January 19 2022 Regular Board Meeting

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

AGENDA

NORTHERN INYO HEALTHCARE DISTRICT
BOARD OF DIRECTORS REGULAR MEETING

January 19, 2022 at 5:30 p.m.

Northern Inyo Healthcare District invites you to join this meeting:

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

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

The Governor of the State of California has issued Executive Orders that temporarily suspend certain requirements of the Brown Act. Please be advised that the NIHD Board Room is closed to the public and that some or all of the District Board members may attend this meeting telephonically or via video conference. This meeting will be accessible to members of the public virtually and telephonically who seek to observe and address the Board of Directors, including giving public comments.

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

A. COVID 19 Community Update *(Board will receive this update)*
B. Approval of the renewal agreement between Northern Inyo Healthcare District and Eastern Sierra Emergency Physicians (*Board will consider the approval of this renewal agreement)*
C. Approval of District Board Resolution 22-01, Nondesignated Public Hospital Bridge Loan Program *(Board will consider the approval of this District Board Resolution)*
D. Policy and Procedure Approval, Charge Capture Policy and Procedure *(Board will consider the approval of this Policy and Procedure)*
E. Recommendation to Appoint a Board Member to the Compliance and Business Ethics Committee *(Board will consider the appointment of a representative)*
F. Discussion of existing Board Committee's (*Board will discuss this item)*
G. Northern Inyo Healthcare District Orthopedic Services December Highlight (*Board will receive this information*)

4. Chief of Staff Report, Sierra Bourne MD:
   A. Radiology Privilege Form *(Board will consider the approval of this form)*
   B. Medical Executive Committee Meeting Report (*Board will receive this information*)

Consent Agenda

5. Approval of District Board Resolution 22-02, to continue to allow Board meetings to be held virtually *(Board will consider the approval of this District Board Resolution)*
6. Approval of minutes of the December 15, 2021 Regular Board Meeting *(Board will consider the approval of these minutes)*
7. Approval of minutes of the December 29, 2021 Special Board Meeting *(Board will consider the approval of these minutes)*
8. Operating Room Flooring Replacement Update (*Board will consider accepting this update)*
9. Chief Executive Officer Report *(Board will consider accepting this report)*
10. Chief Medical Officer Report *(Board will consider accepting this report)*
11. Chief Nursing Officer Report *(Board will consider accepting this report)*
12. Financial and Statistical reports as of November 30, 2021 (*Board will consider accepting this report)*
13. Approval of Policies and Procedures *(Board will consider the renewal of this Policy and Procedure)*
    A. Identity Theft Red Flags Rule Policy

14. Reports from Board members (*Board will provide this information*).
15. Public comments on closed session items.
16. Adjournment to Closed Session to/for:
    A. Conference with Legal Counsel, existing litigation (*pursuant to Paragraph (1) of subdivision (d) of Government Code Section 54956.9).* Name of case: Inyo County LAFCO and NIHD v. SMHD, Case No. 3-2015-8002247-CY-WM-GDS-Sacramento County.
17. Adjournment.

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

NORTHERN INYO HEALTHCARE DISTRICT
RECOMMENDATION TO THE BOARD OF DIRECTORS
FOR ACTION

Date: 01/07/2021

Title: **EASTERN SIERRA EMERGENCY PHYSICIANS CONTRACT RENEWAL**

Synopsis: It is recommended that the Board of Directors approve the proposed contract to allow Eastern Sierra Emergency Physicians (ESEP) to continue to provide physicians services in the respective fields and departments as detailed in the contract.

It is recommended that the Board of Directors approve the proposed contract to allow Eastern Sierra Emergency Physicians (ESEP) to continue to provide physicians services in the respective fields and departments as detailed in the contract. ESEP, in its ongoing partnership with The District, provides emergency medicine, inpatient hospitalist, outpatient medicine, medication assisted treatment, anesthesia, and ultrasound physician services to NIHD. ESEP is eager to build on its decade-long partnership with NIHD to continue to improve access to compassionate, evidence based medical care to the members of our local community and to any individual that seeks care through our shared doors. This three (3) year contract outlines the services and partnership roles ESEP provides in detail. The date the proposed action will become effective is March 1, 2022.

Prepared by: _____
Name: John "Adam" Hawkins, DO
Title: President of ESEP. Medical Director, Emergency Department at NIHD.

Approved by: Kelli Davis
Name Kelli Davis
Title Chief Executive Officer

FOR EXECUTIVE TEAM USE ONLY:

Date of Executive Team Approval: 1-12-2022 Submitted by: Kelli Davis
Chief Officer

AGREEMENT, NORTHERN INYO HEALTHCARE DISTRICT
AND
EASTERN SIERRA EMERGENCY PHYSICIANS

THIS AGREEMENT IS MADE AND ENTERED INTO this 1st day of March, 2022, by and between Northern Inyo Healthcare District (hereinafter referred to as "District") and Eastern Sierra Emergency Physicians Inc. (hereinafter referred to as "ESEP").

I. RECITALS

1. District is a California healthcare district organized and operating under the authority of Health and Safety Code section 32000, et seq. (hereinafter referred to as "The Healthcare District Law"), and governed by a Board of Directors (hereinafter referred to as "Board").
2. District operates Northern Inyo Hospital (hereinafter "Hospital"), an acute care general hospital located at 150 Pioneer Lane, Bishop, Inyo County, California, which includes inpatient and outpatient services, a Rural Health Clinic, and Northern Inyo Associates, a group of 1206 (b) outpatient clinics
3. ESEP is a California professional corporation, dated August 10, 2010, which contracts with qualified and licensed physicians licensed to practice medicine in the State of California and who are certified by the American Board of Emergency Medicine, The American Board of Internal Medicine, The American Board of Family Medicine, or The American Board of Anesthesia, or are board-eligible, and who are qualified for, and practicing, one or more of the medical specialties and applicable subspecialties of emergency medicine, hospitalist medicine, and anesthesia (hereinafter referred to as "Physician Services"). ESEP may, from time to time, negotiate with the District to include new, or remove existing Physician Services.
4. The District desires to retain the services of ESEP as part of the District's Physician Services program inclusive of inpatient, outpatient, and call services on a non-exclusive basis.
5. The parties enter this agreement (hereinafter referred to as "Agreement") in order to provide a full statement of their respective responsibilities in connection with the provision of the Physician Services provided during the term of this Agreement.

Wherefore, in consideration of the promises set forth below, the parties covenant and agree as follows:

II. COVENANTS OF THE PARTIES

1. Covenants of the District

1.1 Space: District shall make space available to ESEP in its emergency department, medical surgical unit, intensive care unit, operating rooms, preoperative unit, and outpatient clinics (hereinafter referred to as "Hospital and Clinics") sufficient to allow ESEP to provide Physician Services in accordance with the terms of this Agreement. District shall accord ESEP full access to Hospital and Clinics and use of all facilities of the Hospital and Clinics relevant to Physician Services. These spaces shall be reasonably staffed and provided with all necessary fixtures, supplies, equipment, and furniture by District at its sole cost. District shall, at their sole expense, provide furnished call rooms for the on duty emergency physician and hospitalist physician for their exclusive use while on duty. District shall maintain these spaces to include, at a minimum, a bed, desk, and computer with electronic health record access.

1.2 Equipment and Supplies: District at its expense shall provide ESEP all necessary expendable and non-expendable equipment and supplies reasonably necessary for the efficient and safe provision of Physician Services in accordance with District policies and the terms of this Agreement.

1.3 *Maintenance:* District shall at its sole cost and expense maintain and repair all equipment and shall provide utilities and services reasonably required for ESEP to fulfill the terms of this Agreement.

1.4 *Liability Insurance:* District shall, at its sole expense, procure and maintain professional liability (malpractice) insurance coverage for the benefit of ESEP and all physicians and physician extenders contracted or employed by ESEP (hereinafter referred to as ESEP Providers") to provide Physician Services and, under such malpractice insurance coverage or a medical director or director and officer or other liability policy maintained by the District, liability coverage of ESEP and ESEP Providers with respect to the administrative responsibilities inclusive of the medical directorship set forth in Exhibit B as well as any elected or appointed leadership position within the medical staff and/or District. This malpractice and other liability coverage will be in force and effective at all times during the term of this Agreement. The policy limits of such coverage shall be at least $1,000,000.00 for any one occurrence and $3,000,000.00 annual aggregate coverage per ESEP Provider. If the District's malpractice insurance or other insurance required by this Agreement is terminated or converted at any time, then District shall also acquire 'tail' coverage in the above stated amounts with a retroactive date to the beginning of the Agreement, in addition to the required coverage for the remaining duration of the Agreement. ESEP agrees to cooperate with District in connection with the purchase and maintenance of such coverage. If this Agreement is terminated for any reason, District shall likewise maintain uninterrupted insurance for ESEP and ESEP Providers who provide services under this Agreement, including but not limited to providing tail coverage, such that the services provided by ESEP and ESEP Providers during the term of the Agreement shall be covered even after termination of this Agreement. District shall provide ESEP and ESEP Providers with copies of certificates of coverage as needed or requested. ESEP and ESEP Providers, in their discretion, may procure and maintain any professional liability insurance coverage at their own expense in addition to, or in place of, the coverage provided for herein.

1.5 *Non-Physician Personnel:* District, at its expense, shall provide the services of licensed registered and vocational nurses and other non-physician technicians and assistants necessary for the efficient and safe provision of Physician Services. District shall be responsible for the selection, management, direction, and control of such personnel for employment purposes, except that ESEP and ESEP Providers shall at times provide a supervisory role and, when acting in a supervisory capacity, be responsible for the direction and control of such personnel for all professional medical matters related to Physician Services. All staffing responsibilities of the District shall be in accordance with District policy. As of the date of this Agreement, District attests that District has, and intends to maintain adequate staffing for ESEP to efficiently and safely provide Physician Services under the terms of this Agreement. District will make every reasonable effort to notify ESEP of staffing limitations or changes related to Physician Services.

2. Covenants of ESEP

2.1 *Services:* ESEP shall provide Physician Services on a prompt and continuing basis in accordance-with the terms of this Agreement. Services shall be provided by duly licensed physicians and/or physician extenders pursuant to "Exhibit A" of this Agreement. It is expected that ESEP will provide clinic and/or hospital care of patients on all contracted days inclusive of weekend days and holidays and when required or otherwise mutually agreed by the parties. ESEP and ESEP providers will be expected to be available at the premises of District during scheduled hours. District and ESEP shall set the initial scheduled work hours within ten (10) days of the mutual execution of this Agreement and thereafter shall work together to provide a mutually beneficial scheduling calendar for the

duration of this Agreement. In the event a scheduled ESEP Provider will not be available for an assigned shift, ESEP shall, whenever possible, provide District no less than forty eight (48) hours notice of any personnel change. In the event ESEP Provider is unavailable for an assigned shift and no alternate ESEP Provider is available to cover the assigned shift, District shall, at their sole expense, procure alternate coverage for Physician Services until such a time that ESEP and ESEP Providers are able to provide Physician Services under the terms of this Agreement. In such an event wherein ESEP Providers are unable to provide Physician Services District shall only assume sole responsibility for Physician Services if failure of ESEP and ESEP providers to provide Physician Services is reasonable and on good cause.

2.2 Personnel: Except as otherwise expressly provided in this Agreement, ESEP may, with prior written approval by District, select and employ or otherwise contract with duly licensed physicians and physician extenders as ESEP, in the sole exercise of their discretion, deems necessary so long as such actions abide by, and are in accordance with, applicable contractual and employment laws and regulations. During the term of this Agreement, ESEP and ESEP Providers shall maintain membership on the Hospital's medical staff and privileges appropriate for Physician Services that ESEP is required to provide pursuant to this Agreement. ESEP and ESEP Providers will abide by the Medical Staff bylaws and any policies and procedures applicable to Physician Services at the District. ESEP and all ESEP Providers shall be board certified or board eligible, unless specifically exempted from this provision by the medical staff as per relevant bylaws or policy. Physician extenders may provide services in the Hospital and Clinics only under the supervision of a qualified Physician. Physician extenders shall be credentialed through the District medical staff office and in accordance with the medical staff bylaws. Physician extenders will be required to abide by minimal proficiency standards and licensure of same. Except as otherwise expressly provided in this Agreement, the terms and conditions by which ESEP Providers are compensated by ESEP shall be at the sole and exclusive discretion of ESEP. In contracting with or employing any ESEP Provider, ESEP shall include the following contractual terms for any ESEP Provider who shall provide Physician Services under this Agreement. ESEP and ESEP Providers will not engage in any activities during the eight (8) hour period immediately preceding the beginning of the scheduled shift that will directly cause ESEP or ESEP Providers to provide a level of care to patients that falls below the standard of care or endangers patient safety. ESEP and ESEP Providers shall adhere to policies and bylaws regarding professional conduct and behavior required by the District and Medical Staff which apply to all providers who provide services at the District and which have been provided to ESEP and ESEP Providers. ESEP shall not continue to utilize an ESEP Provider for Physician Services under this Agreement who has been unavailable for a scheduled shift without more than 72 hours prior notice more than three (3) times in any year, except on finding of good cause.

2.3 Admitting Privileges: ESEP and ESEP providers will apply for, and must receive approval of full privileges before the first scheduled shift. District will reasonably cooperate with ESEP and ESEP Providers to assist with the privilege approval process.

2.4 Quality Assurance: ESEP shall, at the District's expense, cooperate and assist in the collection of data regarding productivity, patient satisfaction, time to treatment, and any other matter on which the District is obligated or desires to collect data from all of its providers so long as same will not interfere with the ability of ESEP to provide services under this Agreement.

2.5 Standards: ESEP shall at all times endeavor to operate the Physician Service in a manner consistent with the highest standards maintained for the operation of such services in comparable healthcare systems. It is understood from time to time the Medical Staff

and/or District may set standards of professional practice and duties generally applicable to all medical staff members. ESEP shall comply with such directives given to it from the Medical Staff and shall also cause all ESEP Providers to do so.

2.6 *District and Governance Authorities:* ESEP, in connection with their operation and conduct of the department, shall endeavor to comply with all applicable provisions of law, and other valid bylaws, rules and regulations and requirements of the Board, the Medical Staff, and the joint commission and other similar accrediting and certifying entities to which the District is subject, and governmental agencies having jurisdiction over, the operations of the District and services, licensing of healthcare practitioners, delivery of services to patients of governmentally regulated third party payers whose members or beneficiaries receive care at the District, including but not limited to rules and regulations promulgated with respect to the transfer of patients from the emergency department.

2.7 *Medical Records:* ESEP and ESEP Providers shall at all times maintain complete and legible medical records, which accurately document the medical necessity of all services rendered to each patient who is treated. Said records shall be kept in the electronic health record (EHR) selected by the District. Such medical records shall be the property of the District and the District shall be solely responsible for the maintenance, safety and security of said medical records. At ESEP's written request, District may, in its discretion, which shall not be unreasonably withheld, provide ESEP with copies of any records reflecting services performed by ESEP or ESEP Providers with respect to, any claims against ESEP or ESEP Providers in the nature of malpractice. District and ESEP shall comply with all applicable federal and state laws and regulations regarding the confidentiality and secure treatment of individually identifiable health information. Upon the expiration or termination of this Agreement, unless a patient specifies otherwise and in accordance with applicable law, District is entitled to the original medical records. For so long as it is required by applicable statute, District will retain medical records and make said records available to ESEP if reasonably necessary for any purpose including patient care and medical malpractice defense.

2.8 *Financial Records:* District and ESEP each shall have access to all financial records of the other party pertinent to the Physician Services rendered by ESEP and all billings and collections made by District under this Agreement for the purpose of any audit or examination necessary to comply with any request or demand to District or ESEP with which District or ESEP respectively, is legally obligated to comply in order to verify cost of services rendered under this Agreement.

2.9 *Laws and Regulations:* ESEP shall maintain and make available all necessary books, documents and records in order to assure that District will be able to meet all requirements for participation and payment associated with public and private third party payment programs, including but not limited to matters covered by Section 1861(v) (1) (I) of the Social Security Act, as amended. With respect to Section 1861(v) (1) (I), it is agreed: Until expiration of four years after furnishing services pursuant to this Agreement, ESEP shall make available upon written request of the Secretary of Health and Human Services or the U.S. Controller General, or any of their duly authorized representatives, this Agreement, books, documents, and records of ESEP that are necessary to verify the nature and extent of costs incurred by District under this Agreement. If ESEP carries out any of the duties of this Agreement with a value of $10,000 or more over a twelve-month period through a subcontract with a related organization, such agreement must contain a clause to the effect that until the expiration of four years after the furnishing of services under the subcontract, the related organization shall make available, upon written request of the Secretary of Health and Human Services, the U.S. Comptroller General, or any of their duly authorized

representatives, the subcontract, and any books, documents and records of the related organization that are necessary to verify the nature and extent of costs incurred by District under this Agreement.

III. COMPENSATION AND BILLING

1. Compensation

1.1 Rates: ESEP and the District have agreed on compensation that District will pay to ESEP for the terms of this Agreement as set forth in "Exhibit B" attached hereto. Compensation as outlined in "Exhibit B" shall be adjusted commiserate with changes in staffing provided by ESEP for Physician Services.

1.2 Patient Charges: ESEP will charge patients on a fee-for-service basis. Charges for services performed by ESEP shall be reasonable, consistent with fair and customary charges in the community, allow consideration for the level of skill or complexity provided, and shall comply with all applicable laws and regulations governing physician charges. If necessary, the District and ESEP will cooperate in setting charge schedules and billing practices in order to facilitate compliance with billing guidelines established by third party payers and all applicable governmental regulations and in negotiating contracts with PPOs, HMOs, IPAs and other managed care organizations and third party payors that affect reimbursement for ESEP services. District shall provide ESEP with copies of all managed care or other payor contracts that govern reimbursement for ESEP Services ("ESEP Payor Contracts"). Any new ESEP Payor Contracts or material amendments to existing ESEP Payor Contracts shall require the approval of ESEP's board or its designee or be within ESEP-approved payor contract parameters.

1.3 Daily Memoranda and Billing: The District shall act as the designated billing and collection agent for ESEP and ESEP Providers. ESEP hereby assigns to District the right to bill and collect such charges. The District will comply with third party payor billing requirements and participate in quality incentive programs of the plans and/or government. In the event District bills patients through a single invoice combining District and ESEP's charges, the billing shall clearly distinguish the professional fees of ESEP and ESEP Providers from those of District's facility fees and those of any non-ESEP professional fees included in the invoice. ESEP shall cooperate in the preparation and filing of such documentation and records as are necessary to allow District to efficiently perform its billing duties as set forth herein. District will collect and retain all facility fees related to Physician Services. If the collected portion of ESEP professional fees generated by Physician's Services at any time is in excess of the compensation for Physician Services as set forth in "Exhibit B" District will compensate ESEP no less than the total amount of collected professional fees. As set forth herein, ESEP shall have the right to review District financial records to verify billing, collection, and payments. District agrees that for the purposes of billing transparency, that District will, no less than quarterly, provide ESEP with all financial records related to billings, collections, and services under this Agreement accompanied by all supporting financial documentation, balance sheets, and records. As ESEP is assigning its rights of payment, billing, and collection from the patients to District, the failure of District to collect fees or billings from patients shall not impact or affect any payments due and owing from District to ESEP for service performed and rendered to patients. District shall pay all monies owed to ESEP based on the rates set forth in "Exhibit B" no later than the fifteenth (15th) day of the month following the month of service. District's obligation to pay ESEP for Physician Services rendered up to the date of termination shall survive the termination of this Agreement. District agrees to indemnify, defend, and hold harmless ESEP in the event a third-party asserts a claim against ESEP arising from allegations that District engaged in improper billing for the services provided by ESEP under this Agreement.

1.4 Payment of All Sums: Under this part all sums owed ESEP by District shall be made at the following address:

Eastern Sierra Physicians
P.O. Box 1448
Bishop, CA 93515

Or such other address or account as ESEP may designate from time to time by notice to the District.

1.5 Reasonable Compensation. Notwithstanding anything in this Agreement to the contrary, in no event shall ESEP's total cash compensation during any Fiscal Year (pro-rated for partial years) for all services provided by ESEP pursuant to this Agreement exceed reasonable, fair market value compensation based on applicable state or federal law, regulations and guidelines and nationally recognized compensation survey data. The compensation referenced herein is intended to comply with applicable law governing physician compensation.

IV. TERM

1. *Term:* The term of this Agreement shall be for three (3) years, or from March 1, 2022 to February 28, 2025 provided that the parties may amend the Agreement during the term in accordance with Section 5.5. Unless provided, in writing, one hundred and twenty (120) days prior to the end of the Agreement the terms of this Agreement shall be automatically renewed for an additional three (3) years, or from March 1, 2025 to February 28, 2028.
2. *Termination:* This Agreement may not be terminated without cause. A party may terminate this Agreement on ninety (90) days written notice to the other party due to a material uncured breach of this Agreement by the other party, provided that the party in breach has been given thirty (30) days' written notice and opportunity to cure, which cure period may precede or overlap or be coincident with the ninety day termination notice period and the other party has failed to cure the breach within that thirty-day period. District may terminate this Agreement and all ESEP rights hereunder immediately upon the occurrence of any of the following causes.
   2.1 Failure of ESEP to provide Physician Services coverage for a period in excess of two (2) consecutive days (48 hours) where ESEP or ESEP Provider was scheduled to provide service coverage and where failure to provide Physician Services was without good cause.
   2.2 Upon a determination by a majority of the Board, after consultation with the executive committee of the medical staff, that ESEP or any of its providers has been guilty of repeated acts of professional incompetence in response to which ESEP has not taken reasonable or appropriate steps.
   2.3 ESEP has, after reasonable prior written notice and an opportunity to rectify, failed to maintain the Physician Service in a manner consistent with the highest standards maintained for the operation of similar services in comparable Districts.
   2.4 ESEP is, after reasonable prior written notice and an opportunity to rectify, engaged in a continuing course of conduct that places District or its medical staff at risk of adverse action in connection with licensing or accreditation entities.
   2.5 ESEP is engaging in or about to engage in conduct that puts the District, its Medical Staff, or parties at risk of harm.
   2.6 Upon appointment of a receiver of ESEP's assets, an assignment by ESEP of its assets for the benefit of its creditors, or any action taken or suffered by ESEP under any bankruptcy or insolvency act that is not remedied within thirty (30) days or said appointment, assignment, or action.

3. *Cooperation.* In the event of termination of the Agreement for any reason whatsoever, the parties agree to cooperate with each other to promptly resolve any outstanding financial, administrative or patient care issues. The parties agree to cooperate to carry out the intent and purpose of this Agreement, including without limitation, the execution and delivery to the other party any further agreements or documents necessary for taking action reasonably required to effectuate the provisions of this Agreement. This clause shall survive the termination of this Agreement.

V. OTHER MATTERS

1. *Indemnification:* Each party shall indemnify and hold harmless the other and its subsidiaries and/or affiliates, if applicable, from and against any and all claims, demands, loses, damages, judgments, penalties, fines, costs, charges, and other expenses (including without limitation litigation costs, reasonable attorneys' fees, witness fees and expenses incident thereto) (collectively referred to as "Claims"), to the extent arising out of or relating to the willful misconduct of a party or any misrepresentation of the warranties contained in this Agreement, provided that ESEP shall have no obligation to indemnify hereunder if the District has insurance available to cover the entirety of the Claims at issue. In the event the District's insurance limits do not cover the entirety of the Claims at issue, ESEP's obligation to indemnify will be limited to amounts in excess of such limits.
2. *Compliance with Anti-Referral Laws:* Each party intends to comply in all respects with all governing laws and regulations relating to fraud and abuse and prohibitions against inappropriate referrals and enter into this Agreement with the intent of conducting their relationship and implementing the agreements contained herein in full compliance with applicable federal, state, and local law, including without limitation, the Medicare/Medicaid anti-kickback statute (the "anti-kickback law") and section 1877 of the Social Security Act (the Stark law), as amended. Notwithstanding any unanticipated effect of any of the provisions of this Agreement, neither party will intentionally conduct itself under the terms of this Agreement in a manner that would constitute a violation of the anti-kickback law or the Stark law. Without limiting the generality of foregoing, the parties expressly agree that nothing contained in this Agreement shall require either party to refer any patients to the other, or to any affiliate or subsidiary of the other. Specifically, ESEP and ESEP Providers are free to secure and maintain contracts and privileges at other hospitals and to admit patients who require hospitalization to any hospital that is desired. ESEP is free to refer patients for diagnosis, treatment or testing to any qualified provider. If any legislation, regulation or government policy is passed or adopted, the effect of which would cause either party to be in violation of such laws due to the existence of any provision of this Agreement, then the parties agree to negotiate in good faith for a period of ninety (90) days to modify the terms of this Agreement to comply with applicable law. Should the parties hereto fail to agree upon modified terms to this Agreement within this time, then either party may immediately terminate this Agreement by giving written notice to the other party.
3. *Independent Contractor:* No relationship of employer, employee, agency, partner, joint venture, or other similar relationship is created by this Agreement, it being understood that ESEP will act hereunder as an independent contractor, and none of the providers performing services for ESEP, whether said providers be members, partners, employees, subcontractors, or otherwise, shall have any claim under this Agreement or otherwise against District for vacation pay, sick leave, retirement benefits, social security, worker's compensation benefits, or employee benefits of any kind; that District shall neither have nor exercise any control or direction over the methods by which ESEP shall perform its work and functions, which at all times shall be in strict accordance with currently approved methods and practices in their field; and the sole interest of District is to ensure that Physician Services shall be performed and rendered in a competent, efficient, and satisfactory manner and in accordance with the

standards required by the Medical Staff and District. ESEP will be solely responsible for the payment of any applicable taxes, fees, benefits, worker's compensation, etc. on behalf of ESEP and ESEP Providers. Notwithstanding the foregoing, District will coordinate and procure the professional liability insurance for ESEP and ESEP Providers as set forth herein, including but not limited to tail coverage upon termination of the Agreement, such that ESEP and ESEP Providers are covered even if claims occur after termination of this Agreement.

4. *Not Exclusive:* It is specifically agreed and understood that ESEP and ESEP Providers shall not be required to limit their practices exclusively to the District, it being understood that additional enterprises and other Physician Services agreements shall be permissible. Provided however, neither ESEP nor ESEP Providers may engage in other agreements or enterprises that will materially interfere with the performance of services required under this Agreement.
5. *Amendment:* This Agreement may be amended at any time by written agreement duly executed by both parties.
6. *Assignment:* ESEP shall not assign, sell or transfer this Agreement or any interest therein without the consent of the District in writing first hand and obtained. Notwithstanding and of the foregoing, it is understood and agreed that, in the event that ESEP forms an alternative professional organization, duly authorized under the laws of this State to practice medicine, said alternative professional organization may be substituted in place of ESEP, with all of the rights and subject to all of the obligations of ESEP under the terms of this Agreement. Said substitution shall be effected upon ESEP by giving written notice to the District.
7. *Attorney's Fees:* In the event that suit, mediation or arbitration, is brought regarding the provisions of this Agreement or the enforcement thereof, the prevailing party shall be awarded its cost of suit and reasonable attorney's fees as part of any judgement rendered therein. The parties agree to submit to mediation prior to the filing of any court proceeding.
8. *Notices:* The notices required by this Agreement shall be effective if mailed, postage prepaid as follows:

    To District at:

    Northern Inyo Hospital Healthcare District
    Attn: Chief Executive Officer
    150 Pioneer Lane
    Bishop, CA 93514

    To ESEP at:

    Eastern Sierra Physicians
    P.O. Box 1448
    Bishop CA, 93515

    Or such other address as a Party may designate from time to time by notice to the other Party.

