Northern Inyo Healthcare District

Board Meeting

Board Meeting - September 16, 2026

Agenda

Agenda 2

Consent Agenda

Meeting Minutes - August 19, 2026 4
Special Meeting Minutes - August 19, 2026 14
Water Management Plan (WMP) Prevention and Control Legionella and Other 16
Emergency Management Plan 23

Governance Committee

Advocacy Tracker 46
OHCA Spending Target Penalty Timeline 51

Strategic Plan - CARES

Compassion - Patient Experience Strategic Plan 52
Accountability - Access Strategic 54
Respect - Workforce Strategic Plan 56
Excellence - Quality Strategic Plan 58
Stewardship - Sustainability Strategic Plan 60

Compliance Report

Compliance Report 62

Finance Committee

CFO - Report Financial Summary and Operation Insights - July 2026 81
NIHD Financial Summary July 2026 86
NIHD KPIs FYE July 2026 89
NIHD Financial Update July 2026 91
NIHD Financial Statements July 2026 103

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

Mission
Northern Inyo Healthcare District provides health care services to improve the quality of life and health for all we serve

Vision
Northern Inyo Healthcare District will be known throughout the Eastern Sierra Region for providing high quality, compassionate, comprehensive care in coordination with regional partners.

AGENDA

NORTHERN INYO HEALTHCARE DISTRICT
BOARD OF DIRECTORS REGULAR MEETING

September 16, 2026, 9:00 am
Open Session scheduled to begin at 10:00 am

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/s/86114057527
Webinar ID: 861 1405 7527
Passcode: 898843

PHONE CONNECTION:
(669) 444-9171
(719) 359-4580
Webinar ID: 861 1405 7527

---

1. Call to order at 9:00 am
2. Public comment on closed session items
3. Adjourn to closed session for:
    a. Conference with legal counsel – Initiation of litigation

       Pursuant to Government Code § 54956.9(d)(4)

       Potential Case(s): One Case (1)

    Open Session Scheduled to begin at 10:00 am
4. Return to open session and report on any actions taken in closed session.
5. Pledge of Allegiance
6. 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.

7. 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 August 19, 2026 Regular Board Meeting
    b. Approval of minutes for August 19, 2026 Special Board Meeting
    c. Approval of minutes for September 10, 2026 Special Board Meeting
    d. Approval of Policies and Procedures
        i. Emergency Management Plan
        ii. Water Management Plan (WMP) Prevention and Control Legionella and Other Waterborne Pathogens
8. Chief Executive Officer Report
    a. Panther Clinic Update – Information Item
    b. Communication Plan – Information Item
    c. Joint Board Meeting – Action Item
9. Governance Committee
    a. Advocacy Update – Information Item
    b. Strategic Plan – Action Item
    c. Compliance Report – Action Item
10. Finance Committee
    a. RHTP (Rural Health Transformation Project) Update – Information Item
    b. Strategic Growth, Wipfli Update – Information Item
    c. Financial and Statistical Report – Action Item
11. Future Agenda Items
12. General Information from Board Members
13. 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 3:41 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 Adam Hawkins, Chief Medical 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 ON CLOSED SESSION ITEMS	Chair Best-Baker reported that at this time, audience members may speak only on closed session agenda items. **Public Comment:** None
ADJOURN TO CLOSED SESSION	Adjourn to closed session at 3:41 pm.
RETURN TO OPEN SESSION	Return to open session at 5:11 pm.
REPORT OUT FROM CLOSED SESSION	No reportable action.
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:** A member of the public shared a positive experience with NIHD and expressed appreciation for the staff and quality of care provided.
CONSENT AGENDA	The Board pulled the following items for further discussion: Approval of minutes for July 15, 2026 Regular Board Meeting Mifeprex (Mifeprstone) Risk Evaluation and Mitigation Strategies (REMS) Program **Public Comment:** None **Board Discussion:** None

Motion by Lent to approve the remaining consent agenda items
2nd: Turner
Pass: 5-0

Approval of minutes for July 15, 2026 Regular Board Meeting

Public Comment: None

Board Discussion: The Board requested that more clarity be included in the meeting minutes to specify what option 3 was in the GO Bond section.

Motion by Egan to approve the minutes of July 15, 2026 with recommended changes
2nd: Smith
Pass: 5-0

Mifeprex (Mifeprstone) Risk Evaluation and Mitigation Strategies (REMS) Program

Public Comment: None

Board Discussion: A Director requested that the policy regarding mifepristone be considered separately from the Consent Agenda and stated opposition to the policy based on personal beliefs regarding the sanctity of life from conception.

Motion by Turner to approve the Mifeprex (Mifeprstone) Risk Evaluation and Mitigation Strategies (REMS) Program
2nd: Egan
Pass: 4-1
Opposed by: Smith

CONSIDERATION OF CREDENTIALING ACTIONS RECOMMENDED BY THE MEDICAL EXECUTIVE COMMITTEE

Public Comment: None

Board Discussion: None

Motion by Turner to approve the credentialing actions recommended by the Medical Executive Committee
2nd: Lent
Pass: 5-0

The following credentials were approved:
Medical Staff Initial Appointments 2026-2027

Scott Thalman, MD *(radiology)* – Courtesy Staff
Collin LaPorte, MD *(orthopedic surgery*) – Courtesy Staff
Kathleen Ferguson, DO (*emergency medicine*) – Active Staff
Nicholas Herzik, MD (*emergency medicine*) – Active Staff

Medical Staff Telemedicine Privileges 2026-2027 – Proxy Credentialing

Joshua Mendelson, MD (*teleneurology*) – Telemedicine Staff (Distant Site: Sevaro)

Additional Privileges

Tammy O'Neill, PA-C (*physician assistant*) – recommendation to add privileges in orthopedic
services to Ms. O'Neill's current appointment, including surgical first assist privileges and
inpatient rounding.

EXTENSION OF TEMPORARY PRIVILEGES FOR GOOD CAUSE

Public Comment: None

Board Discussion: None

Motion by Egan to approve the extension of temporary privileges for good cause
2nd: Turner
Pass: 5-0

The following privileges were extended for good cause.

30-day extension of the temporary clinical privileges granted to Megan Smith-Zagone, MD (*pathology*), based on good cause

CEO REPORT

Renown Leadership on Rural Health Strategy

CEO Wallis introduced leadership from Renown Health and discussed the developing partnership between the organizations. Renown President and CEO Dr. Erling presented Renown's rural health strategy, which focuses on supporting rural hospitals in keeping care within their local communities whenever possible while providing access to higher levels of care when needed. He discussed opportunities for expanded specialty services through traveling specialists and telehealth, access to clinical research and trials, shared technology and virtual-care resources, improved specialty consultations, and more seamless transfers between rural hospitals and Renown. Erling emphasized that Renown's approach is to work with rural hospitals to identify the services and resources needed by their communities rather than prescribe a standardized model.

Chief Information Officer for Renown Health, Podesta, presented information on Renown's Epic Community Connect program and the potential to extend Renown's electronic health record platform to NIHD. Podesta discussed the benefits of a shared electronic health record, including improved access to patient information across organizations, greater continuity of care when patients are transferred between NIHD and Renown, and access to technology and functionality that may otherwise be difficult for a rural hospital to implement independently.

Public Comment: None

Board Discussion:
The Board expressed appreciation for Renown's partnership and discussed the importance of data demonstrating that NIHD transfers patients when a higher level of care is medically necessary, rather than routinely transferring patients out of the community. Members noted that this information helps address public perceptions regarding transfers from NIHD and reflects the level of care being provided locally.

The Board also discussed the potential benefits of a shared electronic health record, particularly improved communication and continuity of care when patients move between NIHD and Renown. A Board member shared a personal experience illustrating difficulties obtaining follow-up information after a patient transfer and noted that a shared EHR could make information available more efficiently to both NIHD providers and patients. The Board expressed appreciation for staff's work in developing the Renown relationship and the progress being made.

FINANCE COMMITTEE

NIH Foundation and Auxiliary Donation
CNO/COO Partridge recognized contributions from the Northern Inyo Healthcare District Foundation and Auxiliary. The Foundation donated $30,000 to support retrofitting existing exam spaces to provide additional and more appropriate space for specialty services, with the potential to expand appointment and service availability. The Auxiliary donated $20,000 for the purchase of two smart beds for the Medical-Surgical Unit. Partridge described the patient-safety and pressure-reducing features of the beds and expressed appreciation for the continued support of both organizations.

Public Comment: None

Board Discussion:
The Board expressed appreciation to the Foundation and Auxiliary for their continued support of the District and recognized the value of the donations in supporting patient care and expanding services.

RHTP (Rural Health Transformation Project) Update

Eastern Sierra Women's Health Program: CEO Wallis reported that NIHD is pursuing RHTP funding for a regional maternal health initiative in partnership with Mammoth Hospital, Southern Inyo Healthcare District, Toiyabe Indian Health Project, and Ridgecrest. NIHD would serve as the regional hub, with funding supporting recruitment and retention, workforce training, telehealth, and emergency obstetric support across participating organizations.

EHR Modernization: CEO Wallis reported that the District is pursuing RHTP funding to support implementation of the Epic electronic health record through Renown Health. The grant could provide funding toward the implementation and transition costs, and Board authorization related to the application was scheduled for consideration at a special meeting later that evening.

Chronic Disease Management and Preventive Care: CEO Wallis reported that NIHD submitted a letter of intent to participate in a consortium led by Southern Humboldt Healthcare District. The proposed program would focus on chronic disease management and preventive care outreach, with RHTP funding supporting the associated program costs.

Public Comment: None

Board Discussion:
The Board expressed particular interest in the Eastern Sierra Women's Health Program and discussed the availability of labor and delivery services throughout the region.

Service Line Update

Behavioral Health: Behavioral health continues to be identified as a significant community need through the Community Health Needs Assessment and the County's Community Health Improvement Plan. NIHD currently provides behavioral health services through several programs but does not have a comprehensive program. The District is working to strengthen and coordinate these services, including contracting with a local psychologist and continuing the Medication-Assisted Treatment (MAT) program as part of the developing behavioral health program.

Dermatology: Dr. Pam Mundell will begin providing dermatology services at NIHD in September, initially two days per month with the potential to expand based on demand. Dr. Mundell currently practices in Mammoth and already serves a significant number of patients from the NIHD service area, allowing those patients to receive dermatology care closer to home.

Telehealth Specialty Services: The District intends to expand access to specialty care through telehealth by beginning with a limited number of specialties, working through the operational process, and expanding the program as patient volume and demand develop.

Wipfli Market Survey/Growth Strategy: The District continues to use the Wipfli market analysis to guide specialty-service growth. The District is considering recruitment of a cardiologist, hematologist/oncologist, and gastroenterologist. To accommodate additional specialty providers, the District is also developing an interim space plan that would relocate Pediatrics and expand the Specialty Clinic from three to six exam rooms while longer-term medical office building plans continue.

Public Comment: None

Board Discussion:
The Board expressed support for strengthening behavioral health services, including continuation and expansion of the MAT program. Members also

discussed the anticipated demand for dermatology services and asked how patients would schedule appointments once the new service becomes available.

Radiology Request for Proposal
An RFP for radiology and imaging services was issued on August 5 to evaluate available options and ensure the services provided continue to align with the District's needs. The RFP was expected to close near the end of August, after which proposals would be evaluated using the criteria established in the RFP.

Public Comment: None

Board Discussion: None

Investment Report
Investment balances increased from approximately $10.3 million at the beginning of the fiscal year to $37.6 million. Approximately $8 million of the increase resulted from the Employee Retention Credit received earlier in the year, while the remaining growth reflected the District's improved cash position. The investment accounts include LAIF, a liquid Five Star Bank account that generally matches the LAIF interest rate, and certificates of deposit that are beginning to mature. Maintaining funds in liquid, interest-earning accounts allows the District to earn interest while keeping funds available when needed.

Public Comment: None

Board Discussion:
The Board discussed the significant improvement in the District's cash and investment position and the importance of distinguishing one-time funds, including the Employee Retention Credit, from ongoing operational improvement. Members also discussed the District's investment strategy and maintaining appropriate liquidity while maximizing interest earnings.

Motion by Lent to accept the Investment Report
2nd: Smith
Pass: 5-0

Financial and Statistical Report
The District reported year-end financial results, with net income finishing ahead of budget, including approximately $4 million in additional Employee Retention Credit revenue recognized during the fiscal year. Operating revenue exceeded budget by approximately $8 million, driven by strong volumes in orthopedics, urology, general surgery, and inpatient services.

Expenses exceeded budget by approximately $8.6 million, reflecting increased patient volumes and associated variable costs, including supplies, orthopedic implants, and professional fees. The District continues to monitor supply costs and pursue opportunities to reduce expenses as volumes grow.

Patient volumes were strong overall for the year, although Emergency Department visits and deliveries were below budget. Rehabilitation volumes improved as orthopedic surgical volumes increased.

Revenue cycle performance also improved, with bad-debt write-offs decreasing by more than $3 million compared with the prior year. The improvement was attributed in part to changes in the District's billing and collection processes.

Public Comment: None

Board Discussion: None

Motion by Smith to accept the Financial and Statistical Report
2nd: Turner
Pass: 5-0

GOVERNANCE COMMITTEE

Advocacy Update
The Board received an update regarding the Office of Health Care Affordability (OHCA) and its 3.5% healthcare spending growth target. The California Hospital Association requested that hospitals submit letters opposing OHCA's proposed enforcement framework. The proposed framework could result in penalties for healthcare organizations that exceed the spending target. The update noted challenges associated with meeting the target when significant healthcare costs, including labor, pharmaceuticals, supplies, and other operating expenses, may be outside of a hospital's control.

Public Comment: None

Board Discussion:
The Board discussed concerns regarding the potential impact of the OHCA framework on NIHD's ability to maintain services, recruit and retain employees, and make necessary investments in access to care. Members also discussed the potential disproportionate impact on rural hospitals. The Board expressed support for submitting a letter opposing the proposed enforcement framework.

Motion by Turner to approve the letter to OHCA
2nd: Smith
Pass: 5-0

Joint Board Meeting
The Board received an update regarding the upcoming joint meeting between NIHD and Mammoth Hospital, scheduled for September 10. The meeting is intended to provide an opportunity for the two boards to discuss shared regional healthcare priorities and opportunities for collaboration. Planning for the meeting and development of the agenda are underway.

Public Comment: None

Board Discussion: None

Board Request for Agenda Items
The Board reviewed a proposed process for Board members to request topics for future agendas. Under the proposed process, a standing agenda item would allow a Board member to briefly identify a topic they would like considered at a future meeting. If one additional Board member supports adding the topic to a future agenda, staff would work with the requesting member to develop the appropriate background information for future Board consideration. The process is intended to provide a consistent and transparent method for bringing forward future agenda requests.

Public Comment: None

Board Discussion:
The Board discussed the importance of limiting comments during the agenda-request process to a brief synopsis of the proposed topic and avoiding substantive discussion of an item that has not been agendized. Members clarified that a second Board member's support would indicate only support for placing the topic on a future agenda, not agreement with any particular position on the issue. If no additional member supports the request, the Chair would move to the next request or agenda item without further discussion.

Motion by Egan to approve the amendments to the Code of Conduct and Civility Policy
2nd: Turner
Pass: 4-1
Oppose: Smith

Consideration of Changing Regular Board Meetings from Evening to Daytime Hours
The Board considered whether to change the regular Board meeting schedule from the current evening meeting time to a daytime meeting. The potential benefits discussed included improved staff availability, reduced disruption to normal operations, and avoiding meetings extending late into the evening. The presentation also identified potential disadvantages, including reduced accessibility for members of the public who work during the day. It was noted that meetings involving topics likely to generate significant public interest, such as labor-related matters, could potentially be scheduled in the evening when appropriate.

Public Comment: None

Board Discussion:
The Board discussed the advantages and disadvantages of daytime and evening meetings, including public accessibility, staff participation, and meetings extending late into the evening. Members discussed retaining flexibility to hold meetings or specific topics in the evening when greater public participation is anticipated. The Board agreed to implement **a** six-month pilot schedule, with

Closed Session beginning at 8:30 a.m. and the Regular Open Session beginning at 10:00 a.m. The Board will evaluate the meeting schedule following the six-month pilot period.

Motion by Smith to approve a six-month pilot change to the Regular Board meeting schedule, with Closed Session beginning at 8:30 a.m. and Regular Open Session beginning at 10:00 a.m.
2nd: Turner
Pass: 5-0

QUALITY COMMITTEE

Quality Dashboard
Quality Manager Feinberg presented the Quality Committee Dashboard for the second quarter. The District reported no CLABSIs, CAUTIs, sentinel events, or patient falls resulting in injury, and the medical transfer rate from the Emergency Department remained low at 4.2%. The 30-day readmission rate increased to 10%; no specific cause for the increase had been identified, and the District will continue to monitor it. Patient experience scores exceeded benchmarks for inpatient services and the Emergency Department, while clinic and outpatient scores were slightly below benchmark. Average length of stay was 69 hours, within the range required to maintain Critical Access Hospital status, and the median Emergency Department wait time was 7.7 minutes.

Feinberg also reported that a streamlined public version of the Quality Dashboard is now available on the NIHD website and will be updated quarterly, providing the public with easier access to the District's quality information.

Public Comment: None.

Board Discussion:
The Board expressed appreciation for the Quality Dashboard and its accessibility, noting that having quality data readily available helps Board members and staff respond to questions from the public.

Security Screening Update

CNO/COO Partridge provided an update on the District's testing of security screening equipment, including a recent demonstration of a weapons detection system being evaluated for potential use at hospital entrances.

Public Comment: None.

Board Discussion:
The Board expressed appreciation to the Marketing Department for its communication regarding the security equipment testing.

GENERAL INFORMATION FROM BOARD MEMBERS

Board members encouraged community participation in the upcoming fair and discussed observations from the Renown presentation, including the centralized waiting room model at Renown South Meadows and the potential benefits of a

shared electronic health record to improve continuity of care when patients are transferred between facilities. Board members also expressed appreciation for the work being done by NIHD leadership, staff, and providers to improve patient care and address concerns within the community.

ADJOURNMENT — Adjournment at 7:30 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 7:35 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 Adam Hawkins, Chief Medical 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
CONSIDERATION OF AUTHROIZATION TO ACCEPT AND EXPEND CALIFORNIA RURAL HEALTH TRANSFORMATION (CalRHT) EHR MODERNIZATION GRANT FUNDS	CEO Wallis explained that the CalRHT EHR Modernization Grant requires a public entity applicant to provide governing body authorization to execute the grant agreement and accept, receive, and expend an award of up to $2 million. The Special Meeting was scheduled to obtain that authorization before submission of the grant application. Wallis reviewed the District's current Cerner EHR, noting that NIHD is in a 10-year contract through 2030 with annual sustainment costs of approximately $1.8 million. He discussed concerns with the original implementation and limitations with the system's data and reporting capabilities, which have affected the District's ability to rely on the information for data-driven decision-making. Wallis compared the current system with the proposed Epic implementation through Renown. He discussed Epic's capabilities and the additional technical support that would be available through Renown, noting that this would provide NIHD with more direct assistance than it currently receives. Wallis reviewed NIHD's eligibility for the current grant cycle, explaining that first-year funding prioritizes organizations moving from paper or non-certified records to a certified EHR. Because NIHD already has a certified EHR, its application will receive fewer points; however, the District intends to apply in case funding remains available and, if unsuccessful, would have an application prepared for a future funding cycle.

Wallis reviewed the financial considerations of transitioning systems. Approximately $3.2 million remains on the Cerner contract over the next three years, while annual support through Renown is estimated to cost approximately $600,000 less; after accounting for those savings, Wallis estimated the transition would result in approximately $1.4 million in additional costs over three years. If the grant is awarded, the grant funding is expected to cover the Epic implementation costs.

Wallis identified benefits of transitioning to Epic, including interoperability with Renown and other Epic users, direct technical support, and the opportunity to support a regional EHR network. He described an "echo" approach in which NIHD could implement first, followed in future years by other regional healthcare organizations, creating greater connectivity among providers.

Wallis also identified disadvantages, including the estimated $1.4 million financial impact over three years and the organizational burden of completing another EHR implementation after multiple system implementations in recent years.

Public Comment: None

Board Discussion:
The Board discussed the financial and operational considerations of transitioning from Cerner to Epic, including the remaining Cerner contract obligations and the impact of undertaking another EHR implementation. Members discussed staff experience with the current Cerner system and noted that feedback regarding a potential transition to Epic had been positive. The Board also asked about other regional hospitals' interest in Epic and alternative implementation options.

Motion by Turner to authorize the acceptance and expenditure of California Rural Health Transformation (CalRHT) EHR Modernization Grant funds.
2nd: Lent
Pass: 5-0

ADJOURNMENT

Adjournment at 8:00 pm.

_____
Melissa Best-Baker
Northern Inyo Healthcare District
Chair

Attest: _____
Maggie Egan
Northern Inyo Healthcare District
Secretary

NORTHERN INYO HEALTHCARE DISTRICT

ANNUAL PLAN

Title: Water Management Plan (WMP) Prevention and Control Legionella and Other Waterborne Pathogens		
Owner: Manager Employee Health & Infection Control	Department: Infection Prevention	
Scope: District Wide		
Date Last Modified: 09/03/2026	Last Review Date: 12/2025	Version: 2
Final Approval by: NIHD Board of Directors	Original Approval Date:	

PURPOSE:

The purpose of this policy is to reduce the risk of infections from Legionella species and other waterborne pathogens at Northern Inyo Healthcare District (NIHD).

RATIONALE:

Legionella is a genus of waterborne bacteria that can be transmitted via aerosolized water droplets. In at-risk individuals, exposure to Legionella bacteria can cause legionellosis (Legionnaires' disease or Pontiac fever). Outbreaks of legionellosis have occurred when building water systems are poorly maintained. Adherence to this policy will reduce the risk of Legionella species and other waterborne pathogens growing in and spreading from water systems in the facility.

DEFINITIONS:

Control limit: An established limit that can be monitored to determine whether a control measure is effective (e.g., temperature range, disinfectant levels, and testing limits).

Control measure: A measure put in place to limit the growth and spread of organisms such as Legionella bacteria or other waterborne pathogens.

Facility water management plan: The facility's plan for identifying and controlling risks in the building's water system for the growth and spread of Legionella species and other waterborne pathogens.

Legionella: A genus of gram-negative bacillus species commonly found in various natural and artificial aquatic environments such as lakes and streams. Legionella bacteria can become a health concern when they enter building water systems. In hospital environments, Legionella species have been found in fixtures associated with water, including sinks, showers, ice machines, and water-dispensing machines. Additionally, Legionella species may be found in cooling towers, evaporative condensers, and incoming city water.

Legionellosis: Infections caused by exposure to Legionella bacteria, including Legionnaires' disease (a potentially life-threatening disease) and Pontiac fever (a milder infection). Pneumonia is the most common clinical manifestation of Legionnaire's disease.

Possible healthcare-associated Legionnaires' disease: A case that spent a portion of the 14 days before date of symptom onset in one or more healthcare facilities, but does not meet the criteria for presumptive healthcare-associated Legionnaires' disease.

Presumptive healthcare-associated Legionnaires' disease: A case with 10 or more days of continuous stay at a healthcare facility during the 14 days before onset of symptoms.

Waterborne pathogens: Pathogenic organisms able to thrive, grow, and spread in water.

Water management program team: A multidisciplinary team with the educational background needed to oversee the development and implementation of the facility's water management program.

POLICY:

The NIHD Water Management team is responsible for overseeing the prevention and control of Legionellosis, including the development and implementation of a comprehensive water management program aimed at reducing the risk of Legionella bacteria and other waterborne pathogens. As new evidence-based practices emerge, this policy will be updated accordingly, and all personnel will be required to adhere to the revised procedures and responsibilities. NIHD utilizes the LAMPS Water Quality Management platform for in-depth information on the NIHD Water Management Plan (WMP) information includes:

- **Configuration Quick Links**
  - Control measures
  - User/Team Members
  - Validation Procedures
  - Water Systems & Buildings
  - Water Management Plan (WMP) Update Notifications
- **Documentation Quick Links**
  - Activity Log
  - Audit Reports
  - Audit Tool
  - Construction Checklists
  - Corrective Actions
  - Team Meeting Notes
  - Water Infection Control Risk Assessment (WICRA) Report Generator
  - WICRA Reports
  - WMP Compliance Reports
  - WMP Performance Score

COMPONENTS OF THE WATER MANAGEMENT PROGRAM (WMP):

- A water management team
- A facility risk assessment to identify where Legionella and other opportunistic waterborne pathogens may grow and spread in the facility water system.

