

Board Meeting

Board Meeting - March 18, 2026

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Mission

* Strong Stewardship * Ethical Oversight *
* Eternal Local Access *

Vision Statement

To be an energized, high performing advocate for the communities we serve, our patients and our staff. The board governs with an eye on the future of health care and its effects on the District and patient care. The Board is committed to continuous evaluation, dedication to our mission, and improvements as a board.

Values

* Integrity * Innovate Vision * Stewardship * Teamwork *

AGENDA

NORTHERN INYO HEALTHCARE DISTRICT BOARD OF DIRECTORS REGULAR MEETING

March 18, 2026, 5:00 pm

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

TO CONNECT VIA ZOOM: (A link is also available on the NIHD Website)

<https://us06web.zoom.us/j/86114057527>

Webinar ID: 861 1405 7527

Passcode: 898843

PHONE CONNECTION:

(669) 444-9171

(719) 359-4580

Webinar ID: 861 1405 7527

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1. Call to order at 5:00 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 comments unless otherwise modified by the Chair. Speaking time may not be granted and/or loaned to another individual for purposes of extending available speaking time unless arrangements have been made in advance for a large group of speakers to have a spokesperson speak on their behalf. Comments must be kept brief and non-repetitive. The general Public Comment portion of the meeting allows the public to address any item within the jurisdiction of the Board of Directors on matters not appearing on the agenda. Public comments on agenda items should be made at the time each item is considered.
 3. Consent Agenda – All matters listed under the consent agenda are considered routine and will be enacted by one motion unless any member of the Board wishes to remove an item for discussion.
 - a. Approval of minutes for February 18, 2026, Regular Board Meeting
 - b. Approval of minutes for March 4, 2026, Special Board Meeting
 - c. Approval of Policies and Procedures

- i. Admission Procedure of Pediatric Patient
 - ii. Cleaning and Care of Surgical Instruments
 - iii. Code Blue (Adult Cardiac Arrest) and Code White (Pediatric Arrest) Documentation
 - iv. Electronic Communication
 - v. Fetal Monitoring NICHD (National Institute of Child Health and Development) Terminology and Procedures
 - vi. Newborn & Pediatric Security and Abduction Policy
 - vii. Password Policy
 - viii. Pediatric Standards of Care and Routines
 - ix. Portable Space Heaters
 - x. Rapid Response Team
- 4. Consideration of Credentialing Actions recommended by the Medical Executive Committee – Action Item
 - a. Medical Staff Initial Appointments 2026-2027
- 5. Chief Executive Officer Report
 - a. SCORE Survey – Information Item
 - b. ACHD Board of Directors Meeting – Information Item
 - c. Compliance Report – Action Item
- 6. Quality Committee
 - a. Community Health Needs Assessment (CHNA) – Action Item
 - b. Quality Dashboard – Information Item
- 7. Finance Committee
 - a. Financial Strategy, short-term – Information Item
 - i. HealthTrust Contract – Action Item
 - ii. Tele-nephrology Contract – Action Item
 - b. Skilled Nursing Facility (SNF) Project – Information Item
 - c. Financial & Statistical Reports – Action Item
 - d. Public Comment, Constituent Complaint – Information Item
 - e. Fiscal Year 26/27 Budget – Information Item
- 8. Governance Committee
 - a. Board Resolution, Consolidated Election – Action Item
 - b. CSDA Site visit with legislators – Information Item

- c. Representative Tangipa, Bill for Financial Support – Information Item
 - d. Potential for Joint Meeting with Mammoth Board of Directors and SMHD Board of Directors, CEOs – Action Item
 - e. Board Bylaws – Action Item
9. General Information from Board Members
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10. Adjournment

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

CALL TO ORDER	Northern Inyo Healthcare District (NIHD) Board Chair Best-Baker called the meeting to order at 3:30 pm.
PRESENT	Melissa Best-Baker, Chair Maggie Egan, Secretary Laura Smith, Treasurer Jean Turner, Member at Large Christian Wallis, Chief Executive Officer Allison Partridge, Chief Operations Officer / Chief Nursing Officer Adam Hawkins, DO, Chief Medical Officer Alison Murray, Chief Human Resources Officer, Chief Business Development Officer Andrea Mossman, Chief Financial Officer
ABSENT	David Lent, Vice-Chair Sam Jeppsen, MD, Chief of Staff
TELECONFERENCING	Notice has been posted, and a quorum participated from locations within the jurisdiction.
PUBLIC COMMENT ON CLOSED SESSION ITEMS	Chair Best-Baker reported that at this time, audience members may speak on closed session items on the agenda that are within the jurisdiction of the Board. Public Comment: None
RETURN TO OPEN SESSION	The Board returned to open session at 5:00 pm. There was no report out from the closed session.
PUBLIC COMMENT	Chair Best-Baker reported that at this time, audience members may speak on any items not on the agenda that are within the jurisdiction of the Board. Public Comment: One member of the public addressed the Board regarding the District's upfront cash collection policy, describing a personal experience with being asked to pay the full deductible amount at the time of service and expressing concern about the financial impact on patients. The speaker requested consideration of limiting point-of-service collections and implementing default payment plan options for higher-cost services. Board Discussion: The Chair stated that, in accordance with the Brown Act, the Board could not engage in discussion at that time and directed that the item be placed on a future agenda for formal review.
CONSENT AGENDA	Public Comment: None The following items were removed for further discussion:

- iv. Electrical Distribution
- V. EOC Management Plan
- vi. NIHD Wireless Connectivity

Motion by Turner to approve the remaining consent agenda items
2nd: Smith
Pass: 4-0

iv. Electrical Distribution

Board Discussion:

A Board member raised a question regarding the language under Category 1 systems, noting that while several critical care areas were listed as examples, the Emergency Department was not specifically identified. The member requested that the Emergency Department be explicitly included in the examples of areas where electrical system failure could result in major injury or death. Administration agreed that the Emergency Department should be added for clarity.

vi. NIHD Wireless Connectivity

Board Discussion:

This item was removed from the Consent Agenda for clarification. During the discussion, it was noted that the item contained a typographical error only and did not involve substantive policy changes.

Motion by Egan to approve Electrical Distribution and NIHD Wireless Connectivity Policies with changes

2nd: Turner

Pass: 4-0

v. EOC Management Plan

Board Discussion:

This item was removed from the Consent Agenda for separate consideration. Following a brief discussion, the item was deferred and will be brought back at a future Board meeting for further review.

CONSIDERATION OF
CREDENTIALING

ACTION RECOMMENDED BY THE MEDICAL EXECUTIVE COMMITTEE

Public Comment: None

Motion by Smith to approve Medical Staff Reappointments 2026-2027

2nd: Egan

Pass: 4-0

Motion by Turner to approve Medical staff initial Appointments 2026-2027

2nd: Egan

Pass: 4-0

Motion by Egan to approve Medical Staff Initial Appointments 2026-2027 – Proxy Credentialing

2nd: Smith
Pass: 4-0

**CHIEF EXECUTIVE
OFFICER REPORT**

Strategic Growth – WIPFLI/WOLD

Representatives from Wipfli and Wold provided an overview of the Strategic Growth Plan process, including progress on the market and demand analysis, affordability analysis, and existing state facility assessment. The team reported completing on-site facility tours and stakeholder interviews and outlined next steps, including space needs analysis, options development, and long-range financial modeling.

Public Comment: None.

Board Discussion

Board members expressed support for the comprehensive planning approach and emphasized the importance of aligning facility improvements with financial sustainability. Questions were asked regarding project timeline, return site visits, financial feasibility, and the use of lean planning methodologies; the consultants responded that the process is expected to take approximately four to six months, pending receipt of state data, and will include additional on-site engagement during options development.

Auxiliary/Foundation Update

Auxiliary Chair Benson reported on ongoing Auxiliary activities, including evaluation of potential equipment purchases such as Emergency Department furniture and an ultrasound unit, continued operation of the gift shop and holiday boutique, and efforts to recruit new members, including outreach to hospital staff and younger volunteers. Foundation Chair Kilpatrick provided an update on recent and upcoming fundraising efforts, including the annual Bunco event, Giving Tuesday campaign, and a planned golf tournament, as well as Care Shuttle operations, Healing Garden enhancements, board recruitment efforts, and consideration of supporting grounds restoration near the Infusion Center.

Public Comment: None.

Board Discussion

Board members expressed appreciation for the continued financial and volunteer support provided by both the Auxiliary and the Foundation and acknowledged the positive impact of their contributions to the District and community.

GO Bond

CEO Wallis provided an update on the District's General Obligation Bond, including recent outreach to the County Board of Supervisors and ongoing

efforts to clarify the bond structure and long-term repayment schedule. CEO Wallis reported that a consultant has been engaged to analyze and reconstruct the bond amortization schedule and evaluate strategies to mitigate potential future taxpayer impact.

Public Comment: None.

Board Discussion

Board members discussed the importance of transparency, coordination with the County Auditor-Controller and Treasurer, and proactive planning to ensure long-term fiscal responsibility. The Board expressed support for continued analysis and public communication regarding the bond repayment strategy.

QUALITY COMMITTEE

Beta

Quality Manager Feinberg provided an update on the Beta program, reporting that several leaders attended a recent conference and are preparing to launch the 2026 SCORE survey focused on culture of safety and employee engagement. She also reported continued implementation of Beta processes related to patient harm events, including root cause analysis and patient and family engagement following reportable incidents.

Public Comment: None.

Board Discussion: None

CHNA

This item will be presented at the March 2026 meeting.

Quality Committee Charter

Administration presented the proposed Quality Committee Charter, noting it follows the same format and structure as previously approved Finance and Governance Committee charters. The charter outlines the committee's purpose, responsibilities, and reporting structure.

Public Comment: None.

Board Discussion: None

Motion by Turner to approve the Quality Committee Charter

2nd: Egan

Pass: 4-0

Quality Dashboard

Quality Manager Feinberg presented the quarterly Quality Dashboard, reporting zero central line-associated bloodstream infections (CLABSI) and catheter-associated urinary tract infections (CAUTI), low readmission and mortality rates, and stable performance across key quality indicators. One sentinel event

involving a patient fall with injury was reported, and administration completed a root cause analysis in alignment with established protocols, including patient and family engagement. Updates were also provided on patient satisfaction scores, employee engagement, turnover, and workplace safety metrics.

Public Comment: None.

Board Discussion

Board members asked for clarification regarding the sentinel event, including the nature of the incident and whether it met Joint Commission reporting criteria. Administration explained that patient falls with injury are among the most common reportable sentinel events, that a root cause analysis was completed, and that the patient and family were engaged consistent with Beta transparency practices. Board members also asked about overall trends in quality metrics and expressed appreciation for the continued strong infection prevention performance and transparent reporting.

FINANCE COMMITTEE

Financial Audit

CFO Mossman presented the final audited financial statements for Fiscal Year 2025, noting minor reclassifications from the draft version previously reviewed by the Board. Changes included the reclassification of estimated third-party settlements to assets and the reallocation of certain expenses between categories, with no impact to total operating expenses or net income. The District's net income for the fiscal year remained approximately \$5 million.

Public Comment: None.

Board Discussion

Board members asked clarifying questions regarding the noted reclassifications and confirmed that the changes did not affect overall financial performance.

Motion by Egan to accept the Financial Audit

2nd: Smith

Pass: 4-0

Financial and Statistical Report

CFO Mossman presented the December Financial and Statistical Report, noting that while overall year-to-date results reflect a budget variance largely due to a reduction in Intergovernmental Transfer (IGT) funding, December operations showed improved performance with increased volumes, particularly in orthopedic services. Accounts receivable days improved to industry-standard levels, and cash collections strengthened, though cash reserves have declined due to operating losses, debt service payments, and capital expenditures. Administration also provided an update on bond covenant metrics and ongoing efforts to improve revenue cycle performance and financial stability.

Public Comment: None.

Board Discussion

Board members discussed the impact of reduced IGT funding, debt service coverage requirements, and cash reserves, and asked questions regarding orthopedic volume trends and operational recovery strategies. Administration responded that volumes are trending upward, revenue cycle improvements are yielding results, and leadership is focused on expense management and service line growth to improve financial performance.

Motion by Smith to accept the Financial and Statistical Report

2nd: Egan

Pass: 4-0

Financial Projection

CFO Mossman presented the updated financial projection, outlining anticipated year-end performance based on current operating trends and the reduction in Intergovernmental Transfer (IGT) funding. The projection reflected a more conservative outlook due to decreased supplemental funding, while also noting recent improvements in surgical volumes, revenue cycle performance, and January preliminary results trending positively. Administration emphasized continued focus on expense management, service line growth, and operational efficiencies to mitigate projected losses.

Public Comment: None.

Board Discussion

Board members discussed the assumptions used in the projection, the impact of reduced IGT funding on cash reserves and bond covenant compliance, and strategies to stabilize financial performance. Administration noted that January results showed improved operating performance and that the projection represents a conservative scenario, with ongoing efforts to strengthen volumes and revenue collections.

Ortho Service Line

CMO Hawkins and Administrative Head of Diagnostic Services Weber provided an update on the Orthopedic Service Line, reviewing historical volume trends, factors contributing to the decline in late 2024, and corrective actions implemented to stabilize operations. They reported steady improvement in surgical case volumes over the past two quarters, improved scheduling processes, and positive preliminary results for January. Leadership outlined continued efforts to strengthen recruitment stability, optimize workflow, and support sustainable growth in orthopedic services.

Public Comment: None.

Board Discussion

Board members asked about the sustainability of current volume increases and whether projections indicate continued growth. CMO Hawkins and Weber responded that current scheduling patterns and referral trends support continued recovery, and that operational adjustments have positioned the service line for ongoing stabilization and growth.

**GENERAL INFORMATION
FROM BOARD MEMBERS**

A Board member reiterated the importance of formally reviewing the District's upfront cash collection policy at a future meeting, referencing earlier public comment and requesting the matter be scheduled for Board discussion.

A Board member reported attending a recent meeting of the County Board of Supervisors and noted the value of continued collaboration and transparency with local government partners regarding District financial matters and strategic planning efforts.

Board members also acknowledged ongoing community outreach efforts and emphasized the importance of maintaining clear communication with the public regarding District operations, financial performance, and future planning initiatives.

ADJOURNMENT

Adjournment at 6:50 pm.

Melissa Best-Baker
Northern Inyo Healthcare District
Chair

Attest: _____
Maggie Egan
Northern Inyo Healthcare District
Secretary

CALL TO ORDER	Northern Inyo Healthcare District (NIHD) Board Chair Best-Baker called the meeting to order at 12:03 pm.
PRESENT	Melissa Best-Baker, Chair David Lent, Vice-Chair Maggie Egan, Secretary Laura Smith, Treasurer Jean Turner, Member at Large Christian Wallis, Chief Executive Officer Allison Partridge, Chief Operations Officer / Chief Nursing Officer Alison Murray, Chief Human Resources Officer, Chief Business Development Officer Andrea Mossman, Chief Financial Officer
TELECONFERENCING	Notice has been posted, and a quorum participated from locations within the jurisdiction.
PUBLIC COMMENT	Chair Best-Baker reported that at this time, audience members may speak on any items not on the agenda that are within the jurisdiction of the Board. Public Comment: None
BROWN ACT	BBK Caughman provided an overview of the Brown Act and its purpose of ensuring transparency and public access to the decision-making processes of local agencies. She reviewed the history of the law, noting that it was created to prevent decision-making outside of public view and to ensure that discussions and deliberations of legislative bodies occur openly. Caughman explained what constitutes a meeting under the Brown Act, including the concept of serial meetings and how communications between members—whether through email, text, intermediaries, or social media—can unintentionally violate the law. She emphasized that board members should avoid replying to group communications or sharing opinions outside of a properly noticed meeting. The presentation also reviewed meeting requirements such as agenda posting timelines, public comment procedures, teleconferencing rules, and the limited circumstances under which closed sessions may occur. Caughman also discussed the relationship between the Brown Act and the Public Records Act, reminding board members that communications related to district business may be subject to public records requests. Board Discussion The board asked questions regarding joint meetings with another healthcare district, use of surveys to gather board input, meeting procedure order, and social media interactions. Discussion also included responding to public comment and exploratory meetings with tribal health organizations. Caughman

provided clarification on Brown Act compliance for each topic.

FISCAL AND FINANCIAL
TRAINING

CSDA provided the required financial and fiscal training for board members. The presentation reviewed the financial oversight responsibilities of board members and provided guidance on best practices for fiscal governance and accountability.

ADJOURNMENT

Adjournment at 3:00 pm.

Melissa Best-Baker
Northern Inyo Healthcare District
Chair

Attest:

Maggie Egan
Northern Inyo Healthcare District
Secretary



NORTHERN INYO HEALTHCARE DISTRICT CLINICAL POLICY AND PROCEDURE

Title: Admission Procedure of Pediatric Patient		
Owner: Manager, ICU and Acute Subacute	Department: Acute/Subacute Unit	
Scope: Acute/Subacute Unit		
Date Last Modified: 10/29/2025	Last Review Date: No Review Date	Version: 10
Final Approval by: NIHD Board of Directors	Original Approval Date: 03/1995	

PURPOSE:

To prepare the pediatric patient and their legal guardian for the hospital stay, establish a friendly, therapeutic relationship between the patient, parents, and hospital staff by thoroughly orienting them to the department, explaining procedures and equipment involved, obtaining necessary information about the patient, and obtaining consents for special treatments or surgery.

POLICY:

All patients will be assigned an appropriate room utilizing diagnosis and age-specific considerations. A “Quick Check” of each patient will be completed within 30 minutes of arrival. The time of admission is the time that the patient arrives at the department.

DEFINITIONS:

Pediatric – The patient age-specific population defined as pediatric is aged 28 days to 13th birthday.

PROCEDURE:

1. Prior to admission:
 - A. Get “Room Ready” by obtaining:
 - a. Age-appropriate crib or bed
 - b. Age-appropriate scale for admission weight
 - c. Measuring tape for head circumference measurement (As Needed)
 - d. Pediatric blood pressure cuff
 - e. Patient labeled pediatric stethoscope
 - f. Age and size-appropriate apparel
2. Upon Admission:
 - A. Greet parents and patient in a friendly manner using AIDET.
 - B. Complete a quick check.
 - C. Obtain a complete set of vital signs, including blood pressure.
 - D. Obtain height and weight
 - a. Obtain the correct colored square paper that corresponds to the Broselow Pediatric Emergency Tape and write the weight on this colored square.
 - i. Attach the colored square to the head of the bed or the foot of the crib
 - ii. Place a colored square on the door
 - iii. Inform parents of the importance of the colored paper
 - iv. Make a copy of the appropriate color Broselow Emergency Tape (front and back) and hang it on the bed or crib, as well as on the door
 - E. Complete the pediatric admission assessment form with the parents’ and patient’s assistance.

- F. Attach the patient security tag to the child's leg or arm and activate it per policy. Inform the parents what this is for, where in the unit they are able to go with the child, and answer any questions related to child security and safety.
- G. After confirming the correct name and date of birth, apply the armband to the pediatric patient.
- H. Apply a duplicate armband to the legal guardian of the pediatric patient. (Parent/Legal guardian)
- I. Complete a **CODE PINK INFORMATION SHEET. Place it in the first section of the chart.**
- J. Ensure that a photo of the child is uploaded onto the EHR.
- K. Make the patient as comfortable as possible.
- L. Discuss NIHD fall prevention and precautions taken while the patient is in the hospital.
 - a. Show the older pediatric patient and all parents how to use the call bell.
 - b. Explain intake and output (I&O) as well as the need to measure all I&O of fluids.
 - c. Explain the use of the urinal, bedpan, commode, and emesis bag.
 - d. If the pediatric patient is able to ambulate, give them a full room orientation.
 - e. Place a pitcher of water at the bedside if the patient is able to drink fluids.
 - f. Explain the use of the pediatric pain scale.
 - g. Give parents the WIFI password.
- M. Review physicians' orders:
 - a. If medication is ordered, print out medication information from Up-to-Date on each medication the RN will be administering
 - b. Calculate dosage based on the pediatric patient's weight
 - c. Verify dose with second RN or qualified Healthcare Professional. (**New Dose calculation needed with weight change.**)
 - d. The Respiratory Therapist will be responsible for double-checking the respiratory medications they will be administering.
- N. Place the vital signs chart taped to the vitals machine. Normal ranges highlighted.
- O. Include parents in the care of the child, being considerate and kind in your approach.
 - a. Provide parents with the Pediatric Unit Welcome Letter. Allow the parent time to read the letter and stand by to answer any questions they may have.
 - b. Parents are to be encouraged to become involved in the child's care.
 - c. Explain to parents that no smoking is allowed at Northern Inyo Hospital, including the outside grounds. The Parent Letter discusses the smoking policy.
- P. Explain all treatments and procedures the parent and patient should anticipate.
- Q. Initiate Patient Care Plan and share with parent and patient as appropriate.
- R. At the time of discharge, the **Child Safety Seat** form will be signed.

REFERENCES:

1. General Acute Care Hospitals, 22 CCR Div. 5, 2014.
2. ANA. (2010). *Nursing Scope and Standards of Practice*. Silver Spring, MD: Nursesbooks.org

CROSS REFERENCE POLICIES AND PROCEDURES:

1. Pediatric Standards of Care and Routines
2. Newborn & pediatric Abduction Prevention Safety and Security
3. Weights for Infant and Pediatric Patients

Supersedes: v.9 Admission Procedure of Pediatric Patient
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NORTHERN INYO HEALTHCARE DISTRICT CLINICAL POLICY AND PROCEDURE

Title: Cleaning and Care of Surgical Instruments		
Owner: Perioperative Manager	Department: Surgery	
Scope: Sterile Processing and Surgery		
Date Last Modified: 09/19/2025	Last Review Date: No Review Date	Version: 6
Final Approval by: NIHD Board of Directors	Original Approval Date: 02/04/2010	

PURPOSE:

Personnel in Sterile Processing have a vital role in the continuing battle against microorganisms. The proper handling of equipment that has been used or contaminated is not a mere function, but an obligation for patient and personnel safety. Continuous emphasis must be exerted in order to have personnel carry out the necessary steps.

POLICY:

Manufacturer's written, validated instructions for handling and reprocessing should be obtained and evaluated to determine the ability to adequately clean and reprocess the equipment. The manufacturer's written instructions should be used to determine how to properly clean and sterilize instruments.

It is our policy NOT TO REPROCESS SINGLE-USE ITEMS for patient use. All personnel practice standardized precautions and wear protective gowns, glasses, goggles, and gloves when appropriate.

PROCEDURE:

New, Repaired, or Refurbished Instruments:

- All new, repaired, or refurbished instruments should be examined, cleaned, and sterilized according to the manufacturer's written instructions before use.
- All moving parts, tips, box locks, ratchets, screws, and cutting edges should be examined for defects and to ensure proper working order.
- Instruments should be pre-treated according to the manufacturer's written instructions when indicated.
- All instruments should be decontaminated according to the manufacturer's written instructions before use.
- All instruments should be sterilized according to the manufacturer's written instructions before use.

Loaner Instruments

Upon scheduling a procedure that requires loaner instrumentation, the Surgery Manager, Materials Management Analyst, or designee contacts the vendor or other hospital facility to arrange a timely delivery of instruments and implants.

- Loaner instruments should be requested when the surgery is scheduled, and delivered in time for the surgical procedure to allow inspection and inventory of instruments.
- Loaner instruments should be logged in and inventoried before use.
- Loaner instruments should be considered contaminated and are delivered to the decontamination area for processing.
- All moving parts, tips, box locks, ratchets, screws, and cutting edges should be examined for defects and to ensure proper working order.
- Vendors will provide manufacturers' written instructions for disassembly, cleaning, packaging, and sterilization of instruments and implants.

- All loaner instruments and implants will be cleaned, inspected, inventoried, wrapped, sterilized, cooled, documented, and tracked to each patient according to published standards, manufacturer instructions, and hospital policy and procedure.
- Quality control sterilization monitoring will be done per hospital policy and procedures.
- If an item must be released from quarantine because of a documented necessity, all other monitors: sterilization cards, chemical integrator, and biological indicator should be reviewed, and documentation reflects that the item was released without the results of the Biological Indicator being known. The physician will be notified of the situation.
- After the surgical procedure is completed, the borrowed instruments should be disassembled, cleaned, and decontaminated.
- The instruments are to be returned to the source from which they were borrowed per their instruction.

Preliminary Steps in Surgery

- Instruments should be wiped with sterile water-moistened sponges as needed during the surgical procedure to remove gross soiling to prevent corrosion, rusting, and pitting.
- Instruments with lumens should be irrigated with sterile water as needed throughout the surgical procedure.
- Cautery tips should be cleaned frequently to prevent eschar build-up.
- Instruments needing repair should be tagged or labeled and removed from service until repaired.

Cleaning and decontamination of Surgical Instruments.

- Decontaminate the instruments at the point of use – see above.
- All instruments opened in the operating or procedure rooms need to be decontaminated, whether or not they have been used.

Sorting

- Sharp instruments should be segregated from other instruments.
- Disposable sharps should be removed and discarded into proper receptacles.
- Reusable sharp instruments, including scissors, should be placed in a separate puncture-proof receptacle for transportation, such as an emesis basin.
- Reusable scalpel handles should be considered sharp instruments

Transportation to Decontamination Area

- Soiled instruments must be transported covered and contained in a manner to prevent exposure to patients or personnel to blood-borne pathogens and other potentially infectious organisms.
- Soiled instruments from the ancillary departments and clinics will be transported to the decontamination area in covered containers by the perioperative courier.
- Hand-carried must be contained in a container with a lid.
- Large quantities of items must be contained in a cart or transport container with doors or a plastic cover.
- Items placed on top of the cart must be contained safely to prevent falling off.

Cleaning

Instruments should be decontaminated in an area separated from locations where clean activities are performed.

- Instruments should not be decontaminated in scrub or hand sinks.
- The decontamination area should be physically separate from clean areas and include a door.

The area should contain:

Sinks

Hand washing facilities

Eye wash station
Automated equipment consistent with the types of instruments to be decontaminated
Compressed air supply
Adaptors and accessories to connect instruments with cleaning equipment and utilities.

Water Quality

- Potable water should be used for manual or mechanical decontamination cleaning methods unless contraindicated by the manufacturer's instructions.
- Softened or de-ionized water should be used for the final rinse.
- Water quality assessment should be performed periodically or after maintenance of water sources. Impurities in the water can reflect insufficient filtration, necessitating repairs based on testing.

Manufacturer's Instructions

Following the manufacturer's instructions decreases the possibility of cleaning agents harming instruments.

Cleaning Methods

Manufacturer's instructions should be followed regarding types of cleaning methods (e.g., manual, automated) to be used for decontamination.

Manual cleaning

- Before beginning the cleaning process, instruments should be rinsed with water to remove gross debris.
- Instruments should be thoroughly washed.
- Some delicate instruments, power equipment, and other instruments that cannot be submerged should be cleaned manually.
- Instruments should be completely submerged in warm water and appropriate detergent for 5 minutes prior to cleaning.
- Instruments should be completely submerged in rinse solution after cleaning.
- Mechanical cleaning of surgical instruments is accomplished by ultra-sonic cleaners, washer-decontaminators/disinfectors, or washer-sterilizers.

Ultrasonic cleaners

- Ultra-sonic cleaners should be used according to the manufacturer's instructions.
- Ultra-sonic cleaners should be used only after gross soiling has been removed.
- Manufacturer's instructions regarding detergent selection and "degassing" should be followed.
- Only instruments made of similar materials should be combined, unless specified otherwise.
- Some instruments should not be placed in an ultrasonic cleaner
 - Chrome-plated instruments
 - Power instruments
 - Rubber, silicone, or plastic instruments
 - Endoscopic lenses
- Instruments with lumens should be submerged and filled with cleaning solution to remove air from within the channel.
- Instruments should be thoroughly rinsed after ultrasonic cleaning.
- A lid should be in place to prevent aerosolization of contaminants.
- Cleaning solutions should be checked between cycles and changed if visibly soiled.
- Ultra-sonic cleaners should be emptied each day, cleaned, rinsed with sterile water, and the chamber wiped with alcohol or other disinfectant, as per the manufacturer's recommendation.

Automated washer decontaminators or disinfectors, washer/sterilizers

The amount of time necessary to efficiently clean and rinse instruments is determined according to the manufacturer's instructions.

Inspection of surgical instruments

- Instruments should be inspected for
 - Cleanliness
 - Alignment
 - Corrosion, pitting, burrs, nicks, and cracks
 - Sharpness of cutting edges
 - Loose set pins
 - Wear and chipping of inserts and plated surfaces
 - Missing parts
 - Any defects
 - Removal of moisture
 - Proper functioning
 - Instruments should be thoroughly dried.

Lubricants

- Use the manufacturer's written instructions for selection and use of lubricants
- Instruments should be clean before lubrication.
- Lubricants should be compatible with the method of sterilization to be used.

Disinfection of Instruments

Instruments will be disinfected prior to handling in the washer-disinfectant following policy and procedure.

Packaging

Instruments to be processed should be packaged and sterilized according to AORN recommendations.

Sterilization

Cleaned surgical instruments should be organized for packaging to allow the sterilant to contact all exposed surfaces.

- Instruments should be placed in a container that is large enough to evenly distribute the metal mass in a single layer.
- Broad-surfaced or concave-surfaced instruments should be placed on edge to facilitate drying.
- Instruments with hinges should be opened, and those with removable parts should be disassembled when placed in trays designed for sterilization, unless indicated to the contrary.
- Instruments should be kept open and unlocked using instrument stringers, racks, or instrument pegs designed to contain instruments.
- Delicate and sharp instruments should be protected using a device such as tip protectors.
- Heavy instruments should be positioned at the bottom of the tray to prevent damage to delicate items.
- Only validated containment devices should be used to organize or segregate instruments within sets.
- Rubber bands should not be used to keep instruments together.
- Paper-plastic peel pouches should not be used inside the tray unless validated by the manufacturer.

Powered Surgical Instruments

Powered surgical instruments and all attachments should be decontaminated, lubricated, assembled, sterilized, and tested before use according to the manufacturer's written instructions.

- Powered instruments and attachments should be cleaned and maintained according to the manufacturer's instructions.
- Attachments should be properly affixed to instruments and tested before use.
- Trigger handles should be placed in a safe position when changing attachments.
- Medical-grade compressed air or nitrogen should be used to operate air-powered equipment according to the manufacturer's instructions.
- To determine the correct pressure setting, use the manufacturer's instructions.
- Only grounded outlets shall be used for electrical powered equipment.

Ophthalmic Surgical Instruments

Special precautions shall be taken before reprocessing ophthalmic surgical instruments.

- Instruments should be wiped clean with sterile water and a lint-free sponge during the surgical procedure to remove viscoelastic solution, which can harden quickly.
- Instruments should be immersed in sterile water immediately at the end of the procedure.
- A single-use cannula should be used whenever possible.
- Manufacturer's instructions for cleaning each instrument should be reviewed and followed.
- Irrigation and aspiration ports, phacoemulsification hand piece, tips, and tubing should be flushed before disconnecting the hand piece from the unit. (see manufacturer instructions for the Quick Rinse system)
- Intraocular lens injectors and lens inserters should be carefully cleaned.

Insulated electrosurgical instruments

- Insulated electrosurgical instruments should be inspected for small breaks in insulation before initial use and after decontamination.
- Insulated instruments should be kept away from sharp instruments and segregated from sharp objects after the case.

Personal Protective Equipment

Personnel handling contaminated instruments and equipment must wear appropriate personal protective equipment (PPE) and should be vaccinated against the Hepatitis B virus.

- PPE consistent with the anticipated exposure should be worn.
- The appropriate PPE for this exposure should include, but not be limited to,
 - A fluid-resistant gown
 - Heavy-duty gloves
 - Mask
 - Face protection
- Hands must be washed after removing PPE.
- Reusable PPE must be decontaminated, and the integrity of the attire must be checked between each use.
- Two pairs of gloves should be worn when cleaning instruments and equipment if there is a risk for perforation.
- Personnel working with contaminated equipment should be vaccinated against the Hepatitis B virus.

Competency

Ongoing education, competency, and validation of personnel facilitate the development of knowledge, skills, and attitudes that affect patient and worker safety.

Documentation

Documentation should be completed to enable the identification of trends and demonstrate compliance with regulatory and accreditation agency requirements.

- Records should be maintained for the time period specified (life of equipment plus 6 years)

PRECAUTIONS:

Care must be taken at all times to ensure that no sharps, i.e., knife blades or needles, are mixed in with instruments to be cleaned. Care must be taken to ensure that careful handling of instruments is followed to prevent injury from sharp instruments such as towel clips, skin hooks, etc.

REFERENCES:

1. Central Supply Technician Training Manual
2. AORN RP Cleaning and Care of Surgical Instruments
3. AAMI ST79
4. TJC: IC.02.01.01, IC.02.05.01
5. Title 22 Standards: 70831 (Central Sterile Supply), 70833 (Autoclaves and Sterilizers)

RECORD RETENTION AND DESTRUCTION:

Sterilization records **must** be maintained for 1 year. The recommendation is that the sterilization records should be maintained for the life of the equipment plus 6 years.

CROSS-REFERENCED POLICIES AND PROCEDURES:

1. Packaging, Wrapping, and Dating Trays and Instruments
2. Precleaning and Returning of Instruments to Sterile Packaging

Supersedes: v.5 Cleaning and Care of Surgical Instruments



NORTHERN INYO HEALTHCARE DISTRICT CLINICAL POLICY AND PROCEDURE

Title: Code Blue (Adult Cardiac Arrest) and Code White (Pediatric Arrest) Documentation		
Owner: Manager of ED and Disaster Planning		Department: Emergency Department
Scope: Hospital Wide		
Date Last Modified: 11/07/2025	Last Review Date: 2/22/18	Version: 4
Final Approval by: NIHD Board of Directors		Original Approval Date: 11/2017

PURPOSE:

- To ensure that Code Blue and Code White resuscitations are documented consistently throughout the hospital.
- To provide a documented record of care delivered during the resuscitation process.
- To serve as verification for reimbursement.

POLICY:

- The *Northern Inyo Hospital Resuscitation Record* will be used for documentation during cardiac arrest, respiratory arrest, or other code blue or code white resuscitation efforts for all adults and pediatrics. The *Neonatal Code Blue Sheet* will be used for all neonatal resuscitations.
- Any cardiac arrest in the operating room will follow the Cardiac Arrest in OR Policy and will use either the *Northern Inyo Resuscitation Record* or the *Neonatal Code Blue Sheet* for documentation, as appropriate.
- Respiratory Therapy shall record their activity and observations in the patient's electronic health record.
- The Code IV RN has responsibility for the documentation done during the resuscitation event, and must review with the Code I RN for complete and appropriate documentation, then will co-sign the *Northern Inyo Hospital Resuscitation Record* document.

PROCEDURE:

- Apply a sticker or write the patient's name on all forms used for documentation.
- Date all forms.
- Chart the specific time of the entry or the specific time each event took place when documenting on the Resuscitation Record.
- Number ALL pages of the resuscitation record in consecutive order beginning with page one and filling in the TOTAL number of all pages. Include all supporting narrative pages and supportive monitor strips. Example: Page 1 of 6
- Write on the lines provided and draw a line through any unused spaces or pages. Note "N/A" in spaces on the record where information is not applicable.
- Record and post rhythm strips of all events of resuscitation- initial rhythm, post-defibrillation, post-resuscitation medication, any change in rhythm, and termination of resuscitation.

DOCUMENTATION:

Page 1 of document

- Document time of arrest and place of arrest. (Med-Surg, ICU, private residence, etc.)
- Document, if appropriate, if brought in by EMS, and what type (BLS, ALS), and estimated pre-hospital downtime.
- Document all other ancillary departments called and arrival time to the unit.
- Document all procedures initiated by EMS in the field or initiated by the Code Blue or Code White team on the unit. (e.g., Endotracheal tube ETT, Intraosseous IO, Nasogastric or Orogastic tube NGT/OGT, Foley Catheter, etc.) Include sizes of tubes, site, drainage, etc.
- Document under *Notes* the patient assessment during the initiation of Code Blue or Code White and other narrative documentation.
- Obtain signatures of all members of the Code Team, including responding physicians and ancillary departments.
- Document, if appropriate, when resuscitation efforts were discontinued and the pronouncing physician.
- Document disposition of patient if transferred to other facility or unit.

Page 2 of the document

- Document initial vital signs on arrival of EMS, Code Blue, or Code White team.
- Document initial assessment according to determined systems.
- Obtain signatures of staff performing assessments.

Page 3 of the document

- Document in appropriate columns: time, MAP/temperature, heart rate, cardiac rhythm, defibrillation joules, O2/ SpO2, ETCO2, medications administered with dosage and route, and initials of staff administering medication, GCS/LOC.
- Document under *Notes* other documentation for procedures and other assessments (CPR in progress, CPR stopped, Portable Chest X-ray, bloods drawn, etc.)
- Obtain signatures of staff administering medications, performing procedures, or involved in continuing resuscitation.

Page 4 of the document.

- Document repeat assessments according to systems. If no change in patient status, “no change” may be written.
- Document any other narrative documentation.

REFERENCES:

1. Code Blue Procedure – Code Blue Team
2. Code White Procedure – Code White Team

RECORD RETENTION AND DESTRUCTION:

CROSS REFERENCE POLICIES AND PROCEDURES:

1. Rapid Response Team
2. Emergency Medication and Code Blue Crash Cart Policy
3. Cardiac Arrest in the Operating Room

Supersedes: v.3 Code Blue (Cardiac Arrest) Documentation
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NORTHERN INYO HEALTHCARE DISTRICT NON-CLINICAL POLICY AND PROCEDURE

Title: Electronic Communication (Email) Acceptable Use Policy and Procedure		
Owner: Director of IT		Department: Information Technology
Scope: Districtwide		
Date Last Modified: 03/13/2026	Last Review Date: No Review Date	Version: 2
Final Approval by: NIHD Board of Directors	Original Approval Date: 06/21/2017	

PURPOSE:

Email is a critical mechanism for business communications at Northern Inyo Healthcare District. Use of Northern Inyo Healthcare District's electronic mail systems and services is a privilege, not a right, and therefore must be used with respect and in accordance with the mission of NIHD.

The objectives of this policy are to outline appropriate and inappropriate use of Northern Inyo Healthcare District's email systems and services to minimize disruptions to services and activities, as well as comply with applicable policies and laws.

SCOPE:

This policy applies to all workforce members, NIHD Board Members, and clinically privileged physicians and allied health professionals. This policy applies to all email systems and services owned by NIHD, all email account users at NIHD (both temporary and permanent), and all district email records.

DEFINITIONS:

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

Restricted Information: Describes any confidential or personal information that is protected by law or policy and that requires the highest level of access control and security protection, whether in storage or in transit. This includes PHI/ePHI and Other Medical Staff and AHP Communication as defined in this section.

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

Other Physician and AHP Communication: Some examples of Other Physician and AHP Communication include, but are not limited to:

- Notice of proposed changes and revisions to the Medical Staff Bylaws and Policies & Procedures;
- CME opportunities;
- Notification of medical record delinquencies;

- CEO memoranda;
- Licensure/certificate expiration notices;
Medical Staff Service/Committee meeting notices.

POLICY:

1. Email access at NIHD is controlled through individual accounts and passwords. Each user of NIHD's email system is required to read and acknowledge understanding of this email acceptable use policy. It is the responsibility of the workforce member, NIHD Board Member, clinically privileged physician, or allied health professional to protect the confidentiality of their account and password information.
2. All email communication from NIHD workforce members to NIHD's clinically privileged Physicians and AHPs will only be sent to valid nih.org email addresses.
3. All email communication from NIHD's clinically privileged Physicians and AHPs should only be transmitted using a nih.org email address, with the following exception:

EXCEPTION

Telemedicine Staff: Emailing of Restricted Information/Other Physician and AHP Communication from NIHD's clinically privileged telemedicine physicians to NIHD's Workforce and/or to any other entity or person should only be transmitted using a nih.org email address **or** an email address associated with the organization with whom NIHD has an agreement. Any exception request to use another organization's email address will be reviewed on a case-by-case basis by the NIHD executive team, the IT department, and the Medical Staff Admin office.

4. NIHD often delivers official communications via email. As a result, all workforce members, NIHD Board Members, clinically privileged physicians, and allied health professionals are expected to check their NIHD email consistently and promptly so that they are aware of important announcements and updates, as well as for fulfilling business and role-oriented tasks.
5. Email users are responsible for mailbox management, including organization and cleaning. If a user subscribes to a mailing list or list serve, he or she must be aware of how to unsubscribe from the list, and is responsible for doing so in the event they no longer wish to subscribe to the mailing list or list serve.
6. Email users are expected to remember that emails sent from NIHD email accounts reflect on the district. Please comply with normal standards of professional and personal courtesy and conduct.
7. Acceptable Email Signatures – Email users will clearly identify their name, relevant certifications, job title, and department. In order to conserve space, graphics other than the district logo are prohibited in email signatures.
Example:
Name, certifications
Title and Department
Northern Inyo Healthcare District
Improving our communities, one life at a time. One Team. One Goal. Your Health!
8. Auto forwarding of emails to accounts outside of NIHD is strictly prohibited.
9. NIHD does not permit emailing unencrypted Protected Health Information (PHI). Emails sent outside the nih.org domain are not always protected from interception during transmission and may be read at their destination by individuals other than the intended recipient. A secure email solution (i.e., encryption) must

be utilized for all email messages containing Restricted Information. – See “Communicating Protected Health Information Via Electronic Email” policy

10. Email messages that include or could potentially include confidential NIHD information may not be forwarded, or otherwise transferred to non-NIHD accounts, including but not limited to personal and commercial email accounts such as Gmail, Yahoo, Hotmail, etc.
11. Email access will be terminated when the workforce member, NIHD Board Member, clinically privileged physician, or allied health professional terminates their association with NIHD. NIHD is under no obligation to store or forward the contents of an individual’s email inbox/outbox after the term of their employment has ceased.
12. The following activities are deemed inappropriate uses of NIHD email systems and services, and are strictly prohibited. Inappropriate use includes, but is not limited to:
 - Use of email for illegal or unlawful purposes, including copyright infringement, obscenity, libel, slander, fraud, defamation, plagiarism, harassment, intimidation, forgery, impersonation, soliciting for illegal pyramid schemes, and computer tampering (e.g., spreading of computer viruses).
 - Use of email in any way that violates NIHD’s policies, rules, or administrative orders, including, but not limited to, the NIHD Code of Business Ethics and Conduct
 - Sending of unreasonably large email attachments. The total size of an individual email message sent (including attachments) should be 10 MB or less. If the need arises to transfer a larger amount of data, please contact the NIHD IT department for file transfer rights.
 - Opening email attachments from unknown or unsigned sources. Attachments are the primary source of computer viruses and should be treated with utmost caution.
 - Sharing email account passwords with another person, or attempting to obtain another person’s email account password. Email accounts are only to be used by the registered user.
 - Excessive personal use of NIHD email resources. NIHD allows limited personal use for communication with family and friends, independent learning, and public service so long as it does not interfere with staff productivity, pre-empt any business activity, or consume more than a trivial amount of resources. NIHD prohibits personal use of its email systems and services for unsolicited mass mailings, non-NIHD commercial activity, political campaigning, and dissemination of chain letters.
13. The email systems and services used at NIHD are owned by the district and are therefore its property. This gives NIHD the right to monitor any email traffic passing through its email system. This monitoring may include, but is not limited to, review by the legal team during the email discovery phase of litigation, observation by management in cases of suspected abuse, or monitoring employee efficiency.
14. Archival and backup copies of email messages may exist, despite end-user deletion, in compliance with NIHD’s records retention policy. The goals of these backup and archiving procedures are to ensure system reliability, prevent business data loss, meet regulatory and litigation needs, and to provide business intelligence.
 - Backup copies exist primarily to restore service in case of failure. Archival copies are designed for quick and accurate access by company delegates for a variety of management and legal needs. Both backups and archives are governed by the company’s document retention policies.

15. Use extreme caution when communicating confidential or sensitive information via email. Keep in mind that all email messages sent outside of NIHD become the property of the receiver. Consider not communicating anything that you wouldn't feel comfortable having made public. Demonstrate particular care when using the "Reply All" command during email correspondence to ensure the resulting message is not delivered to unintended recipients.
16. Any allegations of misuse should be promptly reported to the Human Resources and Information Technology departments. If you receive an offensive email, do not forward, delete, or reply to the message. Instead, report it directly to the IT Helpdesk.

PROCEDURE:

1. All workforce members, NIHD Board Members, and clinically privileged physicians and allied health professionals (AHP) will be issued nih.org email addresses by the NIHD IT Department. (Telemedicine staff may opt out if using an email address associated with the organization with whom NIHD has an agreement)
2. All workforce members, NIHD Board Members, and clinically privileged Physicians and AHPs will be trained on how to set up their email accounts and/or personal computer email access through: Hospital-wide general orientation, and/or scheduled orientation with the IT Department.
3. All clinically privileged Physicians and AHPs, NIHD Board Members, or exempt workforce members wishing to access their nih.org email remotely may follow the URL link, where they will be asked for their login credentials:

<https://webmail.nih.org>
4. Any questions on emailing restricted information should be referred to the Information Technology Department.

REFERENCES:

CROSS REFERENCE P&P:

1. Communicating Protected Health Information Via Electronic Mail (Email)

Supersedes: v.1 Electronic Communication (Email) Acceptable Use Policy
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NORTHERN INYO HEALTHCARE DISTRICT

CLINICAL POLICY

Title: Fetal Monitoring NICHD (National Institute of Child Health and Development) Terminology and Procedures		
Owner: Interim Perinatal Manager	Department: Perinatal	
Scope:		
Date Last Modified: 11/19/2025	Last Review Date: No Review Date	Version: 1
Final Approval by: NIHD Board of Directors	Original Approval Date:	

PURPOSE: To provide standardized and quantitative terminology to describe fetal heart rate tracings and evidence-based interventions

POLICY: NICHD terminology will be used when describing and interpreting fetal heart rate tracings and will be used to determine interventions.

