Northern Inyo Healthcare District

Board Meeting

Quality Meeting - November 12, 2026

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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.

NOTICE

NORTHERN INYO HEALTHCARE DISTRICT
Board of Directors' Quality Committee Meeting
November 12, 2026 at 3:00 pm

The Quality Committee will meet in person at 150 Pioneer Lane, 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
Meeting ID: 325 789 3484

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1. Call to Order at 3:00 pm.
2. Public Comment: At this time, members of the audience may speak only on items listed on this Notice. Each speaker is limited to a maximum of three (3) minutes, with a total of thirty (30) minutes for all public comments unless modified by the Chair. The Board is prohibited from discussing or taking action on items not listed on this Notice. Speaking time may not be transferred to another person, except when arrangements have been made in advance for a designated spokesperson to represent a large group. Comments must be brief, non-repetitive, and respectful.
3. Old Business
   a) Beta Update – Information Item
4. New Business
   a) Meeting minutes August 11, 2026 – Action Item
   b) Quality Dashboard – Information Items
   c) Emergency Department Transfer Project – Information Item
   d) Grievance Committee - Information Item
   e) Patient Safety Committee Structure – Information Item

f) Unusual Occurrence Report (UOR) – Action Item

5. Adjournment

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

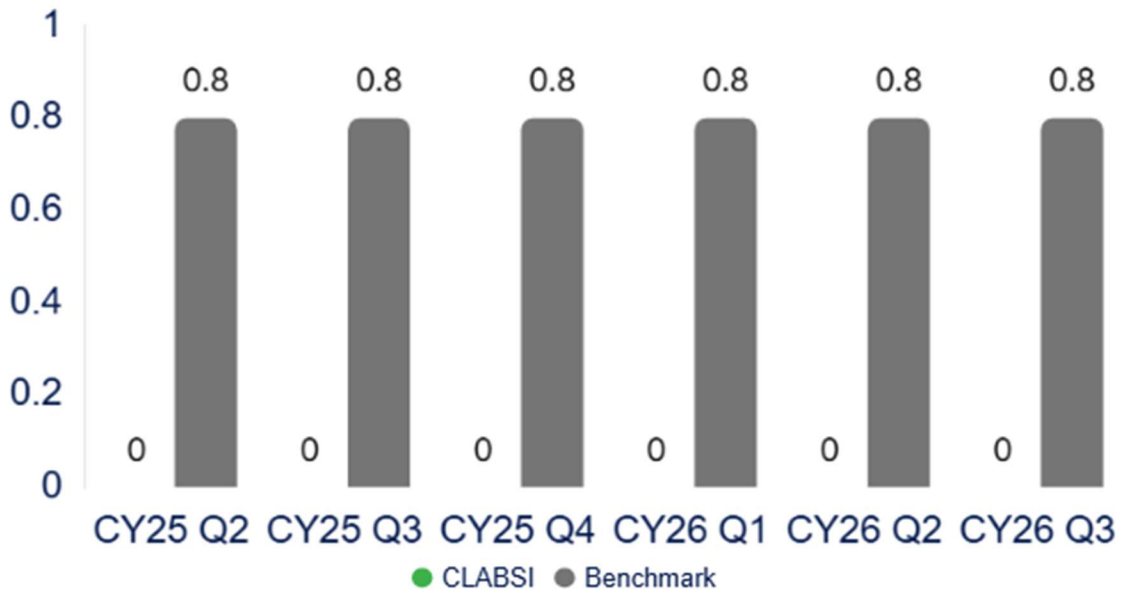
CALL TO ORDER	Northern Inyo Healthcare District (NIHD) Quality Committee Chair Turner called the meeting to order at 3:03 pm.
PRESENT	Jean Turner, Quality Committee Chair Maggie Egan, Quality Committee Vice-Chair Christian Wallis, Chief Executive Officer Allison Partridge, Chief Operations Officer / Chief Nursing Officer Alison Murray, Chief Human Resources Officer / Chief Business Development Officer Adam Hawkins, DO, Chief Medical Officer Andrea Mossman, Chief Financial Officer Alison Feinberg, Manager of Quality and Survey Readiness, Quality Assurance Patty Dickson, Compliance Officer
PUBLIC COMMENT	Chair Turner reported that at this time, audience members may speak on any items on the agenda that are within the jurisdiction of the Board. There were no comments from the public.
BETA	Quality Manager Feinberg reported that the annual SCORE culture and safety survey and departmental debriefs have been completed, with each department identifying an action item based on its results. Senior leadership is also developing an action item, and progress will be monitored throughout the year. With two years of survey experience and data now available, leadership is evaluating whether the SCORE survey and debrief process are providing meaningful, actionable feedback and remain the right fit for the District. Feinberg also reported that the multidisciplinary Grievance Committee has improved coordination, communication with patients, and timely resolution of concerns. Building on that work, the District is further developing its Rapid Event Response and Analysis processes, including additional training and a more systematic approach to serious adverse events and root cause analyses. **Public Comment:** None **Board Discussion:** The Committee expressed appreciation for the work completed by staff and the level of engagement in implementing the BETA initiatives.
MEETING MINUTES	**Public Comment:** None **Board Discussion:** None **Motion by** Egan to approve the May 12, 2026 meeting minutes. **2nd:** Turner **Pass:** 2-0

QUALITY DASHBOARD	Quality Manager Feinberg presented the Quality Dashboard and reported continued strong performance across several patient safety and quality measures, including no sentinel events, no falls with injury, and zero mortality excluding comfort-care patients. The medical transfer rate was 4.2%, representing seven transfers, and remained low. The 30-day readmission rate increased from the prior period but remained below the 13% target; review did not identify a specific cause for the increase, and the measure will continue to be monitored. Patient experience results remained strong, with inpatient scores at 86%, above the 75% benchmark, clinic scores at approximately 92%, and outpatient scores at approximately 83%. She also reviewed emergency department performance, employee engagement results from the SCORE survey, employee turnover, and other safety measures included on the dashboard. **Public Comment:** None **Board Discussion:** The Committee discussed the potential impact of the new dialysis program on patient transfers, with staff anticipating that the transfer rate may decrease as more dialysis patients can be treated locally. Staff noted that the dialysis program will be tracked separately so the Board can evaluate its utilization and impact after the first several quarters of operation. Regarding the increase in 30-day readmissions, Feinberg explained that the cases had been reviewed but no specific cause for the increase was identified and that quarterly fluctuations have occurred historically. The Committee also discussed the strong patient experience results and the value of using the data to provide a broader picture of patient experience across the District.
SECURITY SCREENING UPDATE	Chief Operating Officer Partridge provided an update on new state requirements for weapons detection screening at the Emergency Department and main hospital entrances. The District has selected an AI-assisted weapons detection system to test before determining its final implementation approach. Information regarding the testing has been released to the community to explain the new requirements and clarify that the testing is not in response to a specific security concern. **Public Comment:** None **Board Discussion:** The Committee discussed the operational and financial impact of the mandate. Partridge clarified that compliance will require trained security personnel and increased security coverage and that no funding was provided with the legislation. The District will also establish procedures for addressing prohibited items identified through screening.
GENERAL INFORMATION	None
ADJOURNMENT	Adjourned at 3:28

_____
Jean Turner
Northern Inyo Healthcare District
Quality Committee Chair

Attest: _____
Maggie Egan
Northern Inyo Healthcare District
Quality Committee Vice-Chair

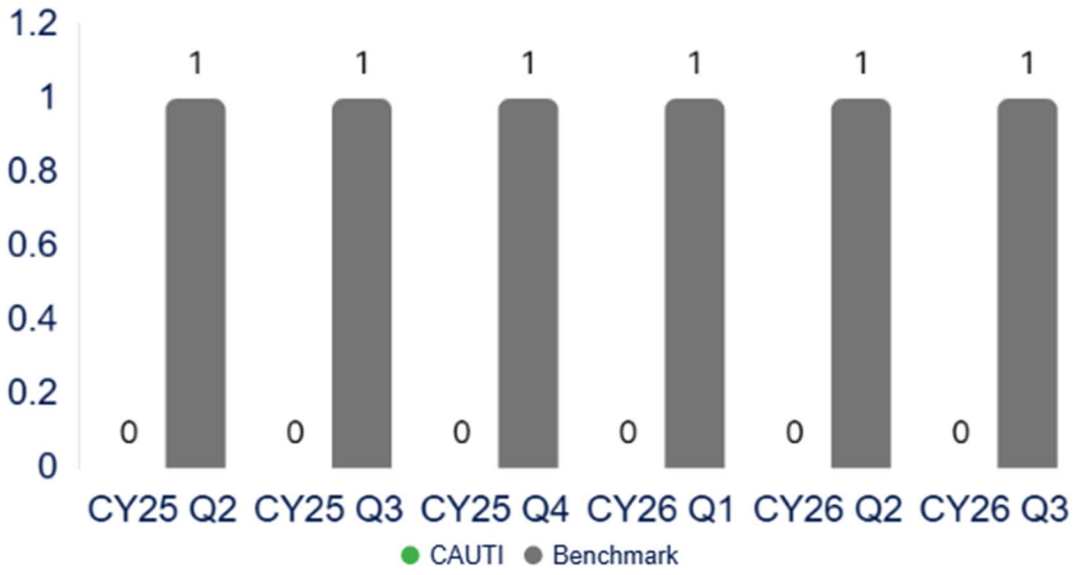
Central Line-Associated Bloodstream Infect <



Central Line-Associated Bloodstream Infections

Infections caused by central line catheters

Catheter-Associated Urinary Tract Infection <



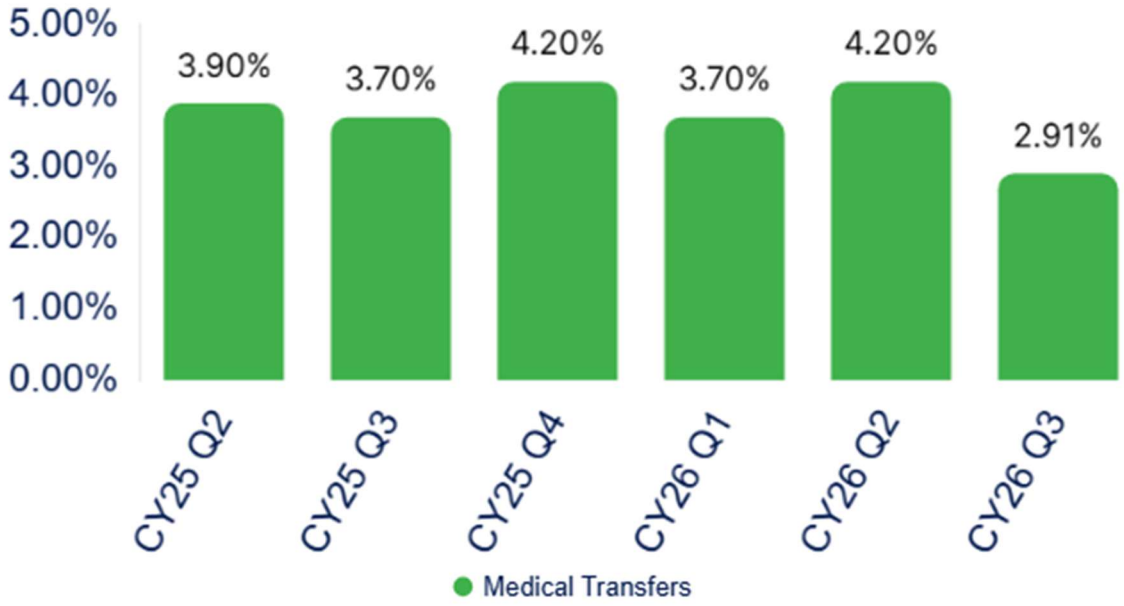
Catheter-Associated Urinary Tract Infection <

