July 21 2021 Regular Meeting

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AGENDA

NORTHERN INYO HEALTHCARE DISTRICT
BOARD OF DIRECTORS REGULAR MEETING
July 21, 2021 at 5:30 p.m.

Beginning July 1, 2021, the Board will again meet in person at 2957 Birch Street Bishop, CA 93514 at 5:30 pm. Members of the public will be allowed to attend in person or via zoom. Public comments can be made in person or via zoom:

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

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

   A. Northern Inyo Healthcare District 2020 Financial Audit Report and Document Presentation by Eide Bailley LLP- *(Board to Review the Presentation and Vote to Accept the Financial Audit Results and Documents)*

   B. Chief Executive Officer Search Update *(information item)*

   C. Pharmacy Update – Colombo Construction (*information item)*

D. Cerner Project Update *(information item)*

E. Compliance Department Quarterly Report *(Board will vote to accept this report)*

F. Global Services by Hyland Professional Services Proposal – Athena Health's Historical Medical Record Upload *(Board will vote to approve this proposal)*

G. Shasta Networks Statement of Work – Conversion of Athena Health's Patient Encounters to PDF Documents *(Board will vote to approve this statement of work)*

4. Chief of Staff Report, Sierra Bourne MD:

A. Policies and Procedures (*Board will vote to approve these Policies and Procedures*)

1. *DI Nuclear Medicine Radiopharmacy Policy*
2. *Medical Staff Department Policy – Pediatrics*
3. *New Line of Service Implementation Policy*
4. *Rabies Vaccination Policy*
5. *Tuberculosis Exposure Control Plan*
6. *Basic Principles of Sterilization*
7. *Cleaning Procedures: Specialized Areas: Sterile Processing*
8. *Operating Room Attire*
9. *Operating Room Sanitation*
10. *Postpartum Patient Care in the PACU*
11. *Rotation Procedures for Patient Cubicle Curtains & Shower Curtains*
12. *Sterilization Recall*
13. *Steris V-Pro Low Temperature Sterilizer Program*
14. *Steris Washer Disinfector*
15. *Storage Requirements for Sterile & Clean Items*

B. Annual Review of Critical Indicators (*Board will vote to approve these Annual Reviews*)

1. Inpatient Medicine Critical Indicators 2021
2. Radiology Services Critical Indicators 2021
3. Utilization Review Critical Indicators 2021

C. Updated Core Privilege Forms (*Board will vote to approve these forms*)

1. Pediatrics
2. Hospitalist

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

Consent Agenda

5. Approval of minutes of the June 4 2021 special meeting *(Board will vote to approve these minutes)*
6. Approval of minutes of the June 16 2021 regular meeting *(Board will vote to approve these minutes)*
7. Interim Chief Executive Officer Report, *(Board will receive this report)*

8. Chief Medical Officer Report, Board will vote to approve this report *(Board will receive this report)*
9. Chief Nursing Officer Report *(Board will receive this report)*
10. Financial and Statistical Report as of May 31, 2021 *(Board will vote to accept this report)*

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11. NIHD Committee updates from Board members (*information items*).
12. Reports from Board members (*information items*).
13. Adjournment to Closed Session to/for:

    A. Conference with Labor Negotiators, Agency Designated Representative: Irma Rodriguez Moisa; Employee Organization: AFSCME Council 57 *(pursuant to Government Code Section 54957.6)*

    B. Conference with legal counsel, anticipated litigation. Significant exposure to litigation (*pursuant to paragraph (2) of subdivision (d) of Government Code Section 54956.9*) seven cases.

    C. Public Employee Performance Evaluation (*pursuant to Government Code Section 54957 (b*)) title: Interim Chief Executive Officer.
14. Return to Open Session and report of any action taken (*information item*).
15. Adjournment.

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

Northern Inyo Healthcare District

Financial Statements and Supplementary Information

Year Ended June 30, 2020

Northern Inyo Healthcare District

Financial Statements and Supplementary Information

Year Ended June 30, 2020

Table of Contents

Independent Auditor's Report

To the Board of Directors
Northern Inyo Healthcare District
Bishop, California

Report on the Financial Statements
We have audited the accompanying financial statements of the business-type activities and discretely presented component unit and aggregate remaining fund information of the Northern Inyo Healthcare District (District), as of and for the year ended June 30, 2020 and the related notes to the financial statements, which collectively comprise the District's basic financial statements as listed in the table of contents.

Management's Responsibility for the Financial Statements
Management is responsible for the preparation and fair presentation of these financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility
Our responsibility is to express opinions on these financial statements based on our audit. We conducted our audit in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinions.

Opinions
In our opinion, the financial statements referred to above present fairly, in all material respects, the respective financial position of the business-type activities and discretely presented component unit and aggregate remaining fund information of the District, as of June 30, 2020, and the respective changes in financial position and cash flows thereof for the year then ended in accordance with accounting principles generally accepted in the United States of America.

Emphasis of Matter

As discussed in Note 16 to the financial statements, the District recorded prior period adjustments for the correction of errors. Our opinions are not modified with respect to this matter.

Other Matters

Required Supplementary Information
Accounting principles generally accepted in the United States of America require that the schedules of changes in the net pension liability and related ratios, schedules of pension contributions, and schedules of investment returns, as listed in the table of contents, be presented to supplement the basic financial statements. Such information, although not a part of the basic financial statements, is required by the GASB, who considers it to be an essential part of financial reporting for placing the basic financial statements in an appropriate operational, economic, or historical context. We have applied certain limited procedures to the required supplementary information in accordance with auditing standards generally accepted in the United States of America, which consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the basic financial statements, and other knowledge we obtained during our audit of the basic financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

Management has omitted management's discussion and analysis that accounting principles generally accepted in the United States of America require to be presented to supplement the basic financial statements. Such missing information, although not a part of the basic financial statements, is required by the Governmental Accounting Standards Board who considers it to be an essential part of financial reporting for placing the basic financial statements in an appropriate operational, economic, or historical context. Our opinion on the basic financial statements is not affected by this missing information.

Other Information
Our audit was conducted for the purpose of forming an opinion on the financial statements that collectively comprise the District's basic financial statements. The combining statement of net position of the District and component units, combining statement of revenues, expenses and changes in net position of the District and component units, and statistical information are presented for purposes of additional analysis and are not a required part of the basic financial statements.

The combining statement of net position of the District and component units and combining statement of revenues, expenses and changes in net position of the District and component units are the responsibility of management and were derived from and relate directly to the underlying accounting and other records used to prepare the basic financial statements. Such information has been subjected to the auditing procedures applied in the audit of the basic financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the basic financial statements or to the basic financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the combining statement of net position of the District and component units and combining statement of revenues, expenses and changes in net position of the District and component units are fairly stated, in all material respects, in relation to the basic financial statements as a whole.

The statistical information has not been subjected to the auditing procedures applied in the audit of the basic financial statements, and accordingly, we do not express an opinion or provide any assurance on it.

Other Reporting Required by *Government Auditing Standards*

In accordance with *Government Auditing Standards*, we have also issued our report dated July 16, 2021, on our consideration of the District's internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements and other matters. The purpose of that report is solely to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on the effectiveness of the District's internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the District's internal control over financial reporting and compliance.

Eide Bailly LLP

Sacramento, California
July 16, 2021

Northern Inyo Healthcare District

Statement of Net Position

June 30, 2020

Assets and Deferred Outflows of Resources	Hospital	Pioneer Medical Associates (12/31/2019)
Current assets:		
Cash and investments	$ 57,722,773	$ 214,659
Receivables:		
Patient accounts - Net	16,121,755	-
Other	939,552	-
Estimated third-party payor settlements	229,131	-
Inventories	2,651,452	-
Prepaid expenses and other	1,591,843	-
Total current assets	79,256,506	214,659
Noncurrent assets:		
Restricted cash and investments	4,582,513	-
Investment in Pioneer Medical Associates	430,946	-
Capital assets:		
Nondepreciable capital assets	3,796,374	353,413
Depreciable capital assets - Net	72,079,822	192,975
Total noncurrent assets	80,889,655	546,388
Total assets	160,146,161	761,047
Deferred outflows of resources - Related to pensions	21,955,960	-
TOTAL ASSETS AND DEFERRED OUTFLOWS OF RESOURCES	$ 182,102,121	$ 761,047

See accompanying notes to financial statements.

Northern Inyo Healthcare District

Statement of Net Position (Continued)

June 30, 2020

Liabilities, Deferred Inflows of Resources, and Net Position	Hospital	Pioneer Medical Associates (12/31/2019)
Current liabilities:		
Accrued payroll and related liabilities	$ 7,995,462	$ -
Accounts payable	3,627,887	-
Accrued interest	134,001	-
Capital lease obligations - Current portion	376,934	-
Bonds and notes payable - Current portion	1,916,847	-
CMS advance - Current portion	1,824,269	-
Unearned revenue	7,074,415	-
Total current liabilities	22,949,815	-
Noncurrent liabilities:		
Bonds and notes payable - Net of current portion	52,679,187	-
Paycheck Protection Program loan	8,927,628	-
Capital lease obligations - Net of current portion	1,393,067	-
CMS advance - Net of current portion	12,769,885	-
Net pension liability	40,821,869	-
Total noncurrent liabilities	116,591,636	-
Total liabilities	139,541,451	-
Deferred inflows of resources - Pensions	2,790,962	-
Net position:		
Net investment in capital assets	22,524,316	-
Restricted for programs	1,568,358	345,500
Unrestricted	15,677,034	415,547
Total net position	39,769,708	761,047
TOTAL LIABILITIES, DEFERRED INFLOWS OF RESOURCES, AND NET POSITION	$ 182,102,121	$ 761,047

See accompanying notes to financial statements.

Northern Inyo Healthcare District

Statement of Revenues, Expenses, and Changes in Net Position

Year Ended June 30, 2020

	Hospital	Pioneer Medical Associates (12/31/2019)
Revenue:		
Net patient service revenue	$ 81,822,003	$ -
Other operating revenue	10,469,085	192,769
Total revenue	92,291,088	192,769
Operating expenses:		
Salaries and wages	34,660,138	-
Employee benefits	22,935,115	-
Professional fees	14,592,157	2,890
Supplies	9,296,085	-
Purchased services	4,404,861	-
Depreciation	4,301,994	14,564
Medical office building, net	771,490	-
Other operating expenses	4,743,855	38,061
Total operating expenses	95,705,695	55,515
Income (loss) from operations	(3,414,607)	137,254
Nonoperating revenue (expenses):		
Tax revenue for operations	625,869	-
Tax revenue for debt services	1,746,739	-
Interest income	598,967	42
Interest expense	(2,376,612)	-
Noncapital grants and contributions	215,342	-
Loss on sale of asset	(36,388)	-
Total nonoperating revenue	773,917	42
Contributions:		
Distributions to PMA investors	-	(100,000)
Change in net position	(2,640,690)	37,296
Net position at beginning of year - As originally stated	41,264,297	697,256
Restatement	1,146,101	26,495
Net position at beginning of year - As restated	42,410,398	723,751
Net position at end of year	$ 39,769,708	$ 761,047

See accompanying notes to financial statements.

Northern Inyo Healthcare District

Statement of Cash Flows

Year Ended June 30, 2020

	Hospital	Pioneer Medical Associates (12/31/2019)
Cash flows from operating activities:		
Receipts from and on behalf of patients	$ 83,734,116	$ -
Receipts from other operating revenue	10,072,464	192,769
Payments to employees	(56,659,998)	-
Payments to suppliers, contractors, and others	(34,530,385)	(40,951)
Medical office building, net	(771,490)	-
Net cash provided by operating activities	1,844,707	151,818
Cash flows from noncapital financing activities:		
District property tax revenue for operations	625,869	-
Noncapital grants received	7,267,489	-
Proceeds from Paycheck Protection Program loan	8,927,628	-
Proceeds from CMS advance	14,594,154	-
Net cash provided by noncapital financing activities	31,415,140	-
Cash flows from capital and related financing activities:		
District tax revenue for debt services	1,746,739	-
Principal paid on long-term debt	(2,293,438)	-
Principal paid on capital lease obligations	(392,774)	-
Interest paid on debt	(1,563,805)	-
Acquisition of capital assets	(2,535,298)	-
Net cash used in capital and related financing activities	(5,038,576)	-

See accompanying notes to financial statements.

Northern Inyo Healthcare District

Statement of Cash Flows (Continued)

Year Ended June 30, 2020

	Hospital	Pioneer Medical Associates (12/31/2019)
Cash flows from investing activities:		
Interest received	$ 535,999	$ 40
Loss on sale of investments	(1,975,557)	-
Partnership contributions (distributions)	133,052	(100,000)
Net cash used in investing activities	(1,306,506)	(99,960)
Change in cash and cash equivalents	26,914,765	51,858
Cash and cash equivalents at beginning of year	30,053,497	162,801
Cash and cash equivalents at end of year	$ 56,968,262	$ 214,659
Reconciliation of cash and cash equivalents to the statements of net position:		
Cash and investments (including restricted cash and investments)	$ 62,305,286	$ 214,659
Less: Investments		
Fidelity mutual funds	292,841	-
Certificates of deposit	2,030,028	-
Guaranteed investment contracts	575,000	-
Money market mutual funds	2,439,155	-
Total cash and cash equivalents	$ 56,968,262	$ 214,659

See accompanying notes to financial statements.

Northern Inyo Healthcare District

Statement of Cash Flows (Continued)

Year Ended June 30, 2020

	Hospital	Pioneer Medical Associates (12/31/2019)
Reconciliation of income (loss) from operations to net cash provided by operating activities:		
Income (loss) from operations	$ (3,414,607)	$ 137,254
Adjustments to reconcile income (loss) from operations to net cash provided by operating activities:		
Depreciation	4,301,994	14,564
Provision for bad debt	18,398,111	-
Pension expense	1,228,963	-
Changes in assets and liabilities:		
Receivables:		
Patient accounts - Net	(16,012,004)	-
Other - Government agency	(396,621)	-
Inventories	(220,111)	-
Prepaid expenses and other	(102,022)	-
Accounts payable	(1,170,819)	-
Accrued payroll and related liabilities	(293,708)	-
Estimated third-party payor settlements	(474,469)	-
Total adjustments	5,259,314	14,564
Net cash provided by operating activities	$ 1,844,707	$ 151,818

See accompanying notes to financial statements.

Northern Inyo Healthcare District

Statement of Fiduciary Net Position of Pension Trust Fund - Plan

December 31,	2019
Assets	
Assets:	
Fixed dollar account	$ 8,710,715
Indexed bond fund	11,993,105
TOTAL ASSETS	$ 20,703,820
Net Position	
Net position restricted for pension benefits	$ 20,703,820
TOTAL NET POSITION	$ 20,703,820

See accompanying notes to financial statements.

Northern Inyo Healthcare District

Statement of Changes in Fiduciary Net Position of Pension Trust Fund - Plan

Year Ended December 31,	2019
Additions:	
Employer contributions	$ 5,242,000
Investment income (loss):	
Experience adjustment	492,973
Interest	1,400,614
Total additions	7,135,587
Deductions:	
Benefits paid	8,053,422
Expenses and related charges	58,625
Total deductions	8,112,047
Change in net position	(976,460)
Net position restricted for pension benefits at beginning of year - As originally stated	22,084,009
Restatement	(403,729)
Net position restricted for pension benefits at beginning of year - As restated	21,680,280
Net position restricted for pension benefits at end of year	$ 20,703,820

See accompanying notes to financial statements.

Northern Inyo Healthcare District

Statement of Fiduciary Net Position of Pension Trust Fund - PEPRA Plan

December 31,	2019
Assets	
Assets:	
Cash	$ 130,977
TOTAL ASSETS	$ 130,977
Net Position	
Net position restricted for pension benefits	$ 130,977
TOTAL NET POSITION	$ 130,977

See accompanying notes to financial statements.

Northern Inyo Healthcare District

Statement of Changes in Fiduciary Net Position of Pension Trust Fund - PEPRA Plan

Year Ended December 31,		2019
Additions:		
Employee contributions	$	15,221
Employer contributions		32,987
Total additions		48,208
Change in net position		48,208
Net position restricted for pension benefits at beginning of year		82,769
Net position restricted for pension benefits at end of year	$	130,977

See accompanying notes to financial statements.

Northern Inyo Healthcare District

Notes to Financial Statements

Note 1: Summary of Significant Accounting Policies

Reporting Entity

Northern Inyo Healthcare District (the “District”) was organized in 1946 under the terms of the Local Health Care District Law and is operated and governed by an elected Board of Directors. The District includes a 25-bed acute care facility that provides inpatient, outpatient, emergency care services, and a rural health clinic in Bishop, California, and it's surrounding area.

Northern Inyo Hospital Foundation, Inc. (the "Foundation") is a legally separate 501(c)(3) tax-exempt nonprofit public benefit corporation. The Foundation acts primarily as a fundraising organization to supplement the resources that are available to the District. Although the District does not control the timing or amount of receipts from the Foundation, the majority of the resources, or income thereon that the Foundation holds and invests are restricted to the activities of the District by the Foundation's bylaws. The Foundation's Board of Directors may also restrict the use of such funds for capital asset replacement, expansion, or other specific purposes. The District shall appoint the Board of Directors for the Foundation per the Foundation's bylaws, and for this reason it is a blended component unit of the District. No separate financial report is prepared for the Foundation.

Northern Inyo Hospital Auxiliary, Inc. (the "Auxiliary") is also a legally separate 501(c)(3) tax-exempt public benefit corporation. The Auxiliary's actions are subject to the approval of the District and for this reason it is a blended component unit of the District. No separate financial report is prepared for the Auxiliary.

Pioneer Home Health Care, Inc. (PHH) is also a legally separate 501(c)(3) tax-exempt public benefit corporation. The District is the sole corporate owner of PHH and for this reason it is a blended component unit of the District. No separate financial report is prepared for PHH.

Northern Inyo Local Hospital District Retirement Plan (the "Pension Trust Fund - Plan") is a retirement plan organized under Internal Revenue Code (IRC) Section 401(a) for District employees who meet certain eligibility criteria. The Pension Trust Fund - Plan is reported in the accompanying financial statements in separate statements of fiduciary net position and changes in fiduciary net position to emphasize that it is legally separate from the District. Separate financial statements for the component unit are not available.

Northern Inyo Local Hospital District PEPRA Retirement Plan (the "Pension Trust Fund - PEPRA Plan") is a retirement plan organized under IRC section 401(a) for a District employee who meets certain eligibility criteria. The Pension Trust Fund - PEPRA Plan is reported in separate statements of in the accompanying financial statements fiduciary net position and changes in fiduciary net position to emphasize that it is legally separate from the District. Separate financial statements for the component unit are not available.

Note 1: Summary of Significant Accounting Policies (Continued)

Discretely Presented Component Unit

Pioneer Medical Associates (PMA) is a partnership established by a group of physicians and practitioners in 1986 within the District campus at 152 Pioneer Lane. In an effort to support the continued recruitment for physicians and services, it has been the practice of the District to work with the PMA partners when appropriate and directed by the Board of Directors to purchase practices of individuals or groups who are leaving the area or retiring. The District currently owns a 66.67% interest in the partnership through acquisitions. PMA is reported in a separate column in the accompanying financial statements to emphasize that it is legally separate from the District. Separate financial statements for the component unit are not available.

Basis of Presentation

The financial statements of the District and its discretely presented component units have been prepared in accordance with the accounting principles generally accepted in the United States (GAAP) as prescribed by the Governmental Accounting Standards Board (GASB) using the economic resources measurement focus.

Use of Estimates in Preparation of Financial Statements

The preparation of the accompanying financial statements in conformity with GAAP requires management to make certain estimates and assumptions that directly affect the reported amounts of assets and liabilities and disclosure contingent assets and liabilities at the date of the financial statements. Estimates also affect the reported amounts of revenue and expenses during the reporting period. Actual results may differ from these estimates.

The District considers significant accounting estimates to be those that require significant judgments and includes the valuation of accounts receivable, including contractual allowances and provision for uncollectible accounts, estimated third-party payor settlements, and an estimate for claims incurred, but not reported under a self-funded health insurance plan and certain amounts recognized under grant programs.

Cash and Cash Equivalents

The District considers its investment in the Local Agency Investment Fund (LAIF) and all highly liquid debt instruments with an original maturity of three months or less to be cash equivalents, excluding noncurrent cash and investments.

The District is authorized under California Government Code (CGC) to make direct investments in local agency bonds, notes, or warrants within the state; U.S. Treasury instruments; registered state warrants or treasury notes; securities of the U.S. government or its agencies; bankers' acceptances; commercial paper; certificates of deposit placed with commercial banks and/or savings and loan companies; repurchase or reverse repurchase agreements; medium-term corporate notes; shares of beneficial interest issued by diversified management companies, certificates of participation, and obligations with first-priority security; and collateralized mortgage obligations.

Note 1: Summary of Significant Accounting Policies (Continued)

Cash and Cash Equivalents (Continued)

All investments are stated at fair value, except for guaranteed investment contracts, which are stated at amortized cost. Investment gain (loss) includes changes in fair value of investments, interest, and realized gains and losses.

Patient Receivables and Credit Policy

Patient receivables are uncollateralized patient obligations that are stated at the amount management expects to collect from outstanding balances. These obligations are primarily from local residents, most of whom are insured under third-party payor agreements. The District bills third-party payors on the patients' behalf, or if a patient is uninsured, the patient is billed directly. Once claims are settled with the primary payor, any secondary insurance is billed, and patients are billed for copay and deductible amounts that are the patient's responsibility. Payments on patient receivables are applied to the specific claim identified on the remittance advice or statement. The District does not have a policy to charge interest on past due accounts.

The carrying amounts of patient receivables are reduced by allowances that reflect management's estimate of the amounts that will not be collected. Management provides for contractual adjustments under terms of third-party reimbursement agreements through a reduction of gross revenue and a credit to patient receivables. In addition, management provides for probable uncollectible amounts, primarily for uninsured patients and amounts patients are personally responsible for, through a reduction of gross revenue and a credit to the allowance for uncollectible accounts based on its assessment of historical collection experience and the current status of individual accounts. Balances that are still outstanding after management has used reasonable collection efforts are written off through a charge to the allowance for uncollectible accounts and a credit to patient receivables.

Patient receivables are recorded in the accompanying statements of net position net of contractual adjustments and an allowance for uncollectible accounts.

The District has a discount policy established for residents of the District. Details of forgone charges related to discounts are discussed further in Note 6.

Investment in PMA

Investment in a partnership is carried at the District's equity in the partnership's net assets. The partnership was organized to provide for the construction and use of a medical office building.

Inventories

Inventories are stated at the lower of cost, determined on the average cost method, or net realizable value.

Note 1: Summary of Significant Accounting Policies (Continued)

Noncurrent Cash and Investments

Noncurrent cash and investments include assets held under indenture agreements.

Fair Value Measurement

Fair value is the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. A three-tier hierarchy prioritizes the inputs used in measuring fair value. These tiers include Level 1, defined as quoted market prices in active markets for identical assets or liabilities; Level 2, defined as inputs other than quoted market prices in active markets that are either directly or indirectly observable; and Level 3, defined as significant unobservable inputs therefore, requiring an entity to develop its own assumptions. The asset's or liability's fair value measurement within the hierarchy is based on techniques that maximize the use of relevant observable inputs and minimizes the use of unobservable inputs.

Assets or liabilities measured and reported at fair value are classified and disclosed in one of the three following categories:

Level 1 - Inputs to the valuation methodology are unadjusted quoted priced for identical assets or liabilities in active markets that the District has the ability to access.

Level 2 - Inputs to the valuation methodology include:

- Quoted prices for similar assets or liabilities in active markets.
- Quoted prices for identical or similar assets or liabilities in inactive markets.
- Inputs, other than quoted prices, those are observable for the asset or liability.
- Inputs that are derived principally from or corroborated by observable market data by correlation or other means.

If the asset or liability has a specified contractual term, the Level 2 input must be observable for substantially the full term of the asset or liability.

Level 3 - Inputs to the valuation methodology are unobservable and significant to the fair value measurement.

The asset’s or liability’s fair value measurement level within the fair value hierarchy is based on the lowest level of any input that is significant to the fair value measurement. Valuation techniques used need to maximize the use of observable inputs and minimize the use of unobservable inputs.

Note 1: Summary of Significant Accounting Policies (Continued)

Capital Assets and Depreciation

Capital assets are recorded at cost if purchased or acquisition value at date received if contributed. The District capitalizes assets using the criteria established by the Office of Statewide Health Planning and Development (OSHPD):

Land, land improvements, buildings, and fixed equipment	$3,000
Major movable equipment	3,000

Depreciation is provided over the estimated useful life of each class of depreciable asset and is computed using the straight-line method.

Estimated useful lives range from 2 to 25 years for land improvements, buildings and improvements, leasehold improvements, and fixed equipment and from 3 to 20 years for equipment.

Accreted Interest

Interest expense on capital appreciation bonds is being accreted on the straight-line basis to maturity of the individual bonds, which approximates interest accreted on the effective interest method.

Compensated Absences

The District accrues all leave time for employees as paid time-off (PTO) in the financial statements. In addition, employees hired prior to January 1, 2003, might have accumulated additional sick leave for major medical health problems. Usage of the additional sick leave must be approved by management.

The total potential liability of the District's accumulated sick leave for major medical was approximately $140,000 for the year ended June 30, 2020. Such benefits do not vest; therefore, no liability has been accrued.

Retirement Plan

For purposes of measuring the net pension liability and deferred outflows/inflows of resources related to pensions, and pension expense, information about the pension net position of the District Retirement Plan ("the Plan") and Northern Inyo Healthcare District PEPRA Retirement Plan (the "PEPRA Plan") and additions to/deductions from the plans' pension net position have been determined on the same basis as they are reported by the Plan and PEPRA Plan. For this purpose, benefit payments (including refunds of employee contributions) are recognized when due and payable in accordance with the benefit terms. Investments are reported at fair value.

Note 1: Summary of Significant Accounting Policies (Continued)

Unearned Revenue

Unearned revenue arise when resources are unearned by the District and received before it has a legal claim to them, as when grant monies are received prior to the incurrence of qualifying expenditures. In subsequent periods, when both revenue recognition criteria are met, or when the District has a legal claim to the resources, the liability for unearned revenue is removed from the applicable financial statement and revenue is recognized.

Unearned revenue consists of receipts of federal awards for which the earnings process was not yet completed at June 30, 2020 because the eligibility requirements were not yet met.

Net Position

Net position of the District is classified in three components. Net investment in capital assets consists of capital assets net of accumulated depreciation and reduced by the current balances of any outstanding borrowings used to finance the purchase or construction of those assets. Restricted, including amounts restricted for debt service and restricted for hospital programs. Unrestricted is the remaining net position that does not meet the definitions above.

When both restricted and unrestricted resources are available for use, it is the District's policy to use restricted resources first.

Net Patient Service Revenue

Net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payors, and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payors. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and are adjusted in future periods as final settlements are determined.

Charity Care

The District provides care to patients who meet certain criteria under its charity care policy without charge or at amounts less than its established rates. The District maintains records to identify the amount of charges forgone for services and supplies furnished under the charity care policy. Because the District does not pursue collection of amounts determined to qualify as charity care, they are not reported as net patient service revenue.

Operating Revenue and Expenses

The District’s statement of revenues, expenses, and changes in net position distinguishes between operating and nonoperating revenue and expenses. Operating revenue results from exchange transactions associated with providing health care services. Nonexchange revenue, including taxes, investment gain, grants, contributions received for purposes other than capital asset acquisition, and certain other revenue, is reported as nonoperating revenue.

Note 1: Summary of Significant Accounting Policies (Continued)

Operating Revenue and Expenses (Continued)

Operating expenses are all expenses incurred to provide health care services, other than financing costs.

District Property Tax Revenue

The District has the authority to impose taxes on property within the boundaries of the health care district. Taxes are received from Inyo County (the "County"), which bills and collects the taxes for the District. Secured property taxes attach as an enforceable lien on property as of January 1 with a levy date on July 1, and are payable in two installments on November 1 and February 1.

Grants and Contributions

The District receives grants as well as contributions from individuals and private organizations. Revenue from grants and contributions (including contributions of capital assets) is recognized when all eligibility requirements, including time requirements, are met. Grants and contributions may be restricted for either specific operating purposes or capital purposes. Amounts that are unrestricted or are restricted to a specific operating purpose are reported as nonoperating revenue. Amounts restricted to capital acquisitions are reported after nonoperating revenue (expenses).

Unemployment Compensation

The District is a part of a pooled unemployment insurance group through California Association of Hospital and Healthcare Systems (CAHHS) for unemployment insurance and does not pay state unemployment tax. Balances overpaid were $19,962 in 2020.

Deferred Outflows/Inflows of Resources

In addition to assets, the statement of net position reports a separate section of deferred outflows of resources. This separate financial statement element, *deferred outflows of resources,* represents a consumption of net position that applies to future periods and so will not be recognized as an outflow of resources (expense) until then. The District has one item that qualifies for reporting in this category. The District reports deferred outflows of resources related to pensions for its proportionate share of collective deferred outflows of resources related to pensions and District contributions to pension plans subsequent to the measurement date of the collective net pension liability.

In addition to liabilities, the statement of net position reports a separate section of deferred inflows of resources. This separate financial statement element, *deferred inflows of resources,* represents an acquisition of net position that applies to future periods and so will not be recognized as an inflow of resources (revenue) until then. The District has one item that qualifies for reporting in this category.

Note 1: Summary of Significant Accounting Policies (Continued)

Deferred Outflows/Inflows of Resources (Continued)

The District reports deferred inflows of resources related to pensions for its proportionate share of collective deferred inflows of resources related to pensions.

Stewardship, Compliance, and Accountability

The District board did not adopt an annual budget in a public meeting on or before September 1 for the fiscal year ended June 30, 2020, in accordance with California State Health and Safety Code Section 32139.

Note 2: Reimbursement Arrangements With Third-Party Payors

The District has agreements with third-party payors that provide for reimbursement to the District at amounts that vary from its established rates. A summary of the basis of reimbursement with major third-party payors follows:

Hospital

Medicare – The Medicare program has designated the District as a critical access hospital (CAH) for Medicare reimbursement purposes. Under this designation, District inpatient, outpatient, and swing bed services rendered to Medicare program beneficiaries are paid based on a cost-reimbursement methodology, with the exception of certain lab and mammography services, which are reimbursed based on fee schedules.

Medi-Cal – Under CAH designation, the District inpatient and swing bed services rendered to Medi-Cal program beneficiaries were paid on a cost-based reimbursement methodology through June 30, 2015. As of July 1, 2015, the State of California established rates are based on the most recently audited cost report for the District. There are no settlements for cost based methods after June 30, 2015. The reimbursement for outpatient services is based on a fee schedule. Starting in 2014, the State of California expanded the provision of coverage to managed care organization in rural California. The District applied for and received supplemental reimbursements for its inpatient and outpatient services during 2020. The supplemental reimbursements are based on a cost based reimbursement method. This method does not guarantee that all cost are recovered after the Federal match and administrative fees are paid.

Physician and Professional Services in Rural Health Clinics

Certain physician and professional services rendered to Medicare and Medi-Cal beneficiaries qualify for reimbursement as Medicare-approved rural health clinic services. Qualifying services are reimbursed based on a cost-reimbursement methodology.

Note 2: Reimbursement Arrangements With Third-Party Payors (Continued)

Hospital Based and Free Standing Physicians and Professional Services

The District has entered into payment agreements with certain commercial insurance carriers, health maintenance organizations, and preferred provider organizations. The basis for payment to the District under these agreements includes discounts from established charges and prospectively determined daily rates.

Accounting for Contractual Arrangements

The District is reimbursed for certain cost-reimbursable items at an interim rate, with final settlements determined after an audit or review of the District's related annual cost reports by the Medicare Administration Contractor. Estimated provisions to approximate the final expected settlements are included in the accompanying statements of net position as due to third-party reimbursement provisions. The cost reports for the District have been final settled through June 30, 2016.

Other Governmental Program Revenue

Supplemental and incentive payments from other governmental programs are netted within net patient service revenue in the statement of revenues, expenses, and changes in net position as a component of contractual adjustments. These amounts include Assembly Bill No. 915 (AB915) incentive income, California Hospital Quality Assurance Fee (HQAF) program, and other supplemental income from Anthem and California Health and Wellness (CHW).

Compliance

The health care industry is subject to numerous laws and regulations of federal, state, and local governments. Compliance with these laws and regulations, particularly those relating to the Medicare and Medi-Cal programs, can be subject to government review and interpretation, as well as regulatory actions unknown and unasserted at this time. Violation of these laws and regulations could result in the imposition of fines and penalties, as well as repayments of previously billed and collected revenue from patient services.

CMS uses recovery audit contractors (RACs) to search for potentially inaccurate Medicare payments that might have been made to health care providers and that were not detected through existing CMS program integrity efforts. Once the RAC identifies a claim it believes is inaccurate, the RAC makes a deduction from or addition to the provider's Medicare reimbursement in an amount estimated to equal the overpayment or underpayment. As of June 30, 2020, the District has not been notified by the RAC of any potential significant reimbursement adjustments.

Note 3: Cash and Cash Equivalents and Investments

Investments

The table below identifies the investment types that are authorized for the District by the CGC. The table also identifies certain provisions of the CGC that address interest rate risk, credit risk, and concentration of credit risk. This table does not address investments of debt proceeds held by bond trustee that are governed by the provisions of debt agreements of the District, rather than the general provisions of the CGC.

Authorized investment type:	Maximum maturity:	Maximum percentage of portfolio:*	Maximum investment in one issuer:
Local agency bonds	5 years	None	None
U.S. Treasury obligations	5 years	None	None
U.S. agency securities	5 years	None	None
Banker's acceptances	180 days	40%	30%
Commercial paper	270 days	25%	10%
Negotiable certificates of deposit	5 years	30%	None
Repurchase agreements	1 year	None	None
Reverse repurchase agreements	92 days	20% of base value	None
Medium-term notes	5 years	30%	None
Mutual funds	N/A	20%	10%
Money market mutual funds	N/A	20%	10%
Mortgage pass-through securities	5 years	20%	None
County pooled investment funds	N/A	None	None
LAIF	N/A	None	None
JPA pools (other investment pools)	N/A	None	None

* Excluding amounts held by bond trustee that are not subject to CGC restrictions.

Interest Rate Risk - Interest rate risk is the risk that changes in market interest rates will adversely affect the fair value of an investment. Generally, the longer the maturity of an investment, the greater the sensitivity of its fair value to changes in market interest rates. One of the ways that the District manages its exposure to interest rate risk is by purchasing a combination of shorter term and longer term investments and by timing cash flows from maturities so that a portion of the portfolio is maturing or coming close to maturity evenly over time as necessary to provide the cash flow and liquidity needed for operations.

Note 3: Cash and Cash Equivalents and Investments (Continued)

Information about the sensitivity of the fair values of the District's investments to market interest rate fluctuations is provided by the following table that shows the distribution of the District's investments by maturity at June 30, 2020:

		Remaining Maturity (in Years)		
	Amount	0-1	1-5	5-10
Investments:				
LAIF	$ 23,241,610	$ 23,241,610	$ -	$ -
Money market mutual funds	2,439,155	2,439,155	-	-
Certificates of deposit	2,030,028	503,650	1,526,378	-
Guaranteed investment contracts	575,000	-	-	575,000
Fidelity mutual fund	292,841	292,841	-	-
Totals	$ 28,578,634	$ 26,477,256	$ 1,526,378	$ 575,000

Credit Risk - Generally, credit risk is the risk that an issuer of an investment will not fulfill its obligation to the holder of the investment. This is measured by the assignment of a rating by a nationally recognized statistical rating organization. The CGC limits the minimum rating required for each investment type. The LAIF is not rated.

Concentration of Credit Risk - No investments in any one issuer (other than U.S. Treasury securities, mutual funds, and external investment pools) represented 5% or more of the total District's total investments at June 30, 2020.

Custodial Credit Risk - Custodial credit risk for deposits is the risk that, in the event of the failure of a depository financial institution, a government will not be able to recover its deposits or will not be able to recover collateral securities that are in the possession of an outside party. The custodial credit risk for investments is the risk that, in the event of the failure of the counterparty (e.g., broker-dealer) to a transaction, a government will not be able to recover the value of its investment or collateral securities that are in the possession of another party. The CGC does not contain legal or policy requirements that would limit the exposure to custodial credit risk for deposits or investments, other than the following provision for deposits: The CGC requires that a financial institution secure deposits made by state or local governmental units by pledging securities in an undivided collateral pool held by a depository regulated under state law. The market value of the pledged securities in the collateral pool must equal at least 110% of the total amount deposited by the public agencies. California law also allows financial institutions to secure District deposits by pledging first trust deed mortgage notes having a value of 150% of the secured public deposits.

At June 30, 2020, the net carrying amount of deposits was $33,670,469, and the bank balance was $32,309,253. Of the bank balance, $750,000 was covered by federal deposit insurance, and $31,559,253 was collateralized (i.e., collateralized with securities held by the pledging financial institutions of at least 110% of the District's cash deposits, in accordance with the CGC).

Note 3: Cash and Cash Equivalents and Investments (Continued)

Investment in State Investment Pool - The District is a voluntary participant in the Local Agency Investment Fund (LAIF) that is regulated by the CGC under the oversight of the Treasurer of the State of California. The fair value of the District's investment in this pool is reported in the accompanying financial statements at amounts based upon the District's pro-rata share of the fair value provided by LAIF for the entire LAIF portfolio (in relation to the amortized cost of that portfolio). The balance available for withdrawal is based on the accounting records maintained by LAIF, which are recorded on an amortized cost basis.

Fair Value Measurements

Following is a description of the valuation methodologies used for assets measured at fair value.

Guaranteed investment contracts are valued at cost.

Certificates of deposit (CDs) are level 2 investments on the fair value hierarchy and mutual funds are level 1.

The methods described may produce a fair value calculation that may not be indicative of net realizable value or reflective of future values. Furthermore, while the District believes its valuation methods are appropriate and consistent with other market participants, the use of different methodologies or assumptions to determine fair value of certain financial instruments could result in a different fair value measurement at the reporting date.

The following tables set forth by level, within the fair value hierarchy, the District's assets at fair value at June 30, 2020:

	Fair Value Measurements Using			
	Level 1	Level 2	Level 3	Total Assets at Fair Value
Assets:				
Money market mutual funds	$ 2,439,155	$ -	$ -	$ 2,439,155
Fidelity mutual fund	292,841	-	-	292,841
CDs	-	2,030,028	-	2,030,028
Fair value	2,731,996	2,030,028	-	4,762,024
Investments not subject to fair value measurement or measured at cost:				
LAIF				23,241,610
Guaranteed investment contracts				575,000
Total investments				$ 28,578,634

Note 3: Cash and Cash Equivalents and Investments (Continued)

Employees' Retirement System - The District's governing body has the responsibility and authority to oversee the investment portfolio. Various professional investment managers are contracted to assist in managing the District's investments; all investment decisions are subject to California law and the investment policy established by the governing body. The District's investments are held by a trust company.

Pension Plan Investment Policy - Pension Trust Fund - Plan

The Plan's investment policy authorizes the Plan to invest in all investments allowed by state statue. These include deposits/investments in insured commercial banks, savings and loan institutions, interest-bearing obligations of the U.S. Treasury and U.S. agencies, interest-bearing bonds of the State of California or any county, township, or municipal corporation of the State of California, money market mutual funds whose investments consist of obligations of the U.S. Treasury or U.S. agencies, separate accounts managed by life insurance companies, mutual funds, and California Funds (created by the State Legislature under the control of the State Treasurer that maintains a $1 per share value, which is equal to the participant's fair value). During the year ended June 30, 2020, there were no changes to the investment policy.

Pension Plan Investment Policy - Pension Trust Fund - PEPRA Plan

The PEPRA Plan's investment policy authorizes the Plan to invest in all investments allowed by state statue. These include deposits/investments in insured commercial banks, savings and loan institutions, interest-bearing obligations of the U.S. Treasury and U.S. agencies, interest-bearing bonds of the State of California or any county, township, or municipal corporation of the State of California, money market mutual funds whose investments consist of obligations of the U.S. Treasury or U.S. agencies, separate accounts managed by life insurance companies, mutual funds, and California Funds (created by the State Legislature under the control of the State Treasurer that maintains a $1 per share value which is equal to the participant's fair value). During the year ended June 30, 2020, there were no changes to the investment policy.

Credit Risk - Pension Trust Fund - Plan and PEPRA Plan

Credit risk is the risk that an issuer of an investment will not fulfill its obligation to the holder of the investment. This is measured by assignment of a rating by a nationally recognized statistical rating organization. The Plan and PEPRA Plan have investment policies that limit investment choices by credit rating.

Custodial Credit Risk - Pension Trust Fund - Plan and PEPRA Plan

For an investment, custodial credit risk is the risk that, in the event of the failure of the counter party (e.g., broker-dealer) to the transaction, the Plan and PEPRA Plan will not be able to recover the value of its investment or collateral securities that are in the possession of another party. The Plan and PEPRA Plans' investment policies do not limit the exposure to custodial credit risk for investments.

The District's retirement system investments are stated at net asset value (NAV) and fair value. The fixed dollar fund is stated at NAV, which is determined based on the total value of all investments in its portfolio minus the value of liabilities.

Note 3: Cash and Cash Equivalents and Investments (Continued)

The index bond fund is stated at fair value and is considered a level 2 investment on the fair value hierarchy. The fixed dollar fund is stated at cost.

Following is a summary of the Plan's investments at December 31:

	2019
Fixed dollar fund	$ 8,710,715
Indexed bond fund	11,993,105
Totals	$ 20,703,820

Following is a summary of the PEPRA Plan's investments at December 31:

	2019
Cash	$ 130,977
Totals	$ 130,977

Restricted cash and investments consisted of the following at June 30:

	2020
Restricted cash and investments:	
Building and improvement fund	$ 1,397,732
Nursing scholarship fund	170,626
Debt service reserve funds held with fiscal agent	3,014,155
Total restricted cash and investments	$ 4,582,513

Note 4: Patient Receivables - Net

Patient receivables - net consisted of the following at June 30:

	2020
Gross accounts receivable	$ 42,711,368
Less:	
Contractual adjustments	18,987,999
Allowance for uncollectible accounts	7,601,614
Patient receivables - Net	$ 16,121,755

Note 4: Patient Receivables - Net (Continued)

The District gross days in accounts receivable was 98.05 at June 30, 2020.

Note 5: Net Patient Service Revenue

Net patient service revenue for the District and component units consisted of the following for the year ended June 30:

	2020
Gross patient service revenue:	
Inpatient services	$ 42,561,188
Outpatient services	116,443,226
Totals	159,004,414
Less:	
Contractual adjustments	60,012,184
Provision for uncollectible accounts	17,170,227
Net patient service revenue	$ 81,822,003

The following table reflects the percentage of gross patient service revenue by payor source for the year ended June 30:

	2020
Medicare	43 %
Medi-Cal	20 %
Other third-party payors	35 %
Patients	2 %
Total	100 %

Note 6: Charity Care

The District provides health care services and other financial support through various programs that are designed, in part, to enhance the health of the community, including the health of low-income patients. Consistent with the mission of the District, care is provided to patients regardless of their ability to pay, including providing services to those persons who cannot afford health insurance because of inadequate resources.

Note 6: Charity Care (Continued)

Patients who meet certain criteria for charity care, generally based on federal poverty guidelines, are provided care based on criteria defined in the District's charity care policy. The District maintains records to identify and monitor the level of charity care it provides. The amount of charges foregone for services and supplies furnished under the District's charity care policy aggregated approximately $375,000 for the year ended June 30, 2020. The estimated cost of providing care to patients under the District's charity care policy aggregated approximately $227,000 in 2020. The cost was calculated by multiplying the ratio of cost to gross charges for the District times the gross uncompensated charges associated with providing charity care.

Note 7: Capital Assets

The District's capital assets activity consisted of the following:

	Balance July 1, 2019	Additions	Transfers	Deletions	Balance June 30, 2020
Nondepreciable capital assets:					
Land	$ 865,330	$ -	$ -	$ -	$ 865,330
Construction in progress	818,411	2,112,633	-	-	2,931,044
Total nondepreciable capital assets	1,683,741	2,112,633	-	-	3,796,374
Depreciable capital assets:					
Land improvements	867,086	-	-	-	867,086
Buildings	89,147,070	-	(3,539)	-	89,143,531
Equipment	35,988,063	422,665	3,539	(476,552)	35,937,715
Total depreciable capital assets	126,002,219	422,665	-	(476,552)	125,948,332
Less - Accumulated depreciation:					
Land improvements	691,088	30,375	-	-	721,463
Buildings	20,767,998	2,404,420	-	-	23,172,418
Equipment	28,547,594	1,867,199	-	(440,164)	29,974,629
Total accumulated depreciation	50,006,680	4,301,994	-	(440,164)	53,868,510
Net depreciable capital assets	75,995,539	(3,879,329)	-	(36,388)	72,079,822
Totals	$ 77,679,280	$ (1,766,696)	$ -	$ (36,388)	$ 75,876,196

At June 30, 2020, construction in progress consisted of pharmacy clean room, major equipment, lab software, and a building retrofit.

Note 7: Capital Assets (Continued)

PMA's capital assets activity consisted of the following:

	Balance January 1, 2019	Additions	Deletions	Balance December 31, 2019
Nondepreciable capital assets - Land	$ 352,694	$ 719	$ -	$ 353,413
Depreciable capital assets - Buildings	1,076,193	-	(717)	1,075,476
Less - Accumulated depreciation	867,937	14,564	-	882,501
Net depreciable capital assets	208,256	(14,564)	(717)	192,975
Totals	$ 560,950	$ (13,845)	$ (717)	$ 546,388

Note 8: Long-Term Debt and Capital Lease Obligations

Long-term debt and capital lease obligations activity consisted of the following:

	July 1, 2019	Additions	Reductions	June 30, 2020	Amounts due within 1 year
Bonds - Direct placements:					
2016 General Obligation Refunding Bond	$ 16,710,000	$ -	$ (293,000)	$ 16,417,000	$ 299,000
General Obligation Bonds, 2009 Series:					
Current Interest Bonds	865,000	-	(865,000)	-	-
Capital Appreciation Bonds	8,144,947	-	-	8,144,947	418,000
Revenue Bonds, 2010 Series	6,680,000	-	(785,000)	5,895,000	835,000
Revenue Bonds, 2013 Series	9,440,000	-	(350,000)	9,090,000	360,000
Subtotal bonds payable	41,839,947	-	(2,293,000)	39,546,947	1,912,000
Bond premiums:					
General Obligation Bonds:					
2009 Series	353,842	-	(37,645)	316,197	-
Revenue Bonds, 2013 Series	127,953	-	(15,053)	112,900	-
Total bonds payable	42,321,742	-	(2,345,698)	39,976,044	1,912,000
Accreted Interest - General Obligation Bonds, 2009 Series	13,520,264	833,716	-	14,353,980	-
Capital lease obligations - Direct borrowings:					
Orchard Software	82,293	-	(70,360)	11,933	11,933
Intuitive Surgical	1,755,218	-	(264,543)	1,490,675	310,553
7 Medical	325,264	-	(57,871)	267,393	54,448
Total capital lease obligations	2,162,775	-	(392,774)	1,770,001	376,934
Direct borrowings:					
PPP loan	-	8,927,628	-	8,927,628	-
PHH mortgage	266,448	-	(438)	266,010	4,847
CMS advance	-	14,594,154	-	14,594,154	1,824,269
Totals	$ 58,271,229	$ 24,355,498	$ (2,738,910)	$ 79,887,817	$ 4,118,050

Note 8: Long-Term Debt and Capital Lease Obligations (Continued)

Long-Term Debt

General Obligation Bonds, 2009 Series

On April 21, 2009, the District issued $14,464,947 in General Obligation Bonds, 2005 Election, 2009 Series to finance the construction and equipping of an expansion and renovation of the Hospital. The 2009 Bonds consist of two types of bonds, Current Interest Bonds and Capital Appreciation Bonds, issued in the amounts of $6,320,000 and $8,144,947, respectively.

Principal on the Current Interest Bonds is payable annually on November 1. Current Interest Bonds mature annually commencing on November 1, 2012, through November 1, 2019, in amounts ranging from $60,000 to $865,000, as well as a bond maturing on November 1, 2038, for $3,150,000. Interest on the Capital Appreciation Bonds is accreted annually and paid at maturity. The Capital Appreciation Bonds mature annually commencing on November 1, 2020, through November 1, 2038, in amounts ranging from $1,020,000 to $3,420,000, including interest accreted through such maturity dates.

The Current Interest Bonds maturing on November 1, 2038, may be called by the District beginning November 1, 2017. The Capital Appreciation Bonds are not subject to redemption prior to their fixed maturity dates. The Current Interest Bond debt was partially extinguished in 2016 using proceeds from the issuance of the 2016 General Obligation Refunding Bond.

The District has pledged its tax revenue as security for the General Obligation Bonds, 2009 Series and these obligations contain a provision that in an event of default, the outstanding amounts become immediately due if the District is unable to make a payment.

Revenue Bonds, 2010 Series

On April 14, 2010, the District issued $11,600,000 in Revenue Bonds, 2010 Series to finance the replacement hospital, finance the bond reserve account, and pay certain costs of issuance related to the 2010 Bonds.

Interest on the 2010 Bonds is payable semiannually on June 1 and December 1 at rates ranging from 5.000% to 6.375%. Mandatory sinking fund deposits to retire the bonds on their term maturity dates, ranging from $510,000 to $1,145,000, are due annually through December 2025.

The 2010 Bonds maturing on December 1, 2021, may be called by the District beginning December 1, 2016.

The District has pledged its gross revenue as security for the Revenue Bonds, 2010 Series and these obligations contain a provision that in an event of default, the outstanding amounts become immediately due if the District is unable to make a payment.

The District is required to maintain a long-term debt service coverage ratio at the end of each fiscal year that is not less than 1.25 to 1 (or 1.1 to 1, if the District has 75 or more days cash on hand) and provide various reporting under the agreement.

Note 8: Long-Term Debt and Capital Lease Obligations (Continued)

Revenue Bonds, 2013 Series

On January 17, 2013, the District issued $11,335,000 in Revenue Bonds, 2013 Series to finance the replacement hospital, finance the bond reserve account, and pay certain costs of issuance related to the 2013 Bonds.

Interest on the 2013 Bonds is payable semi-annually on June 1 and December 1 at rates ranging from 3.875% to 5.000%. Mandatory sinking fund deposits to retire the bonds on their term maturity dates, ranging from $295,000 to $1,805,000, are due annually through December 2029.

The 2013 Bonds maturing on December 1, 2027, may be called, without premium, by the District on December 1, 2013, through December 1, 2015.

The District has pledged its gross revenue as security for the Revenue Bonds, 2013 Series and these obligations contain a provision that in an event of default, the outstanding amounts become immediately due if the District is unable to make a payment.

The District is required to maintain a long-term debt service coverage ratio at the end of each fiscal year that is not less than 1.25 to 1 (or 1.1 to 1, if the District has 75 or more days cash on hand) and provide various reporting under the agreement.

Direct placements:

2016 General Obligation Refunding Bond

On May 12, 2016, the District issued $17,557,000 in a 2016 General Obligation Refunding Bond, to refinance the General Obligation Bonds, 2005 Series in whole and to pay the term portion of General Obligation Bonds, 2009.

Interest on the 2016 bond is payable semiannually on November 1 and May 1 at a rate of 3.450%. Mandatory sinking fund deposits to retire the bonds on their term maturity dates, ranging from $278,000 to $1,874,000, are due annually through December 2035.

The District has pledged its tax revenue as security for the 2016 General Obligation Refunding Bond and these obligations contain a provision that in an event of default, the outstanding amounts become immediately due if the District is unable to make a payment.

Direct borrowings:

Capital Lease Obligations

Lease obligations to Orchard Software are due in total monthly installments of $5,989 in October 2018 through 2021, including interest at 3.000%.

Note 8: Long-Term Debt and Capital Lease Obligations (Continued)

Lease obligations to Intuitive Surgical are due in total monthly installments of $24,344 in March 2019 through 2024, including interest at 3.500%.

Lease obligations to Ascension Capital for 7 Medical are due in total monthly installments of $5,447 in October 2018 through 2025, including interest at 2.500%.

Capital lease obligations are secured by equipment and contain provisions that in an event of default, the outstanding amounts become immediately due if the District is unable to make a payment.

Paycheck Protection Program loan

The District was granted a $8,927,628 loan under the Paycheck Protection Program (PPP) administered by a Small Business Administration (SBA) approved partner. The loan is uncollateralized and is fully guaranteed by the Federal government. The District is eligible for loan forgiveness of up to 100% of the loan, upon meeting certain requirements. The District has recorded a note payable and will record the forgiveness upon being legally released from the loan obligation by the SBA. No forgiveness income has been recorded for the year ended June 30, 2020. The District applied for forgiveness of the PPP loan in March 2021 and is awaiting SBA approval. The District will be required to repay any remaining balance, plus interest accrued at 1 percent due at the maturity date of April 30, 2022. The terms of the loan provide for customary events of default including, among other things, payment defaults, breach of representations and warranties, and insolvency events. The loan may be accelerated upon the occurrence of an event of default.

CMS Advance

The CMS advance liability consists of advanced payments received from the Centers for Medicare & Medicaid Services (CMS), in order to increase cash flow for Medicare Part A providers who were impacted by the COVID-19 pandemic. The District received $14,594,154 in an advanced payment during April 2020, which will be recouped through the Medicare claims processed beginning 365 days after the date of issuance of the advanced payment. This recoupment process will continue until the balance of the advanced payment has been recouped or for 29 months from the date that the advanced payment was issued, at which point any remaining unpaid balance is due. The advanced payment balance is non-interest-bearing through the 29-month repayment period. The outstanding balance at June 30, 2020, was $14,594,154.

Advanced Refunding

The District issued $17,557,000 in General Obligation Refunding Bonds (“2016 GOR Bond") with interest rates of 3.45% in November 2016. The proceeds were used to advance refund and considered defeased $3,150,000 of outstanding General Obligation Bonds Election of 2005, Series 2009 (“2009 GO Bond”), which had interest rates of 5.75% and General Obligation Bonds Election of 2005, Series 2005 (“2005 GO Bond”), which had varying interest rates of 6.00% to 4.25%. Net proceeds of $17,281,182 were derived from the issuance of the 2016 GOR bonds at par, including a $9,103 premium, and after payment of $275,818 in underwriting fees.

Note 8: Long-Term Debt and Capital Lease Obligations (Continued)

Of the net proceeds, $17,281,182 was deposited in an irrevocable trust with an escrow agent to provide funds for the future debt service payment on the 2005 GO Bond and 2009 GO Bond, and $276,071 was used for issuance and other costs. As a result, the 2005 GO Bond and 2009 GO Bonds are considered defeased, and the liability for those bonds has been removed from the statements of net position. At June 30, 2020, the outstanding balance of the 2009 GO Bond was $22,991,176, including accreted interest.

Scheduled principal and interest payments on long-term obligations are as follows:

	General obligation bonds		Revenue bonds		Direct borrowings	
Years Ending June 30,	Principal	Interest	Principal	Interest	Principal	Interest
2021	$ 717,000	$ 1,176,340	$ 1,195,000	$ 745,913	$ 1,829,116	$ 13,190
2022	767,307	1,245,938	1,260,000	680,019	19,270,249	12,942
2023	847,032	1,291,969	1,330,000	608,569	2,437,714	12,682
2024	1,054,855	1,210,614	1,405,000	531,203	250,713	9,332
2025	1,106,909	1,294,596	1,480,000	449,306	-	-
2026-2030	6,642,764	7,869,445	8,315,000	1,001,947	-	-
2031-2035	9,682,353	10,027,885	-	-	-	-
2036-2040	3,743,727	10,422,678	-	-	-	-
Totals	$ 24,561,947	$ 34,539,465	$ 14,985,000	$ 4,016,957	$ 23,787,792	$ 48,146

Direct borrowings:	Capital Leases
Years Ending June 30,	Principal and Interest Payments
2021	$ 430,191
2022	423,140
2023	423,140
2024	572,624
2025	55,137
Less: Amounts attributable to interest	(134,231)
Total	$ 1,770,001

Note 8: Long-Term Debt and Capital Lease Obligations (Continued)

Pledged Revenue

The District has pledged future revenue to repay $11,600,000 million in District revenue bonds issued in March 2010. Proceeds from the bonds are to provide a portion of the funding for its replacement hospital project. The bonds are payable solely from revenues through 2025. The total principal and interest remaining to be paid on the bonds is $7,084,856. Revenue for the current year and principal and interest paid were $92,291,088 and $1,177,888, respectively.

The District has pledged future revenue to repay $11,335,000 in District revenue bonds issued in January 2013. Proceeds from the bonds are to provide a portion of the funding for its remodeling, expansion, improvement, and equipping of the facility. The bonds are payable solely from revenues through 2029. The total principal and interest remaining to be paid on the bonds is $12,682,481. Revenue for the current year and principal and interest paid were $92,291,088 and $765,381, respectively.

Note 9: Retirement Plans

Defined Benefit Plan - The Plan

Plan Description

The District sponsors a single-employer defined benefit pension plan for employees over age 21 with at least one year of service. The plan is governed by the District's Board of Directors, which may amend benefits and other plan provisions and which is responsible for the management of plan assets. The primary factors affecting the benefits earned by participants in the pension plan are employees' years of service and compensation levels. A separate financial report is not prepared for the Plan.

Benefits Provided

The District provides service retirement and pre-retirement death benefits to plan members, who must be District employees and beneficiaries. Benefits are based on years of credited service, equal to one year of full-time employment. Members with five years of total service are eligible to retire at age 55 with statutorily reduced benefits. All members are eligible for pre-retirement death benefits after five years of service. The benefit vesting schedule is 50% vesting after five years, increasing 10% per year to 100% vested after 10 years of service. The Plan was closed to new entrants effective January 1, 2013.

Active participants automatically become 100% vested upon attainment of normal retirement age or if they become totally and permanently disabled.

Note 9: Retirement Plans (Continued)

The Plan's provisions and benefits in effect at June 30, 2020, are summarized as follows:

Hire date	Prior to January 1, 2013
Benefit Payments	Life Annuity
Retirement Age	65-70
Monthly benefits, as a % of eligible compensation	2.50%, not less than $600
Required employer contribution rates	22.1% of applicable payroll

Employees covered at December 31, 2019, by the benefit terms for the Plan are as follows:

Inactive employees or beneficiaries currently receiving benefits	74
Active employees	142
Total	216

Change in Assumptions

The following changes in assumptions from the December 31, 2018, valuation to the December 31, 2019, valuation took place. The discount rate decreased from 5% to 4% to reflect a decrease in anticipated future investment returns. The salary scale assumption decreased from 4% to 3%. The form of payment assumption was changed from 60% lump sum/40% annuity to 50% lump sum/50% annuity, based on retiree elections.

The mortality assumption for valuing annuity liabilities has been updated to incorporated the MP-2019 projection scale which was published by the Society of Actuaries in October 2019, which is applied as a generational projection to the RP-2014 Mortality Table started from a base year of 2006, and replaces the MP-2018 projection scale that was reflected in the December 31, 2018 valuation. These assumption changes increased the present value of accumulated plan benefits by $7,316,149.

Contributions

The employer contribution rates are determined on an annual basis by the actuary and shall be effective on July 1 following notice of a change in the rate. Funding contributions for the Plan are determined annually on an actuarial basis as of January 1 by the Plan. The actuarially determined rate is the estimated amount necessary to finance the costs of benefits earned by employees during the year, with an additional amount to finance any unfunded accrued liability. For the years ended June 30, 2020 and 2019, the employer contribution was $5,500,000 and $4,257,000, respectively.

Net Pension Liability

The District's net pension liability for the Plan is measured as the total pension liability, less the pension plan's fiduciary net position. The net pension liability of the Plan is measured as of December 31, 2019, using an annual actuarial valuation as of December 31, 2019.