9. *Complete Agreement:* This Agreement and its Exhibits, with any subsequent amendments, is the complete Agreement between the parties as to the terms covered herein. All of the promises, representations and warrantees of the parties in regard to the terms of this Agreement are stated herein, or in any amendment. Any prior promises representations or warrantees occurring in the course of negotiations are superseded by this Agreement.
10. *Validity:* If any portion of this Agreement is found to be void or illegal, it shall not affect the validity or enforceability of any other portion thereof.

11. *Counterparts:* This Agreement may be executed in any number of counterparts which, when read together shall constitute one document. A facsimile or other digital signature shall have the same force, effect and validity as an original.

IN WITNESS WHEREOF, the parties have executed this Agreement at Bishop, California, on _____, 2022.

DISTRICT:

_____
BY
Kelli Davis, MBA

ESEP:

_____
BY
John Adam Hawkins, DO

EXHIBIT A: **SPECIALTIES; WORK LOCATION; WORK SCHEDULE; ETC.**

I. *Specialties:* Emergency Medicine, Internal Medicine, Family Medicine, Hospitalist Medicine, Anesthesia and applicable subspecialties thereof.

II. *Practice:*

1. *Emergency Medicine:* ESEP shall provide eight thousand seven hundred and sixty (8760) hours per year of full time emergency medicine Physician Services in the emergency department.
2. *Hospitalist Medicine:* ESEP shall provide hospitalist medicine Physician Services coverage in the intensive care unit and medical surgical unit. Hours per month shall be decided at least one (1) month in advance by agreement between the hospitalist medicine director and the chief medical officer or their designees. ESEP shall, in good faith, work towards providing eight thousand seven hundred and sixty (8760) hours per year of full time hospitalist coverage in the intensive care unit and medical surgical unit.
3. *Hospital Medicine Clinic:* ESEP shall provide outpatient internal medicine and family medicine Physician Services as part of the Hospital Medicine Clinic, hereinafter referred to as "HMC". HMC services shall be provided on a part time basis as determined by the hospitalist medicine director and chief medical officer or their designees.
4. *Anesthesia:* ESEP shall provide part-time (1 FTE out of a 4 FTE coverage program) Anesthesia Physician Services. Schedule and staffing shall be agreed upon by ESEP and District at least one month prior to rendering of anesthesia Physician Services.
5. *Medication Assisted Treatment:* ESEP shall provide outpatient part-time Medication Assisted Treatment Program, hereinafter referred to as "MAT Program". Schedule and staffing shall be agreed upon by ESEP and District at least one month prior to rendering of MAT Physician Services.
6. *Work Location:* Northern Inyo Associates Clinics, Rural Health Clinic, and Northern Inyo Hospital.

III. *Minimum Performance Standards (if any):* To be determined by ESEP medical director(s) and/or chief medical officer and/or the chief of staff and in accordance with the Medical Staff bylaws.

IV. *On-Call Coverage Schedule:* ESEP shall provide eight thousand seven hundred and sixty (8760) hours per year of emergency medicine administrative call, e.g., back-up call.

V. *Additional Duties (if any):* To abide by the bylaws of the Medical Staff; participate in the quality assessment and performance improvement activities of District as well as meet the requirements of meaningful use; code patient visits and procedures for billing purposes in a timely fashion.

VI. *Physician Leadership*: ESEP shall provide medical directorship and physician leadership for the emergency medicine and hospitalists services as outlined in "Exhibit C".

EXHIBIT B: COMPENSATION

I. *Fair Market Value Base Compensation:* $4,600,000 (four million six hundred thousand dollars) per year.

1. Includes eight thousand seven hundred and sixty (8760) hours of Emergency Medicine Coverage
2. Includes eight thousand seven hundred and sixty (8760) hours of Emergency Medicine back-up call
3. Includes ESEP providing approximately 80-85% of 8760 eight thousand seven hundred and sixty (8760) hours per year of full time hospitalist coverage in the intensive care unit and medical surgical unit.
   3.1 *Base Compensation shall be increased to $4,800,000 (four million eight hundred thousand dollars) per year upon full staffing for the provision of hospitalist Physician Services.*
4. Hospitalist Medical Director, $50, 000 (fifty thousand dollars).
5. Emergency Services Medical Director, $50,000 (fifty thousand dollars).

II. *Hospitalist Clinic Compensation:* $175 (one hundred and seventy five dollars) per hour of clinical work and $87.50 (eighty seven dollars and fifty cents) per clinic day for administrative duties.

III. *Emergency Medicine Double Coverage Compensation: $*250 (two hundred and fifty dollars) per hour.

IV. *Inpatient Hospitalist Double Coverage Compensation:* $190 (one hundred ninety dollars) per hour.

V. *Physician Anesthesiologist Compensation:* $460,000 (four hundred and sixty thousand dollars) per physician anesthesiologist per year.

1. $450,000 (four hundred and fifty thousand dollars) compensation for 1 FTE of operating room(s) coverage and call schedule hours for a 4 FTE anesthesia coverage program

2. $10, 000 (ten thousand) ESEP administrative practice management stipend

3. District shall reimburse ESEP an additional $215 (two hundred and fifteen dollars) per hour for each hour worked by an ESEP anesthesiologist that was an emergency fill-in for a shift or portion of a shift assigned to a non-ESEP provider.

VI. *Medication Assisted Treatment Compensation:* $223 (two hundred and twenty three dollars) per hour of clinical work and $25,000 (twenty five thousand dollars) per year for administrative duties.

VII. *Trans-Esophageal Echocardiogram Compensation:* $300 (three hundred dollars) per study.

VIII. *Benefits:*

1. *Liability Insurance:* As noted in 2.1.4 above.
2. *Continuing Medical Education:* Up to $3,000 (three thousand dollars) per year of reimbursement for continuing medical education for each ESEP Provider who works full-time and $2,000 (two thousand) for each ESEP Provider who works part-time. Eligibility is to be determined by ESEP under these criteria and the pertinent ESEP Physician Services Contracts and policies and procedures. This includes, but is not limited to medical conference registrations, fees, and travel expenses, medical licensure, medical exams, medical credentialing, medical society membership fees, medical educational media, and software and/or hardware utilized for continuing medical education purposes.
3. *Annual Raise:* A 3.5% increase to compensation will be applied based on the previous year's total compensation, annually, for the duration of the contract.
4. *Signing Bonus and Moving Expenses:* District shall pay ESEP a $10,000 (ten thousand dollars) sign on bonus and up to $5,000 (five thousand dollars) for moving expenses with receipts per each full time physician recruited by ESEP.

5. *Loan Repayment:* District shall pay newly recruited full time ESEP physicians $20,000 (twenty thousand dollars) per year for three years for use towards repayment of educational loans.

EXHIBIT C: PHYSICIAN LEADERSHIP

The medical director and other leadership services ESEP agrees to provide to District under this Agreement include:

1. Participates in District utilization review
2. Collaborates with clinical and administrative director in establishing and evaluating policies, procedures, and protocols for Physician Services for patient care and medical developments, including new treatment modalities, drug information and other relevant developments.
3. Collaborates with clinical and administrative directors in recommending, developing and implementing new services to be provided as part of Physician Service offerings.
4. Identifies equipment needs and collaborates with clinical and administrative director in coordinating standardization of instrumentation, equipment and supplies for Physician Services.
5. Assists District in providing public education and community outreach concerning Physician Services including, public speaking engagements for community services group, public forums, and seminars and health fairs sponsored by District.
6. Collaborates with clinical and administrative directors in developing policies and procedures governing the use, availability and coordination of Physician Services.
7. Attends meetings District campus, or elsewhere, at reasonable times, and for reasonable periods, in order to accomplish each of the above duties, and rendering reports, recommendations and evaluations as may be reasonably requested by District.
8. Collaborates with clinical and administrative directors to ensure compliance with the District, Board, and Medical Staff bylaws, policies and procedures and rules and regulations, the recommendations of the Joint Commission and the requirements of all federal, state and municipal statutes, regulations, ordinances and directives governing the provision of healthcare services and the practice of medicine.
9. Participation, and California Health & Safety Code 1250 et seq., and the regulations promulgated thereunder applicable to licensed healthcare facilities, and patient privacy and consent laws.
10. Medical directors shall devote time in accordance with work schedule in performing the director services required under this Agreement to ensure the proper management of Physician Services.
11. ESEP medical directors shall provide District with a monthly time log. This time log must be legible, identify with specificity the dates services were performed and specify the nature of ESEP's medical director activity. ESEP shall maintain sufficient back-up information to permit District compliance office and/or finance department to audit and validate the information provided on the time sheets for a period of no less than four (4) years following the expiration of this Agreement. Because either ESEP or District may be called upon to provide a detailed summary of services performed to either state or federal government authorities, ESEP acknowledges and agrees that their failure to provide the monthly time logs constitutes a material breach of "Exhibit C" of this Agreement by ESEP and hereby authorizes District to withhold payment of medical directorship compensation hereunder until ESEP has completed and delivered the applicable time log(s) to District, and invoices submitted more than sixty (60) days after the month in which services are provided will not be paid, and withholding medical director payment as permitted under this Section does not constitute a material breach of this Agreement.
12. ESEP shall serve as liaison to providers, both District and non-District providers in the Eastern Sierra region.

13. ESEP shall promote collaboration between internal and external health care teams in the Eastern Sierra region.
14. Collaborates with clinical and administrative directors in developing an operating budget and a capital budget on an annual basis for the emergency and hospitalist departments.
15. Participate in activities and committees as required by the bylaws of the Medical Staff; participate in the quality assessment and performance improvement activities of District as well as meet the requirements of state of federal mandate; serve as the physician lead for purposes of administrative oversight of the operating rooms and Physician Services.

_____ _____

Kelli Davis, MBA
District

John Adam Hawkins, DO
ESEP

NORTHERN INYO HEALTHCARE DISTRICT
RECOMMENDATION TO THE BOARD OF DIRECTORS
FOR ACTION

Date: December 30, 2021

Title: **NONDESIGNATED PUBLIC HOSPITAL BRIDGE LOAN APPLICATION**

Synopsis: Authorizing the Execution and Delivery of Loan and Security Agreement and Promissory Note.

It is recommended that the Board of Directors approve the resolution of the authorization to execute the loan of $497,000.00 from California Health Facilities Financing Authority to fund the working capital of Northern Inyo Healthcare District and appointing Kelli Davis, Chief Executive Officer, as the Authorized Officer to execute and deliver any and all documents that are necessary for the completion of the loan process.

Prepared by: Dolores Perez, Assistant Controller

Approved by: Vinay Behl, Interim Chief Financial Officer

FOR EXECUTIVE TEAM USE ONLY:

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

RESOLUTION NO 22-01

RESOLUTION OF **NORTHERN INYO HEALTHCARE DISTRICT** AUTHORIZING EXECUTION AND DELIVERY OF A LOAN AND SECURITY AGREEMENT, PROMISSORY NOTE, AND CERTAIN ACTIONS IN CONNECTION THEREWITH FOR THE CALIFORNIA HEALTH FACILITIES FINANCING AUTHORITY NONDESIGNATED PUBLIC HOSPITAL BRIDGE LOAN PROGRAM

Nondesignated Public Hospital Bridge Loan Program

WHEREAS, **Northern Inyo Healthcare District** (the "Borrower") is a nondesignated public hospital as defined in Welfare and Institutions Code Section 14165.55, subdivision (l), excluding those affiliated with county health systems pursuant to Chapter 240, Statutes of 2021 (SB 170), Section 25; and

WHEREAS, Borrower has determined that it is in its best interest to borrow an aggregate amount not to exceed **$497,00.00** from the California Health Facilities Financing Authority (the "Lender"), such loan to be funded with the proceeds of the Lender's Nondesignated Public Hospital Bridge Loan Program; and

WHEREAS, the Borrower intends to use the funds solely to fund its working capital needs to support its operations;

NOW, THEREFORE, BE IT RESOLVED by the Board of Directors of the Borrower as follows:

Section 1. The Board of Directors of Borrower hereby ratifies the submission of the application for a loan from the Nondesignated Public Hospital Bridge Loan Program.

Section 2. **KELLI DAVIS, CHIEF EXECUTIVE OFFICER** (an "Authorized Officer") is hereby authorized and directed, for and on behalf of the Borrower, to do any and all things and to execute and deliver any and all documents that the Authorized Officer(s) deem(s) necessary or advisable in order to consummate the borrowing of moneys from the Lender and otherwise to effectuate the purposes of this Resolution and the transactions contemplated hereby.

Section 3. The proposed form of Loan and Security Agreement (the "Agreement"), which contains the terms of the loan is hereby approved. The loan shall be in a principal amount not to exceed **$497,000.00,** shall not bear interest, and shall mature 24 months from the date of the executed Loan and Security Agreement between the Borrower and the Lender. The Authorized Officer is hereby authorized and directed, for and on behalf of the Borrower, to execute the Agreement in substantially said form that includes the redirection of up to 20% of Medi-Cal reimbursements (checkwrite payments) to Lender in the event of default, with such changes therein as the Authorized Officer may require or approve, such approval to be conclusively evidenced by the execution and delivery thereof.

Section 4. The proposed form of Promissory Note (the "Note") as evidence of the Borrower's obligation to repay the loan is hereby approved. The Authorized Officer is hereby authorized and directed, for and on behalf of the Borrower, to execute the Note in substantially said form, with such changes therein as the Authorized Officer may require or approve, such approval to be conclusively evidenced by the execution and delivery thereof.

Date of Adoption: 01/19/2022

SECRETARY'S CERTIFICATE

I, Topah Spoonhunter **,** Secretary of **NORTHERN INYO HEALTHCARE DISTRICT,** hereby certify that the foregoing is a full, true and correct copy of a resolution duly adopted at a regular meeting of the Board of Directors of **NORTHERN INYO HEALTHCARE DISTRICT** duly and regularly held at the regular meeting place thereof on the 19th day of January , 2022 **,** of which meeting all of the members of said Board of Directors had due notice and at which the required quorum was present and voting and the required majority approved said resolution by the following vote at said meeting:

Ayes:

Noes:

Absent:

I further certify that I have carefully compared the same with the original minutes of said meeting on file and of record in my office; that said resolution is a full, true and correct copy of the original resolution adopted at said meeting and entered in said minutes; and that said resolution has not been amended, modified or rescinded since the date of its adoption, and is now in full force and effect.

_____

Topah Spoonhunter, Secretary
Board of Directors

Date: _____

NORTHERN INYO HEALTHCARE DISTRICT
NON-CLINICAL POLICY AND PROCEDURE

Title: Charge Capture Policy and Procedure		
Owner: Director of Revenue Cycle	Department: Business Office	
Scope: District Wide		
Date Last Modified: 11/03/2021	Last Review Date: No Review Date	Version: 2
Final Approval by: NIHD Board of Directors	Original Approval Date: 02/20/2019	

PURPOSE: To ensure that each service department accurately, completely and in a timely manner, records patient service revenue.

POLICY:

Charges for services provided to patients will be recorded in the appropriate patient visit upon the delivery of care for all system generated charges. Manual charges will be placed within seventy-two (72) hours of the provision of care.

Each service department providing patients with chargeable services and supplies is solely responsible for the timely and accurate posting of their charges to the appropriate patient visit. Each service department is also responsible for the daily reconciliation of all charges to ensure accurate and complete posting of charges into the organization's financial system.

DEFINITIONS:

1. Charge Description Master (CDM): A list detailing the official rate charged by a hospital for individual procedures, services and supplies.

2. Current Procedural Terminology (CPT): These are medical code sets that are used to report medical, surgical and diagnostic procedures and services to entities such as physicians, health insurance companies and accreditation organizations.

3. Modifier(s): A modifier indicates that a service or procedure has been altered by some specific circumstance, but not changed in its definition or code. Modifiers are used to add information or to change the description of a service in order to improve specificity.

4. Service department: Any department within the hospital that provides a service for which a charge can be generated.

PROCEDURE:

1. **Charge Identification and Recording**
    1. The development of procedures to address the charge capture processes shall be service area specific. The procedures need not be the same for different services within a single department (i.e., X-ray, MRI, CT).

2. Each service department will have designated staff positions assigned the responsibility to provide system inherent charge capture entry and review. Assignments will be developed to provide coverage of this responsibility on a daily basis. There will be a minimum of two staff members trained in the charge capture activities so that back-up can be provided at all times.
3. Utilizing the appropriate charge description master (CDM) codes, the caregiver shall accurately document all chargeable services and supplies at the time of service in an appropriate manner and format as designated by each service department's policies and procedures.
4. If charges are generated and entered via documentation of those services, the service department will record all documented charges the appropriate patient visit within twenty-four (24) hours of the provision of the service.
5. All manual charges will be placed on the patient's visit within seventy-two (72) hours of the date the service(s) was rendered by the department providing the service.

2. Charge Audit and Control

1. Each service department will be responsible for the daily reconciliation of charge capture, charge entry, charge interface processes, system inherent charge review and for the appropriate resolution of identified errors and omissions by midnight of the following day.
2. Each service department is responsible for documenting and implementing an audit process to ensure all chargeable services are accurately documented at the time of service.
3. The documented services and supplies will be compared to the daily department census (revenue and usage report), schedules and/or interface service reports within twenty-four (24) hours of the original posting date.
4. All errors or omissions will be corrected on the patient's visit in the system on the day the error or omission is discovered.

3. Interface

1. Each service department is responsible for implementing an audit process to ensure accurate transmittal of system-recorded charges from each subsystem to the financial system.
2. Each service department is responsible for having or developing an interface related error report listing all transmittal failures.
3. Each service department is responsible for reviewing the error report and correcting the error within twenty-four (24) hours of the report.
4. If issues with the report or the correction of the errors occur, the service department should contact the Charge Capture Department for assistance.

4. Documentation

1. Each service department shall prepare individual detailed service area specific charge procedures including the following sections:
    1. Charge capture process
    2. Charge capture reconciliation process
    3. Charge capture auditing procedure
    4. Charge entry auditing procedures
    5. Charge interface procedures
    6. Audit documentation procedures

2. Copies of these procedures will be provided to members of the Executive Team and the Charge Capture Manager.
3. The Charge Capture Manager will ensure internal audit review of these procedures on a random basis.

5. Late Charges

1. Any charges processed more than four (4) days from the date of service delivery to a patient, will be considered a "Late Charge". Exceptions to this are charges for services requiring:
    1. Creation of a charge for a new service
        2. Tests requiring a result before the service is charged
        3. Tests requiring a signed medical report before the service is charged
    2. Late charges are followed as an "Exception" event in the Charge Capture process and are audited for circumstances or processes necessitating corrective action.
    3. It will be necessary to submit late charges to the Charge Capture Department for processing. The Charge Edit Form is attached to this policy.
    4. Extraordinary circumstances resulting in a late charge(s) must be submitted to the Business Office Manager with an explanation of the circumstances on a case-by-case basis so resources and affected areas can be informed as necessary.
    5. Charges for send out services (outside labs) are to be charged at the time of the specimen send out, not as of the result.

6. Charging for Opened and Unopened Supplies

1. Service departments are responsible for patient chargeable supplies issued/used by the department, even when the revenue for the supply is credited to a common revenue department (Supplies Charged to Patients).
2. Patients should not be charged for supplies ordered by the physician or surgeons that were not used during the procedure. These items are to be included in administrative costs of the service department.
3. If the procedure is discontinued due to a medical complication and after the patient is given anesthesia, the provider may be reimbursed by Medicare and the payors for the collective cost of the initially planned procedure; however, a separate bill of unused items for the initial procedure will not be accepted. In this instance the modifier seventy-four (74) applies and will be attached at the claim level. (Reference #7, vi. Below detailing the use of modifier seventy-four (74)).
4. When unused, supplies determined to be inappropriate in size and do not end up fitting, are not reusable (i.e., screws or implants). They can be billed to CMS and commercial payers in the following instances:
    1. The items have come into contact with the patient and are subsequently removed, or if they are unsuccessfully inserted.
    2. Staff must thoroughly document all opened and unused items during each procedure, including the reason for nonuse, and attach documentation to the claims.
    3. Such supplies and implants are to be offered to the patient.

7. Charging for Discontinued Service or Patient Left Without Being Treated

1. If a patient arrives and is registered into the system, documentation must be recorded as to the reason why the patient did not receive the service, or the reason the service was not completed if it began.

1. If the diagnostic service is discontinued because the patient could not tolerate the procedure, charge for the service and a modifier fifty-two (52) will be attached at the claim level.
2. If the service is discontinued due to equipment failure, **do not charge.** Place the applicable department "zero charge" indicative of the reason for the zero charge.
3. If the service is discontinued because the physician or provider could not proceed for reasons related to patient well-being, charge for the service and a modifier fifty-three (53) will be attached at the claim level.
4. If the patient was welcomed and placed in an exam room, vitals were taken and the patient left without seeing the provider, **do not charge.** Place the applicable department "zero charge", indicative of the reason for the zero charge.
5. If a surgery or diagnostic procedure is cancelled after the patient has been made ready and taken to the room where the procedure is to be performed but has not received anesthesia, the provider can cancel or discontinue the procedure. If none of the planned procedure(s) is completed, the first/only procedure is charged with the usual CPT code and a modifier seventy-three (73) will be attached at the claim level. The other procedures are not charged.
6. If a surgery or diagnostic procedure is cancelled due to extenuating circumstances or those that threaten the well-being of a patient, and after the administration of anesthesia or after the procedure has started, the procedure is charged using the usual CPT code and a modifier seventy-four (74) will be attached at the claim level.

2. For any circumstances surrounding a question of to charge or not, contact the Charge Capture Manager or the Business Office Manager.

REFERENCES:

1. Healthcare Business Insights
2. Healthcare Financial Management Association
3. CMS Coding and Billing Manuals

RECORD RETENTION AND DESTRUCTION:

CROSS REFERENCED POLICIES AND PROCEDURES:

Supersedes: v.1 Charge Capture Policy and Procedure

NORTHERN INYO HEALTHCARE DISTRICT
RECOMMENDATION TO THE BOARD OF DIRECTORS
FOR ACTION

Date: December 3, 2021

Title: **Recommendation to appoint a Board member to the Compliance and Business Ethics Committee**

Synopsis: The Compliance Program for NIHD establishes the membership of the Compliance and Business Ethics Committee. The program establishes that a member of the Board will be on the committee. It is recommended that the Board nominate a member to serve on the committee.

Prepared by: Patty Dickson, Compliance Officer

Reviewed by: Kelli Davis
Kelli Davis
Chief Executive Officer

FOR EXECUTIVE TEAM USE ONLY:

Date of Executive Team Approval: 12-6-2021 Submitted by: Kelli Davis
Chief Officer

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

Date: 01/12/2022

Title: **NIHD ORTHOPEDIC SERVICES DECEMBER HIGHLIGHT**

Synopsis: In ensuring Board and Public awareness of services provided by NIHD, the December Healthy Lifestyle Talk "Sports Medicine & You: Helping Athletes Stay in the Game" with Bo Nasmyth Loy, MD, is shared as an information item. The link to the recorded event which took place on December 16th, is included in the highlight advertisement (attached) for information and direction to the recording

Prepared by: Barbara Laughon, Strategic Communication Specialist &
Scot Swan, Digital Marketing Specialist

Approved by: Kelli Davis
Name: Kelli Davis
Title: Chief Executive Officer

FOR EXECUTIVE TEAM USE ONLY:

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

Bo Nasmyth Loy, MD

Dr. Loy grew up on a ranch in Ojai, Calif. He completed his undergraduate studies at the University of Southern California (USC) majoring in Biomedical Engineering with a minor in Philosophy and graduated magna cum laude.

Dr. Loy also obtained his medical degree from USC, graduating with highest distinction. After medical school he completed his orthopedic surgery residency at Beaumont Hospital in Royal Oak, Michigan, a level-one trauma center specializing in complex fracture care and cutting-edge arthroscopic surgeries.

He completed his fellowship at the Taos Orthopedic Institute in Taos, New Mexico where he focused on arthroscopic surgeries of the knee and shoulder. While at Taos he served as the team physician for the US Ski and Snowboard teams.

WATCH HERE:

https://www.youtube.com/watch?v=jBBTz2XQPNw

Northern Inyo Healthcare District

One Team. One Goal. Your Health.

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

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

TO: NIHD Board of Directors
FROM: Sierra Bourne, MD, Chief of Medical Staff
DATE: January 4, 2022
RE: Medical Executive Committee Report

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

A. Radiology Privilege Form (*action item*)

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

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

Radiology

Delineation of Privileges

Applicant's Name: ,

Instructions:

1. Click the Request checkbox at the top of a group to request all privileges in that group.
2. Uncheck any privileges you do not want to request in that group.
3. Sign form electronically and submit with any required documentation.

Facilities
☑ **NIHD**

Required Qualifications	
Education/Training	Completion of an ACGME or AOA accredited Residency training program in Diagnostic Radiology. **OR** Completion of an ACGME accredited residency in Interventional Radiology (integrated program).
Certification	Current certification or active participation in the examination process leading to certification in Diagnostic Radiology by the American Board of Radiology or AOA equivalent.
Clinical Experience (Initial)	Applicant must provide documentation of provision of diagnostic radiology services representative of the scope and complexity of the privileges requested during the previous 24 months (waived for applicants who completed training during the previous year).
Clinical Experience (Reappointment)	Applicant must provide documentation of provision of clinical services representative of the scope and complexity of privileges requested during the previous 24 months.
Additional Qualifications	Current California Fluoroscopy Permit issued by the Radiologic Health Branch. **AND** Applicant must have a contract with the organization to provide services in this specialty.

Core Privileges in Radiology	
Description: Diagnosis of disease/conditions utilizing medical imaging techniques, including X-Rays, Computer Tomography (CT), Magnetic Resonance Imaging (MRI), and Ultrasound.	
Request	Check the Request checkbox to select all privileges listed below. Uncheck any privileges you do not wish to request in the group.
	Select, perform and interpret

☐	Perform history and physical examination
☐	Routine imaging, including bone density scans, fluoroscopy, IVP (intravenous pyelography), x-rays
☐	Diagnostic ultrasound
☐	Diagnostic CT (computed-tomography) or CTA (computed-tomography angiography)
☐	MRI (magnetic resonance imaging) or MRA (magnetic resonance imaging angiography)
☐	Diagnostic nuclear medicine studies
	Procedures
☐	Image guided procedures such as contrast studies of the gastrointestinal and genitourinary systems; arthrography; lumbar puncture; and myelography.
☐	Image guided procedures including percutaneous tube placement; fluid and cyst aspiration; and other procedures requiring the same techniques and skills.
☐	Image guided biopsy and drainage (excludes breast biopsies)
☐	Nerve block, facet injections, and epidurals
☐	Peripheral insertion of central venous catheter (PICC) placement
☐	Paracentesis
☐	Thoracostomy tube placement/Thoracentesis

FPPE (Department Chief to select)	
☐	15 overreads in each of the major radiology modalities (i.e., CT, MRI, Ultrasound, etc.) in which the practitioner has been granted privileges
☐	Feedback from involved clinician or administrative person who is knowledgeable about the services performed by the physician
☐	Reference from a referring physician (related to whether consultation was timely, appropriate and complete).

Privilege Cluster: Breast Imaging and Invasive Privileges

Description: Select, perform and interpret imaging and invasive procedures related to the detection and treatment of cancer of the breast.

