NORTHERN INYO HEALTHCARE DISTRICT

One Team. One Goal. Your Health.

ANNUAL REPORT
2019-2020

Geriatrics Physician Anne Wakamiya, MD, shares a laugh with a staff member. Photo by David Calvert

MISSION

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

VISION

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

VALUES

Values are those beliefs and principles that guide the decision-making and behaviors of staff and thus collectively the actions and accomplishments of an organization. Northern Inyo Healthcare District believes that to successfully achieve its Vision, the District and the staff must abide by six key values and that these values can be divided into three groups.

CORE VALUES

are those values that are the foundation that defines who will choose to dedicate themselves to the well-being of others

Compassion. At NIHD, we not only care deeply about you, but we strive to understand your situation from your point of view. Our compassion is what inspires us to care for you and your loved ones.

Integrity. At NIHD, we know that you expect your healthcare team to embrace the idea that we always do the right thing and are transparent about what we are doing and what we are working on improving.

As staff we believe that these two values define who we are and why we are in healthcare.

ASPIRATIONAL VALUES

are those values that drive the District and its staff to work towards making tomorrow's care better than yesterday's care

Quality/Excellence. At NIHD, we monitor ourselves to ensure that we strive to exceed the accepted standard of care. We believe that you should feel confident that you are receiving the best care possible through your District.

Innovation. At NIHD, we believe that there will always be new ways to care for you and your loved ones. We embrace this continuous review of our progress as we know in our heart of hearts that it will result in the best quality and the best outcomes.

As staff we believe that these two values define how we got to be who we are today and what we want to be able to do for you tomorrow.

PERMISSIVE VALUES

are those values without which a patient would not allow you to engage in his/her care.

Team-Based. At NIHD, we believe that every member of our team is partnered with you, with your loved ones, and with each other to ensure you have the best possible outcome. Without this partnership we cannot understand your goals and we cannot help you achieve those goals. We know our role in your care and strive to achieve that role in a way in partnership with the whole team.

Safety. At NIHD, we believe that everyone should feel secure enough to achieve their goals, be it a patient receiving care or a staff member meeting the needs of the patient in an environment free from risk or distraction.

As staff, we understand that in the absence of our commitment to these two values, you the patient and your loved ones, would not allow us to provide your care.

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NORTHERN INYO HEALTHCARE DISTRICT, FIRST ANNUAL REPORT

2019-2020

1967 Building Dedication plaque – oldest building still on campus. Photo by David Calvert.

WHO WE ARE

IMPROVING OUR COMMUNITIES, ONE LIFE AT TIME

Northern Inyo Healthcare District (NIHD) hospital facilities contain state of the art equipment and qualified, licensed, and certified staff to provide excellence in healthcare. NIHD has 25 inpatient beds, three operating room suites, eleven bays in our pre-operative/post-operative recovery area, and eight bays in our emergency department. NIHD is accredited by The Joint Commission and licensed by the State of California Department of Public Health.

As a Critical Access Hospital, we are committed to providing high quality, comprehensive care in the most patient-friendly way, both locally and in coordination with trusted regional partners. NIHD serves the communities of our District and beyond.

MILESTONES, AWARDS, AND RECOGNITION

EXCELLENCE IN HEALTHCARE

Presentation of Resolution from Assemblyman Devon Mathis, in recognition of being named ACHD's District of the Year. L-R: Board member Robert Sharp, Former CEO Kevin Flanigan, Assemblyman Devon Mathis, board members MC Hubbard and Jean Turner. Photo by Barbara Laughon

Northern Inyo Healthcare District's success with its new Medication Assisted Treatment program garnered the District top honors from the Association of California Healthcare Districts (ACHD), as it named NIHD Healthcare District of the Year for 2019.

Accepting the honors was NIHD's Board of Directors, including Board President Mary Mae Kilpatrick, Vice President Jean Turner, Treasurer MC Hubbard, and Member-At-Large Jody Veenker, along with former Chief Executive Officer Kevin S. Flanigan, MD MBA, and former NIHD Board Member Dr. John Ungersma. Board Member Robert Sharp was unable to attend.

Reflecting on the announcement, Dr. Flanigan stated, "As I looked at the list of nominees and their accomplishments, I knew we deserved to be on the list but I was shocked when we were named, considering what some of the other Healthcare Districts had accomplished in the past year. Some of these Districts are huge and have massive budgets, but none can match our team's energy, commitment, and dedication to the communities we serve."

Calling the evening among the most humbling of his life, Dr. Flanigan credited the effort put forward by the entire NIHD team with securing the honor. "From the Board of Directors, to the leaders, to the medical staff, to the clinicians, to the administrative staff, to the environment of care team, both new and long-standing staff, everyone has a part in this award. Without everyone's commitment to our Mission and our Vision we could not have saved the lives we have through the work we are doing."

Earlier this year, NIHD began a Medication Assisted Treatment program funded and run by the District and other stakeholders for coordination of care. During the preceding three years, the District and others began to review opioid use and identified a trend in the escalation of overdoses, deaths, criminal cases, and medical issues associated with opioid use, misuse, and abuse.

NIHD applied for and was one of 31 named recipients for the Bridge Grant. This allowed for the creation of the MAT program, which is now expanding into other areas of Behavioral Health treatment. Since implementation of the program, NIHD has seen more than 30 enrolled patients in three months; every Emergency Department physician earning special certification to prescribe the highly controlled anti-addiction medication; more than a half dozen patients treated with Narcan by police, first responders or private citizens outside of the hospital; and, adolescents seeking care.

Dr. Flanigan noted his pride in the District's transition from avoiding patients with obvious signs of addiction to identifying patient behaviors consistent with addiction and offering services. "Besides being able to offer this care, the culture shift is one of the greatest accomplishments I have seen," Dr. Flanigan said.

The Association of California Healthcare Districts works with numerous state and local entities to promote the critical role Healthcare Districts play in responding to the specialized health needs of tens of millions of Californians while also having direct accountability to the communities that Districts serve.

MILESTONES, AWARDS, AND RECOGNITION

EXCELLENCE IN HEALTHCARE

The California Health Care Foundation is dedicated to advancing meaningful, measurable improvements in the way the health care delivery system provides care to the people of California, particularly those with low incomes and those whose needs are not well served by the status quo. CHCF works to ensure that people have access to the care they need, when they need it, at a price they can afford.

Since 1964 Northern Inyo Healthcare District has earned The Joint Commission's Gold Seal of Approval® for demonstrating continuous compliance with its rigorous accreditation standards. The Gold Seal of Approval® reflects an organization's commitment to providing safe and effective patient care. Northern Inyo Healthcare District is one of fewer than 15 Joint Commission accredited Critical Access Hospitals in the state of California

An ecstatic Northern Inyo Healthcare District Board of Directors, present and past, posed for photos moments after being named the 2019 Healthcare District of the Year by the Association of California Healthcare Districts.

From left, Ken Cohen, Chief Executive Officer, ACHD, who presented the award; Dr. Kevin S. Flanigan, Former Chief Executive Officer, NIHD; Mary Mae Kilpatrick, President, NIHD Board of Directors; Jean Turner, Vice President, NIHD Board of Directors; Jody Veenker, Member-at-Large, NIHD Board of Directors; MC Hubbard, Treasurer, NIHD Board of Directors; and Dr. John Ungersma, former member, NIHD Board of Directors. Unable to attend: Robert Sharp, Secretary, NIHD Board of Directors. Photo courtesy Chuck Kilpatrick

Stacey Brown MD, named best physician by The Inyo Register newspaper. Brown is shown here, kneeling center, with some of the Rural Health Clinic team. Photo by Barbara Laughon

ACR accreditation is recognized as the gold standard in medical imaging.

ACHD works with numerous state and local entities to promote the profound role Healthcare Districts play in responding to the specialized health needs of tens of millions of Californians, while also having direct accountability to the communities that Districts serve.

ACCOLADES FOR
NORTHERN INYO HEALTHCARE DISTRICT

Dear Mrs. Aspel,
I hope this letter finds you well.

My name is Lou Manzano, and I am a Fire Captain with the Ventura City Fire Department. I have been a firefighter for 20 years and a paramedic for 28 years in a busy 911 system in Southern California that responds to over 24,000 calls a year and serves a population of 110,000+. I am heavily involved in our department's hiring selection process, Training Bureau, and Emergency Operations Bureau. The reason for my heavy involvement in these areas is to ensure that our department hires and trains employees that are professional, competent, caring, and compassionate at all times but specifically during our customer's worst times.

On July 28th, my 15-year-old son Sam and I had an incident happen to us that challenged our character, our bravery, and our determination. Our story goes as follows:

After an incredible four days of outdoor activities in the Mammoth area, we decided it was time to head back home to Newbury Park, CA. We left Glass Creek in the early morning hours and while driving home, I thought that it would be fun to take one last motorcycle ride and visit a remote canyon on the east side of the Bristlecone Forest. Wyman Canyon is a remote canyon located on the east side of the White Mountains, approximately 55 miles from Bishop. It is very desolate due to its location and extreme weather. My plan was to take a short ride through Wyman Canyon to end our vacation with lasting memories.

On our way out of Wyman Canyon and after riding for approximately 50 miles, my son had an accident that would forever change our lives. While riding on a flat dirt road with 10 miles left of riding to Highway 168, his front wheel slipped and caused him to put out his left leg in an attempt to regain his balance. This action ended up breaking his left tibia/fibula. With many details between this moment and us reaching the hospital, this incident proved to be one of the most challenging times of my life.

After a 2.5-hour motorcycle ride back to Bishop with a complete tib/fib fracture, we pulled into your Emergency Department with a bit of uncertainty. Not being from the Bishop area and not knowing the level of care we would receive, I was incredibly surprised at what would transpire during our three-day visit. I knew we would get help, but I wasn't sure of the long term plan for a severely fractured leg in a rural town.

Below is nothing short of a miracle. There are many details that go along with this experience, and below are some of the people that changed our lives forever. I will apologize ahead of time because I did not get everyone's name. My focus was on Sam, but here are some of the professionals that took great care of us:

Doctors - Dr. Samantha Jeppsen, Dr. Mark Robinson, Dr. Dan Cowan

RNs - DeeDee Costello, Rita DeGeus, Jacinda Thomsen, Shauna Murray, Jenny Bates, Alli Downey, Melissa Galvan, Beth Cole, Brent Obinger, Sherri Grant, and many more.

Support Staff (CNA's, PT Techs, X-Ray Techs, RT Techs, Lab Techs, and Security) - Francine Berube, Tyler Honeyman, Ashley Weatherford, Kendra Stone, and many more.

As you can see from the list above, we had close to 25 people taking care of us. The professionals above provided us with the best care during our time of need. Their ability to take our terrible situation and make it better gave us the peace of mind that we were at the right hospital. Their competent, compassionate, and timely care was world-class. They remained composed, professional, informative, and caring throughout our stay.

As a leader of a public service team, I can appreciate all the hard work that goes into your employees to ensure that when it is time to work hard and represent the profession of public service, your team is ready to perform. You should be extremely proud and honored to have a team of such incredible professionals that represented you and your organization in a caring, compassionate and timely way. This team changed our lives forever, and I will always be in debt to your team for what they did for us.

If you should have any questions, please feel free to contact me directly.

Much appreciation and much respect,

Luis Manzano, Fire Captain
Ventura City Fire Department

ONE TEAM. ONE GOAL.
YOUR HEALTH.

Jean Turner
Chair, Board of Directors

CHAIRPERSON'S LETTER

JEAN TURNER

We ended the year with a special board meeting to discuss the 2020-2021 Budget, the Board unanimously voted to postpone the search for a new CEO for one year. The Board also extended the terms of service for Interim CEO Kelli Davis and Interim CMO Dr. William Timbers, also for one year.

The benefit of these actions is two-fold. By postponing the CEO search for one year, the District will save valuable funds in recruitment fees as well as salaries and benefits during a financially challenging time. By extending service terms for Kelli and Dr. Timbers, we will solidify an already strong Executive Team, one that includes CNO Tracy Aspel, until her retirement date later this year, and as we welcome our new CNO, Allison Partridge. The Board is grateful to Kelli, Dr. Timbers and Tracy for agreeing to take on additional work on top of their already robust jobs.

As you may know, under Kelli's leadership, the Executive Team has taken immediate action to strengthen the District financially. Most of these efforts focus on the following:

- District-wide cost savings
- Contract renegotiations of major services
- Overall efficiency within the District
- The addition of some service lines
- Refunding our bonds to reduce debt service and,
- Funding benefits to reinforce financial liquidity

These measures will help the District sustain a strong business model while continuing to meet its obligations to you, the employees, as well as our vendors, our partners, and other stakeholders during these uncertain times. I know there has been great concern regarding the decision to postpone the funding of the Defined Benefit Plan. Let me assure you, the Board and Executive Team are committed to re-funding the plan just as soon as our patient flows return to normal.

The Board would like to thank everyone on the NIHD team for the hard work and out-of-the-box thinking that is helping get us through this time. We appreciate that our team pulls together in these stormy moments of challenge and always looks for the silver linings. You are an inspiration to us and the community you serve!

Recently I have been in touch with some of the challenges in the world we all live in currently and how sometimes I can slip into a slight darkness or depression or fatigue. But then, I remember people who serve at NIHD. I think about all you are doing each and every day; I think about the internal challenges you have been facing and addressing for several months now. I think about what your weariness level must be at times. I worry that you get discouraged at times.

While I do think, frankly, that words seem inadequate, I must make an attempt. It is important to me that each of you realize how much you are appreciated. Please know that I value your professionalism and the amazing list of accomplishments in recent weeks and months.

Sincerely,

Jean Turner
Chair, Board of Directors, Northern Inyo Healthcare District

CHIEF EXECUTIVE OFFICER'S MESSAGE

KELLI DAVIS, MBA

Greetings,

As you prepare to review the annual highlights in this report, it is most important that I express my sincere appreciation and gratitude to the Northern Inyo Healthcare District (NIHD) team members, providers, Board of Directors, Foundation and Auxiliary members, volunteers, and all others who partner with us in serving the needs of our wonderful community every day in one capacity or another. And to our community members, thank you for the trust and support you place in NIHD. The greatest testimonial and recognition you can give to us, is to allow us to share in your healthcare journey and provide the care you need when you need it.

2020 has brought challenges and changes on a daily and sometimes minute by minute basis. Our vision for providing the high-quality care we are known for did not waiver; in fact, it has remained the guiding light for us throughout these unpredictable times. Ensuring we are meeting our community's healthcare needs today, tomorrow, and beyond is the certainty during these uncertain times. In healthcare, the focus on infection prevention and risks is a top priority at all times; the COVID-19 pandemic took the healthcare industry to a whole new level to reduce the risk of exposure. NIHD prepared for and implemented early strategies to reduce risk and prepare for the worst while hoping for the best. Thankfully, this quick action provided a much safer healthcare environment for our community members, team members, providers, and all others. Our team members and providers, the true front line heroes, have managed all patients' care during these challenging times with the greatest of compassion and empathy imaginable. Knowing the hard work that was underway here at the District, the support, generosity and tokens of appreciation from our community members, as a way of saying "we support you – we thank you", was key to replenishing the efforts and instilling lines of energy in our most valuable assets. Thank you.

Having been with the District for ten years and now as a new CEO in 2020, I am not alone in noting there has been much recent change. At the same time, we've experienced a renewed momentum throughout the District, including some new faces and skill sets on the Executive Team and a heightened level of enthusiasm from our Board of Directors. At the core, no matter the role, we all share in and align with the NIHD mission, vision, and values. Soon, we will embark on the development of our new strategic plan for the District. This road map will be a vivid path for every stakeholder to share in, plan in and celebrate with, as we see the accomplishment and the successes being met each step along the way, as outlined in our 2021 -2023 strategic plan. At the District, we are used to hard work, planning, implementing, and of course, navigating the challenges of modern healthcare. This is who we are – "One team. One goal. Your Health". The best is yet to come!

My profound hope is you will enjoy the following highlights as our team shares the accomplishments, the challenges, and the ongoing efforts underway to ensure we are positioned to care for our community members for generations to come.

Sincerely,

Kelli Davis, MBA
Interim CEO

Kelli Davis, MBA
Interim Chief Executive Officer

STRATEGY FORMULATION FOR THE DISTRICT

Northern Inyo Healthcare District has invested in its strategy over the last few years to improve the culture and align the departments for future success. Under previous leadership, we looked at creating a shared mission and vision we could build a plan around.

NIHD designed its vision with the idea that we could achieve great things if everyone is inspired to do so. We created our vision as a goal – an achievable future state. We saw it as something to strive for that was focused on things that were important to not only the hospital, but also those we serve.

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

In order to achieve our vision, we knew it needed to be supported by our mission. Mission statements articulate why we exist as an organization and can drive a positive culture in an organization when correctly written and applied. Our mission, “Improving our community one life at a time. One Team. One Goal. Your Health.” was adopted by the staff and leadership as a way to accomplish these two objectives:

- To reinforce why we exist.
- To give staff and employees a reason for conducting themselves in a way that helps us achieve our vision of the future.

Over the years since creating the mission, we have been able to utilize that mission in our discussions with employees on how to conduct themselves and why we do certain things at the hospital. Anchoring ourselves in our mission has helped to unite employees and keep us focused during tumultuous times.

2020 has been a transition year for Northern Inyo Healthcare District. In the past we have been focused on gathering information to help us decide where to move in the future. Good decisions are made based on understanding data and applying that data to future roles.

Those being:

- Data and Information: Understanding the metrics that would help us achieve our goals and let us know where we stand compared to our benchmarks.
- Patient Experience: Making sure our patients were well taken care of.
- Employee Experience: Ensuring our employees and staff love working at NIHD and serving the people they serve.

We chose those categories because of their immediate need. Patients will always come first at Northern Inyo Healthcare District, but we did not want to lose sight of our employees in that process. Our employees are the most important resource we have. We have invested heavily in our employees and will continue to do so. Data and Information were added to the plan because we knew that we needed to have all the facts to make smart decisions. During the last several years, we have created plans to gather the right information and use it to help us make future decisions.

Once we had a better handle on those areas, we began to look at adding to our plan by creating goals to support our fiscal status and market share, as well as our growth or expanding our reach.

Given the change in leadership, we decided to utilize this year’s planning process to build a plan that would help us achieve our vision for the hospital and fix any misaligned systems, processes, and structures that would impede achieving our goals. This meant digging deeper into what we know about our hospital and the services our patients need.

2020 was a year of gathering information and preparing for our strategic planning process. In 2021 we will incorporate an organizational effectiveness process with other planning tools to eliminate barriers to success and align the organization to our key stakeholders’ needs. Meeting the needs of our stakeholders is a way to ensure that our success is organic and sustainable.

Understanding that our employees and medical staff are two critical stakeholders and have a direct connection to our most crucial stakeholder, our patients, we have surveyed both the staff and medical staff to understand the needs they are seeing. Also, we are in the process of gathering information from OSHPD and previous market studies and Community Health Needs Assessments to give us a more complete view of our situation. Being able to clearly see where we were in the past and compare that information with what needs to change in the future, we will be able to predict what will drive our success and sustainability moving forward.

Our areas of focus will be checked against a balanced scorecard approach to ensure we have a complete plan. Although the names of the categories will change, we expect to have goals that will address:

- Patients and their health needs
- Employees and their growth and satisfaction
- Operational efficiencies and eliminating barriers to success
- Financial success for the hospital
- Growth and providing services that are most needed in the community

We expect to complete our plan somewhere around Fall of 2021. This date will depend on the state’s COVID-19 restrictions and our ability to assemble the appropriate participants.

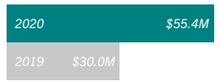
FINANCIAL STATISTICS

KEY SNAPSHOTS FROM THE 2020 FISCAL YEAR

CASH

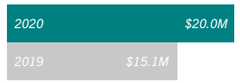
Majority of cash increase in 2020 due to IGT, PPP Loan, and HHS Stimulus

$55.4M



TOTAL PENSION PLAN ASSETS

$20.0M



GROSS REVENUES

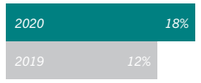
$157.6M

EARNINGS BEFORE INTEREST, TAXES, DEPRECIATION, AND AMORTIZATION

$3.6M

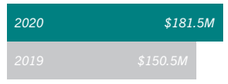
GROSS MARGIN

18%



TOTAL ASSETS

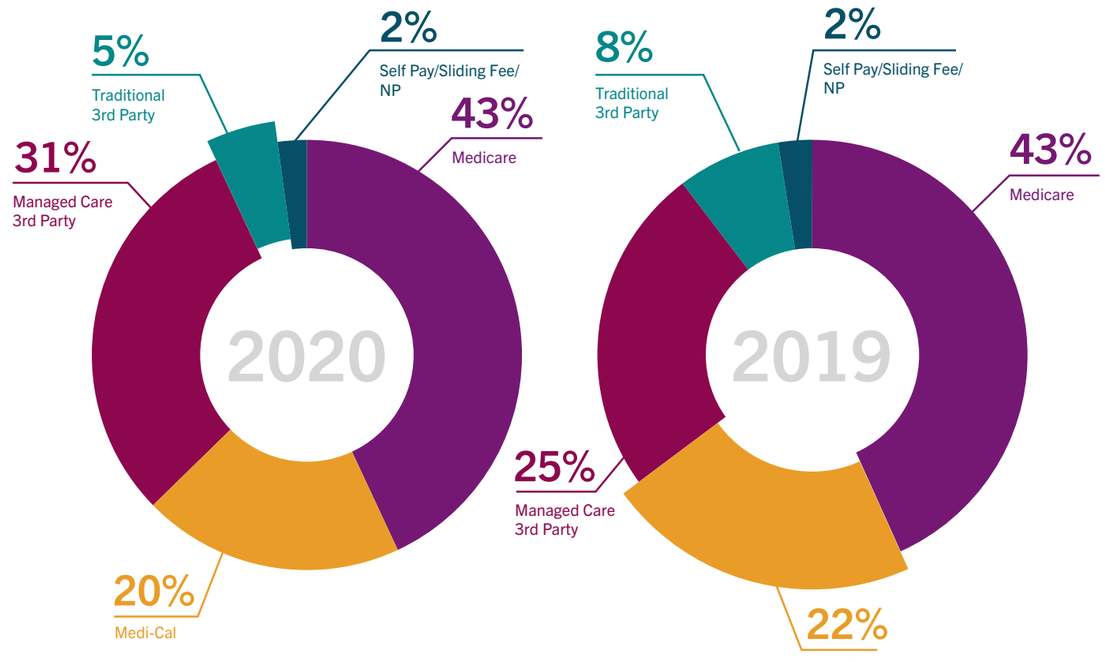
$181.5M



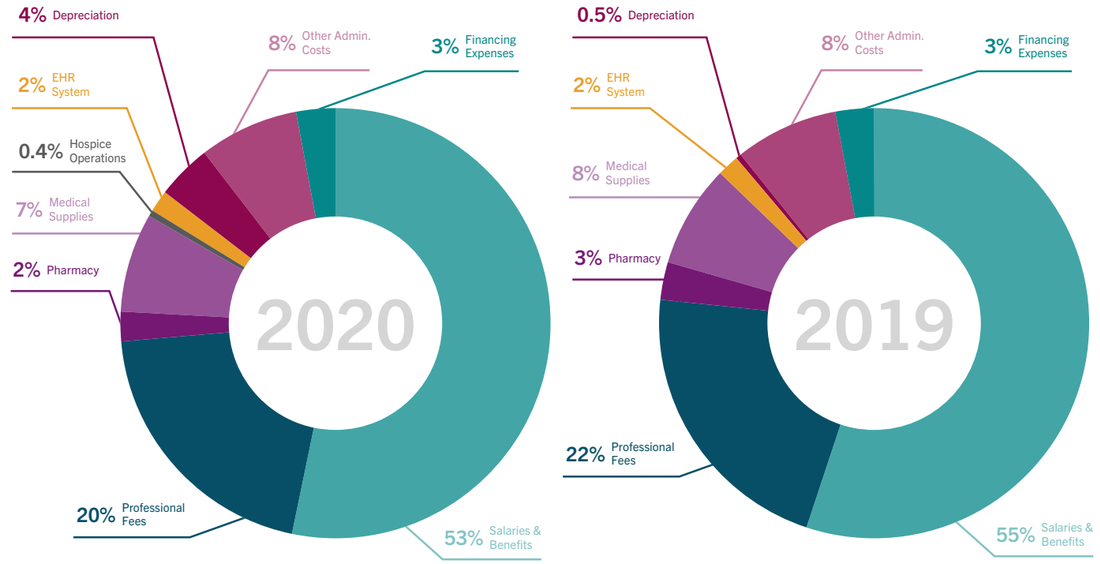
BONDS OUTSTANDING

$38.5M

PAYER MIX



COMPONENTS OF COST



PATIENT SERVICE STATISTICS

1,102 *2020*
1,217 *2019*
DISCHARGES

2,922 *2020*
3,567 *2019*
INPATIENT DAYS

58,148 *2020*
59,256 *2019*
OUTPATIENT VISITS

393 *2020*
470.21 *2019*
OBSERVATION DAYS

3.01 *2020*
3.32 *2019*
LENGTH OF STAY

9,150 *2020*
9,125 *2019*
AVAILABLE PATIENT DAYS

175 *2020*
179 *2019*
DELIVERIES

8,262 *2020*
9,079 *2019*
ED VISITS

1,181 *2020*
1,485 *2019*
SURGICAL CASES

428 *2020*
512 *2019*
CHEMOTHERAPY

15,961 *2020*
15,731 *2019*
IMAGING VISITS

71 *2020*
103 *2019*
ENDOSCOPY PROCEDURES

7,583 *2020*
9,398 *2019*
EKG PROCEDURES

25 *2020*
25 *2019*
NUMBER OF BEDS

CHIEF MEDICAL OFFICER'S REPORT

WILLIAM TIMBERS, MD

This year has been exceptional. Globally, we have seen the pervasive spread of COVID-19 with millions of infections and hundreds of thousands of deaths in the United States alone. Nationally, we have seen ever-widening political divides and near-perpetual protests. Regionally, we have witnessed unprecedented fires across the west, with smoke inundating the Owens Valley resulting in some of the world's worst air quality. As if the amalgamation of these challenges is not enough, the healthcare district has been confronted by leadership changes and marked financial hardship. Yet, despite these trials, the dedication, teamwork, and resolve of the people that are Northern Inyo Healthcare District has also been exceptional.

This is the first Chief Medical Officer contribution to an annual report wherein the Chief Medical Officer is a distinct entity. I hope this report provides you with an overview of the initiatives and projects I have been involved in. However, I want to stress that none of the work I have done or outline here is mine to take credit for alone. Despite the plethora of challenges, the accomplishments we have made this year are second to an exceptional team. When I was asked to step into this role, it was to fill a clinical departure within the Executive Team due to Dr. Flanigan's leave. This coincided with the rapid spread of COVID-19 in the United States and the need for additional clinical guidance in preparing for and mitigation of local spread of the virus. As Chief Medical Officer, I remained a member of the Incident Command team and worked with each clinical department early on in the pandemic to craft the 'NIHD COVID-19 Disaster Operations Action Plan'. A living 40-page document guiding staffing and resource management to facilitate safe clinical operations across the District. This provided the framework for reopening the District, beyond purely essential services, safely and efficiently. I have also been meeting weekly with members of media in the community to provide updates regarding COVID-19 and the District's preparedness. Additionally, I have given COVID-19 related presentations to various community groups, including District staff, Inyo County, and the Bishop Paiute Tribe, to educate and inform. While the pandemic is certainly nowhere near over, we have reached a sort of steady-state where workflows and processes that we implemented early on have become wrote, and less active management is required on a day-to-day basis. While our community and the healthcare district have certainly not been spared from COVID-19, and we have seen our share of death related to the virus, I am extremely proud of the Incident Command team and the District as a whole. I hold the conviction that was it not for early and intentional efforts to minimize and manage the impact of COVID-19 that we would have seen even more morbidity and mortality. With less COVID-19 active management required, I was able to pivot attention to other initiatives and needs within the District that are the traditional purview of a Chief Medical Officer. Kelli Davis, Tracy Aspel, and I reviewed the District's departments and divisions and revised the reporting structures. As part of this re-alignment, the following departments or divisions now fall under the Chief Medical Officer. For each category, I have provided a brief overview.

Physician and Advanced Practice Provider Relations

As Chief Medical Officer, I remain an active staff member and continue to work clinical shifts as an emergency physician, and am attuned to the challenges that providers face as part of their clinical duties. Given my administrative role, I am also acutely aware of the challenges that face the District more broadly. With the recent change and ambiguity in District leadership, a rift developed between the Board of Directors, District administration, and the medical staff. I see the Chief Medical Officer as a fundamental bridge between these parties. To this end, I have been helping to facilitate meetings between Board members and Medical Staff as well and sitting on the Medical Executive Committee and, generally working towards collaboration rather than division. Going forward, I envision the Chief Medical Officer being the primary arbiter of relationships between the administration and Medical Staff.

Physician and Advanced Practice Provider Contract Negotiations

With the recent administrative change, there was and still is a significant backlog of provider contracts that require review and renegotiation. However, across these contracts, there has been notable variation in the wording, compensation, structure, and benefits even amongst providers who work in the same clinical location and provide similar services. I worked with Vinay Behl to create standardized and data-driven compensation models that factor in fair market value, productivity, and quality. I have been working with District legal counsel to ensure that the contracts are standardized, comprehensive, and pass legal

William Timbers, MD
Interim Chief Medical Officer

muster. This is a large initiative, and I estimate it will take the better part of two years to complete. My hope is that by investing this time and effort, however, we will significantly minimize future work and contractual discrepancies making the process of negotiations more streamlined, transparent, and fair.

Physician and Advanced Practice Provider Recruitment

Beyond contract negotiations and modeling, I have also been actively recruiting providers. This had been my responsibility and that of the Chief of Staff, and the decision was made for me to continue recruitment efforts as Chief Medical Officer. In truth, I feel recruitment should continue to be the responsibility of the Chief Medical Officer. As Chief of Staff, my lack of access to existing contracts, fair market analytics, and legal counsel was hobbling. The ability to leverage these tools and direct the process from recruitment to contract negotiation to onboarding with the Medical Staff Office is a much more efficient process. During my tenure as recruiter-in-chief over the past year and a half, we have brought onboard four hospitalists, three of which are full time and local. Five emergency physicians, four of which are full time and local. One general/breast surgeon. One Rural Health Clinic physician (although the credit here is all Dr. Brown's!). One full time and local pediatrician. One plastic/hand surgeon and one anesthesia pain specialist. My hope is to continue to expand our services and work towards bringing full time and local providers on board. I am excited to work in conjunction with the Medical Staff Office and our new Digital Marketing Specialist to this end.

Oversight of Medical Directors and Medical Department Initiatives

A major role and responsibility of the Chief Medical Officer is oversight of Medical Directors. The District contracts with a physician in the Rural Health Clinic, Pediatric, Internal Medicine, Hospitalist, Emergency, and Surgery/Anesthesia departments to act as director and help facilitate District directives and initiatives in each of these clinical areas. This is separate from the Department Chiefs, which are Medical Staff positions under the Chief of Staff and governed by the Medical Staff bylaws. The Chief Medical Officer's role is to ensure that the Medical Department Directors work in concert to further the District's strategic and financial plan. These directors report directly to the Chief Medical Officer. This relationship also provides a conduit for each department to relay needs or concerns to the Executive Team.

Pharmacy Oversight

Pharmacy permeates all District clinical areas, and there is a close collaborative relationship between providers and the pharmacists in providing patient care. Given this overlap and the pharmacy department's peri-clinical nature, the Chief Medical Officer's oversight is appropriate. Recently, pharmacy has been working towards implementing a 340b program, a drug pricing program through the federal government that requires drug manufacturers to provide drugs to eligible healthcare organizations like critical access hospitals at decreased prices. Pharmacy has also revised the markup price for pharmaceutical administration and navigating new requirements mandated by insurance payors. One example of a recent mandate is Anthem's requirement that certain medications be procured through their preferred vendor else the claim be denied. There are also ongoing discussions to steer the need and use case for new medications and therapeutics at the District.