Note 9: Retirement Plans (Continued)

The total pension liability in the December 31, 2019, actuarial valuations were determined using the following actuarial assumptions:

Valuation date (actuarial valuation date)	December 31, 2019
Measurement date (net pension liability measured)	December 31, 2019
Actuarial cost method	Entry-Age Normal Cost Method
Actuarial assumptions	
Discount rate	4.00%
Projected salary increase	3.00%
Investment rate of return	4.00%
Mortality: Pre-retirement	RP-2014 Healthy Mortality w/generational projection from 2006, base year using scale MP-2019.
Mortality: Post-retirement (annuity elected)	RP-2014 Healthy Mortality w/generational projection from 2006, base year using scale MP-2019.
Mortality: Post-retirement (lump sum elected)	Based on date of participation DOP before 7/1/2009: 1984 UP, Mortality table set back four years. DOP on/after 7/1/2009: RP-2000. Table for males set back four years.

Investment Valuations

Investments with a maturity of less than one year when purchased, nonnegotiable certificates of deposit, and other nonparticipating investments are stated at cost or amortized cost. All other investments in the Plan are stated at fair value and are recorded as of the trade date. The Plan categorizes the fair value measurements within the fair value hierarchy established by GAAP.

Concentration of Credit Risk

The Plan's policy does not limit the percentage of any asset in the Plan portfolio. The composition of plan assets consisted of the following at June 30, 2020:

Asset Allocation	Percent of Total Plan Assets
Fixed dollar account	37.8 %
Indexed bond fund	49.7 %
Accrued contributions	12.5 %
Total	100.0 %

Note 9: Retirement Plans (Continued)

Investment Rate of Return

For the year ended June 30, 2020, the annual money-weighted rate of return on Plan investments, net of investment expense, was 8.74%. The money-weighted rate of return expresses investment performance, net of investment expense, adjusted for the changing amounts actually invested

The table below reflects the long-term expected real rate of return by asset class. The rate of return was calculated using the capital market assumptions applied to determine the discount rate and asset allocation. These rates of return are net of administrative expenses.

Asset Class	Asset Allocation	Long-Term Expected Real Rate of Return
Cash	0.41 %	2.25 %
U.S. fixed income	59.34 %	3.54 %
U.S. governmental bonds	5.69 %	3.05 %
U.S. credit bonds	9.96 %	4.16 %
U.S. mortgages	6.91 %	3.62 %
U.S. bank/leveraged loans	11.99 %	4.93 %
U.S. high yield bonds	2.44 %	5.20 %
Private equity	2.85 %	12.12 %
Hedge funds - Multi-strategy	0.41 %	5.64 %
Total	100.00 %	

Note 9: Retirement Plans (Continued)

Changes in the Net Pension Liability

The changes in the net pension liability of the Plan, measured at December 31, 2019, are as follows for the year ended June 30, 2020:

Increase (decrease)	Total Pension Liability	Plan Fiduciary Net Position	Net Pension Liability (Asset)
June 30, 2019	$ 56,095,285	$ 22,084,009	$ 34,011,276
Changes for the year:			
Service cost	1,781,772	-	1,781,772
Interest on total pension liability	2,694,973	-	2,694,973
Differences between actual and expected experience	2,640,361	-	2,640,361
Changes in assumptions	6,850,017	-	6,850,017
Benefit payments	(8,053,422)	(8,053,422)	-
Contributions - Employer	-	5,242,000	(5,242,000)
Net investment income	-	1,893,587	(1,893,587)
Administrative expense	-	(58,625)	58,625
June 30, 2020	$ 62,008,986	$ 21,107,549	$ 40,901,437

The following presents the net pension liability of the District's Plan, calculated using the discount rate, as well as what the District's net pension liability would be if it were calculated using a discount rate that is one-percentage point lower or one-percentage point higher than the current rate:

	2020
1% decrease	3.00%
Net pension liability	$49,598,179
Current discount rate	4.00%
Net pension liability	$40,901,437
1% increase	5.00%
Net pension liability	$33,692,797

The District recognized pension expense of $3,185,248 and $5,222,823 in 2020 and 2019, respectively.

Note 9: Retirement Plans (Continued)

At June 30, 2020, the District reported deferred outflows of resources and deferred inflows of resources related to pensions from the following sources:

	Deferred Inflows of Resources	Deferred Outflows of Resources
Pension contributions made subsequent to the measurement date	$ -	$ 3,000,000
Differences between expected and actual experience	(1,780,425)	6,149,594
Changes in assumptions	(1,009,581)	11,787,760
Net differences between projected and actual earnings on plan investments	-	1,010,286
Totals	$ (2,790,006)	$ 21,947,640

Contributions made after the measurement date in the amount of $3,000,000 are included in the balance of deferred outflows of resources and will be recognized in pension expense during the year ending June 30, 2021.

Other amounts reported as deferred outflows of resources and deferred inflows of resources related to pensions will be recognized as pension expense as follows:

Years Ending June 30,	
2021	$ 3,297,384
2022	2,998,286
2023	2,699,904
2024	2,620,595
2025	1,325,959
Thereafter	3,215,506
Total	$ 16,157,634

Defined Benefit Plan - The PEPRA Plan

Plan Description

The District sponsors a defined benefit pension plan (the "PEPRA Plan"), a single-employer defined benefit plan for the former Chief Executive Officer (CEO). The PEPRA Plan is governed by the Board of Directors, which may amend benefits and other plan provisions and which is responsible for the management of plan assets. The primary factors affecting the benefits earned by participants in the pension plan are employees' years of service and compensation levels. A separate financial report is not prepared for the PEPRA Plan.

Note 9: Retirement Plans (Continued)

Benefits Provided

The District provides service retirement and pre-retirement death benefits to plan members, who must be District employee holding the position of Chief Executive Officer and beneficiaries. Benefits are based on years of credited service, equal to one year of full-time employment. Members with five years of total service are eligible to retire at age 62 with statutorily reduced benefits. All members are eligible for early retirement benefits at age 52 with at least 5 years of credited services with reduced benefits. The benefit vesting schedule is 100% vesting after five years of credited service, or upon total and permanent disability. The plan is closed to new entrants.

The PEPRA Plan's provisions and benefits in effect at June 30, 2020, are summarized as follows:

Hire date	Beginning January 1, 2016
Benefit Payments	Life Annuity
Retirement Age	62 or 5th anniversary of participant
Monthly benefits, as a % of eligible compensation	2% of Average Annual Compensation multiplied by years of Credited Service
Required employee contribution rates	11.75% of applicable payroll
Required employer contribution rates	11.52% of applicable payroll

Employees covered at December 31, 2019, by the benefit terms for the PEPRA Plan are as follows:

Inactive employees or beneficiaries currently receiving benefits	-
Active employees	1
Total	1

Contributions

The employer contribution rates are determined on an annual basis by the actuary and shall be effective on July 1 following notice of a change in the rate. Funding contributions for the PEPRA Plan are determined annually on an actuarial basis as of January 1 by the PEPRA Plan. The actuarially determined rate is the estimated amount necessary to finance the costs of benefits earned by employees during the year, with an additional amount to finance any unfunded accrued liability.

The District's net pension liability for the PEPRA Plan is measured as the total pension liability, less the pension plan's fiduciary net position. The net pension liability of the PEPRA Plan is measured as of June 30, 2020, using an annual actuarial valuation as of January 1, 2020, rolled forward to June 30, 2020, using standard update procedures. A summary of principal assumptions and methods used to determine the net pension liability is shown on the next page.

Note 9: Retirement Plans (Continued)

The total pension liabilities in the January 1, 2020, actuarial valuations were determined using the following actuarial assumptions:

Valuation date (actuarial valuation date)	December 31, 2019
Measurement date (net pension liability measured)	December 31, 2019
Actuarial cost method	Entry-Age Normal Cost Method
Actuarial assumptions	
Discount rate	N/A
Inflation	N/A
Payroll growth	N/A
Investment rate of return	N/A
Mortality: Pre-retirement	N/A
Mortality: Post-retirement (annuity elected)	N/A

The table below reflects the long-term expected real rate of return by asset class. The rate of return was calculated using the capital market assumptions applied to determine the discount rate and asset allocation. These rates of return are net of administrative expenses.

Asset Class	Target Asset Allocation	Long-Term Expected Real Rate of Return
U.S. fixed income	60.00 %	4.23 %
Global equity	40.00 %	7.90 %
Total	100.00 %	

Note 9: Retirement Plans (Continued)

Changes in the net pension liability

The changes in the net pension liability of the PEPRA Plan measured as of December 31, 2019, are as follows for the year ended June 30, 2020:

	Increase (decrease)		
	Total Pension Liability	Plan Fiduciary Net Position	Net Pension Liability (Asset)
June 30, 2019	$ 105,044	$ 87,279	$ 17,765
Changes for the year:			
Service cost incurred	28,238	-	28,238
Interest on total pension liability	6,664	-	6,664
Differences between expected and actual experience	(78,051)	-	(78,051)
Contributions - Employee	-	18,209	(18,209)
Contributions - Employer	-	35,975	(35,975)
Current-year net changes	(43,149)	54,184	(97,333)
June 30, 2020	$ 61,895	$ 141,463	$ (79,568)

The following presents the net pension liability of the District's PEPRA Plan, calculated using the discount rate, as well as what the District's net pension liability (asset) would be if it were calculated using a discount rate that is one-percentage point lower or one-percentage point higher than the current rate:

1% decrease	4.00%
Net pension liability (asset)	$(79,568)
Current discount rate	5.00%
Net pension liability (asset)	$(79,568)
1% increase	6.00%
Net pension liability (asset)	$(79,568)

Note 9: Retirement Plans (Continued)

The District recognized pension income of $64,434 in 2020. At December 31, 2019, the members are active; however, the PEPRA Plan no longer has active members. At June 30, 2020, the District reported deferred outflows of resources and deferred inflows of resources related to pensions from the following sources:

	Deferred Inflows of Resources	Deferred Outflows of Resources
Differences between actual and expected experience	$ (285)	$ 59
Changes in assumptions	(671)	-
Net differences between projected and actual earning on plan investments	-	8,261
Totals	$ (956)	$ 8,320

Other amounts reported as deferred outflows of resources and deferred inflows of resources related to pensions will be recognized as pension expense as follows:

Years Ending June 30,	Increase (Decrease) in Pension Expense
2021	$ 2,628
2022	2,400
2023	1,827
2024	1,054
2025	(88)
Thereafter	(457)
Total	$ 7,364

The deferred outflows of resources, deferred inflows of resources, and net pension liability of the Plan and PEPRA Plan are presented in the statement of net position at June 30, 2020, as follows:

	Deferred outflows of resources	Deferred inflows of resources	Net pension liability (asset)
Plan	$ 21,947,640	$ 2,790,006	$ 40,901,437
PEPRA Plan	8,320	956	(79,568)
Totals	$ 21,955,960	$ 2,790,962	$ 40,821,869

Note 9: Retirement Plans (Continued)

Defined Contribution Plan

The District sponsors and contributes to the Northern Inyo County Local Hospital District 401(a) Retirement Plan (NICLHD), a defined contribution pension plan, for its employees. The plan covers its employees who have attained the age of 21 years and were not a participant in the District's defined benefit plan prior to January 1, 2013, and completed of one year of service. NICLHD is administered by the District.

Benefit terms, including contribution requirements, for NICLHD are established and may be amended by the District's Board of Directors. For each employee in the pension plan, the District is required to contribute 7% as a percent of annual salary, exclusive of overtime pay, to an individual employee account. Employees are not permitted to make contributions to the pension plan. For the year ended June 30, 2020, the District made employer contributions in the amount of $789,151.

Each participant shall have a nonforfeitable and vested right to his or her account for each year of service completed while an employee of the employer, in accordance with the following schedule:

Years	Nonforfeitable Percentage
5	50.0 %
6	60.0 %
7	70.0 %
8	80.0 %
9	90.0 %
10 or more	100.0 %

Contributions payable to NICLHD by the District were $1,142,614 during the year ended June 30, 2020.

Nonvested District contributions are forfeited upon termination of employment. Such forfeitures are used to cover a portion of the pension plan's administrative expenses.

Note 10: Risk Management

The District is exposed to various risks of loss related to medical malpractice; torts; theft of, damage to, and destruction of assets; errors and omissions; injuries of employees; and natural disasters.

The District's comprehensive general liability insurance covers losses of up to $20,000,000 per claim with $30,000,000 annual aggregate for occurrence basis during a policy year regardless of when the claim was filed (occurrence-based coverage). The District's professional liability insurance covers losses up to $5,000,000 per claim with $5,000,000 annual aggregate for claims reported during a policy year (claims-made coverage). Under a claims-made policy, the risk for claims and incidents not asserted within the policy period remains with the District.

Note 10: Risk Management (Continued)

Although there exists the possibility of claims arising from services provided to patients through June 30, 2020, which have not yet been asserted, the District is unable to determine the ultimate cost, if any, of such possible claims, and accordingly no provision has been made for them. Settled claims have not exceeded commercial coverage in any of the three preceding years.

The District is a participant in the Association of California Healthcare Districts' ALPHA Fund, which administers a self-insured workers' compensation plan for participating member hospitals and their employees. The District pays a premium to the ALPHA Fund; the premium is adjusted annually. If participation in the ALPHA Fund were terminated by the District, the District would be liable for its share of any additional premiums necessary for final disposition of all claims and losses covered by the ALPHA Fund.

Note 11: Self-Funded Insurance

The District has a self-funded health care plan that provides medical and dental benefits to employees and their dependents. Employees share in the cost of health benefits. Health care expense is based on actual claims paid, reinsurance premiums, administration fees, and unpaid claims at year-end. The District buys reinsurance to cover catastrophic individual claims over $150,000. The District records a liability for claims incurred, but not reported that is recorded in accrued payroll and related liabilities in the accompanying statements of net position.

The self-funded health care plan liability consisted of the following:

June 30,	2020	2019
Opening balance	$ 2,986,779	$ 1,731,859
Additions - Claims reported	9,244,001	4,952,268
Reductions - Claims paid	(9,893,983)	(3,697,348)
Ending balance	$ 2,336,797	$ 2,986,779

Note 12: Concentration of Credit Risk

The District grants credit without collateral to patients.

Patient receivables consist of amounts due from patients, their insurers, or governmental agencies (primarily Medicare and Medi-Cal) for health care provided to the patients. The majority of the District's patients are from Bishop, California, and the surrounding area.

The mix of receivables from patients and third-party payors was as follows at June 30:

	2020
Medicare	28 %
Medi-cal, including CMSP	25 %
Other third-party payors	29 %
Patients	18 %
Total	100 %

Note 13: Commitments and Contingencies

Litigation

The District may from time to time be involved in litigation and regulatory investigations that arise in the normal course of doing business. After consultation with legal counsel, management estimates that matters, if applicable, existing as of June 30, 2020 will be resolved without material adverse effect on the District's future financial position, results from operations, or cash flows.

Paycheck Protection Program Loan Review

Loans issued under the PPP were subject to good-faith certifications of the necessity of the loan request. Borrowers with loans issued under the program in excess of $2 million are subject to review by the SBA for compliance with the program requirements. If the SBA determines that a borrower lacked an adequate basis for the loan or did not meet program requirements, the loan will not be eligible for loan forgiveness and the SBA will seek repayment of the outstanding PPP loan balance. As such, the potential exists that the District may be deemed ineligible for loan forgiveness and be required to repay the loan.

Note 14: Provider Relief Funds

The District received $6,720,771 of Coronavirus Aid, Relief, and Economic Security (CARES) Act Provider Relief Funds administered by the Department of Health and Human Services (HHS). The funds are subject to terms and conditions imposed by HHS. Among the terms and conditions is a provision that payments will only be used to prevent, prepare for, and respond to coronavirus and shall reimburse the recipient only for healthcare-related expenses or lost revenues that are attributable to coronavirus. Recipients may not use the payments to reimburse expenses or losses that have been reimbursed from other sources or that other sources are obligated to reimburse. HHS currently has a deadline to incur eligible expenses of June 30, 2021. Unspent funds will be expected to be repaid.

These funds are considered subsidies and recorded as a liability when received and are recognized as revenues in the accompanying statement of revenues, expenses, and changes in net position as all terms and conditions are considered met. As these funds are considered subsidies, they are considered nonoperating activities. The terms and conditions are subject to interpretation, changes and future clarification, the most recent of which have been considered through the date that the financial statements were issued. In addition, this program may be subject to oversight, monitoring and audit. Failure by a provider that received a payment from the Provider Relief Fund to comply with any term or condition can subject the provider to recoupment of some or all of the payment. As a result, there is at least a reasonable possibility that recorded estimates will change by a material amount in the near term.

As of June 30, 2020, the District had a liability of $6,720,771, which was included in unearned revenue on the accompanying statement of net position.

Note 15: Condensed Financial Information for Component Units

Following is condensed financial information for blended component units of the District:

Condensed Statement of Net Position - Blended Component Units	Foundation (6/30/2020)	Auxiliary (5/31/2020)	Pioneer Home Health (12/31/2019)
Assets:			
Current assets	$ 319,264	$ 114,442	$ 447,629
Noncurrent assets	-	-	413,843
Total assets	$ 319,264	$ 114,442	$ 861,472
Liabilities:			
Current liabilities	$ -	$ -	$ 214,007
Noncurrent liabilities	-	-	261,163
Total liabilities	-	-	475,170
Net position	319,264	114,442	386,302
Total liabilities and net position	$ 319,264	$ 114,442	$ 861,472

Note 15: Condensed Financial Information for Component Units (Continued)

Condensed statement of revenues, expenses, and changes in net position - Blended component units *Years Ended*	Foundation (6/30/2020)	Auxiliary (5/31/2020)	Pioneer Home Health (12/31/2019)
Operating revenue	$ -	$ (8,486)	$ 1,293,258
Operating expenses	54,712	-	1,342,049
Loss from operations	(54,712)	(8,486)	(48,791)
Nonoperating revenue (expense)	16,127	50,757	(13,508)
Decrease in net position	(38,585)	42,271	(62,299)
Net position - Beginning of year	357,849	72,171	448,601
Net position - End of year	$ 319,264	$ 114,442	$ 386,302

Condensed Statement of Cash Flows - Blended Component Units *Years Ended*	Foundation (6/30/2020)	Auxiliary (5/31/2020)	Pioneer Home Health (12/31/2019)
Cash flows from operating activities	$ (54,712)	$ (8,486)	$ 20,663
Cash flows from noncapital financing activities	16,127	50,757	47
Cash flows from capital and related financing activities	-	-	(13,993)
Change in cash and cash equivalents	(38,585)	42,271	6,717
Cash and cash equivalents - Beginning of year	-	-	-
Cash and cash equivalents - End of year	$ (38,585)	$ 42,271	$ 6,717

Note 16: Restatement

The District identified the following retrospective adjustments and corrections of errors necessary for the financial statements to be presented in accordance with GAAP.

Beginning net position was restated as follows for the year ended June 30, 2020 (December 31, 2019 for PMA and Pension Trust Fund - Plan):

	District	PMA	Pension Trust Fund - Plan
Net position at beginning of year - As originally stated	$ 41,264,297	$ 697,256	$ 22,084,009
Restatements:			
Adjustment to remove the balance of goodwill in PMA	(581,219)	-	-
Adjustment resulting from revision to pension plan actuarial valuation	2,098,937	-	(403,729)
Adjustment to agree net position to revenue and expenses	-	26,495	-
Adjustment to reduce the opening balance of prepaid expenses related to the PHH purchase contribution	300,000	-	-
Adjustment to correct accounts payable and related activity	(671,617)	-	-
Total restatements	1,146,101	26,495	(403,729)
Net position at beginning of year - As restated	$ 42,410,398	$ 723,751	$ 21,680,280

Note 17: Related-Party Transactions

In the ordinary course of business, the District has and expects to continue to have transactions with its employees and elected officials. In the opinion of management, such transactions were on substantially the same terms, including interest rates and collateral, as those prevailing at the time of comparable transactions with other persons and did not involve more than a normal risk of collectibility or present any other unfavorable features to the District.

Note 18: Subsequent Events

Purchase of Pioneer Medical Associates

On January 27, 2021, the District purchased the remaining partnership interests (33.47%) in Pioneer Medical Associates, (a discretely presented component unit), consisting primarily of real property and related improvements, in the amount of $1,017,488. At the date of escrow closing, the District deposited $100,000 into an escrow account. The remaining balance will be paid in two equal installments, with the first installment due on July 1, 2021 and the second installment due on January 1, 2022.

Note 18: Subsequent Events (Continued)

Line of Credit

On April 23, 2021, the District entered into a line of credit agreement with Oak Valley Community Bank (LOC). The LOC provides for borrowings through April 23, 2023 (the Maturity Date). Borrowings will bear interest at the bank's index rate, currently at 0.100% per annum plus 1.00%. The maximum amount that may be outstanding under the Loan Agreement is $3,500,000. The LOC is secured primarily through a deposit account with Oak Valley Community Bank.

Required Supplementary Information

Northern Inyo Healthcare District

Schedule of Changes in the Net Pension Liability and Related Ratios - Plan

Last Ten Fiscal Years (If Available)

Total Pension Liability	2020	2019	2018	2017	2016
Service cost incurred	$ 1,781,772	$ 2,121,997	$ 2,281,116	$ 2,812,178	$ 2,219,985
Interest in total pension liability	2,694,973	2,726,359	2,805,649	3,053,437	3,047,939
Difference between actual and expected experience	2,640,361	3,016,650	1,343,607	(3,295,677)	1,385,608
Change in assumption	6,850,017	(84,200)	(185,137)	(417,283)	12,966,856
Benefit payments	(8,053,422)	(8,082,821)	(5,554,354)	(7,575,753)	(8,213,871)
Net change in total pension liability	5,913,701	(302,015)	690,881	(5,423,098)	11,406,517
Total pension liability - Beginning	56,095,285	56,397,300	56,575,151	61,998,249	50,591,732
Total pension liability - Ending (a)	62,008,986	56,095,285	57,266,032	56,575,151	61,998,249
Plan fiduciary net position:					
Contribution - Employer	5,242,000	6,300,000	5,340,000	5,340,000	3,900,000
Net investment income (loss)	1,893,587	(116,063)	(292,381)	(126,769)	880,376
Administrative expense	(58,625)	(64,562)	(88,502)	(55,640)	(51,336)
Benefit payments	(8,053,422)	(8,082,821)	(5,554,354)	(7,575,753)	(8,213,871)
Net change in plan fiduciary net position	(976,460)	(1,963,446)	(595,237)	(2,418,162)	(3,484,831)
Plan fiduciary net position - Beginning	22,084,009	24,047,455	26,087,619	28,505,781	31,990,612
Plan fiduciary net position - Ending (b)	21,107,549	22,084,009	25,492,382	26,087,619	28,505,781
Net pension liability - Ending (a)-(b)	$ 40,901,437	$ 34,011,276	31,773,650	30,487,532	33,492,468
Plan fiduciary net position as a percentage of the total pension liability	34.04 %	39.37 %	44.52 %	46.11 %	45.98 %
Covered payroll	$ 10,780,522	$ 11,537,345	$ 12,968,106	$ 13,529,712	$ 15,892,425
Net pension liability as percentage of covered payroll	379.40 %	294.79 %	245.01 %	225.34 %	210.74 %

See accompanying notes to required supplementary information.

Northern Inyo Healthcare District

Schedule of Changes in the Net Pension Liability and Related Ratios - Plan

(Continued)

Last Ten Fiscal Years (If Available)

Notes to Schedule:

Note 1:

Changes in assumptions: In 2020, amounts reported as changes in assumptions resulted primarily from adjustments to expected form of, discount rate, payment election, and mortality assumptions.

Note 2:

The beginning balance of total pension liability for 2019 was restated by $868,732 because the actuarial valuation at that date was revised.

Northern Inyo Healthcare District

Schedule of Contributions and Related Ratios - Plan

Last Ten Fiscal Years (If Available)

SCHEDULE OF CONTRIBUTIONS	2020	2019	2018	2017	2016
Actuarially determined contribution	$ 6,072,000	$ 5,484,000	$ 4,716,000	$ 5,340,000	$ 3,900,000
Contributions in relation to the actuarially determined contributions	5,500,000	6,060,000	5,340,000	5,340,000	3,900,000
Contribution excess	$ 572,000	$ (576,000)	$ (624,000)	$ -	-
Covered payroll	$ 11,537,345	$ 12,968,106	$ 13,529,712	$ 15,892,425	17,664,833
Contributions as a percentage of covered employee payroll	47.67 %	46.73 %	39.47 %	33.60 %	22.08 %

Notes to Schedule:

Valuation date:	January 1, 2019
Methods and assumptions used to determine contribution rates:	
Single-employer plan	Entry Age Normal Cost Method
Amortization method	Level percentage of payroll, closed
Remaining amortization period	16 years
Asset valuation method	Market value
Inflation	2.3%
Salary increases	3%, including inflation
Investment rate of return	4.00%
Retirement age	65, or 70 *
Mortality: Pre-retirement	**
Mortality: Postretirement (annuity elected)	***
Mortality: Postretirement (lump sum elected)	****

** RP-2014 Healthy Mortality w/generational projection from 2006, Base Year using Scale MP-2017.
*** RP-2014 Healthy Mortality w/generational projection from 2006, Base Year using Scale MP-2017.
**** DOP before 7/1/2009: 1984 UP, Mortality Table set back four years. DOP On/After 7/1/2009: RP-2000 Table for Males set back four years.

Northern Inyo Healthcare District

Schedule of Investment Returns - Plan

Last Ten Fiscal Years (If Available)

SCHEDULE OF INVESTMENT RETURNS	2020	2019	2018	2017	2016
Annual money-weighted rate of return, net of investment expense	6.39 %	2.96 %	(1.16)%	(0.48)%	3.11 %

Northern Inyo Healthcare District

Schedule of Changes in the Net Pension Liability and Related Ratios - PEPRA Plan

Last Ten Fiscal Years (If Available)

Total Pension Liability	2020	2019
Service cost incurred	$ 28,238	$ 27,705
Interest in total pension liability	6,664	5,017
Difference between actual and expected	(78,051)	71
Change in assumption	-	(382)
Net change in total pension liability	(43,149)	32,411
Total pension liability - Beginning	105,044	72,633
Total pension liability - Ending (a)	61,895	105,044
Plan fiduciary net position:		
Contribution - Employer	35,975	9,583
Contribution - Employee	18,209	9,584
Net change in plan fiduciary net position	54,184	19,167
Plan fiduciary net position - Beginning	87,279	68,112
Plan fiduciary net position - Ending (b)	141,463	87,279
Net pension liability - Ending (a)-(b)	$ (79,568)	$ 17,765
Plan fiduciary net position as a percentage of the total pension liability	228.55 %	83.09 %
Covered payroll	$ 124,180	$ 121,388
Net pension liability as percentage of covered payroll	(64.07)%	14.63 %

Northern Inyo Healthcare District

Schedule of Contributions and Related Ratios - PEPRA Plan

Last Ten Fiscal Years (If Available)

SCHEDULE OF CONTRIBUTIONS	2020	2019
Actuarially determined contribution	$ 13,662	$ 14,089
Contributions in relation to the actuarially determined contributions	13,662	14,089
Contribution deficiency	$ -	$ -
Covered payroll	$ 124,180	$ 121,388
Contributions as a percentage of covered payroll	11.00 %	- %

Notes to Schedule

Valuation date:	January 1, 2019
Methods and assumptions used to determine contribution rates:	
Single-employer plan	Entry Age Normal Cost Method
Amortization method	Level percentage of payroll, closed
Remaining amortization period	16 years
Asset valuation method	Market value
Inflation	2.5%
Salary increases	3%, including inflation
Investment rate of return	4.00%
Retirement age	65
Mortality: Pre-retirement	**
Mortality: Postretirement (annuity elected)	***

** RP-2014 Healthy Mortality w/generational projection from 2006, Base Year using Scale MP-2017.
*** RP-2014 Healthy Mortality w/generational projection from 2006, Base Year using Scale MP-2017.

Northern Inyo Healthcare District

Schedule of Investment Returns - PEPRA Plan

Last Ten Fiscal Years (If Available)

Schedule of investment returns	2020	2019
Annual money-weighted rate of return, net of investment expense	0%	0%

Supplementary Information

Northern Inyo Healthcare District

Combining Statement of Net Position of the District and Component Units

June 30, 2020 (Auxiliary May 31, 2020) (Pioneer Home Health December 31, 2019)

Assets and Deferred Outflows of Resources	Hospital	Foundation	Auxiliary	Pioneer Home Health	Eliminations	Total
Current assets:						
Cash and investments	$ 57,231,579	$ 319,264	$ 114,442	$ 57,488	$ -	$ 57,722,773
Receivables:						
Patient accounts - Net	15,837,454	-	-	284,301	-	16,121,755
Other	939,552	-	-	-	-	939,552
Estimated third-party payor settlements	229,131	-	-	-	-	229,131
Inventories	2,651,452	-	-	-	-	2,651,452
Prepaid expenses and other	1,486,003	-	-	105,840	-	1,591,843
Total current assets	78,375,171	319,264	114,442	447,629	-	79,256,506
Noncurrent assets:						
Noncurrent cash and investments	4,582,513	-	-	-	-	4,582,513
Investment in PMA	430,946	-	-	-	-	430,946
Goodwill in PMA	-	-	-	-	-	-
Capital assets:						
Nondepreciable capital assets	3,666,374	-	-	130,000	-	3,796,374
Depreciable capital assets - Net	71,795,979	-	-	283,843	-	72,079,822
Total noncurrent assets	80,475,812	-	-	413,843	-	80,889,655
Total assets	158,850,983	319,264	114,442	861,472	-	160,146,161
Deferred outflows of resources - Pensions	21,955,960	-	-	-	-	21,955,960
TOTAL ASSETS AND DEFERRED OUTFLOWS OF RESOURCES	$ 180,806,943	$ 319,264	$ 114,442	$ 861,472	$ -	$ 182,102,121

Northern Inyo Healthcare District

Combining Statement of Net Position of the District and Component Units (Continued)

June 30, 2020 (Auxiliary May 31, 2020, Pioneer Home Health December 31, 2019)

Liabilities, Deferred Inflows of Resources, and Net Position	Hospital	Foundation	Auxiliary	Pioneer Home Health	Eliminations	Total
Current liabilities:						
Current maturities of long-term liabilities:						
Bonds and notes payable - Current portion	$ 1,912,000	$ -	$ -	$ 4,847	$ -	$ 1,916,847
Capital lease obligation - Current portion	376,934	-	-	-	-	376,934
CMS advance - Current portion	1,824,269	-	-	-	-	1,824,269
Accounts payable	3,584,944	-	-	42,943	-	3,627,887
Accrued interest and sales tax	134,001	-	-	-	-	134,001
Accrued payroll and related liablities	7,829,245	-	-	166,217	-	7,995,462
Unearned revenue	7,074,415	-	-	-	-	7,074,415
Total current liabilities	22,735,808	-	-	214,007	-	22,949,815
Noncurrent liabilities:						
Bonds and notes payable	52,418,024	-	-	261,163	-	52,679,187
Paycheck Protection Program loan	8,927,628	-	-	-	-	8,927,628
Capital lease obligation	1,393,067	-	-	-	-	1,393,067
CMS advance	12,769,885	-	-	-	-	12,769,885
Net pension liability	40,821,869	-	-	-	-	40,821,869
Total noncurrent liabilities	116,330,473	-	-	261,163	-	116,591,636
Total liabilities	139,066,281	-	-	475,170	-	139,541,451
Deferred inflows of resources	2,790,962	-	-	-	-	2,790,962
Net position:						
Net investment in capital assets	22,524,316	-	-	-	-	22,524,316
Restricted for programs	1,568,358	-	-	-	-	1,568,358
Unrestricted	14,857,026	319,264	114,442	386,302	-	15,677,034
Total net position	38,949,700	319,264	114,442	386,302	-	39,769,708
TOTAL LIABILITIES, DEFERRED INFLOWS OF RESOURCES, AND NET POSITION	$ 180,806,943	$ 319,264	$ 114,442	$ 861,472	$ -	$182,102,121

Northern Inyo Healthcare District

Combining Statement of Revenues, Expenses, and Changes in Net Position of the District and Component Units

For the year ended June 30, 2020 (Auxiliary May 31, 2020, Pioneer Home Health December 31, 2019)

	Hospital	Foundation	Auxiliary	Pioneer Home Health	Eliminations	Total
Revenue:						
Net patient service revenue	$ 80,528,774	$ -	$ -	$ 1,293,229	$ -	$ 81,822,003
Other operating revenue	10,477,542	-	(8,486)	29	-	10,469,085
Total revenue	91,006,316	-	(8,486)	1,293,258	-	92,291,088
Operating expenses:						
Salaries and wages	33,411,326	-	-	1,248,812	-	34,660,138
Employee benefits	22,672,713	-	-	262,402	-	22,935,115
Professional fees	14,588,961	3,196	-	-	-	14,592,157
Supplies	9,280,842	551	-	14,692	-	9,296,085
Purchased services	4,364,939	-	-	39,922	-	4,404,861
Depreciation	4,275,658	-	-	26,336	-	4,301,994
Medical office building, net	771,490	-	-	-	-	771,490
Other operating expenses	4,943,005	50,965	-	(250,115)	-	4,743,855
Total operating expenses	94,308,934	54,712	-	1,342,049	-	95,705,695
Loss from operations	(3,302,618)	(54,712)	(8,486)	(48,791)	-	(3,414,607)
Nonoperating revenue (expense):						
Tax revenue for operations	625,869	-	-	-	-	625,869
Tax revenue for debt service	1,746,739	-	-	-	-	1,746,739
Interest income	598,967	-	-	-	-	598,967
Interest expense	(2,363,057)	-	-	(13,555)	-	(2,376,612)
Loss on sale of asset	(36,388)	-	-	-	-	(36,388)
Noncapital grants and contributions	199,215	16,127	-	-	-	215,342
Net contribution from Pioneer Home Health	(50,804)	-	50,757	47	-	-
Total nonoperating revenue (expense)	$ 720,541	$ 16,127	$ 50,757	$ (13,508)	$ -	$ 773,917
Change in net position - Carry forward	(2,582,077)	(38,585)	42,271	(62,299)	-	(2,640,690)

Northern Inyo Healthcare District

Combining Statement of Revenues, Expenses, and Changes in Net Position of the District and Component Units (Continued)

For the year ended June 30, 2020 (Auxiliary May 31, 2020, Pioneer Home Health December 31, 2019)

	Hospital	Foundation	Auxiliary	Pioneer Home Health	Eliminations	Total
Change in net position - Carry forward	$ (2,582,077)	$ (38,585)	$ 42,271	$ (62,299)	$ -	$ (2,640,690)
Increase (decrease) in net position	(2,582,077)	(38,585)	42,271	(62,299)	-	(2,640,690)
Net position at beginning of year - As originally stated	40,685,676	357,849	72,171	448,601	(300,000)	41,264,297
Restatement	846,101	-	-	-	300,000	1,146,101
Net position at beginning of year - As restated	41,531,777	357,849	72,171	448,601	-	42,410,398
Net position at end of year	$ 38,949,700	$ 319,264	$ 114,442	$ 386,302	$ -	$ 39,769,708

Northern Inyo Healthcare District

Statistical Information

Year Ended June 30, 2020

Bed Complement

	2020	2019	2018	2017	2016
Medical/surgical	11	11	11	11	11
Prenatal/obstetrics	6	6	6	6	6
Pediatric	4	4	4	4	4
Intensive care	4	4	4	4	4
Total licensed bed capacity	25	25	25	25	25

Utilization

	2020	2019	2018	2017	2016
License beds	25	25	25	25	25
Patient days	2,968	3,257	3,474	3,777	3,804
Discharges	1,104	1,037	1,106	1,136	1,069
Occupancy	33 %	36 %	38 %	41 %	42 %
Average stay (days)	2.7	3.1	3.1	3.3	3.3
Emergency room visits	8,262	9,153	8,798	8,764	7,948
Outpatient visits	40,472	38,960	38,651	38,454	37,684

Medical Staff

	2020	2019	2018	2017	2016
Active	54	50	53	44	36
Consulting	19	17	17	30	30
Honorary	11	11	11	10	9
AHP	18	12	10	8	8
Other - Telemedicine	33	27	-	-	-
Total practitioners	135	117	91	92	83

Employees

	2020	2019	2018	2017	2016
Full-time	361	362	330	296	290
Part-time and per diem	124	131	126	98	105
Total employees	485	493	456	394	395
Full-time equivalents	373.57	375.30	392.89	347.29	321.37

Northern Inyo Healthcare District

Statistical Information (Continued)

Year Ended June 30, 2020

Bond Debt Service Coverage *(In Thousands)*	2020	2019	2018	2017	2016
Excess (deficit) of revenue over expenses	$ (2,641)	$ 1,725	$ 1,696	$ 1,086	$ 1,100
Add:					
Depreciation and amortization expenses	4,302	4,267	4,457	5,167	4,956
Interest expense	2,377	2,912	2,893	3,299	3,530
Available to meet debt service	$ 4,038	$ 8,904	$ 9,046	$ 9,552	$ 9,586
Actual debt service:					
2005 General obligation bonds	$ -	$ -	$ -	$ -	$ 899
2009 General obligation bonds	860	1,364	955	625	487
2010 Revenue bonds	1,242	1,178	1,179	1,182	1,178
2013 Revenue bonds	1,179	765	769	764	788
2016 Revenue bonds	762	864	814	860	-
Totals	$ 4,043	$ 4,171	$ 3,717	$ 3,431	$ 3,352
Historical debt service coverage ratio	1.00	2.13	2.43	2.78	2.86

Details regarding the District's outstanding debt can be found in the notes to the financial statements. General obligation bonds are secured by ad valorem taxes on all property within the District subject to taxation by the District. Revenue bonds are secured by a pledge of revenue set forth under the indenture. The coverage calculations presented in this schedule differ from those required by the 2010 and 2013 bond indentures.

ANNUAL FILING OF FINANCIAL AND OPERATING DATA

Name of Issuer: Northern Inyo Healthcare District ("NIHD")

Name of Bond Issues: Revenue Bond Series 2010 (see attached)
Issue date: April 14, 2010

Revenue Bond Series 2013 (see attached)
Issue date January 17, 2013

Attached, as required by the Continuing Disclosure Certificates for the Bonds, is the District's debt service coverage calculation

Dated: July 16, 2021

NORTHERN INYO HEALTHCARE DISTRICT

By Kelli Davis
Interim, Chief Executive Officer

Revenue Bond Series 2010
Issue date: April 14, 2010

Maturity Date	Principal Amount	CUSIP Number
2021	$4,610,000	665297 AU1
2025	4,170,000	665297 AT4

Revenue Bond Series 2013
Issue date January 17, 2013

Maturity Date	Principal Amount	CUSIP Number
2027	$6,325,000	665297 BK2
2029	5,010,000	665297 BL0

Nothern Inyo Healthcare District
July 16, 2021
Debt Service Coverage Ratio Calculation
Calculaton per Appendix A of 2010 and 2013 Revenue Bonds Official Statement (Page A-11)

Debt Service Coverage Ratio Calculation

		HOSPITAL FUND ONLY
Numerator:		
Excess of revenues over expenes		(2,582,077)
+ Depreciation Expense		4,275,658
+ Amortization Expense		-
+ Interest Expense		2,363,057
less Property Tax Revenue pledged for GO bonds		-
Income available to meet debt service		**4,056,638**
Denominator:		
Actual Annual Debt Service:		
2010 Bonds		1,217,993
2013 Bonds		1,975,175
Total Actual Debt Service (2010/2013)		**3,193,168**
Ratio: (numerator / denominator)	**Rx**	**1.27**
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	57,231,579
Cash and Investments-non current	4,582,513
Sub-total	61,814,092
Less - Restricted:	
PRF and grants	(7,074,415)
Held with bond fiscal agent	(3,014,155)
Building and Nursing Fund	(1,568,358)
Total Unrestricted Funds	**50,157,164**
Total Operating Expenses	93,699,629
Less Depreciation	(4,275,658)

Net Expenses		89,423,971
Average Daily Operating Expense	Rx	244,997
Days Cash on Hand		205

Covenant Ratio can be reduced to 1.10 if District has 75 or more Days Csh on Hand per Indenture

TML

FS Agrees to current year financial statements
Rx Recalculated
F Footed

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

Date: June 4, 2021

Title: **COMPLIANCE DEPARTMENT QUARTERLY REPORT**

Presenter(s): Patty Dickson
Compliance Officer

Synopsis: The Compliance Department Quarterly Report updates the Board on the work of the Compliance Department. It provides information on audits, alleged breaches, contract work, and projects. All information in the report is summarized, however, any additional details will be provided to the Board of Directors upon request.

It is recommended that the Board of Directors accept this quarterly Compliance Report.

Prepared by: Patty Dickson
Compliance Officer

Reviewed by: _____
Name
Title

Approved by: _____
Name
Title

FOR EXECUTIVE TEAM USE ONLY:

Date of Executive Team Approval: _____ Submitted by:_____
Chief Officer

NORTHERN INYO HEALTHCARE DISTRICT
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Compliance Report
June 2021

1. **Compliance Department Team**
    a. The Compliance team is pleased to announce that Paige Wagoner has moved from the RHC to the Compliance Team. She is fantastic to work with and is already making great contributions.
    b. The Compliance team is also pleased to announce that Tracy Aspel returned from retirement as the Compliance Policy Project Analyst. Tracy is making great progress preparing the new software, our policies, and training for our leadership team.
2. **Comprehensive Compliance Program review –** no update since Annual Compliance Report of November 2020.
3. **Potential Breaches** and privacy concerns
    a. The Compliance Department has investigated 12 privacy concerns between January 1, 2021 and May 31, 2021.
        i. Investigations closed with no external reporting required – 7
        ii. Investigations still active – 2
        iii. Reported to CDPH/OCR – 3
            1. No determinations received from CDPH
    b. The Compliance Department has investigated 69 alleged breaches in CY 2020.
        i. Investigations closed with no external reporting required – 50
        ii. Investigations still active – 0
        iii. Reported to CDPH/OCR – 19
            1. 3 CDPH cases closed as substantiated without deficiencies
            2. 16 are pending determination by CDPH
    c. Outstanding breaches reported to CDPH between 2016-2019
        i. 2016
            1. 1 case is still in progress
        ii. 2017
            1. 15 cases are in submitted status
            2. 1 case is still in progress
        iii. 2018
            1. 9 cases are in submitted status

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iv. 2019
    1. 3 cases are in submitted status
    2. 1 case is in progress

4. Issues and Inquiries

a. The Compliance Team researches regulatory concerns, ever-changing COVID regulations and guidance, and internal policy as requested by NIHD workforce.
b. Compliance has assisted with more than 50 research requests since the beginning of January 2021.

5. Audits

a. Employee Access Audits
    i. The HIPAA and HITECH Acts imply that organizations must perform due diligence by actively auditing and monitoring for appropriate use of PHI. These audits are also required by the Joint Commission and are a component of the "Meaningful Use" requirements.
    ii. Access audits monitor who is accessing records by audit trails created in the systems. These audits allow us to detect unusual or unauthorized access of patient medical records.
        1. The Compliance Department Analyst manually completes audits for access of previous patient information systems (Athena, Centricity, Paragon, Redoc, Orchard, etc) to ensure employees' access records only on a work-related, "need to know," and "minimum necessary" basis.
            a. Compliance performs hundreds audits monthly. **This will continue for the legacy systems as long as they are accessed.**
            b. Each audit ranges from hundreds of lines of data to thousands of lines of data.
            c. A "flag" is created when any access appears unusual.
            d. Flags are reviewed and resolved by comparison audits, workflow review, discussions with workforce, and discussions with leadership.
            e. See attachment A
    iii. Cerner has a more automated system for auditing. Cerner has a dashboard that displays the data the program monitors on an on-going basis.
        1. Compliance has a dashboard and can review flags for the following event types regularly

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a. User ID matches patient name
b. User has same last name as patient
c. Chart access is unusual pattern for user.
d. Excessive printing or excessive charts being opened for job role.

2. We have only had the new auditing software for two months, and so are still working on how to incorporate executive overview style reports for the Board of Directors. See some sample data
    a. attachment B

b. Business Associates Agreements (BAA) audit
    i. We currently have approximately 160 Business Associates Agreements.
    ii. We have executed around 1 BAAs since January 1, 2021.
c. Vendor Contract reviews
    i. 39 contracts currently in the review process
    ii. More than 100 agreements or contracts have been reviewed and executed since January 2021
d. PACS (Picture Archival and Communication System) User Access Agreements - No update since previous quarterly report
e. HIMS scanning audit – Deferred to Q3 CY 2021 to include Cerner EHR
f. Language Access Services Audit – Deferred to Q3 to ensure documentation in Cerner
    i. Audits for Language Access Services to ensure Limited English Proficiency (LEP) patients are provided with the appropriate access to ensure safe, quality healthcare.
    ii. Audits review documentation of language assistance provided to LEP patients
    iii. Action items from audits allow the Compliance team to work with Language Access Services Manager, Jose Garcia, to develop tools for the workforce to ensure all proper steps are followed.
    iv. Language Access regulations are enforced by the HHS Office of Civil Rights.
g. HIPAA Security Risk Assessment – Due November 2021 (requires collaboration between Compliance Officer and Security Officer)
    i. Annual requirement to assess security and privacy risk areas as defined in 45 CFR 164.3. Review of 157 privacy and security elements performed in conjunction with Information Technology Services.

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1. Periodic update and assessment to be completed in Q3 of CY2021 with system changes of EHR, Time keeping system, Employee badge process, and other technological update.

ii. NIHD is now using VendorMate (GHX) vendor credentialing software. This allows us to be compliant with our Vendor Credentialing Policy, and several facility security elements of 45 CFR 164.
   1. We have over 70 Vendor Companies registered.
   2. We have over 127 Representatives registered.

h. 340B audit – Annual external audit and response plan in progress
i. An audit of NIHD Board of Directors Agendas, Minutes, and Resolutions is in progress.

6. CPRA (California Public Records Act) Requests
a. The Compliance office has responded to two CPRA requests to date in 2021.

7. Compliance Workplan - – no update since previous quarterly report

8. Unusual Occurrence Reports (UOR) - UORs have transitioned to the Compliance Department. ** We continue to update the confusing or missing labeling on the reports.
a. See attached 2020 Summary of Unusual Occurrence Reports (14 pages)
   i. attachment C
b. See attached Q1 CY2021 Summary of Unusual Occurrence Reports (14 pages)
   i. Attachment D

9. Compliance Committees
a. Business Compliance Team
   i. 2021 Conflict of Interest (COI) questionnaires were distributed approximately 2 weeks ago.
   ii. We have received greater than 40% of completed questionnaires from our workforce
   iii. Business Compliance Team will be meeting no less than monthly until all conflicts of interest have been addressed.
b. Billing and Coding Compliance Committee
   i. Sporadic meetings during the Cerner build and go-live. Has now been set for weekly meetings to address coding, provider enrollment, billing, productivity, coding audit information, new services or service lines and similar information
c. Compliance and Business Ethics

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i. Members of committee have been reassessed. Update to Compliance Program to the Board anticipated in July and then we will re-establish regular quarterly meetings.

10. Optimization, update, and audit of Policy Management software

a. Proper policies and policy management is a large component of an effective Compliance Program.
b. A small team comprised of nursing, operations, compliance, and ITS representatives have been completing work on the policy management software optimization. Tracy Aspel has compiled all of this information and we are hoping to bring the steering policy to the Board either in June or July.
c. Tracy, Policy Project Analyst, has reviewed and updated more than 600 policies, ensured the correct version in correct formats are in both the currently published version and the version to be released later this year.
d. Tracy has also provided one-on-one training for the policy software and policy writing with many new and no-so-new members of the District leadership team.

11. Optimization, update, and audit of Contract Management software

a. Approximately 75% of active contracts have been updated to utilize additional features available in the updated software.
b. Paige, Compliance Clerk, is working to update all contracts, standardize entries and include key data for the end users of the system.
c. All historic contracts in the system will still be available for review.

Attachment A

Employee Access Audits

	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21
TOTAL ED SAME LAST NAME ENCOUNTERS	108	115	77	104	108	75	29	51	51	52	55	53
AUDITED ED SAME LAST NAMES ENCOUNTERS	108	115	77	104	108	75	29	51	51	52	55	53
% AUDITED	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
TOTAL ED HIGH PROFILE PT ENCOUNTERS	0	2	0	2	1	0	1	1	3	0	5	9
AUDITED ED HIGH PROFILE ENCOUNTERS	0	2	0	2	1	0	1	1	3	0	5	9
% AUDITED	#DIV/0!	100.0%	#DIV/0!	100.0%	100.0%	#DIV/0!	100.0%	100.0%	100.0%	#DIV/0!	100.0%	100.0%
TOTAL ED - EMPLOYEE ENCOUNTERS	17	19	11	10	24	12	16	10	9	9	21	16
AUDITED ED - EMPLOYEE ENCOUNTERS	17	19	11	10	24	12	16	10	9	9	21	16
% AUDITED	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
TOTAL IP SAME LAST NAME ENCOUNTERS	80	42	54	77	54	31	13	25	14	30	25	32
AUDITED IP SAME LAST NAMES ENCOUNTERS	80	42	54	77	54	31	13	25	14	30	25	32
% AUDITED	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
TOTAL IP HIGH PROFILE PT ENCOUNTERS	0	1	0	0	4	6	0	0	0	0	1	2
AUDITED IP HIGH PROFILE ENCOUNTERS	0	1	0	0	4	6	0	0	0	0	1	2
% AUDITED	#DIV/0!	100.0%	#DIV/0!	#DIV/0!	100.0%	100.0%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	100.0%	100.0%
TOTAL IP - EMPLOYEE ENCOUNTERS	10	13	7	7	9	2	3	0	9	9	11	7
AUDITED IP - EMPLOYEE ENCOUNTERS	10	13	7	7	9	2	3	0	9	9	11	7
% AUDITED	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	#DIV/0!	100.0%	100.0%	100.0%	100.0%
TOTAL OP SAME LAST NAME ENCOUNTERS	537	453	448	618	760	498	225	301	283	253	289	285
AUDITED OP SAME LAST NAMES ENCOUNTERS	537	453	448	618	760	498	225	301	283	253	289	285
% AUDITED	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
TOTAL OP HIGH PROFILE PT ENCOUNTERS	13	5	7	17	28	10	7	0	4	2	11	14
AUDITED OP HIGH PROFILE ENCOUNTERS	13	5	7	17	28	10	7	0	4	2	11	14
% AUDITED	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	#DIV/0!	100.0%	100.0%	100.0%	100.0%
TOTAL OP - EMPLOYEE ENCOUNTERS	185	277	258	159	286	245	242	110	126	145	160	80
AUDITED OP - EMPLOYEE ENCOUNTERS	185	277	258	159	286	245	242	110	126	145	160	80
% AUDITED	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
TOTAL NEW (<90 DAY) EMPLOYEES	15	3	4	12	10	10	19	11	10	14	14	13
AUDITED NEW (<90 DAY) EMPLOYEES	15	3	4	12	10	10	19	11	10	14	14	13
% AUDITED	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
FOR-CAUSE AUDITS	4	6	4	3	2	2	2	9	3	9	8	3
Total # monthly audits	741	994	870	1009	1286	891	551	518	512	523	600	514

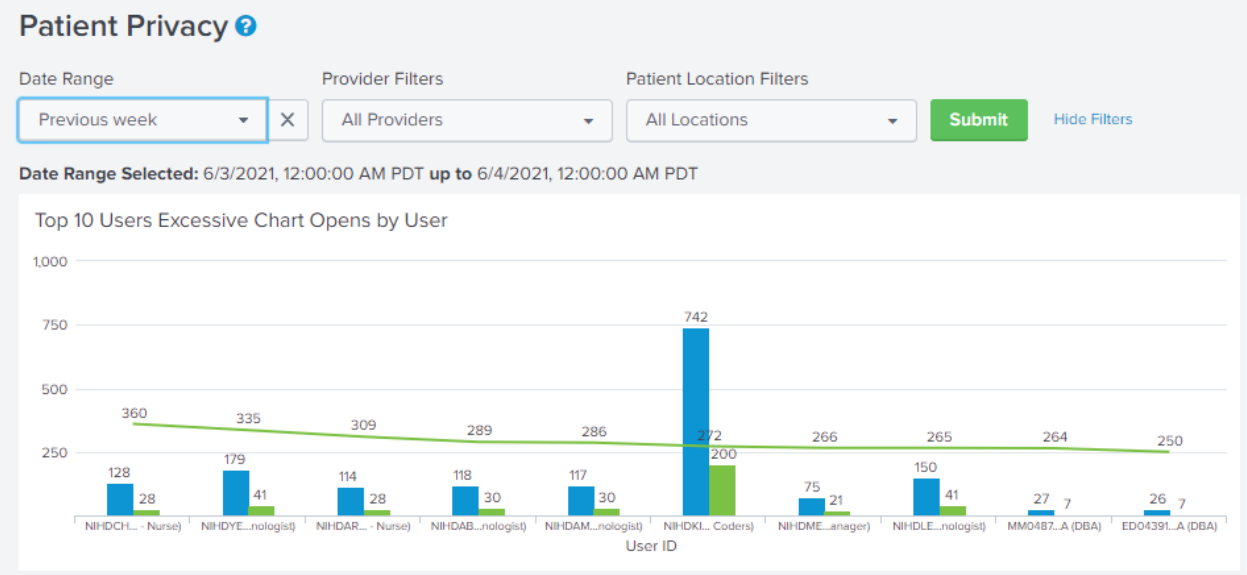
Compliance changed the methodology to provide more effective and efficient auditing of high risk records in August of 2019.

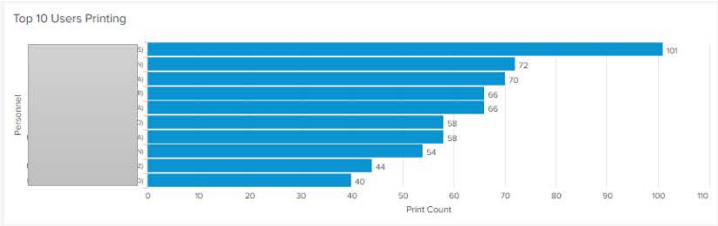
Audit Flags

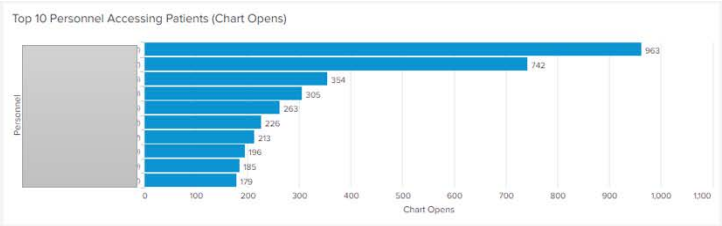
	20-Aug	20-Sep	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	21-May
Employee as patient audit	4	5	15	8	10	6	3	7	4	1
High profile patient audit	0	1	0	0	0	0	0	0	0	1
New employee audit	0	0	0	0	0	2	1	1	2	2
Same last name audit	0	1	3	2	0	0	1	0	3	3
Random	0	0	0	0	0	0	0	0	0	0
Employee Access Audits	0	0	0	0	0	0	0	0	0	0
Total	4	7	18	10	10	8	5	8	9	7
Appears Compliant	4	7	18	10	10	3	5	8	9	7
Appears Non-Compliant	0	0	0	0	0	5	0	0	0	0
Ongoing Investigation	0	0	0	0	0	0	0	0	0	0

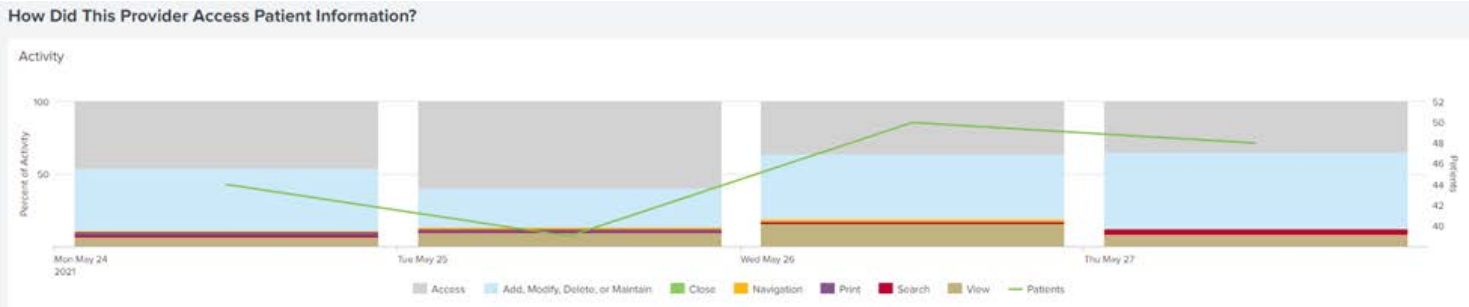
Audit flags are concerns that arise during the audit process. They require additional investigation to determine if the access is appropriate use of patient information.

Sample Cerner Audit Dashboard Tools









What Potential Risks Are Associated to This Provider?

Days with Excessive Records Accessed in the Last 60 Days

1

Chart Printing

15

Multiple Locations Accessed

	Location	Total Unique Accessed	Standard Deviation from Role Average	Chart Opens
1	Encounter Organizations	2	-1.22	17
2	Facilities	2	-1.25	17
3	Buildings	2	-1.25	17
4	Nurse Units	5	-1.29	17

Devices Used

What Account Changes Occurred for This Provider?

