August 17 2022 Regular Board Meeting

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August 17 2022 Regular Board Meeting

Agenda August 17, 2022 Regular Board Meeting

August 17, 2022 Regular Board Meeting Agenda 2

QHR Presentation of 2022 Northern Inyo Healthcare District Community Health Needs Assessment

QHR Bios 5
CHNA Board Presentation 6
NIHD CHNA Executive Summary 15
2022 CHNA Report 20

Northern Inyo Healthcare District Workforce Housing Focus Update

Northern Inyo Healthcare District Workforce Housing Focus Update 101

Chief Financial Officer Update

Chief Financial Officer Update 102

Chief of Staff Report

Medical Executive Committee Report 103
Approval of Policies and Procedures 104

Consent Agenda

District Board Resolution 22-14, continue to allow virtual Board meetings 116
July 20, 2022 Regular Board Meeting Minutes 118
August 8, 2022 Special Board Meeting Minutes 123
Pioneer Home Health Care Quarterly Report 124
Compliance Department Quarterly Report 149
Eastern Sierra Emergency Physician Quarterly Report 193
Financial and Statistical reports for June 31, 2022 195
Governance Committee Meeting Update 196
Approval of Policies and Procedures 197

NORTHERN INYO HEALTHCARE DISTRICT
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AGENDA

NORTHERN INYO HEALTHCARE DISTRICT
BOARD OF DIRECTORS REGULAR MEETING

August 17, 2022 at 5:30 p.m.

Northern Inyo Healthcare District invites you to join this meeting:

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

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

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

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1. Call to Order (at 5:30 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. QHR Presentation of 2022 Northern Inyo Healthcare District Community Health Needs Assessment (*Board will consider the approval of this presentation)*

B. Northern Inyo Healthcare District Workforce Housing Focus Update (*Board will receive and discuss community housing options for workforce needs)*

C. Chief Financial Officer Update (*Board will receive this update)*

4. Chief of Staff Report, Sierra Bourne MD:
   A. Medical Staff Appointments (*Board will consider the approval of this Medical Staff Appointment)*
      1. *Peter Verhey, MD (radiology)- Telemedicine Staff*
   B. Critical Indicators (*Board will consider the approval of these Critical Indicators)*
      1. *Emergency Medicine*
      2. *Inpatient Medicine*
   C. Policies *(Board will consider the approval of these policies)*
      1. *Credentialing Healthcare Practitioners in the Event of a Disaster*
      2. *Rapid Response Team*
   D. Medical Executive Committee Meeting Report *(Board will receive this report)*

Consent Agenda

5. Approval of District Board Resolution 22-14, to continue to allow Board meetings to be held virtually *(Board will consider the adoption of this District Board Resolution)*
6. Approval of minutes of the July 20, 2022 Regular Board Meeting *(Board will consider the approval of these minutes)*
7. Approval of minutes of the August 8, 2022 Special Board Meeting *(Board will consider the approval of these minutes)*
8. Pioneer Home Health Care Quarterly Report (*Board will consider accepting this report)*
9. Compliance Department Quarterly Report *(Board will consider accepting this report)*
10. Eastern Sierra Emergency Physician Quarterly Report *(Board will consider accepting this report)*
11. Financial and Statistical reports for June 31, 2022 (*Board will consider accepting this report)*
12. Governance Committee Meeting Update *(Board will consider accepting this report)*
13. Approval of Policies and Procedures (*Board will consider the approval of these Policies and Procedures)*
    A. Using and Disclosing Protected Health Information for Treatment, Payment and Health Care Operations.
    B. Investigation and Reporting of Unlawful Access, Use or Disclosure of Protected Health Information.
    C. California Public Records Act- Information Requests
    D. New Project Implementation.

E. Compensation of the Chief Executive Officer.

F. Authority of the Chief Executive Officer for Contracts and Bidding.

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14. Reports from Board members (*Board will provide this information*).
15. Public comments on closed session items.
16. Adjournment to Closed Session to/for:
    A. Conference with legal counsel. Significant exposure to litigation. Government Code 54956.9(d)(2) (One case)
    B. Conference with Labor Negotiators, Agency Designated Representatives: Irma Rodriguez Moisa and Andrew M. Aller; Employee Organization: AFSCME Council 57 (pursuant to Government Code Section 54957.6)
    C. Public Employee Performance Evaluation (pursuant to Government Code Section 54957 (b)) title: Chief Executive Officer.
17. Return to open session and report on any actions taken in closed session.
18. 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.

QHR Bios

Lindsay Marietti: Lindsay serves as Director on the Strategy team for QHR Health and supports healthcare leaders across the country to identify future opportunities for sustainable growth. In her current role, Lindsay partners with hospitals to develop strategies that align with the competitive dynamics of their market as well as broader trends impacting the healthcare landscape, including innovation, partnerships, and consumerism.

Kylie Lattimore: Kylie is an Associate Consultant on the Strategy team for QHR Health working with healthcare organizations across the country to conduct community health needs assessments. She helps organizations identify key health priorities, service area gaps, and strategic relationships to improve community health.

Northern Inyo Healthcare District

Community Health Needs Assessment
Board Report

August 17, 2022

The CHNA Process

A Community Health Needs Assessment (CHNA) is designed to provide information about the community's current health status, needs, and disparities and is a requirement of all non-profit hospitals. It has many strategic benefits such as identifying service area gaps, understanding perceptions of the community, and potential partnership and outreach strategies.

Identify and survey local stakeholders

Develop a list of contacts representing individuals with specific knowledge of the community

Solicit feedback from the broader community

Distribute survey to community members to assess significant health needs and progression towards improvement.

- **643** community members provided information on top community health needs.

Analyze health factor and community data

Review relevant data resources to provide quantitative feedback on the local community.

- ***737*** different data points were analyzed during the CHNA process.

Determine top health needs

Evaluate CHNA survey findings and other data inputs to identify top needs that can feasibly be addressed by the hospital.

- **7** health factors were identified as being the top needs in the community.

Develop an implementation plan

Facilitated discussions around key resources, partnerships, and plans to address health priorities.

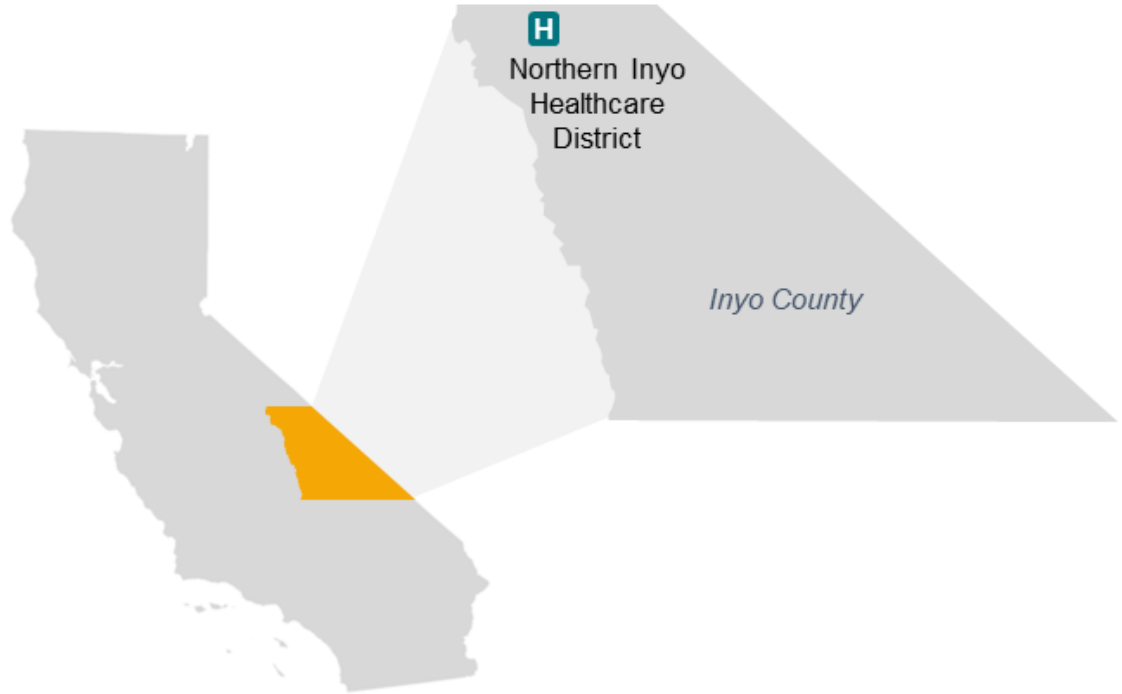
- **3** strategies were developed to address the top health needs in a targeted and efficient way.

Primary Community Served – Inyo County

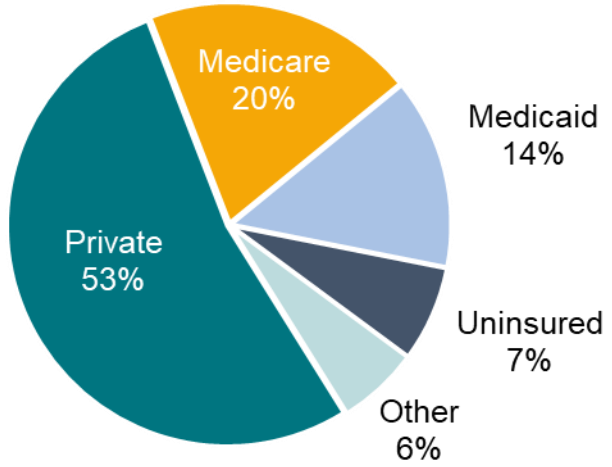
Inyo County Population

Current Population :
18,907

Age 65+ Population:
24.1%
CA: 15.2%



Insurance Coverage



Race/Ethnicity

61%
White

23%
Hispanic

13%
American Indian

Education & Income

High School Diploma or Less:
39%
CA: 36%

Median HH Income:
$59,990
CA: $88,930

Source: *Stratasan, ESRI (2022)*

2022 Health Priorities for Inyo County

Seven health priorities identified from the 2022 CHNA survey

Mental Health
- Mental health provider ratio: **201:1** (*CA: 244:1*)
- Suicide death rate (*per 100,000*): **17.6** (*CA: 10.0*)

Drug/Substance Abuse
- Drug overdose mortality rate *(per 100,000)*: **40.7** (*CA: 17.3*)
- Any opioid overdose ED visits (*per 100,000*): **85.1** (*CA: 40.9*)

Healthcare Services: Affordability
- Uninsured: **6.7%** (*CA: 7.2%*)
- Median household income: **$59,990** (*CA: $88,930*)

Healthcare Services: Physical Presence
- Primary care physician ratio: **1,061:1** (*CA: 1,240:1*)
- Dentist ratio: **1,505:1** (*CA: 1,132:1*)

Access to Senior Services
- Population 65+: **24.1%** (*CA: 15.4%*)
- Medicare annual wellness visits: **15%** (*CA: 20%*)

Cancer
- Cancer mortality *(per 100,000)*: **159.3** (*CA: 130.3*)
- Cancer incidence *(per 100,000)*: **433.3** (*CA: 402.4*)

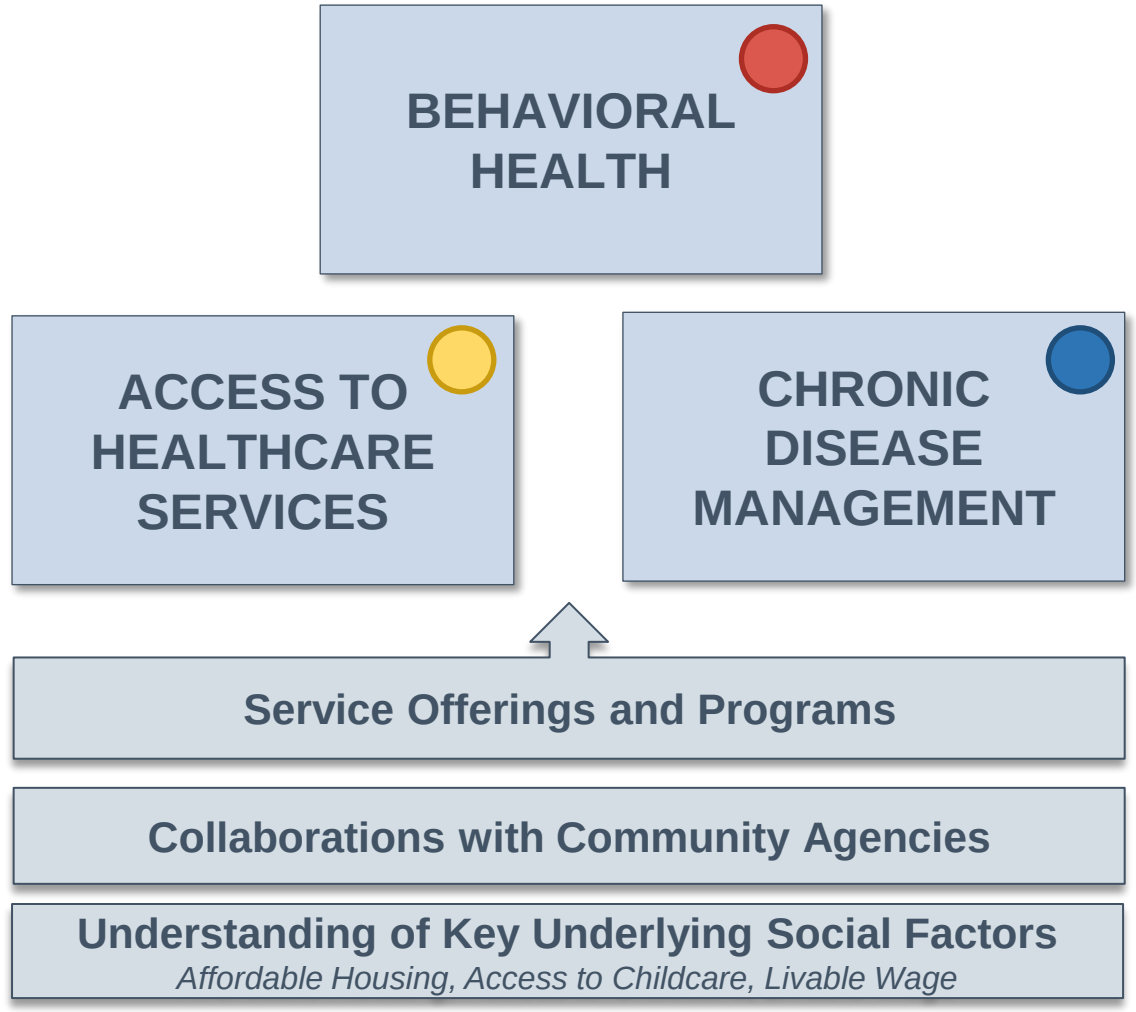
Diabetes
- Diabetes mortality *(per 100,000)*: **16.4** (*CA: 25.4*)
- Adult obesity: **28%** (*CA: 26%*)

QHR Health

Implementation Plan Framework

- Mental Health
- Healthcare Services: Affordability
- Healthcare Services: Physical Presence
- Cancer
- Drug/Substance Abuse
- Diabetes
- Access to Senior Services

Implementation Plan Framework



NIHD CHNA Implementation Plan Summary

Overarching CHNA Priorities:

1. Closing gaps in care for priority populations (racial/ethnic minorities, seniors, children/adolescents, LGBTQ+)
2. Community outreach and education on services/resources available in the community
3. Collaborating with key partners to meet community needs

Behavioral Health

Key Priorities

- Define NIHD behavioral health services throughout the ever-changing behavioral health environment in the community
- Continue successful Drug/Substance Abuse programming and outreach
- Explore opportunities to meet mental health needs, with a focus on connecting patients to community resources.

Future actions to address this need

- Partner with Inyo County to collaborate on behavioral health services.
- Evaluate the need to hire additional behavioral health providers.
- Increase education and awareness of behavioral health services.
- Reduce barriers to care for priority populations.
- Explore opportunities for care coordination.

Access to Healthcare Services

Key Priorities

- Growing outreach/ education and increasing access for priority populations.
- Addressing affordability of care.
- Ensuring access to needed services via multiple channels, including telehealth and partnerships.

Future actions to address this need

- Evaluate opportunities to decrease wait times.
- Grow attendance at Healthy Lifestyle talks.
- Optimize coordination of interpretation services.
- Improve outreach and education on services available at NIHD.
- Increase the number of health fairs in the community.
- Evaluate hours of operation and opportunities to best serve the community.

Chronic Disease Management

Key Priorities

- Providing the right Diabetes/ Cancer service offerings to meet community needs.
- Promoting awareness of current services and supporting patients with care navigation.

Future actions to address this need

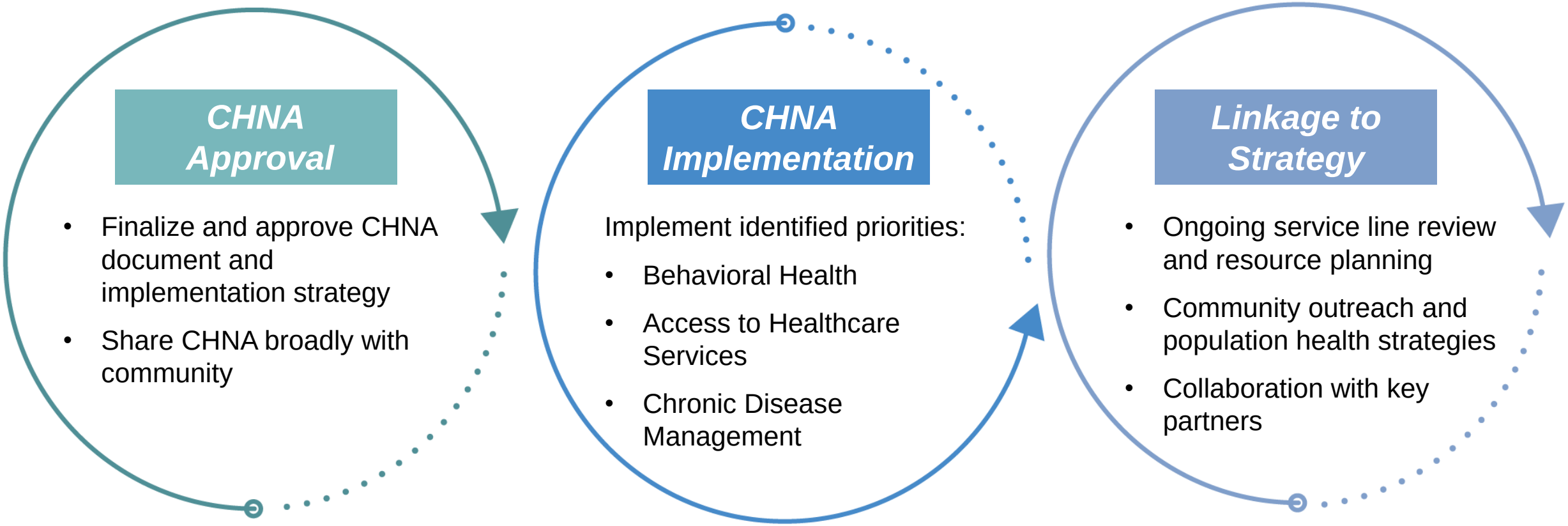
- Support Dietitian in achieving Diabetes Educator certification.
- Improve outreach and education on services available at NIHD.
- Continue to strengthen relationships with partners such as the Eastern Sierra Cancer Alliance and City of Hope to increase access to care for cancer patients.

QHR Health

***Note**: Full implementation plan including a list of resources and future actions can be found in the NIHD 2022 CHNA Report*

Next Steps

CHNA work is positioned to serve as a key input into organizational strategic planning



Questions?

Thank You

QHR™ Health

Strengthening Independent Community Healthcare

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

Northern Inyo Healthcare District 2022

Community Health Needs Assessment

Community Health Needs Assessment (CHNA) Overview

CHNA Purpose

A CHNA is part of the required hospital documentation of "Community Benefit" under the Affordable Care Act for 501(c)(3) hospitals. It provides comprehensive information about the community's current health status, needs, and disparities and offers a targeted action plan to address these areas, including programmatic development and partnerships.

Strategic Benefits

- Identify health disparities and social determinants to inform future outreach strategies
- Identify key service delivery gaps
- Develop an understanding of community member perceptions of healthcare in the region
- Target community organizations for collaborations

The CHNA Process

1 Identification of Local Experts

Develop a list of contacts representing individuals with specific knowledge of local health needs.

2 Community Survey

Launch of surveys to assess significant health needs and progression towards improvement.

3 Data Analysis

Review of relevant data resources to provide quantitative feedback on the local community.

4 Implementation Planning

Facilitation of session with CHNA team to build plans and finalize the CHNA report.

Methods of Identifying Health Needs

Collect & Analyze

Analyze existing data and collect new data

737 indicators collected from data sources

643 surveys completed by community members

Evaluate

Evaluate indicators based on the following factors:

- Worse than benchmark
- Identified by the community
- Impact on health disparities
- Feasibility of being addressed

Develop

Develop an implementation plan for top priorities

Over **30** NIHD and community leaders gathered to discuss services, resources, and partnerships to address each health priority

- Community Disparities
- Available Resources
- Potential Partners

Implementation Plan

Evaluation & Selection Process

Worse than Benchmark Measure

Health needs were deemed “worse than the benchmark” if the supported county data was worse than the state and/or US averages

Identified by the Community

Health needs expressed in the online survey and/or mentioned frequently by community members

Feasibility of Being Addressed

Growing health needs where interventions are feasible and the District could make an impact

Impact on Health Disparities

Health needs that disproportionately affect vulnerable populations and can impact health equity if addressed

Health Need Evaluation

	Worse than Benchmark	Identified by the Community	Feasibility	Impact on Health Disparities
Mental Health	✓	✓	✓	✓
Affordable Housing		✓		✓
Healthcare Services: Affordability	✓	✓	✓	✓
Healthcare Services: Physical Presence	✓	✓	✓	✓
Cancer	✓	✓	✓	✓
Drug/Substance Abuse	✓	✓	✓	✓
Access to Childcare	✓	✓		✓
Diabetes		✓	✓	✓
Access to Senior Services	✓	✓	✓	✓
Livable Wage	✓	✓		✓

2022 Top Health Priorities for Inyo County

Behavioral Health

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NORTHERN INYO HEALTHCARE DISTRICT
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Northern Inyo Healthcare District 2022

Community Health Needs Assessment

Table of Contents

Executive Summary 4
Overview of Community Health Needs Assessment 5
Process and Methods 6
Community Representation 8
Overview of Priority Populations 9
Community Health Needs Assessment Subsequent to Initial Assessment 10
Definition of Area Served by the Hospital 11
Demographics of the Community 11
Community Health Characteristics 13
Methods of Identifying Health Needs 15
Ranked Health Priorities 16
Evaluation & Selection Process 20
Overview of Priorities 21
Implementation Plan Framework 33
Implementation Strategy 35
Appendix 41
Detailed Demographics 43
Leading Causes of Death 44
County Health Rankings 45
Detailed Approach 46
Data Sources 52
Survey Results 54

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

Northern Inyo Healthcare District

150 Pioneer Lane
Bishop, CA 93514
(760) 873-5811
www.nih.org

Dear Community Member:

At Northern Inyo Healthcare District (NIHD), we have spent more than 75 years providing high-quality, compassionate healthcare to the greater Eastern Sierra community. The 2022 Community Health Needs Assessment (CHNA) identifies local health and medical needs and provides a plan of how NIHD will respond to such needs. This document illustrates a few of the ways we plan to efficiently deliver medical services.

We welcome you to review this document not just as part of our compliance with federal law, but of our continuing efforts to meet your health and medical needs. NIHD will conduct this effort at least once every three years. Through the information our community members have shared, we have focused time and resources on identifying the primary needs of the community and ways to meet these needs.

We are pleased to present our CHNA findings to our community. We view the CHNA as a plan for how we, along with other area organizations and agencies, can collaborate to bring the best each has to offer to support change, and address the most pressing identified needs. Most importantly, this report is intended to guide our actions, and the efforts of others, to make needed health and medical improvements in our area.

The healthcare district recognizes it may not have the resources to solve all identified needs and problems. Some issues may be beyond the district's mission or require an action best suited for a response by others. NIHD remains committed to staying abreast of and advocating for the growth, development, and improvements in the health and wellness of our community. It is also important for all of us to understand that some improvements will require personal actions by individuals rather than the response of an organization. We are a strong community capable of great things!

We all live in, work in, and enjoy this wonderful community. Together, we can make our community healthier now and for our future generations! "One team. One goal. Your health."

Thank you for your time and your participation in this effort. We are pleased to present this information and hope you find it informative and helpful!

Respectfully,

Kelli Davis, MBA,
Chief Executive Officer,
Northern Inyo Healthcare District

Executive Summary

Northern Inyo Healthcare District ("NIHD" or the "District") performed a Community Health Needs Assessment (CHNA) together in partnership with QHR Health ("QHR") to determine the health needs of the local community and an accompanying implementation plan to address these identified health needs.

This CHNA report consists of the following information:

1) a definition of the community served by the District and a description of how the community was determined;
2) a description of the process and methods used to conduct the CHNA;
3) a description of how The District solicited and considered input received from persons who represent the broad interests of the community it serves;
4) commentary on the 2019 CHNA Assessment and Implementation Strategy efforts
5) a prioritized description of the significant health needs of the community identified through the CHNA, along with a description of the process and criteria used in identifying certain health needs as significant and prioritizing those significant health needs; and
6) a description of resources potentially available to address the significant health needs identified through the CHNA.

Data were gathered from multiple well-respected secondary sources to build an accurate picture of the current community and its health needs. A survey of a select group of Local Expert Advisors as well as the broad community was performed to review and provide feedback on the prior CHNA, and to ascertain the continued relevance of previously identified needs. Additionally, the group reviewed the data gathered from secondary sources to support the determination of the Significant Health Needs of the community.

The 2022 Significant Health Needs identified for Inyo County are:

- Behavioral Health
- Access to Healthcare
- Chronic Disease Management

In the Implementation Strategy section of the report, the District addresses these areas through identified programs and resources as well as collaboration with other local organizations/agencies. Metrics are included for each health need to track progress.

Community Health Needs Assessment (CHNA) Overview

CHNA Purpose

A CHNA is part of the required hospital documentation of "Community Benefit" under the Affordable Care Act for 501(c)(3) hospitals. It provides comprehensive information about the community's current health status, needs, and disparities and offers a targeted action plan to address these areas, including programmatic development and partnerships.

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The CHNA Process

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3 Data Analysis

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4 Implementation Planning

Facilitation of session with CHNA team to build plans and finalize the CHNA report.

Process and Methods used to Conduct the Assessment

This assessment takes a comprehensive approach to determining community health needs and includes the following methodology:

- Several independent data analyses based on secondary source data.
- Augmentation of data with community opinions.
- Resolution of any data inconsistency or discrepancies by reviewing the combined opinions formed by local expert advisors and community members.

Data Collection and Analysis

The District relies on secondary source data, which primarily uses the county as the smallest unit of analysis. Area residents were asked to note if they perceived that the opportunities and issues identified by secondary sources existed in their portion of the county.

Most data used in the analysis is available from public internet sources and proprietary data. Any critical data needed to address specific regulations or developed by the Local Expert Advisor individuals cooperating in this study are displayed in the CHNA report appendix.

Data sources are detailed in the appendix of this report and include:

- *Stratasan*
- *www.countyhealthrankings.org*
- *www.worldlifeexpectancy.com/usa-health-rankings*
- *Bureau of Labor Statistics*
- *NAMI*
- *AskCHIS*
- *Center for Housing Policy*
- *Zillow Home Value Index*
- *Department of Health Care Access and Information*
- *Centers for Medicare & Medicaid Services: Mapping Medicare Disparities by Population*
- *National Cancer Institute*
- *California Overdose Surveillance Dashboard*
- *Economic Policy Institute*
- *Health Affairs: Leigh & Du*

A standard process of gathering community input was developed. In addition to gathering data from the above sources:

- A CHNA survey was deployed to local expert advisors and the general public to gain input on local health needs and the needs of priority populations. Local expert advisors were local individuals selected according to criteria required by the Federal guidelines and regulations and the District's desire to represent the region's geographically diverse population. 643 survey responses from community members were gathered between May 2022 and June 2022.

Prioritizing Significant Health Needs

The survey respondents participated in a structured communication technique called the "Wisdom of Crowds" method. This approach relies on the assumption that the collective wisdom of participants is superior to the opinion of any one individual, regardless of their professional credentials.

In the District's process, each survey respondent had the opportunity to introduce needs previously unidentified and to challenge conclusions developed from the data analysis. Most respondents agreed with the findings, with only a handful of comments critiquing the data. A list of all needs was developed based on findings from the analysis. The survey respondents then ranked the importance of addressing each health need on a scale of 1 (not important) to 5 (very important), including the opportunity to list additional needs that were not identified.

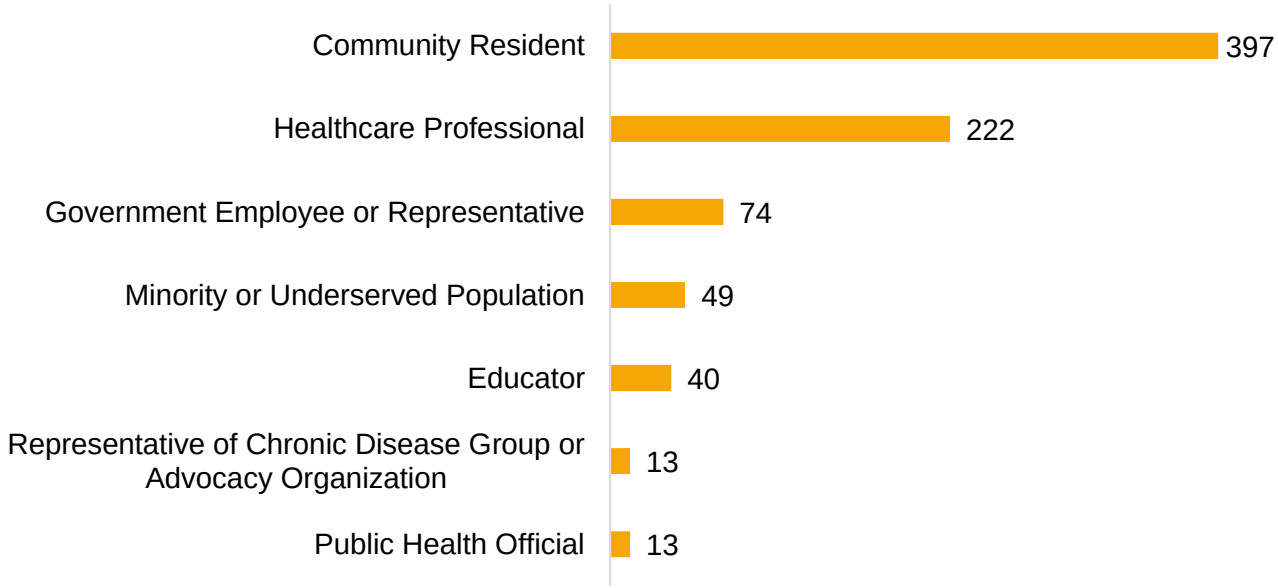
The ranked needs were divided into two groups: "Significant Needs" and "Other Identified Needs." The determination of the breakpoint — "Significant" as opposed to "Other" — was a qualitative interpretation where a reasonable break point in rank order occurred. The District analyzed the health issues that received the most responses and established a plan for addressing them. This plan was developed through a series of work sessions where relevant stakeholders from the District and other community organizations were present.

Input from Persons Who Represent the Broad Interests of the Community

Input was obtained from the required three minimum sources and expanded to include other representative groups. The District asked all those participating in the written comment solicitation process to self-identify into any of the following representative classifications, which are detailed in the appendix to this report. Participants self-identified into the following classifications:

1) **Public Health Official**
2) **Government Employee or Representative**
3) **Minority or Underserved Population**
4) **Chronic Disease Groups**
5) **Community Resident**
6) **Educator**
7) **Healthcare Professional**
8) **Other** (please specify)

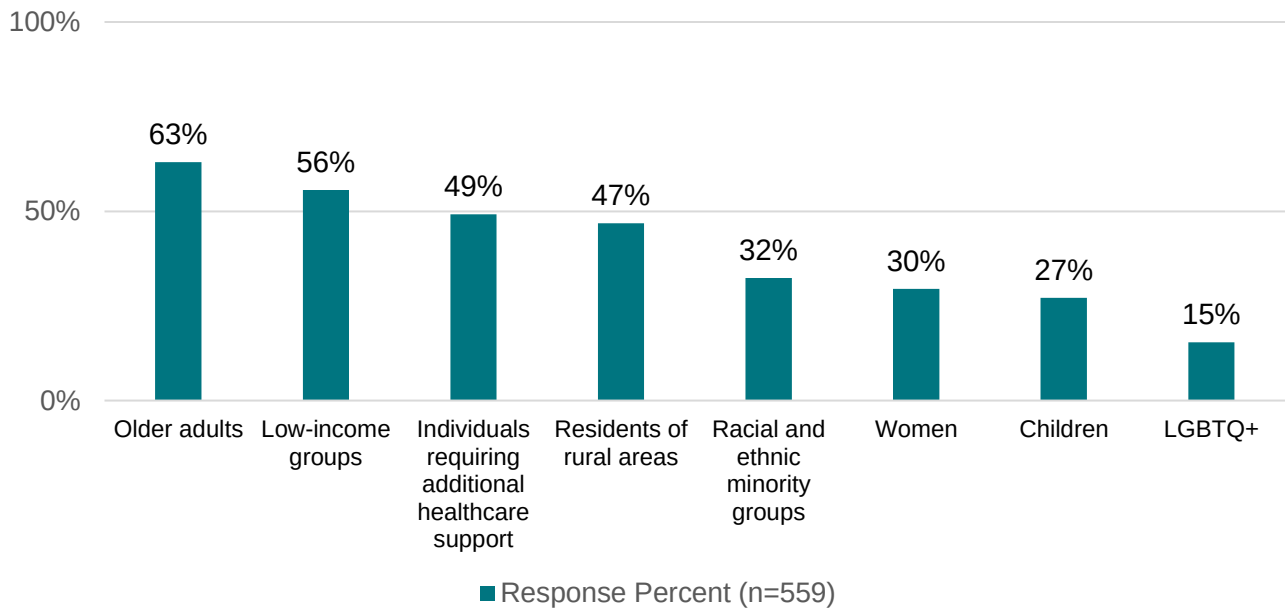
Survey Question: Please select all roles that apply to you (n=575)



Input on Priority Populations

Information analysis augmented by local opinions showed how Inyo County compares to its peers in terms of primary and chronic needs and other issues of uninsured persons, low-income persons, and minority groups. Respondents commented on whether they believe certain population groups ("Priority Populations") would benefit from additional focus and to elaborate on their key needs.

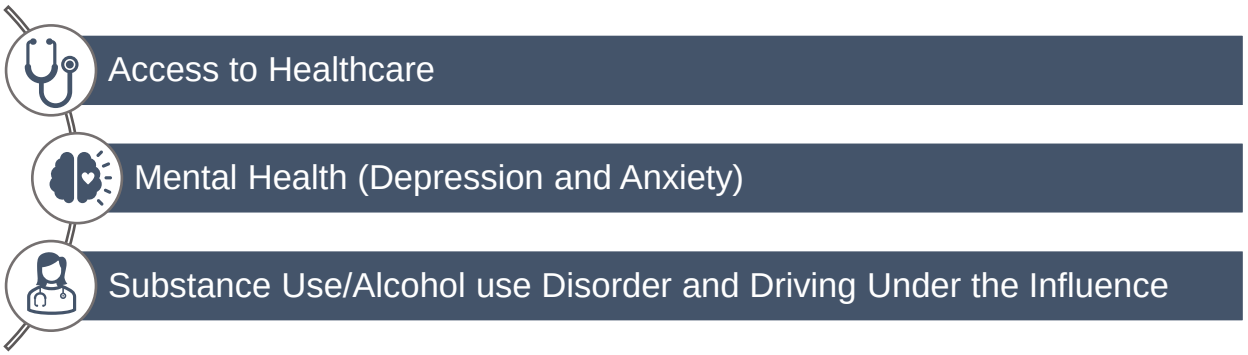
Survey Question: With regard to healthcare, which of the following priority populations should we focus on most as a community? (please select all that apply)



- Local opinions of the needs of Priority Populations, while presented in their entirety in the appendix, were abstracted into the following "take-away" bulleted comments:
  - The top three priority populations identified by the local experts were older adults, low-income groups, and individuals requiring additional healthcare support.
  - Summary of unique or pressing needs of the priority groups identified by the surveyors:
    - Access to specialists
    - Mental health services
    - Affordable healthcare

Input on 2019 CHNA

The IRS Final Regulations establish a required step for a CHNA developed after the initial report. This requirement calls for considering written comments received on the prior CHNA and Implementation Strategy as a component of the development of the next CHNA and Implementation Strategy. Comments were solicited from community members with regards to NIHD"s 2019 CHNA and Implementation Plan and are presented in the appendix of this report. The health priorities identified in the 2019 CHNA are listed below:



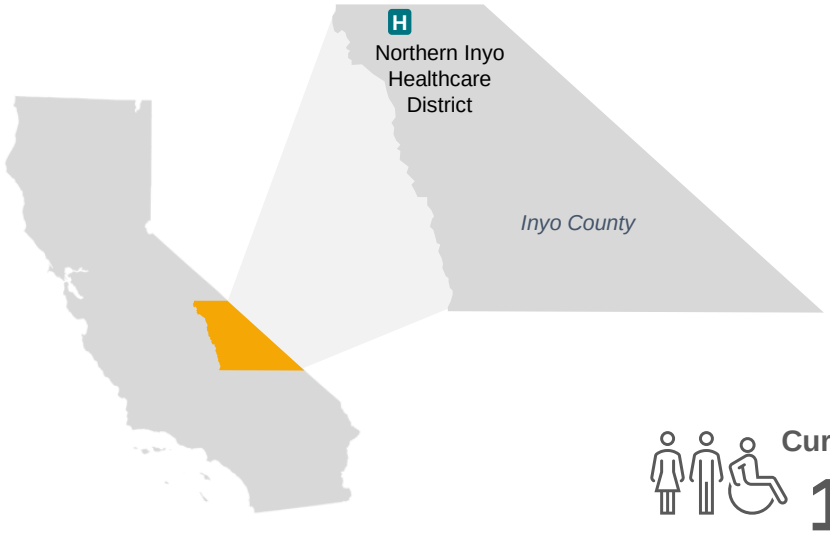
Community Served

For the purpose of this study, NIHD defines its service area as Inyo County in California which includes the following Zip codes:

92384 – Shoshone	92389 – Tecopa	93513 – Big Pine	93526 – Independence
93514 – Chalfant	93549 – Olancha	93549 – Cartago	93514 – Swall Meadows
93515 – Bishop	93522 – Darwin	93542 – Little Lake	92328 – Death Valley
93514 – Bishop	93530 – Keeler	93545 – Lone Pine	93514 – Chalfant Valley

During 2021, NIHD received 61% of its Medicare inpatients from this area.

Inyo County Demographics



Current Population :
18,907

Age

	Inyo County	California
0 – 17	*18.9%*	*22.5%*
18 – 44	*28.6%*	*38.3%*
45 – 64	*28.4%*	*23.8%*
65 +	*24.1%*	*15.4%*

Source: Stratasan, ESRI (2022)

Race/Ethnicity

	Inyo County	California
White	*61.1%*	*40.4%*
Black	*0.5%*	*5.6%*
Asian & Pacific Islander	*1.6%*	*16.3%*
American Indian	*13.3%*	*1.8%*
Other	*23.4%*	*35.9%*
Hispanic*	*23.3%*	*39.4%*

*Ethnicity is calculated separately from Race

Education and Income

	Inyo County	California
Median Household Income	*$59,990*	*$88,930*
Some High School or Less	*9.7%*	*14.1%*
High School Diploma/GED	*28.8%*	*20.7%*
Some College/ Associates Degree	*30.8%*	*27.4%*
Bachelor's Degree or Greater	*30.7%*	*37.8%*

Source: Stratasan, ESRI (2022)

Community Health Characteristics

The data below provides an overview of Inyo County's strengths and weaknesses regarding health behaviors, quality of life, socioeconomic factors, access to health, and physical environment. These statistics were included for reference in the CHNA survey to help prioritize the health needs of the community. For descriptions of each measure and dates of when the data was obtained, please visit https://www.countyhealthrankings.org.

Health Status Indicators

Health Behaviors

Teen Births *per 1,000*	Adult Smoking	Physical Inactivity	Adult Obesity	Driving Deaths Involving Alcohol	Excessive Drinking
27	**14%**	**22%**	**28%**	**21%**	**22%**
CA: 16	*CA: 10%*	*CA: 22%*	*CA: 26%*	*CA: 28%*	*CA: 19%*

Quality of Life

Suicide Rate: 17.6

Per 100,000
Compared to 10.0 in CA

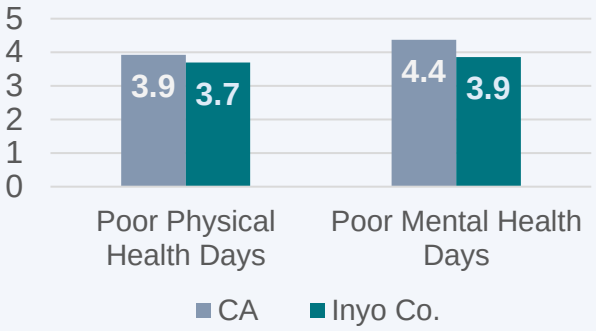
Poor or Fair Health: 18%

Compared to 18% in CA

Low Birthweight: 8%

Compared to 7% in CA

Average number of physically and mentally unhealthy days in the past 30 days



Source: County Health Rankings 2022 Report, worldhealthranking.com (2020)

Socioeconomic Factors

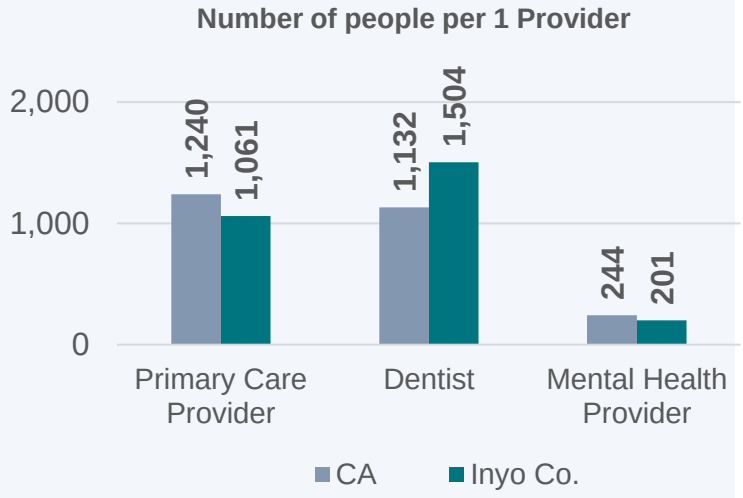
Income Inequality*	Unemployment	Children in Single Parent Households	Children in Poverty	Violent Crime *per 100,000*	Injury Deaths *per 100,000*
4.2	**5.9%**	**26%**	**15%**	**600**	**93**
CA: 5.1	*CA: 7.3%*	*CA: 22%*	*CA: 15%*	*CA: 421*	*CA: 55*

Access to Health

Uninsured: 6.7%
Compared to 7.2% in CA

Preventable Hospital Stays: 2,948
Per 100,000
Compared to 3,067 in CA

Access to Exercise Opportunities: 49%
Compared to 93% in CA



Physical Environment

Air Pollution (µg/m³)	Severe Housing Problems**	Driving to Work Alone	Broadband Access
7.5	**18%**	**69%**	**83%**
CA: 12.9	*CA: 26%*	*CA: 72%*	*CA: 89%*

Source: County Health Rankings 2022 Report, Bureau of Labor Statistics (2021), Stratasan, ESRI (2022)
*Notes: *Ratio of household income at the 80th percentile to income at the 20th percentile*
***Overcrowding, high housing costs, lack of kitchen facilities, or lack of plumbing facilities*

Methods of Identifying Health Needs

Collect & Analyze

Analyze existing data and collect new data

737 indicators collected from data sources

643 surveys completed by community members

Evaluate

Evaluate indicators based on the following factors:

- Worse than benchmark
- Identified by the community
- Impact on health disparities
- Feasibility of being addressed

Develop

Develop an implementation plan for top priorities

Over **30** NIHD and community leaders gathered to discuss services, resources, and partnerships to address each health priority

- Community Disparities
- Available Resources
- Potential Partners

Implementation Plan

Community Survey Data

This process included evaluation of health factors, community factors, and personal factors, given they each uniquely impact the overall health and health outcomes of a community:

- Health factors include chronic diseases, health conditions, and the physical health of the population.
- Community factors are the external social determinants that influence community health.
- Personal factors are the individual decisions that affect health outcomes.

