Northern Inyo Hospital

March 15 2017 Regular Meeting

March 15 2017 Regular Meeting - March 15 2017 Regular Me

AGENDA

NORTHERN INYO HEALTHCARE DISTRICT
BOARD OF DIRECTORS REGULAR MEETING
March 15, 2017 at 5:30 p.m.
In the Northern Inyo Hospital Board Room at 2957 Birch Street, Bishop, CA

1. Call to Order (at 5:30 pm).
2. At this time persons in the audience may speak on any items not on the agenda on any matter within the jurisdiction of the District Board (*Members of the audience will have an opportunity to address the Board on every item on the agenda. Speakers are limited to a maximum of three minutes each.).*
3. Old Business
   A. Bishop Union High School student clinic (*action item*).
4. New Business
   A. Nursing Department Policy and Procedure approvals (*action items*):
      1. *Documentation of Patient Care*
      2. *Orientation to Nursing Departments*
      3. *Patient Valuables*
      4. *Acute/Subacute Performance Improvement*
      5. *Patient Acuity*
      6. *Nursing QAPI*
      7. *Angel Flight*
      8. *Emergency Staffing*
   B. Hospital Wide Policy and Procedure annual approvals (*action items*); Attachment A to Agenda.
   C. General Budget Assumptions for fiscal year 2017/2018 (*action item*).
   D. Request for Proposal (RFP) Policy and Procedure approval (*action item*).
   E. Use of the NIHD Healing Garden (*action item*).
   F. Election of Board member to the Compliance and Business Ethics Committee (*action item*).
   G. Purchase of Pioneer Medical Associates Partnership Interest, Doctors Hathaway and Kamei (*action item*).
   H. Employee Drug and Alcohol Policy (*action item*).
   I. Pay scale update (*action item*).

J. Stryker Orthopedic Supply Contract (*action item*).

K. Introduction of Larry Weber, Director of Diagnostic Imaging and Laboratory (*information item*).

L. District participation in Adopt-A-Highway program (*information item*).

Consent Agenda (action items)

5. Approval of minutes of the February 15, 2017 regular meeting
6. 2013 CMS Validation Survey Monitoring, March 2017
7. Financial and Statistical Reports for the period ending January 31, 2017

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8. Patient Experience Committee Report (*information item*)
9. Workforce Experience Committee Report (*information item*)
10. Chief of Staff Report; Richard Meredick, MD:
    A. Policies/Procedures/Protocols/Order Set approvals (*action items*):
        - *Administration of Drugs: Patient's Own Medications*
        - *Closed-System Transfer Device (CSTD)*
        - *Drugs of Abuse Maternal and Infant*
        - *Misoprostol for Cervical Ripening*
        - *Opioids Waste Policy*
        - *Discharge Planning for the Hospitalized Patient*
        - *Airborne Infection Isolation Rooms (AIIR)*
        - *Respiratory Syncytial Virus (RSV) Policy*
        - *Skin Preparation in the Perioperative*
        - *Cleaning and Processing da Vinci Instruments, Accessories and Endoscopes*
        - *Fern Testing*
        - *Training and Competency in Fern Testing*

    B. Hospital-wide QAPI Plan - Annual Evaluation Calendar Year 2016 (*information item*).

    C. Hospital-wide QAPI Plan – Annual Work Plan Fiscal Year 2017-2018 (*action item*).

    D. Hospital-wide QAPI Plan (*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. Confer with Legal Counsel regarding pending and threatened litigation, existing litigation and significant exposure to litigation, 3 matters pending (*pursuant to Government Code Section 54956.9*).

C. Discuss trade secrets, new programs and services (estimated public session date for discussion yet to be determined) (*Health and Safety Code Section 32106*).

D. Discussion of a personnel matter, CEO contract terms and discussion (*pursuant to Government Code Section 54957*).

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.

ATTACHMENT A TO THE AGENDA FOR THE

NORTHERN INYO HEALTHCARE DISTRICT REGULAR BOARD MEETING,

MARCH 15, 2017

Policies to Board of Directors

Fiscal Services

Department	Title	To BOD	Approved	Comments
Fiscal Services	Capitalization of Assets	3/15/2017		Review Only; no changes
Fiscal Services	Reimbursement for Hospital Business	3/15/2017		Review Only; no changes
Administration-Hospital Wide	Fax, Printing & Making Copies	3/15/2017		Review Only; format updated only

HUMAN RESOURCES
POLICY AND PROCEDURES APPROVAL LIST
MARCH 2017

1. INTRODUCTION
2. FINAL PAYROLL CHECK
3. PAYROLL ADVANCES
4. LEISURE TIME BENEFITS
5. HOLIDAYS
6. SICK LEAVE
7. SHIFT DIFFERENTIAL
8. STATE DISABILITY INSURANCE (SDI)
9. HOSPITALIZATION AND MEDICAL INSURANCE
10. PENSION PLAN
11. LIFE INSURANCE AND LONG TERM DISABILITY INSURANCE
12. DENTAL INSURANCE AND VISION INSURANCE
13. EDUCATIONAL OPPORTUNITIES
14. EDUCATION DAYS POLICY FOR LICENSED EMPLOYEES
15. ABSENCE FROM WORK
16. EXCUSED ABSENCE
17. UNEXCUSED ABSENCE
18. PAID ABSENCE
19. INVOLUNTARY LEAVE OF ABSENCE
20. PARKING

Aspel, Tracy (Director of Nursing Practice)
Area: Published

Ref #	Title	TO BOD	APPROVED	COMMENTS
3622	A Quick Check			
617	Admission / Classification and Charges			
2336	Admission of a patient to Northern Inyo Hospital			
3618	Admission of Hospice Inpatient*			
621	Adoption Policy and Procedure*			
1711	ADVANCED DIRECTIVE			
3617	Age Related and Population Specific Care			
1561	ANGEL FLIGHT			
3871	Authorization of Hours Worked Beyond Regularly Scheduled Shift (Including Overtime Request)			
1479	CALIFORNIA CHILDREN SERVICES REFERRAL			
3933	Capacity Management Plan*			
3858	Central Council			
3856	Clinical Consistency (Practice) Committee			
3862	Clinical Consistency Oversight Committee (CCOC)			
2279	Clinical Decision Making-Medical Staff Practitioner			
3937	Code of Ethics for Nurses			
2307	Cognitive Assessment (MoCA)			
1082	Community Resources			
2335	Competency Notebook			
20	Confidentiality			
3877	Cross-Training of RN Staff			
87	Daily Staffing Sheet / Nursing			
231	Death-Disposition of Body*			
29	Debriefing Sessions For Stressful Situations			
689	Delivery Packs and Instruments			
3865	Department Monthly Staff Meeting			
774	Department of Motor Vehicle Medical Examination			
3852	Department Partnership Council			
3787	Departments That Deliver Nursing Care to Patients			
3819	Deployment of Nursing Staff at Department Level and Patient Care Assignments			
93	Development, Revision and Maintenance of Policies			
3866	Direct Report Monthly Standing CNO Meeting			
3934	Documentation of Case Management Services*			
671	Documentation of Nursing Care Flow Sheet			
91	Durable Medical Equipment (DME) Provision for Patients at Discharge*			
1712	EASTERN SIERRA BREAST CANCER ALLIANCE			
33	Education Days for Licensed Employees			
3931	Education of Patient and Family*			
2350	Emergency Response Cart			
4025	End of Life Option Act*			

2293	Entering an ED Admission (observation, surgery, inpatient status) into Health Information System			
2319	Fall Prevention			
3697	Fatigue Management: Direct Caregivers			
3717	Floating Nursing Staff*			
3962	Follow-Up Phone Calls Post Discharge*			
110	Guidelines for Licensed Nurses Nursing Students Giving Medications			
1553	Home Health Care			
3788	House Supervisor Shift Activity Report			
21	Informed Consent Policy			
2337	Interdisciplinary Plan of Care			
3932	Interdisciplinary Team – Clinical Screens Built into the Initial Nursing Assessment*			
78	Legal Definition of Licensed Vocational Nurse			
77	Legal Definition of Registered Nurse			
79	Licensure of Nursing Personnel			
3961	Management of Discharge Disputes from Medicare			
1554	MEALS ON WHEELS			
787	Medic Alert Tags			
3821	Medical Clinical Alarm Equipment Safety*			
3785	Mission and Vision Statement for Nursing Services			
85	NIH Nursing Department Organizational Chart			
707	Non-Stress Test			
3859	Nurse Executive Council			
3818	Nursing Low Census Days			
3817	Nursing Administrative Coverage			
191	Nursing Assessment & Reassessment			
305	Nursing Care Plan			
3967	Nursing Certification*			
2280	Nursing Chain of Command in Resolving Patient			
1108	Nursing Department Dress Code			
81	Nursing Department Meetings			
3864	Nursing Management Huddle			
3631	Nursing PRN Per Diem Staff			
25	Nursing Services Competency Plan			
3935	Nursing Services Jobs and Titles			
92	Nursing Services Philosophy			
3820	Nursing Services Quality Assurance/Performance Improvement (QA/PI) Plan			
3849	Nursing Services Standing Objective and Annual			
3876	Nursing Standards*			
106	Nursing Status, Guidelines for			
3968	Nursing Students Requesting Clinical Preceptorship			
1568	Ombudsman			
2278	Opening and Closing Nursing Departments			
3810	Organ/Tissue/Eye Donation*			
3803	Organization-Wide Assessment and Reassessment			

3853	Orientation Competency Committee			
4072	Orientation/Cross Training Time Frames			
88	Outpatient Observation (OPO) Policy			
3615	Pathways for Development, Review and Revision of Nursing Standards			
3861	Patient Flow Committee			
3798	Patient Food from Non-Hospital Sources			
2325	Patient Locator			
3842	Patient Requiring Psychiatric Evaluation and			
3802	Patient Safety Attendant or 1:1 Staffing Guidelines*			
113	Patient Transfer Log Policy			
437	Patient Transfer/Discharge to another Facility			
3801	Pediatric Academic Education Policy			
105	Performance Improvement Plan			
3640	Plan for the Provision of Nursing Care			
22	Procedures Requiring Informed Consents			
4051	Pronouncement of Death*			
3855	Quality / Research Committee			
232	Release of Body to Mortuary Authorization for			
109	Responsibilities of Nursing Students and Hospital			
104	Responsibility for Patient Care			
3644	Routine Hours of Work			
3699	Safe Patient Handling – Minimal Lift Program			
3860	Safe Patient Handling Subcommittee			
1971	SKILLED NURSING FACILITIES			
1804	Social Services Orientation of Hospital Personnel			
4076	Staffing Huddle			
3854	Staffing Issues Advisory Committee			
2317	Staffing Management Plan			
3616	Standard of Care: End of Life			
114	Temporary / Registry Nurses			
1314	Therapy Animals and Pets*			
1567	TRANSFER CHECKLIST			
754	Transfer to Other Medical Facilities Maternal and			
3857	US/Secretary Council			
3936	Utilization of Personnel From Outside Agencies			
2312	Utilization Review Plan*			
452	Verbal and/or Phone Medical Staff Practitioner			
115	Visiting Policy			
116	Volunteer Policy			
2338	Week-End Shifts			
1563	WILD IRIS			
118	Withholding Resuscitative Measures			

POLICIES TO THE BOD
PHARMACY

	POLICY & PROCEDURES TO THE BOARD			
	PHARMACY DEPT.			
	TITLE	**TO BOD**	**APPROVED**	**COMMENTS**
1	Look-alike, Sound-alike Drugs	3/15/2017		
2	Drug storage and inspections of Medication Areas	3/15/2017		
3	Investigatinal Drugs	3/15/2017		
4	Controlled Substance Policy Hospital Wide	3/15/2017		
5	High Alert Medications: Prepartion, Dispensing, Storage	3/15/2017		

POLICIES TO THE BOD

PROPERTY MGMT, SECURITY AND MAINTENANCE

	POLICY & PROCEDURES TO THE BOARD			
	PROPERTY MGMT, SECURITY AND MAINTENANCE			
	TITLE	**TO BOD**	**APPROVED**	**COMMENTS**
1	Policy on Reporting Utility System Incident	3/15/2017		
2	Policy on annual Evaluations	3/15/2017		
3	Environmental Tours	3/15/2017		
4	Policy on Environmental Tours	3/15/2017		
5	Annual Evaluations	3/15/2017		
6	Information Collection & Monitoring	3/15/2017		
7	Policy on Occurrence Reporting	3/15/2017		
8	Policy on Reporting Security Incident	3/15/2017		
9	Policy on Reporting Fire Safety Incedent	3/15/2017		
10	Policy on Reporting Property Damage	3/15/2017		
11	Policy on Reporting Hazardous Materials & Waste Incident	3/15/2017		
12	Policy on Reporting Medical Equipment Incident	3/15/2017		

Northern Inyo Hospital - Document List
Site: Hospital
Department: Purchasing
Area: Published

Generated By: Public Viewer

Title	Status	Security	Date Created	Date Submitted	D
Asset Control	Approved	Public	10/31/2014	12/5/2014	12
Asset Management	Approved	Public	10/31/2014	12/5/2014	12
Capitalization of Assets	Approved	Public	4/22/2014	4/22/2014	6/
Delivery of Received Goods	Approved	Public	9/26/2014	12/30/2014	1/
Diagnostic Imaging - Ordering Radioactive Materials	Approved	Public	7/23/2014	4/21/2015	4/
Disposal of Equipment	Approved	Public	10/31/2014	7/1/2015	8/
Emergency Purchases	Approved	Public	6/9/2015	6/9/2015	8/
Hospital District Credit Card Policy	Approved	Public	3/25/2014	4/17/2014	6/
MMIS Contingency Plan	Approved	Public	4/2/2013	4/2/2013	4/
Order Fulfillment	Approved	Public	9/26/2014	12/30/2014	1/
Receiving Capital Equipment	Approved	Public	1/13/2016	3/14/2016	8/
Receiving Process	Approved	Public	7/24/2015	7/24/2015	8/
Storeroom Basics	Approved	Public	9/26/2014	12/30/2014	1/
Temperature Monitoring of Storage Devices and Units	Approved	Public	12/12/2013	12/13/2013	5/

POLICIES TO THE BOD
REHABILITATION

	POLICY & PROCEDURES TO THE BOARD			
	REHABILITATION			
	TITLE	**TO BOD**	**APPROVED**	**COMMENTS**
1	Discharge Planning	3/15/2017		
2	No Show/Cancellation Policy	3/15/2017		
3	General Documentation	3/15/2017		
4	Goals and Objectives	3/15/2017		
5	Information Management Plan	3/15/2017		

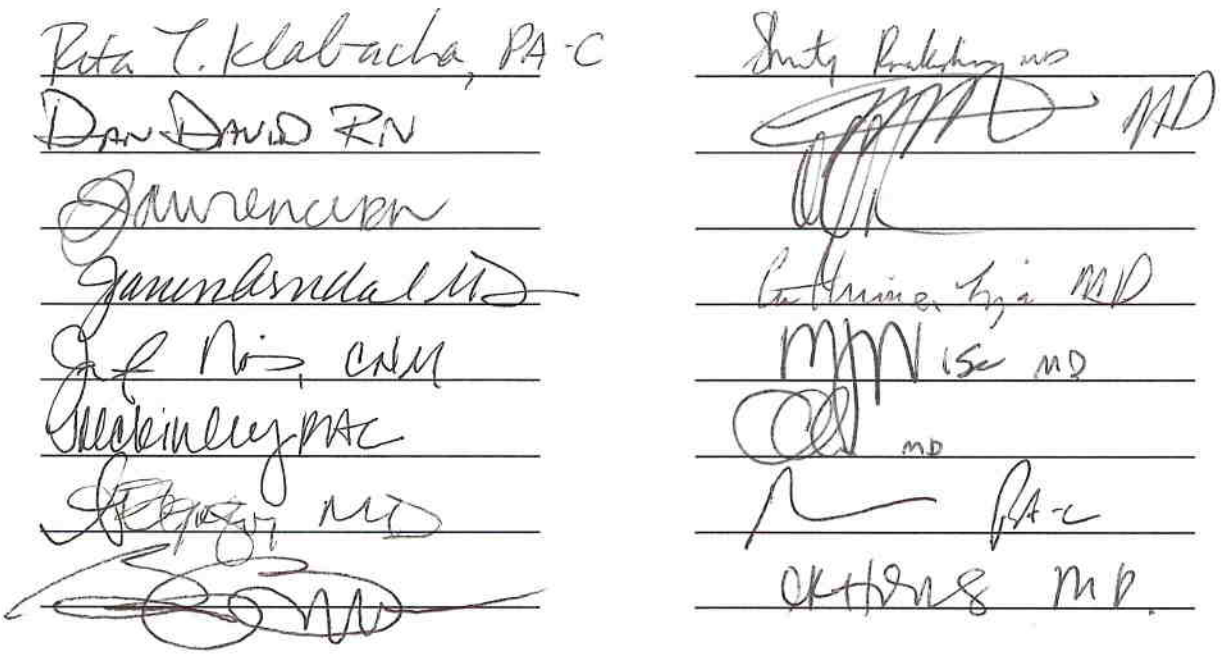
March 2, 2017

Dear Board Members of the Bishop Unified School District and Northern Inyo Healthcare District,

We the undersigned medical staff of the Northern Inyo Hospital Rural Health Care Center (RHC) are in support of the creation of a school-based health center (SBHC) at Bishop Union High to provide confidential reproductive health care education and services to adolescents.

Currently it is difficult for teens to access these services in a place that they feel safe and comfortable in Bishop. Evidence has demonstrated that providing such services does not increase sexual activity but does decrease sexually transmitted infection rates and can decrease the number of teen pregnancies.

Thank you for you consideration of this matter. We believe this will improve the health of our adolescent community.



Rita Klabacha, PA-C

Dan David, RN

Jannalyn Lawrence, RN

Jeannie Arandal, MD

Jennifer Norris, CNM

Jennifer McKinley, PA-C

Anne Gaisor, MD

Stacey Brown, MD

Shruti Ramakrishna, MD

Martha Kim, MD

Mara Yolken, NP

Catherine Leja, MD

Matthew Wise, MD

Charlotte Helvie, MD

Robert Nalumaluhia, PA-C

Cecila Rhodus, MD

Witness to Life
Bishop, California 93514

February 16, 2017

Bishop Unified School District Board
301 North Fowler Street
Bishop, CA 93514

Dear Board Members:

Bishop High School Health Clinic

America's public high schools are charged with an awesome responsibility. The development of our children into responsible young adults requires that the high schools provide opportunities both academically and socially. In order to do this, we must help high school students make good choices. We should be teaching them to take advantage of the education offered by our schools; we must show them how to respect themselves and others and be aware of the consequences of their actions; and in respecting themselves, they must take care of their own health and safety. The community and schools should be doing everything possible to assist them towards this goal.

Therefore, the plan to have a Bishop Union High School based Health Clinic is a noble and proper proposal. We are in complete support of a clinic offering medical attention to injured or ill students, or counseling on other medical issues and/or student personal problems. Early intervention is a key to resolving many issues.

However, it has come to our attention that one of the functions of the Health Clinic may be to provide birth control and pregnancy counseling (without parental consent or knowledge) which may include dispensing contraceptives and abortion information including providing the so called "morning after" pill. We strongly believe that this is not a positive and supportive message to send to our young teenagers in helping them made good choices. The appearance is that Bishop Union High School is condoning the actions of intercourse and abortion, which teens are not equipped to handle either physically or mentally. Their bodies are still in the developmental stages and medical evidence (see attachment) cautions that artificial contraceptives may cause irreversible damage. The High School Board and Administration should be encouraging choices without the side effects of irregular bleeding, hypertension, high blood pressure, bacterial infections, depression (see attachment for more), and we do not feel this is consistent with this message.

We strongly support birth control counseling promoting abstinence. It is the only method that is 100% effective, free from sexually transmitted diseases, and has no side

effects. We also support counseling as an alternative to abortion. We believe that the "morning after pill" is a form of abortion and include it in our objections.

Therefore, we as members of the Witness to Life Group of Bishop, do support the establishment of a Bishop Union High School based Health Clinic. We do, though, adamantly object to the offering of contraceptives and the "morning after pill" to students. We believe that such action is detrimental to helping develop students into moral, responsible adults.

Respectfully yours,

Witness to Life Members

cc Barry Simpson, District Superintendent/Secretary of the Board

Patty Stow
Chris Bowen
Misty Butterfield
Carole Sample
Pat Flanagan
Kathy Stow
Sandy Wingenread
Mary Riley
Jimmy Riley
Christie Arnold
Fr. John Bracey
John Stow
Robert Wingenread

CDC FACT SHEET

Reported STDs in the United States

2015 National Data for Chlamydia, Gonorrhea, and Syphilis

This fact sheet summarizes 2015 data on chlamydia, gonorrhea, and syphilis published in CDC's annual report, *Sexually Transmitted Disease Surveillance, 2015* (available at www.cdc.gov/std/stats). The data are based on state and local STD case reports from a variety of private and public sources.

Many cases of chlamydia, gonorrhea, and syphilis continue to go undiagnosed and unreported, and data on several additional STDs — such as human papillomavirus, herpes simplex virus, and trichomoniasis — are not routinely reported to CDC. As a result, the annual surveillance report captures only a fraction of the true burden of STDs in America. However, it provides important insights into the scope, distribution, and trends in STD diagnoses in the country.

STDs are a substantial health challenge facing the United States. CDC estimates that nearly 20 million new sexually transmitted infections occur every year in this country, half among young people aged 15–24, and account for almost $16 billion in health care costs. Each of these infections is a potential threat to an individual's immediate and long-term health and well-being. In addition to increasing a person's risk for acquiring and transmitting HIV infection, STDs can lead to chronic pain and severe reproductive health complications, such as infertility and ectopic pregnancy.

Snapshot: STDs in the United States, 2015

Despite recent declines, 2015 was the second year in a row in which increases were seen in all three nationally reported STDs. The approximately 1.5 million cases of chlamydia represent the highest number of annual cases of any condition ever reported to CDC. Substantial increases were also seen among reported cases of gonorrhea and syphilis. While young people and women are most severely affected by STDs, increasing rates among men contributed to the overall increase in 2015 across all diseases.

Chlamydia

- Cases reported in 2015: 1,526,658
- Rate per 100,000 people: 479; increase of 6% since 2014

Gonorrhea

- Cases reported in 2015: 395,216
- Rate per 100,000 people: 124; increase of 13% since 2014

Syphilis (primary and secondary)

- Cases reported in 2015: 23,872
- Rate per 100,000 people: 8; 19% increase since 2014

Syphilis (congenital)

- Cases reported in 2015: 487
- Rate per 100,000 live births: 12; 6% increase since 2014

CDC
National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
Centers for Disease Control and Prevention

OCTOBER 2016

Some Groups Bear a Disproportionate Burden of STDs

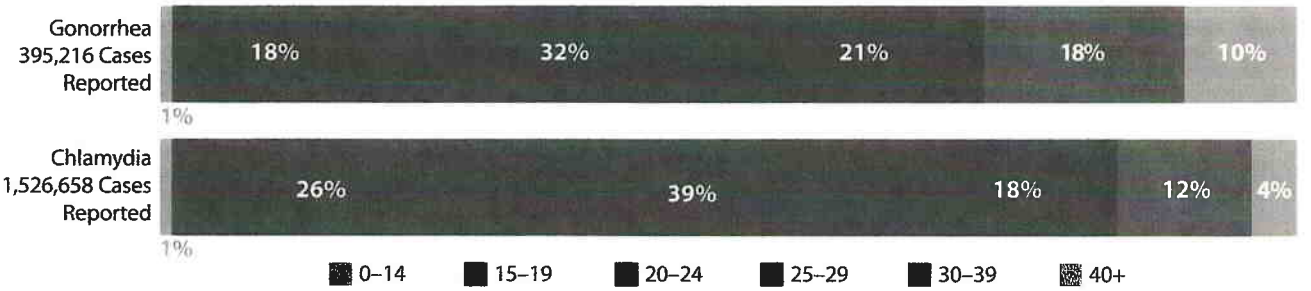
While anyone can become infected with an STD, certain groups, including young people and gay and bisexual men, are at greatest risk.

Gonorrhea and chlamydia primarily affect young people

Surveillance data show both the numbers and rates of reported cases of chlamydia and gonorrhea continue to be highest among young people aged 15-24.

Both young men and young women are heavily affected by STDs — but young women face the most serious long-term health consequences. It is estimated that undiagnosed STDs cause infertility in more than 20,000 women each year.

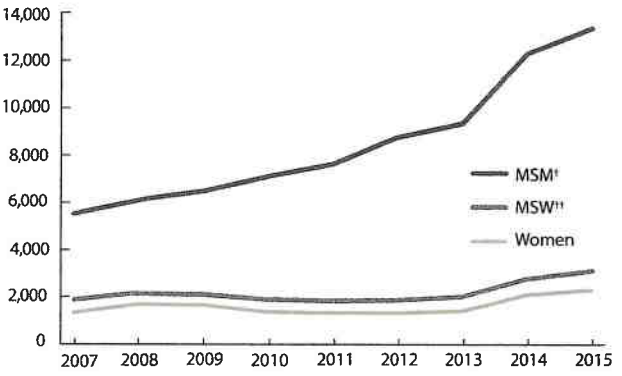
Most Reported Chlamydia and Gonorrhea Infections Occur among 15–24-Year-Olds



Troubling rise in syphilis infections among men, particularly gay and bisexual men

Trend data show rates of syphilis are increasing at an alarming rate (19 percent in 2015). While rates have increased among both men and women, men account for more than 90 percent of all primary and secondary syphilis cases. Men who have sex with men (MSM)* account for 82 percent of male cases where the sex of the sex partner is known. Primary and secondary syphilis are the most infectious stages of the disease, and if not adequately treated, can lead to long-term infection which can cause visual impairment and stroke. Syphilis infection can also place a person at increased risk for acquiring or transmitting HIV infection. Available surveillance data indicate that an average of half of MSM who have syphilis are also infected with HIV.

Gay and Bisexual Men Face Highest – and Rising – Number of Syphilis Infections



† Men who have Sex with Men †† Men who have Sex with Women

Note: Based on available data from states reporting sex of sex partners

Disparities result from a range of factors

A number of individual risk behaviors (such as higher numbers of lifetime sex partners), as well as environmental, social and cultural factors (such as higher prevalence of STDs or difficulty accessing quality health care) contribute to disparities in the sexual health of gay and bisexual men. For example, gay and bisexual men who live in poverty may have trouble accessing and affording quality healthcare, making it difficult to receive STD testing and other prevention services. Additionally, complex issues like homophobia and stigma can also make it difficult for gay and bisexual men to find culturally-sensitive and appropriate care and treatment.

* The term men who have sex with men is used in CDC surveillance systems because it indicates the behaviors that transmit infection, rather than how individuals self-identify in terms of their sexuality.

STD Screening is Critical:

If you are sexually active, be sure to talk to your healthcare provider about STD testing and which tests may be right for you.

Women:

- If you are a sexually active woman younger than 25, or have risk factors such as new or multiple sex partners, you should request annual chlamydia and gonorrhea tests.
- If you are a pregnant woman, you should request syphilis, HIV, chlamydia, and hepatitis B tests early in your pregnancy. If you have new or multiple sex partners, you should also request gonorrhea testing early in pregnancy.

Gay and bisexual men:

- If you are a sexually active man who is gay, bisexual, or has sex with men, you should request tests for syphilis, chlamydia, gonorrhea, and HIV at least once a year. More frequent STD testing is recommended for men at high risk.

Sources:
1. Centers for Disease Control and Prevention. Sexually Transmitted Disease Surveillance 2015. Atlanta: U.S. Department of Health and Human Services; 2016. Available at https://www.cdc.gov/std/stats.

If you are a member of the news media, please visit **www.cdc.gov/nchhstp/Newsroom** or contact the News Media Line at CDC's National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention: 404-639-8895 or **NCHHSTPMediaTeam@cdc.gov**.

Other information requests may be directed to the Division of STD Prevention (**www.cdc.gov/std**) or the CDC-INFO Contact Center: 800-CDC-INFO (800-232-4636).

"YOU DECIDE"

TRENDS IN STDs IN THE UNITED STATES

INFORMATION POSTED ON THE CENTERS FOR DISEASE CONTROL (CDC) WEBSITE
January 2003

Teens are at high behavioral risk for acquiring most STDs. Teenagers and young adults are more likely than other age groups to have multiple sex partners, to engage in unprotected sex, and, for young women, to choose sexual partners older then themselves. Moreover, young women are biologically more susceptible to chlamydia, gonorrhea and HIV.

By far, women bear the greatest burden of STDs, suffering more frequent and more serious complications then men.

Chlamydia and gonorrhea are the most common curable STDs among teens. Curable STDs are typically caused by bacteria that can be killed with antibiotics. However, if these diseases remain undetected and untreated, they can result in severe health consequences later in life. Among teens, it is not uncommon to see more than five percent of young men and five to 10 percent of young women infected with chlamydia (Mertz, CDC, 1998). Rates of gonorrhea are highest in female 15 to 19 years of age and in males 20 to 24 years of age.

Currently, the data are not available to tell us whether HPV, trichomoniasis, or bacterial vaginosis are increasing, but these diseases are extremely widespread.

The United States has the highest rates of STDs in the industrialized world.

Nearly one out of five persons living in the United States think that all STDs are curable, and more than half do not know that other STDs facilitate HIV transmission.

An often unrecognized aspect of STDs, including bacterial STDs, is how frequently persons with these infections have no symptoms or do not recognize symptoms.

CHLAMYDIA

Chlamydia is widespread among the sexually active population, regardless of race, ethnicity, age, or gender. It is more concentrated among adolescents than any other std with the highest rates seen among female adolescents. Data on male adolescents also reveal an alarming level of infection.

Forty percent of chlamydia cases are reported among young people, 15 to 19 years old. Reported prevalence among sexually active women is consistently more than five percent with prevalence among teenage girls often exceeding 10 percent more than one in ten. And while the data are more limited for men, studies of adolescent males tested on high schools and other settings have found prevalence of more than five percent (Cohen, 1998; Ku, 1997).

Ten to 20 percent of women with chlamydia develop one of the most serious complications, pelvic inflammatory disease (PID).

Recent studies and screening programs in multiple settings throughout the country come to the same conclusion: chlamydia continues to exact a devastating toll among our nation's young people.

1.

GONORRHEA

For the first time in nearly two decades, gonorrhea is on the rise, increeasing more than nine percent from 1997 to 1999, after a 72 percent decline from 1975 to 1997. An increase in drug-resistant gonorrhea has been seen in Hawaii and in small clusters in other states.

Ten to 20 percent of women with gonorrhea develop one of the most serious complications, pelvic inflammatory disease (PID).

GENITAL HERPES

Genital herpes continues to increase, spreading across all social, economic, racial and ethnic boundaries, but most dramatically affecting teens and young adults (Fleming, 1997).

Herpes is a sexually transmitted disease (STD) caused by the herpes simplex viruses type 1 (HSV-1) and the type 2 (HSV-2). Most individuals have no or only minimal signs or symptoms from HSV-1 or HSV-2 infection.

HSV-1 and HSV-2 can be found and released from the sores that the viruses cause, but they also are released between episodes from skin that does not appear to be broken or to have a sore. A person almost always gets HSV-2 infection during sexual contact with someone who has a genital HSV-2 infection. HSV-1 causes infections of the mouth and lips, so-called "fever blisters." A person can get HSV-1 by coming into contact with th4e saliva of an infected person. HSV-1 infection of the genitals almost always is caused by oral-genital sexual contact with a person who has the oral HSV-1 infection.

Nationwide, 45 million people ages 12 and older, or one out of five of the total adolescent and adult population, are infected with HSV-2.

HSV-2 infection is more common in women (approximately one out of four women) than in men (almost one out of five).

Since the late 1970s, the number of Americans with genital herpes infection has increased 30%. The largest increase is currently occurring in young white teens. HSV-2 infection is now five times more common in 12 to 19 year-old whites, and it is twice as common in young adults ages 20 to 29 than it was 20 years ago.

HSV-2 usually produces only mild symptoms or signs or no symptoms at all.

IN THE UNITED STATES, HSV-2 MAY PLAY A MAJOR ROLE IN THE HETEROSEXUAL SPREAD OF HIV, THE VIRUS THAT CAUSES AIDS. HERPES CAN MAKE PEOPLE MORE SUSCEPTIBLE TO HIV INFECTION, AND IT CAN MAKE HIV-INFECTED INDIVIDUALS MORE INFECTIOUS.

Most people infected with HSV-2 are not aware of their infection..... most individuals with HSV-2 infection may never have sores, or they may have very mild signs that they don't even notice or that they mistake for insect bites or a rash.

THERE IS NO TREATMENT THAT CAN CURE HERPES.

The consistent and correct use of latex condoms can help protect against infection. However, condoms do not provide complete protection because the condom may not cover the herpes sore(s), and viral shedding may nevertheless occur.

Between 15 to 20 percent of young men and women have become infected with herpes by the time they reach adulthood.

HUMAN PAPILLOMAVIRUS (HPV)

With an estimated 20 million people in the United States currently infected with human papillomavirus (HPV), this viral std also continues to spread. An estimated 5.5 million people become newly infected with HPV each year (Cates, 1999).

Among women under the age of 25, studies have found that 28 to 46 percent are typically infected with HPV.

Genital HPV infection is the most common sexually transmitted disease (STD) in the United States and is of increasing public health concern, yet no prevention programs have been established.

The sequela of genital HPV infection of greatest public health importance is cervical cancer. For over a century, epidemiologic studies have indicated a relationship between cervical cancer and sexual activity, with consistent associations with age of onset of sexual activity, multiple sexual partners, and contact to "high-risk" males, men with multiple partners or prior partners with genital neoplasis.

The disease burden created by genital HPV infection is high..... In the U.S., for example, incidence rates are currently 8.3/100,000, with approximately 14,000 cases and 5000 deaths annually, despite the performance of an estimated 50 million Pap smears per year.

Theoretically, barrier contraceptives such as condoms are less likely to be effective in preventing infections such as genital HPV, which can involve the external genital skin, than they are for infections which are limited to specificmucosal areas and spread by semen (e.g., chlamydia or gonorrhea), although estimation of potential benefit of condoms for HPV is hindered by absence of measures of infectivity.

HUMAN IMMUNODEFICIENCY VIRUS (HIV)

HIV PREVENTION THROUGH EARLY DETECTION AND TREATMENT OF OTHER SEXUALLY TRANSMITTED DISEASES –UNITED STATES RECOMMENDATIONS OF THE ADVISORY COMMITTEE FOR HIV AND STD PREVENTION (ACHSP)

ACHSP considered that the evidence was strong that early detection and treatment of other STDs is an effective strategy for preventing sexually transmitted HIV infection but was concerned that this strategy has not been clearly articulated or implemented as a core strategy for HIV prevention in the United States.

ACHSP concluded that early detection and treatment of curable STDs should be implemented more widey as an HIV prevention strategy in the United States.

Since the beginning of the Acquired Immunodeficiency Syndrome (AIDS) epidemic, researchers consistently have noted a strong epidemiologic association between HIV/AIDS and other STDs in developing and industrialized countries, including the United States.

For example, a much higher prevalence of HIV coinfection exists among persons with any STDs than among those without STDs or a history of STDs.

The U.S. HIV/AIDS epidemic has evolved recently in three ways that suggest that STD cofactor effects are becoming increasingly important.....

Early detection and treatment of other STDs should be a critical component of national, state, and local strategies to prevent HIV infection and AIDS, in concert with the behavioral and other interventions that constitute a comprehensive HIV prevention approach.

3.

PELVIC INFLAMMATORY DISEASE (PID)

Pelvic inflammatory disease (PID) is a general term that refers to infection of the fallopian tubes and of other internal reproductive organs in women. It is a common and serious complication of some STDs.

Untreated PID can lead to serious consequences including infertility, ectopic pregnancy, abscess formation, and chronic pelvic pain.

More than 150 women die from this infection every year.

Sexually active women in their childbearing years are most at risk.

Sumptoms of PID vary from none to severe.

Because of vague symptoms, PID goes unrecognized both by women and by their health care providers about two thirds of the time.

Many women with PID have sex partners who have no symptoms, although their sex partners may be infected with the organisms that can cause PID.

Sexually active women under 25 are more likely to develop PID than are women older than 25.

The main cause of PID is an untreated STD.

Such common methods of birth control as the oral contraceptive pill or the contraceptive shot or implant do not give women protection from STDs.

STDs and PREGNANCY

It is estimated that 30 to 40 percent of excess preterm births and infant deaths are due to STDs and bacterial vaginosis (Goldenberg, 1996).

Many STDs can be passed from an infected woman to fetus, newborn, or infant, before, during or after birth.

Pregnancy does not provide women or their babies any protection against STDs.

STDs can have many of the same consequences for pregnant women as for women who are not pregnant. STDs can cause cervical and other cancers, chronic hepatitis, cirrhosis, and other complications. Many STDs are silent—or present without symptoms—in women. Among the additional consequences pregnant women may suffer from STDs are early onset of labor, premature rupture of the membranes surrounding the baby in the uterus, and uterine infection after delivery.

****

The information presented is meant to educate the reader to the some of the realities of STDs in the United States. For more detailed information go to the CDC Website-"STDs".

This is Abortion

"MEDICAL" ABORTIONS

Emergency Contraception - Plan B (The Morning-After Pill)

Emergency Contraception (EC) contains synthetic progestogen (not to be confused with naturally occurring progesterone) and is a large dose of the common birth control pill, designed to be taken as a single dose within 72 hours after "unprotected sex."

EC works in three ways. First, it attempts to stop ovulation. Depending on where a woman is in her cycle, ovulation may or may not have already occurred before EC was taken. Second, EC attempts to stop fertilization by impeding the transportation of the sperm to the egg. Third, EC tries to stop implantation by altering (thinning) the lining of the uterus (endometrium) so the embryo cannot implant and receive nourishment from the mother.

The first two methods are contraceptive, but if they fail, the third method causes an abortion because it occurs after fertilization.[1]

ella - Ulipristal Acetate (UPA)

Ella is a selective progesterone receptor modulator (SPRM). SPRMs block the action of the hormone progesterone, which is necessary for ovulation and implantation to occur. Progesterone also maintains the lining of the uterus and supports the embryo. Currently, the only other legal SPRM drug available in the United States is RU-486 (mifepristone). Although ella acts similarly to RU-486, it is being billed as an emergency contraceptive.[2] ella is designed to be taken as a single dose within 5 days of "unprotected sex." It is thought to inhibit and delay ovulation, attempting to prevent fertilization. However, ovulation may or may not have already occurred before ella was taken. ella also alters the lining of the uterus, which, if fertilization occurs, can prevent an embryo from implanting, causing an abortion.[3,4]

RU-486 - Mifeprex (The Abortion Pill)

Mifeprex blocks the action of the hormone progesterone which is needed to maintain the lining of the uterus and to provide oxygen and nutrients for the baby. Without it, the baby dies. Mifeprex is used in conjunction with the drug Cytotec (misoprostol), which is taken two days after Mifeprex, causing uterine bleeding (sometimes profuse), strong contractions, and expulsion of the baby.

The pregnant woman first visits the abortionist to obtain the Mifeprex pills, returns two days later to receive misoprostol, and returns a third time to verify that the abortion is complete. The failure rate of this method is about 8 percent if the pills are taken within 7 weeks and up to 23 percent at 8-9 weeks. If the baby survives the abortion, there is a high risk that he or she will suffer mental and/or physical birth defects from the misoprostol.[5,6]

SURGICAL ABORTIONS

Vacuum Aspiration

In this first trimester procedure, the abortionist inserts a hollow plastic suction tube into the dilated cervix. The uterus is emptied by either a manual syringe or a high-powered suction machine. The baby is torn into pieces as he or she is pulled through the hose.[7,8,9]

Dilation and Suction Curettage (D&C)

This is similar to the vacuum aspiration but is generally used after 14 weeks. After the baby is suctioned out of the uterus the abortionist inserts a curette, a loop-shaped steel knife, into the uterus. With this the abortionist cuts the placenta and umbilical cord into pieces and scrapes them out into a basin. The uterus is again suctioned out to ensure that no body parts have been left behind. Bleeding is usually profuse.[10]

Dilation and Evacuation (D&E)

Once the cervix is dilated considerably farther than in first trimester abortions, the abortionist inserts a narrow forceps that resembles a pliers. This instrument is needed because the baby's bones are calcified, as is the skull. The abortionist inserts the instrument into the uterus, seizes a leg or other part of the body and, with a twisting motion, tears it from the baby's body. The spine is snapped and the skull crushed. Body parts are then reassembled and counted to make certain that the entire baby has been removed and that no parts remain in the womb.[11,12,13,14]

Induction or Prostaglandin Abortion

Labor is induced using prostaglandin drugs, and the cervix is dilated. To ensure the baby will be dead upon delivery and to start uterine contractions, the abortionist may inject saline (salt water) or urea (a substance found naturally in urine and blood). To guarantee against a live birth and legal complications, doctors will inject the drug Digoxin or potassium chloride directly into the baby's heart to kill the child before delivery. Other times the baby is delivered alive and left without medical intervention until he or she dies.[15] This method is used in the second or third trimester.[16]

Dilation and Extraction (D&X)

After the mother undergoes two days of dilation, the abortionist performs an ultrasound to locate the child's legs and feet. The abortionist then uses a large forceps to grasp one of the baby's legs. He pulls firmly, forcing the child into a feet-down position.

Using his hands instead of forceps, the abortionist delivers the baby's body in a manner similar to a breech birth. The baby's head remains inside the birth canal. The abortionist uses surgical scissors to pierce the child's head at the base of the skull. The scissors are forced open to enlarge the skull opening. The abortionist then inserts a suction catheter into the brain and vacuums out the child's brain tissue with a machine 29 times more powerful than a household vacuum.[17]

[1]archfami.ama-assn.org/cgi/content/full/9/2/126 (Also see citations from "What About Birth Control?") [2]Food and Drug Administration. May 2010.[3]HRA Pharma. 2010.[4]Ibid. 2009.[5]National Abortion Federation. 2006.[6]RU486Facts.org. 2008.[7]American Pregnancy Association. 2006.[8]National Abortion Federation. 2008.[9]Ibid.[10]American Pregnancy Association. 2006.[11]National Abortion Federation. 2008.[12]National Abortion Federation. 2007.[13]American Pregnancy Association. 2006.[14]Web MD. 2006.[15]Testimony of Jill Stanek, RN. U.S. House of Representatives. 2001.[16]WebMD. 2006.[17]American Pregnancy Association. 2006.

The "Morning-After" Pill: A Risk to Adolescents

American College of Pediatricians – December 2012

The American College of Pediatricians strongly opposes adolescents' over-the-counter (OTC) access to the "morning-after" pill (MAP), a form of emergency contraception. Such ease of access to this drug may increase **unprotected** sexual activity among teens and increase the risk of contracting sexually transmitted infections (STI). MAP use can cause significant adverse effects such as heavy menstrual bleeding, irregular menstruation, and pelvic pain. It also interacts with a wide variety of drugs, a fact unlikely to be known by unsupervised users.[1,2] Under physician supervision, these effects are better managed, including the potentially dangerous possibility of MAP use with ectopic pregnancy. The long-term risk of breast and cervical cancer with the use or overuse of this high-dose synthetic hormone (up to 15 times that of oral contraceptives), is largely unknown. Lower-dose oral contraceptives are available only by prescription; the MAP deserves at least the same physician oversight.

Furthermore, while the MAP is chemically different from the "abortion pill" (RU-486) and does not abort an embryo already implanted in the uterus, it can act as an abortifacient since it "may also prevent...attachment of a fertilized egg to the uterus (implantation)."[3,4] Therefore, it may terminate the life of a child.

Society has long recognized that adolescents possess immature reasoning skills. This is why adolescents are not allowed to buy tobacco or alcohol products, to vote, or to consent to most medical procedures. Research has now documented that important decision-making areas of the human brain are not fully developed until the mid-twenties.[5,6,7,8] Consequently, the College is concerned that adolescents may carelessly use the MAP as a routine form of birth-control at a time in their lives when they are less capable of dealing with the subsequent negative consequences. In a recent report[9] that described adolescent attitudes regarding Plan B (one form of the MAP), the authors stated that, "Some (interviewed) participants felt that having more access to emergency contraception (EC) would cause teens to act promiscuously and irresponsibly..." and "Participants also acknowledged that over-the-counter availability might increase misuse of EC, with some youth taking EC without fully understanding the directions and the potential side effects."

For the well-being of adolescents and the protection of human life, the College urges HHS, the FDA, Congress, and other policy makers to enact policy to restrict the over-the-counter sale of MAP.

The Board of Directors Comment: This statement should in no way be interpreted as an endorsement by the American College of Pediatricians of the "morning-after" pill.

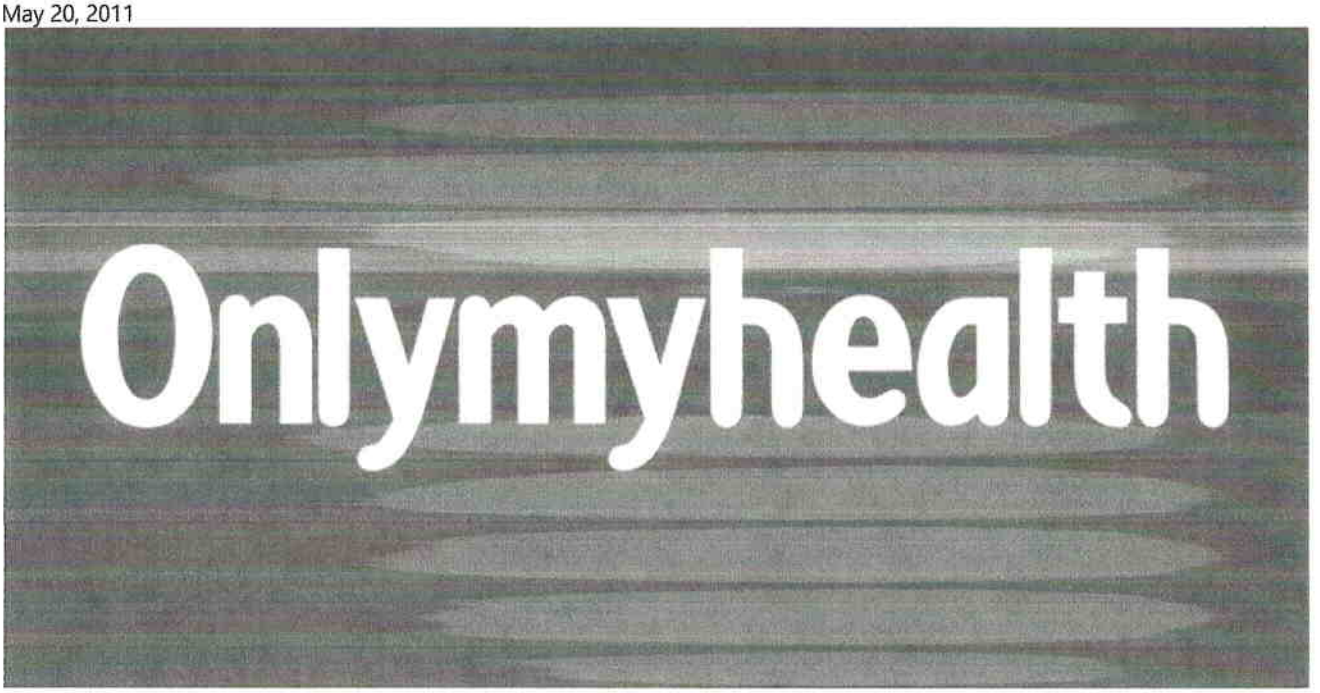
January 1, 2004; Updated December 2012

The American College of Pediatricians is a national medical association of licensed physicians and healthcare professionals who specialize in the care of infants, children, and adolescents. The mission of the College is to enable all children to reach their optimal, physical and emotional health and well-being. More information is available at www.Best4Children.org.

Side effects of Birth Control Pills for Teenagers

By Jenita Gulati, Onlymyhealth editorial team

May 20, 2011



Birth control is a measure taken against unwanted **pregnancy** and the most common way is the use of birth control pills which are 99.7% successful. At the same time, there are side effects attached to it. Increasingly teenagers are beginning the use of birth control pills.

Most commonly observed side effects of birth control pills for **teens** are as follows:

- High risk of acne although in some cases the pills actually relive teenagers of the nasty acne problem.
- Enlargement and tenderness of breast, and lumps in the breast. Formation of cysts in the breast and in some cases, breast cancer.
- Irregular periods and bleeding/spotting in between periods. Sometimes very heavy vaginal bleeding during periods. this condition however, appears only in a few teenagers.
- Nausea and sometimes vomiting is also very common.
- Headaches that might lead to migraine.
- Issues related to eyes such as vision change, vision loss, blood clot in the eyes, and blurred vision.
- A decrease in sex drive and reduced satisfaction in sex.
- Weight gain in some.

- Hypertension.
- High blood pressure (BP).
- Issues related to the lower body such as cramps and swelling in the legs, pain in the calf.
- Issues related to lungs such as blood in cough, chest pain, and shortened breath.
- Jaundice, change in the colour of urine, abdominal pain. Liver cancer is also an extreme side effect of birth control pills when used by teenagers.
- Rashes, itching on the body.
- Rare occurrences of heart attacks, and cervical cancer.
- If one already has problems such as diabetes, hypertension, high BP, then consumption of pills may increase the rate of heart stroke.
- Dizziness and mood swings.
- Vaginal infection.
- Skin pigmentation and skin irritation.
- Smoking also increases the risk of cancer in teenagers.
- Incurable infection of acne yeast.
- Bacterial infections.
- Weakened immune system.

Birth control pills contain two kinds of hormones namely, estrogen and progesterone. Pills with estrogen contain ethinylestradiol but there is a variation in dosage. Some progestins are thought to have androgenic activity while others have anti-androgenic effects. So a dose of estrogen or progesterone determines which kind of side effects the pill will cause. Estrogen content affects menstrual bleeding and high content of it will result in high risk of blood clots. Androgenic progestin increases acne and anti-androgenic progestin on the other hand reduces them.

It is always advisable to consult your doctor before consuming such pills and if you are suffering from any ailment then make sure that the birth control pill does not worsen the situation.

Health | October 3, 2016
By Korin Miller

The Weird Ways Birth Control Can Impact Your Mood

Research looks into the complicated link between hormonal birth control and depression.

Ariel Skelley / Getty Images

Birth control pills are awesome: They give you ways to control when (and if) you get your period and make it lighter and less painful when you do get it, they can clear up your skin, and, of course, they allow you to have sex without getting pregnant. If you struggle with mood swings during PMS, or if you have PMDD (premenstrual dysphoric disorder), hormonal birth control can help keep your mood under control. But hormones are complicated, and the relationship between birth control and mood is confusing, with both scientific and anecdotal evidence suggesting that some methods may actually make some people feel mentally worse, not better.

"Hormones are instrumental in regulating and effecting our emotions," clinical psychologist John Mayer, Ph.D., tells SELF. "The action of birth control pills is directed to hormonal regulation; therefore you have the perfect storm to set the table to have consequences on mood."

Licensed clinical psychologist Alicia H. Clark, Psy.D., agrees. "I have worked with numerous women whose birth control has appeared to suppress their mood," she tells SELF. "When non-

hormonal forms of birth control have been substituted, I have noticed a consistent trend in mood and energy elevation." Now, she asks patients who complain about their mood if they're on hormonal birth control for that reason.

A new study published in JAMA Psychiatry has found a link between hormonal birth control use and an increased incidence of depression. For the study, researchers analyzed data from more than 1 million women in Denmark with no history of depression for 13 years and found that those who used hormonal birth control had a 50 percent greater risk of depression within six months of using hormonal birth control than those who didn't use it.

Overall, the use of any combined oral contraceptive was associated with a 10 percent increased risk of a first diagnosis of depression, and a 20 percent increased risk of using antidepressants. The risk was higher among women aged 15-19, and was also higher among women who used any type of hormonal birth control for six months. Women who used progestin-only pills doubled their risk of developing depression, while those who used the levonorgestrel IUD (aka Mirena) tripled their risk.

It's worth noting here that, as with all studies that find links between two things, correlation doesn't equal causation—just because two things are linked doesn't mean that one thing directly caused the other. After news of the study broke, experts quickly pointed out a few reasons why you can't actually draw any solid conclusions from it. One example: There was no control group. That means that it's possible that taking the pill or hormonal birth control wasn't the cause of the antidepressant use, but potentially a marker for it—for instance, taking the pill could be a sign that someone is more likely to take meds (hat tip to the always on-top-of-it Dr. Jen Gunter). Another expert, epidemiologist Chelsea Polis, PhD, pointed out on Twitter that in media reports about the study, you only see relative risk, rather than absolute risks. Meaning that you only see that the risk increases by a certain percentage—but that doesn't tell you how likely you are to actually be effected by it. (Think of it this way: If the risk of something increases from 2 out of 100 to 3 out of 100, that's a 50% increase in relative risk, but the absolute risk is still very small—only 3 percent). Case in point: The researchers note that most women who use hormonal birth control methods don't get depressed, but say there is a possibility it can happen. The possibility exists, but it's not an issue for the majority of birth control users.

Another thing: Previous research has found the opposite effect to be true. A study published in the American Journal of Epidemiology in 2013 found that women on hormonal birth control were less likely to have symptoms of depression and to have attempted suicide than women who weren't on hormonal birth control.

All that being said, experts aren't shocked that the association exists. Clark says hormonal birth control can be risky for women who may be prone to emotional sensitivity because the sex hormones used in them—estrogen and progesterone—impact emotional and cognitive processing (which then impacts your ability to regulate your mood). Hormonal birth control tricks your body into thinking it's pregnant, she points out, so it's not surprising that it can potentially negatively impact your mood. Indeed, some hormonal birth control options, including pills and the ring, list mood changes and even depression as a possible side effect.

For those same reasons, it's also possible for some women to have mental perks on birth control —indirectly, at least. "Hormonal birth control can improve mood as likely as it can detract," says Mayer. He cites patients who have struggled with difficult periods who feel much better on hormonal birth control. "The emotional relief of not having the extreme symptoms from their former symptoms is very uplifting," he says. "This has been especially true in adolescent girls where their periods can be very painful and disruptive." And some birth control pills—including the often controversial but still popular Yaz—are prescribed to women to alleviate the symptoms of PMDD, an extreme form of PMS that can result in monthly bouts of depression.

At the end of the day, how you respond to birth control is a very personal thing. What works

great for your friend might not be a great fit for you (and vice versa). If you suspect that your birth control is messing with your emotions, talk to your doctor about alternative options. "No woman should have to endure cognitive and mood symptoms in order to maintain reproductive control," says Clark. "There are other effective methods." But if you are afraid of trying out hormonal birth control because of the risks, you should talk to your doctor about that, too—and not be scared by sensationalist headlines.

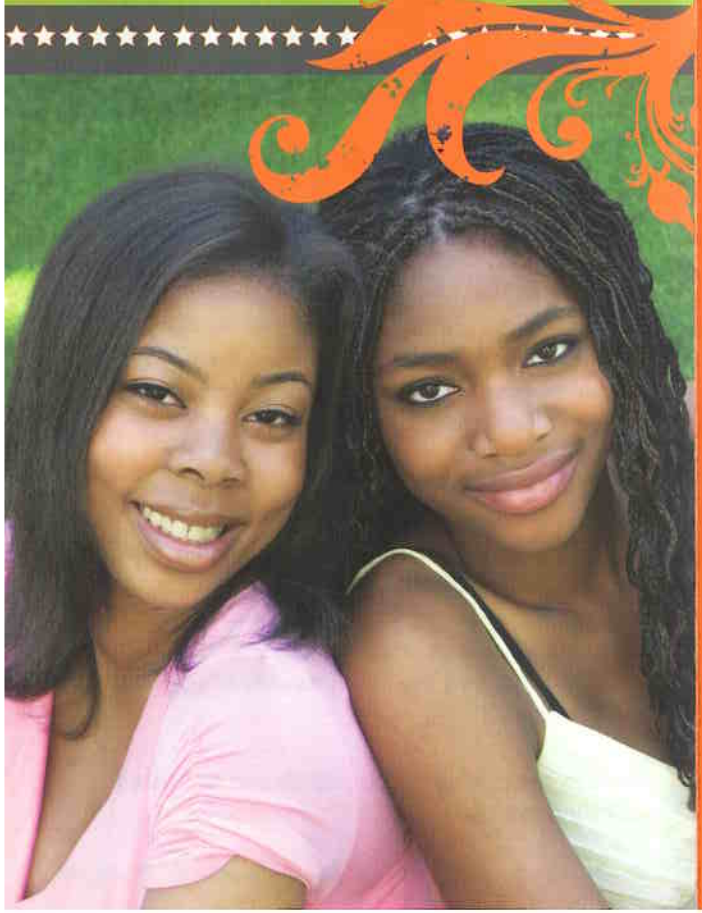
Keywords
Mood, Birth Control, Contraception, Depression

About 614,000 teenage girls become pregnant each year.[1]

That means that about 1 out of every 4 teenage girls gets pregnant before the age of 20![2] Providing for a child when you're still in school is difficult and expensive. In fact, it costs about a quarter of a million dollars to raise a child until they are 18.[3] That's why teen moms often drop out of school and have to rely on welfare.[4]

Becoming a parent is easy, but being a parent is tough!

Babies need a lot more than just food and shelter. Since you and your children deserve the best possible future, wait to have sex.



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Want to know what STDs you should be tested for? Find out at: www.STDWizard.org

ISBN 1-933902-48-5

MedicalInstitute
www.medinstitute.org

WHY ABSTINENCE?

ABSTINENCE DOESN'T MEAN NEVER HAVING SEX.

It's about waiting to have the safest and best sex!

Did you know that every year millions of people get a sexually transmitted infection (STI)?[4] There are over 25 different kinds of STIs. Chlamydia, gonorrhea, syphilis, herpes, human papillomavirus (HPV), and HIV are just some of them. They can be uncomfortable, destructive, and gross! You can catch an STI at any age.

Using a condom is not enough. Condoms are better than nothing, but they're far from perfect.[5,6] Condoms don't make sex "safe," they just make it less risky. Even if you always use condoms correctly, they can still slip or break. And guess what? Some STIs, like HPV and herpes, can be passed by contact with areas not covered by the condom. That's why "messing around" and oral sex are also risky.

Want protection from STIs? Want protection from more than just infections? A condom can't protect your heart. Wait to have sex until you are in a life-long relationship such as marriage. If someone truly loves you they won't pressure you to have sex.

Want real love and intimacy? What builds a meaningful relationship is the time you spend together – talking, doing activities, and getting to know each other.

ASK YOURSELF: DOES THE PERSON YOU'RE WITH ALWAYS...

> Tell the truth?

> Act responsibly?

> Treat you with respect?

> Like you for who you are, not your body?

> Do things for you even when they get nothing in return?

Sex comes when you are able to live out a life-long commitment to another person. It comes when you can provide financially for another person – pay rent, buy food, and even pay medical bills.

Most young people who have sex have their reasons. But are they good ones? Think about it...

"Everyone's doing it." *Don't follow the crowd. Dare to be different.*

"I feel loved." *Will you feel loved when it's over and you're alone?*

"It's hard to say NO." *Yeah, but you can do it. Say "No" now instead of saying "Oh #%#@" later.*

"If I don't... he will leave me." *Don't worry if they leave you – worry about what they could leave you with.*

"But it feels good." *Is one moment of pleasure really worth a lifetime of pain?*

"Girls want a guy who is experienced." *Experienced visiting an STI clinic?*

IT'S NEVER TOO LATE FOR A NEW START!
Abstinence is about respecting yourself and respecting your partner. Tell your partner that you are waiting for the healthiest sex. Let them know exactly where your boundaries are. It feels great to make healthy, smart, bold decisions!

So let's say you choose to go this "abstinence route." What do you do till you're in a life-long relationship? Abstinence makes so many options possible. You can finish your education, prepare for your career, play sports. Pursue your dreams. It's your choice. **IT'S YOUR LIFE**. You deserve the best possible future. Wait to have sex.

Want to know what STDs *you* should be tested for? Find out at **www.STDWizard.org**

SAVE A LIFE!

A movement among the Catholic parishes of Kern and Inyo Counties to inspire reverence for all human life.

INYO COUNTY RESOURCES:

ABOUNDING LOVE PREGNANCY RESOURCE CENTER
Abortion Alternative Hotline
Call:760-920-1061

ANGEL'S NOOK
Newborn baby items.
Call: 760-920-9616

KNIGHTS OF COLUMBUS
OUR LADY OF PERPETUAL HELP
Call: 760-872-7231

COUNSELING AVAILABLE CALL FOR INFORMATION.

WITNESS TO LIFE

PO Box 1401 Bishop, CA 93515

760-920-9616

KERN COUNTY RESOURCES:

RIDGECREST PREGNANCY CARE CENTER
Call: 760-384-2273
Email: pcc@iwvisp.com
Web: www1.iwvisp.com/pcc/

BAKERSFIELD PREGNANCY CENTER
Offering life-affirming help to women and couples facing unplanned pregnancies
Call: 661-326-1915
Email: director@wehelpyou.org
Web: bpcpartners.org

RIGHT TO LIFE KERN COUNTY
Promoting respect for the sanctity of human life from conception until natural death.
Call: 661-864-7508
Web: rtlkc.org or life@rtlkc.org

INFANT OF PRAGUE
Central California Adoption Service
Call: 800-994-2367
Web: Infantofprague.org

OTHER RESOURCES:

RACHEL'S VINEYARD
Healing the pain of abortion.
Call: 707-967-1101
Email: rachelsvineyard@gmail.com
Web: rachelsvineyard.org

NATURAL FAMILY PLANNING
Following God's plan with pregnancies.
Call: 661-392-9071
Web: nfpandmore.org or creightonmodel.com

ABORTION PILL REVERSAL
Nursing team available **24/7.**
CALL: 877-558-0333
Web: abortionpillreversal.com

INFERTILITY - NATURAL PROCREATIVE TECHNOLOGY
Call: 619-577-0997
Web: NaProTechnology.com

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Documentation of Patient Care	
Scope: Nursing Services	Manual: CPM – Admission, Discharge, Transfer, Documentation (ADT)
Source: DON ICU/Acute/SubAcute Services	Effective Date:

PURPOSE:

- Provide information to the health care team members about the patient's clinical condition.
- Serve as a basis for planning and ensuring continuity of care.
- Provide a record of care delivered.
- Serve as verification for third party reimbursement.
- Serve as legal document to protect the interests of the patient, hospital, and responsible practitioners.

POLICY:

Patient care documentation will be done as efficiently as possible using the electronic health care record (EHR), daily assessment and process notes when indicated on the electronic medical record. Documentation should reflect need for hospitalization and medical and nursing plan of care.

An RN must always have final responsibility for every patient and will review and sign all charts to which the RN is assigned to.

Nurses will record observations and care provided by them on the appropriate form.

Certified Nursing Assistants will record the care provided by them on the appropriate area of the patient record.

Student nurses may record observation and care provided by them on the appropriate form. The instructor must approve documentation. The RN responsible for the patient must review and sign the chart.

The RN will be responsible for making an assessment entry on the Patient Record a minimum of every ***12 hours*** and more frequently if patient's condition warrants or care plan indicates a more frequent assessment.

PROCEDURE:

Patient labels will be placed on all forms that are not a part of the EHR, including but not limited to down time forms. Labels are to be placed on the front and back of each page as indicated in the spaces provided.

All forms used for nursing documentation that are not part of the EHR, will be dated front and back.

Date and time (Using Military time) each entry when writing narrative notes.

Record legibly in black or blue ink.

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Documentation of Patient Care	
Scope: Nursing Services	Manual: CPM – Admission, Discharge, Transfer, Documentation (ADT)
Source: DON ICU/Acute/SubAcute Services	Effective Date:

Use abbreviations from the accepted list of abbreviations.

Correct errors by using "strike and amend" in the electronic system
Record out of sequence if necessary using a late entry remark and time appropriately on the electronic record.

NOTE; SEE SPECIFIC NURSING UNIT FOR PROCEDURE ON DOCUMENTATION OF PATIENT CARE IN THAT UNIT

CROSS REFERENCE P&P's:

1. Forms Development and Control Policy
2. Computer Downtime Emergency Department

REFERENCES:

Approvals	**Date**
NEC	2/15/17
Board of Directors	

Initiated: 4/88
Revised:
Reviewed: 3/89, 6/90, 3/92, 7/94, 4/96, 1/99, 8/2000, 11/2003, 5/09CH; 5/11mc; 9/12bs
Revised: 2/17la

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Orientation to Nursing Departments	
Scope: Nursing Services	Manual: NAM – Nursing Competence
Source: Chief Nursing Officer	Effective Date:

PURPOSE:
To provide guidelines for orienting new employees to the home based nursing departments
The goal of orientation is to ensure that orientees receive consistent information regarding policies, procedures, standards and documentation to support practice and familiarize them with the Northern Inyo Hospital vision, mission, values, goals and organizational structure. In addition, each orientee is shown how to independently access online policies, procedures and competencies.

POLICY:
All new employees will be afforded appropriate orientation, in-service training and continuing education programs.

PROCEDURE:
1. After completion of general orientation, the new employee will be provided adequate orientation to their department in order to be prepared for his/her responsibilities and functions.
2. Each new employee will be provided with a clinical based orientation evaluation (CBOE) form specific to their job role. They will be expected to complete the self-evaluation portion.
3. Each new employee will be assigned to a staff member who will guide and coordinate their orientation to the department. Department orientation will be based on individual needs.
4. Each new employee must attend the general hospital orientation class.
5. Each new employee will complete all of the checklists including but not limited to the general orientation checklist as well as the department specific checklist within the first three months of employment.
6. The New Employee will receive weekly feedback and evaluations which includes goals and accomplishments.

Approval	**Date**
NEC	2/15/17
Board of Directors	

Initiated: 2/17la
Reviewed:
Revised:
Index Listing:
Supersedes: New Employee Orientation to Med-Surg Unit, Operating Room Orientation for the Perioperative Nurse, Orientation to the Perioperative Unit for New Nursing Personnel

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Patient Valuables	
Scope: Nursing Services	Manual: CPM – Admission, Discharge, Transfer, Documentation (ADT)
Source: DON ICU/Acute/Subacute Services	Effective Date:

POLICY:
Every patient admitted to the hospital must be asked if they have (in their possession) valuables such as money, watch, jewelry, important papers, credit cards, etc. Family members should be encouraged to take these items home or they should be stored in the designated lock up area accessible by the House Supervisor.

The nurse admitting the patient to the hospital is responsible to see that the patient's valuables are safely secured either with the family or itemized on the valuables envelope and given to the House Supervisor to be securely held under lock in the designated area..