Infections caused by indwelling urinary catheters

NIHD Quality Committee Dashboard

"<" means lower is better

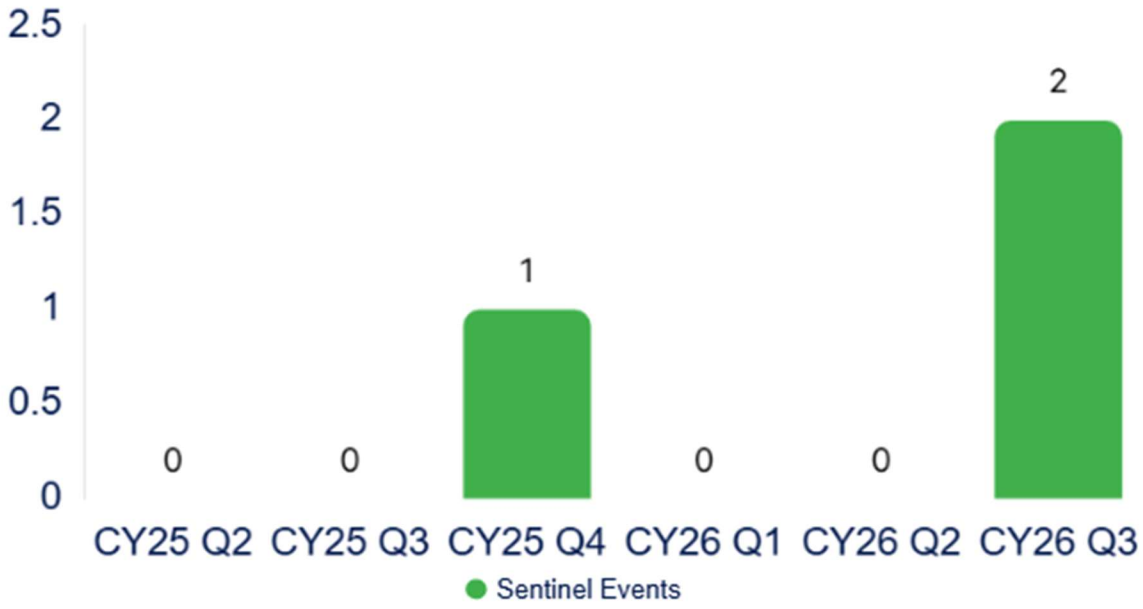
Medical Transfer Rate from ED



NIHD Quality Committee Dashboard

"<" means lower is better

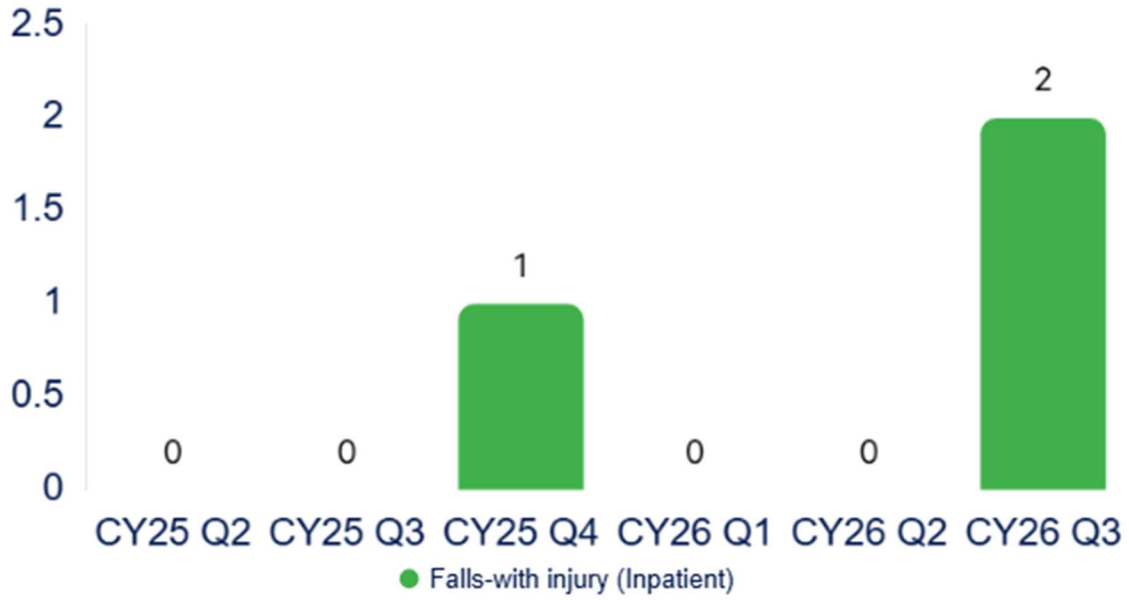
Sentinel Events <



NIHD Quality Committee Dashboard

"<" means lower is better

Patient Falls- With Injury <



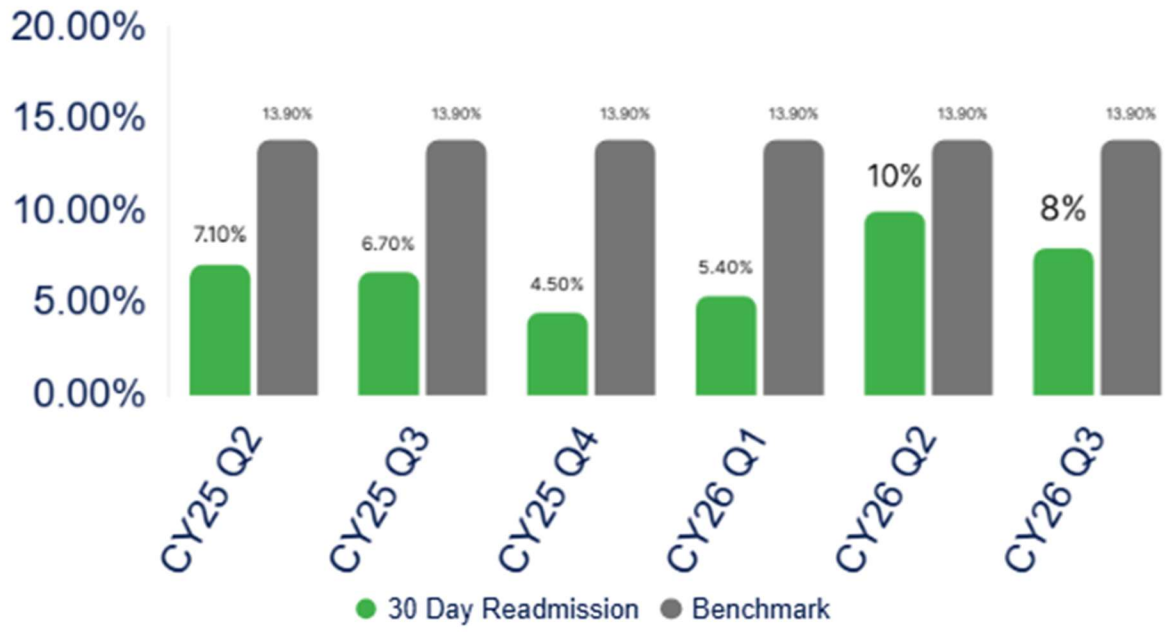
"<" means lower is better

Patient Falls- Without Injury <



"<" means lower is better

30 Day Readmission <



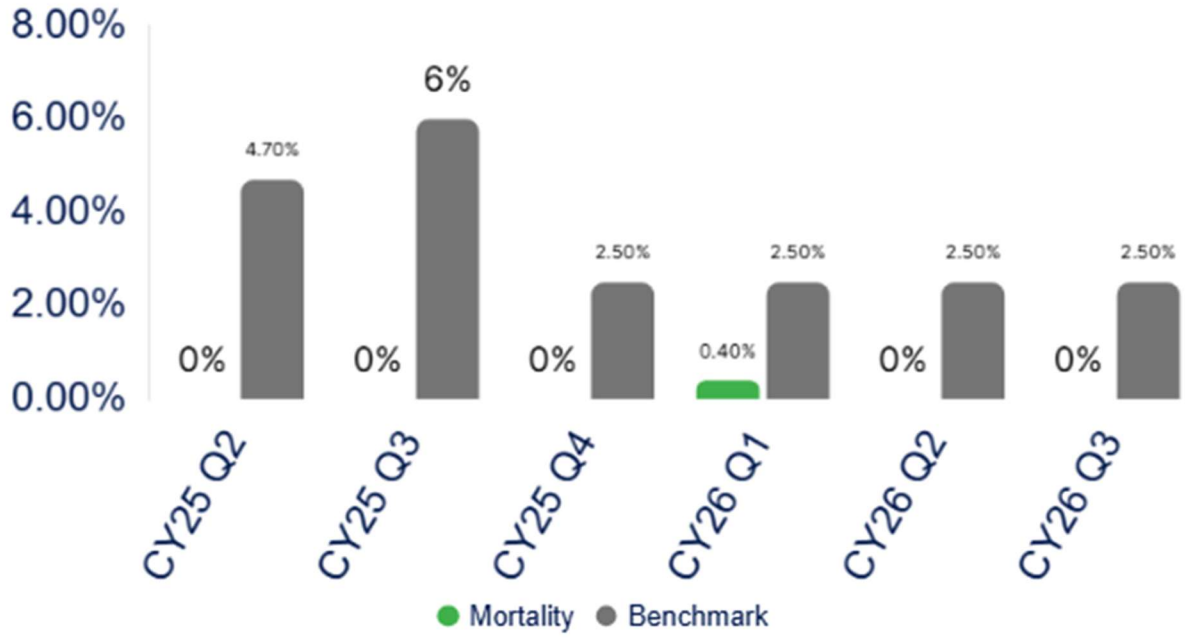
30 Day Readmission

Percentage of patient who, within 30 days of discharge from an inpatient stay, are re-admitted for any reason.

NIHD Quality Committee Dashboard

"<" means lower is better

Mortality <



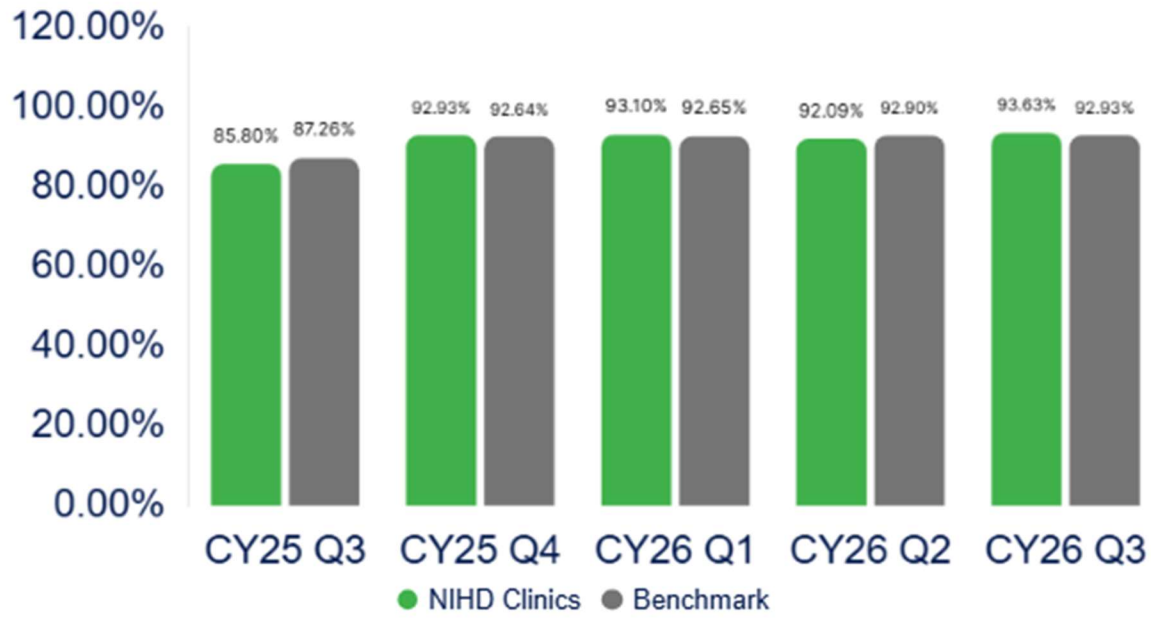
Mortality

Percentage of patient who die as inpatients, exclusive of those on comfort or palliative care.

NIHD Quality Committee Dashboard

"<" means lower is better

Likelihood to Recommend Top Box Score (Clinic)



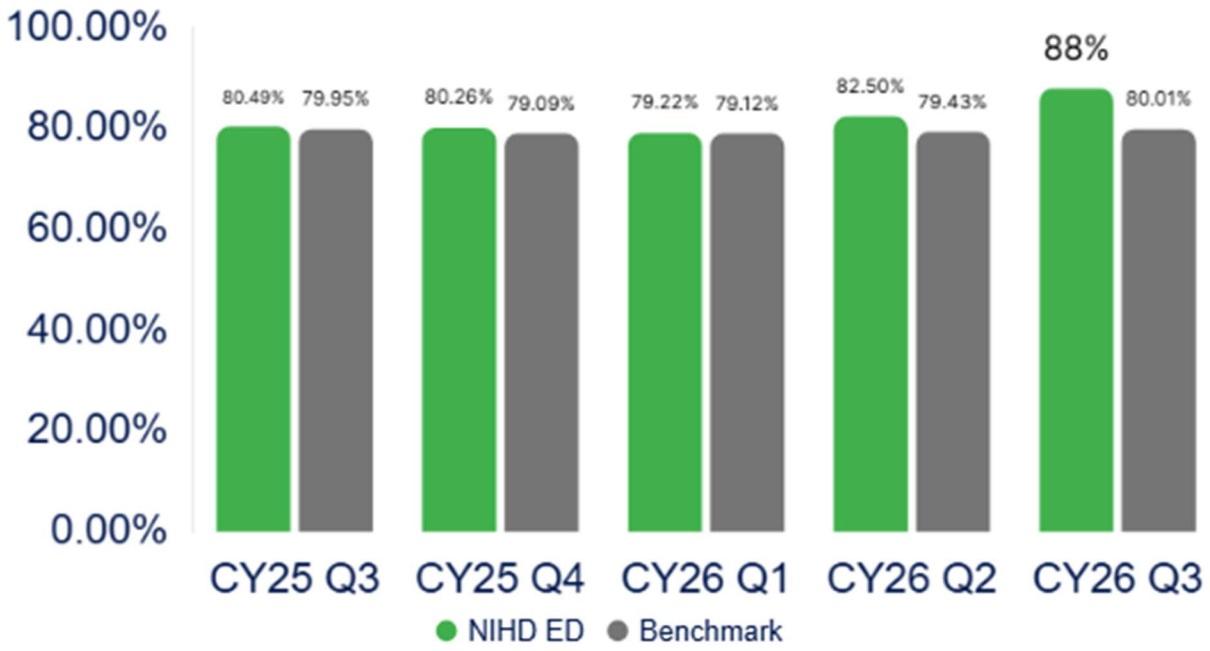
Likelihood to Recommend

Based on patient surveys, the likelihood that the patient would recommend the service area to others. This is measured as a "top box" score, or the portion of patients who gave the highest possible rating.