Nursing interventions may be initiated independently. Interventions requiring a provider order should be completed only after obtaining the order.

PROCEDURE:

NICHD Terminology:

Baseline fetal heart rate is the average fetal heart rate (FHR) rounded to increments of 5 beats per minute during a 10-minute segment, excluding periodic or episodic changes, periods of marked variability, or baseline segments that differ by more than 25 beats per minute. A normal baseline rate ranges from 110 to 160 BPM.

FHR variability is based on visual assessment and excludes sinusoidal patterns. Variability is defined as fluctuations in the FHR baseline of 2 cycles per minute or greater, with irregular amplitude and inconstant frequency. These fluctuations are visually quantified as the amplitude of the peak to trough in beats per minute, as shown below:

Amplitude Range	Classification
Undetectable	Absent
Undetectable to ≤ 5 beats/min	Minimal
6 to 25 beats/min	Moderate
> 25 beats/min	Marked

Intrauterine resuscitation considerations for minimal or absent variability:

- Lateral positioning,
- IV fluid bolus of Lactated Ringer's, per provider order
- Oxygen at 10L/min via nonrebreather facemask if Maternal O2 Sat $< 95\%$ (discontinue as soon as resolved), per provider order
- Modify pushing efforts (every other or every third contraction)

- Decrease or discontinue oxytocin, remove Cervidil, hold Misoprostol, notify provider

Sinusoidal pattern differs from variability in that it demonstrates a smooth, sine wave-like pattern of regular frequency and amplitude and is incompatible with the definition of variability. *See category III*

Acceleration is defined as an apparent abrupt increase in FHR above baseline, with the time from the onset of the acceleration to the acme of less than 30 seconds. The increase is measured from the most recently determined portion of the baseline. The peak is 15 beats per minute or more above the baseline, and the acceleration lasts 15 seconds or more, but less than 2 minutes from the onset to the return to the previously determined baseline. In pregnancies of fewer than 32 weeks of gestation, accelerations are defined as having a peak of 10 beats per minute or more above the baseline and a duration of 10 seconds or longer.

Late deceleration is defined as an apparent gradual decrease and return to baseline FHR in association with a uterine contraction, with the time from onset of the deceleration to its nadir as 30 seconds or longer. The deceleration's timing is delayed, with the nadir of the deceleration occurring after the peak of the uterine contraction.

Intrauterine resuscitation considerations for late decelerations:

- Lateral positioning,
- IV fluid bolus of Lactated Ringer's, per provider order
- Oxygen at 10L/min via nonrebreather facemask if Maternal O2 Sat is < 95% (discontinue as soon as resolved), per provider order
- Modify pushing efforts (every other or every third contraction) per provider order
- Decrease or discontinue oxytocin, remove Cervidil, hold Misoprostol, notify provider

Early deceleration is defined as an apparent gradual decrease and return to the baseline FHR in association with a uterine contraction, with the time from onset of the deceleration to its nadir as 30 seconds or longer. Early decelerations are coincident in timing with uterine contractions, with the nadir of the deceleration occurring simultaneously with the peak of the uterine contraction.

Variable deceleration is defined as an apparent abrupt decrease in FHR below the baseline, with the time from the onset of the deceleration to the nadir of the deceleration as less than 30 seconds. Variable decelerations may or may not be associated with uterine contractions. The decrease from baseline is 15 beats per minute or higher and lasts less than 2 minutes from onset to return to baseline.

Intrauterine resuscitation considerations for variable decelerations:

- Lateral positioning,
- IV fluid bolus of Lactated Ringer's, per provider order
- Oxygen at 10L/min via nonrebreather facemask if Maternal O2 Stats are < 95% (discontinue as soon as resolved), per provider
- Modify pushing efforts (every other or every third contraction) per provider order
- Decrease or discontinue oxytocin, remove Cervidil, hold Misoprostol per provider order
- Amnioinfusion per provider

Prolonged deceleration is defined as a visually apparent decrease in FHR from baseline that is ≥ 15 bpm, lasting ≥ 2 min.

Intrauterine resuscitation considerations for prolonged decelerations:

- Lateral positioning,
- IV fluid bolus of Lactated Ringer's, per provider order
- Oxygen at 10L/min via nonrebreather facemask if maternal O2 stats are < 95% (discontinue as soon as resolved), per provider order
- Modify pushing efforts (every other or every third contraction)
- Decrease or discontinue oxytocin, remove Cervidil, hold Misoprostol, notify provider

NICHD three-tier fetal heart rate classification system

Category I

- FHR tracings include all of the following:

Category I

- baseline rate 110– 160 bpm
- baseline FHR variability moderate
- accelerations present or absent
- late or variable decelerations absent
- early decelerations present or absent

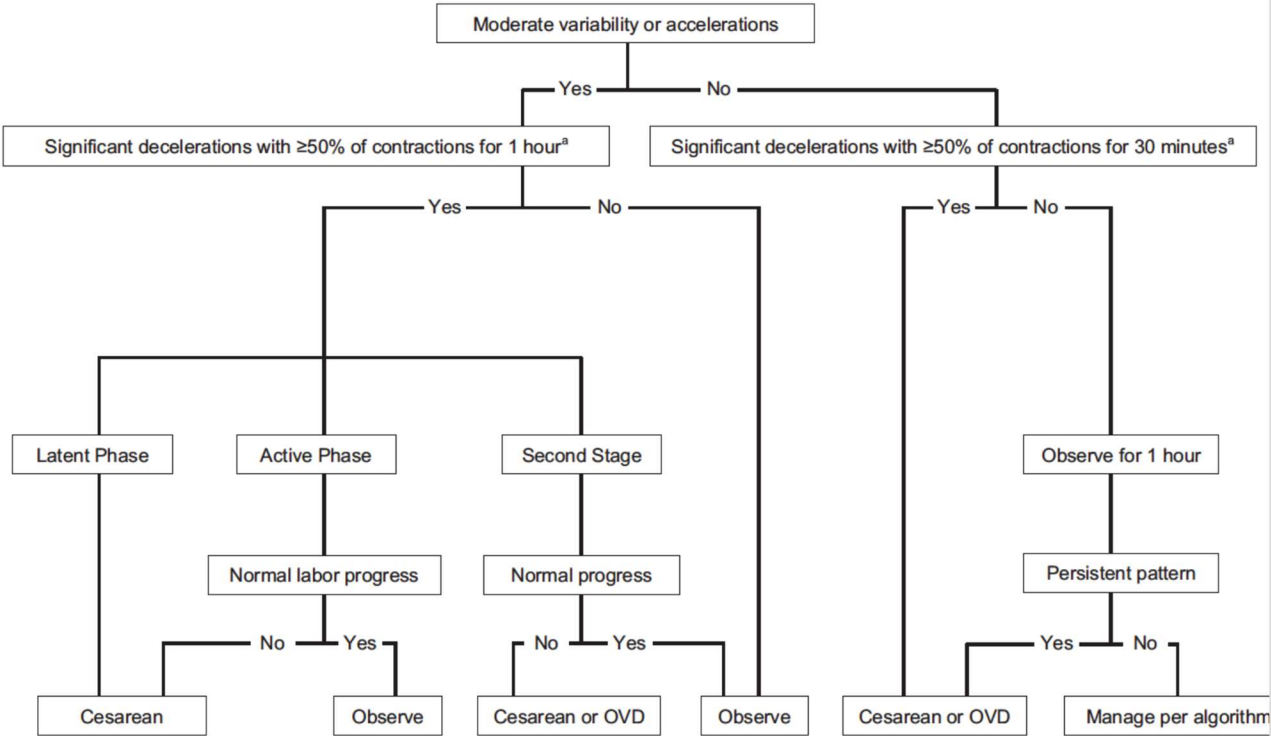
Category III

- All FHR tracings not categorized as Category I or Category III

NICHD three-tier fetal heart rate classification system

Algorithm for Category II Fetal Heart Rate Tracing

FIGURE 1
Algorithm for management of category II fetal heart rate tracings



OVD, operative vaginal delivery.
^aThat have not resolved with appropriate conservative corrective measures, which may include supplemental oxygen, maternal position changes, intravenous fluid administration, correction of hypotension or reduction or discontinuation of uterine stimulation, administration of uterine relaxant, amnioinfusion, and/or changes in second stage breathing and pushing techniques.

NICHD three-tier fetal heart rate classification system

TABLE
Management of category II fetal heart rate patterns: clarifications for use in algorithm

1. Variability refers to predominant baseline FHR pattern (marked, moderate, minimal, absent) during a 30-minute evaluation period, as defined by NICHD.
2. Marked variability is considered same as moderate variability for purposes of this algorithm.
3. Significant decelerations are defined as any of the following:
 - Variable decelerations lasting longer than 60 seconds and reaching a nadir more than 60 bpm below baseline.
 - Variable decelerations lasting longer than 60 seconds and reaching a nadir less than 60 bpm regardless of the baseline.
 - Any late decelerations of any depth.
 - Any prolonged deceleration, as defined by the NICHD. Due to the broad heterogeneity inherent in this definition, identification of a prolonged deceleration should prompt discontinuation of the algorithm until the deceleration is resolved.
4. Application of algorithm may be initially delayed for up to 30 minutes while attempts are made to alleviate category II pattern with conservative therapeutic interventions (eg, correction of hypotension, position change, amnioinfusion, tocolysis, reduction or discontinuation of oxytocin).
5. Once a category II FHR pattern is identified, FHR is evaluated and algorithm applied every 30 minutes.
6. Any significant change in FHR parameters should result in reapplication of algorithm.
7. For category II FHR patterns in which algorithm suggests delivery is indicated, such delivery should ideally be initiated within 30 minutes of decision for cesarean.
8. If at any time tracing reverts to category I status, or deteriorates for even a short time to category III status, the algorithm no longer applies. However, algorithm should be reinstituted if category I pattern again reverts to category II.
9. In fetus with extreme prematurity, neither significance of certain FHR patterns of concern in more mature fetus (eg, minimal variability) or ability of such fetuses to tolerate intrapartum events leading to certain types of category II patterns are well defined. This algorithm is not intended as guide to management of fetus with extreme prematurity.
10. Algorithm may be overridden at any time if, after evaluation of patient, physician believes it is in best interest of the fetus to intervene sooner.

FHR, fetal heart rate; NICHD, Eunice Kennedy Shriver National Institute of Child Health and Human Development.
Clark. Category II FHRT. Am J Obstet Gynecol 2013.

Category III

- FHR tracings include absent baseline FHR variability and any of the following:
 - recurrent late decelerations
 - recurrent variable decelerations
 - bradycardia
 - sinusoidal pattern

Category III FHR tracing is predictive of abnormal fetal-acid base status. Expediently implement fetal resuscitation measures; if no resolution, expedite delivery.

REFERENCES:

Robinson, Barrett Obstetrics & Gynecology (Revised 2008). *A review of NICHD Standardized Nomenclature for Cardiotocography: The Importance of Speaking a Common Language When Describing Electronic Fetal Monitoring*

National Certification Corporation (2021). *Fetal Assessment and Safe Labor Management Monograph.*

AHRQ Safety Program for Perinatal Care; Electronic Fetal Monitoring (2025)

CMQCC. Algorithm for Category II Fetal Heart Rate Tracings (2024)

AWHONN Fetal Monitoring Principles and Practice, 5th Edition (2015)

RECORD RETENTION AND DESTRUCTION:

CROSS REFERENCE POLICIES AND PROCEDURES:

Supersedes:



NORTHERN INYO HEALTHCARE DISTRICT CLINICAL POLICY AND PROCEDURE

Title: Newborn & Pediatric Security and Abduction Policy		
Owner: Interim Perinatal Manager	Department: Perinatal	
Scope: Acute-Subacute unit, Perinatal Unit		
Date Last Modified: 02/07/2026	Last Review Date: 4/17/19	Version: 5
Final Approval by: NIHD Board of Directors	Original Approval Date: 10/2016	

PURPOSE: To provide for the security and safety of all newborns in the Perinatal Department and pediatric patients in the Acute Sub-Acute Department. Additionally, to provide a guideline in the event of an infant or pediatric abduction.

DEFINITIONS:

Neonate: An infant from birth through the 28th day of life.

Pediatrics: Any patient between the ages of 29 days of life through the 12th year of life.

POLICY:

1. All newborns in the Perinatal Department will be under the direct observation of a member of the nursing staff and/or direct caregiver (parent or guardian) at all times. Under no circumstances will a newborn be left unattended.
2. All newborns and pediatric patients in the Acute Sub Acute Department will be under the supervision of a member of the nursing staff and/or direct caregiver at all times.
3. All newborn/pediatric patients will be banded with a security tag on admission or at birth. This tag will be activated in the infant security system.
4. The primary caregiver of the patient will be informed of security precautions at the time of admission or as soon as they are available.
5. Nursing staff will document patient and family education of newborn/pediatric security on the nursing admission assessment form.
6. In the Perinatal Department, all newborns will be identified in the following manner:
 - a. All mother-baby couplets will have matching ID bands placed on them either in the birthing room or O.R., prior to separating mother and infant. However, if an emergency exists, the infant will be properly banded as soon after admission to the nursery as possible.
7. All pediatric patients will be identified in the following manner:
 - a. All newborn and pediatric patients and their designated legal guardian will have matching ID bands placed on them at the time of admission.
8. Hospital staff will notify and work closely with law enforcement agencies if an abduction occurs.

PROCEDURE:

1. **Security Measures:**
 - a. Northern Inyo Hospital (NIH) will utilize an infant/pediatric security system for all infant and pediatric patients. Refer to the Nursing Management of the Infant and Pediatric Security System policy.
 - b. Infant-Mother ID bands will be placed on each mother-baby as soon as delivery as soon as possible. Indicate to the parents verbally and visually that the name bands are matching. Document the band number and the time bands were applied on the Labor and

Delivery Record. The mother will have one wristband, and the baby will have two bands – one applied to a wrist, and the other to an ankle. These bands must be verified as matching and include the following information:

- (i) Mom's First Name, BABY (Sex of infant), Mom's Last Name, Mom's First Name, BABY (Sex of the Infant) Example: "Smith, Jane BABY GIRL".
- (ii) Date and Time of infant's birth
- c. Infant bar code scanning tag will be added once the infant has been registered and infant labels are available. Apply an infant label to the designated tag and attach it directly to the Mother-Baby band that is on the infant's ankle. Verify that all patient identification indicators are identical. This tag will be used for scanning purposes.
- d. All Perinatal Department nurses wear pink accented photo ID badges.
- e. Pediatric patients will utilize an activated security tag in addition to the regular hospital wristband.
- f. Inform mothers in the Perinatal department of security procedures, which include but are not limited to:
 - i. Check for proper identification before giving the baby to anyone
 - ii. Never leave the baby alone or unsupervised in the room
 - iii. Place the baby's bassinet on the side of the bed that is away from the door.
 - iv. All infants should remain in their cribs during transport, i.e., from nursery to mother's room; family members and staff should not be carrying the infant in hallways or outside the Perinatal Department. Each crib will have a crib card with the infant's name, birth date, and physician.
- g. Instruct patients and family members to observe the visiting hours and rules and **NOT** to open the main security door to permit access to other visitors.
- h. Only staff members should allow access to visitors according to patient privacy laws.

2. In the event of an abduction:

- a. Follow the Code Pink abduction procedure outlined in the Emergency Preparedness Procedure chart. AKA "Rainbow chart".
- b. In the event of an abduction, the downtime Code Pink form will be completed and a copy provided to law enforcement.
- c. House Supervisors, Directors of Nursing, Nurse Managers, or Administration:
 - i. Consider moving the primary caregiver of the abducted child to a private room off the Department and assigning a staff member (preferably the nurse assigned to the mother, House Supervisor, or nurse manager) to accompany them at all times, protecting them from stressful contact with the media and other interference.
 - ii. If the incident occurred at shift change, hold the shift scheduled to leave until excused by law enforcement.
 - iii. The House Supervisor or nurse manager should brief all involved staff. In turn, nurses should then explain the situation to other patients in the unit (preferably while the mother and her infant are together).
 - iv. Nursing Administration should be sensitive to the fact that the staff may suffer post-traumatic stress as a result of the abduction.
 - v. Protect the crime scene (area where the abduction occurred) to preserve the subsequent collection of any forensic evidence by law enforcement.
 - vi. Coordinate with the police department by involving the media search for the infant if indicated.

- vii. Coordinate with the police department in notifying the Center for Missing and Exploited Children (NCMEC) at 1-800-843-5678 for technical assistance in handling the ongoing crisis management indicated.
- viii. Any facility providing care to infants and pediatric patients in the surrounding area, such as but not limited to hospitals, physician offices, and clinics, should be notified about the incident and provided with a full description of the patient and the abductor.

REFERENCES:

1. National Center for Missing and Exploited Children; January, 2016, “For Healthcare Professionals: Guidelines on Prevention of and Response to Infant Abductions.”
2. Lehmann, P., Institute for Homeland Security. 2022. “Infant Abduction from Healthcare Facilities: Prevalence, Explanation, and Risk Mitigation”

RECORD RETENTION AND DESTRUCTION:

Documentation is maintained within the patient's medical record, which is managed by the NIHD Medical Records Department.

CROSS-REFERENCED POLICIES AND PROCEDURES:

Supersedes: Newborn and Pediatric Security and Abduction Policy v.3



NORTHERN INYO HEALTHCARE DISTRICT NON-CLINICAL POLICY

Title: Password Policy		
Owner: Director of IT	Department: Information Technology	
Scope: District Wide		
Date Last Modified: 03/13/2026	Last Review Date: 03/03/2026	Version: 4
Final Approval by: NIHD Board of Directors	Original Approval Date: 01/01/2004	

PURPOSE:

Passwords are an important aspect of computer security. They are the front line of protection for user accounts. A poorly chosen password may result in the compromise of NIHD's entire network. As such, all NIHD workforce members, including but not limited to employees, members of the Board of Directors, contractors, and vendors with access to NIHD systems, are responsible for taking the appropriate steps, as outlined below, to select and secure their passwords.

The purpose of this policy is as follows:

1. To establish a standard for the creation of strong passwords
2. To establish a standard for the protection of those passwords
3. To establish a standard for the frequency of change of those passwords.

POLICY:

1. All passwords must be changed every 60 days.
2. Password history will remember the last 24 passwords that cannot be reused.
3. Accounts will be locked out after 8 failed attempts to prevent password-spraying attempts.
4. Passwords must not be inserted into email messages or other forms of electronic communication.
5. All user-level and system-level passwords must conform to the guidelines described below.
 - a. Password must contain a minimum of 12 characters and a maximum of 15 characters. Passwords must contain a combination of capital and lowercase letters, numbers, and symbols
 - b. Passwords should not contain easily recognizable words (i.e., Bishop, Inyo, NIH)
 - c. **Password exception for DMS**– Passwords can **only** contain capital or lowercase letters and not in combination. Example – “TgAgm487&” the password would have to be “tgagm4878&” or “TGAGM4878&”
6. Passwords are not to be shared with anyone, including administrative assistants.
7. If a password is suspected to have been compromised, report the incident immediately to the Information Technology Services Department or the District Information Security Officer.
8. NIHD workforce members cannot use the same password for NIHD accounts as they use for other non-NIHD access (e.g., personal ISP account, shopping sites, benefits, etc.).
 - a.) If an employee's NIHD account(s) are compromised, the ITS department will then investigate the public password breaches to verify that an employee's password(s) are not in the public domain.
 - b.) During an investigation of a security breach, an employee may be asked - Do you use the same password for any other accounts, whether private or public?

9. NIHD workforce members cannot use the "Remember Password" feature of applications (e.g., Internet, Outlook, OWA, etc.).

REFERENCES:

1. HIPAA Security - Security Awareness and Training Standard 164.308(a)(5)(ii)(D)
NIST SP: 800-118, 800-12, 800-82 Rev 2, 800-53 Rev 4, 800-63-2, 800-66 4.5.3
2. The Joint Commission (CAMCAH Manual) Jan. 2022; Standard IM.02.01.03 EP 1.

RECORD RETENTION AND DESTRUCTION: N/A**CROSS-REFERENCED POLICIES AND PROCEDURES:**

1. Computer Screen Lock Policy
2. Information Security and Data Integrity
3. Confidentiality
4. Computer Screen Lock Policy

Supersedes: v.3 Password Policy



NORTHERN INYO HEALTHCARE DISTRICT CLINICAL POLICY AND PROCEDURE

Title: Pediatric Standards of Care and Routines			
Owner: Manager of ICU and Acute/Subacute		Department: ICU and Acute/Subacute	
Scope: Pediatrics			
Date Last Modified: 10/30/2025		Last Review Date: 3/16/16	Version: 7
Final Approval by: NIHD Board of Directors		Original Approval Date:	

POLICY STATEMENT:

1. Pediatric nursing is provided using an interdisciplinary team approach, based on a holistic assessment of patient and family needs, capabilities, and limitations; nursing diagnosis; planning; interventions; and evaluation of patient and family response.
2. Patient expectations as defined will be met for each patient and their family.
3. The patient age-specific population served is:
 - a. Pediatric age 28 days to 13th birthday

PROCEDURE:

The Pediatric patient and family can expect:

ON ADMISSION/TRANSFER INTO DEPARTMENT:

1. To be greeted immediately upon arrival at the unit, including:
 - a. Introduction of nursing and ancillary staff.
 - b. Explanation of what to expect within the next hour.
 - c. Clean patient room with pediatric-appropriate supplies and equipment.
 - d. Assessment of level of assistance required to complete activities of daily living, including transferring, ambulation, self-care, and feeding; support provided to meet identified needs.
 - e. Orientation to room, including call light use, bed operation, TV and light controls, phone, bathroom location and options for patient and family members, safety procedures, equipment in use, and unit routine.
 - f. Pain, potty, and position addressed.
 - g. Additional comfort needs such as fluids, blankets, IV site, traction, safety devices, and communication devices addressed.
2. To receive information about the patient/family's Speak Up Program, Patient Rights, Patient Safety, Pediatric Letter to Family, Patient Advocate, Advance Directives, Infection Control, and Rapid Response.
3. To have an RN assess his/her admitting or transfer condition (quick check) within 30 minutes of arrival.
4. To have an RN initiate a nursing assessment within 4 hours of admission, to be completed within 12 hours, including:
 - a. Physical and social assessment.
 - b. Assessment of communication methods, dietary practices, and home environment.
 - c. Patient profile, to include home medications, pre-arrival medications, reported problems and procedures, implants, allergies, immunizations, family history, education, occupation, use of alcohol, tobacco, and other drugs.

- d. Interdisciplinary referral based on functional screens within the nursing assessment.
- e. Nursing plan of care individualized for the patient.
- 5. To have an RN review and initiate Physician Admitting Orders within 4 hours of admission, including review of the physician's plan of care as written.
- 6. To have an RN initiate discharge planning at the time of admission, to be readdressed throughout the stay, including:
 - a. Patient and family goals for hospitalization
 - b. Referral to interdisciplinary team, including Dietary, Social Services, Physical Therapy, Speech Therapy, and Pharmacy.

THROUGHOUT STAY:

- 1. To be treated in accordance with NIH's policy entitled "Patients' Rights".
- 2. To be kept informed of and involved in the plan of care, including medications, procedures, and discharge needs.
- 3. To have care delivered based on standards of practice for the diagnosis identified.
- 4. To have a Physician (Attending Physician) oversee care with a site visit every 24 hours.
- 5. To have Physician consultations completed within 24 hours of referral.
- 6. To have an RN monitor and assess his/her health status a minimum of every 12 hours, and as the patient's condition warrants (0800, 2000).
- 7. To have the physician updated and informed of response to care and/or significant changes as demonstrated by:
 - a. Abnormal or worsening critical signs specific to the patient's baseline.
 - b. Abnormal or worsening lab values.
 - c. Significant change in Level of Consciousness (LOC).
 - d. Significant or worsening change in physical assessment.
 - e. Significant change or imbalance in Input and Output (I&O).
 - f. Any adverse drug and/or blood reactions, or untoward change as a response to treatment.
 - g. Inability to control pain or obtain pain relief.
 - h. Any untoward occurrence/event occurring in the hospital.
- 8. To receive prompt identification of and intervention for potential and actual complications/side effects, including Rapid Response team initiation.
- 9. To have the parent, if not present, informed of any of the above circumstances or occurrences.
- 10. To have pain assessed and managed in a systematic way to achieve optimal relief.
- 11. To have hourly rounding 0800 to 2400 and every 2-hour rounding 2400 to 0800 to address:
 - a. Pain, potty, position.
 - b. Comfort needs.
 - c. Environment assessment, to include maintenance of a quiet, therapeutic atmosphere.
- 12. To have safety measures identified specific to each patient, including:
 - a. Patient identification band in place on patient and parent; staff to use at least two patient identifiers for medications and procedures.
 - b. Pediatric security tag in place with alarm activated, Code Pink information sheet completed.
 - c. 5 rights of medication administration practiced; all pediatric medication dosages double-checked with a second RN, LVN, or RPh; emergency medications calculated based on admission weight and Broselow-Hinkle Pediatric emergency system.
 - d. Time out as appropriate for identified invasive procedures.
 - e. Fall risk assessment every 12 hours and with a change of condition.
 - i. Interventions in place specific to the patient.
 - ii. High-risk patient to be awoken at the agreed-upon time for toileting.

- iii. Patients ages 4 and under in crib with side rails raised to full height, unless patient sleeps in regular bed at home.
 - iv. Infants in bassinet.
 - f. Skin assessment every 12 hours
 - i. Interventions in place specific to the patient to prevent new breakdown and to treat existing skin breakdown.
 - g. IV site assessment every hour
 - h. Restraint-free environment emphasizing alternatives to restraint:
 - i. Comfort measures.
 - ii. Patient orientation techniques.
 - iii. Patient safety alert devices.
 - iv. Patient location.
 - v. Sitter in room.
 - vi. Restraints are only used if less restrictive measures have not succeeded or are clearly not likely to succeed in preventing injury to the patient.
 - i. Smoke-free environment.
 - j. Assessment for suicidal risk.
- 13. To have preventative measures followed to avoid patient infections, pneumonia, and blood clots.
- 14. To be educated throughout the admission to support understanding of:
 - a. Health status, current diagnosis, and plan of care.
 - b. Self-care needed to maintain and improve health status.
 - c. Basic health and safety practices, including opportunity to communicate concerns about safety issues before, during, and after care is received.
 - d. Oral health.
 - e. Nutrition interventions.
 - f. Habitation or rehabilitation techniques to help the patient reach maximum independence.
 - g. Equipment usage during stay and equipment needs for discharge.
 - h. Fall reduction strategies.
 - i. Pain, risk for pain, and methods of pain management.
 - j. Medication name, dosage, route, timing, and reason for receiving.
- 15. To have continuity of care maintained between caregivers and departments through appropriate sharing of information (SBAR-QC).
- 16. To have confidentiality and privacy maintained in accordance with policy on Patient Rights, State Law, and Federal Law.
- 17. To have nutritional needs assessed, and nutrition provided that meets the patient's special diet, including developmental status, and cultural, religious, or ethnic preferences.
 - a. To be provided with storage for pumped breastmilk, if needed.
 - b. To be provided with formula, bottles, and nipples for feeding, if needed.
- 18. To have services that support family time, schoolwork and education, social work, nursing care, dental care, rehabilitation, and discharge needs.
- 19. To have palliative and terminal care as required.

ON TRANSFER WITHIN NIHD:

- 1. To have the transfer assessment completed by a transferring RN.
- 2. To have the patient assessment completed by the receiving RN.
- 3. To have the transferring RN provide a report of patient condition (SBAR-QC) to the receiving RN.
- 4. To have the patient/family updated on the reason for transfer, the location moved, and the change in plan of care.

5. To be transferred with all belongings.
6. To have medications/orders reconciled upon transfer by the receiving RN/Pharmacy.

ON DISCHARGE/TRANSFER TO ANOTHER FACILITY:

1. To have discharge transfer orders reviewed with the patient/family.
2. To have discharge transfer assessment completed by an RN and report called to the receiving facility RN.
3. To have transportation arranged, including:
 - a. Medical condition.
 - b. Orders for care level during transport.
 - c. IV/Medication maintenance as appropriate.
 - d. Record of care transported with patient.
4. To have the discharging transfer RN give a report to the transport team, MD/RN/Paramedic/EMT as appropriate.
5. To be transferred with all personal belongings and medications.

ON DISCHARGE:

1. To have a discharge assessment completed by an RN.
2. To have written discharge instructions provided to the patient/family member by the RN, including clarification of:
 - a. Who to call for questions.
 - b. Nature of medical condition and what symptoms to report to MD.
 - c. Medications to take, list of medications already given that day, and new prescriptions.
 - d. Follow-up appointment, including outpatient diagnostic test and lab work orders.
 - e. Medical equipment needed at home, including vendor to call for assistance.
 - f. Home Health/Hospice/Meals on Wheels contact information as ordered.
 - g. Activity level and return to work.
 - h. Dietary restrictions.
3. To be provided with the “Release of a Child Under 8 Years of Age” form indicating awareness of federally required child passenger restraint systems, if applicable for the age of the patient.
4. To be discharged with all belongings and medications.
5. To receive a hospital follow-up call.

ON EXPIRATION:

1. To have Family Member/Significant Other/Power of Attorney/Health Care Surrogate, Nursing Home, and Organ Procurement agency notified of impending death.
2. To have all Medical Staff assigned to the case, Family Member/Significant Other/Power of Attorney/Health Care Surrogate, Nursing Home, and Organ Procurement agency notified of death.
3. To have all belongings returned to the family or sent with the body to the funeral home.
4. To have post-mortem care completed and the body released to the Funeral Home or the Medical Examiner.

REFERENCE(S):

1. General Acute Care Hospitals, 22 CCR Div. 5, 2014.
2. ANA. (2010). *Nursing Scope and Standards of Practice*. Silver Spring, MD: Nursesbooks.org

CROSS REFERENCE HOSPITAL P&P:

1. A Quick Check

2. Admission of a Pediatric Patient
3. Hand Off; Standardized Nursing Communications Policy
4. Obtaining Consent for Organ and Tissue Donation
5. Patients' Rights
6. Patient Transfer/Discharge to Another Facility
7. Pediatric Emergency Code System (Broselow-Hinkle)
8. Pediatric Letter to Family
9. Pediatric Service

Supersedes: v.6 Pediatric Standards of Care and Routines*

Approval



NORTHERN INYO HEALTHCARE DISTRICT NON-CLINICAL POLICY

Title: Portable Space Heater		
Owner: Maintenance Manager		Department: Maintenance
Scope: Districtwide		
Date Last Modified: 02/02/2026	Last Review Date: No Review Date	Version: 1
Final Approval by: NIHD Board of Directors		Original Approval Date:

PURPOSE:

Prevent fire and electrical hazards associated with portable space heaters and ensure compliance with CMS Life Safety Code expectations, California Fire Code, and applicable electrical safety requirements across NIHD facilities.

POLICY:

Portable space heaters present a significant fire risk and are generally prohibited in NIHD facilities. They are not permitted in any patient care area or in any smoke compartment that contains patient sleeping or treatment activities. Limited, temporary use may be allowed only in approved, non-patient, non-sleeping staff areas, and only under strict controls with written authorization. NIHD applies a conservative interpretation consistent with common AHJ and accreditation expectations to protect vulnerable patients and staff.

SCOPE:

This policy applies to all NIHD facilities and spaces:

- Hospital patient care, sleeping and treatment areas: **Prohibited.**
- Clinics/MOBs: Determined by occupancy classification and clinical use; the stricter standard applies when unclear.
- Administrative/offsite buildings and other non-healthcare occupancies: May qualify for limited, temporary use with approval.

RESPONSIBILITIES:

All Workforce Members

- Do not bring, use, or store personal space heaters on NIHD property.
- Report temperature concerns via a Facilities work order.

Managers/Supervisors

- Enforce this policy, support education, and correct non-compliance in department spaces.

Facilities Management (Primary Authority)

- Evaluate HVAC/temperature issues first and document the need (e.g., room temperature below 68°F) before considering a heater.
- Assess electrical safety, circuit capacity, and safe placement/clearances.

- Procure/issue approved heater models only and maintain approval/removal documentation.
- Add a sticker showing that NIHD owns the heater.

PROHIBITED USE: (NO EXCEPTIONS)

Portable space heaters are not permitted in the following conditions or locations:

- Any patient care, patient sleeping, or patient treatment area.
- Any smoke compartment containing patient care or sleeping functions (including adjacent support/work areas within the compartment).
- Corridors, exits, stairwells, or any egress path; any location that creates a trip hazard or obstructs evacuation.
- Areas with oxygen use/storage or other identified hazards (as determined by Safety/Facilities).
- When powered by extension cords, power strips, or relocatable power taps.
- Any open-coil/quartz, construction-type, fuel-fired, damaged, altered, or unlisted/unlabeled unit.

LIMITED TEMPORARY USE (APPROVAL REQUIRED)

A portable space heater may be allowed only when all of the following are met:

1. Location: Non-patient, non-sleeping staff area only; not within a patient smoke compartment.
2. Purpose: Temporary supplemental heat while Facilities addresses the underlying HVAC issue.
3. Process: (a) Facilities work order submitted; (b) written approval issued by Facilities (and EOC/Safety as required); (c) inspection and tagging completed before use.

APPROVED HEATER REQUIREMENTS:

Only heaters issued by Facilities may be used. Authorized units must meet all requirements below:

- Listed and labeled to an appropriate standard (e.g., UL 1278 or equivalent).
- Plugged directly into a wall receptacle (no extension cords/power strips).
- Maintain at least 3 feet clearance from combustibles.
- Includes tip-over shutoff and overheat protection.
- Meets CMS/Fire Code exception criteria where applicable (e.g., heating element not exceeding 212°F in nonsleeping staff/employee areas).
- Preferred types: oil-filled radiant or enclosed, low-surface-temperature designs.

SAFE USE RULES:

- Operate only while attended; turn off when leaving the area and at the end of the day/shift.
- No overnight or unattended use.
- Keep cords unobstructed and out of doorways/openings; do not route cords in a manner that creates a trip hazard.
- Do not place under desks, against paper storage, or near moisture sources.

INSPECTION, ENFORCEMENT, AND EDUCATION:

- All authorized heaters require a current approval tag before use (tagging authority as defined by the NIHD process).
- Unapproved heaters will be removed immediately by Facilities/Safety/assigned staff.
- Repeat violations may result in corrective action per NIHD policy.

- Policy is included in new hire orientation and reinforced seasonally; compliance is monitored through EOC rounding.

REFERENCE:

- CMS Life Safety Code survey guidance: K781 (Portable Space Heaters)
- California Fire Code (Title 24, Part 9): portable electric heater requirements (listing/labeling, direct plug-in, clearance) CCR Title 8: electrical safety orders related to flexible cord use (e.g., restrictions on extension cords as a substitute for fixed wiring)
- NFPA 101: portable heater prohibition/exception in healthcare occupancies (interpretive guidance used by CMS/AHJ)

RECORD RETENTION AND DESTRUCTION:

3-Years

CROSS REFERENCE POLICIES AND PROCEDURES:

Supersedes: Not Set



NORTHERN INYO HEALTHCARE DISTRICT CLINICAL POLICY AND PROCEDURE

Title: Rapid Response Team		
Owner: Manager of ED and Disaster Planning	Department: Emergency Department	
Scope: District Wide		
Date Last Modified: 11/07/2025	Last Review Date: No Review Date	Version: 5
Final Approval by: NIHD Board of Directors	Original Approval Date: 06/30/16	

PURPOSE:

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

POLICY:

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

PROCEDURE:

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

1. Early Warning Criteria for Initiating the RRT

Any or all of the following criteria meet the guidelines for initiating the RRT Team.

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

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

3. RRT Structure

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

4. Activation of RRT

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

5. RRT Responsibilities

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

- Call a Code Blue and initiate ACLS procedures as appropriate per Code Blue policy (Adult patients).
- Call a Code White and initiate PALS procedures as appropriate per Code White policy (Pediatric patients).
- Assist with the implementation of the physician's order; and
- Assist in the transport of the patient when necessary.

6. Assessment Guidelines

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

- The primary nurse will be prepared with pertinent patient history, signs and symptoms, and events precipitating this occurrence.
- The RRT leader will perform the initial assessment to include and/or consider:
 - Vital signs
 - Blood glucose
 - Cardiac rhythm
 - Neurological status
 - Fluid status
 - Skin condition
 - Pain
 - Anxiety
 - Recent medication history
 - Lab values
 - Diagnostic test results
- The RT will perform the initial respiratory assessment to include and/or consider:
 - Breath sounds
 - Work of breathing
 - Ventilation pattern and status
 - Chest assessment
 - Oxygenation
 - Airway clearance
 - Ventilation
 - Recent respiratory history (last treatment given)
 - Past respiratory history

7. RRT Immediate Interventions

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

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

8. RRT Equipment

The following supplies and equipment may be needed:

- a. Personal protective equipment should be available at the bedside
- b. Oxygen
- c. Suction regulator and canister, tubing, Yankauer
- d. Suction regulator or unit
- e. Pulse oximeter
- f. Cardiac and vital signs monitoring equipment
- g. Medications as ordered

9. RRT Documentation

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

OUTPATIENT SERVICES USE OF RRT POLICY

1. The Rapid Response Team can also be utilized by outpatient services within the hospital (not clinics) to provide triage and transport to the Emergency Department for care and treatment. For emergent concerns in the NIHD clinics, **please dial 9-911**.
2. A Code Blue should be initiated anytime the patient or visitor becomes unresponsive. For emergent concerns in the NIHD clinics, **please dial 9-911**.
3. A Code White should be initiated anytime the pediatric patient or pediatric visitor becomes unresponsive. For emergent concerns in the NIHD clinics, **please dial 9-911**.
4. If any hospital staff member has a concern about a patient’s condition, they may notify the RRT.

REFERENCES:

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

CROSS-REFERENCED POLICIES AND PROCEDURES:

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

RECORD RETENTION AND DESTRUCTION:

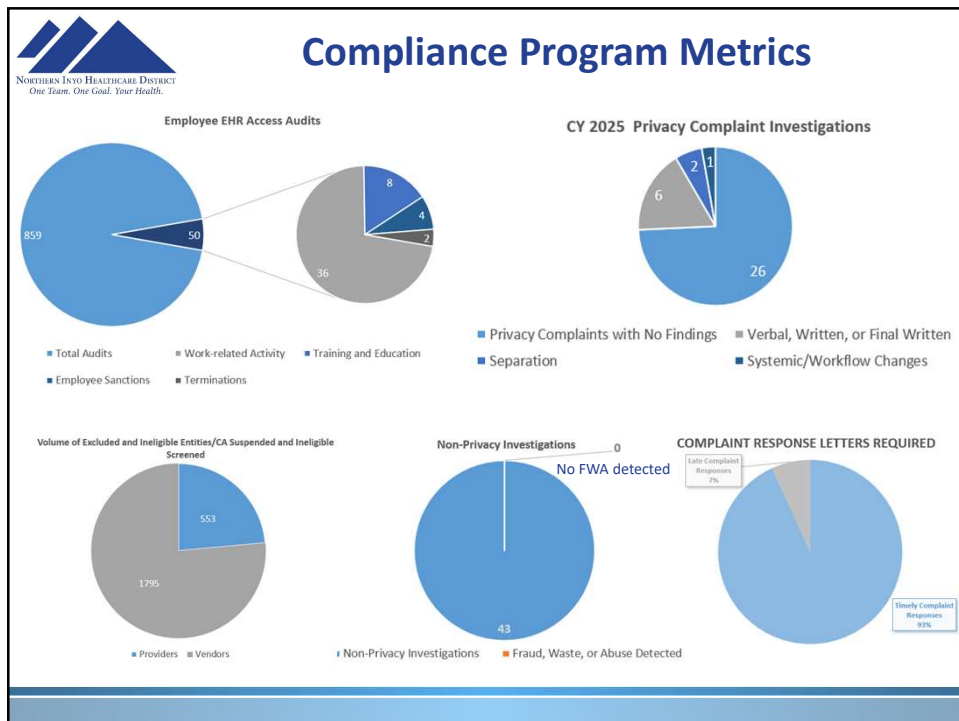
Supersedes: v.4 Rapid Response Team

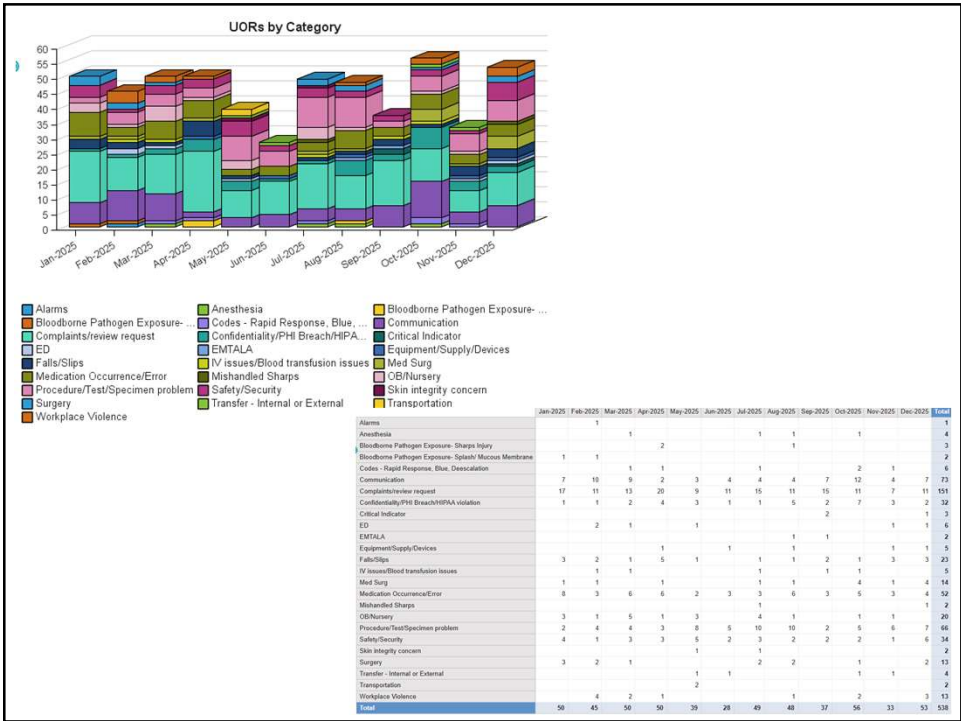
NORTHERN INYO HOSPITAL
Northern Inyo Healthcare District
150 Pioneer Lane, Bishop, California 93514

TO: NIHD Board of Directors
FROM: Samantha Jeppsen, MD, Chief of Medical Staff
DATE: March 3, 2026
RE: Medical Executive Committee Report

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

- A. Medical Staff Initial Appointments 2026-2027 (*action item*)
1. Christopher Urban, MD (*orthopedic surgery*) – Courtesy Staff
 2. Rosie Avila, MD (*obstetrics/gynecology*) – Courtesy Staff
 3. Jeremiah Cheng, MD (*internal medicine/pediatrics*) – Active Staff







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Questions ?



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Northern Inyo Healthcare District

2025 Community Health Needs Assessment

| Board Summary

February 2026



Community Health Needs Assessment (CHNA): Overview

CHNA Purpose:

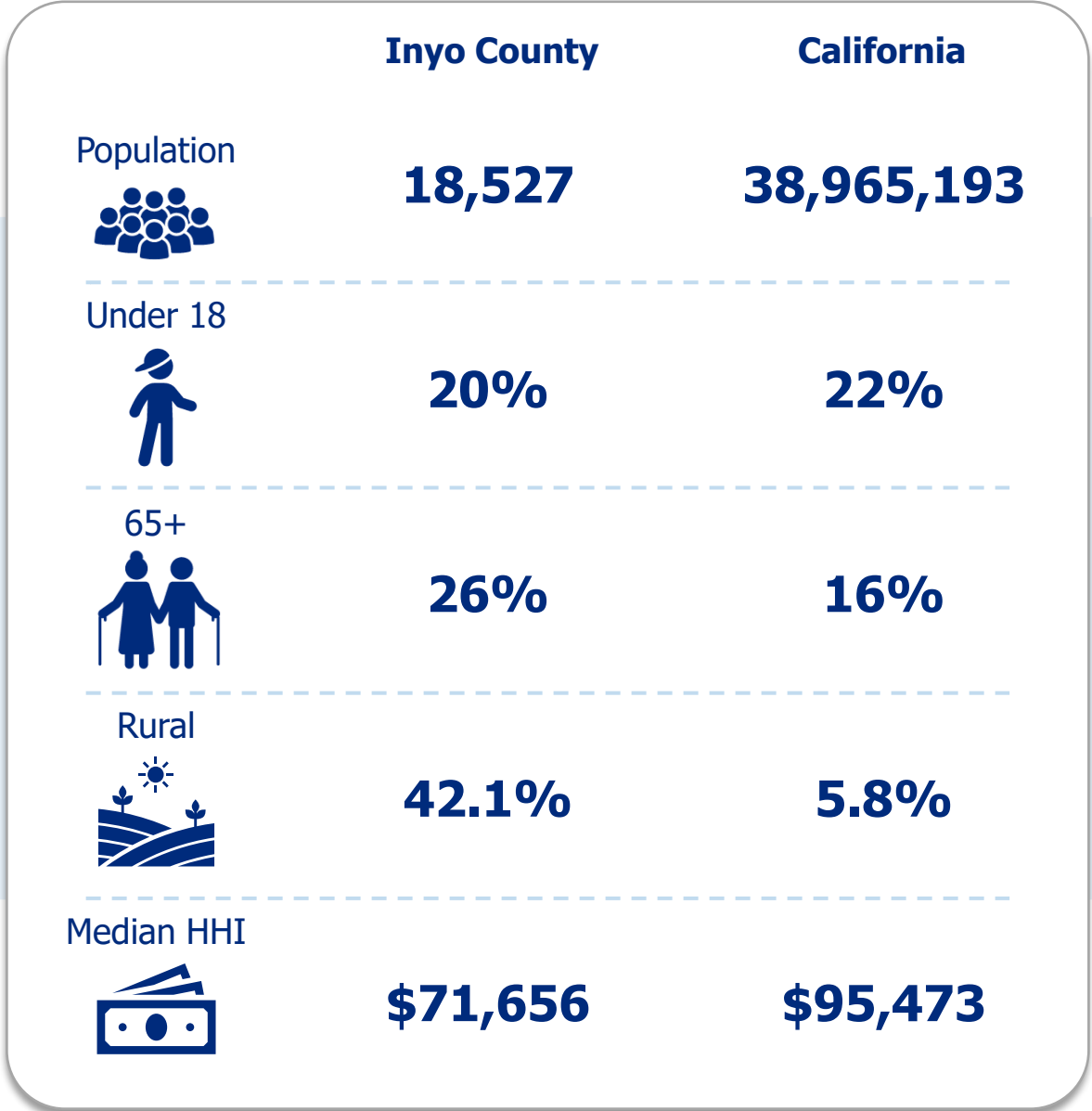
A CHNA is a required assessment for many health organizations to be completed every 3 years. It provides comprehensive information about the community's current health status, needs, and disparities and offers a targeted action plan to address these areas.

