fee Policy for the NIH “B” Clinics. Following review of the discounts indicated it was moved by Doctor Ungersma, seconded by Mr. Watercott, and unanimously passed to approve the proposed NIH “B” Clinics Sliding Scale Discount Fee Policy as presented.
BOARD MEMBER REPORTS	Ms. Hayden asked if any members of the Board wished to report on any items of interest. Director Ungersma provided a report on the Association of California Healthcare Districts Legislative Day that was recently held in Sacramento.
ADJOURNMENT TO CLOSED SESSION	At 6:51 pm Ms. Hayden announced the Board of Directors would adjourn to closed session to: A. Hear reports on the hospital quality assurance activities from the responsible department head and the Medical Staff Executive Committee (*Section 32155 of the Health and Safety Code, and Section 54962 of the Government Code*).

B. Discussion of potential litigation (Government Code section 54956(d)(2)).
C. Discussion of an OB/Gyn arrangements with Jeanine Arndal MD, and Martha Kim MD (*Government Code Section 54957*)

RETURN TO OPEN SESSION AND REPORT OF ACTION TAKEN

At 8:02 pm the meeting returned to open session. Ms. Hayden reported that the Board took no reportable action.

PHYSICIAN AGREEMENTS WITH DOCTORS KIM; ARNDAL; AND KARP

Ms. Hayden then called attention to approval of the following agreements:
- Approval of agreement for General Surgery Services with Allison Robinson, MD
- Approval of relocation Expense Agreement with Allison Robinson, MD
- Approval of agreement for Pediatric Services with Louisa Salisbury, MD
- Approval of Relocation Expense Agreement with Louisa Salisbury, MD
- Approval of changes to OB/Gyn services arrangements with Jeanine Arndal MD, and Martha Kim MD

It was moved by Doctor Clark, seconded by Doctor Ungersma, and unanimously passed to approve all four agreements as presented.

ADJOURNMENT

The meeting was adjourned at 8:05 pm.

_____
Denise Hayden, Vice President

Attest: _____
D. Scott Clark, M.D., Secretary

BUDGET VARIANCE ANALYSIS

Mar-15 Fiscal Year Ending June 30, 2015

Year to date for the period ending March 31, 2015

887	or	40%	more IP days than in the prior fiscal year
$ 4,069,346	or	14.89%	over budget in IP Ancillary Revenue and
$ 2,551,635	or	4.3%	over budget in OP Revenue resulting in
$ 6,620,981	or	7.6%	over budget in gross patient revenue &
$ (2,180,585)	or	-3.8%	under budget in net patient revenue

Year-to-date Net Revenue was	$	54,612,608
Total Operating Expenses were:	$	50,045,974

for the fiscal year to date

$ (1,643,777)	or	0.0%	under budget. Wages and Salaries were
$ (1,606,932)	or	-9.0%	under budget and Employee Benefits
$ 1,472,422	or	12.4%	over budget.
		83%	Employee Benefits Percentage of Wages

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

$ 1,472,422	or 12.4%	Employee Benefits due to funding of Defined Contribution Plan & extremely high Health Claims
$ 934,835	or 54%	Interest Expense over budget due to Accretive Interest on Capital Appreciation Bonds

Other Information:

$ 5,109,450		Operating Income, less
$ (4,493,451)		loss in non-operating activities created a net income of;
$ 615,999	$ (507,722)	under budget.
	41.86%	Contractual Percentages for Year and
	34.96%	Budgeted Contractual Percentages including
$ 317,715	in prior year cost report settlement activity for Medicare & Medi-Cal	

Non-Operating actives included:

$ (3,467,486) loss	$ 729,457	under budget in Medical Office Activities & Over Budget on Interest Expense
$ 271,084	$ (115,307)	under budget in 340B Pharmacy Activity

Contractual Percentage Information

Month Percentage	Year Percentage	
43%	42%	Contractuals are running high as revenue has increased for Medi-Cal and the payment is much lower for Swing Bed Patients based on daily rate

Northern Inyo Hospital
Balance Sheet
Period Ending March 31, 2015

Current Assets:	**Current Month**	**Prior Month**	**Change**
Cash and Equivalents	4,564,180	2,375,162	2,189,018
Short-Term Investments	8,735,540	8,655,510	80,030
Assets Limited as to Use	-	-	-
Plant Replacement and Expansion Fund	2	2	-
Other Investments	978,712	978,712	-
Patient Receivable	46,803,175	47,809,757	(1,006,582)
Less: Allowances	(36,212,583)	(36,366,441)	153,858
Other Receivables	126,813	25,812	101,001
Inventories	3,731,193	3,662,720	68,472
Prepaid Expenses	1,305,280	1,371,069	(65,789)
Total Current Assets	**30,032,311**	**28,512,304**	**1,520,007**
Internally Designated for Capital Acquisitions	1,033,722	1,033,713	10
Special Purpose Assets	833,873	833,853	20
Limited Use Asset; Defined Contribution Pension	400,000	480,030	(80,030)
Revenue Bonds Held by a Trustee	2,678,429	2,516,686	161,743
Less Amounts Required to Meet Current Obligations	-	-	-
Assets Limited as to use	**4,946,024**	**4,864,282**	**81,742**
Long Term Investments	1,452,143	1,452,143	-
			-
Property & equipment, net Accumulated Depreciation	83,565,085	83,951,714	(386,629)
Unamortized Bond Costs	-	-	-
			-
Total Assets	**119,995,562**	**118,780,442**	**1,215,120**

Northern Inyo Hospital
Balance Sheet
Period Ending March 31, 2015

Liabilities and Net Assets			
Current Liabilities:			
Current Maturities of Long-Term Debt	244,643	336,321	(91,678)
Accounts Payable	1,385,528	1,461,400	(75,873)
Accrued Salaries, Wages & Benefits	4,602,272	4,428,519	173,752
Accrued Interest and Sales Tax	775,065	594,274	180,791
Deferred Income	133,248	177,664	(44,416)
Due to 3rd Party Payors	2,207,359	1,351,940	855,419
Due to Specific Purpose Funds	-	-	-
Total Current Liabilities	**9,348,114**	**8,350,118**	**997,996**
Long Term Debt, Net of Current Maturities	50,353,007	50,353,007	-
Bond Premium	1,151,404	1,157,001	(5,597)
Accreted Interest	7,882,278	7,771,729	110,549
Total Long Term Debt	**59,386,689**	**59,281,737**	**104,952**
Net Assets			
Unrestricted Net Assets less Income Clearing	50,426,986	50,314,734	112,253
Temporarily Restricted	833,873	833,853	20
Net Income (Income Clearing)			-
Total Net Assets	**51,260,859**	**51,148,587**	**112,272**
Total Liabilities and Net Assets	**119,995,662**	**118,780,442**	**1,215,220**

NORTHERN INYO HOSPITAL
STATEMENT OF OPERATIONS (new format)
for period ending March 31, 2015