Quality and Risk Management Oversight

Historically there has been minimal physician involvement in, or direction of, Quality and Risk at the District. This is atypical, and one of the cardinal roles of a Chief Medical Officer is oversight of these areas pertaining to clinical care. These quality initiatives include the PRIME grant, which provides funding based on hitting metrics associated with acute bronchitis treatment, Clostridium Difficile, days of antibiotic therapy, and prophylactic antibiotic use after surgical cases. We have historically not met these PRIME metrics and have consequently left $1.2 million in grant funding on the table. My hope is to work with the Quality team and clinicians to rectify this. The National Healthcare Safety Network (NHSN) is a tool used to help track hospital-acquired infections. The Medicare Beneficiary Quality Improvement Project (MBQIP) tracks metrics related to severe sepsis, stroke, elective deliveries between 37-39 weeks gestation, and Emergency Department transfer communication. The Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) is a survey and data collection system that measures patient care experience. Healthcare Effectiveness Data and Information Set (HEDIS) is a pre-selected set of performance measures that fall into six domains. These domains are effectiveness of care, access/availability of care, experience of care, utilization and risk-adjusted utilization, health plan descriptive information, and measures collected using electronic clinical data systems. Health insurance payors tie enrollment to adequate performance within these domains which, consequently impacts compensation. We have historically been behind on our HEDIS reporting which jeopardizes our enrollment with payors. The Quality team has been working hard to catch-up on this backlog and implement new workflows and systems to prevent this lapse from happening in the future. Merit-based Incentive Payment System (MIPS) is a Medicare system that uses provider clinical performance in quality and efficiency to incentivize compensation. Promoting Interoperability is a federal program that allocates incentive payments for adoption and curation of an electronic health record. These programs require diligent data collection and reporting with frequent course correction of clinical practices to ensure benchmarks are met. The stakes are high as failure to meet these metrics carries significant financial and safety risks. Considering the majority of these Quality and Risk metrics are clinical in nature oversight is squarely within the purview of the Chief Medical Officer.

Clinic Licensing Oversight

I have been working with WIPFLI to license the Bronco Clinic as a 1206b exempt clinic, which is a strategy that will allow us to bill for the services provided there and potentially for similar programs in the future. Additionally, I have been exploring the benefits and barriers that are involved in licensing the Northern Inyo Associates (NIA) clinics through the hospital, which would allow for billing a facility fee in addition to a provider fee. This has the potential to significantly increase revenue. The most substantial barrier is that this licensure would require the NIA clinics be OSHPD Level 3 compliant. As the District moves forward with a possible purchase of the Pioneer Medical Associates Building, we will continue to evaluate this option.

Medical Staff Office Oversight

During the past several years, the Medical Staff Office's role and responsibilities have expanded and evolved. The Medical Staff Office is currently involved in physician recruitment, credentialing and privileging, onboarding and orientation of physicians, medical staff membership and quality, and marketing. The Medical Office Staff will also be adopting the responsibility of managing provider enrollment with insurance payors. Like the Chief Medical Officer, the Medical Staff Office is a bridge between the District and Medical Staff.

Electronic Health Record Implementation

Lastly, I have taken on the role of "sponsor" as we move forward with implementation of our new electronic health record, Cerner. This is a District-wide effort with stakeholders in every department across the spectrum of clinical and non-clinical roles. The sponsor's role is to provide executive guidance and communication of pertinent content to the district staff and employees. Thus far my role has been participation in the Steering Committee and Readiness committee, but I expect that the need for frequent communications and information synthesis will increase as we move further into implementation. I look forward to continuing to work with our project management, WIPFLI, as well, as with the Cerner team and our team here at the District.

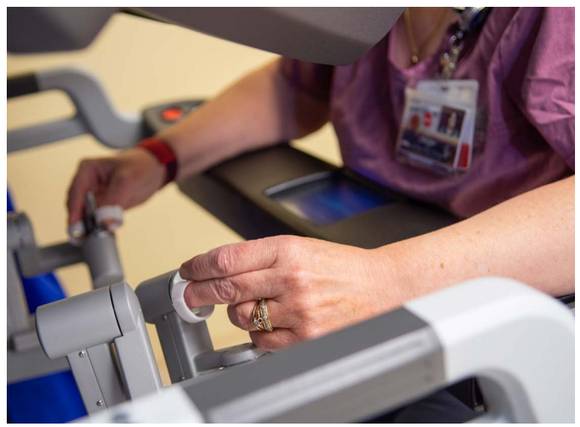
As we move forward I am sure that the role of Chief Medical Officer will continue to evolve and adapt to the needs of the District and the Medical Staff. Some of the responsibilities I have outlined I consider permanent responsibilities of the Chief Medical Officer. Others, such as electronic health records implementation and the COVID-19 response are, hopefully, temporary. I feel privileged to have the opportunity to serve the District and the community in this role, and I look forward to tackling whatever challenges are ahead with this exceptional team.

Respectfully,

William Timbers, MD
Interim Chief Medical Officer
Northern Inyo Healthcare District

SPOTLIGHT ON SURGERY

Hands of General Surgeon Robbin Cromer-Tyler, MD FACS, working the da Vinci Surgical System. Photo by David Calvert



Hands of surgeon Robbin Cromer-Tyler, MD FACS, within the guides of the da Vinci Robot-Assisted System. Photo by David Calvert

Surgical Nurse Nicole Eddy. Photo by David Calvert

Perioperative Team member Chris Cauldwell consults with Orthopedic surgeon Richard Meredick, MD. Photo by David Calvert

General Surgeon Jon Bowersox with surgical team members Oscar Morales and Nicole Eddy. Photo by David Calvert

PLASTIC SURGERY

The Plastic Surgery Division at Northern Inyo Hospital offers a range of reconstructive and aesthetic surgeries, led by Board Certified Plastic Surgeon Dr. David M. Plank. Dr. Plank is specially trained with technical ability and the experience to help you meet your goals.

Born and raised in Cincinnati, Ohio, David M. Plank MD left the Midwest to pursue a career in Plastic Surgery. The route Dr. Plank took to Plastic Surgery was one met with many opportunities and experiences, but one that landed him with a career he is passionate about.

Dr. Plank graduated from Miami University of Ohio with a degree in chemistry and went on to purse his master's degree in physiology at Ball State University. While at Ball State University, Dr. Plank was awarded many research grants, including a NASA grant investigating the long-term effects weightlessness on the body. This training and experience catapulted Dr. Plank to the world famous and top ranked pediatric hospital, Cincinnati Children's Medical Center where he received his Ph.D in Molecular Biology. While earning his doctorate, he interacted with world-class physicians and a Nobel Prize recipient in Physiology. It was these experiences at Cincinnati Children's Hospital and University of Cincinnati where he developed his true passion in medicine and decided to continue his education at the University of Cincinnati School of Medicine.

In 2007, Dr. Plank graduated from the University of Cincinnati College of Medicine where he received several awards for his medical research, innovations, and developed his passion for plastic surgery. Dr. Plank was one of three people in the country to obtain a Plastic Surgery residency position at the prestigious University of South Florida College of Medicine Plastic Surgery program. After residency, Dr. Plank spent a year at University of Pittsburgh where he obtained additional plastic surgery training.

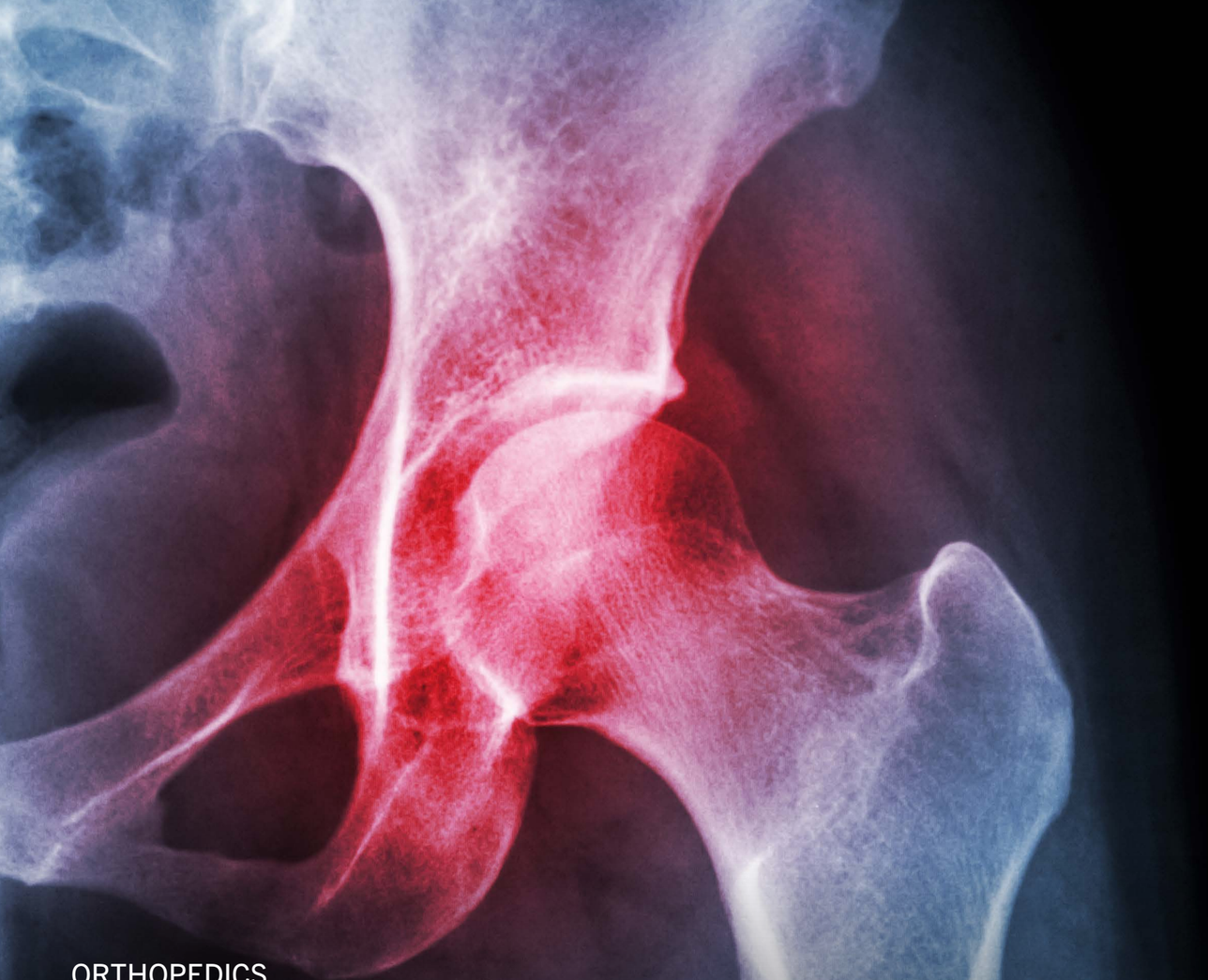
Dr. Plank has always been an avid outdoor enthusiast, spreading this love of the outdoors to his children. He has been visiting Bishop and the Eastern Sierra for 20 years which he is excited to be working at Northern Inyo Hospital.

Dr. Plank regularly gives talks on the medical field to middle school students. Dr. Plank is also an Assistant Professor of Surgery at the University of Central Florida and the Director of their Plastic Surgery Clerkship, where he teaches medical students and residents. Dr. Plank also serves as a Clinical Instructor for the Florida State University College of Medicine.

Dr. David Plank is certified by the American Board of Plastic Surgery and specializes in facial and full body cosmetic and reconstructive plastic surgery. He has contributed a chapter to a textbook and has had 16 peer-reviewed abstracts and articles published in the field of plastic surgery.

Surgical Nurse Oscar Morales.
Photo by David Calvert

General Surgeon Jon Bowersox.
Photo by David Calvert



ORTHOPEDICS

Northern Inyo Associates Orthopedic Surgeons aim to provide a comprehensive evaluation and treatment for a broad scope of musculoskeletal ailments based on the most up-to-date and evidence-based information available. Our department is comprised of three surgeons spanning three generations encompassing greater than 50 years of combined experience in sports medicine/arthroscopy, trauma/fracture care, joint reconstruction, and joint replacement.

Dr. Mark Robinson is Board Certified by the American Board of Orthopaedic Surgery and is a fellow of the American Academy of Orthopaedic Surgeons. Having lived in the Eastern Sierra for many years, he has a thorough understanding of what living an active life means. He brings extensive knowledge and immeasurable experience from his career as an orthopedic surgeon. He provides comprehensive care of orthopedic injury and disease, including complex fracture care and arthritic joint disease.

Dr. Richard Meredick is Board Certified by the American Board of Orthopaedic Surgery and is a fellow of the American Academy of Orthopaedic Surgeons. He is also a member of the American Association of Hip and Knee Surgeons. In addition to completing a sports medicine/arthroscopy fellowship where he focused on sports-related injuries, he has also taken a special interest and completed additional training in joint replacement surgery, including the shoulder, hip and knee. For his joint replacement and select arthroscopic surgeries, he and the anesthesia providers employ the use of regional anesthesia (spinal and peripheral nerve blocks), which has been proven to both decrease pain and increase early mobility leading to lower risks for infection and blood clots. He is a firm believer in multimodal pain management both before and after his surgeries in an effort to minimize narcotic use and subsequently minimize the risk for narcotic abuse and/or long-term dependency. He believes that every patient has the capacity to overcome their ailment or injury when provided with not only the right medical care but also the tools and knowledge to help the patient care for themselves.

Dr. Bo Nasmyth Loy is a fellowship-trained Sports Medicine and Arthroscopy surgeon. He is a member of the Arthroscopy Association of North America, American Orthopaedic Society for Sports Medicine, and the American Academy of Orthopaedic Surgeons. He has worked professionally with the United States Ski and Snowboard teams since 2018, where he empowers athletes to perform at their best, with and without surgery. These same skills, honed with the U.S. Ski and Snowboard team, transition perfectly to providing orthopedic care in the Eastern Sierra. Dr. Loy specializes in arthroscopic surgery of the shoulder and knee. As compared to traditional open surgery, arthroscopy is minimally invasive. This means he can complete most procedures as outpatient surgeries, giving patients the option to go home the same day. Arthroscopy can also minimize pain and the need for pain medication after surgery as well as reduce overall recovery time. If you want to get back to skiing the slopes, climbing and hiking in the Sierras, or any of your activities with better function, Dr. Loy can help you achieve your goals.

Having performed thousands of surgeries and having observed all of these patients recover from their procedures, our surgeons have cultivated an in-depth understanding of what makes a person truly healthy. Life is full of challenges - disease, injury, pain, etc., and our physicians understand that the best way they can help each patient to be healthy is by helping them to cope with and manage their injury or ailment. As surgeons, they are adept at providing surgical solutions to fractures of bones and injuries to soft tissues such as ligaments and cartilage, as well as replacing joints when they are worn out and destroyed by arthritis. Perhaps even more importantly, they understand that often there are ways to manage many ailments non-operatively to avoid potentially unnecessary surgery, particularly when they know the non-surgical outcomes may not differ from surgical outcomes. Recognizing that a patient's care does not end in the office or the operating room, Northern Inyo Healthcare District also has a highly experienced, intuitive, and knowledgeable Rehabilitative Services Staff to assist our surgeons with both non-operative treatment as well as surgical recovery. Before each surgery, the orthopedic service works along with the local primary care providers, medical sub-specialists, anesthesia providers, and hospitalists to provide a comprehensive pre-operative evaluation to ensure that each patient is optimized and safe to proceed with the surgery when deemed necessary. One of our surgeons will see each patient at every office appointment

Orthopedic surgeon Richard Meredick, MD. Photo by David Calvert

throughout his/her care to confirm appropriate progress. All efforts are made from the first visit to the very last to give each and every patient the best possible outcome.

Surgeries Performed include:

- Joint Replacement Surgery (primary and revision)
- Shoulder, Hip (anterior), and Knee
- Minimally Invasive Surgery
- Shoulder (rotator cuff repair/reconstruction, ligament repair for instability)
- Knee (ligament repair/reconstruction, cartilage repair/restoration)
- Elbow and Ankle (arthritis management, cartilage lesions, tendon)
- Hip (impingement)
- Peripheral Nerve/Tendon Entrapment
- Carpal Tunnel Syndrome
- Cubital Tunnel Syndrome
- Trigger Finger
- Comprehensive Fracture Care

OPHTHALMOLOGY

Thomas K Reid, MD, is a comprehensive ophthalmologist. He graduated from John Hopkins University School of Medicine in June 1991 and completed his Ophthalmology residency at the University of Arizona in June 1995 where he served as Chief Resident from July 1994 to June 1995. He has practiced in Bishop since July 1995. He served as NIHD Chief of Surgery and on the Executive Committee, 1997-98 and 2008-2010. He is certified by the American Board of Ophthalmology since 1996 (currently through 2026) and licensed by the Medical Board of California, 1995 to present.

In his 29 years of Ophthalmology experience, Dr. Reid has performed more than 8,000 eye, eyelid, and orbital surgeries, including cataracts, refractive lens implants, glaucoma and retinal detachment repairs, cosmetic and functional eyelid surgeries, treatments for macular degeneration, and LASER treatments for diabetes, macular degeneration, glaucoma, and other conditions. His patients have included other physicians, professionals, artists, and photographers. He has taught courses on cataract surgery at the American Academy of Ophthalmology meeting as well as appearing on local TV and writing articles for the local newspapers.

Dr. Reid sees patients for general eye conditions, including refraction, glaucoma, cataracts, macular degeneration, retinal detachments, diabetic retinopathy, eyelid malpositions, and eyelid tumors. He performs minor procedures in his office, including pterygium removals, YAG capsulotomies, YAG iridotomies, eyelid malpositions and eyelid tumors and VEGF inhibitor injections for wet macular degeneration. He performs outpatient surgery at Northern Inyo Hospital including cataract extractions, lens exchanges, and pneumatic retinopexies.

The most common surgery that Dr. Reid performs at Northern Inyo Hospital is cataract surgery. This is truly an amazing surgery. The surgery is performed when a patient feels their vision is “bad enough,” i.e., affecting their lifestyle and daily living activities (reading, driving, watching TV, finding the golf ball, etc.) enough to justify the small risks of surgery. As long as there are not other compounding medical conditions or diseases of the eye, cataract surgery is about 99 percent successful. With a normal cataract, the chance of a complication that permanently decreases the patient’s vision and cannot be corrected by another surgery is about one out of a thousand. The surgery usually only takes about 10 minutes. Patients are in the hospital for about two to three hours. The recovery time is generally very short. Some patients see 20/20 without glasses the next day and can do all of their normal activities. Some patients need a few more days to see improvement. If patients have astigmatism that they choose not to have corrected, they will need glasses before seeing their best.

Opthalmologist Dr. Tom Reid. Photo by David Calvert

Urology surgeon Dr. Matthew Ercolani

Standard da Vinci Surgical system set up. Photo courtesy of Intuitive

UROLOGY

Since 2019, the urologists of Elite Robotic Surgical Consultants have worked diligently with the Northern Inyo Healthcare District Medical Staff and administration to provide comprehensive urologic services with a special focus on robotic urologic surgery for cancers of the prostate, the bladder, and kidney as well as benign conditions such as pelvic organ prolapse and urinary tract obstruction. We want all our patients in the District to be able to have their urologic issues addressed locally. Similar to other specialties utilizing the DaVinci Xi robotic system, laparoscopic urologic procedures performed with robotic assistance have many advantages for our local patients, including: decreased surgical and anesthesia time in the operating room, decreased blood loss during surgery, less pain after surgery, shorter length of hospital stay for recovery, quicker return to work or normal activities, less risk of surgical site infection, and less risk of a need to return to the hospital for treatment of post-operative complications.

In addition to performing complex robotic urologic procedures, we also treat basic urologic problems in adult males and females, including prostate/voiding problems (BPH), urinary incontinence, kidney stones, erectile dysfunction, urinary tract infections, bladder pain, blood in the urine, androgen deficiency, male sterilization, and diagnosis and management of urologic cancers.

OB/GYN

Minimally invasive gynecologic surgery uses less invasive techniques, such as laparoscopy or hysteroscopy, to surgically treat gynecologic conditions. Minimally invasive techniques require no incisions or a few small incisions. Most of the procedures can be done on an outpatient basis (including hysterectomy). Dr. Jeanine Arndal is a Board Certified OB/Gyn. She has undergone extensive surgical training and has a focus on Robotic and minimally invasive surgical techniques. She has California and Nevada Medical licenses and operates at both Northern Inyo Hospital and Renown Hospital in Reno, NV. This allows her to stay up to date with the most modern surgical techniques and ensures that surgery volume is more consistent with surgeons in larger communities. All of this translates to the best surgical outcomes for patients in our community.

Benefits of Gynecologic Minimally Invasive Surgery

- Smaller or no incisions
- Less blood loss
- Less pain
- Outpatient procedure (or a short hospital stay)
- Faster recovery and return to work, exercise and, other daily activities
- Smaller scars and better cosmetic result
- Lower risk for infection or other complications
- Conditions treated with minimally invasive surgery
- Ectopic pregnancy
- Endometriosis
- Heavy bleeding and painful periods
- Hysterectomy
- Labioplasty
- Ovarian cysts
- Pelvic inflammatory disease
- Pelvic organ prolapse
- Pelvic adhesions
- Pelvic pain
- Postmenopausal bleeding
- Risk reducing surgery for Familial Risk for breast and pelvic cancers.
- Urinary incontinence procedures
- Uterine fibroids
- Uterine polyps

BREAST SURGERY

Northern Inyo Healthcare District launched its Breast Surgery Program in October 2016. This program was a further step forward as a result of the comprehensive breast imaging program started earlier by Dr. Stuart Souders.

Key to the success of a comprehensive breast surgery and breast cancer program is the recruitment of a Patient Navigator. After an extensive search in mid-2016, NIHD was fortunate to have recruited Rosie Graves as our Breast Cancer Navigator. Rosie's duties also included navigating patients with other types of cancers.

A successful, comprehensive breast cancer treatment program requires the establishment of a multidisciplinary approach. Dr. Jay Harness was recruited as a highly experienced breast cancer surgeon to lead the multidisciplinary approach in the latter part of 2016.

The key components of a multidisciplinary breast cancer treatment and evaluation team includes: a Breast Cancer Surgeon, Medical Oncologist, Radiation Oncologist, Breast Radiologist, Breast Pathologist, Genetic Counselor, Physical Therapist, and one of the key positions is the Patient Navigator. NIHD is very fortunate to have dedicated individuals fulfilling each of these critical roles.

All of the multidisciplinary breast cancer treatment team members do not necessarily have to be onsite at NIHD. Dr. Harness and Rosie reached out to comprehensive cancer treatment programs both north and south of Bishop.

To the north, a comprehensive relationship was established with the Cancer Center at the Carson Tahoe Hospital in Carson City, NV. The Carson Tahoe Cancer Center has the needed breast radiation therapy program as well as experienced Medical Oncologists to treat breast cancer. Breast Radiation Oncology services are provided onsite in Carson City, as well as the consultations by both Radiation and Medical Oncologist. If patients require chemotherapy, typically, the first cycle of treatment is given in Carson City and the remaining cycles of treatment are provided at NIHD.

To the south, NIH established a similar comprehensive relationship with the City of Hope satellite in Lancaster, California. Both of the northern and southern relationships have been working extremely well, and NIH is very pleased to be associated with both of these fine institutions. Rosie Graves has worked tirelessly to ensure that our NIH breast cancer patients (as well as other cancer patients) are seen and evaluated as promptly as possible. For patients who need mastectomies and want reconstruction, we have established relationships with breast cancer surgeons and plastic surgeons at St. Joseph Hospital in Orange, the City of Hope in Lancaster, and Renown Hospital in Reno. Only recently has of the possibility of plastic surgeon services been possible at NIHD.

Surgically, Dr. Harness and the team in the NIHD ORs are able to provide state-of-the-art breast cancer and benign breast disease surgical procedures. These procedures include partial mastectomy (lumpectomy) for breast cancer, oncoplastic reconstruction of the breast, sentinel lymph node biopsies of axillary lymph nodes, excisional breast biopsies for benign conditions, removal of breast implants, excision of accessory breast tissue in the axilla (armpit), surgery of the breast ductal system, and other related breast surgery procedures.

The citizens of the Eastern Sierra region and Western Central Nevada are fortunate that NIHD can provide such a comprehensive approach to the diagnosis and treatment of breast cancer at NIHD. All of the members of the multidisciplinary comprehensive team of providers are to be congratulated for their hard work and dedicated service. ■

Dr. Jay Harness performs a lumpectomy on breast cancer patient. Photo courtesy Jay K. Harness

CHIEF NURSING OFFICER'S REPORT

TRACY ASPEL, BSN, RN

Work by the Nursing team and the District this year has focused on the safety of patients, staff, and visitors alike. The last six months have been punctuated by non-stop changes based on best practices and scientific information. The Nursing team has worked collaboratively with Medical Staff providers, clinical departments, and fiscal to improve service performance and quality. Education has played a pivotal role in assuring staff is prepared to perform each day, competently and within the standards, for best patient care.

COVID-19 pandemic has impacted all persons working in the District. On March 6th, a large group of staff leaders from across the District held the first informal meeting to begin planning for the District response to COVID-19. On March 9th, the Incident Command (IC) was opened, and NIHD began its longest disaster planning in our history. As CNO, I was charged with the Incident Commander Role. The roles were assigned. The IC remains functional and continues to meet to solve issues and standardize practices that assure the safety of the patients, staff, and visitors during the pandemic. More than 258 items have been brought to the IC, leading to task force development of key stakeholders. The task teams investigate, research the latest scientific information and standards, present decisions, create standard work, and educate staff and the community. To date, no staff member or patient has acquired a COVID-19 infection at the District, demonstrating exceptional infection control and prevention practices. This has been a remarkable undertaking with a team approach that continues to demonstrate how the District follows our mission statement: Improving Our Communities One Life at a Time. One Team. One Goal. Your Health.

Quality remains a high priority for NIHD. In the fall of 2019, I took a lead role working with Dianne Picken and Dr. Charlotte Helvie to rewrite the Quality Plan. At that time, the vision changes from having separate quality plans, one for the Medical Staff and another for the District, to a single plan that depended upon a collaborative approach. The District Quality FY2020 Plan was developed and has since been revised for FY2021. In this new approach, a Quality Council was born. The Council was led by the CNO with key players that included a board member, physicians, fiscal representative, nursing, project management, and operations. Processes were revamped from the bottom up, including how performance improvement projects would be imagined and developed, implemented, and then finally communicated to the front line staff across the District. This process is now working to roll out several projects that will significantly impact the patients of the District.

Using data to track performance remains crucial to demonstrating where Nursing has challenges and successes. Each Nursing unit keeps a quarterly scorecard (Pillars of Excellence) where this data is tracked. Multiple project teams and drills occur to address safety concerns and patient care issues, each comprised of clinical staff members and leaders. Here are a few of the key project teams, committees, and on-going drills:

- Falls Prevention Project Team
- Alarm Fatigue Project Team
- Pain Management Project Team
- Medication Administration Improvement Committee
- Crash Caesarean Section Process Improvement Drills
- Maternal Hemorrhage Drills
- Drills for placing patients safely into Prone Position for treatment of COVID-19
- GNOSIS training programs in Perinatal and Emergency Department
- Safe Injection Practice education and rounding observations
- Maintenance of Baby-Friendly USA designation
- CNO participation in the Homeless Coalition (CoC), including discharge planning from NIHD for Homeless persons in compliance with California law
- Mom's Support Group weekly meetings
- Safe Patient Handling Committee
- Fit Testing Project Team (creating a process for Respirator N95 fit testing to meet regulations)
- Root Cause Analysis (RCA) to review processes in depth
- Emergency Department Transitional Care (EDTC) audit to assure transfer of patient have complete information for the receiving facility
- Infection Prevention Rounding

Tracy Aspel, BSN, RN
Chief Nursing Officer

The Nursing Department identified significant safety issues related to the electronic health record, Athena Health, and sprang into action. Standard work was created to address safety issues and train staff on consistent approaches to prevent errors. This challenge remains to this date, and safety is maintained by the constant vigilance of the staff.

NIHD was recognized as the "District of the Year" largely due to the development of the "Medication Assisted Treatment Program." The recognition of opioid addiction as a crisis in our community began several years prior. Taking action to provide support and opportunity to treat addiction is now a reality in the Eastern Sierra. Care coordination and treatment includes training to combat overdose with the use of Narcan. This life-saving drug has been distributed and local persons instructed on its use, leading to many lives being saved.

Discharge planning, assuring patients who are leaving the hospital have the equipment, support, and follow-up they need, remains a high priority. This has included great collaboration with Pioneer Home Health Care, Bishop Care Center, and Southern Inyo Healthcare District SNF. Case Management at NIHD works closely with the Rural Health Clinic Care Coordinators to transition patients from hospital support to outpatient support. This helps to keep patients from requiring readmission to the hospital.

The Nursing Department has completed some restructuring in the past year. A new Director of Nursing position was developed; DON Quality and Infection Prevention. This role has responsibility for strategic planning and implementation related to Quality, Survey Readiness, Clinical Informatics, Infection Prevention, and Employee Health. These key areas touch all members of the District, having a great impact on safety. This team will be an essential part of the implementation of Cerner during the next year.

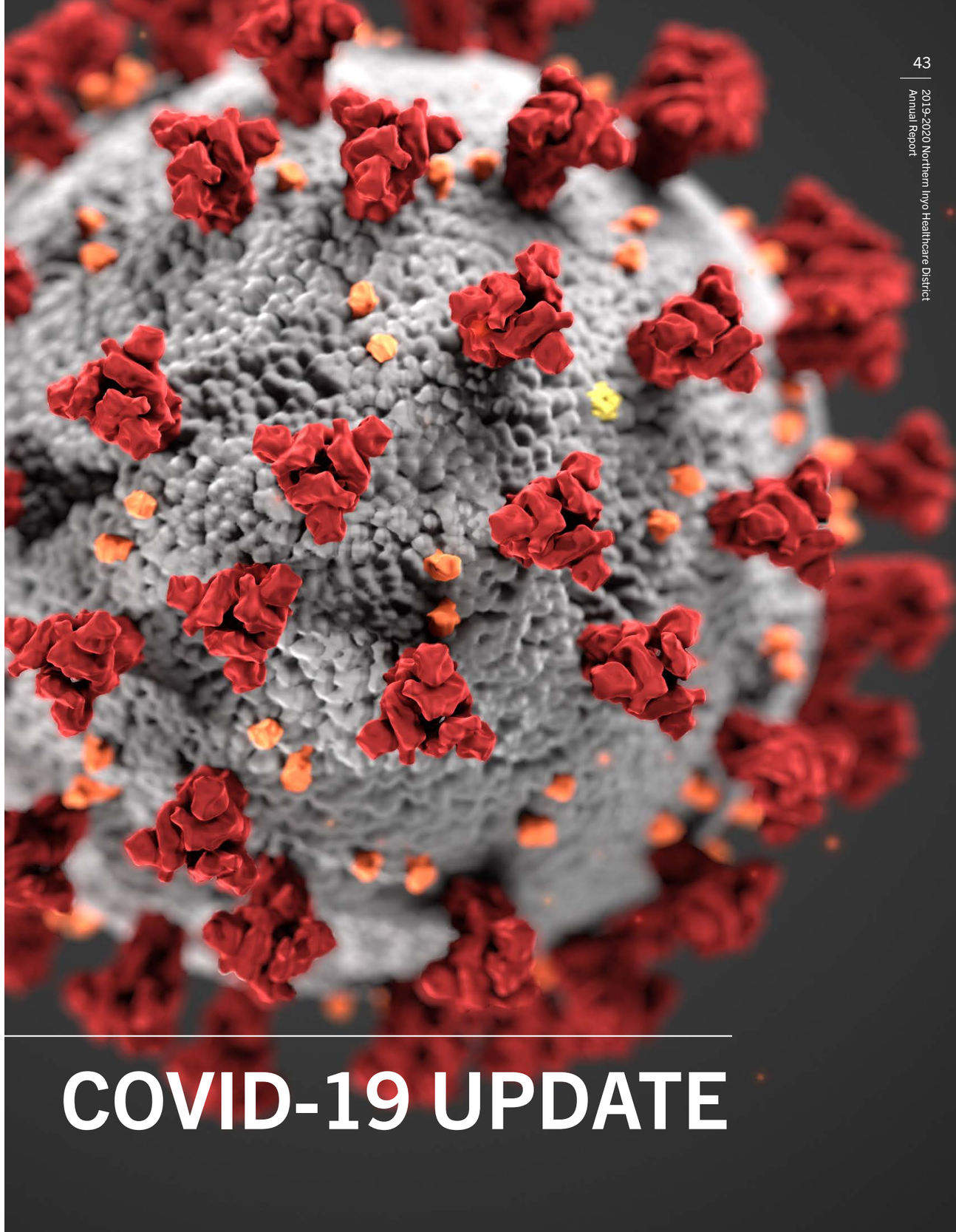
Our most recent success has occurred with the rollout of SMART IV pumps. The Nursing team participated in the selection of these new pumps and recently completed training. The new pumps have many safety features that prevent potential drug administration errors. NIHD switched to these new pumps on August 20th. The NIHD Pharmacy team led the collaboration, and the staff is on-board with the recent change.

The Language Services Department continues to promote excellence in communication for our patients via interpreting and translation services. New equipment has been made available to support this process. Written documents are organized within our intranet to support success for the staff when printing translated forms or information, both the English and Spanish versions are available to the staff and the patient.

Northern Inyo is an amazing place to practice Nursing. It has been my honor and privilege to work at NIHD during these past 40 years. This past year's Nursing Department's accomplishments are due to the committed team, not done by anyone. Thank you, Nursing Department Staff, for the excellence you provide each day in caring for our community.

