



September 23, 2022

NOTICE

The Board of Directors of the Kaweah Delta Health Care District will meet in the City of Visalia City Council Chambers {707 W. Acequia, Visalia, CA} on Wednesday September 28, 2022 beginning at 4:00PM in open session; at 4:01PM and immediately following the 4:30PM open meeting the Board will meet in closed sessions pursuant to Government Code 54956.9(d)(2), 54957(b)(1) and Health and Safety Code 1461 and 32155; at 4:30PM an open session.

All Kaweah Delta Health Care District regular board meeting and committee meeting notices and agendas are posted 72 hours prior to meetings (special meetings are posted 24 hours prior to meetings) in the Kaweah Health Medical Center, Mineral King Wing entry corridor between the Mineral King lobby and the Emergency Department waiting room.

The disclosable public records related to agendas can be obtained by contacting the Board Clerk at Kaweah Health Medical Center – Acequia Wing, Executive Offices (Administration Department) {1st floor}, 400 West Mineral King Avenue, Visalia, CA via phone 559-624-2330 or email: cmoccio@kawahhealth.org, or on the Kaweah Delta Health Care District web page <http://www.kawahhealth.org>.

KAWEAH DELTA HEALTH CARE DISTRICT
Mike Olmos, Secretary/Treasurer

A handwritten signature in black ink that reads "Cindy Moccio". The signature is written in a cursive, flowing style.

Cindy Moccio
Board Clerk / Executive Assistant to CEO

DISTRIBUTION:
Governing Board
Legal Counsel
Executive Team
Chief of Staff

www.kawahhealth.org

KAWEAH DELTA HEALTH CARE DISTRICT BOARD OF DIRECTORS MEETING

City of Visalia – City Council Chambers
707 W. Acequia, Visalia, CA

Wednesday September 28, 2022

OPEN MEETING AGENDA {4:00PM}

1. **CALL TO ORDER**
2. **APPROVAL OF AGENDA**
3. **PUBLIC PARTICIPATION** – Members of the public may comment on agenda items before action is taken and after it is discussed by the Board. Each speaker will be allowed five minutes. Members of the public wishing to address the Board concerning items not on the agenda and within the jurisdictions of the Board are requested to identify themselves at this time. For those who are unable to attend the beginning of the Board meeting during the public participation segment but would like to address the Board, please contact the Board Clerk (Cindy Moccio 559-624-2330) or cmoccio@kaweahhealth.org to make arrangements to address the Board.
4. **APPROVAL OF THE CLOSED AGENDA – 4:01PM**
 - 4.1. **Credentialing** - Medical Executive Committee (MEC) requests that the appointment, reappointment and other credentialing activity regarding clinical privileges and staff membership recommended by the respective department chiefs, the credentials committee and the MEC be reviewed for approval pursuant to Health and Safety Code 1461 and 32155 – *Daniel Hightower, MD Vice Chief of Staff*
 - 4.2. **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461, report of quality assurance committee — *Daniel Hightower, MD Vice Chief of Staff*
 - 4.3. **Conference with Legal Counsel – Anticipated Litigation** – Significant exposure to litigation pursuant to Government Code 54956.9(d)(2) – 1 Case – *Rachele Bergland, Legal Counsel and Evelyn McEntire, Director of Risk Management*
 - 4.4. **Approval of the closed meeting minutes** – August 24, 2022.

Public Participation – Members of the public may comment on agenda items before action is taken and after the item has been discussed by the Board.

Action Requested – Approval of the September 28, 2022 closed meeting agenda.

5. ADJOURN

CLOSED MEETING AGENDA {4:01PM}

1. **CALL TO ORDER**
2. **CREDENTIALING** - Medical Executive Committee (MEC) requests that the appointment, reappointment and other credentialing activity regarding clinical privileges and staff

membership recommended by the respective department chiefs, the credentials committee and the MEC be reviewed for approval pursuant to Health and Safety Code 1461 and 32155.

Daniel Hightower, MD Vice Chief of Staff

3. **QUALITY ASSURANCE** pursuant to Health and Safety Code 32155 and 1461, report of quality assurance committee.

Daniel Hightower, MD Vice Chief of Staff

4. **CONFERENCE WITH LEGAL COUNSEL – ANTICIPATED LITIGATION** – Significant exposure to litigation pursuant to Government Code 54956.9(d)(2) – 1 Case.

Rachele Bergland, Legal Counsel and Evelyn McEntire, Director of Risk Management

5. **APPROVAL OF THE CLOSED MEETING MINUTES** – [August 24, 2022](#).

Action Requested – Approval of the closed meeting minutes – August 24, 2022.

6. **ADJOURN**

OPEN MEETING AGENDA {4:30PM}

1. **CALL TO ORDER**

2. **APPROVAL OF AGENDA**

3. **PUBLIC PARTICIPATION** – Members of the public may comment on agenda items before action is taken and after it is discussed by the Board. Each speaker will be allowed five minutes. Members of the public wishing to address the Board concerning items not on the agenda and within the jurisdictions of the Board are requested to identify themselves at this time. For those who are unable to attend the beginning of the Board meeting during the public participation segment but would like to address the Board, please contact the Board Clerk (Cindy Moccio 559-624-2330) or cmoccio@kaweahhealth.org to make arrangements to address the Board.

4. **CLOSED SESSION ACTION TAKEN** – Report on action(s) taken in closed session.

5. **OPEN MINUTES** – Request approval of the [August 24, 2022 open minutes](#).

Public Participation – Members of the public may comment on agenda items before action is taken and after the item has been discussed by the Board.

Action Requested – Approval of the open meeting minutes August 24, 2022 open board of directors meeting minutes.

6. **RECOGNITIONS** – *Lynn Havard Mirviss*

6.1. Presentation of [Resolution 2172](#) to [Susanna Ehram](#), in recognition as the Kaweah Health World Class Employee of the Month recipient – September 2022.

6.2. Presentation of [Resolution 2173](#) to Tracie Sherman, RN (Director of Child and Maternal Health) retiring from Kaweah Health with 31 years of service.

6.3. Presentation of [Resolution 2174](#) to Michael Boyd, DPM, in recognition of his service as the Kaweah Health Medical Staff Credentials Chair from 1999-2022.

7. INTRODUCTIONS – NEW DIRECTORS

7.1. JC Palermo, Director of Physician Recruitment

7.2. Rhonda Quinones, Interim Director of Maternal Child Health

7.3. Brittany Taylor, Director of Human Resources

- 8. CREDENTIALS** - Medical Executive Committee requests that the appointment, reappointment and other credentialing activity regarding clinical privileges and staff membership recommended by the respective department chiefs, the credentials committee and the Medical Executive Committee be reviewed for approval.

Daniel Hightower, MD Vice Chief of Staff

Public Participation – Members of the public may comment on agenda items before action is taken and after the Board has discussed the item.

Recommended Action: Whereas a thorough review of all required information and supporting documentation necessary for the consideration of initial applications, reappointments, request for additional privileges, advance from provisional status and release from proctoring and resignations (pursuant to the Medical Staff bylaws) has been completed by the Directors of the clinical services, the Credentials Committee, and the MEC, for all of the medical staff scheduled for reappointment, Whereas the basis for the recommendations now before the Board of Trustees regarding initial applications, reappointments, request for additional privileges, advance from provisional status and release from proctoring and resignations has been predicated upon the required reviews, including all supporting documentation, Be it therefore resolved that the following medical staff be approved or reappointed (as applicable), as attached, to the organized medical staff of Kaweah Delta Health Care District for a two year period unless otherwise specified, with physician-specific privileges granted as recommended by the Chief of Service, the Credentials Committee, and the Executive Committee of the Medical Staff and as will be documented on each medical staff member’s letter of initial application approval and reappointment from the Board of Trustees and within their individual credentials files.

- 9. CHIEF OF STAFF REPORT** – Report relative to current Medical Staff events and issues.

Daniel Hightower, MD, Vice Chief of Staff

- 10. CONSENT CALENDAR** - All matters under the Consent Calendar will be approved by one motion, unless a Board member requests separate action on a specific item.

Public Participation – Members of the public may comment on agenda items before action is taken and after the item has been discussed by the Board.

Action Requested – Approval of the September 28, 2022 Consent Calendar.

10.1. REPORTS

- A. [Physician Recruitment](#)
- B. [Environment of Care](#)
- C. [Orthopedic Services](#)
- D. [Outpatient Lab & Pathology](#)
- E. [Rehabilitation Services](#)
- F. [Senior Housing](#)
- G. [Cardiology Quality](#)

- 10.2. Kaweah Delta Health Care District dba Kaweah Health [Scope of Services](#).
- 10.3. [Safety Culture Action Plan Update](#) – August 2022
- 10.4. [Deny application for leave to present a late claim](#) after expiration of the time allowed by law re: Katheryn Lynne Gress, Richard David Gress Jr., Katheryn Michelle Gress, Amy Elizabeth Gress, Christopher Aaron Gress vs Kaweah Delta Health Care District.
- 10.5. POLICIES – Environment of Care
 - A. [EOC 1018](#) - Monitoring Refrigerator and Freezer Temperature
 - B. [EOC 1085](#) - District Electrical Safety Policy
 - C. [EOC 6002](#) -Medical Equipment Defective Device Repair
 - D. [EOC 6004](#) - Medical Equipment Hazardous Device and Recall Notification
 - E. [EOC 6018](#) - Retirement/Deletion of Medical Equipment from MEM Program
 - F. [EOC 2000](#) - Emergency Operations Plan
 - G. [EOC 5001](#) - Facility Fire Response Plan
 - H. EOC 6003 - Medical Equipment- Health Care Device Modification Policy - Reviewed
- 10.6. POLICIES – Board of Directors
 - A. [BOD6](#) Board Reimbursement for Travel and Service Clubs
 - B. [BOD7](#) Presentation of Claims and Service Process
- 10.7. POLICIES – Medical Staff Policy reviewed and approved by the Medical Executive Committee
 - A. [MS42](#) - Process for Quality Review of Medical Staff, Resident Physician, and Advanced Practice Provider Staff Medical Record Documentation (Revised)
- 10.8. POLICIES – Administrative Policies.
 - A. [AP07](#) - Communication with law enforcement regarding requests for information and requests to interview interrogate a patient.
 - B. [AP15](#) – Loan of Kaweah Health Equipment and or Supplies
 - C. [AP40](#) – Vendor Relationships and Conflict of Interest
 - D. [AP.42](#) – Security of Purchased Equipment and or Supplies
 - E. [AP45](#) – Risk Management Plan
 - F. [AP67](#) – District Fleet Vehicles and Management
 - G. [AP70](#) – Code of Ethical Behavior
 - H. [AP91](#) – Unannounced Regulatory Survey Plan for Response
 - I. [AP97](#) – Bioethics Committee
 - J. [AP103](#) – Public Release of Patient Information
 - K. [AP104](#) – Animal Assisted Activities Therapy
 - L. [AP114](#) – Census Saturation Plan
 - M. [AP119](#) – Visiting Regulations for Kaweah Delta Health Care District
 - N. [AP124](#) – Admission Policy
 - O. [AP132](#) – Use of rental, loaner, or demo clinical equipment

- P. [AP135](#) – Capital Budget Purchases
- Q. [AP154](#) – Medication Error Reduction Plan
- R. [AP156](#) – Standard Procurement Practice
- S. [AP158](#) – Solicitation, Fundraising and Distribution of Materials
- T. [AP167](#) – Quote and Proposal Guidelines
- U. [AP171](#) – Medically Ineffective Care

11. **QUALITY – DIVERSION PREVENTION** - A review of committee measures and actions to prevent diversion events.

Evelyn McEntire, Director of Risk Management, Shannon Cauthen, Director of Critical Care Services

12. **STRATEGIC PLAN - Patient and Community Experience** – Detailed review of Strategic Plan Initiative.

Ed Largoza, Director of Patient Experience and Keri Noeske, Chief Nursing Officer

13. **PATIENT THROUGHPUT PERFORMANCE** - Review of patient throughput performance improvement progress report.

Rebekah Foster, Director Care Management & Keri Noeske, Chief Nursing Officer

14. **FINANCIALS** – Review of the most current fiscal year financial results and budget.

Malinda Tupper – Chief Financial Officer

15. **CALIFORNIA HEALTH FACILITIES FINANCIAL AUTHORITY (CHFFA)** - Review of proposed resolution 2175 authorizing execution and delivery of a loan and security agreement, promissory note, and certain actions in connection therewith for the CHFFA non-designated public hospital bridge loan program.

Jennifer Stockton, Director of Finance

Public Participation – Members of the public may comment on agenda items before action is taken and after the Board has discussed the item.

Recommended Action: Approval of Resolution 2175, a resolution of Kaweah Delta Health Care District authorizing its Chief Financial Officer, and/or its Director of Finance to execute and deliver a loan and security agreement, promissory note, and certain actions in connection therewith for the California Health Facilities Financing Authority Nondesignated Public Hospital Bridge Loan Program.

16. REPORTS

- 16.1. **Chief Executive Officer Report** - Report relative to current events and issues.

Gary Herbst, Chief Executive Officer

- 16.2. **Board President** - Report relative to current events and issues.

David Francis, Board President

- 17. APPROVAL OF CLOSED AGENDA AS FOLLOWS:** Closed Meeting Agenda – Immediately following the 4:30PM open session
- 17.1. Conference with Legal Counsel – Anticipated Litigation** – Significant exposure to litigation pursuant to Government Code 54956.9(d)(2) – 1 Case – *Gary Herbst, Chief Executive Officer, Marc Mertz, Chief Strategy Officer, Ben Cripps Chief Compliance and Risk Officer, and Rachele Berglund, Legal Counsel*
 - 17.2. Personnel** – Consideration of the employment of a potential employee {Chief Medical Officer / Chief Quality Officer} per Government Code 54957(b)(1) – *Board of Directors and Gary Herbst, Chief Executive Officer*
 - 17.3. CEO Evaluation** – Discussion with the Board and the Chief Executive Officer relative to the evaluation of the Chief Executive Officer pursuant to Government Code 54957(b)(1) – *Gary Herbst, CEO, Rachele Berglund, Legal Counsel & Board of Directors*
- 18. ADJOURN**

CLOSED MEETING AGENDA

- 1. CALL TO ORDER**
- 2. CONFERENCE WITH LEGAL COUNSEL – ANTICIPATED LITIGATION** – Significant exposure to litigation pursuant to Government Code 54956.9(d)(2) – 1 Case.
Gary Herbst, Chief Executive Officer, Marc Mertz, Chief Strategy Officer, Ben Cripps Chief Compliance and Risk Officer, and Rachele Berglund, Legal Counsel
- 3. PERSONNEL** – Consideration of the employment of a potential employee {Chief Medical Officer / Chief Quality Officer} per Government Code 54957(b)(1).
Board of Directors and Gary Herbst, Chief Executive Officer, and Rachele Berglund, Legal Counsel
- 4. CEO EVALUATION** – Discussion with the Board and the Chief Executive Officer relative to the evaluation of the Chief Executive Officer pursuant to Government Code 54957(b)(1).
Gary Herbst, CEO, Rachele Berglund, Legal Counsel & Board of Directors
- 5. ADJOURN**

In compliance with the Americans with Disabilities Act, if you need special assistance to participate at this meeting, please contact the Board Clerk (559) 624-2330. Notification 48 hours prior to the meeting will enable the District to make reasonable arrangements to ensure accessibility to the Kaweah Delta Health Care District Board of Directors meeting.

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KAWEAH DELTA HEALTH CARE DISTRICT

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MINUTES OF THE OPEN MEETING OF THE KAWEAH DELTA HEALTH CARE DISTRICT BOARD OF DIRECTORS HELD WEDNESDAY AUGUST 24, 2022 AT 4:00PM, IN THE CITY OF VISALIA CITY COUNCIL CHAMBERS – 707 W. ACEQUIA, VISALIA, CA.

PRESENT: Directors Francis, Gipson, Olmos & Rodriguez; M. Manga, MD, Chief of Staff, K. Noeske, CNO; M. Tupper, CFO; M. Mertz, Chief Strategy Officer & Acting CEO; D. Leeper, Chief Information and Cybersecurity Officer & R. Gates, Chief Population Health Officer; J. Batth, Chief Operating Officer; B. Cripps, Chief Compliance Officer, R. Berglund, Legal Counsel; and C. Moccio, recording

The meeting was called to order at 4:00PM by Director Francis.

Director Francis entertained a motion to approve the agenda.

MMSC (*Gipson/Olmos*) to approve the open agenda. This was supported unanimously by those present. Vote: Yes – Olmos, Gipson, Rodriguez, and Francis

PUBLIC PARTICIPATION – None

APPROVAL OF THE CLOSED AGENDA – 4:01PM

- **Credentialing** - Medical Executive Committee (MEC) requests that the appointment, reappointment and other credentialing activity regarding clinical privileges and staff membership recommended by the respective department chiefs, the credentials committee and the MEC be reviewed for approval pursuant to Health and Safety Code 1461 and 32155 – *Monica Manga, MD Chief of Staff*
- **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461, report of quality assurance committee — *Monica Manga, MD Chief of Staff*
- **Conference with Legal Counsel – Anticipated Litigation** – Significant exposure to litigation pursuant to Government Code 54956.9(d)(2) – 3 Cases – *Rachele Berglund, Legal Counsel and Evelyn McEntire, Director of Risk Management*
- **Conference with Legal Counsel – Anticipated Litigation** – Significant exposure to litigation pursuant to Government Code 54956.9(d)(2) – 8 Cases – *Ben Cripps, and Rachele Berglund, Legal Counsel*
- **Approval of the closed meeting minutes** – July 27, 2022.

Public Participation – Members of the public may comment on agenda items before action is taken and after the item has been discussed by the Board – No public present.

MMSC (*Gipson/Rodriguez*) to approve the August 24, 2022 closed agenda. This was supported unanimously by those present. Vote: Yes – Olmos, Rodriguez, Gipson, and Francis

ADJOURN - Meeting was adjourned at 4:01PM

David Francis, President
Kaweah Delta Health Care District and the Board of Directors

ATTEST:

Mike Olmos, Secretary/Treasurer
Kaweah Delta Health Care District Board of Directors

MINUTES OF THE OPEN MEETING OF THE KAWEAH DELTA HEALTH CARE DISTRICT BOARD OF DIRECTORS HELD WEDNESDAY AUGUST 24, 2022 AT 4:30PM, IN THE CITY OF VISALIA CITY COUNCIL CHAMBERS – 707 W. ACEQUIA, VISALIA, CA.

PRESENT: Directors Francis, Gipson, Havard Mirviss, Olmos & Rodriguez; M. Manga, MD, Chief of Staff, K. Noeske, CNO; M. Tupper, CFO; M. Mertz, Chief Strategy Officer & Acting CEO; D. Leeper, Chief Information and Cybersecurity Officer & R. Gates, Chief Population Health Officer; J. Batth, Chief Operating Officer; B. Cripps, Chief Compliance Officer, R. Berglund, Legal Counsel; and C. Moccio, recording

The meeting was called to order at 4:40PM by Director Francis.

Director Francis asked for approval of the agenda.

MMSC (*Havard Mirviss/Gipson*) to approve the open agenda. This was supported unanimously by those present. Vote: Yes – Havard Mirviss, Olmos, Rodriguez, Gipson, and Francis

PUBLIC PARTICIPATION – None.

CLOSED SESSION ACTION TAKEN: Approval the closed minutes from July 27, 2022.

OPEN MINUTES – Request approval of the open meeting minutes July 27 and August 10, 2022.

Public Participation – Members of the public may comment on agenda items before action is taken and after the item has been discussed by the Board.

MMSC (*Olmos/Havard Mirviss*) to approve the open minutes from July 27 and August 10, 2022. This was supported unanimously by those present. Vote: Yes – Gipson, Olmos, Havard Mirviss, Rodriguez, and Francis.

RECOGNITIONS – David Francis

Presentation of Resolution 2171 to Valarie Domingo, in recognition as the Kaweah Health World Class Employee of the Month recipient – August 2022.

INTRODUCTIONS – NEW DIRECTORS

- Hannah Mitchell, Director of Organizational Development

CREDENTIALING – Medical Executive Committee requests that the appointment, reappointment and other credentialing activity regarding clinical privileges and staff membership recommended by the respective department chiefs, the credentials committee and the Medical Executive Committee be reviewed for approval.

Public Participation – Members of the public may comment on agenda items before action is taken and after the item has been discussed by the Board.

Director Francis requested a motion for the approval of the credentials report.

MMSC (*Gipson/Havard Mirviss*) *Whereas a thorough review of all required information and supporting documentation necessary for the consideration of initial applications, reappointments, request for additional privileges, advance from provisional status and*

release from proctoring and resignations (pursuant to the Medical Staff bylaws) has been completed by the Directors of the clinical services, the Credentials Committee, and the Executive Committee of the Medical Staff, for all of the medical staff scheduled for reappointment, Whereas the basis for the recommendations now before the Board of Trustees regarding initial applications, reappointments, request for additional privileges, advance from provisional status and release from proctoring and resignations has been predicated upon the required reviews, including all supporting documentation, Be it therefore resolved that the following medical staff, excluding Emergency Medicine Providers as highlighted on Exhibit A (copy attached to the original of these minutes and considered a part thereof), be approved or reappointed (as applicable), to the organized medical staff of Kaweah Delta Health Care District for a two year period unless otherwise specified, with physician-specific privileges granted as recommended by the Chief of Service, the Credentials Committee, and the Executive Committee of the Medical Staff and as will be documented on each medical staff member's letter of initial application approval and reappointment from the Board of Trustees and within their individual credentials files . This was supported unanimously by those present. Vote: Yes – Havard Mirviss, Olmos, Rodriguez, Gipson, and Francis

CONSENT CALENDAR – Director Francis entertained a motion to approve the consent calendar (copy attached to the original of these minutes and considered a part thereof).

Public Participation – Members of the public may comment on agenda items before action is taken and after the item has been discussed by the Board.

MMSC (Havard Mirviss/Olmos) to approve the consent calendar as submitted. This was supported unanimously by those present. Vote: Yes – Havard Mirviss, Olmos, Rodriguez, Gipson, and Francis.

QUALITY – STROKE PROGRAM - A review Kaweah Health's Certified Stroke Program outcome and process metrics and improvement action plans (copy attached to the original of these minutes and considered a part thereof) – Cheryl Smit, RN-BC, BSN, Stroke Manager & CME Programs, and Shawn Oldroyd, DO, Medical Director Stroke Program.

STRATEGIC PLAN - Strategic Plan – Final Fiscal Year 2022 results and new tool kit – Achievelt - Marc Mertz, Chief Strategy Officer & Acting CEO

STRATEGIC PLAN - Organizational Effectiveness and Efficiency – Detailed review of Strategic Plan Initiative.

Jag Batth, Chief Operating Officer & Kassie Waters, Director Cardiac Critical Care Services

EMPLOYEE ENGAGEMENT - Review of the 2022 Work Environment Pulse Survey *Dianne Cox, Chief Human Resources Officer & Hannah Mitchell, Director of Organizational Development*

PATIENT THROUGHPUT PERFORMANCE - Review of patient throughput performance improvement progress report (copy attached to the original of these minutes and considered a part thereof) – *Jag Batth, Chief Operating Officer*

STANFORD CARDIOTHORACIC SURGERY PHYSICIAN STAFFING – Discussion relative to potential surgeon deployment model and proforma with Stanford Health Care as reviewed and supported by the Board Finance, Property, Services and Acquisition Committee on August 17, 2022 (copy attached to the original of these minutes and considered a part thereof) – *Marc Mertz, Chief Strategy Officer & Acting Chief Executive Officer*

Public Participation – Members of the public may comment on agenda items before action is taken and after the item has been discussed by the Board.

MMSC (Havard Mirviss/Gipson) to authorize management to enter into the necessary agreements and take all necessary steps to enter into a professional services agreement with Stanford Health Care to provide Cardiothoracic Surgery Physician(s) Staffing for Kaweah Health Medical Center Cardiothoracic Surgery Program. This was supported unanimously by those present. Vote: Yes – Havard Mirviss, Olmos, Rodriguez, Gipson, and Francis

BEHAVIORAL HEALTH CONTINUUM INFRASTRUCTURE PROGRAM (BHCIP) GRANT FOR BEHAVIORAL HEALTH – Review and discussion of State grant opportunity as reviewed and supported by the Board Finance, Property, Services and Acquisition Committee on August 17, 2022 - (copy attached to the original of these minutes and considered a part thereof) - *Marc Mertz, Chief Strategy Officer & Acting Chief Executive Officer; Theresa Croushore, Director of Behavioral Health; and Jennifer Stockton, Director of Finance*

Public Participation – Members of the public may comment on agenda items before action is taken and after the item has been discussed by the Board.

MMSC (Olmos/Havard Mirviss) to authorize the officers and agents of Kaweah Delta Health Care District dba Kaweah Health to approve and execute any and all documents necessary to submit the Behavioral Health Continuum Infrastructure Program (BHCIP) grant application. This was supported unanimously by those present. Vote: Yes – Havard Mirviss, Olmos, Rodriguez, Gipson, and Francis

OUTPATIENT PSYCHIATRY CLINIC PRO FORMA – Review and discussion relative to an outpatient psychiatry clinic as reviewed and supported by the Board Finance, Property, Services and Acquisition Committee on August 17, 2022 (copy attached to the original of these minutes and considered a part thereof) – *Marc Mertz, Chief Strategy Officer & Acting Chief Executive Officer; Theresa Croushore, Director of Behavioral Health; and Jennifer Stockton, Director of Finance*

Public Participation – Members of the public may comment on agenda items before action is taken and after the item has been discussed by the Board.

MMSC (Havard Mirviss/Gipson) to authorize management to enter into the necessary agreements and take all necessary steps to develop the Kaweah Health Psychiatric

Outpatient Clinic. This was supported unanimously by those present. Vote: Yes – Havard Mirviss, Olmos, Rodriguez, Gipson, and Francis

BUDGET INITIATIVES – CONTRACTS / UNDERPAYMENTS – Review of budget initiatives (copy attached to the original of these minutes and considered a part thereof) – *Malinda Tupper – Chief Financial Officer and Kim Ferguson, Director of Reimbursement*

FINANCIALS – Review of the most current fiscal year financial results and budget (copy attached to the original of these minutes and considered a part thereof) – *Malinda Tupper – Chief Financial Officer*

REPORTS

Chief Executive Officer Report - Report relative to current events and issues - *Marc Mertz, Chief Strategy Officer and Acting CEO*

- Mr. Mertz thanked the Board for the opportunity to be the Acting CEO in Gary's absence.

Board President - Report relative to current events and issues - *David Francis, Board President*

- Director Francis thanked both Ms. Noeske and Mr. Mertz for their coverage of the CEO office during the past two months.

APPROVAL OF CLOSED AGENDA AS FOLLOWS: Closed Meeting Agenda – Immediately following the 4:30PM open session

Conference with Legal Counsel – Anticipated Litigation – Significant exposure to litigation pursuant to Government Code 54956.9(d)(2) – 1 Case - *Marc Mertz, Chief Strategy Officer & Acting Chief Executive Officer and Rachele Berglund, Legal Counsel*

MMSC (Havard Mirviss/Gipson) approved the closed session following the 4:30PM open session. This was supported unanimously by those present. Vote: Yes – Havard Mirviss, Olmos, Rodriguez, Gipson, and Francis

ADJOURN - Meeting was adjourned at 7:09PM

David Francis, President
Kaweah Delta Health Care District and the Board of Directors

ATTEST:

Mike Olmos, Secretary/Treasurer
Kaweah Delta Health Care District Board of Directors



RESOLUTION 2172

WHEREAS, the Department Heads of the KAWEAH DELTA HEALTH CARE DISTRICT dba KAWEAH HEALTH are recognizing Susanna Ehram, RN, with the World Class Service Excellence Award for the Month of September 2022, for consistent outstanding performance, and,

WHEREAS, the Board of Directors of the KAWEAH DELTA HEALTH CARE DISTRICT is aware of her excellence in caring and service,

NOW, THEREFORE, BE IT RESOLVED that the Board of Directors of the KAWEAH DELTA HEALTH CARE DISTRICT on behalf of themselves, the hospital staff, and the community they represent, hereby extend their congratulations to Susanna for this honor and in recognition thereof, have caused this resolution to be spread upon the minutes of the meeting.

PASSED AND APPROVED this 28th day of September 2022 by a unanimous vote of those present.

President, Kaweah Delta Health Care District

ATTEST:

**Secretary/Treasurer, Kaweah Delta Health Care District
and of the Board of Directors, thereof**

**Susanna Ehrsam, just been recognized by, Ana Castro-Canchola
on 8/16/2022**

Comments: Susy has been with Kaweah and 3North for 8 years. She has excelled as a nurse and promotes optimal care for her patients. She is the nurse you want taking care of you if you are ever in the hospital. She values patient advocacy, dignity and independence. She creates a positive work environment on 3North as a leader and also serves as the “mama” factor to some of the newer nurses. She takes them under her wing, guiding and supporting their growth as their mentor. In the last couple of years, she really shined as a mentor to several day and night shift team members as they look for her even after orientation for clinical and moral support. Susy helps new nurses find their way, their confidence and their ability to shine for their patients. She wants the best for her colleagues and so she agrees to perform the team lead role, where she has found her way in supporting and encouraging the team as a whole while continuing to advocate for all the patients on 3North.

3North would not be 3North without Susy. She is kind, humble, thoughtful, helpful, and just simply an amazing coworker and nurse! As a newer nurse, the job can be stressful for me at times, but I know I can always count on Susy to uplift me & motivate me to keep going! She is a positive light on our floor and she always cheers on and guides the newer nurses. She exemplifies world class service every day with her coworkers and patients. She deserves a raise because a nurse like her, is what makes a nurse like me, love my job at Kaweah!



RESOLUTION 2173

WHEREAS, Tracie Sherman, RN is retiring from duty at Kaweah Delta Health Care District after 31 years of service; and,

WHEREAS, the Board of Directors of the Kaweah Delta Health Care District is aware of her loyal service and devotion to duty;

NOW, THEREFORE, BE IT RESOLVED that the Board of Directors of the Kaweah Delta Health Care District, on behalf of themselves, the hospital staff, and the community they represent, hereby extend their appreciation to Tracie for 31 years of faithful service and, in recognition thereof, have caused this resolution to be spread upon the minutes of this meeting.

PASSED AND APPROVED this 28th day of September 2022 by a unanimous vote of those present.

President, Kaweah Delta Health Care District

ATTEST:

**Secretary/Treasurer, Kaweah Delta Health Care District
and of the Board of Directors, thereof**



RESOLUTION 2174

WHEREAS, Michael (Mike) Boyd, DPM has served as an active member of the Kaweah Health Medical Staff since 1979 and served as the Credentials Chair from 1999-2022 and;

WHEREAS, in that capacity Dr. Boyd has provided excellent leadership for the Medical Staff and supported the mission of the hospital through years of great achievements and growth, and;

WHEREAS, Dr. Boyd has always been available, attentive and responsive to the Board, Medical Staff, and Executive Team of the District in carrying out the duties of his position, and;

WHEREAS, Dr. Boyd has been an effective leader of the Medical Staff relative to the credentialing process.

NOW THEREFORE, BE IT RESOLVED, that the Board of Directors of the Kaweah Delta Health Care District on behalf of themselves, the Medical Center Staff, and the Community they represent, hereby extend their appreciation to Mike Boyd, DPM and in recognition thereof, have caused this resolution to be spread upon the minutes of this meeting.

PASSED AND ADOPTED by unanimous vote of those present at a regular meeting of the Board of Directors of the Kaweah Delta Health Care District on the 28th day of September 2022.

President, Kaweah Delta Health Care District

ATTEST:

Secretary/Treasurer, Kaweah Delta Health Care District and of the Board of Directors thereof



**Physician Recruitment and Relations
Medical Staff Recruitment Report - September 2022**

Prepared by: Sarah Bohde, Physician Recruiter - sbohde@kaweahhealth.org - (559) 624-2772

Date prepared: 9/19/2022

Delta Doctors Inc.	
Family Medicine	2
OB/Gyn	1

Frederick W. Mayer MD Inc.	
Cardiothoracic Surgery	2

Kaweah Health Medical Group	
Audiology	1
Dermatology	2
Endocrinology	1
Family Medicine	3
Gastroenterology	2
Neurology	1
Orthopedic Surgery (Hand)	1
Otolaryngology	2
Pulmonology	1
Radiology - Diagnostic	1
Rheumatology	1
Urology	3

Key Medical Associates	
Adult Hospitalist	1
Dermatology	1
Family Medicine/Internal Medicine	3
Gastroenterology	1
Pulmonology	1

Oak Creek Anesthesia	
Anesthesia - Critical Care	1
Anesthesia - General	2
Anesthesia - Obstetrics	1
CRNA	3

Orthopaedic Associates Medical Clinic, Inc.	
Orthopedic Surgery (Trauma)	1

Other Recruitment	
EP Cardiology	1
Hospice & Palliative Medicine	1
Neurology - Inpatient	1

Sequoia Oncology Medical Associates Inc.	
Hematology/Oncology	1

Valley Children's Health Care	
Maternal Fetal Medicine	2
Neonatology	2
Pediatric Cardiology	1

Valley Hospitalist Medical Group	
Adult Hospitalist	1
Nocturnist	1

Candidate Activity

Specialty/Position	Group	Last Name	First Name	Availability	Referral Source	Current Status
Anesthesia - Critical Care	Oak Creek Anesthesia	Malamud, M.D.	Yan	08/22	Direct - PracticeMatch	Site Visit: 10/17/22
Cardiothoracic Surgery	Independent	Coku, M.D.	Lindita	ASAP	Delta Locums	Currently under review
Cardiothoracic Surgery	Independent	Williams, M.D.	Julio	08/22	Direct - 4/19/22	Initial Screening: 4/22/22; Providing locums/temp coverage in September 2022.
Certified Registered Nurse Anesthetist	Oak Creek Anesthesia	Cummins	Anna	05/23	Comp Health - 8/25/22	Site visit pending in November 2022
Certified Registered Nurse Anesthetist	Oak Creek Anesthesia	Liu	Jia	03/23	Comp Health - 5/16/22	Currently under review
Certified Registered Nurse Anesthetist	Oak Creek Anesthesia	Coelho	Carly	TBD	Direct - 8/11/22	Offer accepted - contract in progress
Certified Registered Nurse Anesthetist	Oak Creek Anesthesia	Enriquez	Richard	12/22	Direct - 9/1/22	Offer accepted - contract in progress
Certified Registered Nurse Anesthetist	Oak Creek Anesthesia	Havlicak	Ashley	01/23	Direct/Referral	Offer accepted
Endocrinology	Kaweah Health Medical Group	Min, M.D.	Lie	ASAP	Direct - PracticeLink	Site visit pending dates
Endocrinology	Key Medical Associates	Nemati, M.D.	Maryam	09/23	Curative - 9/16/22	Currently under review
EP Cardiology	Independent	Cheema, M.D.	Kamal	08/23	Direct - PracticeLink	Currently under review. Has family in Fresno
EP Cardiology	Independent	Dhir, M.D.	Sumer	08/23	Direct - PracticeLink	Currently under review
EP Cardiology	Independent	Tsimploulis, M.D.	Apostolos	08/23	Direct - PracticeLink	Currently under review
Family Medicine	Delta Doctors/Key Medical Associates	Whitlach, M.D.	Sandra	08/23	Kaweah Health Resident	Currently under review
Hospitalist	Valley Hospitalist Medical Group	Adediji, M.D.	Anuoluwapo	08/23	Kaweah Health Resident	Currently under review

Candidate Activity

Specialty/Position	Group	Last Name	First Name	Availability	Referral Source	Current Status
Hospitalist	Valley Hospitalist Medical Group	Chovatiya, M.D.	Jasmin	08/23	Direct - Practice Link	Currently under review
Hospitalist	Valley Hospitalist Medical Group	Curran, M.D.	Justin	08/23	Direct - Loma Linda CareerMD Career Fair	Currently under review
Hospitalist	Valley Hospitalist Medical Group	Gautum, M.D.	Monika	ASAP	Direct - Practice Link	Currently under review
Hospitalist	Valley Hospitalist Medical Group	Issa, M.D.	Angela	08/23	Direct - Practice Link	Currently under review
Hospitalist	Valley Hospitalist Medical Group	Khan, M.D.	Marjan	08/23	Direct - Practice Link	Currently under review
Hospitalist	Key Medical Associates	Lim, M.D.	Francis	ASAP	Direct - Spouse is Endocrinologist candidate, Dr. Lei Min	Currently under review. Needs to work for a 501(c)(3)
Intensivist	Central Valley Critical Care Medicine	Barmaan, M.D.	Benjamin	08/23	Direct - Practice Link	Currently under review
Intensivist	Central Valley Critical Care Medicine	Khanuja, M.D.	Simrandeep	TBD	Comp Health - 6/2/22	Currently under review
Internal Medicine	Kaweah Health Medical Group/Key Medical Associates	Virk, D.O.	Harman	09/23	Direct email	Currently under review
Interventional Radiology	Mineral King Radiology Group	Youssef Ali, M.D.	Mahmoud	09/23	Direct email	Currently under review
Medical Oncology	Sequoia Oncology Medical Associates	Mohammadi, M.D.	Oranus	08/23	PracticeMatch - 3/31/22	Site Visit: 9/16/22
Medical Oncology	Sequoia Oncology Medical Associates	Palla, M.D.	Amruth	08/22	Direct/referral - 1/26/22	Site visit pending dates (Nov/Dec 2022 - Tentative)
Neonatology	Valley Children's	Agrawal, M.D.	Pulak	08/23	Valley Children's - 5/14/22	Site Visit: 6/30/22
Neonatology	Valley Children's	Al Kanjo, M.D.	Mohamed	08/23	Valley Children's - 3/14/22	Site Visit: 4/7/22; Offer extended
Neonatology	Valley Children's	Nwokidu-Aderibigbe, M.D.	Uche	08/23	Valley Children's - 5/14/22	Site Visit: 6/17/22
Neonatology	Valley Children's	Sharma, M.D.	Amit	TBD	Valley Children's - 3/1/22	Site Visit: 3/29/22; Offer extended

Candidate Activity

Specialty/Position	Group	Last Name	First Name	Availability	Referral Source	Current Status
Orthopedic Surgery - Trauma	Orthopaedic Associates Medical Clinic, inc.	Quacinella, M.D.	Michael	08/24	Direct	Currently under review
Pediatric Cardiology	Valley Children's	Ozdemir, M.D.	Ege	08/22	Valley Children's - 3/1/22	Site Visit: 3/23/22; Offer extended
Pediatric Hospitalist	Valley Children's	Mittal, M.D.	Daaman	07/22	Valley Children's - 2/17/22	Site visit: 2/21/22; Offer accepted; Start Date: TBD
Radiology - Diagnostic	Kaweah Health Medical Group	Noorani, D.O.	Azeem	TBD	Staff Care - 6/13/22	Site Visit: 7/18/22; Offer extended
Radiology - Diagnostic	Kaweah Health Medical Group	Zurick, M.D.	Vernon	TBD	Current locum	Currently under review
Rheumatology	Kaweah Health Medical Group	Garg, M.D.	Arina	TBD	Enterprise Medical Recruiter - 8/16/22	Currently under review
Rheumatology	Kaweah Health Medical Group	Li, M.D.	Zi Ying (Kimmie)	08/22	Direct - 11/27/21	Phone Interview: 12/15/21; Site Visit: 4/5/22; Will decide on location in November 2022.
Urology	Kaweah Health Medical Group	Aram, M.D.	Pedram	07/23	PracticeMatch - 3/1/22	Site Visit: 5/26/22; 2nd site visit pending (September)
Urology	Kaweah Health/USC Urology	Rosenberg, M.D.	Shilo	10/22	USC Urology	Offer Accepted: USC Urology clinic opens 10/11/22



**Environment of Care
2nd Quarter Report
April 1, 2022 through July 31, 2022
Presented by
Maribel Aguilar, Safety Officer
559-624-2381
maaguila@kaweahhealth.org**

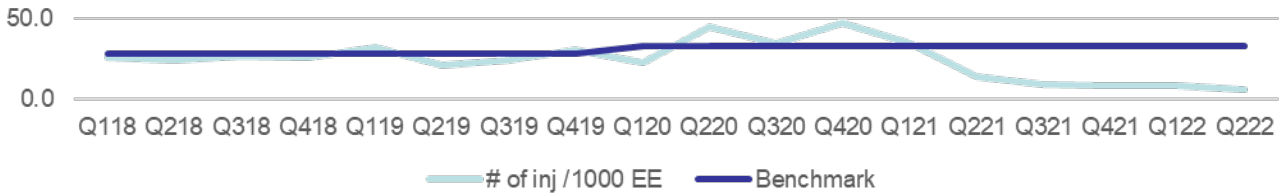


**Kaweah Delta Healthcare District
Performance Monitoring 2nd Qtr.- 2022**

EOC: SAFETY & QIC: SAFETY

Performance Standard: Employee Health: Challenge ourselves to reduce OSHA recordable injuries: In 2018 we had 238 injuries, 2019 - 215 injuries, 2020 - 196 injuries, and 207 total for 2021. Our goal for 2022 is 200 injuries or less.

Injuries / 1000 employees vs National Benchmark



- Evaluation:**
- 31 OSHA recordable injuries in Qtr. 2-2022, plus 502 Covid 19 +
 - Covid 19 vaccination began 12/18/20, boosters began Oct 2021
 - Provided 24 ergo evaluations
 - 2022 Sharps Exposure- Quarter 2- 8 total (0 -GME)
 - Influenza vaccination rate 2021-2022 80%

Type of injury	Q1	Q2	Q3	Q4	Total YTD CY22	Total CY21	Per 1000 emp (EE)	Annualized
Total Incidents	185	108			293	448	35.84	586
Covid 19+	1158	502			1660	793	224.33	3320
OSHA recordable	45	48			93	207	8.72	186
Lost time cases	104	36			140	379	20.15	280
Strain/sprain	30	31			61	116	5.81	122
Sharps Exp	11	8			19	78	2.13	38
# EE end of QTR	5162	5162						

- **Plan for Improvement:**
- Continue to work with Infection Prevention and Organization Leaders to decrease Covid 19+ exposures/ claims by Health Care Workers in 2022.
- Identify employees with ≥ 3 OSHA recordable injuries in last 2 year –Employee Health Services speaks with managers directly noting any trends per employee and/or injuries.
- Same day on-site incident investigation with employee. Follow-up with manager for prevention opportunities and/or process changes and policy review. Investigation/ follow-up may include photos, video and interview of witnesses/ manager.
- Increase Sharps education in General Orientation by Infection Prevention and Manager orientation by EHS. Demo correct sharps activation in new hire physicals with all employees handling sharps.
- Began GME Orientation Sharps Prevention Education June 2022, well received.
- Utilize PT Assistant in Employee Health for Ergonomic evaluations, evaluate for proper body mechanics to prevent injury, stretching exercises and equipment recommendations to ensure safety with our jobs.

OSHA recordable injuries and illnesses are as follows:

- Fatalities (reportable)
- Hospitalizations (reportable)
- Claim with lost work day, or modified work with restrictions (recordable)
- Medical treatment other than First Aid (recordable)

Total Incidents include First Aid and Report Only and ~~71/580~~ work related (Qtr 2 -5 covid claims),

SAFETY (Infection Prevention)

Second Quarter 2022

Infection Prevention Component:

INFECTION PREVENTION COMPREHENSIVE ROUNDS

Performance Standard:

Comprehensive Rounds - Each infection prevention based element of performance and/or environment-of-care criteria meets at least 90% compliance during unit/department rounds performed twice annually.

Goal: >90% compliance rate.

Minimum Performance Level: 90% compliance rate.

Evaluation:

Overall compliance rate for elements during general area rounds in Q1 2022: 78.9%

Rounding of 29 general department areas 10 specialty department areas in Q2 2022.

Elements of highest performance:

Patients on transmission based precautions per Infection Prevention policy.

Staff Workspace maintained in accordance with Infection Prevention principles.

Staff members can verbalize Infection Prevention principles.

Elements of lowest performance:

Environment is clean, organized, and without factors that increase risk of infection.

Medication Room is maintained in accordance with Infection Prevention principles.

Clean Supply Room maintained in accordance with Infection Prevention principles.

General Areas (Inpatient Areas and Clinics): Infection Prevention Element Compliance	Q1	Q2
Staff members can verbalize Infection Prevention principles.	93.9	93.1
Adherence to Kaweah Health's Hand Hygiene policies and procedures.	78.1	69.0
PPE is available, worn and stored appropriately.	96.8	89.3
Environment is clean, organized, and without factors that increase risk of infection.	41.9	60.7
Equipment is visibly clean and in working condition.	87.5	79.3
Hospital approved cleaner/disinfectant available and properly maintained.	84.4	79.3
Clean Supply Room maintained in accordance with Infection Prevention principles.	71.9	67.9
Dirty Supply Room is maintained in accordance with Infection Prevention principles.	62.5	71.4
Linen is maintained in accordance with Infection Prevention principles.	75.0	76.9
Patient care environment maintained in accordance with Infection Prevention principles.	74.2	74.1
Patients on transmission based precautions per Infection Prevention policy.	100	100
Patient Nutrition Area is kept in accordance with Infection Prevention principles.	50.0	81.3
Medication Room is maintained in accordance with Infection Prevention principles.	35.5	50.0
Staff Workspace maintained in accordance with Infection Prevention principles.	78.1	93.6
Staff Kitchen/Lounge is maintained in accordance with Infection Prevention principles.	81.3	98.3
Specialty Areas: Overall Area Compliance		
Laboratory Areas	90.3	n/a
Food Services Areas	91.0	78.8
Sterile Processing Areas	99.5	n/a
Surgical Services	n/a	68.2
Kaweah Kids Center	n/a	100
Pharmacy Areas	n/a	93.1
Laundry	n/a	95%

Plan for Improvement:

Action plans from each area requested for items out of compliance. Leaders of the area are required to submit in writing their actions to correct the items out of compliance. Infection Prevention will follow up with manager or director as appropriate.

SAFETY

Second Quarter 2022

Performance Standard: Reduce Workplace Violence Events

Goal: 20% annual decrease in WPV Events in FY 2023. (<200 events)

Status: 249 total WPV events in FY 2022.

Sponsor: Chris Luttrell

Plan for Improvement: (Summary)

Expand and increase rigor of CPI training.

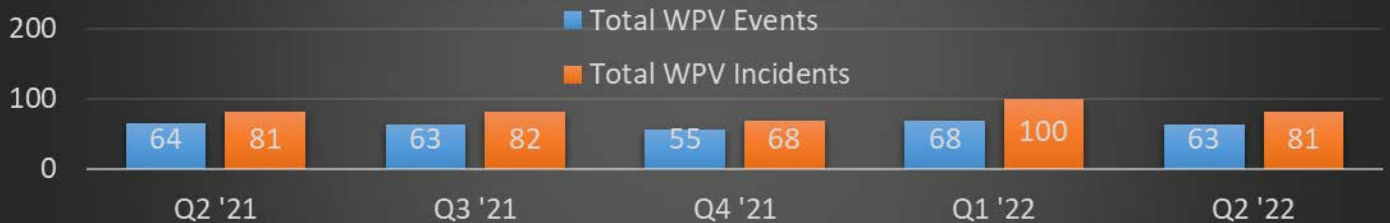
Implement and provide support for electronic flag and tiered Broset.

Continue to evaluate and report on WPV event root causes with the WPV Case Review Team.

Evaluation:

There was a 7% decrease in the total number of WPV events organization-wide in the 2nd quarter of 2022.

Total WPV events and incidents at Kaweah Health

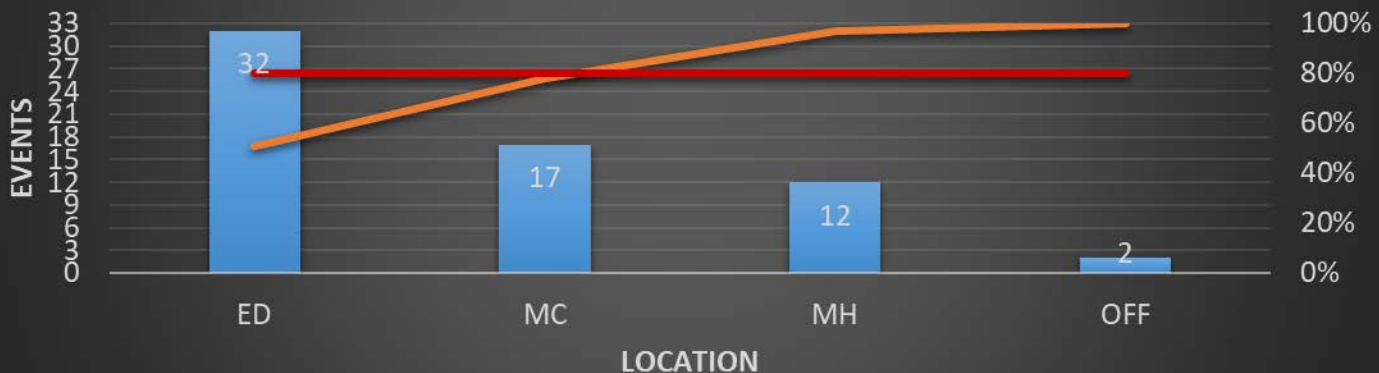


Evaluation:

There was a 7% increase in WPV events in the ED (30 to 32). There was a 29% decrease in WPV events in the Medical Center (24 to 17). There was a 7% decrease in WPV events at Mental Health (13 to 12). There was a 50% increase in WPV events in off-campus areas (2 to 3).

WPV EVENTS PARETO April – June 2022

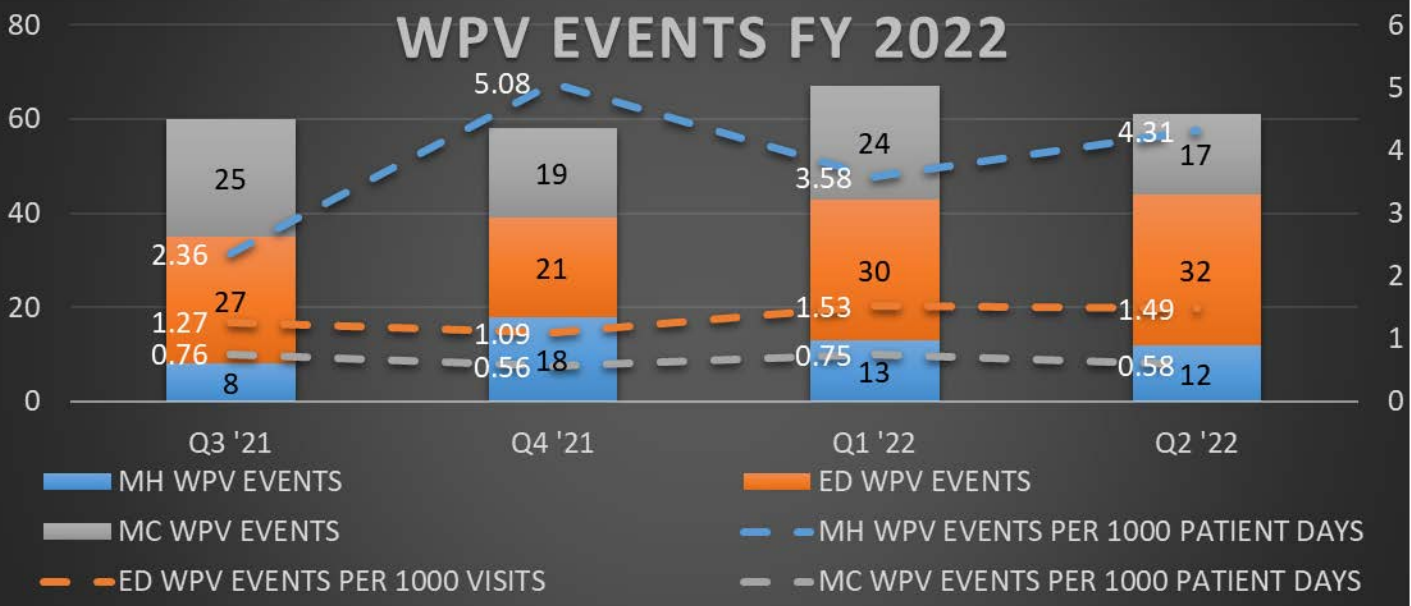
COUNT CUMMULATIVE % 80% LINE



Detailed Plan for Improvement:

1. We must continue to encourage staff to enter incident reports for workplace violence on Midas.
2. All CNAs will be CPI trained beginning July. Half will be trained over the next 3 months, with the second group being trained during the last 3 months of the year. This should help our front line staff to be more aware and cautious when sitting for aggressive behavior patients.
3. The electronic flag is currently in place and working. We must continue to work to educate staff on how to use the toolkit to provide support in engaging with these high-risk patients. In concert with the electronic flag, the tiered broset will be launched during the next quarter.
4. We are continuing to project our focus of increasing the rigor of CPI training at mental health and at our behavioral health clinics off campus. Advanced CPI courses will continue with these high-risk groups.

WPV EVENTS FY 2022



Evaluation:

There was an increase in human factors being a root cause of WPV in Q2. The most prominent of which was a lack of critical thinking. There was an increase in communication being a root cause of WPV in Q2. There is room for improvement in communication about previous behavior between our staff and those bringing patients to us. There is a continued request for more training and education for our staff (specifically CNAs) in maintaining proximity with violent patients and in properly holding patients in crisis.

KH WPV ROOT CAUSES Q2 2022



EOC Component:

Performance Standard:

Goal:

Minimum Performance Level:

SAFETY

Risk Management –Reporting of non-patient safety related injuries within 7 days will be compliant at 100%.

Report non-patient safety related events within 7 days

Report non-patient safety related events within 7 days

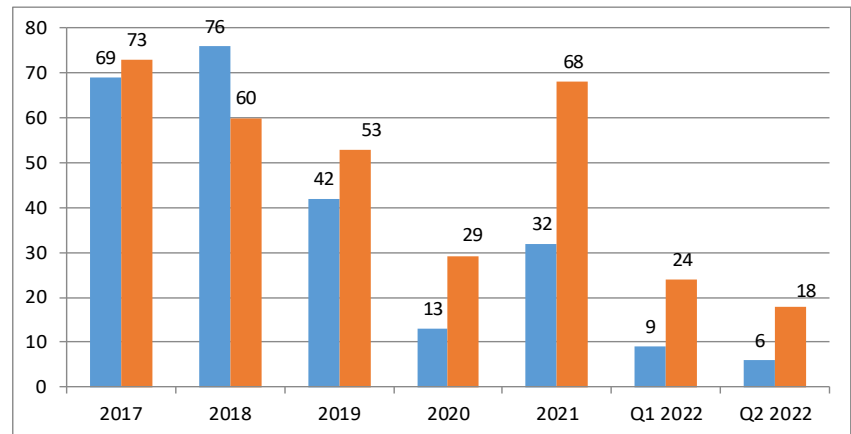
Evaluation:

In 2nd Qtr. 2022, There were 24 events reported and we have met the goal for the second quarter, and calendar year. For non-patient safety events, 24 events are shown. 6 events were reported at TLC (The Lifestyle Center), the orange bar is 18 events. There were no overarching trends. At TLC, Basketball had a couple trips and falls. No safety concerns that require monitoring processing..

Minimum performance measure was met for 2nd Qtr. 2022 at 100% compliance.

Non-Patient Safety Reports

2017 – 2022



TLC Event Report – Six (6) Events
 Kaweah Health and KHMG – Eighteen (18) Events

EMERGENCY PREPAREDNESS

Second Quarter 2022

Performance Standard: Employees able to provide correct responses related to Emergency Preparedness questions. During Hazardous Surveillance Rounds employees will be questioned regarding Code Green response.

Goal: 100% Compliance (all employees surveyed answered correctly)

Status: Goal met for 2nd Quarter 2022

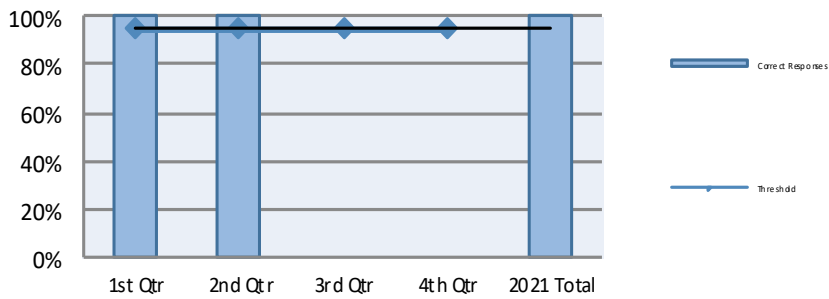
Sponsor: Maribel Aguilar

Evaluation:

Thirty nine departments were surveyed in the 2nd quarter. In all departments surveyed staff were able to verbalize Code Green response, which resulted in a 100% compliance rate.

95% minimum performance level was met for this quarter.

Disaster Policies



Detailed Plan for Improvement:

In each department visited there was knowledge of Code Green response.

UTILITIES MANAGEMENT

Second Quarter 2022

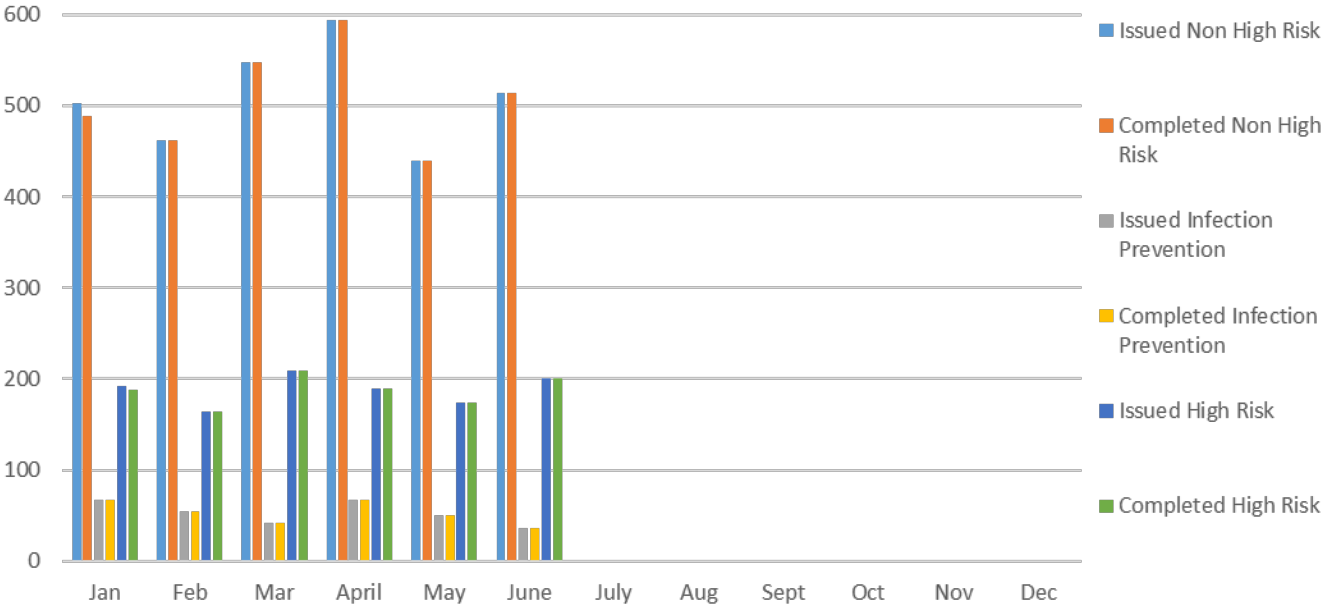
Performance Standard: High Risk, Low Risk, Infection Control Preventive Maintenance to be completed on time

Goal: 100% Compliance (no missed PM's)

Status: Goal met for 2nd Quarter 2022

Sponsor: Steve Gloeckler

Plan for Improvement: Continue to monitor, no improvement area identified.



Evaluation:
2265 of 2265 preventative maintenance work orders were completed on time.

PM Completion %				
	Non-High Risk	Infection Prevention	High Risk	Q4 Summary
April	100.00%	100.00%	100.00%	100.00%
May	100.00%	100.00%	100.00%	100.00%
June	100.00%	100.00%	100.00%	100.00%
Q2 Summary:	100.00%	100.00%	100.00%	100.00%

Plan for Improvement:
Goal met for 2nd Qtr. 2022

LIFE SAFETY

Second Quarter 2022

Performance Standard: Equipment & Supplies stored in accordance with Safety requirements.

Goal: 100% Compliance (no storage compliance issues)

Status: Goal not met for 2nd Quarter 2022

Sponsor: Maribel Aguilar

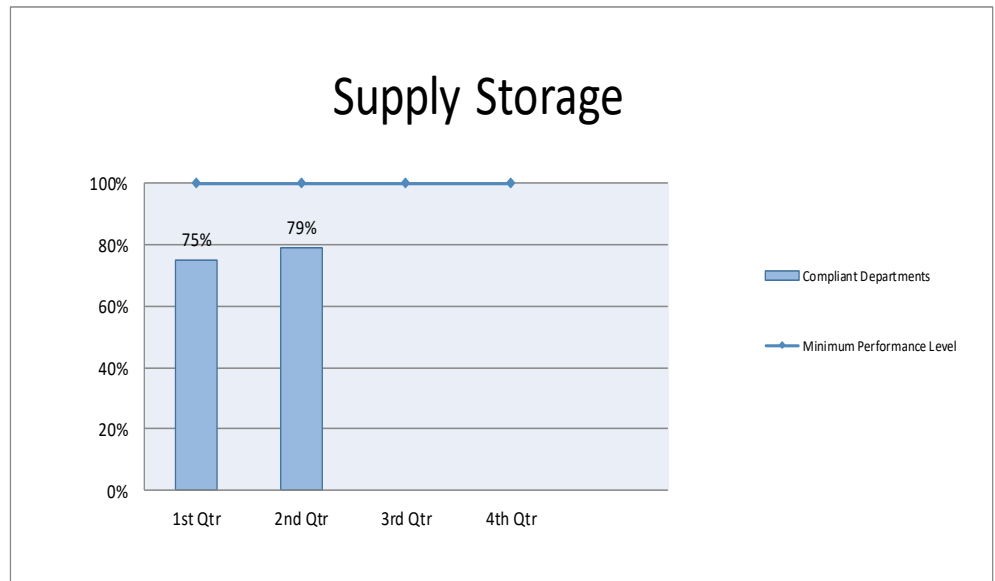
Plan for Improvement: (Summary)

1. For areas with repeat violations, will eliminate non-compliant storage areas.
2. Continue to monitor and educate.

Evaluation:

Thirty nine departments were surveyed in the 2nd quarter. Of the 39 departments, 8 were found to be non-compliant with storage. This resulted in 79% compliance rate.

Minimum Performance Level **was not met** during this quarter.



Detailed Plan for Improvement:

We are in the process of modifying the storage racks in areas of repeat non-compliance. We will continue to monitor through hazard surveillance and report to appropriate director and VP.

Departments not in compliance this quarter include: Kaweah Kids, Foundation, Hospice, KHIP, Retail Pharmacy, Emergency Department, Rehab Hospital, Rehab MOB and MITTs Building.

EOC Component:

SECURITY

Performance Standard:

False Code Pink Activations– Reduce *false* Code Pink activations. Frequent false Code Pink activations are creating alarm fatigue response from support departments and increasing our vulnerability to stop/ identify an abductor in the event of a real Code Pink event.

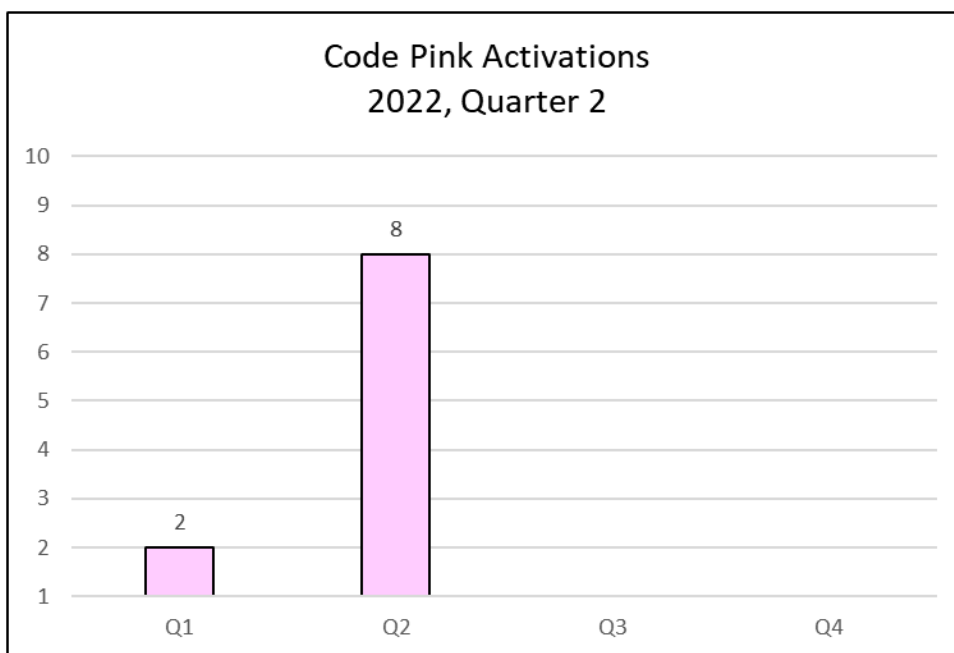
Goal: 100 % compliance rate

Minimum Performance Level: <4 events per Quarter

Evaluation:

In year 2020 the Medical Center experienced 48 *false* Code Pink activations. In year 2021 we ended the year with 33 events, a 31% decrease. For year 2022, the goal is to decrease Code Pink false alarms by 50% of the previous year - <4 per quarter; <16 events for the year.

Goal **Not Met** – Eight (8) Code Pink *false* activations reported for the 2nd quarter



Plan for Improvement:

The majority of *false* Code Pink activations are due to staff forgetting to deactivate or to set the HUGS transmitter in transport when moving the child/newborn from the home unit to the transport unit. Unit leaders for Maternal-child Health units will work with their clinical-clerical staff to improvement system management, especially when short staffed.

Propose that Labor and Delivery leaders attend the upcoming monthly EOC meeting to speak to the increase in false code pink activations and plans for unit specific improvements.

Improvements completed in 2021:

- Security Department provided the Maternal-child Health leaders with a flyer to help educate unit staff.
- Floor tape (CAUTION ALARM WILL SOUND) was installed in Labor and Delivery, OB-OR and Mother-baby units on August 5, 2021 to support alarm safe boundary identification.
- TRL, the company that supports our child abduction security alarm system corrected alarm sensitivity issues in the Pediatrics and Labor and Delivery units to eliminate-mitigate false alarms.

EOC Component:

Medical Equipment Preventive Maintenance Compliance

Performance Standard:

Medical Equipment – Preventive Maintenance Compliance

#1) Non-High Risk Medical Equipment Preventive Maintenance Compliance

#2) High-Risk including Life Support Equipment (HRiLS) Preventive Maintenance Compliance

Goal: 100 % Compliance for each Group

Minimum Performance Level: 100% Compliance

Performance Standard:

#3) High Risk (HRiLS) Missing-in-Action Devices (Not Locatable for Preventive Maintenance)

Goal: <1% of the Total HRiLS inventory is to be Missing for Preventive Maintenance during any month.

Evaluation:

For the reporting quarter, CY 2022, Q2 (Apr-Jun). A count of 3083 Devices were to receive Preventive Maintenance and 3083 of those devices received Preventive Maintenance as scheduled.

Measured Performance Metrics:

#1) PM Compliance for Non-High Risk Devices is 100% and **the 100% Compliance Goal Was Met.**

#2) PM Compliance for High Risk Including Life Support Devices is 100.00% and **the 100% Compliance Goal Was Met.**

#3) High Risk Devices including Life Support (HRiLS) Missing for this reporting Quarter is 2.16% (113 Devices) and **the Compliance Goal of 1.0% of HRiLS Devices Missing was Not Met.**

CY 2021 thru 2022
Clinical Engineering
Quarterly PM Compliance % and Completion Data



Plan for Improvement:

As of August 2022 all technician positions were filled. Continuing to ask the department Managers to review the devices in their areas for devices with PM stickers that are over due and report them to Clinical Engineering so they may be serviced and placed into the PM completed category.

Clinical Engineering has submitted for a passive location system with a goal of dropping the missing totals to near zero in FY23 Capital Budget. Missing in Action HRiLS Devices continues to be greater than 1% of the HRiLS Medical Device inventory. Clinical Engineering is still seeking funding for a device tracking system to quickly locate these devices.

REPORT TO THE BOARD OF DIRECTORS

Orthopedic Service Line

Kevin Bartel, DPT, Director of Orthopedics, Neurosciences & Specialty Practice
Contact Number: 559-624-3441

Kari Knudsen, MPA, BSN, RN NE-BC, Director of Post-Surgical Care
Brian Pearcy, MSN, RN, Director of Surgical Services

September 28, 2022

Summary Issue/Service Considered

1. Providing exceptional comprehensive orthopedic care through quality outcomes, efficiency, and cost effective care.
2. Ensuring that Orthopedics Services continues to provide the full continuum of services to the community.
3. Reduction in direct costs through effective and successful negotiation of contracts with our orthopedic and implant vendors
4. Targeted approach to orthopedic provider and service marketing opportunities based on market share analyses.
5. Market the ROSA Robotic system to our primary and secondary markets.
6. Develop strategies and action plans to reduce the gap between our existing Length of Stay (LOS) and the Geometric Mean Length of Stay (GMLOS) for orthopedic patients.

Analysis of financial/statistical data:

- Overall, the orthopedic case volumes increased by 10% in FY 2022, but are still below pre-pandemic levels. The Orthopedic Service Line had a FY 2022 contribution margin of \$2.56 million, a 61% decrease from FY 2021 which was \$6.51 million.
 - Key contributors to this contribution margin decrease:
 - IP surgery cap (to 8 per day) from August 2021 to March 2022 due to high census, and the intermittent closure of elective surgeries.
 - Movement of some major joint replacement surgeries to the outpatient side (which historically holds a negative contribution margin per case)
 - Increased direct cost expenses associated with patient care
- The inpatient orthopedic case volume decreased by 7% from prior year. Direct cost per case was \$22,391 (25% increase), leading to the contribution margin per case dropping to \$3,338 (25% decrease).

- Total hip and knee surgery, which in FY 2019 made up 40% of inpatient cases and led to 40% of the contribution margin, have steadily been decreasing to now in FY 2022 make up 14% of inpatient cases and 3% of contribution margin.
- The inpatient medical orthopedic volume increased 11% after declines in previous years. Contribution margin per case was \$1,249 (49% decrease from FY 2021), with direct costs per case increasing to \$10,575 (24% increase from FY 2021). The inpatient medical orthopedic service line overall had a contribution margin of \$413,570, a decrease of 44% from FY 2021 which was at \$735,170.
 - Contributing factors to this lower contribution margin are a higher average length of stay of 6.26 days (18% increase from FY 2021) and increased direct costs.
- The outpatient orthopedic surgery volume increased by 23% compared to prior year, but still is under pre-pandemic volume. Compared with FY 2021, net revenue per case remained relatively stable at \$6,890 (1% decrease), but direct cost per case increased 15% to \$7,671, creating a negative contribution margin per case of -\$780. Overall, after having a positive contribution margin in outpatient orthopedic surgery in FY 2021, the total contribution margin dropped into the negative to -\$1,534,760.

Quality/Performance Improvement Data

Orthopedic Surgical Quality Improvement continues to be tracked internally, and reviewed quarterly to identify trends that can be addressed. For 2021 orthopedic hip/knee surgery, surgical site infections (SSI) had a Standardized Infection Ratio of 0.22, meaning we experienced 22% of the anticipated infections based on the cases performed. The 2021 complication rate for orthopedic hip/knee surgery was at 0% for all Medicare cases, outperforming the target rate of 2.3%.

Orthopedics continues to work closely with the trauma department to track the orthopedic trauma transfers. In calendar year 2021, 512 orthopedic consults occurred on trauma cases, with 184 orthopedic related cases transferred out. These cases are tracked and reviewed on a quarterly basis to evaluate for appropriateness. We are working closely with the orthopedic traumatologist to provide call coverage, and continue to assess the need to recruit an additional orthopedic traumatologist.

The average length of stay for orthopedic surgical cases overall is 5.02 days, compared with the geometric mean length of stay of 3.48 days. The average length of stay in 2021 for elective total joint replacement was 2.21 days, compared nationally to 1.89 days.

Actively working with our Market Share analysis vendor (Clarify Health) to identify and target areas of marketing and outreach opportunities to enhance our orthopedic service line visibility and market share while engaging with community referring providers. Actively working with the physician relations and marketing departments to provide educational events in the community, led by the orthopedic surgeons.

Patient Satisfaction overall rating in FY 2022 amongst the orthopedic surgeons averaged in the 70th percentile, which is a decrease from the 77th percentile in FY 2021.

Performance and trends of our orthopedic surgeons are carefully monitored for implant cost per case, surgical volumes, infection rates, complication rates, readmission rates and functional assessments. Case reviews are completed monthly with the orthopedic surgeons regarding

infection, readmission, and complication cases to identify any opportunities with case management.

Orthopedics continues to be designated as a Blue Distinction Center for the spine, knee and hip replacement. To earn this distinction, the orthopedic service line must demonstrate high quality cost-effective care supported by a full range of patient support services with multidisciplinary teams to coordinate and streamline care, including shared decision-making and preoperative patient education.

Policy, Strategic or Tactical Issues

1. The orthopedic co-management agreement continues to function to promote reduced supply and surgical implant costs per case through incentivized compensation, improved quality and safety in direct patient care and patient outcomes, as well as overall growth and efficiency of the service line.
2. The orthopedic co-management outreach and marketing subcommittee continue to focus efforts on analyzing our orthopedic market share in our primary and secondary service areas, and to identify opportunities to hold regular community and referring physician outreach events to highlight our orthopedic service line.
3. Closely monitoring physician alignment in our community, looking at referral leakage and outmigration numbers to align efforts in keeping orthopedic care local for our community. Working closely with marketing, media relations and physician relation teams to create and promote a comprehensive orthopedic program. Recent decision to move our Joint replacement educational class from virtual to in-person.
4. Orthopedic demands continue to grow in the region, and access to care for our community continues to be evaluated. Working closely with our physician recruiting team to identify how to address orthopedic surgeon and orthopedic trauma needs.
5. The ability to promote throughput of orthopedic patients into our post-acute settings has been a priority over the past year, with gaps in coordination of care and discharge planning identified. Efforts recently implemented include daily team length of stay rounds which include nursing leadership and the orthopedic Nurse Practitioner on-site in order to prioritize orthopedic patient discharge planning and throughput.
6. Orthopedic Nurse Practitioner support continues to focus efforts to enhance the recovery and throughput of our orthopedic patients through our health system. Recent expansion of orthopedic Nurse Practitioner coverage days and hours will enhance that effort.
7. Current call contract renewal negotiations for orthopedic surgeon call coverage in the Medical Center are ongoing, with efforts to maintain our consistent inpatient orthopedic coverage in a fiscally-beneficial manner.

Recommendations/Next Steps

1. The orthopedic co-management agreement will continue to promote alignment of both parties' interests in reducing implant costs, improving quality, outcomes & efficiency of services rendered. This agreement allows both groups to timely identify, discuss & implement necessary changes that will benefit the orthopedic service line amidst a changing healthcare climate.

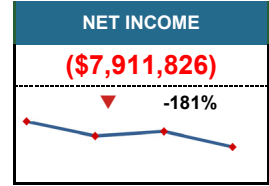
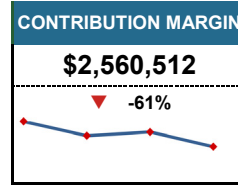
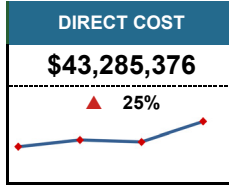
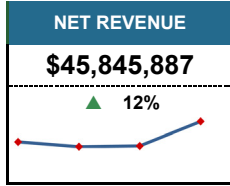
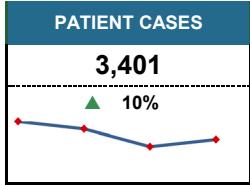
2. Consistently reviewing our local referring physician alignment and market share will allow us to better coordinate our marketing and outreach efforts in efforts to strengthen our orthopedic presence locally and in our secondary service areas.
3. Anticipate the continued movement of total joint replacements into the outpatient surgical space instead of the inpatient arena, as has been the trend over the past 3 years. Working with the outpatient surgery staff, case management, therapies and orthopedic Nurse Practitioners safely and efficiently provide care and appropriate discharge planning of these patients. This includes working with surgical leadership to continually look at ways to improve OR efficiency and timely turnover of cases.
 - a. With a three year trend of rising inpatient spine cases (with an associated positive contribution margin), will look for opportunities to continue promoting and growing this service.
4. The recently implemented Enhanced Recovery After Surgery (ERAS) for orthopedic patients is a surgical pathway that utilizes a patient-centered, evidence-based & multidisciplinary team approach to reduce the length of stay, decrease the surgical stress response & facilitate patient recovery after surgery. This program began collecting data in March 2022, and will continue to be fine-tuned to improve patient outcomes and efficiency of care provided.
5. Focus efforts in reducing the overall length of stay with orthopedic surgical cases towards the geometric mean length of stay. Continue with interdisciplinary team rounds on 4S and Broderick Pavilion to positively impact this effort. Will also continue working with bed allocation leaders to optimally cohort orthopedic patients to stay on Broderick Pavilion and 4S, where optimal patient care occurs for this population.
6. Support recruitment efforts for Board Certified Orthopedic Surgeons in the areas of upper extremity care and trauma.
7. Support the Director of Surgery in the pursuit to accreditate our program as a Center of Excellence in Orthopedic Surgery (COEOS), and our surgeons in becoming Surgeons of Excellence through the Surgical Review Corporation (SRC). Efforts in this area will help improve the safety and quality of patient care, and lower the overall costs associated with successful treatment.
8. Renew our status as a Blue Distinction Center for the spine & knee/hip replacement. Continue to respond to Medicare initiatives related to Orthopedics at the state and national level.

Approvals/Conclusions

In the coming year, orthopedic services will:

1. Work with the entire continuum of care from pre-surgery scheduling & patient education, to post-surgery care processes and discharge planning, in efforts to improve timely orthopedic patient throughput while providing quality and comprehensive care.
2. Continue to review profitability and contribution margin to identify opportunities for volume growth, cost containment (particularly with implants), patient satisfaction & clinical excellence.
3. Analyze the factors currently affecting the actual length of stay, and implement changes to move towards the geometric mean length of stay.

KEY METRICS - FY 2022 TWELVE MONTHS ENDED JUNE 30, 2022



*Note: Arrows represent the change from prior year and the lines represent the 4-year trend

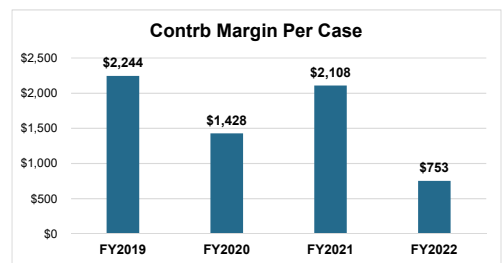
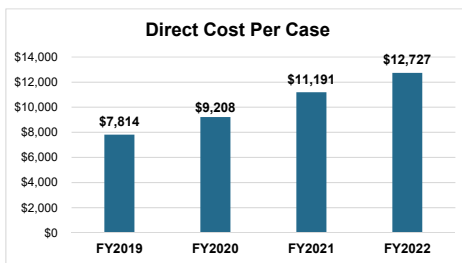
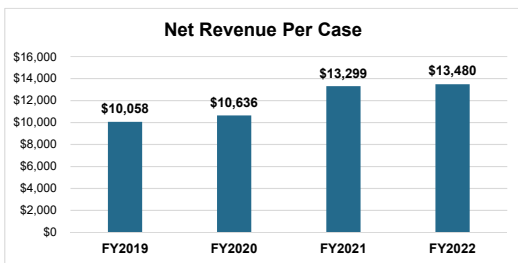
METRICS BY SERVICE LINE - FY 2022

SERVICE LINE	PATIENT CASES	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
Inpatient Orthopedic -Surgical Services	1,103	\$28,378,513	\$24,696,812	\$3,681,702	(\$2,198,952)
Inpatient Orthopedic - Medical Services	331	\$3,913,801	\$3,500,231	\$413,570	(\$676,147)
OP Orthopedic Surgeries	1,967	\$13,553,573	\$15,088,333	(\$1,534,760)	(\$5,036,727)
Services Line Totals	3,401	\$45,845,887	\$43,285,376	\$2,560,512	(\$7,911,826)

METRICS SUMMARY - 4 YEAR TREND

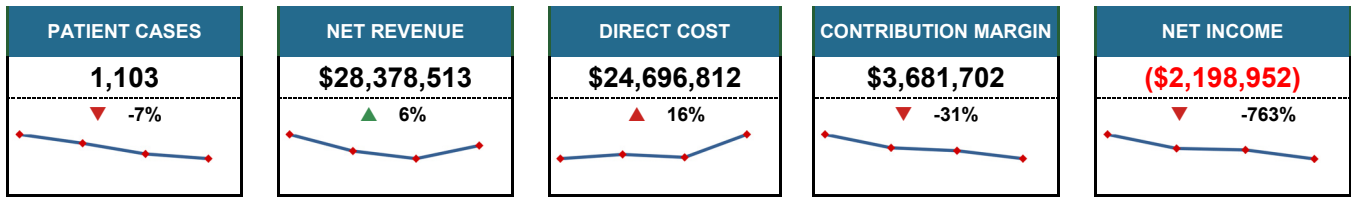
METRIC	FY2019	FY2020	FY2021	FY2022	%CHANGE FROM PRIOR YR	4 YR TREND
Patient Cases	4,164	3,850	3,091	3,401	▲ 10%	
Net Revenue	\$41,880,557	\$40,948,338	\$41,106,700	\$45,845,887	▲ 12%	
Direct Cost	\$32,537,680	\$35,452,320	\$34,591,199	\$43,285,376	▲ 25%	
Contribution Margin	\$9,342,877	\$5,496,018	\$6,515,501	\$2,560,512	▼ -61%	
Indirect Cost	\$8,870,223	\$9,803,371	\$9,335,051	\$10,472,338	▲ 12%	
Net Income	\$472,654	(\$4,307,352)	(\$2,819,550)	(\$7,911,826)	▼ -181%	
Net Revenue Per Case	\$10,058	\$10,636	\$13,299	\$13,480	▲ 1%	
Direct Cost Per Case	\$7,814	\$9,208	\$11,191	\$12,727	▲ 14%	
Contrb Margin Per Case	\$2,244	\$1,428	\$2,108	\$753	▼ -64%	

GRAPHS



Notes:
 Source: Inpatient and Outpatient Service Line Reports
 Selection Criteria Inpatient Data: Entity ID= KDHS, Service Line 1= Orthopedics, Surg vs Medical (S/M)
 Selection Criteria for OP Orthopedic Surgeries: Service Line 1= O/P Surgery and Surgeon Specialty =
 Neurological Surgery, Podiatrist, Sugery - Surgery of the Hand & Orthopaedic Surgery

KEY METRICS - FY 2022 TWELVE MONTHS ENDED JUNE 30, 2022

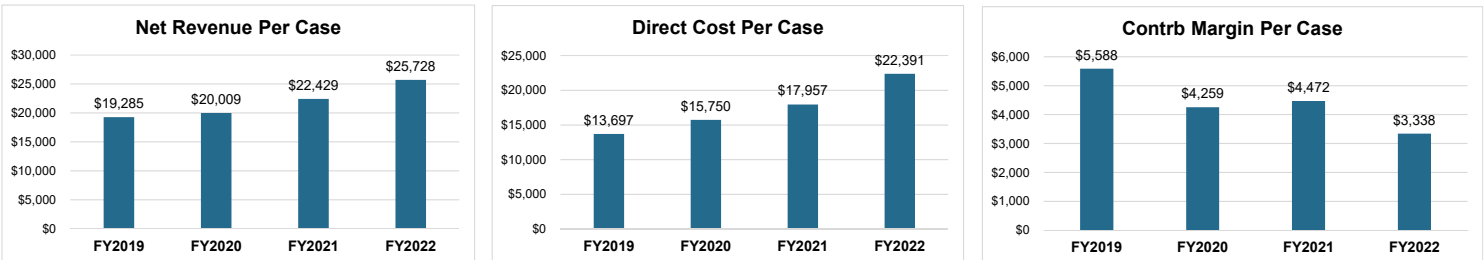


*Note: Arrows represent the change from prior year and the lines represent the 4-year trend

METRICS SUMMARY - 4 YEAR TREND

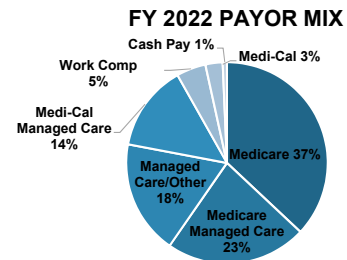
METRIC	FY2019	FY2020	FY2021	FY2022	%CHANGE FROM PRIOR YR	4 YR TREND
Patient Cases	1,545	1,383	1,190	1,103	▼ -7%	
Patient Days	5,254	4,637	4,940	5,688	▲ 15%	
ALOS	3.40	3.35	4.15	5.16	▲ 24%	
GM LOS	3.07	3.17	3.35	3.52	▲ 5%	
Opportunity LOS	0.33	0.18	0.80	1.64	▲ 104%	
Net Revenue	\$29,794,700	\$27,672,134	\$26,690,434	\$28,378,513	▲ 6%	
Direct Cost	\$21,161,234	\$21,782,519	\$21,369,137	\$24,696,812	▲ 16%	
Contribution Margin	\$8,633,466	\$5,889,615	\$5,321,297	\$3,681,702	▼ -31%	
Indirect Cost	\$5,542,705	\$5,815,428	\$5,576,194	\$5,880,654	▲ 5%	
Net Income	\$3,090,761	\$74,187	(\$254,897)	(\$2,198,952)	▼ -763%	
Net Revenue Per Case	\$19,285	\$20,009	\$22,429	\$25,728	▲ 15%	
Direct Cost Per Case	\$13,697	\$15,750	\$17,957	\$22,391	▲ 25%	
Contrb Margin Per Case	\$5,588	\$4,259	\$4,472	\$3,338	▼ -25%	

PER CASE TRENDED GRAPHS



PAYER MIX - 4 YEAR TREND (GROSS CHARGES)

PAYER	FY2019	FY2020	FY2021	FY2022
Medicare	43%	42%	38%	37%
Medicare Managed Care	16%	18%	23%	23%
Managed Care/Other	21%	22%	20%	18%
Medi-Cal Managed Care	13%	10%	12%	14%
Work Comp	3%	3%	3%	5%
Medi-Cal	3%	3%	4%	3%
Cash Pay	0%	1%	0%	1%



Notes:
 Source: Inpatient Service Line Report
 Selection Criteria: Inpatient Service Line is Orthopedics, Surgery Flag= 1 and DaVinci Flag =0

KEY METRICS - FY 2022 TWELVE MONTHS ENDED JUNE 30, 2022

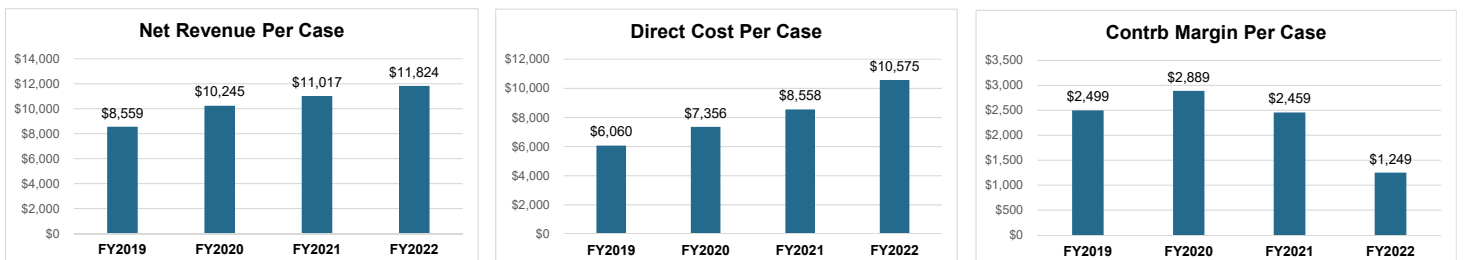


*Note: Arrows represent the change from prior year and the lines represent the 4-year trend

METRICS SUMMARY - 4 YEAR TREND

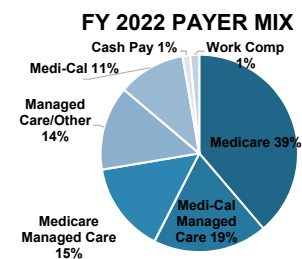
METRIC	FY2019	FY2020	FY2021	FY2022	%CHANGE FROM PRIOR YR	4 YR TREND
Patient Cases	461	331	299	331	▲ 11%	
Patient Days	1,845	1,384	1,583	2,072	▲ 31%	
ALOS	4.00	4.18	5.29	6.26	▲ 18%	
GM LOS	3.44	3.35	3.42	3.41	▶ 0%	
Opportunity LOS	0.56	0.84	1.87	2.85	▲ 52%	
Net Revenue	\$3,945,516	\$3,391,116	\$3,294,066	\$3,913,801	▲ 19%	
Direct Cost	\$2,793,652	\$2,434,807	\$2,558,897	\$3,500,231	▲ 37%	
Contribution Margin	\$1,151,864	\$956,309	\$735,170	\$413,570	▼ -44%	
Indirect Cost	\$1,058,368	\$876,267	\$871,685	\$1,089,717	▲ 25%	
Net Income	\$93,496	\$80,043	(\$136,515)	(\$676,147)	▼ -395%	
Net Revenue Per Case	\$8,559	\$10,245	\$11,017	\$11,824	▲ 7%	
Direct Cost Per Case	\$6,060	\$7,356	\$8,558	\$10,575	▲ 24%	
Contrb Margin Per Case	\$2,499	\$2,889	\$2,459	\$1,249	▼ -49%	

PER CASE TRENDED GRAPHS



PAYER MIX - 4 YEAR TREND (GROSS CHARGES)

PAYER	FY2019	FY2020	FY2021	FY2022
Medicare	43%	41%	42%	39%
Medi-Cal Managed Care	26%	20%	24%	19%
Medicare Managed Care	9%	13%	13%	15%
Managed Care/Other	9%	14%	9%	14%
Medi-Cal	9%	11%	10%	11%
Cash Pay	2%	0%	2%	1%
Work Comp	2%	1%	1%	1%



Notes:
 Source: Inpatient Service Line Report
 Selection Criteria: Entity ID: KDHS, Service Line 1= Orthopedics, Surg vs Medical = M

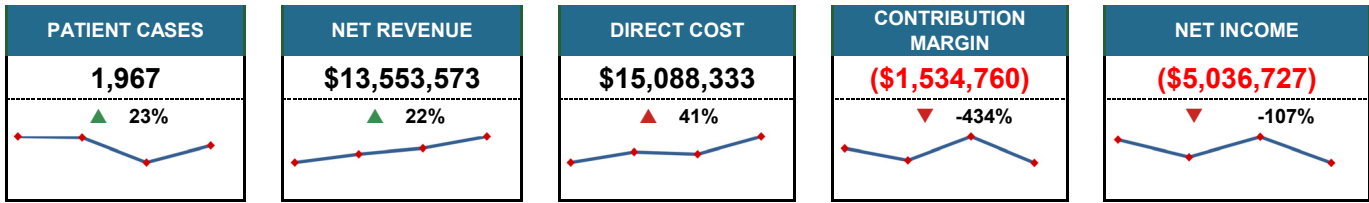
KAWEAH HEALTH ANNUAL BOARD REPORT

FY2022

Orthopedic Services - Outpatient Surgery Service Line

*Includes: Orthopedic Surgery, Neurological Surgery, Podiatry, and Surgery of the Hand.

KEY METRICS - FY 2022 TWELVE MONTHS ENDED JUNE 30, 2022

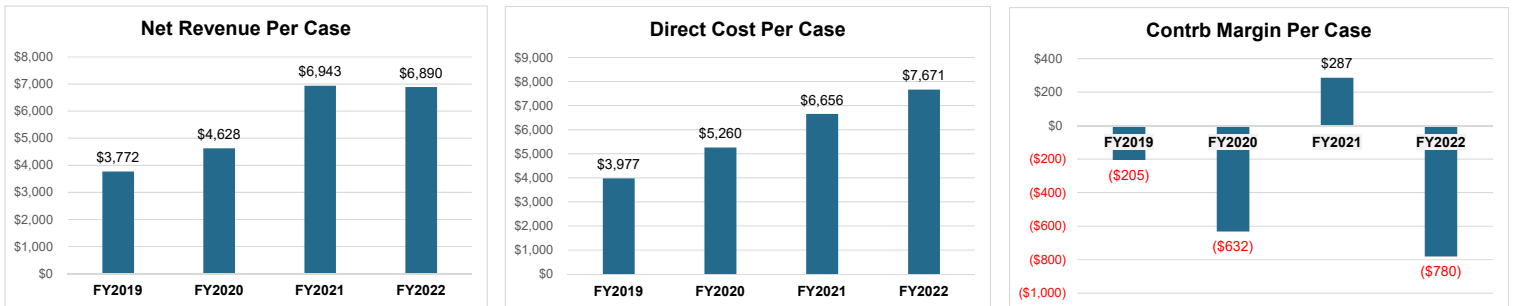


*Note: Arrows represent the change from prior year and the lines represent the 4-year trend

METRICS SUMMARY - 4 YEAR TREND

METRIC	FY2019	FY2020	FY2021	FY2022	%CHANGE FROM PRIOR YR	4 YR TREND
Patient Cases	2,158	2,136	1,602	1,967	▲ 23%	
Net Revenue	\$8,140,341	\$9,885,089	\$11,122,200	\$13,553,573	▲ 22%	
Direct Cost	\$8,582,794	\$11,234,995	\$10,663,165	\$15,088,333	▲ 41%	
Contribution Margin	(\$442,453)	(\$1,349,906)	\$459,035	(\$1,534,760)	▼ -434%	
Indirect Cost	\$2,269,150	\$3,111,676	\$2,887,173	\$3,501,967	▲ 21%	
Net Income	(\$2,711,603)	(\$4,461,582)	(\$2,428,138)	(\$5,036,727)	▼ -107%	
Net Revenue Per Case	\$3,772	\$4,628	\$6,943	\$6,890	▼ -1%	
Direct Cost Per Case	\$3,977	\$5,260	\$6,656	\$7,671	▲ 15%	
Contrb Margin Per Case	(\$205)	(\$632)	\$287	(\$780)	▼ -372%	

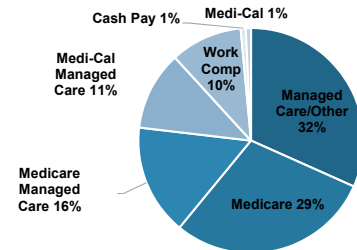
PER CASE TRENDED GRAPHS



PAYER MIX - 4 YEAR TREND (GROSS CHARGES)

PAYER	FY2019	FY2020	FY2021	FY2022
Managed Care/Other	32%	36%	36%	32%
Medicare	26%	26%	29%	29%
Medicare Managed Care	8%	8%	13%	16%
Medi-Cal Managed Care	23%	19%	12%	11%
Work Comp	10%	10%	10%	10%
Cash Pay	0%	0%	1%	1%
Medi-Cal	1%	1%	0%	1%

FY 2022 PAYOR MIX



Notes:

Source: Outpatient Service Line Reports

Selection Criteria for OP Orthopedic Surgeries: Service Line 1= O/P Surgery and Surgeon Specialty = Neurological Surgery, Podiatrist, Surgery - Surgery of the Hand & Orthopaedic Surgery

REPORT TO THE BOARD OF DIRECTORS

OUTPATIENT LAB AND PATHOLOGY

Randall J. Kokka (624-5053)
Director of Clinical Laboratory Services
September 19, 2022

Summary Issue/Service Considered

- Financially, net revenue for outpatient Clinical Laboratory services in FY2022 was approximately eight million dollars. Though trending higher than FY2019 and FY2020, this was essentially unchanged year-over-year. Net outpatient income for FY2022 was just under two million dollars. This was also upward trending from FY2019 and FY2020, but down year-over-year mainly due to increased direct/indirect operational costs. It should be mentioned, the financial data shown did not include the Covid-19 population, which made up a significant portion (approximately fifteen percent) of Clinical Laboratory outpatient volume.
- Outpatient services strategic planning involved the following initiatives: (a) the successful re-opening and continued development of the Hospital Lab patient service center just inside of the Mineral King entrance; (b) the planned opening of a new Lab patient service center in Exeter in the first quarter of calendar year 2023, or sooner; (c) continuation of ongoing discussions for Lab patient service centers in other areas of Visalia and the surrounding communities.
- Employee focused initiatives: (a) the ongoing improvement of working conditions and the physical environment via an extensive construction and remodel project, to include state-of-the-art equipment; (b) frequent reviews of equity and staffing, including the addition of a new Lab Coordinator in the current fiscal year; (c) monthly unit-based-council activities to improve employee recognition, including awards for employee of the month and multiple employee of the year awards. Note: in the past year, one of our staff members was recognized by the statewide professional organization as their Clinical Lab Scientist of the year and as our Kaweah Health employee of the month. In addition, one of our Lab Coordinators was a Starlight Award winner for the professional services division.
- A focus on quality improvement: the Laboratory continued to actively measure a variety of daily/monthly metrics to improve the quality of services and readily collaborated with a variety of internal and external entities. Examples of initiatives: timely daily testing throughput to reduce patient length of stay, reduction of blood culture contamination rates, STAT test turnaround times, order validity, etc.

Quality/Performance Improvement Data

- As in previous years, the Clinical Laboratory continued to be fully accredited by the College of American Pathologists (CAP) and licensed by the State of California and federally (CLIA). We successfully completed proficiency testing in all areas of expertise.
- Daily testing throughput scores were posted outside of the Lab Manager's office and have remained as a focal point. Note: the average monthly score has

exceeded the metric benchmark for the past six months. This is a notable improvement from the delays experienced due to Covid-19 over the past two and a half years.

- STAT test turnaround times were reported in Laboratory and Emergency Department monthly meetings. The Lab reached, or exceeded the metric benchmark every month during the past year and continues to analyze and actively seek additional operational efficiencies.
- Other specific metrics included specimen rejection rates, critical call compliance, blood culture contamination rates, blood bank utilization and proficiency testing success rate. Overall, we are currently in compliance with all of our metric benchmarks, but there are areas of opportunity for improvement.

Policy, Strategic or Tactical Issues

- As in the previous year, the impact of Covid-19 surges on Lab operations was a significant issue during FY2022. Enormous pressure was frequently placed on the main Lab to provide testing supplies to a variety of point-of-care-testing locations and to maintain the capability for high-throughput molecular testing. To wit: the Lab again successfully oversaw and performed thousands of specialized Covid-19 tests in addition to the non-Covid workload.
- The Lab continued to experience staffing pressure, particularly in the areas of phlebotomy and licensed Clinical Lab Scientists- further highlighting the need for strategic planning to support efforts towards improved staffing, compensation and working conditions.
- The Lab is currently in phase two of a planned six-phase construction project. The Lab has already been recognized by a significant industry supplier as a “Center of Excellence” candidate and has secured favorable supply agreements to this end. Going forward, we need to overcome delays and continue to progress through the project and the installation of new equipment.
- In order to execute plans for outreach expansion, the Lab will require the necessary support to plan and develop patient service centers where needed, including marketing studies, advertising, staffing and facilities planning.

Recommendations/Next Steps

- Continue to support the space and equipment acquisition necessary to allow for the performance of high-throughput molecular testing to diagnose Covid-19 and other current, or emerging, infectious diseases.
- Schedule compensation equity reviews in critical need areas in the near future. Likewise, rapid replacement due to staff attrition in both the support and technical areas is crucial. To that end, continued support for the Clinical Lab Scientist Trainee program is essential to meet current and projected staffing needs while avoiding the reliance on expensive, less effective, contract labor.
- Expedited completion of the Lab construction project will greatly enhance operational capabilities, space allocation and working conditions. Concurrent and continual evaluation and acquisition of new technology is necessary to remain a market leader.
- Explore potential collaboration with our reference-testing provider to develop a co-branded website dedicated to Lab services with the goal of enhancing the patient and physician experience. Evaluate and develop optimized methods of outpatient registration and scheduling to reduce wait times at patient service centers.

Approvals/Conclusions

The Lab is on pace to meet or surpass six million tests performed in the current calendar year. As we recover from the initial effects of the Covid-19 pandemic and resultant surges, our goals remain as follows:

1. As a primary focus, to complete our current construction and remodel project. Since it includes significant improvements in equipment and throughput, this remains a high priority and requires ongoing and expedited support from our construction and project management teams.
2. Concurrent to the main Lab's construction project is the continued development of Lab patient service centers as a direct means to improve patient access, convenience and timely service of Lab testing. The re-opening this past year of the Hospital center and the planned opening in Exeter will advance this goal.
3. The Human Resources department has upcoming planned reviews for compensation, particularly as it relates to phlebotomy and Clinical Lab Scientist staff. Remaining relevant to the regional market rates is a crucial factor to reduce attrition and improve year-over-year consistency, quality and overall morale.
4. In the past year, the main Lab was able to obtain additional space, which is slated to be integrated into the current construction project. This significant and needed improvement was highly appreciated and should bear fruit in the near future in terms of allowing for additional testing capacity and variety. In particular, the new area will likely encompass plans for additional molecular testing to meet the challenge of diagnosing current and emerging diseases.
5. Finally, we recently transitioned to a new Pathology service provider, Yosemite Pathology Medical Group, and we look forward to additional depth of services as we develop this new business relationship.