PROCEDURE:
A. Valuables Envelope
1. Print patient's name under "NORTHERN INYO HOSPITAL". (or add patient sticker to the envelope)
2. All cash must be counted and total documented in the presence of the patient or a witness.
3. Items such as wallets, purse, etc. should be described as to size and color, with a general description of the contents. E.g. credit cards, driver's license, etc.
4. Jewelry should be described by appearance. E.g. One yellow colored ring with a white stone; one ladies white colored watch with plastic band. **Do not attempt to identify a piece of jewelry as to the type of stone other than by color and possible size.**
5. Do not attempt to estimate the value of any item except the cash.
6. The patient **must** sign the envelope where it states "Signature of Depositor", when all items have been listed and the envelope is sealed. If the patient is unable to sign, secure a witness to sign for the patient and indicate reason patient is unable to sign.
7. The person who lists and places the valuables in the envelope must date and sign the envelope where it states "Received by" and "Date".
8. When possible, or when an unusually large amount of money or valuables are received, you may want to have another person witness #7.
9. The "tear off" flap must have the same information as #1, #6, and #7 on the envelope. The "flap" is taped to the inside of the patient's medical record chart.
10. The envelope is given directly to the House Supervisor who is then responsible for locking it in the designated area.

B. Removing Items from the Envelope before Discharge
1. If, at a patient's request, cash or other items are removed from the envelope, such information needs to be recorded on the envelope as well as date and time. The valuables envelope may then be re-secured after the nurse and patient verify all contents and sign the acknowledgement. The Envelope is once again given to the House Supervisor.

C. Reclaiming Valuables
1. The tear off flap must be presented to the House Supervisor by the Nurse discharging the patient before valuables can be returned.
2. The contents must be checked in the patient's presence and the patient must sign and date the bottom of the envelope indicating that the patient has received the items listed on the envelope.
3. The empty valuables envelope is placed inside the patient's chart and it becomes part of the record.

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Patient Valuables	
Scope: Nursing Services	Manual: CPM – Admission, Discharge, Transfer, Documentation (ADT)
Source: DON ICU/Acute/Subacute Services	Effective Date:

D. Documentation in the Patient Record
   1. The disposition of valuables must be documented on the admission assessment tab titled "Valuable Information".
   2. Upon discharge from the hospital, the return of valuables is noted in the discharge instructions. Upon transfer to another facility, it should be noted that the patient's valuables were either returned to the patient or to a designated appointee on the unit specific documentation form.

Approval	**Date**
NEC	2/15/17
Board of Directors	

Initiated: 3/89
Reviewed: 6/90; 8/94; 2/98; 9/2000, 03/2006 BSS; 06/17/2009 ch; 6/11jm; BS 9/12
Revised 2/17 la,
Index Listing:

4. Failure to place child under age 2 in a crib (unless patient sleeps in bed)
5. Emergency supplies not available
6. Failure to follow Pediatric Standards of Care.

PROBLEM IDENTIFICATION:
Findings from the hospital wide quality improvement program which concern nursing will be distributed to the Nursing Management Committee who will share this information with the nursing unit committees. This includes findings from:

Quality Review (Incident) Reports
Information from nursing reports
Pharmacy and therapeutics review
Surgical case review
Blood utilization (transfusion) review
Medical records review
Infection control committee reports
Safety committee reports (especially patient-related incidents, such as falls)
Performance Improvement reports
Reports from the Performance Improvement activities of other departments and services

IDENTIFICATION OF PROBABLE CAUSES OF INAPPROPRIATE CARE

Lack of knowledge or skill
Knew what to do, but did not do so
Equipment deficiency
Deficiency in chart documentation
Policy or procedure violation
Inappropriate delay in problem management
Infection control violation

CORRECTIVE ACTION

Once problems are identified, corrective actions will be determined
Identify who or what needs to change.
Identify appropriate action for problem cause, scope, and severity.
Identify goal for when change is to occur.
Establish monitoring program for specific problem.
Document all of above in the Nursing Performance Improvement Committee minutes.
Report incident and action to the Performance Improvement Committee

Any problems which cannot be resolved at the nursing unit level because they are too political, expensive, or too involved will be forwarded to the Nursing Management Committee and if applicable to the hospital wide Performance Improvement Committee for consideration and resolution.

ASSESS ACTIONS AND DOCUMENT IMPROVEMENT
The Acute Sub/Acute Services Nursing Performance Improvement program will be evaluated on an ongoing basis for the effectiveness, importance and relevance of indicators. Which will be included in the formal annual review of the overall program, and this will be documented in the Nursing Management committee minutes.

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Acute Sub Acute Services Performance Improvement Program	
Scope: Acute Sub Acute Services	Manual: NAM – Nursing Quality
Source: Acute Sub Acute Services DON	Effective Date:

Approval	**Date**
CCOC	1/25/17
Board of Directors	

Initiated: 4/97
Revised: 3/98; 11/2000; 2/2001, 2/06 bss; 1/2010bss; 7/11RC; **BS 9/12 1/17la**
Reviewed: 6/11mc
Index Listing: Med-Surg Performance Improvement

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Acute Sub Acute Services Performance Improvement Program	
Scope: Acute Sub Acute Services	Manual: NAM – Nursing Quality
Source: Acute Sub Acute Services DON	Effective Date:

PURPOSE:
The Nursing Department of the Northern Inyo Hospital supports the organization wide commitment to continuously improve the quality of care provided for its patients. This program is planned to promote a comprehensive method to examine, measure and evaluate problems in patient care and to provide opportunities to improve patient care.

OBJECTIVES:
The Acute Sub Acute Service unit of the Nursing Department will, through this Performance Improvement Plan, provide a program which evaluates the delivery of patient care for all patients and seek to continually improve care through a planned and systematic monitoring program. Quality of patient care is evaluated to identify problem areas and opportunities for improvement, and to resolve identified problems. Data is collected through concurrent and retrospective review of records utilizing effective critical indicators, observation of nursing functions, and monitoring of patient / family satisfaction. Quality Improvement activities will be coordinated with other Nursing units, Medical Staff service committees, other hospital departments and patient care support services throughout the hospital.

AUTHORITY AND RESPONSIBILITY
The Acute Sub/Acute Services DON will function as Coordinator for all unit Performance Improvement activities and serve as chair person for the Acute Sub/Acute Services Performance Improvement program. The DON, with the assistance of the unit representatives to the Nursing Performance Improvement Committee, is responsible for the implementation of the nursing quality improvement program on the Acute Sub/Acute Services and for the resolution of problems and issues relating to the provision quality nursing care.

Acute Sub/Acute Services **SCOPE OF CARE**:
The Acute Sub/Acute Services department provides nursing care for patients of all ages meeting the specialized medical care needs of a predominantly elderly patient population, as well as, Surgical, Telemetry, Orthopedic and Pediatric patients.

Acute Sub/Acute Services management is a joint function of the Medical Staff and Nursing Department working in close cooperation with: PT, RT, Lab, Pharmacy, EKG, Dietary, and Radiology departments. The Acute Sub/Acute Services DON supervises: Staff RNs, LVNs, Certified Nursing Assistants, and Department Clerks. Patient care is delivered in nurse patient ratios that are determined by patient acuity *and the State of California mandated staffing ratios*. Nursing functions include: Patient assessment, accurate and timely provision of medications and treatments, maintenance of infection control and patient safety, coordinating patient care with physicians, other departments and services, patient and family education and documentation of nursing care.

Services offered include but are not limited to: continuous cardiac telemetry monitoring, multiple drug therapies, Physical and Respiratory Therapy services. Equipment available includes: IV, PCA, and syringe pumps, blood warmer, defibrillators, pulse oximeters, continuous passive motion (CPM) knee exercisers, blood glucose monitor, cold therapy, a-thrombic pumps, non-invasive blood pressure monitors, , brady/apnea monitor, bed and standing scales, infant scales, patient assist lifter and patient lift.

Title: Acute Sub Acute Services Performance Improvement Program	
Scope: Acute Sub Acute Services	Manual: NAM – Nursing Quality
Source: Acute Sub Acute Services DON	Effective Date:

The 16 bed unit consists of private rooms. All rooms are equipped with wall suction and oxygen outlets, electric beds with emergency head board release and nurse call buttons. Cribs are available for the pediatric population

The Acute Sub/Acute Services DON integrates all nursing quality improvement functions on the unit, tracks identified problems, assist the nursing unit in the development and evaluation of effective performance improvement reviews, ensures appropriate follow up occurs, and prepares reports concerning nursing quality improvement programs for the Nurse Performance Improvement Committee. Activities of the Acute Sub/Acute Services Performance Improvement program will be documented in the minutes of the unit staff meetings and will be reported to the Nursing Management/ Performance Improvement Committee quarterly.

The duties and responsibilities shall include:

1. To involve all nursing staff members in problem identification, development of solutions and in promoting quality patient care.
2. To review nursing indicators for the Medical Surgical Nursing unit and assist in their revision,
3. To analyze the information collected through ongoing monitoring of patient care provided by nursing staff. To establish priorities in targeting areas of patient care for review to include: high risk activities, activities involving large numbers of the patients and areas where need for improvement in patient care has been identified.
4. To identify problems or trends through analysis of the collected information. To determine necessary corrective measures, and resolve problems.
5. To provide recommendations for actions to resolve identified problems.
6. To continue to follow up and review the results of action taken to determine if a problem has been resolved or if there is a need for further action.

NURSING DEPARTMENT IMPORTANT ASPECTS OF CARE:

1. Providing patient centered, comprehensive, patient care
2. Providing all aspects of patient safety, in a safe patient care environment
3. Maintaining patient privacy and confidentiality, and ensuring patient advocacy
4. Maintaining Standard Precautions and Infection Control Standards
5. Ensuring accuracy of administration of all medications and IV therapy
6. Providing complete and accurate patient assessments
7. Providing accurate and concise nursing reports
8. Providing thorough and current patient care plans.
9. Providing prompt and efficient response to Code Blue
10. Assessing and appropriately documenting allergy status
11. Coordinating patient care with other services and departments
12. Documenting patient status, care activities and response accurately in nursing records.
13. Ensuring accuracy of patients consents
14. Providing leadership and coordination of patient care activities for unlicensed staff
15. Ensuring availability and proper use and function of equipment

NURSING DEPARTMENT CRITICAL INDICATORS:

Patients developing decubitus ulcers or damage to integument, while in the hospital
Treatment errors
Medication errors
Complaints from patients and physicians

Patient falls and injuries
Infections
Transfusion reactions
Equipment malfunction or not available
All Code Blue patients

IMPORTANT ASPECTS OF CARE ACUTE SUB/ACUTE DEPARTMENT

In addition to all Nursing Department Important Aspects of Care and Critical Indicators, the Acute Sub/Acute Services department will also utilize the following:

1. Prevention of adverse drug reactions.
2. Prevention of infected peripheral and central venous catheter sites.
3. Prevention of upper respiratory complications not present on admission and/or transfer to the Acute Sub/Acute Services department
4. Prevention of patient falls and/or injury.
5. Appropriate use and function of Acute Sub/Acute Services equipment
6. Standards of care accurately followed for Telemetry patients
7. Timely recognition and appropriate physician notification of significant patient status changes
8. Appropriate transfer of patients to a higher level of care.
9. Assurance that all patients shall have appropriate discharge planning.

CRITICAL INDICATORS Primary and Secondary (patients and/or incidences meeting the secondary screens either meet the standard of care or partially meet the standard of care)

1. Adverse drug reactions
    a. Inappropriate dose, route, time, patient
    b. Inappropriate drug combination
    c. Delayed recognition of drug toxicity
    d. Extravasation of drug causing patient injury, e.g. chemo
2. Infected central venous or peripheral IV catheter site
    a. CVC dressing not changed per policy
    b. CVC not discontinued at first sign of infection (erythema, edema, purulent drainage)
    c. Peripheral IV not discontinued at first sign of tenderness, redness, swelling)
3. Development of upper respiratory complication not present on admission or transfer to the unit
    a. No incentive spirometry
    b. No documentation of turn, cough, or deep breathe
    c. Patient not out of bed within 24-48 hours post op (depending on type of surgery)
    d. Fever develops within 48 hours of decreased activity
    e. Development of increase oxygen need
    f. Development of adventitious lung sounds not present on admission
    g. Increasing fluid retention with dyspnea
    h. Aspiration pneumonia from feeding and or enteral feeding
4. Patient fall or injury
    a. Inadequate assessment of patient activity/risk level on admission
    b. Siderails not in used appropriately
    c. Restraints or safety attendants not in use when indicated necessary by assessment
    d. Adverse medication combination
    e. Policy not followed regarding positioning, transferring, etc.
    f. Damage to integument (decubiti, abrasion, burns, etc.)

   g. Incorrect placement of equipment resulting in injury to patient
   h. Incorrect use of equipment resulting in injury to patient
   i. Patient failure to follow instructions or hospital rules
5. Equipment malfunction not recognized corrected (see equipment list)
   a. No notification of maintenance, biomedical or CS personnel, as indicated
   b. Broken equipment not removed from service
   c. Identification of equipment malfunction not noted on equipment
   d. Delay in equipment repair or return to service
6. Standard of care not followed for Telemetry patient
   a. No written parameters when indicated (DNR)
   b. Protocol not followed by nurse (daily weight, I&O, initiate therapy when indicated
7. Changes in patient status not recognized in a timely manner and physician notified appropriately
   a. No trending of changes in VS, I&O, and other measurable statistics such as: frequency of irrigation, increased wound drainage, swelling
   b. No identification of increasing need for supplemental oxygen requirements such as inconsistent sat checks
   c. No identification and interpretation of abnormal lab values
   d. Physician not notified of changes in patient condition
8. Inaccurate recognition and coordination of transfer of critical patients to higher level of care (CU) or another acute care facility
   a. Did not inform physician of deteriorating patient condition
   b. Did not inform supervisor of changes in patient condition and need for transfer
   c. Transfer consents and form incomplete
   d. Social worker not involved in transfer
9. Readmission within 30 days of discharge with same diagnosis.
   a. Inadequate discharge planning
   b. Discharge instructions not understood
   c. Discharge instructions not written, given verbal
   d. Patient discharged to inappropriate environment

IMPORTANT ASPECTS OF CARE: PEDIATRICS UNIT

In addition to the Acute Sub/Acute Services department Important Aspects of Care that apply to the Pediatric population:

1. All patients under age 2 will be placed in a crib unless patient normally sleeps in bed.
2. All patients IVs will delivered through an IV pump
3. Observation for signs of abuse
4. Provision of an apnea monitor or close observations for patients to young to use call bell system
5. Emergency supplies readily available in unit

CRITICAL INDICATORS: PEDIATRICS

In addition Acute Sub/Acute Services Critical Indicators that apply to Peds:

1. Failure to deliver IVs and IV Medication with a Pump
   a. IV infiltration
2. Failure to observe for and notify appropriate authority of signs of parental abuse
3. Failure to provide apnea monitor or close observation for patient too young to use call bell.

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Patient Acuity – Patient Care Flow Sheet	
Scope: Acute/Subacute Services	Manual:
Source: Acute/SubAcute Services DON	Effective Date: 3-2015

PURPOSE:
The acuity-based staffing system regulates the number of nurses on a shift according to the patients' needs to deliver quality care based on patient data.

POLICY:
The licensed nurse caring for the patient is responsible for completing the information on the Acuity tab under the daily assessment of the electronic medical record every shift. The acuity classifications should be completed twice a day prior to the next 12 hour shift. These acuity classifications are used to determine staffing for the next shift.

CLASSIFICATION INSTRUCTIONS:
1. Check each box beside each criterion, which applies to the patient.
2. Only the miscellaneous category may have more than one box checked
3. Add all total scores.
4. All patients returning from PACU are classified as a Level III until the next acuity is completed.
5. Pediatric patients (ages 0-6) will be classified as a Level III or greater to allow closer observation.

LEVELS OF CARE:

Level I	Patients require minimal care and an average of 4.5 hr/24 hr (Days 1.8 hrs. PMS 1.7, NOCS 1.1)
Level II	Patients require moderate care and an average of 6.4 hr/24 hr (Days 2.5 hrs. PMS 2.3, NOCS 1.5)
Level III	Patients require intermediate care and an average of 8 hr/24 hr (Days 3.2 hrs. PMS 3, NOCS 1.9)
Level IV	Patients require complete care and an average of 11.5 hr/24 hr (Days 4.6 hrs. PMS 4.3 NOCS 2.7)

Approval	**Date**
NEC	3/2/17
Board of Directors	

Initiated: 4/89
Reviewed: 6/90, 3/92, 2/95, 9/2000, 4/04bs; 9/07bs, 6/09CH; 5/11jm; 9/12 BS, 3/15bs
Revised: 2/17la
Supersedes:
Index Listing:

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Nursing Quality Assurance/Performance Improvement (QA/PI)	
Scope: Nursing Department	Manual: NAM – section V (Nursing Quality, Nursing Administration Manual)
Source: CNO	Effective Date:

PURPOSE: The nursing department of Northern Inyo Healthcare District (NIHD) supports the organization wide commitment to continuously improve the quality of care provided for its patients. Nursing involvement in quality assurance and performance improvement effort is based on the nursing philosophy, the quality framework of NIHD and yearly plans established by Nursing and NIHD. This program is to promote a comprehensive method to measure, examine and evaluate problems in patient care and to provide opportunities to improve patient care.

POLICY:

1. Identified within the nursing philosophy is the belief that all patients should receive safe, patient centered, cost effective quality health care services directed toward optimizing achievable health status.
2. Nursing will follow the quality measurement framework established by the Hospital-Wide Performance Improvement Plan.
3. Departmental goals will help to determine key measurements within the Pillars of Excellence QA/PI scorecard.
4. Nursing will support and participate, as requested, identified NIHD PI and risk reduction projects.
5. Nursing will support and participate with the oversight of assigned Functional Chapters for measurement and improvement from The Joint Commission as assigned by the Director of Quality & Risk or designee.
6. The CNO has the responsibility to ensure that the nursing QA/PI is done in a way that monitors the appropriateness of nursing care and develops a resolution to identified problems; this includes the redesign of systems, operations and patient care delivery processes when needed.
7. The Director of Quality & Risk or designee facilitates performance management activities and provides education and consultative services related to standards development and performance improvement processes. This position also facilitates the meeting of regulatory agency requirements, sentinel event investigation as it applies to nursing and supports information management for select areas of measurement.
8. Nursing Role Responsibilities:
    a. Chief Nursing Officer
        i. Leadership for Nursing Quality Assurance/Performance Improvement.
        ii. Continually improves the quality and cost efficiency of patient care.
        iii. Ensures that Nursing QA/PI is coordinated within the NIH QA/PI Plan.
        iv. Reviews and participates in decisions regarding changes required.
        v. Uses the Performance Management Process FOCUS-PDSA as a guide.
    b. Infection Preventionist/Clinical Informatics Quality Nurse Manager
        i. In conjunction with the CNO, provides leadership for Nursing QA/PI.
        ii. Works with nursing to create documentation processes to collect quality data
    c. Director/Manager/Nurse Educator Manager
        i. Continually improves the quality and cost efficiency of patient care for an identified continuum of service and/or assigned programs /departments.
        ii. Develops and assists with development of performance improvement indicators for an identified continuum of services, and/or assigned programs/departments.
        iii. Oversees data collection, analysis, and communication of data analysis results for an identified continuum of service and/or assigned programs/departments.
        iv. Assists with staff education to increase the awareness and understanding of the quality assurance/performance improvement process.
        v. Serves as a role model for performance improvement.

d. Coordinator/House Supervisor
   i. Continually improves the quality and cost efficiency of patient care.
   ii. Assists with development of program/department indicators.
   iii. Participates in data collection and analysis
   iv. Discuss PI issues and activities at program/department/medical staff meetings.
   v. Implements and oversees required changes in daily practice to provide excellence in care.
   vi. Uses the Performance management Process guide, FOCUS-PDSA, as a guide.
   vii. Serves as a role model for performance improvement.

e. Clinical Staff Educator/Staff Nurse/Other Nursing Department Members
   i. Continually improves the quality and cost efficiency of patient care.
   ii. Assist with development of program/department indicators.
   iii. Participates in data collection.
   iv. Participates in program/department staff meetings to discuss performance improvement issues and activities (identifies areas of opportunities and what is working).
   v. Implements required changes in daily practice to provide excellence in care.
   vi. Participates and demonstrates knowledge of educational opportunities related to performance improvement.
   vii. Participates on task forces, committees, and PI teams.

9. Scope
   a. Nursing participates in quality/performance improvement efforts at many levels. Activities may revolve around standards or processes applicable to all of nursing, be conducted at the program/department level, or span the continuum of care for select populations. Likewise, efforts may be of an interdisciplinary nature, or focus on the independent domain of nursing. Activities may involve active problem identification/resolution via ongoing data sources; processes consistent with identified priority goals, and compliance monitoring to structure, process, and outcome standards.
   b. Activities
      The overall Nursing QA/PI Plan is based on the following interdependent activities:
      i. Assessment of priority functions
      ii. Standards development
      iii. Continuing education
      iv. Ongoing performance appraisal
      v. Selective/appropriate use of auditing
      vi. Active problem identification via ongoing data sources (including, but not limited to data from: event reports, infection control, utilization review, patient and staff satisfaction surveys, and stakeholder feedback.
   c. Time Frames for the frequency of evaluation are determined by the specific indicators, data availability and stage of process improvement. Evaluation of PI projects should be conducted at predetermined intervals defined by the process improvement team. Evaluation includes progress towards goal and process stabilization.

PROCEDURE:

1. Goals will be established by the teams in each nursing department on a fiscal year basis.
   a. Goals should support the hospital and Nurse Executive Committee (NEC) strategic plans
   b. Goals should be measureable. PI – Annual Goals form is located on Intranet>Forms>Nursing Administration>PI-Annual Goals.

c. Goals should be evaluated annually by the department team and then reviewed by the NEC.
d. Written goals will be sent to the nursing office upon initiation and after completion of annual review.

2. The Pillars of Excellence format will be utilized to track performance improvement areas.
   a. Indicators will be utilized consistently with the quality measurement framework, such as quality control, service, people, finance or community.
   b. Data collected should be relevant to the department, align with the goals and/or meet regulatory requirements.
   c. The Pillars format is available on the intranet>forms>nursing administration>PI-Pillars of Excellence Template.
   d. Quarterly data will be presented to the NEC based upon schedule. See intranet>forms>nursing administration>PI-schedule of QA/PI Nursing Department Quality Reports.
   e. Each quarter, the updated Pillars of Excellence will be sent to the nursing office and the QA/PI department by the DON or Manager from each nursing department.
   f. Pillars of Excellence data will utilize color coding for ease of interpretation by the staff.

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

   g. Findings that are below average, does not meet goal (red) will be assessed utilizing the failure point's checklist to determine cause and help to determine focus for improvement opportunities. Intranet>forms>nursing administration>PI-Assessment of Failure Points Checklist.
   h. Action plan to correct the issue will be developed with a timeline for follow-up and a responsible person designated. Plan/Do/Study/Act (PDSA) review format will be utilized to improve processes and improve outcome. Intranet>forms>nursing administration>PI-Action Plan.
   i. At the completion of the fiscal year, a review of the Pillars of Excellence will be completed by the Nursing Department Director or Manager and presented to the NEC. This tool is utilized to determine which items should be removed or continued in the Pillars of Excellence for the next fiscal year. A copy of the completed form will be sent by the department director to the nursing office and the QA/PI department. Intranet>forms>nursing administration>PI-Annual Performance Improvement Report.

REFERENCES:

1. CAMCAH 2016 of TJC, Standard NR.02.02.01-EP 5.
2. CAMCAH 2016 of TJC, Standard NR.02.01.01-EP 3, 5 & 6.

CROSS REFERENCE P&P:

1. Nursing Services Philosophy
2. Mission and Vision Statement for Nursing Services

Title: Nursing Quality Assurance/Performance Improvement (QA/PI)	
Scope: Nursing Department	Manual: NAM – section V (Nursing Quality, Nursing Administration Manual)
Source: CNO	Effective Date:

3. Nursing Services Standing Objective and Annual Strategic Focus
4. Nursing Services Jobs and Titles
5. Nursing Standards
6. Hospital-Wide Quality Assurance and Performance Improvement (QA/PI) Plan

Approval	**Date**
NEC	3/2/17
Board of Directors	

Developed: 1/2014
Reviewed:
Revised: 2/2017
Supersedes:
Medical/Surgical Unit Performance Improvement Program;
Nursing Services Quality Assurance/Performance Improvement (QA/PI) Plan
Performance Improvement Post Anesthesia Care Unit
Performance Improvement Program Emergency Department
Performance Improvement - Outpatient Unit;
Performance Improvement Program Perioperative Unit;
Perioperative Unit Performance Improvement Program;
Performance Improvement Program Sterile Processing;
Perinatal / Neonatal Unit Performance Improvement Program;
Intensive Care Unit Performance Improvement Program

Index Listings: Performance Improvement; Nursing PI forms; Pillars of Excellence; Goals

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: ANGEL FLIGHT	
Scope: NIHD	Manual: Social Services
Source: Social Worker	Effective Date:

Angel Flight West
3161 Donald Douglas Loop South
Santa Monica, CA 90405

http://www.angelflightwest.org/index.php

Phone Numbers

Main Number	(310) 390-2958
Toll-Free Number	(888) 4AN-ANGEL
	(888) 426-2643
After-Hours Emergency	(800) 413-1360
Fax	(310) 397-9636

POLICY:

Angel Flight West arranges free air transportation on private aircraft in response to medical and other compelling human needs. The flights are conducted by our volunteer private pilots, using their own aircraft.

All Angel Flight West missions are free of charge. There is never a fee of any kind, neither to the patient nor the healthcare provider. The costs are paid by the volunteer pilots.

In order to request an Angel Flight West mission, you must meet the following requirements:

Financial Need

Angel Flight provides flights to meet a variety of needs, but there ordinarily must be a verifiable financial need on the part of the recipient. The pilots are volunteers, and they are making a substantial financial contribution -- sometimes as much as $1,000 for one flight -- in addition to their time, so the flight should be for a charitable cause.

The exceptions to this requirement are situations in which a private aircraft is the only option over commercial transportation. For example, an individual who lives in a rural area without easy access to commercial transportation, and someone who is highly susceptible to infection because of a weakened immune system and cannot be exposed to crowds, may qualify for an AFW mission.

One-Week Advance Notice

Under most circumstances, you must schedule a flight at least one week in advance. In some cases, we can accommodate shorter lead-times (for example, transplant situations). If your needs are urgent, please call us at 888-426-2643.

Physical Condition

Passengers must be medically stable... be able to walk, and to board and exit the aircraft, with little or no assistance... and be able to sit up in an airplane seat for the duration of the flight. Angel Flight West is not an air ambulance service, and our pilots are not medically trained.

Title: ANGEL FLIGHT	
Scope: NIHD	Manual: Social Services
Source: Social Worker	Effective Date:

Medical Release

Passengers are required to provide a medical release, signed by a physician, indicating that their medical condition would not prevent them from taking the flight and that they can fly in a non-pressurized aircraft.

Waiver of Liability

On the day of your flight, you will be required to sign a Waiver of Liability for yourself and any minor children traveling with you. If another adult is flying with you, that person also will be required to sign a Waiver.

What to expect when you fly with Angel Flight West

Before you request an Angel Flight West mission, please make sure that the person who will be flying is able to handle the following flight-related responsibilities, activities and conditions.

Your pilot arranges the flight schedule

After you have been approved for a flight and Angel Flight West has received the completed paperwork, we will start looking for a pilot to volunteer for your mission. Once a pilot has accepted the assignment, he or she will contact you directly, and all travel arrangements from that point on will be made between the pilot and you.

You need to have a back-up plan

Pilots make the final decisions about the execution of their missions. A pilot may delay or cancel a mission because of bad weather or other critical factors. ***Angel Flight asks that passengers either to have a back-up plan, or to be able to re-schedule their appointments.***

Smaller plane, longer travel time

Your flight will be made in a small private aircraft that probably has from four to six seats. These aircraft are not as fast or as large as a commercial airplane, so the flying time to your destination may be a bit longer than you anticipated.

Weight limitations

A small plane is far more limited in the amount of weight it can carry than a large commercial jet. Because of this, you need to limit your luggage to a maximum of 25 lbs. per person. Luggage must be soft-sided and no larger than what would be allowed on a commercial airplane as a carry-on. These limitations will be strictly enforced. Oxygen, crutches, car seats, strollers, and other such items can be accommodated if you let us know before the day of departure. In addition, please be prepared to tell the pilot your weight, as well as the weights of anyone else who is flying with you.

Title: ANGEL FLIGHT	
Scope: NIHD	Manual: Social Services
Source: Social Worker	Effective Date:

Entering the airplane

In order to board the aircraft, you may have to step up onto a wing that is 16 to 20 inches above the ground, crouch slightly to fit through a small door, then lower yourself into the back seat. If you or one of your traveling companions cannot perform these movements, that person will not be able to fly with us.

Noise during the flight

If you've never flown on a small aircraft before, you'll discover that it's a much different experience than flying on a large commercial jet. The engine noise on small planes can be loud enough to prevent you from having a normal conversation. Some pilots will provide you with headphones to wear during the flight, which will enable you to communicate with the pilot and other passengers, as well as serving to block out most of the noise. If you wish, you can also bring your own ear plugs. On some planes, you might hear different sounds from the engine as it changes speed. Be aware that, for safety reasons, some pilots request that you do not talk during take-off and landing, or even throughout the entire flight. Your pilot will inform you of his or her specific requirements.

Turbulence during the flight

Small planes are more susceptible to air turbulence that large ones, so you might experience more "bumps" than you're used to. These motions are perfectly normal and no cause for alarm.

Temperature during the flight

Some, but not all, AFW planes have heated cockpits, and most do not have air conditioning. Consequently, it can be chilly inside the plane because of the altitude, even if it isn't cold on the ground. And on a hot, sunny summer day, the temperature onboard can be quite warm. To ensure that you're comfortable during the flight, please ask your pilot about the best type of clothing to wear.

No restrooms or food

Restrooms and food service are not available on AFW flights. Please check with your pilot if you want to bring food aboard.

If you're traveling with a child...

If you are traveling with a baby or small child, is it suggested that you give them a bottle, pacifier or, for a slightly older child, gum to chew during take-off and landing. These items will help the child to equalize the changing air pressure, and avoid ear pain.

No ground transportation

Angel Flight West usually is unable to provide ground transportation, so you will need to make those arrangements prior to your departure.

Social services may assist with arrangements for angel flight transportation and provide information to patient as needed.

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: ANGEL FLIGHT	
Scope: NIHD	Manual: Social Services
Source: Social Worker	Effective Date:

Approval	**Date**
NEC	3/2/17
Board of Directors	

Index Listings:
Initiated:
Revised:
Reviewed: 2/2017ta
Supersedes:

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Emergency Staffing	
Scope: Nursing Services (RHC excluded)	Manual: 3. NAM - Utilization of Nursing Staff and Staffing Budget
Source: Director of Nursing Practice	Effective Date:

PURPOSE:

To establish a plan that meets patient's needs in response to lack of available staff required to meet the needs of the patients.

POLICY:

1. When the Emergency Management Plan is activated, staff is expected to respond to the activation. Staff will be assigned to work in a department dependent on the type of activation and needs identified. All staff will work within the competencies of the staff members job description hired.
2. The Capacity Management Plan may be evoked for the house and/or a specific nursing department.
3. Emergency Staffing generally occurs when a department is without any RN's scheduled or is 1 staff (RN/LVN) below required staffing without unlicensed staff support.
    a. The emergency staffing situation may occur as a result of vacancies, volume surges, emergency management plan activation and/or benefit usage.
4. If the emergency staffing situation is not the result of the emergency management plan activation, the House Supervisor in collaboration with the CNO may determine a house wide and/or department specific emergency staffing situation.
    a. A staffing huddle may be called. A plan will be developed to address the staffing event including stabilization and transfer of patients to other facilities.

PROCEDURE:

1. The House Supervisor will determine with input from the Nursing Executive Team when conditions require additional planning for staffing or if it is an Emergency Staffing situation,
    a. Procedures will be followed for the Emergency Management Plan activation.
    b. The Capacity management Plan is followed to flow patients, etc.
2. At any time, a staffing huddle may be called to develop a staffing plan.
    a. A Department may be classified in an emergency staffing situation if no RN is scheduled or the department is 1 nurse (RN) below the staffing guidelines.
    b. LVN staff may be used to supplement RN routine staffing levels.
    c. RN staff from non-traditional departments may be asked to support patient care activities including: 1:1 observation, passing trays, feeding patients, making beds, etc.
3. The CNO and/or Administrator on Call is to be notified any time a department is classified to be in an emergency staffing situation without resolution.

REFERENCES:

1. CAMCAH 2016 of TJC, Standard EM.02.02.07 – EP 2 & 3
2. CAMCAH 2016 of TJC, Standard LD.03.03.01 – EP 3, 4 & 6
3. CAMCAH 2016 of TJC, Standard NR.02.01.01 –EP 1

CROSS REFERENCE P&P or Plans:

1. Emergency Management Plan
2. Capacity management Plan
3. Master Staffing Plan
4. Communicable Disease Staffing Plan internal Disaster

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Emergency Staffing	
Scope: Nursing Services (RHC excluded)	Manual: 3. NAM - Utilization of Nursing Staff and Staffing Budget
Source: Director of Nursing Practice	Effective Date:

Approval	**Date**
NEC	3/2/17
Board of Directors	

Developed: 11/9/14
Reviewed:
Revised: 2/2017ta

ATTACHMENT A TO THE AGENDA FOR THE

NORTHERN INYO HEALTHCARE DISTRICT REGULAR BOARD MEETING,

MARCH 15, 2017

Policies to Board of Directors

Fiscal Services

Department	Title	To BOD	Approved	Comments
Fiscal Services	Capitalization of Assets	3/15/2017		Review Only; no changes
Fiscal Services	Reimbursement for Hospital Business	3/15/2017		Review Only; no changes
Administration-Hospital Wide	Fax, Printing & Making Copies	3/15/2017		Review Only; format updated only

HUMAN RESOURCES
POLICY AND PROCEDURES APPROVAL LIST
MARCH 2017

1. INTRODUCTION
2. FINAL PAYROLL CHECK
3. PAYROLL ADVANCES
4. LEISURE TIME BENEFITS
5. HOLIDAYS
6. SICK LEAVE
7. SHIFT DIFFERENTIAL
8. STATE DISABILITY INSURANCE (SDI)
9. HOSPITALIZATION AND MEDICAL INSURANCE
10. PENSION PLAN
11. LIFE INSURANCE AND LONG TERM DISABILITY INSURANCE
12. DENTAL INSURANCE AND VISION INSURANCE
13. EDUCATIONAL OPPORTUNITIES
14. EDUCATION DAYS POLICY FOR LICENSED EMPLOYEES
15. ABSENCE FROM WORK
16. EXCUSED ABSENCE
17. UNEXCUSED ABSENCE
18. PAID ABSENCE
19. INVOLUNTARY LEAVE OF ABSENCE
20. PARKING

Aspel, Tracy (Director of Nursing Practice)
Area: Published

Ref #	Title	TO BOD	APPROVED	COMMENTS
3622	A Quick Check			
617	Admission / Classification and Charges			
2336	Admission of a patient to Northern Inyo Hospital			
3618	Admission of Hospice Inpatient*			
621	Adoption Policy and Procedure*			
1711	ADVANCED DIRECTIVE			
3617	Age Related and Population Specific Care			
1561	ANGEL FLIGHT			
3871	Authorization of Hours Worked Beyond Regularly Scheduled Shift (Including Overtime Request)			
1479	CALIFORNIA CHILDREN SERVICES REFERRAL			
3933	Capacity Management Plan*			
3858	Central Council			
3856	Clinical Consistency (Practice) Committee			
3862	Clinical Consistency Oversight Committee (CCOC)			
2279	Clinical Decision Making-Medical Staff Practitioner			
3937	Code of Ethics for Nurses			
2307	Cognitive Assessment (MoCA)			
1082	Community Resources			
2335	Competency Notebook			
20	Confidentiality			
3877	Cross-Training of RN Staff			
87	Daily Staffing Sheet / Nursing			
231	Death-Disposition of Body*			
29	Debriefing Sessions For Stressful Situations			
689	Delivery Packs and Instruments			
3865	Department Monthly Staff Meeting			
774	Department of Motor Vehicle Medical Examination			
3852	Department Partnership Council			
3787	Departments That Deliver Nursing Care to Patients			
3819	Deployment of Nursing Staff at Department Level and Patient Care Assignments			
93	Development, Revision and Maintenance of Policies			
3866	Direct Report Monthly Standing CNO Meeting			
3934	Documentation of Case Management Services*			
671	Documentation of Nursing Care Flow Sheet			
91	Durable Medical Equipment (DME) Provision for Patients at Discharge*			
1712	EASTERN SIERRA BREAST CANCER ALLIANCE			
33	Education Days for Licensed Employees			
3931	Education of Patient and Family*			
2350	Emergency Response Cart			
4025	End of Life Option Act*			

2293	Entering an ED Admission (observation, surgery, inpatient status) into Health Information System			
2319	Fall Prevention			
3697	Fatigue Management: Direct Caregivers			
3717	Floating Nursing Staff*			
3962	Follow-Up Phone Calls Post Discharge*			
110	Guidelines for Licensed Nurses Nursing Students Giving Medications			
1553	Home Health Care			
3788	House Supervisor Shift Activity Report			
21	Informed Consent Policy			
2337	Interdisciplinary Plan of Care			
3932	Interdisciplinary Team – Clinical Screens Built into the Initial Nursing Assessment*			
78	Legal Definition of Licensed Vocational Nurse			
77	Legal Definition of Registered Nurse			
79	Licensure of Nursing Personnel			
3961	Management of Discharge Disputes from Medicare			
1554	MEALS ON WHEELS			
787	Medic Alert Tags			
3821	Medical Clinical Alarm Equipment Safety*			
3785	Mission and Vision Statement for Nursing Services			
85	NIH Nursing Department Organizational Chart			
707	Non-Stress Test			
3859	Nurse Executive Council			
3818	Nursing Low Census Days			
3817	Nursing Administrative Coverage			
191	Nursing Assessment & Reassessment			
305	Nursing Care Plan			
3967	Nursing Certification*			
2280	Nursing Chain of Command in Resolving Patient			
1108	Nursing Department Dress Code			
81	Nursing Department Meetings			
3864	Nursing Management Huddle			
3631	Nursing PRN Per Diem Staff			
25	Nursing Services Competency Plan			
3935	Nursing Services Jobs and Titles			
92	Nursing Services Philosophy			
3820	Nursing Services Quality Assurance/Performance Improvement (QA/PI) Plan			
3849	Nursing Services Standing Objective and Annual			
3876	Nursing Standards*			
106	Nursing Status, Guidelines for			
3968	Nursing Students Requesting Clinical Preceptorship			
1568	Ombudsman			
2278	Opening and Closing Nursing Departments			
3810	Organ/Tissue/Eye Donation*			
3803	Organization-Wide Assessment and Reassessment			

3853	Orientation Competency Committee			
4072	Orientation/Cross Training Time Frames			
88	Outpatient Observation (OPO) Policy			
3615	Pathways for Development, Review and Revision of Nursing Standards			
3861	Patient Flow Committee			
3798	Patient Food from Non-Hospital Sources			
2325	Patient Locator			
3842	Patient Requiring Psychiatric Evaluation and			
3802	Patient Safety Attendant or 1:1 Staffing Guidelines*			
113	Patient Transfer Log Policy			
437	Patient Transfer/Discharge to another Facility			
3801	Pediatric Academic Education Policy			
105	Performance Improvement Plan			
3640	Plan for the Provision of Nursing Care			
22	Procedures Requiring Informed Consents			
4051	Pronouncement of Death*			
3855	Quality / Research Committee			
232	Release of Body to Mortuary Authorization for			
109	Responsibilities of Nursing Students and Hospital			
104	Responsibility for Patient Care			
3644	Routine Hours of Work			
3699	Safe Patient Handling – Minimal Lift Program			
3860	Safe Patient Handling Subcommittee			
1971	SKILLED NURSING FACILITIES			
1804	Social Services Orientation of Hospital Personnel			
4076	Staffing Huddle			
3854	Staffing Issues Advisory Committee			
2317	Staffing Management Plan			
3616	Standard of Care: End of Life			
114	Temporary / Registry Nurses			
1314	Therapy Animals and Pets*			
1567	TRANSFER CHECKLIST			
754	Transfer to Other Medical Facilities Maternal and			
3857	US/Secretary Council			
3936	Utilization of Personnel From Outside Agencies			
2312	Utilization Review Plan*			
452	Verbal and/or Phone Medical Staff Practitioner			
115	Visiting Policy			
116	Volunteer Policy			
2338	Week-End Shifts			
1563	WILD IRIS			
118	Withholding Resuscitative Measures			

POLICIES TO THE BOD
PHARMACY

	POLICY & PROCEDURES TO THE BOARD			
	PHARMACY DEPT.			
	TITLE	**TO BOD**	**APPROVED**	**COMMENTS**
1	Look-alike, Sound-alike Drugs	3/15/2017		
2	Drug storage and inspections of Medication Areas	3/15/2017		
3	Investigatinal Drugs	3/15/2017		
4	Controlled Substance Policy Hospital Wide	3/15/2017		
5	High Alert Medications: Prepartion, Dispensing, Storage	3/15/2017		

POLICIES TO THE BOD

PROPERTY MGMT, SECURITY AND MAINTENANCE

	POLICY & PROCEDURES TO THE BOARD			
	PROPERTY MGMT, SECURITY AND MAINTENANCE			
	TITLE	**TO BOD**	**APPROVED**	**COMMENTS**
1	Policy on Reporting Utility System Incident	3/15/2017		
2	Policy on annual Evaluations	3/15/2017		
3	Environmental Tours	3/15/2017		
4	Policy on Environmental Tours	3/15/2017		
5	Annual Evaluations	3/15/2017		
6	Information Collection & Monitoring	3/15/2017		
7	Policy on Occurrence Reporting	3/15/2017		
8	Policy on Reporting Security Incident	3/15/2017		
9	Policy on Reporting Fire Safety Incedent	3/15/2017		
10	Policy on Reporting Property Damage	3/15/2017		
11	Policy on Reporting Hazardous Materials & Waste Incident	3/15/2017		
12	Policy on Reporting Medical Equipment Incident	3/15/2017		

Northern Inyo Hospital - Document List
Site: Hospital
Department: Purchasing
Area: Published

Generated By: Public Viewer

Title	Status	Security	Date Created	Date Submitted	D
Asset Control	Approved	Public	10/31/2014	12/5/2014	12
Asset Management	Approved	Public	10/31/2014	12/5/2014	12
Capitalization of Assets	Approved	Public	4/22/2014	4/22/2014	6/
Delivery of Received Goods	Approved	Public	9/26/2014	12/30/2014	1/
Diagnostic Imaging - Ordering Radioactive Materials	Approved	Public	7/23/2014	4/21/2015	4/
Disposal of Equipment	Approved	Public	10/31/2014	7/1/2015	8/
Emergency Purchases	Approved	Public	6/9/2015	6/9/2015	8/
Hospital District Credit Card Policy	Approved	Public	3/25/2014	4/17/2014	6/
MMIS Contingency Plan	Approved	Public	4/2/2013	4/2/2013	4/
Order Fulfillment	Approved	Public	9/26/2014	12/30/2014	1/
Receiving Capital Equipment	Approved	Public	1/13/2016	3/14/2016	8/
Receiving Process	Approved	Public	7/24/2015	7/24/2015	8/
Storeroom Basics	Approved	Public	9/26/2014	12/30/2014	1/
Temperature Monitoring of Storage Devices and Units	Approved	Public	12/12/2013	12/13/2013	5/

POLICIES TO THE BOD
REHABILITATION

	POLICY & PROCEDURES TO THE BOARD			
	REHABILITATION			
	TITLE	**TO BOD**	**APPROVED**	**COMMENTS**
1	Discharge Planning	3/15/2017		
2	No Show/Cancellation Policy	3/15/2017		
3	General Documentation	3/15/2017		
4	Goals and Objectives	3/15/2017		
5	Information Management Plan	3/15/2017		

2017-2018 General Budget Assumptions

Federal Regulations:

Changes to the ACA will not be included in the department budgets. The extension of the waiver of the ACA non-conforming plan provisions will be recognized.

State Regulations:

The IGT (Intergovernmental Transfers) will be included for the California year of 2015-2016 in the 2nd Quarter and the California year of 2016-2017 in the 4th Quarter. The State fee of 20% will be accessed during Fiscal 2017-18 and expensed accordingly. The Health Plan(s) fee of 2% will be expensed accordingly.

The percentage of Medicaid patients using Managed Medical will be the same as in 2016-2017.

Facility Conditions:

There are (or are not) construction projects which will impact the availability of services in 2017-2018. Equipment installations (To Be Determined during the Capital recommendation process.

Cost of Care Considerations:

Drugs are expected to increase 7 %, medical supplies are expected to increase 3%, food costs are projected to increase 3%, IT services are expected to have no increase, salaries are expected to increase as recommended and to include the California minimum wage. The percentage of employee salaries to be covered by the 401A plan will increase to 30% for the fiscal year.

Other Considerations:

The RHC provider staff will be stable for the year. The provider staff of the NIH clinic will be stable for the year. Non-provider staff turnover is expected to be higher than in 2016-2017 at 20% with a request for additional coders to be added. Changes in Occupational Health, Urgent Care and Telehealth will be reviewed during the budget process.

Cash Flow & Capital Acquisition:

Annual depreciation for 2017-2018 is projected to be $4,224,900 before any capital acquisitions. Principal payments of $2,048,211 will be required. Accrued interest on the 2009 Bonds will increase by $1,772,866 and will generate cash-flow.

NORTHERN INYO HOSPITAL
POLICY & PROCEDURE

Title: Request for Proposal	
Scope: Hospital-Wide	Manual: Administration
Source: Chief Performance Excellence Officer	Effective Date:

PURPOSE: To provide a policy and systematic process for soliciting information and pricing from a supplier or vendor. The Request for Proposal (RFP) is generally used when the user does not have exact specifications or procedures finalized for a product or service. An RFP is issued so that suppliers (proposers) can offer suggested processes or services or alternate proposals to be considered by Northern Inyo Healthcare District (NIHD).

POLICY:

1. *RFP Solicitation*

   a. NIHD shall acquire materials and supplies that cost more than $25,000 through "*competitive means*", except when the Board of Directors determines either that (1) the materials and supplies proposed for acquisition are the only materials and supplies that can meet the district's need, or (2) the materials and supplies are needed in cases of emergency where immediate acquisition is necessary for the protection of the public health, welfare or safety. "*Competitive means*" may include, but is not limited to the RFP approach/process.

2. *RFP Submission.*

   a. RFPs shall be typewritten with all strikeovers and corrections initialed in ink by the person signing the RFP. The RFP shall include legal name of the proposer, the complete mailing address and be signed in ink by a person or persons legally authorized to bind the proposer to a contract. The name of the person signing should be typed or printed below the signature.

   b. An RFP may require that a Proposer complete a *Conflict of Interest and Confidentiality Statement* Form depending on the type of product/service provided.

   c. Proposals may deliver their proposals in the following ways: hardcopy delivery in person, hardcopy sent via mail or shipping method, electronically.

   d. Proposers should not assume that proposals have been received until an Acknowledgement of Request For Proposal receipt is provided by NIHD.

   e. RFPs must be properly identified as an RFP and made to the attention of the Issuing Executive. This applies to RFPs received via Federal Express or UPS. Improperly identified RFPs may be opened solely for identification and only by an authorized official.

      All RFPs will be received by the Issuing Executive on the date and time indicated in the RFP information packet. RFPs received after that time will be considered late and will not be considered. NIHD cannot be held responsible for any delay, regardless of the reason, in transmission of the RFPs. *Important Note: Federal Express considers this a rural area and*

Title: Request for Proposal	
Scope: Hospital-Wide	Manual: Administration
Source: Chief Performance Excellence Officer	Effective Date:

will not guarantee a morning delivery. Most documents sent by Federal Express do not make it by noon on the RFP date is sent overnight the day before.

3. *Inquiries.* Proposers will carefully examine all documents included in this Request for Proposal (RFP) and shall make a written request for interpretation or correction of any ambiguity, inconsistency, or error herein. Any interpretation or correction will be issued as an Addendum and be posted on the NIHD website. Only a written interpretation or correction by Addendum shall be binding. Proposers are cautioned against relying upon any interpretation or correction given by any other method.

4. *Proposal Withdrawal.* Proposers may withdraw their proposals by notifying the District in writing at any time prior to the proposal response time deadline. Proposers may withdraw their proposals in person or through an authorized representative. Proposals, once opened (hard copy or email), become property of the District and will not be returned to the Proposers

5. *Proposal Disclosure.*

   a. Proposers should be aware that proposals will become public records when in judgment of the District, the Public Records Act, requires disclosure. Proposers must invoke, in writing, the exemptions to disclosure provided by law in their response to the RFP by providing a specific statutory authority for claimed exemptions, identifying the data or other materials to be protected, and stating the reasons why such exclusion from public disclosure is necessary.

   b. Proposals will be made available for public inspection at the time the district posts notice of its decision or intended decision concerning contract awards. Any resulting contract award may be reviewed by any person after the contract has been executed by the District. The District has the right to use any and all information/material submitted in response to this Request for Proposals and/or resulting contract from it. Disqualification of a Proposer does not eliminate this right.

6. *Public Records Act.* All material submitted regarding this RFP becomes the property of the District. Proposers should take special note of this as it relates to any proprietary information that might be included in their offer. Any resulting contract may be reviewed by any person after the contract has been executed by the District. The District has the right to use any or all information/material submitted in response to this RFP process and/or any resulting contract from the same. Disqualification of a proposal does not eliminate this right.

Title: Request for Proposal	
Scope: Hospital-Wide	Manual: Administration
Source: Chief Performance Excellence Officer	Effective Date:

7. *Delays.* The District may delay or modify scheduled event dates if it is to the advantage of the District to do so. The District will notify Proposers of all changes in scheduled due dates by posting any changes by addenda on the website.

8. *Addenda.*

   a. If revisions or clarifications to the RFP become necessary, the District will provide written addenda posted on the NIHD website.

   b. It is the responsibility of Proposers to closely monitor postings on the District's website. A completed *Acknowledgement of Receipt of Addendum Form* must accompany proposals. In the event this listing is not with the proposal, it will be assumed that the Proposer is aware of any and all addenda.

   c. The District will not issue addenda less than five (5) days prior to the scheduled deadline date and time for receiving proposals, unless said date is to be postponed.

9. *Oral Presentations and/or Interviews.* At its sole discretion, the District may invite short-listed Proposers to conduct oral presentations or interviews. Presentations or interviews provide an opportunity for Proposers to clarify their proposals for the District. The District will schedule any such presentations or interviews.

10. *Acceptance or Rejection of Proposals.* The District reserves the right to reject any and all proposals when (1) such rejection is in the best interest of the District; or (2) the proposal contains any irregularities; provided, however, that the District reserves the right to waive any minor irregularities and to accept the proposal determined most responsive and responsible and best meeting its needs. The lowest cost proposal does not have to be taken and if a higher cost proposal is judged to be a better value than other proposals, that proposal can be accepted. The right to accept or reject proposals is completely within the District Board and management's discretion regardless of the scoring or competitive details of the proposals. The District reserves the right to select one or more Proposers to proceed to negotiate terms of a contract and to continue to choose to negotiate with any one or more Proposers until such time as the District awards a final contract.

11. *Cancellation.* The District also reserves the right to cancel an RFP at any time and/or to solicit and re-advertise for other proposals. An RFP does not commit the District to award a contract or contracts.

12. *Communication & Lobbying Restrictions.* From the time the District posts an RFP, until it awards a contract to a successful Proposer, any Proposer (or any of its representatives or agents) is prohibited from any communication about the proposal with the Hospital's Executives, Staff, District Board of Directors and/or any agents thereof. No department or office at the District has the authority to solicit or receive official proposals other than the Issuing Executive. All solicitation is performed under direct supervision of the Issuing Executive. This does not apply to oral presentations before evaluation/selection teams, contract negotiations or public presentations made to the Hospital during any duly noticed public meeting. Violation of these provisions shall render any RFP proposal or RFP award to the violator void.

13. *Development Costs.* Neither the District nor its representatives shall be liable for any expenses incurred in connection with the preparation, submission or presentation of a response to an RFP.

14. *Conflicts of Interest & Confidentiality.*

    a. All Proposers will complete a *Proposer Conflict of Interest and Confidentiality Statement Form*. All Proposers must disclose with their proposal the name of any officer, director, or agent who is an elected official, appointed official, independent contractor or an employee of Northern Inyo Healthcare District and/or Northern Inyo Hospital. Further, all Proposers must disclose the name of any elected official, appointed official, independent contractor or employee of the Hospital or the District who owns directly or indirectly, any interest in the Proposer's firm or any of its branches.

    b. No person will serve on an evaluation committee where the action of that committee might benefit that person, or a member of that person's immediate family, or any organization or business with which that person is associated. Valid conflicts shall be disclosed on the *RFP Evaluation Committee Certification of Confidentiality and No Conflict of Interest Form* and be submitted to the Issuing Executive prior to service on said committee. Failure to do so may void the evaluation process.

    c. RFP related information shall be kept confidential and evaluation committee members should not discuss the RFP with Proposers, other constituents, media representatives. If evaluation team members receive a request for information, they should contact the Issuing Executive.

Title: Request for Proposal	
Scope: Hospital-Wide	Manual: Administration
Source: Chief Performance Excellence Officer	Effective Date:

15. *Non-Collusion.* By submitting and signing a proposal response, the Proposer certifies that their offer is made without prior understanding, agreement, or connection with any corporation, firm or person submitting an offer for the same materials, services, supplies or equipment and is in all respects fair and without collusion or fraud. No premiums, rebates or gratuities are permitted, either with, prior to or after any delivery of material or provision of services. Any violation of this provision may result in contract cancellation, return of materials of discontinuation of services and possible removal from the District's Vendor/Bid List(s).

16. *Subcontracting.* Firms submitting proposals may subcontract portions of the engagement to other firms. If this is to be done, that fact, and the name of the proposed subcontracting firms, must be clearly identified in the proposal. However, following award of the contract, no additional subcontracting or changes in subcontractors will be allowed without express prior written consent of the District. No compromise to insurance requirement shall be made for under insured vendors.

17. *Licenses and Permitting.* Proposers, both corporate and individuals must be fully licensed and certified for the type of work to be performed in the State of California or Inyo County at the time of submittal of their response to this solicitation. Should the Proposer not be fully licensed and certified, its proposal shall be rejected.

18. *Special Provisions.*

    a. Compliance with Laws/Permits/Licenses.

        1. Successful proposer shall give all notices and comply with all federal, state and municipal laws, ordinances, rules, statutes, regulations, code and orders of any public authority bearing on the performance of the contract including, but not limited to, the laws referred to in an RFP.

        2. Upon request, Proposer shall furnish copies of any licenses or permits required to comply with these laws, orders, ordinances, rules, statutes, regulations and codes, not currently maintained by the District. The successful Proposer shall be responsible for obtaining all necessary permits and licenses required for performance under any contract results from an RFP for which the District is not currently responsible.

Title: Request for Proposal	
Scope: Hospital-Wide	Manual: Administration
Source: Chief Performance Excellence Officer	Effective Date:

b. Insurance and Liability

1. Within ten (10) days following the District Board's decision to award a contract to Proposer, such successful proposer shall provide Certificates of Insurance evidencing the required coverage. Throughout the term of the contract, successful Proposer shall submit original Certificates of Insurance reflecting the coverage herein.

2. The District shall be named as an additional named insured party and a waiver of subrogation in favor of the District shall be issued on all policies of insurance, as its interest may appear as stated previously. The District shall be provided with 30 days advance written notice prior to any termination, cancellation or material change to said insurance policies.

DEFINITIONS:

1. *Competitive Means*-Any appropriate means specified by the Board, including, but not limited to, the preparation and circulation of a request for a proposal to an adequate number of qualified sources, as determined by the Board in its discretion, to permit reasonable competition consistent with the nature and requirements of the proposed acquisition.

PROCEDURE: See ***Request For Proposal (RFP) Process Map-Annotated*** for RFP workflow and document flow. (Attached)

ATTACHMENTS:

1. Request For Proposal (RFP) Process Map-Annotated
2. RFP Evaluation Committee Confidentiality and Conflict of Interest Form
3. RFP Project Charter Template
4. RFP Pre-Solicitation Advertising Sample
5. RFP Scope of Services/Product Specifications/Features Excel Spreadsheet Template
6. Evaluation Criteria Development Template
7. Evaluation Criteria Development Example
8. RFP Template
9. RFP Addendum Template
10. RFP Addenda Acknowledgment Template
11. Proposer Conflict of Interest & Confidentiality Form Template
12. RFP Package Receipt Form Template
13. Evaluator Rating Sheet Template
14. Instructions for Completion of the RFP Evaluation Criteria Excel Worksheet
15. Overall RFP Scores by Proposer (Blinded) Template
16. Notice of Preliminary Award Template

Title: Request for Proposal	
Scope: Hospital-Wide	Manual: Administration
Source: Chief Performance Excellence Officer	Effective Date:

REFERENCES:

1. The Joint Commission. "Standard LD 04.03.09." *Comprehensive Accreditation Manual for Critical Access Hospitals*. Oak Brook: Joint Commission Resources, 2017. LD-34-LD-38. Print.
2. The Joint Commission. "Standard LD 04.02.03." *Comprehensive Accreditation Manual for Critical Access Hospitals*. Oak Brook: Joint Commission Resources, 2017. LD-29-LD-30. Print.
3. California Health & Safety Code, Division 23, Chapter 2, Article 2, §32132, §32138.

CROSS REFERENCED P&P:

1. Purchasing and Signature Authority

Approval	**Date**
Executive Team	2/28/17
Board of Directors	

Developed: 2/17
Reviewed:
Revised:
Supercedes:

Index Listings: RFP, Request For Proposal, procurement, bid, purchasing, contract, competitive means

RFP EVALUATION COMMITTEE
CERTIFICATION OF CONFIDENTIALITY
AND
NO CONFLICT OF INTEREST

Please read this document in its entirety, complete as directed, initial each page, sign where indicated and give the original document to the Issuing Executive for the RFP. The Issuing Executive will provide you with a copy of the completed document.

RFP Number: [INSERT UNIQUE RFP NUMBER IN THE FOLLOWING FORMAT-AAAAAA-YYYY-## HERE E.G. RADSVS-2016-01]
RFP Description: [INSERT SERVICES TO BE PROCURED HERE]
Evaluator/SME Name: [INSERT EVALUATOR/SME NAME HERE]
Issuing Executive: [INSERT EXECUTIVE RESPONSIBLE FOR RFP MANAGEMENT HERE]
Compliance Officer or designee: [INSERT PERSON RESPONSIBLE FOR RFP ETHICS/CONFLICT OF INTEREST MANAGEMENT; MAY BE ISSUING EXECUTIVE]

To protect the integrity of the public procurement process, it is essential that proposals be evaluated in an unbiased manner and without conflict of interest, and that the contents of proposals remain confidential throughout the evaluation process. You have been selected as an evaluator/subject matter expert not only because of your managerial/technical expertise, but also because the Executive Team and/or your supervisor are not aware of any bias, business or family relationships, or any other conflicts that could affect, or which could be perceived to affect, your fair, honest and impartial participation in the evaluation of proposals. As an evaluator/subject matter expert you are expected to: 1) discharge your duties impartially so as to assure fair, competitive access to Northern Inyo Healthcare District procurement by responsible contractors, and 2) conduct yourself in a manner which fosters public confidence in the integrity of the Northern Inyo Healthcare District procurement process.

Part I - No Foreseeable Conflict of Interest or Bias

I certify that I, and to the best of my knowledge, members of my immediate family, as defined in the *Northern Inyo Healthcare District Code of Business Ethics and Conduct:*

1. Are not current or former employees of any of the firms in the industry that I foresee would submit a proposal.

2. Are not directors, officers, owners, partners, agents, or representatives of any of the firms in the industry that I foresee would submit a proposal.

3. Do not hold any stock or any financial interest in any of the firms in the industry that I foresee would submit a proposal.

I certify that I will not during the RFP process:

1. Solicit or accept, directly or indirectly, any promise of future employment or business opportunity from, or engage, directly or indirectly, in any discussion of future employment or business opportunity with, any director, officer, owner, partner, employee, representative, agent or consultant of an offeror that submits a proposal, or their proposed subcontractors.

2. Ask for, demand, exact, solicit, seek, accept, receive, or agree to receive, directly or indirectly, any money, gratuity, or other thing of value from any director, officer, owner, partner, employee, representative, agent, or consultant of an offeror that submits a proposal, or their proposed subcontractors for this project. I will advise my immediate family that the acceptance of any such gratuity may be imputed to me as a violation, and must therefore be avoided by them.

I understand that my obligations under this certification are of a continuing nature. I will immediately seek the advice of the Compliance Officer or designee and report the circumstances to my supervisor and to the Issuing Executive if at any time during the RFP process:

1. I receive a contact from an offeror that submits a proposal, or their proposed subcontractors, concerning employment or other business opportunity.

2. I receive an offer of a gift from an offeror that submits a proposal, or their proposed subcontractors.

3. I encounter circumstances where my participation might result in a real, apparent, or potential conflict.

Part II - Confidentiality

1. I certify that I will not divulge nor make known, in any manner whatsoever, to any person, other than a member of the RFP evaluation committee or other individual who has a confidentiality statement for the same procurement, or to an investigatory or law enforcement authority, after consultation with the Issuing Executive, any information (which has not already been made available to the public or all interested offerors) pertaining to any and all aspects of the RFP including but not limited to the contents of offerors' proposals, the scoring method, points allotted, evaluator scores, costs, or any other confidential information regarding the RFP process.

2. I understand that unauthorized sharing of information may give an offeror an unfair advantage over another offeror and thereby render the process invalid.

3. I understand that if I divulge such information I may be subject to disciplinary action, including termination of my employment or contractual relationship with Northern Inyo Healthcare District.

Part III - Exceptions

Any exceptions to the certifications that I have made in completing this certification are listed below. ***If additional space is needed, attach additional pages and initial each page of the addition.***

Check here ☐ if there are no exceptions to the certifications.

_____

_____

_____

_____

_____

Part IV - Signature and Certification

I have read and understand the certifications and understanding set out in this document. I further understand that by signing this document, I make the certifications and confirm the understandings herein subject to the provisions of the *Northern Inyo Healthcare District Code of Business Ethics and Conduct.*

_____ _____

Signature (Must be an original ink signature) Date

Project Charter-RFP

Form Rev 3/4/17

General Project Information

Project Name	[INSERT RFP/SERVICES TO BE PROCURED HERE]
Project Sponsor(S)	ENTER sponsors, which are the individuals/group that provides/authorizes resources for the project; has a major stake in the project and may perform an active role in project team occasionally.
Project Manager	[INSERT PROJECT MANAGER/ISSUING EXECUTIVE HERE]
Email Address	[INSERT PROJECT MANAGER/ISSUING EXECUTIVE EMAIL ADDRESS]
Phone Number	ENTER phone number(s) of project manager
Organizational Unit(s)	ENTER functional areas/departments impacted by project
Process(es) Impacted	ENTER process(es) potentially impacted by project; may include supporting processes and processes involving external agencies/organizations/partners
Expected Start Date	ENTER expected start date MM/DD/YY; may be easier after completing high-level schedule with milestones and/or Work Breakdown Structure (WBS)
Expected Completion Date	ENTER expected completion date MM/DD/YY; may be easier after completing high-level schedule with milestones and/or Work Breakdown Structure (WBS)
Estimated Costs	ENTER anticipated costs of project, in $ # # #. # # format, including labor, materials, capital purchases, etc..Initially, only rough estimates may be available and estimates should be refined as the project progresses.

NORTHERN INYO HEALTHCARE DISTRICT

Revised: [INSERT REVISED DATE]

Describe the Problem or Issue, Goals, Objectives, and Deliverables of this Project

Problem or Issue	ENTER problems/issues and related data/information; specific issues should be described and SMART goal concepts also apply to problem/issue statements. What is the specific problem and who/which stakeholders are impacted? When did the problem start? Is there data/evidence to support the problem statement? See Goals/Metrics section below.
Purpose of Project	ENTER high level description of project.
Business Case	ENTER the reason(s) for doing the project. Some of the reasons may include, but are not limited to, business and legal requirements/compliance, opportunities based on customer request, market demands, understand or solve a problem/issue, satisfy social needs/causes; The reasons may also be supported by a cost-benefit analysis (may include Net Present Value, Internal Rate of Return, Discounted Cash Flow, Return on Investment methods), feasibility analysis, the costs/losses/risks associated with NOT doing the project.
Goals / Metrics	ENTER GOALS and related METRICS; what you hope to achieve and what goals you wish to accomplish and how you will know that you achieved them. Goals should address the issues/problems mentioned in the problem statement above and may also include deadlines and budget limits. Goals should be SMART (Specific - Measurable - Achievable/Attainable - Relevant - Time Bound). Please see handouts at the following links for more information: Developing SMART goals for your organization - https://edis.ifas.ufl.edu/fe577 AND Developing SMART Goals - http://www.unh.edu/hr/sites/unh.edu.hr/files/pdfs/SMART-Goals.pdf Is the project focused on a customer/user requirement? How much of the issue do you hope to address? Are the goals of the project clear and realistic? Metrics may be outcome metrics, process metrics, balancing metrics, etc. Metric definitions may be outlined on separate sheets if detailed.
Expected Deliverables	ENTER what the project is supposed to produce i.e. outputs (this includes intermediate & final outputs), as well as project management deliverables such as project charter, work breakdown structure, Gantt chart, responsibility matrix, communication plan, etc..

Define the Project Scope and Schedule

Within Scope	ENTER activities required to meet project objectives. Describe activities in such a way that it will be clear if extra work is added later on; scope may also consider which departments, divisions, sub-processes, sites will be included in the project.
Outside of Scope	ENTER activities that may be important to the project, but are not directly related to the project itself and/or what the project won't do, especially when activities might be assumed as part of the project.

	Key Milestone	Start		Complete

Tentative Schedule	**Phase 1-Planning**			
	Select and finalize [ENTER SVS/PRODUCT TO BE PROCURED] RFP Team			
	Kickoff meeting			
	Create RFP Timeline			
	Pre-solicitation Advertising			
	Document current processes and technology			
	Determine Organizational Priorities			
	Phase 2-Preparation			
	Develop estimated budget (for RFP team information only)			
	Explain NIHD organization i.e. mission, environmental and organizational forces driving the need for new Rad Svs. Contract			
	Describe business requirements			
	Disclose organizational constraints			
	Create evaluation criteria and weighted rubric based on organizational priorities			
	Develop proposal submission deadlines and instructions, including RFP format/template			
	Assemble RFP bidder's packets			
	Phase 3-Review & Revision			
	Phase 4-Approval			
	Phase 5- Distribution and Support			
	Distribute RFP bidder's packets			
	Bidder's questions FAQ answered & distributed (questions from 10/3/16-10/7/16)			
	Bidder's questions FAQ answered & distributed (questions from 10/8/16-10/16/16)			
	Bidder's questions FAQ answered & distributed (questions from 10/17/16-10/23/16)			
	Completed RFP bidder's packets due			
	Phase 6-Response Evaluation			
	Independent Review			
	Vendor Presentations/Reference Checks/Testimonials			
	Consensus Review & Draft Recommendation report for CEO			
	Phase 8-Select vendor & runner-up			
	Select vendor & runner-up, as appropriate			
	Notify bidders of decisions			
	Phase 9-Develop & finalize contract			
	Develop & negotiate contract			
	NIHD Board meeting packets due			
	Contract approval by NIHD Board			
	Phase 10-Project close-out			

Define the Project Resources and Costs

Project Team	ENTER project team members, which include the Project Manager, project management team/support and people who perform the work of the project to produce the project outcome. Does the team have first hand experience of the processes/products/services? If not, how do they intend to get it? Is there a team in place with time and resources to complete the project?