Respectfully,

Tracy Aspel, BSN, RN
Chief Nursing Officer



COVID-19 UPDATE

COVID RESPONSE HIGHLIGHTS

Barbara Laughon, Strategic Communications

Northern Inyo Healthcare District's response to the coronavirus began in a seemingly quiet manner to the casual observer. Early meetings listed on the District's Master Calendar blend well with each day's more routine appointments.

As the weeks go by and news from Wuhan, China darkens, the meetings increase in frequency and intensity. Planning started well before the federal government engaged. Instead, NIHD stayed in tune with the California Department of Public Health's informational briefings. Internal NIHD meetings began in mid-January.

When it was time to engage the entire District in what would become an unprecedented ride, Infection Preventionist Robin Christensen summoned directors and managers to an hour-long meeting. The meeting morphed into a day-long review of staffing levels, supplies, policies, plans, and shared concerns.

The group agreed to meet the next day again, a regular Saturday in a rural town nestled at the gateway to the Sierra Nevada mountains. Saturday days in the spring mean yard sales, people bustling about doing household errands, and meeting friends for hikes and bike rides. On that particular Saturday, much of the District team had volunteered to help staff a 10K run to benefit the local cancer alliance.

As the NIHD team refers to it, March 6, 2020, was the last "normal" day, pre-pandemic in Inyo County. That day became in conversations, the mental milestone usually reserved for holidays and special occasions. It's the kind of day the team hopes to return to in the future.

NIHD key responders

The District initiated an internal Incident Command on March 10 and continues working under it today. Incident Commands use a standardized approach to direct, control, and coordinate emergency response. Above all else,

Central Registration Registrar JoAnn DeJesus works outside alongside the lab staff in the drive-through lab services. Photo by David Calvert

Nancy Landaverde, Lab Ancillary Specialist, readies to test a patient for COVID-19 in NIHD's Lab Drive-through. Photo by David Calvert

Patients seeking care at NIHD's Emergency Room will first encounter a staff member at a portable workstation just within the entrance. Brett Gutierrez, RN BSN, is shown wearing a protective face shield and mask. NIHD has also stepped up its cleaning and disinfection efforts during this critical time. Photo by Barbara Laughon

Talent Pool Screener Maureen Barrett scans a staff member upon arrival for work at NIHD. Photo by David Calvert

NIHD Employee Health RN Colleen Moxley and Quality Assurance and Performance Improvement Analyst Michelle Garcia show just a sampling of the homemade masks provided by local seamstresses as part of Project Cover-up, led in part by retired OR Nurse Barbara Stuhaan. Photo by Barbara Laughon

Lab POCT Coordinator Sandra Sommer reaches for a COVID-19 test. Photo by David Calvert

Incident Commands brings people together to reach a common goal for the community's well-being. The staff working on Incident Command averages 22 team members with additional subject matter experts to sit in as needed.

Physician engagement has played a crucial role in addressing the pandemic. Incident Command leaders Drs. Stacey Brown and William Timbers, NIHD's Interim Chief Medical Officer, rely on many of the District's Medical Chiefs for aid and advice. Among those contributing: Chief of Staff Dr. Charlotte Helvie (Pediatrics), Dr. Richard Meredick (Orthopedics), Dr. Sierra Bourne (Emergency), Dr. Joy Engblade (Hospitalists), Dr. Anne K. Wakamiya (Geriatrics), among others. The Medical Support Staff office issued emergency credentials for other physicians in the area should their aid be required at bedsides.

Equally important is the Nursing teams. Those teams have faced unprecedented challenges, including the emotional struggle of watching cases surge after holidays and events. They also have had the difficult job of aiding families -- many of whom they know personally -- with loss of life. Despite it all, the NIHD Nursing team has remained professional, caring, and unwavering in their compassion for their community.

Ancillary teams, including Respiratory, Laboratory, Diagnostic Imaging, Environmental Services, Laundry, and Admission Services, are the glue keeping our workflows, services, and necessary care together. These teams play a substantial role every day in battling the coronavirus. They are lauded for their commitment to the patients and our community.

Our administrative team members are genuinely our quiet contributors. Many worked from home to reduce the chance of COVID spread in the early months, then returned to the District to resume duties in the summer. They have juggled additional workloads and requests, all while making sure the District adequately serves its community. While they may not be as visible to patients, they are critical to our team, and we thank them for their quiet strength.

Moments we will remember always

March 16, 2020: The Rural Health Clinic team launched drive-in coronavirus testing well before some larger, urban hospitals did. The move was based on when the RHC offered drive-in flu shots more than a decade ago. The testing site continues to see patients, as does an expanded laboratory site at the hospital's Main Lobby.

The first nurse at Northern Inyo Hospital to receive the COVID-19 vaccine, administered by Chief Nursing Officer Allison Partridge.

June 26, 2020: NIHD began offering COVID antibody testing for essential workers. This was part of an ongoing effort with state and county officials to increase local testing services.

August 3, 2020: Mandatory COVID-19 screenings began at NIHD. This means all non-emergent patients and visitors, and staff must undergo a quick temperature check and answer some health questions to enter any NIHD facility. The screening effort continues today.

December 11, 2020: Experiencing a sharp post-Thanksgiving surge in COVID patients in its Emergency Department, NIHD and its trusted regional partners united in warning residents of limited resources and asked residents to help us help those in need by not ignoring or discounting precautions.

December 18, 2020: The long-awaited PfizerNBiotech COVID-19 vaccine arrived at NIHD, signaling a possible moment of change in the pandemic's outcome.

December 19, 2020: NIHD RN Cameron Winston received the first of his two doses of the Pfizer vaccination from CNO Allison Partridge. Cameron made District history. The emotional moment marked the beginning of Inyo's effort to vaccinate healthcare workers and first responders. Nursing leadership takes on the task of vaccinating this group for several weeks.

December 22, 2020: The first box of 100 doses of Moderna vaccine arrived, expanding the amount of vaccine available in Inyo County.

Respiratory Therapist Casey Solomon prepares a ventilator for possible use. Photo by David Calvert

Wayne Martin, the first person over 65 at Northern Inyo Hospital to receive the COVID-19 vaccine. Dr. Stacey Brown administered the shot. Photo by Barbara Laughon

January 13, 2020: NIHD began vaccinating Inyo and Mono residents age 75 and older by appointment. The rush to call for an appointment resulted in NIHD's phone system's crashing after receiving a peak of 801 calls in one minute. In all, the District received more than 10,000 calls to the vaccine hotline on that first day. This move transitioned Inyo County to the first phase of immunizing the general public against the coronavirus. Wayne Martin of Bishop became the first member of the general public to receive the vaccine given by Dr. Stacey Brown.

Critical Contributions from our Community

March saw the launch of Project Cover-up, led by retired surgical nurse Barbara Stuhaan. The effort united dozens of local seamstresses who produced hundreds of cloth masks for the District and all healthcare facilities across the region. They also made masks for essential businesses such as grocery stores and post offices. Literally, if someone needed a mask, Project Cover-up was there.

March also saw community members begin to donate personal protective equipment to area healthcare facilities. In proper philanthropic form, most wanted no recognition; they just wanted healthcare workers to be safe.

In September, The Northern Inyo Hospital Foundation purchased the Clorox Total 360 electrostatic spray cleaning system, bringing the latest technology in disinfecting patient care areas to the District. In use, the system discharges a finely dispersed disinfecting and sanitizing solution with an electrostatic force that easily overcomes gravity. This allows the device to cover and clean out of sight surfaces and other areas that mopping and traditional sprays and foggers cannot reach and in less time.

Many residents and business owners willingly donated lunches and breakfasts to NIHD team members throughout the months as a sign of their support. The District is grateful for these gestures and will remember them always. ■

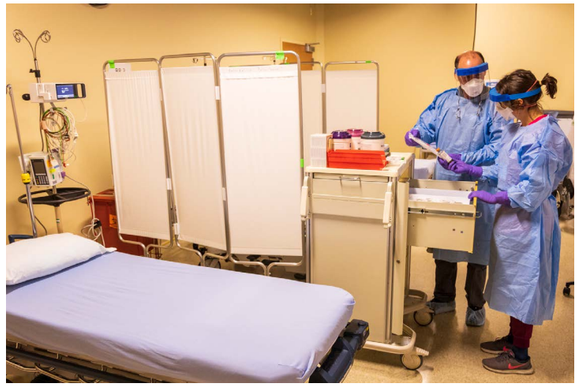
Jack In The Box restaurant provided Breakfast Jacks and wedge potatoes to Northern Inyo Healthcare District's front line staff. Hamid Sharafatian, president of Envision Foods, LLC, of Jack In The Box restaurants, shown far left, said it was important to the local JITB store to recognize all the staff members for their dedication and commitment to the community and their profession. "This crisis has impacted our everyday life and your commitment to the community is truly admirable," Sharafatian told the staff. Also on hand for the delivery was Hector Ramierez, JITB Regional Manager, second from left; and José Juan Torres, manager of the Bishop JITB, far right. Accepting the gift were NIHD Dietary Team members Chris Gaskill and Asia Gonzales, and Director of Clinical Nutrition Services Denice Hynd. Sharafatian and Ramierez drove up from Los Angeles to personally make the presentation. Photo by Barbara Laughon

> *"This crisis has impacted our everyday life and your commitment to the community is truly admirable."*
>
> *-Hamid Sharafatian, president of Envision Foods*

Manny Singh, owner and operator of Bishop's Subway restaurant, recently expressed his gratitude for the efforts put forth by frontline healthcare workers during the COVID-19 pandemic by providing lunch for several departments at Northern Inyo Healthcare District. Singh and Estera Granados, far right, delivered the fresh and tasty sandwiches to NIHD's Main Lobby, where NIHD team members John Harmon, Brooklyn Burley and Justin Nott warmly greeted them. Photo by Barbara Laughon

Northern Inyo Healthcare District is proud to show its support for its colleagues who remain on the front lines at Bishop Care Center. NIHD's Dietary Team recently baked up a storm and put together 100 care packages for those dealing with the realities of COVID-19. Cookies, breads, and pastries along with a note of thanks represent the compassion NIHD team members have for the BCC team. Here, BCC's Teresa Puckett accepts these yummy goodies from Denice Hynd, NIHD's Director of Clinical Nutrition. Photo by Barbara Laughon

NIHD Nursing Care team members Natalie Leroux-Lindsey and Andrew Stevens show the entrance to the overflow area for potential COVID-19 patients. The area outside the special treatment room is sealed off with protective plastic. Medical staff have to enter the area via a zippered curtain wall. Photo by Barbara Laughon



NIHD Nursing Care team members Andrew Stevens, RN MSN-MHA CEN, left, and Natalie Leroux-Lindsey, CNA, work to prepare the Emergency Room's overflow area for potential COVID-19 patients. Photo by Barbara Laughon

NIHD's Respiratory Practitioners Casey Solomon, Austin Archer, and Kevin Lolie show their appreciation for the support the community has shown Northern Inyo Healthcare District during the coronavirus pandemic. Photo by Barbara Laughon

QUALITY

The Northern Inyo Healthcare (NIHD) Infection Prevention program's role is to ensure that the organization has a functioning, collaborative process to minimize the risks of endemic and epidemic Healthcare-Associated Infections (HAI's). NIHD works to optimize the use of resources through a robust preventive program utilizing evidence-based practices and principles. The continuously developing Infection Control Program is part of NIHD's ongoing commitment to providing high-quality healthcare. Through the Infection Control Program, NIHD systematically involves each team member to maintain a safe environment for our patients, visitors, team members, and healthcare providers. Infection Prevention and Control measures prevent or stop infection spread in healthcare settings. There are several targeted areas that the Infection Prevention team concentrates on to reduce HAI's.

- Hand hygiene
- Prevention of Antimicrobial Resistance
- Infection Control Risk Assessment (ICRA) Relating to Construction and Renovation
- Safe Injection Practices
- Targeted Prevention of HAI's
  - Catheter-Associated Urinary Tract Infection (CAUTI's)
  - Central Line-Associated Bloodstream Infection (CLABSI)
  - Surgical Site Infections (SSI)
  - Ventilator-Associated Events (VAE)
  - Multi-Drug Resistant Organisms (MDRO)
- Response to emerging diseases such as COVID-19 and Ebola
- Prevention of Blood-Borne Pathogens Exposures
- Implementation and Education on Standard and Transmission-Based Precautions
- Healthcare Workers Influenza Vaccination Program

The Infection Prevention Program incorporates the following on an ongoing basis to target the above areas:

- Surveillance, prevention, and control of infection throughout the organization.
- Develop alternative techniques to address real and potential exposure.
- Select and implement the best techniques to minimize adverse outcomes.
- Evaluate and monitor the results and revise techniques as needed.
- Administrative support to ensure adherence to the program standards.
- NIHD ensures that all team members are effectively trained and educated on infection control issues and procedures through orientation and an ongoing continuing education program.
- Outbreak investigations

Committees: The Infection Prevention Committee meets quarterly utilizing a multi-disciplinary team approach. Infection Preventionist leads Sharps Injury Prevention Committee, attends Antimicrobial Stewardship, Surgery, Sterile Processing, Transfusion, Anesthesia (SSTA), Safety Committee, and any ad hoc meeting relating to Infection Prevention.

Monitoring: Monitoring and evaluation of key performance aspects of infection control surveillance and management include the following:

- Device-related infections.
- Multi-Drug Resistant Organisms.
- Tuberculosis: Suspected or confirmed in patients and staff
- Occupational Exposure to Bloodborne Pathogens
- Other Communicable diseases
- Employee Health trends
- Surgical Site Infections
- Construction and renovation activities

HAI'S & HAND HYGIENE DATA REPORTED WITHIN PILLARS EXCELLENCE FY 2020

			J-S	O-D	J-M	A-J	YTD
Indicator	Baseline	Goal	Q1	Q2	Q3	Q4	YTD
The number of CLABSI Reported to National Health & Safety Network NHSN	1	0	0 47 days	0 48	0 27	0 37	0 159
The number of positive C-diff Infections reported to NHSN that are Hospital Onset (HO) versus Community Onset (CO) (patient days IP-NB patient days)	12 CO 2 HO	8 CO 1 HO	3 CO 2 HO HO > 6 day stay 797	4 (CO) 1 (HO) 809 HO at day 4	1 (CO) 1 (HO) 750 days See note	0 676 1 CO 1 HO >5 day	8 (CO) 5 (HO) 2423
The number Surgical Site Infections (SSI)	0.5%	0.3%	0 362 Surgeries	1SIP 353 See note	Organ space Surg Jan (amp) 298	Organ space Cyst 177 surgery internal	3 1190
The Number of Catheter Associated UTI's (CAUTI's) AND Non-Catheter reported to NHSN	0	0	0 125	0 127	0 92	0 111	0 455
Quality							
Hand Hygiene compliance per W.H.O guidelines N= Compliant D =Observed	N) 1268 (D) 1286 98%	99%	(N) 222 (D) 222 100%	N (100) D (100) 100%	N(282) D (292) 96.5	(N) 43 (D) 46 93%	(N) 647 (D) 660 98%

INFECTION PREVENTION ACTIVITIES TO HELP PREVENT HAI'S PER THE NATIONAL PATIENT SAFETY GOALS (NPSG)

Catheter-Associated UTI (CAUTI) NPSG 07.06.01

- Implement evidenced-based approach to urinary catheter use, insertion and maintenance.
- Insert indwelling urinary catheters according to established evidence-based guidelines for catheter necessity. Indwelling catheters should not be used for the convenience of healthcare workers.
- Strict aseptic technique must be maintained during catheterization.
- Hand Hygiene before urinary catheter insertion or maintenance
- Provide routine perineal care
- Catheter necessity will be evaluated daily with the physicians. Catheters should be removed as soon as medically possible if situation does not meet the established NIHD guidelines for catheter necessity.
- Use Securing device to prevent possible tension, and prevent obstruction of urinary flow
- A closed drainage system must be maintained. Replace the catheter and drainage system if system integrity is compromised.
- When obtaining urine sample thoroughly disinfect needless sampling port with disinfectant wipe.
- Provide patient education on Catheter -Associated Urinary Tract Infections
- Upon hire and annual hands-on education
- Provider onboarding Education for CAUTI reduction strategies

Central Line-Associated Bloodstream Infection (CLABSI) NPSG 07.04.01

- Insert Central Line according to established evidenced-based guidelines
- Ensure adherence to aseptic technique and document on Central Line Insertion Practice Checklist (CLIP)
- Daily review for Central Line Necessity
- Hand Hygiene before any manipulation of Central Line
- Disinfect catheter hubs, needleless connectors, and injection ports before accessing the catheter
- Place a disinfectant-containing cap on end of needless connecter
- Perform dressing changes according to policy using dressing kit, bio-patch, and stabilizing device
- Provide patient education on Central Line-Associated Bloodstream Infections
- Upon hire and annual hands-on education
- Provider onboarding education on infection reduction strategies

Surgical Site Infection (SSI) NPSG07.05.01

- Surgical Hand Scrub with antiseptic agent just prior to surgery.
- Hand Hygiene before and after caring for each patient
- Hair removal if indicated prior to surgical procedure
- Appropriate Surgical attire
- Surgical patients receive prophylactic antibiotics consistent with current guidelines (specific to each type of surgical procedure).
- Administer Antibiotics within one hour to surgical incision
- Prep surgical area with approved cleaning and disinfecting agent
- Provide patient education Surgical Site Infections
- Provider onboarding education on infection reduction strategies

Multi-Drug Resistant Organisms (MDRO) NPSG 07.03.01

- MRSA Surveillance on all inpatients
- Alert placed on patient if history and/or confirmed MDRO and placed on patient Reported Problems
- Transmission Based Precautions
- Hand Hygiene
- Personal Protective Equipment
- Environmental Cleaning (patient rooms and patient care equipment)
- Access to CDC link “Type and duration of precautions recommended for selected infections and conditions Appendix A1” and Lippincott Procedures Airborne, Contact and Droplet precautions,
- Active and Post-discharge surveillance by Infection Prevention
- Provide patient education on MDRO
- Upon Hire and annual training
- Provider onboarding Education

Ventilator-Associated Event (VAE)

- Peptic Ulcer Prophylaxis
- DVT Prophylaxis
- Daily sedative interruption and extubation readiness assessment
- HOB at 30-45 degrees
- Oral Care Q4 hours and twice daily Oral Chlorhexidine mouth rinse
- Provide patient education on Ventilator-Associated Pneumonia
- Upon hire and annual education to ICU and Respiratory Therapy Staff

Hand Hygiene

- Follow World Health Organization (WHO) guidelines “5 Moment of Hand Hygiene”
- Upon Hire and annual education to all staff
- Hand Hygiene observations
- Slogan to remind staff “HIGH FIVE”
- Nursing and EVS staff direct observance hand hygiene with glow system
- Staff providing direct patient care are not allowed to have fake fingernails or chipped polish.
- Surgical Hand Antisepsis
- Use hospital approved lotion after hand hygiene to prevent and decrease skin dryness and skin cracks.

NIHD District COVID-19 Response:

In December 2019, an emerging virus was identified in Wuhan, China resulting in a global pandemic. This is the first pandemic that NIHD has had to prepare for since Ebola. The pandemic development led to a rapidly changing and evolving group of regulatory guidelines that were challenging to implement and have impacted everyday healthcare delivery at NIHD and across the world. NIHD COVID-19 preparedness started in January 2020 as a multi-disciplinary approach that concentrated on policies and procedures, cleaning and disinfecting, supply chain, and creating the Healthcare Facility Preparedness Checklist Tool. Along with other organizations, NIHD had difficulty obtaining supplies. We worked with local and national organizations and benefitted from community donors' generosity to ensure our staff are protected and can deliver safe care to our patients. NIHD continues to monitor regulatory guidance, which rapidly evolves, creates workflows for all areas of the district, and opens an Incident Command Center. NIHD Infection Prevention, leadership, and staff have worked with community organizations, Inyo County Health Department, first responders, and Inyo County Emergency Management Teams to support safe patient care delivery across the Eastern Sierra region. This teamwork has created a trusting partnership with these organizations and the community.

Summary:

The Infection Prevention Program is a top priority for NIHD's patients, visitors, staff, and community. Avoidable infections can be devastating for patients and their families and have financial implications for the organization. This report describes Infection Prevention’s activities to improve and sustain patient, visitor, and staff safety across NIHD. Infection Prevention is continuously striving to improve evidence-based practices and keeping our patients as safe as possible and protected from avoidable infections. I take great pride in NIHD and the staff members in their role and dedication in preventing infections and ensuring patient safety. NIHD has a new staff member in the role of Infection Prevention, Jennifer Yednock. Jennifer, Marcia Male Employee Health Specialist, and I will be working closely together in the upcoming year on identified key challenges, risks, and a continuous improvement plan. Employee Health and Infection Prevention work together to put in place safeguards for staff and patients alike.

Key achievements this year:

- District-wide collaborative work with COVID-19 response and surge mitigation plan
- Healthcare worker Influenza vaccination rates for 2019-2020 season 98% compliance
- Reduction in Bloodborne Pathogen exposures
- Increase in compliance in annual fit testing rates
- Zero device-associated infections (CAUTI, CLABSI, VAP)
- Safe Injection Tracers
- Antimicrobial Stewardship program increase participation with providers and staff and updated plan and activities

Key Challenges and Risks include:

- COVID-19
- Clostridium difficile (C-diff) infection rates increased
- Decrease in hand hygiene observations
- Water Management Plan
- Infection Prevention Unit Rounding
- Other Infection Prevention tracing activities
- Compliance with Infection Prevention documentation to prevent HAI’s
- Training of new Infection Preventionist

This report was compiled and prepared by: Robin Christensen DON Infection Prevention/Quality 9/16/2020.

CLOROX TOTAL 360 ELECTROSTATIC SPRAYER

In this extraordinary time of the COVID-19 pandemic, the Northern Inyo Healthcare District extends its gratitude to the Northern Inyo Hospital Foundation for once again helping to deliver the highest quality of patient care

Environmental Services Coordinator Andrea Daniels demonstrates the use of the new Clorox Total 360 System in an unoccupied patient room at Northern Inyo Hospital. The system she is using was donated by the NIH Foundation. Such gifts are made possible through public donations to the Foundation. Photo by David Calvert

Environmental Services Coordinator Andrea Daniels dons protective gear before using the new Clorox Total 360 System in an unoccupied patient room at Northern Inyo Hospital. The system she is using was donated by the NIH Foundation. Such gifts are made possible through public donations to the Foundation. Photo by David Calvert

thanks to a recent donation. The NIH Foundation recently purchased the Clorox Total 360 electrostatic spray cleaning system, bringing the latest technology in disinfecting patient care areas to the District.

Clearly, these days, keeping the District safe for anyone coming in – patients, visitors, and District staff – is the most essential thing NIHD's Environmental Services team can do.

"We take this seriously," says ES Manager Richard Miears. "It's something we've always taken seriously. We've never had to dramatically adjust our approach in the past seven years that I've been with the District because our cleaning standards were so high to start with. State and national regulations require it, and our team and community expect it. Our job is to deliver it every day."

Miears talks proudly of how low NIH's post-surgical infection rate is, how it's the lowest in the region, and how long it's been so low. He sees that success as a long-term team effort between the Surgical staff and the ES team. "And with COVID, it's been no different," he says. "The Nursing team does a phenomenal job of communicating the needs with us, then we take it from there."

Andrea Daniels is one of three staff coordinators working with Miears to oversee the ES team's day-to-day operations. She was tasked with learning the Clorox Total 360 system inside and out, then training the rest of the ES team. Her first reaction?

"It's a game-changer for us," Daniels says. "First and foremost, it kills coronavirus and things like MRSA in just two minutes. Then the way it is applied saves us quite a bit of cleaning time. Plus, we're able to turn rooms around faster – something that could make a huge difference in case we should experience a COVID surge."

Preparing to demonstrate the system in an empty patient room, Daniels dons protective gear, everything from a fluid-resistant gown to gloves, an N95 mask, and protective goggles. Having already removed dust and particles from flat surfaces with a microfiber cloth, Daniels crouches down and perfectly aligns the sprayer nozzle with the chemical hose. Switching the system on, she raises up and only has to wait for just a second or two before a fine mist emits from the sprayer.

Carefully aiming the nozzle, Daniels makes sure the spray path overlaps but doesn't soak the ceiling, walls, furniture, or equipment. "A little bit goes a long way," she says over her shoulder, her movements resembling that of a painter. "Before, just washing down the ceiling and walls with a mop could take 45 minutes to an hour, and the repetitious moves were daunting."

Clorox says the key to the Total 360 system is charging the finely dispersed disinfecting and sanitizing solutions with an electrostatic force that easily overcomes gravity. This allows the device to cover and clean out of sight surfaces and other areas that mopping and traditional sprays and foggers cannot reach. Comparing the system to conventional methods, Clorox says the system is four times faster, uses 65 percent less solution, and can cover an impressive 18,000 square feet an hour.

When Daniels completes her demonstration, District staff edge forward to watch the chemical cling, disinfect, then quickly dissipate by drying into the atmosphere. A slight chemical smell wafts in the air but just for a second. The audible level of positive murmurs in the room reveals the staff is impressed. Daniels is clearly happy as her face shows signs of a smile beneath her mask.

"We can't begin to thank the NIH Foundation for what they've done for us," Miears says. "The number of contact rooms our ES staff had to clean since the start of COVID has been overwhelming. Not only does the new system cut cleaning times and stress in half, but it also helps us boost our infection control efficiency. This is win-win not only for us but for our staff and our patients." ■

NIH FOUNDATION

Ann Wagoner
Director of Nursing,
Perioperative Services

PERIOPERATIVE

Northern Inyo Hospital's Perioperative team is responsible for evaluating and preparing all patients scheduled for surgery at the District. The team also includes several treatment areas that most people would not realize are connected to Perioperative.

INFUSION

The Outpatient Infusion patients are currently cared for in the Preoperative / Post-Acute Care Unit while the Infusion Unit is temporarily closed for a Pharmacy remodel. The Outpatient Nursing Unit is staffed daily by the OP/PACU Registered Nurses and an outpatient clerk.
Generally, there are two registered nurses Monday through Friday to care for the outpatients - based on the number of patients scheduled.

All nursing staff administering chemotherapy have completed the Oncology Nursing Society "Chemotherapy and Biotherapy Administration" training.

Our mission is to provide this specialty care to patients of all ages in our community, eliminating the need for driving hundreds of miles to receive needed treatments. Our Infusion team offers service five days a week, Monday through Friday, 8 a.m. to 4 p.m. Appointments are coordinated once the clerk gets the orders, obtains insurance authorization, and ensures the pharmacy has the needed medications. We keep the patient's primary care provider apprised of any complications or further needs. Patients whose acuity exceeds the Outpatient Nursing Unit's scope of care will be transferred to the NIH emergency department either by wheelchair or gurney.

The types of infusions and procedures scheduled are:

- Chemotherapy to treat cancer,
- Biological infusions to treat cancer or some autoimmune diseases,
- Blood transfusions,
- Iron therapy for anemia,
- Antibiotics to treat infections,
- Infusions/injections to treat osteoporosis (Prolia)
- Injections – rabies vaccinations, Rhogam injections,
- Urinary catheter changes,
- Therapeutic phlebotomies,
- Sedation for interventional radiology procedures,
- Bubble study tests (in EKG),
- Argon laser treatments (ophthalmologic), and
- Wound Care such as wound vacuums, Wet-to-dry and packing, Unna wraps, debridement (MD)

STERILE PROCESSING

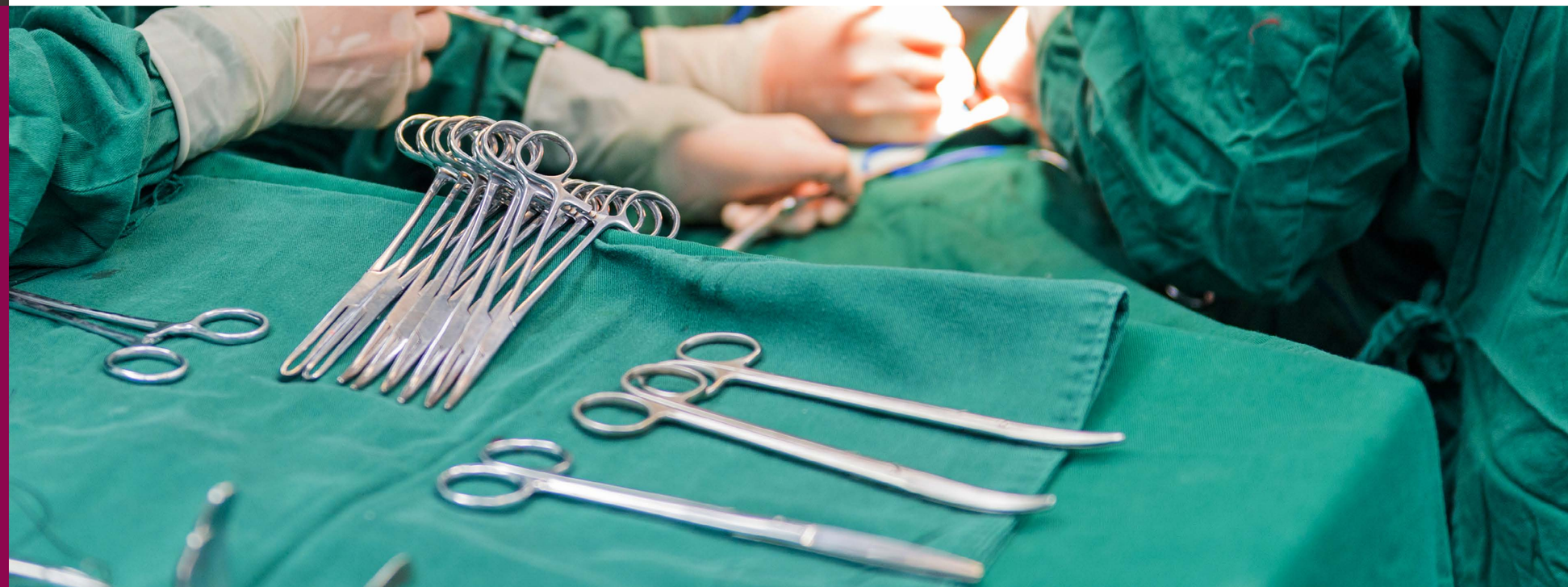
Sterile Processing is vital for any hospital that has a Surgery department.

We have well-trained, knowledgeable Sterile Processing staff members that ensure all instruments and equipment needed for a sterile procedure such as surgery have been decontaminated and sterilized. This is one reason why the surgical infection rate at Northern Inyo Hospital is almost zero.

The Surgery Techs take the instruments and equipment out of the Surgery Suite once the surgery is finished and deliver it to the Sterile Processing staff in the Decontamination Room. There, the team performs initial rinsing and flushing and general initial cleaning.

Next, the instruments and trays go through the Washer/ Decontaminator so the instruments can be inspected for cleanliness and placed in designated trays or special "peel packs." The instruments are then placed in an autoclave for high-temperature vacuum and steam sterilizers for the result: sterile instruments/equipment. The staff operates two large autoclaves in the Sterile Processing unit and two smaller autoclaves located closer to the surgery suites. The Sterile Processing staff cleans the colonoscopies and upper GI Scopes by leak-testing them first, flushing all channels, and sterilizing them in a Steris System1E – which is a machine specifically designed to clean the inside of scopes. There are three System1Es, one in Sterile Processing, and one close to each of the surgery suites. The Sterile Processing team uses the VPro-Max – a sterilizer that uses hydrogen peroxide to sterilize camera heads and other delicate equipment that require sterilization at low temperatures. The Sterile Processing staff starts each day checking the sterilizing equipment and running tests to ensure the machines are functioning correctly.

They keep the records that indicate proper function for each completed autoclave load and document the initial daily check of the VPro-Max and System1E as well. The Sterile Processing staff make rounds to pick up used instruments from the clinics and other departments (nursing units, Diagnostic Imaging, Rehabilitation), assuring these areas have sterile instruments for procedures. Recently, the Sterile Processing staff began reprocessing used N95 masks using the VPro-Max so staff will have adequate Personal Protective Equipment – even if it becomes difficult to purchase new masks in the future. ■



CLINICS

Rural Health Clinic
The Rural Health Clinic (RHC) at Northern Inyo Healthcare District offers comprehensive primary care services to patients of all ages. Our team of 15 highly-experienced providers include Physicians, Nurse Practitioners, and Physician Assistants. In addition to Family Medicine, the RHC offers a Same Day Care service line designed to meet your urgent healthcare needs. Our Primary Care Providers perform a variety of in-office procedures, including skin biopsies, vasectomy, circumcision, and joint injections.

Patients desiring help with substance use disorder are encouraged to contact the RHC and speak with someone about our Medication-Assisted Treatment (MAT) program. Our Care Coordination Team, including our Recovery Support Navigator is committed to helping patients overcome challenges with addiction. Our MAT program offers a patient-centered approach, including individual and family support.

Rural Health Women's Clinic
The Rural Health Women's Clinic offers full-scope obstetrical and gynecological care. Our care team includes physicians board-certified in Obstetrics and Gynecology, in addition to a Certified Nurse Midwife and Physician Assistant. We offer compassionate care to women of all ages, and our services include prenatal care, contraception, annual well-woman exams, and gynecology consultations. Our surgeons are skilled in full-range gynecology surgical services and offer minimally invasive surgery (da Vinci robotic surgeries).