Qualifications

Education/Training	Completion of a residency or fellowship program in radiology approved by the ACGME that included breast imaging and invasive procedures. **AND** For initial qualification, confirmation from program director that applicant is trained and qualified to perform breast imaging and invasive procedures per Mammography Quality Standards Act (MQSA) standards.
Certification	Current certification or active participation in the examination process leading to certification in Diagnostic Radiology by the American Board of Radiology. **OR** Current certification or active participation in the examination process leading to certification in Interventional Radiology and Diagnostic Radiology (integrated certificate) by the American Board of Radiology.
Clinical Experience (Initial)	Applicant must provide documentation demonstrating at least 960 mammographic examinations interpreted within the past 24 months. **OR** Completion of training specified for this privilege cluster during the previous 12 months (see Education/Training above) with letter from training program documenting 240 mammography interpretations under supervision for a 6-month period.
Clinical Experience (Reappointment)	Applicant must provide documentation of provision of clinical services representative of the scope and complexity of privileges requested during the previous 24 months. **AND** Meet the numeric requirements for mammography interpretations per MQSA standards (960 in the past 24 months).
Continuing Education	For initial applicants, a minimum of 60 hours of documented category 1 medical education in mammography. At least 15 of the category 1 hours shall have been acquired within the past 36 months. Hours spent in residency specifically devoted to mammography will be considered as equivalent to category I continuing medical education credits and will be accepted if documented in writing by the appropriate representative of the training institution. **OR** For privilege renewals, a minimum of 15 hours of category 1 medical education in mammography in the past 36 months
Additional Qualifications	For initial qualification, proof of 8 hours of training in digital mammography and 8 hours of training in digital breast tomosynthesis **AND** Applicants must meet and maintain qualifications in conformance with the Mammography Quality Standards Act (MQSA) regulations in order to be granted privileges in mammography. **AND** Applicant must have a contract with the organization to provide services in this specialty.

Request	Check the Request checkbox to select all privileges listed below. Uncheck any privileges you do not wish to request in the group.

	Select, perform and interpret
☐	Mammography, screening and diagnostic
☐	Ultrasound-guided breast biopsy
☐	Stereotactic breast biopsy
☐	Needle/wire localization

FPPE (Department Chief to select)	
☐	15 overreads of each modality for which privileges have been granted
☐	Feedback from involved clinician or administrative person who is knowledgeable about the services performed by the physician
☐	Reference from a referring physician (related to whether consultation was timely, appropriate and complete).

Moderate (Procedural) Sedation

Description: Moderate Sedation/Analgesia ("Conscious Sedation") is a drug-induced depression of consciousness during which the patient responds purposefully to verbal commands, either alone or with light tactile stimulation. No interventions are required to maintain a patent airway and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.

Qualifications

Clinical Experience (Initial)	Applicant must provide documentation of a minimum of 6 sedations during the previous 24 months. **AND** Applicant must complete sedation tutorial at initial granting of privileges and every 2 years thereafter.
Clinical Experience (Reappointment)	Documentation of at least 6 cases within the last 24 months. **AND** Sedation tutorial completed within the last 24 months.
Additional Qualifications	Current ACLS certification (waived for physicians with Emergency Medicine Board certification).

Request	Check the Request checkbox to select all privileges listed below. Uncheck any privileges you do not wish to request in the group.
☐	Moderate Sedation (Must perform 6 every 2 Years)

FPPE (Department Chief to select)	
☐	Retrospective review of 3 cases of administration of moderate sedation
☐	Feedback from involved clinical or administrative personnel

Acknowledgment of Applicant

I have requested only those privileges for which by education, training, health status, current experience, and demonstrated competency I believe that I am competent to perform and that I wish to exercise at Northern Inyo Healthcare District and I understand that:

A. In exercising any clinical privileges granted, I am constrained by applicable Hospital and Medical Staff policies and rules applicable generally and any applicable to the particular situation.

B. Any restriction on the clinical privileges granted to me is waived in an emergency situation and in such situation my actions are governed by the applicable section of the Medical Staff Bylaws or related documents.

Practitioner's Signature NIHD

Department Chief Recommendation - Privileges	
I have reviewed the requested clinical privileges and supporting documentation and my recommendation is based upon the review of supporting documentation and/or my personal knowledge regarding the applicant's performance of the privileges requested:	
Privilege	Condition/Modification/Deletion/Explanation

RESOLUTION NO. 22-02

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

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

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

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

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

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

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

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

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

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

PASSED, APPROVED AND ADOPTED this 19th day of January, 2022 by the following roll call vote:

AYES:
NOES:
ABSENT:

_____
Jody Veenker, Chair
Board of Directors

ATTEST:

_____
Name: _____
Title: _____

CALL TO ORDER	The meeting was called to order at 5:30 pm by Robert Sharp, District Board Chair.
PRESENT	Robert Sharp, Chair Jody Veenker, Vice Chair Mary Mae Kilpatrick, Secretary Topah Spoonhunter, Treasurer Jean Turner, Member-at-Large Kelli Davis MBA, Chief Executive Officer and Chief Operating Officer Vinay Behl, Interim Chief Financial Officer Joy Engblade MD, Chief Medical Officer Allison Partridge RN, MSN, Chief Nursing Officer Sierra Bourne MD, Chief of Staff Keith Collins, General Legal Counsel (Jones & Mayer)
OPPORTUNITY FOR PUBLIC COMMENT	Mr. Sharp announced that the purpose of public comment is to allow members of the public to address the Board of Directors. Public comments shall be received at the beginning of the meeting and are limited to three (3) minutes per speaker, with a total time limit of thirty (30) minutes being allowed for all public comment unless otherwise modified by the Chair. Speaking time may not be granted and/or loaned to another individual for purposes of extending available speaking time unless arrangements have been made in advance for a large group of speakers to have a spokesperson speak on their behalf. Comments must be kept brief and non-repetitive. The general Public Comment portion of the meeting allows the public to address any item within the jurisdiction of the Board of Directors on matters not appearing on the agenda. Public comments on agenda items should be made at the time each item is considered. Public comments were heard from Heather Edwall.
REQUEST TO ADD TO THE AGENDA, CLOSED SESSION ITEM	Legal Counsel, Keith Collins requested that the Board of Directors consider adding one item to the agenda for this meeting, due to the fact that an immediate need to discuss potential actions exists and because this item came to the attention of District Administration following posting of the agenda for this meeting. The request is to place this item on the Closed Session portion of the agenda for this meeting as item 11B and amend the item as follows: - Conference with legal counsel, existing litigation (pursuant to Gov. Code 54956.9(d)(1)). two cases: Cassidy v. NIHD & NIHD v. SMHD It was moved by Jean Turner, seconded by Mary Mae Kilpatrick, and unanimously passed to approve the addition of this agenda item as requested.

NEW BUSINESS

APPROVAL OF THE AMENDMENT NO. 5 TO THE NORTHERN INYO COUNTY LOCAL HOSPITAL DISTRICT RETIREMENT PLAN	Isabel Safie with Best Best & Krieger Law, called attention to the proposed Amendment No.5 to the Northern Inyo County Local Hospital District Retirement Plan. It was moved by Jody Veenker, seconded by Topah Spoonhunter, and unanimously passed to approve the Amendment NO. 5 to the Northern Inyo County Local Hospital District Retirement Plan as presented.
APPROVAL OF THE FREEZE AMENDMENT VALIC 457 PLAN	Isabel Safie with Best Best & Krieger Law, called attention to the proposed Freeze Amendment Valic 457 Plan. It was moved by Ms. Kilpatrick, seconded by Ms. Veenker, and unanimously passed to approve the Freeze Amendment Valic 457 Plan as presented.
APPROVAL OF THE FREEZE AMENDMENT LINCOLN 457 PLAN	Isabel Safie with BBK Law called attention to the proposed Freeze Amendment Lincoln 457 Plan. It was moved by Ms. Turner, seconded by Mr. Spoonhunter, and unanimously passed to approve the Freeze Amendment Lincoln 457 Plan as presented.
NORTHERN INYO HEALTHCARE DISTRICT 2021 ANNUAL FINANCIAL AUDIT REPORT AND DOCUMENT PRESENTATION	Chief Executive Officer, Kelli Davis introduced David Showalter with Edie Bailly. Mr. Showalter provided a presentation of the Northern Inyo Healthcare District 2021 Annual Financial Audit Report. No action was taken.
APPROVAL OF REVENUE BOND AGREEMENTS BETWEEN QUINT & THIMMING, LLP AND NORTHERN INYO HEALTHCARE DISTRICT FOR REFUNDING REVENUE BONDS, SERIES 2021A & TAXABLE REFUND REVENUE BONDS, SERIES 2021B; AND APPROVAL OF DISTRICT BOARD	Interim Chief Financial Officer, Vinay Behl, and Todd Van Deventure with Piper Sandler called attention to the proposed Agreement between Quint & Thimming, LLP and Northern Inyo Healthcare District for Revenue Bond, Series 2021A & 2021B and clarified questions. Brian Quint with Quint & Thimming, LLP, also called attention to proposed District Board Resolution 21-14. NIHD Compliance Officer, Patty Dickson noted that the District Board Resolution appears on the meeting agenda as District Board Resolution 12-14, instead of District Board Resolution 21-14. It was moved by Ms. Veenker, seconded by Ms. Turner, and unanimously passed to approve the Agreements between Quint & Thimming, LLP and Northern Inyo Healthcare District for Refunding Revenue Bonds, Series 2021A & Taxable Refund Revenue Bonds 2021B; and Approval of District Board Resolution 21-14 with the correction as requested by Ms.

RESOLUTION 21-14

Dickson.

POLICY AND PROCEDURE APPROVAL, PROCESSING RETURN MAIL

NIHD Admission Services Manager, Tanya Deleo called attention to the revised NIHD Policy and Procedure titled: *Processing Return Mail*.

It was moved by Ms. Kilpatrick, seconded by Ms. Veenker, and unanimously passed to approve the revised NIHD Policy and Procedure title: *Processing Return Mail Policy and Procedure* as presented.

POLICY AND PROCEDURE APPROVAL, PROCESSING UNITED STATES POSTAL SERVICE MAIL

Admission Services Manager, Tanya Deleo called attention to the revised NIHD Policy and Procedure titled; *Processing United States Postal Service Mail.*

It was moved by Ms. Veenker, seconded by Mr. Spoonhunter, and unanimously passed to approve the revised NIHD Policy and Procedure titled: Processing United States Postal Services Mail policy as presented.

ELECTION OF BOARD OFFICERS FOR CALENDAR YEAR 2022

Mr. Sharp called attention to the appointment of District Board Officers for the 2022 calendar year, and proposed the following slate of officers:

- *Chair:* Jody Veenker
- *Vice Chair:* Mary Mae Kilpatrick
- *Secretary:* Topah Spoonhunter
- *Treasurer:* Jean Turner
- *Member at Large*: Robert Sharp

It was moved by Ms. Turner, seconded by Mr. Spoonhunter, and unanimously passed to approve the slate of officers for the 2022 calendar year as presented.

RECOMMENDATION TO APPOINT A BOARD MEMBER TO THE COMPLIANCE BUSINESS ETHICS COMMITTEE

Ms. Davis requested that this open session item be tabled and discussed at the next Regular Board Meeting.

It was moved by Ms. Veenker, seconded by Ms. Turner, and unanimously passed to table open session item *3I. Recommendation to Appoint a Board Member to the Compliance Business Ethics Committee* as requested by Ms. Davis.

CHIEF OF STAFF REPORT

MEDICAL STAFF APPOINTMENTS

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

1. *Jane Yoon, MD (pediatrics) – Active Staff*
2. *Milan Shah, MD (urology) – Courtesy Staff*
3. *George Chiang, MD (urology) – Courtesy Staff*
4. *Bridget Miranda, NP (urology nurse practitioner) – Advanced*

Practice Provider Staff

5. *Bradley Nelson, MD (cardiology) – Telemedicine Staff (Renown)*
6. *Troy Wiedenbeck, MD (cardiology) – Telemedicine Staff (Renown)*

It was moved by Ms. Turner, seconded by Ms. Kilpatrick, and unanimously passed to approve all six (6) Medical Staff Appointments as requested.

REQUEST FOR ADDITONAL PRIVILEDGES

Doctor Bourne also reported the Medical Executive Committee recommends approval of the following request for Additional Privileges:

1. *Gary Turner, MD (radiology) – request for PICC line insertion privileges.*

It was moved by Ms. Veenker, seconded by Ms. Turner, and unanimously passed to approve the one (1) request for Additional Privileges as requested.

MEDICAL STAFF RESIGNATIONS

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

1. *Anu Agarwal, MD (telecardiology, Renown) – 8/9/2021*
2. *David Nicholson, CRNA (nurse anesthesia) – 9/30/2021*
3. *Richard Seher, MD (telecardiology, Renown) – 8/4/2021*
4. *Sarah Zuger, MD (family medicine) – 12/31/2021*

It was moved by Ms. Veenker, seconded by Mr. Spoonhunter, and unanimously passed to approve all four (4) Medical Staff Resignations as requested.

MEMBERS NOT SUBMITTING A REAPPOINTMENT APPLICATION

Doctor Bourne, provided an update on the following members that will not be submitting reappointment application, with privileges expiring 12/31/2021:

1. *Daniel Davis, MD (orthopedics)*
2. *Kevin Deitel, MD (orthopedics)*
3. *Elizabeth Maslow, MD (infectious disease)*
4. *Wilbur Peralta, MD (internal medicine/hospitalist)*
5. *Louis Rivera, MD (general surgery)*
6. *Richard Seher, MD (telecardiology, Renown)*
7. *Sheila Lezcano, MD (rheumatology)*
8. *Shabnamzehra Bhojani, MD (psychiatry)*
9. *Rajesh Vaid, MD (teleradiogy)*

POLICIES AND PRCEDURES

Doctor Bourne, additionally reported the Medical Executive Committee recommends approval of the following District Wide Policies and Procedures:

1. *Emergency Department Telephone Advice Information*
2. *Blood Alcohol Levels; Law Enforcement - Requested Collection*
3. *Medical Staff Department Policy – Anesthesia*
4. *Medical Staff Department Policy – Surgery*
5. *Non-Physician First Assistant in the Operating Room*
6. *Standardized Procedure – General Policy for the Nurse Practitioner or Certified Nurse Midwife*
7. *Standardized Protocol – General Policy for the Physician Assistant*
8. *Diagnostic Imaging – Radioactive Material Hot Lab Security*

It was moved by Ms. Turner, seconded by Ms. Kilpatrick, and unanimously passed to approve all eight (8) Policies and Procedures as presented.

BIENNIAL REVIEW OF RADIATION SAFETY POLICIES

Doctor Bourne reported, following review and consideration, the Medical Executive Committee recommends approval of the following Biennial Review of Radiation Safety Policies:

1. *ALARA Program*
2. *Diagnostic Imaging – Ordering Radioactive Materials*
3. *Diagnostic Imaging – Handling of Radioactive Packages, Non-Nuclear Medicine Personnel*
4. *Dosimetry Program – Occupational Radiation Exposure Monitoring Program*
5. *Radiology Services Pregnant Personnel*
6. *DI CT Radiation Safety Policy*
7. *Diagnostic Imaging – Imaging Equipment Quality Control*
8. *Diagnostic Imaging – Patient Priority*
9. *DI - Venipuncture by Radiologic Technologists*
10. *DI – CT Contrast Administration*
11. *Sonography Ergonomics Policy*

It was moved by Ms. Veenker, seconded by Mr. Spoonhunter, and unanimously passed to approve all eleven (11) Biennial Review of Radiation Safety Polices as presented.

MEDICAL EXECUTIVE COMMITTEE REPORT

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

_____.

CONSENT AGENDA

Mr. Sharp called attention to the Consent Agenda for this meeting which contained the following items:

1. *Approval of District Board Resolution 21-13, to continue to allow Board meetings to be held virtually.*
2. *Approval of minutes of the November 17, 2021 Regular Board Meeting*
3. *Financial and Statistical reports as of October 31, 2021*
4. *Approval of Policies and Procedures:*
   - *A. Advance Beneficiary Notice- Non-Clinical Policy and Procedure*
   - *B. Medicare Outpatient Observation Notice- Non-Clinical Policy and Procedure*
   - *C. NIHD Code of Business Ethics and Conduct- Non-Clinical Policy*
   - *D. Language Access Services Policy- Non-Clinical Policy*
   - *E. Language Access Services Program- Non-Clinical Policy*

It was moved by Mr. Spoonhunter, seconded by Ms. Veenker, and unanimously passed to approve all four (4) Consent Agenda items as presented.

BOARD MEMBER REPORTS ON ITEMS OF INTEREST

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

PUBLIC COMMENTS ON CLOSED SESSION ITEMS

Mr. Sharp announced that at this time persons in the audience may speak only on items listed on the closed session portion of this meeting. No public comments were heard.

ADJOURNMENT TO CLOSED SESSION

At 7:22 pm Mr. Sharp announced the meeting would adjourn to Closed Session for

A. Conference with legal counsel, anticipated litigation. Significant exposure to litigation (pursuant to paragraph (2) of subdivision (d) of Government Code Section 54956.9) two cases.
B. Conference with legal counsel, existing litigation (pursuant to Gov. Code Section 54956.9(d)(1) two cases.
   Cassidy v. NIHD & NIHD v. SMHD

Mr. Sharp additionally noted that it was not anticipated that an action would be reported out following the conclusion of Closed Session.

RETURN TO OPEN SESSION AND REPORT OF ANY ACTION TAKEN	At 9:34 pm, the meeting returned to Open Session. Mr. Sharp reported that the Board took no reportable action.
ADJOURNMENT	The meeting adjourned at 9:35 pm.

_____
Robert Sharp, Chair

Attest: _____
Mary Mae Kilpatrick, Secretary

CALL TO ORDER	The meeting was called to order at 6:03 pm by Robert Sharp, District Board Chair.
PRESENT	Robert Sharp, Chair Jody Veenker, Vice Chair Mary Mae Kilpatrick, Secretary Topah Spoonhunter, Treasurer Jean Turner, Member-At-Large Kelli Davis, Chief Executive Officer Vinay Behl, Interim Chief Financial Officer Joy Engblade, Chief Medical Officer Allison Partridge, Chief Nursing Officer
OPPORTUNITY FOR PUBLIC COMMENT	Mr. Sharp reported at this time, members of the audience may speak only on items listed on the Notice for this meeting, and speakers will be limited to a maximum of three minutes each. The Board is prohibited from generally discussing or taking action on items not included on the Notice for this meeting. No comments were heard.
APPROVAL OF THE NORTHERN INYO HEALTHCARE DISTRICT OPERATING ROOM FLOORING REPLACEMENT BUDGET	Chief Executive Officer, Kelli Davis introduced NIHD Director of Facilities, Scott Hooker, who called attention to the approval of proposed Northern Inyo Healthcare District Operating Room Flooring Replacement Budget. Mr. Hooker, provided an overview and clarified questions for the Board It was moved by Jody Veenker, seconded by Jean Turner, and unanimously passed to approve the Northern Inyo Healthcare District Operating Room Flooring Replacement Budget as requested.
ADJOURNMENT	The meeting was adjourned at 6:30 pm.

_____
Robert Sharp, Chair

Attest: _____
Mary Mae Kilpatrick, Secretary

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

Date: 1/10/22

Title: **OR FLOORING**

Synopsis: The OR Flooring Project started on Monday January 3rd with a coordinated effort between all our team members at NIHD and the following vendors; Keckler Medical, Steris, Steris Black Diamond. OR 1 was cleared out by Wednesday January 5th. The flooring contractor (McRory's Flooring) arrived on the evening of Thursday January 6th. After a meeting with our Infection Prevention Team Friday Morning the contractor starting working on removing the old flooring. All of the old flooring was removed and the cement was ground down and ready for the new moisture barrier by mid day on Friday January 7th. By end of day January 7th the new moisture barrier had been applied as well as a primer. On Saturday and Sunday the new floor was installed. Monday morning McRory's flooring was hot welding the seams and working on the finish detail work.

We are on schedule for the flooring to be complete by the end of this week. Our EVS team will get in and burnish the floor, once this is complete we will spend the next week putting OR 1 back together. Once OR 1 is signed off and ready for use we will then start on Phase 2 (OR 2) of the project.

Prepared by: Scott Hooker Director of Facilities

Approved by: Kelli Davis
Kelli Davis
Chief Executive Officer

FOR EXECUTIVE TEAM USE ONLY:

Date of Executive Team Approval: 1-12-2022 Submitted by: Kelli Davis
Chief Officer

NORTHERN INYO HEALTHCARE DISTRICT

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

150 Pioneer Lane
Bishop, California 93514

(760) 873-5811

DATE: December 30, 2021

TO: Board of Director's, Northern Inyo Healthcare District

FROM: Kelli Davis, Chief Executive Officer (CEO)

RE: Bi-Monthly CEO Report– Northern Inyo Healthcare District

REPORT DETAIL

2021 – 2024 Strategic Plan Project Pillars include: Finance, People, Service/Patient, Growth, Quality and Community. Each bi-monthly CEO Report will provide an update on key areas of progress with which the CEO is actively involved.

Project Pillar	Project Task	Status Update
People 2.1.1.1	Define, adopt and implement recruitment, on-boarding, off-boarding and training processes for workforce and volunteers	Recruiting Plan was defined and rolled out to District leaders in June 2021 ADP Workforce Now Implementation underway HR Onboarding Specialist developing manager/leader training on the onboarding process Exit Interview Survey and Process in development with People Element IT and HR partnering in the automated notification onboarding/off-boarding process for employees, travelers, volunteers and students.
Service/Patient 3.2.2.3	Implement Commitment to My Co-Worker professionalism training	Employee civility training underway >90% employee completion The "Commitment to My Co-Worker" document is in update review status with consultants
Growth 4.1.1	Define and adopt Marketing Strategy Taskforce philosophy with focus on group think and strategic alignment with proposed and adopted marketing	NIHD Marketing Philosophy has been adopted: "At Northern Inyo Healthcare District, we believe health is our community's foundation. We educate, we

	plans	inform, and we nurture high quality care for those who rely on us, one life at a time".
Quality 5.4	Finalize the Pharmacy Project	Facilities continues to work closely with HCAI (OSHPD) on the 1967 building separation that must occur prior to the new Pharmacy construction project can start. On 12/22/2021 HCAI's Fire Life Safety Officer completed and approved the final step of the building separation. Architects, Construction and District team members are meeting regularly for the next steps.
Community	Incorporate Auxiliary, Foundation and Pioneer Home Health Care in the Strategic Plan	Marketing strategies and CEO presence continue to support all 3 components of NIHD relations. The Auxiliary recently received notice they've received the Margaret Pillsbury grant and will purchase the Level 1 Rapid Fluid Infuser capital equipment item for NIHD Emergency Department. Written monthly CEO reports are now being submitted for the NIH Foundation Board Meetings. This is showing to be helpful in information share and the promotion of informed members for advocacy support. CEO joined Greg Bissonette, Executive Director of the Foundation and Grant Writing, for a meeting on "2022 Strategic Update for NIH Foundation" to facilitate partnerships and advocacy for the NIH Foundation and the role they hold in 2022.

NIHD Rural Health Clinic Celebration

During the week of November 18th, multiple events were held at NIHD to celebrate the RHC's 20th year of providing care to our Eastern Sierra community. Dr. Brown and the RHC team were present and available to share the path to today and the significant role the RHC holds in our community.

NIHD Retirees

It recently came to our attention that during the "halt" of celebrations due to COVID-19, we did not do our annual Years of Service event and ultimately, missed some retirements including

some of our senior team members with decades of service to NIHD. Our HR team and Administrative team have developed an interim recognition of retirements including outreach to team members who did not receive the recognition they so deserved. Our team members are our greatest assets and ensuring they know how valued and appreciated they are for their service to NIHD and our community is essential.

2021 Employee and Provider Engagement and Satisfaction Survey
The NIHD annual survey of employees and providers opened on December 15th and will conclude in mid-January. As of December 28, 44% (231 of 526) of NIHD employees and 20% (13 of 65) providers have completed the survey. The goal is to move toward a 90% District-wide survey participation by 2024 per the 2021-2024 NIHD Strategic Plan.
We continue to emphasize the importance of the voices of our NIHD team. Efforts are underway to motivate for participation and celebrate the active involvement of our team.

COVID-19 Update
On December 22, 2021, the California Department of Public Health (CDPH) issued an order requiring workers in health care facilities to receive booster vaccinations to help combat Covid-19. Health care workers must receive the booster vaccine by February 1, 2021.
This order maintains exemptions for religious beliefs and qualifying medical reasons. Workers with exemptions must continue twice weekly Covid-19 testing.
Health care facilities must begin administering tests for non-boosted workers by December 27.
Upon receipt of the CDPH All Facilities Letter (AFL) with this new booster and testing mandate, the NIHD team immediately began preparation for the provision of testing and another round of Covid-19 vaccinations (boosters) for our workforce. Twice weekly testing of potentially hundreds of staff and providers who have not been boosted and routine vaccine events has a tremendous impact on resources and supplies.

Oracle Buys Cerner
NIHD went "live" with our new electronic health record (EHR) Cerner, on May 12, 2021. On December 20th, a news release from Cerner announced the acquisition of Cerner Corporation by Oracle. The following statement is reflective of the intent of this partnership: "Oracle and Cerner together will help accelerate the transformation of the healthcare industry with modern technologies that deliver better patient outcomes as a lower cost. This is a great opportunity for clients, associates and the industry". Please see the attached press release for additional information.

"Hospital & Health System Landscape" – American Hospital Association
As healthcare facilities continue to try to navigate COVID-19 and industry practices and changes, understanding the bigger picture and just where our small rural healthcare district stands in the healthcare environment is key. Attached, you will find a very interesting "2022 Environmental Scan" put out by the American Hospital Association. This document is worthy of discussions and decision-making and many levels from a leadership, Board, provider and District team as a whole.

Department Reports
Please find the reports from the department leaders I support in the next pages. You are sure to see much work underway, some challenges and of course, some celebration of the amazing work and service provision taking place at NIHD.

Closing
The support and guidance by the NIHD Board of Director's is greatly appreciated. As always, please do not hesitate to contact me with any questions or to share any concerns you may have.

Respectfully submitted,
Kelli Davis - CEO

Featured Post

Oracle Buys Cerner
by Cerner Corporation
Published on December 20, 2021

AUSTIN, Texas and KANSAS CITY, Mo. — December 20, 2021 —

Oracle Corporation (NYSE: ORCL) and Cerner Corporation today jointly announced an agreement for Oracle to acquire Cerner through an all-cash tender offer for $95.00 per share, or approximately $28.3 billion in equity value. Cerner is a leading provider of digital information systems used within hospitals and health systems to enable medical professionals to deliver better healthcare to individual patients and communities.

"Working together, Cerner and Oracle have the capacity to transform healthcare delivery by providing medical professionals with better information—enabling them to make better treatment decisions resulting in better patient outcomes," said Larry Ellison, Chairman and Chief Technology Officer, Oracle. "With this acquisition, Oracle's corporate mission expands to assume the responsibility to provide our overworked medical professionals with a new generation of easier-to-use digital tools that enable access to information via a *hands-free* voice interface to secure cloud applications. This new generation of medical information systems promises to lower the administrative workload burdening our medical professionals, improve patient privacy and outcomes, and lower overall healthcare costs."

"We expect this acquisition to be immediately accretive to Oracle's earnings on a non-GAAP basis in the first full fiscal year after closing—and contribute substantially more to earnings in the second fiscal year and thereafter," said Safra Catz, Chief Executive Officer, Oracle. "Healthcare is the largest and most important vertical market in the world—$3.8 trillion last year in the United States alone. Oracle's revenue growth rate has already been increasing this year—Cerner will be a huge additional revenue growth engine for years to come as we expand its business into many more countries throughout the world. That's exactly the growth strategy we adopted when we bought NetSuite—except the Cerner revenue opportunity is even larger."
"Cerner has been a leader in helping digitize medical care and now it's time to realize the real promise of that work with the care delivery tools that get information to the right caregivers at the right time," said David Feinberg, President and Chief Executive Officer, Cerner. "Joining Oracle as a dedicated Industry Business Unit provides an unprecedented opportunity to accelerate our work modernizing electronic health records (EHR), improving the caregiver experience, and enabling more connected, high-quality and efficient patient care. We are also very excited that Oracle is committed to maintaining and growing our community presence, including in the Kansas City area."