Privilege Changes

0

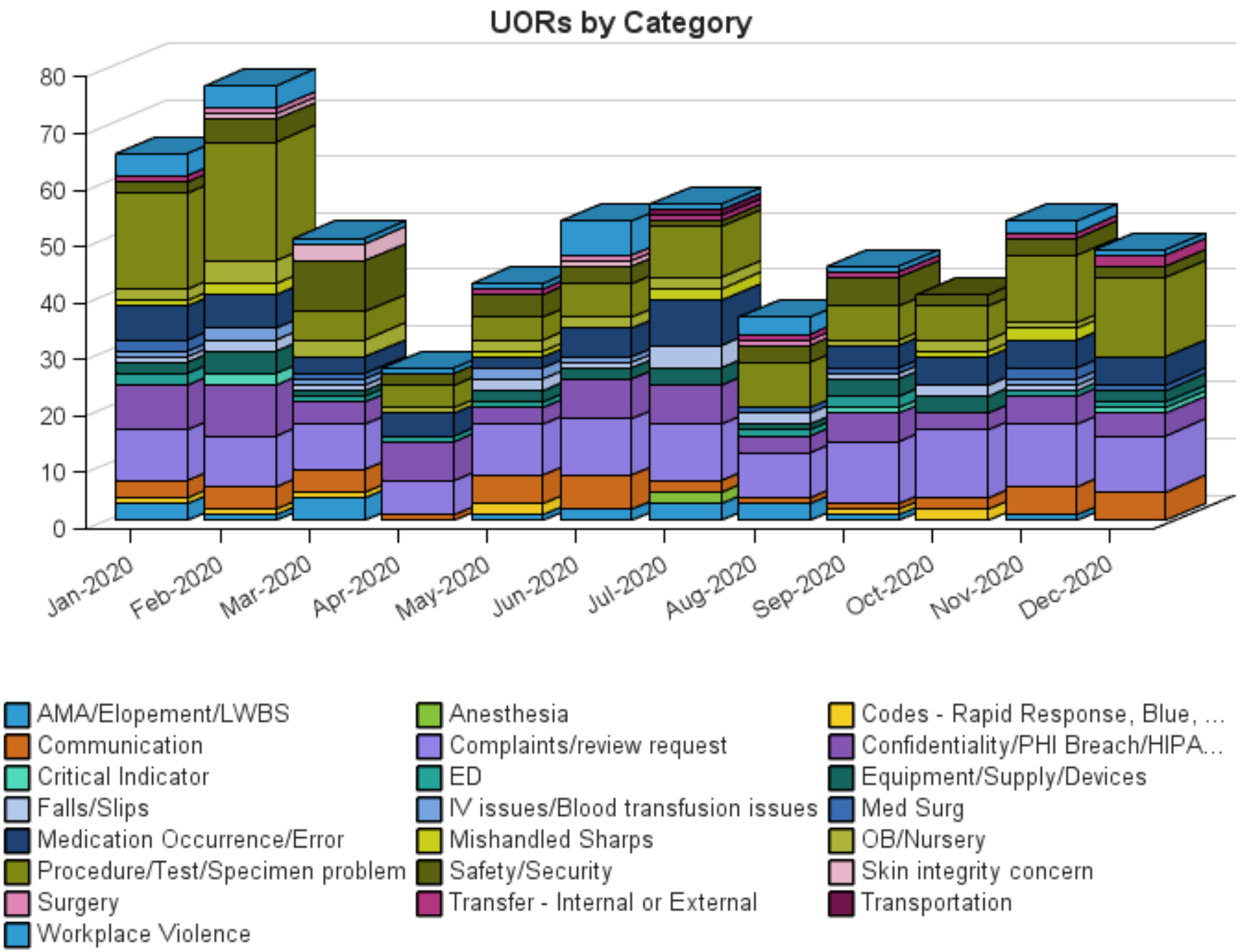
Profile Changes

0

Task and Group Changes

0

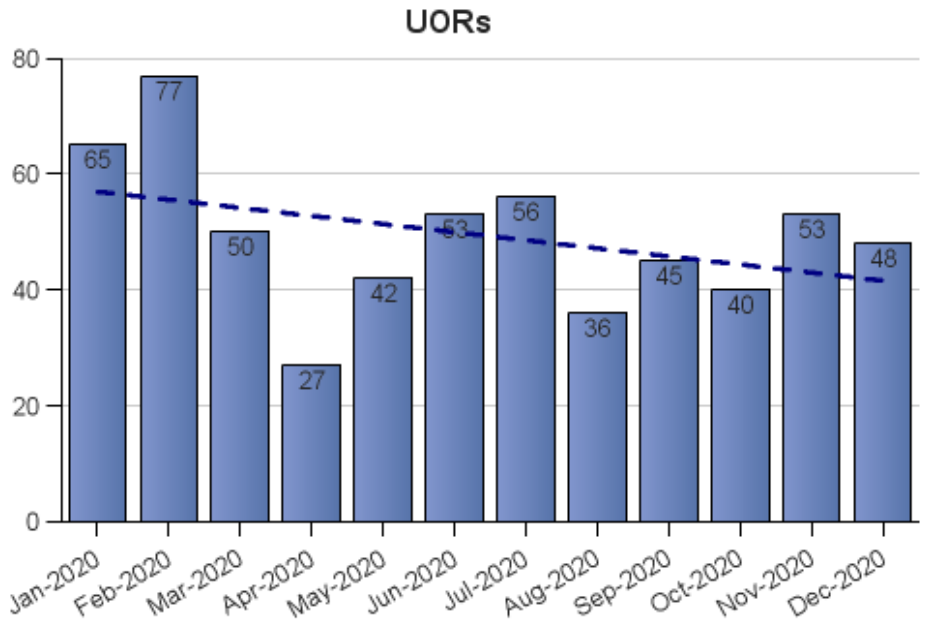
2020 SUMMARY OF UNUSUAL OCCURRENCE REPORTS

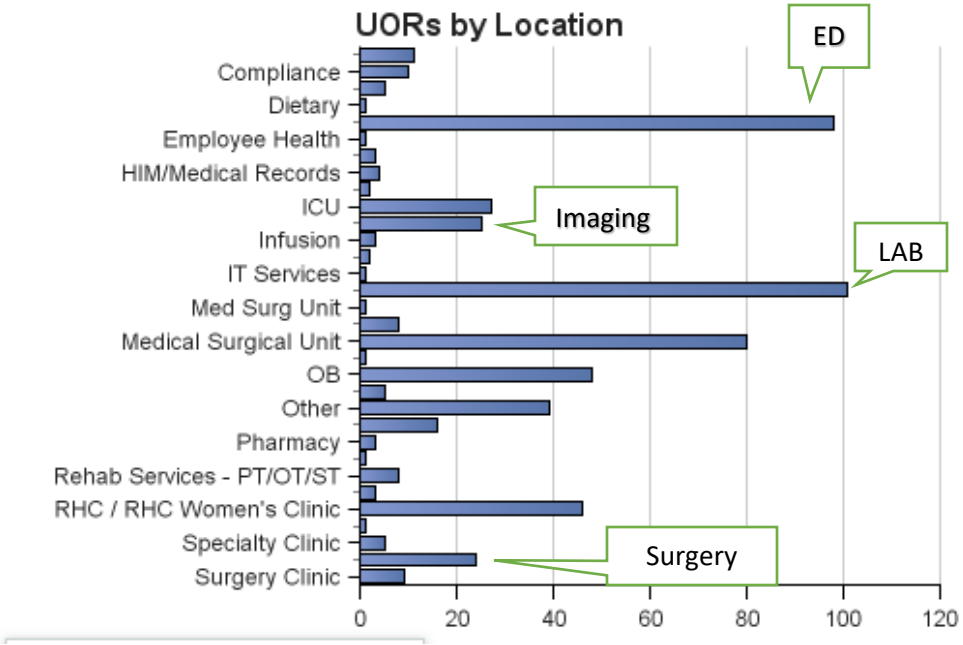


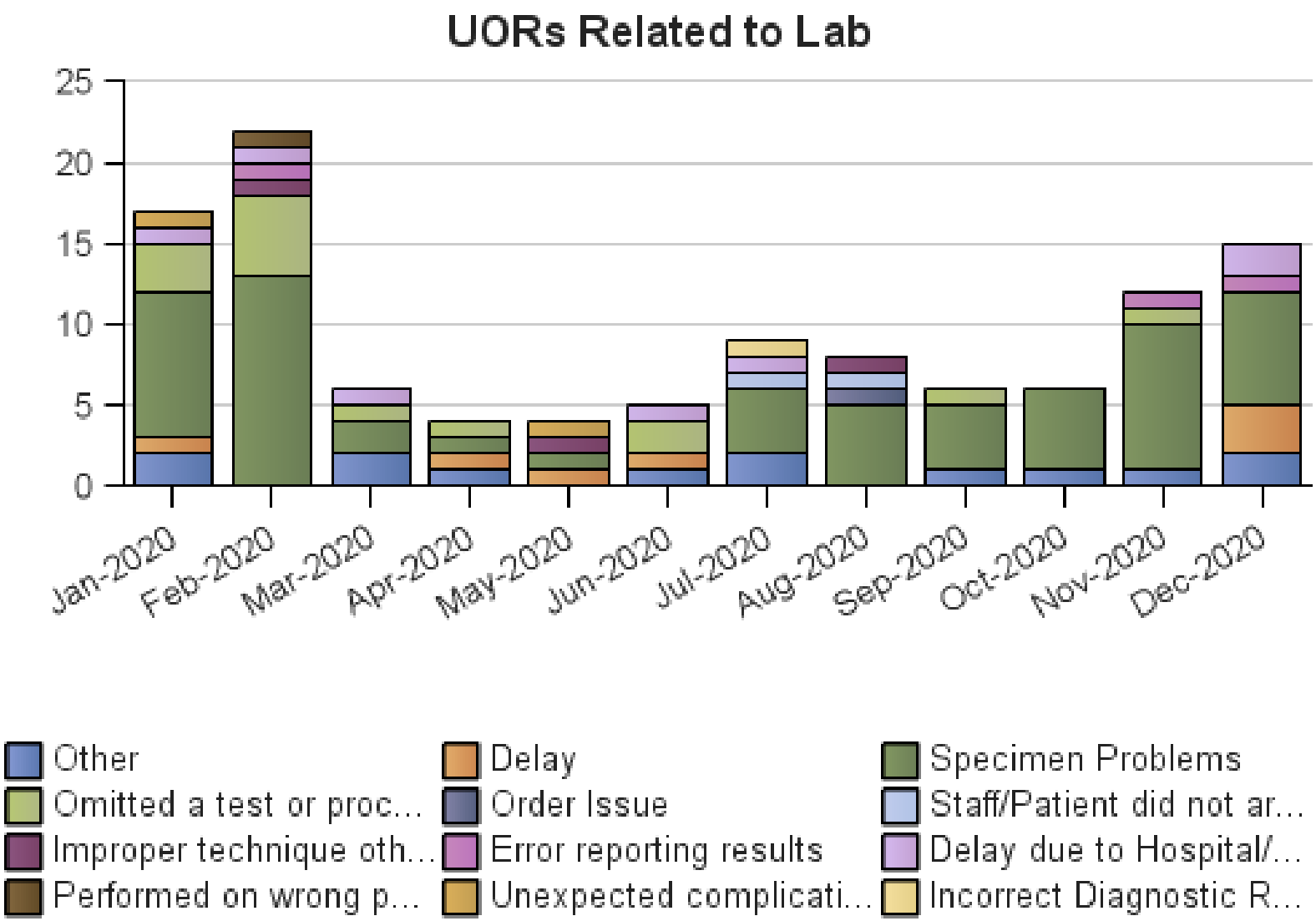
2020 SUMMARY OF UNUSUAL OCCURRENCE REPORTS

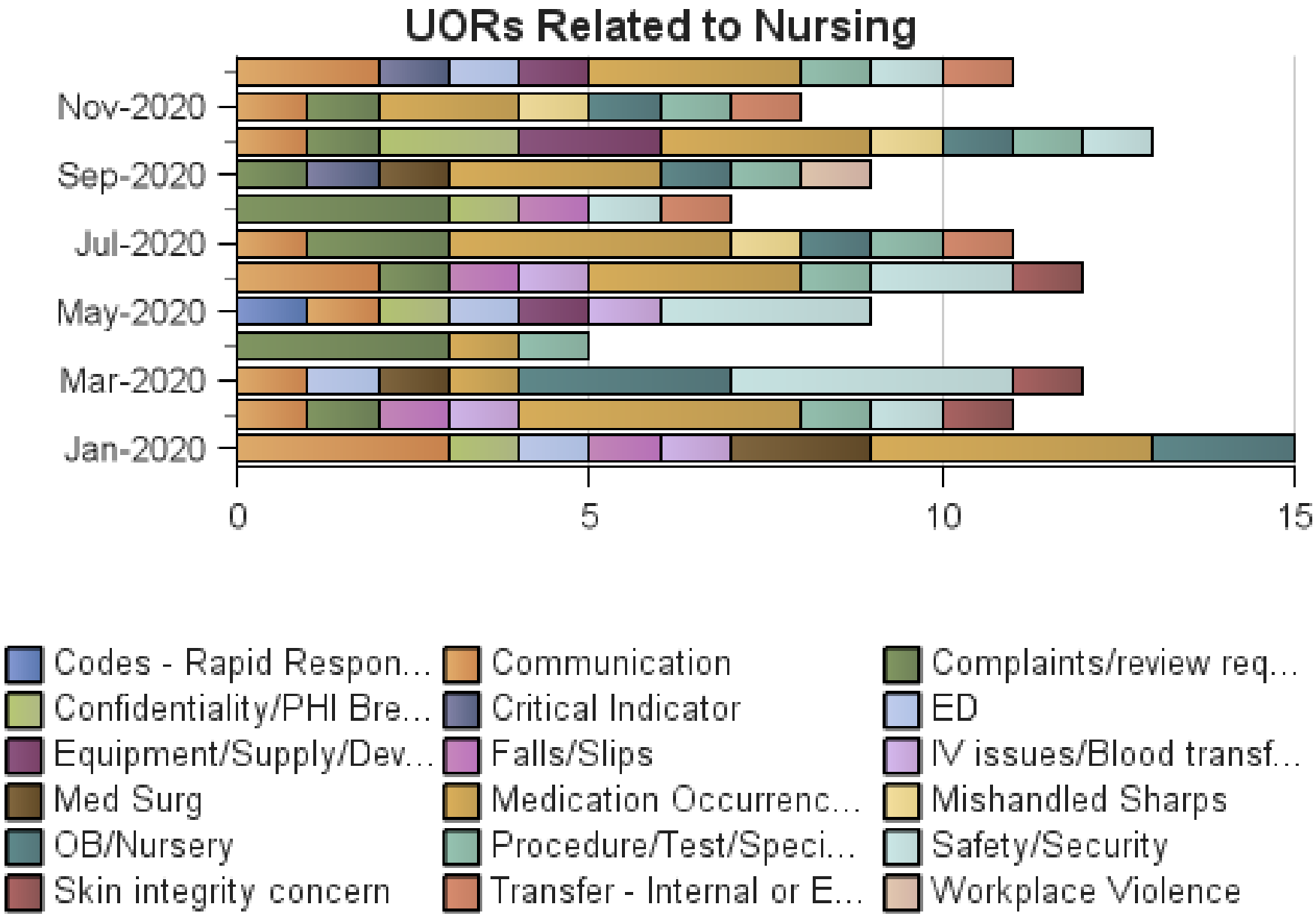
	Jan-2020	Feb-2020	Mar-2020	Apr-2020	May-2020	Jun-2020	Jul-2020	Aug-2020	Sep-2020	Oct-2020	Nov-2020	Dec-2020	Total
AMA/Elopement/LWBS	3	1	4		1	2	3	3	1		1		19
Anesthesia							2						2
Codes - Rapid Response, Blue, Deescalation	1	1	1		2				1	2			8
Communication	3	4	4	1	5	6	2	1	1	2	5	5	39
Complaints/review request	9	9	8	6	9	10	10	8	11	12	11	10	113
Confidentiality/PHI Breach/HIPAA violation	8	9	4	7	3	7	7	3	5	3	5	4	65
Critical Indicator		2							1			1	4
ED	2		1	1	1			1	2		1	1	10
Equipment/Supply/Devices	2	4	1		2	2	3	1	3	3		2	23
Falls/Slips	1	2	1		2	1	4	2	1	2	1		17
IV issues/Blood transfusion issues	1	2	1		2	1					1		8
Med Surg	2		1					1	1		2	1	8
Medication Occurrence/Error	6	6	3	4	2	5	8		4	5	5	5	53
Mishandled Sharps	1	2			1		2			1	2		9
OB/Nursery	2	4	3	1	2	2	2		1	2	1		20
Procedure/Test/Specimen problem	17	21	5	4	4	6	9	8	6	6	12	14	112
Safety/Security	2	4	9	2	4	3	1	3	5	2	3	2	40
Skin integrity concern		1	3			1							5
Surgery		1				1		1					3
Transfer - Internal or External	1				1		1	1	1		1	2	8
Transportation							1						1
Workplace Violence	4	4	1	1	1	6	1	3	1		2	1	25
Total	**65**	**77**	**50**	**27**	**42**	**53**	**56**	**36**	**45**	**40**	**53**	**48**	**592**

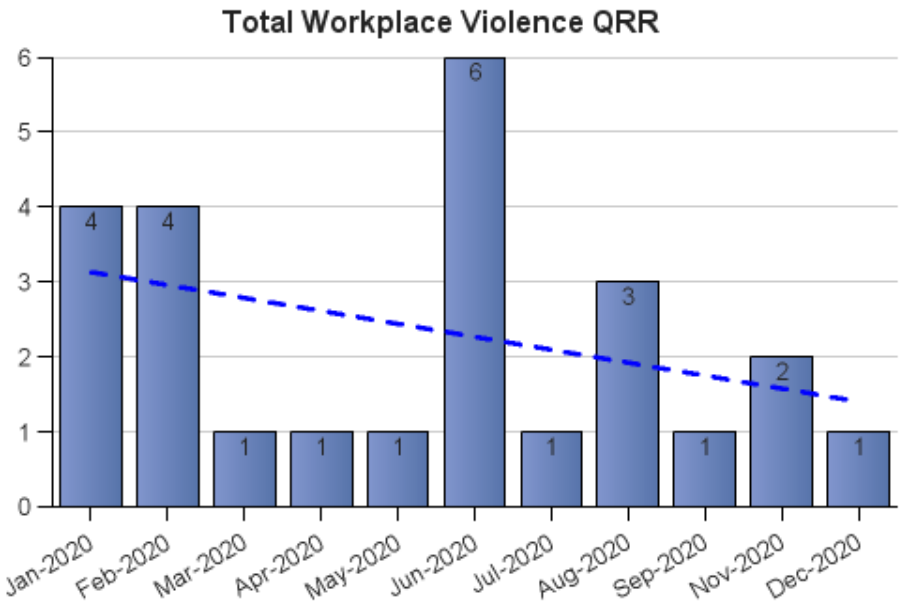
2020 SUMMARY OF UNUSUAL OCCURRENCE REPORTS

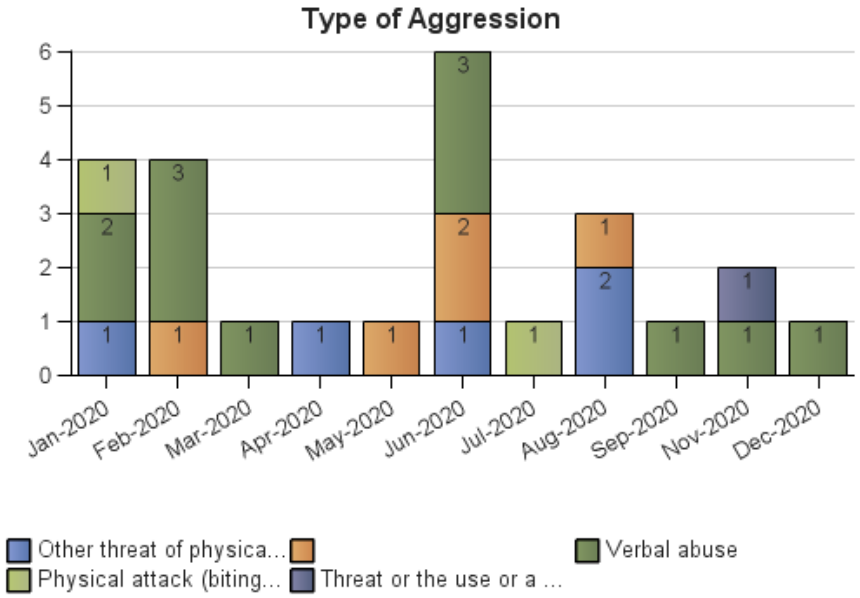


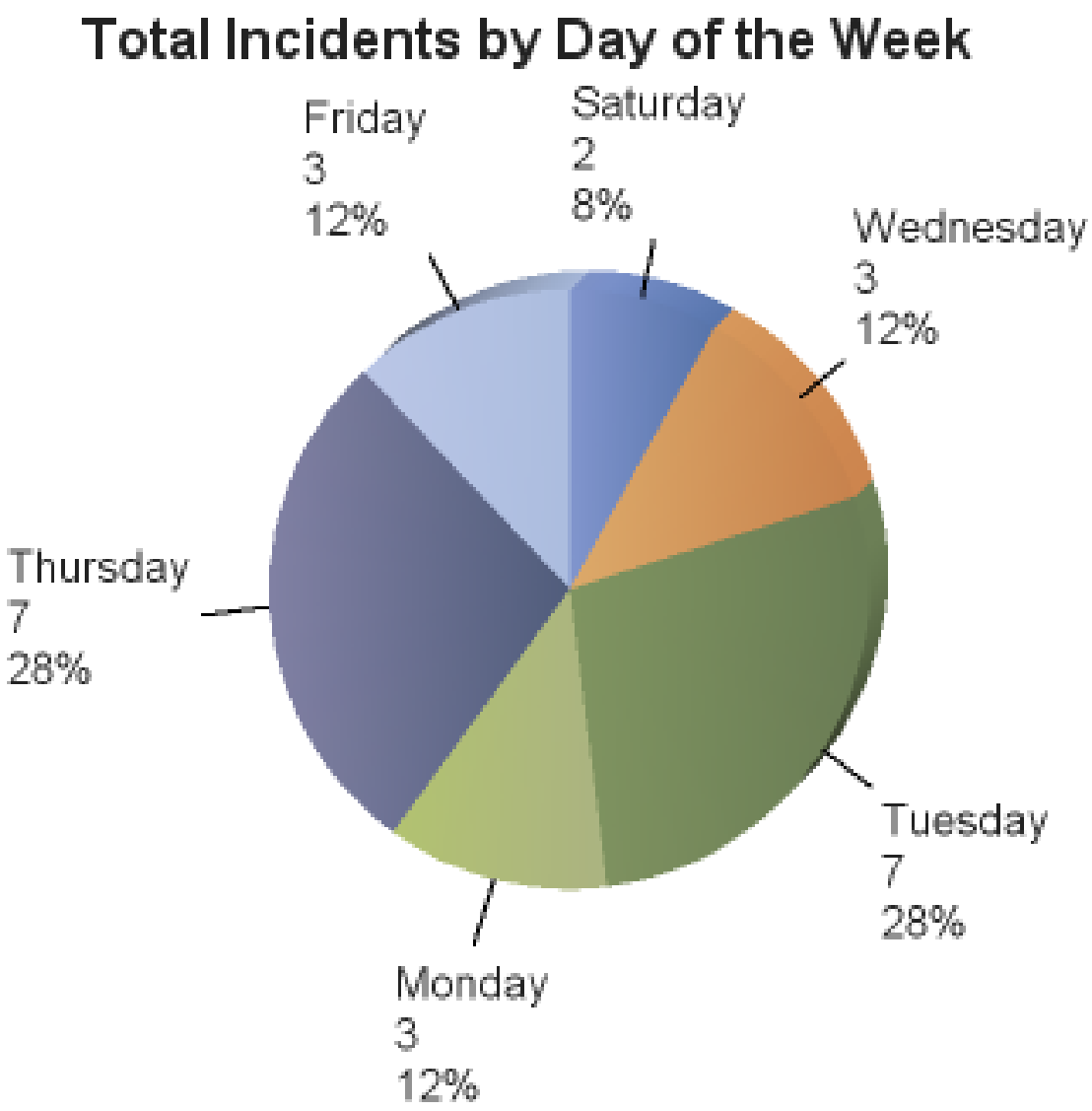


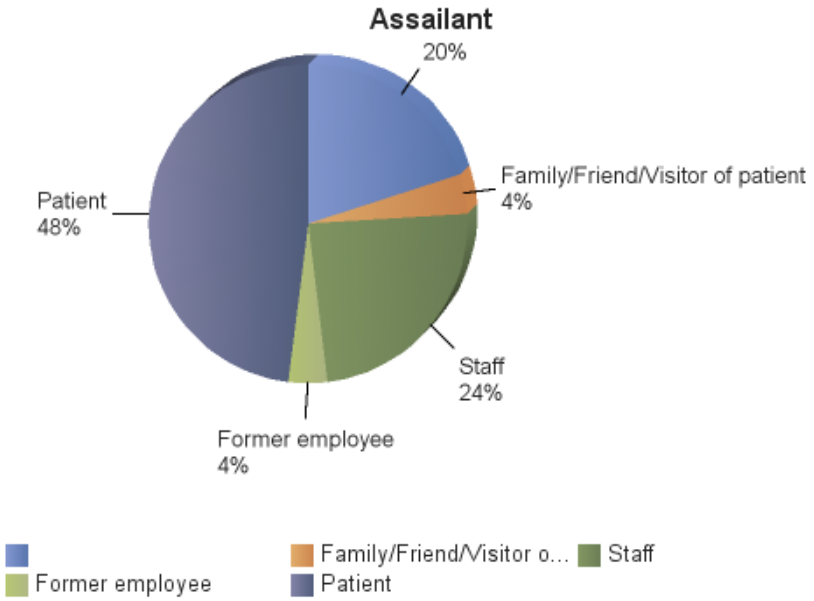

UORs Related to Lab
25
20
15
10
5
0
Jan-2020
Feb-2020
Mar-2020
Apr-2020
May-2020
Jun-2020
Jul-2020
Aug-2020
Sep-2020
Oct-2020
Nov-2020
Dec-2020
Other
Omitted a test or proc...
Improper technique oth...
Performed on wrong p...
Delay
Order Issue
Error reporting results
Unexpected complicati...
Specimen Problems
Staff/Patient did not ar...
Delay due to Hospital/...
Incorrect Diagnostic R...

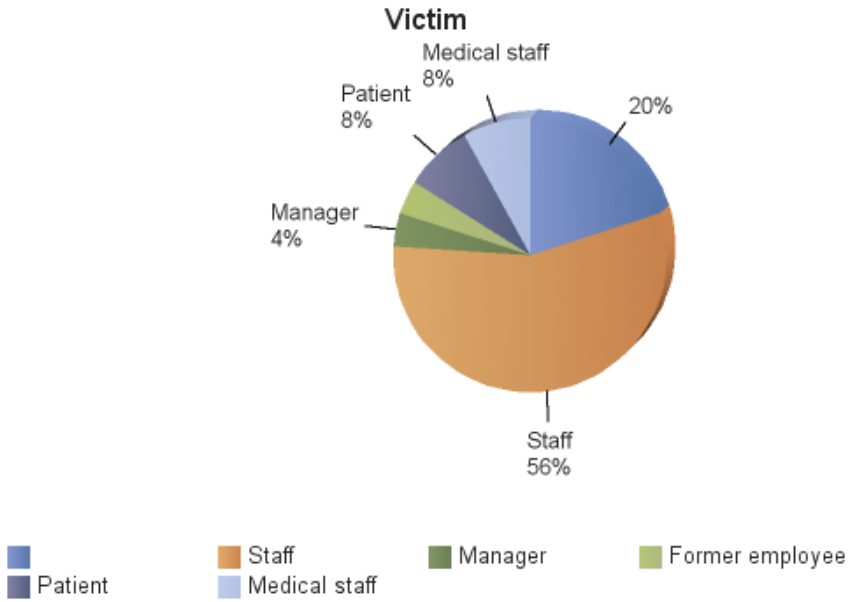

UORs Related to Nursing
Nov-2020
Sep-2020
Jul-2020
May-2020
Mar-2020
Jan-2020
0
5
10
15
Codes - Rapid Respon...
Communication
Complaints/review req...
Confidentiality/PHI Bre...
Critical Indicator
ED
Equipment/Supply/Dev...
Falls/Slips
IV issues/Blood transf...
Med Surg
Medication Occurrenc...
Mishandled Sharps
OB/Nursery
Procedure/Test/Speci...
Safety/Security
Skin integrity concern
Transfer - Internal or E...
Workplace Violence

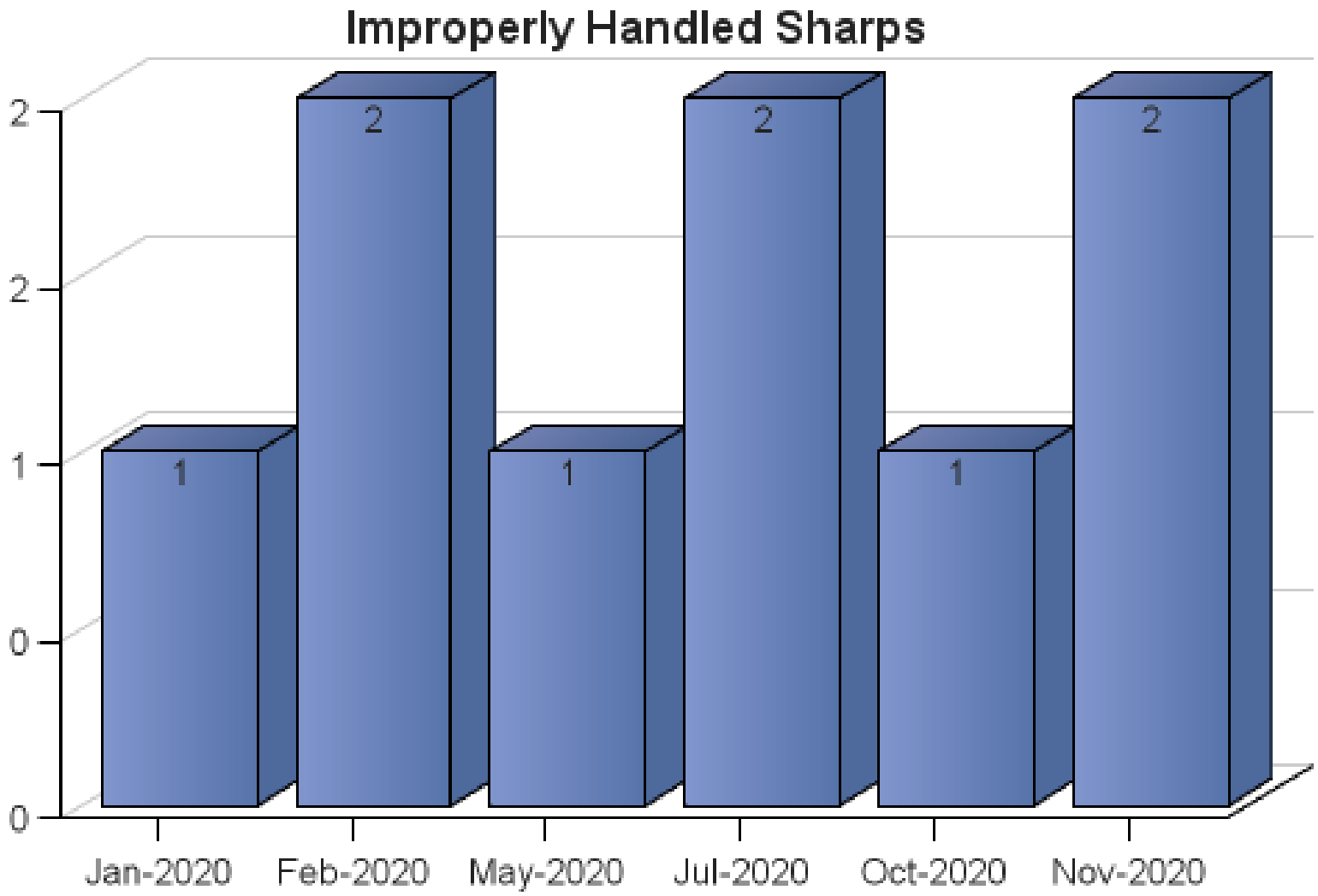

Total Workplace Violence QRR
6
5
4
3
2
1
0
4
4
1
1
1
6
1
3
1
2
1
Jan-2020
Feb-2020
Mar-2020
Apr-2020
May-2020
Jun-2020
Jul-2020
Aug-2020
Sep-2020
Nov-2020
Dec-2020

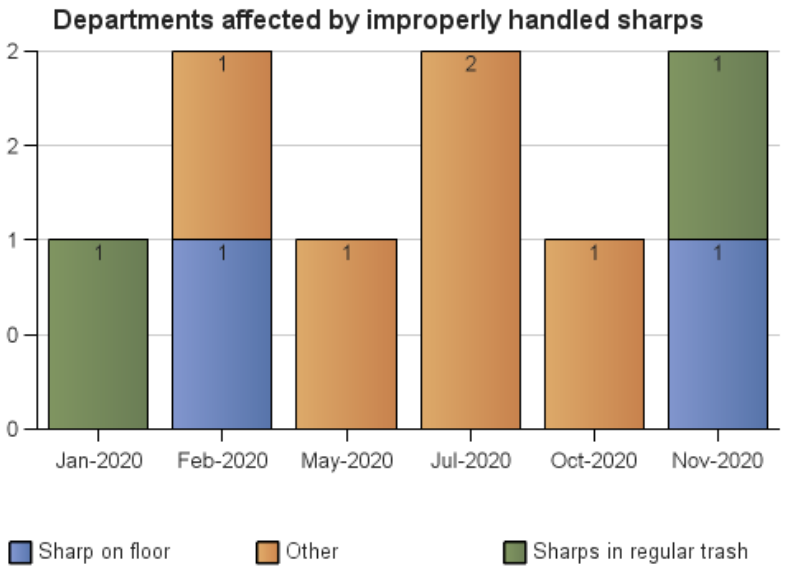

Type of Aggression
6
5
4
3
2
1
0
1
2
1
3
1
1
1
1
3
2
1
1
2
1
1
1
1
Jan-2020
Feb-2020
Mar-2020
Apr-2020
May-2020
Jun-2020
Jul-2020
Aug-2020
Sep-2020
Nov-2020
Dec-2020
Other threat of physica...
Physical attack (biting...
Threat or the use or a ...
Verbal abuse

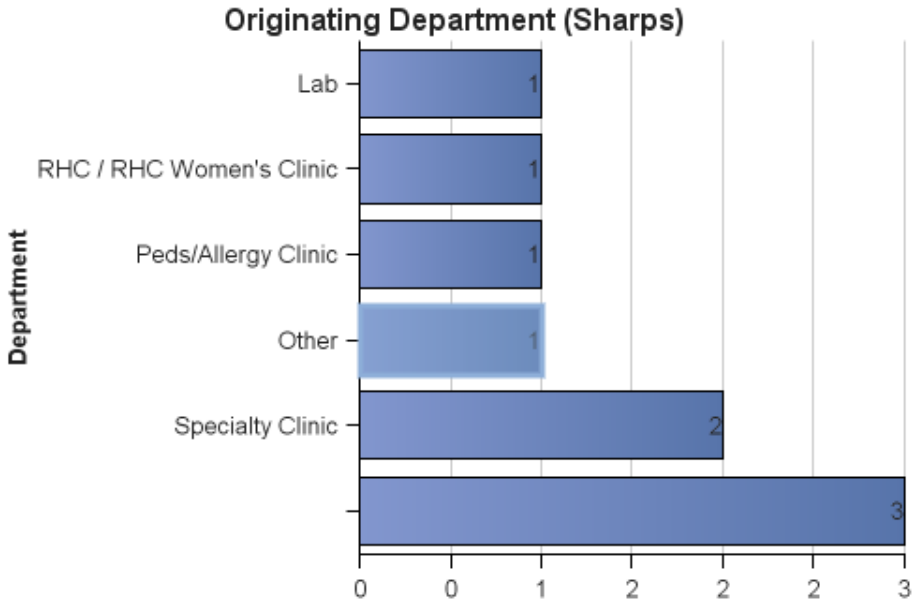

Total Incidents by Day of the Week
Friday
3
12%
Saturday
2
8%
Wednesday
3
12%
Thursday
7
28%
Tuesday
7
28%
Monday
3
12%

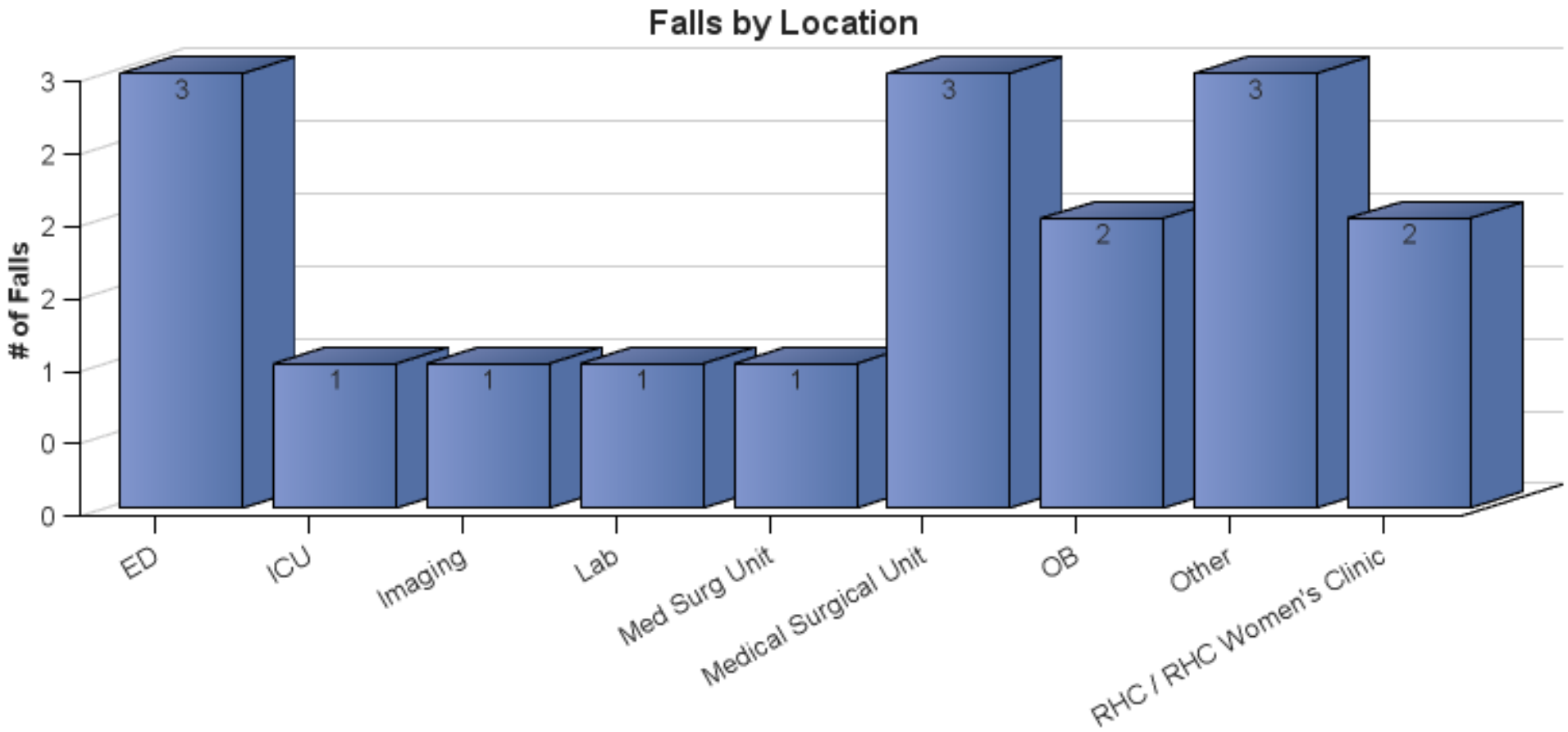

Assailant
20%
Family/Friend/Visitor of patient
4%
Patient
48%
Staff
24%
Former employee
4%
Family/Friend/Visitor o...
Staff
Former employee
Patient

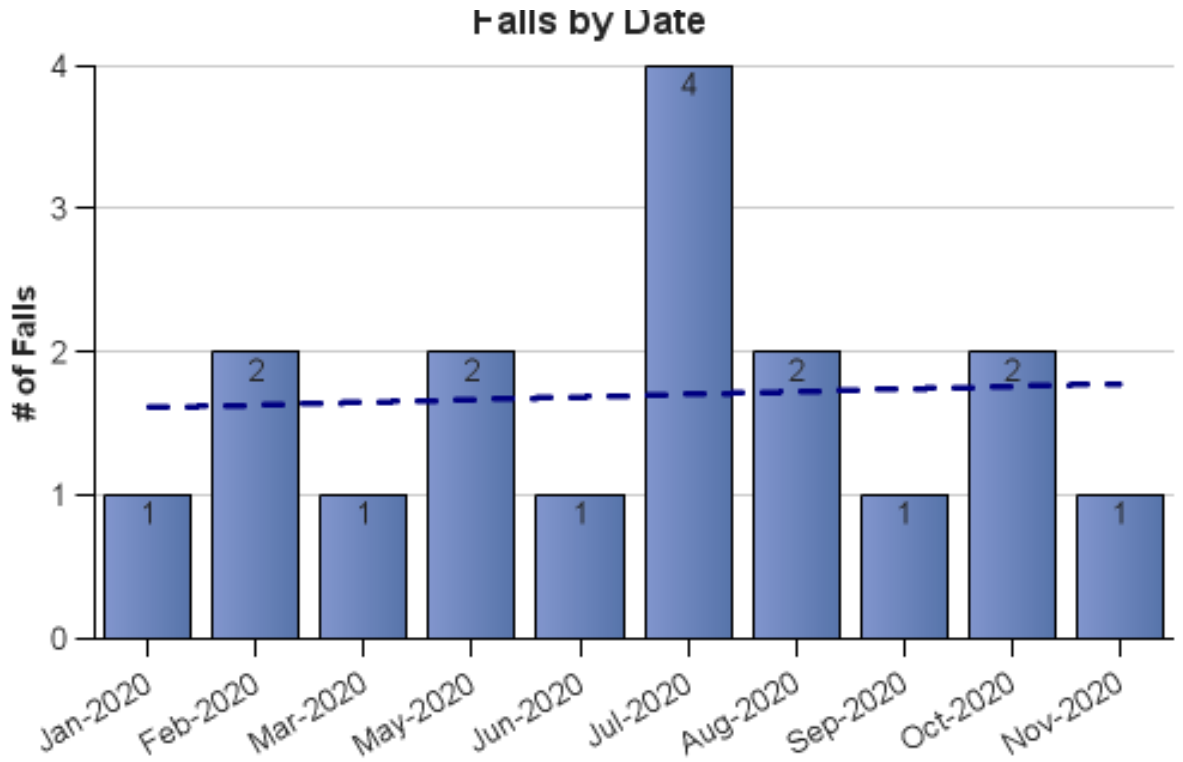

Victim
Medical staff
8%
Patient
8%
20%
Manager
4%
Staff
56%
Staff
Manager
Former employee
Patient
Medical staff


Improperly Handled Sharps
2
2
1
0
0
1
2
1
2
1
2
Jan-2020
Feb-2020
May-2020
Jul-2020
Oct-2020
Nov-2020

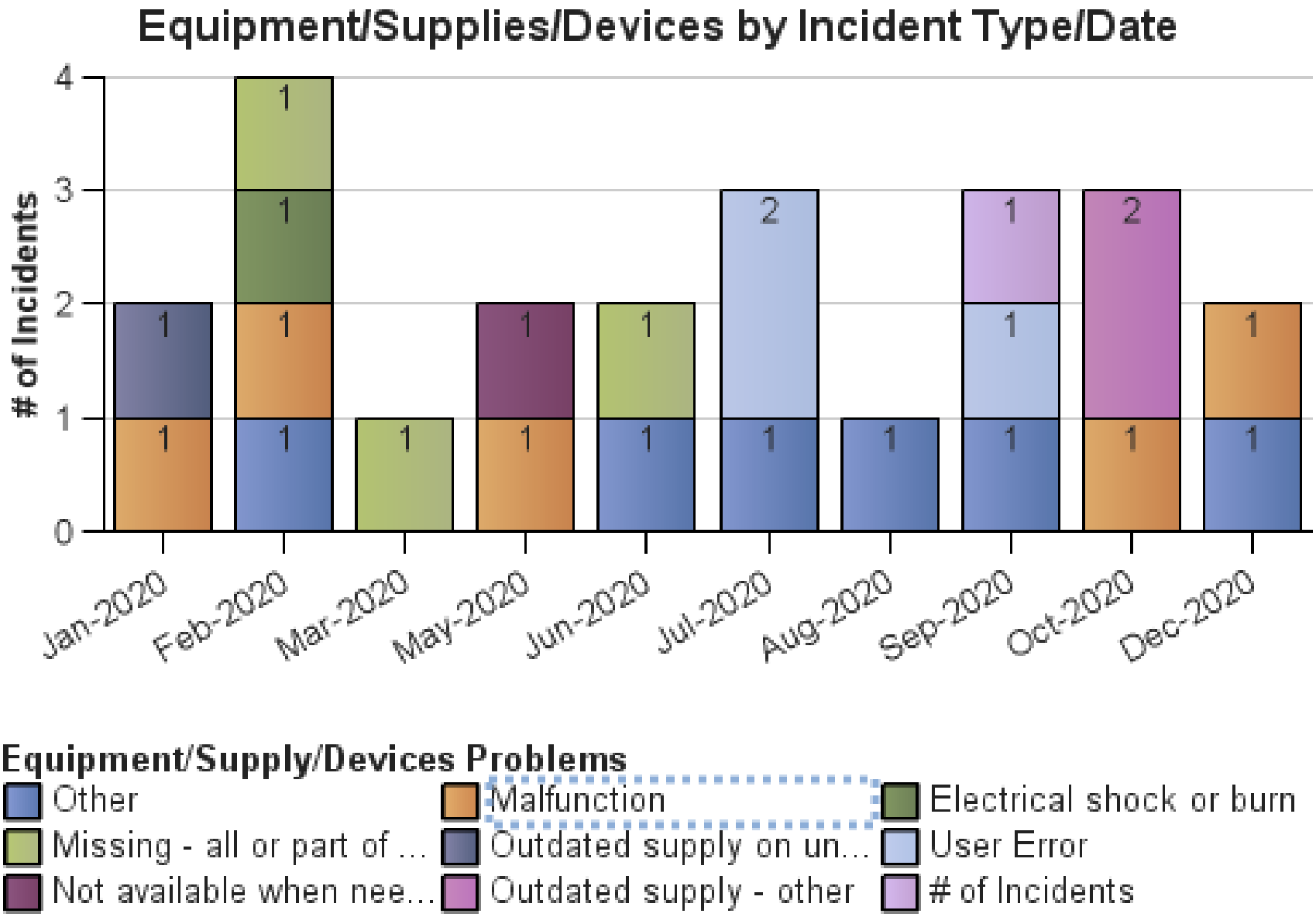

Departments affected by improperly handled sharps
2
2
1
0
1
1
1
2
1
1
1
1
Jan-2020
Feb-2020
May-2020
Jul-2020
Oct-2020
Nov-2020
Sharp on floor
Other
Sharps in regular trash

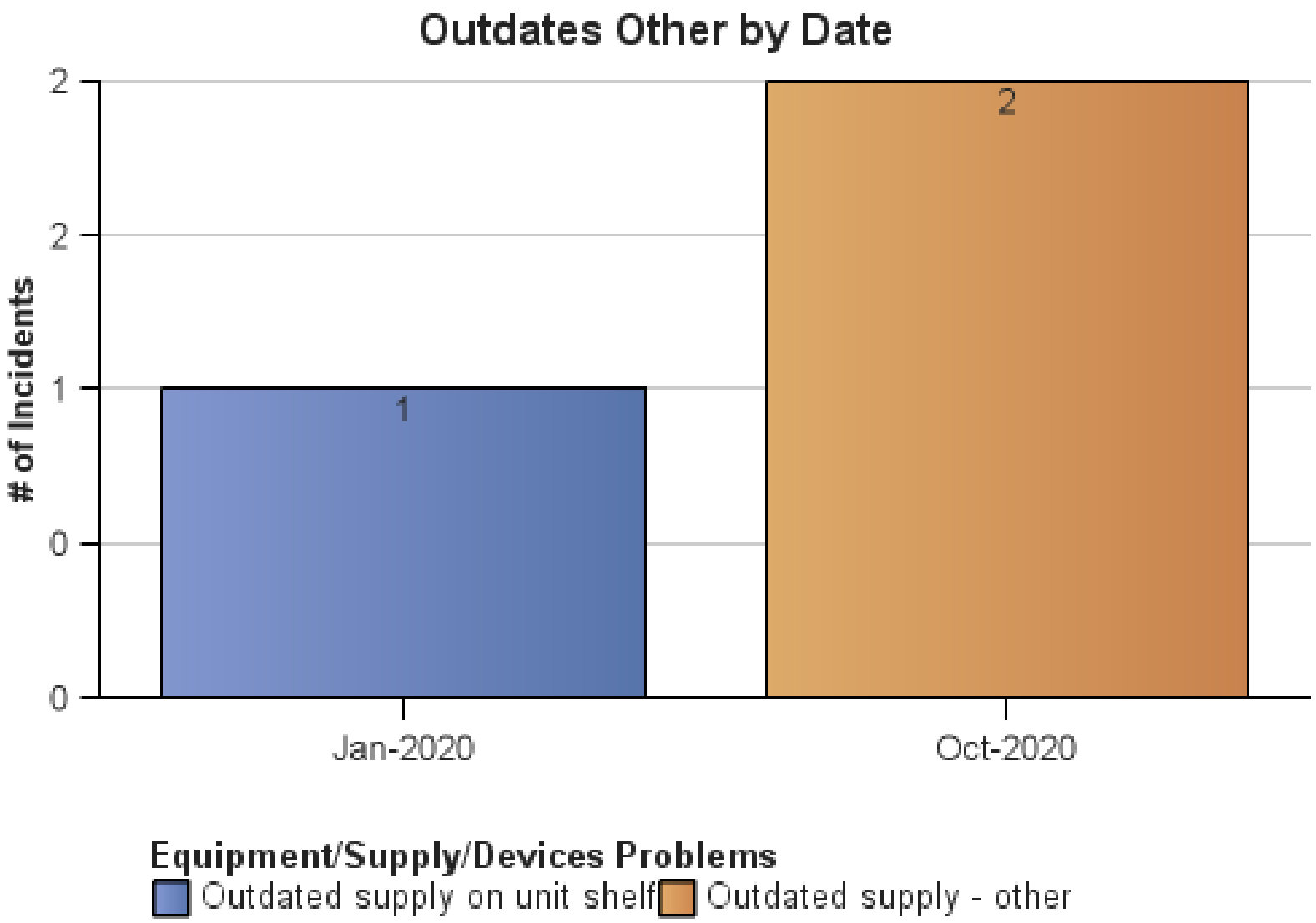

Originating Department (Sharps)
Department
Lab
RHC / RHC Women's Clinic
Peds/Allergy Clinic
Other
Specialty Clinic
1
1
1
1
2
3
0
0
1
2
2
2
3

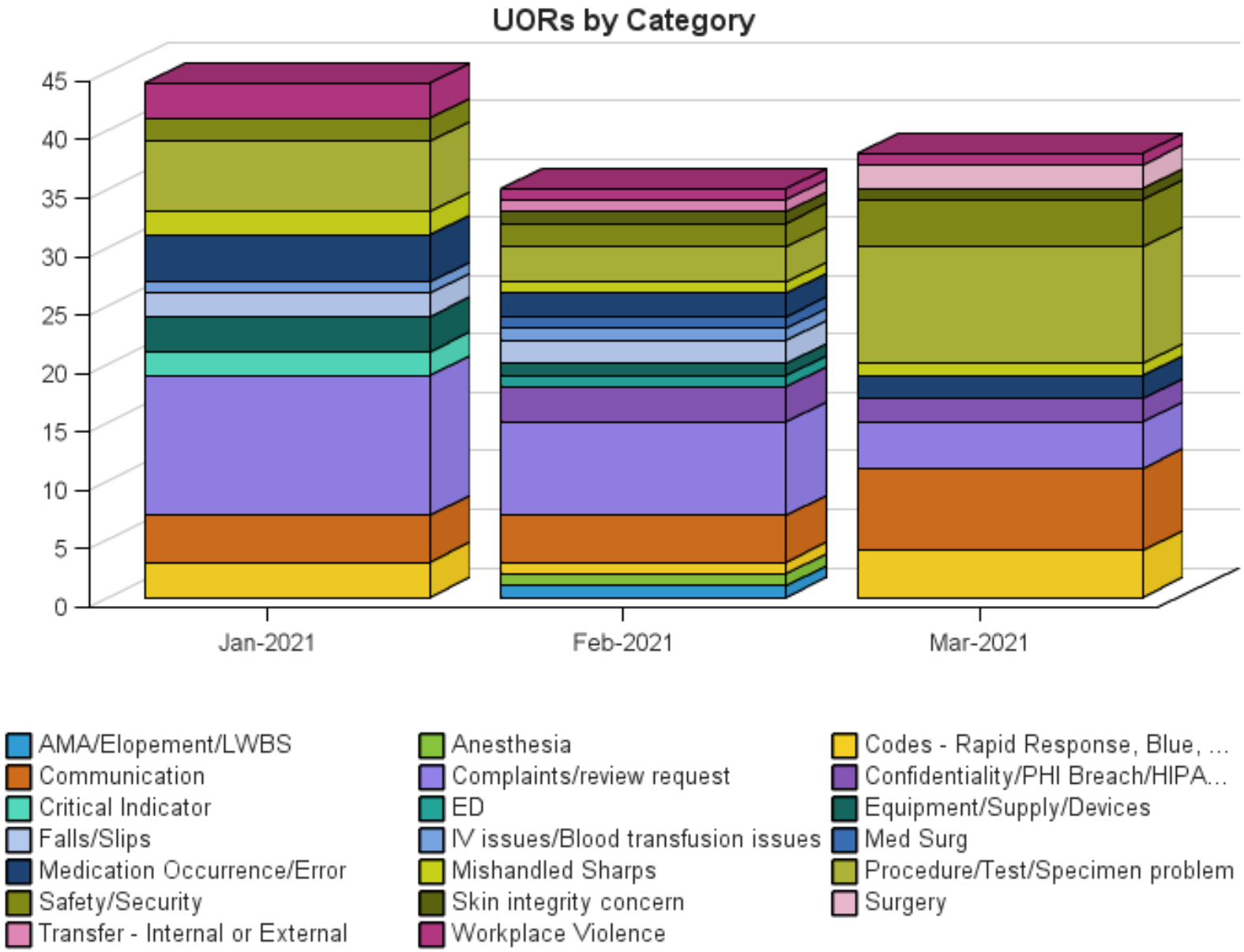

Falls by Location
# of Falls
3
2
2
2
1
0
0
3
1
1
1
1
3
2
3
2
ED
ICU
Imaging
Lab
Med Surg Unit
Medical Surgical Unit
OB
Other
RHC / RHC Women's Clinic



# of Falls	Falls/Slip Problem(s)						Total
	Ambulating	Bathroom	Bed/Crib	Chair	Grounds/floor issues	Other	
Not Identified	4	1		2	3	2	**12**
Confused	2		1			1	**4**
Oriented	1					1	**2**
Total	**7**	**1**	**1**	**2**	**3**	**4**	**18**

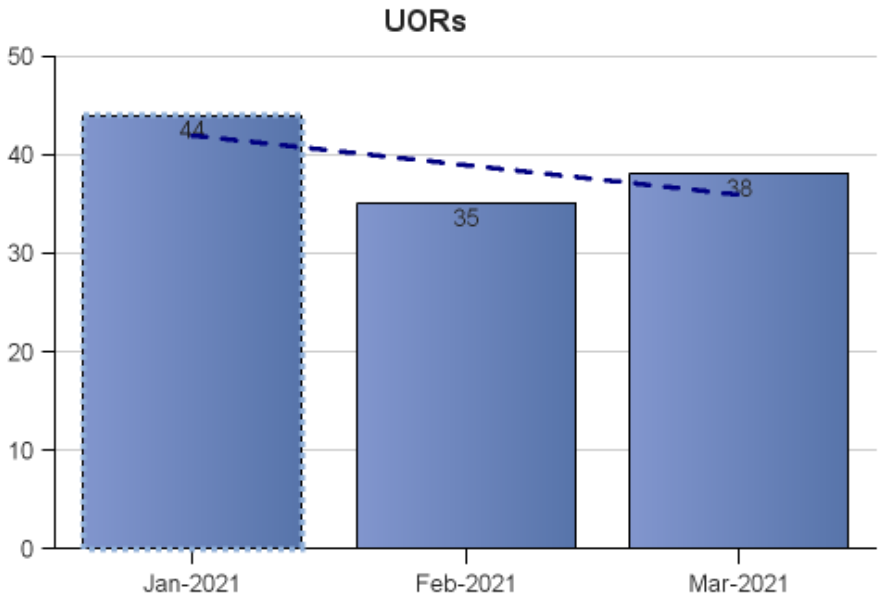

Equipment/Supplies/Devices by Incident Type/Date
# of Incidents
0
1
2
3
4
Jan-2020
Feb-2020
Mar-2020
May-2020
Jun-2020
Jul-2020
Aug-2020
Sep-2020
Oct-2020
Dec-2020
Equipment/Supply/Devices Problems
Other
Malfunction
Electrical shock or burn
Missing - all or part of ...
Outdated supply on un...
User Error
Not available when nee...
Outdated supply - other
# of Incidents

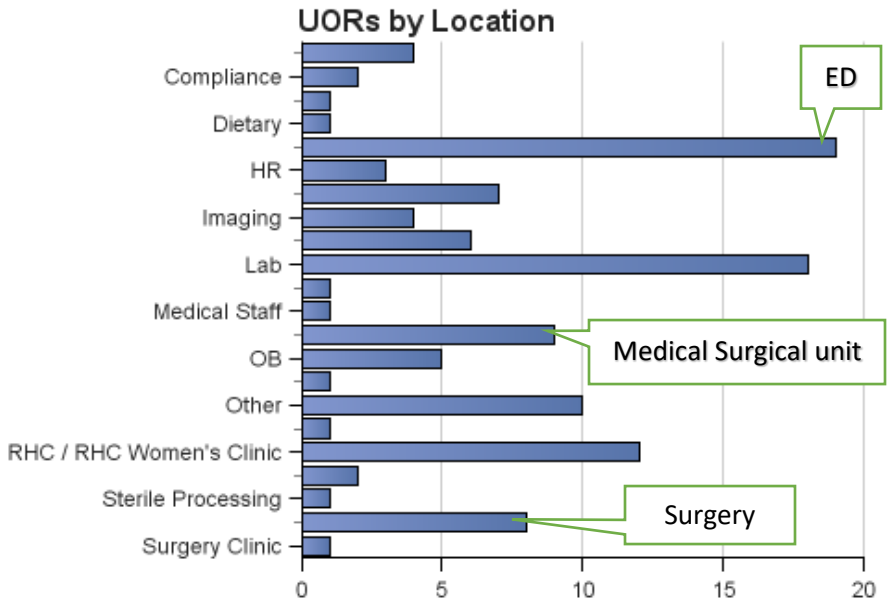

Outdates Other by Date
# of Incidents
2
2
1
0
0
1
2
Jan-2020
Oct-2020
Equipment/Supply/Devices Problems
Outdated supply on unit shelf
Outdated supply - other

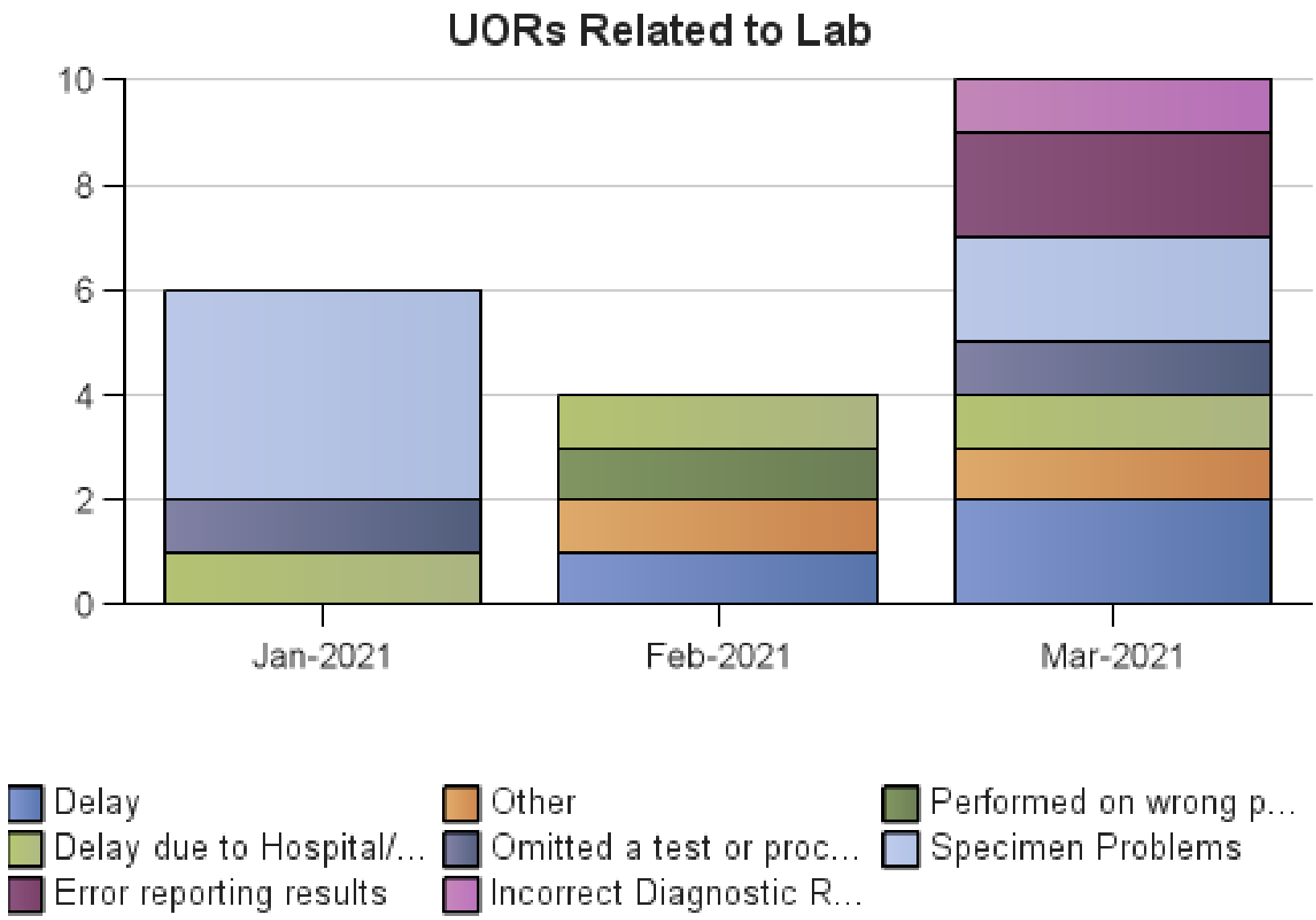

UORs by Category
45
40
35
30
25
20
15
10
5
0
Jan-2021
Feb-2021
Mar-2021
AMA/Elopement/LWBS
Anesthesia
Codes - Rapid Response, Blue, ...
Communication
Complaints/review request
Confidentiality/PHI Breach/HIPA...
Critical Indicator
ED
Equipment/Supply/Devices
Falls/Slips
IV issues/Blood transfusion issues
Med Surg
Medication Occurrence/Error
Mishandled Sharps
Procedure/Test/Specimen problem
Safety/Security
Skin integrity concern
Surgery
Transfer - Internal or External
Workplace Violence