Key Outputs of a CHNA:

- ✓ Identification of health disparities and social determinants to inform future outreach strategies
- ✓ Awareness of key service delivery gaps
- ✓ Deeper understanding of the communities' perceptions of healthcare in the region
- ✓ Collaboration with community organizations to better serve the community

CHNA Process





Service Area Demographics

Race/ Ethnicity	Inyo County	California
Non-Hispanic White	59.0%	34.3%
Non-Hispanic Black	1.0%	5.6%
American Indian or Alaska Native	14.0%	1.7%
Asian	1.9%	16.5%
Native Hawaiian or Pacific Islander	0.2%	0.5%
Hispanic	24.6%	40.4%

Top Health Priority Data: Perspectives from the Community

NIHD & SIHD 2025 (n=381)		
Top 15 Health Priorities		Rank
↑	Healthcare: Affordability	4.58
↑	Access to Specialty Care	4.56
↓	Mental Health	4.54
↑	Geriatric / Elder Care	4.50
↑	Cost of Health Insurance	4.50
↓	Cancer	4.45
↓	Affordable Housing	4.41
↑	Access to Primary Care	4.38
■	Senior Services / Elder Care	4.36
↑	Women's Health	4.29
↓	Healthcare: Location of Services	4.29
↑	Access to Affordable Food	4.24
↑	Heart Disease	4.21
■	Healthcare: Prevention Services	4.19
↓	Substance Use Disorder	4.14

NIHD 2022 (n=643)		
Top 15 Health Priorities		Rank
	Mental Health	4.53
	Affordable Housing	4.46
	Healthcare Services: Affordability	4.41
	Physical Presence	4.38
	Cancer	4.37
	Drug/Substance Abuse	4.30
	Access to Childcare	4.27
	Diabetes	4.24
	Access to Senior Services	4.21
	Livable Wage	4.21
	Heart Disease	4.20
	Women's Health	4.17
	Education System	4.15
	Healthcare Services: Prevention	4.15
	Employment and Income	4.10

National CHNAs (n=10,654)		
Top 15 Health Priorities		Rank
	Cost of Health Insurance	4.57
	Healthcare Affordability	4.56
	Cancer	4.47
	Mental Health	4.47
	Affordable Housing	4.34
	Drug/Substance Use	4.34
	Heart Disease	4.32
	Women's Health	4.26
	Access to Healthcare	4.25
	Diabetes	4.25
	Access to Senior Services	4.23
	Employment and Income	4.21
	Alzheimer's and Dementia	4.19
	Obesity	4.17
	Access to Healthy Food	4.16

Health Needs by City

While individual communities show slight variation in emphasis, the core priorities of access, affordability, mental health, and senior care are consistent across geographies and representative of broader county needs.

Strong Countywide Alignment

Overall CHNA priorities are consistent across communities.

- Healthcare Affordability ranks highly in core communities represented in survey
- Access to Specialty Care is consistently ranked in the top-5 priorities
- Mental Health is a key concern for all communities
- Senior Care and Access to Elder Services are highly prioritized in most communities

Notable Geographic Nuances

There are some differences in emphasis on health needs.

- **Bishop:** Broad emphasis on affordability, access, and mental health
- **West Bishop:** High prioritization of specialty access and senior care
- **Big Pine:** Elevated concern around substance use and illegal drug use
- **Lone Pine:** Strongest emphasis on geriatric care, chronic disease, and location of services

Bishop (48.5%) and West Bishop (15.8%) represent the majority of survey responses for a combined 64% of total. Overall rankings are therefore most influenced by Bishop/West Bishop responses. Big Pine (8.7%, n=33) and Lone Pine (5.8%, n=22) offer directional insights, however, have smaller sample sizes, limiting analysis.

NIHD & SIHD 2025 (n=381)	
Top 5 Health Priorities	Rank
Healthcare: Affordability	4.58
Access to Specialty Care	4.56
Mental Health	4.54
Geriatric / Elder Care	4.50
Cost of Health Insurance	4.50

Bishop (n=184)	
Top 5 Health Priorities	Rank
Mental Health	4.64
Healthcare: Affordability	4.61
Cost of Health Insurance	4.57
Healthcare: Access to Specialty Care	4.55
Geriatric / Elder Care	4.52

West Bishop (n=60)	
Top 5 Health Priorities	Rank
Healthcare: Access to Specialty Care	4.53
Geriatric / Elder Care	4.52
Healthcare: Affordability	4.49
Cancer	4.45
Healthcare: Access to Primary Care	4.44

Top Health Priorities: Implementation Strategy

Care Coordination and Disease Management



Relevant Needs Addressed: Geriatric/Elder Care, Cancer, Women's Health

Goal: Improve health outcomes for high-need populations through disease management, outreach and education, and coordinated care.

Access to Healthcare Services



Relevant Needs Addressed: Access to Specialty Care, Access to Primary Care, Senior Services/Elder Care, Healthcare: Affordability

Goal: Expand healthcare access by strengthening local primary, specialty, and senior-focused care and reducing financial and non-financial barriers through patient navigation, education, and connection to available resources.

Mental Health



Relevant Needs Addressed: Mental Health

Goal: Support community-wide mental health access through collaboration with community partners to expand services, coordinate care, and establish a sustainable mental health delivery model for the region.

Top Health Priorities: Implementation Strategy

Healthcare Access

Future Actions to Address Need:

- Align future strategic planning and master facility planning with key service line and outpatient expansion opportunities to better meet community needs and support future provider recruitment and retention.
- Leverage Patient Throughput Committee to improve patient flow and throughput, increasing appointment availability and timely access to care.
- Develop and deliver community education on navigating the healthcare system, including understanding appropriate levels of care, referral pathways, and available local/regional services.
- Implement financial counseling and patient navigation to support awareness of financial assistance, insurance options, and affordability resources, with targeted education for seniors and other high-need populations.

Mental Health

Future Actions to Address Need:

- Define a sustainable, community-based mental health care model that clarifies NIHD's role within a broader network of providers.
- Strengthen partnerships with community mental health organizations to improve continuity of care following screening or crisis events.
- Improve access to prescriber-level mental health services to address medication management needs.
- Increase coordination and awareness of available mental health and substance use resources across the community.

Care Coordination and Disease Management

Future Actions to Address Need:

- Prioritize patient navigation as the core care coordination function across specialty service lines, supporting continuity from initial patient access through referrals, diagnostics, treatment, and follow-up care.
- Improve utilization of cancer care navigation services by increasing awareness and integration with clinical workflows.
- Partner with senior centers and community organizations to provide education on the healthcare journey, chronic disease management, and preventive care.
- Strengthen coordinated care for seniors by improving continuity in internal medicine and primary care, enhancing navigation of specialty services (including out-of-area care), and supporting care transitions across care settings.

THANK YOU



NORTHERN INYO HEALTHCARE DISTRICT
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Northern Inyo Healthcare District

2025

Community Health Needs Assessment – *Executive Summary*

Approved by board: 10/2/2024



Community Health Needs Assessment

Overview

CHNA Purpose

A CHNA is part of the required documentation of "Community Benefit" under the Affordable Care Act for 501(c)(3) hospitals and fulfills requirements for accreditation for many health and public health entities. However, regardless of status, a CHNA provides many benefits to an organization. This assessment provides comprehensive information about the community's current health status, needs, and disparities and offers a targeted action plan to address these areas, including programmatic development and partnerships.

Organizational Benefits

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

CHNA Process



Demographics and Health Indicators



Inyo County Demographics

	Inyo Co.	CA
Total Population	18,527	38,965,193
65+ Pop. %	25.6%	16.2%
Female Pop. %	49.4%	50.1%
White Pop. %	59.0%	34.3%
Hispanic Pop. %	24.6%	40.4%
Median HH Income	\$71,656	\$95,473

Leading Causes of Death



Heart Disease



Cancer



Accidents



Chronic Lower Respiratory Disease



Stroke

Healthcare Access



1,459:1

Population per 1 Primary Care Physician



1,248:1

Population per 1 Dentist



183:1

Population per 1 Mental Health Provider



9%

Uninsured Population

Health Behaviors



Adult Smoking

Inyo: **14%**

CA: 10%



Excessive Drinking

Inyo: **23%**

CA: 20%



Physical Inactivity

Inyo: **20%**

CA: 22%



Adult Obesity

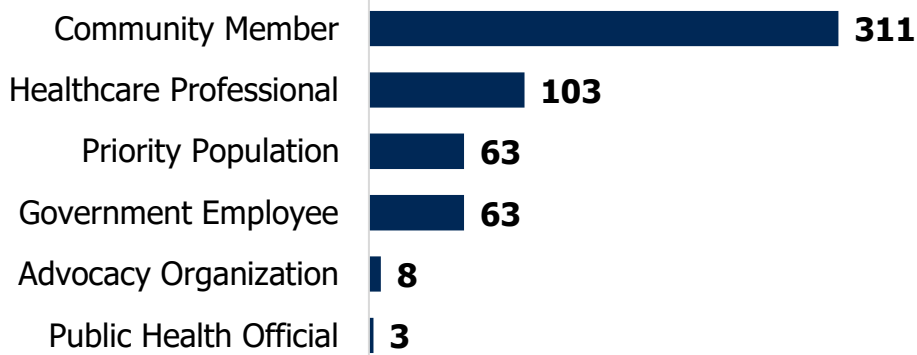
Inyo: **30%**

CA: 28%

Community Survey Data

381 *survey respondents from Nov. – Dec. 2025*

Survey Respondents & Local Expert Make Up:



Ranked Health Priorities

Survey respondents were asked to rank the importance of top health needs on a scale of 1 (not at all) to 5 (extremely). The results of that ranking are displayed below. In 2025, healthcare affordability was the top response, and other highly ranked responses included cost of health insurance, affordable housing, and access to care, suggesting growing financial pressures and perceived barriers to healthcare access.

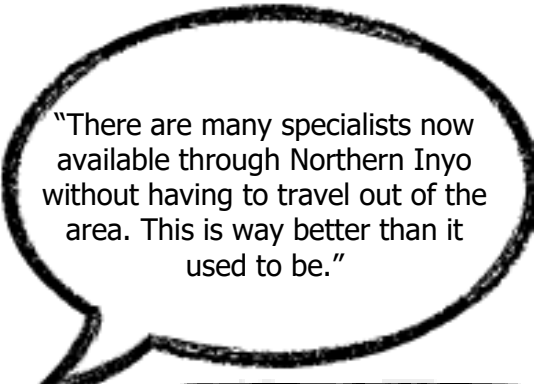
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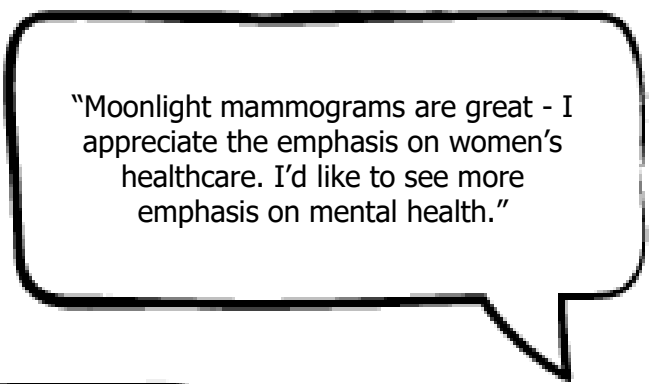
Input on the Actions Taken Since the 2022 CHNA

NIHD considered written comments received on the prior CHNA and Implementation Strategy as a component of the development of the 2025 CHNA and Implementation Strategy. Comments were solicited from community members to provide feedback on any efforts and actions taken by NIHD since the 2022 CHNA and Implementation Plan were conducted. These comments informed the development of the 2025 CHNA and Implementation Plan and are presented in full in the appendix of this report. The health priorities identified in the 2022 CHNA are listed below with a selection of survey responses.

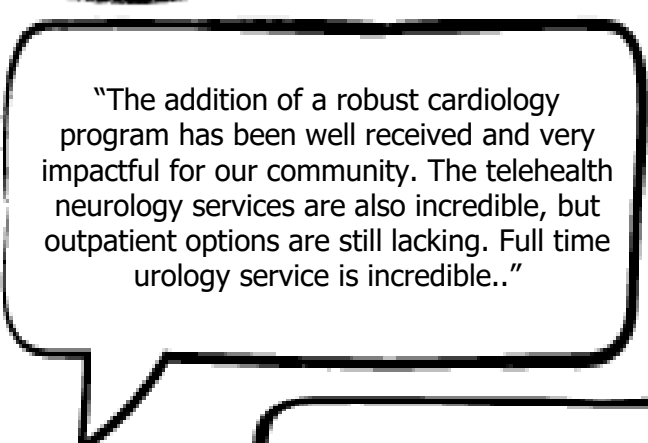
- Behavioral Health
- Access to Healthcare
- Chronic Disease Management



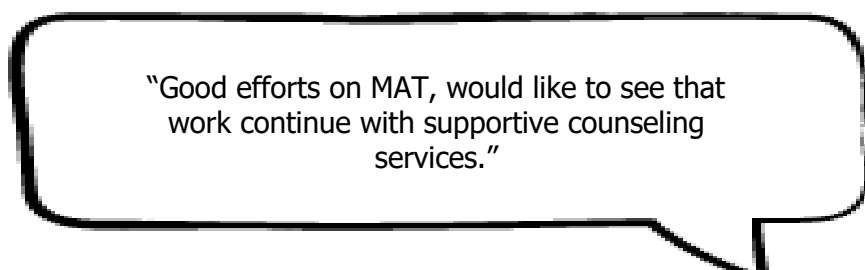
"There are many specialists now available through Northern Inyo without having to travel out of the area. This is way better than it used to be."



"Moonlight mammograms are great - I appreciate the emphasis on women's healthcare. I'd like to see more emphasis on mental health."



"The addition of a robust cardiology program has been well received and very impactful for our community. The telehealth neurology services are also incredible, but outpatient options are still lacking. Full time urology service is incredible.."



"Good efforts on MAT, would like to see that work continue with supportive counseling services."

Implementation Strategy

Health Priority Selection Process

To determine the top health priorities for the community, a structured evaluation and selection process was conducted, where Hospital leaders reviewed both community survey findings and key secondary data indicators, comparing local health outcomes to state benchmarks to identify areas of concern. Each potential priority was assessed based on several criteria: the level of community concern (as reflected in survey responses), whether the issue showed worse-than-average performance compared to the state, the Hospital's capacity and resources to meaningfully address the need, and the alignment with the Hospital's strategic goals.

The top 3 health priorities identified by NIHD for the development of implementation strategies are:



Healthcare Access: Expand healthcare access by strengthening local primary, specialty, and senior-focused care and reducing financial and non-financial barriers through patient navigation, education, and connection to available resources.

Relevant Health Needs: Access to Specialty Care, Access to Primary Care, Senior Services/Elder Care, Healthcare: Affordability



Mental Health: Support community-wide mental health access through collaboration with community partners to expand services, coordinate care, and establish a sustainable mental health delivery model for the region.

Relevant Health Needs: Mental Health



Care Coordination and Disease Management: Improve health outcomes for high-need populations through disease management, outreach and education, and coordinated care.

Relevant Health Needs: Geriatric/Elder Care, Cancer, Women's Health

Health Needs Not Addressed

NIHD acknowledges the significance of all health priorities identified through the community survey and overall assessment. While many of these needs are currently being addressed through existing programs, resources, and strategies led by other community organizations and the Hospital, NIHD has chosen to focus its future efforts on three top-priority areas where it can make the most meaningful impact in line with its strategic goals. By concentrating attention and resources on these key issues, the Hospital aims to strengthen outcomes through targeted programming and strategic collaboration with local partners.



NORTHERN INYO HEALTHCARE DISTRICT
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Northern Inyo Healthcare District

2025

Community Health Needs Assessment

Approved by Board: TBD



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Executive Summary

Northern Inyo Health District (NIHD) performed a Community Health Needs Assessment (CHNA) in partnership with Ovation Healthcare (“Ovation”) to assist in determining the health needs of the local community and an accompanying implementation plan to address the identified health needs. This CHNA report consists of the following information:

- 1) a definition of the community served by the Hospital and a description of how the community was determined;
- 2) a description of the process and methods used to conduct the CHNA;
- 3) a description of how the Hospital solicited and considered input received from persons who represent the broad interests of the community it serves;
- 4) commentary on the 2022 CHNA Assessment and Implementation Strategy efforts;
- 5) a prioritized description of the significant health needs of the community identified through the CHNA along with a description of the process and criteria used in identifying certain health needs as significant and prioritizing those significant health needs; and
- 6) a description of resources potentially available to address the significant health needs identified through the CHNA.

Data was gathered from multiple well-respected secondary sources to help build an accurate picture of the current community and its health needs. A broad community survey was performed in conjunction with Southern Inyo Healthcare District (SIHD) to review and provide feedback on the prior CHNA and to support the determination of the Significant Health Needs of the community in 2025.

The health priorities identified by NIHD from this assessment are:



Healthcare Access



Mental Health



Care Coordination and Disease Management

In the Implementation Strategy section of the report, the Hospital addresses these areas through identified programs and resources with intended impacts included for each health need to track progress towards improved community health outcomes.

Community Health Needs Assessment

Overview

CHNA Purpose

A CHNA is part of the required documentation of "Community Benefit" under the Affordable Care Act for 501(c)(3) hospitals and fulfills requirements for accreditation for many health and public health entities. However, regardless of status, a CHNA provides many benefits to an organization. This assessment provides comprehensive information about the community's current health status, needs, and disparities and offers a targeted action plan to address these areas, including programmatic development and partnerships.

Organizational Benefits

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

CHNA Process

1

Survey the Community

Develop a CHNA survey to be deployed to the broad community in order to assess significant health priorities.

2

Data Analysis

Review survey data and relevant data resources to provide qualitative and quantitative feedback on the local community and market.

3

Determine Top Health & Social Needs

Prioritize community health and social needs based on the community survey, data from secondary sources, and facility input.

4

Implementation Planning

Build an implementation plan to address identified needs with actions, goals, and intended impacts on significant health needs.

Process & Methods

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

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

Data Collection and Analysis

This assessment relies on secondary source data, which primarily uses the county as the smallest unit of analysis. Most data used in the analysis is available from public internet sources and proprietary data. Any critical data needed to address specific regulations or developed by the community members cooperating in this study are displayed in the CHNA report appendix.

All data sources are detailed in the appendix of this report, with the majority of the data used in this assessment coming from:

- County Health Rankings 2025 Report
- Centers for Medicare & Medicaid Services – CMS
- Centers for Disease Control and Prevention – CDC

A standard process of gathering community input was utilized. In addition to gathering data from the above sources, a CHNA survey was deployed to local expert advisors and the general public to gain input on local health needs and the needs of priority populations. Local expert advisors were local individuals selected according to criteria required by the Federal guidelines and regulations and the Hospital's desire to represent the region's economic, racial, and geographically diverse population. Nine hundred forty-five (945) survey responses from community members were gathered in October 2025.

Community Input

Input was obtained from the required three minimum federally required sources and expanded to include other representative groups. The Hospital asked all those participating in the written comment solicitation process to self-identify into any of the following representative classifications, which are detailed in the appendix to this report. Additionally, survey respondents were asked to identify their age, race/ethnicity, and income level to ensure a diverse range of responses were collected.

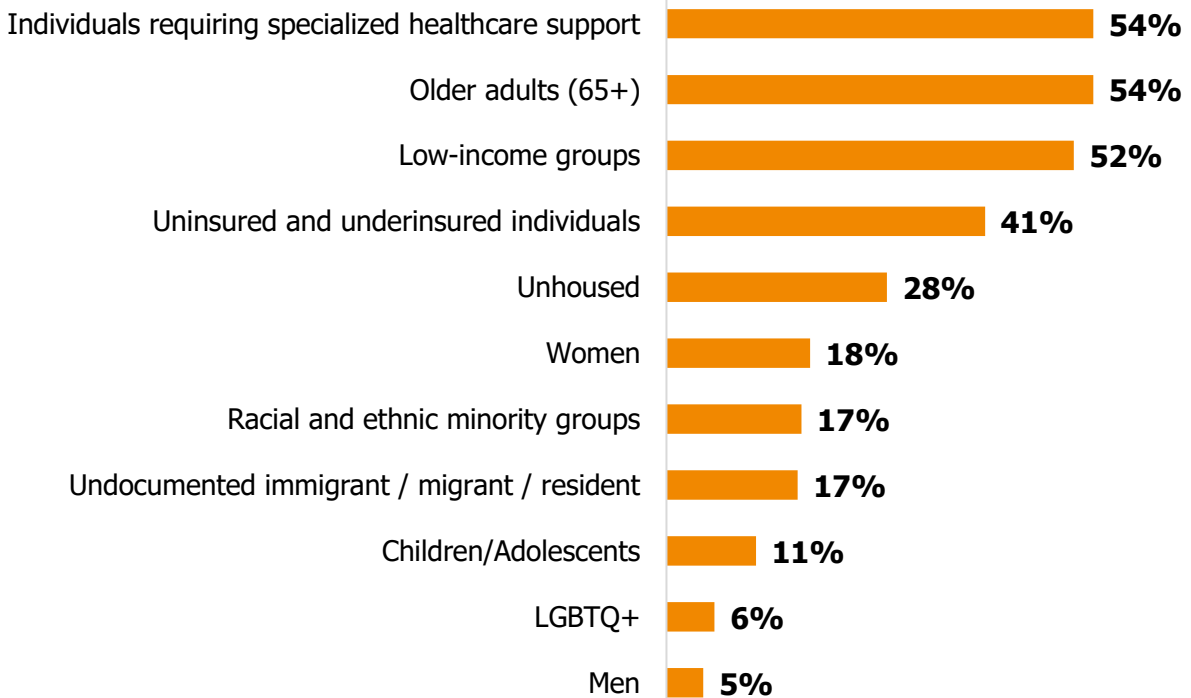
Survey Question: Please select all roles that apply to you (n=379)



Priority Populations

Medically underserved populations are those who experience health disparities or face barriers to receiving adequate medical care because of income, geography, language, etc. The Hospital assessed what population groups in the community (“Priority Populations”) would benefit from additional focus and asked survey respondents to elaborate on the key health challenges these groups face.

Survey Question: Which groups would you consider to have the greatest health needs (rates of illness, trouble accessing healthcare, etc.) in your community?



Local opinions of the needs of Priority Populations, while presented in their entirety in the appendix, were abstracted into the following key themes:

- The top three priority populations identified were older adults (65+), low-income groups, and un/underinsured individuals.
- Summary of unique or pressing needs of the priority groups identified by the respondents:

Access to
Specialty
Care

Financial
Barriers

Care
Coordination

Behavioral
Health

Input on the Actions Taken Since the 2022 CHNA

NIHD considered written comments received on the prior CHNA and Implementation Strategy as a component of the development of the 2025 CHNA and Implementation Strategy. Comments were solicited from community members to provide feedback on any efforts and actions taken by NIHD since the 2022 CHNA and Implementation Plan were conducted. These comments informed the development of the 2025 CHNA and Implementation Plan and are presented in full in the appendix of this report. The health priorities identified in the 2022 CHNA are listed below with a selection of survey responses.

- Behavioral Health
- Access to Healthcare
- Chronic Disease Management

"There are many specialists now available through Northern Inyo without having to travel out of the area. This is way better than it used to be."

"Moonlight mammograms are great - I appreciate the emphasis on women's healthcare. I'd like to see more emphasis on mental health."

"The addition of a robust cardiology program has been well received and very impactful for our community. The telehealth neurology services are also incredible, but outpatient options are still lacking. Full time urology service is incredible.."

"Good efforts on MAT, would like to see that work continue with supportive counseling services."

Community Served

For the purpose of this study, the service area is defined as Inyo County in California. The data presented in this report is based on this county-level service area and compared to state averages. Geographically, NIHD is located in northeast Inyo County. There is one other critical access hospital, Southern Inyo Healthcare District, located at the southern end of the county.

Service Area

Inyo County

Total Population: **18,527**



Source: County Health Rankings 2025 Report, ArcGIS

Service Area Demographics

	Inyo	California
Demographics		
Total Population	18,527	38,965,193
Age		
Below 18 Years of Age	19.8%	21.7%
Ages 19 to 64	54.6%	62.1%
65 and Older	25.6%	16.2%
Race & Ethnicity		
Non-Hispanic White	59.0%	34.3%
Non-Hispanic Black	1.0%	5.6%
American Indian or Alaska Native	14.0%	1.7%
Asian	1.9%	16.5%
Native Hawaiian or Other Pacific Islander	0.2%	0.5%
Hispanic	24.6%	40.4%
Gender		
Female	49.4%	50.1%
Male	50.6%	49.9%
Geography		
Rural	42.1%	5.8%
Urban*	57.9%	94.2%
Income		
Median Household Income	\$71,656	\$95,473

Notes: *Urban is defined by the US Census Bureau as census blocks that encompass at least 5,000 people or at least 2,000 housing units

Source: County Health Rankings 2025 Report

Methods of Identifying Health Needs

Collect & Analyze

Analyze existing data and collect new data



737 indicators collected from data sources



381 surveys completed by community members

Evaluate

Evaluate indicators based on the following factors:



Worse than benchmark



Identified by the community



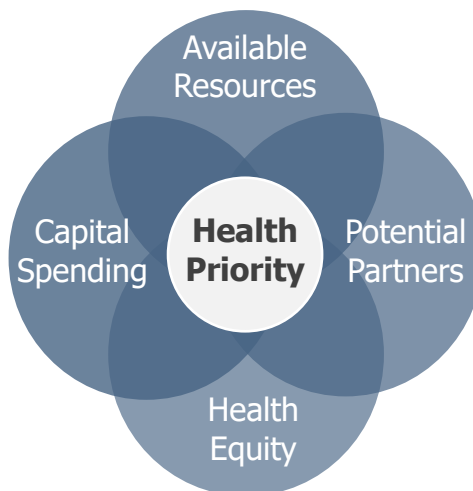
Impact on health disparities



Feasibility of being addressed

Select

Select priority health needs for implementation plan



Prioritizing Significant Health Needs

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

In the Hospital's process, each survey respondent had the opportunity to prioritize community health needs. The survey respondents then ranked the importance of addressing each health need on a scale of 1 (not at all) to 5 (extremely), including the opportunity to list additional needs that were not identified.

The ranked needs were divided into "Significant Needs" and "Other Identified Needs." The determination of the breakpoint — "Significant" as opposed to "Other" — was a qualitative interpretation where a reasonable breakpoint in rank order occurred. The Hospital analyzed the health issues that received the most responses and established a plan for addressing them.

Ranked Health Priorities

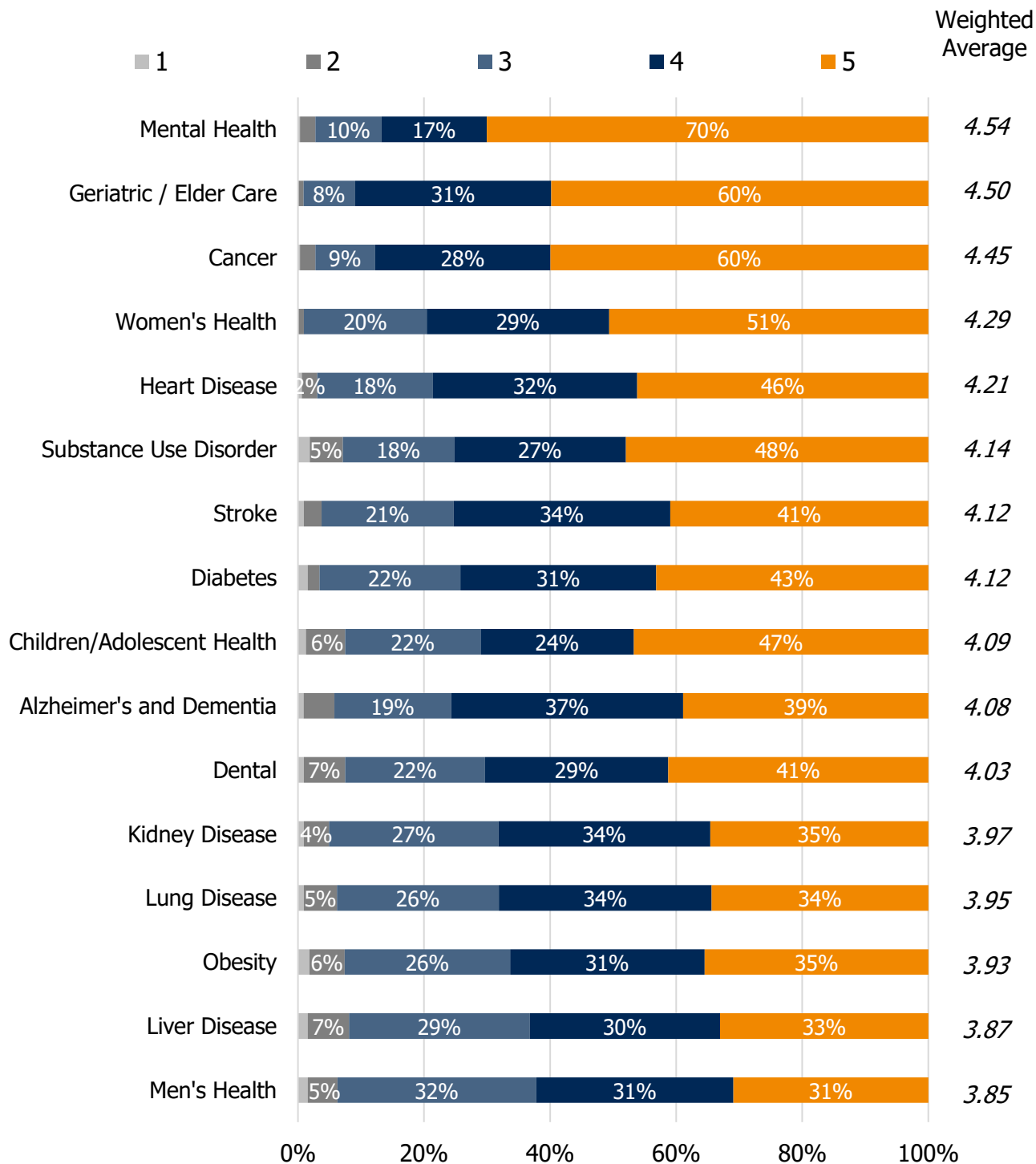
The health priority ranking process included an evaluation of health factors, community factors, and personal factors, given that they each uniquely impact the overall health and health outcomes of a community:

- Health factors include chronic diseases, health conditions, and the physical health of the population.
- Community factors are the social drivers that influence community health and health equity.
- Behavioral factors are the individual actions that affect health outcomes.

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

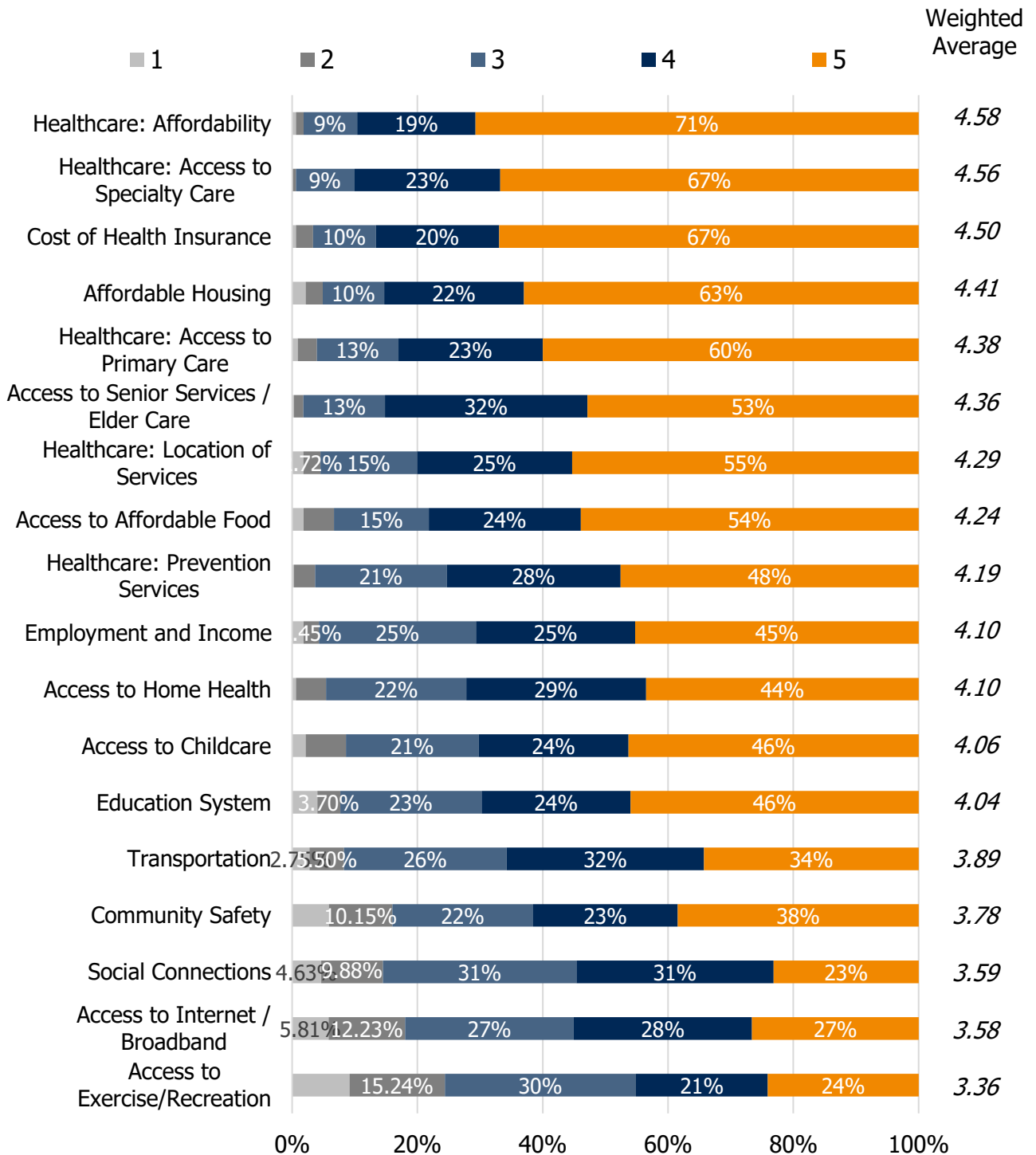
Health Factors

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



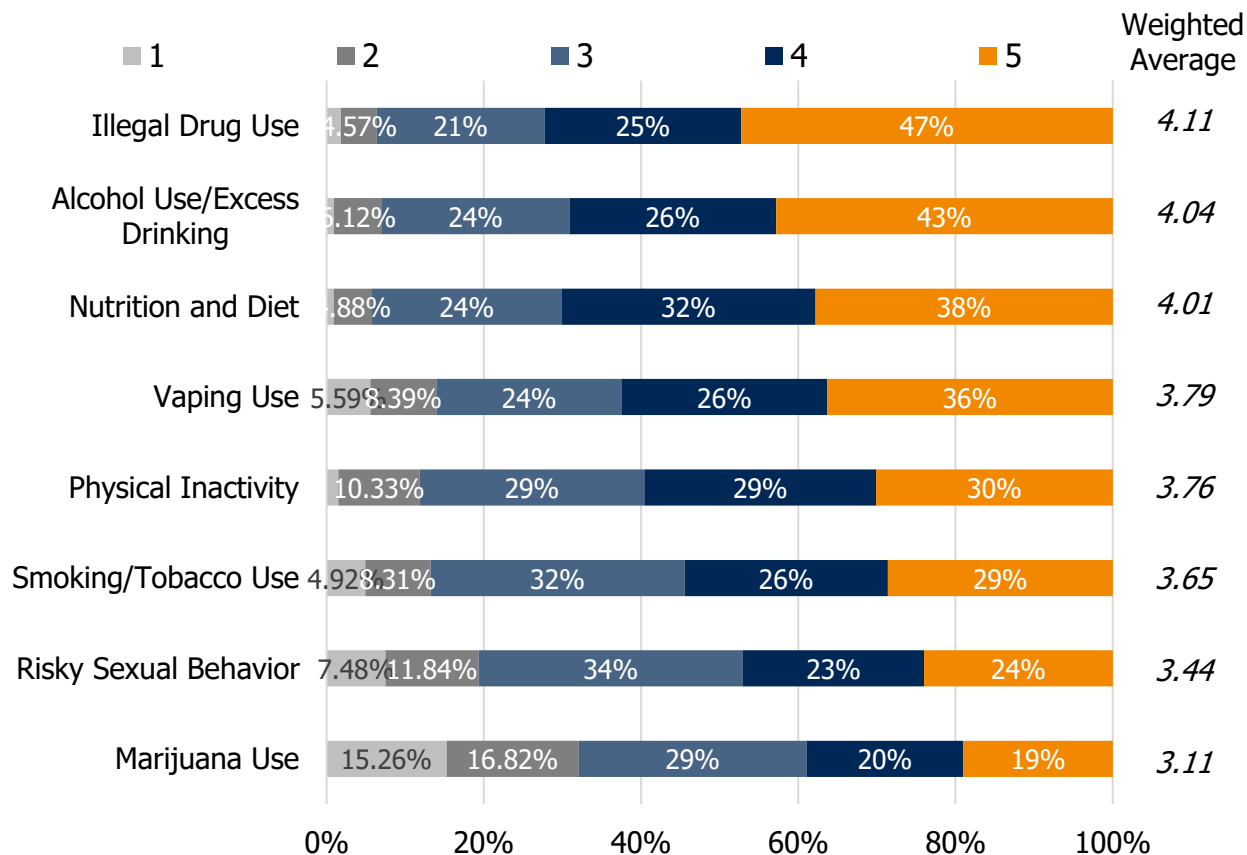
Community Factors

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



Behavioral Factors

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



Overall Health Priority Ranking (Top 10 Highlighted)

Health Issue	Weighted Average (out of 5)	Combined 4 (Important) and 5 (Extremely Important) Rating
Healthcare: Affordability	4.58	89.6%
Healthcare: Access to Specialty Care	4.56	90.0%
Mental Health	4.54	86.7%
Geriatric / Elder Care	4.50	90.9%
Cost of Health Insurance	4.50	86.7%
Cancer	4.45	87.8%
Affordable Housing	4.41	85.3%
Healthcare: Access to Primary Care	4.38	83.0%
Access to Senior Services / Elder Care	4.36	85.2%
Women's Health	4.29	79.6%
Healthcare: Location of Services	4.29	80.1%
Access to Affordable Food	4.24	78.2%
Heart Disease	4.21	78.6%
Healthcare: Prevention Services	4.19	75.3%
Substance Use Disorder	4.14	75.2%
Diabetes	4.12	74.2%
Stroke	4.12	75.3%
Illegal Drug Use	4.11	72.3%
Access to Home Health	4.10	72.2%
Employment and Income	4.10	70.6%
Children/Adolescent Health	4.09	71.0%
Alzheimer's and Dementia	4.08	75.7%
Access to Childcare	4.06	70.3%
Education System	4.04	69.8%
Alcohol Use/Excess Drinking	4.04	69.1%
Dental	4.03	70.3%
Nutrition and Diet	4.01	70.1%
Kidney Disease	3.97	68.2%
Lung Disease	3.95	68.1%
Obesity	3.93	66.4%
Transportation	3.89	65.8%
Liver Disease	3.87	63.2%
Men's Health	3.85	62.2%
Vaping Use	3.79	62.4%
Community Safety	3.78	61.5%
Physical Inactivity	3.76	59.6%
Smoking/Tobacco Use	3.65	54.5%
Social Connections	3.59	54.6%
Access to Internet / Broadband	3.58	55.1%
Risky Sexual Behavior	3.44	47.0%
Access to Exercise/Recreation	3.36	45.1%
Marijuana Use	3.11	38.9%

Survey Ranking Comparison from 2022 to 2025

The 2025 survey highlights consistent concern around healthcare affordability and mental health, but with some notable shifts in priority emphasis from the 2022 survey results. In 2025, healthcare affordability was the top response, and other highly ranked responses included cost of health insurance, affordable housing, and access to care, suggesting growing financial pressures and perceived barriers to healthcare access. Mental health remains a top concern, reflecting continued community focus on behavioral health needs. Newer or elevated priorities include, geriatric/elder care and women's health, indicating increased attention to chronic disease management and priority populations.

2025 NIHD and SIHD Survey (n=381)	
Top 10 Health Priorities	Rank
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Access to Primary Care	4.38
Senior Services / Elder Care	4.36
Women's Health	4.29

2022 NIHD Survey (n=643)	
Top 10 Health Priorities	Rank
Mental Health	4.53
Affordable Housing	4.46
Healthcare Services: Affordability	4.41
Physical Presence	4.38
Cancer	4.37
Drug/Substance Abuse	4.30
Access to Childcare	4.27
Diabetes	4.24
Access to Senior Services	4.21
Livable Wage	4.21

Community Health Characteristics

This section highlights health status indicators, outcomes, and relevant data on the health needs in Inyo County. The data at the county level is supplemented with benchmark comparisons to the state data. The most recently available data is used throughout this report with trended data included where available. A scorecard that compares the population health data of the service area county to that of California can be found in the report appendix.

Behavioral Health

Mental Health

Mental health was the #3 community-identified health priority, with 87% of respondents rating it as important to be addressed in the community (important is categorized as a 4 or 5 rating on the community survey). The suicide mortality rate in Inyo County is 16.2, which is higher than the California average.

Inyo County has better access to mental health providers compared to the state, where there is 1 provider for every 183 county residents. Additionally, the county has higher rates of frequent mental distress compared to the state.

	Inyo	California
Suicide Mortality Rate per 100,000 (2019-2023)	16.2	10.3
Poor Mental Health Days past 30 days (2022)	5.7	4.7
Population per 1 Mental Health Provider (2024)	183:1	213:1
Frequent Mental Distress (2022)	17%	15%

Note: "Frequent Mental Distress" indicates percentage of adults reporting 14 or more days of poor mental health per month

Source: NIH: HDPulse, County Health Rankings 2025 Report, PLACES: Local Data for Better Health

Drug, Substance, and Alcohol Use

Inyo County has a higher drug-related overdose death rate compared to California (50 compared to 26 per 100,000 population, respectively). The prevalence of excessive drinking and alcohol-impaired driving deaths is higher in Inyo County compared to the state. Additionally, the adult smoking rate is higher in Inyo county than the state of California as a whole.

	Inyo	California
Drug-Related Overdose Deaths per 100,000 (2021-2023)	50.2	26.1
Excessive Drinking (2022)	23.3%	19.9%
Alcohol-Impaired Driving Deaths (2018-2022)	28.2%	25.6%
Adult Smoking (2022)	13.8%	9.9%

Source: CDC National Vital Statistics System, County Health Rankings 2025 Report

Chronic Diseases

Cancer

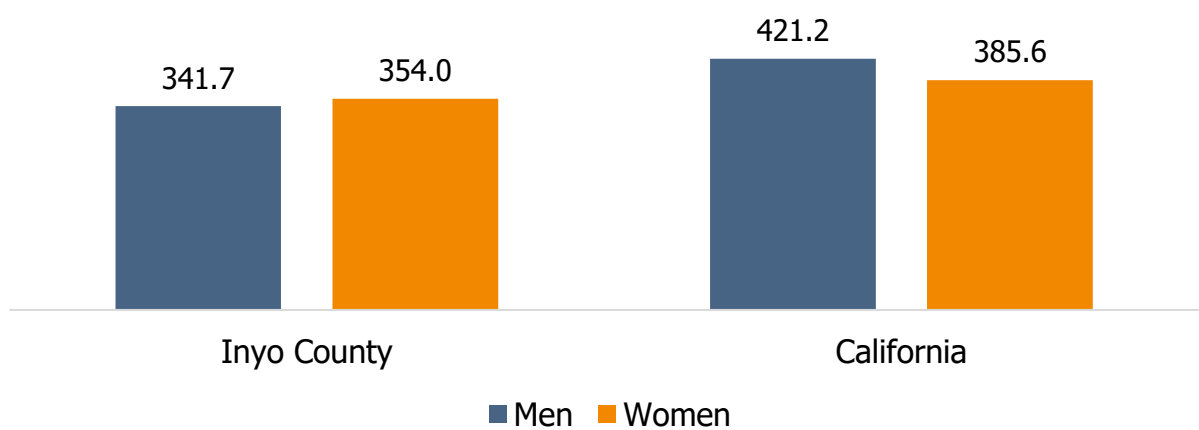
Cancer was identified as the #6 community health issue with 88% of survey respondents rating it as important to address in the community. Cancer is the 2nd leading cause of death in Inyo County. Additionally, 53% of survey respondents said they would like to see additional access to cancer care in Inyo County. Inyo County has both a lower cancer incidence rate and mortality rate compared to California cancer rates.

