MINERS' COLFAX MEDICAL CENTER
REGULAR MEETING OF THE BOARD OF TRUSTEES
September 18, 2026
1:00 p.m.

I. PROCEDURAL ITEMS

A. Call to Order

Chairwoman Jeffrey called a Regular Meeting of the Miners' Colfax Medical Center Board of Trustees to order on Friday, September 18, 2026, at 1:00 p.m. The meeting was held at Miners' Colfax Medical Center Acute Care Facility, Zia Conference Room, located at 203 Hospital Drive, Raton, New Mexico.

Members: Shawn Jeffrey, Chairwoman
Loretta Conder, Vice-Chairwoman
Roy Fernandez, Secretary/Treasurer
David Ortiz, Trustee
Zita Lopez, Trustee

Staff: Brian Cotter, Chief Executive Officer
Rhonda Moniot, Chief Nursing Officer
Crystal Armstrong, Chief Integrated Clinical Officer
Jessica Roberts, MD, Chief of Staff
Rae Hager, Quality Director (outgoing)
Alexis Flores, Quality Director
Stephen Kelley, Long Term Care Administrator
Kim Chavez, Human Resources Director
Leslee Fresquez, Executive Assistant/Recorder

Visitors: Sally Hoger, City of Raton City Commissioner

B. Pledge of Allegiance

Chairwoman Jeffrey led the Board, visitors, and staff in the Pledge of Allegiance and Salute to the New Mexico Flag.

C. Roll Call

Chairwoman Jeffrey: present; Vice-Chairwoman Conder: present; Secretary Fernandez: present; Trustee Ortiz: present; Trustee Lopez: present (telephonically). A quorum of the Board was in attendance.

D. Correction/Approval of Agenda

Trustee Ortiz made a motion to approve the agenda as presented; Secretary Fernandez seconded the motion. Roll call: Chairwoman Jeffrey: yes; Vice-Chairwoman Conder: yes; Secretary Fernandez: yes; Trustee Ortiz: yes; Trustee Lopez: yes. The motion carried unanimously.

E. Correction/Approval of Minutes

The Board reviewed the special meeting minutes of July 15, 2026, and regular meeting minutes of August 21, 2026. Trustee Ortiz moved to approve both meeting minutes with one clerical correction to the August 21, 2026 minutes. Vice-Chairwoman Conder seconded the motion. Roll call:

Chairwoman Jeffrey: yes; Vice-Chairwoman Conder: yes; Secretary Fernandez: yes; Trustee Ortiz: yes; Trustee Lopez: yes. The motion carried unanimously.

II. ACKNOWLEDGMENT OF VISITORS

The Board recognized and welcomed the staff members and visitors in attendance.

III. BOARD OF TRUSTEES ELECTION OF OFFICERS

The Board of Trustees conducted its annual election of officers.

CHAIRMAN:

Loretta Conder nominated Shawn Jeffrey to continue to serve as Board of Trustees Chairwoman.

Roy Fernandez nominated David Ortiz to serve as Chairman of the Board.

Following a brief discussion about the election process, Zita Lopez seconded Loretta Conder's nomination of Shawn Jeffrey. Secretary Fernandez's nomination of David Ortiz did not receive a second.

VICE-CHAIRMAN:

As to the Vice-Chairman office position, Loretta Conder nominated David Ortiz. Roy Fernandez seconded the nomination.

Simultaneously, Zita Lopez nominated Loretta Conder as Vice-Chairwoman; Dr. Conder respectfully declined.

SECRETARY:

David Ortiz nominated Roy Fernandez for Secretary of the Board of Trustees. Loretta Conder seconded the nomination. No further discussion.

Roy Fernandez made a motion to reflect the elections process to elect Shawn Jeffrey as Chairwoman, David Ortiz as Vice-Chairman, and Roy Fernandez as Secretary of the Board of Trustees. David Ortiz seconded the motion. The motion carried by unanimous consent.

The Board congratulated the elected officers.

IV. BOARD OF TRUSTEES PLEDGE – CODE OF CONDUCT

The Board reviewed the Board of Trustee Pledge/Meeting Code of Conduct which reads as follows:

Trustee Pledge

Meeting Code of Conduct

Governance excellence is the lifeblood of a high-quality board of directors. It is vital that each board member takes their responsibilities seriously and pledges their best efforts to follow this code of conduct.