	ACT MTD	BUD MTD	VARIANCE	ACT YTD	BUD YTD	VARIANCE
Unrestricted Revenues, Gains & Other Support						
Inpatient Service Revenue						
Routine	829,625	649,292	180,333	7,221,679	5,738,902	1,482,777
Ancillary	2,543,405	2,442,562	100,843	24,175,684	21,589,115	2,586,569
Total Inpatient Service Revenue	3,373,029	3,091,854	281,175	31,397,363	27,328,017	4,069,346
Outpatient Service Revenue	7,093,378	6,786,817	306,561	62,538,329	59,986,694	2,551,635
Gross Patient Service Revenue	10,466,408	9,878,671	587,737	93,935,692	87,314,711	6,620,981
Less Deductions from Revenue						
Deductions	204,946	321,161	(116,215)	2,158,123	2,838,650	(680,527)
Contractual Adjustments	4,321,081	3,132,004	1,189,077	37,482,677	27,682,868	9,799,809
Prior Period Adjustments *	(39)	-	(39)	(317,715)	-	(317,715)
Total Deductions from Patient Service Revenue	4,525,988	3,453,165	1,072,823	39,323,084	30,521,518	8,801,566
Net Patient Service Revenue	5,940,420	6,425,506	(485,086)	54,612,608	56,793,193	(2,180,585)
Other revenue	214,169	20,461	193,708	542,817	180,843	361,974
Total Other Revenue	214,169	20,461	193,708	542,817	180,843	361,974
Expenses:						
Salaries and Wages	1,840,505	2,008,944	(168,439)	16,149,550	17,756,482	(1,606,932)
Employee Benefits	1,531,289	1,346,264	185,025	13,371,662	11,899,240	1,472,422
Professional Fees	717,698	583,646	134,052	4,843,994	5,158,678	(314,684)
Supplies	521,131	580,564	(59,433)	4,557,046	5,131,434	(574,388)
Purchased Services	306,828	336,480	(29,652)	2,803,387	2,974,057	(170,670)
Depreciation	402,653	414,572	(11,920)	3,607,973	3,664,282	(56,309)
Bad Debts	200,729	221,771	(21,042)	1,802,274	1,960,169	(157,895)
Other Expense	264,879	355,867	(90,988)	2,910,088	3,145,409	(235,321)
Total Expenses	5,785,712	5,848,108	(62,396)	50,045,974	51,689,751	(1,643,777)
Operating Income (Loss)	368,877	597,859	(228,982)	5,109,450	5,284,285	(174,835)
Other Income:						
District Tax Receipts	44,416	45,268	(852)	399,744	400,111	(367)
Tax Revenue for Debt	85,704	87,348	(1,644)	771,336	772,043	(707)
Partnership Investment Income		-	-		-	-
Grants and Other Contributions Unrestricted	32,108	8,231	23,877	56,482	72,753	(16,271)
Interest Income	12,690	11,586	1,104	123,332	102,405	20,927
Interest Expense	(281,490)	(194,891)	(86,599)	(2,657,421)	(1,722,586)	(934,835)
Other Non-Operating Income	5,967	2,858	3,109	9,477	25,262	(15,785)
Net Medical Office Activity	(178,689)	(474,836)	296,147	(3,467,486)	(4,196,943)	729,457
340B Net Activity	22,661	43,716	(21,055)	271,084	386,391	(115,307)
Non-Operating Income/Loss	(256,634)	(470,720)	214,086	(4,493,451)	(4,160,564)	(332,887)
Net Income/Loss	112,243	127,139	(14,896)	615,999	1,123,721	(507,722)

NORTHERN INYO HOSPITAL
OPERATING STATISTICS
for period ending March 2015

		FYE 2015	FYE 2014		
	Month to Date	Year-to-Date	Year-to-Date	Variance from PY	
Licensed Beds	25	25	25		
Total Patient Days with NB	364	3,103	2,216	887	40%
Swing Bed Days	63	615	50	565	
Discharges with NB	115	946	837	109	
Days in Month	31	274	274		
Occupancy	11.74	11.32	8.09	3	
Average Stay (days)	3.17	3.28	2.65	1	
Hours of Observation (OSHPD)*	848	5,060	4,934	126	
Observation Adj Days	35	211	206	5	
ER Visits (OSHPD)	710	6,112	5,802	310	
Outpatient Visits (OSHPD)	3,326	28,422	28,722	(300)	
IP Surgeries (OSHPD)	19	203	218	(15)	
OP Surgery (OSHPD)	90	799	733	66	
Worked FTE's	288.00	299.00	316.00	(17)	
Paid FTE's	313.00	340.00	359.00	(19)	
Payor %					
Medicare		42%	43%	-1%	
Medi-Cal		22%	17%	5%	
Insurance, HMO & PPO		34%	36%	-2%	
Indigent (Charity Care)		0.4%	1%	-1%	
All Other		2%	3%	-1%	
Total		100%	100%		

***Observation Hours have been corrected for the year**

Investments as of 3/31/2015

ID	Purchase Date	Maturity Date	Institution	Broker	Rate	Principal Invested
1	02-Mar-15	01-Apr-15	LAIF (Walker Fund)	Northern Inyo Hospital	0.28%	323,136.85
3	02-Mar-15	01-Apr-15	Local Agency Investment Fund	Northern Inyo Hospital	0.28%	8,312,402.98
4	20-May-10	20-May-15	First Republic Bank-Div of BOFA	Financial Northeaster Corp.	3.10%	100,000.00
				Short Term Investments		**8,735,539.83**
5	16-Apr-14	15-Oct-16	Wachovia Corp New Note	Multi-Bank Service	1.38%	552,142.50
6	13-Jun-14	13-Jun-18	Synchrony Bank Retail-FNC	Financial Northeaster Corp.	1.60%	250,000.00
7	28-Nov-14	28-Nov-18	American Express Centurion Bank	Financial Northeaster Corp.	2.00%	150,000.00
8	02-Jul-14	02-Jul-19	Barclays Bank	Financial Northeaster Corp.	2.05%	250,000.00
9	02-Jul-14	02-Jul-19	Goldman SachsBank USA NY CD	Financial Northeaster Corp.	2.05%	250,000.00
				Long-Term Investments		$1,452,142.50
				Total Investments		**$10,187,682.33**
2	02-Mar-15	01-Apr-15	LAIF Defined Cont Plan	Northern Inyo Hospital	0.28%	400,000.00

Financial Indicators as of March 31, 2015										
	Target	Mar-15	Feb-15	Jan-15	Dec-14	Nov-14	Oct-14	Sep-14	Aug-14	Jul-14
Current Ratio	>1.5-2.0	3.21	3.41	3.46	3.04	2.62	2.69	2.68	2.69	2.58
Quick Ratio	>1.33-1.5	2.66	2.81	2.89	2.56	2.18	2.27	2.21	2.23	2.16
Days Cash on Hand prior method	>75	126.67	138.83	130.36	143.21	127.59	122.64	136.14	138.13	138.95
Days Cash on Hand Short Term Sources	>75	71.26	61.69	60.80	73.66	55.44	61.35	65.50	65.63	57.77
Debt Service Coverage	>1.5-2.0	1.94	1.93	1.97						
Debt Service Coverage as outlined in 2010 and 2013 Revenue Bonds require that the district										
has a debt service coverate ratio of 1.50 to 1 (can be 1:25 to 1 with 75 days cash on hand)										
Debt Service Coverage is calculated as Net Income (Profit/Loss) from the Income Statement										
PLUS Depreciation & Interest Expense added back divided by the Current Interest & Principle										
for TOTAL DEBT from the Debt Information divided by number of closed fiscal periods										
Current Ratio Equals (from Balance Sheet) Current Assets divided by Current Liabilities										
Quick Ratio Equals (from Balance Sheet) Current Assets;Cash and Equivalents through										
Net Patient Accounts Receivlable Only divided by Current Liabilities										
Updated Days Cash on hand Short Term = current cash & short term investments / by total operating expenses / by days in month										

Northern Inyo Hospital
Monthly Report of Capital Expenditures
Fiscal Year Ending June 30, 2015
As of March 31, 2015

MONTH APPROVED BY BOARD	DESCRIPTION OF APPROVED CAPITAL EXPENDITURES		AMOUNT
FY 2011-12	Paragon Physician Documentation Module		111,826 *
FY 2012-13	Paragon Rules Engine/Meaningful Use Stage 2 QeM	Plus annual fees	67,390 *
FY 2013-14	Caldwell Easy III	EEG	50,917
	Athrex Orthopedic Equipment & Instrumentation	Surgery	70,010 *
	Philips Monitors	Infusion Unit	88,247 *
	Blood Gas Analyzer Upgrade	Laboratory	14,687
	Stress Equipment	EKG	39,044 *
	5500 HD Resting ECG System	EKG	29,654 *
	GE OEC 9900 C-Arm	Radiology	163,673 *
	Olympus 3-D Laparascopic Cameras and Scopes	Surgery	487,327 *
	Triad Energy Platform Also on Capital Expenditures	Surgery	49,131 *
	AMOUNT APPROVED BY THE BOARD IN THE PRIOR FISCAL YEARS TO BE EXPENDED IN THE CURRENT FISCAL YEAR		1,171,906
FY 2014-15	Radio Frequent Ablation Hardware		36,580
	Flooring Replacement; ED Corridor & Sterile Pack, Clean Up and Decontamination		195,820
	AMOUNT APPROVED BY THE BOARD IN THE CURRENT FISCAL YEAR TO BE EXPENDED IN THE CURRENT FISCAL YEAR		232,400
	Year-to-Date Board Approved Budgeted Capital		262,581
	Amount Approved by the Board in Prior Fiscal Years to be Expended in the Current Fiscal Year		1,171,906
	Amount Approved by the Board in the Current Fiscal Year to be Expended in the Current Fiscal Year		232,400