Inyo County exhibits a slightly higher cancer incidence rate among women than men, a pattern that contrasts with statewide trends and may reflect population size, cancer type distribution, and screening-related factors rather than a true gender-based disparity.

	Inyo	California
Cancer Incidence Rate Age-Adjusted per 100,000 (2017-2021)	345.4	397.4
Cancer Mortality Rate per 100,000 (2019-2023)	130.1	131.9

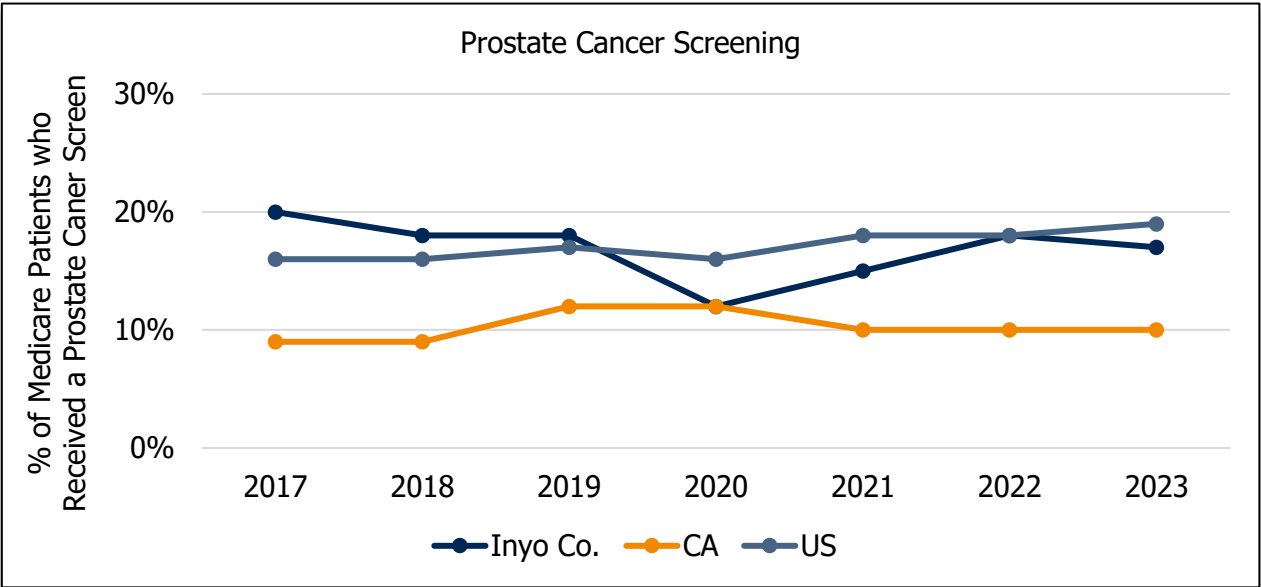
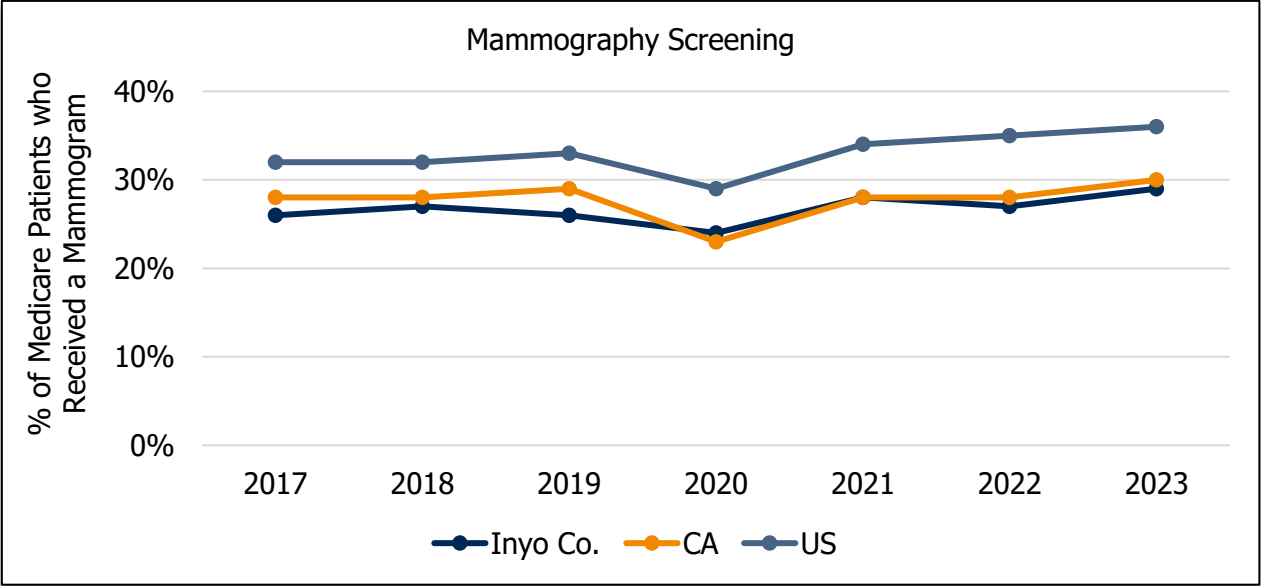
Source: NIH: HDPulse, National Cancer Institute

Cancer Incidence Rates by Gender (per 100,000)



Source: National Cancer Institute

The rate of Medicare enrollees (women age 65+) who have received a mammogram in the past year is comparable between Inyo County and the state (29% and 30%, respectively). These rates have increased in recent years following a dip downward in 2020 during the COVID-19 pandemic. Among Medicare enrollees (men age 65+), Inyo County has a higher rate of prostate cancer screening compared to the state (17% compared to 10%, respectively).



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

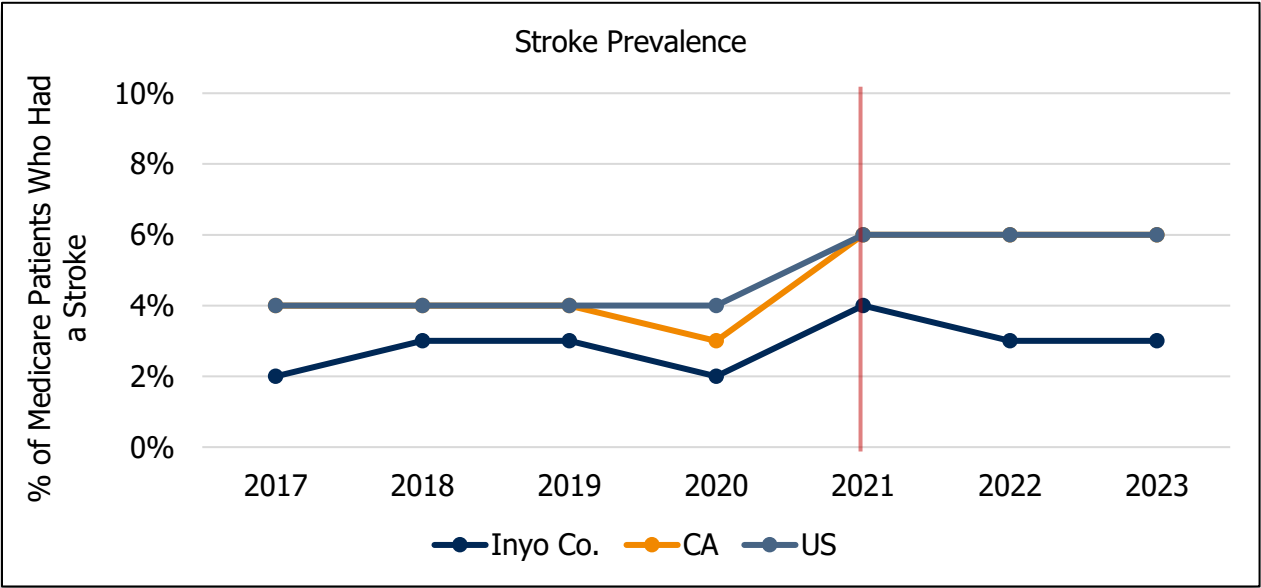
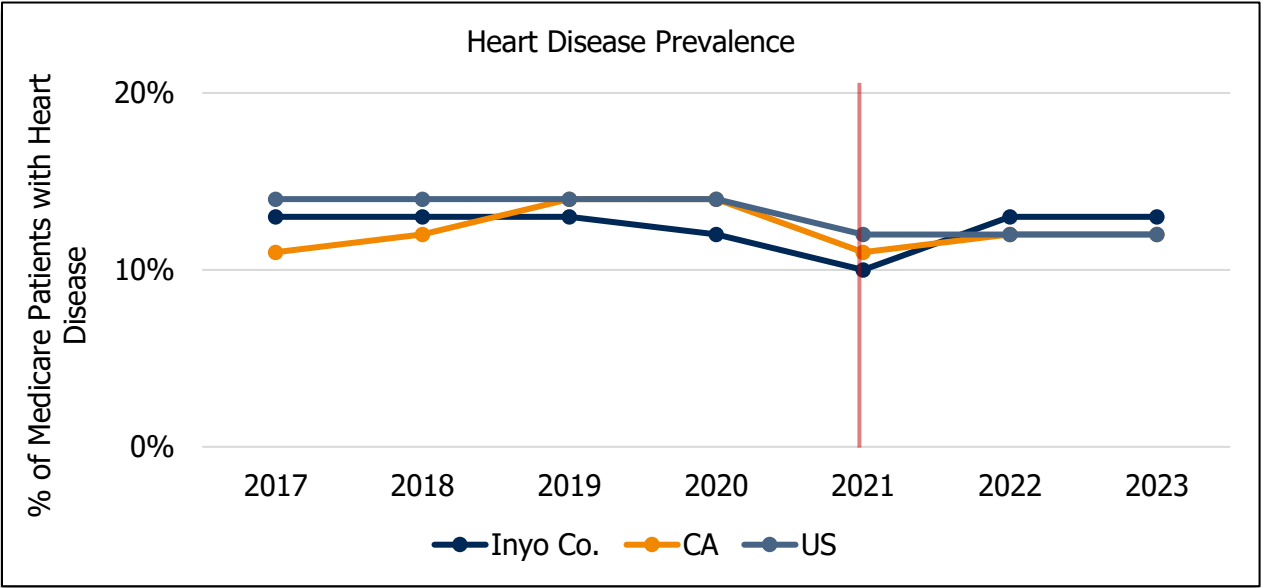
Cardiovascular Health

Heart disease is the leading cause of death in Inyo County though the county has a lower mortality rate for both heart disease and stroke compared to state averages. Looking at risk factors for negative cardiovascular health, Inyo County has a slightly lower prevalence of high blood pressure compared to the California average.

	Inyo	California
Heart Disease Mortality Rate per 100,000 (2019-2023)	137.5	143.6
Stroke Mortality Rate per 100,000 (2019-2023)	32.3	40.1
High Blood Pressure (2021-2023)	35.1%	37.1%

Source: NIH: HDPulse, PLACES: Local Data for Better Health, America's Health Rankings

In the Medicare population, Inyo County has a slightly higher prevalence of heart disease compared to the state (13% compared to 12% respectively), and the prevalence of stroke is the lower than the state (3% and 6%, respectively).



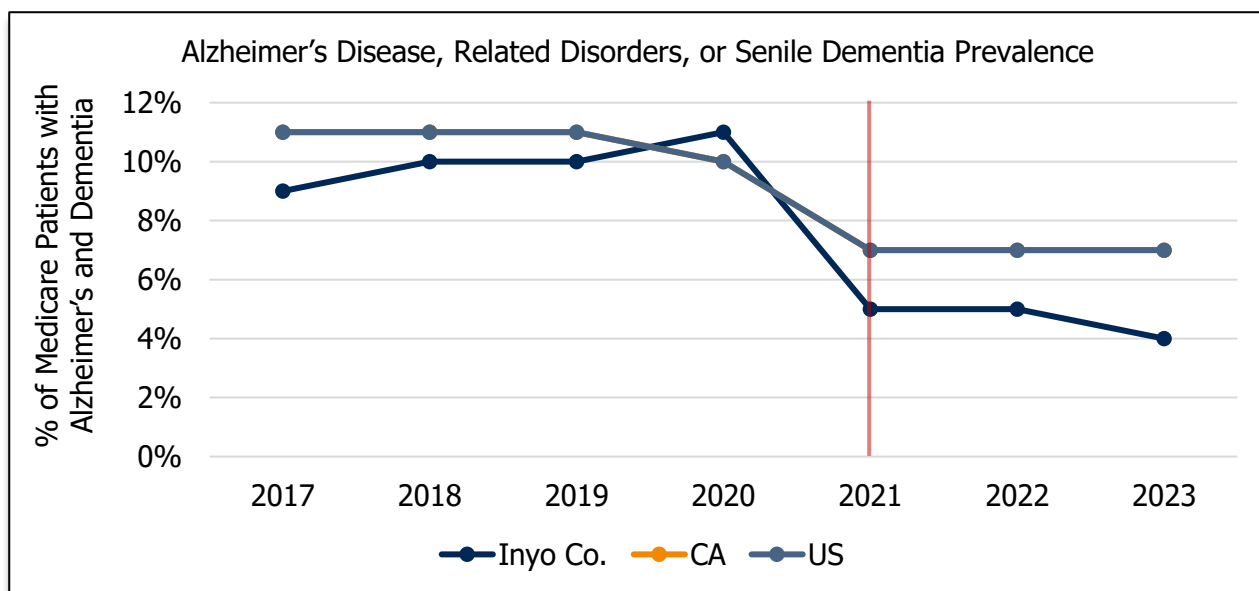
Note: There was a change in the algorithm of reported data in 2021 noted by a red bar. Between 2017 to 2019 and 2021 to 2023, the State and National data overlap
Source: Centers for Medicare & Medicaid Services: Mapping Medicare Disparities by Population

Alzheimer's and Dementia

Inyo County has a lower mortality rate for Alzheimer's compared to the state on average. Additionally, in the Medicare population, the prevalence of Alzheimer's, related disorders, or senile dementia is 4% which is lower than state and national averages of 7%.

	Inyo	California
Alzheimer's Mortality Rate per 100,000 (2019-2023)	10.2	38.8

Source: NIH: HDPulse



Note: There was a change in algorithm in 2021, marked by the vertical red line representing a break in trend lines. Between 2017 to 2023, the State and National data overlap.

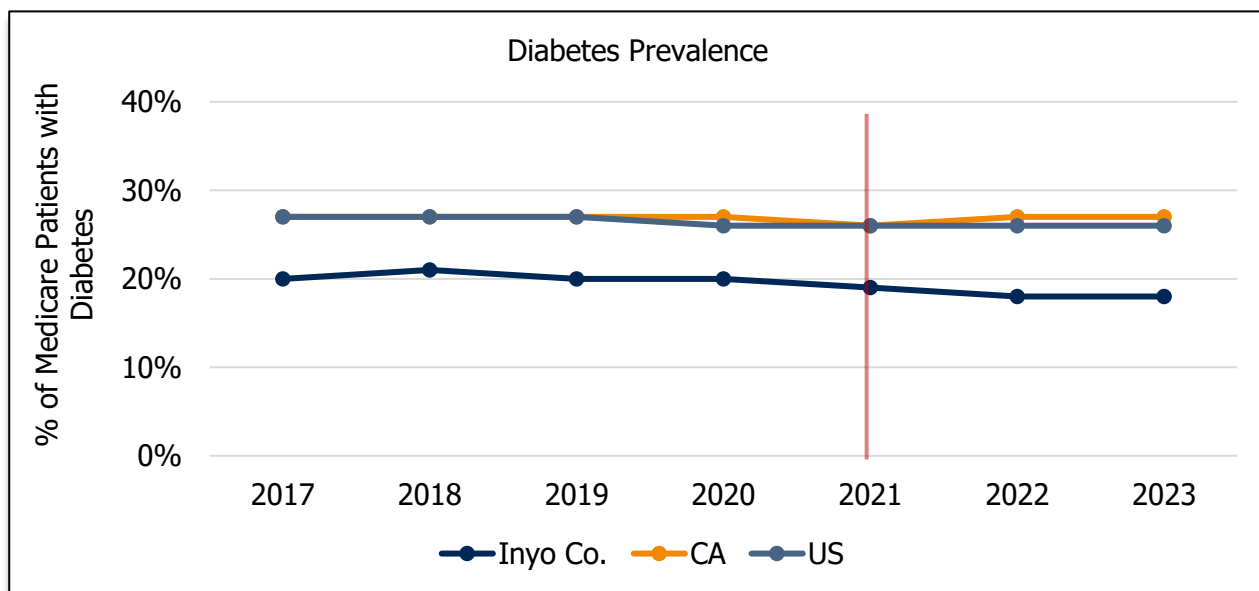
Source: Centers for Medicare & Medicaid Services: Mapping Medicare Disparities by Population

Diabetes

The prevalence of diabetes in Inyo County is the slightly lower than the California average, and the county sees a diabetes mortality rate lower than the state's. When evaluating the Medicare population, Inyo County has a lower prevalence of diabetes compared to the state (18% and 27% respectively), though rates have remained relatively stable over the past several years.

	Inyo	California
Diabetes Mortality Rate per 100,000 (2019-2023)	18.5	24.6
Diabetes Prevalence (2023)	9.3%	10.6%

Source: NIH: HDPulse, County Health Rankings 2025 Report



Note: There was a change in the algorithm of reported data in 2021 noted by a red bar. Between 2017 to 2019 and in 2021, the State and National data overlap

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

Obesity and Unhealthy Eating

In Inyo County, adults have slightly higher rates of obesity than in California on average. Additionally, the county sees lower access to both healthy foods and exercise opportunities (proximity to a park or recreation facility). This combination contributes to an increased risk of chronic diseases and further exacerbates health disparities, especially in low-income and rural communities. Additionally, obesity, physical inactivity, and diet are well-established risk factors for type 2 diabetes development (American Diabetes Association).

	Inyo	California
Adult Obesity (2022)	29.9%	28.3%
Limited Access to Healthy Foods (2019)	7.8%	3.2%
Physical Inactivity (2022)	19.7%	21.6%
Access to Exercise Opportunities (2020-2024)	86.9%	94.3%

Source: County Health Rankings 2025 Report, PLACES: Local Data for Better Health

Healthcare Access

Access & Affordability

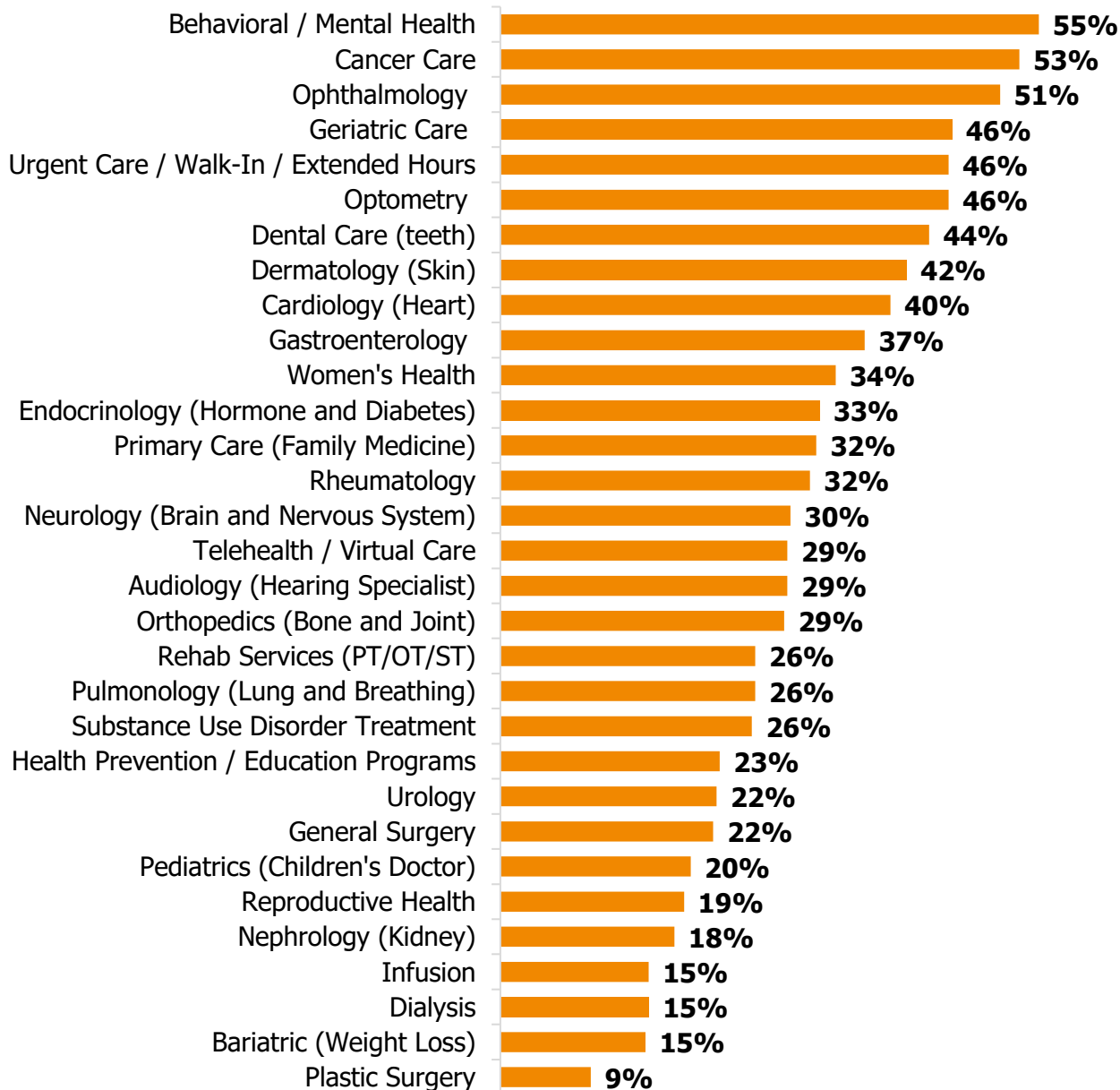
Access to affordable and quality healthcare services is a key driver of improved health outcomes, economic stability, and health equity. In the community survey, 32% of respondents said they would like to see additional primary care availability in the county. Inyo County has a lower household income than the California average and has a comparable uninsured population relative to state rates. Inyo County has 1 primary care physician (MD, DO) for every 1,459 residents, which indicates less access to primary care than the state average (1 physician for every 1,233 residents). Similarly, Inyo County has less access to dental providers compared to California on average.

	Inyo	California
Uninsured Population (2022)	9.0%	9.1%
Population per 1 Primary Care Physician (2021)	1,459:1	1,233:1
Population per 1 Primary Care Provider (APP) (2021)	842:1	1,062:1
Population per 1 Dentist (2022)	1,248:1	1,076:1

Source: County Health Rankings 2025 Report, PLACES: Local Data for Better Health

In the community survey, respondents were asked to identify what healthcare services and programs they would like to see available in their community. Mental Health was the top identified service need, with 55% of respondents saying they would like to see it available in their community, followed by Cancer Care (53%), and Ophthalmology (51%).

Survey Question: What additional services/offerings would you like to see available locally? (select all that apply)



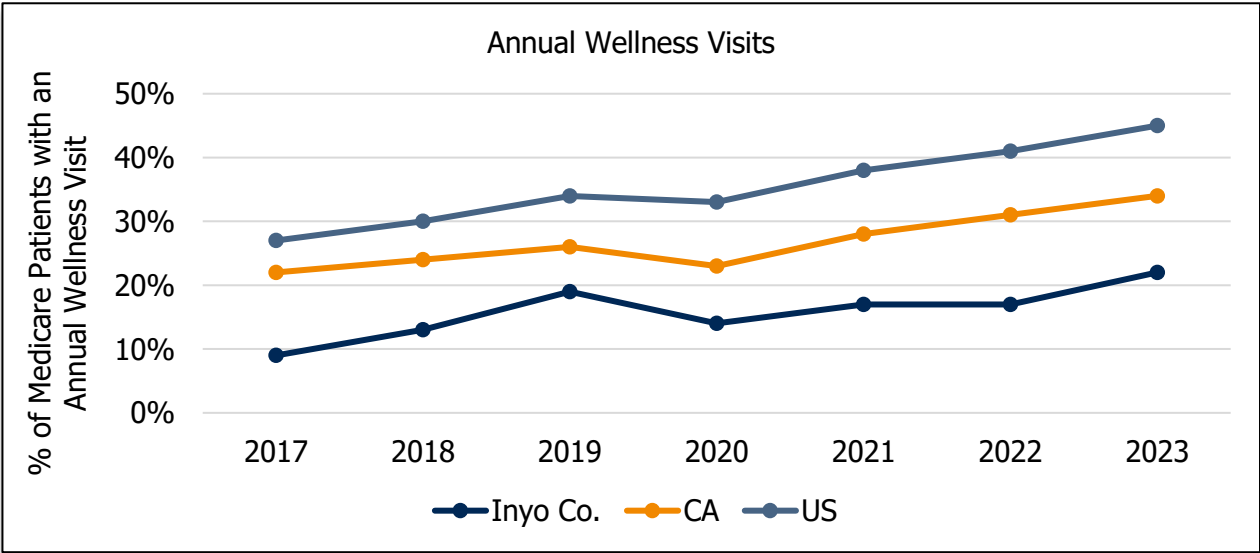
Prevention Services

Prevention services, including routine check-ups, health screenings, and education, can help prevent or detect diseases early when they are easier to treat. Preventive care reduces the burden on healthcare systems by preventing unnecessary hospital stays and costly care. In the community survey, 23% of respondents said they would like to see additional health prevention and education programs available in the community.

Inyo County has lower flu vaccine adherence rates and a lower rate of preventable hospital stays (hospital stays for ambulatory-care sensitive conditions) than the state. This rate represents the effectiveness of preventive care in a community, reflecting how well primary care services manage chronic conditions and prevent avoidable hospital admissions. Additionally, the rate of annual wellness visits in the Medicare population is lower in Inyo County than the California average, with rates increasing in recent years.

	Inyo	California
Preventable Hospital Stays per 100,000 (2022)	1,198	2,257
Flu Vaccination (2022)	39.0%	44.0%

Source: County Health Rankings 2025 Report



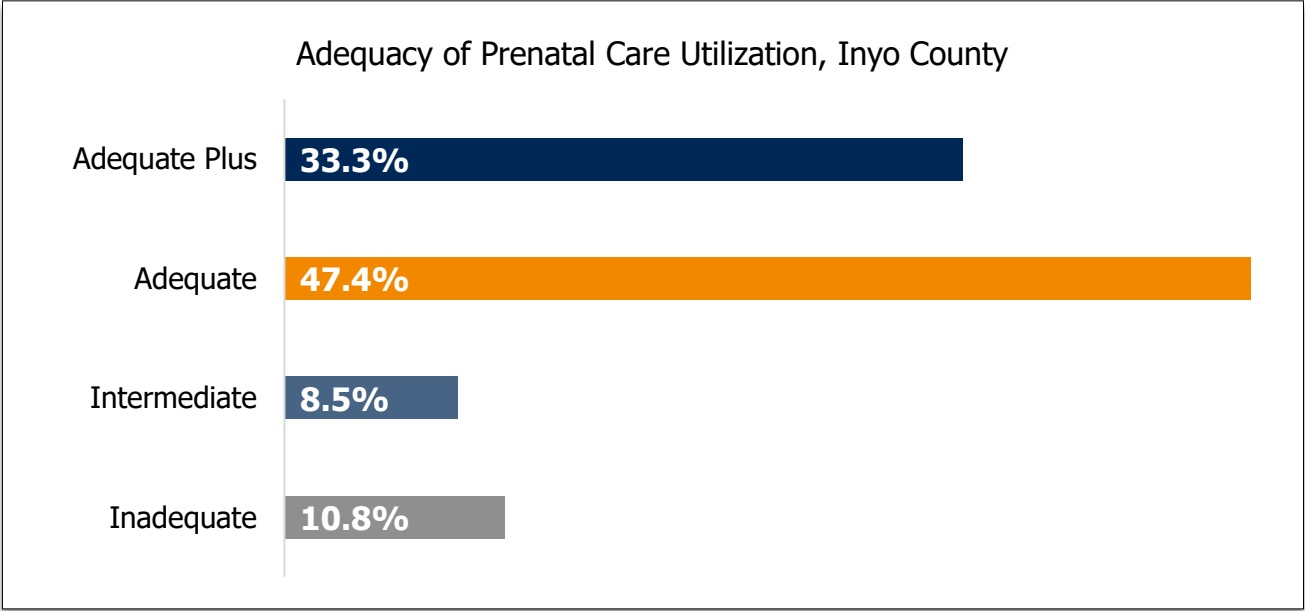
Source: Centers for Medicare & Medicaid Services: Mapping Medicare Disparities by Population

Women’s Health

Rural communities face significant barriers to women’s health, including provider shortages, long travel distances, and financial constraints, which limit access to preventive care, maternity services, and chronic disease management. This lack of access contributes to poorer health outcomes, such as higher rates of late-stage cancer diagnoses, maternal complications, and untreated chronic conditions. Strengthening women’s health services improves maternal and infant health while also supporting the local workforce and promoting long-term community sustainability.

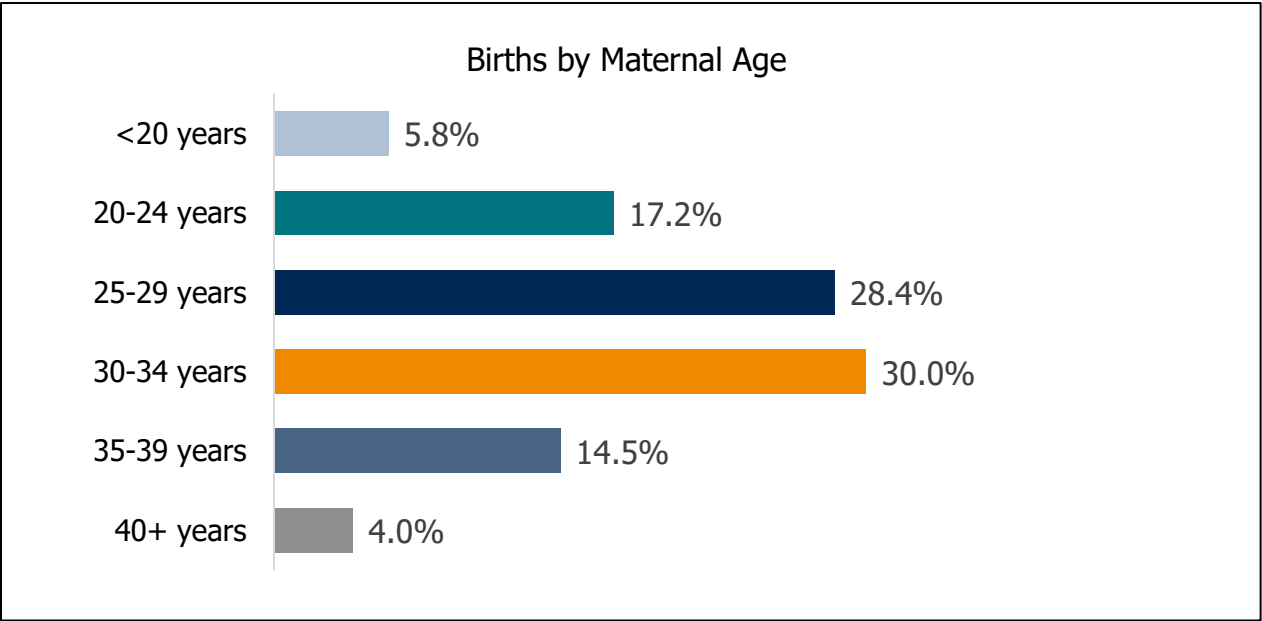
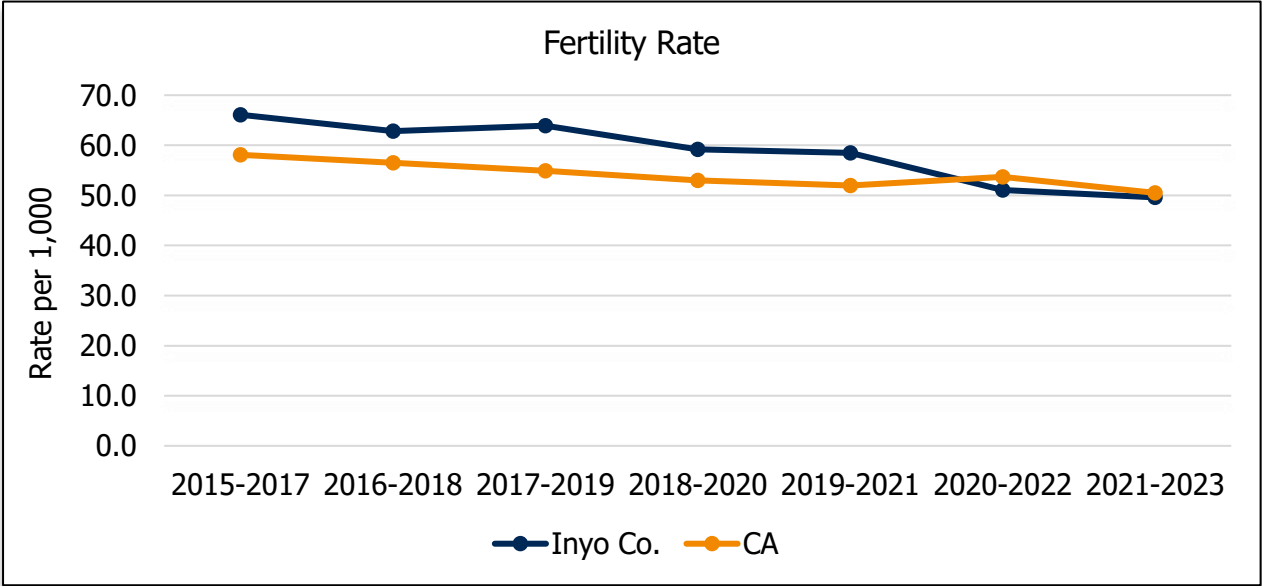
	Inyo	California
Female Population	49.4%	50.1%
Female Population of Reproductive Age (15-44)	32.7%	40.4%
Mammography Screening (2022)	33.0%	36.0%
Adequate Prenatal Care (2021-2023)	80.7%	73.7%

Source: County Health Rankings 2024 Report, ESRI, CDPH



Source: CDPH (2021-2023)

Historically, Inyo County has had a higher fertility rate relative to the state, however the most recent data shows a slight decline, with Inyo County at 49.6 and California at 50.5. Births in Inyo County are now most concentrated among women ages 30–34, surpassing the 25–29 age group that has historically represented the largest share of births. While birth rates remain highest within the 25–29 and 30–34 age bands, these cohorts tend to be more cost-sensitive, focused on convenient access points, and may increased interest in alternative care models, including midwifery, doula services, and birth centers.



Note: Fertility Rate represents number of births per 1,000 females age 15-44
Source: CDPH (2021-2023)

Access to Senior Services

Geriatric/Elder Care and access to senior services were identified as the #4 and #9 survey priorities, respectively. Older adults were identified as the top priority population in the community making access to senior services an important need. Additionally, the population of people 65+ is projected to grow by over 3% in Inyo county over the next five years.

	Inyo	California
Population 65+ (2025)	25.6%	16.2%
5-Year Projected Increase in 65+ Population (2025)	+3.5%	+9.5%

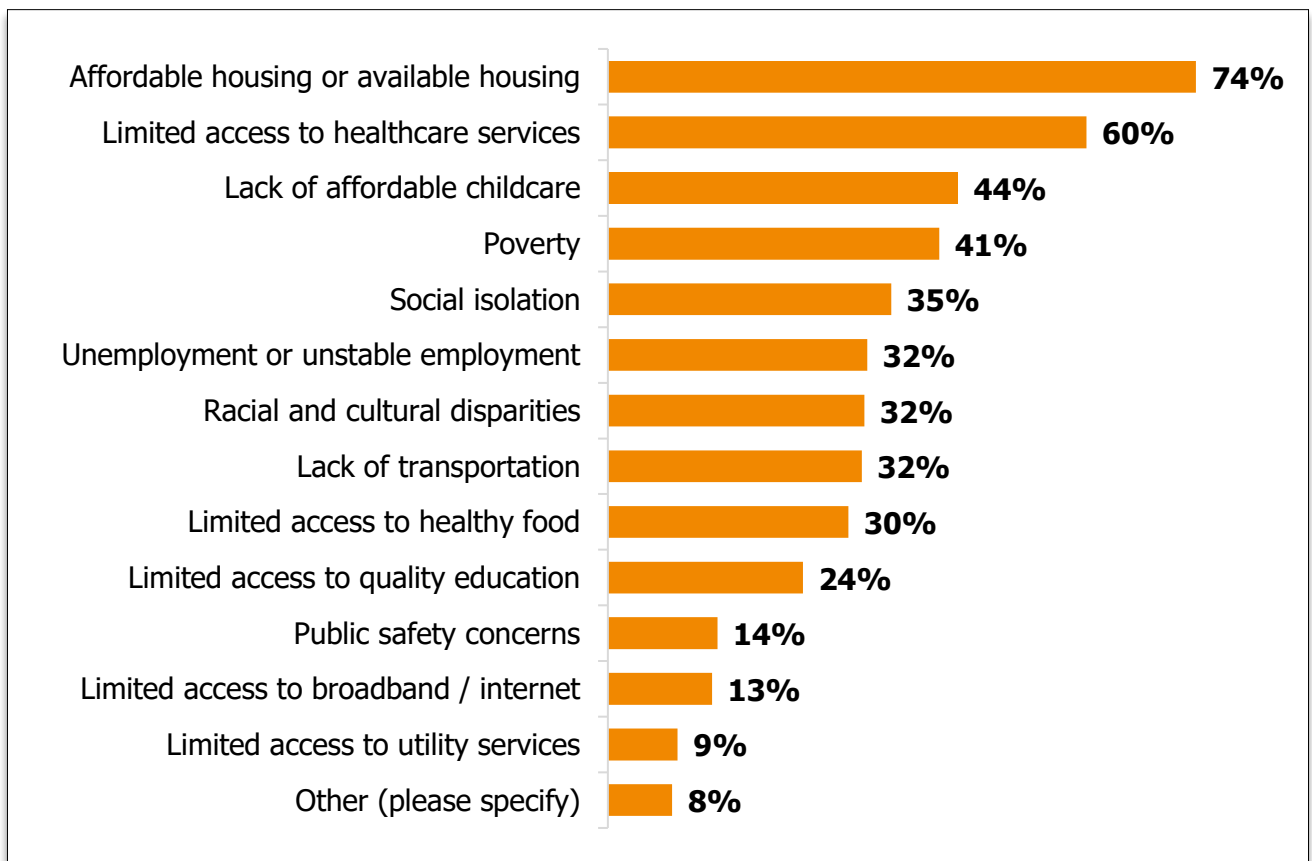
Source: County Health Rankings 2025 Report, ESRI

Social Determinants of Health

Social determinants of health, such as economic stability, education, and access to healthcare, significantly influence health outcomes by shaping individuals' living conditions, behaviors, and access to resources necessary for maintaining good health. These factors can lead to health disparities, with marginalized groups often experiencing worse health outcomes due to these determinants (Healthy People 2030).

Survey respondents were asked to identify the key social conditions that negatively impact the community. The top social condition identified was housing affordability/availability, with 74% of survey respondents reporting it as negatively affecting the community's health, followed by limited access to healthcare services and lack of affordable childcare.

Survey Question: Please select the key social determinants that negatively impact the health of you or your community (select all that apply):



Housing

Access to affordable and safe housing influences a wide range of factors that contribute to physical and mental well-being. There is evidence that a lack of access to affordable and stable housing can lead to negative health outcomes such as mental illnesses and stress, exposure to environmental hazards, and financial instability (Center for Housing Policy). Less Inyo County residents experience severe housing problems (overcrowding, high housing costs, lack of plumbing) than the state average. Additionally, 11% of Inyo County residents spend 50% or more of their household income on housing.

	Inyo	California
Severe Housing Problems (2017-2021)	16.9%	25.8%
Severe Housing Cost Burden (2019-2023)	11.4%	20.0%
Broadband Access (2019-2023)	82.7%	92.5%

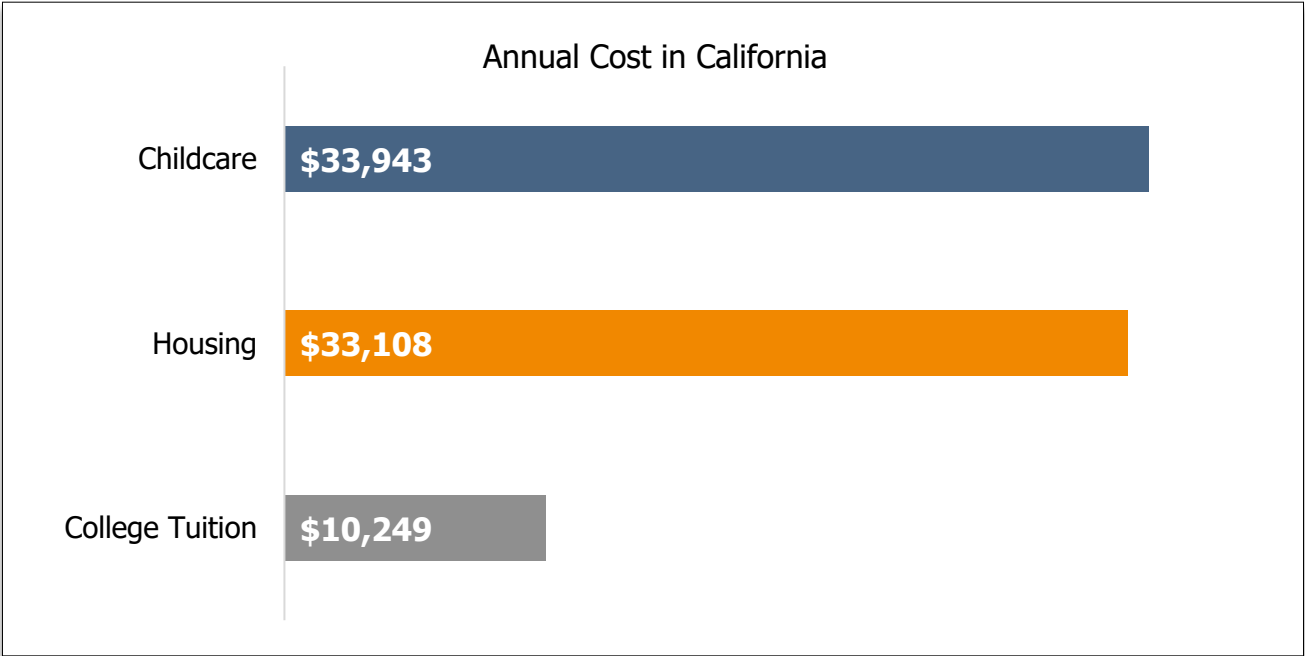
Source: County Health Rankings 2025 Report

Access to Childcare

The average yearly cost of infant care in California is \$19,547. The U.S. Department of Health and Human Services defines affordable childcare as being no more than 7% of a family’s income (Economic Policy Institute). In Inyo County, nearly 31% of household income is required for childcare expenses, and there are approximately 13 childcare centers for every 1,000 children under age 5 in the county, compared to 8 in the state.

	Inyo	California
Children in Single-Parent Households (2019-2023)	29.8%	22.5%
Child Care Cost Burden - % of HHI used for childcare (2023-2024)	30.9%	29.7%
Child Care Centers per 1,000 Under Age 5 (2010-2022)	13	8

Source: County Health Rankings 2025 Report



Note: Annual childcare price for 2 children (an infant and 4-year-old) in a center
Source: Child Care Aware (2023)

Income, Employment, and Education

Income, employment, and education play a role in the community's ability to afford healthcare and impact health outcomes through health literacy and access to health insurance. Educational attainment and employment impact mental health through poverty and unstable work environments, health behaviors like smoking, diet, and exercise, and access to health insurance (HealthAffairs). Additionally, these factors impact people's ability to afford services to live healthy and happy lives like safe housing, transportation, childcare, and healthy food.