Support Resources	ENTER support resources, which may include those people/departments providing mentoring, intermittent resources providing subject matter expertise or tools needed to accomplish project e.g. IT.
Special Needs	ENTER any special needs including resources, tools, equipment, services, materials that are not readily available and require a level of planning beyond the norm. For example, it may be necessary to order an instructional book for project team members and the delivery time is two weeks.

Cost Type	Vendor / Labor Names	Rate	Qty	Amount
Labor		35		$ -
Labor		35		$ -
Labor		35		$ -
Labor		35		$ -
Labor		35		$ -
Labor		35		$ -
Labor		35		$ -
Labor		35		$ -
Labor		35		$ -
Labor		35		$ -
Labor		35		$ -
			Total	$ -

Define the Project Benefits and Customers

Process Owner	Procurement processes (Fiscal Services and/or CEO, depending on specific product or service); ENTER other process/system owners; may or may not be known at start of project.
Key Stakeholders	ENTER stakeholders, who are individuals and organizations that will be influenced and impacted by the project.
Final Customer/User	ENTER entities, department and/or persons who will acquire the project's outcome or product or use the product/service. Customers and users may be different or the same, depending on the project outcome. For example, publishers produce books which are purchased by bookstores and used by students. Are the customers/users of the process/product/service clear?
Expected Benefits	ENTER high level expected benefits to customers/users; examples include reduced waiting times, increased reliability or processes or systems, etc... Is the project focused on a customer/user requirement/need?

Describe Project Risks, Constraints, and Assumptions

Risks	ENTER risks, including severity and probability of risks, if available, as well as the condition/risk and the consequences. This wil help you to identify and mitigate project risks early. If significant risks are identified, conduct a more detailed risk analysis and risk management plan. (See QAPI Department for guidance.)
Constraints	ENTER constraints, which are restrictions or limitation that can affect the performance of a project. Examples may include schedule constraints/deadlines, cost constraints, resource constraints, etc...
Assumptions	ENTER assumptions, which are factors considered to be true without proof or verification. For example, an assumption might be the availability of a required skills set to perform the project. IMPORTANT NOTE: Validate assumptions as the project progresses to reduce project uncertainties and risks.

Prepared by:	ENTER person preparing Project Charter	Date:	ENTER date MM/DD/YY project charter completed

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

Request for Proposal-Radiology Services

Northern Inyo Healthcare District will issue a *Request For Proposal* on or around 10/3/16. We will be seeking highly qualified groups or individuals to provide Radiology Services who share our commitment to improving our communities, one life at a time; and our passion for high quality medical care and service. If interested, we would like to receive a letter of interest with your contact information no later than 10/16/16. Correspondence may be sent to Maria Sirois at maria.sirois@nih.org.

NIHD has a 25-bed, critical access, not-for-profit hospital, that offers the people of our communities access to some of the most advanced radiologic equipment including, MRI, nuclear medicine, CT scanner and U/S. We are located in Bishop, California, a town in between two majestic mountain ranges, the Sierra Nevada mountains to the West and the White Mountains to the East. There are many outdoor recreation opportunities and world-renown scenery.

RFP Scope of Services/Product Specifications/Features
[ENTER SERVICES TO BE PROCURED HERE]

Services or Service/Product/Eqpt. Features	*Currently Have? Yes No*	*Must Have? Yes No*	*Nice to Have? Yes No*	*Requires Eqpt. Purchase? Yes No Don't Know*	*Requires addl. financial resources? Yes No Don't Know*	*Requires addl. staff or staff training? Yes No Don't Know*	*Comments*
EXAMPLE 1 : 24 Hour On-Site Service	No	No	Yes	No	Yes	Yes	Need to get proforma estimates of additional physician and Rad Tech staffing costs.
EXAMPLE 2 : Peripheral/Endovascular/Coronary Artery Stent Placement	No	No	Yes	Yes	Yes	Yes	Will need to have Vascular Surgery team on standby for intervention in the case of stent-related Adverse Events; additional OR staff training required; materials management changes for addition of new medical devices; no investigational devices, since no clinical trial management infrastructure.
[Add services here]							
[Add services here]							
[Add services here]							
[Add services here]							
[Add services here]							
[Add services here]							
[Add services here]							
[Add services here]							
[Add services here]							
[Add services here]							
[Add services here]							
Insert additional rows if needed.							

that NIHD currently offers or existing service/product features we have with existing services/products. Please feel free to make comments on these services and add other current services that I have not included here.

Examples of additional services: These are services that are not currently offered, but examples from a 'wish list'. As a group, it is important decide which of these additional services are reasonable to include in the RFP.

Please add your wish list of services or product/service features here. EXAMPLE 1 shows a service feature, while EXAMPLE 2 shows a new service. Keep in mind that features may furnish details for our evaluation criteria and impact how we evaluate the criteria.

[Enter Svs. to be Procured] RFP Evaluation Criteria

Requirements/Criteria	*Weighting*	*Explanation*
Total	*0.00*	*Must add up to 100.*

Note: Under weighting, please allocate 100 points amongst your evaluation criteria according to level of importance to you.

RFP Evaluation Criteria

Requirements/Criteria	*% Weighting*	*Explanation*
Technology capability	7.5	Demonstrates capabilities and provides examples of how Proposer would work with NIHD and IT to store/transmit images from NIHD Diagnostic Imaging Department to theproposer and from the proposer to provide results/images for providers.
Qualifications and experience, including capability and experience of key personnel and experience with other organizations to provide services.	20.00	Medical staff qualifications including any applicable degrees, additional applicable training, professional certifications/licensing; subspecialties; how referring physician consultations supported.
Proposed approach, including understanding of scope of services to be provided and appropriateness of the proposed services.	10.00	Aligned with NIHD Scope of service and other capabilities that may be appropriate for NIHD patient population
Customer Service/Patient Experience	10.00	How proposer will understand and meet the needs of NIHD patient population and NIHD clinicians; approach towards customer service.
Risk Management/Compliance Experience	10.00	Malpractice claims/litigation, regulatory violations with federal or state agencies, disciplinary actions against proposer, proposer's agents, physicians, by any state agency of licensing board where proposer and/or proposer's agents have provided medical services.
Ability to meet required timelines or other requirements	7.50	How proposer will ensure diagnostic reports are delivered to NIHD in a timely and efficient fashion for regular and "STAT" reports; turnaround times.
References & Testimonials	5.00	Provides positive feedback about various aspects of performance, including herein criteria
Quality and Performance Improvement Program	20.00	Must cooperate with the Hospital to provide a program of Quality Assurance and Performance Improvement consistent with agency and accreditation standards; program includes peer review, over-reads, quality control and equipment monitoring; participation in the development of protocols based on evidence; performance measurement and assessment of services provided.
Staffing Model, Service Coverage & Staff Management	10.00	Details about number of physicians, hours of coverage.
Marketing and Business Development	7.50	Experience with promoting Radiology Services to community & referring physicians; experience with innovating new services.
Total	***100.00***	***Must add up to 100.***

Note: Under weighting, please allocate 100 points amongst your evaluation criteria according to level of importance to you.

EXAMPLE

NORTHERN INYO HEALTHCARE DISTRICT

One Team. One Goal. Your Health.

[INSERT DATE RFP ISSUED HERE]

REQUEST FOR PROPOSAL

[INSERT SERVICES TO BE PROCURED HERE]

RFP [INSERT RFP NUMBER HERE IN FORMAT: YYYY-##]

Due: [INSERT DUE TIME, TIME ZONE, DATE HERE]

Table of Contents

Section 1-Introduction

RFP [INSERT RFP NUMBER HERE IN FORMAT: YYYY-##]

Northern Inyo Healthcare District is requesting proposals from qualified firms or individuals for [INSERT SERVICES TO BE PROCURED HERE].

Proposers may deliver their proposals in the following ways:

1. Hard-copy proposals can be addressed and delivered to: [INSERT ISSUING EXECUTIVE NAME HERE], Administration Office, Northern Inyo Healthcare District, 150 Pioneer Lane, Bishop, CA 93514. If you will be submitting hard copies, please include two copies, with any Proprietary Information in a separate envelope. Proposals can also be delivered in person to the same address. (The Administration Building is generally open Monday-Friday, 0800-1600 and can be accessed via Door #5.)

2. Proposals may be sent as one PDF file, with the exception of any Proprietary Information, which should be sent as a separate PDF file. Electronic submissions may be sent to: [INSERT ISSUING EXECUTIVE EMAIL HERE].

3. Proposals must be received **on or before** [INSERT DUE TIME, TIME ZONE, DATE HERE] at which time a representative of the Executive Team will announce publicly the names of those firms or individuals submitting proposals. **No proposals will be accepted after this time**. No other public disclosure will be made until after award of the contract.

4. Proposers should not assume that proposals have been received until an Acknowledgement of Request For Proposal receipt is provided by NIHD.

Northern Inyo Healthcare District's Overnight Delivery (FedEx, Airborne, and UPS) address is:

[INSERT ISSUING EXECUTIVE NAMEHERE], [INSERT ISSUING EXECUTIVE TITLE HERE]
Administration Building
Northern Inyo Healthcare District
150 Pioneer Lane
Bishop, CA 93514

NORTHERN INYO HEALTHCARE DISTRICT

_____

[INSERT ISSUING EXECUTIVE NAMEHERE],
[INSERT ISSUING EXECUTIVE TITLE HERE]
Issuing Execut

Section 2 – RFP Procedures

Inquiries

Respondents will carefully examine all documents included in this Request for Proposal (RFP) and shall make a written request for interpretation or correction of any ambiguity, inconsistency, or error herein. Any interpretation or correction will be issued as an Addendum and be posted on the website, www.nih.org. Only a written interpretation or correction by Addendum shall be binding. Respondents are cautioned against relying upon any interpretation or correction given by any other method.

Proposal Withdrawal

Proposers may withdraw their proposals by notifying the District in writing at any time prior to the proposal response time deadline. Proposers may withdraw their proposals in person or through an authorized representative. Proposals, once opened (hard copy or email), become property of the District and will not be returned to the Proposers

Proposal Disclosure

Proposers should be aware that proposals will become public records when in judgment of the District, the Public Records Act, requires disclosure. Proposers must invoke, in writing, the exemptions to disclosure provided by law in their response to the RFP by providing a specific statutory authority for claimed exemptions, identifying the data or other materials to be protected, and stating the reasons why such exclusion from public disclosure is necessary.

Proposals will be made available for public inspection at the time the district posts notice of its decision or intended decision concerning contract awards.

Any resulting contract award may be reviewed by any person after the contract has been executed by the District. The District has the right to use any and all information/material submitted in response to this Request for Proposals and/or resulting contract from it. Disqualification of a Respondent does not eliminate this right.

Public Records Act

All material submitted regarding this RFP becomes the property of the District. Proposers should take special note of this as it relates to any proprietary information that might be included in their offer. Any resulting contract may be reviewed by any person after the contract has been executed by the District. The District has the right to use any or all information/material submitted in response to this RFP process and/or any resulting contract from the same. Disqualification of a proposal does not eliminate this right.

Proposal Timetable

[INSERT APPROPRIATE TIMETABLE HERE, IN THE FOLLOWING FORMAT]

Event	Date

Delays

The District may delay or modify scheduled event dates if it is to the advantage of the District to do so. The District will notify Proposers of all changes in scheduled due dates by posting any changes by addenda on the website.

Addenda

If revisions or clarifications to the RFP become necessary, the District will provide written addenda posted on the District website, www.nih.org.

It is the responsibility of Proposers to closely monitor postings on the District's website. A listing acknowledging any and all posted addenda must accompany your proposal. In the event this listing is not with your proposal, it will be assumed that the respondent is aware of any and all addenda.

The District will not issue addenda less than five (5) days prior to the scheduled deadline date and time for receiving proposals, unless said date is to be postponed.

Oral Presentations and/or Interviews

At its sole discretion, the District may invite short-listed respondents to conduct oral presentations or interviews. Presentations or interviews provide an opportunity for Proposers to clarify their proposals for the District. The District will schedule any such presentations or interviews.

Acceptance or Rejection of Proposals

The District reserves the right to reject any and all proposals when (1) such rejection is in the best interest of the District; or (2) the proposal contains any irregularities; provided, however, that the District reserves the right to waive any minor irregularities and to accept the proposal determined most responsive and responsible and best meeting its needs. The right to accept or reject proposals is completely within the District Board and management's discretion regardless of the scoring or competitive details of the proposals. The District reserves the right to select one or more Proposers to proceed to negotiate terms of a contract and to continue to choose to negotiate with any one or more Proposers until such time as the District awards a final contract.

The District also reserves the right to cancel this RFP at any time and/or to solicit and re-advertise for other proposals. This RFP does not commit the District to award a contract or contracts.

Communication & Lobbying Restrictions

From the time the District posts this RFP, until it awards a contract to a successful Proposer, any Proposer (or any of its representatives or agents) is prohibited from any communication about this proposal with the Hospital's Executives, Staff, District Board of Directors and/or any agents thereof. No department or office at the District has the authority to solicit or receive official proposals other than the Issuing Executive. All solicitation is performed under direct supervision of the Issuing Executive. This does not apply to oral presentations before evaluation/selection teams, contract negotiations or public presentations made to the Hospital during any duly noticed public meeting. Violation of these provisions shall render any RFP proposal or RFP award to the violator void.

Development Costs

Neither the District nor its representatives shall be liable for any expenses incurred in connection with the preparation, submission or presentation of a response to this RFP.

Conflicts of Interest

All Proposers must disclose with their proposal the name of any officer, director, or agent who is an elected official, appointed official, independent contractor or an employee of Northern Inyo Healthcare District and/or Northern Inyo Hospital. Further, all Proposers must disclose the name of any elected official, appointed official, independent contractor or employee of the Hospital or the District who owns directly or indirectly, any interest in the Proposer's firm or any of its branches.

Non-Collusion

By submitting and signing a proposal response, the Proposer certifies that their offer is made without prior understanding, agreement, or connection with any corporation, firm or person submitting an offer for the same materials, services, supplies or equipment and is in all respects fair and without collusion or fraud. No premiums, rebates or gratuities are permitted, either with, prior to or after any delivery of material or provision of services. Any violation of this provision may result in contract cancellation, return of materials of discontinuation of services and possible removal from the District's Vendor/Bid List(s).

Subcontracting

Firms submitting proposals may subcontract portions of the engagement to other firms. If this is to be done, that fact, and the name of the proposed subcontracting firms, must be clearly identified in the proposal. However, following award of the contract, no additional subcontracting or changes in subcontractors will be allowed without express prior written consent of the District. No compromise to insurance requirement shall be made for under insured vendors.

Licenses and Permitting

Proposers, both corporate and individuals must be fully licensed and certified for the type of work to be performed in the State of California or Inyo County at the time of submittal of their response to this solicitation. Should the Respondent not be fully licensed and certified, its proposal shall be rejected.

Section 3-Purpose of the RFP

Intent

NIHD is seeking proposals to provide [INSERT SERVICES TO BE PROCURED HERE] that is able to deliver cost-effective, high quality service for our patients, NIHD and clinicians.

Background Information

[UPDATE THE FOLLOWING NIHD BACKGROUND INFORMATION IF THERE ARE CHANGES]

About Us.

NIHD is located in Bishop, California, a town in between two majestic mountain ranges, the Sierra Nevada mountains to the West and the White Mountains to the East. There are many outdoor recreation opportunities and world-renown scenery.

NIHD is a 25-bed, critical access, not-for-profit hospital, with 16 Medical-Surgical beds, 4 Intensive Care Unit beds and 5 Perinatal beds that has been providing healthcare in the Eastern Sierra region since 1946 and currently serves a Primary Service Area population of approximately 13,936 people. (ESRI, 2015). There are also three state-of-the-art surgical theatres and a large, modern Emergency Department.

There are approximately 1000 admissions per year; with 83% admitted through the ED. Our average inpatient daily census is approximately 10.3 with an average length of stay of about 2.98 days. (2016 FY YTD)

Our Accreditation.

NIHD is the only acute care hospital for 150 miles that is accredited by The Joint Commission. This accreditation recognizes our healthcare quality improvement and risk management orientation. Staff

from across the organization work together to develop and implement approaches that have the potential to improve care for the patients in our community.

Our Mission

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

Our Vision

Northern Inyo Healthcare District will be known throughout the Eastern Sierra Region for providing high quality, comprehensive care in the most patient friendly way, both locally and in coordination with trusted regional partners.

[INSERT SECTION HERE WITH BACKGROUND INFORMATION RELATED TO SPECIFIC FUNCTIONAL/PHYSICAL AREAS IMPACTED BY REQUESTED SERVICES PRODUCTS. SUBSECTIONS MAY INCLUDE SPECIFIC AREA MISSION, VISION, VALUES, GOALS, CURRENT STATE, CAPABILITIES, PERTINENT FACILITIES, EQUIPMENT & SOFTWARE SYSTEMS

Term of Contract

The Proposer will select from the following term options:

[INSERT REQUESTED/SUGGESTED/DESIRED TERM OF CONTRACT, AS APPROPRIATE]

Section 4-Specifications/Scope of Work

It is the sole responsibility of the Proposer to read and understand the requirements and specifications herein, as well as the Mandatory Requirements in Section 5.

In this RFP, NIHD seeks the submission of proposal to provide services from any and all interested and qualified proposers. NIHD seeks, by way of this RFP, to obtain the services described in the ***Services*** section above, in a manner that maximizes the quality of services while also maximizing the value to the patients of NIHD.

Proposers must be able to show that they are capable of performing the services requested. Such evidence includes, but is not limited to, the respondent's demonstrated competency and experience in delivering services of a similar scope and type and local availability of the proposer's personnel and equipment resources.

The proposer's proposal should address the following:

> [INSERT CRITERIA TITLE, FOLLOWED BY SPECIFIC QUESTIONS/DOCUMENT/INFORMATION REQUESTS WHICH WILL HELP DETERMINE WHETHER PROPOSER MEETS CRITERIA OR NOT.] Criteria should be based on organizational priorities and be aligned with business requirements

and Evaluator Rating Sheets. Some examples of criteria include, Qualifications & Experience, Customer Service, Financial Considerations, et...Use the following format.

1. ***[INSERT CRITERIA #1 NAME HERE]***

    a. [INSERT QUESTION/DOCUMENT/INFORMATION REQUEST #1 HERE]
    b. [INSERT QUESTION/DOCUMENT/INFORMATION REQUEST #2 HERE]

Section 5-Mandatory Requirements

The successful Proposer will provide [INSERT SERVICES TO BE PROCURED HERE] in accordance with recognized professional standards. The Proposer will agree to the following:

[INSERT MANDATORY REQUIREMENTS HERE]

Special Provisions

[INSERT SPECIAL PROVISIONS HERE] Examples follow

A. Compliance with Laws/Permits/Licenses

Successful proposer shall give all notices and comply with all federal, state and municipal laws, ordinances, rules, statutes, regulations, code and orders of any public authority bearing on the performance of the contract including, but not limited to, the laws referred to in this RFP. Upon request, Proposer shall furnish copies of any licenses or permits required to comply with these laws, orders, ordinances, rules, statutes, regulations and codes, not currently maintained by the District. The successful Proposer shall be responsible for obtaining all necessary permits and licenses required for performance under any contract results from this RFP for which the District is not currently responsible.

B. Insurance and Liability

1. Within ten (10) days following the District Board's decision to award a contract to Proposer, such successful proposer shall provide Certificates of Insurance evidencing the required coverage. Throughout the term of the contract, successful Proposer shall submit original Certificates of Insurance reflecting the coverage herein.

2. The District shall be named as an additional named insured party and a waiver of subrogation in favor of the District shall be issued on all policies of insurance, as its interest may appear as stated previously. The District shall be provided with 30 days advance written notice prior to any termination, cancellation or material change to said insurance policies.

[INSERT SERVICES TO BE PROCURED HERE] RFP [INSERT RFP NUMBER HERE]
Addendum [##]
Date of Addendum: [MM/DD/YY]

Notice to all potential Proposers:
The Request for Proposals (RFP) is modified as set forth in this Addendum. The original RFP documents and any previously issues addenda remain in full force and effect, except as modified by this Addendum, which is hereby made part of the RFP.

Proposal Submittal Deadline:
The RFP submittal deadline remains the same and is not changed by this Addendum.

Modifications:

[INSERT MODIFICATIONS/REVISONS/UPDATES HERE]

Request for Proposal

[INSERT SERVICES TO BE PROCURED HERE] [INSERT RFP NUMBER HERE IN FORMAT: YYYY-NN]

ACKNOWLEDGMENT OF RECEIPT OF ADDENDUM

The undersigned acknowledges receipt of the following Addendum/Addenda to the above mentioned Request for Proposal. Failure to request/receive a copy of an Addendum or failure to return this ACKNOWLEDGMENT form does not relieve the Proposer of responsibility for meeting the requirements of the information contained therein.

Addendum Number	Addendum Content	Date of Issuance
##	[INSERT CHANGES, ADDITIONS, ETC...HERE]	[MM/DD/YY]

Name of Proposer/Firm: _____

Typed/Printed Name: _____ Title: _____

Signature: _____ Date: _____

Telephone/Fax/Email: _____

PROPOSER CONFLICT OF INTEREST AND CONFIDENTIALITY STATEMENT

I certify that [PROPOSER INDIVIDUAL OR ORGANIZATION] has no personal or financial interests and no present employment or activity which would be incompatible with this organization's participation in any activity related to the RFP or execution of the awarded [INSERT SERVICES TO BE PROCURED HERE] Contract. For the duration of this organization's involvement in the [INSERT SERVICES TO BE PROCURED HERE] Contract, this organization agrees not to accept any gift, benefit, gratuity or consideration, or begin a personal or financial interest in a party who is bidding and/or proposing, or associated with a bidder and/or proposer on the [INSERT SERVICES TO BE PROCURED HERE] Contract.

I certify that this organization will keep all [INSERT SERVICES TO BE PROCURED HERE] Contract information confidential and secure. This organization will not copy, give or otherwise disclose such information to any other person unless Northern Inyo Healthcare District has on file a confidentiality agreement signed by the other person, and the disclosure is authorized and necessary to the [INSERT SERVICES TO BE PROCURED HERE] Contract. I understand that the information to be kept confidential includes specifications, administrative requirements, written or electronic materials, etc. I understand that if this organization leaves this [INSERT SERVICES TO BE PROCURED HERE] Contract before it ends, this organization must still keep all Contract information confidential. I agree to follow any instructions provided by [INSERT SERVICES TO BE PROCURED HERE] Contract relating to the confidentiality of [INSERT SERVICES TO BE PROCURED HERE] Contract information.

I fully understand that any unauthorized disclosure made by this organization may be a basis for civil or criminal penalties and/or disciplinary action. I agree to advise the Issuing NIHD Executive immediately in the event that I or another person within this organization either learn or have reason to believe that any person who has access to [INSERT SERVICES TO BE PROCURED HERE] Contract confidential information has or intends to disclose that information in violation of this agreement.

Company Name: [insert company name]
Authorized Representative: [insert authorized representative]
Phone Number: [insert phone number]
Fax Number: [insert fax number]
E-mail Address: [insert fax number]

Signature _____ Date [insert date]

This information is subject to verification by Northern Inyo Healthcare District. If the District finds a misrepresentation, the bid may be automatically disqualified from the procurement process or the contract may be canceled.

Return this Conflict of Interest and Confidentiality Statement, as a condition of receipt of this contract, to:

Northern Inyo Healthcare District
[Insert Issuing Executive Title],[Insert Issuing Executive Name Here]
Administration Office
150 Pioneer Lane
Bishop, CA 93514

Acknowledgement of Receipt of Request for Proposal Package

RFP Number: [INSERT UNIQUE RFP NUMBER IN THE FOLLOWING FORMAT-AAAAAA-YYYY-## HERE, E.G. RADSVS-2016-01]

RFP Description: [INSERT SERVICES TO BE PROCURED HERE]

Upon receipt of documents, please email this page to:

Northern Inyo Hospital
Attention: RFP Issuing Executive, [INSERT ISSUING EXECUTIVE NAME HERE]
150 Pioneer Lane
Bishop, CA 93514
760-873-5811
[INSERT ISSUING EXECUTIVE EMAIL ADDRESS HERE]

Received from: _____
Proposer Point of Contact Name ***Proposer Company Name***

I hereby acknowledge receipt of documents pertaining to the above referenced Request For Proposal.

Receiving Person: _____
Printed Name

Phone: _____ Email: _____

_____
Signature Date

Issuing Executive: _____
Printed Name

Phone: _____ Email: _____

_____
Signature Date

Rev. [INSERT REVISED DATE IN MM/DD/YY, AUTHOR INITIALS HERE, E.G. 1/17/17 mjs]

Sample RFP Evaluation Criteria Worksheet

Requirements/Criteria	*Rater Score*	*Weight*	*Weighted Score*	*Explanation*	*Comments*
Criteria 1 (may include brief explanation here)		0.23	0.00	Includes more detailed explanation of how criteria will be judged and documents, considerations, information that will be looked at.	
Criteria 2		0.16	0.00		
Criteria 3		0.14	0.00		
Criteria 4		0.13	0.00		
Criteria 5		0.09	0.00		
Criteria 6		0.07	0.00		
Criteria 7		0.06	0.00		
Criteria 8		0.06	0.00		
Criteria 9		0.06	0.00		
Total	*0*	100.00%	0.00		
Name (First, Last)					
Date Completed					
Proposer					

Instructions for Completion of the RFP Evaluation Criteria Worksheet

Please read this entire document before completing RFP evaluations!

1. Complete a separate *Evaluation Criteria Worksheet* for each Proposal in the Microsoft Excel template provided.
2. Review the RFP, especially Section 4-Specifications/Scope of Work and Section 5-Mandatory Requirements.
3. Review the proposal, keeping in mind the RFP requirements. You may want to print out a copy and make notes in the margins as you review.
4. Complete the *Evaluation Criteria Worksheet* Excel document.
   a. Review the explanation for each criterion and enter your score in the Rater Score column. The Rater Score column is shaded in green. You should provide a score between 0 and 100 points for each criterion, with 0 being "Does not meet Requirement" and 100 being "Fully meets and exceeds requirement".
   b. Provide a justification for your score in the Comment column to the far right, which is also shaded in green. You should only enter data in the green shaded sections.
   c. DO NOT complete the Yellow shaded sections, as these are fixed or calculated values.
   d. Complete the three shaded green boxes at the bottom with your first and last name, Date Completed and Proposer Name.
5. Return your completed worksheets to me no later than [MM/DD/YY], [Day] at [Time].
6. Other Important Information
   a. During the independent evaluation, you should not discuss the proposals with anyone, even other RFP team members. This first pass is an INDEPENDENT review and your opinion is important.
   b. DO NOT forward the proposal pdf files to anyone outside of the team or to non-NIH email addresses. This information is confidential.

Rev. 2/28/17 mjs

Overall RFP Scores-Blinded

Rater Name	Proposer 1	Proposer 2	Proposer 3	Proposer 4	Proposer 5
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
Average	*#DIV/0!*	*#DIV/0!*	*#DIV/0!*	*#DIV/0!*	*#DIV/0!*

NORTHERN INYO HEALTHCARE DISTRICT

RFP Notification of Preliminary Award

To: Proposers Responding to Request for Proposal (RFP) [ENTER RFP NUMBER HERE IN FORMAT YYYY-##] for [ENTER SERVICES TO BE PROCURED HERE] at Northern Inyo Healthcare District (NIHD)

From: [ENTER ISSUING EXECUTIVE NAME & TITLE HERE]
[ENTER SERVICES TO BE PROCURED HERE] Services RFP Issuing Executive
Northern Inyo Healthcare District
150 Pioneer Lane
Bishop, CA 93514

Date: [ENTER DATE HERE IN FORMAT MM/DD/YY]

The following proposers submitted responses to the above solicitation:

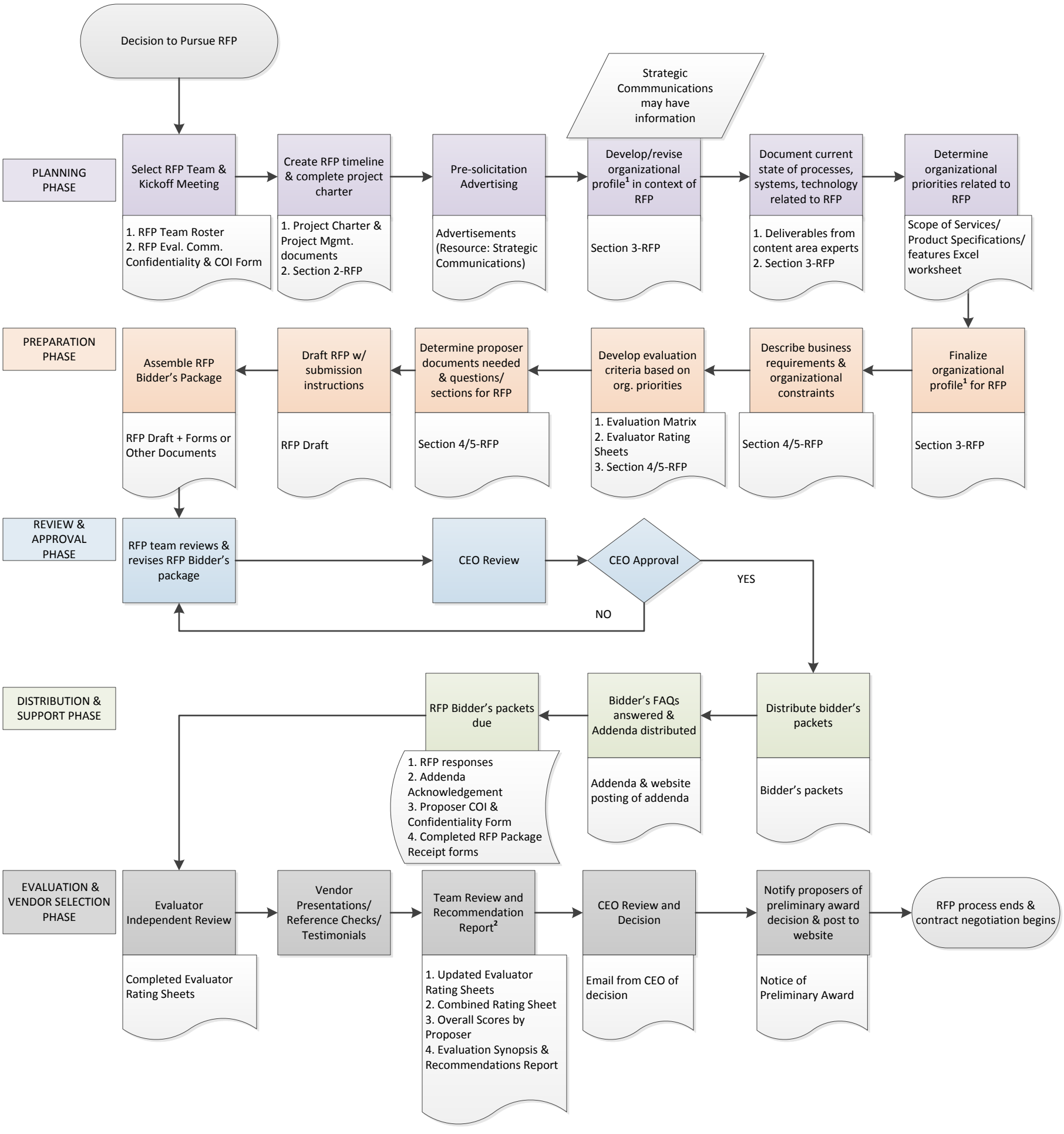
[LIST NAMES OF PROPOSERS HERE]
....
.....

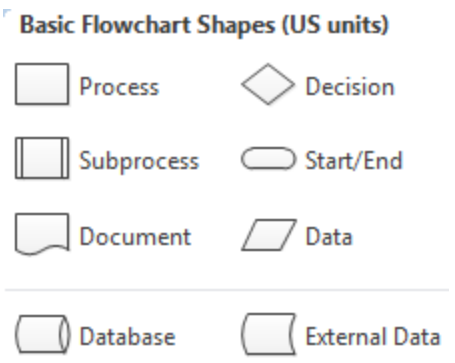
Responses were evaluated according to the criteria stated in the RFP. NIHD announces its intent to potentially award a contract to the following, pending successful contract negotiations and approval by the NIHD Board of Directors in its discretion:

[LIST NAME OF PROPOSER SELECTED FOR PRELIMINARY AWARD HERE]

Regarding Northern Inyo Healthcare District (NIHD) RFP [ENTER RFP NUMBER HERE IN FORMAT YYYY-##] for a [ENTER SERVICES TO BE PROCURED HERE] contract, please be advised that, initial contract negotiations will be held with [ENTER PROPOSER SELECTED FOR PRELIMINARY AWARD HERE]. NIHD reserves the right to potentially proceed to negotiate with one or more of the other proposers at any time in its discretion until such time as an award is approved by the Board of Directors. Northern Inyo Healthcare District thanks you for your participation in the RFP process.

Request For Proposal (RFP) Process Map-Annotated





Created by: Maria Sirois, CPEO
Revised 3/4/17

Important Notes:

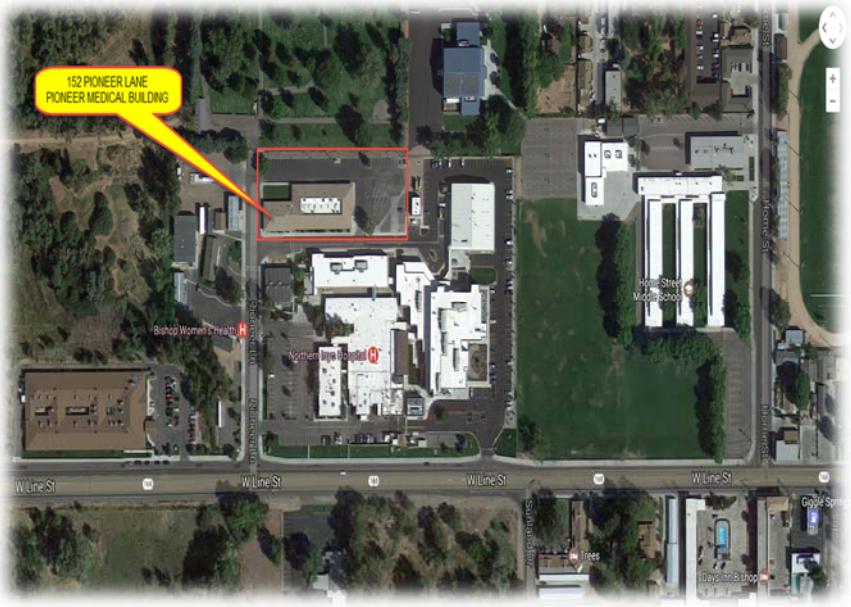
1. The Organizational Profile describes the mission, environmental and organizational forces driving the need for the RFP/procured services.
2. The team and/or CEO are not obligated to select any of the proposers and may state such in their recommendations and re-issue the RFP at a later date.
3. If a mutually acceptable agreement cannot be reached by NIHD and selected proposer, NIHD may select other proposers, re-issue the RFP, or end the RFP outright.

CA BRETTON, MAI

CA BRETTON, MAI

APPRAISAL REPORT

OF



152 Pioneer Lane
Bishop, California

PROPERTY TYPE
On-Campus Medical Office Building

DATE OF VALUE
January 19, 2017

PREPARED FOR
Mr. Kevin S. Flanigan, MD MBA
CEO
Northern Inyo Healthcare District
150 Pioneer Lane
Bishop, CA 93514

PREPARED BY
Cheryl Bretton, MAI
P.O. Box 100 PMB 466
Mammoth Lakes, CA 93546

CHERYL BRETTON, MAI

Mammoth Lakes, California

P.O. Box 100 PMB 466
Mammoth Lakes, California 93546

January 19, 2017

Mr. Kevin S. Flanigan, MD MBA
CEO
Northern Inyo Healthcare District
150 Pioneer Lane
Bishop, CA 93514

RE: 152 Pioneer Lane
Bishop, California

Dear Dr. Flanigan:

I have completed an appraisal of the market value in the referenced property. The Fee Simple Interest in the property is presented first, followed by a discussion and valuation of a 33.474% partial interest. My analysis is presented in the following Appraisal Report.

The Subject is an on-campus medical office building (MOB) located northwest of Northern Inyo Hospital (NIH). The purpose of the appraisal is to estimate the market value of the Fee Simple Estate and a 33.474% partial interest. Northern Inyo Healthcare District intends to use this appraisal as an aid in negotiating a partnership buy-out.

Based on the analysis contained in the following report, the market value of the Subject is concluded in the accompanying table.

OPINION OF MARKET VALUE			
Appraisal Premise	**Interest Appraised**	**Date of Value**	**Value Conclusion**
Market Value "As Is"	**33.474% Partial Interest**	January 19, 2017	**$ 790,000**

It has been a pleasure to assist you in this assignment. If you have any questions concerning the analysis, or if I can be of further service, please contact me.

Respectfully submitted,

Cheryl A. Bretton, MAI
CA State Certification No. AG023954
Expires: October 14, 2018

CERTIFICATION

I certify to the best of my knowledge and belief:

1. The statements of fact contained in this report are true and correct.
2. The reported analyses, opinions, and conclusions are limited only by the reported assumptions and limiting conditions are my personal, impartial and unbiased professional analyses, opinions, and conclusions.
3. I have no present or prospective interest in or bias with respect to the property that is the subject of this report and have no personal interest in or bias with respect to the parties involved with this assignment.
4. I have no bias with respect to the property that is the subject of this report or to the parties involved with this assignment.
5. My engagement in this assignment was not contingent upon developing or reporting predetermined results.
6. My compensation for completing this assignment is not contingent upon the development or reporting of a predetermined value or direction in value that favors the cause of the client, the amount of the value opinion, the attainment of a stipulated result, or the occurrence of a subsequent event directly related to the intended use of this appraisal, such as the approval of a loan.
7. This appraisal assignment was not based upon a requested minimum valuation, a specific valuation, or the approval of a loan.
8. My analyses, opinions, and conclusions were developed, and this report has been prepared, in conformity with the Uniform Standards of Professional Appraisal Practice of The Appraisal Foundation and the requirements of the Code of Professional Ethics and the Standards of Professional Appraisal Practice of the Appraisal Institute.
9. I made a personal inspection of the exterior of the property that is the Subject of this report.
10. No one provided significant real property appraisal assistance to the person signing this report.
11. I am currently certified in the state where the Subject is located.
12. I have performed no services as an appraiser or in any other capacity, regarding the property that is the subject of this report within the three-year period immediately preceding acceptance of this assignment
13. I am a designated member of the Appraisal Institute. The Appraisal Institute conducts a voluntary program of continuing education for its designated members. Designated members who meet the minimum standards of this program are awarded periodic education certification. As of the date of this report, I, Cheryl Bretton, have completed the requirements of the continuing education program of the Appraisal Institute.

Cheryl Bretton, MAI
CA State Certification No. AG023954
Expires: October 14, 2018
Dated: January 19, 2017

TABLE OF CONTENTS

SUMMARY OF SALIENT FACTS

Location	The Subject is located in the Owens Valley area of Inyo County, in the incorporated community of Bishop. The street address 152 Pioneer Lane, Bishop, California
Assessor's Parcel Nos.	011-240-014 and 011-240-1404
Owner of Record	PTSP Pioneer Medical Association / Kamei ASAO
Site	The Subject is located, on-campus, northwest of Northern Inyo Hospital on the east side of Pioneer Lane. The site is level; at street grade with 1.29 acres or, 56,192 SF. The Subject site is a single legal tax parcel with 140 feet of secondary commercial exposure along Pioneer Lane.
Improvements	The site is improved with a 1986-built, free-standing wood-frame/stucco MOB with a gross building area of 16,369 SF and a net leasable of 16,077 SF. The building was expanded in 1990 to eight medical suites with reception area, lobby, examination rooms, restrooms and physicians consultation offices.
Existing Occupancy	NIH occupies the majority of the building.
GP / Zoning	General Commercial / C-1 General Commercial and Retail
Highest and Best Use	
As If Vacant:	Commercial development as market conditions dictates.
As Improved:	As Improved
Date of Valuation	January 19, 2017
Dates of Inspection	January 19, 2017
Exposure Time	Six (6) Months
Property Rights Appraised	Fee Simple Estate

INTRODUCTION

AERIAL AND STREET VIEW MAPS

Figure 1: Aerial Plot Plan Showing Building Placement

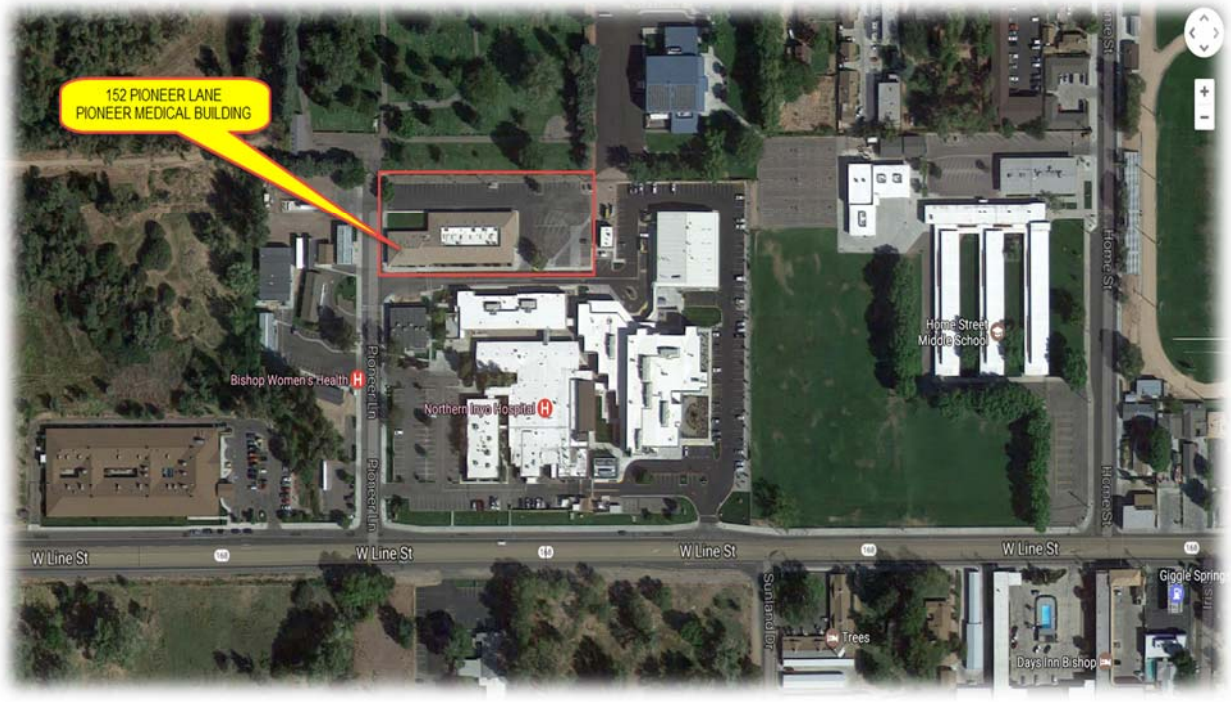
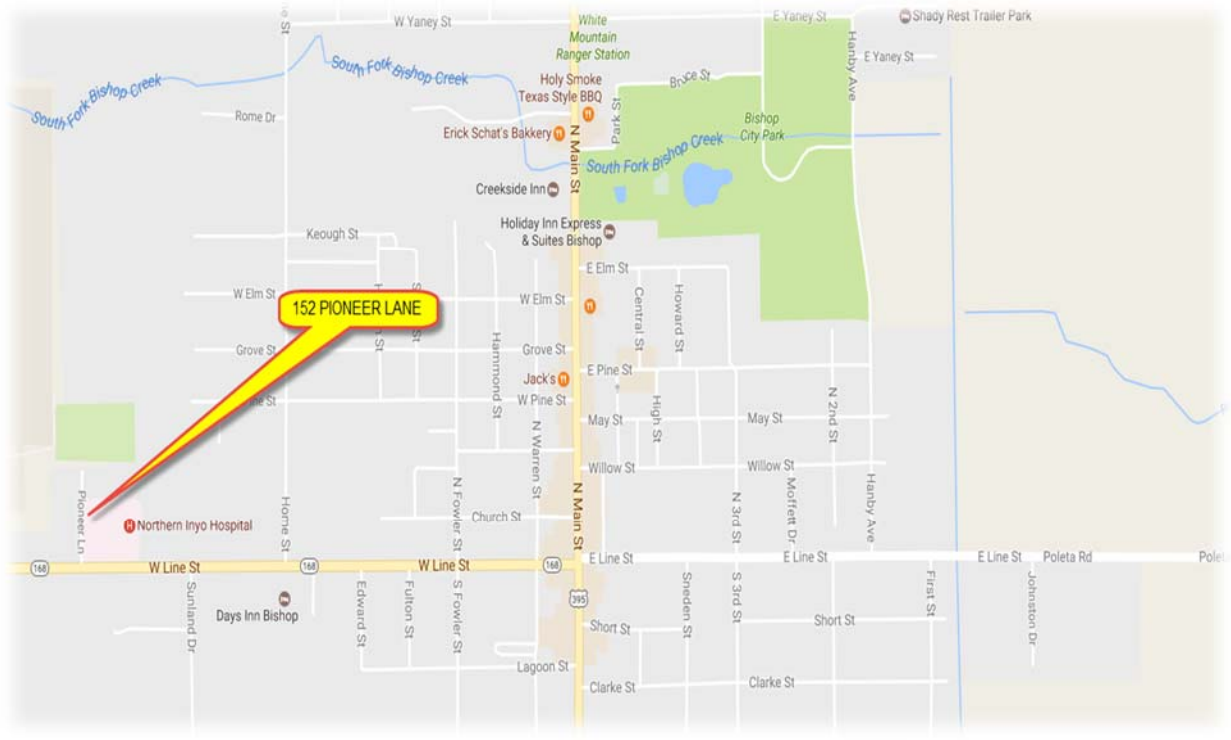


Figure 2: Street View Map



DATE OF THE REPORT, INSPECTION, AND DATE OF VALUE

The date of the report is the date on the letter of transmittal. The date of the last inspection was January 19, 2017 (Only the exterior was available for inspection). The date of value is January 19, 2017.

PURPOSE OF THE APPRAISAL

The purpose of this appraisal is to estimate the market value of the Subject.

INTENDED USE AND USER

The user, Northern Inyo Hospital, will use this appraisal as an aid in negotiating a partnership buy-out.

DEFINITION OF FAIR MARKET VALUE

The current economic definition agreed upon by agencies that regulate federal financial institutions in the United States of America is:

> *The most probable price which a property should bring in a competitive and open market under all conditions requisite to a fair sale, the buyer and seller each acting prudently and knowledgeably, and assuming the price is not affected by undue stimulus. Implicit in this definition is the consummation of a sale as of a specified date and the passing of title from seller to buyer under conditions whereby:*
>
> 1. *Buyer and seller are typically motivated;*
> 2. *Both parties are well informed or well advised, and acting in what they consider their best interests;*
> 3. *A reasonable time is allowed for exposure in the open market;*
> 4. *Payment is made in terms of cash in United States dollars or in terms of financial arrangements comparable thereto; and*
> 5. *The price represents the normal consideration for the property sold unaffected by special or creative financing or sales concessions granted by anyone associated with the sale.*[1]

PROPERTY RIGHTS APPRAISED

The interest appraised represents the Fee Simple Estate and 33.474% partial interest.

SCOPE OF THE APPRAISAL

This appraisal report has been prepared within generally accepted appraisal principals as defined by USPAP.

EXTENT OF PROPERTY IDENTIFICATION

Physical Characteristics

I utilized the following resources;

- the Inyo County Assessor files, and

[1] OCC, 12 CFR Part 34, Subpart C-Appraisals, 34.42 Definitions (g)

- physical inspection.

Legal Characteristics

I was not provided a current Title Report. I did not conduct an independent search of recorded documents. For the purpose of this appraisal report, it is assumed that the title is clear, merchantable, and unencumbered.

Extent of Property Inspection

The property inspection included the exterior only. I did not inspect the interior of the Subject. Per Mr. Scott Hooker, NIH, the suites are occupied by physicians with a patient load. No physical inspection was scheduled.

Type and Extent of Data Researched

I reviewed the micro and macro market environments on physical and economic factors relevant to the valuation process. This process included interviews with regional and local market participants, available published data, and other various resources. I also conducted regional and local research on applicable tax data, zoning requirements, flood zone status, demographics, income and expense data, and comparable listing, sale and rental information. As part of the appraisal assignment, market data was collected in Inyo and Mono County.

Type and Extent of Analysis Applied

The value opinion presented in this report is based upon a review and analysis of the market conditions affecting property values in Inyo County. Data collection and analysis for the three typical approaches were considered.

STATEMENT OF APPRAISER COMPETENCE

I have extensive experience in the appraisal/review of similar property types.

OWNERSHIP AND PROPERTY HISTORY

According to the Inyo County Assessor, the property is currently vested as follows:

PTSP Pioneer Medical Association.

On January 1, 1986, the Existing Partners and the Former Partners formed a general partnership, Pioneer Medical Associates, A California General Partnership. In May of 1986, the Pioneer Medical Association, consisting of nine partners, purchased the Subject site and developed the medical office facility.

On October 17, 2003, Northern Inyo County Local Hospital District purchased from Jon G. McLennan, M.D., Inc, an 18.979% interest in the Pioneer Medical Association. The purchase price of $396,000 was confirmed with a representative of the Buyer. In 2007 and 2008 three more partners were bought out. A fourth partner was bought out subsequent yet; no information was available regarding terms.

EXPOSURE TIME

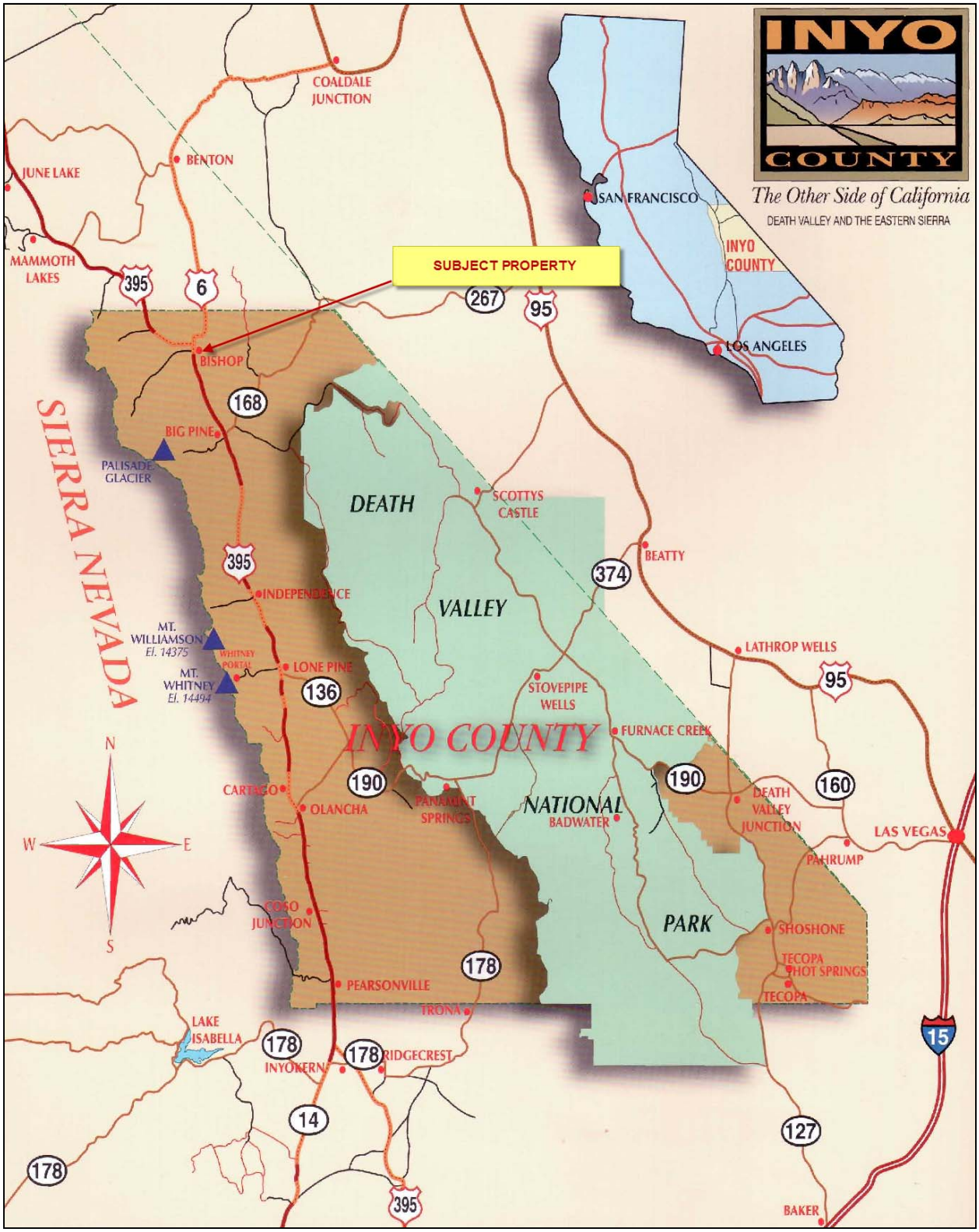
1. The time a property remains on the market.
2. The estimated length of time the property interest being appraised would have been offered on the market prior to the hypothetical consummation of a sale

> at market value on the effective date of the appraisal; a retrospective estimate based upon an analysis of past events assuming a competitive and open market." (The Dictionary of Real Estate Appraisal, Fifth Edition, 2010, Appraisal Institute)

Exposure time is, therefore, interrelated with appraisal conclusion of value. The sales indicate exposure times in the three (**3) month to over four (4) years**. I concluded an exposure/marketing time of **six (6) months or less**.

COMMUNITY FEATURES AND ANALYSIS

Figure 3: Location Map



The County of Inyo is considered a south-central county within the Eastern portion of California. The County is bordered by Kern County on the South, Tulare and Fresno Counties on the West, and Mono County on the North. The County of Inyo is the second largest county in California with approximately 10,000 square miles. Of this area, less than two (2) percent of the lands are privately owned. The balance of the lands are State or Federal.

The County was established in 1866. The County includes many natural resources in its open and wilderness areas including the Inyo National Forest and Death Valley National Monument. These two (2) areas, separated by a distance of approximately 80 miles, include the highest and lowest points in the Continental United States, Mt. Whitney (14,495 feet above sea level) and Badwater in Death Valley (282 feet below sea level). The recreational opportunities provided by these natural resources are a primary source of tourism to the area and represent the main attraction to the area.

Bishop is the only incorporated city in the County of Inyo. The City is bordered by the Department of Water and Power (LADWP) of the City of Los Angeles lands on all sides.

U.S. Highway 395 provides regional access to the City. The City of Bishop and its unincorporated suburbs, located at the upper end of Owens Valley, accounts for more than half of the County population. The remainder of Owens Valley (including Round Valley) accounts for an additional 38 percent of the total County population. The remaining ten (10) percent of the County population is scattered in the other dozen desert valleys. Most residents live in one of the many communities but some people live on outlying farms, ranches and mining claims within the vast open space of the County. All of the communities in the County are rural and this fact is recognized by the people as a benefit of the County. Other urban communities in the County consist of Big Pine, Independence and Lone Pine.

The Bishop area was one of the principal Paiute settlements probably due to the overall productivity of the area's water and soil resources. Although explorers and settlers passed through the Bishop area for nearly 20 years, it was not until Samuel A. Bishop established the St. Francis Ranch with 500 head of cattle in 1861 that Bishop was settled. Both Bishop Creek and the City take their name from this pioneer who left the County of Inyo shortly after establishing his ranch. While mining was the dominant economic activity in the rest of the County, Bishop was settled by cattle and sheep ranchers exploiting the grasslands on Bishop Creek's alluvial plain. After the City of Bishop incorporated in 1903, it became the commercial center of an agricultural economy which diversified as the area's water resources were developed.

Bishop, 203 miles South of Reno, 270 miles North of Los Angeles and 300 miles Northwest of Las Vegas is now primarily a tourist town emphasizing the old west theme. The area offers year-round recreational activities. While the elevation of Bishop is 4,200 feet, the Sierra Nevada Mountains rise to 14,000 feet just West of the City. U.S. Highway 395 provides a major source of tourist and recreation traffic for the area. Bishop is not only the principal urban community of the County of Inyo but is considered the major urban center of Eastern California.

The Bishop Reservation of the Paiute-Shoshone Indian Tribe accounts for 1,400 residents and is located immediately West of the City. The average age in Bishop is slightly greater

than 35 indicating that the majority of the population is between 15 and 59. Retirees or near retirement individuals comprise another significant portion. Bishop accounts for more than 50 percent of primary wage earner employment in the County. Wholesale trades, service and government sectors alone account for almost 70 percent of all employment. It also is the regional retail and commercial service center with the City accounting for more than 50 percent of County retail sales.

With LADWP's purchase of Valley ranches for water rights, as a part of their aqueduct development, local agriculture declined and so did the population. Today, Bishop is the Eastern Sierra's largest urban community in an economy based on tourism and recreation.

Residential land uses comprise approximately 40 percent of the City's land area and are primarily set back from U.S. Highway 395 which is also the Main Street corridor. Present residential development patterns are primarily influenced by the amount and location of private land within the City. As a result, residential development is concentrated in areas that are already developed. This involves the densification of existing residential land uses, as well as in-fill of undeveloped parcels.

LADWP maintains a significant role in the provision of land for commercial, as well as residential purposes. The LADWP's land ownership and leasing policies have and will continue to be extremely important to land use and economic development of Bishop. Short-term policies indicate the continued use of developed parcels and limited development of undeveloped parcels.

While the State of California realized unprecedented population growth, the population of the County of Inyo has not changed significantly in the past ten (10) years.

The economic stability of the area is driven by three (3) economic sectors:

- **tourism,**
- **local spending, and**
- **resource extraction and management.**

Tourism is significant with visitor spending totaling 70.0 percent of all retail and lodging purchases. Local retail spending has declined over time, indicating that residents may be shopping for general merchandise and food purchases outside the County.

DEMOGRAPHIC ANALYSIS

Population and Household Formation

The following table illustrates the population and household changes for the city of Bishop and the County of Inyo. Also included are the projections for the Town of Mammoth Lakes and Mono County as these areas have a significant effect on the County of Inyo.

POPULATION AND HOUSEHOLD PROJECTIONS					
		City of Bishop	County of Inyo	TOML	Mono County
Population					
	2017 Population	3,735	18,477	8,620	14,900
	2012 Population	3,813	18,611	8,360	14,418
Census	2010 Population	3,879	17,546	8,234	14,202
	Growth 2010 - 2017	-3.86%	5.04%	4.48%	4.68%
	Growth 2010 - 2012	-1.73%	5.72%	1.51%	1.50%
Households					
	2017 Households	1,691	8,068	3,383	6,061
	2012 Households	1,707	8,031	3,272	5,850
Census	2010 Households	1,748	8,049	3,229	5,768
	Growth 2010 - 2017	-3.37%	0.24%	4.55%	4.83%
	Growth 2010 - 2012	-2.40%	-0.22%	1.31%	1.40%
Source: ESRI					

Population and households represent basic units of demand in the real estate market. According to the data presented, the area is experiencing decreases in both population and households in the County of Inyo and the City of Bishop. Limited privately owned land restricts future population growth.

Income Distributions

Household income available for expenditure on consumer items is a primary factor in determining the retail supply and demand levels in a given market area. In the case of this study, a projection of household income identifies (in gross terms) the market from which the submarket draws. The following table illustrates estimated household income distribution for the City of Bishop, the County of Inyo, the Town of Mammoth Lakes and Mono County.

POPULATION AND HOUSEHOLD PROJECTIONS									
		City of Bishop		County of Inyo		TOML		Mono County	
		Number	Percent	Number	Percent	Number	Percent	Number	Percent
Households by Income - 2017									
	<$15,000	320	18.9%	1,367	16.9%	276	8.2%	509	8.4%
	$15,000 - $24,999	243	14.4%	950	11.8%	213	6.3%	407	6.7%
	$25,000 - $34,999	307	18.1%	872	10.8%	144	4.3%	514	8.5%
	$35,000 - $49,999	233	13.8%	995	12.3%	788	23.2%	1,147	18.9%
	$50,000 - $74,999	268	15.8%	1,732	21.5%	550	16.3%	1,447	23.9%
	$75,000 - $99,999	124	7.3%	870	10.8%	871	25.8%	1,215	20.1%
	$100,000 - $149,000	159	9.4%	852	10.6%	299	8.8%	419	6.9%
	$150,000 - $199,000	30	1.8%	310	3.8%	141	4.2%	265	4.4%
	$200,000 +	8	0.5%	120	1.5%	99	2.9%	135	2.2%
Total		1,692		8,068		3,381		6,058	
Source: ESRI									

An analysis of the income data indicates that the submarket is generally comprised of lower-middle income economic groups.

Employment

An employment breakdown typically indicates the working class characteristics for a given market area. The specific employment-population of the area is as follows:

AREA EMPLOYMENT AND UNEMPLOYMENT STATISTICS				
Industry	City of Bishop	County of Inyo	TOML	Mono County
2015 Employed Population 16+ by Industry				
Total	1,924	9,172	5,093	8,677
White Collar	52.30%	53.70%	55.60%	57.60%
Management/Business/Financial	7.60%	10.70%	15.30%	15.70%
Professional	18.60%	19.50%	19.80%	21.60%
Sales	13.60%	9.50%	11.00%	10.20%
Administrative Support	12.60%	13.90%	9.50%	10.10%
Services	29.20%	26.20%	29.10%	25.20%
Blue Collar	18.50%	20.20%	15.30%	17.20%
Farming/Forestry/Fishing	1.70%	1.00%	0.10%	0.20%
Construction/Extraction	3.90%	6.10%	7.60%	9.10%
Installation/Maintenance/Repair	4.20%	4.80%	2.60%	2.80%
Production	3.30%	3.70%	1.70%	2.10%
Transportations/Material Moving	5.40%	4.60%	3.30%	3.10%
Source: ERSI				

The previous table illustrates the employment character of the submarket, indicating a mixture of blue and white-collar jobs.

Bishop is Inyo County's principal employment center, accounting for over 50.0 percent of primary wage earner employment. The wholesale trades, service and government sectors alone account for almost 70.0 percent of all employment. Bishop is also the regional retail and commercial service center with the City accounting for over 50.0

percent of total county retail sales. Most of the county and regional wholesale and distributing businesses are located within the City.

CONCLUSION

The County of Inyo is a desirable and attractive place to live and visit. The region's natural attractions contribute to the appeal. However, the lack of private land serves to restrict economic growth in the private sector. Employment is largely service-based, with many businesses serving travelers. The area is not a strong real estate market.

The preceding section discussed a wide variety of economic indicators. Based on the research, one can conclude that Bishop, CA continues to represent a diverse economy, supported by the area's tourist and leisure attractions, its location in route to Mammoth Mountain Ski Area (MMSA) on U.S. Highway 395.

APPRAISAL METHODOLOGY

In appraisal practice, an approach to value is included or omitted based on its applicability to the property type being valued and the quality and quantity of information available.

COST APPROACH

The *Cost approach* includes estimating the cost of all improvements, depreciating them to reflect loss of value from physical, functional and external causes then; land value, entrepreneurial profit and depreciated improvement costs are added, resulting in an opinion of value.

SALES COMPARISON APPROACH

The Sales Comparison Approach utilizes sales of comparable properties, adjusted for differences, to indicate a value for the Subject. Valuation is typically accomplished using physical units of comparison such as price per square foot, price per unit, price per floor, etc., or economic units of comparison such as gross rent multiplier. Adjustments are applied to the physical units of comparison derived from the comparable sale. The unit of comparison chosen for the Subject is then used to yield a total value.

INCOME CAPITALIZATION APPROACH

The Income Capitalization Approach reflects the Subject's income-producing capabilities. This approach is based on the assumption that value is created by the expectation of benefits to be derived in the future. Specifically estimated is the amount an investor would be willing to pay to receive an income stream plus reversion value from a property over a period of time.

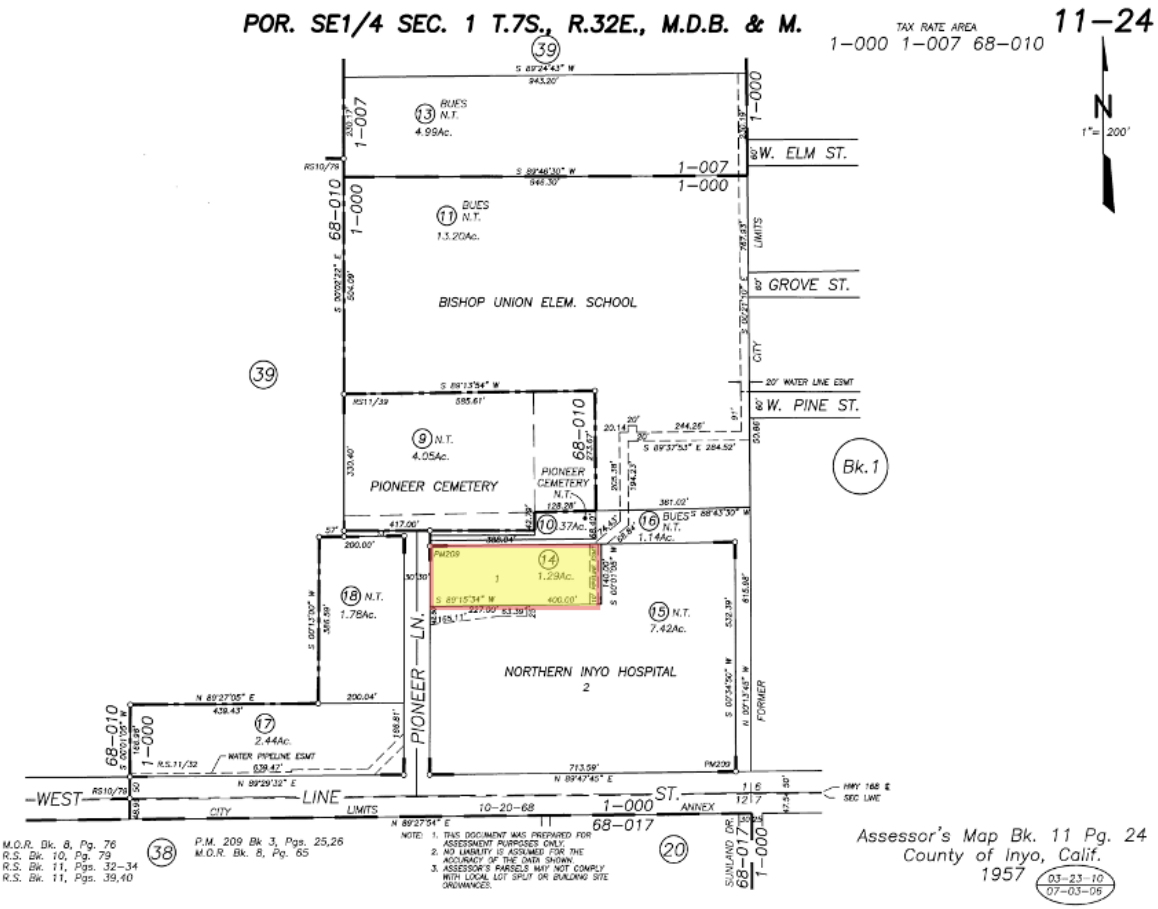
METHODOLOGY APPLICABLE TO THE SUBJECT

The Cost and Income Capitalization Approaches are considered the most applicable and are used. The Sales Comparison Approach is not used due to the lack of medical office building sales and relevant data in the local market.