Northern Inyo Hospital
Monthly Report of Capital Expenditures
Fiscal Year Ending June 30, 2015
As of March 31, 2015

MONTH APPROVED BY BOARD	DESCRIPTION OF APPROVED CAPITAL EXPENDITURES	AMOUNT
	Year-to-Date Board-Approved Amount to be Expended	
	Year-to-Date Administrator-Approved Amount	166,958 *
	Actually Expended in Current Fiscal Year	1,335,955 *
	Year-to-Date Completed Building Project Expenditures	220,502 *
	TOTAL FUNDS APPROVED TO BE EXPENDED	1,723,414
	Total-to-Date Spent on Incomplete Board Approved Expenditures	

Reconciling Totals:

Actually Capitalized in the Current Fiscal Year Total-to-Date	1,723,414
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	0
ACTUAL FUNDS APPROVED IN THE CURRENT FISCAL YEAR TOTAL-TO-DATE	1,723,414

Donations by Auxiliary

Donations by Hospice of the Owens Valley	0
+Tobacco Funds Used for Purchase	0
	0

*Completed Purchase
(Note: The budgeted amount for capital expenditures for all priority requests for the fiscal year ending June 30, 2015, is $3,725,006 coming from existing hospital funds.)

**Completed in prior fiscal year

Northern Inyo Hospital
PLANT EXPANSION AND REPLACEMENT BUILDING PROJECTS
Fiscal Year Ending JUNE 30, 2015
As of March 31, 2015
(Completed and Occupied or Installed)

Item	Project	Amount	Month Total	Grand Total
As of Month Ending January 31, 2015				31,993
Phlebotomy Chair	Infusion Center	4,200		
Surgistool	Infusion Center	1,882		
Infusion Remodel-Flooring Carpet	Infusion Center	4,315		
Infusion Remodel-Paint & Wallcoverings	Infusion Center	2,262		
Infusion Remodel-Signs	Infusion Center	3,205		
Infusion Remodel-Ceiling	Infusion Center	2,523		
Infusion Remodel-Flooring Vinyl	Infusion Center	3,205		
Infusion Remodel-Carpentry Work	Infusion Center	14,258		
Infusion Remodel-Doors & Locks	Infusion Center	4,895		
IT Remodel-Carpentry Work	IT Offices	1,322		
IT Remodel-Doors & Locks	IT Offices	1,354		
IT Remodel-Flooring Carpet	IT Offices	7,143		
IT Remodel-Flooring Vinyl	IT Offices	1,156		
IT Remodel-Paint & Wallcoverings	IT Offices	11,661		
Infusion Remodel-Electrical	Infusion Center	17,829		
Infusion Remodel-Counters	Infusion Center	3,530		
Infusion Remodel-Headwalls	Infusion Center	10,293		
Infusion Remodel-Medical Gas	Infusion Center	12,272		

Northern Inyo Hospital
PLANT EXPANSION AND REPLACEMENT BUILDING PROJECTS
Fiscal Year Ending JUNE 30, 2015
As of March 31, 2015
(Completed and Occupied or Installed)

Item	Project	Amount	Month Total	Grand Total
Infusion Remodel-Electrical	Infusion Center	56,152		
Infusion Remodel-Sinks	Infusion Center	1,459		
Infusion Remodel-Plumbing	Infusion Center	2,212		
IT Remodel-Electrical	IT Offices	21,076		
IT Remodel-Plumbing	IT Offices	304	188,508	
As of Month Ending March 31, 2015				220,502

NORTHERN INYO HOSPITAL
Northern Inyo County Local Hospital District
150 Pioneer Lane, Bishop, California 93514

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

TO: NICLHD Board of Directors

FROM: Mark Robinson, MD
Chief of Medical Staff

DATE: 5/5/2015

RE: Medical Executive Committee report

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

1. Approval of the following policies/procedures, which have been reviewed and recommended by appropriate Medical Staff committees:
   A. Policies/Procedures/Protocols
      i. Cardiopulmonary - *Stress ECHO Procedure*
      ii. Cardiopulmonary - *Stress ECHO*
2. Advancement of Colleen McEvoy's proctoring period based upon Drs. Collins and Helvie's reviews of Colleen McEvoy's charts.
3. ~~Approval of the following form~~:
      i. ~~Confidentiality form and policy~~
4. Approval of *Proposed Telemedicine Bylaws Amendments*

Mark Robinson, MD, Chief of Staff

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Stress Echo Procedure	
Scope: ECHO	Manual: EKG
Source: Cardiopulmonary Director	Effective Date:

PROCEDURE:

1. Arrange patient on their left side and place foam block behind their back for comfort during the study.
2. Tape and acquire 10-15 beats 2D apical 4 chamber images.
3. Tape and acquire 10-15 beats 2D apical 2 chamber images.
4. Tape and acquire 10-15 beats 2D apical long axis images.
5. Tape and acquire 10-15 beats 2D parasternal short axis images.
6. Tape and acquire 10-15 beats 2D parasternal long axis images.
7. Record resting EKG.
8. Stand patient on the treadmill, measure and record blood pressure.
9. Record standing EKG.
10. Start treadmill using specified stress protocol (Bruce, Modified Bruce, etc.).
11. Measure and record blood pressure 2 minutes into each progressive stage of stress.
12. Patient will continue stress until one of the following occurs:
    a. Patient reaches a target heart rate between 85 and 100% of their predicted maximum (220-age).
    b. Patient states that they can no longer continue.
    c. Blood pressure exceeds the safety range of Systolic>220mmHg or Diastolic>110mmHg.
    d. Patient has chest pain greater than 7/10 with corresponding EKG changes.
    e. ST elevation or depression >2mm.
    f. Severe shortness of breath, dizziness or pallor.
    g. Increasing arrhythmia noted on the EKG.
13. Once stress has stopped the patient is quickly repositioned on their left side for image acquisition.
14. Start video tape and continuous digital acquisition and attain all 5 previous views within 90 seconds.
15. Monitor patient until heart rate and blood pressure have returned to normal and any symptoms have abated.
16. Alert the supervising internist in the event of abnormal symptoms, abnormal EKG finding or stress induced segmental wall motion abnormalities.
17. Select representative images of 1 cardiac cycle for each of the 5 post stress acquisitions for paging comparison and record side by side pre and post stress images.
18. Release patient and compose preliminary report for reading consulting Cardiologist.

REFERENCES:

1. Reference: Guidelines and Standards-American Society of Echocardiography Reccomendations for Performance, Interpretation, and Application of Stress Echocardiography. Copyright 2007 by the American Society of Echocardiography doi: 10.1016/j. echo.2007.07.003

CROSS REFERENCE P&P:

1. Stress ECHO

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Stress Echo Procedure	
Scope: ECHO	Manual: EKG
Source: Cardiopulmonary Director	Effective Date:

Approval	**Date**
ICU Committee	**11-3-14**
MEC	
Board	

Developed: 4-7-2014
Reviewed:
Revised: 11-4-2014 per ICU Committee
Supercedes:

Index Listings:

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Stress ECHO	
Scope: ECHO	Manual: EKG
Source: Director of Cardiopulmonary	Effective Date:

Purpose:
To define Stress Echo test policies and procedures

Policy: Pretest Policies:

1. Physician, medical office, or clinic will send an order; after it is scanned into Paragon cardiology department will print the order.
2. The EKG Department will contact the patient and collect pertinent information needed for the test. If the patient has COPD or weighs over two hundred and fifty pounds the patient will be asked to come in for a pre screen echo.
3. The EKG technician will give patient the pre test instructions and obtain a list of patient's medication and ascertain allergy history.
4. The EKG Department will schedule the patient for the test and notify the physician office of the time and date.
5. The patient will check in at the radiology department.
6. EKG Department will obtain informed consent.
7. The echocardiographer will scan the patient to insure a readable study.
8. The EKG technician will prep the patient for a stress test that allows for the echocardiographer to obtain images.
9. An appropriate stress testing protocol will be selected prior to the start of the test.
10. The echocardiographer will acquire resting images.
11. Once the patient is prepared, the supervising physician will be notified and will be present before and during the test, and during the recovery period.
12. The stress test will be performed in the standard way using the stress test procedure.
13. When patient has reach predicted maximal heart rate the patient will be removed immediately from the treadmill and the echocardiographer will obtain post exercise images.
14. When the test has been completed the physician will generate a report, the echocardiographer will send echo study via electronic transmission to the cardiologist who will do the interpretation.