KAWEAH HEALTH ANNUAL BOARD REPORT

Outpatient Clinical Lab Service Line - *Non-COVID Population*

FY2022

***KEY METRICS - FY 2022 TWELVE MONTHS ENDED JUNE 30, 2022**

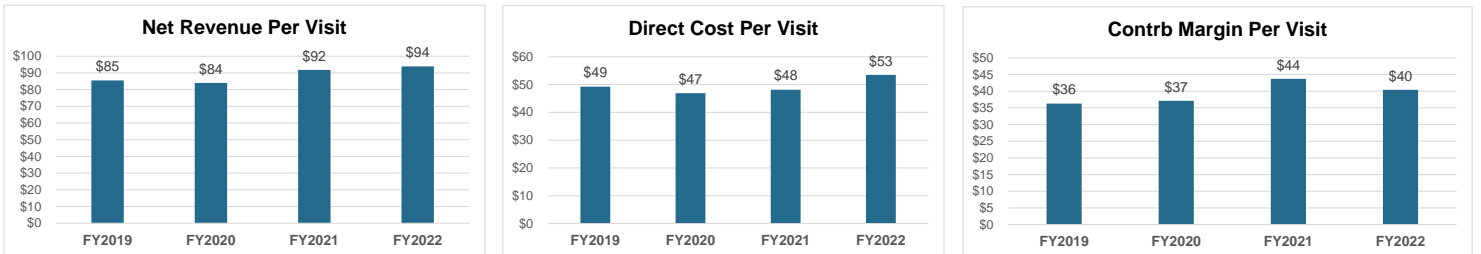


*Note: Arrows represent the change from prior year and the lines represent the 4-yr.

METRICS SUMMARY - 4 YEAR TREND

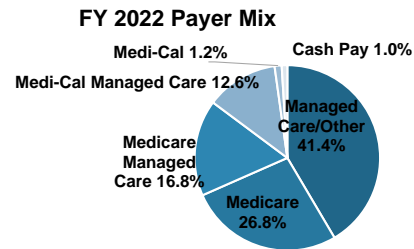
METRIC	FY2019	FY2020	FY2021	FY2022	%CHANGE FROM PRIOR YR	4 YR TREND
Patient Visits	83,278	84,544	87,377	85,090	▼ -3%	
Net Revenue	\$7,120,127	\$7,101,152	\$8,023,673	\$7,988,842	▶ 0%	
Direct Cost	\$4,099,262	\$3,963,427	\$4,205,261	\$4,550,933	▲ 8%	
Contribution Margin	\$3,020,865	\$3,137,724	\$3,818,412	\$3,437,909	▼ -10%	
Indirect Cost	\$1,290,149	\$1,443,451	\$1,435,419	\$1,473,854	▲ 3%	
Net Income	\$1,730,716	\$1,694,273	\$2,382,993	\$1,964,055	▼ -18%	
Net Revenue Per Visit	\$85	\$84	\$92	\$94	▲ 2%	
Direct Cost Per Visit	\$49	\$47	\$48	\$53	▲ 11%	
Contrb Margin Per Visit	\$36	\$37	\$44	\$40	▼ -8%	

PER CASE TRENDED GRAPHS



PAYER MIX - 4 YEAR TREND (PATIENT VISITS)

PAYER	FY2019	FY2020	FY2021	FY2022
Managed Care/Other	44.2%	43.4%	43.9%	41.4%
Medicare	28.5%	27.5%	25.8%	26.8%
Medicare Managed Care	13.9%	14.5%	15.9%	16.8%
Medi-Cal Managed Care	10.5%	11.4%	11.8%	12.6%
Medi-Cal	1.6%	1.7%	1.2%	1.2%
Cash Pay	1.0%	1.2%	1.1%	1.0%



1. The COVID-related visits are excluded from this report. In FY 2022, there were 15,365 COVID-related visits, representing 15% of the total Outpatient Lab volume. In FY 2021, there were just over 27,000 COVID-related visits in FY 2021, representing 24% of the total Outpatient Lab volume.
 Source: Outpatient Service Line Reports
 Criteria: Service Line 1 = Lab and COVID -Related Master Flag= 0

REPORT TO THE BOARD OF DIRECTORS

Rehabilitation Services

Molly Niederreiter, Director of Rehabilitation and Skilled Services, 624-2541
September 20, 2022

Summary Issue/Service Considered

1. Achieving optimum balance of program priorities to address quality of care, compliance, profitability, and quality of work environment.
2. Ensuring that Rehabilitation Services continues to provide the full continuum of services to the community as a District Center of Excellence

Analysis of financial/statistic data for Acute Inpatient Rehabilitation Program:

The inpatient Rehabilitation program ended FY 2022 with a contribution margin of \$2.7 million, a 27% increase from previous year. The annual discharge volumes have improved for the first time since FY 2019, up by 15% to 466 patient cases. Volumes are remaining higher and we are currently at budget.

Patient days are up 11% with the corresponding Average Length of Stay trending down to just under 13 days, nearing FY 2019. This is notable as we have the continued lost volume for the surgical after care patients, 21 discharges for FY 2022 compared to 99 discharges FY 2019. Their Average Length of Stay is 10 days, which historically has helped the overall. The corresponding lost contribution margin from the lost surgical after care is approximately \$500,000 annually.

Net Patient Revenue per case has a nice upward trend over the last four years however not by enough of a margin to offset the increased direct cost per case. The increase in direct cost per case corresponds primarily with the 25% increase in RN productive salary expenses in FY 2022, resulting in a 12% increase in expenses overall. Therapy expenses per case remained stable. In addition, continued utilization of COVID Care unit affecting staffing ratios as it requires a dedicated nurse for a small number of patients (1-3 patients on average). Fortunately, we have not utilized registry nurses to staff this program.

Direct allocations to 6440 Acute Rehabilitation cost center increased \$90,000 in FY 2022, for a total expense of \$1,072,480, 8% higher than FY 2021. Contributing to this are an increase of \$24,000 for Rehabilitation Administration department and increase of \$74,000 for Nursing Administration related to Chartis contract. Utilization Management decreased by \$46,000.

There were also significant shifts in reimbursement/payer mix for FY 2022. Acute Inpatient Rehabilitation is predominantly a Medicare business with a combined 51% of the payer mix. For FY 2022 Medicare discharges are back up substantially, reimbursement per case increasing to \$25,000 with a contribution margin per case of

\$7,829. Managed Care discharges are up as well with a reimbursement per case increasing to \$27,300 and a contribution margin per case of \$9,329. Medi-Cal Managed Care cases have declined slightly in payer mix, which is helpful because the reimbursement per case is much lower at \$19,000 with a far lower contribution margin per case.

Analysis of financial/statistic data for Outpatient Therapy Clinics:

The Outpatient Therapy Rehabilitation Services ended the FY 2022 with a contribution margin of \$2.7 million, down 15% (\$475,000) from FY 2021. Units of service were stable compared to prior year, however a slightly higher (3%) direct cost per unit of service accounting for \$235,000 and a lower reimbursement per unit of service accounting for \$220,000 eroded the contribution margin. Medi-Cal Managed Care reimbursement dropped by 22% causing the contribution margin loss to nearly double from -\$450,000 to -\$800,000 in FY 2022. In FY 2022, 7 of 8 outpatient services had a positive contribution margin, top 4 departments are Therapy Specialists at Akers, Rehabilitation Hospital, Lovers Lane and Hand Therapy Specialists.

Therapy Specialists at Rehabilitation Hospital, Lovers Lane, Dinuba, Hand Therapy Specialists and Cardiac Rehabilitation all saw an increase in volume/units of service; although overall, there was a 1% decrease due to declines at Wound Center, Therapy Specialists at Akers and Exeter. COVID continues to have a negative impact on volume; we are seeing hire cancellations and no shows than FY 2019.

Approximately 8% of the volume in the Out Patient Therapies area represents Kaweah Health employee, including both the KH insurance and KH Worker's Comp. A proxy reimbursement based upon our overall managed care and Workman's Compensation rates for each clinic is included for these accounts in the Service Line Report and on this Board Report.

Cardiac Rehabilitation: The cardiac rehab program has maximized class sizes, however still short one class in order to maintain the required cleaning in the treatment gym. As a result, patient volume increased 5% in FY 2022 compared to prior year. Net Revenue per Unit of Service is up 6% although the contribution margin per Unit of Service decreased from \$30 to \$23. Direct cost per unit of service increased 17%, due to increases in direct allocation and pulmonary services with about \$20,000 in expense in FY 2022 that were not provided in FY 2021. The program maintained a positive contribution margin of \$137,315 for FY 2021, up from \$123,417 in FY 2020. The pulmonary rehab program was closed part of the fiscal year due to COVID, classes resumed in November although not near volumes of FY 2019. Both programs continue to be impacted by COVID as attendance, including cancellations and no-shows are high during surges in community.

Wound Clinic: The wound center's units of service decreased an additional 23% in FY 2022, down approximately 46% since FY 2019. Both stricter screening of hyperbaric patients and gaps in certified provider availability have resulted in the decreased volume. The contribution margin loss improved by 87%, from (\$5) to (\$1). Direct cost per unit of service decreased by 3%, primarily due to management of staffing hours when volumes are low. Net revenue per unit of service increased by 7%. Payer mix has

shifted slightly, with a 3% increase in Medi-Cal managed care/Medi-Cal, which has a (\$310) contribution margin per case, and Medicare/Medicare Managed Care is stable at 54% in FY 2022.

Quality/Performance Improvement Data

Acute Rehabilitation: The program continues to exceed the national benchmark for community discharges, with 84.3% of patients discharged home compared to 81.5% nationally. Average length of stay for the year was 12.9 days, lower than the national average of 13.6 days. Patient satisfaction has averaged 94% overall for FY 2022, placing the program in the 68th percentile, an increase from the 62nd percentile in FY 2021. Referrals for all of the post-acute areas (acute rehabilitation and skilled nursing/Long Term Care) increased significantly from 563 per month FY 2021 to 630/month for FY 2022. The majority of referrals continue to be from Kaweah Health, with small numbers of consistent referrals from Adventist Hanford, CRMC, UC Davis, St Agnes and a recent increase from Clovis Community Hospital. Trends regarding patient falls, urinary tract infection, and hospital acquired skin breakdown continue to demonstrate facility performance exceeding national benchmarks on all indicators.

Outpatient Therapy Clinics: An internal survey measures patient satisfaction and results benchmarked against prior performance. Patient satisfaction averages at or above 96% in each clinic, with ongoing focus on improving patient satisfaction as it pertains to their involvement in setting therapy goals and the outcomes in relation to those goals. Therapy outcomes are reported on a quarterly basis, using pre and post treatment plan outcome tools to measure significant functional improvement and therapy effectiveness. Each therapy clinic uses outcomes measures that are specific to the patient's diagnosis and useful to the clinician. The results are shared with the clinicians in an effort to bring focus to specific areas that could benefit from additional review and update of evidence based treatment approaches. Therapy Specialist at Akers are also sharing outcomes with the providers as a marketing tool.

Acute Therapy Services: In the Medical Center, we report the response time from MD order/admission to nursing unit to the time the therapy evaluation is completed/attempted for Physical Therapy and Speech Therapy. The goal is to complete therapy evaluations within 24 hours of the MD order. Data for 1Q22/2Q22 Physical Therapy 66%/59% Speech Therapy 75%/78%. The report utilized to compile this data broke in January 2022, there is an ongoing ticket with ISS. The ability to meet the goals are impacted by a significantly (40%) higher than normal census in addition, severe staffing shortages (open positions) for all disciplines. The Acute Therapy department prioritizes Neurologic, Orthopedic, Cardiac and Trauma patients and will monitor timely responsiveness to these patients specifically when data is available.

Wound Center: The wound center evaluates the average days to heal for wounds, with results above the national benchmarks most of this fiscal year. Some patients being treated for pressure ulcers wounds that took more than 200 days to heal which skews the data as patients with diabetic ulcers and surgical wounds would be below the national average. Recent hiring of a Nurse Practitioner, open for 1 year, will allow the team to resume regular case reviews of stalled wounds in order to facilitate timely adjustments in the treatment plan for complex wounds that are not initially responsive to treatment. To improve efficiency with the process, information regarding clinical

recommendations is collected and provided to the practitioner instead of requiring their attendance at the chart review.

Cardiac and Pulmonary Rehabilitation: Outcome measures for blood pressure goal, peak metabolic equivalents and psychosocial were initiated. When a full year of data is collected, goals will be established.

Policy, Strategic or Tactical Issues

1. Installation and implementation of the SafeGait 360 Balance and Mobility Trainer in the Rehabilitation hospital completed this spring. The expectation is the Safegait 360 will improve patient outcomes and functional efficiency, increase outside referrals and improve safety for patients and staff. We have IRB approval for a research project will goals for publication.
2. The Commission on Accreditation of Rehabilitation Facilities survey recommendations call for the development of a more comprehensive technology plan. Need Information System Services/Information Technology to dedicate time and resources to this project.
3. The COVID pandemic continues to challenge the rehabilitation services however; the census has recently stabilized/improved in both inpatient and outpatient programs. The rehabilitation hospital continues to admit both acute rehab and skilled nursing COVID positive patients to an isolation wing, recent updates to California Department of Public Health regulations have allowed for more flexibility in accommodating these patients. The outpatient clinics focus on building back volume via marketing.
4. The post-acute liaisons moved their offices from the medical center back over to the Acute Rehabilitation Hospital. In addition, as of October 2nd, they will report through to the Director of Rehabilitation instead of the Director of Throughput and Specialty Care. This will allow for improve oversight, optimization of workflow and productivity.
5. The hyperbaric medicine program at the Wound Center continues to be impacted stricter processes for patient screening and documentation. These stricter processes in combination with gaps in certified provider availability continue to impact created patient volume.
6. The rehabilitation hospital, currently licensed for 45 acute rehabilitation beds and 16 skilled nursing beds, may benefit from adjusting these numbers given the regulatory and payer constraints. We will look to adjust the licensing so that the facility has 31 skilled nursing beds and 30 acute rehab beds. This balance will more than accommodate the demand for acute rehab while allowing for adjustments to the skilled nursing programs. Review of the compliance/regulatory implications of this initiative will be necessary.
7. Transitioning from traditional fax to e-fax for referral process will result in a more efficient admission/intake workflow.
8. Optimize Cardiac referral workflow to ensure follow through on consults as leads for the program.
9. Optimize Kaweah Health website to better market both inpatient and outpatient Rehabilitation programs.
10. Optimize Wound Expert by entering cost of supplies, which will allow us to monitor cost of supplies per wound treatment.

Recommendations/Next Steps

1. Fully implement and monitor effectiveness of goals established via leadership performance system addressing the pillars identified by Kaweah Health (outstanding health outcomes, financial strength, ideal work environment, empower through education and excellent service)
2. Maintain positive productivity in support of improved or sustained positive financial performance for all programs. Ensure ongoing marketing of all inpatient and outpatient programs. Monitor all publicly reported quality measures with goal of achieving or sustaining performance that exceeds national benchmarks.
3. Provide high quality, affordable care for patients in our existing market as well as expand our service to more patients. Continue to work closely with patient billing department to ensure we address all revenue issues promptly.
4. Work closely with post-acute liaisons to stabilize census in the Acute Rehab Program including analysis of current referral processes and workflows.
5. Participate in outreach programs and opportunities such as runs/walks, community forums, and health fairs to market to consumers, physicians, and the overall community. Focus on strategies using social media and consumer reviews.
6. Working with HR with retaining and recruiting clinical staff by re-evaluating loan repayment, clinical ladder, sign-on bonuses, and pay ranges.
7. Determine if centralizing the referral process for the outpatient clinics, as we did with the authorization process, will result in a more efficient and appropriate distribution of patients.
8. Continue to respond to Medicare initiatives related to acute rehabilitation services at the state and national level. Actively monitor processes that support appropriate admissions and documentation that supports medical necessity.
9. Monitor and respond to legislative developments such as the IMPACT Act that impose new requirements for post-acute care related to data collection and quality measures, and that signal forthcoming changes in reimbursement structures that would favor a bundled approach or site neutral payment policies.
10. Review results of employee satisfaction survey with each department, develop, and implement action plans.
11. Implement Post-Acute division strategic plan. Collaborate with key Kaweah Health leaders for improved management of patients with complex needs and chronic conditions.

Approvals/Conclusions

Rehabilitation services will focus in the coming year on:

1. Census development/patient volumes, management of productivity, maintaining compliance with all regulatory and payer expectations, customer satisfaction, clinical excellence and financial performance.
2. Implementation of goals related to Kaweah Health cornerstones for all of rehabilitation services to enhance program development, satisfaction of all stakeholders, program marketing, and ideal work environment for staff, and clinical quality of services.
3. Continued support of shared governance via rehabilitation councils (both nursing unit based council and therapy/business services council).

KEY METRICS - FY 2022 TWELVE MONTHS ENDED JUNE 30, 2022



*Note: Arrows represent the change from prior year and the lines represent the 4-year trend

METRICS SUMMARY - 4 YEAR TREND

METRIC	FY2019	FY2020	FY2021	FY2022	%CHANGE FROM PRIOR YR	4 YR TREND
Patient Cases	528	445	406	466	▲ 15%	
Patient Days	6,697	5,956	5,422	6,040	▲ 11%	
ALOS	12.68	13.38	13.35	12.96	▼ -3%	
Net Revenue	\$11,466,736	\$9,897,695	\$9,271,317	\$10,990,331	▲ 19%	
Direct Cost	\$7,176,951	\$7,222,105	\$7,128,335	\$8,259,040	▲ 16%	
Contribution Margin	\$4,289,784	\$2,675,590	\$2,142,982	\$2,731,290	▲ 27%	
Indirect Cost	\$3,966,299	\$4,157,952	\$4,089,807	\$4,657,328	▲ 14%	
Net Income	\$323,485	(\$1,482,362)	(\$1,946,825)	(\$1,926,038)	▲ 1%	
Net Revenue Per Case	\$21,717	\$22,242	\$22,836	\$23,584	▲ 3%	
Direct Cost Per Case	\$13,593	\$16,229	\$17,557	\$17,723	▲ 1%	
Conrb Margin Per Case	\$8,125	\$6,013	\$5,278	\$5,861	▲ 11%	

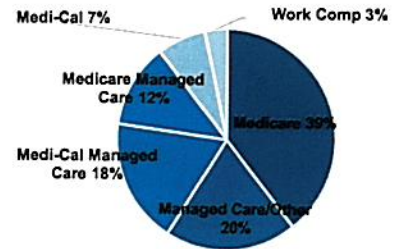
PER CASE TRENDED GRAPHS



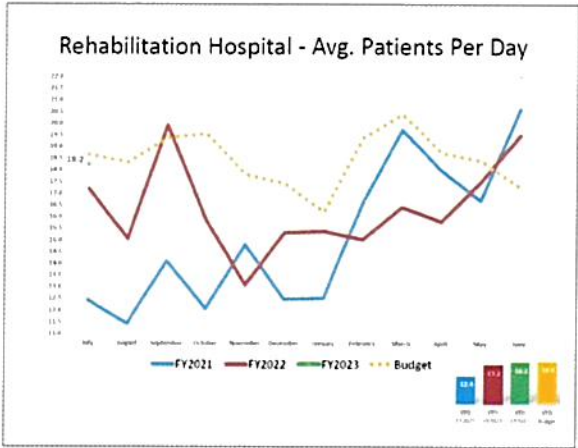
PAYER MIX - 4 YEAR TREND (TOTAL CHARGES)

PAYER	FY2019	FY2020	FY2021	FY2022
Medicare	45%	41%	37%	39%
Managed Care/Other	19%	20%	18%	20%
Medi-Cal Managed Care	20%	21%	19%	18%
Medicare Managed Care	7%	10%	14%	12%
Medi-Cal	6%	7%	11%	7%
Work Comp	3%	1%	2%	3%

FY 2022 PAYER MIX



KEY METRICS - FY 2022 TWELVE MONTHS ENDED JUNE 30, 2022



Notes:
 Source: Inpatient Service Line Report
 Selection Criteria: Service Name is Kaweah Health Rehabilitation Hospital

KAWEAH HEALTH ANNUAL BOARD REPORT

Rehabilitation Services - Outpatient Summary

FY2022

KEY METRICS - FY 2022 TWELVE MONTHS ENDED JUNE 30, 2022



*Note: Arrows represent the change from prior year and the lines represent the 4-year trend

METRICS BY SERVICE LINE - FY 2020

SERVICE LINE	UNITS OF SERVICE	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
Therapies - Akers	100,563	\$3,874,159	\$2,658,452	\$1,215,707	\$268,090
Therapies - KDRH	57,196	\$1,947,719	\$1,527,049	\$420,670	(\$287,799)
Therapy Lover's Lane	24,205	\$904,954	\$539,573	\$365,381	\$195,969
Hand Therapy	36,443	\$1,382,321	\$1,079,003	\$303,318	\$14,159
Therapies - Exeter	23,399	\$708,006	\$553,822	\$154,184	(\$29,437)
Therapies - Dinuba	26,331	\$655,484	\$522,846	\$132,637	(\$2,479)
Cardiac Rehabilitation	4,494	\$491,134	\$388,167	\$102,967	(\$108,446)
Wound Care Center	14,154	\$642,909	\$652,582	(\$9,673)	(\$477,781)
OP Rehabilitation Services Totals	286,785	\$10,606,686	\$7,921,494	\$2,685,192	(\$427,724)

METRICS SUMMARY - 4 YEAR TREND

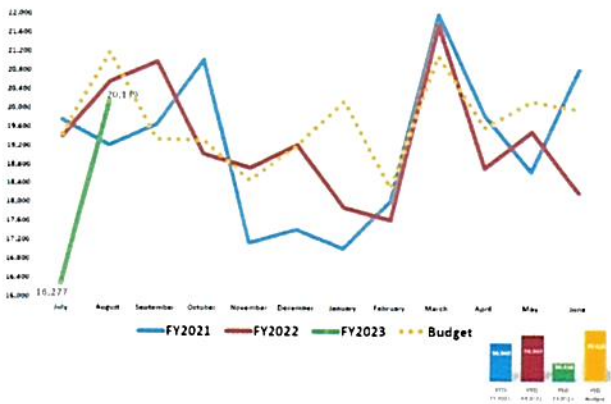
METRIC	FY2019	FY2020	FY2021	FY2022	%CHANGE FROM PRIOR YR	4 YR TREND
Units of Service	307,549	281,869	288,674	286,785	▼ -1%	
Net Revenue	\$11,714,263	\$10,766,948	\$10,897,457	\$10,606,686	▼ -3%	
Direct Cost	\$8,120,808	\$7,751,863	\$7,737,019	\$7,921,494	▲ 2%	
Contribution Margin	\$3,593,456	\$3,015,086	\$3,160,437	\$2,685,192	▼ -15%	
Indirect Cost	\$2,946,117	\$3,652,080	\$2,958,466	\$3,112,916	▲ 5%	
Net Income	\$647,339	(\$636,994)	\$201,972	(\$427,724)	▼ -312%	
Net Revenue Per UOS	\$38	\$38	\$38	\$37	▼ -2%	
Direct Cost Per UOS	\$26	\$28	\$27	\$28	▲ 3%	
Contrb Margin Per UOS	\$12	\$11	\$11	\$9	▼ -14%	

KEY METRICS - FY 2022 TWELVE MONTHS ENDED JUNE 30, 2022

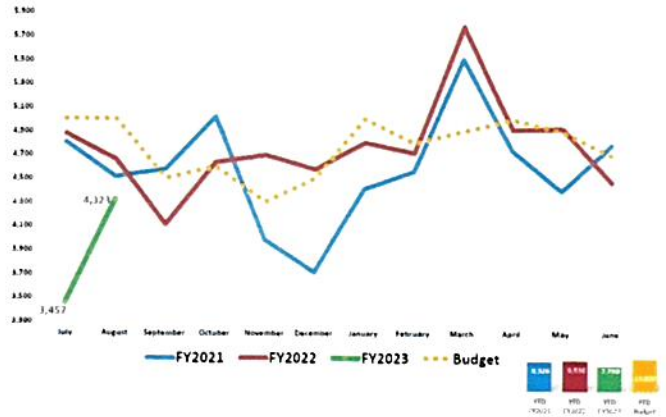
GRAPHS



All O/P Rehab Services Across District



O/P Rehab Services



Notes:
 Source: Outpatient Service Line Reports
 Criteria: Outpatient Service Lines and Secondary Service Line selections
 Criteria: specific selection for each Service Line (noted on the individual Service Line Tabs)

KAWEAH HEALTH ANNUAL BOARD REPORT

Outpatient Services - Therapies - Akers

FY2022

KEY METRICS - FY 2022 TWELVE MONTHS ENDED JUNE 30, 2022

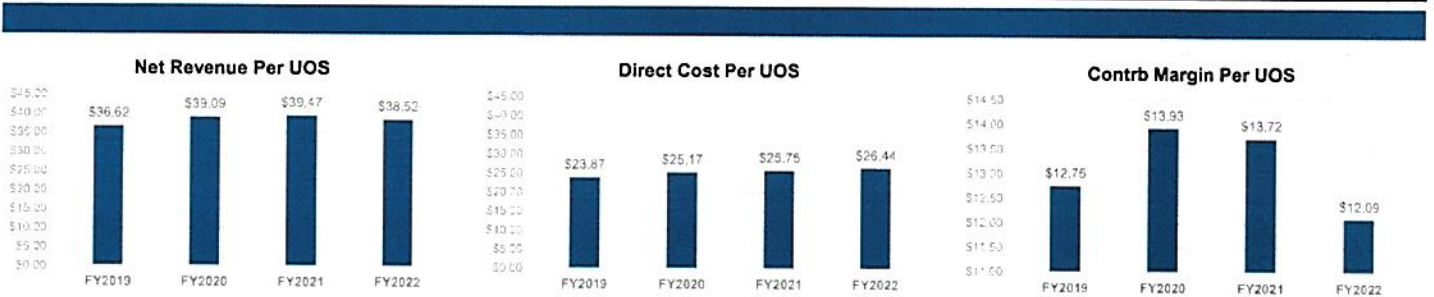


*Note: Arrows represent the change from prior year and the lines represent the 4-year trend

METRICS SUMMARY - 4 YEAR TREND

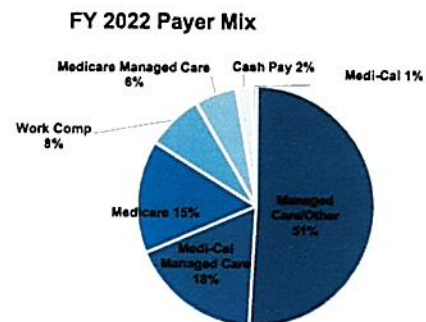
METRIC	FY2019	FY2020	FY2021	FY2022	%CHANGE FROM PRIOR YR	4 YR TREND
Units of Service	110,119	106,432	103,189	100,563	▼ -3%	
Net Revenue	\$4,032,444	\$4,160,594	\$4,072,942	\$3,874,159	▼ -5%	
Direct Cost	\$2,628,361	\$2,678,431	\$2,656,972	\$2,658,452	▶ 0%	
Contribution Margin	\$1,404,083	\$1,482,163	\$1,415,970	\$1,215,707	▼ -14%	
Indirect Cost	\$874,234	\$1,156,267	\$883,089	\$947,617	▲ 7%	
Net Income	\$529,849	\$325,896	\$532,881	\$268,090	▼ -50%	
Net Revenue Per UOS	\$36.62	\$39.09	\$39.47	\$38.52	▼ -2%	
Direct Cost Per UOS	\$23.87	\$25.17	\$25.75	\$26.44	▲ 3%	
Contrb Margin Per UOS	\$12.75	\$13.93	\$13.72	\$12.09	▼ -12%	

PER CASE TRENDED GRAPHS

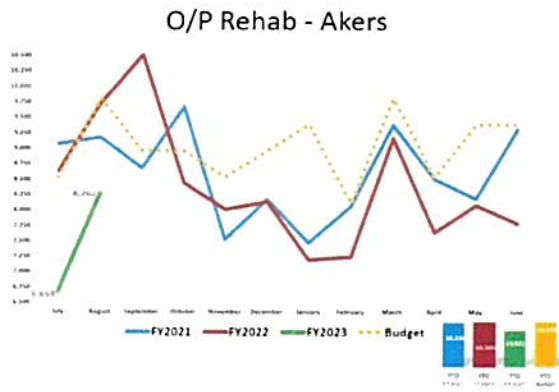


PAYER MIX - 4 YEAR TREND (TOTAL CHARGES)

PAYER	FY2019	FY2020	FY2021	FY2022
Managed Care/Other	54%	55%	55%	51%
Medi-Cal Managed Care	17%	17%	17%	18%
Medicare	17%	16%	14%	15%
Work Comp	6%	7%	7%	8%
Medicare Managed Care	4%	4%	5%	6%
Cash Pay	1%	1%	1%	2%
Medi-Cal	1%	1%	1%	1%



KEY METRICS - FY 2022 TWELVE MONTHS ENDED JUNE 30, 2022



Notes:
 Source: Outpatient Service Line Reports
 Criteria: Outpatient Service Line is O/P Therapies and Secondary Service Line is CCPTS

KAWEAH HEALTH ANNUAL BOARD REPORT

Outpatient Services - Therapies - KHRH

FY2022

KEY METRICS - FY 2022 TWELVE MONTHS ENDED JUNE 30, 2022

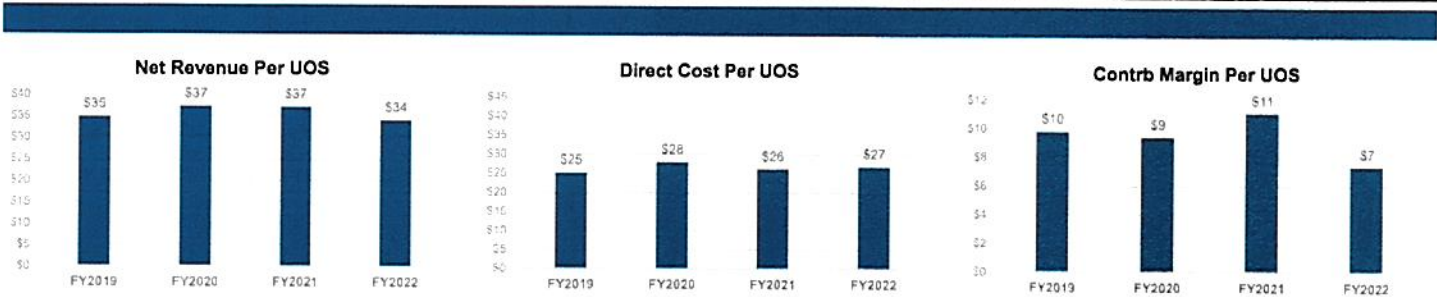


*Note: Arrows represent the change from prior year and the lines represent the 4-year trend

METRICS SUMMARY - 4 YEAR TREND

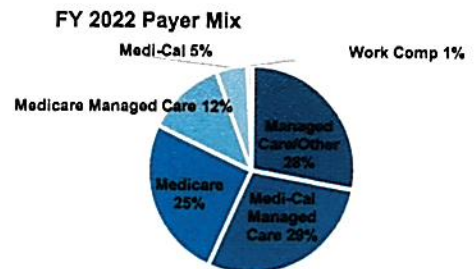
METRIC	FY2019	FY2020	FY2021	FY2022	%CHANGE FROM PRIOR YR	4 YR TREND
Units of Service	56,224	46,800	55,054	57,196	▲ 4%	
Net Revenue	\$1,956,650	\$1,742,582	\$2,043,476	\$1,947,719	▼ -5%	
Direct Cost	\$1,407,545	\$1,302,846	\$1,433,867	\$1,527,049	▲ 6%	
Contribution Margin	\$549,105	\$439,736	\$609,609	\$420,670	▼ -31%	
Indirect Cost	\$622,837	\$781,047	\$665,908	\$708,469	▲ 6%	
Net Income	(\$73,732)	(\$341,311)	(\$56,299)	(\$287,799)	▼ -411%	
Net Revenue Per UOS	\$35	\$37	\$37	\$34	▼ -8%	
Direct Cost Per UOS	\$25	\$28	\$26	\$27	▲ 3%	
Contrb Margin Per UOS	\$10	\$9	\$11	\$7	▼ -34%	

PER CASE TRENDED GRAPHS



PAYER MIX - 4 YEAR TREND (TOTAL CHARGES)

PAYER	FY2019	FY2020	FY2021	FY2022
Managed Care/Other	31%	32%	32%	28%
Medi-Cal Managed Care	18%	21%	27%	29%
Medicare	38%	35%	26%	25%
Medicare Managed Care	8%	7%	10%	12%
Medi-Cal	3%	3%	5%	5%
Work Comp	1%	1%	1%	1%



Notes:
 Source: Outpatient Service Line Reports
 Criteria: Outpatient Service Line is O/P Therapies and Secondary Service Line is Neuro Clinic

KAWEAH HEALTH ANNUAL BOARD REPORT

Outpatient Services - Therapy Lover's Lane

FY2022

KEY METRICS - FY 2022 TWELVE MONTHS ENDED JUNE 30, 2022

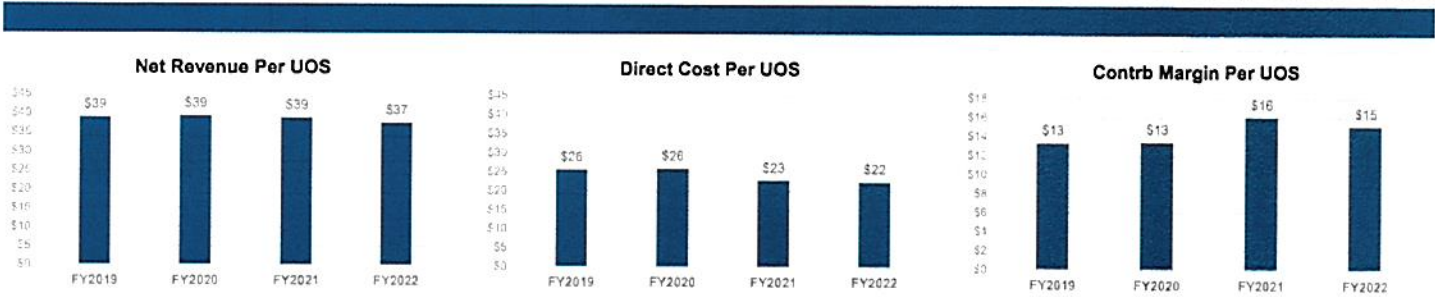


*Note: Arrows represent the change from prior year and the lines represent the 4-year trend

METRICS SUMMARY - 4 YEAR TREND

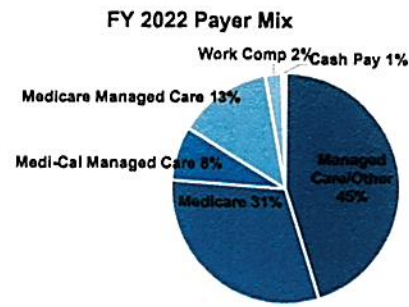
METRIC	FY2019	FY2020	FY2021	FY2022	%CHANGE FROM PRIOR YR	4 YR TREND
Units of Service	19,535	17,975	22,401	24,205	▲ 8%	
Net Revenue	\$757,561	\$703,913	\$866,471	\$904,954	▲ 4%	
Direct Cost	\$498,179	\$463,505	\$507,903	\$539,573	▲ 6%	
Contribution Margin	\$259,382	\$240,408	\$358,568	\$365,381	▲ 2%	
Indirect Cost	\$160,759	\$210,903	\$166,411	\$169,412	▲ 2%	
Net Income	\$98,623	\$29,505	\$192,157	\$195,969	▲ 2%	
Net Revenue Per UOS	\$39	\$39	\$39	\$37	▼ -3%	
Direct Cost Per UOS	\$26	\$26	\$23	\$22	▼ -2%	
Contrb Margin Per UOS	\$13	\$13	\$16	\$15	▼ -6%	

PER CASE TRENDED GRAPHS

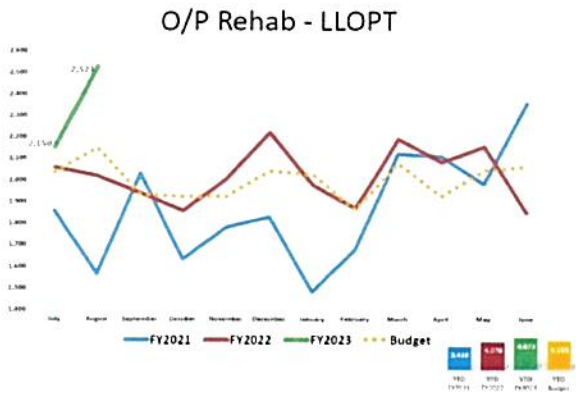


PAYER MIX - 4 YEAR TREND (TOTAL CHARGES)

PAYER	FY2019	FY2020	FY2021	FY2022
Managed Care/Other	51%	51%	50%	45%
Medicare	29%	27%	27%	31%
Medi-Cal Managed Care	8%	7%	8%	8%
Medicare Managed Care	5%	10%	8%	13%
Work Comp	6%	4%	5%	2%
Cash Pay	0%	1%	1%	1%



KEY METRICS - FY 2022 TWELVE MONTHS ENDED JUNE 30, 2022



Notes:
 Source: Outpatient Service Line Reports
 Criteria: Outpatient Service Line is O/P Therapies and Secondary Service Line is Lover's Lane Therapy

KAWEAH HEALTH ANNUAL BOARD REPORT

Outpatient Services - Hand Therapy

FY2022

KEY METRICS - FY 2022 TWELVE MONTHS ENDED JUNE 30, 2022



*Note: Arrows represent the change from prior year and the lines represent the 4-year trend

METRICS SUMMARY - 4 YEAR TREND

METRIC	FY2019	FY2020	FY2021	FY2022	%CHANGE FROM PRIOR YR	4 YR TREND
Units of Service	39,560	32,830	35,310	36,443	▲ 3%	
Net Revenue	\$1,602,997	\$1,366,157	\$1,366,058	\$1,382,321	▲ 1%	
Direct Cost	\$1,143,785	\$965,569	\$926,469	\$1,079,003	▲ 16%	
Contribution Margin	\$459,212	\$400,588	\$439,590	\$303,318	▼ -31%	
Indirect Cost	\$293,512	\$400,048	\$284,974	\$289,159	▲ 1%	
Net Income	\$165,700	\$539	\$154,616	\$14,159	▼ -91%	
Net Revenue Per UOS	\$41	\$42	\$39	\$38	▼ -2%	
Direct Cost Per UOS	\$29	\$29	\$26	\$30	▲ 13%	
Contrb Margin Per UOS	\$12	\$12	\$12	\$8	▼ -33%	

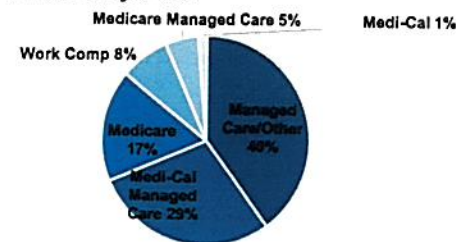
PER CASE TRENDED GRAPHS



PAYER MIX - 4 YEAR TREND (TOTAL CHARGES)

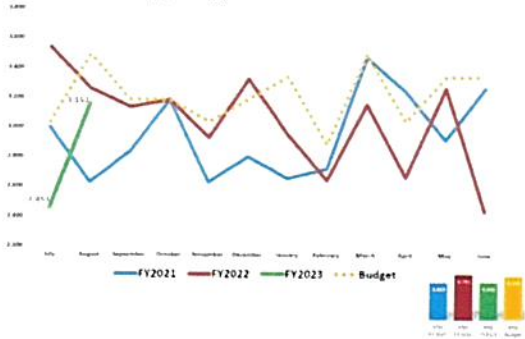
PAYER	FY2019	FY2020	FY2021	FY2022
Managed Care/Other	42%	42%	39%	40%
Medi-Cal Managed Care	16%	25%	27%	29%
Medicare	24%	19%	20%	17%
Work Comp	9%	6%	6%	8%
Medicare Managed Care	7%	8%	8%	5%
Medi-Cal	1%	1%	1%	1%

FY 2022 Payer Mix



KEY METRICS - FY 2022 TWELVE MONTHS ENDED JUNE 30, 2022

Therapy - Cypress Hand Center



Notes:
 Source: Outpatient Service Line Reports
 Criteria: Outpatient Service Line is O/P Therapies and Secondary Service Line is Hand Center
 *Visit = monthly billing

KAWEAH HEALTH ANNUAL BOARD REPORT

Outpatient Services - Therapies - Exeter

FY2022

KEY METRICS - FY 2022 TWELVE MONTHS ENDED JUNE 30, 2022

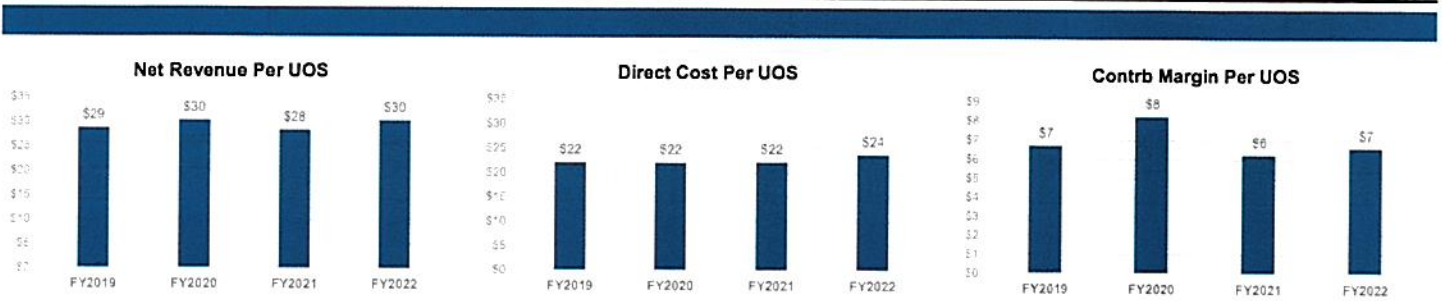


*Note: Arrows represent the change from prior year and the lines represent the 4-year trend

METRICS SUMMARY - 4 YEAR TREND

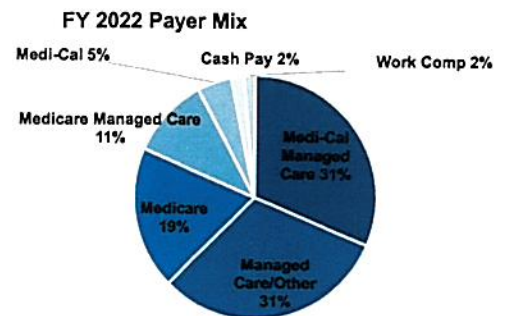
METRIC	FY2019	FY2020	FY2021	FY2022	%CHANGE FROM PRIOR YR	4 YR TREND
Units of Service	25,519	26,389	25,458	23,399	▼ -8%	
Net Revenue	\$733,413	\$798,474	\$721,368	\$708,006	▼ -2%	
Direct Cost	\$562,740	\$581,206	\$562,885	\$553,822	▼ -2%	
Contribution Margin	\$170,673	\$217,268	\$158,483	\$154,184	▼ -3%	
Indirect Cost	\$177,403	\$210,719	\$171,896	\$183,621	▲ 7%	
Net Income	(\$6,730)	\$6,549	(\$13,414)	(\$29,437)	▼ -119%	
Net Revenue Per UOS	\$29	\$30	\$28	\$30	▲ 7%	
Direct Cost Per UOS	\$22	\$22	\$22	\$24	▲ 7%	
Contrb Margin Per UOS	\$7	\$8	\$6	\$7	▲ 6%	

PER CASE TRENDED GRAPHS

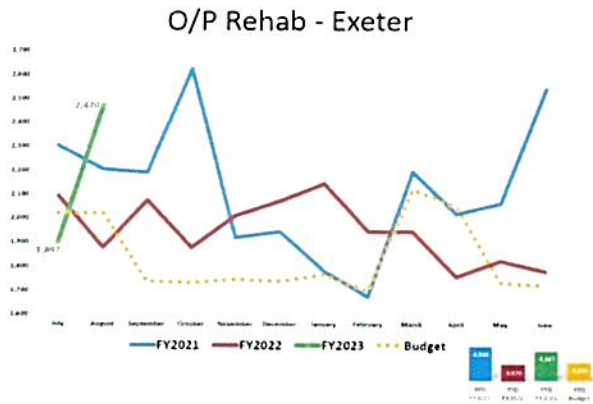


PAYER MIX - 4 YEAR TREND (TOTAL CHARGES)

PAYER	FY2019	FY2020	FY2021	FY2022
Medi-Cal Managed Care	35%	30%	37%	31%
Managed Care/Other	30%	34%	27%	31%
Medicare	23%	24%	18%	19%
Medicare Managed Care	8%	8%	13%	11%
Medi-Cal	1%	2%	3%	5%
Cash Pay	1%	1%	1%	2%
Work Comp	3%	1%	1%	2%



KEY METRICS - FY 2022 TWELVE MONTHS ENDED JUNE 30, 2022



Notes:
 Source: Outpatient Service Line Reports
 Criteria: Outpatient Service Line is O/P Therapies and Secondary Service Line is Exeter Clinic

KAWEAH HEALTH ANNUAL BOARD REPORT

Outpatient Services - Therapies - Dinuba

FY2022

KEY METRICS - FY 2022 TWELVE MONTHS ENDED JUNE 30, 2022

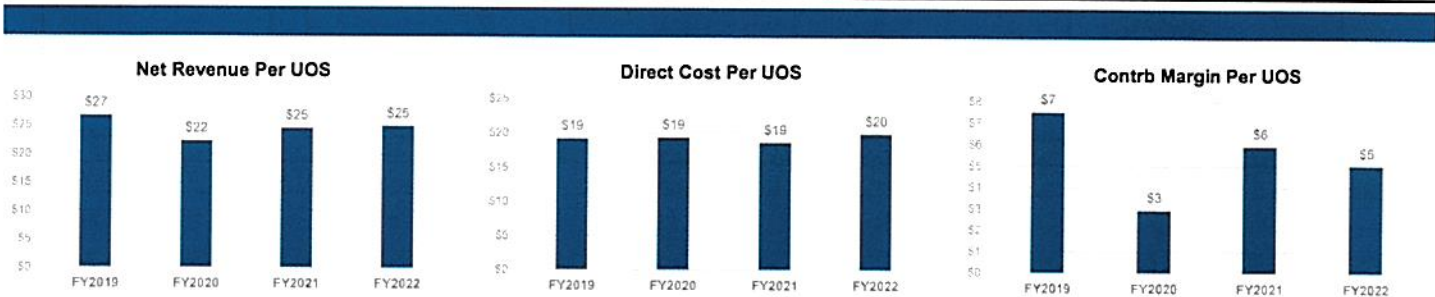


*Note: Arrows represent the change from prior year and the lines represent the 4-year trend

METRICS SUMMARY - 4 YEAR TREND

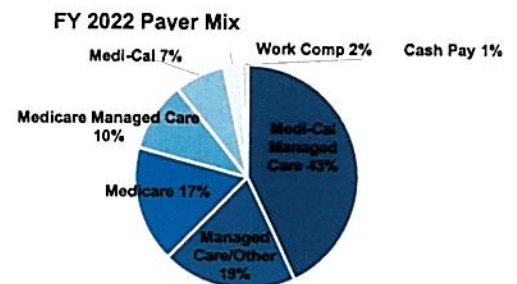
METRIC	FY2019	FY2020	FY2021	FY2022	%CHANGE FROM PRIOR YR	4 YR TREND
Units of Service	23,955	23,163	24,519	26,331	▲ 7%	
Net Revenue	\$638,640	\$515,726	\$600,976	\$655,484	▲ 9%	
Direct Cost	\$459,155	\$447,849	\$455,690	\$522,846	▲ 15%	
Contribution Margin	\$179,486	\$67,877	\$145,286	\$132,637	▼ -9%	
Indirect Cost	\$122,434	\$174,086	\$133,397	\$135,116	▲ 1%	
Net Income	\$57,052	(\$106,209)	\$11,889	(\$2,479)	▼ -121%	
Net Revenue Per UOS	\$27	\$22	\$25	\$25	▲ 2%	
Direct Cost Per UOS	\$19	\$19	\$19	\$20	▲ 7%	
Contrb Margin Per UOS	\$7	\$3	\$6	\$5	▼ -15%	

PER CASE TRENDED GRAPHS

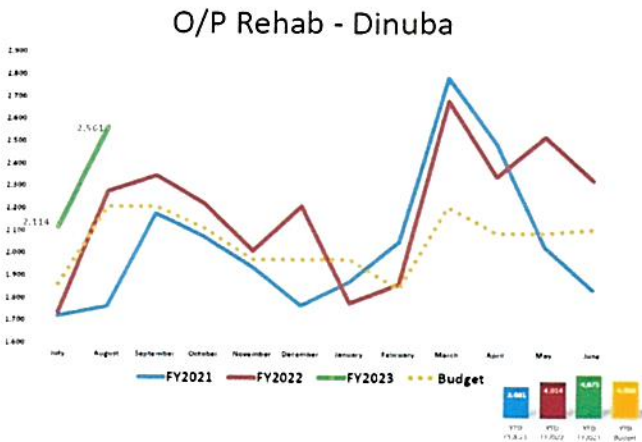


PAYER MIX - 4 YEAR TREND (TOTAL CHARGES)

PAYER	FY2019	FY2020	FY2021	FY2022
Medi-Cal Managed Care	68%	68%	53%	43%
Managed Care/Other	12%	18%	20%	19%
Medicare	11%	7%	13%	17%
Medicare Managed Care	6%	4%	8%	10%
Medi-Cal	2%	1%	2%	7%
Work Comp	1%	1%	2%	2%
Cash Pay	1%	0%	2%	1%



KEY METRICS - FY 2022 TWELVE MONTHS ENDED JUNE 30, 2022



Notes:
 Source: Outpatient Service Line Reports
 Criteria: Outpatient Service Line is O/P Therapies and Secondary Service Line is Dinuba Clinic

KAWEAH HEALTH ANNUAL BOARD REPORT

Outpatient Services - Cardiac Rehabilitation

FY2022

KEY METRICS - FY 2022 TWELVE MONTHS ENDED JUNE 30, 2022

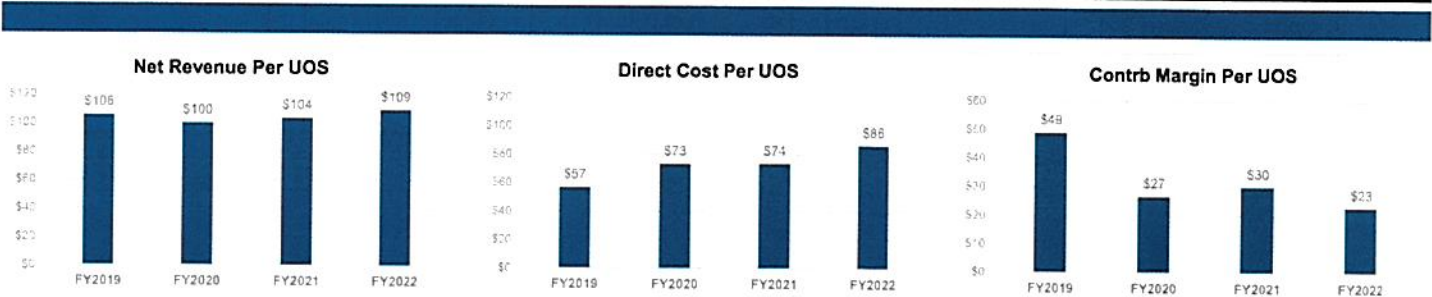


*Note: Arrows represent the change from prior year and the lines represent the 4-year trend

METRICS SUMMARY - 4 YEAR TREND

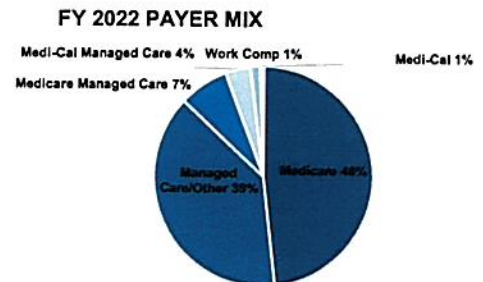
METRIC	FY2019	FY2020	FY2021	FY2022	%CHANGE FROM PRIOR YR	4 YR TREND
Units of Service	6,486	4,366	4,263	4,494	▲ 5%	
Net Revenue	\$685,052	\$436,424	\$441,564	\$491,134	▲ 11%	
Direct Cost	\$368,152	\$319,929	\$313,464	\$388,167	▲ 24%	
Contribution Margin	\$316,900	\$116,495	\$128,099	\$102,967	▼ -20%	
Indirect Cost	\$191,836	\$178,781	\$197,499	\$211,414	▲ 7%	
Net Income	\$125,064	(\$62,286)	(\$69,400)	(\$108,446)	▼ -56%	
Net Revenue Per UOS	\$106	\$100	\$104	\$109	▲ 6%	
Direct Cost Per UOS	\$57	\$73	\$74	\$86	▲ 17%	
Contrb Margin Per UOS	\$49	\$27	\$30	\$23	▼ -24%	

PER CASE TRENDED GRAPHS



PAYER MIX - 4 YEAR TREND (TOTAL CHARGES)

PAYER	FY2019	FY2020	FY2021	FY2022
Medicare	57%	52%	53%	48%
Managed Care/Other	33%	37%	28%	39%
Medicare Managed Care	9%	9%	11%	7%
Medi-Cal Managed Care	1%	2%	6%	4%
Work Comp	0%	0%	2%	1%
Medi-Cal	0%	0%	0%	1%



Notes:
 Source: Outpatient Service Line Reports
 Criteria: Outpatient Service Line is O/P Therapies and Secondary Service Line is Cardiac Rehab

KAWEAH HEALTH ANNUAL BOARD REPORT

Outpatient Services - Wound Care Center

FY2022

KEY METRICS - FY 2022 TWELVE MONTHS ENDED JUNE 30, 2022

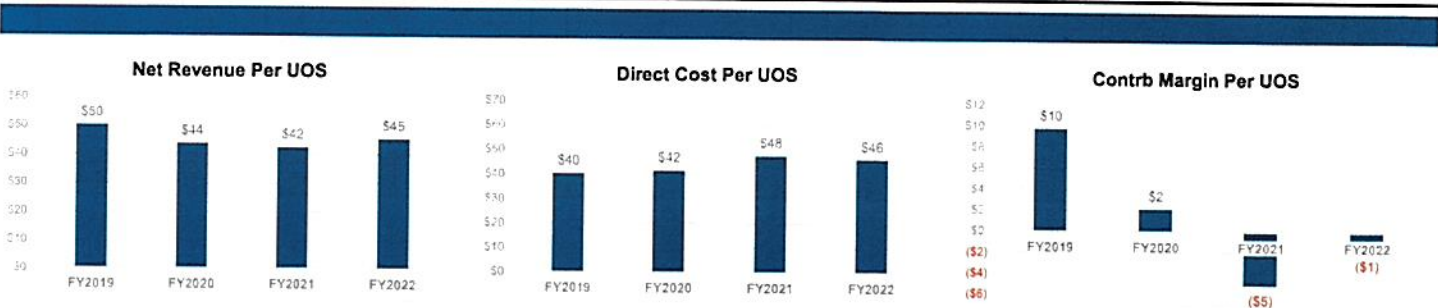


*Note: Arrows represent the change from prior year and the lines represent the 4-year trend

METRICS SUMMARY - 4 YEAR TREND

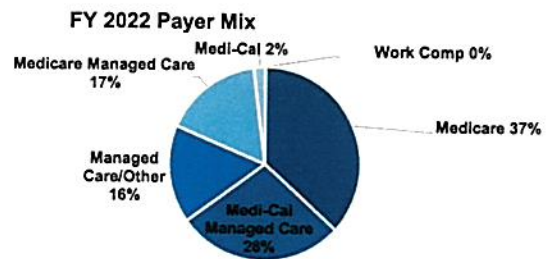
METRIC	FY2019	FY2020	FY2021	FY2022	%CHANGE FROM PRIOR YR	4 YR TREND
Units of Service	26,151	23,914	18,480	14,154	▼ -23%	
Net Revenue	\$1,307,506	\$1,043,078	\$784,601	\$642,909	▼ -18%	
Direct Cost	\$1,052,891	\$992,527	\$879,769	\$652,582	▼ -26%	
Contribution Margin	\$254,615	\$50,552	(\$95,167)	(\$9,673)	▲ 90%	
Indirect Cost	\$503,102	\$540,229	\$455,291	\$468,108	▲ 3%	
Net Income	(\$248,487)	(\$489,677)	(\$550,459)	(\$477,781)	▲ 13%	
Net Revenue Per UOS	\$50	\$44	\$42	\$45	▲ 7%	
Direct Cost Per UOS	\$40	\$42	\$48	\$46	▼ -3%	
Contrb Margin Per UOS	\$10	\$2	(\$5)	(\$1)	▲ 87%	

PER CASE TRENDED GRAPHS



PAYER MIX - 4 YEAR TREND (TOTAL CHARGES)

PAYER	FY2019	FY2020	FY2021	FY2022
Medicare	55%	52%	36%	37%
Medi-Cal Managed Care	17%	22%	26%	28%
Managed Care/Other	16%	14%	19%	16%
Medicare Managed Care	10%	10%	18%	17%
Medi-Cal	2%	0%	1%	2%
Work Comp	1%	0%	1%	0%



Notes:
Source: Outpatient Service Line Reports
Criteria: Outpatient Service Line is Wound Care

REPORT TO THE BOARD OF DIRECTORS

Quail Park (Cypress) and Laurel Court (Memory Care)

Marc Mertz, Chief Strategy Officer, 624-2511
September 21, 2022

Summary Issue/Service Considered

Quail Park (Cypress campus) consists of a senior independent living facility and a secure memory care facility. These are organized as separate legal entities.

The independent living facility is a 127-unit senior retirement village owned 44 percent by Kaweah Health and 56 percent by Living Care Senior Housing. Denis Bryant from Living Care is the Managing Member.

The 40-unit Memory Care Center (Laurel Court) is an Alzheimer's/Dementia facility located east of the Rehabilitation Hospital on Kaweah Health's west campus. It has the same ownership percentage split as Quail Park.

Denis Bryant is the manager of both entities. Lynn Havard Mirviss and Marc Mertz represent Kaweah Health on the Quail Park and Memory Care Center Boards of Members. Cathy Boshaw and the Halverson family represent Living Care Senior Housing on the two boards. Kaweah Health and Living Care have equal voting rights on the boards.

Quality/Performance Improvement Data

Quail Park has historically operated nearly at capacity, significantly above industry benchmarks. As recently as June 2019, Quail Park had a 28-unit waiting list. Like all senior living facilities, Quail Park has been impacted by COVID-19. Many individuals have chosen to delay moving into the facility. According to The National Investment Center for Seniors Housing & Care (NIC), occupancy rates for US assisted living facilities was 77.9% at the end of 2021 (most recent data). This is up from the record low of 74.2% during the pandemic, but below the pre-pandemic level of 84.6%. Similarly, occupancy in independent living facilities remain low at 83.1% at the end of 2021. This is up slightly from the pandemic low of 81.7% but below pre-pandemic levels of 89.7%.

Quail Park's occupancy continues to be significantly depressed as a result of the pandemic, and has been trending downward since 2020.

Quail Park	August 2020	July 2021	August 2022
Occupancy Rate	87%	81%	75%

During fiscal year 2021, Quail Park at Cypress was a defendant in a class action lawsuit related to employment practices. The case alleged that Quail Park failed to properly compensate employees for meal periods, rest breaks, and waiting time. Other accusations include inappropriate rounding of hours and errors on wage statements/paychecks. A settlement was reached during mediation, and Quail Park paid \$721,287 in August 2022.

Quail Park did not have sufficient funds to make the settlement payment and maintain sufficient cash reserves. Owners were asked to make loans to the organization, and Kaweah Health loaned

Quail Park \$220,000 in August 2022. This loan is not reflected in the fiscal year 2022 annual data.

During fiscal year 2022 (July 2021 through June 2022), Quail Park operated at a loss. Kaweah Health’s share of that loss was \$313,648. These losses were funded through Quail Park cash reserves. As a result of the financial performance, Quail Park made no profit distributions to Kaweah Health or the other owners during FY2022.

Since the first profit distributions were made in 2003, Quail Park has paid Kaweah Health profit distributions totaling \$5,272,500. In addition, through a series of loan refinancing activities, Kaweah Health has received an addition \$5,934,841 in distributions. Total distributions to Kaweah Health for this property are \$10,518,841 based on an original investment of \$1,588,770. \$900,000 of the initial investment was made via donation of land, with the remaining \$688,770 being invested in cash provided from the Bettie Quilla Fund.

The 40-unit Memory Care Center, which opened in July 2012, was operating at 77.5% occupancy on June 30, 2021, down from 82.5% in August 2020 and well below its historic near-capacity rate of nearly 100%. By August 2022, occupancy had fallen considerably to 60%.

Memory Care	August 2020	July 2021	August 2022
Occupancy Rate	82.5%	77.5%	60.0%

The Memory Care Center generated a profit during FY2022. Kaweah Health’s share of that profit was \$49,992. Due to the small profits, Memory Care made no profit distributions to owners between July 2021 and June 2022. The Memory Care Center has paid Kaweah Health a total of \$1,408,000 in profit distributions through June 2021. Kaweah Health has received an additional \$1,505,040 in refinance distributions from this property. Total distributions are \$2,642,104 based on an original Kaweah Health investment of \$990,936. Of the \$990,936 investment, \$720,000 was invested via land donation and \$270,936 was invested in cash provided from the Bettie Quilla Fund.

Policy, Strategic or Tactical Issues

COVID-19 has had a significant negative impact on the occupancy rates of senior living facilities nationwide. The Quail Park independent living and memory care centers were not spared. The opening of the Quail Park at Shannon Ranch facilities have probably also contributed to the lower occupancy at the Cypress Locations. Current occupancy rates are now below industry averages.

Living Care has appointed a new Executive Director over the Quail Park and Memory Care facilities on Cypress. The new Executive Director started in January 2022, and has been a long term Living Care employee, most recently managing properties for them in Arizona. They have also recently hired a new Health and Wellness Director/Quality Assurance Nurse for the Memory Care Residences of Visalia.

Residents are become more active in Quail Park programs and activities, and marketing activity has picked up. Facility improvements are also planned, including apartment upgrades and landscaping improvements.

Recommendations/Next Steps

Continue to operate Quail Park and the Memory Care facility as high-level senior retirement centers with services ranging from independent living to assisted living to expanded dementia care.

Approvals/Conclusions

Despite challenging times due to COVID-19, Quail Park is filling a significant health care need in our community, providing exceptional services to its residents, and at the same time generating an income stream for Kaweah Health.

REPORT TO THE BOARD OF DIRECTORS

Quail Park at Shannon Ranch

Marc Mertz, VP/Chief Strategy Officer, 624-2511
September 21, 2022

Summary Issue/Service Considered

In 2016 Kaweah Health approved construction of a new 120-unit independent, assisted, and memory care senior living project called Quail Park at Shannon Ranch near the intersection of Demaree and Flagstaff in northwest Visalia. The 139,000 square foot project is located on a 3.65 acre site next to the 6,100 square foot Urgent Care Center which Kaweah Health opened on a 1.01 acre parcel on the east side of Demaree. The main independent living facility has 100 units ranging from studios to 2-bedroom units, and the secure memory care facility has 20 rooms.

Kaweah Health owns 33 and one third percent of the project, which is held by Northwest Visalia Senior Housing. Other partners are Shannon Senior Care, LLC, BTV Senior Housing, LLC, BEE, Inc., and Millennium Advisors. Shannon Senior Care is owned by members of the Shannon family; BTV is owned by Bernard te Velde, Jr.; BEE is owned by Cathy Boshaw and Doug Eklund of the Seattle area; Millennium Advisors is owned primarily by Denis Bryant, the current managing partner of Quail Park and the Memory Care Center.

The approximately \$40 million project broke ground in March 2018 and was completed in early 2020. All Kaweah Health equity contributions to the project have originated from the Bettie Quilla Fund at Kaweah Health Hospital Foundation. The Quilla Fund is restricted by the donor for support of senior living projects in collaboration with Kaweah Health. Kaweah Health has made a total equity contribution in Quail Park Shannon Ranch of \$3,997,000.

Quality/Performance Improvement Data

Before COVID-19, management expected that occupancy of the main building would reach 50% within 90 days of opening and that the memory care center would be completely filled within that time frame. Early deposits and waiting lists supported this. However, by July 2020 occupancy of the independent living building reached just 7% and the memory care was at 35%.

During the next two years, management worked hard to provide a safe environment for residents and visitors and they have dramatically increased marketing efforts, including offering limited-time discounts to encourage people to move in. As a result, the independent living building reached 28% occupancy by June 20, 2021 and the memory care reached 50%.

By August 2022, occupancy in the independent living building increased to 56% and the Memory Care building was full. The overall occupancy rate of 62.5% is approaching the point at which the facilities will breakeven financially.

Occupancy Rate	July 2020	July 2021	August 2022
Independent Living	7%	28%	56%
Memory Care	35%	50%	100%

Due to the lower-than-expected occupancy, Quail Park at Shannon Ranch (including memory care) has operated at a loss since it has opened. In fiscal year 2022, Kaweah Health's share of those losses was \$989,038. In fiscal year 2021, that loss was \$883,279. To offset these losses, the owners of Northwest Visalia Senior Housing have made a series of cash calls to fund operations. These contributions are being treated as loans payable with a 5% interest rate. Since fiscal year 2020, Kaweah Health has made loan payments totaling \$1,890,251, which was paid entirely from the Bettie Quilla Fund. Approximately \$2,500,000 remains in the Bettie Quilla fund, not counting the loan receivable balance. No additional loans have been requested at this point.

Policy, Strategic or Tactical Issues

The COVID-19 pandemic and its impact on senior living could not have been predicted. Management of Quail Park at Shannon Ranch have continued to actively promote the facility, providing both in-person and virtual tours. The sales staff routinely delivers meals to individuals that have expressed interest in Quail Park as a way to stay in touch with potential residents. The facility is also very active on social media. Management offered various discounts to entice people to move in, although that practice has been discontinued as the occupancy rates have increased in recent months.

Recommendations/Next Steps

Continue to support the startup of Quail Park at Shannon Ranch as performance improves.

Approvals/Conclusions

Quail Park at Shannon Ranch opened at perhaps the worst possible time in recent memory. However, the facility is the premier senior living in Visalia and perhaps the Central Valley. The amenities and services offered are unrivaled in the market. As the pandemic abates, this facility will be a significant asset to the community. The recent increase in resident move-ins has been encouraging and is expected to continue.

KAWEAH HEALTH ANNUAL BOARD REPORT

Senior Housing Joint Ventures

FY2021 - FY2022

	Quail Park	Laurel Court	Shannon Ranch	Total
FY2022				
Loans	\$0	\$0	(\$633,222)	(\$633,222)
Profit distributions	\$0	\$0	\$0	\$0
Total cash inflow (outflow) from investment	\$0	\$0	(\$633,222)	(\$633,222)
Total income (loss) from Investment	(\$313,648)	\$49,992	(\$989,038)	(\$1,252,694)
FY2021				
Loans	\$0	\$0	(\$883,279)	(\$883,279)
Profit distributions	\$297,000	\$77,000	\$0	\$374,000
Total cash inflow (outflow) from investment	\$297,000	\$77,000	(\$883,279)	(\$509,279)
Total income (loss) from Investment	\$297,000	\$77,000	(\$1,434,149)	(\$1,060,149)
From Inception				
Initial investment - land	(\$900,000)	(\$720,000)	\$0	(\$1,620,000)
Initial Investment - cash	(\$688,770)	(\$270,936)	(\$3,997,054)	(\$4,956,760)
Loans	\$0	\$0	(\$1,890,251)	(\$1,890,251)
Profit distributions	\$297,000	\$1,485,000	\$0	\$1,782,000
Refinance distributions	\$5,934,841	\$1,505,040	\$0	\$7,439,881
Total cash inflow (outflow) from investment	\$5,543,071	\$2,719,104	(\$5,887,305)	\$2,374,870
Total income (loss) from Investment	\$9,601,922	\$2,093,096	(\$3,372,169)	\$8,322,849

CARDIAC SURGERY DATA QUALITY ANALYSIS

Q4 2020 → Q3 2021
RISK ADJUSTED DATA

GREEN = BETTER OR EQUAL TO THE STS NATIONAL AVERAGE

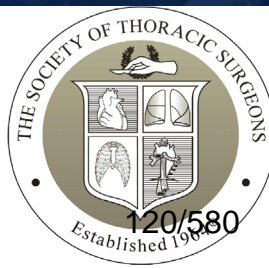
RED = WORSE THAN THE STS NATIONAL AVERAGE

GRAY = NON-RISK ADJUSTED VALUE (FOR REFERENCE ONLY)

DATA ANALYSIS BY THE SOCIETY OF THORACIC SURGEONS NATIONAL ADULT CARDIAC SURGERY DATABASE



[kaweahhealth.org](https://www.kaweahhealth.org)



STAR RATINGS 2020

ISOLATED CORONARY ARTERY BYPASS GRAFTING

STAR RATINGS ARE ONLY CALCULATED ENDING Q2 & Q4 EACH YEAR



STS CABG Composite Quality Rating
Participant: 30045
STS Period Ending Jun 2021



Domain	Rating	Participant		STS				
		Score	98% CI	Score	Min - Max	10th	50th	90th
Overall	★ ★	96.96%	(96.10-97.70)	96.79%	(91.04-98.98)	95.30%	96.95%	98.06%
Absence of Mortality	★ ★	97.72%	(96.61-98.58)	97.54%	(92.00-99.32)	96.28%	97.70%	98.60%
Absence of Morbidity	★ ★	88.98%	(86.55-91.20)	89.42%	(74.39-96.26)	85.06%	89.83%	93.24%
Use of IMA	★ ★	99.00%	(98.06-99.62)	99.36%	(80.47-99.99)	98.63%	99.63%	99.90%
Medications	★ ★ ★	98.44%	(97.28-99.27)	94.30%	(45.31-99.96)	86.59%	96.90%	99.46%

- ★ Worse than Expected. Participant's performance is significantly worse than expected for their specific case-mix.
- ★ ★ As Expected. Participant's performance is not statistically different than expected for their specific case-mix.
- ★ ★ ★ Better than Expected. Participant's performance is significantly better than expected for their specific case-mix.

STAR RATINGS 2020

AORTIC VALVE REPLACEMENT

STAR RATINGS ARE ONLY CALCULATED ENDING Q2 & Q4 EACH YEAR



STS AVR Composite Quality Rating
Participant: 30045
STS Period Ending Jun 2021



Domain	Rating	Participant		STS				
		Score	95% CI	Score	Min - Max	10th	50th	90th
Overall	★ ★	95.45%	(92.97-97.26)	95.39%	(85.27-98.60)	93.11%	95.70%	97.28%
Absence of Mortality	★ ★	98.02%	(96.31-99.09)	97.80%	(93.02-99.40)	96.65%	97.96%	98.76%
Absence of Morbidity	★ ★	89.26%	(84.54-92.99)	89.93%	(77.51-95.90)	86.34%	90.25%	93.10%

- ★ Worse than Expected. Participant's performance is significantly worse than expected for their specific case-mix.
- ★ ★ As Expected. Participant's performance is not statistically different than expected for their specific case-mix.
- ★ ★ ★ Better than Expected. Participant's performance is significantly better than expected for their specific case-mix.

STAR RATINGS 2020

CABG w/ AORTIC VALVE REPLACEMENT

STAR RATINGS ARE ONLY CALCULATED ENDING Q2 & Q4 EACH YEAR



The Society
of Thoracic
Surgeons

STS AVR + CABG Composite Quality Rating
Participant: 30045
STS Period Ending Jun 2021



Domain	Rating	Participant		STS				
		Score	95% CI	Score	Min - Max	10th	50th	90th
Overall	★ ★	92.90%	(89.64-95.40)	92.20%	(79.35-97.47)	88.61%	92.63%	95.23%
Absence of Mortality	★ ★	96.29%	(93.35-98.22)	96.02%	(86.94-99.01)	93.79%	96.34%	97.85%
Absence of Morbidity	★ ★	84.09%	(77.53-89.45)	83.23%	(65.03-93.39)	77.26%	83.71%	88.60%

- ★ Worse than Expected. Participant's performance is significantly worse than expected for their specific case-mix.
- ★ ★ As Expected. Participant's performance is not statistically different than expected for their specific case-mix.
- ★ ★ ★ Better than Expected. Participant's performance is significantly better than expected for their specific case-mix.

Healthgrades

Specialty Clinical Quality Awards & Ratings

Specialty Clinical Quality Awards



America's 50 Best Hospitals for Cardiac Surgery Award™ (2022, 2021, 2020)
Superior clinical outcomes in heart bypass surgery and heart valve surgery



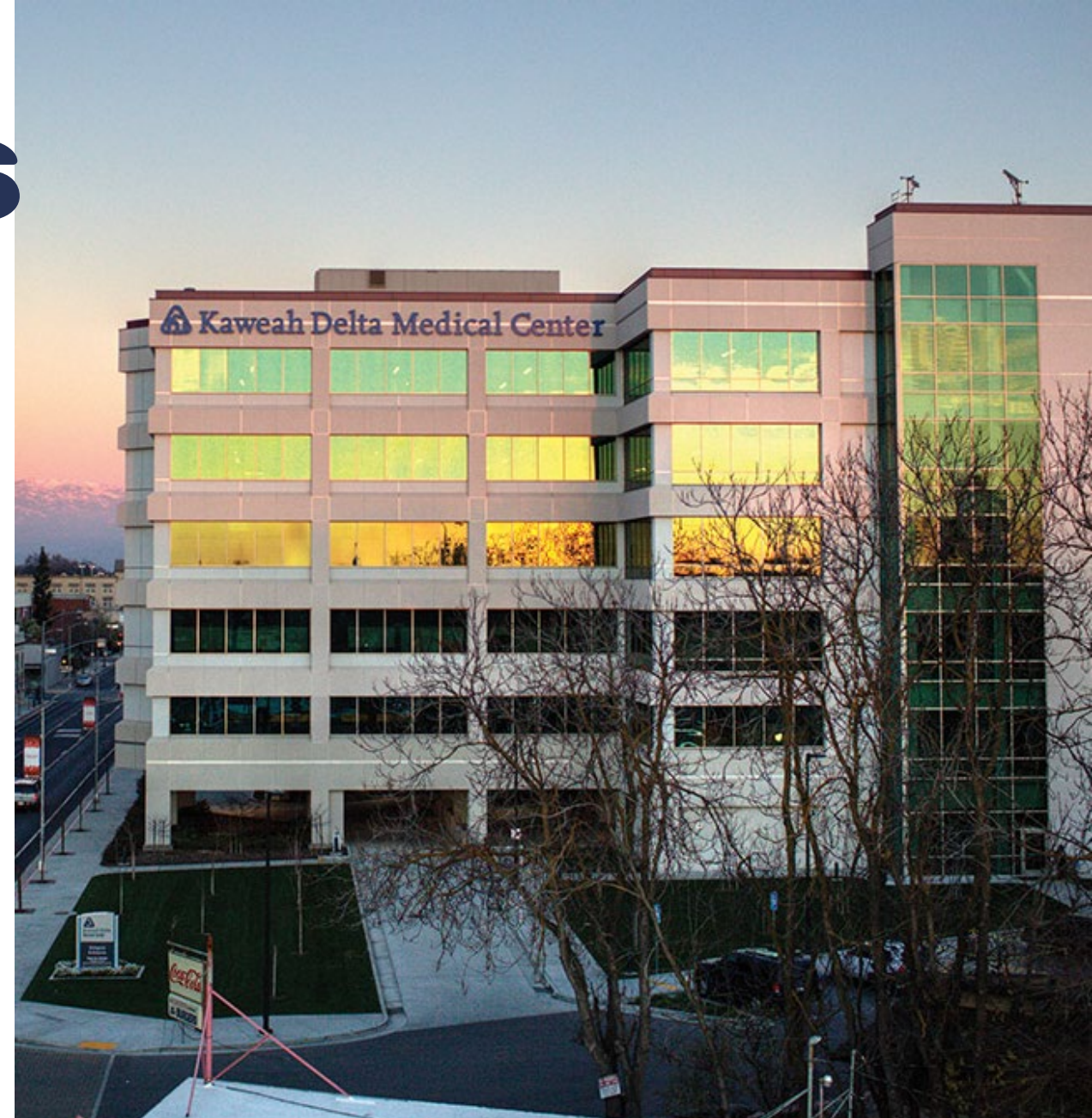
America's 100 Best Hospitals for Cardiac Care Award™ (2019)
Superior clinical outcomes in heart bypass surgery, coronary interventional procedures, heart attack treatment, heart failure treatment, and heart valve surgery

Hospital Quality Awards

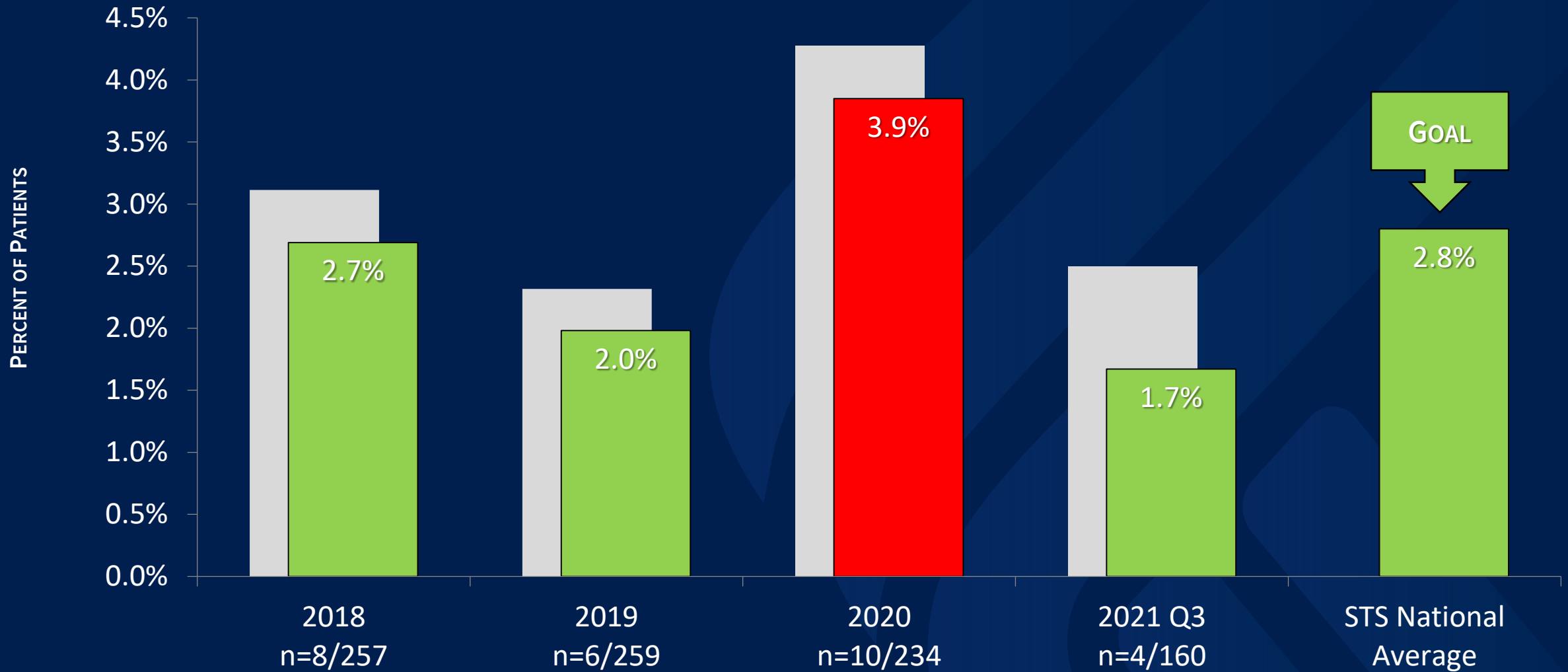


America's 250 Best Hospitals Award™ (2021, 2020, 2019)
Top 5% in the nation for consistently delivering clinical quality

Resource 12/10/2021: www.healthgrades.com/hospital-directory/california-ca-southern/kaweah-health



ALL OPERATIVE MORTALITY¹ RISK ADJUSTED IN COLOR



KAWEAH HEALTH MEDICAL CENTER

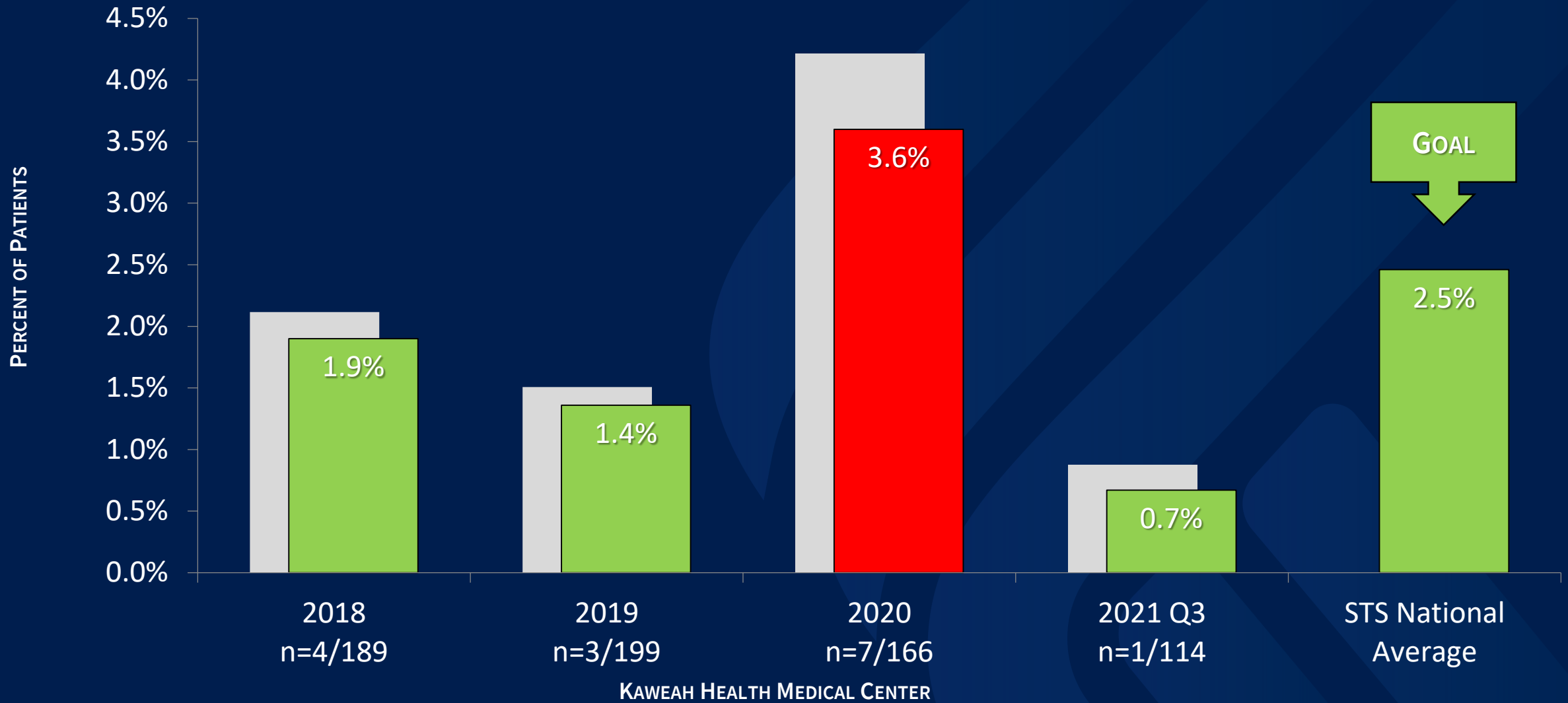
2021 Risk-adjusted O/E = 0.59

*STS National Average Comparison reporting period 01/01/2021 through 09/30/2021

¹ Includes all 7 Major Procedure Categories (CABG, AVR, AVR+CABG, MVR, MVR+CABG, MVP, MVP+CABG)

Excludes Other category procedures, Q3-2020 forward COVID+ pt.'s Excluded 25/580

CABG OPERATIVE MORTALITY RISK ADJUSTED IN COLOR

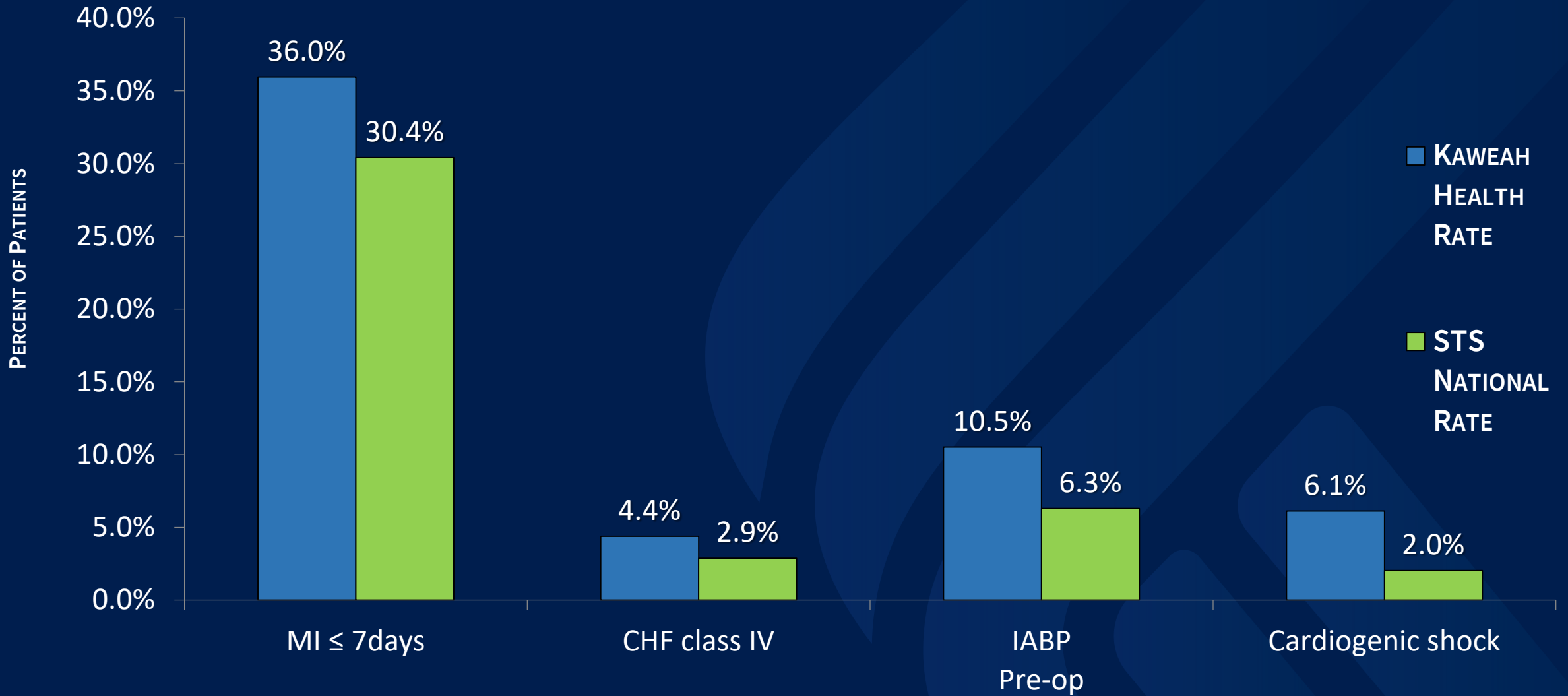


2021 Risk-adjusted O/E = 0.27

*STS National Average Comparison reporting period 01/01/2021 through 09/30/2021

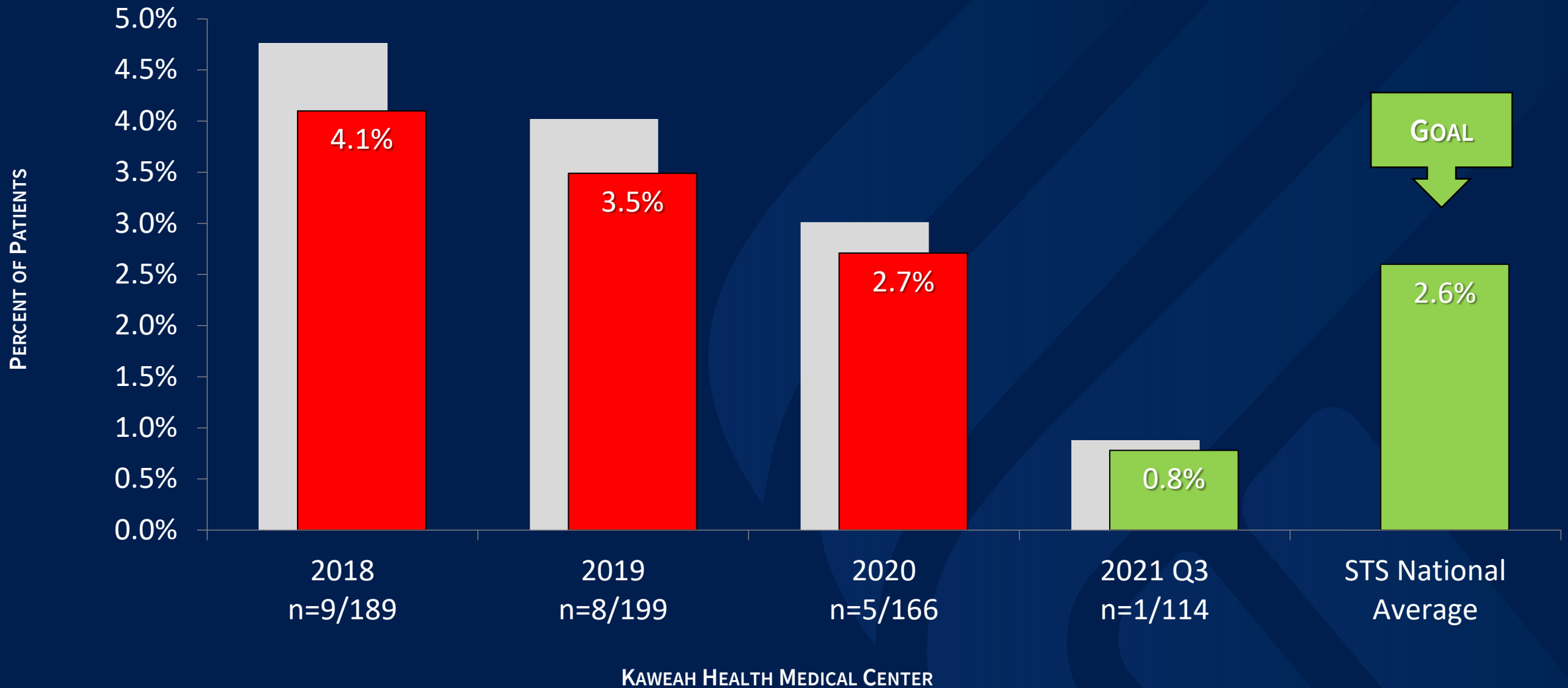
Q3-2020 forward COVID+ pt.'s Excluded.

KAWEAH HEALTH PT. POPULATIONS



*STS National Average Comparison reporting period 01/01/2021 through 09/30/2021– Isolated CABG cases ONLY

CABG RE-OPERATION¹ RISK ADJUSTED IN COLOR



2021 Risk-adjusted O/E = 0.3

*STS National Average Comparison reporting period 01/01/2021 through 09/30/2021

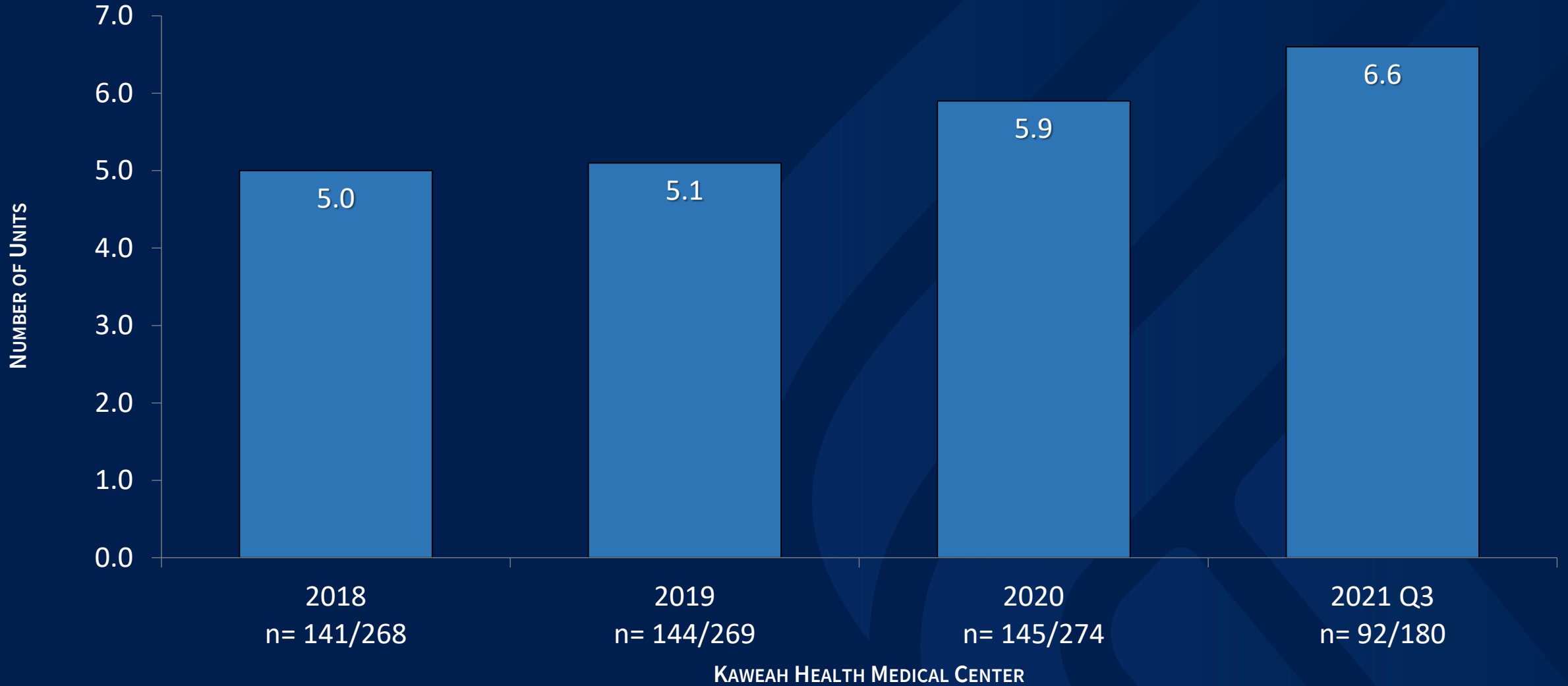
¹Surgeries include Reoperation for bleeding/tamponade, valvular dysfunction, unplanned coronary artery intervention, aortic reintervention or other cardiac reason, Q3-2020 forward COVID+ pt.'s Excluded.

QUALITY INITIATIVE:

INTRA-OPERATIVE PATIENT SAFETY

- ❖ Time out performed with entire surgical team (Surgeon, Anesthesia, RN, Techs and Perfusion)
- ❖ Surgeon led briefing on procedure expectations with entire surgical team after each Time out
- ❖ Perfusion check list completed prior to each case; line safety time out with anesthesia prior to case start
- ❖ Minimize trips to the Sterile Core by Nursing staff
- ❖ Minimize OR traffic (i.e.: coordinated switching of staff for breaks)
- ❖ Noise reduction implemented during cases:
 - Discussions about current surgical case only
 - Avoid conversations about other issues
 - Music to be calming and at a lower volume
 - All phones & beepers at the Nurses desk

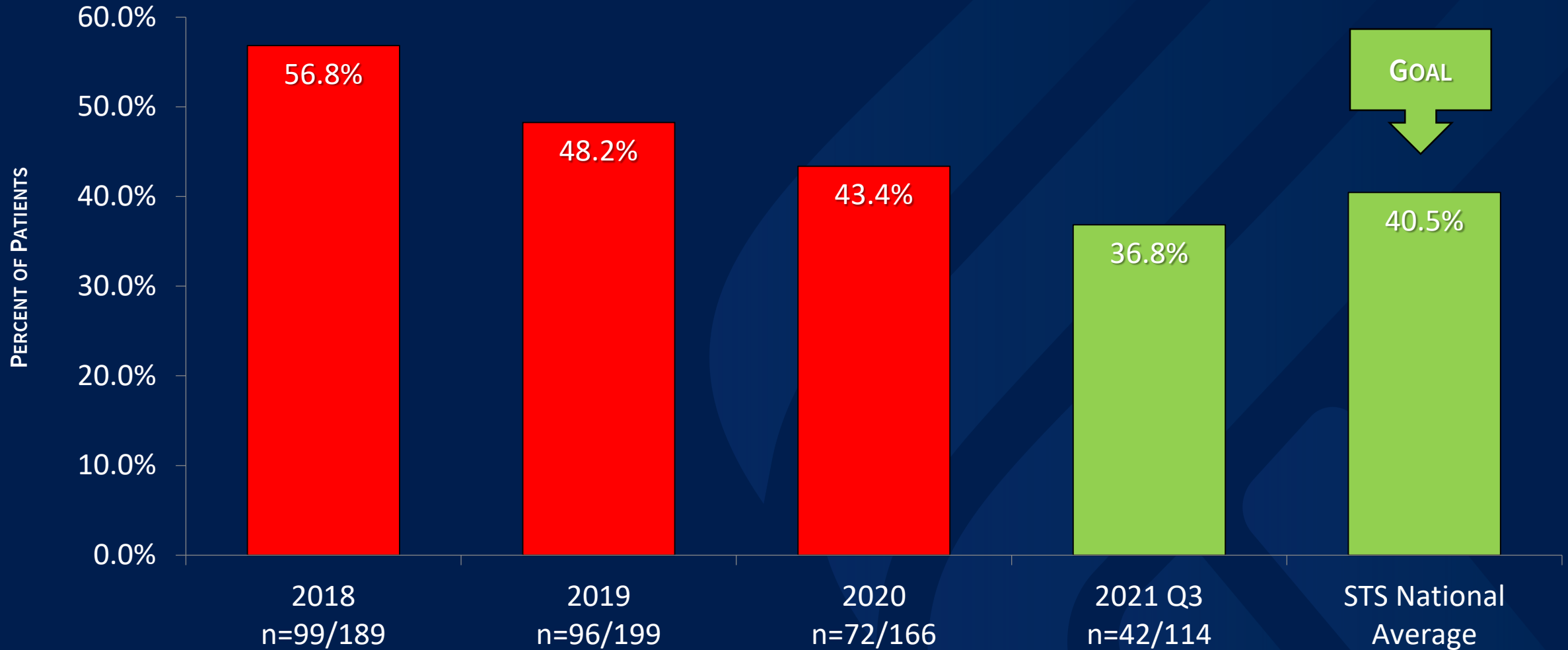
RED BLOOD CELL USAGE – AVERAGE UNITS / PT. RECEIVING RBC¹ (NO NATIONAL COMPARISON DATA)



¹ All STS surgeries – Includes any blood given Intra-op and Post-op (Excludes patients that did not receive any blood from Average; excludes pre-op Hgb<8, Emergent/Salvage, COVID+ patients)

*Comparison Data is not reported on the STS National Outcomes Report 130/580

CABG INTRA & POST-OP BLOOD PRODUCT USAGE¹



KAWEAH HEALTH MEDICAL CENTER

2021 O/E = 0.9

*STS National Average Comparison reporting period 01/01/2021 through 09/30/2021

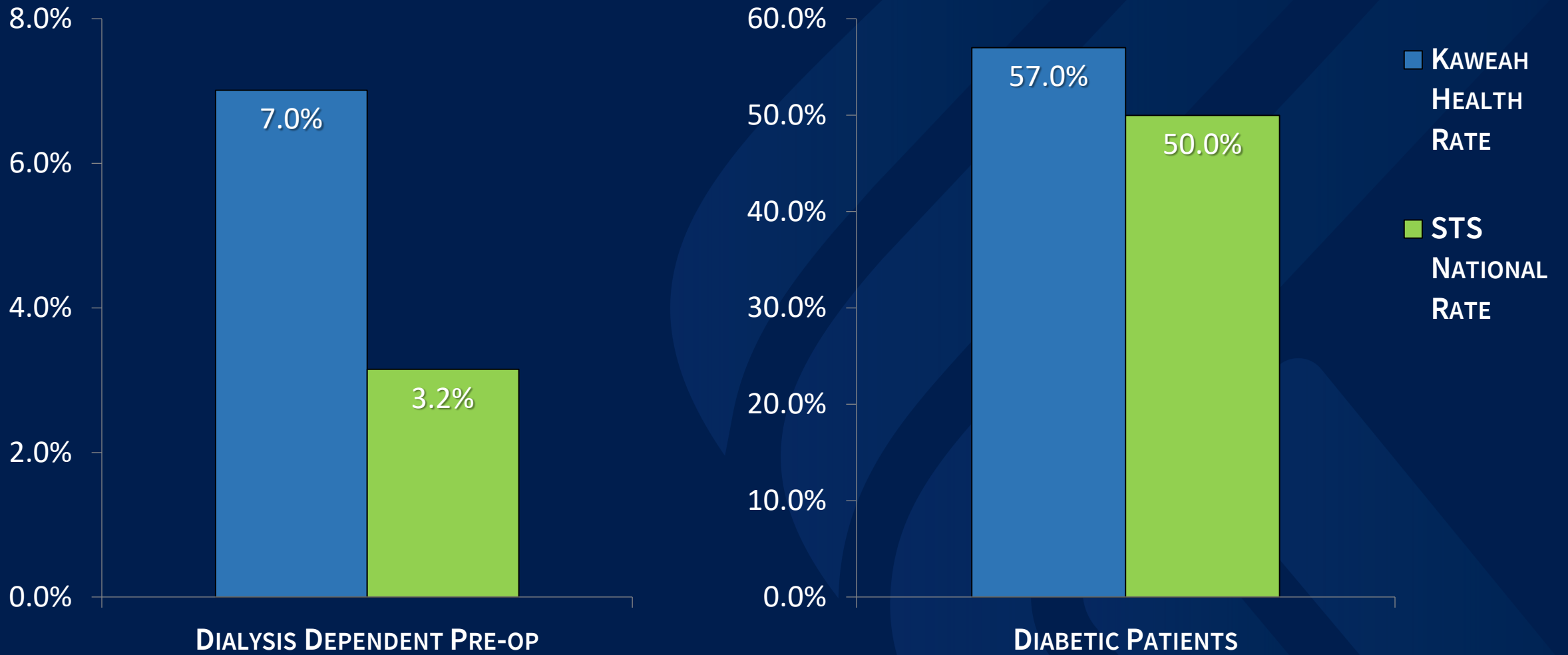
¹Surgeries where at least one unit of Red Blood Cells, Fresh Frozen Plasma, Platelets or Cryoprecipitate was given Intra-and/or Post-operatively. Q3-2020 forward COVID+ pt.'s Excluded.