	Inyo	California
Median Household Income (2023)	\$71,656	\$95,473
High School Completion (2021-2022)	92.8%	84.6%
Some College – Includes Those Who Had and Had Not Attained Degrees (2019-2023)	68.3%	68.0%
Unemployment (2023)	3.8%	4.8%
Children in Poverty (2019-2023)	14.2%	15.0%

Source: County Health Rankings 2025 Report

Evaluation Process

Worse than Benchmark Measure



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

Identified by the Community



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

Feasibility of Being Addressed



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

Impact on Health Equity



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

Health Need Evaluation	Worse than Benchmark	Identified by the Community	Feasibility	Impact on Health Equity
Healthcare: Affordability	✓	✓		✓
Healthcare: Access to Specialty Care	✓	✓	✓	✓
Mental Health	✓	✓	✓	✓
Geriatric / Elder Care	✓	✓	✓	✓
Cost of Health Insurance	✓	✓		✓
Cancer		✓	✓	✓
Affordable Housing		✓		✓
Healthcare: Access to Primary Care	✓	✓	✓	✓
Access to Senior Services / Elder Care	✓	✓	✓	✓
Women's Health	✓	✓	✓	✓

Implementation Strategy

Health Priority Selection Process

To determine the top health priorities for the community, a structured evaluation and selection process was conducted, where Hospital leaders reviewed both community survey findings and key secondary data indicators, comparing local health outcomes to state benchmarks to identify areas of concern. Each potential priority was assessed based on several criteria: the level of community concern (as reflected in survey responses), whether the issue showed worse-than-average performance compared to the state, the Hospital's capacity and resources to meaningfully address the need, and the alignment with the Hospital's strategic goals.

The top 3 health priorities identified by NIHD for the development of implementation strategies are:



Healthcare Access: Expand healthcare access by strengthening local primary, specialty, and senior-focused care and reducing financial and non-financial barriers through patient navigation, education, and connection to available resources.

Relevant Health Needs: Access to Specialty Care, Access to Primary Care, Senior Services/Elder Care, Healthcare: Affordability



Mental Health: Support community-wide mental health access through collaboration with community partners to expand services, coordinate care, and establish a sustainable mental health delivery model for the region.

Relevant Health Needs: Mental Health



Care Coordination and Disease Management: Improve health outcomes for high-need populations through disease management, outreach and education, and coordinated care.

Relevant Health Needs: Geriatric/Elder Care, Cancer, Women's Health

Health Needs Not Addressed

NIHD acknowledges the significance of all health priorities identified through the community survey and overall assessment. While many of these needs are currently being addressed through existing programs, resources, and strategies led by other community organizations and the Hospital, NIHD has chosen to focus its future efforts on three top-priority areas where it can make the most meaningful impact in line with its strategic goals. By concentrating attention and resources on these key issues, the Hospital aims to strengthen outcomes through targeted programming and strategic collaboration with local partners.

Healthcare Access

NIHD Services and Programs Committed to Respond to This Need

- NIHD provides healthcare across a variety of settings including:
 - 24-hour emergency care.
 - Swing bed care.
 - The Rural Health Clinic (RHC) provides primary healthcare services, with same-day and Saturday clinic appointments available.
 - A variety of specialty care services are offered including Women's Health, Orthopedics, Urology, Plastic Surgery, Allergy, Breast Health, and Cardiology.
 - Telehealth services are available for multiple service lines.
- The CAREShuttle is available to provide non-emergency medical transportation services for patients. An additional shuttle was added to meet growing demand.
- A collaboration is in place with Mammoth Hospital to grow local access to specialties, while reducing redundancy of services.
- A Patient Throughput Committee has been developed to address patient throughput opportunities and barriers in key areas (primary care, specialty care, hospital-based care).
- NIHD has a financial assistance program available for patients based on need.
- NIHD posts their chargemaster for IP and OP services on their website and offers customized estimates of care costs.
- A Language Access Services Program is in place, offering interpretation services for patients.
- Clinic providers specialize in caring for seniors.

Goals and Future Actions to Address this Significant Health Need

Goal: *Expand healthcare access by strengthening local primary, specialty, and senior-focused care and reducing financial and non-financial barriers through patient navigation, education, and connection to available resources.*

- Align future strategic planning and master facility planning with key service line and outpatient expansion opportunities to better meet community needs and support future provider recruitment and retention.
- Leverage Patient Throughput Committee to improve patient flow and throughput, increasing appointment availability and timely access to care.
- Develop and deliver community education on navigating the healthcare system, including understanding appropriate levels of care, referral pathways, and available local/regional services.
- Implement financial counseling and patient navigation to support awareness of financial assistance, insurance options, and affordability resources, with targeted education for seniors and other high-need populations.

Healthcare Access

Impact of Actions and Access to Resources

- Improved access to primary and specialty care:
 - 3rd next available appointment rates
 - Future service line plans developed
- Reduced barriers to care, including transportation and financial barriers:
 - CAREShuttle utilization rates
 - Improved awareness and use of financial assistance programs

Other local organizations available to respond to this need

- Inyo County: <https://www.inyocounty.us/>
- Inyo County Aging Services: <https://www.inyocounty.us/services/health-human-services/aging-social-services/aging-services>
- Mammoth Hospital: <https://mammothhospital.org/>
- Southern Inyo Healthcare District: <https://www.sihd.org/>
- Renown Healthcare (Telehealth): <https://www.renown.org/Health-Services/Telehealth>
- Toiyabe Indian Health Project: <https://www.toiyabe.us/>

Mental Health

NIHD Services and Programs Committed to Respond to This Need

- NIHD conducts near-universal screening for prenatal and postnatal depression, with identified opportunities to strengthen follow-up care.
- NIHD Mental Health services include a licensed clinical social worker (LCSW) who provides psychotherapy remotely through the RHC.
- Primary care providers are skilled in addressing basic mental health needs and medication management.
- NIHD offers a Medication Assisted Treatment (MAT) program to address substance use disorder, supported by:
 - Substance use disorder (SUD) physicians
 - SUD nurse practitioner
 - SUD care coordinators
- Mental health crisis response is supported through a partnership with county mental health services.

Goals and Future Actions to Address this Significant Health Need

Goal: *Support community-wide mental health access through collaboration with community partners to expand services, coordinate care, and establish a sustainable mental health delivery model for the region.*

- Define a sustainable, community-based mental health care model that clarifies NIHD's role within a broader network of providers.
- Strengthen partnerships with community mental health organizations to improve continuity of care following screening or crisis events.
- Improve access to prescriber-level mental health services to address medication management needs.
- Increase coordination and awareness of available mental health and substance use resources across the community.

Impact of Actions and Access to Resources

- Partnerships and collaborations coordinated to increase access to mental healthcare
- Reduced suicide mortality rate in Inyo County

Mental Health

Other local organizations available to respond to this need

- Eastern Sierra Counseling: <https://www.easternsierracounseling.com/>
- Inyo County: <https://www.inyocounty.us/>
- Inyo County Sheriff: <https://www.inyocounty.us/services/sheriff>
- Mammoth Hospital: <https://mammothhospital.org/>
- Toiyabe Indian Health Project: <https://www.toiyabe.us/>
- Wild Iris Family Counseling & Crisis Center: <https://wild-iris.org/>

Care Coordination and Disease Management

NIHD Services and Programs Committed to Respond to This Need

- The Rural Health Clinic (RHC) provides primary healthcare services, including chronic disease management.
- Healthy Lifestyle Talks are conducted every month with speakers covering a variety of healthcare topics.
- NIHD participates in community events and provides education to raise awareness of chronic diseases.
- NIHD offers a variety of screening services, including cancer risk assessments, Breast MRI, mammography, and more.
- The dedicated Women's Health RHC offers comprehensive obstetrics and gynecology care across the lifespan, including prenatal and high-risk pregnancy care, family planning and contraceptive services, well-woman exams and preventive screenings, menopause support, and a full range of gynecologic surgical services.
- NIHD offers comprehensive maternity care, including prenatal care, childbirth education, labor and delivery services, and postpartum support.
- The Breast Health Center provides comprehensive services (prevention, detection, surgery, infusion, rehabilitation, nutrition services). NIHD offers a patient-centered 3D mammography system designed with women's comfort and imaging accuracy in mind, with features that reduce discomfort and improve early detection; evening "Moonlight Mammogram" appointments are also available to increase convenience and access.
- NIHD provides an Oncology Patient Navigator to help patients understand their care options, access available services, coordinate appointments, and connect with community resources.
- A partnership is in place with City of Hope to ensure local access to chemotherapy – initial visit at City of Hope followed by chemotherapy at NIHD.

Goals and Future Actions to Address this Significant Health Need

Goal: *Improve health outcomes for high-need populations through disease management, outreach and education, and coordinated care.*

- Prioritize patient navigation as the core care coordination function across specialty service lines, supporting continuity from initial patient access through referrals, diagnostics, treatment, and follow-up care.
- Improve utilization of cancer care navigation services by increasing awareness and integration with clinical workflows.
- Partner with senior centers and community organizations to provide education on the healthcare journey, chronic disease management, and preventive care.
- Strengthen coordinated care for seniors by improving continuity in internal medicine and primary care, enhancing navigation of specialty services (including out-of-area care), and supporting care transitions across care settings.

Care Coordination and Disease Management

Impact of Actions and Access to Resources

- Increased number of preventative screenings (Cancer, Women's Health, etc.)
- Improved community education and awareness of prevention/wellness resources offered
- Enhanced support for seniors navigating multiple providers and services

Other local organizations available to respond to this need

- City of Hope (Partnership for Chemotherapy): <https://www.cityofhope.org/>
- Eastern Sierra Cancer Alliance (Financial Assistance for Cancer Patients Traveling for Care): <https://escanceralliance.org/>
- Inyo County Aging Services: <https://www.inyocounty.us/services/health-human-services/aging-social-services/aging-services>
- Inyo County: <https://www.inyocounty.us/>
- Inyo County Office of Education: <https://www.inyocoe.org/>
- Local Senior Centers

Appendix

Community Data Tables

Leading Cause of Death

The Leading Causes of Death are determined by the official Centers for Disease Control and Prevention (CDC) final death total. The Leading Causes of Death are listed in the tables below in U.S. rank order. Inyo County's mortality rates are compared to the California state average, and whether the death rate was notably higher (red), or lower (green) compared to the state average.

	Inyo	California	U.S.
Heart Disease	137.5	143.6	168.9
Cancer	130.1	131.9	145.4
Accidents	75.7	46.5	59.7
Chronic Lower Respiratory Disease	46.4	27.4	35.9
Cerebrovascular Diseases (Stroke)	32.3	40.1	39.8
Liver	28.2	14.3	13.1
Diabetes	18.5	24.6	23.9
Suicide	16.2	10.3	13.9
Pneumonia	11.2	11.1	10.7
Alzheimer's	10.2	38.8	30.8
Blood Poisoning (Septicemia)	10.1	4.0	10.0
Homicide	N/A	5.8	7.6
Kidney	N/A	10.3	13.4

Source: NIH: HDPulse, CDC (2019-2023)

County Health Rankings

	Inyo	California	US Overall
Length of Life			
Premature Death*	10,431	6,744	8,400
Life Expectancy*	77	78	77
Quality of Life			
Poor or Fair Health	17%	18%	17%
Poor Physical Health Days	4.6	3.9	3.9
Poor Mental Health Days	5.7	4.7	5.1
Low Birthweight*	8%	7%	8%
Health Behaviors			
Adult Smoking	14%	10%	13%
Adult Obesity	30%	28%	34%
Limited Access to Healthy Foods	8%	3%	6%
Physical Inactivity	20%	22%	23%
Access to Exercise Opportunities	87%	94%	84%
Excessive Drinking	23%	20%	19%
Alcohol-Impaired Driving Deaths	28%	26%	26%
Drug Overdose Deaths*	50	26	31
Sexually Transmitted Infections*	262	494	495
Teen Births (per 1,000 females ages 15-19)	21	12	16
Clinical Care			
Uninsured	9%	9%	10%
Primary Care Physicians (MDs & DOs)	1459:1	1233:1	1,330:1
Other Primary Care Providers (APPs)	842:1	1062:1	710:1
Dentists	1248:1	1076:1	1,360:1
Mental Health Providers	183:1	213:1	300:1
Preventable Hospital Stays*	1,198	2,257	2,666
Mammography Screening	33%	36%	44%
Flu Vaccinations	39%	44%	48%
Social & Economic Factors			
High School Completion	93%	85%	89%
Some College	68%	68%	68%
Unemployment	4%	5%	3.6%
Children in Poverty	14%	15%	16%
Children in Single-Parent Households	30%	22%	25%
Injury Deaths*	99.2	62.9	84
Child Care Cost Burden (% of HHI used for childcare)	31%	30%	28%
Child Care Centers (per 1,000 under age 5)	13	8	7
Physical Environment			
Severe Housing Problems	17%	26%	17%
Long Commute - Driving Alone (> 30 min. commute)	19%	41%	37%
Severe Housing Cost Burden (50% or more of HHI)	11%	20%	15%
Broadband Access	83%	93%	90%

*Per 100,000 Population

Key (Legend)



Better than CA



Same as CA



Worse than CA

Source: County Health Rankings 2025 Report

Data and Inputs

Data Limitations

Rural communities and those with low population sizes face several data limitations including but not limited to:

- Small sample sizes: small populations reduce the statistical power and do not capture the full diversity of the community
- Data privacy: to ensure the confidentiality of individuals in small communities, data may be aggregated or withheld
- Data gaps: some events may happen less frequently in small populations leading to limited data and gaps in time
- Resource constraints: rural areas often have less funding for data collection and access to data collection technologies
- Underrepresentation in national surveys: many national level data sources focus on urban areas due to the higher population making access to data in small communities more limited

This assessment is meant to capture the health status of the service area at a specific point in time, combining both qualitative data from the local community through survey collection and quantitative data from multiple sources where the county is available as the smallest unit of analysis.

Local Expert Groups

Survey Respondents self-identify themselves into any of the following representative classifications:

- 1) **Public Health Official** – Persons with special knowledge of or expertise in public health
- 2) **Government Employee or Representative** – Federal, tribal, regional, State, or local health or other departments or agencies, with current data or other information relevant to the health needs of the community served by the Hospital
- 3) **Chronic Disease Groups** – Representative of or member of Chronic Disease Group or Organization, including mental and oral health
- 4) **Community Resident** – Individuals, volunteers, civic leaders, medical personnel, and others to fulfill the spirit of broad input required by the federal regulations
- 5) **Priority Population** – Persons who identify as medically underserved, low-income, racial and ethnic minority, rural resident, or LGBTQ+
- 6) **Healthcare Professional** – Individuals who provide healthcare services or work in the healthcare field with an understanding / education on health services and needs.
- 7) **Other** (please specify)

Data Sources

Source	Data Element	Date Accessed	Data Date
County Health Rankings 2025 Report	Assessment of health needs of the county compared to all counties in the state; County demographic data	December 2025	2014-2023
NIH: HDPulse – CDC	Leading causes of death, median household income	December 2025	2019-2023
PLACES: Local Data for Better Health	County level health, socioeconomic, and environmental data	December 2025	2024
America’s Health Rankings	National and State level data for health, environmental, and socioeconomic measures	January 2026	2022
American Community Survey, US Census Bureau	Social, economic, housing, and demographic information for States	December 2025	2024
NIH National Cancer Institute	State cancer profiles; incidence rates	December 2025	2017-2021
Centers for Medicare & Medicaid Services: Mapping Medicare Disparities by Population	Health outcome measures and disparities in chronic diseases	January 2026	2022
American Diabetes Association	Type 2 diabetes risk factors	January 2026	2005
Centers for Disease Control and Prevention – CDC	Racial and ethnic disparities in heart disease	December 2025	2019
Healthy People 2030 – OASH	Social Determinants of Health	December 2025	n.d.
Center for Housing Policy	Impacts of affordable housing on health	December 2025	2015
Child Care Aware	Childcare costs	January 2026	2023
Health Affairs: Leigh, Du	Effects of low wages on health	December 2025	2022

Survey Results

Based on 381 survey responses gathered from Nov – Dec 2025.

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

Q1: Your role in the community (select all that apply)

Answer Choices	Responses	
Community Member	82.06%	311
Healthcare Professional	27.18%	103
Government Employee or Representative	16.62%	63
Priority Population (medically underserved, low-income, racial and ethnic minority, rural resident, or LGBTQ+)	16.62%	63
Representative of Chronic Disease Group or Advocacy Organization	2.11%	8
Public Health Official	0.79%	3
	Answered	379
	Skipped	2

Q2: Race/ethnicity (select all that apply)

Answer Choices	Responses	
White or Caucasian	81.55%	305
Hispanic or Latino	9.63%	36
American Indian or Alaska Native	4.81%	18
Prefer not to answer	4.81%	18
Asian or Asian American	2.94%	11
Other (please specify)	0.80%	3
Black or African American	0.53%	2
Native Hawaiian or other Pacific Islander	0.53%	2
	Answered	374
	Skipped	7

Q3: Age group

Answer Choices	Responses	
65+	32.98%	125
55-64	18.73%	71
35-44	17.68%	67
45-54	16.36%	62
25-34	8.97%	34
18-24	2.64%	10
Prefer not to answer	2.64%	10
	Answered	379
	Skipped	2

Q4: What is your gender?

Answer Choices	Responses	
Woman	74.01%	279
Man	22.55%	85
Prefer not to say	2.65%	10
Non-binary / Gender non-conforming	0.53%	2
Prefer to self-describe:	0.27%	1
	Answered	377
	Skipped	4

Q5: Which town do you primarily live in?

Answer Choices	Responses	
Bishop	48.3%	184
West Bishop	15.7%	60
Big Pine	8.7%	33
Lone Pine	5.8%	22
Chalfant	3.7%	14
Independence	2.9%	11
Wilkerson	2.1%	8
Tecopa	2.1%	8
Olancho	1.6%	6
Mesa	1.3%	5
Mammoth Lakes	1.3%	5
Other (Less Than 5 Each)	6.6%	25
	Answered	379
	Skipped	2

Q6: Which groups would you consider to have the greatest health needs (rates of illness, trouble accessing healthcare, etc.) in your community? (please select your top 3 responses)

Answer Choices	Responses	
Older adults (65+)	54.44%	196
Individuals requiring specialized healthcare support	54.44%	196
Low-income groups	51.94%	187
Uninsured and underinsured individuals	40.56%	146
Unhoused	28.06%	101
Women	18.33%	66
Racial and ethnic minority groups	17.22%	62
Undocumented immigrant / migrant / resident	16.67%	60
Children/Adolescents	11.39%	41
LGBTQ+	6.11%	22
Men	4.72%	17
	Answered	360
	Skipped	21

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

- Transportation
- More specialist for the area, older patients can not travel out of town.
- Food insecurity for children
- Dental care for low income
- Drug/mental health interventions
- Transportation fear of doctors health care cost
- Long term care , to many have to go out of town for medical
- Access to specialties, such as neurology, dermatology and gastrointestinal specialists. Without those travel of between 150 and 200 miles is required to get the healthcare.
- Mental health care access.
- Local access to specialty providers, fewer wait times to get a specialty appointment, and access to low/no cost routine care for the uninsured and underinsured.
- Telehealth and support for those that need specialized healthcare. Billing and financial help.
- Poor health due to poor nutrition and access to care.
- Aging, women's health, diabetes, heart disease, mobility issues and nutrition issues.
- Being able to afford healthcare-doctor visits, medications, insurance premiums, etc
- Age related illnesses and problems.
- Racially I am worried about stigma towards Latino and Native folks in town, and biases towards them.
- Options for elder care.

- Access to specialists for specific issues such as heart, rehab, cancer.
- Costs of Healthcare here, cash-pay, are very high. Creates a barrier for patients.
- Avoiding care because of cost, financially burdened by medical bills
- Access to care, learning how to apply for insurance, navigating insurance and out of town appointments, transportation to appts in Bishop and out of town, inability to pay for medications. Very limited mental health care that is affordable- both counseling and psychiatry.
- Either home hospice support or a hospice facility. Home support would allow old folks to die in their home with a little help from other community members.
- Lack of specialists, lack of senior care, poor home health services
- Low understanding of available resources
- In some cases fear of official contact for the Migrant community
- Transportation for areas without public transit options (Thank goodness for Care shuttle!!!)
- Gerontology, home health care and assisted living health care (that's not a nursing home!)"
- Affordable care. Easier access to specialists.
- In general, there are no programs targeted towards men. This should be changed.
- Cardiology, oncology, dermatology, and orthopedic localized help is needed as long distance travel, particularly finding driving help, is very difficult for elderly population.
- Not having much specialty care- oncology, cardiology, dermatology.
- ACCESS! Medi-Cal patients have to drive 3-4 hours each way to get health care in Bishop or Ridgecrest. Specialized care is only available across state lines (Las Vegas) or out of the county.
- Undocumented are cash clients which serves as a barrier unless there are specific programs targeting the population. Fear factor. Lack of outreach to population to inform of services and payment options. At one time there was an outreach program helping the uninsured and/or underinsured to enroll in a health plan. It is all on-line now which can function as a barrier.
- Transportation is important. The Care Shuttle isn't enough.
- Residents here who rely on state insurance (Medical) cannot access health care unless they drive at least two hours to Barstow, in another county, or four or five hours to Lone Pine or Bishop.
- More providers who partner with the VA so that local veterans can utilize a wider network of healthcare providers and have options to receive more specialized care.
- Healthcare in general for the unhoused and uninsured, specialized healthcare access for the elderly.
- Language barrier, lack of cultural competency amongst providers, lack of diversity within providers to reflect the population you serve, lack of support with applying for health insurance, specialized care not being available in the area.
- Lack of specialty medicine and lack of low income services. Also, the wait time to get appointments at Rural Health.

- Lack of access to care, long wait times to even get in to see a Dr. waiting months for an initial appointment.
- Specialized care out of our area, cost of transport, overnight stays.
- Access to primary doctor's is limited because there are not enough of them
- No insurance, no regular access to health care providers, difficult social circumstances such as substance use disorders, lack of family/community support, geographical isolation, lack of transportation
- Permanent, on-staff healthcare specialists (doctors and RNs) needed. Home healthcare. Long-term healthcare. Affordable medications. Healthcare history data sharing with other out-of-the-area hospitals and specialists.
- Mental health, general elder care, obesity, diabetes, overall wellness
- Older adults may need more specialty doctors. Uninsured may not have the money to cover the bill.
- Technologically challenged people such as the elderly or people who cannot afford iPhones or other smart phones
- Specialists - Gastroenterologists, Cardiologists, Optometrists, Periodontists
- Money and time off work for healthcare and wellness
- Our Native American population seem to have inconsistent follow up despite Toiyabe being present
- More robust access to specialty clinics; more providers to select from.
- No urgent care in northern inyo
- Limited options for treatment- long waiting periods for preventive care
- Options for elder care.
- PPOs also are an issue. Limited providers if any
- Lack of specialized care or any care for low incomes, elderly. Lack of mental health care.
- Access to affordable healthcare
- Primary care, regular check ups, medications
- People without insurance don't get preventative care
- Better prevention and education. Especially from a young age.
- Not enough Women's clinic providers for the region.
- People living in rural areas self-pay. Health costs are expensive.
- Limited providers for marketplace insurance plans. Still necessary to travel for most specialty procedures, diagnostics, etc
- Having the means to make appointments, access transportation, have a call back number, access the patient portal, pay for care
- Chronic health conditions
- Abortion care and specialized care as well as bias in medicine.
- Lack of Affordable housing
- Lack of Spanish language providers

Q7: Please rate the importance of addressing each health factor on a scale of 1 (Not at all) to 5 (Extremely)

	1	2	3	4	5	Total	Weighted Average
Mental Health	1	8	34	54	227	324	4.54
Geriatric / Elder Care	0	3	27	103	198	331	4.50
Cancer	1	8	31	91	196	327	4.45
Women's Health	0	3	62	92	161	318	4.29
Heart Disease	2	8	60	106	151	327	4.21
Substance Use Disorder	6	17	57	88	155	323	4.14
Diabetes	5	6	72	100	139	322	4.12
Stroke	3	9	67	110	131	320	4.12
Children/Adolescent Health	4	20	69	78	150	321	4.09
Alzheimer's and Dementia	3	16	61	121	128	329	4.08
Dental	3	21	71	93	132	320	4.03
Kidney Disease	3	13	87	109	112	324	3.97
Lung Disease	3	17	83	109	111	323	3.95
Obesity	6	18	85	100	115	324	3.93
Liver Disease	5	21	92	97	106	321	3.87
Men's Health	5	15	101	100	99	320	3.85
Other (please specify)	20						
						Answered	331
						Skipped	50

Other:

- Gun safety , suicide prevention
- Eye care (Ophthalmology), Neurology, Gastrointestinal
- Gender-affirming care
- No psychiatrist in the area at all
- Ophthalmology
- Lack of access to medical and surgical abortions for women which is a shame.
- The heat here is dangerous 4 months every year. We need a 24 hour place of refuge with generator and cots. Some of us need to get horizontal a lot. And we need to do it where we can get cooled off. Closing the cooling center at 4pm, the hottest time, is no good.

- Every health factor would be improved if people knew about the newer nutrition research.
- Wound Care
- Wound care
- LGBTQ+, Native and cultural emphasis
- Eye care
- What do you need to provide is readily accessible, affordable General health and or preventive healthcare, which is primarily advice and may involve specific treatment. You can head off 80 to 85% of high cost chronic disease through timely education and prevention.
- Eye health
- All of these are important
- Optometry
- Menopausal health very important.
- Hearing aids
- Internal Medicine

Q8: Please rate the importance of addressing each community factor on a scale of 1 (Not at all) to 5 (Extremely)

	1	2	3	4	5	Total	Weighted Average
Healthcare: Affordability	2	4	28	62	232	328	4.58
Healthcare: Access to Specialty Care	0	2	31	77	221	331	4.56
Cost of Health Insurance	2	9	33	65	221	330	4.50
Affordable Housing	7	9	32	73	206	327	4.41
Healthcare: Access to Primary Care	3	10	43	76	198	330	4.38
Access to Senior Services / Elder Care	1	5	43	107	175	331	4.36
Healthcare: Location of Services	6	9	51	82	183	331	4.29
Access to Affordable Food	6	16	50	80	178	330	4.24
Healthcare: Prevention Services	1	11	69	91	156	328	4.19
Access to Home Health	2	16	74	95	144	331	4.10
Employment and Income	6	8	82	83	148	327	4.10
Access to Childcare	7	21	69	78	151	326	4.06
Education System	13	12	73	77	149	324	4.04
Transportation	9	18	85	103	112	327	3.89
Community Safety	19	33	73	75	125	325	3.78
Social Connections	15	32	100	102	75	324	3.59
Access to Internet / Broadband	19	40	88	93	87	327	3.58
Access to Exercise/Recreation	30	50	100	69	79	328	3.36
Other (please specify)	17						
						Answered	332
						Skipped	49

Other:

- Low barrier care
- Sense of committee. Music, parades, plays, environmental awareness
- Transportation is low as I know there are vans and volunteer drivers moving people around already, which is good.
- Hospice program.

- Please continue food assistance. Access to telephone-There is no cellular connection here and pay phones often are not working! A simple fall outside wifi can be deadly!
- Re healthcare: Scarcely any healthcare professionals know about the nutrition research of the past 50 years. They all make money from people being sick. They'd make less money if people had the knowledge to eat healthfully.
- Trilingual services
- If you do not want to go outside and exercise that is your decision. No one can force you, and we don't need money going towards persuading people to get outside. Affordable food should also actually be healthy. Access to childcare is important, but providing better support through employers to allow parents to spend more time with their kids and maintain a career is more important. More time allowance for paternity and maternity leave would make a huge difference.
- Cardiology is essential
- Until you have completely fulfilled, the needs for basic routine and or preventative healthcare you have no business spending money on specialist or high cost healthcare professionals, and expensive testing. The vast majority of a community healthcare needs require easy access whether that involves brick and mortar or telehealth, Followed by consistent provider messaging, and affordability of treatment options.
- Access to transportation is hard to find
- I have concerns about seniors who no longer have a license and little support getting food and medical care
- All issues are important
- Access to & *Consistency of* Mental Health Providers
- Access to pet boarding for single individuals who must travel for healthcare services. Providing chemotherapy for cancer patients.

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

	1	2	3	4	5	Total	Weighted Average
Illegal Drug Use	6	15	70	82	155	328	4.11
Alcohol Use/Excess Drinking	3	20	78	86	140	327	4.04
Nutrition and Diet	3	16	79	106	124	328	4.01
Vaping Use	18	27	76	84	117	322	3.79
Physical Inactivity	5	34	94	97	99	329	3.76
Smoking/Tobacco Use	16	27	105	84	93	325	3.65
Risky Sexual Behavior	24	38	108	74	77	321	3.44
Marijuana Use	49	54	93	64	61	321	3.11
Other (please specify)	8						
						Answered	331
						Skipped	50

Other:

- Environmental appreciation and stewardship
- Teen sexual behavior. Drug and alcohol use during pregnancy. Child sexual abuse.
- Judicial reform
- These are active choices made by individuals. You can try to educate, but you cannot force someone to change their lifestyle choices. Proper parenting is what our society needs to address these issues.
- You can provide a vast array of less expensive care if it is mobile, telehealth, nurse practitioner, or PA based, and focuses on basic healthcare needs rather than high cost specialist options for small number of people with specialty needs. A tremendous amount of basic healthcare can be provided by low cost, but highly motivated healthcare professionals and does not require direct MD evaluation every single time. High cost medications, high cost, testing, and high cost specialist evaluation is appropriate sometimes, but not at the cost of providing basic broad spectrum easily accessible low cost options.

- I would say most of these services should be targeted for our youth as preventive care - addressing these issues for adults should involve a component of individual responsibility
- Many of these subjects are already targeted through PH or tribal resources. Will you partner with their existing programs? How?
- NIHD needs to update their website

Q10: Please provide feedback on any actions you've seen taken by NIHD and SIHD Community Hospital to address the significant health needs in your community and what additional actions you would like to see.

- Additional needs include reducing the cost to individuals to receive services. Cost continue to rise at a rate far above the cost of living even with health insurance.
- Potentially provide more options for payment plans as people do want to pay their bills.
- We need a psychiatrist and mental health access priority number one
- There is no Nutrition education for diabetic patients, and no Endocrinologist here in Inyo or Mono County.
- Chronic disease management needs are more in outreach and making sure patients are getting the maintenance they need.
- Monthly blood pressure checks or other health monitoring services might benefit the community.
- Patients don't follow up as they should and could benefit from 'nagging'.
- I would like to hear that the primary care providers are being more assertive/aggressive about follow-up and multi-system care for patients with diabetes and other chronic diseases.
- The hospital shuttle service is a life saver too bad they don't go to Lone Pine any more.
- They should have a person to teach diabetes classes.
- The addition of a robust cardiology program has been well received and very impactful for our community. The telehealth neurology services are also incredible, but outpatient options are still lacking. Full time urology service is incredible.
- Better transportation options for community's far from Bishop
- We travel to Bishop at least one time a week for medical services and this is becoming more challenging as we age
- The mental health options are lacking greatly. Far too many patient per mental health worker.
- We still don't have sufficient mental health services, and the hospital doesn't have a single Psychiatrist that sees patients in our community
- Affordable healthcare is a national issue... the system will remain broken and unaffordable for many classes of people.
- Behavioral health is still lacking severely in our community and is made up with patchwork that is mostly missing
- I would like to see a bed for people experiencing a mental health or substance abuse crisis
- On the topic of behavioral health, please make your psychiatric nurse available without a referral
- I LOVE the women's clinic
- Work with healthcare providers to ensure more in-network providers are available locally, within Inyo County.

- Moonlight mammograms are great - I appreciate the emphasis on women's healthcare
- Need: Neurologist, Ophthalmologist, Gastroenterologist if we don't have a visiting one
- I really appreciate that NIHD provides the Care Shuttle
- Better specialty needs available locally. Bishop or Mammoth, instead of Gardnerville to Sparks
- Having health specialists locally is a must. Having to drive to Reno or Southern California to see a specialist
- More specialized services available at certain times. Need more availability than 1x per month
- Please get a good endocrinologist. Virtual care just lost theirs
- Need a local cardiologist and other specialties. Need gynecologist to replace dr. Arndal since she left
- Thanks for brining cardiology, urology, breast surgeon, continued ortho care. Need dermatology and ENT
- I think access to chronic heart disease management is better with the Cardiology Tream from Reno (Dr. Rowan, Natalie).
- Memory care services for those with Alzheimer's and other mental illnesses that prevent self care
- It would help with making it more manageable to pay bills if they were more timely.
- The hospital needs to get their billing in check. Wrong billing double billing. It's out of control.
- Not consistent enough, too many providers coming and going
- Medical needs of all vary, not all care is available in this community. The cost of healthcare at Northern Inyo is extremely high and unaffordable.
- Tele-health options help a lot and are a lifeline in our remote area
- We have lost an OB so women's health and maternal/fetal health is less well-served now
- The OB/GYN clinic is in a trailer and is the only OB in Bishop available
- Home health care is very limited
- There needs to be more DO/MDs at the RHC for our patients that have complex health issues
- Senior living that is NOT BCC
- As we age, access to local care becomes more critical
- A new building for all the clinics at the hospital
- I have not seen any action by NIHD
- We need ophthalmology!
- There needs to be better outreach to the community
- The efforts to recruit new providers have definitely been noticed, but we need to RETAIN them as well.
- Desperately need a nurse practitioner that can prescribe meds for mentally ill people.

- There are many specialists now available through Northern Inyo without having to travel out of the area. This is way better than it used to be.
- Mental health is chronically underfunded and overwhelmed. NIHD should try for more providers and creative ways to pay/reimburse for services.
- Transportation to and from appointments and home from ER visit, helpful
- I appreciate the expanded lab services at Southern Inyo, although it seems to be shrinking again. Can't get an echo cardio gram in lone pine like we could 6 months ago.
- NIHD continually works toward improving access to healthcare for everyone. More assistance with mental health. I believe a lot of people are depressed and need help, especially since Covid.
- I would like to see more focus on chronic and invisible illnesses in our community.
- I would like to see SIH, NIH, and Mammoth Hospital team up as one entity to help with flow and care throughout of valley
- I like the service that the Rural Clinic provides.
- Veterans need more local options in healthcare providers who partner with the VA.
- Improve strategic communications and marketing so that the community is aware of actions taken and resources/services available
- I'd suggest health education classes, programs, etc. Would be nice to see real community classes. The one's I've seen seem scripted, lacking knowledge and not always a topic of interest for our population.
- Neither Inyo nor Mono County have been able to provide consistent access to local on-site chemotherapy and chronic disease management
- Good efforts on MAT, would like to see that work continue with supportive counseling services.
- The access to orthopedic services was a critical step forward, one which helps many elderly patients in the area and helped cover a critical need for the southern county patients. Access to nephrology could be a progressive step also with the number of diabetic patients in the area, understanding that preventing CKD from progressing to ESRD.
- Care Shuttle, Urgent Care at Rural Health clinic, NIH education/lectures & podcasts
- I've seen breast cancer screening. I would like to see periodic community health screenings for various health issues (blood pressure, stoke, etc.) like we've had in the past
- It would greatly benefit our community to have access to all healthcare needs and all specialized services. The lack of local access to such a wide range of services is extremely disappointing.
- I would like an urgent care or a way to get care without a pcp
- Team with local libraries, schools, pharmacies, and other local health and well being providers to have more community education/outreach events
- Senior care, eye care, dental care, overall care to not travel out of town more than an hour for care
- Improve access to surgical services

Q11: Social drivers of health (SDoH) are conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes. Please select the key social drivers that negatively impact the health of you or your community (select all that apply):

Answer Choices	Responses	
Affordable housing or available housing	73.58%	220
Limited access to healthcare services	59.87%	179
Lack of affordable childcare	43.81%	131
Poverty	41.47%	124
Social isolation	35.45%	106
Unemployment or unstable employment	32.44%	97
Racial and cultural disparities	32.11%	96
Lack of transportation	31.77%	95
Limited access to healthy food	30.10%	90
Limited access to quality education	24.41%	73
Public safety concerns	13.71%	41
Limited access to broadband / internet	13.04%	39
Limited access to utility services	8.70%	26
Other (please specify)	8.03%	24
	Answered	299
	Skipped	82

Comments:

- Extremely poor access to BH care
- Many live in rv or trailers. Rent in many places are going out of range.
- Open and supportive Cooperation verses territorial boundaries
- High cost of living
- None of these personally affect me but I think all of them affect the community
- Lack of knowledge about nutrition.
- Lack of self preservation
- Unacceptable High costs of health care in our area
- Specialized healthcare for elders is lacking
- Lack of medical specialist

- Even those who have stable careers can't afford the rent here. Landlords seem to want to charge top dollar for properties that have questionable conditions. Prices of homes are not reflective of what average annual incomes are.
- Limited access to affordable shopping, food and other necessities.
- Lack of women's healthcare services
- None of the above
- Extreme negativity on Facebook accounts from local community
- Today's world is extremely hard for elderly especially in rural areas. mosr can navigate modern technology which further hinders access to many things including shopping and Healthcare communication. until Marshall's recent opening, I have had to assist elderly order online for many basic needs.
- My Mother is 75 and never learned how to use a computer or had a smart phone. It would be nice if there were classes to help people learn those skills.
- "Party culture"/multi-generational substance availability and use
- Small gene pool that is disassociated from real world environments.
- LGBTQIA equality
- Lack of help and care for elderly, especially families with Alzheimer's patients. Medicare doesn't cover home health and families are worn out even with some home health care which is expensive.
- All of the above affect negatively, but many drivers are due to making poor personal choices in life, ie becoming addicted to drugs/alcohol.
- Low wages

Q12: What barriers keep you or anyone in your household from receiving local healthcare services? (select all that apply)

Answer Choices	Responses	
Limited availability of services or specialties	71.63%	207
Difficulty getting an appointment (long wait times)	49.48%	143
High cost of services	42.21%	122
Billing issues or lack of clarity in billing statements	31.14%	90
Unhappy with previous experience with providers or staff	26.64%	77
Out-of-network for insurance plans	24.57%	71
Poor communication from providers or staff	20.42%	59
Facilities are too far from home	20.42%	59
Perception of low-quality care	19.72%	57
Limited access to telehealth options	19.72%	57
Limited facility hours (inconvenient for working individuals)	17.65%	51
Underinsured/no insurance	15.22%	44
Not aware of the local healthcare services or programs	13.15%	38
Other (please specify)	9.34%	27
Language or cultural barriers	5.19%	15
	Answered	289
	Skipped	92

Comments

- Out of area providers getting current medical records
- Mammoth Hospital is close, easier to deal with and much less drama, staff seems happier there and less stressed
- Lack of ophthalmology, lack of orthopedic care, lack of psychological/psychiatric care
- "Circuit" doctors have always brought their specialty services to the valley, but sometimes one day a month isn't enough. That's improving, though.
- There are no local health care services.
- It's impossible to get a healthful meal in any local restaurant.
- High deductible insurance and high out of pocket cost
- I receive all my healthcare locally.
- Gastroenterology, specifically safe, well done surgery, is an ongoing concern
- Needing to travel several hours away for health care requiring one or more nights in a hotel.

- Transportation
- Specialists are out of the area - I realize that this is part of the nature of living in remote areas and I try to explain this to patients.
- I had ONE bad experience with a local specialist and have decided to go out of town for that issue alone, I will never try again here even if he were to be replaced. However, that one experience counts for a small percentage of my overall health picture; "the rest" I do handle locally and have been VERY happy with the generalists who have chosen long-term practice here!!!
- None
- No barriers
- It's impossible to predict how much I'll owe before going to an appointment. For a pcp they say 0-550\$... and I can't take the risk
- No barriers
- No barriers for us.
- Limited availability of healthcare for Alzheimer's patients and lack of insurance coverage specifically for that.
- No long Covid clinic
- No money no healthcare
- No significant barriers for my household
- Privacy - employees discuss patient information outside of work
- Specialty care

Q13: What additional services / offerings would you like to see available locally? (select all that apply)

Answer Choices	Responses	
Behavioral / Mental Health	55.30%	167
Cancer Care	53.31%	161
Ophthalmology (Eye - Medical Treatment / Surgery)	51.32%	155
Geriatric Care (Elder Care, Home Health, Hospice)	46.36%	140
Optometry (Eye - Vision Screening)	46.03%	139
Urgent Care / Walk-In / Extended Hours	46.03%	139
Dental Care (teeth)	44.04%	133
Dermatology (Skin)	41.72%	126
Cardiology (Heart)	40.07%	121
Gastroenterology (Digestive System/Stomach)	37.42%	113
Women's Health	34.44%	104
Endocrinology (Hormone and Diabetes)	32.78%	99
Primary Care (Family Medicine)	32.45%	98
Rheumatology (Arthritis and Autoimmune Disease)	31.79%	96
Neurology (Brain and Nervous System)	29.80%	90
Audiology (Hearing Specialist)	29.47%	89
Telehealth / Virtual Care	29.47%	89
Orthopedics (Bone and Joint)	29.14%	88
Pulmonology (Lung and Breathing)	26.16%	79
Rehab Services (Physical Therapy, Occupational Therapy, Speech Therapy)	26.16%	79
Substance Use Disorder Treatment	25.83%	78
Health Prevention / Education Programs	22.52%	68
Urology (Urinary System and Male Reproductive)	22.19%	67
General Surgery	21.85%	66
Pediatrics (Children's Doctor)	19.54%	59
Reproductive Health	18.87%	57
Nephrology (Kidney)	17.88%	54
Dialysis	15.23%	46
Infusion	15.23%	46
Bariatric (Weight Loss)	14.90%	45
Other (please specify)	9.60%	29
Plastic Surgery (Reparative/Reconstructive)	9.27%	28
	Answered	302
	Skipped	79

Comments

- Geriatric specialist
- Ear, Nose & Throat specialist. Doctor of Dermatology.
- Inpatient detox for substance abuse

- Access to abortions.
- Most of us get healthcare in Pahrump NV and even there we have a shortage of doctors and most kinds of specialty offices. Hospice home care is most needed. Someone visiting maybe weekly with support from locals as caregivers.
- It seems to me that all of those specialties are available locally, if only on a limited basis.
- Mental health
- Healthful food served in the Senior Center. Honest up-to-date nutrition available to everyone.
- In home support for elders who have private insurance and/or Medicare parts A and B but who cannot afford it
- It seems like there are no Residential Communities For the Elderly (RCFE) in Bishop. Which also means there is very little to now options for Veterans who need assisted living. Why does our community not have group homes for the elderly?
- Pain Management
- Most needed is Urgent Care. There is nothing between the clinic and the emergency room
- Local services need to partner together better! The community needs to get senior living facility (assisted living). Inyo is regressing in resources instead of progressing! We can do better!
- Pain management
- I think the recent loss of local Ortho at NIH with dedicated providers at NIH is a huge loss. I do love Mammoth Ortho and certainly hope this works for the health financially of NIH. Last time this was tried, it did not work well for the NIH health district.
- I forgot to say on a previous question that NIH's addition of Sevaro neurology evaluations seems great!
- Pediatric specialists
- A lab
- ENT, Functional Medicine with IV therapy, Accupuncture
- Massage therapist that takes insurance - to go along with physical therapy treatments
- ENT
- Is it possible for patients with orthopedic issues to be sent to Mammoth rather than flown to Reno? Or possible to be flown south instead of to Reno? Expensive for family and lots of red tape if patient dies in Nevada.
- Menopausal health
- Orthopedic surgeon using robotics

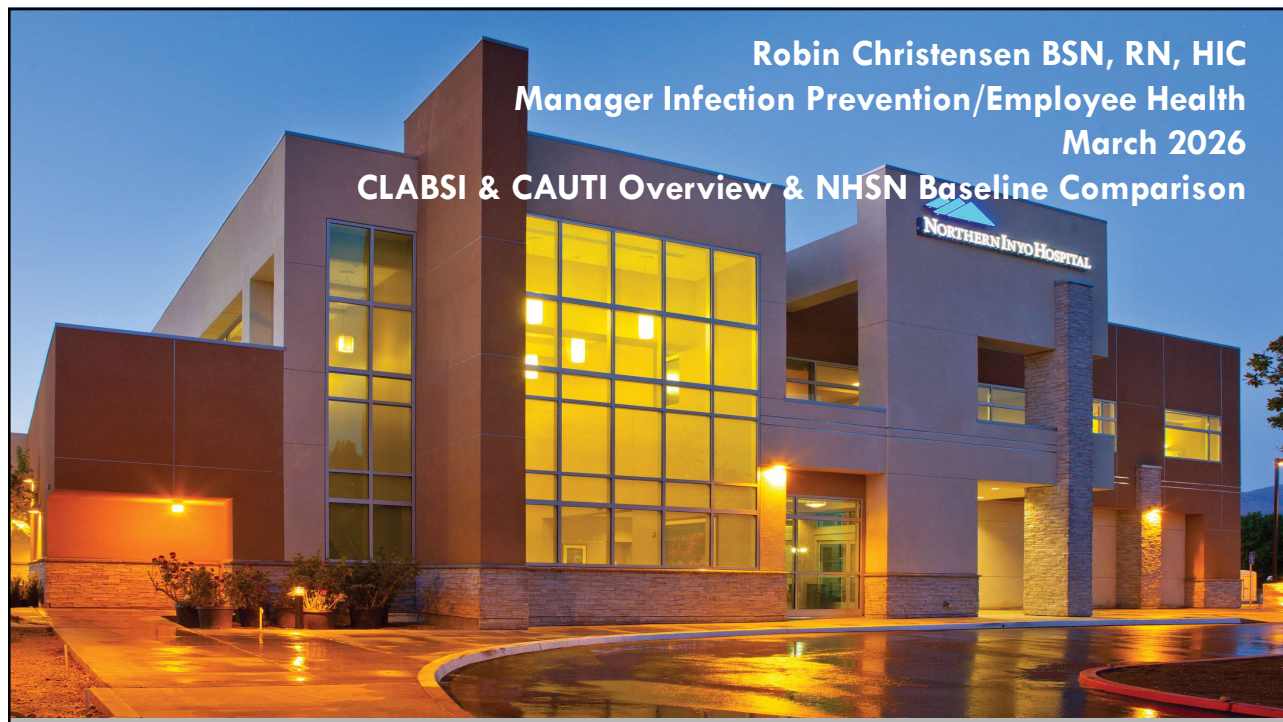
Q14: Where do you typically get most of your health information (advice about managing health conditions, wellness tips, information about treatment options, recommendations for preventive care)? (select all that apply)

Answer Choices	Responses	
Doctor/Healthcare Provider	80.46%	243
Websites/Internet (Google, WebMD, Mayo Clinic)	57.95%	175
Hospital or Clinic	42.05%	127
Family or Friends	28.81%	87
Public Health Agencies (Local Health Department, CDC, etc.)	22.19%	67
Word of Mouth	16.56%	50
Social Media (Facebook, Twitter / X, Instagram, TikTok)	12.25%	37
Newspaper/Magazine (Online Publications)	11.59%	35
Workplace	10.93%	33
Podcasts/YouTube Videos	10.60%	32
AI Platform (ChatGPT)	8.61%	26
Other (please specify)	6.29%	19
School/College	5.63%	17
Newspaper/Magazine (Print Publications)	3.64%	11
Television	2.32%	7
Radio	1.66%	5
	Answered	302
	Skipped	79

Comments:

- Workplace sponsored health programs
- Pharmacist, including the info that comes on the bottle.
- Vetted Substack blogs
- I am a nurse
- Cleveland clinic
- Books
- Integrative nutritionists, specialists who do not follow the mainstream healthcare recommendations. i.e. who use alternative methods for treatment that have been proven successful for many generations.