Procedure:

1. Arrange patient on their left side and place foam block behind their back for comfort during the study.
2. Tape and acquire 10-15 beats 2D apical 4 chamber images.
3. Tape and acquire 10-15 beats 2D apical 2 chamber images.
4. Tape and acquire 10-15 beats 2D apical long axis images.
5. Tape and acquire 10-15 beats 2D parasternal short axis images.
6. Tape and acquire 10-15 beats 2D parasternal long axis images.
7. Record resting EKG , and B/P
8. Record sitting EKG , and B/P
9. Record standing EKG , and B/P

Title: Stress ECHO	
Scope: ECHO	Manual: EKG
Source: Director of Cardiopulmonary	Effective Date:

10. Patient will stand on treadmill and be instructed how to walk and report any signs or symptoms of chest pain, lightheadedness or shortness of breath.
11. At 2 minutes and 45 sec a blood pressure will be taken and patient will be instructed when speed and elevation will increase.
12. Patient will continue exercise until one of the following occurs:
13. Patient reaches a target heart rate between 85 and 100% of their predicted maximum(220 minus age)
    a) Patient states that they can no longer continue.
    b) Blood pressure exceeds the safety range of Systolic >220mmHg or Diastolic > 110mmHg.
    c) Patient has chest pain with corresponding EKG changes and the physician stops the test.
14. Once stress has stopped the patient is quickly repositioned on their left side for image acquisition.
15. Start video tape and continuous digital acquisition and attain all 5 previous views within 90 seconds.
16. Monitor patient until heart rate and blood pressure have returned to normal and any symptoms have abated.
17. Will call the supervising internist in the event of abnormal finding of the echo loops.
18. Select representative images of 1 cardiac cycle for each of the 5 post stress acquisition for paging comparison and record side by side pre and post stress images.
19. Release patient and compose preliminary report for cardiologist to interrupt.

Equipment:

1. Treadmill
2. 12 lead ECG machine and electrodes
3. Razor
4. BP cuff and Oximeter
5. Oxygen and cannula or mask
6. Echocardiography machine (and operator)
7. Crash cart

Contraindications:

1. Acute myocardial infarction
2. Unstable angina
3. Life-threatening arrhythmia
4. Congestive heart failure
5. Significant uncontrolled hypertension
6. Ventricular aneurysm
7. Dissecting aortic aneurysm
8. Pericarditis
9. Myocarditis

Title: Stress ECHO	
Scope: ECHO	Manual: EKG
Source: Director of Cardiopulmonary	Effective Date:

10. Severe anemia
11. Unwilling patient or patient unable to give informed consent
12. Weight limit of 350lbs. (treadmill weight limit)
13. Patient with LBBB (notify the echocardiographer prior to test)
14. Unable to obtain readable images

REFERENCES:

1. Guidelines and Standards-American Society of Echocardiography Recommendations for Performance, Interpretation, and Application of Stress Echocardiography. Copyright 2007 by the American Society of Echocardiography doi: 10.1016/j. echo.2007.07.003

CROSS REFERENCE P&P:

1. Stress ECHO Procedure

Approval	**Date**
ICU Committee	**11-3-14**
MEC	
Board	

Developed: 4-7-2014
Reviewed:
Revised: 11-4-2014 per ICU Committee
Supercedes:

Index Listings:

BISHOP PEDIATRICS AND ALLERGY
Charlotte Helvie, M.D., FAAP
Kristin Collins, D.O., FAAP
Colleen McEvoy, PNP
152 Pioneer Lane, Suite H
Bishop, CA 93514
Ph: (760) 873-6373
Fax: (760)760-3266

April 21, 2015

To: NIH Medical Staff Credentials Committee

Between February 1, 2015 and April 20, 2015, Kristin Collins, D.O., and myself have reviewed more than 500 of Colleen McEvoy's patient charts. Included but not limited to, were well child exams, sick child exams, injuries, labs and other outpatient testing. All charts were appropriate and within her scope, and Colleen consults with us when appropriate; we feel confident in her abilities and recommend her advancement from the proctoring period.

Sincerely,

Charlotte Helvie, M.D., Chief of Pediatrics

PROPOSED REVISIONS TO MEDICAL STAFF BYLAWS

Comment [SB1]: www.access.gpo.gov/su_docs/fedreg/a110505c.html for CFR rules
Check the most recent CFR 485 vs 482
May use the COP manual website for CAH - www.cms.hhs.gov/manuals/downloads/som107_appendixtoc.pdf

3.6.1 TELEMEDICINE PRIVILEGES

Practitioners who wish to provide permitted types of telemedicine services will be credentialed in accordance with this Section, but, unless they separately qualify, apply and are approved for membership in a staff category described in Section 4 of these Bylaws, will not be appointed to the Medical Staff in any membership category.

3.6.1.1 TELEMEDICINE CREDENTIALING

a. In processing a request for telemedicine privileges, the Medical Staff and Hospital may follow the normal credentialing process described in Section 2 of these Bylaws, including but not limited to the collection of information from primary sources. Alternatively, the Medical Staff may elect to rely upon the credentialing and privileging decisions made by distant-site hospitals and telemedicine entities when making recommendations on privileges for individual distant-site practitioners, subject to meeting the conditions required by law and those specified in this Section 3.6.1.

b. Telemedicine privileges shall be for a period of time as specified by individual contract and shall be subject to re-evaluation and renewal pursuant to the same principles and process described in these Bylaws for the renewal of clinical privileges held by Medical Staff members in Section 3.

c. The direct care or interpretive services provided by the distant-site practitioner must meet the professional standards of the Hospital and its Medical Staff at all times. Distant-site practitioners holding telemedicine privileges shall be obligated to meet all of the basic responsibilities that must be met by members of the Medical Staff, as described in Section 2 of these Bylaws, modified only to take into account their distance from the Hospital (e.g., Telemedicine practitioners are exempted from Section 2.4.6 "Coverage and Continuity of Care")

d. Telemedicine privileges may be denied, restricted, suspended or revoked at the discretion of the Medical Executive Committee or the Chief of Staff acting on its behalf, without hearing rights as described in Section 7 and 8 of these Bylaws, except as required by law.

e. Recognizing that telemedicine physicians may be privileged at many healthcare facilities and entities, the Hospital shall conduct the primary verification procedures for an adequate number of hospitals, health care organizations and/or practice settings with whom the telemedicine physician is or has previously been affiliated in order to ensure current competency. In order to assist in this credentialing and privileging process, the Hospital may request information from the telemedicine physician's primary practice site to assist in evaluation of current competency. The Hospital may also accept primary source verification of credentialing information

participating hospital or distant-site entity containing all of the requirements of the CMS Hospital Conditions of related to distant-site telemedicine credentialing, the telemedicine physician must be credentialed and privileged pursuant to the general credentialing and privileging procedures described in these Bylaws, specifically Sections 2 and 3.

