Northern Inyo Healthcare District

Board Meetings

December 11, 2024

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

AGENDA
NORTHERN INYO HEALTHCARE DISTRICT
BOARD OF DIRECTORS REGULAR MEETING

December 11, 2024, at 5:00 p.m.
Northern Inyo Healthcare District invites you to join this meeting:

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

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

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

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1. Call to Order at 5:00 p.m.
2. Public Comment: The purpose of public comment is to allow members of the public to address the Board of Directors. Public comments shall be received at the beginning of the meeting and are limited to three (3) minutes per speaker, with a total time limit of thirty (30) minutes for all public comments unless otherwise modified by the Chair. Speaking time may not be granted and/or loaned to another individual for purposes of extending available speaking time unless arrangements have been made in advance for a large group of speakers to have a spokesperson speak on their behalf. Comments must be kept brief and non-repetitive. The general Public Comment portion of the meeting allows the public to address any item within the jurisdiction of the Board of Directors on matters not appearing on the agenda. Public comments on agenda items should be made at the time each item is considered.
3. Public comments on closed session items
4. Adjournment to closed session to/for:
    a. Discuss trade secrets (Health & Safety. Code § 32106 and Civ. Code 3426.1). The discussion will concern a new service line. The estimated date of public disclosure is May 2025.

b. Public Employee Performance Evaluation pursuant to Government Code Section 54957(b)(1). Title: CEO FY 2025 performance

5. Return to open session.
6. Report on any actions taken in closed session
7. CEO Thank you
8. Oath of Office – *Action Item*
    a. David Lent
    b. David McCoy Barrett
    c. Laura Smith
9. Slate of Officers – *Action Item*
    a. Chair: Jean Turner
    b. Vice Chair: Melissa Best-Baker
    c. Secretary: David Lent
    d. Treasurer: David McCoy Barrett
    e. Member at Large: Laura Smith
10. New Business:
        i. Board of Directors Seminar January 2025 – *Information Item*
    b. Chief Executive Officer Report *(Board will receive this report)*
        i. Strategic Plan - *Action Item*
        ii. Ophthalmology - *Information Item*
    c. Chief Financial Officer Report
        i. Financial & Statistical Reports (*Board will consider the approval of these reports)*
        ii. Revenue Cycle changes – Jorie implementation
    d. Chief Medical Officer Report – No report out
    e. Chief of Staff Reports, Sierra Bourne MD
        i. Medical Staff appointments – *Action Item*
        ii. Medical Staff Appointments 2024-2025 – Proxy Credentialing – *Action Item*
        iii. Medical Staff Reappointments 2025-2026 – *Action Item*
        iv. Medical Executive Committee Meeting Report – *Information Item*

11. Consent Agenda – *All matters listed under the consent agenda are considered routine and will be enacted by one motion unless any member of the Board wishes to remove an item for discussion.*
    a. Approval of minutes of the November 20, 2024 Regular Board Meeting
    b. Approval of Policies and Procedures
        i. Compliance and Business Ethics Committee
        ii. Employee Health Access of Patient Personal Medical Record
        iii. Forms Development and Control Policy
        iv. Linen Laundry Process
        v. NIHD Recruitment and Selection - Education and Experience Equivalency
        vi. Per Diem Employees
        vii. Regulatory Survey Security
        viii. Temporary Loaning of District Equipment

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12. General Information from Board Members (*Board will provide this information)*
13. Adjournment

In compliance with the Americans with Disabilities Act, if you require special accommodations to participate in a District Board meeting, please contact the administration at (760) 873-2838 at least 24 hours prior to the meeting.

NIHD Strategic Plan

Mission Statement: Our purpose is your health; our passion is your well-being.

Values: Respect, Compassion, Stewardship, Excellence, Accountability

Respect: Unwavering support for employees and providers. **Purpose:** Fostering an environment of trust and engagement. **Definition:** Respect entails treating everyone – staff, patients, and their families – with courtesy, professionalism and empathy. To show respect to all people, beliefs, and cultures, acknowledging the inherent value of every person and their role, is of paramount importance.	**Compassion**: Leading with empathy to preserve dignity. **Purpose:** Prioritize patient experience. **Definition:** Compassion means temporarily suspending judgment so that you can appreciate others perspectives or situations when they are different from your own. To be compassionate you need to be genuinely concerned about the other person or people's needs. You need to think about and feel it from their perspective.	**Stewardship:** Mindful use of resources. **Purpose:** Efficient, innovative, and sustainable. **Definition:** Stewardship is the responsible planning, management and use of resources with the aim of ensuring their sustainability. This includes taking into account environmental, social, and economic factors to ensure that future generations can also benefit from these resources.	**Excellence:** Pursuit of excellence in quality and safety. **Purpose:** Zero harm **Definition:** An organizational recognition that achieving excellence requires a daily commitment in order to provide our patients with the highest quality care to achieve the best possible outcome.	**Accountability:** Reliable access to exceptional care. **Purpose:** Responsibly serving the community with integrity. **Definition:** Accountability is the responsibility of the organization to respond to the health priorities of the community while upholding our commitment to our patients and employees. We will be proactive in understanding healthcare related inequities that exists and implementing processes to minimize their negative impact on our patients and community.

Strategic Initiatives (Tactics):				
Workforce	**Patient experience**	**Sustainability**	**No harm**	**Access to care**
Engagement survey: Goal: Increase scores for engagement and job satisfaction every year for the next three years: • Analyze survey results to identify key areas for improvement. • Implement initiatives like regular recognition programs, team-building activities, and feedback mechanisms. • Conduct quarterly check-ins with employees to monitor progress. • Create a communication plan to share improvements and next steps with employees. Goal: Increase participation rates every year for the next three years:	Improve Patient Experience: Goal: Increase HCAHPS: • Assess baseline HCAHPS scores and identify areas for improvement, focusing on empathy, communication, and responsiveness to patient needs. • Launch staff education on empathy and compassionate communication, incorporating HCAHPS-focused training. • Implement a hospital-wide initiative to improve key touchpoints (e.g., pain management, nurse communication) based on HCAHPS results. • Review data and adjust strategies based on survey results, aiming for the 75% target.	Financial Stewardship: Goal: Maintain Financial Health Through Cash Management and Debt Service • Regularly review cash flow projections, identify trends, and implement strategies to ensure that cash on hand remains at or above the required threshold. Goal: Reduce Accounts Receivable (AR) Days to Industry Standard • Implement more efficient billing practices, streamline the claims process, and enhance the	Highest Quality Care: Goal: Continuously deliver the highest quality clinical care by achieving excellence in clinical performance, regulatory compliance, and patient-centered outcomes, with a focus on health equity. • Reimagine the Northern Inyo Healthcare District Quality Assurance and Performance Improvement (QAPI) Plan to align with the District's Strategic Plan. • Achieve the maximum allowable metrics for the Quality Incentive Pool (QIP) annually, with a focus on cancer screenings	Community Needs: Goal: Decrease the amount of time new-to-provider patients have to wait for an appointment. • Measure next third available appointment per provider. • Establish processes that maximize the workflows for patient access, clinical efficiency, and provider productivity. • Monitor on a monthly basis; discuss daily at morning huddle of clinic and patient access leadership; discuss monthly with providers lagging for expected daily appointment.

• Promote the importance of surveys through internal communications and leadership messaging. • Offer incentives such as prize drawings for survey completion. • Simplify survey process to make participation easier. • Share results transparently to encourage future participation.		revenue cycle management system. • Regular audits and training for billing staff will be implemented to minimize delays. Goal: Reduce First Pass Denials • Conduct regular training sessions for the billing and coding teams. • Streamline the claims submission process • Implement a robust audit process to ensure claims are correctly coded and documented before submission.	and mental health services. • Improve the completion rates of cancer screenings (Breast, Colon, and Cervical).	• Continuous monitoring by management and training provided to staff.

Turnover: Goal: Reduce overall turnover rate: • Conduct exit interviews to identify common reasons for turnover. • Develop targeted retention strategies, such as improving work-life balance and offering professional development opportunities. • Work closely with leadership to address high-turnover departments. • Monitor turnover rates quarterly and adjust strategies as needed.	Press Ganey Survey: Goal: Improve Press Ganey Patient Experience Survey Scores • Analyze existing Press Ganey survey data to identify key pain points in patient care and interaction. • Develop an action plan for each department based on survey feedback, including specific training for staff. • Launch initiatives to improve areas such as wait times, patient-doctor communication, and staff responsiveness. • Monitor results and make final adjustments to achieve increase in "very good" ratings.	Budget and Expense Management Goal: Meet or Exceed Budgeted Net Income • Review and adjust operational budgets as needed • Monitor departmental performance against budget expectations • Ensure appropriate cost containment strategies are in place. Goal: Maintain Capital Spending Discipline • Develop a comprehensive capital expenditure plan and establish approval processes to ensure spending is controlled and justified.	Infection Prevention / Control: Goal: Maintain infection rates for healthcare-associated infections (HAIs) and reduce surgical site infections (SSIs). • Zero infections for Central Line-Associated Bloodstream Infection (CLABSI), Catheter-Associated Urinary Tract Infections (CAUTI), Ventilator-Associated Pneumonia (VAP), and Hospital-Onset C. difficile infections. • Reduce Surgical Site Infections for key procedures year-over-year.	Continuous Review of Service Lines: Goal: Meet needs of community in a sustainable manner. • Conduct referral patterns analysis to determine the highest number of outside referrals. • Work with outside stakeholders to develop strategies to address community health needs. • Work with community leaders, governmental agencies, not-for-profit organizations, social clubs, and other third party stakeholders to develop comprehensive plan.

		• Review project costs regularly to identify opportunities for cost savings.		
Retention Rate: Goal: Increase retention rate: • Partner with locals who offer housing options for staff. • Improve internal communication and listen to employee feedback. • Implement career development programs to support career growth. • Conduct regular stay interviews to understand and address employees' needs.	Patient rounding: Goal: Implement Leader Patient Rounding in Patient Care Areas • Establish clear goals for rounding, including frequency, responsibilities, and expected outcomes. • Develop and deploy training for leaders, ensuring they understand the importance of compassionate, empathetic interactions with patients during rounds. • Implement rounds across the hospital, ensuring leaders are present and actively engaging with patients. • Review the effectiveness of rounding through patient feedback, and make adjustments to	Productivity and Staffing: Goal: Establish Staffing Benchmarks and Control Labor Costs • Collect and analyze data on staffing needs and productivity, adjusting hiring, retention, and training strategies accordingly. Goal: Migrate Provider Compensation Models to Include Productivity or Quality Components • Work with providers and legal teams to revise compensation contracts and ensure alignment	Culture of Safety: Goal: Foster a culture of safety through leadership development, employee engagement, and a systematic approach to reducing harm. • Implement BETA HEART Program • Safety Education and Training for Leaders	Community Relations Goal: Promote the District with local, state, and national audiences; develop good-will with the public; communicate the services offered by NIHD. • CEO, executives, management, leaders, and other staff attend and participate in community events. • Develop a robust marketing plan using internal and external strategies to promote the District. • Work with State and Federal Representatives to effectively communicate the needs and challenges of the District.

	improve rounding quality and outcomes.	with performance goals.		
Diversity, Equity, and Inclusion (DEI) Management Plan: Goal: Create an inclusive, equitable, and sustainable culture and work environment: • Conduct DEI training for all employees, ensuring 100% participation. • Establish a DEI advisory committee to monitor progress and suggest improvements. • Create a DEI dashboard to track diversity metrics and share progress with staff. • Implement policies to ensure equitable access to career advancement opportunities.	Leadership Training: Goal: Executive Leadership Training on Quality Customer Experience and Employee Engagement • Identify key training opportunities and providers for leadership, with a focus on customer experience and employee engagement. • Schedule and conduct training for all executive leadership. • Apply learned concepts to leadership practices, including regular monitoring and feedback to staff. • Evaluate the impact of leadership training on patient experience and employee morale.	Service Line Management: Goal: Conduct Annual Service Line Analysis and Ensure ROI for New Services • Collaborate with clinical leadership to assess existing services and determine opportunities for optimization. • For new services, conduct thorough financial assessments before contract initiation.	Prioritizing Health Equity to Reduce Health Disparities: Goal: Prioritize health equity to reduce health disparities by focusing on vulnerable populations and addressing social determinants of health. • Identify priority populations experiencing health equity disparities and implement action plans. • Stratify key clinical KPIs by demographic variables and include findings in the hospital's performance dashboards. • Deepen community relationships to mitigate health disparities and to provide equitable	

			access to high quality services.	
Leadership rounding: Goal: Conduct regular rounding with teams to address issues in real-time. • Develop a rounding schedule and assign responsibilities to leadership. • Log rounding sessions in a centralized system. • Review feedback gathered during rounding sessions and create action items. • Report weekly rounding activity to the Executive Team for accountability.	District-wide education: Goal: Establish and Implement a District-Wide Patient Experience Education Plan • Assess current patient experience standards and create a curriculum tailored to each department and role. • Launch district-wide training, ensuring all employees have access to the materials and sessions. • Complete training for all staff and gather feedback for continuous improvement. • Integrate patient experience education into the onboarding process for new employees.	Cash and Investment Management: Goal: Review Investments Annually for Maximum ROI • Conduct an annual review of all investments, working with financial advisors to adjust strategies for optimal returns.		

Union Negotiations: Goal: Successfully negotiate successor contracts by October 31, 2025. • Form a negotiation team and partner with representatives from key departments. • Develop a negotiation timeline and communication plan. • Meet regularly with union representatives to discuss priorities and address concerns. • Review financial models to ensure proposed contracts align with the District's goals.	Control and Monitoring: Goal: Ensure that patient experience improvements are sustained by instituting a formal observation and feedback process. • Define the control plan, including observation tools, protocols, and a feedback loop for staff. • Conduct initial observations and provide feedback to department leaders. • Expand the control plan to all relevant areas, including regular monitoring and continuous improvement. • Analyze data to ensure that patient care continues to meet established compassion-based standards.	Seismic Compliance: Goal: Achieve Seismic 2030 NPC5 Compliance • Ensure that necessary resources, project teams, and timelines are in place to meet seismic compliance requirements		
Leadership training: Goal: Provide monthly leadership training for all leaders.				

• Identify monthly training topics aligned with organizational goals. • Assign training modules through the Relias Learning Management System. • Monitor and report training completion rates to the Executive Team. • Gather feedback on training sessions to improve future content.				

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November 27, 2024

Editor,

When evaluating healthcare service lines, we have to think about many factors, including community needs, costs, opportunity costs, contribution margins, recruitment challenges, and more. Lately, there has been a lot of discussion in our community about ophthalmology services. These conversations have only scratched the surface. I want to share a deeper look at the factors Northern Inyo Healthcare District (NIHD) has to weigh carefully before making decisions about our services.

There is no question that our community needs an ophthalmologist, but is employing one the best uses of the District's limited resources?

Dr. Tom Reid recently mentioned in a letter to the editor that a second ophthalmologist we hoped to recruit would work three weeks each month. That needs some clarification. The proposed schedule would actually allow for just one week of work each month. During that time, the physician would need to see all the patients typically seen in a month—up to 100 patients daily. That is simply not feasible. Our facilities cannot handle that patient volume, even at half that number.

Additionally, the physician requested a salary far above the fair market value (FMV) for their services. When I suggested a salary closer to FMV, he came back with a counteroffer that was 30 percent higher than the original request—something NIHD cannot afford.

Operating room (OR) time is one of the most expensive resources in a hospital. To stay financially stable, NIHD has to make the best use of that space. The hospital's only revenue for ophthalmology is from the OR time spent on surgeries. At Dr. Reid's request, we agreed not to mark up the cost of specialty lenses, which cost $900 each. This decision results in a loss of about $464 per eye—or $928 per patient.

We also keep our charges fair and competitive, aiming for the 50th percentile compared to other facilities. However, our charges for ophthalmology services are already much lower—around the 20th percentile—and drop below the 15th percentile when you exclude post-anesthesia recovery charges. Because we are a Critical Access Hospital, our reimbursements under Method 2 billing are directly tied

to charges. Lower charges mean less reimbursement, of which larger hospitals using Method 1 billing do not have to worry.

Dr. Reid's calculations do not account for NIHD's overhead costs, labor expenses, or the 60 percent benefits increase. Unlike private practices, we operate under a much more complex and cost-intensive structure.