- A plan for monitoring and applying control measures such as physical controls, temperature management, disinfectant-level controls, visual inspections, and environmental testing for pathogens
- A plan for proactive testing protocols as applicable to the NIHD WMP and acceptable ranges for control measures
- Plans for interventions when control limits are not met
- Compliance with local, state/provincial, and federal regulations pertaining to the prevention and control of Legionella species and other waterborne pathogens
- A written facility water management plan that:

    - Considers the ASHRAE industry standard,
    - Considers the Centers for Disease Control and Prevention's "Developing a Water Management Program to reduce Legionella Growth and Spread in Buildings" toolkit, and
    - Identifies facility-specific control measures

The Water Management Team

- The water management team should include representatives from the hospital's infection prevention, maintenance department, biomed, sterile processing personnel, and microbiology personnel.
- Potential ad hoc members of the water management team may be consulted as needed. These members may include, but are not limited to, outside water management consultants, hospital administrators, other clinical personnel, risk management or legal services personnel, and public health personnel as needed.

Facility Risk Assessment

- The purpose of the facility risk assessment is to identify areas within the facility's water system where control measures are needed to prevent the growth and spread of Legionella species and other waterborne pathogens.
- Facility risk assessments should be reviewed with the water management team and updated annually.
- A process flow diagram should be included in the facility risk assessment to show areas of potential risk where hazards may be present.

Monitoring and Application of Control Measures

- Control measures such as temperature limits and disinfectant levels should be applied to at-risk areas of the facility.
- Monitoring of control measures should quickly and sufficiently identify when the values for those control measures fall outside of established control limits (i.e., values below the minimum acceptable value, above the maximum acceptable value, or outside of the range of acceptable values for the control measure).

Testing Protocols

- Established testing protocols are necessary for the quick identification and remediation of Legionella species within the facility's water system.
- Refer to the facility's WMP for details on testing protocols.

Action/Intervention Plans

- When data indicate that control measures are outside of the control limits, the water management team must apply intervention plans from the facility's plan for managing at-risk areas of the facility's water system.

Regulatory Compliance

- Suspected or confirmed cases of legionellosis must immediately be reported to the local public health department through established avenues of communication.
- The facility's water management team is responsible for ensuring that this policy complies with current regulations regarding the prevention and control of Legionella species and other waterborne pathogens.
- The NIHD Maintenance Department is responsible for ensuring that all necessary state/provincial and federal permits (for water treatment) are obtained and current where applicable.

Written Water Management Plan

- The facility will have a written WMP that covers all the previously identified components of a water management program.
- The WMP and all components will be reviewed and updated annually and as needed.
- Activities, including testing, results, control measures, and interventions, should be communicated to the water management team.

Responsibilities:

- **All Personnel Will:**
    - Comply with all procedures in this policy as they relate to their individual roles within the institution.
    - Report noncompliant behavior to ensure the safety of patients, visitors, and other personnel.
    - Will ensure that they are adequately trained in infection prevention and control policies and procedures.
    - Correctly apply principles of infection prevention and control to ensure the safety of themselves, patients, other personnel, and visitors.
    - Comply with manufactures instruction for use (IFU) with equipment cleaning, rinsing, and/or sterilization.

- **Environmental Services Will:**
    - Ensures that systems are regularly flushed and cleaned, particularly in less frequently used parts of the building, such as unused faucets, showerheads, sinks.
    - Monitor and report any stagnant water around district.

- **Infection Prevention Will:**
    - Monitor microbiology data for the recovery of Legionella species in human specimens.

- Determine whether recovered specimens meet the definition of possible or presumptive healthcare-associated Legionnaires' disease.
- Work with facilities engineering on the application of appropriate control measures to reduce the risk of Legionella growing and spreading in the building water system(s).
- Assist in the application of outbreak control measures when healthcare-associated cases of Legionnaires' disease are identified.
- Report healthcare-associated cases of Legionnaires' disease internally and to the local health department.
- Report to the infection prevention and control committee on the identification of healthcare-associated cases of Legionnaires' disease, outbreak control measures, and other prevention and response-based activities.
- Work with the water management team to ensure that this policy complies with current regulations regarding the prevention and control of Legionella species and other waterborne pathogens.

- **Maintenance Department Will:**

  - Maintain and monitor disinfectant levels.
  - Install and maintain water filters.
  - Report on the operation of any supplemental disinfection system, such as the chlorine dioxide system, to the infection prevention and control committee and infection prevention and control personnel.
  - Regularly report to the infection prevention and control committee and infection prevention and control personnel on out-of-limit test results, corrective actions, changes to the WMP, and other key interventions.
  - Report issues related to the facility's managed control measures, as well as malfunction of those measures, to the infection prevention and control program.
  - Ensure that testing for Legionella species is done in newly constructed/renovated spaces prior to occupancy.
  - Conduct disinfection and investigations of water systems as needed.
  - Maintain cooling towers, evaporative condensers, and potable water distribution systems (e.g., sinks, showers, ice machines, ice- and water-dispensing machines, hot-water generators).
  - Conduct proactive surveillance testing per the facility water management plan.
  - Report surveillance test results to the designated infection prevention and control program personnel.
  - Help maintain a database of water culture test results.
  - Oversee the implementation of flushing water systems.
  - Ensure that all necessary state/provincial and federal permits (for water treatment) are obtained and current where applicable.

- **Microbiology Laboratory Will:**

  - Transfer suspected Legionella specimens to an appropriate processing laboratory.
  - Report all positive Legionella results to the Infection Prevention.
    - Report positive samples of Legionella to the local health department (per jurisdictional requirements).

- **Water Management Team Will:**

    - Review and update this policy on an annual basis and respond to any questions concerning the policy.
    - Review and respond to presumptive or possible healthcare-associated cases of Legionnaires' disease.
    - Assist in the development and implementation of outbreak control measures when healthcare-associated cases of Legionnaires' disease are identified.
    - Ensure that this policy complies with current regulations regarding the prevention and control of Legionella species and other waterborne pathogens.

- **Water Management Vendor Will:**
    - Work with WMP team on developing facility WMP for minimizing the risk of Legionellosis and other water borne illnesses.
    - Complete quarterly and ad hoc water lab tests for Legionella, heterotrophic bacteria plate count (HPC), temperature and free chlorine 12 (C12).
    - Work with WMP team on corrective actions.
- **Education:**
    - Water Management team will receive education at water management committee meetings and as needed.

References:

1. Association for the Advancement of Medical Instrumentation (AAMI). (2023). AAMI Publishes First National Standard on Water Quality for Medical Device Processing. Retrieved from https://array.aami.org/content/news/aami-publishes-first-national-standard-water-quality-medical-device-processing
2. American National Standards Institute (ANSI). (2021). ANSI/ASHRAE Standard 188-2021 for Legionnaires' Disease Risk Management. Retrieved from https://blog.ansi.org/ansi-ashrae-standard-188-2021-legionnaires-risk/
3. Centers for Disease Control and Prevention (CDC). Last reviewed April 17, 2024Investigating Legionnaires' Disease: Defining healthcare facilities and associated cases. Retrieved from https://www.cdc.gov/investigate-legionella/php/healthcare-resources/healthcare-facilities.html?CDC_AAref_Val=https://www.cdc.gov/legionella/health-depts/healthcare-resources/healthcare-facilities.html
4. Centers for Disease Control and Prevention (CDC). March 15, 2024 Steps to Develop a Water Management Program. Published. Retrieved from https://www.cdc.gov/control-legionella/php/wmp/wmp-steps.html
5. Centers for Disease Control and Prevention (CDC). 2021. Healthcare Facility Water Management Program Checklist. Retrieved from https://www.cdc.gov/healthcare-associated-infections/media/pdfs/water-management-checklist-p.pdf
6. Centers for Disease Control and Prevention (CDC) 2024. Federal Requirements to Reduce Legionella Risk. Retrieved from https://www.cdc.gov/control-legionella/php/healthcare/federal-requirement.html
7. The Joint Commission. 2026. Physical Environment PE.04.01.05 EP 1-4 The critical access hospital has a water management program that addresses Legionella and other waterborne pathogens. Note: The water management program is in accordance with law and regulation. Retrieved from https://edition.jcrinc.com/

8. LAMPS Water Quality Management. 2026 Northern Inyo Hospital. Retrieved from https://www.lamps-hcinfo.com/wmpusers/profile/planhome/?planid=712
9. Stout J, Goetz A. Legionella pneumophila. In: *APIC Text*. Association for Professionals in Infection Control and Epidemiology. Published June 23, 2019. Accessed September 28, 2023. Retrieved from https://text.apic.org/toc/healthcare-associated-pathogens-and-diseases/legionella-pneumophila

CROSS-REFERENCED POLICIES AND PROCEDURES:

1. Cleaning Procedures: Contact and Enteric Isolation Rooms at Discharge
2. Cleaning Procedures: Cleaning Patient Care Areas
3. Equipment and Supplies: Care and Use of Floor Care Equipment
4. EOC Management Plan
5. Infection Control Risk Assessments (ICRA) For New Construction or Renovation Projects
6. Low Respiratory Tract Culture

RECORD RETENTION AND DESTRUCTION:

The Centers for Medicare & Medicaid Services (CMS) and The Joint Commission water management requirements do not specify a retention period for test results. However, facilities should retain records for as long as necessary to demonstrate compliance with relevant regulations and to facilitate any required investigations.

Supersedes: v.1 Water Management Plan (WMP) Prevention and Control Legionella and Other Waterborne Pathogens

NORTHERN INYO HEALTHCARE DISTRICT

PLAN

Title: Emergency Management Plan		
Owner: Manager of ED and Disaster Planning	Department: Emergency Department	
Scope: District Wide		
Date Last Modified: 09/03/2026	Last Review Date: 08/01/205	Version: 8
Final Approval by: NIHD Board of Directors	Original Approval Date: 08/01/2008	

PURPOSE:

Northern Inyo Healthcare District Emergency Management Plan follows the Hospital Incident Command System (HICS) format and is the foundation for the all hazards Emergency Preparedness Program. The Emergency Preparedness Program is comprised of 3 basic elements: 1) An all-hazards risk assessment, 2) Emergency Operations Plan (EOP); and 3) a training exercise program.

The Emergency Management Plan is designed to outline the basic infrastructure and operating procedures utilized to mitigate, prepare for, respond to, and recover from emergency situations that tax the routine operating capabilities of the healthcare district. Coordination of planning and response with other healthcare organizations, public health, and local emergency management will be included. The plan also addresses proper plan maintenance, communications, resource and assets management, patient care, continuity of operations, management of staff, evacuations, reunification and contingency planning for utilities failure.

The plan will undergo an annual review process to ensure any plan deficiencies are identified and addressed. An improvement plan will be instituted and maintained to ensure lessons learned and action items identified from exercises and real events are properly addressed and documented.

An emergency incident is defined as natural or manmade events which cause major disruption in the environment of care such as damage to the organization’s buildings and grounds due to severe wind storms, tornadoes, hurricanes, earthquakes, fires, floods, explosions or the impact on patient care and treatment activities due to such things as; the loss of utilities (power, water, and telephones), riots, accidents or emergencies within the organization or in the surrounding community that disrupt the organization’s ability to provide care.

Northern Inyo Healthcare District (NIHD) will manage all emergency incidents, exercises and preplanned (reoccurring/special) events in accordance with the Incident Command System (ICS) design of HICS. HICS has defined organization and job action sheets to accommodate as many positions as needed, depending on the disaster. In the event of a communitywide emergency, the agency’s incident command structure will be integrated into and be consistent with the community command structure. Staff shall receive Incident Command System training appropriate to their level of response and assigned roles and responsibilities to ensure they are prepared to meet the needs of patients in an emergency.

NIHD has established mutual-aid agreements with Mammoth Hospital, Southern Inyo Healthcare District and Toiyabe Indian Health Clinic. In addition, NIHD works in conjunction with hazardous materials response teams, local fire department, local law enforcement, area pharmacies and medical supply vendors.

SCOPE:

The Emergency Operations Plan is designed to guide planning and response to a variety of hazards that could threaten the environment of the NIHD campus or the safety of patients, staff, visitors, or adversely impact the ability of the organization to provide healthcare services to the community. The plan is also designed to assure compliance with applicable codes and regulations. This plan covers all healthcare district facilities (main building, all outbuildings and clinics) and its implementation is the responsibility of all personnel.

Authority for activating the plan will rest with the designated administrator at the time of any incident in need of plan activation**.** Activation of the plan will be conducted in conjunction with agency command staff as well as local emergency management and public health personnel, when appropriate.

The Emergency Plan consists of the Emergency Operations Plan (EOP) and supporting documents. The EOP is the all hazards response overview, includes concept of operations, and organizational structure. The supporting documents provide more detail on the initial response to priority hazards, threats, and events and operational planning. In addition, this plan will define specific goals and objectives, describe preparedness activities, expand the definitions and roles of the Hospital Command Center, and outline response and recovery strategies to be implemented during an emergency event.

SITUATION OVERVIEW:

Hazard Vulnerability Analysis (HVA)

The Disaster Management Committee with the assistance of other pertinent personnel will conduct an HVA of the operations and environment of NIHD. This assessment process helps to identify the hospitals highest vulnerabilities to natural and man-made hazards so that effective preventive measures can be taken and a coordinated response plan can be developed. The results of the HVA will be reviewed with the Inyo Mono Healthcare Coalition (MIHCC) and other emergency management partners. The HVA is completed annually and results will be shared with the Disaster Management Committee, Senior Leadership, and the NIHD Board of Directors.

The critical access hospital’s HVA includes the following:

- Natural hazards (such as flooding, wild fire)
- Human-caused hazards (such as bomb threats or cyber/information technology crimes)
- Technological hazards (such as utility or information technology outages)
- Hazardous materials (such as radiological, nuclear, chemical)
- Emerging infectious diseases (such as the Ebola or SARS-CoV-2 viruses)

The top identified hazards for this facility are found below**.** These top five hazards have been shared at the community and regional level for partner awareness.

Rank	Hazard
1	Wild Fire
2	IT Systems Failure
3	MCI
4	Chemical Exposure
5	Earthquake

PLANNING ASSUMPTIONS

The following set of assumptions governs the parameters by which this plan was developed.

- Emergencies can happen at any time.
- Emergencies will differ in type, size, scope, and duration.
- NIHD is ultimately responsible for the safety of its patients and staff. External resources may or may not be available in emergency situations. NIHD must understand how we are incorporated into local, regional, and state plans and coordination efforts to participate in available resource request processes.
- Local, state, and federal departments and other healthcare facilities may provide assistance necessary to protect lives and property, however, these resources may not be available and NIHD will plan to manage the incident ourselves, at least for a period of time.
- While this plan outlines actions that should be taken during emergency situations, staff will need to adapt their actions as appropriate for the specifics of the situation.
- No emergency plan can cover all possible contingencies, this plan should be used as a guide and a planning tool to prepare staff and the organization for the most likely hazards that could occur as based on the Hazard Vulnerability Analysis.
- The plan must be implemented in a flexible manner to be successful.
- Staff will be familiar with the plan and their expected responsibilities.
- Staff will execute their responsibilities as outlined in this plan during the emergency event.
- Proper execution of this EOP will save lives and reduce damage from the emergency event.

CONCEPTS OF OPERATIONS

Incident Management

Incident management activities are divided into four phases: mitigation, planning, response and recovery. The job action sheet of HICS includes sections addressing each phase. The four phases are described below:

Mitigation: Mitigation activities describes the actions taken to reduce or eliminate the severity of an emergency. NIHD's strategies for mitigation are to assess and prioritize specific hazards and identify means to reduce those hazards as the organization's ability allows.

Planning: Describes the training, supplies, and equipment required to initiate full effective response at the time of an emergency. NIHD's planning activities include developing emergency operations plans and procedures, conducting training for personnel in those procedures, and conducting exercises with staff to ensure they are capable of implementing response procedures when necessary.

Response: Response includes those actions that are taken when a disruption or emergency occurs. It encompasses the activities that address the short-term, direct effects of an incident. Response activities for

NIHD can include activating the incident command center and emergency plans, triaging and treating patients, staff, and visitors who have been affected by an incident, and providing support to other community emergency response agencies when needed.

Recovery: Describes the processes for restoring operations to a normal or improved state of affairs by both short and long term efforts. Recovery activities for NIHD may include the restoration of interrupted utility services, non-vital functions, replacement of damaged equipment, facility repairs, organized return of patients into the facility, and reconstitution of patient records and other vital information systems. Another key consideration in the recovery and response phases of an incident is the tracking of staff hours, expenses, and damages incurred as a result of the emergency. Detailed records will be maintained throughout an emergency to document expenses and damages for possible reimbursement or to properly file insurance claims.

Plan Activation
The Emergency Operations Plan will be activated in response to internal or external threats to the facility. Internal threats could include fire, workplace violence, and loss of power/other utility or other incidents that threaten the well-being of patients, staff, and/or the facility itself. External threats include incidents that may not affect the facility directly but have the potential to overwhelm NIHD resources or put the facility on alert.

Persons Responsible for Plan Activation
Once a threat has been confirmed, the employee obtaining the information must notify their unit supervisor or the House Supervisor immediately. Employees can use the Emergency Preparedness Procedures Quick Reference chart, also known as the Rainbow Chart, which is found in all areas of the hospital for immediate step by step instructions for several emergency situations.

The administrator or administrator on call, and the nursing supervisor on duty, have authority to activate the Incident Command Center (ICC) and initiate all or portions of the emergency operations plan whenever a defined emergency exists. The person activating the emergency plan or Emergency Operating Center (EOC), serves as the Incident Commander until relieved by a senior administrator, or relinquishes responsibility to another individual for breaks or rest periods. It is better to activate the EOC early, and close it soon thereafter, then to delay activation and try to catch up with rapidly moving events.

Position Responsible for Emergency Operations Plan Activation

Position/Title	Contact Number
Primary: Administrator or AOC House Supervisor	See call sheet for AOC cell 760-920-3392 (Sup cell)

The healthcare district may receive three principle notifications: Advisory, Alert and or Activation.

- **Advisory** is given when no system response is needed but the potential for a response exists.
- **Alert** is given when a response is likely or imminent and should prompt an elevated level of response preparedness.
- **Activation** is given when a response is required.

The local Public Health Department or local emergency management office will usually receive these

notifications at which time NIHD will be informed.

Important information to obtain as soon as possible should include but is not limited to:

- Type of incident, including specific hazard/agent, if known
- Location of incident
- Number and types of injuries
- Special actions being taken (e.g., decontamination, transporting persons)
- Estimated time of arrival of first-arriving Emergency Medical Service units.

Alerting Staff (On and Off Duty)
To notify staff that the EOP has been activated, those within the facility will be contacted first through the internal communication systems, if functioning, such as overhead paging, radios, and email.

Staff away from the facility at the time of activation will be contacted via the simplified texting alert system, and phone trees. The individuals responsible for contacting staff include the House Supervisor and individual department directors or managers.

Alerting Response Partners
NIHD works closely with several external partners. The IC or Disaster Manager will be the individual(s) responsible for contacting these external agencies to notify them that the EOP has been activated.

Alerting NIHD Board of Directors
In the event of a real emergency incident or activation of the Emergency Operations Plan, the NIHD Board of Directors will be notified by the Chief Executive Officer or their designee as part of the emergency communication protocol.

ORGANIZATION & ASSIGNMENT OF RESPONSIBILITIES

During an event, specific roles and responsibilities will be assigned to individual positions/titles as well as facility departments.

Essential Services
The table below identifies the department roles and responsibilities during plan activation.

Roles and Responsibilities

Essential Services	Roles and Responsibilities	Point of Contact by Position	Secondary Point of Contact
Administration	Incident Command	Chief Executive Officer	Chief Operations Officer
Medical Staff	Direction of Medical Staff Services	Chief of Emergency Medicine	Chief Medical Officer/Chief of Staff
Dietary	Emergency Food Provisions	Dietary Manager	Dietician
Housekeeping	Preparation and distribution of EVS related supplies.	Manager of EVS	EVS/Laundry Assistant Manager
Maintenance	Facilities Management & Utilities Operations	Director of Facilities	Maintenance Manager
Nursing	Patient Care Operations	Chief Nursing Officer	Inpatient/Outpatient Director of Nursing
Pharmacy	Emergency disposition of	Pharmacy Director	Staff Pharmacist

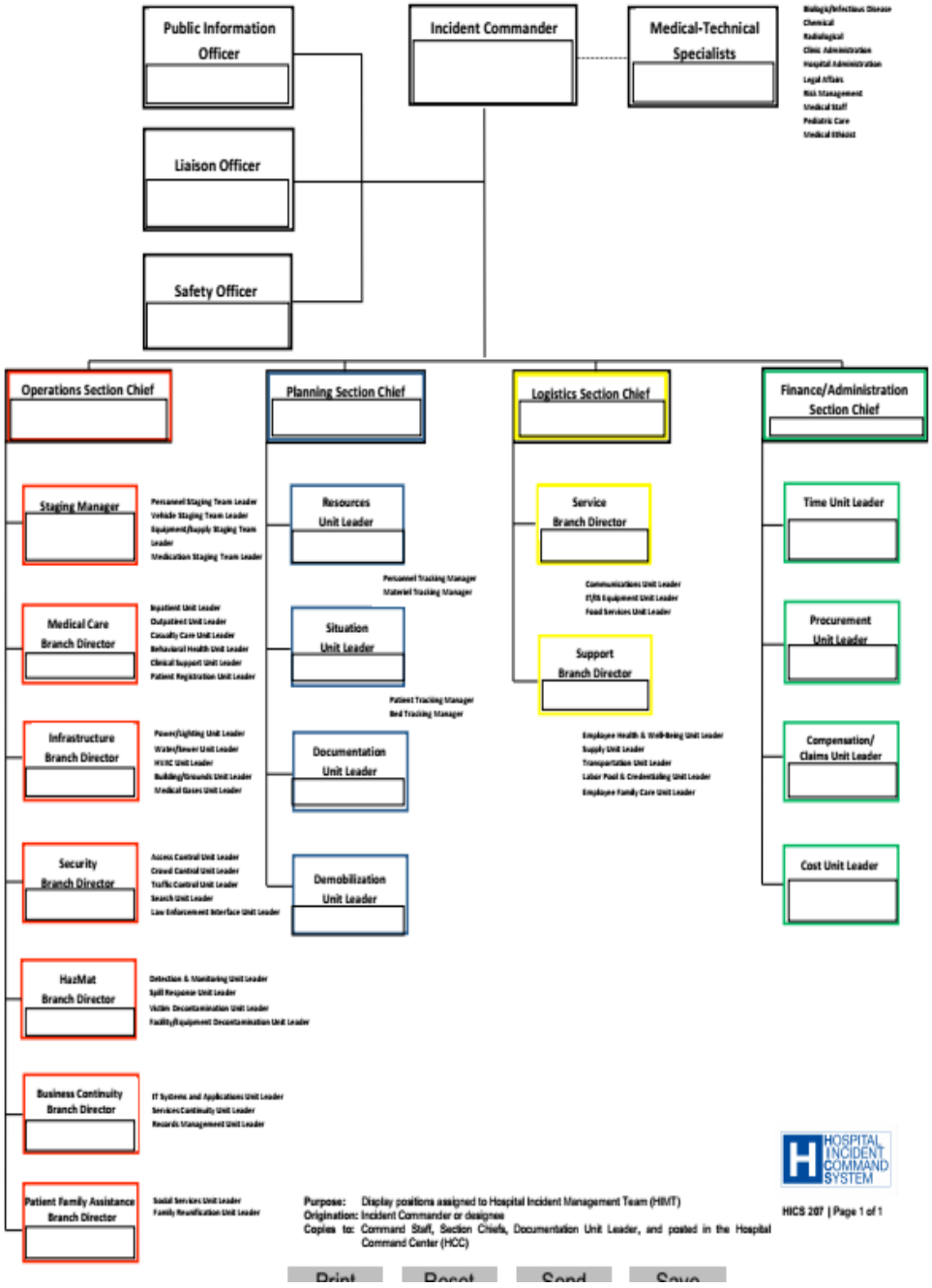
	medications.		
Safety & Security	Maintain safe and secure facilities to operate under emergent situations.	Director of Facilities	Maintenance Manager
Materials Management/Supplies	Provide additional supplies as needed.	Director of Purchasing	Designated Administrator

Positions
Identifying and assigning personnel in the HICS system depends a great deal on the size and complexity of the incident. The HICS is designed to be flexible enough so that the number of staff needed to respond to an incident can be easily expanded or contracted. HICS Form 203 is used to document and assign staff to HICS specifics positions.

DIRECTION, CONTROL, AND COORDINATION

NIHD will coordinate emergency operations from the facility command center. The primary hospital command center will be located in the Second Floor Conference Room (H2063). Should an alternative location be needed off campus, NIHD can utilize one of their off-site locations (Birch Street, Joseph House, etc.) or any of alternative evacuation sites as described in the evacuation section of this document.

Command Structure
Command will be organized according to the ICS model to help manage the implementation of emergency responses and to integrate the facility response with the community and other health care providers. The ICS model plan is developed to manage emergency responses that have unpredictable elements. These are determined as part of the HVA and priority analysis. Plans that stand alone are designed to allow immediately available staff to effect instant activation and to manage the consequences. Most others are designed to use the ICS for emergency management.