In our community survey, each broad factor was broken out into more detailed components, and respondents rated the importance of addressing each component in the community on a scale from 1 to 5. Results of the health priority rankings are outlined below:

Health Factors

Survey Question: Please rate the importance of addressing each health factor on a scale of 1 (Not at all) to 5 (Extremely).

Answer Choices	Weighted Average of Votes (out of 5)
Mental Health	4.53
Cancer	4.37
Drug/Substance Abuse	4.30
Diabetes	4.24
Heart Disease	4.20
Women's Health	4.17
Obesity	4.08
Stroke	4.05
Alzheimer's and Dementia	4.02
Dental	4.00
Kidney Disease	3.95
Lung Disease	3.90
Liver Disease	3.89
Other (please specify)	See appendix

Community Factors

Survey Question: Please rate the importance of addressing each community factor on a scale of 1 (Not at all) to 5 (Extremely).

Answer Choices	Weighted Average of Votes (out of 5)
Affordable Housing	4.46
Healthcare Services: Affordability	4.41
Healthcare Services: Physical Presence (location, services, physicians)	4.38
Access to Childcare	4.27
Access to Senior Services	4.21
Education System	4.15
Healthcare Services: Prevention	4.15
Employment and Income	4.10
Access to Healthy Food	4.04
Community Safety	3.93
Transportation	3.84
Social Support	3.78
Social Connections	3.65
Access to Exercise/Recreation	3.62
Other (please specify)	See appendix

Personal Factors

Survey Question: Please rate the importance of addressing each personal factor on a scale of 1 (Not at all) to 5 (Extremely).

Answer Choices	Weighted Average of Votes (out of 5)
Livable Wage	4.21
Diet	4.00
Employment	3.96
Excess Drinking	3.93
Smoking/Vaping/Tobacco Use	3.84
Physical Inactivity	3.83
Risky Sexual Behavior	3.60
Other (please specify)	See appendix

Overall health priority ranking (top 10 highlighted)

Answer Choices	Weighted Average of Votes (out of 5)
Mental Health	4.53
Affordable Housing	4.46
Healthcare Services: Affordability	4.41
Healthcare Services: Physical Presence (location, services, physicians)	4.38
Cancer	4.37
Drug/Substance Abuse	4.3
Access to Childcare	4.27
Diabetes	4.24
Access to Senior Services	4.21
Livable Wage	4.21
Heart Disease	4.2
Women's Health	4.17
Education System	4.15
Healthcare Services: Prevention	4.15
Employment and Income	4.10
Obesity	4.08
Stroke	4.05
Access to Healthy Food	4.04
Alzheimer's and Dementia	4.02
Dental	4.00
Diet	4.00
Employment	3.96
Kidney Disease	3.95
Community Safety	3.93
Excess Drinking	3.93
Lung Disease	3.90
Liver Disease	3.89
Transportation	3.84
Smoking/Vaping/Tobacco Use	3.84
Physical Inactivity	3.83
Social Support	3.78
Social Connections	3.65
Access to Exercise/Recreation	3.62
Risky Sexual Behavior	3.60

Evaluation & Selection Process

Worse than Benchmark Measure

Health needs were deemed "worse than the benchmark" if the supported county data was worse than the state and/or US averages

Identified by the Community

Health needs expressed in the online survey and/or mentioned frequently by community members

Feasibility of Being Addressed

Growing health needs where interventions are feasible and the District could make an impact

Impact on Health Disparities

Health needs that disproportionately affect vulnerable populations and can impact health equity if addressed

Health Need Evaluation

	Worse than Benchmark	Identified by the Community	Feasibility	Impact on Health Disparities
Mental Health	✓	✓	✓	✓
Affordable Housing		✓		✓
Healthcare Services: Affordability	✓	✓	✓	✓
Healthcare Services: Physical Presence	✓	✓	✓	✓
Cancer	✓	✓	✓	✓
Drug/Substance Abuse	✓	✓	✓	✓
Access to Childcare	✓	✓		✓
Diabetes		✓	✓	✓
Access to Senior Services	✓	✓	✓	✓
Livable Wage	✓	✓		✓

Overview of Priorities

Mental Health

Mental health was the #1 community-identified health priority with 66.8% of respondents rating it as extremely important to be addressed in the community. Mental Health was identified as a top health priority in the 2019 CHNA report. Suicide is the 8th leading cause of death in Inyo County and ranks 21st out of 58 counties (with 1 being the worst in the state) in California for suicide death rate (World Life Expectancy).

Additionally, lack of access to mental healthcare perpetuates disparities in priority populations like racial and ethnic minority groups, residents of rural areas, and LGBTQ+ communities because of a lack of providers and an inclusive behavioral health workforce (NAMI).

While it's difficult to measure the true rate of mental illness in the community, the following data points give insight into the health priority:

	Inyo Co.	California
Average number of mentally unhealthy days (past 30 days)	4.4	3.9
Number of people per 1 mental health provider	201	244
Suicide death rate (*per 100,000*)	17.6	10.0
Adults (18+) who needed help for mental health problems in the past 12 months	18.4%	21.2%

Source: County Health Rankings (2019, 2021), worldlifeexpectancy.com (2020), AskCHIS (2020)

Affordable Housing

Affordable housing was identified as the #2 priority with 67.5% of respondents rating it as extremely important to address in the community. While affordable housing is not traditionally a health priority, there is evidence that a lack of access to affordable and stable housing can lead to negative health outcomes such as mental illnesses, exposure to environmental hazards, and limited funds to afford healthcare (Center for Housing Policy).

	Inyo Co.	California
Severe housing cost burden*	15%	19%
Sever housing problems**	18%	26%
Homeownership	65%	55%
Median home value	$479,145	$799,311
Median household income	$59,990	$88,930

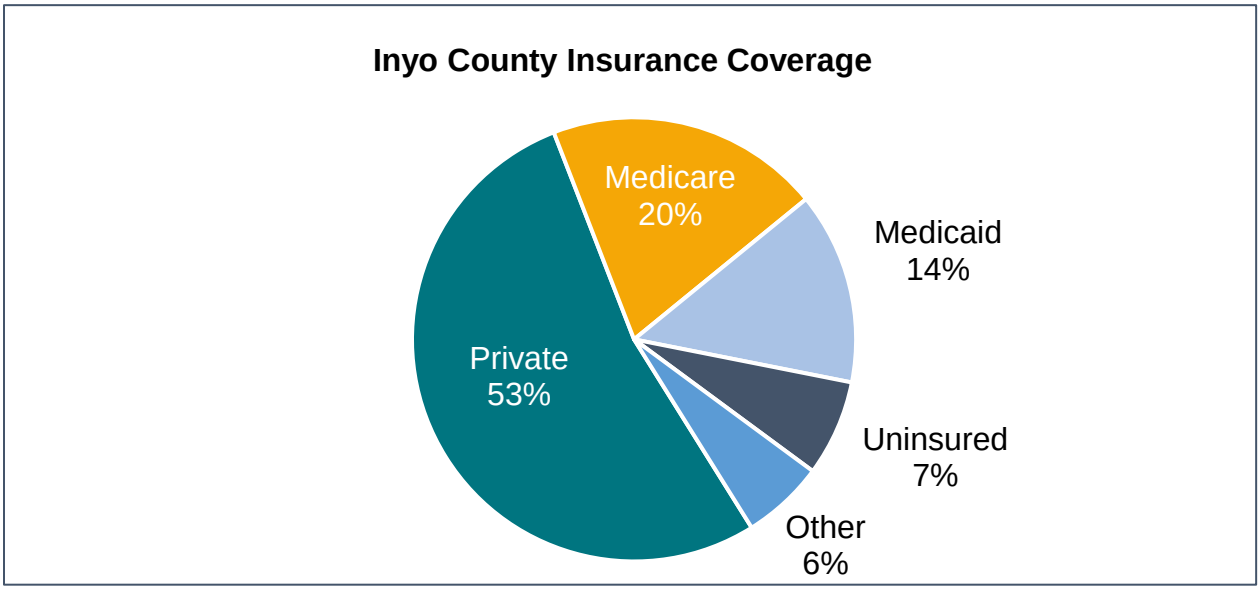
Source: County Health Rankings (2016-2020), Zillow Home Value Index (2022), Stratasan ESRI (2022)
**Percentage of households that spend 50% or more of their household income on housing*
***Overcrowding, high housing costs, lack of kitchen facilities, or lack of plumbing facilities*

Healthcare Services: Affordability

Affordability of healthcare services was the #3 identified health need in the community with 61.4% of survey respondents rating it as extremely important to be addressed. Approximately 7% of Inyo County's population is uninsured, falling slightly below the California average (Stratasan, ESRI). The percentage of adults who delayed receiving prescriptions drugs or medical services in the past 12 months is similar to the state average.

	Inyo Co.	California
Uninsured	6.7%	7.2%
Median household income	$59,990	$88,930
Adults (18+) who delayed prescriptions/medical services in the past 12 months	22.9%	22.0%

Source: Stratasan, ESRI (2022), AskCHIS (2020)



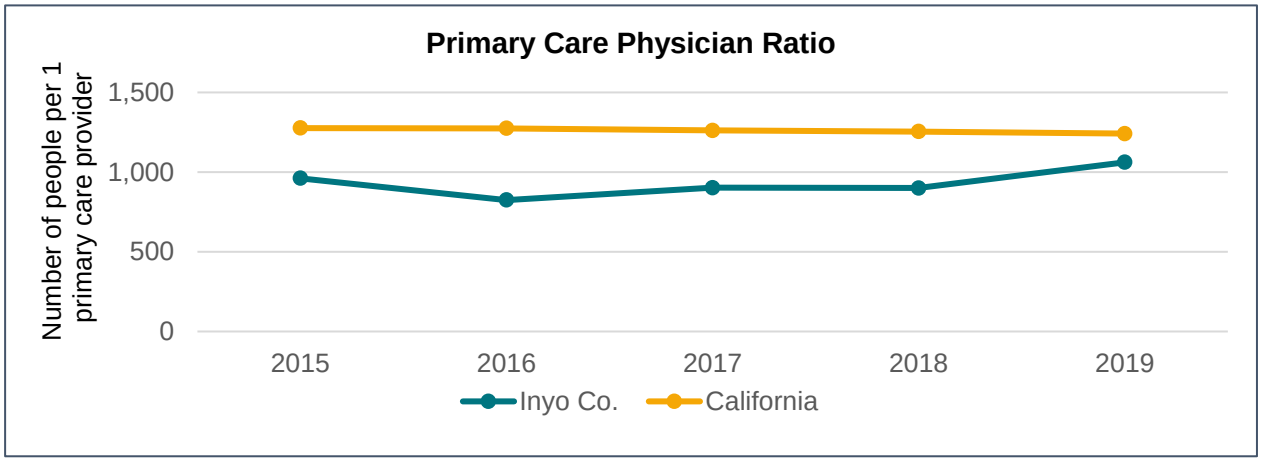
Source: Stratasan, ESRI (2022)

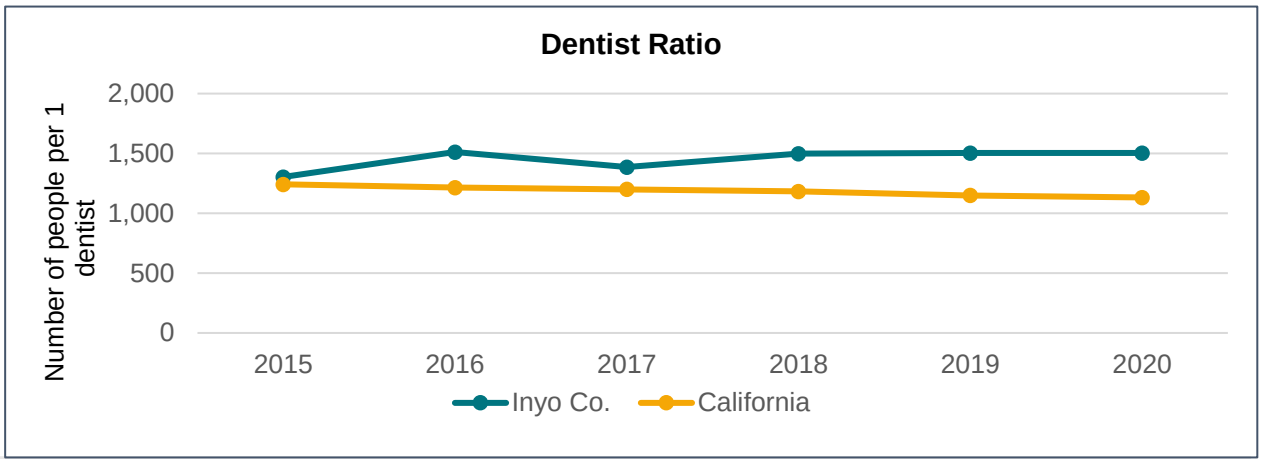
Healthcare Services: Physical Presence

The physical presence of healthcare services was the #4 identified health need in the community with 59.2% of survey respondents rating it as extremely important to be addressed. Inyo County has a slightly lower primary care physician to population ratio than California but has been increasing in recent years (Note that the primary care physician ratio includes M.D.s and D.O.s only and excludes advanced practice providers). The dentist ratio in Inyo County is higher than the state and has remained relatively stable in recent years. Inyo County is classified as a geographic health professional shortage area for primary care.

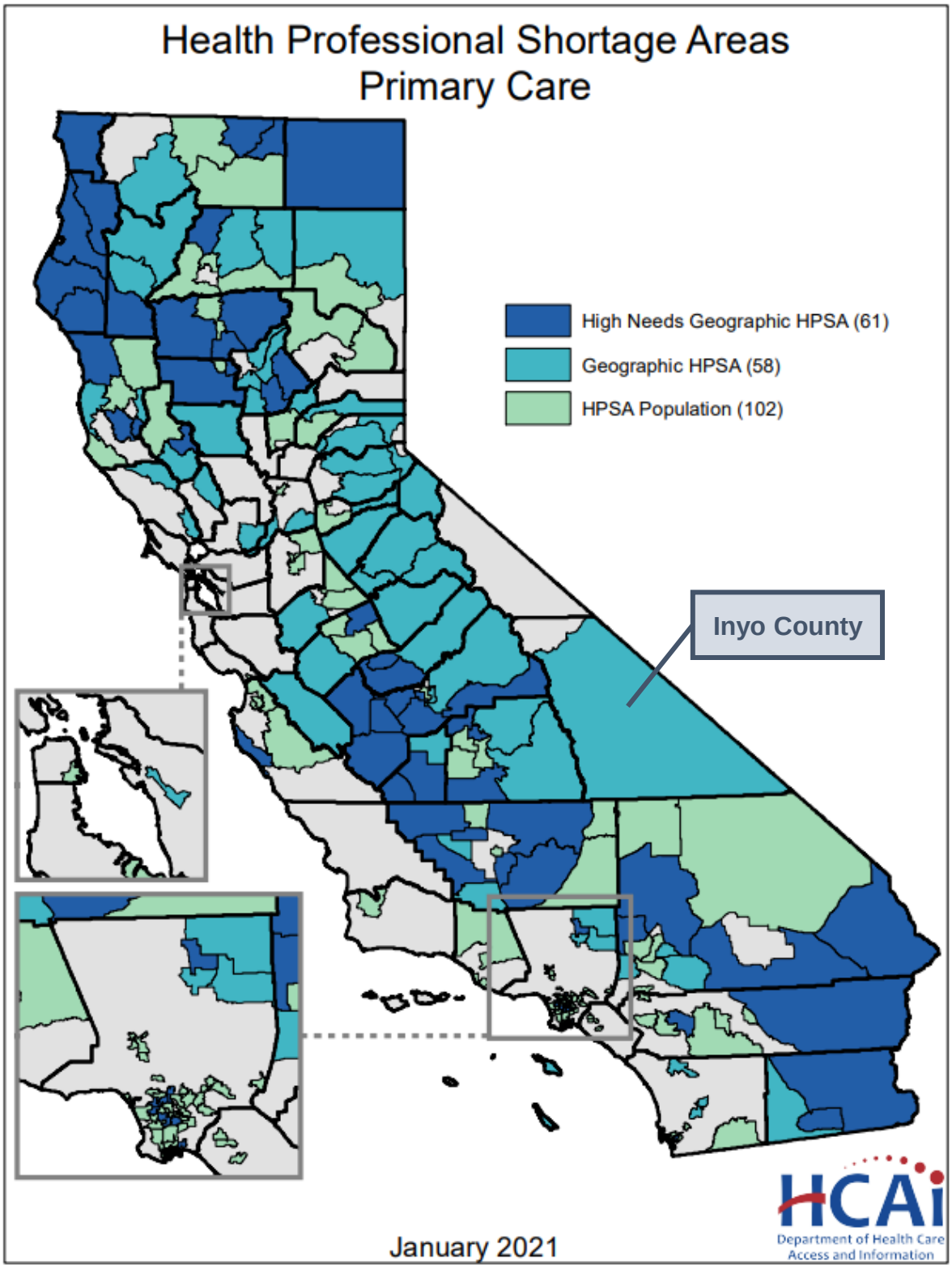
	Inyo Co.	California
Number of people per 1 primary care physician	1,061	1,240
Number of people per 1 dentist	1,505	1,132

Source: County Health Rankings (2019, 2020)





Source: County Health Rankings 2022 Report



Source: [Department of Health Care Access and Information]

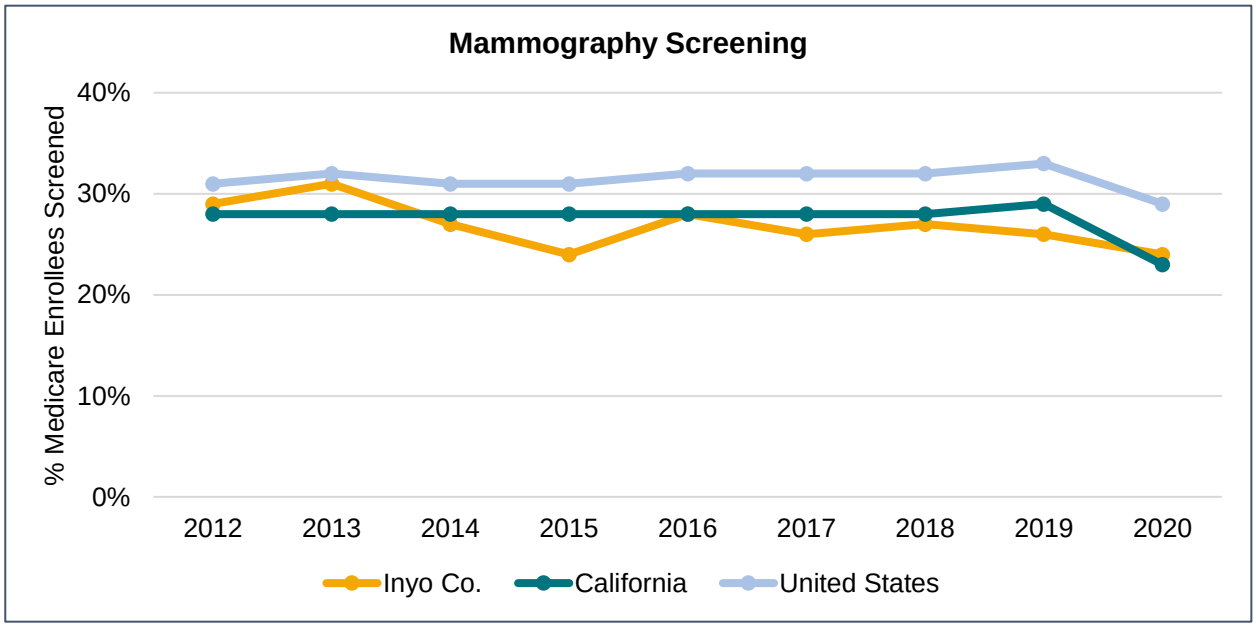
Cancer

Cancer was identified as the #5 health priority with 56.9% of survey respondents rating it as extremely important to be addressed. Cancer is the 2nd leading cause of health in Inyo County and ranks 26th out of 58 counties (with 1 being the worst in the state) in California for cancer death rate (World Life Expectancy).

Inyo County has higher cancer mortality and incidence rates than California. Additionally, 24% of Medicare enrollees (women age 65+) in Inyo County received a mammogram in 2020 and this percentage has decreased in recent years.

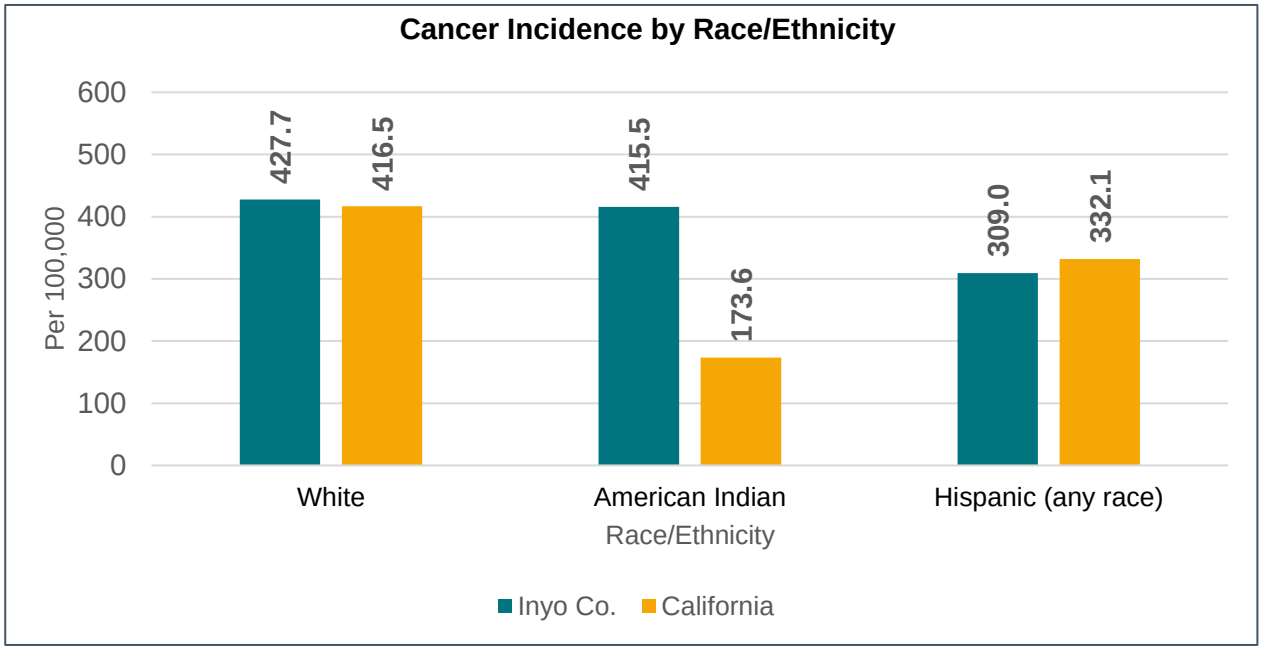
	Inyo Co.	California
Cancer Mortality (*per 100,000*)	159.3	130.3
Cancer Incidence (*per 100,000*)	433.3	402.4

Source: worldhealthranking.com (2019), National Cancer Institute (2014-2018)



Source: Centers for Medicare & Medicaid Services: Mapping Medicare Disparities by Population

In Inyo County, White residents have the highest cancer incidence rate across race and ethnic groups though American Indians have the largest disparity in cancer incidence with over 2 times the incidence rate of California.



Source: National Cancer Institute (2014-2018)
Note: Black and Asian/Pacific Islander are not included in this graph due to lack of data

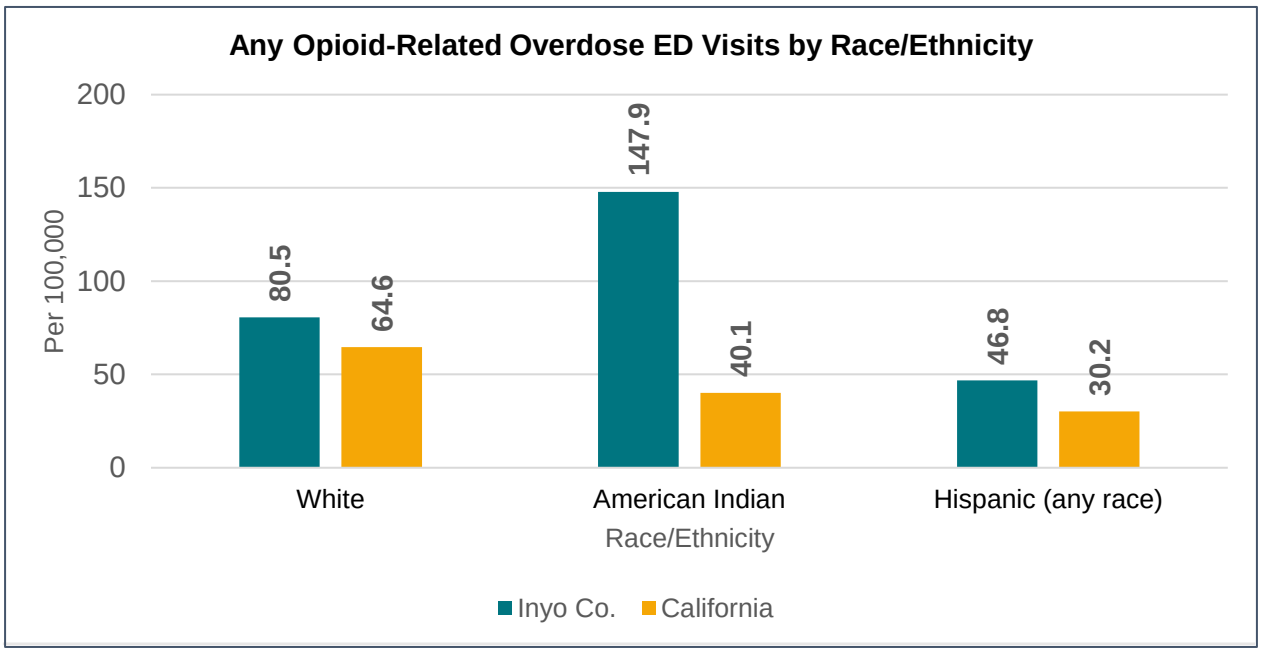
Drug/Substance Abuse

Drug and substance abuse was identified as the #6 health priority with 56.2% of survey respondents rating it as extremely important to be addressed. Drug and substance abuse was identified as a top health priority in 2019.

In Inyo County, the drug overdose mortality rate is more than double the rate in California. The same trend is observed when assessing the rate of opioid-related overdose emergency department (ED) visits. The American Indian population also has a significantly higher rate of opioid-related overdose ED visits than White and Hispanic community members.

	Inyo Co.	California
Drug overdose mortality rate (per 100,000)	40.7	17.3
Any opioid-related overdose ED visits (per 100,000)	85.1	40.9
Any opioid-related overdose hospitalizations (per 100,000)	9.6	10.2

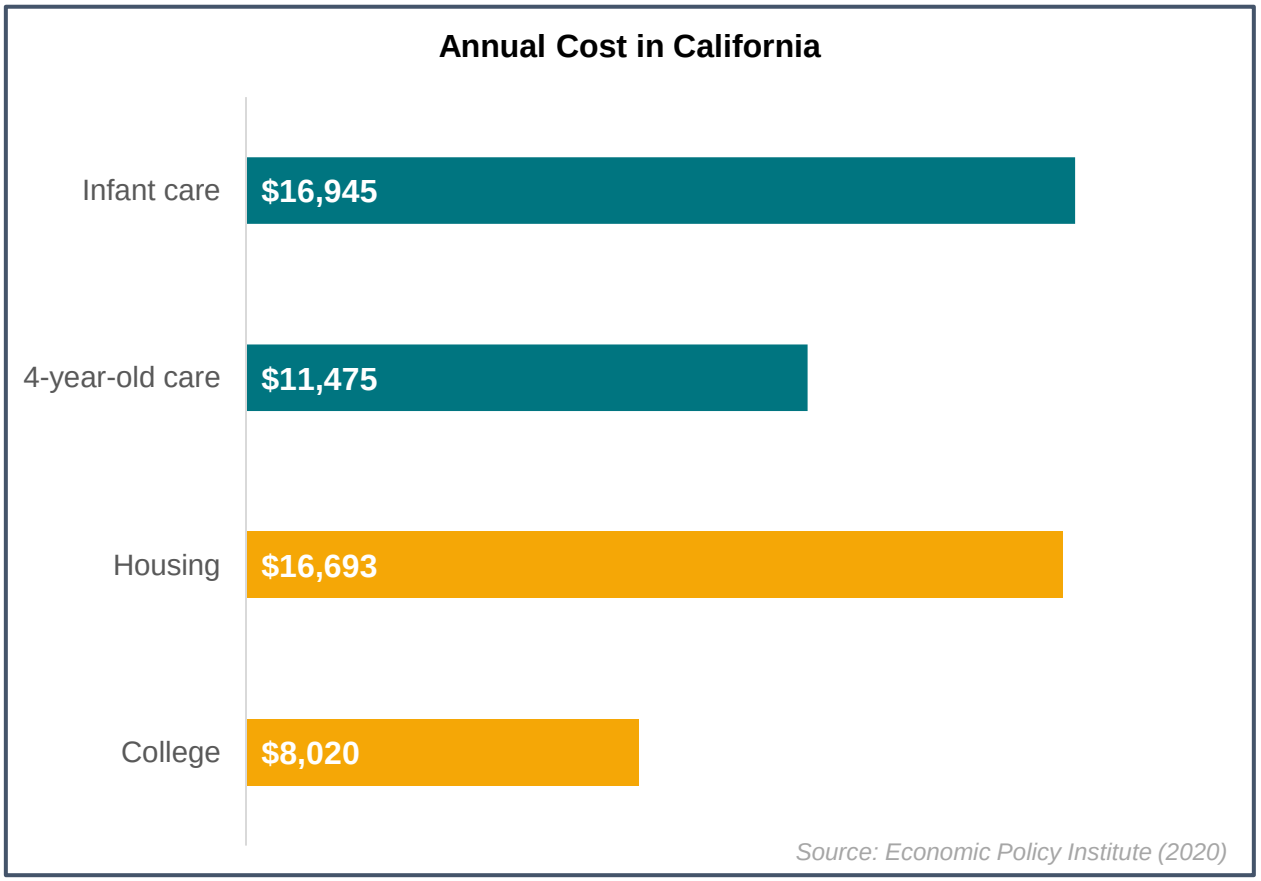
Source: County Health Rankings (2018-2020), California Overdose Surveillance Dashboard (2020)



Source: California Overdose Surveillance Dashboard (2020)
Note: Black and Asian/Pacific Islander are not included in this graph due to lack of data

Access to Childcare

Access to childcare was identified as the #7 priority with 58.2% of respondents identifying it as being extremely important to address in the community. The average yearly cost of childcare in California is $16,945. The U.S. Department of Health and Human Services defines affordable childcare as being no more than 7% of a family's income (Economic Policy Institute). In Inyo County, 34% of household income is required for childcare expenses compared to 27% in California. Additionally, 15% of children live in poverty and 26% live in single-parent households (County Health Rankings).



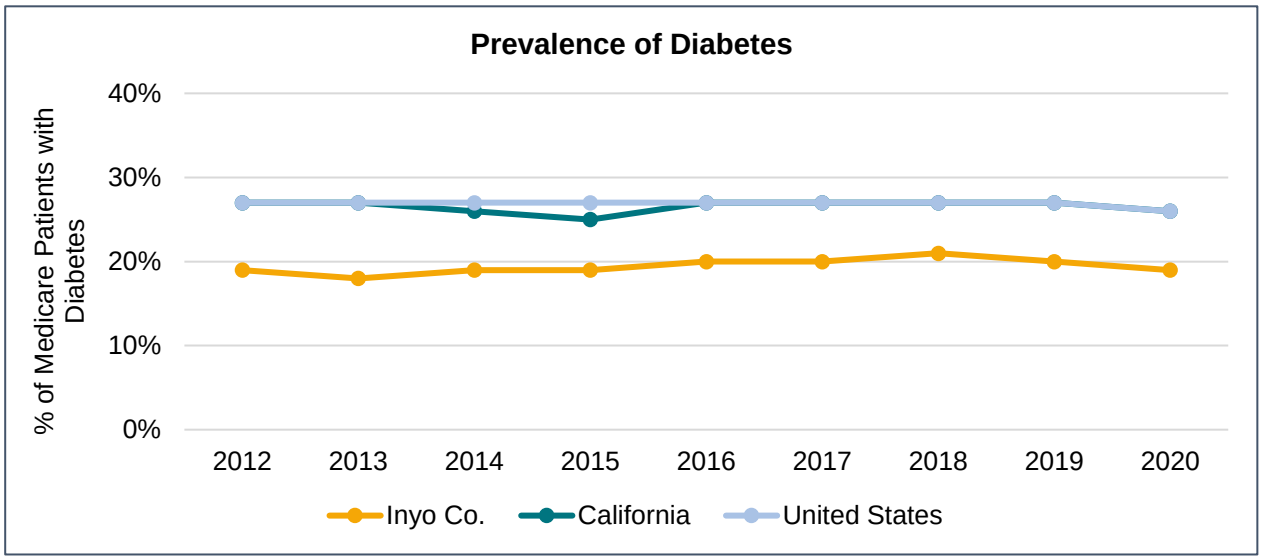
Diabetes

Diabetes was identified as the #8 health priority with 49.5% of respondents rating it as extremely important to address. Diabetes is the 9th leading cause of death in Inyo County and ranks 41st out of 58 counties (with 1 being the worst in the state) in California for diabetes death rate (World Life Expectancy).

Inyo County has a lower rate of diabetes mortality and a lower percentage of adults who have been diagnosed with diabetes compared to California. Inyo County is worse than the state, however, for adult obesity and similar to state rates for physical inactivity. Both are well-established risk factors for type 2 Diabetes development (American Diabetes Association). In the Medicare population, Inyo County has a lower prevalence of diabetes than California and the U.S.

	Inyo Co.	California
Diabetes mortality (*per 100,000*)	16.4	25.4
Adults who have ever been diagnosed with diabetes	9.8%	11.1%
Adult Obesity	28%	26%
Physical Inactivity	22%	22%

Source: worldhealthranking.com (2020), AskCHIS (2020), County Health Rankings (2019)



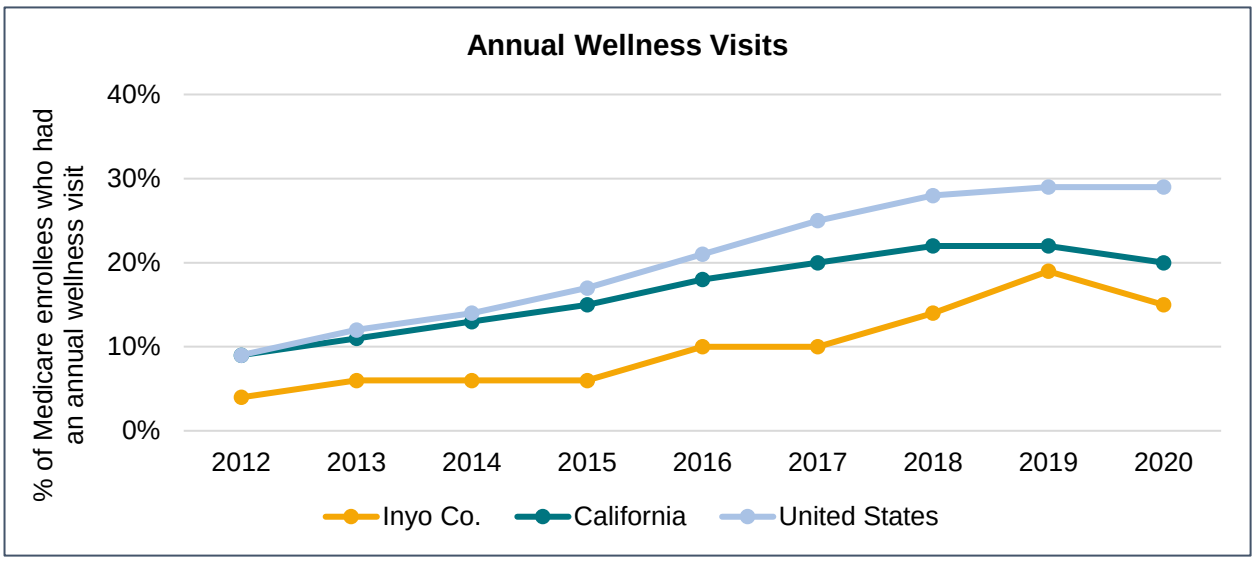
Source: Centers for Medicare & Medicaid Services: Mapping Medicare Disparities by Population

Access to Senior Services

Access to senior services was identified as the #9 health priority with 45.1% of respondents rating it as extremely important to address. Nearly 25% of Inyo County residents are age 65 or older, which is higher than the state average. For Medicare enrollees (65+) in Inyo County, 15% had received an annual wellness visit in 2020, representing a decrease from 2019. Rates have also been increasing the previous 3 years.

	Inyo Co.	California
Population 65+	24.1%	15.4%
Annual wellness visits	15%	20%

Source: Stratasan, ESRI (2022), Centers for Medicare & Medicaid Services: Mapping Medicare Disparities by Population (2020)



Source: Centers for Medicare & Medicaid Services: Mapping Medicare Disparities by Population

Livable Wage

Livable wage was identified as the #10 priority with 52.4% of respondents rating it as extremely important to be addressed in the community. Though a livable wage is not a health outcome, this social indicator plays a role in the community's ability to afford healthcare and impacts health outcomes. A livable wage can impact health status by affecting mental health through poverty and unstable work environments, health behaviors like smoking, diet, and exercise, and having access to health insurance (HealthAffairs).

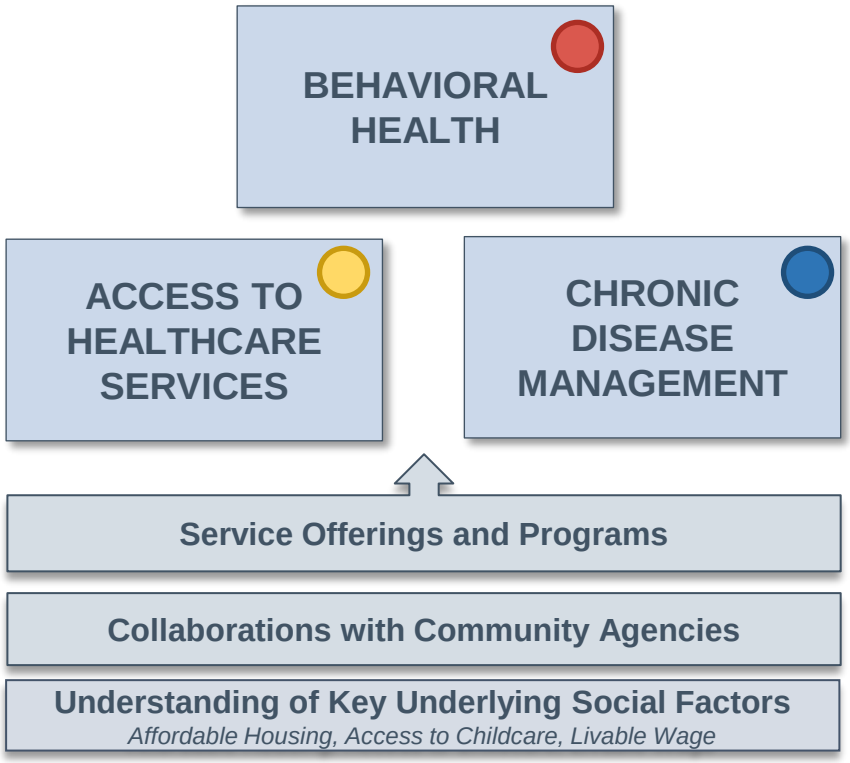
	Inyo Co.	California
Median household income	$59,990	$88,930
Children eligible for free & reduced lunch	54%	59%
Unemployment	5.9%	7.3%
Income inequality*	4.2	5.1
Adults living in poverty (<100%FPL)	9.4%	12.1%

Source: Stratasan ESRI (2022), County Health Rankings (2016-2020), Bureau of Labor Statistics (2021), AskCHIS (2019)
**Ratio of household income at the 80th percentile to income at the 20th percentile*

Implementation Plan Framework

The District's action plan is organized by key groups which will allow the organization to prioritize and address the identified health needs with available time and resources.

- Mental Health
- Healthcare Services: Affordability
- Healthcare Services: Physical Presence
- Cancer
- Drug/Substance Abuse
- Diabetes
- Access to Senior Services



Implementation Plan Strategy

Planning Process

To develop plans for how the District will address each significant health need, facilitated work sessions were held to discuss current resources, future programming, and potential partnerships. Two work sessions were conducted with internal NIHD stakeholders to develop implementation plans for behavioral health, access to healthcare services, and chronic disease management. A subsequent work session was conducted with local partners (Inyo County HHS, Inyo County Behavioral Health, Inyo County Aging and Senior Services, Toiyabe Indian Health Clinic, Pioneer Home Health) to determine how these organizations and NIHD can work together to address the significant health needs in the community.

From these sessions, the following priorities were developed:

Overarching Focus for NIHD:

- Closing gaps in care for priority populations (racial/ethnic minorities, seniors, children/adolescents, LGBTQ+)
- Community outreach and education on services/resources available in the community
- Collaborating with key partners to meet community needs

Behavioral Health

- **Key Priorities**
  - Continue successful Drug/Substance Abuse programming and outreach.
  - Explore opportunities to meet mental health needs, with a focus on connecting patients to community resources.

Access to Healthcare Services

- **Key Priorities**
  - Growing outreach/ education and increasing access for priority populations.
  - Addressing affordability of care.
  - Ensuring access to needed services via multiple channels, including telehealth and partnerships.

Chronic Disease Management

- **Key Priorities**
  - Providing the right Diabetes/ Cancer service offerings to meet community needs.
  - Promoting awareness of current services and supporting patients with care navigation.

Behavioral Health

Mental Health, Drug/Substance Abuse

Key Priorities:

- Define NIHD behavioral health services throughout the ever-changing behavioral health environment in the community (ongoing);
- Continue successful Drug/Substance Abuse programming and outreach;
- Explore opportunities to meet mental health needs, with a focus on connecting patients to community resources.

The District services, programs, and resources available to respond to this need include:

- Medical assisted treatment (MAT) program.
- MAT Oversight Committee guidance and insight to ensure compliance with and advocacy for MAT-related regulations and community needs remained aligned for the safety and well-being of community stakeholders.
- Behavioral health providers:
  - Substance use disorder (SUD) physicians
  - SUD nurse practitioner
  - SUD care coordinators
  - Psychiatrist via telehealth
  - Social workers
- Primary care providers are skilled in addressing basic mental health needs and medication management.
- Telepsychiatry appointments available.
- Case management for new moms with SUD:
  - Referrals for post-partum depression.
  - Community outreach for support.
- Grant-funded patient navigator to provide outreach, education, and connect patients to resources.
- Community events with speakers on substance use education.
- Needle exchange through Inyo and Mono Counties partnership.

Additionally, the District plans to take the following steps to address this need:

- Partner with Inyo County to collaborate on behavioral health services. Ensure that patients know what services are available and where they are provided.
- Evaluate the need to hire additional behavioral health providers.
- Increase education and awareness of specific behavioral health services provided at NIHD, including marketing in multiple languages.
- Reduce barriers and ensure culturally sensitive care for priority populations (Hispanic, Native American, LGBTQ+, youth, un/underinsured).
- Explore opportunity for a multi-community care coordinator to connect residents with community resources and health education.