SITE DATA

ASSESSORS PARCEL MAP

Figure 4: Assessor's Parcel Map



LOCATION

The Subject is located at 152 Pioneer Lane, Bishop, California.

APN

011-240-014 and 011-240-1404

LAND AREA

The legal tax parcel is 140' x 400' totaling 56,192 SF or, 1.29 acres.

ACCESS AND EXPOSURE

Regional and local access is via US 395, W. Line Street and Pioneer Lane.

STREETS

US 395 is a major north/south thoroughfare improved with two lanes of traffic in each direction, concrete curbs, gutters, sidewalks and street lighting. Street parking is not permitted. West Line Street, a secondary route, is improved with one lane of traffic in each direction, concrete curbs, gutters, sidewalks and street lighting. Street parking is permitted. The Subject site has 140 feet of frontage along Pioneer Lane.

TOPOGRAPHY AND DRAINAGE

The topography around the Subject is level and at street grade. It slopes slightly from south to north in the Subject's immediate vicinity. No drainage problems were observed during the physical inspection.

EASEMENTS, RESTRICTIONS, AND ENCROACHMENTS

A current title policy for the property was not provided for the preparation of this appraisal. Based on my visual inspection and review of the plat map, site plan, the property does not appear to be adversely affected by any easements or encroachments. This report assumes there are no additional easements or encroachments that have a negative impact on the value of the property.

UTILITIES/SERVICES

All typical utilities are available.

FLOOD ZONE

According to flood hazard maps published by the Federal Emergency Management Agency (FEMA), the site is within Flood Zone D, as indicated Community No. 06027CO332D, map dated August 16, 1011.

TOXIC HAZARDS

To the best of my knowledge, I have not observed and am not qualified to detect the existence of potentially hazardous material or underground storage tanks which may or may not be present on or near the property.

SEISMIC HAZARD

The site is not located in a Special Study Zone as established by California's Alquist-Priolo Geological Hazards Act.

BORDERING LAND USES

North:	Pioneer Cemetery
South:	NIH
East:	NIH
West:	NIH

BUILDING IMPROVEMENTS/LAYOUT

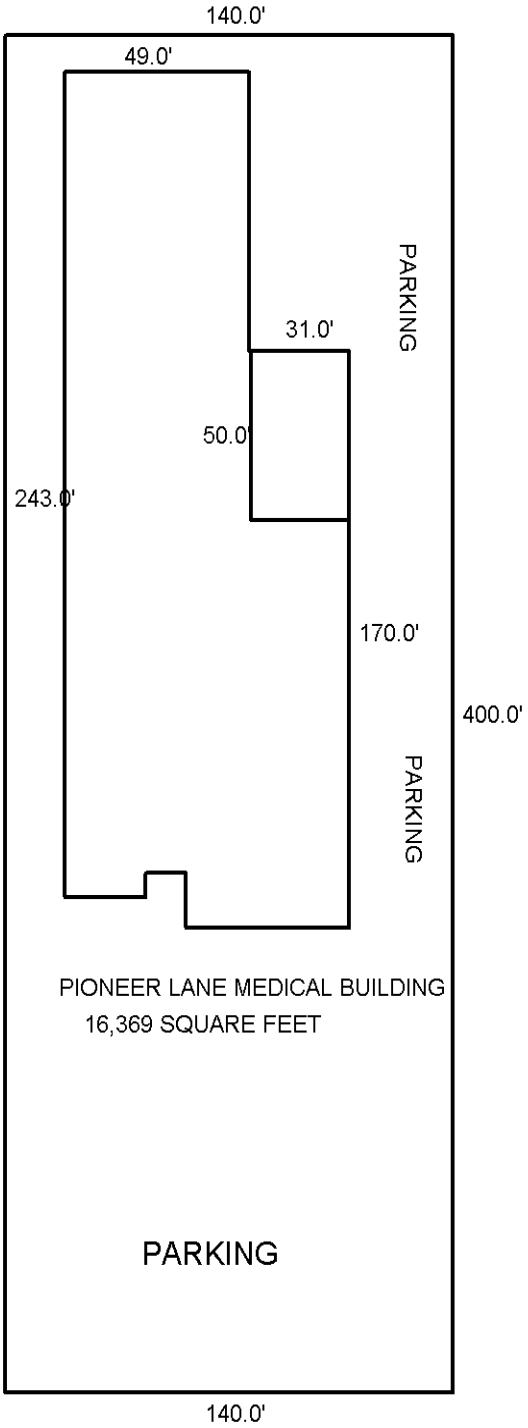
The Subject is a 1986-built MOB with a 1990-built addition. The improvement construction details are summarized below.

Construction	The MOB is wood-frame with stucco siding. The windows are dual-glazed in anodized aluminum frames.
Foundation/Floors	Poured in place reinforced concrete perimeter foundation with wood joists on post & piers.
Frame/Exterior Walls	The exterior walls of the MOB are wood-frame with stucco siding and Brick Veneer Wainscot.
Roof Cover	The roof was not inspected but assumed to be adequate for the current occupancy.
Interior Build-out	
Ceiling:	Suspended "T" bar acoustical tiles with integrated fluorescent panels.
Lighting	The lighting is comprised of ceiling recessed fluorescent lighting, can lighting and tract lighting.
Floor Covering	The floor coverings are typically commercial carpeting in the reception area with vinyl flooring or tile in the exam rooms and utility room.
Walls	The interior demising walls are wood-framed with drywall painted finish.
HVAC	The MOB features gas forced air heat and rooftop air-conditioning units.
Electrical	The electrical system is typical for this property type and is assumed adequate for the intended use.
Fire Protection	The spaces are not sprinklered.
Plumbing	There are two-fixture restrooms in the demised office areas.
Deferred Maintenance	No items of significant deferred maintenance were noted.
Environmental Issues	I was not provided with an environmental report. No evidence of hazardous waste or toxic materials was

	noted during my physical inspection and I have no knowledge of the existence of these substances.
Parking	The 30,000 square foot asphalt paved area has marked, bumpered parking.
Landscaping	Landscaped shrub beds with automatic sprinkler systems.
Security	The parking area is not secured.
Economic Age and Life	The MOB was built in 1986 and 1990. The improvement is in average overall condition.
ADA Compliance	The client/reader's attention is directed to the specific limiting conditions regarding ADA compliance.
Non-Realty Components	The Subject, as appraised herein, is not inclusive of any non-realty components.

BUILDING SKETCH

Figure 5: Building Sketch



LAND USE RESTRICTIONS

The Subject's zoning requirements are summarized in the accompanying table.

ZONING SUMMARY	
Current zoning:	C-1
Legally conforming:	No
Uses permitted:	Retail trading and business
Zoning change	Not likely
Category	**Zoning Requirements**
Minimum Lot Size:	1,500 square feet
Minimum Lot Width:	30 feet
Front Setback:	15 feet
Side Setback:	5 feet
Rear Setback:	15 feet
Height limit:	30 feet
Parking:	1 per 800 SF of Retail / 1 per 1,000 SF of shop space

The General Plan designation is General Commercial. This designation provides a broad category of commercial activities including those establishments offering a wide range of convenience consumer goods and a variety of personal services. The General Plan designation is consistent with the underlying zoning; C-1 zoning district is intended to serve as the retail trading and business area. Offices, business and professional uses are permitted in the C-1 district.

CONCLUSION

The Northern Inyo County Local Hospital District deed restricted the property to development of a medical office building. The MOB is a legal conforming use based on the current zoning and general plan designations.

TAX ANALYSIS

In California, all real property is assessed at 100 percent of full cash value (which is interpreted to mean market value of the Fee Simple Estate) as determined by the Inyo County Assessor. A reassessment occurs only when a property is sold (or transferred) or when new construction occurs (as differentiated from replacing existing construction). Assessments for properties that were acquired before the tax year 1975-1976 were stabilized as of the tax year 1975-1976.

State law limits property taxes to one percent of the assessed value plus voter-approved obligations. If no sale (or transfer) occurs or no new construction takes place, assessments may not increase by more than two percent annually. Taxes are payable in two equal installments, which become delinquent after December 10 and April 10. The following table summarizes the current assessed value and property taxes.

AD VALOREM TAX INFORMATION	
Component	
Assessed Land Value	$565,666
Assessed Improvements Value	1,633,788
Assessed Fixtures	-
Assessed Fixtures/Personal Property Value	-
Total Assessed Value	$2,199,454
Total Taxes	$23,431
Effective Tax Rate:	1.065324%

TAX AND ASSESSMENT CONCLUSION

If the Subject sold for the value estimate in this report, a reassessment at that value would most likely occur, with tax increases limited to 2.0% annually thereafter until the property is sold again. The consequences of this reassessment have been considered in the appropriate valuation sections.

HIGHEST AND BEST USE ANALYSIS

Highest and Best Use is defined as the reasonably probable and legal use found to be physically possible, appropriately supported, financially feasible, that results in the highest present value. Typically two (2) tests of Highest and Best Use are considered;

- as though vacant and,
- as improved.

The Subject is, on-campus, adjacent to the Northern Inyo Hospital and restricted to development of medical facilities. Consequently, the highest and best use of the Subject, "as vacant" and "as improved" is for medical office use.

COST APPROACH

METHODOLOGY

The *Cost approach* is defined as follows:

> *A set of procedures through which a value indication is derived for the fee simple interest in a property by estimating the current cost to construct a reproduction of, or replacement for the existing structure; deducting accrued depreciation from the reproduction or replacement cost; and adding the estimated land value plus an entrepreneurial profit. Adjustments may then be made to the indicated fee simple value of the subject property to reflect the value indication of the property interest being appraised.*[2]

This approach consists of an analysis of the property's physical value. The Principle of Substitution, the underlying rationale of this approach, holds that no prudent person will pay more for a property than the price of a site and the cost of constructing, without undue delay, an equally desirable and useful property. In the cost approach, the following steps are typically employed to reach an estimate of value:

1. Estimate land value as if vacant;
2. Estimate the improvements' replacement cost new, including indirect costs;
3. Estimate the necessary developer's overhead and profit for the type of property being appraised, (including profit on the land);
4. Add land value, replacement cost new, and profit to calculate the total cost new of the property;
5. Estimate accrued depreciation, if any, from physical, functional, and/or external causes; and
6. Deduct accrued depreciation from the total cost new of the property to calculate its current value as indicated by the *cost approach*.

In the *cost approach*, the land value is estimated through consideration of transactions involving comparable sales. The replacement cost of the improvements is supported via typical sources, primarily the Marshall & Swift Cost Estimation Service, a nationally recognized cost service. When applicable, the actual construction costs for the subject are utilized and information for the cost of constructing similar buildings is considered. From this estimate, total accrued depreciation from all sources is subtracted. The contributory value of the land is then added to the depreciated replacement cost of the improvements to indicate the subject property value via the *cost approach*.

[2] American Institute of Real Estate Appraisers, *The Dictionary of Real Estate Appraisal*, 3rd edition (Chicago: American Institute of Real Estate Appraisers, 1993, p. 81)

The land and improvements are valued separately. The land is valued by market comparison. The improvements are valued separately by cost sources that are described in the following section.

LAND VALUATION

In the Bishop commercial real estate market, there is a significant difference in the desirability of commercial exposure (location). There are four distinct commercial areas of the City of Bishop. South of the main commercial business district, downtown (main commercial business district), Line Street, and North Sierra Highway (West Bishop). Market evidence and conversations with real estate professionals indicated the main commercial business district commands the highest price per square foot, followed by South of the main commercial district and finally the North Sierra Highway (West Bishop).

Although the Subject does not fall into any of the above geographical categories, as it is an on-campus site, local commercial land sales are deemed more comparable than non-local on-campus land sales. The accompanying table summarize the comparable data used in the valuation of the Subject land.

SUMMARY OF COMPARABLE MARKET DATA

No.	Property Location	Transaction Type	Transaction Date	Current/Proposed Use GP/Zoning	Adjusted Sale Price	Size (SF)	Size (Acres)	Price Per (SF)
1	474 E. Line Street Bishop, CA	Sale	Dec-12	Warehouse/Warehouse GC / C-2	$150,000	13,504	0.31	$11.11
2	194 E. Willow Street Bishop, CA	Sale	May-15	Vacant Commercial Land GC / C-2	$190,125	10,672	0.25	$17.82
3	686 Hammond Street Bishop, CA	Sale	Jul-14	Vacant Land/Residential Development GC / R-3-P	$345,000	15,682	0.36	$22.00
4	Academy Avenue Bishop, CA	Sale	Jun-14	Vacant Commercial Land GC / C-1	$125,100	4,792	0.11	$26.11
5	106 MacIver Street Bishop, CA	Listing	15 DOM	Vacant Commercial Land GC / C-1	$490,000	32,234	0.74	$15.20
Subject	152 Pioneer Lane			MOB GC / C-1		56,192	1.29	

Market Data No. 1 This comparable represents the sale of an improved commercial/industrial property. The site is 0.31 acres located in the City of Bishop east of US 395 along E. Line Street. The area is mixed use with residential and commercial. The site is developed with a 1949-built warehouse given little value. The improvement will require significant updating and repairs.

The property was exposed to the open market for 305 days with an original asking price of $299,000. The property sold, all cash, for $150,000 in December of 2012.

Market Data No. 2 The site was purchased by the adjoining owner (4-plex) in July 2008 for $189,000 or, $17.74 per square foot. The property was available

on the open market for 273 days @ $269,000 in May of 2007. The property has been available on the open market since early 2014 with an asking price of $215,000. The property sold to a local investor in May of 2015 for $190,125 cash. The Seller will reserved a 'view corridor' via a deed restriction.

Market Data No. 3 This comparable represents the sale of two legal lots. The site was improved with an older SFR given no value. The property sold for future development to multifamily residential.

Market Data No. 4 This comparable represents the sale of a vacant commercial lot purchased by an adjoining land and business owner. The property was not exposed to the open market and sold all cash for $125,100 or, $26.11 per square foot.

Market Data No. 5 This comparable sale represents the current listing of a vacant commercial lot. A prior sale is reported in June 2004 for $400,000 followed by the 2010 sale for $550,000. This site was purchased by the Salvation Army for future development to a community center/thrift store. The development was scrapped and the site has been available on the open market for 15 days with an asking price of $490,000.

ELEMENTS OF COMPARISON – BRACKETING METHOD ANALYSIS AND CONCLUSIONS

Market research suggests that the most applicable comparative measure of value is the overall sale price per square foot. This measure includes the contribution from all components of the sale property including appropriate structural improvements, leases, and water.

The Appraisal of Real Estate, 14th edition (Appraisal Institute, 2013), on page 390 states:

> *"Elements of comparison are the characteristics of properties and transaction that help to explain the variances in the prices paid for real property."*

In the *sales comparison approach* characteristics that influence value in a particular market are identified. The comparative analysis accounts for differences in these – value enhancing - elements between the Subject and the comparable sales. Two comparative analysis techniques are recognized in *The Appraisal of Real Estate*; quantitative and qualitative.

In quantitative analysis, a numeric adjustment to the sale price of the comparable is made to reflect differences between the sale and the Subject. In many markets, there are too few transactions, or the kinds of properties being transacted are too disparate to allow the appraiser to quantify adjustments for each of the various elements of comparison. In this case, qualitative analysis is appropriate.

After the appropriate quantitative adjustments are applied; this appraisal uses a specific kind of qualitative analysis known as 'bracketing'. The sales are categorized into three classes.

- sales that are superior,

- sales that are inferior, and
- sales that are similar to the Subject.

The operating premise of the analysis is ... the Subject's indicated value will be:

- below the range of prices of the 'superior' comparable sales,
- more than the 'inferior' properties, and
- about the same as comparable sales that are rated as 'similar'.

Market study enables the appraiser to understand the characteristics of real property that affect value in a particular market. Elements of comparison include both property-related elements, such as location, parcel size, zoning, and so forth, and transaction-related elements, which addresses such factors as financing, marketing effort, and market dynamics.

The concept of market value assumes a free-will transaction where knowledgeable parties conduct negotiations without duress and in good faith, where properties are adequately exposed to the market, and the consideration is paid in cash. When a transaction departs from these conditions, transaction-related adjustments reflect the impact that the departures may have had on price (if any).

The following chart analyzes the market data recognizing the value-impacting variables in this market.

MARKET DATA ADJUSTMENT GRID					
Comparable Number	1	2	3	4	5
Transaction Type	Sale	Sale	Sale	Sale	Listing
Adjusted Sale Price	$150,000	$190,125	$345,000	$125,100	$490,000
Size (SF)	13,504	10,672	15,682	4,792	32,234
Adjusted Sale (SF)	$11.11	$17.82	$22.00	$26.11	$15.20
Property Rights Conveyed	0%	0%	0%	0%	0%
Financing Terms	0%	0%	0%	0%	0%
Conditions of Sale	0%	5%	0%	0%	0%
Market Conditions	0%	0%	0%	0%	0%
Expenditures After Sale	0%	0%	0%	0%	0%
Subtotal	$11.11	$18.71	$22.00	$26.11	$15.20
Location	+	0	0	0	0
Size	-	-	-	-	-
Offsites	0	0	0	0	0
Configuation	0	0	0	0	0
Frontage/Exposure	0	0	0	0	0
Development Potential	-	-	-	-	-
Overall Adjustment	+	-	-	-	-
Indicated Lower Limit	$11.11 Per SF				
Indicated Upper Limit	$15.20 - $26.11 Per SF				
Indicated Range	$11.11 - $15.20 Per SF				

CONCLUSION

The unadjusted sales prices range from $11.11 to $26.11 per square foot. The accompanying table shows the overall comparison of the market data to the Subject after adjustment.

OVERALL COMPARISON OF SALES TO SUBJECT		
Sale No.	**Inferior**	**Superior**
1	$ 11.11	
2		$ 18.71
3		$ 22.00
4		$ 26.11
5		$ 15.20

The indicated lower limit is $11.11 per square foot. The indicated upper limit is between $15.20 and $26.11 per square foot resulting in an indicated range of value to the Subject between $11.11 and $15.20 per square foot.

From an investor's perspective, a well-positioned and well-managed MOB represents a relatively secure investment opportunity, as there is always a demand for medical care. The two significant factors that relate to value of land designated for a MOB include:

1) the effects of hospitals and hospital proximity on MOBs, and
2) the current medical and political climate, which may alter some of the fundamental aspects of MOB appraisals.

Based on the preceding analysis, none of the comparable data are most representative of the Subject. A price per square foot indication towards the higher end of the range is most appropriate. My conclusion of market value via the S*ales Comparison Approach* is shown in the accompanying table.

LAND VALUATION SUMMARY				
$ / SF		Subject SF		Total
$15.00	x	56,192	=	$842,880

COST APPROACH

To estimate the replacement cost new, the comparative unit method used.

DIRECT COST

The *Marshall Valuation Service* (*MVS*) cost guide, published by Marshall and Swift, Inc., has been used to estimate the direct costs.

Base building costs (direct costs), indicated by the *MVS* cost guide, are adjusted to reflect the physical characteristics. Making these adjustments, including the appropriate local and current cost multipliers, the Direct Building Cost is indicated.

ADDITIONS

Items not included in the direct building cost estimate include parking and walks, signage, landscaping, and miscellaneous site improvements. The cost for these items is estimated separately using the segregated cost sections of the *MVS* cost guide.

INDIRECT COST

Several indirect cost items are not included in the direct building cost figures derived through the *MVS* cost guide. These items include developer overhead (general and administrative costs), property taxes, legal and insurance costs, local development fees and contingencies, lease-up and marketing costs and miscellaneous costs. Research into these costs leads to the conclusion that an average property requires an allowance for additional indirect costs of about 5.0 to 50.0% of the total direct costs.

ENTREPRENEURIAL PROFIT

Entrepreneurial profit represents the return to the developer and is separate from contractor's overhead and profit. This line item, which is a subjective figure, tends to range from 5.0 to 15.0% of total direct and indirect costs for this property type, based on discussions with developers active in this market.

REPLACEMENT COST NEW

Based on the quantity and quality of the available cost data, the Subject's estimated replacement cost new is based primarily on Marshall Valuation Service information.

ACCRUED DEPRECIATION

There are essentially three (3) sources of accrued depreciation:

1. physical deterioration, both curable and incurable;
2. functional obsolescence, both curable and incurable; and
3. external obsolescence.

Physical Deterioration

The Subject's physical condition was summarized in the *Improvement Analysis*. The following chart provides a summary of the remaining economic life.

ECONOMIC AGE AND LIFE (MOB)	
Actual Age	30 Years
Effective Age	20 Years
MVS Expected Life	45 Years
Remaining Economic Life	25 Years
Acrued Physical Incurable Depreciation	44.4%

Functional Obsolescence

Based on a review of the design and layout of the improvements, no forms of curable functional obsolescence were noted.

External Obsolescence

Based on a review of the local retail market and neighborhood, there is nominal external obsolescence.

COST APPROACH CONCLUSION

The value estimate is calculated on the *Cost approach* Schedule shown in the accompanying table.

COST APPROACH				
Building Type:	**MOB**		**Height per Story:**	**9' to 10'**
Quality/Condition:	**Average**		**Gross Building Area:**	
Exterior Wall:	**Wood-Frame**		**MOB**	**16,369 SF**
Number of Stories:	**1**			
Base Building Cost (MOB)				$3,757,898
Additions				
Tenant Improvements				$0
Landscaping & Misc. Site Improvements				$91,000
Subterranean Parking Garage (Included in Base Building Cost)				$0
Other				$0
Direct Building Cost				$3,848,898
Indirect Costs	10.0%	of Direct Building Cost		$384,890
Direct and Indirect Building Cost				$4,233,788
Entrepreneurial Profit	15.0%	of Total Building Cost		$635,068
Replacement Cost New				$4,868,856
Accrued Depreciation				
Curable Physical Deterioration			$0	
Unfinished Shell Space			$0	
Incurable Physical Deterioration	44.4%	of Replacement Cost New less Curable Physical Deterioration	($2,161,772)	
Functional Obsolescence			$0	
External Obsolescence			$0	
Total Accrued Depreciation	44.4%	of Replacement Cost New		($2,161,772)
Depreciated Replacement Cost				$2,707,084
Depreciated Replacement Cost				$2,707,084
Land Value				$842,880
Value Indication				$3,549,964
Rounded				$3,500,000
Value Per SF				$213.82

INCOME CAPITALIZATION APPROACH

Numerous differences exist between medical office buildings and standard office buildings. In major metropolitan markets, the financial condition of an adjoining hospital is considered however; the local market drivers prevail in these rural areas. Financial information is available (https://www.oshpd.ca.gov/HID/Find-Hospital-Data.html) yet; not considered as dominate in determination of achievable rents.

Lease data was collected from the Subject Property. The Subject totals 16,369 SF in gross building area with 16,077 net leaseable area. The original Partnership Agreement involved nine partners that purchased the 56,192 SF on-campus site in May of 1986 for $266,000 or, $4.74 per square foot and developed the facility in the same year.

Northern Inyo Hospital purchased all "partial interests" (medical office suites), except the two remaining Subject interests, in the corporation that owns the building.

It is my understanding after conversations with NIH representatives; the current lease rate at the Subject is $1.25 per square foot per month on a gross lease basis with the tenant responsible for utilities and janitorial. Because NIH offers the suites as part of an overall compensation arrangement to attract physicians; I could not find a consistent trend or confirm the information provided. Therefore I chose not to use this in the analysis.

I assembled information shown in the accompanying table from the Inyo County Assessor's office and per conversations with Mr. Scott Hooker, NIH.

PIONEER MEDICAL BUILDING								
		Transaction		Year	Improv	Adj. Sale	Price	Rent
No.	Seller/Buyer	Type	Date	Built	Suite (SF)	Price	Per SF	Per SF/Month
Suite A	McLennon/NIH	Sale of 18.979%	Oct-03		3,040	$ 396,000	$130.26	
	NIH / Mammoth Hospital	Lease	Aug-04					$ 0.42
Suite B	Kamei & Hathaway	14.63%			2,373			
Suite C	Kamei & Hathaway	14.63%			2,373			
Suite D	Gardner ?	12.82%			2,054			
Suite E	Gardner ?							
Suite F	Kobayashi/NIH	Sale of 12.595%	2007		2,017	$ 21,000	$ 10.41	
Suite G	Clark/NIH	Sale of 8.565%	2008		1,372	$ 198,000	$144.31	
Suite H	Casey/Beck / NIH	Sale of 17.78%	2008		2,848	$ 411,000	$144.31	

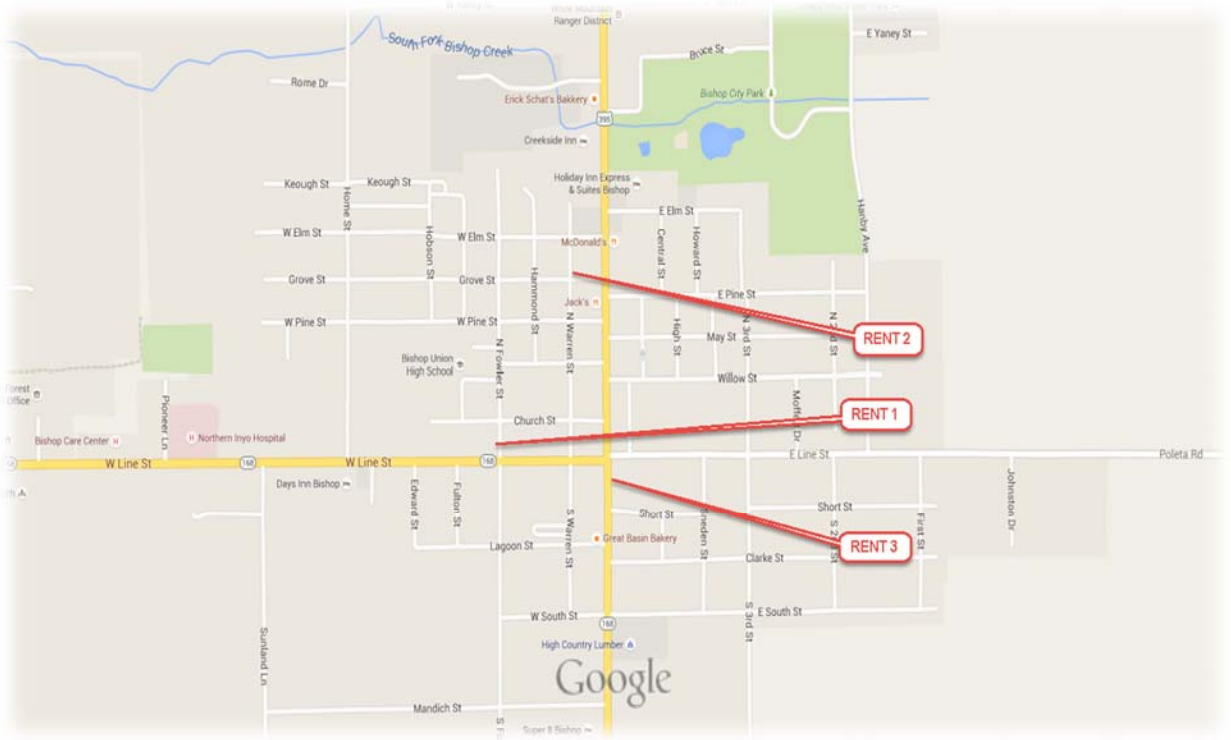
Reader, please note this information is provided for information purposes only. The available information indicates, NIH purchased office suites in the Pioneer Medical

Building based on $10.41 to $144.31 per square foot. No information was available to confirm the sizable range in price per square foot paid for the office suites.

Market participants agreed;

- hospitals, commonly faced with decreased revenue, results in increased competition between hospitals.
- Highly-regarded doctors are the hospitals' primary customers; to attract these physicians, the hospital offers to provide competitively priced high-quality MOB space. Therefore; hospitals are the driving force in the supply and pricing of MOB space.
- Consideration of an achievable rent should address the distorted medical rental comparable data where there is not a true arm's-length transaction.

At this point, I have no comparable on-campus MOB data confirmed as an arm's-length transaction. Hence; I expanded the search for market data off-campus. The following location map and table of rents summarizes the comparable data used in the valuation of the MOB. A detailed description of the rent data is included in the Addenda.



SUMMARY OF COMPARABLE RENTALS

No.	Property Name	Year Built	Occ.	NRA (SF)	Quoted Rental Rate	Expense Basis	Tenant Name	Lease Area (SF)	Lease Date	Term	Monthly Base Rent/SF	CAM
1	Dental Office 645 W. Line Street	1998	100%	2,244	$6,556.36	Modified Gross	Brian L. Carkeet, D.D.S., Inc.	2,244	Jan. 1, 2012	5 Yrs.	$2.92	Modified Net
2	Dental Office 325 Grove Street	1982	100%	1,800	$2,295.00	Net	Overholtzer Property Mgmt Inc.	1800	N/A	5-10 Yrs.	$1.28	Net
3	Mammoth Hospital Bishop Physical Therapy 162 S. Main Street	1964	100%	18,837	$8,600.00	Net	Mammoth Hospital	6,200	N/A	5 Yrs.	$1.39	Net

ANALYSIS OF MOB RENT COMPARABLE DATA

Rent Comparable One

This comparable represents the lease of a wood-frame, 1998-built dental office. The lease commenced January 1, 2012, for a term of five years. The monthly base rent was $2.92 per square foot on a modified net basis. The lease had one year remaining when one of the existing two partners purchased the property. The owning partner agreed not to sell the premises during the term of the lease or any renewal term without notice of price and terms; tenant had the right to exercise a right-of-first-refusal. The tenant was responsible for the interior of the premises while the landlord was responsible for maintenance repair and replacement of the exterior of the premises.

The improvement consists of 2,244 SF and includes one reception area and waiting room, five exam rooms, two office/conference areas, storage, break room and two restrooms in excellent condition.

Rent Comparable Two

This comparable represents the lease of a dental office building. The property was leased by an existing partner for five years on a net lease basis. An existing partner purchased the property and at the time of sale in 2014 the lease rate was $1.28 per square foot per month.

The 1982-built improvement has interior wall finish of painted wallboard with suspended ceiling tiles and suspended fluorescent fixtures. The interior layout includes one reception and waiting room, five exam rooms, two office/conference areas, storage, break room and two restrooms. The improvement has both wall heat and a forced-air gas system and a roof-mounted swamp cooler. The examination rooms are tiled with commercial grade carpeting in corridors and reception areas. Plumbing components include two restrooms, additional sink areas in each examination room and solar hot water. The building improvement is in average overall condition.

Rent Comparable Three

This comparable represents the lease of 6,200 SF in the old Von's building to Mammoth Hospital for a physical therapy office. The improvement consists of an 18,837 SF with retail and medical offices.

According to Mr. Gary Myers, Mammoth Hospital CEO, the lease term is five years on a net basis. Mammoth Hospital completed significant tenant improvements before occupying the space. The current lease rate is $1.39 per square foot per month.

Discussions with Market Participants

Market participants agreed; the immediate office submarket is characterized by smaller local owner/investors who tend to occupy a portion of a larger building. Gross lease terms without base year reimbursements are common, though more sophisticated buildings owners, or owners with property management, include base year stops or some CAM fee. Buildings leased on a gross basis have tenants responsible for utilities and occasionally the CAM and snow removal. Lease terms in the Subject's submarket have typically ranged from month-to-month to five years, and tenant improvement allowances are minimal.

MARKET RENT SUMMARY

The majority of office buildings in Bishop are located in the downtown area fronting on Main Street (US 395) or just off Main Street along Line Street. The typical office space is 1,000 to 5,000 SF, with several governmental spaces of ±10,000 SF, and only a few offices that exceed 10,000 SF.

Due to the lack of sophistication of the Bishop market, there is no consistency in the lease information and terms. Some of the leases are based on a net basis while others are based on a gross lease basis. The immediate submarket is characterized by local businesses and governmental agencies. Lease terms have typically ranged from five- to 10-years, with no tenant improvement allowances.

Rental rates range from $0.65 to $1.60 per square foot, with a variety of lease terms. Asking rates are higher. The majority of the offices are owner-users, with relatively few investors who purchase or develop offices with the intent to rent them out. The relatively small size and tourism /governmental economic base of Bishop does not lend itself to a more typical office rental market commonly found in larger metropolitan communities.

Relocation of the Inyo County Courthouse and the County of Inyo (consolidation of all County offices) from Independence to Bishop continues albeit, at a slow pace. The County of Inyo has been working on consolidation of all the leased and owned space for years. The County currently leases some 40,000 SF in Bishop at an average cost of $1.08 per square foot per month on a gross lease basis.

CONCLUSION

Current rent for a standard office building in Bishop is between $0.65 and $1.60 per square foot per month on varying basis and terms. The typical CAM is between $0.24 and $0.53.

Typically, MOBs lease at higher rates than standard office buildings. Not only are rental rates higher; a MOB can have higher expenses than a typical office building. The Subject improvement is an on-campus stand-alone office building in average condition with an average level of market appeal.

The MOB rent comparable data range from $1.28 to $2.92 per square foot. The rent of $2.92 per square foot for the dental office along W. Line Street is at the high-end of the achievable market rent. The $1.39 per square foot paid by Mammoth Hospital for physical therapy offices along Main Street is at the low end of the achievable rent for the Subject, yet; representative of current market rent for an off-campus medical office. I concluded an achievable market rent for the Subject of $1.45 per square foot per month on a net lease basis.

HISTORIC INCOME AND EXPENSES

No historic income and expense figures were provided.

VACANCY AND COLLECTION LOSS

The rentals surveyed indicate vacancy rates ranging from zero to 100.0%. Considering the current trends discussed in the Market Analysis section, a 4.0% stabilized vacancy loss, with an additional 1.0% collection loss, is reasonable for the Subject property. This results in a total vacancy and collection loss factor equal to 5.0% of potential gross income.

OPERATING EXPENSE ANALYSIS

A MOB can have higher expenses. The greatest variance occurs within the categories of management and utilities. The Subject has MOB tenant improvements; including extensive plumbing, restrooms, examination rooms, cabinets, and storage. Therefore; the standard office building expense comparable data from the local market may not be appropriate.

The typical CAM for a standard office building in Bishop is between $0.24 and $0.53. In estimating the operating expenses for the Subject, I have relied primarily on expense data from the local market as no historical information was provided.

Real Estate Taxes

The real estate taxes for the Subject were previously discussed. As market value assumes a sale, property taxes in my analysis are calculated by applying the published tax rate to the concluded value of the Subject plus direct assessments.

Property Insurance

The insurance expense includes the cost of basic liability as well as multi-peril insurance. It specifically excludes mortgage insurance, earthquake insurance, and boiler insurance. These items reflect owner preferences and are not integral to the operation of the property. The expense comparable indicate a range of $0.33 to $1.00 per square foot. I have estimated an insurance expense equal to $0.75 per square foot.

Utilities (Water, Sewer and Common Area)

Utilities expenses typically include electricity, natural gas, water, sewer and trash removal. Per typical commercial lease agreements, the Tenant is responsible for electrical,

propane, internet and trash service charges. The Landlord is responsible for water, sewer and common area charges. The expense comparable indicate a range of $0.33 to $1.00 per square foot. I have estimated an expense equal to $1.00 per square foot.

General and Administrative

General operating expenses typically include all payroll and payroll related items for all directly employed administrative personnel such as building managers, secretaries, and bookkeepers. Leasing personnel are not included nor are the salaries or fees for off-site management firm personnel and services. This expense category also typically includes administrative expenses such as legal costs pertaining to the operation of the building, telephone, supplies, furniture, temporary help, etc. I have estimated an expense equal to $1.00 per square foot.

Repairs and Maintenance (Exterior)

Included in this expense is the cost of any non-structural repairs and maintenance to the building such as contract services (primarily HVAC maintenance), minor repairs to the physical building components, electrical and plumbing systems, and any labor costs associated with on- or off-site personnel and supplies. Specifically excluded are capital expenditures. The expense comparable indicate a range of $0.25 to $1.57 per square foot. I have estimated a common area maintenance expense equal to $1.00 per square foot.

Landscaping and Security

Landscaping and security expenses are typically handled through outside service contracts. I have estimated an expense equal to $1.00 per square foot.

Management Fee

Typically management fees are written as a percentage of effective gross income. The management fee varies depending upon the type of use and number of tenants. A breakdown of historical management fees were not available. Currently, there is minimal management fee as the owner is acting as the manager. I have utilized a management fee equal to 4.0% of effective gross income.

Reserves for Replacement

In addition to typical operating expenses and non-reimbursable expenses, buyers of investment properties often include a line item replacement reserve for short-lived items. Consistent with investor analyses, this expense is deducted from the annual cash flows in the discounted cash flow analysis but is not used in the estimate of stabilized net operating income.

Total Expense Conclusion

Expenses for the Subject are within the range indicated by the expense comparable data. The assumptions, line-item conclusions, and individual expense estimates are considered reasonable.

DIRECT CAPITALIZATION

Direct capitalization is a method used to convert a single year's estimated stabilized net operating income into a value indication.

CAPITALIZATION RATE

Comparable Sales

The *Sales Comparison Approach* was not used in the analysis due to the lack of comparable building sales. However, two dental office buildings sold to existing partners who were leasing at the time of sale. These data are used as comparable rents and used in determining a market-derived overall capitalization rate. The overall capitalization rates (OARs) confirmed for these sales analyzed are shown in the accompanying table.

COMPARABLE CAPITALIZATION RATES

Rent	Sale Date	Sale Price $/SF	Occupancy	OAR Basis	OAR
1	2014	$ 195.00	100%	Pro-Forma	9.00%
3	2016	$ 200.00	100%	Pro-Forma	7.70%

The overall capitalization rates for these sales were derived based upon the actual or pro-forma income characteristics of the property. These represent the most recent data, which is reflective of current market trends, interest rates, and buyer's expectations and motivation in the market. The local Bishop market is oriented toward owner occupants. The comparable sales exhibited overall capitalization rates of 7.70% and 9.00%.

Additional market data was analyzed due to the weakness of the market-derived capitalization rates.

Published Investor Survey Data and Band of Investment

A second method for establishing an overall capitalization rate for the Subject is to review the criteria of major investors in the marketplace. Most surveys are performed on a national or regional basis. Of the surveys, considered none address the Bishop area specifically. Those surveys considered in this report are the PwC Real Estate Investor Survey, RealtyRates.com, Real Estate Research Corporation.

These surveys typically provide a fairly wide range of cap rates applicable to certain property types and involve only investment or institutional grade properties. Each of the surveys cited in this study reflect what is commonly referred to as investment grade property. This typically includes only class A and good class B level real estate.

The results of the most recent surveys are summarized in the following table.

OVERALL CAPITALIZATION RATES		
Investor Survey	OAR Range	Average
National Medical Office Buildings Market	4.50% - 10.00%	6.78%
Medical Office RealtyRates.com Investor Survey 2nd Quarter 2015	5.84% - 12.87%	8.85%
Source: PwC Real Estate Investor Survey, 3rd Quarter 2016 http://www.realtyrates.com/commentaryg.html		

The band of the investment technique is used as a cross check to the preceding.

BAND OF INVESTMENT					
Mortgage Interest Rate	5.76%				
Mortgage Term (Amortization Period)	23 Years				
Mortgage Ratio (Loan-to-Value)	63%				
Mortgage Constant	0.07855				
Equity Dividend Rate (EDR)	11%				
Mortgage Requirement	63%	x	0.07855	=	0.04949
Equity Requirement	38%	x	0.11240	=	0.04271
	101%				0.09220
Indicated OAR:					**9.20%**
http://www.realtyrates.com/commentaryg.html					

Personal Interviews

I conducted a telephone survey of several real estate investors and advisors to gain insight into the Bishop investment market, focusing on cap rate trends. All agree that the investment market in second-tier cities and resort areas like Bishop are being adjusted by 50-100+ basis points above national cap rates depending on the type of property, and institutional investors have never favored Bishop.

Conversely, this local market is predominately owner-users. Owner-users will adjust the overall rate for diminished risk, include tax benefits and other benefits of ownership 'as income'; reflecting a reduction in expenditures and putting downward pressure on the OAR.

OVERALL CAPITALIZATION RATE CONCLUSION

The following chart summarizes the OAR conclusions.

OVERALL CAPITALIZATION RATE - CONCLUSION	
Source	**Indicated OAR**
Comparable Sales	7.7% - 9.0%
National Investor Survey, 2016	4.5% - 12.8%
Band of Investment	9.20%
Estimate	9.00%

Overall, an OAR in the higher portion of the range is considered appropriate for the following reasons:

- Bishop is a second-tier area where greater risk aversion and increased market gyrations will be the norm. The highest quality assets with credit tenants and staggered, longer-term leases, located in the primary markets will be favored targets.

- Rising health care costs and the desire for accessible medical services are benefitting the national medical office buildings market. However; cost pressures and locational preferences are moving services out of the primary-care hospital setting. More medical providers are seeking tenancy in well-located retail centers.

An overall rate of 9.0% is concluded for the Subject's analysis.

DIRECT CAPITALIZATION SUMMARY

The direct capitalization summary of the Subject's market value is shown in the accompanying table.

DIRECT CAPITALIZATION SUMMARY				
Revenue	Rent	$/SF		Total
Potential Rental Income				
MOB	$ 23,311.65 @	$1.45	$	279,740
Total Revenue			$	279,740
Vacancy and Collection Loss		5%	$	(13,987)
Net Rental Income			$	265,753
Expense Reimbursements		$0.00	$	120,996
Effective Gross Income		$2.00	$	386,749
EXPENSES				
Real Estate Taxes		$15.15	$	34,000
Property Insurance		$0.75	$	12,058
Utilities (Water, Sewer and Common Area)		$1.00	$	16,077
General and Administrative		$1.00	$	16,077
Repairs and Maintenance (Exterior)		$1.00	$	16,077
Landscaping and Security		$1.00	$	16,077
Janitorial		$0.00	$	-
Management Fee		4%	$	10,630
Reserves for Replacement		-	$	-
Operating Expenses		**$7.53**	**$**	**120,996**
Operating Expense Ratio				31.29%
NET OPERATING INCOME		**$1.38**		**$265,753**
OAR			/	9.00%
As Is Value				**$2,952,811**
Less: Lease-up Discount				$0
Total Rounded				**$2,950,000**
Value Per SF				**$183.49**

RECONCILIATION OF VALUE

The value conclusion for each applicable approach is summarized below.

SUMMARY OF VALUE CONCLUSIONS	
Methodology	
Cost Approach	$3,500,000
Sales Comparison Approach	N/A
Income Capitalization Approach	$2,950,000

In the current market, values are below replacement cost; therefore buyers are choosing to purchase existing buildings rather than building-to-suit. Hence, cost to construct is not one of the criteria being considered when a purchase decision is made. However; due to the significant cost involved with development of a MOB the *Cost Approach* applies to the Subject.

The *Cost Approach* to value is reliable, as a market indicator, when the building is new, or nearly new, represents the site's highest and best use, and land values are readily estimated from market data. As the structure becomes older, it is more difficult to accurately estimate the accumulated physical, functional, and economic obsolescence.

Due to the above and the limited volume of comparable on-campus land sales; the *Cost Approach* is considered less applicable and is used primarily as a test of reasonableness.

The *Sales Comparison Approach* is the most direct approach to value and is generally the most easily understood. However, no comparable sales of MOB are available in the area. Two sales of dental offices, purchased by an existing partner, are used in the *Income Capitalization Approach*. These sales are not comparable to the Subject, therefore; the *Sales Comparison Approach* is not used.

None of the market data represent investor participation. The primary market participants are owner-users. Owner-users place significant emphasis on utility of a property rather than its investment value.

The Income Capitalization Approach applies to the Subject property since it is an income producing property that may be leased in the open market. This approach, in which anticipated benefits of ownership are converted into an indication of value, reflects the thinking of the knowledgeable investors in an income-producing investment property. The concluded value by the *Income Approach* was considered to be an accurate indicator of the Subject property's value if it were sold to an investor desiring to lease the building and is given significant emphasis in the final value reconciliation.

My opinion of the "as is" market value, subject to the attached Certification, Limiting Conditions and Special Assumptions, is:

OPINION OF MARKET VALUE			
Appraisal Premise	**Interest Appraised**	**Date of Value**	**Value Conclusion**
Market Value "As Is"	**Fee Simple Estate**	January 19, 2017	**$ 2,950,000**

PARTIAL INTEREST VALUATION

Any division of ownership creates questions as to control and marketability. For an investment property, in particular, issues of control, management, and marketability resulting from divided ownership are detrimental to the ownership position.

The situation of split ownership in real estate, with the parties having proportional rights is common. Normally, the separate parties function as a single entity, and issues of separate value do not arise. When it does, it is normally resolved by sale of the total property (a partition action if court-ordered) and a proportional division of the sale proceeds. In other cases, a private sale is negotiated between the parties, with one party buying out the other.

In neither case does an open market sale of the partial interest occur. Indeed, such sales are very rare.

Common sense would indicate that the issues of control and management, created by divided ownership, would result in some discount relative to the proportional value; and that because of the potential problems of control and management, marketability would be impaired; both combining to reduce market value.

Due to the lack of direct market evidence, I have relied primarily upon a variety of indirect indicators of the existence of, and amount of partial interests discount appropriate to the Subject partial interest. These indirect indicators include a review of literature on the subject, a review of applicable court cases, and evidence from purchases of real estate limited partnership interests on the secondary market.

These articles document the existence and justification of partial interest discounts. The articles, however, generally do not provide a coherent or documented direct methodology for quantifying the amount of the discount. This is particularly true about real property interests. The articles are all in agreement that data from actual arms-length, open market, sale transactions is inadequate (almost non-existent) to use as a basis.

Subject Partial Interest Discount

The indicated data as to real property partial interest discounts generally ranges from 10.0% to over 30.0%. The higher indicators are the discounts in the secondary market for limited partnership interests. Due to their total lack of control and their very small proportional interests, this indicator requires an upward adjustment.

The Subject consists of a single owner-occupied medical office facility with a group of medical professional owners. As a result, the issue of control become less significant.

There are no real major decisions, with inherent decisions as to use, commitments of capital, requirements of financing, and similar long-term issues.

Conclusion of Value 33.474% Undivided Interest

I concluded a 20.0% partial interest discount to be appropriate.

PARTIAL INTEREST VALUATION CONCLUSION		
Fee Simple Interest (100.0%)	$	2,950,000
Pro-rata (33.474%)		33.47%
Pro-rata Value Before Partial Interest Discount	$	987,483
Adjusted for Partial Interest Discount (100.0%-20.0%)		80.00%
Value Conclusion	$	789,986
Rounded	**$**	**790,000**

ASSUMPTIONS AND LIMITING CONDITIONS

1. Unless otherwise specifically noted in the body of the report, it is assumed that title to the property or properties appraised is clear and marketable and that there are no recorded or unrecorded matters or exceptions to total that would adversely affect marketability or value. Cheryl Ann Bretton is not aware of any title defects nor has it been advised of any unless such is specifically noted in the report. Cheryl Ann Bretton, however, has not examined title and makes no representations relative to the condition thereof. Documents dealing with liens, encumbrances, easements, deed restrictions, clouds and other conditions that may affect the quality of title have not been reviewed. Insurance against financial loss resulting in claims that may arise out of defects in the subject property's title should be sought from a qualified title company that issues or insures title to real property.

2. It is assumed that improvements have been constructed or will be constructed according to approved architectural plans and specifications and in conformance with recommendations contained in or based upon any soils report(s).

   Unless otherwise specifically noted in the body of this report, it is assumed: that any existing improvements on the property or properties being appraised are structurally sound, seismically safe and code conforming; that all building systems (mechanical/electrical, HVAC, elevator, plumbing, etc.) are, or will be upon completion, in good working order with no major deferred maintenance or repair required; that the roof and exterior are in good condition and free from intrusion by the elements; that the property or properties have been engineered in such a manner that it or they will withstand any known elements such as windstorm, hurricane, tornado, flooding, earthquake, or similar natural occurrences; and, that the improvements, as currently constituted, conform to all applicable local, state, and federal building codes and ordinances. Cheryl Ann Bretton professionals are not engineers and are not competent to judge matters of an engineering nature. Cheryl Ann Bretton has not retained independent structural, mechanical, electrical, or civil engineers in connection with this appraisal and, therefore, makes no representations relative to the condition of improvements. Unless otherwise specifically noted in the body of the report: no problems were brought to the attention of Cheryl Ann Bretton by ownership or management; Cheryl Ann Bretton inspected less than 100% of the entire interior and exterior portions of the improvements; and Cheryl Ann Bretton was not furnished any engineering studies by the owners or by the party requesting this appraisal. If questions in these areas are critical to the decision process of the reader, the advice of competent engineering consultants should be obtained and relied upon. It is specifically assumed that any knowledgeable and prudent purchaser would, as a precondition to closing a sale, obtain a satisfactory engineering report relative to the structural integrity of the property and the integrity of building systems. Structural problems and/or building system problems may not be visually detectable. If engineering consultants retained should report negative factors of a material nature, or if such are later discovered, relative to the condition of improvements, such information could have a substantial negative impact on the conclusions reported in this appraisal. Accordingly, if negative findings are reported by engineering

consultants, Cheryl Ann Bretton reserves the right to amend the appraisal conclusions reported herein.

3. Unless otherwise stated in this report, the existence of hazardous material, which may or may not be present on the property was not observed by the appraisers. Cheryl Ann Bretton has no knowledge of the existence of such materials on or in the property. Cheryl Ann Bretton, however, is not qualified to detect such substances. The presence of substances such as asbestos, urea formaldehyde foam insulation, contaminated groundwater or other potentially hazardous materials may affect the value of the property. The value estimate is predicated on the assumption that there is no such material on or in the property that would cause a loss in value. No responsibility is assumed for any such conditions, or for any expertise or engineering knowledge required to discover them. The client is urged to retain an expert in this field, if desired.

   I have inspected, as thoroughly as possible by observation, the land; however, it was impossible to personally inspect conditions beneath the soil. Therefore, no representation is made as to these matters unless specifically considered in the appraisal.

4. All furnishings, equipment and business operations, except as specifically stated and typically considered as part of real property, have been disregarded with only real property being considered in the report unless otherwise stated. Any existing or proposed improvements, on or off-site, as well as any alterations or repairs considered, are assumed to be completed in a workmanlike manner according to standard practices based upon the information submitted to Cheryl Ann Bretton. This report may be subject to amendment upon re-inspection of the subject property subsequent to repairs, modifications, alterations and completed new construction. Any estimate of Market Value is as of the date indicated; based upon the information, conditions and projected levels of operation.

5. It is assumed that all factual data furnished by the client, property owner, owner's representative, or persons designated by the client or owner to supply said data are accurate and correct unless otherwise specifically noted in the appraisal report. Unless otherwise specifically noted in the appraisal report, Cheryl Ann Bretton has no reason to believe that any of the data furnished contain any material error. Information and data referred to in this paragraph include, without being limited to, numerical street addresses, lot and block numbers, Assessor's Parcel number, land dimensions, square footage area of the land, dimensions of the improvements, gross building areas, net rentable areas, usable areas, unit count, room count, rent schedules, income data, historical operating expenses, budgets, and related data. Any material error in any of the above data could have a substantial impact on the conclusions reported. Thus, Cheryl Ann Bretton reserves the right to amend conclusions reported if made aware of any such error. Accordingly, the client-addressee should carefully review all assumptions, data, relevant calculations, and conclusions within 30 days after the date of delivery of this report and should immediately notify Cheryl Ann Bretton of any questions or errors.

6. The date of value to which any of the conclusions and opinions expressed in this report apply, is set forth in the Letter of Transmittal. Further, that the dollar amount of any value opinion herein rendered is based upon the purchasing power of the American Dollar on that date. This appraisal is based on market conditions existing as of the date of this appraisal. Under the terms of the engagement, I will have no obligation to revise this report to reflect events or conditions which occur subsequent to the date of the appraisal. However, Cheryl Ann Bretton will be available to discuss the necessity for revision resulting from changes in economic or market factors affecting the subject.
7. Cheryl Ann Bretton assumes no private deed restrictions, limiting the use of the subject property in any way.
8. Unless otherwise noted in the body of the report, it is assumed that there are no mineral deposit or subsurface rights of value involved in this appraisal, whether they be gas, liquid, or solid. Nor are the rights associated with extraction or exploration of such elements considered unless otherwise stated in this appraisal report. Unless otherwise stated it is also assumed that there are no air or development rights of value that may be transferred.
9. Cheryl Ann Bretton is not aware of any contemplated public initiatives, governmental development controls, or rent controls that would significantly affect the value of the subject.
10. The estimate of Market Value, which may be defined within the body of this report, is subject to change with market fluctuations over time. Market value is highly related to exposure, time promotion effort, terms, motivation, and conclusions surrounding the offering. The value estimate(s) consider the productivity and relative attractiveness of the property, both physically and economically, on the open market.
11. Any cash flows included in the analysis are forecasts of estimated future operating characteristics are predicated on the information and assumptions contained within the report. Any projections of income, expenses and economic conditions utilized in this report are not predictions of the future. Rather, they are estimates of current market expectations of future income and expenses. The achievement of the financial projections will be affected by fluctuating economic conditions and is dependent upon other future occurrences that cannot be assured. Actual results may vary from the projections considered herein. Cheryl Ann Bretton does not warrant these forecasts will occur. Projections may be affected by circumstances beyond the current realm of knowledge or control of Cheryl Ann Bretton.
12. Unless specifically set forth in the body of the report, nothing contained herein shall be construed to represent any direct or indirect recommendation of Cheryl Ann Bretton to buy, sell, or hold the properties at the value stated. Such decisions involve substantial investment strategy questions and must be specifically addressed in consultation form.
13. Also, unless otherwise noted in the body of this report, it is assumed that no changes in the present zoning ordinances or regulations governing use, density, or shape are

being considered. The property is appraised assuming that all required licenses, certificates of occupancy, consents, or other legislative or administrative authority from any local, state, nor national government or private entity or organization have been or can be obtained or renewed for any use on which the value estimates contained in this report is based, unless otherwise stated.

14. This study may not be duplicated in whole or in part without the specific written consent of Cheryl Ann Bretton nor may this report or copies hereof be transmitted to third parties without said consent, which consent Cheryl Ann Bretton reserves the right to deny. Exempt from this restriction is duplication for the internal use of the client-addressee and/or transmission to attorneys, accountants, or advisors of the client-addressee. Also exempt from this restriction is transmission of the report to any court, governmental authority, or regulatory agency having jurisdiction over the party/parties for whom this appraisal was prepared, provided that this report and/or its contents shall not be published, in whole or in part, in any public document without the express written consent of Cheryl Ann Bretton which consent Cheryl Ann Bretton reserves the right to deny. Finally, this report shall not be advertised to the public or otherwise used to induce a third party to purchase the property or to make a "sale" or "offer for sale" of any "security", as such terms are defined and used in the Securities Act of 1933, as amended. Any third party, not covered by the exemptions herein, who may possess this report, is advised that they should rely on their own independently secured advice for any decision in connection with this property. Cheryl Ann Bretton shall have no accountability or responsibility to any such third party.

15. Any value estimate provided in the report applies to the entire property, and any pro ration or division of the title into fractional interests will invalidate the value estimate, unless such pro ration or division of interests has been set forth in the report.

16. The distribution of the total valuation in this report between land and improvements applies only under the existing program of utilization. Component values for land and/or buildings are not intended to be used in conjunction with any other property or appraisal and are invalid if so used.

17. The maps, plats, sketches, graphs, photographs and exhibits included in this report are for illustration purposes only and are to be utilized only to assist in visualizing matters discussed within this report. Except as specifically stated, data relative to size or area of the subject and comparable properties has been obtained from sources deemed accurate and reliable. None of the exhibits are to be removed, reproduced, or used apart from this report.

18. No opinion is intended to be expressed on matters which may require legal expertise or specialized investigation or knowledge beyond that customarily employed by real estate appraisers. Values and opinions expressed presume that environmental and other governmental restrictions/conditions by applicable agencies have been met, including but not limited to seismic hazards, flight patterns, decibel levels/noise envelopes, fire hazards, hillside ordinances, density, allowable uses, building codes, permits, licenses, etc. No survey, engineering study or architectural analysis has been made known to Cheryl Ann Bretton unless otherwise stated within the body of this

report. If the Consultant has not been supplied with a termite inspection, survey or occupancy permit, no responsibility or representation is assumed or made for any costs associated with obtaining same or for any deficiencies discovered before or after they are obtained. No representation or warranty is made concerning obtaining these items. Cheryl Ann Bretton assumes no responsibility for any costs or consequences arising due to the need, or the lack of need, for flood hazard insurance. An agent for the Federal Flood Insurance Program should be contacted to determine the actual need for Flood Hazard Insurance.

19. Acceptance and/or use of this report constitutes full acceptance of the Contingent and Limiting Conditions and special assumptions set forth in this report. It is the responsibility of the Client, or client's designees, to read in full, comprehend and thus become aware of the aforementioned contingencies and limiting conditions. Neither the Appraiser nor Cheryl Ann Bretton assumes responsibility for any situation arising out of the Client's failure to become familiar with and understand the same. The Client is advised to retain experts in areas that fall outside the scope of the real estate appraisal/consulting profession if so desired.
20. Cheryl Ann Bretton assumes that the subject property analyzed herein will be under prudent and competent management and ownership; neither inefficient or super-efficient.
21. It is assumed that there is full compliance with all applicable federal, state, and local environmental regulations and laws unless noncompliance is stated, defined and considered in the appraisal report.
22. No survey of the boundaries of the property was undertaken. All areas and dimensions furnished are presumed to be correct. It is further assumed that no encroachments to the realty exist.
23. The *Americans with Disabilities Act* (ADA) became effective January 26, 1992. Notwithstanding any discussion of possible readily achievable barrier removal construction items in this report, Cheryl Ann Bretton has not made a specific compliance survey and analysis of this property to determine whether it is in conformance with the various detailed requirements of the ADA. It is possible that a compliance survey of the property together with a detailed analysis of the requirements of the ADA could reveal that the property is not in compliance with one or more of the requirements of the ADA. If so, this fact could have a negative effect on the value estimated herein. Since Cheryl Ann Bretton has no specific information relating to this issue, nor is Cheryl Ann Bretton qualified to make such an assessment, the effect of any possible non-compliance with the requirements of the ADA was not considered in estimating the value of the subject property.
24. Additional work requested by the client beyond the scope of this assignment will be billed at my prevailing hourly rate. Preparation for court testimony, update valuations, additional research, depositions, travel, or other proceedings, will be billed at my prevailing hourly rate, plus reimbursement of expenses.
25. Please note that my consent to allow an appraisal report prepared by Cheryl Ann Bretton, or portions of such report, to become part of or be referenced in, any offering

or other material intended for the review of others, or to be submitted to others, the granting of such consent will be at my sole discretion and, if given, will be on condition that I will be provided with an Indemnification Agreement and/or Non-Reliance letter, in a form and content satisfactory to us, by a party satisfactory to us. I do consent to your submission of the report to other prospective readers without the need to provide me with an Indemnification Agreement and/or Non-Reliance letter.

26. In addition to the fee for this assignment, you agree to compensate me at a rate to be mutually agreed to, for any time expended by me should I be required (by subpoena or otherwise) or requested by you, your representatives or other entity to become involved in any litigation or legal proceeding in any way involving this engagement to which I am not a party, the appraisal work I produce or the property which is the subject of this assignment. You also agree to pay, on demand, all expenses which I incur in connection with any litigation or proceedings including the fees of my attorneys.

27. You acknowledge that I am being retained hereunder as an independent contractor to perform the services described herein and nothing in this agreement shall be deemed to create any other relationship between us. This assignment shall be deemed concluded and the services hereunder completed upon delivery to you of the appraisal report discussed herein.

28. This study is not being prepared for use in connection with litigation and this document is not suitable for use in a litigation action. Accordingly, no rights to expert testimony, pretrial or other conferences, deposition, or related services are included with this appraisal. If, as a result of this undertaking, Cheryl Ann Bretton or any of its principals, its appraisers or consultants are requested or required to provide any litigation services, such shall be subject to the provisions of my engagement letter or, if not specified therein, subject to the reasonable availability of Cheryl Ann Bretton and/or said principals or appraisers at the time and shall further be subject to the party or parties requesting or requiring such services paying the then-applicable professional fees and expenses of Cheryl Ann Bretton either in accordance with the provisions of the engagement letter or arrangements at the time, as the case may be.

ADDENDA

QUALIFICATIONS

APPRAISER'S QUALIFICATIONS

GENERAL **Cheryl A. Bretton, MAI**

Resident: Mammoth Lakes, California
Post Office Box 100 PMB 466
Mammoth Lakes, CA 93546
Office: (760) 709-0496
E-mail: appraisal@cherylbretton.com

PROFESSIONAL DESIGNATION AND AFFILIATION

The Appraisal Institute:
Designation: MAI #12328

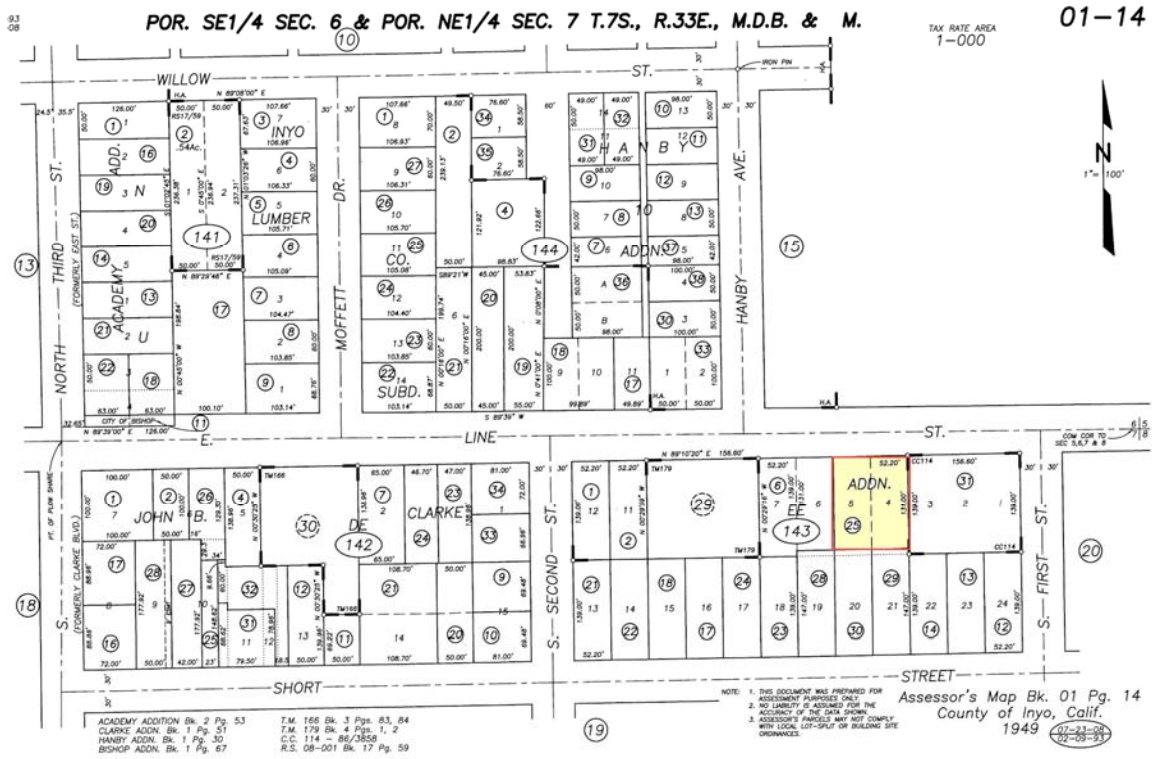
Office of Real Estate Appraisers – State of California
Designation: CA Certification – Number AGO23954

State of Nevada – Department of Business and Industry
Designation: NV Certification – License No. 04174

Department of Real Estate – State of California
Designation: Broker – Number 00863524

COMPARABLE LAND SALE MARKET DATA

Land Sale No. 1



Property Identification

Address	474 E. Line Street, Bishop, Inyo County, California
Tax ID	001-143-25

Sale Data

Grantor	Howard & DL Cleland Trust
Grantee	David & Lisa Kuznitz
Sale Date	December 27, 2012
Deed Book/Page	2012 4247
Marketing Time	305
Financing	Cash
Verification	Jes Schwartzkopf / Mammoth Realty Group; 760 / 934-6000
Sale Price	$150,000

Land Data

Zoning	General Commercial / C-2

Land Size Information

Gross Land Size	0.310 Acres or 13,504 SF

Land Sale No. 1 (Cont.)