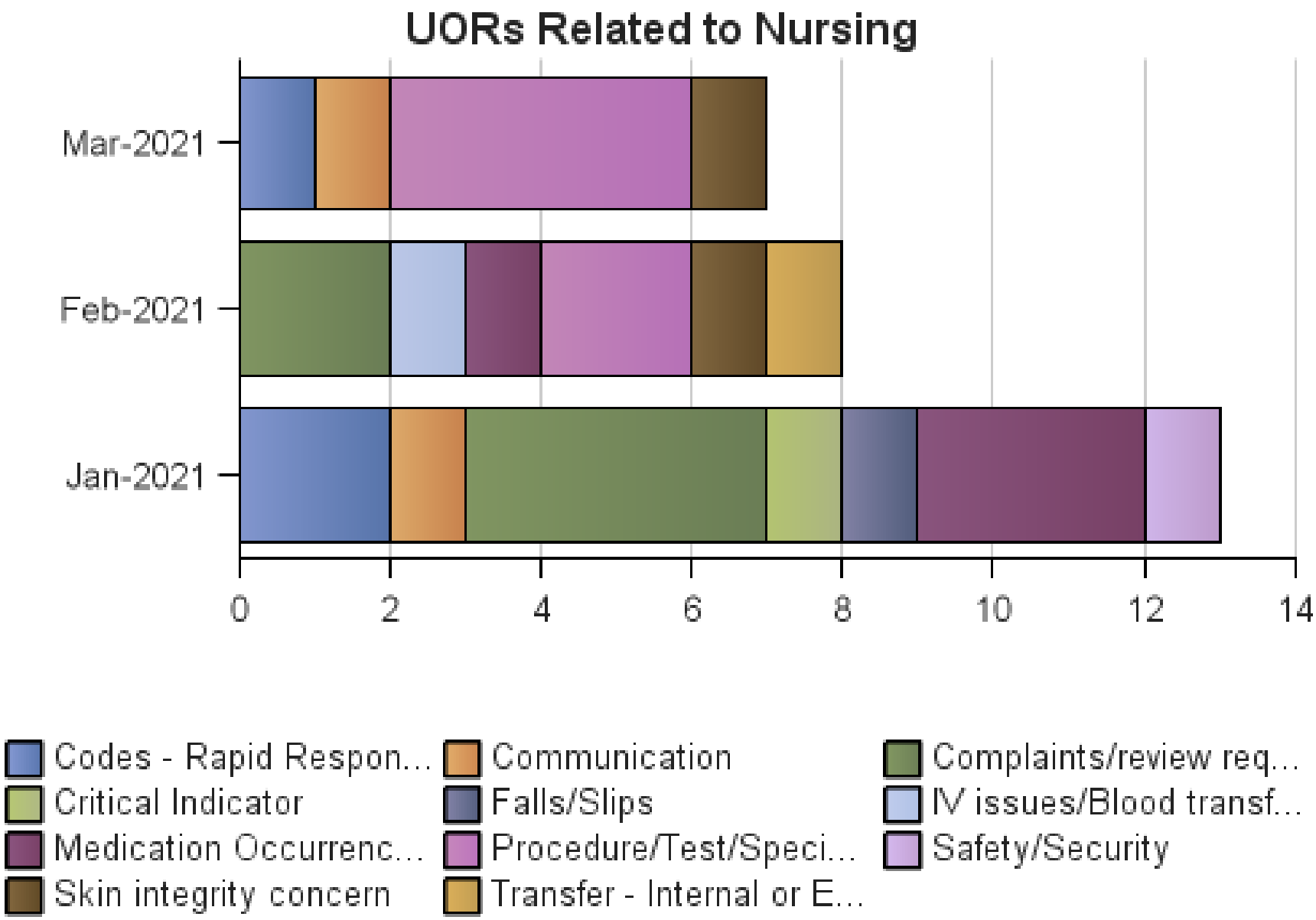
Q1 2021 SUMMARY OF UNUSUAL OCCURRENCE REPORTS

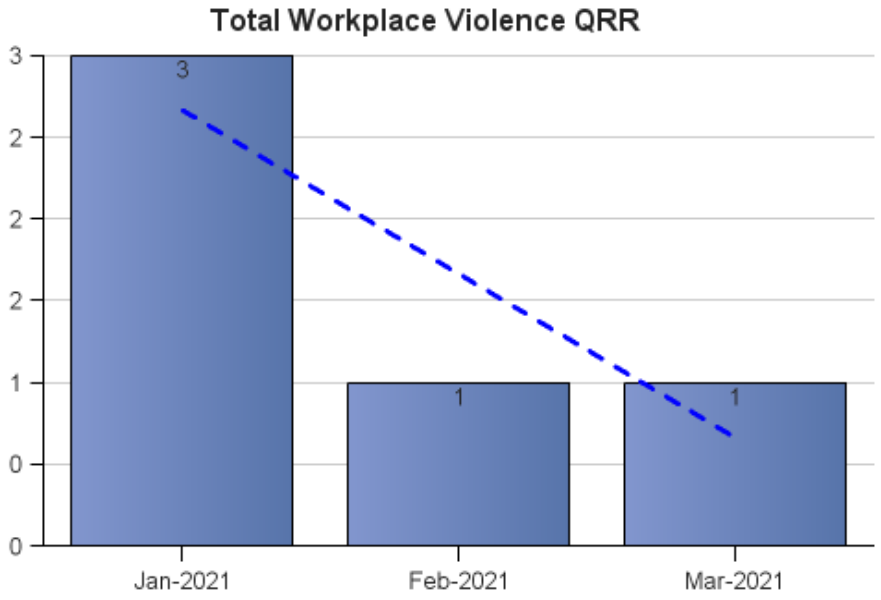
	Jan-2021	Feb-2021	Mar-2021	Total
AMA/Elopement/LWBS		1		1
Anesthesia		1		1
Codes - Rapid Response, Blue, Deescalation	3	1	4	8
Communication	4	4	7	15
Complaints/review request	12	8	4	24
Confidentiality/PHI Breach/HIPAA violation		3	2	5
Critical Indicator	2			2
ED		1		1
Equipment/Supply/Devices	3	1		4
Falls/Slips	2	2		4
IV issues/Blood transfusion issues	1	1		2
Med Surg		1		1
Medication Occurrence/Error	4	2	2	8
Mishandled Sharps	2	1	1	4
Procedure/Test/Specimen problem	6	3	10	19
Safety/Security	2	2	4	8
Skin integrity concern		1	1	2
Surgery			2	2
Transfer - Internal or External		1		1
Workplace Violence	3	1	1	5
Total	**44**	**35**	**38**	**117**

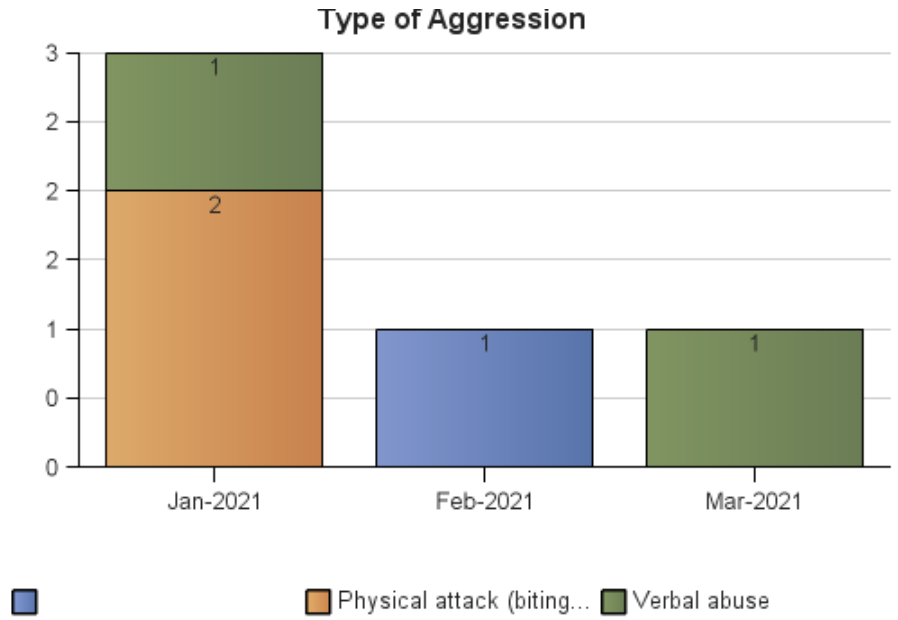

UORs
50
40
30
20
10
0
44
35
38
Jan-2021
Feb-2021
Mar-2021


UORs by Location
Compliance
Dietary
HR
Imaging
Lab
Medical Staff
OB
Other
RHC / RHC Women's Clinic
Sterile Processing
Surgery Clinic
0
5
10
15
20
ED
Medical Surgical unit
Surgery

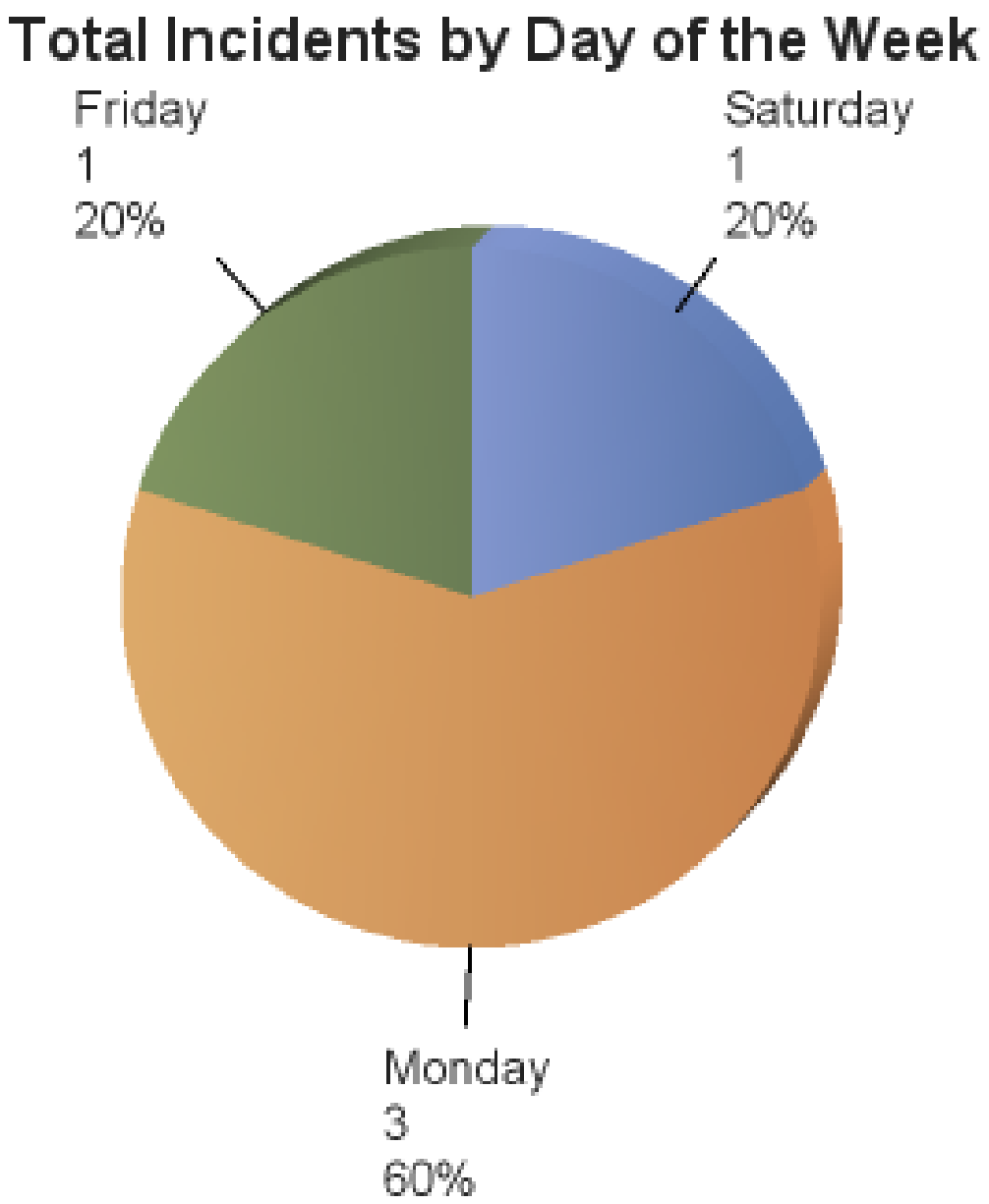

UORs Related to Lab
10
8
6
4
2
0
Jan-2021
Feb-2021
Mar-2021
Delay
Delay due to Hospital/...
Error reporting results
Other
Omitted a test or proc...
Incorrect Diagnostic R...
Performed on wrong p...
Specimen Problems

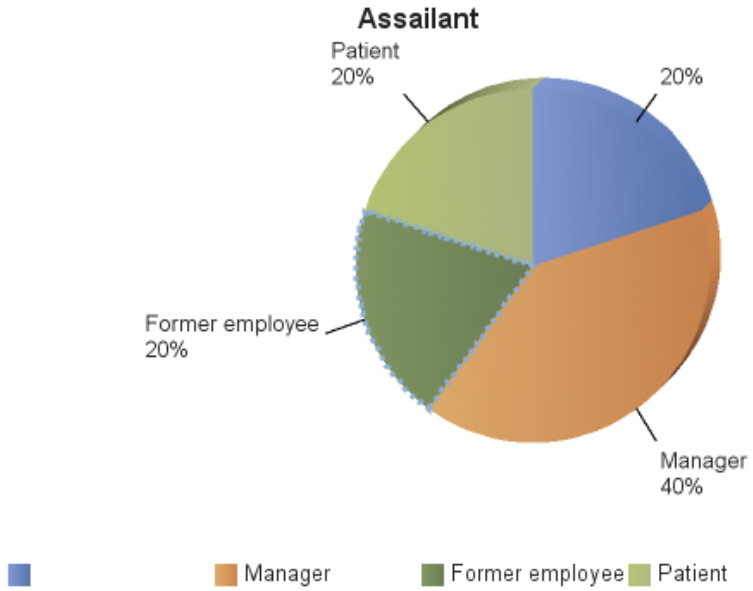

UORs Related to Nursing
Mar-2021
Feb-2021
Jan-2021
0
2
4
6
8
10
12
14
Codes - Rapid Respon...
Communication
Complaints/review req...
Critical Indicator
Falls/Slips
IV issues/Blood transf...
Medication Occurrenc...
Procedure/Test/Speci...
Safety/Security
Skin integrity concern
Transfer - Internal or E...

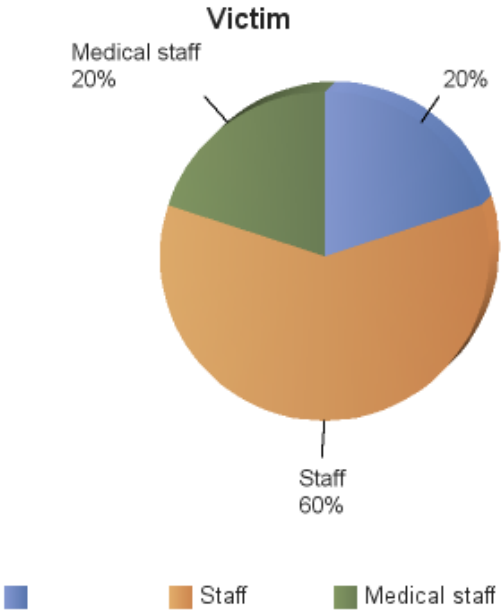

Total Workplace Violence QRR
3
2
2
2
1
0
3
1
1
Jan-2021
Feb-2021
Mar-2021

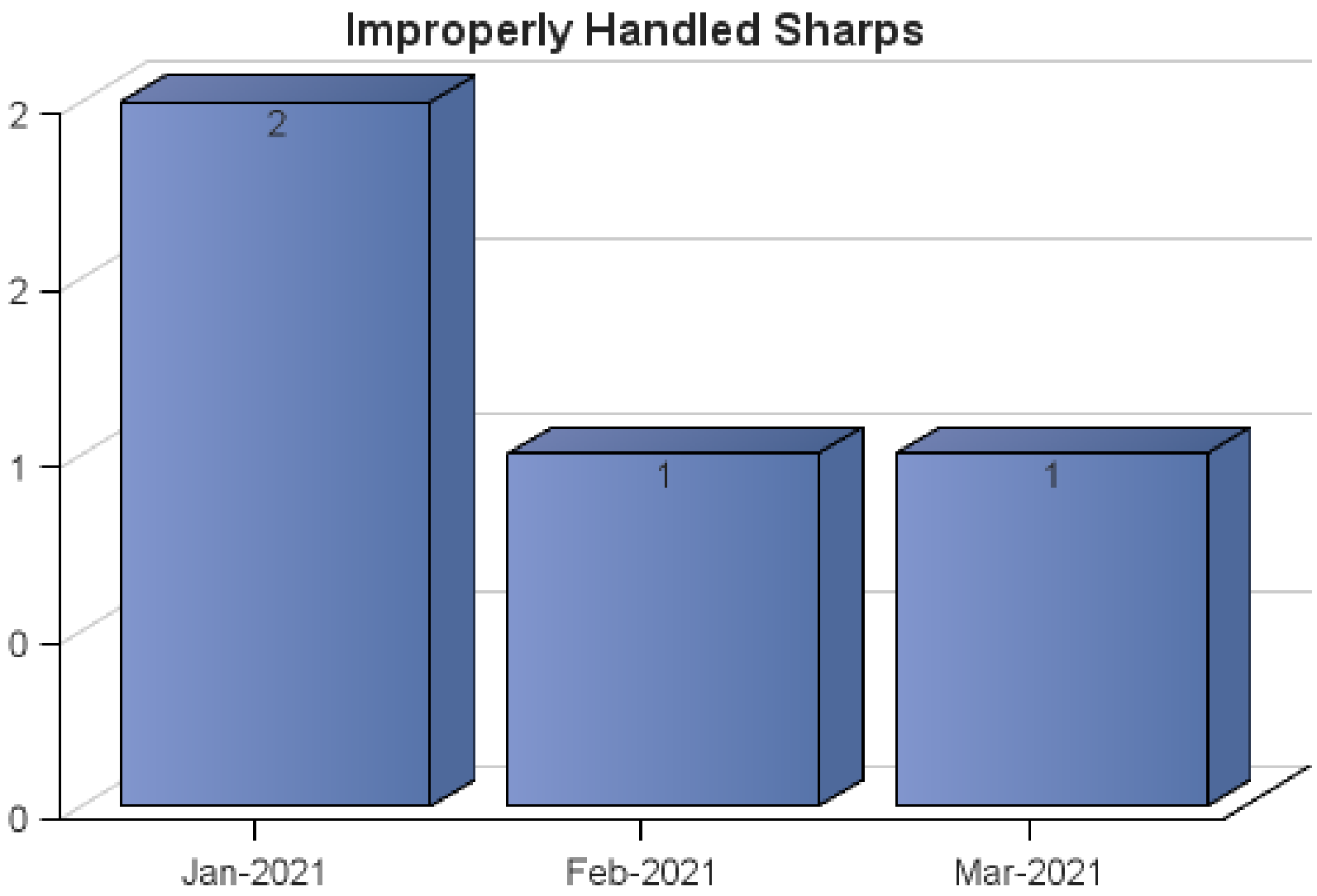

Type of Aggression
3
2
2
2
1
0
1
2
1
1
Jan-2021
Feb-2021
Mar-2021
Physical attack (biting...
Verbal abuse

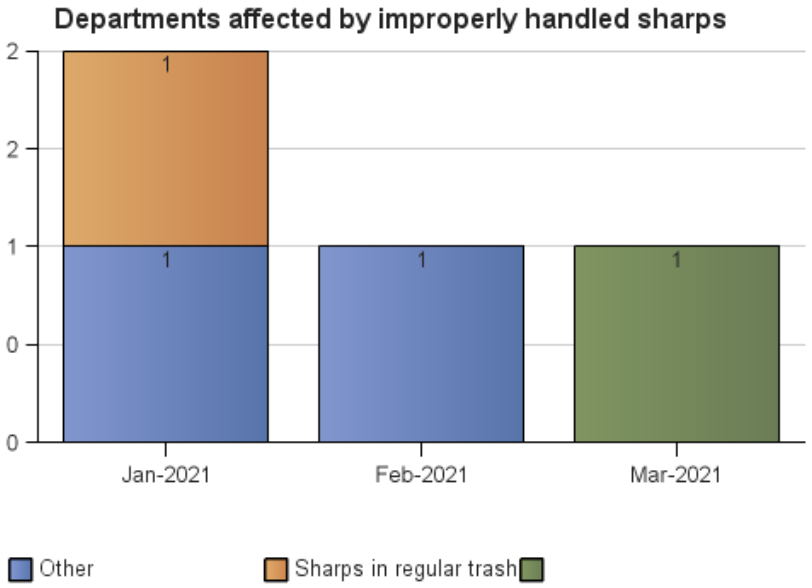
6

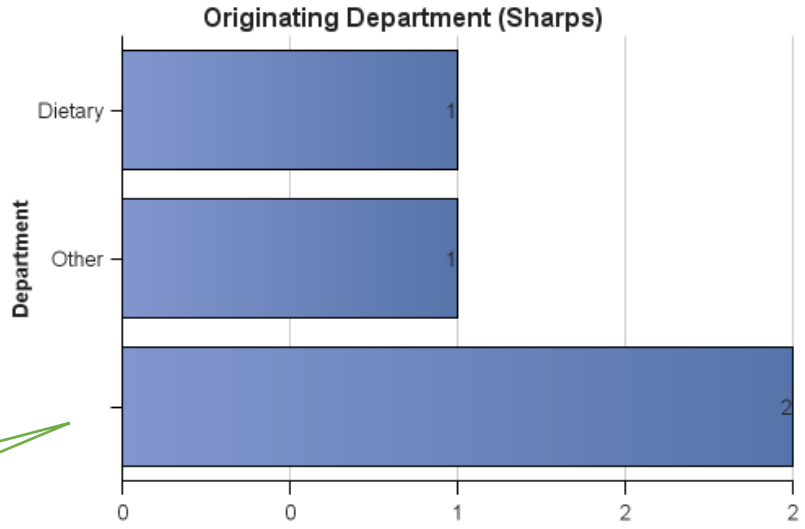

Total Incidents by Day of the Week
Friday
1
20%
Saturday
1
20%
Monday
3
60%


Assailant
Patient
20%
20%
Former employee
20%
Manager
40%
Manager
Former employee
Patient

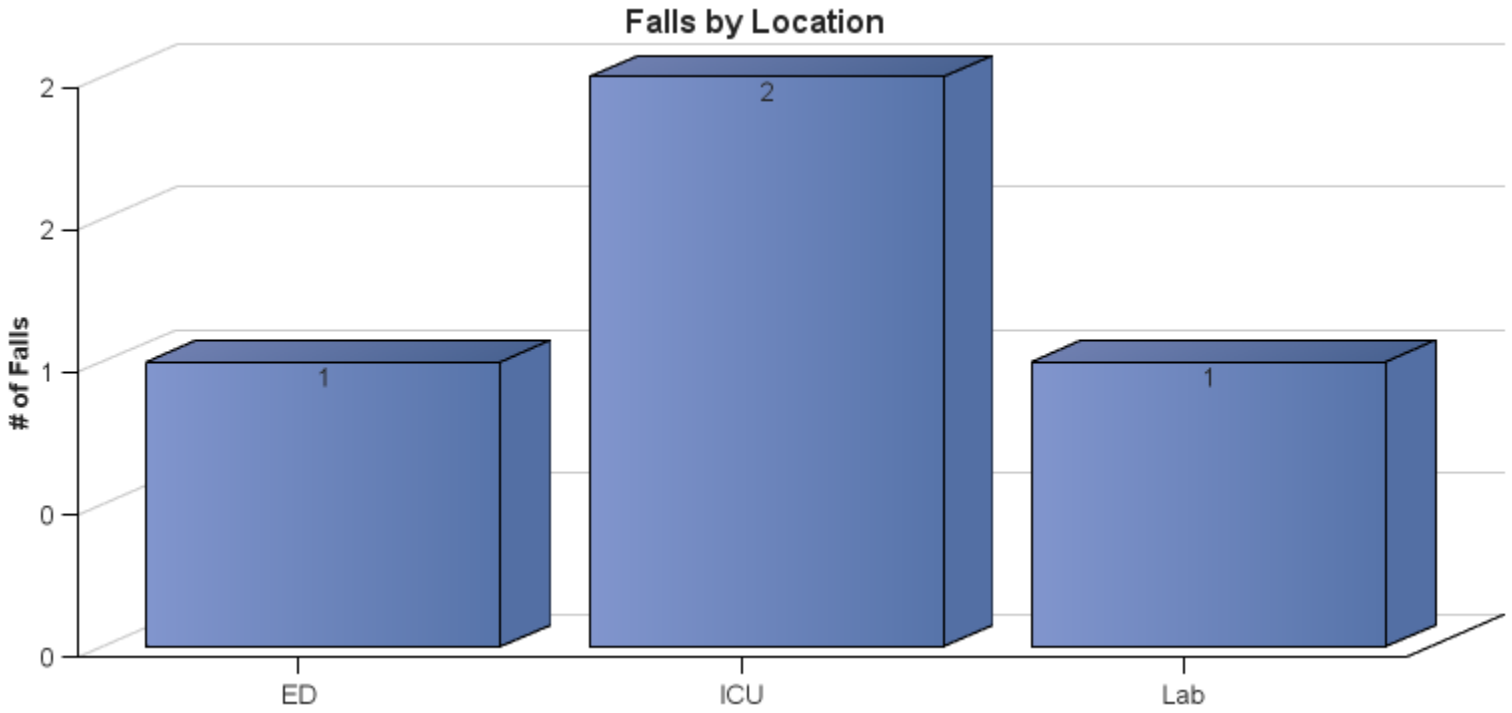

Victim
Medical staff
20%
20%
Staff
60%
Staff
Medical staff


Improperly Handled Sharps
2
2
1
0
0
2
1
1
Jan-2021
Feb-2021
Mar-2021

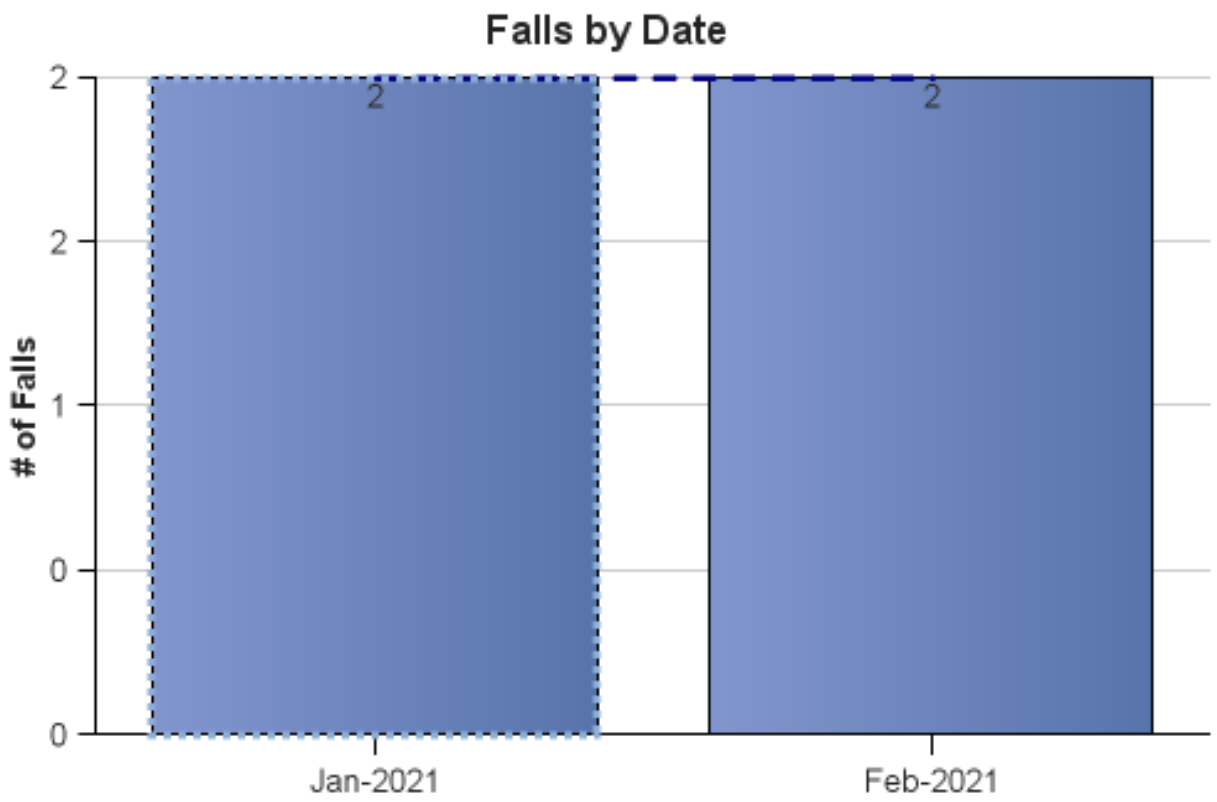


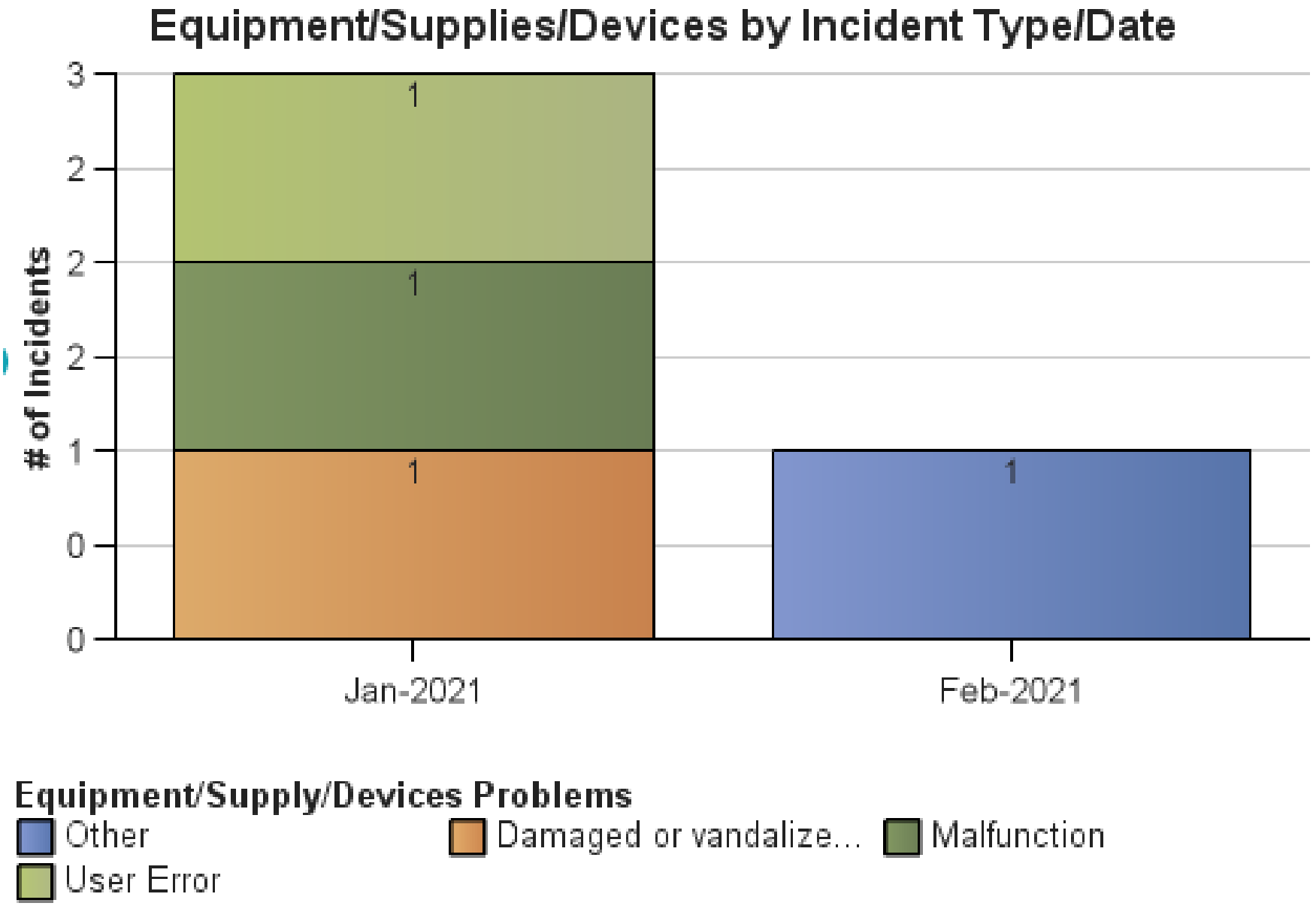


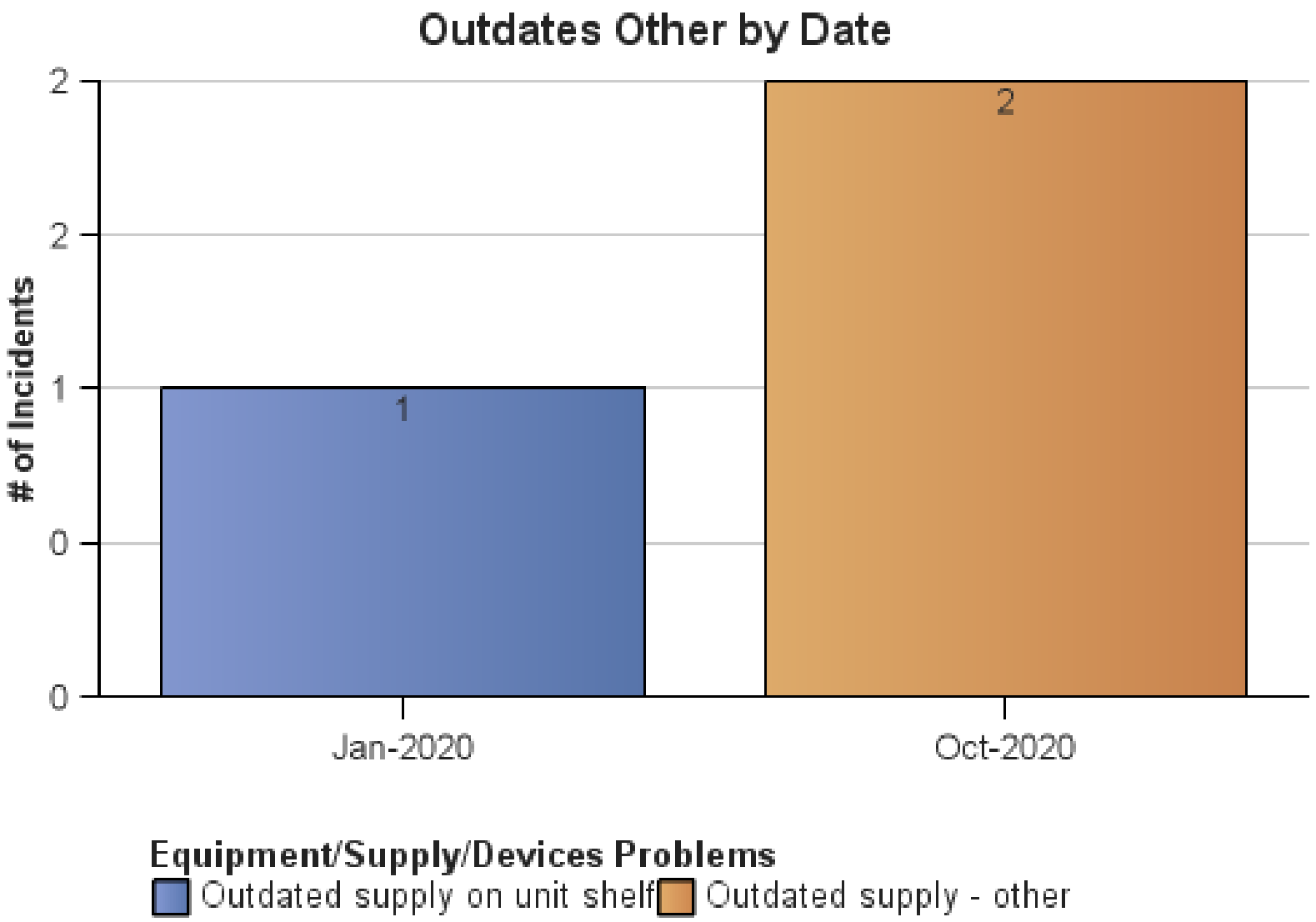
Labeling issues due to a data connection issue. We are working on a resolution.



# of Falls	Falls/Slip Problem(s)			Total
	Ambulating	Chair	Other	
Not Identified		1		1
Confused			2	2
Oriented	1			1
Total	**1**	**1**	**2**	**4**


Falls by Date
# of Falls
2
2
1
0
0
2
2
Jan-2021
Feb-2021


Equipment/Supplies/Devices by Incident Type/Date
# of Incidents
3
2
2
2
1
0
0
1
1
1
1
Jan-2021
Feb-2021
Equipment/Supply/Devices Problems
Other
Damaged or vandalize...
Malfunction
User Error


Outdates Other by Date
# of Incidents
2
2
1
0
0
1
2
Jan-2020
Oct-2020
Equipment/Supply/Devices Problems
Outdated supply on unit shelf
Outdated supply - other

Global Services by Hyland

PROFESSIONAL SERVICES PROPOSAL

Northern Inyo Healthcare District

Document Version: 1

OneContent Image Backload

Document Date: 8 Jun 2021

THIS PROPOSAL WILL EXPIRE **90** DAYS FROM THE ABOVE DATE UNLESS SIGNED BY BOTH PARTIES.

RFS# 39718922 (a Hyland internal request tracking number)

TABLE OF CONTENTS

INTRODUCTION

The purpose of this document (“Services Proposal”) is to define the goals, scope, fees and other important details supporting the delivery of Professional Services for one or more projects defined in the Project Areas section.

PROPOSAL TERMS & USAGE

Hyland Software Inc. (“Hyland”) is pleased to provide the following estimate for professional services related to the use of the OneContent software (“Software”) for Northern Inyo Healthcare District (“Customer”) as described in the Project Areas section of this document.

The content of this Services Proposal is subject to review and revision by both Hyland and Customer until fully executed by both parties.

Upon execution of this Services Proposal, the Hyland project manager or designated resource will contact Customer project team to discuss project logistics and potential start dates. At this time, Hyland resource availability will be reviewed and presented to Customer. Start times can vary based on existing work volumes. The project(s) will begin upon a mutually agreed upon date as soon as resource availability and Customer availability allow. Once the project start date has been determined, resources will be assigned and scheduled to begin delivery of the services described in this Services Proposal.

Services described in this Services Proposal will be provided in accordance with the terms of Schedule 1 - Terms and Conditions, attached to this Services Proposal (“Schedule”). Such Schedule shall be fully incorporated herein; provided that if Customer and Hyland (or one of its predecessors) have previously entered into a separate contract that governs the Services provided under this Services Proposal (such as a stand-alone services agreement, Master Software License, Services and Support Agreement, Hosting Agreement, Subscription Agreement or Framework Agreement), such contract will control in the event of any conflict between Schedule and such contract (regardless of whether the contract contemplates services performed in accordance with a SOW, Contract Supplement, Sales Order, Order From or a Services Proposal). All terms of any purchase order or similar document provided by Customer including but not limited to any Customer pre-printed terms and any terms that are inconsistent or conflict with this Services Proposal shall be null and void.

Please note that some of the resources assigned to perform the Services may be employees of Hyland Software, Inc.’s subsidiaries located in other countries.

After execution, all changes to this Services Proposal will follow the Project Change Control Process. All changes must be made to this Services Proposal through an authorized Change Order unless otherwise agreed to in writing by both Hyland and Customer.

PROJECT AREAS

Hyland will provide the following Professional Services described within this Services Proposal:

Project 1 – OneContent MPI and Image Backload from Athena

Scope

Hyland will provide Professional Services to Customer to implement the MPI and Image Backload solution.

Customer is contracting with Hyland to perform a backload of MPI data and Documents from Customer's current Athena solution into Customer's current OneContent solution.

Hyland will migrate up to Two Hundred Thousand (200,000) Images as part of this proposal.

The MPI data backload process will use a Hyland configured HL7 Inbound Interface to accept the backload of patients (MPI) from the Athena solution.

The image backload process uses, BDI, a flexible document import and migration utility for Hyland OneContent. BDI accepts document input in many well know document formats and performs all necessary conversion to image formats supported by OneContent.

Services Overview

The following is intended to provide Customer an understanding of the associated responsibilities of both Customer and Hyland.

MPI Data Backload Overview

Review the agreed upon scope, objectives, and participants in the project.	Responsible	Responsible
Create MPI backload file from Customer's Athena solution. File format is to be created based on Hyland MPI specifications.	Responsible	
Provide Hyland sample file for upload testing.	Responsible	
Build and configure new inbound Interface on Transagt Server to accept Customer's MPI Backload.		Responsible
Process sample file provided by Customer.		Responsible
Send backload file(s) to OneContent Transagt Server via inbound Interface.	Responsible	
Monitor processing of MPI backload.	Responsible	Responsible
Verify patients in OneContent once backload is completed.	Responsible	
Support Customer with issue resolution.		Responsible

Image Backload Overview

The image backload implementation begins with a discovery process to identify the required operating parameters. This involves identifying document types, number of documents to import, file storage requirements, and hardware resource planning. After the prerequisite discovery process is completed, all required software components will be built in a test environment and tested. Prior to the backload go-live, the built BDI components in the test environment will be replicated in the production environment.

BDI backloads always require dedicated release threads because of the typically large number of documents that will be migrated to OneContent. It is not required to build these release threads in the test environment. The BDI component build process in production will include the dedicated release threads. Release thread components are batch compiler, release server and index upload.

The exception to this is when a BDI backload parallels a new installation of OneContent. In this case, BDI and all required components of the backload release threads will be built and tested in the future production environment.

The following is a typical list of BDI operating parameters that must be resolved before starting a backload process:

1. Document identification –Document type mapping between source system and OneContent
2. Identification of all image formats of documents to be imported into OneContent.
3. Verification that all document formats can be converted to supported OneContent file formats
4. Import document file count and required OneContent file storage
5. Document MPI – verify that patient MPI data for import documents is present in OneContent
6. Identification of all hardware and software components required in OneContent

A. BDI Service
B. Batch Compiler
C. Release Server
D. Index Upload

Assumptions

This project is based upon the below assumptions being true. If for some reason these assumptions prove to be false, this could result in a scope change and may have an impact on the proposed cost and timeline to deliver:

1. Release Requirements
    A. Customer is utilizing a supported release version of all software; and
    B. Service Proposal assumes Customer is live on the current version of third party software and up to date on all maintenance agreements.

2. Implementation Schedule
    A. Customer and Hyland will mutually develop and agree upon a project implementation timeline at project kick-off which shall include implementation timelines, critical events, and the respective responsibilities of both Hyland and Customer;
    B. All Three (3) projects will be implemented together, and
    C. Hyland Resource will collaborate with Customer on processes for working together as a single team for build validation, testing, and issue resolution.

3. Work Requirements
    A. Service delivery will be remote.
    B. Remote work requires a mutually agreed upon remote connection to the OneContent environment.
    C. Resource availability is limited to 40 hours per week during normal business hours, Monday through Friday.

4. MPI Backload Requirements
    A. Customer shall provide Hyland with an MPI backload file from Customer's Athena solution in the agreed upon format for uploading into Customer's current OneContent solution.

5. Image Backload Requirements
    A. Hyland will setup, validate, train, and begin execution of the image backload. Customer will be responsible for monitoring and completing the image backload once successful images have been processed.
    B. Six Hundred Thousand (600,000) images will be backloaded into the OneContent solution from the Customer's current Athena Solution.

6. Inbound Document Feed Changes
    A. Service Proposal assumes no additions, removals, or modifications will be made to any document feeds except for the new BDI feed that will be built and configured for backloading of defined documents\images.

7. Hardware Changes

A. Service Proposal assumes no new hardware will be introduced into the production or test environments unless required by the addition of the Image Backload BDI feed.

8. Workflow Additions
    A. Service Proposal assumes no additions, removals, or modifications to workflow.

9. Testing
    A. Customer will develop test cases in advance of the testing period of the project; and
    B. Customer performs testing and provides Hyland with a notification of any issues based on the test cases developed by Customer. Hyland tracks the issues during Customer's user testing process using Hyland's issue tracker tool, and updates the Customer once the issues are resolved, whether by Hyland's project team or Customer's project team. Once Hyland determines all issues from testing have been resolved, the solution is ready for Go-Live.

10. Training
    A. Service Proposal provides no end user or super user training on the implemented solution.

11. Go-Live
    A. Solution will be migrated to Customer's production environment; and
    B. Assist Customer's IT Staff with Go-Live issue resolution.

12. Project Closure
    A. Service Path includes dedicated time for project closure. Hyland's project manager will schedule a meeting with Customer's project manager and project sponsor. The agenda will include introduction to Hyland's Technical Support Team, discussion of the state of relationship between organizations, and next steps for future opportunities as requested by Customer.

Exclusions

The following items are considered out of scope for this engagement:

1. OneContent Customer DBA Backload Consulting; and
2. In the event the Customer requests any additional services not defined in this proposal, Hyland and Customer will determine the scope of the Additional Services to be provided, and the terms and conditions (including fees to be paid) will be contracted for under a new proposal.

Required Resources

Resource	Rate Type
Project Manager	Solution Consultant
Technical Consultant	Solution Consultant

For details about the required resources, please review Appendix 1. For information about the rate type, please review pricing.

Deliverables

Deliverable
Project Plan
Project Status Report
Software Solution

For details about the deliverables, please review Appendix 2.

CUSTOMER OBLIGATIONS

To facilitate Hyland's execution of the Professional Services, Customer agrees, at a minimum, to the following obligations. The parties acknowledge and agree that failure to meet the responsibilities noted will likely affect project duration, cost and/or quality in the execution and completion of Professional Services.

Project Personnel

1. Customer will assign a project sponsor, who will be actively involved in the project(s) and is the final escalation point for all issues and decisions:
    A. The project sponsor will also ensure that the appropriate Customer personnel are assigned and made available to execute the project(s) successfully.
2. Customer will assign a project manager, who will act as a single point of contact for the Hyland project team and whose responsibilities include, but are not limited to, the following:
    A. Managing all customer obligations as defined within this Services Proposal; and
    B. Coordinating all key departmental decision makers, technical experts, subject matter experts, end user representatives, third party software application resources and project sponsorship.
3. Customer will designate a Software administrator who will undergo any applicable Software training recommended in order to participate actively throughout the project(s) and support all Software environments and solutions:
    A. Software training course(s) (if recommended) are provided separately from this Services Proposal by the Hyland Account Manager.
4. Customer will engage the appropriate business process owners to the project(s), as well as subject matter experts, who are thoroughly knowledgeable about the current business practices in their respective areas and who are capable of performing their assigned project roles:
    A. Business process owners and subject matter experts will be required to attend and contribute to all project meetings to which they have been invited for the duration of the project(s).
5. Customer will provide Information Services (IS)/Information Technology (IT) representative(s) to assist with the Software installation with regard to network and system administration;
6. Customer will provide trained technical team member(s) to assist in supporting and maintaining all aspects of the hardware, network, and/or database maintenance plans throughout the project(s);
7. Customer will provide vendor resources, interface specialists, technical experts, and/or subject matter experts deemed necessary for third party system(s) with which Software will integrate or from which content will be migrated;
8. Customer will make commercially reasonable efforts to maintain consistent resources throughout the project(s):
    A. Any anticipated changes to the core team must be communicated in writing within five (5) business days;
    B. If the change is due to illness or termination of the core team member, the change must be communicated as soon as possible.

Project Management

1. Customer will review the remaining work effort with the Hyland project team throughout the project(s). If, at any time, the number of hours required to complete a project phase exceeds the number of hours estimated by the project teams for that phase, then Hyland will incorporate the Project Change Control Process prior to exceeding the budgeted number of hours;
2. Customer will review all deliverables in accordance to the agreed upon plan. Failure to respond where needed within the designated timelines may result in project delays, loss of resources, and incorporation of the Project Change Control Process;
3. Customer will execute timely decision-making, completion of all deliverables and action items and resolution of issues throughout the course of the project(s); and
4. Customer will arrange for physical workspace and tools (work desks, networked computers, meeting rooms, training rooms, conference phones, whiteboards, etc.) for duration of the project(s) to accommodate scheduled remote activities as dictated by Customer's reasonable security measures.

Software Installation, Access, Integrations and Deployment

1. Customer will ensure all hardware is in place and made ready as dictated by the implementation schedule. This includes full, independent access to all environments in which Hyland is required to work including environments required for migrations or integrations, or multiple development, testing and production environments for Software:
    A. Local and remote VPN access must be provided to applicable Hyland resources through the use of dedicated user account(s) with appropriate privileges to the Software and/or relevant third party applications; and
    B. Access must be provided prior to Hyland's arrival at Customer facilities and/or project discovery sessions.
2. Customer will provide a properly setup environment in accordance with Hyland's prerequisites. Setup will consist of the installation, configuration and administration of, but not limited to, all hardware and operating systems, database instance(s), networking and required third party software;
3. Customer will have at least one (1) non-production Software environment for installation and deployment;
4. Customer will provide proper setup of networking and required third party software environment(s) in accordance with Hyland's prerequisites;
5. Customer will provide all necessary components including, but not limited to, power, lighting, network connections/rights and environmental controls deemed necessary for the proper functioning of and access to the system;
6. Customer will manage setup, execution, and validation of database maintenance plan(s) for each Software instance; and
7. Customer will perform routine, scheduled backups and maintain disaster recovery and contingency plans for each Software instance.

Testing

1. Customer will create, maintain, and execute test plans and cases, as well as track and report testing results during the testing cycle(s); and
2. Customer will train additional end users on the use of the Software.

KEY ASSUMPTIONS

The following are key assumptions that impact the success of the solution, and are applicable to all Project Areas within this proposal:

1. Project start date(s) are subject to a mutually agreed upon schedule after execution of contract;
2. Upon execution of contract by Customer and Hyland, Hyland shall send a Welcome email to Customer with a questionnaire for Customer completion. Customer is responsible for completing questionnaire and returning to Hyland before Hyland can assign project resources and kick-off the project defined within the contents of the executed proposal;
3. Professional Services will be delivered utilizing Hyland's standard implementation methodology;
4. Professional Services will be provided remotely from Hyland offices:
    A. When providing remote services, Hyland and Customer will discuss generally acceptable working hours and take into consideration time zone differences. Issues deemed as non-critical will only be addressed during normal business hours.
5. Each project is intended to be implemented in a timeframe of contiguous weeks. Scheduling delays that impact the project timeline will result in changes to project costs;
6. Each deliverable created will use Hyland's standard deliverable templates. Customer requested changes to deliverable templates may increase project costs or introduce timeline delays; and
7. If necessary after execution, this Services Proposal or corresponding agreement can be adjusted in scope, or a new agreement issued, following the Project Change Control Process.

PROJECT CHANGE CONTROL PROCESS

Requested changes to this Services Proposal will be managed using the Project Change Control Process outlined below.

If any party believes that a change to this Services Proposal is warranted, the party shall issue a Change Request in writing. The Hyland and Customer project teams will review the Change Request, determine the impact and attempt to agree to the change(s). Once the change(s) are agreed upon, Hyland will provide a formal Change Order to Customer outlining the change in Professional Services, the impact on hours, resources, timeline and/or cost.

Customer and Hyland will fully execute each mutually agreed upon Change Order prior to the requested changes taking effect. Customer and Hyland acknowledge that this may affect Professional Services, timelines and deliverables, and therefore will make reasonable efforts to execute any changes to this Services Proposal with enough lead-time to minimize the influence on the project. No Change Order is binding upon the parties until it is executed by both Customer and Hyland.

PRICING

Customer acknowledges that the Professional Services pricing is based solely on the information provided to Hyland and referenced in the above Project Areas.

Fixed Fee Projects

Project	Billing Type	Cost (USD)
Project 1: OneContent MPI and Image Backload from Athena	Fixed Fee	$79,000.00
Total		**$79,000.00 USD**

Payment Milestones			
The costs for the above project(s) represent fixed price Professional Services. Payment milestones for the engagement(s) will be invoiced as listed below.			
Milestone	**Description**	**% of Total**	**Amount**
Project 1 – Project 1: OneContent MPI and Image Backload from Athena			
1	Execution of Contract	75%	$59,250.00
2	Completion of OneContent Backload Tool	25%	$19,750.00
	Total	**100%**	**$79,000.00 USD**

Pricing Assumptions

The pricing was created using the following assumptions:

1. The above cost includes Professional Services fees anticipated to complete the project(s) successfully;
2. For Project 1, Hyland recommends all resources to be remote to maximize project success; and
3. The fixed fee was determined based on information provided to Hyland by Customer and assumptions developed by the parties based upon that information. In the event that (a) any such information is inaccurate or necessary information was not provided to Hyland, (b) Customer fails to fulfill its obligations during this Contract, or (c) reasonably unforeseen technical or system limitations exist or arise, and any of such causes materially and adversely affect the performance of the Professional Services, this fixed fee shall be adjusted equitably to reflect the impacts of such circumstances following the Project Change Control Process.

SIGNATURES

NORTHERN INYO HEALTHCARE DISTRICT	Hyland Software Inc.
By :	By :
Name : (Print)	Name : (Print)
Title :	Title :
Date :	Date :

Purchase Order #: _____
(Invoices issued hereunder may not reflect a PO number if this field is not completed)

APPENDIX 1 – RESOURCE DESCRIPTIONS

The following table provides an overview of the Hyland Global Services resource types and their corresponding responsibilities. Please reference the specific Project Areas for a listing of the required resources.

Resource Type	Responsibilities
Project Manager	Provides project management expertise and is the initial point of project escalation.
Manages project initiation, develops the project plan, and coordinates schedules and resources. Tracks burn down rates, project/solution issues, scope creep and impact, generating change orders as needed.	
Technical Consultant	Provides expertise on Software installation and module configuration.
Documents business requirements, installs and configures solutions to meet requirements, provides administrative training and train the trainer courses, migrates solutions to additional environments and provides user testing issue resolution and go-live support.	

APPENDIX 2 – DELIVERABLE DESCRIPTIONS

The following table provides an overview of the Hyland project deliverables. Please reference the specific Project Areas for a listing of the applicable deliverables.

Deliverable	Description
Project Plan	Defines the projected schedule of project events from initiation through closure.
Delivered within the initiation/discovery phase and updated throughout the project.	
Includes the activities, deliverables, assignments and dates required to complete the project.	
Project Status Report	Provides an overview of project health and important related details.
Delivered after initiation and then regularly throughout the project in a frequency to be determined by the Hyland and Customer Project Managers (e.g., bi-weekly).	
Includes details about the project health, financials (budgeted vs. actuals), critical action items, upcoming key activities, outstanding deliverables, change requests and notable issues/risks.	
Each updated report requires a shared review with Customer and Customer verification for accuracy.	
Software Solution	The Software configuration delivered at the conclusion of the Project, as described in the project scope.
Implementation of the requirements defined in the project scope. Data Migration to new Storage location and provide system admin training to new users.	

SCHEDULE 1 – TERMS AND CONDITIONS

1. DEFINED TERMS.

"Professional Services" shall mean the services performed under the Services Proposal within which this Schedule is incorporated.

"Software" means Hyland's proprietary software products for which Customer has obtained a valid license from Hyland or one of its authorized solution providers.

"Specifications" means the definitive, final functional specifications for Work Products, if any, produced by Hyland under the Services Proposal.

"Working Hour" means the services of one (1) person for a period of one (1) hour (or any part thereof) during regular business hours.

"Work Products" means all items in the nature of computer software, including source code, object code, scripts, and any components or elements of the foregoing, or items created using the configuration tools of the Software, together with any and all design documents associated with items in the nature of computer software, in each case which are created, developed, discovered, conceived or introduced by Hyland, working either alone or in conjunction with others, in the performance of services under this Schedule. If applicable, Work Products shall include any pre-configured templates or VBScripts which have been or may be created or otherwise provided by Hyland to Customer as part of the configuration of the advance capture module of the Software.

2. FULFILLMENT. Hyland will provide the Professional Services as mutually agreed under the Services Proposal. Hyland will provide the Professional Services described in this mutually agreed upon Services Proposal at a time and on a schedule that is mutually agreed upon by the parties. If any delays in such Professional Services occur solely as a result of any incorrect information, incorrect assumption or failure of Customer to perform or fulfill its obligations in connection with any Services Proposal, the performance schedule for the applicable project may be extended. Hyland shall have no liability or responsibility for any costs or expenses resulting from such delays. In the event that performance of any milestone set forth in any Services Proposal is not met due to a delay solely caused by Hyland, and provided that such cause is not an event of force majeure, Hyland agrees, at no additional charge to Customer, to commit such additional resources and personnel as shall be necessary to ensure that such delay does not result in the slippage of later milestones or completion of such Professional Services. The parties agree that any Professional Services or Work Products described in the Services Proposal that have been performed or developed, in whole or in part, prior to the execution of this Services Proposal by the parties nevertheless shall be covered by all terms and conditions of this Services Proposal.

3. CHANGES TO SERVICES PROPOSAL. Hyland or Customer may, at any time, reasonably request a change to any Service Proposal. Any requested change that the parties mutually accept (a "Change") will be set forth in a written change order prepared by Hyland and agreed to and signed by both parties that specifically references the relevant Service Proposal. In the event the parties are unable to mutually agree upon a proposed Change or a proposed change order, and such proposed Change relates to a material component of the project that is the subject of the relevant Services Proposal, either party may terminate such Service Proposal upon not less than thirty (30) days advance written notice to the other party.

4. CUSTOMER'S OBLIGATIONS.

4.1 Assistance and Obligations. Customer agrees that it will cooperate with and assist Hyland in the performance of Professional Services under this Services Proposal; will provide the resources specified in the relevant Services Proposal; and will perform or fulfill all obligations required to be performed or fulfilled by Customer under the terms of the Services Proposal. Customer acknowledges that if it fails to provide assistance and perform or fulfill its obligations in accordance with this Section and the Services Proposal, Hyland's ability to provide such Professional Services, meet the performance schedule set forth in such Services Proposal and keep services fees reasonably in line with any estimates given in the Services Proposal may be adversely affected. During any period in which Hyland is performing services hereunder, Customer shall provide to the Hyland project team independent local (onsite) and remote (offsite) access through the use of secure connections such as a network connection, VPN connection or other similar methods and dedicated user accounts with appropriate privileges to the Software, hardware or virtual machines allocated to the Software system. Remote and local access will be granted for all provisioned environments, including production.