Identified measures and metrics to progress:

- MAT program volume
- Mental health visits/Telepsych visits
- Data analysis of fiscal, resource, space, impact, limitations and availability

Partner organizations that may also address this need:

Organization	Contact/Information
Inyo County	https://www.inyocounty.us/
Mono County	https://monocounty.ca.gov/
Riverside Comprehensive Treatment Center	1201 W. La Cadena Drive Riverside, CA 92501 (951) 749-9240
Southern Inyo Healthcare District	https://www.sihd.org/ (760) 876-5501
Toiyabe Indian Health Project	https://www.toiyabe.us/ (760) 873-8464
Mammoth Hospital	https://mammothhospital.org/ (760) 934-3311
Wild Iris Family Counseling & Crisis Center	https://wild-iris.org/ (760) 873-6601
RAVE – Relief After Violent Encounters	(760) 873-9018
Inyo County Sheriff	https://www.inyocounty.us/services/sheriff (760) 878-0383
Bishop Union High School – Bronco Clinic	https://www.bishopschools.org/o/buhs/page/bronco-health-clinic (760) 873-2086
Other local therapists and providers	

Access to Healthcare Services

Physical Presence, Affordability, Access to Senior Services

Key Priorities:

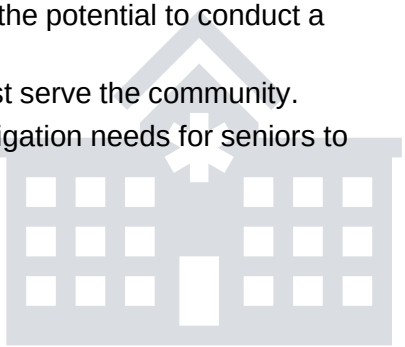
- Growing outreach/ education and increasing access for priority populations.
- Addressing affordability of care.
- Ensuring access to needed services via multiple channels, including telehealth and partnerships.

The District services, programs, and resources available to respond to this need include:

- 24-hour emergency care.
- Swing bed care.
- Telehealth appointments available for multiple service lines.
- The Rural Health Clinic (RHC) provides primary healthcare services.
- The CAREshuttle is available to provide non-emergency medical transportation services for patients.
- Healthy Lifestyle Talks are conducted every month with speakers on a variety of healthcare topics. Talks are offered in person and posted on YouTube to watch at any time.
- Clinic providers are specialized in caring for seniors.
- Same-day appointments are available at the RHC.
- Saturday clinics are available in the pediatric clinic and the RHC.
- Interpretation services are available for patients.
- Bronco Clinic – school-based clinic currently supported by a nurse practitioner who provides services multiple days a week.

Additionally, the District plans to take the following steps to address this need:

- Evaluate opportunities to address wait times across NIHD locations/departments.
- Improve timeliness and clarity of communication with patients on wait times, appointment scheduling, billing, and follow-up appointments.
- Evaluate opportunities to grow the attendance at healthy lifestyle talks and consider the potential to conduct in a community-based location.
- Optimize coordination of interpretation services to ensure patients are connected to interpreters in a timely manner.
- Improve outreach and education on services and expertise available locally at NIHD.
- Increase the number of health fairs in the community, including the potential to conduct a senior health fair.
- Evaluate hours of operation and opportunities to optimize to best serve the community.
- Assess resource and fiscal viability for expansion of patient navigation needs for seniors to connect them with resources both inside and outside of NIHD.



Identified measures and metrics to progress:

- Appointment wait times
- Health fair attendance/number of free screenings provided

Partner organizations that may also address this need:

Organization	Contact/Information
Inyo County Aging Services	https://www.inyocounty.us/services/health-human-services/aging-social-services/aging-services (760) 873-6364
Pioneer Home Health Care	http://www.pioneerhomehealth.com/ (760) 872-4663
VFW	(760)873-5770
Eastern Sierra Pride	https://easternsierrapride.org/
City of Hope – partnership for cancer patients to receive chemotherapy services at NIHD	https://www.cityofhope.org/
Eastern Sierra Cancer Alliance – provide financial assistance for cancer patients to travel for care	https://escanceralliance.org/ (760) 872-3811
Bishop Union High School – Bronco Clinic	https://www.bishopschools.org/o/buhs/page/bronco-health-clinic (760) 873-2086

Chronic Disease Management

Cancer, Diabetes

Key Priorities:

- Providing the right Diabetes/ Cancer service offerings to meet community needs.
- Promoting awareness of current services and supporting patients with care navigation.

The District services, programs, and resources available to respond to this need include:

- The Rural Health Clinic (RHC) provides primary healthcare services.
    - Primary care physicians provide chronic disease management.
- Healthy Lifestyle Talks are conducted every month with speakers on a variety of healthcare topics. Talks are offered in person and posted on YouTube to watch at any time.
- Robust outpatient diabetic services.
- Telehealth appointments available for diabetes services.
- Nutritional services available.
    - Dietitians are available via telehealth and in person.
- Screening services:
    - Cancer risk assessments
    - 3D mammography imaging by GE Healthcare
    - Stereotactic Biopsy
    - Breast MRI
    - Diabetes screenings
- Participation and education at community events to raise awareness of chronic diseases.
- NIHD offers a range of Cancer services, including:
    - Breast Health Center offering comprehensive services (prevention, detection, surgery, infusion, rehabilitation, nutrition services).
    - Cancer patient navigator.
- Partnership with City of Hope to ensure local access to chemotherapy – initial visit at City of Hope followed by chemotherapy at NIHD.
- Wound care services are available to support Diabetic patients.

Additionally, The District plans to take the following steps to address this need:

- NIHD Dietitian is working to achieve Diabetes Educator certification.
- Improve outreach and education on services and expertise available locally at NIHD.
- Continue to strengthen relationships with partners such as the Eastern Sierra Cancer Alliance and City of Hope to increase access to care for cancer patients.

Identified measures and metrics to progress:

- Number of cancer and diabetes screenings
- Quality metrics specific to diabetes/cancer

Partner organizations that may also address this need:

Organization	Contact/Information
City of Hope – partnership for cancer patients to receive chemotherapy services at NIHD	https://www.cityofhope.org/
Eastern Sierra Cancer Alliance – provide financial assistance for cancer patients to travel for care	https://escanceralliance.org/ (760) 872-3811
Toiyabe Indian Health Project	https://www.toiyabe.us/ (760) 873-8464

Appendix

Community Data

Community Demographics

Demographic Profile

	Inyo County				California				US AVG.	
	2022	2027	% Change	% of Total	2022	2027	% Change	% of Total	% Change	% of Total
Population										
Total Population	***18,907***	***18,764***	***-0.8%***	***100.0%***	***39,770,476***	***39,648,278***	***-0.3%***	***100.0%***	***3.6%***	***100.0%***
By Age										
00 - 17	3,566	3,581	*0.4%*	*18.9%*	8,961,163	8,728,849	*-2.6%*	*22.5%*	*0.0%*	*21.7%*
18 - 44	5,408	5,247	*-3.0%*	*28.6%*	15,226,307	15,162,409	*-0.4%*	*38.3%*	*0.3%*	*36.0%*
45 - 64	5,378	4,847	*-9.9%*	*28.4%*	9,470,196	8,994,390	*-5.0%*	*23.8%*	*-4.3%*	*24.9%*
65+	4,555	5,089	*11.7%*	*24.1%*	6,112,810	6,762,630	*10.6%*	*15.4%*	*12.8%*	*17.4%*
Female Childbearing Age (15-44)	2,900	2,801	*-3.4%*	*15.3%*	8,162,002	8,074,897	*-1.1%*	*20.5%*	*0.0%*	*19.5%*
By Race/Ethnicity										
White	11,561	11,062	*-4.3%*	*61.1%*	16,063,951	15,123,047	*-5.9%*	*40.4%*	*-1.3%*	*61.0%*
Black	97	98	*1.0%*	*0.5%*	2,230,475	2,162,657	*-3.0%*	*5.6%*	*0.8%*	*12.4%*
Asian & Pacific Islander	307	327	*6.5%*	*1.6%*	6,467,563	6,823,901	*5.5%*	*16.3%*	*5.6%*	*6.3%*
Other	6,942	7,277	*4.8%*	*36.7%*	15,008,487	15,538,673	*3.5%*	*37.7%*	*7.8%*	*20.3%*
Hispanic*	4,414	4,473	*1.3%*	*23.3%*	15,678,055	15,733,885	*0.4%*	*39.4%*	*3.4%*	*19.0%*
Households										
Total Households	7,987	7,907	*-1.0%*		13,569,836	13,565,803	*0.0%*			
Median Household Income	$ 59,990	$ 64,983			$ 88,930	$ 106,150			*US Avg. $64,730 | $72,932*	
Education Distribution										
Some High School or Less				*9.7%*				*14.1%*		*10.1%*
High School Diploma/GED				*28.8%*				*20.7%*		*27.1%*
Some College/Associates Degree				*30.8%*				*27.4%*		*27.7%*
Bachelor's Degree or Greater				*30.7%*				*37.8%*		*35.1%*

*Ethnicity is calculated separately from Race

Source: Stratasan, ESRI (2022)

Leading Cause of Death

The Leading Causes of Death are determined by the official Centers for Disease Control and Prevention (CDC) final death total. California's Top 15 Leading Causes of Death are listed in the tables below in Inyo County's rank order. Inyo County was compared to all other California counties, California state average, and whether the death rate was higher, lower, or as expected compared to the U.S. average.

Cause of Death			Rank among all counties in CA (#1 rank = worst in state)	Rate of Death per 100,000 age adjusted		Observation (Inyo County Compared to U.S.)
CA Rank	Inyo Rank	Condition		CA	Inyo	
1	1	Heart Disease	24 of 58	144.0	184.5	***Higher than expected***
2	2	Cancer	26 of 58	130.3	159.3	***Higher than expected***
3	3	COVID-19	10 of 58	68.7	94.1	***Higher than expected***
7	4	Lung	14 of 58	28.1	52.5	***Higher than expected***
4	5	Accidents	19 of 58	44.1	52.2	***Lower than expected***
6	6	Stroke	45 of 58	39.1	40.2	***As expected***
9	7	Liver	3 of 58	13.9	24.0	***Higher than expected***
12	8	Suicide	21 of 58	10.0	17.6	***As expected***
8	9	Diabetes	41 of 58	25.4	16.4	***Lower than expected***
10	10	Flu - Pneumonia	35 of 58	13.2	16.0	***As expected***
11	11	Hypertension	9 of 58	13.2	13.0	***As expected***
13	12	Kidney	14 of 58	9.6	10.7	***As expected***
16	13	Blood Poisoning	23 of 58	3.8	6.6	***As expected***
5	14	Alzheimer's	58 of 58	40.6	6.3	***Lower than expected***
14	15	Parkinson's	39 of 58	9.3	6.1	***As expected***
15	16	Homicide	57 of 58	6.1	1.7	***Lower than expected***

**County Death Rate Observation: Higher than expected = 5 or more deaths per 100,000 compared to the US; Lower than expect = 5 or more less deaths per 100,000 compared to the US*

Source: worldlifeexpectancy.com (2020)

County Health Rankings

	Inyo	California	U.S. Median	Top U.S. Performers
Length of Life				
Overall Rank *(best being #1)*	***45/58***			
- Premature Death*	**8,004**	5,679	8,200	5,400
Quality of Life				
Overall Rank *(best being #1)*	***42/58***			
- Poor or Fair Health	**18%**	18%	17%	12%
- Poor Physical Health Days	**3.9**	3.7	3.9	3.1
- Poor Mental Health Days	**4.4**	3.9	4.2	3.4
- Low Birthweight	**8%**	7%	8%	6%
Health Behaviors				
Overall Rank *(best being #1)*	***26/58***			
- Adult Smoking	**14%**	10%	17%	14%
- Adult Obesity	**28%**	26%	33%	26%
- Physical Inactivity	**22%**	22%	27%	20%
- Access to Exercise Opportunities	**49%**	93%	66%	91%
- Excessive Drinking	**22%**	19%	18%	13%
- Alcohol-Impaired Driving Deaths	**21%**	28%	28%	11%
- Sexually Transmitted Infections*	**443.5**	599.1	327.4	161.4
- Teen Births *(per 1,000 female population ages 15-19)*	**27**	16	28	13
Clinical Care				
Overall Rank *(best being #1)*	***30/58***			
- Uninsured	**9%**	9%	11%	6%
- Population per Primary Care Provider	**1,061**	1,240	2,070	1,030
- Population per Dentist	**1,504**	1,132	2,410	1,240
- Population per Mental Health Provider	**201**	244	890	290
- Preventable Hospital Stays	**2,948**	3,067	4,710	2,761
- Mammography Screening	**35%**	37%	41%	50%
- Flu vaccinations	**35%**	43%	43%	53%
Social & Economic Factors				
Overall Rank *(best being #1)*	***24/58***			
- High school graduation	**91%**	84%	90%	96%
- Unemployment	**7.8%**	10.1%	3.9%	2.6%
- Children in Poverty	**15%**	15%	20%	11%
- Income inequality**	**4.2**	5.1	4.4	3.7
- Children in Single-Parent Households	**26%**	22%	32%	20%
- Violent Crime*	**600**	421	205	63
- Injury Deaths*	**93**	55	84	58
- Median household income	**$55,981**	$83,001	$50,600	$69,000
- Suicides	**16**	10	17	11
Physical Environment				
Overall Rank *(best being #1)*	***10/58***			
- Air Pollution - Particulate Matter (µg/m³)	**7.5**	12.9	9.4	6.1
- Severe Housing Problems***	**18%**	26%	14%	9%
- Driving to work alone	**69%**	72%	81%	72%
- Long commute - driving alone	**17%**	42%	31%	16%

Per 100,000 Population

****Ratio of household income at the 80th percentile to income at the 20th percentile***

*****Overcrowding, high housing costs, lack of kitchen facilities, or lack of plumbing facilities***

Key (Legend)

- Better than CA
- The same as CA
- Worse than CA

Source: County Health Rankings 2022 Report

Detailed Approach

Northern Inyo Healthcare District (“NIHD” or the “District”) is organized as a not-for-profit organization. A Community Health Needs Assessment (CHNA) is part of the required hospital documentation of “Community Benefit” under the Affordable Care Act (ACA), required of all not-for-profit hospitals as a condition of retaining tax-exempt status. This study is designed to comply with the standards required of a not-for-profit hospital.

In addition to completing a CHNA and funding necessary improvements, a not-for-profit hospital must document the following:

- Financial assistance policy and policies relating to emergency medical care
- Billing and collections
- Charges for medical care

Further explanation and specific regulations are available from Health and Human Services (HHS), the Internal Revenue Service (IRS), and the U.S. Department of the Treasury.

Project Objectives

NIHD partnered with QHR Health (“QHR”) to:

- Complete a CHNA report, compliant with Treasury – IRS
- Provide the Hospital with the information required to complete the IRS – Schedule H (Form 990)
- Produce the information necessary for the health organizations to issue an assessment of community health needs and document its intended response

Overview of Community Health Needs Assessment

Typically, non-profit hospitals qualify for tax-exempt status as a Charitable Organization, described in Section 501©(3) of the Internal Revenue Code; however, the term ‘Charitable Organization’ is undefined. Prior to the passage of Medicare, charity was generally recognized as care provided for those who did not have the means to pay. With the introduction of Medicare, the government met the burden of providing compensation for such care.

In response, IRS Revenue ruling 69-545 eliminated the Charitable Organization standard and established the Community Benefit Standard as the basis for tax exemption. Community Benefit determines if hospitals promote the health of a broad class of individuals in the community, based on factors including:

- An Emergency Room open to all, regardless of ability to pay
- Surplus funds used to improve patient care, expand facilities, train, etc.
- A board controlled by independent civic leaders
- All available and qualified physicians granted hospital privileges

Specifically, the IRS requires:

- Effective on tax years beginning after March 23, 2012, each 501(c)(3) hospital facility must conduct a CHNA at least once every three taxable years and adopt an implementation strategy to meet the community needs identified through the assessment.
- The assessment may be based on current information collected by a public health agency or non-profit organization and may be conducted together with one or more other organizations, including related organizations.
- The assessment process must take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge or expertise of public health issues.
- The hospital must disclose in its annual information report to the IRS (Form 990 and related schedules) how it is addressing the needs identified in the assessment and, if all identified needs are not addressed, the reasons why (e.g., lack of financial or human resources).
- Each hospital facility is required to make the assessment widely available and downloadable from the hospital website.
- Failure to complete a CHNA in any applicable three-year period results in an excise tax to the organization of $50,000. For example, if a facility does not complete a CHNA in taxable years one, two, or three, it is subject to the penalty in year three. If it then fails to complete a CHNA in year four, it is subject to another penalty in year four (for failing to satisfy the requirement during the three-year period beginning with taxable year two and ending with taxable year four).
- An organization that fails to disclose how it is meeting needs identified in the assessment is subject to existing incomplete return penalties.

Community Health Needs Assessment Subsequent to Initial Assessment

The Final Regulations establish a required step for a CHNA developed after the initial report. This requirement calls for considering written comments received on the prior CHNA and Implementation Strategy as a component of the development of the next CHNA and Implementation Strategy. The specific requirement is:

> *"The 2013 proposed regulations provided that, in assessing the health needs of its community, a hospital facility must take into account input received from, at a minimum, the following three sources:*
>
> *1) At least one state, local, tribal, or regional governmental public health department (or equivalent department or agency) with knowledge, information, or expertise relevant to the health needs of the community;*
> *2) members of medically underserved, low-income, and minority populations in the community, or individuals or organizations serving or representing the interests of such populations; and*
> *3) written comments received on the hospital facility's most recently conducted CHNA and most recently adopted implementation strategy.*
>
> *…the final regulations retain the three categories of persons representing the broad interests of the community specified in the 2013 proposed regulations but clarify that a hospital facility must "solicit" input from these categories and take into account the input "received." The Treasury Department and the IRS expect, however, that a hospital facility claiming that it solicited, but could not obtain, input from one of the required categories of persons will be able to document that it made reasonable efforts to obtain such input, and the final regulations require the CHNA report to describe any such efforts."*

Representatives of the various diverse constituencies outlined by regulation to be active participants in this process were actively solicited to obtain their written opinion. Opinions obtained formed the introductory step in this assessment.

To complete a CHNA:

> *"… the final regulations provide that a hospital facility must document its CHNA in a CHNA report that is adopted by an authorized body of the hospital facility and includes:*
>
> 1) *A definition of the community served by the hospital facility and a description of how the community was determined;*
> 2) *a description of the process and methods used to conduct the CHNA;*
> 3) *a description of how the hospital facility solicited and took into account input received from persons who represent the broad interests of the community it serves;*
> 4) *a prioritized description of the significant health needs of the community identified through the CHNA, along with a description of the process and criteria used in identifying certain health needs as significant and prioritizing those significant health needs; and*
> 5) *a description of resources potentially available to address the significant health needs identified through the CHNA.*
>
> *… final regulations provide that a CHNA report will be considered to describe the process and methods used to conduct the CHNA if the CHNA report describes the data and other information used in the assessment, as well as the methods of collecting and analyzing this data and information, and identifies any parties with whom the hospital facility collaborated, or with whom it contracted for assistance, in conducting the CHNA."*

Additionally, all CHNAs developed after the very first CHNA received written commentary on the prior Assessment and Implementation Strategy efforts. The District followed the Federal requirements in the solicitation of written comments by securing characteristics of individuals providing written comments but did not maintain identification data.

> *"…the final regulations provide that a CHNA report does not need to name or otherwise identify any specific individual providing input on the CHNA, which would include input provided by individuals in the form of written comments."*

The methodology takes a comprehensive approach to the solicitation of written comments. Input was obtained from the required three minimum sources and expanded input to include other representative groups. The District asked all those participating in the written comment solicitation process to self-identify themselves into any of the following representative classifications. Written comment participants self-identified into the following classifications:

1) **Public Health Official** – Persons with special knowledge of or expertise in public health
2) **Government Employee or Representative** – Federal, tribal, regional, State, or local health or other departments or agencies, with current data or other information relevant to the health needs of the community served by the District
3) **Minority or Underserved Population** – Leaders, representatives, or members of medically underserved, low-income, and minority populations, and populations with chronic disease needs in the community served by the District facility. Also, in other federal regulations the term Priority Populations, which includes rural residents and LGBT interests, is employed and for consistency is included in this definition
4) **Chronic Disease Groups** – Representative of or member of Chronic Disease Group or Organization, including mental and oral health
5) **Community Resident** – Individuals, volunteers, civic leaders, medical personnel, and others to fulfill the spirit of broad input required by the federal regulations
6) **Educator** – Persons whose profession is to instruct individuals on a subject matter or broad topics
7) **Healthcare Professional** – Individuals who provide healthcare services or work in the healthcare field with an understanding/education on health services and needs.

   Other (please specify)

The methodology takes a comprehensive approach to assess community health needs, perform several independent data analyses based on secondary source data, augment this with Local Expert Advisor opinions, and resolve any data inconsistency or discrepancies by reviewing the combined opinions formed from local experts. The District relies on secondary source data, and most secondary sources use the county as the smallest unit of analysis.

Most data used in the analysis is available from public internet sources and proprietary data. Any critical data needed to address specific regulations or developed by the survey respondents cooperating in this study are displayed in this CHNA report appendix.

Data sources include:

Website or Data Source	Data Element	Date Accessed	Data Date
Stratasan	Assess characteristics of the primary service area, at a zip code level; and, to access population size, trends and socio-economic characteristics	June 2022	2022
www.countyhealthrankings.org	Assessment of health needs of the county compared to all counties in the state.	June 2022	2013-2020
www.worldlifeexpectancy.com/usa-health-rankings	15 top causes of death	June 2022	2020
Bureau of Labor Statistics	Unemployment rates	June 2022	2021
NAMI	Statistics on mental health rates and services	July 2022	2021
AskCHIS	County-level data on different health topics from the California Health Interview Survey (CHIS)	July 2022	2019-2020
Center for Housing Policy	Impact of housing on health	July 2022	2015
Zillow Home Value Index	Average home value	July 2022	2022
Department of Health Care Access and Information	Health professional shortage area map	July 2022	2021
Centers for Medicare & Medicaid Services: Mapping Medicare Disparities by Population	Health outcome measures and disparities in chronic diseases	July 2022	2020
National Cancer Institute	Cancer incidence rates	July 2022	2014-2018
California Overdose Surveillance Dashboard	Opioid-related ED and hospitalization rates	July 2022	2020
Economic Policy Institute	Childcare costs in California	July 2022	2020
Health Affairs: Leigh & Du	Impact of wage on health	July 2022	2018

A standard process of gathering community input was developed. In addition to gathering data from the above sources:

- A CHNA survey was deployed to Local Expert Advisors and the general community to gain input on local health needs and the needs of priority populations. Local Expert Advisors were local individuals selected according to criteria required by the Federal guidelines and regulations and NIHD's desire to represent the region's geographically diverse population. Community input from 643 survey respondents was received. Survey responses started on May 3rd and ended on June 3rd, 2022.

Having taken steps to identify potential community needs, the respondents participated in a structured communication technique called the "Wisdom of Crowds" method. The premise of this approach relies on the assumption that the collective wisdom of participants is superior to the opinion of any one individual, regardless of their professional credentials.

In the District's process, the survey respondents had the opportunity to introduce needs previously unidentified and to challenge conclusions developed from the data analysis. While there were a few opinions of the data conclusions not being completely accurate, most of the comments agreed with the findings. A list of all needs identified by any of the analyzed data was developed. The survey respondents then ranked each health need's importance from not at all (1 rating) to very (5 rating).

The ranked needs were divided into two groups: "Significant Needs" and "Other Identified Needs." The determination of the breakpoint — "Significant" as opposed to "Other" — was a qualitative interpretation where a reasonable break point in rank order occurred. The District analyzed the health issues that received the most responses and established a plan for addressing them. This plan was developed through a series of work sessions where relevant stakeholders from the District and other community organizations were present.

Survey Results

Due to a high volume of survey responses, not all comments are provided in this report. All comments are unedited and are contained in this report in the format they were received.

Q1: Please select all roles that apply to you.

Answer Choices	Responses	
Community Resident	69.04%	397
Healthcare Professional	38.61%	222
Government Employee or Representative	12.87%	74
Minority or Underserved Population	8.52%	49
Educator	6.96%	40
Public Health Official	2.26%	13
Representative of Chronic Disease Group or Advocacy Organization	2.26%	13
	Answered	575
	Skipped	68

Q2: What zip code do you live in?

Answer Choices	Responses	
93514	81.98%	473
93513	11.44%	66
93526	1.73%	10
93545	1.73%	10
93546	1.56%	9
93512	0.35%	2
93529	0.35%	2
93634	0.35%	2
92328	0.17%	1
93549	0.17%	1
92389	0.17%	1
	Answered	577
	Skipped	66

Other

- 93575
- 84049
- 89508
- 89010

- 89013
- 93530
- 93546
- Mono County resident
- And 91752

Q3: Where do you primarily receive healthcare services?

Answer Choices	Responses	
Northern Inyo Healthcare District	78.90%	460
Somewhere other than Northern Inyo Healthcare District (please specify)	21.10%	123
	Answered	575
	Skipped	68

Comments:

- Toiyabe Indian Health Project (47)
- Mammoth Hospital (22)
- Inyo and another place (5)
- Southern Inyo Healthcare District (5)
- Reno (4)
- Rural Health Clinic (4)
- Nowhere at the moment (3)
- UCLA (3)
- Valley Health (3)
- Arcadia Methodist Group So Cal (2)
- Bakersfield
- Carson city
- Glendale
- Hoag Newport beach
- Kaiser So Cal

- Los Angeles
- Nevada
- Pahrump Nv
- Pandya
- Physician in Bishop not in NIHD
- Ridgecrest, Fresno, Carson
- Riverside
- S. Calif.
- San Diego
- San Francisco
- Santa Barbara
- Southern Mono HCD
- St. Mary's Reno, Nevada
- UC Irvine
- UC San Diego Moores Cancer Center

Q4: Which groups would you consider to have the greatest health needs in your community? (please select all that apply)

Answer Choices	Responses	
Older adults	62.97%	352
Low-income groups	55.64%	311
Individuals requiring additional healthcare support	49.19%	275
Residents of rural areas	46.87%	262
Racial and ethnic minority groups	32.38%	181
Women	29.52%	165
Children	27.19%	152
LGBTQ+	15.38%	86
	Answered	559
	Skipped	84

What do you believe to be some of the needs of the groups selected above?

Key health needs/challenges:

1. Access to specialists (59)
2. Mental healthcare (29)
3. Affordable healthcare (20)
4. Insurance coverage (13)
5. Access to healthcare (13)
6. Timely care (12)
7. Traveling far for care (11)
8. Chronic diseases (9)
9. Social needs (housing, education, food) (9)
10. Preventative care (7)
11. Economic assistance (6)
12. Care coordination (5)
13. Transportation (5)

Key Quotes:

- Older adults don't all live with someone, a lot of the time they need transportation or help with everyday things but being alone can lead to bad accidents and injury.
- Dialysis, specialists have to come in and it is difficult to get appointments, mental health services, transportation.
- I believe some of the needs is to have access to medical specialties in town instead of traveling the distances. There is a need for bilingual services also.
- Trauma healing, nutritional counseling, substance use disorders treatment, affordable fitness classes
- Local providers/Specialists that can provide Healthcare for cancer pts, Cardiologist, Pulmonologist, more local staffing to provide the Healthcare for pts, help providing rides to/from outside providers that pt was referred to.
- More screenings/tests
- Timely referral to specialty services and transportation
- Financial assistance. Bilingual representation for the Hispanic community.
- Obesity, asthma, chronic illness
- Home health, housing, meals

Q5: Please share comments or observations about the actions NIHD has taken to address Access to Healthcare.

Key health needs/challenges:

1. Unknown (74)
2. Care shuttle (31)
3. Telehealth services (21)
4. Noticed increase access, specific actions not specified (16)
5. Need better access to specialists/lack of providers available (17)
6. Urgent care/same day clinic/drive through clinic (11)
7. Long wait times (9)
8. Limited mental health access (7)
9. RHC has helped to increase access (7)
10. Increased education and outreach (6)
11. Addition of the MAT program (6)

Key Quotes:

- Zoom has been helpful as well as drive through testing.
- The Care Shuttle is an excellent step in addressing access issues.
- Rural health has done a great job with same day care.
- NIHD provides transportation through the Care Shuttle.
- Community talks about healthcare.
- I love that I can go to Rural Health on Saturdays.
- While NIH has brought in specialists appointments are infrequent resulting in significant delays.
- Major expansion in healthcare offerings over the last few years. High school clinic, telehealth services, specialty services, breast services, sporadic urology services, etc. They even offer robotic surgery.
- Telemedicine has helped some people not to have to travel out of the area that normally would have had to.
- I have seen more focus with community service opps and information at the clinics.
- HD has a Charity Care program that helps many under or uninsured patients.
- Still need more doctors in the local area.
- The drive thru clinic has been great as well as low cost vaccinations

Q6: Please share comments or observations about the actions NIHD has taken to address Mental Health (Depression and Anxiety).

Key health needs/challenges:

1. Unknown (111)
2. More medical health services are needed (34)
3. Working to recruit providers (13)
4. Tele-behavioral health services (12)
5. Need more access to mental health providers (20)
    1. Psychiatrists (4)
    2. Therapists/counselors (5)
6. Long wait times for appointments (7)
7. Need more education/awareness (7)
8. Noticed increase in programs, specific actions not specified (6)
9. Screenings performed (6)
10. Still barrier for people with some types of insurance (4)
11. MAT program (4)
12. Access has increased through the RHC (3)

Key Quotes:

- Mental health counselors are not widely available. There are also privacy issues for group therapy.
- We need providers for mental health.
- I think we could have more availability or have more information on where we can go to get help or give those who need the help with Mental health.
- Just learned about the addiction program and overdose prevention program. Great first step.
- Improved presence/more providers available through RHC Behavioral Health department.
- Trying to get an appointment with a mental health provider is often a long time away.
- NIHD has recently, in the last 5 years, added on mental health specialists.
- We could use more mental health care facilities.
- On staff social worker.
- Provides baseline care to meet the needs of entry level mental health.
- Those seeking services still can’t get them, particularly if they don’t have money or insurance.

Q7: Please share comments or observations about the actions NIHD has taken to address Substance Use/ Alcohol Use Disorder and Driving Under the Influence.

Key health needs/challenges:

1. Unknown (105)
2. MAT program (65)
3. Noticed increase in programs, specific actions not specified (11)
4. Increased education and outreach (10)
5. Narcan education (6)
6. Services through the RHC (5)
7. Needle exchange program (4)
8. Harm reduction (3)

Key Quotes:

- Good attention to patients with these problems with appropriate doctors.
- The MAT program is a great resource. Perhaps expanding access to therapists could prevent people from the path to addiction earlier in life.
- Harm Reduction Services.
- The MAT program is very helpful for tons of community members.
- I have seen this be addressed through greater NIHD-led community awareness events, but have not had the opportunity to see any actions at the health provider level.
- NIHD has done a fantastic job at getting harm reduction services underway and available to the community. The team you have assembled and project like the mobile harm reduction are super important to keeping people safe and also connecting those with need to resources like outpatient and inpatient rehab, MAT services and other lifesaving programs and services.
- The development of the MAT Program was a great start. NIHD still needs Substance Abuse Counselors to help patients in recovery reach and maintain behavioral/functional stability in their lives.
- The MAT clinic and the opiate addiction task force locally have made huge strides in de-stigmatizing substance abuse care, meeting patients where they are, using a patient navigator, community outreach, and even saving lives.
- NIHD has streamlined the process for drawing the blood of DUI suspects and moved the process to the ER.
- Heard from NIHD's outreach program on opioid addiction which sounds like a great program and hope it will be successful.

Q8: Do you believe the above data accurately reflects your community today?

Answer Choices	Responses	
Yes, the data accurately reflects my community today	74.45%	306
No, the data does not reflect my community today	25.55%	105
	Answered	411
	Skipped	232

Key Comments:

- I'm guessing that 18% exploring problems in underreported.
- I believe affordable housing in this community is 100% a problems. You must be rich of have 2 or 3 jobs to afford a home in bishop. I also believe vaping and smoking and drug and alcohol abuse are much higher. Single parents are numerous.
- Indian population might add to some of our obesity and alcohol problems. Growing homeless population.
- I believe affordable housing in this community is 100% a problems. You must be rich or have 2 or 3 jobs to afford any home in bishop. I also believe vaping and smoking and drug and alcohol abuse are much higher.
- Mostly - seems the hispanic group may be higher
- There are many people on drugs, alcohol, tobacco, obesity. Few go to any health care place.
- I would have guessed to obesity and substance use/abuse numbers were higher
- It's definitely changed due to covid! And population of inyo county is going up and housing is more expensive.
- I believe there's a few changes but very slight.
- Nihd needs to be promoted more to the public
- The housing problem is much worse. I don't think this is an accurate reflection of the drug problem here
- The housing is worse then 18%
- I believe there are more people suffering from mental health and obesity issues.
- Numbers low for native americans
- Housing problems percentage should be a little higher. It is very hard to find affordable housing in this county. The rent and prices of housing has skyrocketed in the last few years.
- I cannot overstate this enough - we need more mental health providers, support for this community.
- I believe that there is a huge housing shortage.
- This fascinating data needed to be presented first. This is compelling data.

- Not sure.....Seems like drinking would be higher, housing issue may be higher as well
- I doubt that 89% have a high school diploma and i feel the median income is lower that stated. We have a larger than 18% housing problem. Higher than than 22% excessive drinking/drug use.
- I feel the health behaviors may be higher since covid-19. Housing issues seems low. There is no affordable housing available in inyo county this has caused community members and workforce to leave inyo county.
- Primary care providers and mental health providers need to be calculated by FTE, not just number of providers working in town.
- It seems like a higher percentage are facing housing problems, smoking, drinking, and mental health in this county.
- While the data reflects the community, there remains an inequity for bipoc
- There are more lower income people
- Mental health provider doesn't show that it is almost impossible to get physiatrist help and mental health providers have long wait. Severe housing crisis. Rent is unaffordable as is home ownership got people on fixed income. More homelessness.
- I feel we have a dentist shortage, affordable counseling, affordable housing shortage
- I don't know what the definition of mental health provider is but I imagine we are doing worse than this. But this is my perception I have no data
- Yes this reflects my community in many way's, but also doesn't help we live in a tourist town where everything is so expensive and with how the economy is right now it doesn't make it any better.
- I think housing is a huge problem.
- I am surprised that severe housing problems is less than the average for california. Lack of affordable housing is still a hugely important issue in our area as it even makes attracting mental health providers and other health care professionals very challenging for our small, rural area.
- The housing numbers are way off. This area has a extremely severe housing problem.
- I believe it undercounts homelessness, especially on the reservations.
- Although much higher in native american population regarding these population health metrics
- Internet access is not stable and access is too costly
- Alcohol/drug use, opioid use
- Feel that homelessness & unemployment is higher.
- Mental health provider appears to be inaccurately represented - minimal mental health providers that take medi-cal insurance.
- I'm surprised by the mental healthcare provider statistic. Where are these people? And do they take my insurance? How many of them are preferred providers?
- Many injurious deaths are from out of county residents and not all suicides are county residents either

- Larger need for ALS ambulance services and educational needs should be met. Urgent cares have a wider range of needs that could also be used here in this community and acute care.
- Housing is at a premium. Many empty buildings that can be rezoned to provide apartments, rooms etc.!!
- I would have to say there are definitely more hispanics in our community than stated, possibly close to or more than white.
- People per mental health provider, is concerning for those who actually seek out help. This is not counting for the ones who need help and cant afford it, are waitlisted, or are to scared to ask for help.
- The housing issue is definitely severe here, the access to eye doctors is becoming extremely difficult with appointments going up to 8 months out to get in for new glasses, and the dental insurance provided through my work still requires me to pay almost everything out of pocket. Grocery prices have sky rocketed, and everything is making is extremely difficult to live here and enjoy bishop.
- It seems like the drinking statistic is low. Housing problems are high. 18% sounds like a wrong assessment. Rental price gouging is an issue. 201 people per mental health provider seems high, easy to get lost in the shuffle.
- Adult smoking and excessive drink to me personally seems like it should be higher. As well as the severe housing problem.
- As a member of a majority group, the above data feels representative, but i am concerned about the methods used to gather this and worry that there are significant groups who have been undercounted
- I think there is more tobacco and alcohol use. And even though the ratios for primary care and mental health are better than the state, the ratios overall are still woefully inadequate and reflect the deficiencies in california as a whole
- I haven’t seen the latest census but seems somewhat accurate
- Housing is a terrible issue and help for people with mental illness is crap
- There are no homes in $56K range most start well above $300K and that’s for a small maybe 3 bed 1-1 1/2 bath built in the 1950’s.
- I believe the minority population is significantly under represented
- This doesn’t account for the transient residents and people traveling.
- I believe the housing issues are greater than stated. I also believe the mental health patient to practitioner ratio is greater than stated.
- Housing is not available.
- Unemployment rate i think might be off. Housing might be off. Drinking, smoking and weight seems off.
- This is all voluntary information, self-report. Which indicates that it may not fully reflect those populations that did not participate. I feel like the mental health provider list in very inaccurate, as there are significantly more primary care providers in the area and yet their people per primary care provider is 1000? This does not align.

Q9: Please rate the importance of addressing each health factor on a scale of 1 (Not at all) to 5 (Extremely)

	1	2	3	4	5	Total	Weighted Average
Mental Health	2	6	39	93	282	422	4.53
Cancer	2	8	61	111	240	422	4.37
Drug/Substance Abuse	4	18	61	102	237	422	4.30
Diabetes	1	12	81	117	207	418	4.24
Heart Disease	2	14	77	132	194	419	4.20
Women's Health	4	12	79	140	185	420	4.17
Obesity	6	23	85	120	183	417	4.08
Stroke	1	15	106	136	161	419	4.05
Alzheimer's and Dementia	3	22	106	126	166	423	4.02
Dental	5	27	102	119	170	423	4.00
Kidney Disease	4	22	111	133	148	418	3.95
Lung Disease	3	27	128	111	149	418	3.90
Liver Disease	3	26	129	119	142	419	3.89
Other (please specify)						30	
						Answered	427
						Skipped	216

Comments:

- Hematology
- Children's health
- Child Abuse
- Men and children's health
- Food Insecurity, Access to Childcare
- End of Life care
- As far as drug/substance abuse prevention, I think it should be more focused on harm reduction strategies. Also, I think the way many doctors address obesity is not helpful, and that it shouldn't be the go-to for health care providers to focus on during a check-up.
- Neurology and ENT needs
- OPTICAL needs are not being met. We seem to think EYES are not important ? Less people with healthy eyesight means less citizens driving-at a time when EST Bus up to Sabrina/South Lake is in danger of being cut ?

- Lbgtquia+ access
- Cancer specialists
- Covid related health care
- Vascular disease
- Menopausal health
- Post partum depression
- Autoimmune diseases
- Dermatology
- Mental health care could aid if not solve other issues listed.
- Eye doctors for people with medi-cal
- Preventative health!
- Spine - ortho
- Not enough speciality care in our rural area.
- Chronic pain

Q10: Please rate the importance of addressing each community factor on a scale of 1 (Not at all) to 5 (Extremely)

	1	2	3	4	5	Total	Weighted Average
Affordable Housing	13	7	38	81	288	427	4.46
Healthcare Services: Affordability	2	12	55	96	262	427	4.41
Healthcare Services: Physical Presence (location, services, physicians)	3	15	53	103	252	426	4.38
Access to Childcare	8	22	54	82	231	397	4.27
Access to Senior Services	3	12	68	151	192	426	4.21
Education System	5	11	90	125	192	423	4.15
Healthcare Services: Prevention	2	12	97	118	190	419	4.15
Employment and Income	7	17	88	127	184	423	4.10
Access to Healthy Food	9	20	94	119	179	421	4.04
Community Safety	9	31	105	115	163	423	3.93
Transportation	12	34	103	128	141	418	3.84
Social Support	13	30	115	142	122	422	3.78
Social Connections	11	33	154	114	107	419	3.65
Access to Exercise/Recreation	25	49	116	103	130	423	3.62
Other (please specify)						12	
						Answered	429
						Skipped	214

Comments:

- Communication of services to community!
- Having a daycare especially specific to hospital employees would be extremely beneficial. It would be great if they were specific to the
- Food Insecurity
- Dermatologist needed here!
- Frequent, reliable, free
- Need more programs for kid whose parents are working and can't take them to the activities they need to be healthy
- All of the above and we all know it as a combined community it's been needed for many years.
- More affordable events for children & teens.

Q11: Please rate the importance of addressing each personal factor on a scale of 1 (Not at all) to 5 (Extremely)

	1	2	3	4	5	Total	Weighted Average
Livable Wage	12	16	62	110	220	420	4.21
Diet	12	15	91	145	157	420	4.00
Employment	15	17	98	128	160	418	3.96
Excess Drinking	25	15	92	121	166	419	3.93
Smoking/Vaping/Tobacco Use	30	26	88	107	164	415	3.84
Physical Inactivity	19	24	110	121	144	418	3.83
Risky Sexual Behavior	29	33	124	121	110	417	3.60
Other (please specify)						15	
						Answered	423
						Skipped	220

Comments:

- Fire maintenance
- Marijuana use
- Substance use
- Safe weapon handling.
- Care should be at my convenience not the doctors
- Diet & exercise!
- Sleep disorders
- Wearing sunscreen
- Drug use

Q12: Overall, how much has the COVID-19 pandemic affected you and your household?