4.11 TELEMEDICINE STAFF CATEGORY

4.11.1 Telemedicine Staff Qualifications

Telemedicine Definitions

a. "Distant Site" is the site where a Telemedicine Provider who provides health care services is located while providing these services via a telecommunications system.

b. "Originating Site" is the where the patient is located at the time health care services are provided via a telecommunications system or where the asynchronous store and forward service originates.

c. Telemedicine Provider is the individual provider who uses the telemedicine equipment at the Distant Site to render services to patients who are located at the Originating Site. The Telemedicine Provider would generally contract with the entity that serves as the Distant Site.

4.11.2 Prerogatives and Responsibilities of the Telemedicine Staff

The Telemedicine Staff shall consist of Telemedicine Providers who provide diagnostic, consulting, or treatment services, from the Distant Site to hospital patients at the Originating Site via telecommunication devices. Telecommunication devices include interactive (involving a real time or near real time two-way transfer of medical data and information) telecommunications between the Telemedicine Provider at the Distant Site and the patient at the Originating Site.

MEDICAL STAFF CATEGORIES
Summary Chart Addendum

Staff Category	Telemedicine
Prerogatives	
Admit	No
Exercise Privileges	Yes as defined in Section 3.6.1
Staff Attend	No
Staff Vote	No
Hold Office	No
Serve as Committee Chair	No
Serve as Committee Member	Yes
Responsibilities	
E.R. Call	No
Attend Staff Meetings	No
Pay Dues	Yes
Pay Application Fee (if reqd)	Yes

NORTHERN INYO HOSPITAL
People you know, caring for people you love.

NORTHERN INYO HOSPITAL
Northern Inyo County Local Hospital District

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

Performance Excellence May 13, 2015

Quality Assurance and Performance Improvement (QAPI) Report

Joint Commission Survey Readiness

1. *Focused Standards Assessment. NIH has completed this project and had a conference call with The Joint Commission on April 23, 2015. The TJC accepted action plans corresponding to opportunities for improvement identified by NIH, with the addition of more metrics. Functional area managers will be responsible for executing the actions plans for standards to which they have been assigned.*

2013 CMS Validation Survey Monitoring

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

   a. Advance Directives Monitoring. No new data since last BOD meeting.

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

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

   d. Dietary hand washing logs have been reported and are at 100% compliance since May 6, 2013. The Dietary department has developed and is testing new handwashing logs with the help of Nel Hecht, Infection Preventionist, to provide more meaningful data.

   e. QAPI continues to monitor dietary referrals and the number of consults completed within 24 hours. No new data since last BOD meeting.

Table 2. Dietary Consults performed when ordered.

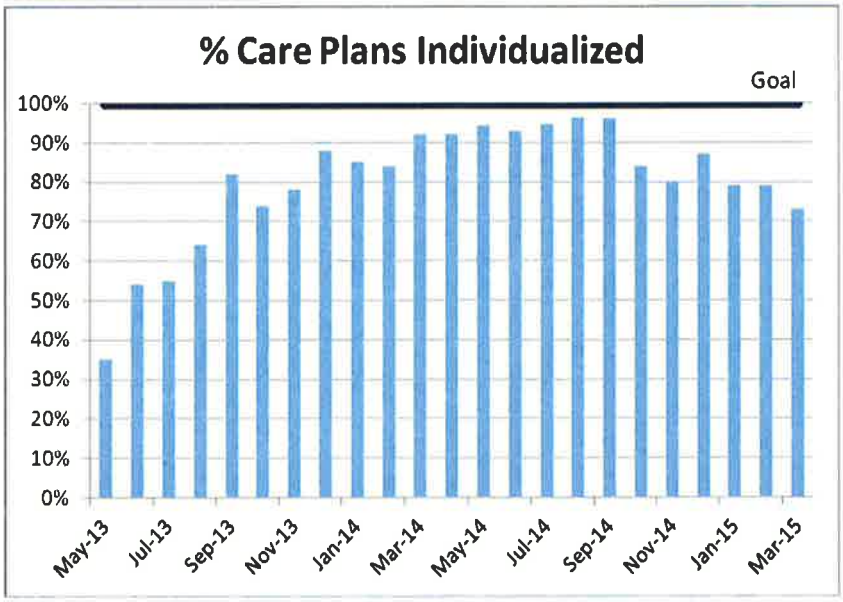
	Mar 2014	*Apr 2014*	*May 2014*	*June 2014*	*July 2014*	*Aug 2014*	*Sept 2014*	*Oct 2014*	*Nov 2014*	*Dec 2014*	*Jan 2015*	*Feb 2015*	*Mar 2015*
Referrals	5	5	2	5	2	5	7	5	6	6	7	9	7
Consults from Referrals within 24 hours	4	5	2	3*	2	3**	3	5	3	4	5	5	4

*2 cases were outside of the required 24 hour window and were completed within 26 hours,10 minutes and 35 hours, 17 minutes of referral.

**2 cases were outside of the required 24 hour window and were completed within 48 hours,19 minutes and 41 hours, 3 minutes of referral. It is important to note that these referrals were made on Saturday and the consults were completed on the following Monday.

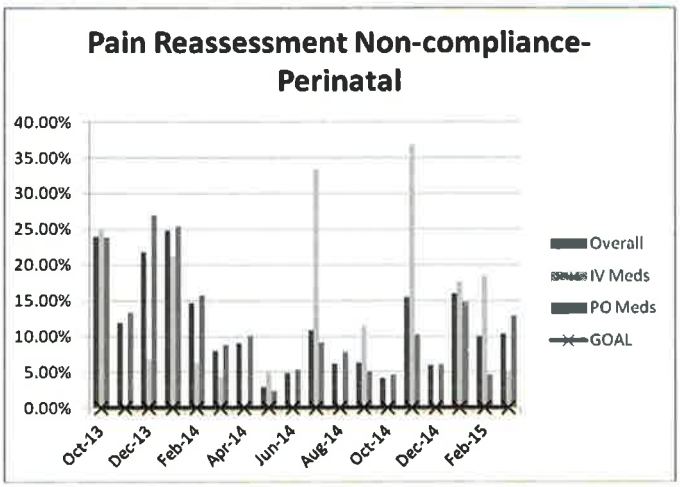
A log was developed at the end of April 2015 to help ensure that consults are performed when ordered. The dietary printer will be checked at specified times for referrals, the dietician on call will be posted with phone number on a white board, the dietician will be called at specified times if there are referrals and the monitoring will be documented on a log sheet kept by the printer. The Dietary department is currently testing this new process.

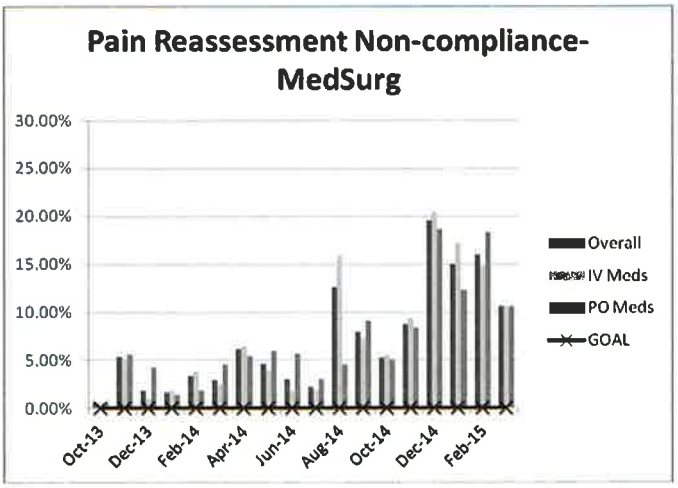
f. Care plans reviewed by Case Management and interventions made to produce care plans. Progress has been made in developing individualized care plans.