In pursuit of governance excellence, I pledge to:

A. Refrain from micromanagement and focus on strategic leadership and policy, not on administrative and operational detail. I will respect distinctions between board and staff roles and will manage any overlap between the respective roles in a spirit of collegiality and partnership that supports the authority of staff and maintains the proper lines of accountability. I will not discuss significant operational concerns or issues with employees or members of the medical staff without the knowledge of the CEO.

B. Recognize that all power of the board is a joint and collective power which only exists when the board is acting together as one body and that I have no power or authority acting individually outside my vote.

C. Attend board and committee meetings regularly and come prepared to fully discuss and deliberate all matters important to the business of the board.

D. Listen carefully to my fellow board members and be willing to consider all points of view during board discussions.

E. Share my point of view, do not dominate discussions, be respectful and courteous in debate, but do not shy away from difficult or contentious issues.

F. Fully support the decisions of the majority once a decision has been reached, even if I am in the minority.

G. Be inquisitive and ask any questions important to the discussions at hand. Strive to push the organization to continuous growth and excellence by bringing to the table our collective knowledge and experience.

H. Keep board discussions and decisions confidential unless directed to solicit stakeholder feedback on specific topics of interest to the board.

I. Take all opportunities to be a good ambassador for the hospital and advocate on behalf of the hospital in matters of public policy issues and encourage philanthropic support that would advance the mission of the hospital.

J. Be a continuous learner and look for opportunities to stay abreast of current topics and trends in healthcare delivery and policy.

K. Follow the conflict-of-interest policies and practices of the hospital.

L. Conduct myself in an ethical, moral, and legal manner always.

M. Celebrate the success of the hospital and the role I play in its mission'

No changes to the Board of Trustees Pledge/Meeting Code of Conduct were identified from the version previously approved in 2025.

Vice-Chairman Ortiz moved to approve the Trustee Pledge and Meeting Code of Conduct as presented; Secretary Fernandez seconded the motion. Roll call: Chairwoman Jeffrey: yes; Vice-Chairman Ortiz: yes: Secretary Fernandez: yes; Trustee Lopez: yes; Trustee Conder: yes. The motion carried unanimously.

Board members were asked to sign the Pledge and Code of Conduct for preservation in official records.

V. EXECUTIVE SESSION

In accordance with the New Mexico Open Meetings Act, closed session to discuss limited personnel matters pursuant to NMSA 1978, Section 10-15-1(H)(2), regarding medical staff credentialing:

1. New Appointment:
   Daniel Sexton, MD - Teleneurosurgery

2. Reappointment:
   Kory Krahl, CRNA – Certified Registered Nurse Anesthetist
   Teddy Silcox, CST – Certified Surgical Technologist

Secretary Fernandez made a motion to enter into executive session for the purpose of discussing medical staff credentialing; Vice-Chairman Ortiz seconded the motion. Roll call: Chairwoman Jeffrey: yes; Vice-Chairman Ortiz: yes; Secretary Fernandez: yes; Trustee Lopez: yes; Trustee Conder: yes. The motion carried unanimously.

The Board entered into closed session discussion at 1:09 p.m.

At 1:16 p.m., Trustee Conder made a motion to return to open session; motion was seconded by Secretary Fernandez. Roll call: Chairwoman Jeffrey: yes; Vice-Chairman Ortiz: yes; Secretary Fernandez: yes; Trustee Lopez: yes; Trustee Conder: yes. The motion carried unanimously.

The Board reconvened in open session.

VI. MEDICAL STAFF PRIVILEGES AND APPOINTMENTS

Chairwoman Jeffrey read aloud the list of providers recommended by the Credentials Committee for new appointment and reappointment:

1. New Appointment:
   Daniel Sexton, MD - Teleneurosurgery

2. Reappointment:
   Kory Krahl, CRNA – Certified Registered Nurse Anesthetist
   Teddy Silcox, CST – Certified Surgical Technologist

The Board corrected the credentialing summary to reflect Teddy Silcox's status as a reappointment rather than a new appointment, and revised the effective date to September 15, 2026.

Vice-Chairman Ortiz made a motion to approve the appointment and reappointment of all providers as presented; Trustee Conder seconded the motion. Roll call: Chairwoman Jeffrey: yes; Vice-Chairman Ortiz: yes; Secretary Fernandez: yes; Trustee Lopez: yes; Trustee Conder: yes. The motion carried unanimously.

VII. MEDICAL STAFF REPORT

Dr. Jessica Roberts presented the Medical Staff Report:

Surgical coverage remains consistent, and efforts continue to recruit and secure regular coverage.

Physician and advanced-practice provider recruitment remains a priority, particularly for primary care, family medicine, OB/women's health, hospitalist coverage, and other needed specialties.