Answer Choices	Responses	
Noticeable impact, has changed daily behavior	39.65%	159
Some impact, does not change daily behavior	34.41%	138
Significant daily disruption, reduced access to needs	16.21%	65
No impact, no change	6.48%	26
Severe daily disruption, immediate needs unmet	3.24%	13
	Answered	242
	Skipped	401

Q13: What has been negatively impacted by the COVID-19 pandemic in your community? (Please select all that apply)

Answer Choices	Responses	
Employment	61.89%	242
Childcare	53.96%	211
Social support systems	52.69%	206
Education	51.92%	203
Access to healthcare services	46.55%	182
Housing	42.46%	166
Food security	32.74%	128
Public safety	30.43%	119
Poverty	30.18%	118
Racial and cultural disparties	23.79%	93
Nutrition	21.23%	83
Transportation	18.16%	71
Other (please specify)	11.25%	44
	Answered	391
	Skipped	252

Comments:

- Mental and Behavioral Health all ages
- Stress, Mental health, isolation, shutdowns, economic decline

- Cost of living
- Mental health
- More social isolation, this has mental health impacts
- Businesses
- Emotional health
- Increase in mental health issues and illness
- Public safety due to homeless, and speeding on HWY 395
- Weight gain
- Mental health
- Sense of normalcy
- Mental health services
- Access to mental health services
- Mental health
- Business closures
- Community cohesion, cooperation, empathy have all been negatively impacted by county and citizen noncompliance with our own health department recommendations/mandates.
- Mental health
- Mental stability, community gatherings
- Mental healthcare
- Mental health suicidal ideation increase in the community
- Mental health
- Polarizing views creating inequalities
- Honestly the lack of concern, cooperation and common consideration for the community needs and well being of others during this covid pandemic. Compromised, elderly, health challenged and many.
- Isolation and depression
- Personal safety
- Community cohesiveness and understanding of science

Q14: Have you or your family delayed using any of the following healthcare services during the COVID-19 pandemic? (Please select all that apply)

Answer Choices	Responses	
Primary care (routine visits, preventative visits, screenings)	39.60%	158
None of the above	32.83%	131
Specialty care (care and treatment of a specific health condition that require a specialist)	25.56%	102
All types of healthcare services	20.55%	82
Elective care (planned in advance opposed to emergency treatment)	20.30%	81
Urgent care/Walk-in clinics	10.53%	42
Emergency care (medical services required for immediate diagnosis and treatment of medical condition)	7.27%	29
Inpatient hospital care (care of patients whose condition requires admission to a hospital)	6.52%	26
Other (please specify)	5.51%	22
	Answered	399
	Skipped	244

Comments:

- Dental and vision
- Waited almost a year to get knee replacement.
- Substance Abuse
- Dental
- Gym
- Physical therapy delayed
- Since 2009, I've gone out of town for women's services because there is no continuity of provider care. Bishop has a transitional medical community. Continuity of care with one provider is important.
- Dental
- Dental
- Dental; we did utilize telemed, and now prefer it. Also went out of town to a large medical center where all staff were compliant with PPE and COVID precautions
- We have been fortunate and have not needed access to any type of healthcare in the last two years.
- Womens clinic, dermatology, colonoscopy
- Delayed a major surgery due to hospitals not allowing surgery in 2020

Q15: How can healthcare and public health entities continue to support the community through the challenges of COVID-19? (please select all that apply)

Answer Choices	Responses	
Serving as a trusted source of information and education	73.06%	282
Offering alternatives to in-person healthcare visits	67.88%	262
Connecting with patients through digital communication channels (e.g., patient portal, social media, etc.)	58.81%	227
Posting enhanced safety measures and process changes to prepare for your upcoming appointment	40.67%	157
Sharing local patient and healthcare providers stories and successes with the community	26.94%	104
Other (please specify)	13.99%	54
	Answered	386
	Skipped	257

Comments:

- I don't know the severity of covid in my town but I suspect it was very severe.
- Education on 3rd booster
- Education regarding vaccines and providing information to anti-vaxers.
- Toiyabe has offered drive thru clinics
- Open up your billing department so people have someone to talk to because its impossible!
- Promote care in the home as an alternative
- Continue you to see patients as always for basic care
- Keeping their physical offices as safe (sanitized) as possible.
- Using their medical knowledge and not just blindly following “rules” which make no sense.
- Community billboards.
- Do not rely on technology for the senior patients. We don't understand how to access.
- Please continue to give latest information.
- Promoting what services our hospital has— I don’t know if they do sleep studies and respiratory care etc
- Wiping down waiting rooms regularly. Wiping down sign in ipads between patients
- Holding steady in promoting good public health and safety.
- Dental

- No challenge if you follow protocol
- By giving truthful facts and statistics or the covid 19 pandemic and giving other medicine options for those not willing to take a vaccine as well as caring for those who have taken the vaccine and are still struggling with covid.
- Health fairs...Health clinics free... Home visits
- Need to have covid vaccine available in the clinics!
- Get better specialized doctors in our valley so we don’t need to travel
- More face to face time with patients
- Need to remember many seniors don't have access to computers or social media.
- Do visits outside (weather permitted)
- Seeing patients face to face
- Need more womens clinic providers - cant get in for an appointment for a month
- Listening, up to date education, up to date awareness of new medical health information, treatments, awareness. The want and desire to do so kindness not negative attitude.
- Mask up, promote vax inc. For workers
- Scheduling more inpatient appoints in a timely manner not 3 months out.
- Expanded connection to healthcare providers in the surrounding communities via virtual appointment to help fill specialist and mental health needs

Q16: COVID-19 has led to an increase in virtual and at-home healthcare options, including telemedicine, telephone visits, remote monitoring, etc. What alternative care options do you believe would benefit the community most? (please select all that apply)

Answer Choices	Responses	
Video visits with a healthcare provider	69.23%	270
Patient portal feature of your electronic medical record to communicate with a healthcare provder	60.00%	234
Smartphone app to communicate with a healthcare provider	51.03%	199
Telephone visits with a healthcare provider	47.69%	186
Remote monitoring technologies to manage chronic diseases (e.g., wearable heart monitor, Bluetooth-enabled scale, Fitbit, etc.)	43.85%	171
Virtual triage/screening option before coming to clinic/hospital	42.82%	167
Other (please specify)	13.33%	52
	Answered	390
	Skipped	253

Comments:

- "On call" office person
- Face to face is always the way to go!
- In person interactions
- A lot of people do not have smart phones or social media
- Many people do not have access to reliable internet or smart phones. This needs to be taken into consideration when providing treatment options and access to information
- We have a very in person community
- Virtual group
- In person visits with real connections.
- For patients that are hard of hearing , and don’t have smart phones in person visits are a must
- In-person mental health/HIV service provider. Telehealth has proven to be difficult for these issues.

- Do need to work on educating the community on how to use the telehealth app/video service
- Home visits for the elderly and disabled
- Email responses from providers
- Face to face interaction with physical exams
- Culturally competent services
- NIH has a patient portal.
- Since some people are limited in their ability to utilize digital technologies, there needs to be a process to help them.
- I think the drive through clinic seems effective for many things; at least from patient standpoint
- In home visit
- Specific portal that's easy to use and most popular amongst big health organizations my chart.
- I think i'm person is critical. With the added remote has come over extended folks doing too much in too little time. Loss of connection to on the ground conditions.
- But to a lower cost because they are virtual
- Add in mental healthcare to what medical healthcare already uses to assist with access to care such as the patient portal, electronic signing of intake forms, etc.
- In person evaluation/assessment is best for quality patient care
- It would depend on who you are trying to reach, again many seniors are not good with todays technology.
- Need better communication access (cell, internet service before telehealth is effective.
- Shorter times to see the doctor
- I see my EOB and the virtual reimbursement rate is so low though, i'm not sure those are viable
- While it's nice to have the portal for messaging and access to records, the elderly we know are hesitant to use it.
- In-patient visits essential for diagnosis, virtual for initial consult
- Prefer one on one visit

Q17: What healthcare services/programs will be most important to supporting community health as we move into the future? (please select all that apply)

Answer Choices	Responses	
Mental health	70.81%	279
Ensuring convenient and affordable healthcare access points	62.18%	245
Primary care	59.64%	235
Specialty care	58.63%	231
Elder/senior care	58.12%	229
Urgent care/Walk-in clinics	57.11%	225
Substance abuse services	51.02%	201
Chronic disease management programming	45.43%	179
Addressing cultural needs and practices impacting health care access, care delivery and outcomes	38.07%	150
Women's health	37.56%	148
Pediatrics/children's health	35.79%	141
EMS/Paramedic Service	34.52%	136
Emergency care	31.98%	126
Addressing patient language and communication needs	28.43%	112
Other (please specify)	8.88%	35
	Answered	394
	Skipped	249

Comments:

- Financial info.
- DME company that provides O2 on discharged patients 24/7
- Men's health
- Behavioral Health including CADC
- Home Health Care
- Having specialist for kidney, lungs, gastroenterologist, migraines etc come at least once a month to our facility. It’s hard for some to go out of town for services they need. Getting the generators needed for DI dept to do RFAs
- Nursing homes

- Better communication within hospital departments and to outside providers
- Optometry providers who take medi-cal only 1 provider locally
- Access to equipment other facilities use only during certain hours, we must be able to provide care with proper equipment if we have a population with these health risks.
- Optical.
- Cardiology, rheumatology
- Trust
- The community needs a second ambulance, as symons ambulance only can afford to staff one ALS unit at one time.
- Outsourcing for a pulmonologist and cardiologist to assist in heart and lung needs in the community.
- Urology, cardiology
- Pain management
- Access to services in rural areas
- Money!
- Patient support services that help them navigate the healthcare system
- NIHD really needs to simplify and improve communication, intake, access to patient records; not to mention drastic improvement of the referral process, which contributes to unacceptable delays in care
- Substance abuse treatment centers for men. And woman and children.
- Pain management
- Dental
- Concerned for people with heart issues, they usually have to go out of the area for that.
- Oncology
- Dermatology
- Cancer care/oncology

Q18: Please share resources and solutions that would support you and the community during the COVID-19 pandemic and in the future.

- Have specialists available locally.
- Provide information about what is happening during pandemics.
- Our hospital is doing all they can and always has.
- Hospital conduct vaccination for the public.
- Covid pay for employees and family
- Family focused events - community support with childcare offered.
- Endocrinologist, cardiologist, psychists
- Streamline the processes, so that all entities are following the same protocols. There were to many facilities with different rules. It should be the same across the board. It is too confusing for people, especially are elderly residents.
- Consistent and accessible information about masking, vaccination and the spread of disease
- Return to unified communication regarding covid incidence nationally, statewide and county wide.
- Use of home health, use of telehealth, newspaper education.
- Increasing tele and phone visits. Assessing the needs for specialty such as pulmonology and EENT.
- Childcare support at the district. Burnout and compassion fatigue prevention for staff
- A well-advertised nursing/advice phone line.
- Accurate COVID-19 information delivered to all residents. Not just posted on facebook.
- Provide a covid testing hotline for employees and employers alike to be able to make a timely appointment for covid testing. This will assist employees in getting back to work sooner than later.
- If you could develop something to rid the community of distrust and anger over a virus and science. Something to reunite the community.
- Updates and education through media campaign in english and spanish.
- My family was able to access a therapist out of the area through telehealth, and that was very helpful to us. Maybe connecting patients and families with resources like this when our local providers are maxed out would be helpful.
- Just for our community to keep staying safe get vaccinated if can and for our health providers to keep doing great work as they have been

- The medication that reduces death rates of covid.
- Access to additional mental health supports including more local providers!
- Better collaboration efforts with different medical facilities and services in the county. Everyone are equal and need to understand that one facility isn't "better" than another one. We all serve the same community! Instead dividing our people, collaborate and serve our communities the best way we can!
- Less wait time to see or talk to a doctor
- Free vaccines, free and readily available ppe
- Open all access points and expect community to behave responsibly when symptomatic.
- Accurate, unbiased information. Both sides of the story
- Holistic approach weight loss plan set-up at all pcp wellness checks if pre covid weight was less than post covid weight
- Figure out how to address covid fatigue so people will be willing to mask when infections spike.
- This area needs to offer resources for higher education; offering paramedic and rn schooling would be a key change.This area could also make great use of an urgent care, most of the time patients are brought into
- This week in virology's clinical updates with dr. Daniel griffin have been very informative throughout the pandemic.
- Mental health counseling
- Covid -19 crisis is around the world, and we should try to help our community by following the CDC rules.
- More ambulances/help for transporting people on 5150 holds. I am a mental health professional who is often on call, and symons consistently turns us down for transport. I often have to do them myself which is not safe.
- Mandates were received poorly however there was reluctance to masking and vaccination. That said, education, encouragement, and even bribery in the form of gifts or money should be used to encourage public health measures instead ideally.
- People complying with mandates. Quick turnaround testing.
- Post-traumatic growth outreach and awareness. Perseverance and a sense of responsibility to take some of the burden off our healthcare workers by allowing and encouraging other workers to return to work.
- Consistency with informed information, honesty and acknowledgement of difficulties
- Trust so community members get vaccinated. Being available to the community

- Educate people that barriers, such as masks and latex gloves, keep people from spreading or getting covid. Of course, thanks politics, that may be impossible.
- Better public awareness about how covid is affecting individuals in the community. It needs to be person so our community understands we need to take care of each other. Some individuals and families should we willing to share their stories.
- More healthy community activities to improve mental health and provide healthy distractions from isolation and boredom- - movie nights in the park, dance lessons, concerts, flea markets, lectures
- Having access to abortion and other women's healthcare somewhere within 3 hours of bishop.
- Give people the information they need to make good discussion about their health. Not information that is biases but ALL information
- Food stamps for people without children... Rental assistance... And other bills too
- Remembering that we are a community. We are all in this together!
- I think we did well with getting through covid. I think that altrusa deserves a big shout out for making mask for the hospital when they could not get them. I don't know if they ever got one.
- More communication with community
- Female psychologists specifically for young girls.
- Retain medical professionals and attract more specialists. I'm afraid the majority of people go without seeing a needed specialist because they cannot travel outside of our area.
- Expanding same day care
- I think NIHD has far exceeded national averages with regards to providing access to all covid related resources and solutions
- Get a full time psychiatrist who is present on site. Same with another general surgeon. And a lactation specialist who is available at least 2-3 times a week.
- More providers and perhaps longer hours of service at some of the clinics.
- Resources and tools to provide for the community to call when needing mental health help.
- More information be produced through social , radio and newspaper. Talking points on topics that are important our community
- Mental health support
- Everyone following the same processes with information backing it for precautions

- More mental health services that are convenient and affordable.
- Mental health services
- Telehealth for specialties
- Specialist doctors
- Access to womens clinic services and dermatology
- Treat everyone equally, with respect and compassion. Invest in decent healthcare facilities that are not temporary buildings.
- Cooperation from the community and updated information from the county on a weekly basis. More availability from our current resources that up to date knowledge based of resource. A community that works together succeeds better, but yeah wishful thinking on my part. I have hope.
- I feel the community is in good hands relating to covid 19
- I found the virtual weekly business meetings with county health quite helpful as well as their weekly updates as the covid situation progressed. I felt grateful that our community provided vaccination access and safety protocols re masking and quarantines.
- Nihd's continued following of its own posted protocols (masking, etc.) And enforcement is appreciated.

NORTHERN INYO HEALTHCARE DISTRICT
REPORT TO THE BOARD OF DIRECTORS
FOR INFORMATION

Date: August 12, 2022

Title: **WORKFORCE HOUSING UPDATE**

Synopsis: Housing for current and potential workforce members, and the community as a whole, continues to be a significant barrier. District leadership continues to monitor and supply NIHD housing status insight for community meetings and as part of housing roundtable/group think venues.
Why? Travelers and new hires who move to the area, struggle to secure temporary (travelers) and initial (employee) housing, and this creates an immediate hardship during the relocation and start time phases.
We commend all community members who are working to minimize or alleviate some of the housing crisis' new workforce members are commonly facing for organizations in our community.
District leadership remains open to participating in and providing insight and information to community discussions/meetings.

Prepared by: Erika Hernandez, Admin Assistant/Board Clerk

Approved by: Kelli Davis, CEO

NORTHERN INYO HEALTHCARE DISTRICT
REPORT TO THE BOARD OF DIRECTORS
FOR INFORMATION

Date: August 12, 2022

Title: **CHIEF FINANCIAL OFFICER UPDATE**

Synopsis: District leadership is pleased to announce the recruitment and hiring of Stephen DelRossi, MSA, as our Chief Financial Officer. Stephen will onboard at NIHD on August 22, 2022.
Vinay Behl, Financial Consultant, has provided CFO services to NIHD since April of 2020. Vinay's contributions to the strategic financial health of the district, and executive leadership and team, are commended and appreciated.
A hand-off/transition plan from Vinay to Stephen is in the process of being defined and will be implemented accordingly.
Stephen will be introduced officially to the Board of Director's and public on September 21st, during the regularly scheduled Board Meeting.

Prepared by: Erika Hernandez, Admin Assistant/Board Clerk

Approved by: Kelli Davis, CEO

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

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

TO: NIHD Board of Directors
FROM: Sierra Bourne, MD, Chief of Medical Staff
DATE: August 2, 2022
RE: Medical Executive Committee Report

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

A. Medical Staff Appointments (*action item*)
    1. Peter Verhey, MD *(radiology)* – Telemedicine Staff

B. Critical Indicators (*action item*)
    1. Emergency Medicine
    2. Inpatient Medicine

C. Policies (*action item*)
    1. *Credentialing Healthcare Practitioners in the Event of a Disaster*
    2. *Rapid Response Team*

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

Emergency Room Service Critical Indicators

2022

1. Physician and Staff Concerns
2. All non-5150 Transfers
3. Unscheduled Return within 72 Hours with admission, transfer, or death
4. All ED physician attended codes
5. All ED deaths
6. Massive Transfusion Protocol initiated
7. Suicide or Attempted Suicide in the ED

Approvals:

Emergency Room Service Committee: 7/18/2022
Medical Executive Committee:
Board of Directors:

Inpatient Medicine Critical Indicators

2022

1. Transfers to higher level of care
2. Transfers from Med/surg to ICU
3. All unanticipated inpatient deaths
4. All 30-day readmissions
5. All intubated patients

Approvals:

Inpatient Medicine Committee: 06/29/2022
Medical Executive Committee:
Board of Directors:

NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL POLICY AND PROCEDURE

Title: Credentialing Healthcare Practitioners in the Event of a Disaster		
Owner: MEDICAL STAFF DIRECTOR	Department: Medical Staff	
Scope: District-Wide		
Date Last Modified: 04/26/2022	Last Review Date: No Review Date	Version: 5
Final Approval by: NIHD Board of Directors	Original Approval Date: 04/15/2020	

PURPOSE:

The purpose of this policy is to outline the credentialing procedure by which a practitioner can be granted temporary privileges in a disaster at Northern Inyo Healthcare District (NIHD).

DEFINITIONS:

1. **Disaster** – an emergency that, due to its complexity, scope, or duration, threatens an organization's capabilities and requires additional and sometimes outside assistance to sustain patient care, safety, or security functions.
2. **Volunteer Healthcare Practitioner** – a licensed independent practitioner or other individual required by law and regulation to have a license, certification, or registration who is presenting to assist in patient care during a disaster. This individual may have existing privileges at NIHD or may be a volunteer not currently privileged at NIHD. Additionally, licensed locum tenens practitioners from a staffing agency, for the purpose of this policy, are also defined as volunteer healthcare practitioners regardless of whether the practitioner is being compensated for the work performed.

POLICY:

1. In the event of a disaster or emergency where the District's emergency management plan has been activated and the District is unable to handle the immediate patient care needs, the medical staff may grant disaster privileges to individuals seeking to volunteer or offer their services after the policy applicability has been met and the procedure outlined in this document has been followed.
2. The following medical staff members listed in order of highest to lowest rank are authorized to grant disaster privileges as further described in this document:
    a. Chief of Staff
    b. Physician member of the Medical Executive Committee
    c. Any ~~service~~ department chief
    d. Any active medical staff member
    e. Designee of any of the above
3. In the event of similar ranking individuals being available, preference would be given to the medical staff member with the practice most appropriate to the background or training of the practitioner seeking disaster privileges.
4. Practitioners granted disaster privileges are expected, to the best of their abilities and under extenuating circumstances, to provide the standard of care ~~commiserate~~ commensurate with their designated clinical role under the supervision of a paired medical staff member or Advanced Practice Provider. This may

include, but is not limited to clinical care, documentation, availability for call, procedures, and consultation with supervising providers when necessary.

5. This policy and procedure is applicable only when the following has occurred:
    a. NIHD declares a disaster and activates its emergency operations plan.
    ~~a.~~b. The Medical Executive Committee (MEC) recognizes the disaster situation as one in which this policy applies. The MEC may choose to convene a special meeting for this purpose or conduct a vote through electronic means. If the nature of the disaster is such that any delay caused by first obtaining a vote of the MEC could reasonably cause patient harm, the highest ranking on-site medical staff member may recognize the disaster situation. That staff member may grant disaster privileges to volunteering practitioners as per the procedure detailed below. This decision must then be approved by the MEC within 24 hours.

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~~**APPLICABILITY:**~~

~~1. This policy and procedure is applicable only when the following has occurred:~~
    ~~a. NIHD declares a disaster and activates its emergency operations plan.~~
    ~~b.~~a. ~~The Medical Executive Committee (MEC) recognizes the disaster situation as one in which this policy applies. The MEC may choose to convene a special meeting for this purpose or conduct a vote through electronic means. If the nature of the disaster is such that any delay caused by first obtaining a vote of the MEC could reasonably cause patient harm, the highest ranking on-site medical staff member may recognize the disaster situation. That staff member may grant disaster privileges to volunteering practitioners as per the procedure detailed below. This decision must then be approved by the MEC within 24 hours.~~

PROCEDURE:

1. Recruitment of Volunteer Healthcare Practitioners
    a. If a ~~Service~~ Department Chief or on-site responsible physician (e.g., hospitalist or emergency medicine physician on-duty) determines that he/she is unable to cover care in his/her service during a disaster and needs additional immediate assistance, a medical staff member or appropriate District personnel (e.g., Incident Command member, House Supervisor, or medical staff office personnel) can begin contacting possible volunteer healthcare practitioners. Reasonable efforts should be made, under the circumstances, to first contact existing NIHD practitioners with appropriate privileges, followed by existing NIHD privileged practitioners who may qualify for disaster privileges or actively-practicing locum tenens practitioners of an appropriate specialty, prior to contacting or accepting other outside volunteer practitioners.
    b. Volunteer healthcare practitioners may also be proactively recruited in the course of disaster staffing preparations when the nature of the disaster allows it. In this case, the medical staff

office, Chief Medical Officer, or appropriate medical staff member with responsibilities in determining staffing for the service may contact possible volunteer healthcare practitioners to determine availability.

c. All District departments and supervisory personnel shall be instructed to direct all volunteering health care practitioners that present to the District to a member of the Incident Command Center, medical staff office personnel, or an on-site responsible medical staff member for possible disaster privileging.

2. Identification Documentation Required
   a. The volunteer healthcare practitioner shall be required to produce a valid government-issued photo identification with a signature (e.g., driver's license or passport).
   b. If the practitioner is not currently privileged at NIHD, he or she will also be required to produce at least one of the following in addition to a government-issued photo identification:
      i. a current license to practice medicine, or other certification or registration, issued by a state, federal, or regulatory agency; or
      ii. identification indicating that the individual is a member of a Disaster Medical Assistance Team, the Medical Reserve Corps (MRC), the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal response organization or group; or
      iii. identification indicating that the individual has been granted authority, by a federal, state or municipal entity, to render patient care, treatment, or services in disaster circumstances; or
      iv. a signed statement by a current District department leader or medical staff member with personal knowledge regarding the practitioner's identity and ability to act as a qualified practitioner during a disaster.
   c. If possible, copies of these documents should be made (or notation of the current hospital or medical staff member with personal knowledge). If it is not possible to make copies, the identification information (including full name, address, license number, issuing agency, etc.) shall be recorded.
   d. If such identification documents are not readily accessible, the medical staff member will be responsible for making the final decision whether to allow the volunteer practitioner to participate in disaster care.
   e. The identification information on the Request for Disaster Privileges form shall be completed by the volunteering healthcare practitioner.

3. Verifications
   a. If the practitioner is currently privileged at NIHD, the medical staff office will confirm their credentials file is up to date and will perform primary source verification of licensure as soon as feasible, but no later than 72 hours after the time that the practitioner presents him/herself. No other primary source verification is necessary provided that the credentials file is up to date.
   b. Volunteering practitioners without current NIHD privileges shall be requested to indicate his/her malpractice carrier (if any) and the name of the hospital(s) where he/she currently holds privileges (if applicable). Primary source verification of licensure, certification or registration, insurance, and hospital affiliations shall be made as soon as the disaster is under control, or within 72 hours from the time the volunteer practitioner presents him- or herself to the hospital, whichever comes first. A query to the National Practitioner Data Bank (NPDB) and Office of Inspector General (OIG) shall also be submitted, unless technologically not possible. In the event

this information cannot be verified, emergency approval of disaster privileges may still be granted pending verification.

c. If primary source verification of licensure, certification or registration cannot be completed within 72 hours of the volunteer's arrival due to extraordinary circumstances, it is performed as soon as possible. The following must be documented:
    i. Reason(s) the verification could not be performed within the 72 hours.
    ii. Evidence of the volunteer practitioner's demonstrated ability to continue to provide adequate care, treatment, or services.
    iii. Evidence of the attempt to perform primary source verification as soon as possible.

4. Approval of Disaster Privileges
    a. The available information shall be reviewed by the highest ranking available individual(s) authorized to grant emergency approval of disaster privileges. The highest ranking available individual(s) shall interview the volunteer to determine the appropriate scope of assigned responsibilities, and make a recommendation based on the available information.
    b. If approved for disaster privileges, approval will be documented on the Request for Disaster Privileges form.
5. Supervision Required
    a. The volunteer practitioner shall be partnered with a member of the medical staff or Advanced Practice Provider (APP) staff. Whenever possible, the partner shall be of similar specialty.
    b. As appropriate and under the circumstances, the medical staff member or APP staff member will oversee the performance of the volunteer practitioner through direct observation, mentoring, or medical record review. Partnering information shall be recorded with the other information regarding the volunteer practitioner. More than one practitioner may be partnered with a single medical staff member or APP.
    c. The volunteer practitioner shall be issued a temporary identification badge (if available) indicating his/her name, status as an approved volunteer practitioner, notation of his/her partner, and when relevant, the specific area(s) of the District in which the practitioner shall be permitted to render care. Current NIHD practitioners may use his/her existing NIHD hospital identification badge in addition to a temporary badge (if available) which identifies he or she is approved for temporary disaster privileges in the specific patient care area.
6. Review and Termination of Privileges
    a. A decision whether to continue the volunteer practitioner's assigned disaster responsibilities is to be made within 72 hours of the practitioner's arrival.
    b. Any such disaster privileges may be terminated at any time, with or without cause or reason, and any such termination shall not give rise to any rights of review, hearing, appeal or other grievance mechanism. Disaster privileges shall be terminated immediately if any information is received that suggests the volunteer healthcare practitioner is not capable of rendering services as approved.
    c. Once the care of disaster victims can be adequately assumed by an appropriate member of the regular medical staff or APP staff with existing privileges for that service, then the volunteer practitioner's privileges will be terminated. An individual who has had privileges terminated pursuant to this section shall be eligible to have disaster privileges reinstated, should circumstances warrant.
    d. Disaster privileges may be terminated by the assigned partner or any of the grantors listed in this policy.

e. The District will make every effort to recognize and thank the services provided by the volunteer healthcare practitioners once the disaster is over.

REFERENCES:

1. The Joint Commission (2016) CAMCAH EM 02.02.13 and EM 02.02.15
2. California Medicaid Services §485.623 Condition of Participation: Emergency Services
3. "Disaster Privileging." Northwell Health. Policy retrieved March 26, 2020. https://medicine.hofstra.edu/pdf/policy/disaster-privileging.pdf

RECORD RETENTION AND DESTRUCTION:

1. Life of policy, plus 6 years

CROSS REFERENCED POLICIES AND PROCEDURES:

1. Request for Disaster Privileges form (attached)
2. InQuiseek – Severe Weather and External Disaster Policy
3. InQuiseek – Credentialing and Employment Policy

Supersedes: v.4 Credentialing Healthcare Practitioners in the Event of a Disaster

NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL POLICY AND PROCEDURE

Title: Rapid Response Team		
Owner: Manager of ED and Disaster Planning	Department: Emergency Department	
Scope: NIHD		
Date Last Modified: 04/12/2022	Last Review Date: No Review Date	Version: 4
Final Approval by: NIHD Board of Directors	Original Approval Date: 06/30/16	

PURPOSE:

To provide a procedure for a rapid assessment of an inpatient with acute status changes. The goal of the Rapid Response Team (RRT) is to improve inpatient outcome by providing a means for rapid and timely intervention of a declining inpatient. The Rapid Response Team can also be utilized by outpatient services to provide triage and transport to the Emergency Department for care and treatment. This does not include patients and visitors in the NIHD clinics. For emergent concerns in the NIHD clinics, please dial 9-911.

POLICY:

Any hospital staff member may initiate a rapid response when recognizing Early Warning Criteria or when prompted to do so by patients or their family or friends. If the physician is at the bedside a discussion between the staff member and provider should occur prior to calling the RRT.

PROCEDURE:

A House Supervisor (HS), an emergency department nurse, and a respiratory therapist will arrive and serve as a resource for the nurse caring for inpatients, or to provide triage and transport to the Emergency Department for a medical screening exam. This does not include patients and visitors in the NIHD clinics. For emergent concerns in the NIHD clinics, please dial 9-911.

1. Early Warning Criteria for Initiating the RRT
   Any or all of the following criteria meets the guidelines for initiating the RRT Team.

   a. Staff member worried, concerned about patient
   b. Acute change in heart rate
   c. Acute change in systolic blood pressure
   d. Acute change in respiratory rate
   e. Acute and persistent change in saturation
   f. Acute change in level of consciousness
   g. Acute decrease in urine output
   h. Significant bleeding
   i. Seizures
   j. Failure to respond to treatment
   k. Agitation or delirium
   l. Syncope
   m. Uncontrolled pain

2. See attached Rapid Response Team Consultation Record for activation criteria.

3. RRT Structure
   The RRT is a group of clinicians who will bring critical care expertise to the declining patient bedside/area. The Team will consist of a Registered Nurse with Critical Care (CCN) Training (i.e. ED nurse or ICU nurse), a Respiratory Therapist (RT), the House Supervisor, and the primary nurse caring for the patient.

4. Activation of RRT
   a. Any staff member may call for the RRT when rapid assessment and intervention is deemed necessary for a declining patient based on the criteria guidelines.
   b. Friend and family members will be educated upon admission on how to activate a rapid response for the patient when they feel the patient's condition is deteriorating.
   c. After a brief assessment, the nurse shall call the RRT on overhead page and provide the room number of the patient.

5. RRT Responsibilities
   a. When a call is made for the team everyone responds. The Critical Care Nurse, who is the team leader of the RRT, will coordinate an appropriate response to the staff member that activated the team.
   b. The primary nurse shall have prepared for the team:
      - The RRT documentation record
      - Patient chart
      - Current medications
      - Recent vital signs
   c. The primary nurse must remain at the patient bedside and assist the RRT.
   d. The primary nurse should be prepared to provide the following information upon arrival of the RRT:
      - What prompted the RRT call?
      - Current HR, RR, BP, Temp
      - Interventions already attempted and results
      - Code status
      - Allergies
      - Pertinent medications
      - Pertinent history
      - Recent diagnostic tests
   e. The Critical Care Nurse is deemed team leader and will perform the initial assessment. Members of the RRT will assist the primary nurse as appropriate with:
      - Physician communication;
      - Obtaining appropriate orders; and
      - Initiation of physician orders.
   f. The RT will perform a complete respiratory assessment and initiate intervention as ordered or per standards of care.

g. The team will:
    - Collaborate assessment findings and recommendations for intervention;
    - Immediately implement treatment or diagnostic services as appropriate per policy or physician order;
    - The primary nurse shall also place a call to the attending physician immediately following the RRT's initial assessment.
    - Call a Code and initiate ACLS procedures as appropriate per code policy.
    - Assist with implementation of physician order; and
    - Assist transport of patient when necessary.

6. Assessment Guidelines

The RRT Team will follow the SBAR process for assessing and communicating. SBAR is an acronym for **S**ituation, **B**ackground, **A**ssessment, and **R**ecommendation.

a. The primary nurse will be prepared with pertinent patient history, signs and symptoms and events precipitating this occurrence.

b. The RRT leader will perform the initial assessment to include and/or consider:
    - Vital signs
    - Blood glucose
    - Cardiac rhythm
    - Neurological status
    - Fluid status
    - Skin condition
    - Pain
    - Anxiety
    - Recent medication history
    - Lab values
    - Diagnostic test results

c. The RT will perform the initial respiratory assessment to include and/or consider:
    - Breath sounds
    - Work of breathing
    - Ventilation pattern and status
    - Chest assessment
    - Oxygenation
    - Airway clearance
    - Ventilation
    - Recent respiratory history (last treatment given)
    - Past respiratory history

7. RRT Immediate Interventions
    a. The RT may initiate the following prior to physician contact:
        - Oral, nasal, nasal tracheal, or artificial airway suctioning
        - Placement of an oral or nasal airway (except patients having recent ENT or oral and/or complications)
        - Obtain pulse oximetry
        - Currently ordered PRN treatments
        - Oxygen application

    b. The RRT may initiate the following prior to physician contact:
        - Cardiac monitoring
        - Currently ordered PRN medications
        - Oxygen application
        - Implementation of any interventions or treatments of the Nursing Units Standards of Care.

8. RRT Equipment
   The following supplies and equipment may be needed:
    a. Personal protective equipment should be available at the bedside
    b. Oxygen
    c. Suction regulator and canister, tubing, yankauer
    d. Suction regulator or unit
    e. Pulse oximeter
    f. Cardiac and vital signs monitoring equipment
    g. Medications as ordered

9. RRT Documentation
    a. The RRT will document on the designated RRT Documentation Record.
    b. The primary RN will insure that all MD orders are written.
    c. The document will be filed in the patient chart under the "Nurses Notes" section.
    d. The RRT Implementation team will review RRT responses to identify opportunities for education and/or improvement.

OUTPATIENT SERVICES USE OF RRT POLICY

1. The Rapid Response Team can also be utilized by outpatient services within the hospital (not clinics) to provide triage and transport to the Emergency Department for care and treatment. For emergent concerns in the NIHD clinics, **please dial 9-911**.

2. A Code Blue should be initiated anytime the patient or visitor becomes unresponsive. For emergent concerns in the NIHD clinics, **please dial 9-911**.

3. If any hospital staff member has a concern about a patient's condition, they may notify the RRT.

REFERENCES:

1. TJC (2016) Comprehensive Accreditation Manual for Critical Access Hospitals. Standard PC 02.01.09 and Standard PC 02.01.1. Joint Commission Resources. Oakbrook, Illinois.
2. TJC (2016) CAMCAH, Functional Chapter Provision of Care. Standard PC 02.01.09. The critical access hospital recognizes and responds to changes in a patient's condition, JCR: Oakbrook Terrace

CROSS REFERENCED POLICIES AND PROCEDURES:

1. DNR
2. Code Blue
3. Clinical Decision Making – notification of medical staff practitioner

RECORD RETENTION AND DESTRUCTION:

Supersedes: v.3 Rapid Response Team*

RESOLUTION NO. 22-14

A RESOLUTION OF THE BOARD OF DIRECTORS OF THE NORTHERN INYO HEALTHCARE DISTRICT MAKING THE LEGALLY REQUIRED FINDINGS TO CONTINUE TO AUTHORIZE THE CONDUCT OF REMOTE "TELEPHONIC" MEETINGS DURING THE STATE OF EMERGENCY

WHEREAS, on March 4, 2020, pursuant to California Gov. Code Section 8625, the Governor declared a state of emergency stemming from the COVID-19 pandemic ("Emergency"); and

WHEREAS, on September 17, 2021, Governor Newsom signed AB 361, which bill went into immediate effect as urgency legislation; and

WHEREAS, AB 361 added subsection (e) to Government Code Section 54953 to authorize legislative bodies to conduct remote meetings provided the legislative body makes specified findings; and

WHEREAS, as of September 19, 2021, the COVID-19 pandemic has killed more than 67,612 Californians; and

WHEREAS, social distancing measures decrease the chance of spread of COVID-19; and

WHEREAS, this legislative body previously adopted a resolution to authorize this legislative body to conduct remote "telephonic" meetings; and

WHEREAS, Government Code 54953(e)(3) authorizes this legislative body to continue to conduct remote "telephonic" meetings provided that it has timely made the findings specified therein.

NOW, THEREFORE, IT IS RESOLVED by the Board of Directors of Northern Inyo Healthcare District as follows:

1. This legislative body declares that it has reconsidered the circumstances of the state of emergency declared by the Governor and at least one of the following is true: (a) the state of emergency, continues to directly impact the ability of the members of this legislative body to meet safely in person; and/or (2) state or local officials continue to impose or recommend measures to promote social distancing.

PASSED, APPROVED AND ADOPTED this 17th day of August, 2022 by the following roll call vote:

AYES:
NOES:
ABSENT:

_____
Jody Veenker, Chair
Board of Directors

ATTEST:

_____
Name: Erika Hernandez
Title: Administrative Assistant/ Board Clerk

CALL TO ORDER	The meeting was called to order at 5:33 pm by Jody Veenker, Board Chair.
PRESENT	Jody Veenker, Chair Mary Mae Kilpatrick, Vice Chair Topah Spoonhunter, Secretary Jean Turner, Treasurer Robert Sharp, Member-at-Large (via zoom) Kelli Davis MBA, Chief Executive Officer and Chief Operating Officer arrived at 6:19 pm. Allison Partridge RN, MSN, Chief Nursing Officer Joy Engblade, MD, Chief Medical Officer Keith Collins, General Legal Counsel (Jones & Mayer)
ABSENT	Vinay Behl, Interim Chief Financial Officer
OPPORTUNITY FOR PUBLIC COMMENT	Ms. Veenker 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 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. No public comments were heard.
NEW BUSINESS	
NORTHERN INYO HEALTHCARE DISTRICT BOARD OF DIRECTORS ORIENTATION PRESENTATION	Northern Inyo Healthcare District (NIHD) HR Manager, Marjorie Routt provided an overview of the proposed NIHD Board of Directors Orientation presentation for new Board members. She explained that this presentation was developed during the Onboarding Ad Hoc Committee. The Board expressed appreciation for all the hard work that went into preparing this presentation.
APPROVAL OF POLICY AND PROCEDURE, ONBOARDING AND CONTINUING EDUCATION OF BOARD MEMBER	Ms. Routt called attention to proposed NIHD Board Policy and Procedure title*: Onboarding and Continuing Education of Board Member* It was moved by Mary Mae Kilpatrick, seconded by Topah Spoonhunter, and unanimously passed to approve the NIHD Board Policy and Procedure, titled: *Onboarding and Continuing Education of Board Member* as presented.

APPROVAL OF THE BOARD MEMBER REFERENCE PACKET

Ms. Veenker called attention to the proposed Board Member Reference Packet. Jean Turner and Robert Sharp explained that this packet was also created by the Onboarding Ad Hoc Committee. Erika Hernandez, Administrative Assistant/ Board Clerk clarified questions for the Board.

It was moved by Ms. Kilpatrick, seconded by Ms. Turner, and unanimously passed to approve the Board Member Reference Packet as presented.

DISCUSSION OF ELECTRONIC RESOURCES AND TOOLS FOR BOARD OF DIRECTORS

An open discussion took place about the current use of NIHD electronic resources and tools available for Board members. Information Technology Services Director, Bryan Harper clarified questions for the Board. Mr. Harper also reported that an update for Blackberry Works is expected to take place within the next 90-day and help resolve issues with the blackberry access to emails. No action taken.

NORTHERN INYO HEALHCARE DISTRICT 2022 COMMUNITY HEALTH NEEDS ASSESMENT CHNA UPDATE

Chief Medical Officer, Joy Engblade, MD provided an update and explained the the Community Health Needs Assessment (CHNA) Committee has had a few meetings with QHR to review and discuss the results of the survey. The district identified three focus areas:

- Behavioral Health
- Access to Healthcare
- Chronic Disease Management

She reported that the CHNA Community Stakeholder Action Plan meeting is scheduled for Monday July 25th, this meeting will allow opportunity to work with community partners.

APPROVAL OF THE DISTRICT BOARD RESOLUTION 22-12, APPROPRIATION LIMITS FOR FISCAL YEAR 2022-2023

Interim Controller, Dolores Perez called attention to proposed District Board Resolution 22-12, Appropriation Limits for Fiscal Year 2022-2023.

It was moved by Mr. Spoonhunter, seconded by Mr. Sharp, and unanimously passed to approve the District Board Resolution 22-12, Appropriation Limits for Fiscal Year 2022-2023 as presented.

BI-ANNUAL REVIEW AND APPROVAL OF NORTHERN INYO HEALTHCARE DISTRICT CONFLICT OF INTERST CODE

Ms. Veenker called attention to a bi- annual review of the NIHD Conflict of Interest Code, no revisions were made.

It was moved by Ms. Kilpatrick, seconded by Ms. Turner, and unanimously passed to approve the NIHD Conflict of Interest Code as presented.

CHIEF OF STAFF REPORT

MEDICAL STAFF APPOINTMENTS

Chief of Staff, Sierra Bourne, MD reported, following review and consideration, the Medical Executive Committee recommends approval of the following Medical Staff Appointments:

1. *Andre Burnier, MD (emergency medicine) – Courtesy Staff*
2. *Nolan Page, DO (emergency medicine) – Courtesy Staff*
3. *Chelsea Robinson, MD (emergency medicine) – Active Staff*

4. *Jad Al Danaf, MD (cardiology, Renown) – Telemedicine Staff*
5. *Alireza Hosseini, MD (endocrinology, Adventist Health) – Telemedicine Staff*

It was moved by Ms. Turner, seconded by Ms. Kilpatrick, and unanimously passed to approve all five (5) Medical Staff Appointments as requested.

MEDICAL STAFF RESGIGNATIONS

Doctor Bourne reported, following review, consideration and approval by the appropriate Committees, the Medical Executive Committee recommends approval of the following Medical Staff Resignations:

1. *James Fair, MD (emergency medicine) – effective 7/1/2022.*
2. *Anna Rudolphi, MD (emergency medicine) – effective 7/1/2022.*

It was moved by Mr. Sharp, seconded by Mr. Spoonhunter, and unanimously passed to approve the two (2) Medical Staff Resignations as requested.

NEW PRIVILEDGE FORMS

Doctor Bourne additionally reported the Medical Executive Committee recommends approval of the following New Privileged Forms:

1. *Addiction Medicine*
2. *Medical Oncology*

It was moved by Mr. Sharp, seconded by Mr. Spoonhunter, and unanimously passed to approve the two (2) New Privilege Forms as requested.

POLICIES

Doctor Bourne reported the Medical Executive Committee recommends approval of the following District-Wide Policies:

1. *Capacity Management – Patient Surge*
2. *Organization-Wide Assessment and Reassessment of Patients*
3. *Standardized Procedure - Certified Nurse Midwife*
4. *Cardiac Monitoring*
5. *Insulin Continuous Subcutaneous Infusion Self-Management of the Patient in the Acute Setting*
6. *Medical Clinical Alarm Equipment Safety*
7. *Patient Restraints (Behavioral & Non-Behavioral)*
8. *Rights of Swing Bed Patients*
9. *Scope of Service Swing Bed*
10. *Standards of Care for the Swing Bed Resident*

It was moved by Mr. Sharp, seconded by Ms. Turner, and unanimously passed to approve all ten (10) Policies as presented.

MEDICAL EXECUTIVE COMMITTEE REPORT

Doctor Bourne provided a report on the Medical Executive Committee meeting and clarified questions.

_____.

CONSENT AGENDA

Ms. Veenker called attention to the Consent Agenda for this meeting which contained the following items:

1. *Approval of District Board Resolution 22-13, to continue to allow Board meetings to be held virtually.*
2. *Approval of minutes of the June 15, 2022 Regular Board Meeting*
3. *Chief Executive Officer Report*
4. *Chief Medical Officer Report*
5. *Financial and Statistical report for April 30, 2022 & May 31, 2022*
6. *Approval of Policies and Procedures*
   - *A. Family Member and Relative in The Workplace*
   - *B. Sending Protected Health Information by Fax*
   - *C. Personal Cell Phone/Electronic Communication Device Use by Workforce*
   - *D. Minimum Necessary Access, Use and Disclosure of Protected Health Information (PHI)*
   - *E. Medical Records Requirements of Swing Bed Admission/Discharge*

It was moved by Ms. Turner, seconded by Mr. Sharp, and unanimously passed to approve all six (6) Consent Agenda items as presented.

BOARD MEMBER REPORTS ON ITEMS OF INTEREST

Ms. Veenker additionally asked if any members of the Board of Directors wished to report on any items of interest. No reports were provided.

PUBLIC COMMENTS ON CLOSED SESSION ITEMS

Ms. Veenker announced that at this time, persons in the audience may speak only on items listed on the Closed Session portion of this meeting. No public comments were heard.

ADJOURNMENT TO CLOSED SESSION

At 6:28 pm Ms. Veenker announced the meeting would adjourn to Closed Session to allow the District Board of Directors to:

A. Conference with legal counsel, significant exposure to litigation. Gov. Code 54956.9(d)(2) (One case)

B. Public Employee Performance Evaluation
Title: District Legal Counsel, Gov. Code. 54957(b) (1).

RETURN TO OPEN SESSION AND REPORT OF ANY ACTION TAKEN

At 7:49 pm, the meeting returned to Open Session. Ms. Veenker reported that the Board took no reportable action.

ADJOURNMENT

The meeting adjourned at 7:50 pm.

_____
Jody Veenker, Chair

Attest: _____
Topah Spoonhunter, Secretary

CALL TO ORDER	The meeting was called to order at 5:30 p.m. by Jody Veenker, District Board Chair.
PRESENT	Jody Veenker, Chair Mary Mae Kilpatrick, Vice Chair Topah Spoonhunter, Secretary Jean Turner, Treasurer Kelli Davis, Chief Executive Officer Allison Partridge, Chief Nursing Officer Joy Engblade, Chief Medical Officer arrived at 6:00 p.m. Robert Sharp, Member-At-Large
ABSENT	Vinay Behl, Interim Chief Financial Officer
OPPORTUNITY FOR PUBLIC COMMENT	Ms. Veenker reported at this time, members of the audience may speak only on items listed on the Notice for this meeting, and speakers will be limited to a maximum of three minutes each. The Board is prohibited from generally discussing or taking action on items not included on the Notice for this meeting. No comments were heard.
ADJOURMENT TO CLOSED SESSION	At 5:32 p.m. Ms. Veenker announced the meeting would adjourn to Closed Session to allow the District Board of Directors to: A. Conference with legal counsel. Significant exposure to litigation. Government Code 54956.9(d)(2) (One case) B. Conference with Labor Negotiators, Agency Designated Representatives: Irma Rodriguez and Andrew M. Aller; Employee Organization: AFSCME Council 57 (pursuant to Government Code Section 54957.6)
RETURN TO OPEN SESSION AND REPORT ON ANY ACTION TAKEN IN CLOSED SESSION	At 8:29 p.m., the meeting returned to Open Session. Ms. Veenker reported that the Board took no reportable action.
ADJOURNMENT	Adjournment 8:30 p.m.