Indicators

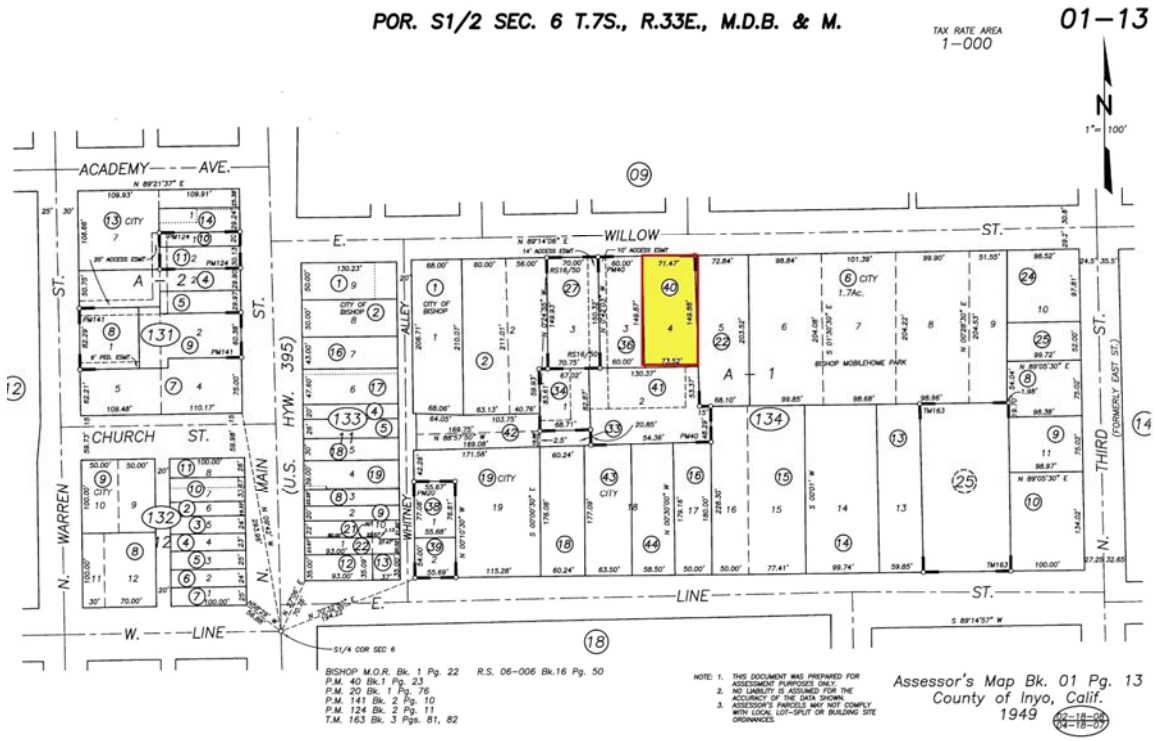
Sale Price/Gross Acre	$483,871
Sale Price/Gross SF	$11.11

Remarks

This comparable sold at $11.11 per square foot in December 2012. The property consists of a 0.31-acre parcel located in the City of Bishop, East of US 395 along E. Line Street. The area is mixed use with residential and commercial, which would be similar to the Subject's development, though overall superior in area with a downtown location. The site is developed with a 1949-built warehouse given little value. The improvement will require significant updating and repairs.

The property was exposed to the open market for 305 days with an original asking price of $299,000. The property sold, all cash, for $150,000 in December of 2012.

Land Sale No. 2



Property Identification

Property Type	Commerical Vacant Land
Address	194 E. Willow Street, Bishop, Inyo County, California 93514
Tax ID	001-134-040

Sale Data

Grantor	Stater, Robin M
Grantee	Bishop Creek Lodge, Inc.
Sale Date	May 07, 2015
Deed Book/Page	2015 1082
Property Rights	Fee Simple
Marketing Time	26
Financing	Cash
Sale History	Listed and expired at $269,000
Verification	Seller / Robin Stater; 760/934-4122, Susan O'Brian / Mammoth Realty Group
Sale Price	$190,125

Land Data

Zoning	General Commercial, C-2 / City of Bishop

Land Sale No. 2 (Cont.)

Topography	Level
Utilities	City of Bishop
Fencing	Yes

Land Size Information

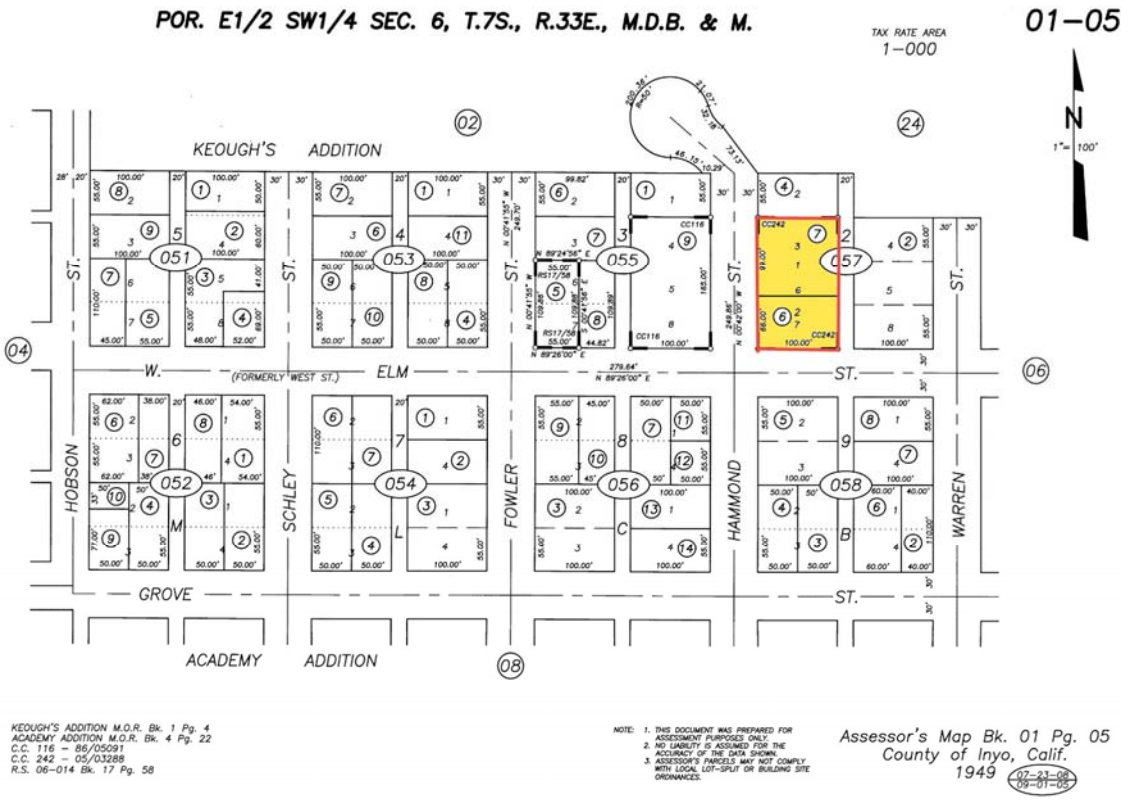
Gross Land Size	0.245 Acres or 10,672 SF

Remarks

This comparable represents the sale of a vacant commercial lot along Willow Street in the city of Bishop. The property was on and off the market for years with the most recent asking price of $215,000. The site sold in May 2015 for $190,125 or, $17.82 per square foot to a local investor. The Seller will reserved a 'view corridor' via a deed restriction.

In 2008, the site was purchased by the adjoining owner (4-plex) for $189,000 or, $17.74 per square foot. The property was available on the open market for 273 days @ $269,000 in May of 2007. The site was purchased for storage and truck parking.

Land Sale No. 3



Property Identification

Address	686 Hammond Street, Bishop, Inyo County
Tax ID	001-057-004 & 007

Sale Data

Grantor	Buck Trust
Grantee	Holman Trust
Sale Date	July 09, 2014
Deed Book/Page	2014 1687
Marketing Time	230
Financing	Cash
Verification	Leon Buck / Owner
Sale Price	$345,000

Land Data

Zoning	CG / R-3-P City of Bishop

Land Size Information

Gross Land Size	0.360 Acres or 15,682 SF

Land Sale No. 3 (Cont.)

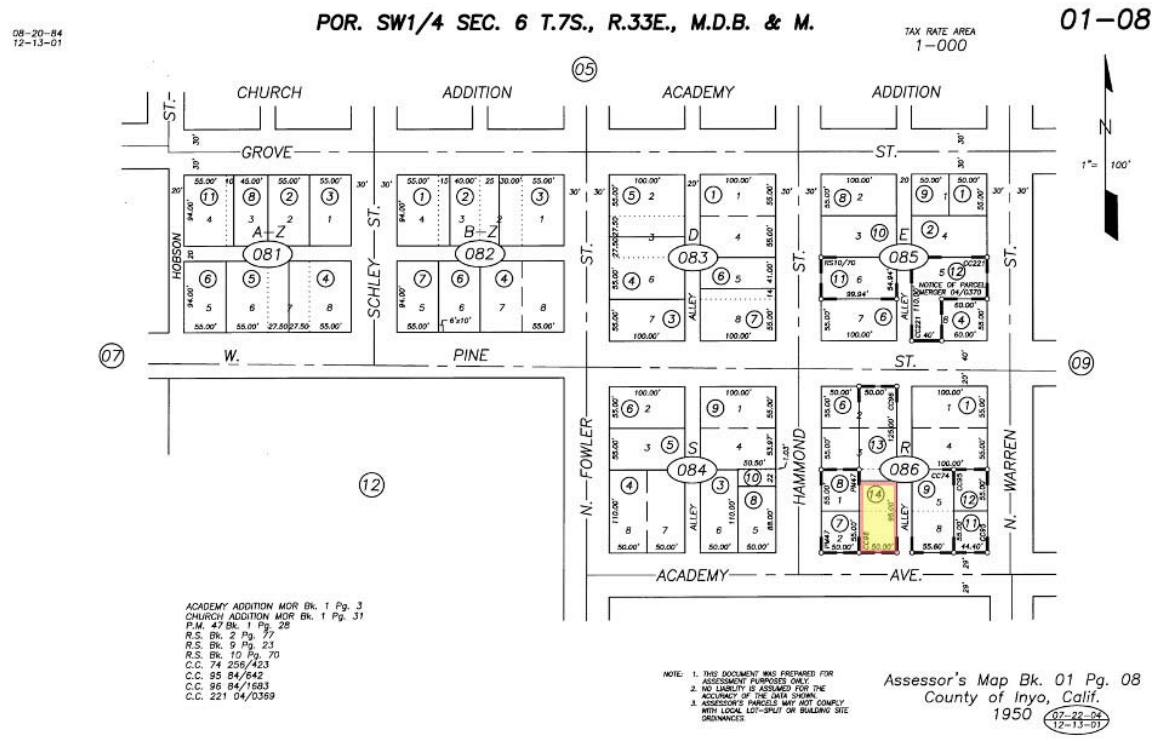
Indicators

Sale Price/Gross Acre	$958,333
Sale Price/Gross SF	$22.00

Remarks

This comparable represents the sale of two legal lots. The site was improved with an older SFR given no value. The property sold for future development to multifamily residential. The property was exposed to the open market for 230 days with an asking price of $345,000 and sold for $345,000 or $22.00 per square foot.

Land Sale No. 4



Property Identification

Address	Academy Avenue, Bishop, Inyo County, California
Tax ID	001-086-14

Sale Data

Grantor	BCI Coco-Cola Bottling Co.
Grantee	Steven White
Sale Date	June 03, 2014
Deed Book/Page	2014 1253
Financing	Cash
Sale Price	$125,100

Land Data

Zoning	GC / C-1

Land Size Information

Gross Land Size	0.110 Acres or 4,792 SF

Indicators

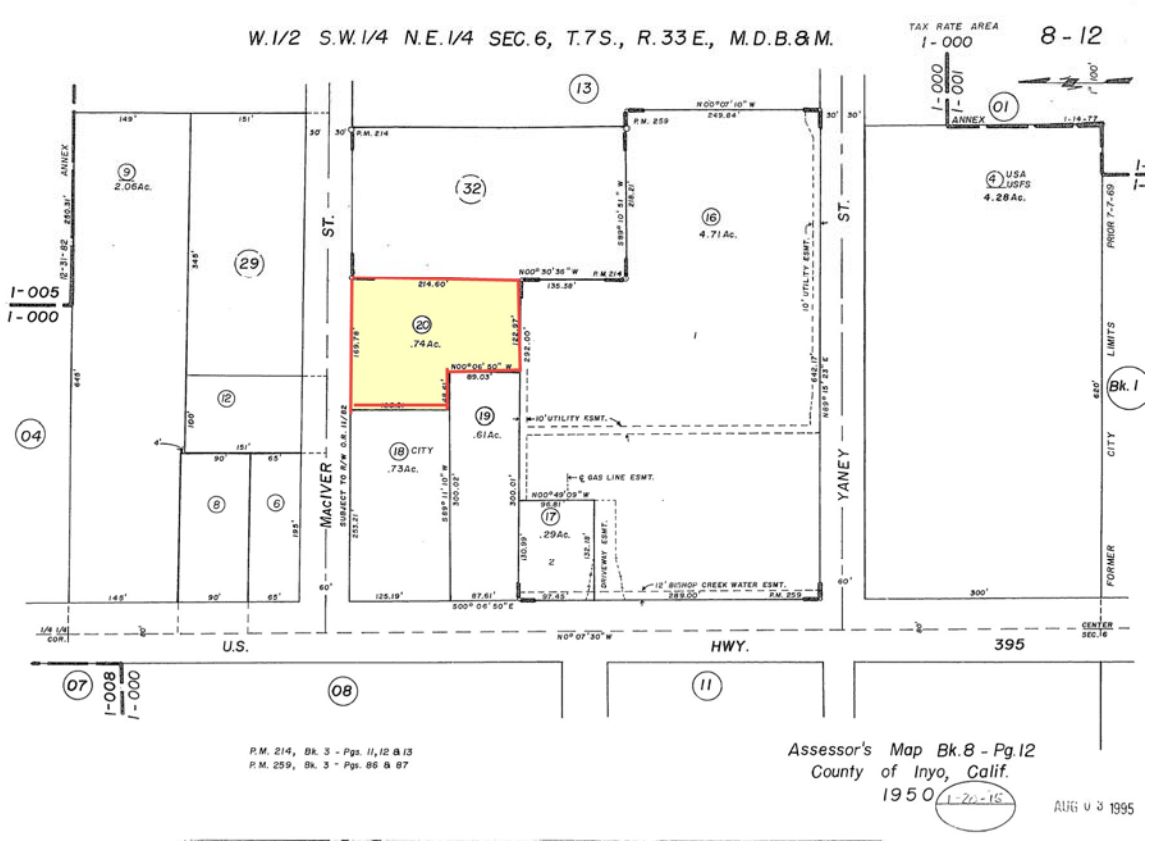
Sale Price/Gross Acre	$1,137,273
Sale Price/Gross SF	$26.11

Land Sale No. 4 (Cont.)

Remarks

This comparable represents the sale of a vacant commercial lot purchased by an adjoining land and business owner. The property was not exposed to the open market and sold all cash for $125,100 or, $26.11 per square foot.

Land Listing No. 5



Property Identification

Property Name	106 Mac Iver Street
Address	106 Mac Iver Street, Bishop, Inyo County, California 93546
Tax ID	008-120-020

Sale Data

Grantor	Salvation Army
Grantee	Salvation Army, a California Corporation
Survey Date	January 10, 2017
Deed Book/Page	2010 0852
Marketing Time	15
Financing	Cash
Sale History	2010 / $550,000
Verification	Randi Pritchard / Eastern Sierra Realty; 760 / 937-4442
Listing Price	$490,000

Land Data

Zoning	Commercial General and Retail, C-1 City of Bishop

Land Listing No. 5 (Cont.)

Land Size Information

Gross Land Size	0.740 Acres or 32,234 SF

Indicators

Sale Price/Gross Acre	$662,162
Sale Price/Gross SF	$15.20

Remarks

A prior sale is reported in June 2004 for $400,000 followed by the 2010 sale for $550,000. This site was purchased by the Salvation Army for future development to a community center/thrift store. The development was scrapped and the site has been available on the open market for 15 days with an asking price of $490,000.

COMPARABLE LEASE DATA

Improved Lease No. 1

Property Identification

Record ID	40
Property Type	Commercial, MOB
Property Name	Carkeet Dental Office
Address	645 W. Line Street, Bishop
Tax ID	001-110-004

Physical Data

SF	2,244
Year Built	1998
Condition	Good

General Lease Data

Tenant	Brian L. Carkeet, DDS, Inc.
Typical Lease Term	Five Years
Lease Type	Modified Net

General Tenant
Summary

Owner	Hopkins Enterprises, LP
Verification	Dr. Carkeet

Remarks

This comparable represents the lease of a wood-frame, 1998-built dental office. The lease commenced January 1, 2012 for a term of five years. The monthly base rent was $2.92 per square foot on a modified net basis. The lease had one year remaining when one of the existing two partners purchased the property. The owning partner agreed not to sell the premises during the term of the lease or any renewal term without notice of price and terms; tenant had the right to exercise a right-of-first-refusal. The tenant was responsible for the interior of the premises while the landlord was responsible for maintenance repair and replacement of the exterior of the premises.

The improvement consists of 2,244 square feet and includes one reception area and waiting room, five exam rooms, two office/conference areas, storage, break room and two restrooms in excellent condition.

Improved Lease No. 2

Property Identification

Record ID	41
Property Type	Commercial, MOB
Property Name	Overholtzer Dental Office
Address	325 Grove Street, Bishop
Tax ID	001-056-014

Physical Data

Land Size	0.130 Acres or 5,663 SF
SF	1,800
Year Built	1982

General Lease Data

Tenant	Overholtzer Property Mgmt. Inc.
Typical Lease Term	Five Years
Lease Type	Net

General Tenant Summary

Owner	Talbot Trust
Verification	Dr. Overholtzer

Improved Lease No. 2 (Cont.)

Remarks

This comparable represents the lease of a dental office building. The 1982-built improvement has interior wall finish of painted wallboard with suspended ceiling tiles and suspended fluorescent fixtures. The interior layout includes (1) reception and waiting room, (5) exam rooms, (2) office/conference areas, storage, break room and (2) restrooms. The improvement has both wall heat and a forced-air gas system and a roof-mounted swamp cooler. The examination rooms are tiled with commercial grade carpeting in corridors and reception areas. The foundation is of reinforced concrete slab with brick exterior decorative and wood-frame walls. The roof of the building is asphalt shingle. Plumbing components include two (2) restrooms, additional sink areas in each examination room and solar hot water.

The property was leased on a ten-year term. The existing partner purchased the property.

Improved Lease No. 3

Property Identification	
Property Type	Commercial, Mixed Use
Property Name	Mammoth Hospital - Southern Mono Healthcare District
Address	162 S. Main Street, Bishop
Tax ID	001-182-40
Physical Data	
Land Size	1.010 Acres or 43,996 SF
SF	6,200
General Lease Data	
Tenant	Mammoth Hospital - Southern Mono Healthcare District
General Tenant Summary	
Owner	RJG Investments LLC
Verification	Mr. Gary Myers

This comparable represents the lease of 6,200 SF in the old Von's building to Mammoth Hospital for a physical therapy office. The improvement consists of an 18,837 SF with retail and medical offices.

According to Mr. Gary Myers, Mammoth Hospital CEO, the lease term is five years on a net basis. Mammoth Hospital completed significant tenant improvements before occupying the space. The current lease rate is $1.39 per square foot per month.

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Employee Drug and Alcohol Policy	
Departments/Scope: Human Resources	
Source: Human Resources	Effective Date:

PURPOSE:

The use of illegal drugs and alcohol misuse by employees are inconsistent with the Hospital's long-standing commitment to maintain a safe, healthy, and productive work environment and a drug-free workplace. Illegal drugs are controlled substances that are not being used or possessed under the supervision of a doctor or other licensed health care professional.

Additional information about the dangers of drug abuse and alcohol misuse in the workplace, sources of help for drug and alcohol problems, this policy, and the consequences that may result from violations of this policy, is available from Human Resources.

POLICY:

1. Whenever employees are working, operating Hospital vehicles, machinery, or equipment, present on Hospital premises, or present in any other location performing services for the Hospital, they are prohibited from:

    a. using, possessing, buying, selling, manufacturing, distributing, dispensing or transferring illegal drugs;
    b. being under the influence of illegal drugs or alcohol; and
    c. possessing or consuming alcohol.

    The Hospital acknowledges that California law permits limited uses of marijuana. However, because such use is still not allowed under federal law, marijuana is considered illegal use under this policy.

2. Employees should report to work fit for duty and free of any adverse effects of illegal drugs or alcohol.

3. This policy does not prohibit employees from the lawful possession and use of prescribed medications. Employees have the responsibility to consult with their doctors or other licensed health care professionals about the effect of prescribed medications on their ability to perform their specific job duties in a safe manner, and to promptly disclose any work restrictions to their supervisors/managers or Human Resources. Employees should not, however, disclose underlying medical conditions, impairments or disabilities unless specifically directed to do so by their doctors or other licensed health care professionals.

4. Employees may possess and consume alcohol at authorized Hospital functions or in certain legitimate business settings such as client entertainment. At all such times, however, employees are expected to act responsibly and to drink moderately (not to the point that they are under the influence). The Hospital may withdraw these privileges if they are abused by an employee or if an employee violates this policy.

5. The Hospital reserves the right to conduct reasonable suspicion and other drug and alcohol tests in accordance with the requirements of state and federal law. Any employee refusing to submit to a requested drug and/or alcohol test may be subject to termination of employment. Employees whose test or tests are positive will not be permitted to work while under the influence of alcohol or with a detectable level of prohibited drugs or alcohol in their system. They will be sent home immediately pending further action and will be given an appointment with the Director of Human Resources.

6. The Hospital reserves the right to inspect all parts and aspects of its premises for illegal drugs, alcohol or other contraband. All employees and visitors may be asked to cooperate in inspections of their persons, work areas and property (such as purses, lunch boxes/bags, briefcases, desks, lockers or cars) that might conceal illegal drugs, alcohol or other contraband.

7. Employees who violate this policy will be subject to appropriate disciplinary action up to and including termination of employment. Depending on the circumstances, an employee's return to work, reinstatement and/or continued employment may be conditioned on the employee's successful participation in and/or completion of a counseling, treatment, or rehabilitation program, the passing of a return-to-duty evaluation or follow-up drug and alcohol tests, and/or other appropriate conditions as determined by the Hospital.

8. Employees with drug and alcohol problems are encouraged to seek help (including, for instance, referral to the Employee Assistance Program) before they become subject to discipline for violating this or other Hospital policies. The Hospital will support, assist, and accommodate such employees to the extent required by applicable law. Employees will not be disciplined by Hospital because they request assistance or accommodation. Employees may not, however, escape discipline by requesting assistance after they violate the Hospital's policies. In addition, employees who request assistance will not be excused from complying with the Hospital's policies, including its standards for employee performance and conduct.

9. The Hospital has implemented a Drug-Free Awareness Program and will occasionally conduct meetings to inform employees of (1) the dangers of drug abuse in the workplace; (2) this drug-free workplace policy; (3) available counseling, rehabilitation and employee assistance programs; and (4) penalties that may be imposed upon employees for drug abuse violations.

Committee Approval	**Date**
Compliance Committee	

Policy and Procedure Committee	
Medical Executive Committee	
Administration	
Board of Directors	

CALL TO ORDER	The meeting was called to order at 5:30 pm by Peter Watercott, President.
PRESENT	Peter Watercott, President John Ungersma MD, Vice President M.C. Hubbard, Secretary Mary Mae Kilpatrick, Treasurer Phil Hartz, Member at Large
ALSO PRESENT	Kevin S. Flanigan MD, MBA, Chief Executive Officer Kelli Huntsinger, Chief Operating Officer Carrie Petersen, Chief Accounting Officer John Tremble, Interim CFO Maria Sirois, Chief Performance Excellence Officer Alison Murray, Interim Chief Human Relations Officer Tracy Aspel, Chief Nursing Officer Sandy Blumberg, Executive Assistant
ABSENT	Joy Engblade MD, Chief of Staff
OPPORTUNITY FOR PUBLIC COMMENT	Mr. Watercott asked if any members of the public wished to comment on any items listed on the agenda for this meeting. No comments were heard.
CONSENT AGENDA	Mr. Watercott called attention to the Consent Agenda for this meeting, which contained the following items: - *Approval of minutes of the January 18 2017 regular meeting* - *2013 CMS Validation Survey Monitoring, February 2017* It was moved by Phil Hartz, seconded by John Ungersma MD, and unanimously passed to approve both consent agenda items as presented, with two housekeeping changes being made to the minutes of the January 18 2017 regular meeting.
FINANCIAL AND STATISTICAL REPORTS AS OF DECEMBER 31, 2016	Chief Accounting Officer Carrie Petersen called attention to the financial and statistical reports for the period ending December 31 2016, noting the following: - Patient volume was down in all areas, with the exception of the Emergency Department - The District funded an Intergovernmental Transfer (IGT) during the month, however incoming dollars from that IGT will not be received until the next accounting period - Long term debt decreased as a result of bond payments made in the month of December - Salaries and wages were under budget and professional fees expense was over budget due to the use of contracted employees - The bottom line excess of expenses over revenues for the month of December was $541,175, however year-to-date we are at a positive $462,859

It was moved by Mary Mae Kilpatrick, seconded by M.C. Hubbard and unanimously passed to approve the financial and statistical reports for the period ending December 31 2016 as presented.

STRATEGIC PLAN UPDATE

Chief Executive Officer Kevin S. Flanigan MD, MBA provided an update on progress made toward achieving the goals of the Northern Inyo Healthcare District (NIHD) Strategic Plan.

CHIEF OF STAFF REPORT

On behalf of Chief of Staff Joy Engblade MD Doctor Flanigan reported following careful review, consideration, and approval by the appropriate Committees the Medical Executive Committee recommends approval of the following hospital-wide policies and procedures, protocols, and order sets:

1. *Cesarean Delivery* (supersedes both *Cesarean Deliveries – Nurses Responsibilities in the OR* and *Cesarean Delivery - Emergency*
2. *Fall Risk Prevention - Perinatal*
3. *Death, Disposition of Body*
4. *Pronouncement of Death*
5. *Scope of Services, Infusion Center*
6. *Scheduling Surgical Procedures*
7. *Patient Safety Attendant or 1:1 Staffing Guidelines*
8. *Credentialing Healthcare Practitioners in the Event of a Disaster*
9. *Medical Staff and Allied Health Professional Application Fee Processing*
10. *Transfusion Criteria*
11. New Transfusion Reaction Document

It was moved by Doctor Ungersma, seconded by Ms. Kilpatrick, and unanimously passed to approve policies 1 through 11 as presented.

Doctor Flanigan also reported the Medical Executive Committee recommends annual approval of the following Critical Indicators:

- Emergency Room Service
- Surgery, Tissue, Transfusion, and Anesthesia
- Medicine/Intensive Care

It was moved by Doctor Ungersma, seconded by Ms. Hubbard, and unanimously passed to approve all three Critical Indicators as requested.

Dr. Flanigan additionally reported that following careful review, consideration, and approval by the appropriate Committees the Medical Executive Committee recommends approval of the following Medical Staff appointments and privileging:

- Saif Siddiqui MD (Teleradiology)
- Robert James MD (Pathology – Locum tenens)

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

The Medical Executive Committee additionally recommends approval of the following:

- Performance Monitoring Plan – Focused Professional Practice Evaluation (FPPE) of Sarah Zuger MD (Family Medicine & OB/Gyn; evaluation methods to include direct observation, medical record review, and discussion with peers (including OB evaluation) for 5 procedures and 5 discharges (Plan set forth by Anne Gasior MD)
- New Practitioner Evaluation Recommendation – (FPPE) for Cecilia Rhodus MD (Pediatrics). Findings: Practitioner has demonstrated competency in performing the clinical privileges granted, evaluation completed by Charlotte Helvie MD
- New Practitioner Evaluation Recommendation – (FPPE) for Manish Pandya MD (Internal Medicine/Hospitalist). Findings: Practitioner has demonstrated competency in performing the clinical privileges granted. Evaluation completed by Joy Engblade MD

It was moved by Mr. Hartz, seconded by Doctor Ungersma, and unanimously passed to approve all three FPPE plans and recommendations as requested.

Doctor Flanigan also stated the Medical Executive Committee recommends the addition of "Portacath Insertion" to interventional radiology privileges. It was moved by Ms. Hubbard, seconded by Doctor Ungersma, and unanimously passed to approve the addition to interventional radiology privileges as requested.

CHIEF EXECUTIVE OFFICER REPORT

Dr. Flanigan provided a Chief Executive Officer report which included the following:

- The modular insert for the Pharmacy has been installed and Northern Inyo Hospital (NIH) is now in compliance with the California Board of Pharmacy (BOP). NIHD Administration; the California Department of Public Health; the Office of State Wide Health Planning and Development (OSHPD); and the California BOP continue to work together to bring the hospital pharmacy into compliance with all three agencies
- The District has hired Mr. Larry Weber to act as Director of Diagnostic Imaging and Laboratory. Mr. Weber will be present at the March regular meeting for purposes of introduction.
- The Electronic Health Record (EHR) Assessment Committee has been formed and will begin looking into the best EHR options available for the District as soon as possible
- The hospital is looking for a new 340B vendor to replace Sentry, who has not fulfilled the obligations of their contract. NIHD continues to partner with Dwayne's Pharmacy in the 340B program.

CHIEF OPERATING OFFICER REPORT

Kelli Huntsinger provided a Chief Operating Officer report which included an introduction of NIHD Dietician Amber Morin. Ms. Morin has recently implemented an outpatient referral program and is also working on dietary referrals with several local agencies, including Toiyabe Indian Health Project.

CHIEF ACCOUNTING OFFICER REPORT

Chief Accounting Officer Carrie Petersen introduced the NIHD revenue cycle team and provided an overview of accounting department functions and services including Admissions and Registration; Credit and Billing; Accounts Payable; Purchasing, Payroll; Veterans services; and the Charity Care program.

CHIEF NURSING OFFICER REPORT

Dr. Flanigan was pleased to report that Tracy Aspel RN has accepted the position of permanent Chief Nursing Officer for NIHD. Ms. Aspel provided an update on Nursing Department activities, which included reporting that a permanent Perinatal Unit Nurse Manager will be coming on board to replace Summer Gilstrap RN, who has filled that position on a temporary basis. Ms. Aspel expressed her appreciation of the outstanding job that Ms. Gilstrap has done for the Healthcare District. She additionally provided an overview of a proposed Nursing Management restructure; and discussed the District's efforts to grow its own (future) managers internally. She additionally reported on the use of Nitrox in the perinatal unit.

CHIEF HUMAN RELATIONS OFFICER REPORT

Interim Chief Human Relations Officer Alison Murray provided an overview of NIHD employee and physician recruiting efforts; as well as a review of current job openings with the District. Ms. Murray noted that in the last year the number of contracted workers employed by the District has been more than cut in half, and many hard to fill positions have been filled with permanent employees. Additionally, the Human Relations Department continues to streamline internal processes.

CHIEF PERFOMANCE EXCELLENCE OFFICER REPORT

Chief Performance Excellence Officer Maria Sirois provided a report which included updates on the following projects:

- Joint Commission Accreditation monitoring
- California Department of Public Health (CDPH) survey readiness
- Development of a hospital-wide Quality Assurance and Performance Improvement Plan
- Service Excellence Trainings for employees
- Antibiotic Stewardship projects
- Workplace Violence assessment
- Language Services assessment
- Pillars of Excellence data and reports

DISTRICT COMPLIANCE REPORT

District Compliance Officer Patty Dickson provided a compliance report which included a review of Protected Health Information (PHI) breaches for the 2016 calendar year; and a review of compliance issues, inquiries, and audits. Ms. Dickson additionally stated that a Business Ethics and

Compliance Committee will be established in the next couple of months, and Director Hubbard volunteered to serve as a member of that Committee.

ANNUAL POLICY AND PROCEDURE APPROVALS

Mr. Watercott called attention to a list of Policies and Procedures presented for annual approval at this meeting, which were included as attachment "A" to the agenda for this meeting. It was moved by Ms. Hubbard, seconded by Mr. Hartz, and unanimously passed to approve all policies and procedures submitted for annual approval as presented.

OLD BUSINESS

BISHOP UNION HIGH SCHOOL CLINIC UPDATE

Bishop Union High School (BUHS) Superintendent Barry Simpson provided an update on the progress of a proposed student health clinic being established on the Bishop high school campus. The proposed clinic would provide students access to healthcare services relating to confidential and sensitive issues including pregnancy; addiction counseling; disease prevention; etc., as allowed for by State law. The Healthcare District would potentially provide a nurse practitioner to provide services for students one or two days per week. The BUHS School Board has yet to approve the clinic concept and is currently debating the controversial elements of this issue and drafting an informational letter for parents. Discussion on this topic followed and it was noted that this may be listed as an action item on the agenda for the March NIHD Board meeting. Director Hartz stated his desire for this topic to be given more than one additional month of consideration. It was noted that if approved, the clinic could potentially open in the fall of 2017.

NURSING DEPARTMENT POLICY AND PROCEDURE APPROVALS

Chief Nursing Officer Tracy Aspel called attention to the following proposed Nursing Department policies and procedures:

- *Admission of a Pediatric Patient*
- *Admission to the Acute/Sub Acute Department*
- *Care Plan, Inpatient*
- *Down Time Procedures for OP, PACU*
- *Fixed Floating*
- *Staffing Huddle*
- *Surgery Charges*
    - *Surgery Charges, Attachment*

It was moved by Ms. Hubbard, seconded by Doctor Ungersma, and unanimously passed to approve all 7 policies and procedures as presented, with two housekeeping changes being made to the content.

HOSPITAL WIDE POLICY AND PROCEDURE APPROVALS

Interim Chief Human Relations Officer Alison Murray called attention to a hospital wide policy and procedure titled *Exempt Employees*, which has been updated in order to comply with current law. It was moved by Ms. Kilpatrick, seconded by Mr. Hartz, and unanimously passed to approve the revised *Exempt Employees* policy and procedure as presented.

Doctor Flanigan also called attention to the following list of proposed or updated hospital wide policies and procedures:

- *Paid Absence*
- *United States Postal Service Mail*
- *Medicare Outpatient Observation Notice*
- *Charge Master Procedures for Clinics*
- *Charity Care Program*

It was moved by Director Hartz, seconded by Ms. Kilpatrick, and unanimously passed to approve all 5 hospital wide policies and procedures as presented.

RADIOLOGY RFP PROCESS AND CONTRACT

Doctor Flanigan provided an overview of the Radiology Services Request For Proposal (RFP) and selection process recently conducted to establish the District's next radiology provider agreement. He explained that *Tahoe Carson Radiology* (TCR) has provided excellent radiology coverage for the District for the last several years; however the RFP process netted a different supplier, which is the *Bishop Radiology* group. Doctor Flanigan expressed his appreciation of TCR's dedication to this community, their level of professionalism, and of the quality of services provided. District legal counsel is in the process of finalizing the details for the new contract with *Bishop Radiology*, based on the guidelines provided in Radiology Services Exhibits A and B. NIHD Staff radiologist and TCR group member Edmund Pillsbury MD spoke on behalf of TCR inquiring as to what their group could have done better in order to have been awarded the contract renewal. Doctor Flanigan explained that many aspects of the Radiology RFP process are confidential; however he will contact TCR Administration on this subject. It was then moved by Ms. Hubbard, seconded by Doctor Ungersma, and passed to establish a new contract with the *Bishop Radiology* group as requested, with Director Hartz voting "no" on this agenda item.

DISTRICT COMPLIANCE PLAN

Compliance Officer Patty Dickson called attention to a proposed Compliance Program for Northern Inyo Healthcare District, noting that the purpose of a Compliance Plan and program is to prevent waste, fraud, and abuse within the organization. Following review of the information provided it was moved by Ms. Kilpatrick, seconded by Mr. Hartz, and unanimously passed to approve the Compliance Program for NIHD as presented, with housekeeping corrections being noted.

DIET MANUAL AND MENUS, RD's FOR HEALTHCARE

Dietician Amber Morin called attention to a Proposed Diet Manual and menus, prepared for the District by *RD's for Healthcare Inc*.. Ms. Morin explained improvements are constantly being made to NIHD Dietary services, and this new manual and menus will improve patient and employee food services even further. It was moved by Ms. Kilpatrick, seconded by Ms. Hubbard, and unanimously passed to approve the *RD's for Healthcare Inc*. Diet Manual and menus as requested.

CARE ACT LETTER OF SUPPORT	Doctor Flanigan called attention to a proposed letter of support for reintroduction of the bipartisan *Critical Access and Rural Equity (CARE) Act*, as recommended by Interim Chief Financial Officer John Tremble. Passage of the CARE Act would help allow Critical Access Hospitals to continue to provide services to rural communities and be reimbursed by Medicare at an appropriate rate. It was moved by Mr. Hartz, seconded by Ms. Hubbard, and unanimously passed to approve the letter of support for the CARE Act as presented.
BOARD MEMBER REPORTS	Mr. Watercott asked if any members of the Board of Directors wished to report on any items of interest. Director Ungersma reported on the annual Association of California Healthcare Districts (ACHD) Leadership Academy, which was recently attended by Directors Ungersma, Hubbard, and Kilpatrick.
ADJOURNMENT TO CLOSED SESSION	At 8:57 pm Mr. Watercott reported the meeting would adjourn to closed session to allow the Board of Directors to: A. Hear reports on the hospital quality assurance activities from the responsible department head and the Medical Staff Executive Committee (*Section 32155 of the Health and Safety Code, and Government Code Section 54962*). B. Confer with legal counsel regarding pending and threatened litigation, existing litigation and significant exposure to litigation, 3 matters pending (*pursuant to Government Code Section 54956.9*). C. Discuss trade secrets, new programs and services (estimated public session date for discussion yet to be determined)(*Health and Safety Code Section 32106*). D. Discussion of a personnel matter (*pursuant to Government Code Section 54957*).
RETURN TO OPEN SESSION AND REPORT OF ACTION TAKEN	At 9:55 pm the meeting returned to open session. Mr. Watercott reported that the Board took no reportable action.
ADJOURNMENT	The meeting was adjourned at 9:56 pm.

_____

Peter Watercott, President

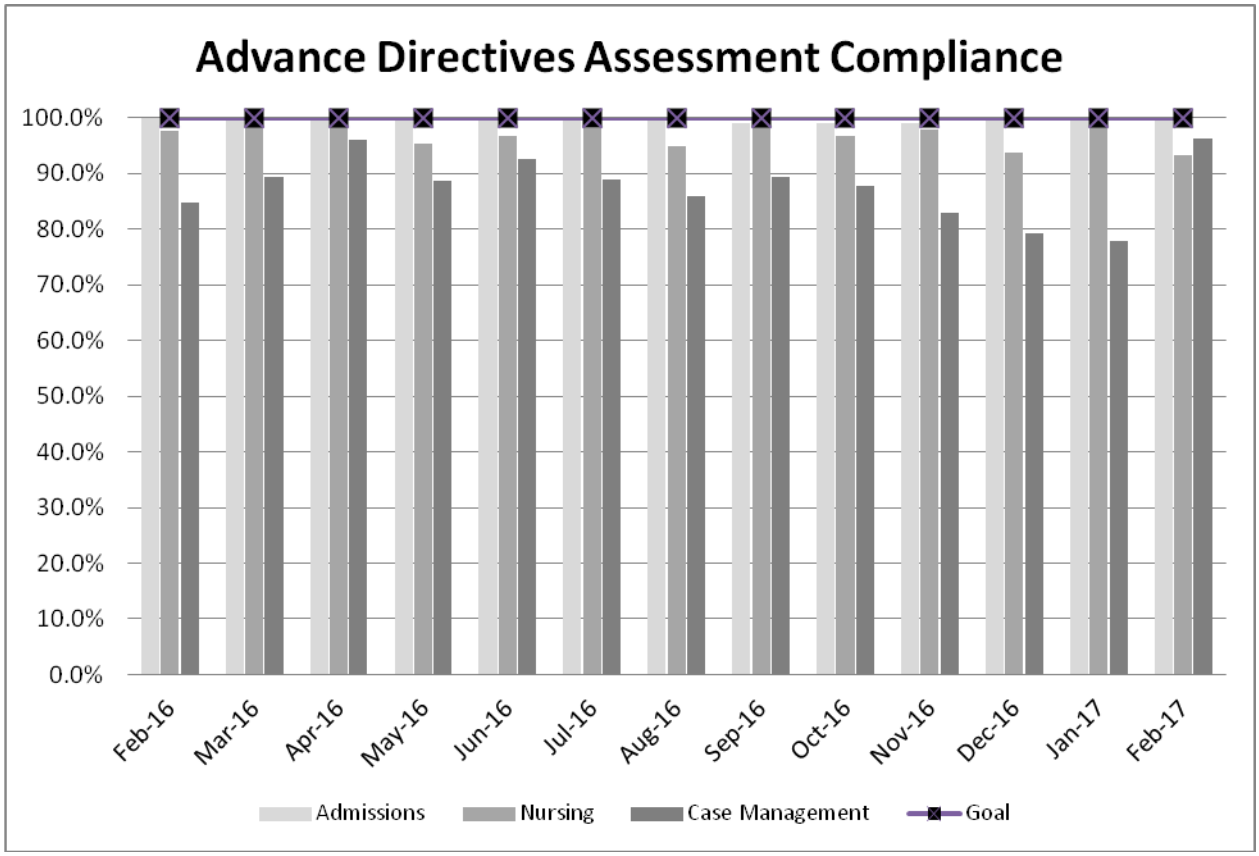
Attest: _____

M.C. Hubbard, Secretary

2013 CMS Validation Survey Monitoring-March 2017

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

    a. Advance Directives Monitoring.

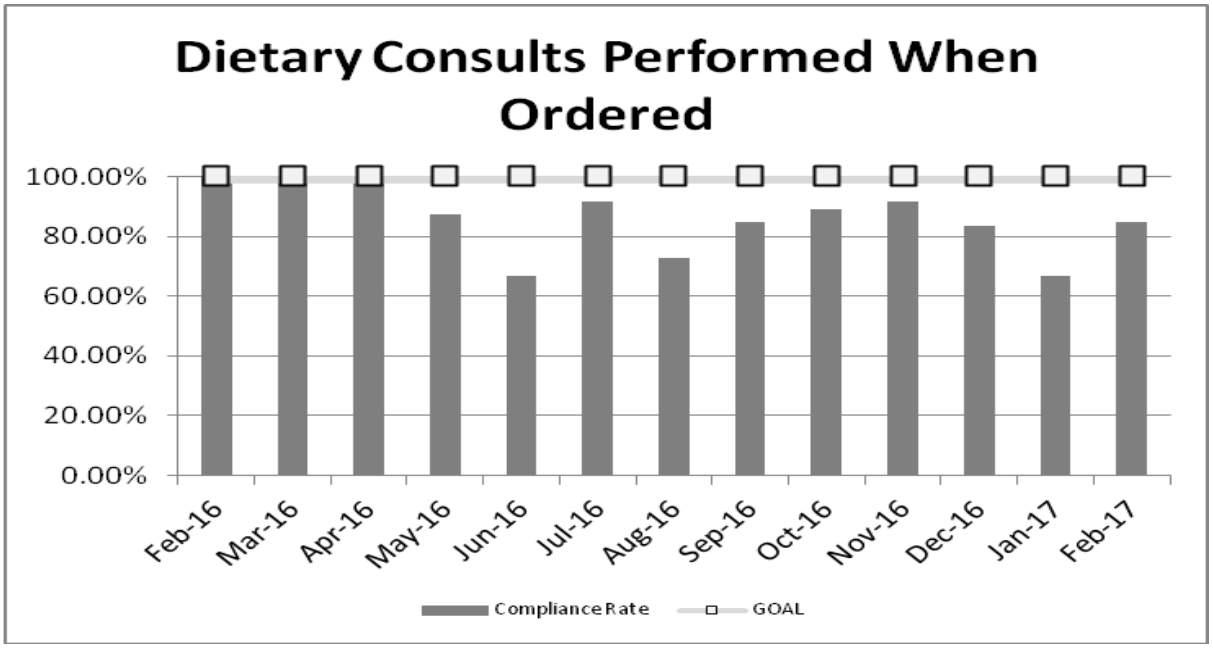


    b. Positive Lab Cultures are being routed to Infection Prevention and each positive is being investigated as to source. Monitoring has been ongoing and reported through Infection Control Committee. QAPI receives data.

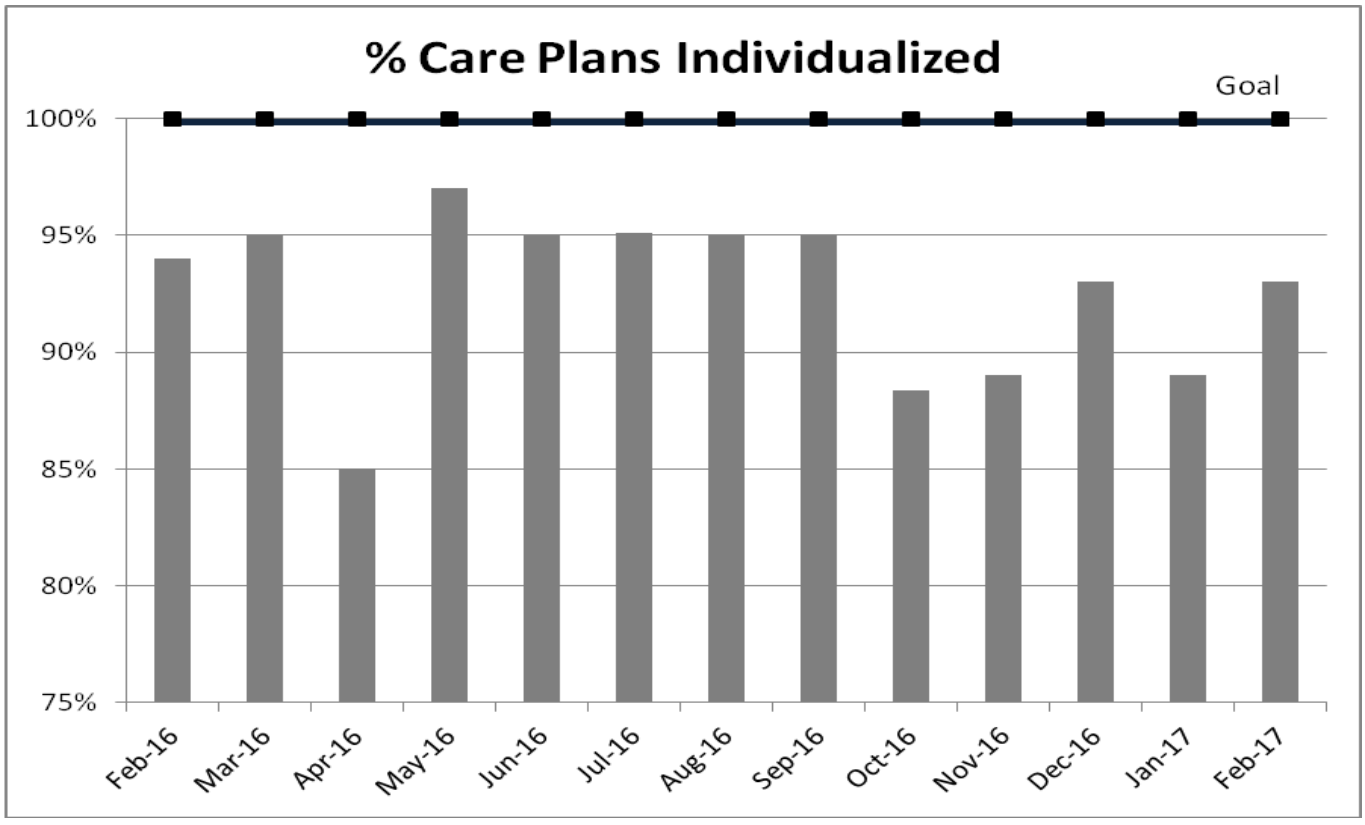
    c. Safe Food cooling monitored for compliance with approved policy and procedure. 100% compliance since May 6, 2013.

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

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

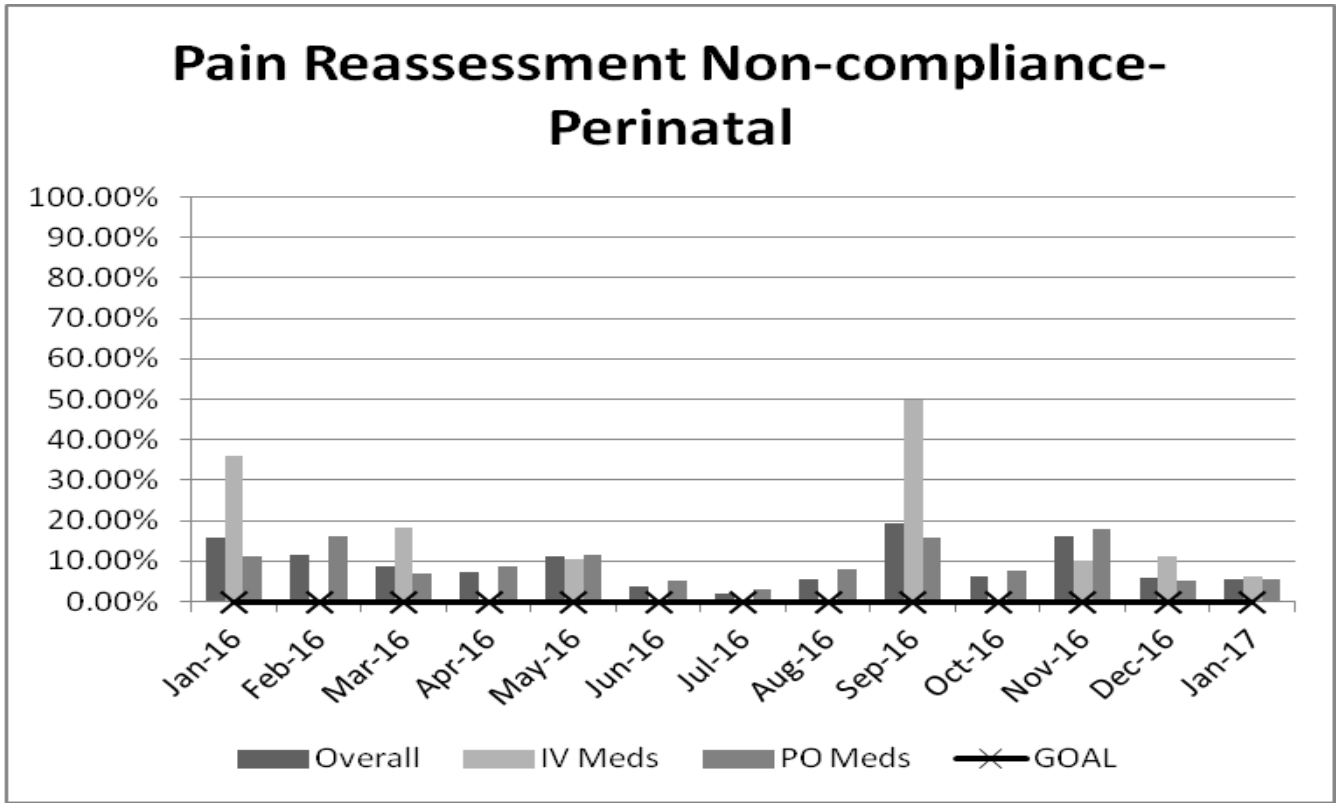


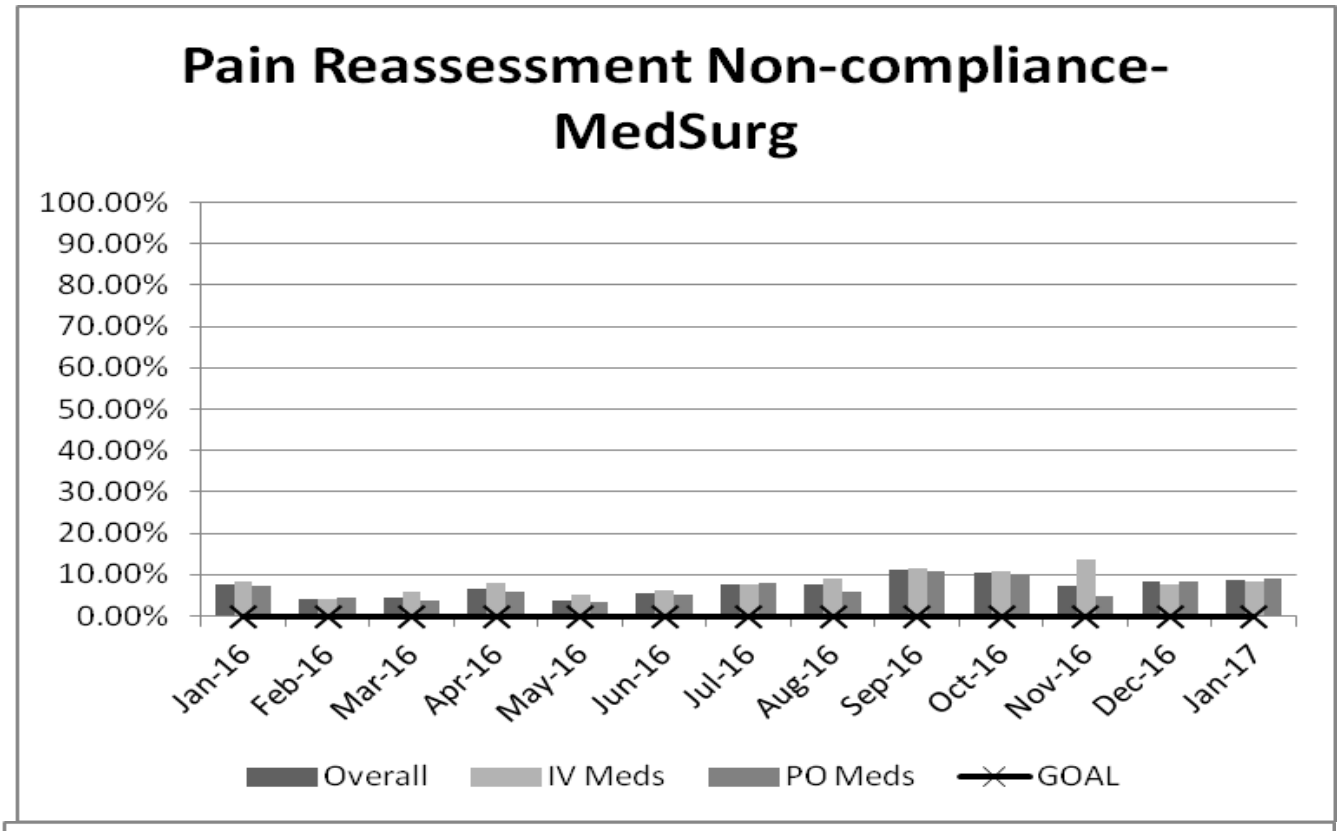
f. Care plans reviewed by Case Management and interventions made to produce care plans. Progress has been made in developing individualized care plans.

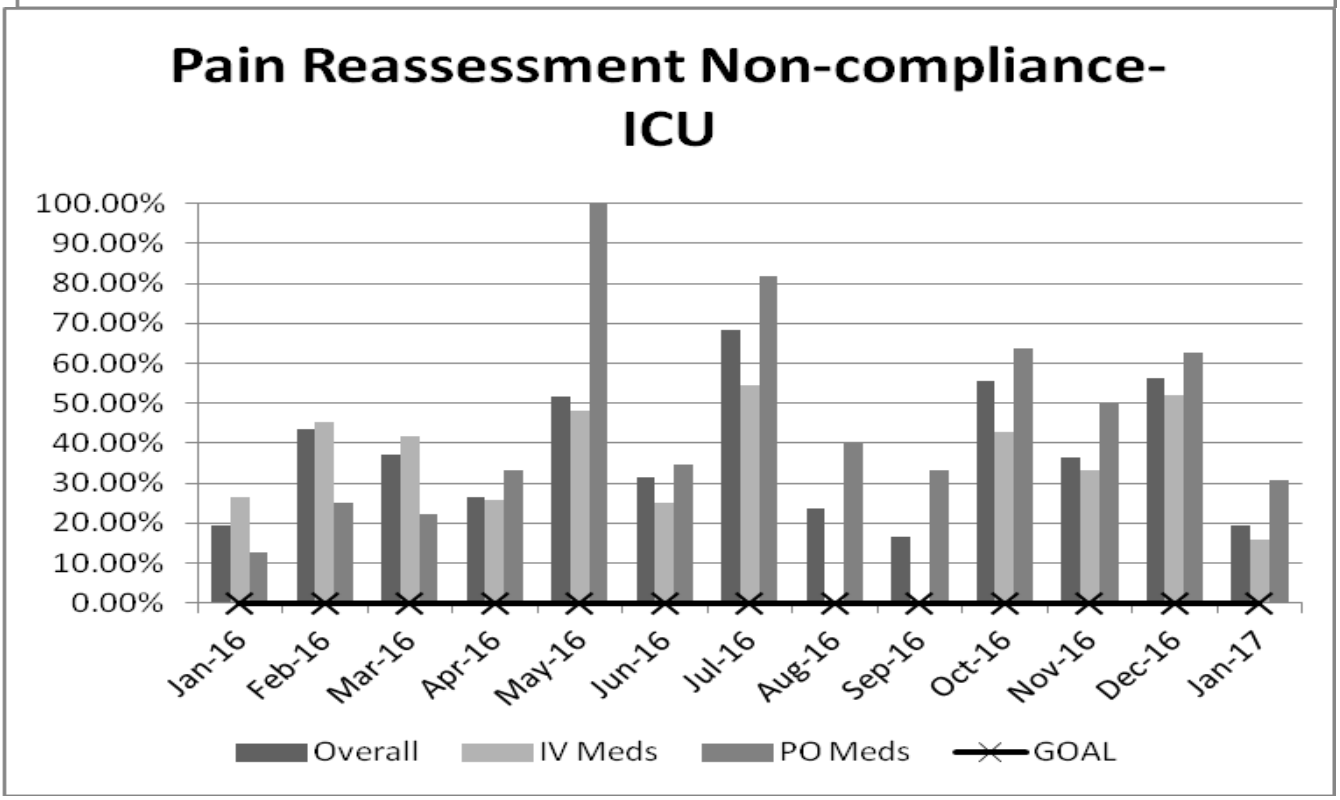


g. Fire drill date, times, attendance and outcomes, smoke detector tests, and fire extinguisher test grids have been approved. All fire drills were complete and compliant from May 6, through present.

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







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

Table 6. Restraint chart monitoring for legal orders.

	Aug 2016	***Sept 2016***	***Oct 2016***	***Nov 2016***	***Dec 2016***	***Jan 2017***	***Feb 2017***	***Goal***
Restraint verbal/written order obtained within 1 hour of restraints	1/1 (100%)	1/1 (100%)	1/2 (50%)	1/1 (100%)	2/2 (100%)	2/2 (100%	1/1 (100%)	100%
Physician signed order within 24 hours	1/1 (100%)	1/1 (100%)	1/2 (50%)	0/1 (0%)	2/2 (100%)	½ (50%)	1/1 (100%)	100%
Physician Initial Order Completed (all areas completed and form/time/date noted/signed by MD and RN)	0/1 (0%)	0/1 (0%)	0/2 (0%)	0/1 (0%)	2/2 (100%)	0/2 (0%)	1/1 (100%)	100%
Physician Re-Order Completed (all areas completed and form time/date/noted/signed by MD and RN)	0/1 (0%)	N/A	2/4 (50%)	1/3 (33%)	2/2 (100%)	3/9 (33%)	0/1 (0%)	100%
Orders are for 24 hours	2/2 (100%)	1/1 (100%)	5/6 (83%)	4/4 (100%)	4/4 (100%)	11/11 (100%)	2/2 (100%)	100%
Is this a PRN (as needed) Order	0/2 (0%)	0/1 (0%)	0/6 (0%)	0/4 (0%)	0/4 (0%)	0/11 (0%)	0/2 (0%)	0%

NORTHERN INYO HEALTHCARE DISTRICT

BUDGET VARIANCE ANALYSIS

Jan-17 *Fiscal Year Ending June 30, 2017*

Year to date for the month ending January 31, 2017

-476	or	-19%	less IP days than in the prior fiscal year
$ (3,518,171)	or	-13.22%	under budget in Total IP Revenue and
$ (357,861)	or	-0.7%	under budget in OP Revenue resulting in
$ (3,876,032)	or	-4.9%	under budget in gross patient revenue &
$ (1,291,467)	or	-2.8%	under budget in net patient revenue

Year-to-date Net Revenue was			$ 45,071,871
Total Operating Expenses were:			$ 42,517,664
			for the fiscal year to date
$ (441,785)	or	-1.0%	under budget. Salaries and Wages were
$ (1,974,644)	or	-13.0%	under budget and Employee Benefits
$ 80,537	or	0.8%	over budget.
		75%	Employee Benefits Percentage of Wages

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

$ 1,232,774	or	24.7%	Professional Fees due to Contract Employees and reflected in salaries and wages being under budget
$ 53,643	or	1.8%	Depreciation Expense continues to run high based on capital purchases
$ 65,340	or	2.9%	Other Expenses are running high due to travel/education that has happened in the first half of fiscal year; should even out over year

Other Information:

$ 2,880,529		Operating Income, less
$ (2,175,830)		loss in non-operating activities created a net income of;
$ 704,698	$ (70,594)	under budget.
	39.67%	Contractual Percentages for Year and
	41.00%	Budgeted Contractual Percentages including

$ 3,637,518 in prior year cost report settlement activity for Medicare & Medi-Cal including Intergovernment Transfer Funds (IGT) from Managed Care Medi-Cal & Contractuals are also reduced for the PRIME IGT of $1,490,000 and Final for Medicare 15

Non-Operating actives included:

$ (2,331,149) loss	$ (111,071)	under budget in Medical Office Activities
$ (70,883)	$ (156,292)	under budget in 340B Pharmacy Activity

Northern Inyo Healthcare District
Balance Sheet
Period Ending January 31, 2017

Assets:	Current Month	Prior Month	Change
Current Assets			
Cash and Equivalents	4,421,769	672,074	3,749,696
Short-Term Investments	9,787,990	11,814,167	(2,026,177)
Assets Limited as to Use	-	-	-
Plant Replacement and Expansion Fund	2	2	-
Other Investments	779,134	779,134	-
Patient Receivable	57,424,503	56,179,545	1,244,957
Less: Allowances	(43,961,893)	(43,010,180)	(951,713)
Other Receivables	692,287	2,138,253	(1,445,967)
Inventories	3,633,746	3,364,327	269,419
Prepaid Expenses	1,488,644	1,431,321	57,323
Total Current Assets	**34,266,183**	**33,368,645**	**897,538**
Internally Designated for Capital Acquisitions	1,124,762	1,124,714	49
Special Purpose Assets	1,191,583	243,821	947,762
Limited Use Asset; Defined Contribution Pension	988,268	928,514	59,754
Limited Use Assets Defined Benefit Plan	14,144,525	14,144,525	-
Limited Use Asset Defined Benefit Plan 003	29,946	9,380	20,566
Revenue Bonds Held by a Trustee	2,375,015	2,215,161	159,855
Less Amounts Required to Meet Current Obligations	-	-	-
Assets Limited as to use	**19,854,099**	**18,666,115**	**1,187,984**
Long Term Investments	2,552,143	2,552,143	-
			-
Property & equipment, net Accumulated Depreciation	81,723,520	81,857,402	(133,882)
Unamortized Bond Costs	-	-	-
Total Assets	**138,395,945**	**136,444,305**	**1,951,641**

Northern Inyo Healthcare District
Balance Sheet
Period Ending January 31, 2017

Liabilities and Net Assets	Current Month	Prior Month	Change
Current Liabilities:			
Current Maturities of Long-Term Debt	611,841	700,019	(88,179)
Accounts Payable	1,607,788	1,426,754	181,035
Accrued Salaries, Wages & Benefits	4,799,334	4,575,029	224,305
Accrued Interest and Sales Tax	133,089	(17,817)	150,907
Deferred Income	243,220	291,864	(48,644)
Due to 3rd Party Payors	872,302	639,030	233,272
Due to Specific Purpose Funds	-	-	-
Other Deferred Credits; Pension	1,427,520	1,427,520	-
Total Current Liabilities	**9,695,095**	**9,042,399**	**652,696**
Long Term Debt, Net of Current Maturities	46,012,756	46,012,756	-
Bond Premium	725,102	726,356	(1,254)
Accreted Interest	10,314,350	10,203,802	110,549
Other Non-Current Liabilities; Pension	33,492,468	33,492,468	-
Total Long Term Debt	**90,544,676**	**90,435,382**	**109,294**
Net Assets			
Unrestricted Net Assets less Income Clearing	36,259,893	36,259,844	49
Temporarily Restricted	1,191,583	243,821	947,762
Net Income (Income Clearing)	704,698	462,859	241,840
Total Net Assets	**38,156,174**	**36,966,523**	**1,189,651**
Total Liabilities and Net Assets	**138,395,945**	**136,444,305**	**1,951,641**

NORTHERN INYO HEALTHCARE DISTRICT
STATEMENT OF OPERATIONS
for period ending January 31, 2017

	ACT MTD	BUD MTD	VARIANCE	ACT YTD	BUD YTD	VARIANCE
Unrestricted Revenues, Gains & Other Support						
Inpatient Service Revenue						
Routine	869,283	891,349	(22,066)	5,165,768	6,181,951	(1,016,183)
Ancillary	2,653,398	2,944,453	(291,055)	17,919,230	20,421,217	(2,501,987)
Total Inpatient Service Revenue	3,522,681	3,835,802	(313,121)	23,084,997	26,603,168	(3,518,171)
Outpatient Service Revenue	7,494,962	7,494,616	346	51,620,907	51,978,768	(357,861)
Gross Patient Service Revenue	**11,017,643**	**11,330,418**	**(312,775)**	**74,705,904**	**78,581,936**	**(3,876,032)**
Less Deductions from Revenue						
Patient Service Revenue Deductions	339,061	174,933	164,128	1,507,333	1,213,245	294,088
Contractual Adjustments	5,098,619	4,470,539	628,080	31,764,218	31,005,353	758,865
Prior Period Adjustments	(1,046,176)	-	(1,046,176)	(3,637,518)	-	(3,637,518)
Total Deductions from Patient Service Revenue	**4,391,504**	**4,645,472**	**(253,968)**	**29,634,033**	**32,218,598**	**(2,584,565)**
Net Patient Service Revenue	**6,626,139**	**6,684,946**	**(58,807)**	**45,071,871**	**46,363,338**	**(1,291,467)**
Other revenue	64,701	53,820	10,881	326,322	373,266	(46,944)
Total Other Revenue	**64,701**	**53,820**	**10,881**	**326,322**	**373,266**	**(46,944)**
Expenses:						
Salaries and Wages	1,884,721	2,188,850	(304,129)	13,206,086	15,180,730	(1,974,644)
Employee Benefits	1,434,001	1,423,901	10,100	9,956,014	9,875,477	80,537
Professional Fees	926,357	718,979	207,378	6,219,237	4,986,463	1,232,774
Supplies	355,973	568,638	(212,665)	4,144,801	3,943,780	201,021
Purchased Services	334,537	342,193	(7,656)	1,965,717	2,373,281	(407,564)
Depreciation	386,434	428,152	(41,718)	3,023,083	2,969,440	53,643
Bad Debts	333,701	198,503	135,198	1,683,823	1,376,715	307,108
Other Expense	335,635	324,933	10,702	2,318,903	2,253,563	65,340
Total Expenses	**5,991,360**	**6,194,149**	**(202,789)**	**42,517,664**	**42,959,449**	**(441,785)**
Operating Income (Loss)	**699,480**	**544,617**	**154,863**	**2,880,529**	**3,777,155**	**(896,626)**
Other Income:						
District Tax Receipts	48,644	49,577	(933)	340,508	343,841	(3,333)
Tax Revenue for Debt	150,920	73,076	77,844	1,056,440	506,818	549,622
Partnership Investment Income		-	-		-	-
Grants and Other Contributions Unrestricted		8,493	(8,493)	554,695	58,903	495,792
Interest Income	17,729	18,563	(834)	116,830	128,745	(11,915)
Interest Expense	(264,364)	(244,925)	(19,439)	(1,856,906)	(1,698,673)	(158,233)
Other Non-Operating Income	2,151	2,208	(57)	14,635	15,314	(679)
Net Medical Office Activity	(412,215)	(352,134)	(60,081)	(2,331,149)	(2,442,220)	111,071
340B Net Activity	(506)	12,315	(12,821)	(70,883)	85,409	(156,292)
Non-Operating Income/Loss	**(457,640)**	**(432,827)**	**(24,813)**	**(2,175,830)**	**(3,001,863)**	**826,033**
Net Income/Loss	**241,840**	**111,790**	**130,050**	**704,698**	**775,292**	**(70,594)**

NORTHERN INYO HEALTHCARE DISTRICT

OPERATING STATISTICS

for period ending January 31, 2017

		FYE 2017	FYE 2016		Variance %
	Month to Date	Year-to-Date	Year-to-Date	Variance from PY	
Licensed Beds	25	25	25		
Total Patient Days with NB	293	2,060	2,536	(476)	-19%
Total Patient Days without NB	275	1,864	2,307	(443)	-19%
Swing Bed Days	24	294	484	(190)	-39%
Discharges without NB	85	621	693	(72)	-10%
Swing Discharges	3	42	70	(28)	-40%
Days in Month	31	215	215		
Occupancy without NB	8.87	8.67	10.73	(2.1)	-19%
Average Stay (days) without NB	3.24	3.00	3.33	(0.3)	-10%
Average LOS without NB/Swing	3.06	2.71	2.93	(0.2)	-7%
Hours of Observation (OSHPD)	910	5,213	3,708	1,505	41%
Observation Adj Days	38	217	155	63	41%
ER Visits All Visits	899	5,695	5,324	371	7%
RHC Visits (OSHPD)	2,402	14,632	15,119	(487)	-3%
Outpatient Visits (OSHPD)	3,209	22,341	22,088	253	1%
IP Surgeries (OSHPD)	24	166	180	(14)	-8%
OP Surgery (OSHPD)	72	672	701	(29)	-4%
Worked FTE's	321.00	323.00	330.00	(7)	-2%
Paid FTE's	373.00	366.00	378.00	(12)	-3%
Hours Worked to Hours Paid%	86.1%	88.3%	87.3%	0.9%	1%
Payor %					
Medicare		40%	40%	0%	
Medi-Cal		23%	24%	-1%	
Insurance, HMO & PPO		34%	35%	-1%	
Indigent (Charity Care)		1.2%	0.3%	0.9%	
All Other		2%	2%	1%	
Total		100%	100%		

Northern Inyo Healthcare District

Financial Indicators as of January 31, 2017

	Target	Jan-17	Dec-16	Nov-16	Oct-16	Sep-16	Aug-16	Jul-16	Jun-16
Current Ratio	>1.5-2.0	3.53	3.69	2.85	2.95	2.60	2.15	2.05	1.98
Quick Ratio	>1.33-1.5	2.93	2.92	2.46	2.41	2.20	1.83	1.74	1.71
Days Cash on Hand prior method	>75	151.40	140.37	160.86	145.43	157.98	168.91	162.64	161.90
Days Cash on Hand Short Term Sources	>75	71.85	62.90	85.97	67.02	77.60	86.56	91.08	96.57
Debt Service Coverage	>1.5-2.0	2.17	2.13	2.46	2.30	2.80	3.18	2.03	1.95
Operating Margin		6.30	5.59	7.48	6.43	8.37			
Outpatient Revenue % of Total Revenue		69.10	69.28	68.11	67.48	67.03			
Cash flow (CF) margin (EBIDA to revenue)		3.94	3.71	5.43	4.53	7.01			
Days in Patient Accounts Receivable	<60 Days	80.80	77.70	75.60	75.00	77.80	78.50	73.10	63.20

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 year-to-date / by days in fiscal year

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

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

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

Accounts Receivable Days are pulled from the AR Aging report

NORTHERN INYO HEALTHCARE DISTRICT

Investments as of January 31, 2017

ID	Purchase Date	Maturity Dat	Institution	Broker	Rate		Principal Invested
3	13-Jan-17	01-Feb-17	Local Agency Investment Fund	Northern Inyo Hospital	0.75%		10,340,132.84
4	13-Jun-14	13-Jun-18	Synchrony Bank Retail-FNC	Financial Northeaster Corp.	1.60%		250,000.00
				SHORT TERM INVESTMENTS		$	10,590,132.84
5	28-Nov-14	28-Nov-18	American Express Centurion Bank	Financial Northeaster Corp.	2.00%		150,000.00
6	02-Jul-14	02-Jul-19	Barclays Bank	Financial Northeaster Corp.	2.05%		250,000.00
7	02-Jul-14	02-Jul-19	Goldman SachsBank USA NY CD	Financial Northeaster Corp.	2.05%		250,000.00
8	20-May-15	20-May-20	American Express Centurion Bank	Financial Northeaster Corp.	2.05%		100,000.00
9	26-Sep-16	27-Sep-21	Comenity Capital Bank	Multi-Bank Service	1.70%		250,000.00
10	02-Sep-16	28-Sep-21	Capital One Bank	Gemini Financial Services, LL	1.70%		250,000.00
11	28-Sep-16	28-Sep-21	Capital One National Assn	Multi-Bank Service	1.70%		250,000.00
12	28-Sep-16	28-Sep-21	Wells Fargo Bank NA	Multi-Bank Service	1.70%		250,000.00
				LONG TERM INVESTMENTS		$	1,750,000.00
				TOTAL INVESTMENTS		$	12,340,132.84
1	12-Jan-17	01-Feb-17	LAIF Defined Cont Plan	Northern Inyo Hospital	0.75%		988,268.31
2	12-Jan-17	01-Feb-17	LAIF PEPRA DB PLAN	Northern Inyo Hospital	0.75%		29,945.59
				LAIF PENSION INVESTMENTS		$	1,018,213.90
							13,358,346.74

NORTHERN INYO HEALTHCARE DISTRICT

Restricted and Specific Purpose Fund Balances
for period ending January 31, 2017

	Current Month	Prior Month	Change
Board Designated Funds:			
Tobacco Fund Savings Account	$ 1,098,039	$ 1,097,990	49
Equipment Fund Savings Account	$ 26,723	$ 26,723	-
Total Board Designated Funds:	**$ 1,124,762**	**$ 1,124,714**	**$ 49**
Specific Purpose Funds:			
* Bond and Interest Savings Account	$ 1,058,468	$ 110,706	$ 947,762
Nursing Scholarship Savings Account	$ 33,036	$ 33,036	$ -
Medical Education Savings Account	$ 76	$ 76	$ -
Joint NIHD/Physician Group Savings Account	$ 100,003	$ 100,003	$ -
Total Specific Purpose Funds:	**$ 1,191,583**	**$ 243,822**	**$ 947,762**
Grand Total Restricted and Specific Purposes Funds:	**$ 2,316,346**	**$ 1,368,535**	**$ 947,811**
	(0)	(0)	

***Bond and Interest Saving Account Activity is the result of receipt of debt service from Inyo County**

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

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

TO: NIHD Board of Directors
FROM: Joy Engblade, MD, Chief of Medical Staff
DATE: March 7, 2017
RE: Medical Executive Committee Report

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

1. **Policy/Procedure/Protocols/Order Sets (Action items)**
   - *Administration of Drugs: Patient's Own Medications*
   - *Closed-System Transfer Device (CSTD)*
   - *Drugs of Abuse Maternal and Infant*
   - *Misoprostol for Cervical Ripening*
   - *Opioids Waste Policy*
   - *Discharge Planning for the Hospitalized Patient*
   - *Airborne Infection Isolation Rooms (AIIR)*
   - *Respiratory Syncytial Virus (RSV) Policy*
   - *Skin Preparation in the Perioperative*
   - *Cleaning and Processing da Vinci Instruments, Accessories and Endoscopes*
   - *Fern Testing*
   - *Training and Competency in Fern Testing*

2. **Hospital-Wide QAPI Plan – Annual Evaluation Calendar Year 2016 (Information item)**

3. **Hospital-Wide QAPI Plan – Annual Work Plan Fiscal Year 2017-18 (Action item)**

4. **Hospital-Wide QAPI Plan (Action Item)**

_____
Joy Engblade, MD, Chief of Staff

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Administration of Drugs: Patient's Own Medications**	
Scope: Hospital-Wide	Manual: **CPM - Medication (MED), Pharmacy**
Source: Director of Pharmacy	Effective Date: Not Approved Yet

PURPOSE:

To insure the quality and integrity of medications brought to the hospital by patients and administered by NIH personnel. To comply with Title 22 CCR 70263

POLICY:

1. ADMINISTRATION OF PATIENT'S OWN MEDICATIONS

   a. A patient's personal medications will not be administered unless not stocked within the hospital and specifically ordered by the prescribing practitioner responsible for the patient. Patients may self-administer medications only in accordance with the "**Administration of Drugs: Self-Administration"** policy and procedure.

   b. There must be a complete written order, name of the medication, strength, dose, route and frequency, by the prescriber for the nurse to administer the patient's own medications. All medications for patient administration must be positively identified by a pharmacist **(A nurse cannot do this).**

   c. Medications identified for administration in accordance with this policy shall be sent to the pharmacy for repackaging and dispensing

   d. Emergency Room patients will not take their own medications unless it is not stocked within the hospital and a physician writes an order for "patient's to take their own medication including the order requirements in part b. The pharmacist and/or physician will need to identify/verify the medication prior to administration. If an emergency patient brings in his/her own medications, physician will review and have the ED nurse enter the home medications into the Paragon system.