Every decision we make involves opportunity costs. For NIHD, that means balancing the community's needs with the space and resources required to support three other growing, life-saving services. NIHD must prioritize these services, as they are critical to our community's health. NIHD purchased equipment for eye care, but that is a sunk cost. Continuing a service that does not align with our long-term financial health just is not sustainable.

Recruiting providers is another challenge, especially in specialties like ophthalmology, where there is a nationwide shortage. Offering services on an intermittent basis is not a viable solution. A service line must be available more frequently to truly serve the community. Recruiting and retaining qualified providers in this competitive market takes significant resources and strategy.

Dr. Reid's practice operates independently of NIHD, so we do not have in-house ophthalmology expertise. Providing these services would mean a steep learning curve to provide proper staffing and support. Our team is not afraid of hard work, but independent practices like Dr. Reid's or those managed by specialized corporations are often better equipped to ensure safe, effective care.

I want to emphasize that we are not definitively giving up on ophthalmology services. Our search continues, but we have to acknowledge the current challenges. As a rural hospital, we can only provide some of the services available in larger cities. Instead, we must focus on the services critical to our community's long-term health and well-being.

In the last few months, our team has made remarkable progress toward fiscal stability. However, I would not say we are in the "free and clear" yet. Protecting NIHD's future means making thoughtful decisions about using our limited resources. I am confident that together we can focus on strategic solutions and safeguard NIHD's ability to serve this community well into the future.

Respectfully,

Stephen DelRossi, MSA
Chief Executive Officer
Northern Inyo Healthcare District

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

DATE: December 2024

TO: Board of Directors, Northern Inyo Healthcare District

FROM: Andrea Mossman, Chief Financial Officer

RE: Financial Summary and Operation Insights as of October 2024

Financial Summary

1. Net Income: October's net loss was $(1.15M) due to lower net revenue which was volume related along with $1M in increased expenses compared to last year. The majority of the increase was due to one-time credits posted last October in other professional fees. For the year, net income is $1.15M and is higher than the prior year by $278k (+32%) due to lower expenses.
2. Operating Income: October's operating loss was $(1.45M) due to lower volumes and higher expenses. For the year, operating loss is $(373k) which is slightly higher than last year-to-date (-8%).
3. EBIDA: October's EBIDA was a loss of $(743k). For the year, EBIDA was $2.89M which is 33% higher than the prior year-to-date.
4. Revenue Breakdown: October's gross revenue was 6% higher than budget and 10% higher than last October due to higher volumes in the outpatient services and clinics. Net revenue is lower due to reduced rates in Medicare outpatient claims that caused a $2M decrease in anticipated reimbursement compared to last October. For the year, gross and net revenue was higher than budget by 5% due to volumes but net revenue was -2% under the prior year due to Medicare outpatient rate reductions.

Deductions Summary

1. Contractual Adjustments: Contractual discounts were higher due to increased gross revenue but were in line with the trend when reviewed as a percentage of gross revenue.
2. Bad Debt: For October, bad debt was higher due to AR cleanup. However, for the year, bad debt was in line with the budget.
3. Write-offs: Other write-offs were higher than the prior year and budget due to aged AR cleanup.

Salaries

1. Per Adjusted Patient Day / Adjusted Employee per Occupied Bed (Adjusted EPOB): Wages and full-time equivalents remained relatively consistent with the prior year while volume increased which caused wages per patient to be lower. This indicated we operated more efficiently compared to last year.
2. Total Salaries: Wages were relatively flat to budget and were higher than last October due to merits. For the year, wages were higher than prior year-to-date by 3% due to merits.
3. Average Hourly Rate: The average hourly rate was lower than budget and up 2% compared to last year due to merits.

Benefits

1. Total Benefits: For October, total benefits were lower than budget due to fewer medical expenses. For the year, benefits were lower than budget due to lower medical, dental, and vision expenses.
2. Benefits % of Wages: For October, we were at 52% of wages. For the year, we were at 48% of wages, which was lower than the prior year by (5%).

Total Salaries, Wages and Benefits (SWB)

1. Salaries, Wages, and Benefits (SWB) / Adjusted Patient Day: For October, we were (7%) under budget and flat to last October. For the year, we were (30%) under budget and (22%) under prior year-to-date. This was due to higher volume meaning we were more productive.
2. Salaries, Wages and Benefits (SWB) % of Total Expenses: For October, we were (3%) lower than budget. For the year, we were lower than budget but higher than prior year. This was due to overall expenses being lower this year with declines in areas such as supplies. For the year, we were at 53% and our goal was 50%.

Contract Labor

1. Contract Labor Expense: For October, contract labor expense was higher to budget and prior year due to volumes and staffing challenges in key areas. For the year, contract labor expense is over budget due to staffing challenges and increased volume but we were under prior year-to-date by $(231k).
2. Contract Labor Rates: For the year, contract labor rates are higher than budget but they were (14%) lower than prior year-to-date. We will continue to evaluation and negotiate rates based on market.
3. Contract Labor Full-Time Equivalents (FTEs): For the year, contract labor is consistent with prior year-to-date.

Other Expenses

1. Physician Expense / Adjusted Patient Day: For the year, physician expenses per patient were (17%) under budget and (15%) under prior year-to-date.
2. Supplies: For the year, supplies were lower than prior year-to-date due to lower pharmacy costs.
3. Total Expenses: For October, total expenses were 3% higher than budget and 11% higher compared to last October. For the year, total expenses were (2%) under prior year-to-date.

Stats Summary

1. Admits (excluding Nursery): For October, admits were down (9%) from last October due to less inpatient surgeries. For the year, admits were up 12% compared to prior year-to-date. This was due to higher deliveries and more emergency department admissions.
2. Inpatient Days (excluding Nursery): For October, inpatient days down up (4%) from last October. For the year, inpatient days were up 27% compared to prior year-to-date.
3. Average Daily Census: Average census increased 27% compared to last year-to-date.
4. Average Length of Stay (ALOS): Average length of stay increased 13% compared to last year but was still below the maximum for a critical access hospital.
5. Deliveries: For the year, Deliveries were 17% higher than last year-to-date.
6. Surgical Procedures: For October, total surgical procedures were 2% higher than last October. For the year, total surgical procedures were 7% higher than last year-to-date. This was due to higher general and urology surgeries.
7. Emergency Department (ED) Visits: Emergency visits were down (4%) compared to last October yet were up 3% compared to last year-to-date. This increased our admissions.
8. Diagnostic Imaging (DI) Exams: For October, DI was up 7% compared to last October. For the year, DI was up 3% compared to last year-to-date.
9. Rehab Visits: Rehab visits were up 64% compared to last year-to-date due to better staffing and corrected billing issues.
10. Outpatient Infusion / Injections / Wound Care Visits: These visits were up 22% compared to last year-to-date.
11. Observation Hours: Observations hours were up 3% compared to last year-to-date.
12. Rural Health Clinic (RHC) Visits: For October, RHC visits were up 11% compared to last October due to women's and clinic visited. For the year, RHC visits increase 3% due to women's and behavioral.

13. Other Clinics: For the year, all clinics increased 20% due to new providers.

Northern Inyo Healthcare District

October 2024 – Financial Summary

** Variances are B / (W)	Current Month				Prior MTD			Year to Date				Prior YTD		
	Actual	**Budget**	**Variance**	**Variance %**	**Actual**	**Change**	**Change %**	**Actual**	**Budget**	**Variance**	**Variance %**	**Actual**	**Change**	**Change %**
Net Income (Loss)	(1,152,036)	(651,303)	(500,733)	77%	11,363	(1,163,399)	10,239%	1,154,206	(3,056,789)	4,210,995	138%	875,889	278,317	32%
Operating Income (Loss)	(1,449,616)	(1,012,884)	(436,732)	43%	(381,153)	(1,068,463)	(280%)	(372,755)	(4,269,953)	3,897,198	91%	(345,105)	(27,649)	8%
EBIDA (Loss)	(742,505)	(287,725)	(454,780)	158%	335,928	(1,078,432)	321%	2,886,374	(1,602,477)	4,488,851	280%	2,176,058	710,315	33%
IP Gross Revenue	3,316,543	3,681,991	(365,448)	(10%)	3,277,300	39,244	1%	15,058,989	14,499,395	559,594	4%	13,842,733	1,216,256	9%
OP Gross Revenue	16,328,013	14,960,459	1,367,554	9%	14,790,086	1,537,926	10%	60,878,975	58,439,160	2,439,815	4%	55,493,297	5,385,677	10%
Clinic Gross Revenue	2,003,181	1,699,019	304,162	18%	1,599,317	403,864	25%	7,121,489	6,545,399	576,090	9%	6,050,015	1,071,474	18%
Total Gross Revenue	**21,647,737**	**20,341,469**	**1,306,268**	**6%**	**19,666,703**	**1,981,035**	**10%**	**83,059,452**	**79,483,953**	**3,575,499**	**4%**	**75,386,045**	**7,673,407**	**10%**
Net Patient Revenue	**8,997,204**	**9,092,714**	**(95,509)**	**(1%)**	**9,044,559**	**(47,355)**	**(1%)**	**37,827,267**	**36,101,913**	**1,725,354**	**5%**	**38,729,638**	**(902,371)**	**(2%)**
Cash Net Revenue % of Gross	*42%*	*45%*	*(3%)*	*(7%)*	*46%*	*(4%)*	*(10%)*	*46%*	*45%*	*0%*	*0%*	*51%*	*(6%)*	*(11%)*
Admits (excl. Nursery)	68	75	(7)	(9%)	75	(7)	(9%)	295	263	32	12%	263	32	12%
IP Days	247	234	13	6%	234	13	6%	1,079	824	255	31%	824	255	31%
IP Days (excl. Nursery)	205	212	(7)	(4%)	212	(7)	(4%)	931	735	196	27%	735	196	27%
Average Daily Census	6.6	6.8	(0.2)	(4%)	6.8	(0.2)	(4%)	7.6	6.0	1.6	27%	6.0	1.6	27%
ALOS	3.0	2.8	0.2	6%	2.8	0.2	6%	3.2	2.8	0.4	13%	2.8	0.4	13%
Deliveries	21	19	2	11%	19	2	11%	75	64	11	17%	64	11	17%
OP Visits	4,313	3,559	754	21%	3,559	754	21%	15,383	13,610	1,773	13%	13,610	1,773	13%
Rural Health Clinic Visits	2,602	2,358	244	10%	2,358	244	10%	9,273	9,253	20	0%	9,253	20	0%
Rural Health Women Visits	594	503	91	18%	503	91	18%	2,114	1,877	237	13%	1,877	237	13%
Rural Health Behavioral Visits	171	179	(8)	(4%)	179	(8)	(4%)	750	643	107	17%	643	107	17%
Total RHC Visits	**3,367**	**3,040**	**327**	**11%**	**3,040**	**327**	**11%**	**12,137**	**11,773**	**364**	**3%**	**11,773**	**364**	**3%**
Bronco Clinic Visits	67	20	47	235%	20	47	235%	132	69	63	91%	69	63	91%
Internal Medicine Clinic Visits	-	-	-	-%	-	-	-%	-	201	(201)	(100%)	201	(201)	(100%)
Orthopedic Clinic Visits	486	363	123	34%	363	123	34%	1,627	1,434	193	13%	1,434	193	13%
Pediatric Clinic Visits	682	619	63	10%	619	63	10%	2,397	2,367	30	1%	2,367	30	1%
Specialty Clinic Visits	597	349	248	71%	349	248	71%	2,252	1,375	877	64%	1,375	877	64%
Surgery Clinic Visits	205	157	48	31%	157	48	31%	671	474	197	42%	474	197	42%
Virtual Care Clinic Visits	75	32	43	134%	32	43	134%	248	175	73	42%	175	73	42%
Total NIA Clinic Visits	**2,112**	**1,540**	**572**	**37%**	**1,540**	**572**	**37%**	**7,327**	**6,095**	**1,232**	**20%**	**6,095**	**1,232**	**20%**
IP Surgeries	9	22	(13)	(59%)	22	(13)	(59%)	52	88	(36)	(41%)	88	(36)	(41%)
OP Surgeries	167	151	16	11%	151	16	11%	559	481	78	16%	481	78	16%
Total Surgeries	**176**	**173**	**3**	**2%**	**173**	**3**	**2%**	**611**	**569**	**42**	**7%**	**569**	**42**	**7%**
Cardiology	-	-	-	-%	-	-	-%	3	-	3	-%	-	3	-%
General	87	84	3	4%	84	3	4%	297	254	43	17%	254	43	17%
Gynecology & Obstetrics	13	30	(17)	(57%)	30	(17)	(57%)	48	63	(15)	(24%)	63	(15)	(24%)
Ophthalmology	24	25	(1)	(4%)	25	(1)	(4%)	81	96	(15)	(16%)	96	(15)	(16%)
Orthopedic	33	20	13	65%	20	13	65%	123	115	8	7%	115	8	7%
Pediatric	-	-	-	-%	-	-	-%	-	-	-	-%	-	-	-%
Plastics	-	-	-	-%	-	-	-%	1	-	1	-%	-	1	-%
Podiatry	-	-	-	-%	-	-	-%	2	1	1	100%	1	1	100%
Urology	18	14	4	29%	14	4	29%	55	40	15	38%	40	15	38%
Diagnostic Image Exams	2,344	2,182	162	7%	2,182	162	7%	8,697	8,419	278	3%	8,419	278	3%
Emergency Visits	859	899	(40)	(4%)	899	(40)	(4%)	3,614	3,515	99	3%	3,515	99	3%
ED Admits	38	34	4	12%	34	4	12%	168	111	57	51%	111	57	51%
ED Admits % of ED Visits	4%	4%	1%	17%	4%	1%	17%	5%	3%	1%	47%	3%	1%	47%
Rehab Visits	1,142	521	621	119%	521	621	119%	3,556	2,173	1,383	64%	2,173	1,383	64%
OP Infusion/Wound Care Visits	333	352	(19)	(5%)	352	(19)	(5%)	1,393	1,141	252	22%	1,141	252	22%
Observation Hours	1,732	1,794	(62)	(3%)	1,794	(62)	(3%)	7,280	7,069	211	3%	7,069	211	3%

Provided by: Chief Financial Officer
Report Name: September 2024 Financial Summary