Public Information Officer
Incident Commander
Medical-Technical Specialists
Liaison Officer
Safety Officer
Operations Section Chief
Planning Section Chief
Logistics Section Chief
Finance/Administration Section Chief
Staging Manager
Medical Care Branch Director
Infrastructure Branch Director
Security Branch Director
HazMat Branch Director
Business Continuity Branch Director
Patient Family Assistance Branch Director
Resources Unit Leader
Situation Unit Leader
Documentation Unit Leader
Demobilization Unit Leader
Service Branch Director
Support Branch Director
Time Unit Leader
Procurement Unit Leader
Compensation/ Claims Unit Leader
Cost Unit Leader
HOSPITAL INCIDENT COMMAND SYSTEM
Purpose: Display positions assigned to Hospital Incident Management Team (HIMT)
Origination: Incident Commander or designee
Copies to: Command Staff, Section Chiefs, Documentation Unit Leader, and posted in the Hospital Command Center (HCC)
HICS 207 | Page 1 of 1
Print
Reset
Send
Save

HICS Positions with Possible Hospital Staffing Position Candidates

HICS Position	Hospital Position
Incident Commander	Chief Executive Officer Administrator On Call Nursing Supervisor Chief Operating Officer Chief Medical Officer Director of Emergency Medicine
Public Information Officer (PIO)	Chief Executive Officer Administrator Manager of Marketing
Safety Officer	Facilities Manager Maintenance Manager DON Infection Prevention
Liaison Officer	Chief Executive Officer Manager of ED/Disaster Administrator
Operations Section Chief	Chief Nursing Officer Chief Operating Officer DON Inpatient or Outpatient Services Administrator
Medical-Technical Specialist(s)	Chief of Staff DON Infection Prevention Information Technologies

Orders of Succession

Orders of succession ensure leadership is maintained throughout the facility during an event when key personnel are unavailable. Succession will follow facility policies for key facility personnel and leadership.

Key HICS Position Assignments and Orders of Succession

Command and Control	Primary	Successor 1	Successor 2
Shift 1			
NIHD Representative	CEO	COO	CFO
Incident Commander	COO	CEO	CMO
Public Information Officer	Director of Marketing	CEO	COO
Safety Officer	Director of Facilities	Maintenance Manager	Designated Administrator
Liaison	Manager of ED/Disaster	Designated Administrator	Designated Administrator
Operations Section Chief	CMO	CNO	DON
Planning Section Chief	CNO	CMO	COO
Logistics Section Chief	Purchasing Director	Manager of ED/Disaster	Manger of Clinical Engineering
Finance/Administration Section Chief	CFO	Controller	Designated Administrator
Shift 2			
NIHD Representative	DON	House Sup	CNO
Incident Commander	House Sup	Clinical Manager	Designated Administrator
Public Information Officer	Designated Administrator	Director of Marketing	CEO
Safety Officer	Maintenance Manager	Quality Manager	Director of Facilities
Liaison	Quality Admin	HR Director	HR Manager
Operations Section Chief	Clinical Manager	DON	ED/Disaster Manager
Planning Section Chief	Clinical Manager	Designated Administrator	Quality Manager
Logistics Section Chief	Designated Administrator	Designated Administrator	Designated Administrator
Finance/Administration Section Chief	Controller	Designated Administrator	Designated Administrator

Delegation of Authority
Delegation of authority specifies who is authorized to make decisions or act on behalf of NIHD leadership and personnel if they are away or unavailable during an emergency. Delegation of authority planning involves the following:

- Identifying which authorities can and should be delegated.
- Describing the circumstances under which the delegation would be exercised and including when it would become effective and terminate.
- Identifying limitations of the delegation.
- Documenting to whom authority should be delegated.
- Ensuring designees are trained to perform the emergency duties.

Emergency Authority Delegation

Authority	Type of Authority	Position Holding Authority	Triggering Conditions
Activate Facility Command Center	Emergency Authority	Administrator on call (AOC)/House Sup.	Immediate Threat, Operations Interruptions
Activate Emergency Annexes and the Emergency Operations Plan	Emergency Authority	Administrator on call (AOC)/House Sup.	Specific Incidents i.e. Power Outage, Active Shooter, etc.
Close facility	Emergency Authority	CEO/COO	Remaining in the facility is unsafe.
Represent facility when engaging Govt. Officials	Administrative Authority	CEO, COO, Compliance Officer	Unannounced Survey, local or national emergency.
Activate facility memorandum of understanding/mutual aid agreements	Administrative Authority	Senior Leadership	Additional resources necessary to operate.

Community-wide Response Involvement
Inyo County is part of the Mutual Aid Region VI (6) of the Southern District of the California Office of Emergency Services (Cal OES). The local emergency response group works with local, county and state planning agencies under Cal OES to define the role each provider will play during an emergency. The anticipated role of NIHD is to function as an acute medical care facility capable of effectively treating many levels of injury/illness. This role might be reduced if environmental circumstances affect the integrity of the campus or the utility systems essential to providing care.

Regional Healthcare Coalition Coordination
NIHD is a member of the Inyo County Unified Command and the Mono Inyo Healthcare Coalition. NIHD participates in regular planning meetings, exercises, and incident review/debriefings.

Both groups are made up of representatives of community emergency response agencies, health care organizations, and other organizations interested in developing coordinated regional emergency response plans. These crucial discussions between key community stakeholders guide the development of the NIHD Emergency Operations Plan and aid in general disaster planning. These groups meet on a regular basis.

INFORMATION COLLECTION, ANALYSIS, AND DISSEMINATION

Information is vital to making good decisions during a crisis. The needed information must be collected in a timely manner, analyzed and disseminated to “need to know” parties to enable them to determine their most appropriate course of action during the incident.

Information is collected and disseminated by various systems which may include:

- Inyo Mono Healthcare Coalition, Inyo County Unified Command, and the California Health Alert Network (CAHAN)
- Local/regional dispatch center
- Local emergency operations centers
- State Public Health Emergency Response Center/State Emergency Operations Center

Essential elements of information contain situational awareness details that are critical to the initial and ongoing response and recovery operations. The elements listed below may not apply to every event, may not be all-inclusive, and may be modified as needed and adjusted per operational period. NIHD is prepared to share this information during a disaster or emergency event with relevant partners:

- Facility operating status
- Facility structural integrity
- Status of evacuations/shelter in-place operations
- Status of critical medical services (e.g., trauma, critical care)
- Critical service/infrastructure status (e.g., electric, water, sanitation, heating, ventilation, and air conditioning)

- Bed or patient status
- Equipment/supplies/medications/vaccine status or needs
- Staffing status
- Emergency Medical Services (EMS) status
- Epidemiological, surveillance or lab data (e.g., test results, case counts, deaths)
- Point of Dispensing (POD)/mass vaccination sites data (e.g., throughput, open/set-up status, etc.)

COMMUNICATIONS

Day to day internal communications are carried out by emails, landline telephones, cell phones, handheld radios, and the internal overhead paging system. Back up communication means include handheld radios and cell phones should landlines and overhead paging systems fail. Internal code alert systems, internal networks, and the overhead paging system are considered vital to the lifesaving functions of the facility and will be considered an emergency if they fail.

External communications are carried out by landline telephones, emails, and cell phones. In the event of a failure of these systems, backup systems such as HAM Radios and Satellite phones, will be utilized.

NIHD has established common equipment, communications and data interoperability resources with emergency medical services (EMS), public health, and emergency management that will be used during incident response. This element will be part of the annual evaluation of NIMS compliance.

NIHD will establish common language that is consistent with language to be used by local emergency management, law enforcement, emergency medical services, fire department, and public health personnel. Plain language will be used in training and tested during drill exercises.

Notification of Civil Authority
Whenever a situation adversely affects NIHD's ability to provide services to the community, the healthcare district notifies appropriate authorities and city-county agencies and coordinates mutual aid and other response activities through the county Emergency Operations Center (EOC), if appropriate, or directly with receiving hospitals.

Several local agencies may play a role in managing an emergency. NIHD maintains a current list of these agencies and key contacts for various kinds of emergency situations. Contacts on the list include police, fire, Emergency Medical Services, local emergency management offices, utility companies and the Red Cross. The Incident Commander, or designee, notifies agencies as appropriate as soon as possible after an emergency response is initiated.

California Department of Health Services requires that all emergency/disaster related occurrences, which threaten the welfare, safety, or health of patients, must be reported to the Department of Health Services, Licensing and Certification Program.

Release of Information
Release of information to the news media follows procedures developed by the Public Information Officer (PIO) who acts as spokesperson for the organization. The Incident Commander will release information as

appropriate to the situation. In larger incidents, the assigned PIO for Inyo County EOC may act as spokesperson for the overall emergency event and report healthcare related information on behalf of the District.

Staff Notification
As previously noted, staff is notified of EOP implementation in several ways: overhead page, landline telephone, cellular phones, CAHAN notification, text message, or runners in the healthcare district. Off duty staff, physicians, and other licensed practitioners will be contacted via departmental call trees, e-mail notification, or mass notification system.

NIHD maintains an updated employee directory and a communication binder containing current contact information for all relevant authorities.

In the event of an emergency or evacuation, the emergency response plan includes a method for sharing and/or releasing location information and medical documentation for patients under the hospital's care to the following individuals or entities, in accordance with law and regulation:

- Patient's family, representative, or others involved in the care of the patient
- Disaster relief organizations and relevant authorities
- Other healthcare providers

Pertinent medical information is transported with each patient as a hard-copy (HICS-260) form.

MANAGEMENT OF PATIENT CARE ACTIVITY

NIHD has a specific plan that addresses management of patient care activities. The plans include procedures for discontinuation of elective treatment, evaluation of patients for movement to other units, release to home or transfer to other facilities as space is needed, management of information about incoming patients and current patients for planning, patient management, and informing relatives and others; and for transport of patients.

Victims will be admitted through the Emergency Department for initial triage and disposition to appropriate area as their condition warrants. Outpatient and elective procedures may need to be canceled and rescheduled, depending on resource allocation and facility status (i.e. condition of department, availability of staff & supplies) as a result of the emergency. Inpatients will be assessed on admission and placed in the following categories for discharge or transfer:

- **Very High Risk** – could only be cared for in an acute facility
- **High Risk** – could be transferred to an acute care facility
- **Moderate Risk** – would be transferred to another facility
- **Low Risk** – could be transferred home
- **Minimum Risk** – could be discharged immediately

Emergency Locations for Patient Care
All patients will enter through Emergency Department, after triage outside, as appropriate.
Patient Treatment Areas will be assigned as follows unless otherwise stated at the time of Code Triage.

- **Triage Area** – Emergency parking lot adjacent to the Emergency Department
- **Immediate Care Area** - Emergency Department
- **Delayed Care Area** – Rural Health Clinic
- **Minor Care Area** – Pioneer Medical Building
- **Morgue** – To be determined at the time of emergency

Pre-assigned locations of various functions (if activated) are as follows unless otherwise stated at the time of the Code Triage:

- **Healthcare District Command Center** – 2nd Floor Conference Room
- **Labor Pool** – Main Lobby
- **Family Center/Human Services Center** – Rehabilitation Building
- **Press Center** – Administration Meeting Room
- **Dependent Adult/Child Care Center/Pediatric-Safe Area (PSA)** – Rehabilitation Building

Patient Populations

NIHD intends to serve all populations that seek healthcare during emergencies including at-risk populations. NIHD may be forced to curtail or consolidate services offered depending on damage to facilities. Services may be transferred to undamaged areas of the hospital or other area hospitals. At-risk or vulnerable populations may have additional needs to be addressed during an emergency or disaster incident, such as medical care, communication, transportation, supervision, and maintaining independence. As needed based on the situation, NIHD would coordinate with the appropriate jurisdiction to request resources from regional, state, or federal assets to augment/increase care when needed and/or available.

Evacuation

A facility evacuation plan is in place and can be implemented in phases. Relocation of staff away from the area of emergency may be undertaken by staff on the spot, moving to areas in adjacent zones. A full evacuation would be implemented if the impact of an emergency renders the healthcare district inoperable or unsafe for occupancy, and would be implemented with the involvement of the Administrator on Call in conjunction with senior leadership.

Shelter in Place

If NIHD administration, along with internal safety and public safety officials, determines that sheltering in place is the safest course of action for patients, staff, and volunteers, the command center will be activated to ensure patient care and staff needs are met. The command center will plan for and ensure care and sustenance needs are met along with ensuring a safe environment.

Chemical and Radioactive Isolation and Decontamination

The management of situations involving nuclear, biological, or chemical contamination is a joint effort between national, state, and local officials and the health care community. NIHD is prepared to manage a limited number of individuals contaminated with hazardous materials and to meet the care needs of others who have been decontaminated by other agencies.

If the facility is contaminated, a contractor experienced in the isolation and decontamination process will be contacted by the Incident Command staff. The Safety Officer, with Public Safety assistance, will assure isolation of the affected area until it is declared safe by appropriate experts.

Reunification

In the event of pediatric surge, mass casualty incident, or a disaster that requires activation of a surge/reunification plan, NIHD will work in conjunction with County Unified Command and other pertinent county partners to activate the Concept of Operations (CONOPS) of the Mono & Inyo Healthcare

Coalition Pediatric Surge Plan. This plan outlines reunification in detail. Included in the plan is a pediatric identification and tracking system for both accompanied and unaccompanied children, rapid survey protocol to identify unaccompanied or displaced children, and defined Pediatric Safe Area (PSA) where uninjured, displaced or discharged children can be held until released to a caregiver. All forms, tools and documents are located in the CONOPS document found in the Disaster Planning Binder.

ESSENTIAL NEEDS FOR STAFF AND PATIENTS

Vulnerable Populations: Clinical activities for vulnerable patient populations including pediatric, geriatric, disabled, or have serious chronic conditions will be provided in the customary way but additional emphasis will be placed on security, safety, and mobility in terms of evacuation should it become necessary during an emergency. NIHD plans for the possibility of a surge in patients. Transportation of patients and supplies will be handled by several means, including but not limited to: NIHD care shuttles, local and county EMS, Inyo-Mono Transit Authority, local law enforcement, and local EMS air support.

Food and Other Nutritional Supplies: The Logistics Section will ensure that supplies in-stock, on campus are sufficient. Food service vendors will be notified and updated to provide for essential needs. The Dietary Department handles all food and water acquisition and delivery.

Medications and Related Supplies: Pharmacy handles both the acquisition and delivery of supplies. Pharmacy also has strategic inventory which contains counter measures for organic phosphates, nerve agents, and pesticides.

Medical/Surgical Supplies (including PPE): The Logistics Section in conjunction with the Purchasing Department handles the acquisition of supplies through its vendors and transport via its delivery personnel.

Medical Oxygen and Supplies: NIHD can provide bottles of gases supplied by normal vendors or disaster response contractors, or by a state resource request. NIHD has an emergency plan for medical gas failure.

Potable or Bottled Water: The Dietary Department handles food and water acquisition and delivery. The Dietary Department maintains an inventory of bottled water on campus for emergency use. NIHD can request local and state support for additional potable water as needed.

Personal Hygiene and Sanitary Needs: Personal hygiene and sanitary needs of patients during emergencies will be provided by NIHD. In addition, when water intended for hand washing is not available, the hospital utilizes waterless alcohol-based hand rub, which is maintained in ample supply at the hospital. The alternative means to personal hygiene can be baby wipes, personal wipes, or alcohol-based rubs. The alternative means to sanitation, if toilets are inoperable, is kitty litter, red bags in toilets, or positioning of water barrels and waste collection barrels. Limit changes of bed linen to those patients who have gross soiling. Environmental Services use of daily water will be curtailed as designated by the Manager of Environmental Services.

Management of Behavior Health Patients: During an emergency, NIHD will arrange for mental health consultation to patients through prearranged county services. The NIHD social worker should be made available to attend to the emotional needs of patients while awaiting county services in the event of a disaster. If necessary, patients should be transferred to a specialized behavioral health setting. If transfer of patients is not possible, then staff should be assigned to monitor patients accordingly to NIHD policy.

Surge and Alternative Care Sites

NIHD plans for the possibility of a surge in patients. The surge tent may be utilized for alternate care site. Other care sites may include Jill Kinmont Boothe School; Bishop City Hall, Pine Street School Gym, and the Tri

County Fairgrounds. Transportation of patients and supplies will be handled by several means, including but not limited to: NIHD care shuttles, local and county EMS, Inyo-Mono Transit Authority, local law enforcement, and local EMS air support.

The Incident Command Center works with Operations, Planning and Logistics Chiefs to coordinate appropriate staff to assure required equipment, medication, medical records, staffing communications and transportation are mobilized to support relocation and management of patients at remote sites.

Patient Tracking

NIHD tracks the location of patients on site during an emergency using wristbands, bed assignment, and electronic management systems. HICS 254-Disaster Victim Patient Tracking Form will be utilized.
In the event that the computer system is down, the registration staff will coordinate the use of the Disaster Victim Patient Tracking Form with the START Triage system, both are maintained on paper. NIHD will ensure that all patient identification wristbands (or equivalent identification) is intact on all patients. If patients are evacuated, the HICS 260 - Patient Evacuation Tracking Form will be used. When more than two patients are being evacuated, the HICS 255 - Master Patient Evacuation Tracking Form should be used to gain a master copy of all those that were evacuated. Information on forms should include, but is not limited to: patient/resident name, date of birth, Medicare/Medicaid number, if minor (accompanied or not), evacuation site location, date of evacuation, arrival time at evacuation site, date of return to facility (if known), and comments/notes.

In addition, NIHD will utilize third-party information such as local emergency response agencies and the Red Cross as appropriate to assist families in locating patients.

Staff Tracking

The management chain of command as well as incident command resource management principles will be used to track the location of on-duty staff.

NIHD uses staff identification badges to identify caregivers and other employees during mass casualty or major environmental disasters. All staff presenting to the facility will need to have a visible NIHD ID in order to enter. Staff without ID’s must report to the Labor pool, be positively identified, and receive a temporary badge or other approved alternate. Key members of the Incident Command team are issued a vest with the ICS Command Title visible to identify their role in the response. These vests move with the job title as more senior staff become available, and during longer incidents where jobs are handed from staff to staff. The Liaison Officer from the Incident Command team is assigned to work with law enforcement, fire services, emergency management agencies, contractors, the media, and volunteer responders to issue NIHD emergency identification or to determine what form of identification will be required for each responding group.

SAFETY AND SECURITY

NIHD completes security assessments to address vulnerabilities campus wide. The Director of Facilities in conjunction with the in-house Security Team is responsible for the overall planning of the Security Services response in day-to-day operations and during emergency events. If insufficient security staff exists to cope with the emergency, a request for assistance from local law enforcement agencies shall be completed.

NIHD requires the facility to establish a command center, a staging or assembly area, and a perimeter with controlled or monitored access points. The on-duty Security Officer or Incident Commander shall direct other

responsibilities as deemed necessary. NIHD security and local law enforcement will maintain access, crowd and traffic control. Volunteers from the labor pool would be used to expand the security force if needed.

The restriction of visitors and guests during critical incidents is a necessary procedure to maintain order, safety, and security for patients, staff and visitors. Upon the notification or realization that an imminent threat to the clinical environment exists, a decision to initiate limited facility access shall be considered through the collaboration of the Administrator on Call, Incident Commander, House Supervisor and the on-duty Security Officer.

The extent of the limited access and entry shall be determined through careful examination of the threat and impact on facility operations.
There are 6 levels of lockdown with varying degrees of access, entry and exit. See Lockdown Policy.

CYBER SECURITY

NIHD has a Cyber Security Incident Response Manual (CSIRM) and Disaster Recovery and Planning (DRP) in place. The purpose of the plan is to have established procedures for managing cyber security incidents that may affect the hospital's information technology systems, staff, patients and visitors. The plan outlines the roles and responsibilities of hospital staff, communication protocols, and incident response procedures.

ALTERNATE SOURCES OF UTILITY SYSTEMS

Alternate emergency plans for supply of utilities for patient care are maintained for these contingencies. Plans include use of emergency power, backup systems for water, HVAC, and medical gas failure. Managers and staff in all departments affected by the plans are trained as part of organizational wide and department specific education. The plans are tested from time to time as part of the regularly scheduled drills of the EOP and actual outages of utility systems.

LOGISTICS

Resources and Assets

Acquiring and Replenishing Food, Water, Medications and Supplies

The amounts and locations of current food, water, pharmaceuticals, medical and non-medical supplies, are evaluated to determine how many hours the facility can sustain itself before needing re-supply. This gives the facility a par value on supplies and aids in the projection of sustainability before terminating services or evacuating if needed supplies are unable to reach the facility. Supplying NIHD in an emergency will be initially satisfied by pulling from local resources. As replenishment becomes necessary, resources will be requested from vendors.

If NIHD is unable to acquire sufficient resources through outside vendors and pre-positioned arrangements to meet the healthcare needs of the community, the Logistics Chief and/or Director of Purchasing will communicate these need to the county and utilize the Medical Health Operation Area Coordination (MHOAC) to help locate resources and replenishments at the state level. If sufficient supplies cannot be acquired through regional or state medical supply, the county emergency management team will provide assistance with coordinating the transfer of patients to other facilities upon request.

Monitoring Quantities of Resources and Assets

The Logistics Chief and/or assigned staff is responsible for monitoring quantities of assets and resources during an emergency. A Resource Accounting Record form (HICS Form 257) should be used when resources and assets are tracked during an emergency.

96 Hour Sustainability

Establishing the sustainability of resources is crucial to determining if services can be rendered during a disaster for three days, based on the facility's hazard vulnerability analysis (HVA). Resource inventory is currently maintained to provide for approximately 96 hours. If this cannot be sustained through current inventory, agreements are in place with suppliers and vendors for the remaining days. If supplies cannot be obtained, policies and procedures are in place in the event the facility may need to evacuate or temporarily close.

Management and Assignment of Staff

Following a disaster, facility personnel must be accounted for. Their location and status should be ensured by unit supervisors, along with the status and location of all patients. They will be tracked during the emergency plan activation to ensure safety and accountability.

Facility personnel may not be assigned to their regular duties or their normal supervisor during emergency plan activation. They may be asked to perform various jobs that are vital to the operation but may not be their normal day to day duties. The Labor Pool is the designated reporting location for reassignment of available staff and volunteers and will be located in the NIHD main lobby. Staff will be assigned as needed and provided information outlining their job responsibilities and who they report to during the event.

If necessary and appropriate, staff may be reassigned to another campus location. Furthermore, staff may be needed to accompany evacuating patients. Staffing assistance from state agencies can be utilized if needed. In the case that NIHD has the need to use volunteers, NIHD has a plan in place to grant emergency privileges to providers. NIHD may use temporary staffing services or travelers to address staffing needs as well.

The Emergency Department physician on duty at the time of the emergency will be responsible for providing medical services for the "Immediate Care" area. Additional physicians may be called in depending on the number of casualties and the nature of their injuries. If "Delayed Care" and/or "Minor Care" areas are established, a physician will be asked to coordinate medical efforts for these functions. The medical staff reviews the EOP at the Medical Executive Committee annually.

Volunteers are responsible for knowing the overhead page, CODE TRIAGE, for the activation of the emergency preparedness plan. Those volunteers assigned to specific departments are responsible to return to their assigned department, unless released to the labor pool. All other volunteers are responsible for reporting to the labor pool, if activated.

Managing Staff Support Needs

All NIHD personnel are considered essential during emergency response situations. The healthcare district recognizes its responsibility to provide meals, rest periods, housing, and psychological support to staff. In addition, the healthcare district recognizes that providing support such as communication services and dependent care to employees' families during emergency situations allows employees to respond in support of the essential functions of the healthcare district. The Operations Chief, working through the Human Service Director and his/her unit leaders will initiate support programs and activities, based on the demands of the specific emergency including but not limited to:

- Emergency lodging and meals

- Emergency transportation
- Emergency child care
- Psychological and bereavement counseling
- Staff prophylaxis or immunizations

Procedures are in place to address the transportation and housing of staff that may not be able to get to or from the facility during an emergency. In addition, a procedure is in place for incident stress debriefing. Staff who are involved in emergency operations are offered an opportunity to address incident related issues with qualified behavioral health professionals.

Finance
Expenditures will be tracked from the beginning of the disaster to include personnel time, supplies, equipment use, rental of equipment, etc. A designated cost center may be assigned given the duration of the disaster. The Finance Section will have processes in place to ensure the needed tracking occurs. Forms that may be used for expense tracking include HICS 252: Section Personnel Time Sheet, HICS 253: Volunteer Registration, HICS 256: Procurement Summary Report, and HICS 257: Resource Accounting Record.

RECOVERY

NIHD has recovery plans to return operations to normal functions after most emergencies. The recovery plans are activated near the completion of the Emergency Operations Plan (HICS). The Incident Commander will determine the degree of activity required. Preset activity that is activated by the “all clear” includes action by medical records to capture the records of emergency services, capture of costs by patient billing, and return of facilities to their original and normal use. The plans also call for resetting and recovering emergency equipment and supplies, and documentation of the findings of the post-event debriefing. If substantial damage has been done to the facility, plans for reconstruction and renovation will be developed at that point. Documentation of current assets (buildings, equipment, etc.) has been recorded for baseline.

Documentation for FEMA assistance will be based on pictures of damages and repairs, documentation and notes on damages and repairs, newspaper reports and stories, video footage from television stations, and records of all expenditures, receipts, and invoices. Short- term recovery frequently overlaps with response.