Dr. Ann Foster provided OB and clinic coverage in early September and is anticipated to return in October. Feedback from patients and staff is positive.

Providers recently interviewed include Dr. Maria Castillo for OB/GYN and family medicine, Dr. Daphne Madden for OB/GYN and family medicine, and Dr. Areej Salem for OB/GYN. Nurse practitioner Nicole Rodriguez, a local practitioner, was interviewed for a possible combined position in the OB and primary clinic.

Assured Imaging will return to MCMC on October 29 to provide mammography services. In connection with those services, a breast health and education examination event is planned for the same date in recognition of women's health and Breast Cancer Awareness month.

The Rural OB Access and Maternal Services (ROAMS) program grant is expected to support the purchase of two (2) rocker-recliners and two (2) sleeper chairs for patient/family use. Staff are also

exploring grant support for a Jada device for postpartum hemorrhage management. At present, there are three (3) patients enrolled in the ROAMS program.

Utilization Review Committee meetings continue. Recent discussions include denials, appeals, case review, and provider participation.

Angella Hall has begun working as the Infection Prevention/Employee Health Nurse. The infection prevention committee has already updated several policies and has planned further work on employee health, infection prevention, and antibiotic stewardship policies.

The Credentials Committee reviewed numerous policies for consistency with the updated Medical Staff Bylaws. Additional associated policies and the rules and regulations will continue through the review and approval process.

The leadership quality series has concluded its first phase, with an additional series planned for October. Dr. Jace Hyder is expected to participate in quality meetings as a physician representative.

Work is planned to update the physician lounge and organize existing materials and resources.

The Board discussed continuity of care, the need for stable physician coverage, reliance on temporary providers, provider schedules, OB volumes, and the hospital's ongoing recruitment strategy. The Board recognized the significant work of clinical, medical staff, human resources, and administrative teams in filling short-term coverage gaps.

The Board received the report; no action was taken.

VIII. DISCUSSION/ACTION ITEMS

A. Policies and Procedures Review

A list of revised hospital policies and procedures, previously provided to the Board of Trustees for review, was presented for consideration and approval:

- Arterial Blood Collection for Blood Gas Analysis
- Suspected Lower Extremity Deep Vein Thrombosis (DVT) – Venous Duplex Ultrasound
- Radiation Safety Plan
- Ear Irrigation
- Fresh Frozen Plasma Administration
- Patient Weight Control
- Controlled Delivery by Registered Nurse
- Hand Hygiene
- Work Restrictions Related to Employee Illness
- Required Fit Testing
- Respiratory Protection Plan
- Licensure, Certification, and Registration Verification
- Blood Product Administration Policy
- Provision of Emergency Department Services
- Trauma Activation Policy

Vice-Chairman Ortiz made a motion to approve the policies and procedures as presented. Secretary Fernandez seconded the motion. Roll call: Chairwoman Jeffrey: yes; Vice-Chairman Ortiz: yes;

Secretary Fernandez: yes; Trustee Lopez: yes; Trustee Conder: yes. The motion carried unanimously.

B. Consideration of Revised Medical Staff Bylaws

The Board reviewed the proposed revised Medical Staff Bylaws recently approved by the General Medical Staff and Medical Executive Committee. Discussion included credentialing, appointment and reappointment processes, due process, provider impairment, and new supporting policies in the process of development. The Board acknowledged the extensive and collaborative review process.

Trustee Conder made a motion to approve the revised Medical Staff Bylaws as presented. Secretary Fernandez seconded the motion. Roll call: Chairwoman Jeffrey: yes; Vice-Chairman Ortiz: yes; Secretary Fernandez: yes; Trustee Lopez: yes; Trustee Conder: yes. The motion carried unanimously.

C. Fiscal Year 2028 Budget Appropriation

CEO Cotter presented the Fiscal Year 2028 Budget Appropriation Request. The request was submitted to the New Mexico Department of Finance and Administration with a cover letter stating that MCMC will not request General Fund appropriations because it anticipates adequate funding through the Healthcare Delivery and Access Act (HDAA), the Land Grant Permanent Fund and patient revenue. As a result, the request is comparable to the FY27 Appropriation request. A discussion followed regarding MCMC's rural workforce challenges and recruitment and retention of providers, nurses, and other essential personnel; competitive market wage adjustments, job classifications and descriptions, and the need for flexibility to sustain services.