Northern Inyo Associates Surgery Clinic
At Northern Inyo Healthcare District, we offer a wide variety of elective and emergency surgical procedures, including minimally invasive procedures using the state-of-the-art da Vinci Robotic Surgery System. We have a team of surgeons that offer open surgery, laparoscopic surgery, and Robot-assisted surgery. Some of the procedures we perform include upper and lower endoscopies (EGD and colonoscopy), hernia repair, gallbladder removal, and evaluation and treatment of hemorrhoids and diverticulitis. Our Surgery Clinic team also includes a physician skilled in breast care, including breast cancer surgery.

Northern Inyo Associates Pediatrics and Allergy
Our team of compassionate and experienced providers partner with families to promote a healthy lifestyle for children, in hopes of helping them achieve their greatest potential. Northern Inyo Healthcare District's Pediatric Clinic includes physicians and nurse practitioners who offer preventative care from newborn through age 18; evaluation and treatment of pediatric patients with acute illness; and management and care coordination for patients with chronic medical conditions. Our services include well-child checks, walk-in immunizations, sports physicals, and allergy testing for environmental and food allergies (adults and pediatrics). Our pediatricians also care for infants and children who are admitted to Northern Inyo Hospital.

Northern Inyo Associates Orthopedic Clinic
As a multi-specialty Orthopedic clinic in the Eastern Sierra, we take pride in our comprehensive approach to treating the whole person- not just the injury or ailment. Our ultimate goal is to restore your mobility, minimize pain, and improve your quality of life. Our orthopedists are skilled and experienced surgeons prepared to operate when necessary but always explore less invasive treatments first. We collaborate with physical and occupational therapists to connect patients with the resources they need for holistic healing. Our specialties include sports medicine, arthroscopy, joint reconstruction, joint replacement, and trauma/fracture care.

Northern Inyo Associates Internal Medicine
Our goal is to provide outstanding care to adult patients in the Eastern Sierra region. Internists are primary care providers who specialize in the diagnosis and treatment of adult health conditions. We offer medication management and specialist care coordination; preventative care including vaccination and cancer screening; evaluation and treatment of memory loss; same day or next day visits for acute health problems; and nursing home care at the Bishop Care Center.

Northern Inyo Associates Specialty Clinic
At NIHD's Specialty Clinic, we offer comprehensive urology services. Our urologists treat such conditions as enlarged prostate, bladder and kidney stones, incontinence, erectile dysfunction, and bladder and kidney cancers. Specializing in minimally-invasive and robotic surgery, the urologists are skilled in progressive surgical techniques. We can perform some in-office urology procedures, including cystoscopy.

Coming soon to NIA Specialty Clinic: plastic and reconstructive surgery and pain management! ■

RHC Physician Uttma Sharma, MD. Photo by David Calvert

PERINATAL-GNOSIS PROGRAM

MATERNAL HEMORRHAGE, INFUSION, STERILE PROCESSING

As a critical access hospital in a rural setting, it is vital to our community that we ensure our Perinatal Healthcare Team provides excellence in care with a focus on patient safety.

The Perinatal Team partnered with a Multidisciplinary Team to use simulation and drills to prepare for complex patient care situations. This includes the following simulations/drills:

- Emergency Cesarean section
- Neonatal Resuscitation
- Maternal Hemorrhage
- Pre-eclampsia/Eclampsia
- Shoulder Dystocia

The Perinatal Department at Northern Inyo Healthcare District also uses a comprehensive educational platform, GNOSIS. Through the GNOSIS platform, our Perinatal Team completes an annual evaluation of clinical proficiencies. With GNOSIS and our simulation/drill program, our Perinatal Team has received recognition from Beta Healthcare in achieving Excellence in OB, which demonstrates our hospital's attention to Perinatal Safety.

During this last year, the Perinatal Team has also focused on enhanced recovery after Cesarean sections. Our hospital recognizes the importance of providing evidence-based, patient-centered care by incorporating a standardized, multidisciplinary approach aimed to optimize recovery from Cesarean delivery and improve maternal and newborn outcomes.

All of this focused training and preparation came together when our team delivered a 26-week gestational infant via emergency Cesarean section in July. This infant was transferred to a higher level of care on his first day of life and continues to amaze his parents and his healthcare team with his growth and development. Our overall preparedness provided the foundation upon which could achieve a positive outcome for the mother and baby.

Acute/Subacute and ICU

Early mobility for trauma patients has been shown to reduce pain and the need for pain medications, reduce ICU-related complications such as hospitalization-associated delirium and skin breakdown. For those on ventilators, it has been shown to reduce the occurrence of ventilator-associated pneumonia and reduce the time required to be on a ventilator. It ultimately has been shown to speed up recovery and reduce the length of hospitalization.

At NIHD, we are developing an early mobility program to ensure that the proven principles of early mobility are being implemented with our patients. This program begins with a safety screening to ensure that patients are appropriate candidates to start our early mobility program. Our program progresses through four different levels, with each level building on the previous one. Each level has different goals that must be met to progress to the next level and criteria that indicate if the patient should stay at their current level. This ensures that the patient safely progresses through the different levels of mobility.

Recently NIHD began utilizing midlines for Intravenous Access. Midlines have a lower infection rate and are less invasive and less expensive than PICC lines. Midlines do not require a chest x-ray and can be used for up to 28 days for a broad range of infusion therapies.

We continue to focus on listening to our patient feedback and acting on the information we receive. Press Ganey scores are reviewed, evaluated, and distributed monthly on Acute/Subacute unit and in the ICU. One example is that we have put a considerable amount of work into improving the Acute/Subacute unit's noise levels. We have replaced the casters on the majority of the vitals machines, which were previously very noisy. We also ordered earplugs and eye masks to help patients sleep and block out the unit's light and noise. We have had the doors adjusted to prevent them from slamming, and have changed the timing of our negative pressure room test alarm from 10 PM to during daytime hours. We have also placed a machine at the nurse's station that tracks environmental noise and can be set to a certain decibels level. A red light lights up if the noise goes above a certain decibel, alerting staff that the unit is getting too noisy. These efforts have allowed us to bring our noise scores from the lowest in all of our Press Ganey categories to our most recent scores of 95 percent of our patients saying it is always or usually quiet on the Acute/Subacute unit. This is one example of multiple initiatives that we have undertaken to ensure that patients have the best experience possible when admitted to the Acute/Subacute unit.

We have also recently begun training NIHD RNs to insert ultrasound-guided IVs. This has given RNs another tool to ensure that patients are not poked more than necessary to gain IV access. Currently, close to 13 NIHD RNs have been trained to insert ultrasound-guided peripheral IVs.

Staff development

Developed a program to train ICU staff by utilizing online learning and collaborating with larger facilities to provide consistent training with high acuity patients.

Emergency Department

In the Emergency Department, physicians and nurses encounter a broad range of problems, often with atypical presentations in a fast-paced and dynamic environment. This can create a high-risk environment and result in failed or delayed diagnosis, assessment, and breakdown in communication.

GNOSIS for Emergency Medicine is a tool utilized by both NIHD emergency physicians and nurses to help improve patient care and work cohesively as a team. Educational courses such as High-Risk Chest Pain, High-Risk Abdominal and Pelvic Pain, Communication in the ED, Nursing Triage in the ED and Pediatric Fever without a Source, are focused on the highest areas of risk in the ED. The evidence-based content ensures that ED teams are using commonly understood protocols and language to minimize misunderstandings and errors.

GNOSIS education:

- Assists in assessing individual and team clinical proficiency and provides insights into the team's knowledge and judgment in high-risk areas of patient care.
- It equips hospital leaders with data to proactively identify and invest in areas that will improve quality and patient safety.

The Emergency Department at NIHD is a proud participant in the National Pediatric Readiness Project (NPRP). The NPRP is an on-going quality improvement initiative, co-led by the Health Resources Services Administration's (HRSA) Emergency Medical Services for Children (EMSC) Program, the American Academy of Pediatrics, the American College of Emergency Physicians and the Emergency Nurses Association. The NPRP aims to ensure that all US emergency departments have the essential resources, guidelines, and protocols in place to provide high quality, effective emergency care to children.

As part of the NPRP, NIHD ED focused on several areas:

- A Physician Coordinator who is a Board Certified Emergency Physician for Pediatric Emergency Care (PECC) and Nurse Coordinator for pediatric emergency care (PECC) who is a Certified Emergency Nurse (CEN) were designated.
- Demonstration and maintenance of pediatric clinical competencies by staff and providers were achieved through continuing education and PALS certification.
- The Quality Improvement and Performance Improvement Plan (QI/PI plan) for the ED was updated to include pediatric-specific indicators such as pediatric weight in kilograms and double-checking of pediatric medications.
- Policies, procedures, and protocols were reviewed for the emergency care of children and revised to address age-specific health care needs.
- The Broselow cart was implemented, containing pediatric equipment, supplies, and medications that are easily accessible, labeled, and logically organized and weight based color-coded.

With GNOSIS and our Pediatric Readiness Project, NIHD has received recognition from Beta Healthcare for Excellence in ED. ■

Larry Weber, MSRS
Director of Diagnostic Services

DIAGNOSTICS

DIAGNOSTIC IMAGING TECHNOLOGY

Computed Tomography (CT) – the cornerstone of Diagnostic Imaging Services
The VCT 64 Lightspeed CT scanner at NIHD is arguably the most important piece of technology at NIHD. Although the technology is used regularly to diagnosis disease and injury for our Outpatient population, this scanner is critical to quickly diagnosing patients that present for emergency services. Our 64-slice CT scanner was the industry's first CT scanner to maintain outstanding image quality while protecting patients by reducing the patient's radiation exposure up to 70 percent. The Lightspeed VCT 64 slice covers 40 mm of patient anatomy per rotation and the 64 sub-millimeter (.625 mm) slices and fast acquisition speed gives us the ability to scan the entire length of the body in less than 10 seconds. This is critical when dealing with emergency patients who may have been involved in a motor vehicle collision or who may be demonstrating stroke like symptoms. In general, CT is ideal for neuro work, angiography, cardiac, pulmonary, and trauma. Additionally, the dose reduction software (ASIR) and low dose protocols makes it a very good option for pediatric scanning. Once our registered technologists complete the exams, the Xtream™ FX workflow solution delivers accelerated reconstruction speed and image quality allowing for more rapid and accurate interpretation and diagnosis by our radiologists.

MRI

Integral to the success of our Orthopedic Service Line
NIHD's GE Signa Excite 1.5 T MRI system is considered the workhorse MRI scanner in the industry. This model was specifically designed to produce faster scan times with a lower signal-to-noise ratio. What this means is we get higher quality images with our patients spending less time in a very confining gantry. The scanners software was recently upgraded to the most current version available and has the ability, through algorithms, to enhance image quality through fat suppression, tissue characterization, and artifact reduction. These enhancements give our Radiologists and our Orthopedic Surgeons the ability to correctly identify disease and/ or injury and to treat the patient locally. Although critical to successful orthopedic practices, the Signa Excite 1.5 Tesla MRI at NIHD is often used by other providers to image the spine, head, and neck, breast, and even abdominal imaging of the pancreas and gall bladder.

ULTRASOUND

The preferred modality for soft tissue imaging
Two highly reliable GE Logic E9 Ultrasound units support the Ultrasound Department at NIHD. The Ultrasound Department at NIHD performs 25+ scans on the average weekday. Because the modality uses sound waves and not radiation, Ultrasound is the preferred imaging technique whenever radiation must be avoided (pediatrics and obstetrics) or whenever evaluating soft tissue structures of the body, such as organs and vascular structures. Although the technology of the Logic E9 is impressive with high definition resolution transducers and improved B-flow vascular imaging, the key to our Ultrasound Department's success at NIHD is our Sonographers. In Ultrasound, the equipment in any organization is only as good as the technologist who uses it. NIHD and our community have five highly skilled Sonographers that have a combined 40+ years of experience scanning patients and have certifications to prove their expertise in Abdominal work, Vascular studies, Obstetrics, and Echo. NIHD even has one Sonographer that is a registered expert in scanning "small parts" such as glands of the head and neck.

Photo by David Calvert

Photo by David Calvert

BREAST HEALTH

From screening to Biopsy all within Diagnostic Services at NIHD

Breast Imaging within the DI department is a key component of Breast Health Services at NIHD. Our Diagnostic Imaging Department has the GE Senoclaire 3D and 2D Mammography unit to provide our community with Digital Breast Tomosynthesis imaging. This imaging technique for mammography can be described as "CT of the breast" as the imaging technique electronically "slices" the breast tissue and creates multiple images in each study. Because of this software and hardware technique, there is now less tissue included in each "sliced" image and, therefore, less opportunity for abnormal tissue to be concealed by dense normal breast tissue. After Breast Screening, if abnormalities are identified, our highly trained technologists obtain highly focused diagnostic images. These additional, highly-focused images allow our Board-Certified Radiologists to determine if the abnormality is suspicious enough to require a biopsy. If needed, NIHD can, through multiple means, biopsy a suspicious area, transfer that tissue specimen to our in-house Histology and Pathology Department.

Our Histology Department is equipped with everything needed to process and prepare breast tissue specimens and any human tissue specimen. The primary instrument used in our Histology lab is the Vacuum Infiltration Processor (or Tissue-Tek VIP). This instrument is used to remove water from cells and replace it with a medium, which solidifies, allowing thin sections to be cut. These sections are cut into slices and placed on slides that our in-house Pathologist then interprets.

The ability to go from screening mammograms to final interpretation of biopsied tissue all within our District is a significant contributor to NIHD being the healthcare leader in the Eastern Sierra.

DIAGNOSTIC CARDIOLOGY SERVICES

Basic ECG to nuclear cardiac Stress tests

An electrocardiograph (ECG) is the staple of any cardiac workup. NIHD has the ability and expertise within our Cardiopulmonary Department to accurately obtain ECG's so that our providers will immediately know of any emergent cardiac condition. Once the current cardiac state is evaluated through ECG, NIHD can complete multiple tests that provide additional diagnostic cardiac information to our local providers.

Echocardiography is the second most commonly used diagnostic test for cardiac disease. The echocardiogram is a specialized ultrasound exam used to evaluate all aspects of cardiac function. Because NIHD has the PhilipsiE33 ultrasound unit, a newly purchased and implemented transesophageal probe, and is led by a Stanford-trained Echocardiographer with almost 35 years' experience in the field, NIHD's echocardiography program provides the most complete and comprehensive echocardiograms available.

The cardiopulmonary department also has The CASE™ Exercise Testing System that is used to evaluate cardiac function during exercise. Otherwise known as a stress test, this test is a valuable tool in diagnosing early Coronary Artery Disease. When indicated, the stress test can be followed with an injection of a radiopharmaceutical.

The stressing of the heart causes the dilation of all coronary vessels, and this allows for rapid absorption of the pharmaceutical agent by the heart. After absorption is complete, the patient is imaged within our Nuclear Medicine Department.

The nuclear camera used at NIHD is specifically designed to enhance the diagnostic value of Nuclear Stress Tests. The GE Infinia Hawkeye Nuclear Medicine camera has attached to it a 4-slice CT scanner. The CT scanner attached to the nuclear camera aides in the diagnostic process by applying an attenuation correction algorithm that accounts for and corrects varying densities in the chest and upper abdomen caused by patient size and gender.

By accurately diagnosing disease and the severity of disease of the heart locally, NIHD can save cardiac patients time and money as they progress down the path of diagnosis and treatment.

Ultrasound Technologist Marci Boyd performs one of the District 25-plus scans for the week. Photo by David Calvert

LABORATORY SERVICES

Where 70 percent of clinical decisions are made

The Medical Laboratory at Northern Inyo Healthcare District delivers providers the most comprehensive information needed to accurately and efficiently diagnose many health conditions. According to the National Institute for Health, 70 percent of all clinical decisions are made as a result of lab test results. NIHD Laboratory Services include a complex combination of knowledge, abilities, and technology and compose multiple specialty areas. The specific specialties include our Chemistry section, Hematology, Coagulation and Blood Bank, Microbiology, Histology/pathology, and our Point of Care (POC) testing. Each specific area of the lab is led by a section coordinator that is responsible for ensuring that the section establishes and maintains stringent quality control measures. These quality control measures include making sure the equipment is calibrated correctly and that the staff running the tests keep competency to perform the test. The Laboratory is the only service in the hospital with a stand-alone bi-annual accreditation survey conducted by The Joint Commission. This stand-alone survey results from the many standards that must be met to maintain licensing as Medical Laboratory services.

Due to the importance of having lab results available to make clinical decisions and because of our District's remote location, NIHD has duplicated some of its equipment to continue to provide results to our providers even if we have equipment downtime. Two areas where we duplicate equipment is in our Chemistry department and our Hematology area.

The Cell-Dyn Ruby is a hematology analyzer that measures and analyzes red and white blood cells and platelets in whole blood. A Complete Blood Count (CBC) is one of the most common tests that is used to determine patient health. The information extrapolated from a CBC will let the physician know whether the patient is typical, anemic, or if there is additional testing that needs to be done due to immature cells in any of the cell lines. The analyzer's WBC count function helps diagnose infection, inflammation, and other malignant diseases of the blood. Utilizing just the hemogram, a physician can determine if the patient needs a blood transfusion. NIHD performs approximately 80 CBCs a day. At NIHD, we have two Ruby analyzers so that there is no interruption in patient care due to technical issues or routine maintenance.

In Chemistry, our Abbott Architect is a multi-module chemistry analyzer with a testing menu that is extensive. The most common tests processed through the Architect is a Basic or Complete Metabolic Panel (BMP/CMP), lipid panels, thyroid panels, hepatic function panels, drugs of abuse, therapeutic drug monitoring, syphilis, HIV, HCG quantitative levels, and many more. Recently our test menu has expanded, adding both procalcitonin and SARS-CoV-2 IgG antibody detection. This technology is vital in determining heart damage or a potential or extremely recent cardiac event by testing a patient's troponin levels. The clinician can utilize this information immediately to diagnose and treat the patient, potentially preventing damage or further heart damage and even saving a patient's life. The Medical Laboratory at NIHD is an integral part of the health care delivery at Northern Inyo Healthcare District.

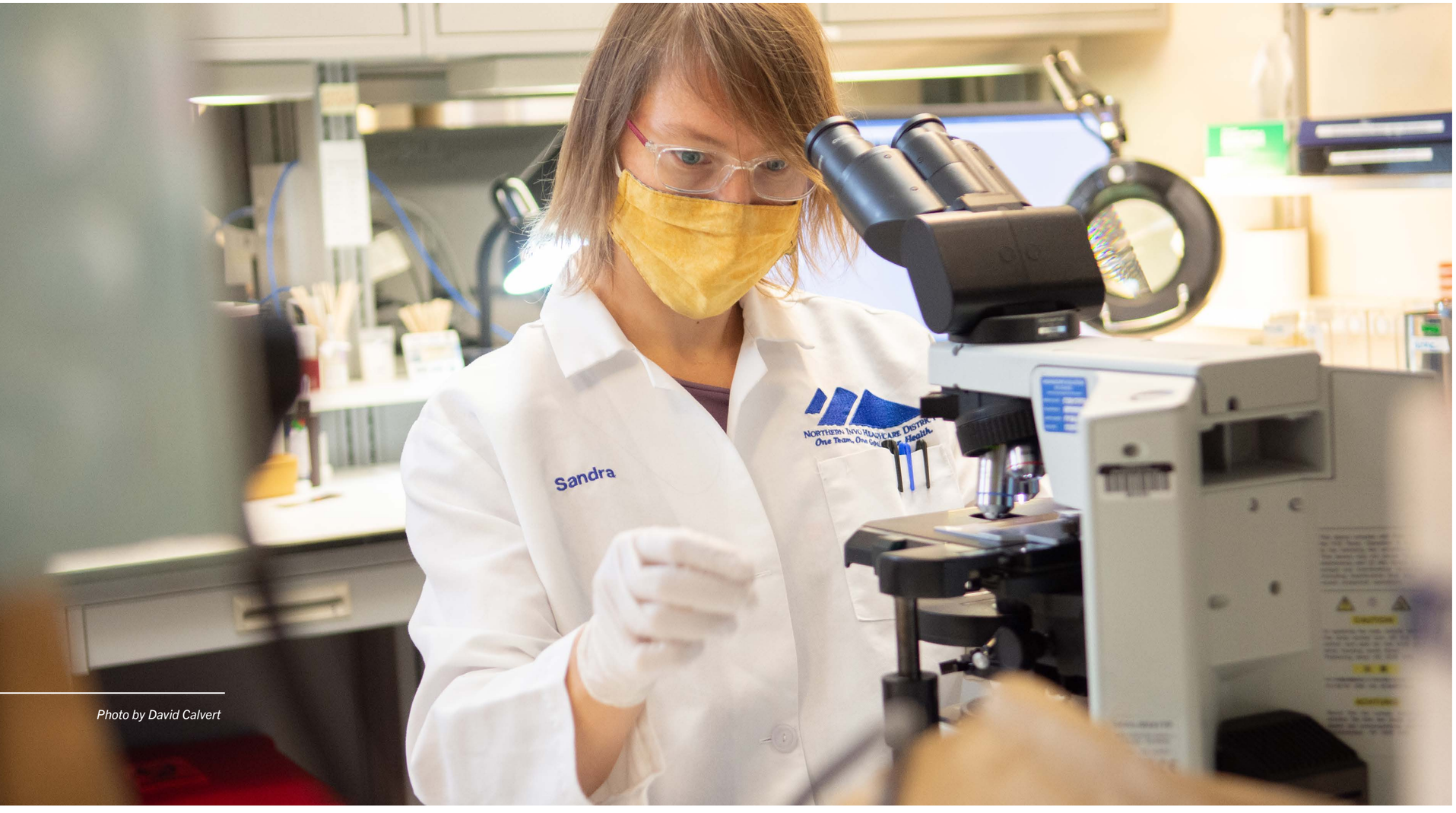


Photo by David Calvert

Morgan Scientific SpiroAir

The Morgan Scientific SpiroAir is the Gold Standard for testing a person's pulmonary function. Pulmonary function Tests (PFTs) are noninvasive tests that show how well the lungs are working. The tests measure lung volume, capacity, rates of flow, and gas exchange. Providers may order these test for patients having symptoms of lung problems, if there is exposure to certain substances in the environment or workplace, to monitor chronic lung disease, or to assess a patient's lungs before a surgery. This information can help healthcare providers here at NIHD diagnose and decide the treatment of certain lung disorders such as asthma, COPD, chronic bronchitis, lung fibrosis, and many more lung diseases.

Vacuum Infiltration Processor or Tissue-Tek VIP

Vacuum Infiltration Processor or Tissue-Tek VIP is the primary instrument used in Pathology/Histology. This device is used for the processing of human tissue specimens and is intended to facilitate the in vitro examination of tissue for morphology changes. Tissue processing is a procedure of removing water from cells and replacing it with a medium, which solidifies, allowing thin sections to be cut. Once the tissue is properly fixed with formalin, it goes through a process that involves dehydration, clearing, and infiltration. Our VIP can accommodate up to 300 tissue cassettes and offers several programmable processing options, which gives NIHD the ability to process all specimens in-house with a typical turnaround time of 24 hours. This is instrumental in providing on-site Pathology services to our community so our patients can have their procedures done in Bishop as opposed to driving to Reno.

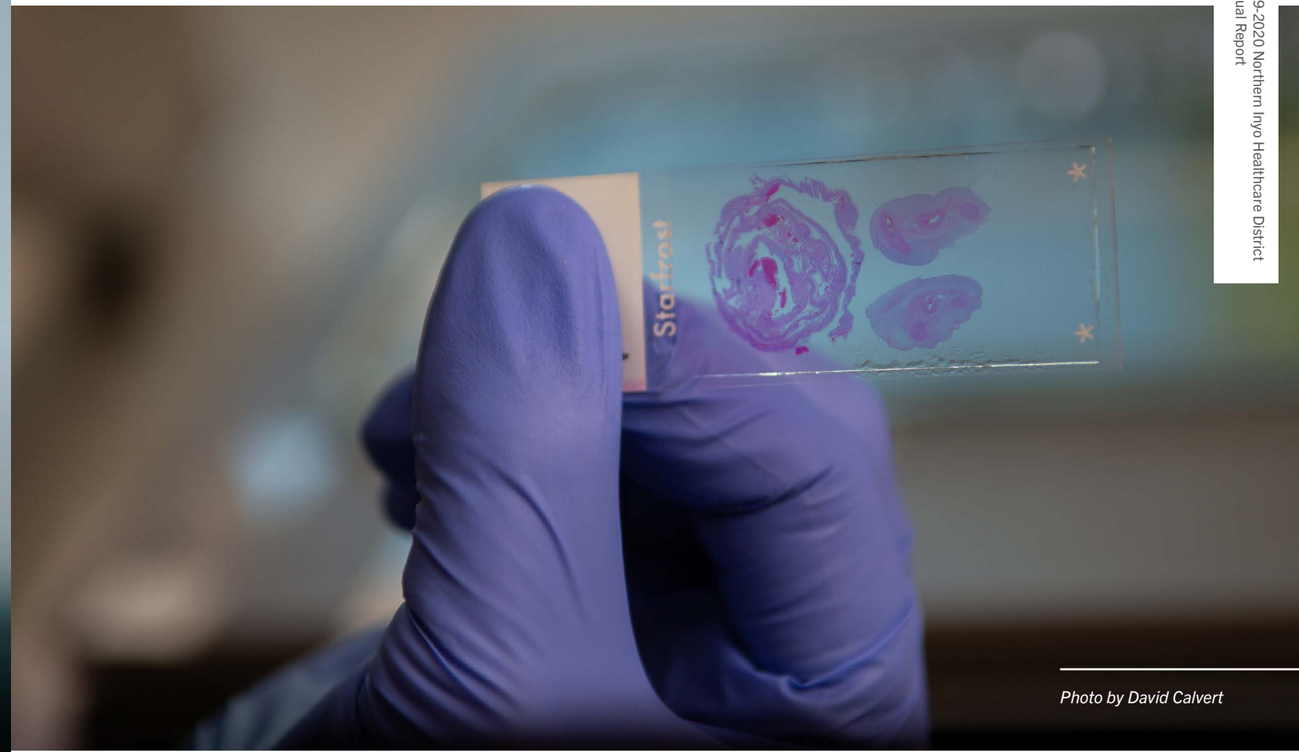


Photo by David Calvert

Tissue Embedding Center
The Tissue Embedding Center or Histo Pro 150 is our embedding station, which completes the preparation of paraffin tissue blocks. Embedding is a process in which tissues are enclosed in a mold with liquid paraffin, placed on the cold plate to solidify the paraffin, supporting the tissue's orientation. Some specimens are the size of one strand of hair, and only microscopic review can determine sections that contain malignancy or clear resection margins. Using this instrument enables the pathologist to view the tissue on-site to give providers actionable results quickly.

Microtome Cryostat

Microtome Cryostat, or Cryostat, is essentially an ultrafine "deli-slicer." We use this to obtain a frozen section biopsy, a thin slice of tissue cut from frozen tissue for rapid microscopic diagnosis during surgery. This allows our on-site pathologist to determine whether there are clear margins, or if another sample is needed, so they can immediately communicate this information to the surgeon. Any additional tissue can be obtained to know the extent of the lesion and guide intra-operative patient management. Having this technology at NIHD gives the providers actionable results immediately, decreasing the time between testing, diagnosis, and treatment to provide excellent continuity of care to our community.

GE LOGIQ E9

Although primarily used for cardiac imaging at Northern Inyo, our Nuclear Medicine Department is capable of providing a full array of services to our providers, including imaging studies needed to diagnose pulmonary embolism, identifying kidneys and gallbladder disease, used in breast sentinel node localization as part of our very successful Breast Health Services, and as a means to stage many types of cancer.

Performance of echocardiograms at NIHD is accomplished using the Philips iE33 ultrasound system. This equipment is capable of providing our Echocardiographers all the tools needed to provide the highest quality exams for interpretation by a Cardiologist.

The benefits of having Transesophageal Echocardiography in our District is that this procedure produces higher quality images than the standard transthoracic echo. The higher quality images are a result of placing the transducer closer to the heart via an invasive procedure and has a higher resolution transducer. The most common reasons for needing the higher resolution Transesophageal Echo is for the detection of infective endocarditis, embolic source in patients with stroke, aortic pathology, or to clear patients for cardioversions.

Echocardiography is the second most commonly utilized diagnostic modality in Cardiology behind EKG. It is a powerful diagnostic tool, and in the hands of an expert sonographer, can make the diagnosis of almost any cardiac pathology. This is a huge asset to the members of our community and surrounding communities. It eliminates the need to travel out of town for this simple procedure. The addition of stress and Transesophageal Echocardiography increases our ability to provide valuable services here in Bishop.

The Echocardiography program at NIHD started in January of 2001. The first year we did 174 echocardiograms. That number has steadily increased each year. In 2019 we performed 880 echocardiograms. This year the number is likely to be somewhat smaller due to the coronavirus. Besides providing access for our patients to these important services, the program also generates considerable revenue to support other hospital programs. The annual billings generated by the Echocardiography program currently exceed $2.5 million. ■

LANGUAGE ACCESS

Northern Inyo Healthcare District recognizes that access to health care services is the right of every patient. NIHD, through its Language Access Services Department, ensures equal and meaningful access to health care services for patients experiencing language or communication barriers. Consequently, the District offers bilingual services in qualifying languages, qualified medical interpreting services for spoken languages, and American Sign Language (ASL) 24 hours a day, seven days a week.

LANGUAGE ACCESS SERVICES PROGRAM

The Language Access Services Department, through the Language Access Service Program defines the District's language or communication assistance approved resources, services, levels of service, and the assessment and training required for workforce providing language services on behalf of the District.

The program utilizes the services of workforce qualified as approved bilingual, dual-role, and qualified medical interpreters, nationally Certified Healthcare Interpreters, as well as the interpreting services from CyraCom, and the Health Care Interpreter Network (HCIN).

During the last 10 years, NIHD has seen an increase in the number of entry-level job-seeking applicants, who self-identify as Hispanic or Spanish-speakers. Currently, the District's workforce participating in the Language Access Services Program includes 28 Approved Bilingual Employees in clinical and non-clinical areas, seven dual-role interpreters, six Qualified Medical Interpreters, and two nationally Certified Healthcare Interpreters™.

INTERPRETING SERVICES

NIHD provides in-person interpreting services in Spanish, over the phone and video remote interpreting services in more than 240 different languages, including American Sign Language (ASL), 24 hours a day, seven days a week.

Over the phone interpreting services are available from any telephone at the District, with video remote interpreting services through any of the 28 video-remote interpreting units distributed throughout the District.

During the 2019/2020 fiscal year, the District provided health care services to non-English speaking patients totaling 35,840 minutes of over the phone and video remote interpreting services (combining the services provided by both: CyraCom and HCIN) in the following languages: American Sign Language, Cantonese, French, German, Gujarati, Italian, Japanese, Korean, Kunama, Mandarin, Punjabi, Russian, Spanish, and Tamil.

The Language Access Services Call Center has been functioning since 2017. The Call Center functions by providing coverage for some of our own needs, and sharing our interpreter services within the HCIN network. During the 2019/2020 fiscal year, the Call Center received 8,419 video-calls, providing 116,195 minutes of interpreting services in Spanish.

Patients and providers prefer in-person interpreting services. The District implemented Interpreter Intelligence Scheduling System to facilitate providing more in-person interpreting services throughout the District. Due to the COVID-19 pandemic, we are limiting the District's workforce interaction with patients to reduce the risk of infection. However, NIHD-approved interpreters assist, on average, with 45 requests for in-person interpreting every month.

TRANSLATIONS

Language Access Services includes providing translation of vital documents, significant communications, and significant publications. During the 2019/2020 fiscal year, the Department translated 104 different documents, most of them related to COVID-19 for the District's use, and in a supporting role for Inyo County Public Health Department. Translation of COVID-19 education and prevention for the community, as well as consent for vaccination for the District's workforce (and the public) has been a priority.

The Language Access Services Department ensures the District is compliant with state and federal law regarding language access services, as well as meeting The Joint Commission standards on patient-centered communication and fulfilling the District's commitment to provide meaningful access to limited English proficient individuals. NIHD provides high quality health care services to all patients, in all languages, through qualified or certified healthcare interpreters. ■

Frank Laiacona, Pharm-D APP
Director of Pharmacy

PHARMACY

The Pharmacy Department at NIHD is an active and versatile component integral to the hospital at large. Our professional, technical, and clerical staff forms a cohesive unit that provides 24/7 pharmacy support to the District. That being stated, the Pharmacy is open and staffed for 10 ½ hours each day. After hours Pharmacist personnel are on call for order verification, drug information, and in critical cases returning to the facility to prepare medications and extemporaneous products.