_____
Jody Veenker, Chair

Attest: _____
Topah Spoonhunter, Secretary

Pioneer Home Health Care, Inc. (PHHC)

2nd Quarter Summary Report for NIHD for 8/17/22 Board Meeting

Dear Northern Inyo Healthcare District Board Members,

Please see the attached summary of the services we have provided through the second quarter of 2022.

1. Admission Analysis by referral source for Home Health services.
2. Admission Analysis by referral source for Hospice services.
3. Home Health visit totals, with historical visit numbers included for comparison.
4. Hospice visit totals, with the historical visit numbers included for comparison.
5. Personal Care Program (PCP) hours

PROGRAM REPORTS

Home Health Program

Statistics through June 2022
120 admits
1038 visits
17,478 miles traveled – average 16.84 miles per HH visit
Present number of active patients = 32

Patient Driven Grouping Models (PDGM) continues to pay off, much more than the previous PPS system, and our new analytic tool SHP is helping us provide accurate coding, and improved evaluation of functionality, resulting in a larger "budget" or reimbursement payment for each patient. Addressing this upfront allows us to provide the best care, based on patient need.

Value Based Purchasing (VBP) is starting January 1, 2023 and will affect us by either reducing or increasing our reimbursement by 5%. This will be based on 1) functional improvements, 2) survey results, and 3) if the patient had any ER visits or re-hospitalizations during the first 60 days of our care. We have recently started more intense staff training on how these results are calculated, and have started addressing accurate functional assessments, increasing patient participation in post care surveys, identifying re-hospitalization risk, avoiding ER visits, and working on an individualized, more concise discharge plan. Our goal is "person centered care" for optimum results, with overall care satisfaction.

We will also begin staff training for the new Outcome and Assessment Information Set (OASIS E) assessment tool towards the end of the year, as use of this new assessment tool begins January 1st 2023. This standardized tool is used as part of the home health care reimbursement system and provides insight on the patients' status and functionality for care planning purposes.

Continue to need increased staffing to meet community needs: Full-Part time, per diem, weekend RN's and per diem PT/OT/ST, and part time/per diem home health aides.

Hospice Program

Statistics through June 2022

Have served 18 hospice patients and provided 269 home visits this year
Average length of stay (LOS) = 56.78 days
4,505 miles traveled – average miles traveled per HOS visit = 16.75
Present number of patients = 4

We received an anonymous $600 donation to provide another grief support group, which is now in progress, we are using the Jill Kinmont Booth school location for the meeting, due to a larger than normal number of participants. We have twelve to fourteen participants in the current group with a brewing waiting list. Flyer attached. We will provide a pre-recorded holiday grief presentation, "How to Cope with Grief during the Holidays" and one more grief support group towards the end of the year, as well as our annual Hospice Light Up A Life event.

Continue to need part time hospice nurses, especially for weekend and night duty and certified home health aides.

PHHC was approved by the California Department of Public Health to present the 40 hour course which allows a Certified Nurse's Aide (CNA) to transition into the role of Certified Home Health Aide (CHHA). Having CHHA's would benefit both the Hospice program as well as the Home Health program.

Personal Care Program (PCP)

Statistics through June 2022

Present number of active clients is 20
Staffing: currently have 10 caregivers
4135 hours of caregiving have been provided to community members

Creation of a Per diem position was completed in an effort to provide a competitive wage, focusing more on the hourly wage vs benefits.

We are now working with 3 groups that may result in third party payers to augment the current PCP $26/hr rate. We are still trying to work out the details where these programs can subsidize our hourly fee, all in an effort to procure and retain more clients.

We continue to need PCP employees, while many express interest, few take the necessary steps to complete the hiring process, our competition continues to be "under the table" operations, and we are focusing our marketing toward nursing students, college students, per diem work for already employed CNA or MA's.

Agency Wide:

There was an increase in mileage reimbursement rates, increased from .58 cents a mile to 62.5 cents a mile. This is across the board for home health and hospice clinicians as well as PCP employees, adding to the overall cost of providing care for all programs.

On July 23rd we held a successful yard and bake sale held by staff and hospice volunteers, netting a total of $2,571.....our most lucrative yard sale to date. We have also started posting items on our new Virtual Hospice Thrift Store Facebook page which has been successful as well. At this time we are working on posting more items on a regular basis and working on obtaining more visibility.

401K opportunities for all new employees provided now, due to the new California law where all businesses must provide a retirement plan opportunity to all employees regardless of hours worked. All current employees have been offered this opportunity.

Staff is working on multiple Quality Assurance Improvement Program (QAPI) projects, focus is on expediting hospice admissions, providing all necessary services in a timely manner, accurate documentation as well as safe discharges from all programs. As always the goal is successful "person centered care".

Upcoming staff meeting will focus on strategic planning for the agency, set goals for each program, and develop teams to review policy and procedure as well as organizational policies.

Respectfully submitted by

Ruby Allen RN, Administrator

Pioneer Home Health Care
Personal Care Program Hours

For period ending January 31, 2022

	15-Jan	31-Jan	15-Feb	28-Feb	15-Mar	31-Mar	15-Apr	30-Apr	15-May	31-May	15-Jun	30-Jun
PCA Billable Hours @$25.00	203.25	154.50	162.00	154.37	176.75	197.18	201.00	194.09	218.00	271.98	195.84	162.08
PCA Billable Hours @$26.00	42.33	49.00	52.00	67.25	110.25	119.50	206.54	91.00	115.00	114.17	109.33	111.59
PCA Billable Hours @$30.00	50.50	61.00	43.00	51.00	57.18	60.00	55.00	52.00	54.00	68.50	49.00	54.75
Total Billable Hours	296.08	264.50	257.00	272.62	344.18	376.68	462.54	337.09	387.00	454.65	354.17	328.42
PCA Billable Chgs @$25.00	5081.25	3862.50	4050.00	3859.25	4418.75	4929.50	5025.00	4852.25	5450.00	6799.50	4896.00	4052.00
PCA Billable Chgs @$26.00	1100.58	1274.00	1352.00	1748.50	2866.50	3107.00	5370.04	2366.00	2990.00	2968.42	2842.58	2901.34
PCA Billable Chgs @$30.00	1515.00	1830.00	1290.00	1530.00	1715.40	1800.00	1650.00	1560.00	1620.00	2055.00	1470.00	1642.50
Total Billable Chgs	7696.83	6966.50	6692.00	7137.75	9000.65	9836.50	12045.04	8778.25	10060.00	11822.92	9208.58	8595.84

	15-Jul	31-Jul	15-Aug	31-Aug	15-Sep	30-Sep	15-Oct	31-Oct	15-Nov	30-Nov	15-Dec	31-Dec	Annual Totals
PCA Billable Hours @$25.00	158.83	145.50											
PCA Billable Hours @$26.00	107.50	109.75											
PCA Billable Hours @$30.00	52.50	51.58											
Total Billable Hours	318.83	306.83	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	4760.59
PCA Billable Chgs @$25.00	3970.75	3637.50	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	
PCA Billable Chgs @$26.00	2795.00	2853.50	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	
PCA Billable Chgs @$30.00	1575.00	1547.40	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	
Total Billable Chgs	8340.75	8038.40	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	124220.01

Hours by Month:

January	560.58
February	529.62
March	720.86
April	799.63
May	841.65
June	682.59
July	625.66
August	0.00
September	0.00
October	0.00
November	0.00
December	0.00
	4760.59

PCP Hours 22, 21, 20

Hospice of the Owens Valley / Hospice
Admission Analysis by Referral Source

for period ending 01/31/22

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	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Totals
Acute Rehab - Carson													0
Acute Rehab - Renown Health													0
Acute Rehab - Other													0
Clinic - Mammoth Lakes Fam Med													0
Clinic - Rural Health NIH	1	2	3		2	1							9
Clinic - SIH													0
Clinic - Toiyabe						1	1						2
Family / Friend / Self													0
Hospital - Carson/Tahoe													0
Hospital - Glendale Adventist													0
Hospital - Loma Linda													0
Hospital - Mammoth Lakes													0
Hospital - Northern Inyo													0
Hospital - Renown Medical Center													0
Hospital - Sierra Surg - Carson													0
Hospital - Southern Inyo													0
Hospital - St. Mary's	1												1
Hospital - UCLA Medical Center													0
Hospital - USC / Keck Med													0
Hospital - VA													0
Hospital - Other			1										1
Other													0
Physicians' Office Local	1	1			1	1							4
Physicians' Office Out-of-Counties													0
SNF - Bishop Care Center													0
SNF - Southern Inyo													0
SNF - Other													0
Another Hospice Agency													0
Totals	3	3	4	0	3	3	1	0	0	0	0	0	17

Hospice
Actual YE 123122 per Ndoc

	Actual
Acute Rehab - Carson	
Acute Rehab - Renown Health	
Acute Rehab - Other	
Clinic - Mammoth Lakes Fam Med	
Clinic - Rural Health NIH	9
Clinic - SIH	
Clinic - Toiyabe	2
Family / Friend / Self	
Hospital - Carson/Tahoe	
Hospital - Glendale Adventist	
Hospital - Loma Linda	
Hospital - Mammoth Lakes	
Hospital - Northern Inyo	
Hospital - Renown Medical Center	
Hospital - Sierra Surg - Carson	
Hospital - Southern Inyo	
Hospital - St. Mary's	1
Hospital - UCLA Medical Center	
Hospital - USC / Keck Med	
Hospital - VA	
Hospital - Other	1
Other	
Physicians' Office Local	4
Physicians' Office Out-of-Counties	
SNF - Bishop Care Center	
SNF - Southern Inyo	
SNF - Other	
Another HH Agency	
Workers Comp Insurance	
	17

Hospice Referral History

for period ending 01/31/22

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Totals
2022	3	3	4	0	3	3	1	0	0	0	0	0	17
2021	0	6	1	3	1	3	3	2	3	1	4	2	29
2020	3	3	4	0	3	3	1	0	0	0	0	0	17
2019	5	2	3	2	1	2	3	3	2	0	5	1	29
2018	3	5	0	2		1	3	4	0	3	5	3	29
2017	1	1	0	0	2	6	0	2	3	0	2	3	20
2016	0	0	0	1	0	1	3	1	0	2	0	0	8
	15	20	12	8	1	19	14	12	8	6	16	9	140
Average q mo:	3	3	2	1	2	3	2	2	1	1	3	2	

Pioneer Home Health Care / Home Health
Admission Analysis by Referral Source

for period ending 01/31/22

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Totals
Acute Rehab - Carson													0
Acute Rehab - Renown Health			1			1							2
Acute Rehab - Other			1		1								2
Clinic - Mammoth Lakes Fam Med						1							1
Clinic - Rural Health NIH	3	2	1	2	1								9
Clinic - SIH				2									2
Clinic - Toiyabe	2	1	1		2	2	1						9
Family / Friend / Self													0
Hospital - Carson/Tahoe		2				2							4
Hospital - Glendale Adventist	1				1								2
Hospital - Loma Linda													0
Hospital - Mammoth Lakes	2		3		2								7
Hospital - Northern Inyo	13	8	7	6	3	3	6						46
Hospital - Renown Medical Center		2		2	1	1	3						9
Hospital - Sierra Surg - Carson													0
Hospital - Southern Inyo													0
Hospital - NIH Observation			3	4	4	4	5						20
Hospital - UCLA Medical Center						1							1
Hospital - USC / Keck Med													0
Hospital - St Mary's							1						1
Hospital - other	1		1	1	1	3	3						10
Other													0
Physicians' Office Local	5	2	2	2	3	2							16
Physicians' Office Out-of-Counties		1											1
SNF - Bishop Care Center	1	4	4	7	4	2	5						27
SNF - Southern Inyo	1												1
SNF - Other			1	1	1	1							4
Another HH Agency													0
Workers Comp Insurance													0
Totals	29	22	25	27	24	23	24	0	0	0	0	0	174

Actual YE 123122 per Ndoc

	Actual
Acute Rehab - Carson	0
Acute Rehab - Renown Health	2
Acute Rehab - Other	2
Clinic - Mammoth Lakes Fam Med	1
Clinic - Rural Health NIH	9
Clinic - SIH	2
Clinic - Toiyabe	9
Family / Friend / Self	0
Hospital - Carson/Tahoe	4
Hospital - Glendale Adventist	2
Hospital - Loma Linda	0
Hospital - Mammoth Lakes	7
Hospital - Northern Inyo	46
Hospital - Renown Medical Center	9
Hospital - Sierra Surg - Carson	0
Hospital - Southern Inyo	0
Hospital - NIH Observation	20
Hospital - UCLA Medical Center	1
Hospital - USC / Keck Med	0
Hospital - St Mary's	1
Hospital - Other	10
Other	0
Physicians' Office Local	16
Physicians' Office Out-of-Counties	1
SNF - Bishop Care Center	27
SNF - Southern Inyo	1
SNF - Other	4
Another HH Agency	0
Workers Comp Insurance	0
	174

Home Health Referral History

for period ending 01/31/22

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Totals
2022	29	22	25	27	24	23	24	0	0	0	0	0	174
2021	21	19	23	25	1	16	18	18	16	19	15	15	206
2020	14	21	24	18	25	32	29	37	25	20	22	24	291
2019	16	21	19	15	1	19	14	20	12	22	23	16	198
2018	11	13	12	23		12	13	12	14	33	19	13	175
2017	16	12	14	21	2	15	12	16	13	13	12	11	157
2016	29	15	30	20	19	27	12	17	14	15	15	16	229
2015	22	27	19	27	21	30	26	21	17	18	18	18	264
2014	34	28	25	23	1	17	38	22	25	22	23	24	282
2013	34	27	26	28	15	29	17	17	36	27	21	27	304
2012	25	26	24	26	2	18	22	21	24	26	24	23	261
2011	26	25	34	6	3	33	26	22	23	16	21	23	258
2010	28	22	29	2	1	25	20	26	22	31	26	28	260
	305	278	304	261	115	296	271	249	241	262	239	238	3059
				4	4								
Average q mo:	25	23	25	22	10	25	23	21	20	22	20	20	

Pioneer Home Health Care
2022 Home Health Visits

	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	YTD
Blue Cross													
SN					2	1	2						5
PT						2	2						4
OT					1	4	1						6
ST													0
MSW													0
CHHA													0
Totals	0	0	0	0	3	7	5	0	0	0	0	0	15
Supplies													0
Blue Shield													
SN													0
PT							2						2
OT													0
ST													0
MSW													0
CHHA													0
Totals	0	0	0	0	0	0	2	0	0	0	0	0	2
Supplies													0
Other Insurance													
SN													0
PT													0
OT													0
ST													
MSW													0
CHHA													0
Totals	0	0	0	0	0	0	0	0	0	0	0	0	0
Supplies													0
Medicare													
SN	53	48	36	40	31	23	24						255
PT	40	61	79	67	53	62	66						428
OT	11	31	36	53	66	66	65						328
ST			2										2
MSW	2	6	4	4	8	4	5						33
CHHA													0
Totals	106	146	157	164	158	155	160	0	0	0	0	0	1046
Supplies	165	95	85	85	155	30	75						690

Pioneer Home Health Care
2022 Home Health Visits

	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	YTD
Workmans Comp													
SN					1								1
PT					1								1
OT					2								2
ST													0
MSW													0
CHHA													0
Totals	0	0	0	0	4	0	0	0	0	0	0	0	4
Supplies													0
Medi-Cal Managed Care													
SN	10	4	3	4	1	1							23
PT	8	4	6	5	5	1							29
OT	8	3		7	4	3							25
ST	1	3											4
MSW	2		2										4
CHHA													0
Totals	29	14	11	16	10	5	0	0	0	0	0	0	85
Supplies						20							20
Medicare Advantage													
SN	6		5	3	2	2	1						19
PT	2		8	2	2		1						15
OT			1	9	2	1	1						14
ST													0
MSW													0
CHHA													0
Totals	8	0	14	14	6	3	3	0	0	0	0	0	48
Supplies	105		20										125
Patient Pay													
SN		2	2			3	2						9
PT													0
OT													0
ST													0
MSW													0
CHHA													0
Totals	0	2	2	0	0	3	2	0	0	0	0	0	9
Supplies													0

Pioneer Home Health Care
2022 Home Health Visits

	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	YTD
PHHC HH Charity Care													
SN													0
PT													0
OT													0
ST													0
MSW													0
CHHA													0
Totals	0	0	0	0	0	0	0	0	0	0	0	0	0
Supplies													0
2022 HHA VISIT TOTALS													
	Jan	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**YTD**
SN	69	54	46	47	37	30	29	0	0	0		0	312
PT	50	65	93	74	61	65	71	0	0	0	0	0	479
OT	19	34	37	69	75	74	67	0	0	0	0	0	375
ST	1	3	2	0	0	0	0	0	0	0	0	0	6
MSW	4	6	6	4	8	4	5	0	0	0	0	0	37
CHHA	0	0	0	0	0	0	0	0	0	0	0	0	0
Totals	**143**	**162**	**184**	**194**	**181**	**173**	**172**	**0**	**0**	**0**	**0**	**0**	**1209**
Supplies	270	95	105	85	155	50	75	0	0	0	0	0	835
													1209

Pioneer Home Health Care
2022 Home Health Charges

	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	YTD
Blue Cross													
SN	0	0	0	0	750	375	750	0	0	0	0	0	1875
PT	0	0	0	0	0	750	750	0	0	0	0	0	1500
OT	0	0	0	0	375	1500	375	0	0	0	0	0	2250
ST	0	0	0	0	0	0	0	0	0	0	0	0	0
MSW	0	0	0	0	0	0	0	0	0	0	0	0	0
CHHA	0	0	0	0	0	0	0	0	0	0	0	0	0
Totals	0	0	0	0	1125	2625	1875	0	0	0	0	0	5625
Supplies													0
Blue Shield													
SN	0	0	0	0	0	0	0	0	0	0	0	0	0
PT	0	0	0	0	0	0	750	0	0	0	0	0	750
OT	0	0	0	0	0	0	0	0	0	0	0	0	0
ST	0	0	0	0	0	0	0	0	0	0	0	0	0
MSW	0	0	0	0	0	0	0	0	0	0	0	0	0
CHHA	0	0	0	0	0	0	0	0	0	0	0	0	0
Totals	0	0	0	0	0	0	750	0	0	0	0	0	750
Supplies													0
Other Insurance													
SN	0	0	0	0	0	0	0	0	0	0	0	0	0
PT	0	0	0	0	0	0	0	0	0	0	0	0	0
OT	0	0	0	0	0	0	0	0	0	0	0	0	0
ST	0	0	0	0	0	0	0	0	0	0	0	0	0
MSW	0	0	0	0	0	0	0	0	0	0	0	0	0
CHHA	0	0	0	0	0	0	0	0	0	0	0	0	0
Totals	0	0	0	0	0	0	0	0	0	0	0	0	0
Supplies													0
PPS Medicare													
SN	19875	18000	13500	15000	11625	8625	9000	0	0	0	0	0	95625
PT	15000	22875	29625	25125	19875	23250	24750	0	0	0	0	0	160500
OT	4125	11625	13500	19875	24750	24750	24375	0	0	0	0	0	123000
ST	0	0	750	0	0	0	0	0	0	0	0	0	750
MSW	750	2250	1500	1500	1500	1500	1875	0	0	0	0	0	10875
CHHA	0	0	0	0	0	0	0	0	0	0	0	0	0
Totals	39750	54750	58875	61500	57750	58125	60000	0	0	0	0	0	390750
Supplies	165		85	65	155	30	75						575

Pioneer Home Health Care
2022 Home Health Charges

	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	YTD
Workmans Comp													
SN	0	0	0	0	375	0	0	0	0	0	0	0	375
PT	0	0	0	0	375	0	0	0	0	0	0	0	375
OT	0	0	0	0	750	0	0	0	0	0	0	0	750
ST	0	0	0	0	0	0		0	0	0	0	0	0
MSW	0	0	0	0	0	0	0	0	0	0	0	0	0
CHHA	0	0	0	0	0	0	0	0	0	0	0	0	0
Totals	0	0	0	0	1500	0	0	0	0	0	0	0	1500
Supplies													0
Medi-Cal Managed Care													
SN	3750	1500	1125	750	375	375	0	0	0	0	0	0	7875
PT	3000	1500	2250	1125	1875	375	0	0	0	0	0	0	10125
OT	3000	1125	0	2625	1500	1125	0	0	0	0	0	0	9375
ST	375	1125	0	0	0	0	0	0	0	0	0	0	1500
MSW	750	0	750	375	0	0	0	0	0	0	0	0	1875
CHHA	0	0	0	0	0	0	0	0	0	0	0	0	0
Totals	10875	5250	4125	4875	3750	1875	0	0	0	0	0	0	30750
Supplies						20							20
Medicare Advantage													
SN	2250	0	1875	1125	750	750	375	0	0	0	0	0	7125
PT	750	0	3000	750	750	0	375	0	0	0	0	0	5625
OT	0	0	375	3375	750	375	375	0	0	0	0	0	5250
ST	0	0	0	0	0	0	0	0	0	0	0	0	0
MSW	0	0	0	0	0	0	0	0	0	0	0	0	0
CHHA	0	0	0	0	0	0	0	0	0	0	0	0	0
Totals	3000	0	5250	5250	2250	1125	1125	0	0	0	0	0	18000
Supplies	105												105
Patient Pay													
SN	0	750	750	0	0	1125	750	0	0	0	0	0	3375
PT	0	0	0	0	0	0	0	0	0	0	0	0	0
OT	0	0	0	0	0	0	0	0	0	0	0	0	0
ST	0	0	0	0	0	0	0	0	0	0	0	0	0
MSW	0	0	0	0	0	0	0	0	0	0	0	0	0
CHHA	0	0	0	0	0	0	0	0	0	0	0	0	0
Totals	0	750	750	0	0	1125	750	0	0	0	0	0	3375
Supplies													0

Pioneer Home Health Care
2022 Home Health Charges

	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	YTD
PHHC HH Charity Care													
SN	0	0	0	0	0	0	0	0	0	0	0	0	0
PT	0	0	0	0	0	0	0	0	0	0	0	0	0
OT	0	0	0	0	0	0	0	0	0	0	0	0	0
ST	0	0	0	0	0	0	0	0	0	0	0	0	0
MSW	0	0	0	0	0	0	0	0	0	0	0	0	0
CHHA	0	0	0	0	0	0	0	0	0	0	0	0	0
Totals	0	0	0	0	0	0	0	0	0	0	0	0	0
Supplies													0
TOTAL 2021 CHARGES													
SN	25875	20250	17250	16875	13875	11250	10875	0	0	0	0	0	116250
PT	18750	24375	34875	27000	22875	24375	26625	0	0	0	0	0	178875
OT	7125	12750	13875	25875	28125	27750	25125	0	0	0	0	0	140625
ST	375	1125	750	0	0	0	0	0	0	0	0	0	2250
MSW	1500	2250	2250	1875	1500	1500	1875	0	0	0	0	0	12750
CHHA	0	0	0	0	0	0	0	0	0	0	0	0	0
Totals	53625	60750	69000	71625	66375	64875	64500	0	0	0	0	0	450750
Supplies	270	0	85	65	155	50	75	0	0	0		0	700

Pioneer Home Health Care
2022 Home Health Visits

Home Health Visits
through December 2022

	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	YTD
SN	69	54	46	47	37	30	29	0	0	0	0	0	312
PT	50	65	93	74	61	65	71	0	0	0	0	0	479
OT	19	34	37	69	75	74	67	0	0	0	0	0	375
ST	1	3	2	0	0	0	0	0	0	0	0	0	6
MSW	0	6	6	4	8	4	5	0	0	0	0	0	33
CHHA	0	0	0	0	0	0	0	0	0	0	0	0	0
Totals	**139**	**162**	**184**	**194**	**181**	**173**	**172**	**0**	**0**	**0**	**0**	**0**	**1205**
													1205
								Average visits per month =					
2021	141	143	128	167	133	116	133	137	146	129	114	110	**1597**
2020	121	124	134	189	148	191	202	242	203	195	153	174	**2076**
2019	91	118	116	134	131	129	131	142	94	165	147	160	**1558**
2018	61	75	71	107	73	49	73	120	93	160	138	93	**1113**
2017	104	86	72	88	63	65	70	84	53	75	61	49	**870**
2016	143	117	161	139	126	138	98	87	92	67	87	78	**1333**
2015	144	180	164	154	170	174	197	144	127	124	130	101	**1809**
2014	211	210	172	143	170	143	217	172	191	153	140	139	**2061**
2013	213	178	195	207	152	226	133	138	211	260	185	192	**2290**
2012	134	173	196	219	201	175	158	160	156	195	197	149	**2113**
2011	199	239	230	152	203	215	199	169	200	184	159	177	**2326**
2010	243	193	228	185	226	209	172	195	151	189	219	231	**2441**
2009	237	193	237	170	179	233	256	196	172	178	154	203	**2408**
2008	177	159	145	156	172	202	216	154	208	184	199	205	**2177**
2007	146	119	135	134	124	99	157	118	137	121	138	169	**1597**

Pioneer Home Health Care
2022 Home Health Miles

Average Miles and Visits through December 2022					
		YTD # of Visits	**YTD # of Miles**	**Ave MI Per Visit**	
SN		312	5854	18.76	
PT		479	8823	18.42	
OT	0	375	5438	14.50	
ST		6	93	15.50	
MSW		33	673	20.39	
CHHA		0	0	0.00	
TOTALS		1205	20881	17.33	
			Prior Miles	**New Monthly Miles**	**SUMS**
SN			5081	773	5854
PT			7637	1186	8823
OT			4250	1188	5438
ST			93	0	93
MSW			644	29	673
CHHA					0
		Totals	17705	3176	20881

Pioneer Home Health Care
2022 Hospice Visits

	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	YTD
HOS Blue Cross													
SN													0
PT													0
OT													0
MSW													0
Aide													0
Chaplain	0												0
Bereavement													0
Totals	0	0	0	0	0	0	0	0	0	0	0	0	0
Regular Supplies													0
HOS Blue Shield													
SN													0
PT													0
OT													0
MSW													0
Aide													0
Chaplain													0
Totals	0	0	0	0	0	0	0	0	0	0	0	0	0
Supplies													0
HOS Other Insurance													
SN													0
PT													0
OT													
MSW													0
Aide													0
Chaplain													0
Totals	0	0	0	0	0	0	0	0	0	0	0	0	0
Supplies													0
HOS Medicare													
SN	20	24	47	21	31	40	32						215
PT													0
OT							1						1
MSW	4	3			1	5	1						14
Aide	3	3				2	1						9
Chaplain	14	15			15	14	12						70
Totals	41	45	47	21	47	61	47	0	0	0	0	0	309
Supplies	5					15							20

Pioneer Home Health Care
2022 Hospice Visits

	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	YTD
HOS PHHC Charity Care													
SN													0
PT													0
OT													0
MSW													0
Aide													0
Chaplain													0
Totals	0	0	0	0	0	0	0	0	0	0	0	0	0
Supplies													0
HOS Medi-Cal Managed Care													
SN			6	1									7
PT													0
OT													0
MSW													0
Aide													0
Chaplain													0
Totals	0	0	6	1	0	0	0	0	0	0	0	0	7
Supplies													0
HOS Medicare Advantage													
SN													0
PT													0
OT													0
MSW													0
Aide													0
Chaplain													0
Totals	0	0	0	0	0	0	0	0	0	0	0	0	0
Supplies	105												105
2021 HOSPICE VISIT TOTALS													
	Jan	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**YTD**
SN	20	24	53	22	31	40	32	0	0	0	0	0	222
PT	0	0	0	0	0	0	0	0	0	0	0	0	0
OT	0	0	0	0	0	0	1	0	0	0	0	0	1
MSW	4	3	0	0	1	5	1	0	0	0	0	0	14
Aide	3	3	0	0	0	2	1	0	0	0	0	0	9
Chaplain	14	15	0	0	15	14	12	0	0	0	0	0	70
Bereavement	0	0	0	0	0	0	0	0	0	0	0	0	0
Totals	**41**	**45**	**53**	**22**	**47**	**61**	**47**	**0**	**0**	**0**	**0**	**0**	**316**
Supplies	110	0	0	0	0	15	0	0	0	0	0	0	**125**

Pioneer Home Health Care
2022 Hospice Visits

Hospice Visits

through December 2022

	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	12/21/202	YTD
SN	20	24	53	22	31	40	32	0	0	0	0	0	222
PT	0	0	0	0	0	0	0	0	0	0	0	0	0
OT	0	0	0	0	0	0	1	0	0	0	0	0	1
MSW	4	3	0	0	1	5	1	0	0	0	0	0	14
Aide	3	3	0	0	0	2	1	0	0	0	0	0	9
Chaplain	14	15	0	0	15	14	12	0	0	0	0	0	70
Bereavement	0	0	0	0	0	0	0	0	0	0	0	0	0
Totals	**41**	**45**	**53**	**22**	**47**	**61**	**47**	**0**	**0**	**0**	**0**	**0**	**316**

Average visits per month = **41.0**

2021	3	16	36	37	29	33	27	33	22	16	49	42	**343**
2020	51	30	36	21	24	23	24	23	25	19	11	23	**310**
2019	25	27	12	39	25	22	26	36	37	38	66.0	62	**415**
2018	27	25	50	39	53	51	23	56	32	32	37.0	16	**441**
2017	2	9	0	0	0	20	15	24	21	12	24	19	**146**
2016				2	1	11	19	18	18	14	16	0	**99**

Hospice Volunteer Visits

	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	YTD
													0

Hospice Visits - Volunteers

2021													
2020	3	2	3	0	4								12
2019	1	0	2	1	1	5	5						**15**
2018	1	4	3	4	3	6	4	7	2	0			34
	165												

Pioneer Home Health Care
2022 Hospice LOS

through December 2022

Name	MR#	INS	SOC Date	D/C or Death Date	LOS	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	TOTAL	LOS carryover
[redacted]					432	31	28	31	30	31	30	31						212	220
					300	31	28	31	30	31	30	26						207	93
					81	31	7											38	43
					14	14												14	
					4	4												4	
					6		4	2										6	
					107		28	31	30	18								107	
					171		18	31	30	31	30	31						171	
					47		25	22										47	
					103			18	30	31	24							103	
					6			6										6	
					11			6	5									11	
					27					6	21							27	
					57					15	30	12						57	
					54						23	31						54	
					87					26	30	31						87	
					55						30	25						55	
					3						3							3	
					17							17						17	
					0													0	
						111	138	178	155	189	251	204	0	0	0	0	0	1226	356

Redacted by NIHD Compliance Officer

	Closed only	YTD Active & Closed	
		This Yr Only	1226
Total LOS	841	Total LOS	1582
# of Patients	15	# of Patients	19
Closed Pts Ave.	56.07	All Pts Ave.	83.26

Pioneer Home Health Care
2022 Home Health Mileage

through December 2022

	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	YTD
Costs													
Supplies	5.00	0.00	0.00	0.00		15.00							20.00
DME	510.00	340.00											850.00
DeltaRX	311.16	490.73	435.93	909.86	537.10	425.03	725.18						3834.99
	826.16	830.73	435.93	909.86	537.10	440.03	725.18	0.00	0.00	0.00	0.00	0.00	4704.99

165

Pioneer Home Health Care
2022 Hospice Mileage

Average Miles and Visits					
through December 2022					
		YTD	**YTD**		
		# of Visits	**# of Miles**	**Ave MI Per Visit**	
SN		222	2888	13.01	
PT		0	0	#DIV/0!	
OT	0	1	30	30.00	
MSW		14	126	9.00	
Aide		9	74	8.22	
Chaplain		70	1572	22.46	
Bereavement		0	0	#DIV/0!	
TOTALS		316	4690	14.84	
			Prior	**New Monthly**	**SUMS**
			Miles	**Miles**	
SN			2301	587	2888
PT					0
OT				30	30
MSW			120	6	126
Aide			74	0	74
Chaplain			1284	288	1572
Bereavement					0
		Totals	3779	911	4690

Grief Support Group

Summer 2022

July14th (7-8 week course)

6:30 pm Thursdays

Grief support handbook provided

Location: 363 Academy Avenue
Bishop, CA 93514
Contact: Patrick Thompson to sign up

760-872-4663

Courtesy of Hospice of the Owens Valley

NORTHERN INYO HEALTHCARE DISTRICT
REPORT TO THE BOARD OF DIRECTORS
FOR INFORMATION

Date: August 1, 2022

Title: **Compliance Board Report Quarter 2 CY 2022**

Synopsis: The Compliance Department Quarterly Report updates the Board on the work of the Compliance Department. It provides information on audits, privacy investigations and 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.

Prepared by: Patty Dickson, Compliance Officer

Approved by: Kelli Davis
Kelli Davis, CEO

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

Northern Inyo Healthcare District

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www.nih.org

Quarterly Compliance Report –Q2 calendar year 2022
March 2022

1. Comprehensive Compliance Program review

A. A review of the NIHD Compliance Program will be on the agenda for the Q3 2022 Compliance and Business Ethics Committee meeting.

2. Audits

A. Employee Access Audits - The Compliance Department Analyst, Conor Vaughan, completes audits for access of patient information systems to ensure employees' access records only on a work-related, need-to-know, and minimum necessary basis.

i. Cerner semi-automated auditing software tracks all workforce interactions and provides a summary dashboard for the compliance team. The dashboard provides "flags" for unusual activity.

a. New Employee Audits: 45
   I. Flags: 5
   II. Flags resulting in policy violations: 1

b. For Cause Audits: 8
   I. Flags: 0
   II. Flags resulting in policy violations: 0

c. In "own" chart flags: 11
   I. Flags resulting in policy violations: 11
      i. Provided education and training: 11
      ii. Repeat violations: 0

d. Same Last Name Search Flags: 263
   I. Resulted in follow up with employee: 263
   II. Flags resulting in disciplinary action: 1

B. Business Associates Agreements (BAA) audit

i. Business Associates are vendors who access, transmit, receive, disclose, use, or store protected health information to provide business services to the District. These vendors range from our billing and coding companies to companies that provide medical equipment that transmits protected health information to the electronic health record. The Business Associates Agreements assure NIHD that the vendor meets the strict governmental

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regulations regarding how to handle, transmit, and store protected information to protect NIHD and NIHD patient information.

ii. NIHD currently has approximately 175 Business Associates Agreements.
    a. 2 are currently in negotiation

C. Contract and Agreement reviews/audit
    i. Contracts and agreements are in the following status:
        a. ~110 are fully executed/completed
        b. ~65 are in the review process
        c. ~15 are on hold
        d. ~20 existing contracts are also in the review process

D. PACS (Picture Archival and Communication System) User Access Agreements
    i. We have completed a successful trial of Nuance Powershare, which allows rapid transfer of imaging studies between facilities. We are now negotiating a contract for continued use.

E. HIMS scanning audit
    i. Scheduled for Q3 CY 2022

F. Email security audit/reviews
    i. Reviewed at least once a month
    ii. Review emails security systems for violations of data loss prevention rules
        a. Typically results in reminder emails to use email encryption sent to members of workforce.
        b. Occasionally results in full investigations of potential privacy violations.
            I. 1 investigation currently in progress

G. Language Access Services Audit
    i. Compliance is waiting for Cerner to develop a report to allow selection of English as a Second Language (ESL) patients.
    ii. Language Access regulations are enforced by the HHS Office of Civil Rights.

H. 340B program audits
    i. Annual 340B audit completed.
        a. The pharmacy team is currently developing and implementing action plans based on the recommendations from the audit.
    ii. DHCS Self Audit

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   a. California Department of Health Care Services (DHCS) requested an audit for Medi-Cal patients for duplicate discounts. NIHD does not use 340B for Medi-Cal patients (they are "carved-out"), as Cerner cannot accept modified Medi-Cal claims back into the revenue cycle process.
   b. Audit found a small number of "self-pay patients" who were retroactively qualified for Medi-Cal. Those claims have been reviewed, and corrections have been submitted to DHCS.
   c. DHCS requested additional claim and drug information.
   d. NIHD Pharmacy team has submitted all requested information.

I. Vendor Diversity Audit – NIHD has approximately 1350 vendors.
   i. Health and Safety Code Section 1339.85-1339.87 required the Department of Health Care Access and Information (HCAI, formerly OSHPD) to develop and administer a program to collect hospital supplier diversity reports including certified diverse vendors in the following categories: minority-owned, women-owned, lesbian/gay/bisexual/transgender-owned, and disabled veteran-owned businesses.
   ii. NIHD has 3 certified diverse vendors
      a. 0% spend for CY 2021 with diverse vendors
      b. CY 2021 report was submitted and accepted by HCAI 06/17/2022, well before the 07/01/2022 deadline.
      c. Diversity reports are now required annually in California. As of this time, there is no requirement to have a percentage of spend with diverse vendors; however, there is discussion of requiring plans for California organizations and businesses to develop plans to increase vendor diversity.

J. Provider Verifications
   i. More than 350 new referring providers were reviewed in the first 6 months of CY 2022 to ensure they are not on a California or federal exclusions list
   ii. One out of the 350 providers was on the exclusions lists. Compliance contacted the provider and the patient to address the referrals.
      a. The patient wants to continue to see the provider. The excluded provider will work with the patient's primary care provider to ensure referrals are valid and patient still gets care desired/needed.

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iii. NIHD may not bill for referrals for designated health services from excluded providers. Billing for referrals from excluded providers could put NIHD at risk for false claims.

3. **HIPAA Security Risk Assessment (SRA)** – Due October/November 2022
4. **CPRA (California Public Records Act) Requests**
   A. The Compliance office has received six (6) CPRA requests to date in 2022.
      i. Three have been completed and three are currently in progress
5. **Compliance Work Plan** – Updated February 2022
   A. No updates since previous report.
6. **Conflicts of Interest**
   A. The Compliance department emailed the NIHD workforce the 2022 Conflicts of Interest (COI) form.
      i. Compliance Clerk is processing COI forms received and will notify the Business Compliance Team when ready to schedule a meeting to review the forms.
   B. No COI forms submitted to the compliance department noted any knowledge or concern for the following:
      i. Business transactions with an aim for personal gain.
      ii. Gifts, loans, tips, or discounts to create real or perceived obligations.
      iii. Use of NIHD resources for purposes other than NIHD business, NIHD sponsored business activities, or activities allowed by policy.
      iv. Bribes, kickbacks, or rewards with the intent to interfere with NIHD business or workforce.
      v. Use of NIHD money, goods, or services to influence government employees, or for special consideration or political contribution.
      vi. False or misleading accounting practices or improper documentation of assets, liabilities, or financial transactions.
7. **Unusual Occurrence Reports** (UOR)
   A. UOR report data for January 1, 2022 through June 30, 2022 attached
   B. Notable trends:
      i. UORs regarding complaints and requests to review billing/care are the highest with 55 through June 30, 2022
      ii. Falls are trending up in the facility with 13.

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iii. Specimen issues are trending down following implementation of a new training and competency plan implemented in the phlebotomy area.

8. Privacy Investigations

A. Privacy investigations/potential breaches between January 1, 2022 – July 31, 2022
   i. Reported to CDPH/OCR – 4
      a. Two breaches were substantiated with no deficiencies
      b. One potential breach is "in progress" with CDPH
      c. One potential breach is in "submitted" status with CDPH
   ii. Investigations still active in the Compliance Department - 3
   iii. Investigations closed by the Compliance Department with no reporting required - 18

B. Privacy investigations from 2021
   i. Reported to CDPH/OCR 2021– 4
      a. Two breaches have been substantiated with no deficiencies
      b. Two potential breaches are in submitted status with CDPH
   ii. Investigations still active with Compliance Department – 0
   iii. Investigations closed by NIHD with no reporting required – 43

C. Privacy investigations from 2020 (outstanding with regulatory agency)
   i. Reported to CDPH/OCR 2020
      a. One potential breach reported to CDPH is still in "progress" status according to the CDPH website. No determination has been made at this time.
      b. Seven potential breaches reported to CDPH are still in "submitted" status at this time.

D. Privacy investigations from 2019 (outstanding with regulatory agency)
   i. Reported to CDPH/OCR 2019
      a. One potential breach reported to CDPH is still outstanding, in "progress" according to the CDPH website. No determination has been made at this time.

9. Investigations

A. Compliance has conducted or assisted with 25 investigations/reviews that were not related to privacy/breach allegations.
   i. Regulatory agency requests (examples below, not an inclusive list)
      a. Department of Health Care Services (DHCS)

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b. California Department Public Health (CDPH)
c. Inyo County (subpoenas, etc.)

ii. Workplace Violence/Safety/Security issues
iii. Third party payer grievances or reviews
iv. Workforce compliance and ethics violations
v. Contractual obligation disputes
vi. Fraud, waste, and abuse concerns

10. Compliance and Business Ethics Committee (CBEC)

A. Meeting conducted July 2022
   i. Reviewed Compliance Work plan, discussed OIG updates
   ii. Tabled review of Compliance Program for Q3
   iii. Approved 5 policies/procedures
B. No meeting in Q2 calendar year 2022 – no quorum
C. Meeting conducted in February 2022 for CY Q1
   i. Discussion of Fiscal Services' mandatory "Single Audit" related to federal funding the District received. Vinay will present results to the Board of Directors when available.
   ii. Approved 2 policies and procedures
   iii. Review of ongoing investigations
   iv. Revenue Cycle Update
   v. Review of 340B self-audit
D. Next meeting will be scheduled in August 2022

11. Issues and Inquiries

A. Compliance has researched over a hundred issues for various District workforce members and leadership in 2022. They include COVID-19 mandates and changes, COVID-19 exceptions and exemptions, minor privacy regulations, Substance Abuse and Mental Health Services Administration (SAMHSA) regulations, mandatory and permissive releases of information, adoption processes, confidentiality issues, release of information and information blocking regulations, Sexual Assault Response Team (SART) regulations and information, physician departures, regulatory updates, and many other areas of interest and concern.

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

A. Proper policies and policy management is a large component of an effective Compliance Program.

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B. Tracy Aspel, Compliance Policy Management Administrator, continues to work with leadership to facilitate updated policies and leadership growth.
C. Ms. Aspel continues to facilitate policy updates for both Clinical Consistency Oversight Committee (CCOC) and Non-clinical Consistency Oversight Committee (NCOC).