2. IDENTIFICATION OF PATIENT'S OWN MEDICATIONS

   a. Medications brought into the facility by patients will not be administered unless the medication containers are clearly and properly labeled, the drugs have been positively identified, their quality and integrity is not questionable, and documentation of such identification is made on the Medication Administration Record.

   b. A pharmacist must examine and positively identify a patient's personal drugs. Documentation of patients' own medication identification shall be made on the MAR by the statement "Identified by [identifier's initials].

Title: **Administration of Drugs: Patient's Own Medications**	
Scope: Hospital-Wide	Manual: **CPM - Medication (MED), Pharmacy**
Source: Director of Pharmacy	Effective Date: Not Approved Yet

c. Patient's own drugs shall be entered on the MAR as "patient's own med" along with the name, strength, route, and dosage. Nurses will document administration of patient's own medications per general administration policies.

3. STORAGE OF PATIENT'S OWN MEDS—NON CONTROLLED SUBSTANCES

a. Patient's own medications brought in to the hospital that are not to be administered to the patient in accordance with this policy will be sent home with the patient's family or representative if possible. Nursing staff will initially fill out the medication reconciliation before sending the medications home with the family or patient's agent.

b. In the event the patient's medications cannot returned home, they may be stored in the pharmacy according to the following process:

i. Patient's home medications will be packaged in a sealable "Patient's Medicine Inventory" security bag and stored in a locked cabinet located on Med Surg's medication room.
ii. The nurse will write the patient's name and ID on the face of the security bag. The nurse will, in the presence of the patient or patient's representative, count the number of bottles and list the bottle with the name of the medication as stated on the prescription label. The nurse will not open or inventory the prescription bottles but only note the number of bottles and the label on each.
iii. The nurse will seal the bag in the presence of the patient or patient's representative. The nurse will sign the bag and give the tear off receipt to the patient or patient's representative.
iv. Nursing staff will call pharmacy to inform them that home medications are in the locked cabinet.
v. If it is after hours, please communicate with the oncoming shift to notify Pharmacy the next day in AM.
vi. Pharmacy staff will secure the sealed bag within the pharmacy for the duration of the patient's stay
vii. Upon discharge, the patient will receive his/her sealed medication bag back. Unclaimed patient meds will be destroyed after 30 days per section 5 below.

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NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Administration of Drugs: Patient's Own Medications**	
Scope: Hospital-Wide	Manual: **CPM - Medication (MED), Pharmacy**
Source: Director of Pharmacy	Effective Date: Not Approved Yet

4. USE OF PATIENT'S OWN MEDS—CONTROLLED SUBSTANCES

a. Patients' own controlled substance prescriptions must be brought to the pharmacy prior to administration to the patient. The controlled substances will be inventoried and recorded into the pharmacy's stock of controlled substances.

b. Pharmacy will produce a label for single doses of the medication and will package single unit doses for distribution to the nursing unit of the patient.

c. No more than a 12 hour supply will be dispensed to the patient's medication nurse.

d. The number of doses dispensed will be recorded in the pharmacy and reconciled each day with the electronic MAR record of administrations.

5. DESTRUCTION OF UNRETURNED DRUGS

a. Personal drugs from expired patients and personal drugs on hand more than thirty (30) days after discharge shall be destroyed in accordance with applicable law.

b. Drugs listed in Schedules II, III or IV of the Federal Comprehensive Drug Abuse Prevention and Control Act of 1970, as amended, shall be destroyed in the presence of two pharmacists or a pharmacist and a registered nurse employed by the hospital.

c. The name of the patient, the name and strength of the drug, the prescription number, the amount destroyed, the date of destruction and the signatures of the witnesses required above shall be recorded in a separate log. Such log shall be retained for at least three years.

d. Drugs not listed under Schedules II, III or IV of the Federal Comprehensive Drug Abuse Prevention and Control Act of 1970, as amended, shall be destroyed in the presence of a pharmacist.

PROCEDURE:
NA

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Administration of Drugs: Patient's Own Medications**	
Scope: Hospital-Wide	Manual: **CPM - Medication (MED), Pharmacy**
Source: Director of Pharmacy	Effective Date: Not Approved Yet

Committee Approval	**Date**
Clinical Consistency Oversight Committee	1/25/17
Pharmacy and Therapeutics Committee	2/16/17
Medical Executive Committee	3/7/17
Board of Directors	

Revised 9/12, 6/15. 01/17
Reviewed 7/05, 10/06, 10/07, 9/08, 9/09, 9/10, 9/11,6/15
Supersedes

Reference: The Compliance Guide to the JACHO's Medication Management Standards, Second Edition

Cross Reference: Administration of Drugs and Biological

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Closed-System Transfer Device (CSTD)	
Scope: Pharmacy and Nursing	Manual: Pharmacy, Infusion Center
Source: Director of Pharmacy	Effective Date: 10 FEB 2017

POLICY: Use of Closed-System Transfer Device (CSTD) for the administration of cytotoxic chemotherapy.

At the effective date of this policy, Northern Inyo Healthcare District (NIHD) will adopt the use of a CTSD for administration of cytotoxic chemotherapy.

BACKGROUND:
Numerous studies demonstrate that there is measureable exposure to cytotoxic chemotherapy in health care personnel who prepare and administer cytotoxic chemotherapy.[1-6]
The Centers for Disease Control, National Institute for Occupational Safety and Health (NIOSH) recommend that health care institutions adopt measures to decrease healthcare worker exposure to hazardous medications.[7] The new United States Pharmacopeia (USP) chapter 800 will mandate the use of a CSTD for administration of all cytotoxic medications in the near future. [8]
There are several CSTD systems available all of which have demonstrated ability to reduce healthcare worker exposure to cytotoxic medications.

PROCEDURE:
NIHD will implement a CSTD for the administration of the chemotherapeutic medications listed in appendix A which are administered Intravenously, Intramuscularly, Subcutaneously or via bladder irrigation.
Pharmacy will purchase and supply CSTD equipment.
Appendix A will be a supplement to this policy which will be updated by the Pharmacy and Therapeutics Committee annually. Modification of Appendix A will not require an update to the policy.
Pharmacy personnel will use the CSTD according to manufacturer's instructions for all chemotherapy drugs in Appendix A.
Nursing personnel will use the CSTD according to the manufacturer's instructions for administering all chemotherapy drugs in Appendix A.
Unit managers will be responsible for ensuring that personnel have completed and documented appropriate proprietary training for the chosen CSTD.

REFERENCES:

1. Connor TH, Anderson RW, Sessink PJ, et al. Effectiveness of a closed-system device in containing surface contamination with cyclophosphamide and ifosfamide in an IV admixture area. *Am J Health-Syst Pharm.* 2002;50(1):68-72

2. Spivey S, Connor TH. Determination of sources of workplace contamination with antineoplastic drugs and comparison of conventional IV drug preparation versus a closed system. *Hosp Pharm.* 2003;38:135-139.
3. Wick C, Slawson MH, Jorgenson JA, et.al. Using a closed system protective device to reduce personnel exposure to antineoplastic agents. *Am J Heath-syst Pharm.* 2003;60(22):2314-2320.
4. Harrison BR, Peters BG, Bing MR. Comparison of surface contamination with cyclophosphamide and fluorouracil using a closed-system drug transfer device versus standard preparation techniques. *Am J Health-Syst Pharm.* 2006;63(18):1736-1744.
5. Nyman H, Jorgensen J, Slawson MH. Workplace contamination with antineoplastic agents in a new cancer hospital using a closed-system drug transfer device. *Hosp Pharm.* 2007;42:219-225.
6. Sessnick PJM, Connor TH, Jorgenson JA, et.al. Reduction in surface contamination with antineoplastic drugs in 22 hospital pharmacies in the US following implementation of a closed-system drug transfer device. *J Oncol Pharm Prac.* 2011;17(1)39-28
7. Centers for Disease Control and Prevention. National Institute for Occupational Safety and Health. Preventing Occupational Exposures to Antineoplastic and Other Hazardous Drugs in Health Care Settings, https://www.cdc.gov/niosh/docs/2004-165/pdfs/2004-165sum.pdf accessed 16 January 2017.
8. United States Pharmacopeial Convention. General chapter <800> Hazardous Drugs-Handling in Healthcare settings. http://www.usp.org/sites/default/files/usp_pdf/EN/m7808_pre-post.pdf accessed 16 January 2017.

CROSS REFERENCES:

1.

Approval	**Date**
P&T	02/16/2017
MEC	03/07/2017
BOD	

Developed:
Reviewed:
Revised:
Index:
Supersedes:

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Closed-System Transfer Device (CSTD)	
Scope: Pharmacy and Nursing	Manual: Pharmacy, Infusion Center
Source: Director of Pharmacy	Effective Date: 10 FEB 2017

APPENDIX A
HAZARDOUS CHEMOTHERAPY MEDICATIONS REQUIRING USE OF A CLOSED-SYSTEM TRANSFER DEVICE WITHIN NORTHERN INYO HEALTHCARE DISTRICT (JAN 2017)

Antimetabolites:
- Cladribine
- Cytarabine
- Fludarabine
- 5-Fluorouracil
- Gemcitabine
- Methotrexate

Antitumor Antibiotic:
- Bleomycin

Epipodophyllotoxins:
- Etoposide
- Teniposide

Taxnes:
- Paclitaxel
- Docetaxel

Vinca Alkaloids:
- Vinblastine
- Vincristine
- Vinorelbine

Alkylating Agents:
- Busulfan
- Cyclophosphamide
- Mechlorethamine
- Thiotepa

Anthrocayclines:
- Daunorubicin
- Doxorubicin
- Epirubacin
- Idarubicin
- Mitoxantrone

Camptothecins:
- Irinotecan
- Topotecan

Platinum Analogs:
- Cisplatin
- Carboplatin
- Oxaliplatin

Monclonal Antibiodies:
- Afatinib
- Bortezomib
- Carfilzomib
- Pertuzumab

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Drugs of Abuse Maternal and Infant	
Scope: Laboratory, Perinatal, Social Services	Manual: CPM – Patient Safety (PS)
Source: Director of Nursing Practice	Effective Date: 10/16/2007

PURPOSE:
To comply with CA 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 file a CPS report and request an evaluation 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.
3. All mothers and newborns identified as high risk will be referred to the NIH social worker.

The attending physician will order The Drugs of Abuse Screen on the newborn (detecting amphetamines, cannabis (hereafter THC), cocaine, opiates, benzodiazepines, phencyclidines, barbiturates and tricyclic antidepressants). The urine test provides only a preliminary result. A meconium or cord tissue sample for drug screening should be ordered by the infant's physician when indicated, after consultation with the mother's physician and social worker.

Maternal High Risk Factors:
   a. Late prenatal care (hereafter PNC) (<4visits), no PNC, or PNC in another area with no transfer to local care provider.
   b. History of substance use (in the last 4 years), even if mother denies recent use
   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
   j. Prior hospital/ED visit related to substance abuse

4. The MD will order testing on any mother who is suspected (i.e., per Maternal High Risk Factors listed above) or self-reports using alcohol or illicit drugs will have a urine drug screen 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).

5. 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. Upon delivery, the delivery nurse will collect an umbilical cord segment, follow chain of custody, and send to lab to hold until determined if the cord segment will be sent for testing. 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, meconium, or piece of cord for drug testing.

6. 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.

7. 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, whose mother has a high-risk factor stated earlier, or mother acknowledges recent drug use, the Pediatrician needs to be notified and order received to obtain urine, meconium or cord sample for drug testing.

8. Collection of mother's urine for Drugs of Abuse Screen specimen and completion of Laboratory Order:
   a. Verify the identification of the individual to be tested using the arm band and compare identification to the patient sticker, 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 by: Your initials, time/date of collection
   d. On Computer order management "Urine for Drugs of Abuse Screen."

9. Collection of infant's urine or meconium:
   a. Verify the identification of the infant to be tested using the arm band and compare identification to the patient sticker, the request slip and specimen container.
   b. The infant's urine or meconium will be obtained via urine bag (may use cotton balls in bag to obtain urine and squeeze into the specimen container) or meconium from the diaper (using a clean tongue depressor stick into the specimen container).
   c. Close the lid on the specimen container. Chain of custody paperwork and process will be followed as instructed on the chain of custody paper.
   d. On computer order management order urine, meconium, or cord sample for drug screen.

10. Chart in nurses notes that specimen was obtained and taken to the Lab. Notify Social Services of admission of "at-risk" mom and baby. Enter the order for a social worker consultation. The hospital social worker will:
    a. Perform an assessment to determine any patient's insight into risk factors and influence on newborn, as well as motivation to seek treatment or support.
    b. Work with Attending MD and assist per request.
    c. 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 of this report, to be sure that a follow-up is done. This verbal report to CPS must be made within 24 hours of a positive drug screen result. Drug screen results will be sent to CPS, even if the newborn and mother have been discharged.

If the hospital social worker is not available, the provider (RN, LVN, or MD) providing care must file the CPS report.

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Drugs of Abuse Maternal and Infant	
Scope: Laboratory, Perinatal, Social Services	Manual: CPM – Patient Safety (PS)
Source: Director of Nursing Practice	Effective Date: 10/16/2007

REFERENCES:

HEALTH AND SAFETY CODE – HSC

Division 106. Personal Health Care (Including Maternal, Child, and Adolescent) [123100-125850] (*Division 106 added by Stats. 1995, Ch. 415, Sec.8.)*

Part 2. Maternal, Child, and Adolescent Health [123225-124250] (*Part 2 added by Stats. 1995, Ch. 415, Sce. 8)*

Chapter 2. Maternal Health [123375-123620] (*Chapter 2 added by Stats. 1995, Ch. 415, Sec. 8)*

Article 4. Perinatal Health Care [123550-123610] *(Article 4 added by Stats. 1995, Ch. 415, Sec. 8)*

123605 (a) Each county shall establish protocols between county health departments, county welfare departments, and all public and private hospitals in the county, regarding the application and use of an assessment of the needs of, and a referral for, a substance exposed infant to a county welfare department pursuant to Section 11165.13 of the Penal Code.
(b) The assessment of the needs shall be performed by a health practitioner, as defined in Section 11165.8 of the Penal Code, or a medical social worker. The needs assessment shall be performed before the infant is released from the hospital.
(c) The purpose of the assessment of the needs is to do all of the following:
(1) Identify needed services for the mother, child, or family, including, where applicable, services to assist the mother caring for her child and services to assist maintaining children in their homes.
(2) Determine the level of risk to the newborn upon release to the home and the corresponding level of services and intervention, if any, necessary to protect the newborn's health and safety, including a referral to the county welfare department for child welfare services.
(3) Gather data for information and planning purposes.
(Added by Stats. 1995, Ch. 415, Sec. 8. Effective January 1, 1996.)

PENAL CODE – PEN

Part 4. Prevention of Crimes and Apprehension of Criminals [11006-11460] *(Title 1 added by Stats. 1953, Ch. 1385)*

Title 1. Investigation and Control of Crimes and Criminals [11150-11199.5] *(Chapter 2 added by Stats. 1953, Ch.70)*

Chapter 2. Control of Crimes and Criminals [11150-11199.5] *(Chapter 2 added by Stats. 1953, Ch. 70.)*

Article 2.5 Child Abuse and Neglect Reporting Act [11164-11174.3] *(Heading of Article 2.5 amended by Stats. 1987, Ch. 1444, Sec. 1.)*

11165.3.

As used in this article, "the willful harming or injuring of a child or the endangering of the person or health of a child," means a situation in which any person willfully causes or permits any child to suffer, or inflicts thereon, unjustifiable physical pain or mental suffering, or having the care or custody of any child, willfully causes or

Title: Drugs of Abuse Maternal and Infant	
Scope: Laboratory, Perinatal, Social Services	Manual: CPM – Patient Safety (PS)
Source: Director of Nursing Practice	Effective Date: 10/16/2007

permits the person or health of the child to be placed in a situation in which his or her person or health is endangered.

(Amended by Stats. 2004, Ch. 842, Sec. 1. Effective January 1, 2005.)

Approval	**Date**
CCOC	2/27/17
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Developed:
Revised: 10/07 jk, 1/09 jk, 1/17SG, HF
Reviewed: 9/12jk
Index Listings:
Supersedes:

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Misoprostol for Cervical Ripening	
Scope: Departmental	Department: **Obstetrics**
Source: OB Nurse Manager	Effective Date: 7/2009

Misoprostol can be used for cervical ripening or labor induction in the third trimester of pregnancy.

POLICY:

Patients undergoing cervical ripening or labor induction with Misoprostol should undergo fetal heart rate monitoring and uterine activity monitoring in a hospital setting in the perinatal unit.

CONTRAINDICATIONS:

1. Placenta previa, abruptio placenta or unexplained vaginal bleeding
2. Asthma, glaucoma, or cardiac, renal or hepatic disease
3. Previous C/S or major uterine surgery
4. Patients on Pitocin. (Pitocin should not be started until at least 4 hours after the last dose of Misoprostol. If the patient was on Pitocin, you should wait at least 30 minutes prior to using Misoprostol.)

PROCEDURE:

1. Obtain informed consent and place on the chart. Physicians will discuss the risks and benefits including possible side effects of the medication prior to administration of the medication. This may be done in the office but documentation will be on the NIH record.
2. Nursing should complete a full nursing assessment including vital signs prior to this procedure. Cervical exam should indicate less than 2 cm dilated and 50% effaced, or Bishop score of less than 7, and the patient has less than 4 contractions per 10 minutes.
3. Complete an EFM baseline strip.
4. Patients will remain on CEFM for 1-2 hours after the initial dose. At least a 20-minute strip every hour thereafter.
5. If at any time the EFM changes to a category III strip, the MD will be notified and continuous monitoring will resume. Fetal Resuscitation should begin.
6. Medication administration:
    a. The MD or CNMW will order the dosing. Insertion may be by the MD, CNMW or L&D RN.
    b. NPO for the first dose for 1-2 hours
    c. IV of LR with18 gauge needle rate per MD
    d. Have the patient empty their bladder prior to each dose.
    e. Insert dose (per MD order sheet) into the posterior fornix of the vagina. Do not use lubricating jelly. You may use normal saline or sterile water.
    f. Patient should remain on bedrest after the insertion up to 2 hours. They may ambulate and empty their bladder prior to the next dose.

Title: Misoprostol for Cervical Ripening	
Scope: Departmental	Department: **Obstetrics**
Source: OB Nurse Manager	Effective Date: 7/2009

g. The dose may be repeated every 3-6 hours up to a maximum of 6 doses in 24 hours. Withhold doses if there are two or more painful contractions in 10 minutes, has adequate cervical ripening (Bishop score greater than 8, 80%, 3 cm dilated), patient enters active labor, has hyperstimulation or tachysystole or EFH shows a category III strip.
h. Vital signs should be monitored including BP and pulse every hour, temperature and respirations every 4 hours.

Note: For hyperstimulation, change patient position such as left or right side, apply oxygen, consider tocolytics, if ordered by MD, such as Terbutaline or Magnesium and/or attempting to flush remaining dose from the vaginal vault with normal saline.

DOCUMENTATION:

Document on designated forms

1. Assessment
2. Interventions and responses
3. Medications times and dose
4. Patient education and care plan

Committee Approval	**Date**
Pharmacy and Therapeutics Committee	02/16/2017
Perinatal/Pediatrics Committee	11/07/2016
Medical Executive Committee	03/07/2017
Board of Directors	

Revised 7/2009 JK,
7/2011jk,
8/2016 SG

Reviewed 7/2011jk,
8/2016 SG

Supercedes

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Opioids Waste Policy	
Scope: Hospital wide	Manual:
Source:	Effective Date: 12/16/15

PURPOSE:
To ensure the safe handling and wasting of opioids.

DEFINITION: Two licensed personnel (i.e. 2 RN's, RN + LVN or 1 RN + Pharmacist, RN + pharmacy technician, RN + physician) will document wasting and destruction of controlled substances, the person who wastes the medication and a witness. The witness must physically witness the destruction and wasting.

POLICY:

1. Medications must be stored and transferred to the patient for administration in their original container, containers prepared by the pharmacy, or in labeled syringes together with the original container.
2. Medications must be in the possession of a licensed person at all times from the receipt of the medication to the time of administration.
3. Medications may be administered to the patient, returned to the Omnicell as credit if not administered to the patient, or wasted in accordance with this policy.
4. Controlled substances shall be handled in accordance with the procedure in this policy.
5. Any unused portion of controlled substances must be destroyed beyond reclamation, and disposed of appropriately. The destruction and wasting process must be witnessed and documented appropriately on the medication automated dispensing cabinet (Omnicell) by the individual wasting and the witness.
6. Return any non-administered controlled substances to the automated dispensing cabinet (Omnicell) return bin by selecting the name of the drug to be returned; this also cancels the charge.
7. All controlled medications (CII to CV) wasted must be recorded in Omnicell).
8. Pharmacy runs an Omnicell report daily and tracks all controlled substances which are dispensed, administered and wastes.

PROCEDURE:

1. Retrieve the opioid from the Omnicell (automated dispensing cabinet)

2. Compare and verify the medication against the electronic medication administration record (eMAR).

3. When controlled substances are unusable, the dose should be discarded in the pharmaceutical waster container (blue lid with white container) and the "WASTE" function should be used to document the waste. <u>Do not dispose of a medication in the automated dispensing cabinet (Omnicell). Only use the Omnicell to document the procedure.</u>

4. Utilize a second licensed individual as defined above. The witness must physically observe all destruction and waste.
    a. Administration and wasting of **parenteral opioids**:
        i. Open the vial or carpuject with the witness
        ii. Withdraw the correct dosage amount into a syringe
        iii. Label the syringe with the correct medication and dose
        iv. Withdraw the remainder of the medication into another syringe and measure for accuracy
        v. Once the accurate amount of waste is confirmed by waste the fluid into the pharmaceutical waste container (blue lid with white container)
        vi. Dispose of the sharps into red sharps container
        vii. Record the waste in the Omnicell utilizing a witness
        viii. The administering RN will immediately take the medication along with the empty vial or carpuject to the patient
        ix. The administering nurse will follow standard medication administration procedures in accordance with the Medication Bar Code Administration Policy

    b. Wasting of epidural remaining parental infusion or PCA cassettes with remaining solutions not completed:
        - Any residual volume in the PCA container is measured, wasted in the pharmaceutical waste bin, witnessed, and documented and recorded by two licensed staff in the EMAR.
        - One licensed staff member will draw up the remaining solution with syringe (i.e. PCA cassette) and the second licensed staff member will witness the disposal of the total amount solution being wasted into the pharmaceutical blue container.

    c. Wasting of patches (i.e. Fentanyl):
        i. Documentation of actual disposition for a full dose or any other remaining partial dose
        ii. One licensed staff member will wear gloves before folding the adhesive side of the patch over itself and the witness will document the disposal the patch disposed into the pharmaceutical container (blue lid with white container)

    d. Administration and wasting of **oral opioids**:
        i. Waste of oral medication will be witnessed. The table will be crushed and disposed of in the pharmaceutical waste container (blue lid with white container). A Capsule will be opened and the contents emptied into a pharmaceutical waste container.
        ii. Nurses will follow the standard medication administration procedures in accordance with the Medication Bar Code Administration Policy. The same

Title: Opioids Waste Policy	
Scope: Hospital wide	Manual:
Source:	Effective Date: 12/16/15

RN removing the controlled substance from the Omnicell will be the one to administer the medication via electronic bar code scanning.

iii. Two nurses will take the whole tablet from Omnicell to the patient's room. The nurse who removed the medication will be the one to administer the partial dose to the patient. Both nurses will return to the Omnicell to waste the partial tablet.
iv. Cut tablet and place the tablet portion to be administered into an administration cup
v. Place the tablet portion to be wasted into a separate administration cup
vi. Both licensed staff members will confirm waste amount
vii. Administer the oral dose to the patient
viii. Record the waste in the Omnicell utilizing the second licensed staff member as witness

CROSS REFERENCE P&P:

1. Omnicell Automated Dispensing Cabinet Policy
2. Administration of Medications and Biological
3. Pharmaceutical and Biohazardous Waste Policy

Approval	Date
Clinical Consistency Oversight Committee	1/25/17
Pharmacy and Therapeutics Committee	02/16/17
Medical Executive Committee	03/07/17
Board of Directors	

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Revised: 12/16
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Index Listings: Medication storage, Handling, Narcotic, Opiate, Waste, Return, Disposition

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Discharge Planning for the Hospitalized Patient	
Scope: Case Management/Social Services	Manual: Case Management
Source: Director of Nursing Practice	Effective Date:

PURPOSE: To ensure an effective discharge plan is in place to meet the patient's continuing healthcare needs post-hospitalization. Discharge Planning is an integral part of the hospital's provision of care, involving the assessment and treatment of the patient's bio, psycho, social needs that contribute to continuity of care to ensure a safe recovery post-hospitalization. The Case Management staff recognizes the relationship between psychosocial factors, the patients' health/illness, the influence these factors have on the patient's recovery, and the potential for re-hospitalization. The goal is to provide all patients with discharge planning that creates a continuity of care that includes the input and coordination of the interdisciplinary care team, the primary care practitioner, the patient and their family, and/or primary care givers.

POLICY:

1. Discharge planning will be conducted with all in-patients admitted to NIH, or upon request from the Emergency Department or PACU, according to state and federal regulatory requirements.
2. Discharge planning will be conducted by either an RN or a social worker trained in the process of effective discharge planning and case management. Supervision and oversight of the discharge planning process shall be by the Director of Nursing Practice.
3. A hospitalized patient and the patient's family and/or care giver shall be given the opportunity to participate in the discharge planning process.
4. Discharge planning evaluations will be initiated upon admission. Complete evaluations will be conducted, at a minimum, within 24 hours of admission, unless the patient's medical condition prevents the evaluation, in which case the RN case manager or social worker should attempt to engage the patient's family to begin the evaluation process.
5. Patients shall be discharged based upon attainment of patient care goals as evident in the interdisciplinary plan of patient care and access to sufficient resources.
6. The entire interdisciplinary care team shall have input into the discharge planning process, including physicians, nursing staff, rehabilitation staff, social services/case managers, respiratory staff, pharmacists, etc.
7. The discharge planning needs of the patient shall be reassessed daily during the Interdisciplinary Care Team meetings. Changing needs of the patient or family/caregivers shall be taken into consideration and reflected in the discharge plan and documented.
8. If discharge plans include transferring a patient to another facility, NIH will collaborate with the patient and/or family to make arrangements for the transfer, and include all necessary medical information and documentation to facilitate continuity of care.

PROCEDURE:

1. The discharge planning process will include the following elements:
   A. **Screening** of all patients which includes identifying risk factors that have the potential to create adverse health consequences to the patient post-hospitalization. Screening risk factors can include bio, psycho, social components such as diagnosis, age, lack of adequate resources or sources of support, co-existing illnesses, behavioral health issues, etc.

   B. **Evaluation.** This process involves interviewing the patient, family, and/or caregivers to determine their needs, preferences, challenges, resources and how they are coping and

adjusting to the illness and hospitalization. The interview should attempt to ask the following questions and gather the following information:

- Current living situation, including identifying any potential safety issues
- Sources of support, both financial resources and family/caregiver assistance.
- Upon discharge, will the patient be capable of performing their own ADL's ; if not what type of assistance will they need?
- What equipment will the patient need if they are returning home?
- What referrals are important to facilitate a safe and effective discharge? (e.g. nursing home placement, out-pt. rehabilitation, home health services, etc.)
- Will the patient's insurance cover post-discharge services?
- Do they have transportation to follow up appointments?
- Are there any safety concerns with this patient? (e.g. fall risk, negligent spouse or caregiver, can the patient continue to safely drive)
- Are the patient's family and /or caregivers competent, capable and willing to help provide care or assistance to the patient? How much, for how long?
- What changes have occurred in the patient's physical or cognitive functioning that will require adjustments in the services or support provided to the patient post-discharge? (e.g. has the pt. moved from one level of care to another?)
- Has there been a change in the patient's cognitive functioning and executive decision-making ability? Are they capable of making sound decisions regarding their post-hospital needs?
- Does the patient have a behavioral health problem that adds a layer of complexity to their hospitalization and creates additional risk to their health and safety, such as a psychiatric diagnosis, suicidal ideations, or a history of substance abuse and dependence? If so, are they motivated to address these issues as part of the discharge plan?
- Does the patient and family and/or caregiver demonstrate good insight and awareness into the nature and contributing factors that led to the patient's hospitalization?
- Does the patient and family and/or caregivers have realistic expectations about post-hospitalization and recovery?
- Are the patient and family coping effectively with the patient's illness, hospitalization or diagnosis?
- What behavioral health needs do the patient and family and/or caregiver need in order to improve their functioning, enhance their hospital experience, or to ensure the patient's continuity of care upon discharge? (e.g. crisis intervention, brief grief counseling, education about illness or diagnosis)
- Does the patient have an Advanced Directive or a Durable Power of Attorney? Make sure it's on file and up to date.
- If the patient is a minor, are they eligible and meet the criteria for California Children Services?
- If the patient is a minor, was the cause of the injury or illness the result of neglect or potential abuse on the part of an adult or legal guardian? While it is not our responsibility to investigate and decide the causes of such incidents leading to illness or injury, we are mandated reporters required to follow the state laws, which includes filing a verbal and written report to California Child Protective Services.

Title: Discharge Planning for the Hospitalized Patient	
Scope: Case Management/Social Services	Manual: Case Management
Source: Director of Nursing Practice	Effective Date:

- Any bio, psycho, social factors that have the potential to complicate a successful discharge in a timely manner, or create risk to the patient for continuity of care.

C. Development This process requires that the case manager/social worker take the results and findings of the evaluation and present them to the Interdisciplinary Care Team for additional information and get their input, based upon their assessments or observations.

- All discharge plans will be developed in collaboration with the patient, the patient's family and/or caregivers, and the attending physician. Discharge options will be considered and reviewed.
- The patient's family members and/or caregivers may attend a care conference so that the care team can provide education and clarify goals and resources needed for an effective discharge and continuity of care.
- The attending physician will provide clarity and leadership about anticipated time frames for discharge and specific needs for the patient based upon diagnosis, recovery process, the patients response to treatments and therapies, on-going medical needs, and continuity of care.
- The case manger or social worker will take any new or additional information obtained from the Interdisciplinary Care Team and incorporate it into the discharge plan.
- If the Interdisciplinary Care Team decides to transition the patient to a Swing Bed, the case manager or social worker are responsible for providing written notice of transfer to the patient and family that includes explanation for the decision and how this decision will impact the discharge planning process.
- Once a plan has been developed and agreed upon by the patient (whenever possible), their family and/or caregiver, and the Interdisciplinary Care Team the case manager/social worker will document the plans under the Paragon Discharge Planning tab and begin the Implementation phase of discharge planning.
- Discharge plans will be reassessed daily with the Interdisciplinary Care Team so that changes in the care level or needs of the patient can be adequately modified in the discharge plan.
- The discharge planning process will assess and take into consideration patterns or trends that contributed to a patient readmission if prior hospitalization was within the last 30 days.

D. Implementation This process will be driven by the findings and results of the evaluation and will often include tasks such as:

- Calling various skilled nursing homes seeking short or long term placement for the patient, and making arrangements for patient transfers, along with relevant medical records necessary to provide continuity of care.
- If the patient is returning home, referring for home health services or durable medical equipment, if indicated.
- Researching alternative housing options if patient needs additional assistance but does not meet the criteria for skilled placement.(e.g. Assisted living, or family members)
- Ensuring the patient and family are aware of all follow-up appointment for the patient.
- Collaborating discharge plans and patient's post-hospitalization needs with other community providers (e.g. Toiyabe clinic and case management services)

Title: Discharge Planning for the Hospitalized Patient	
Scope: Case Management/Social Services	Manual: Case Management
Source: Director of Nursing Practice	Effective Date:

- Making referrals for additional out-patient sources of support which could include referrals for drug and alcohol treatment, on-going counseling services, resources for homelessness, psychiatric evaluations, or other community based services.
- Provide education (within scope of practice) to patients and their family/caregivers regarding rationale about discharge disposition, importance of adherence to discharge plan, and follow up with aftercare.
- If neglect, abuse or safety issues meet criteria for mandated reporting, notify CPS or APS with 24 hours. Written reports must be completed within 72 hours, sent to the reporting agency, with a copy filed in the patient's chart in medical records.
- Daily documentation should be made in the patient's electronic medical record indicating progress made towards discharge plans or any changes or updates made to the discharge plan. (See P &P on Documentation Requirements and Guidelines)
- Each patient will receive a **Discharge Instructions Packet that will include:**
  A. Discharge instructions and directions related to discharge disposition.
  B. New Prescriptions and medication lists with directions
  C. Educational materials
  D. Billing and insurance paperwork
  E. Relevant community resources, including contact information for Skilled Nursing facilities in the region, and home health services.

The Discharge Instruction Packet can be provided by the patient's nurse, but it is the case manager or social workers responsibility to ensure that each patient receives a completed packet upon discharge.

REFERENCES:

1. Department of Health and Human Services, Centers for Medicare & Medicaid Services; CMS Manual, Conditions of Participation 482.43(a) – 482.43 (e)
2. California Department of Public Health, Senate Bill 675: Hospital Discharge Planning and Family Caregivers; Health and Safety Code section 1262.5, Chapter 494
3. The Comprehensive Accreditation Manual for Critical Care Access Hospitals as published by The Joint Commission; Standards PC.04.01.03; PC.04.02.01; PC.04.01.05

CROSS REFERENCE P&P:

1. Documentation of Case Management Services
2. Interfaculty Transfer Guidelines
3. Follow-Up Phone Calls Post Discharge

Committee Approval	**Date**
CCOC	**2/27/2017**
UR Committee	**2/23/2017**
MEC	**3/07/2017**
BOD	

Developed: 4/2016
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Revised:
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NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: ~~Negative Pressure rooms~~ **Airborne Infection Isolation Rooms (AIIR)**	
Scope: NIHD	Department: **CPM - Infection Control- Patient Care (ICP)**
Source: Quality Informatics/Infection Preventionist	Effective Date:

PURPOSE:

To provide a negative pressure room required for airborne precautions for patients known or suspected to have serious illnesses transmitted by airborne droplet nuclei. ~~This room is also known as an AIIR (Airborne Infection Isolation Room) See airborne precautions policy.~~

POLICY:

1. ~~There are 2 negative pressure rooms in Northern Inyo Hospital. They are located as follows:~~
   a. ~~Medical surgical~~ Acute-Subacute unit room 5, (this room has an ante chamber, new construction)
   b. Intensive care unit room 1, (this room has an ante chamber, new construction)
   c. ~~The is a current Negative pressure room in the old facility being used by the Infusion unit, room 29-6, 1st floor of the original building.~~ Infusion Center room 6, (No ante chamber, old construction)

2. All patients with known or suspected serious illnesses transmitted by airborne droplet nuclei will be placed in one of the AIIR rooms until at which time it is determined that they do not have an airborne disease needing this type of precautions.
   a. This will be determined by culture results or symptoms
   b. See appendix A from the CDC located on Nursing and Physician desktop ~~and attached~~ for duration of needed precautions, and Lippincott Procedures Airborne Precautions
3. Each of the rooms on the 2nd floor, ~~MS~~ Acute-Subacute #5 and ICU #1 will have a room pressure controller. This controller is designed to maintain a constant pressure differential. It measures the actual room pressure differential using TSI's unique, bi-directional pressure sensor, and modulates a damper or variable frequency drive to maintain set point. The controller has audible and visual alarms. The negative pressure is always on. The door to the room must always be closed.
4. Sputum Inductions will be performed in the Airborne Infection Isolation Room (AIIR) located in ICU rm 1 or Acute-Subacute rm 5; attempt to use ICU rm1 first. If these rooms are unavailable perform sputum induction in Infusion room 6.

DEFINTION:

Airborne Infection Isolation Room (AIIR) - Formerly, negative pressure isolation room

- An AIIR is a single-occupancy patient-care room used to isolate persons with a suspected or confirmed airborne infectious disease. Environmental factors are controlled in AIIRs to minimize the transmission of infectious agents that are usually transmitted from person to person by droplet nuclei associated with coughing or aerosolization of contaminated fluids.

- AIIRs should provide negative pressure in the room (so that air flows under the door gap into the room); and an air flow rate of 6-12 ACH (6 ACH for existing structures, 12 ACH for new construction or renovation); and direct exhaust of air from the room to the outside of the building or recirculation of air through a HEPA filter before returning to circulation.

Title: ~~Negative Pressure rooms~~ **Airborne Infection Isolation Rooms (AIIR)**	
Scope: NIHD	Department: **CPM - Infection Control- Patient Care (ICP)**
Source: Quality Informatics/Infection Preventionist	Effective Date:

Wall panel: A panel located outside the ante chamber room that includes an audible and visual alarm to warn staff when pressurization is lost or drifts past the preset pressure value.

PROCEDURE:

- ~~Be sure~~ Ensure negative pressure setting light is green and there are no alarms in Acute-Subacute room 5 and ICU room 1. Infusion Center room 6 smoke test done prior to use by the Maintenance Department
- Don appropriate PPE for type of precautions while in the ante chamber prior to entering the room with the patient. All staff must wear properly fitted N95 mask or Purified Air Powered Respirator (PAPR) before entering room
- Patient ~~should~~ must have a surgical mask on when they are admitted to the room, or if they leave the room for a procedure
- Admit patient as per any other patient
- Keep door closed between room and ante chamber as well as between ante chamber and the hallway.
- Post Airborne precautions signs on the anti chamber door as well as the door to the room itself.
- All Donning and Doffing of PPE should be done in the ante chamber.
- When the patient is discharged the room should be clean as for any precautions room.
- If the Airborne Isolation Rooms loses pressurization and does not correct itself by closing the doors, the Maintenance Department must be contacted immediately.

Monitoring AIIRs

- **The AIIR is monitored and documented Bi-monthly by the Maintenance Department for the Acute-Subacute rm 5 and ICU rm 1**
- **Nursing staff will complete daily verification when a patient in Airborne Isolation is placed in Acute-Subacute rm 5 and ICU 1. This is confirmed by ensuring that the green light located on the wall panel is on**
- **The flow-meter on the AIIR (Acute-Subacute & ICU) is checked yearly and if found to be in the yellow or red zone the filter will be changed by Biomed.**
- **A smoke test will be done and documented monthly on Infusion Room 6 by the Maintenance Department**
- **A smoke test will be done by the Maintenance Department on Infusion Room 6 with each use when a patient is place in Airborne Isolation**

~~**Alternative to Negative Pressure Rooms:**~~

~~Airborne infection isolation can also be achieved by the use of Hospi-Gard Portable Filtration Units (H.G.U.). The portable units provide airborne isolation throughout Northern Inyo Hospital District. Refer to the Hospi-Gard Portable Filtration (H.G.U) policy and procedure.~~

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: ~~Negative Pressure rooms~~ **Airborne Infection Isolation Rooms (AIIR)**	
Scope: NIHD	Department: **CPM - Infection Control- Patient Care (ICP)**
Source: Quality Informatics/Infection Preventionist	Effective Date:

Documentation:

- Document ~~on the electronic record~~ medical record when the patient was placed in precautions and that the negative pressure is on and working.
- Document each shift on the ~~electronic~~ medical record that the patient remains in precautions with the negative pressure on and working.
- Document each shift that correct isolation precaution signage is in place
- Document on the ~~electronic~~ medical record when the patient is removed from precautions.

References:

1. **Centers for Disease Control and Prevention. (2009). Healthcare Infection Control Practices Advisory Committee (HICPAC). Retrieved from http://www.cdc.gov/hicpac/2007ip/2007ip_glossary.html**
2. **Centers for Disease Control and Prevention. (2014). 2007 Guideline for isolation precautions: Preventing transmission of infectious agents in healthcare settings. Retrieved from http://www.cdc.gov/hicpac/2007IP/2007ip_appendA.html**

Cross References:

1. **Airborne Precautions in Lippincott Procedure**
2. ~~**Hospi-Gard Portable Filtration (H.G.U)**~~
3. **Aerosolized Transmissible Disease Plan**

Approval	**Date**
CCOC	**01/25/2017**
Infection Control Committee	**02/28/2017**
MEC	**03/07/2017**
Board of Directors	

Developed: 5-2011;
Reviewed: 9/12bs
Revised: 1/2017 RC
Supersedes: Negative Pressure Room
Index: Negative Pressure room, airborne precaution room

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Respiratory Syncytial Virus (RSV **Policy**	
Scope: NIHD	Manual: CPM-Infection Control-Patient Care (ICP)
Source: Quality Nurse/Infection Control Preventionist	Effective Date:

PURPOSE:
To immediately isolate patients with known or suspected RSV infection, to help prevent exposure and spread of RSV to patients, visitors and staff members.

POLICY:
1. RSV should be suspected in any small child admitted with respiratory problems during the ~~winter~~ months of October through April.
2. RSV test is recommended for all children admitted under the age of 5 with respiratory symptoms ~~and precautions used until test results returned.~~
3. Contact Precautions will initiated and maintained until RSV result is negative.
4. If RSV test is not ordered by physician the patient will remain in isolation until discharge

DEFINTION:
Respiratory Syncytial Virus (RSV): is a respiratory virus that infects the lungs and breathing passages. Healthy people usually experience mild, cold-like symptoms and recover in a week or two. But RSV can be serious, especially for infants and older adults

PROCEDURE:
1. Place patient in contact precautions
2. If patient coughing or sneezing staff are to wear a mask according to standard precautions.
3. Respiratory Therapy to wear N95 mask when administering nebulized treatments as per the Aerosolized Transmissible Disease policy
4. Post isolation signage and place isolation cart outside patient room
5. Educate parents or legal caretakers on contact precautions and hand hygiene
6. Document in patient medical record
    - Type of precautions contact
    - Start date and time
    - Type of teaching provided
    - Precautions stop date and time if applicable

PREVENTION:

1. Gloves - for handling secretions and touching the contaminated environment i.e., side rails, controls, etc.

2. Isolation Gowns – When entering the room if unknown RSV status. If child has nasal secretions and you are holding that child then gowns recommended.

3. Masks – as indicated under Standard Precautions.(If patient coughing then a surgical mask is indicated within 3 feet of coughing patient)
4. Respiratory Etiquette If age appropriate encourage patient to:
    - Use cough or sneeze into his or her elbow and not hands

Title: Respiratory Syncytial Virus (RSV **Policy**	
Scope: NIHD	Manual: CPM-Infection Control-Patient Care (ICP)
Source: Quality Nurse/Infection Control Preventionist	Effective Date:

- Cover mouth and nose with tissue when coughing or sneezing, dispose of the used tissue in appropriate waste receptacle, and then perform hand hygiene.

5. Hand Hygiene - after removing gloves; before leaving room.
6. Parents - must be informed of the need for hand washing to decrease contamination of the environment, i.e., side rails, telephones. Instruct family for the reason the child is in contact precautions. **Instruct the immediate family that they do not need to gown but that they must not walk around the hospital after being in the patient room and should leave the hospital directly after leaving patients room.**

REFERENCES:

1. Centers for Disease Control and Prevention (2014). Respiratory Syncytial Virus Infection (RSV). Retrieved from https://www.cdc.gov/rsv/
2. Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings 2007 https://www.cdc.gov/hicpac/2007ip/2007ip_appenda.html

CROSS REFERENCE P&P:

1. Lippincott Procedure: Contact Precautions
2. Aerosolized Transmissible Disease (ATD)

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CCOC	1/25/17
Infection Control	02/28/2017
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Supercedes:
Index Listings: RSV

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Skin Preparation in the Perioperative Unit**	
Scope: Surgery	Manual: **Surgery - ICP**
Source: Perioperative Director of Nurses	Effective Date:

PURPOSE:

- To remove dirt and oil on skin.
- To reduce microbial count at the operative site in order to decrease potential for postoperative wound infection.
- To promote postoperative wound healing.

POLICY:

1. All patients undergoing surgical intervention will have appropriate preoperative skin preparation.
2. The antiseptic agent used should be selected based on surgeon preference and patient assessment:
   - The patient should be assessed for allergy or sensitivity to skin preparation agents
   - The patient should be assessed for contraindications to specific skin preparation agents
   - The surgical site to be prepped
   - The presence of organic matter e. g. facial cosmetics, including blood;
     The efficacy of antiseptic agents is dependent on the cleanliness of the skin. Removal of superficial soil, debris, and transient microbes before applying antiseptic agents reduces the risk of wound contamination by decreasing the organic debris on the skin.
   - Neonatal status
   - Large open wounds
   - A review of the manufacturer's information
   - Surgeon's preference including use of antiseptic pre-op showers.
3. If preoperative showers have not been performed, a surgical wash should be done either in the preoperative area or immediately before applying the antiseptic agent in the intra-operative setting.
4. **The surgical site should be identified before the skin preparation**. This verification minimizes the risk of prepping the wrong area, which could contribute to wrong site surgery.
   a. Verification should be done in advance of the "time out" period, which occurs immediately before the surgeon makes the incision.
   b. The skin marker used to make the surgical site mark should
      - not facilitate microbial growth, and
      - provide a mark that remains visible after the surgical prep.
5. The patient's skin condition should be assessed for the presence of lesions or other tissue conditions at the surgical site before skin preparation begins.
   a. The presence of scratches, exudates, open sores, or unintentional removal of lesions traumatizes the skin at the surgical site and provides an opportunity for colonization by microorganisms.
5. Some anatomic areas contain more debris than others (e.g., umbilicus, under the fingernails, under the foreskin). Cleaning these areas separately from the surgical prep prevents distribution of microorganisms from these areas to the surgical site.
6. The Umbilicus should be cleaned with Q-tips and prep solutions in any abdominal surgery.

PROCEDURE:

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Title: **Skin Preparation in the Perioperative Unit**	
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PREOPERATIVE PREPARATION:

Hair Removal

- A physician's order, including site, is required for removal of hair. When method of hair removal is not included in the order, a clipper shall be used to remove hair.
- May be performed in the preoperative unit or in the patient's room.
- Is avoided in the operating room except in emergency situations.
- Is performed as close to the operative time as possible.
- Is performed only by appropriately trained personnel. The face and eyebrows are not shaved unless specifically ordered.
- Removal of eyelashes is accomplished with scissors.
- Electric clipper shave is the method of choice for hair removal.

❖ A razor should not be used to remove hair at the surgical site.
  - ➢ The use of a razor abrades the skin surface and enhances microbial growth.

❖ Cleansing of open traumatic orthopedic injuries with exposed bone can be facilitated by pulse lavage, a high pressure parallel water jet, or brush-suction irrigation as per physician's preference . Use of a protective shield is beneficial to avoid aerosolization of wound contaminants of onto the sterile field.

INTRAOPERATIVE SKIN PREPARATION AGENT:

A. Only hospital and FDA approved antimicrobial agents may be used for skin preparation.
B. Criteria for selection skin preparation agent include
   - Effectiveness against broad spectrum of bacteria
   - Initial action and duration time of effectiveness
   - Ease of application
   - Potential for skin irritation
   - Cost effectiveness

C. Intraoperative skin preparation may be performed by a registered nurse or the surgeon.

CHLORHEXIDINE SKIN PREP:

(Chlorhexidine gluconate solution 4.0 %)

1. Obtain a disposable prep tray- pour 4% Chlorhexidine solution.
2. Using sterile technique apply **undiluted** Chlorhexidine solution liberally to the surgical wound site, developing lather and scrub the area for at least two minutes.
3. Dry area with sterile paper towel from tray then repeat the process for another 2 minutes. Dry with sterile towel.

When using this product:

- ➢ Keep out of eyes, ears and mouth.
- ➢ May cause serious and permanent eye injury if placed or kept in the eye during surgical procedures, or may cause deafness when instilled in the middle ear through perforated eardrums.

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CHLORAPREP:

Warnings: For external use only. **Flammable, keep away from fire or flame.**

Do not use:

- ChloraPrep on children less than 1 year of age age because of the potential for excessive skin irritation and increased drug absorption.
- On patients with known allergies to Chlorhexidine and isopropyl alcohol.
- For lumbar puncture or in contact with the meninges.
- On open skin wounds or a general skin cleanser.

Directions:

1. Before using this product see insert for important information.
2. To reduce the risks of fire the following strategies are recommended:
   - At the end of prep, discard any portion of the solution which is not required to cover the prep area. It is not necessary to use the entire amount available.
   - Use in a well ventilated area.
   - Avoid getting solution into hairy areas. **Wet hair is flammable**. Hair may take up to one hour to dry.
   - Do not allow solution to pool.
   - Tuck prep towels to absorb solution, and then remove wet materials from the prep area.
   - Drape after solution is completely dry.
3. Maximal treatment area for one applicator is approximately 13.2 in. by 13.2 in. Discard the applicator after a single use.
4. Pinch the wing of the applicator to break the ampule and release the antiseptic. Do not touch the sponge. Wet the sponge by repeatedly pressing and releasing the sponge against the treatment area until liquid is visible on the skin.
5. **Dry surgical sites** (such as abdomen or arm): use repeated back-and-forth strokes for approximately 30 seconds. Completely wet the treatment area with antiseptic. Allow the area to air dry for approximately **three (3) minutes**. Do not blot or wipe dry.
6. **Moist surgical sites (such as the inguinal fold)**: Use repeated back-and-forth stroke of the sponge for approximately 2 minutes. Allow the area to air dry for approximately three (3) minutes. Do not blot or wipe away.

POVIDONE IODINE SKIN PREP:

1. Obtain a disposable prep tray, pour Povidone Iodine USP 7.5% scrub solution with 0.75 % available Iodine in one basin, recommended amount is 1 cc per 20 square inches.
2. Pour Povidone Iodine undiluted topical 10 % prep solution with 1% available Iodine into another section.
3. Pour sterile water into another section. Wet skin with sterile water.
4. Using sterile technique, apply **undiluted** scrub solution liberally to the surgical wound site, developing lather and scrub the area for 5 minutes.
5. Rinse scrub solution off the skin with prep sponges and sterile water.

6. Apply a liberal amount of Povidone Iodine topical prep solution and allow to dry.

VAGINAL PREPS:

Patients having vaginal surgery shall be prepped with Povidone Iodine ***prep solution*** in the vaginal vault, and Povidone Iodine ***scrub*** diluted with water on the labia and vaginal mucosa. Use two sponges soaked in Povidone Iodine prep solution on sponge stick to swab the vagina, (surgeon preference).

Povidone Iodine *Scrub* solution or Chlorhexidine solution is not used inside the vaginal vault.

PRECAUTIONS: Always assure the patient has no allergies to Iodine before using.
If the patient is allergic to Iodine a Techni-care (Chloroxylenol 3%) vaginal prep can be used. Technicare is safe for usage on mucous membranes.

POVIDONE IODINE OPHTHALMIC PREPS:

(Betadine 5%)

Make sure container is intact before use. To open completely twist off tab, do not pull off. Gently squeeze entire contents of bottle into a sterile prep container.

While patient is still in the preoperative unit, instill two Proparacaine drops into the affected eye per physician order. Confirm operative eye by visibility of the colored dot and verbally with the patient prior to installation of drops .

1. Place sterile Ophthalmic Povidone Iodine (Betadine 5% solution) into prep tray - **Do not dilute -** place 1cc syringe in tray.
2. Saturate sterile prep sponge to prep lids, brow and cheek in a circular ever-expanding fashion until the entire field is covered.
3. While gently separating the lids, irrigate the cornea, conjunctiva and palpebral fornices with 3-4 drops of Betadine 5% Sterile Ophthalmic prep solution using a sterile syringe.
4. Saturate sterile cotton-tipped applicator (Q-tip) to prep lashes and lid margins.
   - One Q-tip while eye is closed, cleaning both upper and lower lids.
   - Open eye slightly by placing finger under brow and using two Q-tips prep upper lid with one and lower lid with one.
   - Use last Q-tip to prep closed lids once again.
5. Repeat sterile prep sponge to prep lids, brow and cheek in a circular ever-expanding fashion until the entire field is covered.
6. After the Betadine solution has been left in contact for two minutes, sterile BSS solution in a three ml syringe from the surgical technician should be used to flush the residual prep solution from the cornea, conjunctiva, and the palpebral fornices.
7. Repeat sterile prep sponge to prep lid after rinsing with BSS.
8. With dry sponge gently pat the eye dry so the drape will stick.
9. If the patient is allergic to Betadine solution:
   - Prep outside of the eye and eye lids with normal saline solution as described above.
   - Use Vigamox 0.5% Antibiotic Solution and instill 3-4 drops in the affected. **Do Not Rinse**.

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DURAPREP SKIN PREP:

1. For patients who have not had a preoperative skin scrub in holding room i.e.; trauma patients with traction or fractured hips and emergency patients please follow these guidelines when utilizing Duraprep.
2. Obtain a disposable prep tray, pour Povidone Iodine scrub solution or Chlorhexidine in one basin, diluting with sterile water.
3. Open Duraprep package onto sterile prep field.
4. Using sterile technique apply scrub solution liberally to the surgical wound site, developing lather and scrub the area for at least 3 minutes.
5. **DRY AREA** with sterile paper towel from tray then apply the Duraprep solution according to following procedure.

APPLICATION OF DURAPREP

1. For surgical wounds that have been previously cleaned in holding room.
2. Place kit on table and open hospital wrap.
3. Duraprep solution is water insoluble; therefore avoid contact with reusable items (such as basins and instruments).
4. To assemble, invert applicator. With sponge face down, press the cap end of the applicator. Prep will flow into the sponge.
5. Clean umbilicus with swabs when applicable (moisten swabs by pressing against prep-soaked sponge applicator)
6. Use sponge applicator to paint operative site. Begin when fluid level reaches indicator line on the applicator barrel. It is not necessary to scrub. (Simply paint a single uniform application.)
7. If pooling occurs, immediately blot with sponge applicator and continue to apply a uniform application.
8. Once a uniform coating is applied, allow Duraprep solution to dry thoroughly (approximately 2-3 minutes). Do not blot. As it dries, Duraprep solution turns from a shiny to a dull appearance alerting the user that the solution is no longer flammable.
9. Discard applicator.
10. Begin draping only after Duraprep solution is dry. If incise drapes are used, apply directly to dry prep. On completion of surgical procedure, removal of incise drape will remove Duraprep film.
11. Duraprep film is intended to be left on the skin and gradually wear away.
12. If desired, prep can be removed with 3M 8610 or 8611 Remover lotion, or with alcohol saturated gauze. Apply dressing following standard practices.

PRECAUTIONS:

For external use only.

Duraprep surgical solution contains alcohol which is **flammable**. Until dry, do not use around spark flame (i.e., electrocautery).Use in well-ventilated area. Do not use in or near eyes. Isopropyl alcohol is a moderate eye irritant. If product gets into eyes, flush immediately with water.

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Avoid using Duraprep in the ears or on mucous membranes. Not recommended for use on patients with known sensitivity to Iodine.
NOT RECOMMENDED FOR USE ON CHILDREN UNDER 1 YEAR OF AGE

TECHNI-CARE (Chloroxylenol 3%) SKIN PREP:

Techni-care is a broad spectrum topical antiseptic microbicide for professional degerming. Techni-care is safe for usage on mucous membranes.

1. **For Preoperative Skin Preparation-**
   a) Obtain a disposable prep tray, squirt desired amount of Techni-care into well of tray. **Do not dilute.**
   - Apply Techni-care liberally to surgical site and swab for 2 minutes.
   - Allow to Air Dry
   - **Techni-Care** can be used for a vaginal prep

2. **For wound care and general skin cleansing (not surgical preps)** - Rinse area with water, apply Techni-care and cleanse gently. Rinse thoroughly.

GENERAL CONSIDERATIONS:

1. Only non countable sponges may be used for skin preparation.
2. For intact skin, preparation begins at the incision site and progresses to the periphery.
3. Sponges used to cleanse areas at the periphery are not returned for use at the incision site, the prep is continued with a new sponge each application.
4. Method for application and exposure time are noted above.
5. Area should be large enough to avoid wound contamination by inadvertent movement of drapes during the procedure. It should accommodate an extension of the incision, the need for additional incisions, and all drain sites.
6. The prep solutions should be applied in a manner that prohibits pooling beneath the patient, tourniquet, electrodes, or electrosurgical disperse pad. The patient can experience chemical burns if pooling occurs.
7. The prep solution should be allowed to air dry before drapes are applied. Use protective measures to prevent skin and tissue injury due to prolonged contact with skin prep agents. Chemical burns and skin irritation are more likely when antiseptic solutions are not allowed to dry and remain in contact with the skin for prolonged periods of time.
8. Check for pooling on or under the patient e.g., soaked linen, soaked adhesive tape, drips on padding under tourniquet cuffs, solution running off surgical sites and onto patient's backs, epidural prep sites. Remove and replace the soaked articles. Use gauze to wick pooling.
   - Wash off the Povidone Iodine prep solution after the epidural procedure is finished.
   - Wash off the Povidone Iodine prep solution when surgical procedure is finished.
9. When the incision site is more highly contaminated than the surrounding skin:

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- If a highly contaminated area is part of the procedure, the area with a lower bacterial count is prepped first, followed by the area of higher contamination, as opposed to working from the incision site toward the periphery.

10. The prepared area of skin should extend to an area large enough to accommodate potential shifting of the drape fenestration, extension of the extension, the potential for additional incisions, and all potential drain sites.
11. To prevent surgical fires, flammable prep agents must be thoroughly dried and vapors dissipated before applying drapes.

DOCUMENTATION OF SKIN PREPARATION:

Documentation of skin preparation will include:

- Area prepped
- Method of hair removal
- Type of solution used
- Person performing skin prep
- Condition of skin before and after prep.

REFERENCE: Manufacturer Literature for each prep solution.
Manual of Operating Room Management
AORN Standards and Recommended Practices for Perioperative Nursing
JCAHO IC.02.01.01 and Title 22 Standards 70739

CROSS REFERENCE:

1. Preoperative Skin Preparation

Committee	**Date**
CCOC	12/12/16
Infection Control Committee	02/28/2017
MEC	03/07/2017
Board of Directors	

Developed: 5/97 BS
Revised: 1/98 BS 02/01BS; 6/2011BS, BS 9/12, BS 10/2016
Index listings: Skin preparation / Prep

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Cleaning and Processing daVinci Instruments, Accessories and Endoscopes	
Scope: Sterile Processing	Manual: Infection Control Blue Manual, Sterile Processing
Source: DON Perioperative Services	Effective Date:

PURPOSE:

To assure the daVinci instruments, accessories and endoscopes are properly cleaned, disinfected and reprocessed.