Northern Inyo Healthcare District

October 2024 – Financial Summary

** Variances are B / (W)	Current Month				Prior MTD			Year to Date				Prior YTD		
	Actual	**Budget**	**Variance**	**Variance %**	**Actual**	**Change**	**Change %**	**Actual**	**Budget**	**Variance**	**Variance %**	**Actual**	**Change**	**Change %**
PAYOR MIX														
Blue Cross	35.2%	19.2%	16.0%	83.0%	19.2%	16.0%	83.0%	26.0%	17.3%	8.7%	50.2%	17.3%	8.7%	50.2%
Commercial	4.6%	2.6%	2.1%	81.2%	2.6%	2.1%	81.2%	4.7%	2.8%	1.9%	66.7%	2.8%	1.9%	66.7%
Medicaid	19.7%	26.9%	(7.3%)	(27.0%)	26.9%	(7.3%)	(27.0%)	26.2%	22.2%	4.0%	17.9%	22.2%	4.0%	17.9%
Medicare	40.5%	50.4%	(9.9%)	(19.7%)	50.4%	(9.9%)	(19.7%)	39.9%	52.9%	(13.0%)	(24.6%)	52.9%	(13.0%)	(24.6%)
Self-pay	-%	0.9%	(0.9%)	(100.0%)	0.9%	(0.9%)	(100.0%)	2.4%	3.9%	(1.6%)	(40.4%)	3.9%	(1.6%)	(40.4%)
Worker's Comp	-%	-%	-%	-%	-%	-%	-%	0.8%	0.7%	0.2%	28.0%	0.7%	0.2%	28.0%
Other	-%	-%	-%	-%	-%	-%	-%	-%	0.1%	(0.1%)	(100.0%)	0.1%	(0.1%)	(100.0%)
DEDUCTIONS														
Contract Adjust	(10,875,577)	(9,949,334)	(926,243)	9%	(9,911,289)	(964,289)	10%	(39,516,690)	(38,190,361)	(1,326,329)	3%	(31,529,690)	(7,987,000)	25%
Bad Debt	(302,126)	(685,674)	383,549	(56%)	(421,557)	119,431	(28%)	(2,958,198)	(2,835,818)	(122,379)	4%	(3,005,089)	46,891	(2%)
Write-off	(1,472,830)	(613,748)	(859,083)	140%	(289,298)	(1,183,532)	409%	(2,609,115)	(2,355,860)	(253,254)	11%	(2,123,016)	(486,099)	23%
CENSUS														
Patient Days	205	212	(7)	(4%)	212	(7)	(4%)	931	735	196	27%	735	196	27%
Adjusted ADC	43	41	2	5%	41	2	5%	42	33	9	28%	33	9	28%
Adjusted Days	1,335	1,272	63	5%	1,272	63	5%	5,138	4,003	1,135	28%	4,003	1,135	28%
Employed FTE	369.1	352.9	16.2	5%	352.9	16.2	5%	360.8	356.9	3.9	1%	356.9	3.9	1%
Contract Labor FTE	21.3	29.6	(8.3)	(28%)	29.6	(8.3)	(28%)	26.1	25.3	0.8	3%	25.3	0.8	3%
Total Paid FTE	390.4	382.5	8.0	2%	382.5	8.0	2%	386.9	382.1	4.7	1%	382.1	4.7	1%
EPOB (Employee per Occupied Bed)	1.9	1.8	0.1	6%	1.8	0.1	6%	1.6	2.1	(0.4)	(20%)	2.1	(0.4)	(20%)
EPOC (Employee per Occupied Case)	0.3	0.3	(0.0)	(3%)	0.3	(0.0)	(3%)	0.1	0.1	(0.0)	(21%)	0.1	(0.0)	(21%)
Adjusted EPOB	12.5	10.8	1.6	15%	10.8	1.6	15%	9.1	11.2	(2.1)	(19%)	11.2	(2.1)	(19%)
Adjusted EPOC	1.9	1.8	0.1	6%	1.8	0.1	6%	0.4	0.5	(0.1)	(20%)	0.5	(0.1)	(20%)
SALARIES														
Per Adjust Bed Day	2,713	2,797	(83)	(3%)	2,554	159	6%	2,646	3,521	(875)	(25%)	3,296	(650)	(20%)
Total Salaries	3,622,038	3,557,883	64,156	2%	3,249,591	372,448	11%	13,594,457	14,094,111	(499,654)	(4%)	13,191,257	403,200	3%
Average Hourly Rate	55.40	56.92	(1.52)	(3%)	51.98	3.41	7%	53.61	56.19	(2.58)	(5%)	52.59	1.02	2%
Employed Paid FTEs	369.1	352.9	16.2	336.7	352.9	16.2	5%	360.8	356.9	3.9	1%	356.9	3.9	1%
BENEFITS														
Per Adjust Bed Day	1,421	1,635	(214)	(13%)	1,537	(116)	(8%)	1,269	2,072	(803)	(39%)	1,745	(477)	(27%)
Total Benefits	1,896,266	2,079,967	(183,702)	(9%)	1,955,349	(59,083)	(3%)	6,517,954	8,292,234	(1,774,281)	(21%)	6,985,824	(467,870)	(7%)
Benefits % of Wages	52%	58%	(6%)	(10%)	60%	-8%	(13%)	48%	59%	(11%)	(19%)	53%	(5%)	(9%)
Pension Expense	376,124	498,151	(122,026)	(24%)	393,873	(17,748)	(5%)	1,668,477	1,992,135	(323,658)	(16%)	1,789,393	(120,916)	(7%)
MDV Expense	1,232,338	748,612	483,726	65%	1,256,181	(23,843)	(2%)	3,458,334	2,994,448	463,886	15%	4,004,359	(546,025)	(14%)
Taxes, PTO accrued, Other	287,803	833,205	(545,402)	(65%)	305,295	(17,492)	(6%)	1,391,143	3,305,651	(1,914,509)	(58%)	1,192,071	199,071	17%
Salaries, Wages & Benefits	5,518,304	5,637,850	(119,546)	(2%)	5,204,940	313,364	6%	20,112,411	22,386,345	(2,273,934)	(10%)	20,177,081	(64,670)	(0%)
SWB/APD	4,134	4,432	(298)	(7%)	4,091	42	1%	3,915	5,593	(1,678)	(30%)	5,041	(1,126)	(22%)
SWB % of Total Expenses	53%	56%	(3%)	(5%)	55%	(2%)	(4%)	53%	55%	(3%)	(5%)	52%	1%	2%

Provided by: Chief Financial Officer
Report Name: September 2024 Financial Summary

Northern Inyo Healthcare District

October 2024 – Financial Summary

** Variances are B / (W)	Current Month				Prior MTD			Year to Date				Prior YTD		
	Actual	Budget	Variance	Variance %	Actual	Change	Change %	Actual	Budget	Variance	Variance %	Actual	Change	Change %
PROFESSIONAL FEES														
Per Adjust Bed Day	2,094	1,781	313	18%	1,421	673	47%	1,915	2,236	(321)	(14%)	2,518	(603)	(24%)
Total Physician Fee	1,699,955	1,463,822	236,132	16%	1,432,267	267,688	19%	6,273,644	5,853,689	419,955	7%	5,762,924	510,719	9%
Total Contract Labor	543,829	379,333	164,496	43%	371,183	172,647	47%	1,768,450	1,421,860	346,590	24%	1,999,924	(231,474)	(12%)
Total Other Pro-Fees	551,485	423,133	128,352	30%	4,418	547,067	12,384%	1,796,837	1,673,355	123,482	7%	2,315,233	(518,396)	(22%)
Total Professional Fees	2,795,269	2,266,288	528,981	23%	1,807,867	987,402	55%	9,838,931	8,948,903	890,027	10%	10,078,082	(239,151)	(2%)
Contract AHR	143.96	72.35	71.62	99%	70.79	73.17	103%	96.40	79.96	16.44	21%	112.47	(16.07)	(14%)
Contract Paid FTEs	21.3	29.6	(8.3)	(28%)	29.6	(8.3)	(28%)	26.1	25.3	0.8	3%	25.3	0.8	3%
Physician Fee per Adjust Bed Day	1,273	1,151	123	11%	1,126	148	13%	1,221	1,462	(241)	(17%)	1,440	(219)	(15%)
PHARMACY														
Per Adjust Bed Day	272	363	(90)	(25%)	223	49	22%	202	461	(259)	(56%)	428	(225)	(53%)
Total Rx Expense	363,699	461,460	(97,761)	(21%)	283,643	80,056	28%	1,040,056	1,845,839	(805,783)	(44%)	1,711,845	(671,789)	(39%)
MEDICAL SUPPLIES														
Per Adjust Bed Day	372	337	35	10%	543	(171)	(31%)	403	429	(25)	(6%)	517	(113)	(22%)
Total Medical Supplies	496,964	428,910	68,054	16%	690,604	(193,640)	(28%)	2,072,277	1,715,884	356,392	21%	2,067,653	4,624	0%
EHR SYSTEM														
Per Adjust Bed Day	19	106	(87)	(82%)	215	(196)	(91%)	27	135	(108)	(80%)	137	(110)	(80%)
Total EHR Expense	25,930	135,000	(109,070)	(81%)	273,794	(247,864)	(91%)	140,462	540,000	(399,538)	(74%)	548,880	(408,418)	(74%)
OTHER EXPENSE														
Per Adjust Bed Day	627	639	(12)	(2%)	661	(33)	(5%)	635	870	(234)	(27%)	797	(162)	(20%)
Total Other	837,124	812,512	24,612	3%	840,299	(3,176)	(0%)	3,263,718	3,480,583	(216,865)	(6%)	3,191,034	72,684	2%
DEPRECIATION AND AMORTIZATION														
Per Adjust Bed Day	307	286	21	7%	255	52	20%	337	363	(26)	(7%)	325	12	4%
Total Depreciation and Amortization	409,531	363,578	45,953	13%	324,565	84,966	26%	1,732,168	1,454,312	277,856	19%	1,300,170	431,998	33%
TOTAL EXPENSES	10,446,820	10,105,597	341,223	3%	9,425,712	1,021,108	11%	38,200,022	40,371,866	(2,171,845)	(5%)	39,074,744	(874,722)	(2%)
Per Adjust Bed Day	7,826	7,943	(118)	(1%)	7,409	417	6%	7,435	10,086	(2,651)	(26%)	9,762	(2,327)	(24%)
Per Calendar Day	336,994	325,987	11,007	3%	304,055	32,939	11%	310,569	328,227	(17,657)	(5%)	317,681	(7,112)	(2%)

Provided by: Chief Financial Officer
Report Name: September 2024 Financial Summary

Northern Inyo Healthcare District
Income Statement
Fiscal Year 2025

	10/31/2024	Oct Budget	10/31/2023	2025 YTD	2024 YTD	Budget Variance	PYM Change	PYTD Change
Gross Patient Service Revenue								
Inpatient Patient Revenue	3,316,543	3,681,991	3,277,300	15,058,989	13,842,733	(365,448)	39,244	1,216,256
Outpatient Revenue	16,328,013	14,960,459	14,790,086	60,878,975	55,493,297	1,367,554	1,537,926	5,385,677
Clinic Revenue	2,003,181	1,699,019	1,599,317	7,121,489	6,050,015	304,162	403,864	1,071,474
Gross Patient Service Revenue	21,647,737	20,341,469	19,666,703	83,059,452	75,386,045	1,306,268	1,981,035	7,673,407
Deductions from Revenue						-		-
Contractual Adjustments	(10,875,577)	(9,949,334)	(9,911,289)	(39,516,690)	(31,529,690)	(926,243)	(964,289)	(7,987,000)
Bad Debt	(302,126)	(685,674)	(421,557)	(2,958,198)	(3,005,089)	383,549	119,431	46,891
A/R Writeoffs	(1,472,830)	(613,748)	(289,298)	(2,609,115)	(2,123,016)	(859,083)	(1,183,532)	(486,099)
Other Deductions from Revenue	-	-	-	(152,618)	-	-	-	(152,618)
Deductions from Revenue	(12,650,533)	(11,248,755)	(10,622,143)	(45,236,620)	(36,657,794)	(1,401,777)	(2,028,389)	(8,578,826)
Other Patient Revenue								-
Incentive Income	-	-	-	2,000	-	-	-	2,000
Other Oper Rev - Rehab Thera Serv	-	-	-	2,435	1,387	-	-	1,048
Medical Office Net Revenue	-	-	-	-	-	-	-	-
Other Patient Revenue	-	-	-	4,435	1,387	-	-	3,048
Net Patient Service Revenue	**8,997,204**	**9,092,714**	**9,044,559**	**37,827,267**	**38,729,638**	**(95,509)**	**(47,355)**	**(902,371)**
CNR%	**41.6%**	**44.7%**	**46.0%**	**45.5%**	**51.4%**	**-3.1%**	**-4.4%**	**-5.8%**
Cost of Services - Direct								-
Salaries and Wages	3,033,243	2,979,516	2,804,438	11,442,096	11,343,360	53,727	228,805	98,736
Benefits	1,587,436	1,741,220	1,679,949	5,553,662	5,985,190	(153,784)	(92,513)	(431,528)
Professional Fees	1,956,752	1,639,974	1,442,077	7,192,464	6,938,888	316,778	514,676	253,577
Contract Labor	466,567	325,441	278,108	1,536,351	1,733,859	141,126	188,460	(197,508)
Pharmacy	363,699	461,460	283,643	1,040,056	1,711,845	(97,761)	80,056	(671,789)
Medical Supplies	496,964	428,910	690,604	2,072,277	2,067,653	68,054	(193,640)	4,624
Hospice Operations	-	-	-	-	-	-	-	-
EHR System Expense	25,930	135,000	273,794	140,462	548,880	(109,070)	(247,864)	(408,418)
Other Direct Expenses	687,481	667,269	664,293	2,565,063	2,514,578	20,212	23,188	50,484
Total Cost of Services - Direct	8,618,072	8,378,790	8,116,905	31,542,431	32,844,253	239,282	501,167	(1,301,822)
General and Administrative Overhead								
Salaries and Wages	588,796	578,367	445,153	2,152,361	1,847,897	10,429	143,643	304,463
Benefits	308,829	338,747	275,400	964,292	1,000,633	(29,918)	33,430	(36,342)
Professional Fees	294,687	246,980	(5,392)	878,016	1,139,270	47,707	300,079	(261,254)
Contract Labor	77,262	53,892	93,075	232,099	266,065	23,370	(15,813)	(33,966)
Depreciation and Amortization	409,531	363,578	324,565	1,732,168	1,300,170	45,953	84,966	431,998
Other Administative Expenses	149,642	145,243	176,006	698,655	676,455	4,400	(26,364)	22,200
Total General and Administrative Overhead	1,828,748	1,726,807	1,308,807	6,657,591	6,230,491	101,941	519,942	427,099
Total Expenses	**10,446,820**	**10,105,597**	**9,425,712**	**38,200,022**	**39,074,744**	**341,223**	**1,021,108**	**(874,722)**
Financing Expense	217,525	185,154	179,095	797,356	715,417	32,371	38,431	81,939
Financing Income	181,031	238,960	228,125	1,041,630	912,498	(57,930)	(47,094)	129,132
Investment Income	40,963	133,181	158,200	183,436	333,357	(92,218)	(117,237)	(149,921)
Miscellaneous Income	293,111	174,593	185,286	1,099,250	690,556	118,518	107,826	408,695
Net Income (Change in Financial Position)	**(1,152,036)**	**(651,303)**	**11,363**	**1,154,206**	**875,889**	**(500,733)**	**(1,163,399)**	**278,317**
Operating Income	(1,449,616)	(1,012,884)	(381,153)	(372,755)	(345,105)	(436,732)	(1,068,463)	(27,649)
EBIDA	(742,505)	(287,725)	335,928	2,886,374	2,176,058	(454,780)	(1,078,432)	710,315
Net Profit Margin	-12.8%	-7.2%	0.1%	3.1%	2.3%	-5.6%	-12.9%	-30.8%