13. Rural Health Clinic Compliance Software

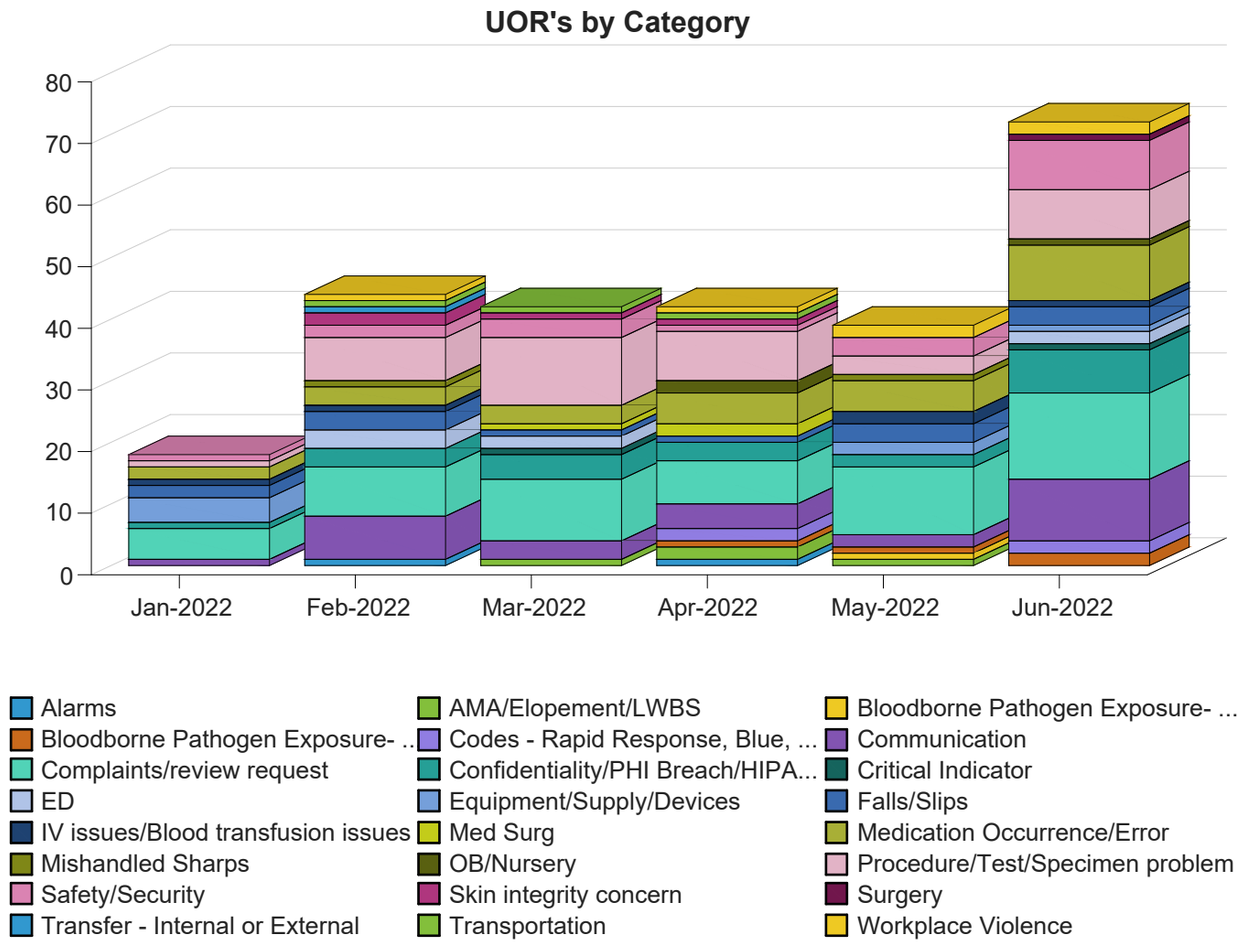
A. InQuiSeek software is fully implemented following set up and implementation facilitated by Tracy Aspel.
B. The routine maintenance, users' updates, and updates are now handled by the clinic leadership team.

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

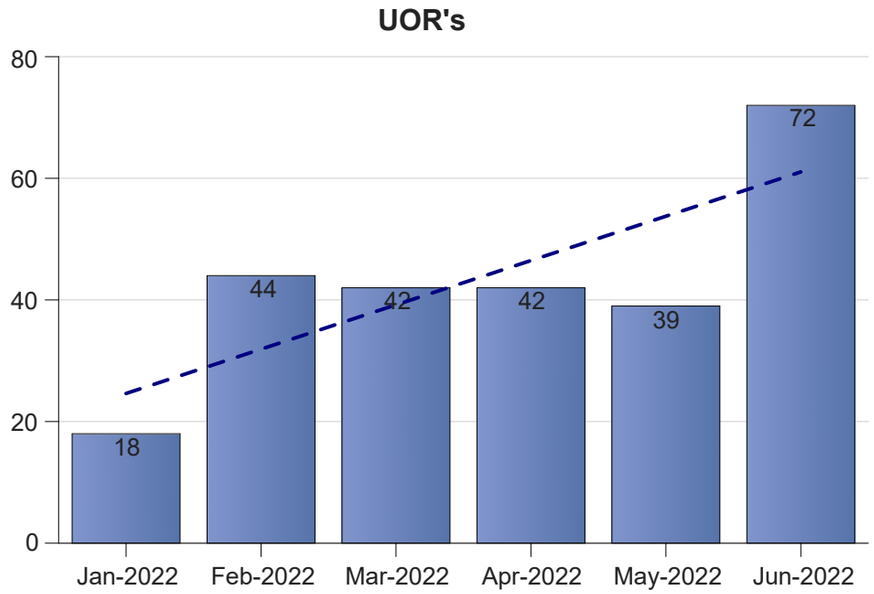
A. Updating contracts/agreements status is being facilitated by Katie Manuelito, Compliance Contracts Analyst
B. Including automated reminders for appropriate lead time for District leadership to review and update contracts that are expiring or auto-renewing, to ensure the District is meeting the requirements for monitoring contracts
C. Hosts about 2000 contracts (including archived and current contracts/agreements)

15. Forms Committee

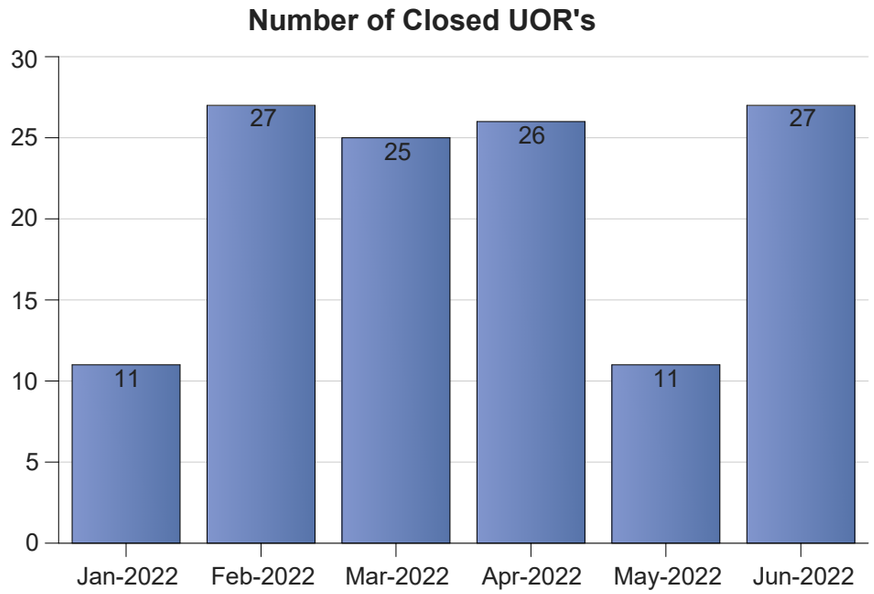
A. NIHD develops forms in compliance with our Forms Control Policy. Forms are branded with NIHD logos. There are standardized templates, designated fonts, official translations, and mandatory non-discrimination and language access information.
B. All forms used at the District for patient care, regulatory requirements, orders, down-time documentation, standardized workflows, and process improvement are submitted to the Forms Committee. Once approved they are maintained in a location on the NIHD Intranet (a quick link named "Approved Forms") for access by NIHD workforce.
C. More than 100 forms have been developed or revised from January 1, 2022 through July 2022


UOR's by Category
80
70
60
50
40
30
20
10
0
Jan-2022
Feb-2022
Mar-2022
Apr-2022
May-2022
Jun-2022
Alarms
AMA/Elopement/LWBS
Bloodborne Pathogen Exposure- ...
Bloodborne Pathogen Exposure- ...
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
OB/Nursery
Procedure/Test/Specimen problem
Safety/Security
Skin integrity concern
Surgery
Transfer - Internal or External
Transportation
Workplace Violence

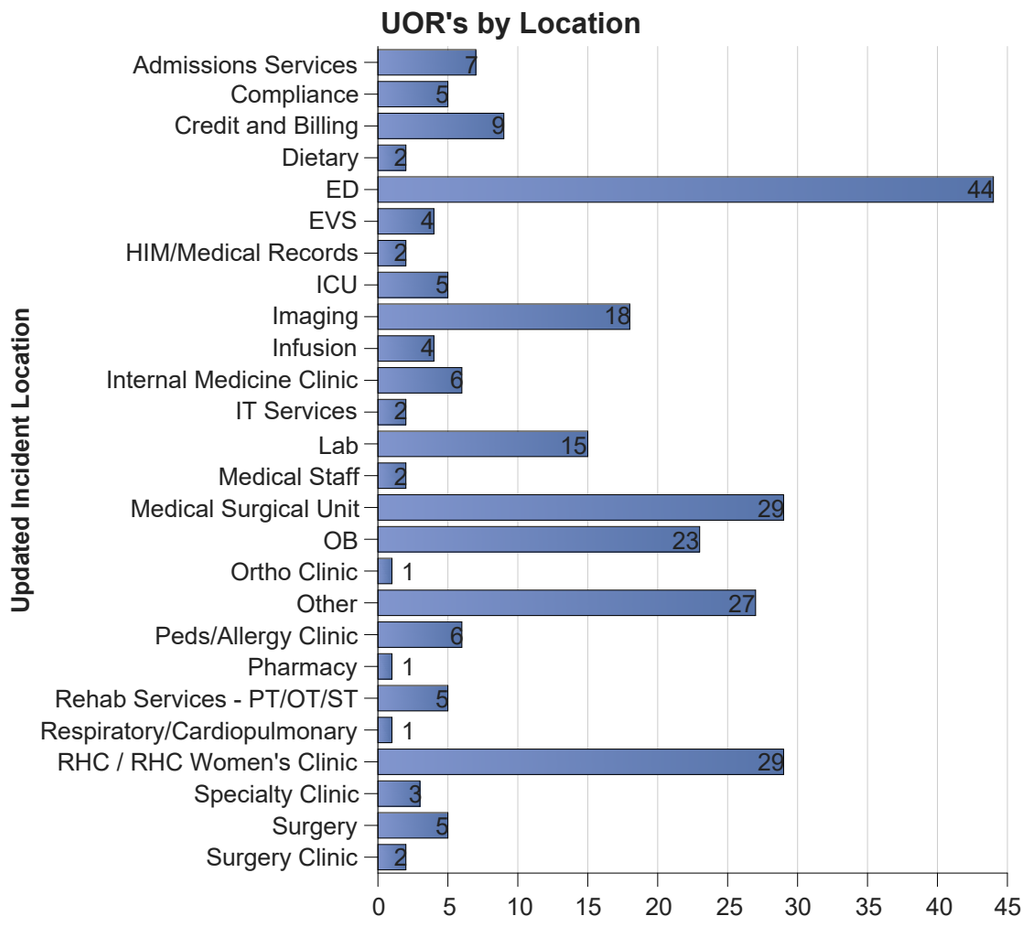
	Jan-2022	Feb-2022	Mar-2022	Apr-2022	May-2022	Jun-2022	Total
Alarms		1		1			**2**
AMA/Elopement/LWBS			1	2	1		**4**
Bloodborne Pathogen Exposure- Sharps Injury					1		**1**
Bloodborne Pathogen Exposure- Splash/ Mucous Membrane				1	1	2	**4**
Codes - Rapid Response, Blue, Deescalation				2		2	**4**
Communication	1	7	3	4	2	10	**27**
Complaints/review request	5	8	10	7	11	14	**55**
Confidentiality/PHI Breach/HIPAA violation	1	3	4	3	2	7	**20**
Critical Indicator			1			1	**2**
ED		3	2			2	**7**
Equipment/Supply/Devices	4				2	1	**7**
Falls/Slips	2	3	1	1	3	3	**13**
IV issues/Blood transfusion issues	1	1			2	1	**5**
Med Surg			1	2			**3**
Medication Occurrence/Error	2	3	3	5	5	9	**27**
Mishandled Sharps		1			1		**2**
OB/Nursery				2		1	**3**
Procedure/Test/Specimen problem	1	7	11	8	3	8	**38**
Safety/Security	1	2	3	1	3	8	**18**
Skin integrity concern		2	1	1			**4**
Surgery						1	**1**
Transfer - Internal or External		1					**1**
Transportation		1	1	1			**3**
Workplace Violence		1		1	2	2	**6**
Total	**18**	**44**	**42**	**42**	**39**	**72**	**257**



Jan-2022	18
Feb-2022	44
Mar-2022	42
Apr-2022	42
May-2022	39
Jun-2022	72
Total	**257**



	Closed
Jan-2022	11
Feb-2022	27
Mar-2022	25
Apr-2022	26
May-2022	11
Jun-2022	27
Total	**127**

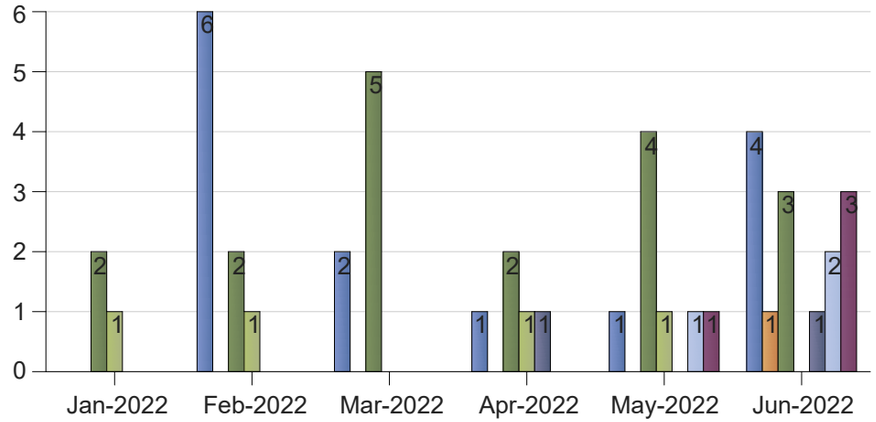


Admissions Services	7
Compliance	5
Credit and Billing	9
Dietary	2
ED	44
EVS	4
HIM/Medical Records	2
ICU	5
Imaging	18
Infusion	4
Internal Medicine Clinic	6
IT Services	2
Lab	15
Medical Staff	2
Medical Surgical Unit	29
OB	23
Ortho Clinic	1
Other	27
Peds/Allergy Clinic	6
Pharmacy	1
Rehab Services - PT/OT/ST	5
Respiratory/Cardiopulmonary	1
RHC / RHC Women's Clinic	29
Specialty Clinic	3
Surgery	5
Surgery Clinic	2
Total	**257**

000002

UOR's Related to Nursing by Nursing Unit Involved

(only when Nursing Unit Involved = Yes)



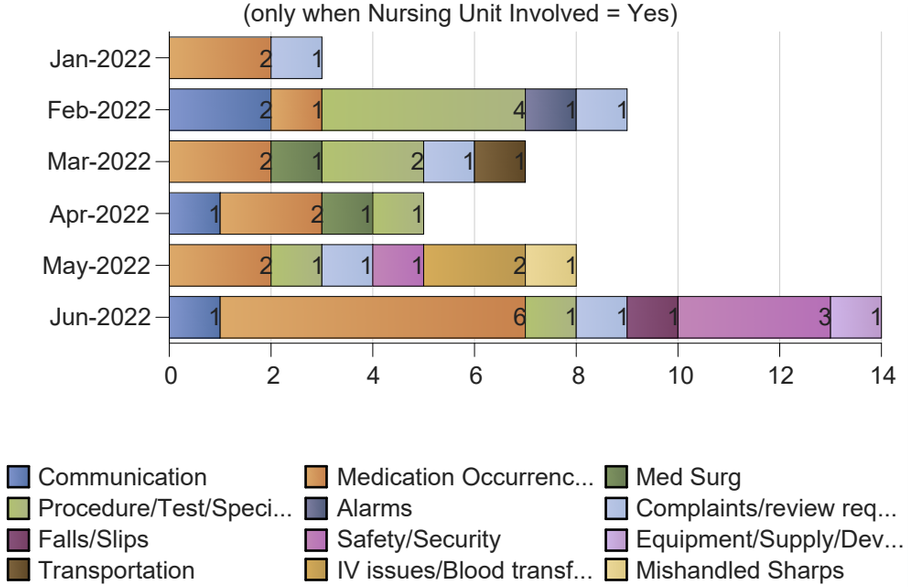
	Yes
Emergency	14
Infusion	1
Medical/Surgical	18
OB	4
OR	2
PACU	3
RHC	4
Total	**46**

Updated Nursing Unit Involved

Emergency, Infusion, Medical/Surgical, OB, OR, PACU, RHC

UOR's Related to Nursing

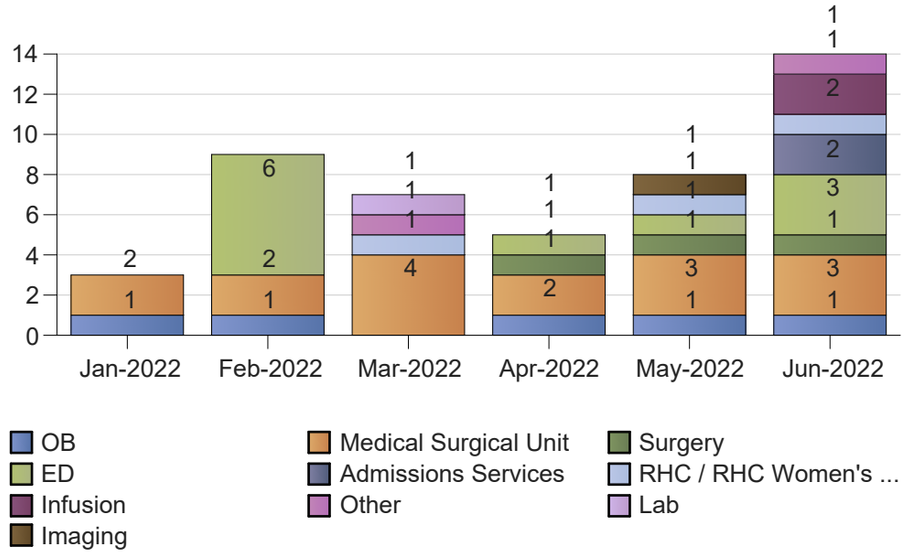
(only when Nursing Unit Involved = Yes)



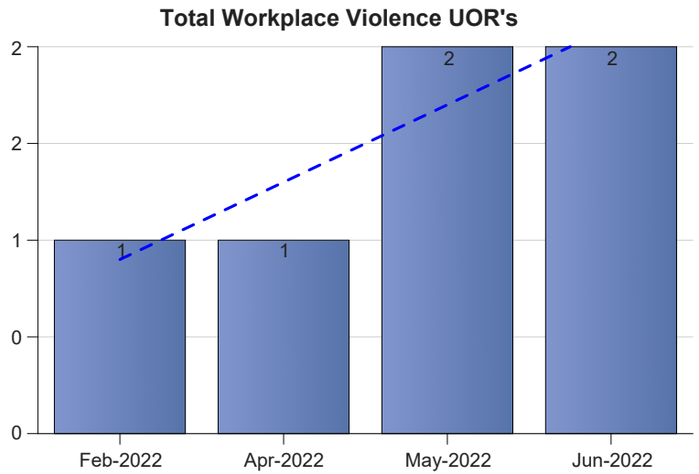
	Jan-2022	Feb-2022	Mar-2022	Apr-2022	May-2022	Jun-2022	Total
Communication		2		1		1	**4**
Medication Occurrence/Error	2	1	2	2	2	6	**15**
Med Surg			1	1			**2**
Procedure/Test/Specimen problem		4	2	1	1	1	**9**
Alarms		1					**1**
Complaints/review request	1	1	1		1	1	**5**
Falls/Slips						1	**1**
Safety/Security					1	3	**4**
Equipment/Supply/Devices						1	**1**
Transportation			1				**1**
IV issues/Blood transfusion issues					2		**2**
Mishandled Sharps					1		**1**
Total	**3**	**9**	**7**	**5**	**8**	**14**	**46**

UOR's Related to Nursing by Location

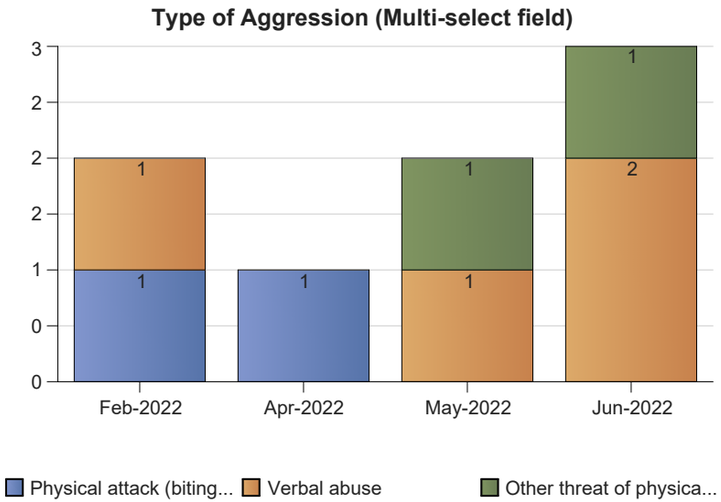
(only when Nursing Unit Involved = Yes)



	Jan-2022	Feb-2022	Mar-2022	Apr-2022	May-2022	Jun-2022	Total
OB	1	1		1	1	1	**5**
Medical Surgical Unit	2	2	4	2	3	3	**16**
Surgery				1	1	1	**3**
ED		6		1	1	3	**11**
Admissions Services						2	**2**
RHC / RHC Women's Clinic			1		1	1	**3**
Infusion						2	**2**
Other			1			1	**2**
Lab			1				**1**
Imaging					1		**1**
Total	**3**	**9**	**7**	**5**	**8**	**14**	**46**

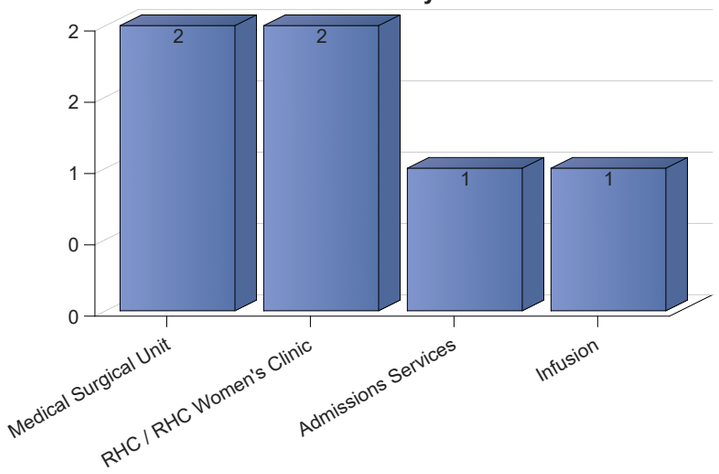


	Feb-2022	Apr-2022	May-2022	Jun-2022	Total
Workplace Violence	1	1	2	2	**6**
Total	**1**	**1**	**2**	**2**	**6**



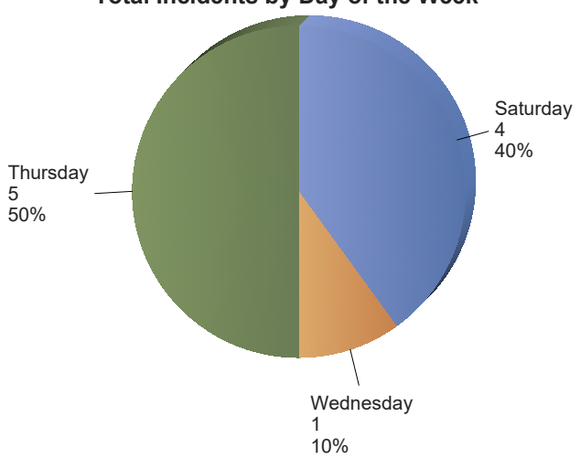
	Feb-2022	Apr-2022	May-2022	Jun-2022	Total
Physical attack (biting, choking, grabbing, hair pulling, kicking, punching/slapping, scratching, spitting, striking, etc)	1	1			**2**
Verbal abuse	1		1	2	**4**
Other threat of physical force			1	1	**2**
Total	**2**	**1**	**2**	**3**	**8**

Total WPV Incidents by Location

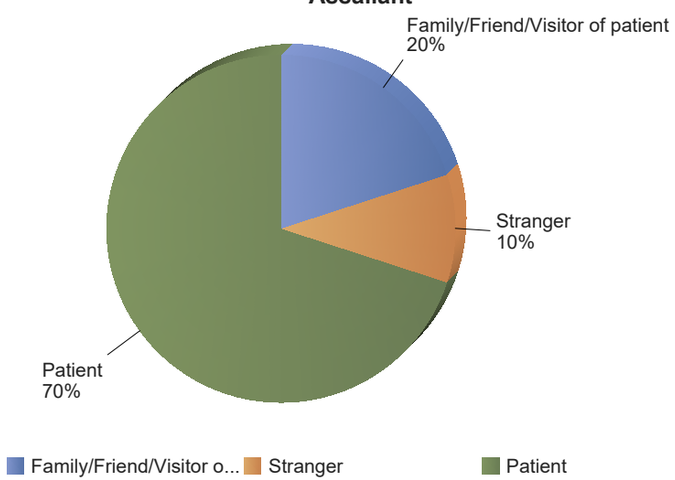


Medical Surgical Unit	2
RHC / RHC Women's Clinic	2
Admissions Services	1
Infusion	1
Total	**6**

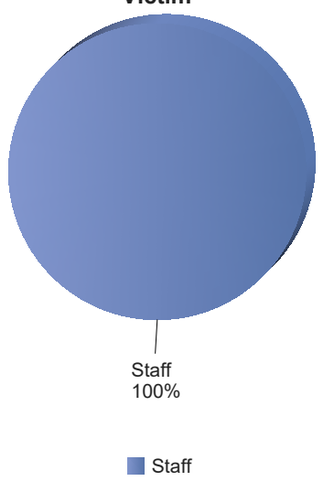
Total Incidents by Day of the Week

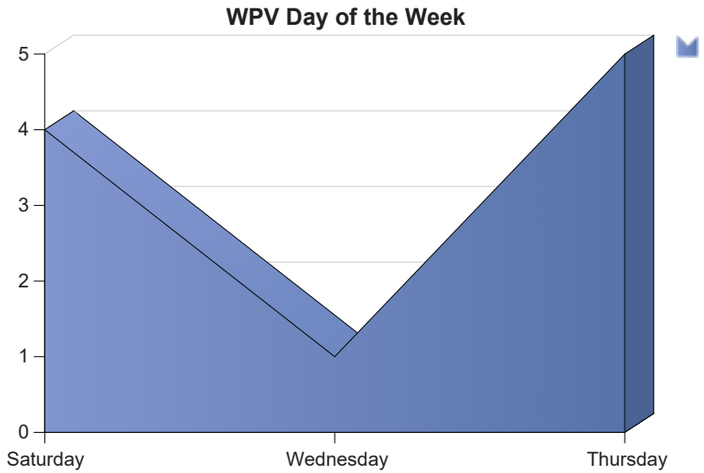


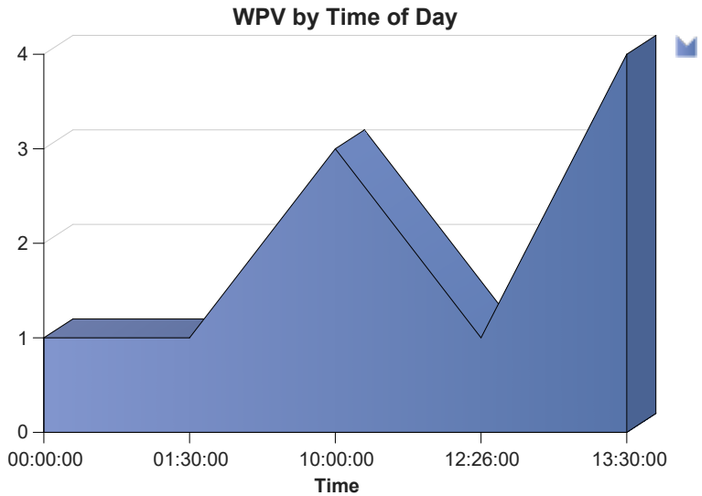
Assailant

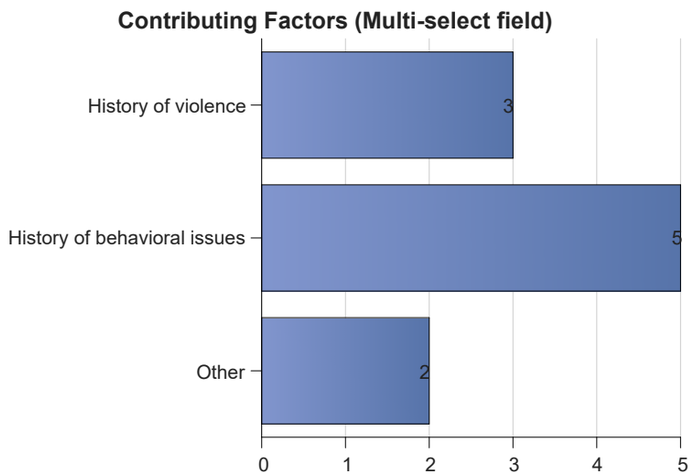


Victim





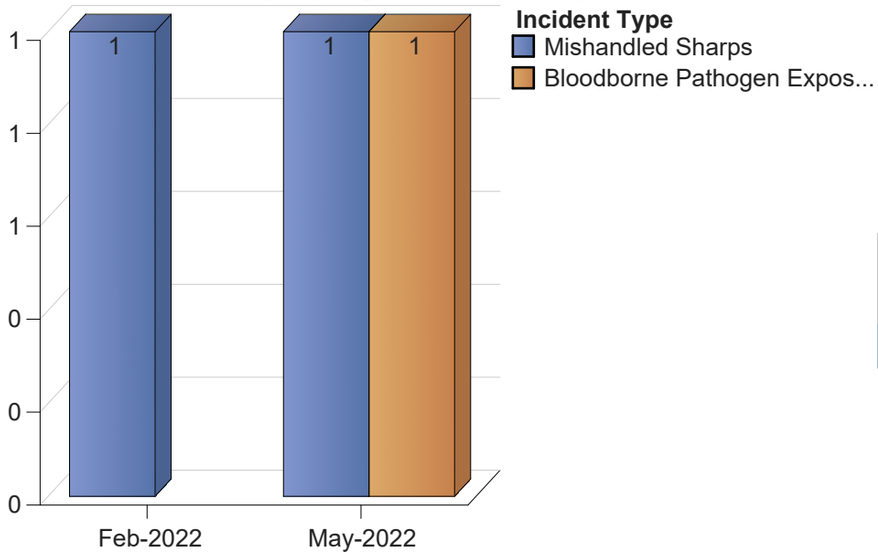




History of behavioral issues	3
History of violence	2
Other	2
Total	**7**

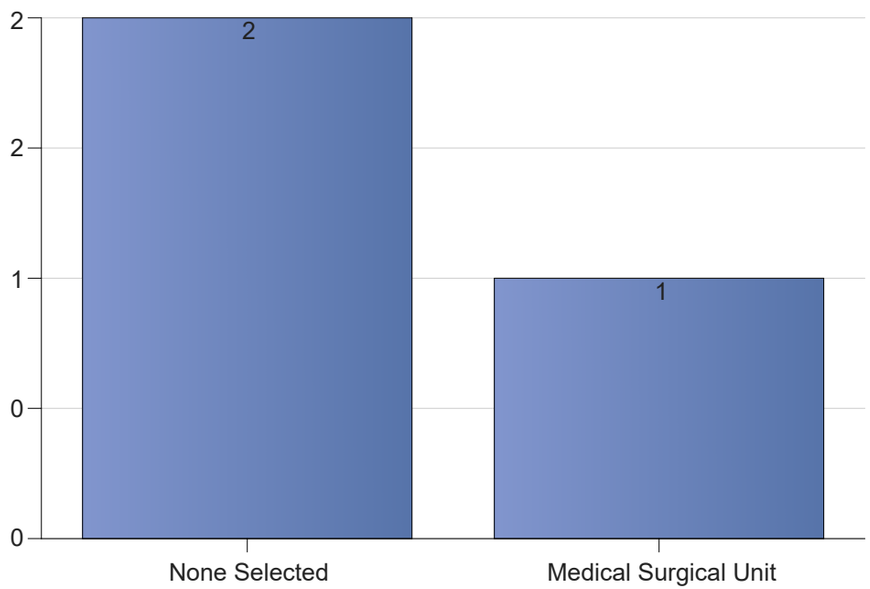
RHC Incidents by Day of the Week - No Data Available

Improperly Handled Sharps



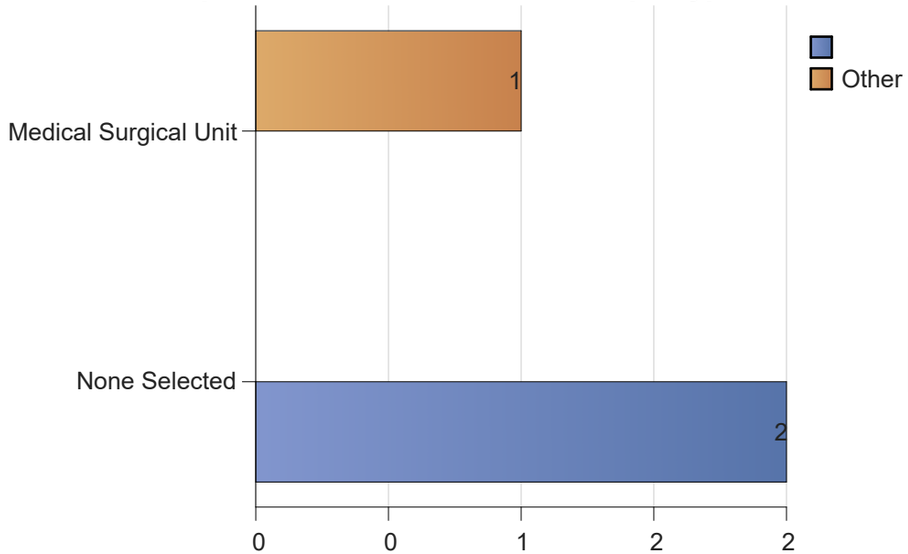
	Feb-2022	May-2022	Total
Mishandled Sharps	1	1	**2**
Bloodborne Pathogen Exposure- Sharps Injury		1	**1**
Total	**1**	**2**	**3**

Departments affected by improperly handled sharps



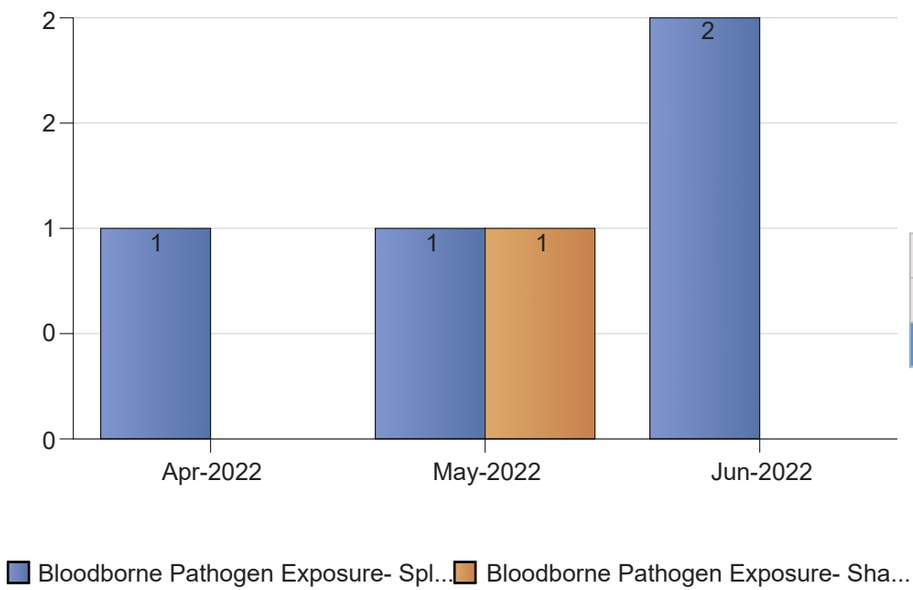
None Selected	2
Medical Surgical Unit	1
Total	**3**

Department and Mishandled Sharps Type



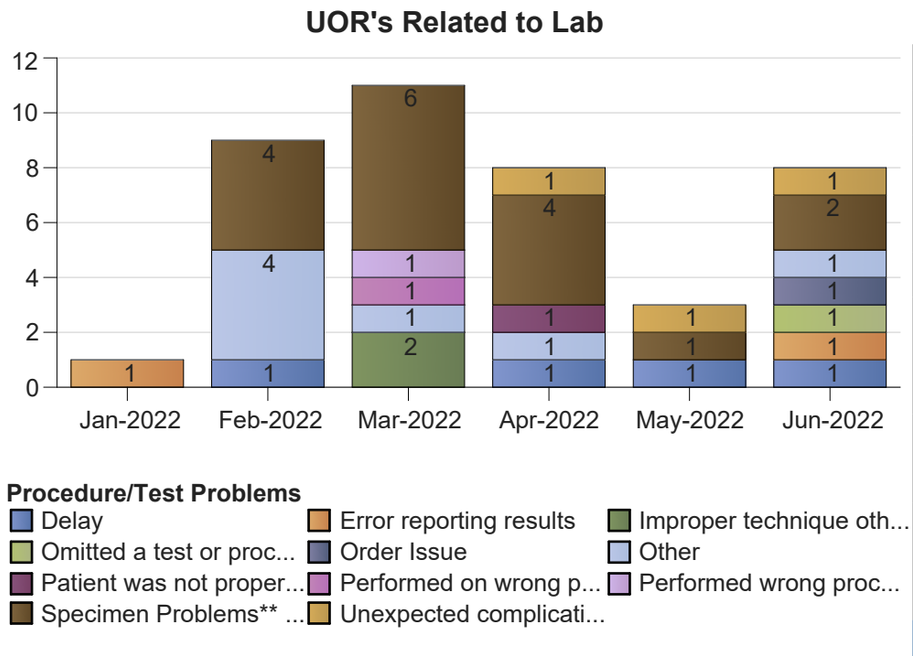
	Mishandled Sharps Type		Total
	None Selected	Other	
None Selected	2		**2**
Medical Surgical Unit		1	**1**
Total	**2**	**1**	**3**

Bloodborne Pathogen Exposure

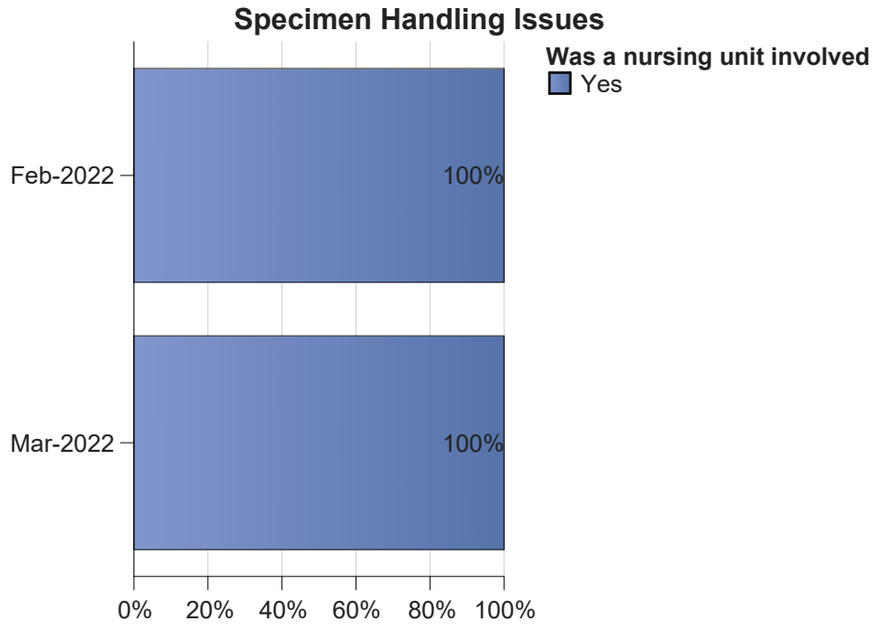


	Apr-2022	May-2022	Jun-2022	Total
Bloodborne Pathogen Exposure- Splash/ Mucous Membrane	1	1	2	**4**
Bloodborne Pathogen Exposure- Sharps Injury		1		**1**
Total	**1**	**2**	**2**	**5**

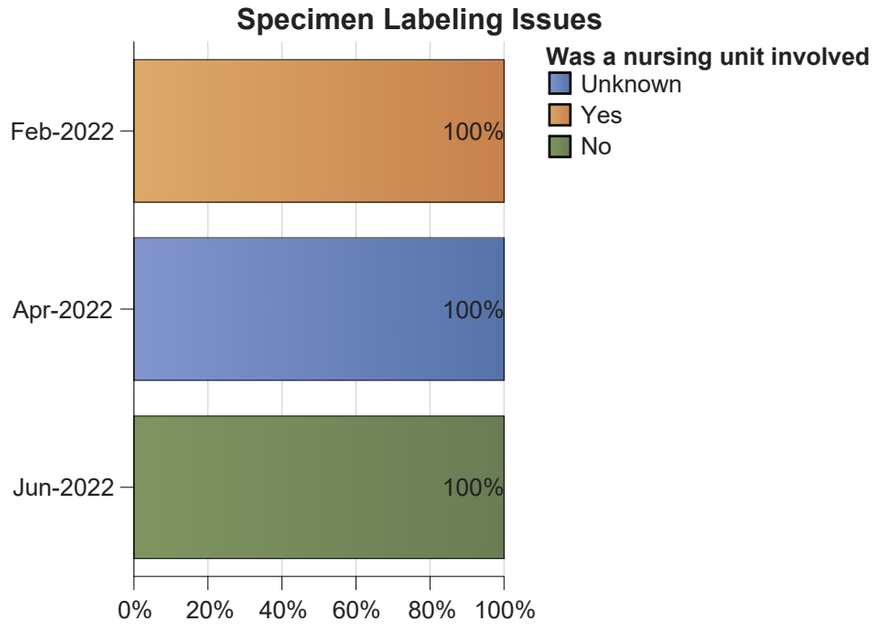
ItemCustomId	Incident Type	Mishandled Sharps	Updated Incident Location
004089	Bloodborne Pathogen Exposure- Sharps Injury		
004031	Mishandled Sharps	Other	Medical Surgical Unit
003799	Mishandled Sharps		



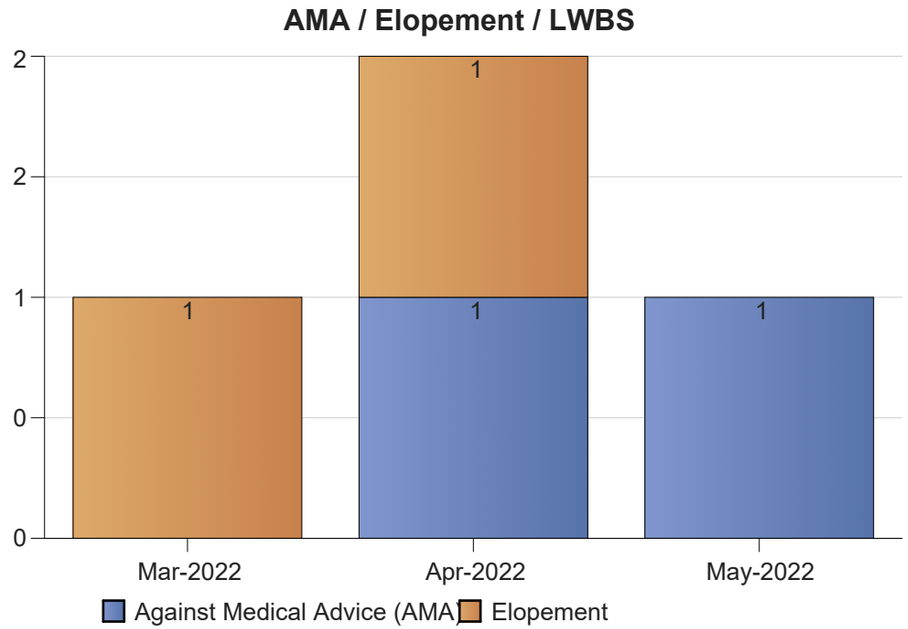
	Jan-2022	Feb-2022	Mar-2022	Apr-2022	May-2022	Jun-2022	Total
Delay		1		1	1	1	**4**
Error reporting results	1					1	**2**
Improper technique other than a break in sterile technique			2				**2**
Omitted a test or procedure						1	**1**
Order Issue						1	**1**
Other		4	1	1		1	**7**
Patient was not properly prepared for the procedure or test				1			**1**
Performed on wrong patient			1				**1**
Performed wrong procedure			1				**1**
Specimen Problems** LAB ALWAYS SELECT THIS ONE***		4	6	4	1	2	**17**
Unexpected complications				1	1	1	**3**
Total	**1**	**9**	**11**	**8**	**3**	**8**	**40**