NIHD Quality Committee Dashboard

"<" means lower is better

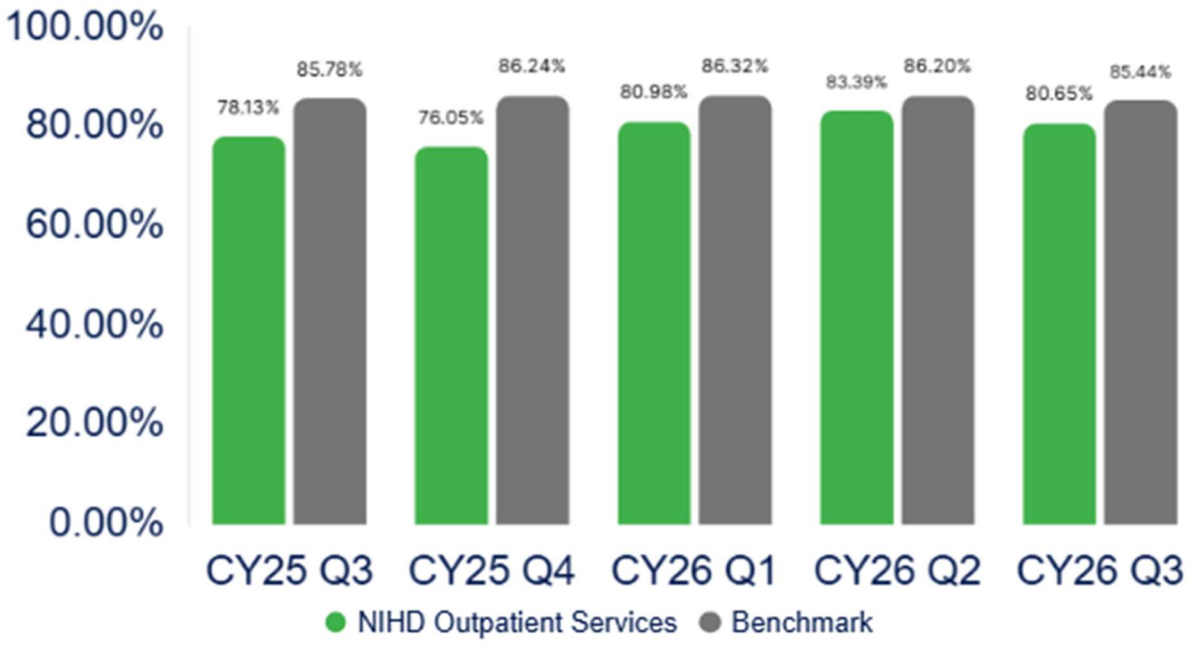
Likelihood to Recommend Top Box Score (ED)



Likelihood to Recommend

Based on patient surveys, the likelihood that the patient would recommend the service area to others. This is measured as a "top box" score, or the portion of patients who gave the highest possible rating.

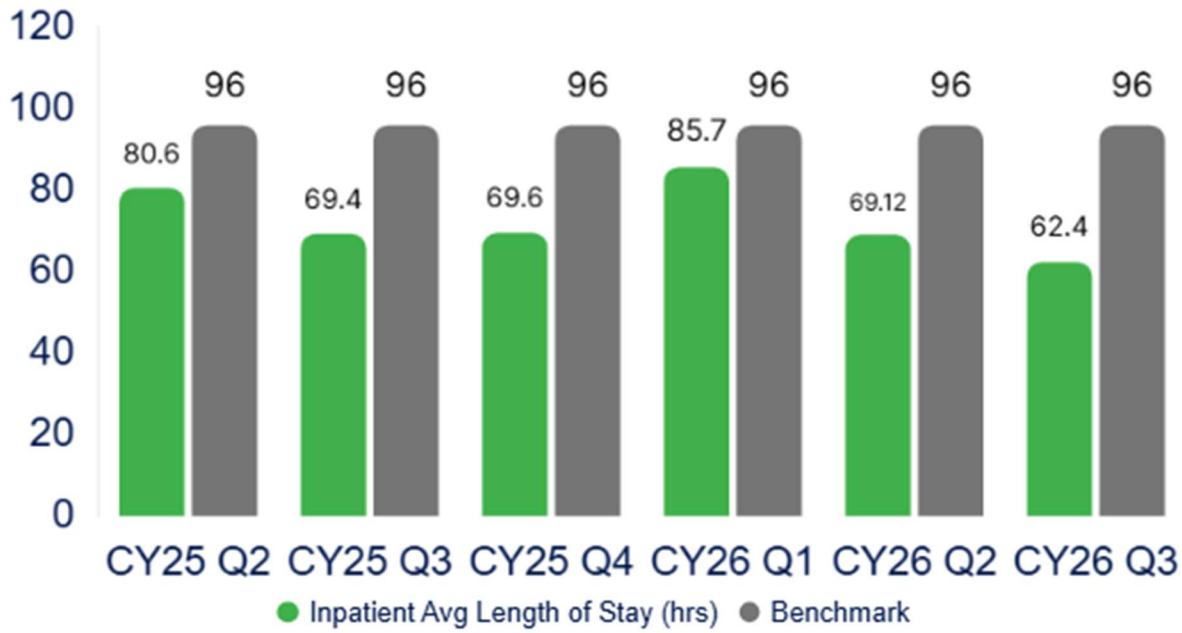
Likelihood to Recommend Top Box Score (OP)



Likelihood to Recommend

Based on patient surveys, the likelihood that the patient would recommend the service area to others. This is measured as a "top box" score, or the portion of patients who gave the highest possible rating.

Inpatient Average Length of Stay (hours) <



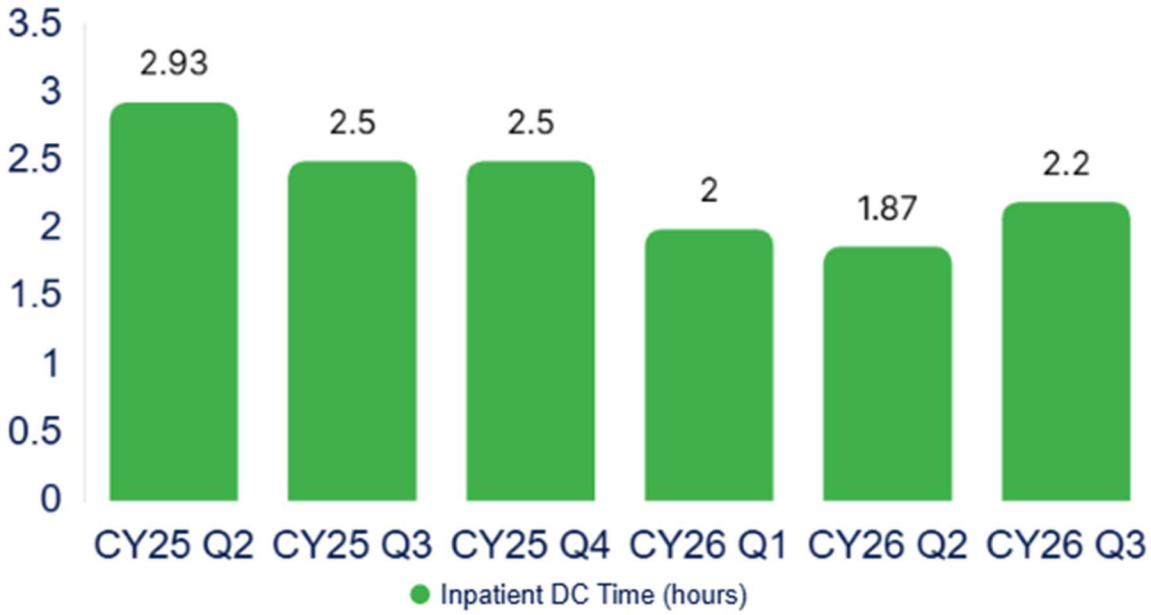
Inpatient Average Length of Stay

Average length of inpatient hospital stays. Annual average must remain below 96 hours to maintain Critical Access Hospital status.

NIHD Quality Committee Dashboard

"<" means lower is better

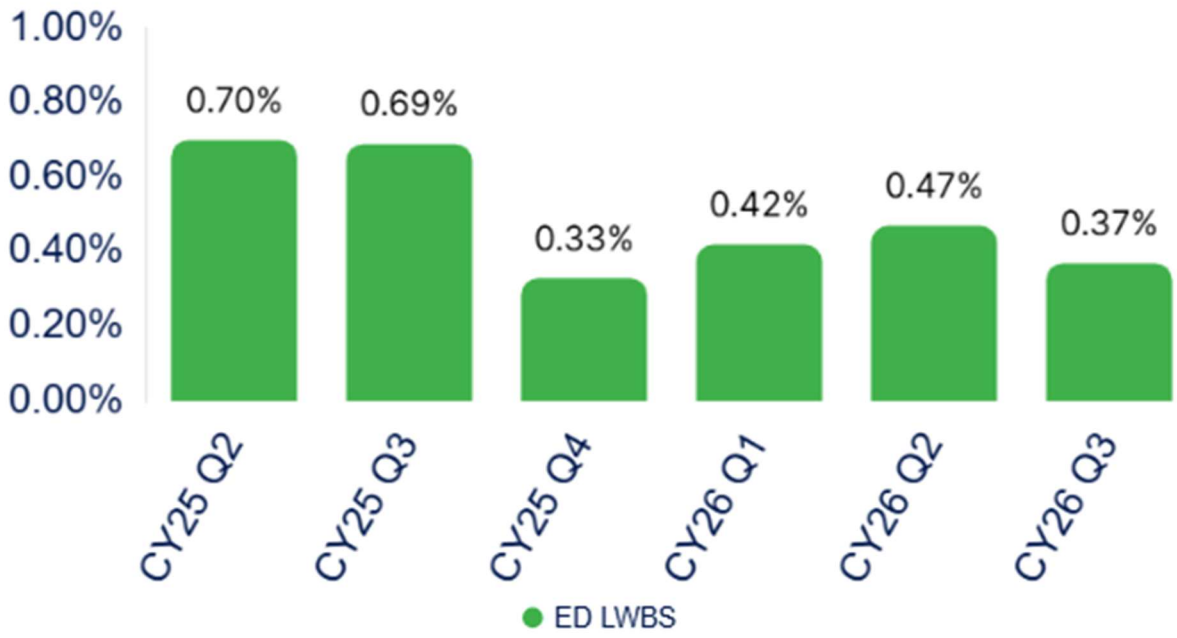
Inpatient Discharge Time (hours) <



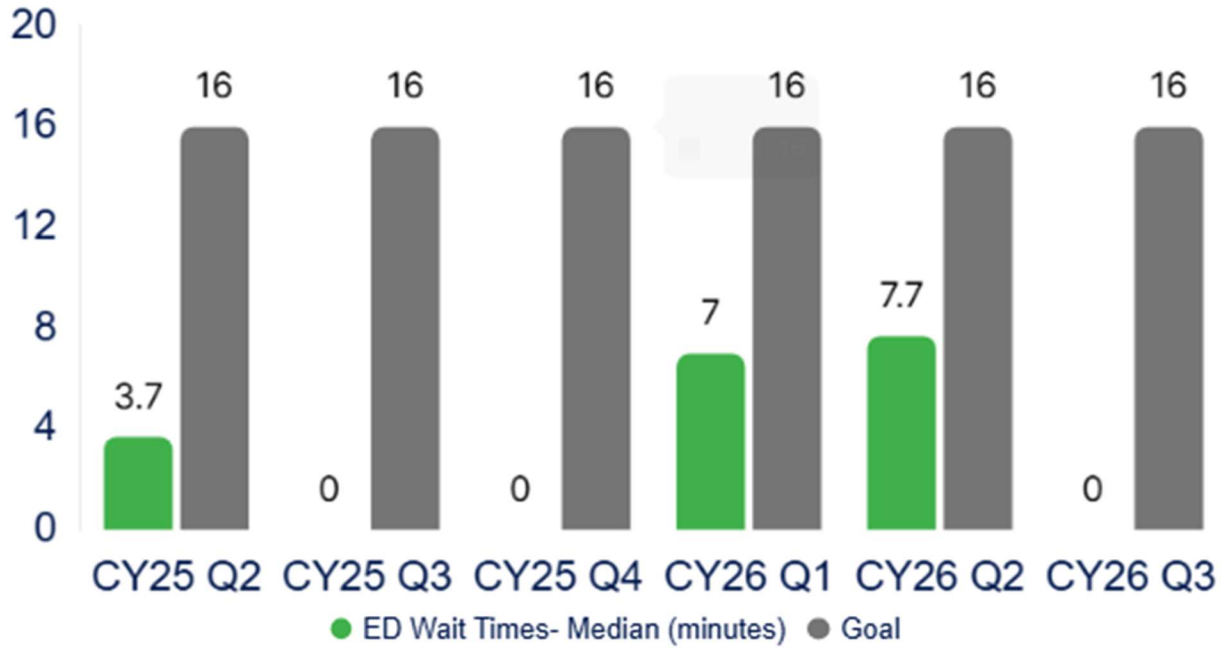
NIHD Quality Committee Dashboard

"<" means lower is better

ED Left Without Being Seen <



ED Wait Times- Median (minutes) <



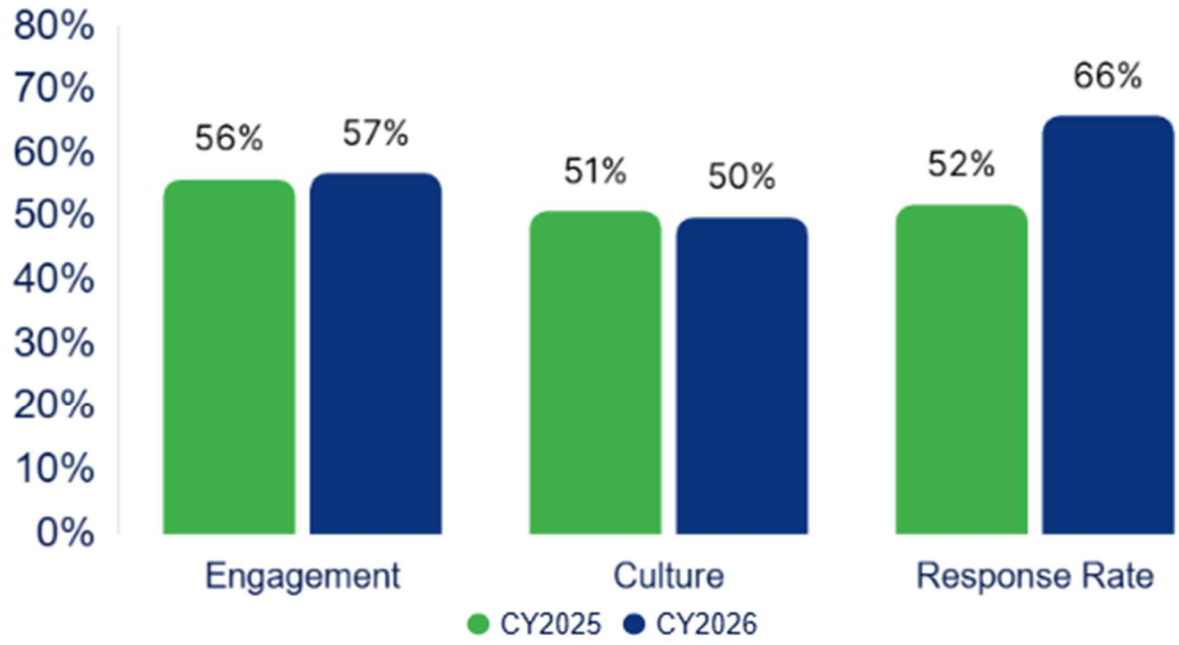
ED Wait Times

Median time from triage to when patient is seen by a provider.