Initiation and Recovery
The decision to enter into the recovery stage of an event is made by the CEO/Designated Administrator. In this stage, the hospital will undertake recovery procedures to return the facility to normal operations.

Recovery Protocol
In order to efficiently recover from an event, protocols must be followed. Listed below are protocols important to recovery operations.

Recovery protocols:
- Prioritize health care service, delivery, and recovery objectives by organizational essential functions.
- Maintain, modify, and demobilize healthcare workforce according to the needs of the facility.
- Work with local emergency management, service providers, and contractors to ensure priority restoration and reconstruction of critical building systems.
- Maintain and replenish pre-incident levels of medical and non-medical supplies.

- Work with local, regional, and state emergency medical system providers, patient transportation providers, and non-medical transportation providers to restore pre-incident transportation capability and capacity.
- Work with local emergency management, service providers, and contractors to restore information technology and communication systems.
- Prepare after-action reports, corrective action reports, and improvement plans.

Restoration of Services
The CEO/Designated Administrator will coordinate the restoration of services after an emergency situation affecting the hospital.

Staff/Patient Re-Entry
The CEO/Designated Administrator will work with the California Department of Public Health Licensing & Certification Unit to give approval for the return of staff and patients to the facility.

Staff Debriefing
A debriefing will be conducted within 30 days of the incident to collect lessons learned from the incident or exercise. These lessons learned will be used to revise and update the plan. The ED/Disaster Manager or designee will be responsible for coordinating the debriefing.

After-Action Report
After any real incident or exercise where the emergency operations plan is activated, an after-action report (AAR) will be written. The purpose of the AAR is to document the overall performance of the organization during the exercise or real event. It will contain a summary of the scenario or events, staff actions, strengths, issues, opportunities for improvement, and best practices.

The purpose of the after-action report is to ensure issues and opportunities for improvement are adequately addressed to improve response capabilities to future events. If necessary, an improvement plan will be developed to include a list of issues to be addressed, tasks that will be performed to address them, individuals responsible for completing the tasks, and a timeline for completion.

The ED/Disaster Manager will be responsible for coordinating the development of the after-action report and will ensure identified improvements are completed within the targeted timeframes.

Request for 1135 Wavier
The 1135 waiver allows reimbursement during an emergency or disaster even if providers can’t comply with certain requirements that would under normal circumstances bar Medicare, Medicaid or Children’s Health insurance program (CHIP). The waiver applies to federal requirements only and not state licensures. Waiver requests can be made by sending an email to the CMS Regional Office in California. Information of the facility and justification for requesting the waiver is required.

PLAN DEVELOPMENT AND MAINTENANCE

The ED/Disaster Manager is the qualified individual to lead the Emergency Management Program and works under the general direction of the Chief Nursing Officer (CNO), the Chief Medical Officer (CMO) and the

Chief Executive Officer (CEO). The ED/Disaster Manager in collaboration with the Disaster Management Committee, is responsible for managing all aspects of the Emergency Management Program. The Disaster Management Committee advises senior leadership regarding emergency management issues which may necessitate changes in policies and procedures, orientation or education of personnel and/or purchase of equipment.

The Disaster Management Committee is responsible for the following:

- Oversees the emergency management program
- Provides input and assists in the coordination of the preparation, development, implementation, evaluation, and maintenance of emergency management program.
- Meets quarterly
- Includes multidisciplinary representatives (senior leadership, nursing services, medical staff, pharmacy services, infection prevention, facilities engineering, security, and information technology)

In addition, senior leadership provides direct oversight and support of the Emergency Management Program through the Disaster Management Committee. Senior leadership reviews all after action reports (AAR) and improvement plans related to the emergency management program.

Annual Program Evaluation

The Disaster Management Committee is responsible for performing the annual evaluation of the EOP. The annual evaluation examines the objectives, scope, performance, and effectiveness of the EOP and the HVA. The annual evaluation uses a variety of information sources including reports from internal policy and procedure review, after action reports, and summaries of other activities. In addition, findings by outside agencies, such as accrediting or licensing bodies or qualified consultants, are used. The findings of the annual evaluation lead to changes/improvements in the emergency management plan. The annual evaluation is presented to the Disaster Committee and to senior leadership via the Executive Committee. The emergency management plan is required reading for all NIHD workforce.

Training Program

Each new staff member of NIHD participates in a general orientation that includes information related to the EOP. Examples of such information include; emergency preparedness procedures, job-specific roles, emergency communication plans, Rainbow Chart, and location of emergency supplies and equipment.

The Human Resources Department conducts the general orientation program and is responsible for scheduling, managing and documenting staff completion.

New staff members also receive a department-specific orientation. Each department manager or Clinical Staff Educator (CSE) provides new staff members with a department-specific orientation to their role in the Emergency Management Program. Information specific to the Emergency Management Program is included in the continuing education program. The ED/Disaster Manager in coordination with the Disaster Committee, collaborates with individual department heads to develop content and supporting materials for general and department-specific orientation and continuing education programs.

Exercise Program

NIHD will test its plan and operational readiness at least twice per year, utilizing high hazard scenarios per the HVA. NIHD will participate in a community full scale exercise at least annually; if such exercise opportunity is

accessible. If not accessible, the hospital will conduct a full scale exercise. NIHD will also conduct one additional exercise of any type at least annually.

All exercises and real events will be documented using the AAR template. This report shall be completed within 60 days of the exercise or real event. The ED/Disaster Manager will be responsible for coordinating the exercises, after action reporting, and improvement planning. The AAR or improvement plan will be incorporated into the emergency plan as soon as it is feasible. All improvement items will be tracked.

All exercises will incorporate elements of the National Incident Management System and Hospital Incident Command System. Future exercises should be planned and conducted to reflect anticipated hazards, incorporating gaps and improvement action items identified during previous exercises and real events.

Independent Study (IS) IS-100, IS-200, IS-700 and IS-800 are available to all healthcare district personnel likely to have a leadership role in emergency preparedness, incident management, and or emergency response during an incident.

DEFINITIONS

a. **Hospital Incident Command System (HICS)** – The "All Hazards" plan used to manage emergencies. This describes a management method that may be adapted to most emergency situations, both internal and external.
b. **Emergency Operations Plan (EOP)** – The program to identify, plan for, prepare for, drill, recover from, and evaluate the response to the drills and actual emergencies, and to identify processes and elements that may be improved with better planning, equipment, or training.
c. **Emergency -** Emergencies are defined as natural or manmade events which cause major disruption in the environment of care such as damage to the organization's buildings and grounds due to severe wind storms, tornadoes, hurricanes, earthquakes, fires, floods, explosions; or, the impact on patient care and treatment activities due to such things as the loss of utilities (power, water, and telephones), riots, accidents or emergencies within the organization or in the surrounding community that disrupt the organization's ability to provide care.
d. **Hazard Vulnerability Analysis (HVA):** a structured process to evaluate the potential for conditions or events that are likely to have a significant adverse impact on the health and safety of the patients, staff, and visitors of NIHD or on the ability of NIHD to conduct normal patient care and business activities.

REFERENCES:

1. California Office of Emergency Services (CALOES), (2023) https://www.caloes.ca.gov/

2. Federal Emergency Management Agency (FEMA), ICS-100: Introduction to Incident Command System, (2023) https://www.fema.gov/national-incident-management-system

3. Joint Commission Resources, (2023) Emergency Management in Healthcare: An All Hazards Approach. https://www.jointcommission.org/resources/patient-safety-topics/emergency-management

4. Comprehensive Accreditation Manual for Critical Access Hospitals (CAMCAH), (2023) Emergency Management Reference Guide https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_w_cah.pdf

5. Centers for Medicare Services (2023) 1135 Waivers Emergency Preparedness https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/1135Waivers

CROSS REFERENCED POLICIES AND PROCEDURES:

1. HICS Organization Chart
2. Credentialing Health Care Practitioners in the Event of a Disaster
3. Emergency Room Overcrowding
5. Capacity Management: Patient Surge
6. Evacuation Policy
7. Emergency Response Plan-Medical Gas Failure
8. Emergency Response Plan-HVAC Failure
9. Lockdown Plan
10. Active Shooter
11. Disaster Management Committee
12. Disaster Plan Perioperative Unit
13. Sterile Processing Disaster Plan
14. Triage of Patients Suspected of Ebola
15. Cyber Security Incident Response Manual

RECORD RETENTION AND DESTRUCTION: Emergency Operation Plan documents need to be retained for 15 years.

Supersedes: v.7 Emergency Management Plan

Advocacy Tracker			
Priority	**Legislation**	**Description**	**Status**
Priority	**Legislation**	**Description**	**Status**
1	AB 1923 - Soria	~~**Distressed Hospital Loan Program - $250 million**~~ ~~- Expands and funds California's Distressed Hospital Loan Program to provide financial assistance to hospitals at risk of closure. The bill broadens eligibility and allows for loan forgiveness based on financial need, with the goal of stabilizing hospital operations. It is intended to preserve access to care, particularly in rural and underserved communities.~~ **This was was amended to change to an entirely different topic. This is called agut and amend.**	Introduced (2/12/26) Passed Assembly Health Committee (15-0 on 4/23/26) Passed Assembly Appropriations Committee (5/14/26) (Placed on Susp Passed the Assembly (78-0 on 5/27/26) Referred to the Senate Health Committee (6/10/26) Passed Senate Health Committee (7/1/26) Re-Referred to Senate Appropriations Committee
1	AB 1607 - M. Gonzalez	**Extension of sunset for Maddy Emergency Medical Services Fund** Removes the sunset on counties' authority to levy penalties that fund the Maddy Emergency Medical Services (EMS) Fund, maintaining the funding mechanism for emergency medical and trauma services. By preserving this funding structure, the bill supports continued operation of EMS systems. These services are critical to maintaining access to emergency care, particularly in rural and underserved communities. **Update:** Extends funding for the Maddy EMS Fund and Richie's Fund through January 1, 2037.	Passed Assembly Health Committee (16-0 on 3/24/26) Passed Assembly Public Safety Committee (9-0 on 4/14/26) Passed the Assembly (72-1 on 4/20/26) Passed Senate Health Committee (11-0 on 6/17/26) Re-referred to the Senate Public Safety Committee (6/18/26) Passed Senate Public Safety Committee (6-0 on 7/1/26) Passed Senate Floor (38-0) On Governor's Desk
1	HR 8209 - Tonko	**Bipartisan legislation introduced to extend School-Based Health Centers grant program through 2031** The SBHC grant program provides competitive funding to support the establishment and operation of school-based health centers. Grants can be used to acquire or lease equipment, support workforce training, pay staff salaries and cover operational and management costs. The program prioritizes communities facing significant barriers to care, including areas with high rates of uninsured children. **Update:** Awaits consideration by the full House of Representatives. It would authorize $55 million annually for FY 2027–2031 to support School-Based Health Centers.	Introduced (4/6/26) Passed House Energy & Commerce Health Subcommittee (voice vote o Passed House Energy & Commerce Committee (46-0 on 5/21/26) Awaiting consideration by the full House of Representatives
1	AB 1882 - Ellis	**Payments For Standby Labor and Delivery Services** The bill would create the Safe Delivery Fund Pilot Program, administered by the Department of Health Care Access and Information, to help hospitals cover uncompensated standby costs for obstetric and related inpatient specialty services in areas with limited access to maternity care. It would fund eligible hospitals that serve geographically isolated populations and would be harmed by losing obstetric services, with payments limited to $5 million per hospital each year. Participating hospitals would have to report staffing and service data quarterly, use funds only for specified clinical capacity costs, and remain subject to audits and program reviews.	

Advocacy Tracker			
Priority	**Legislation**	**Description**	**Status**
2	AB 2282 - Alanis	**Free Standing Emergency Department for Del Puerto HCD** Authorizes the establishment of a freestanding emergency department in the Del Puerto area to expand access to emergency medical services. The bill is intended to address gaps in emergency care availability in a rural and underserved region. It supports improved access to timely care where hospital-based emergency services are not readily available.	Passed Assembly Health Committee (16-0 on 4/22/26) Passed Assembly Appropriations Committee (15-0 on 5/14/26) Passed the Assembly (76-0 on 5/29/26) Referred to the Senate Health Committee (6/11/26) Passed Senate Health Committee (7/1/26) In Senate Appropriations Committee - Placed on Suspense File Passed Senate Appropriations Committee Passed Senate Floor (37-2) On Governor's Desk
2	AB 2311 - Schiavo	**Healthcare Districts hiring physicians** Expands the authority of healthcare districts to employ physicians and directly provide medical services. The bill is intended to improve access to care by allowing districts greater flexibility in staffing and service delivery. It supports rural and underserved communities where recruiting and retaining providers is a challenge.	Passed Assembly Health Committee (17-0 on 4/22/26) Passed Assembly Appropriations Committee (15-0 on 5/14/26) Passed the Assembly (79-0 on 5/29/26) Referred to the Senate Health Committee (6/11/26) Passed Senate Health Committee (7/1/26) In Senate Appropriations Committee - Placed on Suspense File Passed Senate Appropriations Committee Passed Senate Floor (40-0) On Governor's Desk
3	SB 1187 - Durazo	**Brown Act - Relates to what makes majority for a legislative body** This bill would repeal certain future Brown Act requirements for eligible local legislative bodies related to electronic access, agenda translation, and interpretation assistance, while declaring the measure an urgency statute. **This bill was significantly amended to the changes above.**	Passed Senate Local Government Committee (6-0 on 4/23/26) Passed Senate Judiciary Committee (12-0 on 5/6/26) Passed the Senate (39-0 on 5/29/26) Referred to the Assembly Local Government Committee (6/11/26) Passed Assembly Local Government Committee (8-0 on 7/1/26) Passed Assembly Floor (73-0) On Governor's Desk
3	AB 1789 - Boerner	**Campaign Finance and Ethics Training Requirements** Requires most state and local candidates for elected office, as well as certain campaign treasurers, to complete FPPC-approved training on campaign finance and ethics laws. The bill is intended to improve compliance with the Political Reform Act, reduce reporting violations, and increase public confidence in elections. The requirements would likely apply to candidates for local special district boards, including healthcare districts, beginning January 1, 2029.	Passed the Assembly (78-0 on 5/26/26) Passed Senate Elections and Constitutional Amendments Committee (5-0 on 6/16/26) Re-referred to Senate Appropriations Committee (6/16/26) Senate Appropriations Committee - Placed on Suspense File Passed Senate Appropriations Committee Passed Senate Floor (39-0) On Governor's desk
1	AB 2353 - Pacheco	**Requires review of any new mandate for hospitals** Requires an independent evaluation of legislation that imposes new requirements on hospitals to assess its cost and impact on healthcare affordability. The bill aims to provide lawmakers with better information on how proposed policies affect hospital operations and overall healthcare costs. It is intended to improve decision-making and prevent unintended financial strain on hospitals and the healthcare system. **Update:** The bill now establishes the Health Mandates Review Program and the Center for Health Provider Policy Impact to provide independent analyses of proposed hospital mandates and their impacts on hospital operations, healthcare affordability, workforce, and access to care before new requirements are enacted.	Passed Assembly Health Committee (11-0 on 4/21/26) Passed Assembly Appropriations Committee (12-0 on 5/14/26) Passed the Assembly (56-1 on 5/27/26) Referred to the Senate Health Committee (6/10/26) Senate Health Committee - Hearing cancelled

Advocacy Tracker			
Priority	**Legislation**	**Description**	**Status**
1	AB 2208 - Stefani	**Maintains three month retroactive eligibility for Medi-Cal. Puts in place co pays for Medi-Cal as required by HR-1** maintains the current three-month retroactive eligibility period for Medi-Cal, allowing patients to receive coverage for services provided prior to enrollment. The bill also implements cost-sharing requirements, including co-pays, in alignment with federal policy changes under H.R. 1. It is intended to preserve access to coverage while aligning Medi-Cal policies with federal requirements.	Introduced (2/19/26) Passed Assembly Health Committee Passed Assembly Appropriations Committee Passed the Assembly Referred to the Senate Health Committee (6/10/26) Passed Senate Health Committee (7/1/26) Referred to Senate Appropriations Committee - Placed on the Suspens Held on Suspense File
2	AB 1811 - Rogers	**Health Professions Shortage Areas preservation** These designations support recruitment and retention of healthcare providers by maintaining eligibility for existing federal and state incentive programs, such as loan repayment and grants. The bill is intended to preserve provider availability in underserved and rural communities. **Update:** The bill was amended to preserve Health Professional Shortage Area (HPSA) designations that existed on January 1, 2025, through January 1, 2035, ensuring affected communities remain eligible for state incentive programs despite changes to federal HPSA designations.	Passed Assembly Health Committee (16-0 on 3/24/26) Passed Assembly Appropriations Committee (15-0 on 5/6/26) Passed the Assembly (79-0 on 5/14/26) Referred to Senate Health Committee (Was not heard in committee)
2	AB 2386 - Alvarez	**Licensed Physicians from Mexico Program** Expands California's physician workforce pathways by allowing physicians from Mexico who complete a limited-term program to transition to full licensure and continue practicing in the state. The bill also creates a provisional licensing pathway for internationally trained physicians to practice under supervision and eventually obtain full licensure. It is intended to address physician shortages—particularly in underserved and rural areas—while maintaining oversight and training requirements. **Update:** The bill was amended to clarify eligibility, supervision, and licensure requirements for internationally trained physicians participating in the provisional licensing pathway.	Passed Assembly Business and Professions Committee (12-2 on 4/21/2 Passed Assembly Appropriations Committee (11-2 on 5/14/26) Passed the Assembly (54-9 on 5/26/26) Referred to Senate Business, Professions and Economic Development C Amended in the Senate (6/16/26) Passed Senate Business, Professions and Economic Development Comr Re-referred to Senate Appropriations Committee (6/22/26) Senate Appropriations Committee hearing scheduled - Placed on Suspe Held on Suspense File
2	AB 2497 - Johnson	**Physical Therapy Scope of Practice Expansion** Modernizes and expands the scope of practice for physical therapists in California. Authorizes physical therapists to perform additional services such as musculoskeletal ultrasound, broader direct access treatment, referrals for imaging, and certain tissue penetration procedures commonly referred to as dry needling. The bill is intended to improve access to musculoskeletal care and reduce administrative barriers, but has generated opposition from acupuncture groups and others concerned about training standards and patient safety. **Update:** The bill was amended to further define education, competency, and certification requirements for physical therapists performing dry needling and other newly authorized procedures.	Passed Assembly Business and Professions Committee (15-0 on 4/22/2 Passed Assembly Appropriations Committee (15-0 on 5/14/26) Failed on Assembly Floor (26-19 on 5/28/26)

Advocacy Tracker			
Priority	**Legislation**	**Description**	**Status**
2	AB 1460 - Rogers	**Pharmacy / 340B Program** Prohibits pharmaceutical manufacturers from restricting qualifying nonhospital 340B clinics from using contract pharmacies to dispense discounted medications to eligible patients. The bill is intended to protect access to the federal 340B program and preserve pharmacy-related funding mechanisms used by safety-net and rural healthcare providers. Supporters state the bill protects patient access and operational sustainability, while opponents raise concerns regarding transparency and oversight of contract pharmacy arrangements. **Update:** Adds annual audit, recertification, and reporting requirements for participating 340B clinics while strengthening protections for the use of contract pharmacies.	Passed Assembly Health Committee (16-0 on 4/8/26) Passed Assembly Appropriations Committee (15-0 on 5/14/26) Passed the Assembly (79-0 on 5/28/26) Referred to Senate Health Committee (6/10/26) Passed Senate Health Committee (11-0 on 6/25/26) Re-referred to Senate Judiciary Committee (6/25/26) Amended in the Senate (6/27/26) Was not heard in Senate Health Committee
3	AB 2729 - Bonta	**Employer fee for employees on Medi-Cal** Would impose a fee on large employers whose employees rely on Medi-Cal for health coverage. The bill is intended to shift some of the cost burden to employers whose workers depend on public health programs. It aims to support Medi-Cal funding but may increase costs for certain employers. **Update:** The bill now establishes a framework for implementing the employer fee through the state budget process.	Passed Assembly Health Committee (11-3 on 4/21/26) Re-referred to Assembly Appropriations Committee (4/22/26) Placed on the Assembly Appropriations Suspense File (5/6/26) Amended and re-referred to Assembly Appropriations Committee (5/1 Did not move any further. Dead for 2026.
3	AB 1900 - Kalra	**Single payer health system** Proposes the establishment of a statewide single-payer health care system in which the state would finance and oversee coverage for all Californians. The bill would significantly restructure how hospitals and providers are paid by replacing much of the current multi-payer system with a state-administered model. While intended to expand access and control costs, it would have major implications for hospital reimbursement, financial sustainability, and operations.	In Rules - Dead for 2026
3	AB 1671 - Tangipa	**Creates grant program for providers to serve in rural areas** Establishes a grant program to support healthcare providers who commit to serving in rural and underserved areas. The bill is intended to improve workforce recruitment and retention by offering financial incentives to providers. It aims to expand access to care by increasing the availability of healthcare professionals in rural communities.	In Asm Appropriations -Held on Suspense File Dead for 2026
3	AB 2665 - Tangipa	**Budget request for Northern and Southern Inyo HCDs** a budget request that seeks state funding support specifically for the Northern and Southern Inyo Healthcare Districts. The bill is intended to provide financial resources to sustain operations, infrastructure, or services in these rural districts.	Pulled
3	SB 1422 - Durazo	**Allows for individuals who are unsatisfactory immigration status to appply for full scope Medi-Cal** Expands eligibility for full-scope Medi-Cal to individuals regardless of immigration status. The bill is intended to increase access to comprehensive health coverage for underserved populations. It would likely increase enrollment in Medi-Cal and expand access to care across the healthcare system.	Passed Senate Health Committee (11-0 on 4/9/26) Passed Senate Appropriations Committee (7-0 on 5/23/26) Placed on inactive file in Senate

Advocacy Tracker			
Priority	**Legislation**	**Description**	**Status**
3	AB 2131 - Rubio	**Exclude freestanding structures like congregate living health facilities or hospices from seismic requirements.** Exempts certain freestanding health care facilities, such as congregate living health facilities and hospices, from California's hospital seismic safety requirements. The bill is intended to reduce regulatory and financial burdens on these smaller or non-acute care facilities. It recognizes that these facilities may not require the same level of seismic compliance as full acute care hospitals.	In Asm Health - Dead for 2026
3	AB 1018 Bauer-Kahan	**Automated Decision Systems** Regulates the use of automated decision systems and artificial intelligence tools used in areas such as healthcare, employment, housing, insurance, and public services. The bill would require impact assessments, bias evaluations, transparency disclosures, and certain consumer protections related to AI-assisted decision making. It is intended to address concerns regarding discrimination, accountability, and oversight of AI systems, but may create additional compliance and operational requirements for healthcare organizations and public agencies.	Passed Assembly Privacy and Consumer Protection Committee (9-3 on Passed Assembly Judiciary Committee (8-3 on 4/29/25) Passed Assembly Appropriations Committee (10-3 on 5/23/25) Passed the Assembly (50-16 on 6/2/25) Referred to the Senate Judiciary Committee (6/11/25) Passed Senate Judiciary Committee (7-2 on 6/26/26) Passed Senate Appropriations Committee (5-2 on 8/29/26) On Senate Floor. Did not pass. Dead for 2026.
3	AB 225 Bonta	**Facility Fees for Outpatient Services** Prohibits hospitals from charging facility fees for telehealth visits, preventive services, and certain outpatient office visits that are commonly provided in hospital-owned clinics. Facility fees are additional charges billed by hospitals, separate from the provider's professional fee, and can represent a significant source of outpatient revenue. Recent amendments would also require hospitals to notify patients when facility fees may be charged and report facility fee revenue and utilization data to the state. The bill could reduce hospital revenue and increase reporting requirements for facilities that rely on outpatient clinic services. **Update:** The bill was amended to narrow the prohibition on facility fees by exempting certain outpatient services, including emergency, observation, surgery, and diagnostic services. It also clarifies hospital notice requirements and requires annual reporting of facility fee revenue, utilization, and payer information to the state.	Passed Assembly Health Committee (11-4 on 4/8/26) Passed Assembly Appropriations Committee (10-5 on 5/23/26) Passed the Assembly (51-17 on 6/2/26) Referred to the Senate Health Committee (6/16/26) Senate Health Committee hearing scheduled (bill pulled from hearing)

Spending Target Penalty Timeline

	2026	2027	2028	2029	2030	2031	2032
2025-2026	Exceeds Target	Data Reported in September	**PIP Development January-June** **~2.5 Year PIP Begins in July**	**PIP Implementation**	**PIP Ends ~December Entity noncompliant with PIP *AND* does not meet Target**	**Penalty Assessed Against 2026 Spending Year (Fall/Winter)**	
2026-2027	Exceeds Target	Data Reported in September	**PIP Development January-June** **~1.5 Year PIP Begins in July**	**PIP Implementation**	**PIP Ends ~December Entity noncompliant with PIP *AND* does not meet Target**	**Penalty Assessed Against 2027 Spending Year (Fall/Winter)**	**Depending upon PIP duration, penalty may be assessed in 2032**

Health & Safety Code § 127502.5

Value: Compassion

Strategic Plan for Patient Experience

Purpose: To prioritize patient experience by emphasizing compassionate care through all touchpoints in the hospital environment.