	Feb-2022	Mar-2022	Total
Yes	2	1	**3**
Total	**2**	**1**	**3**

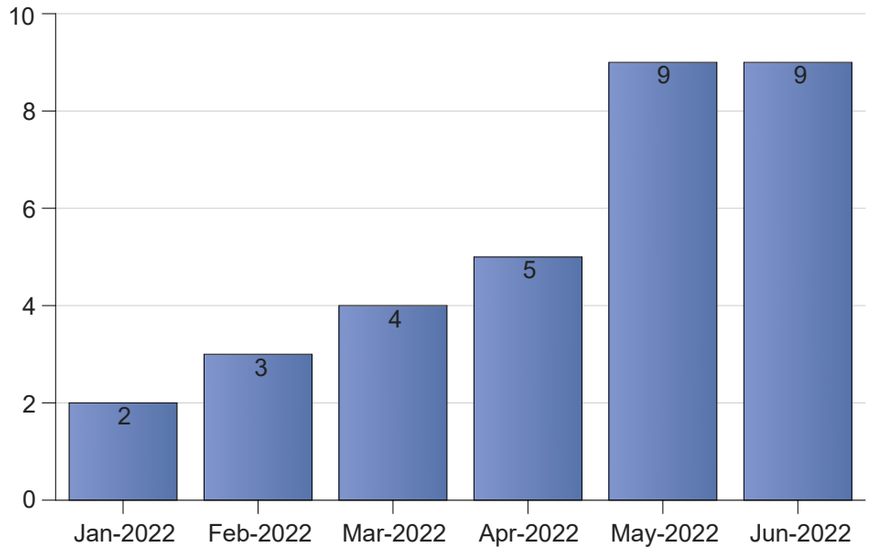


	Feb-2022	Apr-2022	Jun-2022	Total
Unknown		1		**1**
Yes	4			**4**
No			1	**1**
Total	**4**	**1**	**1**	**6**



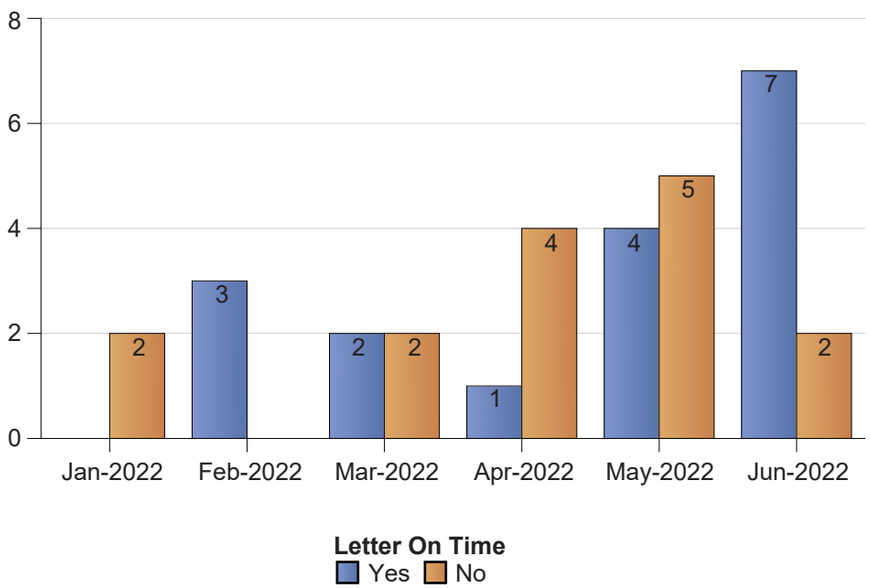
	Mar-2022	Apr-2022	May-2022	Total
Against Medical Advice (AMA)		1	1	**2**
Elopement	1	1		**2**
Total	**1**	**2**	**1**	**4**

UOR's with Complaint Response Required



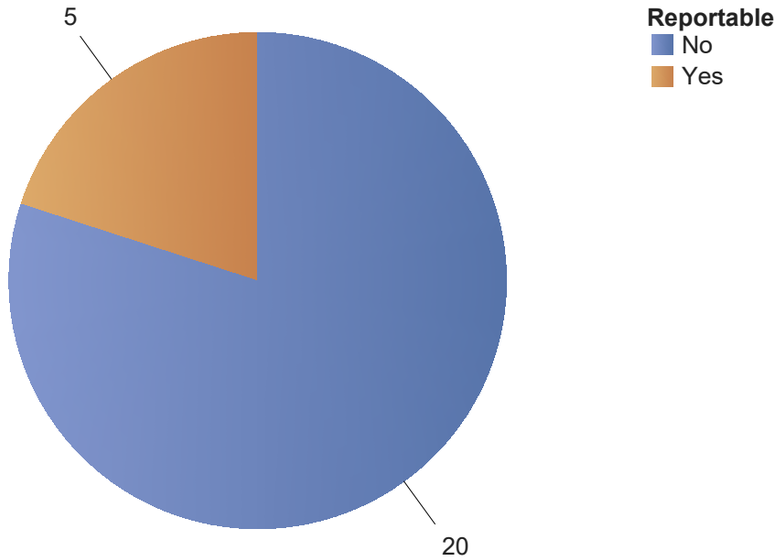
Jan-2022	2
Feb-2022	3
Mar-2022	4
Apr-2022	5
May-2022	9
Jun-2022	9
Total	**32**

UOR's with On Time Responses

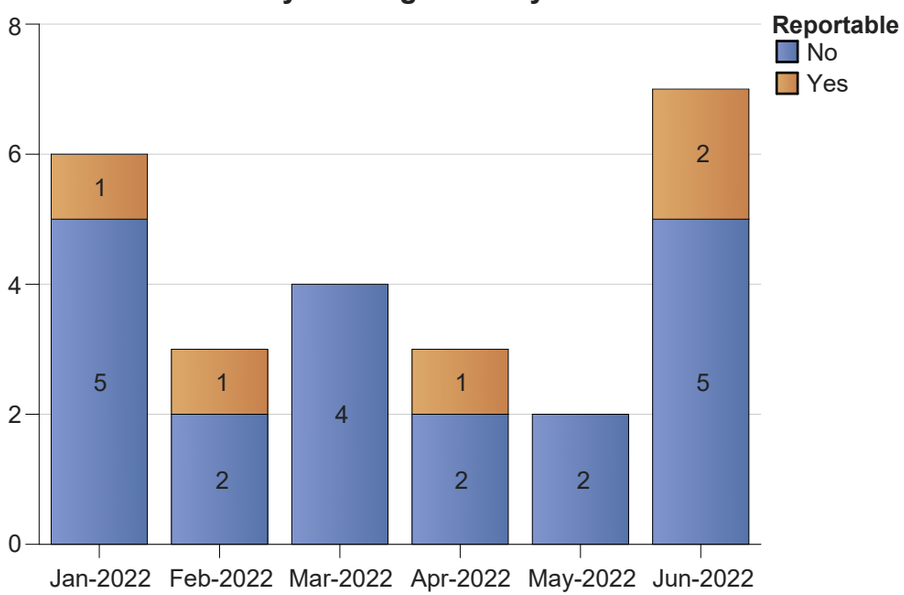


	Yes	No	Total
Jan-2022		2	**2**
Feb-2022	3		**3**
Mar-2022	2	2	**4**
Apr-2022	1	4	**5**
May-2022	4	5	**9**
Jun-2022	7	2	**9**
Total	**17**	**15**	**32**

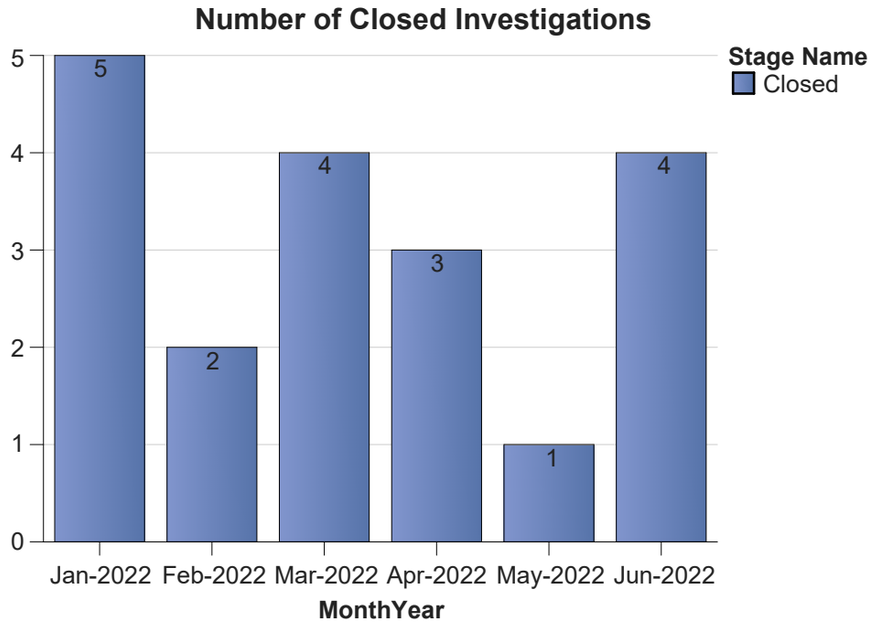
Total Privacy Investigations



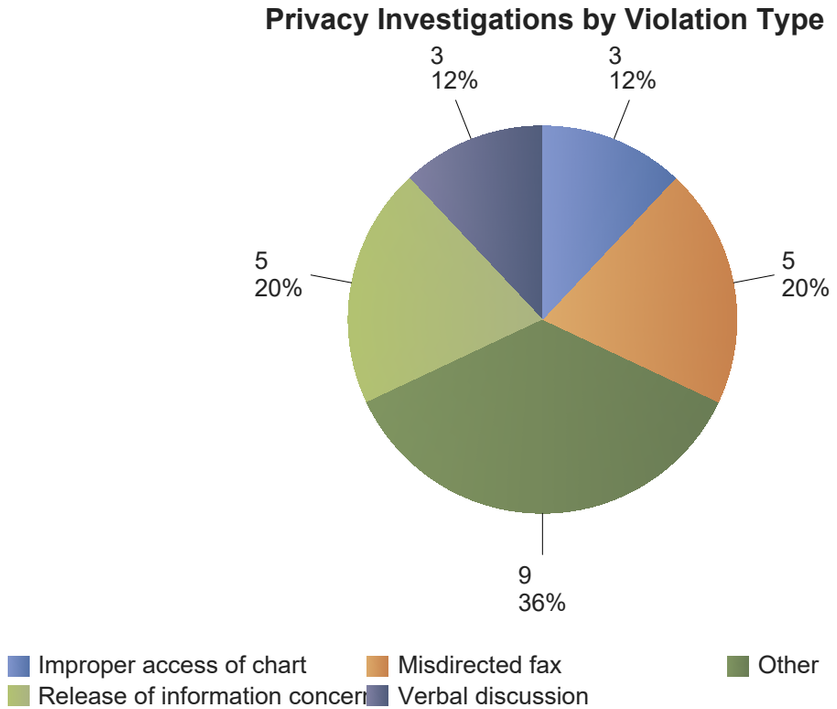
Privacy Investigations by Month/Year



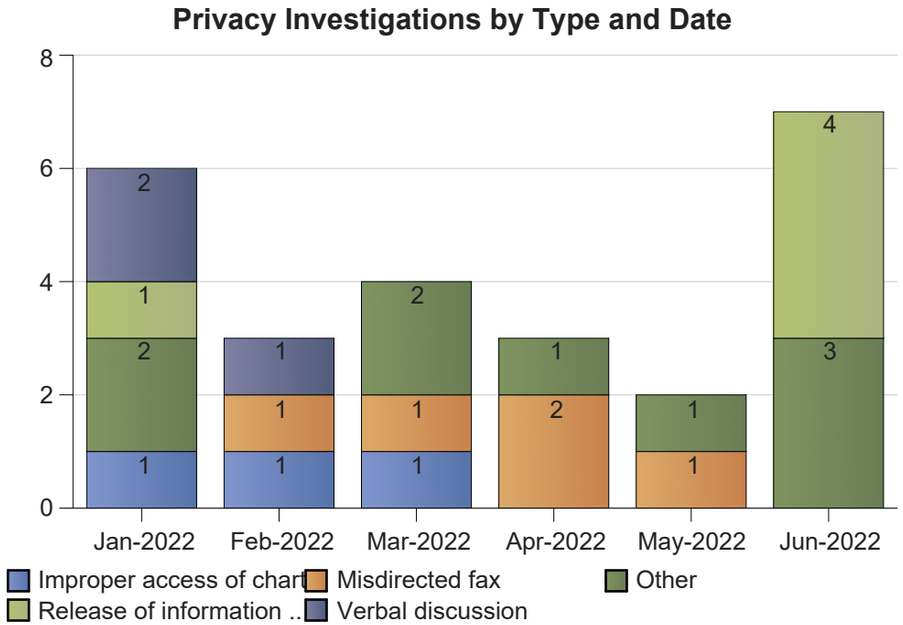
	No	Yes	Total
Jan-2022	5	1	**6**
Feb-2022	2	1	**3**
Mar-2022	4		**4**
Apr-2022	2	1	**3**
May-2022	2		**2**
Jun-2022	5	2	**7**
Total	**20**	**5**	**25**



	Closed	Total
May-2022	1	**1**
Mar-2022	4	**4**
Jun-2022	4	**4**
Jan-2022	5	**5**
Feb-2022	2	**2**
Apr-2022	3	**3**
Total	**19**	**19**
Total	**19**	**19**

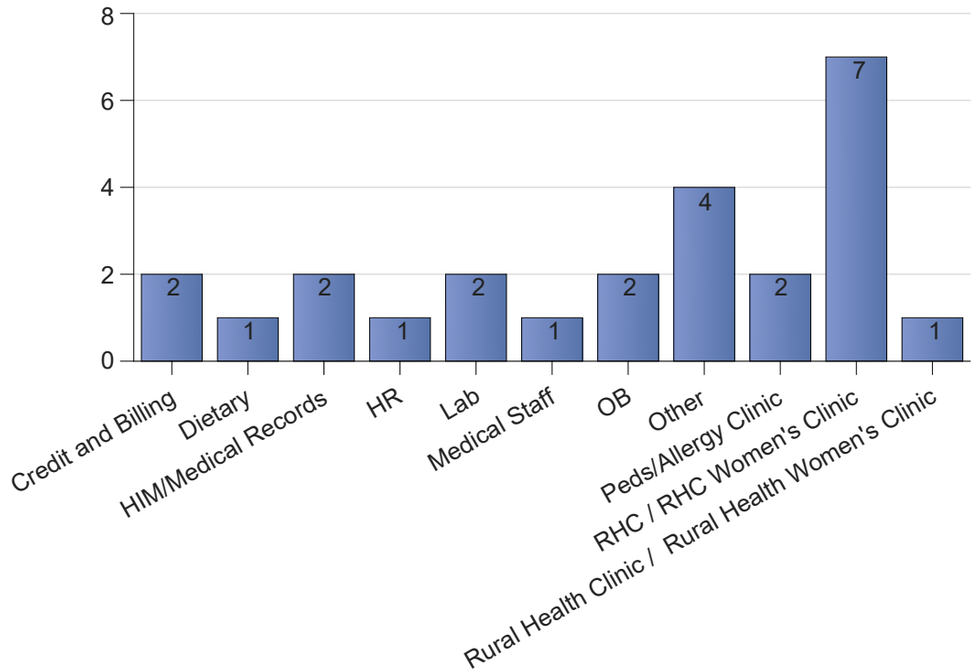


Improper access of chart	3
Misdirected fax	5
Other	9
Release of information concern	5
Verbal discussion	3
Total	**25**



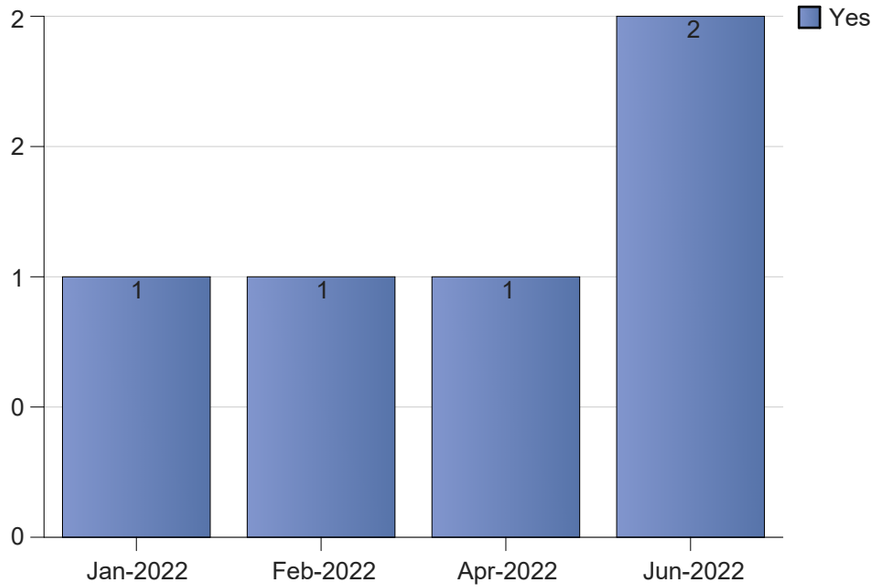
	Jan-2022	Feb-2022	Mar-2022	Apr-2022	May-2022	Jun-2022	Total
Improper access of chart	1	1	1				**3**
Misdirected fax		1	1	2	1		**5**
Other	2		2	1	1	3	**9**
Release of information concern	1					4	**5**
Verbal discussion	2	1					**3**
Total	**6**	**3**	**4**	**3**	**2**	**7**	**25**

Investigations by Location



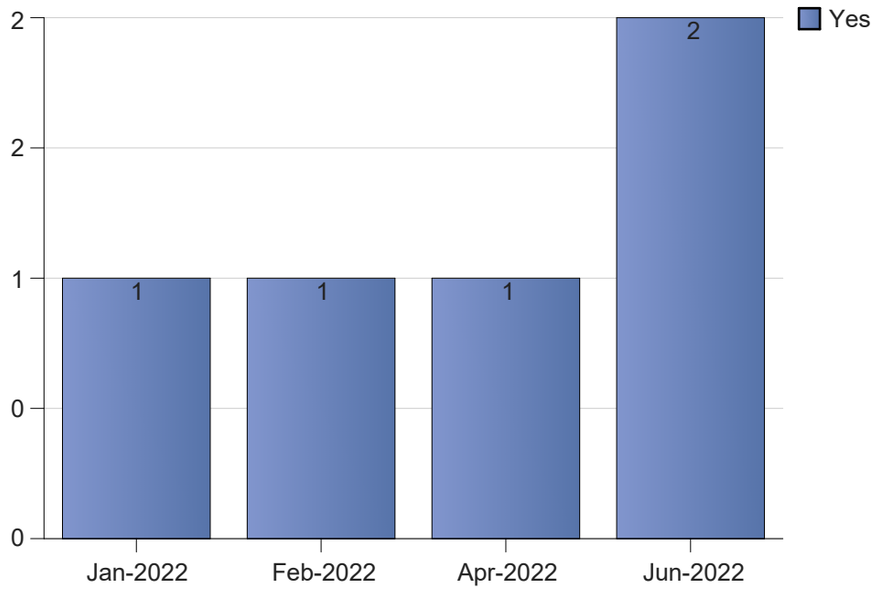
Credit and Billing	2
Dietary	1
HIM/Medical Records	2
HR	1
Lab	2
Medical Staff	1
OB	2
Other	4
Peds/Allergy Clinic	2
RHC / RHC Women's Clinic	7
Rural Health Clinic / Rural Health Women's Clinic	1
Total	**25**

Reported to OCR timely

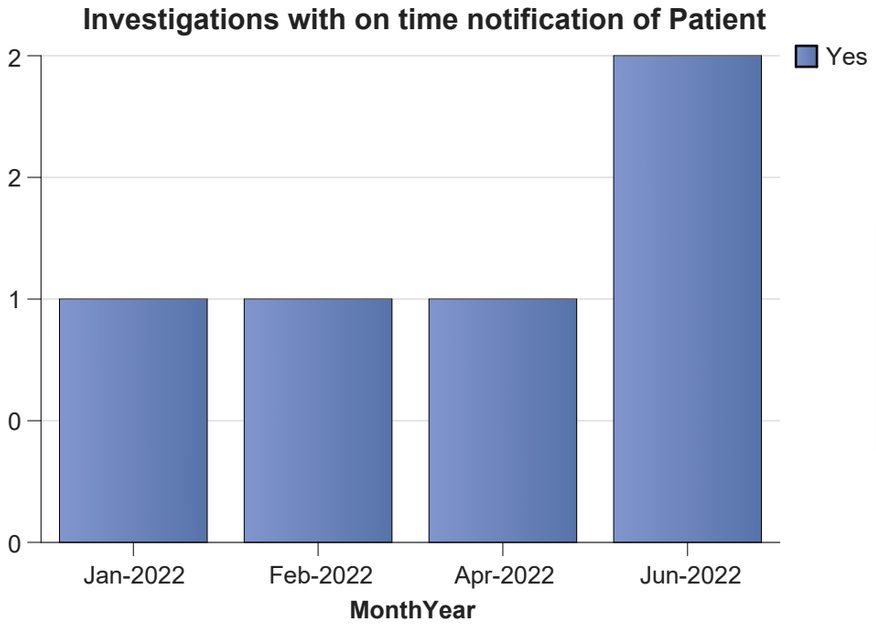


	Yes	Total
Jan-2022	1	**1**
Feb-2022	1	**1**
Apr-2022	1	**1**
Jun-2022	2	**2**
Total	**5**	**5**

Reported to CDPH timely

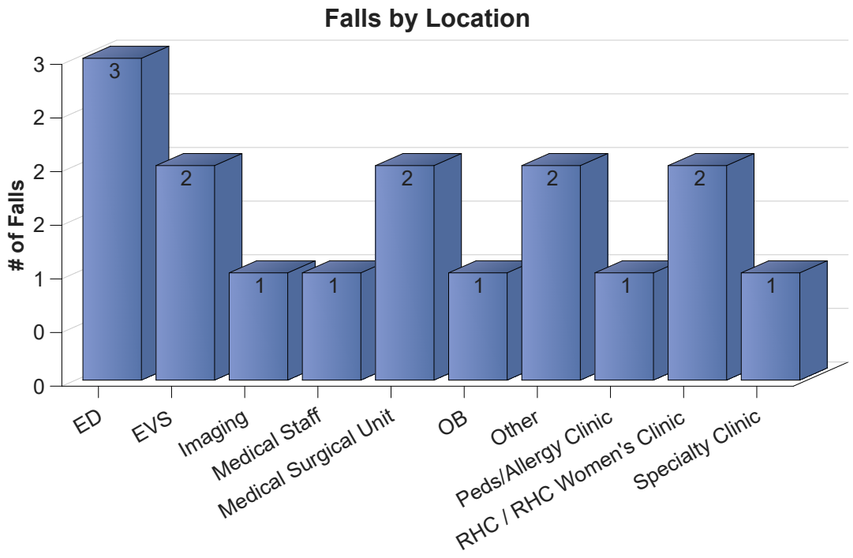


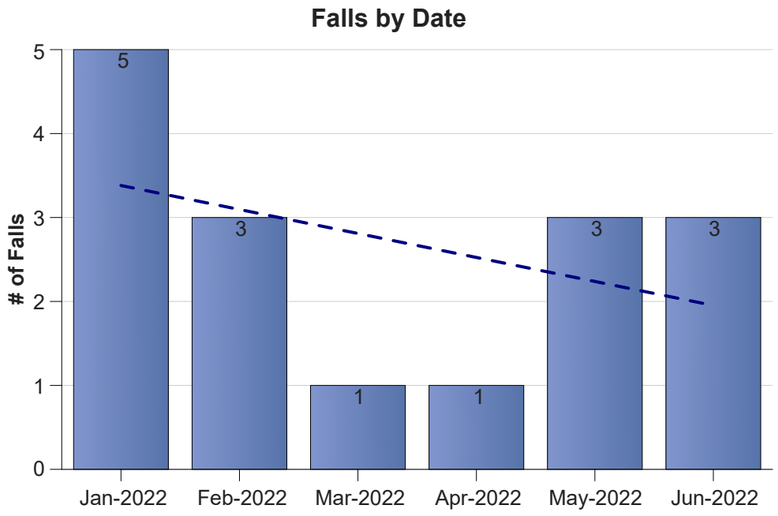
	Yes	Total
Jan-2022	1	**1**
Feb-2022	1	**1**
Apr-2022	1	**1**
Jun-2022	2	**2**
Total	**5**	**5**



	Yes	Total
Jan-2022	1	**1**
Feb-2022	1	**1**
Apr-2022	1	**1**
Jun-2022	2	**2**
Total	**5**	**5**

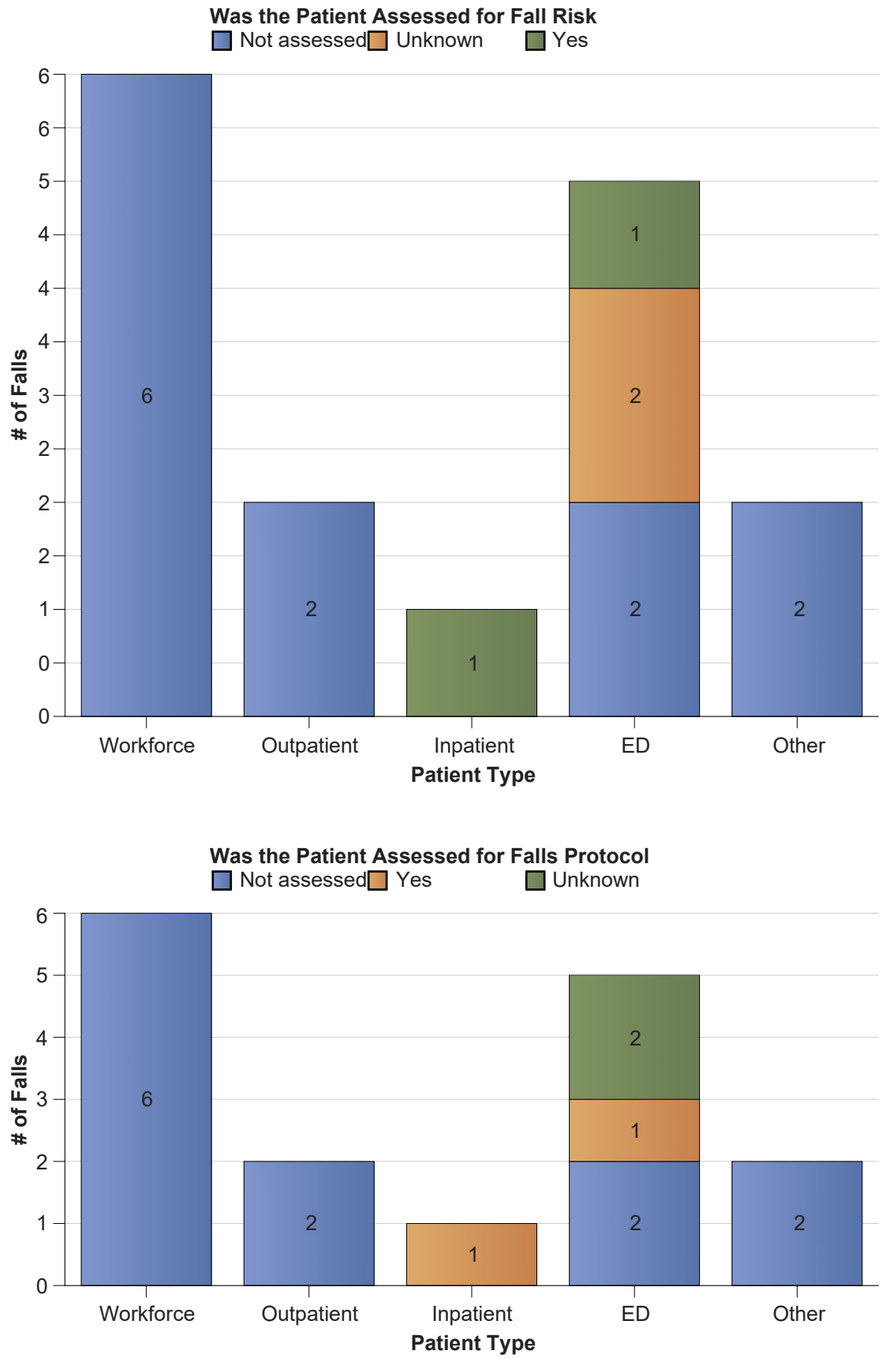
# of Falls	Falls/Slips	Total
ED	3	**3**
EVS	2	**2**
Imaging	1	**1**
Medical Staff	1	**1**
Medical Surgical Unit	2	**2**
OB	1	**1**
Other	2	**2**
Peds/Allergy Clinic	1	**1**
RHC / RHC Women's Clinic	2	**2**
Specialty Clinic	1	**1**
Total	**16**	**16**





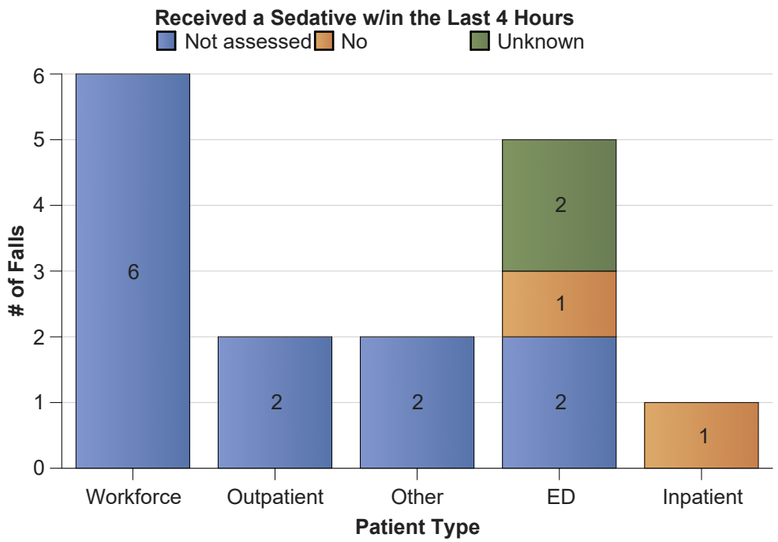
# of Falls	Falls/Slip Problem(s)									Total
	Not Identified	Ambulating	Bathroom	Bed/Crib	Chair	Grounds/floor issues	Ice/weather related	Other	Other Person	
Not Identified	4	1			1		1	4	1	**12**
Oriented		2	1	1		1		1		**6**
Total	**4**	**3**	**1**	**1**	**1**	**1**	**1**	**5**	**1**	**18**

# of Falls	Was there any injury?			
	Not Identified	Unknown	Yes	Total
Not Identified	6			**6**
ED	3	1	1	**5**
Inpatient	1			**1**
Other	2			**2**
Outpatient	2			**2**
Total	**14**	**1**	**1**	**16**

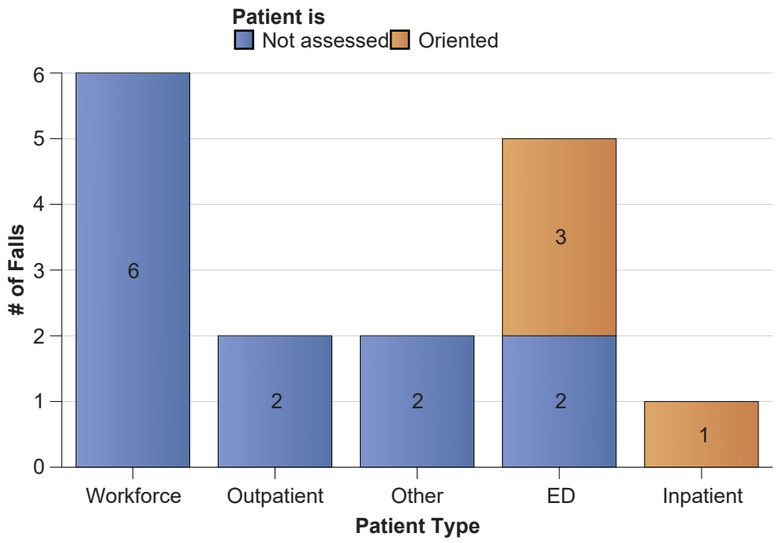


# of Falls	Was the Patient Assessed for Fall Risk			
	Not assessed	Yes	Unknown	Total
Workforce	6			**6**
Outpatient	2			**2**
Inpatient		1		**1**
Other	2			**2**
ED	2	1	2	**5**
Total	**12**	**2**	**2**	**16**

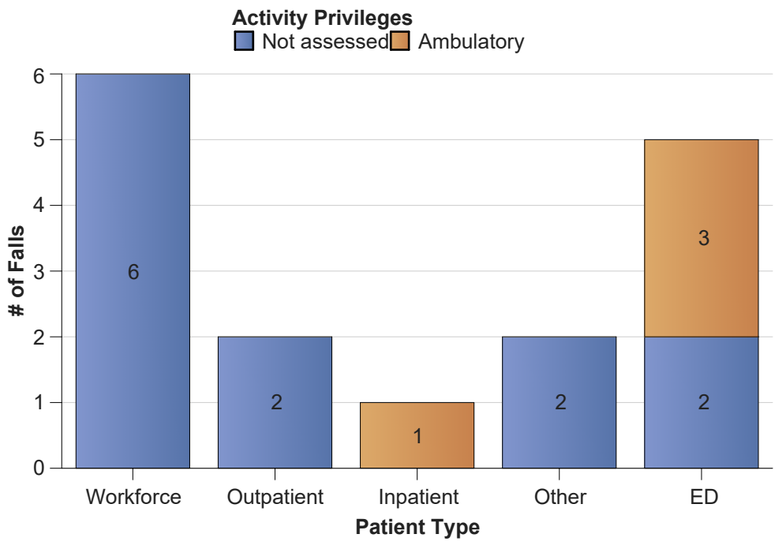
# of Falls	Was the Patient Assessed for Falls Protocol			
	Not assessed	Yes	Unknown	Total
Workforce	6			**6**
Outpatient	2			**2**
Inpatient		1		**1**
Other	2			**2**
ED	2	1	2	**5**
Total	**12**	**2**	**2**	**16**



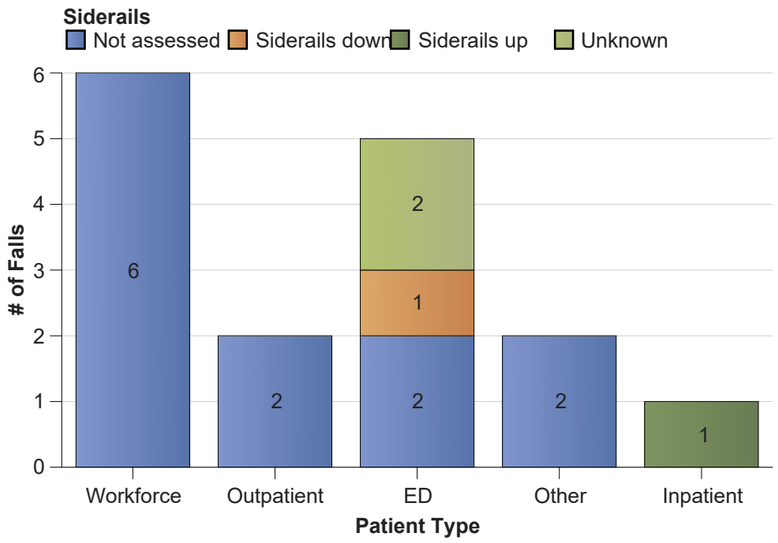
# of Falls	Received a Sedative w/in the Last 4 Hours			
	Not assessed	Unknown	No	Total
Workforce	6			**6**
Outpatient	2			**2**
Other	2			**2**
ED	2	2	1	**5**
Inpatient			1	**1**
Total	**12**	**2**	**2**	**16**



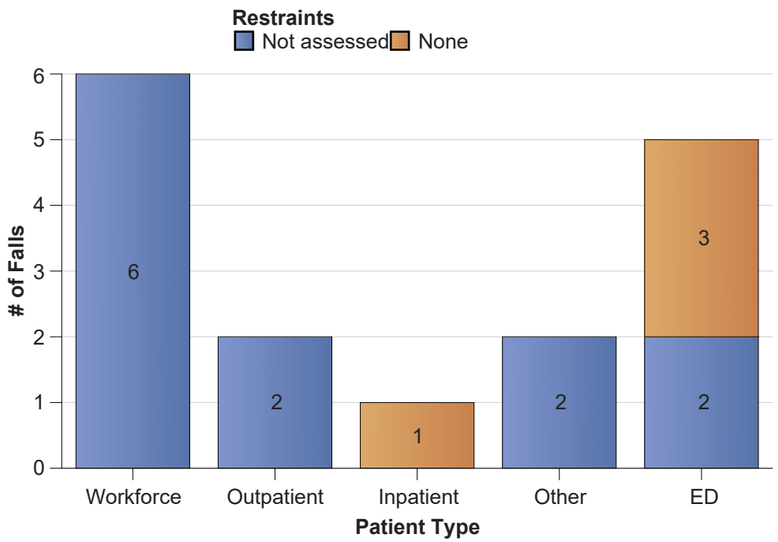
# of Falls	The Patient Is		
	Not assessed	Oriented	Total
Workforce	6		**6**
Outpatient	2		**2**
Other	2		**2**
ED	2	3	**5**
Inpatient		1	**1**
Total	**12**	**4**	**16**



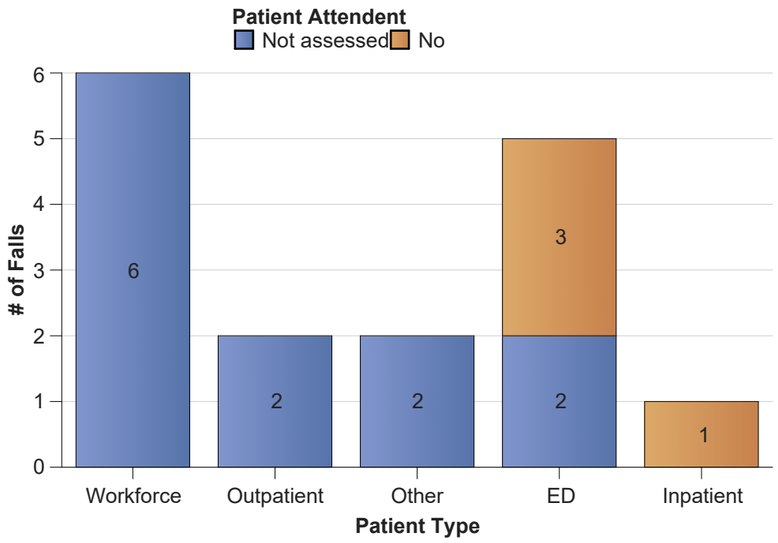
# of Falls	Activity Privileges		
	Not assessed	Ambulatory	Total
Workforce	6		**6**
ED	2	3	**5**
Inpatient		1	**1**
Other	2		**2**
Outpatient	2		**2**
Total	**12**	**4**	**16**



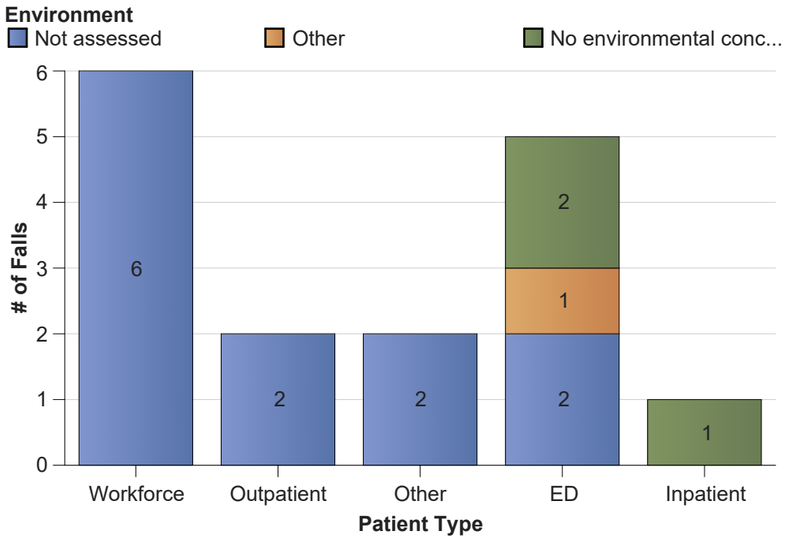
# of Falls	Siderails				
	Not assessed	Unknown	Siderails down	Siderails up	Total
Workforce	6				**6**
Outpatient	2				**2**
Other	2				**2**
ED	2	2	1		**5**
Inpatient				1	**1**
Total	**12**	**2**	**1**	**1**	**16**



# of Falls	Restraints		
	Not assessed	None	Total
Workforce	6		**6**
Outpatient	2		**2**
Other	2		**2**
Inpatient		1	**1**
ED	2	3	**5**
Total	**12**	**4**	**16**



# of Falls	Patient Attendent		
	Not assessed	No	Total
Workforce	6		**6**
Outpatient	2		**2**
Other	2		**2**
ED	2	3	**5**
Inpatient		1	**1**
Total	**12**	**4**	**16**



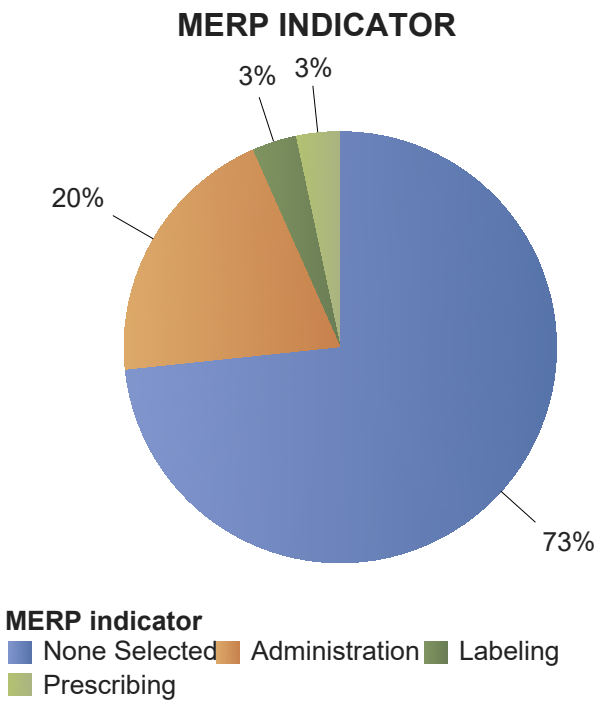
# of Falls	Environment			
	Not assessed	No environmental concerns	Other	Total
Workforce	6			**6**
Outpatient	2			**2**
Other	2			**2**
Inpatient		1		**1**
ED	2	2	1	**5**
Total	**12**	**3**	**1**	**16**

# of Falls	Fall Witnessed				Fall Alleged		Assisted to Floor			Found on Floor			
	Not Identified	No	Yes	Total	Not Identified	Total	Not Identified	Yes	Total	Not Identified	No	Yes	Total
Not Identified	6			**6**	6	**6**	6		**6**	6			**6**
ED	3		2	**5**	5	**5**	4	1	**5**	4	1		**5**
Inpatient		1		**1**	1	**1**	1		**1**			1	**1**
Other	2			**2**	2	**2**	2		**2**	2			**2**
Outpatient	2			**2**	2	**2**	2		**2**	2			**2**
Total	**13**	**1**	**2**	**16**	**16**	**16**	**15**	**1**	**16**	**14**	**1**	**1**	**16**

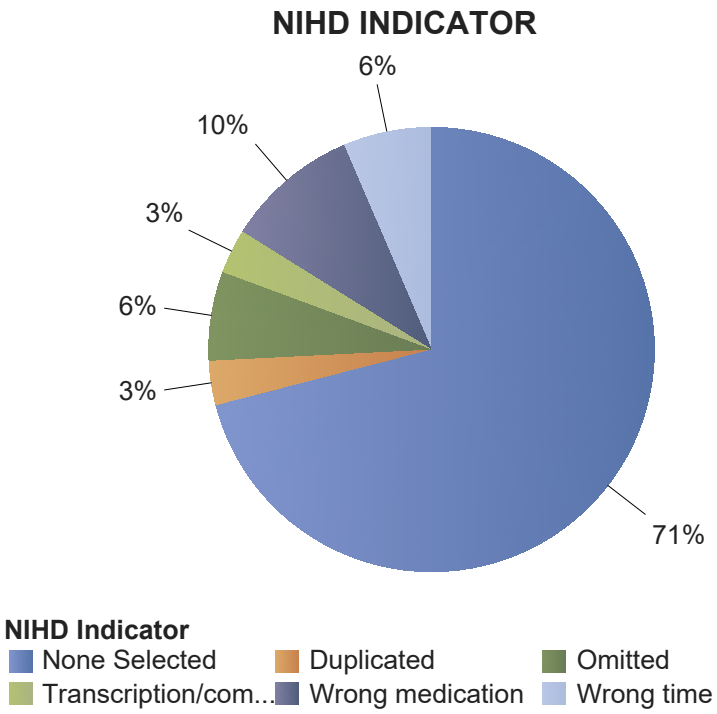
Medication Occurrences are medication issues that did not reach the patient. They were caught prior to administration.