NIHD Quality Committee Dashboard

"<" means lower is better

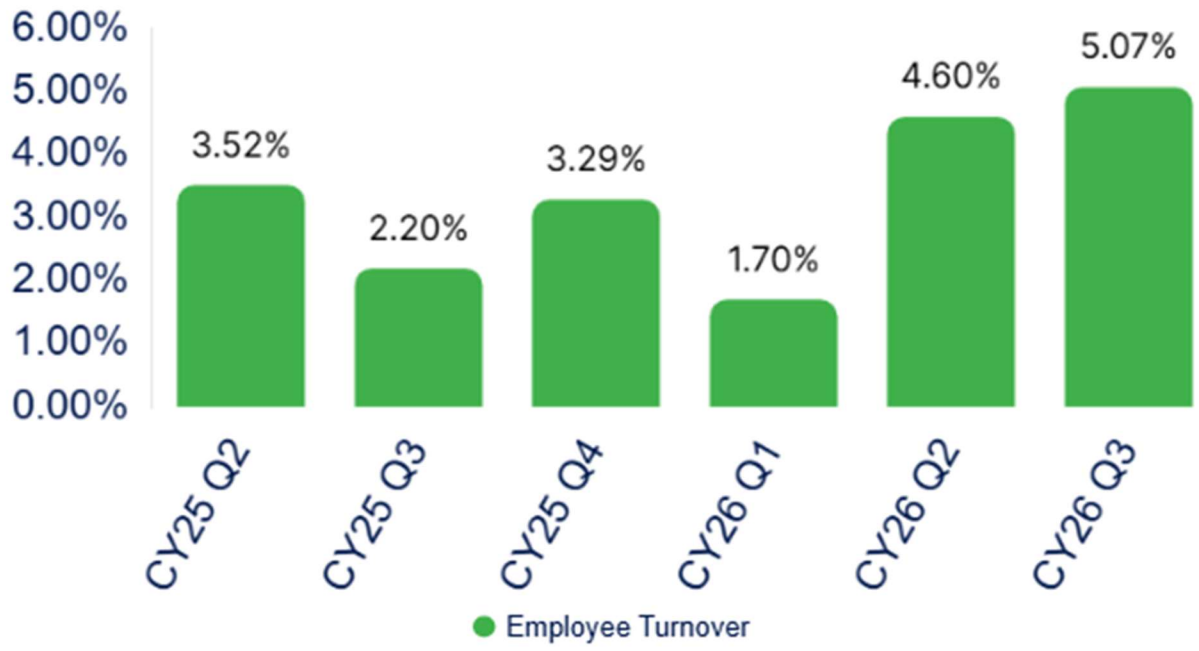
Employee SCORE Survey Results



NIHD Quality Committee Dashboard

"<" means lower is better

Employee Turnover



NIHD Quality Committee Dashboard

"<" means lower is better

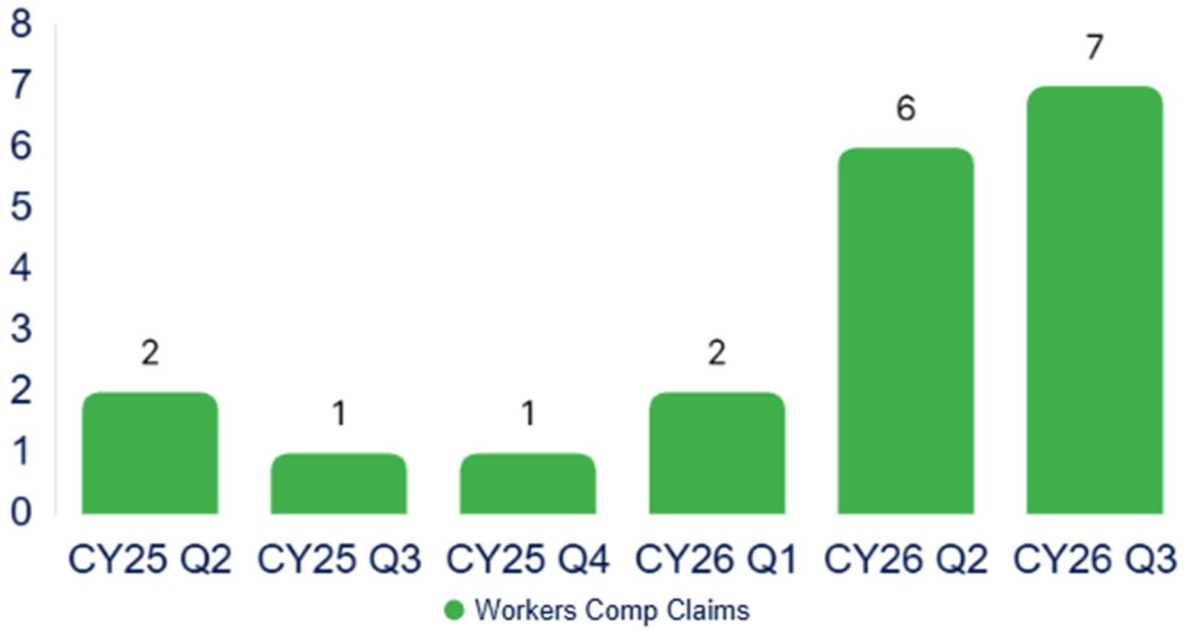
Reportable Incidents- Employees



NIHD Quality Committee Dashboard

"<" means lower is better

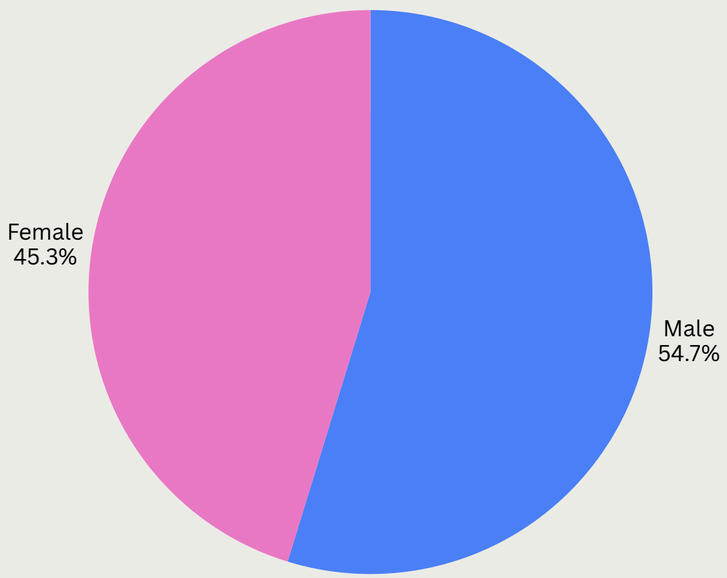
Workers Comp Claims

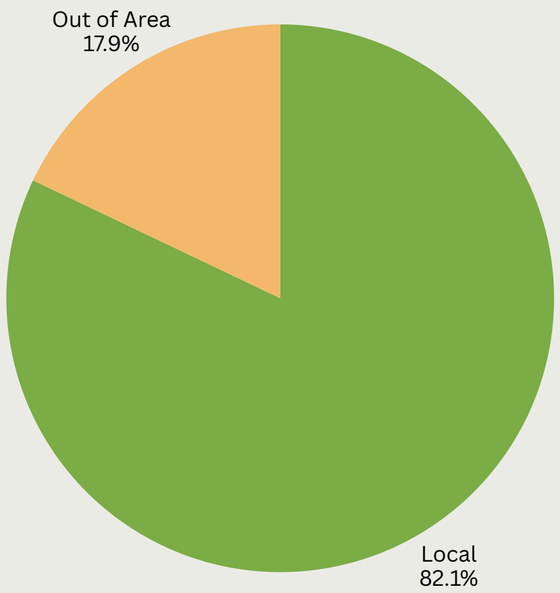


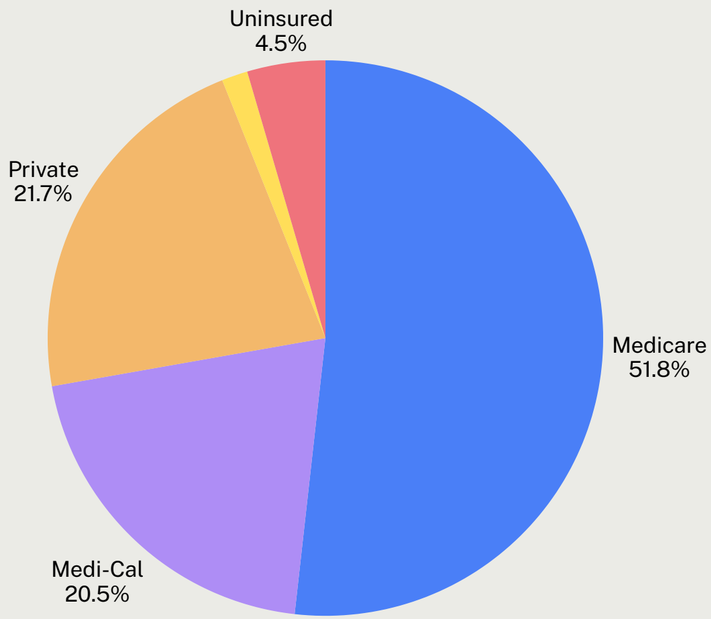
TRANSFER DATA REVIEW

10/28/2026

Patient Demographics

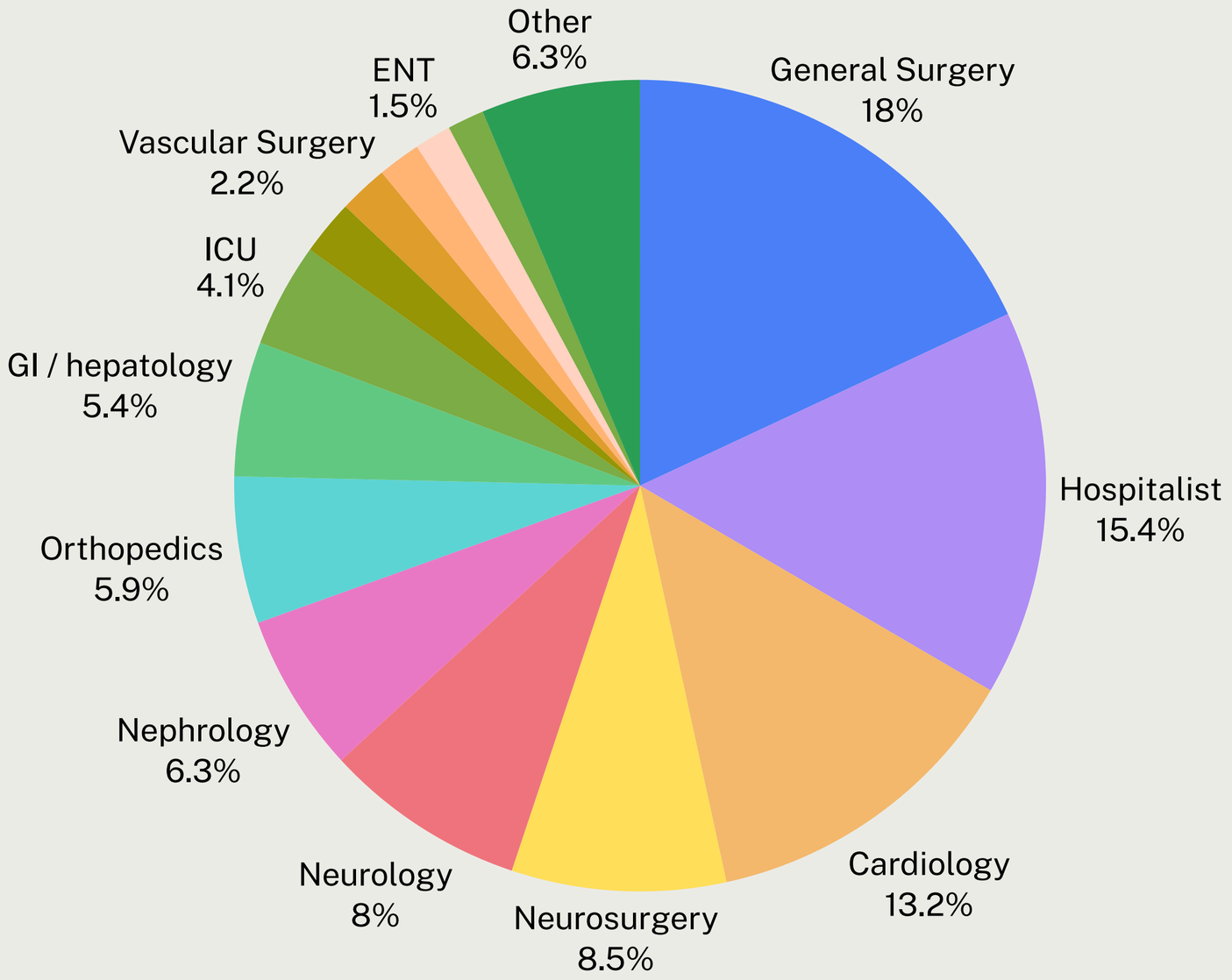




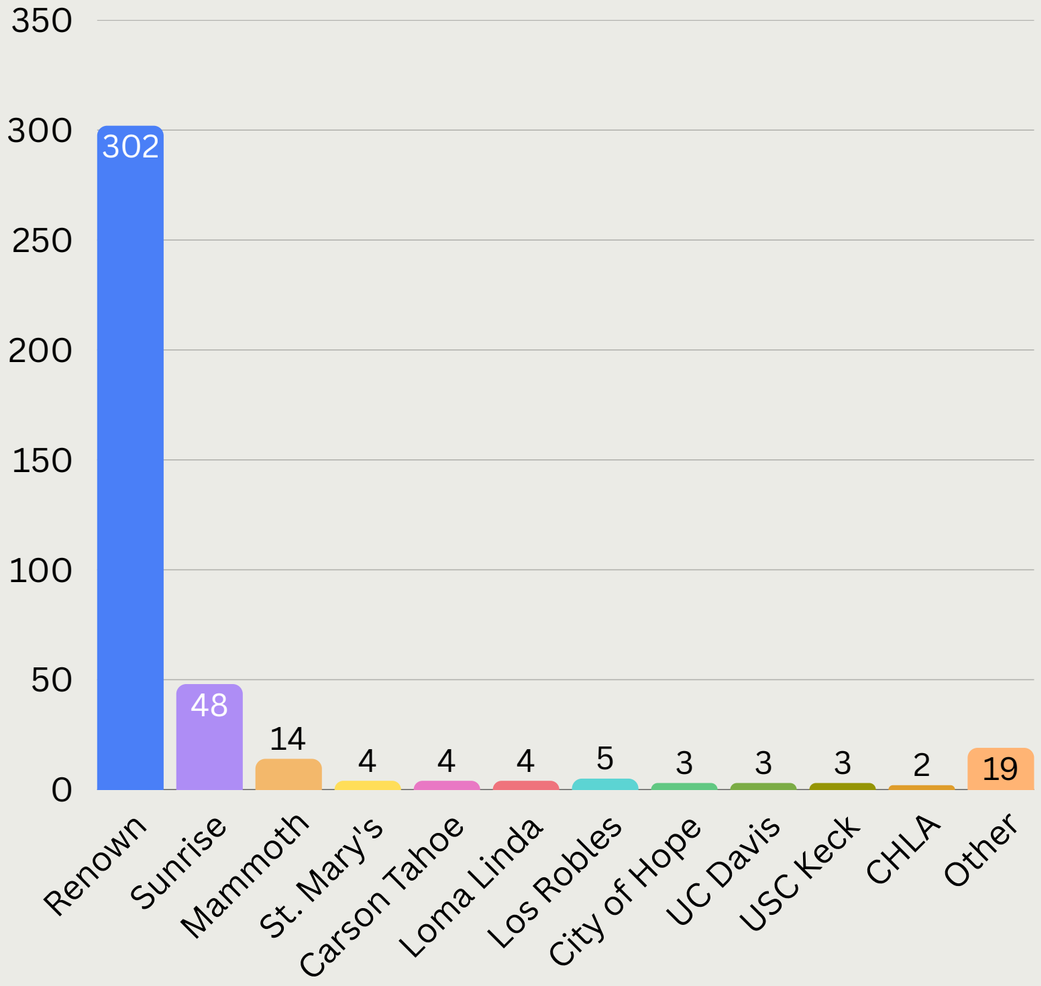


Average age 61.5

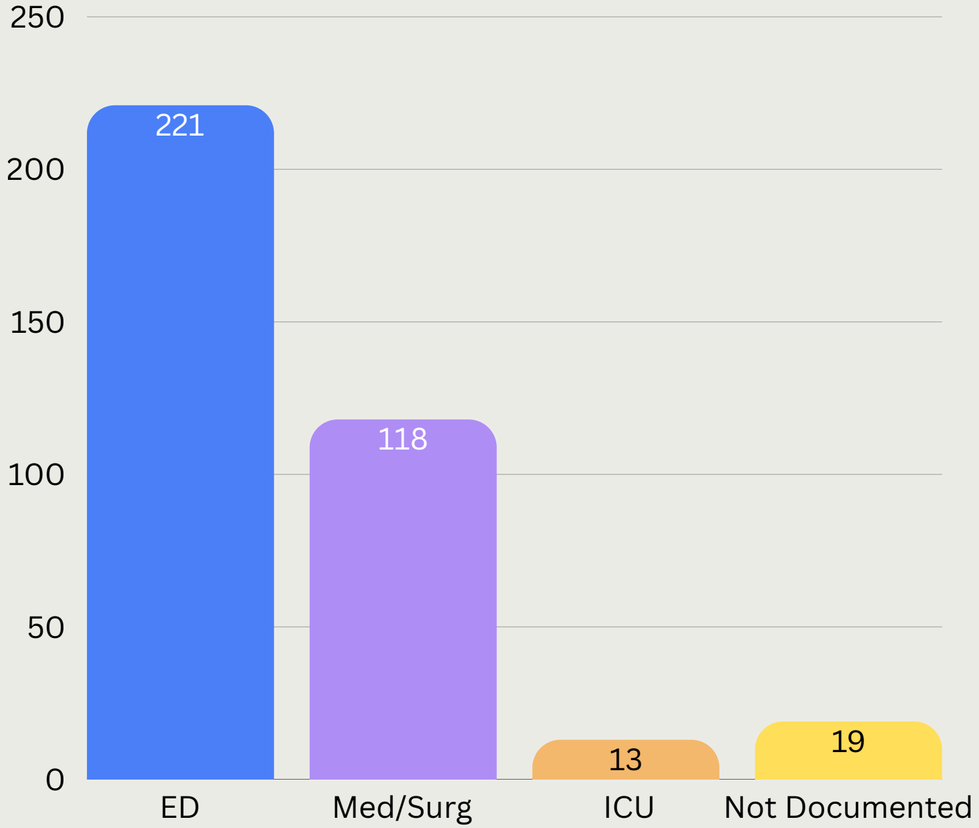
Specialties and Services Associated With Transfer