Each day, clinical, administrative, and distributive activities are performed by a staff comprised of a Director, Clinical and 340B Coordinator, Staff Pharmacists, Pharmacy Technicians, and a Pharmacy Clerk who assists the Director with financial and billing spreadsheet analysis. A 340B specialist is onboarding who will energize, educate and renegotiate to improve our program's performance.

The challenge of multi-regulatory compliance by any hospital pharmacy requires diligence and cadence. Additionally, being licensed within the State of California only adds a degree of difficulty to this task. Auditing department activities is a perpetual assignment for quality assurance and performance improvement.

The Pharmacy Department recently underwent a rigorous and thorough annual inspection by the California State Board of Pharmacy without receiving any citations, fines, or mandated corrections by the inspector. The Pharmacy has completed all its mandatory filings and self-assessments. The specified personnel manage and adjudicate controlled substance procurement and utilization.

Inventory was conducted on June 30th, 2020, with results showing a positive variance to the preceding year with improved rotations of inventory dollars. The department continues to be a strong revenue generator for the District, with the outlook for the forthcoming year to show continued growth.

Professionally, the key objective for the department falls within the realm of patient safety. Adverse drug reactions continue to plague health care organizations, and NIHD's performance positively exceeds industry standards.

The Pharmacy has a member representative to multiple key committees. This participation enables a continued dialogue to embrace best professional practice standards and their improvement. For example, the Antibiotic Stewardship Committee's actions have had an overall impact on decreasing antibiotic use in inappropriate situations, reducing the potential for bacterial antibiotic resistance. The MAIC committee generates discussion for medication misadventures and examination of processes. During the past 36 months, the sheer number of events have markedly dropped, indicating the strategies implemented post committee discussion has fostered a safer climate here in the District.

The Pharmacy Department has several capitalization projects ongoing at this time. These include a construction project, an upgrade to our automatic drug dispensing units, a new EHR, and a recent build and rollout of smart pump technology for the facility.

Pharmacy Construction Project

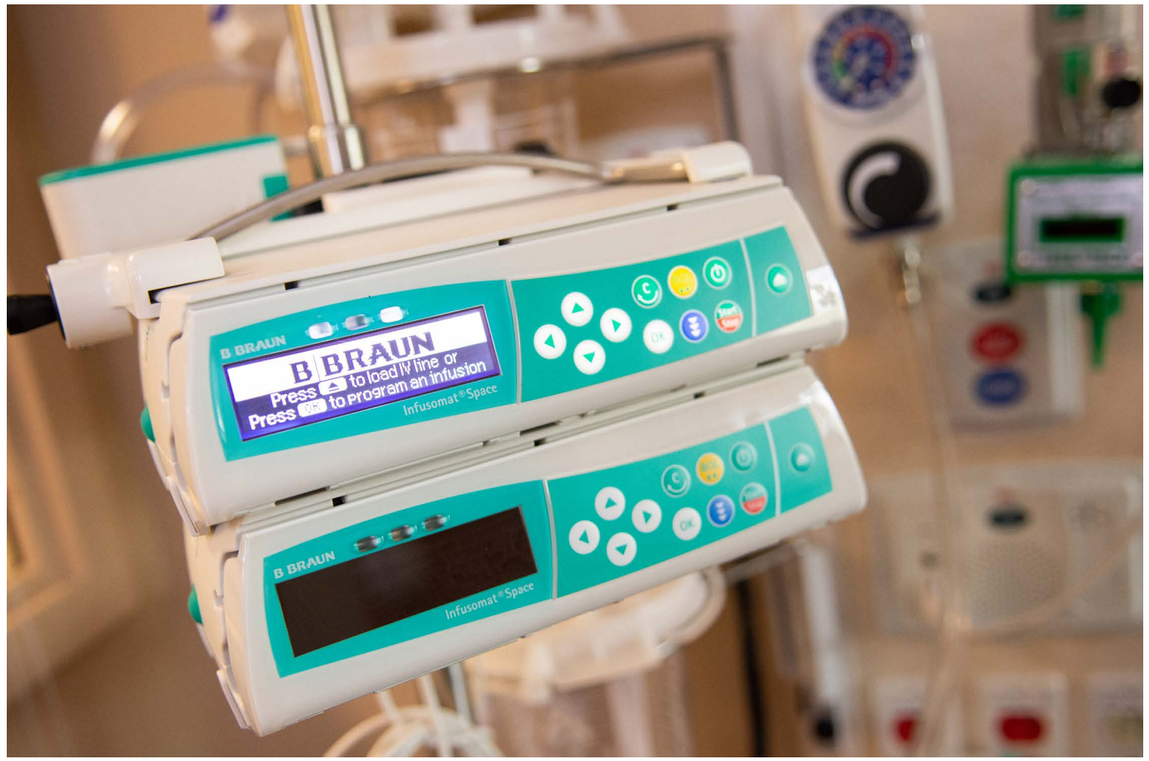
The physical plant which the Pharmacy occupies is dated and required a vision to acclimate to the current expectations for pharmacy services. In the past five years, several regulations, namely USP 795, USP 797, and USP 800, required pharmacies in the U.S. to prepare sterile medications aseptically while protecting staff from potentially harmful agents. The pharmacy received a waiver from the California Board of Pharmacy to maintain best-practice standards, although not fully meeting this requirement with the existing physical plant. The present Pharmacy clean room is a segregated compounding room with engineering features that include a Germ-free Bioflow Air Chamber, which protects personnel from hazardous agents while maintaining a sterile environment for compounding. It is also home to a Baker EdgeGUARD Laminar Flow Hood, which maintains an aseptic environment for compounding. These two primary engineering control units reside in a positive pressure room, assuring a reduction in possible contamination. Furthermore, pharmacy staff does surface sample testing and product sterility testing with the cooperation of Dynalabs to confirm aseptic space and products. A new pharmacy with a state-of-the-art clean room fully meeting these regulations has been approved. This was accomplished by bringing leadership, space, equipment, and personnel together synergistically to allow for form and flow to increase efficiency. Date of completion expected in the second half of 2021.

Omnicell Medication Management System.
Photo courtesy of Y Studios.

Omnicell XT Upgrade Project
The existing 5G dispensing cabinets operate on Windows 7 software that will sunset on October 31st, 2020. The District has procured an upgrade package to the XT series of cabinet, which runs on Windows 10. This will enhance accountability and patient safety by fully coordinating prescribing, distributing, and administering medications to patients. Completion date expected December 2020. Diversion of controlled substances and medication errors are greatly diminished with the use of this technology. Medications must pass successfully through layers of safeguards that these units provide to be administered to patients. Daily staff adjudicate the controlled substance utilization so that every controlled substance removed for patient use is reconciled to zero for the smallest unit of use.

EHR Conversion
The present electronic health record operating system will be converted to the Cerner *CommunityWorks*™ product. A robust EHR correlates to enhanced patient safety, increased efficiency, rigorous information retrieval, ease of documentation, and staff accountability. This system's reporting tools will prove to be an invaluable aid to further strengthen our District's performance in many areas.

Pharmacy Clerk Amber Barker working in the compounding area. Photo by David Calvert



BBraun Smart Pump Implementation
Intravenous medication administration represents a crucial aspect of patient care with some distinctive risks associated with it. Smart pumps establish and maintain the guardrails related to safe practices for parenteral drug therapy. Thirty years ago, nurses hung a bag with gravity and watched for how many drops would fall into a chamber connected by a line to a patient for a minute. This would be extrapolated into how many milliliters of drug or fluid would be administered over an hour and how long the bag would last. This led to many variances of medication administration because of the variables of the conditions, equipment, and users' observations. Smart pump technology takes most, if not all, of the guesswork and interpretive skills out of the equation. The pumps deliver rates of medication administration consistently without variance. These rates are also predefined by drug in the pump memory; thus, if a medication can cure at 100 ml per hour or injure at 200 ml per hour by design, these smart pumps will prevent any med from being administered at the wrong rate or dose. The pumps have interactive capabilities and can communicate essential data contemporaneously. The smart pumps provide key support in safe medication practices. ■

TELEHEALTH

Jessica Nichols, RHC Clinical and Telehealth Program Manager

In our Virtual Care Clinic at the Northern Inyo Healthcare District (NIHD), the Telehealth Program allows patients to see a specialist or other health care professional miles away without leaving the beautiful Eastern Sierra.

A telehealth visit is very much like a regular face-to-face visit with a provider, except that we use video technology to see, hear and speak to a medical provider. The provider can also see, hear and talk to you. You will receive the same level of privacy that you would expect at your provider's office. Telehealth utilizes video conferencing technology, which allows examination, diagnoses, and treatment. A telehealth specialist will be with you in a private exam room to operate the equipment, introduce you to the specialist, and assist with your examination.

Telehealth was introduced to NIHD in 2018 as a unique new service line. Our Virtual Care Clinic's current specialty services are Endocrinology, Cardiology, Infectious Disease, Rheumatology, and most recently, adult and adolescent Psychiatry services. Our friendly telehealth providers love our Bishop patients and feel quite envious of our small-town community. District patients have expressed gratitude for this service and feel connected to our providers even though they are miles away.

We have seen tremendous growth and success in our Telehealth program over the last two years, with the COVID-19 pandemic providing an opportunity for rapid expansion. As we quickly learned more about the virus, it was easy to offer telehealth to our District patients. COVID-19 restrictions reduced the ability to provide in-person visits at NIHD. Telehealth allowed patients to safely

Endocrinologist Nilem Patel, MD, discusses diagnosis with a patient via telehealth. Photo by David Calvert

connect virtually with their provider from the comfort of their own home. Within a week, more than 25 providers were trained (along with support staff) throughout our outpatient clinics to utilize telehealth technology. The Medical Assistants have become telehealth champions: helping our patients navigate the virtual visit process from start to finish. We've been impressed by our community's level of technological expertise. Guidelines were developed at the NIHD COVID Incident Command to determine what type of visit would qualify for telehealth vs. an in-person visit. Each clinic has unique criteria for this. Even as we are slowly increasing our in-person visits, we continue to see all kinds of telehealth visits. For example, Dr. Helvie can conduct a well-child visit virtually, just as Dr. Brown can follow-up with post-hospitalization concerns.

Telehealth has allowed our patients to continue to receive the exceptional care they deserve. We anticipate Telehealth will continue in primary care beyond the current pandemic.

Jessica Nichols
RHC Clinical and Telehealth Program Manager

RHC Physician Stacey Brown, MD, talks with a patient via telehealth. Photo by David Calvert

Dan David
Care Coordination Manager

BEHAVIORAL HEALTH & OPIOIDS

MAKING A DIFFERENCE

Medication-assisted treatment (MAT) is vital in helping people overcome addiction challenges. For the past two years, Northern Inyo Healthcare District's Rural Health Clinic has played a crucial role in helping our communities combat this issue.

By definition, MAT programs use medications combined with counseling and behavioral therapies to provide a whole-patient approach to treating substance use disorders. These programs are clinically driven and tailored to meet each patient's needs. The medications used in these programs have the approval of the Food and Drug Administration (FDA).

The ultimate goal of MAT is full recovery, including the ability to live a self-directed life. Studies show this treatment:

- Improves patient survival
- Increases retention in treatment
- Decreases opiate use and other illicit activity among people with substance use disorders
- Increases patients' ability to gain and maintain employment
- Improve birth outcomes among women who have substance use disorders

OUR APPROACH

Like others, our MAT program follows the patient-centered approach, offering individual and family support. Our team is highly trained and experienced in delivering MAT services based on evidence-based practices. To date, the MAT program has served more than 170 patients this past year. It continues to expand services with the addition of a Substance Use Counselor and Community Harm Reduction Coordinator.

Fatal overdose death is preventable, and our MAT team has worked hard to saturate our community with that message. We have given out more than 1,500 boxes of Narcan®, a nasal spray that can help reverse an opioid overdose, which has saved 26 lives already.

Among our successes this year, the MAT Program held a drive-through event where we passed out more than 200 opioid overdose rescue kits, featuring Narcan®. Our MAT team also provides prevention education to the local high school and the community. It also raises awareness about substance use issues and the importance of harm reduction while reducing stigma.

STATEWIDE ATTENTION

NIHD's MAT Program has garnered statewide recognition for its work. Substance Abuse Mental Health Services (SAMHSA) and the California Department of Healthcare Services (DHCS) highlighted our work in presentations showing how we create wraparound services for patients.

Our program has been part of the California Bridge Program and MAT in the county jail expansion grant. We have also presented our plan to expanding access to MAT in the County Justice System and our efforts to engage diverse populations. ■

Allison Partridge, MSN, RN
Chief Nursing Officer

CHANGE OF GUARD

TRACY ASPEL PASSES THE BATON TO ALLISON PARTRIDGE

Nature's season of change will serve as the backdrop for change in nursing leadership at Northern Inyo Healthcare District. As veteran nursing leader Tracy Aspel prepares for her October retirement, the District named Allison Partridge as its new Chief Nursing Officer, effective mid-September.

When asked what she hopes to bring to the District, Partridge's list of aspirations is exact. "I hope to continue the work that Tracy, and those before her, started. I'm striving for continuous process improvement, continued excellence in care, and striving to ensure that we're meeting the needs of the community."

That last point – meeting the community's needs – impacted the new CNO as she said the words. "Meeting those needs is huge," she said. "We're rural; we're far away from any major healthcare facility. We have to work with our community partners to make sure we're doing the best we can for those who count on us every day. It's that simple."

NIHD's Interim Chief Executive Officer Kelli Davis said Partridge has proven herself to be an inclusive leader who takes into consideration differing viewpoints. "I find her to be a very positive and authentic person who stands by doing what's best for the whole, whether that's a single Nursing department or the entire District. Allison works hard to help others achieve their goals and meet their aspirations in growth and development. I look forward to seeing what she brings to the District in the next year."

Partridge currently serves as NIHD's Director of Nursing for Emergency and Inpatient Services. That has put the 20-plus year nursing veteran at the forefront of the District's pandemic response, alongside Aspel, Davis, and Drs. Will Timbers and Stacey Brown.

Bolstered by a 16-member incident command and the support of District physicians and employees, Partridge and these leaders find themselves tackling both basic and complicated needs.

"As far as the District's response to the pandemic, I think we are spot on," she said. "We've got a very structured, organized format that we're following in addressing this. We assure we stay up-to-date and apprised of the most current information from both Centers for Disease Control and the California Department of Public Health. We're using that information to help drive the decisions we make. It's been a lot of work and is continuously changing, but we've adapted, and we've stayed focused."

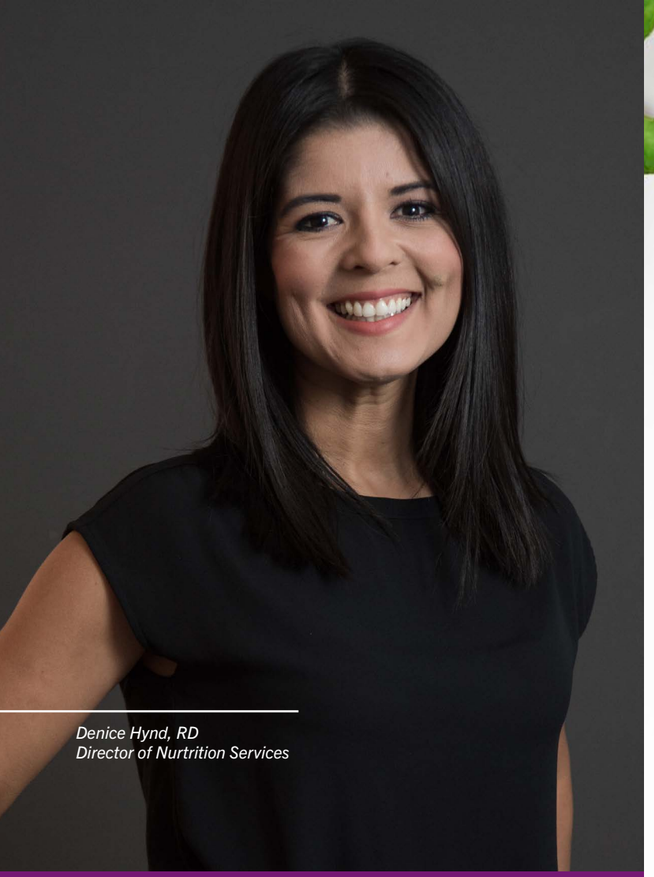
Before joining NIHD almost three years ago, Partridge spent most of her career at San Pedro's Providence Little Company of Mary Medical Center. She credits Providence's in-house leadership development program with preparing her to serve as NIHD's Chief Nursing Officer.

Partridge holds a Bachelor's and Master's degree in Nursing. She has extensive training in Lean Leadership, Six Sigma, and Mission-Focused Leadership. Of all of her education, Partridge is most proud of her Master's degree with an emphasis on leadership, and not for a reason most expected. She earned her Master's as a working adult and mother. "I have a deep respect for anyone trying to juggle all that. It was not easy," she said.

As for her years with NIHD, Partridge values the time she spent getting to know the District, the communities it serves, and the Nursing teams she works with. "I look at our teams, and I see so much potential and such great opportunity, and that's exciting," she said. "Throughout the District, you see this really heightened desire to achieve excellence, and together, I know we can do it."

Partridge also understands the love the community has for its nurses. "We are a small community, and for the nurses, that brings this deep desire to provide excellence in care," she said. "I genuinely think that's because here, as a nurse, you often know the person you are caring for or someone who loves them, and people respond to that."

Partridge and her husband, Jayson, have been married for 18 years. They have two children, Drew, age 17, and Natalie, 15. The family relocated to the Sierra to enjoy all the outdoor adventures and seasons it offers.



Denice Hynd, RD
Director of Nurtrition Services

NUTRITIONAL SERVICES

CLINICAL

Northern Inyo Healthcare District employs two full-time Registered Dietitians (RD), one of which is a certified Spanish language interpreter. Our dietitians spend a significant amount of time at the patients' bedside gathering pertinent lifestyle and diet information to develop a nutrition intervention that is specially tailored for the individual. Through multidisciplinary collaboration, the patient is provided with a therapeutic diet that is closely monitored and modified during their inpatient stays. One of the RD's patient-goals is to avoid unintentional weight loss. This is accomplished through offering nutrition supplementation in the form of whole-food-smoothies and offering heart-healthy snacks in between meals. Some of the patient's favorite snacks include baked sweet potato chips with guacamole and raspberry-walnut yogurt parfait.

COMMUNITY

Disseminating evidenced-based health information comes naturally to the Nutritional Services Department at Northern Inyo Healthcare District. The dietitians have hosted a series of Healthy Lifestyle Talks that promote practical approaches to achieving wellness. Topics such as Mindful Weight Loss for the New Year, Reducing Picky Eating in Children, and Identifying Hidden Sugars in Your Food are well attended by members of the community. The nutrition-focused Healthy Lifestyle Talks are offered in English and Spanish.

The dietitians also sit on disease-specific panels as the experts in using nutrition as a preventive measure. These panels include The Breast Health Team during Moonlight Mammograms and the facilitators of NIHD's Diabetes Education Empowerment Program.

DISTRICT WELLNESS

The Nutritional Services Department hosts free cooking lessons to NIHD staff, where new recipes are developed and executed by the staff. In 2019, the workforce was invited to prepare their own versions of chia-pudding, mixed arugula salad, homemade balsamic vinaigrette, and warm lentil-feta salad. For those who want to challenge their skills further, they are invited to participate in the District's Maintain-No-Gain weight maintenance challenge that occurs over the holiday season; and our Spring Into Weight Loss challenge, where the goal is to lose three-to-five percent of total weight over the course of four months. The worksite wellness programs are well attended and encourage friendly competition among its participants.

KITCHEN OPERATIONS

Patient Meals
The dietary department begins preparing patient meals at four in the morning seven days a week. Each patient meal is carefully crafted to ensure all patient preferences, allergies, and intolerances are considered. Our cooks prepare seasonally appropriate meals from scratch, paying close attention to recipe-builds as each patient has a unique diet prescription to which they must adhere. Our extensively trained Diet Clerks interview each patient daily to explain further each meal's components, textures, and flavor profiles. This is done to increase oral intake, which will ultimately support the patient in regaining their strength and improving their health outcomes. If a patient does not care for the planned items being served that day, they are offered meal alternatives that encompass traditional American-fare favorites.

One of our favorite meals to prepare and serve is our "Celebration Meal" offered to all new mothers after giving birth. The two celebration meals most requested include the spinach ravioli in cream sauce and the poached salmon in lemon sauce. Each celebration meal is paired with a hot-fudge lava cake, or a lemon-raspberry ricotta cheesecake, and finished with sparkling apple cider in single-serve champagne glasses.

Staff Meals
As a NIHD team member, you can order snacks and meals through our Café service window without needing your pocket-book! Our Payroll Department has created an easy-pay system, where the employee swipes their badge at check-out, allowing their total to be deducted at their next paycheck. The employee cafeteria offers scratch-made salads, hot entrees, and trendy grab-and-go snacks. Some of staff's favorite picks include chia-pudding made with non-fat Greek yogurt topped with fresh fruit & granola, mixed kale salad with shredded purple cabbage and sunflower seeds, and our pork carnitas plate. In 2019, the dietary department safely served 82,177 meals, of which the hospital staff consumed the majority. ■

NIHD Cook Alicia Campos prepares healthy salads for the staff lunches. Photo by David Calvert

NIHD Cook Maria Lawrence works to prepare the daily meals. Photo by David Calvert

A healthy selection of salads. Photo by David Calvert

Some of the NIHD Kitchen staff, l-r, Tyra Icenhower, Maria Lawrence, Alicia Campos, Registered Dietitian Denice Hynd, Emilia Lopez, and Tracy Benninger. Photo by David Calvert

Scott Hooker
Director of Facilities

FACILITIES MANAGEMENT

The main Northern Inyo Healthcare District campus covers approximately 14 acres and houses 11 buildings with a total square footage of 160,000 square feet. These buildings range from patient care facilities to administrative, maintenance, and laundry structures.

In addition, the District owns the Birch Street Annex facility, comprised of two buildings located in the former Cerro Coso Community College site. The larger annex building, roughly 7,318 square feet, houses the meeting facility for our Board of Directors as well as office space for the NIH Auxiliary, the Eastern Sierra Cancer Alliance, and the Kern Regional Center. It also houses a computer server room, a commercial paper shredding machine, and storage rooms for the District. The smaller building is leased to Kern Regional Center and covers 1,000 square feet.

The District also owns a former bed-and-breakfast in the downtown Bishop area called The Joseph House. Purchased by NIHD in 2018, the Joseph House is named for its original owners and consists of a five-bedroom house, a studio apartment off the garage, and a separate one-bedroom cottage. The purpose of the purchase was to secure steady housing for physicians, surgeons, visiting nurses, and others who travel here to serve the District for short periods. Most of these visitors utilize the main house, while our Radiologist group exclusively uses the cottage.

Some of the challenges that NIHD faces with our properties is that they vary drastically in ages and in meeting our growing needs. Some structures are very old and require upgrades to stay compliant with the many national and state agencies – such as Office of Statewide Health Planning and Development, Centers for Medicare and Medicaid Services, and the California Department of Public Health, and many more – who provide oversight to the District.

Perhaps one of the most considerable challenges to the District, and other area employers, remains the shortage of housing in the greater Bishop area. In the Owens Valley, private land ownership sits at about two percent of the available lands. The rest remains in the control of the U.S. Forest Service, Bureau of Land Management, City of Los Angeles, local tribes, and a small handful of private businesses.

Actions & Results

NIHD has taken action to maintain compliance and meet the state's very stringent seismic requirements. In the last 15 years, we built a new two-story Hospital Building that features more steel underground than above ground. We've also built a new Digital Imaging Building and Support Services Building to keep up and allow for growth. Still, some areas of our campus remain challenged for space, such as the Rural Health Clinic.

While the Joseph House has met some of our needs for those traveling in and out of the area regularly, long-term housing for contracted employees remains a problem. If we can provide contracted employees with housing, it naturally gives us leverage to bring highly qualified people to the area. Yet to date, we find ourselves scrambling to help new employees find suitable homes in which to live.

MAINTENANCE

The Maintenance Department is a relatively small group providing a broad range of maintenance services on our many buildings and sites. Not only does our team provide maintenance on our healthcare buildings, but they also maintain our Joseph House property and several other rental properties that we use for contract employee housing.

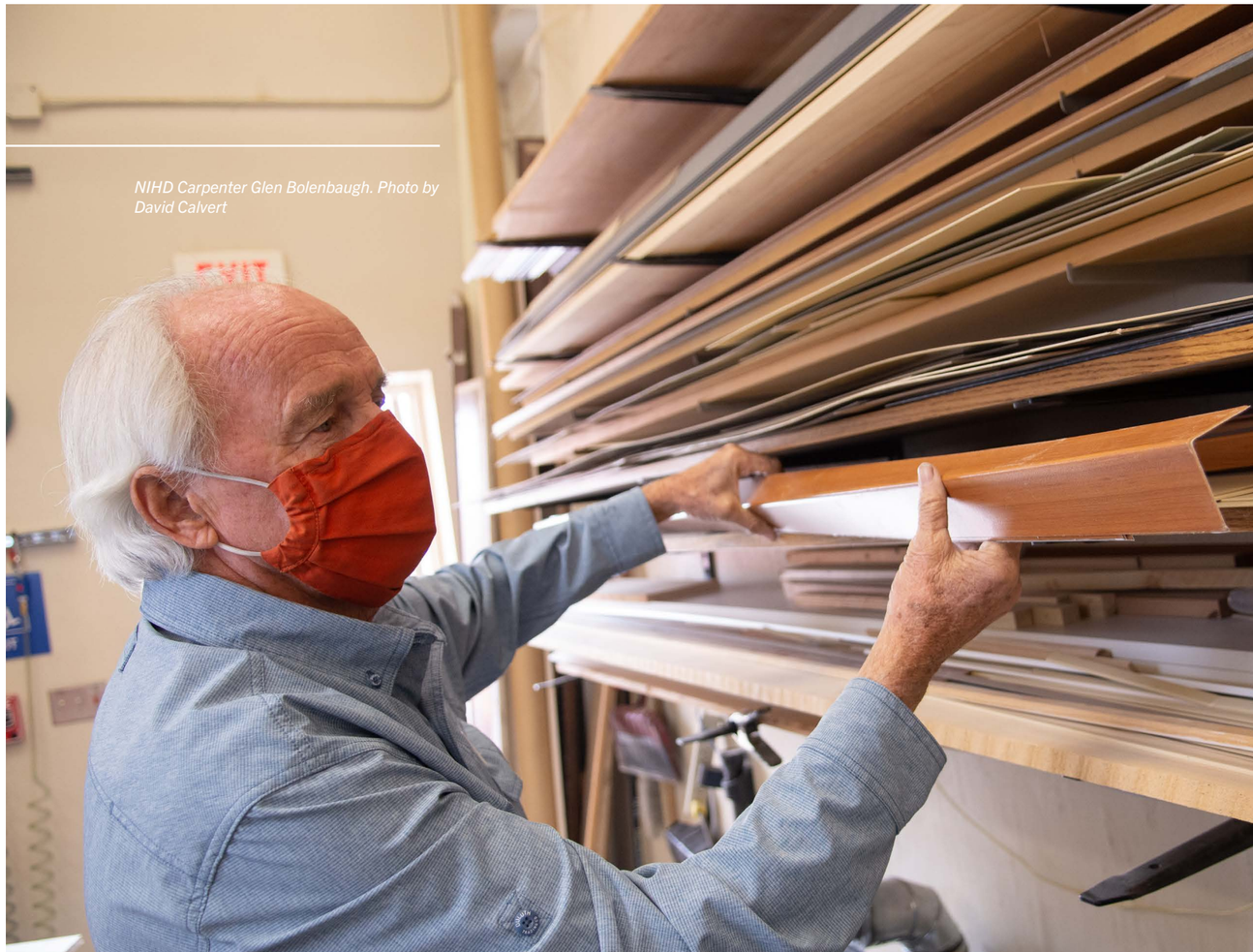
Our Maintenance Department initiated a new work order management system this past year. This new system helps the department promptly manage work orders and prioritize compliant work versus non-compliant work. This will help us during our many surveys with CDPH, CMS, Joint Commission, OSHPD. This system will also help us save on costs.

SECURITY

Our Security Department consists of six employees. Our hours of operation are Monday through Thursday, 6 p.m. to 3:30 a.m. and Friday and Saturday, 12 noon to 4 a.m. NIHD is fortunate that all of our officers are active or retired law enforcement and remain licensed. The skills and knowledge they bring to the District are unmatched and deserve recognition. During the time of COVID-19, our Security Officers found themselves facing additional challenges that went above and beyond their job descriptions. Again, we are fortunate to have such skilled officers to enhance our District's safety and security.

ENVIRONMENTAL SERVICES

The Environmental Service team operates Monday through Sunday, 4 a.m. to 12:30 a.m. Our staff cleans areas from Birch Street, to the Joseph House, to our Surgery Suites and Post-Acute Care Unit. Our goals are to have a clean building that our community can be proud of and maintain the lowest infectious rate for a hospital as possible.



NIHD Carpenter Glen Bolenbaugh. Photo by David Calvert

Director of Facilities Scott Hooker reviews plans for the separation of two NIHD buildings. Photo by David Calvert

We currently have 23 full-time employees in the Environmental Services Department, and the team we have right now does a fantastic job keeping up with daily routines and the added stresses that came with addressing a global pandemic. We do have some challenges in keeping a full staff, keeping the manager and assistant manager on the hunt for positive and effective team members.

The Environmental Services team is always looking for new equipment, chemicals, and materials to ensure that our hospital stays safe and clean. The NIH Foundation recently gifted the departments with a Total Clorox 360 Electrostatic Sprayer. This innovative sprayer delivers Clorox solutions to the front, back, and sides of surfaces, as well as those areas not always visible to the naked eye. The sprayer has been a great addition to ES' arsenal of cleaning tools as it uses 65 percent less solutions while reducing the time for a terminal clean by roughly half.

Achievements for this year:

- We have picked up new technology that has helped us achieve faster turnaround times on patient room discharges.
- We are continually improving our chemical line to help us maintain low infectious rates.
- We have the only Operating Suite Environmental Services certified trainer in the Owens Valley.
- We have picked up new pieces of equipment to help keep our Environmental Services staff safe.

LAUNDRY SERVICES:

The Laundry team operates Monday through Friday, from 5 a.m. to 4:30 p.m. We currently have five employees that stagger-start through the day. We service all linens in the hospital and clinics, wash certain areas scrubs, wash dietary aprons, wash Environmental Services cleaning equipment and wash personal protective equipment such as washable coats for the Nursing/Physician staff.

Each month, Laundry washes around 13,000-to-16,000 pounds of materials. We strive to keep units and clinics fully stocked with freshly cleaned linens. It is somewhat unique for a hospital our size to have its own fully functional laundry department, but it is necessary due to our remote location. We are fortunate to have a strong team dedicated to serving our community.

Achievements for this year:

- The laundry department is laundering washable PPE coats and washable masks, which has saved NIHD in our disposable ordering shortage during COVID-19.
- Upgrading a hot water heater/boiler in our support building, which has made our washing machines run more efficiently.

In conclusion, it is an honor and privilege to serve alongside our medical team, the ancillary staff, and administration. Together, we can and do make a difference for our community. ■

Barbara Laughon, Strategic Communications

COMMUNITY OUTREACH

GIVING BACK

Those that know the beginnings of Northern Inyo Healthcare District understand that our very presence in the community comes from the fact that in 1946 the residents of Bishop and Big Pine voted us into existence. Worn down from traveling long distances to receive quality healthcare, the residents formed a committee to develop a Healthcare District. It was not easy, but the group fought hard and won our future at the ballot box.

According to the Association of California Healthcare Districts (ACHD), these districts respond to the specialized health needs of California communities. Voters created 78 Healthcare Districts to fulfill local health care needs. Of these, 54 serve the state's rural areas. Healthcare Districts provide access to essential health services and are directly accountable at the community level. As a result, tens of millions of Californians receive access to care that would otherwise be out of reach.

As NIHD approaches its 75th year of service, we realize that the District's community outreach plays as significant a role as it did in the decades that followed our establishment. Here is a look at just some of the efforts our team members make each year:

Healthy Lifestyle Talks – Established in 2015 with the commitment of one physician and one staff member, NIHD launched a talk series designed to educate area residents about the many service lines and the physicians and advanced care providers behind them. In the following five years, Healthy Lifestyles grew from just four to 24 talks per year. Featuring a 30-35 minute presentation by the guest speaker, the hour's remainder goes to an often lively question and answer period.

The talks focused on topics as varied as Orthopedics, Breast Cancer Awareness, Mindful Weight Loss, Geriatrics, Speech Language Pathology, Women's Pelvic Floor issues, and healthcare advancements in Chiapas, Mexico, by the local Rotary Club and NIHD's Women's Health team.

Faced with the limitations brought by the COVID-19 pandemic, NIHD paused the talks for seven months before reinitiating them via the Zoom teleconferencing platform. These free talks remain open to the public.

Walk with a Doc – NIHD joined the national Walk with a Doc program in 2019 as part of the annual Rural Health Day celebration. Its premise is simple: connect patients with physicians outside of their offices and get patients to engage in regular physical activity. The fit between NIHD and Walk with a Doc seemed like a natural one.