Medication Errors are those issues that did reach the patient.

	# of Errors	# of Occurrences	Total
Jan-2022	4	1	**5**
Feb-2022	2	1	**3**
Mar-2022	3		**3**
Apr-2022	4	1	**5**
May-2022	3	2	**5**
Jun-2022	4	5	**9**
Total	**20**	**10**	**30**

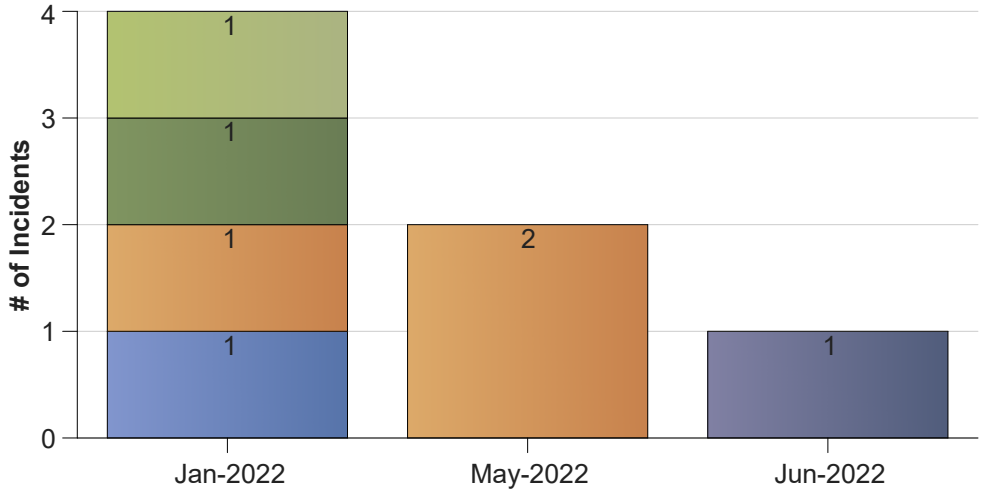


None Selected	22
Administration	6
Labeling	1
Prescribing	1
Total	**30**



None Selected	22
Duplicated	1
Omitted	2
Transcription/computer entry errror	1
Wrong medication	3
Wrong time	2
Total	**31**

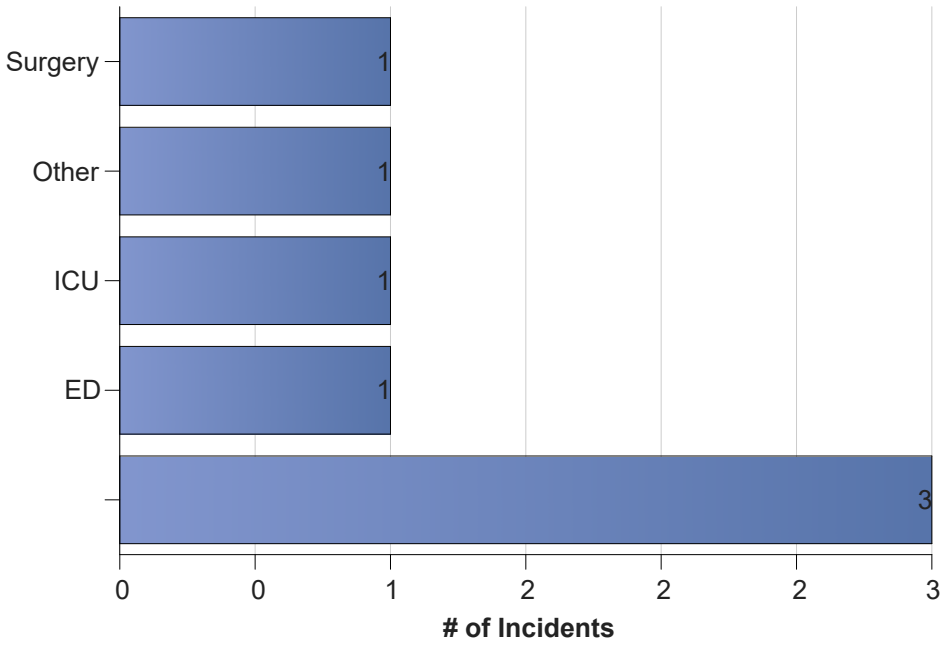
Equipment/Supplies/Devices by Incident Type/Date



Equipment/Supply/Devices Problems

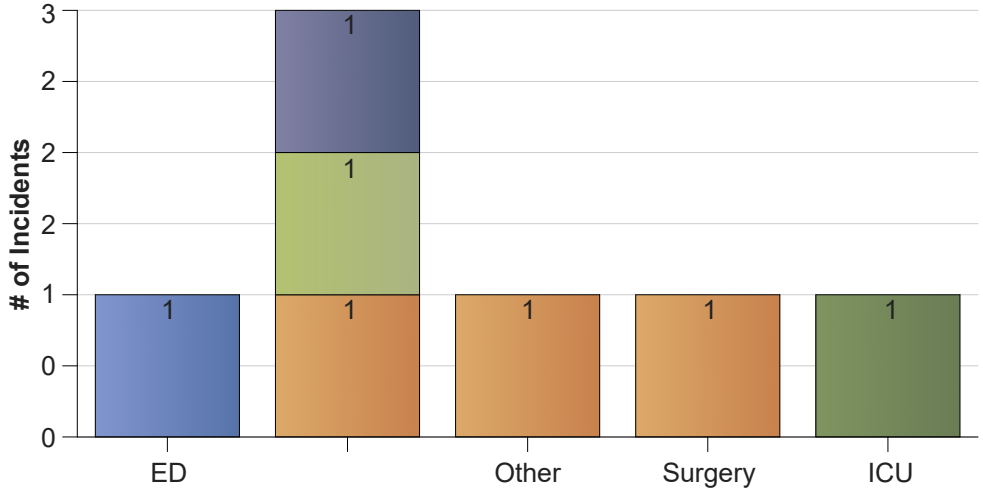
# of Incidents | Malfunction | Not available when nee... | Other | User Error

Equipment/Supplies/Devices by Location



No Data Available

Equipment/Supplies/Devices by Incident Type/Location



Equipment/Supply/Devices Problems

# of Incidents
Malfunction
Not available when nee...
Other
User Error

No Data Available

NORTHERN INYO HEALTHCARE DISTRICT

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

150 Pioneer Lane
Bishop, California 93514

(760) 873-5811 Ext. 3415

DATE: August, 2022

TO: Board of Directors, Northern Inyo Healthcare District

FROM: J. Adam Hawkins, DO

RE: Eastern Sierra Emergency Physicians (ESEP) Quarterly Report

ESEP Report:

This summer we saw a significant increase in the volume of patient's seeking care through the Emergency Department at Northern Inyo Hospital. This also resulted in amplified inpatient volumes. Despite the challenge's that come along with a higher patient census, our physicians, along with our amazing nursing and ancillary staff partners, have continued to deliver fantastic clinical care. ESEP has not yet had to rely on double coverage physician staffing and has been able to maintain a high standard of care while keeping physician staffing costs at baseline levels. During these busy times ESEP welcomed four new ER physicians to our community and group. Dr. Chelsea Robinson from UCLA, Dr. Nolan Page from Arrowhead Regional, Dr. Michael McEnany from University of New Mexico, and Dr. Andre Burnier from Stanford Medical Center. We also said goodbye to some fantastic physicians who are taking on the next chapter in their lives. Dr.'s Jimmy Fair and Anna Rudolphi have moved their family to Bozeman, MT. Dr. William Timbers has moved back to his childhood home in Vermont. We were very said to see these physicians leave but we are excited for the next chapter for them and their families.

ESEP is very proud that we are able to continue to lean on our broad network within the fields of Emergency Medicine and Inpatient Hospitalist Medicine to attract and recruit physicians from the top teaching institutions in the nation. Our recruiting continues to focus on bringing in physicians who are highly trained but also express a desire to become a part of the greater communities of the Owens Valley. We are exceedingly confident that our new physicians will deliver ongoing evidence-based, compassionate care which will result in the enduring trust in the care our community members expect from Northern Inyo Hospital.

Clinically, we are continuing to track metrics as it pertains to the appropriate treatment of sepsis and the implementation and execution of conscious sedation in the Emergency Department. Our physician and nursing teams have showed quarter over quarter improvement in both of these areas since the data collection began. We are hopeful to reach 100% compliance in both arenas within the coming months.

The leadership team within ESEP is eager to work more closely with The District and its billing and collections partners. We have received some preliminary data in regards to our physicians

charting and billing practices. We look forward to working closely with The District over the coming months to analyze the data and find where improvements can be made.

Otherwise, our Emergency Medicine, MAT Program, Anesthesia, and Hospitalist programs are running smoothly. Thank you for your time as always!

FY2022

Unit of Measure	July 2021	August 2021	September 2021	October 2021	November 2021	December 2021	January 2022	February 2022	March 2022	April 2022	May 2022	June 2022
Gross Accounts Receivable	40,330,632	39,434,879	38,647,332	44,286,627	44,778,400	46,530,215	48,807,267	45,713,629	44,886,090	45,868,344	49,184,707	46,457,770
Average Daily Revenue	497,169	478,408	485,427	486,248	490,359	491,569	485,625	481,170	483,445	488,374	494,998	456,527
Gross Days in AR	81.12	82.43	79.62	91.08	91.32	94.66	100.50	95.01	92.85	93.92	99.36	101.76
Key Statistics												
Acute Census Days	215	170	196	254	306	188	290	232	228	184	275	210
ICU Census Days	0	7	33	11	7	0	2	0	9	9	12	9
Swing Bed Census Days	24	0	0	0	0	0	0	12	12	0	0	4
Total Inpatient Utilization	239	177	229	265	313	188	292	244	249	193	287	223
Avg. Daily Inpatient Census	7.7	5.7	7.6	8.5	10.4	6.1	9.4	8.7	8.0	6.4	9.3	7.4
Emergency Room Visits	783	745	674	766	687	706	721	625	654	671	859	820
Emergency Room Visits Per Day	25	24	22	25	23	23	23	22	21	22	28	27
Observation Days	67	54	56	56	56	67	53	43	53	60	71	60
Operating Room Inpatients	24	23	14	16	21	17	18	19	18	121	23	22
Operating Room Outpatient Cases	107	89	89	82	98	126	3	6	61	54	104	97
Observation Visits	64	54	50	51	45	60	51	42	53	54	62	54
RHC Clinic Visits	2,297	2,743	2,775	3,030	2,707	2,722	3,426	2,559	2,808	2,708	2,892	2,668
NIA Clinic Visits	1,679	1,614	1,699	1,726	1,744	1,557	1,518	1,396	1,744	1,655	1,670	1,820
Outpatient Hospital Visits	8,690	9,250	8,980	9,162	8,728	8,630	8,526	7,994	9,525	8,676	9,069	9,256
Hospital Operations												
Inpatient Revenue	2,774,294	2,563,061	3,193,923	3,361,605	3,958,181	2,404,683	3,708,290	2,908,927	3,231,022	2,950,716	4,083,934	3,137,689
Outpatient Revenue	11,563,898	10,530,380	10,677,079	10,581,296	10,120,970	11,882,529	8,803,380	8,539,211	11,061,511	11,801,078	12,009,784	11,790,414
Clinic (RHC) Revenue	1,074,051	1,155,594	1,126,962	1,206,362	1,137,285	1,136,568	1,448,892	1,067,009	1,246,889	1,250,044	1,264,841	1,292,210
Total Revenue	15,412,242	14,249,034	14,997,964	15,149,263	15,216,437	15,423,780	13,960,561	12,515,147	15,539,422	16,001,838	17,358,559	16,220,313
Revenue Per Day	497,169	459,646	499,932	488,686	507,215	497,541	450,341	446,970	501,272	533,395	559,954	540,677
% Change (Month to Month)		-7.55%	8.76%	-2.25%	3.79%	-1.91%	-9.49%	-0.75%	12.15%	6.41%	4.98%	-3.44%

NORTHERN INYO HEALTHCARE DISTRICT
REPORT TO THE BOARD OF DIRECTORS
FOR INFORMATION

Date: 08/09/2022

Title: **NIHD Governance Committee Meeting Update**

Synopsis: The Governance Committee conducted a bi-annual review of the following Board policies:

- Compensation of the Chief Executive Officer.
- Authority of the Chief Executive Officer for Contracts and Bidding.

The committee recommends that the Board consider the approval of these two polices as presented.

Prepared by: Erika Hernandez, Administrative Assistant/ Board Clerk

Approved by: Kelli Davis
Kelli Davis, CEO

NORTHERN INYO HEALTHCARE DISTRICT
NON-CLINICAL POLICY AND PROCEDURE

Title: Using and Disclosing Protected Health Information for Treatment, Payment and Health Care Operations		
Owner: Compliance Officer	Department: Compliance	
Scope: District Wide		
Date Last Modified: 06/22/2022	Last Review Date: No Review Date	Version: 3
Final Approval by: NIHD Board of Directors	Original Approval Date: 07/17/2013	

PURPOSE: To describe how Northern Inyo Healthcare District (NIHD) will protect the privacy of its patients' Protected Health Information (PHI) while allowing workforce members to use and disclose PHI for treatment, payment, or health care operations.

DEFINITIONS:
Information blocking (or data blocking): Interference with access, exchange or use of electronic health information is considered information blocking. Information blocking is a serious problem because it can prevent timely access to information needed to manage patients' health conditions and coordinate their care. Further, it can prevent information from being used to improve health, make care more affordable, and research new treatments and cures.

POLICY: In accordance with city, state, and federal laws and regulations, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Northern Inyo Healthcare District (NIHD) will protect patient records and other information that may reveal a patient's identity when using or disclosing such information for purposes of treatment, payment, or health care operations.

PROCEDURES:

1. **Protecting the privacy and confidentiality of patients' PHI**
    a. In accordance with city, state, and federal laws and regulations, including HIPAA, Northern Inyo Healthcare District will:
        i. Appropriately use, manage, control, disclose, and release PHI; and
        ii. Comply with the terms of the requirement of the Notice of Privacy Practices.

    b. Employees are provided with HIPAA privacy training at employment that provides detailed information required to protect a patient's right to privacy.

    c. NIHD will provide training for its workforce members on how to use, manage, control, disclose and release patients' PHI.

d. Workforce members and affiliates of NIHD will continue to comply with existing city, state, and federal laws and regulations that govern confidentiality of patient PHI, including certain specially protected categories of PHI such as HIV/AIDS information, substance abuse and treatment records, and mental health records.

2. **Using and disclosing PHI**
NIHD will use and disclose a patient's PHI in accordance with city, state, and federal laws and regulations, including HIPAA, and primarily for purposes of:

Treatment:

a. NIHD may use a patient's PHI to provide him/her with treatment or services.
b. A patient's PHI may be shared by different Departments of NIHD as long as each Department sharing the PHI is providing or has, in the past, provided services and treatment.
c. NIHD may disclose a patient's PHI to its physicians, other health care professionals, and other NIHD personnel who are involved in the patient's healthcare.
d. NIHD may disclose a patient's PHI to people outside NIHD who are involved in the patient's healthcare.

Payment:

a. NIHD may use and disclose a patient's PHI to bill and collect for the treatment and services provided to the patient.
b. NIHD may disclose a patient's PHI to the patient's health plan to obtain prior approval for treatment and/or to determine whether the patient's plan will cover the treatment.
c. NIHD may disclose a patient's PHI to other health care providers to facilitate the other health care providers' billing and collection efforts and as permitted by law.

Health Care Operations:

a. NIHD may use and disclose a patient's PHI for purposes of its own operations.
b. NIHD may combine PHI about many patients to decide what additional services should be offered, what services are not needed and whether certain new treatments are effective.
c. NIHD may combine the PHI in its possession with PHI from other health care providers in order to compare its performance with other like providers and to make improvements in the care and services offered.
d. NIHD may disclose a patients PHI to its physicians, other health care professionals, and other NIHD personnel for educational purposes provided that such disclosure is the minimum necessary for such purposes.
e. NIHD may disclose a patient's PHI to other health care organizations as permitted by law, or as required for the improvement of its provision of care.

3. **Preventing Health Information Blocking**
Information blocking happens when electronic health information is not appropriately shared or used for authorized purposes. This can include failure to release records timely. NIHD will make every effort to assist patients to receive their medical records, per request, while protecting their records from inadvertent, incorrect disclosure.

i. Patients may obtain their records via the electronic health record portal.
ii. Signed release of records (ROI) will be obtained prior to printing and releasing copies of patient records, if possible. It may not be required.
iii. If patient is unable to print/sign and send ROI to NIHD, alternate ways to confirm verbal authorization to disclose will be undertaken. Confirmation of identity using name, date of birth and at least one other identifier shall be utilized. The workforce may choose to call the patient back, utilizing a phone number listed within the patient's chart to support identification process. If a patient comes to pick up records at NIHD, photo identification may be utilized or patient may provide NIHD workforce member with confirming information to assure identification.
iv. When able to obtain a signature on the ROI form, it becomes a part of the patient's medical record.
v. When unable to obtain a signed ROI, the process for obtaining assurance of correct identification shall be documented within the patient's medical records by the workforce member releasing the record.
vi. Exceptions to information blocking:
    1. If sharing information is prohibited by law, you must withhold the information.
    2. Information Blocking has 'Safe Harbors' - 8 exceptions. If you have concerns about releasing information that may fall under the 'Safe Harbors', consult the NIHD Privacy Officer/Compliance officer or Administrator-On-Call.

REFERENCES:

1. Health Insurance Portability and Accountability Act of 1996 (HIPAA)
2. HHS.gov HIPAA Enforcement. https://www.hhs.gov/hipaa/for-professionals/compliance-enforcement/index.html (July 25, 2017).
3. Health IT Security: *Status, Challenges of Information Blocking Rule Compliance*, J. McKeon (Nov. 16, 2021).

RECORD RETENTION AND DESTRUCTION:

Release of records documentation shall be maintained within the patient's medical records. The medical record is maintained within the NIHD Medical Records Department.

CROSS REFERENCED POLICIES AND PROCEDURES:

1. InQuiseek - #380 Medical Records Policy
2. Authorization for the Release of Laboratory Results to the Patient
3. Minimum Necessary Access, Use and Disclosure of Protected Health Information (PHI)

Supersedes: v.2 Using and Disclosing Protected Health Information for Treatment, Payment and Health Care Operations*

NORTHERN INYO HEALTHCARE DISTRICT
NON-CLINICAL POLICY

Title: Investigation and Reporting of Unlawful Access, Use or Disclosure of Protected Health Information		
Owner: Compliance Officer	Department: Compliance	
Scope: District Wide		
Date Last Modified: 06/22/2022	Last Review Date: No Review Date	Version: 3
Final Approval by: NIHD Board of Directors	Original Approval Date: 03/19/2014	

PURPOSE:

To define the policy and procedures for investigations of suspected breaches of the privacy or security of protected health information (PHI) and the reporting of such breaches to legally required entities.

DEFINITIONS:

Breach/Unauthorized Activity - The unauthorized acquisition, access, use or disclosure of PHI which compromises the security or privacy of the PHI.

Compromise the Security or Privacy of PHI – An act or omission that poses a significant risk of financial, reputational or other harm to the subject of PHI.

Disclosure - The release, transfer, provision of, access to, or divulging in any other manner of information outside the entity holding the information.

Electronic Protected Health Information or ePHI*:* Is PHI that is transmitted by electronic media or is maintained in electronic media. For example, ePHI includes all PHI that may be transmitted over the Internet, or stored on a computer, a CD, a disk, magnetic tape, jump drive (USB), or other media.

Protected Health Information (PHI) - individually identifiable health information that is transmitted or maintained in any form or medium, including electronic PHI.

Unsecured PHI – PHI that is not secured through use of technology or methods approved by the Secretary of Health and Human Services.

Use of PHI – The sharing, employment, application, utilization, examination, or analysis of individually identifiable information within an entity that maintains such information.

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

POLICY:

Northern Inyo Healthcare District (NIHD) shall comply with breach notification requirements under federal and state law, including the HIPAA privacy and security regulations, the HITECH regulations, the California Medical Information Act, and other relevant regulations. The Compliance Department shall investigate potential breaches of PHI and ePHI, determine whether notification is required, and manage the investigation, notification, and post-investigation process, as applicable.

A. Reporting Potential Breaches
    1. NIHD workforce are required to immediately report unauthorized acquisition, access, use, or disclosure of PHI ("Breaches") to the Compliance Department utilizing the Unusual Occurrence Report (UOR) found on the NIHD Intranet. The Compliance Officer or their designee may receive a verbal report and assist the reporting in completion of the documentation within the UOR system. Staff may also utilize the House Supervisor in the absence of Compliance personnel.
        a. The person who committed the breach is expected to self-report when they become aware of the error or as soon as possible.
        b. If a breach is discovered by workforce (not the person who committed the breach) they must report as soon as possible.
    2. Examples of potential Breaches that the workforce should report include but are not limited to:
        a. PHI mailed, faxed or electronically transmitted to the wrong recipient;
        b. Accessing the medical record of a co-worker, colleague, friend, family member or celebrity without authorization;
        c. Lost or stolen computers, laptops, or other electronic computing devices;
        d. Lost or stolen medical records (electronic or paper documents containing PHI);
        e. Unlawful verbal disclosures of PHI;
        f. Posting PHI on public websites;
        g. Malicious software virus detected in electronic information systems used in connection with PHI; and
        h. Intentional access to PHI for non-treatment, non-payment or non-healthcare operation purposes.

B. Preliminary Investigation - The Compliance Officer or designee shall conduct a preliminary investigation of all reports of unauthorized activity, and shall:
    1. Determine if the unauthorized activity involved Unsecured PHI or other individually identifiable information subject to protections under state or federal laws.
    2. Confirm additional facts underlying each report of unauthorized activity by reviewing the submitted UOR form.

C. Assessment of Potential Breaches - In assessing a potential breach, the Compliance Officer shall:
    1. Determine whether the potential breach fits within one of the following exceptions to the definition of Breach:
        a. The unauthorized activity involved the unintentional acquisition, access, or use of PHI by an NIHD workforce member;
        b. The unauthorized activity involved the inadvertent disclosure of PHI from an authorized workforce member or authorized individual within NIHD to another authorized member or authorized individual within NIHD; or

c. The unauthorized activity involved unauthorized disclosures in which an unauthorized person to whom PHI was disclosed would not have been able to retain the information.

2. Conduct an assessment to determine whether the unauthorized activity poses a significant risk of financial, reputational or other harm to the subject of the PHI. The assessment may be conducted using the HIPAA Breach Decision Tool and Risk Assessment Documentation which may be found in the California Hospital Association Privacy Manual;
3. Determine whether steps were or should be taken to mitigate any known harm arising from the unauthorized activity;
4. Determine whether individual, governmental or other notice is required under federal or state law and oversee the provision of such notice; and
5. Create and maintain documentation regarding the investigation, risk assessment and related decision-making regarding the Compliance Officers review and response to the unauthorized activity.

D. Notification

1. Breach of PHI - When the Compliance Officer determines a Breach has occurred, notification shall be made in accordance with the following:
    a. Patient notice timing: Patient notification must be made without unreasonable delay and in no event later than 15 business days of discovery of the Breach.
    b. Patient notice method: Notice to the patient(s) shall be provided in writing by USPS First Class or certified mail or by email if the individual has indicated a preference to receive email communications. For individuals for whom NIHD has insufficient contact information, refer to the U.S. Code of Federal Regulations, 45 C.F.R. 164.404, or the Compliance Officer should consult NIHD Legal Counsel.
    c. Notice to the patient(s) shall contain a form titled "Notice of Data Breach":
        i. The security breach notification shall be written in plain language, shall be titled "Notice of Data Breach," and
        ii. Shall present the information under the following headings:
            a) "What Happened,"
            b) "What Information Was Involved,"
            c) "What We Are Doing,"
            d) "What You Can Do," and
            e) "For More Information."
        iii. Additional information may be provided as a supplement to the notice.
    d. NIHD shall offer paid credit monitoring to patient(s) whose social security number, credit card information, or other significant financial information has been breached. The offer shall be for no less than 12 consecutive months of credit monitoring service.
    e. California Department of Public Health (CDPH) notification must be made without unreasonable delay and in no event later than 15 business days of discovery of the Breach. Notice to the CDPH shall be provided online through the California Healthcare Event and Reporting Tool (CalHEART). CDPH notification shall include all fields on the CalHEART notification tool.
    f. Media Notification: If a Breach of Unsecured PHI involves the PHI of more than 500 residents of a state, notification must be made to a prominent media outlet without unreasonable delay and in no event later than 15 business days of the discovery of the Breach. The Compliance Officer shall consult with NIHD Legal Counsel for consultation prior to publication of any Media Notification.

g. Notification to the U.S. Department of Health and Human Services' Secretary ("Secretary"): If a Breach of Unsecured PHI involves the PHI of 500 or more individuals, notification must be made to the Secretary. Such notification shall be made at the same time individual notification is provided. In addition, notification of Breaches of individual PHI or Breaches of less than 500 individuals shall be made to the Secretary no later than 60 calendar days after the end of each calendar year. Nothing herein prevents the Compliance Officer of notifying the Secretary at the same time notification is made to CDPH.

E. HIPAA Accountings of Disclosures - The Compliance Officer or designee shall determine whether unauthorized activity is subject to inclusion in disclosures which must be tracked in order to comply with HIPAA accountings and disclosures requirements.

F. Breaches Involving Business Associates - In the event NIHD is notified of unauthorized activity by an NIHD HIPAA Business Associate, the Compliance Officer will investigate and assess the potential Breach in accordance with the Business Associate Agreement. The NIHD Compliance Officer or designee will coordinate with appropriate representatives of the Business Associate in order to ensure that NIHD receives all relevant and necessary information and documentation, and in accordance with the terms of the applicable Business Associate Agreement.

G. Post-Investigation Follow-up
   1. The Compliance Department will work with Legal Counsel, Information Technology Services, Human Resources, Risk Management and any other department as necessary to mitigate any harmful effects of any breach that are known to NIHD.
   2. The Compliance Department shall document and track a plan of action, if any, including Sanctions, as appropriate.

REFERENCES:

1. 42 U.S.C. Section 17932
2. 45 CFR 164.400
3. California Civil Code Section 1798.82
4. California Health and Safety Code Section 1280.15
5. California Civil Code Section 56.05

RECORD RETENTION AND DESTRUCTION:

All documents related to PHI breach investigations will be maintained for a minimum of eight (8) years.

CROSS REFERENCED POLICIES AND PROCEDURES:

1. Communicating Protected Health Information Via Electronic Mail (Email)
2. Disclosures of Protected Health Information Over the Telephone
3. Minimum Necessary Access, Use and Disclosure of Protected Health Information (PHI)
4. Using and Disclosing Protected Health Information for Treatment, Payment and Health Care Operations
5. Workforce Access to His or Her Own Protected Health Information

Supersedes: v.2 Investigation and Reporting of Unlawful Access, Use or Disclosure of Protected Health Information

NORTHERN INYO HEALTHCARE DISTRICT
NON-CLINICAL POLICY AND PROCEDURE

Title: California Public Records Act – Information Requests		
Owner: Compliance Officer	Department: Compliance	
Scope: District Wide		
Date Last Modified: 06/22/2022	Last Review Date: No Review Date	Version: 4
Final Approval by: NIHD Board of Directors	Original Approval Date: 01/19/2016	

PURPOSE:

This policy establishes guidelines for the employees of Northern Inyo Healthcare District (NIHD) to follow when there has been a request for information under the California Public Records Act.

DEFINITIONS:

California Public Records Act – The fundamental precept of the California Records Act is that governmental records shall be disclosed to the public, upon request, unless there is a specific reason not to do so.
Public Record – Any writing containing information relating to the conduct of the public's business prepared, owned, used, or retained by the entity regardless of physical form or characteristics.

POLICY:

All California Public Records Act requests for NIHD related information are to be referred to the Compliance Officer.

EXEMPTIONS FROM DISCLOSURE - Key exemptions include:

- Preliminary drafts, notes, or memoranda not retained in the ordinary course of business.
- Records relating to "pending litigation". Documents that may be withheld under this section must be specifically prepared for litigation in which the Hospital is party.
- Personnel, medical, or similar files where disclosure would constitute an "unwarranted invasion of privacy".
- Police files, including investigatory or security files compiled by any state or local police agency.
- Real estate appraisals or prospective public supply and construction contracts may be withheld until the property is acquired or all of the contract agreements are obtained.
- Exemptions based on prohibitions of disclosure under federal or state law, including provisions relating to privilege. This includes:
  - Attorney-client/attorney work product and doctor-patient privileges
  - "Official Information" privilege governing "information acquired in confidence by a public employee in the course of his/her duty and not open, or officially disclosed, to the public prior to the time the claim of privilege is made".
  - "Trade Secret" privilege. "Trade Secret" is defined as "information, including a formula, pattern, compilation, program, device, method, technique, or process, that: (1) Derives independent economic value, actual or potential, from not being generally known to the public or to other persons

who can obtain economic value from its disclosure or use; and (2) Is the subject of efforts that are reasonable under the circumstances to maintain its secrecy.
  - Any other state or federal law protecting records, including HIPAA, FERPA, etc.
- The "Catch-all" or "Balancing Test"
  - Is applied to protect records, even when there is no other exemption that would apply, where "on the facts of the particular case the public interest served by not making the record public clearly outweighs the public interest served by disclosure of the record".
  - Includes the "Deliberative Process" privilege, to protect candid internal pre-decisional deliberations.
  - Includes "burdensomeness". A request might be so burdensome, and the public interest in the material so small, that the balancing test might allow us to deny the request.
  - Balances the public interest in disclosure against the public interest (not strictly the Hospital's interest) in withholding.

PROCEDURE:

1. Requests to inspect and copy public records should be made directly to the Compliance Office.
2. The District is entitled to review and redact records before producing them to the requester.
3. Public records are open to inspection during the normal business hours of the Compliance Office. The "open to inspection" provision does not require that an individual be given immediate access to the records upon request. In all cases, the records would first need to be located and collected, possibly from multiple locations.
4. An appointment to inspect records may be necessary under these circumstances. If the requester requests access to a large number of documents, the requester may need to make additional appointments to complete the document inspection process.
5. Upon either the completion of the inspection or the oral request of NIHD personnel, the person conducting the inspection shall relinquish physical possession of the records.
6. Persons inspecting NIHD records shall not destroy, mutilate, deface, alter, or remove any such records from the District.
7. NIHD reserves the right to have District personnel present during the inspection of records in order to prevent the loss or destruction of records.
8. The operational functions of the District will not be suspended to permit inspection of records.
9. NIHD is required to determine within 10 days (can be extended to 24 days for voluminous/complex requests) after receipt of a records request whether or not the requested records exist and/or are subject to disclosure, and to notify the person making the request of the reasons for that determination. The records themselves are not required to be released in 10 days. At the time of making a determination, NIHD will provide a good faith estimate of when the records will be available.
10. NIHD is required to "assist the member of the public in making a focused and effective request that reasonably describes an identifiable record".
11. NIHD may not consider the identity of the requester or the purpose for the request, in making its determination.
12. NIHD does not have to create new records or answer questions. The California Public Records Act simply requires access and disclosure of existing records. However, we are required to extract data from an existing database upon request.
13. Copies will be provided upon request, at a cost of $0.25 per page for scanned or paper copy or $15.00 for USB electronic format. The requester may inspect records at no cost. Staff time for searching, collecting, reviewing, and redacting documents, is not considered to fall within the "direct cost of duplication". Pre-payment for all copying/scanning, electronic format costs are required before release of public records.

14. Notification of Human Resources Leadership if the request comes from a current employee.
15. Notification of Medical Staff Office if the request involves providers (physician or advanced practice providers).

REFERENCES:

1. California Government Code §6250, 6252(f), 6253.9
2. "The ABC's of Privacy and Public Record", by Maria Shanle
3. www.thefirstamendment.org/capra.html
4. California Hospital Association – Compliance Manual (2021).
5. California Hospital Association – Record and Data Retention Schedule (2018).

RECORD RETENTION AND DESTRUCTION:

Record retention requirements vary based on the document type, legal and accreditation requirements. Destruction of relevant records will be suspended upon receipt of legal process or other notice of pending or reasonably foreseeable investigations or litigation, whether government or private.

CROSS REFERENCED POLICIES AND PROCEDURES:

1. Compliance Program for Northern Inyo Healthcare District
2. Public Records Requests (Board of Directors)

Supersedes: v.3 California Public Records Act – Information Requests

NORTHERN INYO HEALTHCARE DISTRICT
NON-CLINICAL POLICY

Title: New Project Implementation		
Owner: Manager of Project Management	Department: Project Management	
Scope: District Wide		
Date Last Modified: 07/08/2022	Last Review Date: No Review Date	Version: 1
Final Approval by: NIHD Board of Directors	Original Approval Date:	

PURPOSE:
The purpose of this policy is to establish a standard process that will facilitate transparency, adherence to professional practices, endorse compliance with regulatory statutes and accreditation requirements, and promote uniformity of practice to ensure revenue viability prior to the implementation of a project at Northern Inyo Healthcare District (NIHD). Projects require varying levels of skills, knowledge, engagement, motivation, documentation and reporting. The aim of the Project Professional is to provide a set of guidelines that can be adopted to suit the requirements of each project to reach the project's goals.

POLICY:
New projects will be reviewed with the respective Chief before actions are taken to implement. Once the project has been reviewed and approved by the Chief, a Project Request Form must be completed for the Project Management Office to engage in the implementation process. The project management model outlined by this policy has been designed to accommodate project needs across the District.

DEFINITIONS:
A **project** is a set of tasks that are carefully planned in order to arrive at a particular goal or outcome. All projects are a temporary effort to create value through a unique product, service or result with a beginning and an end. Each project is unique and differs from routine operations (the ongoing activities of an organization) because projects reach a conclusion once the goal is achieved.

A **Project Professional** is certified or trained in project management processes. They have the authority to represent the organization, and manage project teams, budgets, schedules and guide the team to meet the expectations of the project.

A **Project Team Lead** is a subject matter expert, usually of a particular specialization or area, who has the vision of the project. They will be responsible for specific aspects of a project as noted in the project phases.

DISCOVERY and PLANNING PHASES:

1. **The following will be determined before the new project request is submitted:**
    a. Identify benefits and costs associated with the new project:
        i. Evaluate most recent community needs assessment to ensure it is in alignment.
        ii. Contact potential vendors for services and/or devices needed for the project.
        iii. Collect information for a cost-accounting analysis or Return on Investment (ROI), to determine profitability of the service.
    b. Present project request to respective Chief

i. Received approval from Chief
ii. Submit Project Request Form

2. The Project Professional will complete the following with the Project Team Lead:

a. Cost of project
   i. Estimation of cost of the project
   ii. Document budget approval
   iii. Track costs by a set process throughout the project
b. Project overview
   i. Set goals and scope of the project
   ii. Establish project time line
   iii. Gather specification from vendors
c. Project Team
   i. Establish the project team(s) internal and external to NIHD
d. Review requirements for the project with specific areas below:
   i. Facility determination
      1. Remodeling of an existing space
      2. Access to new location
   ii. Staffing evaluation
      1. Evaluation of support staffing needs
      2. Medical Staff with skill sets to meet needs
   iii. Materials Management
      1. Identify new supplies and capital expenses
      2. Equipment research
   iv. Clinical Informatics
      1. Documentation and system training and requirements
   v. Infection Prevention
      1. Assess the need to engage on the project
   vi. Pharmacy
      1. New medication needs
      2. Proper storage of medications
   vii. Environmental Services
      1. Assess the need to engage on the project
   viii. Clinical Engineering
      1. Review all devices that touch a patient
   ix. Billing and Charge Capture
      1. Identify Current Procedural Terminology (CPT) for services to be offered
      2. Enrollment for Providers and Advance Practice Providers with insurance companies
      3. Modifier and billing requirements
   x. Information Technology Services (ITS)
      1. Continued support needed for maintenance of the new system or devices
      2. Computer, telephone(s), wiring and cable access, etc.
      3. Cyber Security, firewall, network
   xi. Strategic Communications
      1. Assess the need to engage on the project
   xii. Dietary
      1. Assess the need to engage on the project
   xiii. Compliance overview
      1. Licensing and other regulatory requirements

2. Business Associates Agreement (BAA) and Contract review
    a. Chief Financial Officer review of contract
    b. Chief Executive Officer executes contract(s)

IMPLEMENTATION and GO LIVE PHASES:

1. **The Project Professional, Project Team Lead and Project Team will complete the following:**
    a. Track the requirements documented in the Discovery/ Planning Phase
    b. Engage with the project team on specific tasks for each member
    c. Track timelines and completion of tasks
    d. Report to leaders the progress, obstacles, risks and timelines for the project as indicated
    e. Schedule meetings and coordinate with vendor(s) as needed
    f. Report to NIHD committees and/or councils an indicated

EVALUATION and CLOSURE PHASES:

1. Measure of success reviewed in set number of days (10 days, 21 days or 45 days)
2. Review workflows to ensure the initial process is working as expected
3. Review coding and billing processed
4. Transition the project to normal operations

REFERENCE:

1. Agency for Healthcare Research and Quality, "How Do We Implement Best Practices in Our Organization" Series
2. PMBOK Guide, 5th Edition, "A Guild to the Project Management Body of Knowledge"

RECORD RETENTION AND DESTRUCTION: NA

CROSS REFERENCED POLICIES AND PROCEDURES:

1. New Line of Service Implementation
2. Grant Program Activities
3. Infection Control Risk Assessments (ICRA) For Demolition, Renovation, Or New Construction Projects
4. Quality Assurance & Performance Improvement (QAPI) Plan

Supersedes: Not Set

NORTHERN INYO HEALTHCARE DISTRICT
NON-CLINICAL POLICY AND PROCEDURE

Title: Compensation of the Chief Executive Officer		
Owner: ADMIN EXECUTIVE ASSISTANT	Department: Administration	
Scope: Board of Directors, Chief Executive Officer		
Date Last Modified: 07/07/2022	Last Review Date: No Review Date	Version: 2
Final Approval by: NIHD Board of Directors	Original Approval Date: 05/16/2018	

PURPOSE: The Chief Executive Officer (CEO) of Northern Inyo Healthcare District (NIHD) is the person responsible for the efficient operation of NIHD. Therefore, it is the desire of the NIHD Board of Directors (BOD) to provide a fair compensation (salary and benefits) to the CEO.

POLICY:

1. Annually (as of hire date) the NIHD Board of Directors shall evaluate the performance and review the compensation of the Chief Executive Officer to determine if an adjustment to compensation is appropriate.

PROCEDURE:

1. The BOD President shall appoint two members of the BOD as an Ad Hoc committee to research comparability data of similar organizations and similar qualified individuals.
2. At a BOD meeting (may be during closed session), the Ad Hoc committee will make a recommendation to the full BOD for any compensation (salary and/or benefits) adjustments based on a review of the data and CEO Performance Review.
3. During the Open Session of the Meeting Agenda, the BOD President will report any action taken on the recommendation. The meeting at which the compensation adjustment is approved the minutes are to include the documentation of how the BOD reached its decisions and the effective date.

REFERENCES:

1. 5 U.S.C. § 5304 - U.S. Code - Unannotated Title 5. Government Organization and Employees § 5304. Locality-based comparability payments
   Current as of January 01, 2018.

2. Office of Human Resource Management; *Locality-based comparability pay.* *https://www.commercehttps://www.commerce.gov/hr/practitioners/compensation-policies/general-pay/locality-based-comparability-pay*.

RECORD RETENTION AND DESTRUCTION:

Records related to CEO compensation must be maintained for term of employment, plus ten (10) years.

CROSS REFERENCED POLICIES AND PROCEDURES:

1. Chief Executive Officer Compensation Philosophy

2. Compensation of the Chief Executive Officer

Supersedes: v.1 Compensation of the Chief Executive Officer

NORTHERN INYO HEALTHCARE DISTRICT
NON-CLINICAL POLICY AND PROCEDURE

Title: Authority of the Chief Executive Officer for Contracts and Bidding		
Owner: ADMIN EXECUTIVE ASSISTANT	Department: Administration	
Scope: Board of Directors, Chief Executive Officer (CEO)		
Date Last Modified: 07/06/2022	Last Review Date: No Review Date	Version: 2
Final Approval by: NIHD Board of Directors	Original Approval Date: 05/16/2018	

PURPOSE: Establish policy and procedure process for Authority for Contracts and Bidding.

POLICY:

Northern Inyo Healthcare District (NIHD) shall comply with the requirements of California Health and Safety Code Section 32132, which set forth competitive means bidding requirements. "Competitive means" includes any appropriate means specified by the Board of Directors (BOD), including, but not limited to, the preparation and circulation of a request for a proposal to an adequate number of qualified sources, as determined by the BOD in its discretion, to permit reasonable competition consistent with the nature and requirements of the proposed acquisition.

When the BOD awards a contract through competitive means, the district's requirements, as determined by the evaluation criteria specified by the board. The evaluation criteria may provide for the selection of a vendor on an objective basis other than cost alone.

PROCEDURE:

1. NIHD "shall acquire materials and supplies that cost more than twenty-five thousand dollars ($25,000) through competitive means, except when the board determines either that (1) the materials and supplies proposed for acquisition are the only materials and supplies that can meet the district's need, or (2) the materials and supplies are needed in cases of emergency where immediate acquisition is necessary for the protection of the public health, welfare, or safety." (Ca. H&S Code Section 32132)
2. This bidding process "Shall not apply to medical or surgical equipment or supplies, to professional services, or to electronic data processing and telecommunications goods and services. Medical or surgical equipment or supplies includes only equipment or supplies commonly, necessarily, and directly used by, or under the direction of, a physician and surgeon in caring for or treating a patient in a hospital." (Ca. H&S Code Section 32132)
3. "Bids need not be secured for change orders that do not materially change the scope of the work as set forth in a contract previously made if the contract was made after compliance with bidding requirements, and if each individual change order does not total more than 5% (five percent) of the contract." (Ca. H&S Code Section 32132)
4. The professional services to which the bidding rules do not apply include those of persons who are highly skilled in their science or profession; persons such as Attorney At Law, architect, engineer or artist; and persons whose work requires skill and technical learning and ability of a rare kind.

5. The hospital administrator or designated staff shall mail notice of the action or decision to the affected applicant or medical staff member within the time specified in the applicable bylaw or rule.

REFERENCES:

1. California Health and Safety Code Section 32132

RECORD RETENTION AND DESTRUCTION:

CROSS REFERENCED POLICIES AND PROCEDURES:

Supersedes: v.1 Authority of the Chief Executive Officer for Contracts and Bidding