Secretary Fernandez made a motion to approve the FY28 Budget Appropriation; motion was seconded by Vice-Chairman Ortiz. Roll call: Chairwoman Jeffrey: yes; Vice-Chairman Ortiz: yes; Secretary Fernandez: yes; Trustee Lopez: yes; Trustee Conder: yes. The motion carried unanimously.

D. 2026 Strategic Initiatives Review

CEO Cotter introduced the review of the 2026 Strategic Initiatives, explaining that the update and discussion were intended to confirm whether MCMC's proposed strategic objectives remain the right priorities for MCMC and its leadership team, and to consider:

- Are the current initiatives appropriate and relevant?
- Should new initiatives be added?
- Should existing initiatives be revised, combined, or retired?
- Are the specific areas of focus and performance measures under each initiative appropriate?

The goal of the review is to incorporate feedback and recommendations into the development of the 2027 Strategic Plan, and guide implementation and follow-up throughout calendar year 2027.

The CEO explained that the strategic initiative process establishes MCMC's goals and objectives for the upcoming year and identifies measures of success and performance indicators. These initiatives are intended to align employee efforts with organizational priorities, communicate progress toward key milestones, and recognize achievements and successes throughout the year.

Clinical Operations – Rhonda Moniot, CNO

- **Improve patient experience in the Emergency Department as evidenced by an increase in positive comments in Press Ganey by October 2026 –** Moniot reported that Press Ganey patient-experience results show a significant improvement following implementation of this initiative. Top-box scores were sustained during the most recent quarter, with a slight increase. Clinical Operations will continue reviewing positive and negative comments and using the feedback as part of ongoing quality-improvement efforts.

- **Meet and attest to requirements for Merit-based Incentive Payment System (MIPS) for CY 2025 by March 2026 with a score >75 –** MCMC completed the required 2025 MIPS reporting and attestation activities by the March 2026 deadline. Final performance scores have not yet been released; however, leadership anticipates exceeding the target score of 75. The final score will determine the applicable positive payment adjustment, with results expected before year end.

- **Develop and implement a plan for clinical department education working collaboratively with the education department by October 2026 –** clinical operations collaborated with the education department to implement an organized education plan. Required competencies were completed, and education was provided monthly rather than being consolidated into a single annual session. This approach was well received by staff and supported timely completion of required education and competency requirements.

- **Develop and renew crash cart supplies, resources, checklists and overall knowledge base of emergency procedures by October 2026 –** with funding from the MCMC Auxiliary, MCMC replaced and standardized crash carts. Staff reviewed cart contents, removed supplies that were no longer needed, updated emergency checklists and resources, and expanded education on emergency procedures. Ongoing mock-code activities, including Code Blue and Code White exercises, are helping strengthen staff readiness and response capabilities.

- **Work collaboratively with Quality to create a culture of positivity, respect and professionalism among the Clinical Staff –** clinical operations and Quality have worked jointly to foster a more positive, respectful and professional environment. Clinical staff and ancillary departments, including laboratory, radiology, respiratory, and pharmacy, have met to address workflow concerns, improve communication, and resolve issues through a collaborative, team-based approach. These efforts are intended to strengthen interdisciplinary relationships and support coordinated patient care.

Quality/Patient Safety – Rae Hager, RN, Director of Quality

- **Work collaboratively with all hospital departments to create a culture of positivity, respect and professionalism –** progress continues on MCMC's culture initiative. During the first quarter, all planned activities were completed, including issuance of a staff culture survey and continuation of CEO and senior leadership town halls to promote transparency, communication and staff engagement.

Culture and safety huddles have been implemented successfully and are held each morning with clinical staff. These huddles provide an opportunity for units to share current concerns, operational needs, and safety issues so that staff remain informed and coordinated.

Education on the Action Cue reporting platform was provided through annual reviews, manager meetings, and one-on-one discussions. Training emphasized appropriate system use, event reporting, and the role of managers in addressing issues promptly and constructively.

Second quarter activities included planning for progressive-discipline education for managers. Some managers have already participated in related courses, and leadership will work with the new Human Resources Director to establish a consistent approach that supports policy compliance, fair accountability, appropriate documentation, and staff recognition.

The next staff culture survey is scheduled to open September 21 and remain available until October 25. The survey will remain anonymous while allowing results to be reviewed at the department level. Information Technology has developed multiple access options, including mobile access through a QR code, to encourage broad staff participation.

- **Successfully train new Education/Informatics Nurse** – the education/informatics nurse position was successfully filled and initially supported by Alexis Flores. As Flores transitions into the Quality Director role, the position has reopened. In the interim, Flores will continue providing support to maintain continuity in education and informatics responsibilities until the vacancy is filled.