QUALITY INITIATIVE:

BLEEDING EVENT & BLOOD PRODUCT USAGE

- ❖ Quarterly review of blood usage throughout Pt. stay
- ❖ TEG coagulation monitoring
- ❖ Antifibrinolytic agents
- ❖ Heparin monitoring
- ❖ Heparin coated circuits
- ❖ Hemostasis achieved during procedure
- ❖ Cell saver utilized during surgery
- ❖ Restrictive transfusion criteria
- ❖ Surgeon approval of each transfusion
- ❖ Treatment of pre-operative anemia or transfusion as needed

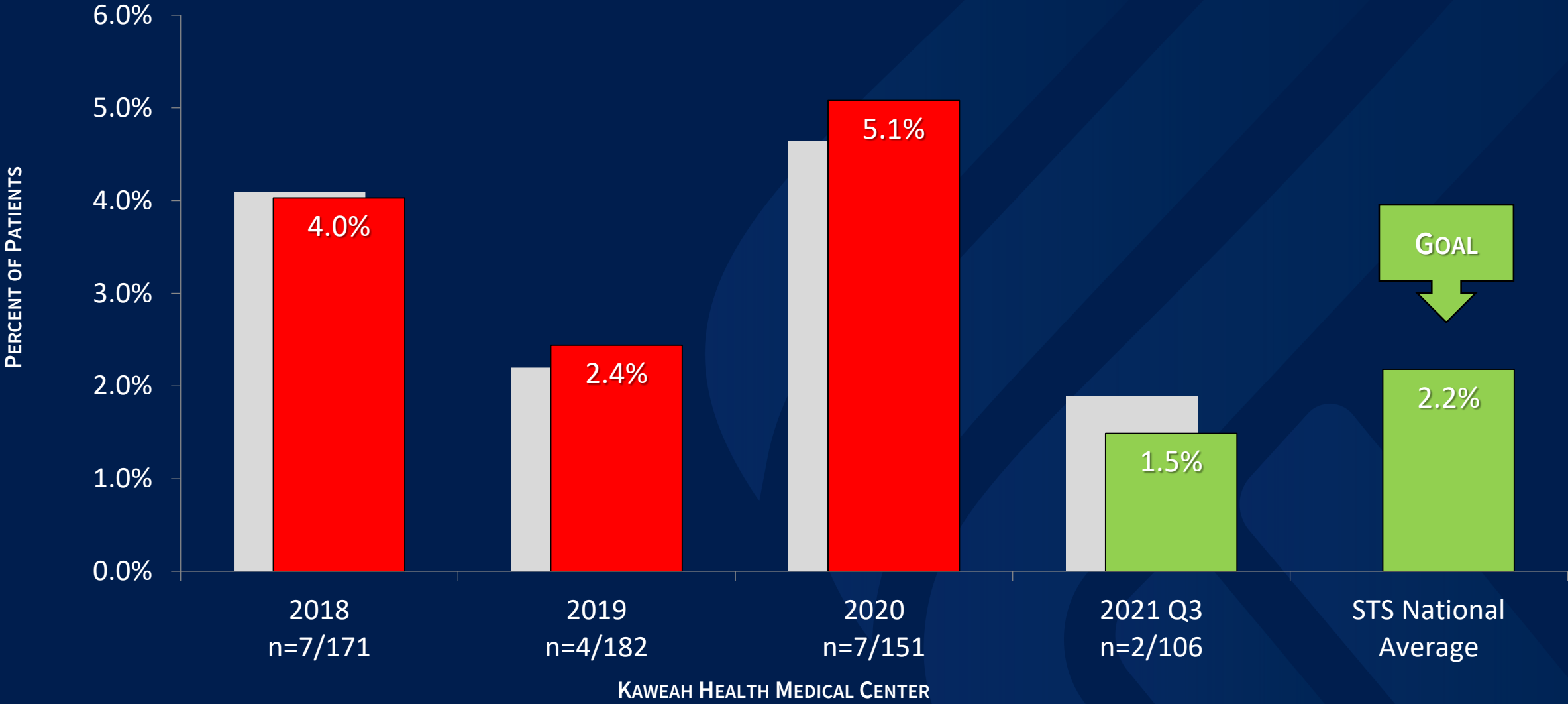
KAWEAH HEALTH PT. POPULATIONS



*STS National Average Comparison reporting period 01/01/2021 through 09/30/2021- Isolated CABG cases ONLY

CABG Post-Op Renal Failure¹

RISK ADJUSTED IN COLOR



2021 Risk-adjusted O/E = 0.7

*STS National Average Comparison reporting period 01/01/2021 through 09/30/2021

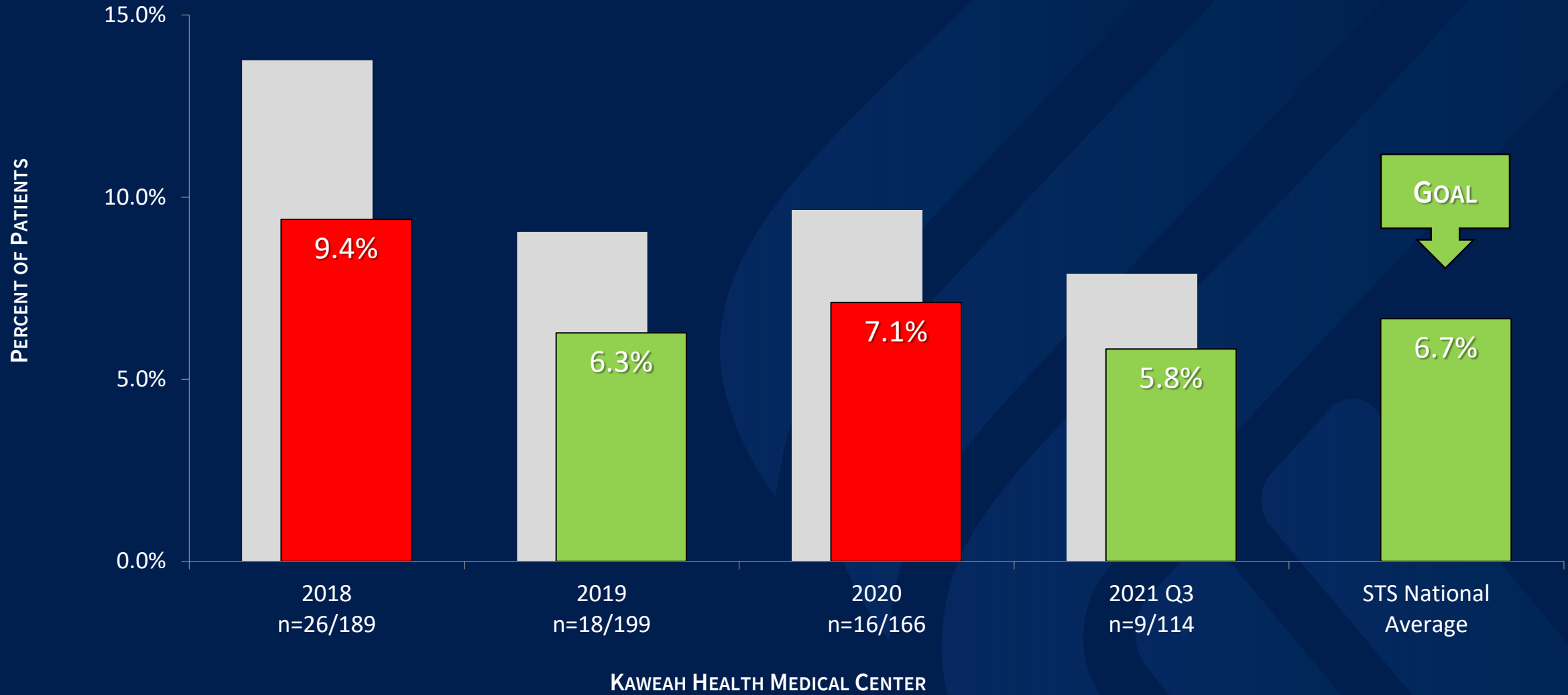
¹ Excludes patients with preoperative dialysis or preoperative Creatinine ≥ 4 , Q3-2020 forward COVID+ pt.'s Excluded.

QUALITY INITIATIVE:

RENAL FAILURE

- ❖ Risk factor evaluation pre-operatively
- ❖ Timing of surgery considered
- ❖ Diabetes control
- ❖ Liberal hydration
- ❖ Intra-operative blood flow & pressure controlled by perfusion and anesthesia
- ❖ Blood pressure management peri-operatively

CABG PROLONGED VENTILATION RISK ADJUSTED IN COLOR



2021 Risk-adjusted O/E = 0.9

*STS National Average Comparison reporting period 01/01/2021 through 09/30/2021

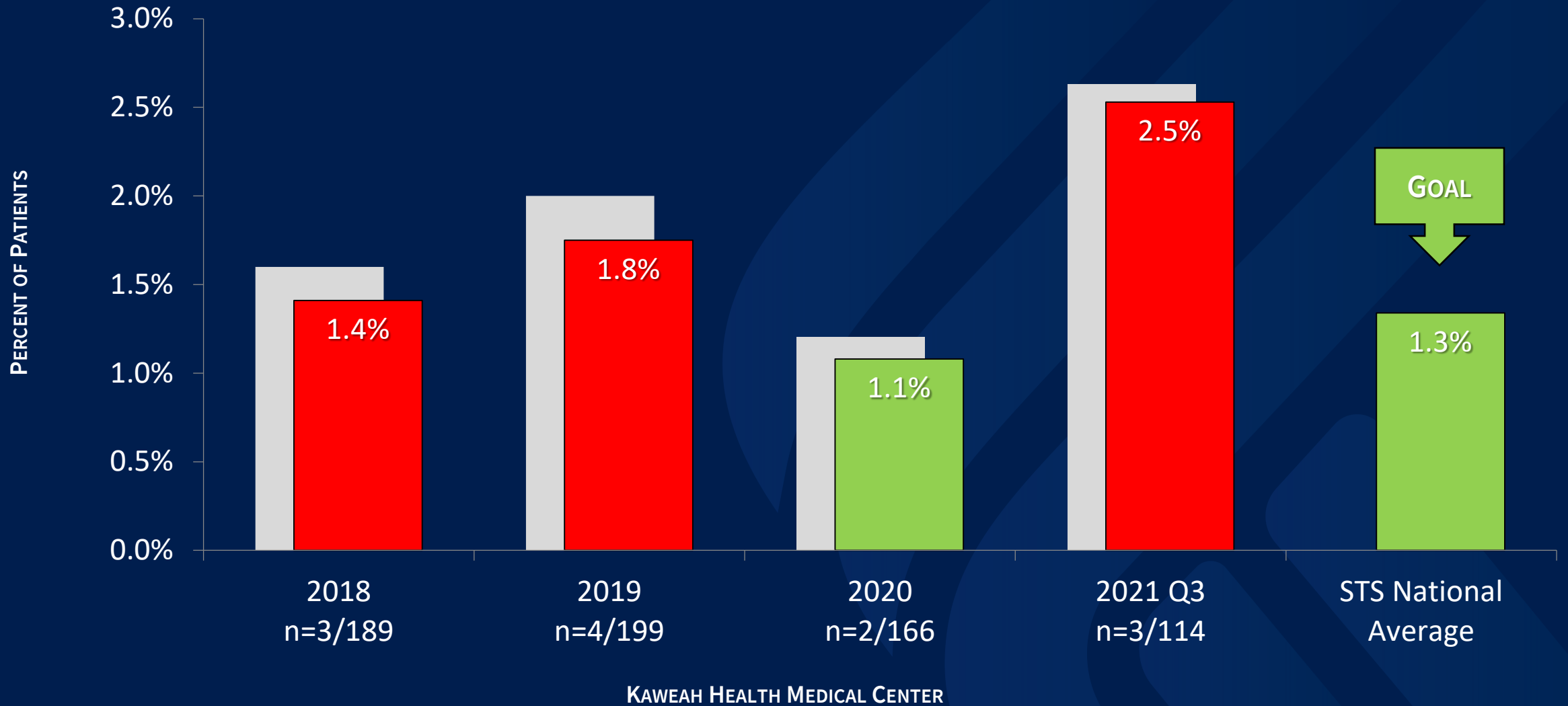
Q3-2020 forward COVID+ pt.'s Excluded.

QUALITY INITIATIVE:

PROLONGED VENTILATION

- ❖ Monthly audit & analysis of prolonged ventilation times and delayed Extubation due to medical necessity
- ❖ Action Plan for 100% completion of Cardiac Extubation Tool ~ monitored by CVICU nurse manager
- ❖ Sedation and Analgesia to be used in an appropriate and conservative manner
- ❖ Avoid Benzodiazepines and narcotic drips
- ❖ To illicit calm awakening utilize Propofol & precedex drips when medically necessary
- ❖ Train nursing, medical and ancillary staff on the Fast Track Extubation Protocol available in PolicyTech
- ❖ Address ventilation time of each Pt. in rounds and shift reports by RN, RT & MD
- ❖ Promote Respiratory Therapy Education Tool for patients
- ❖ Review of Anesthesia Protocols
- ❖ Positive Base excess or > -2.0 on CVICU arrival
- ❖ Core Temperature $> 36.0^{\circ}\text{C}$ on CVICU arrival

CABG Post Op Permanent Stroke Risk Adjusted in Color



2021 Risk-adjusted O/E = 1.9

*STS National Average Comparison reporting period 01/01/2021 through 09/30/2021

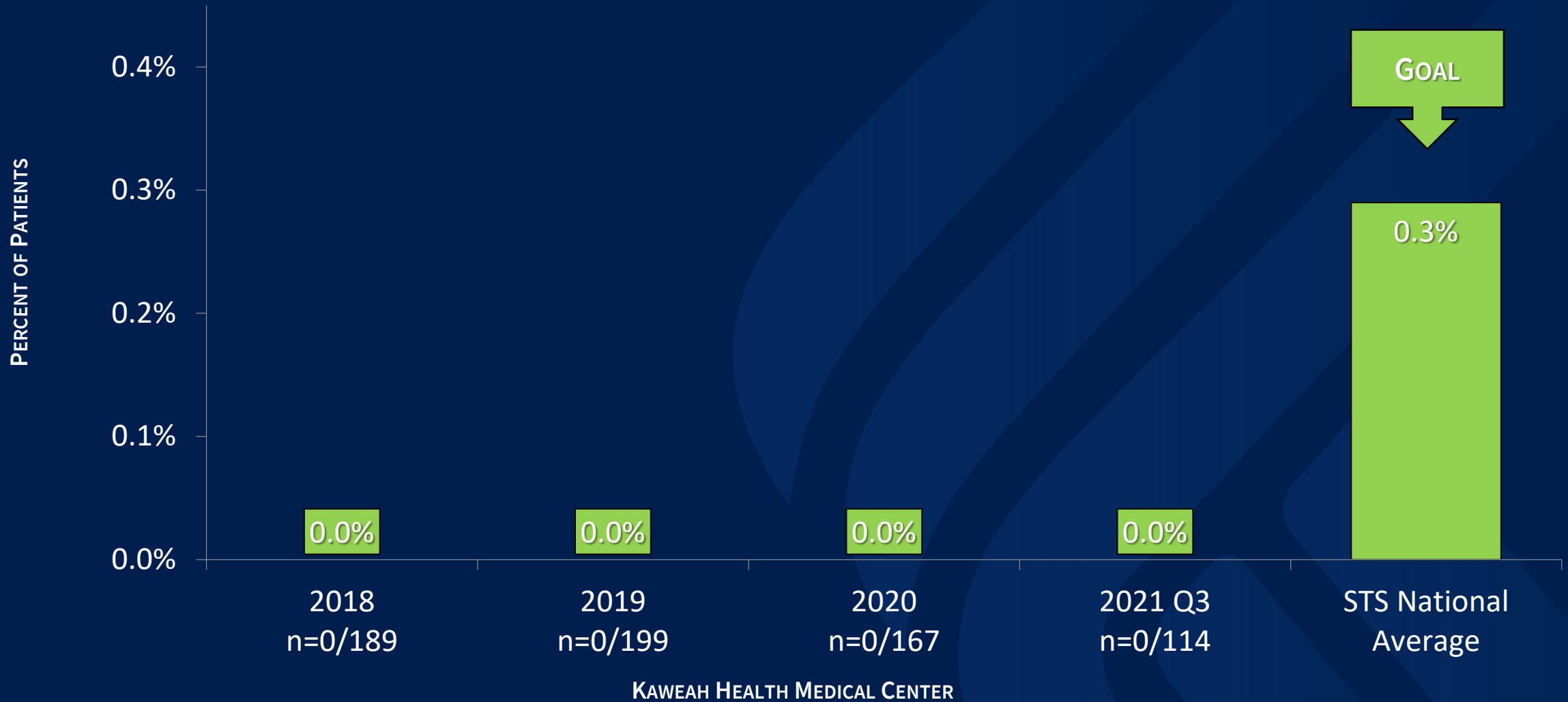
Q3-2020 forward COVID+ pt.'s Excluded.

QUALITY INITIATIVE:

STROKE PREVENTION

- ❖ Risk factor, neurological evaluation
- ❖ TEE, CT of the aorta with evaluation as needed
- ❖ Carotid Doppler ~ Ultrasound
- ❖ Invox cortical brain monitoring
- ❖ Intraoperative blood flow & pressure control by perfusion and anesthesia
- ❖ Intraoperative temperature control

CABG Post Op Deep Sternal Wound Infection RISK ADJUSTED IN COLOR



2021 Risk-adjusted O/E = 0

*STS National Average Comparison reporting period 01/01/2021 through 09/30/2021

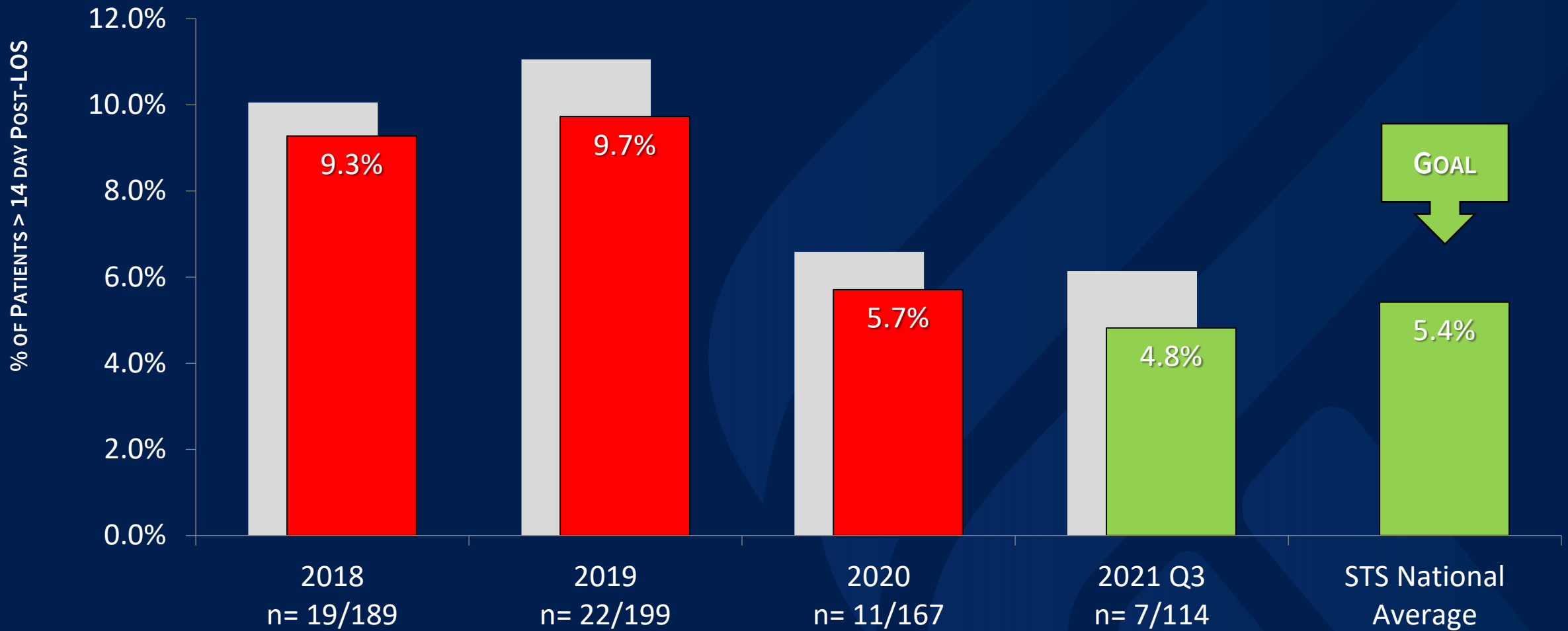
Q3-2020 forward COVID+ pt.'s Excluded.

QUALITY INITIATIVE:

INFECTION PREVENTION

- ❖ Glucose control w/ Glucomander – insulin drip or subcutaneous
- ❖ Two Chlorhexidine baths prior to surgery
- ❖ Chlorhexidine mouth wash used morning of surgery
- ❖ MRSA screening of each patient
- ❖ Terminal cleaning of operating rooms monitored daily
- ❖ Disposable ECG monitoring cables on each patient
- ❖ Use of Early closure technique for vein harvest incisions
- ❖ Vancomycin paste for sternal application
- ❖ Silver Nitrate or Prevena suction dressing applied to sternum
- ❖ Prophylactic antibiotic treatment for 48 hours
- ❖ Early removal of central lines and Foley catheter

CABG Post Op Length of Stay >14 Days Risk Adjusted in Color



KAWEAH HEALTH MEDICAL CENTER

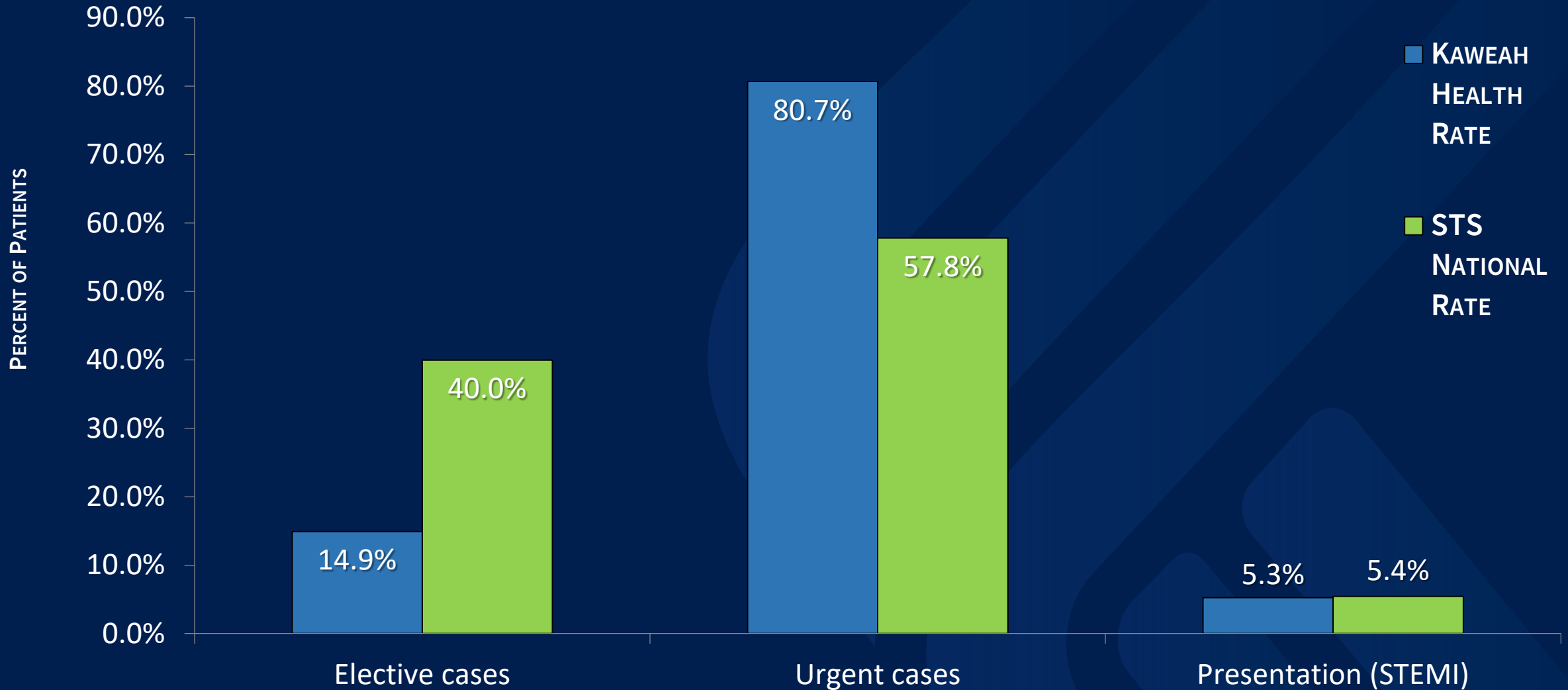
2021 Risk-adjusted O/E = 0.9

*STS National Average Comparison reporting period 01/01/2021 through 09/30/2021

Post-operative Length of Stay: Long Stay is greater than 14 days (PLOS > 14 Days), Q3-2020 forward COVID+ pt.'s Excluded.

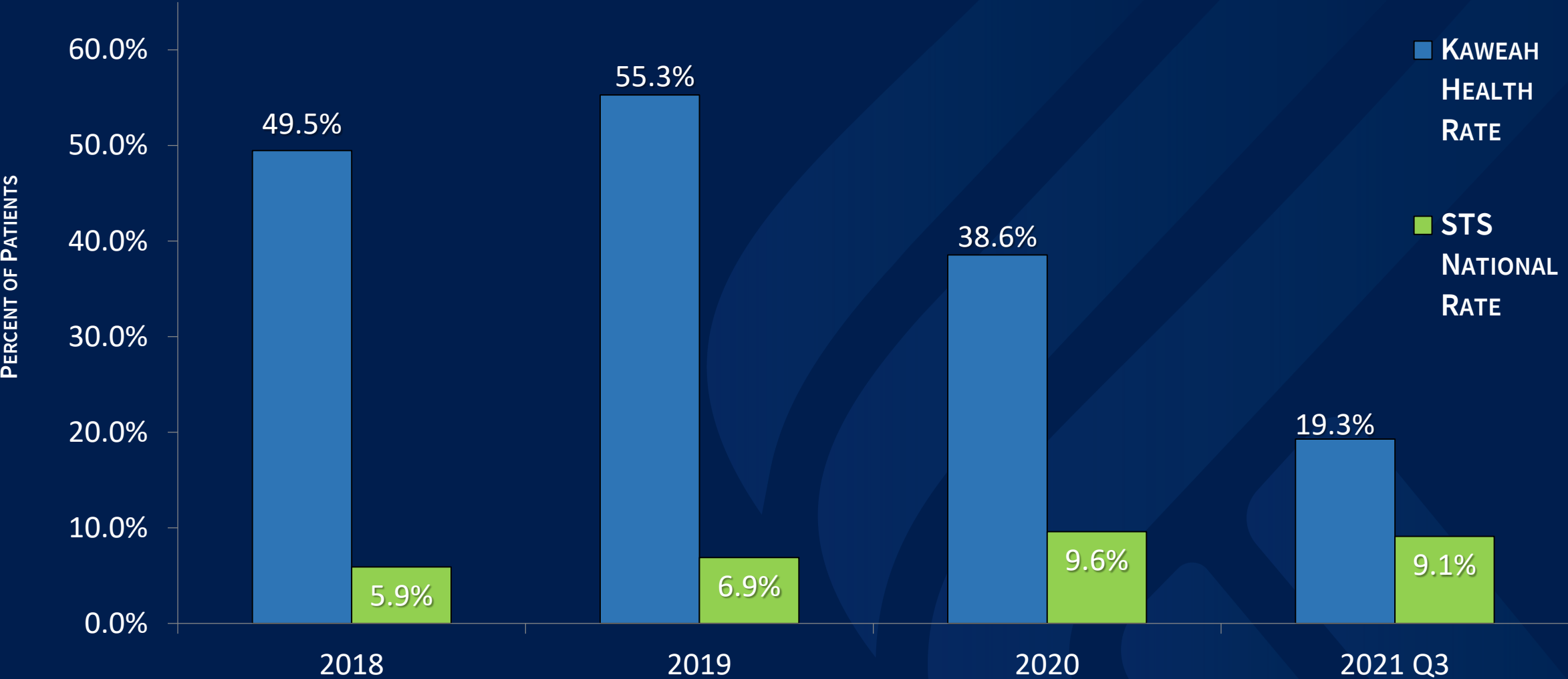
142/580

KAWEAH HEALTH PT. POPULATIONS



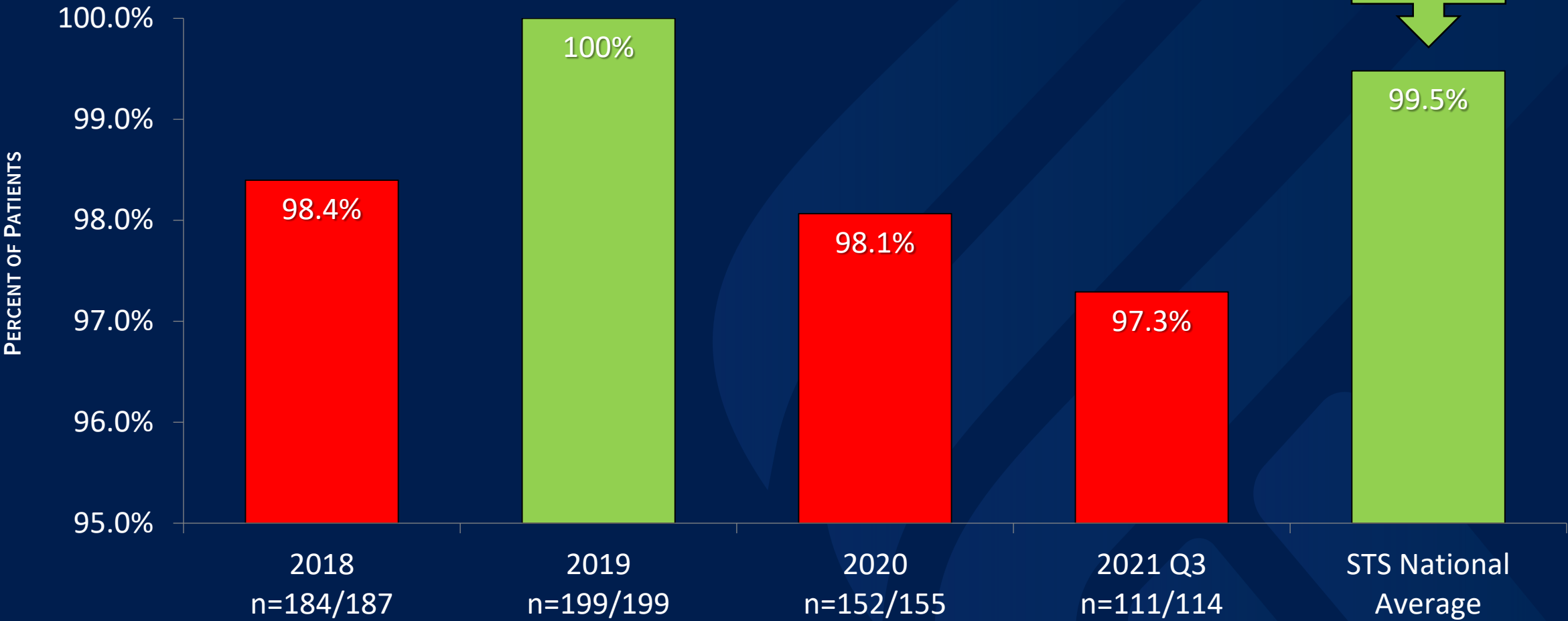
*STS National Average Comparison reporting period 01/01/2021 through 09/30/2021 – Isolated CABG cases ONLY

KAWEAH HEALTH RADIAL ARTERY USAGE



*STS National Average Comparison reporting period - 1/1 through 12/31 of each year – Isolated CABG cases ONLY

CABG INTERNAL MAMMARY ARTERY USAGE¹



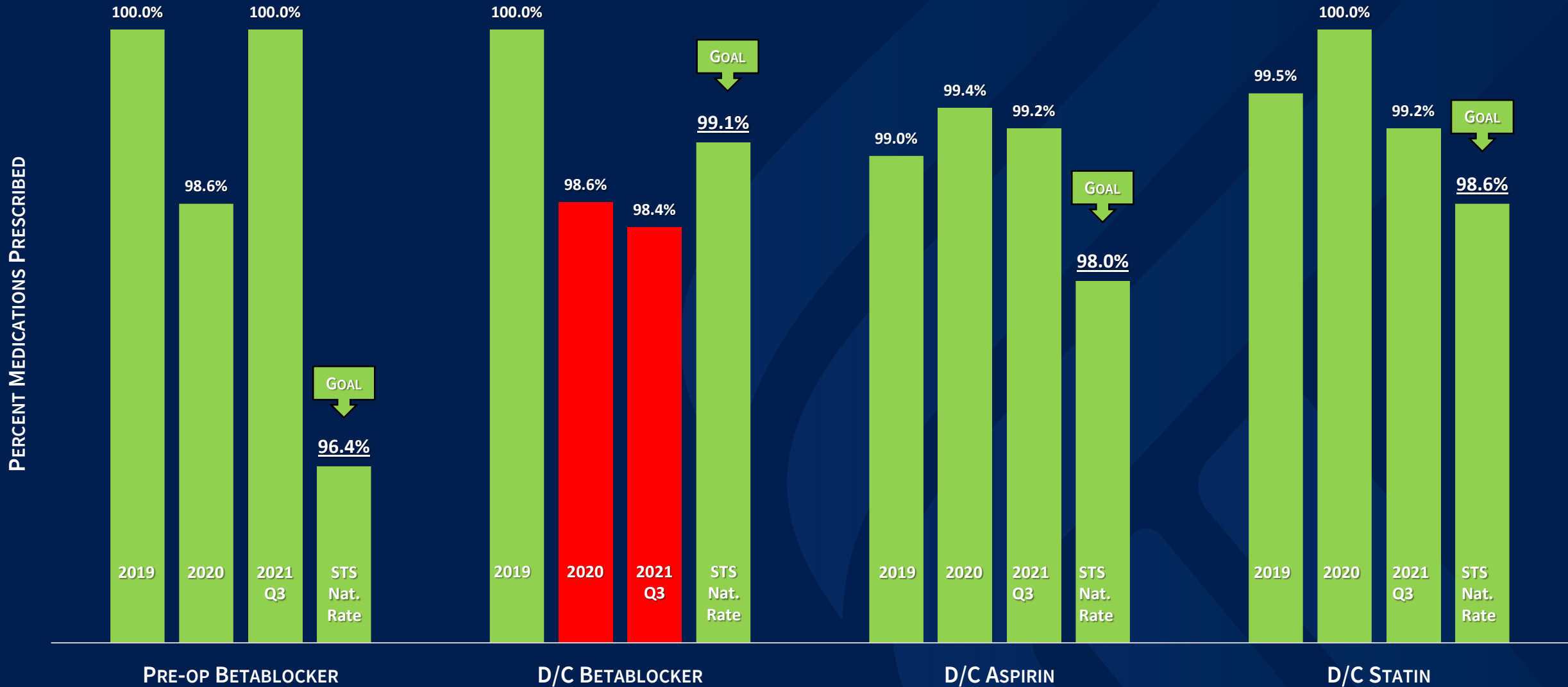
KAWEAH HEALTH MEDICAL CENTER

2021 O/E = 1.0

*STs National Average Comparison reporting period 01/01/2021 through 09/30/2021

¹Surgeries where at least one internal mammmary artery, left or right, was used as a bypass graft. Excludes emergent or salvage cases, No LAD disease, previous thoracic or cardiac surgery, subclavian stenosis or Hx of mediastinal radiation. Q3-2020 forward COVID+ pt.'s Excluded.

CABG Prescribed Medications Pre-op & Discharge



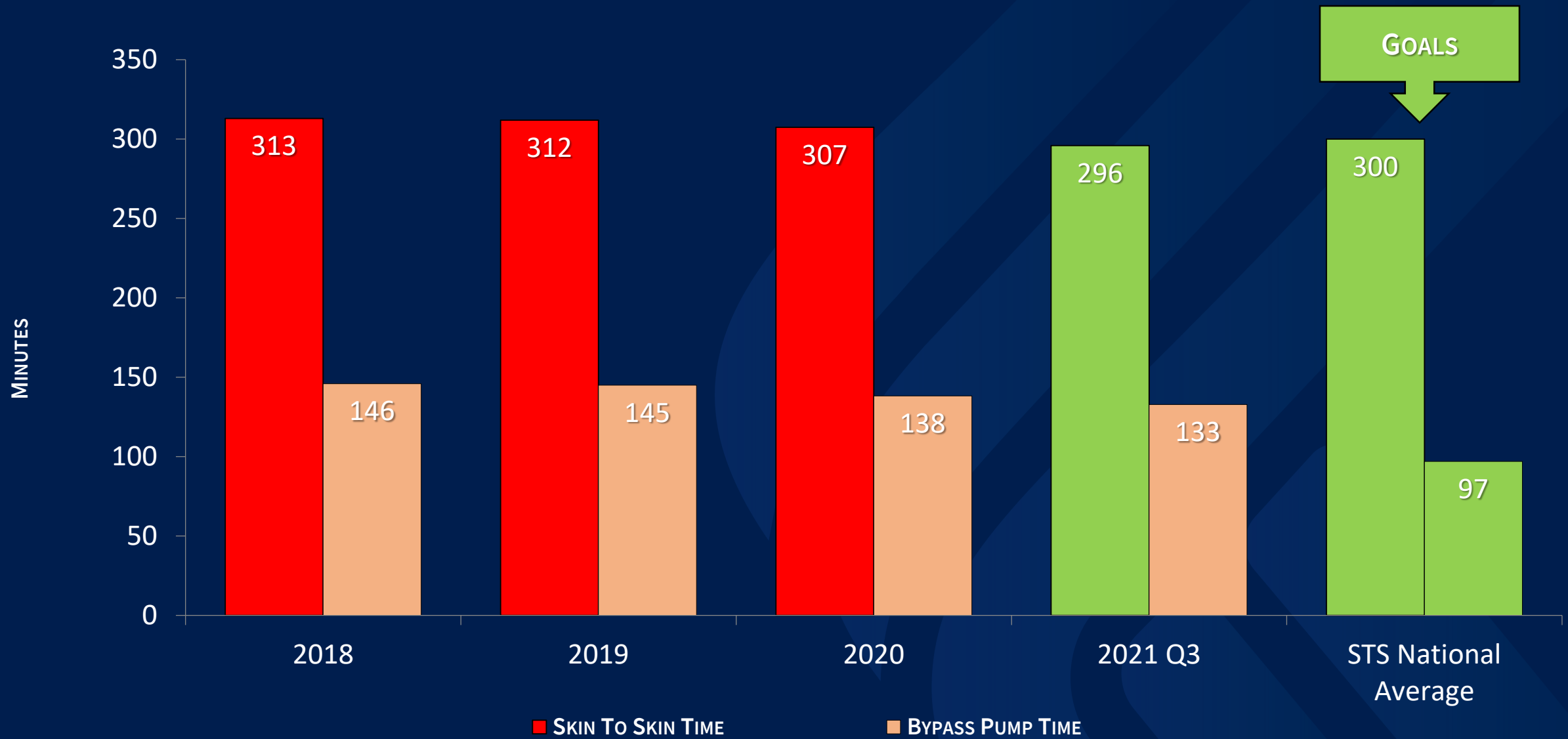
2021 O/E = 1.0

*STS National Average Comparison reporting period 01/01/2021 through 09/30/2021

Performance is measured by the proportion of patients who receive all of the perioperative medications for which the patient is eligible. The required perioperative medications are: 1) preoperative beta blockade therapy; 2) discharge anti-platelet medication; 3) discharge beta blockade therapy; and 4) discharge anti-lipid medication.

Note: patients who die prior to discharge are not eligible for discharge medications; contraindicated medications are considered non-eligible.

CABG SKIN-TO-SKIN AND BYPASS PUMP DURATIONS



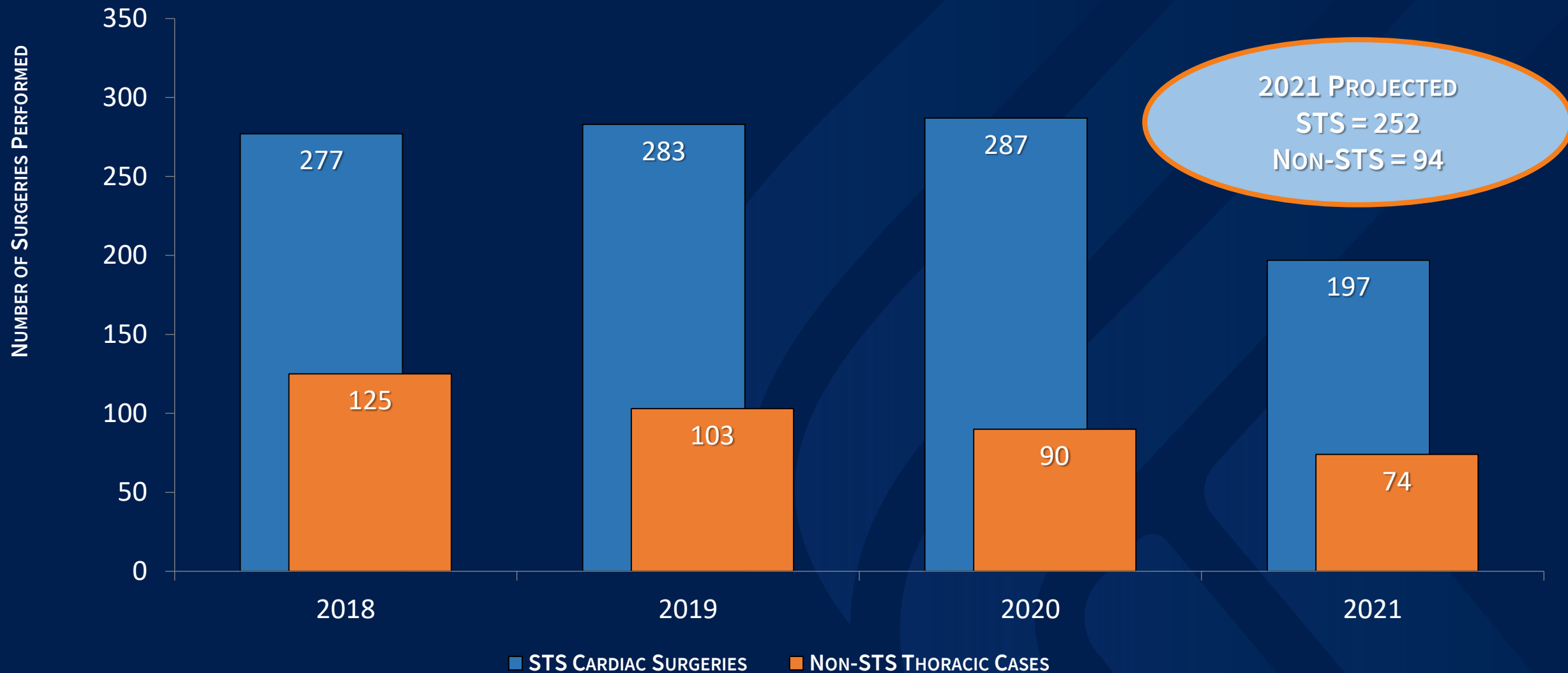
2021 O/E Skin Times = 1.0

2021 O/E Pump Times = 1.4

*STS National Average Comparison reporting period 01/01/2021 through 09/30/2021

147/580

KAWEAH HEALTH CARDIOTHORACIC SURGERY VOLUMES¹



¹ Cardiac surgery as defined per STS database. Includes all 7 Major Procedure Categories (CABG, AVR, AVR+CABG, MVR, MVR+CABG, MVP, MVP+CABG) + Other Heart only procedures.

Live with passion.

Health is our passion. Excellence is our focus. Compassion is our promise.



PERCUTANEOUS CORONARY INTERVENTION (PCI) DATA

QUALITY ANALYSIS

****Q4 2020 → Q3 2021****

RISK ADJUSTED DATA

NEON GREEN = IN THE TOP 10% OF THE NATION

LIGHT GREEN = BETTER OR EQUAL TO THE NATIONAL AVERAGE

RED = WORSE THAN NATIONAL AVERAGE

GRAY = NON-RISK ADJUSTED VALUE (FOR REFERENCE ONLY)

*COMPARISON REPORTING PERIOD VARIES PER METRIC



Quality Improvement
for Institutions



AMERICAN
COLLEGE of
CARDIOLOGY



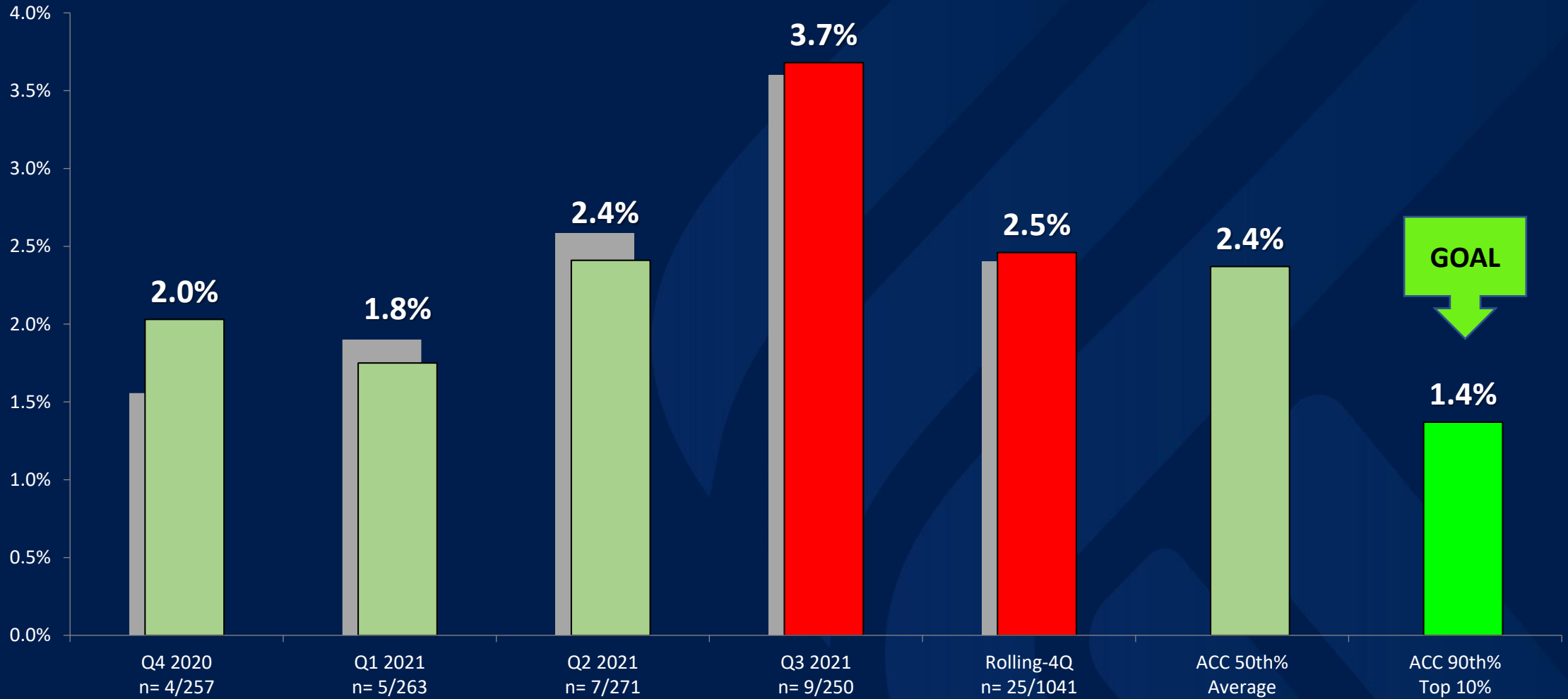
Kaweah Health™
MORE THAN MEDICINE. LIFE.



kaweahhealth.org

150/580

PCI IN-HOSPITAL MORTALITY RATE¹ RISK ADJUSTED^{IN-COLOR} (ALL PATIENTS)



R4Q Risk-Adjusted O/E = 1.1

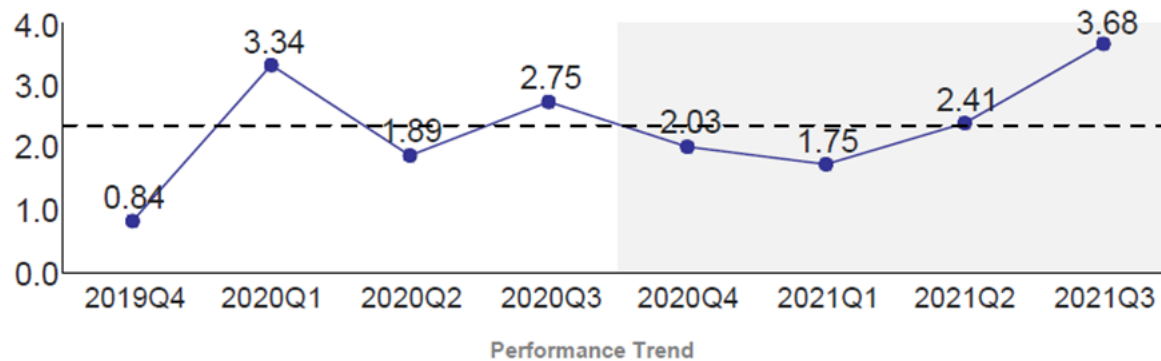
¹ PCI in-hospital mortality rate for all patients, risk adjusted. Exclusions include patients with a discharge location of "other acute care hospital." (ref: 4739, 4736)

*Comparison reporting period is 10/01/20 through 09/30/21

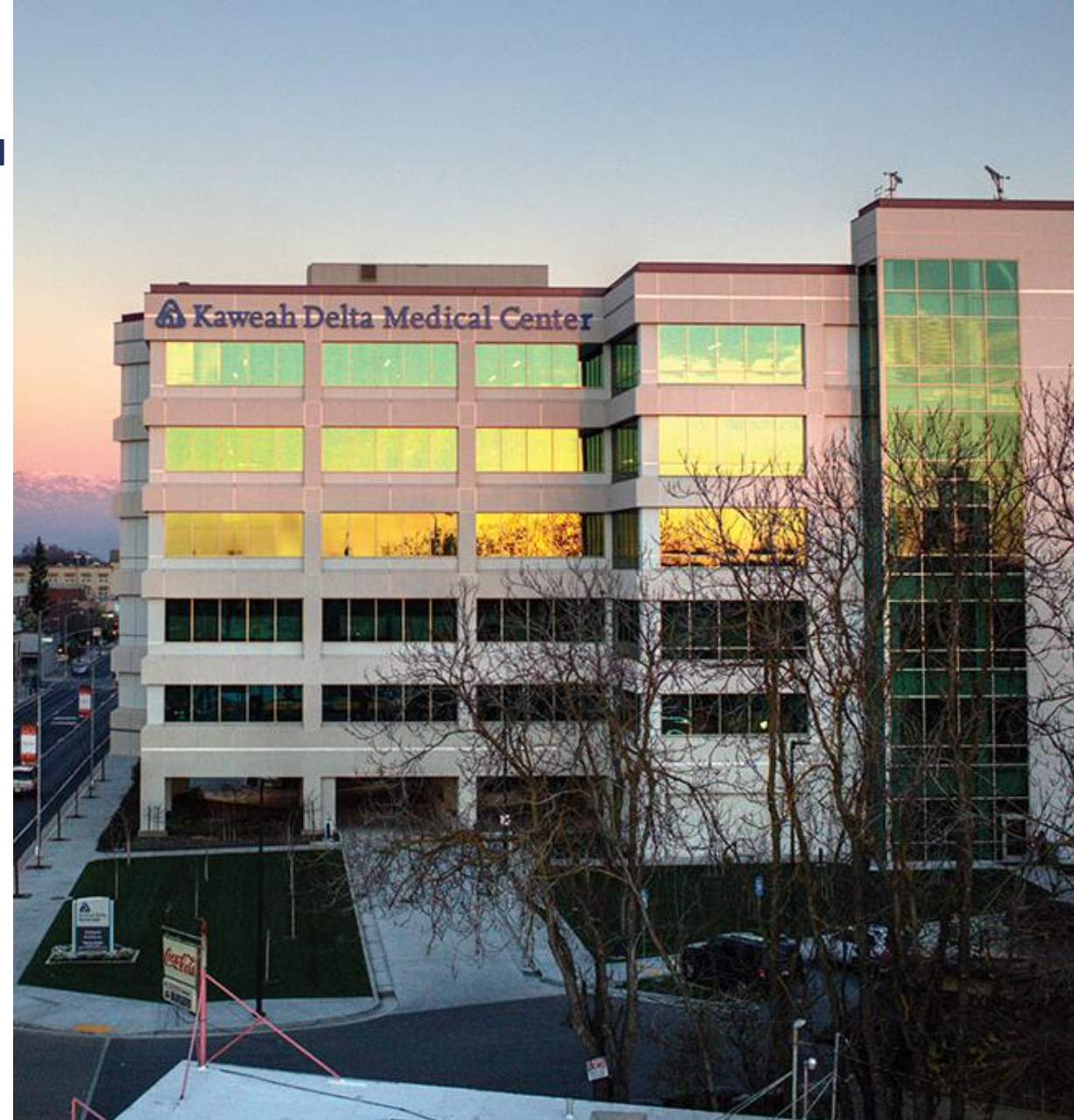
PCI MORTALITY RATE¹

RISK ADJUSTED TWO YEARS

(ALL PATIENTS)

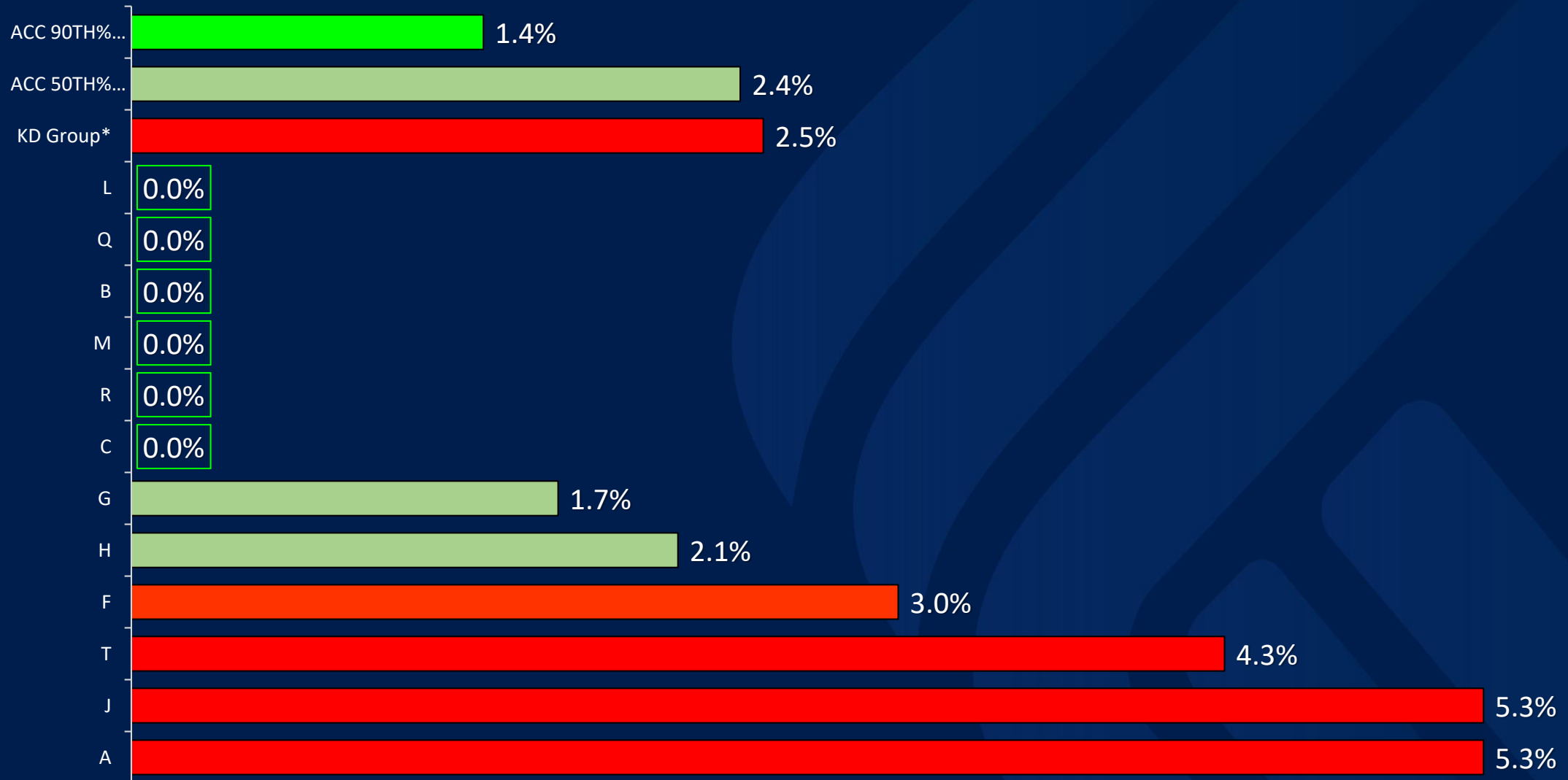


¹ PCI in-hospital mortality rate for all patients, risk adjusted. Exclusions include patients with a discharge location of “other acute care hospital.” (ref: 4739, 4736)



PCI MORTALITY¹ RATE BY PHYSICIAN

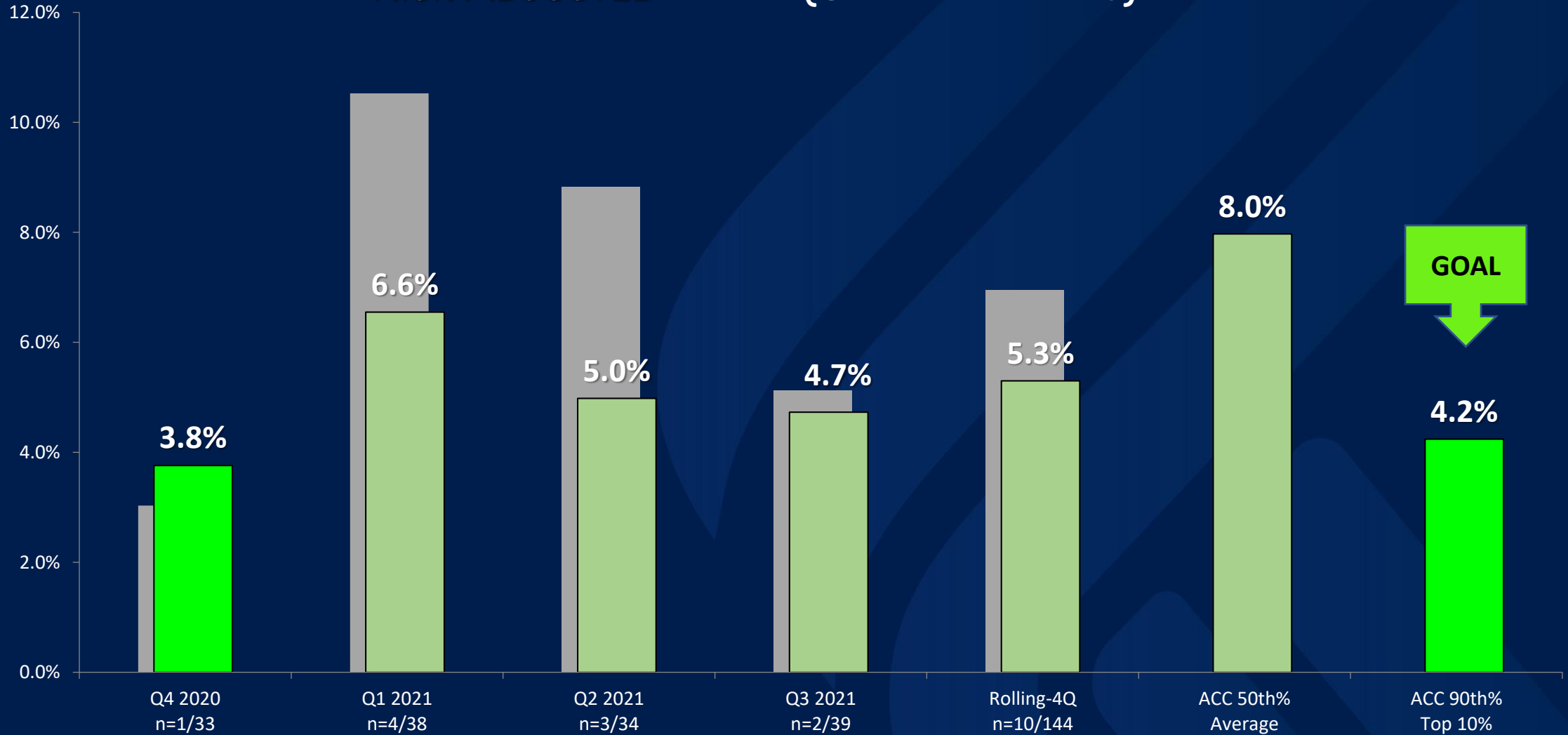
ALL PATIENTS – ROLLING 4 QUARTERS (Q4 2020 – Q3 2021*)



¹ PCI in-hospital mortality rate for all patients for that MD. Exclusions include patients with a discharge location of “other acute care hospital.” (ref: NCDR/ACC Physician Dashboard)

* Comparison reporting period is 10/01/20 through 09/30/21– Raw DATA all Quarters – NOT-RISK-ADJUSTED

PCI IN-HOSPITAL MORTALITY RATE¹ RISK ADJUSTED^{IN-COLOR} (STEMI PATIENTS)



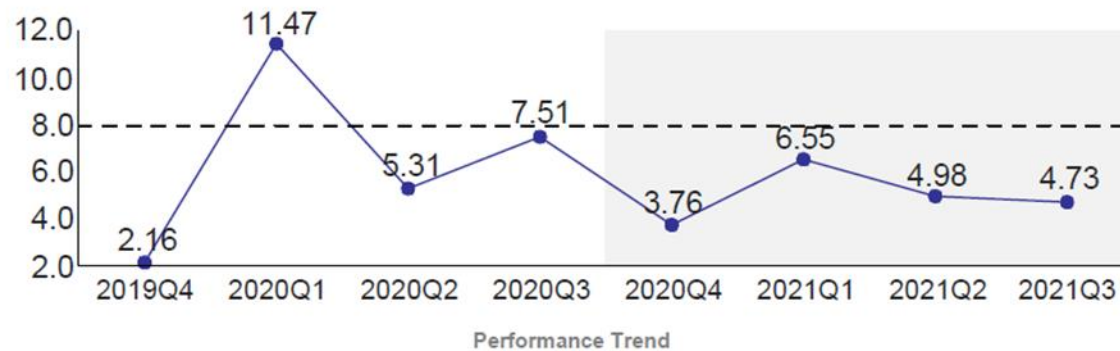
R4Q Risk-Adjusted O/E = 0.7

¹ PCI in-hospital mortality rate for STEMI Pt.'s. (ref: 4740, 4734)

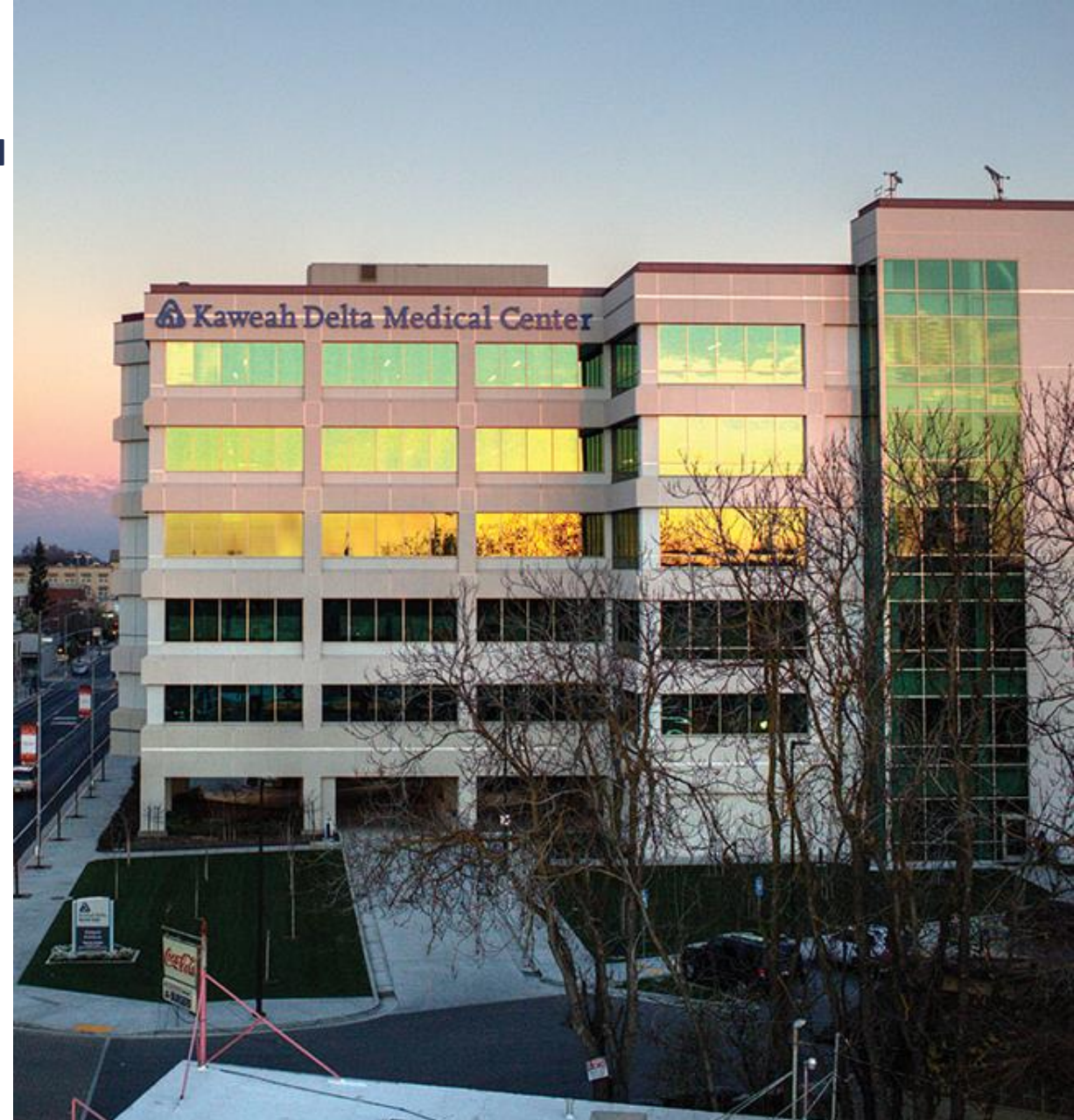
* Comparison reporting period is 10/01/20 through 09/30/21

PCI MORTALITY RATE¹

RISK ADJUSTED TWO YEARS (STEMI PATIENTS)

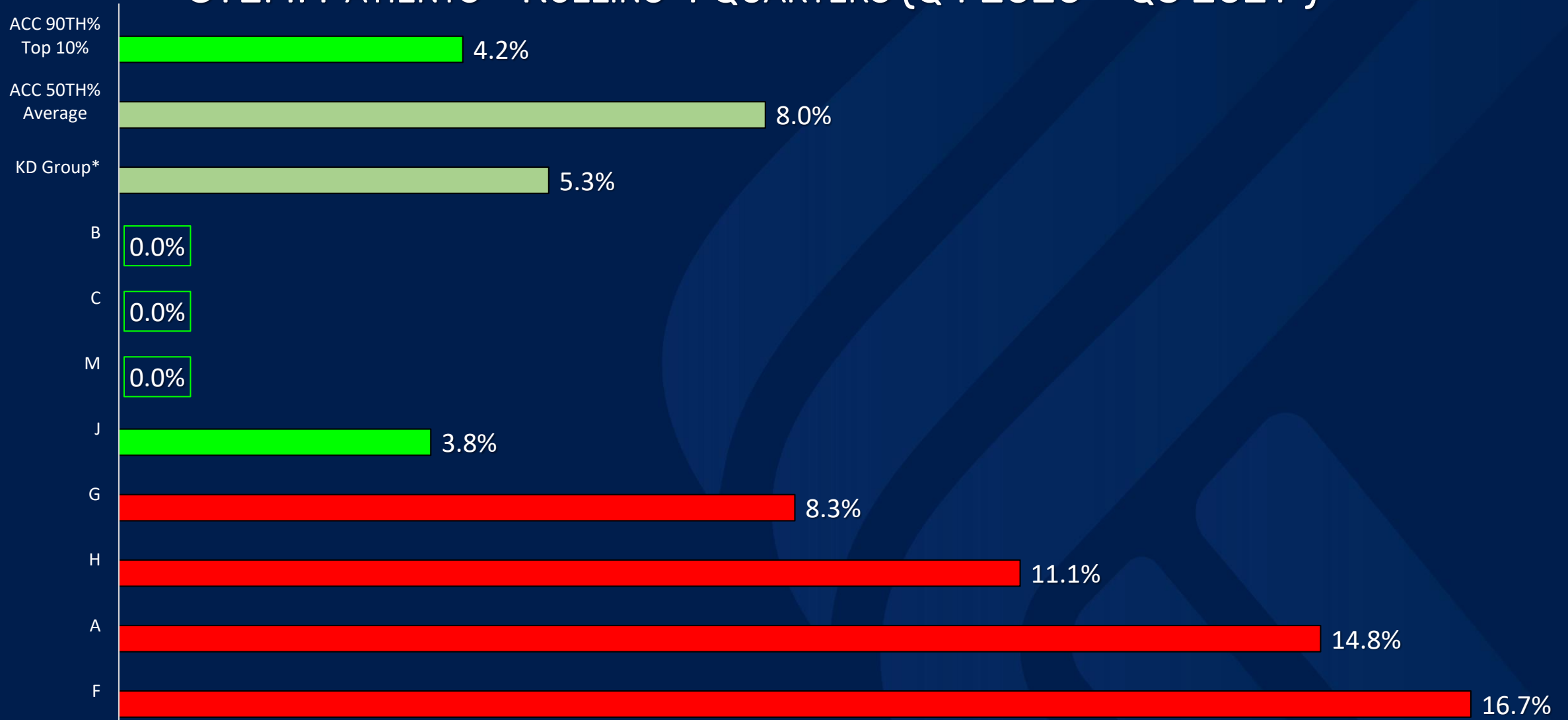


¹ PCI in-hospital mortality rate for STEMI patients, risk adjusted. Exclusions include patients with a discharge location of “other acute care hospital.” (ref: 4740, 4734)



PCI MORTALITY¹ RATE BY PHYSICIAN

STEMI PATIENTS – ROLLING 4 QUARTERS (Q4 2020 – Q3 2021*)

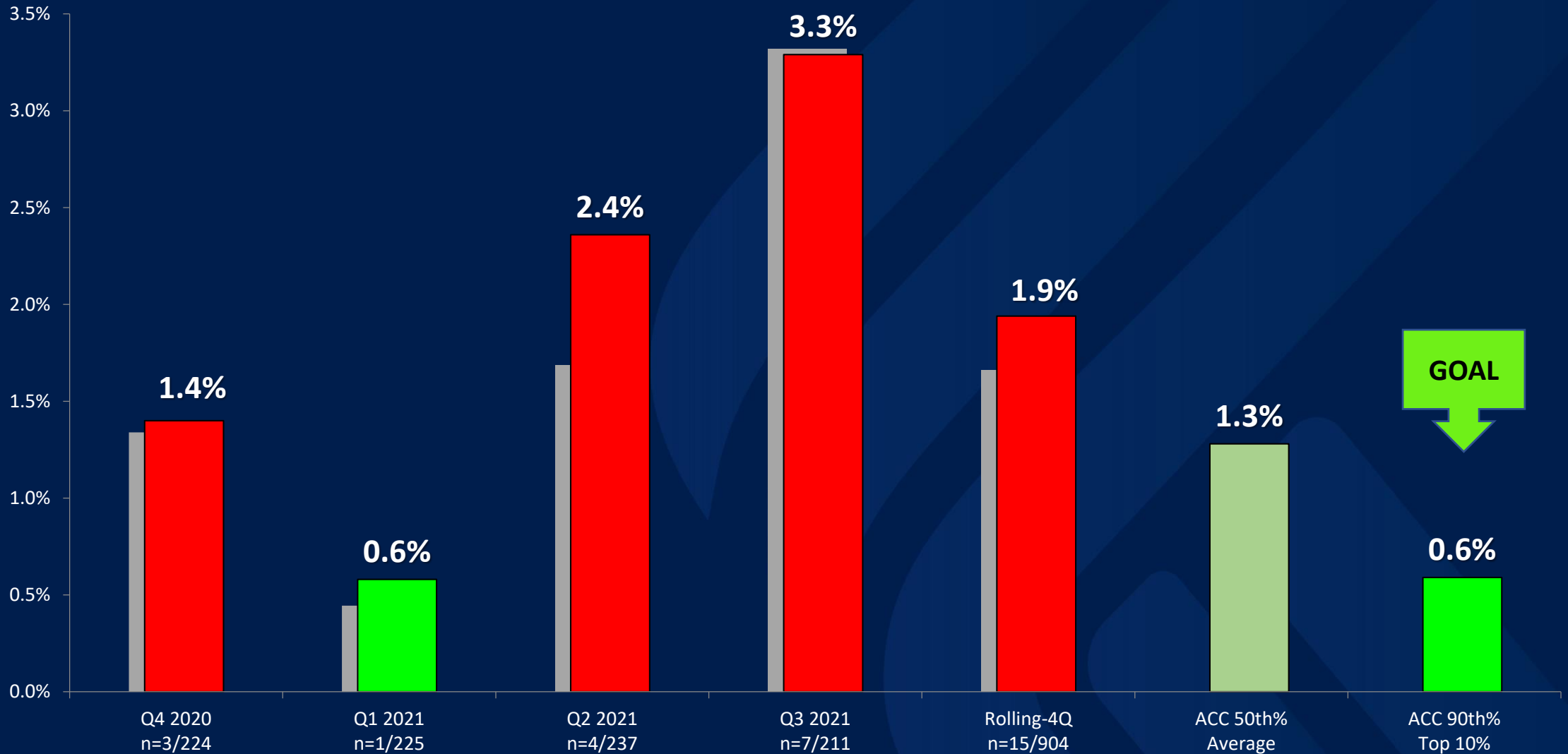


¹ PCI in-hospital mortality rate for STEMI patients for that MD. Exclusions include patients with a discharge location of “other acute care hospital.” (ref: NCDR/ACC Physician Dashboard)

* Comparison reporting period is 10/01/20 through 09/30/21 – Raw DATA all Quarters – NOT-RISK-ADJUSTED

PCI IN-HOSPITAL MORTALITY RATE¹

RISK ADJUSTED^{IN-COLOR} (NSTEMI, UNSTABLE ANGINA, ELECTIVES)



R4Q Risk-Adjusted O/E = 1.7

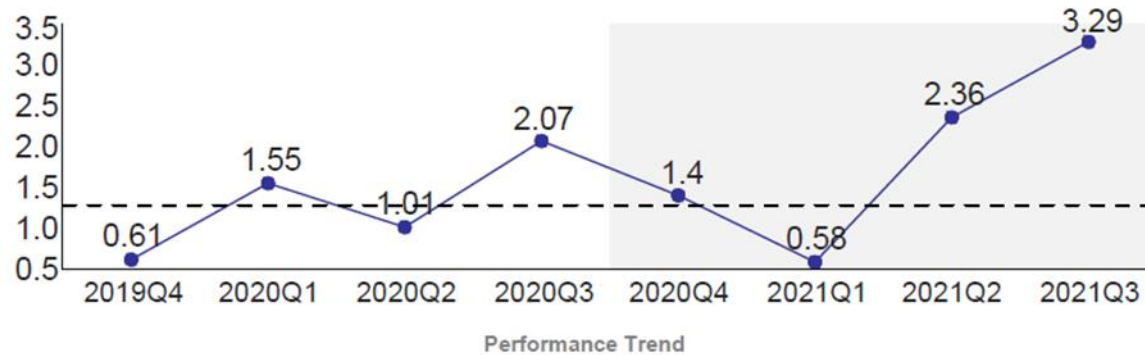
¹ PCI in-hospital mortality rate for all patients Excluding STEMI. Exclusions include patients with a discharge location of "other acute care hospital." (ref: 4741, 4735)

* Comparison reporting period is 10/01/20 through 09/30/21

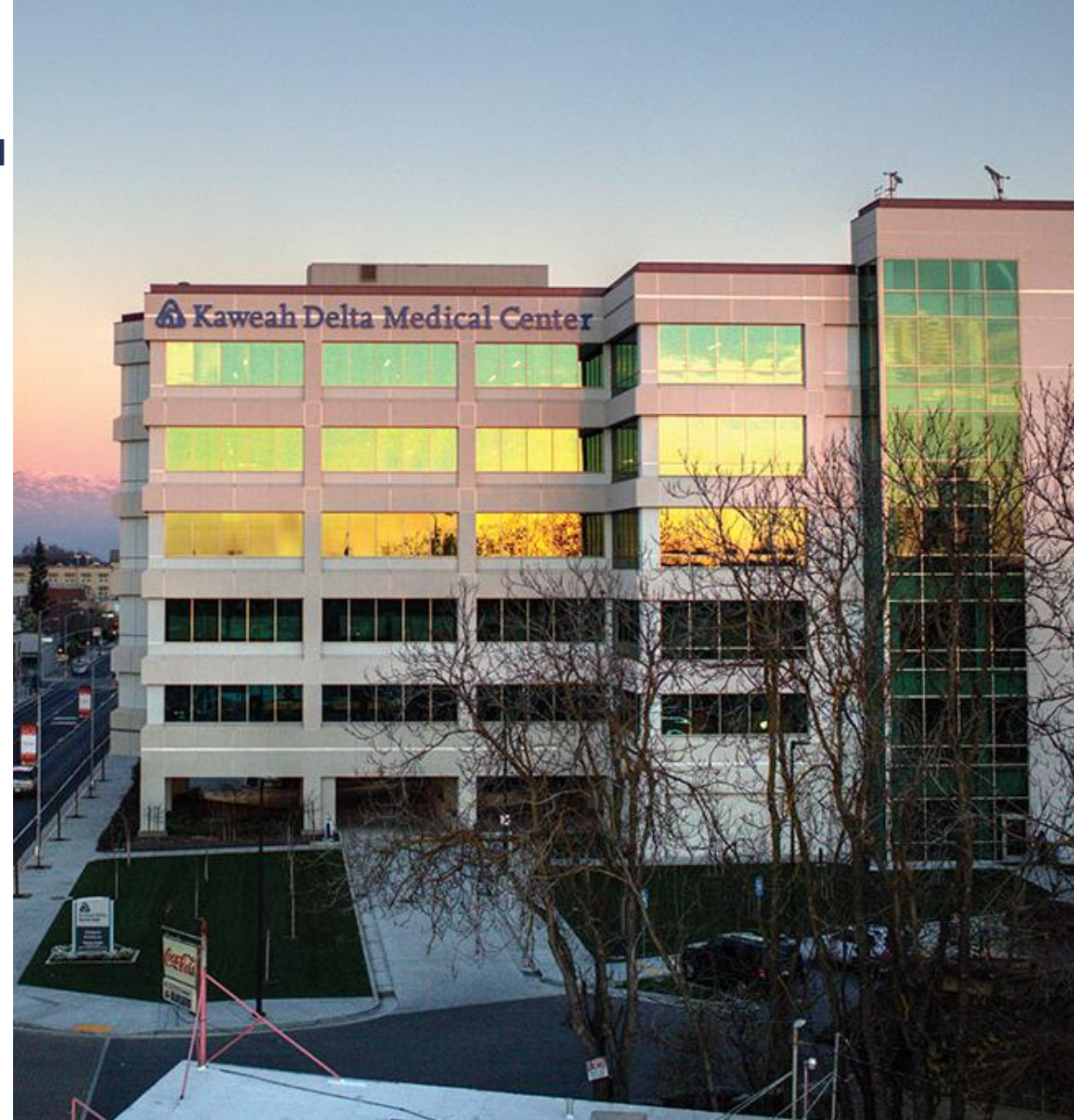
157/580

PCI MORTALITY RATE¹

RISK ADJUSTED TWO YEARS
(NSTEMI, UNSTABLE ANGINA, ELECTIVES)

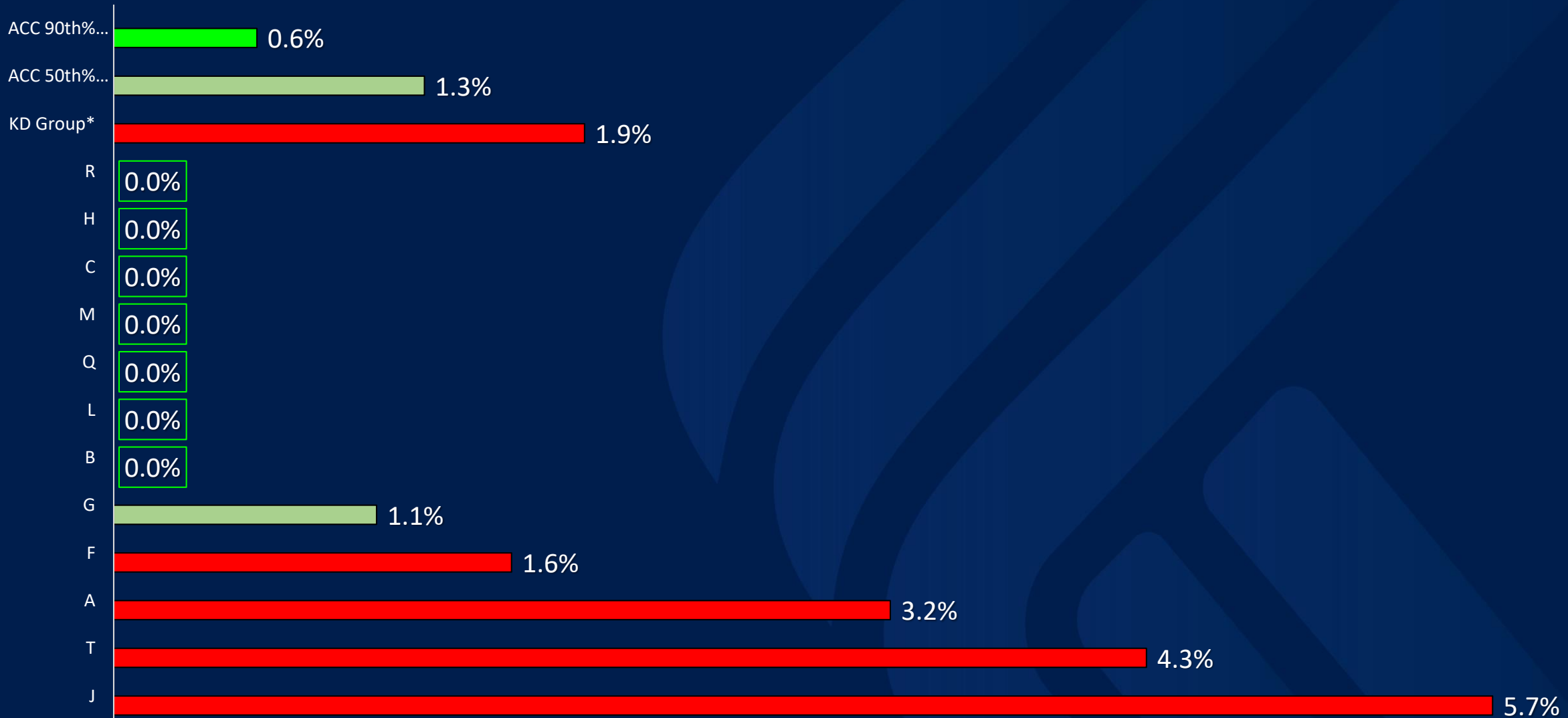


¹ PCI in-hospital mortality rate for all patients Excluding STEMI patients, risk adjusted. Exclusions include patients with a discharge location of “other acute care hospital.” (ref: 4741, 4735)



PCI MORTALITY¹ RATE BY PHYSICIAN

N-STEMI, USA, ELECTIVE PATIENTS – ROLLING 4 QUARTERS (Q4 2020 – Q3 2021*)



¹ PCI in-hospital mortality rate for N-STEMI, USA, Elective patients for that MD. Exclusions include patients with a discharge location of “other acute care hospital.” (ref: NCDR/ACC Physician Dashboard)

* Comparison reporting period is 10/01/20 through 09/30/21– Raw DATA all Quarters – NOT-RISK-ADJUSTED

STEMI TRIAGE GUIDELINES

THOUGHTFUL PAUSE

➤ Should go to CVICU first, not the Cath Lab

- Cardiac Arrest with CPR \geq 20 minutes and un/minimally responsive
- Cardiogenic Shock, age \geq 80
- STEMI \geq 24 hours without Chest Pain
- Excess risk of bleeding (e.g. active internal bleed, ICH < 3 mos, Hct < 22, PLT < 30K)
- Altered Mental Status
- Apparent sepsis or other conditions (other than pure cardiogenic shock) that would markedly increase the risk of dying within 30 days
- Pre-existing DNR / No Code Status

❖ Consider lytic agents for symptoms < 3 hours, anticipated DTB time > 120 minutes and low risk of bleeding

❖ These are intended as guidelines, not to supersede clinical judgement

*Adopted from the Cleveland Clinic Heart Institute: Triage Guidelines for STEMI patients.

PREDICTED MORTALITY MODEL

ELEMENTS INCLUDED IN THE MORTALITY RISK ADJUSTMENTS- v5

- Age, Gender
- Cerebral Vasc. Disease
- Peripheral Vasc. Disease
- Chronic Lung Disease
- Previous PCI
- In-stent Thrombosis w/in 30 days of prior PCI
- Diabetes Mellitus
- CHSA Clinical Frailty Scale
- NYHA Class I/II/III/IV
- Kidney Disease (pre-op creatinine)
- Renal Failure (Dialysis)
- Left Ventricular Ejection Fraction
- Systolic Blood Pressure
- Cardiac Arrest - timing
 - Responsiveness after arrest, prior to PCI
- Surgical Treatment recommendation
- Aortic Stenosis
- STEMI (any timing or stability)
- PCI of Left Main or Proximal LAD
- PCI Status
 - Salvage PCI
 - Refractory Cardiogenic Shock
 - Cardiogenic Shock
 - Acute Heart Failure
 - Emergent, urgent, elective
 - Cardiovascular Instability

QUALITY INITIATIVE

TREATMENT ALGORITHM FOR INVASIVE CARDIAC PROCEDURES

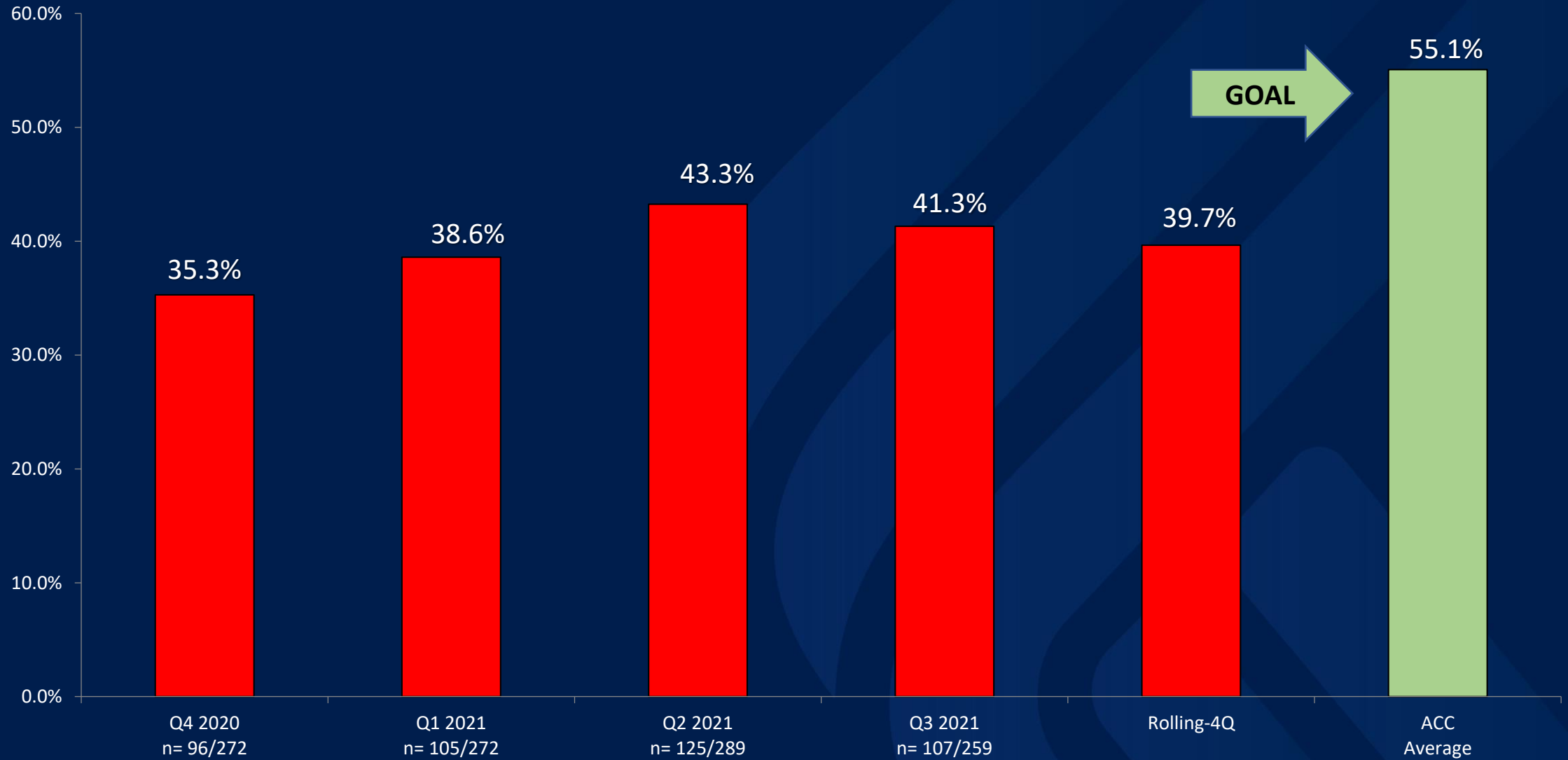
- Targeted Temperature Management
 - Immediate hypothermia measures to be implemented on cardiac arrest patients
- 12-Lead ECG must be done within 10 minutes of arrival to hospital
- ACT initiated – (Do not delay cooling measures)
 - Assessment for unfavorable resuscitation features
 - Consultation between ED, Critical Care and Cardiology physicians
 - Transport to Cath Lab urgently when consensus reached

QUALITY INITIATIVE

VITALLY IMPORTANT ETHICAL STEPS

- Physician collaboration & coordination between departments is required
- Cardiologist must participate in all thoughtful pause discussions
- ED physician and Cardiologist will consult with an Intensivist as needed for difficult cases
- Intensivist will respond to the ED for thoughtful pauses as requested
- Thoughtful pause must be documented in patient's EMR by a Provider
- Honest communication between all parties is required to maintain transparency and trust. Families must be given aggressive treatment options with their corresponding prognosis or futility
- Ethical issues are unavoidable in the care of critically ill patients but we must maximize our ethical decision-making
 - Clinical judgments of the multidisciplinary physicians must be observed whenever possible
 - Diagnostic tools and data must be readily available for discussion in real time so that critical decisions can be made quickly
 - Additional research into emerging data on this topic and diagnostic tools to keep our patients receiving state of the art care
 - Transparent discussions at the practice and policy making levels about what characterizes appropriate or futile care
 - Assessing patient wishes, respecting DNR and advanced directives even in times of family crisis and proxy decision makers
- Lastly and importantly, frank and honest discussions with families as to what is futile care

PCI RADIAL ARTERY ACCESS

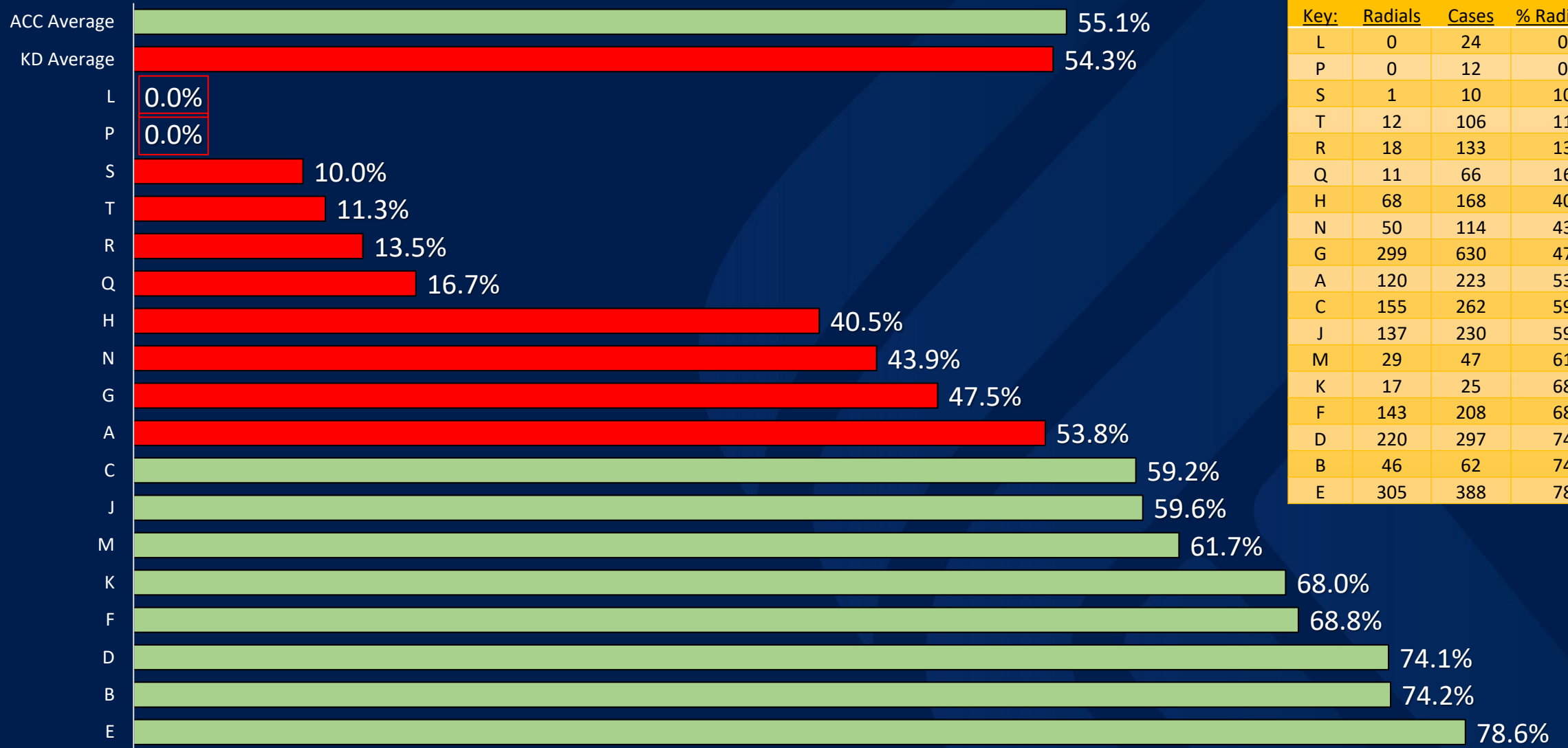


R4Q O/E = 1.1

(ref: NCDR Detail Line 4163) When no Percentile rankings are available, US Like Volume Group R4Q Averages are used for comparison purposes.

* Comparison reporting period is 10/01/20 through 09/30/21

ALL CATH'S RADIAL ARTERY USE¹ BY PHYSICIAN ROLLING 4 QUARTERS (Q4 2020 – Q3 2021*)

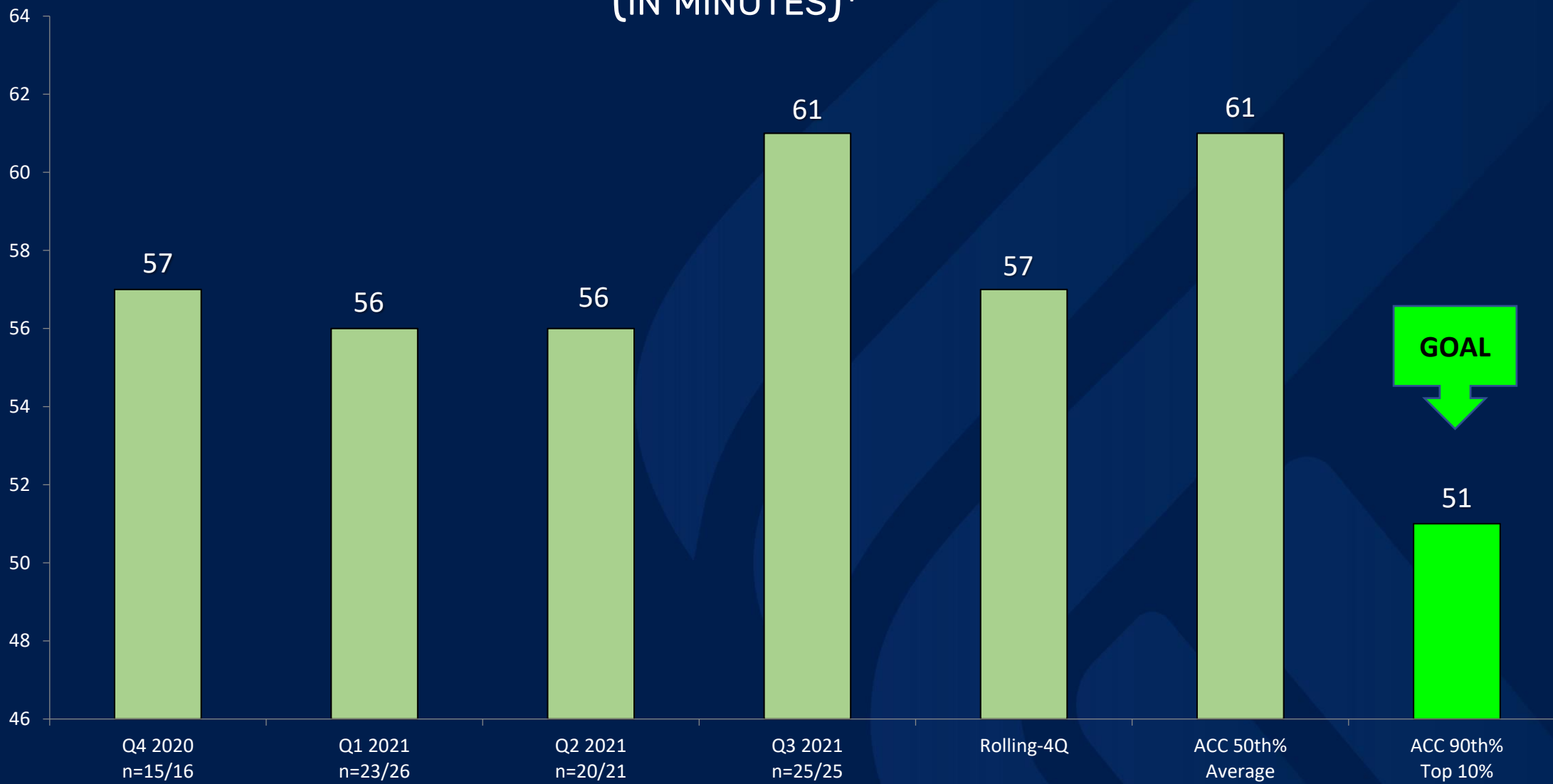


Key:	Radials	Cases	% Radial Usage
L	0	24	0.0%
P	0	12	0.0%
S	1	10	10.0%
T	12	106	11.3%
R	18	133	13.5%
Q	11	66	16.7%
H	68	168	40.5%
N	50	114	43.9%
G	299	630	47.5%
A	120	223	53.8%
C	155	262	59.2%
J	137	230	59.6%
M	29	47	61.7%
K	17	25	68.0%
F	143	208	68.8%
D	220	297	74.1%
B	46	62	74.2%
E	305	388	78.6%

¹ PCI & Diagnostic Cardiac Catheterization Procedures - Arterial Access Site equaling "Radial" for all patients for that MD. No Exclusions; Pt.'s with an aborted Radial attempt included in denominator (ref: SENSIS Statistical Manager) When no Percentile rankings are available, US Like Volume Group R4Q Averages are used for comparison purposes.