Walk with a Doc founder David Sabgir, MD, a cardiologist in Columbus, OH, was frustrated that he could not convince most of his patients to do regular physical activity. "People had great intentions when they left the office," he says.

Then he hit upon a bold idea. He would ask patients to walk with him. That was in 2005, and "we had 101 for the very first one." It's grown to 530 chapters worldwide, most of those in the U.S. The doctor leads the Walk and gives a brief talk on a health topic. "We encourage people to walk 30 or 45 minutes if they can," Sabgir says. Unless bad weather forces the Walk indoors, the activity is outside, he says.

"It's a perfect way to break the ice with patients," he says. "There is something really special about getting outside the walls of the office and being in nature." The feedback from patients, he says, is good. "They say they love it, and it's always in all caps." NIHD is working to reinitiate this program during the pandemic, keeping social distancing precautions in mind.

Breast Cancer and Colorectal Cancer Awareness Months – Much of NIHD's best-laid plans begin as small conversations in small offices that start with the rhetorical question, "Hey, you know what we should do?"

Such is the case with October's Breast Cancer Awareness and March's Colorectal Cancer Awareness efforts. Community numbers showed a high occurrence of both diseases and staff members felt we needed to extend our outreach in both areas. With the support of leadership and other team members, NIHD had grown its presence during both months.

Keenly aware that there is strength in numbers, NIHD teamed up with trusted local partners, including Eastern Sierra Cancer Alliance (ESCA), Toiyabe Indian Health, Mammoth Hospital, and Southern Inyo Healthcare District. Doggedly seeking support from local government, these groups have secure proclamations from the Inyo County and Mono County Boards of Supervisors, The Bishop City Council, and Mammoth Town Council. These efforts help raise needed awareness for early detection, promote knowing family history, and support non-profits like ESCA that assist residents on personal cancer journeys.
In addition, NIHD launched its successful Moonlight Mammograms program in 2015. Designed to offered extended screening hours for busy women, Moonlight Mammograms resulted in the screening of more than 175 women – many for the first time – in its five-year history. We proudly offer translation services during this annual event, drawing a growing number of Spanish-speaking women to NIHD. Educational talks, coupled with live music and tasty treats round out the evenings. Pandemic precautions forced Moonlight Mammograms into a by-appointment-only format, but NIHD looks forward to the day when it can resume the original format.

Each March, our General Surgery office extends its hours for preventative consultations. During this event, prospective patients can meet one-on-one with Dr. Robbin Cromer-Tyler to discuss their risk factors and available screening options. This time lends itself to discuss any questions and concerns the patient may have about their chosen screening option or risk factors. We strongly believe that colorectal cancer is preventable, treatable, and beatable with regular screenings and early detection.

TeamNIHD (Lynda Vance, Michelle Garcia and former CEO Kevin Flanigan) donates to The Wish Tree. Photo by Barbara Laughon

And they're off! NIHD and the Eastern Sierra Cancer Alliance teamed up to also put a focus on Colorectal Cancer Awareness each March with a 5K/10K walk/run. Photo by Gayla Wolf

Colorectal Cancer Run beneath the towering and white-capped Sierra Nevada mountains. Photo by Gayla Wolf

“The feedback from patients, he says, is good. “They say they love it, and it’s always in all caps.”

-David Sabgir, MD

NIHD also helped ESCA launch the Blue Ribbon Fun Run and Walk each March as part of Colorectal Cancer Awareness Month. Designed to promote physical activity and health, the walk and run also help raise awareness and needed ESCA funds.

Also, NIHD physicians made time during both of these months to host educational talks at local businesses, again raising awareness for early detection of these diseases. These visits to Caltrans, Los Angeles Department of Water and Power, and others encouraged those perhaps on the fence for screening to make appointments, in some cases saving lives through early detection. While very busy, many of our physicians are gracious with their time. When given enough notice to avoid impacting patient needs, they will often make themselves available for speaking engagements.

Lending our support – NIHD is committed to supporting many community events and organizations in their efforts to make life better in the Eastern Sierra. Among those we support are:

- Eastern Sierra Tri-County Fair
- Bishop Mule Days Celebration
- Vitalant Blood Drives
- Toiyabe Health Fair
- Eastern Sierra Cancer Alliance
- Wild Iris
- Inyo County Health and Human Services Elder Health Fair
- Breastfeeding Awareness Month
- Bishop Volunteer Fire Department
- Big Pine Volunteer Fire Department
- Bishop Police National Night Out
- National Bike Month with Caltrans
- IMACA's Wish Tree Program
- IMACA & Salvation Army Food Drives
- Solutions for Homeless

NIHD, Southern Inyo Healthcare District, Toiyabe Indian Health Project and Eastern Sierra Cancer Alliance members just after receiving a proclamation from the County of Inyo declaring the first-ever Community Pink Day. Photo by Barbara Laughon

NIHD, Toiyabe Indian Health Project and Eastern Sierra Cancer Alliance came together to raise awareness for Breast Cancer Awareness by launching a Community Pink Day. Here the groups show the City of Bishop proclamation naming the third Friday in each October Community Pink Day. Photo by Barbara Laughon

Greg Bissonette
Executive Director,
NIH Foundation

FUNDRAISING THROUGH THE YEARS

The Northern Inyo Hospital Foundation is there when a need arises that cannot be met by the District's budget alone. When that happens the Foundation reaches out—on behalf of the community—to secure donations that will allow us to purchase the critical equipment and establish the vital patient programs that support everyone's well-being. Throughout each year, the Foundation receives funds from the generosity of grateful patients, targeted outreach campaigns, local donors, and engaging fundraising events in the community.

2016 DAISY Excellence in Nursing Award Winner, Rhonda Aihara. Photo by Gayla Wolf/The Honey Bee

2016 Employee of Year, Robin Christensen. Photo by Gayla Wolf/The Honey Bee

2016 Physician of the Year, Stacey Brown, MD. Photo by Gayla Wolf/The Honey Bee

Foundation's 2017 Avenue of Excellence Winners – DAISY Excellence in Nursing Winner Cynthia Dayhuff and NIHD Employee of the Year Francine Berube. Photo by Barbara Laughon

2017 Physician of the Year, Dr. Jeanine Arndal with Former CEO Kevin Flanigan. Photo by Barbara Laughon

2018 NIHD Employee of the Year Lynda Vance with Former ITS Director Robin Cassidy. Photo by Laura Molnar

2018 Physician of the Year Charlotte Helvie, MD with Former CEO Kevin Flanigan. Photo by Laura Molnar

2018 DAISY Excellence in Nursing Award winner Abel Jones with CNO Tracy Aspel. Photo by Laura Molnar

The Foundation has brought about many new programs and purchased essential equipment for the District in the past few years. With the inception of the CAREshuttle service, to the Breast Health Center and helping launch the telemedicine services at the Rural Health Clinic, to our most recent purchase of the Clorox Total 360 electrostatic sprayer cleaning system, the Foundation is impacting the health and wellbeing of all those the District serves.

Much of this work is supported by the Foundation's annual gala event, the Avenue of Excellence Award Dinner. Started in 2016, the event recognizes outstanding service from all corners of the District. Through recognition of a physician, a nurse, and an employee, the Foundation seeks to honor and celebrate those who go above and beyond in their dedication to serving the needs of Northern Inyo Healthcare District's patients. This event brings together the community in a festive spirit of giving to help further the initiatives of the Foundation and highlight the excellence the honorees embody in their devotion to serving our community.

One of the biggest successes for the Foundation has been the CAREshuttle free transportation service. Since its beginning in 2016, the CAREshuttle has delivered a much-needed service to the region. Where patients were going without medical care because of a lack of transportation options, the CAREshuttle has accomplished:

- More than 5,000 transports have taken place
- Almost 150,000 miles have been driven
- 6,000 volunteer hours have been provided by drivers
- The Foundation purchased a third vehicle was purchased in June of 2019

Then, here are just a couple of stories from those the CAREshuttle has helped.

> "My parents began using the CAREshuttle services when they reached their mid-80s. They had both become less sure of their ability to drive, and decided it would be a good idea to stop. Dial-a-Ride was not a possibility for them, as their home is located down a dirt road and is thus off-limits for Dial-a-Ride drivers. My husband and I had committed to assisting them (and moved to Bishop to do so), but our virtual work schedules did not permit us to transport them to all their medical appointments. They

appreciated having the CAREshuttle available and remarked many times on the drivers' kindness. My dad has since passed away, and my mom is at the Care Center following a stroke. We were thrilled to discover that the CAREshuttle management was open to taking her home now and then for a half-day visit. Being back in her beloved home space is the highlight of her life now, and all the more because she is not likely to ever recover sufficiently to go home for good. Grateful thanks to all who make the CAREshuttle's services possible for people like my parents!" - Jenny R.

"I live in Independence, but don't drive myself. That left me relying on someone else's schedule to get me to my appointments, which was a challenge. I can't say enough about the CAREshuttle; it's always on time, it gets me to my appointments that I might otherwise have missed, and the drivers are just wonderful!" - Maryhelen M.

The Foundation is also proud to share the success of The Breast Health Center of NIHD. Through initial capital investments from the Foundation, this initiative has facilitated care for almost 100 breast cancer patients since its start. The Center's first surgeries were performed on patients that would have otherwise chosen not to have surgery due to issues with traveling out of town. By providing excellent, specialized care for our breast health patients, the Center offers its patients all of their treatment needs locally. The NIHD Breast Health Center organizes a team consisting of the primary care physician, mammographer, breast surgeon, pathologist, oncologist, and other specialists to coordinate each breast cancer patient's best care. This multi-disciplinary team meets regularly to review its patients' treatment plan and looks to accomplish as much of that patient's care locally.

The Foundation has also been instrumental in some very critical purchases of equipment for the District. With proceeds from the first Avenue of Excellence Award Dinner, the Foundation purchased the RHC's initial telemedicine unit to connect its patients with specialists outside the area and alleviate the burden of travel to these providers. This service has become even more critical in the face of the COVID-19 health crisis. Also born out of this national health emergency, the Foundation has stepped up, and through the support of generous donors, purchased the Clorox Total 360 electrostatic sprayer cleaning system to help sanitize patient rooms. According to the staff using this device, it has cut in half the time it takes to disinfect a room thoroughly. This is making a dramatic impact on the Environmental Services Department's workflow and improving the efficiency and quality of cleaning patient rooms.

The Grant Writing Department also falls under the larger umbrella of fundraising for the District, and 2019 was an extremely successful year in securing grants to enhance the care provided to our patients. In response to the opioid crisis facing our country, the District was awarded more than $400,000 across five different grants to treat this epidemic. These were implemented across the District's service lines from the Emergency Department to the Rural Health Clinic. ■

Marjorie Routt
District Education Coordinator

OUR LEADERSHIP PHILOSOPHY

District Education's goal is to provide support and resources to all Northern Inyo Healthcare District departments and team members. In partnering with District leadership, District Education is continually seeking ways to offer the opportunity for growth, knowledge, and competency to our workforce. We live by the mantra, "District Education, where fun and competency unite."

Achieving our goal is of utmost importance to us as a highly developed workforce best serves those who rely on it. District Education has partnerships with multiple organizations and platforms to support and encourage workforce development. Our learning program's foundation is our partnership with Relias Media, which offers a platform for regulatory and elective training.

Relias Learning Management System (RLMS) provides more than 2,350 courses with continuing education opportunities from multiple accreditation boards at a state and national level. Content includes, but is not limited to, acute care ambulatory, behavioral health, emergency and critical care, nutrition and dietetics, perioperative, rehabilitation, respiratory, business, communication, and leadership.

In addition to the content provided, the RLMS offers one platform for NIHD to provide training from internal and external vendors. Examples include Resuscitation Quality Improvement (RQI), workplace violence training, and internal customer service/patient experience programs.

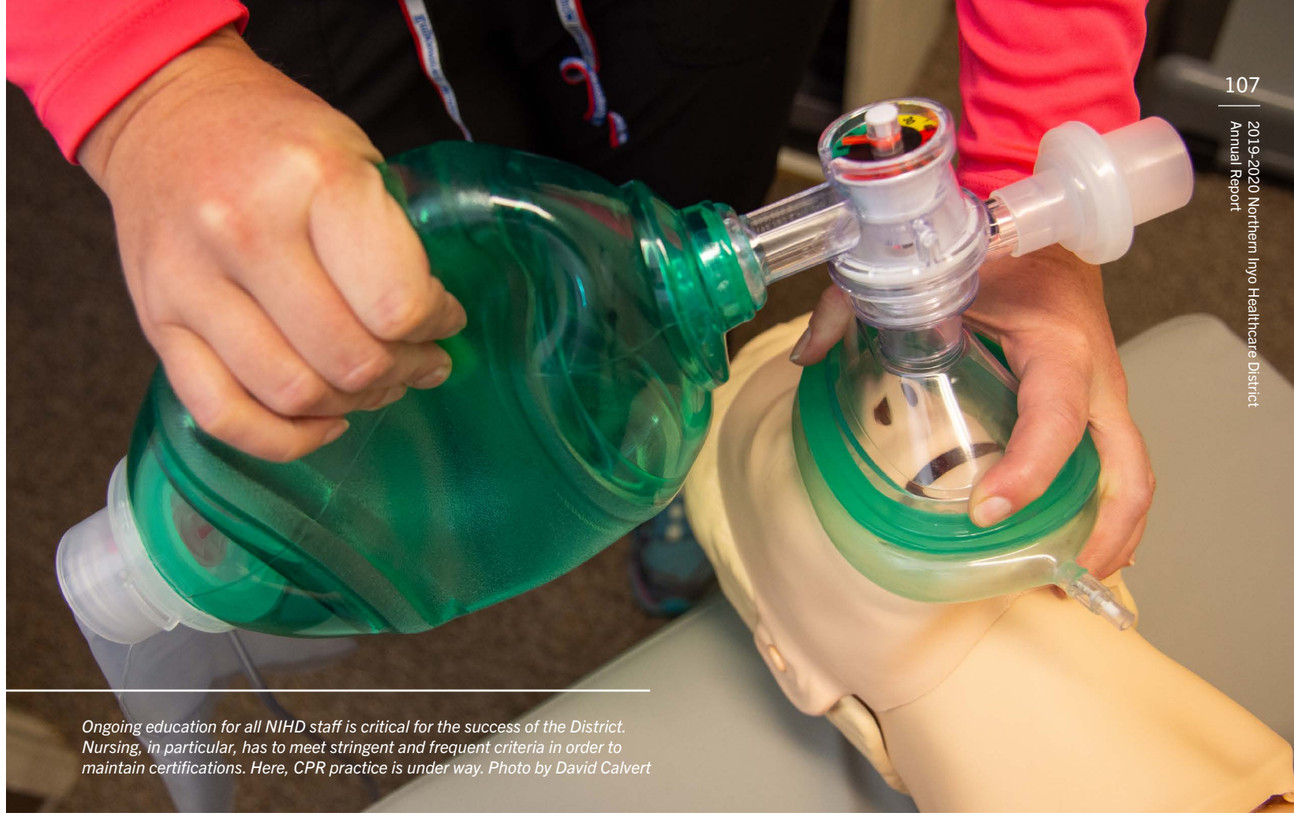
Traditional resuscitation certification (BLS, ACLS, PALS) is a bi-annual certification. In the 2015 update, the American Heart Association (AHA) determined that the standard two-year certification is not sufficient for skills competency. Resuscitation skills acquired begin to deteriorate after three months of initial training without repetitive use. The 2018 AHA update indicated that frequent low dose training is vital for provider competency.

Supported and managed by District Education, NIHD adopted Resuscitation Quality Improvement (RQI 2020) for necessary certifications throughout the District. RQI 2020 is offered within our RLMS, allowing staff to complete required re-certifications in quarterly increments, supporting workforce competency in vital lifesaving skills.

Much as NIHD and District Education are committed to competency, safety also remains a top priority. In 2018 the State of California became the first state to mandate annual workplace violence training for high-risk positions and front-line staff. NIHD partnered with HSS to offer Techniques of Effective Aggression Management (TEAM) district-wide. Going above and beyond the requirement, NIHD offers all staff HSS TEAM Essentials foundational training within our learning management system, followed by live hands-on training in HSS TEAM Advanced. The TEAM program focuses on recognizing and managing aggression and practical techniques for disengaging with an aggressive individual.

Partnered with annual reviews and continued updates on our internal plan, Education and District leadership are committed to providing a safe work environment.

District Education's future is bright as we look forward to launching our internal customer service program that focuses on the patient and workforce experience. Exceptional Customer Service is the foundation for establishing the best patient care experience we can offer. In striving to achieve this, we encourage our workforce to identify ways to connect with our patients, visitors, and others. It all starts with applying "Hi, Eyes, and Smiles" in our unique work settings. People always will remember how we make them feel when they leave our care. Our goal is to leave them with a positive, friendly experience.



Ongoing education for all NIHD staff is critical for the success of the District. Nursing, in particular, has to meet stringent and frequent criteria in order to maintain certifications. Here, CPR practice is under way. Photo by David Calvert

District Education Coordinator Marjorie Routt and Assistant Maintenance Manager Robert Ralston work through exercises designed to deflect physical violence in the workplace. Photo by David Calvert

TALENT MANAGEMENT

The Human Resources Department has six team members dedicated to ensuring our employees' employment cycle is complete. From the moment someone applies to retirement and everything in between, we are here to serve them.

The HR department went through multiple changes in the past year, which resulted in many positive outcomes to enhance our service to the organization and community. We want to highlight a few of our accomplishments this year:

STAFF

The HR Staff consists of the Director of Human Resources, Labor Relations Specialist Analyst, HR Generalist-Benefit Specialist, HR Generalist-Recruitment Specialist, HR Clerk, and District Education Coordinator. This year we added the HR Clerk position and the Education Coordinator joined our team. While we each have specific duties, we are all trained to help with all the HR department's day-to-day activities.

ELECTRONIC EMPLOYEE FILES

This year the HR team, with help from our Rural Health Clinic Student trainees, audited more than 490 employee files and prepared them to be shipped and scanned into our Human Resources Information System (HRIS). By completing this project, we met our goal of housing all employee files electronically, which lessened our storage needs and brought efficiency to our employee records filing.

RELOCATED

We moved to the main hallway by the Old Main entrance from the Administration building where HR has resided for years. The move allows all employee services to be centrally located.

When an employee enters our office, they are greeted by our HR Clerk, who then helps them or redirects to one of our specialists or the director.

UNION

In the fall of 2019, our second union formed. This time it was a large segment of our employees. Our Labor Relations Specialist took on the challenge of a second union contract and, after multiple negotiations by the fall of 2020, reached an agreement. Our Labor Relations Specialist represents the District at the bargaining table and is our union expert and liaison for all union-related issues.

COVID-19

When the COVID-19 pandemic hit, it changed the way we administered several policies, such as telework and leave of absence. Our workforce looked to HR for guidance on policy and procedure. Once temporary policies were in place, our Benefits Specialist went to work administering them. We saw a spike in leave requests immediately as well as canceled planned leaves.

Navigating through the new policies and changing procedures and all the new laws that are in effect, our Benefits Specialist has become the go-to person for our employees not just for COVID-19, but all leave of absence and benefit needs.

PEOPLE

The Recruitment Specialists handle all employment changes for the District, from job offers and on-boarding, to internal transfers and promotions. In the last year, we have hired more than 100 new employees to the District, processed more than 150 employee promotions, transfers, and status changes.

Our retention rate for the last year was 98.17 percent, with an average tenure of 6.90 years. We have been successful in providing the opportunity for employee career growth while still hiring our community members.

We are always assessing our efficiency and continual service improvements to serve our employees and community better through all healthcare changes. It is the service provided that makes us NIHD's Human Resources. ■

Lynda Vance
District Project Management Specialist

PROJECT MANAGEMENT

VALUE OF PROJECT MANAGEMENT

Organizations turn to project management to deliver results consistently, reduce costs, increase efficiencies and improve customer and stakeholder satisfaction. Strong, organization-wide commitment to project management yields long-term business value and competitive advantage.

NEW PROJECT MANAGEMENT DEPARTMENT

In April 2020, the project manager position changed to the District Project Management Specialist under the CEO. This moved project management from under Information Technology Services (ITS) to a separate District department. The NIHD Project Management Department will highlight all the important processes in projects for all District areas. Implementing new systems or services can be very daunting and overwhelming if you have not gone through the process before. This is where Project Management comes in to help. Project Management removes roadblocks while providing leadership and vision, motivation, coaching, and inspiration for the team to do their best work. We can learn from the successes and failures of our past projects, lending to our subject matter expertise in many aspects of delivering healthcare projects. Continuous oversight and proper planning can make a difference for the project team to know who is doing what, when, and how. Risk management is critical to project success and ensures proper expectations are set around what can be delivered, when, and how much — a proper plan for executing strategic goals. We also ensure that the goals of projects closely align with the strategic goals of the District.

UPDATES TO CHANGE MANAGEMENT

At the end of June 2020, Project Management and ITS began working on change processes to incorporate all changes in the District together. The NIHD Change Team has always been active in weekly meetings, and the aim is to be more inclusive with all changes. The change committee's goals are to minimize the impact on patients and staff when implementing any changes and celebrate the growth these changes bring. This year, close to 150 changes were reviewed. The future goal is to keep increasing the number of reviews by 50 percent.

COMPLETED PROJECTS

This year, the Project Management Specialist completed 16 projects through the entirety of the project life cycle. The next page's graph shows the high-level numbers by the Pillars of Excellence (Finance, Growth, People, Quality and Patient Safety, and Service Operation Excellence). **To review the details of the projects, see the following table.*

CURRENT PROJECTS

Projects go through a life cycle or stages as they progress through to completion. Currently, NIHD has 29 projects in various stages. Let us break them down into three areas: the finishing stage, active stage, and discovery stage.

In the finishing stage, NIHD has 10 projects that will help in many areas of the District. Our departments are looking for ways to improve from upgrading, moving, and streamlining to implementing new systems. Here are a few projects that have launched or will be ready to launch soon: Upgrade policy manager, Workforce Intelligence Solutions and Analytics, Anesthesia Electronic Health Record, Smart IV Pumps, Tele-psychiatry, Powershare of images with other facilities, Medical Staff Schedule Software, digitizing employee records and Cloud Analytics, Workflow streamline for sensitive services.

The active stage is the next set of projects. These 13 projects are getting kick-off and ramping up with many activities. We have a few big projects happening right now, like implementing our new electronic health record (Cerner) and all the systems that connect and the clinic process improvement. All of these projects are exciting and will improve our processes like these: Streamline timekeeping, payroll, and Human Resources into one system; update the setup for the Bronco clinic; improve social media presence; upgrade medicine cabinets; implement electronic charge capture system; upgrade and train on contract storage system; move two clinics in the PMA building; open a new clinic for virtual care.

Last is the discovery stage. These six projects are just getting started in the validation stage to ensure all the proper check-offs have been completed, and project teams and timelines are being created. These new projects span from the growth of services to updates of existing areas: update the scheduling system to accommodate more staff, transparency of services for patient charges, growth of transport services for patients, and office resets for new staff.

FUTURE OF PROJECT MANAGEMENT

In the coming year, the Project Management Department has three objectives to complete for department development, alongside working on all the projects. The first is improving project processes to include a uniform approval process. A standard approval process will benefit NIHD by decreasing costs and streamlining the project process. Secondly, to set up a detailed project timeline by quarters for all projects. This will help reduce resource and change fatigue as well as increase the viability of projects. The third goal is change management. The Change Committee has great processes, and our goal is to increase the number of reviewed changes by 50 percent in the coming year. This will be achieved by expanding knowledge and fostering a growth mindset.

Pillars	Project Name	Delivery Date	Project Goals
Growth	Define Process for Office/Computer Moves	10/15/19	Establish a Move process for NIHD offices
Growth	Unassigned Space for Meeting area	11/01/19	Have a large meeting space to vet new EHR vendors
Service Operation Excellence	Cardiopulmonary Department Build in 7medical for Scheduling	11/04/19	Have one place to schedule patients in 7medical. To decrease department overbooking.
Growth	eSig Access Electronic Forms	12/02/19	Have an electronic process to streamline form signatures for patients.
Service Operation Excellence	ITS Verizon Flip Phone Transition	01/10/20	Replace all old Flip Phones as they are end of Support
Service Operation Excellence	Integrate 7Medical with ECHO to store images	01/10/20	Store images of Echo studies in 7Medical to allow for ease of access and coping of studies.
Service Operation Excellence	Transition breast imaging interpretation to TCR	01/22/20	Set up infrastructure to allow for local and remote breast imaging interpretations
Growth	Lab PCR Testing additions	01/27/20	Expansion of PCR testing capacity from 4 to 16 tests as well as added new testing for Flu AB and RSV
Growth	EKG electronic workflow	01/31/20	electronic workflow for EKG
Quality and Patient Safety	OSHPD reports with Athena	03/02/20	Create a process to be compliant with OSHPD reports with Athena and meet due dates
Finance	MacroHelix 340b integration with Athena	03/04/20	Create a process to be compliant with 340b reports with athena and meet compliance and increase Revenue
People	NIHD Website with Scorpion	03/31/20	Marketing focus on a vast array of services NIHD offers.
Quality and Patient Safety	EHR Search 2019	04/01/20	Vet potential vendors and decide on a new EHR for NIHD in an inclusive way to fulfill goals of following best practices, improved patient safety, patient experience, employee satisfaction, quality of care, records portability, and portal technologies.
People	Move Team	6/30/2020	Complete moves of offices, departments and individuals in an efficient manner. Completed 40 moves encompassing 125 staff members. Benefits included being compliant with staff spacing and social distancing and department reorganizations.
Quality and Patient Safety	VendorMate - Credentialing Software	06/30/20	Have a web-based product to meet regulatory goals for tracking our vendors while at NIHD. This saves hundreds of hours in development a tracking process internally with minimal cost.

Bryan Harper
Director of ITS

PROTECTING OUR DATA AND PHI

It is next to impossible to capture the breadth and depth of the ITS and Clinical Engineering's team's relationship to the activities, initiatives, and services of Northern Inyo Healthcare District. Instead, what we do in this annual report describes a collection of our larger accomplishments from the year.

It is worth noting a few things you will not see. You will not see stories explaining how the ITS or Clinical Engineering teams are involved every time a team member views a webpage, reads an email, makes or changes a calendar appointment, have an antivirus update, get a paycheck, record their time, fire up Zoom or join a meeting, printing prescriptions, make a phone call, pay a bill, post a payment, report a phish, medical device maintenance, etc. You will not see a recounting of attacks the firewalls block, the thousands of spam stopped, nightly local backups, nightly backups to our Birch Street office, the hundreds of medical device checks that are performed monthly etc.

INFRASTRUCTURE PROJECTS

Firewall Upgrade
The Firewall is a device responsible for managing internet connectivity, security, remote access, and VPN tunnels to collaboration entities. It is among the top five most complex and critical systems in District operations. In the past, we used Cisco as the vendor and their ASA/Firepower platform for Firewall services. A need to change was evident when we received notice from Cisco that this platform was approaching end-of-life and support would be ending soon. A decision

was required to either upgrade the current platform or change vendors. Decision drivers include Cost (Capital Expense and Operational Expense), Support (internal and

Figure 1

vendor availability), and function (does it meet our needs). Continuing with Cisco required purchasing new hardware, recurring support contracts, and new service contracts at a premium cost. Life expectancy of this platform is normally about 24 months. There are many other proven vendors for Firewall platforms available. The decision was to go with Fortinet's Fortigate platform because it meets all of the requirements mentioned above. Fortinet is a leader in the industry exceeding Cisco in 2019's Gartner Magic quadrant (fig.1). The Fortigate platform runs on our existing virtual infrastructure, so there are no hardware costs

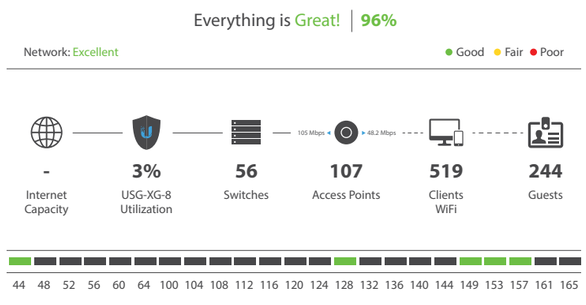


Figure 2

without sacrificing our redundancy requirement. Upgrades are seamless, and management is more streamlined than Cisco's platform. Fortinet support is also world-class. Cost savings to change to Fortinet's platform reflects a savings of thousands of dollars to the District. Transition to and management of this new platform utilizes current NIHD staff, saving a professional service contract's cost, likely in the tens of thousands of dollars.

Network Hardware Upgrade

The NIHD network system is how all digital communications are conducted; the phone system, all computer communications, overhead paging, and more. The network system hardware reached the end of life/end of support and required a hardware refresh. To continue using Cisco was estimated to be in the multiple hundreds of thousands of dollars in Capital Expense plus about $100,000 in annual Operational Expense. The decision to switch vendors was driven primarily by cost, and considerations were given to functionality and stability. Ubiquiti was chosen as the new platform because it was much less expensive and provided a 10Gb vs. 1GB connections between buildings, servers, and internet access. Sacrifices were encountered because Ubiquiti access layer switches do not have redundant power supplies or the support infrastructure that Cisco can afford (Although Cisco's support has diminished considerably in the past two years.) This causes NIHD to rely on local staff and internet community postings and professional services for support. However, we're able to engineer redundancy and extra equipment to allow for fast recovery in case of hardware failure while maintaining significant cost savings keeping Capital Expense under $70,000 and Operational Expense at zero. Equipment replaced included: Core network switches, routers, access layer switches, cameras, and wireless access points. Ubiquiti also has a central network controller (fig. 2), which reduces network management costs and increases visibility. Many challenges were encountered and overcome during the transition. The result is a faster, stable network infrastructure at a minimal cost.

Patient Monitoring system

Clinical Engineering took on replacing our aging Philips Central Monitoring system for monitoring patients within the hospital. The vendor no longer supported the system, and the operating system was becoming obsolete and a potential vulnerability to our cybersecurity posture. We pulled in all data we could and worked with the clinical departments and leadership to come up with a solution that would work for all involved. Ultimately, we decided on a new Philips system. This met our clinical goals and ended up being the most fiscally responsible solution. It was a long process that took around nine months to complete from start to finish. We are now fully compliant with a user-friendly system that is now ready for integration with our new health information system in 2021.

What is in the future for 2021?

As the NIHD ITS Director, I am always challenging my teams to make the healthcare technology experience better and more secure for our patients, physicians, and staff. In keeping with that philosophy, the ITS team and the District will be implementing our new computerized health information system from Cerner that automates all aspects of the healthcare process from registration to clinical documentation to measuring outcomes, including continuing to growing our Telehealth platforms. ■

ITS and Clinical Engineering Team with its prestigious Penetration Test Certification. From left to right: ITS Coordinator Kim Pham, Manager of Clinical Engineering Scott Stoner, Network System Engineer Dean Lewis, Computer Services Analyst Jason Babb, Application Administrator Dee Booth, Director of ITS Bryan Harper, ITS System Administrator David Jacobs, Biomedical Engineer Jeffery Townsend, Biomedical Engineer John Heslinger, Enterprise Application Analyst Jeannette Smith, and Computer Services Analyst Scott Stoll. Photo by David Calvert

ANNUAL COMPLIANCE REPORT, 2020

1. **Compliance Department** – The Compliance Department at NIHD is responsible for oversight of the Compliance Program, review of contracts and Business Associates Agreements (BAA), privacy and confidentiality, including compliance with State and Federal Privacy laws, auditing of employee access to electronic health records (EHR), review of claims audits, and compliance with healthcare laws, regulations, and accrediting body guidance. The Compliance Department provides support, policy guidance, and regulatory research for members of the NIHD team. The NIHD Compliance team consists of two members of the workforce.

    a. Patty Dickson, Compliance Officer – Reports to the Chief Executive Officer and NIHD Board of Directors. Responsible for oversight of the NIHD Compliance Program and regulatory compliance for the District

    b. Conor Vaughan, Compliance Analyst – Reports to the Compliance Officer. Completes EHR access audits, investigations, research, and analysis, and provides support to Compliance Officer for all aspects of Compliance Department services

2. **Comprehensive Compliance Program review**

    a. As of June 1, 2020, 94.3 percent of the District's employees (including temporary, traveler, and contract workers) have reviewed the Compliance Program. Of employees who have been here longer than 90 days, 98.2 percent have reviewed. These numbers fluctuate due to employee turnover.

    b. 98.72 percent of District workforce, including providers, have completed HIPAA training

    c. HIPAA Rounding – Developed HIPAA walk-through audit sheets, allows for tracking and just-in-time training for areas at risk for privacy concerns, breaches, and security issues. Started in January 2020. On hold as of March 2020. Will resume when COVID restrictions for the workforce are lifted.

    d. Audits as listed below to review for fraud, waste and abuse, and privacy monitoring.