- **Develop and implement a plan for clinical department education working collaboratively with the clinical departments** – the clinical department education plan has been implemented successfully. Clinical operations, education, and department leaders, collaborated to provide structured monthly education and complete required competencies throughout the year. Staff responded positively to the monthly education model because it distributes learning and competency requirements across the year rather than requiring staff to complete all education during a single, concentrated session. The ongoing approach has helped departments meet education requirements while supporting practical, timely learning for clinical staff.

- **Successfully hire, onboard, and train Infection Prevention and Employee Health Nurse** – the position was successfully filled; Angella Hall has been hired, onboarded, and trained for the role.

Clinical Ancillary/Case Management/Utilization Review – Crystal Armstrong, CICO

- **Collaborate effectively with departments under CICO oversight** – during the first year of the CICO role, progress was made in establishing effective oversight and stronger working relationship across the care management, utilization review, radiology, respiratory and laboratory departments. Agency management support was placed in radiology and laboratory, helping stabilize operations and provide needed leadership. The focus has been

on building manager accountability, departmental self-sufficiency, and consistent communication. Armstrong stated that this initiative has been met.

- **Establish and implement three quality initiatives for each department** – each department is working on at least three quality-improvement initiatives based on identified needs. Ancillary managers meet weekly, with monthly management meetings to review quality dashboards, performance measures and active improvement projects. Departments are engaged in ongoing quality work and have demonstrated progress toward their identified objectives. Armstrong stated that this initiative has been met.

- **Successfully hire, onboard, and train a new care manager and lab manager** – the care manager position has been successfully filled and is adapting well to the combined Care Management and Utilization Review responsibilities.

  The laboratory manager objective is partially complete. A contract laboratory manager was retained to provide leadership and advance priority projects. Leadership is working with Human Resources to review the position's classification and compensation and to develop a retention and long-term staffing plan. The laboratory department is also proactively preparing for a Joint Commission survey.

- **Work collaboratively with Quality to create a culture of positivity, respect and professionalism in the Ancillary/CM/UR Departments** – departments worked collaboratively to address communication barriers and reduce silos among clinical and ancillary teams. Focused interdisciplinary discussions and huddles helped resolve concerns, improve relationships, and support a more collaborative, solution-oriented approach. The "No Gossip" and communication campaigns were introduced to reinforce respectful communication, accountability, and professionalism. Armstrong stated that this initiative remains an ongoing cultural-improvement priority.

A discussion followed about progressive discipline procedures, including supervisor training, zero-tolerance violations, union requirements, and employee due-process rights. Leadership recommended ongoing, scenario-based education to ensure consistent compliance with state rules and personnel actions.

Workforce Development – Kim Chavez, Human Resources Director

- **Continue partnerships with recruitment agencies** – recruitment agency partnerships remain active to support coverage needs in OB, surgery, hospitalist services, and nurse practitioner positions, including holiday coverage and longer-term staffing needs.

- **Employee Recognition Program** – the Employee of the Quarter program continues to receive strong employee participation and nominations. The DAISY Award was also successfully implemented and well received, with peer recognition noted as a valuable contributor to employee morale.

- **Conduct leadership development and management skills education & training** – leadership and management training will continue for all staff.

- **Review/update all MCMC management job descriptions** - Human Resources is collecting and reviewing existing job descriptions and will continue developing or updating descriptions for positions that do not currently have them.

- **Create a culture of positivity, respect, and professionalism among the HR/Security staff** – Human Resources will continue collaborating with Quality to promote a respectful, professional workplace culture, reinforce appropriate progressive discipline, and recognize employees for positive performance.

Financial Health – Brian Cotter, CEO

- **Implement new Cerner/Oracle patient accounting system in early/to mid-2026** – the anticipated Cerner/Oracle patient accounting system implementation has not moved forward as originally expected. Leadership has maintained regular contact with Cerner/Oracle representatives and continues to address system concerns. Current efforts are focused on a Cerner laboratory optimization project.

- **Achieve success in HDAA (SB17) and Rural Hospital Funding (SB161)** – MCMC continues to participate in the Health Delivery and Access Act (HDAA) program and rural hospital funding opportunities. Leadership is monitoring anticipated changes in HDAA funding, including expected reductions in available assessment-related and federal matching funds over the next ten (10) years.

  Quality reporting remains an important component of HDAA participation. MCMC continues to submit required quality data and educate staff on reporting requirements. Financial reporting processes have also been strengthened through completion of a base-year and reporting-year reconciliation.