* Comparison reporting period is 10/01/20 through 09/30/21- *RAW DATA 165/580

IMMEDIATE PCI FOR STEMI (IN MINUTES)¹

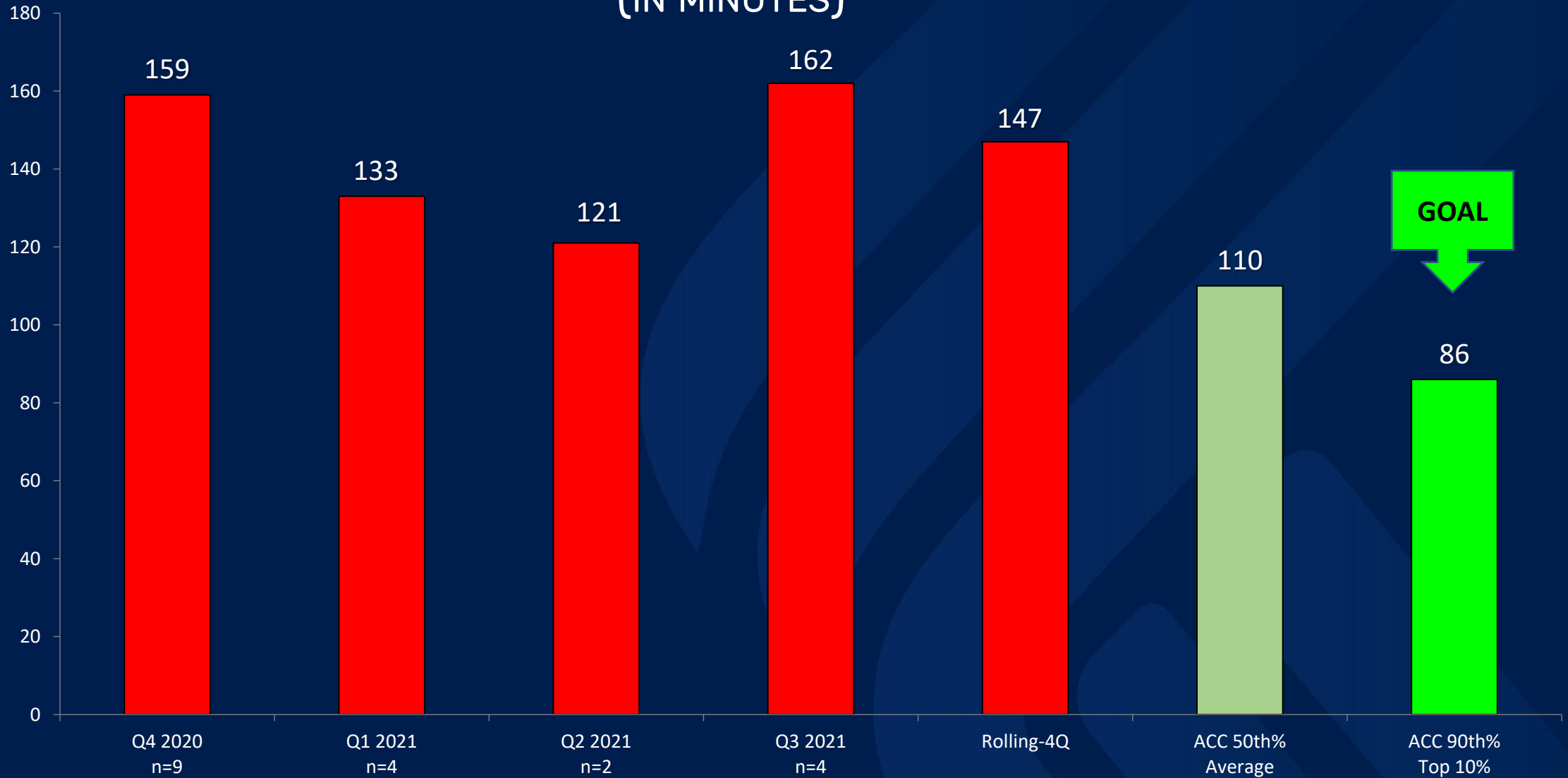


R4Q O/E = 0.9

¹ Median time frame from hospital arrival to immediate PCI for STEMI pts in minutes. Exclusions: Patients transferred in from another acute care facility; Reasons for delay does not equal none. N= pt.'s receiving PCI within 90 minutes. (ref: 4448) 166/580

* Comparison reporting period is 10/01/20 through 09/30/21

IMMEDIATE PCI FOR STEMI TRANSFERS (IN MINUTES)¹



R4Q O/E = 1.3

¹ Median time from ED arrival at STEMI transferring facility to immediate PCI at STEMI receiving facility among transferred patients (excluding reason for delays); Reasons for delay does not equal none. (ref:4452, 10888)

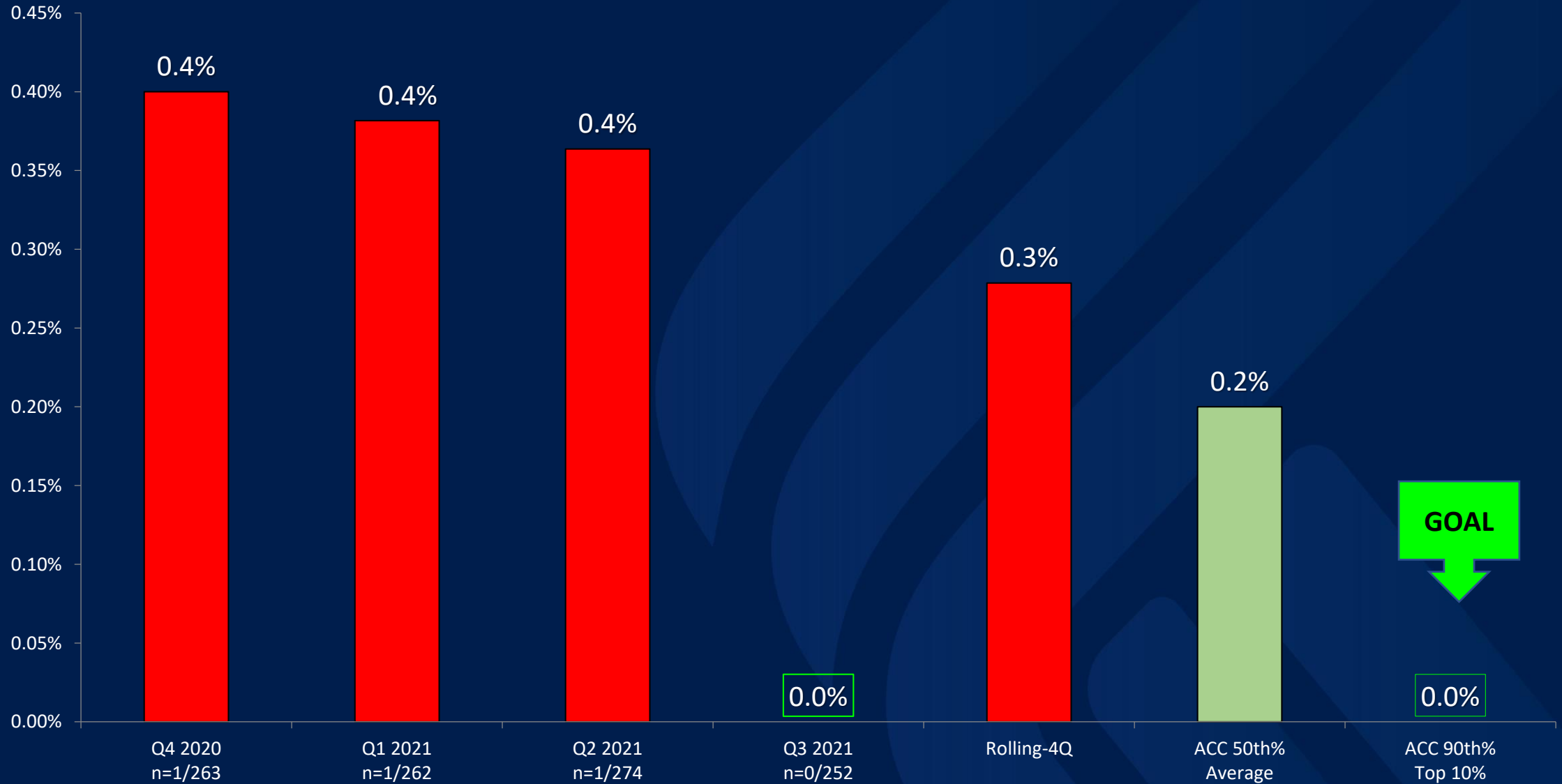
* Comparison reporting period is 10/01/20 through 09/30/21

QUALITY INITIATIVE

BEST PRACTICE IN DOOR TO BALLOON

- 4 Staff on call at all times (initiated Fall 2020)
 - Crew response time of 20 minutes
- Recognition of staff: Monthly fastest Door to Balloon award to incentivize staff
- Cardiac Alerts to be called at the time of leaving transferring hospitals
- Initial ED EKG to be placed in EMR or Tracemaster immediately
- STEMI taskforce with ED, Quality and Cath Lab to review ED STEMI hand off practices
 - Including STEMIs called in the field and from other facilities
- Cardiac Alerts called within 10 minutes of ED arrival unless Thoughtful Pause is documented

STROKE POST PCI¹



R4Q O/E = 1.4

¹ Exclusions: Patients with an Intervention this admission (Surgery, EP, Other); Pt's discharged to *Other Acute Care Facility* (ref: 4235)

* Comparison reporting period is 10/01/20 through 09/30/21

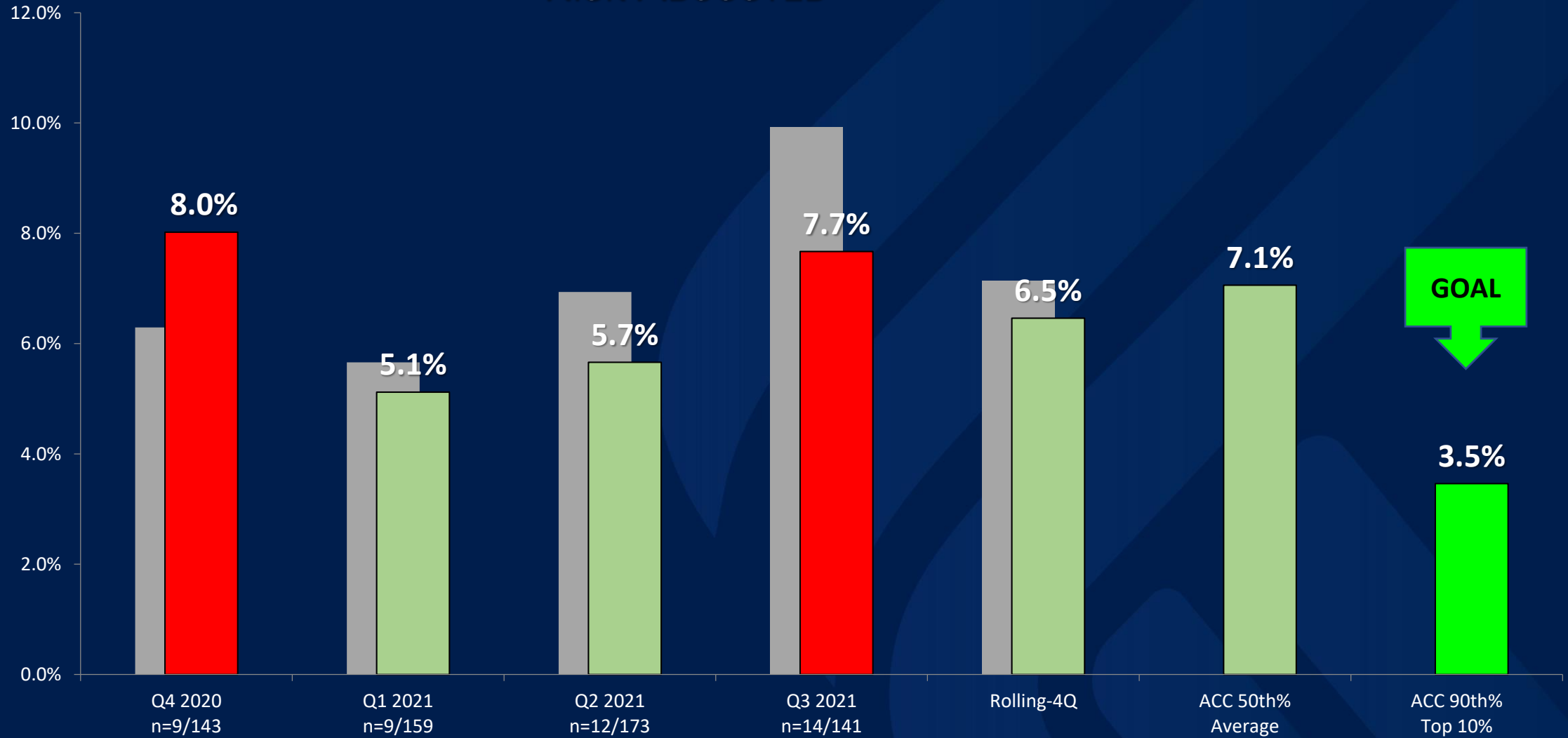
169/580

QUALITY INITIATIVE

STROKE RECOGNITION AND TREATMENT

- Assess Stroke Risk factors in PCI for each patient
- Age, gender, history of CVA, End Stage Renal Disease, Diabetes, Hypertension, Peripheral Vascular Disease, Smoking, Congestive Heart Failure, Atrial Fibrillation, CABG surgery or emergent PCI
- Rapid recognition of stroke symptoms in Cath Lab
- Use of the clear protocol for recognition and interventions will facilitate efficient care in the unlikely event of a stroke in Cath Lab

ACUTE KIDNEY INJURY¹ Post PCI RISK ADJUSTED^{IN-COLOR}



R4Q Risk-Adjusted O/E = 0.8

¹ Proportion of pt.'s with a rise of serum creatinine of > 50% or ≥0.3 mg/dL over the pre-procedure baseline; all pt.'s w/ New Requirement for Dialysis. Exclusions: pt.'s on dialysis pre-procedure; pt.'s second PCI within this episode of care; same day discharges. (ref: 4882)

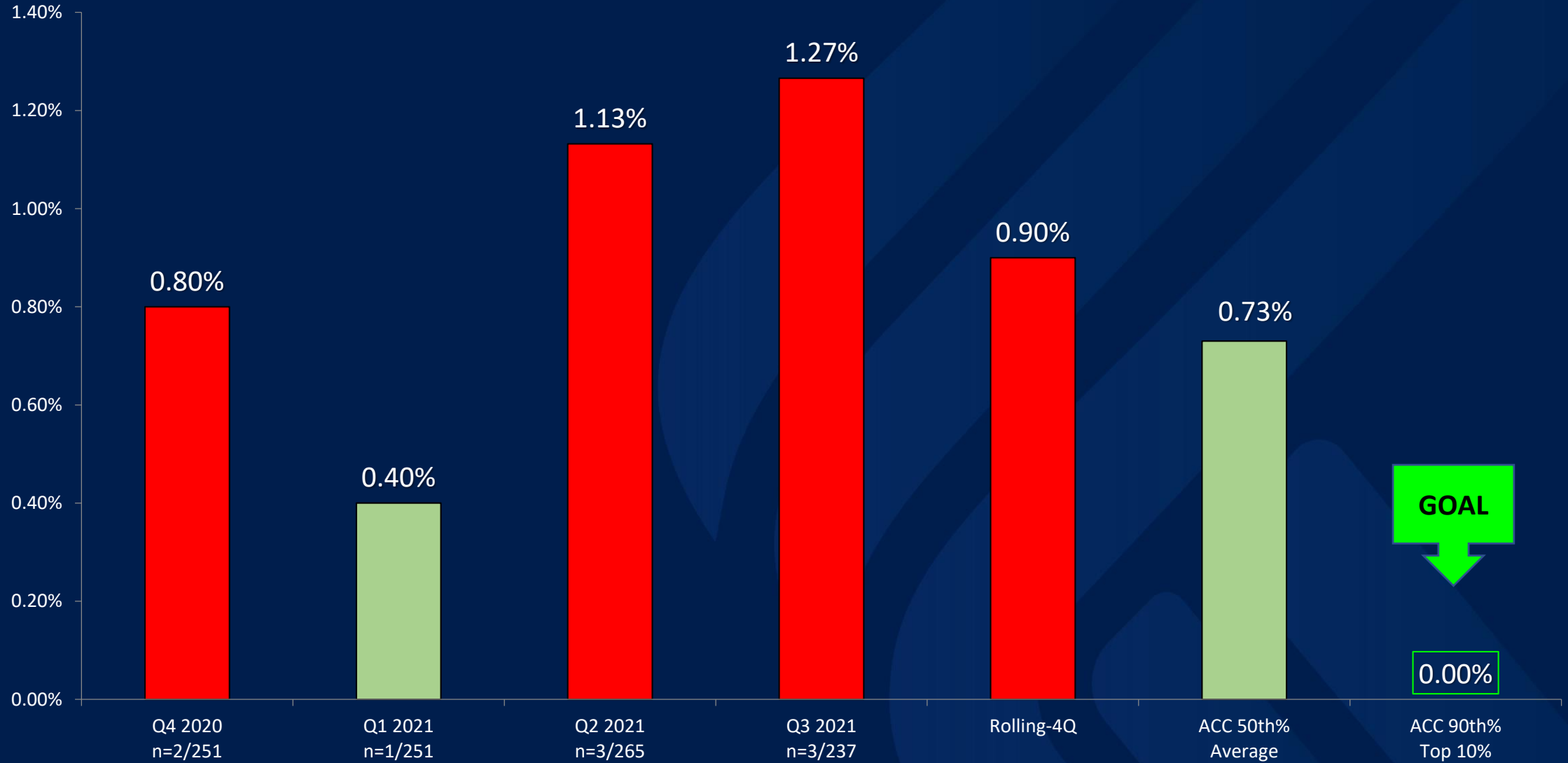
* Comparison reporting period is 10/01/20 through 09/30/21

QUALITY INITIATIVE

ACUTE KIDNEY INJURY

- Renal impairment = estimated glomerular filtration rate \leq 60mL/min
- Hydration Needs
 - Pre procedure: Normal Saline at 250 ml/hour to be started upon arrival
 - Intra procedure:
 - LVEDP $<18 \rightarrow$ NS 500 mL/hr for 4 hours
 - LVEDP $>19 \rightarrow$ NS 250 mL/hr for 4 hours
 - Post procedure: Normal Saline at 250 ml/hour for 6-24 hours
- Outpatients; increase in oral hydration encouraged the day before arrival. Patients are encouraged to drink clear liquid up to 2 hours prior to procedure
- Post procedure labs must be ordered; Metabolic panel one day post procedure
- Track and Report contrast utilization for Diagnostic and Interventional procedures

TRANSFUSION POST-PCI OF RBCs¹



R4Q O/E = 1.2

¹ Proportion of pt.'s who receive a transfusion of whole blood or RBCs during or after, but within 72 hours of PCI procedure.

Exclusions: Patients on dialysis; EP study or CABG or other major surgery during the same admission; Pt.'s with a pre-procedure hemoglobin <8g/dL or no value. (ref: 4288)

* Comparison reporting period is 10/01/20 through 09/30/21

KAWEAH HEALTH POLICY (TR-00036)

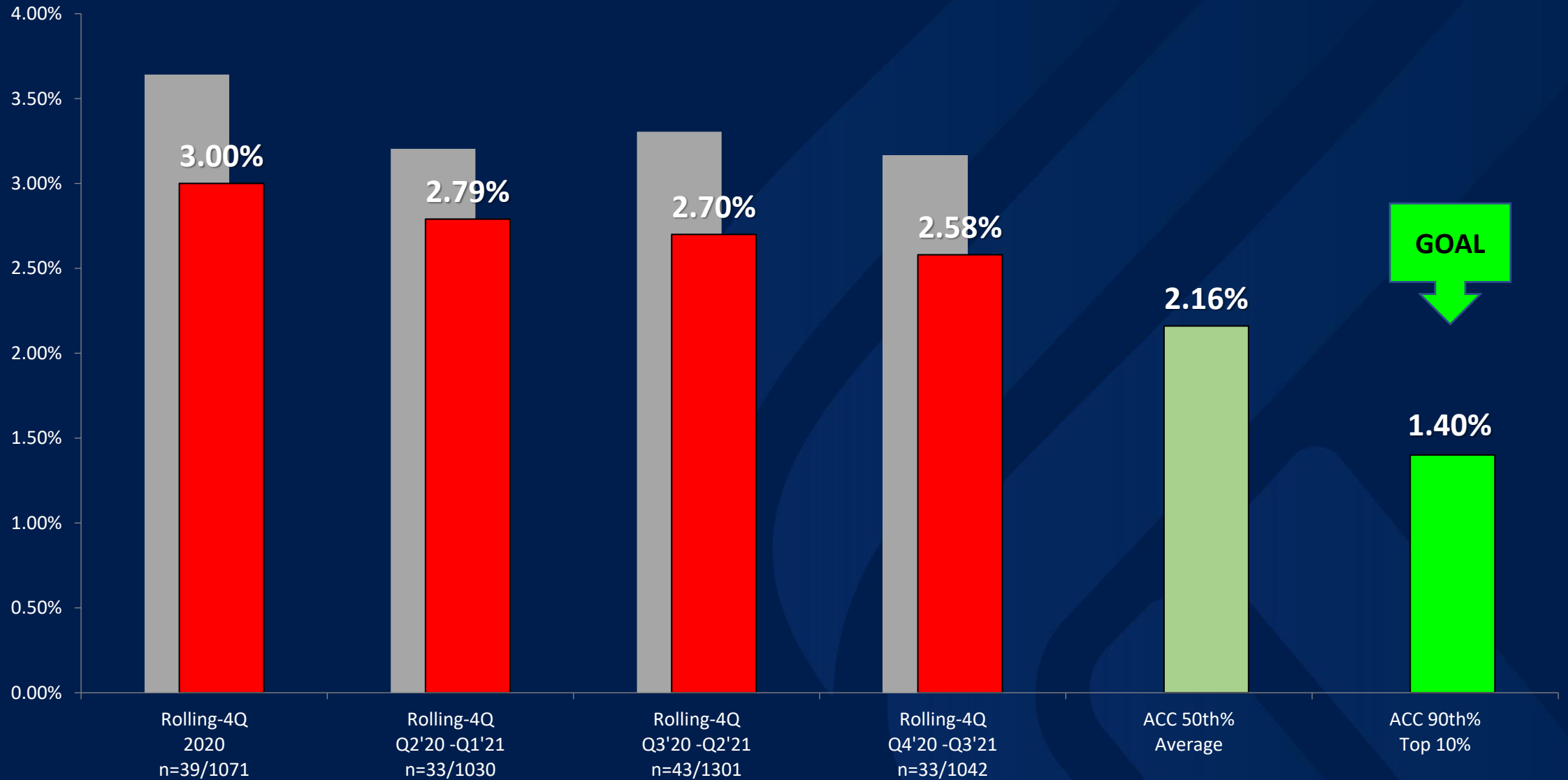
GUIDELINES FOR USAGE OF BLOOD PRODUCTS (RELEASE CRITERIA)

DATE APPROVED: 09/08/2015

- A. Pre-transfusion hematocrit of less than 24% or hemoglobin less than 8 grams/dl.

- B. Transfusion may be administered when hemoglobin levels are 8-10 grams/dl in the following circumstances:
 - 1. Acute Blood Loss/Active Bleed
 - 2. Presence of Symptomatic Anemia
 - 3. HGB <9 w/ Chemotherapy
 - 4. HGB <10 w/ Radiation Treatment

RISK STANDARDIZED BLEEDING RATE¹



R4Q Risk standardized bleeding ratio = 0.93 / R4Q O/E = 1.5 ¹ Pt's with a Bleeding event defined as 1) occurring within 72 hours of procedure (Bleeding at access site, hematoma at access site, retroperitoneal bleed, GI, GU or any transfusion) 2) occurring during hospitalization (hemorrhagic stroke, tamponade, Hgb drop ≥ 4 g/dL requiring transfusion, or a procedural intervention/surgery to reverse/stop or correct the bleeding) Exclusions: subsequent PCI procedures, death w/in 24 hours, CABG this hospitalization, transfusion in presence of mechanical support. (ref: 4934) * Comparison reporting period is 10/01/20 through 09/30/21

QUALITY INITIATIVE

BLEEDING REDUCTION PROTOCOL

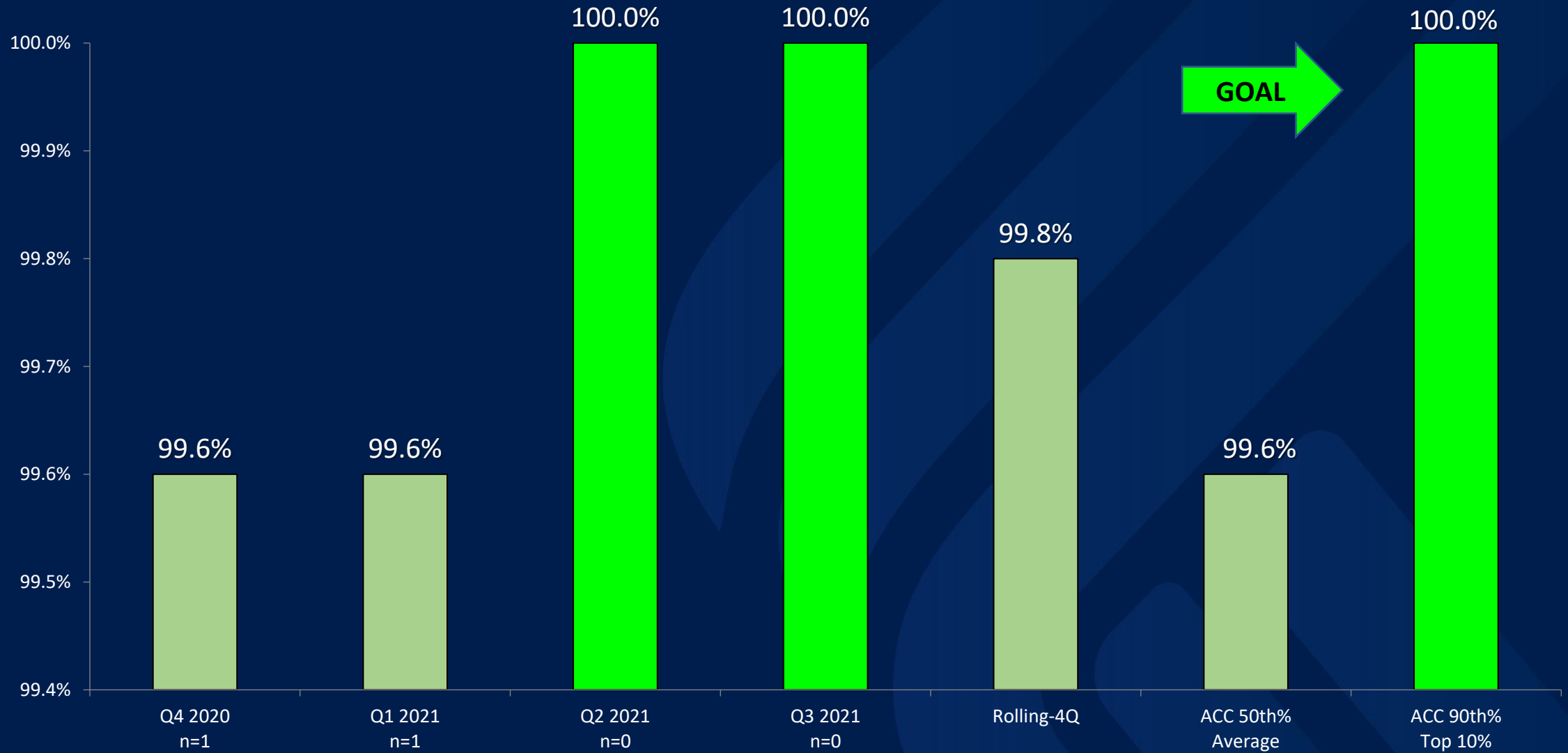
- Establish a vascular site protocol in accordance with SCAI safe femoral access guidelines
 1. Radial as Primary Access Site
 2. Use of Ultrasound Guidance for accessing the artery
 3. Use of Fluoroscopy to mark the Femoral head
 4. Micro puncture needle used as standard device
- Hemostasis Management Best Practices standardized for Post Procedure Bleeding and Sheath Removal
 - Education Program on Hemostasis Management & Early Recognition of Post-op Bleeds
 - Includes recognition of signs and symptoms of bleeding & Standardized Communications between:
 1. The procedure team and physician emphasizing the quality of the groin stick and use of sealant devices
 2. The procedure team and post-op nurse emphasizing the vascular access site assessment

QUALITY INITIATIVE

BLEEDING REDUCTION PROTOCOL (CONT.)

- Manual sheath removal
 - Hold manual pressure minimum of 20 minutes
 - Frequent vital signs and distal pulse monitoring
 - Diligent vascular access site assessment
 - Assess Patient for pain
- Vascular sealant device
 - Hold manual pressure minimum of 5 minutes
 - Frequent vital signs and distal pulse monitoring
 - Diligent vascular access site assessment
 - Assess patient for pain
- RN Education: Mandatory self study presentation (Post Study test must be completed)
 - Added to Nursing Unit Annual Competency
 - Added to core curriculum nursing education (Cardiac and CVICU units)
 - 4 Tower, 2 North, 3 West, CVICU, ICU and CVICCU.
- Post-PCI Bleed Mock Simulation performed 2/year. In the skills lab and the nurses home unit

ASA PRESCRIBED AT DC¹

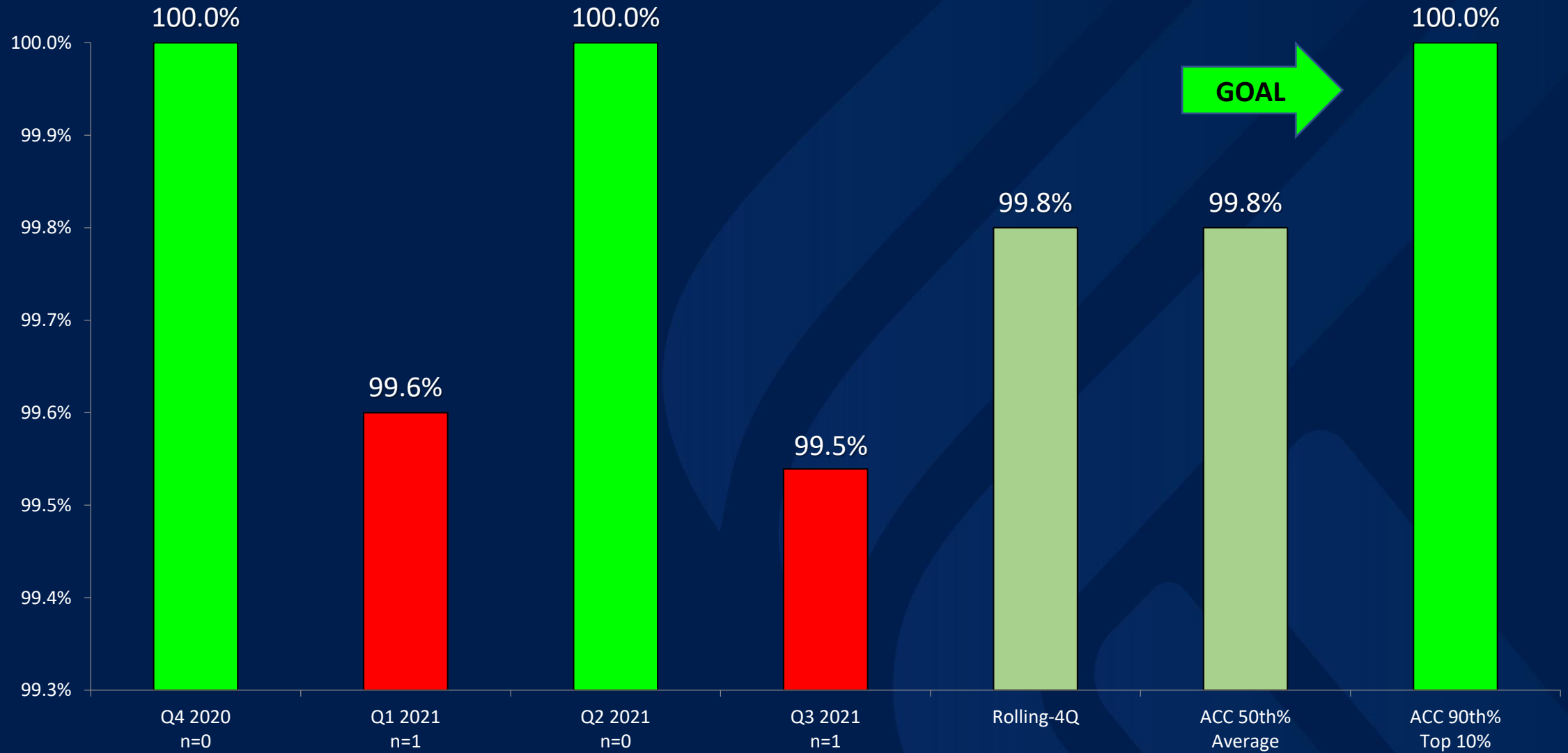


R4Q O/E = 1.0

¹ Proportion of pt.'s (without a documented contraindication) with a PCI attempted or performed that were prescribed aspirin at discharge. Exclusions: pt.'s that were discharged on Comfort Measures only; discharged to "Other acute care hospital", "Hospice", "Left against medical advice (AMA)" or deaths. (ref: 4702)

* Comparison reporting period is 10/01/20 through 09/30/21

P2Y12 INHIBITOR PRESCRIBED AT DC¹

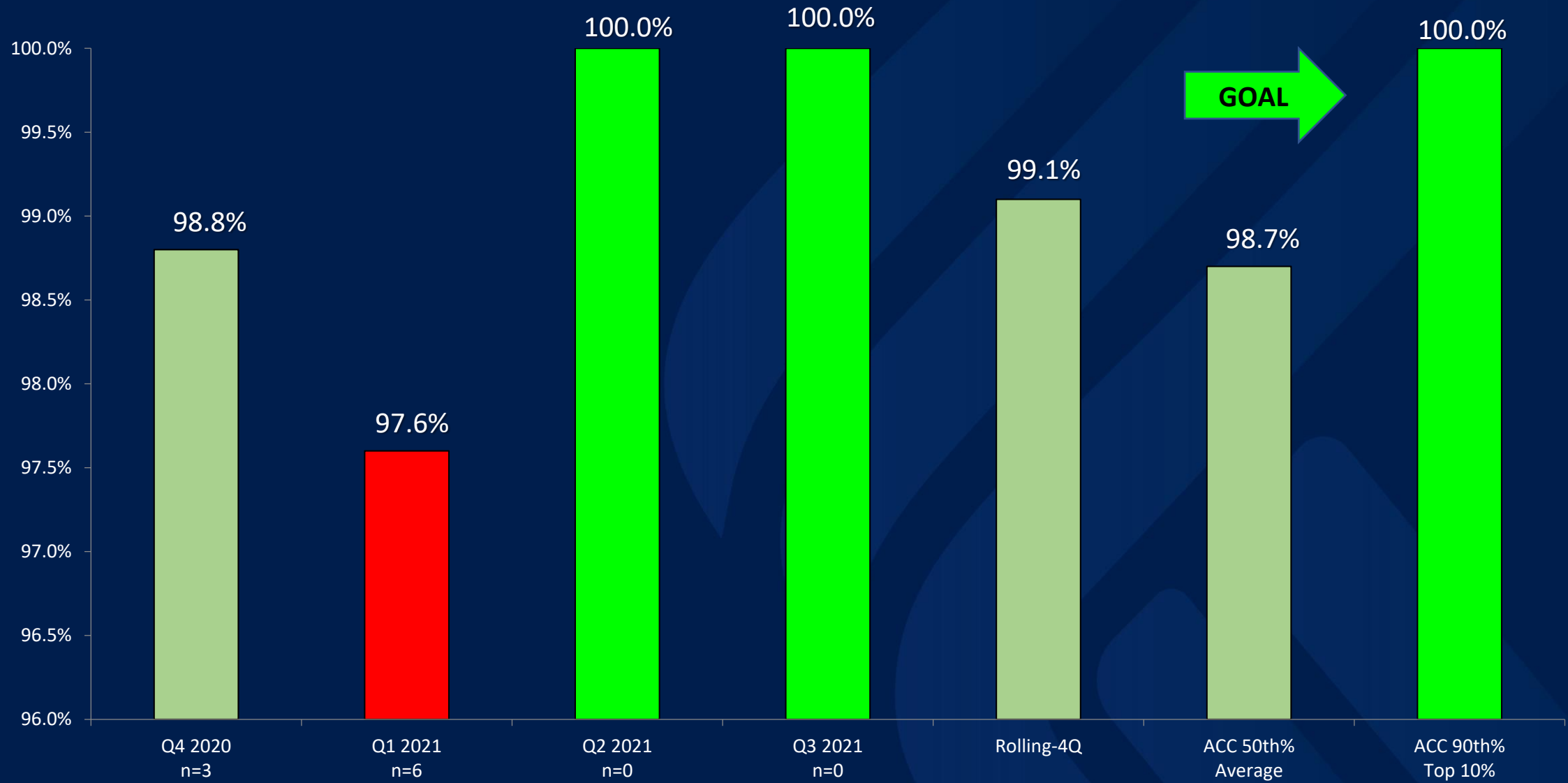


R4Q O/E = 1.0

¹ Proportion of pt.'s (without a documented contraindication) with a cardiac stent placed that were prescribed a thienopyridine/P2Y12 inhibitor at discharge. Exclusions: pt.'s that were discharged on Comfort Measures only; discharged to "Other acute care hospital", "Hospice", "Left against medical advice (AMA)" or deaths (ref: 4711)

* Comparison reporting period is 10/01/20 through 09/30/21

STATINS PRESCRIBED AT DC¹



R4Q O/E = 1.0

¹ Proportion of pt.'s (without a documented contraindication) with a PCI attempted or performed that were prescribed a statin at discharge. Exclusions: pt.'s that were discharged on Comfort Measures only; discharged to "Other acute care hospital", "Hospice", "Left against medical advice (AMA)" or deaths. (ref: 4707)

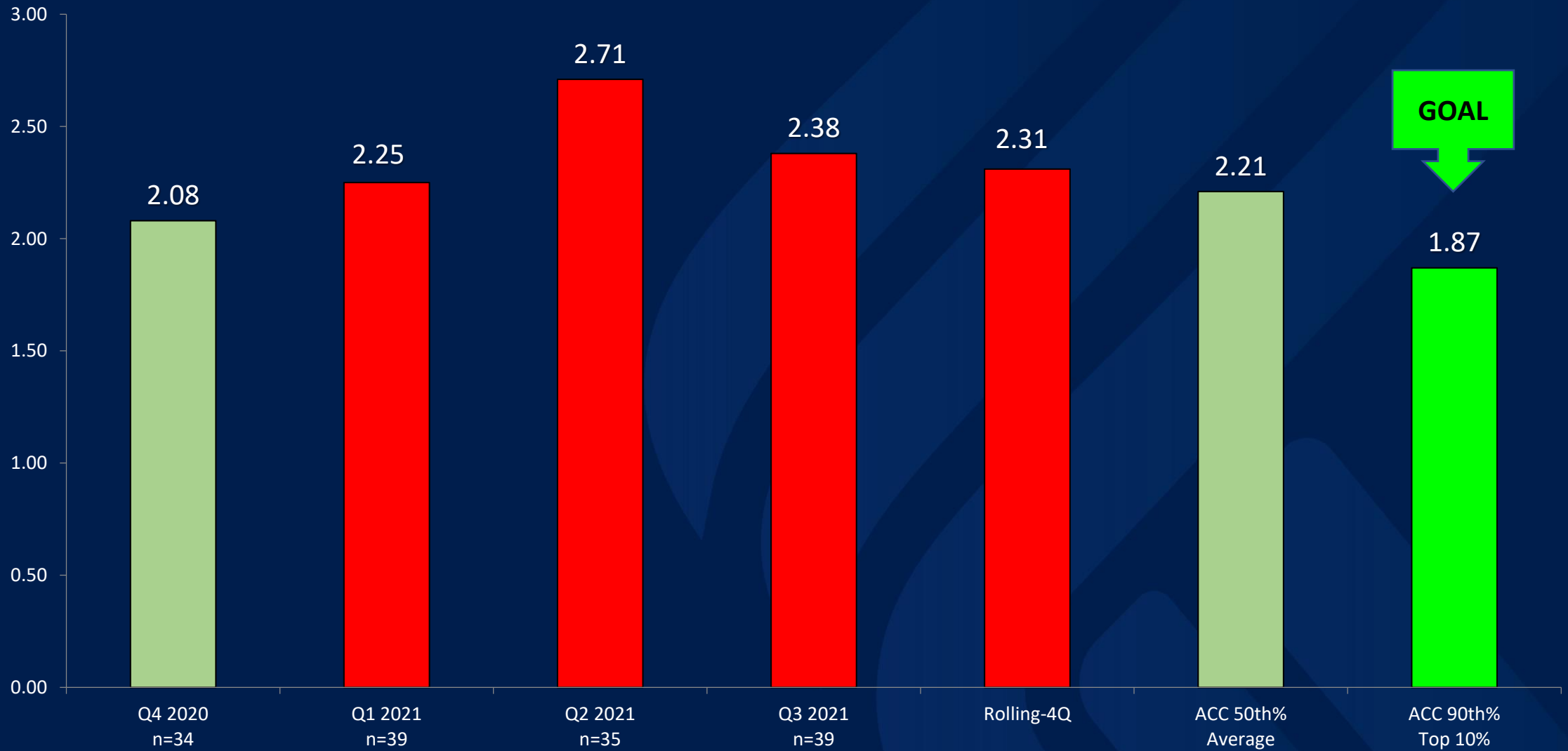
* Comparison reporting period is 10/01/20 through 09/30/21

QUALITY INITIATIVE

DISCHARGE MEDICATIONS

- Implement PCI specific Discharge Order Set
- Educate Hospitalists and Nurse Practitioners on importance of specific discharge medications in this patient population and utilization of new Order Set.
- Track utilization of Order Set & track fallouts
- Continue to contact Lead Hospitalist, Lead Nurse Practitioner with all fallout specifics
- Improve Clinical documentation in the Discharge Summary of any contraindications
- Improve Clinical documentation in the Discharge Summary clarifying any pending diagnosis (i.e. possible NSTEMI, possible MI)

POST-PCI LENGTH OF STAY¹ - STEMI



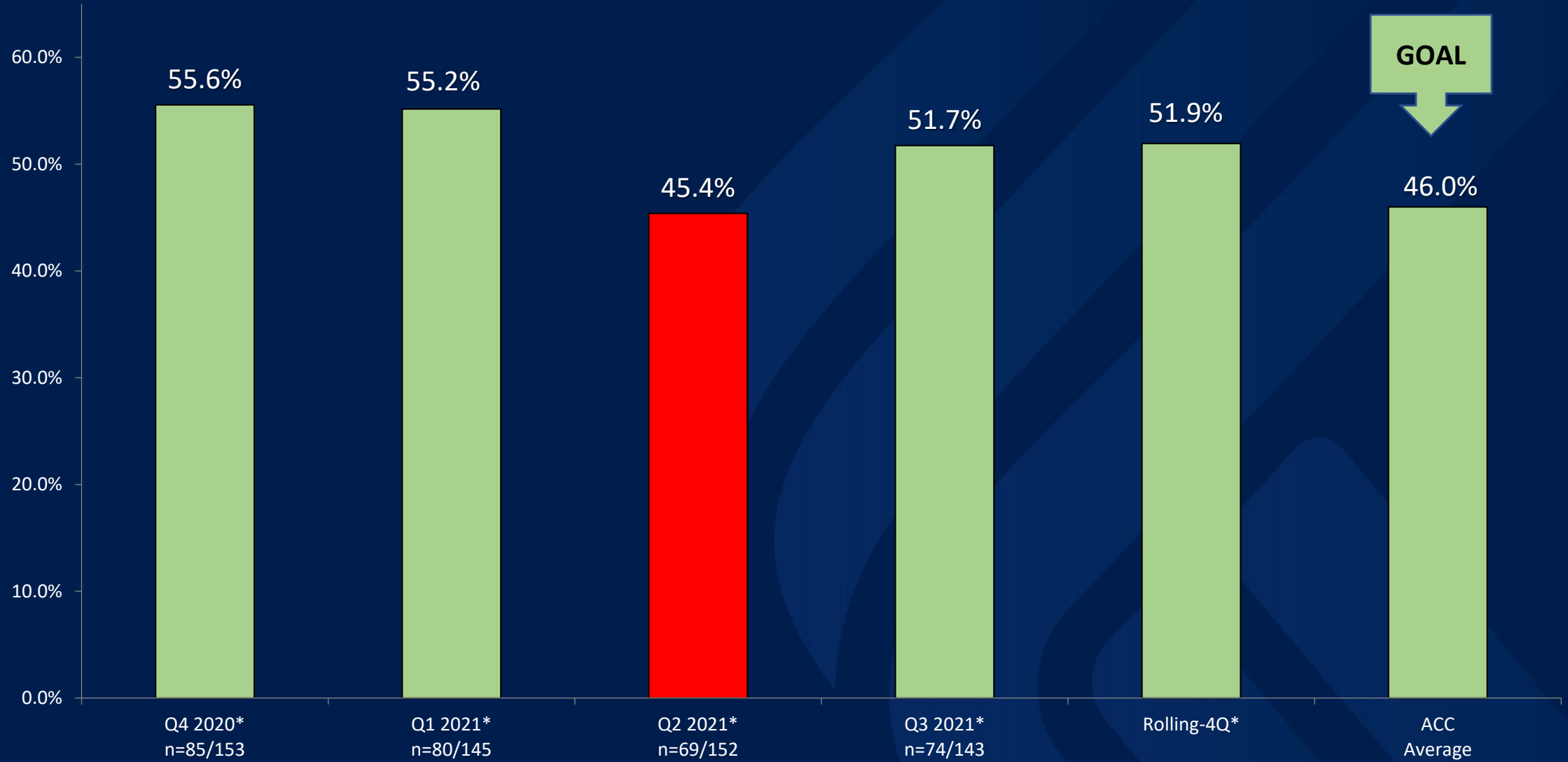
R4Q O/E = 1.0

¹ Median Post-procedure length of stay in STEMI patients. Exclusions: pt.'s discharged to Another Acute Care Facility; death during procedure (ref:4340, 10894)

* Comparison reporting period is 10/01/20 through 09/30/21

182/580

POST-PCI SAME DAY DISCHARGE - ELECTIVES



R4Q O/E = 0.9

¹ Elective scheduled patients discharged on the same day as procedure. Exclusions: mortalities and pt.'s discharged to Another Acute Care Facility or AMA (ref:4971)
When no Percentile rankings are available, US Like Volume Group R4Q Averages are used for comparison purposes.

* Comparison reporting period is 10/01/20 through 09/30/21- *RAW DATA ALL QUARTERS

Live with passion.

Health is our passion. Excellence is our focus. Compassion is our promise.





Scope of Services

Purpose

Kaweah Health offers its services to patients whose medical needs can be met within the capability of Kaweah Health's employees, medical staff and facilities.

Criteria for Entry/Admission to Service

Kaweah Health's scope of services includes general, psychiatric and rehabilitation inpatient and outpatient diagnosis and treatment as well as home health and hospice care services. All departments collaborate to provide the best care possible for our patients, to improve outcomes, and achieve our mission, vision and goals. Each individual area of Kaweah Health defines the types and ages of patients served, the hours of operation, staffing, the types of services provided, and the goals or plans to improve quality of service.

For each program or service, Kaweah Health defines the appropriate professional staff and facilities needed to provide the services in a manner consistent with Kaweah Health's mission. Additionally, Kaweah Health identifies types of patient conditions and concerns that cannot be appropriately treated at the hospital and arranges for appropriate referral and/or transfer for such patients.

Patients

The population served at Kaweah Health includes all ages regardless of national or ethnic origin, economic status, lifestyle, creed or philosophical beliefs. Patients can expect appropriate procedures, treatments, interventions and care will be provided according to established policies, procedures, protocols and order sets that have been developed to ensure patient safety and positive quality outcomes. Appropriateness of procedures, treatments, interventions, and care will be based upon patient assessments, re-assessments, and desired outcomes. Respect for patient individual needs, rights and confidentiality will be maintained.

Services

Kaweah Health is fully licensed and accredited. The hospital offers primary and specialty services; these professional services are offered in a caring and compassionate manner.

Clinical Diagnostic/Treatment Services

Adult & Pediatric Medical/Surgical services and Subspecialties

Adult Critical Care Services

Operative and Invasive Services

Anesthesia

Emergency Services

Level III Trauma Services

Diagnostic Radiology Services

- General Radiology
- MRI
- CT Scan
- Ultrasound
- Nuclear Medicine

- Mammography

Interventional Radiology
 Acute Rehabilitation Services
 Rehabilitation Services – Outpatient

- Physical Therapy
- Occupational Therapy
- Speech Therapy
- Hyperbaric and Wound Care

Respiratory Care
 Clinical Laboratory and Pathology Services
 Sleep Lab
 Cardiopulmonary Diagnostics
 Case Management/Discharge Planning
 Nutritional Services
 Pharmaceutical Services
 Home Health Services
 Home Infusion Pharmacy Services
 Hospice
 Infusion Therapy Services (outpatient)
 Chaplaincy Services
 Cardiac Cath Lab
 Cardiac Clinic Services
 Cardiovascular Surgery
 Cardiac Rehabilitation Services
 Pulmonary Rehabilitation
 Pain Management Services
 Urgent Care
 Maternal Health Services
 Neonatal Intensive Care
 Occupational Medicine
 Neurological Services
 Neurosurgical Services
 Dialysis for Inpatients and Outpatient
 Oncology Services - Inpatient and Outpatient
 Acute Mental Health Services
 Rural Health Clinics
 Subacute Services
 Urology Services

Support Services
 Administration
 Admissions
 Materials Management Services
 Employee Assistance Program
 Environmental Services
 Food Services
 Finance
 Human Resource Management
 Information Technology
 Plant, Engineering and Maintenance Services
 Employee Health Services

Health Records Information Services
Sterile Processing
Education Services
Volunteer Services
Quality Management Services
Linen Services
Patient Accounting
Physician Recruitment
Medical Staff
Risk Management
Compliance and Internal Audit
Infection Prevention
Patient and Family Services

Community Services

Community Outreach
Community Support Groups
Library Services
Population Health Management Clinic
Marketing/Public Relations
Diabetes Education
Lifestyle Center

Employees

Kaweah Health is committed to excellence in clinical practice. We recognize that people are our major resource, ever capable of growth. Professional competence and quality care are assured through the recruitment, retention and continuing education of a highly skilled employee.

Staffing plans for patient care units are evaluated to determine that the personnel can provide competent services within the scope of professional licensing and training for the appropriate level and scope of care needed. Staffing plans are department specific and available in each nursing unit.

Collaboration

Kaweah Health maintains and promotes positive relationships with the community and provides patient-centered care and services through: A mission, vision, and value statement that serves as a foundation; Strategic planning with Governance, Leadership, and Physicians; establishment of shared values that guide employee behavior; ongoing evaluation of services provided through participation in national performance improvement activities; priority focus on patient relations, their interests, needs and expectations; and establishing and coordinating programs and services with other providers, associations, public and private agencies, physicians, and insurers.

Support Services

Other hospital services will be available to ensure that direct patient care services are maintained in an uninterrupted and continuous manner by coordinated, identified organizational functions such as leadership/management, information systems, environmental services, fiscal/patient financial services, and performance improvement. These services support the comfort and safety of our patients and are fully integrated with the patient service departments of the organization.

References

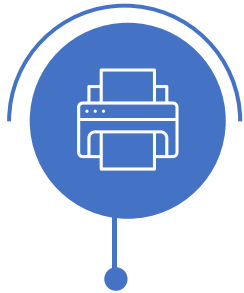
LD 01.03.01, EP3 and PC 01.01.01, EP7

Safety Culture Action Plan Update August 2022

SAFETY ATTITUDES QUESTIONNAIRE (SAQ) TIMELINE

MARCH 2021

Results from 2020/2021 SAQ survey reports disseminated to leadership



JUNE 2021

SAQ Action plans developed and received by 6/18/21



JULY - OCT 2021

SAQ role debriefs completed by 9/20/21, action plan developed QIC by 10/15/21



AUG 2021

Leaders submit worksheets to VP for employees ≤ 2.88 on annual evaluation or believed to be under-performing



2Q 2022

Pulse Survey Administered
Stress Recognition Annual training completed; Safety culture action plan by role completed



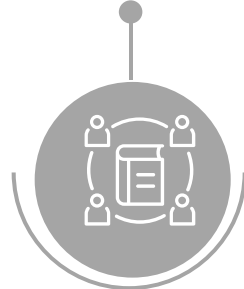
1Q 2023

SAQ Administered



APR - MAY 2021

Unit/Department SAQ results debriefed with staff
Leader Team STEPPS training
Just culture staff awareness campaign



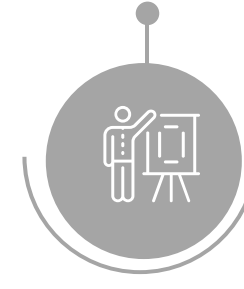
JULY 2021

SAQ Results and action plan reported to Board of Directors



JULY- DEC 2021

Event reporting and just culture education to targeted units/depts.
Revisions to select event reporting forms and acknowledgements



4Q 2021

Staff Team STEPPS simulation training (medical team training) offered ongoing

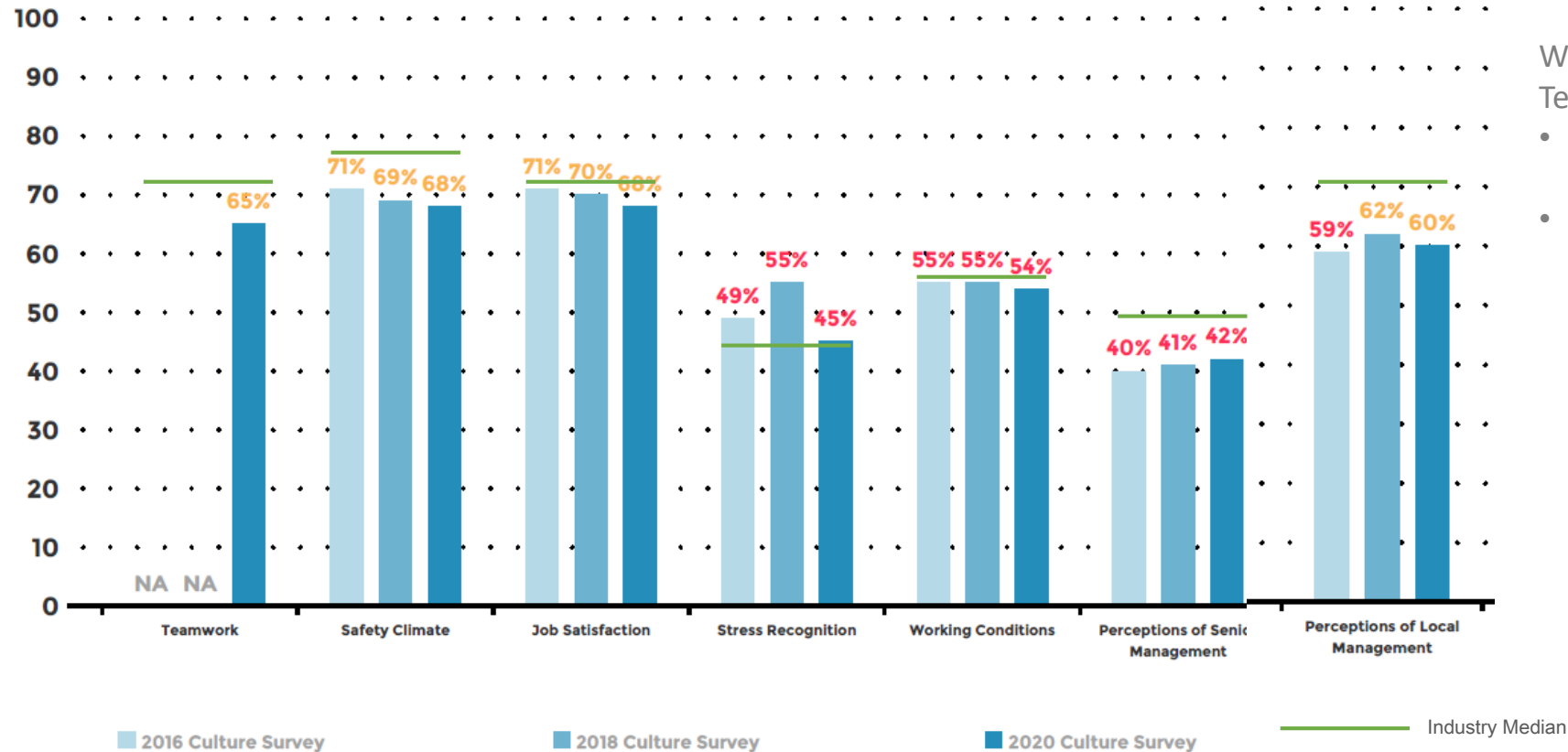


3Q 2022

Action plan update and survey results reported to Board of Directors

SAQ Results 2020/2021 - Trending by Domain

Domain Scores



Why is there no historical data in Teamwork Category?

- 2 Questions in the Teamwork Climate category changed
- An analysis was conducted by Pascal Metrics and it was determined that you cannot trend at the domain level or those specific questions when changing from one domain to the other. Therefore we cannot compare Teamwork Climate domain scores to our past survey results

What is Working Well

SAQ Results 2020/2021

Questions \geq 80% Positive Response

Domain	Question
Teamwork Climate	It's easy for personnel here to ask questions when there is something that they do not understand
Safety Climate	I know the proper channels to direct questions regarding patient safety in this work setting
	I am encouraged by others in this work setting to report any patient safety concerns I may have
	Medical errors are handled appropriately in this work setting
Job Satisfaction	I like my job
	I am proud to work in this work setting
Custom - Just Culture	When I see others doing something unsafe for patients, I speak up
	Nurses/staff support a culture of patient safety in this work setting
	When staff make clinical errors, we focus on learning rather than blaming
	The unit manager supports and leads a culture of patient safety in my work setting

Where is the Opportunity for Improvement?

SAQ Results 2020/2021

Domain	Question
Job Satisfaction	Morale in this work setting is high
Stress Recognition	I am more likely to make errors in tense or hostile situations
	Fatigue impairs my performance during emergency situations (e.g., emergency resuscitation, seizure)
Working Conditions	Problem personnel are dealt with constructively by our senior management
Custom - Just Culture	The event reporting system is easy to use
Perceptions of Senior Management	The staffing levels in this work setting are sufficient to handle the number of patients
Perceptions of Local Management	Problem personnel are dealt with constructively by our local management

2022 Pulse Survey Positive Response Rate Vs 2020/21 SAQ

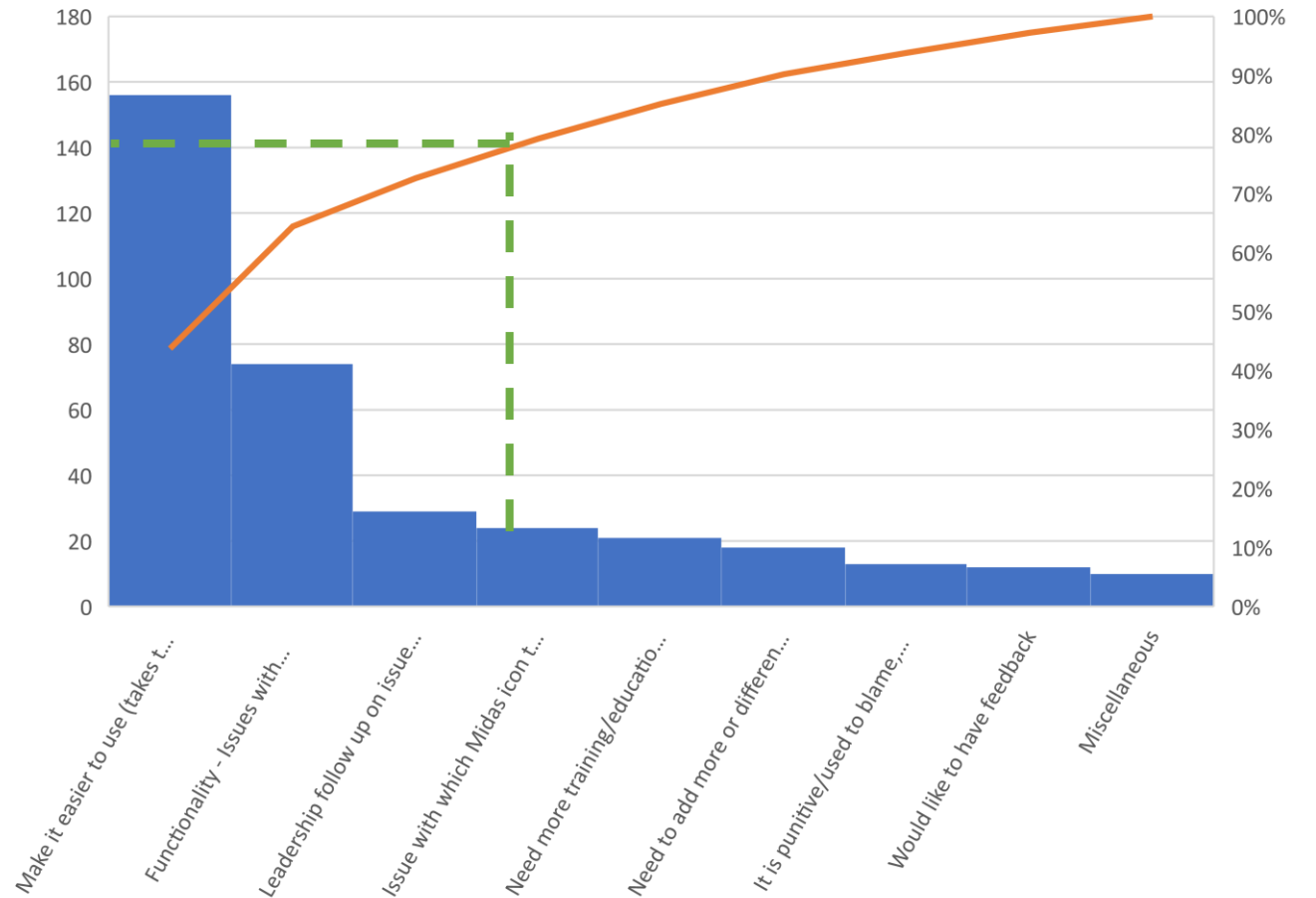
Pulse survey administered after improvement strategies implemented to evaluate effectiveness. Questions are answered on a 1-5 Likert scale. A positive response is considered a 4 “agree” or a 5 “strongly agree”

SAQ (Proprietary) Question	2020/21 SAQ	Like Pulse Survey Question	May 2022 Pulse
Fatigue impairs my performance during emergency situations (e.g., emergency resuscitation, seizure)	48%	I recognize that being mentally or physically exhausted impacts my ability to work during critical situations.	87%
I am more likely to make errors in tense or hostile situations	58%	I recognize that during high risk, high stress, complex situations I am more likely to make a mistake.	76%
Morale in this work setting is high	58%	Personnel have a good attitude and positive outlook in my work area.	74%
Problem personnel are dealt with constructively by our local management	51%	My local management (Manager and Director) deals with challenging personnel appropriately and effectively.	66%
Problem personnel are dealt with constructively by our senior management	56%	My Executive Team member deals with challenging personnel appropriately and effectively.	61%
The event reporting system is easy to use.	59%	The event reporting system is easy to use.	53%
The staffing levels in this work setting are sufficient to handle the number of patients	36%	Staffing is satisfactory for the number of patients we care for in my area.	45%

Pulse Survey Comment Analysis - "What would you change about the event reporting system?"

Comment Category	Count
	656
Make it easier to use (takes too long, too difficult, etc..)	156
Functionality - Issues with entering FIIN, empoloyee and facility (ie. outpatient) look up	74
Leadership follow up on issues/accountability	29
Issue with which Midas icon to use/icon location	24
Need more training/education on it's use/intent	21
Need to add more or different categories/event types, drop down options	18
It is punitive/used to blame, call-out others, or when there is a conflict	13
Would like to have feedback	12
Miscellaneous	10
Events are not taken seriously/pointless/waste of time/nothing ever done about issues	4

April 2022 Pulse Survey Comments: What Would you Change About the Event Reporting System? ("nothing" excluded) (n=656)



Safety Culture Summary

- Quality Improvement efforts addressed the 7 SAQ questions that resulted in less than 60% positive response from the 2020/2021 survey (see reference slides for summary of improvement actions)
- Additional improvement actions such as enhancements to team training and just culture program also in place (see reference slides for summary of improvement actions)
- Pulse survey resulted in improvement in 6/7 “like” SAQ questions indicating that improvement strategies have been effective.
- One 2022 pulse survey question did not improve from the 2020/21 SAQ “The event reporting system is easy to use”.
 - Free text question “What would you change about the Midas system” posed to pulse survey respondents to solicit insight and data to guide improvement. This is a custom question that is not part of the SAQ proprietary measurement tool, but is part of our just culture measurement strategy.
 - Free text responses grouped into categories; Pareto chart developed to guide brainstorming for improvement strategies (see previous slide)
 - **Next Steps** – Refine and develop plan to address root causes

Questions?

Reference Materials Action Plan Summary for Safety Culture Improvement

SAQ 2020/2021 Questions ≤ 60% Positive Response

Domain	Question	Analysis (solicited during staff debrief sessions)	Action Plan
Job Satisfaction	Morale in this work setting is high	<ul style="list-style-type: none"> SAQ administered in Dec 2020 to Feb 2021, SAQ results could be associated with timing of survey during COVID-19 surge SAQ Results compared to like questions in the employee engagement (EE) survey which showed several like EE questions scored higher than the matching SAQ question. Which Indicates timing of SAQ survey was a factor with low scoring results for this SAQ question (SAQ was administered during height of pandemic/staff shortages). 	<ul style="list-style-type: none"> Include a measure in the May 2022 pulse survey to evaluate results. Question “Personnel have a good attitude and positive outlook in my work area” added to pulse survey questions.
Stress Recognition	I am more likely to make errors in tense or hostile situations	<ul style="list-style-type: none"> Significant increase in SAQ Stress Recognition domain score from 2016 to 2018 due to mandatory training for all staff in SAQ departments/units approximately 4 months before 2018 SAQ administered; Training was embedded in new hire orientation only ongoing Overall 10 point drop in the 2021 Stress Recognition domain score from the 2018 survey, but above the industry median. Pascal Metrics (industry expert) indicates improvement strategies should be focused on education 	<ul style="list-style-type: none"> include Stress Recognition in Mandatory Annual Testing (MAT) in 2022; Administered 3/1/22 Evaluate effectiveness via pulse survey in May 2022 with SAQ like stress recognition questions
Stress Recognition	Fatigue impairs my performance during emergency situations (e.g., emergency resuscitation, seizure)		

SAQ 2020/2021 Questions ≤ 60% Positive Response

Domain	Question	Analysis (solicited during staff debrief sessions)	Action Plan
Working Conditions	Problem personnel are dealt with constructively by our senior management	<ul style="list-style-type: none"> Results analyzed from highest to lowest by work setting and disseminated to VP 	<ul style="list-style-type: none"> Employee Relations class targeted to leaders within chain of command, this class offering is ongoing METER committee established May 2021 which escalates egregious or trending concerns due to lack of professionalism or personnel issues. From May 2021-July 2022 5,570 events reviewed in total, 150 events escalated to Executive Team (ET). 88/150 were escalated to ET only, 10 escalated to Chief of Staff (COS) only, and 52 went to both ET and COS. Human Resources tracking employees with an evaluation score of less than 2.5% and working with the Directors and Managers to ensure improvement or appropriate next steps. Occurs each quarter (first of January, April, and July). Linked In Learning sessions “Monthly Leadership Topics” which included topics on managing difficult situations Pulse survey question in May 2022 to evaluate effectiveness

SAQ 2020/2021 Questions ≤ 60% Positive Response

Domain	Question	Analysis (solicited during staff debrief sessions)	Action Plan
Custom - Just Culture	The event reporting system is easy to use	<p>Feedback solicited during SAQ staff debrief sessions which revealed the following insight:</p> <ul style="list-style-type: none"> • Staff commented on the difficulty of selecting category type and several mandatory fields. The requirement to select a category was removed approximately 1.5 years ago, as well as several categories were removed. Many staff not aware of changes. Staff who were commented on other event forms that continue to be long (ie. falls and adverse drug events). • Staff commented they do not submit events because they don't know if anyone reads them or does anything with them • Some commented that the event reporting process feels punitive and unaware that events can be submitted anonymously 	<ul style="list-style-type: none"> • Targeted education provided to 28 units/depts through staff meetings (lowest score, high risk processes/care) completed 1Q 2022. Education objectives included: Importance of reporting and why, what and how to report, and just culture review • Stakeholder review and revision of falls and adverse drug event reporting forms completion target date • Implemented staff email thank you and acknowledgement of receipt of event report and communication of review by METER Committee (Midas Event Triage & Ranking)(Jan 2022). • Optimization of event reporting system, to include restructure of event categories and type in partnership with Cal Poly Department of Industrial and Manufacturing Engineering (target completion Oct 2022) • Evaluate effectiveness through pulse survey question “The event reporting system is easy to use” and solicit comments to help identify root causes

SAQ 2020/2021 Questions ≤ 60% Positive Response

Domain	Question	Analysis	Action Plan
Perceptions of Senior Management	The staffing levels in this work setting are sufficient to handle the number of patients	<ul style="list-style-type: none"> Analyze results with employee engagement survey results (July 2021); SAQ results could be associated with timing of survey during COVID-19 surge. Results analyzed from highest to lowest by work setting and disseminated to VP 	<ul style="list-style-type: none"> Budget planning included leader sign off, shift bonus Recruiting events, hiring in anticipation turnover, shift bonuses Student RN interns, travelers Improving efficiency for staff, for example, reducing documentation time Eliminating work that is not necessary or impactful Retention committee formed 2Q 2022 Exit and onboarding and stay pulse surveys starting 1Q 2022 Kaweah Health School of Nursing under development with Unitek Employee Huddles have addressed questions about staffing & pay Evaluate effectiveness through pulse survey in May 2022, considering additional pulse survey to determine who “problem personnel” are
Perceptions of Local Management	Problem personnel are dealt with constructively by our local management	<ul style="list-style-type: none"> Analyze results with employee engagement survey results; SAQ results could be associated with timing of survey during COVID-19 surge. Results analyzed from highest to lowest by work setting and disseminated to VP 	<ul style="list-style-type: none"> Employee Relations class targeted to leaders within chain of command; class is ongoing METER committee established May 2021 which escalates egregious or trending concerns due to lack of professionalism or personnel issues. From May 2021-July 2022 5,570 events reviewed in total, 150 events escalated to Executive Team (ET). 88/150 were escalated to ET only, 10 escalated to Chief of Staff (COS) only, and 52 went to both ET and COS. Human Resources tracking employees with an evaluation score of less than 2.5% and working with the Directors and Managers to ensure improvement or appropriate next steps. Occurs each quarter (first of January, April, and July). Linked In Learning sessions “Monthly Leadership Topics” which included topics on managing difficult situations Pulse survey May 2022 to evaluate effectiveness, considering additional pulse survey to gain insight on the identity of the “problem personnel”.

Safety Culture – Organizational Initiatives – 2021/22

Addresses SAQ Domain	Safety Culture QI Strategy
Teamwork Climate	<p>TeamSETPPS Leadership (Medical Team Training)</p> <ul style="list-style-type: none"> • 38 Kaweah leaders participated in training May & June 2021. Plan to have another cohort before the end of 2022 • Evaluation indicated the training accomplished goals: participants felt it was useful to their role/work, and learning occurred • >60 medical team tools implemented in 38 Kaweah locations/departments <p>TeamSTEPPS Staff</p> <ul style="list-style-type: none"> • All new hires in patient care roles complete CUS (I am concerned, uncomfortable, this is a safety situation) training; achieved training goals (>90% correct response rate) from 2017-2022 (2020 n=6,726). 99% of staff indicate ability to use CUS during a patient safety situation in 2022 • Broad dissemination of “Say it again, Sam” (aka 2 challenge rule) TeamSTEPPS tool, approved by Patient Safety Committee for 3Q 2021 • 1Q 2022 Staff version of TeamSTEPPS simulation training go live
<p>Perceptions of Local and Senior Management</p> <p>Safety Climate</p>	<p>Just Culture Steering Committee</p> <ul style="list-style-type: none"> • Plan for Just Culture expanded staff awareness campaign 2021-2022 to include: • GME Just Review lessons learned published • Video rolled out at staff meetings and incorporated into new employee and physician orientations • Leadership refresher training and scenario reviews • Monthly topics (LTM, staff meetings, Communication Board, Compass) • Evaluate training of new medical staff leaders and charge nurses • Incorporating JC into mandatory annual training • Pulse survey for staff to gauge effectiveness • Just Culture Champion Certificate Program – Planned for 2023 • Planned action: Charge nurse 2 hour training on Just Culture Sept-Dec 2022
Safety Climate	<ul style="list-style-type: none"> • 12 Good Catch awards (staff and providers) in 2021 • Hero of the Year awarded in 2022 • Sepsis Heroes awarded monthly (providers and RNs who provide best practice care to septic patients) • Safety Star – awarded monthly for exceptional hand hygiene compliance as noted in the BioVigil system

Safety Culture – Organizational Initiatives – 2021/22

Addresses SAQ Domain	Safety Culture BY ROLE QI Strategy
Teamwork Climate	<p>Action Plan:</p> <ul style="list-style-type: none">• Local leadership evaluate role & unit/department specific concerns; corrective action plan• Continue to reinforce TeamSTEPPS® tool “CUS” through the organization, and broadly introduce, spread and reinforce the TeamSTEPPS® 2 Challenge Rule (Kaweah Health terms this tool: “Say it again, Sam”). Say is again Sam campaign started Nov 2021.• Developing plan to incorporate job shadowing in RN orientation to gain a better understanding of ancillary roles (ie. telemonitors, lab, and transporters). In progress



September 28, 2022

**Sent Via Certified Mail
No.70201290000129798353
Return Receipt Requested**

Daniel L. Harralson, Esq.,
Law Office of Daniel L. Harralson
P.O Box 26688
Fresno, CA 93729-6688

NOTICE OF ACTION ON APPLICATION FOR LATE CLAIM RELIEF (Gov. Code sec. 911.4)

RE: Katheryn Lynne Gress, Richard David Gress, Jr, Katheryn Michelle Gress, Amy Elizabeth Gress, Christopher Aaron Gress.

NOTICE IS HEREBY GIVEN that your application, which you presented on September 2, 2022, for leave to present a claim after expiration of the time allowed by law for doing so was **denied** on September 28, 2022.

WARNING

If you wish to file a court action on this matter, you must first petition the appropriate court for an order relieving you from the provisions of Government Code 945.4 (claims presentation requirement). See Government Code Section 946.6. Your petition must be filed with the court within six (6) months after the date, set forth above, on which your application for leave to present a late claim was denied.

You may seek the advice of an attorney of your choice in connection with this matter. If you wish to consult an attorney, you should do so immediately.

Sincerely,

Mike Olmos
Secretary/Treasurer, Board of Directors

cc: Richard Salinas, Attorney at Law

Policy Number: EOC 1018	Date Created: 03/01/2008
Document Owner: Maribel Aguilar (Safety Officer/Life Safety Mgr)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration), Board of Directors (EOC/Emergency Preparedness)	
Monitoring Refrigerator and Freezer Temperatures	

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

POLICY: All refrigerators and freezers containing food and medications for patient use will have temperature ranges monitored in compliance with all laws and regulations.

PROCEDURE:

1. Refrigerator and freezer temperatures will be monitored daily and documented on the appropriate temperature chart. Exception: refrigerators/freezers containing vaccine are checked at minimum twice a day. The managers of the respective units are accountable for ensuring that all appropriate refrigerators are checked at the required frequency.
2. Normal temperature ranges are:
 - a. Refrigerators
 1. Food Temperature: 0 degrees C (32 degrees F) and 4 degrees C (40 degrees F).
 2. Medication Temperature 2 degrees C (36 degrees F) and 8 degrees C (46 degrees F).
 - b. Freezers:
 1. Food Temperature: -18 degrees C (0 degrees F) or lower.
 2. Medication Temperature: Shall be stored at less than or equal to minus (-) 20 degrees C (minus (-) 4 degrees F) Note: This definition differs from CCR section 1735.1, alternate range permitted if otherwise specified by pharmaceutical manufactures(s) for the product
3. If the temperature is not within normal range:
 - a. Record the temperature on the "Temperature Chart"
 - b. Adjust the temperature control.
 - c. Contact Maintenance.
 - d. Contact Food & Nutrition Services (FNS) to remove and dispose of all food items from the refrigerator.
 - e. A repeat temperature will be taken within 2 hours and recorded.
 1. If at the 2 hour check the temperature is IN range, nothing further needs to be done except to document the in-range temperature in the column labeled "temperature 2 hours later".
 2. If at the 2 hour check the temperature is OUT of range, document the temperature in the column labeled "temperature 2 hours later" contact maintenance for expedited service.
 - f. Contact Pharmacy to discuss alternate medication storage to be used until repairs are completed or unit is replaced and to consider disposal.
4. Document ALL corrective actions taken (e.g. adjusted temperature dial, perishable items discarded, refrigerator taken out of service, etc.) and your signature in the designated area of the form

Monitoring Refrigerator and Freezer Temperatures

2

5. Departments that are not staffed 7 days per week or that do not have a method to check daily will be equipped with a thermometer that records maximum High and Low temperatures on the days the area is closed and will otherwise follow this policy and procedure . The unit manager or designee will document the “recorded” temperatures the next business day as described below :
 - a. Record the current temperature on the temperature chart in the area that corresponds with the current day of the month.
 - b. Record the Minimum (MIN) temperature on the temperature chart on the date(s) that correspond with the date(s) the area was closed.
 - c. Record the Maximum (MAX) temperature on the temperature chart on the date(s) that correspond with the date(s) the area was closed.
 - d. Reset the thermometer by pressing the “memory clear” button located on the front of the thermometer
 - e. If the min/max temperatures for medication storage were not in the desired range on the days the unit was closed, the effected medications will be segregated, a pharmacist will be contacted, and the medications will not be used until determined by the pharmacist that they are suitable for use
6. All refrigerators in patient care areas will be cleaned as needed and at least once a week by Environmental Services.
7. If the refrigerator thermometer is broken or missing, contact the Food & Nutrition Services Department for replacement. Traceable thermometers used in medication-containing refrigerators/freezers are distributed by the Pharmacy Department.

"These guidelines, procedures, or policies herein do not represent the only medically or legally acceptable approach, but rather are presented with the recognition that acceptable approaches exist. Deviations under appropriate circumstances do not represent a breach of a medical standard of care. New knowledge, new techniques, clinical or research data, clinical experience, or clinical or bio-ethical circumstances may provide sound reasons for alternative approaches, even though they are not described in the document."

Policy Number: EOC 1085	Date Created: 04/01/2010
Document Owner: Maribel Aguilar (Safety Officer/Life Safety Mgr)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration), Board of Directors (EOC/Emergency Preparedness)	
District Electrical Safety Policy	

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

POLICY:

Kaweah Delta Health Care District, will comply with all rules and regulations of the **NFPA 70, National Electrical Code, CDPH**, and other regulatory agencies as required. Any staff member who knowingly, willfully, or negligently fails to comply with this policy will be subject to disciplinary action, up to and including termination.

All personnel will be responsible for assessing the condition of electrical equipment they use.

- A. The Clinical Engineering department will be responsible for the electrical safety inspection of all patient-care-related electrical equipment.
- B. AC powered (Class 1 Devices) devices used at Kaweah Delta Health Care District, shall have a three-pronged plug attached to the power cord of the device. The power cord of these devices will be no less than three conductors, with an integral ground wire of the appropriate size to accommodate the current load of the device. The device will be Nationally Recognized Testing Laboratories (NRTLs).

Exception:

Double Insulated (Class 2 Devices) AC powered devices that are so labeled shall not be subject to the above requirement. However, they must have a NRTL certification on the 2 wire power cord with a two-pronged plug in good condition.

- C. Personal electrical items that are brought into the District by a patient or family member of a patient, shall be governed by the rules and procedures contained in EOC Policy: EOC 6015.
- D. Personal electrical items that are brought into the District by an employee or staff member of Kaweah Delta Health Care District, shall fall under the same rules and regulations and must be approved by department management following EOC 015.

EXTENSION CORD USE:

- 1. The use of extension cords, shall be permitted for **TEMPORARY USE ONLY**.
 - a. **For a period not to exceed 24 hours.**
 - b. Extension cords shall not be covered by carpeting, clothing, furniture, or other objects that could prevent adequate air circulation and cooling of the cord.
 - c. Extension cords shall not be used in bathrooms.
 - d. Extension cords used in wet or damp areas shall be connected to a ground fault interrupter device (GFCI) circuit.
- 2. The Maintenance / Facilities Engineering department shall be responsible for the control and issuance of all Extension Cords with the following guidelines:

CONSTRUCTION OF ELECTRICAL EXTENSION CORDS:

- Will have three (3) conductors of copper.
- Will be type SO, ST, or STO. Type SH is not acceptable.
- Will be 16 gauge or larger, depending on the electrical load and length.
- Will have UL tested hospital grade, male and female caps, rated at 20 amps.

PROCEDURE:

The Facilities Engineering Department will be responsible for the storage and issuing of electrical extension cords as needed to the departments, excluding the Environmental Services.

Each department will contact the Maintenance / Facilities Engineering Department in the event of a requirement for an electrical extension cord. The department will provide the following information:

- 1. Location where extension cord is required.**
- 2. What equipment the extension cord will be used with.**

RELOCATABLE POWER TAPS (RPTs) AND POWER STRIP USE:

1. In new health care facilities or existing facilities that undergo renovation or a change in occupancy, patient care rooms and patient bed locations shall be provided with receptacles as required in Section 6.3.2.2.6 of NFPA 99-2012.
2. Power strips that are deemed unsafe by the Engineering Services, Safety, or Biomedical Engineering departments or hospital administrators will be taken out of service.
3. In the patient care vicinity, power strips may not be used to power non-patient care-related electrical equipment (e.g., personal electronics).
4. Outside the patient care vicinity, some types of power strips may be used for both patient care-related electrical equipment and non-patient-care-related electrical equipment.
5. In patient care rooms:
 - Patients and visitors are prohibited from using a personally owned EXTENSION CORD, POWER STRIP OR POWER TAP.
6. In all non-patient care rooms, power strips or relocatable power taps that are UL listed 1363A or UL60601-1 and meet NEC, NFPA, and OSHA requirements may be used.

Summary of Appropriate Use of Power Strips in Designated Areas

Power Strip Type	Patient Care Vicinity	Patient Care Room	Non-Patient Care Area
UL 60101-1 SPRPT	A	A	A
UL 1363A RPT	A	A	A
RPT	N	N	A
Power Strip	N	N	A

A = Allowed N = Not Allowed

Notes:

1. Power strips providing power to patient care-related electrical equipment in use with patients must be SPRPTs listed as UL 1363A or UL 60601-1 compliant.
2. Power strips providing power to non-patient care-related electrical equipment in patient care rooms must be RPTs listed as UL 1363A compliant.

7. Resident rooms in long-term care or other residential care facilities using line-operated patient-care-related electrical equipment in the patient care vicinity must comply with NFPA 99-2012 power strip requirements and this policy.

Definitions:

NFPA – National Fire Protection Agency (National Electrical Codes)

UL Listed – (Instead of UL Approved), certifies that the ENTIRE DEVICE meets or exceeds ALL Underwriter’s Laboratories Testing Standards for Electrical Device Safety and Manufacturing Guidelines. UL “Approved” applies SPECIFICALLY to an INDIVIDUAL component of the device itself, and does NOT meet the Electrical Safety Policy of the District.

GFCI – Ground Fault Circuit Interrupt. Describes a device or circuit that is designed to Interrupt Current should the device that is plugged into it, lose its electrical ground path due to short circuit, or similar failure. Most GFCI circuits are utilized in Wet or Surgical Areas where the possibility of electrical shock may be increased.

Daisy-Chained – Plugging TWO, or Multiple Extension Cords, or Multi-Outlet Power Strips, or Surge Protectors into each other, to form a continuous line of outlets. This creates an overload condition on the circuit that the FIRST cable is plugged into, and creates a Fire Hazard.

Ampacity is defined in Section 3.3.7 of NFPA 99-2012: *Health Care Facilities Code* as “the current, in amperes, that a conductor can carry continuously under the conditions of use without exceeding its temperature rating.”

Patient bed location is defined in Section 3.3.136 of NFPA 99-2012 as “the location of a patient sleeping bed, or the bed or procedure table of a critical care area.”

Patient care area. See *Patient care room.*

Patient-care-related electrical equipment is defined in Section 3.3.137 of NFPA 99-2012 as “electrical equipment . . .that is intended to be used for diagnostic, therapeutic, or monitoring purposes in a patient care vicinity.”

Patient care room is defined in Section 3.3.138 of NFPA 99-2012 as “any room of a health care facility wherein patients are intended to be examined or treated.” Note that this term replaces the term “patient care area” used in the 1999 edition of NFPA 99.

Patient care vicinity is defined in Section 3.3.139 of NFPA 99-2012 as “a space, within a location intended for the examination and treatment of patients [i.e., patient care room], extending 1.8 m (6 ft.) beyond the normal location of the bed, chair, table, treadmill, or other device that supports the patient during examination and treatment and extends vertically to 2.3 m (7 ft. 6 in.) above the floor.”

Power strip is a block of electrical sockets that attaches to the end of a flexible cable (typically with a grounded plug on the other end), allowing multiple electrical devices to be powered from a single electrical receptacle.

Receptacle is defined in Section 3.3.154 of NFPA 99-2012 as “a contact device installed at the outlet for the connection of an attachment plug. A single receptacle is a single contact device with no other contact device on the same yoke. A multiple receptacle is two or more contact devices on the same yoke.”

Relocatable power tap (RPT) is a power strip of the polarized or grounded type equipped with overcurrent protection and listed as in compliance with UL 1363.

Special purpose relocatable power tap (SPRPT) is a power strip of a polarized or grounded type equipped with overcurrent protection and listed as in compliance with UL 1363A or UL 60601-1 for use with medical equipment. SPRPTs come in two types: Type 1 – permanently attached to equipment assembly and Type 2 – non-mounted type.

Reference:

NFPA 93-1999 Standard for Health Care Facilities
CCR Title 22 70837 (e) Department of Health Services
National Electrical Code NFPA 99-2005, NFPA 70-2011
Life Safety 101
CMS Categorical Waiver Ref: S&C: 14-46-LSC
NFPA 70: *National Electrical Code*®
NFPA 99: *Health Care Facilities Code*
Underwriter’s Laboratories standard 1363, 1363A and 60601-1

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Policy Number: EOC 6002	Date Created: 04/01/2010
Document Owner: Maribel Aguilar (Safety Officer/Life Safety Mgr)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration), Board of Directors (EOC/Emergency Preparedness)	
Medical Equipment Defective Device Repair Policy	

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

Purpose:

To establish an effective system for the reporting, coordinating, completing, and following up on defective Electronic / Electro-mechanical Health Care devices contained in the Medical Equipment Management Program.

Definition: Corrective Maintenance

"Corrective Maintenance," shall be defined as follows: Any action, or actions, necessary to restore a defective device to a state of operation as originally designed, to eliminate any malfunction of operation from its normal condition, and to return a piece of equipment to a level of confidence by the end user of the device.

Standard:

When it is determined that a device has failed or malfunctioned, it is important that the necessary repairs are completed in a timely and cost-effective manner, so as to minimize device downtime, and ensure that service to our patients is kept at the optimum level of safety and effectiveness. The following procedures shall be followed to ensure this effectiveness.

Procedure:

1. The Defective Device Repair System shall be divided into 2 categories. The categories which a defective device falls into shall be established and followed as defined, by all departments with no exceptions.

- a. Stat / Emergency

This represents a situation of a dire state and is a safety concern to the patient, a visitor, or staff personnel of Kaweah Health. The lack of immediate corrective action in this case could cause extremely detrimental repercussions for the Hospital, and or loss of life or limb. The primary mission and service of the Hospital is affected. This type of event shall be reported by telephone to the on-call clinical engineer through the Hospital PBX Operator, for immediate contact.

This category shall be responded to IMMEDIATELY by any member of the Clinical Engineering Department, as a "First Responder Contact." Upon inspection of the device in question, the device shall be repaired immediately, or taken out of service, until such time that the device can be returned to an operationally ready state. At NO TIME shall any repairs, adjustment, calibrations, or setting changes, be attempted, or accomplished while a device is connected to a patient.

Documentation: A MIDAS occurrence Report shall be filled out completely and the proper procedure shall be followed for routing the Occurrence Report to the Risk Manager, by the reporter. If an injury or death has occurred, a Safe Medical Device Act Report shall be filed with the appropriate parties, by Risk Management and/or Clinical Engineering. The above procedures shall be followed in accordance with the existing [Safe Medical Device Act/Medical Device Tracking and Reporting Policy](#) .

b. Routine

This situation represents a corrective action, which should be taken, but by its nature does not jeopardize the primary mission or function of the Hospital in a significant way.

Devices requiring corrective actions that fall into this category shall have a "Red" Defective Equipment tag applied to them that has been COMPLETELY filled out. A Clinical Engineering work order must be submitted through Kaweah Compass. Clinical Engineering Department shall be in service of these reported devices within 72 hours.

2. The Manager of Clinical Engineering shall assign workloads to the Clinical Engineering Department personnel as necessary. A review of completed work requests shall be made to ensure completeness of the repair and that all necessary repair data has been collected and logged in the device service history. Upon completion of any repair, the technician involved shall notify the unit lead person or designee of the current repair status of the device(s). This notification may be in the form of a verbal notification, or a written note or completed work order sheet that will be left with the device indicating that all repairs have been completed and the device may be returned to service.
3. Defective devices that require the replacement of internal parts shall have all replacement part information provided in the work order. This information shall include; Part Number, Quantity Required and Date which the part was replaced.
4. A system shall be developed by the director of Clinical Engineering to track Device Downtime and Cost of repairs. Every effort shall be expended to ensure that downtime and repair costs shall be kept to an absolute minimum. A copy of the Non-Stock Requisition shall be kept by the clinical engineering department for review by the Manager of the unit responsible for the device repair showing the cost of the parts necessary to complete the repair.
5. The Manager of Clinical Engineering and designee(s), shall have written, prior authorization to sign for all repairs necessary to return the device to an Operationally Ready condition. This authorization shall be provided by the Finance Department, with approval by the CIO of Information System Services.

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Policy Number: EOC 6004	Date Created: 04/01/2010
Document Owner: Maribel Aguilar (Safety Officer Safety Mgr)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration), Board of Directors (EOC/Emergency Preparedness)	
Medical Equipment Hazardous Device and Recall Notification Policy	

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

DEFINITION:

Medical Device:

Medical devices range from simple tongue depressors and bedpans to complex programmable pacemakers with micro-chip technology and laser surgical devices. In addition, medical devices include in vitro diagnostic products, such as general purpose lab equipment, reagents, and test kits, which may include monoclonal antibody technology.

Certain electronic [radiation emitting products](#) or products with medical application and claims meet the definition of medical device. Examples include diagnostic ultrasound products, x-ray machines and medical lasers. If a product is labeled, promoted or used in a manner that meets the following definition in section 201(h) of the Federal Food Drug & Cosmetic (FD&C) Act it will be regulated by the [Food and Drug Administration \(FDA\)](#) as a medical device and is subject to premarketing and postmarketing regulatory controls.

A device is:

1. "An instrument, apparatus, implement, machine, contrivance, implant, in vitro reagent, or other similar or related article, including a component part, or accessory which is:
 - A. recognized in the official National Formulary, or the United States Pharmacopoeia, or any supplement to them,
 - B. intended for use in the diagnosis of disease or other conditions, or in the cure, mitigation, treatment, or prevention of disease, in man or other animals, or
 - C. intended to affect the structure or any function of the body of man or other animals, and which does not achieve its primary intended purposes through chemical action within or on the body of man or other animals and which is not dependent upon being metabolized for the achievement of any of its primary intended purposes."

This definition provides a clear distinction between a medical device and other FDA regulated products such as drugs.

If the primary intended use of the product is achieved through chemical action or by being metabolized by the body, the product is usually a drug.

Human drugs are regulated by FDA's [Center for Drug Evaluation and Research](#) (CDER).

Biological products which include blood and blood products, and blood banking equipment are regulated by FDA's [Center for Biologics Evaluation and Research](#) (CBER).

FDA's [Center for Veterinary Medicine](#)(CVM) regulates products used with animals.

If your product is not a medical device but regulated by another Center in the FDA, each component of the FDA has an office to assist with questions about the products they regulate.

In cases where it is not clear whether a product is a medical device there are procedures in place to use The Division of Industry and Consumer Education ([DICE](#)) [Staff Directory](#) to assist you in making a determination.

PURPOSE:

To promulgate notifications of Device Recalls and Hazardous Device Notifications from manufacturers and / or the Food and Drug Administration, a system shall be installed to provide a means of follow-up and compliance with these Recalls and Notifications. To this end, the following guidelines and procedures shall be strictly adhered to without exception.

STANDARD OF PRACTICE:

Hospitals normally receive notifications of Hazardous Devices or Device recalls through certified letters from the Device Manufacturer or the Food and Drug Administration. These notices contain the device or item identification, the problem, and any recommendations for resolution. These notices are normally directed to the Hospital Chief Executive Office, the Chair of the EOC Committee, Director of Materials Management, or other designated individuals. All such received Notifications, or Recalls shall be followed-up to their conclusion. Hard copies of all received and completed notifications will be maintained for a minimum of two (2) years. Alternative (electronic or electronic media) storage methods will also be utilized as backup methods of record storage.

PRESCRIBED ACTION:

RECALLS

1. Medical Devices that have been identified as having been recalled for whatever reason by the device manufacturer, or the Food and Drug Administration, acted upon per the recall guidelines including the immediate cessation of user and removal of the device, until such time

that the device(s) have been certified safe for use by the appropriate manufacturer or the Food and Drug Administration.

2. All Recall Notifications received by Kaweah Delta Health Care District shall be processed utilizing the processes outlined in the Flowchart attached to this policy.
3. Copies of ALL Recall notifications shall be maintained for a minimum of two (2) years and electronic media copies shall be maintained in a separate database for security and compliance purposes.
4. The individual assigned responsibility for the Recall Notification, (Or their designee), will:
 - A. Complete all steps shown on the Recall notice to its final completion
 - B. Document these steps as required on the form
 - C. Forward the completed form to Risk Management for processing
5. The Risk Management Department shall be responsible for keeping an accurate log of all incoming Recalls and Hazardous Device Notifications, and for ensuring compliance with all Hazardous Device Notifications. A log shall be maintained which lists the following information:
 - A. Date the Recall or Notification was received by the Risk Management Dept
 - B. Where the Recall or Notification was originated, (Manufacturer or FDA)
 - C. Device or Product affected
 - D. Departments or units that are affected by the Recall or Notification
 - E. Date the Recall or Notification was complied with
 - F. Any Follow-up information
6. Recalled devices that have been implanted by Physicians shall be identified and patient notification shall be coordinated through the Medical Staff office. The implanting physician shall have the option and responsibility for notifying the patient of an applicable recall.

HAZARDOUS DEVICE NOTIFICATIONS

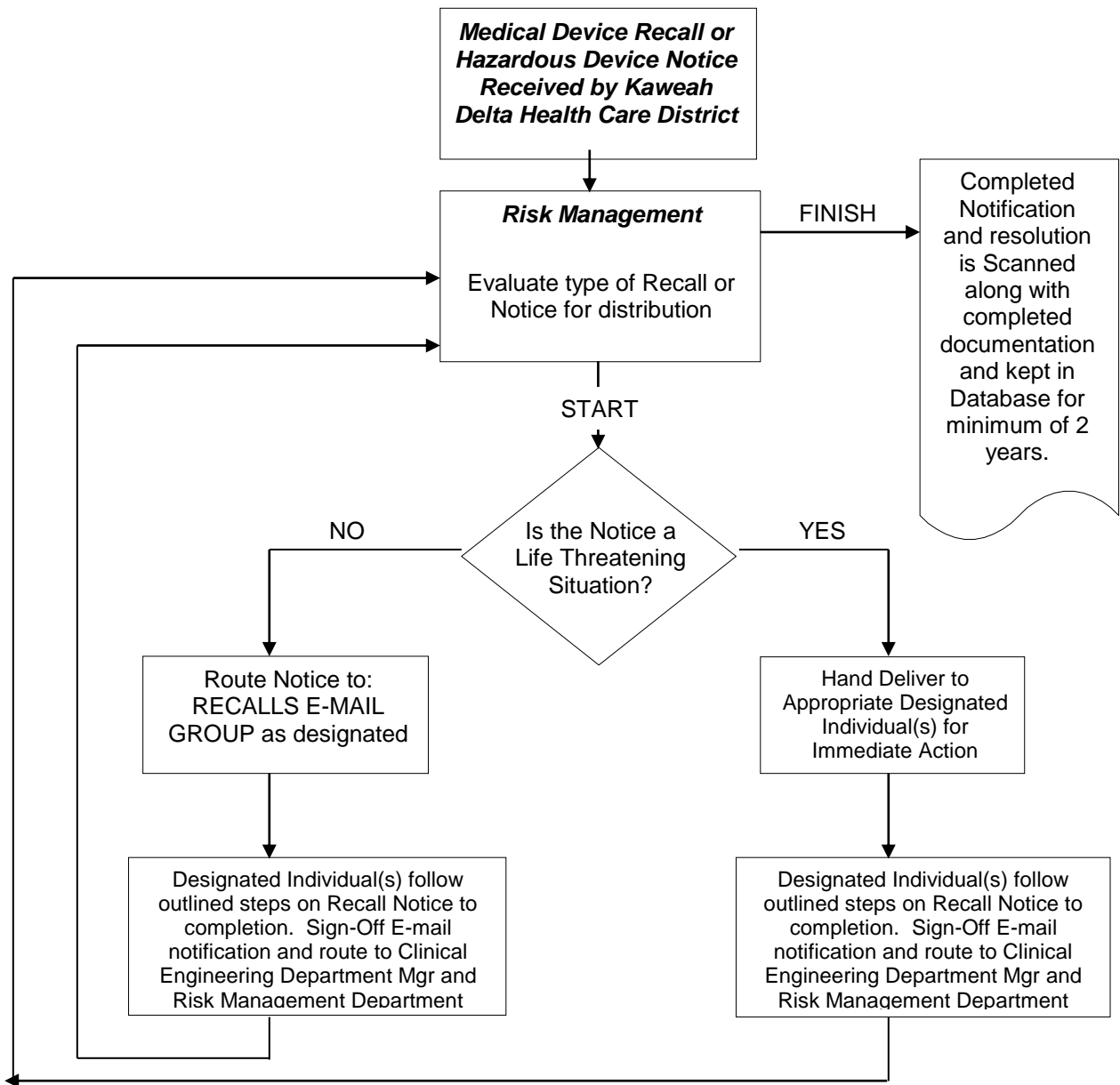
1. Copies of the Device Notification shall be provided to the appropriate individual(s) or designee, that have direct control of the suspect device(s). Risk Management, or designee, shall be responsible for the correct routing of these copies. Copies of all Notifications shall be routed to the following (Non-inclusive):
 - A. Administration
 - B. EOC Committee Chair
 - C. Risk Management
 - D. Clinical Engineering
 - E. Infection Prevention Depts. (If applicable)

- F. Central Logistics
- G. Performance Improvement
- H. Director of Quality and Patient Safety

2. The Risk Manager shall report to the EOC Committee, on a quarterly basis, the current status of any and all completed and outstanding Device Recall and Hazardous Device Notifications.

A. Documentation shall be maintained to record these reports.

3. Any follow-up action(s) necessary shall be reported to the Environment of Care Committee, or their designee:



Type of Recall/Notification	Responsible Individual
-----------------------------	------------------------

Pharmacy Products Recalls	Director of Pharmacy (Or Designee)
Laboratory Products/Devices Recalls	Director of Laboratory (Or Designee)
Dietary Products	Director of Food Services (Or Designee)
X-ray Film, Barium Products	Director of Imaging & Radiation (Or Designee)
Medical/Surgical Supplies and Equipment	Director of Material Management (or Designee)
O/T Therapy Devices or Products	Director of Rehabilitation Services (Or Designee)
Respiratory Care Products or Devices	Director of Respiratory Svc.(Or Designee)
Engineering Supplies or Equipment	Director of Facilities and Planning Services (Or Designee)
Housekeeping Supplies	Director of Environmental Services (Or Designee)
Medical Devices	Director of Clinical Engineering (Or Designee)
General Product	Director or Financial & Logistical Planning (Or Designee)
General Supplies	Director of Procurement & Logistics (Or Designee)

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Approvers: Board of Directors (Administration), Board of Directors (EOC/Emergency Preparedness)	
Retirement/Deletion of Medical Equipment From MEM Program	

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POLICY:

When a medical device is no longer a viable unit of service and has reached the end of its useful life, or if it is deemed missing after three consecutive months, it shall be retired in the Medical Equipment Inventory and a Retirement Record will be created in the Medical Equipment Data Base (MEDB) with appropriate retirement status applied to the device. This device shall not be placed back into service except under specific circumstances.