- Healthcare training, physician resources, and scientific studies
- UpToDate
- Independent research
- I am a provider so I have a bit more expertise in finding out answers
- Due to multiple past incidents, I admit to having developed a considerable amount of suspicion around the "usual sources" of information (especially government, inept/inadequately informed providers, and those whose attitudes are not conducive to an acceptable level of patient "care").
- CME
- I am a healthcare provider
- Medical journals



WHAT IS CLABSI & CAUTI

- **CLABSI (CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTION):** LABORATORY-CONFIRMED BLOODSTREAM INFECTION WHERE AN ELIGIBLE CENTRAL LINE WAS IN PLACE FOR MORE THAN 2 CONSECUTIVE CALENDAR DAYS ON THE DATE OF THE EVENT (OR THE DAY BEFORE).
- **CAUTI (CATHETER-ASSOCIATED URINARY TRACT INFECTION):** A SYMPTOMATIC URINARY TRACT INFECTION (SUTI) OCCURRING IN A PATIENT WHERE AN INDWELLING URINARY CATHETER WAS IN PLACE FOR MORE THAN 2 CONSECUTIVE CALENDAR DAYS ON THE DATE OF THE EVENT (OR THE DAY BEFORE).

NHSN BASELINE COMPARISON

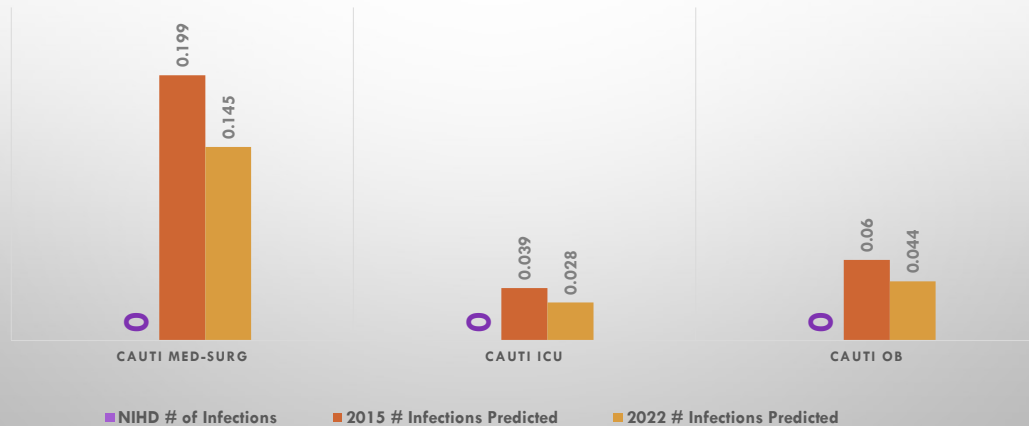
- CDC PERIODICALLY UPDATES THE NATIONAL BENCHMARK USED TO CALCULATE PREDICTED INFECTION RATES.
- **KEY POINT**
 - INFECTION EVENTS AND MONITORING DO **NOT** CHANGE.
 - ONLY THE EXPECTED BENCHMARK IS RECALCULATED.
- **2015 BASELINE (PREVIOUS)**
 - PRE-COVID NATIONAL COMPARISON STANDARD.
 - REFLECTED OLDER PREVENTION PRACTICES AND PATIENT POPULATIONS.
- **2022 REBASELINE**
 - UPDATED FOR POST-PANDEMIC HEALTHCARE ENVIRONMENT.
 - ACCOUNTS FOR HIGHER PATIENT COMPLEXITY, STAFFING CHANGES, AND NEW RISK MODELS.
 - HOSPITALS MAY SEE HIGHER SIRS EVEN IF PERFORMANCE IS UNCHANGED.

NHSN SIR & SUR WHAT IT MEANS

- TWO KEY MEASURES:
 - **SIR (STANDARDIZED INFECTION RATIO):** COMPARES ACTUAL INFECTIONS TO WHAT WAS PREDICTED.
 - **SUR (STANDARDIZED UTILIZATION RATIO):** COMPARES DEVICE USE (LIKE CATHETERS OR CENTRAL LINES) TO WHAT WAS PREDICTED.
- PREDICTIONS ARE RISK-ADJUSTED FOR PATIENT POPULATION AND FACILITY FACTORS.
- HOW TO READ THE SIR OR SUR
 - > **1.0** MORE INFECTIONS OR DEVICES THAN PREDICTED.
 - < **1.0** FEWER INFECTIONS OR DEVICE THAN PREDICTED.
 - = **1.0** INFECTIONS OR DEVICES ARE THE SAME AS PREDICTED.

2015 & 2022 BASELINE COMPARISON

2025 CAUTI INFORMATION



NIHD PREVENTATIVE & ONGOING STRATEGIES

- REVIEW DEVICE NECESSITY DAILY
- DEVICE UTILIZATION REDUCTION
 - TRACER ACTIVITIES
- UPON HIRE AND ANNUAL HANDS ON SKILLS TRAINING
 - EVIDENCED-BASED PRACTICES
 - MONITOR CENTRAL & PICC LINE INSERTIONS
- CLEANING & DISINFECTING ENVIRONMENT AND EQUIPMENT
 - SURVEILLANCE & IMPROVEMENT ACTIVITIES



STRATEGIC FINANCIAL PLAN

- **COMPLETED**
 - REVENUE CYCLE MANAGEMENT UTILIZING AI (JORIE)
 - ORTHOPEDICS SERVICE LINE RECOVERY
 - NEGOTIATED LABOR AGREEMENT
- **IN PROGRESS**
 - RENEW PROVIDER CONTRACTS UNDER WRVU/PRODUCTIVITY MODEL
 - PATIENT THROUGHPUT PROCESS IMPROVEMENT
 - INPATIENT DIALYSIS SERVICE
 - MAMMOTH HOSPITAL PARTNERSHIP ON WOMEN'S HEALTH

STRATEGIC FINANCIAL PLAN

- **SHORT TERM INITIATIVES (3-12 MONTHS)**
 - STAFFING – RURAL HOSPITAL BENCHMARKING (HEALTH TRUST)
 - SUPPLY CHAIN RE-ENGINEERING – LEAN (RSM), CONTRACT REVIEW (MOI CASE ANALYSIS)
 - OUTPATIENT PHARMACY PROGRAM WITH 340B PRICING
 - HOSPITAL BASED PROCEDURE ROOM (OUTPATIENT PROCEDURES)
 - DEVELOP A PROGRAM TO SUPPORT LAUNDRY SERVICES FOR THE LOCAL HOTELS/MAMMOTH HOSPITAL
 - PROP 13 TAX TO THE APPROPRIATE LEVEL (NO GANN APPROPRIATIONS LIMIT)
- **LONG TERM STRATEGY (12-24 MONTHS)**
 - STRATEGIC SERVICE LINE GROWTH (WIPFLI)
 - DISTINCT PART SKILLED NURSING PROGRAM (DP/SNF)
 - RURAL HEALTH TRANSFORMATION PROGRAM



DATE: March 2026
TO: Board of Directors, Northern Inyo Healthcare District
FROM: Christian Wallis, CEO
RE: HealthTrust Contract

MEMORANDUM

Background

Northern Inyo Healthcare District received a proposal from HealthTrust Workforce Solutions (HWS) to conduct a Labor Benchmarking and Optimization Assessment. HealthTrust provides consulting services focused on workforce management, productivity benchmarking, and staffing optimization for healthcare organizations nationwide.

Labor represents the largest operating expense for most healthcare organizations, and benchmarking performance against peer hospitals can help identify opportunities to improve efficiency while maintaining quality patient care.

Discussion

The proposed engagement includes a facility-wide review of staffing, scheduling, and labor productivity, using department-level data and leadership interviews to compare NIHD's labor utilization against peer hospital benchmarks.

The assessment is expected to take approximately 1–2 months and will result in a report outlining benchmarking results and recommended opportunities to improve workforce efficiency and operational performance.

The proposed professional fee is \$44,000, with 50% due upon contract execution and 50% upon delivery of the draft report, plus travel expenses if incurred.

Recommendation

Administration recommends that the Board approve entering into an agreement with HealthTrust Workforce Solutions to conduct the Labor Benchmarking and Optimization Assessment.

Approval would authorize a professional services contract in the amount of \$44,000, plus travel expenses if incurred.



DATE: March 2026
TO: Board of Directors, Northern Inyo Healthcare District
FROM: Adam Hawkins, Chief Medical Officer
RE: Tele nephrology

MEMORANDUM

Background

Northern Inyo Healthcare District is exploring the addition of tele-nephrology services to support the care of patients with renal disease. Given our geographic isolation and the lack of local nephrology coverage, this program would provide our providers with reliable access to nephrology expertise for consultation, dialysis management, and general clinical guidance for renal-related conditions.

Currently, patients who require inpatient dialysis must be transferred by fixed-wing aircraft to tertiary care centers. Each transfer represents a significant disruption to patient care and requires approximately 230 miles of round-trip air transport. Establishing local dialysis capability would allow many of these patients to remain in our community while receiving the care they need.

TeleNeph, LLC is a telemedicine nephrology provider. Their physicians provide consultation and clinical guidance through secure telehealth platforms.

Discussion

Staff is proposing that NIHD enter into a Professional Nephrology Services Agreement with TeleNeph, LLC to provide tele-nephrology consultation services for our providers and patients. Through this agreement, our providers would have 24/7 access to board-certified nephrologists via telemedicine.

The agreement includes a monthly base fee of \$2,500 and a one-time implementation fee of \$2,500. Additional consultation fees related to inpatient dialysis support would be based on patient volume. The initial contract term is still being negotiated.

In order to support the development of inpatient dialysis capability, staff is also recommending the purchase of two NextStage dialysis machines. The estimated cost is approximately \$37,000 per machine, for a total capital expense of \$74,000.

Recommendation

Staff recommends Board approval of the Professional Nephrology Services Agreement with TeleNeph, LLC and approval of the purchase of two NextStage dialysis machines at an estimated total cost of \$74,000.



DATE: March 2026
TO: Board of Directors, Northern Inyo Healthcare District
FROM: Andrea Mossman, Chief Financial Officer
RE: Financial Summary and Operation Insights January 2026

Financial Summary

1. Net Income (loss): January's net income was \$1.9M due to favorable revenue related to more blue cross volume, which improved our net revenue.
2. Operating Income (loss): January's operating income was \$385k due to the higher than budgeted net revenue.

Action Plan: Revenue has improved due to growing orthopedic surgical cases. We continue to work on service line strategies and operational efficiency projects

Stats Summary

1. Admits (excluding Nursery): Admits were under budget by 17 admits (-19%) due to lower deliveries and ER admits.
2. Inpatient Days (excluding Nursery): Inpatient days were under budget by 9 days (-3%) due to lower admits.
3. Average Daily Census: Census was at budget.
4. Average Length of Stay (ALOS): Length of stay was higher than budget by 0.7 days (+25%).
5. Deliveries: Deliveries were under budget by -6 (-30%).
6. Surgical Procedures: Total surgeries were under budget by -22 (-16%) due to Dr. Reid's retirement. However, orthopedics were +10 (+67%) over budget.
7. Emergency Department (ED) Visits: ED visits were 43 over budget (+5%).
8. Diagnostic Imaging (DI) Exams: Exams were 21 over budget (+1%).
9. Rehab Visits: Visits were 71 over budget (+10%) due to increased orthopedics volume.
10. Outpatient Infusion / Injections / Wound Care Visits: These visits were -278 under budget (-35%).
11. Observation Hours: Observations hours were down (19%).

12. Rural Health Clinic (RHC) Visits: RHC visits were 122 above budget (+4%) due to primary care and women's.

13. Other Clinics: Clinic visits were -64 under budget (+3%) due to declines in all clinics other than specialty.

Action Plan: Volumes were slower in the outpatient setting but higher in several key areas such as orthopedic surgeries. We are working on projects to improve scheduling efficiency in both the clinics and operating room. We are marketing the new orthopedics group including in Ridgecrest.

Revenue Summary

1. Gross revenue was \$1.2M over budget due to the unbudgeted price increase and higher volumes in the clinics and ER.

Action Plan: We will continue to work on efficiency in schedules and increasing surgical volume.

Deductions Summary

1. Deductions were higher than budget by \$566k due to higher than budgeted revenue. NR% of gross charges was 1% higher than budget due to a favorable payor mix that shifted to blue cross from Medicaid.

Action Plan: We will continue to work on cash flow actions to reduce write-offs and increase cash. We will continue to work on increasing surgical volumes, which reimburse at a higher rate than a medical admit.

Salaries

1. Total Salaries: Salaries were over budget by 8% due to unbudgeted raises and aggressive cuts in the budget.

2. Average Hourly Rate: Average hourly rate was 7% higher than budget due to unbudgeted raises.

Action Plan: We have developed reports to monitor our largest expense better including overtime, missed meal and rest breaks, and call pay to ensure we are staffing effectively. Additionally, we are reviewing where the increase of 5 FTEs occurred to determine if that was due to rising volumes.

Benefits

1. Total Benefits: Benefits were under budget by \$517k (34%). Our benefits are continuing to improve due to less utilization.

2. Benefits % of Wages: We were 27% for January.

Action Plan: We will continue to review opportunities with our benefits broker to save money while still offering quality benefits to our employees.

Total Salaries, Wages and Benefits (SWB)

1. Salaries, Wages and Benefits (SWB) / Adjusted Patient Day: This was 4% higher than budget due to unbudgeted raises.
2. Salaries, Wages and Benefits (SWB) % of Total Expenses: This was at 46% without contract labor and 49.4% with contract labor. Our goal is 50% or less which is industry standard.

Contract Labor

1. Contract Labor Expense: Contract labor was under budget by \$43k due to lower FTEs.
2. Contract Labor Rates: Rates were 11% over budget due to women's services.
3. Contract Labor Full-Time Equivalents (FTEs): We used (21%) less than budgeted for contract labor FTEs.

Action Plan: We are retaining employees and using less contract workers. However, are having staffing challenges and are paying higher rates in order to support labor & delivery services.

Other Expenses

1. Physician Expense / Adjusted Patient Day: Physician expenses were 13% over budget due to unbudgeted contract increases.
2. Other Professional Fees: Other professional fees were over 11% due to higher billing and collection fees. However, our AR days are lower and our write-offs are also lower helping improve our cash.
3. Supplies: Supplies were over budget by \$102k due to higher than budgeted orthopedic surgical volumes.
4. Total Expenses: Expenses were over budget \$265k (3%) due to higher supply costs, physician fees, and unbudgeted raises.

Action Plan: We are educating leaders to be the "CEO of their own cost center" and manage their expenses to budgets FYE 2026. We will continue to monitor spend and find opportunities to save.

Cash Summary

1. Days Cash on Hand: Days cash on hand was 72 due to receiving our largest IGT. Our bond requirement is 75 days if we are profitable and 100 if we are not profitable.
2. Estimated Days until Depletion (excluding supplement/IGT): We have 416 days until depleted if no more cash is collected.
3. Unrestricted Cash: Unrestricted cash balance is now \$23M. This is \$4.2M higher than last January.

Action Plan: The cash flow action team continues to work on projects to decrease billing delays and

improve cash. Our AR days has improved by 11 days since last January meaning we get cash in the door quicker. Jorie AI billing is helping us improve AR and cash flow.

Northern Inyo Healthcare District
January 2026 – Financial Summary

	Current Month				Prior MTD			Year to Date				Prior YTD		
	Actual	Budget	Variance	Variance %	Actual	Change	Change %	Actual	Budget	Variance	Variance %	Actual	Change	Change %
** Variances are B / (W)														
Net Income (Loss)	1,879,313	100,500	1,778,813	1,770%	180,468	1,698,845	(941%)	(1,343,839)	7,188,990	(8,532,828)	119%	9,141,648	(10,485,487)	(115%)
Operating Income (Loss)	385,170	(152,530)	537,700	(353%)	(42,761)	427,932	1,001%	(10,478,160)	(4,873,994)	(5,604,166)	(115%)	(2,102,697)	(8,375,464)	398%
EBIDA (Loss)	2,303,607	517,654	1,785,953	345%	589,632	1,713,975	(291%)	1,663,077	10,109,067	(8,445,990)	84%	12,101,675	(10,438,598)	(86%)
IP Gross Revenue	3,998,937	3,720,076	278,861	7%	3,280,133	718,805	22%	25,610,425	25,847,513	(237,088)	(1%)	24,651,407	959,018	4%
OP Gross Revenue	15,795,037	15,129,676	665,361	4%	14,664,711	1,130,326	8%	101,310,896	102,159,989	(849,093)	(1%)	100,660,232	650,664	1%
Clinic Gross Revenue	2,125,119	1,880,288	244,831	13%	1,862,148	262,971	14%	13,906,358	12,397,409	1,508,949	12%	12,312,334	1,594,024	13%
Total Gross Revenue	21,919,093	20,730,040	1,189,053	6%	19,806,992	2,112,101	11%	140,827,679	140,404,911	422,768	0%	137,623,973	3,203,706	2%
Net Patient Revenue	10,558,997	9,756,188	802,809	8%	10,518,255	40,742	0%	61,743,692	64,295,940	(2,552,248)	(4%)	64,630,827	(2,887,135)	(4%)
<i>Cash Net Revenue % of Gross</i>	<i>48%</i>	<i>47%</i>	<i>1%</i>	<i>2%</i>	<i>53%</i>	<i>(5%)</i>	<i>(9%)</i>	<i>44%</i>	<i>46%</i>	<i>(2%)</i>	<i>(4%)</i>	<i>47%</i>	<i>(3%)</i>	<i>(7%)</i>
Admits (excl. Nursery)	73	90	(17)	(19%)	90	(17)	(19%)	482	525	(43)	(8%)	525	(43)	(8%)
IP Days	272	282	(9)	(3%)	282	(9)	(3%)	1,601	1,834	(233)	(13%)	1,834	(233)	(13%)
IP Days (excl. Nursery)	240	237	3	1%	237	3	1%	1,356	1,581	(225)	(14%)	1,581	(225)	(14%)
Average Daily Census	7.7	7.6	0.1	1%	7.6	0.1	1%	6.3	7.4	(1.0)	(14%)	7.4	(1.0)	(14%)
ALOS	3.3	2.6	0.7	25%	2.6	0.7	25%	2.8	3.0	(0.2)	(7%)	3.0	(0.2)	(7%)
Deliveries	14	20	(6)	(30%)	20	(6)	(30%)	124	131	(7)	(5%)	131	(7)	(5%)
OP Visits	3,920	4,193	(273)	(7%)	4,193	(273)	(7%)	28,209	27,310	899	3%	27,310	899	3%
Rural Health Clinic Visits	2,571	2,355	216	9%	2,355	216	9%	16,579	16,064	515	3%	16,064	515	3%
Rural Health Women Visits	548	511	37	7%	511	37	7%	3,759	3,627	132	4%	3,627	132	4%
Rural Health Behavioral Visits	85	216	(131)	(61%)	216	(131)	(61%)	836	1,360	(524)	(39%)	1,360	(524)	(39%)
Total RHC Visits	3,204	3,082	122	4%	3,082	122	4%	21,174	21,051	123	1%	21,051	123	1%
Bronco Clinic Visits	41	52	(11)	(21%)	52	(11)	(21%)	240	265	(25)	(9%)	265	(25)	(9%)
Internal Medicine Clinic Visits	-	-	-	-%	-	-	-%	-	-	-	-%	-	-	-%
Orthopedic Clinic Visits	352	377	(25)	(7%)	377	(25)	(7%)	2,301	2,516	(215)	(9%)	2,516	(215)	(9%)
Pediatric Clinic Visits	632	687	(55)	(8%)	687	(55)	(8%)	4,040	4,233	(193)	(5%)	4,233	(193)	(5%)
Specialty Clinic Visits	605	520	85	16%	520	85	16%	4,705	3,794	911	24%	3,794	911	24%
Surgery Clinic Visits	140	170	(30)	(18%)	170	(30)	(18%)	947	1,101	(154)	(14%)	1,101	(154)	(14%)
Virtual Care Clinic Visits	27	55	(28)	(51%)	55	(28)	(51%)	296	406	(110)	(27%)	406	(110)	(27%)
Total NIA Clinic Visits	1,797	1,861	(64)	(3%)	1,861	(64)	(3%)	12,529	12,315	214	2%	12,315	214	2%
IP Surgeries	13	7	6	86%	7	6	86%	64	78	(14)	(18%)	78	(14)	(18%)
OP Surgeries	102	130	(28)	(22%)	130	(28)	(22%)	878	921	(43)	(5%)	921	(43)	(5%)
Total Surgeries	115	137	(22)	(16%)	137	(22)	(16%)	942	999	(57)	(6%)	999	(57)	(6%)
Cardiology	-	-	-	-%	-	-	-%	13	4	9	225%	4	9	225%
General	64	76	(12)	(16%)	76	(12)	(16%)	539	501	38	8%	501	38	8%
Gynecology & Obstetrics	11	10	1	10%	10	1	10%	76	81	(5)	(6%)	81	(5)	(6%)
Ophthalmology	-	20	(20)	(100%)	20	(20)	(100%)	68	154	(86)	(56%)	154	(86)	(56%)
Orthopedic	25	15	10	67%	15	10	67%	134	160	(26)	(16%)	160	(26)	(16%)
Pediatric	-	1	(1)	(100%)	1	(1)	(100%)	-	1	(1)	(100%)	1	(1)	(100%)
Plastics	-	-	-	-%	-	-	-%	1	1	-	-%	1	-	-%
Podiatry	1	1	-	-%	1	-	-%	3	4	(1)	(25%)	4	(1)	(25%)
Urology	14	13	1	8%	13	1	8%	108	91	17	19%	91	17	19%
Diagnostic Image Exams	2,304	2,283	21	1%	2,283	21	1%	15,479	14,815	664	4%	14,815	664	4%
Emergency Visits	876	833	43	5%	833	43	5%	5,934	6,025	(91)	(2%)	6,025	(91)	(2%)
ED Admits	46	63	(17)	(27%)	63	(17)	(27%)	294	316	(22)	(7%)	316	(22)	(7%)
ED Admits % of ED Visits	5%	8%	-2%	(31%)	8%	-2%	(31%)	5%	5%	0%	(6%)	5%	0%	(6%)
Rehab Visits	796	725	71	10%	725	71	10%	5,370	5,924	(554)	(9%)	5,924	(554)	(9%)
OP Infusion/Wound Care Visits	518	796	(278)	(35%)	796	(278)	(35%)	4,475	3,521	954	27%	3,521	954	27%
Observation Hours	1,434	1,781	(347)	(19%)	1,781	(347)	(19%)	7,982	11,317	(3,335)	(29%)	11,317	(3,335)	(29%)

Northern Inyo Healthcare District
January 2026 – Financial Summary

** Variances are B / (W)

PAYOR MIX (Patient Days)

	Current Month				Prior MTD			Year to Date				Prior YTD		
	Actual	Budget	Variance	Variance %	Actual	Change	Change %	Actual	Budget	Variance	Variance %	Actual	Change	Change %
Blue Cross	23.2%	20.7%	2.5%	12.2%	20.7%	2.5%	12.2%	24.6%	24.5%	0.2%	0.6%	24.5%	0.2%	0.6%
Commercial	9.4%	8.2%	1.2%	14.8%	8.2%	1.2%	14.8%	6.6%	7.2%	(0.6%)	(8.9%)	7.2%	(0.6%)	(8.9%)
Medicaid	17.7%	29.5%	(11.7%)	(39.8%)	29.5%	(11.7%)	(39.8%)	22.3%	27.1%	(4.8%)	(17.7%)	27.1%	(4.8%)	(17.7%)
Medicare	47.6%	40.3%	7.4%	18.3%	40.3%	7.4%	18.3%	44.2%	38.9%	5.3%	13.7%	38.9%	5.3%	13.7%
Self-pay	1.9%	1.3%	0.6%	47.3%	1.3%	0.6%	47.3%	2.3%	1.8%	0.6%	31.4%	1.8%	0.6%	31.4%
Worker's Comp	-%	-%	-%	-%	-%	-%	-%	-%	0.5%	(0.5%)	(100.0%)	0.5%	(0.5%)	(100.0%)
Other	-%	-%	-%	-%	-%	-%	-%	-%	0.1%	(0.1%)	(100.0%)	0.1%	(0.1%)	(100.0%)

PAYOR MIX (Gross Revenue)

Blue Cross	30.3%	25.8%	4.5%	17.4%	25.8%	4.5%	17.4%	28.0%	26.9%	1.1%	4.2%	26.9%	1.1%	4.2%
Commercial	7.1%	7.6%	(0.5%)	(6.6%)	7.6%	(0.5%)	(6.6%)	6.1%	6.5%	(0.4%)	(5.8%)	6.5%	(0.4%)	(5.8%)
Medicaid	16.5%	17.3%	(0.9%)	(4.9%)	17.3%	(0.9%)	(4.9%)	18.1%	19.5%	(1.4%)	(7.4%)	19.5%	(1.4%)	(7.4%)
Medicare	42.9%	46.4%	(3.5%)	(7.6%)	46.4%	(3.5%)	(7.6%)	44.9%	43.4%	1.5%	3.4%	43.4%	1.5%	3.4%
Self-pay	1.5%	1.6%	(0.1%)	(5.4%)	1.6%	(0.1%)	(5.4%)	2.0%	2.4%	(0.4%)	(17.5%)	2.4%	(0.4%)	(17.5%)
Worker's Comp	0.9%	1.1%	(0.1%)	(13.5%)	1.1%	(0.1%)	(13.5%)	0.8%	1.2%	(0.4%)	(33.2%)	1.2%	(0.4%)	(33.2%)
Other	0.8%	0.2%	0.6%	308.5%	0.2%	0.6%	308.5%	0.2%	0.2%	0.0%	6.1%	0.2%	0.0%	6.1%

DEDUCTIONS

Contract Adjust	(11,166,102)	(9,943,164)	(1,222,938)	12%	(8,951,555)	(2,214,548)	25%	(73,593,790)	(68,960,653)	(4,633,137)	7%	(66,141,525)	(7,452,265)	11%
Bad Debt	117,631	(119,730)	237,361	(198%)	1,386,194	(1,268,563)	(92%)	(2,344,101)	(830,387)	(1,513,713)	182%	205,927	(2,550,028)	(1,238%)
Write-off	(311,625)	(731,396)	419,771	(57%)	(1,723,376)	1,411,751	(82%)	(3,146,096)	(5,072,582)	1,926,486	(38%)	(6,909,364)	3,763,269	(54%)

CENSUS

Patient Days	240	237	3	1%	237	3	1%	1,356	1,581	(225)	(14%)	1,581	(225)	(14%)
Adjusted ADC	42	45	(2)	(5%)	45	(2)	(5%)	35	41	(6)	(15%)	41	(6)	(15%)
Adjusted Days	1,317	1,432	(115)	(8%)	1,432	(115)	(8%)	7,454	8,825	(1,371)	(16%)	8,825	(1,371)	(16%)
Employed FTE	373.4	368.9	4.5	1%	368.9	4.5	1%	378.1	367.8	10.2	3%	367.8	10.2	3%
Contract Labor FTE	18.7	23.6	(4.9)	(21%)	23.6	(4.9)	(21%)	19.5	25.5	(5.9)	(23%)	25.5	(5.9)	(23%)
Total Paid FTE	392.1	392.5	(0.4)	(0%)	392.5	(0.4)	(0%)	397.6	393.3	4.3	1%	393.3	4.3	1%
EPOB (Employee per Occupied Bed)	1.6	1.7	(0.0)	(1%)	1.7	(0.0)	(1%)	2.0	1.7	0.3	18%	1.7	0.3	18%
EPOC (Employee per Occupied Case)	0.3	0.3	0.0	5%	0.3	0.0	5%	0.1	0.0	0.0	19%	0.0	0.0	19%
Adjusted EPOB	8.9	10.0	(1.1)	(11%)	10.0	(1.1)	(11%)	11.2	9.6	1.6	16%	9.6	1.6	16%
Adjusted EPOC	1.6	1.7	(0.1)	(4%)	1.7	(0.1)	(4%)	0.3	0.2	0.0	17%	0.2	0.0	17%

SALARIES

Per Adjust Bed Day	2,821	2,400	421	18%	2,770	51	2%	3,472	2,671	800	30%	2,572	900	35%
Total Salaries	3,714,863	3,435,715	279,148	8%	3,966,354	(251,491)	(6%)	25,879,816	23,574,865	2,304,950	10%	22,700,790	3,179,025	14%
Average Hourly Rate	56.16	52.58	3.58	7%	60.70	(4.54)	(7%)	55.72	52.17	3.55	7%	50.23	5.48	11%
Employed Paid FTEs	373.4	368.9	4.5	364.4	368.9	4.5	1%	378.1	367.8	10.2	3%	367.8	10.2	3%

BENEFITS

Per Adjust Bed Day	757	1,058	(300)	(28%)	1,169	(412)	(35%)	1,294	1,207	87	7%	1,199	95	8%
Total Benefits	997,381	1,514,243	(516,861)	(34%)	1,674,059	(676,678)	(40%)	9,645,710	10,652,406	(1,006,696)	(9%)	10,584,237	(938,527)	(9%)
Benefits % of Wages	27%	44%	(17%)	(39%)	42%	-15%	(36%)	37%	45%	(8%)	(18%)	47%	(9%)	(20%)
Pension Expense	355,878	371,359	(15,481)	(4%)	379,316	(23,438)	(6%)	2,499,696	2,745,584	(245,888)	(9%)	2,804,922	(305,226)	(11%)
MDV Expense	253,101	782,153	(529,052)	(68%)	895,963	(642,862)	(72%)	4,867,420	5,424,610	(557,191)	(10%)	5,557,917	(690,497)	(12%)
Taxes, PTO accrued, Other	388,402	360,730	27,672	8%	398,780	(10,378)	(3%)	2,278,594	2,482,212	(203,617)	(8%)	2,221,398	57,197	3%
Salaries, Wages & Benefits	4,712,244	4,949,957	(237,713)	(5%)	5,640,413	(928,169)	(16%)	35,525,526	34,227,271	1,298,255	4%	33,285,027	2,240,499	7%
SWB/APD	3,578	3,457	121	4%	3,939	(361)	(9%)	4,766	3,878	887	23%	3,772	994	26%
SWB % of Total Expenses	46%	50%	(4%)	(7%)	53%	(7%)	(13%)	49%	49%	(0%)	(1%)	50%	(1%)	(1%)

Northern Inyo Healthcare District
January 2026 – Financial Summary

** Variances are B / (W)

PROFESSIONAL FEES

Per Adjust Bed Day
Total Physician Fee
Total Contract Labor
Total Other Pro-Fees
Total Professional Fees
Contract AHR
Contract Paid FTEs
Physician Fee per Adjust Bed Day

PHARMACY

Per Adjust Bed Day
Total Rx Expense

MEDICAL SUPPLIES

Per Adjust Bed Day
Total Medical Supplies

EHR SYSTEM

Per Adjust Bed Day
Total EHR Expense

OTHER EXPENSE

Per Adjust Bed Day
Total Other

DEPRECIATION AND AMORTIZATION

Per Adjust Bed Day
Total Depreciation and Amortization

TOTAL EXPENSES

Per Adjust Bed Day
Per Calendar Day

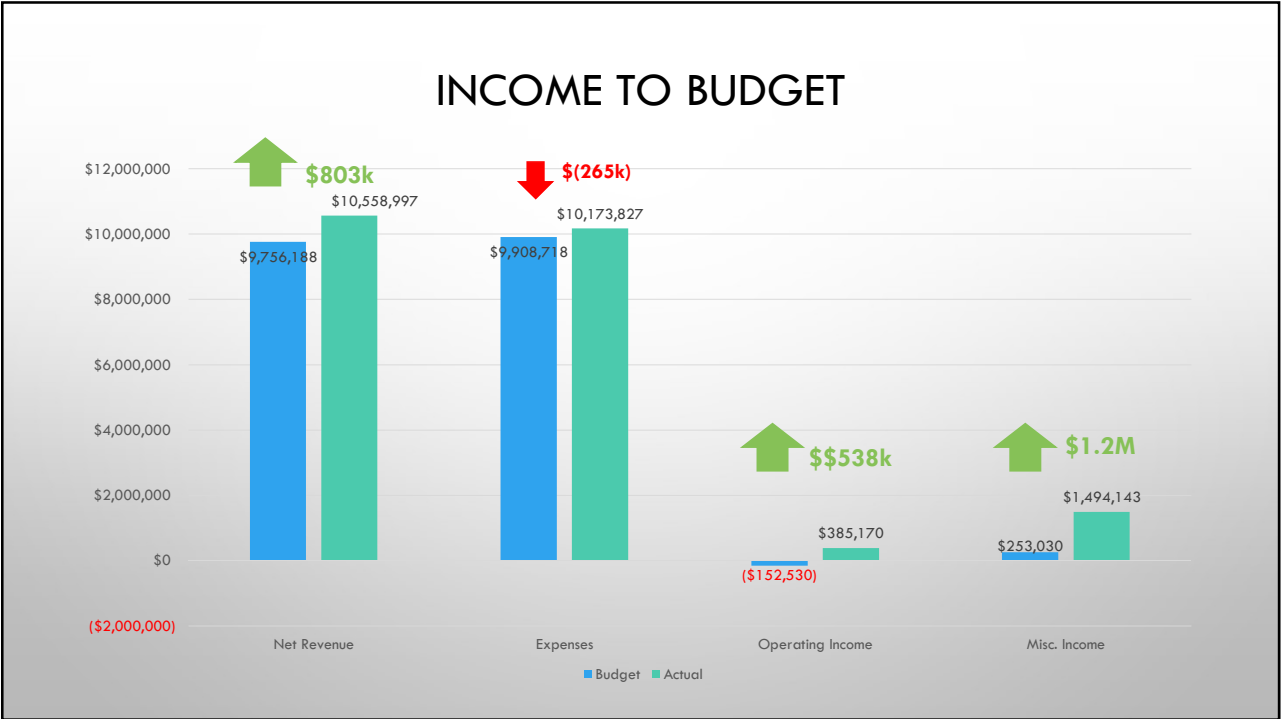
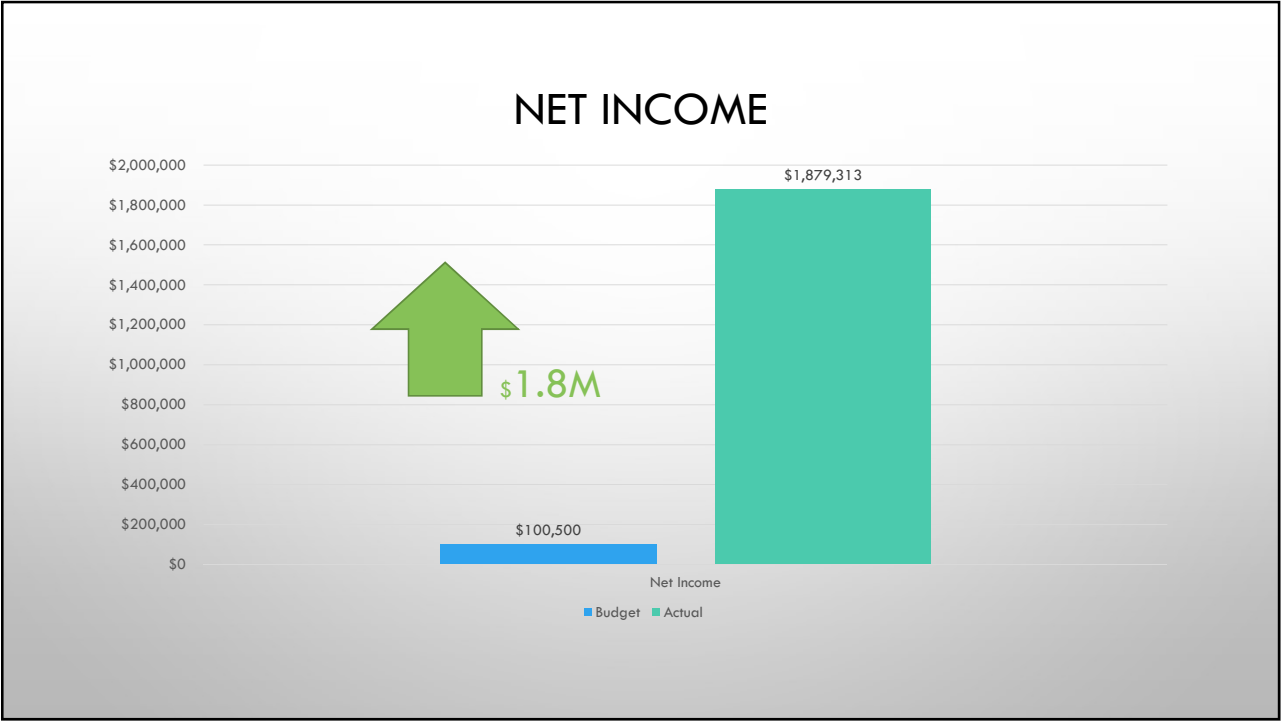
Current Month				Prior MTD			Year to Date				Prior YTD		
Actual	Budget	Variance	Variance %	Actual	Change	Change %	Actual	Budget	Variance	Variance %	Actual	Change	Change %
2,318	1,913	405	21%	1,788	530	30%	2,735	2,208	527	24%	1,999	735	37%
1,942,693	1,715,762	226,930	13%	1,579,218	363,475	23%	12,239,030	11,988,824	250,205	2%	10,859,673	1,379,357	13%
318,690	361,796	(43,106)	(12%)	312,240	6,450	2%	2,491,253	2,875,106	(383,852)	(13%)	3,336,525	(845,272)	(25%)
791,250	661,164	130,086	20%	668,438	122,812	18%	5,655,165	4,620,194	1,034,972	22%	3,449,015	2,206,151	64%
3,052,633	2,738,722	313,910	11%	2,559,896	492,737	19%	20,385,449	19,484,124	901,325	5%	17,645,213	2,740,236	16%
96.15	86.40	9.75	11%	74.57	21.59	29%	103.86	91.92	11.94	13%	106.68	(2.81)	(3%)
18.7	23.6	(4.9)	(21%)	23.6	(4.9)	(21%)	19.5	25.5	(5.9)	(23%)	25.5	(5.9)	(23%)
1,475	1,198	277	23%	1,103	372	34%	1,642	1,359	283	21%	1,231	411	33%
360	315	45	14%	330	30	9%	394	355	39	11%	294	100	34%
474,261	451,577	22,684	5%	473,056	1,204	0%	2,934,153	3,131,904	(197,750)	(6%)	2,594,684	339,470	13%
396	309	87	28%	299	97	32%	478	347	131	38%	406	73	18%
521,289	442,141	79,149	18%	428,092	93,197	22%	3,566,161	3,065,977	500,185	16%	3,581,777	(15,616)	(0%)
18	22	(4)	(19%)	29	(11)	(37%)	35	25	9	36%	27	7	27%
23,914	32,115	(8,201)	(26%)	41,264	(17,350)	(42%)	258,115	224,803	33,312	15%	241,265	16,850	7%
733	613	120	20%	705	28	4%	878	693	185	27%	728	150	21%
965,193	877,053	88,140	10%	1,009,132	(43,939)	(4%)	6,545,533	6,115,779	429,754	7%	6,425,532	120,001	2%
322	291	31	11%	286	36	13%	403	331	73	22%	335	68	20%
424,294	417,154	7,140	2%	409,164	15,130	4%	3,006,916	2,920,077	86,839	3%	2,960,027	46,889	2%
10,173,827	9,908,718	265,109	3%	10,561,017	(387,190)	(4%)	72,221,852	69,169,934	3,051,919	4%	66,733,524	5,488,328	8%
7,726	6,920	805	12%	7,376	350	5%	9,689	7,838	1,851	24%	7,562	2,127	28%
328,188	319,636	8,552	3%	340,678	(12,490)	(4%)	335,916	321,721	14,195	4%	310,388	25,527	8%

Key Financial Performance Indicators		Industry	FYE 2024		FYE 2025						Variance to	Variance to FYE	
		Benchmark	Jan-24	Average	Jan-25	Average	Oct-25	Nov-25	Dec-25	Jan-26	PM	2025 Average	Variance to PYM
Volume													
Admits		41	79	69	90	71	76	67	73	73	-	2	(17)
Deliveries	n/a		8	17	20	17	15	18	17	14	(3)	(3)	(6)
Adjusted Patient Days	n/a		1,009	977	1,432	1,125	1,161	880	1,022	1,317	295	192	(115)
Total Surgeries		153	175	146	137	140	147	112	131	115	(16)	(25)	(22)
ER Visits		659	818	826	833	852	819	726	886	876	(10)	24	43
RHC and Clinic Visits	n/a		4,859	4,607	4,943	4,772	5,154	4,384	4,976	5,001	25	229	58
Diagnostic Imaging Services	n/a		2,262	2,069	2,283	2,129	2,274	1,957	2,157	2,304	147	175	21
Rehab Services	n/a		743	662	725	838	764	769	703	796	93	(42)	71
AR & Income													
Gross AR (Cerner only)	n/a	\$ 56,381,675	\$ 52,823,707	\$ 45,458,077	\$ 50,813,697	\$ 38,777,469	\$ 37,941,078	\$ 40,266,148	\$ 42,782,472	\$ 2,516,324	\$ (8,031,225)	\$ (2,675,605)	
AR > 90 Days	\$ 6,599,901.18	\$ 27,771,536	\$ 23,112,391	\$ 17,533,888	\$ 20,669,422	\$ 14,855,434	\$ 14,887,324	\$ 14,240,093	\$ 13,540,953	\$ (699,139)	\$ (7,128,468)	\$ (3,992,935)	
AR % > 90 Days	15%	50.04%	44.2%	38.57%	40.6%	38.3%	39.2%	35.4%	31.7%	-3.7%	-8.9%	-6.9%	
Gross AR Days (per financial statements)	60	84	85	71	80	58	66	53	61	7	(20)	(11)	
Net AR Days (per financial statements)	30	69	58	76	71	36	55	67	63	(5)	(8)	(13)	
Net AR	n/a	\$ 20,997,993	\$ 16,938,200	\$ 25,749,510	\$ 19,370,868	\$ 11,138,154	\$ 13,862,975	\$ 21,831,732	\$ 21,330,628	\$ (501,105)	\$ 1,959,760	\$ (4,418,882)	
Net AR % of Gross	n/a	37.2%	31.9%	56.6%	38.5%	28.7%	36.5%	54.2%	49.9%	-4.4%	11.4%	-6.8%	
Gross Patient Revenue/Calendar Day	n/a	\$ 671,199	\$ 619,457	\$ 638,935	\$ 634,418	\$ 671,419	\$ 571,795	\$ 752,964	\$ 707,068	\$ (45,896)	\$ 72,649	\$ 68,132	
Net Patient Revenue/Calendar Day	n/a	\$ 302,421	\$ 292,759	\$ 339,299	\$ 273,563	\$ 308,780	\$ 253,195	\$ 324,041	\$ 340,613	\$ 16,572	\$ 67,050	\$ 1,314	
Net Patient Revenue/APD	n/a	\$ 9,291	\$ 8,757	\$ 7,346	\$ 8,088	\$ 8,246	\$ 8,631	\$ 9,832	\$ 8,018	\$ (1,814)	\$ (70)	\$ 672	
Wages													
Wages	n/a	\$ 3,251,713	\$ 3,285,431	\$ 3,966,354	\$ 3,661,965	\$ 3,694,416	\$ 3,562,811	\$ 4,037,755	\$ 3,714,863	\$ (322,892)	\$ 52,897	\$ (251,491)	
Employed paid FTEs	n/a	346.54	353.69	368.89	370.77	377.37	378.81	386.31	373.41	(12.90)	2.64	4.52	
Employed Average Hourly Rate	\$55.50	\$ 52.97	\$ 53.49	\$ 60.86	\$ 56.89	\$ 55.42	\$ 55.02	\$ 59.17	\$ 56.32	\$ (2.85)	\$ (0.57)	\$ (4.55)	
Benefits	n/a	\$ 1,248,638	\$ 1,640,216	\$ 1,674,059	\$ 1,401,858	\$ 1,826,000	\$ 1,547,641	\$ 1,094,758	\$ 997,381	\$ (97,376)	\$ (404,477)	\$ (676,678)	
Benefits % of Wages	30%	38.4%	48.8%	42.2%	39.8%	49.4%	43.4%	27.1%	26.8%	-0.3%	-12.9%	-15.4%	
Contract Labor	n/a	\$ 383,806	\$ 518,351	\$ 312,240	\$ 447,445	\$ 358,976	\$ 504,270	\$ 131,351	\$ 318,690	\$ 187,339	\$ (128,755)	\$ 6,450	
Contract Labor Paid FTEs	n/a	21.60	23.49	23.64	23.89	19.09	19.88	18.89	18.71	(0.18)	(5.18)	(4.93)	
Total Paid FTEs	n/a	368.14	377.18	392.52	394.65	396.46	398.69	405.19	392.12	(13.07)	(2.53)	(0.40)	
Contract Labor Average Hourly Rate	\$ 81.04	\$ 100.31	\$ 123.22	\$ 74.77	\$ 120.98	\$ 106.43	\$ 148.37	\$ 39.36	\$ 96.42	\$ 57.05	\$ (24.56)	\$ 21.65	
Total Salaries, Wages, & Benefits	n/a	\$ 4,884,157	\$ 5,443,998	\$ 5,952,653	\$ 5,511,268	\$ 5,879,392	\$ 5,614,723	\$ 5,263,863	\$ 5,030,934	\$ (232,929)	\$ (480,334)	\$ (921,719)	
SWB% of NR	50%	52.1%	62.1%	56.6%	72.0%	61.4%	73.9%	52.4%	47.6%	-4.8%	-24.4%	-8.9%	
SWB/APD	2,204	\$ 4,841	\$ 5,104	\$ 4,157	\$ 5,284	\$ 5,065	\$ 6,380	\$ 5,152	\$ 3,820	\$ (1,332)	\$ (1,464)	\$ (337)	
SWB % of total expenses	50%	49.9%	55.4%	56.3%	55.6%	52.5%	53.5%	50.2%	49.4%	-0.7%	-6.2%	-6.9%	