4.2 Third Party Software Rights. Notwithstanding any contrary terms, if Customer requests Hyland to perform Professional Services on or with respect to any third party software, Customer represents and warrants to Hyland that Customer has all necessary rights to allow Hyland to do so.

4.3 Protection of Customer's Systems. CUSTOMER UNDERSTANDS THAT IT IS SOLELY RESPONSIBLE TO TAKE APPROPRIATE MEASURES TO ISOLATE AND BACKUP OR OTHERWISE ARCHIVE ITS COMPUTER SYSTEMS, INCLUDING ITS COMPUTER PROGRAMS, DATA AND FILES.

4.4 Safe Work Environment. Customer will be responsible for and shall ensure that while Hyland employees, agents or subcontractors are on Customer's premises, all proper and legal health and safety precautions are in place and fully operational to protect such persons.

5. SERVICES FEES. Except as otherwise provided in the Services Proposal: (a) Hyland will charge services fees to Customer for Professional Services at Hyland's then-current standard list price for the applicable Professional Services; and (b) Hyland shall invoice Customer for Professional Services fees monthly, in arrears, based on the number of Working Hours required to complete the project and the applicable hourly fees; and Customer shall pay in full within thirty (30) days after the invoice date. Any estimates of fees or Working Hours required to complete the project are approximations of the anticipated amount of fees and time needed to complete the project. The actual number of Working Hours may vary.

6. TRAVEL AND EXPENSES. Customer shall be responsible to pay or reimburse Hyland for all customary and reasonable out-of-pocket costs and expenses incurred by Hyland in connection with the performance of services under this Services Proposal (including fees and expenses relating to travel, meals, lodging and third party vendor registration requirements) in accordance with Hyland's applicable internal policy for the reimbursement of costs and expenses to its employees ("Hyland Expense Policy"). Except as otherwise provided in any applicable Services Proposal, Hyland shall invoice Customer for all reimbursable costs and expenses on a monthly basis, in arrears; and Customer shall pay in full each such invoice in accordance with the General Terms.

7. CERTAIN REMEDIES FOR LATE PAYMENT. All past due amounts shall bear interest at the rate of one and one-half percent (1.5%) per month (or, if lower, the maximum rate lawfully chargeable) from the date due through the date that such past due amounts and such accrued interest are paid in full. In the event of any default by Customer in the payment of any amounts due hereunder, which default continues unremedied for at least ten (10) calendar days after the due date of such payment, Hyland shall have the right to suspend or cease the provision of any services under this Services Proposal unless and until such default has been cured.

All payments under this Services Proposal are exclusive of all applicable taxes and governmental charges (such as duties), all of which shall be paid by Customer (other than taxes on Hyland's income). In the event Customer is required by law to withhold taxes, Customer agrees to furnish Hyland all required receipts and documentation substantiating such payment. If Hyland is required by law to remit any tax or governmental charge on behalf of or for the account of Customer, Customer agrees to reimburse Hyland within thirty (30) days after Hyland notifies Customer in writing of such remittance. Customer agrees to provide Hyland with valid tax exemption certificates in advance of any remittance otherwise required to be made by Hyland on behalf of or for the account of Customer, where such certificates are applicable.

8. WORK PRODUCTS

8.1 Ownership. THIS AGREEMENT IS NOT A WORK-FOR-HIRE AGREEMENT. Hyland or its suppliers retain on an exclusive basis for itself or themselves all right, title and interest in and to any intellectual property developed, discovered, conceived or introduced by Hyland in the performance of the Services Proposal, including, but not limited to, all patents, patent applications, copyrights and other intellectual property rights relating to or associated with the Work Products.

8.2 Work Products License. Customer agrees to take all reasonable steps to protect all Work Products, and any related documentation from unauthorized copying or use. Hyland grants to Customer a limited, non-exclusive and non-assignable license for the duration of the term of the license agreement pursuant to which Customer received the right to use the Software with which the Work Products will be used ("License Agreement"), to use the Work Products only internally, only in connection with Customer's own data and only in connection with Customer's authorized use of the software under the License Agreement. Customer may not: (a) make or authorize the making of copies of any Work Products; (b) remove any Hyland notices in the Work Products; (c) sell, transfer, rent, lease, time share or sublicense the Work Products to any third party; or (d) disassemble, decompile, reverse engineer or otherwise attempt to derive source code from any Work Product for any reason. Customer further agrees that, in connection with any use of the Work Products by Customer, the Work Products shall not be copied and installed on additional servers unless Customer has purchased a license therefore.

8.3 Modification of Work Products.

8.3.1 Form of Delivered Work Products. The form in which Hyland delivers Work Products will be determined by Hyland depending on the purpose and functionality of the Work Product.

8.3.2 Configuration Work Products. If Hyland delivers a Work Product: (a) in the form of (1) source code which is compiled by tools in the Software to machine language form; or (ii) a script; or (b) created using the configuration tools in the Software (a "Configuration Work Product"), then Hyland grants to Customer the limited right to modify the Configuration Work Product, provided such modified Configuration Work Product is used only in compliance with the terms of the limited license to such Work Product granted under this Section.

8.3.3 Independent Work Products. If Hyland delivers a Work Product which is not a Configuration Work Product (an "Independent Work Product"), then, except as otherwise provided in the last sentence of this paragraph, Customer may not alter or modify such Independent Work Product. If Hyland delivers an Independent Work Product, and Customer desires to obtain the right to modify the Independent Work Product, then the parties may mutually agree that Hyland shall deliver to Customer a copy of the format of the Independent Work Product that is necessary to enable the Customer to complete its modifications, subject to and upon the payment by Customer to Hyland of any additional Professional Services fees as Hyland may charge to prepare and deliver such format. In such case, Hyland grants to Customer the right to modify, and if necessary, compile the delivered format of the Independent Work Product, provided such modified Independent Work Product is used only in compliance with the terms of the limited license to such Work Product granted under this Section.

9. LIMITED WARRANTY FOR SERVICES AND WORK PRODUCTS

9.1 Limited Warranty for Professional Services. For a period of sixty (60) days from the date of completion of Professional Services, Hyland warrants to Customer that such Professional Services have been performed in a good and workmanlike manner and substantially according to industry standards. This warranty specifically excludes (a) non-performance issues caused as a result of incorrect data or incorrect procedures used or provided by Customer or a third party or failure of Customer to perform and fulfill its obligations under this Services Proposal; and (b) any Professional Services in the nature of staff augmentation.

9.2 Limited Warranty for Work Products. For a period of sixty (60) days from and including the date that Hyland has delivered a completed Work Product to Customer, Hyland warrants to Customer that such Work Product, when properly installed and properly used, will function in all material respects as described in the Specifications. The terms of this warranty shall not apply to, and Hyland shall have no liability for any non-conformity related to, any Work Product that has been (a) modified or added to by Customer or a third party, (b) used in combination with equipment or software other than that which is consistent with the Specifications, or (c) misused or abused.

9.3 Remedy. Hyland's sole obligation, and Customer's sole and exclusive remedy for any non-conformities to the express limited warranties under Sections 9.1 and 9.2 shall be as follows: provided that, within the applicable sixty (60)-day period, Customer notifies Hyland in writing of the non-conformity, Hyland will use commercially reasonable efforts to re-perform the non-conforming services in an attempt to correct the non-conformity(ies), or, in the case of a Work Product, either repair or replace the non-conforming Work Product, which may include the delivery of a commercially reasonable workaround for the non-conformity. If Hyland is unable to correct such non-conformity(ies) after a reasonable period of time or determines that repair or replacement of the Work Product is not commercially reasonable, Customer's sole and exclusive remedy shall be to terminate the Services Proposal, in which event Hyland will refund to Customer any portion of the services fees under such Services Proposal relating directly to such non-conforming

Professional Services or to the creation and implementation of the non-conforming Work Product, in either case paid prior to the time of such termination.

9.4 Disclaimer of Warranties. Except as expressly set forth above, Hyland makes no warranty or representations regarding any Work Products, information or services provided under this Services Proposal. Hyland disclaims and excludes any and all other express, implied and statutory warranties, including, without limitation, warranties against infringement, the implied warranties of merchantability and fitness for a particular purpose, and warranties that may arise or be deemed to arise from any course of performance, course of dealing or usage of trade. Hyland does not warrant that any services, Work Products provided will satisfy Customer's requirements or are without defect or error, or that the operation of any software provided under this Services Proposal will be uninterrupted. Hyland does not assume any liability whatsoever with respect to any third party hardware, firmware, software or services.

10. TERMINATION.

10.1 By Customer. Customer may terminate the Services Proposal for breach as stated in section 10.2. below or for convenience, upon not less than thirty (30) days advance written notice to Hyland to such effect.

10.2 By Either Party. Either party may terminate the Services Proposal, effective immediately upon written notice to the other party, if the other party has committed a breach of a material provision of this Schedule and has failed to cure the breach within thirty (30) days after the receipt of written notice of the breach given by the non-breaching party.

10.3 Terminating a Services Proposal. In the event of any termination of a Services Proposal, Customer agrees to compensate Hyland for all Professional Services already performed prior to, and including, the date of termination, except to the extent that Hyland has breached its obligations to perform such Professional Services and such breach is the cause of such termination.

11. LIMITATIONS OF LIABILITY.

11.1 HYLAND'S LIABILITY FOR ANY LOSS OR DAMAGES ARISING OUT OF OR IN CONNECTION WITH THE SERVICES PROPOSAL, INCLUDING, BUT NOT LIMITED TO, THE PERFORMANCE OR NON-PERFORMANCE OF SERVICES OR THE USE OR INABILITY TO USE ANY WORK PRODUCTS, SHALL IN NO EVENT EXCEED THE AMOUNT THAT HAS BEEN ACTUALLY PAID BY CUSTOMER TO HYLAND FOR HYLAND'S PERFORMANCE UNDER THIS SERVICES PROPOSAL.

IN NO EVENT WILL HYLAND OR ITS DIRECT OR INDIRECT SUPPLIERS BE LIABLE FOR ANY INDIRECT, SPECIAL, INCIDENTAL, CONSEQUENTIAL OR PUNITIVE DAMAGES, LOSS OF BUSINESS PROFITS, BUSINESS INTERRUPTION, LOSS OF DATA OR INFORMATION, THE COST OF RECOVERING SUCH DATA OR INFORMATION, OR THE COST OF SUBSTITUTE SERVICES OR WORK PRODUCTS, EVEN IF HYLAND OR SUCH SUPPLIERS HAVE BEEN ADVISED OF THE POSSIBILITIES OF SUCH DAMAGES.

12. GENERAL TERMS

12.1. Force Majeure. No failure, delay or default in performance of any obligation of a party to this Services Proposal (except the payment of money) shall constitute a default or breach to the extent that such failure to perform, delay or default arises out of a cause, existing or future, beyond the control (including, but not limited to: action or inaction of governmental, civil or military authority; fire; strike, lockout or other labor dispute; flood; war; riot; theft; earthquake; natural disaster or acts of God; national emergencies; unavailability of materials or utilities; sabotage; viruses; or the act, negligence or default of the other party) and without negligence or willful misconduct of the party otherwise chargeable with failure, delay or default. Either party desiring to rely upon any of the foregoing as an excuse for failure, default or delay in performance shall, when the cause arises, give to the other party prompt notice in writing of the facts which constitute such cause; and, when the cause ceases to exist, give prompt notice of that fact to the other party. This section shall in no way limit the right of either party to make any claim against third parties for any damages suffered due to said causes. If any performance date under this Services Proposal is postponed or extended pursuant to this section for longer than ninety (90) calendar days, Customer, by written notice given during the postponement or extension, and at least thirty (30) days prior to the effective date of termination, may terminate Hyland's right to render further performance of services after the effective date of termination; provided, that Customer will be responsible for payment for the services provided by Hyland through the effective date of termination in accordance with the terms of this Schedule.

12.2. Governing Law and Jurisdiction. This Services Proposal and any claim, action, suit, proceeding or dispute arising out of this Services Proposal shall in all respects be governed by, and interpreted in accordance with, the substantive laws of the State of Ohio U.S.A. (and not by the 1980 United Nations Convention on Contracts for the International Sale of Goods, as amended), without regard to the conflicts of laws provisions thereof. Venue and jurisdiction for any action, suit or proceeding arising out of this Services Proposal shall vest exclusively in the federal or state courts of general jurisdiction located in Cuyahoga County, Ohio U.S.A.

12.3 Binding Effect and Assignments. This Services Proposal shall be binding upon and shall inure to the benefit of the parties and their respective successors and permitted assigns. Neither party may assign its rights or obligations under this Services Proposal, in whole or in part, to any other person or entity without the prior written consent of the other party. Any change in control resulting from an acquisition, merger or otherwise shall constitute an assignment under the terms of this provision. Any assignment made without compliance with the provisions of this section shall be null and void and of no force or effect.

12.4 Entire Agreement. The Services Proposal (including this Schedule) constitutes the entire agreement and understanding of the parties with respect to the subject matter hereof and supersedes all prior and contemporaneous agreements, documents and proposals, oral or written, between the parties with respect thereto. To the extent there is a conflict between this Schedule and the Services Proposal, the terms of this Schedule control.

***** END OF DOCUMENT *****

2000 Tolman Creek Rd
Ashland, OR 97520
(541) 488-6820
sales@shastanetworks.com

STATEMENT OF WORK

Migration of Athenahealth Charts to Cerner

June 8, 2021

THIS AGREEMENT, dated as of the last date indicated after the signatures ("Effective Date"), is made by and between Shasta Networks LLC ("Shasta") with its principal place of business at 2000 Tolman Creek Rd, Ashland, Oregon 97520, and Northern Inyo Healthcare District ("Client") with its principal place of business at 150 Pioneer Ln, Bishop, California 93514.

DESCRIPTION AND SCOPE OF SERVICES
This section describes the technical and project management services to be performed by Shasta which includes collaborating with the Client, athenahealth, and Cerner.

Proposed Work Effort

The Client has transitioned EHRs from athenahealth to Cerner. Cerner is limited in how it can accept patient charts (embedded, base64 encoded PDFs in HL7-ORU messages) and athenahealth is limited in how it can export charts from its EHR (HTML documents).

This gap will be bridged by Shasta by converting athenahealth's historical encounter charts from HTML to encoded PDFs embedded in HL7 for ingestion by Cerner.

As of June 8, 2021, 47 hours have been spent on evaluating the technology requirements and building a proof-of-concept converter, reviewing final data in scope, and modifying the converter to accommodate changes in data structure and size from previous examples.

To complete the project and ensure a successful migration of historical charts into Cerner, it is estimated that an additional 40-60 hours will be required to complete the proof-of-concept by importing generated messages into Cerner, and, finally, deliver all 60,000 historical charts.

The project will be billed as part of the existing Managed Services Agreement ("MSA") at an hourly rate of $225.

TERM OF SERVICE

Services will be performed out of Shasta's corporate office in Ashland, Oregon. If travel is required, the Client will cover all reasonable travel expenses with prior written approval.

Shasta may be contacted by

Telephone Support Line (541) 488-6820 x1
Email support@shastanetworks.com
Mail 2000 Tolman Creek Rd, Ashland, Oregon 97520

This Agreement is for a service-based engagement according to the statement of work contained in this document. The engagement will begin on June 9th, 2021, and end on September 15th, 2021.

INVOICING AND PAYMENTS
Shasta will invoice the Client monthly as part of the existing MSA between the Client and Shasta.

Shasta will accept payment in the form of a check or wire transfer directly to Shasta's account listed on the invoice. Shasta requires payment within 30 days of invoicing. The Client has five business days to dispute an invoice. After 5 days, the invoice shall be considered final. All amounts will be paid in United States dollars and the terms are Net 30.

MISCELLANEOUS
Labor rates and milestone payments are subject to change if there are significant changes in the scope and/or complexity of work requested by the Client. This will be mutually agreed to by the Client and Shasta. No work will commence without the Client's written approval.

Onsite services are not covered in this Statement of Work but, if travel is required, reasonable travel expenses incurred by Shasta's staff will be paid for by Client, with approval by Client prior to booking any travel.

IN WITNESS WHEREOF, this Agreement has been signed and delivered by a duly authorized representative of each party as of the last date indicated after the signatures.

Client	**Shasta Networks LLC**
By:	By:
Name:	Name: Jacek Zagorski
Title:	Title: Founder & CEO
Date:	Date:

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

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

TO: NIHD Board of Directors
FROM: Sierra Bourne, MD, Chief of Medical Staff
DATE: July 6, 2021
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. Policies and Procedures (*action items*)
    1. *DI Nuclear Medicine Radiopharmacy Policy*
    2. *Medical Staff Department Policy – Pediatrics*
    3. *New Line of Service Implementation Policy*
    4. *Rabies Vaccination Policy*
    5. *Tuberculosis Exposure Control Plan*
    6. *Basic Principles of Sterilization*
    7. *Cleaning Procedures: Specialized Areas: Sterile Processing*
    8. *Operating Room Attire*
    9. *Operating Room Sanitation*
    10. *Postpartum Patient Care in the PACU*
    11. *Rotation Procedures for Patient Cubicle Curtains & Shower Curtains*
    12. *Sterilization Recall*
    13. *Steris V-Pro Low Temperature Sterilizer Program*
    14. *Steris Washer Disinfector*
    15. *Storage Requirements for Sterile & Clean Items*

B. Annual Review of Critical Indicators (*action item*)
    1. Inpatient Medicine Critical Indicators 2021
    2. Radiology Services Critical Indicators 2021
    3. Utilization Review Critical Indicators 2021

C. Updated Core Privilege Forms (*action item*)
    1. Pediatrics
    2. Hospitalist

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

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: DI NM Radiopharmacy Policy	
Scope: Nuclear Medicine, Pharmacy	Manual: Nuclear Medicine (Diagnotic Imaging)
Source: Operations –DIRECTOR OF DIAGNOSTIC SERVICES	Effective Date:

PURPOSE:
To establish guidelines for the ordering, reconstitution, and quality control of radiopharmaceuticals.

POLICY:
1. The ordering of all radioactive pharmaceuticals will be approved (prior to ordering) by an Authorized User, the Radiation Safety Officer, or designee (Nuclear Medicine Technologist) familiar with the possession limits, and restrictions, under the Radioactive Materials license.
2. The ordering and possession of radiopharmaceuticals, and the components to reconstitute "cold' kits into radiopharmaceuticals, is under the direction of an Authorized User and the Director of Pharmacy Services.
3. The elution of a molybdenum/technetium generator, and the reconstitution of all "cold' kits will follow manufacturers' recommendations.
4. All radiopharmaceuticals will be reconstituted within the Isolator, even in cases that would meet the immediate use exemption for USP 797.
5. All radiopharmaceuticals will have the manufacturers recommended quality control tests performed prior to administration.

REFERENCES:
1. Journal of Nuclear Medicine Technology, June 2020.

CROSS REFERENCE Procedure:
1. Radiopharmaceutical Preparation Procedure

Approval	**Date**
Clinical Consistency Oversight Committee	6/1/2021
Radiology Services Committee	6/16/2021
Medical Executive Committee	7/6/2021

Developed: 4/21rd
Reviewed:
Revised:
Supersedes:

NORTHERN INYO HEALTHCARE DISTRICT MEDICAL STAFF
POLICY AND PROCEDURE

Title: Medical Staff Department Policy – Pediatrics	
Scope: Pediatric Practitioners	Manual: Medical Staff
Source: Chief of Pediatrics	Effective Date:

PURPOSE: To delineate clear expectations for practitioners in the department of pediatrics at Northern Inyo Healthcare District (NIHD).

POLICY: All practitioners granted privileges in the department of pediatrics will adhere to the following protocols.

PROTOCOL:

1. Call:
    a. Practitioners participating in call coverage shall return phone calls as soon as possible and within 10 minutes and be at bedside as soon as possible and within 30 minutes if needed in an emergency. Non-emergent consults will be completed within 24 hours and within a reasonable amount of time as agreed upon by the pediatric practitioner and the practitioner requesting consult.
    b. All pediatrics patients admitted will be rounded on in the hospital within 24 hours of admission and everyday thereafter.
        i. Healthy term newborns born before 5pm will be examined before the end of the day.
        ii. Healthy newborns born after 5pm may be examined the next day unless nursing or OB provider request sooner assessment.
        iii. Newborns with complications will be examined as soon as reasonably possible or as agreed upon by the pediatric practitioner and the staff member identifying the concern.
        iv. Pediatric patients will have orders placed at the time of admission and be examined prior to admission in the clinic or emergency department.
2. Meeting attendance:
    a. Attend monthly pediatric provider meetings and monthly pediatric team meetings.
    b. Attend additional meetings per medical staff bylaws requirements or assignment to committees.
    c. Advanced Practice Providers (APPs) can vote at pediatric department meetings and vote for department Chief.
3. Credentialing:
    a. Physician practitioners in the department of pediatrics must be board certified or board eligible by the American Board of Pediatrics and are strongly encouraged to be members of the American Academy of Pediatrics.
4. Focused Professional Practice Evaluation (FPPE):
    a. Practitioners new to NIHD will be expected to complete FPPE as per policy. For clinic work FPPE is expected to include at least eight days of chart review of all patients seen. Inpatient work will include chart review of at least the first eight newborn admissions and eight inpatient pediatric admissions.
5. Ongoing Professional Practice Evaluation (OPPE):
    a. Practitioners will be expected to participate in all requirements of OPPE as per medical staff policy. Providers must average eight neonatal encounters and four pediatrics encounters every six months over the OPPE cycle. Every two years at re-credentialing if this average has not been met additional proctoring may be assigned in order to maintain admitting privileges.

Title: Medical Staff Department Policy – Pediatrics	
Scope: Pediatric Practitioners	Manual: Medical Staff
Source: Chief of Pediatrics	Effective Date:

6. Peer Review:
    a. Inpatient charts identified by critical indicators will all be subject to peer review as per the peer review policy.
    b. This will include ongoing peer review of 10 outpatient encounter charts each month.
7. Re-Entry:
    a. Pediatric practitioners working in the outpatient clinic setting may be eligible for re-entry per policy. Due to the low volume of inpatient pediatric and nursery patients re-entry in these areas will require training at an outside facility to re-obtain competency.

REFERENCES:

1. None.

CROSS REFERENCE P&P:

1. Northern Inyo Healthcare District Medical Staff Bylaws
2. *Focused and Ongoing Professional Practice Evaluation Policy*
3. *Practitioner Re-Entry Policy*

Approval	**Date**
Perinatal/Pediatrics Committee	05/25/2021
Medical Executive Committee	07/06/2021
Board of Directors	
Last Board of Directors Review	

Developed: 01/2021 ch
Reviewed:
Revised:
Supersedes:
Index Listings:

NORTHERN INYO HEALTHCARE DISTRICT

POLICY AND PROCEDURE

Title: **New Line of Service Implementation**	
Scope: District Wide	Manual: Quality
Source: Chief Medical Officer	Effective Date:

PURPOSE:

The purpose of this policy is to establish a strategic commitment to deliver excellent services to our patients by establishing a guideline to follow when considering a new line of service. This requires sufficient space, equipment, staffing, and financial resources are in place or available within a specified period of time to support the request. This will facilitate adherence to professional practices, endorse compliance with regulatory statutes and accreditation requirements, promote uniformity of practice, and assess revenue viability of potential new lines of service at Northern Inyo Healthcare District (NIHD).

POLICY:

Suggestions for a new service line may come from the administration, medical staff, strategic plan, the NIHD BOD or other sources. Each suggestion should come through the respective Chief for presentation at the Executive meeting.

~~A new line of service becomes a Quality Improvement initiative, as such will be submitted to the Quality Council, who will oversee the implementation of this policy in coordination with the QAPI process.~~

Completion of QAPI Request Form is required. The Executive team will do an initial assessment ~~and Project Standard workflows will be followed. The Quality Council will do an initial assessment~~ of the feasibility of the new service line including a cost analysis. ~~.~~ Once the service line has been reviewed, the project will move to the Quality Council or other appropriate department to complete the items under "Discovery Phase" below. When the work under "Discovery Phase" is completed, the new service line will be presented to the Board of Directors for approval. After BOD approval, the "Implementation Phase" may begin. Once the new service line has been implemented, an update should be provided to the Executive team, Quality Council if appropriate, and appropriate department as outlined in the "Evaluation Phase." ~~(See District-Wide QAPI plan.)~~

~~Prior to presentation of a new service line option to the NIHD Board of Directors for consideration, standard preliminary business evaluations (return on investment) is required. The executive team will reviewed and may approve the recommendations. If approved the results of that work will be included in the Board packet and presentation. Board approval is required.~~

~~Standard project workflows require completing a Project QAPI Request Form. This will place the new line of service proposal into the established project process for discovery. Upon approval by the Board of Directors, the project review process will be followed before implementation begins.~~

DEFINITIONS:

A new line of service at NIHD is defined as a grouping of medical care provider(s), their skills and areas of expertise, products and/or supplies, that when provided together will provide a new provision of care that NIHD is able to offer to the community. Some elements of these groupings may already exist at NIHD, but when grouped with the other elements, a new type of care will be offered.

DISCOVERY PHASE:

1. The following will be determined before the new line of service is proposed to the Board of Directors:
    a. Identify benefits and costs associated with opening a new service line:
        i. Evaluate most recent community needs assessment or perform a limited needs assessment for the new service

Title: **New Line of Service Implementation**	
Scope: District Wide	Manual: Quality
Source: Chief Medical Officer	Effective Date:

ii. Complete a cost-accounting analysis or Return on Investment (ROI), to determine profitability of the service

b. Facility determination
   i. Remodeling of an existing space
   ii. Access to new location
c. Staffing
   i. Evaluation of support staffing needs
   ii. Medical Staff with skill sets to meet needs
d. Materials Management
   i. Identify new supplies and capital expenses
   ~~i.~~ii. Clinical Engineering for patient care equipment
e. Documentation and system requirements
   i. Clinical/Quality Informatics
   ~~ii. ITS Informatics~~
f. Pharmacy Assessment
   i. New medication needs
   ii. Proper storage of medications
g. Compliance overview
   i. Licensing requirements
   ii. Other regulatory or guidance requirements
h. Identify Current Procedural Terminology (CPT) for services to be offered
i. Review billing requirements
j. Define the ITS support
   i. Computers, telephone(s) etc.
   ii. Wiring and cable access
k. Strategic Communications
l. Dietary needs
m. Present findings to the Executive Team and, as appropriate, the Executive Team will approve submission to the Board of Directors for approval

IMPLEMENTATION PHASE:

1. Upon Board of Directors approval, the following tasks will be performed prior to beginning the new service:
   a. Business Associates Agreement (BAA) and Contract review
      i. Compliance Officer or designee reviews, negotiates and executes BAA, done in conjunction with contract review to ensure no contract provision override the BAA
      ii. Director of the proposed new line of service and the appropriate Chief Officer review the contract
      iii. Compliance Officer review of contract
      iv. Chief Executive Officer executes contract(s), if applicable
   b. Project Management Team
      i. Identify team members

ii. Assign specific tasks to each area
iii. Develop assessment tool and a follow-up plan to assess the success, profitability, or additional needs of the service, and how this is to be measured
iv. Set timelines for completion of tasks

c. Credentialing
   i. Medical Staff Office completes Medical Staff On-Boarding
d. Staffing
   i. Human Resources and/or Medical Staff Office will develop staffing and recruitment plan as appropriate
e. Billing
   i. Provider Enrollment submitted
   ii. Make adjustments to any billing related practices as needed
f. Charge Capture
   i. Identify charges by CPT code that will be billed out
   ii. Ensure charge codes are created in the Charge Master and Fee Schedules of the EHR and all ancillary systems
   iii. Create charge sheets
   iv. Develop workflows for charge entry and daily reconciliation
g. Materials Management
   i. Acquire new supplies and equipment
   ii. Set up the office space
h. Clinical/Quality Informatics & ~~/~~Infection Control
   i. Build documentation templates ~~for hospital based services~~
   ii. Provide electronic health record application training to end-users ~~education to medical providers (nurses and physicians)~~
   ~~ii.~~iii. Research integration and testing with current electronic health record
   ~~iii.~~iv. Assess for possible Infection Control issues and mitigate any that are found

~~i. ITS Informatics~~
   ~~i. Build system needs and documentation templates for clinical practices~~
   ~~ii. Research integration with current EHR~~
      ~~1. Integration testing~~
   ~~iii. Application training and education~~

~~j.~~i. ITS and Clinical Engineering supply hardware and technical support
   i. Provide access to all appropriate systems
   ii. Arrange for/purchase of all devices necessary to the line of service (computers, telephones, medical devices and/or specialized equipment)

~~k.~~j. Pharmacy Review
   i. Build medication codes in appropriate systems
   ii. Acquire medications
   iii. Address medication storage

~~l.~~k. Dietary Review

Title: **New Line of Service Implementation**	
Scope: District Wide	Manual: Quality
Source: Chief Medical Officer	Effective Date:

i. Determine if there will be any costs associated with Dietary needs during implementation

~~m.~~l. Development of forms, educational resources, policies and procedures specific to the new service

i. Forms, internal documentation, chart documents, patient documents, must be reviewed and if appropriate, approved by the Forms Committee

~~n.~~m. Interpreter Services translate forms

~~o.~~n. Strategic Communications develop marketing plan

~~p.~~o. Assure that Contracts and/or all appropriate paperwork has been completed and returned to CEO

~~q.~~p. Quality Council will participate in development of performance metrics for evaluation phase.

EVALUATION PHASE:

1. Using assessment tool developed through the development of the project to review and evaluate the new line of service
2. Provide feedback to Quality Council on performance metrics
3. Submit review to Executive Team

REFERENCES:

1. Healthcare Business Insights, Revenue Cycle Academy; "Checklist of New Service Line Considerations"
2. Advisory Board, "Service Line Strategy Advisor"
3. The McKinsey Quarterly, "Service Line Strategies", Health Care - July 2008
4. Open Minds, 2011 Planning and Innovation Institution, "The Tools You Need to Successfully Launch a New Service Line & Diversify Your Revenue Streams", John Talbot, Ph.D., Executive Vice President
5. Agency for Healthcare Research and Quality, "How Do We Implement Best Practices in Our Organization" Series
6. Modern Healthcare Insights: "Innovative Look at Service Line Organizations", Series
7. Health Care Advisory Board: "Achieving Service Line Excellence; Best Practices for Creating a High-Performance Service Line Infrastructure:, Research Report, April 1, 2008

CROSS REFERENCE P&P:

1. Request for Establishment of New Privilege or New Service

Committee Approval	**Date**
Financial Leadership	2/25/2020
Compliance	2/26/2020
Non-clinical Consistency Oversight Committee	4/2/2020
Medical Executive Committee	~~4/7/2020~~7/6/2021
Executive Team Meeting	
Board of Directors	

NORTHERN INYO HEALTHCARE DISTRICT

POLICY AND PROCEDURE

Title: **New Line of Service Implementation**	
Scope: District Wide	Manual: Quality
Source: Chief Medical Officer	Effective Date:

Developed: 11/2019wr
Reviewed:
Revised: **4/2/2020wr, 5/2020ta, 6/2021je**
Supersedes:

NORTHERN INYO HEALTHCARE DISTRICT
~~POLICY AND~~ PROCEDURE

Title: Rabies Vaccination	
Scope: Emergency, Infusion Center, NIHD Clinics	Manual: Infusion Center
Source: DON Perioperative Services	Effective Date: 10/12

~~To outline care for patients that come to the hospital District for rabies post exposure prophylaxis.~~

~~POLICY~~: **PURPOSE**:

Rabies post exposure should be started as soon after the exposure as possible but may be started up to 6 months after exposure. The day the post exposure treatment is started is deemed Day 0. Patients that have had no prior rabies immunization should receive Human Rabies Immune Globulin and a rabies vaccination on Day 0 and a repeat rabies vaccination on days 3, 7, and 14, (day 28 only if ordered by physician).
For patients that have had prior rabies immunization, only Day 0 and Day 3 rabies vaccine need to be given. The (Human) Rabies Immune Globulin does not need to be given to patients that have received prior rabies immunization and have confirmed adequate rabies antibody titer.

PRECAUTIONS:
Immediate and thorough washing of all bite wounds and scratches with soap and water is recommended.
Check for allergic reaction to Human Rabies Immune Globulin and rabies vaccine before beginning treatment.
Tetanus prophylaxis and measures to control bacterial infection should be given as indicated.

PROCEDURE:

1. In the Emergency Department:

- Document date of exposure, wound site, patient weight and allergies on the Rabies Post Exposure Prophylaxis order form.
- The wound should be washed with soap and water unless this was already done.
- The (Human) Rabies Immune Globulin (20 IUnits/kg) should be injected/infiltrated around and in the wound site by the physician. As much as possible should be injected around the wound and the rest should be injected IM in the gluteal or lateral thigh site (at a site distant to the rabies vaccine).
- A 1ml dose of Rabies Vaccine should then be given IM in the deltoid
- A Vaccine Information Statement (VIS) from the CDC website should be given to the patient.
- Immunization consent information and the VIS version (date at the bottom of the VIS) should be documented.
- The patient should be given instructions to return to the ED or OP Nursing for the remainder of the rabies vaccine doses (Days 3, 7, and 14, (day 28 only if ordered by physician)).

2. In the ED or Infusion Center or RHC Family Practice:

- The rabies vaccine (1ml) should be given IM in the deltoid site on days 3, 7, 14, (and 28 if ordered by physician).
- Patients that have had prior rabies immunization need a day 3 vaccination only (in addition to the Day 0 treatment outlined above.)

REFERENCES:
http://www.cdc.gov/rabies/medical_care/vaccine.html

CROSS REFERENCES: Rabies Post Exposure Prophylaxis, Rabies Vaccine, Rabies Immunization

NORTHERN INYO HEALTHCARE DISTRICT
~~POLICY AND~~ PROCEDURE

Title: Rabies Vaccination	
Scope: Emergency, Infusion Center, NIHD Clinics	Manual: Infusion Center
Source: DON Perioperative Services	Effective Date: 10/12

Approval	**Date**
CCOC	6/3/2021
Pharmacy and Therapeutics	6/17/2021
Medical Executive Committee	7/6/2021
~~Board of Director~~	
Last Board of Director review	1/17/18

Developed: 9/12 AW
Reviewed:
Revised: 2/15, 4/2020aw, 5/21aw

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Tuberculosis Exposure Control Plan	
Scope: NIHD	**Department:** CPM: Infection Control Patient Care (ICP)
Source: Quality Informatics Nurse/Infection Preventionist Manager	**Effective Date: September 2007**

PURPOSE:
The three primary goals of Northern Inyo Healthcare District (NIHD) Tuberculosis Control Program are the achievement of early detection, isolation and treatment of persons with active tuberculosis (TB). The TB Control Program is reviewed annually and included in the onboarding and annual Infection Control Education Programs.

I. Assignment of Responsibility

1. Coordination/management of program – Infection Preventionist
2. Program management will also include the following persons:
    - Infection Preventionist
    - DON Quality/Infection Prevention
    - Employee Health/ Nurse Specialist
    - Respiratory Therapy Manager
    - Director of Plant Operations
    - Infection Control Committee Chair
    - Employee Health appointee
    - Pharmacy

II. Risk assessment, TB infection control plan, and periodic assessment

1. Annual risk assessment
    - Obtain information concerning TB in the community from Inyo County Health Department.
    - Evaluate data concerning TB patients in the facility.
    - Evaluate data concerning tuberculin skin-test (TST) conversions, or positive TB diagnostic testing among Health Care Workers (HCW) in the facility.
    - Rule out evidence of person-to-person transmission.
2. Written TB infection control program
    - Select initial risk protocols.
    - Develop written TB infection control protocols.
3. Repeat risk assessment at appropriate intervals.
    - Review current community and facility surveillance data and TST results.
    - Review records of TB patients.
    - Observe Health Care Worker infection-control practice.
    - Evaluate maintenance of engineering controls.

III. Identification, evaluation and isolation of patients

1. Early identification and isolation of patients with active tuberculosis or suspected of having tuberculosis.
    - Utilize Standard Precautions and Airborne Precautions for all patients.
    - Patients with symptoms of respiratory infection and severe cough must be triaged as quickly as possible.
2. Coughing patients are instructed on Respiratory etiquette
    - To cover their cough with tissues and dispose in appropriate receptacle

- Cough/sneeze into the crook of their elbow
- Have surgical mask applied.
- Tissue dispensers are placed within reach of patients throughout the facility.
- Signs are placed in ~~all~~ waiting areas to remind patients to "Cover Your Cough."
- Respiratory hygiene stations equipped with tissues, face masks and alcohol-based when not in a pandemic or national supply shortage/ hand rubs, at all hospital and clinic entrances
- Nursing and registration staff have been trained, and are encouraged, to provide tissues and encourage patients to utilize the hygiene stations, and remind patients to cover cough using respiratory cough etiquette techniques Patients in outpatient waiting areas who are unable to contain their secretions should have surgical face mask applied and be moved to an exam room. If no exam room available place patient in isolated area and away from other patients and visitors.

Assessment includes questions asking:

a. Have you had a cough for more than three weeks?
b. Do you have:
    i. Hemoptysis
    ii. Cough
    iii. Weight loss
    iv. Fatigue
    v. Night sweats
    vi. Fever
    vii. Purulent sputum

3. A patient answering **yes** to any of the above without any underlining infection or disease is suspicious for TB and shall be placed in respiratory isolation while medical evaluation is completed.
4. Options for this interim placement are:
    a. ER treatment room with Airborne Precaution signage door closed.
    b. Room 5 (negative pressure room) Medical surgical unit.
    c. Room 1 (negative pressure room) ICU
    d. Any other unoccupied room – place Airborne Precaution signage on closed door.
5. Further evaluation of the patient may include:
    a. Obtain chest X-ray.
    b. Obtain history of TB exposure.
    c. Collect AFB smear/cultures x 3 on three separate days
    d. Administer TST or Quantiferon-TB Gold if applicable

IV. Managing patients suspected of having TB

a. Continue airborne isolation until TB is ruled out or ruled out by Inyo County Health Director.
b. Treatment initiated as determined by M.D.
c. Particulate Respirator (N95) or Powered Air Purifying Respirator (PAPR) is to be worn by all persons entering the room.
d. Visitors are to be triaged and limited to not expose other persons unnecessarily.
e. Visitors to be instructed in wear and fit of N95.

f. Patient on Airborne Isolation Room may only leave room for essential purposes only. HCW to wear N95 or PAPR; patient must wear regular surgical mask.
g. Isolation may be discontinued after three (3) consecutive negative AFB smears are obtained.
h. TB patients can share the same room if drug resistant TB has been ruled out in both patients.
i. If Suspected or confirmed patient is seen in outpatient departments avoid having patients sit in waiting rooms. Direct patient to enter by shortest route to exam room.

VI. Surgical Procedures on Patients Suspected of Having TB

a. All procedures not deemed urgent should be postponed until patient is no longer infectious.
b. Schedule surgery at end of day.
c. Traffic in and out of the operating room must be kept to a minimum.
d. Surgical team to wear N95 or Powered Air Purifying Respirator (PAPR) instead of surgical masks.
e. Follow airborne precautions
f. Don N95 or PAPR-If possible recover patient in Airborne Infection Isolation Room (AIIR). If unable recover patient in PACU close door and place Airborne Isolation signage. Limit visitors

VII. Cough-inducing procedures (bronchoscopy, ET intubation, sputum inductions).

a. Do not perform such procedures on TB patients unless absolutely necessary.
b. Perform such procedures in Airborne Infection Isolation Rooms. If unable complete procedure in room with door closed at all times and traffic must be limited.. HCW must wear N95 or PAPR
c. After completion of procedures, TB patients should remain in the booth or special enclosure until their coughing subsides. Encourage patient to wear surgical mask before and after procedure. .

VIII. Respiratory Protection Program

A. Use N95 Powered Air Purifying Respirator (PAPR) as required by OSHA.
B. Upon hire and annual fit testing completed on healthcare workers who are at risk for airborne infection, as outline in the Aerosolized Transmissible Disease Plan.
C. Fit testing for N95 or (PAPR)
    1. Mask must fit snugly around the face to prevent air leakage.
    2. If excessive facial hair prevents adequate fit, hair should be removed or HCW should use PAPR after training.
    3. Masks should not be reused unless directed by the Infection Preventionist or designee due to national shortage or pandemic. If masks are re-used store in paper bag.
    4. If a medical condition, i.e., asthma, makes it difficult for the HCW to wear a N95 or PAPR for extended periods of time, contact the Employee Health nurse. If it is determined that the HCW cannot wear PAPR or N95, he/she must not care for TB patients.

XI. Engineering Controls

A. Institute Airborne Precautions; post "Airborne" signage that is clearly visible.
B. The following areas are designated as Airborne Infection Isolation Rooms, under the stated conditions:
    1. Room 5 (Med-Surg) negative pressure room
    2. ICU Room 1 (negative pressure room)
    3. Any patient room – minimal negative pressure
        Door closed with Airborne Isolation sign visible

C. Monitoring and maintaining ventilation system:
1. Airborne Infection Isolation Rooms are Room 5 on the Medical Surgical unit and Room 1 in the ICU, must be assessed:
   a. When isolation is initiated
   b. Daily when room is in use
   c. Quarterly for accurate negative pressure by maintenance personnel
2. Non-AIIR rooms the HEPA filters are changed quarterly *Note: The AIIIR Rooms don't have filters they are straight piped to exhaust fans.*

D. When discontinuing isolation (patient discharged) complete terminal clean per Environmental Services procedures Follow below table

TABLE 1 Air Exchange Within NIHD Departments:

Department Name	Air exchange per Hour (ACH)	Minutes Required for Removal efficiency †	
		99%	99.9%
Emergency Department	6 ACH	46	69
Emergency Department Triage	12 ACH	23	35
Med-Surg Non AIIR	6 ACH	46	69
ICU Non AIIR	6 ACH	46	69
AIIR M/S 5 & ICU 1	12 ACH	23	35
OB	6 ACH	46	69
Pre-op/PACU	6 ACH	46	69
OR	25 ACH	14	21
Outpatient Infusion	6 ACH	46	69
Clinics	2	138	207

* This table can be used to estimate the time necessary to clear the air of airborne *Mycobacterium tuberculosis* after the source patient leaves the area or when aerosol-producing procedures are complete.
† Time in minutes to reduce the airborne concentration by 99% or 99.9%.

XII. HCW TB training and education

A. Program education will be conducted annually. Healthcare workers that are identified as High Risk will have to attend the education see section XV.
B. TB education will include:
   1. Transmission
   2. Signs and symptoms
   3. Screening

Title: Tuberculosis Exposure Control Plan	
Scope: NIHD	**Department:** CPM: Infection Control Patient Care (ICP)
Source: Quality Informatics Nurse/Infection Preventionist Manager	**Effective Date: September 2007**

4. Isolation Procedures
5. Occupational Groups at Greatest Risk
6. Respirator Use
7. Surveillance and therapy
8. Prevention
9. Purpose and use of control measure.
10. Knowledge of Policy and Procedures
11. Awareness of high-risk procedures and protective measures to be instituted.
12. Epidemiology to TB in the facility
13. Discontinuation of airborne precautions

XIII. Medical surveillance of employees

A. Follow "Employee Tuberculosis Surveillance Policy" in the Infection Control Manual
B. Base surveillance on County Risk Assessment and regulatory guidelines
C. Assure that immunosuppressed HCWs are removed from all contact with patients possibly infected with TB

XIV. Infection Prevention or designee will coordinate with Public Health Department to initiate contact investigations.

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XV. Departments included in the TB Plan include:

1. Admission Services (Outpatient Clerks, e.g. ED, RHC) Exceptions: Admission Services Director; Insurance Verifier;	9. Pharmacy
2. Nursing Department (RNs, LVNs, CNAs, Medical Office Assistants) Case Managers- RNs	10. Rehabilitation Department
3. Environmental Services/Talent Pool	11. Cardiopulmonary
4. Physicians/Advanced Practice Providers	12. Radiology Department
5. Laboratory Clinical Staff	13. Security
6. Language Services- Director and Interpreters	14. Social Services
7. Maintenance/Plant Operations	15. Students (if there is potential for patient contact with airborne isolation patients)
8 Dieticians & Diet Clerks	16.

REFERENCES:

1. Centers for Disease Control and Prevention. (2019). TB Infection Control in HealthCare Settings. Retrieved from https://www.cdc.gov/tb/topic/infectioncontrol/TBhealthCareSettings.htm
2. Centers for Disease Control and Prevention. (Last accessed 3/16/21). Guidelines for Prevention of Transmission of Mycobacterium Tuberculosis in the Health Care Facility. Retrieved from https://www.cdc.gov/mmwr/preview/mmwrhtml/rr5417a1.htm?s_cid=rr5417a1_e

Title: Tuberculosis Exposure Control Plan	
Scope: NIHD	**Department:** CPM: Infection Control Patient Care (ICP)
Source: Quality Informatics Nurse/Infection Preventionist Manager	**Effective Date: September 2007**

3. Curry International Tuberculosis Center. (2011). Tuberculosis Infection Control A practical Manual for Preventing TB. Retrieved from https://www.currytbcenter.ucsf.edu/sites/default/files/ic_book_2011.pdf

CROSS REFERNCES:

1. **Aerosolized Transmissible Disease Exposure Plan Respiratory Protection Program**
2. **Employee Tuberculosis Surveillance Program**
3. **Airborne Infection Isolation Room (AIIR)**
4. **N95 Mask Fit Testing Using Porta Count Pro**
5. **Employee Health Surveillance Program**
6. **Lippincott Procedures Airborne Precautions, Standard Precautions, Respiratory Hygiene and Cough Etiquette ambulatory care**
7. **Infectious/Non Infectious Waste Disposal Procedure**
8. **Care and Donning of a Powered Air Purifying Respirator**
9. **Linen Laundry Processes AB 2679**

Committee Approval	Date
CCOC	3/30/2021
Infection Prevention Committee	6/22/2021
Inpatient Services Committee	6/23/2021
Med Exec committee	7/6/2021
Board of Executives	

Developed: 3/95
Reviewed**:** 3/95; 6/97; 4/2000; 3/2001; 10/2002; 5/2003; 2/2004; 7/2005; 9/2007; 8/11RC;9/12bs, 6/13bs
Revised: 03/21 RC
Index Listings: Exposure Control Plan – TB; Tuberculosis – Exposure Control Plan

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Basic Principles of Sterilization	
Scope: Sterile Processing	Manual: Infection Control- Patient Care (ICP), Sterile Processing
Source: Surgery / Sterile Processing Manager	Effective Date:

PURPOSE:
Since sterilization is essential for the destruction of all microorganisms, knowledge of the basic principles is necessary.

POLICY:

- Devices used in a hospital should have properties which would not be adversely affected by sterilization.
- Items intended for single (one-time) use will not be reprocessed
- Devices to be sterilized must be free from all foreign substances to permit surface contact with the sterilizing agent.
- Devices should be assembled and positioned so that complete penetration of the sterilizing agent is possible.
- Prescribed time and temperature must be assigned and followed for complete destruction of all microorganisms.
- Sterilizers and sterilizing agents should be checked periodically for efficiency and accuracy.
- Sterilizers should be operated according to instructions of the manufacturer.
- In the event of a sterilization failure, all supplies will be recalled.

Bacteria in the spore form Bacillus (stearothermophilus) are used to test the efficiency of the sterilization process. Though relatively harmless themselves, they are very resistant to steam, gas and heat. They are frequently used as controls for standard sterilizing procedures. The aim of sterilization is to destroy the spore forming microorganisms. When this occurs, the less resistant types are also destroyed. The commercially prepared Biological/Integrator Challenge Pack to test the efficiency of the hospital sterilizers.

Because of the many sources of possible sterilization failure, a system of controlling the sterilization process is essential. There are three types of controls: **mechanical, biological and chemical** controls.

1. **Mechanical:** Manufacturers have supplied several devices to assist in identifying and preventing malfunction and operational errors. Among these:
   - A recording thermometer, which gives a written report of the time and temperature of the loads processed. This also serves as a permanent record.
   - An indicating thermometer, which points out the temperature at the exhaust line.

2. **Biological:** Culture tests are the best means of confirming the sterility of a particular article or evaluating the effectiveness of a sterilizer. These are performed daily and should be repeated after a sterilizer has been repaired. Prepared cultures such as Biological Challenge Test should be placed in the front bottom part of the sterilizer closest to the drain. After sterilization, the cultures are incubated and monitored in Sterile Processing for 24 hours per manufacturer's instructions. Reports are kept on file in Sterile Processing.

3. **Chemical Controls of Sterilizer Indicators:** These controls detect cool air pockets at the center of a load. Their limitations, however, should be recognized. These controls do not prove sterilization. Only cultures will prove sterilization. There are several types of indicators, including:

Title: Basic Principles of Sterilization	
Scope: Sterile Processing	Manual: Infection Control- Patient Care (ICP), Sterile Processing
Source: Surgery / Sterile Processing Manager	Effective Date:

- Class 6 chemical indicator which is a cycle verification indicator designed to react to all critical variables for specific sterilization cycles;
- Sterilizer indicating tape, which is used to close the package and to show that the article has been exposed to heat.
- Chemical Indicator Locks and chemical indicator filters on the container systems.

NOTE: All prevacuum sterilizers are tested daily with a DART (Daily Air Removal Test) which documents that the prevacuum portion is functioning properly.

Despite the many advantages of steam heat as a sterilizing agent, positive sterilization may be impeded by certain factors. The main impediment is the presence of air in the sterilizing chamber. If small amounts of air remain in the chamber, they will concentrate in pockets in the load and can be difficult to remove. Other impediments may result from procedural errors. Personnel should recognize the following errors which may result in sterilizing failures:

- **Overloading:** Loose packing of the sterilizer is needed to allow free access of steam and escape of air.
- **Oversized or too tight packs:** Air elimination, which is needed, is difficult to achieve if packs are too large or wrapped too tightly.
- **Improper operation of sterilizer:** Examples of improper operation of the sterilizer are: Neglecting to follow the manufacturer's directions, shortening the exposure period, failing to regularly clean the outlet screen and exhaust line, and failing to have regular inspection and proper maintenance.

REFERENCES:

- IAHCSMM Central Service Technical Manual 8th Edition Chapter 6
- Amsco/Steris Technique Manual
- AORN RP for Sterilization
- AAMI ST79 8, 9, 10
- Title 22 Standard 70833
- TJC: EC.02.04.03, IC.02.01.01

Approval	**Date**
CCOC	5/4/2021
Infection Prevention Committee	6/22/2021
MEC	7/6/2021
Board of Directors	
Last Board of Director review	

Developed:
Reviewed:
Revised: 02/01; 8/2010 BS; 5/2015 BS, 4/21aw

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Cleaning Procedures: Specialized Areas: Sterile Processing	
Scope: **Environmental Services, Sterile Processing**	Department: **Environmental Services, Sterile Processing**
Source: MANAGER OF ENVIRONMENTAL SERVICES	Effective Date: Not Approved Yet

PURPOSE:

To establish the procedure for Environmental Services cleaning the Sterile Processing Department.

	Supplies Needed	**Equipment Needed**
GENERAL:	Germicidal Detergent	Wet Mop
	Cleaning Cloths	Floor Scrubber
	Paper Towels	Floor Machine
	Liquid Hand Soap	**Ladder****
		Caution Signs

**** For use in this area only**

INSTRUCTIONS:

1. Observe surgical dress requirements at all times. Sterile Processing is a **"Clean Area"**.
2. Use germicidal detergent in all areas and on all items unless instructed to do otherwise.

PROCEDURE – DAILY:

1. Empty wastebaskets, clean with germicidal cleaner. Replace liners.
2. Put up **"Wet Floor"** signs. Wet mop.
3. Replenish soaps, sanitizer and paper towels as needed.

PROCEDURE - WEEKLY:

1. Clean underneath tables.

PROCEDURE – MONTHLY:

1. Wash walls from ceiling to floor. Wash doors from top down.
2. Scrub and buff all floors.
3. Clean all fixtures.
4. Clean vents.
5. Clean ceiling.
6. Clean fire extinguisher and clock.
7. Clean window sills.

Approval	**Date**
CCOC	6/1/2021
Infection Prevention Committee	6/22/2021
MEC	7/6/2021

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Cleaning Procedures: Specialized Areas: Sterile Processing	
Scope: **Environmental Services, Sterile Processing**	Department: **Environmental Services, Sterile Processing**
Source: MANAGER OF ENVIRONMENTAL SERVICES	Effective Date: Not Approved Yet

Revised 4/2011; 4/27/2021 AS
Reviewed 5/1994 MDE; 1/1995 MDE; 3/1998 MDE; 1/2001 MDE; 1/2004 MDE; 3/2006 MDE; 1/2010 MDE; 5/2011 MDE, 8/16/17 BOD
Supersedes

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Operating Room Attire*	
Scope: Surgery	Manual: Surgery - Infection Control-Environmental (ICE)
Source: Surgery / Sterile Processing Manager	Effective Date:

PURPOSE:
The human body and inanimate surfaces inherent to the surgical environment are major sources of microbial contamination and transmission of microbes; therefore, surgical attire and appropriate personal protective equipment (PPE) are worn to promote worker safety and a high level of cleanliness and hygiene within the perioperative environment.

The purpose of operating room attire is to provide effective barriers that prevent the dissemination of microorganisms to the patient. These barriers coincidentally protect personnel from infected patients. These barriers prohibit contamination of the operative wound and sterile field by direct contact.

POLICY:
The operating rooms are entered from a "Clean" limited access corridor.

Hospital personnel having business with perioperative clerk and Surgery / Sterile Processing Manager may enter the non-restricted area through the Surgery Office to conduct their business without donning surgical attire.

Only necessary personnel for patient care are allowed in the semi-restricted and restricted area and must adhere to the following guidelines

All persons who enter the semi-restricted and restricted areas of the surgical suite should be in surgical attire intended for use only within the surgical suite. Identification badges should be secure on the surgical attire top, is visible and be cleaned if it becomes soiled.

PROCEDURE:
1. **Attire:** Operating room attire consists of body covers such as two-piece pant suits. Clean, fresh attire is donned each time on arrival at the operating room suite and as necessary when garments become wet or grossly soiled.
    - Surgical attire is to be laundered in the hospital laundry or a health care-accredited laundry facility.
    - Surgical attire that has been penetrated by blood or other potentially infectious materials should be removed immediately or as soon as possible and replaced with freshly laundered, clean surgical attire.
    - Surgical attire will be made of materials that meet or exceed the standards of the National Fire Protection Association.
    - Surgical attire should be made of low-linting material, provide comfort and promote a professional appearance

2. **Shoes:** Dedicated shoes worn only in the operating room should remain in the operating room; if worn outside the operating room, clean shoe covers should worn over them. Upon returning from the outside and before entering the surgical environment, remove shoe covers or replace shoe covers with fresh clean ones.

- Shoe covers are to be changed whenever they become wet, soiled or torn and should be removed before leaving the surgical suite.
- Waterproof shoe covers should be used when there is a higher risk of becoming contaminated with bodily fluids i.e.; Cesarean Section and Arthroscopic procedures.

3. **Travelling outside the OR with surgical attire**.
If staying in the hospital (same building), the surgical scrubs do not have to be changed. Surgical attire is not to be worn outside of the surgical area except to get equipment, food, or attend in-house classes or meetings. If leaving the hospital, by going from one building into another or going outside into the environment, the surgical scrubs will need to be changed completely before entering the surgical environment. Cover apparel can be worn but has been found to have little or no effect on reducing contamination of surgical attire; cover apparel must be changed and laundered in the same manner scrub uniforms are.

4. **Maintenance Personnel:**
Coveralls, caps and shoe covers are provided for maintenance personnel entering restricted areas.
- In emergencies, when maintenance personnel must enter the operating rooms while surgery is in process, regular standards for changing into surgical scrubs will be enforced.
- Other ancillary personnel such as respiratory therapists/pathologists and OB personnel may also wear coveralls or clean surgical scrubs.

5. **Warm Up Jackets:**
When non- scrubbed personnel are wearing warm-up jackets they are to be snapped closed with the cuffs down to the wrists.
- Wearing warm-up jackets snapped closed prevents the edges of the front f the jacket from contaminating a skin prep area or the sterile surgical field.
- Warm up-jackets with wrist-length sleeves decrease the skin squames shedding that occurs from the skin and hair on arms.
- It is recommended in our facility that all non-scrubbed personnel must wear warm-up jackets especially during a Total Joint Procedure.

6. **Head and Beard Covers:**
Head and beard covers must cover hair (head and beard) and scalp skin completely in the restricted and semi-restricted areas. They will be clean, lint free and changed daily and/or when soiled or torn.

7. **Masks:**
Masks are worn at all times in the restricted areas of the operating room suite where sterile supplies are opened and during any surgery.
- The mask should cover the mouth and nose and be covered in a manner to prevent venting.
- A fresh clean surgical mask should be worn for every procedure.
- Masks are worn upon entering the room during an operation, during set up.

- Masks should be changed between cases or at any time they become damp.
- The filter portion of the mask should not be left dangling around the neck and should only be handled by the ties when removing.
- Hand hygiene must be performed after removal of masks.

8. **Gloves:**
Gloves should be selected and worn depending on the tasks to be performed. Sterile gloves will be worn when performing sterile procedures. Unsterile gloves may be worn for other tasks.
- Gloves should be changed between patient contacts or after contact with contaminated items when task is completed.
- Hands should be washed after removing gloves.
- Double gloving is recommended on all surgical procedures.
- Sterile gloves should be wiped prior to procedure with wet towel or sponge to remove powder, if powdered glove are worn.
- If a sterile glove is punctured or torn it must be changed immediately.

9. **Sterile Gown:** (See the Lippincott Procedure: Surgical Asepsis: Surgical Attire for donning a sterile gown and gloves)
A sterile gown is worn over scrub suit to permit wearer to come within the sterile field. The gown must provide a protective barrier from strike through.
- Although entire gown is sterile, the back is not considered sterile nor is any area below table level once gown is donned.
- Wraparound gowns that provide sterile coverage to the back by a generous overlap are recommended.

10. **Jewelry:**
All persons entering the semi-restricted or restricted areas of the surgical suite should have jewelry contained.

11. **Nails:**
Nail polish and artificial nails shall not be worn within the semi-restricted and restricted. Nails should be natural and length should be no more than one quarter inch long and well-manicured.

12. **Badges:**
- Identification badges should be worn by all personnel in the operating room.
- Identification badges should be secured on the surgical attire top, be visible, and be cleaned if they become soiled.
- Badge holders such as lanyards, chains, or beads pose a risk for contamination and may be very difficult to clean.

13. **Fanny Packs:**

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Scope: Surgery	Manual: Surgery - Infection Control-Environmental (ICE)
Source: Surgery / Sterile Processing Manager	Effective Date:

Fanny packs, backpacks and briefcases are discouraged in the semi-restricted and restricted areas of the perioperative suite. These items due to the porous nature of the materials used in the construction may be difficult to clean or disinfect adequately and may harbor pathogens, dust, and bacteria.

PERSONNAL PROTECTIVE EQUIPMENT (PPE)

- Eyewear or a face shield is worn to reduce risk of blood or body fluids from patient splashing into the eye of sterile team members. Protective eyewear that becomes contaminated should be discarded or decontaminated as promptly as possible according to manufacturer's recommendation.
- Additional protective attire such as fluid resistant aprons, gowns or shoe covers should be worn when contact with blood or body fluid is unavoidable.
- Lead aprons will be worn under sterile gowns to protect against radiation exposure during procedures performed under fluoroscopy or image intensification.
- Sterile air helmet system will be utilized on all total joint procedures and at physician request on other procedures.
- If CDPH (California Dept. of Public Health) or CDC (Center for Disease Control) guidelines are initiated for patient infection or widespread pandemic, the Operating Room personnel would be informed and educated for compliance with the guidelines.

DOCUMENTATION:

Any known breaks in sterile techniques will be brought to the attention of the surgical team for immediate correction and will be noted in the operating room record under comments. The Surgery / Sterile Processing Manager will be notified and the incident will be tracked on an Unusual Occurrence Report (or currently used quality analysis record).