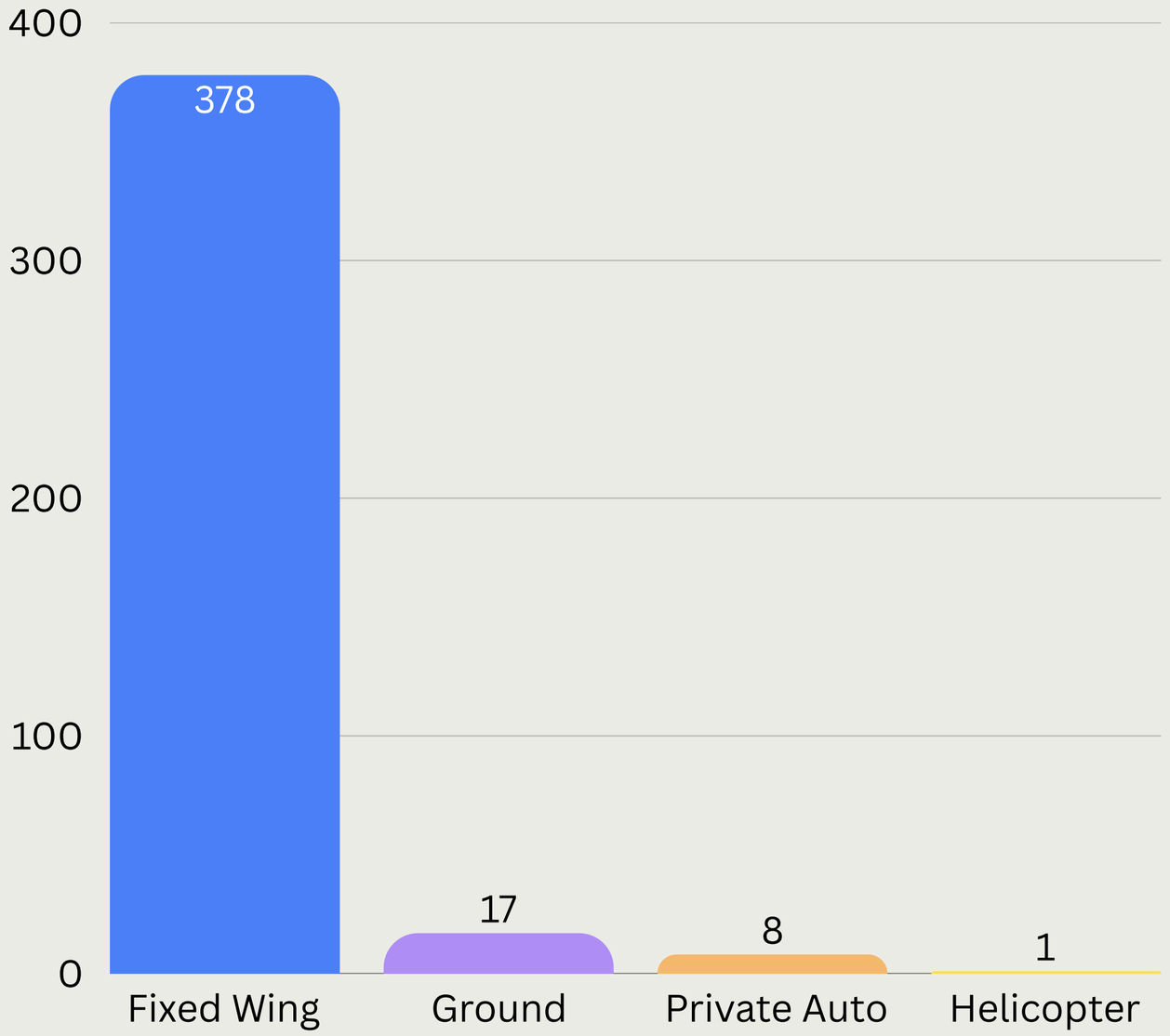
Receiving Facilities



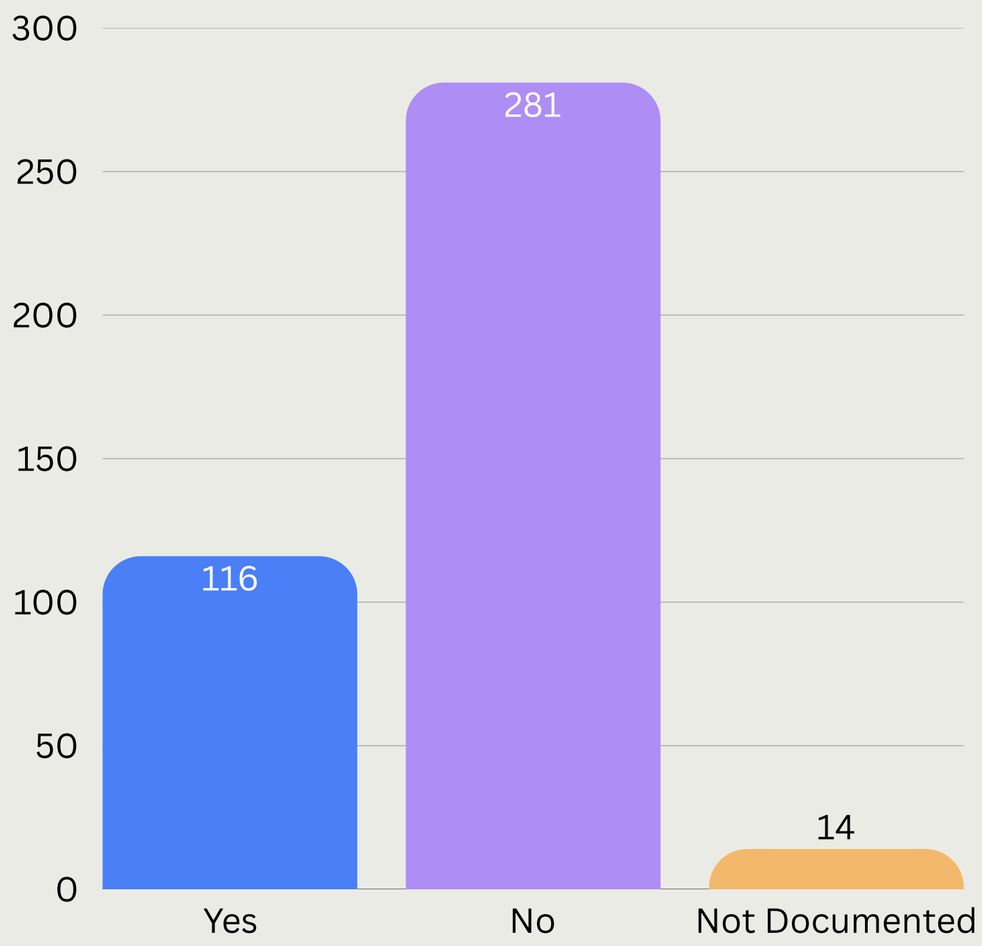
Receiving Location



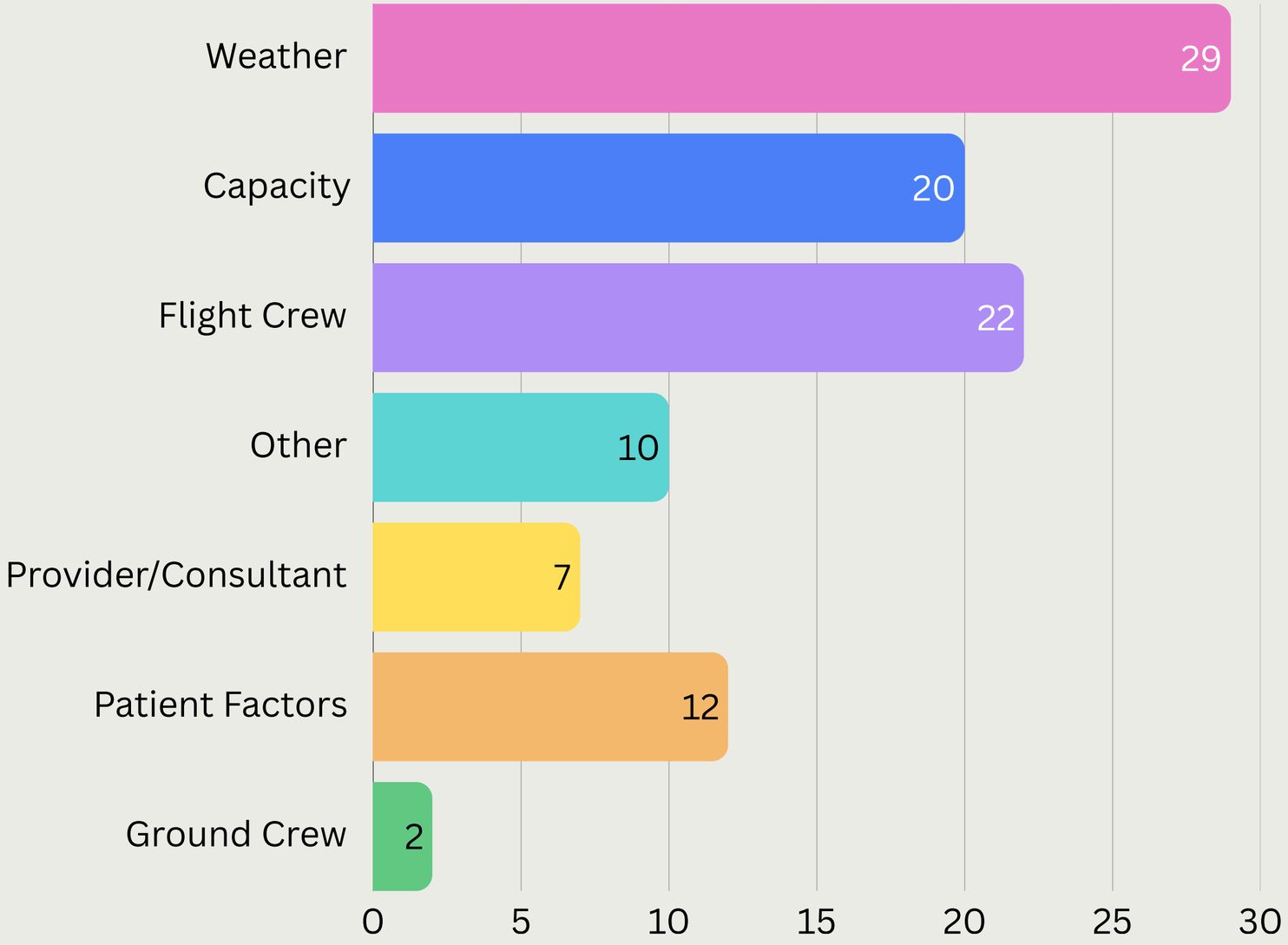
Method of Transport



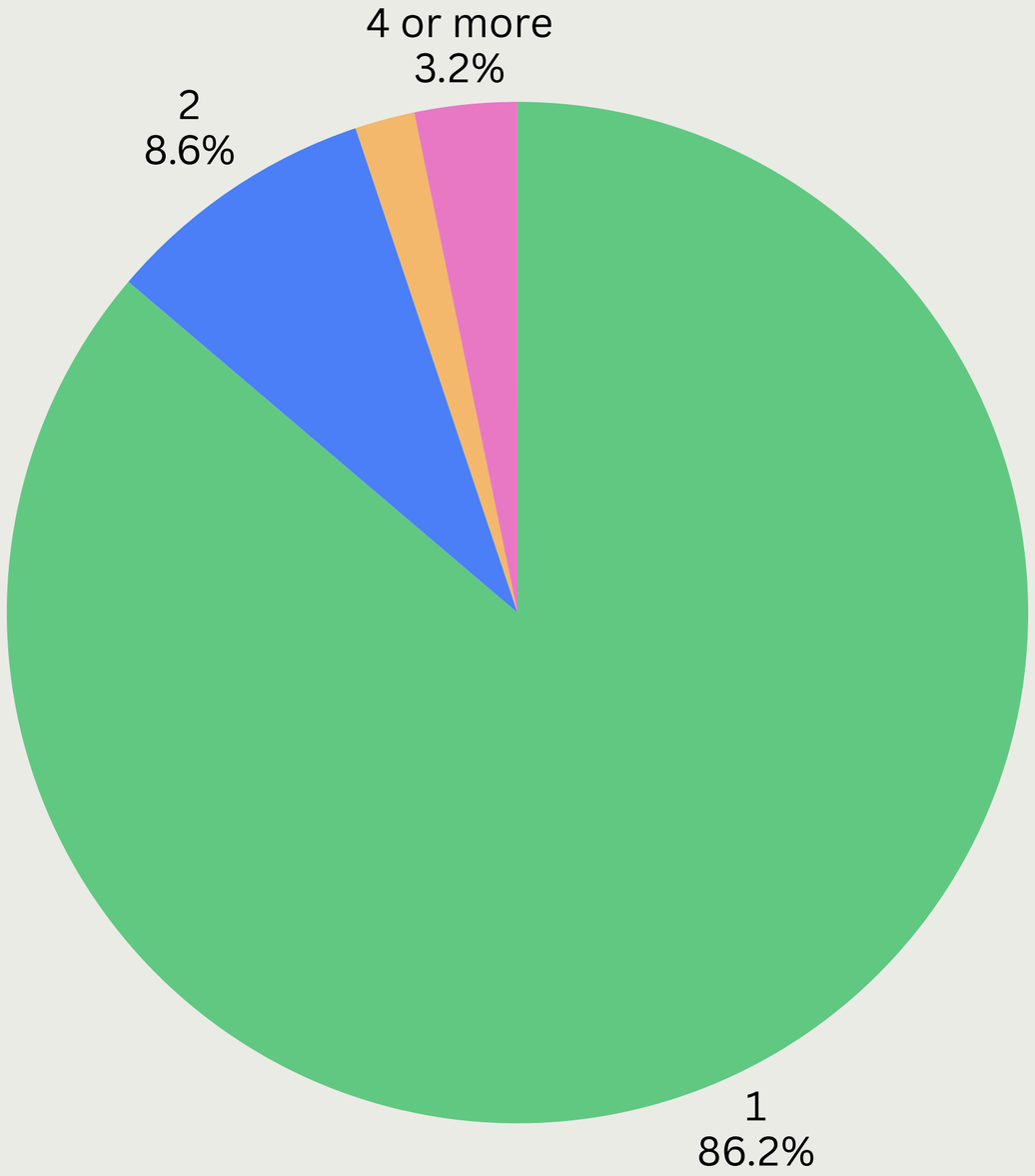
Transfer Delays



Transfer Delay Reasons



Facilities Contacted before Acceptance



Analyzing Transfer Patterns

- Biliary disease: 38 cases
- GI Bleed: 32 cases
- ESRD or Dialysis Needs: 32 cases
- EEG access: 7 cases
- MRI/MRCP access: 10 cases
- Only 1 transfer to Mammoth in 2026
    - Post-tonsillectomy hemorrage ENT

Analyzing Transfer Patterns: Biliary Disease 38 Cases

- 20 needed possible ERCP
- 18 other cases
  - 9 complex cases (mass, malignancy, stent migration, etc)
  - 3 needed MRCP
  - 3 surgeon concerns
  - 2 HD dependent
  - 1 anesthesia concerns

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

DATE: November 2026

TO: Board of Directors, Northern Inyo Healthcare District

FROM: Adam Hawkins, DO, Chief Medical Officer

RE: Grievance Resolution Committee Structure and Process

MEMORANDUM

Committee Structure

The Grievance Resolution Committee (GRC) is a multidisciplinary committee established under Northern Inyo Healthcare District's Patient Safety Program and reports to the Patient Safety Committee. Its primary responsibility is to ensure patient and family grievances are reviewed thoroughly, consistently, and timely, with a focus on appropriate resolution, patient communication, and organizational improvement.

The committee functions in a multidisciplinary structure and evaluates concerns from clinical, operational, financial, and patient experience perspectives. A collaborative environment is approaches with other committees and department. For example, if events require a process improvement change or additional operation improvement, the GRC will connect with the Clinical Events Committee.

Ultimately, the Patient Safety Committee serves as a central forum for bringing together findings from different areas of the organization and the GRC supports this philosophy by determining appropriate grievance resolutions, and ensuring identified concerns are communicated to the appropriate leadership or committee for follow-up.

Grievance Process

NIHD has an established grievance resolution process designed to ensure patient and family concerns are acknowledged, appropriately investigated, and resolved in a timely and consistent manner.

Receipt and Initial Review

Patient and family grievances are documented in the Unusual Occurrence Reporting (UOR) system. The Compliance Department reviews the report, identifies whether it meets the definition of a grievance, and assigns it to the Grievance Resolution Committee and other appropriate stakeholders.

The Quality Department contacts the patient to better understand their concerns, identify their desired outcome, and coordinate the review process.

Investigation and Committee Review

Depending on the nature of the grievance, additional reviews may be initiated, including clinical or Medical Staff peer review, departmental operational review, and financial review.

The GRC meets weekly or as needed to review grievances. During these meetings, the committee evaluates:

- The patient's concerns and desired resolution.
- Clinical and operational findings, including communication gaps, delays, or process failures.
- Billing concerns and potential financial adjustments.
- Opportunities for service recovery, corrective action, and process improvement.

The committee determines whether sufficient information is available to reach a resolution or whether additional investigation is necessary. Significant patient harm events are escalated through the appropriate patient safety and BETA HEART processes.