POLICY:

All daVinci instrument and endoscopes will be cleaned and reprocessed utilizing this procedure to assure patient safety. Only perioperative/sterile processing personnel who have been appropriately trained on the cleaning and reprocessing of daVinci instruments, accessories and endoscopes will be responsible for reprocessing of daVinci equipment.

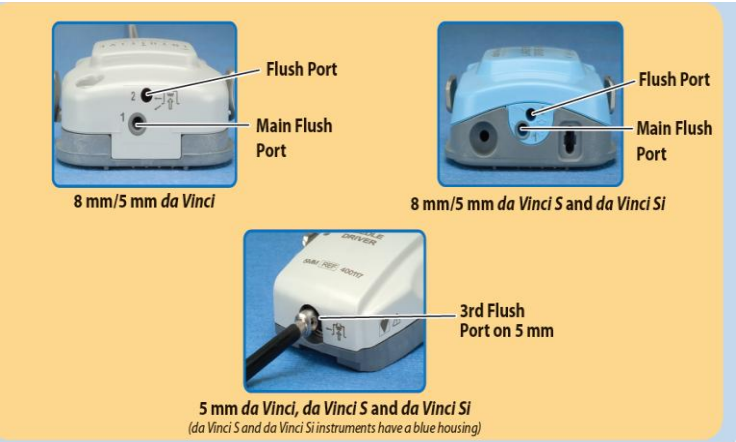
Sterile Processing personnel will complete the training modules/competency validation on the daVinci website relating to the cleaning, disinfection and sterilization of daVinci instrumentation and endoscopes**.**

PROCEDURE:

For reusable EndoWrist instruments, accessories, and endoscopes that require sterilization.
Before first use and immediately after each procedure, the devices must be cleaned and sterilized.
Unless specifically stated otherwise, only pH-cleaning agents must be used at all times during the cleaning process.
Do not allow debris to dry on or inside the device intraoperatively.
In order to keep the device from drying when soiled, keep the device in water or an enzymatic bath between surgical procedure and reprocessing.

EndoWrist Instruments:

1. Location of Flush Ports:
   Instruments that employ a disposable tip and/or tip accessory require disassembly before cleaning, disinfection and sterilization**.**



Title: Cleaning and Processing daVinci Instruments, Accessories and Endoscopes	
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2. Cleaning the Instrument:

1. Scrub

Thoroughly clean the outside of the entire instrument using **running water with a clean, soft nylon bristled brush**. **Move** the instrument wrist through its full range of motion while scrubbing.

Check the instrument including the tip and wrist section visually for cleanliness, while moving the wrist through its full range of motion. Pay particular attention to the instrument tip, the cables and the pulleys. Repeat scrubbing as needed.

WARNING: When scrubbing the tip of cautery instruments, take care not to damage the insulation.

2. Flush

Flush the main flush port for at least 20 seconds, using pressurized water at a minimum of **30 psi**. While flushing the instrument, hold the tip down and **move the wrist through its full range of motion**. Continue flushing **until all water exiting the instrument is clear**.

Flush the remaining flush ports for at least 20 seconds each using pressurized water at a minimum of **30 psi**. Continue flushing **until all water exiting the instrument is clear**.

8 mm and 5 mm Instruments

8 mm and 5 mm Instruments

5 mm Instruments Only

***A luer fitting** attached to a filtered water line (as shown) is recommended for connecting to the flush ports.*

30 psi minimum | *20 seconds minimum each port*

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3. Prime and Ultrasonically Clean

Prime the instrument using a syringe: **inject a minimum of 15cc of pH-neutral enzymatic cleaning solution into the main flush port** while immersing the instrument tip in the ultrasonic bath. Immediately submerge the remainder of the instrument. The recommended ultrasonic cleaning cycle is based on running at a minimum power density of 48 watts/gallon (ultrasonic power output / internal tank volume), and at an ultrasonic frequency of 38kHz or greater.

Run the instruments fully immersed in an ultrasonic bath filled with a pH-neutral **enzymatic cleaning solution for a minimum of 15 minutes**.

NOTE: We recommend a pH-neutral enzymatic cleaner specifically made to clean medical instruments, prepared according to the manufacturer's instructions. ***The enzymatic bath should be as close to 113 °F or 45 °C without exceeding the recommended temperature of the enzymatic detergent manufacturer.*** Regular maintenance is necessary for ultrasonic equipment to operate properly. Refer to the manufacturer's documentation for information about specific ultrasonic cleaning units.

*The enzymatic bath should be as close to **113 °F or 45 °C** without exceeding the recommended temperature of the enzymatic detergent manufacturer.*

15cc prime minimum

ENZ

15 minutes minimum

CAUTION: Do not expose instruments to hydrogen peroxide (H_2O_2), bleach, or alkaline-based cleaning agents, as this may result in instrument damage.

CAUTION: Prolonged exposure to either ultrasonic cleaning or cleaning agents may result in instrument damage.

4. Repeat Flush

Repeat Flush. Remove the instrument from the ultrasonic bath and repeat flush per Step 2.

NOTE: Repeat Step 3 (Prime and Ultrasonically Clean) and Step 4 (Flush) as necessary if water does not run clear.

CAUTION: If the water does not run clear, or does not flow through all flush ports even after repeating Steps 3 and 4 a few times, do not use the instrument. Contact *Intuitive Surgical* Customer Service.

8 mm and 5 mm Instruments

8 mm and 5 mm Instruments

5 mm Instruments Only

***A luer fitting** attached to a filtered water line (as shown) is recommended for connecting to the flush ports.*

H_2O ***30 psi minimum*** ***20 seconds minimum each port***

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5. Repeat Scrub

Thoroughly clean the outside of the entire instrument using **running water with a clean, soft nylon bristled brush**. **Move** the instrument wrist through its full range of motion while scrubbing.

Check the instrument including the tip and wrist section visually for cleanliness, while moving the wrist through its full range of motion. Pay particular attention to the instrument tip, the cables and the pulleys. Repeat scrubbing as needed.

6. Rinse

Thoroughly rinse the outside of the instrument to remove any residual debris or cleaning agents. Specifically rinse into the area **where the instrument shaft enters the housing**. Visibly inspect the exterior of the device, paying special attention to the instrument tip. There should be no visual contamination of the device (e.g. adherent soil). If the device has any residual contamination, repeat steps 1 through 6 (above).

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7. Dry

Dry the instrument completely. Make sure that all water empties from the instrument shaft and main flush port by vertically positioning the instrument with the tip up. Dry the outside of the instrument with a lint-free cloth.

Air may be blown through all flush ports and on the exterior of the instrument including the tip and the wrist section to facilitate drying.

8. Lubricate

Lubricate the tip and wrist mechanism with a **pH-neutral, steam-permeable** instrument lubricant per the manufacturer's instructions.

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Supplemental Cleaning Instructions

da Vinci Harmonic and *da Vinci* Harmonic ACE Curved Shears 8 mm and 5 mm instruments

CAUTION: *da Vinci* Harmonic Curved Shears Insert (PN 400169) and da Vinci Harmonic ACE Curved Shears Insert (PN 400272) are disposable and for single use only. Do not reprocess them.

1. Scrub the outside of the instrument housing with a soft, nylon bristled brush. Use a soft, nylon bristled bottle brush to clean the inside of the housing through the opening. See figure below. (If using the 8 mm instrument, use the bottle brush to clean the opening of attached 8 mm tube.)
2. Rinse the inside of the instrument housing thoroughly with tap water. While flushing the instrument, hold the distal end down and away from your body. The rinsing should continue until the water exiting the instrument housing is clear.

CAUTION: If the water is not clear, or does not flow through the housing, do not use the instrument. Should this occur, contact *Intuitive Surgical* Customer Service.

3. Immerse the instrument housing in an ultrasonic bath filled with an enzymatic cleaning solution for at least 15 minutes. We recommend using an enzymatic cleaner specifically made to clean medical instruments. Prepare the enzymatic bath according to the manufacturer's instructions.
4. Scrub the outside of the instrument housing with a soft, nylon bristled brush. Use a soft, nylon bristled bottle brush to clean the inside of the housing. (If using the 8 mm instrument, use the bottle brush to clean the openings of attached 8 mm tube).
5. Rinse the inside of the instrument with tap water. While flushing the instrument, hold the distal end down and away from you. Continue rinsing until water exiting the instrument is clear.
6. Thoroughly rinse the outside of the instrument housing to remove any residual debris or cleaning agents.
7. After cleaning, dry the outside of the instrument housing with a lint-free cloth.
8. Proceed to sterilization.

Supplemental Cleaning Instructions

EndoPass Delivery Instrument

During the cleaning process, all flush ports must be rinsed with pressurized water. Flush instrument with cartridge attached first, and then remove cartridge and flush again. After flushing, clear water should be seen exiting the instrument. If the water is not clear, or does not flow through all flush ports, **do not use the instrument**.

1. Scrub the outside of the instrument and cartridges with a soft, nylon bristled brush. Slide the outer tube through its full range of motion while scrubbing.
2. Rinse the inside of the instrument through all flush ports with pressurized water. Flush instrument with the cartridge attached, moving the outer tube through the full range of motion, until water exiting the instrument runs clear. Remove cartridge and continue flushing while moving the outer tube through the full range of motion and confirm that the water exiting the instrument is clear.
3. Clean the instruments by using a syringe to inject enzymatic cleaning solution into all flush ports. Then immerse the separate instrument and cartridges in an ultrasonic bath filled with an enzymatic cleaning solution for at least 15 minutes. We recommend using an enzymatic cleaner specifically made to clean medical instruments. Prepare the enzymatic bath according to the manufacturer's instructions.
4. Scrub the outside of the instrument and cartridges with a soft, nylon bristled brush. Slide the outer tube through its full range of motion while scrubbing.
5. Rinse the inside of the instrument with pressurized water using all flush ports. Move the outer tube through the full range of motion and flush with cartridge attached and unattached as described above. Continue to rinse until the water exiting the instrument flows clear.

   Flush ports are identified on the instrument housing by the following symbol:
6. Thoroughly rinse the outside of the instrument and cartridge to remove any residual debris or cleaning agents.
7. After cleaning, dry the outside of the instrument with a lint-free cloth. Dry the inside of the instrument by injecting alcohol into all flush ports, then blow pressurized air through all the flush ports.
8. Proceed to sterilization.

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Supplemental Cleaning Instructions

5 Fr Introducer

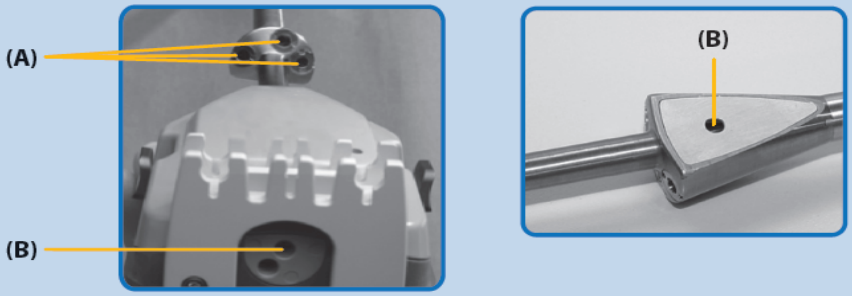
Follow all cleaning instructions for *EndoWrist* instruments. Use the female luer at the rear of the instrument in place of flush port 1.

Flushing the Instrument

EndoWrist Stabilizer

Use the following steps to maintain the best performance with the *EndoWrist* Stabilizer Instrument:

1. Scrub the outside of the instrument with a soft, nylon bristled brush. Move the instrument wrist joint through its full range of motion while scrubbing. Scrub the underside of the feet carefully.
2. Rinse the inside of the instrument through all flush ports **(A)** and luer fittings **(B)** with pressurized water. While flushing the instrument, hold the tip down and move the wrist through its full range of motion. Continue rinsing until water exiting the instrument runs clear.



Flush Ports and Luer Fittings

CAUTION: During the cleaning process, be sure to point the instrument tip down and away from you. All flush ports must be rinsed with pressurized water. After cleaning, clear water should be seen exiting the instrument. If the water is not clear, or water does not flow through all flush ports, do not use the instrument. Should this occur, contact *Intuitive Surgical* Customer Service.

3. Clean the instruments by using a syringe to inject pH-neutral enzymatic cleaning solution into all flush ports and luer fittings. Then immerse the instruments in an ultrasonic bath filled with pH-neutral enzymatic cleaning solution for at least 15 minutes. We recommend using an enzymatic cleaner specifically made to clean medical instruments. Prepare the enzymatic bath according to the manufacturer's instructions.
4. Rinse the inside of the instrument through all flush ports and luer fittings with pressurized water. While flushing the instrument, hold the tip down and move the wrist through its full range of motion. The rinsing should continue until the water exiting the instrument is clear.
5. Thoroughly rinse the outside of the instrument to remove any residual debris or cleaning agents.
6. After cleaning, dry the outside of the instrument with a lint-free cloth.
7. *Intuitive Surgical* recommends using a pH-neutral, steam permeable instrument lubricant to lubricate the jaw and wrist mechanism after cleaning but before sterilization.
8. Proceed to sterilization.

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Disinfection for *EndoWrist* Instruments

(This is an optional step. All Intuitive Surgical reusable product must be sterilized prior to patient use. The hospital policy and regional guidelines should dictate whether the product must be disinfected after cleaning and prior to sterilization.)

Intuitive Surgical has validated the following method as being compatible for use with *EndoWrist* instruments: A thermal disinfection cycle in a washer/disinfector system using pH-neutral cleaning agents only (enzymatic cleaners/detergents/lubricants).

The thermal disinfection cycle should not exceed temperatures of 285 °F or 140 °C.

In select countries outside the U.S., the Medisafe SI PCF system is validated for thermal disinfection. Contact Medisafe International for complete details.

NOTE: The disinfection step should be done ***in addition*** to the complete cleaning and sterilization steps and cannot be considered a substitute.

NOTE: Except for thermal disinfection with Medisafe SI PCF System (in select countries outside the U.S.), all other validation testing was limited to compatibility ***only*** and does not include efficacy of the disinfection process.

Sterilization for *EndoWrist* Instruments

Sterilization of the instruments has been validated using pre-vacuum steam autoclaving. The devices should be wrapped using a Central Supply Room (CSR) wrap that has been FDA cleared for the sterilization parameters provided. We recommend the sterilization parameters shown below:

Pre-vacuum sterilization:

- Pre-vacuum at 270-272 °F (132–134 °C)
- Minimum exposure time for the U.S.: 4 min.
- Minimum exposure time for countries following European guidelines: 3 min.
- Dry time: 20 minutes

Following steam sterilization, allow all components to cool to room temperature. Sudden changes in temperature may damage the components.

WARNING: The use of "flash" sterilization is not recommended.

WARNING: Do not sterilize at temperatures over 285 °F or 140 °C.

WARNING: *EndoWrist* instruments have not been validated for STERRAD®, EtO, Steris® or other sterilization methods.

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Cleaning for Accessories

For a list of accessories that require cleaning and sterilization, refer to Instrument and Accessory Cleaning and Sterilization Matrix on page 2.

NOTE: Instruments that employ a disposable tip and/or tip accessory require disassembly before cleaning, disinfection, and sterilization. Refer to the applicable section of this manual for disassembly instructions.

NOTE: Some accessories may require specific cleaning instructions. Refer to the supplemental cleaning instructions below.

1. Thoroughly clean entire device using running water with a clean soft, nylon bristled brush, paying special attention to the crevices and joints. Rotate the device in all directions while scrubbing.
2. Thoroughly rinse the device under running water to ensure that all debris has been washed away. If the device has lumens, ensure that the lumens are flushed under running water.
3. Submerge the entire device in an ultrasonic bath filled with a pH-neutral enzymatic cleaner and sonicate for at least 15 minutes.

   We recommend a pH-neutral enzymatic cleaner specifically made to clean medical instruments, prepared according to the manufacturer's instructions. The enzymatic bath should be as close to 113 °F or 45 °C as allowed without exceeding the recommended temperature of the enzymatic detergent manufacturer. Regular maintenance is necessary for ultrasonic equipment to operate properly. Refer to the manufacturer's documentation for information about specific ultrasonic cleaning units.

   The recommended ultrasonic cleaning cycle is based on running at a minimum power density of 48 watts/gallon (ultrasonic power output / internal tank volume), and at an ultrasonic frequency of 38kHz or greater.
4. Repeat step 1: Scrub the entire device using running water with a clean soft, nylon bristled brush. Rotate and move the device in all directions while scrubbing.
5. Rinse the device thoroughly to remove any residual debris or cleaning agents. Visibly inspect the exterior of the device, paying particular attention to the crevices. There should be no visual contamination of the device (e.g. adherent soil). If the device has any visual contamination, repeat steps 1 through 5 (above).
6. Dry the device completely with a lint-free cloth. If the device has lumens, ensure that all water is emptied from the lumens. Air may be blown to facilitate drying.
7. Proceed to sterilization.

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Supplemental Cleaning Instructions

PK Instrument Cords

1. Disconnect the cord from the generator and the instrument. Inspect the cord for fraying or degradation. Do not use cord if it shows signs of wear.
2. Wipe down the external surfaces of the cord with a solution of warm, soapy (enzymatic, biocidal, detergent) water prepared per the manufacturer's instructions.
3. Using a round, small diameter soft bristle brush moistened with the soapy water, gently scrub cord crevices to loosen any soil.
4. Flush the exterior of the cord with running water to remove detergent and other soils.
5. Visibly inspect the exterior of the cord for any adherent soil, paying particular attention to the crevices around the connectors.
6. Repeat if needed.
7. Gently wipe the cord dry.
8. Proceed to sterilization.

da Vinci and *da Vinci S* Light Guide Cables

NOTE: The *da Vinci Si* light guide does not require cleaning or sterilization.

Cleaning:

CAUTION: Do not ultrasonically clean the light guides. There is a risk of damaging the device.

1. Clean the guide by soaking it in a cleaning solution. Do not use synthetic detergents or oil-based soap. These chemicals may be absorbed into the guide and could leak out and cause tissue reaction.
2. Use a soft-bristle brush (such as a toothbrush) to remove visible debris. Rinse adequately in warm water with a final rinse of distilled water to avoid watermarks. Do not use ultrasonic cleaners.

Disinfection:

Do not use disinfecting solutions containing peracetic acid or chlorine compounds. Follow the instructions of the disinfecting solution manufacturer for timeline recommendations. Avoid soaking the guide for more than 10 minutes.

Disinfection for Accessories

(This is an optional step. All Intuitive Surgical reusable product must be sterilized prior to patient use. policy and regional guidelines should dictate whether the product must be disinfected after cleaning and prior to sterilization.)

Intuitive Surgical has validated the following method as being compatible for use with *da Vinci*® System accessories: A thermal disinfection cycle in a washer/disinfector system using pH-neutral cleaning agents only (enzymatic cleaners/detergents/lubricants).

The thermal disinfection cycle should not exceed temperatures of 285 °F or 140 °C.

NOTE: The disinfection step should be done ***in addition*** to the complete cleaning and sterilization steps and cannot be considered a substitute.

NOTE: All the validation testing was limited to compatibility ***only*** and does not include efficacy of the disinfection process.

Sterilization for Accessories

(see sterilization parameters for PK Instruments Cords on next page)

Sterilization of the devices should be performed using pre-vacuum steam autoclaving. The devices should be wrapped using a Central Supply Room (CSR) wrap. In the U.S., this wrap must be FDA-cleared for the sterilization parameters provided. We recommend the sterilization parameters shown below:

Pre-vacuum sterilization:

- Pre-vacuum at 270-272 °F (132–134 °C)
- Minimum exposure time for the U.S.: 4 min.
- Minimum exposure time for countries following European guidelines: 3 min.
- Dry time: 20 minutes

Following steam sterilization, allow all components to cool to room temperature. Sudden changes in temperature may damage the components.

WARNING: The use of "flash" sterilization is not recommended.

WARNING: Do not sterilize at temperatures over 285 °F or 140 °C.

WARNING: These devices have not been validated for use with STERRAD®, EtO, Steris® or other sterilization methods.

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Supplemental Sterilization Instructions

PK Instrument Cords

Sterilize the cord by one of the following methods:

- Gravity Steam Sterilization – full cycle at 270-275 °F (132–135 °C) for 15 minutes with slow cool down cycle. Drying time will vary according to wrapping material.
- Pre-vacuum Steam Sterilization – full cycle at 270-275 °F (132-135 °C) for 3 minutes.
- STERRAD® 100S sterilization system – full cycle.

da Vinci and *da Vinci S* Light Guide Cables

Sterilize these cables using the Sterilization for Accessories instructions on the preceding page, and follow these supplemental instructions:

Light guides should be packed loosely. To ensure sterility, light guide loops should not touch during sterilization. Small bubbles in the silicon tubing may be caused by the pressure differential during autoclave sterilization. The bubbles will dissipate in time and do not affect the guide's performance. Allowing the guide to rapidly cool after sterilization can cause fiber breakage. Allow the guide to cool slowly. Do not use any other sterilization methods.

Cleaning for Endoscopes

Intuitive Surgical endoscopes should be cleaned and sterilized before each use. Before cleaning the products, please review the important information listed below.

- The endoscopes are not supplied sterile and must be cleaned and sterilized before the first use.
- Exercise care when cleaning and handling the distal end of the endoscope. Do not exert excessive force on distal windows and never clean with sharp objects or instruments.

CAUTION: Do not ultrasonically clean *Intuitive Surgical* endoscopes. There is a risk of damaging the endoscope.

CAUTION: Do not autoclave 8.5 mm and 12 mm *Intuitive Surgical* endoscopes. Autoclave cycles introduce high temperatures and sudden temperature changes, which will cause damage to the endoscope.

NOTE: Automated cleaning and washing systems are not compatible with *Intuitive Surgical* endoscopes.

NOTE: *Intuitive Surgical* 8.5 mm and 12 mm endoscopes should not be processed in temperatures exceeding 158 °F (70 °C).

NOTE: The endoscope may require disassembly before cleaning, disinfection, and sterilization. Remove the camera sterile adapter from the endoscope. If applicable, remove any light guides and light guide adapters from the light ports on the endoscope.

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Cleaning for Endoscopes

1. Check

Check that the endoscope is not damaged and that all lenses are intact and firmly in place.

2. Scrub

Thoroughly clean the outside of the entire endoscope using running water with a clean, soft nylon bristled brush, paying special attention to the endoscope tip and rear black ring nut. Rotate the black ring nut through its full range of motion while scrubbing to facilitate cleaning between the slots in the ring nut.

3. Soak

Soak the endoscope in a pH-neutral enzymatic cleaner (such as Endozime®), following the manufacturer's recommendations. Make sure that all components are completely immersed in the enzymatic cleaner.

4. Repeat scrub

At the end of the soaking period, use a soft nylon bristled brush to **thoroughly clean** the outside of the entire endoscope while still immersed in the enzymatic cleaner. Pay special attention to the endoscope tip and rear black ring nut. Rotate the black ring nut through its full range of motion while scrubbing to facilitate cleaning between the slots and the ring nut.

5. Rinse

Rinse the endoscope thoroughly to remove any residual debris or cleaning agents. Pay special attention to the rear black ring nut area.

6. Dry

Dry the endoscope with a soft, lint-free cloth to prevent water spots on the lenses.

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Sterilization for Endoscopes

CAUTION: Do not use STERRAD NX or 100NX Standard or Flex Cycles for *Intuitive Surgical* endoscopes.

CAUTION: Do not immediately cool a hot endoscope after sterilization by exposing it to air or liquid. Sudden temperature changes may cause damage to the endoscope.

CAUTION: Do not autoclave 8.5 mm or 12 mm *Intuitive Surgical* endoscopes. Autoclave cycles introduce high temperatures and sudden temperature changes, which will cause damage to the endoscope.

Refer to the table below for compatible sterilization methods of *Intuitive Surgical* endoscopes.

Endoscope Sterilization Compatibility Matrix		Sterilization				
System	Endoscope	Autoclave (Pre-vacuum)	STERIS System 1E* V-PRO	STERRAD 50, 100S, 200	STERRAD 100NX Express Cycle†	EtO‡
da Vinci and *da Vinci S*	 12 mm Endoscope		●	●	●†	●
	 8.5 mm Endoscope		●	●	●†	●
	 5 mm Endoscope	●		●	●†	●
da Vinci Si	 8.5 mm Endoscope		●	●	●†	●
	 12 mm Endoscope		●	●	●†	●

*STERIS system 1E is a liquid chemical sterilant processing system cleared by FDA under special usage guidelines. Please contact STERIS Inc. for complete details.
†Contact Advanced Sterilization Products (ASP) for availability in your region.
‡See EtO sterilization parameters on page 2.

NOTE: Follow the manufacturer's recommendations for proper sterilization.

Cleaning and Sterilization of the Stapler System

1.4 Stapler Instrument Reprocessing Preparation in the Operating Room

The instructions in this section only pertain to the Stapler instrument. Reprocessing preparation in the operating room is not required for the Stapler Motor Pack or the Stapler Cable.

CAUTION: Do not submerge the Stapler Motor Pack.

Note: Carefully remove all accessories, including the Stapler Motor Pack and all disposable attachments such as reloads and sheaths, before reprocessing.

Note: When instruments expire, they are automatically inactivated and can no longer be used. Expired instruments must be properly disposed of.

When disposing of *Intuitive Surgical* instruments, accessories, or components, follow institution biohazard protocol and all applicable national and local laws and guidelines.

Disposable accessories include:

- Cannula Seals – Used on all Cannulae
- Stapler 45 Reload
- Stapler Sheath

Re-usable accessories include:

- Stapler Motor Pack
- Stapler Cable

For disassembly instructions, including removal of reload and sheath, see the *EndoWrist* 45 Stapler System Instruments and Accessories User Manual Addendum.

Removing the Cannula Seal

Firmly grasp the cannula seal and pull it out of the cannula.

Prime and Soak

Note: The cleaning preparation process (as described below) must begin within 60 minutes after the procedure. *Intuitive Surgical* recommends starting immediately after the procedure to avoid drying of residual soil on devices.

1. Prime the instruments using a syringe with a Luer fitting to fill the Primary Flush Port with 15 mL cold water, or with enzymatic cleaner prepared in accordance with the chemical manufacturer's directions.

Figure 1.1 Prime instruments with cold water or instrument cleaner

2. Soak the instruments in cold water or cleaner, or spray the instruments with a pH-neutral preparation cleaner. Alternatively, if the foregoing cannot be done, then employ a method to keep the instrument tips moist. Observe the specifications of the chemical manufacturer.

Figure 1.2 Soak instruments in cold water or cleaner

Transport to Sterile Processing Department

Observe your in-house hygiene regulations, and use only suitable containers to transport devices to the Sterile Processing Department.

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1.5 Preparation for Cleaning

Check Supplies

Luer fitting ordered from *Intuitive*

Scrub brush provided by *Intuitive*

Legally marketed, pH neutral steam permeable lubricant bottle with drop tip provided by *Intuitive*

Cable soak tub

Syringe (>20 ml)

Figure 1.3 Cleaning supplies

Inspect Before Cleaning

Remove the Stapler 45 Reload, Stapler Sheath, and Stapler Motor Pack from the instrument before starting, as described in the *EndoWrist*® Stapler 45 System Instruments and Accessories User Manual Addendum. Refer to Figure 1.4 for instrument orientation.

⚠ **CAUTION: Do not clean the Stapler 45 instrument with the Stapler Motor Pack, Stapler 45 Reload, or Stapler Sheath installed.**

1.6 Overview of Instrument Orientation, Flush and Lubrication Areas

The images in this section illustrate the Stapler 45 Instrument Cleaning Steps that follow in section 1.7, starting on page 9.

Figure 1.4 Stapler 45 instrument

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Instrument Flush Areas (8 Total)

The primary flush port (flush port 1) is located on the instrument shaft closest to the housing, and a secondary flush port (flush port 2) is located on the back of the housing. (Note that the shaft rotates, so the primary flush port may be positioned at different orientations.) Two distal flush ports and two tube seal flush ports are located on the instrument shaft near the jaws. Additional flush locations include the proximal crotch of jaws and the lead screw (wrist) area. See Figure 1.5.

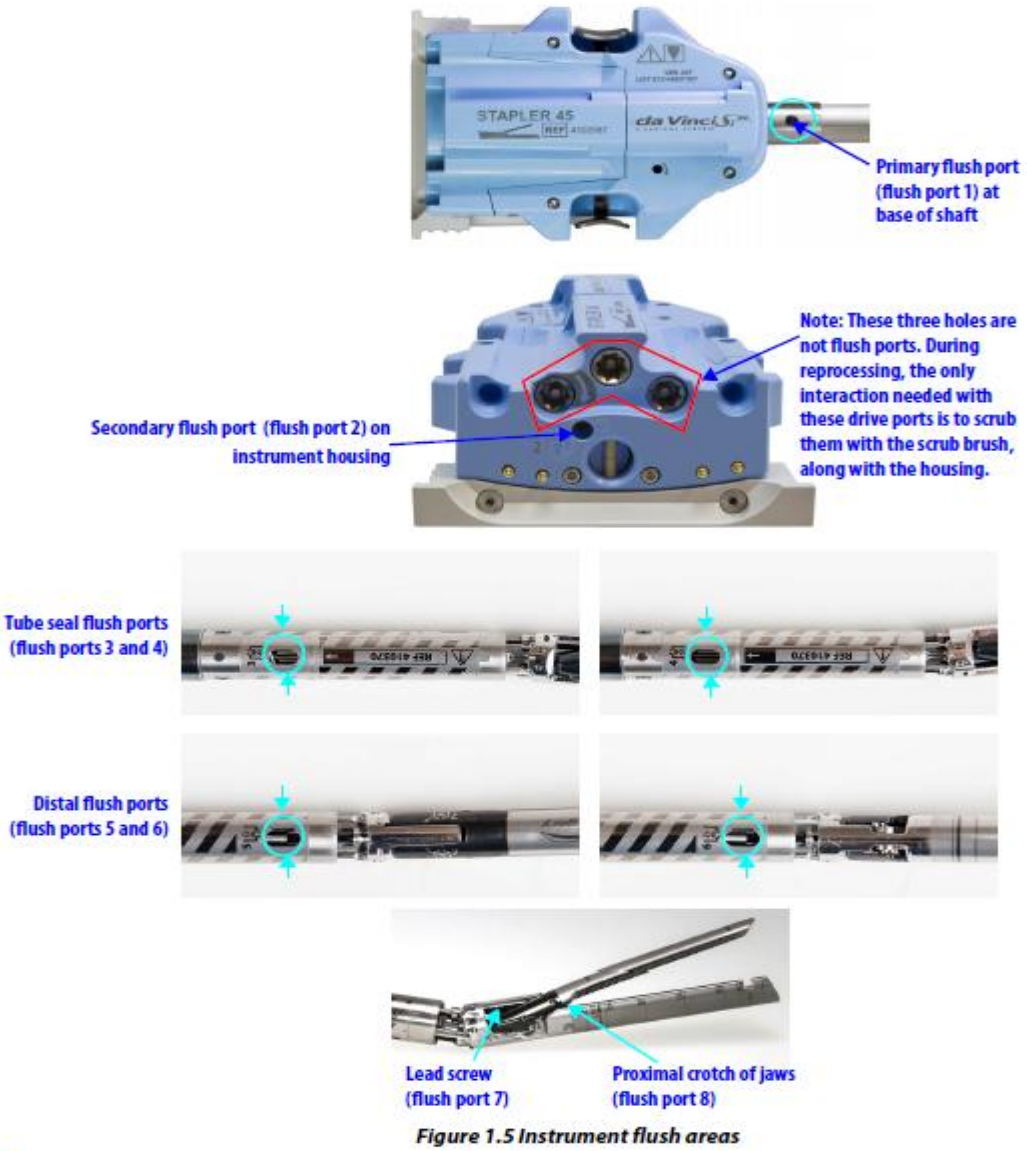

Figure 1.5 Instrument flush areas

Instrument Lubrication Areas (8 Total)

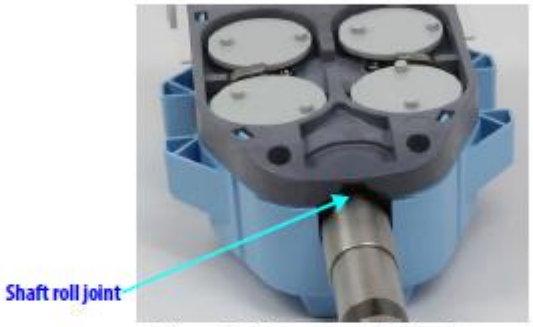

Figure 1.6 Instrument lubrication areas

1.7 Stapler 45 Instrument Cleaning Steps

⚠ **CAUTION: During scrubbing and flushing do not push the Stapler jaws against the sink or other hard surfaces, as this may cause instrument damage.**

⚠ **CAUTION: Do not use excessive force when moving the Stapler through its range of motion.**

Follow these steps to clean the Stapler 45 instrument.

Step 1: Rinse and Scrub

- Rinse
  - Hold the Stapler 45 instrument vertically. Rinse with water to remove the majority of loose debris from the instrument.
- Scrub
  - Scrub the outside of the **entire** instrument under running water with a scrub brush, starting at the housing and ending at the jaws. Move the instrument tip through its full range of motion while scrubbing (left, right, up, and down). Pay special attention to the wrist and jaws, as described below:
    - **Scrub the wrist:** Scrub all around the pivot of the wrist while moving through its full range of motion (3, 6, 9, and 12 o'clock positions).
    - **Scrub the jaws:** Scrub the jaws thoroughly, including the anvil, reload housing and proximal opening.
    - Repeat scrubbing until there is no visible soil remaining on the instrument jaws.

Step 2: Flush

Use the Luer fitting with pressurized water, minimum 30 psi, to flush the eight flush areas (Figure 1.5):

- **Area 1:** Primary flush port at shaft base
- **Area 2:** Secondary flush port at instrument housing
- **Area 3:** Tube seal flush port 1, aiming toward the tube seal
- **Area 4:** Tube seal flush port 2, aiming toward the tube seal
- **Area 5:** Distal flush port 1, aiming toward the wrist
- **Area 6:** Distal flush port 2, aiming toward the wrist
- **Area 7:** Lead screw
- **Area 8:** Proximal crotch of jaws

Note: The Luer fitting does not attach to the distal and tube seal flush ports. Hold the tip of the Luer fitting as close as possible to the flush ports and jaws while flushing.

- Flush the primary flush port for at least 20 seconds using pressurized water, minimum 30 psi, until all exit water runs clear (Figure 1.7). Use the Luer fitting ordered from *Intuitive*. This will avoid damage to the flush tube inside the shaft of the instrument.

Figure 1.7 Flush primary flush port

- Flush the secondary flush port for at least 20 seconds using pressurized water, minimum 30 psi, until all exit water runs clear (Figure 1.8).

Figure 1.8 Flush secondary flush port

- Hold the Luer fitting in place and flush the proximal crotch of the jaws (Figure 1.12). Flush for at least 20 seconds using pressurized water, minimum 30 psi, until all exit water runs clear.

Figure 1.12 Flush the proximal crotch of the jaws

Step 3: Prime and Ultrasonically Clean

⚠ **CAUTION: Prolonged exposure to ultrasonic cleaning or cleaning agents may result in damage to the instrument.**

ℹ **Note: The recommended ultrasonic cleaning cycle is based on running at a minimum power density of 48 watts/gallon (ultrasonic power output / internal tank volume), and at an ultrasonic frequency of 38 kHz or greater.**

ℹ **Note: We recommend a pH-neutral enzymatic cleaner specifically made to clean medical instruments, prepared according to the chemical manufacturer's instructions for concentration and temperature. Regular maintenance is necessary for ultrasonic equipment to operate properly. Refer to the manufacturer's documentation for information about specific ultrasonic cleaning units.**

- Prepare a solution of water and pH-neutral enzymatic cleaner (at the manufacturer's recommended concentration and temperature) in an ultrasonic bath.
- Prime the instrument using a syringe: immerse partially open jaws in solution and inject a minimum of 20 cc of the solution into the primary flush port.

  Alternatively, the user may prime the instrument outside of the ultrasonic bath. While orienting the instrument with the distal tip pointing down, prime the instrument with the syringe: inject at least 20 cc of the solution into the primary flush port and then place the instrument into the ultrasonic bath while maintaining the distal tip below the instrument housing.
- Immediately submerge the entire instrument.
- Run the ultrasonic bath for **15 minutes**.

Step 4: Repeat Flush

- Remove the instrument from the ultrasonic bath.
- Flush all eight areas per Step 2: Flush to ensure that all detergent residue is removed.

⚠ **CAUTION: Prolonged exposure to high pH detergents, or if not rinsed properly, causes surface deposits (which appear as brown stains); this interferes with the smooth operation of the instrument.**

- Hold the Luer fitting in place and flush each of the four flush ports on the tip of the shaft (two distal flush ports and two tube seal flush ports) for at least 20 seconds each, using pressurized water, minimum 30 psi, until all exit water runs clear.
  - While flushing the two tube seal flush ports: position the Luer fitting at an angle so that the water flows toward the seal (Figure 1.9).
  - While flushing the two distal flush ports: position the Luer fitting at an angle so that the water flows toward the jaws (Figure 1.10).

Figure 1.9 Flush up toward the seal

Figure 1.10 Flush down toward the jaws

- While moving the tip through its full range of motion, flush both sides of the lead screw area, as shown in Figure 1.11. Flush for at least 20 seconds using pressurized water, minimum 30 psi, until all exit water runs clear.

Figure 1.11 Flush the lead screw area

Note: Repeat Step 3: Prime and Ultrasonically Clean and Step 4: Repeat Flush as necessary if water does not run clear.

CAUTION: If the water does not run clear, or does not flow through all flush ports even after repeating Step 3: Prime and Ultrasonically Clean and Step 4: Repeat Flush, do not use the instrument. Contact *Intuitive Surgical* Customer Service.

Step 5: Rinse

- Hold the Stapler instrument vertically. Thoroughly rinse the outside of the entire instrument with water to remove any residual debris or cleaning agents. Specifically rinse into the area where the instrument shaft enters the housing and around the wrist (Figure 1.13).
- Visually inspect the exterior of the instrument, paying special attention to the jaws. There should be no visual contamination (for example, adherent soil). If the instrument has any residual soil, repeat Step 1: Rinse and Scrub through Step 5: Rinse.

Figure 1.13 Rinse outside of entire instrument

Optional Step: Thermal Disinfection

CAUTION: Unless otherwise specified, *EndoWrist* Instruments and Accessories are not compatible with chemical disinfection.

Thermal disinfection may be performed as required by hospital policy and regional guidelines. The *EndoWrist* Stapler 45 Instrument is compatible with the thermal disinfection cycle in an automated washer/disinfector.

Note: The thermal disinfection step may be performed in addition to the complete cleaning instructions and prior to completing the sterilization instructions. Thermal disinfection is not a substitute for cleaning and sterilization.

Step 6: Dry

- Dry the instrument completely. To ensure that all water empties from the instrument shaft and primary flush port, partially open the jaws and position the instrument vertically with the tip facing the ceiling.
- Dry the outside of the instrument with a lint-free cloth. Compressed dry air (CDA) may be blown through all flush ports to facilitate drying.
- Ensure the instrument is completely dry before proceeding to Step 7: Lubricate.

Step 7: Lubricate

Note: Failure to properly lubricate the Stapler instrument as described below may prevent successful completion of the calibration process during surgical use.

Use a legally marketed pH-neutral, steam permeable instrument lubricant bottle with drop tip (shown at left) to lubricate each of the eight lubrication areas shown in Figure 1.6 (page 9):

Legally marketed, pH neutral steam permeable lubricant bottle with drop tip provided by *Intuitive*

- **Area 1:** Proximal crotch of jaws
- **Area 2:** Lead screw
- **Areas 3, 4:** Grip cable pulleys (each side)
- **Areas 5,6:** Cardan joints (silver ball joints) [each side]
- **Area 7:** Tube seal flush ports (either side)
- **Area 8:** Shaft roll joint

Lubricate the instrument as follows:

1. Apply one to two drops of lubricant to the proximal crotch of the jaws, see Figure 1.14.

Figure 1.14 Lubricate the proximal crotch of jaws

2. Apply one to two drops of lubricant to the lead screw, see Figure 1.15.

Figure 1.15 Lubricate the lead screw

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3. Apply one to two drops of lubricant to both of the grip cable pulleys, see Figure 1.16.

Figure 1.16 Lubricate the grip cable pulleys (two pulleys, one on each side of the jaws)

4. Apply one to two drops of lubricant to both Cardan joints at the wrist, see Figure 1.17.

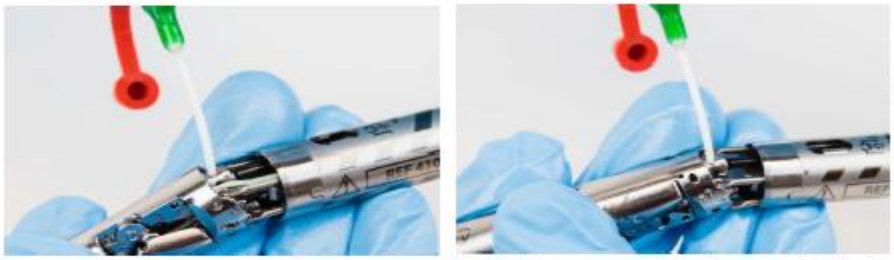


Figure 1.17 Lubricate the Cardan joints (two silver ball joints, one on each side of the shaft)

5. Apply one to two drops of lubricant to the tube seal through either of the tube seal flush ports on the shaft: hold the instrument with the jaws facing up so that gravity aids the lubrication down to the tube seal, see Figure 1.18.

Figure 1.18 Lubricate the tube seal through either of the tube seal flush ports

6. Apply one to two drops of lubricant to the roll joint, see Figure 1.19.

Figure 1.19 Lubricate the roll joint

1.8 Stapler 45 Accessory Cleaning Instructions

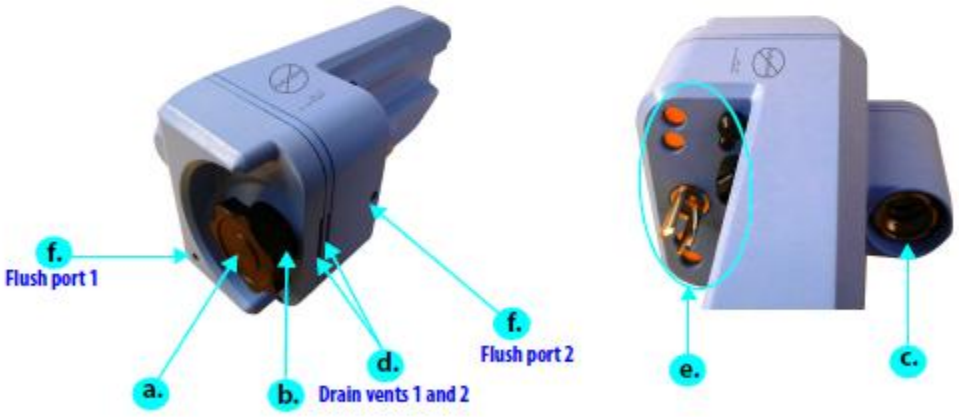
Cleaning the Stapler Motor Pack

⚠ **CAUTION: Do not place the Stapler Motor Pack in an ultrasonic bath.**

⚠ **CAUTION: Do not submerge the Stapler Motor Pack**

Step 1: Scrub and Rinse

- Prepare a solution of water and pH-neutral enzymatic cleaner (at the manufacturer's recommended concentration and temperature).
- Apply the solution to the entire surface of the Stapler Motor Pack, including the areas shown below (Figure 1.20); but **do not submerge the Stapler Motor Pack in the solution**.



a. Release knob
b. Release knob shaft
c. Cable receptacle
d. Drain vents (total of two)
e. Stapler instrument interface area
f. Primary flush port (1) and Secondary flush Port (2)

Figure 1.20 Stapler Motor Pack cleaning areas

- Use a scrub brush moistened with the solution to gently scrub all surfaces, including crevices and the areas in Step 1 (Figure 1.20), for a minimum of two minutes to loosen any soil. ***Turn the release knob while scrubbing***.
- Rinse all surfaces with room temperature running water, including the release knob (while turning) and the areas in Step 1 (Figure 1.20), to remove detergent and other soils. Continue to rinse until no soil is visible.

Step 2: Flush

- Use a spray gun, or equivalent, such as a Luer fitting and hose to flush pressurized room temperature water (minimum 30 psi) into each flush port for a minimum of 20 seconds.

Step 3: Repeat Rinse and Flush

- Repeat Rinse and Flush to remove residual soil or detergent before continuing to Step 4.
- Visually inspect the exterior of the device, paying special attention to the crevices. There should be no visible contamination of the device (for example, adherent soil). If the device has any visible contamination, repeat steps 1 through 3.

Optional Step: Chemical Disinfection

⚠ **CAUTION: The Stapler Motor Pack is not compatible with thermal disinfection.**

⚠ **CAUTION: Never put the Stapler Motor Pack in a washer disinfector or autoclave.**

⚠ **CAUTION: Do not expose the Stapler Motor Pack to any temperatures greater than 135 °F (57 °C), as damage may occur.**

Chemical disinfection may be performed as required by hospital policy and regional guidelines. The *EndoWrist* Stapler Motor Pack can be wiped down with 70% Isopropyl Alcohol or CaviWipes® for surface chemical disinfection.

ℹ **Note: The surface chemical disinfection step may be performed in addition to the complete cleaning instructions and prior to completing the sterilization instructions. Chemical disinfection is not a substitute for cleaning and sterilization.**

Step 4: Dry

- Drain excess water from the drain vents, cable receptacle, and two flush ports. Gently wipe dry with a lint-free cloth.
- Place the Stapler Motor Pack vertically with the release knob facing down (Figure 1.21), and allow water to drain for 5 minutes.

Figure 1.21 Stapler Motor Pack vertical, release knob facing down

- Drain excess water from the release knob shaft. Gently wipe dry with a lint-free cloth.
- Place the Stapler Motor Pack in a tilted position with the front-end and drain vents facing down (Figure 1.22). Allow water to drain for 5 minutes.

Figure 1.22 Stapler Motor Pack tilted with drain vents facing down

- Drain excess water from the drain vents, cable receptacle, Stapler instrument interface area, and flush ports.
- Gently wipe dry with a lint-free cloth. Compressed dry air (CDA) may be blown on all surfaces and crevices to facilitate drying.

Cleaning the Stapler Cable

⚠ **CAUTION: Disconnect the Stapler Cable from the ICB and the Stapler Motor Pack before cleaning.**

Complete the following steps to clean the Stapler Cable, refer to Figure 1.23 for reference.

Figure 1.23 Stapler Cable end

Step 1: Soak

- Prepare a solution of water and a pH-neutral enzymatic cleaner (at the manufacturer's recommended concentration and temperature) in the cable soak tub.
- Submerge the Stapler Cable into the solution. Move the sleeve on each cable end back-and-forth **five** times. Soak for five minutes. Again, move the sleeve on each cable end back-and-forth five times, then remove the cable from the solution.

Step 2: Scrub Cable Ends

- Use a scrub brush moistened with the solution to gently scrub both cable ends, including where the pins engage and the cable sleeves, to loosen any soil. Actuate cable sleeves while scrubbing.

Step 3: Rinse Cable Ends

- Thoroughly rinse both cable ends, including where the pins engage and the cable sleeves, with room temperature running water.

Step 4: Repeat Scrub and Rinse of Cable Ends

- Pull down and hold the cable sleeve, and repeat steps 2 and 3 for both cable ends.

Step 5: Scrub Length of Cable

- Scrub the full-length of the cable surfaces to loosen any soil.

Step 6: Rinse the Length of the Cable

- Thoroughly rinse the exterior of the cable with room temperature running water.

Step 7: Visually Inspect

- Visually inspect the exterior of the device, paying special attention to both cable ends, where the pins engage, and the cable sleeves. There should be no visible contamination of the device (for example, adherent soil). If the device has any visible contamination, repeat steps 1–6.

Optional Step: Thermal Disinfection

⚠ **CAUTION: Unless otherwise specified, *EndoWrist* Instruments and Accessories are not compatible with chemical disinfection.**

Thermal disinfection may be performed as required by hospital policy and regional guidelines. The *EndoWrist* Stapler Cable is compatible with the thermal disinfection cycle in an automated washer/disinfector.

Note: The thermal disinfection step may be performed in addition to the complete cleaning instructions and prior to completing the sterilization instructions. Thermal disinfection is not a substitute for cleaning and sterilization.

Step 8: Dry

- Gently wipe dry with a lint-free cloth. Compressed dry air (CDA) may be blown on all surfaces and crevices to facilitate drying.

Cleaning the Stapler Release Kit

The Stapler Release Kit consists of a Manual Unclamp Tool, an Emergency Grip Release Tool, and a tag with instructions. It is provided for intraoperative scenarios.

Figure 1.24 Stapler Release Kit

⚠ **CAUTION: Do not use the Stapler Release Kit on the instrument during reprocessing, as instrument damage could occur.**

Title: Cleaning and Processing daVinci Instruments, Accessories and Endoscopes	
Scope: Sterile Processing	Manual: Infection Control Blue Manual, Sterile Processing
Source: DON Perioperative Services	Effective Date:

Step 1: Scrub and Rinse

- Scrub
  - Scrub the outside of the entire device using running water with a scrub brush, paying special attention to the crevices. Rotate the device in all directions while scrubbing.
- Rinse
  - Rinse the device with room temperature running water. Continue to rinse until no contamination is visible. If the device has lumens, ensure that the lumens are flushed under running water.

Step 2: Ultrasonically Clean

- Prepare a solution of water and pH-neutral enzymatic cleaner (at the manufacturer's recommended concentration and temperature). Submerge the entire device in the ultrasonic bath and sonicate for 15 minutes.

Step 3: Repeat Scrub and Rinse

- Scrub the outside of the entire device using running water and a scrub brush.
- Rinse the device with room temperature running water to remove residual debris or cleaning agents.
- Visually inspect the exterior of the device, paying special attention to the crevices. There should be no visible contamination of the device (for example, adherent soil). If the device has any visible contamination, repeat steps 1–3.

Optional Step: Thermal Disinfection

⚠ **CAUTION: Unless otherwise specified, *EndoWrist* Instruments and Accessories are not compatible with chemical disinfection.**

Thermal disinfection may be performed as required by hospital policy and regional guidelines. The *EndoWrist* Stapler 45 Instrument is compatible with the thermal disinfection cycle in an automated washer/disinfector.

Note: The thermal disinfection step may be performed in addition to the complete cleaning instructions and prior to completing the sterilization instructions. Thermal disinfection is not a substitute for cleaning and sterilization.

Step 4: Dry

- Gently wipe dry with a lint-free cloth. If the device has lumens, ensure all water is emptied from the lumens. Compressed dry air (CDA) may be blown on all surfaces and crevices to facilitate drying.

Note: For cleaning instructions of *EndoWrist* Cannula Kit (PN 420378), refer to the Reprocessing User Manual.

Title: Cleaning and Processing daVinci Instruments, Accessories and Endoscopes	
Scope: Sterile Processing	Manual: Infection Control Blue Manual, Sterile Processing
Source: DON Perioperative Services	Effective Date:

1.9 Sterilization Instructions

WARNING: The use of "flash" sterilization is not recommended for any devices addressed in this document.

Note: *Intuitive Surgical* has validated the parameters and instructions for cleaning and sterilization of its instruments and accessories as set forth herein, but has not evaluated or validated any other parameters or instructions for other sterilization units. *Intuitive Surgical* cannot assure device cleanliness or sterility if the validated parameters and instructions are not followed in their entirety.

Note: Follow the manufacturer's instructions for proper use and storage of container systems and trays. If using wrapped trays, the trays should be double-wrapped using a central supply room (CSR) wrap. In the U.S., this wrap must be FDA-cleared for the sterilization parameters provided.

Note: Do not stack trays during sterilization.

Note: After steam sterilization, allow all components to cool to room temperature. Sudden changes in temperature may damage the components.

Sterilizing the Stapler 45 Instrument

Sterilize the Stapler 45 instrument using pre-vacuum steam autoclaving. Carefully place the instruments in a compatible, secure tray or tray/container system. See Appendix A for compatible trays. Arrange the instruments such that they will not collide. A maximum of two instruments should be placed in a tray at one time, with total reprocessing load not to exceed the validated weight specified in the instrument tray manufacturer's instructions.

Double-wrap the tray using a central supply room (CSR) wrap or using a container compatible with the tray used. See Appendix A for further information. Sterilize using the following parameters:

- Preconditioning Pulses: 4
- Pre-vacuum at 270 – 272 °F or 132 – 134 °C
- Minimum exposure time: 4 minutes
- Minimum dry time: 30 minutes

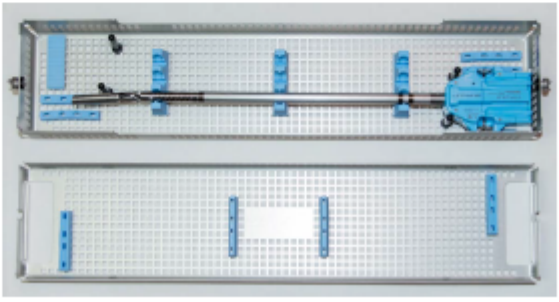


Figure 1.25 Summit Medical validated instrument tray

CAUTION: Do not sterilize the Stapler Instrument at temperatures higher than 279 °F (137 °C).

Sterilizing the Stapler Motor Pack

Note: The Stapler Motor Pack must be completely dry prior to low-temperature sterilization, or the sterilization cycle may fail.

Place the Stapler Motor Pack into a compatible, secure tray or tray/container system. See Appendix B for compatible Stapler Motor Pack trays.

Double-wrap the tray using a central supply room (CSR) wrap or using a container compatible with the tray used. See Appendix B for further information on compatible containers. Sterilize according to the information on validated sterilization methods included in Appendix B.

Figure 1.26 APTIMAX Stapler Motor Pack tray and holders

Sterilizing the Stapler Cable and *EndoWrist* Stapler Cannula Kit

CAUTION: Do not sterilize the Stapler accessories at temperatures higher than 279 °F (137 °C).

Sterilization should be performed using pre-vacuum steam autoclaving. Carefully place the accessories in a compatible, secure tray or tray/container system. See Appendix A for compatible trays.

Double-wrap the tray using a central supply room (CSR) wrap or using a container compatible with the tray used. See Appendix A for further information. Sterilize using the following recommended parameters:

- Preconditioning Pulses: 4
- Pre-vacuum at 270 – 272 °F or 132 – 134 °C
- Minimum exposure time: 4 minutes
- Minimum dry time: 30 minutes

Figure 1.27 Summit Medical validated accessory tray

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Cleaning and Processing daVinci Instruments, Accessories and Endoscopes	
Scope: Sterile Processing	Manual: Infection Control Blue Manual, Sterile Processing
Source: DON Perioperative Services	Effective Date:

Sterilizing the Stapler Release Kit

CAUTION: Do not sterilize the Stapler Release Kit at temperatures higher than 279 °F (137 °C).

Note: It is recommended that the Stapler Release Kit be individually sterile-wrapped, labeled, and placed in the Vision Cart drawer.

Each time the Stapler Release Kit is reprocessed, inspect it for legibility of the instruction tag or damage to the tools. Discard if the tag is not legible or if damage is observed.

Sterilization should be performed using pre-vacuum steam autoclaving. Individually double-wrap the Stapler Release Kit using a central supply room (CSR) wrap that has been FDA cleared and sterilize using the sterilization parameters provided. Sterilize using the following recommended parameters:

- Preconditioning Pulses: 4
- Pre-vacuum at 270 – 272 °F or 132 – 134 °C
- Minimum exposure time: 4 minutes
- Minimum dry time: 30 minutes

1.10 System Maintenance

Preventive maintenance is required and must be performed by an authorized *Intuitive Surgical* Service Representative. There are no user-serviceable parts among the system components.

1.11 Disposal

To dispose of *Intuitive Surgical* instruments, accessories, or any of their components, follow all applicable national and local laws and guidelines.

- Discard Stapler 45 Reloads in a sharps container.
- Discard the Stapler Cable when the Stapler Motor Pack expires.
- Discard the Stapler Release Kit when the Stapler Motor Pack expires.

REFERENCES:
Intuitive Surgical Reprocessing Instructions for daVinci Instruments, Accessories, Stapler 45 and Endoscopes
AORN Guidelines for Perioperative Services (Sterilization and Disinfection)
AAMI ST79;7.5
JCAHO IC.02.02.01, Title 22; 70833

Approval	Date
NEC	11-5-2016
Infection Control Committee	02/28/2017
MEC	03/07/2017
Board of Directors	

Responsibility for review and maintenance: Perioperative DON
Index listings: Cleaning and Processing daVinci Instruments, Accessories and Endoscopes
Developed: 11/2016 BS
Reviewed:
Revised:
~~Supercedes:~~

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Fern Testing	
Scope: Perinatal	Manual: Lab- Point of Care
Source: POC Coordinator	Effective Date:

I. PURPOSE

The fern test detects the leakage of amniotic fluid. Premature rupture of membranes (ROM) can lead to fetal infection and subsequent mortality. Detection of membrane rupture and induced labor can eliminate this risk.

II. PRINCIPLE

The fern test is based upon the ability of amniotic fluid to form a microscopic crystalline pattern suggestive of fern leaves when the fluid specimen is allowed to air dry on a glass slide. The phenomenon is due to the interaction of high concentrations of electrolytes and protein in amniotic fluid relative to other fluids that may be present in the posterior vagina.

III. SCOPE

The procedure is performed in the perinatal department by physicians, mid-level practitioners and registered nurses (RN) who have been trained and maintain competency in this moderately complex procedure.

IV. REAGENTS, EQUIPMENT AND MATERIALS

1. Gloves
2. Sterile vaginal speculum
3. Sterile swab
4. Microscope
    a. Care of the microscope provided for fern testing is important but also quite simple:
        i. Cover the microscope when not in use primarily to protect the objectives and oculars from dust accumulation
        ii. Clean the objective lens following each use with the lens cleaner and lens paper provided; NOTE: Do not use a dry cloth, “Kleenex” or gauze when cleaning the lens; this will generally scratch the sensitive glass surfaces
        iii. Keep the10x objective lens free from oil at all times
    b. Weekly maintenance of the microscope by competent staff:
        i. Clean dust in microscope area
        ii. Clean oculars with lens cleaner and lens paper provided; dry with a clean, dry lens paper
        iii. Clean stage with a suitable cleaner, e.g. tissue wipes moistened with deionized water or alcohol wet wipes, then dry with tissue wipes
        iv. Clean condenser with lens paper and lens cleaner provided, then dry condenser with dry piece of lens paper
        v. Record date and initial of person who performed maintenance on the microscope maintenance log
        vi. Laboratory director or designee will review and sign the microscope maintenance log monthly

vii. Maintenance logs will be kept for a minimum of two years

c. Annual inspection/Preventative maintenance (PM) of the microscope by a specialist will be arranged by the laboratory
   i. Document action taken with date and signature of authorized personnel
   ii. Inspection/PM records are kept for a minimum of five years

d. Repairs:
   i. Necessary repairs will be performed by a service professional
   ii. Document action taken with date and signature of authorized personnel
   iii. Repair records will be kept for a minimum of five years

5. Clean microscope slide -- do NOT leave fingerprints on slide; this can cause a false positive
6. Commercial lens paper and lens cleaner
7. Tissue wipes, e.g. Kimwipes
8. Biohazard container

V. QUALITY CONTROL

1. This provider-performed microscopy procedure (PPMP) is classified as "moderately complex". Control materials are not available to monitor the entire testing process. Testing personnel are required to maintain competency.
2. To confirm the tester's ability to recognize the ferning crystallization pattern characteristic of dried amniotic fluid a second trained and competent RN examines the dried smear. Results of both RNs must agree and are recorded on the patient log.

VI. SPECIMEN

1. Acceptable specimens
   a. Fresh vaginal pool samples collected with a sterile swab according to procedure and labeled with patient name, date of birth, date/time collected and initials of collector
2. Unacceptable specimens
   a. Samples over one hour old
   b. Unlabeled specimens
   c. Specimens contaminated by blood, urine, cervical mucus, semen or alkaline antiseptic solutions -- these contaminates may cause false positive results (Note, the presence of meconium indicates ruptured membranes)
   d. Specimens contaminated with lubricant or antiseptic
   e. Specimens collected over 24 hours since rupture -- may cause false negative results
   f. Specimens collected when volume of leakage is small -- may cause false negative result
3. Storage
   a. For best results, test specimen as soon as possible after collection

Title: Fern Testing	
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   b. Keep at room temperature until testing
4. Collection
   a. Check patient ID by confirming two identifiers
   b. Explain procedure to patient
   c. Position the patient in the dorsal lithotomy position
   d. Avoiding the use of lubricant or antiseptic, place a sterile speculum into the vaginal vault; do not touch the mucus plug in the cervix
   e. Using a sterile swab, obtain a sample of the vaginal secretion from the posterior vaginal pool
   f. Label the swab container with patient name and date of birth, date/time of collection and collector's initials

VII. PROCEDURE

1. Smear a thin layer of the fluid obtained on the center portion of a clean glass microscope slide; be sure the layer is thin; spread evenly
2. Allow the slide to air dry for at least 5 – 7 minutes; do not wave or blow on the slide and do not apply heat to assist in drying
3. Using a microscope, examine the dried smear under low power without a cover slip
4. If ferning is difficult to locate, examine all fields on the slide thoroughly

VIII. INTERPRETATION OF RESULTS

1. If present, the amniotic fluid crystallizes to form a fern-like pattern due to the relative concentrations of sodium chloride, proteins, and carbohydrates in the fluid

IX. RESULTS

1. Positive = presence of a fern pattern indicates the presence of amniotic fluid and ROM
2. Negative = absence of a fern pattern indicates the absence of amniotic fluid and ROM

X. REPORTING

1. Record the presence of "ferning" or "no ferning" on the "Fern Test Patient Log" with the patient's name, date of birth, date of testing, initial of testing personnel and QC results
2. Record the presence of "ferning" or "no ferning" on the patient's medical record chart
3. Include the date/time, and name of person performing the test

XI. REFERENCES

1. Addison, Lois Anne. Laboratory Medicine, July 1999. P.451
2. University of New Mexico Health Sciences Center, Fern Test Procedure
3. UCSF POC Fern Test Procedure, June 2013

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Scope: Perinatal	Manual: Lab- Point of Care
Source: POC Coordinator	Effective Date:

4. "Amniotic Fluid Fern Testing"; Family Birthing Suites – the Finley Hospital, 20040515 S. Raymond; United Clinical Laboratories Technical Director/CIO January 1, 2007 (HR.3.10 in the Comprehensive Accreditation Manual for Laboratory and Point-of-Care Testing)

Approval	Date
Medical Director of the Laboratory	2/28/17
CCOC	2/27/17
Peri/Peds Committee	3/01/17
Medical Executive Committee	3/07/17
Board of Directors	

Developed: 2/17
Reviewed:
Revised:
Supersedes:

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Training and Competency in Fern Testing	
Scope: Perinatal	Manual: Lab- Point of Care
Source: POC Coordinator	Effective Date:

I. PURPOSE

CLIA '88, Centers for Medicare and Medicaid Services (CMS), and the State of California laboratory regulations require that all laboratories have on-going mechanisms to monitor accurate patient test management. Fern testing is categorized as "moderately complex" testing. Therefore all individuals performing fern testing or overseeing fern testing performed by trainees, are required to successfully complete training and show that they are proficient in test procedure and reporting test results.

II. PROCEDURE

All testing personnel are trained and evaluated for competency on the fern test including pre-analysis, analysis and post-analysis components. When new test methodology or instrumentation is instituted, employees are retrained and reevaluated. The Point of care (POC) coordinator and department supervisor will develop a program for competency assessment and acceptability standards based on the training protocol, procedure manual, and departmental policies. Supervisors and managers will evaluate common group deficiencies, review current policies and procedures and take corrective action to improve performance.

A. Training and Orientation

1. All trainees will read the policy and procedure
2. Orientation/Training on the test system will be provided through demonstration
3. Successful orientation will be evaluated by use of a written test and initial competency assessment
4. Training will be provided by competent training staff
5. Personnel qualified to perform training is clinical staff with at least 1 year experience in fern testing and documented training and competency
6. Orientation and training is documented on a training checklist and filed in the POC department and kept for a minimum of 2 years; a copy of the document(s) is placed in employee personnel file

B. Competency

Competency for fern testing is assessed at the time of orientation, followed by a 6 month and 12 month evaluation and annually thereafter or as needed.

1. Competency for fern testing is assessed using all of the following six methods:
    a. Direct observation of routine patient test performance, including patient preparation, specimen handling, processing and testing
    b. Monitoring recording and reporting of test results
    c. Review of worksheets, QC records and preventative maintenance records
    d. Direct observation of performance of microscope maintenance and function checks
    e. Assessment of test performance through testing external PT samples or testing previously analyzed specimens (blind testing)
2. Assessment of problem solving skills by use of a written test

3. Independent performance with no to little additional support is considered successful
4. Successful performance is equal to or greater than 80% correct for the written test
5. Competency is assessed by a qualified designee
6. Personnel qualified to observe and assess competency are competent clinical staff with at least 1 year experience in fern testing
7. Observed competency is documented on a competency checklist and filed in the POC department and kept for a minimum of 2 years; a copy of the document(s) is placed in employee personnel file

C. Online Competency

NIHD's POC department utilizes an on-line competency challenge program hosted by the University of Washington. A link to this program along with additional instructions on how to log into the program is sent via email by the POC team. There are approximately five questions and 80% of the questions must be answered correctly to pass.

D. Proficiency testing

The POC department contracts with the Wisconsin State Laboratory of Hygiene (WSLH), a CMS approved proficiency testing program that meets regulatory requirements for variety and frequency of testing. Proficiency testing will be conducted bi-annually and consists of two images (paper and online version).

1. Proficiency samples are rotated among testing staff who perform patient testing
2. Testing personnel tests the proficiency samples the same way that patient samples are tested
3. The staff who perform the proficiency testing and the medical director and/or technical
   coordinator sign attestations documenting that proficiency samples were tested in the same manner as patient specimens
4. Testing personnel reports proficiency sample results the same way that patient samples are reported
5. Proficiency records are kept for two years; proficiency performance evaluations are kept for 5 years
6. A failure is unsuccessful performance in an event and warrants an investigation using the
   "Proficiency Testing Checklist for Corrective Action"; the investigation is documented and records are kept for 5 years

III. CORRECTIVE ACTION

Retraining and reassessment of employee competency must occur when problems are identified with employee performance.