Goal 1: Improve patient experience, focusing on compassion, communication, and overall care satisfaction, as measured by HCAHPS, CGCAHPS and Press Gainey.

Objective: Increase HCAHPS (Inpatient), CGCAHPS (Outpatient) and Press Gainey (ED) Top Box Scores to over 90% by 2027.

Tactic C1.1: Establish a hospital wide patient satisfaction committee that meets at least quarterly which covers all patient care areas.
Tactic C1.2: Ensure all patient facing departments have an action plan with at least 2 projects to improve the patient experience.
Tactic C1.3: Establish a structured program to involve physicians in improving patient satisfaction through regular feedback, targeted training, and clear expectations for patient-centered communication.

KPI: HCAHPS, CGCAHPS and Press Gainey scores pulled by “Top Box” percentage (not percentile).

Goal 2: Ensure patients who have a less-than-satisfactory experience receive appropriate care and support

Objective: Implement a consistent process for responding to patient concerns, ensuring that all negative feedback is acknowledged, investigated, and resolved in a timely manner.

Tactic C2.1: Redesign the UOR system and ensure all patient related submissions are completed within 90 days.
Tactic C2.2: Develop a QR code that is posted all over the hospital which allows patient to immediately provide feedback (positive and negative).
Tactic C2.3: Develop a response process to contact patients within 72 hours who report low satisfaction scores, acknowledge concerns, and resolve issues when possible. Document outcomes and use trends to drive ongoing quality improvements.
Tactic C2.4: Create a multidisciplinary grievance committee which resolves more serious patient complaints that involve multiple departments.

KPI: Percentage of patient grievance addressed within the response time.

Goal 3: Implement a hospital wide program on quality customer experience.

Objective: Ensure 100% of team members and physicians complete a structured training program on customer experience.

Tactic C3.1: Implement AIDET as a basic framework to build trust and reduce patient anxiety.
Tactic C3.2: Ensure every team member understands the organizations philosophy on customer service.
Tactic C3.3: Design and implement a formal hospital-wide program to improve patient satisfaction through standardized processes, staff engagement, and ongoing performance monitoring.

KPI: Percentage of team member program completion by December 2026.

Value: Accountability

Strategic Plan for Access to Care

Purpose: To strengthen organizational performance by creating clear expectations, ownership, transparency, and responsibility for outcomes.

Goal 1: Improve access to care for primary and specialty care appointments.

Objective: Reduce the number of patients leaving the Eastern Sierra region for healthcare services.

Tactic A1.1: Initiate a market survey to identify the key services to keep patients local.
Tactic A1.2: Develop a master facility plan which initially focuses on outpatient exam room expansion to allow for the recruitment of providers identified in the master facility plan.
Tactic A1.3: Engage regional healthcare partners to develop a clinically integrated network that maximizes local resources.
Tactic A1.4: Establish a functional telehealth program that provides specialty services to patients from their home or in the outpatient clinics.
Tactic A1.5: Build an inpatient dialysis program which is financially sustainable and keeps non-critical dialysis patients at our hospital.

KPI: 3rd Next Available, Utilization rates, Cancellation/No show rates, leakage rates, transfer rates

Goal 2: Build a behavioral health program that addresses the most critical needs of our community.

Objective: Increase the behavioral health services provided to the region.

Tactic A2.1: Conduct a data review that identifies the most urgent behavioral health needs of our community.
Tactic A2.2: Develop a behavioral health outpatient service (telehealth or in person) that provides sustainable support for patients with mental health needs.
Tactic A2.3: Engage the County and other local partners to ensure program continuity and care coordination of services.
Tactic 2.4: Provide community outreach to local organizations on mental health education and awareness.

KPI: Mental health program fully established.

Goal 3: Establish sustainable service lines based on community clinical needs.

Objective: Develop and maintain at least five sustainable service lines based on market analysis by December 2027.

Tactic A3.1: Conduct a market analysis to identify at least five specialty service lines with strong growth potential.
Tactic A3.2: Develop and implement a phased “bridge plan” to expand exam room capacity within the PMA building.
Tactic A3.3: Create and execute a proactive recruitment strategy to attract top-tier specialists to Bishop for clinical practice.

KPI: All service lines are staffed and operational with good access to care.

Goal 4: Engage the community in fostering a culture of health and wellness.

Objective: Develop a community engage program to support healthy lifestyles and promote hospital resources by December 2027.

Tactic A4.1: Develop and execute an annual communications plan to highlight various areas of the hospital to the local community.
Tactic A4.2: Design a quarterly NIHD hospital update for the community and distribute through existing paper media channels.
Tactic A4.3: Engage local leaders in conducting or participating in health events which highlight community health concerns and hospital resources.

KPI: Full community engagement program.

Goal 5: Become a strong voice in the local, county, state and national legislation process.

Objective: Implement an annual advocacy platform and actively engage in at least three legislative actions per year by September 2027.

Tactic A5.1: Develop an advocacy platform that reflects the challenges and concerns of critical access hospitals, rural communities and special districts.
Tactic A5.2: Hire a lobbyist to develop a legislative tracker which prioritizes legislation through the lens of the NIHD advocacy platform.
Tactic A5.3: Engage professional associations such as CHA, DHLF, ACHD, CSDA, etc. to seek support for NIHD high priority issues.

KPI: Three legislative actions per year.

Value: Respect

Strategic Plan for Workforce

Purpose: To improve employee engagement, strengthen retention, and foster a positive workplace culture through clearly defined goals, action steps, and measurable outcomes.

Goal 1: Improve the team member and physician experience through targeted engagement strategies.

Objective: Increase engagement scores from an average of 53% to 70% by 2030.

Tactic W1.1: Apply HR best practices in employee satisfaction surveying to increase response rates to above 80%.
Tactic W1.2: Implement annual employee engagement survey action plans for each department and medical staff, culminating in an executive-level summary report at the end of each cycle.
Tactic W1.3: Establish a consistent, organization-wide communication cadence to keep staff and physicians informed of hospital initiatives and updates.

KPI: Annual team member (staff and physicians) engagement and culture survey.

Goal 2: Improve the quality of work life and professional development for team members

Objective: Achieve a retention rate of 90% or higher (annually) by December of 2026.

Tactic W2.1: Negotiate a labor contract allowing for salary growth while still aligning with good fiscal responsibility.
Tactic W2.2: Develop an employee events committee with an annual plan and budget to provide opportunities to bring team members together.
Tactic W2.3: Establish clear and accessible career pathways that support employee growth and internal advancement.
Tactic W2.4: Enhance onboarding and early retention through a structured process that promotes early engagement, connection, and success in role.

KPI: Retention rates

Goal 3: Foster a culture of leadership development and growth.
Objective: Ensure 100% of leaders have an opportunity to develop leadership skills.

Tactic W3.1: Establish a structured budget that supports leaders in accessing professional development opportunities on a biennial basis.
Tactic W3.2: Implement a standardized leadership education framework aligned with the organization's core leadership philosophy and expectations.

Tactic W3.3: Create an Administrator-on-Call program designed to strengthen and develop future hospital senior leaders through hands-on experience.

KPI: Leadership development and engagement survey

Value: Excellence

Strategic Plan for Quality

Purpose: To advance clinical excellence by delivering high-quality care, strengthening patient safety, and promoting equitable health outcomes.

Goal 1: **Strengthen care coordination across the continuum of care to ensure seamless, patient-centered transitions in order to improve health outcomes.**

Objective: Improve care continuity through enhanced communication, collaboration, and transitions of care to support better patient outcomes.

Tactics:
Tactic E1.1: Develop and implement patient care navigation programs to guide patients seamlessly through the continuum of care.
Tactic E1.2: Redesign the surgical patient journey to create a seamless transition from the outpatient clinical consultation through the operating room.
Tactic E1.3: Evaluate a strategic partnership with the Bishop Care Center to enhance care transitions, improve care coordination, and identify opportunities to reduce costs and increase revenue.
Tactic E1.4: Establish partnerships with regional hospitals to expand access to care, improve care coordination, and strengthen referral networks.
Tactic E1.5: Implement a shared electronic health record (EHR) across regional hospital partners to improve communication, care coordination, and continuity of care.

KPI: OR utilization rates, SNF transfer time, swing bed utilization, patient navigation numbers

---

Goal 2: **Achieve excellence in quality and safety through continuous improvement in clinical performance, regulatory compliance, and patient-centered outcomes.**

Objective: Enhance quality and safety of care by improving clinical performance, maintaining regulatory readiness, and driving better patient outcomes through continuous improvement.

Tactics:
Tactic E2.1: Implement standardized quality monitoring and communication tools to proactively identify issues, drive timely resolution, and support continuous quality improvement. (i.e. including quality dashboards, daily huddles, board oversight, etc.)
Tactic E2.2: Strengthen and sustain the Quality Improvement Project (QIP) to improve performance on pay-for-performance quality measures and maximize value-based reimbursement.
Tactic E2.3: Maintain continuous survey readiness by monitoring compliance with Joint Commission standards and implementing ongoing performance improvements.
Tactic E2.4: Develop a Community Advisory Council to strengthen community engagement, gather feedback, and communicate hospital initiatives.

KPI: QIP, SSI rates, HAI rates, Falls, Falls with injury, Sentinel events, 30 day readmissions, mortality

---

Goal 3: **Foster a culture of safety through leadership development, employee engagement, and a systematic approach to reducing harm.**

Objective: Successfully implement all five Beta HEART domains program by 2030.

Tactics:
Tactic E3.1: Culture of safety: Develop a culture of safety by implementing a Just and Fair Culture framework that promotes accountability, open communication, learning, and continuous improvement.
Tactic E3.2: Rapid event and analysis: Implement a 24/7 human-factors-based rapid event response and analysis protocol to ensure timely review of safety events, identify system issues, and drive immediate corrective actions.
Tactic E3.3: Communication and transparency: Implement a standardized disclosure and transparency pathway to strengthen communication, ensure consistency, and promote trust following patient safety events.
Tactic E3.4: Care for the caregiver: Establish a Care for the Caregiver program with accessible peer support to address the emotional and psychological impact on second victims.
Tactic E3.5: Early resolution: Implement a proactive early resolution framework that emphasizes transparency and fair compensation to reduce reliance on adversarial litigation.

KPI: Achievement of BETA HEART domains

Value: Stewardship

Strategic Plan for Sustainability

Purpose: To promote the efficient, innovative, and responsible use of NIHD resources while balancing environmental, social, and economic priorities to ensure long-term organizational sustainability.

Financial Stewardship

Goal 1: Maintain Financial Health by Developing Actionable Cash Flow Management Techniques

Objective: Develop policies and processes to maintain at least 75 days cash on hand, below 60 days accounts receivable and debt service ratio of above 1.1 by June 2027.

Tactic S1.1: Establish a cross-functional team to redesign and optimize the cash flow process.
Tactic S1.2: Deploy an AI-driven strategy to enhance billing and collections efficiency.
Tactic S1.3: Identify and eliminate bottlenecks in the processing of the "holds report" to improve turnaround time.

KPI: Days Cash on Hand (target 75 days minimum), AR Days (Target of below 60 days), Debt Service Coverage Ratio (target 1.1 or higher).

Goal 2: Instill Organization Financial Stewardship through Budget Management Practices

Objective: Ensure the operating income meets or exceeds budgeted expectations through effective financial management, revenue generation, and cost control.

Tactic S2.1: Establish a structured learning program to help leaders understand and effectively manage their budgets.
Tactic S2.2: Empower leaders by increasing purchasing authority thresholds to enable more autonomous decision-making.
Tactic S2.3: Design a standardized process for leaders to develop, own, and actively manage their budgets.
Tactic S2.4: Implement a monthly budget review cadence that supports accountability, growth, and continuous learning across departments.
Tactic S2.5: Conduct a supply chain optimization review every three years to improve resource efficiency and overall effectiveness.

KPI: Operating Income vs. Budget (target: meet or exceed budgeted annually).

Goal 3: Ensure Financial and Operational Stability for a Sustainable Future

Objective: Create long term financial strategy that will ensure growth, manage expenses and foster sustainability.

Tactic S3.1: Create a long range financial plan based on the growth initiatives outlined in the strategic plan.

Tactic S3.2: Enhance the grant program to ensure maximization of government funds.
Tactic S3.3: Develop goals, expectations and accountability for the NIHD Foundation.
Tactic S3.4: Develop a capital management process to ensure phased equipment replacement, facility projects, and IT resources are maintained at their highest level.
Tactic S3.5: Identify untapped financial opportunity to grow cash (laundry, food service, pharmacy, procedures, etc.)
Tactic S3.6: Redesign physician agreements to promote share financial responsibility through hybrid contracts (base salary + RVU).

KPI: 100% plans built by June 2026.

Goal 4: Control Labor Costs Through Effective Management of Our Human Resource

Objective: Ensure staffing benchmarks adhere to appropriate productivity based standards.

Tactic S4.1: Ensure appropriate stewardship of manageable labor costs through the proper alignment of staff time and reduction of reliance on contracts, overtime, and premium pay.
Tactic S4.2: Develop productivity tools to support data driven, daily management of personnel.
Tactic S4.3: Conduct triennial "benchmarking" to constantly review and adjust FTE expenses.

KPI:

- Salary, wages, and benefits as a percentage of total expenses (at or below 50%)
- Staffing to NIHD benchmark adherence

Goal 5: Identify Methods to Manage Our Public Funds Using the Principles of Safety, Liquidity and Yield.

Objective: Ensure all financial resources are managed and invested appropriately to ensure stability and growth.

Tactic S5.1: Ensure government taxing authorities (GO bond and Prop 13) are managed in an accurate, reliable and predictable manner to ensure transparency with the District tax payers.
Tactic S5.2: Invest unrestricted funds (reserves) into appropriate, high interest bearing accounts.
Tactic S5.3: Increase pension funding to achieve and maintain a funded status above 80% by 2030.

KPI:

- Predictable bond payment schedule through 2038.
- Investments: Meets or exceeds LAIF rates for public investments.
- Pension Plan: Financial investment continues to grow at a rate of 10% a year.

Northern Inyo Healthcare District

Compliance Board Report

September 2026

Purpose

This packet is provided to the Governance Committee for review and recommendation. It will then be sent to the full Board for review and approval. The packet includes Board compliance education, current-state assessment, significant compliance and privacy risk updates, and the proposed annual Compliance workplans.

Requested Board Action

Accept the September 2026 Compliance Board Report and approve the Draft 2026 Compliance Workplan and Draft 2027 Compliance Workplan.

Reporting Structure

Compliance Program metrics will be reported through the Governance Committee. Compliance will report quality-related Unusual Occurrence Report (UOR) data through the Quality Committee. This separates Compliance Program oversight from facility quality and safety reporting while preserving Compliance review, regulatory escalation, and collaboration when a UOR presents a compliance risk.

Board Review Focus

- Oversight of the Compliance Program through the HHS OIG Seven Elements framework.
- Current compliance strengths, vulnerabilities, workload pressures, identified trends, and corrective-action priorities.
- Focused updates involving grievances, privacy, public records, cybersecurity, and regulatory compliance.
- Workplan priorities intended to strengthen governance, monitoring, documentation, continuity, corrective-action effectiveness, and risk reduction.

Prepared by: Patty Dickson, Compliance Officer

Table of Contents

Section	Packet Page(s)
Cover Memo	1
Table of Contents	2
Board Compliance Education	3-5
Compliance Program Strengths, Weaknesses, Opportunities, and Threats (SWOT) / Gap Summary	6-7
Compliance Oversight Dashboard - Compliance-Related UOR Metrics	8
UOR Trend Identification and Response - Complaint/Grievance Timeliness	9
Privacy Investigations Summary	10
California Public Records Act Workload & Complexity	11
Aesto Cybersecurity Incident	12-13
Release of Information Privacy Risk & Risk-Reduction Controls	14
2026 Compliance Workplan - Draft	15-17
2027 Compliance Workplan - Draft	18-19

Pagination note: The bold number in the lower-right corner is the consecutive packet page number and corresponds to this table of contents.

Board Oversight of the Compliance Program

Office of Inspector General Seven Elements, program maturity, and Board oversight

Purpose

This briefing is designed to help the Board distinguish between having compliance policies and maintaining an effective, operating Compliance Program. The U.S. Department of Health and Human Services (HHS) Office of Inspector General (OIG) Seven Elements provide the organizing framework; mature-program practices and Corporate Integrity Agreement (CIA) requirements provide useful points of comparison.

Board oversight responsibility

The Board's role is to oversee whether the program has sufficient authority, independence, resources, information, and follow-through to identify and reduce material compliance risk.

Board-level questions typically include:

- Is the Compliance Officer able to elevate concerns directly and without interference?
- Are significant risks, investigations, audit findings, and corrective actions reported in a meaningful way?
- Are corrective actions assigned, completed, validated, and monitored?
- Does the program have enough capacity to perform monitoring, auditing, education, investigations, and risk assessment?

What is a Corporate Integrity Agreement?

A Corporate Integrity Agreement is a negotiated agreement between HHS OIG and a healthcare organization, usually as part of resolving alleged fraud, false claims, kickback, quality-of-care, or similar enforcement matters. CIAs generally require a highly formalized compliance structure for a defined period. Requirements commonly include Board oversight, independent reviews, compliance reporting, training, risk assessment, monitoring, and documented corrective action.

CIAs provide practical examples of the controls, oversight, monitoring, and evidence OIG may require when an organization must demonstrate program effectiveness. CIAs provide insight into the OIG's expectations for a fully functioning Compliance Program.

A mature program does not mean a perfect program. It means the organization has a functioning structure to identify risk, respond to problems, document decisions, learn from findings, and verify that corrective action is sustained.

The OIG Seven Elements of an Effective Compliance Program

The Seven Elements provide a common structure for evaluating whether a Compliance Program is operating effectively and connect Board oversight to the findings and priorities in the broader Strengths, Weaknesses, Opportunities, and Threats (SWOT)/gap analysis on the following pages.

Element	What it requires	What the Board should expect to see
1. Written Standards, Policies & Procedures	Current standards of conduct and risk-specific policies; periodic review; clear ownership and accessibility.	Current material policies tied to identified risks, with evidence of review and implementation.
2. Compliance Leadership & Oversight	Qualified Compliance Officer with appropriate authority, independence, resources, direct Board access, and a functioning compliance committee or equivalent oversight structure.	Direct access, substantive reporting, functioning oversight, and the ability to escalate risk without interference.
3. Training & Education	Onboarding, annual education, and targeted role-based training tied to actual risk. Completion and effectiveness should be tracked.	Training directed to actual risk, with completion and effectiveness information.
4. Effective Lines of Communication	Accessible reporting channels, confidentiality where appropriate, prompt follow-up, and a strong non-retaliation framework.	Multiple reporting paths, including confidential or anonymous reporting, and meaningful follow-up.
5. Auditing & Monitoring	Risk-based workplan, routine monitoring, targeted audits, trend analysis, internal reporting, and follow-up on findings.	Evidence that auditing and monitoring occur and that findings change priorities or controls.
6. Enforcement & Accountability	Consistent application of standards, investigations, appropriate discipline or corrective action, screening/exclusion controls where applicable, and documentation of outcomes.	Consistent accountability and documentation of investigation and corrective-action outcomes.
7. Response, Investigation & Prevention	Prompt investigation, root-cause analysis, corrective action, re-testing, and preventive measures to reduce recurrence.	Closed-loop corrective action with ownership, completion evidence, effectiveness validation, and escalation of repeat findings.

Board takeaway

The Seven Elements are interdependent. Program effectiveness depends not only on policies and training, but also on meaningful oversight, risk-based monitoring, accountability, and sustained corrective action.

Evidence of Program Effectiveness

The following indicators illustrate the types of evidence a Board should expect from a mature Compliance Program.

Governance and access

A functioning Compliance Committee, direct Compliance Officer access to senior leadership and the Board, and regular reporting focused on significant risk.

Risk-based auditing and monitoring

A documented risk assessment and workplan, recurring monitoring, targeted audits, trend analysis, and follow-up testing.

Meaningful metrics

Reporting that shows trends, exceptions, aging, corrective-action status, and other information that helps the Board understand whether controls are working.

Corrective-action discipline

Assigned ownership, due dates, completion evidence, effectiveness testing, sustained monitoring when needed, and escalation of overdue or ineffective remediation.

Reporting culture

Accessible reporting channels, including confidential or anonymous options, non-retaliation protections, prompt triage, and documented follow-up.

Program resilience

Documented core processes, continuity procedures, sufficient Compliance capacity, and enough structure that important oversight functions do not depend on informal knowledge alone.

CIA examples commonly formalize these same expectations through required Board oversight, training, independent reviews, monitoring, reporting, and documented corrective action.

Reference framework: HHS OIG General Compliance Program Guidance (2023) and publicly available OIG Corporate Integrity Agreements.

Compliance Program - Board SWOT Summary

Calendar Year 2026

Findings by Risk Severity

HIGH
Compliance Committee has been inactive since 2020; the formal program oversight and review structure should be restored.

HIGH
Corrective Action Plans need stronger tracking to closure, effectiveness validation, and sustained monitoring.

HIGH
Health Information Management Release of Information remains a high-risk area requiring enhanced, ongoing auditing until objective results demonstrate sustained control effectiveness.

HIGH
Key compliance processes and institutional knowledge remain concentrated in the Compliance Officer. Executive and leadership consultation is a program strength and should continue; risk reduction should focus on stronger process documentation, repeatable decision frameworks, backup/continuity procedures, and cross-training.

MOD-HIGH
Several operational/system-administration functions remain in Compliance; mature functions need documented ownership and structured handoff planning.

MOD-HIGH
Employee access auditing is active but largely manual, limiting scalability and available monitoring capacity.

MODERATE
Notice of Privacy Practices and breach-policy alignment remain active policy priorities.

MODERATE
Billing, coding, and denial monitoring should move to a recurring risk-based audit cycle.

MODERATE
NIHD's lean rural structure places a broader range of oversight and consultative responsibilities within Compliance than in many larger systems.

Strengths - Seven Elements

1. Oversight & Leadership
Direct Chief Executive Officer reporting, direct Board access, and established Board reporting.

2. Policies & Procedures
Centralized policy controls and practical process design when compliance controls are missing.

3. Training & Education
Annual, onboarding, department, one-on-one, just-in-time, email, Relias, KnowBe4, and risk-based education.

4. Communication
Accessible Compliance function with UOR, complaint, direct-contact, escalation channels, and an anonymous compliance hotline.

5. Auditing & Monitoring
Security Risk Analysis, access audits, third-party review, exclusions, conflicts of interest, Release of Information audits, and targeted monitoring.

6. Enforcement & Accountability
Policies, training, screening, investigations, corrective action, and discipline support accountability.

7. Response & Prevention
Compliance-led investigations, breach assessments, regulatory reporting, corrective action, and trend-based prevention.

Compliance Program Priorities & Oversight

NIHD Compliance Program - Seven-Element Status & Priorities

Element	Status	Current Priority
1. Policies & Procedures	Moderate-Strong	Complete Notice of Privacy Practices updates and align breach-policy language with current practice.
2. Leadership & Oversight	Moderate-Strong	Restart the Compliance Committee and use Governance Committee reporting for Compliance Program metrics.
3. Training & Education	Strong	Maintain risk-based reinforcement across established training channels.
4. Lines of Communication	Strong	Strengthen formal feedback, escalation, and anonymous reporting awareness.
5. Auditing & Monitoring	Moderate-Strong	Formalize recurring risk-based audits, including contracts and Business Associate Agreements (BAAs), Release of Information, billing, coding, and denials.
6. Enforcement & Accountability	Moderate-Strong	Strengthen evidence of ownership, follow-up, closure, and consistent accountability.
7. Response & Corrective Action	Moderate-Strong	Formalize Corrective Action Plan governance and sustained effectiveness monitoring.

CAH + District Context

Critical Access Hospital: Lean staffing and limited redundancy require practical, sustainable controls.

California public healthcare district: Brown Act, California Public Records Act, public contracting, conflicts, public funds, governance, and transparency duties broaden the compliance environment.

Quality and safety support model: Compliance assists with safety, risk, and regulatory escalation. Quality is focused primarily on quality-improvement programs such as the Merit-based Incentive Payment System (MIPS) and Quality Incentive Program (QIP), which limits capacity for processing and trending quality UORs.

Board Oversight Priorities

- Confirm Compliance Committee restart, charter, cadence, and effectiveness.
- Approve the 2026 and 2027 Compliance Workplans.
- Review Compliance Program metrics, Corrective Action Plan (CAP) status, significant risk trends, and progress against workplan priorities.