"Oracle's Autonomous Database, low-code development tools, and Voice Digital Assistant user interface enables us to rapidly modernize Cerner's systems and move them to our Gen2 Cloud,"

said Mike Sicilia, Executive Vice President, Vertical Industries, Oracle. "This can be done very quickly because Cerner's largest business and most important clinical system already runs on the Oracle Database. No change required there. What will change is the user interface. We will make Cerner's systems much easier to learn and use by making Oracle's *hands-free* Voice Digital Assistant the primary interface to Cerner's clinical systems. This will allow medical professionals to spend less time typing on computer keyboards and more time caring for patients."

Highlights

- All-cash tender offer for $95.00 per share, or approximately $28.3 billion that is immediately accretive to Oracle's earnings.
    - Accretive to Oracle's earnings on a non-GAAP basis in the first full fiscal year after closing and will contribute substantially more to earnings in the second fiscal year and thereafter.
    - Cerner will be a huge additional revenue growth engine for Oracle for years to come as Oracle expands Cerner's business into many more countries throughout the world.
    - Transaction is expected to close in calendar year 2022. The closing of the transaction is subject to receiving certain regulatory approvals and satisfying other closing conditions including Cerner stockholders tendering a majority of Cerner's outstanding shares in the tender offer.
    - Oracle anticipates retaining an investment grade credit rating.

- Oracle brings significant experience helping power the largest industries.
    - Oracle provides industry solutions that run the core operations for customers in the world's largest industries.
    - Industries covered by Oracle today include, among others, Financial Services, Telecom, Utilities, Pharmaceuticals, Hospitality, Retail, Food & Beverage, Construction & Engineering, Manufacturing and Government.
    - Oracle also brings best in class cloud infrastructure to drive digital modernization, substantially lowering the total cost of IT in these critical industry sectors.

- Cerner is a leader in the healthcare IT industry and a complementary business to Oracle.
    - Cerner is a leading provider of digital information systems used within hospitals to enable medical professionals to deliver better healthcare to individual patients and communities.
    - Cerner has over four decades of experience modernizing electronic health records, improving the caregiver experience, and streamlining and automating clinical and administrative workflows.

- Together, Oracle and Cerner will protect customer investments and transform healthcare.
    - According to a recent study by the Mayo Clinic[1], physicians spend 1 to 2 hours on EHRs and desk work for every hour spent in face-to-face contact with patients, as well as an additional 1 to 2 hours of personal time on EHR related activities.
    - Working together, Cerner and Oracle have the capacity to address these issues and transform healthcare delivery by providing medical professionals with better

information—enabling them to make better treatment decisions resulting in better patient outcomes.
    - Customer investments in Cerner are also protected with this combination and will grow in value over time as more modern and connected technologies are made available.
    - With Oracle's resources, infrastructure and cloud capabilities, Cerner will accelerate the pace of product and technology development to enable more connected, high-quality, and efficient care.
        - Oracle's focus on usability and voice enabled user interfaces will dramatically reduce the amount of time that medical providers spend dealing with systems and increase the time they spend directly caring for patients.
    - Significant opportunity to help customers use Oracle's modern technologies such as cloud, AI, ML and other innovations to make care more accessible, secure, efficient and effective for patients and caregivers.
        - Cerner systems running on the Oracle Gen2 Cloud will be available 24 by 7 by 365. Goal is to deliver zero unplanned downtime in the medical environment.
        - With Cerner systems running on the Oracle database, only specifically authorized medical professionals can access patient data. IT professionals running the systems are unable to look at patient data.
    - Oracle and Cerner are committed to continued and enhanced stewardship of health information, which will be bolstered by Oracle's global operational infrastructure.

- Cerner will be organized as a dedicated Industry Business Unit within Oracle.
    - Cerner will be Oracle's anchor asset to expand into healthcare and together we will improve medical care for individuals and communities around the world.
    - Oracle intends to maintain and grow Cerner's community presence, including in the Kansas City area, while utilizing Oracle's global footprint to reach new geographies faster.

More information about this announcement is available at the Oracle and Cerner corporate websites.

Welcome to the 2022 Environmental Scan

We had hoped that by now, COVID-19 would have been a public health emergency that had been solved or mostly brought under control. We now know that we will be co-existing with COVID-19 in some way for the foreseeable future, with no hard stop in sight. This will continue to affect not only our nation's health, but also the ability of hospitals and health systems to improve it … let alone transform it.

The AHA's 2022 Environmental Scan offers a mixed picture for our field right now. There are bright spots for sure, promising developments and many inspiring stories to share. At the same time, there continue to be areas of serious concern, especially around the issue of strengthening the resiliency and capacity of our dedicated workforce.

With another year of pandemic experience under our belts, hospitals and health systems are innovating as never before, finding and sharing solutions and best practices with each other.

The demonstrated ability of care providers to consider new ideas, try new methods and remain nimble in the face of the pandemic bodes well not only for the short term, but also for the long game as our field's established business models continue to undergo significant change.

RICK POLLACK
President and CEO
American Hospital Association

'Our goal is to help you deal with the now, near and far as you approach every day with one goal in mind: providing the best care to every patient and protecting your community.'

The transformation of our health care system was well underway before COVID-19 appeared, and many of the future trends identified in the 2022 Environmental Scan are sure to be met with the same willingness to adapt and think creatively.

Even as the pandemic lingers, this is a good time to pause, take a breath and thoughtfully consider the landscape ahead, with plenty of focus on the post-COVID world.

What do we take away from this experience to reevaluate, reboot, and re-imagine to create a better future?

This report offers our best thinking and information to consider on a range of issues that confront us all, including: co-existing with COVID-19, access and affordability, innovation and delivery transformation, health equity, behavioral health, and the future of workforce and health care employment trends, among others.

We hope that the statistics and projections in this Environmental Scan will help hospital and health system leaders chart the best course to the future for their organizations, providing a comprehensive understanding of the many influences at work that impact our health care system.

Our goal is to help you deal with the now, near and far as you approach every day with one goal in mind: providing the best care to every patient and protecting your community.

HOSPITAL & HEALTH SYSTEM LANDSCAPE

The pandemic has resulted in historic challenges for hospitals and health systems and the communities they serve. Hospitals and health systems are navigating financial and operational pressures that include: the high costs associated with preparing for a surge of COVID-19 patients and resource-intensive treatment; added expenses due to supply chain and labor market disruptions; and loss of revenue due to the lower patient volumes for nonemergent care. Economic stability must be gained to ensure that hospitals and health systems can continue to provide vital care to communities across the nation.

Hospitals' Financial Challenges

UNPRECEDENTED FINANCIAL LOSSES TO U.S. HOSPITALS AND HEALTH SYSTEMS CONTINUE IN 2021 AFTER HISTORIC LOSSES IN 2020

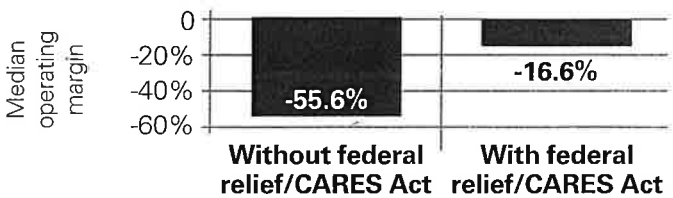
$54 BILLION

2021 net income loss estimate

"Financial Effects of COVID-19: Hospital Outlook for the Remainder of 2021," Kaufman, Hall & Associates LLC, Sept. 2021.

HOSPITALS' FINANCIAL HEALTH DETERIORATING

% Decrease in median operating margin in 2020 compared with 2019



"National Hospital Flash Report," Kaufman, Hall & Associates LLC, January 2021.

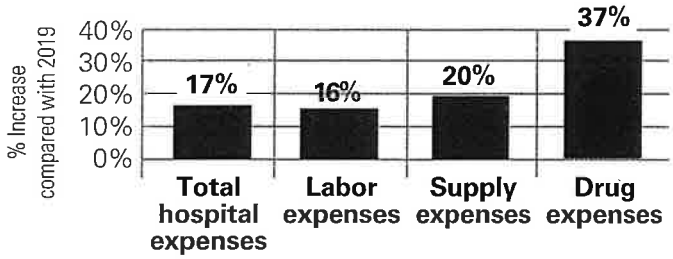
2021 Financial insights

These projections examine data from Q1 & Q2 2021 and do not factor in recent increases in COVID-19 cases from the Delta variant, which could drive margins even lower in the second half of the year.

- Higher costs of caring for sicker patients and fewer outpatient visits than pre-pandemic levels could lead median hospital margins to be 11% below pre-pandemic levels by year's end.
- The median length of stay is up 8% compared to 2019 for most hospitals, and up as high as 18% for some hospitals with 500 beds or more.
- More than a third of hospitals are expected to end 2021 with negative operating margins.
- If there were no relief funds from the federal government, losses in net income would be as high as $92 billion.

"Financial Effects of COVID-19: Hospital Outlook for the Remainder of 2021," Kaufman, Hall & Associates LLC, Sept. 2021.

EXPENSES INCREASE COMPARED WITH PRE-PANDEMIC LEVELS



% Change in year-to-date expenses per adjusted discharge, 2021 compared with 2019 (Jan. 1 to Sept. 30)

"Financial Effects of COVID-19: Hospital Outlook for the Remainder of 2021," Kaufman, Hall & Associates LLC, Oct. 2021.

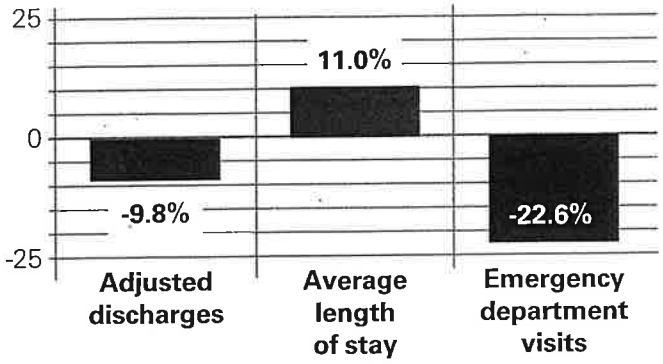
LABOR COSTS INCREASE IN 2021

- Hospitals and health systems are paying **$24 billion** more per year for qualified clinical labor than they did pre-pandemic.*
- The annual rate of turnover in emergency, ICU and nursing departments has increased from **18% pre-pandemic to 30%** in 2021. This number could increase as mandates take effect.*
- The use of agency and temporary labor increased **132%** for full-time workers and **131%** for part-time workers.*
- Travel nurse rates jumped more than **200%**. Hospitals are spending approximately **62.5%** more for travel RNs than they did at the start of 2020.†

* Alkire, Michael J. et al. "PINC AI Data Shows Hospitals Paying $24B More for Labor Amid COVID-19 Pandemic," Data & Analytics Blog, Premier, Inc., Oct. 6. 2021.
† "2021 NSI National Health Care Retention & RN Staffing Report," NSI Nursing Solutions Inc., March 2021.

Hospital Volumes and Utilization

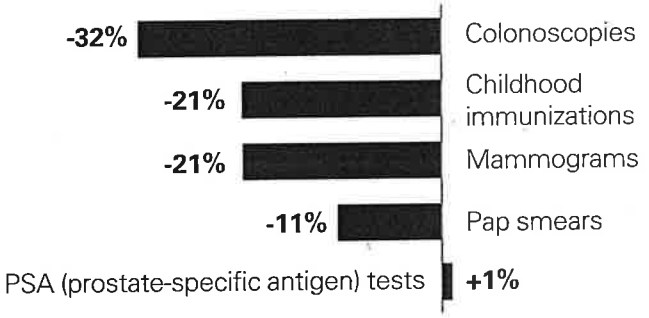
2020 NATIONAL VOLUMES (Compared with 2019)



"National Hospital Flash Report," Kaufman, Hall & Associates, LLC, January 2021.

MANY PREVENTIVE SERVICES DECREASED IN 2020

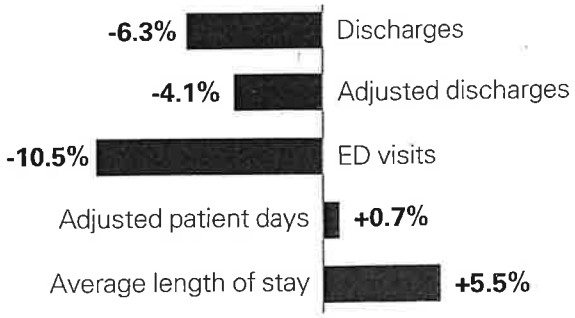
Showing % change when comparing March 13, 2020 - Dec. 31, 2020, with same time period in 2019.



Martin, Katie et al. "The Impact of COVID-19 on the Use of Preventive Health Care," Health Care Cost Institute, April 16, 2021.

2021 NATIONAL VOLUMES, YEAR TO DATE

Showing % changed when comparing 2021 with 2019 (Jan. 1 to Sept. 30).



"National Hospital Flash Report," Kaufman, Hall & Associates, LLC, Oct. 2021.

Looking Ahead to 2029

- Behavioral health virtual visits may increase by 50%.
- Growth in hospital-at-home helps to move patients out of skilled nursing facilities despite an aging population.
- Growth opportunities require organizations to invest in chronic disease-management services.
- COVID-19 creates an enduring demand for specialist care required to support chronic COVID-impacted conditions.

"2021 Impact of Change® Forecast Highlights: COVID-19 Recovery and Impact on Future Utilization," Sg2, a Vizient company, June 2, 2021.

2029 FORECAST: CARE IN ALTERNATIVE SETTINGS ON THE RISE

Site of care	Patient volumes 2019	Patient volumes 2029	% Change
Hospital outpatient department	35.5 million	42.3 million	+19%
Ambulatory surgery center	32.0 million	40.1 million	+25%
Physician office/clinic	19.2 million	22.7 million	+18%
Home-based services	413.8 million	474.9 million	+15%
Inpatient	30.4 million	30.1 million	-1%
Skilled nursing facility	3.2 million	3.0 million	-6%
Emergency department	91.7 million	86.9 million	-5%

"2021 Impact of Change® Forecast Highlights: COVID-19 Recovery and Impact on Future Utilization," Sg2, a Vizient company, June 2, 2021.

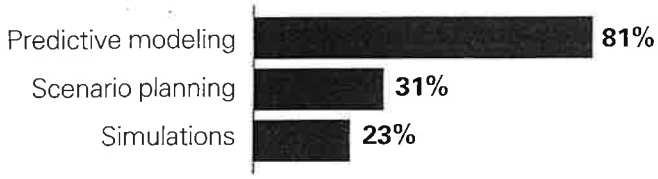
Learn more about relief and recovery efforts through the AHA's advocacy efforts at aha.org/advocacy/action-center.

Supply Chain

SHORTAGES ARE PREVALENT

93% of provider executives reported experiencing supply chain shortages.

PLANNED INVESTMENTS



"Medical cost trend: Behind the numbers 2022," PwC's Health Research Institute, June 2021. © PwC. Not for further distribution without the prior written permission of PwC. PwC refers to the US member firm or one of its subsidiaries or affiliates, and may sometimes refer to the PwC network. Each member firm is a separate legal entity. Please see www.pwc.com/structure for further details.

TOP STRATEGIES FOR RESILIENCE AND AGILITY

Investing now or will invest within two years

- Deepen collaborative relationships with key customers and suppliers.
- Diversify the supply base (multisourcing).
- Supply chain segmentation.
- Redesign products — reduce variety, increase common components.
- Diversify markets including geographies or product lines.

"A New Role for CSCOs in Supply Sourcing: Postpandemic changes to supply bases, markets and manufacturing locations," Gartner Inc., 2021.

PPE MARKUP

Personal protective equipment (PPE) prices were marked up **2,000%** for isolation gowns and **6,000%** for N95 masks during the early weeks of the pandemic.

"Top health industry issues of 2021: Will a shocked system emerge stronger?" PwC's Health Research Institute, April 2021. © PwC. Not for further distribution without the prior written permission of PwC. PwC refers to the US member firm or one of its subsidiaries or affiliates, and may sometimes refer to the PwC network. Each member firm is a separate legal entity. Please see www.pwc.com/structure for further details.

The AHA Dynamic Ventilator Reserve

This initiative is a public-private partnership that brings together health systems from across the country to share ventilators with hospitals experiencing shortages. The program was reactivated in August 2021 due to renewed demand. More than 100 ventilators have been shared nationwide.

Learn more at ahadata.com/dynamic-ventilator-reserve.

Challenges to sustainable domestic PPE manufacturing*

- Higher labor costs result in higher product costs.
- Limited access to raw materials makes scaling production challenging and costly. Each type of PPE requires raw materials that may be difficult to obtain domestically.
- Costs associated with meeting regulatory standards (i.e., new entrants, waste water treatment, testing fabrics).

Considerations to strengthen the supply chain

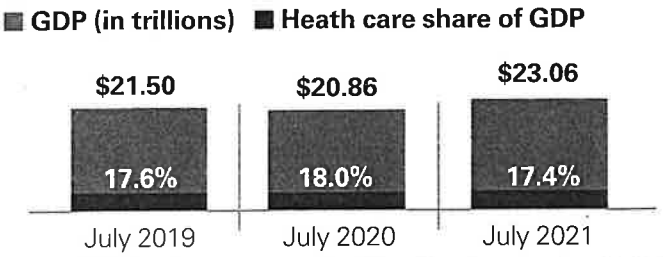
- Grow the capacity of the overall supply chain, increase the ability to store and manage excess supplies, and reevaluate just-in-time and lean inventory management principles.†
- Diversify manufacturing sites as well as sources of raw materials to ensure supply-chain sustainability, including on-shore and near-shore locations.†
- Support advancements in reuse and reprocessing technologies to mitigate supply challenges while decreasing waste and environmental impact.†
- Invest in new product development.†
- Encourage significant federal investment or incentives.†
- Increase end-user inventories and incentivize additional cushion.†
- Develop and adapt data standards including the Unique Device Identifier (UDI) to aid in early detection and mitigation of supply shortages.†
- Build a national inventory distribution network utilizing the approximately 500 distribution centers located across the country.‡
- Develop a complete picture of the end-to-end supply chain through increased visibility and mapping.‖
- Consider the interdependencies of the global supply chain (i.e., raw materials).‖
- Use of data standards including the UDI to reduce/eliminate counterfeit product.#

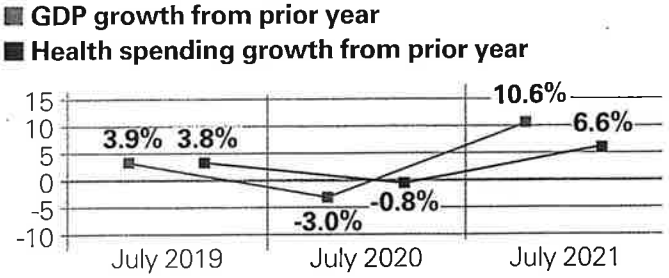
*"COVID-19: Continued Attention Needed to Enhance Federal Preparedness, Response, Service Delivery, and Program Integrity," U.S. Government Accountability Office, July 19, 2021.
†"COVID-19 Part II: Evaluating the Medical Supply Chain and Pandemic Response Gaps," statement of the American Hospital Association for the Committee on Homeland Security and Governmental Affairs of the U.S. Senate, May 19, 2021.
‡"AHRMM Health Care Learning Community (HCLC): Recommended Inventory Reserve Strategies," The Association for Health Care Resource & Materials Management of the AHA, 2021.
‖Ramaswami, Rama. "6 Key Actions to Manage Logistics and Supply Chain Disruptions," Gartner, Inc. Oct. 6, 2020.
#McLean, Scott et al. "CNN Investigation: Tens of millions of filthy, used medical gloves imported into the US," CNN, Oct. 25, 2021.

National Economic Landscape

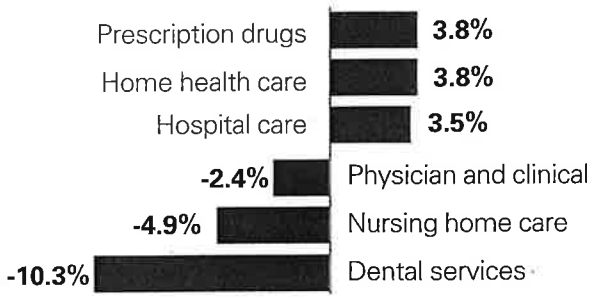
GROSS DOMESTIC PRODUCT (GDP)*

GDP growth is outpacing national health spending growth.





CUMULATIVE SPENDING GROWTH*



EMPLOYMENT: AUGUST 2021*

Field	% Below February 2020 employment level
Nursing and residential care	-11.3%
Health care	-3.1%
Hospital	-1.6%
Ambulatory care	-0.6%
Total employment	-3.5%

Over 20 million Americans lost their jobs in April 2020, driving the unemployment rate up to 14.7%, the highest rate since the Great Depression.†

* Miller, George and Turner, Ani et al. "September 2021 Health Sector Economic Indicators Briefs," Altarum, Sept. 17, 2021.
† Rugaber, Christopher. "U.S. unemployment surges to a Depression-era level of 14.7%," AP News, May 8, 2020.

CO-EXISTING WITH COVID-19

As the health care field and society move toward a new normal, science and public health practices will continue to be the guiding force to ensure that people can live, work and play safely. In addition to serving on the front lines of caring for COVID-19 patients, the people working in hospitals and health systems are trusted messengers and can share evidence-based information about the virus to their communities.

COVID-19 Infection and After-effects

Six most common post-COVID conditions

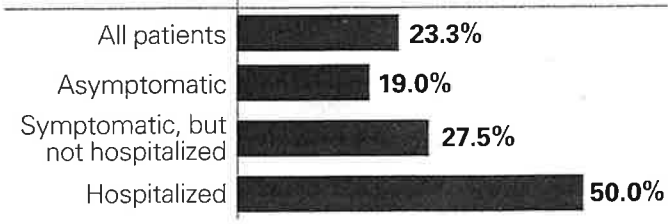
1. Pain
2. Breathing difficulties
3. Hyperlipidemia
4. Malaise and fatigue
5. Hypertension
6. Anxiety

HOSPITALIZATION

The odds of death 30 days or more after initial diagnosis with COVID-19 were 46 times higher for patients who were hospitalized and discharged than for patients who had not been hospitalized.

"A Detailed Study of Patients with Long-Haul COVID: An Analysis of Private Healthcare Claims," FAIR Health Inc., June 15, 2021.

POST-COVID CONDITIONS



"A Detailed Study of Patients with Long-Haul COVID: An Analysis of Private Healthcare Claims," FAIR Health Inc., June 15, 2021.

COVID-19 POSITIVITY RATE IS LOWEST AMONG THOSE WHO ALWAYS WORE A MASK*

Mask-wearing practice outside of the home	Tested positive for COVID-19
All the time	11%
Sometimes, but not all the time	13%
Occasionally, but not often	18%
Never	23%

- Masking in combination with vaccination is even more effective at preventing COVID-19 transmission.†

* Nather, David. "People who wore masks were less likely to get sick," Axios, June 7, 2021 (Axios-Ipsos Coronavirus Index polling data from March 2020 to May 24, 2021).
† Lockerd Maragakis, Lisa, M.D. "Coronavirus Face Masks & Protection FAQs," Johns Hopkins Medicine, June 3, 2021.

WEARABLES TRACK COVID-19 PATIENT RECOVERY

Length of time to return to baseline:

Resting heart rate 79 days

Step count 32 days

Sleep quantity 24 days

Radin, Jennifer M., et al. "Assessment of Prolonged Physiological and Behavioral Changes Associated With COVID-19 Infection," JAMA Network Open, July 7, 2021. doi:10.1001/jamanetworkopen.2021.15959.

PANDEMIC PROMPTS CHANGES TO THE HOSPITAL PHYSICAL ENVIRONMENT

Top measures implemented to help address the pandemic

% Responses by construction and design professionals

Reduced seating in patient areas 82%

Added protective barriers to interaction spaces 74%

Increased airborne infectious isolation capacity 69%

Increased telehealth capacity 60%

Separate entry points for COVID-19 suspected vs. other patient types 56%

Separate entry points for staff and patients 56%

"Health Facilities Management/ASHE 2021 Hospital Construction Survey," The American Society for Health Care Engineering of the AHA, April 2021.

Cost of COVID-19

MAJOR DECLINE IN LIFE EXPECTANCY IN U.S.

- Life expectancy declined by nearly two years from 2018 to 2020, the largest decline since 1943.
- The U.S. mortality rate increased by 23% in 2020, experiencing 522,000 more deaths than normally would be expected.
- Average loss of life expectancy in the U.S. was nearly nine times greater than the average in 16 other developed countries, whose residents can expect to live 4.7 years longer than Americans.
- Americans died at younger ages during this period.

YEARS OF LIFE EXPECTANCY LOST

Race/ethnicity	Years lost
White Americans	1.36
Black Americans	3.25
Hispanic Americans	3.88

Szabo, Liz. "Black and Hispanic Americans Suffer Most in Biggest US Decline in Life Expectancy Since WWII," Kaiser Health News, June 24, 2021.

COST OF A HOSPITALIZATION (JAN. 2020 – APRIL 2021)

	Median charge amount	Median estimated allowed amount (negotiated in-network fee with providers)
COVID-19 hospitalization with complexities	$208,136	$70,098
General COVID-19 hospitalization	$54,262	$25,188
COVID-19 non-hospitalization	$2,289	$893

"National Average Charge for a Complex Hospital Stay for COVID-19 Is $317,810, FAIR Health Finds," FAIR Health, Sept. 21, 2021.

UNVACCINATED HOSPITALIZATION COSTS

$5.7 BILLION Estimated cost of COVID-19 hospitalizations among unvaccinated adults from June through August 2021.

Amin, Krutika and Cox, Cynthia. "Unvaccinated COVID-19 hospitalizations cost billions of dollars," Health Spending Brief, Peterson-Kaiser Family Foundation Health System Tracker, Sept. 14, 2021.

Vaccination

U.S. COVID-19 VACCINATION PROGRAM CURBS DEATH TOLL

Without a vaccination program, by the end of June 2021 there would have been approximately **279,000 additional deaths** and as many as **1.25 million additional hospitalizations**.

Galvani, Alison et al., "Deaths and Hospitalizations Averted by Rapid U.S. Vaccination Rollout," The Commonwealth Fund Issue Brief, July 7, 2021. https://doi.org/10.26099/wm2j-mz32.

COVID-19 VACCINATION EFFECTIVE AGAINST THE DELTA VARIANT

Compared with vaccinated adults, unvaccinated adults have:

5x the risk of infection

10x the risk of hospitalization

10x the risk of death

Scobie, Heather M. et al. "Monitoring Incidence of COVID-19 Cases, Hospitalizations, and Deaths, by Vaccination Status — 13 U.S. Jurisdictions, April 4–July 17, 2021," CDC MMWR Morbidity and Mortality Weekly Report ePub: Sept. 10, 2021. doi: http://dx.doi.org/10.15585/mmwr.mm7037e1.

VACCINATION REDUCES COVID-19 REINFECTION

Among individuals with previous COVID-19 infection, the unvaccinated were **2.3 times more likely to experience reinfection** compared with those who were fully vaccinated.