- **Plan, propose, and coordinate annual capital spending plan** – MCMC has remaining capital funds from a prior year and is developing a new capital spending plan. Approximately $1M in capital needs have been identified, including items such as replacement defibrillators, respiratory therapy equipment, ultrasound equipment and other aging clinical equipment. Requests have been submitted through the state infrastructure capital improvement plan and rural health innovation funding.

- **Work collaboratively with Quality to create a culture of positivity, respect, and professionalism in financial departments** – Leadership continues working with departments to improve communication, clarify responsibilities, and support collaboration in areas such as payroll, accounting, and staff coverage during absences.

Medical Staff/Medical Executive Committee – Jessica Roberts, MD, MCMC Chief of Staff

- **Continue to refine processes related to peer review and provider quality monitoring (OPPE, FPPE) with Texas A&M** – the Medical Executive Committee continues to meet monthly to review cases, determine referrals for external review by Texas A&M, and evaluate peer-review findings. Quality staff compile reports and provider feedback for quarterly review. The FPPE policy, including performance indicators and monitoring requirements, has been completed. Dr. Roberts stated that this objective has been met and will remain an ongoing process.

- **Review and update Medical Staff Bylaws –** bylaws have been successfully reviewed and updated. Future work will focus on related documents, including Medical Staff Rules and Regulations and other pending governance materials.

- **Complete medical staff leadership and credentialing education –** medical staff leaders participated in the Leadership Quality Series, including education designed for physicians and managers. Leadership will continue to share available education opportunities and encourage broader medical staff participation.

- **Improve provider performance and professionalism –** peer-review processes have strengthened, contributing to fewer community concerns and case reports. Leadership emphasized the importance of following the established quality improvement and peer-review processes rather than attempting to address concerns outside formal process.

- **Collaborate with Quality to create a culture of positivity, respect, and professionalism among the medical staff –** Dr. Roberts reported that the medical staff has made progress in promoting respectful, collaborative and professional working relationships. Leadership continues to encourage physician engagement in committees and decision-making, reinforcing that all providers are part of the care team and should have a voice in MCMC's improvement efforts. Dr. Roberts stated this will be an ongoing priority moving forward.

Long Term Care – Stephen Kelley, Long Term Care Administrator

- **Reduce RN agency staffing –** Long Term Care continues to work toward reducing reliance on agency nursing staff; however recruitment and retention remains challenging. The facility currently relies heavily on agency RNs and CNAs, with frequent turnover as agency assignments commonly last thirteen (13) weeks. Recruitment, onboarding, and retention efforts will continue to build a more stable, permanent workforce and strengthen resident continuity of care.

- **Regulatory readiness/maintain 5-Star rating –** Long Term Care successfully completed its recent survey with one (1) deficiency. Required follow-up documentation was submitted and accepted, and all survey-related items have been cleared. Despite staffing challenges, staff have maintained regulatory readiness and continue to provide consistent resident care. The facility remains focused on sustaining compliance and protecting its quality rating.

- **Implement capital improvement plan, focus on new dryers –** the planned dryer replacement has been completed. New dryers have been installed and are operating effectively, replacing units that were more than thirty (30) years old. The existing commercial washers remain operational and continue to support laundry needs for both facilities.

- **Lead organization-integrated emergency preparedness effort –** an Environment of Care and Emergency Preparedness Committee has been reactivated to coordinate emergency planning, water management, environmental safety, and facility-response activities. A joint Hazard Vulnerability Analysis has been completed and MCMC has been recognized for 100% completion of FEMA emergency management training. Water management efforts remain ongoing.

- **Work collaboratively with Quality to create a culture of positivity, respect, and professionalism among the Long Term Care staff** – Kelley reported strong collaboration with hospital departments and support services. Leadership recognized the contributions of staff involved in the Environment of Care Committee, emergency preparedness, infection prevention, laboratory support, and facility operations. The teams continue to work together to resolve operational concerns, strengthen communication, and maintain a respectful, solution-focused culture that supports staff, residents, and regulatory readiness.

Black Lung/Outreach – Kimberly Chavez, Human Resources Director/Senior Leader for Black Lung and Outreach

- **"D" Grant deliverables** – the program continues to meet all federal "D" grant deliverables on time. Required reports, including education and community-assessment data, are submitted as scheduled. The program has not needed to request extensions.

- **"H" Grant deliverables** – "H" grant deliverables are also being completed timely. Program staff continue to collect data and submit reports in accordance with federal grant requirements.