PROCEDURE:

- I. Guidelines for authorization of retiring medical equipment devices from the Inventory:
 - A. Circumstances that authorize the retiring of a device from the Active Inventory:
 1. Age
 2. Operational Condition
 3. Repair / Support Costs
 4. End of Original Equipment Manufacturer Support
 5. New Technology
 6. Lack of qualified trained personnel to operate device/system
 7. Service history marked could not locate with no other corrective maintenance records for greater than 12 months.
 - B. Circumstances that authorize the deletion of a device from Medical Equipment Inventory.
 1. End of regulatory period which requires storage of device information.
- II. The following guidelines will be strictly adhered to when retiring or deleting equipment:
 - A. Retirement of equipment:

1. The Clinical Engineering (CE) Department shall be notified, by request through the use of a clinical engineering work order, to remove the device from service by the device's owning department Unit Manager, or designee.
2. The device in question shall be removed by Clinical Engineering Staff no later than the next business week.
3. The CE Staff member shall pick up the device(s) and take it to the Clinical Engineering Department, or to a temporary holding location for processing.
4. ALL identification labels, (I.D. tags, inspection stickers, etc.), shall be removed from the device and returned to the Management of the Clinical Engineering Department.
5. The device shall be immediately removed from clinical application and physically transferred to a **SECURED** holding area.
6. The Clinical Engineering Department or Materials Management will control access to this holding area.
7. The work order will be classified as a Retirement Inspection and all notes about the devices status, condition will be recorded.
8. The device shall be classified as "RETIRED" in the MEDB along with the date of retirement retired.
9. The manager of the "Unit of Ownership" of the device will be notified of the device retirement, along with the appropriate representative of Finance.

(NOTE: ALL procedures contained herein shall be in compliance with Administrative Policy AP-86 for the Sale or Disposal of District Equipment).

The following information shall be provided:

- a. Device Type
- b. Manufacturer
- c. Model
- d. Serial
- e. Biomedical I.D. Number
- f. Hospital Asset Tag Number (When Available)
- g. Unit of ownership (Cost Center)
- h. Date of Retirement
- i. Device Disposition status (Hold for sale / trade-in, scrapped, etc)

10. Devices shall be placed in storage holding under the following guidelines, with NO exceptions:
 - a. Devices retired from service with no subsequent plans for use or reuse, shall be held in storage for not more than thirty (30 days), after which they will be sold or scrapped.
 - b. Devices retired from service for future trade-in value, shall be held in storage for not more than ninety (90) days. Vendor trade-in devices shall be accounted for by the Vendor and removed from the District within that time period.
 - c. The Clinical Engineering Department shall maintain a listing of retired devices that are placed in storage, and will ensure it is reviewed annually. Access to this listing shall be made available to all requesting department directors/managers.

11. AT NO TIME SHALL A DEVICE THAT HAS BEEN DESIGNATED AS RETIRED BE RETURNED TO ACTIVE SERVICE UNTIL INSPECTED BY A MEMBER OF THE CLINICAL ENGINEERING DEPARTMENT AND DESIGNATED AS SAFE TO PLACE INTO SERVICE.
 - a. A device that has been placed in storage under the above guidelines may be returned to active service under the following guidelines
 - I. The device shall be inspected under the Scheduled Preventive Maintenance procedure designated for the device and an electrical safety inspection shall also be performed.
 - II. The device shall have a new Biomedical ID Number (Clinical Engineering I.D. tag), affixed and that number shall be recorded into the MEDB. All prior records for this device will be appended to new ID assigned if available.
 - III. The Finance department will be notified of the activation of the device if the depreciated value of the device is in excess of \$5000.00.

B. Deletion of Equipment

1. MEM Program

- a. In conjunction with District Policies and Directives, all device histories and information, shall remain a permanent part of the MEDB for a period of seven (7) years after date of retirement. This data shall be stored digitally, and access shall be controlled through the Director of the Clinical Engineering Department.

REFERENCE: Administrative Policy AP86

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Emergency Operations Plan

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Emergency Operations Plan

Purpose

Kaweah Delta Health Care District herein after referred to as Kaweah Health (KH) is committed to providing a healthy and safe environment for our patients, visitors and employees. This plan describes a comprehensive, organization-wide Emergency Management system that addresses KH's emergency management program and ensures an effective response to a variety of disasters.

The purpose of the **Emergency Operations Plan** is to define the program that Kaweah Health to respond effectively to events that pose an immediate danger to the health and safety of patients, staff, and visitors. The Emergency Operations Plan consists of a number of procedures designed to respond to those situations most likely to disrupt the normal operations of the hospital. Each response is designed to assure availability of resources for the continuation of patient care during an emergency. *An emergency is an unexpected or sudden event that significantly disrupts the organization's ability to provide care, or the environment of care itself, or that results in a sudden, significantly changed or increased demand for KH's services.* The emergency may be natural, such as an earthquake, or human-made, or a combination of both. Inherent in the Emergency Operations Plan, whenever possible, is the intent to collaborate with partnerships within the community, and with agencies having jurisdiction, such as the local fire, police, Department of Homeland Security, and County of Tulare.

This Emergency Operations Plan (EOP) has been developed so that Kaweah Health can effectively plan for, and respond to, emergencies in six critical areas:

- Communications
- Resources and Assets
- Safety and Security
- Staff Responsibilities
- Utilities Management
- Patient Clinical and Support Activities

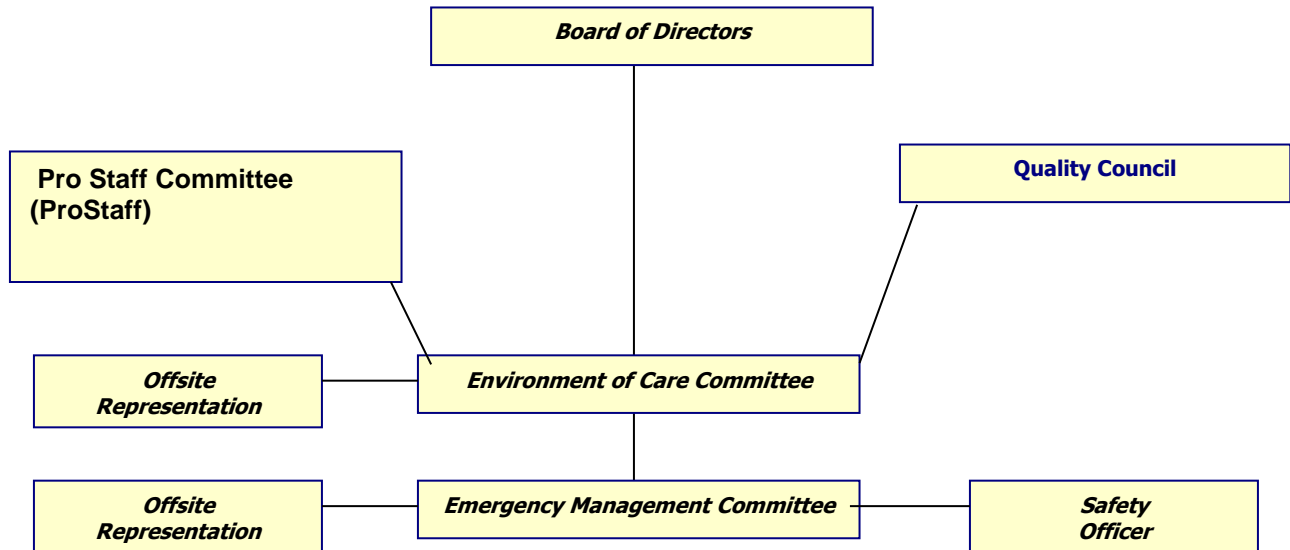
II. AUTHORITY

The authority for the establishment of an Emergency Operations Plan is with TJC EM.01.01.01. The authority for overseeing and monitoring the Emergency Operations Plan is with the Environment of Care Committee, and Emergency Management Subcommittee, Title 22, California Code of Regulations, additionally requires a written disaster plan. The Emergency Operations plan is developed at the Emergency Management Subcommittee level, and approved at the *Environment of Care* Committee. The plan is a multi-disciplinary effort of leadership within the District, including medical staff review and input.

III. ORGANIZATION

Reporting Structure: following represents how the Emergency Management program's reporting structure is organized:

**Organization – Emergency Management Reporting
Kaweah Health**



Responsibilities

1. **The Board of Directors.** The Board of Directors receives regular reports of the activities of the Emergency Operations Plan and program from the Environment of Care Committee in the form of a quarterly report. The Board of Directors also provides support to facilitate the ongoing activities of the Emergency Operations Plan.
2. **ProStaff Committee (ProStaff).** This Council receives an annual report from the Environment of Care Committee, which includes information relating to the Emergency Operations Plan, and provides assistance as needed in the development of quality indicators.
3. **Quality Management Committee:** Reviews annually reports of Emergency Preparedness, which are a part of the Environment of Care Committee report. Medical Staff serves on the Emergency Management Committee.
4. **Environment of Care Committee and Emergency Management Committee.** The Environment of Care Committee works in collaboration with the Emergency Management Committee for managing all aspects of the Emergency Operations Plan and Program.
5. **Management.** Managers are responsible for orienting new personnel to the procedures of the department and, as appropriate, to job and task specific responsibilities for emergency management.
6. **Staff.** Individual personnel are responsible for learning and following job and task specific procedures for emergency response and for participation in emergency activities as appropriate to their jobs.

IV. Objectives

The primary goal and objective of the Emergency Operations Plan is to mitigate harm to life and property due to unforeseen circumstances. The plan is intended to identify risks to the organization and balance these risks against preparedness and mitigation strategies in place and to use information relating to this risk analysis in design, planning, implementation and evaluation of the overall plan. The Emergency Operations Plan comprehensively describes the District's approach to responding to

Emergency Operations Plan

emergencies within the organization or in its community that would suddenly and significantly affect the need for the District's services, or its ability to provide those services. The plan addresses four phases of emergency management: mitigation, preparedness, response and recovery as they relate to the above six critical areas.

Broad objectives of the Emergency Operations plan include:

- Identifying and assessing vulnerabilities and hazards, which may impact on the District.
- Strategic planning for emergency response
- Effectively managing disaster supplies and resources
- Exercising critical program elements
- Providing training and assessing staff knowledge

V. Scope

The scope of this management plan applies to Kaweah Health, and any off site areas per KH license.

Each off site area is required to have a unit specific emergency plan that addresses the unique considerations of each area, including, but not limited to, initial emergency response. Offsite areas are monitored for compliance with this plan by Environment of Care committee members.

The hospital's leaders, including leaders of the medical staff, participate in planning activities prior to developing an Emergency Operations Plan.

The District's leaders participate in planning activities at the Emergency Management Subcommittee. It is at this committee level that the *Hazard Vulnerability Analysis* is conducted, drill exercises are designed and planned, education relating to drill implementation is prepared, the inventory of organizational assets is developed and monitored, and activities relating KH's Hospital Incident Command Center are developed.

All activities that emanate from the Emergency Management Subcommittee are integrated into the Emergency Operations plan, and are brought forth to the *Environment of Care* Committee.

The hospital conducts a hazard vulnerability analysis (HVA) to identify potential emergencies that could affect demand for the hospital's services or its ability to provide those services, the likelihood of those events occurring, and the consequences of those events. The findings of this analysis are documented.

At the Emergency Management Subcommittee, in a multidisciplinary forum that includes medical staff involvement, the HVA is analyzed at least on an annual basis, or whenever experiences warrant additional review. Historical experience, geographical location, weather and climate conditions, local hazards, political conditions and populations served are factored into the analysis, and balanced against the District's mitigation strategies and preparedness activities. When the HVA is completed, collaboration with the local fire department, and other governmental or municipal agencies as applicable, occur to assist in defining priorities within the HVA and to ascertain capacities to support the needs of unexpected events. The HVA process is documented, and kept on file in the Emergency Management Subcommittee and *Environment of Care* minutes. The HVA is part of the routine agenda of the Emergency Management Subcommittee to keep members apprised of the current status, and to be easily accessible in the event changes are required. The HVA is kept current for each emergency management subcommittee meeting in order to determine how changing mitigation strategies may impact identified risks.

The hospital uses its hazard vulnerability analysis as a basis for defining mitigation activities (that is, activities designed to reduce the risk of and potential damage from an emergency).

During the HVA process, mitigation strategies are defined that reduce the risk of potential damages that might occur from an emergency situation. See **ATTACHMENT A - HAZARD VULNERABILITY ANALYSIS (detailed analysis)**. The top five hazards have been identified as follows:

HVA - 2022– Top 5 Risks

Event	Rationale
Epidemic 67%	An especially severe influenza pandemic could lead to high levels of illness, death, social disruption, and economic loss.
Chemical Exposure 56%	Pesticides are widely used in our agriculture areas.
Fog 56%	Central Valley fog is very heavy and there is a history of multi-vehicle (100+) accidents on local highways.
Mass Casualty (Hazmat) 56%	Pesticides are widely used in our agriculture areas.
Patient Surge 56%	Crisis across our state has increased the last year. Patient volume continues to increase not solely related to Covid 19.

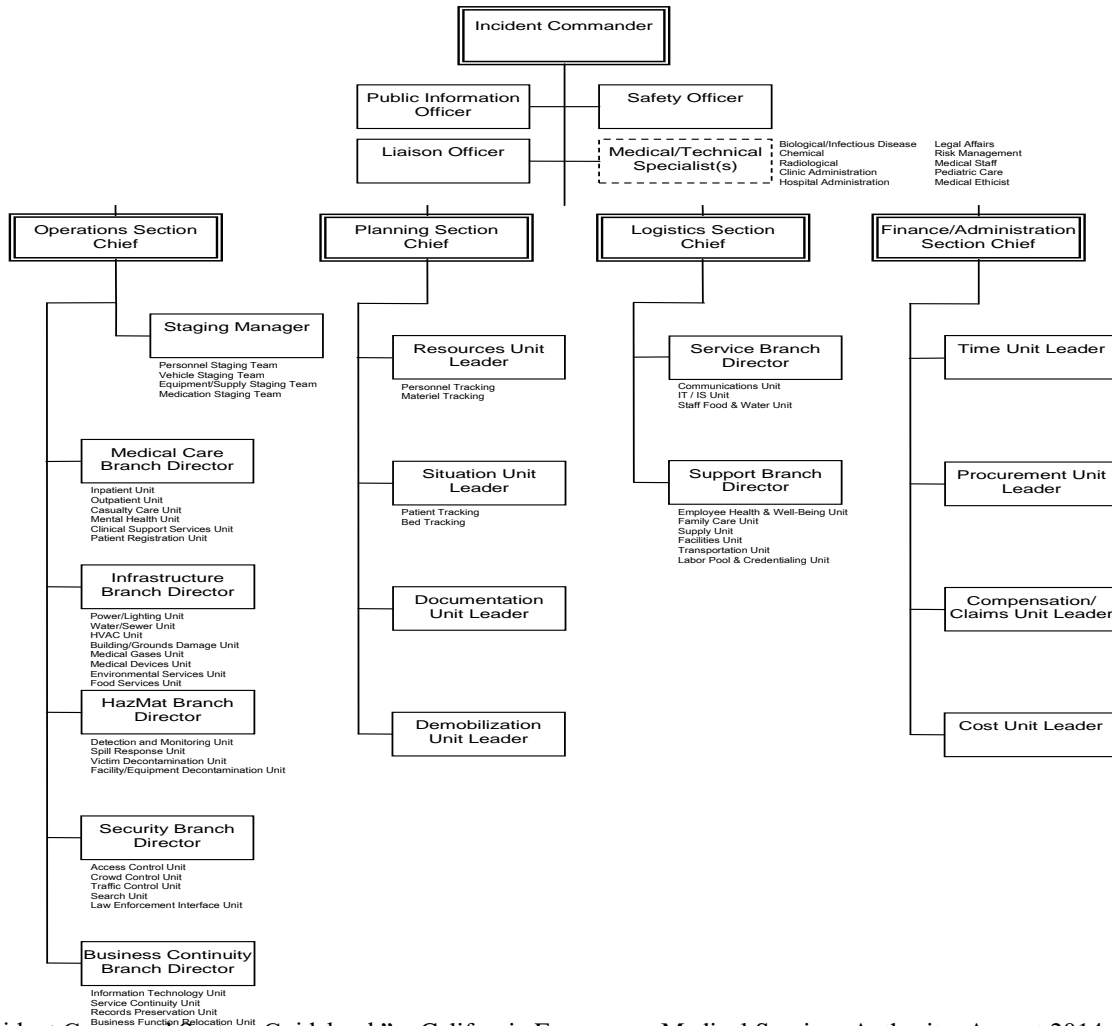
The hospital uses its hazard vulnerability analysis as a basis for defining the preparedness activities that will organize and mobilize essential resources.

The HVA is used as a planning tool in defining preparedness activities that will organize and mobilize essential resources. It is also used to determine what assets may be needed to augment emergency preparedness at KH, and what community partnerships may be invoked to strengthen response and or mitigation.

The hospital’s incident command structure is integrated into and consistent with its community’s command structure.

Kaweah Health uses the Hospital Incident Command System (HICS) as a scalable response to different types of emergencies. The District has adopted NIMS (National Incident Management System), and has integrated NIMS into pre-planning for disasters. Key personnel with the District are expected to respond to the Hospital Command Center if activated, and to assume functional responsibilities within the HICS command structure. HICS and NIMS training are required for staff that assumes leadership roles in the management of emergencies. HICS is compatible with an “all hazards approach” for the management of disasters, and is consistent with our local agencies having jurisdiction, such as the fire and police. HICS appointees are selected at the Emergency Management Subcommittee based upon parallel functions within their day-to-day job activities, and anticipated HICS response for a variety of scenarios. However, it is possible that a multiple number of employees can equally assume a HICS role due to the nature of standardized responses. For example, any member of the administrative team could be expected to assume the Incident Commander Role in the event pre-identified HICS appointees are unable to assume the Incident Commander role due to injury during a disaster or because he/she are not on site during the event. HICS education will apply to those individuals who could at any time assume a HICS role. At least annually HICS participants receive education/training relative to their role and anticipated responses during a drill or actual event. The education for HICS staff may be given “pre-drill”, with “anticipated actions” identified for the planned scenario. It should be noted that not all HICS appointees may be activated during a disaster due to the “scalability” of the command response, i.e., only those HICS positions that are essentially needed for the planned scenario or actual event should be activated. The chart below identifies how HICS is organized at Kaweah Health:

Hospital Incident Command Structure* Kaweah Health



* “Hospital Incident Command System Guidebook” – California Emergency Medical Services Authority, August 2014

The hospital keeps a documented inventory of the resources and assets it has on site that may be needed during an emergency, including, but not limited to, personal protective equipment, water, fuel, and medical, surgical and medication-related resources and assets. Kaweah Health maintains an inventory of assets and resources that are maintained on-site that could be used in the event of an emergency. The inventory includes, at a minimum, but is not necessarily limited to, the following:

- Two trailers with supplies and equipment
- Personal protective equipment
- Water
- Fuel
- Medical supplies
- Pharmaceuticals
- Food supplies

The inventory is assessed by the Emergency Management Committee on an ongoing basis. During an emergency, KH will monitor the quantities of assets and resources by using the inventory as a planning tool. The inventory will be updated daily by Materials Management, or “stakeholders” of information relating to supplies/equipment/services for the duration of the emergency, and the

Emergency Operations Plan

updated inventory communicated to the Hospital Command Center. See **ATTACHMENT B: INVENTORY OF ASSETS AND RESOURCES**.

The hospital's leaders, including leaders of the medical staff, participate in the development of the Emergency Operations Plan.

The Emergency Operations Plan is developed as an outcome of pre-planning meetings at the Emergency Management Subcommittee. As members of the Emergency Management Subcommittee medical staff leadership participate in the development of the Emergency Operations Plan. Leadership within the Hospital Command Center will make decisions in an emergency. The EOP requires the Hospital Command Center to determine what specific response procedures are needed during an emergency, including the decision to continue operations if inventory supplies are used, and it is not imminent that re-stocking will occur. Response options may include minimizing operations or closure of operations. Relocation of patients and staff to an alternate care site may be another option. The Hospital Command Center may initiate collaboration with countywide Emergency Operations as needed when planning involves a loss or diminishing supplies, or when patients may need to be moved to an alternate care site. Other response options that will be determined at the Hospital Command Center may include staged or total evacuation.

The Emergency Operations Plan identifies the hospital's capabilities and establishes response procedures for when the hospital cannot be supported by the local community in the hospital's efforts to provide communications, resources and assets, security and safety, staff, utilities or patient care for at least 96 hours.

In the event of a disaster and it is known that KH cannot be supported by the local community, an immediate assessment of the six critical areas will be initiated by the Hospital Command Center (communications, resources and assets such as food, fuel, water, linen, supplies and pharmaceuticals, staff security and utilities). The safety and security of patients will be assessed by managers and or lead personnel on every unit, and the security of the buildings will be assessed by the Security Branch Director and his appointed officers. The Infrastructure Branch Director will assess utilities, including power, HVAC, potable water and fuel. Patient clinical and support activities will be assessed when the District's infrastructure and resources are taxed. All managers will conduct bed availability and staffing needs for current patients, as well as for expected incoming patients if known. Hospital Command personnel will use the *Inventory of Organizational Assets* as a planning guide in determining resource needs and allocation, and whether or not conservation strategies will be initiated.

The hospital develops and maintains a written Emergency Operations Plan that describes the recovery strategies and actions designed to help restore the systems that are critical to providing care, treatment, and services after an emergency.

Kaweah Health has developed recovery strategies that will assist management in resumption of normal operations (**see Attachment C – "Manager's Recovery Guidelines"**). Within HICS are scenarios for various types of emergencies that include recovery guidelines, including which HICS participants are responsible for implementation.

The Emergency Operations Plan describes the processes for initiating and terminating the hospital's response and recovery phases of the emergency, including under what circumstances these phases are activated.

The individual who assumes the Incident Commander role at KH has the authority to initiate and terminate the District's response and recovery phases of the emergency. The Emergency Operations Plan is activated when an unexpected or sudden event significantly disrupts KH's ability to provide care, or that results in a sudden and increased demand for services.

The Emergency Operations Plan identifies alternative care sites for care, treatment and services that meet the needs of its patients during emergencies.

Alternate care sites have been identified as follows:

A. Alternate Care Site #1: Emergency Department Parking Lot (Tents)

Emergency Operations Plan

- B. Alternate Care Site #2: Kaweah Health Rehab Hospital
Phone number: 559-624-3700
- C. Alternate Care Site #3: Kaweah Health Mental Health
Phone: 559-624-3322
- D. Alternate Care Site #4: Kaweah Health South Campus
Phone: 559-624-6204

If the hospital experiences an actual emergency, the hospital implements its response procedures related to care, treatment and services for its patients.

In the event of an actual emergency, Kaweah Health is prepared to respond using HICS to manage the event, which includes oversight of activities relating to the care, treatment and services for our patients. Activities relating to emergency management may include the establishment of a triage and/or decontamination area, deployment of staff, allocation of resources and equipment, monitoring of supplies and actions taken, and documentation of the event, if possible. Through the hazard vulnerability process, the KH is poised to respond to emergencies, fully activating HICS, which is scalable to the event.

Crisis standards of care guidelines can be used for disaster situations when district healthcare resources are overwhelmed during a declared Code Triage. The decision to initiate Crisis Standards of Care will only be implemented on the order of the Incident Commander. When Crisis Standards of Care are initiated; district policies may be temporarily suspended in order to provide the best possible care for the greatest number of patients when district resources are overwhelmed during disaster situations.

As part of its Emergency Operations Plan, the organization prepares for how it will communicate during emergencies.

Communications

How staff will be notified that emergency response procedures have been initiated.

When the Emergency Operations Plan is activated, the Command Center will establish mechanisms for initial and ongoing communication with staff. The type of emergency will determine the specific modes of communication. Various types of communications available are: District telephone systems, Cisco phones, two-way radios, cellular phones, electronic mail, fax, and runners. Key members of the Hospital Command Center, who have assumed a HICS role, will be notified upon activation of the Emergency Operations Plan. KH leadership will be notified via the X matters web based messaging system. HICS staff ordinarily reports to the Hospital Command Center (HCC) for an initial briefing regarding the nature of the emergent event. At this time the scope of the event and its anticipated impact on the organization is determined, as well as the need for the activation of other HICS personnel.

Notification of staff in various departments will be managed by the following: overhead page (main hospital, telephone (Digital Display on all Cisco phones), e-mail and runner. Off site areas: Telephone Display on all Cisco phones, areas without Cisco phones will be notified by call tree, two way radios, email, and fax.

Staff not on duty at the time of the emergency are notified (if necessary) through activation of department / unit call- back procedures. Other ways to notify staff are as follows:

1. The Communications Unit Leader will set up a message phone for incoming employee calls and broadcast this through local radio and television networks.

2. Staff should monitor the Emergency Alert System/Network. Notice to return to work may be announced over this radio service. It is the responsibility of the Communications Unit Leader to notify the Emergency Alert System of any facility needs and information.

3. Local Radio stations: the local radio stations have agreed to broadcast hospital

Emergency Operations Plan

information for employees. The Public Information Officer will take responsibility for notifying the radio stations and compiling the information to be broadcast. Employees and physicians can monitor the following station:

Emergency Alert System (EAS) Network: KMJ – 580

The Hospital Command Center, throughout the duration of the emergency, will keep key response leaders apprised regarding the status of the emergency, the status of the organization, and any anticipated needs during the upcoming twenty-four hour period. Information will be provided to staff, from the Hospital Command Center, through various venues: by overhead page, e-mail, and through communication with managers and supervisors. Fax may be used for physicians.

How the hospital will communicate information and instruction and instruction to its staff and licensed independent practitioners during an emergency.

Staff in various departments and care areas on duty at the time of the emergency will be notified as follows, depending upon capability:

- By overhead page
- By telephone and or FAX if operating
- By email
- By runner
- By hand-held radios
- By combination of the above

Licensed Independent Practitioners who are within KH premises will be notified as above.

Licensed Independent Practitioners who may be in their private offices will be notified by telephone, by fax (if operating), by runners if they are located in close proximity to KH. The Public Information Officer will also be making announcements for Licensed Independent Practitioners through radio and television media.

Staff not on duty at the time of the emergency are notified (if necessary) through activation of department /unit call-back procedures. If phone service is disrupted, the following will be considered:

- Notify staff through public service announcements on local television and radio (e.g., KMJ through the Public Information Officer)
- Notify staff through announcements placed on the District's website and social media sites.

How the hospital will notify external authorities that the emergency response measures have been initiated.

Communication with various external authorities may occur as follows:

Government Notification

The Hospital Incident Commander will confirm with the declaring authority whether the hospital is on ACTIVATION status. The Medical Health Operational Area Coordinator (MHOAC) will be notified by the Liaison Officer the status of the District.

Tulare County OES (Office of Emergency Services) Disaster and Mass Casualty Notification

The District will activate communication with the County OES Duty Officer by way of telephone (624-7499),

Email, and message services. Notifications may be activated for the following reasons:

- 1) Sharing of facilities for referral of casualties
- 2) Sharing of equipment and supplies
- 3) Supplementing, as needed, physicians, personnel and volunteers
- 4) Sharing transportation vehicles with personnel

How the hospital will communicate with external authorities during an emergency.

The District will activate communication with the external authorities by way of telephone, Emergency Department EMS Radio system, Satellite phone, message services and Status-Net. If Status-Net is utilized, communications will be handled by a Mobile

Emergency Operations Plan

Intensive Care Nurse (MICN) A MICN is an Emergency Department RN that is certified by the Central California Emergency Medical Services Agency. They receive specialized training in emergency communications including use of the Status-Net system.

How the hospital will communicate with patients and their families, including how it will notify families when patients are relocated to alternate care sites

Patient Care providers will communicate with patients using routine methods, such as verbal, and though call light response. The PIO will establish processes to communicate pertinent information to patients and their families – including when patients are relocated to an alternative care site. Consistent with law and regulation and surrounding confidentiality of patient information, families may be apprised of the following:

- Verification that the patient is at the organization
- The general condition of the patient
- If the patient is going to be moved to an alternate care site, then the name, address, and specific care area of that site, as well as the anticipated timeframe for relocation.

How the hospital will communicate with the community or the media during an emergency

The Command Center will establish a Public Information Center for providing timely and accurate information to the public during a crisis or emergency situation. During an event, the Public Information Officer (PIO) will handle:

- Media and public inquiries;
- Emergency public information and
- Rumor monitoring and response;
- Media monitoring; and

Other functions required for coordinating, clearing with appropriate authorities, and disseminating accurate and timely information related to the incident, particularly regarding information on public health, safety and protection, and patient care and management issues. All media and community inquiries will be managed through the PIO. The effective use of the media to convey information during and following an incident is critical. The information provided to the public must include direction on what actions should and should not be taken, along with appropriate details about the incident and the actions being taken by the District. The PIO will work closely with the PIO at other community response agencies so that any contradictory or confusing messages coming from different sources can be avoided.

How the hospital will communicate with purveyors of essential supplies, services and equipment during and emergency.

The Logistics Section Chief and Operations Section Chief of the HICS Command Center will work collaboratively to assure that there is appropriate communication with vendors that may provide essential supplies, services, and equipment once emergency measures are initiated. Memorandums of understanding (MOU) may be invoked with key vendors to assure priority delivery and service to the organization during an emergency. For each vendor, the District has defined:

- Vendor contact information
- The type of critical supplies, equipment, and/or service that will be provided during an emergency

[See Vendor List Page 12](#)

How the hospital will communicate with other healthcare organizations in its contiguous geographic area regarding the essential elements of their respective command structures, including the names and roles of individuals in their command structure and their command structure telephone numbers.

The Hospital Command Center will use normal methods of communication, e.g., phones (landlines and cellular), and email to communicate with other healthcare organizations, providing these services have not been interrupted. If communications have been interrupted, the Hospital Command Center will

Emergency Operations Plan

communicate to other healthcare facilities in our geographic area by Status Net through the County. At a minimum the following may be communicated to and from these healthcare organizations:

- Essential elements of the command structures and control centers for emergency responses
- Names and roles of individual(s) in their command structures and the telephone number of their command center.
- Resources and assets that could potentially be shared in an emergency response.
- If requested, and if in accordance with law and regulation, the names of patients and deceased individuals brought to the organization.

Names and individuals in other Hospital Command Centers are as follows:

Name of Hospital	Name of Emergency Coordinator	Number and email of Emergency Coordinator	Number of Hospital Command Center
Sierra View Hospital	David Wittington	559-788-6008 dwhittington@sierra-view.com	559-791-3730
St. Agnes Hospital, Fresno	Joseph Lopez Jami De Santiago	(559) 450-3721 559-450-2475 Joseph.lopez001@samc.com Jami.desantiago@samc.com	559-450-2475
Veterans Administration Hospital - Fresno	Fred Rodarte	559-225-6100 x5331 fred.rodarte@va.gov	
Kaiser Permanente Fresno Medical Center	Jaime E. Sutton	559-320-6230 Jamie.e.sutton@kp.org	559-448-2257
-Valley Children's Hospital	Ashely Ave	559-353-6227 aave@valleychildrens.org	559-353-8680
Community Regional Medical Center-Fresno	Aaron Dwoskin	559-231-7717	559-353-8680
Fresno Surgical Hospital	Julie Gresham	559-447-7316	559-431-8000
Madera Community Hospital	Nick Noland	559-675-5521 nnolan@maderahospital.org	559-675-5555
Adventist Health Tulare	Ryan Essepien Claudia Razo	essepiR@ah.org razomc@ah.org	559-240-2706 559-309-5190

How the hospital will communicate with other healthcare organizations in its contiguous geographic area regarding the sources and assets that could be shared in an emergency response. Kaweah Health will communicate with the above healthcare organizations through landline, and or email with respect to the sharing of resources and assets; however, if communications have failed, the Liaison Officer will communicate through Emergency cell phones or satellite phone, using the County to facilitate communications between hospitals. Runners may be used as a last resort, if they are able to use their vehicles.

How the hospital will communicate the names of patients and the deceased with other healthcare organizations in its contiguous geographic area. Kaweah Health will communicate the names of the patients and the deceased with other healthcare organizations in its contiguous geographic area through normal communication channels if operational, only with an individual designated to be the Public Information Officer (PIO). If normal communications are not operating, the Liaison Officer, in coordination with the PIO, will transfer information to the County through emergency cell phones, or satellite phone (including agencies having jurisdiction, such as the police and fire).

How and under what circumstances, the hospital will communicate information about patients to third parties (such as other healthcare organizations, the state health department, police and the FBI) The Public Information Officer will establish a plan to communicate pertinent patient information to third parties – including when patients are relocated to an alternative care site. Every attempt will be made to remain consistent with law

Emergency Operations Plan

and regulation surrounding patient confidentiality. The Public Information plan to communicate patient information will include minimally the following:

- Verification that the patient is at the medical center.
- The general condition of the patient
- If the patient is going to be moved to an alternate care site, including the name, address, and specific care area of that site, as well as the anticipated timeframe for relocation.

The emergency operations plan describes the following: How the hospital will communicate with identified alternate care sites.

Depending on the nature, scope, and duration of the emergency, the Hospital Command Center will establish periodic communication with designated alternate care sites. The first choice of communication will be landline, cellular phone and e-mail. If these forms of communication are disrupted, runners will be dispatched from the Labor Pool to send and retrieve information if it is safe to do so. The purpose of communication will be to:

- Apprise alternate care sites as to the status of the organization, its operational capability, and the anticipated need for assistance.
- Determine the status of the alternate care site(s), their operational capability, and their ability to receive patients should it become necessary.

The hospital establishes backup systems and technologies for the communication activities Kaweah Health has established the following as back-up communications in the event normal lines of communication are inoperable:

- Hand-held radios and satellite phones are available for internal communication between the Command Center and key patient care and other areas throughout the District.
- Runners can be dispatched from the Labor Pool to transmit information
- Cellular phones and satellite phones can be used for communication with external agencies.
- Radio communication between the Emergency Department and the EMS agency through the Emergency Department EMS Radio system
- Email and Internet capability is available in all sites of care.

The hospital implements the components of its emergency operations plan that require advance preparation to support communications during an emergency.

Through various activities, KH participates in advance preparation to support communications during an emergency. These include, but are not limited to:

- Maintenance of communication equipment (e.g., hand-held radios, Satellite phones)
- Practice with alternate communications during drill exercises (e.g., hand-held radios, HAM radio, activation of runners)
- Practice with downtime procedures relative to email and internet capabilities (e.g., during routine service repairs and or equipment maintenance, electrical shut-downs)

AS PART OF ITS COMMUNICATION PLAN, KH MAINTAINS THE NAMES AND CONTACT INFORMATION OF THE FOLLOWING

Staff, physicians and other licensed practitioners, other hospitals and critical access hospital volunteers, entities providing services under arrangement, relevant federal, state, tribal, regional, and local emergency preparedness staff, other sources of assistance. The district, in the Incident Command Center, hold a listing pertinent phone numbers for disaster events.

The hospital operations plan describes the following: Process for communicating information about the general condition and location of patients under the organization's care to public and private entities assisting with disaster

Kaweah Health will activate communication with external authorities by way of telephone and via fax if required. If systems are compromised runners will be assigned to assist in such communication.

Process in the event of an evacuation to release patient information to family, patient representative, or others responsible for the care of the patient.

Emergency Operations Plan

The PIO will establish a process to communicate pertinent information to patients and their families. During evacuation, the hospital command center will appoint an individual from each floor to gather patient information and have available for family or patient representative.

The hospital maintains documentation of completed and attempted contact with the local, state, tribal, regional, and federal emergency preparedness officials in its service area.

Kaweah Health participated on a quarterly basis in planning meetings with Tulare County Public Health Emergency Preparedness program and with Central California Healthcare Coalition.

The Emergency Operations Plan included a continuity of operations strategy that covers: A succession plan that lists who replaces key leaders during an emergency.

KH follows an administration chain of command structure. The house supervisor is the first point of contact for all district emergencies. They are supported by the Director on call and administrator on call.

The hospital has procedures for requesting an 1135 waiver for care and treatment at an alternate care site.

When the district has initiated their Incident Command Center and the President declares a disaster or emergency under the Stafford Act or National Emergencies Act and the HHS Secretary declares a public health emergency the liaison officer will submit a request to operate under a 1135 waiver for care and treatment at an alternate care site.

The Emergency Operations Plan describes a means to shelter patients, staff and volunteers on site who remain in the facility.

The district will utilize all available office space to accommodate patient, staff and volunteers on site who remain in the facility. This includes all district properties in the surrounding areas.

As part of its Emergency Operations Plan, the [organization] prepares for how it will manage resources and assets during emergencies.

Resources and Assets

The emergency operations plan describes how the hospital will obtain and replenish medications, medical supplies, and non-medical related supplies that will be required throughout the response and recovery phases of an emergency, including access to and distribution of medication caches that may be stockpiled by the hospital, its affiliates, or local, state or federal resources. The Operations Chief and Staging Manager will coordinate with Pharmacy and Materials Management the initial delivery of supplies, equipment and pharmaceuticals upon activation of a CODE TRIAGE ACTIVATION. Prioritization will be given to those areas either immediately impacted by the emergency, or are likely to be so.

Carts containing pre-positioned pharmaceuticals, supplies, and equipment, will be sent to designated staging areas. The contents of the carts will be rotated out on a regular basis to assure that inventory does not expire. Equipment designated for pre-positioning is included in the organization's medical equipment inventory and is maintained in accordance with pre-established preventive maintenance requirements.

Ongoing replenishment of supplies, equipment and pharmaceuticals.

For the duration of the emergency – including response and recovery phases – the Operations Section Chief and Staging Manager are responsible for monitoring the inventory of supplies (including personal protective equipment), equipment, and pharmaceuticals in the various care areas. Replenishment from storage areas (Central Supply, Storeroom, etc) will occur on an as needed basis.

A general inventory of supplies (including personal protective equipment), equipment and pharmaceuticals will be taken in their respective storage areas on at least a daily basis (or more frequently if necessary) for the duration of the emergency. Remaining inventory shall be measured against the rate of consumption that is occurring as a result of the emergency. When existing inventory of critical supplies (including personal protective equipment), equipment, and/or pharmaceuticals are in danger of reaching insufficient levels, then contingency plans with outside vendors will be implemented. See Vendor List below:

Emergency Operations Plan

Type of Service	Name of Vendor	Telephone Number
AIR/GAS	Air Liquide Guard	217-8195
BOILER	California Boiler	625-5151
	R.F McDonald	498-6949
BOTTLED WATER	US Food Service	1-800-682-1228
HVAC	American Air	651-1776
	Grants A/C	734-7361
	Brott Mechanical, Inc	688-7571
GENERATORS	Quinn Engine System	896-4040
HAZARDOUS MATERIALS	Atlas Environmental	860-8871
	Healthwise Services	834-3333
FUEL	Valley Pacific	7328381
PNEUMATIC CONTROLS/ENERGY MANAGEMENT	Trane Summit Siemens Bldg Systems	271-4625 276-2600
PNEUMATIC TUBE SYSTEM 4" AND 6"	Swisslog/Translogic	800-525-1841
ELECTRICIANS	American	651-1776
EQUIPMENT SUPPLY	Grainger	635-2524
	Fastenal	739-2620
	McMaster Carr	562-692-5911
FIRE ALARMS	Siemens Inc	559-276-2600
MEDICAL SUPPLIES	Cardinal Healthcare	909-605-0900
NURSE CALL SYSTEM	Central Cal Electronics	485-1254
PHARMACIES	AmeriSource Bergen	800-635-4907
PLUMBERS	Robert Marks	625-8038
	American Air	651-1176
	Parker & Parker	625-4020
SECURITY	AAA Security	594-5600
RESPIRATORY CARE SERVICES	Certified Medical Testing	1800-243-5427
MEDICAL GASES	Air Liquide	445-1756

If emergency replenishment from outside vendors is not feasible, the community-wide EOC should be contacted to facilitate access to, and distribution of, stockpiled supplies, equipment, and pharmaceuticals. Other healthcare organizations in the immediate geographical location should also be contacted to see if necessary supplies, equipment, and pharmaceuticals could be made available.

Ongoing replenishment of non-medical supplies

For the duration of the emergency – including response and recovery phases –

Logistics Section Chief and the Infrastructure Branch Director in coordination with Materials Management are responsible for monitoring the non-medical supply inventory. These supplies include, but are not necessarily limited to:

- Food
- Water
- Linen
- Fuel for Emergency Power Generators
- Fuel for Vehicles

A general inventory of non-medical supplies will be taken in their respective storage areas on at least a daily basis (or more frequently if necessary) for the duration of the emergency. Remaining inventory shall be measured against the rate of consumption that is occurring as a result of the emergency. When existing inventory of critical non-medical supplies are in danger of reaching insufficient levels, and then contingency plans with outside vendors will be implemented.

Emergency Operations Plan

Sustainability of operations without external support

It is possible that the nature, scope, and duration of the emergency may preclude outside agencies, vendors, authorities, or other vital entities from assisting the organization in a timely manner. Outside assistance may not be available for up to 96 hours following initiation of the Emergency Operations Plan.

Kaweah Health has designed its operations so that it can be self-sufficient for a designated time frame depending on resources and assets being affected. The table below summarizes the organization's ability to be self-sufficient in key areas. Hours of self-sufficiency is based on the following:

- The average amount of resource or asset within the organization at any given time.
- The estimated consumption of the resource or asset based on maximum capacity of patients and staff.

Resource or Asset	Hours Self Sufficient
1. Potable Water	168 with water conservation plan*
2. Food	168 with food rationing and dry food plan**
3. Fuel for Emergency Generators	96+
4. Pharmaceuticals – Analgesics / Narcotics	96+ with Cache supplies from local EOC
5. Pharmaceuticals – Broad Spectrum Antibiotics	96+ with Cache supplies from local EOC

Surgeries	Emergency Only Sterilization sent off site
Dialysis Patients	Diverted to other facilities (Clinic Patients)
In Patients	Sponge bath with “wipettes” Hand washing with alcohol gel
All Staff	Hand washing with alcohol gel
All Staff/Patients	Consume bottled drinks-try to limit to no more than 2 quarts per day; ration plan is implemented by Food/Nutritional Care Services
Toilets	If able to flush, flush after 3 rd usage. If unable to flush, insert plastic bags into toilets, and seal when finished; EVS to remove to terminal waste collection area
Generators	Can run for approximately 7 days depending upon load usage.
HVAC System	On e-power.

*Food Supply – Patients Employees/MD/s, Other	4 day supply for 1,000 total people per day, which includes patients, employees, physicians, & visitors Disaster menu established for 7 days	Meets 168-Hour sustainability: if food supplies begin to diminish, food-rationing plan will go into effect (e.g., 2 meals per day with snacks). We will use food from cold sources first (refrigerator and freezers), then change to dry supplies.
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Food and Nutrition Services Disaster Plan

1. Food and Nutrition Services Director or designee will communicate with the Command Center regarding staffing, supplies, kitchen conditions and any expected deliveries that may require security clearance.
2. Emergency call lists will be activated.

Emergency Operations Plan

3. Temporary off-site kitchen when needed
 - a. South Campus = 1633 S. Court Avenue
 - b. West Campus (Rehab Hospital) = 840 S. Akers St. Visalia, CA
4. The 96- hours disaster food and supplies are stored at Creekside. The key is labeled #1.
5. When food items for the same day are prepared, use when possible. If not, use the cold disaster menus located in the Chef's office.
6. Utilize the 2-day Cold Disaster Menu first then the Meals for All for 5 days.
7. There is a supply of perishable and non-perishable foods in the department refrigerators, freezers and storeroom. This food should be used first and utilized to feed staff.
8. An inventory of available foods should be completed as soon as possible. If utilities are down:
 - a. Use perishable foods (refrigerated and frozen) first, then fresh food, then canned food.
 - i. Please note:
 1. Utilize dry stores with shortest shelf life i.e bread, rolls
 2. A full freezer will hold temperature for 48 hours if the door remains closed.
 3. A refrigerator will hold temperature safely for about 4 hours if the door remains closed.
 - b. Per Engineering, no equipment is attached to the emergency power.
 - c. Three (3) emergency electrical sockets are available. Location: by the gas shut off valve, behind the supplement storage area and dry storage area.
 - d. Lighting is limited. Use lanterns located in the Chef's office. Battery is in Chef's office.
9. Using the most current diet sheets identify patients and their diets. This information can be used to plan the amount and type of foods to be sent to the nursing units and to write meal identifier tickets
10. Meals for patients will be assembled in the kitchen using supplies from kitchen (dry and cold storage areas) using the disaster menu. Meals will be placed in paper bags for delivery to the nursing units.
11. Additional personnel will be required to assemble and deliver meals. Use 3 people to deliver meals and remove garbage. In addition, 4 -5 people will be required to assemble meals for patients and staff. 2 – 3 cooks will be needed to prepare the foods.
12. When the dish machine is not functional, the "3 sink method" method of cleaning and sanitizing is required. The first sink shall contain a dish/pot detergent solution for removing food debris. The second sink shall contain clean water for rinsing. The third sink shall contain a sanitizing solution of Quaternary Ammonium Sanitizer (Oasis 146) and water after soaking in sanitizing solution for 1 minute, remove items and allow to air dry.

If critical assets and resources have neared depletion levels, and there is no anticipated assistance from external sources in the near future, then the Command Center will need to make a determination as to whether or not operational capability can be sustained. Possible actions include:

- Continuing current operational capability based on anticipated assistance from external sources
- Curtailing or modifying selected operational capability
- Closing and evacuating the facility(s)

Decisions involving curtailment, modification, or halting of operational capability will be made by the highest-ranking administrator in conjunction with the County of Tulare.

Emergency Operations Plan

The emergency operations plan describes how the hospital will share resources and assets with other health care organizations within the community, and outside of the community if necessary. Kaweah Health will share assets and resources with other local hospitals if needed. Within community, assets and resources will likely be shared with:

Name of Hospital	Name of Emergency Coordinator	Number and email of Emergency Coordinator	Number of Hospital Command Center
Valley Children's Hospital	Ashley Ave	559-353-9227 Aave@valleychildrens.org	559-353-8680
Sierra View Medical Center	David Whittington	dwhittington@sierra-view.com	559-799-6008
St. Agnes Hospital, Fresno	Joseph Lopez	(559) 450-3721 (559-450-2475
Kaiser Permanente Fresno Medical Center	Jamie E. Sutton	5593206230	559-448-2257

The emergency operations plan will describe how the hospital will monitor quantities of its resources and assets during and Pharmacy, Food/Nutritional Services, and Materials Management, at the onset of any emergency, will determine the current quantities of medications, food/water, supplies, and linens. Daily usage will be measured against the current available quantities. If it is determined that the rate of usage/consumption is greater than expected replenishment, local resources will be accessed. If necessary, conservation measures will go into effect as stated above. If it is determined KH can no longer support the care, treatment and services for the patients, a decision will be made by the Incident Commander to transfer and or evacuate patients.

The emergency operations plan will describe arrangements for transporting some or all patients, their medications, supplies, equipment and staff to an alternate care site when the environment cannot support care, treatment. Also included are the arrangements for transferring pertinent information, including essential clinical and medication-related information with patients moving to alternate care sites. The Planning Section Chief, Security Branch Director, and the Patient Tracking Manager are responsible for coordinating the transfer and transporting of patients to alternate care sites should KH need to be evacuated. An EMS Strike Team(s) would be requested through the Central California EMS Agency Duty Officer. This would include transporting the patient's medication, necessary equipment and supplies, as well as pertinent clinical and medication-related information.

A tracking system will be implemented that notes at least the following:

- The patient's name
- The patient's medical record or other identification number
- The disposition of the patient (where the patient was sent to)
- Whether or not family was notified (attempts should be made to notify family prior to transfer)
- Whether or not the patient's medical record was sent. At least copies of the H&P, operative reports, current medications (including last dose given), and most recent care records should be sent.
- When the patient was transferred
- When the patient arrived at the receiving facility and where the patient was placed
- When report was given on the patient to the receiving facility, and to whom the report on the patient was given.

Patients will be assessed to determine if they need to be transported by BLS or ALS as appropriate to their clinical condition. If necessary, qualified hospital staff will accompany the patient.

Emergency Operations Plan

The hospital implements the components of its emergency operations plan that require advance preparation to provide for resources and assets during emergencies. One function of the Emergency Management Subcommittee is to plan in advance, and in an ongoing fashion, an inventory of organizational assets and resources relating to emergency preparedness. This effort is a multi-disciplinary process, with monthly meetings that are driven by a standard agenda. The inventory is modified as new assets and resources are accumulated, and revised as quantities may be used during drills and or actual events.

As part of its Emergency Operations Plan, the medical center prepares for how it will manage security and safety during an emergency

Security and Safety

Description for internal security and safety

Upon initiation of Code Triage Activation, the Hospital Command Center will determine the need to activate the Security Branch Director position of HICS. This decision is based on the nature, scope, anticipated duration, and likely impact of the emergency on the safety of persons and the security of the facility. The *Job Action Sheet* for the Security Branch Director provides guidelines for the individual who assumes the role. Access control and hospital shutdown will be of primary importance.

Coordination of security activities with community agencies.

It may become necessary to supplement internal security efforts with assistance from external law enforcement agencies, based upon the nature of the incident. The decision to request assistance from such agencies will be made by the Incident Commander based on incoming information, and the scope of the event. The Security Branch Director will work in coordination with the Operations Section Chief when coordinating with outside community agencies.

Once a decision is made to integrate with external law enforcement agencies, the Security Branch Manager will coordinate with a designated lead officer(s) of the agency having jurisdiction, and agree on the following issues:

- Incident Command
- Integration of Law Enforcement into Organization Operations
- Decision Making
- Rules of Engagement for Crowd Control
- Chain of Custody

Law enforcement will prevail, with consideration given to specific Kaweah Health concerns that may arise.

Management of hazardous material and waste

During emergencies, when the structural integrity of the building may be impacted, for example, due to an earthquake or internal flood, the Safety Officer, in conjunction with Facilities staff, will assess all areas that contain hazardous materials to determine if there are any spillages as follows:

- Above ground diesel storage tank located at ISS
- Above ground diesel storage tank located at Facilities Plant
- Above ground diesel storage tank located in Acequia Wing Basement
- Laboratory located in Mineral King Basement
- Hazardous Materials Waste Storage Area located North of the Ambulance Bay (in dumpster enclosure)
- Surgery Soiled Utility Room
- OB Surgery Soiled Utility Room
- Environmental Services Chemical Storage Room located in West Basement
- Kitchen, 1st floor Mineral King Wing
- Laundry Area

If any spillages are determined, the area will be cordoned, with staff evacuated. The SDS for the spilled material will be obtained. If a spill kit can be safely used, this will be the procedural response. If the nature of the spilled material poses risk to the employee or the building, an outside hazardous materials response team will be called. In the interim, the areas will be cordoned, with staff evacuated. Any staff member that has experienced signs and symptoms relating to an exposure will be escorted to the Emergency

Emergency Operations Plan

Department for treatment. The Safety Officer will work in coordination with the outside hazardous materials response team.

Radioactive, biological and chemical isolation/decontamination

Kaweah Health has staff that is trained for decontamination response, including decontamination equipment. The Emergency Department follows district policies and has procedures for decontamination, which includes the care of the patient while minimizing risk to employees. Primary goals for emergency department personnel in handling a contaminated patient include termination of exposure to the patient, patient stabilization, and patient treatment, while not jeopardizing the safety of district emergency facilities and personnel. Termination of exposure can best be accomplished by removing the patient from the area of exposure and by removing contaminants from the patient.

Personnel must first address life-threatening issues and then decontamination and supportive measures if a radioactive exposure occurs. Priority is given to the ABC with simultaneous contamination reduction. Once life-threatening matters have been addressed, emergency department personnel can then direct attention to thorough decontamination, secondary patient assessment, and identification of materials involved. If a chemical exposure has occurred, decontamination occurs first, and then emergency management of the patient.

Personal Protective Equipment. Any staff member providing patient care to a contaminated patient must wear the appropriate personal protective wear. Decontamination must occur outside of the Emergency Department by staff that are trained specifically for decontamination response within KH. Should large-scale decontamination be required, HICS will be activated, with specific response guidelines implemented by staff that assumes HICS positions.

Control of entrance into and out of the medical center during and emergency

It is likely that access to the organization's facility(s), and movement within the facility(s), will need to be monitored and controlled for the duration of the emergency. Upon activation of the Code Triage Activation, the following may occur:

- 1) Entrances to the Hospital will be staffed by Security or designated personnel through the Labor Pool. Visitors and other non-hospital personnel will be instructed to proceed to designated areas (DM 2225 Security Lockdown of Entry Doors). If necessary, entrances and exits will be locked down to prevent ingress or egress as warranted.
- 2) Movement by visitors and other non-hospital personnel will be restricted to a minimum. If visitors need to move beyond designated areas, they will be identified and their intended location within the facility will be ascertained.
- 3) Appropriate staff will be assigned to monitor vehicular access to the facility(s) and assure that access to the Emergency Department and other designated staging areas is unimpeded.

The Operations Section Chief and/or Security Branch Manager will assume responsibility for managing the aforementioned activities.

Control of movement of individuals with the health care facility during an emergency, including control of vehicular access.

It is likely that access to the facilities in Kaweah Health, and movement within the facility, will need to be monitored and controlled for the duration of the emergency. Upon activation of the Code Triage, the following may occur, and will be under the responsibility of the Security Branch Director:

- Entrances to the facilities in Kaweah Health will be staffed by Security or designated personnel through the Labor Pool. Visitors and other non-hospital personnel will be instructed to proceed to designated areas. If necessary, entrances and exits will be locked down to prevent ingress or egress as warranted.
- Movement by visitors and other non-hospital personnel will be restricted to a minimum. If visitors need to move beyond designated areas, they will be identified and their intended location within the facility will be determined.
- Vehicular access to the facilities in Kaweah Health will be monitored by Security, including access to the Emergency Department and other designated staging areas is unimpeded.

Advance preparation for security and safety during and emergency

Emergency Operations Plan

Security and safety issues are regularly addressed at the Emergency Management Subcommittee, and various aspects are periodically rehearsed during pre-planned drills, which are designed and implemented through the Emergency Management Subcommittee.

The medical center prepares for the management of staff during an emergency.

Roles and responsibilities for staff during emergencies

Roles and Responsibilities of staff for communications, resources and assets, safety and security, utilities and patient management begin at the Emergency Management Subcommittee through the HICS structure appointments, through the careful monitoring of the KH's inventory of organizational assets, and through ongoing assessment of risk and mitigation strategies when assessing hazard vulnerabilities. Drills are designed with specific objectives relating to functional responsibilities of staff during exercises based upon risk to the District. Integrated into drill planning are resource and asset allocation and utilization. These activities are preplanned during ongoing Emergency Management Subcommittee meetings. These activities additionally support ongoing training for staff that may include other types of learning, such as new hire orientation, annual re-training, and pre-drill training.

Staff roles and responsibilities in an emergency are largely determined by the priority emergencies identified as a result of the HVA, as well as the reporting relationships in the command and control operations of the organization.

Depending on the nature, scope, and durations of the emergency, staff may be asked to assume specific duties and responsibilities other than those normally noted in their position description. This most likely will involve assuming a HICS job function. In this case, the Job Action Sheet for that specific job function defines the staff person's role and responsibilities. Staff roles and responsibilities are identified in at least the following key areas with respect to the Job Action Sheet:

- Communications
- Resources and Assets
- Safety and Security
- Utilities
- Clinical Activities

In addition, staff roles and responsibilities may be further identified as it relates to unit-specific planning, policies and procedures and specific competencies.

All staff' have – at a minimum – the following responsibilities relative to the above mentioned areas:

- To communicate situational needs, observations, operational status, and issues in a clear, concise, and timely manner to the appropriate individual(s) or entity(s).
- To conserve resources and assets and utilize said resources and assets appropriately
- To be aware of, and maintain, the safety and security of themselves, their patients and the environment in which care, treatment, and service are rendered.
- To appropriately utilize and conserve utilities, and to report disruption or failure of utilities to the appropriate individual(s) or entity(s) in a timely manner.
- To assure that clinical activities are carried out in accordance with accepted standards of care, and in a safe and efficacious manner.

Staff are minimally trained relative to the codes for activation of the Emergency Operations Plan, and where to report for assignment. In addition, specific training is required for staff in accordance with the National Incident Command System (NIMS) as follows:

Staff Role	NIMS Based Training
<ul style="list-style-type: none">• Personnel likely to be involved as initial responders	<ul style="list-style-type: none">• ICS-100: Introduction to ICS or equivalent• FEMA IS-700: NIMS, An Introduction

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<ul style="list-style-type: none"> Personnel likely to function as Unit / Care Area Supervisors or Specialists in HICS 	<ul style="list-style-type: none"> ICS-100: Introduction to ICS or equivalent ICS-200: Basic ICS or equivalent FEMA IS-700: NIMS, An Introduction
<ul style="list-style-type: none"> Personnel likely to function as Managers, Unit Leaders, and Branch Directors in HICS 	<ul style="list-style-type: none"> ICS-100: Introduction to ICS or equivalent ICS-200: Basic ICS or equivalent FEMA IS-700: NIMS, An Introduction
<ul style="list-style-type: none"> Personnel likely to function as the Incident Commander, PIO, Safety Officer, Liaison Officer or Section Chief in HICS 	<ul style="list-style-type: none"> ICS-100: Introduction to ICS or equivalent ICS-200: Basic ICS or equivalent FEMA IS-700: NIMS, An Introduction FEMA IS-800.A: National Response Plan (NRP), An Introduction* <p>* NOTE: Personnel whose primary responsibility is emergency management must complete this training.</p>

Managing staff support activities during and emergency

Depending on the nature, scope, and duration of the emergency, the Hospital Command Center will establish mechanisms to meet the needs of staff. Such mechanisms include, but are not necessarily limited to:

- Housing
- Transportation
- Communication
- Food and Water
- Stress Debriefing
- Child/Elder Care

If possible, unoccupied inpatient care areas of the facility will be converted into sleep rooms for staff and their children, including elder care. If unoccupied patient care areas are not available, unoccupied general areas may be converted into dormitory style housing with cots, blankets, etc.

It may be necessary to transport staff to the facility from a remote location. If so, a collection point will be determined, and staff reporting to the facilities in Kaweah Health will be instructed to meet there. Coordination with local transportation companies (bus, taxis, etc) will be used to transport staff to the facilities in Kaweah Health as needed. Chaplains and Social Workers shall be made available to staff on an as needed basis to cope with the stress of the emergency. The Logistics Section Chief and the Support Branch Director are responsible for implementing processes necessary to meet the needs of staff as noted above.

The Service Branch Director will coordinate with the Infrastructure Director to assure that adequate amounts of food and water are supplied to staff. Communications will include landlines, cell phones, E-mail, or runners and bull horn if normal communications are not operating.

Depending on the nature, scope, and duration of the emergency, it may be possible to share resources and assets with other healthcare organizations both within and outside the community.

These assets and resources include, but are not necessarily limited to:

- Personnel
- Beds
- Transportation
- Linen
- Fuel
- Personal Protective Equipment
- Medical Equipment and Supplies

Emergency Operations Plan

All licensed staff coming to work at the District will need competencies assessed by Human Resources and Nursing. If personnel from the District are going to be shared with another facility, staff will be apprised of the following information:

- The location and type of facility that they are being sent to
- The type of care, treatment, and service they are being asked to provide
- The expected duration of the assignment
- The contact information at the receiving organization.

Staff will be instructed to wear their identification badges. If possible, copies of pertinent documents such as licensure, competencies, etc. will be made and given to staff to take with them. An accurate record will be maintained of who went where and how long they stayed.

For equipment and supplies, an accurate inventory will be maintained of what was sent to other facilities and when, so that appropriate reimbursement can occur.

If resources and assets are to be shared outside of the organization's geographic service area, then the Liaison Officer will coordinate efforts from Kaweah Delta Health Care District with the County Emergency Operations Center.

The identification of licensed independent practitioners, staff, authorized volunteers The role of licensed independent practitioners (LIP') as well as designated allied health practitioners (AHP') is to render medical evaluation and care during the emergency within the scope of their competence and privileges granted unto them by the medical staff. LIP's and AHP's are responsible for reporting to the Physician Labor Pool. Staff and physicians are responsible for wearing their name badges during the emergency period. In addition, staff assigned to specific roles and responsibilities during the emergency (e.g. HICS positions) will be identified with color-coded vests.

Initial and ongoing training relevant to their emergency response role is provide to all staff, volunteers, and individual providing on-site services. Staff demonstrate knowledge in drills and exercises and critique activity.

Preparation /Management of Utilities during an Emergency EP 2-9

Alternate means of provision of electricity, water for consumption and essential care activities, equipment/sanitary purposes, fuel, medical gas,/vacuum systems, and essential utilities (vertical/horizontal transport, heating and cooling systems, steam for sterilization)

Complementing the efforts to meet the medical care needs of the patients and protecting the staff will be the maintenance of overall facility operations. This responsibility primarily rests with the Infrastructure Branch in the Operations Section. The responsibilities include maintaining the normal operational capability of the facility including power and lighting, water, HVAC, medical gases, and building/grounds, increasing capacities when patient surge requirements dictate; and identifying and fixing utility service-delivery failures. The acquisition of equipment parts or outside contractors will be coordinated with the Support Branch.

The Infrastructure Branch Director is also responsible for assuring that there is an alternate means of meeting essential utilities when normal supply mechanisms are compromised or disrupted. At a minimum, this means identifying alternate providers both within and outside the local community, and invoking memoranda of understanding for priority delivery and supply during an emergency. A summary of the key utility and alternate means / providers is as follows:

Essential Utility	Alternate Means of Provision
<ul style="list-style-type: none"> • Electricity-power and lighting 	Self-Generation
<ul style="list-style-type: none"> • Water for Consumption and Essential care Activities 	<p>Arrowhead – Memorandum of Understanding on file for priority delivery.</p> <p>Water Conservation Plan will be implemented (page 12) if quantities begin to diminish before</p>

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	water deliveries can occur. See Disaster Policy 2216, Water Systems Failure/Disruption.
<ul style="list-style-type: none"> Water Needed for Equipment & Sanitary Purposes 	<p>Water for Equipment: If water supplies diminish and equipment is no longer able to be supported, a decision will be made by the Incident Commander to divert patients, evacuate patients and close operations.</p> <p>Water for Sanitary Purposes: If water supplies diminish before replenishment can occur, water conservation will be implemented (page 13).</p>
<ul style="list-style-type: none"> Medical Gases/Air 	3000 Gallon bulk oxygen storage is available, which will provide oxygen for 7-10 days, depending upon usage; plus, we have a 500-gallon back-up tank, which will provide approximately one day of usage.(Downtown Campus).
<ul style="list-style-type: none"> Heating, Ventilation & Air Conditioning 	Loss of HVAC will be dependent upon seasonal requirements. Windows will be opened if we are experiencing high heat, with cooling measures instituted (extra water consumption, cold trays, no blankets). If it is winter, extra blankets will be obtained, warm tray menu will go into effect. In both cases, if the HVAC loss is sustained for greater than four hours, patients will go on divert until the HVAC issue is resolved. If the HVAC loss results in adverse effects for patient and staff, a decision to close operations and evacuate patients will be made by the Incident Commander.
<ul style="list-style-type: none"> Steam for Sterilization 	If there is no water for steam sterilization, instruments will be sent to an outside vendor for sterilization, and or an adjacent hospital with whom we have made arrangements.
<ul style="list-style-type: none"> Fuel required for building operations, generators and essential transport that the hospital would typically provide. 	Conservation plan will be put in place and memorandum of understandings will be invoked for fuel.

Management of Patients during Emergencies

Patient scheduling, triage, assessment, management of clinical

When the Emergency Operations Plan is initiated, and for the duration of the emergency event, the Hospital Command Center will implement processes relating to the following:

- Triage of Patients
- Scheduling of Patients
- Assessment and Treatment of Patients
- Admission, Transfer, Discharge, and, if necessary, evacuation of patients

Within HICS, there are job action sheets that outline the specific duties and responsibilities of the Section Chiefs, Branch Directors and Unit Leaders relative to the above. In addition, the following general guidelines will apply:

Triage of Patients Done by Emergency Department MICN or Emergency Medicine Attending Physician. May also be delegated to an Emergency Medicine Resident as designated by the Emergency Medicine Attending Physician

If disaster involves Trauma Patients, then Triage of trauma patients may be delegated to a Trauma Surgeon Attending Physician (or Surgical Resident designated by the Surgical Attending Physician) During an emergency, victims of an internal or external disaster will be triaged to determine their necessary level of care. Patients will be assigned to one of the following triage categories utilizing the START and Jump START triage system:

- Immediate Treatment area
- Delayed Treatment area
- Minor Treatment area
- Deceased or Expectant area

Patients whose clinical needs fall outside of the scope of services or ability of KH to care for them will be promptly identified and transferred to a healthcare facility equipped to provide appropriate care.

Scheduling of Patients

Depending on the nature, scope, and duration of the emergency, non-urgent tests, procedures, diagnostic studies, and care appointments may need to be delayed or canceled. When possible, patients will be notified of any delay or cancellation and when routine service is expected to resume. A record will be maintained of any cancellations so that patients can be contacted at the conclusion of the emergency to have their medical care needs met.

Admitting Patients

Admissions during an emergency will be limited to the following:

- Emergency Department Patients
- Disaster Victims
- Pregnant Patients in Labor
- Critically Ill Persons

Non-disaster and/or emergency admissions will be screened to determine their necessity for admission. Routine admissions may be resumed if authorized by the Command Center. Patient admissions will follow normal procedure as much as possible.

Potential Discharge & Transfer of Patients

Patients housed on the various care units will be evaluated for possible transfer or discharge in the event that it becomes necessary to release selected existing patients in order to make room for more seriously injured patients. Patients will be classified for transfer or discharge as follows:

- Patients that can be safely discharged to the care of relatives or friends.
- Patients that can be safely transferred to another medical care facility. (NOTE: Critical Care Units will identify patients who can be transferred to a nursing floor)

Evacuation of Patients

If the nature, scope, and/or duration of the emergency is such that KH can no longer support care, treatment, or service, then it may become necessary to evacuate part or all of the facility(s).

The decision to evacuate shall be made by the Incident Commander in collaboration with the Section Chiefs within the Command Center. If necessary, communication will also occur with the County Emergency Operations Center, Central California Emergency Medical Services Agency, and the Department of Health Services.

The order to evacuate a given area is based on the safety of remaining in that area as compared to the risk of moving the patient population in question. Familiarity with several types of evacuation is necessary for all hospital personnel. Specific plans must be worked out within individual departments. Evacuation must take into consideration the number and types of patients, as well as alternative means of life support and cessation of invasive procedures when possible and considering the available resources at the disposal of the staff at the time the evacuation is to take place. There are generally four types of evacuation. Each may be a separate and complete operation or all may have to be used in successive stages if circumstances dictate. (KH DM2810)

Partial Evacuation. Partial evacuation is removing the patient(s) and staff from a dangerous area to one of safety within the Hospital. The area being vacated will be marked as *unsafe* by Security. Once the area has been cleared of patients and staff, the area will remain off limits until repaired or cleared of the danger by the local agency having jurisdiction.

Horizontal Evacuation. Horizontal evacuation is the removal of all patients laterally by bed, wheelchair, stretcher or other type of transport, to an adjacent protected area. The patients in immediate danger are removed first, including those that might be separated from safety if fire or other danger enters the corridor. Ambulatory patients are moved next. Contrary to some opinions, panic is never caused by helpless people. Ambulatory patients are to be instructed to line up outside of their rooms forming a chain by holding hands and following the lead staff member. All rooms are to be carefully checked for stragglers, looking particularly in all closets, under the bed and in the bathrooms. Each room door, after it is checked, is to be sealed with tape in such a manner that each room door cannot be opened without breaking the seal. Once in the evacuation area, patients must be rechecked to see that no one is missing.

Total Evacuation. In the hospital, patients will be evacuated to the nearest evacuation collection point outside of the hospital, with the goal to transfer to either: an alternate care site near the premises, or Kaweah Health. Patients requiring ventilator support will need special assistance during evacuation and must be moved with caution. In the event of total failure, electrical systems and building integrity, ventilator dependent patients will be maintained with manual support using a bag valve tube or mask. The order to evacuate is made by the person in the highest authority at the time of the disaster. Coordination with the Central California EMS Agency will be necessary to request an EMS Strike Team(s) & EMS Disaster Medical Support Units.

Clinical services for vulnerable populations

Special consideration will be given to vulnerable patient populations, including but not necessarily limited to, the following:

- Pediatric Patients
- Geriatric Patients
- Disabled Patients
- Patients with a Serious Chronic Medical Condition
- Patients with Addictions

Staff, within their scope of practice, in the various care areas will be required to identify vulnerable patients and their specific care needs. These will be noted in their plan of care and communicated to other care providers as warranted by the patient's condition and circumstances. Each patient identified will be escorted by a patient care provider.

Patient hygiene and sanitation needs

Technical specialist experts (e.g., Infection Control) will be appointed by the Incident Commander to be responsible for assuring that patient and staff hygiene and sanitation needs are met during the emergency. The following will be considered:

- All non-essential environmental cleaning services will be discontinued and resources reallocated to patient care and treatment areas, as well as staff mobilization areas.
- Central Supply will re-supply personal hygiene articles such as toothbrushes, toothpaste, shaving articles, feminine hygiene articles, soap, and alcohol based hand gel or foam.
- If necessary, arrangements will be made to bring in additional portable restrooms to handle increases in-patient, visitor, and staff volumes.
- Waterless bath packets can be procured to allow for personal hygiene in a waterless environment.

Patient mental health needs

The mental and emotional needs of patients will be monitored by chaplains and social workers within the District. If it is feasible during the event, psychiatrists and clinical psychologists will be requested to assist as needed. Nurses will be requested to provide psycho-social support as needed, within their scope of practice, to patients exhibiting emotional or mental duress during the emergency.

Mortuary services

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If morgue services become unable to accommodate increasing fatalities, the following actions will be taken:

- The County Emergency Operations and Public Health Department will be contacted to provide temporary morgue services such as an environmentally controlled trailer.
- Local mortuaries will additionally be contacted to arrange for direct transport of deceased individuals to the mortuary.
- If the County local mortuaries are not available, body bags will be used to protect each expired patient, and stacked until other arrangements can be made.

Documentation and tracking of patients clinical information

Documentation will occur per normal protocol throughout the emergency. Each patient is provided with a unique clinical record identifier (i.e., a medical record number or account number). All clinical information about the patient will be noted on forms or other documentation tools with the patient's name and assigned number. In addition, the location of the receiving facility or alternate site shall be documented. If normal documentation procedures have been disrupted because of the emergency, then downtime or designated alternate procedures will be used.

During disasters, the medical center may grant disaster privileges to volunteer licensed independent practitioners.

The granting of disaster privileges

Definitions. Volunteer practitioners include:

- Licensed independent practitioner: physicians (M.D. or D.O.), podiatrist (DPM), dentist or oral maxillofacial surgeon (DDS, DMD), Psychologist.
- Physician Assistants and Advanced practice registered nurses (NP and PA)

Authority for granting privileges. During disaster(s) in which the emergency management plan has been activated and the hospital is unable to meet immediate patient needs, the chief executive officer/designee and/or chief of staff/designee has the option to grant privileges during a disaster. The responsible individual is not required to grant privileges to any individual and is expected to make such decisions on a case-by-case basis in accordance with the needs of the hospital and its patients, and on the qualifications of its volunteer practitioners. The medical staff oversees the professional performance of volunteer licensed independent practitioners, either by direct observation, mentoring or clinical record review.

Once the immediate disaster situation is under control, the privileges are terminated. Additionally, privileges granted during a disaster may be terminated at any time without any reason or cause. Termination of privileges granted in a disaster does not entitle the individual to a hearing or other due process.

The procedure for granting disaster privileges include the following processes:

1. The individual being given privileges during a disaster (applicant) must:
 - A. Complete the privilege form: This form includes the applicant's statement that he/she is licensed, the license number, the state issuing the license and his/her area of specialty.
 - B. Present a valid government issued photo identification issued by a state or federal agency, e.g., driver's license or passport, and at least one of the following:
 - A current picture hospital ID card that clearly identifies professional designation
 - A current license to practice
 - Primary source verification of the license
 - Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), or MRC, ESAR-VHP, or other recognized state or federal organizations or groups

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- Identification indicating that the individual has been granted authority to render patient care, treatment, and services in disaster circumstances (such authority having been granted by a federal, state or municipal entity)
 - Identification by current hospital or medical staff member(s) who possesses personal knowledge regarding volunteer's ability to act as a licensed independent practitioner during a disaster
2. The CEO/designee and/or the chief of staff/designee may grant privileges during a disaster.
 3. Medical staff coordination is accomplished by the chief of staff/designee who will assign physicians to appropriate areas.
 4. The privilege form shall be forwarded as soon as possible to the medical staff office to immediately verify as much information as possible, including verification of licensure, hospital affiliation, National Practitioner Data Bank and OIG query. A record of this information will be retained by the medical staff office. Primary source verification of licensure begins as soon as the immediate situation is under control, and is completed within 72 hours from the time the volunteer practitioner presents to the organization. In the extraordinary circumstances that primary source verification cannot be completed in 72 hours (for example, no means of communication or a lack of resources), it is expected that it be done as soon as possible. In this extraordinary circumstance, there must be documentation of the following: why primary source verification could not be performed in the required time frame; evidence of a demonstrated ability to continue to provide adequate care, treatment, and services; and an attempt to rectify the situation as soon as possible. Primary source verification of licensure would not be required if the volunteer practitioner has not provided care, treatment, and services under the disaster privileges.
 5. The CEO/designee, in consultation with the chief of staff/designee, makes a decision (based on information obtained regarding the professional practice of the volunteer) within 72 hours related to the continuation of the disaster privileges initially granted.
 6. To ensure oversight of the professional performance of volunteer licensed independent practitioners:
 - a. If medical staff members are available, concurrent mentoring will occur; the volunteer will be paired with a current member of the medical staff. Should medical staff members not be available due to the extent of the disaster, practitioner-specific outcome data will be collected when conducting record reviews after the disaster situation is resolved.
 - b. Staff and patient satisfaction surveys will be conducted to assess care provided by volunteer practitioners.
1. Any information gathered that is not consistent with that provided by the individual must be referred to the chief of staff/designee immediately, who will determine any additional necessary action. A physician's privileges approved during a disaster will be immediately terminated in the event that any information received through the verification process indicates any adverse information or suggests the person is not capable of rendering services in an emergency.
 2. Each physician will be required to wear a hospital badge signifying that the volunteer is authorized.

Disaster Clinical/Privilege/Practice Prerogative Approval Form. A *Disaster Clinical Privilege /Practice Prerogative Approval* form will be completed for each volunteer, which includes unique identifying information about the volunteer, such as specialty, office address, phone number license/certification/registration number and expiration date, driver's license or passport number, date of birth, social security number, name of professional liability insurance carrier and limits of liability, etc.

Primary Source Verification. Kaweah Health personnel involved in the credentialing process will use the appropriate licensing/certification/registration on-line and print verification if possible:

- Medical Board of California: www.medbd.ca.gov (for MDs, DPMs and PAs)
- California Osteopathic Medical Board: www.ombc.ca.gov (for D.O.s)
- California Board of Registered Nursing: www.rn.ca.gov (for RNs, NPs)
- Board of Behavioral Sciences: www.bbs.ca.gov (for MFCC's, and LCSWs)
- California Psychology Board: www.psychboard.ca.gov (for clinical psychologists)

If computer access is not available, a copy of the practitioner's license/certification/registration and driver's license or other identification will be made and attached to the *Disaster Privilege/Prerogative Approval* form. If a copier is not available, the hospital representative will perform a visual verification of the above documents, and document such verification. If primary source verification cannot be accomplished at the time of initial credentialing, it must be performed as soon as the immediate situation is under control, and completed no later than 72 hours from the time the volunteer presented to the hospital. In extraordinary circumstances when primary source verification cannot be completed, the following must be documented:

- Why primary source verification could not be performed in the required timeframe
- Evidence of a demonstrated ability to continue to provide adequate care, treatment and services, and
- An attempt to rectify the situation as soon as possible.

Medical Staff Services shall query the National Practitioner Data Bank and other sources as needed per *Temporary Privilege* policy for purposes of an important patient care need as soon as the emergency situation has been contained. Primary source verification is not required if the volunteer has not provided care, treatment and services under the disaster privileges.

Identification. Practitioners granted disaster privileges shall be issued a temporary badge or sticker to allow staff to readily identify these individuals. Badges should contain the volunteer's name, specialty or AHP category, and a notation stating, "practicing with disaster privileges".

Oversight. If possible, the practitioner should be paired with a medical staff member and should act only under the direct supervision of a medical staff, AHP, or hospital employee, as appropriate, to observe or mentor the volunteer. If partnering is not possible, oversight will be conducted by medical record review. Based on the oversight, the Chief Executive Officer or Chief of Staff or their designees have the authority to determine if the granted disaster privileges should continue. Disaster privileges may be terminated at any time without any stated reason or cause. The declaration by the CEO or designee, which the emergency is over will automatically terminate all emergency privileges. Termination of disaster privileges shall not afford hearing rights under the Medical Staff Bylaws or any other authority.

The medical center may assign disaster responsibilities to volunteer practitioners who are not licensed independent practitioners, but who are required by law and regulation to have a license, certification or registration.

Granting Privileges. When the disaster plan has been implemented, and the immediate needs of the patients cannot be met, KH may implement a modified credentialing and privileging process for eligible volunteer practitioners and or allied health practitioners. A process is in place, which provides safeguards to assure volunteer practitioners are competent to provide safe and adequate care, treatment and services. This section applies to individuals that are not licensed independent practitioners (i.e., individuals who are required by law and regulation to have a license, certificate or registration to practice their profession, such as registered nurses, licensed vocational nurses, MFCC's, LCSWs and Clinical Psychologists).

Assignment of Disaster Privileges. The Chief Executive Officer or Chief of Staff or their designees have the authority to grant disaster privileges. Designees for the CEO include the COO and CNO. Designees for the Chief of Staff include the Vice Chief of Staff, Secretary-Treasurer, or any Department Chairperson. The responsible individual is not required to grant privileges to any individual and is expected to make decisions on a case-by-case basis. The procedure for granting disaster privileges include the following processes:

- Current picture hospital ID card
- Current license to practice

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- Primary source verification of the license
- Identification that the individual is a member of a Disaster Medical Assistance Team (DMAT) or MRC, ESAR-VHP, or other recognized state or federal organization or group
- Identification indicating that the individual has been granted authority to render patient care treatment and services in disaster circumstances, such authority having been granted by a federal, state or municipal entity
- Identification by current hospital or medical staff member(s) who possess personal knowledge regarding the volunteer's ability to act as a licensed independent practitioner during a disaster

Primary Source Verification. Kaweah Health personnel involved in the credentialing process will use the appropriate licensing/certification/registration on-line and print verification if possible:

- California Board of Registered Nursing: www.rn.ca.gov (for RNs, NPs)
- Board of Behavioral Sciences: www.bbs.ca.gov (for MFCC's, and LCSWs)
- California Psychology Board: www.psychboard.ca.gov (for clinical psychologists)

If computer access is not available, a copy of the practitioner's license/certification/registration and driver's license or other identification will be made and attached to the *Disaster Privilege/Prerogative Approval* form. If a copier is not available, the hospital representative will perform a visual verification of the above documents, and document such verification. If primary source verification cannot be accomplished at the time of initial credentialing, it must be performed as soon as the immediate situation is under control, and completed no later than 72 hours from the time the volunteer presented to the hospital. In extraordinary circumstances when primary source verification cannot be completed, the following must be documented:

- Why primary source verification could not be performed in the required timeframe
- Evidence of a demonstrated ability to continue to provide adequate care, treatment and services, and
- An attempt to rectify the situation as soon as possible.

Primary source verification is not required if the volunteer has not provided care, treatment and services under the disaster privileges.

Identification. Volunteer practitioners granted disaster privileges shall be issued a temporary badge or sticker to allow staff to readily identify these individuals. Badges should contain the volunteer's name, specialty or AHP category, and a notation stating, "practicing with disaster privileges".

Oversight. If possible, the voluntary practitioners should be paired with a staff member who is similar licensed, and should act only under their direct supervision as appropriate, who will observe or mentor the volunteer. If partnering is not possible, oversight will be conducted by medical record review. Based on the oversight, the Chief Executive Officer or Chief of Staff or their designees have the authority to determine if the granted disaster privileges should continue. Disaster privileges may be terminated at any time without any stated reason or cause. The declaration by the CEO or designee, which the emergency is over will automatically terminate all emergency privileges.

Evaluation of the effectiveness of emergency management planning activities

On an annual basis, at the Environment of Care Committee, KH will conduct an annual review of the effectiveness of emergency management planning activities. This review will be forwarded to senior leadership for review. The annual review will include the following processes:

- The Objectives of the Emergency Operations Plan will be evaluated as follows: The intent of the objectives will be reviewed to determine if still relevant and applicable, and if change or modification is required.
- The Scope of the Emergency Operations Plan will be evaluated as follows: Planning activities will be reviewed to determine if modifications are required due to changes within the District, its structure, the patient population served, community planning partners or other factors that may have an impact on disaster response to emergencies.

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- The *Hazard Vulnerability Analysis* will be reviewed to determine if risks, preparedness and mitigation strategies have changed or altered to lower or increase overall probability of defined risks.
- The *Inventory of Organizational Assets* will be reviewed to determine if resources and assets relating to emergency preparedness have been changed, or require change.

Evaluation of the effectiveness of the Emergency Operations Plan

Kaweah Health conducts exercises to assess the effectiveness of the Emergency Operations Plan at least twice a year, stressing the limits of the plan to support assessment of preparedness and performance. The design of exercises will reflect likely disasters, and will test the District's ability to respond to emergencies, and to provide care, treatment and services under stressed situations. Off-site areas classified as business occupancy (as defined by the *Life Safety Code*) will conduct one such drill a year.

Influx of patients, escalating event and community participation. At least one drill a year conducted by the District will include an influx of simulated patients, and one drill will simulate an escalating event in which the surrounding community is unable to support the hospital. This portion of the drill may be conducted separately or in conjunction with a community wide drill, or tabletop exercise. One exercise will be conducted in participation with the County and or State of California.

Evaluation of drills: Exercises will incorporate likely scenarios as identified on Kaweah Health's *Hazard Vulnerability Analysis*, with an evaluation tool used that monitors and assesses staff response to handling of communications, resources and assets, security, staff, utilities and patients. An individual(s) will be selected whose sole responsibility during exercises is to monitor performance. Opportunities for improvement will be addressed during debriefing by a multidisciplinary process, which includes independent practitioners, and documented, with a final evaluation completed at the Emergency Management Subcommittee. It will be the responsibility of the Emergency Management Subcommittee members to follow-through with documented deficiencies, with information provided to the Environment of Care Committee. Identified deficiencies are expected to be resolved prior to the next planned exercise, with interim measures put in place until final modifications are made. Subsequent exercises reflect modifications made and or interim measures identified.

-Description	Quantities/Descriptions	96 Hour Sustainability and Critical Asset	Individual Responsible Phone
Accommodations – Employees/Families	Kaweah Health Kids Child Care Center will accommodate childcare during a disaster. The rationale was to offer support/care to employees during a disaster, letting them know that their children could remain close by if no other accommodations could be made for them. Individuals to oversee setting up the accommodations, assuming childcare responsibility would be appointed from the Hospital Command Center.		Kaweah Kids Director 624-2471
Alternate Care Site	Alternate Care Site #1: Emergency Department Parking Lot (Tents) Surge Tent Policy #DM 2226 Alternate Care Site #2: Kaweah Health Rehab Hospital Phone: 559-624-3700 Alternate Care Site #3: Kaweah Health Mental Health Phone: 559-624-3322 Alternate Care Site #4: KH South Campus Phone: 559-624-6204 Emergency Room Triage Area- Acequia Wing Conference Room		Safety Dept. 624-2381
Bulk Oxygen Storage	3000 Gallon bulk oxygen storage, which will provide oxygen for 7-10 days, depending upon usage; plus, we have a 500 gallon back-up tank, which will provide approximately one day of usage	3000 gallon will provide oxygen for 7-10 days. 500 gallon will provide approximately 1 day use.	Maintenance Director 624-2327
*Communications – Alternate types	<p>Districtwide</p> <ul style="list-style-type: none"> • HT 1250 Radios, charger, battery and clips. • Xmatter messaging available for Leadership and employees • Emergency cell phones available at each campus • Text Messaging • Landlines throughout the medical center • Runners • Satellite Phone available at campuses: South Campus - 00881651456907 KH Rehab - 00881651456906 Exeter - 00881651456908 Kaweah Health Medical Center – 00881651456904 <p>Emergency Department</p> <ul style="list-style-type: none"> • StatusNet911: Multi-Agency Emergency Communication System capable of communicating with all area regional hospitals & EMS Dispatch Centers • Kenwood TK-2140 hand portable radio capable of communicating with all area regional hospitals & EMS Dispatch Centers. • Two Motorola MIP 5000 radios with Hospital Emergency Administrative Radio System, Hospital Med Channels & EMS Dispatch Centers. • Dedicated MICN Laptop & Cellular Broadband Card. This laptop is equipped with the StatusNet & Hospital Paging systems. <p>Dedicated EMS Communications Cellular Phone.</p>	<p>-Hand-held radios available at each campus</p> <p>-Emergency cell phones available at each campus</p> <p>-Runners available via Labor Pool.</p> <p>-PBX (on emergency power) will extend to 96 hour sustainability if not damaged.</p>	Communications Manager 624-2280
Cots	20 sleeping cots are available in Disaster trailers		Safety Dept. 624-2381

Emergency Operations Plan

Decontamination Shower	(3) Portable Decontamination Shower located in Emergency Department & Decon Trailer		Safety Dept. 624-2381
Education Plan – Decontamination	Employees trained on 10.2021		Safety Dept. 624-2381
Emergency Operations Plan	Revised approved by BOD 2020		Safety Dept. 624-2381
Emergency Equipment Inventory and Location	See Attached Emergency Equipment Inventory Equipment located in Lab Basement Cage, Trailers at CHC, Trailer at Warehouse and 515 W. Willow.		Safety Dept. 624-2381
Food Plan - Disaster	We will utilize food from cold sources first (refrigerators & freezers), then change to dry supplies	We will utilize food from cold sources first (refrigerators & freezers), then change to dry supplies	Director Nutritional Services 624-5081
Food Supply – Patients, Employees/MDs, other	In the event of a disaster existing food inventories will be utilized to feed patients, staff, others. Menus will be adjusted to utilize (on-hand at the time) food supplies. Typically enough food is on site to feed 800-1,000 people per day for 3 – 4 days.	If food supplies begin to diminish, "Memos of Understanding" (M.O.U.s) are in place with Costco & Smart & Final to procure supplies as needed. Emergency plans have also been set up with US Foods & Sysco.	Director Nutritional Services 624-5081
*Fuel	4000 gallon tank located on premises; however, usually the tank has approximately 3600 gallons of diesel fuel available		Maintenance Director 624-2327
Generator-portable	3 available		Maintenance Director 624-2327
HEPA Filters	5 available		Maintenance Director 624-2327
Letters of Agreement • Cardinal Health • Professional Hospital Supply • Medline • Sysco (Food)	LOA for Cardinal Health – priority delivery agreement LOA for PHS – priority delivery agreement LOA for Medline – priority delivery agreement Agreements with local vendors	Cardinal has agreed to deliver from alternate sites. If Cardinal cannot deliver we have agreements with secondary suppliers. If those suppliers cannot deliver we have agreements with local vendors	624-2596

<p>Water – For All</p>	<p>Cal-Water Management Team has placed a back-up engine tied to a water pump that supplies water to the main campus. So in the event of a major power failure they will be able to provide water to our main campus.</p> <p>Secondary Plan: Nutritional Services has Emergency Water Plans for KH, West Campus and South Campus to provide water for 4 days. Emergency Water is stored in Nutritional Services Storage Areas.</p> <p>Water Conservation Strategies</p> <table border="1" data-bbox="522 339 1335 1003"> <tr> <td>Surgeries</td> <td>Emergency only Sterilization sent off site</td> </tr> <tr> <td>Dialysis Patients</td> <td>Diverted to other facilities</td> </tr> <tr> <td>In Patients</td> <td>Sponge bath with “wipettes” Hand washing with alcohol gel</td> </tr> <tr> <td>All Staff</td> <td>Hand washing with alcohol gel</td> </tr> <tr> <td>All Staff/Patients</td> <td>Consume bottled drinks-try to limit to no more than 2 quarter per day; ration plan is implemented by Nutrition Services</td> </tr> <tr> <td>Toilets</td> <td>If able to flush, flush after 3rd usage. If unable to flush, insert plastic bags into toilets, and seal when finished. EVS to remove to terminal waste collection area</td> </tr> <tr> <td>Sinks</td> <td>Affix signs: “Do Not Use”</td> </tr> <tr> <td>Chillers</td> <td>This is only affected if boilers can no longer run.</td> </tr> <tr> <td>Boilers</td> <td>Season will determine heating and or chilling needs.</td> </tr> <tr> <td>Generators</td> <td>Can run for approximately 7 days depending upon load usage.</td> </tr> <tr> <td>HVAC</td> <td>On e-power.</td> </tr> </table>	Surgeries	Emergency only Sterilization sent off site	Dialysis Patients	Diverted to other facilities	In Patients	Sponge bath with “wipettes” Hand washing with alcohol gel	All Staff	Hand washing with alcohol gel	All Staff/Patients	Consume bottled drinks-try to limit to no more than 2 quarter per day; ration plan is implemented by Nutrition Services	Toilets	If able to flush, flush after 3 rd usage. If unable to flush, insert plastic bags into toilets, and seal when finished. EVS to remove to terminal waste collection area	Sinks	Affix signs: “Do Not Use”	Chillers	This is only affected if boilers can no longer run.	Boilers	Season will determine heating and or chilling needs.	Generators	Can run for approximately 7 days depending upon load usage.	HVAC	On e-power.	<p>168 hours sustainability with water conservation measures if needed</p>	<p>Maintenance Director 624-2327</p>
Surgeries	Emergency only Sterilization sent off site																								
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HVAC	On e-power.																								
<p>Linens</p>	<p>24-hour supply on hand Daily deliveries Linen Conservation Plan will need to go into effect if there is interference with deliveries:</p> <ul style="list-style-type: none"> ○ Bed Bath every 3rd day ○ Change linen every 3rd day if not soiled; clean chux daily <ul style="list-style-type: none"> ○ Use alcohol gel or wipes for hand washing ○ Whenever possible use wipes instead of wash cloths ○ Change hospital gowns every 3rd day unless soiled; encourage use of personal sleeping attire if at the hospital <ul style="list-style-type: none"> ○ Agreement in place with Mission Linen 	<p>Meets 96 hour sustainability with power by cogeneration plant. Agreement in place with Mission Linen a local firm</p>	<p>EVS Director 624-2380</p>																						

Emergency Operations Plan

Hazard Vulnerability Completed – Top Five Hazards – revised 22022	2022 HVA- Top 5 Risks		Safety 624-2381
	Event	Rational	
	Epidemic 78%	An especially severe influenza pandemic could lead to high levels of illness, death, social disruption, and economic loss.	
	Chemical Exposure 56%	Pesticides are widely used in our agriculture areas.	
	Fog 56%	Central Valley fog is very heavy and there is a history of multi-vehicle (100+) accidents on local highways.	
	Temperature Extremes 50%	We have months of considerable temperatures in summer months.	
Isolation Rooms – Negative Pressure	Total Number of Isolation Rooms: 17		Director – House Supervision 624-2642
Licensed Beds	270 Unspecified General Acute Care 89 Perinatal Services 41 Intensive Care 23 Intensive Care Newborn Nursery 12 Pediatric Services 45 Rehabilitation Center at KDRH		Director – House Supervision 624-2642
Personal Protective Equipment	Mask – respirator TB – 14 cases (210 masks per case) in Materials 85 cases (210 masks per case) in Emergency Supplies		
*Pharmacy Meds on Supply	Pharmacy Cache from the State: two chem. Packs (1) for approximately 450 (1) for hospital, servicing 1000 employees Can request syringes from Tenet Cache and 25/580 from local sister hospital	Can reach 96-hour sustainability with access to Tenet Cache and from other Tenet hospitals.	Pharmacy Director 624-2470

Pharmacy Chem Pack contents

**Emergency Services: Treatment Capacity 454 Patients
EMS Chempack Contents***

Can reach 96-hour sustainability with Pharmacy Chem Pack contents

Emergency Operations Plan

Drug/Dosage Form/Device	NDC/Product #	Number of units/box
Antidote Treatment-Nerve Agent Auto-Injector (ATNAA)	11704-777-01	200
Atropine Sulfate 0.4 mg/ml 20 ml vial	63323-234-20	100
Pralidoxime 1 gm 20 ml vial	60977-141-01	276
Diazepam 5 mg/ml Auto Injector	6505-01-274-0951	150
Diazepam 5 mg/ml 10 ml vial	0409-3213-02	25
Sterile H2O Inj 20 ml	0409-4887-20	100
Atropen 0.5 mg*	11704-104-01	144
Atropen 1 mg*	11704-105-01	144

*KH has 2 Chempacks on the Medical Center premises; each Chempack is designed to treat 454 patients.

Pharmacy Supplies

Our hospital pharmacies disaster drug procurement plan is outlined in Pharmacy Manual 6.25.0. We have an established plan that was developed in conjunction with our primary drug distributor (AmeriSourceBergen). We have a list of medications that would be available for use in the event of a disaster. In the event of a disaster, we would notify the distributor of such an event and processes put in place to assure drug procurement based on the pre-developed drug list is executed. Per our Disaster Recovery Plan with our distributor, they will obtain assistance from local Emergency Services companies, the CA Office of Emergency Services, local law enforcement agencies, private contractors, the media, and military organizations. These agencies will be used to transport product overland or via helicopter if necessary.

Can reach 96-hour sustainability with our Disaster Recovery Plan

Pharmacy Director
624-2470

Surge Capacity Plan

Surge Capacity Plan in place; key issues addressed:

- o Census Saturation Plan AP. 114 in place
- o Identification of Isolation Rooms with Negative Pressure Availability of Infection Control Nurses x24 hours/7 days week
- o Bio-Safety Level 2 rating for Microbiology Laboratory, and is capable of testing for: influenza A&B antigens, RSV antigen, C. diffile toxin, E coli 0157, VRE and MRSA, routine cultures and anti-microbial susceptibilities, fungus and yeast isolation/identification. The Clinical Lab is equipped to rule out bio-terrorism organisms and rare and unusual organisms. The lab is able to refer specimens to reference labs and Tulare County Public Health Department.

Director – House Supervision
624-2642
Safety
624-2381

Emergency Operations Plan

	<ul style="list-style-type: none"> o (3) month supply of small regular size Tecol N-95 respirators; high risk departments have designated fit-testers who can fit test employees if needed; N-95 respirators may be able to be accessed from Tulare County cache o Pharmacy – Disaster Drug Procurement Plan in conjunction with our primary drug distributor based on pre-developed drug list. o Employee/family accommodations will be made available as needed 		Safety 624-2381												
Tents	Have two tents available for use		Director 624-2327												
*Security – Ways to Increase	Security Staff is in-house. We have a current contract with Triple A Security for additional security staff if needed in an emergency.	Can reach 96 hours sustainability with In- house staff and contract with Triple A Security.	Security Manager 624-5591												
*Staffing hours – Ways to increase	<table border="1"> <thead> <tr> <th>Priority</th> <th>Strategy</th> </tr> </thead> <tbody> <tr> <td>One</td> <td>Adapt staffing ratios to need. Each of the designated patient care levels (critical, complex/ critical, basic, and supportive) will require different staffing ratios.</td> </tr> <tr> <td>Two</td> <td>8-hour shifts may be changed to 12-hour shifts.</td> </tr> <tr> <td>Three</td> <td>Prioritize tasks so only essential patient care tasks are provided by staff.</td> </tr> <tr> <td>Four</td> <td> <ul style="list-style-type: none"> • Use media to contact volunteer healthcare workers. • Acquire staff through established MOUs and partnerships with other sister facilities. • Consider alternate labor sources such as MRCs, Community Emergency Response Teams (CERTs), etc., through County </td> </tr> <tr> <td>Five</td> <td>Consider flexing scope of practice of staff to provide necessary care with available staff (when authorized by the Governor during a declared state of emergency to allow flexed scope of practice).</td> </tr> </tbody> </table>	Priority	Strategy	One	Adapt staffing ratios to need. Each of the designated patient care levels (critical, complex/ critical, basic, and supportive) will require different staffing ratios.	Two	8-hour shifts may be changed to 12-hour shifts.	Three	Prioritize tasks so only essential patient care tasks are provided by staff.	Four	<ul style="list-style-type: none"> • Use media to contact volunteer healthcare workers. • Acquire staff through established MOUs and partnerships with other sister facilities. • Consider alternate labor sources such as MRCs, Community Emergency Response Teams (CERTs), etc., through County 	Five	Consider flexing scope of practice of staff to provide necessary care with available staff (when authorized by the Governor during a declared state of emergency to allow flexed scope of practice).	Can reach 96-hour sustainability with our Staffing Strategies.	House Supervisor 624-2642
Priority	Strategy														
One	Adapt staffing ratios to need. Each of the designated patient care levels (critical, complex/ critical, basic, and supportive) will require different staffing ratios.														
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Five	Consider flexing scope of practice of staff to provide necessary care with available staff (when authorized by the Governor during a declared state of emergency to allow flexed scope of practice).														
Staffing – Physicians & Resident Physicians	Must report to the Physician Labor Pool		Medical Staff Director 624-2358												
Ventilators	33 total ventilators plus 3 in storage which will be on preventive maintenance inventory and kept maintained for emergencies		Director Respiratory Services 624-2417												

Decontamination Shower	Emergency Department – 1 built in shower with 500 gallon waste water containment tank. 1 Portable decon shower + 2 portable decon shower stored in decon trailer.	
Equipment – Bioterrorism – located in of the County provided trailer.		
	55 Gal. Containment Drums w/ dollies	4
	Don-It Post Decon Personal Privacy Kits – Adult – 20 per case	7 cs
	3M Nickel Batteries	5
	4'X100' Safety Fence	3
	Boxes Nitril Gloves (LG)	10
	Boxes Nitril Gloves (MD)	10 bx
	Boxes Nitril Gloves (SM)	10
	Case Gatorade Mix	1
	Casualty Manager shelter	1
	Container 2 buckets, brush and sponges	1
	Cooling Vests	23
	Decon Tent	1
	Don-It Personal Privacy Kit (Adult)	16
	Don-It Personal Privacy Kit (Youth)	8
	Don-It Post Decon Personal Privacy Kits – Child – 20 per case	4 cs
	Extraction Litters	4

Emergency Operations Plan

	Hard Hats	4
	Hazorb Booms	7
	Honda 10,000 Generator	1
	Honda 3000 Generator with Tele Lite Kit	2
	hoses	3
	Igloo 10 gallon water jug	1
	Igloo Ice Chest (40 QT)	1
	Level B Suits	5
	Level B Suits (M)	5
	Level D Suits (LG)	25
	Manometer	1
	Minute Man Heppa	1
Equipment – Bioterrorism – located in of the County provided trailer (at South Campus) 1633 S. Court St. Visalia, Ca 93292		
	Model Pelair 24,000 Portable air conditioner	2
	On Scene Bio Protective Kit (XL)	320
	On Scene Bio-Tec Kit (2XL)	400
	On Scene Bio-Tech Kit (2XL)	582
	PAPR FR-57 Filters (cases)	9
	Pig Spill Blocker Dikes	4
	Pop-Up Tent	2
	Powered Air Purifying Respirators (PAPR) –	26
	Quick Shade Instant Canopy (10'X10')	2
	Quick Shade Instant Canopy (10X10)	2

Emergency Operations Plan

	Rubbermaid 5 Drawer Tool Box	1
	Rubbermaid Cart (grey)	1
	Safety Vests- Orange	1
	Safety Vests w/ White Reflectors	11
	Safety vests-Green	3
	Spill Berm Rub Orange	2
	System CPF 3 Keppler Suits (LG)	2
	Tool Box	1
	Traffic Cones	10
	Traffic Delineators	11
	Red Helmets(10)	10
	Caution Tape and Hazard Tape (<i>tub</i>)	1
	Tyvek Coverall (XL)	25
	Tyvex Coverall White (2X)	25
	Tyvex Coverall White (3X)	25
	Used Air Filters (Practice)	14
	Wrench Set	1
Equipment – Warehouse 240 South Dunsworth, Visalia Ca	Clean Air RX Air 3000 Air Purifier	1
	Generator Cord	1
	Mintie 1000V Hepa	2
	Mintie ECU 2 Bundle	1
	OmniAire 1000 V (Hepa Air Units)	2
	Poly Pad	1
	Pressure Kit	1
	Star Heater	1
	Don-It Personal Privacy Kit	

Emergency Operations Plan

Equipment- Decon Trailer	3M 10 Unit battery Charger (PAPR)	2
	3M Battery Packs	15
	5 Unit Charging Stations	3
	Asbestos Vac	1
	Bar Code Reader	2
	Booties (10LG)	1 cs
	Booties (6-SM/6-2XL)	1 cs
	Booties (8XL)	1 cs
	Booties (9 Med)	1 cs
	Non Researchable PAPR Batteries (26)	1 bx
	Bull Horns	2
	Cases 3M Cartridges of filters (6 each)	15 cs
	Chemical Tape (20 rolls)	2 bx.
	Communication Radio Batteries	20
	Decon Suits (2XL)	12
	Decon Suits (3XL)	33
	Decon Suits (L)	6
	Decon Suits (Med)	6
	Decon Suits (XL)	18
	EPV 200 Ventilator	3
	Green Duffle Bags	2 bag
	Level B Suits (XL)	18
	Level B Suits (3XL)	6
	Level B Suits (L)	34

Emergency Operations Plan

	Level B Suits (M)	6
	Level D Suits (LG)	25
	Level D Suits (XL)	9
	Lithium Mag Disposable batteries	5
	Modular ECU 2 Tent	1
	Multi casualty triage kit	1
	Nickel Cadmium Batteries	3
	Orange Duffle Bags	1bag
	PAPR bags with unit and filters	22
	PAPR Cartridges	117cs
	Personal belongings bags	2 bx
	Phillips Heart Start Defibrillators	2
Equipment- 515 Building	Pocket Hand Held Computers	2
	Portable Decon Shower	3
	Portable Suction Units	9
	Power Heart AED 3 Defibrillators	2
	Pre and Post Decon Bags (Small/Med)	2 bx
	Pre and Post Decon Bags (Youth).	1 bx
	Radiation Detector	1
	Radio Chest Packs	10
	Rubber Gloves (Size 7)	12
	Rubber Gloves (Size11)	12
	Scissors	33
	Spinal Immobilization Board	12
	Steel Toe Boots (1-Size 8, 3- Size 10)	1
	Steel Toe Boots (Size 10 Green)	3
	Steel Toe Boots (Size 11 Orange)	3

Emergency Operations Plan

	Steel Toe Boots (Size 12 Orange)	3
	Steel Toe Boots (Size 6 Green)	2
	Steel Toe Boots (Size 7 Orange)	3
	Steel Toe Boots (Size 7 Orange)	4
	Steel Toe Boots (Size 8 Green)	8
	Steel Toe Boots (Size 8 Orange)	7
	Steel Toe Boots (Size 9 Green)	3
	Stereoscopes	13
	Clipboards (suite case)	1
Equipment – Evacuation	<ul style="list-style-type: none"> • Stryker evacuation chair at staff elevator landings on the 3rd and 4th floors. 	