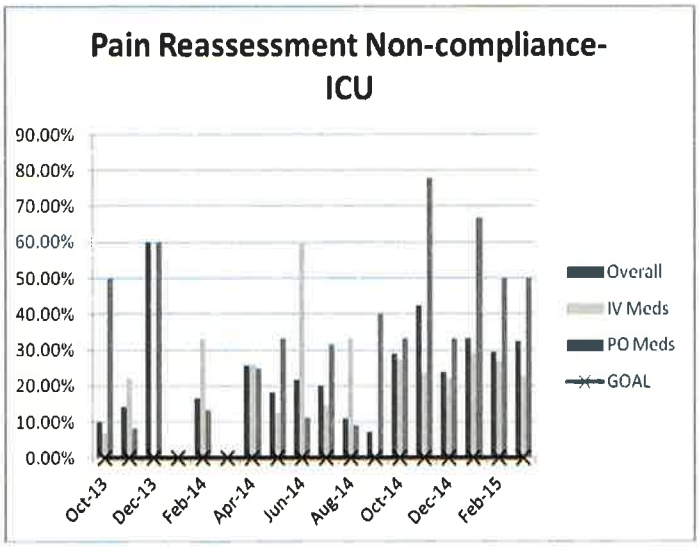


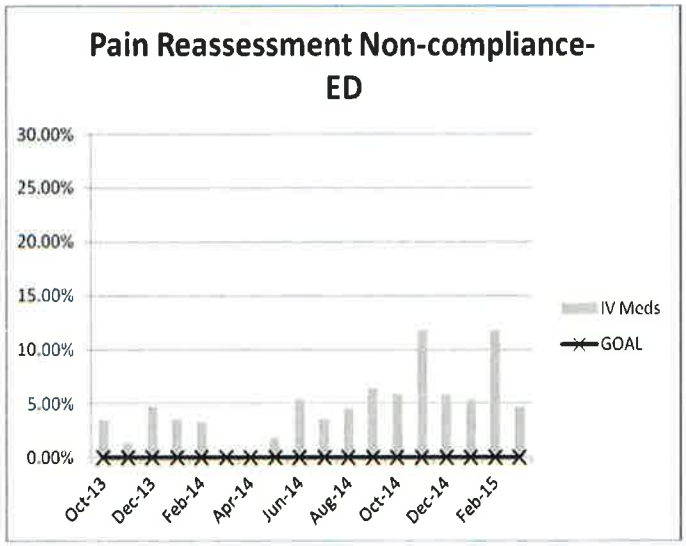
g. Fire drill date, times, attendance and outcomes, smoke detector tests, and fire extinguisher test grids have been approved. All fire drills were complete and compliant from May 6, through present.

h. Pain Re-Assessment. NIH conducts pain re-assessment after administering pain medications and uses a 1-10 scale. No data since last BOD meeting.









Clinical Documentation Improvement

1. Emergency Department Charge Capture Improvement Project charter completed and project initiated.
   a. Defined desired outcomes & process characteristics, assessed current outcomes & process characteristics through staff interviews, document review, observation, research industry practices on this job function, identified process owners and made recommendations, in process of implementing recommendations for testing.
   b. HIMS Coordinator and Quality Improvement Analyst have made the following improvements to the ED charge entry process:
      - Made revisions to training materials including more screen shots, a Powerpoint presentation; organized training materials to match the Level of Care worksheet.*Currently testing new training materials*
      - Created job description & competencies/skills checklists to reflect the actual work. *Hired employee according to new position.*
      - Developed a new audit process and set performance goal for % charts with correct charges. *Monitoring and evaluation will occur through June 30, 2015. Quarterly audits will be conducted thereafter.*
      - ***Next steps: Develop audit report template and additional performance metrics.***

2. OB Biliscan Charge Capture Improvement Project charter drafted, approved; *project resumed.*

3. ICD-10 Implementation project: U.S. Department of Health and Human Services has issued a final rule to change the code sets that are used for reporting diagnoses & procedures on patient medical records, claims and other transactions. Hospital-wide impact on multiple software systems and processes. *Project started: testing software, coders in ICD-10 training, CDI staff reviewing previous training.*

Quality-In-Sights Hospital Incentive Program (Q-HIP) – New Data Reporting Requirement

1. Anthem Blue Cross/Blue Shield Quality-In-Sights Hospital Incentive Program (Q-HIP) Implementation:
   NIH received update from Anthem Blue Cross/Blue Shield that data is not due at this time. However, NIH has used the opportunity to assess and improve compliance with best practices in some areas.

Leap Frog Survey

1. In March and April, 2015, management and staff will identify improvement related to Leap Frog survey sections since the 2014 Leap Frog survey and plan to conduct the 2015 Leap Frog Survey. 2015 survey materials have been released and we are planning our 2015 efforts. *Leapfrog kick-off party held on 5/4/15.*

Performance Excellence Training

1. Continue to develop train-the-trainer AIDET implementation strategy. First team meeting held on 9/26/14. Project Status: Organizing focus group for patients to provide feedback on customer service issues.

2. Lean Six Sigma Green Belt training. (For more information about this methodology, please visit http://asq.org/cert/six-sigma-green-belt/bok. Lean Six Sigma is a scientific, data-driven methodology for improving processes and systems.

First class was held on January 9, 2015 and the following topics were covered:

- Value of Six Sigma
- A Systems Approach & Baldrige
- Organizational Drivers & Metrics
- Organizational Goals & Six Sigma Projects
- Lean Principles Introduction
- Team Dynamics Introduction

Second class was held on January 16, 2015 and the following topics were covered:

- Change Management & Culture
- Project Management
- Business Results: Cost of Poor Quality & Saving Lives
- Management & Planning Tools

Third class was held on February 6, 2015 and the following topics were covered:

- Process Management, Analysis & Documentation
    - Voice of the Customer, Customer-Centric Best Practices
    - Process Mapping, Work Instructions, Policies & Procedures

Fourth class (short ½ class) was held on February 13, 2015 and the following topics were covered:

- Working With Data
- Probability & Statistics
- Collecting & Summarizing Data

Fifth class (short ½ class) was held on March 13, 2015 and the following topics were covered:

- Measurement System Analysis
- Process Capability & Performance
- Deming's Red Bead Game
- Review & revise team project charters

Sixth class was held on April 24, 2015 and the following topics were covered:

- *Qualitative Analysis*
    - *Brainstorming & Affinity Diagrams*
    - *Fishbone/Cause & Effect/Ishikawa Diagrams & 5 Whys?*
    - *Failure Modes, Effects and Criticality Analysis & Pareto Charts*
    - *Review Lean & Process Analysis*
- *Quantitative Analysis*
    - *Statistical Probability Distributions & Hypothesis Testing*
    - *Exploratory Data Analysis (Multi-Vari, Regression, Correlation)*

Baldrige and the Journey to Excellence

1. See Handout – Category 3- Customer & Market Focus

Strategic Communications Report

Marketing/Internal Communication Projects

1. A. Sunny Sawyer, PA-C, joins Rural Health Clinic advertisement (See Attached.)
2. NIH VA Liaison advertisement (See Attached.)

Press Releases

1. *None.*

Events

3. *Altrusa-sponsored Health Fair was held on May 2, 2015 at the fairgrounds. The NIH booths were enjoyed by adults and children, especially the teddy bear X-Ray/MRI machine. Children and/or families received education on the following topics:*
   a. *Infection control – handwashing and wearing masks*
   b. *Nutrition & exercise*
   c. *Going to the hospital*
   d. *The NEST program*

Medical Staff Office Report

Medical Staff Office Updates

1. Opportunities for improvement have been identified in the physician and Allied Health Professional (AHP) on-boarding and off-boarding processes and related projects will begin soon. *Draft project charter completed.*
2. *Ethan Aukee, new Medical Staff Support Coordinator, started work in the Medical Staff Office. He will also be assisting with some QAPI activities.*

Ethan Aukee-Medical Staff Support Coordinator

Please welcome our new Medical Staff support Coordinator

Ethan was born and raised in Bishop, CA. Ethan graduated from Cal Lutheran University in 2012. Recently Ethan moved back to Bishop and is excited to join the NIH team.

Performance Improvement Projects Key: FOCUS-PDSA CYCLE: F (Find), O (Organize), C (Clarify), U (understand), S(Select), P(Plan), D(DO), S (Study), A (Act) (See FOCUS-PDSA Handout)

You Asked. We Listened.

Sunny Sawyer, PA-C, joins Rural Health Clinic

Northern Inyo Hospital welcomes Sunny Sawyer, Physician's Assistant (PA-C), our newest practitioner to join the Rural Health Clinic (RHC) healthcare team.