A. Criteria for Remediation

Authorized training staff will perform remedial training for the following reasons:

1. When testing personnel fails an assigned proficiency test(s)

2. When deficiencies are being observed during competency assessment; this will be at the
   discretion of the authorized preceptor
3. When deficiencies are being observed during routine patient testing; this will be at the discretion of the supervisor
4. When an individual fails to comply repeatedly with testing and/or QC requirements
5. When testing staff is non-compliant with regulatory requirements after reasonable attempts of contact have been made by the supervisor and/or POC staff

B. Retraining and Reassessment

After determination that remediation is required, the following process will be initiated:

1. Department supervisor and/or director of nursing will be notified that individual will require retraining and that he/she is prohibited to perform fern testing until remediation is complete
2. Competent staff will review data and determine if instrument malfunction may have contributed to the problem
3. Authorized training staff will conduct remediation training that will include:
   a. Review of test procedure
   b. Review of QC logs to determine if staff performs QC correctly
   c. Observation of specimen collection
   d. Observation of specimen testing; if possible this will be done using specimens that the trainer observed the testing staff collect
   e. Successful completion of a written test
   f. Remediation will be documented and filed in the POC department and kept for a minimum of 2 years; a copy of the document(s) is placed in employee personnel file

C. Non-compliance

When it has been determined that staff is non-compliant with scheduling remediation the following steps will be taken:

1. Notification of department supervisor, director of nursing and/or compliance officer that the individual may not perform fern testing effective immediately
2. Privileges to perform testing will be revoked until staff has complied with retraining requirements

IV. REFERENCES

1. 2017 Comprehensive Accreditation Manual of Laboratory and Point-of-Care Testing, The Joint Commission, HR.01.06.01, EP 18
2. U.S. Department of Health and Human Services, CLIA ’88 Final Rules, Federal Register, 1992, Subpart M, §493.1351 - §493. 1495, U.S. Government Printing Office, Wash. DC, Vol. 57, No. 40. February 28, 1992
3. CADPH-Laboratory Field Services. Laws and Regulations Relating to Clinical Laboratories, Excerpts from the California Business and Professional Code and

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Training and Competency in Fern Testing	
Scope: Perinatal	Manual: Lab- Point of Care
Source: POC Coordinator	Effective Date:

the California Code of Regulations, Berkeley, CA, January 1, 1991

Approval	**Date**
Medical Director of the Laboratory	02/28/17
CCOC	02/27/17
Peri/Ped Committee	03/01/2017
Medical Executive Committee	03/07/2017
Board of Directors	

Developed: 2/17
Reviewed:
Revised:
Supersedes:

Hospital-Wide QAPI Plan Annual Evaluation Calendar Year: 2016

1. **Goal Achievement**

PILLAR	Goal	Achievement	Notes
Quality	Joint Commission Survey Readiness (Ongoing) • Identify relationships between various committee roles/responsibilities and TJC standards • Identify and track RCAs, current and suggested projects and relationship to TJC standards. • Conduct 2 tracers per quarter, which may include the following areas: Infection Control, Medication Administration, Advance Directives, National Patient Safety Goals (NPSGs), especially method of handoff communication, restraints, pain management. • Monitoring of TJC website for NIH visit and development and implementation of a notification plan.	Partially Met Partially Met Partially Met Partially Met	• R-Icon TJC standards have been assigned to Executive team members for oversight for completion of the FSA • QAPI is now tracking Root Cause Analysis events and ideas generated & implemented (See Table below for summary or recent RCA events) • 1 & 2 tracers were conducted in 2014 & 2015, respectively, but no evidence of tracers was performed in 2016; CPEO & CNO instead prepared Survey Readiness guide and briefed directors & managers on guide early in January 2016 • QAPI coordinator monitors the TJC website during periods of expected events, but a more systematic approach could be developed.
Quality	Performance Measurement System Assessment & Improvement • Map data flows and processing for CMS core measures and other selected metrics. • Create performance measurement crosswalk document to show which metrics are reported to which organizations, including but not limited to CMS, CDPH, CalHEN, TJC. The document will also include references to data/metric definitions and frequency of reporting. • Reduce data processing time for mandated and selected metric reporting	Partially Met Partially Met Partially Met Met	• The QAPI Department has created a metric log and started collecting metric metadata for CMS, CalHEN/CalHIIN metrics. The log needs more work including the addition of new metrics and completion of all fields. • The QAPI department continues to make improvements to data processing tasks.

Quality	Policy and Procedure Management System Redesign Project • Design and implement a user-friendly system for developing, reviewing, revising and approving evidence-based policies and procedures and install and configure the MCN software to complement new policy & procedures management processes. • The new system will consider the ability to merge, categorize, synthesize, and share organizational and industry best practices.	Partially Met	• Developed a policy & procedure checklist, process map, DRAFT Policy & Procedure, *"Development, Review, Revision and Approval of Policies & Procedures"* and Policy & Procedure Writing Guidelines • Some P&Ps tested against checklist, which was found to be effective in helping to produce improved policies; some testing of P&Ps in new policy repository system.
Quality	Develop Performance Improvement Project Proposal, Evaluation and Management Process • Design and deploy project proposal, evaluation and management processes and templates	Partially Met	• Developed Project Charter template with instructions, but need to develop scaled down charter for proposal template.
People	Professional Development of management and staff • Provide training, guidance, coaching, mentoring to management and staff on performance improvement methodologies, root cause analyses (RCAs), data reporting and analysis • Design performance excellence/QAPI training for management and staff at all levels • Conduct in-service seminars and workshops at request of departmental/functional managers, as appropriate	Met	• CPEO conducted multiple one-on-one training sessions on various topics, including project management, PI topics • QAPI staff developed PDSA training module (Powerpoint w/ video links,quiz) to be used with managers, directors, other leaders
People	Workplace Violence Assessment and Improvement Project • Audit against CalOSHA, TJC, and/or ASHRM requirements, guidelines, identify opportunities for improvement and implement selected improvement ideas.	Partially Met	• Completed WV operational/compliance audit against requirements, guidelines, etc., identified and prioritized OFIs. • Completed DRAFT policies for De-escalation Team and WV Incident Reporting • Handover to Workforce Experience Committee
People	Develop and Deploy Workforce Proposal (Kaizen Teian, Intrapreneurship) System • Develop hospital-wide systematic approach to incorporating workforce ideas into problem-solving, process/system improvement, which is aligned with NIH QAPI process improvement methodologies.	Not Met	• Should develop innovation model and incorporate into Kaizen Teian project.

Service	Conduct Patient Experience Assessment & Improvement • Evaluate effectiveness of methods used to collect, evaluate and disseminate patient engagement and complaint data • Develop patient engagement benchmarks/competitor comparisons • Develop and deploy customer service training program in the RHC and improve RHC patient experience Avatar Overall score by at least 5 points • Develop and implement plan to improve Perinatal patient experience by achieving a minimum of 50th percentile rankings in all composite survey dimensions.	On hold On Hold On Hold On Hold	• Patient Experience Survey vendor, Avatar Solutions, was acquired by Press-Ganey; therefore, we have had to re-implement our patient experience survey, which has not been completely implemented as of 1/30/17.
Service	Metric Goals • Improve RHC patient experience Avatar Overall score by at least points • Improve Perinatal patient experience by achieving a minimum of 50th percentile rankings in all composite survey dimensions.	On Hold On Hold	• Patient Experience Survey vendor, Avatar Solutions, was acquired by Press-Ganey; therefore, we have had to re-implement our patient experience survey, which has not been completely implemented as of 1/30/17.
Service	Improve Patient Flow & Service Reliability • Orthopedic Patient Flow Improvement Project • Wound Care Standardization Project	Partially Met Partially Met	• Several meetings held and process maps created; unclear if still a priority. • Several meetings held; two nursing staff members attended wound care training; Nicole Eddy is leading these efforts.
Finance	Antibiotic Stewardship Program Development & Implementation, with a focus on: • Reduction of broad-spectrum antibiotic use • Decrease of inappropriate use of antibiotics across hospital and healthcare system • Reduction of hospital associated Clostridium difficile infections • Research shows ABS reduces costs	Partially Met	• 4 staff members completed the Making a Difference in Infectious Diseases (MAD-ID) training-Basic Program (1 physician, 2 pharmacists, CPEO) • Antibiotic Stewardship Plan was developed and approved by committees • PRIME program reports submitted and hospital received approximately $2M for the effort • NEXT steps include executing work outlined in NIHD ASP plan and PRIME plan.

2. **Metric/Indicator.** See Pillars of Excellence.
3. **Root Cause Analysis (RCA) Events.** From 1/1/16-2/10/16, five (5) Root Cause Analyses were conducted, from which 34 improvement ideas or interventions were generated. Twenty (20) of these ideas have already been implemented. The RCAs covered the following topics:

Month/Year	**Topic**	**# Improvement Ideas/Interventions Generated**
6/2016	Miscellaneous Order, Warfarin	6
7/2016	Vancomycin & IV Contrast	4
8/2016	Post Partum Pitocin Administration	9
10/2016	Fall w/ Injury	11
2/2017	Anticoagulant Therapy	4

Hospital-Wide QAPI Plan Annual Work Plan: FY 2017-18*

1. **Goals**

PILLAR	Goal	Achievement	Notes
Quality	Joint Commission Survey Readiness (Ongoing) • Conduct at least two (2) tracers per quarter, which may include, but are not limited to, the following areas: Infection Control, Medication Administration, Advance Directives, National Patient Safety Goals (NPSGs), especially method of handoff communication, restraints, pain management. • Monitoring & implementation of 2017 FSA R-icon standard action plans for non-compliant standards		
Quality	Patient Safety • Conduct at least one (1) Root Cause Analysis per quarter • Conduct at least one(1) Failure Modes Effects and Criticality Analysis per year • AHRQ Culture of Safety Survey • Train staff and implement TeamSTEPPS program in at least one clinical department		
Quality	Incident Reporting • Implement electronic incident reporting system		
Quality	Performance Measurement System Assessment & Improvement • Update metric/indicator log, Appendix 4 of the Hospital-Wide QAPI plan • Add several new CMS/CalHIIN metrics to reporting, including SEPSIS metrics • Hire Clinical Quality Improvement Analyst-PQRS/Peer Review o Research, Select and Adopt PQRS metrics (physician level) for three medical service areas. o Streamline and Standardize Peer Review Processes		

Quality	Develop Performance Improvement Project Proposal, Evaluation and Management Process • Design and deploy project proposal, evaluation and management processes and templates		
Quality	Policy and Procedure Management System Redesign Project • Design and implement a user-friendly system for developing, reviewing, revising and approving evidence-based policies and procedures and install and configure the MCN software to complement new policy & procedures management processes. • The new system will consider the ability to merge, categorize, synthesize, and share organizational and industry best practices.		
People	Professional Development of management and staff • Implement PDSA training module for all leaders • Provide training, guidance, coaching, mentoring to management and staff on performance improvement methodologies, root cause analyses (RCAs), data reporting and analysis		
Quality	Sepsis • Research and develop/adopt Sepsis best practices • Increase awareness/education of Sepsis for clinicians		
Service	Develop Patient Experience Data • Develop patient engagement benchmarks/competitor comparisons in Press-Ganey • Develop departmental scorecard reports in Press-Ganey		
Service	Metric Goals • Improve RHC patient experience overall score to % top box 51st percentile • Improve Perinatal patient experience overall score to %top box 51st percentile.		• Consider implementing at least two new best practices from the HCAHPS Handbook for inpatient units and from the CGCAHPS Handbook for the RHC.

Service	Increase employee focus on patients • Work with HR and/or the Workforce Experience Committee (WEC) to recognize & reward *Extreme* Customer Service		• Consider using a concept similar to that shown in, "The Joint Commission Guide to Improving Staff Communication", Joint Commission Resources, 2005, p. 104.
Service	Improve Patient Flow & Service Reliability • Orthopedic Patient Flow Improvement Project • Wound Care Standardization		
Finance	Antibiotic Stewardship Program Development & Implementation, with a focus on: • Reduction of broad-spectrum antibiotic use • Decrease of inappropriate use of antibiotics across hospital and healthcare system • Reduction of hospital associated Clostridium difficile infections • Research shows ABS reduces costs		
Important Notes *The Annual Work plan will go from April 1, 2017-June 30, 2018, after which a Fiscal Year Annual work plan and evaluation cycle will begin.			

2. **Metric/Indicator.** See Pillars of Excellence proposed template for reporting period starting on 7/1/17.

NORTHERN INYO HEALTHCARE DISTRICT

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

Indicator	Baseline	Goal	J-S Q1	O-D Q2	J-M Q3	A-J Q4	YTD
Service							
1. Patient satisfaction							
a. RHC- Overall score % Top Box							
b. Emergency Department- Overall score % Top Box							
c. HCAHPS Perinatal- Overall score % Top Box							
d. HCAHPS MedSurg- Overall score % Top Box							
Note:							
Quality							
1. Adverse Drug Events-Anticoagulants*							
2. Adverse Drug Events-Opiates*							
3. Adverse Drug Events-Insulin*							
4. Surgical Site Infections*,1							
5. Central Line Associated Bloodstream Infections (CLABSI) CLABSI/Line Days (Per 1000 Line Days)*							
6. Catheter Associated Urinary Tract Infections (CAUTI) CAUTI/Catheter Days (Per 1000 Catheter Days)*							
7. Sepsis-Overall Sepsis Rate OR Sepsis Mortality Rate							
8. Falls With Injuries (Per 1000 Patient Days)*							
9. 30 Day Readmission Rate (Inpatient)*							
*Note: Baseline period for these metrics is FY 16-17. 1. SSI National average is about 2.0%.							
People							
1. Overall Turnover Rate, 3							
2. Total Recordable Incident Rate (OSHA) per 100 employees-Modified**, 3							
3.Benchmark data for these metrics only available per annum and since the number of incidents accumulates, but number of employees is relatively constant, it is most appropriate to compare only per annum data to the goal. To compute YTD prior to year end, an average of the quarterly metric denominator will be used. **OSHA metric is per 100 FTE; NIH proxy measure is per 100 employees. National average for hospitals is 6.2. (Reference available in PEX office)							
Finance							
1. Current Ratio							
2. Days Cash on Hand-Short Term Sources							
3. Debt Service Coverage Ratio							
4. A/R Days (Inpatient & Outpatient)							

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

Important General Notes:

1. Goals in Blue are stretch goals and may follow a 'zero defects' approach outlined in the Hospital-Wide Quality Assurance and Performance Improvement (QAPI) plan. On some metrics, we have set the bold goal of zero defects (best-in-class). For the metrics with a goal of zero, either we are best-in-class and get a blue color code or not best-in-class and get a red code. It is important to note that a code of red in the 'Quality' category of indicators for metrics with goals of zero does not necessarily indicate poor performance, just that we have not met our goal of zero. For example, on Surgical Site infections for Quarter 1, FY 15-16, we did not meet our goal of zero defects, but are still outperforming most of the country with an infection rate of 4 times LOWER than the national average of 2.0%.
2. Patient Satisfaction/Patient Experience-For each department the highest number of frequencies determines the overall assignment of Red (Below Average), Yellow (About Average), Green (Above Average), or Blue (Best in Class). It is recommended that specific performance categories be assessed by area leadership to identify opportunities for improvement.

NORTHERN INYO HEALTHCARE DISTRICT

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

Indicator	Baseline	Goal	J-S Q1	O-D Q2	J-M Q3	A-J Q4	YTD
Service							
1. Patient satisfaction							
a. RHC- Overall score % Top Box							
b. Emergency Department- Overall score % Top Box							
c. HCAHPS Perinatal- Overall score % Top Box							
d. HCAHPS MedSurg- Overall score % Top Box							
Note:							
Quality							
1. Adverse Drug Events-Anticoagulants*							
2. Surgical Site Infections*,[1]							
3. Central Line Associated Bloodstream Infections (CLABSI) CLABSI/Line Days (Per 1000 Line Days)*							
4. Catheter Associated Urinary Tract Infections (CAUTI) CAUTI/Catheter Days (Per 1000 Catheter Days)*							
5. Sepsis-Overall Sepsis Rate OR Sepsis Mortality Rate							
6. Falls With Injuries (Per 1000 Patient Days)*							
7. 30 Day Readmission Rate (Inpatient)*							
*Note: Baseline period for these metrics is FY 16-17. 1. SSI National average is about 2.0%.							
People							
1. Overall Turnover Rate, 3							
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3.Benchmark data for these metrics only available per annum and since the number of incidents accumulates, but number of employees is relatively constant, it is most appropriate to compare only per annum data to the goal. To compute YTD prior to year end, an average of the quarterly metric denominator will be used. **OSHA metric is per 100 FTE; NIH proxy measure is per 100 employees. National average for hospitals is 6.2. (Reference available in PEX office)							
Finance							
1. Current Ratio							
2. Days Cash on Hand-Short Term Sources							
3. Debt Service Coverage Ratio							
4. A/R Days (Inpatient & Outpatient)							

LEGEND	
	Best-in-Class Performance, Exceeds Goal
	Above Average, Meets Goal
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Important General Notes:

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2. Patient Satisfaction/Patient Experience-For each department the highest number of frequencies determines the overall assignment of Red (Below Average), Yellow (About Average), Green (Above Average), or Blue (Best in Class). It is recommended that specific performance categories be assessed by area leadership to identify opportunities for improvement.

Hospital-Wide QUALITY ASSURANCE & PERFORMANCE IMPROVEMENT (QAPI)

PLAN

20176

150 Pioneer Lane, Bishop, CA 93514 Tel : 760-873-5811 Fax : 760-872-2768

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Section 1 Introduction

Mission & Vision

Northern Inyo Healthcare District (NIHD) adopted a new mission statement on 11/18/15, as follows:

" Improving Our Communities one life at a time. One Team. One Goal. Your Health."

The Northern Inyo Hospital Performance Excellence Section, Hospital-Wide QAPI plan and Patient Experience Committee *mission* is:

"It's Not An Act, But A Habit."

This mission is aligned with the hospital mission and emphasizes the infinite continuous cycle of learning and improvement in all that we do.

The Northern Inyo Hospital Performance Excellence Section, Hospital-Wide QAPI plan and Patient Experience Committee *vision* is:

"Through the use of continuous improvement and learning efforts in the Northern Inyo Healthcare District, the people of the Eastern Sierra community will have access to safe, effective, patient-centered, timely, efficient and equitable healthcare that will result in an excellent patient experience and ever improving health outcomes."

Purpose

The Hospital-wide Quality Assurance and Performance Improvement (QAPI) Plan establishes a hospital wide program and interdisciplinary approach to improve patient care and services at Northern Inyo Hospital.

Scope of Service and Authority

The scope of this plan will include all patient care and support services throughout the hospital and will encompass all ancillary care facilities.

The Northern Inyo Healthcare District Board of Directors establishes this plan which supports the mission of Northern Inyo Healthcare District and is ultimately responsible for the quality of patient care and services provided. The NIHD Board of Directors delegates the development, implementation and evaluation of the QAPI plan to the Medical Staff and the Hospital Administrator.

The Northern Inyo Hospital Administrator delegates performance improvement activities to QAPI department, other functional areas and~~executive~~ committees which make up the Integrated QAPI Organizational Structure outlined in Appendix 1.

The Northern Inyo Hospital Medical Staff is charged with participating in the QAPI Plan to achieve quality patient care and compliance with regulatory/accreditation organizations. Medical Staff members will contribute to all QAPI activities through Medical Staff Service committees, project team activities and by assuming leadership roles, as necessary, in QAPI processes and activities.

Introduction

The following Hospital-wide QAPI Plan serves as the foundation of the commitment of Northern Inyo Hospital (NIH) to continuously improve the quality of the treatment and services it provides.

Quality. Quality services are services that are provided in a safe, effective, recipient-centered and timely fashion.

NIH is committed to ongoing improvement of the quality of care its consumers receive. The organization continuously strives to ensure that:

- The treatment provided incorporates evidence-based, effective practices
- Risk to consumers, providers and others is minimized and errors in the delivery of services are prevented
- Consumers' individual needs and expectations are respected; consumers-or those whom they designate-have the opportunity to participate in decisions regarding their treatment; and services are provided with sensitivity and caring
- Procedures, treatments and services are provided in a timely and efficient manner, with appropriate coordination and continuity across all phases of care and all providers of care

Performance Improvement Principles. Performance Improvement is a systematic approach to assessing services and improving them on a priority basis. The NIH approach to quality is based on the following principles:

- ***Patient Focus***. High quality organizations focus on their internal and external customers and on meeting or exceeding needs and expectations.
- ***Employee Empowerment***. Effective programs involve people at all levels of the organization in improving quality.
- ***Leadership Involvement***. Strong leadership, direction and support of quality improvement activities by the governing body and CEO are key to performance improvement. This involvement of organizational leadership assures that quality improvement initiatives are consistent with providers' mission and/or strategic plans.
- ***Data Informed Practice***. Successful PI processes create feedback loops, using data to inform practice and measure results. Fact-based decisions are likely to be correct decisions.
- ***Statistical Tools***. For continuous improvement of care, tools and methods are needed that foster knowledge and understanding. Continuous Quality Improvement (CQI) organizations use a defined set of analytic tools such as run charts, cause and effect diagrams, flowcharts, Pareto charts, histograms and control charts to turn data into information.
- ***Prevention Over Correction.*** Continuous Quality Improvement entities seek to design good processes to achieve excellent outcomes rather than fix processes after the fact.
- ***Continuous Improvement.*** Processes must be continually reviewed and improved. Small incremental changes do make an impact and providers can almost always find an opportunity to make things better.

Performance Improvement Activities. Performance improvement activities emerge from a systematic and organized framework for improvement. This framework adopted by the hospital leadership, is understood, accepted and utilized throughout the organization, as a result of continuous education and involvement of staff at all levels in performance improvement. Performance improvement involves two primary activities:

- Measuring and assessing performance of services through collection and analysis of data.
- Conducting quality improvement initiatives and taking action where indicated, including:
  - Design of new services
  - Improvement of existing services

Some of the tools used to conduct these activities are described in Appendix B, at the end of this plan.

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Section 2 Leadership and Organization

Leadership. The key to the success of the Performance Improvement process is leadership. The following describes how the leaders of NIH provide support to quality improvement activities.

The QAPI Department and QI Medical StaffPatient Experience Committee provides ongoing operational leadership of QAPI activities at NIH. It meets at least quarterly and not less than 10 times per year and consists of the following individuals:

- Chief Performance Excellence Officer, or designee
- Chief Medical Officer
- Chief Nursing Officer
- Chairperson for medical staff Quality Improvement Committee (also holds position as the Vice Chief of Staff)

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The QAPI DepartmentPatient Experience Committee responsibilities:

- Developing and approving the Quality Assurance and Performance Improvement (QAPI) strategic and action plans. Evaluate and make recommendations for improvement to QAPI plan and send to Board of Directors for final approval.
- Establishing measurable objectives based upon priorities identified through use of established criteria for improving the quality and safety of services
- Developing indicators of quality on a priority basis
- Periodically assessing information based on the indicators, taking action via performance improvement initiatives to solve problems and pursue opportunities to improve performance
- Establishing and supporting specific quality improvement initiatives
- Reporting to the Board of Directors on performance improvement activities of NIH on a regular basis, at least quarterly.
- Formally adopting a specific approach to Continuous Quality Improvement such as Plan Do Study Act (PDSA) or FOCUS PDSA, as well as other QAPI approaches, which may include methods such as LEAN Toyota Production System, Six Sigma or formal project management methods.
- Serve as the Patient Grievance Committee, which will review grievances on an Ad Hoc basis, as appropriate.

The Patient Experience Council consists of the following individuals:
To Be Determined

The Patient Experience Council responsibilities:

- Supporting and guiding implementation of QAPI activities at NIH
- Providing feedback on the efficacy of QAPI activities at NIH

The Quality Improvement Committee meets at least 10 times per year and is responsible for overall supervision of patient care services, quality monitoring, and hospital assessment and improvement activities. The committee is composed of the following:

- Medical Executive Committee members, Vice Chief of Staff is chair
- Administrator
- Chief Nursing Officer
- ~~Chief Performance Excellence Officer~~Director of Quality & Risk

The Quality Improvement Committee has the following responsibilities:

- Oversee the implementation of the Hospital-wide QAPI plan to improve the quality of care and service provided by the medical staff which affect patient health, safety.
- Revise the Hospital-wide QAPI plan as necessary to set forth specific mechanisms for reviewing, evaluating and maintaining the quality, appropriateness and efficiency of patient care within the hospital.
- Nurse practitioners, clinical nurse specialists and physician assistants at Northern Inyo Hospital will be evaluated by a member of the Northern Inyo Hospital staff who is a doctor of medicine or osteophathy and such evaluation shall be reported to the Credentials Committee and to the Quality Improvement Committee at least annually.
- Take appropriate remedial actions to address deficiencies found through QAPI activities and document the outcomes of all remedial actions.
- Assess corrective actions when indicated by the findings and recommendations generated by the peer review process. The outcomes of all remedial actions will be documented.
- Support continuing healthcare education and the development of appropriate educational programs for physicians and hospital staff.
- Along with the Patient Experience Committee, the Northern Inyo Hospital Medical Staff Quality Improvement Committee will review the Hospital-wide QAPI plan and any associated plans at least annually.
- Provide summary reports to the District Board of Directors on a periodic basis.
- Serve as the Patient Grievance Committee, which will review grievances on an Ad Hoc basis, as appropriate.

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Board of Directors responsibilities:

- Supporting and guiding implementation of QAPI activities at NIH
- Reviewing, evaluating and approving the QAPI plan annually

Leader responsibilities:

Support QAPI activities through planned coordination and communication of the results of measurement activities related to QAPI initiatives and overall efforts to continually improve the quality of care provided. This sharing of QAPI data and information is an important leadership function. Leaders, through a planned and shared communication approach, ensure the Board of Directors, staff, recipients and family members have knowledge of and input into ongoing PI initiatives, as a means of continually improving performance.

Planned communications may include, but are not limited to, the following methods:

- Storyboards and/or posters displayed in common areas
- Sharing of NIH annual QAPI plan evaluation
- Newsletters and handouts
- Community development efforts, press releases

Hospital-Wide Committees & Functional Departments:

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Report their findings, actions and follow up quarterly, on a rotating schedule (to be established by the QAPI department) to the Patient Experience Committee or other appropriate Executive Committee, as designated by the Executive Team. These include, but are not limited to the following:

- Designated structural, process and outcome metrics
- Performance Improvement Projects
- Results and improvements of The Joint Commission (TJC) Tracer Activity
- Results and improvements operational/process audits
- Actions and improvements of Root Cause Analyses and/or Failure Modes Effects (and Criticality) Analyses (FMEAs/FMECAs)
- Significant findings from internal audits such as the TJC Focused Standards Assessment
- Results, response and status of all accreditation surveys

Section 3 Goals and Objectives

The Patient Experience Committee identifies and defines goals and specific objectives to be accomplished each year. These goals include training of clinical and administrative staff regarding performance improvement principles and specific quality improvement initiative(s). Progress in meeting these goals and objectives is an important part of annual evaluation of QAPI activities.

The following are the ongoing *LONG-TERM* goals for NIH QAPI plan:

- To evaluate and improve performance measurement systems to assess key processes or outcomes.
- To bring managers, clinicians and staff together to review data and clinical adverse occurrences to identify problems.
- To carefully prioritize identified problems and set goals for their resolution.
- To achieve measurable improvement in highest priority areas.
- To meet internal and external reporting requirements.
- To provide education and training to managers clinicians and staff
- To develop or adopt necessary tools, such as practice guidelines, patient experience surveys and quality indicators

The annual QAPI Work Plan summary for accomplishing these goals in the year 2016 is shown in Appendix 3:

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Section 4 Performance Measurement

Performance Measurement is the process or regularly assessing the results produced by NIH. It involves identifying processes, system and outcomes that are integral to the performance of the service delivery system, selecting indicators of these processes, systems and outcomes, and analyzing information related to these indicators on a regular basis. Performance Improvement involves taking action as needed based on the results of the data analysis and the opportunities for performance they identify.

The purpose of measurement and assessment is to:

- Assess the stability of processes or outcomes to determine whether there is an undesirable degree of variation or a failure to perform at an expected level.
- Identify problems Selection of a process or outcome to be measured, on a priority basis.
- Assess the outcome of the care provided.
- Assess whether a new or improved process meets performance expectations.

Measurement and assessment involves:

- Selection of a process or outcome to be measured, on a priority basis.
- Identification and/or development of performance indicators for the selected process or outcome to be measured.
- Aggregating data so that it is summarized and quantified to measure a process or outcome.
- Assessment of performance with regard to these indicators at planned and regular intervals.
- Taking action to address performance discrepancies when indicators indicate that a process is not stable, is not performing at an expected level or represents an opportunity for improvement.
- Reporting within the organization on findings, conclusions and actions taken as a result of performance assessment.

Selection of a Performance Indicator. A performance indicator is a quantitative tool that provides information about the performance of a clinic's process, services, functions or outcomes. Selection of a Performance Indicator is based on the following considerations:

- Relevance to the mission
- Regulatory/Accreditation Requirement
- Clinical Importance
    - Problem prone
    - High Risk
    - High Volume
- Scientific Foundation: Relationship between the indicator and the process, system or clinical outcome.
- Validity: Whether the indicator assesses what it purports to assess
- Meaningfulness: Whether the results of the indicator can be understood, the indicator measures a variable over which NIH has control, and the variable is possible to change by reasonable performance improvement efforts.
- Standardized definitions
- Availability of industry benchmarks

Performance Indicators selected for NIH QAPI plan. For purposes of this plan, a review of current performance indicators will be reviewed and the following information documented in the Performance Indicator/Metric Log (See Appendix 4): name, definition, data collection and assessment plans.

Performance Indicator/Metric (Complete this table for each indicator which is selected.)	
Name	Name. Usually a brief two or three word title
Definition	Definition. Explanation of data elements and the type of numerical value to be used to express the indicator (percentage, rate, number of occurrences, etc..)
Data Collection Plans*	Describes how the data is collected, method & frequency of collection, who will collect the data and run the report, data sources, data processing.
Assessment Plans	Who and how often data is assessed, including which committees
Reporting Requirements	Regulatory agencies and standards applicable

*The QAPI department will work closely with Nursing Informatics, IT, Medical Records and/or other appropriate parties to develop data into usable formats which are amenable to assessment and analysis and will include ongoing, concurrent and retrospective monitoring of data required by federal and state programs (e.g. CMS, MERP), as well as voluntary participation in programs such as the California Hospital Engagement Network (CalHEN).

Measurement of the metrics in the Performance Indicator/Metric Log (Appendix4) may be organization-wide in scope, targeted to specific areas, departments or services, or focused on selected populations. These measurements may be ongoing, time limited, intensive or recurring. The duration, intensity and frequency of monitoring are based on the needs of the organization, external requirements and the results of the data analysis.

The ~~Chief Performance Excellence Officer~~Director of Quality & Risk, or designee, will coordinate the collection and compilation of data as defined in this plan. Data or information regarding individual physicians and independent licensed practitioners will be shared with the Medical Staff for storage in the medical staff office peer review documents and credentialing folders.

Data, information and performance improvement activities will be shared at the Department Heads meeting, as appropriate.

Assessment. Assessment is accomplished by comparing actual performance on an indicator with:

- Self over time.
- Pre-established standards, goals, benchmarks, or expected levels of performance.
- Information concerning evidence-based practices.
- Other hospitals,clinics or similar service providers

Data will be assessed for patterns, trends and/or variations that may identify opportunities for improvement. Data will be intensely assessed when a significant undesirable performance or variation is noted. Intense analysis may also be necessary when performance levels or variation indicate a serious issues, such as the following:

1. A sentinel event has occurred, triggering a root cause analysis.
2. Performance varies significantly from that of other organizations or recognized standards.

Section 5 Performance Improvement Initiatives

Once the performance of a selected process has been measured, assessed and analyzed, the information gathered is shared with appropriate departments, committees and medical staff leaders to identify opportunities for improvement. (OFIs). OFIs are prioritized and quality initiatives are selected based on the highest priority OFIs.

The purpose of an initiative is to improve the performance of existing services or to design new services.

The FOCUS-PDSA improvement model is utilized at NIH, as well as other process improvement/design methods such as Six Sigma and LEAN. (See Appendix 2 for descriptions of these concepts and other performance improvement tools.) Additionally, project management and system/process design methods may be used.

Section 6 QAPI Plan Evaluation

An evaluation will be completed at the end of each calendar year. The annual evaluation is conducted by the ~~Patient Experience Committee~~Director of Quality & Risk and kept on file in the QAPI office, along with the QAPI Plan. These documents will be reviewed by the Quality Improvement and/or Medical Executive Committee and the NIHD Board of Directors.

The evaluation summarizes the goals and objectives of NIH's QAPI plan, the performance improvement activities, conducted during the past year, including targeted process, systems and outcomes, performance indicators utilized, the findings of the measurement, data aggregation, assessment and

analysis processes, and the performance improvement initiatives taken in response to the findings. QAPI Annual reports will include:

- Summary of progress towards meeting the Annual Goals/Objectives.
- For each of the goals, include a brief summary of progress.
- Brief summary of the findings for each of the indicators used during the year, including both the outcomes of the measurement process and the conclusions and actions taken in response to these outcomes.
- Summary of progress for Performance Improvement Initiatives and projects including project activities, results, next steps and holding the gains; also include implications of performance improvement projects/initiatives on outcomes, systems or QAPI processes.
- Recommendations: Based upon the evaluation and Lessons Learned analyses, state the actions needed for improving QAPI plan effectiveness.

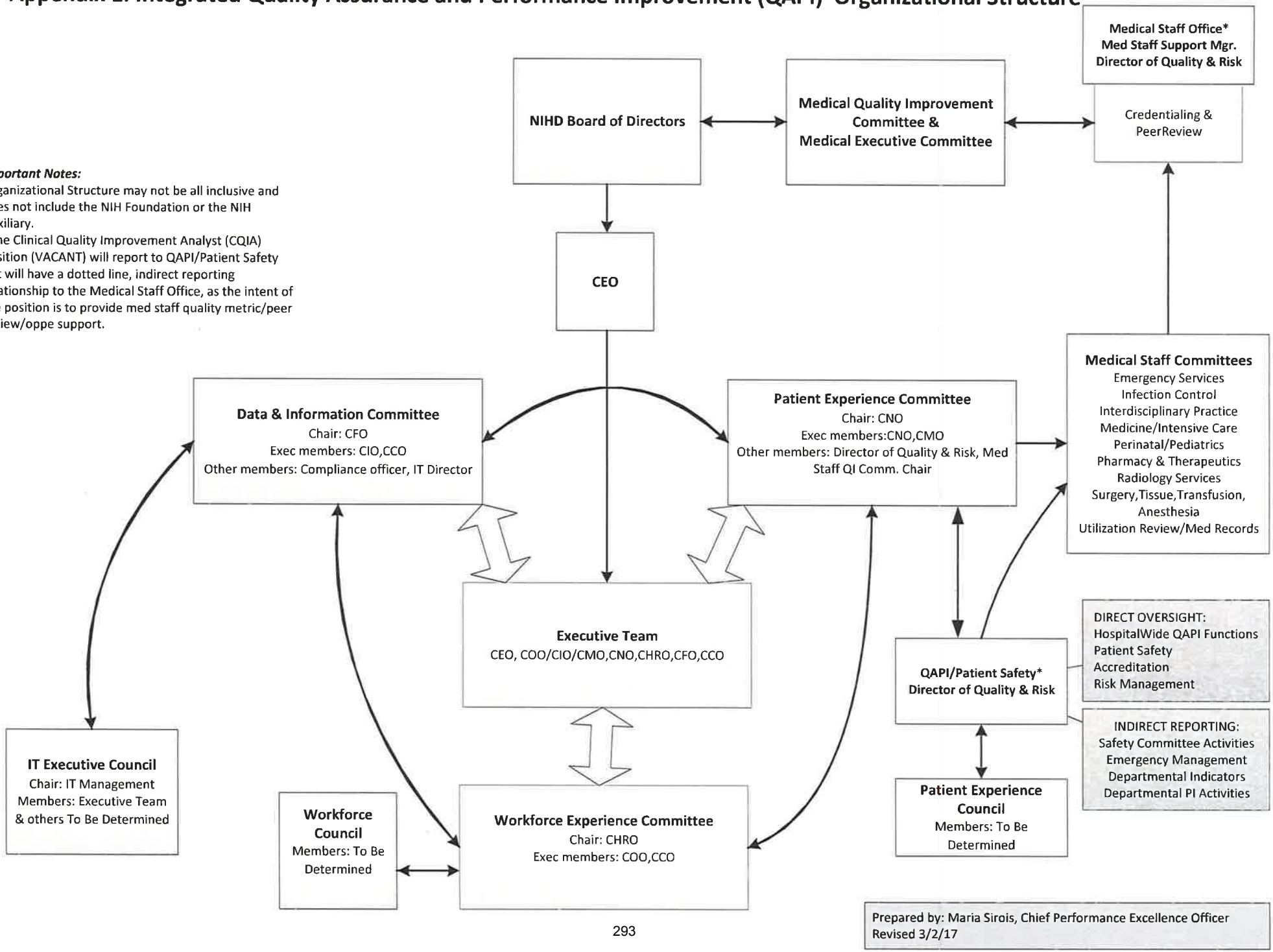
HOSPITAL-WIDE QUALITY ASSURANCE & PERFORMANCE IMPROVEMENT (QAPI) PLAN

2016

Committee Approval	**Date**
Medical Executive Committee	2/2/16
Board of Directors	2/17/16

Appendix 1. Integrated Quality Assurance and Performance Improvement (QAPI) Organizational Structure

Important Notes:
Organizational Structure may not be all inclusive and does not include the NIH Foundation or the NIH Auxiliary.
*The Clinical Quality Improvement Analyst (CQIA) position (VACANT) will report to QAPI/Patient Safety but will have a dotted line, indirect reporting relationship to the Medical Staff Office, as the intent of the position is to provide med staff quality metric/peer review/oppe support.



Prepared by: Maria Sirois, Chief Performance Excellence Officer
Revised 3/2/17

Quotation

stryker

Hospital **Northern Inyo Hospital** Date **3/14/2017**

Orthopaedic Implants and Instruments

	Value	***Discount***	Disc %	Extended Price
IMPLANT & INSTRUMENT TOTAL	**$ 1,688,921.00**	**$ 1,529,317.97**	**91%**	**$ 159,603.03**

****One time discount in conjunction with intial investment and execution of TIA****

	Description	List Price Value	Discount	Discount %	Extended Price
Trauma & Extremities - Trauma Inventory Agreement***					
	AxSOS Basic Large Frag Plating System	$ 63,865.00			
	AxSOS Extremity Small Frag Plating System	$ 75,007.00			
	AxSOS3 5.0 Dist Femur Periarticular Plating System	$ 98,833.00			
	AxSOS3 4.0 Periarticular Plating System	$ 169,858.00			
	- Distal Anterolateral Tibia				
	- Distal Medial Tibia				
	- Proximal Lateral Tibia				
	- Proximal Medial Tibia				
	- Proximal Humerus				
	VariAx Ankle Fracture System	$ 83,182.00			
	VariAx Distal Radius Plating System	$ 95,360.00			
	VariAx Modular Hand Plating System	$ 112,942.00			
	VariAx Elbow, Humerus, and Clavicle Plating System	$ 276,368.00			
	VariAx Compression Plating and Forearm Plating System	$ 24,677.00			
	EMS - Elbow Management System (Plates, Radial Head, etc)	$ 70,821.00			
	Gamma3 Cephomedullary Nailing System	$ 71,390.00			
	Omega3 Compression Hip Screw	$ 43,457.00			
	T2 Tibial Nailing System	$ 109,965.00			
	T2 Kids Flexible Nailing System	$ 15,727.00			
	T2 SCN Retrograde Nailing System	$ 136,315.00			
	T2 Interlock Screws and Disposables	$ 21,708.00			
	Hoffman 3 Modular External Fixation System (Large)	$ 46,160.00			
	Hoffman COMPACT Modular External Fixation System	$ 44,769.00			
	Asnis III 6.5/8.0 Ti Cannulated Screws	$ 59,149.00			
	Asnis III 4.0 Ti Cannulated Screws	$ 33,834.00			
	Asnis III 5.0 Ti Cannulated Screws	$ 35,534.00			
	IMPLANT TOTAL	**$ 1,688,921.00**	**$ 1,529,317.97**	**91%**	**$ 159,603.03**

TRAUMA INVENTORY AGREEMENT

This Trauma Inventory Agreement (this "Agreement") is effective as of the date of last signature below (the "Effective Date") by and between Northern Inyo Hospital with a place of business at 150 Pioneer Lane, Bishop, CA 93514 ("Customer") and Howmedica Osteonics Corp., with a place of business at 325 Corporate Drive, Mahwah, NJ 07430 (hereinafter referred to as "Stryker"). For purposes of this Agreement, Stryker and Customer may each be referred to individually as a "Party" and collectively, as the "Parties".

Background:

Customer and Stryker have entered into that certain SINGLE SITE PRODUCT PRICING AGREEMENT dated _____ (the "Pricing Agreement") which governs the terms and conditions under which Stryker will sell to Customer and Customer will purchase from Stryker certain trauma implant products manufactured by Stryker (the "Products"). In light of Customers' expected future purchases of Products under the Pricing Agreement and Customer's agreement to purchase Products from Stryker as set forth herein, Stryker has agreed to provide Customer with a one-time Product price concession on the Products set forth on Schedule A (collectively, the "Stryker Inventory"), in accordance with the terms and subject to the conditions of the Pricing Agreement and this Agreement. All purchases and sales of Products other than the specific Stryker Inventory being sold by Stryker to Customer pursuant to this Agreement shall be subject to the pricing and other terms and conditions set forth in the Pricing Agreement. If applicable, in order to accommodate the Stryker Inventory, Customer has requested that Stryker take title to and remove from its premises certain of Customer's current owned inventory of trauma implant products and related instrument sets that are competitive with the Products (the "Competitive Inventory"). Notwithstanding the foregoing, Stryker shall not remove any competitive tissue products from Customer's premises.

Now, therefore, in consideration of the mutual promises and benefits made and contained in this Agreement, the receipt and sufficiency of which are hereby acknowledged, the Parties hereby agree as follows:

1. Term. The term of this Agreement (the "Term") shall commence on the Effective Date and continue until the later of (a) the termination or expiration of the Pricing Agreement or (b) the third anniversary of the Effective Date.

2. Stryker Inventory. Stryker shall provide Customer with the Stryker Inventory. Following the provision of the Stryker Inventory to Customer, Stryker will invoice Customer for the Stryker Inventory, which invoice (together with any related documentation) will reflect that the Stryker Inventory is being sold to Customer at a discount. During the Term, Stryker represents and warrants that an unexpired unit of each Product within the Stryker Inventory shall at all times be reasonably available for Customer's use. For the avoidance of doubt, if Customer advises Stryker that a unit of any such Product has expired or has an expiration date of [thirty (30)] days or less, Stryker shall within five (5) business days replace the expired or expiring Product with an unexpired unit of the same Product at no charge to Customer; provided, that Customer's sole remedy for a breach of this representation and warranty shall be to obtain the replacement Product at no charge; and provided further, that this representation and warranty and undertaking to replace applies only to Product units supplied as part of the Stryker Inventory, and not to Product units subsequently purchased by Customer.

3. Competitive Inventory. Prior to fulfilling Customer's request to remove the Competitive Inventory, the Parties shall use commercially reasonable efforts to identify the Competitive Inventory to be removed pursuant to this Agreement. Customer hereby authorizes Stryker to have, and agrees to provide Stryker with, reasonable access to Customer's premises and records relating to the inventory that may constitute Competitive Inventory for the purposes of establishing the Competitive Inventory. Promptly following the determination and agreement by the Parties of all the Competitive Inventory, (i) the Competitive Inventory to be removed will be listed on Schedule B to this Agreement (the "Competitive Inventory List"), (ii) Customer shall acknowledge such agreement by signing the Competitive Inventory List, and (iii) the Parties will make arrangements for Stryker to take possession of the Competitive Inventory. Subject only to completion of the Competitive Inventory List and Customer's signature thereto, Customer hereby transfers to Stryker its entire right, title and interest in and to the Competitive Inventory (which specifically excludes any competitive tissue products). Customer represents and warrants that the Competitive Inventory and all rights thereto are owned by Customer free and clear of all liens, encumbrances, security interests or other adverse claims against title.

4. Inventory Commitment. In exchange for the terms and pricing set forth in this Agreement, Customer agrees that no less than 90% of Customer's inventory of the Products and "like" competitive products (including, without limitation, inventory that is owned by or consigned to Customer) shall consist of Stryker's products (the "Inventory

Commitment"). "Like" competitive products shall mean technology, product, equipment, systems, software and services that could reasonably be deemed to be substitutes for the Products; provided that such technology, product, equipment, systems, software and services satisfy critical clinical efficacy requirements. A determination to purchase technology, product, equipment, systems, software and services from sources other than Stryker, where such purchases would result in the failure of Customer to satisfy the Inventory Commitment must be based on a material, substantiated deficiency in the Stryker technology, product, equipment, systems, software and services. No more frequently than once every six months during the term, Customer, shall upon request by Stryker provide Stryker with such information as reasonably requested by Stryker to verify Customer's compliance with the Inventory Commitment, which may include, without limitation, requisition records, copies of purchase orders placed with other vendors, internal records of expenditures, and certificates of company officers as to expenditures. Failure to meet the Purchase Commitment or supply a Compliance Report will result in forfeiture of the pricing as agreed upon in the Pricing Agreement.

5. Discount; Reporting. The Stryker Inventory constitutes a discount off the aggregate price of all Products purchased under the Pricing Agreement during the Term. Stryker's invoice accompanying the Stryker Inventory will reflect that such Products are provided at up to a 90% discount off their regular purchase price under the Pricing Agreement, and Customer shall apply such discount to the aggregate purchase price of all Products purchased under the Pricing Agreement during the Term. Stryker, as supplier, hereby informs Customer, of Customer's obligation to make required reports (including properly reporting all prices paid net of all discounts for items supplied hereunder and under the Pricing Agreement) under the Federal Medicare and Medicaid Anti-Kickback Statute and the regulations thereunder (42 CFR Part 1001.952(h)) and as otherwise required of Customer by law or contract. Customer covenants that it shall make all required reports.

6. Confidentiality. Each Party shall hold in strictest confidence this Agreement and related materials and any information or material that is (a) related to the business of the other Party, (b) designated by the other Party as proprietary or confidential, herein or otherwise, or (c) is provided or delivered to such Party under circumstances which would reasonably lead one to believe it is designated as confidential or proprietary (collectively, the "Confidential Information"). Each Party hereby covenants and agrees that it shall not disclose any such information to any third party (other than their respective accountants, consultants or attorneys who have a need to know such information in furtherance of this agreement) without prior written authorization of the other Party. Confidential Information does not and shall not include information that: (i) is already lawfully known to the receiving Party at the time such information is disclosed by the other Party hereto; (ii) was or becomes publicly known through no wrongful act of the receiving Party; (iii) was or is rightfully received from a third party without restriction; (iv) was or is independently developed by the receiving Party without the use of any Confidential Information; (v) is approved for release by written authorization of the Party disclosing such information under this Agreement; or (vii) is required to be disclosed by applicable law, regulation or financial reporting requirements. The Parties agree that any breach or threatened breach of this clause would cause irreparable harm to the other Party, that a remedy at law may be inadequate to remedy such a breach or threatened breach, and that this clause may be enforced by way of a restraining order or injunction in addition to any other available legal remedies.

7. Miscellaneous.

   7.1. This Agreement shall be governed by and construed in accordance with the laws of the State of California, without regard to any conflict or choice of law provisions. The Parties consent and agree that any and all litigation between them arising from this Agreement and the business relationship created shall take place in the State of California and the Customer consents to the jurisdiction of the federal and state courts located in the State of California courts in such an event.

   7.2. This Agreement shall inure to the benefit of, and be binding upon, Customer and Stryker and their respective successors and assigns.

   7.3. Any notice required under this Agreement shall be in writing sent by registered mail, postage prepaid, and addressed to the Parties at their respective addresses as first set forth above.

   7.4. This Agreement sets forth the entire agreement and understanding between the Parties as to the subject matter hereof and has priority over and supersedes all documents, verbal consents or understandings made between Customer and Stryker prior to execution of this Agreement with respect to the subject matter hereof. Notwithstanding anything contained in this Section 7.4 to the contrary, the pricing terms set forth

in this Agreement are only applicable to the Stryker Inventory and shall not apply to any other sale of Products. Any such additional sales of Products shall be made in accordance with the terms and subject to the conditions of the Pricing Agreement. None of the terms of this Agreement may be amended, waived or modified except in writing signed by the Parties.

7.5. This Agreement may be executed in one or more counterparts (which may be delivered by facsimile, PDF or other electronic means, with the same effect as an original counterpart), each of which shall be deemed an original, but which together shall constitute a fully executed Agreement.

7.6. Sections 6 (Confidentiality) and 7 (Miscellaneous) of this Agreement shall survive its termination or expiration.

IN WITNESS WHEREOF, each Party has duly executed and delivered this Agreement as of the day and year first written above.

HOWMEDICA OSTEONICS CORP.	**Northern Inyo Hospital**
By: _____	By: _____
Name: _____	Name: _____
Title: _____	Title: _____
Date: _____	Date: _____

SCHEDULE A
Stryker Inventory

Stryker Implant Sets:

1	Asnis 4.0 Ti Cannulated Screws
1	Asnis 5.0 Ti Cannulated Screws
1	Asnis 6.5/8.0 Ti Cannulated Screws
1	AxSOS Extremity Plating System
1	AxSOS Basic Frag
1	AxSOS 3 4.0 Ti
1	AxSOS 3 5.0 Ti
1	Elbow Management System
1	Gamma3
1	Hoffmann 3
1	Hoffmann Compact
1	Omega3
1	T2 Tibial Nails
1	T2 Kids
1	T2 SCN
1	T2 Interlock Screws and Disposables
1	VariAx Distal Radius
1	VariAx Ankle
1	VariAx Forearm Plates
1	VariAx Modular Hand Plating System
1	VariAx Elbow & Clavicle Plating System

By signing below, Howmedica Osteonics Corp. hereby transfers to Customer all right, title and interest in and to the products listed above in accordance with the terms and subject to the conditions of that certain Trauma Inventory Agreement dated as of _____ (reference date of last signature on page 3), by and between Howmedica Osteonics Corp. and Customer.

HOWMEDICA OSTEONICS CORP.	**Northern Inyo Hospital**
By: _____	By: _____
Name: _____	Name: _____
Title: _____	Title: _____
Date: _____	Date: _____

SCHEDULE B
Competitive Inventory

1	Synthes Mini Modular Hand Plating
1	Synthes Small Frag Set
2	Synthes Locking Small Frag Set
1	Synthes Large Frag Plating and Screws
1	Synthes Periarticular Plating System
1	Synthes External Fixator - Large
1	Synthes External Fixator - Medium
1	Synthes Distal Radius External Fixator Set
1	Synthes Cortex, Cancellous, and Locking Screws
1	Synthes 4.0 Cannulated Screws
1	Synthes 4.5 Cannulated Screws
1	Synthes 7.3 Cannulated Screws
1	Synthes Variable Angle Ankle LCP
1	Synthes Variable Angle Elbow LCP
1	Synthes Trochanteric Fixation Nail System
1	Synthes DHS Hip Screw Set
1	Synthes Proximal Humerus Plates Long
1	Synthes LCP Distal Tibia Set
1	Synthes Tibial Plateau Plate Set
1	Synthes LCP Clavicle Plating

By signing below, Customer hereby (i) transfers to Howmedica Osteonics Corp. all right, title and interest in and to the products listed above in accordance with the terms and subject to the conditions of that certain Trauma Inventory Agreement dated as of _____ (reference date of last signature on page 3), by and between Howmedica Osteonics Corp. and Customer and (ii) acknowledges and agrees that complete and accurate photographic images of the products listed above were taken by Howmedica Osteonics Corp. prior to the removal of such products from Customer's premises and such photographic images represent the products actually removed by Howmedica Osteonics Corp.

HOWMEDICA OSTEONICS CORP.	**Northern Inyo Hospital**
By: _____	By: _____
Name: _____	Name: _____
Title: _____	Title: _____
Date: _____	Date: _____

Letter of Commitment – Northern Inyo Hospital

Customer Facility Name: Northern Inyo Hospital _____

Customer Facility Address: 150 Pioneer Lane _____

Bishop, CA 93514 _____

_____

Customer acknowledges that it is committing to Stryker Trauma and Extremities to be 90% of the total trauma product on the shelf for the following product categories:

Product Category	**(check below)**	**Competitive Inventory, on the shelf**
AxSOS Plating		
Variax Extremity Plating		
MMI Foot Products		
Hip Fracture		
IM Nails		
External Fixation		
Cannulated Screws		
Biologics		

Special Notes

Competitive products include, but are not limited, to Synthes, Depuy, Zimmer, Biomet/EBI, Wright Medical, Integra, Arthrex and Smith and Nephew Trauma Products and Sets.

HOWMEDICA OSTEONICS CORP.:

By: _____

Name: _____

Title: _____

Date: _____

Northern Inyo Hospital:

By: _____

Name: _____

Title: _____

Date: _____

SINGLE SITE PRODUCT PRICING AGREEMENT

This **SINGLE SITE PRODUCT PRICING AGREEMENT** and any attached and referenced Schedules (collectively, the "Agreement") is between Northern Inyo, located at 150 Pioneer Lane Bishop CA 93514 ("Customer"), and Howmedica Osteonics Corp., a New Jersey corporation with a place of business at 325 Corporate Drive, Mahwah, NJ 07430 ("Company") (each, a "Party" and collectively, the "Parties").

BACKGROUND:

Company manufactures and sells certain medical device and/or biologics products. Customer owns and operates a hospital. Customer wishes to purchase products at the prices and subject to the terms, conditions and assurances set forth herein.

The Parties therefore agree as follows:

1. Definitions. "Products" has the meaning set forth in Schedule A.

2. Term. This Agreement is effective as of the last date of signature below (the "Effective Date"), and shall continue through and expire three (3) years thereafter (the "Initial Term").

3. Products and Prices for the Products. Only Products expressly covered by Schedule A and purchased under this Agreement are eligible for the pricing in this Agreement. Product pricing shall be as set forth on Schedule A. Product pricing (including any price concessions set forth on Schedule A) is contingent upon Customer's compliance with all terms and conditions set forth in this Agreement including, but not limited to, those set forth in Schedule A and the requirement to pay outstanding invoices as set forth in the below section entitled "Invoices/Payments." If Customer does not meet a term or condition, pricing for the Products shall upon 30 days' notice revert to the Company's published price list then in effect (without any price concessions) on a prospective basis, and Customer agrees to pay in accordance with that published price list. If and when Company confirms its compliance with such terms and conditions, then during the period of such compliance, pricing (and any price concessions) shall again be as set forth on Schedule A on a prospective basis.

4. Tissue Products. The Parties acknowledge and agree that certain Products set forth herein may constitute Tissue Products (as hereinafter defined) and that applicable law, including, without limitation, the National Organ Transplant Act (NOTA), may prohibit the "sale" of such Tissue Products. It is therefore the intent of the Parties that any references to the "sale" of Products (including purchase terms and pricing) herein shall be construed in a manner that is consistent with NOTA and all other applicable laws, and that any price paid by Customer for Tissue Products hereunder represents Company's cost associated with the collection, processing and storage of such Tissue Products as well as the provision of technical and other field support to health care providers with respect to such Tissue Products and not a sale of the material itself. For purposes hereof, the term "Tissue Products" means human bone and other human tissue materials that are procured and processed by or on behalf of Company and are intended for clinical use in certain orthopedic or other applications.

5. Product-Related Services. Company agrees to provide technical training, including both initial training for new users and supplemental training for existing users, as needed to promote the safe and effective use of the products sold under this Agreement. Such technical training shall be provided for any health care practitioner who uses or intends to use the product and is employed by, or is on the active medical staff of, the Customer. If Company provides the technical training to a health care practitioner, it may pay for or reimburse the reasonable expenses, including meals, lodging and transportation, actually incurred by eligible recipients in connection with the technical training provided under this paragraph.

6. Purchase Orders. For Products being directly purchased from Company, Customer must submit to Company written purchase orders for such Products prior to the shipment of such Products. For any Product held by Customer on a consignment, bailment or loaner basis, Customer must submit to Company a written purchase order for such Products within 48 hours after the withdrawal from consignment, bailment or loaner inventory of such Product.

7. Shipment and Delivery. Except for those Products purchased on a consignment basis as set forth in Schedule B, all Products purchased directly from Company are shipped F.O.B. shipping point, freight prepaid and added to the invoice. Freight charges shall be determined in accordance with the following schedule:
   - $0 for standard deliveries;

8. Invoices/Payments. Upon shipment of Products to Customer (or in the case of consignment as set forth in Schedule B, upon receipt of Customer's purchase order as discussed in Schedule B), Company will submit to Customer an invoice for such Products, and Customer must pay in full invoices within 30 days from the date of invoice. In the event Customer wishes to dispute an invoice or portion thereof, Customer must notify Company in

writing within 15 days of its receipt. The writing must provide Company with sufficient detail regarding the basis and amount of the dispute. If Customer does not dispute an invoice within 15 days of its receipt of same, the invoice will be deemed to have been approved by Customer.

9. Reporting.

   a. Company, as supplier, hereby informs Customer, as buyer, of Customer's obligation to make required reports (including reporting on net prices paid for items supplied hereunder) under the Federal Medicare and Medicaid Anti-Kickback Statute and the regulations thereunder (42 CFR Part 1001.952(h)).

   b. Customer will meet with Company at least semi-annually to review (i) volume, market share and other conditions on which pricing under this Agreement is predicated; (ii) payment records reflecting timeliness and amounts paid to Company under all provisions of this Agreement; (iii) aggregated and blinded payment records reflecting purchases from and payments to other vendors of products similar to or the same as the Products; (iv) purchase order information; and (v) all other material aspects of the Parties' performance under this Agreement. Customer will provide accurate and complete data to Company as reasonably requested by Company to permit Company to verify the basis for discount pricing to Customer.

10. WARRANTY. ANY WARRANTIES PROVIDED BY COMPANY WITH RESPECT TO A GIVEN PRODUCT ARE AS DESCRIBED IN THE LABELING ACCOMPANYING UNITS OF THAT PRODUCT ON PURCHASE. COMPANY HEREBY EXPRESSLY DISCLAIMS ANY AND ALL EXPRESS OR IMPLIED WARRANTIES REGARDING THE PRODUCTS INCLUDING, BUT NOT LIMITED TO, MERCHANTABILITY AND FITNESS FOR A PARTICULAR PURPOSE.

11. LIMITATION OF LIABILITY. IN NO INSTANCE WILL COMPANY BE LIABLE TO CUSTOMER FOR INCIDENTAL, PUNITIVE, SPECIAL, COVER, EXEMPLARY, MULTIPLIED OR CONSEQUENTIAL DAMAGES OR ATTORNEYS' FEES OR COSTS FOR ANY ACTIONS UNDER OR RELATED TO THIS AGREEMENT.

12. Indemnity. Company agrees to indemnify Customer from any third party liability and/or damages which Customer may suffer directly as a result of a defect in workmanship or design of the Products. This indemnification applies only if the instructions outlined in the Product's labeling, manual, and/or instructions for use are followed. This indemnification does not apply to liability and/or damages arising from: (i) an injury due to the negligence of any person other than an employee or agent of Company; (ii) the failure of any person other than an employee or agent of Company to follow any instructions for use of the Product; or (iii) the use of any product not purchased from Company, or Product that has been modified, altered, reprocessed, or repaired by any person other than an employee of agent of Company. Customer agrees to hold Company harmless and indemnify Company against any claims or losses or injuries arising from (i), (ii), or (iii) above resulting from the negligence or willful misconduct of any employee or agent of Customer.

13. Insurance.

   a. Company will maintain adequate general liability insurance, including coverage for Products and completed operations, auto liability insurance and workers compensation and employer's liability insurance to cover liability arising out of this Agreement, including Products purchased by Customer from Company under the Agreement. To the extent permitted by law, Company has the right to self-insure to comply with this requirement. When requested by Customer, Company will furnish an insurance certificate signed by an authorized agent evidencing the above referenced insurance coverage.

   b. Customer shall maintain adequate insurance to cover liability arising out of this Agreement, including liability arising out of Customer's indemnity obligations set forth in Section 10 above. To the extent permitted by law, Customer has the right to self-insure to comply with this requirement. Upon request by Company, Customer will provide a certificate of insurance evidencing such coverage.

14. Termination, Effect. Either Party may terminate this Agreement at any time, without cause, by giving 30 days' advance written notice to the other Party. All accrued rights or responsibilities will survive termination or expiration of this Agreement. Upon termination or expiration of this Agreement, Customer shall, within ten days, pay Company all amounts owed pursuant to this Agreement.

15. Confidentiality. Company and Customer: (a) shall hold in confidence this Agreement and the terms and conditions contained herein (including, without limitation all terms relating to Product pricing) and any information and materials which are related to the business of the other or are designated as proprietary or confidential, herein or otherwise, or which a reasonable person would consider to be proprietary or confidential information; and (b) hereby covenant that they shall not disclose such information to any third party without prior written authorization

of the one to whom such information relates. The rights and remedies available to a party hereunder shall not limit or preclude any other available equitable or legal remedies.

16. Miscellaneous.

a. No Party shall be liable for failure of or delay in performing obligations set forth in this Agreement, and no Party shall be deemed in breach of its obligations, if such failure or delay is due to natural disasters or any causes reasonably beyond the control of such Party.

b. This Agreement shall be governed by and construed in accordance with the laws of the State of California and the Parties consent and agree that any and all litigation arising from this Agreement will be conducted by state or federal courts located in State of California, and Customer consents to the jurisdiction of the California courts in such an event.

c. This Agreement shall inure to the benefit of, and be binding upon, Customer and Company and their respective successors and assigns. Customer represents to Company that it is duly authorized to execute this Agreement. Neither Party may assign any of its rights or obligations under this Agreement, without the prior written consent of the other Party. Any purported assignment in violation of the preceding sentence will be void.

d. Any notice required under this Agreement shall be in writing, sent by registered mail, postage prepaid, and addressed to the Parties at their respective addresses as first set forth above.

e. This Agreement constitutes the entire agreement between the Parties concerning the subject matter of this Agreement and supersedes all prior negotiations and agreements between the Parties concerning the subject matter of this Agreement. This Agreement may only be amended by written agreement of the Parties. In the event of an inconsistency or conflict between this Agreement and any purchase order, invoice, consignment agreement or similar document relating to the purchase of any units of any Product, this Agreement will control.

f. The Warranty, Liability, Confidentiality and Miscellaneous provisions of this Agreement shall survive its termination or expiration.

IN WITNESS WHEREOF, each Party has executed and delivered this Agreement as of the date respectively set forth underneath such Party's name below.

COMPANY:	CUSTOMER:
HOWMEDICA OSTEONICS CORP.	**NORTHERN INYO**
By: _____	By: _____
Name: _____	Name: _____
Title: _____	Title: _____
Date: _____	Date: _____

Schedule A - Products and Pricing

A. Product. Any product not listed on Schedule A and/or introduced after the date of this signed agreement will be negotiated separately and agreed to in writing by both parties prior to its sale. "Product" means all items/the following categories of items listed in *Northern Inyo_Trauma Price File 3.8.2017.xlsx*

B. Performance Requirements and Prices. The prices for Products are set forth in the Table 1.

C. Wasted Products. Notwithstanding anything to the contrary contained in this Agreement, the price to be paid by Customer to Company for any Product that is withdrawn by Customer from consignment, bailment or loaner inventory, if any, and opened, but not implanted into a patient or otherwise used in connection with a procedure, will be discounted by 50% off of Company's published list price for such Product as in effect at the time of the wasting of such Product.

D. Instrumentation. Company may provide certain of its non-disposable orthopaedic surgical instruments ("Instrumentation") to Customer as follows:

1) Instrumentation shall be provided by Company on a loaned basis. Company may, in certain circumstances, charge Customer a usage fee as set forth in the applicable price file. The quantity of Instrumentation shall be as mutually agreed to by Customer and Company.

2) Customer shall have no ownership interest in the Instrumentation; however, Customer is responsible for maintaining the Instrumentation in good condition and for using reasonable care in its handling and storage. Customer shall be responsible for any loss of or damage to the Instrumentation. Upon expiration or termination of this Agreement, Instrumentation shall be removed from Customer and returned to Company at Company's expense.

3) Instrumentation shall be provided by Company on a loaned basis at no additional cost or expense to Customer except as noted in the preceding paragraph. The Instrumentation provided is restricted for use with the Products only and is not separately reimbursable and has no independent value. Customer shall maintain appropriate property insurance on the Instrumentation during the term of this Agreement to provide coverage against loss by theft, fire damage, acts of nature or other cause. Upon request by Company, Customer will provide a certificate of insurance evidencing such coverage, which will name Company as a named insured and loss payee, as its interests may appear. Upon expiration or termination of this Agreement, Customer shall, within ten days, deliver as directed by Company all Instrumentation then in its possession or control.

Schedule B - Consignment

In the event Company chooses to provide Customer with an option to consign Products, such consignment arrangement is conditioned on and subject to the following:

A. Company will place at Customer's facility on a consignment basis, such quantities and types of Product as the Customer and Company may mutually agree upon (collectively, the "Consigned Inventory"). Customer must provide appropriate space to store and safeguard the Consigned Inventory.

B. All Consigned Inventory is the property of Company until withdrawn at Customer's facility; however, Customer accepts all risk of loss and full responsibility for the condition of, any shortages in and the payment for all Consigned Inventory which may be used, opened, lost, or damaged. Customer must return to Company all damaged Consigned Inventory, and Company will arrange to have the damaged items destroyed. Customer must use reasonable efforts to (i) identify all Consigned Inventory as being the property of Company, (ii) separate Consigned Inventory from other property of Customer, and (iii) maintain complete and accurate records concerning the Consigned Inventory.

C. Customer, in its sole discretion, will determine whether to withdraw items of Consigned Inventory. As a Product is withdrawn from the Consigned Inventory, the Product shall be deemed to have been purchased by Customer, title in the Product shall pass to Customer and title in the sale proceeds shall vest in and belong to Company. Within two days from the withdrawal from consignment of any Consigned Inventory, Customer must issue to Company a hard copy of a purchase order for such withdrawn items. In the event Customer fails to issue a purchase order to Company, Company, at its option, may place Customer on credit hold and remove Consigned Inventory from Customer's premises.

D. Company may audit (including a physical inventory) the consignment arrangement during business hours upon 72 hours notice to Customer. In the event that Company's audit of the Consigned Inventory at the Customer concludes that inventory is missing, Customer agrees that it shall pay to Company any monies which are due and owing based on the missing inventory. In the event that Company's audit of the Consigned Inventory at the Customer concludes that a surplus exists, Company will adjust consignment inventory levels to reflect the amount as determined by the audit. Customer and Company agree to meet within 15 days after an audit of the inventory has been taken by Company, to resolve whether a surplus or a shortfall exists.

E. Upon notice or expiration or termination of the Agreement, Customer shall, within ten days, deliver as directed by Company all Consigned Inventory then in its possession or control.