Northern Inyo Healthcare District
Balance Sheet
Fiscal Year 2025

	PY Balances	7/31/2024	7/31/2023	8/31/2024	8/31/2023	9/30/2024	9/30/2023	10/31/2024	10/31/2023	PM Change	PY Change
Assets											
Current Assets											
Cash and Liquid Capital	18,718,414	20,537,230	15,220,072	17,874,637	18,008,863	17,374,679	18,771,541	16,909,058	15,130,616	(465,621)	1,778,442
Short Term Investments	6,418,451	7,565,620	10,513,789	7,570,368	10,555,533	7,574,716	10,555,533	6,876,555	10,658,191	(698,160)	(3,781,636)
PMA Partnership	-	-	-	-	-	-	-	-	-	-	-
Accounts Receivable, Net of Allowance	17,924,674	18,219,994	16,283,014	20,277,373	13,668,526	19,842,483	15,119,591	18,705,429	18,412,645	(1,137,054)	292,784
Other Receivables	4,754,052	4,293,186	3,071,746	4,361,004	321,629	4,823,782	794,581	4,771,477	1,149,410	(52,305)	3,622,067
Inventory	6,103,723	6,087,428	5,120,179	6,083,763	5,099,597	6,112,780	5,155,489	6,079,443	5,210,947	(33,336)	868,497
Prepaid Expenses	1,119,559	1,463,004	2,154,415	1,782,536	2,821,462	1,933,935	2,326,052	1,353,383	2,377,751	(580,552)	(1,024,368)
Total Current Assets	**55,038,873**	**58,166,463**	**52,363,215**	**57,949,681**	**50,475,610**	**57,662,375**	**52,722,787**	**54,695,345**	**52,939,560**	**(2,967,030)**	**1,755,785**
Assets Limited as to Use											
Internally Designated for Capital Acquisition	-	-	-	-	-	-	-	-		-	-
Short Term - Restricted	1,467,786	1,467,914	1,466,418	1,468,042	1,466,541	1,468,166	1,466,663	1,468,293	1,466,789	128	1,505
Limited Use Assets										-	-
LAIF - DC Pension Board Restricted	-	-	870,163	-	828,419	-	828,419	-	828,417	-	(828,417)
LAIF - DB Pension Board Restricted	10,346,490	10,346,490	15,684,846	10,346,490	13,076,830	10,346,490	13,076,830	10,346,490	13,076,830	-	(2,730,340)
PEPRA - Deferred Outflows	-	-	-	-	-	-	-	-		-	-
PEPRA Pension	-	-	-	-	-	-	-	-		-	-
Deferred Outflow - Excess Acquisition	573,097	573,097	573,097	573,097	-	573,097	573,097	573,097		-	573,097
Total Limited Use Assets	10,919,587	10,919,587	17,128,106	10,919,587	13,905,249	10,919,587	14,478,346	10,919,587	13,905,247	-	(2,985,660)
Revenue Bonds Held by a Trustee	376,411	370,707	1,072,480	365,005	912,490	359,303	752,501	353,592	746,796	(5,711)	(393,204)
Total Assets Limited as to Use	**12,763,784**	**12,758,208**	**19,667,005**	**12,752,634**	**16,284,281**	**12,747,056**	**16,697,511**	**12,741,473**	**16,118,832**	**(5,583)**	**(3,377,360)**
Long Term Assets											
Long Term Investment	1,846,138	751,539	2,776,508	754,812	2,783,284	755,869	2,790,423	999,950	2,797,561	244,081	(1,797,611)
Fixed Assets, Net of Depreciation	84,474,743	84,191,632	84,781,121	83,865,858	77,751,338	84,066,999	76,854,908	83,828,939	77,676,251	(238,060)	6,152,688
Total Long Term Assets	**86,320,881**	**84,943,172**	**87,557,629**	**84,620,670**	**80,534,623**	**84,822,868**	**79,645,331**	**84,828,890**	**80,473,812**	**6,022**	**4,355,077**
Total Assets	**154,123,537**	**155,867,842**	**159,587,849**	**155,322,985**	**147,294,513**	**155,232,299**	**149,065,629**	**152,265,708**	**149,532,205**	**(2,966,591)**	**2,733,503**
Liabilities											
Current Liabilities											
Current Maturities of Long-Term Debt	4,146,183	4,217,792	4,936,019	4,204,640	798,370	4,771,637	190,197	4,782,382	655,101	10,746	4,127,281
Accounts Payable	5,010,089	4,451,768	4,929,766	5,232,265	6,750,705	4,443,274	6,935,344	3,949,738	6,819,778	(493,535)	(2,870,040)
Accrued Payroll and Related	6,224,657	6,279,496	7,600,696	4,607,440	11,656,151	4,915,339	12,664,513	5,437,529	12,669,463	522,190	(7,231,934)
Accrued Interest and Sales Tax	109,159	192,510	169,971	261,700	244,123	78,276	96,606	166,600	166,957	88,325	(357)
Notes Payable	446,860	446,860	1,532,689	446,860	1,633,708	446,860	1,633,708	446,860	1,633,708	-	(1,186,847)
Unearned Revenue	(4,542)	(4,542)	(4,542)	(3,242)	(4,542)	(4,542)	(4,542)	(4,542)	(4,542)	-	-
Due to 3rd Party Payors	693,247	693,247	693,247	693,247	693,247	693,247	693,247	693,247	693,247	-	-
Due to Specific Purpose Funds	-	-	-	-	-	-	-	-	-	-	-
Other Deferred Credits - Pension & Leases	12,599,823	12,597,753	1,942,292	12,595,684	1,873,995	12,593,614	1,873,995	12,591,545	1,873,995	(2,070)	10,717,550
Total Current Liabilities	**29,225,475**	**28,874,885**	**21,800,138**	**28,038,593**	**23,645,757**	**27,937,705**	**24,083,068**	**28,063,360**	**24,507,707**	**125,655**	**3,555,652**
Long Term Liabilities											
Long Term Debt	36,301,355	36,202,581	37,511,965	36,103,552	33,455,530	36,004,290	33,341,647	34,797,823	32,730,530	(1,206,467)	2,067,293
Bond Premium	165,618	162,481	200,126	159,344	196,989	156,207	193,852	153,070	190,715	(3,137)	(37,645)
Accreted Interest	16,991,065	17,084,422	16,635,302	17,177,780	17,314,009	17,271,137	17,409,141	16,560,403	17,504,273	(710,734)	(943,869)
Other Non-Current Liability - Pension	32,946,355	32,946,355	47,257,663	32,946,355	47,257,663	32,946,355	47,257,663	32,946,355	47,257,663	-	(14,311,308)
Total Long Term Liabilities	**86,404,394**	**86,395,839**	**101,605,056**	**86,387,031**	**98,224,191**	**86,377,989**	**98,202,303**	**84,457,651**	**97,683,181**	**(1,920,338)**	**(13,225,529)**
Suspense Liabilities	-	-	-	-		-	-	-	-	-	-
Uncategorized Liabilities (grants)	31,506	94,166	44,693	147,821	36,944	147,821	36,944	127,821	68,644	(20,000)	59,177
Total Liabilities	**115,661,375**	**115,364,890**	**123,449,887**	**114,573,445**	**121,906,892**	**114,463,515**	**122,322,315**	**112,648,832**	**122,259,532**	**(1,814,683)**	**(9,610,700)**
Fund Balance											
Fund Balance	31,992,031	36,994,377	31,992,032	36,994,377	23,268,194	36,994,377	23,268,194	36,994,377	23,786,064	-	13,208,312
Temporarily Restricted	1,467,786	1,467,914	1,466,417	1,468,042	2,610,472	1,468,166	2,610,594	1,468,293	2,610,720	128	(1,142,426)
Net Income	5,002,346	2,040,662	2,679,513	2,287,121	(491,045)	2,306,242	864,526	1,154,206	875,889	(1,152,036)	278,317
Total Fund Balance	**38,462,163**	**40,502,952**	**36,137,962**	**40,749,539**	**25,387,621**	**40,768,784**	**26,743,313**	**39,616,876**	**27,272,672**	**(1,151,908)**	**12,344,204**
Liabilities + Fund Balance	**154,123,537**	**155,867,842**	**159,587,849**	**155,322,985**	**147,294,513**	**155,232,299**	**149,065,629**	**152,265,708**	**149,532,205**	**(2,966,591)**	**2,733,503**
(Decline)/Gain		1,744,305	(1,044,798)	(544,858)	(415,868)	(90,686)	1,771,115	(2,966,591)	466,576	(2,875,905)	(3,433,167)

Northern Inyo Healthcare District
Long-Term Debt Service Coverage Ratio
FYE 2025

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

Long-Term Debt Service Coverage Ratio Calculation

Numerator:	HOSPITAL FUND ONLY
Excess of revenues over expense	$ 1,154,206
+ Depreciation Expense	1,732,168
+ Interest Expense	797,356
Less GO Property Tax revenue	689,268
Less GO Interest Expense	168,333
"Income available for debt service"	**$ 2,826,128**
Denominator:	
Maximum "Annual Debt Service"	
2021A Revenue Bonds	$ 112,700
2021B Revenue Bonds	894,160
2009 GO Bonds (Fully Accreted Value)	
2016 GO Bonds	
Financed purchases and other loans	1,546,875
Total **Maximum Annual Debt Service**	**$ 2,553,735**
	851,245
Ratio: (numerator / denominator)	**3.32**
Required Debt Service Coverage Ratio:	1.10
In Compliance? (Y/N)	**Yes**

Unrestricted Funds and Days Cash on Hand

	HOSPITAL FUND ONLY
Cash and Investments-current	$ 23,785,613
Cash and Investments-non current	999,950
Sub-total	24,785,564
Less - Restricted:	
PRF and grants (Unearned Revenue)	-
Held with bond fiscal agent	(353,592)
Building and Nursing Fund	(1,468,293)
Total Unrestricted Funds	**$ 22,963,678**
Total Operating Expenses	$ 38,200,022
Less Depreciation	1,732,168
Net Expenses	36,467,854
Average Daily Operating Expense	$ 296,487
Days Cash on Hand	**77**

Northern Inyo Healthcare District
Statement of Cash Flows
Fiscal Year 2025

CASH FLOWS FROM OPERATING ACTIVITIES	
Receipts from and on Behalf of Patients	37,845,038
Payments to Suppliers and Contractors	(16,391,989)
Payments to and on Behalf of Employees	(21,880,860)
Other Receipts and Payments, Net	369,470
Net Cash Provided (Used) by Operating Activities	(58,341)
CASH FLOWS FROM NONCAPITAL FINANCING ACTIVITIES	
Noncapital Contributions and Grants	31,125
Property Taxes Received	-
Other	1,041,630
Net Cash Provided (Used) by Noncapital Financing Activities	1,072,755
CASH FLOWS FROM CAPITAL AND CAPITAL RELATED FINANCING ACTIVITIES	
Principal Payments on Long-Term Debt	(1,106,909)
Proceeds from the Issuance of Refunding Revenue Bonds	-
Payment to Defease Revenue Bonds	-
Interest Paid	(797,356)
Purchase and Construction of Capital Assets	(208,905)
Payments on Lease Liability	10,155
Payments on Subscription Liability	(472,737)
Property Taxes Received	-
Net Cash Provided (Used) by Capital and Capital Related Financing Activities	(2,575,752)
CASH FLOWS FROM INVESTING ACTIVITIES	
Investment Income	183,436
Rental Income	26,650
Net Cash Provided (Used) by Investing Activities	210,086
NET CHANGE IN CASH AND CASH EQUIVALENTS	(1,351,251)
Cash and Cash Equivalents - Beginning of Year	25,136,864
CASH AND CASH EQUIVALENTS - END OF YEAR	23,785,613

Key Financial Performance Indicators	Industry Benchmark	Oct-22	Oct-23	FYE 2024 Average	Jul-24	Aug-24	Sep-24	Oct-24	Variance to Prior Month	Variance to FYE 2024 Average	Variance to Prior Year Month
Volume											
Admits	41	60	75	71	75	75	83	68	(15)	(3)	(7)
Deliveries	n/a	17	19	17	18	19	17	21	4	4	2
Adjusted Patient Days	n/a	866	1,272	1,035	1,164	1,362	1,312	1,335	23	300	63
Total Surgeries	153	132	173	146	134	168	133	176	43	30	3
ER Visits	659	830	899	840	903	905	947	859	(88)	19	(40)
RHC and Clinic Visits	n/a	4,397	4,619	4,607	4,252	4,921	4,808	4,907	99	300	288
Diagnostic Imaging Services	n/a	2,035	2,182	2,069	2,274	2,221	2,194	2,344	150	275	162
Rehab Services	n/a	669	521	662	719	808	887	1,142	255	480	621
AR & Income											
Gross AR (Cerner only)	n/a	$ 51,620,313	$ 53,295,391	$ 52,823,707	$ 56,859,164	$ 57,648,281	$ 58,109,192	$ 51,585,302	$ (6,523,890)	$ (1,238,406)	$ (1,710,090)
AR > 90 Days	$ 7,688,895.45	$ 23,532,351	$ 23,888,672	$ 24,488,432	$ 24,988,857	$ 32,958,845	$ 34,041,771	$ 22,371,529	$ (11,670,242)	$ (2,116,903)	$ (1,517,143)
AR % > 90 Days	15%	45.6%	44.50%	46.7%	44.5%	57.2%	58.6%	43.4%	-15.2%	-3.3%	-1.1%
AR Days	43.00		86.92	85.52	89.02	92.17	85.85	73.87	(11.98)	(11.64)	(13.05)
Net AR	n/a	$ 19,941,094	$ 18,412,645	$ 16,938,200	$ 21,642,722	$ 24,802,720	$ 22,664,310	$ 20,692,706	$ (1,971,604)	$ 3,754,506	$ 2,280,061
Net AR % of Gross	n/a	38.6%	34.5%	31.9%	38.1%	43.0%	39.0%	40.1%	1.1%	8.2%	5.6%
Gross Patient Revenue/Calendar Day	n/a	$ 531,085	$ 634,410	$ 619,457	$ 617,364	$ 683,348	$ 702,988	$ 698,314	$ (4,674)	$ 78,857	$ 63,904
Net Patient Revenue/Calendar Day	n/a	$ 245,217	$ 291,760	$ 292,759	$ 337,843	$ 315,574	$ 285,805	$ 290,232	$ 4,428	$ (2,526)	$ (1,528)
Net Patient Revenue/APD	n/a	$ 8,778	$ 7,111	$ 8,757	$ 8,998	$ 7,183	$ 6,537	$ 6,740	$ 203	$ (2,018)	$ (371)
Wages				353,702.78					-	-	(184,141.35)
Wages	n/a	$ 2,814,461	$ 3,249,591	$ 3,285,431	$ 3,359,076	$ 3,241,107	$ 3,372,236	$ 3,622,038	$ 249,802	$ 336,608	$ 372,447
Employed paid FTEs	n/a	380.32	352.89	353.69	366.38	366.24	391.40	369.11	(22.29)	15.43	16.23
Employed Average Hourly Rate	$ 38.00	$ 41.78	$ 51.98	$ 53.32	$ 51.76	$ 49.96	$ 50.26	$ 55.40	$ 5.14	$ 2.08	$ 3.41
Benefits	n/a	$ 2,577,241	$ 1,955,349	$ 1,640,216	$ 1,509,407	$ 1,478,605	$ 1,634,036	$ 1,896,266	$ 262,229	$ 256,049	$ (59,083)
Benefits % of Wages	30%	91.6%	60.2%	50.3%	44.9%	45.6%	48.5%	52.4%	3.9%	2.0%	-7.8%
Contract Labor	n/a	$ 1,081,444	$ 371,183	$ 518,351	$ 507,387	$ 829,876	$ (112,642)	$ 543,829	$ 656,471	$ 25,478	$ 172,646
Contract Labor Paid FTEs	n/a	50.02	22.14	23.49	29.45	32.19	24.84	21.32	(3.52)	(2.17)	(0.82)
Total Paid FTEs	n/a	430.34	375.03	377.18	395.83	398.43	416.25	390.44	(25.81)	13.26	15.41
Contract Labor Average Hourly Rate	$ 81.04	$ 122.05	$ 94.64	$ 126.74	$ 97.26	$ 145.55	$ 118.60	$ 143.96	$ 25.36	$ 17.23	$ 49.32
Total Salaries, Wages, & Benefits	n/a	$ 6,473,146	$ 5,576,123	$ 5,443,998	$ 5,375,870	$ 5,549,587	$ 4,893,631	$ 6,062,133	$ 1,168,502	$ 618,135	$ 486,010
SWB% of NR	50%	85.2%	61.7%	63.2%	51.3%	56.7%	57.1%	67.4%	10.3%	4.2%	5.7%
SWB/APD	2,607	$ 7,475	$ 4,384	$ 5,346	$ 4,618	$ 4,075	$ 3,731	$ 4,541	$ 810	$ (805)	$ 157
SWB % of total expenses	50%	71.3%	59.2%	56.7%	59.6%	56.3%	55.1%	58.0%	2.9%	1.3%	-1.1%