Cavanaugh, Alyson M. et al. "Reduced Risk of Reinfection with SARS-CoV-2 After COVID-19 Vaccination — Kentucky, May-June 2021," CDC MMWR Morbidity and Mortality Weekly Report ePub: Aug. 6, 2021. doi: http://dx.doi.org/10.15585/mmwr.mm7032e1.

STATE VACCINATION RATES: IMPACT ON CHILDREN

In August 2021, **hospitalizations for children up to age 17 were 3.7 times higher** in states with the lowest vaccination rates compared with states with the highest vaccination rates.

Siegel, David A. et al. "Trends in COVID-19 Cases, Emergency Department Visits, and Hospital Admissions Among Children and Adolescents Aged 0–17 Years — United States, August 2020–August 2021," CDC MMWR Morb Mortal Wkly Report ePub: Sept. 3, 2021. doi: http://dx.doi.org/10.15585/mmwr.mm7036e1.

PHYSICIAN VACCINATION RATE

96% of U.S. physicians were vaccinated as of June 2021.

"Physician COVID-19 Vaccination Study (Final Report)," American Medical Association, June 2021.

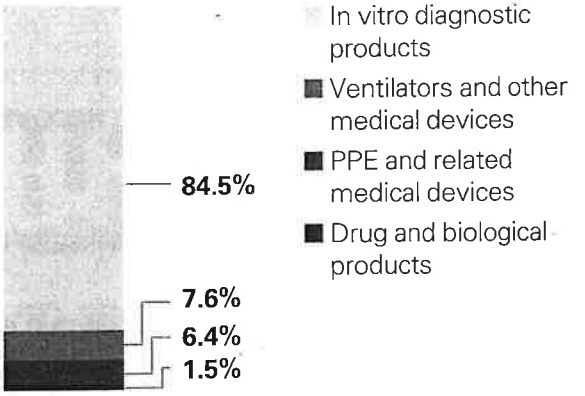
Emergency use authorizations (EUAs)

EUAs RISE SHARPLY

23 EUAs issued by the Food and Drug Administration (FDA) between 2010 and 2019.

342 EUAs issued by the FDA between Feb. 1 and Oct. 28, 2020.

IN VITRO DIAGNOSTIC PRODUCTS COMPRISE THE MAJORITY OF EUAs



"Top health industry issues of 2021: Will a shocked system emerge stronger?" PwC's Health Research Institute, April 2021. © PwC. Not for further distribution without the prior written permission of PwC. PwC refers to the US member firm or one of its subsidiaries or affiliates, and may sometimes refer to the PwC network. Each member firm is a separate legal entity. Please see www.pwc.com/structure for further details.

WORKFORCE

Hospitals and health systems need compassionate and skilled professionals to fulfill the core mission of caring for people. The pandemic has exacerbated the challenges already facing the health care workforce, including shortages and burnout. The AHA and its members are committed to supporting structural changes, resources for individuals and capacity-building measures to ensure a strong, resilient and diverse workforce.

Resiliency

FRONT-LINE HEALTH CARE WORKERS

- **62%** report that worry or stress related to the pandemic has a negative impact on their mental health.
- **13%** report they received mental health services or medication, and **20%** report they thought they might need such services but did not get them.

Kirzinger, Ashley et al. "KFF/The Washington Post Frontline Health Care Workers Survey," Kaiser Family Foundation, April 6, 2021.

Nurse leaders

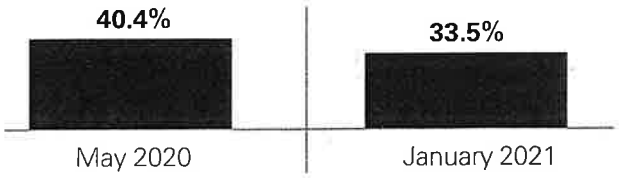
SELF-REPORTED EMOTIONAL HEALTH

	% Reponses Feb. 2021	% Responses Aug. 2021	% Change
Emotionally healthy	51%	43%	-16%
Neutral	33%	32%	-3%
Not emotionally healthy	16%	25%	+56%

"AONL COVID-19 Longitudinal Study Report: Nurse Leaders' Top Challenges and Areas for Needed Support, July 2020 to August 2021," American Organization for Nursing Leadership and Joslin Marketing, August 26, 2021.

NURSES' SENTIMENT TOWARD THEIR PROFESSION

The percentage of nurses who would encourage others to become a nurse



"COVID-19 Trend Data & the Impact on Nurses: Four Key Trends to Consider," AMN Healthcare, January 2021.

Nurses consider leaving profession

22% of nurses may leave their current position providing direct patient care within the next year.

Top 3 factors influencing the decision to leave

- Insufficient staffing levels
- Demanding nature/intensity of workload
- Emotional toll of the job

Top 3 initiatives that could effectively support well-being

- More appropriate and sufficient recognition
- Open lines of communication
- Embedding more breaks and flexibility in operating model

Berlin, Gretchen et al. "Nursing in 2021: Retaining the healthcare workforce when we need it most," McKinsey & Company, May 11, 2021.

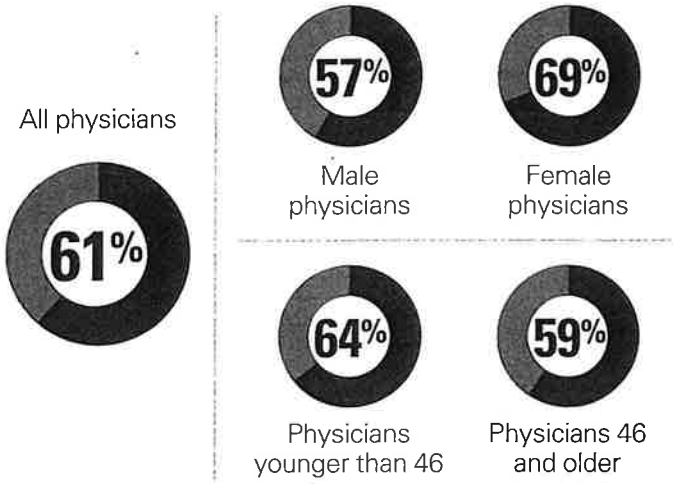
TOP CHALLENGES DURING THE PANDEMIC

	% Reponses July 2020	% Responses August 2021	% Change
Emotional health and well-being of staff	50%	75%	+50%
Surge staffing, training and reallocation	54%	61%	+13%
Staff retention, furloughs, layoffs	24%	47%	+96%
Communicating and implementing changing policies	55%	34%	-38%
Access to PPE	47%	14%	-70%

"AONL COVID-19 Longitudinal Study Report: Nurse Leaders' Top Challenges and Areas for Needed Support, July 2020 to August 2021," American Organization for Nursing Leadership and Joslin Marketing, August 26, 2021.

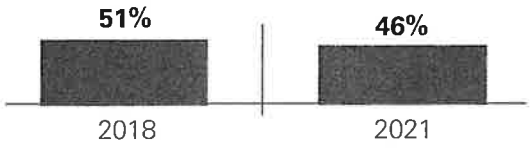
Physicians

FREQUENTLY EXPERIENCE FEELINGS OF BURNOUT



PHYSICIANS' SENTIMENT TOWARD THEIR PROFESSION

The percentage of physicians who would encourage others to become physicians



"The Physicians Foundation 2021 Physician Survey, COVID-19 Impact Edition: A Year Later," The Physicians Foundation, 2021. Available at https://physiciansfoundation.org/physician-and-patient-surveys/the-physicians-foundation-2021-physician-survey

MENTAL HEALTH AMONG PUBLIC HEALTH WORKERS

53% Public health workers who report experiencing at least one mental health condition.

- Experiencing post-traumatic stress disorder (PTSD): **36.8%**
  - Respondents 29 or younger experienced the highest percentage of PTSD: **47.4%**
- Public health workers who reported being unable to take time off from work were more likely to report adverse mental health symptoms.

Survey conducted March 29 – April 16, 2021; respondents were asked to report symptoms in the preceding two weeks.

Bryant-Genevier, Jonathan et al. "Symptoms of Depression, Anxiety, Post-Traumatic Stress Disorder, and Suicidal Ideation Among State, Tribal, Local, and Territorial Public Health Workers During the COVID-19 Pandemic — United States, March-April 2021," CDC Morbidity and Mortality Weekly Report, July 2, 2021.

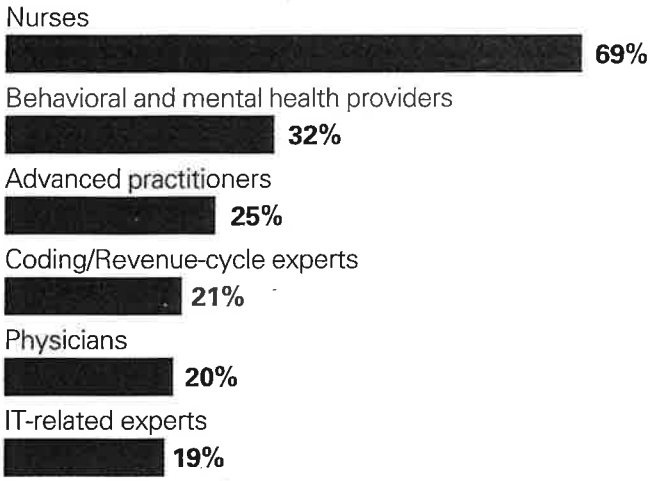
Learn more about the AHA's workforce agenda at aha.org/workforce.

Shortages

Health care leaders' perspective

COVID-19 IMPACT ON STAFFING SHORTAGES

Health care executives were asked which current staffing shortages are worse than one year ago.*



Health care executives polled January – February 2021

- **90%** of nurse leaders expect a nursing shortage post-pandemic.†

* "2021 Provider Health IT & Corporate Services Trends," Guidehouse Center for Health Insights analysis of an executive survey conducted by Healthcare Financial Management Association, May 26, 2021, https://guidehouse.com/insights/healthcare/2021/2021-provider-health-it-corp-svcs-survey

† "AONL COVID-19 Longitudinal Study Report: Nurse Leaders' Top Challenges and Areas for Needed Support, July 2020 to August 2021," American Organization for Nursing Leadership and Joslin Marketing, August 26, 2021.

Nurse Shortage

NURSING VACANCY RATE IN HOSPITALS

2021 average: **10%**

Average time for a hospital to hire an experienced RN, regardless of specialty: **89 days**

"2021 NSI National Health Care Retention & RN Staffing Report," NSI Nursing Solutions Inc., March 2021.

NURSING SCHOOLS

Enrollment in baccalaureate and graduate nursing programs increased by **5.6%** in 2020.*

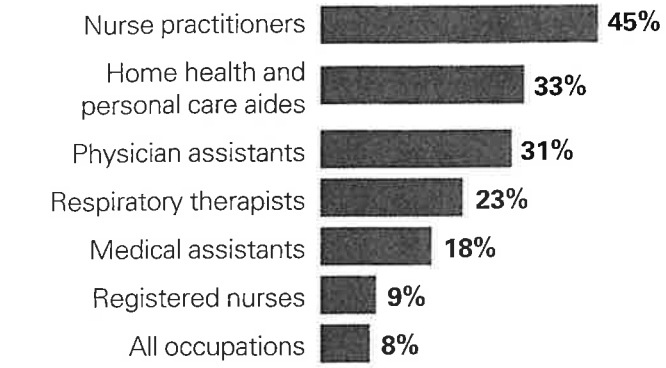
U.S. nursing schools turned away **80,521** qualified applications in 2020 due to an insufficient number of clinical sites and faculty as well as resource constraints.*

National nurse faculty vacancy rate: **7.2%**.†

* "Student Enrollment Surged in U.S. Schools of Nursing in 2020 Despite Challenges Presented by the Pandemic," American Association of Colleges of Nursing, April 1, 2021.
† "Fact Sheet: Nursing Faculty Shortage," American Association of Colleges of Nursing, September 2020.

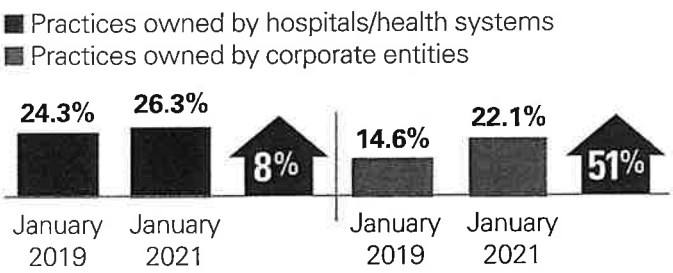
Health care employment trends

HEALTH CARE EMPLOYMENT GROWTH: PROJECTION 2020-2030



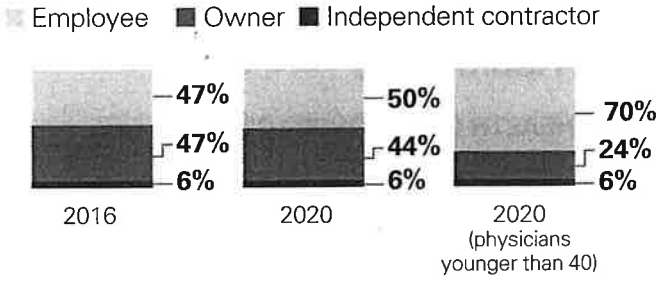
"Occupational Outlook Handbook," U.S. Bureau of Labor Statistics, Sept. 8, 2021, https://www.bls.gov/ooh/healthcare/home.htm.

U.S. PHYSICIAN PRACTICE OWNERSHIP



"COVID-19's Impact On Acquisitions of Physician Practices and Physician Employment 2019-2020," Physicians Advocacy Institute, prepared by Avalere Health, June 2021.

PHYSICIAN EMPLOYMENT WITHIN PRACTICE



Kane, Carol K., "Recent Changes in Physician Practice Arrangements: Private Practice Dropped to Less Than 50 Percent of Physicians in 2020," American Medical Association Policy Research Perspectives, May 14, 2021.

Black physicians

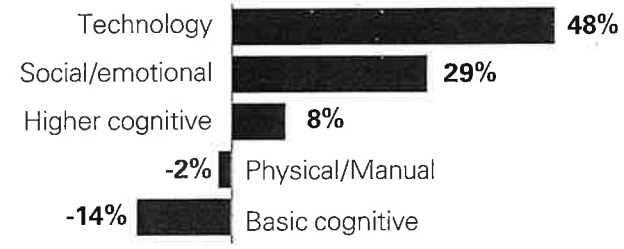
The proportion of U.S. physicians who are Black has increased by only 4% over the past 120 years, and the share who are Black men remains unchanged since 1940.

"Proportion of Black physicians in U.S. has changed little in 120 years, UCLA research finds," UCLA Health, April 20, 2021.

Future of work

2030 FORECAST: JOBS WILL REQUIRE DIFFERENT SKILLS

% Change in total hours worked by 2030

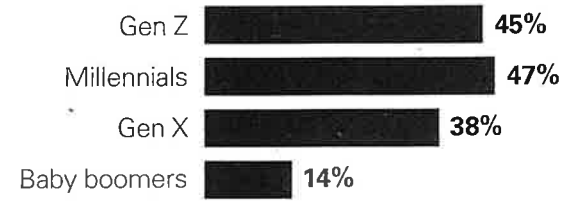


"The Next Normal: The future of capability building," McKinsey & Company, www.mckinsey.com, Accessed Aug. 7, 2021.

Remote work

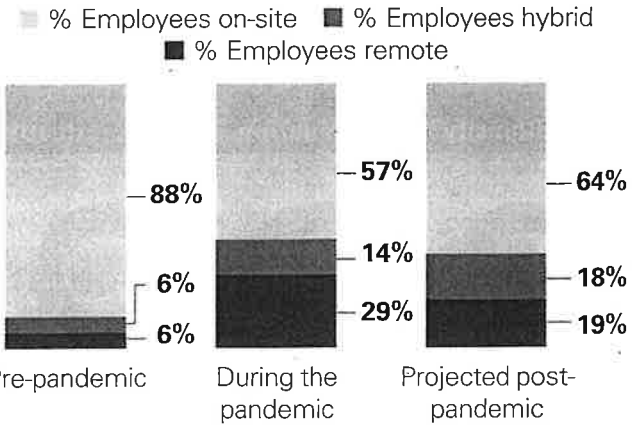
GENERATIONAL DIFFERENCES

Respondents were asked if they would sacrifice future earnings to work remotely.



"What's next for America's workforce post-COVID-19?" PwC's Workforce Pulse Survey findings, March 24, 2021. © PwC. Not for further distribution without the prior written permission of PwC. PwC refers to the US member firm or one of its subsidiaries or affiliates, and may sometimes refer to the PwC network. Each member firm is a separate legal entity. Please see www.pwc.com/structure for further details.

REMOTE WORK: HEALTH CARE PROVIDERS



50% of health care organizations report changing hiring policies to source talent and let talent stay outside of their typical geographic footprint.

"Get Ready for the Post-Pandemic Healthcare Talent Revolution," Oliver Wyman, May 24, 2021.

HEALTH EQUITY

The ongoing disproportionate impact of COVID-19 on structurally or historically marginalized communities has catalyzed hospitals and health systems to renew their commitment to promote racial justice and health equity. Health risks are associated with racial, ethnic, geographic, socio-economic and environmental factors. Advancing equitable practices are closely tied to the health care field's core work of improving value, quality and patient safety.

COVID-19 Disparities

COVID-19 CUMULATIVE DEATH RATE PER 100,000 POPULATION

- All U.S. counties: **199 people**
- Nonmetropolitan counties: **227 people**

COVID CASES AND DEATHS BY RACE/ETHNICITY AS OF SEPT. 12, 2021

Race/Ethnicity	% population	% cases	% deaths
White	60.11%	51.0%	59.0%
Hispanic/Latino	18.45%	27.4%	18.2%
Black	12.54%	11.8%	13.8%
Asian	5.76%	3.1%	3.7%
American Indian/ Alaska Native	0.74%	1.1%	1.2%
Native Hawaiian/ Pacific Islander	0.18%	0.3%	0.2%
Multiple/Other, non-Hispanic	2.22%	5.3%	3.8%

"COVID Data Tracker: Demographic Trends of COVID-19 cases and deaths in the US reported to CDC," CDC, https://covid.cdc.gov/covid-data-tracker/#demographics. Accessed Sept. 13, 2021.

SINCE THE BEGINNING OF THE PANDEMIC, PEOPLE IN HISTORICALLY MARGINALIZED COMMUNITIES WERE:

- **48%** more likely to have died from COVID-19.
- **28%** more likely to have been diagnosed with COVID-19.
- **23%** more likely to be in a COVID-19 hot spot.
- **17%** less likely to have been tested for COVID-19.
- **8%** less likely to have been fully vaccinated.

"The U.S. Covid Community Vulnerability Index," Surgo Ventures, precisionforcovid.org/ccvi. Accessed Sept. 27, 2021.

JOB LOSS INEQUITY IN 2020 (JAN. – NOV.)

- Black and Hispanic workers faced 1.6 to 2.0 times the unemployment rates compared with white workers.
- Households with less than $30,000 in annual income faced double the unemployment rates of higher-income households.
- Women accounted for 56% of workforce exits since the start of the pandemic, despite making up 48% of the workforce.

Dua, A., Ellingrud, K., Lazar, M., Luby, R., Srinivasan, S., and Van Aken, T. "Achieving an inclusive US economic recovery," McKinsey & Company, Feb. 3, 2021.

Learn more from the AHA Institute for Diversity and Health Equity at ifdhe.aha.org.

Rural Health Care

RURAL HEALTH CARE COVERAGE

1 in 5 Americans live in rural areas.*

1 in 3 Rural adults are enrolled in Medicare.*

1 in 6 Rural adults ages 19-64 are uninsured.*

NEARLY 25% of rural individuals younger than 65 are covered by Medicaid.†

22% of rural adults are dually enrolled in Medicaid and Medicare.†

*"Access to Affordable Care in Rural America: Current Trends and Key Challenges Research Report," Assistant Secretary of Planning and Evaluation Office of Health Policy, July 9, 2021.
†"Medicaid and Rural Health Issue Brief," Medicaid and CHIP Payment and Access Commission, April 2021.

PANDEMIC EFFECTS ON RURAL AMERICANS

Rural households were asked about their experiences during the pandemic

Rural households using telehealth
46%

Unable to get medical care for a serious problem when they needed it
24%

White rural households facing serious financial problems
36%

Black or Latino rural households facing serious financial problems
85%

Adult household member has lost job, been furloughed or had wages/hours reduced
43%

Serious problems caring for children
54%

Serious problems keeping the education of children going
34%

Households with children that have serious problems with internet connection to do schoolwork/jobs, or they lack high-speed internet connection at home
40%

"The Impact of Coronavirus on Households in Rural America," NPR, Robert Wood Johnson Foundation, Harvard T.H. Chan School of Public Health, October 2020.

RURAL HEALTH ACCESS

- **28%** of rural Americans live in a county without a rural health clinic.*
- **6 out of 10** primary care health professional shortage areas are located in rural areas.*
- **47%** of rural hospitals have 25 or fewer staffed beds.†
- As of September 2021, **138 hospitals have closed** since 2010.‡

*"Medicaid and Rural Health Issue Brief," Medicaid and CHIP Payment and Access Commission, April 2021.
† "Fast Facts: U.S. Rural Hospitals," AHA Annual Survey Database, FY2015-FY2021, May 2021.
‡"181 Rural Hospital Closures since January 2005," The Cecil G. Sheps Center for Health Services Research, https://www.shepscenter.unc.edu. Accessed Sept. 23, 2021.

Learn more about the AHA's rural health resources at aha.org/rural.

Digital Health Equity

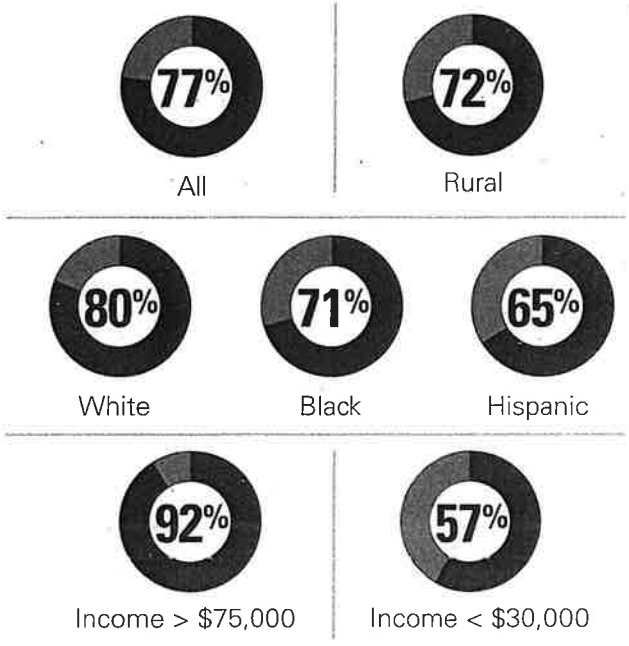
Current barriers to digital access

There are millions of individuals across the country who lack the technology, finances or digital health literacy needed to take advantage of digital solutions. While there have been gains in bringing high-speed broadband service to all Americans, a recent report from Microsoft estimates that 157.3 million Americans do not use the internet at broadband speeds.* At the end of 2019, the Federal Communications Commission estimated that 14.5 million Americans lacked access to fixed broadband service at threshold speeds.†

Even where broadband is available, there are millions of families that cannot afford it.‡ According to estimates from the U.S. Census, 13.9% of urban households and 19.2% of rural households do not have a broadband subscription.§ Racial and ethnic populations, people living on tribal lands, older adults and people with lower levels of education and income also are less likely to have broadband at home.‖

*McKinley, Shelley. "Microsoft Airband: An annual update on connecting rural America," Microsoft, March 5, 2020.
† "Fourteenth Broadband Deployment Report," Federal Communications Commission, Jan. 19, 2021.
‡Porter, Eduardo. "A Rural-Urban Broadband Divide, but Not the One You Think Of," New York Times, June 1, 2021.
§Martin, Michael. "Computer and the Internet Use in the United States: 2018," United States Census Bureau, April 2021.
‖"Internet/Broadband Fact Sheet," Pew Research Center, April 7, 2021."Expanding Broadband Access," U.S. Department of the Interior, bia.gov/service/infrastructure/expanding-broadband-access, Accessed Nov. 14, 2021.

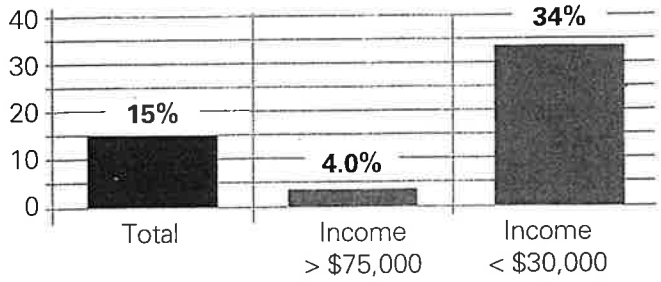
U.S. ADULTS' HOME BROADBAND ACCESS



"Internet/Broadband Fact Sheet," Pew Research Center, Washington, D.C., April 7, 2021, pewresearch.org/internet/fact-sheet/internet-broadband.

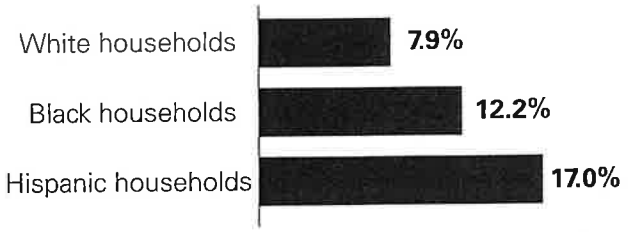
BROADBAND AFFORDABILITY

% of home broadband users who had trouble affording high-speed internet during the pandemic



McClain, Colleen. "34% of lower-income home broadband users have had trouble paying for their service amid COVID-19," Pew Research Center, Washington, D.C., June 3, 2021, pewresearch.org/fact-tank/2021/06/03/34-of-lower-income-home-broadband-users-have-had-trouble-paying-for-their-service-amid-covid-19.

LACK OF COMPUTER ACCESS BY RACE/ETHNICITY

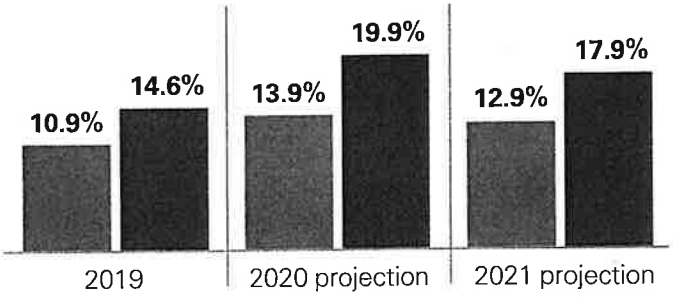


2021 State of Black America, "The New Normal: Diverse, Equitable, and Inclusive," executive summary, National Urban League, July 2021.

Social Determinants of Health

FOOD INSECURITY

■ % Total population experiencing food insecurity
■ % Children experiencing food insecurity



"The Impact of the Coronavirus on Food Insecurity in 2020 & 2021," Feeding America, March 2021.

Learn more about the AHA's resources and framework addressing societal factors that influence health at aha.org/societalfactors.