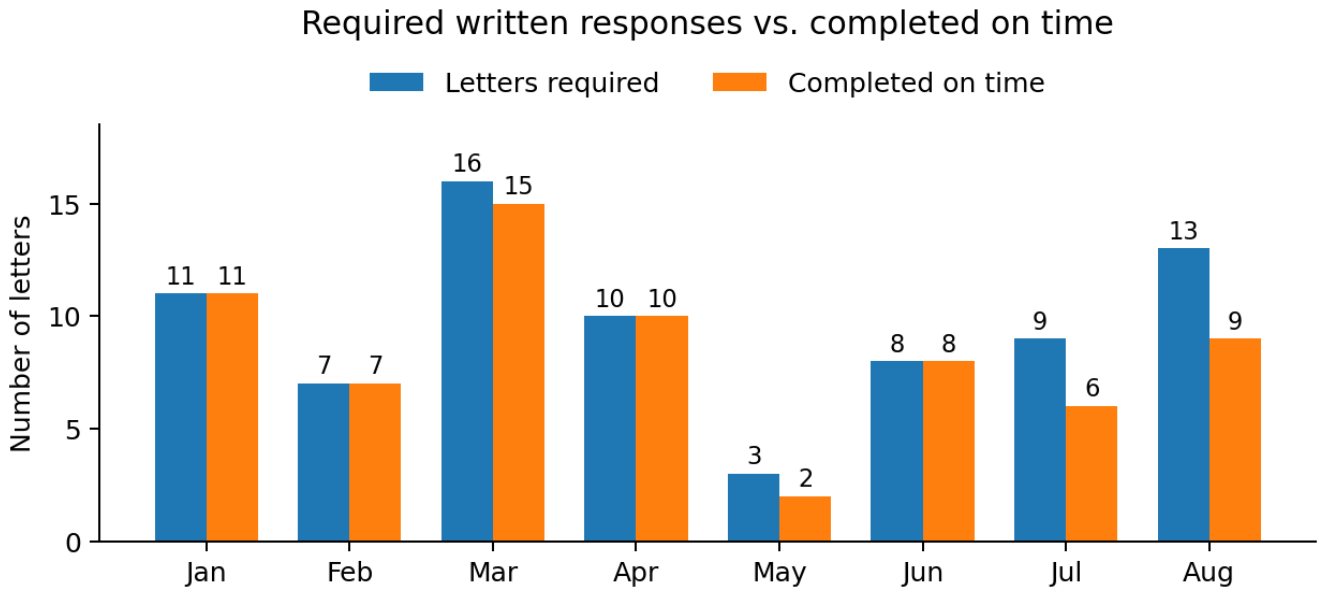
Near-Term Program Priorities

Restore formal Compliance Committee oversight; strengthen Corrective Action Plan governance; continue risk-based Release of Information monitoring; prioritize third-party, Business Associate Agreement, billing/coding/denial, and enterprise policy/incident-management work consistent with the approved workplans.

Compliance Oversight Dashboard

Compliance-related UOR metrics | January-August 2026

111	77	68	88%
Complaint / review requests 26.7% of all UORs	Required written responses	Completed on time	Year-to-date timeliness



Trend signal

The monthly comparison shows the change clearly: June was 8 of 8 on time, July declined to 6 of 9, and August declined to 9 of 13. Seven of the nine late responses year-to-date occurred in July and August.

Reporting boundary

This dashboard focuses on the two UOR metrics most directly related to Compliance: complaint/review activity and required written-response timeliness. Most other UOR categories primarily relate to facility quality and safety and are reported by Compliance through the Quality Committee. Compliance continues to review UORs for potential regulatory, privacy, fraud, ethics, or other compliance escalation.

UOR Trend Identification and Response

Complaint / Grievance Response Timeliness | January-August 2026

77	68	88%
Required response letters	Completed on time	Year-to-date timeliness

Trend Identified

Written complaint/grievance response timeliness declined during July and August. Seven of the nine late responses year-to-date occurred during those two months. This is a meaningful policy-compliance trend that warrants correction; however, the letter-timeliness measure does not fully reflect the performance of the underlying grievance-resolution process.

Context and Substantive Improvement

Substantive grievance handling has improved. The Grievance Committee and coordinated multidisciplinary review process have supported faster review, decision-making, and follow-up for significant grievances and patient-harm events. The current issue is a transitional gap in standardizing written-response timeliness rather than a decline in substantive grievance resolution.

Policy Consideration

The current policy requires written contact within a designated timeframe. The Joint Commission has advised NIHD to revise the timeline to provide a more realistic interval for completion. That update has not yet been finalized. Some initial letters have therefore been late under the existing policy even while investigation and resolution were progressing.

Response / Corrective Action

- Standardize the coordinated grievance workflow and accountability for required written communication.
- Track every grievance requiring written communication through completion.
- Revise the grievance policy timeline consistent with Joint Commission feedback and realistic response expectations.

Assessment

The late-letter trend is best characterized as a temporary policy and workflow issue during implementation of an improved grievance process. The higher-priority outcome, timely and substantive resolution of complex grievances and patient-harm events, has improved. The corrective action should address the remaining timeliness issue without disrupting those gains.

Board-level interpretation

The July and August change is a written-response timeliness issue occurring during transition to a more coordinated grievance process. Corrective action is focused on standardizing the workflow and preserving the improvements in multidisciplinary review, resolution, and follow-up.

Privacy Investigations | 2026

Investigations logged January-July 2026 | Status through September 1, 2026

23 Investigations	**3** Reportable 13%	**96%** Closed 22 of 23	**100%** Required regulatory reports timely 3 of 3	**67%** Patient notices timely 2 of 3

Investigation trends

Privacy investigations involved a range of disclosure, access, communication, and Release of Information concerns. Public Board reporting is intentionally aggregated because individual event categories or circumstances could identify employees or patients in a small organization and community.

Reporting assurance and program risk

Regulatory reporting: All required reports to the Office for Civil Rights and California Department of Public Health were submitted timely.

Patient notification timeliness: Two of three required patient-notification processes were completed within the applicable timeframe. One large-scale notification process was late in part because of the volume and complexity of validating the affected population and coordinating the required response. Late patient notification can increase exposure to regulatory findings and potential monetary penalties; accordingly, notification timeliness remains an identified Compliance Program risk and corrective-action priority.

Priority actions

- Strengthen readiness and workflow controls for large-scale notification events, including early escalation of resource and vendor needs.
- Maintain risk-based Release of Information auditing and monitoring as a control for a high-risk privacy function.
- Use objective performance data to determine the appropriate intensity of monitoring.
- Continue internal trend analysis and targeted privacy education while keeping public Board reporting appropriately aggregated.

California Public Records Act Workload & Complexity

Through September 2, 2026

14 Requests received	**5** Complex / non-routine	**9** Routine / standard	**36%** Complexity rate

Request volume by quarter

Q1	5 requests
Q2	3 requests
Q3 through Sept. 2	6 requests

Complexity factors

Five of the 14 requests required one or more enhanced handling factors. These factors overlap and are not intended to add to 14.

Multiple departments / record sources 5	**Rolling production** 3	**Legal review** 2
Significant redaction / exemption analysis 2	**Unusually large record volume** 2	**Vendor confidentiality contact** 1

Why complexity matters

Complex requests can require coordinated searches across departments or record sources, evaluation of statutory exemptions, legal or third-party confidentiality review, redaction and supporting legal citations, management of statutory deadlines, documentation of disclosure determinations, and staged or rolling production. A modest request count can therefore represent a substantial compliance workload and legal-risk function.

Board takeaway

Public-records workload is driven by complexity as well as volume. The Board should expect Compliance to maintain timely, legally supportable response processes and to escalate material legal, operational, or transparency risks when they arise.

Aesto Cybersecurity Incident - Operational and Financial Impact

Summary

NIHD was notified of a cybersecurity incident involving a third-party legacy data archive vendor. Approximately 51,000 affected individuals required notification. The incident involved personal information, including Social Security numbers. External legal and breach-response vendors were required because of the volume and complexity of the incident, the need for specialized legal review, and the need to coordinate the response in a manner that supported cybersecurity insurance coverage.

The incident has resulted in a finite direct financial obligation, primarily the District's $50,000 cyber-insurance retention and internal staff time. Significant breach-response functions were transferred to insured third-party professionals. While residual civil and regulatory exposure remains, including the possibility of statutory fines or penalties, NIHD expects applicable insurance policies to provide coverage for covered liabilities. Management currently considers the risk of a material adverse financial impact to the District to be low, but not zero.

Operational impact

NIHD devoted approximately 160 staff hours to validating and reconciling the affected population and associated data. Some work was performed by employees from other departments during available downtime without flexing schedules or incurring overtime; however, the majority of the internal workload was performed by NIHD's Compliance/Privacy Department. The primary operational impact was therefore staff time and diversion of Compliance/Privacy resources from normal responsibilities while the affected population was verified and the response coordinated.

Required breach-response activities

Because NIHD had not previously managed a breach of this scale, the response required coordinated legal, regulatory, notification, insurance, and patient-support activities. Privacy counsel and a third-party notification vendor coordinated through NIHD's cybersecurity insurer handled or supported the legal risk assessment, state and other regulatory notifications, individual notices, media and substitute notices where required, credit-monitoring and identity-protection services, and establishment and operation of the incident call center.

Financial impact

NIHD's cybersecurity insurance policy has a $50,000 per-incident retention, which represents the District's maximum direct insurance retention for covered breach-response expenses. Subject to policy terms and coverage determinations, covered expenses above the retention are paid through the cybersecurity insurance program. Accordingly, although the overall cost of responding to an incident affecting approximately 51,000 individuals is substantially greater than the District's retention, NIHD's direct out-of-pocket exposure for covered breach-response services is limited to $50,000, plus the internal cost associated with approximately 160 hours of staff time.

The District also continues to evaluate contractual responsibility associated with the legacy archive vendor and its successor. Any potential recovery or allocation of costs to the responsible third party would further reduce NIHD's ultimate financial impact.

Residual Legal and Regulatory Risk

Although NIHD's direct breach-response costs are substantially limited by its insurance coverage, the incident is not entirely without residual financial risk. There remains a potential for civil claims, statutory penalties, regulatory assessments, or fines arising from the incident or the notification process.

NIHD maintains insurance coverage that is expected to respond to covered civil liability and certain regulatory fines, penalties, or assessments, subject to applicable policy terms, exclusions, limits, and insurability under law. Accordingly, the District's current assessment is that the likelihood of a material uninsured financial

impact is low, but not zero.

The remaining exposure will depend on factors including the outcome of any regulatory review, whether any affected individuals assert claims, the applicability of insurance coverage to particular penalties or damages, and the extent to which NIHD may recover costs from Aesto or other responsible parties.

Release of Information Privacy Risk & Risk-Reduction Controls

Health Information Management auditing, monitoring, and control effectiveness | September 2026

Residual Risk: Very High

Release of Information is a high-risk privacy function because errors can result in unauthorized disclosure of protected health information. Health Information Management and Compliance auditing and monitoring are ongoing risk-reduction controls used to test workflow reliability, identify trends, and validate whether controls are functioning effectively.

Risk-reduction control structure

Health Information Management maintains operational responsibility for the Release of Information process. Compliance provides independent risk-based auditing, trend review, regulatory assessment, and escalation when monitoring identifies material control weakness or compliance risk. Monitoring intensity should remain proportionate to the inherent risk of the function and demonstrated control performance.

Ongoing oversight

- Maintain risk-based auditing and monitoring while Release of Information remains a high-risk privacy function.
- Trend results to identify recurring control weaknesses and determine when corrective action is needed.
- Use objective performance measures and sustained audit results to determine whether monitoring should be maintained, modified, reduced, or redirected.

Board oversight

Receive aggregate reporting on Release of Information risk trends, control effectiveness, corrective-action status, and any material privacy or regulatory concerns.

2026 Compliance Workplan - Draft

Purpose and Planning Approach

The 2026 workplan is intentionally limited to a small number of priority initiatives for the remainder of the calendar year. Core Compliance Program functions continue throughout the year and are not repeated as separate projects merely to create a longer workplan.

Ongoing Compliance Program Functions

- Board and executive compliance reporting and regulatory guidance; Compliance Program metrics reported through the Governance Committee.
- Quality-related UOR data reported by Compliance through the Quality Committee, with Compliance review and escalation when a UOR presents a compliance risk.
- Compliance education, onboarding, department-level education, one-on-one and just-in-time training, and security awareness education.
- Privacy and compliance investigations, breach risk assessments, required regulatory reporting, and complaint review.
- Ongoing risk-based Release of Information auditing and monitoring because Release of Information is a high-risk privacy function.
- Employee access auditing and third-party access review; exclusion screening; conflict-of-interest administration.
- Compliance-related contract and Business Associate Agreement review; policy and procedure oversight; regulatory research.
- California Public Records Act coordination, including request tracking, deadline management, search coordination, exemption/redaction review, documentation, and requester communication.
- Targeted auditing and monitoring based on identified risk, complaints, UORs, privacy events, billing/coding concerns, public-records activity, or regulatory priorities.

2026 Priority Action Items

1. Compliance Committee Reconstitution and Workplan Governance

Seven Element Alignment: Leadership, Oversight & Independence; Communication

2026 Deliverable: Reconstitute the Compliance Committee; finalize the charter; establish meeting cadence; obtain approval of the 2026 workplan; begin structured review of program activity, risk, Corrective Action Plans, and meaningful metrics.

Continuity: Use the Committee as the standing program oversight and review mechanism; mature the metric set and use results to guide annual priorities.

2. Corrective Action Plan Governance and Effectiveness Monitoring

Seven Element Alignment: Auditing & Monitoring; Response & Corrective Action; Enforcement & Accountability

2026 Deliverable: Implement centralized corrective-action tracking with responsible owner, due date, evidence of implementation, effectiveness review, closure criteria, and ongoing monitoring when indicated. Prioritize high-risk open actions, including Security Risk Analysis follow-up.

Continuity: Test sustained effectiveness, trend recurring findings, escalate overdue or ineffective actions, and incorporate results into risk assessment and audit planning.

3. Third-Party, Business Associate Agreement, High-Risk Contract, and Release of Information Risk Review

Seven Element Alignment: Policies & Procedures; Auditing & Monitoring; Response & Corrective Action

2026 Deliverable: Prioritize review of existing and legacy Business Associate Agreements and high-risk contracts following the recent third-party breach; verify required agreements, key privacy/security provisions, execution, access relationships, and continuing obligations. Continue risk-based Release of Information auditing as a high-risk privacy function.

Continuity: Expand recurring vendor/contract monitoring and continue risk-based Release of Information auditing based on risk and demonstrated control performance.

4. Enterprise Policy and Incident Management Modernization

Seven Element Alignment: Policies & Procedures; Communication; Auditing & Monitoring; Response & Prevention

2026 Deliverable: Participate in a Project Management-led, cross-functional evaluation of District-wide policy-management and incident-reporting systems, including workflow, interoperability, automation, regulatory/accreditation needs, reporting, usability, and long-term sustainability.

Continuity: Implement selected solutions and redesigned workflows; use improved policy and incident-management processes to strengthen monitoring, reporting, training, and corrective-action follow-up.

5. Risk-Based Monitoring Plan and 2027 Workplan Development

Seven Element Alignment: Auditing & Monitoring; Training; Leadership & Oversight

2026 Deliverable: Refresh the compliance risk assessment using UOR trends, privacy and Release of Information findings, billing/coding/denial concerns, regulatory developments, audit results, California Public Records Act activity, and Committee input. Establish or refine recurring billing, coding, and denial monitoring. Present the 2027 workplan for approval.

Continuity: Execute the 2027 risk-based audit program and adjust priorities as new regulatory, operational, privacy, billing, cybersecurity, or public-records risks emerge.

2026 to 2027 Continuity at a Glance

Area	2026	2027
Governance	Restart Committee and approve workplan	Recurring program-effectiveness oversight
Corrective Action	Build closed-loop tracking	Test sustained effectiveness and recurrence
Third-Party / Privacy Risk	Prioritize legacy BAAs, high-risk contracts, breach-related review, and high-risk ROI audits	Recurring risk-based vendor/contract/privacy/ROI audit cycle

Public Records	Standardize CPRA documentation and quarterly timeliness review	Continue quarterly CPRA log/documentation audits and trend complexity
Enterprise Systems	Cross-functional evaluation and selection	Implementation, integration, governance, and workflow redesign
Auditing	Refresh risk assessment and monitoring plan	Disciplined risk-based audit program, including accountability consistency
Sustainability	Document processes and continuity procedures	Pilot structured ownership review only with Executive Leadership approval

2027 Compliance Workplan - Draft

Purpose and Planning Approach

The 2027 plan intentionally continues the 2026 initiatives rather than restarting the program each calendar year. It shifts from governance and assessment work toward implementation, effectiveness testing, recurring risk-based auditing, and selected new audit priorities.

Ongoing Compliance Program Functions

- Board and executive compliance reporting and regulatory guidance; Compliance Program metrics reported through the Governance Committee.
- Quality-related UOR data reported by Compliance through the Quality Committee, with Compliance review and escalation when a UOR presents a compliance risk.
- Compliance education, onboarding, department-level education, one-on-one and just-in-time training, and security awareness education.
- Privacy and compliance investigations, breach risk assessments, required regulatory reporting, and complaint review.
- Ongoing risk-based Release of Information auditing and monitoring because Release of Information is a high-risk privacy function.
- Employee access auditing and third-party access review; exclusion screening; conflict-of-interest administration.
- Compliance-related contract and Business Associate Agreement review; policy and procedure oversight; regulatory research.
- California Public Records Act coordination, including request tracking, deadline management, search coordination, exemption/redaction review, documentation, and requester communication.
- Targeted auditing and monitoring based on identified risk, complaints, UORs, privacy events, billing/coding concerns, public-records activity, or regulatory priorities.

2027 Priority Action Items

1. Compliance Committee and Program Effectiveness

Seven Element Alignment: Leadership, Oversight & Independence; Communication

2027 Deliverable: Maintain regular Compliance Committee meetings; review meaningful metrics tied to the Seven Elements and NIHD's risk profile; review significant investigations, audit trends, corrective actions, education, exclusion screening, privacy/security, public-records trends, and emerging regulatory risk.

Continuity: Continuation of the 2026 Committee restart and governance work.

2. Corrective Action Effectiveness and Recurrence Monitoring

Seven Element Alignment: Auditing & Monitoring; Response & Corrective Action; Enforcement & Accountability

2027 Deliverable: Perform effectiveness reviews on closed corrective actions; identify recurring themes; escalate overdue or ineffective remediation; incorporate recurring issues into training, policy revisions, leadership follow-up, and audit planning.

Continuity: Continuation and maturation of the 2026 centralized corrective-action process.

3. Third-Party, Contract, Business Associate Agreement, and Privacy/Release of Information Audit Program

Seven Element Alignment: Policies & Procedures; Auditing & Monitoring; Response & Corrective Action

2027 Deliverable: Continue risk-based Business Associate Agreement and high-risk contract audits; verify vendor/access termination controls where applicable; continue Release of Information audits based on risk and demonstrated control performance; maintain privacy/security monitoring and targeted investigations.

Continuity: Builds directly on the 2026 third-party breach response, legacy agreement review, and high-risk Release of Information monitoring.

4. Enterprise Policy and Incident Management Implementation

Seven Element Alignment: Policies & Procedures; Communication; Auditing & Monitoring; Response & Prevention

2027 Deliverable: Implement or advance selected District-wide policy and incident-management systems and workflows. Establish cross-functional governance, training, reporting standards, appropriate automation, and monitoring expectations.

Continuity: Implementation phase of the 2026 cross-functional evaluation and selection process.

5. Risk-Based Compliance Audit Program

Seven Element Alignment: Auditing & Monitoring; Enforcement & Accountability

2027 Deliverable: Execute the annual risk-based monitoring plan, including recurring billing/coding/denial reviews and other priorities supported by data. Conduct a corrective-action and accountability consistency review. Add targeted audits based on Office of Inspector General, Centers for Medicare & Medicaid Services, California, accreditation, privacy/security, and NIHD-specific risks.

Continuity: Uses the 2026 risk assessment and monitoring framework to drive a disciplined annual audit cycle.

6. Structured Sustainability and Ownership Review

Seven Element Alignment: Leadership & Oversight; Auditing & Monitoring

2027 Deliverable: Pilot a structured review of selected mature Compliance-supported operational or system-administration functions. Document governance, control, continuity, and ownership considerations. Any ownership change requires Executive Leadership review and approval.

Continuity: Begins cautiously after 2026 documentation work and does not assume functions will be transferred.

Northern Inyo Healthcare District

Chief Financial Officer Report

Financial Summary and Operational Insights – July 2026

Date: September 2026
To: Board of Directors, Northern Inyo Healthcare District
From: Andrea Mossman, Chief Financial Officer

Executive Summary

Northern Inyo Healthcare District delivered an exceptionally strong financial performance in July 2026, with results significantly exceeding budget. The month benefited from strong patient volumes across multiple service lines, continued growth in surgical activity, favorable payor mix, improved revenue cycle performance, and strong non-operating income.

July net income was **$932,000, or $899,000 favorable to budget**. The operating loss of **$194,000 was $955,000 better than budget**, reflecting the strength of operating revenue despite higher expenses associated with increased patient activity.

Patient volumes remained strong across the organization, with particularly notable performance in orthopedic surgery, Emergency Department, diagnostic imaging, and rehabilitation. Surgical volume was **13% above budget**, continuing the positive trend in the District's surgical programs.

Higher volumes also resulted in increased expenses. Professional fees were $572,000 above budget, driven primarily by higher physician productivity, Labor & Delivery contract staffing, and increased cash collection fees. Labor management and expense discipline therefore remain important areas of focus as the organization continues to pursue growth.

Liquidity strengthened further during the month. Northern Inyo Healthcare District ended July with **114 days cash on hand and $40 million** in unrestricted cash, approximately $12 million higher than the prior year. Improvements in accounts receivable, bad debt, and aged receivables also contributed to stronger cash flow.

Overall, July results demonstrate continued momentum in patient volumes, surgical growth, revenue cycle performance, and liquidity while highlighting the need to manage labor and professional fees.

Financial Performance

July closed with **net income of $932,000**, exceeding budget by **$899,000**. The operating loss was **$194,000**, which was **$955,000 favorable to budget**.
The favorable operating performance was primarily attributable to:

- Strong patient volumes across several key service lines.
- Continued growth in orthopedic surgical activity.
- Higher-than-budgeted Emergency Department, rehabilitation, and diagnostic imaging volumes.
- A favorable payor mix, including a **2.7 percentage-point increase in Blue Cross volume compared with budget**, representing a favorable reimbursement impact.
- Continued improvements in revenue cycle performance and collections.

These gains were partially offset by higher operating expenses associated with increased patient activity, physician productivity, Labor & Delivery staffing requirements, and cash collection fees.
Board takeaway: July results reflect broad-based operational strength and continued surgical growth. Management remains focused on converting volume growth into sustainable operating improvement while maintaining discipline over the associated cost structure.

Volume and Operational Performance

Patient activity remained strong throughout July, with most major service lines exceeding budget.

Service Metric	July Performance
Admissions	85; in line with budget and **33% above July 2025**
Inpatient Days	**7% above budget**; 8% above prior year
Average Daily Census	8% below budget; 8% above prior year
Emergency Department Visits	**10% above budget**
Rehabilitation Visits	**12% above budget**
Rural Health Clinic Visits	9 visits below budget
Diagnostic Imaging	**8% above budget**
Surgical Cases	**15 cases / 13% above budget**

Orthopedic procedures continued to be the primary driver of surgical growth. The broad-based volume performance across inpatient and outpatient services supports the District’s strategic focus on expanding surgical programs and improving utilization of existing capacity.

Board takeaway: Volume growth remains a significant strength, particularly in surgical services, Emergency Department, imaging, and rehabilitation. Management will continue to evaluate capacity, scheduling, staffing, and resource utilization to ensure growth is financially sustainable.

Revenue Performance

July gross patient revenue exceeded budget by approximately **$3.0 million**, primarily reflecting higher patient volumes.

Contractual allowances increased in line with gross revenue; however, net patient revenue remained approximately **13% above budget** for the month.

The favorable payor mix, including higher Blue Cross volume, further supported reimbursement performance.

Continued improvement in coding, collections, denials management, and overall revenue cycle performance remains a priority as the District seeks to sustain these gains.

Expense Performance

Operating expenses were **$338,000, or 3%, above budget** in July.
Key expense variances included:

- **Salaries, wages, and benefits:** 2% above budget, primarily due to a higher average hourly rate and increased MDV expenses.
- **Supplies:** $1.8 million above budget, largely consistent with the significant increase in patient volumes.
- **Professional fees:** $572,000 above budget, driven by higher physician productivity, Labor & Delivery contract labor, and higher-than-budgeted cash collection fees.

While increased expenses are expected as volumes grow, management will continue to monitor whether incremental revenue is generating an appropriate contribution margin and will focus on opportunities to improve productivity and reduce unnecessary cost growth.

Labor and Workforce

Labor management remains a key organizational priority.

July contract labor expense was **$177,000 above budget**, with staffing challenges concentrated in several key areas, particularly Labor & Delivery. Contract staffing averaged approximately **3.4 FTEs above budget** during the month.