					FYE 2024 Average	Jul-24	Aug-24	Sep-24	Oct-24	Variance to Prior Month	Variance to FYE 2024 Average	Variance to Prior Year Month
Physician Spend												
Physician Expenses	n/a		$ 1,606,452	$ 1,432,267	$ 1,507,510	$ 1,553,004	$ 1,399,376	$ 1,621,308	$ 1,699,955	$ 78,647	$ 192,445	$ 267,688
Physician expenses/APD	n/a		$ 1,855	$ 1,126	$ 1,478	$ 1,334	$ 1,028	$ 1,236	$ 1,273	$ 37	$ (205)	$ 147
										$ -	$ -	$ -
Supplies												
Supply Expenses	n/a		$ 502,912	$ 974,247	$ 776,504	$ 387,610	$ 904,005	$ 353,623	$ 496,964	$ 143,341	$ (279,540)	$ (477,283)
Supply expenses/APD			$ 581	$ 766	$ 780	$ 333	$ 664	$ 270	$ 372	$ 103	$ (408)	$ (394)
Other Expenses												
Other Expenses	n/a		$ 497,936	$ 1,443,075	$ 1,891,477	$ 1,696,938	$ 2,007,341	$ 2,008,508	$ 2,187,768	$ 179,260	$ 296,291	$ 744,693
Other Expenses/APD	n/a		$ 575	$ 1,134	$ 1,878	$ 1,458	$ 1,474	$ 1,531	$ 1,639	$ 108	$ (239)	$ 504
Margin												
Net Income	n/a		$ (2,499,292)	$ 11,363	$ 383,763	$ 2,041,456	$ 248,064	$ 19,121	$ (1,152,036)	$ (1,171,157)	$ (1,535,799)	$ (1,163,399)
Net Profit Margin	n/a		-32.9%	0.1%	3.0%	19.5%	2.5%	0.2%	-12.8%	-13.0%	-15.8%	-12.9%
Operating Income	n/a		$ (2,674,919)	$ (381,153)	$ (686,403)	$ 1,459,716	$ (77,526)	$ (302,930)	$ (1,449,616)	$ (1,146,686)	$ (763,213)	$ (1,068,463)
Operating Margin		2.9%	-35.2%	-4.2%	-10.9%	13.9%	-0.8%	-3.1%	-16.1%	-13.0%	-5.2%	-11.9%
EBITDA	n/a		$ (2,861,610)	$ 335,928	$ 841,932	$ 2,482,790	$ 689,172	$ 459,316	$ (742,505)	$ (1,201,821)	$ (1,584,436)	$ (1,078,432)
EBITDA Margin		12.7%	-37.6%	3.7%	8.7%	23.7%	7.0%	4.7%	-8.3%	-12.9%	-17.0%	-12.0%
Debt Service Coverage Ratio		3.70		3.4	3.3	0.8	7.3	5.5	3.3	(2.2)	0.0	(0.1)
Cash												
Avg Daily Disbursements (excl. IGT)	n/a		$ 316,166	$ 304,199	$ 355,328	$ 367,107	$ 398,922	$ 315,796	$ 399,234	$ 83,439	$ 43,906	$ 95,035
Average Daily Cash Collections (excl. IGT)	n/a		$ 363,506	$ 295,510	$ 299,110	$ 349,783	$ 262,199	$ 302,042	$ 359,292	$ 57,251	$ 60,182	$ 63,782
Average Daily Net Cash			$ 47,340	$ (8,688)	$ (56,218)	$ (17,324)	$ (136,723)	$ (13,754)	$ (39,942)	$ (26,188)	$ 16,276	$ (31,254)
Unrestricted Funds	n/a		$ 26,063,196	$ 26,372,783	$ 23,536,438	$ 27,015,779	$ 24,366,780	$ 24,708,310	$ 22,963,678	$ (1,744,632)	$ (572,760)	$ (3,409,105)
Change of cash per balance sheet	n/a		$ 1,467,245	$ (5,820,632)	$ (541,459)	$ 1,876,964	$ (2,648,999)	$ 341,530	$ (1,744,632)	$ (2,086,162)	$ (1,203,174)	$ 4,076,000
Days Cash on Hand (assume no more cash is collected)		196	89	87	72	98	84	58	77	19	5	(10)
Estimated Days Until Depleted			-	444	406	506	413	440	442	2	37	(2)
Years Until Cash Depletion			-	1.22	1.11	1.39	1.13	1.21	1.21	0.01	0.10	(0.00)

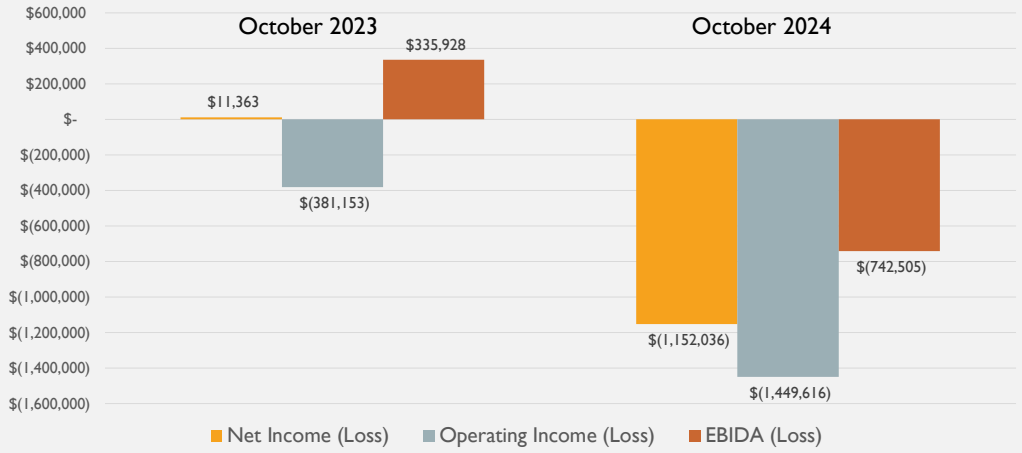
NORTHERN INYO HEALTHCARE DISTRICT
One Team. One Goal. Your Health.