- **Work collaboratively with legal to update UNM agreements and build a stronger partnership** – new agreements have been completed with the University of New Mexico. The Black Lung "D" grant has a new five (5) year contract, and the Outreach "H" grant has a new four (4) year contract. The program collaborated with the University of New Mexico to establish agreements supporting provider coverage. The partnership with UNM remains strong and supports continued services to patient populations.

- **Plan and produce 8 m-DoLBLE exams (4 IN & 4 out of state) incorporating new relationship with Arizona** – the program completed seven (7) m-DoLBLE examinations, including services provided in Utah, Arizona, and throughout New Mexico. Examinations were not conducted during the Wyoming Outreach trip because Wyoming operates its own black lung program. The program exceeded its annual patient-service expectation, serving more than one hundred (100) patients during the year.

- **Work collaboratively with Quality to create a culture of positivity, respect, and professionalism among the Black Lung and Outreach Staff** – the team continues to work collaboratively and maintains a positive, respectful work environment.

  The program was also nominated for the New Mexico Hospital Association Quest for Quality Award in recognition of its work.

Governance – CEO/Board of Directors

- **Oversee strategic plan, initiatives and progress** - The Board and leadership team continued quarterly review of strategic-plan initiatives and progress reports. Discussion reflected meaningful progress across multiple areas, while recognizing that several initiatives require continued work and ongoing oversight.

- **Review CEO/Leadership Team community and promotional activities** - The CEO and leadership team remained actively involved in community and promotional activities throughout the year. Efforts included community clean-up events, Rotary participation,

engagement with city and county leaders, and continued social-media outreach. These activities support community visibility, relationships, and public confidence in the hospital.

- **Review Compliance Monitoring Log biannually** - The Board noted that the compliance monitoring log has not yet been formally reviewed on a biannual basis. Leadership recommended adding this item to a future executive-session agenda to ensure the Board is informed of compliance matters and can provide appropriate oversight.

- **Complete CEO/Board NMHA education, training, and credentialing education** - Board members and the CEO completed the annual New Mexico Hospital Association (NMHA) education, training, and credentialing requirements at a recent NMHA meeting. This objective has been met.

- **Work collaboratively with Quality to create a culture of positivity, respect, and professionalism among the CEO and Board of Directors** - The CEO and Board continue to support a culture of transparency, professionalism, and respectful communication. The CEO reported providing regular updates to Board members to ensure they receive timely information directly from leadership.

The Board received this update and no action was taken.

IX. FINANCIAL REPORT

The Board reviewed financial reports through August. Total assets decreased from approximately $40.1M to $38.9M, primarily due to continued bad-debt write-offs and cleanup of aged accounts receivable. Accounts receivable decreased from approximately $14.4M to $12.1M. Management expects the write-off process to stabilize by the end of the first quarter of2027.

Year-to-date gross patient revenue was approximately $10M, compared with $8.9M in the prior year. However, bad-debt adjustments of approximately $836,000 reduced total operating revenue to approximately $4.9M, compared with $5.7M in the prior-year period.

Operating expenses were below budget for the month and year to date. The year-to-date operating loss was approximately $2.1M, which was favorable to the budgeted loss of approximately $2.3M. Increased employee benefits, contract labor, purchased services, and information technology agreements contributed to year-to-date expense variances.

Patient utilization increased in several areas, including acute inpatient admissions, observation admissions, clinic visits, and patient days. Management noted that increased observation admissions reflect improved coordination among providers, care management, and utilization review to ensure appropriate patient status and safe discharge planning. Surgical cases and swing-bed admissions were lower than the prior year.

Days in accounts receivable improved from seventy-two (72) to sixty-five (65) days. The Board discussed the need for a more detailed accounts receivable aging report and whether the bad-debt write-offs may require a budget adjustment. Updated capital outlay information is expected at the next meeting.

The Board received the report; no action was taken.

X. CEO REPORT

The CEO reported continued positive performance in key operational metrics. The admission rate remained near ten (10) percent, while the transfer rate decreased to seven (7) percent, reflecting improved collaboration among physicians, hospitalists, nursing, and other clinical staff. Emergency Department performance remained strong, with door-to-provider time averaging approximately six (6) minutes, average length of stay decreasing to one hundred forty-seven (147) minutes, and a low rate of patients leaving without being seen or completing treatment.

Medical-surgical patient days remained steady, with continued observation utilization and lower swing-bed activity. Clinic productivity was noted, with expectations for improvement as staffing stabilizes. Surgery metrics were added to the report, showing a favorable mix of outpatient procedures. Management noted that outpatient surgery growth benefits both patient access and hospital reimbursement, particularly with consistent surgical coverage.