Seeing an RHC provider for same-day appointments has been a challenge for our community. Sunny Sawyer's new role as the walk-in/same-day visit Physician's Assistant enhances service and allows greater access to affordable healthcare. She will be available five days a week starting May 4 for RHC patients.

Not New to Bishop

A native Californian and former botanist, Sunny is familiar with all that Bishop offers and is excited to be back. She is a graduate of Campbell University in North Carolina. Her interests include family medicine, wound repair and minor surgical procedures.

Health and Wellness For You and Me

Sunny embraces a balanced lifestyle for herself and her patients. "I want patients to be actively involved in their medical care and treatment plan. My goal is to take care of your immediate needs and connect you with primary care and specialty providers."

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ANNOUNCING... NIH VA Liaison

Lorie Thompson, Patient Representative, has been named our VA Liaison. She is excited to help local veterans to access healthcare in their community. Lorie has 16 years experience working with patients & is here to assist you with the new CHOICE Program.

Lorie Thompson

Hours: 9:00 a.m. to 4:00 p.m., Monday-Friday
Location: Credit and Billing Information Office, Room 107A in the Administration building off of Pioneer Lane (Enter through door No. 5)
Telephone: (760) 873-2170
Call or come see Lorie if you need information or assistance with the VA CHOICE Program!

Thank you for your service to our country!

AMENDMENT NO. 4
TO THE
NORTHERN INYO COUNTY LOCAL
HOSPITAL DISTRICT RETIREMENT PLAN

RECITALS

A. The NORTHERN INYO COUNTY LOCAL HOSPITAL DISTRICT ("Employer"), adopted the NORTHERN INYO COUNTY LOCAL HOSPITAL DISTRICT RETIREMENT PLAN (the "Plan") for the benefit of its Employees and their Beneficiaries, effective March 1, 1975, and subsequently amended and restated the Plan as of January 1, 2009.

B. It is necessary for the Employer to amend the Plan in order to clarify the terms under which certain Employees shall be eligible to continue participating in the Plan.

C. Section 8.1 of the Plan provides that the Employer reserves the right to amend the Plan at any time by an instrument in writing executed in the name of the Employer by an officer or officers duly authorized to execute such instrument.

D. The Employer hereby amends the Plan effective as of the date that this Amendment No. 4 is executed in accordance with the terms set forth at Section 8.1 of the Plan.

AMENDMENT

NOW, THEREFORE, Employer hereby amends SECTION II of the Plan to replace the current language at Section 2.1 with the following:

> 2.1 Eligible Class of Employees. All Employees, including those represented by a collective bargaining representative, are eligible to participate in the Plan if their initial Date of Participation, determined by Section 2.2, is before January 1, 2013 ("Eligible Employee"). However, an Eligible Employee represented by a collective bargaining representative that has bargained for a retirement benefit plan shall continue to participate in this Plan (rather than another plan) only where their collective bargaining agreement provides for continued participation in this Plan.

EMPLOYER:

NORTHERN INYO COUNTY LOCAL HOSPITAL WATER DISTRICT

By: _____
Victoria Alexander-Lane, CEO

Date: _____

APPROVED AS TO FORM AND CONTENT
BEST BEST & KRIEGER LLP

By:_____
Attorneys for Employer

AMENDMENT NO. 3
TO THE
NORTHERN INYO COUNTY LOCAL
HOSPITAL DISTRICT RETIREMENT PLAN

RECITALS

A. The NORTHERN INYO COUNTY LOCAL HOSPITAL DISTRICT ("Employer"), adopted the NORTHERN INYO COUNTY LOCAL HOSPITAL DISTRICT RETIREMENT PLAN (the "Plan") for the benefit of its Employees and their Beneficiaries, effective March 1, 1975, and subsequently amended and restated the Plan as of January 1, 2009.

B. It is necessary for the Employer to amend the Plan to comply with final regulations issued by the Internal Revenue Service under Section 415 of the Internal Revenue Code ("Final 415 Regulations").

C. The Employer hereby amends the Plan retroactively effective January 1, 2008 in accordance with the procedures for correcting nonamender plan failures under Section 2.01(2) of Revenue Procedure 2013-12.

D. Section 8.1 of the Plan provides that the Employer reserves the right to amend the Plan at any time.

AMENDMENT

NOW, THEREFORE, Employer hereby amends SECTION III of the NORTHERN INYO COUNTY LOCAL HOSPITAL DISTRICT RETIREMENT PLAN to add the following as a new Section 3.9:

3.9 Annual Benefit. Effective for limitation years ending after December 31, 2007, the following provisions will apply.

(a) The "Annual Benefit" otherwise payable to a Participant under the Plan (including benefits allocated or paid under another qualified defined benefit plan maintained by the Employer) at any time shall not exceed the Maximum Permissible Benefit. If the benefit the Participant would otherwise accrue in a limitation year would produce an Annual Benefit in excess of the Maximum Permissible Benefit, then the benefit shall be limited (or the rate of accrual reduced) to a benefit that does not exceed the Maximum Permissible Benefit.

(b) The "Annual Benefit" is the benefit payable annually in the form of a "Straight Life Annuity." Except as provided below, where a benefit is payable in a form other than a Straight Life Annuity, the benefit shall be adjusted to an actuarially equivalent Straight Life Annuity that begins at the same time as such other form of benefit and is payable on the first day of each month, before applying the limitations of this Section 3.9. For a Participant who has or will have distributions commencing at more than one Annuity Starting Date, the Annual Benefit shall be determined as of each such

Annuity Starting Date (and shall satisfy the limitations of this Section 3.9 as of each such date), actuarially adjusting for past and future distributions of benefits commencing at the other Annuity Starting Dates. For this purpose, the determination of whether a new Annuity Starting Date has occurred shall be made without regard to Regulations Section 1.401(a)-20, Q&A 10(d), and with regard to Regulations Section 1.415(b)1(b)(1)(iii)(B) and (C).

No actuarial adjustment to the benefit shall be made for (a) survivor benefits payable to a surviving spouse under a qualified joint and survivor annuity to the extent such benefits would not be payable if the Participant's benefit were paid in another form; (b) benefits that are not directly related to retirement benefits (such as a qualified disability benefit, preretirement incidental death benefits, and postretirement medical benefits); or (c) the inclusion in the form of benefit of an automatic benefit increase feature, provided the form of benefit is not subject to Code Section 417(e)(3) and would otherwise satisfy the limitations of this Article, and the Plan provides that the amount payable under the form of benefit in any limitation year shall not exceed the limits of this Article applicable at the Annuity Starting Date, as increased in subsequent years pursuant to Code Section 415(d). For this purpose, an automatic benefit increase feature is included in a form of benefit if the form of benefit provides for automatic, periodic increases to the benefits paid in that form.

The determination of the "Annual Benefit" shall take into account benefits transferred from another defined benefit plan but shall disregard benefits attributable to Employee contributions or rollover contributions.

For limitation years beginning on or after July 1, 2007, the actuarially equivalent straight life annuity is equal to the greater of (I) the annual amount of the straight life annuity (if any) payable to the Participant under the Plan commencing at the same Annuity Starting Date as the Participant's form of benefit; and (II) the annual amount of the straight life annuity commencing at the same Annuity Starting Date that has the same actuarial present value as the Participant's form of benefit, computed using a 5% interest rate assumption and the applicable mortality table defined in the Plan for that Annuity Starting Date.

(c) The "Defined Benefit Dollar Limitation" is $160,000, as automatically adjusted, effective January 1 of each year, under Section 415(d) of the Code in such manner as the Secretary shall prescribed, and payable in the form of a straight life annuity. Any new limitation shall apply to limitation years ending with or within the calendar year for which the adjustment applies.