NIHD FINANCIAL UPDATE

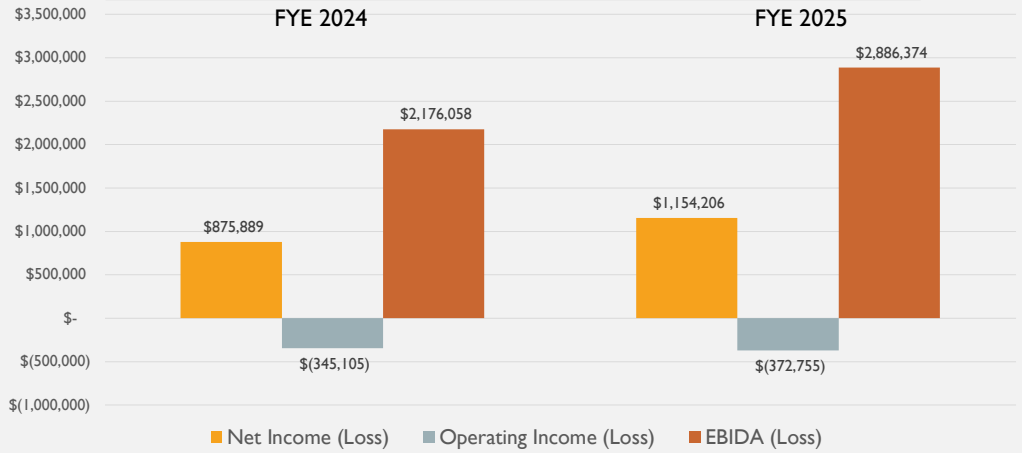
October 2024

INCOME

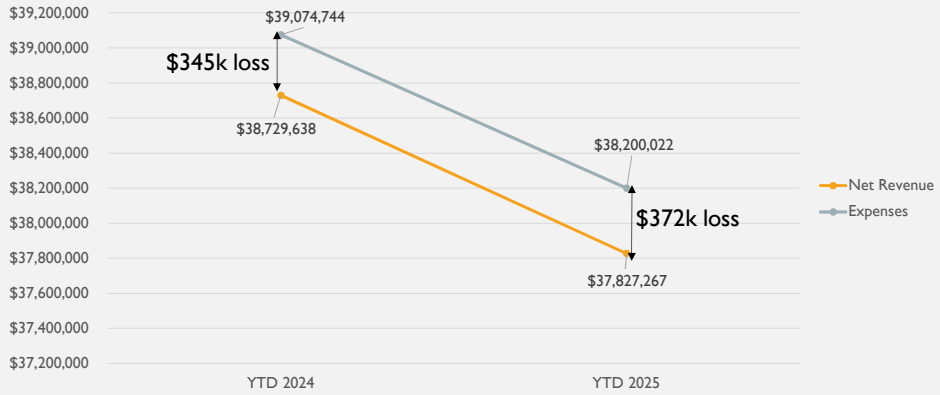
OCTOBER 2024 FINANCIAL PERFORMANCE



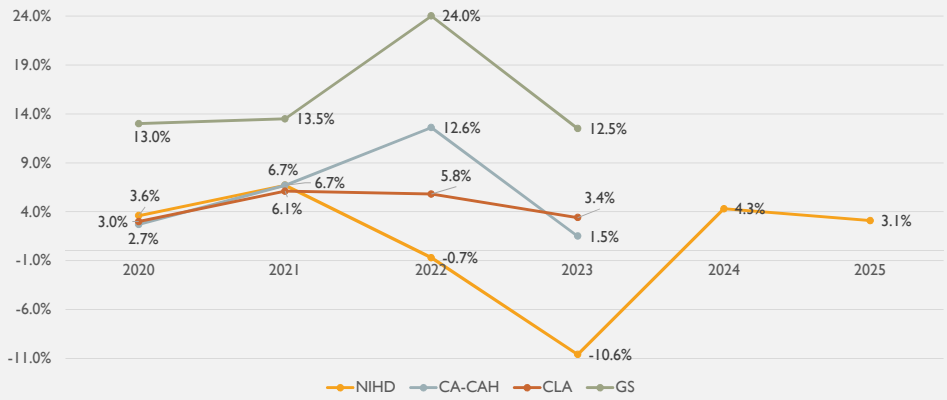
FYE 2025 FINANCIAL PERFORMANCE



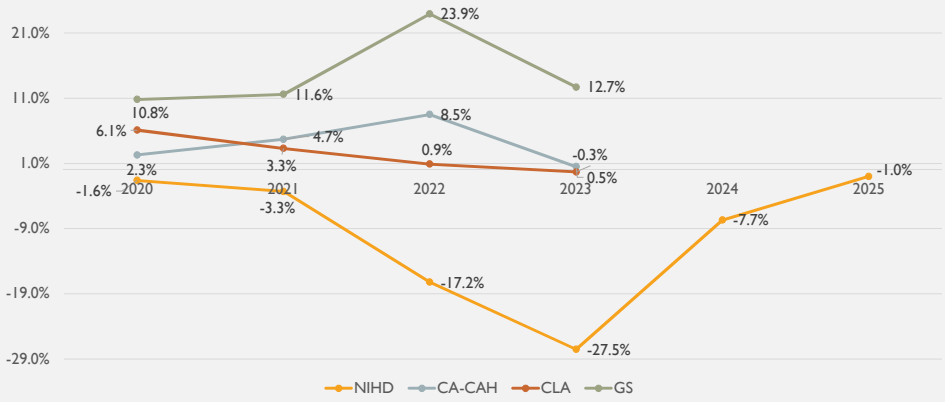
YTD OPERATING INCOME (LOSS) PERFORMANCE



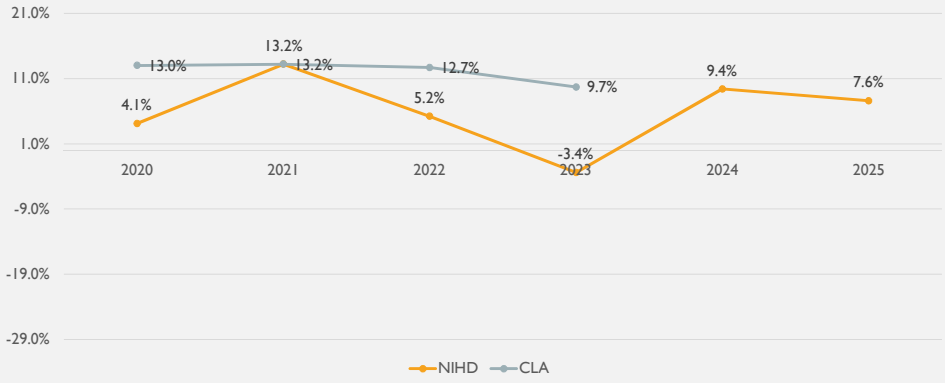
NET PROFIT MARGIN



OPERATING MARGIN

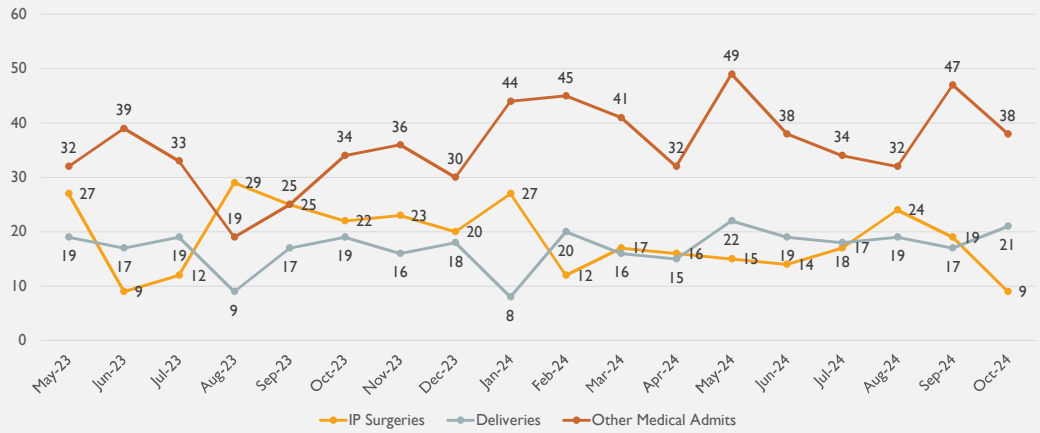


EBIDA MARGIN

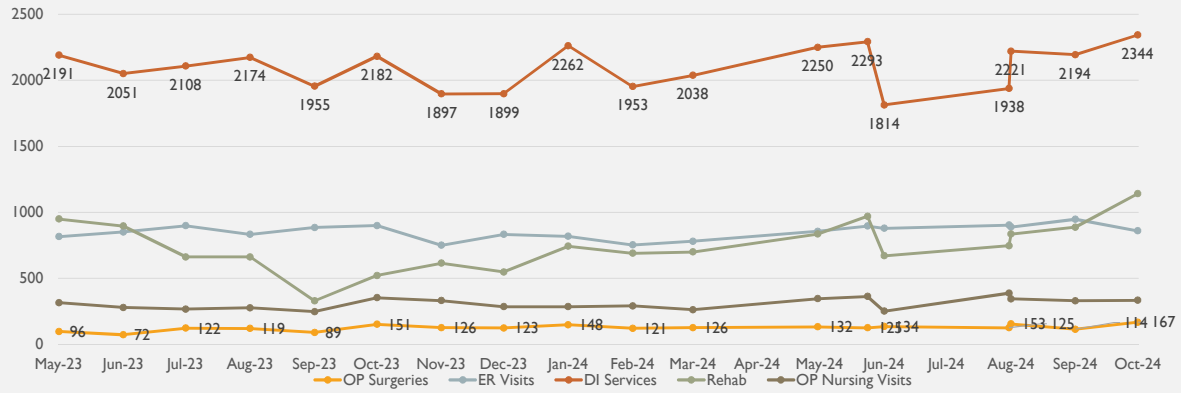


VOLUMES

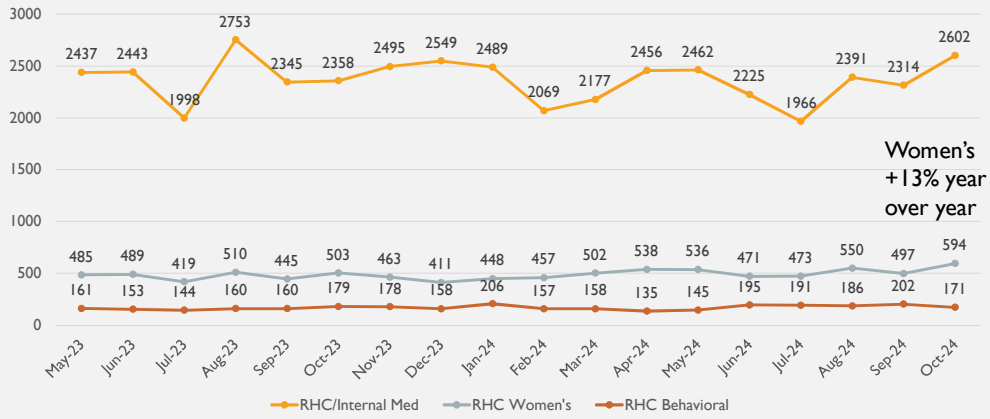
INPATIENT VOLUME PERFORMANCE



OUTPATIENT VOLUME PERFORMANCE

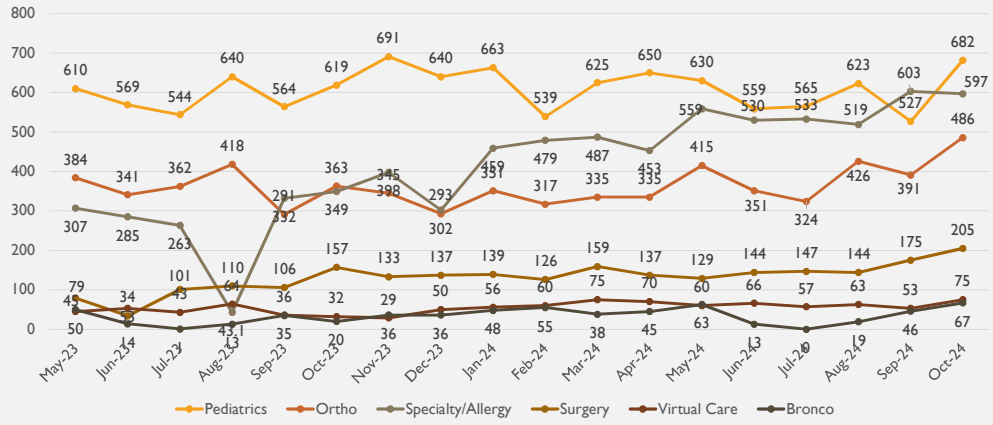


RHC VOLUME PERFORMANCE



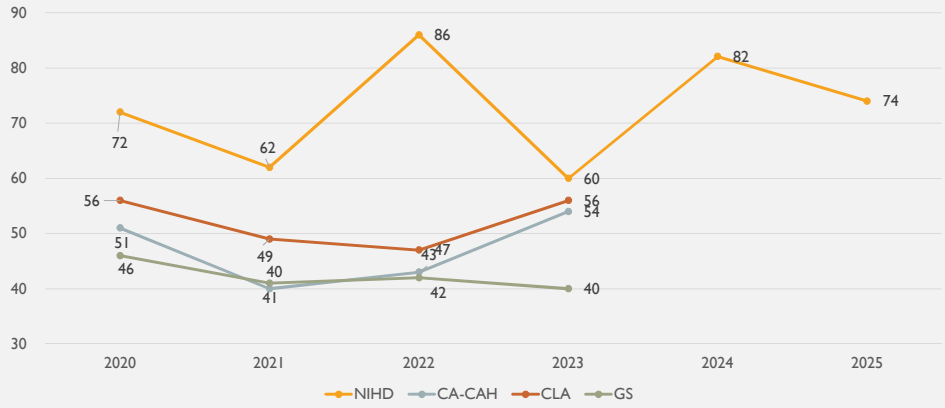
Women's +13% year over year

CLINIC VOLUME PERFORMANCE

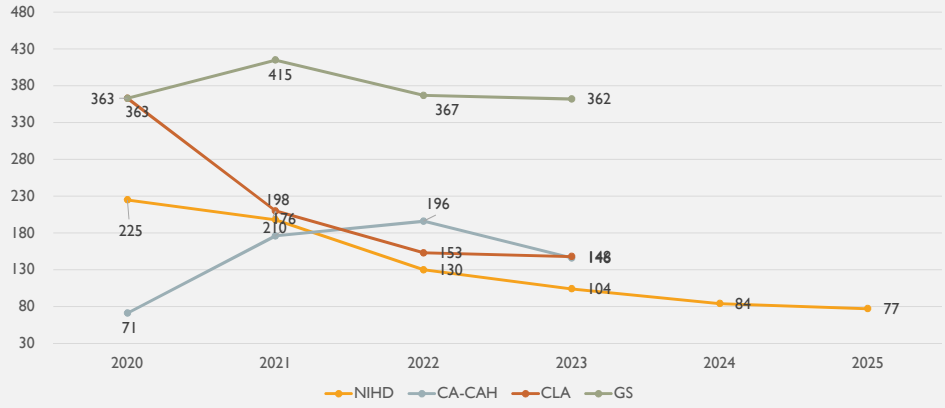


KEY PERFORMANCE INDICATORS

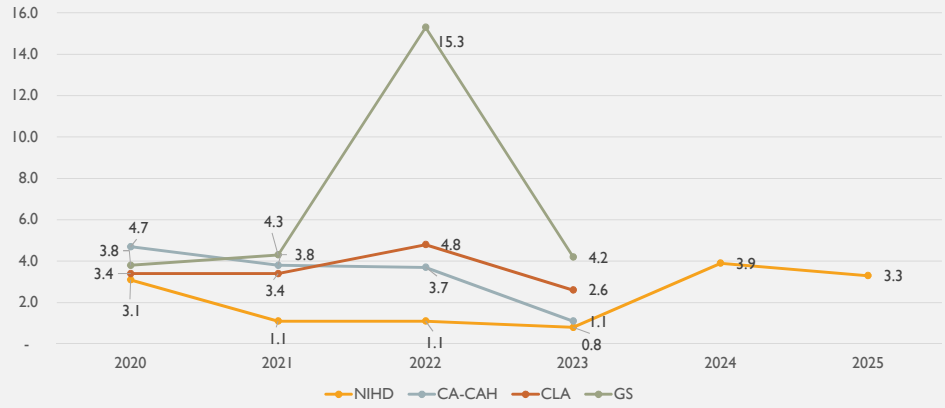
AR DAYS



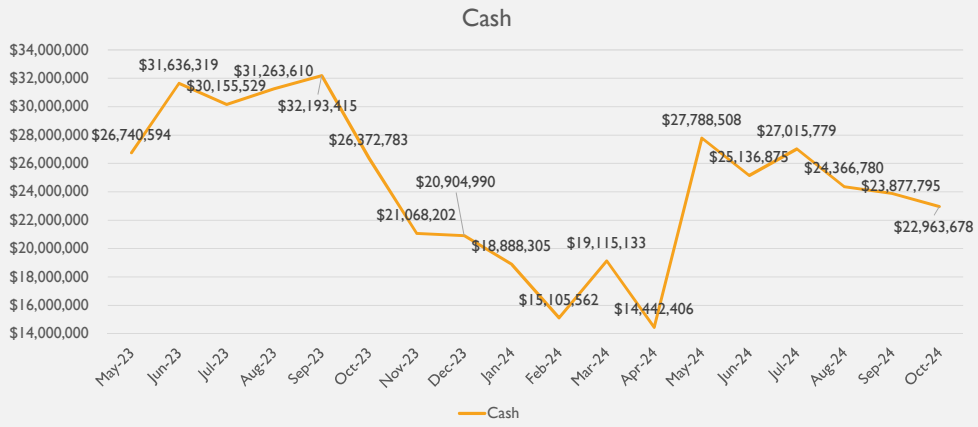
DAYS CASH ON HAND



DEBT SERVICE COVERAGE RATIO



UNRESTRICTED FUNDS



WAGE COSTS

	October 2022	October 2023	October 2024
Total Paid FTEs	430	375	390
Salaries, Wages, Benefits (SWB) Expense (incl. contract labor)	$6,473,146	$5,576,123	$6,062,133
SWB % of total expenses (including contract labor)	71.3%	59.2%	58%
Employed Average Hourly Rate	$41.78	$51.98	$55.40
Benefits % of Wages	91.6%	60.2%	52.4%

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

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

TO: NIHD Board of Directors
FROM: Sierra Bourne, MD, Chief of Medical Staff
DATE: December 3, 2024
RE: Medical Executive Committee Report

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

A. Medical Staff Appointments 2024-2025 (*action item*)

1. John B. Reid III, MD (*orthopedic surgery*) – Active Staff
2. Margo Lella, FNP (*family nurse practitioner*) – Advanced Practice Provider Staff
3. Megann Young, MD (*emergency medicine*) – Courtesy Staff

B. Medical Staff Appointments 2024-2025 – Proxy Credentialing (*action item*)

As per the approved credentialing and privileging agreements, and as outlined by 42CFR 482.22, the Medical Staff has chosen to recommend the following practitioners for Telemedicine privileges relying upon the Distant-Site entity's credentialing and privileging decisions.

1. LaTangela Smith, DO (*neurology*) – Telemedicine Staff (Sevaro Neurology Group)

C. Medical Staff Reappointments 2025-2026 (*action item*)

Last Name	First Name	Creds	Specialty	Category
Akalin	Murat	MD	Psychiatry	Consulting
Akinapelli	Abhilash	MD	Cardiovascular Disease	Telehealth
Amsalem	David	MD	Emergency Medicine	Active
Arbogast	Steven	DO	Neurology	Telehealth
Arndal	Lara	MD	Obstetrics & Gynecology	Active
Bakshi	Nandini	MD	Neurology	Telehealth
Boo	Thomas	MD	Family Medicine	Active
Bourne	Sierra	MD	Emergency Medicine	Active
Chen	Michael	MD	Neurology	Telehealth
Cromer-Tyler	Robbin	MD	Surgery (General Surgery)	Active
Davis	Clayton	DO	Urology	Active
Dennis	Darren	PA-C	Physician Assistant	APP
Do-Nguyen	Amy	MD	Emergency Medicine	Active
Drew	Tracy	FNP	Nurse Practitioner, Family	APP
Gasior	Anne	MD	Family Medicine	Active
Goshgarian	Anne	MD	Emergency Medicine	Active
Haun	Elizabeth	FNP	Nurse Practitioner, Family	APP
Jeppsen	Samantha	MD	Emergency Medicine	Active
Joos	Jennifer	PA-C	Physician Assistant	APP
Khieu	Mike	MD	Cardiovascular Disease	Telehealth

Kip	Katrinka	MD	Pediatric Cardiology	Telehealth
Kirkham	Daniel	MD	Diagnostic Radiology	Courtesy - FPPE
Kirkham-Garcia	Cali	MD	Emergency Medicine	Active
Kobner	Scott	MD	Emergency Medicine	Active
Landrito	Earl	MD	Diagnostic Radiology	Courtesy
Leja	Catherine	MD	Family Medicine	Active
Lopez	Michael	MD	Anesthesiology	Courtesy - FPPE
Loy	Bo	MD	Orthopaedic Surgery	Active
Loy	Tamara	PNP	Nurse Practitioner, Pediatrics	APP
Ludwick	Joseph	MD	Pediatric Cardiology	Telehealth
Mandal	Atashi	MD	Internal Medicine	Active
McEvoy	Colleen	PNP	Nurse Practitioner, Pediatrics	APP
Narula	Rajiv	MD	Neurology	Telehealth
Nelson	Bradley	MD	Cardiovascular Disease	Telehealth
Olito	Atalanta	DO	Anesthesiology	Courtesy - FPPE
Olson	Cheryl	MD	Surgery (General Surgery)	Courtesy
Prakash	Neal	MD	Neurology	Telehealth
Radulescu	Vlad	MD	Cardiovascular Disease	Telehealth
Ramirez	Maria	MD	Internal Medicine	Courtesy
Rasoumoff	Theodore	MD	Anesthesiology	Active
Reddy	Aravind	MD	Neurology	Telehealth
Robinson	Allison	MD	Surgery (General Surgery)	Active
Robinson	Mark	MD	Orthopaedic Surgery	Active
Saba	Carolyn	MD	Anesthesiology	Courtesy
Saha	Sam	MD	Neurology	Telehealth
Schunk	Stefan	MD	Internal Medicine	Active
Shah	Ruchir	MD	Neurology	Telehealth
Sullivan	Laura	MD	Cardiovascular Disease	Telehealth
Sharma	Uttama	MD	Family Medicine	Active
Tang	Andrew	MD	Internal Medicine	Courtesy
To	Thomas	MD	Cardiovascular Disease	Telehealth
Tur	James	MD	Internal Medicine, Psychiatry	Active
Wiedenbeck	Troy	MD	Cardiovascular Disease	Telehealth
Wiles	Connor	MD	Surgery (General Surgery)	Active
Xu	Cathy	MD	Pediatrics	Courtesy - FPPE
Yates	Karvier	MD	Anesthesiology	Courtesy - FPPE

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

CALL TO ORDER	Northern Inyo Healthcare District (NIHD) Board Chair Melissa Best-Baker called the meeting to order at 5:00 pm.
PRESENT	Jean Turner, Vice Chair Ted Gardner, Secretary David McCoy Barrett, Treasurer Mary Mae Kilpatrick, Member at Large Stephen DelRossi, Chief Executive Officer Allison Partridge, Chief Operations Officer / Chief Nursing Officer Alison Murray, Chief Human Resources Officer, Chief Business Development Officer Andrea Mossman, Chief Financial Officer Sierra Bourne, MD, Chief of Staff
ABSENT	Melissa Best-Baker, Chair – participated as a member of the public Adam Hawkins, DO, Chief Medical Officer
PUBLIC COMMENT ON CLOSED SESSION ITEMS	No public comments were made on closed-session items.
ADJOURNMENT TO CLOSED SESSION	Adjournment to closed session at 05:01 pm.
RETURN TO OPEN SESSION	Called back to order at 05:24 pm Vice-chair Turner stated there were no reportable actions from the closed session.
PUBLIC COMMENT	Vice-chair Turner reported that at this time, audience members may speak on any items not on the agenda but within the Board's jurisdiction. Phyllis Matola commented on Dr. Thomas Reid's letter in the paper. She expressed concern and a desire to offer ophthalmology services locally. Susan Branston commented and wrote a letter to the board expressing a desire for the hospital to hire an ophthalmologist. Eva Fulgilson mimicked a desire to research and hire an ophthalmologist.
NEW BUSINESS	
CHIEF EXECUTIVE OFFICER REPORT	Vice-chair Turner called attention to new business. 1. CEO addendum discussion ensued. Motion to approve the CEO addendum: Barrett Second: Kilpatrick Passed: 4-0

2. Compliance report discussion ensued. Turner called attention to the Compliance Business Ethics Committee and the desire to revisit this committee in January 2025.

Motion to accept the compliance report: Kilpatrick
Second: Barrett
Passed: 4-0

3. Compliance Regulatory Changes and Hot Topics discussion ensued.

CHIEF EXECUTIVE OFFICER REPORT

Vice-chair Turner called attention to the CEO.

1. Transfer of ownership RCTMD Inc. from Cromer-Tyler to Loy discussion ensued.
2. Cooperation of the Foundation, DelRossi stated that Alison Murray is the Executive sponsor for the Foundation, Ashley Reed is the Board Clerk, and Andrea Mossman will be doing the finances. Turner asked whether the Foundation would be sending the yearly support letter. Murray expressed that would be sent before the end of the year.
3. Orthopedic Physician Jeb Reid started on Nov 4, 2024, and discussion ensued.
4. The Inyo Associates Dinner was attended by DelRossi and Murray, they were able to give updates about the hospital at the meeting.
5. Eastern Sierra Cancer Alliance Walk was on Oct 19, 2024. NIHD signed a contract with the cancer alliance giving them the same discounts offered to Medicaid in support and help with their mission.

CHIEF FINANCIAL OFFICER REPORT

Vice Chair Turner called attention to the CFO report.

1. CFO Departmental Report discussion ensued.
2. NIHD Financial Update Report discussion ensued.

Motion to approve Financial reports: Gardner
Second: Barrett
Passed: 4-0

CHIEF MEDICAL OFFICER REPORT

No report out

CHRO / CBDO REPORT

Vice Chair called attention to the CHRO/CBDO Report

1. Strategic plan discussion ensued. The plan is set to be approved at the December 2024 meeting.
2. Departmental report discussion ensued. Kilpatrick asked about the grant writer, and Murray expressed the contract is still in the works.

CHIEF OF STAFF REPORT

Vice Chair Turner called attention to the chief of staff report

1. Perinatal/Pediatrics Chair Dr. Ricci. She expressed gratitude for the 2 full-time RNs working in pediatrics, the new heating/cooling, and flooring. She explained that she helps with the QIP measures, the Bronco Clinic, and the community on the First 5 board. She explained

obstetrics and pediatrics are helping with the increase in Mammoth and Ridgecrest baby deliveries here in Bishop. We are actively recruiting for Pediatrics.

Sierra Bourne:

1. MEC – IV fluid conservation measures noted that NIHD has been working
2. Artera communication platform, is a patient reminder system and is going well.
3. Medical staff are interested in potential AI assistance.
4. Some of the medical staff are concerned with Inyo County's influenza vaccination requirement and have written a letter to Inyo County's Dr. Richardson.

CONSENT AGENDA

Vice-chair Turner called attention to the consent agenda. No items were removed from the consent agenda for further discussion.

Motion to approve the consent agenda: Gardner
Second: Kilpatrick
Passed: 4-0

GENERAL INFORMATION FROM BOARD MEMBERS

Turner noted the ACHD conference will be in San Diego in 2025.

ADJOURNMENT

Adjournment at 7:19 pm.

_____
Jean Turner
Northern Inyo Healthcare District
Chair

Attest: _____
David Lent
Northern Inyo Healthcare District Chair
Secretary

NORTHERN INYO HEALTHCARE DISTRICT
NON-CLINICAL POLICY AND PROCEDURE

Title: Employee Health Access of Patient Personal Medical Record		
Owner: Manager Employee Health & Infection Control	Department: Infection Prevention	
Scope: Employee Health		
Date Last Modified: 12/04/2024	Last Review Date: No Review Date	Version: 3
Final Approval by: NIHD Board of Directors	Original Approval Date: 09/20/2018	

PURPOSE:
To ensure that Northern Inyo Healthcare District is compliant with state and federal laws regarding separation of Employee Health records and patient medical records.