REFERENCES:

1. TJC: IC.02.05.01
2. AORN Perioperative Standards and Recommended Practices Surgical Attire
3. Lippincott Procedure Surgical Asepsis: Surgical Attire

Approval	**Date**
CCOC	5/4/2021
Infection Prevention Committee	6/22/2021
STTA	5/12/2021
MEC	7/6/2021
Board of Directors	
Last Board of Directors Review	

Developed:
Reviewed:
Revised: 02/01 BS; 8/2011BS, 9/12 BS, 8/2015 BS, 4/21aw, 5/21
Supersedes:

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Operating Room Sanitation	
Scope: Perioperative and Environmental Services	Manual: Infection Control Blue Manual, Surgery
Source: Surgery / Sterile Processing Manager	Effective Date:

PURPOSE:

- To provide effective environmental sanitation within the surgical setting.
- Sanitation techniques shall be established to control and reduce the possibility of cross-infection of surgical patients and personnel in the operating room.
- All surgical procedures are considered potentially infectious; therefore, no special cleaning technique is required after known septic cases providing routine cleaning is always adequate and thorough.

POLICY:

The patient should be provided a clean, safe environment.

The following procedure will be adhered to regarding operating room cleaning and disinfection.

- Before the first scheduled operation of the day all horizontal surfaces in the OR (e g, furniture, surgical lights, booms, equipment) will be damp dusted with a clean cloth (preferably lint free) or microfiber cloth. Plasma and monitor screens will have cleaned according to manufacturer's instructions. Floors will be wet mopped.

- The area in which the surgical team has functioned and horizontal surfaces is the area that shall be cleaned between cases. The perimeter of the room and vertical surfaces of furniture shall be terminally cleaned daily. The entire surgical team must be aware of what is to be accomplished to carry out the following method of cleaning.

- The Surgery rooms and all areas coming in contact with the surgical team or the patient are cleaned thoroughly between procedures and after the last case with a hospital germicidal approved for the operating room.

- Environmental Protection Agency (EPA) – registered disinfectants should be used to clean floors, non-critical equipment, and other surfaces.

- Reusable string and microfiber mops and cleaning cloths should be changed after each use.

- The operating room environmental personnel, as well as nursing personnel are instructed in basic theory of infection control and understand the housekeeping function in maintaining asepsis and preventing transmission of disease.

- Environmental cleaning and disinfection is a team effort involving surgical personnel and environmental services personnel. The responsibility for verifying a clean surgical environment rests with perioperative nurses.

- The operating rooms are cleaned by the circulating nurse on duty or environmental service personnel in "emergency call situations following the sanitation procedure for "between case cleaning."

- Preparation of the OR should include visual inspection for cleanliness before carts, supplies, equipment, and instrument sets are brought in the room.

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Operating Room Sanitation	
Scope: Perioperative and Environmental Services	Manual: Infection Control Blue Manual, Surgery
Source: Surgery / Sterile Processing Manager	Effective Date:

EQUIPMENT:

- Mop bucket specific for operating room.
- Clean mop head.
- Fresh solution of hospital germicidal approved for the operating room.
- Gloves, eye protection, mask and an isolation gown if applicable (e g, contact precautions).
- Cleaning cloths.

PRECAUTIONS:

- All personnel performing environmental cleaning duties in the operating room will adhere to standard precautions at all times.

- All personnel handling contaminated items must wear appropriate PPE (personnel protective equipment) to reduce the risk for exposure to blood borne or other potentially infectious microorganisms and hazardous materials.

- All body fluids (e g, semen, vaginal secretions, cerebrospinal fluid, synovial fluid, pleural fluid, pericardial fluid, peritoneal fluid, amniotic fluid, saliva,) except sweat are potentially infectious.

- Gloves must be worn when it is reasonably anticipated that personnel may have contact with blood or other potentially infectious materials while handling or touching contaminated items or surfaces.

- Hand hygiene should be performed when gloves are removed and as soon as possible when hands are soiled.

- Masks, eye protection, and face shields must be worn whenever contact with splashes, spray, or droplets of blood or other potentially infectious material is anticipated.

- All personnel mixing or using hospital germicidal approved for the operating room must wear gloves and eye protection.

- In case of contact with eyes or skin, flush with water immediately for 15-20 minutes and contact physician for further treatment advice. If swallowed call poison control center or doctor immediately for treatment advice. Remove contaminated clothing. If inhaled move to fresh air, call poison control center or doctor for further treatment advice.

- An EPA – registered, hypochlorite based disinfectant should be used to clean a patient area when a patient is diagnosed or suspected of infection with Clostridium difficile (C. difficile)

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Source: Surgery / Sterile Processing Manager	Effective Date:

- **Contact precautions** should be instituted when performing environmental cleaning and disinfection of rooms used to care for patients colonized or infected with **drug resistant pathogens.**

- Consistent adherence to approved cleaning and disinfection is crucial for the prevention of antibiotic-resistant organism transmission. One study found that VRE was recovered from 50% of inadequately cleaned surfaces after inoculation.

- Closure of the room or extraordinary cleaning and disinfection procedures are not required.

- Airborne disease (ie,rubeola, varicella, tuberculosis-TB, Covid-19), must use a properly fit tested **N95 mask** or powered air purifying respirator until complete air exchange has been achieved.

- The period of time required for the ventilation system to achieve a 99.9 % air exchange (eg, 28 minutes for 15 air exchanges).

- Access to the room should be restricted until the 99.9% air exchange has been completed.

- Heavy or large pieces of equipment or furniture must be moved with two or more staff members to avoid injury to personnel, the equipment or furniture, as well as the room.

WHEN CLEANING UP SPILLS DURING A PROCEDURE, NEVER USE LAP SPONGES. LAP SPONGES ARE NEVER TO BE TAKEN INTO A ROOM FOR CLEANING PURPOSES WHEN A SURGICAL CASE IS IN PROGRESS AS THEY COULD INTERFERE WITH THE COUNT.

PROCEDURE:

BEFORE THE FIRST OPERATION OF THE DAY:

1. Damp dust overhead operating lights, furniture, flat surfaces and all portable or mounted equipment with a hospital germicidal approved for the operating room. Allow to air dry.

2. Mop floors with hospital germicidal approved for the operating room.

3. Walls up to the end of the tile are to be washed every Monday and the day before a Total Joint Procedure, this can also be done the morning of the procedure by the early environmental person.

DURING SURGICAL PROCEDURES:

1. Throughout the surgical procedure, an effort is made to confine contamination to as small an area as possible around the operating room table.

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Scope: Perioperative and Environmental Services	Manual: Infection Control Blue Manual, Surgery
Source: Surgery / Sterile Processing Manager	Effective Date:

2. Areas contaminated by organic matter, such as blood, body fluids and tissue during the procedure shall be contained or wiped up immediately with hospital germicidal approved for the operating room by the gloved circulating nurse.

3. Sponges are deposited into a plastic lined bucket. As soon as possible they are counted and sealed in an impervious bag.
    - To facilitate the counting and containment of the sponges, use of plastic counting receptacles that individually display the sponges is allowed for longer procedures. Bag sponges as soon as possible in order to avoid wet sponges left to hang over the sides of the bucket where they can drip onto the floor. Sponges are then placed in a container lined with a **RED BAG** to be discarded.

4. To decrease the possibility of cross contamination and transmission of disease, gloves or an instrument or both is utilized in counting and collecting sponges.

5. Traffic will be kept to a minimum to decrease air turbulence and skin desquamation. Doors will remain closed during the procedure.

BETWEEN CASE CLEANING:

At the end of the surgical procedure, all items that have come in contact with the patient shall be considered contaminated.

1. All instruments, trash and linen used during the procedure are considered contaminated and are contained before removal from the room for proper disposal. Items that were open for the procedure and not used are also considered contaminated and are contained before removal from the room for proper disposal.

2. Prior to removal of gown and gloves, the scrubbed person places all instruments, trays, and basins in appropriate containers in preparation for their disposal. All trash and linen is deposited in a designated receptacle and sealed prior to removal from the room.

3. Sharps such as needles and blades are discarded into puncture-proof containers to prevent injury to other personnel.

4. The contents of anesthesia suction containers are discarded into a flushing hopper, or they can have Cida-gel or another chlorine gelling power added to congeal contents of the suction containers before disposition into red bagged container. Neptune suction fluid is disposed of by docking the Neptune and following manufacturer's recommendations. Protective measures including eye protection is to be utilized at all times when dealing with body fluids.

5. Operating rooms should be cleaned after each surgical or invasive procedure with a lint-free or microfiber cloth moistened with a hospital germicidal approved for the operating room.

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Scope: Perioperative and Environmental Services	Manual: Infection Control Blue Manual, Surgery
Source: Surgery / Sterile Processing Manager	Effective Date:

7. Walls and doors are spot cleaned as necessary.

8. The floor is wet mopped with a hospital germicidal approved for the operating room, changing mop head after each case, except where it is necessary to change more frequently, i.e.; total joint replacement, cesarean section. Furniture including the operating room table is moved so that the entire floor can be cleaned. Two or more staff members (RNs, scrub techs, environmental service personnel, etc.) must be available and assist in moving the OR table so the floor can be mopped.

9. The operating room table including mattress is cleaned with a hospital germicidal approved for the operating room and remade with fresh linen.

10. Kick buckets are cleaned and relined, and new trash and laundry bags provided. Anesthesia circuit and suction sets are replaced and the room is reviewed to assure all supplies are correctly placed and in working condition.

11. Shoe covers are changed if soiled, and masks are changed between cases. Scrub attire is also changed if soiled or wet.

AT THE CONCLUSION OF THE OPERATING ROOM SCHEDULE:

1. All furniture including wheels and castors are thoroughly cleaned. Handles of drawer, cabinets, and doors are cleaned. Surgical lights and other permanent fixtures are cleaned. Cabinet doors and operating room doors are cleaned.

2. Kick buckets and trash receptacles are cleaned.

3. Scrub areas including sinks and faucet spray heads are cleaned daily. Disposable brushes are replenished as needed. Soap dispensers are cleaned and refilled.

4. Floors in the operating room, scrub area, sub-sterile area, and corridors are wet mopped with a hospital germicidal approved for the operating room. Two or more staff members (RNs, scrub techs, environmental service personnel, etc.) must be available and assist in moving the OR table so the floor can be mopped.

5. Stretchers, utility carts, and transportation carts are cleaned after each use.

6. Cleaning equipment is disassembled, cleaned, and dried prior to storage.

PERIODIC CLEANING:

1. Air conditioning and heating grills are to be cleaned at least bi-monthly.

2. Cabinets and shelves are to be cleaned routinely with a hospital germicidal approved for the operating room.

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Title: Operating Room Sanitation	
Scope: Perioperative and Environmental Services	Manual: Infection Control Blue Manual, Surgery
Source: Surgery / Sterile Processing Manager	Effective Date:

3. Upper walls and Ceilings are to be washed down as needed due to splashing, and at least bi- monthly.

4. Overhead light tracts are to be cleaned at least bi-monthly by the environmental services personnel.

5. Offices, lounges and locker rooms are to be cleaned daily according to hospital environmental services policy.

DOCUMENTATION: None

REFERENCES:

AORN Guidelines for Perioperative Practice (2018): Environmental Cleaning
TJC: IC.02.02.01

CROSS REFERENCE P&P:

Operating Room Attire
Infection Control in OR/PACU Environment

Approval	**Date**
CCOC	5/4/2021
Infection Prevention Committee	6/22/2021
STTA	5/12/2021
Medical Executive Committee	7/6/2021
Board of Directors	
Last Board of Director review	

Revised ; 2/01 BS; 12/2011BS, BS 9/12, AW 12/14, 4/21aw
Last Board of Director review: 1/17/18; 1/16/19, 3/18/2020
Index Listings: Sanitation in the operating room/ Cleaning in the operating room Operating Sanitation

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Postpartum Patient Care in the PACU	
Scope: Perioperative	Manual: PACU
Source: OP/PACU Manager	Effective Date: 3/98

PURPOSE:
To provide standard PACU as well as standard obstetrical care for all obstetrical patients. The postpartum patients cared for by PACU nursing staff are usually C-section or forceps delivery patients who have had a spinal, epidural or occasionally a general anesthetic.

POLICY:
Postpartum patients coming from the operating room are recovered in the PACU but may be recovered in their private room on the postpartum floor if the patient is stable following a vaginal delivery. An identified support person will be allowed in the PACU with the postpartum patient if the patient condition is stable.
PACU standards of care as well as physician orders applicable to the PACU period will be followed.

PROCEDURE:
- The patient will be transferred to the PACU or the patient's room on the postpartum floor by the anesthesiologist and OR RN. Report will be given to the PACU RN by the anesthesiologist and OR RN.
- Routine PACU care will be initiated. In addition to the PACU Standards of Care and PACU Guidelines, the following will also be assessed:
- On admission to the PACU and every 15 minutes for the first hour, the patient will be assessed for signs/symptoms of PIH (pregnancy induced hypertension) including DTR's (deep tendon reflexes) and clonus. The obstetrician will be notified of any new signs/symptoms of PIH. If MgS04 (magnesium sulfate) therapy is initiated the Lippincott policy: Magnesium sulfate administration, obstetric patient will be followed. Note: accurate DTR and clonus checks may not be elicited on a patient with a spinal or epidural anesthesia.
- Strict I & O should be kept on patients with PIH or after a C-section.
- Fundal checks should be initiated on arrival to the PACU and continued every 15 minutes thereafter unless flow is very heavy and/or the fundus is boggy, in which case fundal massage should be used. (See the Obstetric Hemorrhage Care Guidelines). There is a postpartum hemorrhage kit in the Omni-cell in Surgery. Nurse's notes should contain charting on fundal height/firmness, lochia flow/color, and pad changes necessary.
- Most times the patient will have Pitocin in the IV that has been running in surgery. Check the doctor's orders when/if another IV needs to be hung in the PACU period. Standard pre-mix Pitocin should be hung on an infusion pump as the Pitocin may be continued for several liters.
- Unless the patient is not stable or the PACU is exceptionally crowded, the single identified support person of a postpartum patient will be allowed to visit the patient in the PACU.
- If the postpartum patient is recovered in the PACU the baby may be brought over to the PACU by an OB nurse for bonding with the parents. The nursery RN will stay with the baby in the PACU.
- Individual peripad/ice packs should be used on the perineum for vaginal deliveries if ordered by the doctor.

DOCUMENTATION:
Postpartum assessments (fundal checks, amount of lochia, DTR / clonus checks, headache, epigastric pain, and visual disturbances) should be charted in the PACU record in addition to the standard PACU documentation.

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Postpartum Patient Care in the PACU	
Scope: Perioperative	Manual: PACU
Source: OP/PACU Manager	Effective Date: 3/98

CROSS REFERENCE POLICIES / PROCEDURES:

- Vaginal Delivery in the OR
- Cesarean Delivery
- Emergency Medication Boxes in Perinatal Unit
- Lippincott policy: Magnesium sulfate administration, obstetric patient
- Lippincott policy: Postpartum hemorrhage management

Approval	**Date**
CCOC	5/4/2021
STTA	5/12/2021
Peri-Peds Committee	5/25/2021
Medical Executive Committee	7/6/2021
Board	
Last Board of Director review	

Index Listing: Care of the Postpartum Patient, PACU; Postpartum patient in the PACU
Revised: 2/98 AW, 02/01 AW, 05/11AW, 8/11 AW, 09/12 AW, 4/21aw
Last Board of Director review: 1/17/18; 2/18/2020

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: **Rotation Procedures For Patient Cubicle Curtains and Shower Curtains**	
Scope: District Wide	Department: **Environmental Services, Laundry**
Source: Environmental Services Director	Effective Date:

PURPOSE:
To establish a time frame and procedures for rotating all patient privacy and shower curtains.

POLICY:
1. Privacy and shower curtains will be checked before the room is cleaned.
2. Privacy and fabric shower curtains will be rotated and sent to laundry at least once every 3 months. Plastic shower curtains will be sent to laundry when soiled.
3. All curtains removed or added to the patient's room will be logged in the privacy and shower curtain log form, which will be stored in the areas' environmental service closet. Quarterly records are kept in the Curtain Log Binder in the E.S. Manager's office.

PROCEDURE:
1. When the patient's room requires a terminal cleaning, enter the full curtain change in your area's privacy and shower curtain log book.
2. When cleaning a room post patient discharge, check the following:
3. If the shower or the privacy curtain is soiled or expired, remove immediately.
4. Place the soiled and or expired curtain into a clear bag and place in the dirty laundry basket.
5. Once the room is completely cleaned, add the clean curtain(s) to the patient's room.
6. After the cleaned curtains have been hung up, go to your areas log book and record the room's information.
7. If 3 or more curtains are taken down during a shift on your floor, you must notify a Coordinator in laundry immediately.
8. Always manage your floor's curtain supply in a way that you do not short your supply.
9. If you send a curtain to laundry, that same curtain will not be delivered until 9am next day.
10. If you are having trouble hanging a curtain, call another E.S. attendant for assistance.
11. If there is a curtain emergency, please notify your EVS Manager immediately.
12. If there is a broken curtain track, call maintenance.

Committee Approval	**Date**
Clinical Consistency Oversight Committee	6/1/2021
Infection Prevention Committee	6/22/2021
Medical Executive Committee	7/6/2021
Last Board of Directors Review Date	
Board of Directors	

Responsibility for review and maintenance: EVS Manager
Index Listings:
Developed:
Revised: 10-18-2016, AS 12/13/2016
Reviewed: 5/21as

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Sterilization Recall Policy*	
Scope: Sterile Processing	Manual: Sterile Processing
Source: Surgery / Sterile Processing Manager	Effective Date:

PURPOSE:
To ensure that all items available for patient care are properly sterilized. Should failure of sterilization process occur, all items processed may be retrieved by sterile processing personnel.

To ensure sterilization, the sterilization date is applied to all sterilized items and packaging is considered sterile unless the integrity of the packaging has been compromised.

POLICY:
Sterilizers are checked daily for proper functioning by use of live spore cultures. The biological System is incubated and monitored in sterile processing and read in 24 hours per manufacturer literature.

Sterilization records are kept in the sterile processing unit. If during culture period growth of any kind takes place, the Perioperative Director of Nurses and Operating Room Coordinator are notified. The attending physician is notified when applicable.

Sterilizing in the affected autoclave is discontinued until the biomedical engineer and/or sterilizer service provider has serviced the sterilizer to correct any problem.

All items sterilized in that autoclave from the time of the last negative culture are recalled and reprocessed per procedure.

PROCEDURE:

RETRIEVAL PROCESS:

- Every item sterilized in the sterile processing area is marked with internal indicators sensitive to time and temperature, as well as, external autoclave sensitive tape. Each item sterilized is marked with sterilization date and is considered sterile until its integrity is compromised.
- Each item is marked with date, autoclave letter and load number and is recorded on Ver Doc Steamload Release System (load envelope) for that load when sterilized.
- If failure of sterilization cycle is indicated either by graph indicator or internal or external pack indicators, all items from that autoclave cycle are retrieved per record of Ver Doc Steamload Release System (load envelope). Previous loads are spot-checked for sterilization.
- Biomedical engineer is notified and autoclave is not used until fault is identified and repaired.
- Sterilized supplies in all units are checked for integrity prior to use.
- Any item where the packaging integrity has been compromised will be returned to sterile processing for reprocessing.

DEFINITIONS:
Sterilization may be defined as the established and approved process by which all forms of microorganisms are destroyed. There are effective ways to obtain sterilization. They are:

1. Saturated steam under pressure.
2. Ethylene oxide gas
3. Dry Heat
4. V Pro processed instruments

Title: Sterilization Recall Policy*	
Scope: Sterile Processing	Manual: Sterile Processing
Source: Surgery / Sterile Processing Manager	Effective Date:

5. Steris processed instruments

Ethylene oxide gas is not utilized at this institution.
Dry Heat is not a method utilized at this institution.

Sterilization life of packages:
The sterilized packages are considered sterile until outdate unless the integrity of the packaging has been compromised.

DOCUMENTATION:
All positive biological cultures that indicate recall of product are documented in log book in sterile processing and also in the quality assurance log book including possible causes of failure and maintenance/service representative findings.

The positive biological culture should be sent to the laboratory for sub culturing (**the recall should not be delayed during this testing**).

REFERENCE:
1. IAHCSMM Central Supply Training Manual
2. TJC: IC.02.02.01
3. Title 22: 70833
4. AORN RP Sterilization
5. ANSI/AAMI ST79

Approval	**Date**
CCOC	5/4/2021
Infection Control Committee	6/22/2021
MEC	7/6/2021
Board of Directors	
Last Board of Director review	

Initiated: 2/01
Revised: 05/2011 BS, 9/12 BS; 05/2015 BS, 5/17 AW, 4/21aw
Reviewed:
Index Listings: Sterile Processing Recall Policy/Sterilization Recall/ Recall Sterilization

NORTHERN INYO HEALTHCARE DISTRICT
PROCEDURE

Title: Steris V-Pro 1 Low Temperature Sterilizer System	
Scope: Sterile Processing	Manual: Sterile Processing
Source: Surgery / Sterile Processing Manager	Effective Date:

PURPOSE:
The V-Pro Low Temperature Sterilizer System is intended for use in the terminal sterilization of properly prepared, cleaned, rinsed and dried reusable metal and nonmetal medical devices.

The sterilizer operates at low pressure and temperature, suitable for processing medical devices sensitive to heat and moisture. Current operating information re: the low-temperature sterilization sterilizer in use (V-Pro Max) can be found in the manufacturer's manual in Sterile Processing or on-line in OneSource)

OBJECTIVES:
1. Assure safe and correct operations of V-Pro Low Temperature Sterilizer
2. Provide monitoring of sterility.
3. Provide recall and outdate retrieval procedures.

THIS STERILIZER CAN STERILIZE:
- Instruments with diffusion-restricted spaces (e.g., hinged portion of forceps and scissors)
- Medical devices with single stainless-steel lumen with:

VALIDATION TESTING:
- Validation testing was conducted for all lumen sizes using a maximum of 20 lumens per load. Loads should not exceed this validated number of lumens.
- Validation loads consisted of two instrument trays and two pouches for a total weight of 19.65 lb (8.91 kg)

- The V-PRO Low Temperature Sterilization System is NOT intended to process:
  - Liquids
  - Linens
  - Powders
  - Cellulose materials

PRECAUTIONS:
- Any visible liquids in the chamber must be treated as concentrated hydrogen peroxide. Observe all hydrogen peroxide handling precautions.
- When handling hydrogen peroxide, wear Personal Protective Equipment and observe all Safety Precautions.

  PPE including:
  - Goggles or face shield
  - Chemical-resistant gloves (barrier laminate, butyl rubber, nitrile rubber, neoprene rubber, polyvinyl chloride or viton)

- Corrosive: Causes irreversible eye damage or skin burns. May be fatal if inhaled. Harmful if swallowed or absorbed through skin. Do not get in eyes, on skin or on clothing. Do not breathe spray mist.
- User should wash hands before eating, drinking, chewing gum, using tobacco, or using the toilet. User should remove contaminated clothing and wash before reuse.

PROCEDURE:

Prior to Sterilization:
All materials and articles must be thoroughly cleaned and dried.

- **Cleaning:**
  - Remove all blood, tissue and soil from items following device manufacturer's instructions.
  - Use appropriate cleaner or detergent following manufacturer's instructions for cleaning each type of device
- **Rinsing:**
  - Thoroughly rinse all items to remove all detergent or cleaner residue.
- **Drying:**
  - Dry all items thoroughly.
  - Ensure **ALL** moisture is removed from all internal parts including lumens.
  - Only dry items are to be placed in Sterilization Unit.
- **Inspecting:**
  - Visually inspect all items for cleanliness after this cleaning process.
  - If visual soil or moisture is discovered, reclean and dry prior to sterilization.
  - Inspect for flaws or damage. All damaged devices or instruments should be replaced or repaired before using.

Packaging and Loading:

- Use only approved sterilization trays and instrument organizers for use with the
- V-PRO Low Temperature Sterilization System. These trays and organizers are specially designed to allow diffusion of Vaprox-HC Hydrogen Peroxide sterilant vapor around every item in the load. Follow manufacturer instructions for use.
  - Arrange items in tray to ensure proper diffusion of Vaprox HC Hydrogen Peroxide Sterilant vapor throughout load.
  - Do **NOT** stack trays within trays.
  - Do **NOT** wrap instruments within a wrapped tray.
  - Do **NOT** use other padding with V-PRO Sterilization Trays.
  - **NEVER** place linen, cellulose or other materials listed in **Table A-2** inside a V-PRO Sterilization Tray.
  - Place Verify Chemical Indicator for V-PRO Sterilizer inside trays.

- **Device Wraps:**
  - Select the proper size wrap for the items to be sterilized.
  - Use only] V-PRO Low Temperature Sterilization wrap approved for use in the United States.
  - Wrap according to manufacturer's technical Information.
- **Pouches:**
  - Use only V-PRO Low Temperature Sterilization System compatible **Tyvec pouches** (see figure A-1) approved for use in the United States.
  - Follow operating instructions included with pouches**.**
  - Do **NOT** place pouched instruments within a second pouch
  - Place Verify Chemical Indicator for V-PRO Sterilizer inside pouches.
  - Place pouches on edge, if possible.
  - Arrange pouches so transparent side of pouch faces the opaque side of the next pouch.
  - Do **NOT** stack pouches on top of each other.
- **Biological Indicator Test Pack:**
  - Use a compatible BI or Test Pack for monitoring the V-Pro Low Temperature Sterilization System approved for use in the United States.
  - Follow the biological monitor Operating Instructions for use.
- **Verify Chemical Indicator:**
  - Use only FDA approved V-PRO Low Temperature Sterilization System compatible Chemical Indicator following the CI operating instructions.
  - The Verify Chemical Indicator for the V-PRO 1 Sterilizer is a process indicator developed and validated specifically for use in the V-PRO Low Temperature Sterilization System, and meets the requirements of ANSI/AAM/ISO 11140-1 for class 1 vaporized hydrogen peroxide sterilization indicators.
  - Indicators are to be used in each processing cycle to indicate vaporized hydrogen peroxide exposure.
  - Interpret the Verify Chemical Indicator color change results using the CI instructions for use.

Before Operating Sterilization Unit

- See Section 6.4 of attachment

1. Ensure chamber interior is clean.
   - Refer to Section 8.2, Cleaning Sterilization System, if cleaning is necessary.
2. Close sterilizer door.
3. Ensure sterilant cartridge is installed.
   - Refer to Section 4.2, Sterilant Cartridge Installation and Removal.
4. Verify printer is supplied with sufficient amount of paper.
   - A colored warning stripe is visible when paper roll is near the end.

- Refer to Section 8.4, Change Printer Paper Roll, if the paper roll needs replaced.

5. **NOTE: When V-Pro Low Temperature Sterilization Unit is first turned on, IN STANDBY screen will display. Unit needs approximately 40 minutes to reach operating temperature.**

Load Sterilization Unit as Follows:

1. Open chamber door
2. Slide shelf half way out of Sterilization Unit Chamber.
3. Verify load is properly prepared.
4. Place load on shelf and slide shelf back into chamber. Ensure shelves are completely inside chamber before closing door.
5. Close chamber door. Latch door by moving handle clockwise until it stops. Sterilization Unit is now ready to run a processing cycle. (See Section 6.5, of attachment, VHP Sterilization Cycle Operation, for instructions on running the cycle).

VHP Sterilization Cycle Operation:

Before running VHP cycle,

- See Section 6.3 of attachment

NOTE: For VHP Sterilization Cycle, note the following:

- If Start Cycle touch pad is pressed while the chamber door is open, a display screen will appear directing the operator to **close the door** before continuing cycle operation.
- Control through the display panel will alert the user to replace an invalid, expired or empty Vaprox HC sterilant cartridge (cup) prior to starting cycle.
  - Refer to Section 4.2, of attachment, Sterilant Cartridge Installation and removal, for more information.
- If an alarm occurs during the cycle operation:
  - Refer to section 7 of attachment, troubleshooting, for instructions on correcting the alarm condition.

The sterilization cycle proceeds through three phases:

CONDITION:

- This cycle phase consists of the reservoir filling and a vacuum pulse to remove air and moisture from the chamber. When the set point is reached, load is tested for acceptable moisture content.
- If content is acceptable, cycle will proceed.
- If content is not acceptable, cycle will repeat.
- This phase is ordered by the control.

STERILIZE:

- This cycle phase consists of a serried of four pulses (vacuum pulled to set point;
- Sterilant vapor drawn into chamber; hold for programmed time;
- Filtered air is introduced to set point; deep vacuum pulled to set point and is ordered by the control.

AERATION:

- This cycle phase consists of pulling a vacuum to set point and continuing to evacuate for programmed time. This phase is to reduce chamber vapor concentration. Once aeration phase is complete, chamber pressure is brought to atmospheric and the chamber door unlocked.

BIOLOGICAL MONITORING:

- A live spore test utilizing Geobacillus stearothermophilus is the most reliable form of biological monitoring.
- Must use BIs specific for the V-PRO Low temperature Sterilization system and follow the operating instructions included with the biological.

❖ To verify the sterilization process, insert the V-PRO Biological Test Pack in the sterilization unit chamber **on the center of the top shelf.**
❖ Run test pack through a typical cycle.
❖ On completion, review and monitor the test pack. Documenting results.

Sterilant Cartridge Installation and Removal:

❖ The V-PRO Low Temperature Sterilization Unit Control automatically tracks the amount of Vaprox HC Hydrogen Peroxide Sterilant used and sterilant expiration date and prompts the user on the control display when a new cartridge is needed.
❖ HMI display will alert the user to replace an invalid, expired or spent Vaprox HC Sterilant cartridge prior to starting a cycle.
❖ Position or replace sterilant cartridge as follows:
  - Put on Personal Protective Equipment as noted above.
  - Open cartridge interface door.
  - Remove and properly discard spent cartridge.
  - Remove new cartridge from carton. Ensure cartridge is not past expiration date (printed on label). **Sterilization Unit will not permit expired sterilant to be used in a cycle.**
  - Place new cartridge into interface and close door. Cartridge will only fit one way in interface.

❖ **NOTE:**
  - Steris Vaprox HC Hydrogen Peroxide Sterilant cartridges contain high-purity 59% hydrogen peroxide and are filled under controlled conditions to assure effectiveness through the expiration date.

- **Once cartridge interface door is closed and cycle is started, door cannot be opened again until cartridge is empty.**

After loading Sterilization Unit, ensure Sterilization Unit is properly set-up for operation.

1. From CYCLE (or Ready) screen (See Figure 6-3 in attachment), Operator may perform one of the following functions:
    a. **Press STANDBY** touch pad and STANDBY screen displays (See figure 6-1 in attachment)
    b. **Press OPTIONS** touch pad and OPTIONS screen displays (see Figure 6-4 in attachment).
        - See Section 6.5.1, Control Options, for more information.
    c. **Press STATUS** touch pad and STATUS (out-of-Cycle) screen displays (see Figure 6-5 in attachment).
    d. **Press BLACK ARROW** (located at lower left) touch pad to return to CYCLE screen.
    e. To start VHP Sterilization Cycle, **press START CYCLE** touch pad. OPERATING screen displays (See Figure 6-6 in attachment).
        - Cycle counts down.
        - The Abort touch pad is located in the lower right corner (see Section 6.5.2, Aborting Cycles, for more information).

NOTE: For OPERATING screen displayed times and pressures, note the following:

- The projected cycle completion time shown on the display is estimated. The control automatically evaluates the cycle progress and corrects the estimated time at the beginning of each phase.
- Current time and pressure (as well as temperature and phase) are displayed and printed (extended printout) at each point (refer to Figure 5-11 in attachment).

CONTROL OPTIONS:

The VHP Cycle parameters are not adjustable; however, the operator does have some options available.

- Pressing the OPTIONS touch pad (see Figure 6-3 in attachment)) displays OPTIONS screen (see Figure 6-4 in attachment).
- From the OPTIONS screen, the operator options are as follows:

NOTE: For Control Display touch panel screen touch pad definitions, refer to TABLE 2-2 in attachment.

1. **Print Options** – Pressing this touch pad displays PRINT OPTIONS screen. This option sets type of printout: Normal or EXTENDED (refer to Section 5-6, Printouts in attachment)
2. **Set Sate and Time** – Pressing this touch pad displays CHANGE DATE/TIMER screen. This option sets TIME and DATE formats and changes actual time and date as follows.

a. Pressing **Time Format** touch pad changes the time display from AM/PM to 24 HR. Touch pad toggles between choices.
b. Pressing Date Format touch pad changes date format from mm-dd-yy to dd-mm-yy. Pressing touch pad again changes date format to yy-mm-dd. Touch pad scrolls per press.
c. Pressing **Set Time** touch pad displays SET TIME screen. Current time appears on touch pads and at screen bottom. Pressing Hours, Minutes or Seconds touch pad displays a key pad to enable change. Enter change on key pad and press **Return Arrow**.
Press **Set** touch pad to record requested change.
d. Pressing **Set Date** touch pad displays SET DATE screen. Current date appears on touch pads and at screen bottom. Press Month, Day or year touch pad will display a key pad to enable change. Enter change on key pad and press **Return Arrow**.

3. **Change Machine Setup** – Pressing this touch pad displays MACHINE SETUP screen. This option enables changing units of measure. Pressing **Temp Units** touch pad changes Fahrenheit to Celsius and pressing **Pressure Units** touch pad changes mbar to Torr.
4. **Start Leak Test** – Pressing this touch pad displays OPERATING screen. Leak Test time counts down on the screen. Abort touch pad is located in lower right corner. Leak test passes through three phases: Cycle Preparation, Leak Test and Aerate.
NOTE: Refer to Section 8.3, in attachment, Leak Test, for more information

ABORTING CYCLES:

While running the VHP Sterilization Cycle, it may be necessary to end (abort) the cycle operation before scheduled completion because of a sterilization Unit malfunction.

Sterilization Cycle can be aborted any time during normal unit operation. If a cycle aborted, the **load must be repackaged and reprocessed.**

NOTE: For control Display touch panel screen touch pad definitions.

- Refer to table 2-2 in attachment.

To abort the VHP Sterilization Cycle in Progress:

1. **Press abort** touch pad (**inverted red triangle**) on the OPERATING screen.
- See Figure 6-6 in attachment.
2. **ABORT CYCLE** screen displays as follows.
This screen allows operator a final chance to continue with current cycle in progress instead of aborting cycle operation.
3. Press **YES**. Printer records time cycle was aborted.
NOTE: for an aborted cycle, note the following:

- If the cycle is aborted before the sterilization phase, the control system safely relieves chamber vacuum before allowing opening of the chamber door.

- If the cycle is aborted during or after sterilization phase, a complete Aeration phase is performed.
  - Press lower right touch pad to silence alarm.
  - Pressing Cycle Status pad (lower Left) displays the status screen.
  - Pressing Back Arrow touch pad (lower Left) returns CYCLE (or Ready) screen to control display see (Figure 6-3 in attachment).

When abort phase is complete:

- ABORT Complete screen is displayed.
- Once the door is opened, display returns to **CYCLE (or Ready)** screen (see Figure 6-3 in attachment)
- Sterilization Unit may be unloaded.
- **The load must be repackaged and reprocessed after the cycle is aborted.**

UNLOAD STERILIZATION UNIT

- The sterilization Unit shelves will slide out halfway to facilitate chamber unloading (see Figure 6-2 in attachment).
- Ensure shelves are returned to chamber before closing door.

NOTE: STERIS recommends leaving Sterilization Unit Powered ON and door closed when not in use.

- Unit needs approximately 40 Minutes to reach operating temperature.

DOCUMENTATION:
TIME & TEMPERATURE CHARTS

All computer tapes from V-Pro Low Temperature Sterilizer System documenting sterilization times and loads for each day will be monitored daily and maintained accessible for review for at least one year.

REFERENCES:

Steris V-PRO 1 Low Temperature Sterilization System Operators Manual
AORN RP for Sterilization
AAMI ST58 Annex H
OneSource (on-line IFU document management system)
Vaporex HC Hydrogen Peroxide Sterilant Material Safety Data Sheet (MSDS).

Approval	**Date**
CCOC	5-4-21
Infection Prevention Committee	6/22/2021
MEC	7/6/2021

Developed: 5/17/2011 BS
Reviewed: 5/2015 BS

NORTHERN INYO HEALTHCARE DISTRICT
PROCEDURE

Title: Steris V-Pro 1 Low Temperature Sterilizer System	
Scope: Sterile Processing	Manual: Sterile Processing
Source: Surgery / Sterile Processing Manager	Effective Date:

Revised: 4/21aw
Index Listings: Steris V-Pro Low Temperature Sterilizer System, V-Pro

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Steris Vision Single Chamber Washer Disinfector	
Scope: Sterile Processing	Manual: Sterile Processing
Source: Surgery / Sterile Processing Manager	Effective Date:

PURPOSE:
Reusable medical devices will be contacting blood or compromised tissues, such devices must be terminally processed in accordance with device manufacturer's instructions and/or Good Hospital Practices before each use in human patients.

Washer disinfector is intended only to perform the initial step in the processing of soiled, reusable medical devices including utensils, trays, glassware, bedpans and urinals, rubber and plastic goods, simple hard-surfaced rigid surgical instruments, such as forceps and clamps, theatre shoes and other similar and related articles found in healthcare facilities.

POLICY:
To insure that personnel who operate washer sterilizer are adequately trained in the safe use of equipment

PRECAUTIONS:
- All personnel who operate or maintain the equipment are trained in its operation and in its safe use.
- Personnel working with toxic chemicals and vapors have comprehensive instructions in the washer/disinfector process, relevant health hazards and methods to detect the escape of toxic materials.
- There is regular training of all personnel concerned with the operation and maintenance of the equipment; attendance records are maintained; and that evidence of understanding is demonstrated.
- Current Material Safety Data Sheets (MSDS) should be available to all users in the department.

SAFETY PRECAUTIONS
WARNING – PERSONAL INJURY AND/OR EQUIPMENT DAMAGE HAZARD:
- Always load empty baskets on appropriate loading cart or surface.
- Always use a hold down screen to secure small or light items. While loading instrument racks, do not place miscellaneous articles on the sides of instrument trays. Incorrect rack loading/overloading could lead to injury and/or damage to the equipment or instruments.
- If an obstruction is present in the chamber door, obstruction sensor will detect obstruction and door will not close. Wait until water flow has stopped before removing an obstruction.
- Regularly scheduled preventive maintenance is required for safe and reliable operation of this equipment. Contact STERIS to schedule preventive maintenance.
- Repairs and adjustments to this equipment must be made only by STERIS or STERIS-trained service personnel. Repairs and adjustments performed by

unqualified personnel or installation of unauthorized parts could cause personal injury result in improper equipment performance, void the warranty or result in costly damage. Contact STERIS regarding service options.

WARNING - PERSONAL INJURY HAZARD:

- Risk of pinch point between door and threshold when the door opens. **Keep fingers away from threshold.**
- Risk of pinch point between door and upper panel.
  - **Do not push on top portion of doors**
  - **Do not push on door when door is rising**
  - **Do not push on door when door is jammed.**

WARNING - ELECTRIC SHOCK AND/OR BURN HAZARD:

- Fasteners and star washers are used to ensure protective bonding continuity. Always reinstall any star washer which may have been removed during installation or servicing.
- Pressing bottom portion of **POWER (ON/OFF**) toggle switch to turn off washer/disinfector **DOES NOT** cut off electrical power. Lockout/Tagout building electrical disconnect switch to turn off power to washer/ disinfector for maintenance or repairs.
- Repairs and adjustments to this equipment must be made only by STERIS or STERIS-trained service personnel. Service personnel must disconnect all utilities to unit before servicing. No one should service unit unless all utilities have been properly locked out. Always follow local electrical codes and safety-related work practices.

WARNING – CHEMICAL BURN AND/OR EYE INJURY HAZARD:

- Chemicals are caustic and can cause adverse effects to exposed tissues. **Do not** allow chemicals used in the washer/disinfector to contact eyes, skin, or do not attempt to swallow.
- Read and follow the precautions and instructions on the chemical label and in the Material Safety Data Sheet (MSDS) prior to handling the chemical, refilling the chemical container or servicing the chemical injection pump.
- Wear appropriate Personal Protective Equipment (PPE) whenever handling the chemical or servicing the chemical injection pump and lines.
- Wear gloves and eye protection when using a descaling product. Avoid contact with the eyes or skin. If a descaling product spills or splashes on you, flush the affected area with water for 15 minutes. If swallowed, **DO NOT induce vomiting**. Administer an alkali with plenty of water. Seek medical attention immediately.

WARNING –BURN HAZARD:

- Except for an emergency, **do not open door** while cycle is in progress. In an emergency, first stop cycle by pressing **STOP** followed by **ABORT** on touch

screen. Wait for water flow to stop. Once door is opened, wear appropriate PPE whenever reaching into the chamber.

- If an **obstruction** is present in chamber door, **DO NOT attempt** to remove the object. Door automatically raises and remains open. Hot water and steam may be sprayed through door opening. Always wear appropriate PPE and wait for water flow to stop.
- Inner surfaces of washer/disinfector are very hot after cycle is completed. Allow washer/disinfector to cool down before touching chamber.
- Always wear appropriate PPE, including gloves as well as a face shield, and avoid all contact with inner walls when reaching into chamber.

WARNING –SLIPPING HAZARD:

- To prevent slips, keep floors dry. Promptly clean up any spills or drippage. For spills or drippage of detergents or other chemicals, follow safety precautions and handling procedures set forth on detergent or chemical label and/or MSDS.

CAUTION –POSSIBLE EQUIPMENT DAMAGE:

- Always select a cycle appropriate for the items being processed. Failure to do so may result in product damage.
- Filters may be damaged from foreign oils and other contaminants. When replacing the filters, do not touch new filter with bare hands. Open plastic wrapping and hold filter through the wrapping when inserting into the filter housing.
- Suction tips (as well as other items) must be fully enclosed within the accessory (curved suction tips facing inward) to prevent obstruction in conveyor system.
- Use nonabrasive cleaners when cleaning unit. Follow directions on containers and rub in a back-and-forth motion (in same direction as surface grain). Abrasive cleaners will damage stainless steel Cleaners rubbed in a circular motion or applied with a wire brush or steel wool on door and chamber assemblies can be harmful to stainless steel. Do not use these cleaners on painted surfaces.
- Use silicone lubricant to lubricate squeeze tubes. Petroleum-based lubricants, such as petroleum jelly or grease, will damage squeeze tubes.
- When choosing a detergent, select one with low-chloride content. Detergents with a high-chloride content must not be used; as such detergents may harm stainless steel.
- Wipe all plastic surfaces or painted surfaces with 70% isopropyl alcohol cleaner (such as glass or countertop cleaners).

PROCEDURE: See Manufacturer Operator Manual under attachments, left gray side bar.

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Steris Vision Single Chamber Washer Disinfector	
Scope: Sterile Processing	Manual: Sterile Processing
Source: Surgery / Sterile Processing Manager	Effective Date:

Section 3 of operator manual contains component identification and photographs. Personal must be familiar with all components before operation of equipment.

OPERATING INSTRUCTIONS: (See also Operator Manual beginning pg. 4-1, attached)

1. Verify building electrical supply disconnect switch is positioned to ON.
2. Verify washer/disinfector supply valves are opened.
3. Press **OPEN DOOR** on touch screen to open chamber load door.
4. Verify chamber is empty and all material has been removed.
5. Verify debris screen is clean and properly inserted in place
   - (refer to Section 6.3, Debris Screen in operator manual, attached, for more details).
6. Manually rotate spray arm assemblies on top and on bottom of chamber to ensure movement is not obstructed. If spray arm assemblies do not rotate freely, inspect and clean Rotary Spray Arm Assemblies.
   - (refer to Section 6.9 in operator manual)
7. Open printer door and verify there is sufficient paper available. A colored warning stripe is visible when paper roll is near end. **NOTE: Do not** operate printer without paper.
   - (Refer to Section 6.8.1, Printer Paper Roll in operator manual, attached, if paper roll needs to be replaced).
8. Verify chemical supplies (located at a remote location). Ensure pickup tubes are in good condition and placed in proper containers. If supplies are low or have run out, install new containers
   - (refer to Section 6.7, Chemical Container Replacement in operator manual, attached).
   - Do not insert pickup tube into container without verifying it is for the proper application.
9. **IMPORTANT:** Maximum loading weight (accessory rack and accessory rack contents inside Washer/Disinfector is 135 lb (61 kg).
10. **NOTE:** The nature of the item to be processed can require additional actions such as dismantling for separate processing, manual pre-cleaning of difficult surfaces, etc., prior to the item being processed in the washer/disinfector.
11. Verify all channels allow free passage of water before device is loaded into washer/disinfector (refer to specific device manufacturer's instructions).
12. Confirm all necessary connections were made before, and were still in place at the end of cycle.
13. Ensure no items stick out or hang out of rack. Always use a rack designed to handle appropriate type of items to be processed. (See Accessories below).
14. All hinged surgical instruments with handles, such as scissors, hemostats and forceps, must be stringed before being placed in a rack to optimize cleaning of

hinges. A maximum of 50 items, open at a 90 degree angle, must be placed in each instrument tray.

15. Instruments must always be placed in an instrument tray for processing, never alone on a manifold rack.
    a. Mesh instrument tray: The mesh instrument tray is designed to hold small miscellaneous items. It can be used with or without the flexible hold-down screen. (Photo pg. 4-3 operator manual, attached)
    b. Flexible hold-down screen: The flexible hold-down screen is designed to retain small miscellaneous items in place in the mesh instrument tray, vision multi-function rack for small items, two-level Vision manifold rack and three-level Vision manifold rack. (Photo pg. 4-3 operator manual, attached)
    c. Vision Multi-function rack for small items: The Vision Multi-function rack is designed to hold small basins, small bowls, light handles, glass cups, etc. The rack can be placed on either level of the two-level vision manifold rack and three-level Vision manifold rack. (Photo pg 4-4 operator manual, attached)
    d. Vision Multi-function rack for large items: This rack is designed to hold trays, basins, bowls, theatre shoes, baby bottles, bedpans, etc. The Vision multi-function rack for large items can be placed on the lower level of the two-level Vision manifold rack. (Photo pg. 4-4 operator manual, attached)
    e. General purpose Vision rack: the design is to hold non-critical medical devices such as lamp handles, kidney dishes and bowls. The Vision multi-function rack for small items and the Vision multi-function rack for large items can be placed in the general purpose Vision rack. (Photo pg 4-5 operator manual, attached)
    f. Multi-Level Vision Manifold Racks: IMPORTANT – ALL THE FOLLOWING MULTI-LEVEL Vision manifold racks are equipped with irrigation ports. If desired, dedicated flexible hoses (provided within flexible hoses for cannulated instruments accessory) can be connected to irrigation ports to allow processing of cannulated instruments.
        i. Two-level Vision manifold rack is designed to hold trays of surgical instruments and hard goods individually on each level. Vision multi-function rack for small items can be placed on either level and the Vision multi-function rack for large items can be placed on the lower level of the two-level of the two-level Vision manifold rack. (Photo pg. 4-6 operator manual, attached)
        ii. Three-level Vision manifold rack is designed to hold trays of surgical instruments and hard goods individually on each level. (Photo pg. 4-7 operator manual, attached)

iii. Four-level Vision manifold rack and Four-level Vision SC manifold rack are designed to hold one or two instrument trays, or two mesh instrument trays, on each level. (Photo pg. 4-8 operator manual, attached)

iv. Five-level Vision manifold rack is designed to hold two mesh instrument trays on each level. (Photo pg. 4-9 operator manual, attached)

v. MIS Vision SC manifold rack is designed to be used only with the Rigid MIS cycle. The design is to be used in the washer/disinfector for the efficient cleaning, drying and intermediate level disinfection of rigid minimally invasive surgical instruments. See MIS Vision SC manifold rack operator manual for more information on loading and routine maintenance. STERIS does not intend, recommend or represent in any way the MIS Vision SC manifold rack be used in the washer/disinfector for the terminal disinfection or sterilization of any regulated medical device. If there is any doubt about a specific material or product, contact the instrument manufacturer for recommended washing techniques. (Photo pg. 4-10 operator manual, attached)

vi. AN Vision SC manifold rack is designed to be used in the washer/disinfector for the efficient cleaning, rinsing, drying and intermediate level disinfection of different types of anesthesia tubing, bags, masks and respiratory goods. T o used only with the ANESTHESIA/RESPIRATORY GOODS cycle. (Photo pg. 4-11 operator manual, attached)

g. Flexible Hoses for Cannulated Instruments: The multi-level Vision manifold racks are equipped with irrigation ports. If desired, dedicated flexible hoses (provided within Flexible hoses for cannulated instruments accessory) can be connected to irrigation ports to allow processing of cannulated instruments. NOTE: The flexible hoses for cannulated instruments accessory can be ordered by contacting STERIS. Flexible hoses are installed following the Installation Instructions provided with the accessory.

To connect cannulated instruments to flexible hoses, proceed as follows:

1. Ensure flexible hoses are connected to irrigation ports as per Installation Instructions.
2. Manually clean any visible soil on part of each cannulated instrument where flexible hose will be connected.
3. Connect each flexible hose to each cannulated instrument. NOTE: To hold properly on flexible hoses, cannulated

instruments minimum diameter should be 1/8" (3mm) and maximum diameter should be of 5/16" (8mm).

Dos:

The flexible hoses and cannulated instruments must be appropriately connected and placed within basket to avoid damage to hoses and or cannulated instruments.

ENSURE TO:

- Appropriately connect flexible hoses to multi-level Vision manifold rack irrigation ports
- Appropriately place flexible hoses within basket
- Manually clean visible soil on each cannulated instrument where flexible hose will be connected
- Connect appropriate extremity of cannulated instrument to flexible hose to ensure complete irrigation of instrument
- Verify each cannulated instrument connection to flexible hose is secure to avoid disconnection
- Verify light cannulated instruments are appropriately placed within basket side to ensure instruments remain within basket while cycle is in progress

DON'TS

The flexible hoses and cannulated instruments must be appropriately connected and placed within basket to avoid damage to hoses and/or cannulated instruments.

ENSURE NOT TO:

- LEAVE FLEXIBLE HOSES AND CANNULATED INSTRUMENTS ON TOP OF BASKETS
- LET FLEXIBLE HOSES AND CANNULATED INSTRUMENTS HANG OUT OF BASKET AND MULTI-LEVEL Vision manifold rack
- Let flexible hoses hang out of basket and multi-level Vision manifold rack
- Let light cannulated instruments incorrectly placed within basket to ensure instruments do not lift while cycle is in progress
- Let light cannulated instruments incorrectly placed within basket to ensure instruments and flexible hoses do not lift and interfere with rotary spray arms while cycle is in progress
- Let cannulated instruments stick out of basket and multi-level Vision manifold rack

16. MANUAL LOADING

Title: Steris Vision Single Chamber Washer Disinfector	
Scope: Sterile Processing	Manual: Sterile Processing
Source: Surgery / Sterile Processing Manager	Effective Date:

A. Press OPEN DOOR to open load door
B. Bring transfer cart next to washer/disinfector loading door and ensure transfer cart brakes are applied. Carefully push loaded basket or accessory rack inside chamber
C. Press CLOSE DOOR to close load door
D. Select desired cycle to process

CODE	**CYCLE NAME**	**USE**
00	INSTRUMENTS	To process surgical instruments.
01	UTENSILS	To process bedpans, trays, basins, bowls and theatre shoes.
04	PLASTIC GOODS	To process plastic ware.
05	ANESTHESIA/RESPIRATORY GOODS	To process anesthesia tubes, bags, masks and respiratory goods.
CODE	**CYCLE NAME**	**USE**
06	GENTLE CYCLE	To process delicate surgical instruments.
07	RIGID MIS	To process rigid minimally invasive surgical instruments.
08	ORTHOPEDICS	To process orthopedic instruments.
26 to 39	CYCLE 26 TO CYCLE 39	For custom-programmed processing.
	DECONTAM*	Decontamination cycle, there is no bar code tag for the DECONTAM cycle.

E. Washer/disinfector enters in cycle mode and appropriate cycle automatically starts. Display shows: the cycle started, time remaining. Printer shows: cycle started, cycle name, date and time.
F. Cycle proceeds through selected cycle phases. When loading sequence is completed and appropriate cycle has begun, washer/disinfector proceeds through the different phases. The cycle in process screen is displayed throughout the cycle and shows estimated remaining time to the cycle completion. The first time a specific cycle is processed, a remaining time of 20 minutes is displayed on the screen. Next time this specific cycle is processed, the estimated remaining time to cycle completion will be displayed. As washer/disinfector progresses through the cycle, cycle parameters can be monitored by pressing DETAILS on upper left corner of cycle in process screen. Display shows cycle written data of parameters on the

screen. Press GRAPH on touch screen to view the graph of the current cycle data. Display shows a graph of cycle progress. Press CLOSE on upper right corner of touch screen until returning to cycle in process screen. (For a description of each Phase see operator manual, attached pg. 4-26 to 4-28 and tables 5-1 to 5-4)

IMPORTANT: If a warning condition occurs requiring the operator attention, a WARNING symbol appears on the touch screen and an audible signal sounds. The operator presses the WARNING Symbol on the touch screen to view the list of warning messages generated during the cycle (See Section 7.1 pg. 7-2 for list of warning messages, operator manual attached)

IMPORTANT: If a malfunction or an alarm occurs during a cycle an alarm sounds and display shows ALARM MESSAGE, press SILENCE BUZZER on touch screen. This records time at which operator acknowledged alarm. If operator has been able to solve alarm condition using section 7, trouble shooting, press RESUME. If alarm requires aborting cycle, press ABORT. See Section 4.10, responding to an Alarm, for more information (operator manual attached)

IMPORTANT: To pause a cycle, press STOP on touch screen. Once interrupted, cycle can either be RESUMED OR ABORT by touching button on touch screen (see 4.11, pause a Cycle for more information, operator manual attached).

IMPORTANT: To abort a cycle, Press STOP on touch screen. Display shows: ABORT OR RESUME, Press ABORT to abort cycle. Washer/disinfector performs Abort Sequence. Washer/ disinfector drains and display returns to Ready screen.

IMPORTANT: If a cycle is aborted before the Thermal Rinse phase is completed, a supervisor must enter its login name and corresponding password to open load door because thermal disinfection was not performed.

IMPORTANT: If desired, the operator can be authorized to open the load door before the Thermal Rinse phase without the need of a supervisor entering its password. The supervisor password requirement can be disabled in the Machine setup menu of the Supervisor mode.

17. UNLOADING WASHER/DISINFECTOR
    a. When cycle is complete an audible signal sounds and chamber unload door opens. Cycle completed screen is displayed until unload door is closed.

       NOTE: A warning symbol might be displayed on touch screen so operator can access a list of warning messages. Press on WARNING symbol before the unload door closes to access the list of warning messages (see Section 4.9, Responding to a Warning Message, for more details, operator manual attached)

b. A printout of cycle processing data is generated; an extended printout can be generated at the end of the cycle. The extended cycle printout feature is enabled in the machine setup menu of the supervisor mode.
c. Bring transfer cart next to washer/disinfector unload door and ensure transfer cart brakes are applied.
d. Carefully pull basket or accessory rack onto transfer cart.
e. Close door after being sure there are no warning messages. Display returns to Ready screen.

18. Washer/Disinfector should remain ON at all times except when performing maintenance or repairs, then operator needs to lockout/ tagout main electrical disconnect switch to OFF position.
19. **POWER FAILURE:** If power failure occurs and there is no basket or accessory rack in washer/disinfector, washer/disinfector power up sequence begins when power is restored. When power up sequence complete display shows READY screen. If power failure occurs during a cycle, cycle must be aborted.
20. **DOOR OBSTRUCTION:** If an obstruction is present in the chamber door, do not attempt to remove the object. A door obstruction sensor detects the obstruction. Door automatically stops from closing and rises automatically. An alarm will sound and display shows, alarm message. Press SILENCE BUZZER on touch screen, OR, Press ALARM REPLY ON TOUCH SCREEN TO ACKNOWLEDGE ALARM AND SILENCE BUZZER. Display shows: ABORT OR RESUME CYCLE? Always wear appropriate PPE and wait until water flow stops before removing an obstruction from chamber door. When operator is able to solve alarm condition, press RESUME, cycle resumes at beginning of phase where cycle was interrupted and display returns to cycle in process screen. **IF OPERATOR IS UNABLE TO REMOVE OBSTRUCTION FROM CHAMBER DOOR, CALL A QUALIFIED SERVICE TECHNICIAN. DO NOT ATTEMPT TO MANUALLY OPEN DOOR! CALL A QUALIFIED SERVICE TECHNICIAN.**
21. IMPORTANT: Good Hospital Practice dictates all instruments be inspected for visible debris after processing in the Washer/Disinfector. Any instrument with visible debris must be rewashed until clean and free of visible debris prior to terminal processing. Failure to reprocess until all visible debris have been removed may impede the terminal processing.

CYCLE AND CONTROL VALUE PROGRAMMING: Operator Manual pg. 5-1, attached.

DOCUMENTATION:

ROUTINE MAINTENANCE: Operator Manual pg. 6-1, attached.

Preventive Maintenance Guide Table, pg. 6-2 to 6-4, laminated and placed in preventive maintenance log located in central service. Sample log attached.

REFERENCES:

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Steris Vision Single Chamber Washer Disinfector	
Scope: Sterile Processing	Manual: Sterile Processing
Source: Surgery / Sterile Processing Manager	Effective Date:

Steris Corp. Operator Manual, Reliance Vision Single-Chamber Washer/Disinfector
AORN RP Care of Instruments
AORN RP of Sterilization
AAMI ST 79

Approval	**Date**
CCOC	5/4/2021
Infection Prevention Committee	6/22/2021
MEC	7/6/2021
Board of Directors	
Last Board of Director review	

Developed: 7/19/2012 PM
Reviewed:
Revised: 5/2015 BS, 4/21aw
Index Listings: Reliance Vision Single-Chamber Washer/Disinfector; Washer/Disinfector; Instrument Washer; Instrument Disinfector

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Storage Requirements for Sterile and Clean Items	
Scope: Sterile Processing	Manual: Sterile Processing
Source: Surgery / Sterile Processing Manager	Effective Date:

PURPOSE:
To assure all items in a designated "clean area" are stored appropriately to maintain their integrity and sterility.

POLICY:
Sterilized materials should be packaged, labeled, and stored in a manner to ensure sterility, and each item should be marked with the sterilization date.

PRECAUTIONS:
If any sterile item becomes soiled or damaged in any way, it must be considered contaminated and unsafe for use on a patient. It must be removed from stock immediately and reprocessed if applicable or disposed of.

- Sterility is event-related and depends on the amount of handling, conditions during transportation and storage, and the quality of the packaging material. Limiting exposure to moisture, dust, and excessive light or handling and temperature and humidity extremes decreases potential contamination of sterilized items.

PROCEDURE:
1. Sterile packages should be stored under environmentally controlled conditions.
   - Temperature should not exceed 75 degrees F (24 degrees C).
   - Storage area should have at least four air exchanges per hour.
   - Relative humidity should be controlled, not to exceed 70%.
   - Traffic should be controlled to limit access to those trained in handling sterile supplies.
   - Supplies should be stored in a manner that allows adequate air circulation, ease of cleaning, and compliance with local fire codes.
   - Sterile items should be stored at least eight to ten inches above the floor, and at least 18 inches below sprinkler heads, and two inches from outside walls.
2. Outside shipping containers should not be allowed in the sterile storage area because they serve as generators of, and reservoirs for, dust. Supplies should be removed from shipping cartons before entering sterile processing area when possible.
3. Ideally, items should not be stacked or piled on top of each other in storage. If space determines this must occur, then items should be of the same size and shape.
4. All storage spaces are clearly labeled and any item sterilized by the hospital must contain the name of item, month, day, and year of expiration.
5. When it is necessary to store and issue clean but unsterile items, these should be segregated as much as possible from sterile items, particularly items manufactured and sterilized by the hospital.
6. Check carefully before sterilized items are placed on the shelf that the package is completely dry and that the shelf is clean and dry.
7. If the item is seldom used, before storing on shelf, place in dust wrapper.
8. All items steam sterilized in double paper wrappers are considered sterile for one year unless the integrity of the packaging has been compromised. Each sterile processing procedure tray is to be placed in a dust cover and stored on the appropriately marked shelf.
9. All peel packed items sealed with heat prior to autoclaving are considered sterile for 6 months unless the integrity of the packaging has become compromised.
10. When storing hospital sterilized items make sure the most recent sterilized item is placed behind the items to be outdated first.