Maternal Health

RATES OF SEVERE MATERNAL MORBIDITY

- **Increased by 9%** for all women from 2018 to 2020.*
- **63% higher** in majority Black communities than majority White communities in 2020.*
- **32% higher** in majority Hispanic communities than majority White communities in 2020.*
- Women in rural and underserved communities face additional risks and challenges that can lead to higher rates of maternal mortality and other severe health complications.†

*"Racial Disparities in Maternal Health," Blue Cross Blue Shield, The Health of America Report® May 20, 2021.
†"The Additional Risks and Challenges for Pregnant Women in Rural and Underserved Communities," U.S. Government Accountability Office, May 13, 2021.

Learn more about the AHA's Better Health for Mothers and Babies initiative at aha.org/advocacy/maternal-and-child-health.

Gun Violence

COST OF GUN VIOLENCE

$1 MORE THAN BILLION ANNUALLY Initial hospital costs of gun injuries. Costs associated with physicians' fees not included could add 20% to that total.

"Firearm injuries: Health Care Service Needs and Costs," U.S. Government Accountability Office, June 2021.

ELECTRONIC HEALTH RECORDS SHOW INCREASE IN FIREARM INJURIES

- **73%** increase in 2020, compared with 2018 and 2019.
- From March 2018 to April 2021:
  - Increased between **76% and 89%** for communities of color.
  - Increased **40%** for the White population.
  - Black male patients ages 18 – 34 experienced more firearm incidents than patients from other groups.

Bohochik, Ryan and Johnston, Thayer et al. "2020 Firearm Injuries Up More Than 70% – Worse in Black and Hispanic Young Men," Epic Health Research Network, Sept. 15, 2021. Retrieved from: ehrn.org.

Learn more about the AHA's Hospitals Against Violence initiative at aha.org/violence.

BEHAVIORAL HEALTH

Hospitals and health systems provide essential behavioral health care services to millions of Americans. The pandemic will have a long-term effect on people's mental health and the behavioral health ecosystem. The health care field is stepping up to improve access to care, including the integration of physical and behavioral health services, community partnerships to expand the care continuum, suicide prevention and stigma reduction.

Mental Health and Lifestyle

COVID-19 AND MENTAL HEALTH

40.9% of adults reported at least one behavioral condition related to the pandemic, including symptoms of anxiety, depression, trauma or stress-related disorder, or having started or increased substance use to cope with stress or emotions related to COVID-19.

Czeisler, Mark É. et al. "Mental Health, Substance Use, and Suicidal Ideation During the COVID-19 Pandemic — United States, June 24 – 30, 2020," CDC Morbidity and Mortality Weekly Report, 69(32), August, 14, 2020, doi: 10.15585/mmwr.mm6932a1.

PANDEMIC IMPACT ON HEALTH & LIFESTYLE

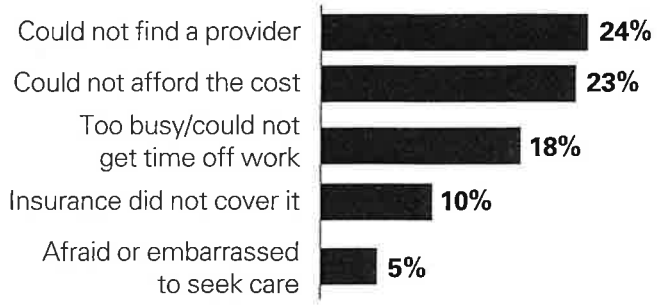
	% Increase: All respondents	% Increase: Men	% Increase: Women
Anxiety	37%	32%	40%
Stress	35%	31%	38%
Weight gain	33%	31%	34%
Nicotine	21%	28%	17%
Alcohol	20%	28%	15%
Opioids	10%	15%	7%

"The 2021 Health Care Insights Study," CVS Health, July 8, 2021.

ACCESS TO MENTAL HEALTH SERVICES

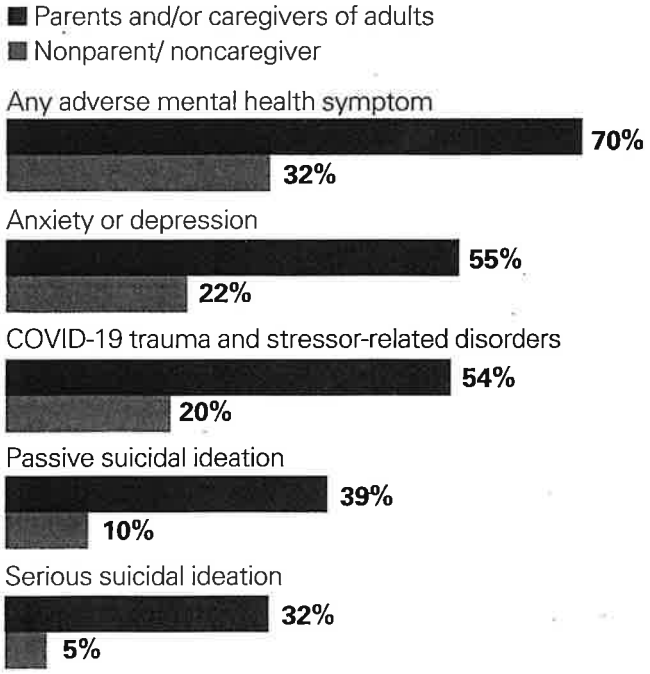
32% of adults say they needed but were unable to get mental health services from March 2020 to March 2021.

THE MAIN REASONS ADULTS DID NOT RECEIVE MENTAL HEALTH SERVICES



Kearney, Audrey. "Mental Health Impact of the COVID-19 Pandemic: An Update," Kaiser Family Foundation, April 14, 2021.

CAREGIVERS' MENTAL HEALTH DURING THE PANDEMIC



Czeisler Mark É. et al. "Mental Health Among Parents of Children Aged <18 Years and Unpaid Caregivers of Adults During the COVID-19 Pandemic — United States, December 2020 and February-March 2021," CDC Morbidity and Mortality Weekly Report, June 18, 2021, 70(24);879–887.

MENTAL HEALTH PROFESSIONAL SHORTAGE

- There are more than 5,800 mental health professional shortage areas in the U.S.
- The shortages impact nearly 129 million Americans.

"Data.HRSA.gov: Shortage Areas," Health Resources & Services Administration, https://data.hrsa.gov/topics/health-workforce/shortage-areas, Sept 9, 2021.

LONELINESS IN THE U.S. DURING THE PANDEMIC

% of respondents reporting serious loneliness

Across all groups

Top respondent groups

Ages 18-25

Mothers of young children

- Loneliness is linked to early mortality, depression, anxiety, heart disease, substance abuse and domestic abuse.

Weissbourd, Richard et al. "Loneliness in America: How the Pandemic Has Deepened an Epidemic of Loneliness and What We Can Do About it," Making Caring Common Project of Harvard Graduate School of Education, February 2021.

Delivery model strategies to increase coordination and integration of behavioral health care

- Include behavioral health in value-based payment or total cost of care models.
- Support new provider partnerships.
- Eliminate regulatory barriers to care coordination.
- Reimburse for transitional care.
- Provide access to the full continuum of services including inpatient and residential behavioral health care.
- Provide funding for infrastructure development.
- Encourage greater availability of telepsychiatry.
- Address inadequate reimbursement and workforce shortages, and fully implement the mental health parity law.

"TrendWatch: Increasing Access to Behavioral Health Care Advances Value for Patients, Providers and Communities," American Hospital Association, May 2019.

LGBTQ+

LGBTQ YOUTH AND MENTAL HEALTH

- **70%** stated that their mental health was poor most of the time or always during COVID-19.
- **42%** seriously considered attempting suicide in the past year.
- **48%** reported they wanted counseling from a professional in the past year, but were unable to receive it.
- **30%** experienced food insecurity in the past month.

"National Survey on LGBTQ Youth Mental Health 2021," The Trevor Project, May 2021.

HISTORICALLY UNDERREPRESENTED POPULATIONS

U.S. adults reporting more stress and mental health challenges within the past year (June 2021)

Populations	% reporting an increase of challenges	% receiving treatment
LGBTQ+	49%	41%
Black	46%	21%
Native American	45%	24%
Hispanic	42%	26%
Asian American	40%	11%
All adults	40%	24%

- The top obstacles for seeking treatment: Cost and insurance coverage

"National Council for Mental Wellbeing: Minority Mental Health Month Polling," Poll conducted by Morning Consult and released by the National Council for Mental Wellbeing, July 21, 2021.

Drug overdoses and opioids

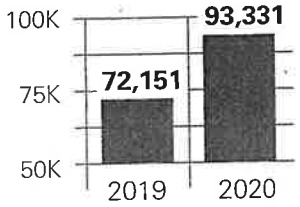
EMERGENCY DEPARTMENT VISITS INCREASE

Increase in emergency department visits for opioid overdoses in the U.S. in 2020.

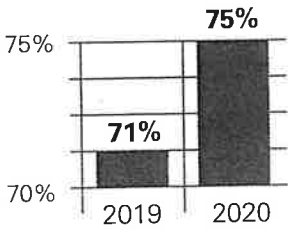
Soares, William E. et al. "Emergency Department Visits for Nonfatal Opioid Overdose During the COVID-19 Pandemic Across Six US Health Care Systems," Annals of Emergency Medicine, July 28, 2021; doi: 10.1016/j.annemergmed.2021.03.013.

DRUG OVERDOSE DEATHS INCREASE*

Total drug overdose deaths



% Deaths due to opioids



- Highest number of overdose deaths ever recorded in a 12-month period and largest increase since 1999†

*"Vital Statistics Rapid Release: Provisional Drug Overdose Death Counts," CDC National Center for Health Statistics, https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm. Accessed Aug. 4, 2021.
†Chappell, Bill. "Drug Overdoses Killed A Record Number Of Americans In 2020, Jumping By Nearly 30%," NPR, July 14, 2021.

Learn more about the AHA's behavioral health resources at aha.org/behavioralhealth

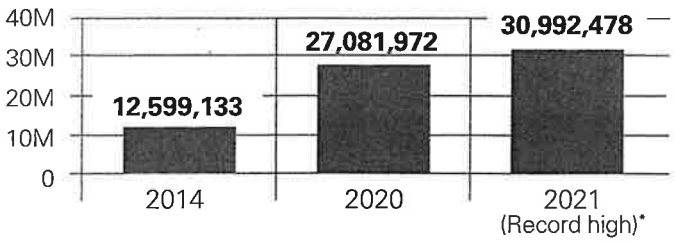
ACCESS AND AFFORDABILITY

The pandemic has spurred a national conversation about how to strengthen the health care system. To create a reimagined health ecosystem, individuals and communities need to be able to access and afford health care. Health coverage opens the door to health care services. For people who have this access, cost can still be a barrier to essential services. The AHA and its members are working to preserve and expand access to high-quality, equitable, affordable care.

Coverage

AFFORDABLE CARE ACT (ACA) ENROLLMENT

Total ACA-related enrollment: marketplace, Medicaid and the basic health program.



**Record high, does not include totals from the special enrollment period Feb. 15 - Aug. 15, 2021.*

"Health Coverage Under the Affordable Care Act: Enrollment Trends and State Estimates," Assistant Secretary for Planning and Evaluation, Office of Health Policy, June 5, 2021.

ACA SPECIAL ENROLLMENT PERIOD

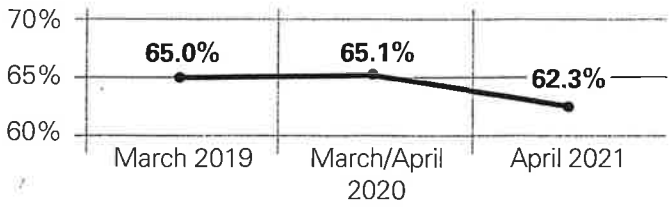
2.8 MILLION Number of people who enrolled in the ACA during the special enrollment period from Feb. 15 - Aug. 15, 2021.

Includes enrollment in federally facilitated and state-based marketplaces.

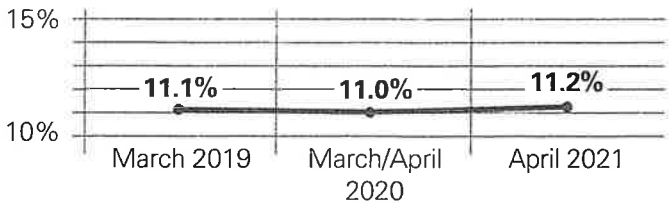
"2021 Final Marketplace Special Enrollment Period Report," Department of HHS & Centers for Medicare & Medicaid Services, Sept. 15, 2021.

HEALTH INSURANCE COVERAGE TRENDS AMONG U.S. ADULTS YOUNGER THAN 65

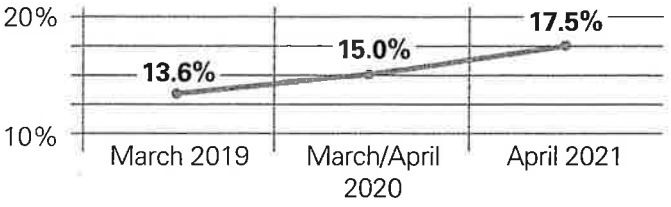
Employer-sponsored insurance coverage



Uninsured rate



Public coverage (Medicaid, ACA)



Karpman, Michael and Zuckerman, Stephen. "The Uninsurance Rate Held Steady during the Pandemic as Public Coverage Increased, "The Urban Institute," August 2021.

MEDICAID AND CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

Medicaid growth

CHIP growth

As of April 2021:

- A record high **82.3 million** people are covered through Medicaid and CHIP.
- Children represent **48.5%** of the total Medicaid and CHIP program enrollment.

"April 2021 Medicaid and CHIP Enrollment Trends Snapshot," CMS Center for Medicaid and CHIP Services, Sept. 15, 2021.

MEDICARE ADVANTAGE GROWTH

Year	Number of enrollees	% of Medicare beneficiaries
2019	22 million	36%
2020	24 million	39%
2021	26 million	42%

Fried, Meredith et al. "Medicare Advantage in 2021: Enrollment Update and Key Trends," Kaiser Family Foundation, June 21, 2021.

Prescription Drugs

AFFORDABILITY

U.S. adults were surveyed about the cost of prescription drugs.

- **83%** report that the cost of prescription drugs is unreasonable.
- **26%** say it is difficult to afford the cost of their medicine.
- **29%** do not take their medicine as prescribed due to costs.

Hamel, Liz. "Public Opinion on Prescription Drugs and Their Prices," Kaiser Family Foundation, Oct. 18, 2021.

PRESCRIPTION DRUG PRICES HIGHER IN THE U.S.

Results of an analysis of 20 brand-name prescription drugs among the highest expenditures in the U.S. Medicare Part D program:

- U.S. prices paid at the retail level by consumers and other payers were more than **two to four times higher** than prices in Australia, Canada and France.

"Prescription Drugs: U.S. Prices for Selected Brand Drugs Were Higher on Average than Prices in Australia, Canada, and France," U.S. Government Accountability Office, March 2021.

AMERICANS WANT NEGOTIATION

74% of Americans feel the federal government should directly negotiate with pharmaceutical companies to reduce the cost of prescription drugs.

"Health Insurance Trends," eHealth, May 2021.

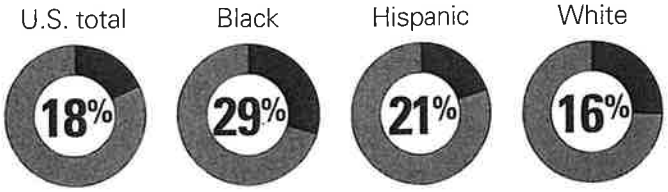
Learn more about the AHA's leadership on the issues of affordability and value through The Value Initiative at aha.org/value-initiative

Consumers

ABILITY TO AFFORD HEALTH CARE

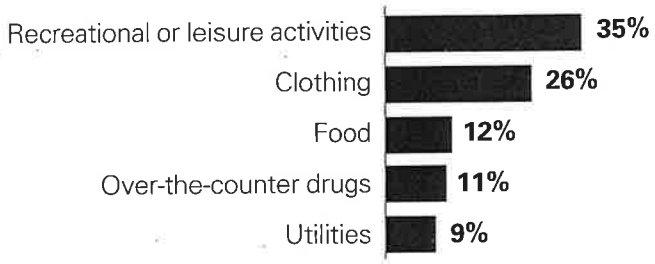
Over a 12-month period, which covers the first full year of the COVID-19 era, **18% of U.S. adults** and **35% of low-income earners** report that they or a member of their household did not seek treatment for a health problem due to cost of care.

% OF U.S. ADULTS UNABLE TO AFFORD QUALITY CARE IF NEEDED TODAY



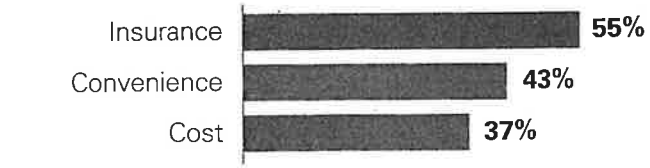
REDUCTION IN HOUSEHOLD SPENDING DUE TO COST OF CARE

U.S. adults who reduced spending due to cost of care did so on the following household items:



Witters, Dan. "In U.S., An Estimated 46 Million Cannot Afford Needed Care," Gallup, March 31, 2021.

TOP FACTORS CONSUMERS CONSIDER WHEN DECIDING WHERE TO SEEK CARE



PATIENT CHALLENGES

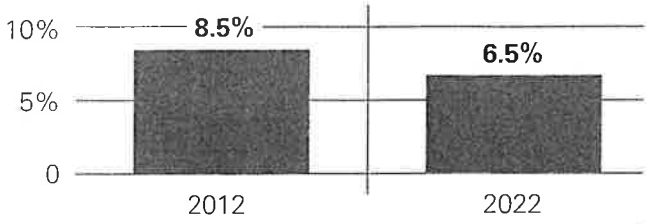
Providers said that all or most of their patients are facing a significant challenge with:

"The 2021 Health Care Insights Study," CVS Health, July 8, 2021.

Employers and Employees

MEDICAL COST TREND ESTIMATE

Medical cost trend is the projected percentage increase in the cost to treat patients from one year to the next, assuming benefits remain the same. It impacts commercial insurers' plans and is used to calculate premiums for the coming year.



Potential catalysts of increased health care spending in 2022

- Some care deferred during the pandemic returns in 2022.
- COVID-19 costs (i.e., testing for COVID-19, treating patients and administering vaccinations) likely will persist.
- The mental health and substance-use crises will persist.
- Poor pandemic-era behaviors may lead to deterioration of U.S. population health.
- Preparation costs for the next pandemic including forecasting tools, supply chain, PPE, staffing and infrastructure changes.
- Addressing health disparities highlighted by the pandemic, including greater diversity in clinical trials and investment in social determinants of health.
- Improving patient relationships and expanding capacity through mobile apps, patient portals, CRM tools, virtual care and analytics.

Potential reasons for decreased health care spending in 2022

- Consumers embrace lower-cost sites of care.
- Health systems find ways to provide more health care for less, including remote workforces, process automation and cloud technology.

"Medical cost trend: Behind the numbers 2022," PwC's Health Research Institute, June 2021.

INNOVATION AND DELIVERY TRANSFORMATION

The AHA is working with its member hospitals and health systems to rebuild and reimagine the health care system. The pandemic's acceleration of telehealth is another step forward in delivery transformation. Investment in digital health and adoption of novel technologies will continue and amplifies the need to prioritize cybersecurity. New models focused on value-based care will not only advance transformation but also may better prepare the health system for the next pandemic.

Telehealth

Virtual health care and business models are evolving, moving to a range of services enabling longitudinal virtual care, integration of telehealth with other virtual health solutions and hybrid virtual/in-person care models.

PANDEMIC IMPACT ON TELEHEALTH

Telehealth utilization:

- April 2020: **78 times higher** than pre-pandemic levels.
- February 2021: **38 times higher** than pre-pandemic levels.

Consumers:

- **40%** will continue using telehealth going forward.

Physicians:

- **58%** view telehealth more favorably than they did before the pandemic.
- **84%** offer virtual visits and **57%** would prefer to continue offering virtual care.

Bestsennyy O., Gilbert G., Harris A & Rost J. "Telehealth: A quarter-trillion-dollar post-COVID-19 reality?" McKinsey & Company, July 9, 2021.

CONSUMER USE OF TELEHEALTH

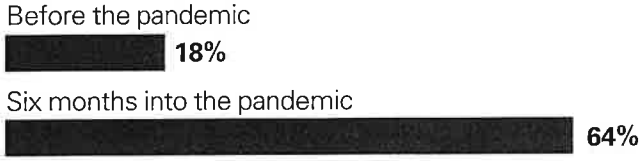
Surveyed U.S. adults who see a health care provider at least once a year (March 2021)

69% of U.S. patients report having seen a health care provider via telehealth since the pandemic began.

48% of U.S. patients would be likely to switch, or have switched, to a different provider if their current provider did not offer telehealth appointments.

March 2021 NextGen survey conducted by The Harris Poll among 1,733 U.S. patients 18+. "National Survey Shows Online Access and Telehealth are Keys to Patient Loyalty," May 20, 2021. For further information on the survey, contact **tstegmaier@nextgen.com**.

MEDICARE PROVIDERS OFFERING TELEHEALTH:



MEDICARE TELEHEALTH ACCESS

27% of beneficiaries participated in a telehealth visit

Method of communication

Telephone | Video | Both

Wyatt, Koma et al. "Medicare and Telehealth: Coverage and Use During the COVID-19 Pandemic and Options for the Future," Kaiser Family Foundation, May 19, 2021.

Telehealth: Health care provider perspective

Top areas for future telehealth expansion

- Chronic care management
- Mental/behavioral health
- Urgent care
- Primary care

Top barriers to advancing telehealth

- Patient access to technology
- Uncertainty around reimbursements
- Clinical workflows/integration into the electronic health record
- Rural access to broadband

"The Intersection of Value and Telehealth," Center for Connected Medicine & KLAS Research, August 2021.

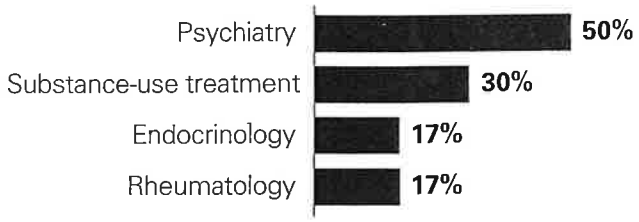
Telehealth insurance claims

CLAIMS INCREASE

4,347% Increase in telehealth insurance claims from March 2019 to March 2020

"Health Industry Cybersecurity — Securing Telehealth and Telemedicine," Healthcare & Public Health Sector Coordinating Councils, April 2021.

SHARE OF TELEHEALTH OUTPATIENT AND OFFICE VISIT CLAIMS — TOP SPECIALTIES



Bestsennyy O., Gilbert G., Harris A & Rost J. "Telehealth: A quarter-trillion-dollar post-COVID-19 reality?" McKinsey & Company, July 9, 2021.

Learn more about the AHA's telehealth resources at aha.org/telehealth

Technology

Consumer sentiment: Digital technology

WEARABLE TECH AND HEALTH DEVICES

36% Own a wearable health device or use a smartphone to track wellness

50% Would allow information to be sent directly from the device to their doctor's office

57% Believe the data are useful and want them collected by their doctor

SOCIAL MEDIA

72% of Americans have some type of social media profile

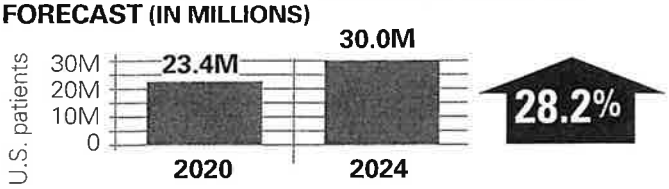
62% Trust the information they get from social media, if it comes directly from health care providers

INTERNET

Google processes about **70,000** health-related search queries every minute.

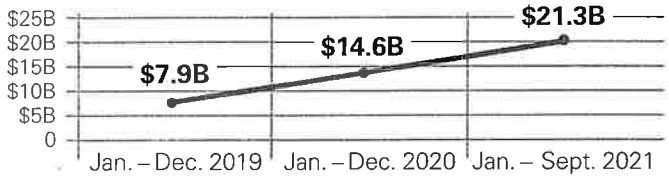
"NRC Health 2021 Healthcare Consumer Trends Report," NRC Health, Jan. 13, 2021.

REMOTE PATIENT MONITORING-UTILIZATION FORECAST (IN MILLIONS)



Dolan, Shelagh. "The technology, devices, and benefits of remote patient monitoring in the healthcare industry," Insider Intelligence, July 28, 2021.

VENTURE CAPITAL INVESTMENT INTO THE DIGITAL HEALTH SPACE



Krasniansky, Adriana et al. "Q3 2021 digital health funding: To $20B and beyond!" Rock Health, Oct. 4, 2021

AUTOMATION OF ADMINISTRATIVE TASKS

73% of health care provider executives said their organizations are working on improving the clinician experience by automating administrative tasks.

"Top health industry issues of 2021: Will a shocked system emerge stronger?" PwC's Health Research Institute, April 2021. © PwC. Not for further distribution without the prior written permission of PwC. PwC refers to the US member firm or one of its subsidiaries or affiliates, and may sometimes refer to the PwC network. Each member firm is a separate legal entity. Please see www.pwc.com/structure for further details.

Health systems and AI

50% of health care leaders report using AI to help manage COVID-19. Examples include:

- Clinical decision support.
- Bed management, device management and staffing.
- Analytics and assessment.
- Tracking ICD-10 codes to find at-risk individuals.
- Contact tracing.

Top uses of AI

- Clinical decision support: **61%**
- Dictation assistant or transcription: **50%**
- Diagnostic medical imaging: **48%**

Planning to leverage AI for:

- Virtual assistant: **41%**
- Revenue-cycle management: **38%**
- Fraud detection: **28%**

"Top of Mind for Top Health Systems 2021 — Digital health priorities in the era of COVID-19," Center for Connected Medicine and KLAS, October 2020.

Cybersecurity

AI AND CYBER DEFENSE

20% of executives in health care reported seeing benefits from using artificial intelligence in cyber defense.

"Medical cost trend: Behind the numbers 2022," PwC's Health Research Institute, June 2021. © PwC. Not for further distribution without the prior written permission of PwC. PwC refers to the US member firm or one of its subsidiaries or affiliates, and may sometimes refer to the PwC network. Each member firm is a separate legal entity. Please see www.pwc.com/structure for further details.

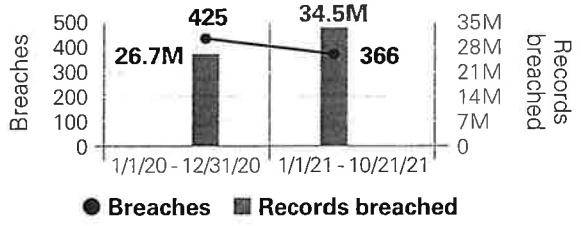
TELEHEALTH CYBERSECURITY CHALLENGES

Challenge	% Increase in 2020
Website/internet-protocol malware security alerts	**117%**
Security patching of known vulnerabilities	65%
Endpoint vulnerabilities that enable data theft	56%
File-transfer protocol vulnerabilities	42%

"Health Industry Cybersecurity — Securing Telehealth and Telemedicine," Healthcare & Public Health Sector Coordinating Councils, April 2021.

HEALTH CARE HACKING/IT INCIDENTS

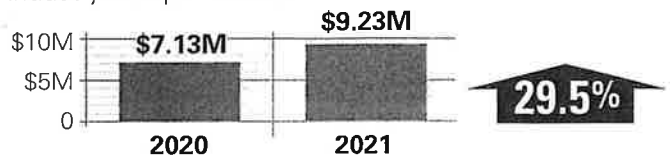
The number of records breached per incident is increasing.