3. **Audits**

    a. Employee Access Audits - The Compliance Department Analyst manually 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. Approximately 3,000 audits were conducted for Quarter 3 of calendar year 2020.

        ii. The HIPAA and HITECH Acts imply that organizations must perform due diligence by actively auditing and monitoring appropriate PHI use. These audits are also required by the Joint Commission and are a component of the "Meaningful Use" requirements.

        iii. Access audits monitor who is accessing records by audit trails created in the systems. These audits allow us to detect unusual or unauthorized access of patient medical records.

        iv. Audits are also conducted when requested or "for cause."

        v. Compliance performs between 500-1,000 audits monthly.

            1. Each audit ranges from hundreds of lines of data to thousands of lines of data.

            2. A "flag" is created when any access appears unusual.

            3. Flags are reviewed and resolved by comparison audits, workflow review, discussions with workforce, and discussions with leadership.

    b. Business Associates Agreements (BAA) audit

        i. BAAs are required by federal Health Information Portability and Accountability Act (HIPAA) for any business associate who creates, receives, transmits, or stores NIHD protected health information (PHI).

        ii. We currently have approximately 185 Business Associates Agreements.

    c. Vendor Contract reviews

        i. Approximately 70 contracts reviewed in conjunction with legal counsel since July 1, 2020

        ii. Reviewing all Athena and Partners contracts for notification of cancellation or renegotiation timelines – roughly 15 contracts in review

    d. PACS (Picture Archival and Communication System) User Access Agreements - No new requests since the previous quarterly report. These agreements are required by state and federal privacy laws to ensure the confidentiality of PHI.

    e. HIMS audit – Scheduled for Q1 2021

        i. Audits ensure accuracy of the legal medical record, correct document placement, and correct release of information

    f. Language Access Services Audit

        i. Audits for Language Access Services to ensure Limited English Proficiency (LEP) patients are provided with the appropriate access to ensure safe, quality healthcare.

        ii. Audits review documentation of language assistance provided to LEP patients

        iii. Action items from audits allow the Compliance team to work with Language Access Services Manager José Garcia, to develop tools for the workforce to ensure all proper steps are followed.

        iv. Language Access regulations are enforced by the HHS Office of Civil Rights.

    g. HIPAA Security Risk Assessment

        i. Completed October 2020 (requires collaboration between Compliance Officer and Security Officer)

        ii. Annual requirement to assess security and privacy risk areas as defined in 45 CFR 164.3. Review of 157 privacy and security elements performed in conjunction with Information Technology Services.

        iii. NIHD is using VendorMate (GHX) vendor credentialing software. This allows us to be compliant with our Vendor Credentialing Policy, and several facility security elements of 45 CFR 164. Vendor mate tracks when vendors arrive and depart the facility.

            1. We have more than 70 Vendor Companies registered.

            2. We have 130 Representatives registered.

    h. 340B audit

        i. The 340B Program administered by Healthcare Resources and Services Administration (HRSA) enables NIHD to stretch scarce federal resources as far as possible, reaching more eligible patients and providing more comprehensive services. Manufacturers participating in Medicaid agree to provide outpatient drugs to healthcare providers at significantly reduced prices.

        ii. Compliance provides assistance and support to 340B Program Manager, Pharmacist Jeff Kneip.

        iii. Annual external audit is scheduled for January 2021

    i. Claims Audit

        i. Compliance with correct coding and insurance billing is a major component of the fraud, waste, and abuse programs and a high area of interest for HHS OIG.

        ii. HHS OIG Medicare Fraud Control Units recovered $1.9 Billion in fraudulent, wasteful, or systemic abuse of the Medicare and Medicaid program monies in 2019. NIHD audits and fraud, waste

and abuse programs have been developed to ensure that the District complies with regulations.

iii. External insurance billing/claims audit is scheduled for FY 2021

j. Provider and vendor reviews

i. Compliance reviews all providers who send referrals to the District to ensure they are not on the Federal List of Excluded Individuals and Entities (LEIE) or the state Suspended and Ineligible Providers list. Accepting referrals from excluded individuals may be considered fraudulent activity.

ii. Compliance reviews and verifies hundreds of providers and vendors each year.

iii. Compliance also plays a role, in conjunction with Admissions Services, clerks, and the Information Technology Services Department, to ensure all provider fax numbers are entered into all systems (electronic health systems and fax machines), to reduce the risk of misdirected faxes (potential breaches) by NIHD workforce.

4. Compliance Workplan

a. Compliance Officer creates and updates a Compliance Workplan annually. This work plan focuses on areas of interest in the Health and Human Services Office of Inspector General (OIG) Annual Workplan and areas of interest for the District's Medicare Administrative Contractor (MAC).

b. The NIHD workplan is evaluated and updated quarterly and as needed.

5. Privacy Breaches

a. State and Federal laws designate strict access, use, and disclosure of protected/confidential health information. Enforcement may be civil and criminal against individuals and the District. Fines up to a maximum penalty for each violation of a particular HIPAA requirement or prohibition is $59,522, with a calendar-year cap of $1,785,651 for all violations.

b. The Compliance Department takes a proactive approach by providing privacy and confidentiality training and education via the learning management system, in-person training, annual reviews, policy review requirements, meeting attendance, emails, and just-in-time training.

c. When an alleged breach occurs, the Compliance Department reviews, investigates, develops a damage mitigation plan, reports to the proper authorities and affected individuals, provides education and training, and works with the leadership to sanction the workforce as required by HIPAA laws and NIHD policy.

d. At the time of this annual report, work of the Compliance Department has completed mitigation plans accepted by state and federal authorities such that the District has, thus far, received no financial penalties for FYs 2018, 2019, and 2020. Several breach investigation reviews are still underway with the California Department of Public Health Medical Breach Enforcement Section.

e. The Compliance Department has investigated 65 alleged breaches in CY 2020.

i. Investigations closed with no reporting required – 48

ii. Investigations still active – 2

iii. Reported to CDPH/OCR – 15

6. Issues and Inquiries

a. Members of the leadership team frequently contact the Compliance department to review and research specific areas of regulations or accreditation guidance.

b. Compliance has researched approximately 50 areas of regulatory concern since June 2020

7. CPRA (California Public Records Act) Requests

a. The Compliance office either has responded or is responding to 46 CPRA requests thus far in 2020.

8. CDPH Licensing Survey Response and Monitoring

a. The Compliance Department provided assistance and guidance to the leadership team for the response to the most recent CDPH licensing survey. Corrective action plans were developed for all areas noted on the survey. Once action plans were completed, the Compliance team assisted leadership with continuous monitoring to ensure sustained compliance.

b. All action plans were met with sustained compliance.

9. The Joint Commission Survey Response and Monitoring

a. The Compliance Department provided assistance and guidance to the leadership team for the response to the most recent Joint Commission accreditation survey. Corrective action plans were developed for all areas noted on the survey. Once action plans were completed, the Compliance team assisted leadership with continuous monitoring to ensure sustained compliance was achieved.

b. All action plans were successfully completed with sustained compliance.

10. California Division of Occupational Safety and Health (CAL DOSH) Complaint

a. On rare occasions, the District receives notification of a complaint to DOSH.

b. In 2020, there was a complaint of incinerator fumes entering the support building on the NIHD Campus. A plan to decommission the incinerator with all supporting documentation was submitted in response.

c. No further communication from CAL DOSH at this time (12/28/2020).

11. Compliance and Business Ethics Committee (CBEC)

a. The Compliance and Business Ethics Committee was created by the NIHD Compliance Program. It is comprised of members of the leadership team and tasked with review of compliance and ethics concerns.

b. Subcommittees of the CBEC include the Business Compliance Team, which is tasked with reviewing conflicts of interest that may occur in the District; The Billing and Coding Compliance Committee is tasked with reviewing and discussing all billing, coding, and related compliance concerns; and, the NIHD Forms Committee ensures that all NIHD forms are compliant with state and federal regulations, appropriately worded, and have a consistent NIHD format.

12. Projects

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

i. Anticipated go-live Q1 FY 2021

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

iii. A small team comprised of nursing, operations, compliance, and ITS representatives have been completing work on the policy management software optimization.

iv. Clean up work is on-going. Development of optimal processes to assign policies will assure that policies are only given to readers who must review them.

v. Will reduce employer costs by allowing for better use of employee time by reducing policy assignments to those necessary and required.

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

i. Training for licensed users completed

ii. Key contract metrics are currently being added

iii. Reducing visible contracts from almost 1800 to the about 400 currently active contracts

iv. All historic contracts in the system will still be available for review.

FINANCIAL REPORTS

NORTHERN INYO HEALTHCARE DISTRICT

2019-2020 FISCAL YEAR

FROM THE DESK OF THE CHIEF FINANCIAL OFFICER

VINAY NARJIT SINGH BEHL, MS, MBA, CPA

This has been a challenging year with severely constrained financial resources as we navigated the onslaught of COVID since February 2020. The management of Northern Inyo Healthcare District (NIHD) refocused and realigned various initiatives to address lockdowns, postponement of elective surgeries, and strategies in continuing to provide essential medical care while preparing for an increase in COVID cases. To this I always give the analogy of changing tires while driving the car. This was a challenging task to continue essential operations and introduce new initiatives in line with the vision of our new interim Chief Executive Officer, Kelli Davis.

As we navigated these unchartered waters, we did secure much-needed funding in the form of Provider Relief grants of $ 6.7 million from the Department of Health & Human Services, Medicare advance funds of $14.4 million, and Payroll Protection Program loan under CARES Act of $8.5 million. As you will see, the District's various projects to improve workflows, standardize processes, renegotiate contracts, and implement a new Group Purchasing Organization (GPO) with potential savings in supplies and pharmacy costs of 25 percent, which ultimately improve efficiency and economy of operations. The Board of Directors of NIHD provided guidance and unstinted support to improve governance in clinical operations and finance. The time of the year was ripe for refinancing and refunding existing debt and renegotiating debt service, providing savings of approximately $1 million per year for the next five years. In addition to cutting costs and adding service lines like Plastic Surgery and expanding Urology, we also tackled improvement in Revenue Cycle Management processes.

This Annual Report includes a compilation of the operating results and financial position of the NIHD. The financial reports presented represent a summary of data generated by the hospital, Rural Health Clinic, Women's Health, Internal Medicine, and Surgery clinics. Additional information regarding the organizational structure can be found in the Notes to Financials section of the Annual Report.

The Annual Report is compiled to provide useful information about the entity's operations and programs and ensure its accountability to the citizens of Inyo County. While NIHD's management believes this information to be accurate, it should be noted that these documents are unaudited and not intended to be used for any financial decisions. The Financials and Statistics section presents Management's Discussion and Analysis and financial statements for NIHD. This section includes selected statistical and financial ratio information. Management's Discussion and Analysis provides a review of the financial operations, and the Notes to Financials section offers an additional explanation for the reader.

INTERNAL CONTROL STRUCTURE

NIHD's management established and maintained an internal control structure to achieve the objectives of effective and efficient operations, reliable financial reporting, and compliance with applicable laws and regulations. Management applied the internal control standards to meet each of the internal control objectives and to assess internal control effectiveness. When evaluating the effectiveness of internal control over financial reporting and compliance with financial-related laws and regulations, management followed the assessment process to assure that NIHD is committed to safeguarding its assets and is providing reliable financial information.

One objective of an internal control structure is to provide management with reasonable, although not absolute, assurance that assets are safeguarded against loss from unauthorized use or disposition. Another objective is to ensure that transactions are executed in accordance with appropriate authorization and recorded properly in the financial records to permit the preparation of financial statements in accordance with generally accepted accounting principles. Annually, management provides assurances on internal control over financial reporting along with a report on identified material weaknesses and corrective actions. As a recipient of federal and state funds, NIHD is responsible for ensuring compliance with all applicable laws and regulations.

The audit procedures are conducted in accordance with auditing standards generally accepted in the United States of America and Government Auditing Standards issued by the Comptroller General of the United States. The District has appropriate Budgetary Controls and on an annual basis, NIHD's Board of Directors approves budgets for hospitals and clinics. On a monthly basis, the CFO provides review of the budget vis-à-vis monthly reports that compare the budget and actual operating results. Department heads are expected to review the reports and identify significant variances from their budget. If necessary, action plans are implemented that will improve negative variances.

CASH & RISK MANAGEMENT

The cash management policy includes all receipts and disbursements so that investment earnings are maximized, and vendor relations are maintained.

The NIHD Risk Management Exposures to loss are handled by various methods, including participation in state-administered insurance programs, purchase of commercial insurance, and self-retention of specific risks. The key to managing risk is to ensure that programs are in place that educate and guide employees to the best practices for our industry. We have a responsibility to safeguard our patients so that no additional harm comes to them while under our care. We are similarly committed to ensuring a safe workplace for our employees. In addition to the typical litigation risks with which we are faced, we have to recognize the risk and rewards associated with the health care industry. Continual evaluation of existing programs and new service development is the only way to maintain or increase our competitive advantage.

BOND REFUNDING

The 2010 Bonds totaling $11,600,000 issued by the District dated March 31, 2010, were to (a) finance the remodeling, expansion, improvement and equipping of the health facilities,(b) fund the Bond Reserve Account and (c) pay certain costs and expenses relating to the issuance and sale of the 2010 Bonds. Redeemable December 1, 2020 without premium.The Series 2013 Bonds totaling $11,335,000 dated January 17, 2013 were used, together with certain other monies, to (a) reimburse the District for certain costs incurred in remodeling, expanding, improving, and equipping the Hospital, (b) refund all outstanding Northern Inyo County Local Hospital District (Inyo County, California) Revenue Bonds, Series 1998 (the "1998 Bonds"), (c) fund the Bond Reserve Account related to the Series 2013 Bonds and (d) pay certain costs and expenses relating to the issuance and sale of the Series 2013 Bonds. Redeemable December 1, 2023 without premium. Redemption prior to December 1, 2023, will be redeemable by

Vinay Narjit Singh Behl, MS, MBA, CPA
Chief Exective Healthcare Financial Advisor

paying for defeasement of the bonds until that date. Accordingly, the Series 2013 Bonds are on parity with the 2010 Bonds, and both are limited obligations of the District payable solely from Revenues in accordance with Indenture.

The 2021 Refunding of the 2010 & 2013 Revenue Bonds is to flatten the debt service required payments under the current amortization structure to a more manageable schedule to establish a more solid economic footing for the hospital going into the future.

Budget Planning and Spending Cuts

The District took preemptive measures to reduce the rate of spend and also budget in an uncertain environment. All departmental heads were required to explore cost-cutting opportunities and plan departmental activities to support their departments' economy and efficiency.

Division of Finance and Accounting Services (DFAS) prepared a detailed budget document for each department to depict the main cost and revenue drivers. Departments needed to work with DFAS to evaluate and prepare a zero-base budget for fiscal 2020-21. The budget was presented to the board in the meeting to be held on June 21, 2021.

We anticipated significant economic impacts from the COVID-19 pandemic. The severe reduction in patient activity was expected to result in significant decreases in inpatient and outpatient revenues and liquidity issues for the District. While the federal and state governments were releasing funding to supplement revenues and stimulus programs like the CARES Act were providing loans to support staff and avoid furloughs, it was incumbent upon District management to work with NIHD clinical and administrative teams to evaluate each expense category and defer discretionary expenses and only spend in critical areas. The magnitude of the crisis is immense, and stimulus may not be enough to support our current cost model.

Further challenges emanated from Athena's EHR system that put substantial constraints on patient claims collection. This has, in turn, required substantial and immediate increases in Capital and Operating expenditures needed to implement a new EHR system.

Departmental leaders were authorized to make exemptions from these prohibitions only in addressing a health emergency, avoiding a significant revenue loss, integration, or pooling of activities resulting in net cost savings.

CERNER COMMUNITYWORKS

Implementation of New Electronic Health Record System

CommunityWorks is a cloud-based deployment of the traditional Cerner EHR platform, tailored to meet the unique needs of the community, critical access, and specialty hospitals. This model provides an integrated digital record of a patient's health history that includes clinical and financial data across the continuum of care.

Through this model, Cerner is able to scale award-winning solutions and services with a predictable cost of ownership, providing an economical business model for these hospitals. Cerner also collaborates with these hospitals to identify opportunities to increase value for providers and their patients.

The ability to share information across facilities spanning the entire continuum of care helps keep health care providers connected to their patients and provide a higher standard of care. Cerner can help organizations shift from reactive care to proactive health management by utilizing expertise in technology, process improvement, and transformational leadership.

Key benefits of integration

The true integration included with the Cerner CommunityWorks delivery model is designed to:

- Improve the clinical workflow experience. One chart means less digging for patient information and the entire care team sees the same data.
- Improve the patient experience. One patient portal to schedule visits, review patient data, and communicate with the care team.
- Reduce reliance on third parties.
- Streamline reporting as one EHR platform means one set of reports.

Implementation of new GPO contract

GPOs work by combining the acquiring volume of their members and using that as leverage to negotiate the best discounts with vendors sources and negotiates prices for drugs, medical devices, and other products and services on behalf of healthcare providers

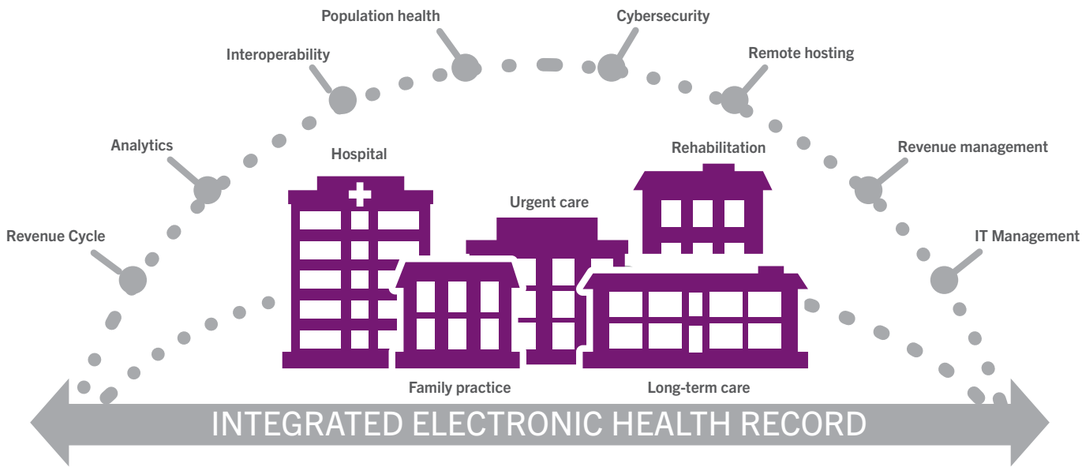
GPOs are saving hospitals between 10-to-18 percent per year on their supply chain costs. Moreover, it is projected that using group purchasing organizations will have saved the entire US healthcare system somewhere around $392.2 billion to $864.4 billion between the years 2013 and 2022. GPOs are in the business of saving hospital administrators from the burden of finding critical cost savings themselves. This allows hospitals to focus on their core mission of providing first-class patient care.

Integration vs. interfacing: architecture matters

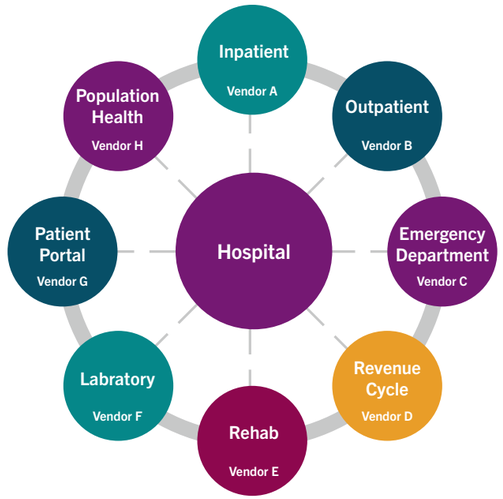
Filling numerous solution gaps with third parties and interfacing disparate technology platforms, even if offered by the same company, is not true integration. A truly integrated EHR platform is when all of a health system's venues of care leverage a single chart on one database.
With the Cerner Community Works cloud-based delivery model, health systems receive that truly integrated EHR platform. And with more than $7 billion cumulative investment in R&D and a strong, strategic future vision, hospitals can be confident that Cerner is prepared to help them in the now and next.

One patient. One record.

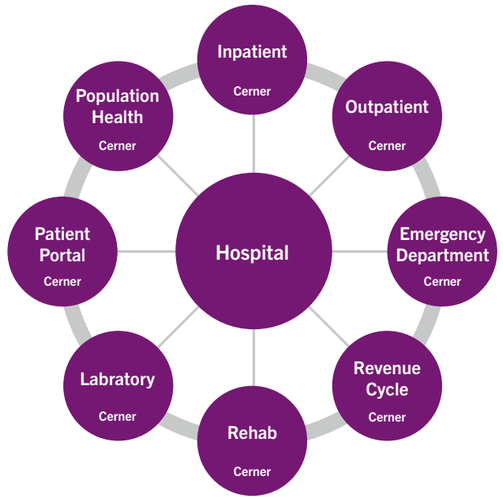
Cerner supports more than 40 specialty workflows that span across all the venues your health system supports. From the hospitals to clinics, physician practices to long-term care facilities and everywhere in between, Cerner helps provide the solutions and services needed to connect and streamline your data.



DISCONNECTED STATE OF HEALTH IT



INTEGRATED STATE OF HEALTH IT WITH CERNER



Comparison between a hospital currently leveraging several disparate IT systems and bolt-on third-party modules and what that hospital's future IT landscape could look like when utilizing an integrated EHR platform from Cerner across their continuum of care.

NIHD entered into a new contract with Community Health Corp(CHC), a leading GPO in the nation. CHC, as its mission, will bring cost savings and deliver the best products and services at the highest value. CHC will help realize savings related to their supply chain management through purchasing efficiencies, price discounts, and other group acquisition benefits. CHC will add predictability and efficiencies to hospital supply chain management. It will enable new and innovative healthcare technologies and the distribution of healthcare supply chain management best practices.

In today's times, health-care providers are coming to rely on GPO for a much broader range of services integral to cost-effective patient outcomes. These services include data analysis, market research, innovative technology integration, electronic product tracing, infection control, and the development of shared knowledge among health-care providers and supply chain experts to enable best practices. All of these services will work to further lower costs and improve operations.

CARES Act funding and PPP loans

The Coronavirus Aid, Relief, and Economic Security Act, also known as the CARES Act, is a $2.2 trillion economic stimulus bill passed by the 116th U.S. Congress and signed into law by President Donald Trump on March 27, 2020, in response to the economic fallout of the COVID-19 pandemic in the United States. NIHD received $8.5 million in PPP loan and $6.7 million in provider relief funding, enabling it to continue essential services during a very low utilization period from March through June 2020. The District also received $14.4 million in Medicare advance payments bolstering its cash reserves.

CLINICS WORKFLOW OPTIMIZATION PROJECT

I. The Opportunity & Challenge

The outpatient clinics at Northern Inyo Health have been experiencing inefficiencies in workflows resulting in lost productivity, revenue loss, staff and provider frustration, and long patient wait times. This results in an annual loss of approximately $6.578M, not including percentage of missing slips, leakage, or supply cost. Additionally, provider compensation will transition to an RVU model in early 2021. This requires a shift in current processes to meet patient volume goals.

Leadership identified the Rural Health Clinic, the largest clinic, to begin improvement work as the pilot site. The RHC is also experiencing high staff turnover, which has led to increased challenges with patient care and staff burnout. Improvements will be spread to the other clinics over the next few months.

These changes will support NIH in reaching its vision to be known throughout the Eastern Sierra Region for providing high quality, comprehensive care in the most patient-friendly way, both locally and in coordination with trusted regional partners. These changes are also the first of many improvements we expect to see across the health system.

Expected Benefits: Improved patient experience, increased revenue, and increased clinic capacity.
Secondary Benefits: Increased staff and provider engagement.
Outcome Goal: To eliminate waste, improve patient flow, and streamline staff workflows to optimize patient value in the RHC by December 2020.

Assessment

Four weeks before the core team came together, our lean management consultant conducted a thorough assessment. The assessment included leadership and staff interviews, onsite observations, and data analysis. The purpose of this assessment was to identify initial areas of focus and begin collecting critical performance data.

The Clinic Leadership Team identified key subject matter experts for the team from cross-functions including Medical Assistance, Front Office, Nursing, Lab, Providers, Practice Management, Revenue Cycle, and Informatics.

Kaizen Team

Kaizen translates to "Change for the better" and is a method used by many industries, including healthcare, to make rapid improvements.

The team participated in a four-day Kaizen Event, a facilitated workshop, where they analyzed the current state of the outpatient clinic, identified pain points and opportunities, designed and tested countermeasures, and began implementing changes expected to improve the following areas of focus:

1. Scheduling to Check-in
2. Facilities Redesign and Check-in
3. Exam to Billing

Kaizen Kick-off: After reviewing the problem definition, project objectives, and performance data, the team received training on the basics of process improvement.

On day one, the team mapped the patient, provider, and staff workflows. They identified 62 pain points or "wastes" in the current state process. Waste is defined as any activity that does not transform the inputs of the process into an

output that the customer is willing to pay for. These are opportunities for improvement.

On day two, they grouped the opportunities into similar categories and brainstormed the possible source of the issues. Three root causes were identified.

- Lack of Standardization
- No Feedback Loops/Visibility
- Staffing Constraints

On day three the team brainstormed dozens of countermeasures to eliminate the root cause issues. They narrowed down their ideas and prioritized by level of impact and effort required for implementation.

On day four, they began socializing and testing some of the ideas on the floor and designing the countermeasures' rollout. Over the next four weeks, the team implemented the remaining countermeasures and began tracking key performance indicators (KPIs).

II. The Process
Team in Action: Countermeasures

**See Table 2*

Leadership Development & Culture Change
The Outpatient Leadership Team has engaged in the following work.

- Leader Standard Work
- Leader Rounding
- Daily Huddles
- Coaching

Through the Daily Huddles at the Huddle Board, leaders have an opportunity to share key announcements quickly, recognize team members, and review daily performance metrics. Staff and providers have an opportunity to ask questions, receive communication, and share their ideas.

Additionally, the Clinic Leadership Team received individual and group coaching to further develop their leadership skills, identify and remove barriers, and continue their performance goals. They are currently working on making NIHD's core values more visible and incorporate them into the daily culture.

III. The Outcome: Results
In just a few weeks of implementing changes at the Rural Health Clinic, the needle has moved on several KPIs. We expect to see the dial move further over the next few months as staff, providers, and patients adjust to the new processes. In addition to the metrics below, we track patient visit lead time and daily patient volume.

- Copay collection
- Patient no shows
- Daily open slots
- Weekly missing slips
- Provider participation in huddles
- Staff improvement ideas submitted

Organizational change requires the commitment and engagement from every employee, provider, and leader. The Kaizen and Outpatient Leadership Team are leading the way on living NIHD's core values of Compassion, Integrity, Quality and Excellence, Innovation, Team-Based, and Safety.

Pre-Visit Prep	Registration	Patient Prep	Visit	Checkout	Billing, Auth, Referral
Leadership Structure Redesign	Co-pay Collection Standard Work	MA Layout Redesign	Room Utilization	Scheduling Follow-up Appts in Room	Daily Review of Missing Slips
Daily Management Tier 1 Huddle	In-Room Registration	In-Room Vitals	Load Level Provider Schedule	Faster Room Turnover	Improve Authorization and Referral Process
No Show Reduction	Front Rapid Response Team (RN with Reception)	Procedure Cart	Reduction in Provider Interruptions		
Phone Triage/ Script		Inventory Kanban Replenishment System	Point of Service Lab Draws		
Staff Skills Matrix/ Development Plan					

Table 2

PRICE TRANSPARENCY MANDATE BY CMS

Northern Inyo implemented the price transparency mandate by CMS on Jan 1, 2021. To improve price transparency, all U.S. hospitals and health systems are required to provide lists of standard hospital charges — also called a chargemaster—so patients can compare prices across hospitals.

Northern Inyo Healthcare District Average Charges by Type of Patient Group
All hospitals and health systems also are required to provide a listing of average charges by types of patient groups, referred to as MS-DRGs (Medicare Severity Diagnosis Related Groups). Patients can view similar listings posted by different hospitals, which provide a more direct comparison of charges than the standard charges in the chargemaster.

Northern Inyo Healthcare District Shoppable Services Prices
All hospitals and health systems also are required to post a list of at least 300 Shoppable Services along with the corresponding prices for each of those services. Each of these Shoppable Services includes the following amounts: Gross Charge, Discounted Cash Price, Payer-Specific Negotiated Charges, De-Identified Minimum Negotiated Charge, and De-Identified Maximum Negotiated Charge.

NIHD'S 10 POINT ACTION PLAN FOR FINANCIAL SUSTAINABILITY

As healthcare organizations face increased financial pressure, it is increasingly essential for us to craft strategies that ensure our organizations have the financial resources required to operate over the long term. Under our CEO Kelli Davis's leadership, we have constructed a 10-point program to ensure financial stability.

Securing Federal & State funding: With the current pressure on liquidity, we explored all avenues to seek federal and state funding. We received $ 14 million in Medicare advance payments, $ 6.7 million in Provider Relief Funds from the Department of Health and Human Services.

Paycheck Protection Program loan: We also received PPP loan under CARES Act for $ 8.5 million. We are also exploring various grants for meeting vaccination costs.

Adding Service lines: During the year, management has worked with CMO to add various specialty lines to the existing portfolio. We added Plastic Surgery and Breast Surgery.

New Group Purchasing Organization: We entered into a new Group Purchasing Organization contract during the year to enable leveraging the existing network and bargaining power of a larger Group Purchasing Organization like Community Hospital Corp. This effort is estimated to save the hospital $3 million.

Renegotiating contracts: Hospital is actively renegotiating various large service and equipment contracts. We are also working with our vendors to structure payments so that there is a lessor burden during the COVID pandemic of excess payments.

Long term Capital Improvement plan: The District is evaluating a strategic long-term Capital Improvement Plan to determine investments in facilities in the next five to 10 years.

Digital Transformation: The District has implemented various enterprise resource planning applications, including but not limited to budget planning, Docusign, concur expense management, EHR, all geared towards efficient work flow and elimination of redundant tasks.

Bond Refunding: The District is aggressively taking advantage of lower interest rates and refunding its existing bonds to save $ 1 million in yearly debt service for the next five years.

Robust Revenue Cycle Operations: The District is doing a wholistic review of Revenue Cycle Operations, including a revenue integrity program where chargemasters and markups are reviewed and compared with peers in the geographical area.

Lean Management: The District has embarked upon an efficiency project in the Rural Health Clinic and other specialty clinics. The goal is to target various inefficiencies and ensure a well-coordinated and exceptional patient experience where patient visits are seamless and efficient, resulting in more provider time to schedule more visits and improve access.

NORTHERN INYO HEALTHCARE DISTRICT

FINANCIAL STATEMENTS AND SUPPLEMENTARY INFORMATION

Year Ended June 30, 2020

NORTHERN INYO HEALTHCARE DISTRICT

FINANCIAL STATEMENTS AND SUPPLEMENTARY INFORMATION

YEAR ENDED JUNE 30, 2020

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CPAs & BUSINESS ADVISORS

INDEPENDENT AUDITOR'S REPORT

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

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

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

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

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

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

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

Emphasis of Matter

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

Other Matters

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

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

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

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

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

Other Reporting Required by Government Auditing Standards

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

Sacramento, California
July 16, 2021

NORTHERN INYO HEALTHCARE DISTRICT

STATEMENT OF NET POSITION

JUNE 30, 2020

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

NORTHERN INYO HEALTHCARE DISTRICT

STATEMENT OF NET POSITION (CONT.)

JUNE 30, 2020

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

NORTHERN INYO HEALTHCARE DISTRICT

STATEMENT OF REVENUES, EXPENSES, AND CHANGES IN NET POSITION

YEAR ENDED JUNE 30, 2020

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

NORTHERN INYO HEALTHCARE DISTRICT

STATEMENT OF CASH FLOWS

YEAR ENDED JUNE 30, 2020

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

NORTHERN INYO HEALTHCARE DISTRICT

STATEMENT OF CASH FLOWS (CONT.)

YEAR ENDED JUNE 30, 2020

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

NORTHERN INYO HEALTHCARE DISTRICT

STATEMENT OF CASH FLOWS (CONT.)

YEAR ENDED JUNE 30, 2020

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

NORTHERN INYO HEALTHCARE DISTRICT

STATEMENT OF FIDUCIARY NET POSITION OF PENSION TRUST FUND - PLAN

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

NORTHERN INYO HEALTHCARE DISTRICT

STATEMENT OF CHANGES IN FIDUCIARY NET POSITION OF PENSION TRUST FUND - PLAN

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

NORTHERN INYO HEALTHCARE DISTRICT

STATEMENT OF FIDUCIARY NET POSITION OF PENSION TRUST FUND - PEPRA PLAN

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

NORTHERN INYO HEALTHCARE DISTRICT

STATEMENT OF CHANGES IN FIDUCIARY NET POSITION OF PENSION TRUST FUND - PEPRA PLAN

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

NORTHERN INYO HEALTHCARE DISTRICT

NOTES TO FINANCIAL STATEMENTS

NOTE 1: SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Reporting Entity

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

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

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

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

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

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

Discretely Presented Component Unit

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

Basis of Presentation

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

Use of Estimates in Preparation of Financial Statements

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

NOTES TO FINANCIAL STATEMENTS

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

Cash and Cash Equivalents

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

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

Cash and Cash Equivalents (Continued)

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

Patient Receivables and Credit Policy

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

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

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

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

Investment in PMA

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

Inventories

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

Noncurrent Cash and Investments

Noncurrent cash and investments include assets held under indenture agreements.