POLICY:
Workforce in the Employee Health role shall not access personal medical records of patients or workforce. Employee Health will maintain an independent database for employee health records.

DEFINTION:

Personal medical record: Individually identifiable health information provided to, or obtained by, NIHD in its role as a health care provider, including, but not limited to, documentation of personal healthcare, routine preventive care, acute illness care, and care of chronic disease.

Employee health record: Health information provided to, or obtained by, NIHD in its role as an employer.

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

PROCEDURE:
1. Results for tests ordered by the Employee Health Department shall be provided to the Employee Health Department.

2. Workforce that desire to provide specific documents from their medical record to the Employee Health Department shall complete and sign a Release of Information Authorization and present it to the Health Information Management (HIM)/Medical Records department. HIM shall provide the documents according to policy.

REFERENCES:

1. California Hospital Association. (2017). Employee Health information, Chapter 9 Compliance Privacy Health Information Manual 8th ed. Sacramento CA: California Hospital Association. https://calhospital.org/wp-content/uploads/2012/02/privacy_2017web.pdf
2. Occupational Safety and Health Administration (OSHA). Clinicians. Retrieved 9/3/24 https://www.osha.gov/clinicians
3. Occupational Safety and Health Administration (2020 revised). Access to Medical and Exposure Records. https://www.osha.gov/sites/default/files/publications/osha3110.pdf
4. California Hospital Association Record and Data Retention (2018). https://calhospital.org/wp-content/uploads/2012/01/recordretention2018_web_preview.pdf

RECORD RETENTION AND DESTRUCTION:

Employee Health Records will be retained for 30 years

CROSS REFERENCED POLICIES AND PROCEDURES:

1. Scope of Service Employee Health
2. Responsibility and Process for Releasing Personal Health Information

Supersedes: v.2 Employee Health Access of Patient Personal Medical Record

NORTHERN INYO HEALTHCARE DISTRICT
COMMITTEE CHARTER

Title: Compliance and Business Ethics Committee		
Owner: Compliance Officer	Department: Compliance	
Scope: Committee Membership		
Date Last Modified: 11/01/2024	Last Review Date: No Review Date	Version: 2
Final Approval by:	Original Approval Date:	

COMMITTEE PURPOSE

Northern Inyo Healthcare District (hereinafter "NIHD" or "the District") is a governmental~~,~~ district healthcare organization and operates in a complex, dynamic, and heavily regulated environment. NIHD's business involves an environment that is highly regulated at both the federal and state level. To assist the District's executive management in its responsibilities relating to NIHD's operational compliance with applicable legal requirements and sound ethical standards, the District's Board of Directors has established a Compliance and Business Ethics Committee, which will provide oversight and guidance for the implementation of the Compliance Program, and direction to the Compliance O~~o~~fficer. The Compliance and Business Ethics Committee shall receive a report from the Compliance Officer quarterly.

Mission

The mission of Northern Inyo Healthcare District's Compliance and Business Ethics Committee is to provide oversight and guidance of the Compliance Program to ~~and~~ create a culture that encourages ethical conduct and a commitment to compliance with the law in order to improve our communities, one life at a time.

COMMITTEE MEMBERSHIP

The Compliance and Business Ethics Committee (CBEC) consists of multiple representatives. The members of the CBEC include those individuals designated below and other members as requested, including representatives of senior management, chosen by the District's Chief Executive Officer in consultation with the Compliance Officer:

- Compliance Officer
- Chief Financial Officer
- Information Security Representative (Director of Information Technology)
- Medical Staff Representative
- As appropriate, member of the Board of Directors, Health Information Management Director, Chief Nursing O~~o~~fficer, or department designee from Emergency, Laboratory, Pharmacy, Imaging, Purchasing, and other areas

The Compliance Officer serves as the chairperson of the Compliance and Business Ethics Committee. The CBEC serves in an advisory role and has authority to adopt or implement policies following Board approval. The Compliance Officer will consult with members of the CBEC on a regular basis and may call meetings of all or some members of the CBEC.

FREQUENCY OF MEETINGS

The Compliance and Business Ethics Committee shall meet no less than quarterly, approximately 3 weeks before a Board of Directors' meeting. A majority of the Committee constitutes a quorum for the transaction of business. The Committee shall take action by the affirmative vote of a majority of the Committee members present at a duly held meeting.

~~COMMITTEE GOALS~~

COMMITTEE RESPONSIBILITIES

The Compliance and Business Ethics Committee will undertake the following responsibilities and duties and any other activities related to the District's Compliance Program.

Compliance and Ethics Standards and Policies

- Oversee the development or modification, issuance, distribution, and review of the Code of Business Ethics, and Conduct, and appropriate Compliance policies.
- Oversee the development and implementation of employee communication and training regarding the Code of Business Ethics and Conduct, policies, ~~and~~ business ethics, and compliance issues.

Employee and Contractor Training

- Oversee the development and implementation of appropriate and adequate training regarding the Code of Business Ethics and Conduct, business ethics, policies, and Compliance Program
- Oversee the development and implementation of employee communication regarding the Compliance Program ~~and issues~~.
- Oversee administration of a program for all employees and appropriate contractors to ensure that they receive, read, acknowledge, understand~~ing of~~, and ~~agree to~~ comply with the District's Code of Business Ethics and Conduct and policies.

Reporting and Complaints Processes

- Oversee the District's processes, including a toll-free telephone number, through which employees may seek advice on application of the District's Code of Business Ethics and Conduct and policies, and report potential Code, policy, and legal violations.
- Oversee, on the basis of quarterly reports from the Compliance Officer, the investigations of compliance violations reported to the Compliance Officer.

Monitoring and Auditing Compliance

With the Code of Business Ethics and Conduct, policies, and legal requirements:

- Development~~,~~ and revision~~,~~ of Annual Work Plan and Annual Audit Plan.~~;~~
- Ensure appropriate internal and~~/or~~ external audits and surveys are conducted to verify adherence to the Code of Business Ethics and Conduct, policies, and applicable legal requirements.
- Oversee periodic employee surveys to test awareness of the District's compliance guidelines and procedures.
- Direct the Compliance Officer to commission special audits as necessary to verify adherence to the Code of Business Ethics and Conduct, policies and~~/or~~ legal requirements.

Enforcement and Discipline

- Oversee appropriate and consistent discipline is imposed for violations of the Code of Business Ethics and Conduct, policies, and legal requirements
- Receive quarterly reports from the Compliance Officer regarding reported disciplinary action taken during the prior quarter.

Response and Prevention

- Oversee the action taken by the District to ensure violations of the Code of Business Ethics and Conduct, policies, and ~~/or~~ legal requirements are remedied.
- Oversee steps taken to prevent similar violations from occurring in the future

RETENTION AND DESTRUCTION OF RECORDS

Agendas and minutes from the Compliance and Business Ethics will be maintained for six (6) years.

Documents related to Enforcement and Discipline will become a part of the workforce member's Human Resource's file, which ~~are~~ is maintained for the length or employment, plus six (6) years.

Policy and ~~/or~~ Procedures developed to create response and prevention will be maintained for the length of time the document is in effect, plus six (6) years.

Audit records will be maintained for fifteen (15) years.

Supersedes: v.1 Compliance and Business Ethics Committee

NORTHERN INYO HEALTHCARE DISTRICT
NON-CLINICAL POLICY AND PROCEDURE

Title: Forms Development and Control Policy		
Owner: Compliance Officer	Department: Compliance	
Scope: District Wide		
Date Last Modified: 11/06/2024	Last Review Date: 04/21/2022	Version: 3
Final Approval by: NIHD Board of Directors	Original Approval Date: 10/28/2011	

PURPOSE:
Provide a standard process for development, review, and approval of all forms, downtime documents, handouts, patient documents, and postings (posters, flyers, etc.) that are used by District workforce, posted in District spaces (Union bulletin board allowed spaces excepted), or given to the public/patients, or part of a standardized process to ensure uniformity in practice.

POLICY:

1. Forms, downtime documents, handouts, patient documents, and postings that are used by District workforce or provided to District patients and public, or used as part of a standardized process should be submitted for approval to the Forms Committee SmartSheet, prior to use or posting.
2. Only approved forms, downtime documents, handouts, patient documents, and postings may be used or posted at the District.
    a. Documents posted on the MOU approved bulletin board spaces are exempt from this policy.
    b. Human Resource postings related to state and federal labor laws are also exempt.
    c. Documents created inside the electronic health system, by the electronic health record, are not subject to this policy.
3. The Forms Committee shall review and approve all forms via in-person or serial meetings via email, downtime documents, handouts, patient documents, and postings in accordance with the design standards and guidelines set forth in this Policy.
4. The Northern Inyo Healthcare District (NIHD) Forms Committee has the responsibility for defining standards for layout, format, identification, regulatory compliance, posting locations, and placing/archiving from the approved forms location on the intranet.
5. NIHD Forms Committee shall:
    a. Review for reading level, 12-point font, and translations per regulations to meet patient and District needs.
    b. Ensure that documents maintained in the permanent, legal medical record (paper-based, electronic, and imaged) are appropriate for patient care, risk management, and financial administration.
    c. Provide guidance to forms users as to what forms are considered part of the patient's medical record.
    d. Ensure that all Northern Inyo Healthcare District forms meet the requirements of the Joint Commission, California state statutes and federal laws and regulations governing health care, and health care documentation.
    e. Reduce the duplication of information in the permanent, legal health record through consolidation of forms.

f. Improve the level of communication among health care providers by ensuring a minimum set of data elements be included in every permanent, legal medical record whether maintained in a paper-based, electronic or imaged format.
g. Make the final determination as to where the form will reside in the medical record.
h. The Compliance Department will maintain the following information on file:
    i. Bar coded, final electronic versions of all forms
    ii. Correspondence/special instructions from the form sponsor regarding the form

6. The NIHD Forms Committee shall determine its composition and initially be comprised of:
    a. Compliance
    b. Infection Prevention
    c. Health Information Management (HIMS Department)
    d. Strategic Marketing
    e. Diagnostic Services leadership
    f. Medical Staff (as needed)
    g. Nursing leadership
    h. Clinic leadership
    i. Patient access leadership
    j. Materials Management, ad hoc
7. The NIHD Forms Committee may make changes to its composition by majority vote of its members.
8. The NIHD Forms Committee may meet in person or via serial email meetings as deemed necessary by the membership.

DEFINITIONS:

FORM - Any printed, typed, or electronic document with blank spaces for insertion of required or requested information (handwritten or electronically generated) that is made a part of a patient's permanent, legal medical record.

FORM SPONSOR – Individual who requests the production of a new or revised form. The form sponsor is responsible for completing all necessary paperwork in accordance with the forms approval process. The form sponsor will work with the Forms Committee to distribute the form to the necessary locations within and external to NIHD and verifies that the obsolete versions of the same form have been removed from use.

VITAL DOCUMENT – Vital Documents shall include, but are not limited to, documents that contain information for accessing NIHD services and/or benefits. The following types of documents are examples of Vital Documents:

1) Informed Consent;
2) Advance Directives;
3) Consent and complaint forms;
4) Intake forms with potential for important health consequences;
5) "Notices pertaining to the denial, reduction, modification or termination of services and benefits, and the right to file a grievance or appeal;"[1]
6) Other hearings, notices advising LEP persons of free language assistance, or applications to participate in a program or activity to receive benefits or services.[2]

NIHD shall make available translated versions of Vital Documents, into the target language of any group that comprises at least 5% of the population of the geographical area served by the hospital, or of the actual patient population.[3]

PROCEDURE (New Forms):

1. The form sponsor will submit the form request through the appropriate link on the intranet.

2. Forms sponsors will need to ensure the form is in compliance with hospital abbreviations policy or otherwise spell out abbreviations and acronyms the first time used on the form. If necessary, an abbreviation key may be placed on the form for reference.
3. The Compliance team will work with form sponsors to ensure form is ready for approval.
4. Forms Committee may meet in person, teleconference, or have serial approval voting via electronic process.
5. Once approved, forms will be published to the Intranet.
6. Forms will be filed electronically on a shared drive for reproduction upon request.
7. The form sponsor will be responsible for distribution and training on new forms, as needed.

PROCEDURE (Revising Existing Forms):

1. Form sponsor will make revisions as needed and resubmit the electronic form, preferably in word and PDF using the Request for Form Approval link on the intranet. The Compliance team will assess the revisions to ensure appropriateness for submission for approval.
2. Revision of generic documents (such as informed consent) for specific procedures or clinics should be submitted via the Request for Form Approval link on the intranet.
3. Form will be re-bar coded, if appropriate.
4. Revision date will be entered on the bottom of the form.
5. Once approved, form will be filed electronically on a shared drive to access for reproduction upon request.
6. The form sponsor will be responsible for distribution and training, and ensures that the obsolete versions of the same form have been removed from use.

REFERENCES:

1. California Health and Safety Code § 1367.04(b)(1)(B)(i)-(vi)
2. According to the Title VI Office of Civil Rights Guidance, the definition of Vital Documents "may depend upon the importance of the program, information, encounter, or service involved, and the consequences to the LEP person if the information in question is not provided accurately or in a timely manner."
3. Title VI of the 1964 Civil Rights Act, Emergency Medical Treatment and Active Labor Act, and California Health and Safety Code Section 1259.

RECORD RETENTION AND DESTRUCTION: N/A

CROSS-REFERENCE POLICIES AND PROCEDURES:

1. Barcode Rules & Assignments

Supersedes: v.2 Forms Development and Control Policy

NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL POLICY AND PROCEDURE

Title: Linen Laundry Processes AB 2679		
Owner: Manager Employee Health & Infection Control	Department: Infection Prevention	
Scope: District Wide		
Date Last Modified: 12/04/2024	Last Review Date: No Review Date	Version: 3
Final Approval by: NIHD Board of Directors	Original Approval Date: 12/18/2019	

PURPOSE:
Patient linens are a potential means of cross contamination between patients, healthcare workers and the environment. This policy describes the process for managing patient linen at NIHD to reduce the risk of disease transmission to patients, staff, and to meet General Assembly Bill 2679-Linen Laundry Processes.

POLICY:
1. All soiled linen is considered contaminated. Adherence to standard precaution will be utilized and staff will perform hand hygiene after contact with soiled linen.
2. Soiled linen shall be handled as little as possible and with minimum agitation to prevent contamination of the air and persons handling the linen
3. Linens used at NIHD will be cleaned, handled and transported according to federal (Centers for Medicare Services), state (Title 22 Licensing and Certification California Code of Regulations), Senate Bill AB 2679, and local regulations. In addition, adherence to guidelines and standards set forth by the Healthcare Laundry Accreditation Council and the Association for Professionals in Infection Prevention and Epidemiology (APIC) is required.
4. NIHD will allow for more energy and water efficient processes to be used in the processing of hygienically clean linens.
5. Laundry Equipment will be maintained according to the manufactures instructions. Maintenance documentation will be held and maintained by the NIHD Maintenance Department.
6. Appropriate laundry weight and volume will be followed. NIHD practice is that all clean linen is weighed after washed and folded before being delivered to the clinical departments. A log is kept for all weight and is maintained in the laundry department.
7. Wet or damp textiles will not be left overnight.
8. Temperature, relative humidity, and moisture control in linen storage areas will be maintained to prevent microbial proliferation.
9. Laundering cycles consist of flush, main wash, bleaching, rinsing, and souring.[1274] Cleaned wet textiles, fabrics, and clothing are then dried, pressed as needed, and prepared (e.g., folded and packaged) for distribution back to the facility.
10. Separate rooms shall be maintained in the hospital for storage of clean linen and for storage of soiled linen. Storage shall not be permitted where air distribution is impeded such as air conditioning or ventilating systems.
11. Linen carts shall only be used for the storage of transportation of only clean or dirty linen specified carts.
12. Soiled linen shall be transported and stored in only labeled, designated “Soiled Linen Carts.” Clean linen shall be transported and stored in only labeled, “Designated Clean Linen.” Clean linen covers are made of washable materials, which should be cleaned/disinfected bi-annually and as needed. Clean linen

transportation carts will be cleaned weekly and as needed. A log will be maintained in the laundry department with cleaning schedule and documentation.