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Storage Requirements for Sterile and Clean Items	
Scope: Sterile Processing	Manual: Sterile Processing
Source: Surgery / Sterile Processing Manager	Effective Date:

11. All sterile processing items are routinely rotated as new supplies are received in the department; new stock at the back of the storage area and older stock in front according to the principle of "first in, first out"
12. All areas storing sterilized instruments processed in sterile processing are checked routinely for compromised integrity and items needing reprocessing are returned to sterile processing for reprocessing.

REFERENCE: AORN RP Packaging Systems
AORN RP Sterilization
AAMI ST79 8
Title 22: 70831
TJC: IC.02.02.01

Approval	**Date**
CCOC	5/4/2021
Infection Prevention Committee	6/22/2021
MEC	7/6/2021
Board of Directors	
Last Board of Director review	

Revised 02/01 BS; 5/16/2011 BS, BS 9/12; 05/2015BS, 4/21aw
Index Listings: Storage Requirements for Sterile & Clean Items/ Sterile Items storage of/ Clean Items storage of

Inpatient Medicine Critical Indicators

2021

1. Transfers to higher level of care
2. Transfers from Med/surg to ICU
3. All inpatient deaths
4. All readmissions
5. All intubated patients

Approvals:

Inpatient Medicine Committee: 06/23/2021
Medical Executive Committee: 7/6/2021

Radiology Services Committee

Critical Indicators

2021

1. Death within 24 hours of invasive procedure.
2. Admission to ED within 24 hours of invasive procedure.
3. Severe contrast reaction.
4. Code Blue in the department
5. Patient called back for having wrong procedure performed.
6. Staff concerns.

Approvals

Radiology Services Committee: 06/16/2021

Medical Executive Committee: 7/6/2021

Utilization Review Critical Indicators

2021

1. Discharge Disputes
2. Status Issues
3. Placement issues
4. Denials
    a. Swing Bed Denials
    b. Social Admission Denials
    c. SNF Denials
5. Untimely Records Completions

Approvals:

UR Committee: 6/24/2021

Medical Executive Committee: 7/6/2021

Northern Inyo Healthcare District
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Pediatrics

Delineation of Privileges

Applicant's Name: ,

Instructions:

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

Facilities

☑ NIHD

Required Qualifications

Education / Training	Completion of an ACGME or AOA accredited Residency training program in Pediatrics.
Certification	Current certification or active participation in the examination process leading to certification in Pediatrics by the American Board of Pediatrics or AOA equivalent.
Clinical Experience (Initial)	Applicant must provide documentation of provision of pediatrics services representative of the scope and complexity of the privileges requested during the previous 24 months.
Clinical Experience (Reappointment)	Applicant must provide documentation of provision of clinical services representative of the scope and complexity of privileges requested during the previous 24 months.

Core Privileges in Pediatrics

Description: Provision of primary care services, managing common, acute and chronic illnesses and diseases from birth through young adulthood (21 years of age) with acute and chronic disease.

Qualifications

Additional Qualifications	Current NRP and PALS certification required for working in the inpatient setting. STABLE preferred. Current BLS and PALS certification required for working in the outpatient setting.

Request

Check the Request checkbox to select all privileges listed below.
Uncheck any privileges you do not wish to request in the group.

☐	Admit to inpatient or appropriate level of care (Must perform 4 every 6 Months)
☐	Perform history and physical examination
☐	Evaluate, diagnose, treat and provide primary care to patients from birth to young adulthood with acute and chronic disease including health promotion.
☐	Care and management of newborn in the normal newborn nursery (Must perform 8 every 6 Months)
☐	Attendance at both normal newborn and high risk deliveries
☐	Management of airway including endotracheal intubation

FPPE (Service Chief to select)	
☐	Newborn privileges - 8 retrospective case reviews chosen to represent a diversity of medical conditions and management challenges
☐	Pediatric inpatient privileges - 8 retrospective case reviews chosen to represent a diversity of medical conditions and management challenges
☐	Pediatric outpatient privileges - a minimum of 8 days of chart review of all patients seen
☐	Feedback from involved clinician or administrative person who is knowledgeable about the services performed by the physician

Special Procedures in Pediatrics

Qualifications

Additional Qualifications	Requires experience in the last 24 months and recommendation by the Chief of Pediatrics.

Check the Request checkbox to select all privileges listed below.
Uncheck any privileges you do not wish to request in the group.

Request	
☐	Arterial puncture
☐	Arthrocentesis and joint injection
☐	Casting and splinting of simple fracture or imobilization of sprains
☐	Circumcision of infant less than 1 month of age (corrected for prematurity) with or without local anesthetic
☐	Insertion/removal of implanted contraceptive device (e.g. Nexplanon)
☐	Nail removal
☐	Lingual frenotomy
☐	Local anesthetic techniques including regional nerve blocks, peripheral nerve blocks and trigger point injections

☐	Lumbar puncture
☐	Management of epistaxis including placement of posterior nasal hemostatic packing
☐	Perform simple skin biopsy or excision
☐	Removal of foreign body: cornea, conjunctive, ear, nose
☐	Removal of extra digit
☐	Skin tag removal
☐	Umbilical catheterization
☐	Wart destruction
☐	Wound care, I&D abscess, simple debridement, aspiration, wound closure and local anesthetic techniques

FPPE (Service Chief to select)	
☐	Concurrent proctoring of 3 procedures.
☐	Feedback from involved clinician or administrative person who is knowledgeable about the services performed by the physician

Moderate (Procedural) Sedation

Description: Moderate Sedation/Analgesia ("Conscious Sedation") is a drug-induced depression of consciousness during which the patient responds purposefully to verbal commands, either alone or with light tactile stimulation. No interventions are required to maintain a patent airway and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.

Qualifications

Education/Training	The applicant must provide evidence of training during residency and/or fellowship OR if training occurred greater than 1 year ago the applicant must provide evidence of ongoing clinical practice.
Clinical Experience (Initial)	Applicant must provide documentation of provision of clinical services representative of the scope and complexity of the privileges requested during the previous 24 months (waived for applicants who completed training during the previous year). AND Applicant must complete sedation tutorial at initial granting of privileges and every 2 years thereafter.
Clinical Experience (Reappointment)	Documentation of at least 6 cases within the last 24 months. AND Sedation tutorial completed within the last 24 months.
Additional Qualifications	Current ACLS certification AND/OR Emergency Medicine Board Certification.

Request	Check the Request checkbox to select all privileges listed below. Uncheck any privileges you do not wish to request in the group.
☐	Moderate Sedation (Must perform 6 every 2 Years)

FPPE (Service Chief to select)	
☐	Retrospective review of 3 cases of administration of moderate sedation
☐	Feedback from involved clinical or administrative personnel

Acknowledgment of Applicant

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

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

B. Any restriction on the clinical privileges granted to me is waived in an emergency situation and in such situation my actions are governed by the applicable section of the Medical Staff Bylaws or related documents.

_____

Practitioner's Signature NIHD

Service Chief Recommendation - Privileges

I have reviewed the requested clinical privileges and supporting documentation and my recommendation is based upon the review of supporting documentation and/or my personal knowledge regarding the applicant's performance of the privileges requested:

Privilege	Condition/Modification/Deletion/Explanation

Northern Inyo Healthcare District
One Team. One Goal. Your Health.

Hospitalist

Delineation of Privileges

Applicant's Name: ,

Instructions:

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

Facilities

☑ NIHD

Required Qualifications

Education/Training	Completion of an ACGME or AOA accredited Residency training program in Internal Medicine. OR Completion of an ACGME or AOA accredited Residency training program in Family Medicine.
Certification	Current certification or active participation in the examination process leading to certification in Internal Medicine by the American Board of Internal Medicine or AOA equivalent. OR Current certification or active participation in the examination process leading to certification in Family Medicine by the American Board of Family Medicine or AOA equivalent.
Clinical Experience (Initial)	Applicant must provide documentation of provision of inpatient medicine services representative of the scope and complexity of the privileges requested during the previous 24 months.
Clinical Experience (Reappointment)	Applicant must provide documentation of provision of inpatient medicine services representative of the scope of privileges requested during the past 24 months.
Additional Qualifications	Current ACLS certification required.

Inpatient Core Privileges

Description: Provision of inpatient medical care managing both common and complex illnesses. Hospitalists at NIHD are required to perform all core privileges.

Request	Check the Request checkbox to select all privileges listed below. Uncheck any privileges you do not wish to request in the group.
☐	Admit to inpatient or appropriate level of care
☐	Perform history and physical examination
☐	Evaluate, diagnose, provide consultation and medically manage and treat adult patients presenting with general medical problems
☐	Evaluate, diagnose, provide consultation and medically manage and treat adult patients presenting with critical illness needing ICU care.
☐	Ventilator management
☐	Elective electrical cardioversion (must have sedation privileges or ensure sedation is provided by a privileged physician, such as anesthesia)

FPPE (Service Chief to select)	
☐	Monitoring of practice for a duration of 6 months.
☐	Feedback from involved clinician or administrative person who is knowledgeable about the services performed by the physician.

Outpatient Core Privileges	
Description:	
Request	Check the Request checkbox to select all privileges listed below. Uncheck any privileges you do not wish to request in the group.
☐	Evaluate, diagnose, perform H&P, provide consultation, medically manage and treat adult patients.

FPPE (Service Chief to select)	
☐	Five retrospective chart reviews chosen to represent a diversity of medical conditions and management challenges.
☐	Feedback from involved clinician or administrative person who is knowledgeable about the services performed by the physician.

Special Privileges	
Description:	
Request	Check the Request checkbox to select all privileges listed below. Uncheck any privileges you do not wish to request in the group.
☐	Anoscopy
☐	Arterial line placement
☐	Arterial puncture and blood gas sampling
☐	Arthrocentesis
☐	Bronchoscopy
☐	Central venous line placement
☐	Cryo ablation of superficial lesions
☐	EKG/Holter/Event Monitor interpretation
☐	Endotracheal intubation
☐	Incision and drainage or aspiration of a superficial soft tissue mass
☐	Lumbar puncture
☐	Nail procedures
☐	Paracentesis
☐	Pulmonary function testing and interpretation
☐	Remove non-penetrating foreign body from the eye, nose, or ear
☐	Skin biopsy
☐	Sigmoidoscopy
☐	Stress test interpretation
☐	Therapeutic injection - small or large joint
☐	Thoracentesis
☐	Trigger point injection
☐	Tube thoracotomy
☐	Wound care including: simple superficial debridement; suture; and performance of topical or field infiltration of anesthetic solutions

FPPE (Service Chief to select)

☐	Proctoring of 3 procedures.
☐	Feedback from involved clinician or administrative person who is knowledgeable about the services performed by the physician.
☐	Reference from Medical Director of Cardiopulmonary Services.

Moderate (Procedural) Sedation

Description: Moderate Sedation/Analgesia ("Conscious Sedation") is a drug-induced depression of consciousness during which the patient responds purposefully to verbal commands, either alone or with light tactile stimulation. No interventions are required to maintain a patent airway and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.

Qualifications

Clinical Experience (Initial)	Applicant must provide documentation of a minimum of 6 sedations during the previous 24 months. AND Applicant must complete sedation tutorial at initial granting of privileges and every 2 years thereafter.
Clinical Experience (Reappointment)	Documentation of at least 6 cases within the last 24 months. AND Sedation tutorial completed within the last 24 months.
Additional Qualifications	Current ACLS certification (waived for physicians with Emergency Medicine Board certification).

Request	
	Check the Request checkbox to select all privileges listed below. Uncheck any privileges you do not wish to request in the group.

FPPE (Service Chief to select)

☐	Retrospective review of 3 cases of administration of moderate sedation
☐	Feedback from involved clinical or administrative personnel

Acknowledgment of Applicant

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

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

B. Any restriction on the clinical privileges granted to me is waived in an emergency situation and in such situation my actions are governed by the applicable section of the Medical Staff Bylaws or related documents.

Practitioner's Signature NIHD

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

CALL TO ORDER	The meeting was called to order at 5:30 pm by Robert Sharp, District Board Chair.
PRESENT	Robert Sharp, Chair Jody Veenker, Vice Chair Mary Mae Kilpatrick, Secretary Topah Spoonhunter, Treasurer Jean Turner, Member-at-Large Kelli Davis MBA, Interim Chief Executive Officer Joy Engblade, MD, Chief Medical Officer Allison Partridge RN, MSN, Chief Nursing Officer Vinay Behl, Interim Chief Financial Officer
OPPORTUNITY FOR PUBLIC COMMENT	Mr. Sharp announced that at this time, members of the audience may speak only to items listed on the Notice for this meeting. No public comments were heard.
APPROVAL OF OPERATIONS AND CAPITAL BUDGET FOR FISCAL YEAR 2021-2022	Interim Chief Financial Officer Vinay Behl presented an overview of the budget preparation process for the 2021-2022 fiscal year, which included the following: – Review of budget assumptions – Review of historical and projected patient visits and revenues – Review of income statements – Review of department budget requests and capital budget requests It was moved by Ms. Veenker, seconded by Ms. Turner, and unanimously passed to approve the fiscal year 2021-2022 operations and capital budgets for approval as presented.
ADJOURNMENT TO CLOSED SESSION	At 6:10 pm Mr. Sharp announced the meeting would adjourn to Closed Session for: A. Public Employee Performance Evaluation: title, Interim Chief Executive Officer (pursuant to Government Code Section 54957(b)).
RETURN TO OPEN SESSION AND REPORT OF ACTION TAKEN	At 6:45 pm the meeting returned to Open Session. Mr. Sharp reported the Board took no reportable action.
ADJOURNMENT	The meeting was adjourned at 6:45 pm.

_____
Robert Sharp, Chair

Attest: _____
Mary Mae Kilpatrick, Secretary

CALL TO ORDER	The meeting was called to order at 5:30 pm by Robert Sharp, District Board Chair.
PRESENT	Robert Sharp, Chair Jody Veenker, Vice Chair Mary Mae Kilpatrick, Secretary Topah Spoonhunter, Treasurer Jean Turner, Member-at-Large Kelli Davis MBA, Interim Chief Executive Officer and Chief Operating Officer Joy Engblade MD, Chief Medical Officer Allison Partridge RN, MSN, Chief Nursing Officer Vinay Behl, Interim Chief Financial Officer Keith Collins, General Legal Counsel (Jones & Mayer)
ABSENT	Sierra Bourne MD, Chief of Staff
URGENT NEED TO ADD TO AGENDA	Northern Inyo Healthcare District (NIHD) Legal Counsel Keith Collins requested that the Board of Directors consider adding one item to the agenda for this week's meeting, due to the fact that an immediate need to discuss potential action exists and because this item came to the attention of District Administration following posting of the agenda for this meeting. The item is: - *Litigation under Gov Code 54956.9(d)(2).* It was moved by Mr. Sharp, seconded by Jody Veenker, and unanimously passed to approve the addition of this agenda item as requested.
OPPORTUNITY FOR PUBLIC COMMENT	Mr. Sharp announced that 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 being allowed 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 advanced 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 he 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. No comments were heard.

NEW BUSINESS

COVID 19 UPDATE

Chief Nursing Officer Allison Partridge, RN, MSN provided a monthly Covid 19 update which included the following:

- CalOSHA and CDC masking Guidelines update
- Inyo County Covid cases remain low
- NIHD continues to offer vaccinations to members of the public in the front lobby
- NIHD patient clinics are assisting by providing a flexible schedule to accommodate patient who need to schedule a second dose.

CERNER PROJECT UPDATE

Daryl Duenkel provided a Cerner update, now 4 weeks after Go Live, stating there has been no interruption in patient care and minimal impact to the District's revenue stream. Mr. Duenkel stated that three committees continue to meet weekly to identify issues as they arise, and they are coming up with solutions. Mr. Duenkel also reported that during these early days revenue is very likely to experience an impact in cash flow as billing discrepancies start being resolved. Materials Management is also being watched closely for discrepancies. Service requests are 65% resolved, continuing to work on 35%. Cerner staff is continuing to provide support remotely through the first quarter. Employees have demonstrated support in moving away from Athena. Mr. Duenkel stated that super users have been given extra training to provide support to new onboarding providers.

Jean Turner expressed appreciation for the update report.

COLOMBO CONSTRUCTION PROJECT UPDATE

Louis Vargas, provided a Building Separation project update report and stated that NIHD passed the OSHPD inspection. OSHPD is now reviewing the plans for final approval.

Mr. Vargas also provided updates on the Omnicell Project noting that the targeted goal is to have Omnicell installed in September.

2021 NIHD STRATEGIC PLAN PRESENTATION

Interim Chief Executive Officer and Chief Operating Officer Kelli Davis, stated that The Executive Team has been meeting regularly to discuss best solutions to address strategic concerns from the Board of Directors. David Sandberg provided an overview of the completed Strategic Plan for 2021-2023, and he explained how this plan would help address NIHD top priorities including; building strong leadership teams and providing transparency. He additionally discussed the importance of ensuring that departments are staffed appropriately.

Mr. Sharp commented that staffing in the HR department has been an ongoing concern. Ms. Davis reported that the executive team has been working with Allison Murray, HR Director for several months in recruiting positions for the HR department, and is pleased to report that several positions have been filled. The Executive Team is looking into hiring an HR consultant. Ms. Davis will apprise the board with more details at a future date.

Ms. Turner thanked Ms. Davis for the attention to the HR component to the Strategic Plan. Ms. Veenker also shared her appreciation for the work that went into this plan. Board members Turner, Veenker and Sharp mention the importance of sharing this information with the community. Mrs. Davis, concurred with board members. Discussion took place on how frequently reporting will occur, and final decision on this topic was not made.

Ms. Davis then called attention to approval of the proposed 2021 NIHD Strategic Plan as presented by Mr. Sandberg. It was moved by Ms. Kilpatrick, seconded by Ms. Turner, and unanimously passed to approve the 2021-2023 NIHD Strategic Plan as presented.

POLICY AND PROCEDURE APPROVAL PASSWORD POLICY

Information Technology Services Director, Bryan Harper called attention to the revision to the proposed policy titled *Password Policy,* the policy has been revised to change passwords from 60 to 90 days which will be around same time as password changes for the Electronic Health Record system. A document will be sent out with instructions on how to change passwords. Mrs. Turner thanked Bryan for all his help.

It was moved by Ms. Turner, seconded by Ms. Veenker, and unanimously passed to approve the revised Password Policy as presented.

POLICY AND PROCEDURE APPROVAL, CELL PHONE PROCUREMENT AND ISSUANCE

Mr. Harper called attention a proposed policy titled *Cell Phone Procurement and Issuance*, which outlines the process for issuance of cell phones to meet the needs of the hospital team.

It was moved by Ms. Turner, seconded by Ms. Veenker, and unanimously passed to approve the Cell Phone Procurement and Issuance policy as presented.

POLICY AND PROCEDURE APPROVAL, LOST AND FOUND ITEMS

Admission Services Manager, Tanya DeLeo called attention to a revised NIHD policy titled, *Lost and Found Items*, the policy which has been revised to designate the Admissions Services Department to be the recipient of lost and found items.

It was moved by Ms. Turner, second by Topah Spoonhunter, and

unanimously passed to approve the updated Lost and Found Items policy and procedure as presented.

POLICY AND PROCEDURE APPROVAL, ENVIRONMENTAL SERVICES RADIO PROCEDURE

NIHD Facilities Manager Scott Hooker called attention to a proposed policy titled, *Environmental Services Radio Procedure.* The purpose of the policy is to provide constant communication within the NIHD Environmental Services Department (EVS) and between the EVS Department and all other departments.

It was moved by Ms. Turner, second by Ms. Kilpatrick, and unanimously passed to approve the Environmental Services Radio Procedure as presented.

POLICY AND PROCEDURE APPROVAL, DEVELOPMENT REVIEW AND REVISION OF POLICIES AND PROCEDURES

Patty Dickson, Compliance Officer called attention to the process on how to revise policy or procedure by leadership team depending on department compliance with CMS guidelines. Ms. Dickson provided a historical prospective on the need for this policy. Ensuring staff is provided with the support to be able to update current and future policies.
Ms. Turner thanked Ms. Dickson and Tracy Aspel for their work in getting policies updated.

It was moved by Ms. Turner, seconded by Ms. Veenker, and unanimously passed to approve the proposed policy and procedure as presented.

COMPLIANCE DEPARTMENT QUARTERLY REPORT

Patty Dickson provided an overview of the Compliance Department Quarterly report, which included information on UOR's, summary work of 2020 & 1st part of 2021. Approval of the report was then tabled, pending an update being made to the attachments included in the packet.

It was moved by Mr. Spoonhunter, seconded by Ms. Veenker and unanimously passed to table approval of the Compliance Department Quarterly report as requested.

APPROVAL OF DISTRICT BOARD RESOLUTION 12-05, APPROPRIATION LIMIT

Mr. Sharp called to attention to proposed District Board Resolution 12-05, which establishes the District's annual Appropriations limit for the year 2021-2022

It was moved by Ms. Veenker, seconded by Mr. Spoonhunter, and unanimously passed to approve District Board Resolution 12-05 as presented.

BOARD MEETING VENUE DISCUSSION

District Legal Counsel Keith Collins provided an update on Brown Act requirements during the COVID-19 pandemic, and discussion took place on how to conduct Board of Directors meetings moving forward. Discussion on Hybrid meeting. At the conclusion of the discussion Mr. Sharp proposed that the Board and appropriate staff members resume meeting in person as of July 1st, with outside participants and members of the public being encouraged to participate via Zoom. All remaining board members concurred.

CHIEF OF STAFF REPORT

On behalf of Chief of Staff Sierra Bourne, MD Ms. Davis and Joy Engblade, MD reported following careful review and consideration the Medical Executive Committee recommends approval of the following:

MEDICAL STAFF APPOITMENTS

1. Kevin Efros, MD *(anesthesiology)* – Active Staff
2. Michael Santomauro, MD *(urology)* – Courtesy Staff
3. Andrew Tang, MD *(internal medicine/hospitalist)* – Courtesy Staff

It was moved by Ms. Turner, seconded by Mary Mae Kilpatrick and unanimously passed to approve items 1-3 as requested.

CHANGE IN STAFF CATEGORY

They additionally reported that the Medical Executive Committee recommends approval of the following

1. Michael Phillips, MD *(emergency medicine*)- change from Active Staff to Honorary Staff

It was moved by Ms. Kilpatrick, seconded by Mr. Spoonhunter, and unanimously passed to approve the Change In Medical Staff Category as requested.

POLICY AND PROCEDURE APPROVALS

Ms. Davis also reported following careful review, consideration, and approval by the appropriate Committees the Medical Executive Committee recommends approval of the following District-Wide Policies and Procedures:

1. *Dilation and Curettage or modified suction curettage procedures in the Emergency Department*
2. *Bloodborne Pathogen Exposure Control Plan*
3. *Nursing Care Guidelines in the PACU*
4. *Local Anesthesia in Surgery*
5. *PACU Discharge Criteria*
6. *Pathology Specimens in the Operating room*
7. *Patient Warmer (Warm Air Hyperthermia System)*
8. *Standards of Care in the Perioperative Unit: Pediatric Patient*
9. *Preoperative Preparation and Teaching*
10. *Scheduling Surgical Procedures*

11. Scope of Service PACU
12. Sponge, Sharps, and Instrument Counts
13. Surgery Equipment and Routine Supplies

It was moved by Mr. Sharp, seconded by Ms. Veenker, and unanimously passed to approve all 13 District-Wide Policies and Procedures as presented.

MEDICAL EXECUTIVE COMMITTEE REPORT

Ms. Davis requested that an update on this item be tabled at next regular board meeting, pending update from Doctor Bourne.
It was moved by Ms. Turner, seconded by Ms. Veenker, and unanimously passed to table update of the Medical Executive Committee Report as requested.

_____.

CONSENT AGENDA

Mr. Sharp called attention to the Consent Agenda for this meeting which contained the following items:

- Approval of minutes of the May 19, 2021 regular meeting

It was moved by Ms. Kilpatrick, seconded by Ms. Veenker and unanimously passed to approve the minutes of the May 19, 2021 regular meeting as presented.

- Financial and Statistical reports as of April 30, 2021

It was moved by Ms. Veenker, seconded by Ms. Turner and unanimously passed to approve the Financial and Statistical reports of April 30, 2021 as presented.

NIHD COMITTE UPDATES FROM BOARD MEMBERS

Mrs. Sharp also asked if any members of the Board of Directors wished to report on their attendance at any NIHD Committee meetings Director Veenker shared her experience with the Wellness Committee. Ms. Tuner commented on her participation to ACHD, and discussed upcoming trainings. Mr. Spoonhunter commented that he recently participated in CEO Search Committee meeting, and reported the committee is actively searching. Discussion took place on the stake holder interview process, and Ms. Davis shared conversation with the search firm. Mr. Sharp shared his appreciation for the work being done on physician contracts.

BOARD MEMBER REPORTS ON ITEMS OF INTEREST

Mr. Sharp additionally asked if any members of the Board of Directors wished to report on any items of interest. No additional comments were heard.

ADJOURNMENT TO CLOSED SESSION	At 7:57 pm Mr. Sharp reported the meeting would adjourn to Closed Session to allow the District Board of Directors to: *A. Conference with legal counsel, existing litigation (pursuant to Gov. Code 54956.9(d)(1)). One case: NIHD v. SMHD.* *B. Conference with legal counsel, anticipated litigation. Significant exposure to litigation (pursuant to paragraph (2) of subdivision (d) of Government Code Section 54956.9) three cases.* *C. Conference with legal counsel, existing litigation (pursuant to Gov. Code Section 54956.9 (d)(1).* Mr. Sharp additionally noted that it was not anticipated that any action would be reported out following the conclusion of Closed Session.
RETURN TO OPEN SESSION AND REPORT OF ACTION TAKEN	At 9:15 pm the meeting returned to Open Session. Mr. Sharp reported that the Board took no reportable action.
ADJOURNMENT	The meeting adjourned at 9:15 pm.

_____
Robert Sharp, Chair

Attest: _____
Mary Mae Kilpatrick, Secretary

NORTHERN INYO HEALTHCARE DISTRICT

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

150 Pioneer Lane
Bishop, California 93514

(760) 873-5811

DATE: July 21, 2021

TO: Board of Director's
Northern Inyo Healthcare District

FROM: Kelli Davis, Interim Chief Executive Officer (CEO)

RE: Bi-Monthly Interim CEO Report– Northern Inyo Healthcare District

REPORT DETAIL

Employee & Physician Engagement Survey

NIHD has partnered with People Element, an employee/physician engagement and human capital consulting firm, to facilitate and oversee our annual engagement survey and action forum. This is a 3 year commitment that will expire with the completion of the 2022 survey term.

550 survey invitations were sent out to employees and physicians of NIHD. 316 survey responses were received, garnering a 57% participation rate. Overall survey results identified our employees and physicians "do not feel valued, they do not feel organizational issues are effectively resolved and they are confused with where the District is going in future". Individual department survey scores may reflect differing favorability scores requiring individualized action plans for improvement.

Leadership, at all levels, is currently conducting team meetings to discuss these areas of low scores, defining the current state of feelings and the actions necessary for improved engagement and satisfaction moving forward. Each departmental action plan will be entered, worked and monitored in the People Element survey platform throughout the remainder of the year.

At an Executive Team level, we are focused on the overall survey results with low favorability noted above and through review and discussions, we are identifying key areas of focus centering around increased access between team members and leadership (rounding), increased communication venues for current and future organizational updates/engagement (monthly internal communication tools and town halls) and increased recognition and morale boosting opportunities (recognition program) for team members. These focus areas have been built into the NIHD 2021 – 2023 Strategic Plan, focusing on:

- Improving annual survey scores in leadership domain to >75% overall favorability;
- Increasing survey participation by >20% annually (goal of >90% by 2023).

Regular reports to the Board of Director's are planned.

Leadership Development

LEAD (Leadership*Engagement*Accountability*Development) **Academy**- continues with 2 hour + meetings every other Thursday through August.

As you will recall, NIHD has partnered with the Hospital Association of Southern California (HASC) to bring an "intensive 12-module training experience using innovative tools and experiential learning" virtual academy to NIHD leaders. "LEAD is built on the underlying principle that effective leadership requires productive relationships to support excellence in patient care, sustainable business objectives and a safe patient environment" (HASC).

The 12-modules will be delivered through a 2-hour virtual e-learning session every 2 weeks for 6 months. The first round of Director's, Managers, and Assistant Managers selected for LEAD were direct reports to the Interim CEO/COO. Their session will conclude in August. The next session will include leaders from the CNO and CMO reporting group. Their session will begin in Aug/Sept.

Progressive Education and Training Opportunities

Heid Jane Olquin and Mona Hathout, Progressive Resources Management, Inc., have partnered with NIHD for team training throughout the District. Training on *"Professionalism: Civility and Effective Communication – A Prescription for Success!"* is being deployed to assist us in civility training and techniques for our teams.

Organizational Structure Charts

Organization charts defining the NIHD structure are being redesigned for ease of updating, viewing, printing and other use. OrgChart Premium software has been approved and will be overseen by Human Resources.

COVID-19

NIHD continues to be fully focused on prevention, testing and caring for patients who are COVID-19 positive. The District has noted a slowing in the vaccination process with fewer vaccinations being distributed. NIHD in partnership with Dr. Brown, is looking into an incentive program designed to refresh the interest in getting vaccinated. Legal review of this proposed new approach is being done with a response and guidance expected shortly. If allowed to move forward, we are looking at free movie passes, yogurt certificates and possibly raffle opportunities to draw more community members in for vaccinations.

NIHD Strategic Plan

With the adoption of the 2021 – 2023 NIHD Strategic Plan in place, work has begun to bring the Plan to life through:

- Assigning priority levels
- Develop Key Performance Indicators or "OKR's" for metrics
- Defining and designing teams for each strategy, project, task and sub-task
- Ongoing bi-weekly calls with David Sandberg for guidance and input

This is a 3-year Plan that will have weekly work groups focusing on all aspects of the Plan with each Executive Team member having ownership/oversight of assigned areas.

The reporting outline for the Board is being defined based on discussions at the June 2021 Board Meeting.

Information Items for Board Members

2030 Hospital Building Seismic Requirements - California's Office of Statewide Health Planning and Development (OSHPD) has stringent seismic design requirements for hospitals. Their oversight includes thorough plan review, approval of all designs, continuous construction project inspections, materials testing and strict monitoring of all construction projects of any size done in the hospital environment.

Under SB1953, by January 2030, all acute care hospital buildings must be capable of not only surviving a major earthquake, but also must be capable of providing ongoing services after an earthquake.
The cost associated with a retrofit of this size for most California hospitals is tremendous. California Hospital Association (CHA) is advocating for an extension on the 2030 deadline through focus groups, legislative action and more. Recently, they have focused on changes to the bill that would afford less stringent post-disaster requirements for care provision and an extension for compliance from 2030 to 2037. Attached is a CHA Alert for Lawmakers and supporting information for your review.

"Governance Boards' 2021 Challenges and Focus" by Harry Hertz, June 15, 2021, provides insight on areas of focus in 2021 for governing boards. Attached is the article for your review is attached.

"Governing Board and Contract Management: Meeting CMS, TJC and DNV Requirements" – this training opportunity has been purchased by NIHD in the form of a DVD and transcript for Board, leadership and compliance review. This training is described as:
"CMS has issued many citations related to Governing Board and specifically, contract management. This program will discuss the standards for hospitals accredited by The Join Commission and DNV which are closely cross-walked to the CMS CoPs.
The governing board of a hospital is responsible for oversight of contracted services and tips to ensure compliance will be discussed. Hospitals must also have a process to evaluate the contracted services to ensure that the performance indicators are met and that compliance with the provisions contained in the contract regulations and standards with oversight from the Board".
As soon as the DVD and transcripts arrive, an alert will be sent out with viewing opportunities to follow.

Department Reports

Please find the reports from the department leaders I support in the next pages. You are sure to see much work underway, some challenges and of course, some celebration of the amazing work and service provision taking place at NIHD.

Closing

The support and guidance by the NIHD Board of Director's is greatly appreciated. As always, please do not hesitate to contact me with any questions or to share any concerns you may have.

Respectfully submitted,
Kelli Davis - Interim CEO

June 25, 2021

President pro Tempore Toni Atkins
California State Senate
State Capitol, Room 205
Sacramento, CA 95814

Speaker Anthony Rendon
California State Assembly
State Capitol, Room 219
Sacramento, CA 95814

The Honorable Richard Pan, MD
Chair, Senate Health Committee
State Capitol, Room 2191
Sacramento, CA 95814

The Honorable Jim Wood, DDS
Chair, Assembly Health Committee
State Capitol, Room 6005
Sacramento, CA 95814

The Honorable Susan Talamantes Eggman
Chair, Senate Subcommittee No. 3
State Capitol, Room 5019
Sacramento, CA 95814

The Honorable Joaquin Arambula
Chair, Assembly Subcommittee No.1
State Capitol, Room 5155
Sacramento, CA 95814

SUBJECT: Disaster Preparedness Modernization – SPONSOR

Dear Legislators:

Over the past year, hospitals across California responded to the unprecedented challenge of an unprecedented pandemic with an unprecedented effort — caring for massive surges of COVID-19 patients whose lives were saved thanks to the care they received. These extraordinary efforts helped keep thousands upon thousands of California families whole, but they also drained significant financial resources. Even with federal financial relief, **hospitals in the Golden State still endured a net loss of**

more than $8 billion last year. And the financial losses continue to mount, with California hospitals projected to lose up to an additional $2.2 billion in 2021 and no additional federal relief in sight.

If we have learned anything during the pandemic, it's that hospitals need flexibility to deploy innovative approaches and adapt to rapidly changing circumstances to care for patients in a disaster. The future of hospital *disaster response must be focused on ensuring people's health care needs are met*, not on complying with arbitrary regulations that gird the infrastructure of the past — whether that disaster is an earthquake, disease outbreak, or more severe, widespread wildfires. It's time for lawmakers to take a fresh look at a 1990s state law that will further drain billions of dollars from hospitals and — if not modified — is likely to result in hospital closures across the state.

Specifically, it's imperative that the Legislature **adopt the proposal through this year's state budget process that will refocus 2030 hospital seismic requirements on emergency services and provide additional time until 2037 for hospitals to comply as they begin to recover from the impact of the pandemic.**

This reform will substantially lower the estimated $100+ billion price tag carried by the current law. At a time when hospitals, lawmakers, employers, and the public are all concerned about rising health care costs, **this proposal represents an immediate and effective action lawmakers can take now to make health care more affordable**.

This bill does three things:

1. **Refocus the Requirement on Post-Event Emergency Medical Services**

The first component of the proposal is to *refocus* the current standard. That standard requires that every hospital building be able to be *fully operational* following an earthquake, even those that would have no utility after a disaster. Nearly two-thirds (64%) of California hospitals have not yet been able to retrofit or replace their buildings to achieve this level. Unless current law is changed, hospitals unable to secure the funding to complete that construction in the next several years by January 1, 2030, will be forced to close their doors. With hospital margins and revenue forecasts left in bad shape by the pandemic, it will be difficult if not impossible to secure financing for projects of this magnitude.

No community should lose its local hospital because of an outdated state law.

Hospitals train constantly for disasters, including internal and external patient transfers, all with an intense focus on strategies to keep patients safe. This bill recognizes the existing planning and capability of every hospital to manage disaster response, and focuses resources on the needs of this community once a disaster strikes, in the emergency room, and on the services needed to support emergency care.

Specifically, the *operational* standard should be modernized to apply only to those buildings in which *post-event emergency medical services* are located. These services include the emergency department, and the resources and services necessary to support it, including food, water, pharmaceutical supplies, clinical laboratory service, radiology service, operating rooms, pre-and post-surgery spaces, and more. No one is, or should be, receiving knee replacements, plastic surgeries, or other non-emergency services following an earthquake or other disaster.

Further, given that a disaster can result in a surge of patients, the hospital would be required to have services necessary to support the emergency department at a level of 150% what they have historically needed to care for patients who present at the emergency department. This ensures hospitals will have the capacity to care for a surge of patients based on historic levels.

2. Strengthen Patient Care Areas

Second, hospitals know they would be remiss in their obligations in seeking this reform if their buildings weren't already safe. Today, more than 96% of all patient care buildings have met the state's rigorous seismic life safety construction standards for 2020, with the remaining handful of buildings required to come into compliance no later than 2025. This means patients and workers will be protected when the next earthquake strikes.

This proposal would further ensure the stability of these buildings by requiring an additional state-led engineering evaluation to ensure compliance with the life safety standards. Hospitals will need to certify they are: 1) among the lowest collapse probability and in the areas of the state with the lowest seismic activity or 2) buildings that are single-story wood-framed construction, which is — by design — of very low risk of collapse.

Some have raised the concern that labor and delivery services might not be seismically safe. That is misleading. All patient care areas will be required to be in buildings that withstand an earthquake. In addition, following a seismic event, hospitals will forgo accepting new patients in labor, directing them to neighboring hospitals, as occurs today with emergency departments when a hospital is on diversion. Any patients in delivery in need of a surgical space could be cared for in the emergency department or one of the operating rooms that will support it, which will be operational post-event.

To provide an even greater level of safety, the remaining buildings would further be required to anchor and brace equipment and utility lines to prevent anything in the ceilings from falling — further protecting patients and staff.

3. Provide Additional Time to Comply

Under this proposal, hospitals will have until 2037 to comply with these requirements, providing hospitals with the breathing room necessary to financially recover from the pandemic, all while hospitals remain in compliance with the 2020 seismic life safety standard.

Your Support Is Needed

Opponents to these changes have incorrectly stated that there are hardship exemptions and funds to complete these requirements. That is simply not true. The 2030 seismic standard is state law, and there are no exemptions. Unless the Legislature acts to provide relief, there will be hospitals unable to comply and patients who lack access to care. Other concerns around the inavailability of some *non-emergency* services following a disaster present a false choice. As we've learned from the pandemic, the greatest resource during an emergency is our state's health care workers, whose efforts will be fully directed at emergency care, and not at non-emergent hospital services.

As you consider this proposal, it's important to remember that, by definition, it requires that **the most critical aspect of health care — emergency care — be available to those who need it during and after the next disaster.** By creating a network of hospitals with post-event emergency services throughout

the state, California will be well-positioned to respond to a seismic event, or any other disaster that comes our way.

For these reasons, CHA and its more than 400 hospital and health system members respectfully request your "YES" vote on legislation to modernize the 2030 seismic standard.

Should you have any questions, please call Kathryn Austin Scott on her Cell: (916) 812-7406

Sincerely,

Kathryn Austin Scott
Senior Vice President, State Advocacy and Relations
California Hospital Association

Ann-Louise Kuhns
President and CEO
California Children's Hospital Association

Janelle Blanco
Executive Director
United Hospital Association

Sherreta Lane
Vice President Finance & Policy
District Hospital Leadership Forum

Cathy Martin
CEO
Association of California Healthcare Districts

Anne McCleod
President and CEO
Private Essential Access Community Hospitals

Erica Murray
President and CEO
California Association of Public Hospitals
and Health Systems

Lori Cappello Dangberg
Vice President
Alliance of Catholic Health Care

cc: Angie Wei, Legislative Affairs Secretary, Office of the Governor
Tam Ma, Deputy Legislative Affairs Secretary, Office of the Governor
Mark Ghaly, Secretary, California Health and Human Services Agency
Elizabeth Landsberg, Director, Office of Statewide Health Planning and Development
Marjorie Swartz, Office of the Senate President pro Tem
Agnes Lee, Office of the Speaker of the Assembly
Vince Marchand, Consultant, Senate Health Committee
Lara Flynn, Consultant, Assembly Health Committee
Joe Parra, Consultant, Senate Republican Caucus
Gino Folchi, Assembly Republican Caucus
Scott Ogus, Senate Budget and Fiscal Review Committee
Andrea Margolis, Assembly Budget Committee
Anthony Archie, Consultant, Senate Republican Caucus
Joe Shinstock, Consultant, Assembly Republican Caucus

CALIFORNIA HOSPITAL ASSOCIATION

CHA Key Messages

Drawing Upon the Lessons of COVID-19, California Must Modernize its Disaster Preparedness Standards for Hospitals

1. **California, like states throughout of the country, must draw on the lessons of COVID-19 to think differently about disaster planning.**
   - The COVID-19 pandemic has shown that hospitals can quickly mobilize to execute emergency preparedness plans and employ flexible approaches to care for patients with the greatest needs during a disaster.
   - During the pandemic, hospitals rapidly converted spaces to create triage units and increase ICU capacity, redeployed staff, transported critical supplies (*including PPE*) to those areas hardest hit, postponed non-emergency procedures, and brought in necessary additional resources, including staffing, to care for critically ill patients.
   - These extraordinary efforts saved millions of lives, but they also drained significant financial resources from hospitals, and it will take years to return to any sense of normalcy. California hospitals lost more than $14 billion in 2020, and even with federal financial relief, hospitals in the Golden State still had a net loss of more than $8 billion last year. And the losses are continuing to mount, with hospitals expected to lose up to an additional $2.2 billion in 2021.

2. **Modernizing the state's hospital disaster preparedness standards will help preserve access to care before and after the next disaster, while also helping to keep health care costs in check.**
   - If we have learned anything during the pandemic, it's that hospitals need flexibility to deploy innovative approaches *to care for patients* in a disaster.
   - Hospitals also must be able to invest in a *strong, well-trained workforce* that can treat the trauma, injury, or illness that results from a disaster, while also being able to safely evacuate patients when appropriate.
   - That's why an outdated, 1990s state law requiring hospitals to spend billions of dollars on ensuring the continued operation of *buildings* after a major earthquake must be modified.
   - More than two-thirds (64%) of California hospitals have not yet been able to meet this operational requirement. Unless the existing law is changed, hospitals unable to comply with this standard by Jan. 1, 2030, will be forced to close their doors. Forever.
   - This proposal also will substantially lower the estimated $100+ billion price tag posed by the current law. At a time when lawmakers, employers, and the public are all concerned about rising health care costs, this proposal is a pivotal shift in the efforts to make health care more affordable.

3. **It is imperative that the Legislature adopt the proposal through the state budget process that will re-focus the state's 2030 seismic requirements to be fully operational on *only* those buildings that provide *emergency services*.**

- Under this proposal, hospitals will have until 2037 to comply with the requirements, providing hospitals with the breathing room necessary to financially recover from the pandemic.
- Additionally, this proposal will require many hospitals to strengthen existing buildings that house non-emergency services.
- Hospitals know they would be remiss in their obligations in seeking this reform if their buildings weren't already safe. Today, more than 96% of all patient care buildings have met the state's rigorous seismic safety construction standards, with the remaining handful of buildings required to come into compliance no later than 2025. This means patients and workers will be safe when the next earthquake strikes.
- Some stakeholders are concerned this proposal will result in a lack of health care services for communities recovering from a major earthquake. Nothing could be further from the truth. Rather, this proposal will ensure emergency care is available to those who need it — whether before, during, or after the next disaster.

Governance Boards' 2021 Challenges and Focus

June 15, 2021
By: Harry Hertz

I believe we have reached an inflection point for governance boards (aka boards of directors) as we enter the "new normal" for organizations and society as a whole. Boards in 2021 will need to place a significant focus on ten critical areas. (I hesitate to call them the Big Ten because college sports fans will immediately think there are 14.) These ten areas are based on numerous published studies (some key ones are referenced in this blog post) and my own experiences over the last year. While this blog is focused on boards of directors, many of the critical focus areas also apply to CEO's and other senior organizational leaders.

Introduction

It is no surprise that data published by McKinsey & Company on May 4, 2021 indicate that boards increased their attention in 2020 on corporate (organizational) resilience and that every other topic dropped in attention. Attention to resilience rose from 44% to 60%, while focus on major societal trends and workforce-related topics dropped by 13% and 9-10%, respectively. While resilience certainly continues to be important in 2021, other topics are demanding increasing attention. I have summarized my top ten topics below, recognizing that there frequently is overlap among these topics when organizations take a systems perspective to leadership and management. After sharing the ten areas, I will relate them to board responsibilities and the Baldrige framework's core values.

Ten Critical Areas

1. Lessons from the Past Year

This has been an unprecedented year, characterized by a pandemic, the likes of which almost all of us had never experienced before, and by the emergence of a long-overdue call for true social justice in the United States. We all reacted, personally and organizationally, to the rapidly evolving environment. Organizations with effective resiliency plans did relatively well and were role models for community resilience, as well.

One notable characteristic of the resilient organizations was their ability to rapidly shift communication mechanisms and establish two-way, remote communication with employees, customers, and other key stakeholders virtually "overnight." We have all learned the importance of communication and listening over the last year.

Of course, our experiences over the last year go beyond adapting to new communication modes. We have experienced and learned a lot. Now it is time to consolidate those lessons learned and make them part of our strategic, operational, and resiliency plans, rather than dive head-first into disorganized and differing perceptions of the "new normal."

2. Risk Management

Having come through this past year, boards and senior leaders need to assess if their organizations' crisis management plans were up to the challenges they faced. Going forward, all organizations will need to develop a (refreshed) enterprise risk-management plan. According to a McKinsey recommendation on board responsibilities, enterprise risk, culture, and strategy will need to be embedded in all board decisions and to be treated in an aligned fashion.

Risk management is about preparing for an uncertain future. Among the current uncertainties are how many of the myriad changes we have made and experienced during the past year will prove permanent and which of the changes will either revert to a former state or to a new and different state. In its discussion of the new era of board stewardship, Deloitte Insights 2021 Directors' Alert states that "strong and resilient boards will have the diversity of skills and backgrounds to make reasoned assumptions about the present and the future...steering the organization through turbulent times." According to a Harvard Law School Forum on Corporate Governance in 2021, after the pandemic, key risk considerations for the boards must be cybersecurity, data protection, and legal compliance.

There appears to be fairly unanimous agreement among a cross-section of experts that an important component of risk management for boards is related to organizational leadership. Were the senior leaders of the organization up to the leadership challenge they faced during the past year? Are there emergency replacements who are capable of stepping in if a crisis impacts a senior leader? Abraham Lincoln cautioned against changing horses mid-stream, but he also was keenly aware of the risk of keeping an unprepared leader at the helm of an organization. One of Lincoln's leadership principles was to keep seeking "until you find your Grant." In other words, give every leader a chance, but if they are not up to the job they need to be replaced, even during the heat of battle. Thus, he made numerous leadership changes until he installed General Ulysses S. Grant. How well is your organization set for leadership?

The National Association of Corporate Directors (NACD) in its 2021 Governance Outlook states that boards will face heightened expectations to apply a "mission-critical" risk framework in their oversight. They cite several court decisions where the mission criticality of an action or lack of action led to the court's decisions. In an era where organizational missions and purposes are being challenged and redefined, this board oversight focus is increasingly important.

The NACD report further states that board committee charters should be reviewed annually and updated, if necessary, to reflect key areas of risk in the committee's

oversight purview. Committees (and the full board, if needed) should be charged with timely review of existing risks and should also, with organizational senior leadership guidance, address new or evolving risks.

3. Mission and Purpose

The Baldrige Excellence Framework's glossary of key terms defines *mission* as your organization's overall function. It answers the question, "What is your organization trying to accomplish?" Some organizations also define a larger *purpose* for existence. This purpose defines the fundamental reason the organization exists. It inspires the organization. *Purpose guides the setting of an organization's values. Mission is guided by the organization's values.*

As organizations are called on to serve a larger set of stakeholders than shareholders and customers, boards play a key role in setting and overseeing that higher purpose. Many corporations have adopted the Business Roundtable's 2019 "Statement on the Purpose of a Corporation" that calls for a shift away from shareholder primacy toward a broader view of responsibility and accountability to a wider group of stakeholders.

In its 2021 Governance Outlook, the NACD states that boards have a role in understanding the organization's key stakeholders, how they are identified by senior leadership, the impact of the organization on these stakeholders, and any related risks.

A clear statement of purpose that brings value to society provides a basis for leadership and board decisions and enhanced employee and customer engagement. Furthermore, a meaningful statement of purpose reinforces a strong organizational culture, allowing everyone to celebrate organizational contributions, which is especially valuable during and right after times of crises.

4. Diversity, Equity, and Inclusion (DEI)

Both the Harvard Law School Forum on Corporate Governance and NACD's 2021 Governance Outlook call for two perspectives on DEI. The first perspective is a risk-based perspective, with growing demands for transparency and accountability regarding equity considerations within the workforce. For publicly traded and for public-benefit organizations, stockholders and contributors want numeric data to track progress on diversity and equity in the workforce, so they can decide where to invest their money and time.

The second—and, in my opinion, more important—focus, is on proactively addressing DEI opportunities for the organization. Boards should work with organizational leaders to ensure diversity, equity, and inclusion in hiring, promotion, senior leadership presence, and board membership. Boards and organizations need to consider DEI as part of strategic planning. Boards should work with their organization's leadership to assess business practices for unintentionally discriminatory processes related to the treatment of employees, customers, and communities served.

5. Societal Contributions

Organizations are increasingly measured on environmental, social, and governance (ESG) contributions. There is a growing sensitivity to these considerations in consumer spending and investor decisions, in employees' choice of where to work, and in charitable giving. And this sensitivity has been heightened during the past year. Being role-model citizens in the community that houses the organization adds value to the organization's reputation and stature.

How an organization addresses ESG is an important part of continuity planning and strategy and thus is a board-level consideration. Public disclosure of commitments is considered an important reputational issue. Therefore, boards should also ensure that an organization's ESG commitment is borne out in action.

6. Strategy

Strategy has always been a significant topic for governance boards. Deloitte in its 2021 Directors Alert states that changes in business models loom particularly large as organizations emerge from the pandemic. The nature of work and the workplace have also changed dramatically and will impact strategic planning as organizations plan for the new normal and beyond. Employee retention will be a challenge as competition for workforce member's heats up. Boards need to pay attention to all aspects of workforce management, including the special attention to DEI I mentioned in #4 above.

As organizations experience the new normal in their business environment, there is an expectation that there will be new and continuing short-term pressures on organizations, including the heightened attention to cybersecurity I referenced in #2. Boards have a responsibility to balance those short-term pressures with a longer-term sustainability strategy for the organization. This means some attention to strategy will become part of every board meeting for organizations. Addressing vulnerabilities and associated strategic risks will require the varied expertise of a diverse board with differing individual insights.

7. Innovation and Strategic Opportunities

Along with new vulnerabilities, crises always present new opportunities. Boards need to ensure that such opportunities are identified and evaluated for the strategic benefit they might provide. McKinsey highlights strategic opportunities related to all aspects of digitization and the acceleration of consumer expectations. Remote work has led to innovations that might generate strategic advantages going forward. Ideas have come from all parts of the organization during the past year. Boards need to work with senior organizational leaders to see that these ideas are captured and evaluated for strategic opportunities.

8. Support for Senior Leaders

Senior leaders (and all employees) have likely experienced the most challenging year of their tenure as leaders (or employees). Boards need to give their organizations' leaders emotional support and an attentive ear. They also need to decide what feedback to give senior executives, how to adjust their goals, and how to evaluate their performance for this challenging year. In making compensation decisions, the Harvard Law School Forum included particular mention of the board's need to balance rewarding leaders' hard work and high performance with any perception brought on by employee furloughs, layoffs, or downsizing.

Maybe it is most important—after a year in which many boards took on added roles—for boards to bear in mind the difference between the oversight role of the board and the leadership role of senior leaders and to respect the difference as the new normal emerges.

9. Team Dynamics

There are two aspects of team dynamics that need board consideration:

1. Boards, like workforce members, have learned to operate through videoconferencing and "remote work." How has that impacted board dynamics? What has changed that should be preserved? Are there new board members who have never received a proper orientation or met the other board members? Would an internal board feedback session be appropriate?
2. Team dynamics within the organization have changed. People and teams have become more empowered. Senior leaders have established changed relationships with middle managers and the empowered teams. Boards need to help senior leaders adapt to and adopt changes that should be preserved.

10. Speed of Decisions

The urgency of the past year has led to new and faster decision-making processes at all levels of the organization. It is time to look at permanently modifying processes for speed. It is also time to recalibrate decision-making processes to ensure that the need for speed has not replaced the use of data- and fact-based decision making when that is needed.

Board Responsibilities and the Baldrige Core Values

The Baldrige Excellence Framework is underpinned by a set of 11 core values and concepts. These core values have served as the basis for defining role-model attributes for boards of directors' performance. Now is a good time to take a fresh look at these role-model characteristics as boards recalibrate themselves for "new normal" operation and want to make sure they do so with a clear picture of their role and the organizational senior leaders' role.

Let me share some thoughts on a few of the Baldrige core values, in particular, as boards recalibrate:

- *Ensuring a systems perspective*: Boards need to make sure that senior leaders are taking a holistic look at the organization and its many functions and processes. Now is a good time to reconsider the larger ecosystem (partners, suppliers, customers, communities) in which the organization operates.
- *Focus on organizational success (sustainability)*: Boards need to work with senior leaders to create a focus on short- and longer-term factors that affect the organization, its reputation, and its ongoing success. They need to focus on the "big picture," ensuring that organizational planning anticipates future marketplace, economic, and technological influences and disruptions.
- *Ensuring ethics and transparency*: Boards and senior leaders need to set the tone for ethical and transparent operation of the organization. Has the organization and the board remained true to its ethical principles over the last year? Might now be the time for an audit? Might this provide the opportunity to become the ethical role model you want the organization to be for the future?

The next board meeting is the time to set the tone for the future. What tone will your board set?

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

DATE: July 2021

TO: Board of Directors
Northern Inyo Healthcare District

FROM: Interim CEO Board Report
Bryan Harper, Director of ITS/CISO

RE: Department Update

REPORT DETAIL

NEW BUSINESS
ITS continues working on hardware upgrades and patches.

ITS is starting a large VMware Platform upgrade.

Internal Security Pre-Penetration testing has started.

ITS is currently still working on a secure in house messaging platform that could be used for Provider communications.
are here.

ITS is adding new SHA 256 certs to all servers (replacing all outdated SHA1)

Clinical Engineering has had a successful launch for integration with Cerner for Patient Monitors, Fetal Monitors, EKG, Anesthesia, and OR Integration. Internal Medicine Efficiency project is now complete pending some minor remodels. Bronco Clinic and Pediatric are on the Horizon for new equipment installs.

OLD BUSINESS
ITS identified known wireless interference and removed or replaced devices.

ITS has completed the large NetApp Storage upgrade and completed the data moves to ensure stability and security.

Clinical Engineering is in the final stretches working with Cerner for Patient Monitor, Fetal Monitor, EKG, Anesthesia, and OR integration with Cerner. We are currently waiting for availability to finish the Internal Medicine Efficiency project, all parts and pieces are here.

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DATE: July 2021

TO: Board of Directors
Northern Inyo Healthcare District

FROM: Interim CEO Board Report
Scott Hooker, Director of Facilities

RE: Department Update

REPORT DETAIL

MAINTENANCE/FACILITIES

New Business:

Work has continued on the building separation project Colombo Construction will be providing an update to the Board in July. Pharmacy relocation documents will be re submitted to OSHPD in July 8th. OSHPD has agreed to review and accept them but not issue a permit until the separation project is complete.

Ping and Associates Architectural firm is preparing OSHPD documents for the Omnicell replacement project.

Old Business:

Work continues on the chiller plant upgrade. Contract signed documents being prepared.
This is a very technical and complicated project. OSHPD is requiring many details and documents for this project. We will continue to push as hard and fast as we can on this project so that we can get the temporary chiller returned.
Ping and associates have provided a quote to do the design and engineering phase of the work.

Work is ongoing with the building maintenance program. Access points for this system are being installed at key points in the plant system is up and running training to take place in the next week.

Temp Chiller

Work continues to meet OSHPD requirements.

SECURITY

New Business:

Security is running smoothly we had three good qualified applicants that were requested to hire through HR.

Old Business:
Security is currently operating with 3 officers. Security is onsite Sunday – Thursday 600p-330a Friday and Saturday noon-400a.

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150 Pioneer Lane
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DATE: July 2021

TO: Board of Directors
Northern Inyo Healthcare District

FROM: Interim CEO Board Report
Andrew McKie, Interim Director of Revenue Cycle

RE: Department Update

REPORT DETAIL

NEW BUSINESS
Month End Financials:
Charges - $13,243,408 (June) and $91,309,850 (2021)
Payments - $5,581,009 (June) and $44,027,186 (2021)
AR - $35,619,174

Cerner Up-Date
Weekly meetings with NIHD Teams and Cerner to improve process and analyze data

Staffing Up-date
Cheryl Brooks (Medical Records Coordinator) retired in June
Marnie Davis is our new coordinator working with Helen Zurek (HIM Manager)

Also, currently interviewing to hire more staff to provide customer service and process charity applications in the Credit/Billing Department)

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150 Pioneer Lane
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DATE: May 2021

TO: Board of Directors
Northern Inyo Healthcare District

FROM: Interim CEO Board Report
Larry Weber, Director of Diagnostic Services

RE: Department Update

REPORT DETAIL

NEW BUSINESS

Cardiopulmonary (CP):

With the successful implementation of the Cerner EHR, NIHD's CP department has successfully transitioned to an electronic EKG workflow for image acquisition and interpretation. We are happy to report that CP is fully staffed with zero travelers in the department. As will be the reported in each section, NIHD leadership and staff received the report from People element that demonstrates the engagement of our employees' and how they feel about NIHD as a place to work. CP had 10 of 15 employees (66%) respond to the survey with an overall favorability rating of 63% (favorability being defined as a response score of 4 or 5 on the 5 point Likert scale used by People Element). The three suggested areas of action include improving the employees' perception of how much senior leadership values the employee, How effective senior leadership is in resolving key organizational issues, and how supported the employees feel in maintaining a good work-life balance. CP leadership and staff are currently creating action plans on how we can positively impact (from the employees' perspective) these key opportunity areas.

Diagnostic Imaging (DI):

DI has also been successful in transitioning to a new EHR and RIS. As part of this transition, DI has transitioned to a new Mammography tracking system and are moving away from our previous system (PenRad). Relative to the employee engagement survey, DI had 10 of 19 employees take the survey (53% participation rate) and had an overall favorability score of 62%. Key areas that are suggested by People Element that will have the largest favorable impact on employee engagement within DI include staff have the resources and equipment needed to be successful on the job and also had as key opportunities the two areas cited in the CP report, specifically wanting to see improvement in the employees feeling valued by senior leadership and senior leaderships ability to resolve key organizational issues. The action planning with leadership and staff within DI has been occurring and feedback from employees to this point include the need to transition away from tablets and implement desktop workstations for the

technologists to be able to do their job and the desire to have leadership backfill a vacant tech position so that the ability to take vacations are improved. DI leadership will be working with Senior leadership to gain support for these initiatives.

Laboratory Services (the lab):
The lab has also successfully transitioned to the Cerner EHR and has successfully implemented electronic workflow in two new areas of the lab (Pathology and Blood Bank). The transition to electronic workflow in these two areas is seen as a key improvement for Nursing and Lab Staff at NIHD. The Employee Engagement results for the lab demonstrated that 13 of 22 employees (59% response rate) with an overall favorability score of 65%. Key areas of opportunity to improve engagement of the employees in the lab include improvement in management's effectiveness in resolving issues, improvement in supporting work-life balance, and the employee feeling valued by the organization as a whole. Lab leadership has been holding staff meetings where discussion revolved around the staff feedback provided in the survey and action plans on how we can improve the staff's perception on key issues.

OLD BUSINESS
Cardiopulmonary:
No old business to report

Diagnostic Imaging:
No old business to report on for Diagnostic Imaging

Laboratory Services:
No old business to report on for the Lab

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DATE: July 2021

TO: Board of Directors
Northern Inyo Healthcare District

FROM: Interim CEO Board Report
Lynda Vance, Project Management Specialist

RE: Department Update

REPORT DETAIL

NEW BUSINESS

Project Clerk and Coordinator: New temporary project clerk has been hired to assist in projects. She will assist until a project coordinator can be hired. The coordinator position is a new position to help in the project management office with the Project Management Specialist. I look forward to following the new recruitment process to hire this new team member.