Fair Value Measurement

Fair value is the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. A

NORTHERN INYO HEALTHCARE DISTRICT

NOTES TO FINANCIAL STATEMENTS

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

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

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

Level 2 - Inputs to the valuation methodology include:

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

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

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

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

Capital Assets and Depreciation

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

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

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

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

Accreted Interest

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

Compensated Absences

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

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

Retirement Plan

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

NOTES TO FINANCIAL STATEMENTS

Investments are reported at fair value.

Unearned Revenue

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

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

Net Position

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

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

Net Patient Service Revenue

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

Charity Care

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

Operating Revenue and Expenses

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

Operating Revenue and Expenses (Continued)

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

District Property Tax Revenue

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

Grants and Contributions

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

Unemployment Compensation

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

NORTHERN INYO HEALTHCARE DISTRICT

NOTES TO FINANCIAL STATEMENTS

Deferred Outflows/Inflows of Resources

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

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

Deferred Outflows/Inflows of Resources (Continued)

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

Stewardship, Compliance, and Accountability

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

NOTE 2: REIMBURSEMENT ARRANGEMENTS WITH THIRD-PARTY PAYORS

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

Hospital

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

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

Physician and Professional Services in Rural Health Clinics

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

Hospital Based and Free Standing Physicians and Professional Services

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

Accounting for Contractual Arrangements

The District is reimbursed for certain cost-reimbursable items at an interim rate, with final settlements determined after an audit or review of the District's related annual cost reports by the Medicare Administration Contractor. Estimated provisions to approximate the final expected settlements are included in the accompanying statements of

NOTES TO FINANCIAL STATEMENTS

net position as due to third-party reimbursement provisions. The cost reports for the District have been final settled through June 30, 2016.

Other Governmental Program Revenue

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

Compliance

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

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

NOTE 3: CASH AND CASH EQUIVALENTS AND INVESTMENTS

Investments

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

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

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

NORTHERN INYO HEALTHCARE DISTRICT

NOTES TO FINANCIAL STATEMENTS

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

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

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

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

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

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

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

Investment in State Investment Pool - The District is a voluntary participant in the Local Agency Investment Fund (LAIF) that is regulated by the CGC under the oversight of the Treasurer of the State of California. The fair value of the District's investment in this pool is reported in the accompanying financial statements at amounts based upon the District's pro-rata share of the fair value provided by

NOTES TO FINANCIAL STATEMENTS

LAIF for the entire LAIF portfolio (in relation to the amortized cost of that portfolio). The balance available for withdrawal is based on the accounting records maintained by LAIF, which are recorded on an amortized cost basis.

Fair Value Measurements

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

Guaranteed investment contracts are valued at cost.

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

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

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

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

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

Pension Plan Investment Policy - Pension Trust Fund - Plan

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

NORTHERN INYO HEALTHCARE DISTRICT

NOTES TO FINANCIAL STATEMENTS

Pension Plan Investment Policy - Pension Trust Fund - PEPRA Plan

The PEPRA Plan's investment policy authorizes the Plan to invest in all investments allowed by state statue.

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

Credit Risk - Pension Trust Fund - Plan and PEPRA Plan

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

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

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

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

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

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

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

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

	2019
Cash	$ 130,977
Totals	$ 130,977

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

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

NOTE 4: PATIENT RECEIVABLES - NET

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

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

NOTES TO FINANCIAL STATEMENTS

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

NOTE 5: NET PATIENT SERVICE REVENUE

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

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

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

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

NOTE 6: CHARITY CARE

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

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

NORTHERN INYO HEALTHCARE DISTRICT

NOTES TO FINANCIAL STATEMENTS

NOTE 7: CAPITAL ASSETS

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

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

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

PMA's capital assets activity consisted of the following:

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

NOTES TO FINANCIAL STATEMENTS

NOTE 8: LONG-TERM DEBT AND CAPITAL LEASE OBLIGATIONS

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

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

NORTHERN INYO HEALTHCARE DISTRICT

NOTES TO FINANCIAL STATEMENTS

Long-Term Debt

General Obligation Bonds, 2009 Series

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

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

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

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

Revenue Bonds, 2010 Series

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

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

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

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

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

Revenue Bonds, 2013 Series

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

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

The 2013 Bonds maturing on December 1, 2027, may be called, without premium, by the District on December 1, 2013, through December 1, 2015. The District has pledged its gross revenue as security for the Revenue Bonds, 2013 Series and these obligations contain a provision that in an event of default, the outstanding amounts become immediately due if the District is unable to make a payment.

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

DIRECT PLACEMENTS:

2016 General Obligation Refunding Bond

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

NOTES TO FINANCIAL STATEMENTS

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

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

DIRECT BORROWINGS:

Capital Lease Obligations

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

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

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

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

Paycheck Protection Program loan

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

CMS Advance

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

Advanced Refunding

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

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

NOTES TO FINANCIAL STATEMENTS

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

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

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

Pledged Revenue

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

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

NOTES TO FINANCIAL STATEMENTS

NOTE 9: RETIREMENT PLANS

Defined Benefit Plan - The Plan

Plan Description

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

Benefits Provided

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

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

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

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

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

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

Change in Assumptions

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

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

Contributions

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

Net Pension Liability

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

NORTHERN INYO HEALTHCARE DISTRICT

NOTES TO FINANCIAL STATEMENTS

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

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

Investment Valuations

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

Concentration of Credit Risk

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

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

Investment Rate of Return

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

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

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

NOTES TO FINANCIAL STATEMENTS

Changes in the Net Pension Liability

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

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

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

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

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

NORTHERN INYO HEALTHCARE DISTRICT

NOTES TO FINANCIAL STATEMENTS

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

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

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

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

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

Defined Benefit Plan - The PEPRA Plan

Plan Description

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

Benefits Provided

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

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

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

NOTES TO FINANCIAL STATEMENTS

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

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

Contributions

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

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

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

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

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

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

NORTHERN INYO HEALTHCARE DISTRICT

NOTES TO FINANCIAL STATEMENTS

Changes in the net pension liability

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

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

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

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

NOTES TO FINANCIAL STATEMENTS

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

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

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

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

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

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

Defined Contribution Plan

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

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

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

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

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

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

NOTE 10: RISK MANAGEMENT

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

NORTHERN INYO HEALTHCARE DISTRICT

NOTES TO FINANCIAL STATEMENTS

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

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

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

NOTE 11: SELF-FUNDED INSURANCE

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

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

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

NOTE 12: CONCENTRATION OF CREDIT RISK

The District grants credit without collateral to patients.

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

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

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

NOTE 13: COMMITMENTS AND CONTINGENCIES

Litigation

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

NOTES TO FINANCIAL STATEMENTS

Paycheck Protection Program Loan Review

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

NOTE 14: PROVIDER RELIEF FUNDS

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

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

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

Note 15: Condensed Financial Information for Component Units

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

Condensed Statement of Net Position - Blended Component Units

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

NORTHERN INYO HEALTHCARE DISTRICT

NOTES TO FINANCIAL STATEMENTS

Condensed statement of revenues, expenses, and changes in net position - Blended component units

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

Condensed Statement of Cash Flows - Blended Component Units

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

NORTHERN INYO HEALTHCARE DISTRICT

NOTES TO FINANCIAL STATEMENTS

NOTE 16: RESTATEMENT

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

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

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

NOTE 17: RELATED-PARTY TRANSACTIONS

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

NOTE 18: SUBSEQUENT EVENTS

Purchase of Pioneer Medical Associates

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

Line of Credit

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

REQUIRED SUPPLEMENTARY INFORMATION

NORTHERN INYO HEALTHCARE DISTRICT

SCHEDULE OF CHANGES IN THE NET PENSION LIABILITY AND RELATED RATIOS - PLAN

Last Ten Fiscal Years (If Available)

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

See accompanying notes to required supplementary information.

NORTHERN INYO HEALTHCARE DISTRICT

SCHEDULE OF CHANGES IN THE NET PENSION LIABILITY AND RELATED RATIOS - PLAN

Last Ten Fiscal Years (If Available)

Notes to Schedule:

Note 1:

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

Note 2:

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

NORTHERN INYO HEALTHCARE DISTRICT

SCHEDULE OF CONTRIBUTIONS AND RELATED RATIOS - PLAN

Last Ten Fiscal Years (If Available)

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

Notes to Schedule:

Valuation date:	January 1, 2019

Methods and assumptions used to determine contribution rates:

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

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

NORTHERN INYO HEALTHCARE DISTRICT

SCHEDULE OF INVESTMENT RETURNS - PLAN

Last Ten Fiscal Years (If Available)

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

NORTHERN INYO HEALTHCARE DISTRICT

SCHEDULE OF CHANGES IN THE NET PENSION LIABILITY AND RELATED RATIOS - PEPRA PLAN

Last Ten Fiscal Years (If Available)

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

NORTHERN INYO HEALTHCARE DISTRICT

SCHEDULE OF CONTRIBUTIONS AND RELATED RATIOS - PEPRA PLAN

Last Ten Fiscal Years (If Available)

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

Notes to Schedule

Valuation date: January 1, 2019

Methods and assumptions used to determine contribution rates:

Single-employer plan	Entry Age Normal Cost Method
Amortization method	Level percentage of payroll, closed
Remaining amortization period	16 years
Asset valuation method	Market value
Inflation	2.5%
Salary increases	3%, including inflation
Investment rate of return	4.00%
Retirement age	65
Mortality: Pre-retirement	**
Mortality: Postretirement (annuity elected)	***

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

NORTHERN INYO HEALTHCARE DISTRICT

SCHEDULE OF INVESTMENT RETURNS - PEPRA PLAN

Last Ten Fiscal Years (If Available)

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

SUPPLEMENTARY INFORMATION

NORTHERN INYO HEALTHCARE DISTRICT

COMBINING STATEMENT OF NET POSITION OF THE DISTRICT AND COMPONENT UNITS

JUNE 30, 2020 (AUXILIARY MAY 31, 2020) (PIONEER HOME HEALTH DECEMBER 31, 2019)

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

NORTHERN INYO HEALTHCARE DISTRICT

COMBINING STATEMENT OF NET POSITION OF THE DISTRICT AND COMPONENT UNITS (CONT.)

JUNE 30, 2020 (AUXILIARY MAY 31, 2020, PIONEER HOME HEALTH DECEMBER 31, 2019)

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

NORTHERN INYO HEALTHCARE DISTRICT

COMBINING STATEMENT OF REVENUES, EXPENSES, AND CHANGES IN NET POSITION OF THE DISTRICT AND COMPONENT UNITS

FOR THE YEAR ENDED JUNE 30, 2020 (AUXILIARY MAY 31, 2020, PIONEER HOME HEALTH DECEMBER 31, 2019)

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

NORTHERN INYO HEALTHCARE DISTRICT

COMBINING STATEMENT OF REVENUES, EXPENSES, AND CHANGES IN NET POSITION OF THE DISTRICT AND COMPONENT UNITS (CONT.)

FOR THE YEAR ENDED JUNE 30, 2020 (AUXILIARY MAY 31, 2020, PIONEER HOME HEALTH DECEMBER 31, 2019)

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

NORTHERN INYO HEALTHCARE DISTRICT

STATISTICAL INFORMATION

YEAR ENDED JUNE 30, 2020

Bed Complement

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

Utilization

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

Medical Staff

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

Employees

	2020	2019	2018	2017	2016
Full-time	361	362	330	29	290
Part-time and per diem	124	131	126	98	105
Total employees	485	493	456	394	395
Full-time equivalents	373.57	375.30	392.89	347.29	321.37

NORTHERN INYO HEALTHCARE DISTRICT

STATISTICAL INFORMATION (CONT.)

YEAR ENDED JUNE 30, 2020

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

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

Robert Sharp
Board Chair, Zone III

2021 CHAIRPERSON'S LETTER

ROBERT SHARP

With the ever-changing landscape of healthcare and the continuous rising costs creating obstacles for our rural community to obtain proper preventative and lifesaving healthcare we seek to ways to navigate these challenges to provide quality care to all. It is our focus as a team to synergize with community partners, patients, and each other to assure long-term sustainability to continually provide quality services to all of the Eastern Sierra and nearby communities. We offer a competitive and very unique place to work, live, and play being in the Eastern Sierra with nearby global attractions such as Yosemite National Park, Lake Tahoe, Mammoth Mountain, Death Valley, and Joshua Tree National Park. We are focusing on transparency, collaboration, efficiency, and long term financial & team goals. We have an amazing team that continues to tackle COVID, EHR conversion to Cerner Communityworks, reorganized departments, continue with construction projects all with an interim team of leaders that have done work light years beyond the board's expectations with the support of their teams. Their work quality and teamwork is to be commended and NIHD continues to lead and be the place to be.

Robert Sharp
2021 Chair, Board of Directors, Northern Inyo Healthcare District

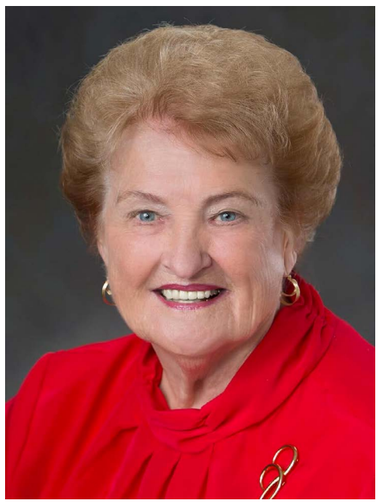
BOARD OF DIRECTORS

Robert Sharp
Board Chair, Zone III

Jody Veenker
Board Vice Chair, Zone I

Topah Spoonhunter
Treasurer, Zone V

Jean Turner
Member at Large, Zone II



Mary Mae Kilpatrick
Secretary, Zone IV

L-R Jody Veenker, Robert Sharp, Topah Spoonhunter, Jean Turner, and Mary Mae Kilpatrick; standing in the Healing Garden with the 1949 Copula and the 2011 building in the rear, showing both NIHD's past and our present. Photo by David Calvert

EXECUTIVE MANAGEMENT

Kelli Davis, MBA
Chief Executive Officer

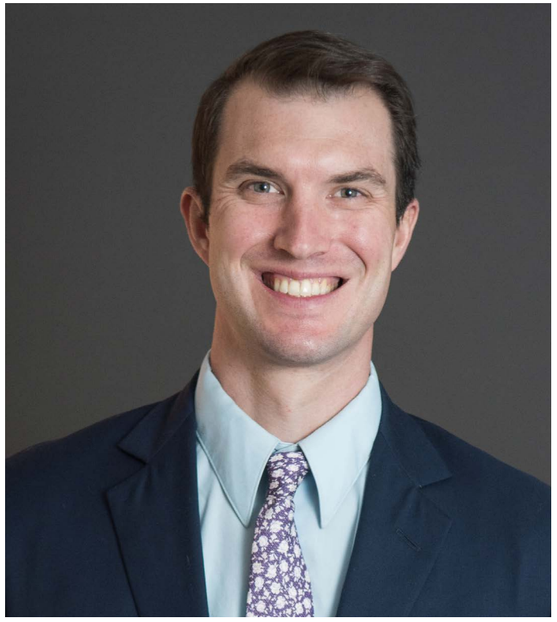
Bio: Kelli Davis is the Interim Chief Executive Officer for Northern Inyo Healthcare District. She leads more than 550 team members and providers, dedicated to the health and well-being of the Eastern Sierra community.

Kelli joined NIHD in 2010 as the Director of Health Information Management, later transitioning to Chief Compliance Officer, and was then promoted to Chief Operations Officer in 2016. She was appointed as Interim Chief Executive Officer in 2020.

In her newest role, Davis is committed to ensuring the sustainability of NIHD for decades to come. She and the Executive Team have been diligent in transparency, team building, cost controls, and adapting to an ever-changing health care environment while navigating unanticipated challenges, including the COVID-19 pandemic.

Davis holds a Master's Degree in Health Care Administration, multiple certifications in healthcare compliance, ethics, and privacy. She is an active member of the American College of Healthcare Executives, American Health Information Management and the Society for Human Resource Management.

Davis is fourth of six generations of Inyo County residents. She and her husband have six grown children and seven grandchildren, many of whom continue to reside in the Bishop area.



William Timbers, MD
Chief Medical Officer

Bio: Dr. William Timbers is an Emergency Medicine physician and foundering partner with Eastern Sierra Emergency Physicians and the Interim Chief Medical Officer for the Northern Inyo Healthcare District. Dr. Timbers has also served as the Vice Chief of Staff and Chief of Staff for the Northern Inyo Medical Staff. Hailing from Vermont, Dr. Timbers has always been drawn to close-knit mountain communities, and he enjoys life in the Eastern Sierra with his wife and two young children. Dr. Timbers completed his medical school education at the University of Vermont in Burlington, Vermont, and completed his residency training in emergency medicine at Beth Israel Deaconess Medical Center and Harvard University in Boston, Massachusetts. As an Emergency Physician, Dr. Timbers evaluates and treats a wide variety of illnesses and injuries across every body system, ranging from minor to life threatening. Dr. Timbers is particularly interested in emergency critical care and orthopedic trauma. Outside of work, Dr. Timbers enjoys backcountry skiing, mountain biking, travel, and spending time with his family.

Allison Partridge, MSN, RN
Chief Nursing Officer

Bio: Allison Partridge is the Chief Nursing Officer of Northern Inyo Healthcare District. She has 20-plus years of experience as a Registered Nurse and holds both a Bachelor's and Master's degree in Nursing. Additionally, Allison has extensive training in lean leadership, Six Sigma, and mission-focused leadership. Allison began her career in the acute care inpatient setting then transitioned to the Emergency Department before beginning her journey as a leader. Allison has more than ten years of leadership experience beginning as a Supervisor in the Emergency Department then transitioning to Department Manager, Department Director, and then multi-department Director prior to accepting the role as Chief Nursing Officer. Before joining the NIHD team, Allison spent her early nursing career at Memorial Medical Center in Modesto, then relocated to Southern California, where she joined the Providence Health and Services team at Little Company of Mary San Pedro. Allison joined the NIHD team in 2018 when she and her family relocated to the Eastern Sierra. When not working Allison enjoys spending time with her husband and two children in the beautiful outdoors of the Eastern Sierra.

Vinay Narjit Singh Behl, MS, MBA, CPA
Chief Financial Officer

Bio: Vinay Narjit Singh Behl has served in a Chief Financial Officer role for various federal, state and private organizations managing budgets of over $20 billion. He has served as Chief Financial Officer of a subsidiary of Guardian Life Insurance Corporation from 2015 through 2017, managing dental services and enabling organic and inorganic growth for the organization; Chief Financial Officer of an operating division of the United States Department of Health & Human Services from 2010 through 2015; and Vice President of Finance for various multinational software companies having worked from 1997 through 2010.

Vinay is a licensed CPA in California and Delaware with various specializations in Accounting, Audit and Finance. He holds a Bachelor's and Master's in finance and graduated with a Master's in Business Administration from University of California, Davis, specializing in mergers and acquisitions. Vinay is a Chartered Accountant; Certified Internal Auditor among many other specialized certifications.

He is also a graduate of the prestigious Strategic Leadership program for Healthcare Executives from Cornell University. In addition, Vinay has held official positions as an advisory board member on the Performance and Accountability committee composed of eight members selected nationwide of American Institute of Certified Public Accountants (AICPA) tasked with recommending performance improvements and governance in large organizations. Vinay was recognized as "CFO of the Year" by *Sacramento Business Journal* for the year 2014. Vinay is also the recipient of National Agency Award for Healthcare Finance from Department of Health & Human Services. Vinay has also consulted for large Healthcare organizations like UC Davis health system.

LEADERSHIP
OPERATIONAL & SYSTEM SUPPORT

Greg Bissonette
Executive Director, NIH Foundation

Robin Christensen
Director of Quality and Infection Prevention

Dan David
Care Coordination Manager

Tanya DeLeo
Admission Services Manager

José Garcia
Language Access Services Manager

Thad Harlow
Director of Rehabilitation

Bryan Harper
ITS Director - CISO

Scott Hooker
Director of Facilities

Steven Kent
Asst. Controller

Frank Laiacona
Director of Pharmacy

Barbara Laughon
Strategic Communications

Jannalyn Lawrence
Clinical Staff Director, Rural Health Clinic and Northern Inyo Associates

LEADERSHIP
OPERATIONAL & SYSTEM SUPPORT *(CONTINUED)*

Neil Lynch
Director of Purchasing

Dolores Perez
Asst. Controller

Dianne Picken
Medical Staff Support Manager

Amy Stange
Cardiopulmonary Manager

Lynda Vance
District Project Manager

Ann Waggoner
Director of Nursing, Perioperative Services

Larry Weber
Director of Diagnostic Services

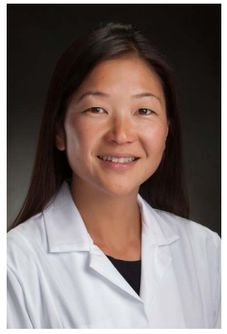
Not Pictured:
Julie Allen, *Surgery Manager*
Tammy Andersen, *OP/PACU Manager*
Jenny Bates, *Assistant Manager, Emergency Department*
Brooklyn Burley, *Assistant Manager, Acute/Subacute ICU*
Sandy DeGiovanni, *Clinical Lab Manager*
Patty Dickson, *Compliance Officer*
Alison Feinberg, *RN Manager, Quality/Informatics/Survey Readiness*
Jeff Garrison, *Admission Services Assistant Manager*
Rosa Gonzalez, *Primary Care Assistant Manager*
Isabel Landeverde, *Specialty Care Practice Manager*
Ryan McVeitty, *Surgery Supply Change Manager*
Richard Miears, *Manager of Environmental Services*
Jason Moxley, *Maintenance Manager*
Jessica Nichols, *Primary Care Practice Manager*
Justin Nott, *Manager Acute/Subacute ICU*
Gina Riesche, *Manager, Emergency Department*
Wendy Runley, *Charge Capture Manager*
Annette Saddler, *Environmental Services/Laundry Assistant Manager*
Scott Stoner, *Manager of Clinical Engineering*
Julie Tillemans, *Perinatal Manager*
Thomas Warner, *Dietary Manager*
Sarah Yerkes, *Rehabilitation Office Assistant Manager*

MEDICAL STAFF

OFFICERS, SERVICE CHIEFS & MEDICAL COMMITTEES 2020-2021

OFFICERS

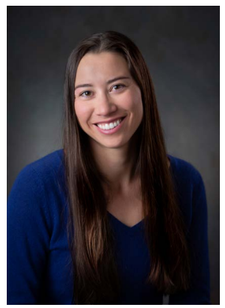
Charlotte Helvie, MD
Chief of Staff



Joy Engblade, MD
Vice Chief of Staff

Stacey Brown, MD
Immediate Past Chief of Staff

SERVICE CHIEFS



Sierra Bourne, MD
Chief of Emergency Room Service

Martha B. Kim, MD
Chief of Obstetrics

Kristin Meredick, MD
Chief of Pediatrics

Robbin Cromer-Tyler, MD
Chief of Surgery

Anne Wakamiya, MD
Member-at-Large, [Medical] Executive and Quality Improvement Committees

Not Pictured:
Nickoline Hathaway, MD, *Chief of Medicine/Intensive Care*
Edmund Pillsbury, MD, *Chief of Radiology*

COMMITTEES

BYLAWS COMMITTEE
Stacey Brown, MD
Charlotte Helvie, MD
William Timbers, MD

CREDENTIALS COMMITTEE
Asao Kamei, MD, Chair
Samantha Jeppsen, MD
Martha B. Kim, MD
Catherine Leja, MD
Anne K. Wakamiya, MD

EMERGENCY SERVICES COMMITTEE
Sierra Bourne, MD, Chief/Chair
David Amsalem, MD
Michael Dillon, MD
James Fair, MD
Daniel Firer, MD
Anne Goshgarian, MD
Adam Hawkins, DO
Samantha Jeppsen, MD
Dave Pomeranz, MD
Anna Rudolphi, MD
Carolyn Tiernan, MD
William Timbers, MD
Joy Engblade, MD
Tammy O'Neill, PA-C (non-voting member)
Gina Riesche, ED Nurse Manager (Ex-Officio non-voting member)
Allison Partridge, CNO (Non-voting participant)
Frank Laiacona, Director of Pharmacy (Non-voting participant)

EXECUTIVE COMMITTEE
Charlotte Helvie, MD, Chief of Staff
Sierra Bourne, MD, Chief of Emergency Room Service
Stacey Brown, MD, Immediate Past Chief of Staff
Robbin Cromer-Tyler, MD, Chief of Surgery
Nickoline Hathaway, MD, Chief of Medicine/ICU Service
Martha B. Kim, MD, Chair of Perinatal/ Pediatrics
Anne K. Wakamiya, MD, Member-at-Large
Kelli Davis, MBA, Interim CEO (Ex-Officio non-voting member)
William Timbers, MD, Interim CMO

INFECTION CONTROL COMMITTEE
Joy Engblade, MD, Chair
Stacey Brown, MD
Catherine Leja, MD
Anne K. Wakamiya, MD
Robin Christensen, RN, Infection Control Preventionist
Marcia Male, Employee Health Nurse (Non-voting participant)
Larry Weber, Director of DI and Lab (Ex-Officio non-voting member)
Kelli Davis, MBA, COO and Interim CEO
Amy Stange, Manager of Cardiopulmonary (Non-voting participant)
Ann Wagoner, RN, DON Perioperative (Non-voting participant)
Denice Hynd, Dietician (Non-voting participant)
Richard Miears, Environmental Services Manager (Non-voting participant)
Allison Partridge, CNO (Non-voting participant)
Frank Laiacona, Director of Pharmacy (Non-voting participant)

INTERDISCIPLINARY PRACTICE COMMITTEE
Catherine Leja, MD, Chair
Stacey Brown, MD
Anne Gasior, MD
Charlotte Helvie, MD
Sarah Zuger, MD
Tracy Drew, FNP
Ann Wagoner, RN, DON Perioperative Services
Allison Partridge, RN, CNO
Jannalyn Lawrence, RN, Manager of RHC Clinic Operations
Julie Tillemans, RN, Manager of Perinatal Services
Kelli Davis, MBA, COO and Interim CEO

LIBRARY AND MEDICAL EDUCATION COMMITTEE
Same as and meets with Quality Improvement Committee

MEDICAL STAFF ASSISTANCE COMMITTEE
Anne Gasior, MD
Catherine Leja, MD
Carolyn Tiernan, MD
Anne K. Wakamiya, MD
Uttama Sharma, MD

MEDICINE/INTENSIVE CARE SERVICE COMMITTEE
Nickoline Hathaway, MD, Chief/Chair
Joy Engblade, MD
Thomas Boo, MD
Stacey Brown, MD
Anne Gasior, MD
Asao Kamei, MD
Catherine Leja, MD
Sarah Zuger, MD
Eva Wasef, MD (Ex-Officio non-voting member)
Justin Nott, RN, Manager of ICU/Acute/ Subacute (Ex-Officio non-voting member)
Amy Stange, Manager of Cardiopulmonary (Ex-Officio non-voting member)
Jannalyn Lawrence, RHC Manager of Clinical Operations (Non-voting participant)
Paul Connolly, RHC Administrative Staff Director (Non-voting participant)
Frank Laiacona, Director of Pharmacy (Non-voting participant)
Jeff Kneip, Pharm.D (Non-voting participant)
Ann Wagoner, RN, DON Perioperative (Non-voting participant)

COMMITTEES (CONT.)

Larry Weber, Director of DI and Lab (Non-voting participant)

Thad Harlow, Director of Rehabilitation (Non-voting participant)

Allison Partridge, CNO (Non-voting participant)

QUALITY IMPROVEMENT COMMITTEE

Physician Members of Executive Committee (see Executive Committee)

Kelli Davis, MBA, COO and Interim CEO (Ex-Officio non-voting member)

Allison Partridge, RN, CNO (Ex-Officio member)

PERINATAL/PEDIATRICS COMMITTEE

Martha B. Kim, MD, Chief of OB, Chair

Kristin Meredick, MD, Chief of Pediatrics

Charlotte Helvie MD

Anne Goshgarian, MD

Sarah Zuger, MD

Justin Nott, RN, Manager of ICU/Acute/Subacute (Non-voting participant)

Brooklyn Burley, RN, Assistant Manager of ICU/Acute/Subacute (Non-voting participant)

Julie Tillemans, RN, Perinatal Nurse Manager (Ex-Officio non-voting member)

Allison Partridge, RN, CNO (Non-voting participant)

Frank Laiacona, Director of Pharmacy (Non-voting participant)

PHARMACY & THERAPEUTICS COMMITTEE

Nickoline Hathaway, MD, Chair

Michael Dillon, MD

Anna Rudolphi, MD

Kristin Meredick, MD

Curtis Schweizer, MD

Frank Laiacona, Director of Pharmacy

Allison Partridge, RN, CNO

Robin Christensen, Infection Preventionist (Non-voting participant)

Jeff Kneip, Pharm.D (Non-voting participant)

Larry Weber, Director of DI and Lab (Non-voting participant)

Gina Riesche, ED Nurse Manager (Non-voting participant)

Justin Nott, RN, Manager of ICU/Acute/Subacute (Non-voting participant)

Kelli Davis, MBA, COO and Interim CEO (Ex-Officio non-voting member)

PURCHASING PRIORITIES COMMITTEE

Physician Members of Executive Committee (see Executive Committee)

Allison Partridge, RN, CNO (Ex-Officio non-voting member)

Kelli Davis, MBA, Interim CEO (Ex-Officio non-voting member)

RADIOLOGY SERVICES COMMITTEE

Edmund Pillsbury, MD, Chair/Chief

Robbin Cromer-Tyler, MD

James Fair, MD

Richard Meredick, MD

Bo Nasmyth Loy, MD

All Contract Radiologists with Medical Staff Membership

Larry Weber, Director of DI and Lab (Ex-Officio non-voting member)

Ann Wagoner, RN, DON Perioperative (Non-voting participant)

SURGERY, TISSUE, TRANSFUSION AND ANESTHESIA COMMITTEE

Robbin Cromer-Tyler, MD, Chief/Chair

L. Jeanine Arndal, MD

J. Daniel Cowan, MD

Andrew Hewchuck, DPM

Richard Meredick, MD

Thomas Reid, MD

Allison Robinson, MD

Mark Robinson, MD

Curtis Schweizer, MD

Eva Wasef, MD

David Pomeranz, MD

David Nicholson, CRNA (Non-voting participant)

Amy Saft, CRNA (Non-voting participant)

Allison Partridge, RN, CNO (Ex-Officio non-voting member)

Ann Wagoner, RN, DON Perioperative (Ex-Officio non-voting member)

Frank Laiacona, Director of Pharmacy (Non-voting participant)

UTILIZATION REVIEW / MEDICAL RECORDS COMMITTEE

Stefan Schunk, MD, Chair

Nickoline Hathaway, MD

Joy Engblade, MD

William Timbers, MD, Interim CMO

Allison Partridge, RN, CNO (Ex-Officio non-voting member)

Paul Connolly, RHC Administrative Staff Director (Non-voting participant)

Mary Ellen Tillemans, Business Office (Ex-Officio non-voting member)

Melanie Fox, Case Manager (Ex-Officio non-voting member)

Heather Edwall, LCSW (Non-voting participant)

Jalaine Beams, Coding Coordinator (Non-voting participant)

Cheryl Brooks, Chart Data Control Clerk (Non-voting participant)

NURSING LEADERSHIP

HOSPITAL

Gina Reische, Manager of Emergency Department

Jenny Bates, Assistant Manager of Emergency Department

Ann Wagoner, Director of Perioperative Services

Julie Allen, Surgery Manager

Tammy Andersen, PACU Manager

Julie Tillemans, Perinatal Manager

Justin Nott, Med-Surg/ICU Manager

Brooklyn Burley, Med-Surg/ICU Assistant Manager

Robin Christensen, Director of Nursing, Quality and Infection Prevention

Alison Feinberg, Quality/Informatics Manager

CLINICAL

Jannalyn Lawrence, Clinical Staff Director, Rural Health Clinic and Northern Inyo Associates

Jessica Nichols, Primary Care Practice Manager

Rosa Gonzalez, Primary Care Assistant Manager

Isabel Landaverde, Specialty Care Practice Manager

Dan David, Care Coordination Manager

L-R: Robin Christensen, Allison Partridge and Ann Wagoner. Photo by David Calvert

NORTHERN INYO HEALTHCARE DISTRICT

One Team. One Goal. Your Health.