"Cases Currently Under Investigation," Department of HHS Office for Civil Rights, https://ocrportal.hhs.gov/ocr/breach/breach_report.jsf. Accessed Oct. 29, 2021.

COST OF A DATA BREACH

For 11 consecutive years, health care had the highest industry cost per breach.



"Cost of a Data Breach Report 2021," Ponemon Institute and IBM Security, July 28, 2021.

Learn more about the AHA's cybersecurity resources at aha.org/cyberrisk

Delivery and Payment Models

Accountable Care Organizations (ACOs)

Organizations participating in value-based payment arrangements during the pandemic had greater financial resilience and flexibility to provide care through novel approaches. They had developed organizational competencies they could redeploy during a public health emergency.

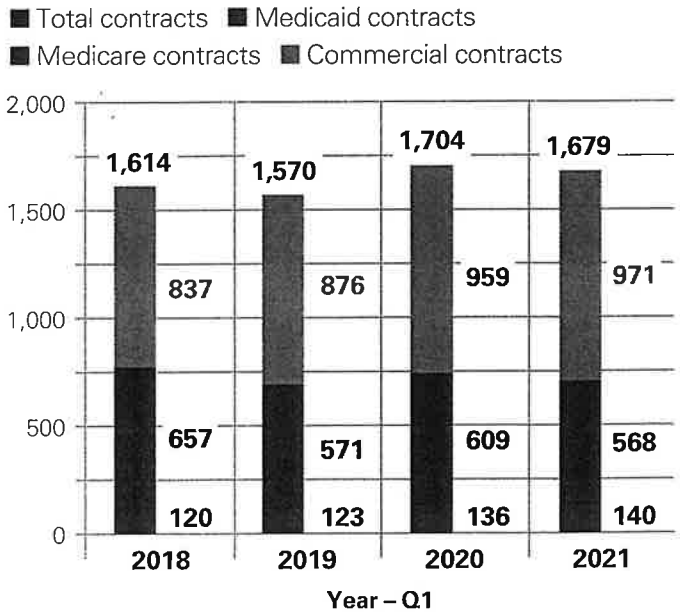
ACO TRENDS AND LIVES COVERED: ALL PAYERS

Year - Q1	Total number of ACOs	Total lives covered
2018	1,015	37,113,213
2019	950	37,214,760
2020	990	36,848,375
2021	956	36,254,938

ACO ENTRANTS AND EXITS: ALL PAYERS

Year	Number of ACO entrants	Number of ACO exits
2018	122	72
2019	59	77
2020	61	36

ACO CONTRACTS BY PAYER



Note: The average number of contracts per ACO has increased slightly from 1.6 in Q1 2018 to almost 1.8 in Q1 2021.

Data from Muhlestein, David et al. "All-Payer Spread Of ACOs And Value-Based Payment Models In 2021: The Crossroads And Future Of Value-Based Care," Health Affairs Blog, June 17, 2021. doi: 10.1377/hblog20210609.824799.

HEALTH CARE EXECUTIVES' PERSPECTIVE

58% of providers already participating in at-risk or value-based programs plan to add value-based contracts within the next 12 months.

85% report that the pandemic accelerated the need for health care delivery innovation.

"A Provider Outlook on Value-based Innovations in Care Delivery," Sage Growth Partners and DataGen, Aug. 3, 2021.

Team-based care

The pandemic is a pivotal event that may have lasting influence on core values and attitudes toward teamwork and interprofessional practice.*

IMPROVED OUTCOMES AND COST REDUCTIONS ASSOCIATED WITH INTERPROFESSIONAL COLLABORATIVE PRACTICE†

Outcome measure	% Reduction
Patient charges	48.2%
Hospitalizations	17.7%
Emergency department visits	16.7%
Hemoglobin A1c levels	0.8%

Study occurred with high-risk patients in a family medicine residency program.

*Barret, Michalec and Lamb, Gerri. "COVID-19 and team-based healthcare: The essentiality of theory-driven research," Journal of Interprofessional Care, Aug. 18, 2020, 34:5, 593-599, doi:10.1080/13561820.2020.1801613.
†Guck, Thomas P. et al. "Improved Outcomes Associated With Interprofessional Collaborative Practice," Annals of Family Medicine, August 2019, 17 (Suppl 1) S82, doi: 10.1370/afm.2428.

Hospital-at-Home: Success factors

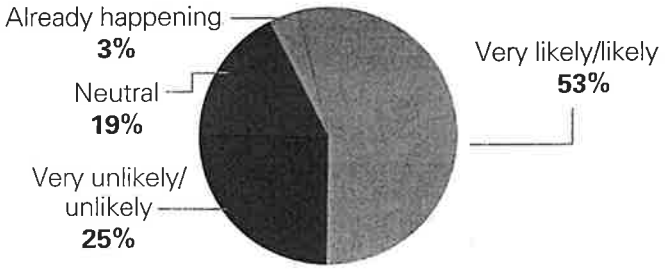
The pandemic and associated public health emergency amplified the need for providers to increase capacity to provide safe care outside the hospital setting. Recent regulatory flexibilities allowed for providers to leverage the latest innovations to pursue this aim. In addition to telehealth, some providers were able to implement or expand hospital-at-home programs.* HaHs have existed since the mid-1990s. Various studies have shown that HaH is feasible, safe, highly satisfactory and cost-effective. Success factors include:†

- **People:** Well-coordinated multidisciplinary team that includes clinical teams, suppliers, nursing care coordinators and supporting nonclinical staff.
- **Processes:** Patient screening and enrollment, care delivery protocols including daily virtual and in-person check-ins and escalation of care.
- **Technology:** EHR, home-monitoring tools, telehealth and a communication platform.
- **Supply chain:** Service provider partners and goods such as medical equipment, oxygen, medicines and food.
- **Analytics:** Quality metrics and cost data.

*"CMS Announces Comprehensive Strategy to Enhance Hospital Capacity Amid COVID-19 Surge," CMS Press release, Nov. 25, 2020.
†Farah, Marina, M.D. "Hospital at Home: Delivering hospital-level care without the hospital," The Hospitalist, May 25, 2021.

HOSPITAL-AT-HOME EXPANSION

Health care strategists were asked about their likelihood of incorporating HaH services by 2027 for at least 50% of stable, chronically ill patients.



"Futurescan 2022-2027: Health Care Trends and Implications," AHA's Society for Health Care Strategy & Market Development, 2021.

Learn more about the AHA's hospital-at-home resources at aha.org/hospitalathome

American Hospital Association™

Advancing Health in America

Vision

A society of healthy communities where all individuals reach their highest potential for health.

Mission

To advance the health of individuals and communities. The AHA leads, represents and serves hospitals, health systems and other related organizations that are accountable to the community and committed to health improvement.

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Your Source for News and Insight

AHA Today is a daily roundup of news and resources from the AHA, including breaking health policy news, educational opportunities, reports, toolkits and stories from the field. Subscribe at **aha.org/ahatoday**.

MARKET SCAN

AHA Market Scan e-newsletter brings you insights and analysis on the field's latest developments in health care disruption, transformation and innovation. Subscribe at **aha.org/marketscan**.

ADVANCINGHEALTH
A podcast by the American Hospital Association

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NORTHERN INYO HEALTHCARE DISTRICT
Improving our communities, one life at a time.
One Team, One Goal, Your Health!

150 Pioneer Lane
Bishop, California 93514
(760) 873-5811

DATE: January 2022

TO: Board of Directors
Northern Inyo Healthcare District

FROM: CEO Board Report
Alison Murray, Acting Director of Human Resources

RE: Department Update

REPORT DETAIL

HR Manager (Marjorie Routt): Overseeing the implementation of multiple ADP modules with a heavy emphasis on Payroll. Facilitating the return of employee engagement activities such as Employee of the Month, Birthday Celebrations, and retirement recognition.

Recruitment (Brittney Watson): Working very hard to assist District leaders during the COVID crisis staffing shortage. Partnering with Strategic Communications to get job postings on multiple social media platforms. Year-end recruitment statistics as follows:

2021 Recruitments – 318 requisitions posted in 2021
2021 New Hires – 121 new hires in 2021
2021 Applications – 1,292 applications received in 2021
2021 Acceptance rate – 87% (best available data)

Process updates: Recruitment timeline created, objectivity measures introduced at application stage, Staffing Request Forms updated

Onboarding (Sarah Rice): Getting back to Onboarding full-time since our Payroll Specialist has now been returned back to full-time and Sarah no longer has to cover. Recently the new Org Chart software has been implemented and she is working on streamlining this process. Completion of the Onboarding process and providing full manager training including a "Getting to Know You Letter" that newly hired employees can complete for their managers. Working on a Board of Directors onboarding process as well. Year-end onboarding statistics as follows:

Onboarding Stats:
Head Count as of 12/24/2021: 447

New Hires:
Permanent Staff: 101 (from Checklist)/121 (from ADP)
Travelers: 39
Temps: 31
Contract: 10
Transfers: 21
Separations: 138

Compliance Stats:
Fit Test Tracking project began in early 2019. In April of 2019, Employees were at an 88.05% compliance rate and Physicians were at a 38.37% compliance rate. As of 12/24/2021, Employees are at a 96.80% compliance rate and physicians are at an 81.71% compliance rate.

Licenses for Nursing and the Clinics have remained compliant to date

Payroll (Reuben Morgenstein): Payroll Specialist retuned from LOA. ADP comprehensive Payroll implementation. Will provide payroll support to the Head of Payroll who will oversee the process and assist with reporting and analysis requirements. Along with processing regular payroll every two weeks, payroll also processed a total; of 393 Demand Checks for employees as needed.

Benefits (Carlos Madera): Completed full implementation of the new retirement plans with Empower and Hooker & Holcombe. Implementing LOA module in ADP. Overseeing all COVID paid sick leave for employees. Year-end benefit/LOA statistics as follows

Leaves of Absence: 61
Workman's Comp processed: 32
Accommodations: 30
Open Enrollment: 219 participants completed enrollment
New benefits:
Tri-Ad we had a total of 59 participants
Empower 457(b) we had a total of 122 participants enroll
DB Actuary Transfer: 193 participants
401(a) Actuary Transfer: 316 participants
Retirements processed: 17

HR/District Education (Carmela Arceo): This past year we worked to educate nursing departments on building modules, skills checklist and events within the Relias Learning Management System. This increases our ability to track trainings offered through the district. Our goal for 2022 is to continue to increase usage of our systems for tracking in an effort to increase compliance and staff development. This past year we were able to assign, implement and track 25,620 courses within the system.

Professionalism Training:
92% of district staff have completed professionalism and civility training
100% of our district leaders completed professionalism and civility training

LEAD (Leadership Training):
Cohort 1: 20 leaders from CEO, COO, CFO completed 3/2021-8/2021

Cohort 2 20 leaders from CNO, CMO Launched 9/16/2021 runs through February 2022

2021 District completion status – Assigned Trainings

Year to date:	Completion- 90%
	Past due – 8%
Quarter 1:	Completion - 97%
	Past due – 3%
Quarter 2:	Current completion – 95%
	Past due – 5%
Quarter 3:	Current Completion – 89%
	Past due – 11%
Quarter 4:	Current Completion – 79%
	Past due – 14%

Human Resources (Alison Murray): Employee Engagement survey launched December 15. Continued work on strategic planning for HR department as well as District. Overseeing staff compliance with the state mandate requiring vaccination or testing for employees including booster vaccines. Preparing for union contract negotiations in 2022. Open recruitment for Labor Relations Specialist.

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

150 Pioneer Lane
Bishop, California 93514
(760) 873-5811 Ext. 3415

DATE: January 2022

TO: Board of Directors, Northern Inyo Healthcare District

FROM: CEO Board Report
Barbara Laughon, Manager, *Marketing, Communications & Strategy*

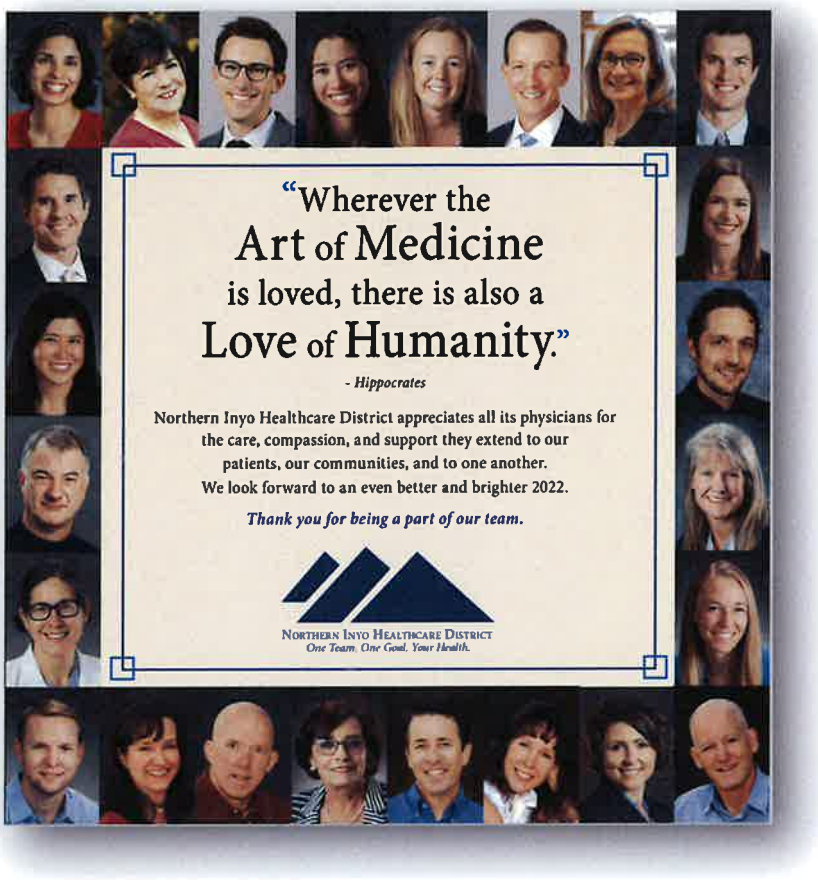
RE: Department Update

REPORT DETAIL

New Marketing Business

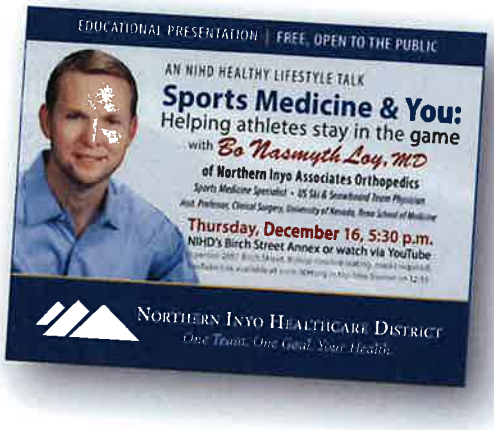
- **The Strategic Communications team presented its Marketing Philosophy** to the NIHD Marketing Taskforce Committee for approval. The approved philosophy reads: "One Life at a Time: At Northern Inyo Healthcare District, we believe health is our community's foundation. We educate, we inform, and we nurture high quality care for those who rely on us, one life at time."

- **TeamNIHD participated in two gift drives this holiday season**, coordinated with community partners by the Strat Comm team. The first drive saw NIHD lend a hand to the local **CASA** (Court-Appointed Special Advocates) program which serves foster children. We were able to provide wish-tree style gifts to 12 children. We also hosted a gift drive for the patients at the **Bishop Care Center** with TeamNIHD donating enough items to provide gifts for all 60 BCC patients. Many thanks to **Michelle and Diana Garcia**, **Tanya DeLeo** and the entire **Admissions team**, **Rosie Graves, Carmela Arceo, Oscar Esparza,** and **Dominic Jahn** for their assistance in coordinating, wrapping and delivering the BCC gifts. Shown above with TeamNIHD are BCC's Director of Nursing Kelly Rice, RN; Erlene Domke, RN, MDS; and, Jayneann Hinek, LVN.



- **NIHD showed gratitude to its Physicians** with a special holiday ad in *The Inyo Register*, as shown above. Our department is especially grateful for the time and talent the physicians grant us in our efforts.

- **Orthopedic Surgeon Dr. Boy Loy hosted a Healthy Lifestyle Talk** on Thursday, Dec. 16 entitled "Sports Medicine & You: Helping athletes stay in the game." The Health Lifestyle Talk was broadcast live on NIHD's YouTube page and can be viewed here: https://youtu.be/jBBTz2XQPNw. Up next is **Registered Dietitian Kalina Gardiner with "A Healthier Way to Weight Loss"** on Thursday, Jan. 20th, and **Registered Dietitian Lindsey K. Hughes and RHC Registered Nurse Elizabeth Haun on Diabetes Prevention** on Thursday, Jan. 27. A heart health panel talk is anticipated for February with a focus on Colorectal Cancer Awareness in March.



- **Media requests came in** from local media outlets (*The Inyo Register* and *The Sheet)* as well as a request from *The San Francisco Chronicle* (who interviewed CMO Dr. Joy Engblade on COVID and its effects on rural hospitals) and from *Medscape,* the print version of WebMD, who requested an interview with Dr. Engblade on navigating generational topics among medical staff.

- **We supported the move of the vaccine clinics into The Rural Health Clinic and Pediatric Clinic** with print advertisements in English and Spanish. We continue to work with the Incident Command and our county partners to keep information flowing regarding COVID efforts.

- **We spotlighted the Rural Health Clinic Team on our social media outlets** and we are getting many positive comments and likes. The RHC team will continue to be spotlighted into early January.

- **We produced the internal communication, *Chiefly Speaking***, which features information for the NIHD staff and providers from our Executive Team. December marked our fifth issue.

- **With the help of Jesse Steele of *Eastern Sierra NOW,* we produced a series of four holiday wishes videos shared on social media outlets**. We also took the audio wishes from our team and spotlighted them in ads on KSRW-FM and KIBS-FM. We are grateful to the following members of TeamNIHD for lending their talents to this effort: **Launa Strickland**, **Shawn Williams**, **Sandra Sommer**, **Ashley Weatherford**, **Kari Rennaker**, **Jose MacArthur**, **Lindsay Randall**, **Nicole Cooper**, **Denny Smith**, **Dr. Carolyn Tiernan**, **Dr. Stacey Brown**, and **Dr. Jane Yoon**.

- On behalf of Scot Swan, Amanda Long, and myself, we wish the Board, the Executive Team, and our community a healthy and happy New Year in 2022!

NORTHERN INYO HEALTHCARE DISTRICT
Improving our communities, one life at a time.
One Team, One Goal, Your Health!

150 Pioneer Lane
Bishop, California 93514
(760) 873-5811

DATE: January 2022

TO: Board of Directors
Northern Inyo Healthcare District

FROM: CEO Board Report
Bryan Harper, Director of ITS/CISO

RE: Department Update

REPORT DETAIL

NEW BUSINESS

Service Desk staff continue working on hardware upgrades.

The team is working on a new printer method for all workstation removing the need for print servers. (testing phase)

Team members are working on documented issues from security risk assessment and penetration testing.

Staff have completed the build and testing of our SCCM server and patches are now being rolled out to servers and workstations again.

Staff have removed roaming profiles from all users. (this should decrease login wait times)

CE team is helping in the process of scoping for larger district-wide projects such as the OR floor replacement

OLD BUSINESS

The technical team is in the process of a large VMware Platform upgrade.

The ITS completed the roll out of SSON with 2FA which will meet the requirements to obtain and keep Cyber security insurance going forward.

ITS resolved the credit card issues and all area should now have the ability to take credit cards.

CE/ITS resolved outstanding ultrasound disconnect issue for two areas.

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150 Pioneer Lane
Bishop, CA 93514
(760) 873-5811

DATE: January 2022

TO: Board of Directors
Northern Inyo Healthcare District

FROM: CEO Board Report
Greg Bissonette, Foundation Executive Director/Grant Writer

RE: Department Update

REPORT DETAIL

FOUNDATION

November and December were somewhat quiet for the Foundation with a regular board meeting held in November and December's business being pushed until January due to a lack of a quorum. November's did see approval of over $2,000 being donated to the District in support of the 75th anniversary celebrations and CAREshuttle expenses. At the time of this writing (December 22nd), donations into the Foundation for these two months totaled $2,250. This being the end of the calendar year, and when I track annual giving to the Foundation, I can report that 2021 saw total giving at $20,920. Almost half of that, $10,800, coming from the direct mail campaign around not being able to hold the Avenue of Excellence award dinner again due to the COVID-19 pandemic. With the anticipation that some other last minute donations may come in before the end of the year, I can report back updated numbers in my March report.

GRANT WRITING

During this reporting period, a new grant opportunity for vaccine administration was pursued through the Physicians for a Healthy California's CalVaxGrant program. I was able to register three locations within the District that were administering vaccines, the RHC, the Peds Clinic, and the hospital, which could result in an award of $30,000 ($10,000 for each location). That grant will be completed before the end of the year, with awards happening in early 2022.

Administration and maintenance for all other current grants is ongoing.

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150 Pioneer Lane
Bishop, California 93514
(760) 873-5811

DATE: January 2022

TO: Board of Directors
Northern Inyo Healthcare District

FROM: CEO Board Report
Larry Weber, Director of Diagnostic Services

RE: Diagnostic Services Department Update

REPORT DETAIL

NEW BUSINESS

Cardiopulmonary (CP):

The Cardiopulmonary department has stabilized the staffing of the department which was reported to the board as critical in November. We are down to one vacant position and are actively recruiting to fill that vacancy. CP leadership is doing its due diligence to fully understand the need to replace our transport ventilators that are now end of life. As is the entire hospital, the CP department is in the midst of completing our second annual employee engagement survey. As a result of our first survey, staff voiced the desire for more training to care for neonates that require intensive care level of care. We were pleased to report to the staff that we are in the process of finalizing an agreement with Pomona Valley Hospital Medical Center where our therapists will be able to work within their Neonatal Intensive Care Unit (NICU) and receive hands on training. This training will prove invaluable when that level of care is needed at NIHD.

Diagnostic Imaging (DI):

The Radiology department resumed their monthly QC meetings in X-Ray and CT. We will continue to expand our QC program in DI to include QC review of Ultrasound Services. Standard Operating Procedure review and revisions are in full swing with an effort to have all policies and procedures reviewed and in the new policy manager by mid-year 2022. Also in January, we will begin updating 3-year capital plan to include FY 2025.

Laboratory Services (the Lab):

The Joint Commission accepted our Evidence of Standards Compliance and we have gained "Fully Accredited" Accreditation status with The Joint Commission. We have had two resignations of full time CLS staff. Michael Klauer resigned due to family reasons and Julietta Doon Resigned due to conflicts with schedule. Staffing remains good due to our contracted long term travelers with Med Pro Staffing solutions. We had our first lab services quality improvement committee meeting with great success. meetings will be held monthly and will

focus in improving key performance indicators within laboratory services. We will be finalizing the transition to our new Hematology Analyzers in January. This represents a significant improvement in technology in our district and helps us automate Reticulocyte (immature red blood cells) counts and the analysis of body fluids. I reported in November that Rich Hayden, interim laboratory manager accepted the manager position on a full-time permanent status. Unfortunately, due to a family emergency, he has had to decline the position. Rich will be staying on as interim manager for a period of 6 months while we search for a permanent manager.

OLD BUSINESS

Cardiopulmonary:

No old business to report for Cardiopulmonary

Diagnostic Imaging:

No old business to report on for Diagnostic Imaging

Laboratory Services:

No old business to report on for the Lab

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DATE: January 2022

TO: Board of Directors
Northern Inyo Healthcare District

FROM: Interim CEO Board Report
Neil Lynch, Purchasing Director

RE: Department Update

REPORT DETAIL

NEW BUSINESS
Back orders. We are experiencing significant delays across most supply chain categories. Covid-19, weather, shipping bottle necks, and manufacturing delays have made ordering difficult. Most resources are focused on minimizing delays.

OLD BUSINESS
(Complete) Purchasing continues to work on GPO (Group Purchasing Organization) transition. We are compiling data for analysis to determine contract compliance rate.

(Complete) GHX EDI integration has begun. IT continues has completed set up on the back end, purchasing staff is training and will be testing system through October.

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(760) 873-5811

DATE: January 2022

TO: Board of Directors
Northern Inyo Healthcare District

FROM: CEO Board Report
Rich Miears, Manager of Environmental Services & Laundry

RE: Department Update

REPORT DETAIL

ENVIRONMENTAL SERVICES
The Environmental Service team operates Monday –Sunday 400am to 1230am. Our staff cleans areas from Birch Street, to the Joseph house to our OR's and PACU. We currently have 25 fulltime employees in ES with zero vacant spots to fill. ES staff is staying busy with COVID cases in the ED.

LAUNDRY
The Laundry team operates Monday –Friday from 500am to 1530pm. We currently have 4 employees with one Fulltime position to fill. Our chemical line is still good. Dryer#2 has been down for over a month because it's taking a long time to get the part in. Our staff is doing great. Our washable PPE is at a great back-up level. The Laundry staff hasn't had to work on the weekends for a while now.

Other Information:
Talent Pool- Currently has 7 employees and are in the process of hiring 3 more. We haven't had an applicant in ADP for a Talent Pool employee since 11/19/2021. We have been using Sierra Employment Services to get our Talent Pool staff.

Screeners- We have 5 temp screeners from Sierra Employment to cover Radiology 5 days per week, Main and the ED entrance 7 days per week. Linda Bull is our newest temp screener. They are all really nice and do a great job!

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DATE: January 2022

TO: Board of Directors
Northern Inyo Healthcare District

FROM: CEO Board Report
Scott Hooker, Director of Facilities

RE: Department Update

REPORT DETAIL

MAINTENANCE/FACILITIES

New Business:

OSHPD is now known as HCAI, their fire life safety officer will be onsite December 22nd to hopefully perform the final inspection on the building separation project. Pharmacy project is under HCAI review and is tracking on schedule for an expedited review.

OSHPD Projects (6 projects)

Building Separation Project - The Fire Life Safety Officer will be onsite December 22nd to perform the final inspection, hopefully we will be able to close this project out.

Pharmacy Project - Received our 1st back check comments from HCAI, not to many comments all are easily addressable. OSHPD has agreed to do an expedited review on the Pharmacy plans

Temporary Chiller Project – This project is monitored by HCAI until we get rid of the temporary chiller. That will happen after the Chiller Plant Upgrade (or condenser plant upgrade).

Chiller Plant Upgrade / Condenser Plant Upgrade – HCAI approved the project, Colombo Construction has this project out to bid.

Omnicell Medication Cabinet Replacement Project – plans are at HCAI expected delivery of the product and install expected in February

OSHPD changed its name – the new name is California Department of Health Care Access and Information (HCAI)

SECURITY

New Business:

Security is running smoothly we hired on new Security Officer; Roger Romero.

Old Business:

Security is currently operating with 6 officers. Security is onsite Sunday – Thursday 600p-330a Friday and Saturday noon-400a.

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150 Pioneer Lane
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(760) 873-5811

DATE: January 2022

TO: Board of Directors
Northern Inyo Healthcare District

FROM: Interim CEO Board Report
Thomas Warner, Dietary Manager

RE: Department Update

REPORT DETAIL

NEW BUSINESS

Kalina Gardiner implemented an 8-week staff weight loss challenge, "NIHD's Healthy Fall Drop" which culminated on December 16th. 54 participants initially signed up, with about 20 weekly participants. She presented to two high-school classes on "Eating 2 Fuel: How to eat for test taking, performing arts and sports" with about 25 students in each class. Also, Kalina will be doing her first Healthy Lifestyle Talk on "A Healthier Way to Weight Loss" in January. She is also working with Colleen McEvoy, NP on collaborating with the Bronco Clinic in the New Year.