		Industry		FYE 2024		FYE 2025		Variance to						Variance to FYE	
		Benchmark	Jan-24	Average	Jan-25	Average	Oct-25	Nov-25	Dec-25	Jan-26	PM	2025 Average	Variance to PYM		
Physician Spend	Physician Expenses	n/a	\$ 1,586,690	\$ 1,613,172	\$ 1,099,861	\$ 1,507,510	\$ 1,932,281	\$ 1,597,620	\$ 1,946,664	\$ 1,942,693	\$ (3,971)	\$ 435,183	\$ 842,832		
	Physician expenses/APD	n/a	\$ 1,108	\$ 1,565	\$ 768	\$ 1,476	\$ 1,664	\$ 1,815	\$ 1,905	\$ 1,475	\$ (430)	\$ (1)	\$ 707		
Supplies															
	Supply Expenses	n/a	\$ 900,961	\$ 832,644	\$ 1,159,592	\$ 776,504	\$ 1,004,885	\$ 835,043	\$ 1,169,433	\$ 995,550	\$ (173,883)	\$ 219,046	\$ (164,042)		
	Supply expenses/APD		\$ 629	\$ 822	\$ 810	\$ 744	\$ 866	\$ 949	\$ 1,145	\$ 756	\$ (389)	\$ 12	\$ (54)		
Other Expenses															
	Other Expenses	n/a	\$ 2,127,997	\$ 1,939,040	\$ 1,566,740	\$ 1,824,207	\$ 2,376,590	\$ 2,440,391	\$ 2,116,095	\$ 2,204,650	\$ 88,555	\$ 380,443	\$ 637,910		
	Other Expenses/APD	n/a	\$ 1,486	\$ 1,861	\$ 1,094	\$ 1,787	\$ 2,047	\$ 2,773	\$ 2,071	\$ 1,674	\$ (397)	\$ (113)	\$ 580		
Margin															
	Net Income	n/a	\$ 173,184	\$ 253,100	\$ (322,849)	\$ 383,722	\$ (1,132,695)	\$ 3,176,018	\$ (632,700)	\$ 1,879,313	\$ 2,512,013	\$ 1,495,591	\$ 2,202,162		
	Net Profit Margin	n/a	1.6%	3.7%	-3.4%	3.0%	-11.8%	41.8%	-6.3%	17.8%	24.1%	14.8%	21.2%		
	Operating Income	n/a	\$ (50,046)	\$ (1,557,761)	\$ (404,286)	\$ (686,444)	\$ (1,620,972)	\$ (2,891,928)	\$ (450,779)	\$ 385,170	\$ 835,950	\$ 1,071,615	\$ 789,456		
	Operating Margin	2.9%	-0.5%	-26.1%	-4.3%	-10.9%	-16.9%	-38.1%	-4.5%	3.6%	8.1%	14.6%	7.9%		
	EBITDA	n/a	\$ 582,348	\$ 676,999	\$ 197,779	\$ 841,891	\$ (697,302)	\$ 3,593,558	\$ (197,022)	\$ 2,303,607	\$ 2,500,629	\$ 1,461,716	\$ 2,105,828		
	EBITDA Margin	12.7%	5.5%	9.4%	2.1%	8.7%	-7.3%	47.3%	-2.0%	21.8%	23.8%	13.1%	19.7%		
	Debt Service Coverage Ratio	3.70	7.1	3.9	2.4	3.3	(5.0)	(0.6)	(0.7)	0.4	1.1	(2.9)	(2.0)		
Cash															
	Avg Daily Disbursements (excl. IGT)	n/a	\$ 359,843	\$ 350,828	\$ 424,036	\$ 355,328	\$ 416,814	\$ 388,940	\$ 380,372	\$ 354,878	\$ (25,494)	\$ (450)	\$ (69,158)		
	Average Daily Cash Collections (excl. IGT)	n/a	\$ 239,449	\$ 340,919	\$ 289,440	\$ 299,110	\$ 388,454	\$ 278,666	\$ 325,614	\$ 289,881	\$ (35,732)	\$ (9,229)	\$ 441		
	Average Daily Net Cash		\$ (120,394)	\$ (9,908)	\$ (134,596)	\$ (56,218)	\$ (28,360)	\$ (110,274)	\$ (54,758)	\$ (64,996)	\$ (10,238)	\$ (8,779)	\$ 69,599		
	Upfront Cash Collections		\$ 60,336	\$ 54,286	\$ 34,946	\$ 36,146	\$ 77,539	\$ 43,734	\$ 42,688	\$ 62,345	\$ 19,658	\$ 26,200	\$ 27,400		
	Upfront Cash % of Gross Charges	1%	0.3%	0.3%	0.2%	0.2%	0.4%	0.3%	0.2%	0.3%	0.1%	0.1%	0.1%		
	Unrestricted Funds	n/a	\$ 22,744,726	\$ 23,774,285	\$ 18,888,305	\$ 23,536,438	\$ 26,719,622	\$ 21,356,431	\$ 21,028,877	\$ 23,124,630	\$ 2,095,753	\$ (411,808)	\$ 4,236,325		
	Change of cash per balance sheet	n/a	\$ 7,670,424	\$ 321,485	\$ (2,016,685)	\$ (321,485)	\$ 300,674	\$ (5,363,191)	\$ (327,554)	\$ 2,095,753	\$ 2,423,306	\$ 2,417,238	\$ 4,112,438		
	Days Cash on Hand (assume no more cash is collected)	196	74	73	45	72	84	66	65	72	7	(0)	27		
	Estimated Days Until Depleted (operating cash only)		370	2,399	337	406	671	396	389	416	27	10	79		
	Years Until Cash Depletion (operating cash only)		1.01	6.57	0.92	1.11	1.84	1.09	1.07	1.14	0.07	0.03	0.22		



VOLUME & INCOME



VOLUME & INCOME ACTION PLAN

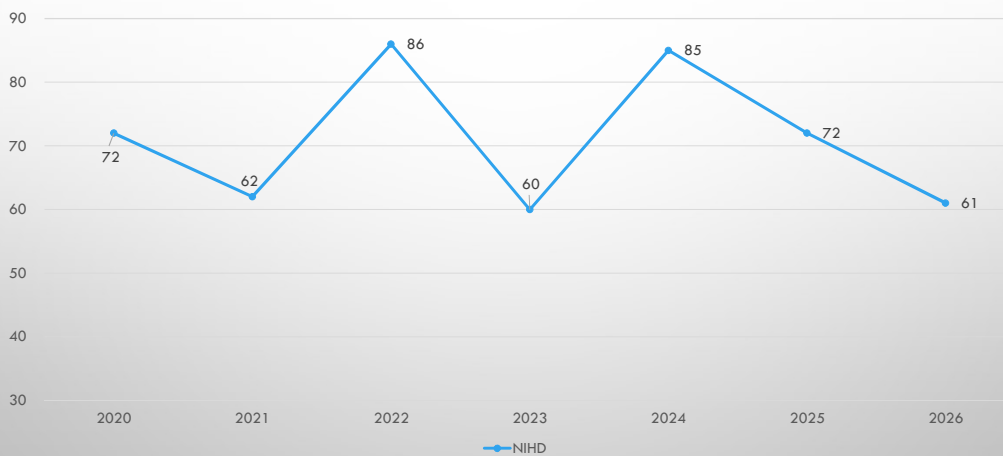
- THE MAMMOTH ORTHOPEDIC INSTITUTE BEGAN ORTHOPEDIC SURGERIES IN JULY. THEIR SURGICAL VOLUME HAS STEADILY INCREASED THE PAST FEW MONTH. ORTHOPEDICS SURGERIES WERE ABOVE BUDGET.
- WE ARE WORKING ON REVIEWING OPERATIONAL EFFICIENCY INCLUDING OR UTILIZATION AND SPACE UTILIZATION REVIEWS TO MAXIMIZE PATIENT FLOW AND CARE.
- WE ARE BEING MORE DELIBERATE IN OUR SERVICE LINE STRATEGY.
- ADDITIONALLY, WE ARE EDUCATING LEADERS TO BE THE "CEO OF THEIR OWN COST CENTER" AND MANAGE THEIR EXPENSES TO BUDGETS FYE 2026.
- WE HAVE DEVELOPED REPORTS TO MONITOR OUR LARGEST EXPENSE BETTER INCLUDING OVERTIME, MISSED MEAL AND REST BREAKS, AND CALL PAY TO ENSURE WE ARE STAFFING EFFECTIVELY. REPORTS WILL BE SENT TO LEADERS MONTHLY WITH ACCOUNTABILITY PLANS BEING PUT IN PLACE TO REDUCE PREMIUM PAY.

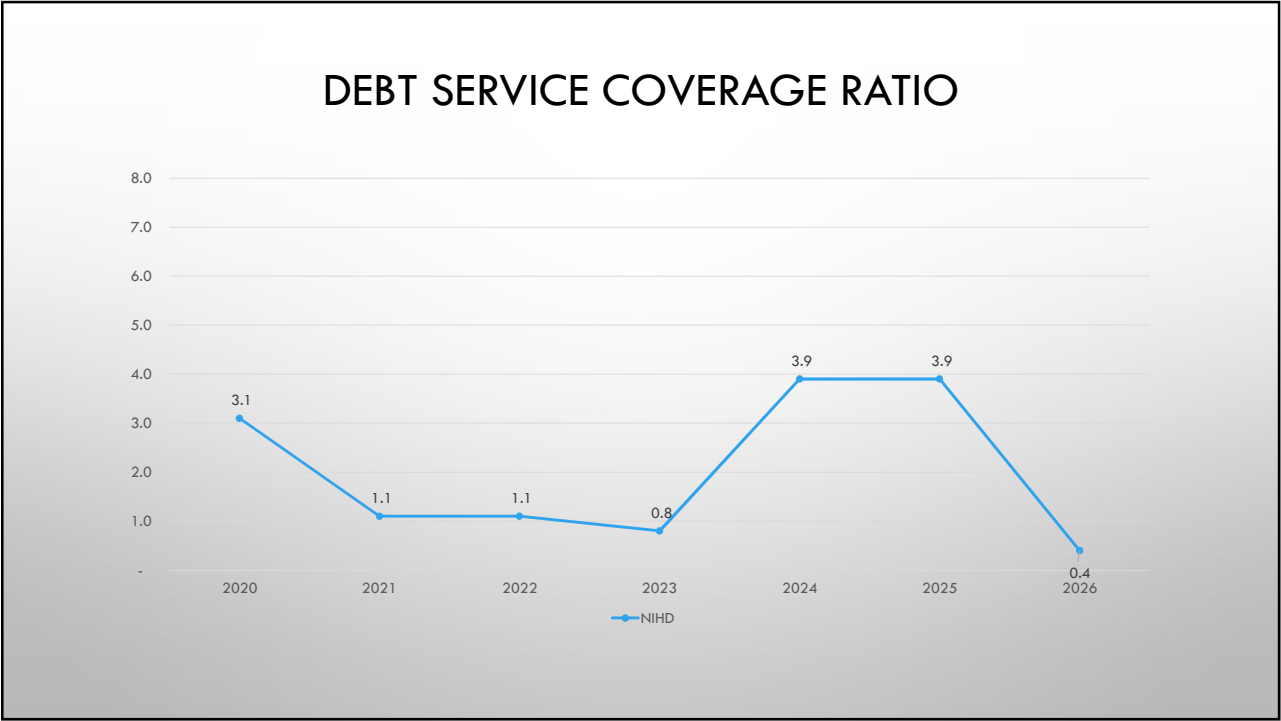
CASH PERFORMANCE

INCOME TO CASH

	FYE 2026
Net Income (loss)	\$(1,343,839)
Principal Payments on Long-Term Debt (balance sheet only)	\$(1,861,947)
Other Debt (long-term leases & subscriptions – balance sheet only)	\$(563,846)
Capital purchases (balance sheet only)	\$(568,351)
IGT Revenue Recognized but Cash Not Received (cash vs. accruals)	\$(1,036,942)
Impact to Cash	\$(4,031,086)
Adjusted Net Income (cash basis)	\$(5,374,925)

GROSS AR DAYS





UNRESTRICTED FUNDS



CASH ACTION PLAN

- THE CASH FLOW ACTION TEAM IS WORKING TO IMPROVE PROCESSES IN ALL ASPECTS OF BILLING AND COLLECTIONS.
- WE HAVE HIRED A NEW AI-BASED BILLING COMPANY, JORIE, AND HAVE HIT RECORD CASH COLLECTIONS THE PAST FEW MONTHS. THE AUTOMATION IS NOW LIVE IN SEVERAL AREAS.
- WE HAVE MOVED \$11M IN CASH TO FIVE STAR BANK TO EARN BETTER RETURNS ON OUR CASH.
- WE HAVE ANOTHER \$5.5M IN THE LAIF EARNING 3.8% INTEREST.
- WE COLLECTED \$220K MORE IN CY 2025 UPFRONT THAN WE DID IN EITHER CY 2023 OR CY 2024.
- AR DAYS ARE AT A RECORD LOW FOR THE ORGANIZATION.
- WE HAVE SWITCHED OUR MEDI-CAL BILLING TO JORIE AS OF DECEMBER TO IMPROVE COLLECTIONS EVEN FURTHER.
- WE HAVE RECEIVED A NET OF \$900K FROM UNDERPAYMENTS ON CLAIMS

Northern Inyo Healthcare District
Income Statement
Fiscal Year 2026

	10/31/2025	Oct Budget	10/31/2024	11/30/2025	Nov Budget	11/30/2024	12/31/2025	Dec Budget	12/31/2024	1/31/2026	Jan Budget	1/31/2025	2026 YTD	Budget Variance	PYM Change
Gross Patient Service Revenue															
Inpatient Patient Revenue	3,663,512	3,432,674	3,316,543	3,068,437	3,683,029	3,654,138	4,837,635	3,265,690	2,658,147	3,998,937	3,720,076	3,280,133	25,610,425	278,861	718,805
Outpatient Revenue	15,012,546	16,276,892	16,328,013	12,251,051	12,068,831	12,133,332	16,353,865	14,301,930	12,983,214	15,795,037	15,129,676	14,664,711	101,310,896	665,361	1,130,326
Clinic Revenue	2,137,938	2,016,861	2,003,181	1,834,353	1,712,532	1,695,930	2,150,379	1,649,095	1,632,767	2,125,119	1,880,288	1,862,148	13,906,358	244,831	262,971
Gross Patient Service Revenue	20,813,996	21,726,427	21,647,737	17,153,841	17,464,392	17,483,401	23,341,878	19,216,715	17,274,128	21,919,093	20,730,040	19,806,992	140,827,679	1,189,053	2,112,101
Deductions from Revenue															
Contractual Adjustments	(10,574,256)	(9,943,164)	(10,328,421)	(9,501,354)	(9,622,417)	(9,645,351)	(11,815,242)	(9,943,164)	(8,575,086)	(11,166,102)	(9,943,164)	(8,951,555)	(73,593,790)	(1,222,938)	(2,214,548)
Bad Debt	242,346	(119,730)	(302,126)	226,725	(115,868)	2,304,836	(1,124,188)	(119,730)	(526,905)	117,631	(119,730)	1,386,194	(2,344,101)	237,361	(1,268,563)
A/R Writeoffs	(909,911)	(731,396)	(1,472,830)	(283,363)	(707,802)	(1,097,867)	(357,172)	(731,396)	(1,479,007)	(311,625)	(731,396)	(1,723,376)	(3,146,096)	419,771	1,411,751
Other Deductions from Revenue	-	(179,562)	-	-	(173,770)	-	-	(179,562)	-	-	(179,562)	-	-	179,562	-
Deductions from Revenue	(11,241,821)	(10,973,852)	(12,103,377)	(9,557,992)	(10,619,856)	(8,438,382)	(13,296,602)	(10,973,852)	(10,580,998)	(11,360,096)	(10,973,852)	(9,288,737)	(79,083,987)	(386,244)	(2,071,359)
Other Patient Revenue															
Incentive Income	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Other Oper Rev - Rehab Thera Serv	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Medical Office Net Revenue	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Other Patient Revenue	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Net Patient Service Revenue	9,572,175	10,752,575	9,544,361	7,595,849	6,844,535	9,045,019	10,045,276	8,242,864	6,693,130	10,558,997	9,756,188	10,518,255	61,743,692	802,809	40,742
CNR%	46.0%	49.5%	44.1%	44.3%	39.2%	51.7%	43.0%	42.9%	38.7%	48.2%	47.1%	53.1%	43.8%	1.1%	-4.9%
Cost of Services - Direct															
Salaries and Wages	3,155,300	2,899,508	3,033,243	3,026,638	2,790,979	2,944,227	3,435,111	2,888,220	3,119,241	3,119,201	2,884,813	3,402,211	22,004,391	234,388	(283,010)
Benefits	1,561,958	1,289,162	1,587,436	1,252,353	1,191,782	1,616,715	933,385	1,288,785	1,445,404	846,729	1,285,519	1,412,693	8,168,977	(438,790)	(565,965)
Professional Fees	2,141,550	1,828,541	1,956,752	1,817,462	1,683,241	1,765,895	2,193,430	1,864,795	1,757,982	2,160,806	1,878,634	1,769,446	13,690,995	282,172	391,361
Contract Labor	257,899	303,030	466,567	423,986	347,300	495,129	84,298	270,699	366,331	210,212	238,645	373,323	1,882,703	(28,433)	(163,111)
Pharmacy	432,888	451,577	363,699	308,065	437,010	628,990	491,024	451,577	446,090	474,261	451,577	473,056	2,934,153	22,684	1,204
Medical Supplies	571,996	442,141	496,964	526,979	427,637	406,800	678,410	442,141	348,884	521,289	442,141	428,092	3,566,161	79,149	93,197
Hospice Operations	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
EHR System Expense	42,185	32,115	25,930	45,755	32,115	47,276	35,831	32,115	12,263	23,914	32,115	41,264	258,115	(8,201)	(17,350)
Other Direct Expenses	829,934	699,541	687,481	787,124	660,753	854,548	566,683	630,395	554,226	677,001	615,178	764,432	4,883,348	61,823	(87,431)
Total Cost of Services - Direct	8,993,710	7,945,613	8,618,072	8,188,360	7,570,816	7,759,581	8,418,171	7,868,725	8,050,420	8,033,412	7,828,621	8,664,517	57,388,843	204,791	(631,105)
General and Administrative Overhead															
Salaries and Wages	539,116	495,411	588,796	536,174	494,427	519,714	602,644	506,699	540,406	595,662	550,901	564,143	3,875,424	44,760	31,519
Benefits	264,041	217,926	308,829	295,289	281,007	96,641	161,373	222,818	233,464	150,653	228,724	261,366	1,476,733	(78,071)	(110,713)
Professional Fees	649,380	554,467	294,687	726,582	672,923	231,039	609,538	518,213	235,635	573,136	498,292	478,210	4,203,201	74,844	94,926
Contract Labor	101,078	118,766	77,262	80,283	65,763	88,238	47,053	151,097	306,137	108,478	123,151	(61,083)	608,551	(14,673)	169,561
Depreciation and Amortization	435,393	417,154	409,531	417,540	417,154	409,531	435,678	417,154	409,164	424,294	417,154	409,164	3,006,916	7,140	15,130
Other Administrative Expenses	210,428	177,367	149,642	243,549	204,448	481,883	221,599	246,514	262,025	288,192	261,875	244,700	1,662,185	26,317	43,492
Total General and Administrative Overhead	2,199,437	1,981,092	1,828,748	2,299,417	2,135,721	1,827,047	2,077,884	2,062,494	1,986,831	2,140,415	2,080,097	1,896,500	14,833,009	60,318	243,915
Total Expenses	11,193,147	9,926,705	10,446,820	10,487,777	9,706,537	9,586,628	10,496,055	9,931,219	10,037,251	10,173,827	9,908,718	10,561,017	72,221,852	265,109	(387,190)
Financing Expense	181,041	196,180	215,407	171,993	196,180	206,574	174,430	196,180	201,339	171,708	196,180	205,348	1,256,809	(24,472)	(33,640)
Financing Income	260,000	181,031	181,031	260,000	181,031	181,031	260,000	181,031	181,031	1,393,000	181,031	181,031	2,953,000	1,211,969	1,211,969
Investment Income	73,728	47,322	40,963	66,342	47,322	56,648	347,664	47,322	45,165	102,405	47,322	46,487	732,090	55,082	55,918
Miscellaneous Income	335,591	1,214,625	293,111	5,913,597	217,829	248,404	(615,154)	9,215,471	9,187,671	170,446	220,857	201,059	6,706,041	(50,411)	(30,613)
Net Income (Change in Financial Position)	(1,132,695)	2,072,668	(602,761)	3,176,018	(2,611,999)	(262,101)	(632,700)	7,559,289	5,868,407	1,879,313	100,500	180,468	(1,343,839)	1,778,813	1,698,845
Operating Income	(1,620,972)	825,870	(902,460)	(2,891,928)	(2,862,001)	(541,610)	(450,779)	(1,688,355)	(3,344,121)	385,170	(152,530)	(42,761)	(10,478,160)	537,700	427,932
EBIDA	(697,302)	2,489,822	(193,230)	3,593,558	(2,194,845)	147,431	(197,022)	7,976,443	6,277,571	2,303,607	517,654	589,632	1,663,077	1,785,953	1,713,975
Net Profit Margin	-11.8%	19.3%	-6.3%	41.8%	-38.2%	-2.9%	-6.3%	91.7%	87.7%	17.8%	1.0%	1.7%	-2.2%	16.8%	16.1%
Operating Margin	-16.9%		-9.5%	-38.1%	-41.8%	-6.0%	-4.5%	-20.5%	-50.0%	3.6%	-1.6%	-0.4%	-17.0%	5.2%	4.1%
EBIDA Margin	-7.3%		-2.0%	47.3%	-32.1%	1.6%	-2.0%	96.8%	93.8%	21.8%	5.3%	5.6%	2.7%	16.5%	16.2%

Northern Inyo Healthcare District
Balance Sheet
Fiscal Year 2026

	PY Balances	10/31/2025	10/31/2024	11/30/2025	11/30/2024	12/31/2025	12/31/2024	1/31/2026	1/31/2025	PM Change	PY Change
Assets											
Current Assets											
Cash and Liquid Capital	20,757,956	19,711,431	16,909,058	14,348,583	10,295,002	14,510,441	9,262,111	16,796,957	16,381,395	2,286,516	415,562
Short Term Investments	7,741,599	6,511,054	6,876,555	6,271,772	6,872,978	6,021,285	6,873,880	6,069,608	7,420,527	48,323	(1,350,919)
PMA Partnership	-	-	-	-	-	-	-	-	-	-	-
Accounts Receivable, Net of Allowance	16,645,748	11,138,154	19,252,585	13,862,975	20,054,289	21,831,732	18,106,671	21,330,628	21,232,772	(501,105)	97,855
Other Receivables	9,238,007	12,675,718	4,771,477	18,836,206	9,458,105	13,490,140	18,665,903	12,584,787	8,279,368	(905,353)	4,305,419
Inventory	5,334,241	5,325,812	6,079,443	5,329,753	6,117,401	5,368,712	6,141,928	5,345,822	6,129,163	(22,890)	(783,342)
Prepaid Expenses	1,106,127	1,495,596	1,353,383	1,423,818	1,091,960	1,500,971	852,094	1,904,391	1,483,581	403,420	420,811
Total Current Assets	60,823,678	56,857,764	55,242,502	60,073,106	53,889,735	62,723,281	59,902,587	64,032,193	60,926,806	1,308,911	3,105,386
Assets Limited as to Use											
Internally Designated for Capital Acquisition	-	-	-	-	-	-	-	-	-	-	-
Short Term - Restricted	1,469,292	1,469,800	1,468,293	1,469,924	1,468,417	(711,423)	1,468,545	(711,295)	1,468,673	128	(2,179,968)
Limited Use Assets	-	-	-	-	-	-	-	-	-	-	-
LAIF - DC Pension Board Restricted	-	-	-	-	-	-	-	-	-	-	-
LAIF - DB Pension Board Restricted	9,393,030	9,393,030	10,346,490	9,393,030	10,346,490	9,393,030	10,346,490	9,393,030	10,346,490	-	(953,460)
PEPRA - Deferred Outflows	-	-	-	-	-	-	-	-	-	-	-
PEPRA Pension	-	-	-	-	-	-	-	-	-	-	-
Deferred Outflow - Excess Acquisition	573,097	573,097	573,097	573,097	573,097	573,097	573,097	573,097	573,097	-	-
Total Limited Use Assets	9,966,127	9,966,127	10,919,587	9,966,127	10,919,587	9,966,127	10,919,587	9,966,127	10,919,587	-	(953,460)
Revenue Bonds Held by a Trustee	297,382	274,405	353,592	268,661	347,848	262,916	342,104	257,439	336,360	(5,477)	(78,921)
Total Assets Limited as to Use	11,732,801	11,710,332	12,741,473	11,704,712	12,735,852	9,517,621	12,730,236	9,512,271	12,724,620	(5,349)	(3,212,349)
Long Term Assets											
Long Term Investment	497,086	497,137	999,950	736,076	747,654	497,152	748,961	258,065	747,838	(239,086)	(489,772)
Fixed Assets, Net of Depreciation	81,644,252	80,788,073	83,828,939	80,414,574	83,555,961	80,152,672	83,368,289	79,823,636	83,497,234	(329,036)	(3,673,599)
Total Long Term Assets	82,141,338	81,285,210	84,828,890	81,150,650	84,303,615	80,649,823	84,117,250	80,081,701	84,245,072	(568,123)	(4,163,371)
Total Assets	154,697,817	149,853,306	152,812,864	152,928,467	150,929,203	152,890,725	156,750,074	153,626,165	157,896,498	735,439	(4,270,334)
Liabilities											
Current Liabilities											
Current Maturities of Long-Term Debt	3,599,764	3,733,143	4,780,264	3,746,074	4,742,849	3,734,182	4,616,414	3,735,906	4,601,872	1,724	(865,966)
Accounts Payable	4,413,297	5,934,043	3,949,738	5,086,695	4,337,497	4,804,574	4,496,145	6,329,466	4,559,038	1,524,892	1,770,429
Accrued Payroll and Related	3,525,333	5,038,910	3,453,920	3,953,250	1,532,265	4,825,174	2,073,837	4,441,717	2,929,795	(383,457)	1,511,923
Accrued Interest and Sales Tax	83,538	109,061	166,600	10,834	192,433	80,904	275,828	142,138	358,675	61,234	(216,537)
Notes Payable	339,892	339,892	446,860	339,892	446,860	339,892	446,860	339,892	446,860	-	(106,968)
Unearned Revenue	-	-	(4,542)	-	(4,542)	-	(4,542)	-	(4,542)	-	4,542
Due to 3rd Party Payors	3,324,903	3,324,903	693,247	4,331,882	693,247	4,331,882	693,247	4,331,882	693,247	-	3,638,635
Due to Specific Purpose Funds	-	-	-	-	-	-	-	-	-	-	-
Other Deferred Credits - Pension & Leases	8,758,790	8,750,511	12,591,545	8,748,442	12,589,475	8,746,372	12,589,475	8,744,302	12,585,336	(2,070)	(3,841,033)
Total Current Liabilities	24,045,518	27,230,464	26,077,633	26,217,069	24,530,084	26,862,981	25,187,264	28,065,305	26,170,281	1,202,323	1,895,024
Long Term Liabilities											
Long Term Debt	33,367,666	31,853,055	34,797,823	30,916,770	34,698,029	30,808,805	33,927,979	30,675,496	33,830,169	(133,309)	(3,154,673)
Bond Premium	127,973	115,425	153,070	112,288	149,933	109,151	146,796	106,014	143,659	(3,137)	(37,645)
Accreted Interest	17,272,679	16,708,764	16,560,403	16,793,152	16,653,761	16,877,539	16,742,795	16,961,927	16,831,830	84,388	130,097
Other Non-Current Liability - Pension	31,874,258	31,874,258	32,946,355	31,874,258	32,946,355	31,874,258	32,946,355	31,874,258	32,946,355	-	(1,072,097)
Total Long Term Liabilities	82,642,576	80,551,502	84,457,651	79,696,468	84,448,078	79,669,753	83,763,925	79,617,695	83,752,012	(52,058)	(4,134,317)
Suspense Liabilities	-	-	-	-	-	-	-	-	-	-	-
Uncategorized Liabilities (grants)	61,310	54,957	127,821	34,957	127,821	34,957	127,821	34,957	127,821	-	(92,864)
Total Liabilities	106,749,404	107,836,923	110,663,105	105,948,494	109,105,983	106,567,691	109,079,010	107,717,956	110,050,114	1,150,265	(2,332,158)
Fund Balance											
Fund Balance	40,722,935	46,313,053	37,326,592	48,100,501	37,262,030	48,076,134	37,241,338	45,781,867	37,236,063	(2,294,267)	8,545,804
Temporarily Restricted	1,469,292	1,469,800	1,468,293	1,469,924	1,468,417	1,470,052	1,468,545	1,470,180	1,468,673	128	1,507
Net Income	5,756,186	(5,766,469)	3,354,874	(2,590,452)	3,092,773	(3,223,152)	8,961,180	(1,343,839)	9,141,648	1,879,313	(10,485,487)
Total Fund Balance	47,948,412	42,016,384	42,149,759	46,979,974	41,823,220	46,323,034	47,671,064	45,908,208	47,846,384	(414,826)	(1,938,176)
Liabilities + Fund Balance	154,697,817	149,853,306	152,812,864	152,928,467	150,929,203	152,890,725	156,750,074	153,626,165	157,896,498	735,439	(4,270,334)
(Decline)/Gain		(1,937,979)	(2,419,435)	3,075,161	(1,883,661)	(37,742)	5,820,871	735,439	1,146,425	773,181	(410,985)

Northern Inyo Healthcare District
Long-Term Debt Service Coverage Ratio
FYE 2026

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

Long-Term Debt Service Coverage Ratio Calculation

<u>Numerator:</u>	HOSPITAL FUND ONLY
Excess of revenues over expense	\$ (1,343,839)
+ Depreciation Expense	3,006,916
+ Interest Expense	1,256,809
Less GO Property Tax revenue	2,067,000
Less GO Interest Expense	273,717
"Income available for debt service"	\$ 579,170
<u>Denominator:</u>	
Maximum "Annual Debt Service"	
2021A Revenue Bonds	\$ 112,700
2021B Revenue Bonds	892,400
2009 GO Bonds (Fully Accreted Value)	
2016 GO Bonds	
Financed purchases and other loans	1,506,725
Total Maximum Annual Debt Service	\$ 2,511,825
	1,465,231
Ratio: (numerator / denominator)	0.40
Required Debt Service Coverage Ratio:	1.10
In Compliance? (Y/N)	No

Unrestricted Funds and Days Cash on Hand

	HOSPITAL FUND ONLY
Cash and Investments-current	\$ 22,866,565
Cash and Investments-non current	258,065
Sub-total	23,124,630
Less - Restricted:	
PRF and grants (Unearned Revenue)	-
Held with bond fiscal agent	-
Building and Nursing Fund	-
Total Unrestricted Funds	\$ 23,124,630
Total Operating Expenses	\$ 72,221,852
Less Depreciation	3,006,916
Net Expenses	69,214,937
Average Daily Operating Expense	\$ 321,930
Days Cash on Hand	72

Northern Inyo Healthcare District
Statement of Cash Flows
Fiscal Year 2026

CASH FLOWS FROM OPERATING ACTIVITIES

Receipts from and on Behalf of Patients	61,780,802
Payments to Suppliers and Contractors	(37,836,874)
Payments to and on Behalf of Employees	(38,016,779)
Other Receipts and Payments, Net	364,095
Net Cash Provided (Used) by Operating Activities	(13,708,756)

CASH FLOWS FROM NONCAPITAL FINANCING ACTIVITIES

Noncapital Contributions and Grants	4,679,760
Property Taxes Received	886,000
Net Cash Provided (Used) by Noncapital Financing Activities	5,565,760

**CASH FLOWS FROM CAPITAL AND CAPITAL RELATED
FINANCING ACTIVITIES**

Principal Payments on Long-Term Debt	(1,861,947)
Proceeds from the Issuance of Refunding Revenue Bonds	-
Payment to Defeasement Revenue Bonds	-
Interest Paid	(1,256,809)
Purchase and Construction of Capital Assets	2,721,942
Payments on Lease Liability	(52,880)
Payments on Subscription Liability	(510,966)
Property Taxes Received	2,953,000
Net Cash Provided (Used) by Capital and Capital Related Financing Activities	1,992,339

CASH FLOWS FROM INVESTING ACTIVITIES

Investment Income	732,090
Rental Income	43,641
Net Cash Provided (Used) by Investing Activities	775,731

NET CHANGE IN CASH AND CASH EQUIVALENTS

(5,374,925)

Cash and Cash Equivalents - Beginning of Year

28,499,555

CASH AND CASH EQUIVALENTS - END OF YEAR

23,124,630

Department-Led Budget Calendar

Task	Due Date
Financial & Stat History completed	1/8/2026
Budget schedule completed	1/8/2026
Budget templates completed	1/13/2026
Department Leaders Training	1/14/2026
Volume rollforward completed	2/20/2026
FTEs Completed	2/20/2026
Wages, Contract Labor, & Benefits Completed	2/20/2026
Supplies Completed	2/20/2026
Physician Expenses Completed	2/20/2026
All Other Expenses Completed	2/20/2026
Department Leaders Expense Budget Draft Due	2/20/2026
Exec Team Finalizes Expense Budget Draft	2/27/2026
Department Leaders Revenue Budget Draft Due	3/20/2026
Exec Team Finalizes Revenue Budget Draft	3/31/2026
Exec Team Reviews Dept Budgets	4/10/2026
Dept Leaders Adjust Budget	4/17/2026
Dept Leaders Meetings to Review Final Budgets	4/24/2026
Exec Team Final Approval of Draft	5/1/2026
Final Draft Presented to Finance Committee	5/12/2026
Final Draft Presented to Board	5/20/2026
Final Budget Approved by Board (if needed)	6/17/2026

RESOLUTION NO. 26-01

**RESOLUTION OF THE BOARD OF DIRECTORS OF THE
NORTHERN INYO HEALTHCARE DISTRICT
REQUESTING CONSOLIDATION OF ELECTION**

WHEREAS, it is necessary that four (4) directors be elected to the Board of Directors of Northern Inyo Healthcare District, one each from Zones I, II, III, and V of said District; and

WHEREAS, the Board of Directors desires to consolidate the District election with the statewide general election to be held on November 3, 2026.

NOW, THEREFORE, BE IT RESOLVED that the Board of Directors of Northern Inyo Healthcare District hereby requests that the Inyo County Elections Office consolidate the election of directors of the District with the statewide election to be held on November 3, 2026.

BE IT FURTHER RESOLVED that the Hospital Chief Executive Officer be, and is hereby, directed to file copies of this Resolution with the Inyo County Elections Office of the County of Inyo, State of California.

Adopted, signed, and approved this 18th day of March, 2026.

Melissa Best-Baker, Chair

Attest:

Ashley Reed, Board Clerk



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

NORTHERN INYO HEALTHCARE DISTRICT

BYLAWS

ADOPTED BY THE
NORTHERN INYO HEALTHCARE DISTRICT
BOARD OF DIRECTORS

REVISED AND ADOPTED IN CONFORMANCE WITH THE LOCAL HEALTH CARE DISTRICT
LAW (DIVISION 23, COMMENCING WITH SECTION 32000 OF THE CALIFORNIA HEALTH
AND SAFETY CODE) ON FEBRUARY 21, 2024

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ARTICLE I NAME, AUTHORITY, AND OFFICES

Section 1. NAME

The name of this non-profit health care district organization shall be the Northern Inyo Healthcare District, hereinafter "the District".

Section 2. AUTHORITY

- a) This District, having been established January 11, 1946, by vote of the residents of the District under the provisions of Division 23, commencing with Section 32000 of the California Health and Safety Code, otherwise known as the Local Health Care District Law, and ever since said time having been operated thereunder, these bylaws are adopted in conformance therewith, and subject to the provisions thereof.
- b) In the event of any conflict between these bylaws and the Local Health Care District Law, the latter shall prevail. To the extent they are not in conflict with these bylaws, the proceedings of the District Board shall be guided by the most recent edition of Robert's Rules of Order.

Section 3. OFFICES

The principal office for the transaction of business of the District is hereby fixed within the boundaries of the District as determined by the Board of Directors.

Section 4. TITLE OF PROPERTY

The title to all property of the District shall be vested in the District, and the signature of the Chair and/or Secretary, or any officer designated by the Directors, as authorized at any meeting of the Directors, shall constitute the proper authority for the purchase or sale of property, or for the investment or other disposal of funds which are subject to the control of the District.

ARTICLE II PURPOSES AND SCOPE

Section 1. PURPOSES

The purposes of the Northern Inyo Healthcare District shall include, but not be limited to the following:

- a) Within available resources, to provide facilities and health services for quality acute and continued care of the injured and ill, including health maintenance and education, regardless of sex, race, creed, cultural or national origin.
- b) To coordinate, wherever possible and feasible, the activities of the District with health agencies and other health facilities providing specialized as well as comprehensive care.
- c) To conduct educational and research activities essential to the attainment of its purposes.
- d) To do any and all other acts necessary to carry out the provisions of the Health Care District Law.

Section 2. SCOPE OF BYLAWS

- a) These bylaws shall govern the Northern Inyo Healthcare District, its Board of Directors, and its relationship to affiliated or subordinate organizations. The primary purpose of these bylaws is to provide rules for the self-governance of the District and the Board of Directors, to provide a structure for the Board of Directors to fulfill its functions and responsibilities with respect to an organized self-governing Medical Staff, and to provide a structure for Administration of the licensed healthcare inpatient and outpatient facilities operated by the District (specifically Northern Inyo Hospital, 1206 D and 1206 B clinics).
- b) The Board of Directors may delegate certain powers to the Authority of the Board's committees, the Medical Staff, and to other affiliated and subordinate organizations and groups governed by the District, such powers to be exercised in accordance with the respective bylaws or guidelines of such groups. All powers and functions not expressly delegated to such affiliated or subordinate organizations or groups are to be considered residual powers vested in the Board of Directors of this District.
- c) The Bylaws, Rules and Regulations of the Medical Staff and other affiliated and subordinate organizations and groups governed by the District, and any amendments to such bylaws, shall not be effective until the same are approved by the Board of Directors of the Northern Inyo Healthcare District. The provisions of these District bylaws shall be construed to be consistent with the Medical Staff's bylaws. Except that these Bylaws shall not conflict with the bylaws of the Medical Staff as approved by the Board of Directors, the Board of Directors may review these Bylaws and revise them as it deems appropriate.

Section 3. TAX EXEMPT STATUS

There shall be no contemplation of profit or pecuniary gain, and no distribution of profits to any individual, under any guise whatsoever; nor shall there be any distribution of assets or surpluses to any individual on the dissolution of this District.

Section 4. DISPOSITION OF SURPLUS

Should the operation of the District result in a surplus of revenue over expenses during any particular period, such surplus may be used and dealt with by the Directors for charitable District purposes or for improvements hospital's facilities for the care of the sick, injured, or disabled, or for other purposes not inconsistent with the Local Health Care District ~~Law Act~~, or these bylaws. The Board of Directors may authorize the disposition of any surplus property of the District by any method determined appropriate by the Board.

Section 5. INDEMNIFICATION

- a) Any person made or threatened to be made a party to any action or proceeding, whether civil or criminal, administrative or investigative, by reason of the fact that he/she, his/her estate, or his/her personal representative is or was a Director, officer or employee of the District, or an individual (including a medical staff appointee) acting as an agent of the District, or serves or served any other corporation or other entity or organization in any capacity at the request of the District while acting as a Director, officer, employee or agent of the District shall be and hereby is indemnified by the District, as provided in Sections 825 et.seq. of the California Government Code.
- b) Indemnification shall be against all judgments, fines, amounts paid in settlement and reasonable expenses, including attorney's fees actually and necessarily incurred, as a result of any such action or proceeding, or any appeal therein, to the fullest extent permitted and in the manner prescribed by the laws of the State of California, as they may be amended from time to time, or such other law or laws as may be applicable to the extent such other law or laws is not inconsistent with the law of California, including Sections 825 et.seq. of the California Government Code.
- c) Nothing contained herein shall be construed as providing indemnification to any person in any malpractice action or proceeding arising out of or in any way connected with such person's practice of his or her profession.

Section 6. FISCAL YEAR

The fiscal year of the District shall commence on the first day of July, and each year shall end on the last day of June.

ARTICLE III BOARD OF DIRECTORS

Section 1. ELECTION

The Board of Directors shall be elected as provided in The Local Healthcare District Law, which shall also govern eligibility for election to the Board of Directors.

Section 2. POWERS

The Board of Directors shall have and exercise all the powers of a Healthcare District as set forth in the Healthcare District Law. Specifically, the Board of Directors shall be empowered as follows:

- a) To control and be responsible for the overall governance of the District, including the provision of management and planning.
- b) To make and enforce all rules and regulations necessary for the administration, government, protection, and maintenance of hospitals and other facilities under District jurisdiction and to ensure compliance with all applicable laws.
- c) To appoint a Chief Executive Officer and to define the powers and duties of such appointee, and to delegate to such person overall responsibility for operations of the District, the Hospital, and affiliated entities as specified herein and consistent with Board of Directors' Policies. The Board shall also retain legal counsel and independent auditors as needed for District and Hospital operations.
- d) To authorize the formation of other affiliated or subordinate organizations which they may deem necessary to carry out the purposes of the District.
- e) To periodically review and develop a strategic plan for the District and the Hospital.
- f) To determine policies and approve procedures for the overall operation and affairs of this District and its facilities according to the best interests of the public health and to assure the maintenance of quality patient care.
- g) To enter into Joint Powers Agreements with other public entities, and to carry out the District's responsibilities regarding such Joint Powers Authority as prescribed by law.
- h) To evaluate the performance of the Hospital in relation to its vision, mission, and goals.
- i) To provide for coordination and integration among the Hospital's leaders to establish policy, maintain quality care and patient safety, and provide for necessary resources.
- j) To be ultimately accountable for the safety and quality of care, treatment, and services.
- k) All powers of the Board of Directors, which are not restricted by statute, may be delegated by an employment agreement, policies, and by direction of the Board to the Chief Executive Officer or to others employed by or with responsibilities to the District, to be exercised in accordance with that delegation.
- l) In the event of a vacancy in any Board office established by Article V of these Bylaws (Chair,

Vice Chair, etc.), the Board of Directors shall select someone to fill such vacancy and to serve until the next regular election of officers, unless such person earlier resigns or is removed in accordance with said Article.

- m) To do any and all other acts and things necessary to carry out the provisions of these bylaws or of the provisions of the Local Health Care District Law.

Section 3. COMPENSATION

The Board of Directors shall serve without compensation except that the Board of Directors, by a majority vote of the members of the Board, may authorize payment not to exceed one hundred dollars (\$100) per meeting, or for each committee meeting or other meeting authorized by Board or Chair of the Board, and not to exceed five (5) meetings a month as compensation to each member of the Board of Directors, in accordance with Section 32103 of the California Health and Safety Code, as amended.

Each member of the Board of Directors shall be allowed his/her necessary traveling and incidental expenses incurred in the performance of official business of the District pursuant to the Board's policy.

A budget for the Board of Directors' educational expenses is developed yearly. At least annually, the entire Board will review their travel and incidental expenses.

Section 4. VACANCIES

Any vacancy upon the Board of Directors shall be filled by the methods prescribed in Section 1780 of the Government Code.

ARTICLE IV MEETINGS OF DIRECTORS

Section 1. REGULAR MEETINGS

The regular meetings of the Board of Directors of the Northern Inyo Healthcare District shall be held monthly, or as periodically determined by the Board, on such day and at such time as the Board of Directors shall from time-to-time establish by resolution and/or motion.

Section 2. SPECIAL MEETINGS

Special meetings of the Board of Directors may be called by the Chair or three (3) Directors, and notice of the holding thereof shall be received by each member of the Board of Directors at least twenty-four hours (24) before said meeting.