13. Soiled linen shall be sorted in a separate enclosed room by a person instructed in methods of protection from contamination. Staff shall not immediately handle clean linen until protective attire worn in the soiled linen area is removed and hands are washed.
14. Soiled linen shall be handled, stored and processed in a safe manner that will prevent the spread of infection and will assure the maintenance of clean linen *(Refer to P&P Handling Soiled Linen).*
15. Appropriate PPE must be worn when handling and changing chemicals, which include: liquid resistant lab gown, Exam gloves, chemical & sharp proof gloves, goggles, and full face shield.
16. Laundry bags will be closed before placing in container for transport.
17. The center divider door shall remain closed in laundry facility area where contaminated linen is received, to minimize the potential for re-contaminating cleaned laundry with aerosolized contaminated lint.
18. Laundered textiles that have been properly laundered and disinfected, may be used in newborn nursery.
19. When a machine is out of service, a sign indicating, "Machine is under maintenance." Only Maintenance Department can remove sign when maintenance complemented

DEFINTIONS:

1. Clean linen: Laundry/ Linen that has gone through the sanitization process that is ready to be used by healthcare staff.
2. Contaminated Laundry**:** Laundry, which has been soiled with blood or other potentially infectious material or may contain sharps.
3. Hygienically clean**:** Textiles that are free from microorganisms in quantities that are capable of causing disease.

PROCEDURE:

1. Linens shall be washed using an effective soap or detergent and thoroughly rinsed to remove soap or detergent and soil. Linens shall be exposed to water at a minimum temperature of 71 degrees C (160 degrees F) for at least 24 minutes during the washing process, or a lower temperature of 60 degrees C (140 degrees F.) for 24 minutes may be utilized if the linens are subsequently passed through a flatwork ironer at 110-115 feet per minute at a temperature of 300 degrees F. or a tumbler dryer at a temperature of 180 degrees F. (see reference#7)
2. Equipment textiles/linen shall be laundered according to manufactures instructions.
3. Packaging, transporting, and storing clean textiles by methods that will ensure their cleanliness and protect them from dust and soil during interfaculty loading, transport, and unloading
4. NIHD will maintain a contract for off-site laundering services to be utilized during high volume and downtime. Clean linens provided by an off-site laundry must be packaged prior to transport to prevent inadvertent contamination from dust and dirt during loading, delivery, and unloading. Functional packaging of laundry can be achieved in several ways, including
    - placing clean linen in a hamper lined with a previously unused liner, which is then closed or covered
    - placing clean linen in a properly cleaned cart and covering the cart with disposable material or a properly cleaned reusable textile material that can be secured to the cart; and
    - wrapping individual bundles of clean textiles in plastic or other suitable material and sealing or taping the bundles.
5. Coated or laminated fabrics become contaminated with blood or other body surfaces, NIHD will follow manufactures instruction for decontamination and cleaning take into account the compatibility or the rubber backing with the chemical germicide or detergents used. If the backing develops surface cracks, the item will be discarded.

6. Microbiologic sampling will be conducted during outbreak investigations if epidemiologic evidence indicates a role for healthcare textiles and clothing in disease transmission.

REFERENCES:

1. California Department Public Health. (2018). AFL 18-49 Assembly Bill (AB) 2679- Linen Laundry Processes. Retrieved from https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/AFL-18-49.aspx
2. California Legislative Information. (2018). AB-2679 Health facilities: linen laundry. Retrieved from https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201720180AB2679
3. Center for Disease Control and Prevention. (2015). Infection Control. Background G. Laundry and Bedding. Retrieved from https://www.cdc.gov/infectioncontrol/guidelines/environmental/background/laundry.html
4. Infection Control Today. (June 18, 2015). Best Practices to Prevent Infections during Laundering of Healthcare Textiles. Retrieved from https://www.infectioncontroltoday.com/view/best-practices-prevent-infections-during-laundering-healthcare-textiles
5. Westlaw California Code of Regulations/ (2019) Site Accessed 9-24-24). § 71629. Laundry Service 22 CA ADC § 71629 Barclay Official California Code of Regulations. Retrieved from https://govt.westlaw.com/calregs/Document/IB4B419A95B6111EC9451000D3A7C4BC3?originationContext=document&transitionType=StatuteNavigator&needToInjectTerms=False&viewType=FullText&ppcid=4f22e24d22df406496b4d5299432098d&contextData=%28sc.Default%29

RECORD RETENTION AND DESTRUCTION:

CROSS REFERENCED POLICIES AND PROCEDURES:

1. Handling Soiled Linen
2. Lippincott Standard Precautions

Supersedes: v.2 Linen Laundry Processes AB 2679

NORTHERN INYO HEALTHCARE DISTRICT
NON-CLINICAL POLICY

Title: NIHD Recruitment and Selection - Education and Experience Equivalency		
Owner: Human Resources Manager	Department: Human Resources	
Scope:		
Date Last Modified: 11/08/2024	Last Review Date: No Review Date	Version: 1
Final Approval by: NIHD Board of Directors	Original Approval Date:	

PURPOSE:

The purpose of this policy is to provide guidance and outline the definitions and processes of application evaluation, and experience and education rating, during the recruitment and selection process at Northern Inyo Healthcare District (NIHD). This policy covers applications submitted for all recruitments managed by the department of Human Resources, and had no bearing or impact on any wage discussion or calculations.

DEFINITIONS:

Recruitment – the act of searching for or finding candidates to fill a vacant position.

Candidate – a person who has submitted a hiring application for a vacancy posted by NIHD

Job Description – a written document that outlines essential requirements and responsibilities of a position. All positions in the District must have an accompanying job description.

Experience – a candidates provided work history that is most relevant or related to the position they have submitted an application to.

Education – a candidates provided school history that is most relevant or related to the position they have submitted an application to. Education may consist of any level of schooling from K-12 to graduate school, trade school, professional licensure or certificate programs, or any other program that prepares attendees for employment after completion.

Screening – reviewing a candidate's application, resume, and any additional provided information to ensure a candidate meets the minimum requirements for a vacancy.

Application Rating Tool – a tool utilized in application screening. The screener will assign a point value to the minimum and preferred qualifications of a position based on the job description and evaluate an applicant's education, experience and certifications against said qualifications to obtain a score for passage or failure of the application on to interviews.

POLICY:

Northern Inyo Healthcare District is committed to ensuring all stages of recruitments, including the application evaluation stage, are conducted in a fair and appropriate manner, consistent with all Federal and State regulations the District is required to follow. The Human Resources Department is responsible for overseeing the recruitment and selection process at NIHD These procedures and processes will be reviewed regularly, and may be amended due to changes in regulations, recommendation of legal counsel, or under other circumstances, as needed.

In order to maintain consistency in practices, the information in this document is intended to provide guidance to any persons screening applications to determine if a candidate has achieved the minimum qualifications as provided in a

vacancies job description. Candidate qualification met through equivalent exchange of education and experience will be treated with the same weight as qualifications met through requirements as provided in the vacancy job description, but will not have any additional weight during hiring wage calculations.

If a candidate meets the position requirements for both education and experience without exchanging one for the other, no substituted education or experience will be applied.

Experience:
All experience provided by a candidate that is within the same field, and carries the same or similar title, and/or scope of duties and responsibilities is considered directly related experience. Any duration of directly related experience will be credited towards any qualification for the vacant position at an equal duration.

All experience provided by a candidate that is within the same or a related field that has related, transferrable knowledge or skills, but does not have the same title, duties, and/or responsibilities, is considered generally related experience. Any duration of general related experience will be credited towards any qualification at a prorated duration, dependent upon the duties, responsibilities, and transferability of skills and knowledge to the vacant position.

All experience provided by a candidate that is not within the same or a related field and is not similar or has no transferrable skills to the vacancy is considered unrelated experience. Unrelated experience is not considered nor credited towards any qualification for the vacant position.

For candidates who have not obtained the required level of education, directly related experience in excess of the minimum required may be substituted for the education requirements. Generally related experience and unrelated experience may not be used to substitute education requirements. The substitution may be considered at the following levels:

Directly Related Experience	Education Requirement
2 years	Associate's Degree (A.A., A.S., A.A.S, etc.)
4 years	Bachelor's Degree (B.A., B.S., B.S.N., etc.)
6 years	Master's Degree (M.A., M.S., M.P.H., etc.)

For positions that require license or certification, there will be no accepted equivalent experience credit for any education required to obtain the required license or certification. For example, a graduate degree may be required to obtain a state license for a position, a bachelor's degree and enhanced experience will not be accepted in lieu of a graduate degree as the required license would be unobtainable under that circumstance.

Education:
Education provided by a candidate that is within the same or a closely related field is considered relevant education.

Any relevant education provided by a candidate that is in excess of the required education may be deemed as equivalent to experience, and substituted as such. If a candidate has multiple degrees or certifications in excess of any requirements, only the highest level of education will be considered and applied as a substitution.

The substitution may be considered at the following levels:

Education	Experience Credit
Associate's Degree (A.A., A.S., A.A.S, etc.)	1 year
Bachelor's Degree (B.A., B.S., B.S.N., etc.)	2 years
Master's Degree (M.A., M.S., M.P.H., etc.)	3 years
All Doctorates (Ph.D., Ed.D., J.D., D.Chem, etc.)	4 years
Vocational training/certification	Dependent upon position and training/certification

REFERENCE:

RECORD RETENTION AND DESTRUCTION:

HR Records, including those relating to hiring, will be held for the life of employment or duration of the hiring process, plus 6 years

CROSS REFERENCE POLICIES AND PROCEDURES:

NIHD Recruitment and Selection

Supersedes: Not Set

NORTHERN INYO HEALTHCARE DISTRICT
EMPLOYEE HANDBOOK

Title: Per Diem Employees		
Owner: Human Resources Manager	Department: Human Resources	
Scope: District Wide		
Date Last Modified: 11/06/2024	Last Review Date: No Review Date	Version: 1
Final Approval by: NIHD Board of Directors	Original Approval Date:	

PURPOSE: To establish a policy related to per diem requirements for maintaining employment.

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POLICY:

A. A Per Diem employee shall be available to work a minimum of 300 hours per year, including hours spent on call, and yearly competency hours, unless an approved Medical Leave of Absence prevents her/him from fulfilling this commitment. The District shall guarantee that each Per Diem employee is offered a minimum of 300 hours.

B. Per Diem employees must be available to work at least one of the following holidays each year: Christmas Day, New Year's Day, Thanksgiving Day, Memorial Day, Independence Day, Labor Day in departments that are open or provide on call support on these holidays. The department leader may approve Christmas Eve and New Year's Eve as substitutes to better meet the department need.

C. Per Diem employees must be available to work four (4) shifts during weekends (Friday p.m. through Sunday p.m. inclusive) in a calendar year in departments that have 24 hour operations.

D. A Per Diem employee is required to submit her/his available hours based on schedule needs within two (2) weeks of the posted schedule. Per Diem employees will be scheduled by rotation if more than one request is made for the same shift. If a Per Diem employee is cancelled, that shift will count in required hours.

E. Per Diem employees may choose to work for opposing shifts.

F. Once the final department schedule has been posted, Per Diem employees are expected to work all assigned shifts.

G. After 120 days of non-availability, unrelated to an approved Leave of Absence for her/his own serious health condition, the Per Diem employee may be separated.

REFERENCES:

RECORD RETENTION AND DESTRUCTION:

Employee records, including those involving termination will be held for:

- The length of employment, plus 10 years.

Maintain payroll records for non-pension workforce for a minim of 15 years.
Employees entitled to pension: life of employee plus 6 years

CROSS REFERENCE POLICIES AND PROCEDURES:

Supersedes: Not Set
Legal Review: Atkinson, Andelson, Loya, Ruud & Romo 10/30/2020

NORTHERN INYO HEALTHCARE DISTRICT
NON-CLINICAL POLICY AND PROCEDURE

Title: Regulatory Survey Security		
Owner: Compliance Officer	Department: Compliance	
Scope: District Wide		
Date Last Modified: 11/01/2024	Last Review Date: No Review Date	Version: 6
Final Approval by: NIHD Board of Directors	Original Approval Date: 08/17/2005	

PURPOSE: To provide a procedure for positively identifying regulatory agency personnel and guarding against imposters posing as such.

POLICY: NIHD will verify all surveyors or inspectors prior to providing them access to District facilities and restricted areas.

PROCEDURE: If any person ~~or persons~~ identifying ~~themselves~~ as regulatory surveyors [e.g. from The Joint Commission (TJC) or California Department of Public Health (CDPH)], or a federal inspector] is encountered, immediately escort the person~~(s)~~ to one of the following (in order of preference):

1. Chief Executive Officer
~~1.~~2. Chief Operation Officer
~~2.~~3. Administrator-on-call
~~3.~~4. Chief Nursing Officer
~~4.~~5. Chief Medical Officer
~~5.~~6. Chief Human Resources Officer
~~6.~~7. Chief Financial Officer
~~7.~~8. Compliance Officer
~~8.~~9. House Supervisor

Administrative personnel will:

1. Collect business card or gather identification of the surveyor or ~~/~~inspector.
2. Call the agency from which the surveyor(s) claims to have been sent to verify their legitimacy
    a. **TJC – 630-792-5757**
    b. **CDPH – 909-383-4777**
3. Assign a hospital employee to accompany the surveyor(s) during their survey

In the event that the surveyor~~(s)~~ refuses to allow verification of ~~their~~ his or her identification or if the administration suspects that the surveyor is an imposter:

1. Call the local **Police – 873-5866**
2. Go to the TJC website and fill out the Homeland Security Incident Report (even if the imposters claim to be from another agency)

REFERENCES:

1. The Joint Commission (CAMCAH Manual) – The Accreditation Process (ACC); Surveyor Arrival and Preliminary Planning Session (Jan 1, 2024).
2. California Hospital Association - California Hospital Survey Manual (2021).
3. California Hospital Association – Record and Data Retention Schedule (2018).

RECORD RETENTION AND DESTRUCTION:
Records related to Accreditation/Licensing surveys and plans of correction will be maintained by NIHD for 15 years.

CROSS REFERENCED POLICIES AND PROCEDURES:
1. Security Management Plan
2. Governmental Agent Services
3. InQuiseek – Physical Plant Safety: General Policy

Supersedes: v.5 Regulatory Survey Security

NORTHERN INYO HEALTHCARE DISTRICT
NON-CLINICAL POLICY

Title: Temporary Loaning of District Equipment		
Owner: Compliance Officer	Department: Compliance	
Scope:		
Date Last Modified: 11/01/2024	Last Review Date: No Review Date	Version: 3
Final Approval by: NIHD Board of Directors	Original Approval Date:	

PURPOSE: To establish policy related to equipment being loaned for use outside of the District facilities.

POLICY:
Northern Inyo Healthcare District (NIHD) shall seek alternate options to assist persons requiring equipment in lieu of loaning equipment from the District. If no other option for obtaining the equipment is available, the District will consider temporary loan of equipment.
NIHD is not licensed to sell durable medical equipment (DME), therefore ~~we make attempts~~ attempts are made to find alternate sources for patients requiring DME supplies and ~~/~~equipment. The Office of the Inspector General has determined that providing items or services of more than nominal value ($10 individually and $50 in the aggregate annually per patient) is seen as an enticement (the patient or their family are more likely to come to NIHD for services), and as such, personnel are banned from providing DME is excess of the aforementioned stated values.~~.~~
Exceptions to this policy should be discussed and approved by the Administrator on Call (AOC) on a case-by-case basis.
If it is determined that equipment will be temporarily loaned for use outside of the District, the patient or family care giver will be required to complete the 'Equipment Loan Form' and be expected to return borrowed items timely and in good condition. The f~~F~~orm is available in the approved forms folder on the intranet.

REFERENCE:
1. Office of Inspector General: Offering Gifts and Other Inducements to Beneficiaries (August 2002).

RECORD RETENTION AND DESTRUCTION:
Equipment Loan Form will be completed by NIHD House Supervisor and signed by the patient, ~~or~~ family or ~~/~~caregiver. The form will be stored in the House Supervisor office until the item has been returned and found to be in good condition~~;~~ after which time the form shall be destroyed via NIHD shredding process.

CROSS REFERENCED POLICIES AND PROCEDURES: N/A

Supersedes: v.2 Temporary Loaning of District Equipment