ATTACHMENT C

Manager’s Recovery Guidelines (Recovery Checklist Post Disaster)

Manager’s Recovery Guidelines

Damage Assessment	Staff Requirements	Equipment Requirements	Document Requirements	Other
Assess patient safety post incident.	Assess current capacity of staff and possible overtime hours.	Assess equipment for operational status	Document requirements are critical to financial recovery.	Data safety: whenever possible, data in your computer(s) should be on back up files
Assess employee safety post incident	Determine if staffing needs were met, and if additional staff was utilized, or overtime was used.	Identify what alternates to current equipment can be used.	Document hours worked by staff during the incident, and post incident and until the incident is declared resolved.	
Assess area safety to determine where it is safe to move	Ensure staff hours worked during the incident are disaster-coded properly to the disaster cost center.	Notify Biomed for equipment needs.	Photograph damages to building and equipment. Contact photography or departments with digital cameras , videos (Engineering)	
Complete Damage Assessment in your area. If damage has occurred, obtain photographs of the area—preferably by camera or digital camera. Keep as part of records; originals to the Cost Officer with date, time, location, contact person.		Document all rental usage. Try to rent as opposed to purchase as rental fees are more easily recoverable, than purchase fees.	Maintain files for P.O.’s relating to rental of equipment needs, or purchase of supplies relating to the incident. If in doubt, write “PO-Emergency Incident”, and the P.O.’s will be evaluated at a later date. Originals to Cost Officer	
Make copy of completed <i>Damage Assessment form</i> and maintain in your records		Photograph damaged equipment. Originals to Cost Officer: date, time, location, contact person.	All food/nutrition/supply need to be documented as distributed during the disaster to determine cost of nutritional deliveries for patients, staff, visitors.	
Bring <i>Damage Assessment form</i> to the Command Post				
Be on the alert for other damages that may occur (eg., noticeable structural or non-structural damages from after shocks post earthquake).				NOTE: Ensure all disaster worked hours, purchased or rented services or equipment or supplies are coded to the Disaster Cost Center—obtained from Payroll or Purchasing.
Document any new damages on a second <i>Damage Assessment form</i> and bring to the Command Post.				

DESCRIPTION	YES	NO
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Emergency Operations Plan

A. Damage Assessment Form 1. Area assessed for visual damages using <i>Damage Assessment Form</i> . If an earthquake occurred, and there are "aftershocks", area must be re-assessed using the same form, and resent to the Command Post.	If Yes, describe major damages: (use separate pages if necessary)	
B. Staff Requirements 1, Were staff requirements assessed?	If Yes, describe how many staff personnel were required and what job codes:	
2, Are hours worked by staff being charged to the Disaster Cost Center?	Cost Center being used on timecard is:	
C. Equipment Requirements 1. Identify what type of equipment is being purchased or rented for the disaster. Rent whenever possible.	If Yes, identify type of equipment, quantity, duration of rental and cost per unit. Copies of all P.O.'s to the Cost Officer.	
D. Document Requirements		
1. Have you photographed the area?	If Yes, ensure photograph and copies are maintained; original to Cost Officer. If "No", request immediate Photography Services.	
2 Have you maintained copies of all P.O's related to the Disaster?	If Yes, copies of all P.O's to the Cost Officer. If you are unsure if the P.O. is related to the disaster, note your concerns on a separate piece of paper attached to the P.O.	
3 If involved with Food Services, have you itemized all food services related to the care of victims, families, staff, etc., during the time of the disaster?	If Yes, copies of all P.O's to the Cost Officer. If you are unsure if the P.O. is related to the disaster, note your concerns on a separate piece of paper attached to the P.O	
4. Have you itemized all P.O's during the disaster.	If Yes, copies of all P. O's to the Cost Officer. If you are unsure if the P.O. is related to the disaster, note your concerns on a separate piece of paper attached to the P.O.	
E. Other Any other itemizations should be stated on a separate page, and attached.	If Yes, state all itemizations on a separate page and attach. If more space is required, categorize each entry with letters and numbers on this page (EG. A1, D2, etc.)	
F. Consequential Events. Were there any consequential events as a result of this disaster?	If yes, describe on a separate page, using an UOR, and attach.	
Business Loss. Were services closed as a result of this incident?	If yes, state what services were closed, with best estimate of loss of revenue. Identify in detail on a separate piece of paper, with heading entitled "Business Loss", and bundle with other information, sending to Cost Officer. Identify your name, department and phone number.	

Appendix A

Procedures for specific areas of high risk as determined by hazard vulnerability analysis:

Epidemic

Procedure:

- a. Determine how many patients have been infected. Ensure implementation of surge plan, proper triage and infection precautions
- b. Anticipate an increased need for medical supplies, antivirals, IV fluids and pharmaceuticals, oxygen, ventilators, suction equipment, respiratory protection/PPE, and respiratory therapists, transporters and other personnel
- c. Conduct disease surveillance, including number of affected patients/personnel
- d. Continue isolation activities as needed
- e. Consult with infection control for disinfection requirements for equipment and facility
- f. Continue patient management activities, including patient cohorting, patient/staff/visitor medical care issues.

Chemical Exposure

In the event of a chemical incident where patients are being brought into the facility the following measures will be taken:

- a. Notify Administration, House Supervisor, Hospital Safety Officer, Security and Emergency Department Nurse Manager.
- b. Determine area of decontamination and staging.
- c. See DM 2211 Decontamination plan for more detailed information
- d. Consider HICS activation

Fog

In times where fog is too dense and staff are unable to report to work the following steps shall be taken.

- a. Notify Administration, House Supervisor, Hospital Safety Officer, and Security
- b. Gather information regarding staff shortage
- c. Begin call back procedures
- d. Consider cancelling elective procedures
- e. Begin discharging patients as appropriate

Mass Casualty (Haz Mat)

In the event we experience a large scale haz mat incident and we experience high number of casualties.

- a. Notify Administration, House Supervisor, Hospital Safety Officer, Security and Emergency Department Nurse Manager.

Emergency Operations Plan

- b. Security to secure a perimeter around the area to keep people out of the area.
- c. Notify Visalia Haz Mat Team to assist. .
- d. Consider activating HICS.

Patient Surge (See Census Saturation Plan AP114)

- a) Notify Administration, House Supervisor, Hospital Safety Officer, Security and Emergency Department Nurse Manager.
- b) A census saturation meeting will be held at the discretion of the House Supervisor, and will include the Directors who have leadership responsibility for the nursing units with the greatest census/acuity impact. This meeting will occur at 11:00 a.m. and can be canceled as determined by the House Supervisor.
- c) Bed status may be reassessed and communicated every 2-4 hours by the House Supervisor or their designee as needed.
- d) If it is determined that the Census Crisis is to persist past 12 hours, the CNO or Chief Operating Officer(COO) may be asked to attend the bed meeting.
- e) Nursing Directors, Chief Medical Officer (CMO), Chief of Staff or Medical staff designee or any other stakeholders determined to be appropriate for the event may be included. The purpose will be to review the inpatient activity and to assist in decision making to provide relief for the ED and/or surgery, cath lab services.
 - a. Chief of Staff or Medical Staff designee determines need to cancel procedures.
 - b. If procedures cancellation is required, affected medical staff members are contacted by the Chief of Staff and/or the CMO along with the patients effected.
- f) The House Supervisor and/or Nursing Director on call will open an identified patient Discharge Lounge as needed to house discharged adult patients while they wait for their private transportation home.



Policy Number: EOC 5001	Date Created: 10/01/2011
Document Owner: Maribel Aguilar (Safety Officer/Life Safety Mgr)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration), Board of Directors (EOC/Emergency Preparedness)	
Facility Fire Response Plan	

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

Policy: Kaweah Delta Health Care District herein after referred to as Kaweah Health (KH) will maintain a current Facility Fire Response Plan that addresses multiple features designed for the protection of life and property in the event of a fire.

Purpose: The purpose of the Kaweah Health’s facility Fire Response Plan is to provide an environment conducive to the prevention of facility fires and the protection of life and property in the event of a fire.

Scope: The scope of the Kaweah Health)Facility Fire Response Plan pertains to all property, buildings, and grounds owned and operated by Kaweah Delta Health Care District.

Authority and Responsibility: It shall be the responsibility of the Director of Facilities Operations in conjunction with the Risk Manager, Safety Officer and administration to implement the content of the Kaweah Health Facility Fire Response Plan to ensure the protection of life and property in the event of a fire within the confines of Kaweah Health Care facilities

Fire Safety Training: All employees, guild members, Licensed Independent Practitioners and other staff members will receive in-depth training on department-specific plans as well as the facility fire response in an effort to keep both plans at maximum effectiveness.

I. FIRE PREVENTION:

An unsafe act or unsafe conditions or both cause most fires. If each and every employee performed their duties in a safe manner and were alert to remove, correct and/or report unsafe conditions to their supervisor, most fires would be prevented.

A. Fire Resistive Construction:

1. It is the responsibility of the Kaweah Health Maintenance Department to maintain the initial standard of Type I fire resistive construction of Kaweah Health.
2. The Maintenance Department and Facility Planning department will monitor future construction changes and additions in such a manner as to protect the lives and ensure the physical safety of the patients, the employees, and the visitors to the hospital.
3. Whenever, for any reason, a smoke barrier wall or a fire wall is penetrated in order to run conduit, pipe or telephone cable, a Fire/Smoke Wall Penetration Permit will be issued and the Maintenance Department will check to see that the opening has been properly repaired.
4. No grills or windows will be cut in doors without the approval of the Maintenance Manager. No doors will be removed, or the designation of swing changed, without the Maintenance Managers permission. No hardware will be changed that might keep an automatic smoke control door from closing, that might disable panic hardware, or that might allow a fire door to stand open due to removal of a door closer.
5. Any partitions added to the building will be constructed of steel studs and fire resistant 5/8 inch

sheet-rock.

6. All materials and fabrics will meet Class A requirements for all hospital settings.

B. No Smoking Policy:

1. Communication of the policy will be by signage at campus entrances, building entrances, parking areas and reminders from staff when necessary. Job applicants will be notified of the policy upon application and during orientation.
2. As the fifteen (15) minute employee break is a paid break, staff will not be permitted to use tobacco products during these times. Employees will be required to leave the campus if they choose to use tobacco products during their lunch break.
3. This policy applies to all persons while on KH property. Employees found to be in violation of this policy will be subject to corrective action up to and including termination.
4. All employees will be responsible for the enforcement of this policy. Should an employee be found using tobacco products on KH property, the incident should be reported to the department manager.
5. “Script” cards will be developed which can be given to employees, visitors or patient. If a family member chooses not to abide by the policy it is not the responsibility of the KH employee to force the family member to discontinue smoking.
6. Patients will not be permitted to smoke while under KH’s care, even with a physician order.
7. KH will assist with compliance by sponsoring smoking cessation programs and providing smoking cessation education materials.
8. Persistent non-compliance with this policy should be directed to the following personnel:
 - Medical Staff – Vice President for Medical Affairs and Chief Medical Officer
 - KH Staff – Appropriate Director and Executive Team Member

C. Housekeeping Practices:

1. EVS in conjunction with occupants of the respective areas must monitor all facilities to avoid the accumulation of empty boxes, trash, wet and/or oily rags or other flammables or combustibles.
2. Do not stack boxes within eighteen inches from the bottom of the sprinkler heads.
3. Fire doors may not be wedged open or blocked with equipment. If a fire door does not have a mechanical hold open device installed, it is to remain in the closed position.
4. Wheeled equipment is permitted to be left unattended in the corridor for more than 30 minutes provided:
 - The equipment does not reduce the clear unobstructed corridor width to less than 5 feet.
 - The wheeled equipment is limited to equipment that is in use, medical emergency equipment not in use, and patient lift and transport equipment. Beds are not considered transport equipment or emergency medical equipment, so they are not allowed in corridors.

D. Electrical Hazard Prevention:

Electrical devices with frayed cords or wires and defective switches or plugs should be taken out of use, tagged with the defect, and reported to the appropriate department, Clinical Engineering or Maintenance Department.

E. Flame Spread Ratings:

The responsibility of acquiring flame spread ratings and the acquisition of approved equipment will be vested in the Hospital Architect of record, Facilities Planning Director, Director of Facilities Operations and the Director of Materials Management.

1. Kaweah Health shall maintain on file flame spread ratings on covering/finishing materials used within the facility.
2. These shall include, but not be limited to:
 - a. Carpet - flame retardant
 - b. Wall coverings - flame retardant
 - c. Drapes - flame retardant
 - d. Waste baskets - constructed of nonflammable material
 - e. Upholstery - flame retardant
 - f. Bedding - flame retardant
 - g. Decorations - flame retardant
3. Material will not be purchased if material flame spread rating data is not available

II. **FIRE IDENTIFICATION:**

Kaweah Health, Main Campus, is equipped with a Simplex 2120 Multiplex Fire and a Siemens Fire Finder XLS Alarm System. This system will identify, signal, and annunciate, upon activation of one of the initiation devices, any Code Red incidents. Employees will also be depended upon for quick, accurate detection and identification of fire.

A. **Initiation Devices:**

The Fire Alarm System provides the following means of initiating and identifying fire and smoke.

1. **Smoke Detectors** - There are smoke detectors located throughout the facility. Specific rooms and corridors are equipped with smoke detectors.
2. **Duct Detectors** - There are duct detectors installed on many of the KH air handlers. These are duct-mounted smoke detectors.
3. **Heat Detectors** - There are standard heat/thermo detectors located in the kitchen area, janitor closets and some mechanical areas. These detectors are combination rate of rise and set point operated.
4. **Flow Switches** - There are flow switches which annunciate fire sprinkler zones. Department-specific fire responses identify any sprinkler zone that serves that department.
5. **Pull Stations** - There are manual pull stations located throughout the facility. There will be a pull station located at all stair and ground floor exits and at various other locations. Department-specific fire responses note the pull station for that area.
6. Employees and licensed practitioners should report any odors of smoke or sighting of smoke to PBX Immediately by calling the code phone number 44 inside the main facility or 911 for all other locations.

B. **Alarm Signaling:**

Upon activation of any initiation device such as smoke detector or any device mentioned in “Fire Identification” section herein, an audible and visual alarm will activate.

1. **Audible Alarms:** There are chimes located throughout the facility. These will sound until an “All Clear” is called.
2. **Visual:** There are wall-mounted strobe lights located throughout the facility. These will remain lit until an “All Clear” is called.

C. **Communication:**

Upon identification of any Code Red incident, a series of communication events will take place. These events integrate mechanical and human responses.

1. Activation of any of our initial devices will be relayed to our outside monitoring company who will immediately contact Visalia fire dispatch for response of the initial firefighting units to the facility.
2. Simultaneously, this activation of the fire alarm system will display the zone and location at the main enunciator panels located in PBX.
3. The PBX operator will read the signal from the enunciator board and page “Code Red” two times. The location, device, and zone will be communicated via the public address system with the volume booster engaged. An “All Clear” will be announced by the PBX operator, two times, after notification of “All Clear” by the Maintenance Department Personnel, Safety Department Personnel or Fire Department. This same procedure will be followed on all shifts.
4. Our telephone system will be used for identification of a Code Red incident by dialing **44** at the hospital.
5. During a Code Red incident the telephone system should be limited to emergency calls only.

6. An alternate communication system will be used upon loss of the public address system, phones, or radio. Should the Code Red incident take place on the first floor and require evacuation of the PBX staff, the PBX manager will order transfer of communication operations to the ER.

D. **Fire Alarm Device Failure:**

To ensure staff knowledge and awareness in the event of pull station or any fire alarm system failure.

1. All employees, Guild members, or other staff, including licensed practitioners that attempts to operate a manual fire alarm pull station should recognize that within seconds of pulling the handle on the pull station, audible and visual alarms will initiate.
2. Should the signaling devices (audible and visual) fail to initiate, the following protocol shall be used.
 - a. Alternate locations of fire alarm pull stations should be found. These alternate locations should be identified in the department-specific fire responses.
 - b. All exits have a fire alarm pull station
 - c. Communicate the exact location and any other incident specifics to PBX by dialing **44** at the nearest available phone after activating pull station.

III. **CODE RED TEAM AND INCIDENT COMMAND STRUCTURE:**

A. **Code Red Command Center:**

1. A Code Red command center will be set up in the Physician’s Lounge across from PBX. This center becomes the communication hub during a disaster and fire incident.
2. First shift command center staffing will consist of the Maintenance Personnel supervisor, and fire department designee. Need for an administrative representative will be evaluated as necessary.
3. The safety officer, when not at the fire location, will be stationed at the command center. All communication pertaining to extinguishment, evacuation or other emergency response will be transmitted from the command center to all necessary locations.
4. The second and third shift command center will be set up in the Physician’s Lounge with the arrival of the fire department, maintenance personnel, and safety officer.

B. **Management of Smoke Transmission:**

1. Kaweah Health will require a fire alarm system that will limit the transfer of smoke. The buildings are equipped with a Fire Alarm System that addresses and accomplishes compartmentization of smoke by automatic controls.
2. The Fire Alarm System provides for activation of smoke dampers upon initiation of all automatic device Priority I alarms.
3. Documentation of the fire/smoke damper system is evidenced by life safety and mechanical drawings kept on file in the Maintenance department.

IV. **CODE RED EMERGENCY RESPONSE:**

A. **First Responder Procedures in Fire Area:**

The specific plan for each department specifies the details of actions to be undertaken by employees in the event of a fire in your area. In general, the person discovering the fire (employees, volunteers and Licensed Practitioners) must immediately:

RACE

1. **Rescue** - REMOVE any persons in immediate danger.
2. **Alarm** - Communicate the presence of fire by immediately activating the nearest fire alarm pull station.
3. Call, or designate someone to call the operator by dialing (Hospital Specific Number) to report the exact location and type of fire. If possible, have someone stay by the pull station to direct the Code Red responders to the site.
4. **Confine/Contain** – Close Doors, clear hallways. Equipment in hallways should be moved to inside unit/patient rooms with the door closed.
5. **Extinguish/Evacuate** - The fire should be extinguished if it is small and easily controllable by use of the fire extinguishers; however, all personnel in the fire area must evacuate the area as instructed in their fire response.

B. **Recommended Actions for All Personnel including Licensed Practitioners including During a Fire Alarm:**

1. Personnel should stay in the area in which they are at the time of the alarm. They should follow the instructions of the person in charge of that area at the time. Personnel should not be transiting

through the corridors unless they have specific fire-related duties.

2. All patient room doors are to be kept closed to aid in the evacuation; however, patient bathroom doors may be open. Any other door may ONLY be closed if it has been ascertained that NO PERSONS are in the room at the time of the alarm.
3. **DO NOT USE ELEVATORS.** Use stairways only. Elevators are to be utilized only by the fire department.
4. Personnel should attempt to reassure patients that the situation is under control and that they will be attended to throughout the event.
5. Visitors already in the hospital should remain with the patient in their room unless instructed otherwise by the person in charge of the area.
6. All visitors/vendors attempting to enter the hospital should be intercepted by an employee, and instructed to wait outside in the parking lot until the alarm is cleared.
7. Telephones should not be used during a Code Red. The paging system and any telephone conversation deemed essential should be limited to fire directives and emergencies only.
8. All nonessential electrical equipment should be turned off.
9. Guild members should remain in the area to which they are assigned and should follow the directions of the person in charge of that area.
10. All personnel should be prepared to follow their plan to evacuate their department upon orders from the person in charge as conditions warrant.
11. All staff including licensed practitioners will cooperate with firefighting authorities.

C. **Code Red Response Procedures:**

1. Code Red members will vary according to shift, will respond immediately to the announced location of the fire and will be in charge of the situation until the fire department arrives.
2. All available engineers, environmental service aides, security staff and nursing supervisor will report immediately to the fire location.
3. Maintenance personnel will determine the location and severity of the fire and smoke as well as assess the amount and spread of smoke, flame and area affected, spread patterns, and the extinguishing of the fire. This information will be continually transmitted to the command center.
4. Security staff will provide foot traffic control and maintain egress availability at stairway entrance. Environmental services staff will report to the department head or charge nurse to assist in evacuation preparation.
5. Code Red responders will serve as supplemental staff necessary for horizontal evacuation. Horizontal evacuation preparation is mandatory, in all zones, pending determination of fire and/or smoke severity. If a call for vertical evacuation is determined necessary, the Code Red responders will assist in the evacuation.

D. **Extinguishment of Fire:**

Kaweah Health is equipped with portable fire extinguishers, kitchen hood extinguishing systems, and specific areas covered with a fire sprinkler system.

1. Response to the Code Red includes use of portable fire extinguishers if the fire is containable as assessed by personnel on scene. All employees will be trained in use of portable extinguishers as part of their annual safety training.
2. Kitchen grill fires will be extinguished by an Ansul hood extinguishing system.
3. Kaweah Health has a fire pump that serves a stand pipe system with hose cabinets located at each end of each floor. The fire pumps also backs up the areas that are served by sprinklers.
4. The Visalia Fire Department, with back up from Tulare County units, serves as responders to this facility. The Visalia Fire Department has stations located within a two-mile radius of Kaweah Health. This provides us with a response time, which is normally five minutes, or less. Our policy is to allow professional fire fighters to extinguish any fire assessed above a minor category, which allows hospital staff to concentrate on an organized and timely evacuation.

E. **Disabling the Fire Alarm System:**

1. Kaweah Health will protect its buildings against unauthorized disabling of fire alarm system. Maintenance personnel or the fire alarm vendor shall not disable any portion of the fire alarm system without securing approval of the Facilities Director, notification of the house supervisor, and local fire department when the system will be off line for more than ¼ hour. California Department of Public Health will be notified if the failure exceeds 4 hours. In the event the Director of Maintenance is not present, the house supervisor may substitute.
2. Fire watch shall be instituted in all areas where system is inactive. Fire watch staffing as follows:
 - a. Security - All patient areas with assistance from Maintenance as needed.
 - b.

Security will be responsible to conduct a fire-watch if the failure exceeds 4 hours. All areas will be monitored each hour. Security will maintain documentation of the fire-watch.

V. **EVACUATION PROCEDURES:**

Kaweah Health recognizes the necessity for a timely and organized evacuation in the event of a verified Code Red situation. Evaluation of the Code Red as to the need for calling an internal disaster will be made by the safety officer or the highest level administrative representative in-house, giving access to a personnel pool will be established at the first floor conference room.

A. **Departmental Evacuation:**

1. All departments will evacuate following department-specific plans: first to horizontal zones, then vertical to east and west parking lot evacuation stations.
2. All zones effected will evacuate in accordance with a horizontal strategy and, if necessary, a vertical evacuation.
 - a. Horizontal strategy is moving from smoke compartment of incident to adjacent smoke compartment.
 - b. Vertical evacuation is complete evacuation of the smoke compartment of incident and alarm to a lower floor or to north or south parking lot stations if determined necessary by safety officer, nursing supervisor, administrative representative or ordered by the fire department.
3. Maintenance Personnel will use two way radios and cell phones for communication and coordination purposes.
4. All available ambulance companies will be notified by emergency room staff of the evacuation. The ambulances will be utilized for transporting patients to other area hospitals if determined necessary by administrative representative.

B. **Patient Evacuation:**

If the fire alarm sounds while transporting a patient from one department to another, the following procedures should be followed:

1. Evacuation while transporting patients via elevators
 - a. Fire announcement cannot be heard in elevators.
 - b. If the fire alarm is activated by a smoke detector located by elevator lobbies, all elevators will automatically go to the ground floor. If the fire is located on the ground floor, all elevators will automatically stop on the second floor.
 - c. When an elevator stops, the employee should exit with the patient and place the patient in the first safe area (room) available, close the door and remain with the patient until "All Clear" sounds or evacuation orders are given.
 - d. If any sensor other than those directly in front of the elevators activates the fire alarms, the elevator service will not be interrupted.
 - e. If employee exits, elevator and fire alarm is sounding, the employee should verify location of the fire, move the patient to the closest safe area (room) and remain with the patient until "All Clear" sounds or evacuation orders are given.
2. Evacuation of patients while transporting via hallways or other common areas:
 - a. If the fire alarm occurs while on the floor in transit, immediately move the patient to the closest safe area on that floor. The employee should remain with the patient until "All Clear" sounds or evacuation orders are given.
 - b. If the patient and the transporter have not left the floor and the fire alarm sounds, return the patient to their room. The transporter will remain on the patient floor until "All Clear" sounds. If evacuation is required, the employee will remain on the floor and get further instructions from the floor supervisor/manager.
3. Triaging Patients:
 - a. Emergency room physician will be in charge of the triage of patients.
 - b. All available physicians and interns will evacuate with the patients to the parking lot in order to assist with triage of patients.
 - c. Nurse managers/charge nurses from each nursing unit will assess their patients' condition and report any immediate need to the emergency room physician.
 - d. Personnel from each nursing unit will remain with their assigned unit.
 - e. Nurse managers/charge nurses will delegate patient care to their unit personnel and any additional non-nursing staff from other departments if necessary and available.

VI. **CODE RED TRAINING AND DRILLS:**

A. **Code Red Training:**

The Safety Department is responsible for conducting fire drills. The organization, training, equipping and supervision of hospital personnel in response to a fire alarm is the responsibility of the Safety Officer.

1. **Fire Drills:**

- a. The hospital shall hold unannounced fire drills quarterly on each shift, which shall be treated as a true fire as much as possible.
- b. Department managers or their designee shall complete a fire drill critique form and submit a copy to the safety office within twenty-four hours of each drill.

2. **Hospital Personnel:**

All hospital personnel will be trained and periodically in-serviced on their department-specific fire response as well as the hospital-wide fire response in accordance with the following schedule.

- a. Initial training at the time of hire
- b. Once annually
- c. Districtwide life safety training is conducted annually.
 - (1) Verification of initial and annual training will be evidenced by a completion of training in our electronic learning system.

B. **Code Red Drills:**

Kaweah Health will perform fire drills on a timely basis that educate and test all employees, Guild members, Licensed Independent Practitioners and other staff on proper Code Red response.

1. **Frequency of Drills:**

A Code Red Drill shall be performed once per shift per quarter. The need for additional drills will be assessed by the Environment of Care Committee based on the effectiveness of previous drills and any life safety deficiencies identified and not corrected.

2. **Responsibility:**

- a. The Director of Facilities Operations along with support and assistance from the Safety Officer, Environment of Care Committee, and Maintenance Department Manager will be responsible for performance of all Code Red Drills.
- b. All aspects of department plans will be followed but will not include actual evacuation, either horizontal or vertical.
- c. All department managers will complete or assign responsibility for completing a Code Red critique form. The Environment of Care Committee will critique the incident location and facility-wide response. Completed critique forms will follow the protocol ascribed to in the life safety plan.

3. **Fire Drill Procedures:**

- a. Prior to initiating a Code Red Drill, notification of the impending drill will be made by the safety department staff to PBX, monitoring company, and the Visalia Fire Department.
- b. The Code Red Drill will commence with a life safety coordinator either initiating an automatic fire alarm device or placing a red flashing beacon light, representing a fire, somewhere in the facility. All further actions taken will be subject to the Code Red critique policy.

4. **Code Red Critique:**

- a. Kaweah Health requires that all Code Red Drills and incidents be monitored, and that staff response be evaluated for effectiveness of training.
- b. The Code Red critique form is divided into the following categories of evaluation.
 - (1) Notification
 - (2) Mechanical response
 - (3) Staff response
 - (4) Random sample (staff)
 - (5) Code Red response
 - (6) Overall evaluation and rating
- c. All questions must be answered.
- d. Corrective action must be taken and tracked for the Environment of Care Committee.
- e. Completed forms will be forwarded to the Safety Officer.
- f. The Safety Officer will submit a quarterly report to the Environment of Care Committee on all Code Red critiques. The report will include required actions to be taken and any recommendations.
- g. When the need for additional training is identified by use of the Code Red critique, this training and education will become the responsibility of the department managers.

Documentation of this additional training will be by:

- (1) Department minutes
 - (2) Completed action plan
- h. The Environment of Care Committee will perform Monitoring and follow-up of actions taken for effectiveness.

"These guidelines, procedures, or policies herein do not represent the only medically or legally acceptable approach, but rather are presented with the recognition that acceptable approaches exist. Deviations under appropriate circumstances do not represent a breach of a medical standard of care. New knowledge, new techniques, clinical or research data, clinical experience, or clinical or bio-ethical circumstances may provide sound reasons for alternative approaches, even though they are not described in the document."



Policy Number: BOD6	Date Created: 03/27/2013
Document Owner: Cindy Moccio (Board Clerk/Exec Assist-CEO)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration)	
Board Reimbursement for Travel and Service Clubs	

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE: To provide reimbursement to members of the Kaweah Delta Health Care District dba Kaweah Health Board of Directors, consistent with legislative regulations, for the performance of the duties of their office.

POLICY: Each member of the Board of Directors shall be allowed his/her actual necessary traveling and incidental expenses including service organization dues incurred in the performance of official business of ~~the District~~ Kaweah Health.

PROCEDURE: Travel and incidental expenses including service organization dues will be reimbursed to Board members that are paid with personal credit cards or cash upon the submittal of itemized receipts to the ~~Executive Assistant to the Board of Directors~~ Board Clerk.

Any charges made with ~~the District~~ Kaweah Health issued Wells Fargo credit card requires submittal of itemized receipts with 10 days of completion of travel for reconciliation of the Kaweah ~~Delta~~ Health Wells Fargo Visa card provided to members of the Board of Directors.

I. Travel

- A. Meals will be reimbursed with the submittal of an itemized meal receipt.
- B. Air Fare for board member for the cost of coach fares and standard luggage fees. If the traveler chooses to travel in a premium class such as business or first, the difference in cost between coach travel rates and the premium travel rates must be paid by the traveler.
- C. Parking, taxi, or rental car fees and other transportation expenses will be reimbursed.
- D. If driving, mileage will be reimbursed at current IRS guidelines.
- E. Hotel room will be covered in full for Board Member. Lodging costs shall not exceed the maximum group rate published by the conference or activity sponsor as long as the group rate is available to the Board member at the time of booking. Any additional nights beyond or prior to the conference shall be incurred by the Board member.
- F. Conference registration for Board Members will be paid in full.

II. **Service Club District Reimbursed Memberships**

Kaweah ~~Delta Health Care District~~Health recognizes the value of professional and service club memberships for its members of the Board of Directors. All Board members are encouraged to participate in such activities to benefit health care education and community involvement. As such Board members may have dues for these memberships paid for by the District. Members of the Board of Directors are eligible for membership in a community organization. ~~The District~~Kaweah Health will not reimburse for meals, fines, or other assessments at regular meetings.

"These guidelines, procedures, or policies herein do not represent the only medically or legally acceptable approach, but rather are presented with the recognition that acceptable approaches exist. Deviations under appropriate circumstances do not represent a breach of a medical standard of care. New knowledge, new techniques, clinical or research data, clinical experience, or clinical or bio-ethical circumstances may provide sound reasons for alternative approaches, even though they are not described in the document."



Policy Number: BOD7	Date Created: 10/30/2013
Document Owner: Cindy Moccio (Board Clerk/Exec Assist-CEO)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration)	
Presentation of Claims and Service Process	

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

POLICY: Suits for money or damages filed against a public entity such as Kaweah Delta Health Care District dba Kaweah Health are regulated by statutes contained in division 3.6 of the California Government Code, commonly referred to as the Government Claims Act. Government Code § 905 requires the presentation of all claims for money or damages against local public entities such as Kaweah Health, subject to certain exceptions. Claims for personal injury and property damages must be presented within six (6) months after accrual; all other claims must be presented within one (1) year.

Presentation of a claim is generally governed by Government Code § 915 which provides that a claim, any amendment thereto, or an application for leave to present a late claim shall be presented to Kaweah Health by either delivering it to the clerk, secretary or auditor thereof, or by mailing it to the clerk, secretary, auditor, or to the governing body at its principal office.

Service of process on a public entity such as Kaweah Health is generally governed by Code of Civil Procedure § 416.50 which provides that a summons may be served by delivering a copy of the summons and complaint to the clerk, secretary, president, presiding officer or other head of its governing body.

This policy is intended to precisely identify those individuals who may receive claims on behalf of Kaweah Health and those individuals who may receive a summons and complaint on behalf of Kaweah Health.

PROCEDURE:

- I. **Presentation of a Government Claim**

- A. Personal Delivery. Only the Board Clerk, the Board Secretary, or the Auditor are authorized to receive delivery of a Government Claim on behalf of Kaweah Health. In the absence of the Board Clerk, the Board Secretary, and the Auditor, the ~~Vice President,~~ Chief Compliance and Risk Officer. In the absence of the Board Clerk the Executive Assistant to the Chief Operating Officer or the Executive Assistant to the Chief Nursing Officer is authorized to receive personal delivery of a government claim on behalf of Kaweah Health. No other individual is authorized to receive delivery of a Government Claim on behalf of Kaweah Health.
- B. Mailing. Only the Board Clerk, the Board Secretary, or the Auditor are authorized to receive mailing of a Government Claim on behalf of Kaweah Health. No other individual is authorized to receive mailing of a Government Claim on behalf of Kaweah Health, unless the claim is addressed to the Board of Directors and mailed to the Board of Directors of Kaweah Health at 400 West Mineral King Avenue, Visalia, CA, 93291, the principal office of the Board of Directors.
- C. Processing a Presented Claim. If a claim is (1) delivered to the Board Clerk, the Board Secretary, or the Auditor. In the absence of the Board Clerk, the Board Secretary, and the District's Auditor, the ~~Vice President,~~ Chief Compliance and Risk Officer, the Executive Assistant to the Chief Operating Officer or the Executive Assistant to the Chief Nursing Officer is authorized to receive personal delivery of a government claim on behalf of the District; or (2) received in the mail addressed to the Board Clerk, the Board Secretary, or the Auditor; or (3) received in the mail addressed to the Board of Directors of Kaweah Health at 400 West Mineral King Avenue, Visalia, CA, 93291, the claim shall be immediately provided to the Board Clerk, in the Board Clerks absence the Executive Assistant to the Chief Operating Officer or the Executive Assistant to the Chief Nursing Officer- shall so the date, time and manner of delivery/ mailing can be recorded ~~by the Board Clerk~~ in a log to be maintained in the Board Clerk's office. The Board Clerk shall then make prompt arrangements to have a copy of the claim, as well as the log information for the claim, provided to the Kaweah Health Risk Management Department and to the legal counsel for Kaweah Health who will be representing Kaweah Health with respect to the claim. In the event that a claim is accepted by the Auditor or the Executive Assistant to the Chief Operating Officer or the Executive Assistant to the Chief Nursing Officer, in the absence of the Board Clerk, the claim shall be marked with the date/time and manner of delivery/ mailing recorded. The claim shall be immediately forwarded to the Risk Management Department to be processed as noted above.

If delivery of a claim is attempted on any individual other than the Board Clerk (in the absence of the Board Clerk - the Executive Assistant to the Chief Operating Officer or the Executive Assistant to the Chief Nursing Officer), the Board Secretary, or the Auditor, then the person attempting delivery shall be advised by the individual on whom delivery of a claim is being attempted that he/she is not authorized to receive delivery of a claim on behalf of Kaweah Health and he/she shall decline to accept delivery. If a claim is delivered to any individual other than the Board Clerk (in the absence of the Board Clerk - the Executive Assistant to the Chief Operating Officer or the Executive Assistant to the Chief Nursing

~~Officer) Board Clerk~~, the Board Secretary, or the Auditor, then the claim shall be promptly forwarded directly to Kaweah Health's general counsel for possible return to the sender. The ~~general~~ counsel shall advise the District's Risk Management Department of the handling of the improperly presented claim.

If a claim is received in the mail that is not addressed to the Board Clerk, the Board Secretary, or the Auditor and is not addressed to the Board of Directors of the District at 400 West Mineral King Avenue, Visalia, CA, 93291, then the claim shall be promptly forwarded directly to Kaweah Delta's general counsel for possible return to the sender. Kaweah Delta's general counsel shall advise the Risk Management Department of the handling of the improperly presented claim.

II. Service of Summons and Complaint.

- A. Personal Delivery. Only the Board Clerk (in the absence of the Board Clerk - the Executive Assistant to the Chief Operating Officer or the Executive Assistant to the Chief Nursing Officer)~~Board Clerk~~, the Board Secretary or the Board President is authorized to accept delivery of a summons and complaint on behalf of Kaweah Delta. In the absence of the Board Clerk, the Board Secretary, or the Board President, the Chief Compliance and Risk Management Officer and the Executive Assistant to the Chief Operating Officer or the Executive Assistant to the Chief Nursing Officer is authorized to receive personal delivery of a Summon and Complaint on behalf of Kaweah Delta. In the absence of the Board Clerk, Board Secretary, Board President ~~and~~ the Chief Compliance and Risk Management Officer, the Executive Assistant to the Chief Operating Officer or the Executive Assistant to the Chief Nursing Officer the Administration Department staff will contact Kaweah Delta's general counsel who will advise how to proceed with the service of the summons and complaint. No other individual, and no other manner of service, is authorized in the absence of a court order or a specific authorization from the Board President, who is granted limited authority as described in this policy.
- B. Processing a Delivered Summons and Complaint. If a summons and complaint are delivered to the Board Clerk, the Board Secretary or the Board President, they shall be immediately provided to the Board Clerk so the date, time and manner of delivery can be recorded by the Board Clerk in a log to be maintained in the Board Clerk's office. In the absence of the Board Clerk, the Board Secretary, or the Board President, the Vice President, Chief Compliance & Risk Management Officer or the Executive Assistant to the Chief Operating Officer or the Executive Assistant to the Chief Nursing Officer is authorized to receive personal delivery of a Summon and Complaint on behalf of the District. The Board Clerk shall then make prompt arrangements to have a copy of the summons and complaint, as well as the log information for the summons and complaint, provided to the ~~-Risk~~ Management Department and to the legal counsel for Kaweah Health who will be representing Kaweah Health with respect to the litigation.

If service of a summons and complaint is attempted on any individual other than the Board Clerk (in the absence of the Board Clerk - the Executive Assistant to the Chief Operating Officer or the Executive Assistant to the Chief Nursing

Officer) Board Clerk, the Board Secretary or the Board President, then the person attempting delivery shall be advised by the individual on whom delivery is being attempted that he/she is not authorized to accept service of a summons and complaint on behalf of Kaweah Health and he/she shall decline to accept service.

An exception to the forgoing may be made only in circumstances where legal counsel for Kaweah Health receives prior authorization from the Board President to accept service of a summons and complaint on behalf of Kaweah Health.

If a summons and complaint is received under circumstances other than by delivery to the Board Clerk, the Board Secretary or the Board President, or through receipt by legal counsel with prior authorization from the Board President to accept service on behalf of Kaweah Health, then the summons and complaint shall be promptly forwarded directly to Kaweah Health's general counsel for possible return to the party who attempted service. Kaweah Health's general counsel shall advise the Risk Management Department of the handling of the improperly served summons and complaint.

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Policy Number: MS 42	Date Created: 07/21/2022
Document Owner: April McKee (Medical Staff Svcs Manager)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration); Medical Executive Committee; Boyce, Teresa; McKee, April; Moccio, Cindy	
Process for Quality Review of Medical Staff, Resident Physician, and Advanced Practice Provider Staff Medical Record Documentation	

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE

To define the process by which the quality of medical record documentation is reviewed, monitored and reported; identify opportunities for documentation improvement and take appropriate action when necessary.

POLICY

The Health Information Management Committee will conduct routine medical record reviews to assure the documentation accurately reflects and documents medical events occurring during either hospitalization or clinic visits to ensure they meet The Joint Commission requirements for content. Members of the committee will review medical records to assure each represents an accurate description of the patient's condition and progress while either hospitalized or seen in a clinic, including adverse or unexpected occurrences and identification of responsibility for patient care rendered during hospitalization or clinic visits. Results of the reviews are utilized to assess a practitioner's professional performance as part of the credentialing, privileging and corrective action processes. All information is privileged and confidential in accordance with medical staff bylaws, rules and regulations, state laws, and other regulations pertaining to confidentiality and non-discoverability.

MEMBERSHIP

The documentation review team will be comprised ~~of members of the HIM Committee including Physicians, Advanced Practice Providers, Registered Nurses and~~ of the HIM Health Information Analysts.

MEETINGS

The documentation review team will meet as often as needed to review records. ~~In addition to medical staff committee members, HIM Department professionals and Clinical Documentation Specialists supporting the committee may attend the documentation review meetings.~~ The documentation review team will also attend the monthly HIM Committee business meeting to provide the findings. The Findings are verified by the HIM Committee.

PROCEDURE

1. Category I: Documentation Referrals
 - a. Clinicians, nurses, case managers, clinical documentation specialists, coders, etc. identify documentation discrepancies.
 - b. Complete Midas event form to request review.

- c. Request will be forwarded to documentation team.
- d. Documentation review team will review record documentation for appropriateness, completes Quality Review Documentation form and sends to HIM Department.
- e. HIM Department will compile data and report to HIM Committee.

2. Category II: Reappointment

- a. Medical Staff Office will provide a list of practitioners up for reappointment:
 - i. 250 – 300 practitioners/year
 - ii. 20 – 25 practitioners/month
- b. Documentation review team will review 3 – 5 records of each practitioner up for reappointment for Ongoing Professional Practice Evaluation (OPPE):
 - i. 60 – 125 records /month
- c. Documents to be reviewed: Emergency Department Notes, History and Physicals, Consultation Notes, Progress Notes, Operative/Procedure Notes, Discharge Summaries, Office Clinic Notes, etc.
- d. Documentation review team will review record documentation for appropriateness, completes Quality Review Documentation form and sends to HIM Department.
- e. HIM Department will compile data and report to HIM Committee.

3. Category III: Ongoing Record Review

- a. Documentation review team will perform their ongoing record review audits
- b. Documents to be reviewed: Behavioral Health History and Physical's and psych evals, Main Op and post op report, VOTO's, pre/post anesthesia, History and Physical's at TC South, TC West, Rehab and Cardio, op and post op report cardio, discharge summary at TC South, TC West and Sub-Acute. Also any documentats that seem appropriate to be added.
- c. HIM Department will compile data and report to HIM Committee
- e. d. All fallouts will be presented and HIM Committee will determine what is entered into the Physician Tracking System**Brief**

FINDINGS AND REPORTING

- 1. Satisfactory Finding
 - a. Text/email to provider with a copy to the Medical Staff Office~~Letter to practitioner with a copy to the Medical Staff Office.~~
- 2. Unsatisfactory Finding
 - a. First Occurrence: Provider will receive text/email and have 30 days to correct issue. HIM to document in Midas Physician Tracking System. Letter to practitioner with copy to Chair of Department, Graduate Medical Education Office (as applicable) and Medical Staff Office Repeat, focused review in 60 days. Focus review on 3 -5 charts in area that was deficient in the initial review.
 - b. Second Occurrence-and beyond: Text/Email to provider with copy to Dept. Chair, Medical Director, GME, Med Staff Office (as applicable). Dept. Chair must meet with provider within 1 week of notification (Telephone/In-Person/Video Conference) and complete collegial intervention process, document in Midas. Focus review in 30 days on 3-5 charts in area that was deficient. review by a second member of the documentation review team for confirmation; refer to Peer Review Committee; letter to practitioner with a copy to Chair of Department, Graduate Medical Education Office (as applicable) and Medical Staff Office.
 - b.c. Third Occurrence: Notification to provider via email with a copy to Dept. Chair/ Medical Director/GME/ Med Staff Office (as applicable). Occurrence

[report written and sent to the Behavioral Committee. Updates to Ongoing Professional Practice Evaluation \(OPPE\). Trending metrics sent to MEC, Med Staff Office, VP for contract if applicable](#)

3. Results will be reviewed at monthly HIM Committee meeting. Trending metrics will be reported monthly to the Medical Staff Office and Medical Executive Committee.
4. All adverse determinations will be reviewed by a physician prior to action being taken.

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**Kaweah Delta
Health Care District**

Administrative Manual ~~Subcategories of
Department Manuals not selected.~~



Kaweah Health.

Policy Number: AP07	Date Created: No Date Set
Document Owner: Cindy Moccio (Board Clerk/Exec Assist-CEO)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration)	
Communication with law enforcement regarding requests for information and requests to interview interrogate a patient	

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

I. PURPOSE:

To provide guidelines to Kaweah Delta Health Care District (herein after referred to as Kaweah Health) staff when handling requests from law enforcement officials.

To ensure appropriate communication between Kaweah HealthDHCD staff and law enforcement officials.

II. POLICY:

- A. Law enforcement officers entering Kaweah HealthDistrict facilities for the purpose of obtaining patient information or to interview and/or interrogate a patient shall be referred to the Director of Risk Management, the ~~District Compliance and Privacy~~ Officer or the Kaweah HealthDelta Hospital House Supervisor for assistance.
- B. Law enforcement officials must provide Kaweah HealthDHCD staff with proper identification.
- C. Staff members shall cooperate with law enforcement personnel to the fullest extent possible.
- D. The release of information to law enforcement officials must meet the standards of the HIPAA privacy regulations (45 C.F.R. § 164.512(f), (i)) and all applicable laws.
- E. Patients or their legal representatives will be notified of a law enforcement official's request to interview or interrogate. Consideration should be given to the patient's medical condition; patient's physician should advise patient of any adverse medical consequences (see Guidelines for Releasing Patient Information to Law Enforcement).
- F. No Kaweah HealthDHCD staff member will ever attempt to physically prevent an officer from interrogating a patient.

III. PROCEDURE:

- A. When a law enforcement official requests permission to interview/interrogate a patient or requests information regarding a patient, staff will contact the Director of Risk Management (ext. 2340), the Chief

Communication with law enforcement regarding requests for information and requests to interview
interrogate a patient 2

~~Compliance and Risk Officer~~~~Compliance and Privacy Officer~~ (ext 5006) or
the Kaweah ~~HealthDelta~~ Medical Center House Supervisor (~~ext 2154~~).

B. Staff will provide the Director of Risk Management, the ~~Chief~~ Compliance
and ~~Privacy~~~~Risk~~ Officer and/or the Kaweah ~~HealthDelta~~ Medical Center's
House Supervisor with information regarding the patient and will identify
what information has been requested by law enforcement.

References:

- California Hospital Association Consent Manual: Chapters 6, 13, 16 and 17
- _____ HIPAA privacy regulations (45 C.F.R. § 164.512(f), (i))
- Guidelines for Releasing Patient Information to Law Enforcement

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Policy Number: AP15	Date Created: No Date Set
Document Owner: Cindy Moccio (Board Clerk/Exec Assist-CEO)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration)	
Loan of Kaweah Health Equipment and/or Supplies	

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

POLICY: When not in use by the ~~District~~Kaweah Delta Health Care District dba Kaweah Health and under specific and limited circumstances, certain equipment and/or supplies may be loaned by District facilities to other health care providers and/or organizations within the community.

PROCEDURE:

- I. Other healthcare providers and/or community organizations requesting loan of District-owned equipment and/or supplies may make their request to the Department Manager/Supervisor with responsibility over the specific service area in which the item is stored. Department Managers/Supervisors receiving such requests may, at their discretion, loan equipment and/or supplies which are maintained within their service area provided they are assured that the equipment will be returned in good repair and in sufficient time should ~~the District~~Kaweah Health have an immediate need for its return and provided there are adequate supplies on hand such that the loaned supplies are excess inventory.

When the requester is unsure as to the service area holding custody of equipment and/or supplies, the request to borrow shall be directed to the ~~Nursing Coordinator~~House Supervisor at Kaweah ~~Delta~~Health Medical Center or the Administrator on Call at Kaweah ~~Delta~~Health Rehabilitation Hospital.

- II. Neither equipment nor supplies may be loaned to any individual for personal use, even in cases where the individual requesting loan is a staff member or physician of ~~the District~~Kaweah Health.
- III. Equipment and/or supplies held as inventory within the Organizational Development Department or Clinical In-service Education Department may **not** be loaned or borrowed by individuals outside of ~~the District~~Kaweah Health without the express consent of the Director of Organizational Development or Director of Clinical Education.

Loans to departments within ~~the District~~Kaweah Health will be permitted only at

- times when the equipment or supplies are not in use by the Organizational Development Department or Clinical In-service Education Department and only in cases where the borrower is completely and fully trained in the equipment use.
- IV. All equipment loaned will be returned promptly, will be cleaned, inspected by Clinical Engineering when appropriate and will be in good working order. Loaned supplies will be promptly replaced with the identical item by the party requesting the loaned supply. Supplies will not be sold to other parties – only loaned and replaced with the identical item. Requests to borrow equipment and/or supplies from health care providers, community organizations, and/or District departments who have previously failed to meet this standard will not be honored.

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Policy Number: AP40	Date Created: 06/01/1998
Document Owner: Cindy Moccio (Board Clerk/Exec Assist-CEO)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration)	
Vendor Relationships <u>and Conflict of Interest</u>	

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POLICY:

This policy provides guidelines for employees, including Resident Physicians, to avoid conflicts of interest in the performance of their duties, assists to prevent employees from engaging in situations or potential situations in which accusations of conflict of interest might be made, and seeks to protect Kaweah Delta (herein after referred to as Kaweah Health)[a](#) from losses due to actions or activities by employees of Kaweah HealthDelta.

A conflict of interest may occur if an employee’s outside activities, financial or other personal interests influence or appear to influence his or her professional obligations to Kaweah HealthDelta, patients or colleagues such that an independent observer might reasonably question whether the individual’s professional actions or decisions are being influenced by the outcome of personal gain, financial or otherwise.

Situations of actual or potential conflict of interest are to be avoided by all employees, including personal, financial, or romantic involvement with a competitor, supplier, patient or employee of Kaweah HealthDelta which impairs the ability to exercise good judgment on behalf of Kaweah HealthDelta or creates an actual or potential conflict of interest. Employees have an obligation to prevent actual or potential conflicts of interest. It is expected that all employees will exercise the utmost good faith in all transactions related to their duties on behalf of Kaweah HealthDelta, and will practice ethical behaviors.

In addition to potential conflicts of interest, we also recognize that improper gifts, compensation, meals, travel expenses, education subsidies, honoraria, and other forms of financial exchanges between providers and vendors can implicate the federal Anti-Kickback Statute (“AKS”) and can potentially result in civil and criminal penalties. Moreover, the Physician Payment Sunshine Act (“Sunshine Act”) requires applicable vendors to annually report any Teaching Hospital or any physician, dentist, optometrist, podiatrist or chiropractor who has accepted certain types of remuneration or transfers from the vendor. These reports are made available to the public on a searchable website. In view of the ethical, legal, financial, and perceptual risks, we have established reasonable and appropriate limitations on the nature and amounts of financial exchanges as set forth in this policy. These limitations and safeguards are premised upon the principles of the Federal Anti-Kickback Statute and the longstanding guidance from regulatory agencies professional organizations

including Office of Inspector General (OIG) and American Medical Association (AMA), respectively.

PROCEDURE:

Conflict of Interest

- I. While it is impossible to list every circumstance giving rise to a possible conflict of interest, a conflict of interest may arise for an employee in one or more of the following situations:
 - A. Indirectly or directly holds a position or a material financial interest in any outside concern from which he/she has reason to believe Kaweah [HealthDelta](#) secures goods or services, buys or sells stocks, bonds, or other securities, or that provides services competitive with Kaweah [HealthDelta](#).
 - B. Competes directly or indirectly with Kaweah [HealthDelta](#) in the purchase or sale of property, property rights, or services.
 - C. Discloses or uses information relating to Kaweah [HealthDelta](#)'s business for personal profit or advantage, or for the profit or advantage of his/her immediate family or a third party.
 - D. Renders directive, material, or consultative services to any outside concern that does business with or competes with Kaweah [HealthDelta](#), or renders any service in competition with Kaweah [HealthDelta](#).
 - E. Participates in any activities for personal profit or provides service to any industry, civic, or charitable affairs that is likely to involve use of his/her normal work hours.
- II. An employee involved in any of these types of relationships or situations which may be a conflict of interest must immediately and fully disclose the relevant circumstances to his/her immediate Department Director, Human Resources, or Compliance. All disclosed information will be treated as confidential, accessible only to authorized individuals.
 - A. If an actual or potential conflict is determined, Kaweah [HealthDelta](#) may take whatever actions appear appropriate according to the circumstances, including Disciplinary Action, up to and including termination of employment.
 - B. Employees who fail to report situations which are discovered from sources other than the employee and are determined to be conflicts of interest will be subject to for Disciplinary Action, up to and including termination of employment.

Gifts, Gratuities and Vendor Relationships

I. PROHIBITED ACTIVITIES

Employees are prohibited from accepting certain gifts, payments and other offers that may, or have the potential to, influence the referral or cost of federal health care business, including:

- Patient gifts or items of value should not be solicited or accepted from patients or their families. The patient or family should be directed to the Kaweah [HealthDelta](#) Hospital Foundation
- Cash and cash-equivalent gifts such as gift cards or gift certificates
- On-site meals provided by a Vendor outside of an on-site meeting or education event
- Items that are capable of personal use such as a DVD player or an iPod
- Personal entertainment items such as tickets to sporting events or concerts, or vacation excursions that can be perceived as conveying a personal benefit to the recipient
- Expense paid travel to luxurious or resort-type locations that can be perceived as extravagant and conveying a personal benefit to the recipient
- Payments for listening to a vendor's marketing presentation or for completing written evaluations for a vendor's product or service
- Payments for recruiting patients for clinical research activities unless such research activity is approved by an appropriate Institutional Review Board (IRB)
- Payments in exchange for an endorsement of the vendor or the vendor's products/services
- Payments or accommodations for Shadowing arrangements in a patient care setting, unless the vendor has a defined role in the care of the patient (s) and is registered through Supply Chain Management
- Payments or accommodations for Ghostwriting arrangements, e.g., allowing a vendor to author a published article or other document and attribute the authorship to a physician or other employee

II. PERMISSIBLE ACTIVITIES

On occasions, it may be permissible to accept a meal or other invitation from a current or potential vendor. However, the purpose must never be to induce or influence a business transaction. As a general rule, the cost must be reasonable. The invitation should be declined if the occasion has the appearance of extravagance or if acceptance of the invitation could be reasonably perceived by anyone as having the intent to influence a business decision involving Kaweah [HealthDelta](#). To be acceptable, the occasion resulting from the invitation should conform to the following guidelines: (1) the cost and location must be reasonable and not extravagant; (2) paid expenses for any travel costs or overnight lodging for his/her family are prohibited; and (3) the invitation is for an ordinary business meal or gathering during which the host is present and business is conducted.

Promotional “Branded” Items: Items such as mugs, pens, and similar items may be accepted from a vendor as long as they do not exceed nominal value and no more than twenty dollars (\$20) in the aggregate annually per recipient.

Gift Baskets and Other Business Courtesies: Policy permits employees to accept infrequent (e.g., annual or holiday-related) gift baskets if (i) the gift is consumable (food, candy, fruit, non-alcoholic beverages) or decorative / floral; and (ii) the gift is intended for the benefit of a group of employees; and (iii) the gift has a nominal value and no more than one hundred dollars (\$100). All employee recognition and rewards must be processed through Human Resources (see HR.131 Employee Recognition and Acknowledgement Programs).

Travel Expenses: Reasonable coverage of travel expenses by a vendor or business associate is acceptable when the employee is: (1) presenting at a conference; (2) participating in a meeting for the purpose of sponsored research protocol review; (3) participating as a member of a governmental panel; and (4) participating as part of an approved “speaker’s bureau” engagement.

Vendor paid travel for any other circumstances not listed above require prior approval by Human Resources, Compliance, and/or the respective [Vice President \(VP\) Executive Team Member](#). Unapproved vendor paid travel expenses are subject to be returned to the vendor and the employee or the employee’s cost center will be charged for the incurred travel expenses.

All vendor paid travel expenses authorized under this section must be reasonable and appropriate. Under no circumstance will vendors be permitted to pay/reimburse expenses for travel (1) to luxurious, extravagant, or resort destinations, (2) extended to an individual’s spouse or family member; (3) when the primary focus is social with minimal or no business activity (e.g., golf or other recreation).

All vendor paid travel expenses offered by a potential or current vendor to discuss, promote or showcase vendor products or services, if not explicitly defined in an existing vendor contract, require prior [approval by the respective Vice President \(VP\) Executive Team Member](#).

Meals and Beverages: Employees may accept off site meals provided by vendors if the meals are reasonable. “Reasonable” is defined as a meal that would otherwise comply with the Travel and Expense Reimbursement Policy.

Honorariums and Consultations: Employees who are invited to speak or provide genuine consulting services can accept reimbursement in the form of honoraria or compensation for time and expenses under the following conditions: (1) travel, lodging and meal expense reimbursement is reasonable and directly related to the engagement; (2) compensation fees received are no more than fair market value; (3) presentations or consultation

engagements must be of scientific/academic permit and/or benefit Kaweah [HealthDelta](#); (4) consultations and service agreements must be in writing; and (5) honoraria or fees from consultation engagements shall be made payable to Kaweah Delta Health Care District. Speaking and/or consulting engagements require prior ~~Vice President (VP)~~ [Executive Team member](#) approval.

Individuals must not do private consulting work for a vendor who conducts business with the hospital, or who wants to conduct business with the hospital, without receiving prior approval for the activity from Human Resources or Compliance.

Education and Training: Unrestricted subsidies to underwrite the cost of continuing education conferences that contributes to the provision of care are permissible if the following criteria are met: (1) the primary purpose of the education must be the distribution of objective scientific information or educational activity; (2) acceptance of education support must never be made, conditioned on or related in any way to preexisting or future business relationships with the vendor; and (3) the vendor's support is of minimal individual value but promotes the educational nature of the conference; and (4) the funds offered may be used to provide refreshments at educational sessions.

Referral Sources: Any gifts or entertainment involving physicians or other persons in a position to refer patients are subject to federal laws, rules and regulations regarding these practices and must be undertaken with the utmost integrity and good judgment. Individuals uncertain about whether a particular event or function may be accepted should contact Human resources or Compliance for direction.

Short Term Loans of Devices or Equipment: Free trials and short-term loans are permissible to accept from vendors, ONLY if the trial or loan arrangement is approved and arranged through Supply Chain Management as outlined in AP.132 Use of Rental, Loaner, or Demo Clinical Equipment.

Ownership, Investment Interest, Licensing, Royalty, or Stock Options: Employees are permitted to own stock in any [publicallypublicly](#) traded company, including pharmaceutical and device manufacturers, as part of an employee's investment portfolio. However, in some circumstances, some stock options and investment interests are subject to disclosure and management in accordance with the Conflict of Interest policies for research. If such financial interest is provided directly from a Sunshine Act vendor to a covered recipient, the transaction is subject to be reported to the Open Payments Database.

*Visits by Vendor Representatives: **Visits by Vendor Representatives shall be managed by the procedures outlined in AP.14 Department Visits by Vendor Representatives.***

Miscellaneous: For situations not otherwise addressed in the policy, please contact Human Resources or Compliance for direction.

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Approval



Policy Number: AP42	Date Created: No Date Set
Document Owner: Cindy Moccio (Board Clerk/Exec Assist-CEO)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration)	
Security of Purchased Equipment and or Supplies	

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POLICY: Maintaining the security of DistrictKaweah Health equipment and supplies is a high priority. All DistrictKaweah Health staff members are responsible for and will ensure, to the extent possible, the safety and security of all DistrictKaweah Health-owned property in their possession and/or within their proximity.

PROCEDURE:

I. Storage Areas

All areas used to store supplies or equipment on a temporary basis before delivery to using departments shall remain secure at all times.

All access doors to these areas will remain closed and locked at all times when items are not being processed into or out of the holding area by staff members authorized to do so.

II. Warehouse

All supplies and equipment received at the Warehouse or Kaweah Delta Medical Center loading dock is the responsibility of staff members assigned to and working within those areas until properly delivered to and signed for by the ordering department.

Special attention and care shall be taken of items with “resale” or “street value”. If there exists a time where there is concern regarding the safe delivery of any item(s), the individual responsible for that delivery will make contact with his/her supervisor for guidance and assistance to help ensure success.

III. Ordering Department(s)

At the point when supplies and/or equipment are delivered to ordering department(s), security of delivered items becomes the responsibility of the department(s) taking possession.

IV. Shipping equipment for repairs

All equipment returned to a vendor for repair must be insured for the purchased value of the equipment. Capital equipment items should not be shipped anywhere without being properly insured.

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Policy Number: AP45	Date Created: No Date Set
Document Owner: Cindy Moccio (Board Clerk/Exec Assist-CEO)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration)	
Risk Management Plan	

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PURPOSE: The Board of Directors hereby makes a commitment to empower the Chief Executive Officer to implement and maintain an organization-wide Kaweah Delta Health Care District Risk Management Plan. The Board of Directors of Kaweah Delta Health Care District dba Kaweah Health (hereinafter KDHCDC) recognizes that the primary purpose of KDHCDC is to provide high quality, customer-oriented, and financially strong healthcare services that meet the needs of those we serve.

POLICY: Risk Management works to continually improve the ongoing delivery of health care services and strengthen the organization by focusing on loss prevention, loss reduction, risk assessment, risk reduction, risk financing and claims management activities.

PROCEDURE: Although Risk Management is the business of all ~~Kaweah-Delta~~ KDHCDC employees, the Director of Risk Management is designated to oversee the Risk Management Plan in collaboration with the Executive Team and the Medical Staff.

- I. KDHCDC strives to provide safe delivery of high quality, customer oriented and fiscally responsible health care. The Risk Management program is comprised of activities designed to minimize adverse effects of loss upon KDHCDC's human, physical, and financial assets by:
 - a) Facilitating the timely identification and resolution of risks in an effort to reduce or prevent the potential for injury or loss;
 - b) Fostering effective patient and family communication regarding patient care and safety problems;
 - c) Identifying, investigating, and assessing events with loss potential or with potential for adverse outcomes;
 - d) Using loss prevention and control techniques to minimize loss frequency and severity;
 - e) Using sound risk financing to find the appropriate financial tools for insuring and otherwise protecting KDHCDC's assets;

- f) Employing claims management to assure claims against ~~the District~~KDHCD are properly addressed, evaluated, and managed resulting in the best possible result;
- g) Educating Leaders within the organization of their responsibility to assist the Director of Risk Management in identifying and communicating risk management issues. Risk Management will provide leadership in patient safety through the promotion of best practices, such as:
 - i) Promoting a non-punitive reporting culture through education of staff members and modeling non-punitive investigations.
 - ii) Conducting event-related root cause analysis to ensure service recovery and performance process improvement in conjunction with the Quality & Patient Safety~~Performance Improvement~~ Department.
 - iii) In collaboration with the Quality & Patient Safety Department~~Performance Improvement~~, tracking responses to The Joint Commission Sentinel Event Alert recommendations.
 - iv) In collaboration with the Biomedical Engineering Department, receiving, distributing and tracking responses to recalls and product warnings.
 - v) In collaboration with all departments, ensuring all reports are made to the CALIFORNIA DEPARTMENT OF PUBLIC HEALTH (CDPH) and other regulatory agencies in a timely and appropriate manner.
 - vi) Working in collaboration with the Quality & Patient Safety Department~~Performance Improvement~~, Case Management, Compliance, the Medical Staff and other leaders to identify trends and areas of practice that could benefit from process improvement.
 - vii) Giving KDHCD the ability to exercise internal controls over:
 - a. Reducing financial losses associated with claims experience;
 - b. Decreasing the number, frequency and severity of claims; and
 - c. Negotiating a reasonable, stable annual insurance program through commercial insurance and/or self-insurance.
 - viii) Acting as a resource for the disclosure of adverse events to patients and families in compliance with The Joint Commission standards and with sound ethical principles. Disclosure of adverse outcomes is essential in order to maintain patient and family trust which is the key element to any provider-patient relationship. It is imperative that adverse events be disclosed to the patient and/or their family;
- h) ~~In collaboration with the Patient Experience Department,~~ implementing the District'sKDHCD's Complaint and Grievance Policy, insuring compliance with the policy, maintaining a complaint and grievance database, tracking and trending the data and reporting to ~~District~~KDHCD staff and committees regularly;

- i) Assisting the Medical Staff with Risk Management questions and concerns;
- j) Coordinating meetings with ~~the District's~~KDHCD's insurance broker. The meetings shall be held semi-annually and upon request-;
- k) Coordinating an insurance review by an independent consultant of all of KDHCD's insurance policies every ~~three~~ (32) years;
- l) Coordinating a review of KDHCD's excess coverage every year with the ~~Vice President of Finance;~~Chief Financial Officer;
- m) Coordinating annual risk assessments in conjunction with KDHCD's excess professional liability insurance carrier. The areas to be assessed will be identified by the Director of Risk Management and the Executive Team.-

II. ACCOUNTABILITY AND AUTHORITY:

The authority and responsibility for the establishment, maintenance, support, and evaluation of the Risk Management Program is vested in the Board of Directors. The Board delegates the responsibility for the implementation of risk management functions to the Chief Executive Officer of the hospital. The coordination of all hospital and medical staff risk management activities is assigned to KDHCD's Director of Risk Management. Risk Management is a collaborative effort. The Director of Risk Management will inform the CEO and the Medical Executive Committee of all significant risks identified. In addition, each member of the management team and hospital staff is responsible for Risk Management activities within their respective departments. The Director of Risk Management will serve as a resource for all departments and the management team.

III. CONFIDENTIALITY:

Information gathered for Risk Management purposes is considered to be privileged and confidential in accordance with hospital bylaws, state laws and regulations pertaining to confidentiality and non-discoverability. All information, including Occurrence Reports, which is gathered for Risk Management and Performance Improvement purposes, is considered to be confidential attorney-client communication. Information is privileged if it was prepared with the intent that it will be transmitted to KDHCD's attorney for use in litigation which may arise out of an event. While statistical information and trends regarding occurrences may be reviewed through the Performance Improvement process, specific information regarding any potential or actual open claim must be kept confidential. Risk Management information used as part of the Performance Improvement process will be kept confidential by KDHCD staff who have access to such information. Risk Management information will be available only to authorized individuals who have a legitimate need to know this information based upon their responsibilities. Risk Management review information may be disclosed to The Joint Commission, CDPH, CMS or other regulatory entities as required by law.

IV. LEGAL COUNSEL:

The Director of Risk Management or their designee will function as a liaison between KDHC's attorneys, administration and staff in the investigation of complaints, pre-litigation and litigation data collection. In addition, The Director of Risk Management will act as a resource in the resolution of legal issues arising throughout the District.

In order to control the cost of legal fees and to streamline the dissemination of legal advice received, the following shall be adhered to:

Direct access to KDHC's Administrative Counsel is limited to the following people:

- a) Board of Directors
- b) Chief Executive Officer
- c) Executive Assistant to the Board and the CEO
- d) All ~~Vice Presidents~~ Executive Team members
- e) Director of Risk Management
- f) President of the Medical Staff
- g) Chief Compliance & Risk Officer or designee
- h) Internal Auditor
- i) Chief of the Medical Staff
- j) Chair of the Medical Staff Credentials Committee
- k) Chair of the Medical Staff By-Laws Committee
- l) Director of Patient Accounting Services or Credit Manager

Direct access to Professional and Liability Counsel is limited to the following people:

- a) Board of Directors
- b) Chief Executive Officer
- c) Executive Assistant to the Board and the CEO
- d) All ~~Vice Presidents~~ Executive Team members
- e) Chief Compliance & Risk Officer or designee Chi
- f) Director of Risk Management Dir

V. RISK MANAGEMENT TECHNIQUES:

The two components of Risk Management are risk control and risk financing.

A. Examples of risk control techniques are:

1. Risk Avoidance: abandoning or not engaging in an activity rather than accepting the associated risk;
2. Risk Assessment: two (2) assessments to be completed annually by an independent consultant or by a representative of the District's excess professional liability carrier;
3. Loss Prevention: reducing or eliminating the chance of loss by establishing and maintaining quality improvement and safety management programs;
4. Loss Reduction: reducing the potential severity of the loss;
5. Separation of Exposure Units: dispersing assets and activities to reduce the risk of loss in a single event;
6. Non-Insurance Transfer: making contractual arrangements in which KDHCD does not accept the obligation of others.

B. Examples of risk financing techniques are:

1. Risk Transfer: involves the use of external resources for (1) non-insurance transfer, e.g. agreements addressing loss obligation or (2) insurance transfer, e.g. purchase commercial liability coverage;
2. Risk Retention: involves the use of internal funds to (1) treat losses as current operating expenses, (2) create reserves for loss liabilities, either funded or unfunded.

The philosophy of KDHCD's Board of Directors is to implement the risk financing technique of insurance transfer for various loss exposures. The affordability will be determined based upon cost/benefit analysis using premium quotations from commercial carriers and acceptable insurance industry standards. Preference should be given to obtain commercial coverage through insurance carriers "Admitted" in California thus providing KDHCD with protection provided by the Insurance Commission, State of California.

In addition, insurance will be purchased for various loss exposure in accordance with any legal obligations arising out of the law, contracts/written agreements, etc.

For those significant loss exposures for which affordable insurance is unable to be obtained (such as General & Professional Liability), the Board approved Principles of Self-Insurance will be followed. EXHIBIT A

An independent insurance evaluation will be performed every ~~three (3) other~~ years to determine the adequacy of existing general and professional liability coverage.

VI. RISK CONTROL:

Each division of KDHCD will actively participate in the organization wide Risk Management Plan. The KDHCD Risk Management Plan ~~super~~sedes individual division plans.

An independent annual risk control evaluation will be performed and reported to the Board. Specifically, the independent evaluation of KDHCD's risk management process will evaluate the impact of the KDHCD's Performance Improvement and Risk Management programs in both limiting risks and favorably impacting quality outcomes. The Risk Control survey will be accomplished by a comprehensive on-site survey interchanged with a modified survey during alternate years. ~~The areas to be assessed will be determined at the beginning of each fiscal year and no later than July 30.~~

The Self-Assessment Tool for Risk Control Program Evaluation is included in EXHIBIT B. Some sections can be applied to all departments while others are specific to certain areas. The Self-Assessment Tool is primarily used as a guide for evaluation of the KDHCD organization wide Risk Management program.

VII. RISK ASSESSMENT FOR NEW PROGRAMS AND/OR SERVICES:

In conjunction with the ~~Chief Director of Compliance & Risk Officer~~ and the District's General Counsel, all proposed acquisitions, contracts, leases, new programs or services and construction must be evaluated for risk following the steps contained in EXHIBIT C. All department managers should be familiar with the process described within those guidelines.

All contracted services and alternate patient care services are required to implement quality improvement and risk management programs.

In addition, all contracts/leases should be reviewed, utilizing the Risk Manager or Administrative Legal Counsel as necessary, for indemnification and hold harmless agreements and for insurance requirements. Major contracts and leases should then be referred to KDHCD's Administrative Legal Counsel for a final review. All contracts should be reviewed in compliance with the following administrative policies:

- i) AP.40 Vendor Relationships
- ii) AP.69 Requirements for Contracting with Outside Service Providers
- iii) AP.96 Public Bidding of Contracts

VIII. RISK MANAGEMENT REPORTING SCHEDULE:

- i) The Director of Risk Management reports to the Board of Directors on a quarterly basis. (claims, settlement, changes in insurance, results of annual risk assessments, grievances, Sentinel Event data and Adverse Event data).
- ii) The Director of Risk Management provides information to the Medical Executive Committee as requested.
- iii) The Director of Risk Management reports to Quality Council as requested.
- iv) The Risk Management Department provides other reports as requested.
- v) The Director of Risk Management in conjunction with the Director of Quality & Patient Safety Department~~Performance Improvement~~ and the Chief QualityMedical Officer has the responsibility of insuring all necessary and appropriate reports are provided to:
 - a. The Joint Commission;
 - b. CDPH;
 - c. CMS; and
 - d. Other licensing and credentialing agencies.

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EXHIBITS

- A. Principles of Professional Liability Self-Insurance
- B. Self Assessment Tool - Risk Control Program Evaluation
- C. Risk Assessment for New Programs and Services

approval

EXHIBIT A

PRINCIPLES OF PROFESSIONAL LIABILITY SELF-INSURANCE

1. Professional liability self-insurance fund is a distinct trust fund, which is not commingled with other funds and which is separately administered by an outside trustee who invests and disburses the funds only by established, written guidelines.
2. The fund shall be funded to a minimum confidence level of 95% while working to achieve a funding level, which will produce a 99% confidence level.
3. Professional liability self-insurance fund will assume no risks beyond professional and general liability and those associated risks commonly insured by standard professional liability risk policies. Risk of automobiles, workers compensation and other liability risks such as childcare and the fitness center, or joint ventures, will not be assumed by this fund.
4. An independent annual risk control evaluation will be performed and reported to the Board of Directors. Specifically, the independent evaluation of KDHCDC's risk management process will evaluate the impact of KDHCDC's performance improvement and risk management programs in both limiting risks and favorably impacting upon quality outcomes. The Risk Control survey will be accomplished by a comprehensive on sight survey interchanged with a modified survey during alternate years.
5. Independent, outside annual actuarial study of the adequacy of the professional liability self-insurance trust will be carried out and reported to the Board of Directors. The Director of Finance will coordinate this study with the assistance of KDHCDC's Risk Management Department.
6. The professional liability trust fund will not be used to insure the risks of the medical staff.
7. The District's Directors and Officers policy will be used for those members of the medical staff who are acting as agents of KDHCDC by such actions as committee participation.

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8. All physician members of the medical staff with **clinical privileges** to practice at KDHCD shall carry a minimum of one million dollars per occurrence/three million dollars in the aggregate of professional liability insurance coverage through an insurance company approved by the California Insurance Commission. Non-physician members of the medical staff (including Allied Health professionals) shall carry a minimum of one million dollars per occurrence/three million dollars in the aggregate of professional liability insurance through an insurance company approved by the California Insurance Commission.
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approval

EXHIBIT B

SELF-ASSESSMENT TOOL RISK CONTROL PROGRAM EVALUATION

1. Review compliance with established standards (policies and procedures) including:
 - a. Adequacy and understanding of current standards
 - b. Consistency of their application throughout the hospital or system
 - c. Management support
 - d. Effectiveness of standards in actual practice
2. Audit the effectiveness of internal claims administration, including:
 - a. Timeliness of claim and file set-up
 - b. File documentation
 - Identification of all entities involved in the claim
 - Risk analysis (liability and injury)
 - Expert opinions or medical expert review
 - Logging system for claims
 - Quality of claim management and supervision
 - c. Reserve philosophies in conjunction with Defense Counsel, including accuracy, prompt review and revision
 - d. Settlement policy and practices
 - e. Monitoring system to determine the adequacy of claims investigation
 - f. Completeness, accuracy and timeliness of claims data
 - g. Use of claims data for identifying trends and patterns
3. Analyze methods of allocating risk management costs to specific cost centers, including:
 - a. Remedial actions taken by departments to reduce exposure to future incidents and claims
 - b. Budgeting system
 - c. Financial period status reports to the various cost centers
4. Review Occurrence Reporting system, including:
 - a. System design
 - b. Relationship to the Performance Improvement Plan
 - c. Management of system throughout KDHCDC
 - d. Confidentiality protections
 - e. Use of unit specific trend data
 - f. Effectiveness of incident/event investigation and system used to identify and prioritize potential claims.
5. Evaluate activities designed to address and resolve customer complaints and grievances, including:
 - a. Review of existing practices to handle complaints and grievances by use of specific trend data.

- b. Analysis of system for identifying and addressing trends and patterns.
6. Analyze hospital communication networks, including:
- a. Medical staff relations
 - b. Interactions with committees
 - c. Perception by hospital staff of their role in risk management activities
 - d. Methods for conflict resolution
7. Evaluate loss prevention effectiveness with the following functions:
- a. Performance Improvement
 - b. Nursing
 - c. Medical staff
 - d. Health Information Management
 - e. Infection control
 - f. Case Management

**EXHIBIT C
RISK ASSESSMENT
FOR NEW PROGRAMS AND SERVICES**

A successful risk management assessment can be accomplished by following these steps:

1. **CLASSES OF PATIENTS/CLIENTS SERVED**

Define the patient population and the expectations of that population.

2. **RESPONSIBILITIES OF THE HEALTH CARE PROFESSIONAL**

Define the level, numbers and qualifications of all professionals, employees and physicians involved in the product or service. Sufficient staff, trained to render the care required by health care industry standards, is needed. Credentialing, delineation of privileges, skills assessment and contract review are activities required to protect corporate liability exposures.

3. **OPERATING PROCEDURES**

Review of all operating procedures for medical, legal and patient/employee safety considerations.

4. **MEDICAL EQUIPMENT AND SUPPLIES**

Evaluate equipment and supplies used and contracts for potential risks. Equipment hazard and incident procedures must be implemented to allow for immediate risk management and biomedical engineering intervention.

5. **REGULATIONS**

Evaluate compliance with licensure and accreditation for each class of patient or client served, paying attention to health care industry standards (local, state and national).

6. **SOCIAL AND ECONOMIC CONSIDERATIONS**

Evaluate source of payment and utilization review procedures for their impact on patient perception and potential risks of financial loss. Consider patient relations and total family involvement in the product or service.

7. **CORPORATE ASSETS**

Evaluate the facilities and support services required. An example would be the need for 24 -hour patient contact in home health due to the patient acuity or technical sophistication of the procedures.

8. CONTRACT REVIEW

- a. Timeliness of proposed contract review
- b. Criteria used for contract review
- c. Maintenance of indemnity agreements and insurance certificates

"These guidelines, procedures, or policies herein do not represent the only medically or legally acceptable approach, but rather are presented with the recognition that acceptable approaches exist. Deviations under appropriate circumstances do not represent a breach of a medical standard of care. New knowledge, new techniques, clinical or research data, clinical experience, or clinical or bio-ethical circumstances may provide sound reasons for alternative approaches, even though they are not described in the document."

approved



**Kaweah Delta
Health Care District**

Subcategories of Department Manuals
not selected.



Kaweah Health

Policy Number: AP67	Date Created: 03/01/2007
Document Owner: Cindy Moccio (Board Clerk/Exec Assist-CEO)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration)	
<u>District Fleet Vehicles and Management</u> District Vehicles	

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

POLICY: ~~The District~~Kaweah Delta Health Care District dba Kaweah Health ~~owns, owns leases,~~ operates and provides vehicles which may be used for authorized staff only when engaged in the performance of ~~District Kaweah Health~~ business.

PROCEDURES:

I. Drivers License and Fines

Staff members whose job description duties require the operation of a ~~District Kaweah Health~~ owned vehicle while engaged in ~~District Kaweah Health~~ business are required to possess a valid California Drivers License. This will be verified as part of the hiring process. In addition a DMV check will be completed on all new employees hired into a position that requires driving.

Any and all fines incurred as a result of driving and/or parking violations are the exclusive responsibility of the driver.

II. ~~District Kaweah Health~~ Van

III. ~~The District Kaweah Health~~ maintains a van to be used on a reservation basis only for drivers approved through the Risk Management Department assuming it is available. To reserve ~~the District a~~ Kaweah Health Van the following must be completed:

A. Approval must be obtained from the employee's manager or director.

B. Request to reserve the van must be made at least five business days before it is to be used. This allows adequate time for authorization, issuance of PIN numbers and DMV checks.

C. The Kaweah ~~Delta Health Care District~~ Health Driver Attestation Form (Attachment 1) will be completed and a copy of the employee's driver license will be submitted to Risk Management at the time the van is requested (at least five days before it is to be used). The information must be faxed to 635-4064. Ensure that all drivers who might be driving the van during the period checked out complete the required documentation.

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D. The van will be picked up in PBX on the day it is needed and returned when the employee returns to town. The van should always be returned with the full tank of gas.

~~4.~~

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~~III-IV.~~ Hours Worked

Time spent by a staff member driving a ~~District Kaweah Health~~ vehicle while on ~~District Kaweah Health~~ business during normal working hours will be considered hours worked for pay purposes.

~~V.~~ Gasoline and Supplies Expenses

Each ~~District Kaweah Health~~ Vehicle will have a WEX Fuel Card included in the glove box for use. To use the WEX card, an assigned driver must be issued a PIN from the Fleet Card Coordinator in Finance. Those assigned a WEX Pin number must do the following:

- A. Complete the WEX PIN Authorization Form (Attachment 2)
- B. Use the WEX card exclusively when fueling District vehicles
- C. Enter the exact current mileage at the time of the purchase at the pump
- D. Use self service pumps and fuel of the type and grade specified by the manufacturer
- E. If a problem is encountered at the time of fueling, contact WEX immediately using the 800 number on the back of the card.

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~~III-F.~~ Report a lost, damaged or stolen card to the Fleet Card Coordinator immediately upon discovery. associated with gasoline, other items or supplies directly related to the operation of a District vehicle, which are paid for by a staff member, will be reimbursed by the District in compliance with District policy.

~~IV-VI.~~ Vehicle Maintenance and/or Maintenance Issues

Each vehicle will have an Enterprise Maintenance Card included in the glove box, along with authorized locations where maintenance can be performed. It is the responsibility of the Department using the vehicle to ensure that appropriate maintenance is completed on the fleet vehicle, including oil changes, tire rotations and other routine maintenance items. Questions regarding non routine maintenance or services must be director to the Director of Facilities and Maintenance. Any malfunctions and/or maintenance requirements of the vehicle which are either noticed or brought to the attention of a staff member operating the vehicle will be reported to the Maintenance Department immediately upon the vehicles return.

~~V-VII.~~ Traffic Accidents

In the event that a staff member is involved in a traffic accident while in a ~~District Kaweah Health~~ vehicle, regardless of the extent of damage or the lack of injuries, the staff member will report the accident immediately to their Supervisor, ~~the Police Department and Risk Management~~ and the Director of Facilities and Maintenance.

In the event of a traffic accident, staff members are expected to cooperate fully with the authorities and reply to questions of investigating officers.

However, staff members should make no voluntary statements or make any admissions of liability.

VI. Monthly Safety Inspection and Annual Training

A monthly safety inspection will be completed each month for each vehicle that is part of the ~~District~~Kaweah Health Fleet. The monthly safety inspection will be completed to ensure that basic safety features of each vehicle are working effectively. It is the responsibility of the Director to which the vehicle is assigned that all vehicle safety issues are remediated in a timely manner using an approved vendor, as outlined in Section IV of this policy.

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In addition, a driving safety training course will be required annually for all employees in a driving job code. This training course will be provided through Net Learning.

Drivers of vehicles that transport children will be trained in child seat safety.

VI. Monthly Reporting

Each month an email will be sent from the Facilities and Maintenance Department to each Director who is assigned a ~~District~~Kaweah Health vehicle or vehicles. This email will include reports regarding vehicle usage, maintenance costs, oil changes that are due to be completed, and fueling reports. It is the responsibility of each director to review this information for appropriateness and to ensure that indicated maintenance be completed.

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Approved

District Vehicles

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ATTACHMENT 2

**WEX Personal Identification Number (PIN) Authorization Form
Kaweah Delta Healthcare District dba Kaweah Health**

Last Name _____ First Name _____

Job Title _____ Employee ID _____

Dept Name _____ Dept # _____

Business Phone _____

Manager/Director Approval Signature _____

Date _____

Employees authorized to fuel company vehicles are issued a (4) digit Driver ID to be used with ~~Kaweah Delta Healthcare District~~ **Kaweah Health** (KDH) WEX Fuel Card. This document is to verify that you understand your responsibilities and the company's policies regarding the use of your Personal Identification Number (PIN).

Employee Acceptance Statements

1. I have been issued a Driver ID, which authorizes me to fuel company vehicles only, using the WEX Fuel Card.

2. I understand that my PIN identifies me by name on a fuel report and that I am accountable for all transactions made using my PIN. Therefore, I will not share my PIN with anyone. If I believe someone else knows my PIN, I will immediately notify the Fleet Card Coordinator.

3. I understand that each time I use a WEX Fuel Card I am required to completely fill the vehicle's fuel tank and enter an accurate odometer reading. This will allow the monitoring of fuel usage and track required maintenance intervals. My failure to do this may result in disciplinary action.

4. I understand that each WEX Fuel Card is assigned to an individual ~~District~~ **Kaweah Health** vehicle or specific fueling purpose (example: off road equipment fuel card). I understand that it is against District policy to swap or share cards between vehicles or to use any card for other than the intended purpose, including personal vehicles or non-business purposes. Using the WEX Fuel Card for any purpose other than official business use will be considered theft of ~~District~~ **Kaweah Health** property.

Evidenced by my signature below, I understand and agree to the above statements. I acknowledge I have read and been given an opportunity to discuss the ~~District~~ **Kaweah Health** Fleet Vehicles Policy. I understand that violations of this policy can result in administrative,

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disciplinary and/or criminal action by Kaweah ~~DeltaHealth~~ up to and including termination.

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Employee Name _____

Employee Signature _____ Date _____

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Policy Number: AP70	Date Created: No Date Set
Document Owner: Cindy Moccio (Board Clerk/Exec Assist-CEO)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration)	
Code of Ethical Behavior	

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

POLICY: The Governing Board of Kaweah Delta Health Care District (“Kaweah Delta”) has established this statement of organizational ethics in recognition of the institution’s responsibility to its patients, employees, physicians, and the community it serves. It is the responsibility of every member of this hospital community – governing board member, administration, medical staff members, and employees – to act in a manner that is consistent with this policy and its supporting policies. The behavior of all members of this hospital community will be guided by the following principles:

1. All patients, employees, physicians, and visitors deserve to be treated with dignity, respect, and courtesy.
2. Kaweah Delta ~~Health Care District~~ will fairly and consistently represent itself and its capabilities.
3. Kaweah Delta ~~Health Care District~~ will provide services to meet the identified needs of its patients and will constantly seek to avoid providing those services that are unnecessary or ineffective.
4. Kaweah Delta ~~Health Care District~~ will observe a uniform standard of care throughout the organization.
5. Kaweah Delta ~~Health Care District~~ will promote the delivery of high quality and cost effective healthcare.
6. Kaweah Delta ~~Health Care District~~’s Code of Conduct reflects Kaweah Delta’s commitment to providing high quality services to its patients, and its commitment to ethical and legal business practices.

PROCESS: The District will constantly strive to follow and expand on these principles.

I. Admissions, transfer, and discharge

Regardless of the settings in which this organization provides patient services, we will follow well-designed standards of care based upon patient needs. We will provide services only to those patients for whom this organization can safely provide care. Even as we work to provide care in a more economical manner to patients and providers, we will strive to provide care that meets ~~the District’s~~Kaweah Delta’s own standards of quality. Written criteria will guide caregivers in deciding to admit, treat, transfer, or discharge patients.

We will not turn patients away who are in need of ~~the District's~~Kaweah Delta services because they are unable to pay or because of any other factor that is substantially unrelated to patient care.

Conversely, employees may not provide clinical treatment to individuals who are not Kaweah Delta patients (co-workers, family members). Except in emergent situations when delegation of treatment is not possible, employees must transfer treatment/care of their family to a co-worker. Examples of inappropriate acts include:

- Employees providing treatment to a co-worker who is not a registered Kaweah Delta patient
- Misappropriation of Kaweah Delta resources (using supplies, tests, and medications for personal use)
- Conducting a lab draw for your spouse on a unit instead of referring your spouse to the lab draw station
- Drawing your spouses lab at home and bringing it to the facility for testing

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II. Marketing

Kaweah Delta ~~Health Care District~~ will fairly and accurately represent itself and its capabilities.

III. Respect for the patient

We will treat all patients with dignity, respect, and courtesy. All patients (or their significant others) will be involved – to the extent that is practical and possible – in decisions regarding the care that we deliver. We will inform patients about alternative therapies and the risks associated with the care we offer them. We will seek to understand and respect their objectives for care. We will communicate openly and honestly with patients, their family members and/or the person they designate as their caregiver.

IV. Resolution of conflict in patient care decisions

We recognize that conflicts might arise among those who participate in hospital and patient care decisions. Whether this conflict is between members of the administration, medical staff, employees, or governing board members, or between patient caregivers and the patients, we will seek to fairly and objectively resolve all conflicts. In cases where mutual satisfaction cannot be achieved, it is the policy of this Board to involve the Administrator On Call or the Director of Risk Management to oversee resolution of the conflict. (See AP.08 Complaint and Grievance Policy). Other staff and second opinions will be involved as needed to pursue a mutually satisfactory resolution.

V. Recognition of potential conflicts of interest

We understand that the potential for conflict of interest exists for decision makers at all levels throughout ~~the District~~Kaweah Delta – including governing board members, administration, the medical staff, and all other employees. It is ~~the District~~Kaweah Delta's policy to request the disclosure of potential

conflicts of interest so that any appropriate action be taken to ensure that the conflict does not inappropriately influence important decisions.

Governing Board members, administration, and medical staff leaders are required to submit an annual disclosure form and to disclose potential conflicts related to decisions that arise during the course of a year. The Executive Leadership, Governing Board or the Medical Executive Committee will review potential conflicts and take appropriate action. In the event a potential conflict of interest has a direct impact on patient care, the institution may convene an Ethics Committee meeting to assist in the resolution of the issue.

VII. Fair billing practice

~~The District~~Kaweah Delta will invoice patients or third parties only for services actually provided to patients, and will provide assistance to patients seeking to understand the cost of their care. The District will attempt to resolve questions and objections of patients while considering the institution's best interests as well.

VIII. Confidentiality

~~The District~~Kaweah Delta recognizes the extreme need to maintain the confidentiality of patient-related information as well as other information. As such, patient information will not be shared in an unauthorized manner, and sensitive information concerning personnel and management issues will be maintained in the strictest confidence and accessible only to those individuals authorized to review and act upon such information.

IX. Integrity

Clinical decision making is based on patient need without regard to how the hospital compensates its leaders, managers, clinical staff, and licensed independent practitioners.

Underlying each of the above principles is our overall commitment to act with integrity in all of ~~the District's~~Kaweah Delta's activities and to treat ~~the District's~~ employees, patients, visitors, physicians and the many constituents we serve with utmost respect. ~~The Kaweah Delta's District~~ Code of Conduct is a real expression of Kaweah Delta's ~~the District's~~ commitment to integrity, accountability and excellence. The Code establishes the variety of legal, professional and ethical standards that govern and regulate the work of Kaweah Delta~~the District~~, its employees, physicians and volunteers.

X. Related policies and documents

1. The following related policies and procedures and other documents provide further and specific guidance for ethical conduct at Kaweah Delta Health Care District: Advance Directives; AP.112
2. Bioethics Committee; AP.097
3. Patient Self-Determination Act and Self-Directives; AP.055
4. Patient Placement Guidelines; AP.115
5. Public Release of Patient Information; AP.103

6. Public Relations, Marketing and Media Relations; AP.006
7. Patient Privacy/Use and Disclosure of Patient Information; AP.107
8. Conflict of Interest; AP.023
9. Complaint and Grievance Management; AP.008
10. Organ and Tissue Donation; CP.49
11. Review of Billing Practices; CP.02
12. Patient Rights and Responsibilities; AP.053
13. Discharge Planning; CC.03
14. Plan for Provision of Patient Care
15. Chain of Command for Resolving Clinical Issues; NS.05
16. Withholding/Withdrawing Life-Sustaining, Pre-Hospital; DNR PR.02
17. District Mission and Vision Statements
18. Do not Resuscitate; PR.02
19. Informed Consent Verification; PR.05
20. Complaint and Grievance Policy; AP.08
21. Vendor Relationships and Conflict of Interest; AP.40
22. Compliance Program Administration; CP.01
- 24-23. Code of Conduct
- 22-24. Anti-Harassment and Abusive Conduct
- 23-25. Behavioral Standards of Performance

"These guidelines, procedures, or policies herein do not represent the only medically or legally acceptable approach, but rather are presented with the recognition that acceptable approaches exist. Deviations under appropriate circumstances do not represent a breach of a medical standard of care. New knowledge, new techniques, clinical or research data, clinical experience, or clinical or bio-ethical circumstances may provide sound reasons for alternative approaches, even though they are not described in the document."

approval



**Kaweah Delta
Health Care District**

Subcategories of Department Manuals
not selected.



Kaweah Health

Policy Number: AP91	Date Created: No Date Set
Document Owner: Cindy Moccio (Board Clerk/Exec Assist-CEO)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration)	
Unannounced Regulatory Survey Plan for Response	

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE: To ensure that the appropriate [District-Kaweah Health](#) personnel respond in a coordinated and timely manner upon notification that surveyors and/or an outside regulatory agency have arrived for an unannounced visit to Kaweah Delta Health Care District [dba Kaweah Health](#).

POLICY: All unannounced regulatory visits to [Kaweah Delta Health Care District](#) [Kaweah Health](#) will be handled in a coordinated and timely manner.

- A. Surveyors will be provided immediate access to medical records. ~~A District-Kaweah Health staff person will access the medical record as requested by and on behalf of the surveyor.~~
- B. ~~Surveyor user names will not be audited to determine which records were viewed during the survey process. This is to ensure complete anonymity as to which patient records were reviewed.~~
- C. A District staff person will be available to accompany a surveyor during his/her visit.
- D. If a surveyor requests to interview a [District-Kaweah Health](#) employee during the visit, [District-Kaweah Health](#) staff have the right to request another [District-Kaweah Health](#) staff member, the Director of Risk Management or the ~~Compliance and Privacy Officer~~ [Chief Compliance & Risk Officer](#) be present during the interview, as appropriate. ~~Additionally, employees or employee representative's have the right to discuss possible regulatory violations or patient safety concerns with the California Department of Public Health's inspector privately during the course of an investigation or inspection by the Department.~~
- E. In order to ensure compliance with HIPAA, state and federal privacy laws, [District-Kaweah Health](#) employees should validate surveyor credentials and purpose for the visit through on-campus interviews. Off-site phone interviews disallow this process and are, therefore, strongly discouraged.

Commented [EM1]: This is no longer the process used to access patient records. Instead, the KD escort navigates the patient record on behalf of the surveyor.

PROCEDURE:

- I. Upon arrival to any campus of ~~the District~~ [Kaweah Health](#), Administration at Kaweah ~~Delta Health~~ Medical Center will be notified (624-2221) and the regulatory surveyors will be escorted to the following location based on the ~~District-Kaweah Health~~ campus where they arrive at which time credentials will be verified.

If the surveyors are from Joint Commission go directly to item II

CAMPUS	OFFICE TO TAKE SURVEYORS	STAFF TO VERIFY CREDENTIALS
Kaweah Delta Health Medical Center	Administration	Administration
Kaweah Delta Health Skilled Nursing	Director of SNF	Director of SNF
Kaweah Delta Health Rehabilitation Hospital	Director of Rehabilitation Hospital	Director of Rehabilitation Hospital
Kaweah Delta Health Mental Health Hospital	Director of Mental Health Hospital	Director of Mental Health Hospital
Kaweah Delta Dialysis - Porterville	Manager of Porterville Dialysis	Manager of Porterville Dialysis
Kaweah Delta Health Dialysis - Visalia	Manager of Visalia Dialysis	Manager of Visalia Dialysis
Kaweah Delta Health Rural Health Clinics	Director of Kaweah Delta Health Rural Health Clinics {Exeter, Woodlake, Dinuba & Lindsay}	Director of Kaweah Delta Health Rural Health Clinics

- A. Upon arrival to the appropriate location as indicated in the preceding chart, the ~~District~~ staff member assisting the surveyors will provide each surveyor with the appropriate surveyor identification badge.
 Surveyor identification badges must be worn at all times while on ~~District~~ [Kaweah Health](#) premises. Surveyor identification badges will be displayed above the waist so as to be fully visible to ~~District-Kaweah Health~~ personnel and Security staff. At the conclusion of each visit, surveyors will immediately return the vendor identification badge and check out of the facility.
- B. The following individuals shall be notified by e-mail and by phone of their arrival.

Title	Phone	Cell
Chief Executive Officer	624-2330	740-2496
Applicable SVP or VP Chief:		
Chief Compliance & Risk Officer	624-5006	559-280-3105
SVP & COO Chief Operating Officer (COO)	624-2221	679-8726 917-
SVP & CFO Chief Financial Officer (CFO)	624-4065	0490

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VP & Chief of Human Resources	624-2362	956-821-5926 559-300-1742
VP & CNO Chief Nursing Officer (CNO)	624-2221	740-6487269- 569-0118
VP & Chief Information & Cybersecurity Officer CIO	624-5410	909-633-5278
VP Strategic Planning & Development Chief Strategy Officer	624-2359	799-2557310- 227-6357
Risk Manager	624-2511	310-227- 6357786-6908
Director of Performance Improvement Quality and Patient Safety Compliance & Privacy Officer	624-2169	737-7097707- 7086 624-5006 280-3105

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- C. An e-mail will be sent to “Unannounced Survey Alert” including what outside regulatory agency is here, why they are here (if that information is provided), who is escorting them, and to what area they will be going.
- D. A notification log shall be prepared by Administration and maintained in Administration documenting that the appropriate personnel were notified of the visit from the outside regulatory agency. This log will reflect the following data:
 - 1. Date of the visit
 - 2. What agency is making the visit and the name of the representative from that agency
 - 3. Case # (if available)
 - 4. Patient(s) the visit is concerning (if applicable)
 - 5. Follow up report receipt date
- E. ~~Risk Management will activate the usernames upon the surveyors arrival and deactivated at the conclusion of the survey.~~ Upon conclusion of the surveyor’s visit, the ~~District Kaweah Health~~ staff member who assisted/accompanied the surveyor shall notify (via phone, email or in-person) the CEO of the key issues/conclusions of the surveyor’s findings.
- F. Room designation for surveyors
- G. Reserve the Acequia Wing Conference a meeting Room as the daily meeting room for the surveyors and escorts. This room will also serve as the secure location for storage of requested survey documents to be delivered by various KDHC DKaweah Health personnel and the secure location for storage of surveyor’s personal items (handbags, laptop computers, etc.).
 - 1. If there is a Board of Directors or Medical Staff meeting that must be moved out of the Acequia Wing to accommodate surveyors, a new location for the Board or Medical Staff meeting will take precedence to meetings already booked in other locations.

Commented [EM2]: No longer the process used to access medical records.

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- H. Arrange daily food service for surveyors if requested. Typical needs are for breakfast, lunch and afternoon snack, beverage service and bottled water available all day.
- ~~E-I. Reserve the Blue Room for the room for the Exit Conference on the final day of the survey from 1200-1700.~~

- II. Items III-V pertain specifically to unannounced surveys by the Joint Commission.
- III. The Director of ~~Performance Improvement Quality~~ and Patient Safety or designee will monitor the Joint Commission's secure Extranet website for impending survey information. Posting of survey announcement and surveyor biographies to the Extranet indicates possible impending survey. If survey is imminent, the following action is taken immediately:
 - A. Notify CEO, COO, CNO and CMO
 - B. Print surveyor biographies to facilitate positive identification on arrival.
- IV. Regardless of location, upon arrival to ~~Kaweah Health the District~~, the Joint Commission surveyor(s) should be greeted, Administration notified (624-2221) **and the surveyors will then be escorted to Administration at Kaweah Delta Medical Center where positive identification can be verified.** Immediate notification to the Director of ~~Performance Improvement Quality~~ and Patient Safety or designee is required. Identification will be verified by comparing the surveyor(s) documentation with the biographies printed from the Extranet. If a discrepancy exists, security will be notified immediately. Additional notification will be made to local law enforcement and to the Joint Commission. If the credentials of the JOINT COMMISSION survey team are verified, the following actions will be taken immediately:
 - A. Upon arrival to Administration the surveyors will obtain the appropriate surveyor identification badge. Surveyor identification badges must be worn at all times while on ~~District Kaweah Health~~ premises. Surveyor identification badges will be displayed above the waist so as to be fully visible to ~~District Kaweah Health~~ personnel and Security staff. At the conclusion of the Joint Commission survey, surveyors will immediately return the vendor identification badge to the Administration or the Director of ~~Performance Improvement Quality~~ and Patient Safety.
 - B. One of the executive assistants in Administration will call the PBX operator and direct them to immediately announce by overhead page "Attention all staff. Kaweah ~~Delta Health~~ welcomes the Joint Commission surveyors with us today". The announcement will be repeated three times in one-minute intervals.
 - C. One of the executive assistants in Administration will notify all KDHCD Executive Team Support members and email out the "Readiness Checklist" to the Leadership Team to be completed immediately by Director's or designee upon notification of survey (and daily by 8 am). ~~The Readiness Checklist will be faxed to Performance Improvement the Quality department (635-4089)~~

~~within two hours of the initial request and daily by 8am each day of the survey.~~ Each Executive Team Support member or their designee will contact their Executive Team member's Director's by phone of the unannounced survey.

- D. One of the executive assistants in Administration will send an email to "Everyone" with high importance (red ! symbol) using the following text "An unannounced Joint Commission survey is in progress. See your area manager for additional information and instructions."

V. Additional Responsibilities by Service Area

A. One of the executive assistants in Administration

- 1. Reserve ~~the Acequia Wing~~ Conference Room as the daily meeting room for the surveyors and escorts. This room will also serve as the secure location for storage of requested survey documents to be delivered by various KDHCD personnel and the secure location for storage of surveyor's personal items (handbags, laptop computers, etc.). One of the Executive Assistants in Administration shall have a portable copy machine delivered to ~~the Acequia Wing Conference~~this Room on day 1 of the survey. Also see page 4 wherein Facilities Department is to deliver a locking cabinet for secure storage to ~~the Acequia Wing Conference Room~~designated meeting room upon survey arrival.
- 2. Arrange daily food service for surveyors. Typical needs are for breakfast, lunch and afternoon snack, beverage service and bottled water available all day.
- 3. Reserve ~~the Blue Room~~a meeting room for the Exit Conference on the final day of the survey, 1400-1700 hours.