Lindsey will be implementing a CDC-recognized lifestyle change education series known as the National Diabetes Prevention Program- or National DPP- starting in February 2022. Inyo County community members who have a diagnosis of Prediabetes will be given the opportunity to learn how to lower their risk of developing Type 2 Diabetes through interactive classes. Topics include proper nutrition, weight management, physical activity, and much more!

OLD BUSINESS

The Dietary department as a whole continues to strive for employee and patient satisfaction in all the meals we do, we had a full thanksgiving spread for staff working on thanksgiving and will do a Prime Rib dinner for staff working on Christmas. We appreciate all the support from the executive team and the Board Members during this year of trials and tribulations.

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DATE: January 2022

TO: Board of Directors
Northern Inyo Healthcare District

FROM: CEO Board Report
Lynda Vance, Manager of Project Management

RE: Department Update

REPORT DETAIL

NEW BUSINESS

Project Management Specialist: We completed the process with HR for the new Project Management Specialist. I am excited to welcome Brandon Cox to the team. Brandon comes with 20 plus years of experience working on projects centered in construction and communications.

Project Process updates: With the addition of staff to the Project Management Team, I will have time to complete the work on streamlining project processes, tracking, and reporting.

Projects *(this is a summary of the high-level work, not a complete list)*

Discovery – 9 (Mammo and Stereo Equipment Replacement, PACS Replacement, Phlebotomy draw area update, DI Coordinator offices, Onboarding Workflow Efficiency, BDM Interface Cerner project, OneContent upgrade, Cerner Portal Relaunch, Clearing House Mini-Grants)

Actively Working – 21 (**OR and PACU Flooring**, Employee Health Management System Agility, Myla Lab/Micro Middleware, Cerner Support and SR review, Hematology Analyzer, HCIQ and Valify GPO CHC Project, Omnicell Cabinets, ADP Empower/ Payroll and Employee services, Zoll Defibrillator Replacement, City of Hope Telehealth, Report Governance Committee, GHX, MAT Grant Project, Smartsheet upgrade for PHI compliance, State Mandate Tracking, Scanning-clinic efficiency, i2i with Cerner, Flu and NSHN tracking**,** Experian Pricing transparency, OneContent athena upload, Internal Med Office update)

Closing – 7 (Reference Lab price updates, Advance Capture, i2i with athena, Bronco Clinic Restart, Supply requisition Challenges, PPM SaaS, OneContent Centricity upload)

Moves Completed - 3 (Perinatal Manager Office, Employee Health Work Station addition, IT apps admin relocation)

On Hold Projects - 11 (InQdocs Subscription Service, Copay Workflow Improvement, FEEs system, Hemodialysis for IP, Kitchen Update, Wound Care, Additional Ortho Services, Logisticare/Modivcare Transport, Surgery/ PACU office changes, SAP Concur, Door Access Badge standard workflow)

Northern Inyo Healthcare District

150 Pioneer Lane
Bishop, CA 93514
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www.nih.org

Date: 12/28/21
To: Board of Directors
From: Joy Engblade, MD, MMM, FACP, Chief Medical Officer
Re: Bi-Monthly CMO report

Medical Staff Department update

Physician recruiting continues to be fairly active. We are planning for two interview visits; one with an urologist who will complete his training by the summer of 2023 and another with a general surgeon who will be interviewing with her husband who is an otolaryngologist. We are excited for all interviews. We continue to recruit for a family practice physician for the Rural Health Clinic.

The Medical Staff Department continues to be busy with reappointments and provider enrollment, two big areas that are essential for physician credentialing and reimbursement for the District. The new software, CredentialStream is up, with most information populated now, planning to be fully functional by March 2022. This will allow anyone in the District to electronically search for a physician's privileges on the spot.

We will also be busy hosting medical students and nurse practitioner students this winter, across multiple departments. This is an exciting time for us to share our knowledge and show the students the subtle differences in medical care delivery in a rural community.

Pharmacy Department update

We are moving forward with the Pharmacy construction project. Regular updates are received from Scott Hooker and Colombo construction. The building separation is nearly complete and we will be working to start pharmacy construction in early 2022.

The Pharmacy department continues to support Covid vaccination efforts, as the Covid vaccines moved to the Rural Health and Pediatric clinics. We will also be supporting Covid boosters for employees in early January 2022. The pharmacists continue to be our expert source of information for new Covid medications. We appreciate their knowledge and expertise, especially during this time of quickly changing medications and indications.

Quality Department update

The Quality Department continues to report on a number of regulatory requirements, meeting all deadlines. A quarterly dashboard has been created to display this data including Promoting Interoperability (PI)- Hospital, Merit-based Incentive Payment System (MIPS)- Clinic, Medicare and Chip Reauthorization Act (MACRA)- Anesthesia and The Joint Commission ORYX.

We have been partnering with a company called i2i, which is assisting with pulling data from Athena and Cerner. We are networking with other hospitals who are also using i2i to leverage the most efficiency with this platform. QIP continues to be a program that we are participating in, through the state.
We continue to recruit for support positions in our Quality department.

Covid 19

We continue to have weekly Incident Command meetings and we share information across the District and with our community partners. With Omicron on the rise, we have confirmed that all of our current testing (antigen and PCR) are able to detect the variant. As noted above, we continue to stay up to date with CDPH requirements, medication indications for Covid and variants, and vaccination recommendations.

Physician Compensation Update

I continue to work with VMG, our fair market value consultants as well as a small working group including Stacey Brown, Stefan Schunk and Lindsey Ricci. Fair market value is tricky right now, given the Covid pandemic and the interpretation of the data. I asked the physicians for an extension (my hope was to get all data out by the end of 2021, but I will need an extra 2 months). I appreciate everyone's patience.

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150 Pioneer Lane
Bishop, California 93514
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DATE: January 2022
TO: Board of Directors, Northern Inyo Healthcare District
FROM: Allison Partridge, RN, MSN, Chief Nursing Officer
RE: Department Update

REPORT DETAIL

Old Business

COVID-19

The District continues to manage the daily challenges that COVID-19 has presented. We continue with weekly incident command meetings. We review the District's current state of preparedness during incident command and identify any areas or opportunities that require additional review and or problem-solving. Our Infection Prevention Team continues to monitor and provide updates on both national and local status and recommendations. NIHD continues to partner with Inyo County Public Health in the administration of COVID-19 vaccines and is working to create accessibility of vaccines in the RHC and NIA clinics. The District also has processes in place for the administration of Monoclonal Antibody Therapy.

New Business

Operating Room (OR) Flooring Project

The OR Flooring Project kicked off Monday January 3rd. There has been great collaboration on this project through a team of key stakeholders throughout the District. We are very eager to see this project through successful completion.

Defibrillator Project

The District is currently in the process of replacing our defibrillators throughout the clinical areas. This project is led by Jenny Bates, Justin Nott, Scott Stoner, and Lynda Vance. The new defibrillators will bring advanced technology including CPR feedback. Training of the Super-users has been completed and end-user training will begin in the upcoming weeks.

Recruitment

In collaboration with our Human Resource Team we continue to focus on recruitment and retention of team members to fill open vacancies throughout the District.

Team Recognition

- The District celebrated the retirement of Ann Wagner, Perioperative Director on December 22nd.
- Congratulations to Lauren Billings, RHC MA, and Erica Esparza, RHC MA, for completing the Cerro Cosa MA program.
- Congratulations to Kaylyn Rickford RHC MA, who was appointed as a board member to the California Certifying Board of Medical Assistants.

The New Year of 2022 is not without challenges. It is with utmost gratitude that we recognize all our team members throughout the District who continue to work every day to support our patients and community through this pandemic.

Each department leader has submitted a department specific report to follow.

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150 Pioneer Lane
Bishop, California 93514

(760) 873-5811 Ext. 3415

DATE: January 2022

TO: Board of Directors, Northern Inyo Healthcare District

FROM: Jenny Bates, ED Manager

RE: Department Update

REPORT DETAIL

Old Business

The ED team continues to provide safe and effective care for our local community members and visitors to our area. The ED continues to operate under NIHD's Covid emergency preparedness plan while ensuring the highest level of safety.

New Business

The ED team has recently opted in for the upcoming Beta Quest for Zero: Excellence in the ED, which is a patient safety initiative designed to support excellent care in the ED. The overall goal of the Quest for Zero is to improve patient safety and high reliability and reduce patient harm.

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150 Pioneer Lane
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(760) 873-5811 Ext. 3415

DATE: January 2022

TO: Board of Directors, Northern Inyo Healthcare District

FROM: Justin Nott, Med/Surg and ICU Manager

RE: Department Update

REPORT DETAIL

Med/Surg and ICU

Recently, a large focus for med/surg and the ICU has been ensuring that we have appropriate staffing. We have currently filled many of the med/surg positions that were previously posted, but we will still have travelers covering those positions until the new hires have been fully oriented to their new positions. In the ICU, we have 3 open RN positions posted, and we currently have all of those positions staffed with travelers.

The RCU has been open for the majority of the current quarter. The med/surg and ICU staff have continued to go above and beyond, frequently floating to the RCU whenever they are needed.

We continue to move forward with the development of a peripherally inserted central catheter (PICC) team. The Nurses receiving the PICC training are currently working on the online portion of their training and will begin the in person hands-on portion of their training in January 2022.

We continue to focus on completing all annual clinical competencies and all annual training on safe patient handling equipment. Multiple sessions have been scheduled throughout December to ensure that all staff are signed off on their annual training be the end of the year.

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(760) 873-5811 Ext. 3415

DATE: January 2022

TO: Board of Directors, Northern Inyo Healthcare District

FROM: Jannalyn Lawrence, *Director of Outpatient Clinics*

RE: Department Update

REPORT DETAIL

Old Business

It's hard to believe I'm reporting yet another rise in COVID, but here we are; we remain endlessly proud of and grateful for our frontline workers in the Car Clinic. Just this week we expanded to add a second provider and MA team to accommodate increased demand. They have braved the rain and snow in recent weeks and remain as committed as ever to the health of our community.

New Business

We administered the first doses of COVID vaccine in the RHC and NIA Pediatric Clinic on Wednesday December 15. We have opened up weekly vaccine clinics in both locations for community members to sign up and have been full every week! We also offer the vaccine during regularly-scheduled provider visits in both locations.

I am pleased to share some exciting staff recognition: Lauren Billings and Erica Esparza both completed Cerro Coso's Medical Assistant program with flying colors! They are valuable members of the RHC back office team. Kaylyn Rickford, MA, was recently appointed as a board member of the CA Certifying Board of Medical Assistants. This is an honorable achievement.

NIHD, specifically our MAT team, has been identified as one of the CA Bridge Program's 2021 Naloxone Distribution MVPs. They were recognized for creating low-barrier access to Naloxone and the Bridge Program is impressed with our efforts to saturate the community with this life-saving medication.

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150 Pioneer Lane
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DATE: January 2022

TO: Board of Directors, Northern Inyo Healthcare District

FROM: Robin Christensen DON Quality/Infection Prevention

RE: Department Update

Clinical Informatics, Survey Readiness, Infection Prevention, & Employee Health

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REPORT DETAIL

Old Business

Clinical Informatics: We still have two open positions. The leadership team continues to work closely with Amanda Santana, Clinical Informaticist, and other departments to ensure that the District's needs are met. Amanda continues to onboard new providers, students, clinical, and administrative staff weekly due to off cycle-onboarding. In addition, the team continues to work with all departments to help improve workflow efficiency and optimization.

Survey Readiness: The Quality/Survey readiness team continues tracer activities throughout the District. The team continues to experience significant participation from all departments, and the teams are taking the tracer activity as learning opportunities. In addition, leadership continues presenting information relevant to the regulatory requirements for their department and steps they are taking for continuous survey readiness.

Employee Health: Employee Health continues to encourage staff to get their COVID-19 vaccine and booster dose, and 2021-2022 influenza vaccine. The team collaborates with Human Resources and RHC to streamline the employee onboarding process. In addition, Employee Health continues to simplify the manual process of Employee Health records to help prepare for Agility implementation the new Employee Health database.

Infection Prevention: Continues to work with Inyo County Health Department with COVID-19 related activities. Infection Prevention works closely with Human Resources to ensure that NIHD meets COVID-19 regulatory guidelines relating to employees and patients. In addition, the team monitors and provides updates on local, state, and federal guidelines and recommendations.

New Business

Clinical Informatics: The team continues to open and monitor Cerner Service Desk tickets for the NIHD District. The leadership team will be reviewing current open positions and evaluating the job descriptions based on the department's needs. Clinical Informatics will also be partnering with other key stakeholders on the Cerner portal re-launch.

Survey Readiness: Getting ready to expand a new group of tracer activities to other departments. The team closely monitors for any new regulatory changes or updates and distributes the information to key stakeholders to help ensure that the District remains complaint. In addition, we continue to collect and update the survey readiness binder with the required documents for CDPH and The Joint Commission; this will include distributing 2022 National Patient Safety Goals.

Employee Health: The team will be interviewing for a temporary Employee Health Clerk to assist with the implementation of Agility, vaccine data collection, and entry, and assisting with onboarding of new employees, providers, students, and volunteers. In December, we had the Agility kick-off meeting, and we will be partnering with several other departments throughout the District to help with the implementation. In addition, Employee Health plays a vital role in onboarding new staff, providers, students, and volunteers; there has been a significant increase in onboarding throughout the District.

NIHD healthcare worker (HCW) influenza vaccine rates for 2021-2022 are 74.2 %. We have 500 HCW's who received the vaccine, three staff members with unknown status, and 96 HCW’s who have declined the vaccine.

Infection Prevention: Continues to report COVID-19 data to CDPH daily. Infection Prevention and Employee Health continue to collect NIHD workforce COVID-19 data to report to CMS via the NHSN portal. Infection Prevention continues to monitor and report Hospital Acquired Infection data.

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150 Pioneer Lane
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(760) 873-5811 Ext. 3415

DATE: January 2022

TO: Board of Directors, Northern Inyo Healthcare District

FROM: Julie Tillemans, *Perinatal Nurse Manager*

RE: Department Update

REPORT DETAIL

Old Business

The Perinatal GoMoms Team participated in our first direct virtual simulation training, with a topic of Postpartum Hemorrhage Management. Based on the learnings from the drill we are working to enhance our current workflows with evidence based practices from Stanford University Hospital, including adopting a simple checklist to utilize during such events. Our next obstetric simulation is planned for January 4th and will focus on management of hypertensive emergencies in pregnancy.

New Business

I am very excited to present a high level overview of a Perinatal Tier 2 project for the 2022 year. Lisa Matheny, the Director of Risk Management and Patient Safety is going to present a lecture and interactive class to all Perinatal nursing staff, obstetricians, and pediatricians starting in January 2022. The session will begin in January and be offered again in March and May. The sessions will include the following topics:

- Open discussion on Perinatal practices and team dynamics
- Promoting and achieving a culture of safety
- Conflict resolutions
- Role playing difficult cases
- Professional liability and communicating with confidence

Our goal is to make a team of experts into an expert team!

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150 Pioneer Lane
Bishop, California 93514

(760) 873-5811 Ext. 3415

DATE: January 2022

TO: Board of Directors, Northern Inyo Healthcare District

FROM: Tammy Andersen, *Perioperative Manager*

RE: Department Update

REPORT DETAIL

New Business

- The OR Flooring Project starting January 3rd.
- After 40 years Ann Wagoner retired but will be back two days a week to help support the OR Flooring Project.
- Tammy Andersen transitioned to the role of Perioperative Manager.

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DATE: January 2022

TO: Board of Directors, Northern Inyo Healthcare District

FROM: Jose Garcia, *Language Access Services Manager*

RE: Department Update

REPORT DETAIL

The Language Access Services Department supports the District's mission by ensuring timely, and accurately language or communication assistance is provided to limited English proficient patients and/or their legal representatives.

Old Business

The Department successfully implemented the transition of the District's over the phone interpreting service provider, and in conjunction with the deployment of 23 iPads for video or voice interpreting services; access to interpreter services at all clinical and non-clinical access points, embodies improving our communities, one life at a time, providing equal access to high quality health care services.

New Business

Providing language or communication assistance may include, but it is not limited to translation of Vital Documents, significant communications, and significant publications, as well as oral interpreting services.

The Department's 21/22 budget includes providing a 40-hour healthcare interpreters' training for the District's qualified workforce. During the next quarter, the Department will request Chief's approval for, and start the training's planning and scheduling.

The Department is working in partnership with Compliance, and the Forms Committee in getting forms updated and translated as needed.

Language Access and Health Informatics are working on getting Cerner to build the necessary fields to collect all legally required information on patient's primary and preferred language, and their LEP (Limited English Proficient) status.

FY2021	Actual	Actual	Actual	Estimate	Estimate
Unit of Measure	**Jul-21**	**Aug-21**	**Sep-21**	**Oct-21**	**Nov-21**
Cash, CDs & LAIF Investments	51,541,102	51,660,613	51,218,981	44,626,386	48,069,372
Days Cash on Hand	194	192	192	164	175
Gross Accounts Receivable	40,330,632	39,434,879	38,647,332	45,621,898	45,730,808
Average Daily Revenue	497,079	459,646	500,563	488,452	507,215
Gross Days in AR	81.14	85.79	77.21	93.40	83.82
Key Statistics					
Acute Census Days	171	156	170	314	314
Swing Bed Census Days	24	0	0	0	20
Total Inpatient Utilization	195	156	170	314	334
Avg. Daily Inpatient Census	6.3	5.0	5.7	10.5	11.1
Emergency Room Visits	712	680	619	592	633
Emergency Room Visits Per Day	23	22	21	19	21
Operating Room Inpatients	6	6	19	13	14
Operating Room Outpatient Cases	101	86	84	87	86
Observation Days	77	59	62	56	49
RHC Clinic Visits	2,302	2,683	2,780	2,956	2,708
NIA Clinic Visits	1,829	1,808	1,731	1,961	1,809
Outpatient Hospital Visits	4,472	4,762	4,452	4,267	4,234
Hospital Operations					
Inpatient Revenue	2,774,294	2,563,061	3,191,692	3,354,047	3,958,181
Outpatient Revenue	11,561,101	10,530,380	10,697,544	10,581,296	10,120,970
Clinic (RHC) Revenue	1,074,051	1,155,594	1,127,660	1,206,664	1,137,285
Total Revenue	15,409,445	14,249,034	15,016,896	15,142,006	15,216,437
Revenue Per Day	497,079	459,646	500,563	488,452	507,215
% Change (Month to Month)		-7.53%	8.90%	-2.42%	3.84%
Salaries	2,138,510	2,212,918	2,099,073	2,251,406	2,363,977
PTO Expenses	249,855	249,855	249,855	249,855	249,856
Total Salaries Expense	2,388,364	2,462,773	2,348,927	2,501,261	2,613,832
Expense Per Day	77,044	79,444	78,298	80,686	87,128
% Change		3.12%	-1.44%	3.05%	7.98%
Operating Expenses	6,882,843	7,013,237	7,294,767	7,285,504	7,477,297
Operating Expenses Per Day	222,027	226,233	243,159	235,016	249,243
Capital Expenses	36,416	3,000	-	-	9,546
Capital Expenses Per Day	1,175	97	-	-	318
Total Expenses	8,511,732	8,533,790	8,636,587	8,744,986	8,837,738
Total Expenses Per Day	274,572	275,284	287,886	282,096	294,591
Gross Margin	1,732,096	(81,114)	645,366	588,339	435,250
Debt Compliance					
Current Ratio (ca/cl) > 1.50	2.13	2.10	2.84	2.36	2.36
Quick Ratio (Cash + Net AR/cl) > 1.33	1.80	1.73	2.29	1.94	1.94
Days Cash on Hand > 75	194	192	192	164	175

	FY 2020	FY 2021	Actual Jul-21	Actual Aug-21	Actual Sep-21	Estimate Oct-21	Estimate Nov-21
Total Net Patient Revenue	76,229,126	86,844,620	8,614,939	6,932,123	7,940,133	7,873,843	7,912,547
IGT Revenues	13,729,686	20,295,927	394,000	1,106,255	530,242	416,667	416,667
Total Patient Revenue	89,958,812	107,140,547	9,008,939	8,038,378	8,470,376	8,290,510	8,329,214
Cost of Services							
Salaries & Wages	26,275,799	27,016,877	2,138,510	2,212,918	2,099,073	2,251,406	2,363,977
Benefits	18,316,171	22,382,407	1,618,760	1,635,349	1,795,655	1,865,201	1,865,201
Professional Fees	19,573,242	22,565,034	1,871,274	1,896,180	1,978,664	1,880,419	1,927,430
Pharmacy	3,105,981	4,035,279	274,517	354,714	344,942	336,273	344,680
Medical Supplies	4,199,962	4,136,111	277,812	255,157	358,049	344,676	353,293
Hospice Operations	505,000	-	-	-	-	-	-
Athena EHR System	1,164,797	1,480,088	112,267	114,869	132,491	123,341	126,424
Other Direct Costs	4,813,483	5,810,258	589,703	544,051	585,893	484,188	496,293
Total Direct Costs	77,954,434	87,426,053	6,882,843	7,013,237	7,294,767	7,285,504	7,477,297
Gross Margin	12,004,378	19,714,494	1,732,096	(81,114)	645,366	588,339	435,250
Gross Margin %	13.34%	18.40%	20.11%	-1.17%	8.13%	7.47%	5.50%
General and Administrative Overhead							
Salaries & Wages	4,681,985	3,906,499	319,290	323,708	319,740	325,542	341,819
Benefits	4,150,743	3,754,395	283,420	299,665	312,500	312,866	320,688
Professional Fees	2,337,874	3,978,605	421,033	420,876	222,237	371,993	381,293
Depreciation and Amortization	4,275,662	4,094,658	370,335	358,995	347,178	332,720	341,038
Other Administrative Costs	1,412,451	1,396,332	234,811	117,308	140,164	116,361	119,270
Total General and Administrative Overhea	16,858,715	17,130,488	1,628,889	1,520,552	1,341,820	1,459,482	1,504,107
Net Margin	(18,584,023)	(17,711,920)	103,207	(1,601,666)	(696,454)	(871,143)	(1,068,857)
Net Margin %	-24.38%	-20.39%	1.20%	-23.10%	-8.77%	-11.06%	-13.51%
Financing Expense	2,362,880	1,413,155	179,672	179,585	176,035	176,219	176,219
Financing Income	2,372,608	1,755,654	173,785	173,785	173,785	(0)	(0)
Investment Income	600,420	387,349	23,766	16,876	20,534	16,474	16,474
Miscellaneous Income	1712917.01	1361183.52	172,440	66,574	9,045,548	125,242	125,242
Net Surplus	(2,531,273)	4,675,038	687,526	(417,762)	8,897,620	(488,980)	(686,695)

NORTHERN INYO HEALTHCARE DISTRICT
NON-CLINICAL POLICY AND PROCEDURE

Title: Identity Theft Red Flags Rule Policy		
Owner: Admission Services Manager	Department: Admissions Services	
Scope: District Wide		
Date Last Modified: 12/01/2021	Last Review Date: No Review Date	Version: 1
Final Approval by: NIHD Board of Directors	Original Approval Date: 12/18/2019	

PURPOSE:

As an issuer of credit to recipients of its healthcare services, Northern Inyo HealthCare District (NIHD) adopts an Identify Theft Prevention Program to assist in identifying, detecting, and mitigating risks of identity theft affecting patients of the Hospital and clinics.

POLICY:

It is NIHD's intent to provide safeguards to protect patients by detecting Red Flags and preventing or mitigating Identity Theft without impacting appropriate care of patients or compliance with the Emergency Medical Treatment and Active Labor Act (EMTALA).

DEFINITIONS:

I. Identity theft - fraudulently using the identifying information of another person.
II. Medical Identity Theft - When an individual assumes or attempts to assume the identity of another person through fraudulent means or false pretenses and obtains or attempts to obtain medical service or goods, or to make false claims for medical services or goods.
III. Red Flag - a pattern, practice, or specific activity that indicates the possible existence of Identity Theft.

PROCEDURE:

I. IDENTIFICATION OF RED FLAGS

Activities involving Identity Theft generally fall within one of the following general types of red flags:

A. Suspicious documents
B. Suspicious personal identifying information, such as a suspicious address
C. Unusual use of – or suspicious activity relating to – a covered account
D. Alerts from others (e.g. customer, identity theft victim, or law enforcement)

II. DECTECTION OF RED FLAGS

A. NIHD has adopted the following procedures to aid in the detection of red flags for identity theft:

i. New Patient - Obtain appropriate identifying information and insurance information. This should include the following:

1. Full legal name
2. Date of Birth
3. Address
4. Make copy of Government issued or other valid picture ID, e.g. Driver's License
5. When applicable, make copy of patient's insurance card
6. Verify eligibility and insurance company's information
7. Have patient sign Conditions of Admission

ii. Existing Patient
Verify and update the personal and insurance information listed

1. During each return patient visit registration have patient show valid picture ID
2. Make copy of insurance card, including existing insurance listed
3. Verify eligibility and insurance company's information, including existing insurance listed
4. Verify validity of requests for changes of billing addresses
5. Have patient sign Conditions of Admission with each patient visit registration
6. Verify identification of patients before releasing any personal information.

iii. Emergency Care – No Delay
Providing identification is not a condition for obtaining emergency care. The process of confirming a patient's identity must **never** delay the provision of an appropriate medical screening examination or necessary stabilizing treatment for emergency medical conditions.

III. PREVENTION AND MITIGATION OF IDENTITY THEFT

A. If a patient notifies NIHD of possible identity theft in regard to their medical record or bill, an investigation will be coordinated with the appropriate department(s) (e.g., Patient Financial Services, Compliance, and Medical Records) pursuant to bill, an investigation will be coordinated with the appropriate department(s)) pursuant to NIHD established departmental procedures.

B. In determining an appropriate response to a red flag or other threat of identity theft, NIHD will consider aggravating factors that may heighten the risk of identity theft, such as a data security incident that results in unauthorized access to a patient's account records, or notice that a patient has become aware of someone fraudulently claiming to obtain medical services in the name of the patient.

C. Appropriate responses may include:

i. Monitoring a covered account for evidence of identity theft
ii. Contacting the patient
iii. Placing Billing Hold on account
iv. Reopening a covered account with a new account number
v. Not opening a new covered account
vi. Closing an existing covered account
vii. Notifying Compliance, law enforcement, and the designated governmental hotlines; or
viii. Determining that no response is warranted under the particular circumstances.

D. Internal Notifications:

Any NIHD employee who becomes aware of a potential or actual breach of personal information should report it to their manager and/or the Compliance Department for follow-up. The Compliance Office shall be notified of all breaches.

E. External Notification:
The Compliance Office will work with the appropriate department(s) to determine if any reports to outside agencies are required.

IV. PROGRAM OVERSIGHT

A. This policy shall be reviewed annually.

B. The Compliance Office shall report to the Board, at least annually, on Northern Inyo HealthCare District's compliance with the identity theft program.

REFERENCES:

1. FTC's Identity Theft Prevention Red Flag Rules-16 C.F.R. Section 681.2 (2008) Fair and Accurate Credit Transactions (FACT) Act of 2003.
2. Code of Federal Regulations – Title 16. (amended Dec 6, 2012) https://www.ecfr.gov/current/title-16/chapter-I/subchapter-F/part-681

RECORD RETENTION AND DESTRUCTION:
Photo identification is maintained within the NIHD Hospital Information System/Medical Record. NIHD Medical Records Department manages the document retention.

CROSS REFERENCED POLICIES AND PROCEDURES:

1. Admission Policy RHC

Supersedes: Not Set