Section 3. QUORUM

A majority of the members of the Board of Directors shall constitute a quorum for the transaction of business, and motions and resolutions shall be passed if affirmatively voted upon by a majority of those voting at the time the vote is taken. If a member has a conflict of interest and may not vote, they may not be counted towards a quorum.

Section 4. ADJOURNMENT

A quorum of the Board of Directors may adjourn any Directors' meeting to meet again at a stated day and hour; provided, however, that in the absence of a quorum, a majority of the Directors present at any Directors' meeting, either regular or special, may adjourn until the time fixed for the next regular meeting of the Board of Directors. An adjourned meeting can consider only the business of the meeting which was adjourned. An adjourned meeting must be completed prior to the convening of a new meeting.

Section 5. PUBLIC MEETINGS

~~All meetings of the Board of Directors whether regular, special or adjourned, shall be open to the public in accordance with Government Code Sections 54950 through 54961, commonly known as the Ralph M. Brown Act provided, however, that the foregoing shall not be construed to prevent the Board of Directors from holding executive sessions to consider the appointment, employment, promotion, demotion or dismissal of an employee or public officer, as the term is defined by law, or to hear complaints or charges brought against such officer or employee, to discuss labor negotiations, or to consult with legal counsel concerning litigation to which the District is a party, and prospective and probably litigation, as provided in Sections 54956.7 through 54957 of the Government Code. In addition, closed sessions may be held to discuss trade secrets as defined in Government Code Section 54956.7, and provided in Section 32106 of the Health and Safety Code. To the extent not in violation with the Ralph M. Brown Act or the California Public Records Act, and California Health and Safety Code Section 32155, any information and reports protected from discovery by California Evidence Code Section 1157 that are provided to the Board of Directors by the Medical Staff shall be presented and discussed in closed sessions, maintained as confidential and not released except as required by applicable laws. All meetings of the Board of Directors, whether regular or special, shall be open to the public, except as otherwise permitted by law, and shall be conducted in accordance with the Ralph M.~~

Brown Act (Government Code Sections 54950 et seq.). The Board of Directors may hold closed sessions only as authorized by law.

Information and reports provided to the Board of Directors by the Medical Staff that are protected from disclosure under California Evidence Code Section 1157 or applicable provisions of the California Health and Safety Code shall be presented and discussed in closed session, maintained as confidential, and disclosed only as required by law.

Section 6. MINUTES

~~A book of minutes of all public meetings of the Board of Directors shall be kept at the principal office of the District and shall be open for public inspection upon request. Minutes of all public meetings of the Board of Directors shall be maintained as official District records, and shall be available for public inspection upon request, in accordance with applicable law.~~

Section 7. SCOPE OF MOTIONS AND RESOLUTIONS

The decisions of the Board establishing general rules or procedures of the District and/or procedures affecting the Directors shall be made by motion or resolution. All motions or resolutions become effective at the time voted upon affirmatively by a majority of the Directors voting at the time the vote is taken.

ARTICLE V OFFICERS AND THEIR DUTIES

Section 1. OFFICERS

The officers of the Board of Directors of the Northern Inyo Healthcare District shall be a Chair, Vice Chair, Secretary, Treasurer, and Member at Large.

Section 2. ELECTION OF OFFICERS

- a) The slate of proposed officers for the Board of Directors shall rotate each year as follows:

Member at Large becomes the Treasurer
 Treasurer becomes Secretary
 Secretary becomes Vice Chair
 Vice Chair becomes Chair
 Chair becomes Member at Large

At the yearly December meeting, the Board of Directors shall vote whether to accept the proposed slate of officers, or whether to propose an alternative slate. Each officer shall hold the office for one year, or until a successor shall be elected and qualified, or until the officer is otherwise disqualified to serve.

- b) If an officer of the Board, other than the Chair, is unable to act, the Board may appoint some other member of the Board of Directors to do so, and such person shall be vested temporarily with all the functions and duties of the office.
- c) Any officer on the Board of Directors may resign at any time or be removed as a Board officer by the majority vote of the other Directors then in office at any regular or special meeting of the Board of Directors. In the event of a resignation or removal of an officer, the Board of Directors shall elect a successor to serve for the balance of that officer's unexpired term.

Section 3. DUTIES

- a) Chair: The Board of Directors shall elect one of its members to act as Chair. If at any time the Chair shall be unable to act, the Vice Chair shall assume office and perform the duties of the office. If the Vice Chair is also be unable to act, then the Secretary/Treasurer shall assume the office and shall immediately conduct a Board election to appoint a Chair, and such person shall be vested temporarily with all the functions and duties of the Chair. The Board of Directors shall elect one of its members to serve as Chair. In the absence or inability of the Chair to act, the Vice Chair shall assume the duties of the Chair. If both the Chair and Vice Chair are unable to act, the Board shall designate another officer or Director to serve temporarily until a Chair is elected.

The Chair or a member of the Board of Directors acting as such, as above provided:

- (1) Shall preside over all meetings of the Board of Directors, and shall review all requested agenda items submitted to the Chair and the Chair & Chief Executive Officer pursuant to the Board's written policies; Shall preside over meetings of the Board of Directors and coordinate with the Chief Executive Officer on the development of Board meeting

agendas in accordance with Board policies.

- (2) Shall sign as Chair on behalf of the District all instruments in writing that the Chair has been specifically authorized by the Board to sign;
 - (3) ~~Shall act as the main liaison between the Board and management for communications and oversight purposes. It is expected that the Chair will discuss District business with the Chief Executive Officer and Vice Chair regularly;~~ Shall serve as the primary liaison between the Board of Directors and the Chief Executive Officer for purposes of communication and governance oversight, while recognizing that authority resides with the full Board.
 - (4) Shall appoint or remove members of committees subject to approval by the Board of Directors.
 - (5) ~~Shall have, subject to the advice and control of the Board of Directors, general responsibility for the affairs of the District and generally shall discharge all other duties which shall be required of the Chair by the Bylaws of the District. The Chair's duties are limited to leadership and facilitation of the Board's governance role and do not include unilateral authority over District policy, governance, or operations, which are reserved to the full Board of Directors or delegated to the Chief Executive Officer.~~
- b) Vice Chair: ~~The Vice Chair shall, in the event of death, absence, or other inability of the Chair, exercise all the powers and perform all the duties herein given to the Chair. It is expected that the Vice Chair will participate in regular discussions with the Chair and Chief Executive Officer regarding District business.~~ The Vice Chair shall, in the absence or inability of the Chair, exercise all powers and perform all duties of the Chair as provided in these Bylaws.
- c) Secretary:
- (1) The member of the Board who is elected to the position of Secretary shall act in this capacity for both the District and the Board of Directors;
 - (2) ~~Shall be responsible for seeing that records of all actions, proceedings and minutes of meetings of the Board of Directors are properly kept and are maintained at the District offices;~~ Shall ensure that records of Board proceedings, including meeting minutes, are maintained as official District records.
 - (3) ~~Shall serve, or cause to be served, all notices required either by law or these bylaws, and in the event of absence, inability, refusal, or neglect to do so, such notices may be served by any person thereunto directed by the Chair of the Board of Directors of this District;~~ Shall ensure that procedures are in place for providing all notices required by law or these Bylaws.
 - (4) ~~Shall be responsible for seeing that the seal of this District is in safekeeping at the District and shall use it under the direction of the Board of Directors;~~
 - (5) ~~Shall perform such other duties as pertain to the office and as are prescribed by the Board of Directors. The Secretary may delegate his or her duties to appropriate management personnel.~~ Shall perform such other duties as may be assigned by the Board of Directors

and may delegate duties to appropriate management personnel.

- d) Member at Large: The Member at Large shall have all the powers and duties of the Secretary in the absence of the Secretary, and shall perform such other duties as may from time to time be prescribed by the Board of Directors.
- e) Treasurer:
 - (1) ~~Shall have the responsibility for the safekeeping and disbursal of funds in the treasury of the District in accordance with the provisions of the Local Healthcare District Law and in accordance with resolutions, procedures, and directions as the Board of Directors may adopt;~~Shall be responsible for oversight of the safekeeping and disbursement of District funds in accordance with the Local Health Care District Law and Board-adopted resolutions, policies, and procedures.
 - (2) ~~Shall receive monthly reports from management with respect to the financial condition of the District and shall present such reports to the Board of Directors as directed by the Board of Directors;~~ Shall review financial information provided by management and support the Board of Directors in its oversight of the District's financial condition.
 - (3) Shall perform such other duties as they pertain to this office and as prescribed by the Board of Directors. The Treasurer may delegate his or her duties to appropriate management personnel.

ARTICLE VI COMMITTEES

Section 1. COMMITTEES

- a) ~~The Board of Directors may sit as a Committee of the Whole on any and all matters, or may create such Standing Committees, ad hoc Committees, or task force Committees as are deemed appropriate.~~The Board of Directors may meet as a Committee of the Whole or establish committees as it deems appropriate.
- b) ~~The duties of these committees shall be to develop and make policy recommendations to the Board and to perform such other functions as shall be stated in these bylaws or in the resolution or motion creating the committee. Each Standing Committee will include two Board members, one of whom shall act as Chair of the Standing Committee. The Chair and Board members of each Standing Committee shall be appointed by the Chair of the Board and approved by the Board at the earliest possible time at the beginning of each calendar year and shall serve for one year, or until a successor has been appointed and approved. Other members of each standing committee are automatically members with one year terms, or until a successor has been appointed and approved. The two Board members shall be the only voting members of each Standing Committee, unless otherwise provided for in these Bylaws.~~ Committees of the Board serve in an advisory capacity to conduct detailed review and discussion of assigned matters and to present recommendations or completed items to the full Board of Directors for consideration, approval, or further action. Standing Committees shall consist of two members of the Board of Directors and one alternate. Annually, following the election of Board officers, Committee members and alternates shall be appointed by the Chair of the Board. An alternate member may vote only when serving in place of an absent committee member.

- c) ~~Special or ad hoc committees may be appointed by the Chair with the approval of the Board of Directors for such specific tasks as circumstances warrant. Special committees may consist only of Board members, or they may include individuals not on the Board. Voting rights on special committees shall be specified by the Board of Directors at the time the committee is created. No committee so appointed shall have any power or authority to commit the Board of Directors or the District in any manner; however, the Board may direct the particular committee to act for and on its behalf, by special vote.~~ Special or ad hoc committees may be appointed by the Chair of the Board, subject to approval by the Board of Directors, for specific tasks as circumstances warrant. Such committees may be composed of Board members and may also include individuals who are not members of the Board. Voting rights, if any, shall be specified by the Board of Directors at the time the committee is created. No special or ad hoc committee shall have authority to commit the Board of Directors or the District, except when the Board directs a committee to act on its behalf by special vote.
- d) ~~All committees shall keep minutes of each meeting and shall maintain their minutes at the District offices and shall submit reports to the Board as requested.~~ Committees shall keep minutes of each meeting and submit reports to the Board of Directors as requested. Minutes shall be maintained as official District records.
- e) ~~Aside from committees upon which the Chair is appointed as a voting member, the Chair of the Board shall be an ex officio member of each committee, without being a voting member. The Chair shall be notified of all committee meetings.~~

Section 2. STANDING COMMITTEES

Governance Committee:

- a) ~~Members of this standing committee shall include two representatives from the Board of Directors and the Chief Executive Officer. The Compliance Officer and others may attend as requested. The two members of the Board of Directors shall be the only members of the Committee with voting privileges.~~ Members of this Standing Committee shall consist of two members of the Board of Directors and one alternate.
- b) —
- c) ~~The function of this Committee is to recommend amendments or changes to the District bylaws and Board policies. This Committee shall make recommendations to the Board of Directors for edits and updates to Board Bylaws, Board Policies and plan Board Self-Assessments, Board strategic meetings, format for Chief Executive Officer evaluation and other areas of governance.~~ The function of this Committee is to review and recommend amendments to the District's Bylaws, Board policies, advocacy, and to advise the Board of Directors on matters of Board governance.
- d) —
- e) ~~This committee shall meet no less than quarterly.~~ This committee shall meet quarterly or as needed.
- f) —

Compliance/Quality/Safety/Risk Committee: Quality Committee:

~~Members of this standing committee shall include a committee of the whole of the Board of Directors, the Chief Executive Officer, the Chief Medical Officer, Chief of Staff, and others as requested. The Directors shall be the only members of the Committee with voting privileges. Members of this Standing Committee shall consist of two members of the Board of Directors and one alternate.~~

~~The function of the Compliance/Quality/Safety/Risk Committee (CQSRC) is to analyze data regarding compliance, safety and quality of care, treatment and services and establish priorities for performance improvement. The function of this Committee is to advise the Board of Directors on quality-related governance matters.~~

~~a) —~~

~~b) The Compliance/Quality/Safety/Risk Committee (CQSRC) shall meet no less than quarterly. This committee shall meet quarterly or as needed.~~

~~c) —~~

~~Finance and Audit Committee: Finance Committee:~~

~~a) Members of this standing committee shall include a committee of the whole of the Board of Directors, Chief Financial Officer, the Chief Executive Officer and others as requested. The Directors shall be the only members of the Committee with voting privileges. Members of this Standing Committee shall consist of two members of the Board of Directors and one alternate.~~

~~b) —~~

~~a) The Finance Committee in consultation with the Chief Executive Officer and Chief Financial Officer shall be responsible for reviewing and monitoring the annual budget and, as appropriate, its long-term capital expenditure plan. The Finance Committee shall make recommendations to the Board on retention of auditors and approve audits, and business plans pursuant to subsidiary organizations. The function of the Finance Committee is to provide Board-level oversight of the District's financial condition and performance and to advise the Board of Directors on financial matters.~~

~~b) —~~

~~c) The Finance and Audit Committee shall meet no less than quarterly. Committee shall meet quarterly or as needed.~~

Section 3. AD HOC COMMITTEES

~~From time to time, the Board may appoint an "ad hoc" committee for specialized issues and projects. The Board of Directors may establish ad hoc committees to address specific issues or projects, as needed.~~

ARTICLE VII CHIEF EXECUTIVE OFFICER

Section 1 GENERAL PROVISIONS

The Board of Directors shall have the authority to employ and discharge the Chief Executive Officer and shall specify the terms and conditions of the person's employment. The performance of the Chief Executive Officer will be evaluated on an annual basis by the Board of Directors based on performance criteria established ~~from time to time~~ by the Board of Directors.

The Chief Executive Officer shall be responsible for the overall management of the Hospital and District, and has the necessary ~~and full~~ authority to effect this responsibility subject to the Board's oversight, any policies and directives issued by the Board, and as called upon pursuant to the JPA Agreement. Chief Executive Officer is directly responsible to the Board of Directors and the Authority, for the management of the Hospital and all of its departments and activities.

Section 2. QUALIFICATIONS, DUTIES, AND RESPONSIBILITIES

Qualifications, specific duties, and responsibilities of the Chief Executive Officer shall be set forth in the appropriate section of the Policy Manual and any employment agreement with the Chief Executive Officer.

ARTICLE VIII MEDICAL ADMINISTRATION IN THE HOSPITAL

Section 1. ESTABLISHMENT OF A MEDICAL STAFF

There shall be a Medical Staff for the Hospital established in accordance with the requirements of the Local Health Care District Law, whose membership shall be comprised of all physicians, dentists, and podiatrists who are duly licensed and privileged to admit and care for patients in the Hospital. The Board of Directors shall appoint the Medical Staff, which shall be an integral part of the Hospital. The Medical Staff derives its authority from the Board of Directors and shall function in accordance with the Medical Staff Bylaws, Rules and Regulations, and Policies that have been approved by the Medical Staff and by the Board.

The Medical Staff shall be represented before the Board of Directors by the Chief of Staff or his/her designee and shall be afforded full access to the Board through the Board's regular meetings and committees as described herein. The Medical Staff, through its officers, department chiefs, and committees, shall be responsible and accountable to the Board of Directors for the discharge of those duties and responsibilities set forth in the Medical Staff's Bylaws, Rules and Regulations, and Policies, and as delegated by the Board of Directors from time to time.

Section 2. BYLAWS, RULES AND REGULATIONS

The Medical Staff is responsible for the development, adoption, and periodic review of the Medical Staff Bylaws and Rules and Regulations, consistent with these District Bylaws, applicable laws, government regulations, and accreditation standards. The Medical Staff Bylaws, Rules and Regulations, and all amendments thereto, shall become effective upon approval by the Medical Staff and the Board of Directors.

Section 3. BOARD ACTION ON MEMBERSHIP AND CLINICAL PRIVILEGES

- a) Medical Staff Responsibilities: The Medical Staff is responsible to the Board of Directors for the quality of care, treatment and services rendered to patients in the Hospital. The Board of Directors shall delegate to the Medical Staff the responsibility and authority to investigate and evaluate all matters relating to Medical Staff membership status, clinical privileges, and corrective action, except as provided in Section 3(d). The Medical Staff adopt and forward to the Board or committee of the Board specific written recommendations, with appropriate supporting documentation, that will allow the Board of Directors to take informed action. When the Board of Directors does not concur with a Medical Staff recommendation, the matter shall be processed in accordance with the Medical Staff Bylaws and applicable law before the Board renders a final decision. The Board of Directors shall act on recommendations of the Medical Staff within the period of time specified in the Medical Staff Bylaws or Rules and Regulations, or if no time is specified, then within a reasonable period of time. However, at all times the final authority for appointment to membership on the Medical Staff of the Hospital remains the sole responsibility and authority of the Board of Directors.
- (b) Criteria for Board Action: The process and criteria for acting on matters affecting Medical Staff membership status and clinical privileges shall be as specified in the Medical Staff Bylaws.
- (c) Terms and Conditions of Staff Membership and Clinical Privileges: The terms and conditions of membership status in the Medical Staff, and the scope and exercise of clinical

privileges, shall be as specified in the Medical Staff bylaws unless otherwise specified in the notice of individual appointment following a determination in accordance with the Medical Staff Bylaws.

- (d) Initiation of Corrective Action and Suspension: Where in the best interests of patient safety, quality of care, or the Hospital staff, and after consultation with the Chief of Staff, the Board of Directors shall have the authority to take any action that it deems appropriate with respect to any individual applying for or appointed to the Medical Staff or who is seeking or exercising clinical privileges or the right to practice in the Hospital. Action taken by the Board of Directors in such matters shall follow the procedures for corrective action outlined in the Medical Staff Bylaws, Rules and Regulations. The Board shall notify the Executive Committee immediately of any such action.

Chief Executive Officer may summarily suspend or restrict clinical privileges of any Medical Staff member where failure to take action may result in imminent danger to the health of any individual and when no person authorized to take such action by the Medical Staff is available, provided that the Chief Executive Officer has made reasonable documented attempts to contact the person or persons so authorized. A suspension by the Chief Executive Officer that has not been ratified by the Medical Executive Committee within two working days, excluding weekends and holidays, shall terminate automatically.

- (e) Fair Hearing and Appellate Procedures: The Medical Staff Bylaws shall establish fair hearing and appellate review mechanisms in connection with Staff recommendations for the denial of Staff appointments, as well as denial of reappointments, or the curtailment, suspension, or revocation of privileges. The hearing and appellate procedures employed by the Board of Directors upon referral of such matters shall be consistent with the Local Health Care District Law Section 32150 et. seq. of the California Health and Safety Code, and those specified in the Medical Staff Bylaws, Rules and Regulations to the extent not inconsistent therewith. Any doctor or other practitioner who feels aggrieved by any adverse recommendation or deprivation of Medical Staff status or clinical privileges shall be required, as a condition to exercising his or her right of appeal to the Board, to pursue his or her appeal through orderly channels of appeal and at the proper time and in the manner prescribed by the Bylaws and procedures of the Medical Staff of this hospital. When the Medical Staff has made its final ruling and decision concerning the appeal of any aggrieved doctor or practitioner in accordance with the Bylaws of the Medical Staff, and such doctor or practitioner then desires to appeal to the Board, he or she shall give notice in writing to the Hospital Administrator within ten (10) days next following the date of the entry of the final order of the Medical Staff. Said notices must state in substance the grievance made and complained of, and must be given in the time and manner herein specified, or the Board shall not take cognizance thereof except at its discretion. If said notice is so given within said time, then it shall be the duty of the Board to then consider such grievance in its entirety and render the decision of the Board in writing, and deliver a copy of its decision and findings to the aggrieved doctor or practitioner. Such decision shall be final.

The Medical Staff shall have the right to be heard, through its Chief of Staff or designee at meetings of the Board.

Section 4. ACCOUNTABILITY TO THE BOARD

The Medical Staff shall conduct and be accountable to the Board for conducting activities that contribute to the preservation and improvement of quality patient care and safety in the

Hospital.

Section 5. DOCUMENTATION

The Board shall receive and act upon the findings and recommendations emanating from the activities required by Section 4. All such findings and recommendations shall be in writing and supported and accompanied by appropriate documentation upon which the Board can take appropriate action.

Section 6. COMPENSATED MEDICAL DIRECTOR POSITIONS

Compensated Medical Director positions shall be responsible to the Chief Executive Officer and the Medical Staff for documentation of activities related to their assignment. Compensated Medical Directors shall be approved by the Chief Executive Officer and for fit and compensation amount. Medical Staff may appoint Service Directors, the slate of Service Directors must be approved by the Board of Directors.

ARTICLE IX AMENDMENT OF BYLAWS

These Bylaws may be amended by affirmative vote of a majority of the total number of members of the Board of Directors at any regular or special meeting of the Board of Directors, provided a full statement of such proposed amendment shall have been sent to each Board member not less than forty-eight (48) hours prior to the meeting.

Affirmative action may be taken to amend these Bylaws by unanimous vote of the entire Board membership at any regular or special meeting of the Board of Directors, in which event the provision for forty-eight (48) hours notice shall not apply.



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

NORTHERN INYO HEALTHCARE DISTRICT

BYLAWS

ADOPTED BY THE
NORTHERN INYO HEALTHCARE DISTRICT
BOARD OF DIRECTORS

REVISED AND ADOPTED IN CONFORMANCE WITH THE LOCAL HEALTH CARE DISTRICT
LAW (DIVISION 23, COMMENCING WITH SECTION 32000 OF THE CALIFORNIA HEALTH
AND SAFETY CODE) ON FEBRUARY 21, 2024

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ARTICLE I NAME, AUTHORITY, AND OFFICES

Section 1. NAME

The name of this non-profit health care district organization shall be the Northern Inyo Healthcare District, hereinafter "the District".

Section 2. AUTHORITY

- a) This District, having been established January 11, 1946, by vote of the residents of the District under the provisions of Division 23, commencing with Section 32000 of the California Health and Safety Code, otherwise known as the Local Health Care District Law, and ever since said time having been operated thereunder, these bylaws are adopted in conformance therewith, and subject to the provisions thereof.
- b) In the event of any conflict between these bylaws and the Local Health Care District Law, the latter shall prevail. To the extent they are not in conflict with these bylaws, the proceedings of the District Board shall be guided by the most recent edition of Robert's Rules of Order.

Section 3. OFFICES

The principal office for the transaction of business of the District is hereby fixed within the boundaries of the District as determined by the Board of Directors.

Section 4. TITLE OF PROPERTY

The title to all property of the District shall be vested in the District, and the signature of the Chair and/or Secretary, or any officer designated by the Directors, as authorized at any meeting of the Directors, shall constitute the proper authority for the purchase or sale of property, or for the investment or other disposal of funds which are subject to the control of the District.

ARTICLE II PURPOSES AND SCOPE

Section 1. PURPOSES

The purposes of the Northern Inyo Healthcare District shall include, but not be limited to, the following:

- a) Within available resources, to provide facilities and health services for quality acute and continued care of the injured and ill, including health maintenance and education, regardless of sex, race, creed, cultural or national origin.
- b) To coordinate, wherever possible and feasible, the activities of the District with health agencies and other health facilities providing specialized as well as comprehensive care.
- c) To conduct educational and research activities essential to the attainment of its purposes.
- d) To do any and all other acts necessary to carry out the provisions of the Health Care District Law.

Section 2. SCOPE OF BYLAWS

- a) These bylaws shall govern the Northern Inyo Healthcare District, its Board of Directors, and its relationship to affiliated or subordinate organizations. The primary purpose of these bylaws is to provide rules for the self-governance of the District and the Board of Directors, to provide a structure for the Board of Directors to fulfill its functions and responsibilities with respect to an organized self-governing Medical Staff, and to provide a structure for Administration of the licensed healthcare inpatient and outpatient facilities operated by the District (specifically Northern Inyo Hospital, 1206 D and 1206 B clinics).
- b) The Board of Directors may delegate certain powers to the Authority of the Board's committees, the Medical Staff, and to other affiliated and subordinate organizations and groups governed by the District, such powers to be exercised in accordance with the respective bylaws or guidelines of such groups. All powers and functions not expressly delegated to such affiliated or subordinate organizations or groups are to be considered residual powers vested in the Board of Directors of this District.
- c) The Bylaws, Rules and Regulations of the Medical Staff and other affiliated and subordinate organizations and groups governed by the District, and any amendments to such bylaws, shall not be effective until the same are approved by the Board of Directors of the Northern Inyo Healthcare District. The provisions of these District bylaws shall be construed to be consistent with the Medical Staff's bylaws. Except that these Bylaws shall not conflict with the bylaws of the Medical Staff as approved by the Board of Directors, the Board of Directors may review these Bylaws and revise them as it deems appropriate.

Section 3. TAX EXEMPT STATUS

There shall be no contemplation of profit or pecuniary gain, and no distribution of profits to any individual, under any guise whatsoever; nor shall there be any distribution of assets or surpluses to any individual on the dissolution of this District.

Section 4. DISPOSITION OF SURPLUS

Should the operation of the District result in a surplus of revenue over expenses during any particular period, such surplus may be used and dealt with by the Directors for charitable District purposes or for improvements hospital's facilities for the care of the sick, injured, or disabled, or for other purposes not inconsistent with the Local Health Care District Law, or these bylaws. The Board of Directors may authorize the disposition of any surplus property of the District by any method determined appropriate by the Board.

Section 5. INDEMNIFICATION

- a) Any person made or threatened to be made a party to any action or proceeding, whether civil or criminal, administrative or investigative, by reason of the fact that he/she, his/her estate, or his/her personal representative is or was a Director, officer or employee of the District, or an individual (including a medical staff appointee) acting as an agent of the District, or serves or served any other corporation or other entity or organization in any capacity at the request of the District while acting as a Director, officer, employee or agent of the District shall be and hereby is indemnified by the District, as provided in Sections 825 et.seq. of the California Government Code.
- b) Indemnification shall be against all judgments, fines, amounts paid in settlement and reasonable expenses, including attorney's fees actually and necessarily incurred, as a result of any such action or proceeding, or any appeal therein, to the fullest extent permitted and in the manner prescribed by the laws of the State of California, as they may be amended from time to time, or such other law or laws as may be applicable to the extent such other law or laws is not inconsistent with the law of California, including Sections 825 et.seq. of the California Government Code.
- c) Nothing contained herein shall be construed as providing indemnification to any person in any malpractice action or proceeding arising out of or in any way connected with such person's practice of his or her profession.

Section 6. FISCAL YEAR

The fiscal year of the District shall commence on the first day of July, and each year shall end on the last day of June.

ARTICLE III BOARD OF DIRECTORS

Section 1. ELECTION

The Board of Directors shall be elected as provided in The Local Healthcare District Law, which shall also govern eligibility for election to the Board of Directors.

Section 2. POWERS

The Board of Directors shall have and exercise all the powers of a Healthcare District as set forth in the Healthcare District Law. Specifically, the Board of Directors shall be empowered as follows:

- a) To control and be responsible for the overall governance of the District, including the provision of management and planning.
- b) To make and enforce all rules and regulations necessary for the administration, government, protection, and maintenance of hospitals and other facilities under District jurisdiction and to ensure compliance with all applicable laws.
- c) To appoint a Chief Executive Officer and to define the powers and duties of such appointee, and to delegate to such person overall responsibility for operations of the District, the Hospital, and affiliated entities as specified herein and consistent with Board of Directors' Policies. The Board shall also retain legal counsel and independent auditors as needed for District and Hospital operations.
- d) To authorize the formation of other affiliated or subordinate organizations which they may deem necessary to carry out the purposes of the District.
- e) To periodically review and develop a strategic plan for the District and the Hospital.
- f) To determine policies and approve procedures for the overall operation and affairs of this District and its facilities according to the best interests of the public health and to assure the maintenance of quality patient care.
- g) To enter into Joint Powers Agreements with other public entities, and to carry out the District's responsibilities regarding such Joint Powers Authority as prescribed by law.
- h) To evaluate the performance of the Hospital in relation to its vision, mission, and goals.
- i) To provide for coordination and integration among the Hospital's leaders to establish policy, maintain quality care and patient safety, and provide for necessary resources.
- j) To be ultimately accountable for the safety and quality of care, treatment, and services.
- k) All powers of the Board of Directors, which are not restricted by statute, may be delegated by an employment agreement, policies, and by direction of the Board to the Chief Executive Officer or to others employed by or with responsibilities to the District, to be exercised in accordance with that delegation.
- l) In the event of a vacancy in any Board office established by Article V of these Bylaws (Chair,

Vice Chair, etc.), the Board of Directors shall select someone to fill such vacancy and to serve until the next regular election of officers, unless such person earlier resigns or is removed in accordance with said Article.

- m) To do any and all other acts and things necessary to carry out the provisions of these bylaws or of the provisions of the Local Health Care District Law.

Section 3. COMPENSATION

The Board of Directors shall serve without compensation except that the Board of Directors, by a majority vote of the members of the Board, may authorize payment not to exceed one hundred dollars (\$100) per meeting, or for each committee meeting or other meeting authorized by Board or Chair of the Board, and not to exceed five (5) meetings a month as compensation to each member of the Board of Directors, in accordance with Section 32103 of the California Health and Safety Code, as amended.

Each member of the Board of Directors shall be allowed his/her necessary traveling and incidental expenses incurred in the performance of official business of the District pursuant to the Board's policy.

A budget for the Board of Directors' educational expenses is developed yearly. At least annually, the entire Board will review its travel and incidental expenses.

Section 4. VACANCIES

Any vacancy upon the Board of Directors shall be filled by the methods prescribed in Section 1780 of the Government Code.

ARTICLE IV MEETINGS OF DIRECTORS

Section 1. REGULAR MEETINGS

The regular meetings of the Board of Directors of the Northern Inyo Healthcare District shall be held monthly, or as periodically determined by the Board, on such day and at such time as the Board of Directors shall from time-to-time establish by resolution and/or motion.

Section 2. SPECIAL MEETINGS

Special meetings of the Board of Directors may be called by the Chair or three (3) Directors, and notice of the holding thereof shall be received by each member of the Board of Directors at least twenty-four hours (24) before said meeting.

Section 3. QUORUM

A majority of the members of the Board of Directors shall constitute a quorum for the transaction of business, and motions and resolutions shall be passed if affirmatively voted upon by a majority of those voting at the time the vote is taken. If a member has a conflict of interest and may not vote, they may not be counted towards a quorum.

Section 4. ADJOURNMENT

A quorum of the Board of Directors may adjourn any Directors' meeting to meet again at a stated day and hour; provided, however, that in the absence of a quorum, a majority of the Directors present at any Directors' meeting, either regular or special, may adjourn until the time fixed for the next regular meeting of the Board of Directors. An adjourned meeting can consider only the business of the meeting that was adjourned. An adjourned meeting must be completed prior to the convening of a new meeting.

Section 5. PUBLIC MEETINGS

All meetings of the Board of Directors, whether regular or special, shall be open to the public, except as otherwise permitted by law, and shall be conducted in accordance with the Ralph M. Brown Act (Government Code Sections 54950 et seq.). The Board of Directors may hold closed sessions only as authorized by law.

Information and reports provided to the Board of Directors by the Medical Staff that are protected from disclosure under California Evidence Code Section 1157 or applicable provisions of the California Health and Safety Code shall be presented and discussed in closed session, maintained as confidential, and disclosed only as required by law.

Section 6. MINUTES

Minutes of all public meetings of the Board of Directors shall be maintained as official District records; and shall be available for public inspection upon request, in accordance with applicable law.

Section 7. SCOPE OF MOTIONS AND RESOLUTIONS

The decisions of the Board establishing general rules or procedures of the District and/or procedures affecting the Directors shall be made by motion or resolution. All motions or resolutions become effective at the time voted upon affirmatively by a majority of the Directors voting at the time the vote is taken.

ARTICLE V OFFICERS AND THEIR DUTIES

Section 1. OFFICERS

The officers of the Board of Directors of the Northern Inyo Healthcare District shall be a Chair, Vice Chair, Secretary, Treasurer, and Member at Large.

Section 2. ELECTION OF OFFICERS

- a) The slate of proposed officers for the Board of Directors shall rotate each year as follows:

Member at Large becomes the Treasurer.
 Treasurer becomes Secretary
 Secretary becomes Vice Chair
 Vice Chair becomes Chair
 Chair becomes Member at Large

At the yearly December meeting, the Board of Directors shall vote whether to accept the proposed slate of officers or to propose an alternative slate. Each officer shall hold the office for one year, or until a successor shall be elected and qualified, or until the officer is otherwise disqualified to serve.

- b) If an officer of the Board, other than the Chair, is unable to act, the Board may appoint some other member of the Board of Directors to do so, and such person shall be vested temporarily with all the functions and duties of the office.
- c) Any officer on the Board of Directors may resign at any time or be removed as a Board officer by the majority vote of the other Directors then in office at any regular or special meeting of the Board of Directors. In the event of a resignation or removal of an officer, the Board of Directors shall elect a successor to serve for the balance of that officer's unexpired term.

Section 3. DUTIES

- a) Chair: The Board of Directors shall elect one of its members to serve as Chair. In the absence or inability of the Chair to act, the Vice Chair shall assume the duties of the Chair. If both the Chair and Vice Chair are unable to act, the Board shall designate another officer or Director to serve temporarily until a Chair is elected.
- (1) Shall preside over meetings of the Board of Directors and coordinate with the Chief Executive Officer on the development of Board meeting agendas in accordance with Board policies.
 - (2) Shall sign as Chair on behalf of the District all instruments in writing that the Chair has been specifically authorized by the Board to sign;
 - (3) Shall serve as the primary liaison between the Board of Directors and the Chief Executive Officer for purposes of communication and governance oversight, while recognizing that authority resides with the full Board.

- (4) Shall appoint or remove members of committees subject to approval by the Board of Directors.
- (5) The Chair's duties are limited to leadership and facilitation of the Board's governance role and do not include unilateral authority over District policy, governance, or operations, which are reserved to the full Board of Directors or delegated to the Chief Executive Officer.
- b) Vice Chair: The Vice Chair shall, in the absence or inability of the Chair, exercise all powers and perform all duties of the Chair as provided in these Bylaws.
- c) Secretary:
 - (1) The member of the Board who is elected to the position of Secretary shall act in this capacity for both the District and the Board of Directors;
 - (2) Shall ensure that records of Board proceedings, including meeting minutes, are maintained as official District records.
 - (3) Shall ensure that procedures are in place for providing all notices required by law or these Bylaws.
 - (4) Shall perform such other duties as may be assigned by the Board of Directors and may delegate duties to appropriate management personnel.
- d) Member at Large: The Member at Large shall have all the powers and duties of the Secretary in the absence of the Secretary, and shall perform such other duties as may from time to time be prescribed by the Board of Directors.
- e) Treasurer:
 - (1) Shall be responsible for oversight of the safekeeping and disbursement of District funds in accordance with the Local Health Care District Law and Board-adopted resolutions, policies, and procedures.
 - (2) Shall review financial information provided by management and support the Board of Directors in its oversight of the District's financial condition.
 - (3) Shall perform such other duties as they pertain to this office and as prescribed by the Board of Directors. The Treasurer may delegate his or her duties to appropriate management personnel.

ARTICLE VI COMMITTEES

Section 1. COMMITTEES

- a) The Board of Directors may meet as a Committee of the Whole or establish committees as it deems appropriate.
- b) Committees of the Board serve in an advisory capacity to conduct detailed review and

discussion of assigned matters and to present recommendations or completed items to the full Board of Directors for consideration, approval, or further action. Standing Committees shall consist of two members of the Board of Directors and one alternate. Annually, following the election of Board officers, Committee members and alternates shall be appointed by the Chair of the Board. An alternate member may vote only when serving in place of an absent committee member.

- c) Special or ad hoc committees may be appointed by the Chair of the Board, subject to approval by the Board of Directors, for specific tasks as circumstances warrant. Such committees may be composed of Board members and may also include individuals who are not members of the Board. Voting rights, if any, shall be specified by the Board of Directors at the time the committee is created. No special or ad hoc committee shall have authority to commit the Board of Directors or the District, except when the Board directs a committee to act on its behalf by special vote.
- d) Committees shall keep minutes of each meeting and submit reports to the Board of Directors as requested. Minutes shall be maintained as official District records.

Section 2. STANDING COMMITTEES

Governance Committee:

1. Members of this Standing Committee shall consist of two members of the Board of Directors and one alternate. The function of this Committee is to review and recommend amendments to the District's Bylaws, Board policies, advocacy, and to advise the Board of Directors on matters of Board governance.
2. This committee shall meet quarterly or as needed.

Quality Committee:

1. Members of this Standing Committee shall consist of two members of the Board of Directors and one alternate. The function of this Committee is to advise the Board of Directors on quality-related governance matters.
2. This committee shall meet quarterly or as needed.

Finance Committee:

1. Members of this Standing Committee shall consist of two members of the Board of Directors and one alternate. The function of the Finance Committee is to provide Board-level oversight of the District's financial condition and performance and to advise the Board of Directors on financial matters.
2. The Finance Committee shall meet quarterly or as needed.

Section 3. AD HOC COMMITTEES

The Board of Directors may establish ad hoc committees to address specific issues or projects, as needed.

ARTICLE VII CHIEF EXECUTIVE OFFICER

Section 1 GENERAL PROVISIONS

The Board of Directors shall have the authority to employ and discharge the Chief Executive Officer and shall specify the terms and conditions of the person's employment. The performance of the Chief Executive Officer will be evaluated on an annual basis by the Board of Directors based on performance criteria established by the Board of Directors.

The Chief Executive Officer shall be responsible for the overall management of the Hospital and District, and has the necessary authority to effect this responsibility subject to the Board's oversight, any policies and directives issued by the Board, and as called upon pursuant to the JPA Agreement. [The](#) Chief Executive Officer is directly responsible to the Board of Directors and the Authority; for the management of the Hospital and all of its departments and activities.

Section 2. QUALIFICATIONS, DUTIES, AND RESPONSIBILITIES

Qualifications, specific duties, and responsibilities of the Chief Executive Officer shall be set forth in the appropriate section of the Policy Manual and any employment agreement with the Chief Executive Officer.

ARTICLE VIII MEDICAL ADMINISTRATION IN THE HOSPITAL

Section 1. ESTABLISHMENT OF A MEDICAL STAFF

There shall be a Medical Staff for the Hospital established in accordance with the requirements of the Local Health Care District Law, whose membership shall be comprised of all physicians, dentists, and podiatrists who are duly licensed and privileged to admit and care for patients in the Hospital. The Board of Directors shall appoint the Medical Staff, which shall be an integral part of the Hospital. The Medical Staff derives its authority from the Board of Directors and shall function in accordance with the Medical Staff Bylaws, Rules and Regulations, and Policies that have been approved by the Medical Staff and by the Board.

The Medical Staff shall be represented before the Board of Directors by the Chief of Staff or his/her designee and shall be afforded access to the Board through the Board's regular meetings and committees as described herein. The Medical Staff, through its officers, department chiefs, and committees, shall be responsible and accountable to the Board of Directors for the discharge of those duties and responsibilities set forth in the Medical Staff's Bylaws, Rules and Regulations, and Policies, and as delegated by the Board of Directors from time to time.

Section 2. BYLAWS, RULES, AND REGULATIONS

The Medical Staff is responsible for the development, adoption, and periodic review of the Medical Staff Bylaws and Rules and Regulations, consistent with these District Bylaws, applicable laws, government regulations, and accreditation standards. The Medical Staff Bylaws, Rules and Regulations, and all amendments thereto, shall become effective upon approval by the Medical Staff and the Board of Directors.

Section 3. BOARD ACTION ON MEMBERSHIP AND CLINICAL PRIVILEGES

- a) Medical Staff Responsibilities: The Medical Staff is responsible to the Board of Directors for the quality of care, treatment, and services rendered to patients in the Hospital. The Board of Directors shall delegate to the Medical Staff the responsibility and authority to investigate and evaluate all matters relating to Medical Staff membership status, clinical privileges, and corrective action, except as provided in Section 3(d). The Medical Staff ~~adopt~~adopts and ~~forward~~forwards to the Board or committee of the Board specific written recommendations, with appropriate supporting documentation, that will allow the Board of Directors to take informed action. When the Board of Directors does not concur with a Medical Staff recommendation, the matter shall be processed in accordance with the Medical Staff Bylaws and applicable law before the Board renders a final decision. The Board of Directors shall act on recommendations of the Medical Staff within the period of time specified in the Medical Staff Bylaws or Rules and Regulations, or if no time is specified, then within a reasonable period of time. However, at all times, the final authority for appointment to membership on the Medical Staff of the Hospital remains the sole responsibility and authority of the Board of Directors.
- (b) Criteria for Board Action: The process and criteria for acting on matters affecting Medical Staff membership status and clinical privileges shall be as specified in the Medical Staff Bylaws.
- (c) Terms and Conditions of Staff Membership and Clinical Privileges: The terms and conditions of membership status in the Medical Staff, and the scope and exercise of clinical

privileges, shall be as specified in the Medical Staff bylaws unless otherwise specified in the notice of individual appointment following a determination in accordance with the Medical Staff Bylaws.

- (d) Initiation of Corrective Action and Suspension: Where in the best interests of patient safety, quality of care, or the Hospital staff, and after consultation with the Chief of Staff, the Board of Directors shall have the authority to take any action that it deems appropriate with respect to any individual applying for or appointed to the Medical Staff or who is seeking or exercising clinical privileges or the right to practice in the Hospital. Action taken by the Board of Directors in such matters shall follow the procedures for corrective action outlined in the Medical Staff Bylaws, Rules and Regulations. The Board shall notify the Executive Committee immediately of any such action.

The Chief Executive Officer may summarily suspend or restrict clinical privileges of any Medical Staff member where failure to take action may result in imminent danger to the health of any individual, and when no person authorized to take such action by the Medical Staff is available, provided that the Chief Executive Officer has made reasonable documented attempts to contact the person or persons so authorized. A suspension by the Chief Executive Officer that has not been ratified by the Medical Executive Committee within two working days, excluding weekends and holidays, shall terminate automatically.

- (e) Fair Hearing and Appellate Procedures: The Medical Staff Bylaws shall establish fair hearing and appellate review mechanisms in connection with Staff recommendations for the denial of Staff appointments, as well as denial of reappointments, or the curtailment, suspension, or revocation of privileges. The hearing and appellate procedures employed by the Board of Directors upon referral of such matters shall be consistent with the Local Health Care District Law Section 32150 et. seq. of the California Health and Safety Code, and those specified in the Medical Staff Bylaws, Rules and Regulations to the extent not inconsistent therewith. Any doctor or other practitioner who feels aggrieved by any adverse recommendation or deprivation of Medical Staff status or clinical privileges shall be required, as a condition to exercising his or her right of appeal to the Board, to pursue his or her appeal through orderly channels of appeal and at the proper time and in the manner prescribed by the Bylaws and procedures of the Medical Staff of this hospital. When the Medical Staff has made its final ruling and decision concerning the appeal of any aggrieved doctor or practitioner in accordance with the Bylaws of the Medical Staff, and such doctor or practitioner then desires to appeal to the Board, he or she shall give notice in writing to the Hospital Administrator within ten (10) days next following the date of the entry of the final order of the Medical Staff. Said notices must state in substance the grievance made and complained of, and must be given in the time and manner herein specified, or the Board shall not take cognizance thereof except at its discretion. If said notice is so given within said time, then it shall be the duty of the Board to then consider such grievance in its entirety and render the decision of the Board in writing, and deliver a copy of its decision and findings to the aggrieved doctor or practitioner. Such a decision shall be final.

The Medical Staff shall have the right to be heard, through its Chief of Staff or designee, at meetings of the Board.

Section 4. ACCOUNTABILITY TO THE BOARD

The Medical Staff shall conduct and be accountable to the Board for conducting activities that contribute to the preservation and improvement of quality patient care and safety in the

Hospital.

Section 5. DOCUMENTATION

The Board shall receive and act upon the findings and recommendations emanating from the activities required by Section 4. All such findings and recommendations shall be in writing and supported and accompanied by appropriate documentation upon which the Board can take appropriate action.

Section 6. COMPENSATED MEDICAL DIRECTOR POSITIONS

Compensated Medical Director positions shall be responsible to the Chief Executive Officer and the Medical Staff for documentation of activities related to their assignment. Compensated Medical Directors shall be approved by the Chief Executive Officer, and for [the](#) fit and compensation amount. Medical Staff may appoint Service Directors; [the](#) slate of Service Directors must be approved by the Board of Directors.

ARTICLE IX AMENDMENT OF BYLAWS

These Bylaws may be amended by affirmative vote of a majority of the total number of members of the Board of Directors at any regular or special meeting of the Board of Directors, provided a full statement of such proposed amendment shall have been sent to each Board member not less than forty-eight (48) hours prior to the meeting.

Affirmative action may be taken to amend these Bylaws by unanimous vote of the entire Board membership at any regular or special meeting of the Board of Directors, in which event the provision for forty-eight (48) ~~hours~~hours' notice shall not apply.