Salaries, wages, and benefits represented approximately **52% of operating expenses**, compared with the District's long-term goal of maintaining labor expense at **50% or less**.

Management's focus will remain on reducing reliance on agency labor, improving workforce productivity, aligning staffing with patient volumes, and strengthening recruitment and retention in areas with persistent staffing needs.

Cash and Liquidity

Liquidity remained strong and continued to improve during July.

- **Days Cash on Hand:** 114 days
- **Unrestricted Cash:** $40 million
- **Increase in unrestricted cash versus prior year:** approximately $12 million

Revenue cycle performance also continued to strengthen:

- **Accounts receivable days** improved by 9 days compared with July 2025.
- **Bad debt and write-offs** improved by $275,000 compared with July 2025.
- **Accounts receivable over 90 days** decreased by $733,000 compared with July 2025.

The combination of strong operating performance, improved collections, and disciplined cash management has materially strengthened the District's liquidity position.

Board takeaway: The District enters the remainder of FY2027 from a position of strong liquidity. Continued focus on revenue cycle performance and operating cash generation will be important to preserve this financial flexibility.

Strategic Priorities for Fiscal Year 2027

Management will continue to focus on the following priorities throughout FY2027:

- **Grow strategic service lines**, with continued expansion of orthopedic, urology, and general surgery programs.
- **Optimize operating room utilization** and improve clinic scheduling efficiency to maximize existing capacity.
- **Strengthen revenue cycle performance** through improved coding, denials management, collections, and cash conversion.
- **Improve labor productivity** and reduce reliance on contract and agency staffing.

- **Reduce supply and operating room costs** through supply chain management, standardization, and utilization initiatives.
- **Maintain expense discipline** while investing in service-line growth and other strategic priorities.
- **Protect liquidity and financial flexibility** through continued focus on operating performance and cash generation.

Conclusion

July 2026 was a strong month for Northern Inyo Healthcare District. Revenue and patient volumes significantly exceeded expectations, surgical growth continued, revenue cycle performance improved, and liquidity strengthened.

At the same time, management recognizes that sustained volume growth must be accompanied by disciplined management of labor, supplies, professional fees, and other variable costs. The FY2027 focus will therefore remain on achieving profitable growth, improving operational efficiency, and preserving the District's strong liquidity position.

Northern Inyo Healthcare District

July 2026 – Financial Summary

** Variances are B / (W)	Current Month				Prior MTD			Year to Date				Prior YTD		
	Actual	**Budget**	**Variance**	**Variance %**	**Actual**	**Change**	**Change %**	**Actual**	**Budget**	**Variance**	**Variance %**	**Actual**	**Change**	**Change %**
Net Income (Loss)	931,657	32,456	899,201	2,770%	1,708,447	(776,790)	45%	931,657	32,456	899,201	(2,770%)	1,708,447	(776,790)	(45%)
Operating Income (Loss)	(193,757)	(1,148,504)	954,747	(83%)	1,126,706	(1,320,463)	117%	(193,757)	(1,148,504)	954,747	83%	1,126,706	(1,320,463)	(117%)
EBIDA (Loss)	1,433,540	473,415	960,126	203%	2,149,780	(716,240)	33%	1,433,540	473,415	960,126	(203%)	2,149,780	(716,240)	(33%)
IP Gross Revenue	4,579,167	4,104,865	474,302	12%	3,914,942	664,225	17%	4,579,167	4,104,865	474,302	12%	3,914,942	664,225	17%
OP Gross Revenue	17,637,358	15,146,266	2,491,091	16%	13,644,556	3,992,802	29%	17,637,358	15,146,266	2,491,091	16%	13,644,556	3,992,802	29%
Clinic Gross Revenue	1,962,654	1,916,013	46,641	2%	1,578,797	383,857	24%	1,962,654	1,916,013	46,641	2%	1,578,797	383,857	24%
Total Gross Revenue	**24,179,179**	**21,167,144**	**3,012,035**	**14%**	**19,138,295**	**5,040,884**	**26%**	**24,179,179**	**21,167,144**	**3,012,035**	**14%**	**19,138,295**	**5,040,884**	**26%**
Net Patient Revenue	**11,143,101**	**9,850,118**	**1,292,983**	**13%**	**10,473,138**	**669,963**	**6%**	**11,143,101**	**9,850,118**	**1,292,983**	**13%**	**10,473,138**	**669,963**	**6%**
Cash Net Revenue % of Gross	*46%*	*47%*	*(0%)*	*(1%)*	*55%*	*(9%)*	*(16%)*	*46%*	*47%*	*(0%)*	*(1%)*	*55%*	*(9%)*	*(16%)*
Admits (excl. Nursery)	85	85	-	-%	64	21	33%	85	85	-	-%	64	21	33%
IP Days	268	252	17	7%	245	24	10%	268	252	17	7%	245	24	10%
IP Days (excl. Nursery)	230	220	11	5%	213	18	8%	230	220	11	5%	213	18	8%
Average Daily Census	7.4	8.1	(0.7)	(8%)	6.9	0.6	8%	7.4	8	(0.7)	(8%)	6.9	0.6	8%
ALOS	2.7	3.0	(0.2)	(8%)	3.3	(0.6)	(18%)	2.7	3	(0.2)	(8%)	3.3	(0.6)	(18%)
Deliveries	16	21	(5)	(24%)	21	(5)	(24%)	16	21	(5)	(24%)	21	(5)	(24%)
OP Visits	4,543	4,118	425	10%	4,118	425	10%	4,543	4,118	425	10%	4,118	425	10%
Rural Health Clinic Visits	2,250	2,339	(89)	(4%)	2,233	17	1%	2,250	2,339	(89)	(4%)	2,233	17	1%
Rural Health Women Visits	645	548	97	18%	548	97	18%	645	548	97	18%	548	97	18%
Rural Health Behavioral Visits	89	106	(17)	(16%)	106	(17)	(16%)	89	106	(17)	(16%)	106	(17)	(16%)
Total RHC Visits	**2,984**	**2,993**	**(9)**	**(0%)**	**2,887**	**97**	**3%**	**2,984**	**2,993**	**(9)**	**(0%)**	**2,887**	**97**	**3%**
Bronco Clinic Visits	-	-	-	-%	-	-	-%	-	-	-	-%	-	-	-%
Internal Medicine Clinic Visits	-	-	-	-%	-	-	-%	-	-	-	-%	-	-	-%
Orthopedic Clinic Visits	366	321	45	14%	321	45	14%	366	321	45	14%	321	45	14%
Pediatric Clinic Visits	568	536	32	6%	536	32	6%	568	536	32	6%	536	32	6%
Specialty Clinic Visits	732	657	75	11%	644	88	14%	732	657	75	11%	644	88	14%
Surgery Clinic Visits	155	168	(13)	(8%)	138	17	12%	155	168	(13)	(8%)	138	17	12%
Virtual Care Clinic Visits	-	-	-	-%	41	(41)	(100%)	-	-	-	-%	41	(41)	(100%)
Total NIA Clinic Visits	**1,821**	**1,682**	**139**	**8%**	**1,680**	**141**	**8%**	**1,821**	**1,682**	**139**	**8%**	**1,680**	**141**	**8%**
IP Surgeries	12	13	(1)	(8%)	6	6	100%	12	13	(1)	(8%)	6	6	100%
OP Surgeries	123	107	16	15%	115	8	7%	123	107	16	15%	115	8	7%
Total Surgeries	**135**	**120**	**15**	**13%**	**121**	**14**	**12%**	**135**	**120**	**15**	**13%**	**121**	**14**	**12%**
Cardiology	6	3	3	100%	-	6	100%	6	3	3	100%	-	6	-%
General	70	71	(1)	(1%)	69	1	1%	70	71	(1)	(1%)	69	1	1%
Gynecology & Obstetrics	13	9	4	44%	11	2	18%	13	9	4	44%	11	2	18%
Ophthalmology	-	-	-	-%	17	(17)	(100%)	-	-	-	-%	17	(17)	(100%)
Orthopedic	38	25	13	52%	15	23	153%	38	25	13	52%	15	23	153%
Pediatric	-	-	-	-%	-	-	-%	-	-	-	-%	-	-	-%
Plastics	-	-	-	-%	-	-	-%	-	-	-	-%	-	-	-%
Podiatry	-	-	-	-%	-	-	-%	-	-	-	-%	-	-	-%
Urology	8	12	(4)	(33%)	9	(1)	(11%)	8	12	(4)	(33%)	9	(1)	(11%)
Diagnostic Image Exams	2,520	2,343	177	8%	2,326	194	8%	2,520	2,343	177	8%	2,326	194	8%
Emergency Visits	1,021	931	90	10%	922	99	11%	1,021	931	90	10%	922	99	11%
ED Admits	57	37	20	54%	37	20	54%	57	37	20	54%	37	20	54%
ED Admits % of ED Visits	6%	4%	2%	40%	4%	2%	39%	6%	4%	2%	40%	4%	2%	39%
Rehab Visits	970	863	107	12%	820	150	18%	970	863	107	12%	820	150	18%
OP Infusion/Wound Care Visits	780	535	245	46%	535	245	46%	780	535	245	46%	535	245	46%
Observation Hours	1,540	1,344	196	15%	1,344	196	15%	1,540	1,344	196	15%	1,344	196	15%

Provided by: Chief Financial Officer
Report Name: July 2026 Financial Summary

Northern Inyo Healthcare District

July 2026 – Financial Summary

** Variances are B / (W)	Current Month				Prior MTD			Year to Date				Prior YTD		
	Actual	Budget	Variance	Variance %	Actual	Change	Change %	Actual	Budget	Variance	Variance %	Actual	Change	Change %
PAYOR MIX (Patient Days)														
Blue Cross	25.5%	16.4%	9.1%	55.2%	16.4%	9.1%	55.2%	25.5%	16.4%	9.1%	55.2%	16.4%	9.1%	55.2%
Commercial	4.8%	-%	4.8%	-%	-%	4.8%	-%	4.8%	-%	4.8%	-%	-%	4.8%	-%
Medicaid	29.7%	22.7%	7.1%	31.1%	22.7%	7.1%	31.1%	29.7%	22.7%	7.1%	31.1%	22.7%	7.1%	31.1%
Medicare	35.0%	53.9%	(18.9%)	(35.1%)	53.9%	(18.9%)	(35.1%)	35.0%	53.9%	(18.9%)	(35.1%)	53.9%	(18.9%)	(35.1%)
Self-pay	4.3%	7.0%	(2.7%)	(38.8%)	7.0%	(2.7%)	(38.8%)	4.3%	7.0%	(2.7%)	(38.8%)	7.0%	(2.7%)	(38.8%)
Worker's Comp	0.7%	-%	0.7%	-%	-%	0.7%	-%	0.7%	-%	0.7%	-%	-%	0.7%	-%
Other	-%	-%	-%	-%	-%	-%	-%	-%	-%	-%	-%	-%	-%	-%
PAYOR MIX (Gross Revenue)														
Blue Cross	29.0%	26.3%	2.7%	10.2%	26.3%	2.7%	10.2%	29.0%	26.3%	2.7%	10.2%	26.3%	2.7%	10.2%
Commercial	6.4%	5.9%	0.6%	9.6%	5.9%	0.6%	9.6%	6.4%	5.9%	0.6%	9.6%	5.9%	0.6%	9.6%
Medicaid	19.4%	18.9%	0.6%	3.0%	18.9%	0.6%	3.0%	19.4%	18.9%	0.6%	3.0%	18.9%	0.6%	3.0%
Medicare	40.2%	45.2%	(5.0%)	(11.1%)	45.2%	(5.0%)	(11.1%)	40.2%	45.2%	(5.0%)	(11.1%)	45.2%	(5.0%)	(11.1%)
Self-pay	3.4%	2.8%	0.6%	21.5%	2.8%	0.6%	21.5%	3.4%	2.8%	0.6%	21.5%	2.8%	0.6%	21.5%
Worker's Comp	1.4%	0.7%	0.8%	111.0%	0.7%	0.8%	111.0%	1.4%	0.7%	0.8%	111.0%	0.7%	0.8%	111.0%
Other	0.1%	0.2%	(0.1%)	(59.4%)	0.2%	(0.1%)	(59.4%)	0.1%	0.2%	(0.1%)	(59.4%)	0.2%	(0.1%)	(59.4%)
DEDUCTIONS														
Contract Adjust	(13,045,153)	(10,606,853)	(2,438,300)	23%	(8,798,796)	(4,246,357)	48%	(13,045,153)	(10,606,853)	(2,438,300)	23%	(8,798,796)	(4,246,357)	48%
Bad Debt	305,386	(421,653)	727,040	(172%)	654,669	(349,283)	(53%)	305,386	(421,653)	727,040	(172%)	654,669	(349,283)	(53%)
Write-off	(296,521)	(434,769)	138,248	(32%)	(370,847)	74,326	(20%)	(296,521)	(434,769)	138,248	(32%)	(370,847)	74,326	(20%)
CENSUS														
Patient Days	230	220	11	5%	213	18	8%	230	220	11	5%	213	18	8%
Adjusted ADC	39	42	(3)	(6%)	39	(0)	(0%)	39	42	(3)	(6%)	34	6	17%
Adjusted Days	1,217	1,298	(81)	(6%)	1,040	177	17%	1,217	1,298	(81)	(6%)	1,040	177	17%
Employed FTE	377.9	376.5	1.4	0%	376.5	1.4	0%	377.9	376.5	1.4	0%	376.5	1.4	0%
Contract Labor FTE	22.7	19.4	3.4	17%	19.4	3.4	17%	22.7	19.4	3.4	17%	19.4	3.4	17%
Total Paid FTE	400.6	395.8	4.8	1%	395.8	4.8	1%	400.6	395.8	4.8	1%	395.8	4.8	1%
EPOB (Employee per Occupied Bed)	1.7	1.9	(0.1)	(7%)	1.9	(0.1)	(7%)	1.7	1.9	(0.1)	(7%)	1.9	(0.1)	(7%)
EPOC (Employee per Occupied Case)	0.3	0.3	0.0	2%	0.3	0.0	2%	0.3	0.3	0.0	2%	0.4	(0.1)	(13%)
Adjusted EPOB	9.2	9.1	0.1	1%	9.1	0.1	1%	9.2	9.1	0.1	1%	9.1	0.1	1%
Adjusted EPOC	1.7	1.6	0.2	10%	1.6	0.2	10%	1.7	1.6	0.2	10%	1.9	(0.1)	(6%)
SALARIES														
Per Adjust Bed Day	3,193	2,945	249	8%	3,231	(37)	(1%)	3,193	2,945	249	8%	3,231	(37)	(1%)
Total Salaries	3,885,878	3,822,680	63,198	2%	3,359,076	526,802	16%	3,885,878	3,822,680	63,198	2%	3,359,076	526,802	16%
Average Hourly Rate	58.05	57.32	0.73	1%	50.37	7.69	15%	58.05	57.32	0.73	1%	50.37	7.69	15%
Employed Paid FTEs	377.9	376.5	1.4	375.1	376.5	1.4	0%	377.9	376.5	1.4	0%	376.5	1.4	0%
BENEFITS														
Per Adjust Bed Day	1,279	1,155	124	11%	1,451	(173)	(12%)	1,279	1,155	124	11%	1,451	(173)	(12%)
Total Benefits	1,556,100	1,498,699	57,401	4%	1,509,047	47,053	3%	1,556,100	1,498,699	57,401	4%	1,509,047	47,053	3%
Benefits % of Wages	40%	39%	1%	2%	45%	-5%	(11%)	40%	39%	1%	2%	45%	(5%)	(11%)
Pension Expense	327,953	359,697	(31,744)	(9%)	446,946	(118,993)	(27%)	327,953	359,697	(31,744)	(9%)	446,946	(118,993)	(27%)
MDV Expense	941,754	782,746	159,008	20%	704,677	237,077	34%	941,754	782,746	159,008	20%	704,677	237,077	34%
Taxes, PTO accrued, Other	286,393	356,256	(69,864)	(20%)	357,423	(71,031)	(20%)	286,393	356,256	(69,864)	(20%)	357,423	(71,031)	(20%)
Salaries, Wages & Benefits	5,441,978	5,321,379	120,599	2%	4,868,122	573,856	12%	5,441,978	5,321,379	120,599	2%	4,868,122	573,856	12%
SWB/APD	4,472	4,099	373	9%	4,682	(210)	(4%)	4,472	4,099	373	9%	4,682	(210)	(4%)
SWB % of Total Expenses	48%	48%	(0%)	(1%)	52%	(4%)	(8%)	52%	51%	1%	2%	58%	(6%)	(10%)

Provided by: Chief Financial Officer
Report Name: July 2026 Financial Summary

Northern Inyo Healthcare District

July 2026 – Financial Summary

** Variances are B / (W)	Current Month				Prior MTD			Year to Date				Prior YTD		
	Actual	Budget	Variance	Variance %	Actual	Change	Change %	Actual	Budget	Variance	Variance %	Actual	Change	Change %
PROFESSIONAL FEES														
Per Adjust Bed Day	2,805	2,188	617	28%	2,279	526	23%	2,805	2,188	617	28%	2,279	526	23%
Total Physician Fee	1,984,916	1,862,464	122,452	7%	1,553,004	431,912	28%	1,984,916	1,862,464	122,452	7%	1,553,004	431,912	28%
Total Contract Labor	438,597	261,317	177,280	68%	507,387	(68,790)	(14%)	438,597	261,317	177,280	68%	507,387	(68,790)	(14%)
Total Other Pro-Fees	989,599	716,913	272,686	38%	309,118	680,481	220%	989,599	716,913	272,686	38%	309,118	680,481	220%
Total Professional Fees	3,413,111	2,840,694	572,418	20%	2,369,508	1,043,603	44%	3,413,111	2,840,694	572,418	20%	2,369,508	1,043,603	44%
Contract AHR	108.85	76.20	32.65	43%	147.96	(39.11)	(26%)	108.85	76.20	32.65	43%	147.96	(39.11)	(26%)
Contract Paid FTEs	22.7	19.4	3.4	17%	19.4	3.4	17%	22.7	19.4	3.4	17%	19.4	3.4	17%
Physician Fee per Adjust Bed Day	1,631	1,435	196	14%	1,494	138	9%	1,631	1,435	196	14%	1,494	138	9%
PHARMACY														
Per Adjust Bed Day	339	323	17	5%	73	266	362%	339	323	17	5%	73	266	362%
Total Rx Expense	412,925	418,961	(6,036)	(1%)	76,416	336,509	440%	412,925	418,961	(6,036)	(1%)	76,416	336,509	440%
MEDICAL SUPPLIES														
Per Adjust Bed Day	461	525	(64)	(12%)	619	(158)	(26%)	461	525	(64)	(12%)	619	(158)	(26%)
Total Medical Supplies	560,387	681,358	(120,971)	(18%)	643,409	(83,022)	(13%)	560,387	681,358	(120,971)	(18%)	643,409	(83,022)	(13%)
EHR SYSTEM														
Per Adjust Bed Day	24	42	(18)	(42%)	151	(126)	(84%)	24	42	(18)	(42%)	151	(126)	(84%)
Total EHR Expense	29,771	54,679	(24,908)	(46%)	156,658	(126,887)	(81%)	29,771	54,679	(24,908)	(46%)	156,658	(126,887)	(81%)
OTHER EXPENSE														
Per Adjust Bed Day	803	956	(153)	(16%)	761	42	6%	803	956	(153)	(16%)	761	42	6%
Total Other	976,802	1,240,594	(263,791)	(21%)	790,986	185,817	23%	976,802	1,240,594	(263,791)	(21%)	790,986	185,817	23%
DEPRECIATION AND AMORTIZATION														
Per Adjust Bed Day	412	340	73	21%	424	(12)	(3%)	412	340	73	21%	424	(12)	(3%)
Total Depreciation and Amortization	501,883	440,958	60,925	14%	441,333	60,550	14%	501,883	440,958	60,925	14%	441,333	60,550	14%
TOTAL EXPENSES	11,336,858	10,998,623	338,236	3%	9,346,432	1,990,426	21%	11,336,858	10,998,623	338,236	3%	9,346,432	1,990,426	21%
Per Adjust Bed Day	9,317	8,473	844	10%	8,989	328	4%	9,317	8,473	844	10%	8,989	328	4%
Per Calendar Day	365,705	354,794	10,911	3%	301,498	64,207	21%	365,705	354,794	10,911	3%	301,498	64,207	21%

Provided by: Chief Financial Officer
Report Name: July 2026 Financial Summary

Key Financial Performance Indicators	Industry Benchmark	Jul-24	FYE 2025 Average	Jul-25	Jun-26	FYE 2026 Average	Jul-26	Variance to PM	Variance to FYE 2026 Average	Variance to PYM
Volume										
Admits	41	75	69	64	87	75	87	-	12	23
Deliveries	n/a	18	17	21	17	16	16	(1)	(0)	(5)
Adjusted Patient Days	n/a	1,164	977	1,218	1,189	1,098	1,217	28	119	(1)
Total Surgeries	153	134	141	121	152	138	135	(17)	(3)	14
ER Visits	659	903	837	922	897	849	1,021	124	172	99
RHC and Clinic Visits	n/a	4,252	4,772	4,567	4,851	4,771	4,805	(46)	34	238
Diagnostic Imaging Services	n/a	2,274	2,129	2,326	2,381	2,241	2,520	139	279	194
Rehab Services	n/a	719	838	820	849	816	970	121	154	150
AR & Income										
Gross AR (Cerner only)	n/a	$ 56,859,164	$ 50,813,697	$ 43,999,341	$ 49,621,284	$ 43,895,991	$ 48,479,909	$ (1,141,375)	$ 4,583,918	$ 4,480,568
AR > 90 Days	$ 7,271,986.32	$ 24,988,857	$ 19,638,850	$ 17,867,182	$ 16,901,235	$ 15,623,287	$ 17,133,809	$ 232,574	$ 1,510,522	$ (733,373)
AR % > 90 Days	15%	44.5%	38.6%	40.6%	34.1%	35.8%	35.3%	1.3%	-0.4%	-5.3%
Gross AR Days (per financial statements)	60	92	80	71	64	63	62	(2)	(1)	(9)
Net AR Days (per financial statements)	30	54	71	62	40	65	60	21	(5)	(2)
Net AR	n/a	$ 18,219,994	$ 19,370,868	$ 16,184,152	$ 21,326,669	$ 20,633,479	$ 21,593,930	$ 267,260	$ 960,450	$ 5,409,777
Net AR % of Gross	n/a	32.0%	38.5%	36.8%	43.0%	46.4%	44.5%	1.6%	-1.9%	7.8%
Gross Patient Revenue/Calendar Day	n/a	$ 617,364	$ 634,418	$ 620,270	$ 777,717	$ 694,615	$ 779,974	$ 2,256	$ 85,359	$ 159,703
Net Patient Revenue/Calendar Day	n/a	$ 337,843	$ 273,563	$ 260,693	$ 427,684	$ 319,513	$ 359,455	$ (68,229)	$ 39,942	$ 98,762
Net Patient Revenue/APD	n/a	$ 8,998	$ 8,088	$ 6,636	$ 10,793	$ 8,978	$ 9,157	$ (1,636)	$ 179	$ 2,522
Wages										
Wages	n/a	$ 3,359,076	$ 3,661,965	$ 3,623,073	$ 3,763,985	$ 3,705,110	$ 3,885,878	$ 121,893	$ 180,768	$ 262,805
Employed paid FTEs	n/a	361.94	370.77	376.49	391.92	379.65	377.87	(14.05)	(1.78)	1.38
Employed Average Hourly Rate	$55.50	$ 52.54	$ 56.78	$ 54.47	$ 56.18	$ 56.30	$ 58.21	$ 2.04	$ 1.91	$ 3.74
Benefits	n/a	$ 1,509,407	$ 1,401,858	$ 1,460,662	$ (613,596)	$ 1,312,122	$ 1,556,100	$ 2,169,696	$ 243,978	$ 95,438
Benefits % of Wages	30%	44.9%	39.0%	40.3%	-16.3%	35.6%	40.0%	56.3%	4.4%	-0.3%
Contract Labor	n/a	$ 507,387	$ 447,445	$ 285,536	$ 402,182	$ 361,823	$ 438,597	$ 36,415	$ 76,773	$ 153,061
Contract Labor Paid FTEs	n/a	27.86	23.89	19.36	17.06	19.55	22.75	5.69	3.20	3.39
Total Paid FTEs	n/a	389.80	394.65	395.85	408.98	399.20	400.62	(8.36)	1.42	4.77
Contract Labor Average Hourly Rate	$ 81.04	$ 103.08	$ 117.91	$ 83.49	$ 137.89	$ 106.68	$ 109.15	$ (28.74)	$ 2.47	$ 25.66
Total Salaries, Wages, & Benefits	n/a	$ 5,375,870	$ 5,511,268	$ 5,369,271	$ 3,552,571	$ 5,379,055	$ 5,880,575	$ 2,328,004	$ 501,520	$ 511,304
SWB% of NR	50%	51.3%	70.3%	51.3%	27.7%	56.0%	56.1%	28.5%	0.1%	4.9%
SWB/APD	2,416	$ 4,618	$ 5,064	$ 4,409	$ 2,988	$ 5,020	$ 4,833	$ 1,844	$ (187)	$ 424
SWB % of total expenses	50%	59.6%	57.3%	54.5%	44.0%	51.7%	51.9%	7.8%	0.2%	-2.6%