Cerner Project: With Cerner live in May, we are in the transition period to close out this project and move it to a maintenance phase. In conjunction with this transition, Cerner staff will be onsite in July for a leadership assessments. I have continued to work with the revenue cycle team on challenges.

Project Process updates: Working on streamlining project processes, tracking and reporting.

Projects *(this is a summary of the high-level work, not a complete list)*

Discovery – 14 (Additional Ortho Services, FEEs system, Ortho Clinic Provider office update, Pediatric efficiency project, Compliance office desk update, Surgery/ PACU office changes, Phlebotomy draw area update, HIMS desk ergonomic update, Central Registration office updates, Plant Chiller Upgrade, OR Flooring, Omnicell Cabinets, Grant project tracking, Report Governance tracking)

Actively Working – 10 (Smartsheet upgrade for PHI compliance, Reference Lab price updates, i2i with athena, i2i with Cerner, ADP to Replace Kronos Time areas, Bronco Clinic Restart, Experian Pricing transparency, Cerner Project outside Wipfli Scope, OneContent Centricity upload, Internal Med Office update)

Closing – 5 (Cerner (EHR); Roche/ Cobas POC middleware, Steris/ HexaVue OR EHR integration, GPO replacement to CHC, InQdocs Subscription Service)

Moves Completed - 3 (HR Manager, Project Clerk, RHC exam rooms and Halls)

On Hold Projects - 6 (GHX, Logisticare/Modivcare Transport, SAP Concur, Door Access Badge standard workflow, Myla Lab/Micro Middleware, Employee Health Management System)

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150 Pioneer Lane
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DATE: July 2021

TO: Board of Directors
Northern Inyo Healthcare District

FROM: Interim CEO Board Report
Alison Murray, Acting Director of Human Resources

RE: Department Update

REPORT DETAIL

HR Manager (Marjorie Routt): Effective July 4, 2021, Marjorie Routt took on the role of Manager of Human Resources. A member of NIHD team since 2014, Marjorie has served the District with positions within the Rural Health Clinic, Nursing Administration, and Human Resources. She officially joined the HR Team in January 2020. In her new role, Marjorie will be responsible for the day-to-day operations of the personnel department while supporting the benefits, recruitment, onboarding, education and payroll functions. Marjorie holds a Bachelor of Science degree in Applied Management and is currently pursuing her Professional in Human Resources certification. Marjorie is also an active member of the Society of Human Resource Management. She will be seeking her Master's degree in Business Administration with a primary focus on Human Resource Management and Leadership. Marjorie is excited to serve the District in this new role and looks forward to working alongside all of you to meet the needs of our team and community.

Recruitment (Brittney Watson): Brittney completed her Master's program earning her a Master's of Public Administration. New recruitment process has been launched and Brittney is meeting with leaders to ensure they have proper training.

Onboarding (Sarah Rice): Successfully printed brand new badges for all employees and medical staff. Purchase of Org Chart software in ADP and implementation of program begins this week. Continued audits of current employee requirements (licensure, certification, fit tests, OIG, I-9, TB testing, etc.). Personnel file audit to begin August 2021.

Payroll (Reuben Morgenstein): ADP Payroll go-live complete.

Benefits (Carlos Madera): Ongoing support for employees who have COVID-related absences and other leaves of absences. Implementation of ADP LOA platform launched 7/1/21. Actively working on implementation of retirement plan changes.

HR/District Education (Kylee Fowler): Ongoing support for annual mandatory courses. District-wide civility training launched to all employees this month. Creation of a Manager Emotional Intelligence training underway. Second round of LEAD Academy for leaders will begin in August (20 leaders almost done with current first round of training).

Human Resources (Alison Murray): District-wide compensation review with union contract negotiations (wages) beginning in August. HR Consultant hired to provide the team with additional resources to complete large projects. Employee Handbook policy revisions completed and revised policies being prepared for approvals. Desk audits continuing to be done for every position in HR for strategic planning purposes and completion of Standard Operating Procedures for each role. Employee engagement survey results released to leaders for strategic planning.

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DATE: July 2021

TO: Board of Directors
Northern Inyo Healthcare District

FROM: Interim CEO Board Report
Greg Bissonette, Foundation Executive Director/Grant Writer

RE: Department Update

REPORT DETAIL

FOUNDATION

May and June saw regular board meetings take place with new business comprised of approving an appeal letter to be mailed to all existing donors in lieu of holding the in-person annual award dinner, presentations by the Foundation's financial advisor on investment strategies, and by Oscar Esparza updating the Board on the CAREshuttle program and requesting a new vehicle.

GRANT WRITING

On the Grant Writing side, the District has been engaged in an audit for one of our grants with Sierra Health Foundation, the Opioid Use Disorder — Prevention and Education in Communities of Color grant. The Sierra Health Foundation requested a detailed expenditure list that included all purchases and their amounts corresponding to each approved budget category. That detailed expense list was provided to them and from that, they requested a sampling for full documentation purposes, including timecards, paystubs, invoices, checks and cleared checks. Full documentation was provided on that sampling and I am currently addressing follow-up questions to that documentation. During this investigative process, it was discovered that not all of the approved funding was spent and that may lead to the District returning the unspent funds.

Administration and maintenance for our current grants is ongoing. There were no new grants that were under consideration or being applied for during this period.

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DATE: July 2021

TO: Board of Directors, Northern Inyo Healthcare District

FROM: Interim CEO Board Report
Barbara Laughon, Manager, *Marketing, Communications & Strategy*

RE: Department Update

REPORT DETAIL

Old Marketing Business

- Collaborative work continues with the regional Healthcare Communications coalition for unified messaging around COVID-19 and the subsequent vaccination efforts.
- Work continues with the NIHD Chiefs in regards to the Strategic Plan and other Employee Engagement plans.

New Marketing Business

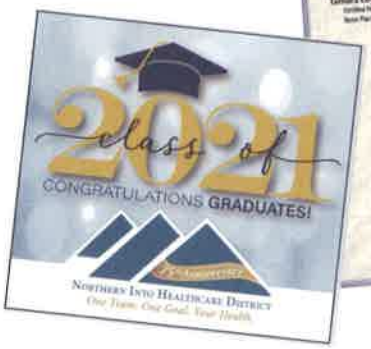
- NIHD has hired a new Digital Marketing Specialist, set to begin August 23. Scot Swan comes to us from Bakersfield, holds a degree in Digital Media Communications, and has solid experience in social media, video and podcasting. Contractor Amanda Long, owner of Social Media Squad, continues to assist with Digital Marketing and will ultimately serve the District as a consultant as Scot gets settled and familiar with NIHD.
- Many thanks to NIHD Breast Surgeon Dr. Cheryl Olson for spending a couple hours with the local media on June 28. We took this scheduling opportunity to introduce Dr. Olson (shown at right during her Sierra Wave Media interview) to our local media partners who help NIHD and its regional partners to make Breast Cancer Awareness Month a community-wide event. Dr. Olson was interviewed by Terrance Vestal of *The Inyo Register,* Ken Harrison of *KIBS/KBOV radio*, and Jesse Steele and MC Hubbard of Sierra Wave Media.

- Planning is beginning for Breast Cancer Awareness Month both internally and with our trusted regional partners. More to come on this.

- Many thanks to NIHD Oncology Patient Navigator Rosie Graves and Mono County Public Health Nurse Margee Neer for speaking on KIBS and KSRW about a collaborative Cancer Survivorship event, "Honoring Life with Cancer." NIHD hosted a booth at the June 27 event to spotlight our services to cancer patients, and Breast surgeon Dr. Cheryl Olson and Registered Dietitian Kalina Gardiner both gave presentations. Sponsoring the event were California Rural Indian Health Board, California Tribal Comprehensive Cancer Control Program, Toiyabe Indian Health Project, Eastern Sierra Cancer Alliance, City of Hope, Mammoth Hospital, and Northern Inyo Healthcare District.

  Contributing their time and energies to the event were NIHD staff members, from left to right, standing: Michelle Garcia, Kelli Davis, Dr. Cheryl Olson, Rosie Graves, and José Garcia. Seated from left: Rich Hayden, Amy Stange, Chrisy Almeida, and Kalina Gardiner. *(Photo by Barbara Laughon/Northern Inyo Healthcare District)*

- We participated in *The Inyo Register*'s Annual Grad Tab, a celebration of local graduates, and the newspaper's celebration of the County Office of Education's Community Star recipients with a spotlight on our pediatric team consisting of Drs. Kristin Meredick, Anne Gasior and Lindsey Ricci, and Certified Pediatric Nurse Practitioners Tami Loy and Colleen McEvoy.



Digital Marketing Update

Top Performing Facebook Posts:

By Lifetime Engagements

By Lifetime Engagements

NorthernInyoH...
Tue 6/22/2021 8:47 am P...

Getting to know, Rose Gonzalez. We took a little break, but we're back to ou

Total Engagements	**1,032**
Reactions	291
Comments	27
Shares	1
Post Link Clicks	56
Other Post Clicks	657

NorthernInyoH...
Wed 6/9/2021 3:07 pm P...

Have questions about the COVID-19 vaccine? In this video, Inyo County Health

Total Engagements	**194**
Reactions	15
Comments	21
Shares	1
Post Link Clicks	46
Other Post Clicks	111

NorthernInyoH...
Fri 6/18/2021 8:06 am PDT

June is Cataract Awareness Month! Cataracts are the leading cause of vision loss

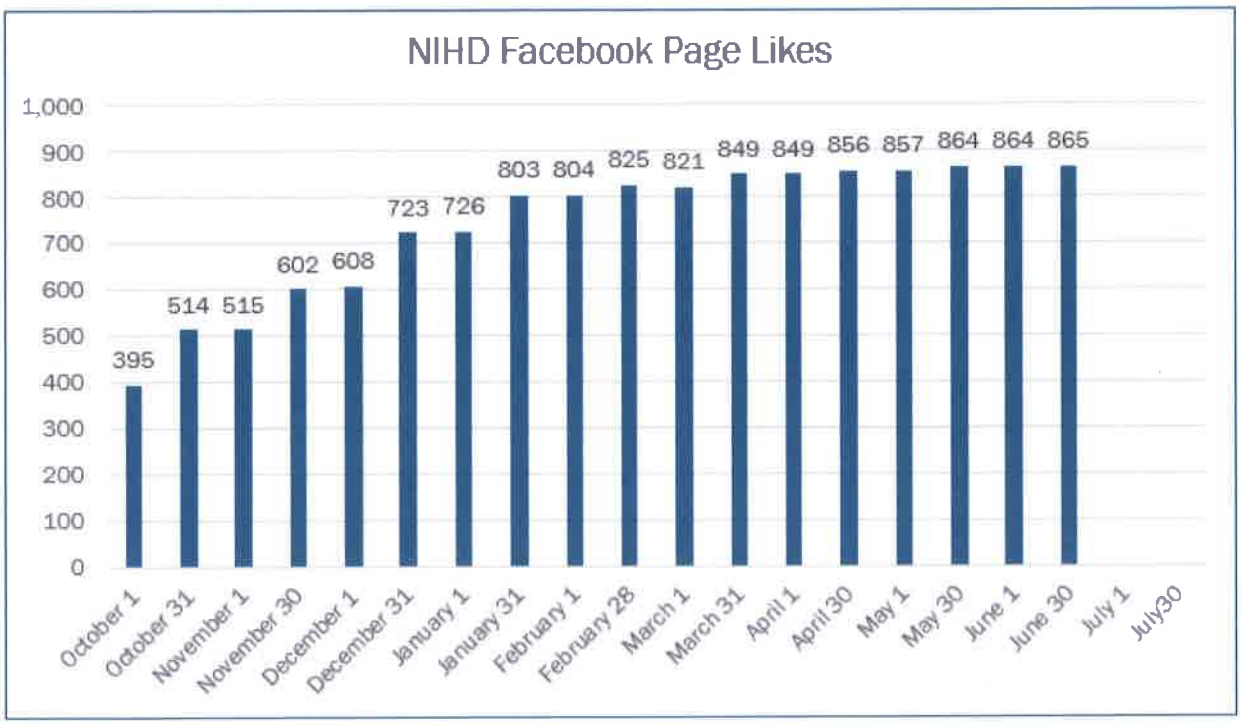
Total Engagements	**178**
Reactions	32
Comments	1
Shares	2
Post Link Clicks	—
Other Post Clicks	143

NorthernInyoH...
Thu 5/13/2021 5:15 pm

As part of National Women's Health Week, NIHD asked Drs. Jeanine Arndal and Martha

Total Engagements	**153**
Reactions	15
Comments	0
Shares	5
Post Link Clicks	3
Other Post Clicks	130

NIHD Facebook Page Overall Likes:

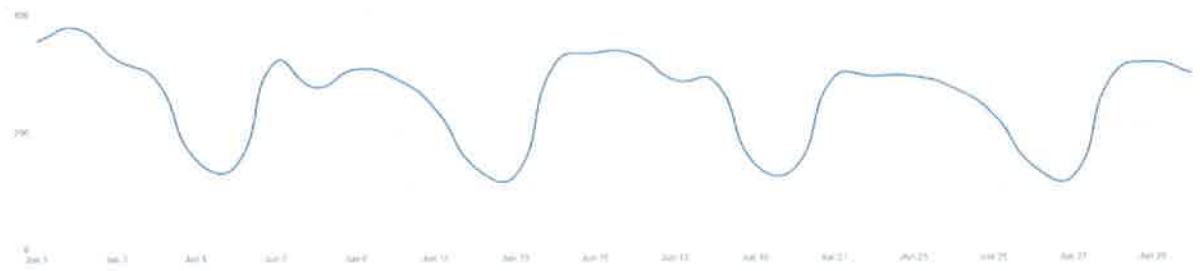


NIHD Website Statistics:

- Visitation:
  - May: 7,442 visitors
  - June: 7,713 visitors
  - Total for 2021: 52,862 with monthly average of 7,551

June Statistics

Visitors



Visitors	Page Views	Avg Visit Duration	Bounce Rate	Avg Visited Pages
7.7k	18.5k ↗	01:36 ↗	58% ↘	2.1 ↗

Device/Browser

44% Mobile | 54% Desktop | 2% Tablet

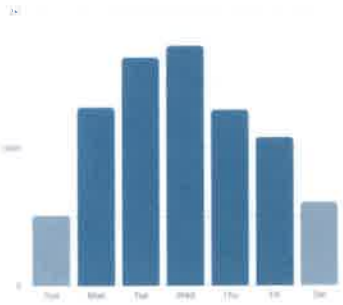
Browser	Visits
Chrome	4,004
Safari	3,094
Edge	594
Internet Explorer	340

Top 5 Traffic Sources

Page	Visits
Organic	5,133
Direct	2,541
Referral	771
Social Media	216
Paid	85

Popular Times

Day | Hour | Day & Hour



New vs Returning Visits

New Visits	Returning Visits
61%	39%

Paid Advertising vs Organic Visits

Paid Visits	Paid	Organic Visits	Organic
85	1.6%	5.1k	98.4%

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

DATE: July 2021

TO: Board of Directors
Northern Inyo Healthcare District

FROM: Interim CEO Board Report
Neil Lynch, Purchasing

RE: Department Update

REPORT DETAIL

NEW BUSINESS
Purchasing will wrap up Cerner item master cleanup, continue GPO transition, and begin pre-work with GHX for EDI integration with Cerner.

OLD BUSINESS
Purchasing continues to work on Cerner preparation, workflow, and integration. PPE supply chain is stable. GPO transition is in progress.

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(760) 873-5811

DATE: July 2021

TO: Board of Directors
Northern Inyo Healthcare District

FROM: Interim CEO Board Report
Rich Miears, Manager of Environmental Services & Laundry

RE: Department Update

REPORT DETAIL

ENVIRONMENTAL SERVICES

The Environmental Service team operates Monday –Sunday 400am to 1230am. Our staff cleans areas from Birch Street, to the Joseph House to our OR's and PACU. We currently have 24 fulltime employees in ES with one vacant spot to fill.

LAUNDRY

The Laundry team operates Monday –Friday from 500am to 1530pm. We currently have 5 employees with one staff member out on LOA that stagger starts thru the day. No issues with our chemical line. All equipment is working well. Our staff is doing great.

OTHER INFORMATION

Talent Pool: Talent Pool is currently at 3 employees with 7 spots to fill. We haven't had an applicant in ADP since the end of April. We are trying to use Sierra Employment to help us fill in spots, but no luck so far.

Screeners: We have 4 temporary screeners and 2 back up screeners with one vacant spot to fill from Sierra Employment. The screeners cover Radiology 5 days per week, Main and the ED entrance 7 days per week. We have a new back–up screener coming 7/12/2021. Our screeners are all really nice and do a great job!

Northern Inyo Healthcare District

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

Date: 7/9/21

To: Board of Directors

From: Joy Engblade, MD, MMM, FACP, Chief Medical Officer

Re: Bi-Monthly CMO report

Medical Staff Department update

Updates regarding Physician Recruiting:

Hopefully some of you have the chance to meet Dr. David Coffman a few weeks ago. He is a general surgeon coming from Maine. He has verbally accepted an offer from us! We are early in the process but hoping for a November start date.

Dr. Jane Yoon, pediatrician will be delayed in starting. We are hoping for an August 9th start date.

Dr. Siyavash Fooladian, anesthesia will be providing locum coverage for us, starting in late August.

We continue to recruit for an Internal Medicine physician.

Pharmacy Department update

As you know, we have been working on the pharmacy construction project for many years. In past years, the Board of Pharmacy (BOP) has given us a waiver to continue our current process for sterile compounding of hazardous drugs while under construction. They deemed our current process safe but not fully compliant with BOP regulations. Unfortunately, the construction project has had many delays. We had a visit from the Board of Pharmacy Inspector, JK Fujimoto on June 23rd. Overall the inspection went well but, as expected, we will no longer be able to compound hazardous drugs on site. With the partnership of Dwayne's Friendly Pharmacy, we are working on a transition to move our sterile compounding to Dwayne's site. In the meantime, construction on the pharmacy project continues.

We have received a forgivable loan from Anthem Blue Cross, to help us establish our Antibiotic Stewardship Program. This program is multifaceted and focuses on the appropriate use of antibiotics across the District. We have had an Antibiotic Stewardship Program for several years, but this funding has allowed us to contract with a group called ID Connect, who specialize in guiding Antibiotic Stewardship Programs to be more efficient and effective.

Quality Department update

The Quality and Informatics department continues to be busy with their multiple responsibilities. This includes:

- Supporting the District with the Cerner transition.
- Pulling reports out of Cerner with 11 more employees planning to undergo training.
- Regulatory reporting with reporting the Inpatient Quality Reporting Program (IQR) for the Hospital-acquired Infection (HAI) requirements for April-June 2021 before July 30th deadline.
- Educating staff regarding survey readiness with regular updates at the Safety Huddle.
- Evaluting HEDIS and QIP measures and developing new workflows in Cerner to better meet the measures.

Not only does the department do a large amount of reporting, they have also secured several small and medium sized grants to help offset costs associated with antibiotic stewardship, data integration, and the Pre-operative and post-discharge clinic.

Covid 19

We continue to have weekly Incident Command meetings and we are making plans to get back to Full Operations. We continue to encourage everyone to get Covid 19 vaccinated. We have transitioned to a single dose Covid 19 vaccine clinic in the Rural Health Clinic with plans to expand vaccine access to the Pediatric Clinic. We continue to wear masks around the District for staff and patients, per CDPH guidelines.

Physician Compensation

The ad hoc committee has now established a Physician compensation goal and philosophy. The next step is to discuss the various compensation models with the Physicians across the District and get feedback. We will also be working to pull data out of Cerner to provide to the Physicians.

Cerner Transition

Overall, the Cerner transition has been positive with the expected bumps along the road. We continue to work on workflows for medication refills, Patient Portal, and lab orders. Thanks for being patient with us.

CMO Role

As part of the strategic plan, the Board has asked for a more defined CMO role. I have developed an outline of the CMO role with recommendations from Dr. Sierra Bourne, Chief of Staff and Dianne Picken, Director Medical Staff Office. I anticipate that this role will evolve as needs in the District change. I'm also open to feedback, so Board members, please let me know if this is the information you seek.

<u>Executive Team</u>

- Member of the Executive Team
- Communicate District initiatives with Medical Staff and Providers
- Bring ideas from Medical Staff and Providers to Executive attention as appropriate
- Attend Board Meetings and other District or community meetings as appropriate

Pharmacy Department

- Support Director and department needs
- Oversee pharmacy operations
- With Exec team, oversee pharmacy construction project

Medical Staff Department

- Support Director
- Prioritize Medical Staff projects
- Provider Recruiting, coordinate with Medical Staff office for site visit
- Coordinate onboarding with Med Staff office and receiving department
- Provider retention
- Provider wellness, in partnership with Chief of Staff (COS)
- Provider education in partnership with Vice COS
- Attend MEC meetings, provide District updates and gain feedback from MEC members
- Partner with COS on Medical Staff and District initiatives; discuss issues on a case by case basis regarding best domain, i.e. Medical Staff issue vs CMO issue

Quality Department/Clinical Informatics

- Support Director
- Champion Quality initiatives across the District and assists with implementation
- Chair Quality Council
- Support Clinical Informatics
- Champion EMR from Provider standpoint
- Assist Providers with clinical workflows in EMR
- Participate in survey readiness
- Champion Infection Prevention across the District

Risk

- Patient safety champion
- Participate in UOR process
- Communicate with Beta
- Work closely with Compliance
- Work with Legal

Physician contracts

- Compensation Committee, member
- Structure contracts across the District
- Negotiate with physician groups
- Monitor adherence to contracts, intervene when necessary
- Approve payment to physicians via payroll

Medical Directors

- Provide evaluations and feedback to Medical Directors

Clinical Oversight

- Provide operational support/ clinical oversight to clinical areas in partnership with directors, managers, assistant managers
    - Rural Health Clinic
    - Rural Health Women's Clinic
    - NIA Clinics
        - Internal Medicine
        - Orthopedics
        - Pediatrics
        - General Surgery
        - Specialty Clinic
        - Virtual care clinic
    - Emergency Department
    - Hospital Medicine Department
    - Radiology Department
    - Anesthesia Department
    - Pathology Department
    - Cardiopulmonary Department
        - TEE program
- Partner with HIM to ensure proper documentation and timeliness
- Assist with developing Clinical Guidelines
- Partner with departments to develop new services lines or bring efficiency to existing service lines
- Monitor the local, state and national landscape for opportunities to improve health care delivery

<u>Clinical work (individualized based on specialty of CMO)</u>

- Member of Medical Staff, in good standing
- Ongoing clinical work, based on specialty; for myself as a hospitalist, working 5-6 shifts (12 hour) per month
- Cardiopulmonary coverage 1 week per month (EKG, stress tests, PFT's, Zio, Holter)
- Outpatient infusion clinical support; point person for outside oncologists

NORTHERN INYO HEALTHCARE DISTRICT

Improving our communities, one life at a time.
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150 Pioneer Lane
Bishop, California 93514

(760) 873-5811 Ext. 3415

DATE: July 2021

TO: Board of Directors, Northern Inyo Healthcare District

FROM: Justin Nott, Med/Surg and ICU Manager

RE: Department Update

REPORT DETAIL

Med/Surg and ICU

On med/surg and in the ICU we continue to focus on ensuring that all areas of the Cerner implementation are going smoothly. Staff are completing and turning into management documentation self-audits which allows them to ensure that all aspects of charting are being completed. We are also closely monitoring all daily charges for all med/surg and ICU cost centers to ensure that charges are flowing appropriately.

Med/surg staff have just completed their annual skills day. This involves evaluating all nursing staff on key competencies. This serves as an opportunity for nursing staff to demonstrate their competencies with different nursing procedures and also serves as a refresher for the skills that are not frequently preformed on the floor.

ICU staff will be completing their skills day within the next couple months.

We have just purchased an ICU bed that allows us to provide the best possible care to our patients. One of the key new features of this ICU bed is automatic percussion and vibration, which improves lung function by loosening secretions leading to improved airway clearance. It also includes a low air loss mattress and an automatic rotation feature which are both ideal for patients with a high risk for skin breakdown.

We have hired a new ICU clinical staff educator, Juya Ghanaie. Juya has an extensive background as an ICU RN and has worked with the Association of Critical Care Nurses (AACN) as a volunteer ambassador and as an auditor of their education materials.

We are currently exploring the possibility of developing a peripherally inserted central catheter (PICC) team to ensure that there is always staff available to insert a PICC line when it is medically necessary.

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Bishop, California 93514
(760) 873-5811 Ext. 3415

DATE: July 2021
TO: Board of Directors, Northern Inyo Healthcare District
FROM: Ann Wagoner, Perioperative and Infusion Unit
RE: Department Update

REPORT DETAIL

Old Business

Continued work with Cerner to ensure charting and charging are complete daily in the OR, PACU, and Infusion. Chemotherapy charting has been particularly challenging.

New Business

Donovan Otto, OR RN is retiring after over 34 years here at NIHD. Donovan started in the ICU when he moved to Bishop and trained to become an OR RN several years later. He will be missed – no doubt about it! We are still recruiting experienced OR RNs.

A surgery huddle in front of the white board in the OR has been initiated – these are quick 5 minute huddles (starting at 0705) to cover the day's cases including equipment, safety, and staffing.

Preoperative Covid testing has decreased as we have been able to validate full Covid vaccination for most of the surgical patients – this has simplified the preoperative preparation which is appreciated by our patients and the staff.

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(760) 873-5811 Ext. 3415

DATE: July 2021
TO: Board of Directors, Northern Inyo Healthcare District
FROM: Jenny Bates
RE: Department Update

REPORT DETAIL

Old Business

The community's health and well-being is our priority and the Emergency Department is always available and open to provide safe and essential emergency care. The ED continues to operate under the District's Covid emergency preparedness plan and we ensure the highest levels of safety are observed. We will continue to observe State guidelines, having patients and visitors wear masks at all times while in the ED. The ED team is well aware of the Delta variant of COVID-19 and continue to triage and treat patients accordingly.

New Business

1. Cerner conversion has gone well for the ED staff and physicians. We are still working closely with Pharmacy to resolve medication scanning issues, but the team has adapted well and we have had very few hiccups throughout the conversion process.
2. The ED team received a 3% discounted rate from Beta, by meeting almost all of our Sepsis requirements. The Sepsis initiative will carry over into next year, where we hope to see our Sepsis identification rates improve and physician compliance in using the Sepsis bundles improve.

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(760) 873-5811 Ext. 3415

DATE: July 2021

TO: Board of Directors, Northern Inyo Healthcare District

FROM: Summer Gilstrap, Interim Perinatal Assistant Nurse Manager

RE: Department Update

REPORT DETAIL

Old Business

Cerner go-live was a success. Still working on making changes to Cerner to make our workflow simpler.

New Business

The Perinatal unit has completed the BETA tier 2, and was awarded the full credit in achieving both tier 1 and tier 2. It has been a full schedule with the increased learning required for BETA, Cerner go-live (all the training that went with preparing for go-live), and delivering babies! The unit currently has all travel nurses on night-shift, but we have hired 2 RN's and 1 of our current RN's will complete her orientation before end of the year. We are also interviewing 3 more experienced L&D RNs, so the forecast is hopeful to have majority of our own staff, if not fully staffed by permanent RNs on the OB unit.

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DATE: July 2021
TO: Board of Directors, Northern Inyo Healthcare District
FROM: Robin Christensen Director Quality/ Infection Prevention
RE: Department Update

REPORT DETAIL

REPORT DETAIL

Old Business

Clinical Informatics: The Clinical Informatics team continues to work on Cerner projects and partner with departments across the District. The team participates in Cerner solution weekly calls and training of all new providers and clinical staff. In addition, the Informatics team continues to provide support to all departments and providers.

Employee Health: Continues to review employee health records to ensure compliance with immunizations and titers. Employee Health and Rehab continue to collaborate with ergonomic rounding within NIHD departments.

Infection Prevention: Continues to work with Inyo County Health Department with COVID-19 related activities. The team continues to monitor and provide updates on local, state, and federal guidelines and recommendations. In addition, we continue to work with Cerner and in the Infection Prevention application that offers an infection control solution that includes analysis, regulatory reporting, and surveillance capabilities to help identify patients at risk for hospital-acquired infections and drug-resistant organisms. Cerner will be providing support with the IP department six months after go-live.

New Business

Clinical Informatics: The team continues to work with all departments to help improve workflow efficiency and promote the adoption Cerner.

Employee Health: Continues to work collaboratively with Human Resources and RHC to streamline the employee onboarding process. Employee Health is working with ED leadership with workflows relating to employee exposure.

Infection Prevention: Infection Prevention continues working with Cerner with workflow or identified issues. Cerner's Infection Prevention application has allowed the IP team to complete real-time chart audits for potential hospital-acquired infections or patients at risk. Infection Prevention works closely with Human Resources and Compliance to ensure that NIHD meets COVID-19 regulatory guidelines relating to employees and patients.

Survey Readiness: The weekly Accreditation Readiness Team meeting is resuming on July 14th, 2021, led by the Quality Department. The Survey readiness team will start focusing on tracer activity to help identify risks that may impact patient safety and quality standards. In addition, the team continues to collect the required documents and policies, and procedures that the surveyors will request upon entry to the District.

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(760) 873-5811 Ext. 3415

DATE: July 2021

TO: Board of Directors, Northern Inyo Healthcare District

FROM: Jose Garcia, *Language Access Services Manager*

RE: Department Update

REPORT DETAIL

Old Business

Replacing outdated iPads used for video remote interpreting will be completed in the next 30 days.

The Department assisted with the Cerner implementation by providing translated forms for the eSignature process, and ensuring the District is able to collect the patients' demographic data required by law.

The Department continues supporting the District's COVID-19 response by translating forms, information and marketing materials.

New Business

The Department has deployed 20 new iPads for video and voice remote interpreting. New iPads, through their individual application, can connect to any of the three different companies the District contracts with for video, and over the phone interpreting: CyraCom, the Health Care Interpreter Network (HCIN), and LanguageLine. These iPads provide NIHD workforce the ability to connect to a video or voice remote interpreter in more than 240 different languages, 24 hours a day, seven days a week.

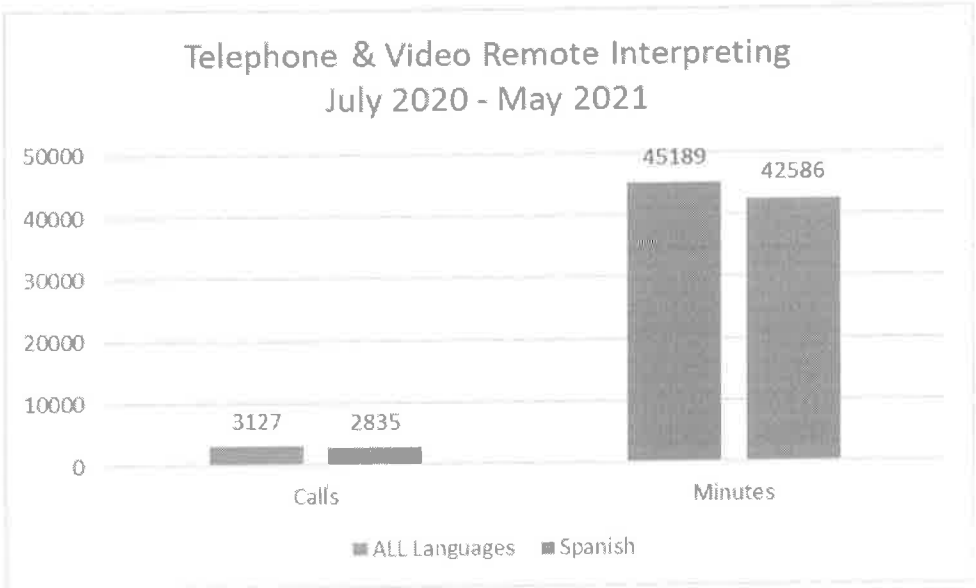
This update includes a partial Departmental annual report for the 2020/2021 fiscal year. The final report will be completed as soon as the June 2021 data becomes available. During this time period, the District's commitment to providing meaningful access to ALL patients, through language or communication assistance (in-person, over the phone, and through video remote interpreting), includes delivering services in the following languages (in alphabetical order): American Sign Language (ASL), French, Gujarati, Hindi, Japanese, Mandarin, Mongolian, Polish, Spanish, Thai, and Vietnamese.

The following tables and charts illustrate the partial report for all interpreting services provided during the 2020/2021 FY, including the number of telephone/video calls made, as well as the amount of time spent interpreting for each of the three different service providers.

Telephone and video remote interpreting for ALL languages, including Spanish, have reached 3,127 calls. Spanish, with 2,835 calls, represents 90.6% of all calls made; however, its utilization (42,586 minutes) accounts for 94.2% of all interpreting done through the contracted services.

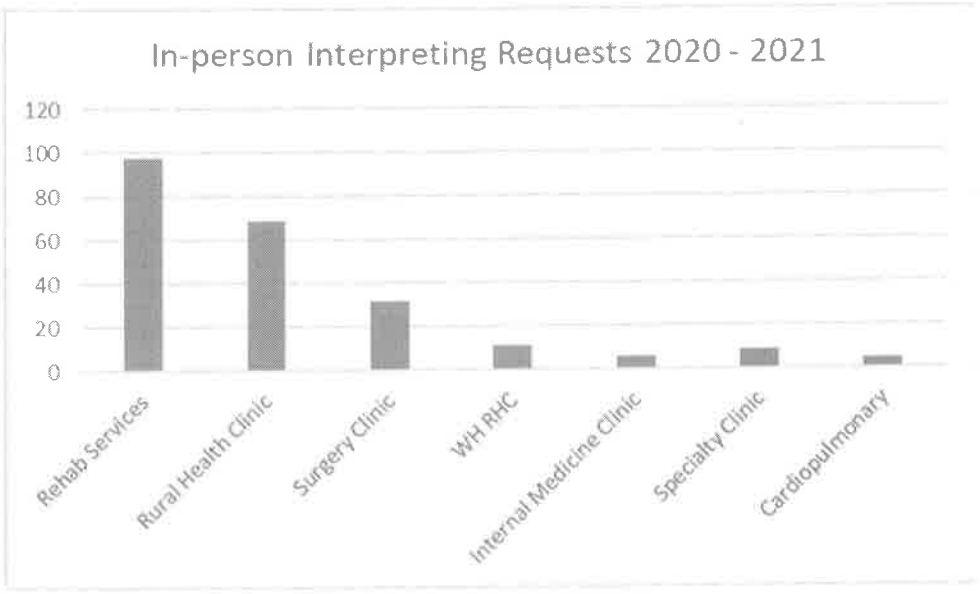
Telephone & Video Remote Interpreting **ALL Languages** July 2020 – May 2021		
Service Provider	**# of Calls**	**Minutes**
CyraCom	2304	30,962
HCIN	756	12,957
LanguageLine	67	1,270
TOTAL	**3,127**	**45,189**

Telephone & Video Remote Interpreting **SPANISH Only** July 2020 – May 2021		
Service Provider	**# of Calls**	**Minutes**
CyraCom	2021	28,591
HCIN	750	12,783
LanguageLine	64	1,212
TOTAL	**2,835**	**42,586**



Additionally, The District's Interpreter Services Call Center RECEIVED 5,115 service calls (from within the HCIN network), providing 67,712 minutes of interpreting services in Spanish during the same time period: July 1st, 2020 through May 31st, 2021.

The Department provides on-demand in-person interpreting services, and by appointment through the utilization of the Interpreter Intelligence scheduling system; in-person interpreting services are provided throughout the District. During same time period, July 2020 to May 2021, through the scheduling system, the department received 221 interpreting requests.



Written communication is as important as verbal communication. The Language Access Services, and Compliance Departements have been working together ensuring patients' forms deemed Vital Documents, significant communications and significant publications, are translated into Spanish. From July 2020 to May 2021, 108 translations were completed.

Sincerely,

Jose Garcia, CD, CHI

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Bishop, California 93514

(760) 873-5811 Ext. 3415

DATE: July 2021

TO: Board of Directors, Northern Inyo Healthcare District

FROM: Allison Partridge, RN, MSN, Chief Nursing Officer

RE: Department Update

REPORT DETAIL

Old Business

COVID-19

The District as a whole continues to manage daily the challenges that COVID-19 has presented. We continue with weekly incident command meetings. We review the District's current state of preparedness during incident command and identify any areas or opportunities that require additional review and or problem-solving. Our Infection Prevention Team continues to monitor and provide updates on both national and local status and recommendations. NIHD continues to partner with Inyo County Public Health in the administration of COVID-19 vaccines and has recently transitioned to single dose clinics. This offers flexibility to the community in that they can register for either a 1st or 2nd dose at a time and location that works for them.

New Business

Cerner

The district continues to work through the acclimation process for Cerner. It has been wonderful to see the sharing of knowledge as we transition from "how do I use the system" to "how do I optimize the system?" Cerner continues to provide exceptional support in partnering with our teams in problem solving workflows and any issues that arise.

Annual Competency Validation

Skills Days are underway in each of the clinical departments. These events are led by our clinical staff educators (CSE). Each year the CSE's complete a department assessment to identify the skills that will be covered in these events. The skills are selected based on several criteria: high risk low volume, regulatory requirement, team request, new service line/procedure. There is a great deal of preparation and planning that goes into these events and they are very well received by our teams.

Employee Engagement Survey

Each of our Department Leaders is meeting with the teams they support to review and action plan the employee engagement survey. They are collaborating with their teams to better understand our team member's perspective and select areas of focus that are important to their departments.

Efficiency Work

Efficiency work continues at the clinics. Our expert partner is back onsite with a focus on translating learnings to the other clinics and evaluating ways to optimize workflows post Cerner.

Each department leader has submitted a department specific report to follow.

Overview: April billed charges were over budget by $7.4M.

April YTD is $142M compared to budget of $111M.

	Charges	Budget
January 2020	16,271,574	14,095,678
February 2020	13,886,140	13,186,280
March 2020	12,141,181	14,095,678
April 2020	6,887,085	13,640,980
May 2020	10,687,793	14,095,678
June 2020	13,443,103	13,640,980
July 2020	14,939,822	11,862,737
August 2020	13,989,077	11,533,455
September 2020	14,652,230	10,715,581
October 2020	14,539,677	12,487,777
November 2020	12,978,658	11,166,411
December 2020	15,139,508	11,863,789
January 2021	13,060,873	13,778,625
February 2021	12,879,445	11,639,016
March 2021	15,505,494	9,383,779
April 2021	14,266,929	6,870,945
May 2021	14,819,908	10,854,286

Gross Accounts Receivables in Athena total 27.3M and Cerner 6.6 totaling 33.9 in May, down from $34.2M at the end of April.

Gross Legacy AR was written off in 2020 Audit.

Salaries and Wages for hospital operations were down up from April.

Actual Salaries percentage is 28% compared to Budget of 34% of Net Patient Revenues.

	Salaries & Wages	Cost Per Day
January 2020	2,169,008	69,968
February 2020	2,144,412	73,945
March 2020	2,306,958	74,418
April 2020	1,999,126	66,638
May 2020	2,082,141	67,166
June 2020	2,130,598	71,020
July 2020	2,244,335	72,398
August 2020	2,263,144	73,005
September 2020	2,142,762	71,425
October 2020	2,227,959	71,870
November 2020	2,161,607	72,054
December 2020	2,596,191	83,748
January 2021	2,097,117	67,649
February 2021	2,104,702	75,168
March 2021	2,316,452	74,724
April 2021	2,260,211	72,910
May 2021	2,405,288	77,590

May 2021 Financial Results: Revenues trended higher than budget in May

Athena costs were up 111k vs 97k monthly average, Pensions costs in total 200k higher than budget.

Medical, Dental, Vision expense was up by 750k for April. Will have similar monthly expense for rest of year.

Labcorp testing of 200-400k per month, and G&A costs were 128k higher than budget-professional fees.

FY2021

Unit of Measure	July 2020	August 2020	September 2020	October 2020	November 2020	December 2020	January 2021	February 2021	March 2021	April 2021	May 2021
Cash, CDs & LAIF Investments	56,272,847	55,214,586	52,965,190	53,539,618	50,491,090	47,413,188	44,556,758	42,840,110	48,843,100	45,968,807	44,355,140
Days Cash on Hand	226	225	220	218	153	143	162	150	166	139	142
Gross Accounts Receivable	46,949,619	48,287,230	45,195,462	39,988,328	38,951,324	41,570,823	39,066,151	38,262,376	36,741,318	34,157,246	36,243,401
Average Daily Revenue	481,930	466,595	473,708	472,527	464,702	468,886	462,027	461,791	466,134	467,064.85	468,082.45
Gross Days in AR	97.42	103.49	95.41	84.63	83.82	88.66	84.55	82.86	78.82	73.13	77.43
Key Statistics											
Acute Census Days	263	275	232	203	210	310	246	198	216	178	203
Swing Bed Census Days	42	44	34	8	20	8	16	28	15	7	3
Total Inpatient Utilization	305	319	266	211	230	318	262	226	231	185	206
Avg. Daily Inpatient Census	9.8	10.3	8.9	6.8	7.7	10.3	8.5	8.1	7.5	6.2	6.9
Emergency Room Visits	691	639	581	624	516	504	524	480	583	608	709
Emergency Room Visits Per Day	22	21	19	20	17	16	17	15	19	20	23
Operating Room Inpatients	31	26	39	23	27	18	21	12	10	17	25
Operating Room Outpatient Cases	81	74	74	74	79	90	38	68	89	112	76
Observation Days	44	32	46	48	39	28	37	37	68	63	55
RHC Clinic Visits	2,670	2,614	2,535	2,730	2,490	2,758	2,954	3,282	3,533	2,557	2,026
NIA Clinic Visits	1,792	1,794	1,918	1,681	1,555	1,642	1,290	1,408	1,640	1,604	1,379
Outpatient Hospital Visits	4,431	3,558	4,139	3,560	3,531	3,837	4,140	4,188	5,139	4,903	4,290
Hospital Operations											
Inpatient Revenue	3,201,903	3,105,168	3,469,234	2,495,776	2,626,028	4,084,113	3,318,446	2,323,227	2,335,831	2,270,420	2,674,728
Outpatient Revenue	10,836,050	10,143,216	10,036,379	10,848,725	9,124,901	10,195,061	8,853,180	9,762,269	12,073,580	11,070,780	10,891,625
Clinic (RHC) Revenue	901,868	740,693	1,146,616	1,195,178	1,227,729	896,334	889,247	793,949	1,096,083	925,729	1,253,555
Total Revenue	14,939,822	13,989,076	14,652,230	14,539,679	12,978,658	15,175,508	13,060,873	12,879,445	15,505,494	14,266,929	14,819,908
Revenue Per Day	481,930	451,261	488,408	469,022	432,622	489,533	421,318	459,980.17	500,177.23	475,564.29	478,061.55
% Change (Month to Month)		-6.36%	8.23%	-3.97%	-7.76%	13.15%	-13.93%	9.18%	8.74%	-4.92%	0.53%
Salaries	2,244,335	2,263,143	2,142,762	2,227,959	2,161,607	2,596,191	2,097,117	2,104,702	2,316,452	2,260,211	2,405,288
PTO Expenses	221,460	234,078	225,291	249,855	258,672	124,932	370,227	234,842	248,272	259,667	198,965
Total Salaries Expense	2,465,795	2,497,221	2,368,053	2,477,814	2,420,279	2,721,123	2,467,344	2,339,544	2,564,724	2,519,878	2,604,253
Expense Per Day	79,542	80,556	78,935	79,929	80,676	87,778	79,592	83,555	82,733	83,996	84,008.17
% Change		1.27%	-2.01%	1.26%	0.93%	8.80%	-9.33%	4.98%	-0.98%	1.53%	0.01%
Operating Expenses	6,681,333	6,598,376	6,443,189	6,700,067	7,141,845	9,200,728	7,008,652	6,808,627	7,892,831	7,801,114	7,486,263
Operating Expenses Per Day	215,527	212,851	214,773	216,131	238,062	296,798	226,086	243,165.24	254,607	260,037	241,492.37
Capital Expenses	118,728	243,872	146,626	47,518	24,398	47,743	1,042,766	27,227	13,867	196,773	42,480
Capital Expenses Per Day	3,830	7,867	4,888	1,533	813	1,540	33,638	972.39	447.33	6,559	1,416
Total Expenses	8,056,147	7,962,211	7,811,638	7,971,619	8,554,701	10,596,071	8,352,961	7,928,865	9,134,536	9,586,642	9,072,800
Total Expenses Per Day	259,876	256,846	260,388	257,149	285,157	341,809	269,450	283,174	294,662	319,554.74	292,670.96
Gross Margin	2,200,258	1,770,841	1,569,390	1,411,167	667,943	(182,482)	676,805	196,229	366,044	7,839,446	2,320,500
Debt Compliance											
Current Ratio (ca/cl) > 1.50	1.51	1.49	1.47	1.47	1.53	1.52	1.42	1.36	1.43	1.51	1.55
Quick Ratio (Cash + Net AR/cl) > 1.33	1.41	1.38	1.36	1.37	1.41	1.39	1.29	1.23	1.33	1.41	1.19
Days Cash on Hand > 75	226	225	220	218	185	143	162	150	166	139	142

	July 2020	August 2020	September 2020	October 2020	November 2020	December 2020	January 2020	February 2021	March 2021	April 2021	May 2021	YTD
Total Net Patient Revenue	8,687,629	8,263,810	8,097,629	8,115,806	7,769,540	6,200,317	7,685,457	7,004,855	8,258,874	7,429,719	8,448,097	85,961,734
IGT Revenues										8,210,841	1,358,667	9,569,508
Total Patient Revenue	8,687,629	8,263,810	8,097,629	8,115,806	7,769,540	6,200,317	7,685,457	7,004,855	8,258,874	15,640,560	9,806,763	95,531,241
Cost of Services												
Salaries & Wages	2,244,335	2,263,143	2,142,710	2,225,170	2,161,607	2,595,806	2,097,117	2,104,702	2,316,452	2,260,211	2,405,288	24,816,542
Benefits	1,225,408	1,444,212	1,619,767	1,486,044	1,593,888	1,473,236	1,676,074	1,403,697	1,733,968	2,126,588	2,368,317	18,151,200
Professional Fees	1,675,216	1,595,368	1,519,996	1,735,617	1,989,323	2,046,081	2,153,241	1,928,594	2,092,969	1,982,469	1,992,931	20,711,804
Pharmacy	338,142	338,490	381,958	300,720	263,434	417,203	353,199	372,421	474,852	347,263	30,395	3,618,075
Medical Supplies	363,541	223,970	295,749	351,185	784,257	271,735	158,048	429,519	418,016	426,798	238,484	3,961,301
Hospice Operations	-	-	-	-	-	-	-	-	-	-	-	-
Athena EHR System	85,401	86,356	129,219	145,890	103,674	89,294	70,400	68,680	228,428	143,678	110,920	1,261,940
Other Direct Costs	490,492	504,985	432,218	479,088	521,573	622,365	500,574	501,014	628,147	514,106	339,928	5,534,488
Total Direct Costs	6,422,535	6,456,524	6,521,615	6,723,714	7,417,757	7,515,719	7,008,652	6,808,627	7,892,831	7,801,114	7,486,263	78,055,351
Gross Margin	2,265,095	1,807,286	1,576,014	1,392,093	351,782	(1,315,402)	676,805	196,229	366,044	7,839,446	2,320,500	17,475,890
Gross Margin %	26.07%	21.87%	19.46%	17.15%	4.53%	-21.22%	8.81%	2.80%	4.43%	50.12%	23.66%	18.29%
General and Administrative Overhead												
Salaries & Wages	341,944	326,215	323,043	340,706	348,981	335,952	331,284	299,846	356,050	344,356	345,608	3,693,986
Benefits	280,576	230,351	312,949	273,351	315,017	276,133	253,272	225,528	(5,740)	395,643	408,513	2,965,593
Professional Fees	164,077	187,479	170,202	172,012	230,121	266,252	294,396	150,882	437,286	790,953	384,972	3,248,632
Depreciation and Amortization	348,949	350,898	350,981	351,061	351,069	351,787	332,743	333,225	322,062	329,298	339,866	3,761,938
Other Administrative Costs	135,601	182,537	152,383	134,422	174,792	208,638	132,613	110,757	132,047	(74,722)	107,579	1,396,647
Total General and Administrative Overhe	1,271,147	1,277,479	1,309,559	1,271,552	1,419,981	1,438,762	1,344,309	1,120,238	1,241,705	1,785,528	1,586,536	15,066,795
Net Margin	993,948	529,807	266,455	120,541	(1,068,198)	(2,754,164)	(667,504)	(924,009)	(875,661)	6,053,918	733,964	2,409,095
Net Margin %	11.44%	6.41%	3.29%	1.49%	-13.75%	-44.42%	-8.69%	-13.19%	-10.60%	38.71%	7.48%	2.52%
Financing Expense	121,150	119,676	114,676	134,694	146,215	115,920	115,226	113,409	115,513	109,058	100,798	1,306,334
Financing Income	56,337	56,337	56,337	56,337	1,076,210	56,337	56,337	56,337	56,337	56,337	172,412	1,755,654
Investment Income	50,812	29,010	34,393	52,775	23,405	34,188	34,130	20,452	15,723	21,543	52,391	368,823
Miscellaneous Income	251,916	86,266	(10,970)	71,822	310,748	97,626	48,457	174,171	123,663	58,280	67,617	1,279,595
Net Surplus	1,231,863	581,743	231,540	166,781	195,949	(2,681,933)	(643,806)	(786,458)	(795,451)	6,081,020	925,586	4,506,834

	May 2021
Assets	
Current Assets	
Cash and Liquid Capital	6,402,401
Short Term Investments	37,145,336
PMA Partnership	326,892
Accounts Receivable, Net of Allowance	16,097,113
Other Receivables	13,269,588
Inventory	3,099,949
Prepaid Expenses	1,101,931
Total Current Assets	77,443,211
Assets Limited as to Use	
Internally Designated for Capital Acquisitions	-
Short Term - Restricted	2,674,718
Limited Use Assets	
LAIF - DC Pension Board Restricted	1,199,780
DB Pension	22,177,561
PEPRA - Deferred Outflows	8,320
PEPRA Pension	79,568
Total Limited Use Assets	23,465,229
Revenue Bonds Held by a Trustee	3,233,401
Total Assets Limited as to Use	29,373,348
Long Term Assets	
Long Term Investment	1,506,919
Fixed Assets, Net of Depreciation	74,869,272
Total Long Term Assets	76,376,190
Total Assets	183,192,750
Liabilities	
Current Liabilities	
Current Maturities of Long-Term Debt	1,479,105
Accounts Payable	2,008,002
Accrued Payroll and Related	12,528,562
Accrued Interest and Sales Tax	410,646
Notes Payable	8,927,628
Unearned Revenue	20,581,876
Due to 3rd Party Payors	1,150,000
Due to Specific Purpose Funds	(25,098)
Other Deferred Credits - Pension	3,043,153
Total Current Liabilities	50,103,873
Long Term Liabilities	
Long Term Debt	37,634,947
Bond Premium	383,696
Accreted Interest	13,751,980
Other Non-Current Liability - Pension	40,901,437
Total Long Term Liabilities	92,672,060
Suspense Liabilities	(1,913,044)
Uncategorized Liabilities	535,416
Total Liabilities	141,398,306
Fund Balance	
Fund Balance	34,612,929
Temporarily Restricted	2,674,680
Net Income	4,506,834
Total Fund Balance	41,794,444
Liabilities + Fund Balance	183,192,750

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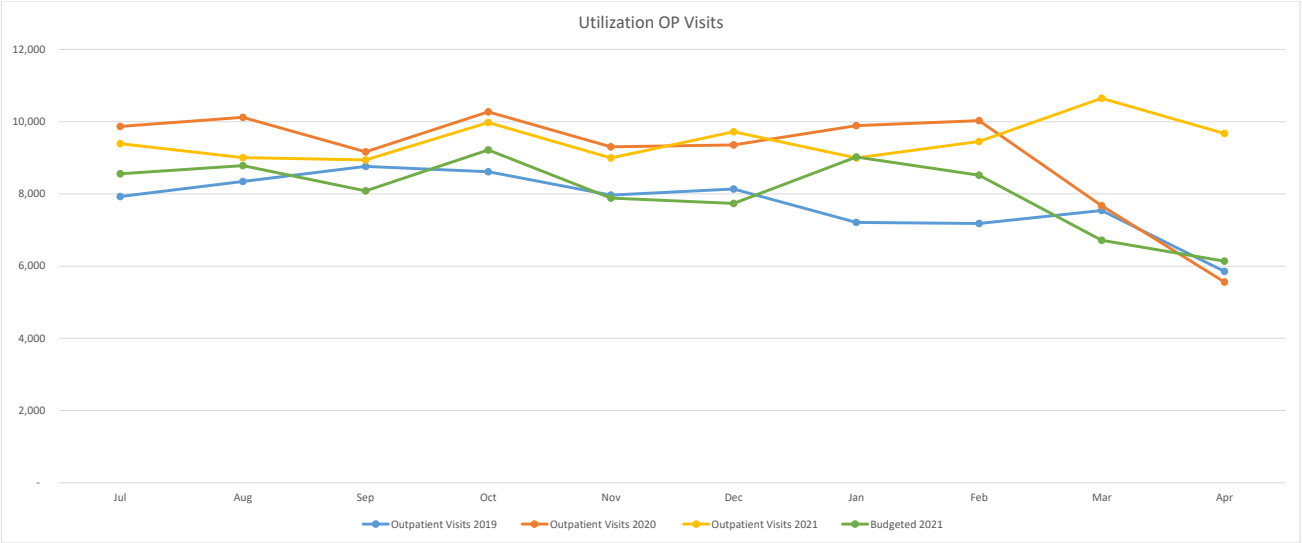
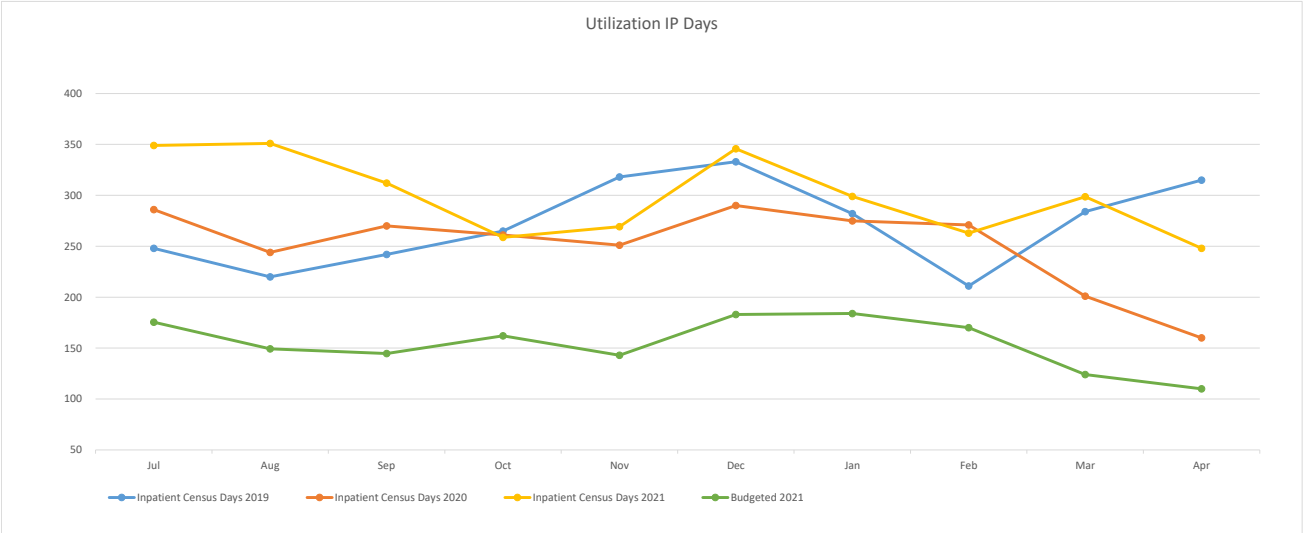
	Budget 5/31/2021	Actual 5/31/2021	Budget Expense as a % of Revenue 5/31/2021	Actual Expense as a % of Revenue 5/31/2021	Actual 4/30/2021	Budget Expense as a % of Revenue 4/30/2021	Actual Expense as a % of Revenue 4/30/2021
Total Net Patient Revenue	5,969,857	9,806,763			15,640,560		
Cost of Services	34%	28%					
Salaries & Wages	2,012,068	2,405,288	33.70%	24.53%	2,260,211	33.70%	14.45%
Benefits	1,270,219	2,368,317	21.28%	24.15%	2,126,588	21.28%	13.60%
Professional Fees	1,395,753	1,992,931	23.38%	20.32%	1,982,469	23.38%	12.68%
Pharmacy	169,281	30,395	2.84%	0.31%	347,263	2.84%	2.22%
Medical Supplies	309,943	238,484	5.19%	2.43%	426,798	5.19%	2.73%
Hospice Operations	38,762	-	0.65%	0.00%	-	0.65%	0.00%
Athena EHR System	106,263	110,920	1.78%	1.13%	143,678	1.78%	0.92%
Other Direct Costs	170,141	339,928	2.85%	3.47%	514,106	2.85%	3.29%
Total Direct Costs	5,472,430	7,486,263	91.67%	76.34%	7,801,114	91.67%	49.88%
Gross Margin	497,427	2,320,500			7,839,446		
Gross Margin %	8.33%	23.66%			50.12%		
General and Administrative Overhead	7%	4%					
Salaries & Wages	416,866	345,608	6.98%	3.52%	344,356	6.98%	2.20%
Benefits	322,279	408,513	5.40%	4.17%	395,643	5.40%	2.53%
Professional Fees	219,578	384,972	3.68%	3.93%	790,953	3.68%	5.06%
Depreciation and Amortization	344,075	339,866	5.76%	3.47%	329,298	5.76%	2.11%
Other Administrative Costs	59,011	107,579	0.99%	1.10%	(74,722)	0.99%	-0.48%
Total General and Administrative Overhead	1,361,809	1,586,536	22.81%	16.18%	1,785,528	22.81%	11.42%
Net Margin	(864,382)	733,964			6,053,918		
Net Margin %	-14.48%	7.48%			38.71%		
Financing Expense	203,109	100,798	3.40%	1.03%	109,058	3.40%	0.70%
Financing Income	174,290	172,412	2.92%	1.76%	56,337	2.92%	0.36%
Investment Income	37,740	52,391	0.63%	0.53%	21,543	0.63%	0.14%
Miscellaneous Income	24,016	67,617	0.40%	0.69%	58,280	0.40%	0.37%
Net Surplus	(831,446)	925,586			6,081,020		


Utilization OP Visits
12,000
10,000
8,000
6,000
4,000
2,000
-
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
Outpatient Visits 2019
Outpatient Visits 2020
Outpatient Visits 2021
Budgeted 2021


Utilization IP Days
400
350
300
250
200
150
100
50
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
Inpatient Census Days 2019
Inpatient Census Days 2020
Inpatient Census Days 2021
Budgeted 2021

Management Discussion and Analysis

Revenue continues to be robust given strong inpatient days and outpatient visits.
- Inpatient days in May were 206 compared to budgeted of 144.
- Outpatient visits in May were 8,535 compared to 7,688 budgeted for the month.
- Cerner was implimented on 05/17/2021. Some Stats were estimated due to new processes. Will update in June.
- Salaries are in line with budget 34% to actual of 28% of net patient revenues.
- Gross margins are considerably higher due to IGT being recorded.
- AR continues with clean up efforts and contractuals and bad debt reserves are starting to stabalize.
- Cash balances have stabilized due to good collections at 80 Million year to date.
- AR days trending lower with increased collection efforts and new Rev Cycle Director in place.
- Recorded 4.4M for IGT FY2020 revenues
- Recorded 2.8M for IGT FY2021 revenues will record the same in June.
- Year to Date Net Income 4.5 Million

1. Discussed draft overall generic district compensation philosophy
2. Discussed potential hurdles and use of certain verbiage
3. Discussed the importance of data driven metrics if metrics will be used
4. Discussed the importance of Cerner implementation and ability to gather needed data
5. Discussed renewal of contracts while compensation philosophy is being worked out
6. Discussed the importance of being physically sustainable
7. Discussed the District's obligation to be around market rate
8. Agreed there is further work and research to be done