Resolution and Follow-Up

Once the committee reaches a determination, the Quality Department or designee communicates the outcome to the patient through direct follow-up and a written resolution letter.

Resolution may include clarification of care, an apology, service recovery, financial adjustments when appropriate, or identification of operational and clinical improvements.

The Quality Department coordinates follow-up on identified actions. Beyond resolving individual concerns, the committee uses patient feedback to identify recurring trends, recommend improvements, and support organizational learning and accountability.

Case Volume

During CY 26 Q3, the committee averaged approximately 7 grievances per month, with 6 HEART events identified during the quarter.


Board of Directors
Quality Committee
MAIC
Patient Safety Committee
Peer Review
Falls Committee
Safe Patient Handling
Grievance Resolution Committee (GRC)
Environment of Care Committee (formerly Safety)
Clinical Events Review Committee
Infection Prevention Committee (IP)
Alarm Fatigue Committee
Grievances, HEART Events
Clinical Errors and Near Misses
Antibiotic Stewardship
Sharps Committee

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

DATE: November 2026

TO: Board of Directors, Northern Inyo Healthcare District

FROM: Adam Hawkins, DO, Chief Medical Officer

RE: Patient Safety Committee

MEMORANDUM

Overview

Over the past year, & in conjunction with the work we have pursued through BETA HEART, we have been working to strengthen how Northern Inyo Healthcare District identifies, responds to, and learns from patient safety events. One of our primary goals has been to develop a more coordinated and consistent approach to patient safety across the District.
Historically, much of this work has occurred through individual departments, committees, and processes. While each serves an important purpose, we believe there is an opportunity to better connect these efforts and develop a more comprehensive Patient Safety Program.

Proposed Program Structure

- District-wide coordination: We are developing a Patient Safety Program to coordinate an organized and rapid response to any patient safety event on our campus.
- Clear accountability: Defining responsibility for reviewing safety concerns, coordinating follow-up, and ensuring issues are addressed.
- Consistent response: Developing a more standardized approach to evaluating events, investigating significant concerns, and implementing corrective actions.
- A culture of safety: Encouraging staff to report concerns, near misses, and errors without fear of inappropriate blame or retaliation, with a focus on improving systems.
- Proactive improvement: Identifying high-risk processes and opportunities to prevent harm before an adverse event occurs.

Moving Forward

Ultimately, we want to move beyond simply identifying and documenting patient safety concerns. We want to build a program that ensures concerns are appropriately investigated, assigned to the right teams, and translated into meaningful improvements. This work is ongoing, and we look forward to sharing more as the program develops.

Unusual Occurrence Report (UOR) Overview

January 1 · September 30, 2026

PURPOSE OF SUBMISSION

Submitted to the Quality Committee for review and recommendation to the full Board of Directors.

Report scope

Occurrence reporting volume, categories, trends, aging, response timeliness, and selected reporting details.

Unusual occurrence

An unanticipated occurrence that deviates from regular District operations, whether or not injury occurs. A UOR supports investigation, tracking, trending, and identifying opportunities for performance improvement.