B. Director of ~~Performance Improvement~~Quality and Patient Safety or Designee

- 1. If not already accomplished, print surveyor biographies from the Joint Commission website and deliver 15 copies to Administration on morning of unannounced survey.
- 2. Prepare/deliver opening conference presentation.
- 3. Arrange for temporary surveyor badges.
- 4. Arrange for survey escorts
- 5. E-mail survey schedule to leadership/communication group as soon as possible.

C. Patient Access

- 1. Prepare printed copy of patient census and deliver to Administration as soon as possible day 1 of survey and by 8 am each of survey thereafter. Census at minimum to include patient name, account

number, medical record number, age, unit/room number, diagnosis and admit date. Include each campus census:

- a) Kaweah ~~Delta-Health~~ Medical Center
 - b) Kaweah ~~Delta-Health~~ Skilled Nursing (Subacute and Transitional Care)
 - c) Kaweah ~~Delta-Health~~ Rehabilitation Hospital and Kaweah Delta Mental Health Hospital
2. Prepare printed copy of surgical/procedural schedules and deliver to Administration as soon as possible day 1 of survey and by 8 am each of survey thereafter. Include the following:
- a) Inpatient and outpatient surgical schedule
 - b) Endoscopy lab schedule
 - c) Cardiac Cath lab schedule
 - d) Interventional radiology/Special Procedures schedule
- D. Medical Staff Manager or Designee
1. Notify Medical Executive Committee membership of survey ASAP
 2. Notify credentials committee chair of requested attendance at credentials session.
 3. Notify P&T chair of requested attendance at medication management session.
- E. Director of Facilities Operations or Designee
1. Deliver required Environment of Care (EOC) documents to Administration.
 2. Deliver a locking cabinet to the ~~Acequia Wing Conference~~ designated meeting r-Room for use of secure storage of surveyor belongings (with enough keys for each survey escort)
 3. Deploy all facilities staff to
 - a) Remove clutter and obstructions throughout hospital
 - b) Ensure cleanliness of facility beginning with areas surrounding Administration
- F. Director of Health Information or Designee
1. Deliver medical record statistic form to Administration
 2. Review electronic physician orders for signatures, dates and times – if not, call physician to come and sign
- G. Director of Clinical Education or Designee
1. Alert educators for potential need for competency review.
- H. Director of Food & Nutrition Services or Designee

1. Deploy food services staff to check refrigerators for expired food
 2. Direct staff to make rounds on patient care units and remove dirty trays, carts, etc.
- I. Nursing Units: **Daily** during survey week (Nursing Director or designee accountable)
1. Utilize "Day of Survey Checklist" (Attachment A)
 2. Identify three charts daily for surveyors to use of patients who have been in various units in the hospital and have been in the hospital at least 3 days or may be ready for discharge. Ensure these charts are complete (complete initial assessment, good daily notes, care-planning, etc)
 3. Review all restraint patients and ensure current order and documentation up to date
- J. Other Clinical Service areas
1. Utilize "Day of Survey Checklist" **daily** (Attachment A)
 2. Management/Staff to ensure
 - a) No food ~~or drink~~ in patient care areas, drinks are sequestered (ie in cupboard)
 - b) Areas clean and free of clutter
 - c) No supplies stored on floors
 - d) Confidential information out of public view
 - e) ~~Review National Patient Safety Goals with staff~~
- K. Information Systems
1. Chief Clinical Information Officer or designee- to notify appropriate staff of need to assist with online chart reviews throughout survey
- L. Human Resources (HR)
1. Be on alert for need to review HR files. KDHC staff escorting surveyors will notify HR as files are requested.
 2. ~~Print list of past twelve months termed employees~~

Attachment A

Unit: _____ **E Fax to 735-3064 or Fax to 635-4089 upon completion**

Day of Survey Checklist	YES/CHECK IF COMPLIANT
1. Halls clear, no equipment blocking medical gas shut off valve or fire pull stations.?	
2. Unit/department clean (including drawers and cabinets).?	
3. Garbage/Biohazard not overflowing, lids are closed.?	
4. No outside shipping cardboard in patient care areas, or where patient supplies stored (check under sinks and counters).?	
5. Sharps containers no more than ¾ full.?	
2. Nothing stored on floors or 18 inches from ceiling and/or fire sprinklers.?	
3. Doors are not propped open	
3-4. Employees know performance improvement activities posted in unit/department (include safety culture if applicable) (posted within department—preferably communication board)?	
5. All refrigerator log(s) complete.	
6. Patient refrigerator clean, patient food labeled with date and not expired	
4-7. Laundry bins in hallways are at least 8' apart, or 1 per pod (in MK units) Employees can explain Standard Isolation (Universal Precautions)?	
8. Crash cart log up to date, with no gaps. Defibrillator plugged in, tamper-resistant seals in place on crash carts.	
9. Isolation patient rooms - Patient Care areas: If isolation door caddy/ss are present are they are stocked, appropriate isolation precaution sign is posted on door.?	
5. Medication area clean and locked?	
6. Medication refrigerator clean?	
5-10. Hand Hygiene supplies are stocked (ie. soap and sanitizer) Patient refrigerator clean, patient food in refrigerator labeled and dated?	
11. Cleaning supplies are stocked and ready to use	
6-12. Supplies current (no expired lab tubes, supplies, etc) (check all supply places, drawers, etc) Refrigerator log(s) complete?	
7-13. Ice machines clean (no scale in bin, etc.).?	

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<u>14. Oxygen tanks stored properly (in carts/caddy's/holder)?</u>	
<u>15. Medication area clean and locked.</u>	
8. Medications <u>stored properly, no expired medications, current (no expired medications)</u>	
9. Medications are not prepared within 1' of water (ie beside a sink with <u>no barrier</u>) <u>Supplies current (no expired lab tubes, supplies, etc) (check all supply places, drawers, etc)</u>	
10. Patient's own medications properly stored per policy?	
11. Open <u>multi-use vials dated, not expired and label does not cover up medication bottle label?</u>	
<u>12. Under sink clean?</u>	
<u>13. Employees can locate MSDS?</u>	
<u>13. Crash cart log up to date, with no gaps? All crash cart drawers locked?</u>	
14. As applicable to your discipline review charts for completeness (ie <u>NADB, initial admission assessments, risk assessments, medication administration documentation, care plans, etc</u>)	
15. Nursing areas <u>daily</u> identify three good medical records of a patient here at least 3 days and preferably with multiple disciplines working with the patient (ensure chart is complete! – initial assessment, good daily notes, etc)	
<u>16. Ensure restraint documentation is complete orders present and signed</u>	
<u>17. Ensure <u>all</u> order sets (i.e. pressure ulcer) are signed</u>	

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approval



Policy Number: AP97	Date Created: No Date Set
Document Owner: Cindy Moccio (Board Clerk/Exec Assist-CEO)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration), Executive Team A	
Bioethics Committee	

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

Purpose: In recognition of the complexity of modern medical practice and the multiple ethical issues which may arise in the provision of patient care, Kaweah Delta-Health Medical Center will establish and maintain a Bioethics Committee to assist patients, families, hospital and medical staff in effectively addressing bioethical issues.

Policy: The Bioethics Committee (hereinafter referred to as “the committee”) shall -fulfill the following functions:

1. Provide education for patients, families, hospital and medical staff regarding relevant bioethics issues.
2. Provide the institution assistance with the analysis and development of policies and procedures regarding bioethics issues.
3. Provide Bioethics Consultation Services to assist patients, families, hospital and medical staff in addressing bioethics issues arising in the provision of patient care. This is an advisory function, only.
- ~~3-4.~~ Identifies trends in potential knowledge gaps in ethical care/decision making in which training could be developed and executed.

Procedure:

- I. Education: In cooperation with the hospital/medical staff, the committee will assist in identifying educational needs and develop (or assist others in the development of) appropriate educational resources to meet these needs. These resources can include presentations, CME courses, etc. The goal will be to provide participants with language, concepts and a body of knowledge to assist in addressing complex ethical issues arising in hospital practice.
 1. Identified educational needs will be reviewed at the next available committee meeting or by the Chair ~~or Vice-Chair~~ between meetings if the need is urgent.
 2. Committee members will establish contact with a point person for the educational need and will work with this individual to develop a plan for addressing the need.

3. A summary of educational service provided will be reviewed at next available meeting of the committee.
 4. Materials used in the educational service will be archived in the Bioethics Committee Chair and/or Vice Chair- Office for possible use in future educational services.
 5. Committee member providing educational service will obtain feedback from the “customer” regarding effectiveness of service provided and include this is summary presentation to the committee
- II. Policy Review & Development: The committee will assist the institution and its professional staff in the analysis of current policies and the development of new policies and procedures regarding bioethical issues.
1. ~~Hospital Kaweah Health~~ and Medical staff members who identify possible need for policy review/development will contact the Bioethics Committee Chair ~~or Vice Chair or Vice Chair~~ to request placement of policy on committee meeting agenda. Chair or ~~Vice Chair Vice Chair~~ will provide immediate review and consult with appropriate hospital/medical staff a, if the need is urgent.
 2. Policy/procedure will be reviewed at committee meeting and committee member will be assigned to assist staff in further analysis and review as needed.
 3. Results of analysis and review and committee recommendations will be discussed and documented in the minutes of the next committee meeting.
- III. Bioethics Consultation Service: The committee will provide both informal and formal consultation services at the request of medical staff, hospital staff, patients, family members and/or surrogate decision makers regarding bioethical issues which arise in the course of patient care provision.
1. Requests for bioethics consultation will be submitted by contacting the Bioethics Committee Chair or by contacting the Medical Staff Office Vice Chair and Chair and and will be responded to within 24 hours or by the next business day.
 - ~~1-2.~~ Urgent bioethical issues which arise after business hours or on weekends/holidays, will be reviewed by House Supervisor and/or the Director on Call for the hospital who will contact the Bioethics Chair as appropriate.
 - ~~2-3.~~ Depending on the issue, a committee member will be identified as “Team Lead” who will provide initial review and will consult with committee chair to determine appropriate level of consultation.
 - ~~3-4.~~ If Informal Consultation services are indicated:
 - a. Team Lead facilitates contact between requestor and appropriate committee member.

- b. Committee member provides consultation services and provides a summary of same at next scheduled committee meeting.

4-5. If **Formal Consultation** Services are indicated:

- a. Team Lead will obtain the following information: Review of Medical Record noting patient's diagnosis/prognosis/treatment plan; formulate bioethical issues/questions; establish decision makers (i.e., patient, family, surrogate).
- b. Team Lead will consult with Chair to establish plan for physician contact and consultation process/structure.
- c. Team Lead will contact all appropriate parties and schedule Bioethics Consultation meeting (s) as appropriate.
- d. Team Lead will ensure that all parties are advised of recommendations provided through the consultation process and that these recommendations are documented.
- e. If, following Formal Consultation, the bioethics issues remain unresolved, Bioethics Chair will consult with appropriate hospital/medical staff to determine appropriate plan of action.
- f. Summary of Formal Consultation will be provided by Team Lead at next committee meeting.

IV. Appointment and Membership: The committee shall be a multidisciplinary body including representatives from the following disciplines: medical staff, nursing, social work, pastoral care, risk management, board members and community members.

- 1. New members will be recommended by the committee and appointed by the Bioethics Committee Chair or Vice Chair. ~~or Vice Chair.~~

- 2. The Chair of the committee will be appointed by the Chief of Staff.

- 3. The Vice Chair of the committee will be chosen by the membership of the committee.

- 3-4. Co-chairs may be appointed per Bioethics Committee members majority vote and agreement of the Chief of Staff.

- 4-5. Membership shall be for a period of two (2) years with staggered terms to assure continuity. Committee Members can serve beyond the 2 year period ~~by mutual~~ by mutual agreement of the Chair/Vice Chair and the committee member.

- 6. Each hospital (employee) member will whenever possible designate a temporary replacement who will attend meetings in the event that a committee member is unable to fulfill committee responsibility.

- 5-7. Changes in Bioethics Committee leadership positions will be reviewed and approved by the Chief of Staff.

- V. Meetings: The Bioethics Committee shall meet ~~quarterly~~quarterly, with additional meets scheduled as appropriate to address urgent matters.
1. Meeting agenda will be developed by the Chair and distributed one week prior to the meeting.
 2. For business purposes, two members shall constitute a quorum.
 3. Actions of the committee will be taken by the vote of a majority of the members attending the meeting.
 4. Each member will be required to attend at least three (3) of the committee's regularly scheduled meetings each year. Failure to do so may ~~will~~ be considered voluntary resignation and the vacancy will be filled by appointment of a new member.
- VI. Record Keeping: The committee will maintain minutes of all meetings which will include summaries of all case reviews and recommendations.
1. Minutes will be submitted to the Chair for approval by the committee.
 2. Minutes will not include identifying information about specific patient, family members, individual requesting consultation or professional staff participating in the case review process.
 3. Records of the committee meetings and functions will be maintained in accordance ~~with applicable~~with applicable laws governing the confidentiality of records and medical review committees.
- When appropriate, actions and recommendations of the committee will be documented in the patient record.
- VII. Reporting: The Bioethics Committee reports regularly into the medical staff and organization's QAPI program.
- IX. Liability: Kaweah ~~Delta Health~~ Medical Center will provide liability protection for the committee members who do not have such protection by virtue of their status as members of the professional staff.
- X. Adoption and Approval of Policies and Procedures: Policies and procedures of the committee will be reviewed as appropriate by the membership of the committee.
1. Proposed modifications of approved policies and procedures will be submitted to the committee in writing as soon as possible at least four (4) weeks in advance of a regularly scheduled meeting.
 2. Following recommendation by the committee, policies/procedures will be forwarded to the appropriate committee for subsequent action.

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of care. New knowledge, new techniques, clinical or research data, clinical experience, or clinical or bio-ethical circumstances may provide sound reasons for alternative approaches, even though they are not described in the document."

approval



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Administrative Manual:-

Policy Number: AP103	Date Created: No Date Set
Document Owner: Cindy Moccio (Board Clerk/Exec Assist-CEO)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration)	
Public Release of Patient Information	

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE: To provide guidelines for communication of specific patient information upon inquiry from the media or a member of the public.

POLICY: Basic patient information, as detailed below, may be released upon an inquiry concerning a specific patient, unless the patient specifically requests that such information be withheld. (Reference: Civil Code Section 56.16 and CHA Consent Manual and California Health Information Privacy Manual). However, there are special situations and circumstances that are described in more detail below and where applicable, should be followed.

Media requests for information should be forwarded to the Marketing and Public Relations Department during business hours and to the Nursing Supervisor at all other times. If necessary, the nurse in charge of any unit may provide the information requested.

Marketing, the Nursing Supervisor, or the nurse in charge of the unit may handle requests for information from the general public where the patient is receiving care. Information is limited as detailed below.

PROCEDURE:

I. Basic Information Which May Be Publicly Released

The only information which may be released to the public is confirmation of the patient's presence in the hospital and the general condition of the patient. Information about the condition and location of a patient may be released only if the inquiry specifically contains the patient's name. No information can be given out if a request does not include the patient's name.

Other patient information cannot be released unless the patient specifically authorizes the release through a written authorization form.

A. General Conditions

In describing a patient's condition, employees should limit their comments to the following one-word descriptions:

1. **Undetermined.** Patient is awaiting physician assessment.
2. **Good.** Vital signs are stable and within normal limits. Patient is conscious and comfortable. Indicators are excellent.
3. **Fair.** Vital signs are stable and within normal limits. Patient is conscious but may be uncomfortable. Indicators are favorable.
4. **Serious.** Vital signs may be unstable and not within normal limits. Patient is acutely ill. Indicators are questionable.
5. **Critical.** Vital signs are unstable and not within normal limits. Patient may be unconscious. Indicators are unfavorable.
6. **Treated and Released.** Received treatment but not admitted.
7. **Treated and Transferred.** Received treatment. Transferred to a different facility.

"Stable" is not an accurate description of a patient's condition. This term should be avoided.

No statement may be made that there was a suicide or attempted suicide.

No statement may be made that a child's injuries appear to be the result of child abuse.

No statement may be made as to whether the patient is intoxicated or whether the ingested material is alcohol or other drugs regardless of whether the patient records are subject to state and federal regulation of drug or alcohol abuse patient records. Federal regulations and California law strictly prohibit the giving of any information about mental health or drug and alcohol abuse patients, including information as to whether or not they are in the hospital. While reporters may have information from the police concerning persons who subsequently become psychiatric or drug and alcohol abuse patients, all such inquiries should be answered, "We cannot, under federal regulations and/or California law, comment on the matter."

B. Location of a Patient

Disclosure of information concerning the patient's location to persons who inquire about the patient by name is permitted. However, caution should be exercised in disclosing this information over the phone. Release of such information is intended to facilitate visits by family and friends, as well as the delivery of gifts or flowers. Location should not be released to media. If such a request is made, contact the House Supervisor to handle the situation.

II. Special Situations

A. Death of a Patient

Privacy protections continue to apply to a patient's medical information even after the patient's death. The death of a patient is a "patient condition" and may be disclosed using the one-word "deceased." However, a patient's death may not be routinely announced by Kaweah ~~Delta~~-Health ~~Care District (Kaweah Delta)~~, but rather by the patient's physician or the coroner. Care should be taken to make sure that the patient's family has been notified and does not object to disclosure prior to making any announcement of a patient's death.

B. Public Figures

1. Public figures are entitled to the same considerations for privacy as all other members of the public.
2. The hospital should work with the public figure or his or her designee to answer these questions with minimum disruption for all concerned and to provide the appropriate cooperation with the media.

C. Patient or Patient's Family Contacts Media

The laws regarding the release of patient information apply even when the patient or the patient's family contacts the media. Other than cooperating to the extent described above, refer issues to Kaweah ~~Delta's Health's~~ Chief Compliance and Privacy Risk Officer, Director of Risk Management, Media Relations Department, Marketing Department, Administration, or House Supervisor.

D. Community Disasters

Marketing Department staff will coordinate media communications in the event of a disaster.

E. Identity of Physician

The attending physician's name should not be given to the news media without the permission of the physician and written authorization of the patient.

F. Release of Patient Information for Minors

Release of information for a minor requires that written consent be obtained prior to releasing information from either:

1. The minor, if he/she consented to the treatment; or
2. The parent or legal guardian, if it was necessary for the hospital to obtain his/her consent for treatment of the minor.

Once consent has been given, the general rules regarding release of patient information will apply.

G. Inquiries must contain the patient's name, unless the inquiry comes from clergy

Information about the condition and location of an inpatient, outpatient or emergency department patient may be released only if the inquiry specifically contains the patient's name. No information is to be given if a request does not include a specific patient's name. This includes inquiries from the press.

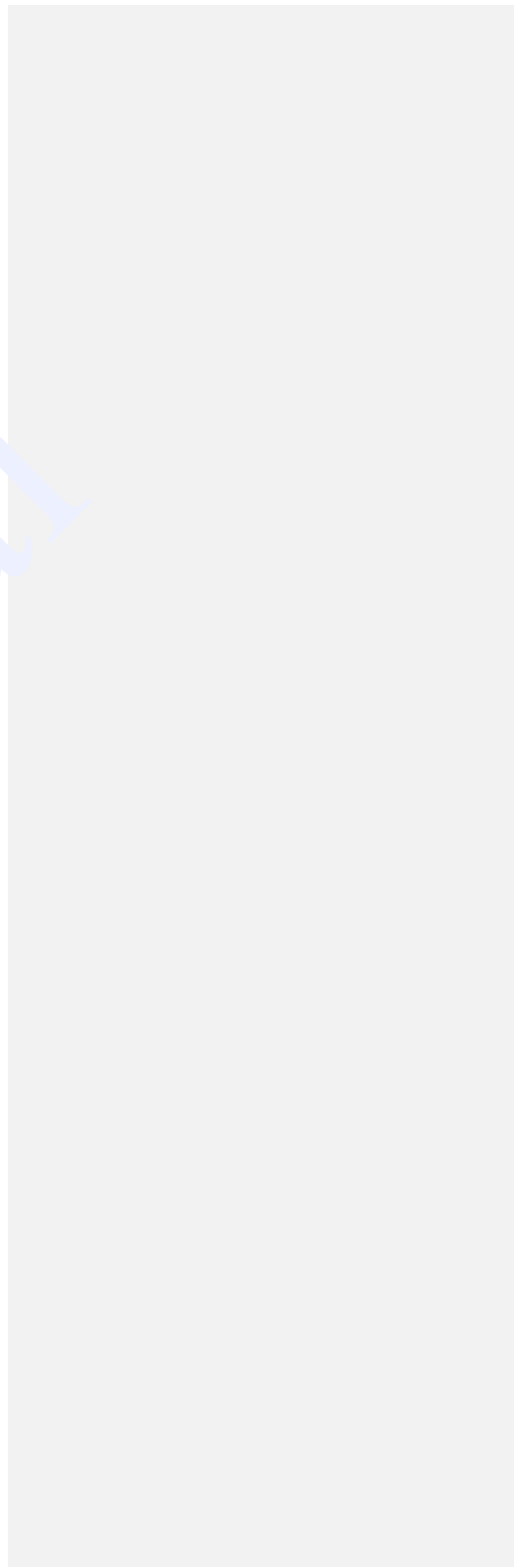
Inquiries from the clergy are an exception. Federal and State privacy regulations expressly permit hospitals to release the patient's name, location in the hospital, general condition and religion, so long as the patient has not refused release of the information. Clergy do not need to ask for the individual by name. Clergy may access the census via their assigned user ID and their own password.

H. Media Visits

When a member of the media needs to be on Kaweah ~~Health Delta~~ property for business purposes, they must arrange their visit through the ~~Marketing and PublicMedia~~ Relations Department or Administration. An appropriate Kaweah ~~Health Delta~~ staff member or security must accompany reporters and photographers at all times. Media access to departments or areas within Kaweah ~~Delta-Health~~ facilities may be restricted for safety and confidentiality reasons at any time.

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approval





Policy Number: AP104	Date Created: No Date Set
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Approvers: Board of Directors (Administration)	
Animal Assisted Activities / Therapy (AAA/AAT)	

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

~~**PURPOSE:** To govern safe, conscientious, and professional involvement of animals in Animal Assisted Activities/Therapy within Kaweah Delta Health Care District.~~

POLICY: The Recreation Therapist and Activity Coordinators ~~located at the West campus~~ will coordinate and supervise the AAA/AAT program assuring that all participants are in compliance. Animal-Assisted Activities (AAA) provide opportunities for motivational, educational, recreational, and/or therapeutic benefits to enhance quality of life. Specially trained professionals, para-professionals, or volunteers in association with animals that meet specific criteria deliver AAA.

Animal-Assisted Therapy (AAT) is a goal-directed intervention in which an animal that meets specific criteria is an integral part of the patient's treatment process. AAT is directed and or delivered by a health or human service professional with specialized expertise and within the scope of practice of his or her profession. AAT is designed to promote improvement in human physical, social, emotional, and/or cognitive functioning. AAT may be group or individual in nature. ~~The process is documented and evaluated.~~

PROCEDURE:

- I. Any employee/authorized volunteer wishing to be involved in AAA/AAT must be registered with an AAA/AAT organization such as the Delta Society, Therapy Dogs International, etc. ~~The AAA/AAT coordinator is available to evaluate for registration.~~ AAA/AAT is currently limited to dogs.
- II. A yearly health/vaccination certificate will must be kept on file ~~in~~ with the ~~Kaweah Delta Rehabilitation Hospital~~ Recreation Therapist or Activity Coordinatory office.
- III. Handlers will evaluate the animal's health prior to each visit and will not bring an animal whose general well being is compromised or who has external parasites.
- IV. Animals found to have external parasites or who demonstrate illness during a visit will be immediately removed from the premises.

- V. Animals will be effectively controlled by leash (six foot maximum)
- VI. Animals will be bathed/groomed prior to visit.
- VII. Animals are not allowed in areas where medications are prepared or where food is being served.
- VIII. All persons coming in contact with animals shall utilize proper and frequent hand washing. Animals are not to be fed by patients during the visit.
- IX. The rights of patients, visitors, and staff not wishing to have contact with an animal will be respected.
- X. The rights of the animals for access to water, exercise areas, safety and freedom from undue stress will be respected.
- XI. The presence of animals in the hospital shall not lessen the standard of housekeeping or contribute to an objectionable odor.
- XII. Animals are to be toileted prior to visit. If toileting need arises during the visit, outdoor grass areas may be used. It is the responsibility of the handler to properly dispose of waste. Should an "accident" occur, the handler should seek assistance from staff/housekeeping for appropriate clean up.
- XIII. Should an incident occur (scratch, bite, severe adverse or allergic response, etc.) standard hospital injury protocol will be implemented.
- XIV. Incidents will be review by the AAA/T coordinator, rehabilitation director, and handler. The animal may be placed on probation or asked to retire.
- XV. Female animals shall either be spayed or determined not to be in estrus while visiting.
- XVI. Human-animal volunteer teams may have their privilege for participation in the program suspended or revoked if any of the following occur:
 - A. The handler is unable to demonstrate adequate control of an animal.
 - B. The animal's temperament, behavior, or health is not appropriate (either on one visit or consistently over time).
 - C. The handler does not maintain standards of personal appearance for self or the animal.
 - D. Confidentiality is breached.
 - E. Volunteer misses three consecutive visits.

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Policy Number: AP114	Date Created: No Date Set
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Approvers: Board of Directors (Administration)	
Census Saturation Plan	

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

To define the plan for:

- Routine assessment and management of hospital census status.
- Patient placement and resource/staff deployment at peak census times.
- Alternatives for patient placement during census crisis.
- Optimal placement of critically ill patient(s) in the absence of Intensive Critical Care (ICU) bed(s)

This procedure assumes:

- Aggressive management of the patient's care, focusing on discharge preparation, is occurring in all service settings, and patients are appropriate as defined in the utilization management plan.
- Aggressive activation of staffing resources to meet the needs of presenting patients.

GOAL: To meet essential patient needs with coordination of resources; and to define measures to be taken when needs exceed routine resources. The responsibility for determining the census saturation level includes input from all units/departments. Generally, each departments representing lead nurse will report the unit census and anticipated activity which collectively helps determine the corresponding census level. This reporting process occurs within the Bed Meetings. Reporting the identified census level is the responsibility of the House Supervisor.

Definitions:

1. Level 1 – Green - Go
2. Level 2 – Yellow - Early Caution
3. Level 3 – Red – Census Crisis
4. Maternal Child census saturation – addendum I
5. Emergency Department (ED) saturation– addendum II

PROCEDURE:**Level I – Green - Go:**

A. Criteria:

1. Acute Care bed capacity is adequate for scheduled patients and normal admission/discharge activity anticipated and,
2. Staffing levels are adequate for census and acuity levels and,
3. No patients waiting in ED for placement in an appropriate in-patient or observation bed after request is submitted to the Admission Coordinator greater than 30 minutes.

B. Actions

1. Bed meeting is convened promptly at 0745, 1630 and 0430 and led by the House Supervisor or their designee, who has authority to direct any necessary redeployment of resources.
2. Attendees may include: Nurse Manager or designated Lead Nurse from each KD inpatient unit, ED, Surgery, Cath Lab, and Case Management designee, Staffing Coordinator and Director on call.
3. Staffing Coordinator completes and copies the census/staffing reports prior to the meeting and brings multiple copies for all.
4. House Supervisor completes the staffing /census email report at the end of each bed meeting and emails the current Census Status to the communication group.

Level 2 – Yellow – Early to Late Caution

A. Criteria

1. Up to 5 units at staffed or full capacity and,
2. Anticipated admissions exceed anticipated discharges or transfers for next 8 hours or,
3. ED has 6 patients waiting greater than 60 minutes for placement in an in-patient or observation bed after request is submitted to the Admissions Coordinator.
4. If two or more of the conditions exist, the census status is raised to the next level, YELLOW.

B. Actions

1. Completion of all actions listed in Level I.
2. ED Surge Plan of Action Level I activated. See addendum for details.
3. House Supervisor and Admissions Coordinator review updated admission and discharge information, complete a revised census status report as needed.
4. Census status is changed as indicated, communicated via email to the Chief Nursing Officer (CNO) and the Communication Group. If the status needs to be escalated to Level 3, actions are taken as listed.
5. If it is determined that the census status may worsen due to a low number of or slow acquisition of discharge orders, the Case Management Medical

Director along with other pertinent Medical Directors and Department Directors will be notified. This will be accomplished via the Medical Staff office or by the House Supervisor.

6. Environmental Services will focus staff on cleaning assigned dirty rooms designated in teletracking first and stay in close communication with the Admissions Coordinator or House Supervisor.

Level 3 – Red – Census Crisis

A. Criteria

1. Six or more units at capacity or,
2. One and/or more overflow locations in use or,
3. ED holding more than 6 patients for greater than 60 minutes for in patient bed placement, and/or,
4. ED has 10 or more patients waiting over 2 hours to receive the medical screening and the medical screening cannot be provided in the time frame specified due to lack or ability to move patient to in-patient beds.
5. If two or more of these conditions exist or any other similar scenario, the census status will be raised to level 3, RED.

B. Actions

1. All Actions taken as specified in levels 1-3.
2. ED Surge Plan of Action Level II initiated and move to level III as indicated. See addendum for details.
3. A census saturation meeting will be held at the discretion of the House Supervisor, and will include the Directors who have leadership responsibility for the nursing units with the greatest census/acuity impact. This meeting will occur at 11:00 a.m. and can be canceled as determined by the House Supervisor.
4. Bed status may be reassessed and communicated every 2-4 hours by the House Supervisor or their designee as needed.
5. If it is determined that the Census Crisis is to persist past 12 hours, the CNO or Chief Operating Officer(COO) may be asked to attend the bed meeting. Nursing Directors, Chief Medical Officer (CMO), Chief of Staff or Medical staff designee or any other stakeholders determined to be appropriate for the event may be included. The purpose will be to review the inpatient activity and to assist in decision making to provide relief for the ED and/or surgery, cath lab services.
 - a. Chief of Staff or Medical Staff designee determines need to cancel procedures.
 - b. If procedures cancellation is required, affected medical staff members are contracted by the Chief of Staff and/or the CMO along with the patients effected.
6. The House Supervisor and/or Nursing Director on call will open an identified patient Discharge Lounge as needed to house discharged adult patients while they wait for their private transportation home.

- a. Patients will need to meet the following criteria for placement in the Discharge Lounge:
 - 1) Have a written discharge order.
 - 2) Be 18 years of age or older.
 - 3) Alert and oriented.
 - 4) Ambulatory or requiring minimal assistance.
 - 5) Able to sit in a chair or rest on a bed/gurney for a prolonged period of time.
 - 6) Comprehend home care instructions or have a care giver who can comprehend and agree to manager care.
 - b. Patients not considered candidates for the Patient Discharge Lounge include:
 - 1) Organic Brain Syndrome, acute confusion, Alzheimer's/Dementia.
 - 2) Special equipment needs, i.e. traction, nebulizer respiratory treatments and/or suctioning, CAPD, etc. (portable O2 is permissible)
 - 3) All discharge needs will be addressed prior to moving the patient to the Discharge Lounge.
7. Nursing Director and/or House Supervisor will help direct the utilization of additional space as indicated for ED use and/or pending admission patients. This process may occur at level yellow and red as needed. The following areas should be considered when determining that most appropriate area depending on the scenario:
- a. Pediatric Med/surg overflow
 - b. 3 West 20 () ward room
 - c. Cath Lab Holding Area
 - d. Endoscopy if not in use as a treatment area for ED
 - e. Ambulatory Services Center
 - f. Post Partum Med/surg overflow female pts. only
 - g. Kaweah Delta South Campus, for transferring of current lower acuity inpatients.
 - h. Kaweah Delta Rehabilitation Hospital
8. If there are no other options, the House Supervisor may assign patients to staff even though the staffing ratio is not met for a period of time. All resources should then be brought to bear on securing additional staff so patient care is adequately staffed.

1. CENSUS SATURATION ACTION PLAN

Addendum to Census Saturation Plan 11-03

Level 1 – Green (GO): Capacity adequate for scheduled patients and normal admission/discharge activity anticipated. Adequate staffing and no patients waiting in the Emergency Department greater than 30-minutes for a bed after acceptance for admission.

	ACTION	ACCOUNTABILITY
1)	Bed meeting is convened at 0745 and 1630 and led by the Admission Coordinator or House Supervisor.	House Supervisor
2)	Redeployment of resources as necessary.	House Supervisor
3)	Staffing Facilitator completes and copies the census/staffing reports prior to the meeting.	Staffing Facilitator
4)	House Supervisor completes the staffing/census report at the end of each bed meeting.	House Supervisor
5)	Census saturation status will be emailed to the communication group by the House Supervisor or the Admission Coordinator.	House Supervisor/ Admissions Coordinator

Approve

Level 2 – Yellow (EARLY CAUTION): One to five units at staffed or full capacity. Anticipated in-flow exceed anticipated outflow for next 8 hours. ED has 1-3 patients waiting in the Emergency Department greater than 30-minutes for a bed after acceptance for admission.

	ACTION	ACCOUNTABILITY
1.	Completion of all actions in Level 1 ED Surge Plan of Action I Initiated	House Supervisor or Nursing Director on-call.
2.	House Supervisor and Admission Coordinator review updated admission and discharge information, and complete a revised Census Status Report as needed.	House Supervisor and Admission Coordinator
3.	Census status is changed and communicated via e-mail.	Admission Coordinator/House Supervisor
4.	Communication to Case Management, Medical Director, and Department Medical Directors as needed via the Medical Staff Office.	Medical Staff Office
5.	Activate designated Discharge Lounge as needed	House Supervisor/Nursing Director
6.	EVS staff concentrates on cleaning dirty patient rooms.	EVS Director, Admissions Coordinator, House Supervisor

Level 3 – Red (CENSUS CRISIS): Six or more units at staffed or full capacity. One or more overflow locations in use; Emergency Department holding more than 6 for greater than 60 minutes (see III.A.3). ED has 10 or more patients waiting more than 2 hours to receive medical screening due to inability to move ED patients to in-patient beds.

	ACTION	ACCOUNTABILITY
1.	Bed status reassessed and communicated as determined by the House Supervisor. 2.) Main Campus Unit Director group and the CNO will meet at 11:00 a.m. with the House Supervisor to assist with leadership activities on their respective units. The focus is to help provide through-put support and improve the admission of patients from the ED to the in-pt. units.	House Supervisor/Admission Coordinator
2.	ED Surge Plan of Action Level II initiated and moving to Level III as indicated per the addendum.	ED Leadership/House Supervisor
3.	Conference may need to be arranged to review surgery and invasive procedure schedule for the following day(s). Attendees to include House Supervisor, CNO/designee/COO, Nursing Director on call; Chief Medical Officer; Chief of Staff or Medical Staff designee, Directors of Surgical Services, Emergency Services, and acute inpatient nursing services.	House Supervisor
4.	The conference convening group may assess the need to cancel scheduled procedures.	Chief of Staff or Medical Staff designee
5.	If procedure cancellation is required, affected medical staff members are contacted and patients are called.	Chief of Staff and/or Vice President Chief Medical Officer, Medical Staff Office.
6.	All previously listed placement options considered for ED patients and/or in-patient admissions. 100% occupancy. Surge tent will be considered for activation to function as the ED lobby reception, existing ED lobby will function as Intake. Intake will function as Fast Track treatment area.	House Supervisor/Director on-call. House Supervisor/Director on-call.

Addendum to Administrative Census Saturation Policy Census Saturation for Maternal Child Health

Pediatric Surge Plan 2015

Current Capacity

12 patients

2-3 RNs per shift

Triggers

- 12 patients with inability to discharge or transfer out
- ED holding Pediatric patients without the possibility to transfer

Staffing Plan

Registered Nurses

1. Pediatric Charge Nurse goes into staffing
2. MCH Flex Team
3. OT
4. Float staff from NICU
5. Pediatric Nurse Manager
6. ED staff with Pediatric experience
7. Registry

Respiratory Therapist

Increased capacity to support pediatric ventilated patients and increased demands of children on high flow and breathing treatments.

Physicians

Current staffing pattern may not support expected volume and acuity of patients. Consider community Pediatricians for in house support or locum tenens for additional support

Admission Criteria

1. All admissions to pediatrics must be triaged through the ED or the Pediatric hospitalist by phone
2. Pediatric nurses will support the triage nurse as able in the ED
3. Consider canceling elective pediatric surgical cases
4. Stable surgical patients (≥ 14 years) could triage out to the general med-surg floors

Ventilated Patients

1. Respiratory therapist must be present
2. Consider transfer to adult ICU, to be cared for by ICU nurse with pediatric nurse to act as resource. Refer to policy Care of Critically Ill Pediatric Patients.
3. Create PICU in Peds room 1 and open up rooms 2 & 3, would need critical care nurse to act as a resource (NICU or ICU) depending on the age.

Revised 11/6/2015

N. Loya

Expansion Plan**Plan A – Expand to 19 beds**

- Expand room 1 to accommodate 3 patients
- Open dividers between room 2 & 3 to accommodate 3 patients
- Utilize the Mother Baby Newborn Nursery for up to 4 patients
- Utilize the treatment room for 1 patient

Plan B –Expand to 25 beds

- Plan A and below
- Double up rooms 4, 7-11 with toddler beds, cribs, bassinets. Considerations: oxygen, suction, electrical outlets, patient privacy, family accommodations

Plan C – Overflow to Mother baby unit if beds are available**Plan D – Overflow to Broderick Pavillion for up to an additional 11 beds**

- Need state approval and adult patients may need to be relocated

Supplies & Equipment

- Rent additional toddler beds and/or cribs
- Rent additional portable suction
 - RT has _____
- Monitors
 - Pediatrics has 5 gammas with tele
 - MB has 3 gammas without tele
 - Endo has ordered 5 gammas without tele (9/8/14)
 - Rent M300s as indicated
- Ventilators
 - NICU has 4
 - Peds has 1
 - RT has _____
 - Medical transport has 1
 - Rent as indicated
- Warmers
 - Peds has 1
 - NICU has 9 (9/8/14)
 - L&D has 18 (9/8/14)
 - Rent as indicated
- Pumps
 - Will need an alaris pump for every patient that needs IV fluids/medications
 - Peds has 11 syringe modules (without med library)
 - Rent as indicated
- Supplies
 - Central supply has 3 days worth of supplies on hand
 - Supplies can be delivered next day
 - Utilize corporate cards for purchases at local stores

Revised 11/6/2015
N. Loya

- Supplies can be delivered next day
- Utilize corporate cards for purchases at local stores

03/07/2016
M. Filiponi

Labor and Delivery Census Saturation/Surge Plan

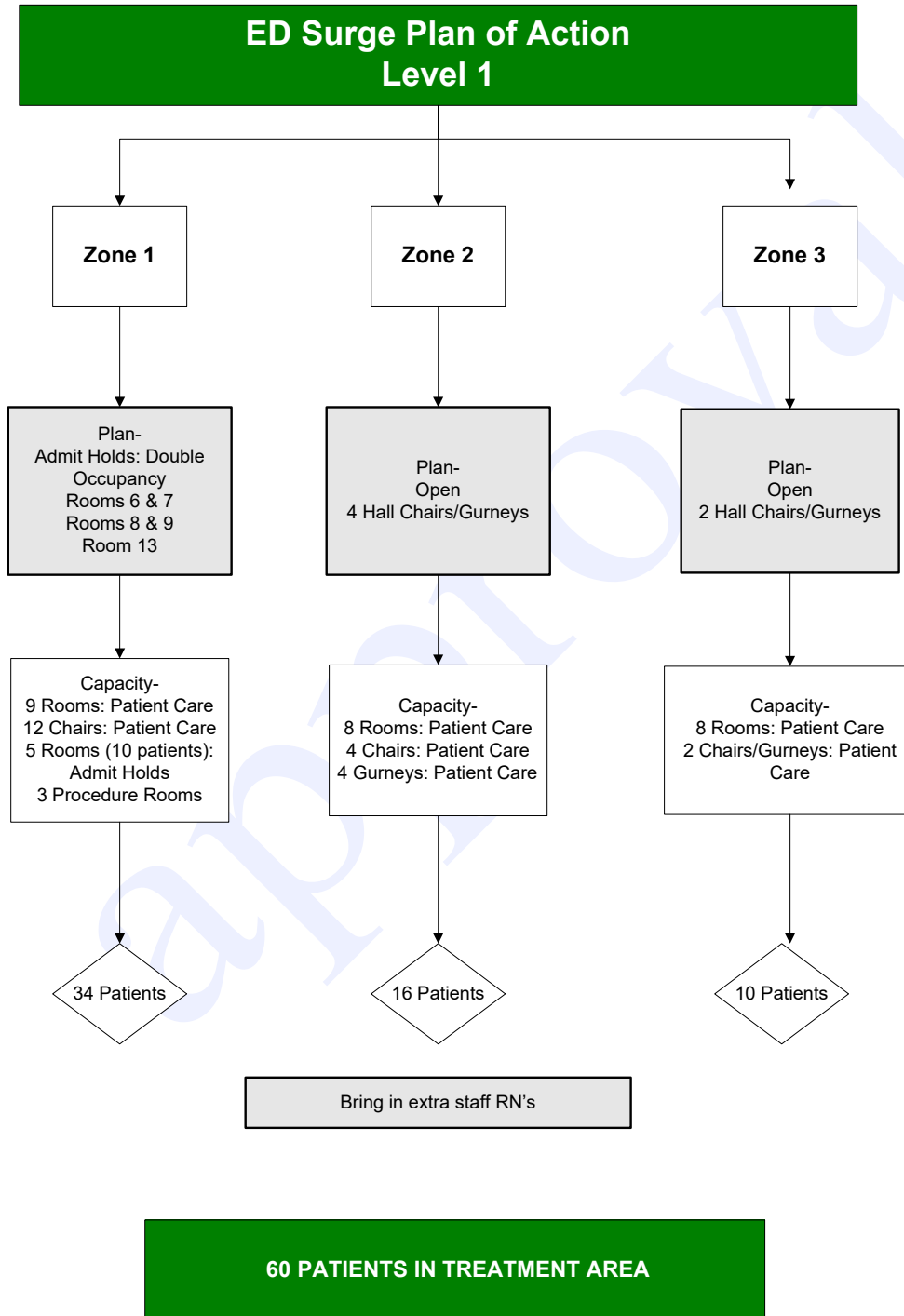
- When the census is saturated and the Labor Unit is down to 2 rooms (including 2E 20).
- Call L&D Manager – she will coordinate implementation of Surge Plan and call off elective inductions and surgeries.
- Identify patients who can be discharged.
 - Call provider and discharge ASAP.
- Identify patients who can be safely triaged off the unit (within 30 minutes).
 - Stable Antepartums Patients.
 - Patients who are not continuous EFM.
 - Patients not laboring.
 - Patients who are delivered go early.
 - Call MD's, inform them of the need to triage off unit. Get an order for transfer off the L&D Unit and inform them where they will go.
- Transfer groups of 3 patients if possible – send RN
 - Transfer options
 - 2S 1, 2, 3
 - MB
 - Peds – **last resort**
- If no patients eligible for transfer (all laboring or unstable antepartums), use the alternate beds below in the following order until a labor bed is available.
 - 1st: 2E01 – up to 2pt can labor here and set up warmer
 - 2nd: 2E21 – up to 3pt can labor here and set up warmer
 - 3rd: LT – over flow laboring patients here – warmer will need portable O2

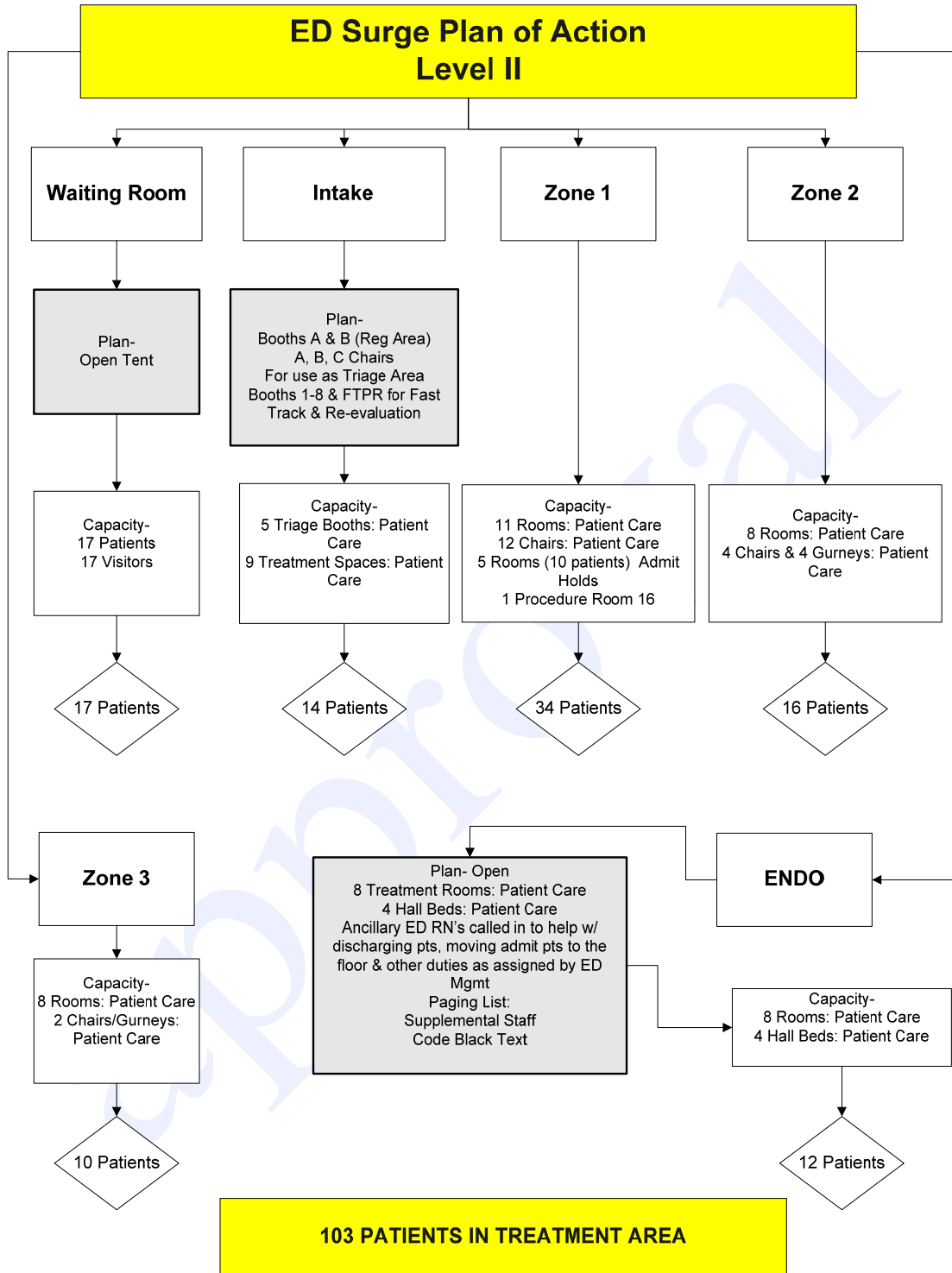
NICU Surge Plan for high census

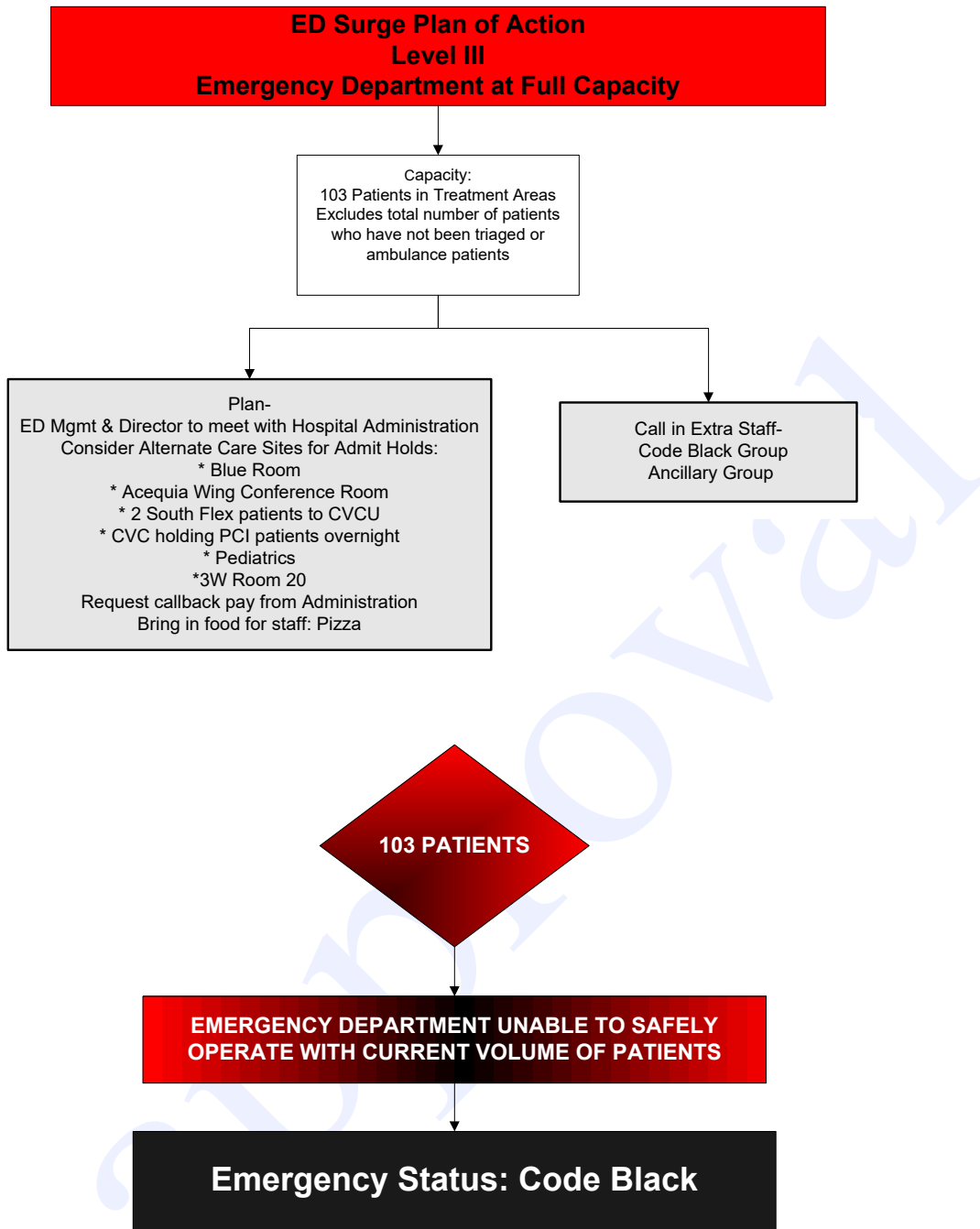
In the event that the NICU & NC reaches its maximum capacity of patients (14 NICU patients/8 intermediate patients. 1 bed must remain open in the NICU for admission and or stabilization for transport) a surge/flex plan has been created.

- When the NICU has reached its maximum amount of patients with only 1 bed open for stabilization and transport 4 additional bed spaces have been created in the mother/baby nursery
- This holding area is equipped with 4 NICU beds with the capability of physiologic monitoring, iv therapy and medication administration, as well as adequate computer charting area and computers.
- This area is to be used as an intermittent holding area for stable NICU patients until appropriate arrangements have been made for transport of new admissions.

- A. Action:
 - 1.







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Approvers: Board of Directors (Administration), Executive Team A	
Visiting Regulations for Kaweah Delta Health Care District	

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE: Visitor access is regulated because the desires of the public to visit friends and family must be balanced with the needs of all patients for privacy and rest, the environment needed by the medical staff and hospital staff to carry out their work, and everyone’s need for safety and security. In extenuating circumstances, exceptions to this policy may be considered by the Nurse Manager, ~~or House~~ Supervisor or designee.

POLICY:

- I. General visiting hours are 8:00a.m. to 9:00p.m.
 - A. Patients can request “no visitors” at any time. A sign will be posted on the door of the patient’s room to that effect.
 - B. It is suggested that no more than two (2) visitors be in a patient’s room at one time as a limiting guideline. The nurse has the ability to allow more or less as the need dictates. Other visitors must go to public lobby areas, by the visitor elevator, in the main lobby, or in the cafeteria to wait. An adult must accompany children at all times.
 - C. Nursing staff may limit the number of visitors to fewer than two (2) if it is in any patient’s best interest, or at the request of patient or physician.
 - D. Staff may request that visitors leave the room while they provide patient care, or if visitors are interfering with the treatment or rest of any patient. Nursing staff may also ask any visitor to leave the patient care area if the visitor is being loud or disruptive in anyway.
 - E. An interpreter may stay at the bedside of patients, if necessary.
 - F. Children under 12 years of age are not allowed to visit unless cleared by the Nurse Manager, House Supervisor or designee upon contact by Security.
 - G-1. For the health of all patients and staff, once authorized ~~by the House Supervisor~~, the visit should be as brief as possible and the visitor should be directed to stay in the patient room.

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- II.
- III. These regulations apply to all acute and med-surg areas of Kaweah ~~Delta Medical Center~~Health. Skilled Nursing, Mental health (MH.154) and Acute Rehabilitation (PR.04) have policies, which are specific to those respective clinical areas. The patient may have one person, an adult family member or friend, in attendance at all times throughout their hospital stay if the patient is in a private room. If the patient desires, this can be different people and different times. Those authorized to remain will be issued a visitor sticker which must be visibly displayed.
 - A. If a sleeping chair is available, it will be provided for the overnight visitor.
 - B. The visitor may be asked to wait outside the room while hospital staff provides direct care.
 - C. ICU, CV-ICU, and surgery patients may have immediate family remain in the waiting rooms.
 - D. For pediatric patients, the parents and/or primary care takers will be issued four orange bands for twenty-four (24) hour access.
 - E. For Labor and Delivery and ~~post-partum~~post-partum patients, three family members or friends will be issued pink arm bands for (24) hour access.
 - F. For Neonatal Intensive Care Unit patients, two family members will be issued green armbands for (24) hour access.
- IV. Cell phones are prohibited in posted areas. Cell phones and pagers are to be on vibrate/silent mode. Camera phones are prohibited to be used to take pictures or recordings in all patient care areas.
- V. Eating is allowed only in the public dining areas and, with the patient's permission, in the patient's room.

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Policy Number: AP124	Date Created: No Date Set
Document Owner: Cindy Moccio (Board Clerk/Exec Assist-CEO)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration)	
Admission Policy	

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE: Kaweah ~~Health Delta Medical Center~~ is dedicated to providing care appropriate to each patient’s needs.

POLICY: A patient must be admitted by a member of Kaweah ~~Delta Medical Center’s (KDMC’s)~~ Health Medical Staff. The decision to admit a patient requires a complex medical judgment which can be made only after the physician has considered a number of factors, including the patient’s medical history and current medical needs.

The decision to admit rests with the Admitting Physician who is responsible for deciding ~~and ensuring whether the patient will be admitted as an inpatient or placed as an outpatient~~ the status of the patient on admission (inpatient, observation or outpatient). Physicians are responsible for determining if admission is medically necessary and for ensuring services provided to the patient are also reasonable and necessary.

Physician admission orders are required and may be hand written by the physician, entered by the physician electronically, given verbally or via telephone to a Registered Nurse, or by fax (See Policy ~~PC. 194 Orders: Licensed Independent Practioner (LIP) and PC. 195 Orders: Processing & Notation of No~~ in Medication Orders. DC.04 Physician’s Orders). Allied Health Professionals may provide physician orders as allowed by medical staff bylaws. Admitting orders shall be clear and specific as to the admission status and level of care required for the patient. They will also include the diagnosis (reason for admission), and the level of care required for the patient.

As required by Medicare Conditions of Participation, review for appropriateness of admissions will follow the District’s Utilization Review Plan (See AP.111).

PROCEDURE:

- I. Medical Staff shall follow ~~Hospital~~ the Medical Staff Bylaws and Rules and Regulations regarding admissions. All admissions other than outpatient surgeries, planned inpatient surgeries scheduled through the surgery scheduling department, or for testing or procedure, will be routed to the Admission Coordinator to verify appropriateness of admission, clarification of orders if necessary, determination of availability of the type of unit/bed needed, or any specialty services that may be required.
- II. Admitting physicians must provide admitting orders that are clear and specific as to admission status (using status/admission criteria) and level of care or placement using KDMC terminology specifying levels of care (ICU, ICCU, Med/Surg, Peds), and diagnosis(es) for which the patient is being admitted to the acute hospital for services. If a patient presents to the ED and has no physician, or their existing physician does not have privileges at KDMC, the patient will be assigned a member of KDMC's Hospitalist Teams who will oversee their care (Adult or Pediatric).
 - A. Adult patients from clinics will be assigned to the on call physician for that particular clinic. Pediatric patients from clinics are assigned to the Pediatric Hospitalist Team.
 - B. Requests for direct admission (not ED to ED) from other hospitals will be triaged by the Transfer Center RN or if unavailable, the House Supervisor:
 - 1) Review of medical necessity for admission to KDMC -Services;
 - 2) Initiation of the KDMC Transfer packet, including Transfer Agreement;
 - 3) Assures Admitting Physician acceptance – assures on-call coverage if patient transferred for surgery, procedure, or specialty care and is admitted by a physician who does not provide that type of service or care.;
 - 4) Coordinates admission with admissions already scheduled or under way and assigns an appropriate unit/bed. Takes into consideration census, bed capacity and staffing.
 - 5) Determines if there are -other services needed
 - 6) Ensures proper authorizations are obtained from the insurance payer if applicable.
- III. All direct admissions shall be routed by telephone to the Admission Coordinator to verify necessity of admission using InterQual® Criteria and to determine the appropriate service/unit/bed for the patient taking into consideration all other current admissions, staffing patterns and hospital

needs. The following information will be collected from the physician by the Admission Coordinator:

- A. Patient's name
 - B. Date of Birth
 - C. Social Security # or Medical Record #
 - D. Insurance
 - E. Diagnoses with pertinent medical information (VS, level of consciousness, abnormal labs and/or diagnostics) and reason for hospitalization.
 - F. Appropriate patient status (Inpatient, Outpatient, Observation)
 - G. Level of care requested by physician (Med/Surg, ICCU, ICU)
 - H. Any other information pertinent to the care of the patient (i.e., blind, developmentally disabled, special equipment, confusion, or level of consciousness).
- IV. The Admission Coordinator will collect and evaluate information concerning patient admission status and level of care to assist physicians in unit/bed placement (See Policy AP.115) that is most appropriate for the needs of the patient. RN Case Manager in the Emergency Department (ED) assists with admissions coming through the ED.
- V. The PACU or lead surgery RN will contact the Admission Coordinator if an outpatient surgery is going to be admitted instead of discharged or the level of care for a post-surgical patient has changed.
- VI. Admission criteria at all levels of admission are based on InterQual® criteria. New onset or continued medical issues requiring acute care and supported by clinical findings and the complexity of treatment required to meet the patient's current medical needs will be evaluated on every acute care admission.
- VII. The following terminology shall be used to specify patient admission status:
- Admit to Inpatient** - Patient has clear diagnosis and meets both severity of illness and intensity of service for acute care. This includes patients having surgery that requires an inpatient stay.

Place In Observation - Patient is hemodynamically stable, their clinical

diagnosis is unclear and the patient is not meeting acute care criteria. Diagnosis, treatment, stabilization and discharge can reasonably be expected in less than 24 hours. Or the patient has had a surgical procedure which will require observation due to uncontrolled pain, bleeding, etc. (Exception: Medicare guidelines allow up to 48 hours based on clearly documented medical necessity that clearly explain reasons for continued observation

Place As Outpatient - Patient having minor medical or other procedures such as blood transfusions, infusion therapy, biopsies, interventional procedures in radiology, declots and outpatient chemotherapy, or scheduled for outpatient surgery. Expectation is that the patient will be discharged after a normal, short recovery time (4 to 6 hours). This status does not change no matter where the patient recovers.

VIII. Change in Admission Status Orders (Inpatient or Outpatient):

If a physician decides to change a patient's admission status once the patient reaches the unit, the order must be entered into the electronic system, may be hand written or given verbally or via telephone to a Registered Nurse, faxed to the Order Processing System. The physician must document clearly in the progress notes the medical reason for the decision to change the patient's status.

A patient can be changed from observation to inpatient status when a patient's severity of illness changes. This must be clearly documented in the medical record by the physician.

In cases where Case Management determines, in consultation with a physician advisor, that an inpatient admission does not meet the InterQual's® inpatient criteria, the hospital must change the patient's admission status from inpatient to outpatient and is required to submit an outpatient (as opposed to an inpatient) claim for medically necessary services that were furnished to the patient, provided all of the following conditions are met:

1. The change in patient admission status from inpatient to outpatient observation is made prior to patient's discharge or release, (i.e., while the patient is still physically in the hospital)
2. The hospital has not submitted an inpatient claim to Medicare for the admission
3. A physician (Admitting, Attending, a Physician Advisor) concurs with the Case Management decision; and

4. The physician's concurrence with the Case Management decision is documented in the patient's medical record and an order has been correctly written prior to discharge.

The change in status will be communicated to Patient Accounting so the account can be billed with "condition code-44" ~~letting-informing~~ Medicare ~~know~~ that the inpatient admission was changed to outpatient or observation from an initial inpatient order.

Patients that develop unexpected complications after an outpatient surgery or procedure, or who are not recovering as expected 4-6 hours after the procedure can be placed in observation or admitted to inpatient status with physician documentation of the complication and the reason for the change. Verbal or written order must be obtained for a change in status. The order with change of status will be faxed to the Order Processing System.

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Policy Number: AP132	Date Created: No Date Set
Document Owner: Cindy Moccio (Board Clerk/Exec Assist-CEO)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration)	
Use of rental, loaner, or demo clinical equipment	

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

OVERVIEW: Due to patient census levels or specific diagnostic/treatment needs of a patient, it periodically becomes necessary for Kaweah Delta Health Care District dba Kaweah Health to augment its inventory of clinical diagnostic or treatment devices through the use of rental, loaner, or demo equipment. In accordance with Joint Commission requirements, as well as Title 22 and CDPH regulations, ~~the District~~Kaweah Health will have a system in place to identify, track, and control such items during the period of time these devices are in District possession. "Possession" will be defined as the period of time beginning with ~~the District~~Kaweah Health's acceptance of the device and ending when the device physically leaves ~~the District~~Kaweah Health and is returned to the vendor.

PURPOSE: This policy will define appropriate methods for requesting rental, loaner or demo equipment, those individuals who will have authority to request that such devices be brought into the facility, and who will have authority and responsibility for procuring them. Once such devices arrive at the facility, this policy will define the process for inspection and acceptance of the devices for patient use. Finally, the policy will define the responsibilities of the clinical staff utilizing these devices and the appropriate methods for returning them once they are no longer needed for patient care or diagnosis.

PROCEDURES:

- I. **ORDERING** - Only Central Logistics (Distribution) will have authority to requisition clinical equipment from any vendor for use on a rental, loaner or demo basis. Under no circumstances will individual departments place orders for clinical equipment directly with a vendor without working through Central Logistics as follows:
 - A. For devices requiring a physician order (such as specialty beds or wound vacs), nursing units that process orders ~~through the District's Order Processing Center (OPC) will submit the request for the device to the OPC. OPC~~ will enter the order into ELMER Power Chart and the order will print on Central Logistics' department printer notifying them of the request. This document will serve as the authorization for Central Logistics to contact the vendor and procure the requested

equipment. ~~Clinical/nursing units not utilizing the OPC to process physician orders will enter orders for the device directly into ELMER. These ELMER orders will also be sent to Central Logistics' department printer and will serve as the authorization for the procurement of the requested device.~~

- B. The requisition of devices not requiring a physician order can be authorized only by the Nursing House Supervisor, the director or manager/lead of the requesting clinical/nursing unit, or the Central Logistics (Distribution) Warehouse/Distribution Manager when deemed necessary for the general operational needs of ~~the District~~Kaweah Health. Requests of this nature will be documented and approved on ~~the District~~Kaweah Health's standard Purchase Order Nonstock Requisition Form and submitted to Central Logistics for procurement of the requested device. Devices brought into the facility on a loaner or demo basis will follow the same procedure.
- C. Supporting documentation (Power Chart~~ELMER orders or Purchase Order Nonstock~~ Requisition Form) will be entered into ~~the District~~Kaweah Health's materials management information system and issued a purchase order number in accordance with the Materials Management Department's departmental purchasing procedures. The purchase order will serve as the official payment authorization for the Finance Department once the invoice for the device is received from the vendor. Loaner or demo equipment brought into the facility at no charge will follow this same process, but will be documented on a "no charge" purchase order for tracking and documentation purposes.
- II. **RECEIVING** -All vendors utilized for the procurement of clinical rental equipment shall strictly adhere to all policies and procedures of Kaweah Delta Health Care District, governing the rental and delivery of said devices. Vendor failure to comply with these policies and procedures may result in voidance of contractual obligations to said vendor, or exclusion of the vendor from conducting business within ~~the District~~Kaweah Health.
- A. During transit, or immediately upon arrival at Kaweah Delta Health Care District, the vendor delivery personnel will request that Central Logistics contact the Clinical Engineering Department to notify them of the impending receipt of the rental device.
- B. If the delivery is received between the hours of 0600 and 1430 Monday through Friday, Central Logistics will contact Clinical Engineering at ext. 2296, or through the hospital operator. If the delivery is received after 1430, Monday through Friday, or 24 hours on weekends or holidays, the Central Logistics department will contact the hospital operator to reach the on-call Biomedical Technician. Once the device reaches a District facility, the Biomedical Technician will do the following:
1. The Biomedical Technician will perform an electrical safety inspection on each piece of clinical rental equipment to verify it meets all applicable Title 22 and

CDPH requirements for patient safety. **AT NO TIME WILL ANY RENTAL MEDICAL DEVICE BE PLACED INTO PATIENT USE UNTIL COMPLETION OF AN ELECTRICAL SAFETY INSPECTION BY CLINICAL ENGINEERING STAFF. NO EXCEPTIONS.** The Biomedical Technician will also verify the following:

- a. Receipt of a current electrical safety inspection sheet from the vendor.
 - b. Receipt of a current preventive maintenance report from the vendor.
 - c. Physical condition and operational readiness of each device.
2. Should any device fail to meet the above requirements, the device WILL NOT be accepted for use, and the vendor will be responsible for immediately removing the device from the premises, until such time as compliance is reached or the discrepancy resolved.
 3. The Biomedical Technician will log ALL received devices onto the Rental Log Spreadsheet maintained by the Clinical Engineering Department and make any and all updates as required with the following information:
 - a. Device type
 - b. Date received
 - c. Requesting unit
 - d. Vendor/company name
 - e. Serial or vendor I.D.
 - f. Date safety inspected
 - g. Verification of required inspection documentation

III. **PATIENT USE** - Use of clinical rental equipment for patient diagnosis and/or treatment will be dictated by any and all applicable policies found in ~~the District Kaweah Health~~'s Patient Care Manual, Environment of Care Manual, or other similar District policy manuals pertaining to clinical rental equipment of a like or similar nature to the equipment (owned or rented) identified in those policies. These policies include, but are not limited to, Patient Care Policy ~~CP. 43 "Support Surface and Specialty Bed Selection"~~, Patient Care Policy ~~CPPC.230-92~~ "Wound Therapy: Negative Pressure Wound Therapy (NPWT) Device", Environment of Care Policy 1085 "District Electrical Safety Policy", Environment of Care Policy 6001 "Medical Equipment Management Plan", and Environment of Care Policy 6015 "Hospital Electrical Safety Policy and Personal Items", etc.

In addition, in order to reduce the cost of renting clinical equipment to the greatest extent possible, nursing/clinical departments will discontinue use of the equipment and return it to Central Logistics as soon as is clinically practical and appropriate for the patient being diagnosed/treated by the clinical equipment. Clinical equipment, other than specialty beds, will be marked appropriately and placed in the using department's soiled utility room for retrieval by the Central Logistics staff and return to the vendor. Specific policy and procedure for managing the use, processing, and return of such clinical equipment will be governed by Patient Care Policy ~~PC.209MS-18~~ "Equipment Accessed through Central Logistics (Distribution)".

RETURNS - Upon completion of the period of use, or at the time the physician discontinues the order, Central Logistics will be promptly notified to coordinate removal of the rented item, either by discharging the patient or by discontinuing the order in [Power ChartELMER](#). Equipment (other than beds) should be placed in the soiled utility room for retrieval by the Central Logistics staff during normal rounds. The nursing unit may also call Central Logistics to notify them that equipment is ready to be picked up. Central Logistics will contact the vendor(s) necessary for immediate pickup and removal from the premises. Central Logistics will update the Rental Log Spreadsheet monitored by the Clinical Engineering Department with the date the device left the facility.

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Policy Number: AP135	Date Created: No Date Set
Document Owner: Cindy Moccio (Board Clerk/Exec Assist-CEO)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration)	
Capital Budget Purchases	

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POLICY: The Leadership Team assists in the development of the capital budget each fiscal year. This capital budget must be approved by the Board prior to any commitments occurring. This policy ensures that the appropriate procurement procedures are followed with respect to capital purchases.

DEFINITIONS:

- I. Definition of Capital Equipment - capital equipment is defined as any single piece of equipment with a purchase price of \$5,000 or greater, and an expected useful life of greater than one year. The total cost of the item includes any shipping, handling, freight, acceptance costs, installation fees, or taxes associated with placing the item into use within ~~the District~~Kaweah Health.
- II. The Capital Committee exists improve controls and the vetting process without creating significant delays to the unbudgeted or non-vetted capital request process. This includes requests for new service lines, new clinical practices, new technology, procedures/equipment (outside of the Value Analysis Committee) and unbudgeted capital requests. This committee will meet weekly, if needed, and will be comprised of Executive team members, Finance, and Clinical Engineering and will be managed by the Materials Management Department. Any items needing further discussion, as determined by the Capital Committee, will be approved by the entire Executive Team.

PROCEDURE:

- I. All capital purchases must be procured through the Materials Management Department, unless prior approval is obtained from the Chief Executive Officer, Chief Operating Officer or Chief Financial Officer and obtaining the capital item through the normal purchasing procedure via Materials Management is not appropriate or practical or the purchase relates to

- construction under District Policy AP136, "Construction In Progress Accounts".
- II. Capital purchases are only to be made for their stated and approved use. For example, if 4 gurneys were approved to be purchased, then the funds can only be used for 4 gurneys.
 - III. In rare situations where the funds need to be reassigned and used for something other than their original approved use, including covering operating expenses, must be approved by the Capital Committee. Once approval is obtained, the Financial Accounting Manager or designee must be notified so that a new capital line can be created and the budgeted dollars moved accordingly.
 - IV. If operating expenses are to be used to purchase capital items, authorization must be obtained from the Capital Committee prior to the funds being committed, except for expenditures falling within the authority limits referenced above. The Financial Accounting Manager or designee must be notified so that a new capital line can be created and the budgeted dollars moved accordingly.
 - V. Annually, the Board of Directors may approve a general contingency fund in the capital budget. Use of these dollars requires the approval of the Capital Committee prior to a commitment of the funds. Once approval is obtained, the Financial Accounting Manager or designee must be notified so that a new capital line can be created and the budgeted dollars moved accordingly.
 - VI. Purchases of unbudgeted capital items of \$25,000 or less may be approved by the Capital Committee. Unbudgeted purchases greater than \$25,000 must be approved by the Board of Directors.
 - VII. Process for submitting a request to the Capital Committee
 - A. Fill out the Interest Form (Exhibit A) and send to the Director of Procurement & Logistics
 - B. Forms reviewed to ensure they meet criteria. If yes, items are placed on agenda
 - C. Directors present need
 - D. Discuss ROI if appropriate
 - E. Look at market data as needed
 - F. Questions will be asked during and after presentations
 - G. Final discussions and decision will be made with committee members
 - H. Final reports will be created and sent to the appropriate leaders
 - I. If approved by the Capital Committee proceed to the Process to be followed for using approved capital budget funds.
 - VIII. Process to be followed for using approved capital budget funds:
 - A. Requestor must complete the Capital Justification Form (Exhibit B)
 - B. Submit Quote to MD Buy line for a Capital Quote review

- C. If the purchase is part of a Construction in Progress (CIP) activity, the nonstock must also be reviewed and approved by the Director of Construction Services.
- D. The completed Exhibit B, MD Buy line report and original quote and purchase order requisition must be submitted to the applicable Executive Team member for review and approval of Exhibit B
 - 1. To complete a purchase order requisition form follow the Materials Management policies and procedures.
- E. The Executive of the requesting Director will initially approve the completed capital purchase package consisting of: Exhibit B, MD Buy line report and original quote, authorizing Materials Management to proceed with final negotiations. Evidence of approval must be in writing.
- F. Materials Management will finalize negotiations with vendor. As directed, they will include an Executive Team member as a part of the negotiation process.
- G. If there are updated quotes based on negotiations, Materials Management will submit the complete capital purchase package consisting of: Exhibit B, MD Buy line report, original quote, final quote and purchase order requisition to the appropriate Executive for final authorization. Evidence of Executive approval must be in writing on the purchase order requisition
- H. Upon approval by the Executive, the complete capital purchase package will be submitted to the Materials Management for processing.
- I. The designated buyer will be responsible for executing a purchase order for the item as designated.
- J. The items will be delivered to the appropriate individuals according to Materials Management policies and procedures.
- K. The invoice will be processed once received in accordance with Finance policies and procedures.
- L. Capital funds may be “frozen” at the discretion of the Board of Directors and/or Executive Team.
- M. If asset is a replacement item, notify Finance of the specific asset being disposed of prior to ordering the new item. See Administrative Policy 86 for the appropriate disposal procedures.

EXHIBIT A

Interest Form

New Clinical Practice ____ Technology ____ Service Line ____

- I. Individual requesting:
- II. Briefly explain what is being requested and how it relates to our Strategic Goals and Mission:
- III. Briefly explain the reason for the request and check below as appropriate:
 Safety ____ Cost effectiveness ____ Patient Care ____
 Other _____
- IV. Is this related to a clinical procedure or patient care? _____
 If YES proceed to the following Clinical Sections 1-5, if NO, proceed to Section 6

CLINICAL SECTION

Section 1 - Contact Details: Depts / Programs involved

Head of Dept/Unit/Discipline/Service:
 Program: _____ Program Director: _____

Section 2 - Overview of Clinical Request

Has the FDA approved of this new /changed clinical item?
 Category of New or Changed Clinical Item: Circle all that apply:

Diagnostic Technique	Prosthesis	Medical Procedure	Surgical Procedure
Implantable Device	Allied Health Procedure	Nursing Procedure	Other (Specify)

Section 3 - Clinical Need

Comparison with current Kaweah Delta Healthcare District practice:

Comparison with other alternatives:

Patient Health Outcomes/Health Service Outcomes:

Section 4 – Summary of Evidence of Safety, Efficacy and Clinical Effectiveness. Please attach support.

Section 5 - Conflict of Interest Review

Once Sections 1-5 are completed submit to the MAC for approval

Date MAC reviewed _____ Request approved Yes__ No__ With conditions

NONCLINICAL SECTION

Section 6 – Summary of Market Analysis and Volume projections. Please attach details

Section 7 - Operational Needs. Please attach supporting detail as needed

- **Location**

- **Space consideration**

- **Staffing**

- **Equipment Needs**

Section 8 - Financial Impact: Summary of overall financial impact. Please attach details with assumptions.

Section 9 - Marketing Plan and Strategy

Section 10- Implementation Plan. Please attach detail as appropriate.

- **Launch/implementation Timeline**
- **Facility Requirements**
- **Information System requirements**
- **Medical Staff requirements**
- **Payer contracting activities**
- **Regulatory requirements and Standards to consider**
- **Licensing Needs and Requirements**
- **Communication plan**
- **Feasibility and exit strategy – potential difficulties**
- **Budget impact and implications**
- **Follow-Up plan on reporting on Volume/Financial results**

Once Sections 1-5 are completed submit to the Execute Team Meeting for approval :

- **Date ET reviewed _____ Request approved Yes_____ No_____**
- **If approved by ET please evaluate if Board approval is needed.**

Exhibit B

**Kaweah Delta Health Care District
CAPITAL EQUIPMENT PURCHASE JUSTIFICATION**

This form must be completed and attached to the MD Buyline report and original quote prior to submission to the Executive Team for authorization to proceed.

Cost Center: _____

Date: _____

Requestor's Name (Must be a Director), Title, Ext: _____

Funding Source: Bonds – x _____ / _____
Director of Finance Review and Approval/Date

Capital Budget Line # _____

Operating Budget Transfer from Acct # _____

Cash Reserves with Board Approval (see attached minutes)

Other _____

Identify Budget Contingency Fund or Other Source, including CIP#

Capital Equipment Description (What)

Equipment Description:

Model and/or Part numbers:

Quantity:

Justification for Acquisition (Why)
Will this equipment result in improved productivity, reduced costs, new net revenue or clinical quality improvement?

Financial Summary (including tax, shipping and installation)

Annual Maintenance or Other Costs (if applicable)

New or Replacement – if Replacement list assets that will be disposed?

Requesting Director

_____ Requesting Director

_____ Date:

TECHNICAL REVIEW AREAS:

I have reviewed the above-noted capital equipment request for technical implications pertaining to my department and agree that all have been appropriately planned as part of this purchase.

Clinical Engineering review

_____ Director Clinical Engineering

_____ Date:

ISS review

_____ Director Information Technology

_____ Date:

Maintenance review

_____ Director of Facilities Operations

_____ Date:



Policy Number: AP154	Date Created: No Date Set
Document Owner: Cindy Moccio (Board Clerk/Exec Assist-CEO)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration)	
Medication Error Reduction Plan	

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OVERVIEW

Kaweah Delta Health Care District [dba Kaweah Health](#) is dedicated to the mission of excellence in safe medication use by analyzing errors, understanding their system based causes and disseminating practical recommendations that can help healthcare providers and patients. The [District Kaweah Health](#) Medication Error Reduction Plan is in place to achieve our mission and meet the intent of SB 1875 “to eliminate or substantially reduce medication-related errors”. The plan is divided in five sections that are concordant with general principles identified by the California Department of Public Health as likely to be beneficial in accomplishing the aim of reducing medication error. These principles are:

Principle 1 – Establish an organized quality system that addresses the issue of a facility-wide reduction of medication errors.

Principle 2 – Develop effective reporting mechanisms to ensure medication related errors are reviewed.

Principle 3 – Establish a baseline assessment and then, at a minimum annually review the effectiveness of the plan to reduce medication errors.

Principle 4 – Technology implementation shall be part of the plan

Principle 5 – Review pertinent literature related to the reduction of medication errors in review and on-going development and review of the plan.

Medication safety objectives and priorities are actively adjusted throughout time, based on internal/external medication error data, as well as the emerging, dynamic needs of the patients we serve. As such, the MERP described in this policy is supplemented by a “working plan” maintained by the Medication Safety Quality Focus Team.

Medication Error Reduction Plan (MERP)

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Principle 1 – Establish an organized quality system that addresses the issue of a facility-wide reduction of medication errors.

The medication use system is complex with broad organizational impact. The Medication Safety Quality Focus Team (QFT), chartered by the Quality Council, directs health system actions regarding reductions in errors attributable to medications. The Medication Safety QFT charters sub-groups, Quality Action Teams, to work on specific tasks.

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Medication Safety QFT is multi-disciplinary and consists of representation from Medical Staff, Nursing, Pharmacy, Performance Improvement, Quality and Patient Safety, Risk Management, Administration and Information System Support. This QFT meets formally on a regular basis to address the issue of a facility-wide reduction in medication errors. Evaluation and assessment efforts address each process of the medication use system including: prescribing, prescription order communications, product labeling, packaging and nomenclature, compounding, dispensing, distribution, administration, education, monitoring, and use.

Quality Action Teams report their findings and recommendations to Medication Safety QFT, which reports to the Pharmacy & Therapeutics Committee, Quality Medical Committee, Professional Staff Quality Committee and Quality Council, in addition to other departments when indicated. Refer to AP Policy .41 "Performance Improvement Plan, Quality Improvement and Patient Safety Plan" for council/committee organization, governance and responsibilities.

Principle 2 – Develop effective reporting mechanisms to ensure medication related errors are reviewed.

The Occurrence Reporting Program establishes an organizational framework for our current adverse drug event (ADE) reporting process. This program defines responsibility and information flow of medication related safety issues identified through the occurrence reporting system (refer to Administrative Policy AP.10 "Occurrence Reporting Process"). Based on a description of the event and/or further investigation, actions are taken to minimize the possibility of event reoccurrence. Medication error data is examined by Medication Safety QFT to ensure underlying system vulnerabilities are identified and incorporated in the MERP. In addition, aggregate ADE data is trended and used by the Medication Safety QFT to improve the medication use process. The ADE self-reporting process is supplemented by use of concurrent methods such as direct observation, retrospective /concurrent methods such as chart review and proactive methods with the use of trigger tools as a means to identify actual or potential medication-related errors.

The severity of events is categorized by the National Coordinating Council for Medication Error Reporting and Prevention NCC-MERP Index A through I. High severity events, category E through I, Severity 3 Adverse Drug Events are defined as ADEs that result in an unexpected death, code, or require an invasive procedure or resuscitation. Severity 3 ADEs are reviewed by the Medication Safety QFT and are forwarded to recommended for additional review or action peer review when indicated. No harm events, category A through D, may also be reviewed by the QFT based on the potential for harm. These events are identified by the multidisciplinary ADE subcommittee.

Ongoing efforts are made to reduce medication-related errors via the formulary management system, medication use evaluations, and use of external medication error data from organizations (e.g. Institute of Safe Medication Practices, the United States Pharmacopeia, The Joint Commission and other authoritative sources). For example, potential and actual medication errors are identified and reported through ~~our~~ the annual Chemotherapy Medication Use Evaluation, which involves a retrospective review of clinical care.

~~Kaweah Delta Health Care District~~ Kaweah Health has in place a multidisciplinary framework in which ~~S~~entinel and/or ~~A~~dv ~~E~~vents are identified and responded to appropriately (refer to Administrative Policy AP .87 "Sentinel Event and Adverse Event Response and Reporting").

Principle 3 – Establish a baseline assessment and then, at a minimum annually review the effectiveness of the plan to reduce medication errors.

~~Kaweah Delta Health Care District~~ Kaweah Health MERP goals are established and reviewed annually in accordance with Health & Safety (H&S) Code 1339.63. The purpose of the annual review of the MERP is to determine the effectiveness of the plan. Medication error reduction plan goals are designed to eliminate or substantially reduce errors in the procedures and systems including, but not necessarily limited to, prescribing, prescription order communications, product labeling, packaging and nomenclature, compounding, dispensing, distribution, administration, education, monitoring, and use.

Internal and external data and information are utilized to identify weakness in the systems and procedures. From these identified weaknesses, MERP goals and objectives are established.

The MERP is modified as warranted to guide improvements in areas where weakness or deficiencies are noted, based on internal/external medication error data, as well as the emerging, dynamic needs of the patients we serve.

The effectiveness of MERP goals may be assessed using any or all of the following medication safety assessment methods: occurrence report review, direct

observation, chart review, and trigger tool review. The final determination of effectiveness is a consensus opinion of the Medication Safety QFT.

Five levels of determination of effectiveness have been established for MERP Goals:

1. Effective in reducing system / process weakness
2. Partially effective in reducing system / process weakness
3. Potentially effective in reducing system / process weakness.
4. Not effective in reducing system / process weakness.
5. Unable to assess effectiveness in reducing system / process weakness

The Medication Safety QFT reviews the effectiveness of its activities and develops a plan for improvement annually.

The Institute for Safe Medication Practices (ISMP) self-assessment is one tool used to assess the KDHC medication use system. The ISMP self-assessment tool is designed to assess medication safety practices and identify opportunities for improvement. The self-assessment questions are arranged in categories that encompass the 11 procedures and systems listed under subdivision (d) of Health & Safety (H&S) Code 1339.63. These procedures and systems include: prescribing, prescription order communication, product labeling, packaging and nomenclature, compounding, dispensing, distribution, administration, education, monitoring, and use. Completion of the self-assessment involves scoring a series of questions aimed at determining an organizational implementation of more than 200 characteristics that most significantly influence safe medication use. Goals are established to drive improvements in the areas identified as having the most opportunity for improvement based on ISMP self-assessment data and ADE data.

External medication-related alerts and new regulatory standards are utilized to modify current systems to promote reduction in medication errors. Using the ISMP self-assessment tool, on a periodic basis the Medication Safety QFT will identify in each of the 11 procedures and systems weaknesses or deficiencies that could contribute to errors. In each system, Short and long term goals are established by the Medication Safety QFT to address identified weaknesses or deficiencies in the medication use system. These goals are incorporated in the MERP. The Medication Safety QFT reviews annually the effectiveness of the MERP in meeting short and long term goals established to address areas in the medication use system where weakness or deficiencies are noted to achieve the desired medication error reductions. The MERP is modified as warranted to guide improvements in areas where weaknesses or deficiencies are noted. The Quality Council is responsible for monitoring key outcomes related to Medication Safety QFT activities. This includes evaluation and approval of the MERP effectiveness, outcomes and goals on an annual basis.

Principle 4 – Technology implementation shall be part of the plan.

Technology plays role in Kaweah [Delta Health Care District's Health's](#) MERP. The MERP "working plan" describes the medication-related technology to be

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implemented and how it is expected to reduce medication-related errors. Medication-related technology decisions are based on independent, expert scientific advice and data, which has shown that it₇ will reduce/eliminate medication errors.

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Principle 5 – Review pertinent literature related to the reduction of medication errors in review and on-going development and review of the plan.

Leaders of the Medication Safety Quality Focus and Action Teams continually monitor the literature to identify targets of opportunity for drug therapy improvement projects. Examples of sources utilized include: Institute for Safe Medication Practices, ~~Hospital Advisory Board Publications~~, Food and Drug Administration and Institute for Health Care Improvement-~~(HH)~~.

"These guidelines, procedures, or policies herein do not represent the only medically or legally acceptable approach, but rather are presented with the recognition that acceptable approaches exist. Deviations under appropriate circumstances do not represent a breach of a medical standard of care. New knowledge, new techniques, clinical or research data, clinical experience, or clinical or bio-ethical circumstances may provide sound reasons for alternative approaches, even though they are not described in the document."



Policy Number: AP156	Date Created: No Date Set
Document Owner: Cindy Moccio (Board Clerk/Exec Assist-CEO)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration)	
Standard Procurement Practices	

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

POLICY: To outline the general procurement policies and responsibilities of Kaweah Delta Health Care District dba Kaweah Health.

REFERENCES:

- AP19 Travel, Per Diem and Other Employee Reimbursements
- AP40 Vendor Relationships
- AP46 Commercial Card Expense Reporting (CCER) Program
- AP69 Requirements for Contracting with Outside Service Providers
- AP96 Public Bidding of Construction Contracts
- AP135 Capital Budget Purchases
- AP136 Construction in Progress Accounts
- AP166 Competitive Bidding of Contracts
- AP167 Quote and Proposal Guidelines

DEFINITIONS:

Capital/Major Equipment – any single piece of equipment with a purchase price of \$5,000 or greater, and an expected useful life of greater than one year. The total cost of the item includes any shipping, handling, freight, acceptance costs, installation fees, or taxes associated with placing the item into use within Kaweah Health. See AP135 “Capital Budget Purchases” for the policy relating to the purchase of capital equipment. See AP166 “Competitive Bidding of Contracts” for the policy relating to competitive bidding of purchase contracts.

Minor Equipment – any single piece of equipment with an expected useful life of less than one year or a purchase price of less than \$5,000. The total cost of the item includes any shipping, handling, freight, acceptance costs, installation fees, or taxes associated with placing the item into use within Kaweah Health.

Supplies – disposable items allocated with funds from the operating budget, including such items as disposable surgical materials, printing, office products but EXCLUDES equipment.

Service Contracts – the furnishing of time and effort by a contractor involving the support of equipment and systems, such as preventative maintenance service agreements or software support agreements. This excludes delivery of a specific product or equipment. See AP167 “Quote and Proposal Guidelines” for the policy regarding quote and proposal requirements for service contracts.

Services – the furnishing of labor, time and effort by a contractor which binds Kaweah Health to either perform services, commit Kaweah Health assets for the benefit of a third party or pay another party for services, such as employment agreements, collective bargaining agreements and professional service agreements. Refer to AP69 “Requirements for Contracting with Outside Service Providers” for procedures. See also, AP167 “Quote and Proposal Guidelines” for the policy regarding quote and proposal requirements for service contracts.

PROCEDURE:

I. Materials Management Responsibilities

- A. Materials Management has the authority to commit Kaweah Health funds for supplies, equipment and service contracts, subject to the availability of approved budgeted funds and the presence of a duly-authorized purchase order, non-stock or other form of requisition.
- B. Prepare and process purchase orders (POs) in accordance with this policy.
- C. Select suppliers in accordance with legal requirements of the District. However, suggestions by departments will be considered whenever they are competitive or when delivery requirements or other unique requirements so demand.
- D. Assist departments with returning ordered items for vendor credit and coordinating with Accounts Payable to ensure proper refund is received from the vendor.

II. Procurement Authority of Operating Departments

By virtue of their special needs and the roles they fill at Kaweah Health, the following operating departments are authorized to purchase Supplies and Services (all other purchases must be processed through Materials Management, including Major and Minor equipment, Capital purchases and Service Contracts):

- A. Dietary
- B. Pharmacy
- C. Marketing
- D. Information Systems Services
- E. Maintenance
- F. Clinical Engineering
- G. Environmental Services
- H. Construction Services

III. Invoice Address

All invoices must be addressed to 400 W. Mineral King, Attention: FINANCE DEPARTMENT, Visalia, CA 93291 - and not to independent operating departments.

IV. Prohibited Use of District Vendor Relationships, District Accounts or Procurement System for Personal Use

Using District relationships, District accounts or the procurement system, including deliveries to the receiving dock, for personal purchase of any type of good or service is prohibited and may result in disciplinary action, up to and including dismissal from employment, and may in some circumstances constitute a criminal act punishable by law.

V. Required Authorization for Procurement

All purchase order requisitions must be signed by a duly authorized signor, which includes, but may not be limited to:

- A. Capital items – Unless otherwise designated by the Chief Executive Officer, Materials Management is prohibited from purchasing capital equipment unless a member of the Executive Team has approved the purchase, indicating approval by signing the purchase order requisition.
- B. Construction in Progress - Whenever possible, purchases for Construction in Progress accounts should be procured through Materials Management. Prior to establishing a Construction in Progress account, the source of funding must be approved by the Board of Directors, Chief Executive Officer or Chief Financial Officer in accordance with AP 136 “Construction in Progress Accounts”. For capital budget lines, approval must be in accordance with AP135 “Capital Budget Purchases”.
- C. Supplies, Service Contracts and Minor Equipment other than Office Supplies and Electrical Equipment– Signors on purchase order requisitions authorizing purchases must be an authorized signor for the department for which operating budget funds will be utilized to secure the purchase. Authorization is indicated on the completed “Purchase Authorization Sheet” maintained by the Accounts Payable Specialist.
- D. Office Supplies and Minor Office Equipment – Purchases of office supplies and minor office equipment must be made through Office Depot by an authorized user of Office Depot. The individual making these purchases must be authorized to purchase for the department for which operating budget funds will be utilized to secure the supply purchase. Authorization is indicated on the completed “Purchase Authorization Sheet – Office Depot Users” maintained by Materials Management. Authorized users are only able to procure approved, contracted items (“unrestricted” items) from the Office Depot website. Requests for the purchase of restricted items must be sent to Materials Management for processing, accompanied by a purchase order requisition signed by the Director of the department authorizing the restricted purchase.
- E. Electrical Equipment – All requests to purchase electrical equipment must be approved by Clinical Engineering. If the equipment does not meet appropriate space requirements, load and phase requirements, minimum safety standards and appropriate warranties and manufacturer’s reliability, the equipment will not be ordered.
- F. ISS All requests for purchases relating to ISS systems, software, telecommunications or any other IS technology must be approved by an ISS Director or the Chief Information Officer (CIO).

VI. Standard Procurement Procedures:

- A. Each District cost center/department is assigned a District Buyer to process purchase order requisitions and represent Kaweah Health during the procurement process of the requested item.
- B. General procurement procedures for Capital items or Construction in Progress being procured through Materials Management, Electrical Equipment approved for purchase by Clinical Engineering, ISS purchases approved by an ISS

Director or the CIO, Supplies (other than Office Depot orders), Service Contracts and Minor Equipment include:

1. Requesting department completes a purchase order requisition, which is located on Finance Online.
2. The purchase order requisition must be signed by a duly-authorized signor as described in Section V above.
3. The purchase order requisition along with supporting documentation is forwarded to Materials Management. Information that must be clearly indicated on the non-stock include, but are not limited to:
 - a) The part number, product number, item stock number, catalog number or other number identifying the order
 - b) Quantity and price per unit
 - c) Department number and Expense or Capital account coding
 - d) Authorized signature in accordance with Section V above
 - e) Quotes for Capital purchases must be attached
4. A District Buyer will place the order and monitor the procurement process until the order is successfully filled or canceled.
5. Upon arrival of the item(s), Receiving will inspect the item(s) against the packing slip and the purchase order. The item(s) will then be delivered to the department that made the request for order.
6. The department is responsible to inspect the item(s) and an authorized staff member will sign the Receiving Report to note acceptance.
7. The Receiving information along with the PO will be forwarded to the Finance Department for processing payment according to policy and procedure.

C. Procurement Procedures for Office Supplies and Minor Office Equipment – Kaweah Health receives a preferred customer discount from Office Depot. As a result, purchases of office supplies and minor office equipment must be made through Office Depot by an authorized user of the Office Depot website who is authorized to purchase for the department for which operating budget funds will be utilized to secure the supply purchase. Authorization is indicated on the completed “Purchase Authorization Sheet – Office Depot Users” maintained by Accounts Payable.

1. Office Depot Web Site
 - a) All supplies available for purchase by District Office Depot Users are accessed through Office Depot’s website.
 - b) Office Depot website access is granted by Accounts Payable through the completion of an “Office Depot Log On Request” form.
2. Unrestricted Office Depot Supplies –
 - a) Unrestricted Office Depot purchases are made on-line on the Office Depot website.
 - b) The purchaser will see “restricted item” at the end of the item order number indicating that the item is restricted and can only be ordered by Materials Management or Executive Administrative Assistants.
 - c) No purchase order requisition is required to be completed for preapproved items.
 - d) The purchaser is responsible to ensure that the supplies were appropriately received and utilized.

- e) Finance processes payments on all Office Depot on-line orders through electronic data interchange between Kaweah Health and Office Depot.

3. Restricted Office Supplies –

- a) Restricted office supplies must be processed on a purchase order requisition through Materials Management using the same procedures in Section V (D) above.
- b) Departments submitting purchase order requisition to purchase supplies from another vendor other than Office Depot must clearly indicate on the purchase order requisition why the item could not be purchased through Office Depot.

D. Procurement of Knowledge Based Information – Except for items disclosed below, all requests for the purchase of, or subscription to, knowledge-based information in the form of books, journals, magazines, pamphlets, videos, audios, and/or computer software will be placed through Materials Management. Under the following circumstances, knowledge-based information may be purchased directly by the employee using the employee's District assigned commercial card in accordance with District Administrative Policy AP46 "Commercial Card Expense Reporting (CCER) Program".

1. Purchase of, or subscription to, knowledge-based information in the form of books, journals, magazines, pamphlets, videos and audios that will be located in the department for the sole use of department personnel and not commonly utilized by other departments of Kaweah Health *and*
 - a) can be purchased through a professional organization where Kaweah Health would receive a better discount rate using the employee's membership discount rate *or*
 - b) must be purchased by employees who have membership accounts with the professional organizations *or*
 - c) which are available at an off-site conference being attended by an employee which is the most cost effective time to secure the purchase.

VII. Procurement Procedures for Purchases paid for by District Purchasing Card:

- A. Kaweah Health purchasing card may be used for certain local purchases on a limited basis, when obtaining goods, supplies or services through the normal purchasing procedure is not appropriate or practical for the given situation. See District Policy AP46 for examples of allowable purchases.

VIII. Emergency Procurement Procedures:

As a general rule, the requesting department will be responsible for determining product requests which are to be classified as an emergency. Examples of emergency purchases are:

1. the replacement of an x-ray tube which burns out,
2. the request for a part to repair a piece of equipment which is giving support to a patient,
3. the request for a product, unavailable from current inventories, which is needed to treat a trauma patient,

4. the acquisition of a product deemed necessary to the well-being of a patient in a traumatic situation.

Materials Management is responsible for providing procurement support for emergency requests. General procedures for emergency purchases include:

A. During normal working hours (Monday through Friday, 7:00 am to 4:30 pm)

1. The department will notify Materials Management when an emergency item is needed and the exact time the item is needed.
2. Once contacted, Materials Management will issue a purchase order to the vendor who can respond most expeditiously.
3. The responsible District Buyer will do his/her best to ensure the costs involved are reasonable with respect to existing market and/or contract conditions.
4. If the responsible Buyer has reason to believe that the request can be accommodated by use of normal procurement practices they are to inform the requesting department and provide guidance and direction as to the process which is to be used. Any disputes or disagreements which arise with the requesting department are to be reported to the Director of Procurement and Logistics for assistance or confirmation that the course of action taken is appropriate.
5. The Buyer will notify the Receiving Department of the emergency shipment, and if the item will be delivered after normal working hours.
6. The emergency items will be picked up in Receiving. If the item is expected to arrive during late evening hours, Receiving will set up the drop off location for the item.
7. The item will be delivered immediately to the requesting department.
8. The receiving report and packing slip will be forwarded to the Buyer to be processed during the next working day.

B. After normal working hours

1. The department will be responsible to identify a vendor who can respond most expeditiously.
2. It will be the responsibility of the individual from the department to do his/her best to ensure the costs involved are reasonable with respect to existing market and/or contract conditions.
4. Departments may arrange for the emergency delivery of products outside of normal working hours, provided they notify Materials Management on the next regular working day. Materials Management will then arrange for a purchase order to be issued.
5. All emergency purchases processed after hours less than \$49,999 must be followed with appropriate written documentation defining the emergency nature of the request. The documentation is to be signed by the requesting department's Director and provided to Materials Management the next business day. For purchases exceeding \$49,999, the documentation must be signed by the department Vice President.



Purchase Authorization Sheet

Staff Member

Name Printed:

Signature:

Authorized by*: _____

Date: _____

*Must be a Director, Vice-President or CEO

Departments Authorized for:	Department Name	Effective Date
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Restrictions: i.e., dollar amounts, time limits , supply items only, repairs , etc.

RETURN TO CINDY HERBRAND
Fax #: 713-2273



Purchase Authorization Sheet For Office Depot Users

Staff Member

Name Printed: _____

Signature: _____

Authorized by*: _____ Date: _____

***Must be a Director, Vice-President or CEO**

Departments Authorized for:	Department Name	Effective Date

Restrictions: For Office Depot supplies **only**.

Office Depot website orders only. Items from "approved" website listing only. \$100 limit.

RETURN TO CINDY HERBRAND
Fax #: 713-2273

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approval



**Kaweah Delta
Health Care District**

Administrative Manual
~~Subcategories of Department Manuals
not selected.~~



Kaweah Health.

Policy Number: AP158	Date Created: No Date Set
Document Owner: Cindy Moccio (Board Clerk/Exec Assist-CEO)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration)	
Solicitation, Fundraising and Distribution of Materials	

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

Policy: Kaweah Delta Health Care District (herein after referred to as Kaweah Health) supports community organizations who engage in health-related charitable and fundraising activities/events that are consistent with or advance Kaweah HealthDelta's mission. To avoid disruption of healthcare operations or disturbance to patients, and to maintain appropriate order and discipline, solicitation and distribution of literature on Kaweah HealthDelta premises and among Kaweah HealthDelta staff shall be governed by the following procedures.

Definitions:

Distribution: Disbursing, delivering, issuing, or posting printed and/or electronically produced materials or items of any type.

Solicitation: Approaching, inviting, encouraging, or requesting employees, patients, or visitors to purchase goods, support an initiative or cause, become members of an organization, or make contributions of time, money, merchandise, or property.

Working time: The time when an employee is scheduled and expected to be properly engaged in performing his/her work tasks. Working time does not include authorized break periods or meal periods when the employee is not expected to be properly engaged in performing work-related activities or duties.

For Profit: Net proceeds to recognized organizations or Kaweah HealthDelta Departments do not meet the definition of "sale of goods for profit" under the terms of this policy.

Procedure:

- I. All solicitation and/or distribution of materials within Kaweah HealthDelta

facilities and among Kaweah ~~HealthDelta~~ staff, patients, and the public, are subject to the following rules:

- A. Kaweah ~~HealthDelta~~ employees may not solicit or distribute materials at any time, for any purpose, during working time (see definition above).
- B. Kaweah ~~HealthDelta~~ employees may not solicit or distribute materials at any time, for any purpose, in patient care areas, or other areas where healthcare operations occur. Examples include, but are not limited to, patient rooms and places where patients receive treatment, or in any other area that would cause disruption of health care operations including corridors in patient treatment areas or rooms used by patients and/or physicians.
- C. Kaweah ~~HealthDelta~~ has implemented the use of electronic mail (email) as a method to conduct and facilitate health care operations. Thus, Kaweah ~~HealthDelta~~ employees may not solicit or distribute materials at any time using Kaweah ~~HealthDelta~~ Email.

- i. NOTE: Solicitations related to activities administered by Kaweah ~~HealthDelta~~ or the Kaweah ~~DeltaHealth~~ Hospital Foundation are not subject to this provision. Examples include communications from the Kaweah ~~HealthDelta~~ Hospital Foundation and from Kaweah Korner.

- D. Kaweah ~~HealthDelta~~ maintains bulletin boards located throughout its facilities for the purpose of communicating with its employees. Postings on these boards are limited to Kaweah ~~HealthDelta~~-related material including statutory and legal notices, safety and disciplinary rules, Kaweah ~~DeltaHealth~~ policies, memos of general interest related to Kaweah ~~DeltaHealth~~, operating rules and procedures, and other Kaweah ~~DeltaHealth~~ items. All postings concerning the solicitation or distribution of materials must be compliant with the terms of the policy.