(d) The "Defined Benefit Compensation Limitation" is 100% of a Participant's "High Three-Year Average Compensation," payable in the form of a straight life annuity. For purposes of this Section 3.9, "High Three-Year Average Compensation" has the following meaning:

(1) the average 415 Compensation for the three consecutive Years of Credited Service (or, if the Participant has less than three consecutive Years of

Credited Service, the Participant's longest consecutive period of service, including fractions thereof, but not less than one year) with the Employer that produces the highest average. A Participant's 415 Compensation for a Year of Credited Service shall not include 415 Compensation in excess of the limitation under Code Section 401(a)(17) that is in effect for the calendar year in which such Year of Credited Service begins. In the case of a Participant who is rehired by the Employer after a severance from employment, the Participant's "High Three-Year Average Compensation" shall be calculated by excluding all years for which the Participant performs no services for and receives no 415 Compensation from the Employer (the break period) and by treating the years immediately preceding and following the break period as consecutive.

(e) The "Maximum Permissible Benefit" is the lesser of the applicable Defined Benefit Dollar Limitation or the Defined Benefit Compensation Limitation (both adjusted where required, as provided in (1) and, if applicable, in (2) below).

(1) If the Participant has less than 10 years of participation in the Plan, the Defined Benefit Dollar Limitation shall be multiplied by a fraction – (i) the numerator of which is the number of years of participation in the Plan (or part thereof), and (ii) the denominator of which is ten (10). In the case of a Participant who has less than ten Years of Credited Service with the Employer, the Defined Benefit Compensation Limitation shall be multiplied by a fraction -- (i) the numerator of which is the number of Years of Credited Service with the Employer (or part thereof, and (ii) the denominator of which is ten (10).

(2) If the Annuity Starting Date for the Participant's benefit is prior to age 62, the Defined Benefit Dollar Limitation for the Participant's Annuity Starting Date is the annual amount of a benefit payable in the form of a straight life annuity commencing at the Participant's Annuity Starting Date that is the actuarial equivalent of the Defined Benefit Dollar Limitation (adjusted under subparagraph (1) above for years of participation less than ten (10), if applicable) with actuarial equivalence computed using a five-percent (5%) interest rate assumption and the applicable mortality table for the Annuity Starting Date as defined in Section 3.8(e)(ii) of the Plan (and expressing the Participant's age based on completed calendar months as of the Annuity Starting Date).

(3) If the Annuity Starting Date for the Participant's benefit is after age 65, the Defined Benefit Dollar Limitation at the Participant's Annuity Starting Date is the annual amount of a benefit payable in the form of a straight life annuity commencing at the Participant's Annuity Starting Date that is the actuarial equivalent of the Defined Benefit Dollar Limitation, with actuarial equivalence computed using a 5% interest rate assumption and the applicable mortality table for that Annuity Starting Date as defined in the Plan (and expressing the Participant's age based on completed calendar months as of the Annuity Starting Date).

(4) No adjustment shall be made to the Defined Benefit Dollar Limitation to reflect the probability of a Participant's death between the Annuity Starting Date and age 62, or between age 65 and the Annuity Starting Date, as applicable, if

benefits are not forfeited upon the death of the Participant prior to the Annuity Starting Date. To the extent benefits are forfeited upon death before the Annuity Starting Date, such an adjustment shall be made

(f) The application of this Section 3.9 shall not cause the Maximum Permissible Benefit for any Participant to be less than the Participant's Accrued Benefit under all the defined benefit plans of the Employer as of the end of the last limitation year beginning before July 1, 2007 under provisions of the plans that were both adopted and in effect before April 5, 2007.

(g) Notwithstanding anything else in this Section 3.9 to the contrary, the benefit otherwise accrued or payable to a Participant under this Plan shall be deemed not to exceed the "Maximum Permissible Benefit" if: (i) the retirement benefits payable for a limitation year under any form of benefit with respect to such Participant under this Plan and under all other defined benefit plans (without regard to whether a plan has been terminated) ever maintained by the Employer do not exceed $10,000 multiplied by a fraction – (I) the numerator of which is the Participant's number of Years (or part thereof, but not less than one year) of Service (not to exceed ten (10)) with the Employer, and (II) the denominator of which is ten (10); and (ii) the Employer has not at any time maintained a defined contribution plan in which the Participant participated (for this purpose, mandatory Employee contributions under a defined benefit plan, individual medical accounts under Code Section 401(h), and accounts for post-retirement medical benefits established under Code Section 419A(d)(1) are not considered a separate defined contribution plan).

EMPLOYER:

NORTHERN INYO COUNTY LOCAL HOSPITAL DISTRICT

By:_____

Title: _____

APPROVED AS TO FORM AND CONTENT
BEST BEST & KRIEGER LLP

By:_____
Attorneys for Employer

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www.nih.org

TO: Board of Directors

FROM: Leon Freis, R.Ph., COO/CIO

RE: Request for approval of purchase of Dragon Software Licenses and Training

DATE: April 29, 2015

Background:

NIH spends about $146,000 per year on transcription.

Transcription has been largely supplanted by voice recognition software and pre-built documentation aids such as Physician Documentation (PhysDoc) templates.

Our voice recognition software (Dragon) requires an increase in licenses in order to be fully deployed. A new round of training is necessary to create NIH staff trainers who can work one-on-one with those who currently use transcription.

Our only full time transcriptionist is leaving the State on June 1, 2015

Proposal:

9 Dragon Medical 360 | Network Edition	$19,791.00
9 Annual Support-Clinically Speaking Network	$ 3,564.00
6 Dragon Medical Network Edition Non-Physician	$ 4,800.00
1 Year Maintenance and Upgrade Assurance Option 1	$ 1,440.00
Clinically Speaking Voice Recognition Onsite Training for Centricity	$ 5,000.00
California Sales Tax - 8%	$ 2,367.60
Total	$36,962.60

Ongoing additional yearly cost: Approximately $ 5,004

Yearly savings: Approximately $141,000

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TO: Board of Directors

FROM: Leon Freis, R.Ph., COO/CIO

RE: Request for early replacement of Tissue Processor

DATE: May 5, 2015

Background:

NIH's Tissue Processor is the machine that makes slides for the pathologist to view and make diagnoses.

Ours was purchased in 1993 and is no longer made, or serviced by the company.

The Tissue Processor has been a very reliable machine, but just broke down. It was going to be included in the next Capital Budget request.

We are sending samples to Mammoth for processing, but this delays diagnoses.

Request:

Purchase VIP-6 Tissue Processor:	$79,754.00
Shipping:	$ 300.00
Tax:	Included above.
Total:	$80,054.00

Leon Freis

To Board

From: Fran Yuschak
Sent: Monday, May 04, 2015 2:10 PM
To: Leon Freis
Subject: Tissue Tek is down

Hi Leo

This is just an FYI. The tissue processor in Pathology is down. We are trying to get a service person out to work on it meanwhile we have to send specimens to Mammoth to get tissue processed. Here are the issues;

1. The item is no longer serviceable from the company, Scott Stoner is looking into another company that might be able to work on it.
2. I am hoping we can get this repaired until the new budget is approved.
3. We have submitted a request to replace this instrument due to its age for this years budget
4. Depending upon whether we can currently fix this machine we may need to expedite the request.

Fran Yuschak, CLS,MT(ASCP)SM, Director of Laboratory
Northern Inyo County Local Hospital District / 150 Pioneer Lane / Bishop, California 93514
(760) 873-2002
Fran.Yuschak@nih.org

CAPITAL EXPENDITURE BUDGET REQUEST

Department: Pathologyk
Requested by: Rita Young

Budget year: *2015/2016*
Estimated cost: *$79,754.00*
Requested Priority: 1

GENERAL INFORMATION:

Item description:
Tissue Processor VIP-6

Purpose:
Prepare slides for Pathologist diagnosis

Is this item required or recommended by third-party or regulatory agencies?
Yes ☐ No ☒ N/A ☐
If yes, please explain: .

Is this item a replacement item?
Yes ☒ No ☐ N/A ☐
If yes, please explain: Our current unit was purchased in 1993. No longer made and no longer serviceable

Will this request require more than one purchase?
Yes ☐ No ☒

Describe any associated installation costs, site preparation, construction costs, additional equipment or supply costs or additional staffing requirements:
Shipping cost of $300.00. No other additional costs.

Additional comments:
.

Department Head Signature: Fran Yuschak Date: 4/14/15