Prepared by Patty Dickson, Compliance Officer
Northern Inyo Healthcare District | November 2026

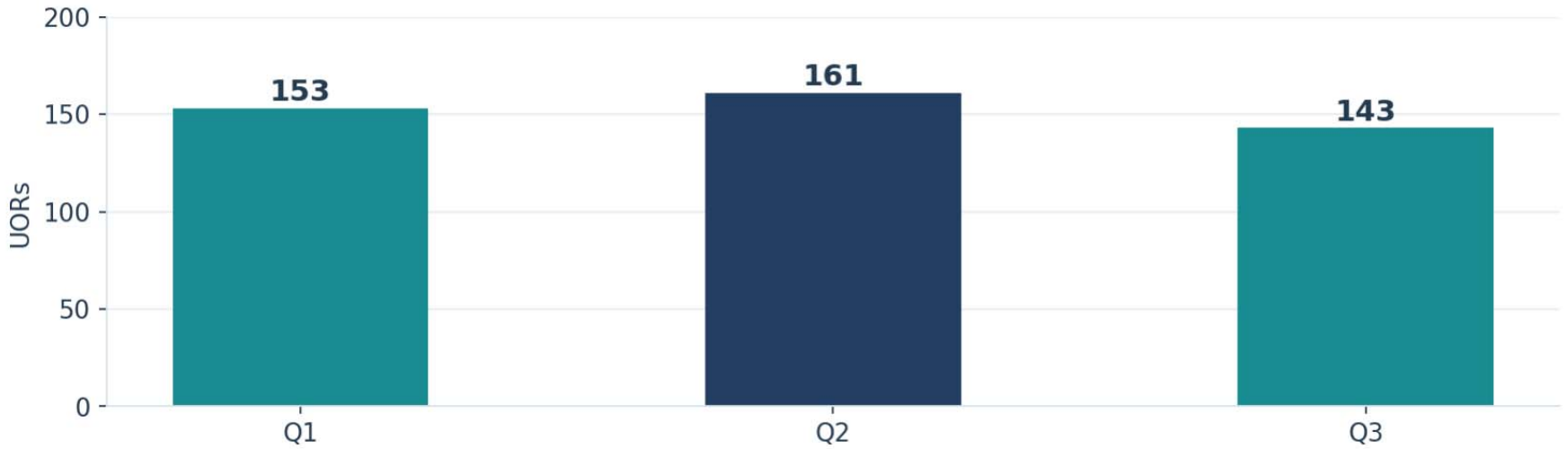
Unusual Occurrence Report (UOR) Overview | January·September 2026

All reported incident categories included

457

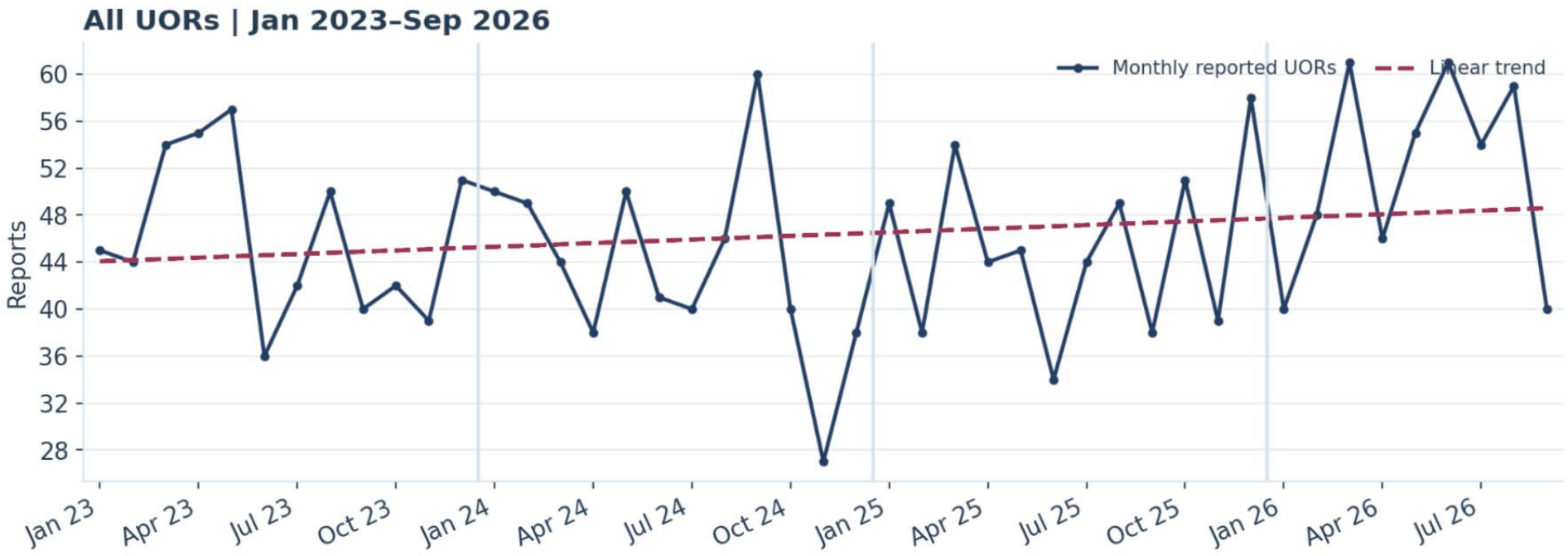
Total reported UORs

January 1–September 30, 2026



Historical Reporting Volume | 2023–2026

Monthly UOR counts and trend line | Through September 30, 2026

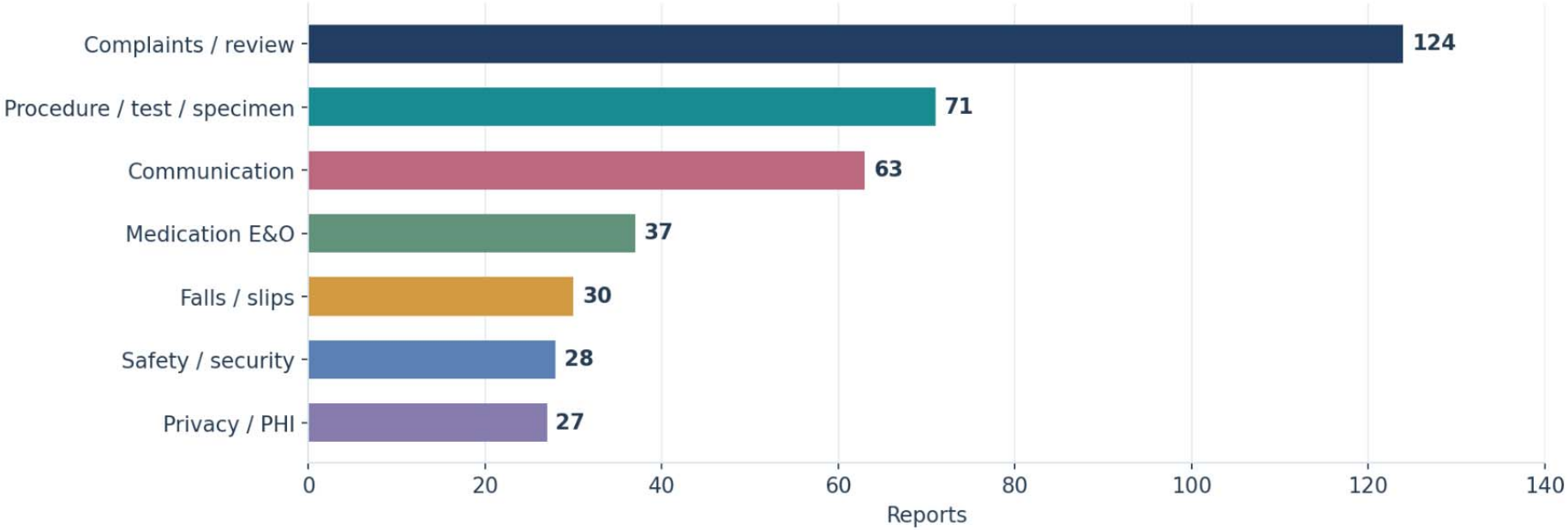


Reporting timing consideration

Some laboratory quality variance reports may be entered in batches rather than at the time of the event. This may contribute to month-to-month fluctuations in recorded UOR volume; the extent has not been quantified.

Top Seven Reported Incident Categories

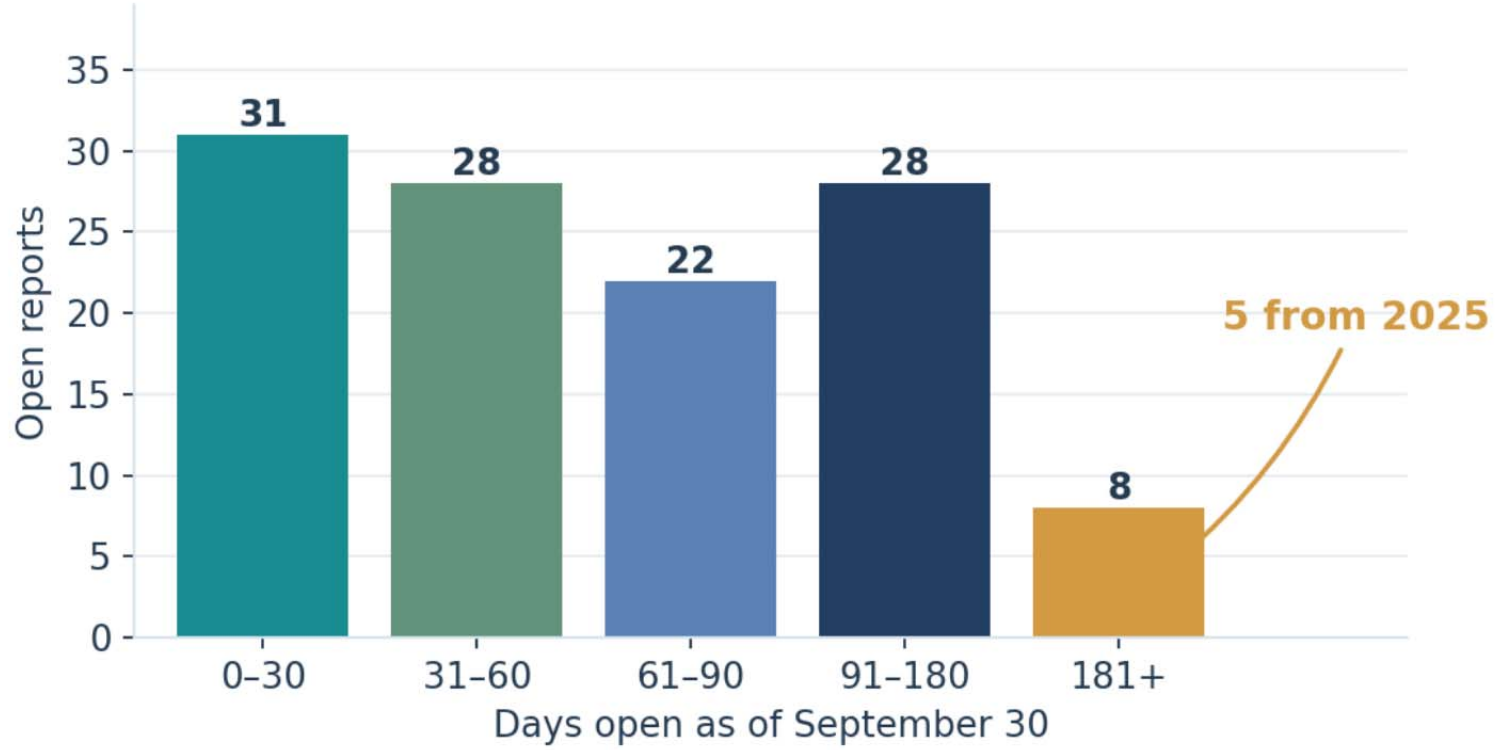
January 1–September 30, 2026 | Includes Medication Errors and Occurrences (E&O) and privacy reports



UOR Aging Report | September 30, 2026

UORs Excluding Medication and Privacy Reports | Creation and closure dates

117 **UORs open on September 30**

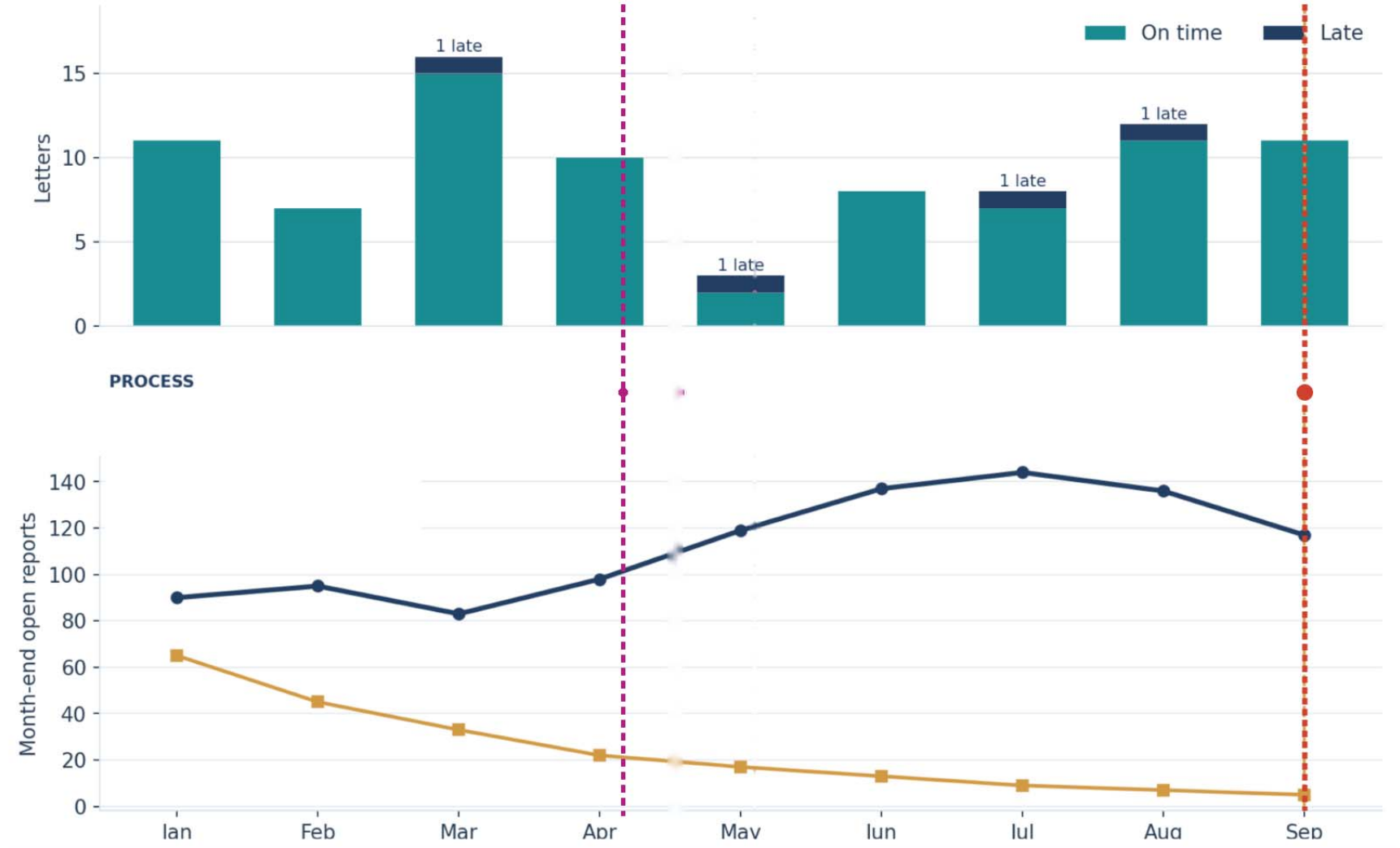


Scope: Medication error and privacy reports are excluded from these aging counts.