The CEO provided an update on the Rural Health Transformation Program. Eastern Plains Council of Governments (EPCOG) was awarded the Healthy Horizons initiative, and a regional meeting was scheduled to discuss roles, responsibilities, and initiatives related to maternal health, behavioral health, telemedicine, and opioid treatment. The hospital's Rural Health Innovation Fund application was submitted, with a response expected from the New Mexico Health Care Authority by the end of September.

Progress continues on finalizing the hospitalist program agreement with Western Healthcare. Contract discussions are approximately ninety-five (95) percent complete. Under the proposed model, hospitalists would be employed by the hospital rather than serving as independent contractors, which is expected to reduce malpractice and overall program costs, improve continuity of care, and strengthen physician participation on the medical staff and related committees.

The CEO introduced a draft Fiscal Year 2027 strategic planning template organized around the pillars of people, service, quality, finance, and growth. The plan will include measurable goals, baselines, targets, responsible parties, and reporting frequency. Leadership will continue refining the plan, with a goal of presenting it to the Board in November.

Management continues discussions with UNM regarding potential partnership opportunities, including clinical support, training, and reciprocal learning opportunities. The CEO also reported continued participation in coding and clinical documentation improvement meetings and noted that a cash register and Clover payment station will be implemented at Long-Term Care to improve cash handling and payment tracking.

The CEO discussed outreach efforts related to upcoming Medicaid reenrollment requirements and work or volunteer requirements. Management expressed concern that these changes could cause coverage losses and create significant financial and operational challenges for rural hospitals and patients. The hospital is participating in statewide and regional discussions and plans to continue community education efforts.

The CEO also reported advocacy efforts related to rural health, women's health, Medicare Advantage oversight, and the Rural Health Transformation Program. Discussions have occurred with congressional staff and Senator Ben Ray Luján's office regarding the need for greater accountability in Medicare Advantage medical loss ratios and improved support for rural healthcare providers.

Management reported that Long-Term Care remains under water restrictions, with showers being provided in an alternate location.

The CEO noted the hiring of Marie Kington as the new Emergency Department Manager. Kington has more than 20 years of emergency nursing and leadership experience. Management reported that she has made a positive initial impression and intends to focus on staff recruitment, training, and reduction of agency staffing.

The Board received the report; no action was taken.

XI. EXECUTIVE SESSION

In accordance with the NM Open Meetings Act, closed session to discuss:

A. Limited personnel matters, pursuant to NMSA 1978, Section 10-15-1(H)(2)

Secretary Fernandez moved to enter into closed session; the motion was seconded by Vice-Chairman Ortiz. Roll call: Chairwoman Jeffrey: yes; Vice-Chairman Ortiz: yes; Secretary Fernandez: yes; Trustee Lopez: yes; Trustee Conder: yes. The motion carried unanimously.

At 4:00 p.m., the Board entered into closed session discussion.

At 6:20 p.m., Vice-Chairman Ortiz made a motion to return to open session; Trustee Lopez seconded the motion. Roll call: Chairwoman Jeffrey: yes; Vice-Chairman Ortiz: yes; Secretary Fernandez: yes; Trustee Lopez: yes; Trustee Conder: yes. The motion carried unanimously.

XII. OPEN SESSION/ANNOUNCEMENTS

No announcements were made.

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XIII. ADJOURNMENT

With no further business to discuss, Vice-Chairman Ortiz made a motion to adjourn the meeting. The motion was seconded by Secretary Fernandez. Roll call: Chairwoman Jeffrey: yes; Vice-Chairman Ortiz: yes; Secretary Fernandez: yes; Trustee Lopez: yes; Trustee Conder: yes. The motion carried unanimously

The meeting was adjourned at 6:21 p.m.

ATTEST:

_____ _____

Shawn Jeffrey, Chairwoman **Date**

_____ _____

David Ortiz, Vice-Chairman **Date**

XIII. ADJOURNMENT

With no further business to discuss, Vice-Chairman Ortiz made a motion to adjourn the meeting. The motion was seconded by Secretary Fernandez. Roll call: Chairwoman Jeffrey: yes; Vice-Chairman Ortiz: yes; Secretary Fernandez: yes; Trustee Lopez: yes; Trustee Conder: yes. The motion carried unanimously

The meeting was adjourned at 6:21 p.m.

ATTEST:

Shawn Jeffrey — 10-16-26

Shawn Jeffrey, Chairwoman — **Date**

[signature] — 10-16-2026

David Ortiz, Vice-Chairman — **Date**