Physician Spend	Industry Benchmark	Jul-24	FYE 2025 Average	Jul-25	Jun-26	FYE 2026 Average	Jul-26	Variance to PM	Variance to FYE 2026 Average	Variance to PYM
Physician Expenses	n/a	$ 1,369,822	$ 1,507,510	$ 1,509,326	$ 1,894,150	$ 1,811,516	$ 1,984,916	$ 90,765	$ 173,400	$ 475,590
Physician expenses/APD	n/a	$ 1,177	$ 1,476	$ 1,239	$ 1,593	$ 1,676	$ 1,631	$ 38	$ (45)	$ 392
Supplies										
Supply Expenses	n/a	$ 786,000	$ 776,504	$ 832,800	$ 816,217	$ 967,638	$ 973,312	$ 157,096	$ 5,674	$ 140,512
Supply expenses/APD		$ 675	$ 744	$ 684	$ 687	$ 892	$ 800	$ 113	$ (92)	$ 116
Other Expenses										
Other Expenses	n/a	$ 1,871,006	$ 1,824,207	$ 2,141,584	$ 1,806,779	$ 2,214,853	$ 2,498,056	$ 691,277	$ 283,203	$ 356,472
Other Expenses/APD	n/a	$ 1,607	$ 1,787	$ 1,758	$ 1,520	$ 2,068	$ 2,053	$ 533	$ (15)	$ 294
Margin										
Net Income	n/a	$ (341,503)	$ 383,722	$ (1,345,152)	$ 4,778,752	$ 877,257	$ 931,657	$ (3,847,095)	$ 54,400	$ 2,276,809
Net Profit Margin	n/a	-3.9%	3.0%	-16.6%	37.2%	7.0%	8.4%	-28.9%	1.4%	25.0%
Operating Income	n/a	$ (590,588)	$ (686,444)	$ (1,771,492)	$ 4,760,792	$ (671,709)	$ (193,757)	$ (4,954,549)	$ 477,952	$ 1,577,735
Operating Margin	2.9%	-6.8%	-9.9%	-21.9%	37.1%	-9.9%	-1.7%	-38.8%	8.2%	20.2%
EBITDA	n/a	$ (16,938)	$ 841,891	$ (911,671)	$ 5,269,239	$ 1,346,683	$ 1,433,540	$ (3,835,699)	$ 86,857	$ 2,345,211
EBITDA Margin	12.7%	0.2%	9.0%	-11.3%	41.1%	11.9%	12.9%	-28.2%	1.0%	24.1%
Debt Service Coverage Ratio	3.70	60.0%	3.9	(4.5)	5.6	(0.1)	0.5	(5.1)	0.6	5.0
Cash										
Avg Daily Disbursements (excl. IGT)	n/a	$ 296,364	$ 355,328	$ 347,474	$ 507,119	$ 430,840	$ 376,919	$ (130,199)	$ (53,921)	$ 29,445
Average Daily Cash Collections (excl. IGT)	n/a	$ 254,229	$ 340,919	$ 289,930	$ 342,069	$ 335,789	$ 359,424	$ 17,355	$ 23,635	$ 69,494
Average Daily Net Cash		$ (42,135)	$ (14,409)	$ (57,544)	$ (165,049)	$ (95,051)	$ (17,495)	$ 147,554	$ 77,556	$ 40,049
Upfront Cash Collections		$ 59,145	$ 36,146	$ 77,997	$ 69,792	$ 66,519	$ 59,895	$ (9,896)	$ (6,623)	$ (18,101)
Upfront Cash % of Gross Charges	1%	0%	0.2%	0.4%	0.3%	0.3%	0.2%	-0.1%	-0.1%	-0.2%
Unrestricted Funds	n/a	$ 30,155,529	$ 23,536,438	$ 28,084,672	$ 39,597,763	$ 28,328,253	$ 39,973,321	$ 375,558	$ 11,645,068	$ 11,888,649
Change of cash per balance sheet	n/a	$ 1,158,888	$ (321,485)	$ 2,945,857	$ 1,821,634	$ 1,204,912	$ 375,558	$ (1,446,076)	$ (829,354)	$ (2,570,298)
Days Cash on Hand (assume no more cash is collected)	196	102	73	92	122	88	114	(7)	26	22
Estimated Days Until Depleted (operating cash only)		716	1,633	499	417	466	447	30	(20)	(52)
Years Until Cash Depletion (operating cash only)		1.96	4.48	1.37	1.14	1.28	1.22	0.08	(0.05)	(0.14)

NIHD Financial Update

Chief Financial Officer

July 2026 Results

Northern Inyo Healthcare District

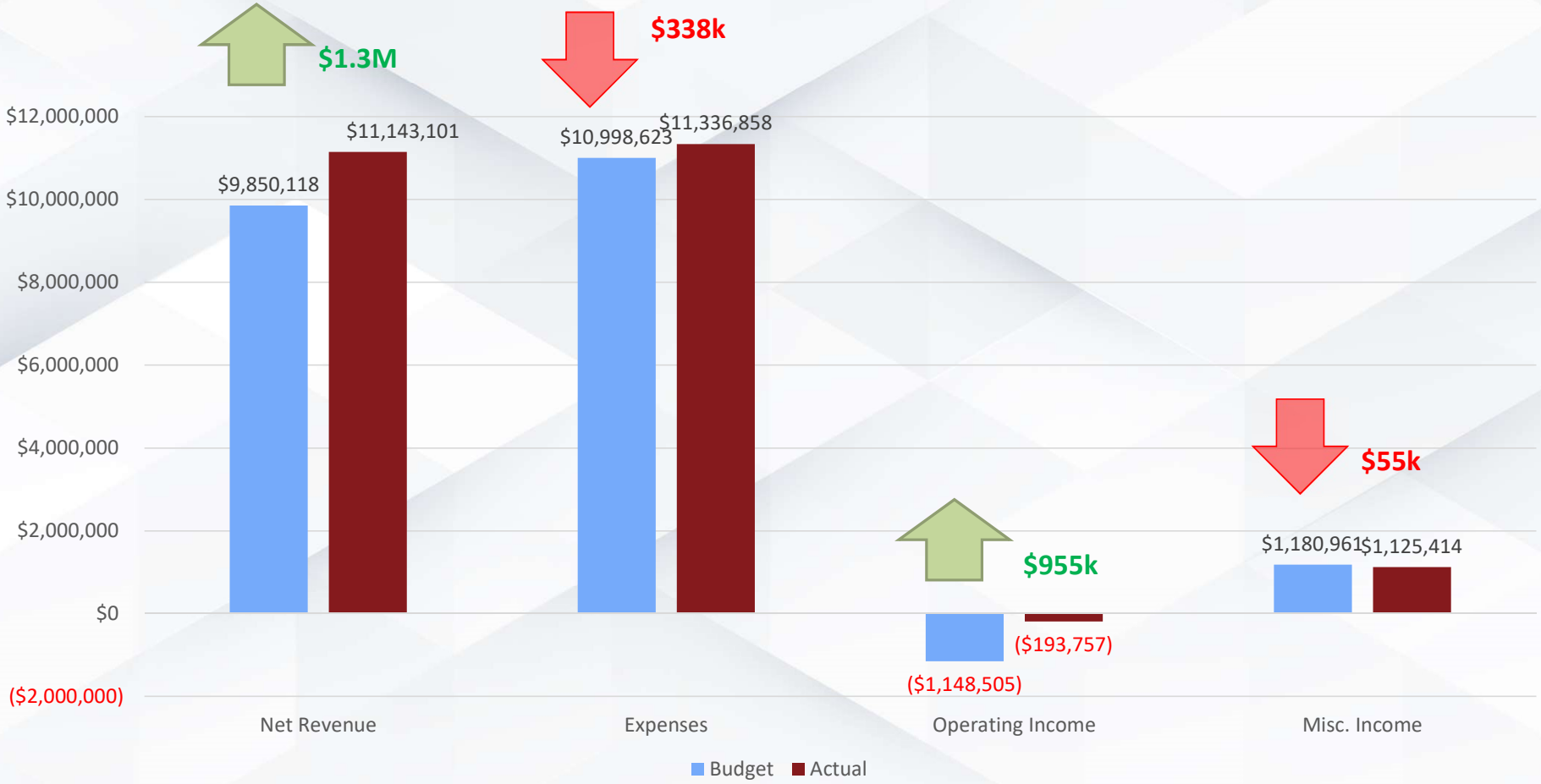
INCOME PERFORMANCE

NORTHERN INYO HEALTHCARE DISTRICT

Net Income


$1,000,000
$900,000
$800,000
$700,000
$600,000
$500,000
$400,000
$300,000
$200,000
$100,000
$0
$931,657
$899k
$32,456
Net Income
Budget
Actual

Income to Budget



Volume & Income Action plan

- Surgical volumes were better than budget in orthopedics.
- 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.
- We are working on a staff benchmarking analysis to determine if we are appropriately staffing by skill mix in all departments.
- Leaders are doing a great job of managing their expenses and helping build budgets for the next fiscal year.

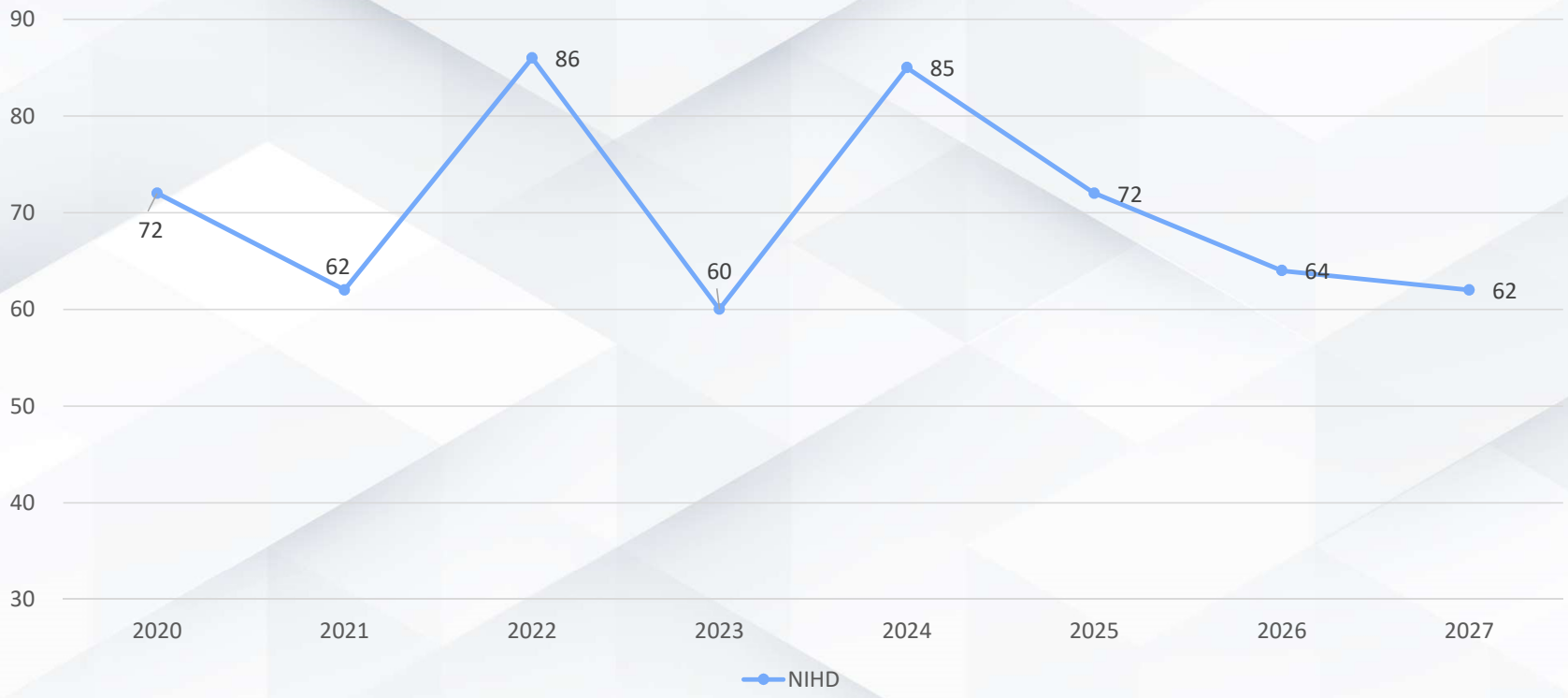
Cash Performance

NORTHERN INYO HEALTHCARE DISTRICT

Income to Cash

	FYE 2026
Net Income (loss)	**$931,657**
Principal Payments on Long-Term Debt (balance sheet only)	$0
Other Debt (long-term leases & subscriptions – balance sheet only)	$(107,095)
Capital purchases (balance sheet only)	$(8,694)
Timing of accruals vs cash	$(440,315)
Impact to Cash	**$(556,104)**
Adjusted Net Income (cash basis)	**$375,553**

Gross AR Days



Debt Service Coverage Ratio

Days Cash on Hand

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 automation is working well and we continue to meet with them to find more opportunities to automate and improve cash.
- We have moved $20M in cash to Five Star Bank to earn better returns on our cash.
- We have another $11M in the LAIF Earning over 4% interest.
- AR days are at a record low for the organization.

Northern Inyo Healthcare District
Income Statement
Fiscal Year 2027

	7/31/2026	Jul Budget	7/31/2025	2027 YTD	Budget Variance	PYM Change
Gross Patient Service Revenue						
Inpatient Patient Revenue	4,579,167	4,104,865	3,358,250	4,579,167	474,302	1,220,916
Outpatient Revenue	17,637,358	15,146,266	14,063,969	17,637,358	2,491,091	3,573,389
Clinic Revenue	1,962,654	1,916,013	1,806,164	1,962,654	46,641	156,490
Gross Patient Service Revenue	24,179,179	21,167,144	19,228,383	24,179,179	3,012,035	4,950,796
Deductions from Revenue						
Contractual Adjustments	(13,045,153)	(10,606,853)	(9,525,069)	(13,045,153)	(2,438,300)	(3,520,084)
Bad Debt	305,386	(421,653)	(1,264,234)	305,386	727,040	1,569,620
A/R Writeoffs	(296,521)	(434,769)	(357,591)	(296,521)	138,248	61,071
Other Deductions from Revenue	-	146,249	-	-	(146,249)	-
Deductions from Revenue	(13,036,287)	(11,317,026)	(11,146,895)	(13,036,287)	(1,719,262)	(1,889,392)
Other Patient Revenue						
Incentive Income	210	-	-	210	210	210
Other Oper Rev - Rehab Thera Serv	-	-	-	-	-	-
Medical Office Net Revenue	-	-	-	-	-	-
Other Patient Revenue	210	-	-	210	210	210
Net Patient Service Revenue	**11,143,101**	**9,850,118**	**8,081,488**	**11,143,101**	**1,292,983**	**3,061,613**
CNR%	**46.1%**	**46.5%**	**42.0%**	**46.1%**	**-0.4%**	**4.1%**
Cost of Services - Direct						
Salaries and Wages	3,290,203	3,822,680	3,094,605	3,290,203	(532,477)	195,598
Benefits	1,298,976	1,498,699	1,252,765	1,298,976	(199,723)	46,211
Professional Fees	2,260,084	2,579,376	1,650,515	2,260,084	(319,292)	609,569
Contract Labor	378,756	261,317	190,675	378,756	117,439	188,081
Pharmacy	412,925	418,961	444,467	412,925	(6,036)	(31,542)
Medical Supplies	560,387	681,358	388,333	560,387	(120,971)	172,054
Hospice Operations	-	-	-	-	-	-
EHR System Expense	29,771	54,679	54,679	29,771	(24,908)	(24,908)
Other Direct Expenses	716,136	1,240,594	785,085	716,136	(524,457)	(68,948)
Total Cost of Services - Direct	8,947,239	10,557,664	7,861,124	8,947,239	(1,610,425)	1,086,115
General and Administrative Overhead						
Salaries and Wages	595,675	-	528,468	595,675	595,675	67,207
Benefits	257,124	-	207,897	257,124	257,124	49,226
Professional Fees	714,430	-	503,103	714,430	714,430	211,327
Contract Labor	59,841	-	94,861	59,841	59,841	(35,020)
Depreciation and Amortization	501,883	440,958	433,481	501,883	60,925	68,402
Other Administative Expenses	260,666	-	224,045	260,666	260,666	36,620
Total General and Administrative Overhead	2,389,619	440,958	1,991,856	2,389,619	1,948,661	397,763
Total Expenses	**11,336,858**	**10,998,623**	**9,852,980**	**11,336,858**	**338,236**	**1,483,878**
					-	-
Financing Expense	168,415	195,629	197,282	168,415	(27,214)	(28,867)
Financing Income	384,000	354,840	260,000	384,000	29,160	124,000
Investment Income	127,759	54,116	58,186	127,759	73,643	69,573
Miscellaneous Income	782,071	967,635	305,436	782,071	(185,564)	476,634
Net Income (Change in Financial Position)	**931,657**	**32,456**	**(1,345,152)**	**931,657**	**899,201**	**2,276,809**
Operating Income	(193,757)	(1,148,504)	(1,771,492)	(193,757)	954,747	1,577,735
EBIDA	1,433,540	473,415	(911,671)	1,433,540	960,126	2,345,211
Net Profit Margin	8.4%	0.3%	-16.6%	8.4%	8.0%	34.4%
Operating Margin	-1.7%	-11.7%	-21.9%	-1.7%	9.9%	25.6%
EBIDA Margin	12.9%	4.8%	-11.3%	12.9%	8.1%	33.1%

Northern Inyo Healthcare District
Balance Sheet
Fiscal Year 2027

	PY Balances	7/31/2026	7/31/2025	PM Change	PY Change
Assets					
Current Assets					
Cash and Liquid Capital	28,460,222	28,731,778	19,787,525	271,556	8,944,253
Short Term Investments	11,137,546	11,241,543	7,800,231	103,997	3,441,312
PMA Partnership	-	-	-	-	-
Accounts Receivable, Net of Allowance	21,307,775	21,593,930	16,184,152	286,154	5,409,777
Other Receivables	2,954,416	3,796,999	10,594,449	842,584	(6,797,450)
Inventory	5,537,948	5,561,610	5,325,022	23,662	236,588
Prepaid Expenses	1,762,519	2,137,092	1,310,343	374,572	826,749
Total Current Assets	**71,160,427**	**73,062,952**	**61,001,722**	**1,902,525**	**12,061,230**
Assets Limited as to Use					
Internally Designated for Capital Acquisition	-	-	-	-	-
Short Term - Restricted	1,470,800	1,470,928	1,469,420	128	1,508
Limited Use Assets			-	-	-
LAIF - DC Pension Board Restricted	-	-	-	-	-
LAIF - DB Pension Board Restricted	3,743,510	3,743,510	9,393,030	-	(5,649,520)
PEPRA - Deferred Outflows	-	-	-	-	-
PEPRA Pension	-	-	-	-	-
Deferred Outflow - Excess Acquisition	573,097	573,097	573,097	-	-
Total Limited Use Assets	4,316,607	4,316,607	9,966,127	-	(5,649,520)
Revenue Bonds Held by a Trustee	230,052	224,574	291,637	(5,477)	(67,063)
Total Assets Limited as to Use	**6,017,459**	**6,012,110**	**11,727,185**	**(5,349)**	**(5,715,075)**
Long Term Assets					
Long Term Investment	-	-	496,916	-	(496,916)
Fixed Assets, Net of Depreciation	78,338,535	77,848,511	81,304,067	(490,025)	(3,455,557)
Total Long Term Assets	**78,338,535**	**77,848,511**	**81,800,984**	**(490,025)**	**(3,952,473)**
Total Assets	**155,516,421**	**156,923,572**	**154,529,890**	**1,407,151**	**2,393,682**
Liabilities					
Current Liabilities					
Current Maturities of Long-Term Debt	3,440,037	3,443,154	3,618,572	3,117	(175,418)
Accounts Payable	4,416,081	4,531,548	5,160,660	115,467	(629,111)
Accrued Payroll and Related	4,276,351	4,614,062	3,876,752	337,711	737,310
Accrued Interest and Sales Tax	76,902	140,328	149,575	63,426	(9,247)
Notes Payable	229,820	229,820	339,892	-	(110,072)
Unearned Revenue	-	-	-	-	-
Due to 3rd Party Payors	4,125,564	4,125,564	3,324,903	-	800,661
Due to Specific Purpose Funds	-	-	-	-	-
Other Deferred Credits - Pension & Leases	5,006,479	5,006,479	8,756,720	-	(3,750,241)
Total Current Liabilities	**21,571,235**	**22,090,956**	**25,227,074**	**519,721**	**(3,136,118)**
Long Term Liabilities					
Long Term Debt	30,065,301	29,955,981	33,237,566	(109,321)	(3,281,585)
Bond Premium	90,328	87,191	121,699	(3,137)	(34,508)
Accreted Interest	17,383,865	17,468,253	17,361,713	84,388	106,540
Other Non-Current Liability - Pension	28,132,971	28,132,971	31,874,258	-	(3,741,287)
Total Long Term Liabilities	**75,672,466**	**75,644,396**	**82,595,236**	**(28,070)**	**(6,950,840)**
Suspense Liabilities	-	-	-	-	-
Uncategorized Liabilities (grants)	134,005	134,005	54,922	-	79,083
Total Liabilities	**97,377,707**	**97,869,357**	**107,877,232**	**491,651**	**(10,007,875)**
Fund Balance					
Fund Balance	45,944,004	56,651,630	46,528,390	10,707,626	10,123,239
Temporarily Restricted	1,470,800	1,470,928	1,469,420	128	1,508
Net Income	10,723,910	931,657	(1,345,152)	(9,792,253)	2,276,809
Total Fund Balance	**58,138,714**	**59,054,215**	**46,652,658**	**915,501**	**12,401,557**
Liabilities + Fund Balance	**155,516,421**	**156,923,572**	**154,529,890**	**1,407,151**	**2,393,682**
(Decline)/Gain		1,407,151	(167,926)	1,407,151	1,575,078

Northern Inyo Healthcare District
Long-Term Debt Service Coverage Ratio
FYE 2027

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

Long-Term Debt Service Coverage Ratio Calculation

Numerator:	HOSPITAL FUND ONLY
Excess of revenues over expense	$ 931,657
+ Depreciation Expense	501,883
+ Interest Expense	168,415
Less GO Property Tax revenue	311,000
Less GO Interest Expense	37,839
"Income available for debt service"	**$ 1,253,116**
Denominator:	
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**
Ratio: (numerator / denominator)	**5.99**
Required Debt Service Coverage Ratio:	1.10
In Compliance? (Y/N)	**Yes**

Unrestricted Funds and Days Cash on Hand

	HOSPITAL FUND ONLY
Cash and Investments-current	$ 39,973,321
Cash and Investments-non current	-
Sub-total	39,973,321
Less - Restricted:	
PRF and grants (Unearned Revenue)	-
Held with bond fiscal agent	-
Building and Nursing Fund	-
Total Unrestricted Funds	**$ 39,973,321**
Total Operating Expenses	$ 11,336,858
Less Depreciation	501,883
Net Expenses	10,834,975
Average Daily Operating Expense	$ 349,515
Days Cash on Hand	**114**

Northern Inyo Healthcare District
Statement of Cash Flows
Fiscal Year 2027

CASH FLOWS FROM OPERATING ACTIVITIES	
Receipts from and on Behalf of Patients	11,148,298
Payments to Suppliers and Contractors	(5,736,192)
Payments to and on Behalf of Employees	(5,880,575)
Other Receipts and Payments, Net	(136,300)
Net Cash Provided (Used) by Operating Activities	(604,769)
CASH FLOWS FROM NONCAPITAL FINANCING ACTIVITIES	
Noncapital Contributions and Grants	657,705
Property Taxes Received	73,000
Net Cash Provided (Used) by Noncapital Financing Activities	730,705
CASH FLOWS FROM CAPITAL AND CAPITAL RELATED FINANCING ACTIVITIES	
Principal Payments on Long-Term Debt	-
Proceeds from the Issuance of Refunding Revenue Bonds	-
Payment to Defease Revenue Bonds	-
Interest Paid	(168,415)
Purchase and Construction of Capital Assets	8,694
Payments on Lease Liability	(8,597)
Payments on Subscription Liability	(98,497)
Property Taxes Received	384,000
Net Cash Provided (Used) by Capital and Capital Related Financing Activities	117,184
CASH FLOWS FROM INVESTING ACTIVITIES	
Investment Income	127,759
Rental Income	4,674
Net Cash Provided (Used) by Investing Activities	132,433
NET CHANGE IN CASH AND CASH EQUIVALENTS	375,553
Cash and Cash Equivalents - Beginning of Year	39,597,769
CASH AND CASH EQUIVALENTS - END OF YEAR	39,973,321