An open report does not necessarily represent an unresolved safety concern.

UOR Resolution and Process Improvement

January·September 2026 | Complaint letters, UOR backlog, and workflow milestones



Scope: Open-report trends exclude medication and privacy reports; milestones mark process start dates.

Initial Complaint Response Letter Timeliness

Initial response letters sent within 7 days | 2019-2026

2019

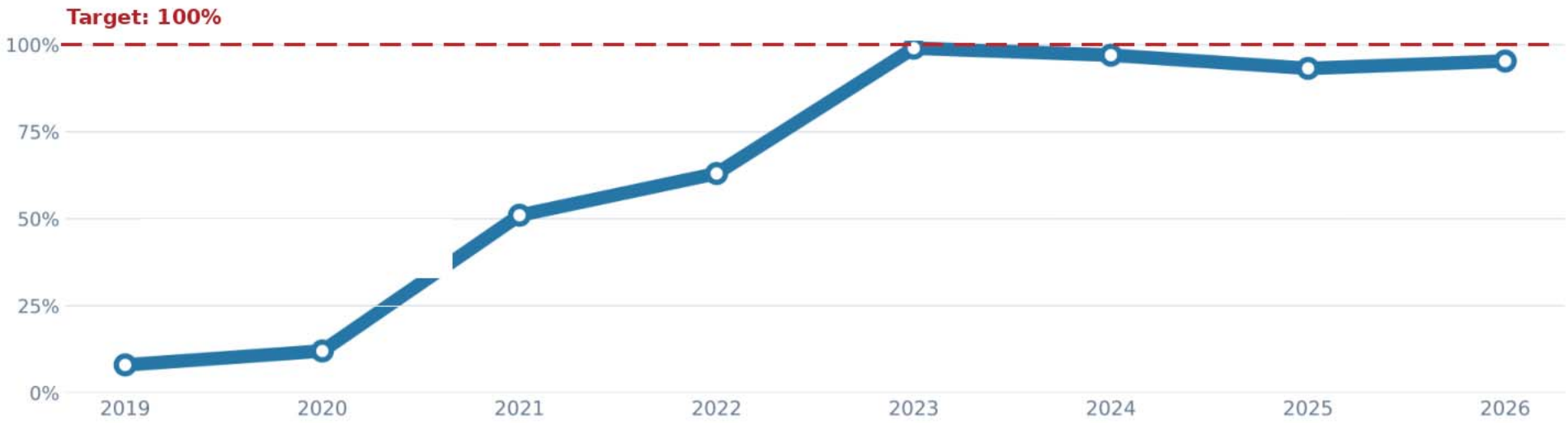
8%

ON TIME

2026

95.3%

ON TIME



2026 data through September 30. Target: 100% of initial letters within 7 days.

Historical Trend | Complaints and Review Requests

January 2023·September 2026



Privacy-Related UORs | Historical Reporting Trend

January 2023–September 2026

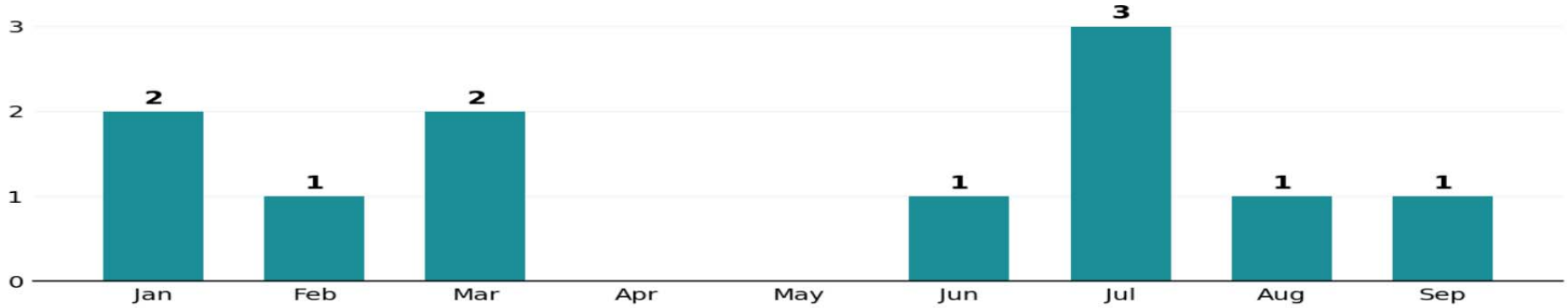


Workplace Violence | Reporting Overview

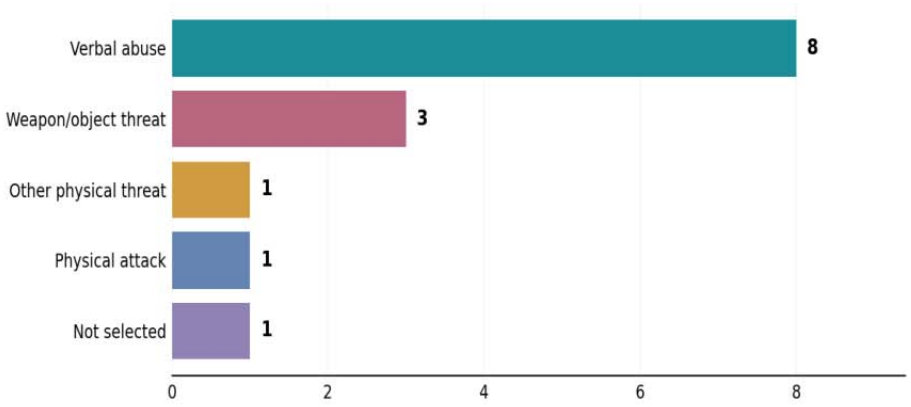
January–September 2026 | Unusual Occurrence Reports (UOR)

11 Workplace violence reports

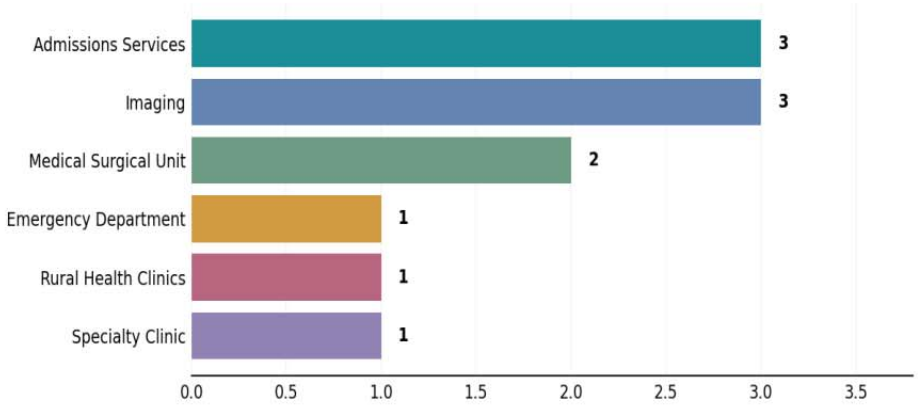
Reports by Month



Reported Aggression Types



Incident Locations

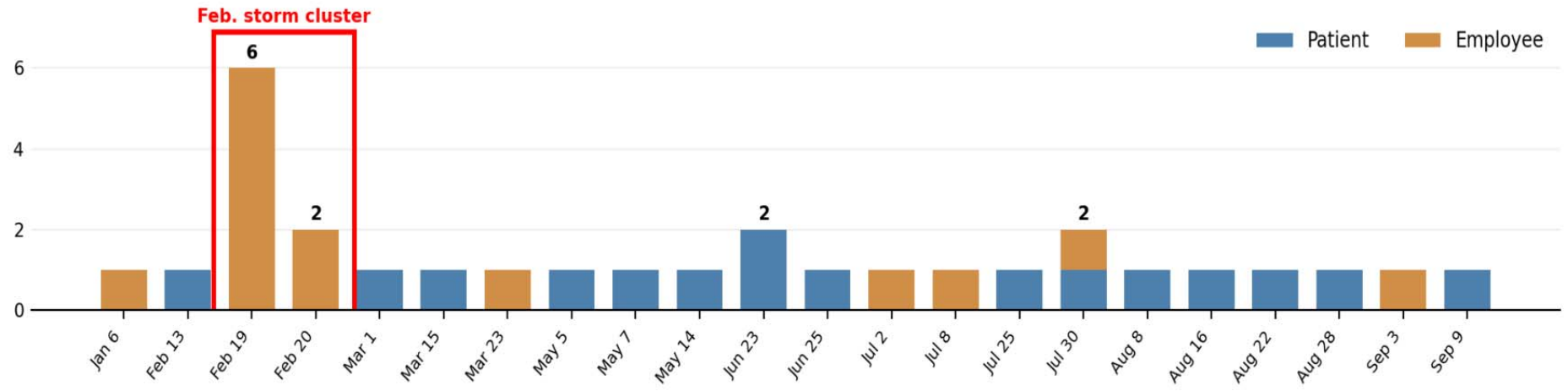


Aggression is a multi-select field; selections may exceed the 11 reported incidents.

Falls and Slips | Reporting and Risk Assessment

January 1·September 30, 2026 | Unusual Occurrence Reports (UOR)

30	TOTAL FALLS/SLIPS
14	EMPLOYEE FALLS
8	STORM CLUSTER



Bars are stacked by patient and employee classification. Red outline highlights the February 19–20 storm-related employee cluster.

Winter Storm | Trend and Corrective Action

Finding: 8 employee falls during February 19·20 storm (57% of employee falls).

Cause: Snow and ice accumulation exceeded manual removal capacity despite extensive Facilities response.

Corrective action: Snow-removal tractor and appropriately sized equipment ordered.

Status: Equipment delivery, winter readiness, and effectiveness to be verified.

Medication Errors and Occurrences | 2026

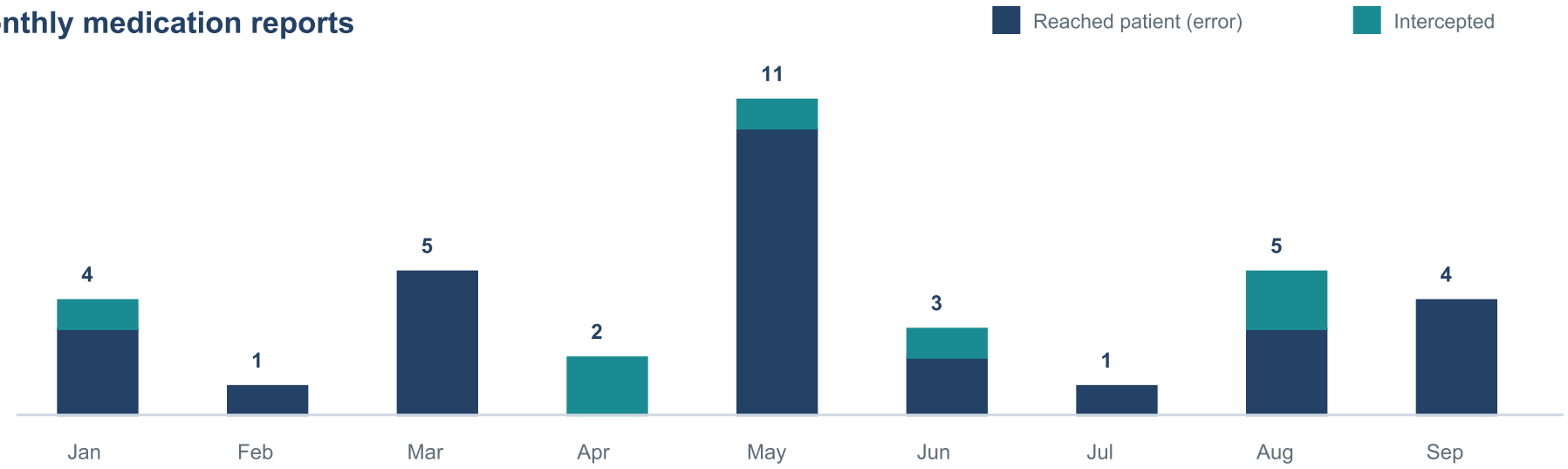
January 1-September 30, 2026 | Medication reporting and MERP indicators

36
Medication-specific reports

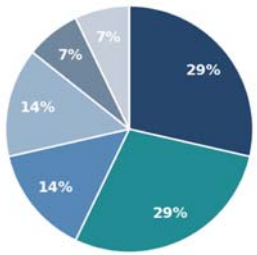
29
Errors reaching the patient

7
Occurrences intercepted

Monthly medication reports



July-September 2026: MERP indicator selections



Administration	**4 (29%)**
Order communication	**4 (29%)**
Labeling	**2 (14%)**
Prescribing	**2 (14%)**
Distribution	**1 (7%)**
Not selected	**1 (7%)**

14 indicator selections across 10 July-September reports

Source: Medication Errors and Occurrences reports, January-September 2026. Of 37 medication-related UORs, 36 have medication-specific classification fields. One was filed through the regular UOR workflow and reviewed by MAIC; its classification fields were not captured.