- i. Note: All postings on bulletin boards located in employee lounges or breakrooms concerning the solicitation or distribution of materials must be compliant with the terms of the policy.

- E. ~~ii. Kaweah HealthKaweah Delta Health Care District~~ (Public Agency) shall not conduct raffle or opportunity prize drawings.

- ~~F.E.~~ Solicitation or distribution of materials in any way connected with the sale of any goods or services for profit is strictly prohibited, at any time by or among Kaweah ~~Health Delta~~ staff, patients or visitors. Examples include, but are not limited to, Mary Kay, Arbonne, Herbalife, Amway, or any other type of product, good, or service, sold for profit.

- ~~G.F.~~ Solicitations or distribution of materials in any way connected to a political party or religious organization are prohibited.

II. Permitted Activities:

- A. Kaweah ~~HealthDelta~~ Hospital Foundation sponsored activities or other efforts to support and further the mission of Kaweah ~~DeltaHealth~~. Examples include, but are not limited to, the Foundation Golf Classic,

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Kaweah HealthDelta employees, by the representatives of employee organizations that have not been recognized by Kaweah HealthDelta pursuant to Kaweah HealthDelta's Resolution shall be governed by the provisions of the Meyers-Milias-Brown Act, Government Code Sections 3500 et seq., as interpreted by the Public Employees Relations Board and/or courts of competent jurisdiction.

V. Visits by Vendor Representatives

- A. Visits by Vendor Representatives shall be managed by the procedures outlined in AP.14 Department Visits by Vendor Representatives.

"These guidelines, procedures, or policies herein do not represent the only medically or legally acceptable approach, but rather are presented with the recognition that acceptable approaches exist. Deviations under appropriate circumstances do not represent a breach of a medical standard of care. New knowledge, new techniques, clinical or research data, clinical experience, or clinical or bio-ethical circumstances may provide sound reasons for alternative approaches, even though they are not described in the document."

approved



Administrative Manual ~~Subcategories of Department Manuals not selected.~~



Policy Number: AP167	Date Created: No Date Set
Document Owner: Cindy Moccio (Board Clerk/Exec Assist-CEO)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration)	
Quote and Proposal Guidelines	

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

POLICY: Kaweah Delta Health Care District (~~“District”~~herein after referred to as Kaweah Health) enters into contracts with various providers for services.

This policy outlines the process established related to the negotiation of such contracts where competitive bidding pursuant to Health and Safety Code §32132 is not required (See policy AP.166).

Kaweah Health~~The District~~ reserves the right to direct competitive bidding for any contract whether or not competitive bidding is required by law or required by the terms of this policy. Competition helps to maximize the value received for the use of District funds and promotes openness and transparency with all stakeholders. ~~The District~~Kaweah Health promotes sound procurement practices to ensure that service providers have fair opportunity to participate in ~~the District’s~~Kaweah Health’s acquisition of these services. This policy establishes guidelines for the development, solicitation, evaluation, and award of quotes and proposals at ~~the District~~Kaweah Health for certain contracts where Health and Safety Code §32132 does not apply.

Each ~~Senior Vice President, Executive Team Member~~Vice President or through formal designation his/her designee shall be responsible for negotiating and executing contracts pertaining to their Division and should follow the guidelines contained in this policy or the Competitive Bidding policy (AP.166).

Please refer to Administrative Policy AP.96 for the Public Bidding of Construction contracts, and AP.166 for the Competitive Bidding of contracts pursuant to Health and Safety Code §32132. See the Vendor Selection Flowchart attached to this policy as a guide to help determine which policy applies to each contract.

The quote and proposal guidelines are integral to AP69 – Requirements for contracting with outside service providers, and should be followed within the context of that policy.

This policy applies to both new service agreements and the renewal of existing service provider agreements.

1. Special review and/or evaluation criteria:

- **Regardless of the annual amount of the contract, prior to the start of the contracting process, all physician professional service contracts and all exclusive provider arrangements for clinical services shall be evaluated by a committee comprised of the ~~Chief Operating Officer, officer,~~ Chief Operating Officer, Chief Nursing Officer, Chief Medical Officer and the Chief Financial Officer.** Medical Directorships are not considered exclusive provider arrangements within this policy provision and are covered under CP.03 "Medical Director Contracts" for informational purposes.
- Any contract for services of \$1.0 million or more annually, any multi-year contract aggregating to \$1.0 million or more over the contract term, or any contract of a sensitive nature that might warrant such a review as determined by the responsible Vice President should be reviewed. The responsible Vice President will also consult with the DIO on operational perspectives of these contracts prior to execution (not approved-).

2. When to obtain a quote or use the RFP (proposal) process:

- When the services requested are **less than \$10,000** annually, no formal bid or quote is required.
- For services that do not require public or competitive bidding, which cost **\$10,000 or more but less than \$100,000** annually, the requesting ~~VP~~ Executive Team Member or delegate must obtain a formal quote in writing from a minimum of two service provider sources, three quotes are recommended. The receipt of quotes must be indicated on the AP.69 contract checklist including a short description of the service provider selection, and the quotes forwarded with the checklist (see procedure 5. of AP 69 related to review of contract checklist by the Director of Financial and Logistical Planning or the Finance Manager prior to signing contracts). See exhibit A for an example of the contract checklist procedure related to economic consideration including quote arrangements and vendor justification statement.
- For services which cost **\$100,000 or more** annually, the requesting VP or delegate must follow the formal Request for Proposal (RFP) process outlined below.

REFERENCES:

AP.69	Requirements for contracting with outside serviced providers
AP.166	Competitive Bidding of Contracts
AP.96	Public Bidding of Construction Contracts
AP.156	Standard Purchasing Practices
AP.40	Vendor Relations and Conflict of Interest Vendor Selection Flowchart – Attached

DEFINITIONS:

“Quote”: A quote is used mainly when the specifications of a service are already known and price is the main or only factor in selecting a successful vendor.

“Proposal”: A proposal is used where there is no pre-defined service requirement, but rather a set of outcomes or deliverables needed to meet the project objective(s). This allows the responding vendors to use their best resources to propose solutions that meet the project objective(s).

“Sole provider” When only one service provider is considered during the contract process.

PROCEDURE:**1. RFP – Request for proposal process**

The RFP is a method of soliciting information and pricing from a service provider. An RFP is issued for service providers to describe and define requested processes or services. The following outlines ~~the District's Kaweah Health's~~ RFP procedure. This procedure must be used for service contracts exceeding \$100,000 annually that are not required to be ~~publically~~publicly or competitively bid pursuant to Health and Safety Code §32132 (See policies AP.96 and AP.166). It is important to note that the RFP process may take up to 90 days and that adequate time for planning, evaluation, and approval by the RFP Evaluation Committee shall be considered prior to contract renewal date or initial required date of service delivery.

A. The RFP document and development

The preparation of the RFP document outlining the project specifications, services required and the provider qualifications is the responsibility of the requesting VP or delegate.

See RFP document requirements and model in Exhibit B.

B. RFP Solicitation

The RFP document must be sent by email with a delivery receipt request to the service providers identified by the appropriate Vice President or their designee. Retain copies of all emails and email delivery confirmations. A hard-copy shall be mailed (return receipt requested) to vendors without email or upon request.

A minimum of three service provider proposals should be solicited. If three proposals cannot be obtained or, if time will not permit obtaining three proposals, two proposals will suffice with the Vice-President's approval.

If questions arise after receipt of proposals, communication should be restricted to the requesting VP or their designee.

C. RFP Evaluation and Service Provider Selection

The requesting VP or designee shall thoroughly evaluate the proposals received and complete a written summary of the recommended service provider including the contributing reasons for the recommendation.

Copies of the RFP document, written summary and proposals received must be forwarded to the RFP Evaluation Committee two weeks prior to the monthly RFP Evaluation Committee meeting using a PDF format via email. See exhibit C for RFP Committee submission Form.

The RFP Evaluation Committee will be comprised of at least five members including the Chief Operating Officer, ~~the Director of Financial and Logistic Planning~~, the Director of Finance, Internal Audit leadership~~the Director of Internal Audit~~, the Finance Manager and a rotating Clinical Director (chosen by the Chief Operating Officer on an annual basis).

The evaluation team's function is to provide support to the service requester and to provide an additional independent review of the selection process. The Evaluation Committee will review the submitted documents and approve/deny the recommendation or request additional supporting documentation. The service requester may be invited to attend the committee meeting to discuss your RFP process with the committee members.

3. Sole Source Arrangements

A service provider may be proposed as sole source if:

- The requested service is an integral repair contract compatible with existing equipment.
- The requested service has unique specifications that are not available from other service providers.
- The requested service is essential to remain in compliance with regulatory standards.
- The requested service is one with which staff have specialized training/extensive expertise and retraining would incur substantial cost in time, or a change of service provider would disrupt the existing process and cause the District to incur substantial replacement cost.

For all contracts greater than \$10,000 annually, the sole source arrangement must be reviewed and approved by the Evaluation Committee. The sole source recommendation and contributing factors (including applicable research) will be submitted to the RFP Evaluation Committee in lieu of Quotes or RFP documents. See exhibit C for RFP Committee submission Form.

Exhibit A – Example of AP.69 Checklist for Economic Consideration

Economic Consideration:

Lease/Buy In/Out Source Quotes Sole Source RFP required

Two or more quotes are included with this checklist – complete two questions below:

1. Vendor selected: _____
2. Why: _____

Sole Source arrangement approved by RFP Committee – approval attached.

RFP selection approved by RFP Committee – approval attached.

Exhibit B –RFP Document Requirements and Example

RFP documents should include the following elements:

- Introduction--a summary of the organization, including the mission statement
- Project overview
- Goals and purpose
- Scope of work – description of services requested
- Minimum qualifications, if applicable
- Special requirements, if applicable
- Time constraints – when to begin services, or project completion date
- Contents/requirements of proposal – General information about vendor, staff, experience, approach -to providing service, associated fees, client references
- Submission of proposal- - how to submit (email or site visit), to whom, timing of submission and selection, who to contact for questions

Exhibit B –RFP Document Requirements and Example***Example RFP Document***

March 1, 20~~22~~21~~2~~

Ms. Smith
ABC Accounting Firm
12345 N. Flower St.
Visalia, CA 93291

Re: Request for Proposal of Independent Audit Services

Kaweah ~~Health, Delta Health Care District (the “District”)~~, a local health care district formed in 1961, is a political subdivision of the State of California organized pursuant to the State’s Local Health Care District Law as set forth in the State’s Health and Safety Code. ~~The District~~Kaweah Health is governed by a separately elected Board of Directors. The geographic area that composes ~~the District~~Kaweah Health encompasses approximately 183 square miles in northern Tulare County and includes the City of Visalia as well as neighboring unincorporated areas.

~~The District~~Kaweah Health is one of the area’s most progressive health care providers. It is our goal that our community has access to a broad spectrum of high-quality health care services. For more than 640 years, it has been our mission to serve our community’s health care needs. Our comprehensive scope of services offers everything from a well-respected pediatric hospitalist program to nationally recognized cardiac and cancer programs and much more.

~~The District’s~~Kaweah Health’s consolidated financial statements are prepared in accordance with the pronouncements of the Governmental Accounting Standards Board. ~~The District~~Kaweah Health is not generally subject to state and federal income taxes.

~~The District’s~~Kaweah Health’s audited financial statements are scheduled to be presented to the District’s Board of Directors on Monday, November 14, 20~~21~~22 in order to comply with applicable bond covenants. There is also an expectation that the audit firm’s representatives will meet with Kaweah Health’s~~the District’s~~ Audit Committee on three separate occasions during the course of the audit in the form of planning, mid-audit status, and post-audit meetings.

The enclosed information regarding ~~the District~~Kaweah Health is provided to assist in your evaluation of our request for a proposal related to the annual financial statement audit of ~~the District~~Kaweah Health and of the Plan for the fiscal year ended June 30, 20~~21~~22. Enclosed is the following for your review:

- Official Statement related to the Kaweah ~~Delta Health Care District~~Health Revenue Bonds
- Consolidated Financial Statements of ~~the District~~Kaweah Health for the Years ended June 30, 20~~2010~~ and 20~~21~~ including the -independent auditor's report and management's discussion and analysis

All proposals must be signed by an officer of the proposing organization who has the authority to commit the firm to the services provided at the fees quoted.

Please submit your proposal by email to mjones@kdhedkawahhealth.org. If you wish to send a copy, please send to:

Ms. M. Jones
Kaweah Delta Health Care District
Finance Department
400 West Mineral King
Visalia, California 93291

All proposals must be received by Monday, April 1, 20~~21~~2.

Proposal Requirements:

1. Provide a description of your firm's specific knowledge of the healthcare and governmental industries and any specific experience performing audits of institutions similar in size and complexity to ~~the District~~Kaweah Health. Include a listing of clients and references if possible.
2. Provide a description of your firm's specific knowledge and experience related to the audit of defined benefit pension plans.
3. Provide a summarized description of your audit process to include the use of experts within your firm such as actuarial, information systems and other resources.
4. Indicate the office that will be servicing the engagements and provide the names and qualifications of the management and leaders of the engagement teams.
5. Provide proposed timing of the engagements to include planning, control testing, field work and report presentation.
6. Provide proposed fees related to the engagements including estimated hours, rate per hour, other expenses and proposed rates for additional time charges (if necessary).

7. Provide a description of your firm's experience and ability to perform audit and accounting services related to the issuance of general obligation or revenue bonds (e.g., comfort letters, consent letters).
8. Describe your firm's requirements and policies related to the review of an official statement that includes the audited financial statements of an audit client.
9. Provide any additional information you believe to be important in our analysis of your organization's proposal.

Questions and/or Requests:

All questions and/or requests for further information should be referred to Ms. Jones, Director of Finance, Kaweah ~~Delta Health Care District Health~~ at (559) 624-1234 or mjones@kawahhealthhed.org. Proposals will be evaluated by ~~the District~~Kaweah Health as soon as possible after the above indicated due date of April 1, 20~~21~~22. Each proposer will be contacted soon after a selection has been made to inform each of the selection process results.

~~The District~~Kaweah Health reserves the right request clarification of information submitted in any proposal and to request additional information from any proposer. ~~The District~~Kaweah Health will not be liable for any costs incurred by proposers in the preparation and production of proposals, or for the costs of any services performed prior to the selection of the auditor.

Sincerely,

Ms. M. Jones
Director of Finance
Kaweah ~~Delta Health Care District~~Health

Exhibit C

**RFP Summary or Sole Source Vendor Selection
Submission to RFP Committee**

Contract for: _____

Submission Date: _____ Contract Effective Date: _____

Responsible VP: _____ Submitted by: _____

New service Existing service

RFP Document attached

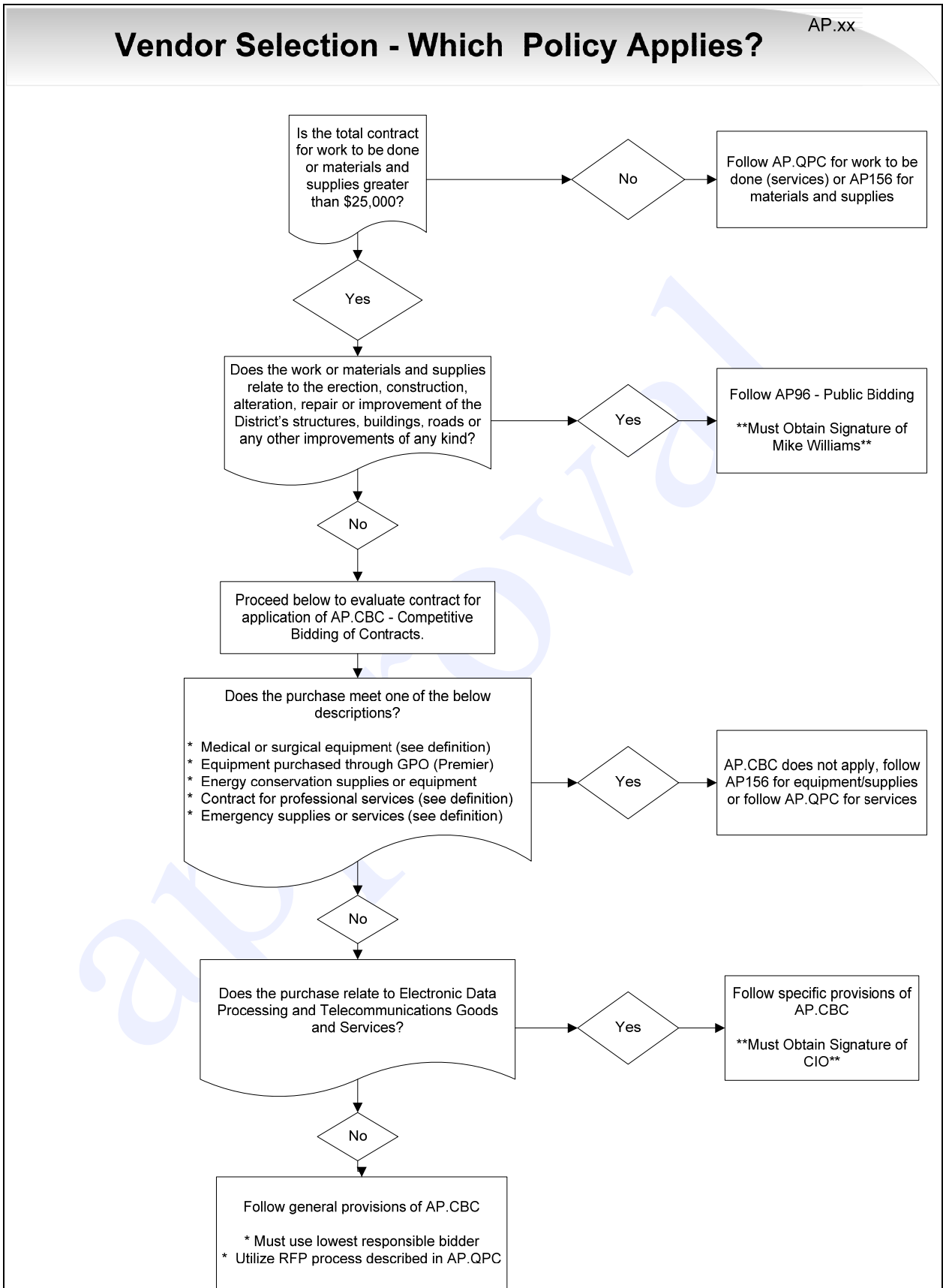
Three or more vendor proposals obtained – proposals attached

Two vendor proposals obtained, VP approval _____ - proposals attached

Sole Source arrangement recommended (No RFP) – proposal attached

Vendor recommended: _____

Reason for vendor recommendation (RFP) **or** sole source justification:



"These guidelines, procedures, or policies herein do not represent the only medically or legally acceptable approach, but rather are presented with the recognition that acceptable approaches

exist. Deviations under appropriate circumstances do not represent a breach of a medical standard of care. New knowledge, new techniques, clinical or research data, clinical experience, or clinical or bio-ethical circumstances may provide sound reasons for alternative approaches, even though they are not described in the document."

approval



Policy Number: AP171	Date Created: No Date Set
Document Owner: Cindy Moccio (Board Clerk/Exec Assist-CEO)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration), Medical Executive Committee	
Medically Ineffective Care	

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

This policy is intended to provide a mechanism for resolution of conflicts when the treatment team believes that: continuing treatment is non-beneficial, or when the burden of suffering and intrusiveness of treatment significantly outweighs any potential benefit, or when a treatment is contrary to generally accepted medical standards, but the patient/surrogate or conservator continues to request the disputed treatment. This policy is developed to:

- A. Provide written guidelines that will assist with end of life decisions when treatment is considered medically ineffective.
- B. Assure that patients and/or family, conservator, or surrogates are informed and involved in decisions related to care or treatment that is considered medically ineffective.
- C. Outline a process for physicians and staff to follow when a patient or his/her surrogate decision maker has requested treatment that in the best judgment of the Responsible Physician (as defined below) is medically ineffective in compliance with the relevant California statutes and case law regarding health care decisions.

DEFINITIONS:

- A. Medically Ineffective or Non-Beneficial Treatment: Any medical treatment or study that, in the Responsible Physician’s professional judgment, produces effects that cannot reasonably be expected to be experienced by the patient as beneficial or to accomplish that patient’s expressed and recognized medical goals, or has no realistic chance of returning the patient to a level of health that permits survival outside of the acute care setting.
- B. Responsible Physician: The attending/treating physician whose responsibility it is to make most major medical decisions with the patient.

If a patient's attending physician is unable or unwilling to participate in this process, the Chief of Staff, after consultation with the applicable department chair, may appoint a responsible physician to discharge the responsibilities identified in this policy.

- C. Surrogate/Conservator/Agent: An individual designated to make healthcare decisions on behalf of an unemancipated minor (usually a parent) or an adult patient who lacks the capacity to make such decisions. In cases where there is no legally designated agent via an advance directive, the physician will identify the most appropriate surrogate based on his or her determination of the person who has demonstrated the most knowledge of the patient's wishes and values, and can best provide substituted judgment.
- D. Capacity: A person's ability to understand the nature and consequences of proposed health care, including its significant benefits, risk, and alternatives, and to make and communicate a health care decision.

PRINCIPLES:

- A. KDHCD-Kaweah Delta Health Care District dba Kaweah Health supports Opinion 2.035 of the American Medical Association, which has been adopted for use by the California Medical Association: "Futile Care: Physicians are not ethically obligated to deliver care that in their best professional judgment will not have a reasonable chance of benefitting their patients. Patients should not be given treatments simply because they demand them. Denial of treatment should be justified by reliance on openly stated ethical principles and acceptable standards of care, not the concept of futility which cannot be meaningfully defined..."
- B. KDHCD-Kaweah Health and physicians of the KDHCD-Kaweah Health Medical Staff are not obligated to provide a patient with medical treatment that in the Responsible Physician's best judgment will not be beneficial. This policy applies to all patients regardless of race, color, national origin, religion disability, age, sex, marital/family status, socioeconomic status, sexual orientation or genetic identification. This policy is in compliance with California Probate Code sec. 4735 and 4736;
 - 1. Section 4735: A health care provider or health care institution may decline to comply with an individual health care instruction or health care decision that requires medically ineffective health care or health care contrary to generally accepted health care standards applicable to the health care provider or institution.
 - 2. Section 4736: A health care provider or health care institution that declines to comply with an individual health care instruction or health care decision shall do all of the following:
 - a. Promptly inform the patient, if possible, and any person then authorized to make health care decisions for the patient.

- b. Unless the patient or person then authorized to make health care decisions for the patient refuses assistance, immediately make all reasonable efforts to assist in the transfer of the patient to another health care provider or institution that is willing to comply with the instructions or decision.
- c. Provide continuing care to the patient until a transfer can be accomplished or until it appears that a transfer cannot be accomplished. In all cases, appropriate pain relief and other palliative care should be continued.

PROCEDURE:

- A. Prior to a determination of medically ineffective care the physician and other members of the care team will have engaged with the patient and/or surrogate decision makers in goals of care conversations that are effective in identifying the patient/surrogate's goals and interests; identifying treatment options consistent with these goals and interests; and specifying when the goals or interests are not achievable or are contrary to generally accepted health care standards.

The determination that a particular treatment or intervention is medically ineffective is made through consultation involving the attending physician, the care team and the patient or surrogate decision maker, when available. If a patient lacks decisional capacity and has no surrogate decision maker, the attending physician and care team may make a determination of medically ineffective care after consultation with the Bioethics Committee. If conflicts arise among care givers or between care givers and the patient or surrogate, the Bioethics Committee shall address such conflicts. The determination is to be entered into the progress notes by the Attending Physician and will include a summary of discussions with care team members and others.

- B. At no point will determinations of medically ineffective care be made based on financial issues, the patient's age, lifestyle, previous compliance with medical treatment or lack thereof, or the personal values of the physician or care team.
- C. The attending physician will engage the patient with decision-making capacity or the incapacitated patient's surrogate when a treatment is deemed to be medically ineffective. The physician will explain the reasons for this determination and discuss options for ensuring the patient's comfort and dignity, including comfort care and palliative care consultation, if appropriate.

The physician will seek the patient or surrogate's assent with the treatment plan prior to implementation.

- D. If assent is obtained from the patient/surrogate decision maker, the physician will document this in the patient's chart and will write appropriate orders.

- E. Consultation with the Bioethics Committee shall be conducted: (a) if there is disagreement between caregivers; (b) if there is disagreement between caregivers and the patient or surrogate.

CONFLICT RESOLUTION:

Conflicts related to the determination of medically ineffective care between physicians, patients, family members, surrogates, conservators, nurses and other health care personnel will be addressed as follows:

- A. If conflict arises among members of the treatment team, such as a dispute between nursing and physician(s), a team meeting should be held to discuss the case and try to arrive at a consensus regarding the treatment plan.
- B. If conflict arises between family members, or between the Responsible Physician and the patient or surrogate, a family conference should be held with the treatment team to attempt to achieve consensus regarding prognosis, goals of care, and treatment plan.
- C. When the Responsible Physician, after consensus of the treatment team, determines that a treatment is non-beneficial, he or she should inform the patient or surrogate of this determination, including the rationale supporting this determination. The Responsible Physician should recommend that the non-beneficial treatment(s) be replaced with optimal comfort/palliative care while reassuring the surrogate/family that the patient will not be abandoned.
- D. If the conflict persists, the Responsible Physician should offer to seek another opinion(s) from one or more additional physicians (“consultant”) with the appropriate expertise, with input from the patient or surrogate about the choice of the consulting physician who will provide the second opinion. In addition, the patient/surrogate may seek counsel and input from other individuals to provide spiritual counsel or social support.
- E. If the conflict persists, or if at any point in the process a values conflict is identified, involvement of the Ethics Committee should be requested. The Ethics Committee may meet with the members of the treatment team as well as the patient/surrogate. The role of the Ethics Committee is to apply bioethical principles to help facilitate a resolution of the conflict in accordance with the Medical Staff Bylaws.
- F. If the Ethics Committee supports the patient’s/surrogate’s position and the Responsible Physician remains unpersuaded, the patient/surrogate will be offered transfer of care to another physician who is willing to offer treatment.

Until transfer is accomplished, the Responsible Physician is responsible for continuing treatment.

- G. If the Ethics Committee supports the Responsible Physician's determination that certain proposed treatments are non-beneficial, the patient/ surrogate should be notified in writing of this determination and informed that the futile/medically ineffective treatment will not be provided.
- H. If the patient/ surrogate still disagree with withdrawing/withholding the disputed treatment, then Risk Management, Administration and the Chief of the Medical Staff (or designee) must be notified for case review.
 - 1. It is the responsibility of the patient/surrogate to find an acceptable medical practitioner or institution and arrange for the transfer of the patient.

Reasonable efforts will immediately be made to assist in the transfer of the patient, unless the patient or surrogate refuses assistance.
 - 2. The patient/surrogate can seek a judicial mandate to continue treatment at KDMC. Continuing care will be provided to the patient until a transfer can be accomplished or it appears that the transfer cannot be accomplished. No new treatment, which has been determined to be futile/medically ineffective, will be initiated unless court-ordered.
 - 3. If the patient has not been transferred or a judicial mandate has not been issued within a reasonable period of time, not to exceed fifteen (15) days, the treatment in question may be withheld or withdrawn.

"These guidelines, procedures, or policies herein do not represent the only medically or legally acceptable approach, but rather are presented with the recognition that acceptable approaches exist. Deviations under appropriate circumstances do not represent a breach of a medical standard of care. New knowledge, new techniques, clinical or research data, clinical experience, or clinical or bio-ethical circumstances may provide sound reasons for alternative approaches, even though they are not described in the document."

Board of Directors Report

Diversion Prevention Committee

September 28, 2022

Evelyn McEntire, Director of Risk Management &
Shannon Cauthen, Director of Critical Care Services



kaweahhealth.org

What is Drug Diversion?

Drug Diversion is a term used when an individual removes, takes, or finds medication(s) that are prescribed or ordered for someone else and uses them for him/herself.

Examples:

- A patient is prescribed two pills- the person gives one pill to the patient and keeps one for themselves.
- A person uses an empty syringe to remove medicine from IV tubing to inject into themselves
- A person finds a medication and takes it home instead of returning it.



Goals

Education

- Upon hire and annually

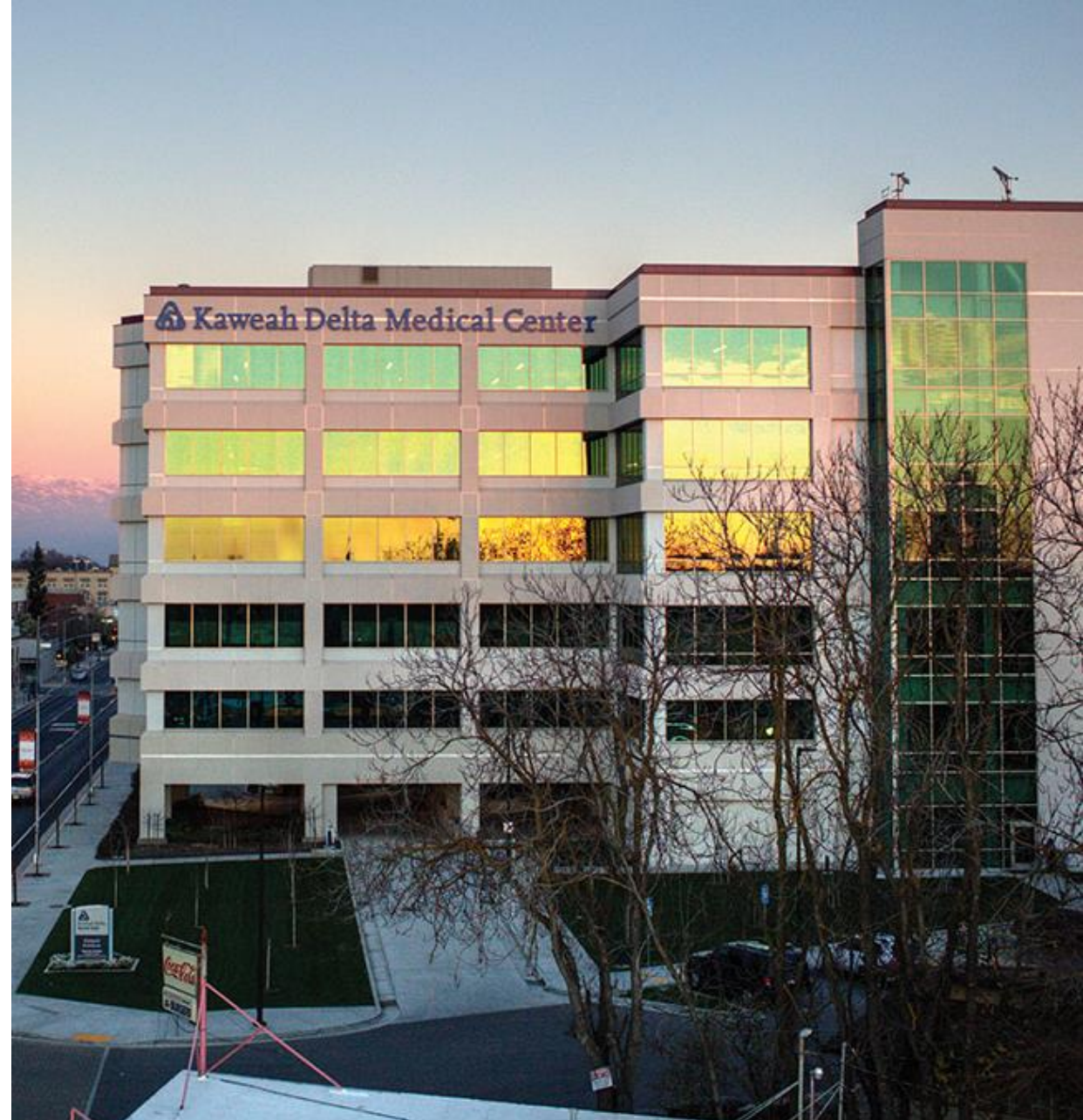
Accountability

- Use standardized software/reports and follow-up with team members using Just Culture

Sustainability

- Ensure ongoing monitoring and maintain a pulse on organizational action items

Integrated into the organizational Quality Assessment Performance Improvement (QAPI) program by reporting through the Patient Safety and Medication Safety Committees.



Software and Reports

Bluesight

- High reliability software that monitors and tracks all controlled substance medication activity from start to finish
- Alerts Nurse Managers to any variance related to the handling of a controlled substance
- Nurse Managers follow up with employees to investigate the situation and identify any potential diversion situations.

IRIS Scores

- IRIS (Individual Risk Identification Score)
- Proprietary Bluesight formula that provides a numerical risk score (risk for diversion) for all licensed staff
- Calculations based on waste network, full package returns, time from dispense to administration, etc.
- Nurse Managers and Directors jointly review scores and summarize the investigation in Bluesight.

Bluesight Optimization

What can we do to ensure we maximize Bluesight's potential?

- Develop expectations for leadership response times (who responds when Nurse Manager (NM)/Director are on vacation?)
- Publish guidance from HR on how to handle investigations when staff are on a Leave of Absence
- Seek guidance from Bluesight and other hospitals using this software on their use of an IRIS score
- Standardize process for resolving Bluesight discrepancies when they involve providers (namely Anesthesia)
- Provide 1:1 training to Nurse Managers and Directors on how to investigate (i.e.: first compare user score to hospital metrics then compare it to users in same work group)
- Develop practice guidelines to assist leaders in consistency amongst investigations and staff follow-up.

Diversions Prevention Committee (DPC) and IRIS Scores

IRIS Scores are reviewed and investigated at a local level by the Nurse Managers and Directors. Any investigations that reveal concern for diversion are escalated/reported immediately.

DPC's role in IRIS Score Reviews:

- a -Pharmacy team member enters a report when they notify user that has had a high IRIS score for more than two of last six months.
- DPC to review the MIDAS and corresponding investigations in Bluesight and make recommendations for corrective action.



Audit Review

- Following the Plan of Correction in May of 2021, a number of pharmacy audits were reviewed and reported through DPC for compliance monitoring. All audits achieved 100% compliance and have since been modified or dropped from our audit review.
- In an effort to provide safe patient care and full transparency, on-going reviews include:
 - Pharmacy team and Anesthesia Department Chair to review 10 short cases per month.
 - Anesthesia Department Chair reviews one case per provider per quarter. Approximately 60 Anesthesia providers are reviewed each quarter.
 - When the Anesthesia Department Chair's cases are reviewed, a different Anesthesia provider reviews his/her cases.
 - Concerns are notated in an Excel spreadsheet and follow up is tracked and completed by Pharmacy and the Anesthesia Department Chair.

District Knowledge and Awareness of Diversion Prevention

- Committee Members conduct 15 audits/quarter to determine staff’s understanding of diversion prevention. These results drive District-wide education. Next audits are due October 31st.

Date:					
Auditor’s Name:					
Role of Person Interviewed:					
<input type="checkbox"/> Ancillary Clinical Staff who do not have access to controlled substances (i.e., CNAs, therapies, RT)					
<input type="checkbox"/> Business/support staff that work outside clinical areas					
<input type="checkbox"/> Licensed staff who have access to controlled substances (i.e., RN, pharmacist, provider, GME resident)					
<input type="checkbox"/> Non-Clinical Staff who work in clinical areas (i.e., HUC, transporters)					
Questions (Ask four different Individuals these questions – record if staff is able to answer correctly with a Y/N).	Y/N	Y/N	Y/N	Y/N	Y/N
Describe drug diversion and provide at least two examples?					
Name three common behaviors you might see with suspicion of diversion activities that should raise a red flag.					
Who should you alert if you note used syringes in bathrooms, hallways, or offices? (mark “Y” if staff respond notify a supervisor or leader)					
What would you do if you suspect diversion with a team member?					

Adding anonymous compliance line as an appropriate means of reporting concerns based on staff feedback during audits!

District-wide Education

- Incorporated Diversion Prevention training into New Hire orientation and yearly Mandatory Annual Training (MAT) for all staff
- Developed education based on the knowledge gaps identified from quarterly audits of hospital staff
- Marketing created educational memes and these were introduced to Leadership Team for dissemination to staff
- Reminded leaders to be aware of the sensitive nature of this content when sharing with staff
- Developed diversion investigation flowchart and disseminated to Leadership Team for standardization and expectations

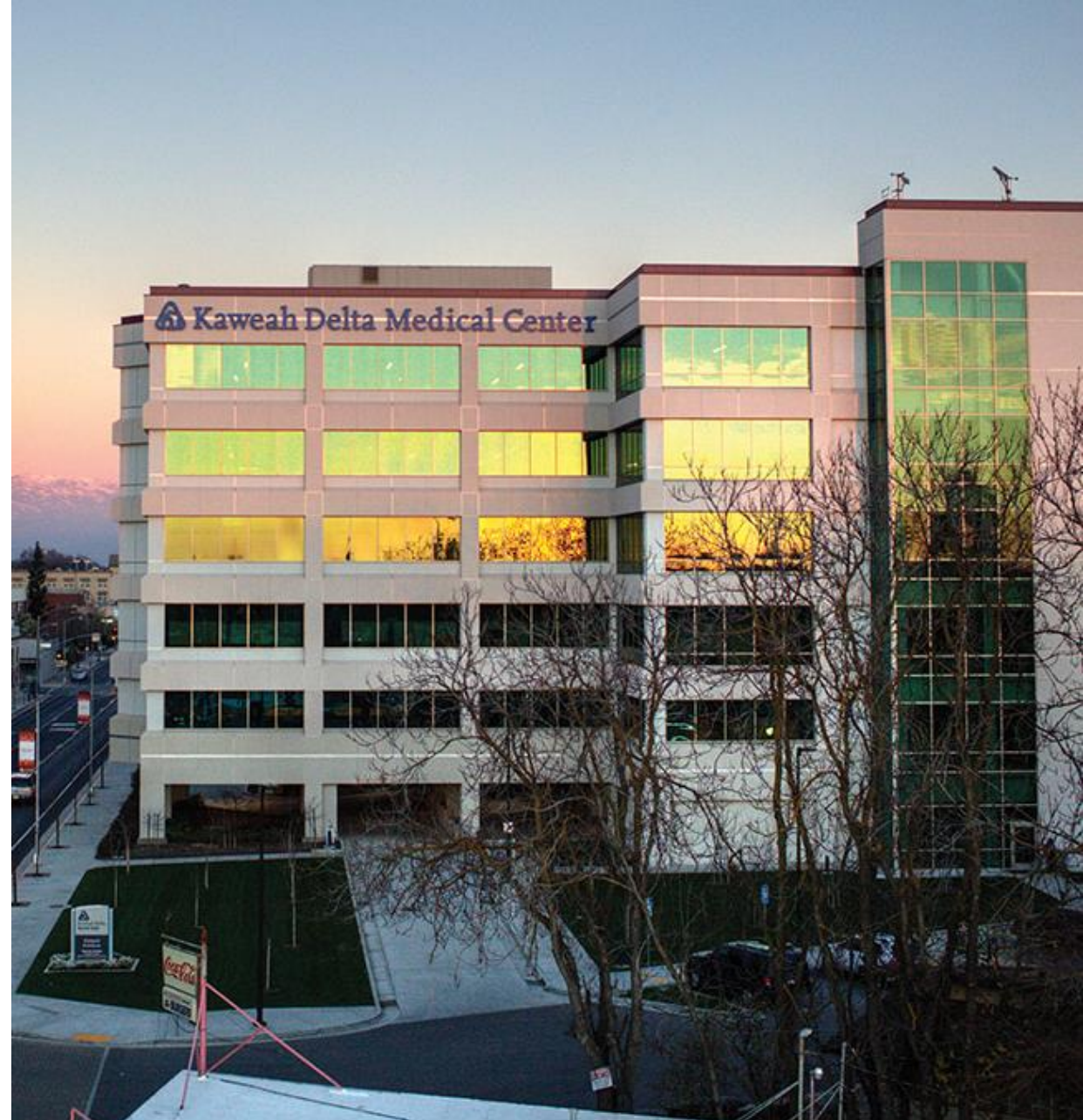


Next Steps

- Education
 - Develop “Lego Man” education based on knowledge gaps identified in quarterly audit



- On-going monitoring of Pharmacy audits
- Develop practice guidelines for leaders to streamline investigations and staff follow-up
- Continue to promote a culture of awareness and prevention



Live with passion.

Health is our passion. Excellence is our focus. Compassion is our promise.



Strategic Plan

Fiscal Year 2023

Presentation to the Board of Directors
September 28, 2022



[kaweahhealth.org](https://www.kaweahhealth.org)

Contents

- Overview of the Kaweah Health Strategy Structure and Plan Documents.....3
- Fiscal Year 2023 Strategic Plan Reporting Schedule.....6
- Fiscal Year 2023 Strategic Plan.....7
 - Strategic Plan Overview8
 - Detailed report for Patient and Community Experience.....15

Overview of Kaweah Health's Strategy Structure



Overview of Strategic Plan Documents

Kaweah Health Strategic Plan: Fiscal Year 2023

Our Mission

Health is our passion.
Excellence is our focus.
Compassion is our promise.

Our Vision

To be your world-class healthcare choice, for life.

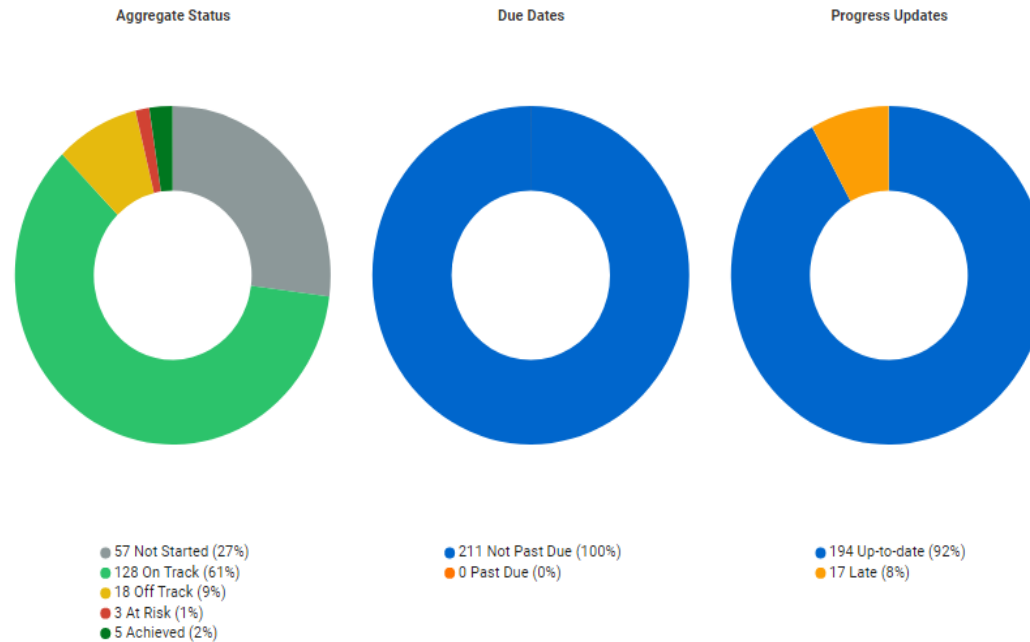
Our Pillars

Achieve outstanding community health.
Deliver excellent service.
Provide an ideal work environment.
Empower through education.
Maintain financial strength.

For a more detailed review of each individual Strategic Initiative use the hyperlinks below:

- [Empower Through Education](#)
- [Ideal Work Environment](#)
- [Strategic Growth and Innovation](#)
- [Organization Efficiency and Effectiveness](#)
- [Outstanding Health Outcomes](#)
- [Patient and Community Experience](#)

Kaweah Health Strategic Plan FY2023 Overview



Overview

- A one page overview of the Strategic Plan
- Includes the Mission, Vision, and Pillars
- The doughnut graph provides a visual of the overall performance across the six Strategic Initiatives:
 - Aggregate Status – Current status of all task items listed at the strategy, objective, and outcomes/metric level
 - Due Dates – items current and past due
 - Progress Updates – items that had timely updates or were late

Overview of Strategic Plan Documents

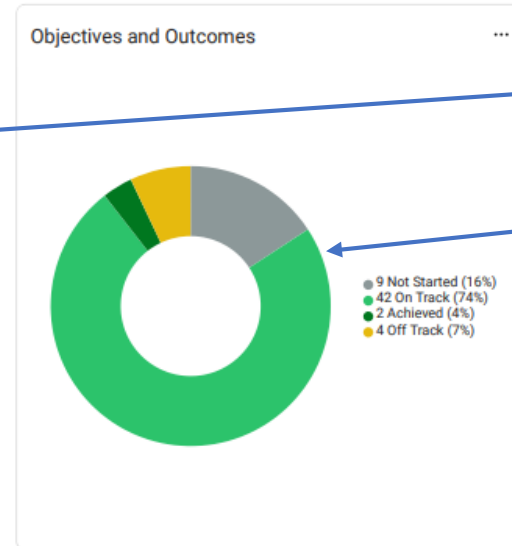
Initiative Summary

Strategic Growth and Innovation

Objective: *Grow intelligently by expanding existing services, adding new services, and serving new communities. Find new ways to do things to improve efficiency and effectiveness.*

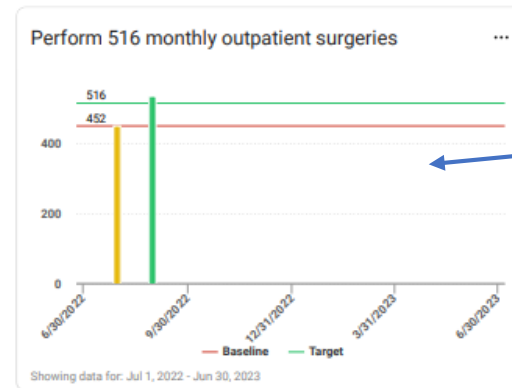
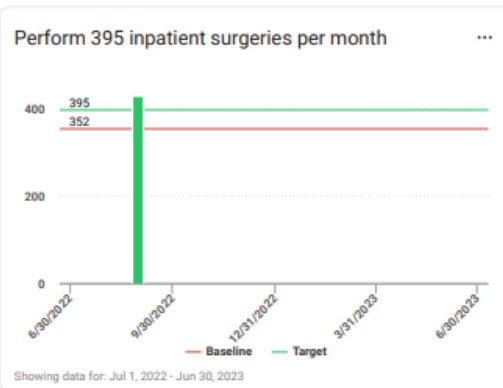
FY2023 Strategic Plan - Strategic Growth and Innovation Strategies

#	Name	Description	Status	Assigned To
3.1	Recruit and Retain Providers	Recruit and retain the best physicians and providers to address unmet community needs and to support Kaweah Health's growth.	On Track	JC Palermo
3.2	Grow Inpatient Volumes in our Primary Service Area	Grow our inpatient volumes, particularly the surgical cases, with an emphasis on key service lines and our expanded service area.	On Track	Marc Mertz
3.3	Grow Outpatient Volumes	Increase access to outpatient care in locations that are convenient to our community.	On Track	Ivan Jara
3.4	Modernize our Facilities	Update our facilities to create a better patient experience and to provide our employees and medical staff with a better work environment.	On Track	Marc Mertz
3.5	Improve Community Engagement	Continue and expand our efforts to engage our community so that we can better serve their health and wellness needs, and to gain the community's insights and support regarding our initiatives. Seek ways to expand our current reach and gain more widespread feedback and outreach	On Track	Marc Mertz
3.6	Innovation	Create, develop, and implement new processes, systems, or services, with the aim of improving efficiency, effectiveness, or competitive advantage	On Track	Marc Mertz
3.7	Expand Health Plan & Community Partnerships	Improve and strengthen relationships with health plans, community partners, and participate in local/state/federal programs and funding opportunities to improve access, quality, and outcomes for the community	On Track	Ivan Jara



Each of the six Strategic Initiatives has a 1 page summary of the objectives, strategies, and performance metrics.

- The table displays the Initiative's Strategies, description, status and responsible person.
- The graph illustrates a visual status of all Initiative's items (strategies, objectives, outcomes/metrics).
- Status:
 - Not Started – task start date is in the future
 - On Track – running within budget, timeline, result
 - Off Track – potential to derail, needs attention
 - At Risk – major barriers/issues, fallen behind, over budget
 - Achieved – met defined outcome/target
 - Not Achieved – did not meet defined outcome/target



- Includes the metrics dashboard to demonstrate performance. Dashboards are provided in chart or graph.
- For Initiatives with multiple outcomes metrics, 2-3 key metrics were selected to be displayed in the dashboard.

Strategic Initiative Board Reporting Schedule

STRATEGIC INITIATIVE	OWNERS	EXECUTIVE TEAM PRESENTATION	LEADERSHIP TEAM PRESENTATION	BOARD OF DIRECTORS PRESENTATION
Organizational Effectiveness and Efficiency -Overview	Jag Batth Kassie Waters	August 8	August 16	August 24
Patient and Community Experience - Overview	Keri Noeske Ed Largoza	September 12	September 20	September 28
Outstanding Health Outcomes - Overview	Doug Leeper Sonia Duran-Aguilar	October 10	October 18	October 26
Empower through Education – Overview	Lori Winston, MD Lacey Jensen	November 14	November 22	November 30
Ideal Work Environment - Overview	Dianne Cox Raleen Larez	December 12	December 20	December 28
Organizational Effectiveness and Efficiency – Performance Update	Jag Batth Kassie Waters	December 12	December 20	December 28
Strategic Growth and Innovation- Performance Update	Marc Mertz Ivan Jara	January 9	January 17	January 25
Patient and Community Experience- Performance Update	Keri Noeske Ed Largoza	January 9	January 17	January 25
Outstanding Health Outcomes- Performance Update	Doug Leeper Sonia Duran-Aguilar	February 13	February 21	February 22
Empower through Education – Performance Update	Lori Winston, MD Lacey Jensen	March 13	March 21	March 22
Ideal Work Environment – Performance Update	Dianne Cox Raleen Larez	April 10	April 18	April 26
Strategic Growth and Innovation – Performance Update	Marc Mertz Ivan Jara	May 8	May 16	May 24

FY23 Strategic Plan

Kaweah Health Strategic Plan: Fiscal Year 2023

Our Mission

Health is our passion.
 Excellence is our focus.
 Compassion is our promise.

Our Vision

To be your world-class healthcare choice, for life.

Our Pillars

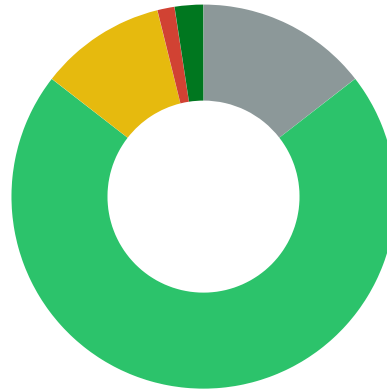
- Achieve outstanding community health.
- Deliver excellent service.
- Provide an ideal work environment.
- Empower through education.
- Maintain financial strength.

For a more detailed review of each individual Strategic Initiative use the hyperlinks below:

- [Empower Through Education](#)
- [Ideal Work Environment](#)
- [Strategic Growth and Innovation](#)
- [Organization Efficiency and Effectiveness](#)
- [Outstanding Health Outcomes](#)
- [Patient and Community Experience](#)

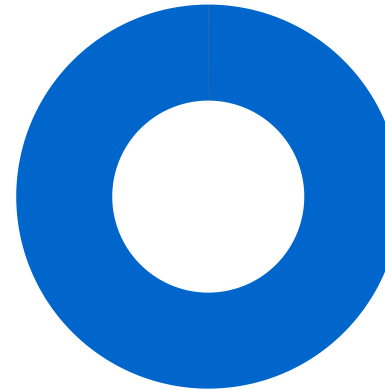
Kaweah Health Strategic Plan FY2023 Overview

Aggregate Status



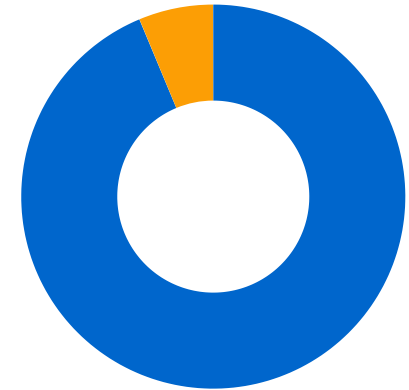
- 30 Not Started (14%)
- 147 On Track (71%)
- 22 Off Track (11%)
- 3 At Risk (1%)
- 5 Achieved (2%)

Due Dates



- 207 Not Past Due (100%)
- 0 Past Due (0%)

Progress Updates



- 194 Up-to-date (94%)
- 13 Late (6%)

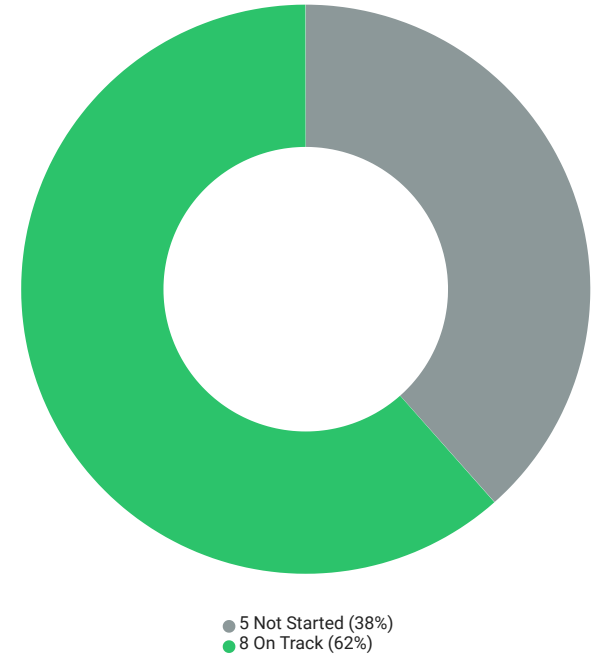
Empower Through Education

Objective: Implement initiatives to **develop the healthcare team** and **attract and retain** the very best talent in support of our mission.

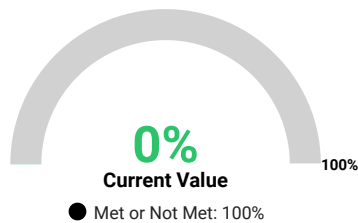
FY2023 Strategic Plan - Empower Through Education Strategies

#	Name	Description	Status	Assigned To
1.1	Expand Educational Offerings	Increase the expectations and participation of educational opportunities. Improve quality metrics through interdisciplinary educational opportunities.	On Track	Lacey Jensen
1.1.3	Lippincott solutions implemented and adopted	Increase the expectations and participation of educational opportunities. Improve quality metrics through interdisciplinary educational opportunities.	Not Started	Lacey Jensen
1.2	Improve Resiliency of the Kaweah Health Team	Increase caregiver support and promote wellness.	On Track	Dianne Cox
1.3	Increase and Improve Leadership Education	To increase the effectiveness of leadership, Kaweah Health will increase the number of mandatory and non-mandatory trainings, programs, and classes for leaders.	On Track	Lacey Jensen
1.4	Mentorship and Succession Planning	Develop consistent and sustainable succession planning and mentorship programs throughout Kaweah Health. Improve employee satisfaction through career ladder development.	On Track	Dianne Cox
1.5	Increase Nursing Cohort Seats	Kaweah Health has grown larger and faster than the local educational organizations. More opportunities, need expansion starting with RN seats in our local schools.	On Track	Dianne Cox
1.6	Expand GME	Take advantage of available resources to allow for growth. Partner with Sierra View to expand GME services.	On Track	Lori Winston

Objectives and Outcomes

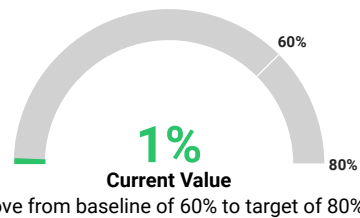


Launch Just Culture Certificate Program



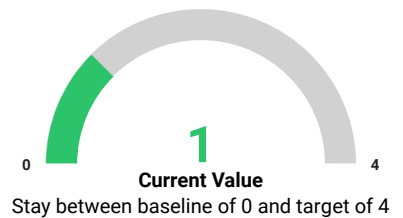
Last updated 09/23/2022
Showing data for: All Time

ACGME Faculty Development



Last updated 08/31/2022
Showing data for: All Time

Maintain quarterly Schwartz rounds



Last updated 09/23/2022
Showing data for: All Time

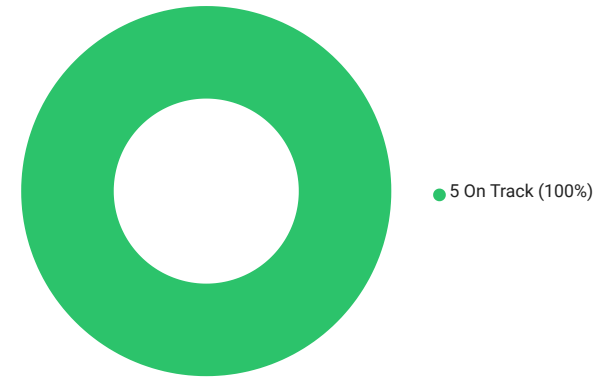
Ideal Work Environment

Objective: Foster and support healthy and desirable working environments for our Kaweah Health Teams

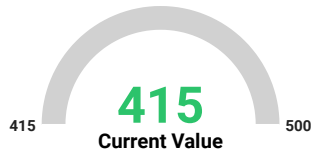
FY2023 Strategic Plan - Ideal Work Environment Strategies

#	Name	Description	Status	Assigned To
2.1	Employee Retention	Kaweah Health is facing the same challenges as many employers in the labor market and must make retention a top priority.	On Track	Dianne Cox
2.2	Kaweah Health Team Works Well Together	There is a need to continue to align the efforts of all Kaweah Health teams to ensure world class service.	On Track	Raleen Larez
2.3	Expand Volunteer Programs	Volunteer engagement has declined with the pandemic. Kaweah Health relies on a strong volunteer program to continue to spark career path engagement and to provide world class service.	On Track	Dianne Cox
2.4	Strategy pending evaluation of Lifecycle Work Environment Survey	TBD	Not Started	Dianne Cox

Objectives and Outcomes



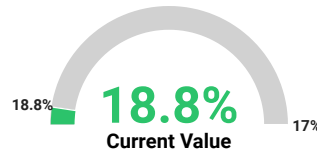
Expand Volunteer Programs



Move from baseline of 415 to target of 500

Last updated 09/22/2022
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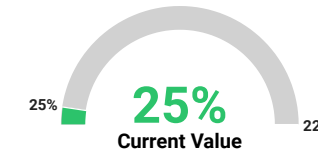
Decrease overall KH turnover rate



Move from baseline of 18.8% to target of 17%

Last updated 09/22/2022
Showing data for: All Time

Decrease nursing turnover rate



Move from baseline of 25% to target of 22%

Last updated 09/22/2022
Showing data for: All Time

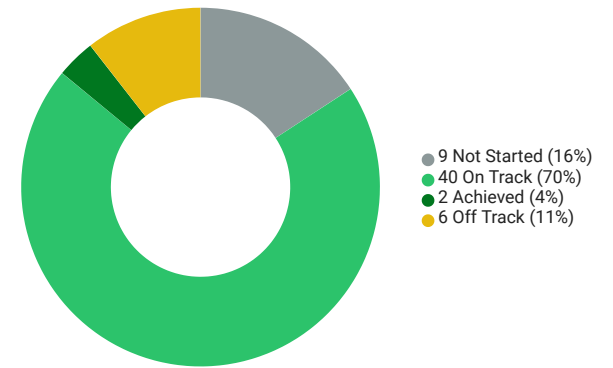
Strategic Growth and Innovation

Objective: Grow intelligently by expanding existing services, adding new services, and serving new communities. Find new ways to do things to **improve efficiency and effectiveness**.

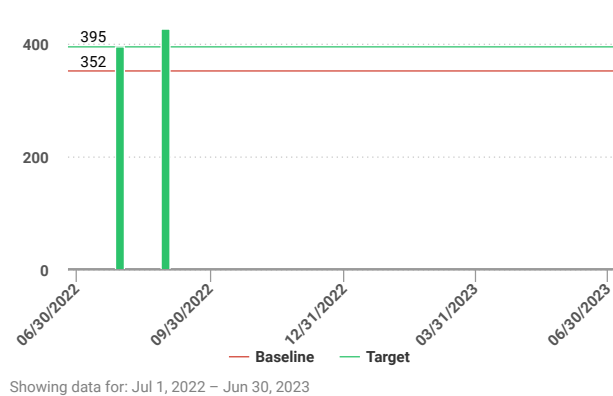
FY2023 Strategic Plan - Strategic Growth and Innovation Strategies

#	Name	Description	Status	Assigned To
3.1	Recruit and Retain Providers	Recruit and retain the best physicians and providers to address unmet community needs and to support Kaweah Health's growth.	Off Track	JC Palermo
3.2	Grow Inpatient Volumes in our Primary Service Area	Grow our inpatient volumes, particularly the surgical cases, with an emphasis on key service lines and our expanded service area.	On Track	Marc Mertz
3.3	Grow Outpatient Volumes	Increase access to outpatient care in locations that are convenient to our community.	Off Track	Ivan Jara
3.4	Modernize our Facilities	Update our facilities to create a better patient experience and to provide our employees and medical staff with a better work environment.	On Track	Marc Mertz
3.5	Improve Community Engagement	Continue and expand our efforts to engage our community so that we can better serve their health and wellness needs, and to gain the community's insights and support regarding our initiatives. Seek ways to expand our current reach and gain more widespread feedback and outreach	On Track	Marc Mertz
3.6	Innovation	Create, develop, and implement new processes, systems, or services, with the aim of improving efficiency, effectiveness, or competitive advantage	On Track	Marc Mertz
3.7	Expand Health Plan & Community Partnerships	Improve and strengthen relationships with health plans, community partners, and participate in local/state/federal programs and funding opportunities to improve access, quality, and outcomes for the community	On Track	Ivan Jara

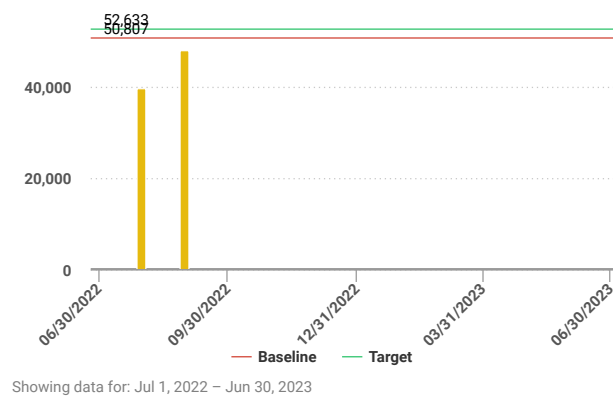
Objectives and Outcomes



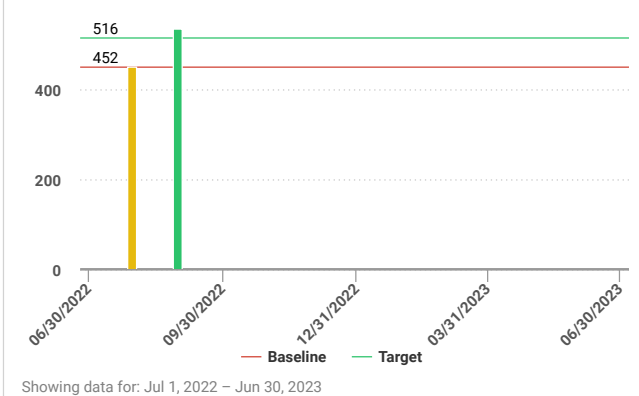
Perform 395 inpatient surgeries per month



See 52,633 ambulatory visits per month



Perform 516 monthly outpatient surgeries



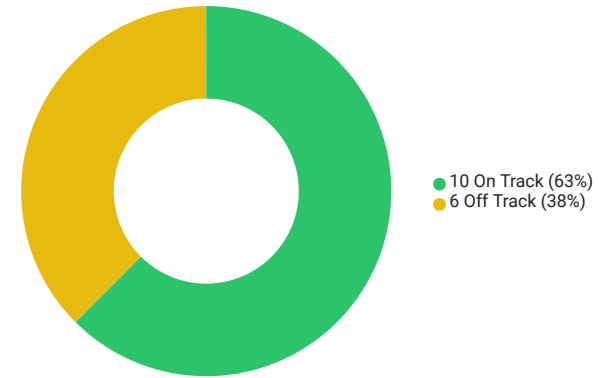
Organizational Efficiency and Effectiveness

Objective: Increase the efficiency and effectiveness of the Organization to reduce costs, lower length of stay and improve processes.

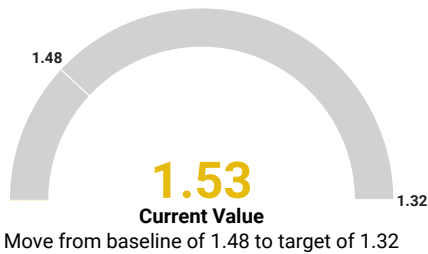
FY2023 Strategic Plan - Organization Efficiency and Effectiveness Strategies

#	Name	Description	Status	Assigned To
4.1	Patient Throughput and Length of Stay	Implement patient flow processes that are effective and efficient to improve patient throughput and lower the overall Length of Stay.	Off Track	Rebekah Foster
4.2	Operating Room Efficiency/Capacity	Improve Operating Room Efficiency, Capacity and Utilization to meet surgery volume needs.	On Track	Brian Piearcy
4.3	Supply Management and Standardization	Establish a process to identify revenue and cost savings opportunities across Kaweah Health.	On Track	Steve Bajari

Objectives and Outcomes

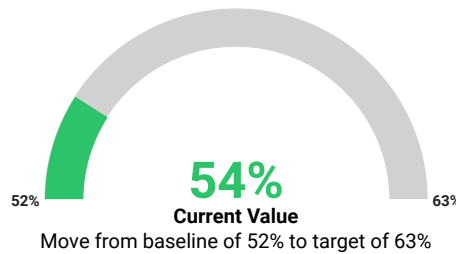


Inpatient Observed to Expected Length of Stay



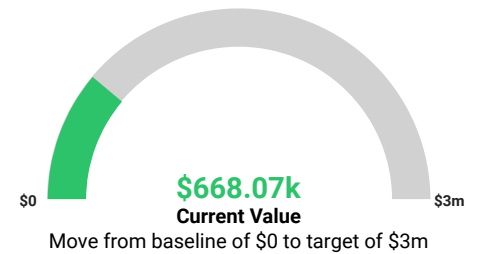
Last updated 08/31/2022
Showing data for: All Time

Overall OR Utilization



Last updated 08/31/2022
Showing data for: All Time

Identified Cost Savings and Revenue Opportunities



Last updated 08/31/2022
Showing data for: All Time

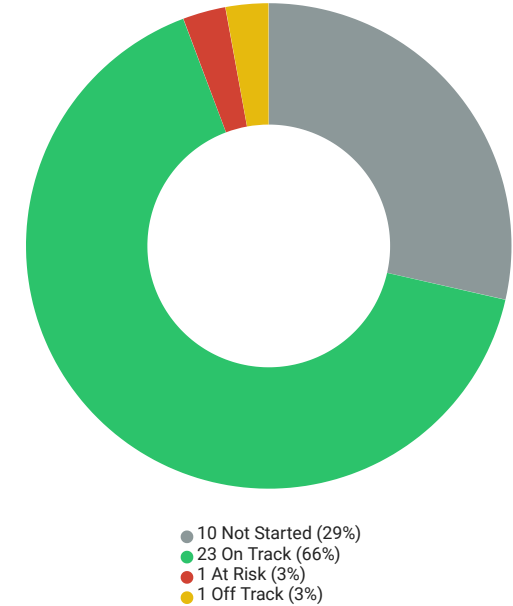
Outstanding Health Outcomes

Objective: To consistently *deliver high quality care* across the health care continuum.

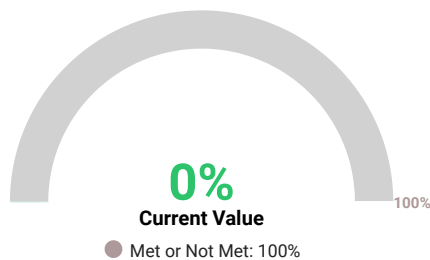
FY2023 Strategic Plan - Outstanding Health Outcomes Strategies

#	Name	Description	Status	Assigned To
5.1	Standardized Infection Ratio (SIR)	Over the next 3 years, achieve an "A" Leapfrog Safety Score and a CMS 5 Star Rating through the consistent application of best practices and innovative strategies.	On Track	Sandy Volchko
5.2	Sepsis Bundle Compliance (SEP-1)	Over the next 3 years, achieve an "A" Leapfrog Safety Score and a CMS 5 Star Rating through the consistent application of best practices and innovative strategies	On Track	Sandy Volchko
5.3	Mortality and Readmissions	Over the next 3 years, achieve an "A" Leapfrog Safety Score and a CMS 5 Star Rating through the consistent application of best practices and innovative strategies	On Track	Sandy Volchko
5.4	Team Round Implementation	Enhance coordination of care and culture among the health care team	On Track	Lori Winston
5.5	Quality Improvement Program (QIP) Reporting	Develop a comprehensive strategy to improve capture of quality data codes and improve QIP performance.	At Risk	Sonia Duran-Aguilar
5.6	HUMANA Medicare Advantage (MA)	Maintain a 4 STAR Medicare Advantage Rating and > 80% HCC reassessment/PAF visit completion rate for HUMANA MA Lives assigned to Kaweah Health Rural Health Clinics, SHWC and KHMG	On Track	Sonia Duran-Aguilar
5.7	Diabetes Management	Optimize inpatient glycemic management	On Track	Sonia Duran-Aguilar

Objectives and Outcomes

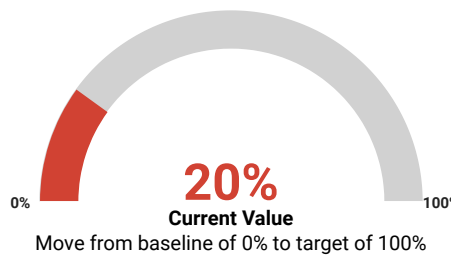


Roll out to Primary Care physician groups and Ac...



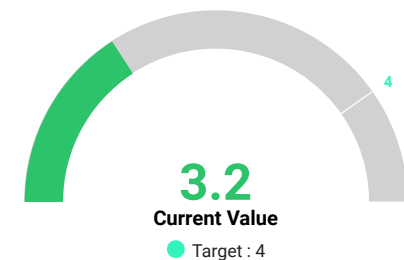
Last updated 08/31/2022
Showing data for: All Time

Meet QIP measure performance



Last updated 08/31/2022
Showing data for: All Time

Medicare Advantage STAR Rating for Humana live



Last updated 07/31/2022
Showing data for: All Time

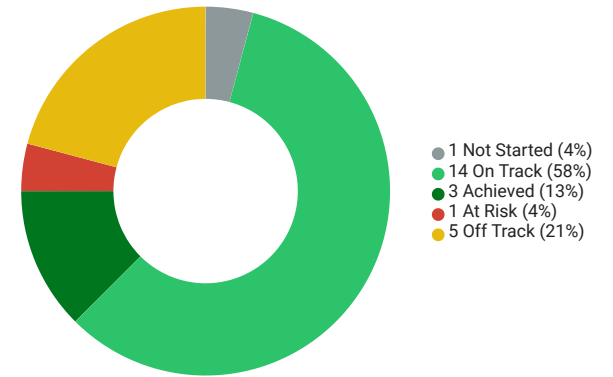
Patient and Community Experience

Objective: *Develop and implement strategies that provide our health care team the tools they need to deliver a world-class health care experience.*

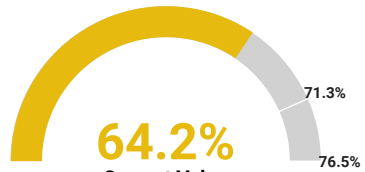
FY2023 Strategic Plan - Patient and Community Experience Strategies

#	Name	Description	Status	Assigned To
6.1	World-Class Service	Develop and implement strategies that provide our health care team the tools they need to deliver a world-class health care experience.	On Track	Ed Largoza
6.2	Physician Communication	Develop and implement strategies that provide our health care team the tools they need to deliver a world-class health care experience.	On Track	Ed Largoza
6.3	Nursing Communication	Develop and implement strategies that provide our health care team the tools they need to deliver a world-class health care experience.	Off Track	Keri Noeske
6.4	Enhancement of Systems and Environment	Develop and implement strategies that provide our health care team the tools they need to deliver a world-class health care experience.	On Track	Ed Largoza

Objectives and Outcomes



Achieve Overall Rating Goal on HCAHPS Survey



Move from baseline of 71.3% to target of 76.5%

Last updated 08/31/2022
Showing data for: All Time

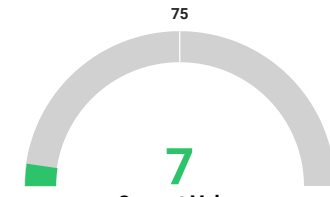
Achieve Patient Feedback Score Goal on ED Survey



Move from baseline of 3.6 to target of 4

Last updated 08/31/2022
Showing data for: All Time

Decrease lost belongings by 25%



Stay below target of 75

Last updated 08/31/2022
Showing data for: All Time

FY23 Patient and Community Experience

Patient and Community Experience: World-Class Service Champion: Ed Largoza

Problem / Goals & Objectives

Problem Statement:

Employees throughout the organization have a different definition of "World-Class".

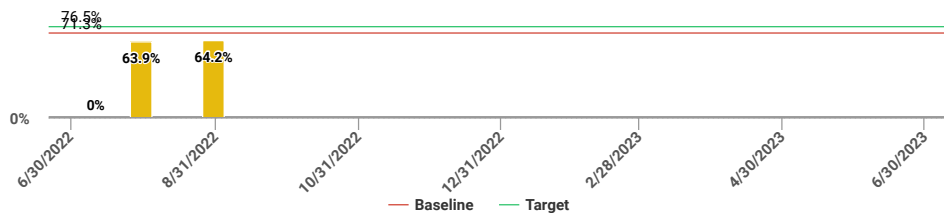
Goals and Objectives:

Develop strategics that provide our health care team the tools they need to deliver a world-class health care experience.

Plan

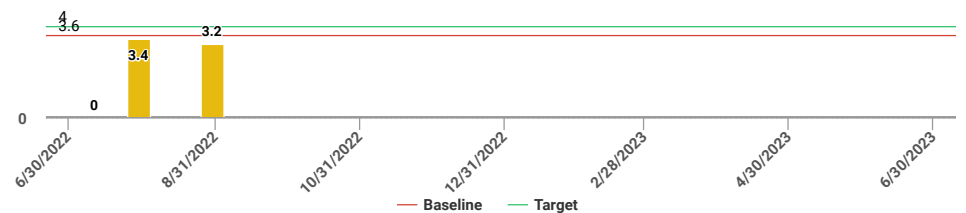
#	Name	Start Date	Due Date	Assigned To	Status	Last Comment
6.1.1	Provide trainings & tools to team members on how to deliver world-class service.	7/1/2022	6/30/2023	Ed Largoza	On Track	Provided trainings to leaders on new patient experience reporting tool for hospital, clinics, KHMG, home health, hospice, rehab, and outpatient surgery. Recordings for NRC's Annual Symposium: Human Understanding and Huron's conference on What's Right in Health Care made available to operational leaders.
6.1.2	Enhance patient navigation across the health care continuum.	7/1/2022	6/30/2023	Ed Largoza	On Track	WELL APP (appointment reminder/text platform) to launch in September. SINGLECOMM (phone system) Phase 1 go live in September. VALER (referrals management/authorization system) Phase 1 go live in November/December. Referrals/Orders Workflow Redesign - September pilot of scheduling ultrasounds at Rural Health Clinics before patient leaves the appointment. BENCHMARK PORTAL (customer service training program) completed by end of the year.
6.1.3	Relaunch a Patient & Family Advisory Council.	7/1/2022	6/30/2023	Ed Largoza	On Track	Reviewing Patient & Family Advisory Council (PFAC) applicants with orientation planned for October. Targeted relaunch of the council in November.
6.1.4	Achieve Overall Rating Goal on HCAHPS Survey	7/1/2022	6/30/2023	Ed Largoza	Off Track	August data not finalized. 67 surveys returned so far. NRC Key Drivers: 1) Communication with Nurses 2) Communication with Doctors 3) Care Transitions Comments from patients giving <9 or 10: A) Long waits in ED B) Noise C) Frequency of cleaning rooms 2 Units - Above Goal (76.5%). 1 Unit - Above CMS 50th Percentile (72%). 6 Units - Below CMS 50th percentile (72%).
6.1.5	Achieve Patient Feedback Score Goal on ED Survey	7/1/2022	6/30/2023	Ed Largoza	Off Track	531 Surveys. Trends in negative comments 1) Long Wait Times 2) Lack of Response C) Lack of Compassion

Achieve Overall Rating Goal on HCAHPS Survey (Goal 76.5%)



Showing data for: Jul 1, 2022 - Jun 30, 2023

Achieve Patient Feedback Score Goal on ED Survey (Goal 4)



Showing data for: Jul 1, 2022 - Jun 30, 2023

Patient and Community Experience: Physician Communication

Champions: Dr. Carstens and Ed Largoza

Problem / Goals & Objectives

Problem Statement:

Based on Patient Experience Score and feedback from healthcare team, improvement is needed in physician communication with patients and family.

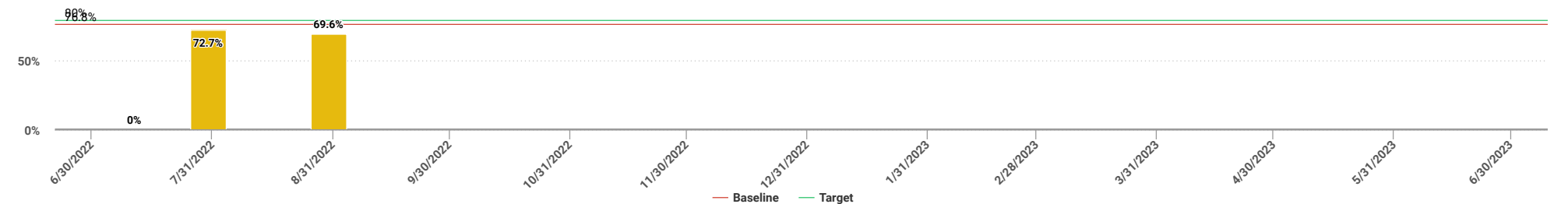
Goals and Objectives:

To reach the 50th percentile in physician communication on HCAHPS survey. Provide team members tools and processes to improve communication with patients and family.

Plan

#	Name	Start Date	Due Date	Assigned To	Status	Last Comment
6.2.1	Implement Patient Experience Scripting course to enhance provider communication	7/1/2022	6/30/2023	Ed Largoza	On Track	Partnered with Dr. Van Dyk, Dr. Sukhija, Dr. Carstens and hospitalists Dr. Tedaldi and Dr. Gunde to tailor training for inpatient physicians. Evaluating course materials to provide to other physician groups.
6.2.2	Provide training on enhancing provider communication with patients	7/1/2022	6/30/2023	Ed Largoza	Achieved	Duplicate of the work done with scripting physician communication
6.2.3	Give direct coaching for providers performing under expectations in doctor communication.	7/1/2022	6/30/2023	Ed Largoza	On Track	Established routine meetings with hospitalists leaders. Developed improvement plans for physician >6% under 50th percentile. Plans to launch in September & October. Will evaluate results in November & December for improvements.
6.2.4	Pilot 'Sit for a bit' program to encourage providers to get eye-level with patients and establish a positive rapport.	7/1/2022	6/30/2023	Ed Largoza	On Track	Focus on training and performance improvement. Will target launching this initiative in 2023.
6.2.5	Achieve the 50th percentile on physician communication scores	7/1/2022	6/30/2023	Ed Largoza	Off Track	August data not finalized. 65 surveys so far. Physician Communication measures how often doctors 1) Treated patients with courtesy & respect 2) Listened carefully to patients 3) Explained things in ways patients could understand

Achieve the 50th percentile on physician communication scores (Goal 80%)



Showing data for: Jul 1, 2022 - Jun 30, 2023

Patient and Community Experience: Nursing Communication Champion: Keri Noeske

Problem / Goals & Objectives

Problem Statement:

Based on Patient Experience Score and feedback from healthcare team, improvement is needed in nursing communication with patients and family.

Goals and Objectives:

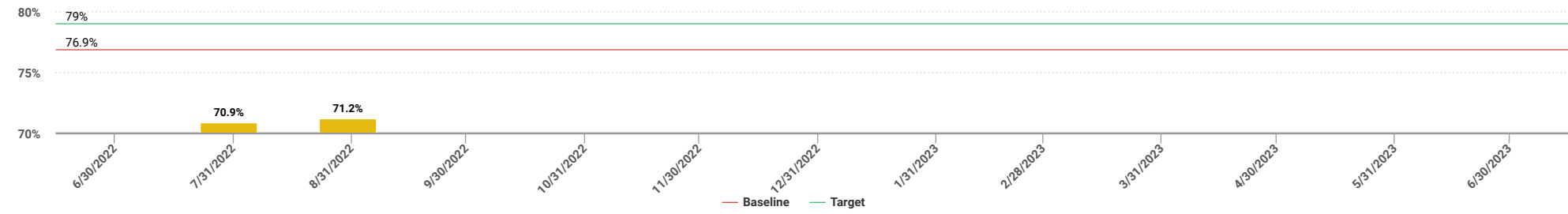
To reach the 50th percentile in nursing communication on HCAHPS survey. Provide team members tools and processes to improve communication with patients and family.

Plan

#	Name	Start Date	Due Date	Assigned To	Status	Last Comment
6.3.1	Develop an expectation for use of best practices	7/1/2022	6/30/2023	Keri Noeske	Not Started	
6.3.2	Enhance Leader Rounding on Patients	7/1/2022	6/30/2023	Keri Noeske	At Risk	Department leaders have not yet fully adopted and integrated leader rounding at a high enough volume for impactful changes with this strategy. As other strategic initiatives are reached, this action item will become more attainable. Will also explore alternatives to leader rounding for impact.
6.3.3	Continue Use of Communication Whiteboards	7/1/2022	6/30/2023	Keri Noeske	Achieved	Whiteboard use has been implemented throughout HCAHP inpatient care units. Expectation is established, initial compliance audits demonstrated use. Ongoing monitoring and interventions to keep use on track integrated into leadership workflow.
6.3.4	Review and planning for development of communications skills to include narrating the care, handling conflicts and consistency in communications	7/1/2022	6/30/2023	Keri Noeske	On Track	Managers will provide scenarios, perspective and tools via staff meetings, huddles and employee rounding. Team members will have integration of these skills throughout the year to improve nurse to patient communication.
6.3.5	Bedside Rounds – Health Care Team	7/1/2022	6/30/2023	Keri Noeske	On Track	Ongoing, rolled out on all inpatient care M/S units. Continue to observe, provide feedback and help with barriers and struggles in the different areas. Identify fallouts to use of the technique and coach/mentor nursing and providers in improving the process.
6.3.6	Employee Rounds – 1:1 Leader with Employee	7/1/2022	6/30/2023	Keri Noeske	On Track	All nursing leaders provide 1:1 meetings with team members, at all levels. These are ongoing. Directors are doing more 1:1 meetings with frontline team members. Executive attending staff meetings and shift huddles for communications too.
6.3.7	Role Specific Training – Back to Basics	7/1/2022	6/30/2023	Keri Noeske	Off Track	Need to develop the back to basics approach to integrate into routine communications at the department level. Then roll out via staff meetings, huddles, 1:1 meetings and as general ongoing expectation.
6.3.8	Achieve the 50th percentile on nursing communication scores	7/1/2022	6/30/2023	Ed Largoza	Off Track	August data not finalized. 66 surveys so far. Nurse Communication measures how often nurses 1) Treated patients with courtesy & respect 2) Listened carefully to patients 3) Explained things in ways patients could understand

Patient and Community Experience: Nursing Communication Champion: Keri Noeske

Achieve the 50th percentile on nursing communication scores (Goal 79%)



Showing data for: Jul 1, 2022 - Jun 30, 2023

Patient and Community Experience: Enhancement of Systems and Environment Champion: Ed Largoza

Problem / Goals & Objectives

Problem Statement:

Opportunity to incorporate more technology into workflows around patient access and communication.

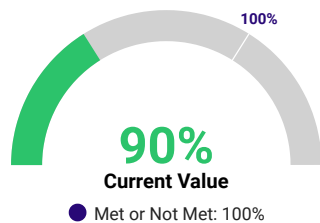
Goals and Objectives:

Explore and implement software solutions to enhance ability to communicate with patients (i.e.: add appointment reminder texting, improve access to patient records, and education).

Plan

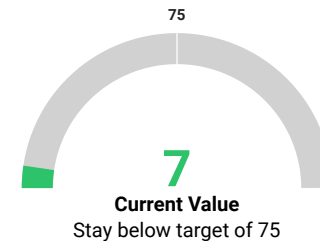
#	Name	Start Date	Due Date	Assigned To	Status	Last Comment
6.4.1	EMR/Technology enhancements	7/1/2022	6/30/2023	Ed Largoza	On Track	Updated Patient Portal for increased functionality: update health information, review lab results & discharge summaries, request medication refills, message provider, and update contact & insurance information. AMWELL (new telehealth platform) go live in first have of 2023.
6.4.2	Improve internal & external wayfinding	7/1/2022	6/30/2023	Ed Largoza	On Track	Update of interior signs to be completed in October. Use of QR codes to increase access to wayfinding maps in October/November. Evaluating parking lot signage for external wayfinding. Planning to bring for ET review and feedback in October/November.
6.4.3	Improve environment	7/1/2022	6/30/2023	Ed Largoza	On Track	Added internal trash receptacles to the downtown campus. External trash cans to be added by November. Refurbishing Ambrosia Cafe. Creating green space for visitors. Replacement of porte cochere bulbs for more energy efficient and brighter.
6.4.4	Comfort cart	7/1/2022	6/30/2023	Ed Largoza	Achieved	Comfort cart implemented - ongoing partnership with volunteer services to staff cart.
6.4.5	Implement Well Health	7/1/2022	6/30/2023	Ed Largoza	On Track	Phase 1 launch on 9/27/22
6.4.6	Decrease lost belongings by 25%	7/1/2022	6/30/2023	Ed Largoza	On Track	Will reconvene stakeholders as fallouts continue to occur. Need to reinforce process of proper labeling, documenting, and storing of belongings. Update to electronic documentation coming by the end of November.

Implement Well Health (as of 8/31/22)



Last updated 8/31/2022
Showing data for: All Time

Decrease lost belongings by 25% (as of 8/31/22)



Last updated 8/31/2022
Showing data for: All Time

Throughput/LOS

September 2022 Board Update



[kawahhealth.org](https://www.kawahhealth.org)

Patient Progression

Monthly Accomplishments:

- Case Manager Assistants hired and present on all floors. Optimizing daily workflow to incorporate them into discharge planning.
- Moved CM staff to weekdays with reduced coverage. Implementing remote access for CM staff to increase coverage again on the weekends with per diem staff.

Critical Issues/Barriers:

- Staffing challenges
- Alignment of staff incentives and organizational goals
- Delays with consults and follow-up for medical decision making by attending providers.

Transfer Center Operations

Monthly Accomplishments:

- Education to specialist/on-call providers on accepting transfers by medical director. Monitoring acceptance rate for improvement.

Critical Issues/Barriers:

- Increased inpatient census challenges ability to provide inpatient bed to transfer patients timely.
- On-call physician or surgeon declining cases without reviewing

Emergency Department (ED) to Inpatient Admission Process

Monthly Accomplishments:

- Implementation of staffing by demand matrix for the ED RNs started on 6/12/2022
- Initiated RN:RN hand-off, mitigating delays (sent to Clin ED for essential info flier for implementation)
- ED launch point auto update with bed status with Cap-man go live

Critical Issues/Barriers:

- Staffing limitations: nursing, case management, ancillary areas – slows down patient care
- Changing patient acuity and COVID patient volume
- Discrepancies between admission criteria between ED and inpatient providers – delays decisions for admission
- Alignment of staff incentives and organizational goals

ED Care Model Redesign

Monthly Accomplishments:

- Weekly meetings to evaluate workflows. Spaghetti diagrams to streamline workflows. Committee members engagement: Providers, Nursing leadership, Frontline staff
- Definition of internal and external surge volumes – identification of resources and plans to address
- Onboarding of LVN team members to support volume and workflow.
- Resumed use of Zone 6 for low acuity ED patient volume – goal of 90 minutes turnaround time,

Critical Issues/Barriers:

- Staffing limitations – hiring and onboarding will take time to have full team
- Changing acuity and surge of patients – operations have to adjust with these changes
- Delivery of education to team members on flow changes with competing priorities.

Long Stay Committee

Monthly Accomplishments:

- Shifted to reviewing 1-5 days over LOS along with touch base on complex team patients.
- Every 4th Tuesday review top 10 Long LOS cases and review last month top 10 for any barrier workflows that could be addressed and changed for next time.
- Subcommittee created to address barriers due to consults. First meeting was 9/13/22.

Critical Issues/Barriers:

- Addressing consult barriers in patient throughput.
- Poor understanding of determinations of patient capacity – need for education of medical staff, nursing and case management.

Patient Placement

Monthly Accomplishments:

- Finalize patient placement matrix & communicated plan to all stakeholders
- Implemented phase 1 of patient placement matrix (by diagnosis)

Critical Issues/Barriers:

- Alignment with Cerner Capacity Manager implementation
- Optimize outpatient service line
- Continued high volume and demand for inpatient beds – limits ability to implement phases 2 and 3

Observation Program

Monthly Accomplishments:

- Work will officially begin on this effort in October.
- Observation unit primary focus on 2S will initiate on October 3.

Critical Issues/Barriers:

- This work will begin once the COVID+ patient census declines and stabilizes; properly cohorting patients in this environment is exceedingly difficult.

Draft Performance Scorecard

Leading Performance Metrics – Inpatient & Observation

Metric	Patient Type	Definition	Goal	Current Performance Compared to Baseline					
				Jan - Nov '21 Baseline (Monthly Average or Median)	Apr '22	May '22	Jun '22	Jul '22	Aug '22
Observation Average Length of Stay (Obs ALOS) <i>(Lower is better)</i>	Overall	Average length of stay (hours) for observation patients	37.9	44.01	56.41	49.35	50.43	52.05	65.65
Inpatient Average Length of Stay (IP ALOS) <i>(Lower is better)</i>	Overall		5.64	6.31	5.87	6.01	6.18	6.03	5.89
	Non-COVID	Average length of stay (days) for inpatient discharges	N/A	5.62	5.74	5.71	5.67	5.75	5.59
	COVID		N/A	10.63	15.33	17.60	13.47	7.94	8.93
Inpatient Observed-to-Expected Length of Stay <i>(Lower is better)</i>	Overall	Observed LOS / geometric mean length of stay for inpatient discharges	1.32	1.48	1.48	1.56	1.58	1.53	1.53
% of Discharges Before 12 PM <i>(Higher is better)</i>	Overall	% of inpatients discharged before 12 PM	35%	11.5%	11.4%	13.6%	12.4%	13.0%	13.0%
Surgical Backfill Volume <i>(Higher is better)</i>	Overall	Incremental inpatient elective surgical cases over baseline; pending established baseline	TBD	TBD	TBD	TBD	TBD	TBD	TBD
Discharges	Overall	Count of IP & observation discharges	N/A	1,768	1,685	1,709	1,679	1,651	1,731
	Inpatient-Non-COVID	Count of non-COVID IP discharges	N/A	1,264	1,291	1,317	1,252	1,141	1,204
	Inpatient-COVID	Count of COVID IP discharges	N/A	197	18	35	87	170	120
	Observation	Count of observation discharges	N/A	307	376	357	340	340	407

*O/E LOS to be updated to include cases with missing DRG when available

Source: Encounter Data Excludes: Mother/Baby, Behavioral Health, and Pediatrics

Draft Performance Scorecard

Leading Performance Metrics – Emergency Department

Metric	Patient Type	Definition	Goal	Current Performance Compared to Baseline					
				Jan - Nov '21 Baseline (Monthly Average or Median)	Apr '22	May '22	Jun '22	Jul '22	Aug '22
ED Boarding Time <i>(Lower is better)</i>	Overall	Median time (minutes) for admission order written to check out for inpatients and observation patients	286	336	332	399	458	443	462
	Inpatients	Median time (minutes) for admission order written to check out for admitted patients	287	338	330	397	452	437	451
	Observation Patients	Median time (minutes) for admission order written to check out for observation patients	259	304	416	520	602	705	620
ED Admit Hold Volume <i>(Lower is better)</i>	Overall >4 Hours	Count of patients (volume) with ED boarding time \geq 4 hours	N/A	640	727	771	804	772	774
ED Average Length of Stay (ED ALOS) <i>(Lower is better)</i>	Overall	Median ED length of stay (minutes) for admitted and discharged patients	N/A	347	357	372	378	364	361
	Discharged Patients	Median ED length of stay (minutes) for discharged patients	214	268	277	294	300	299	290
	Inpatients	Median ED length of stay (minutes) for admitted inpatients	612	720	704	826	916	864	911
	Observation Patients	Median ED length of stay (minutes) for observation patients	577	679	801	1,086	1,164	1,079	1,085
ED Visits	Overall	Count of ED visits	N/A	5,596	5,578	5,930	6,124	6,388	6,492
	Discharged	Count of ED visits for discharged patients	N/A	3,998	4,056	4,356	4,585	4,842	4,936
	Inpatients	Count of ED Visits for admitted patients	N/A	1,216	1,138	1,212	1,164	1,180	1,141
	Observation Patients	Count of ED Visits for observation patients	N/A	380	384	362	375	366	415

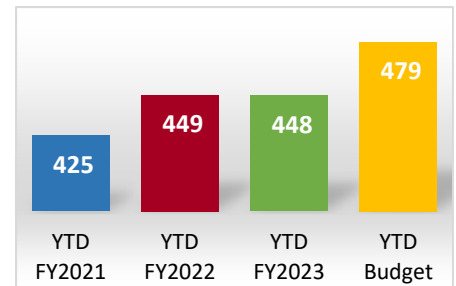
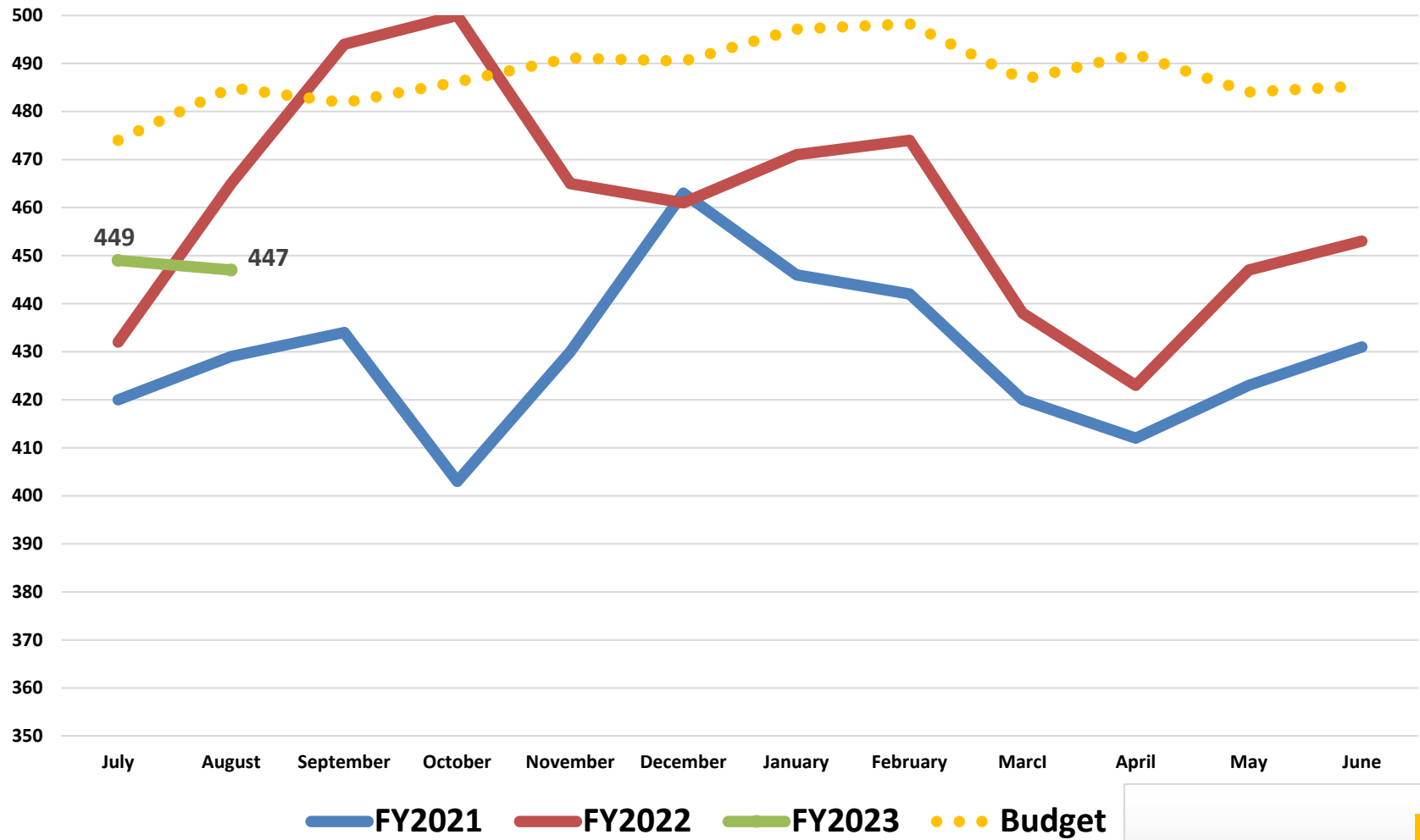
*Previous month to be updated for admitted patients to align with exclusion criteria

Source: ED Encounter Data Excludes: Mother/Baby, Behavioral Health, and Pediatrics

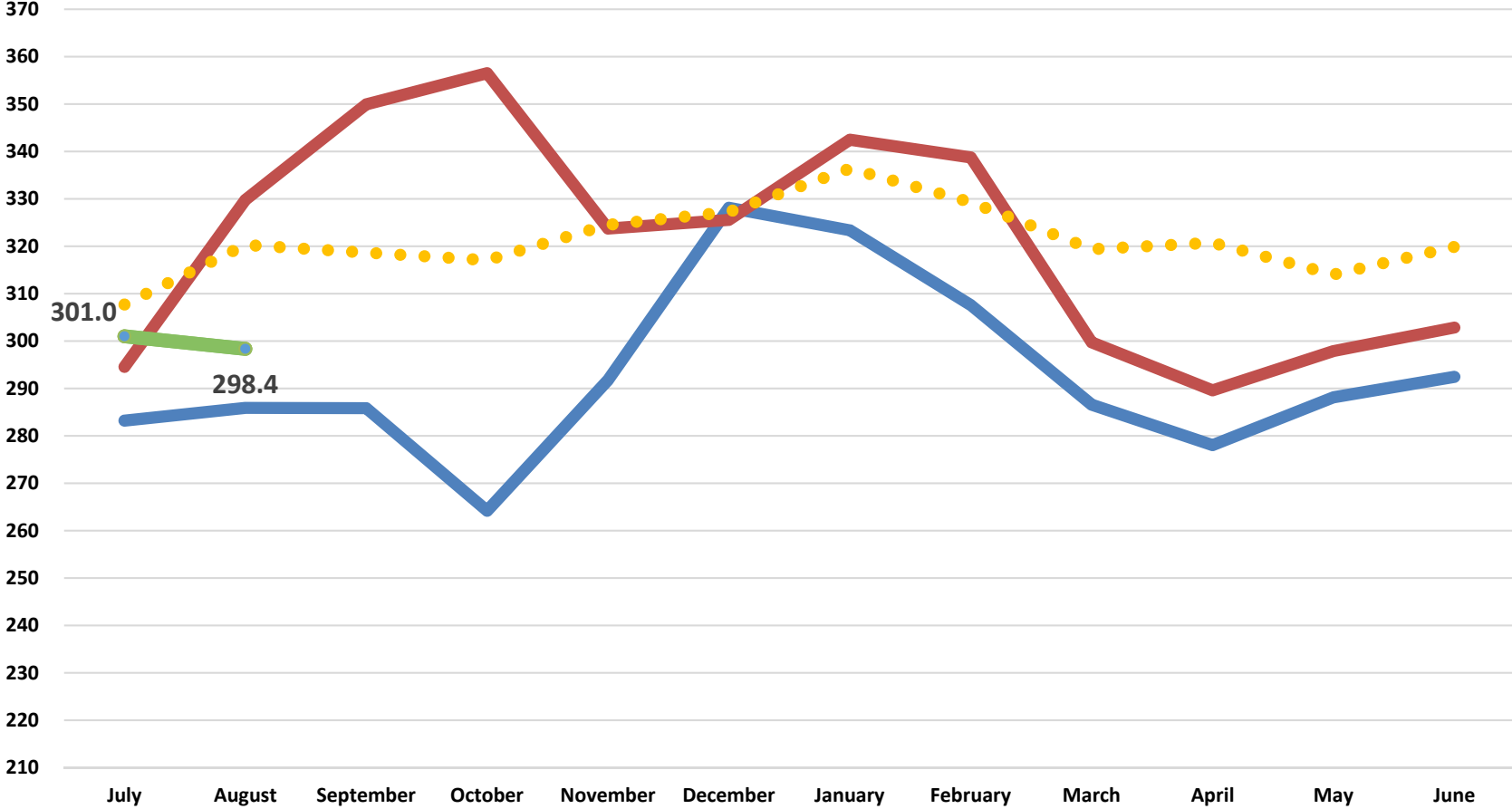
CFO Financial Report

Month Ending August 2022

Average Daily Census



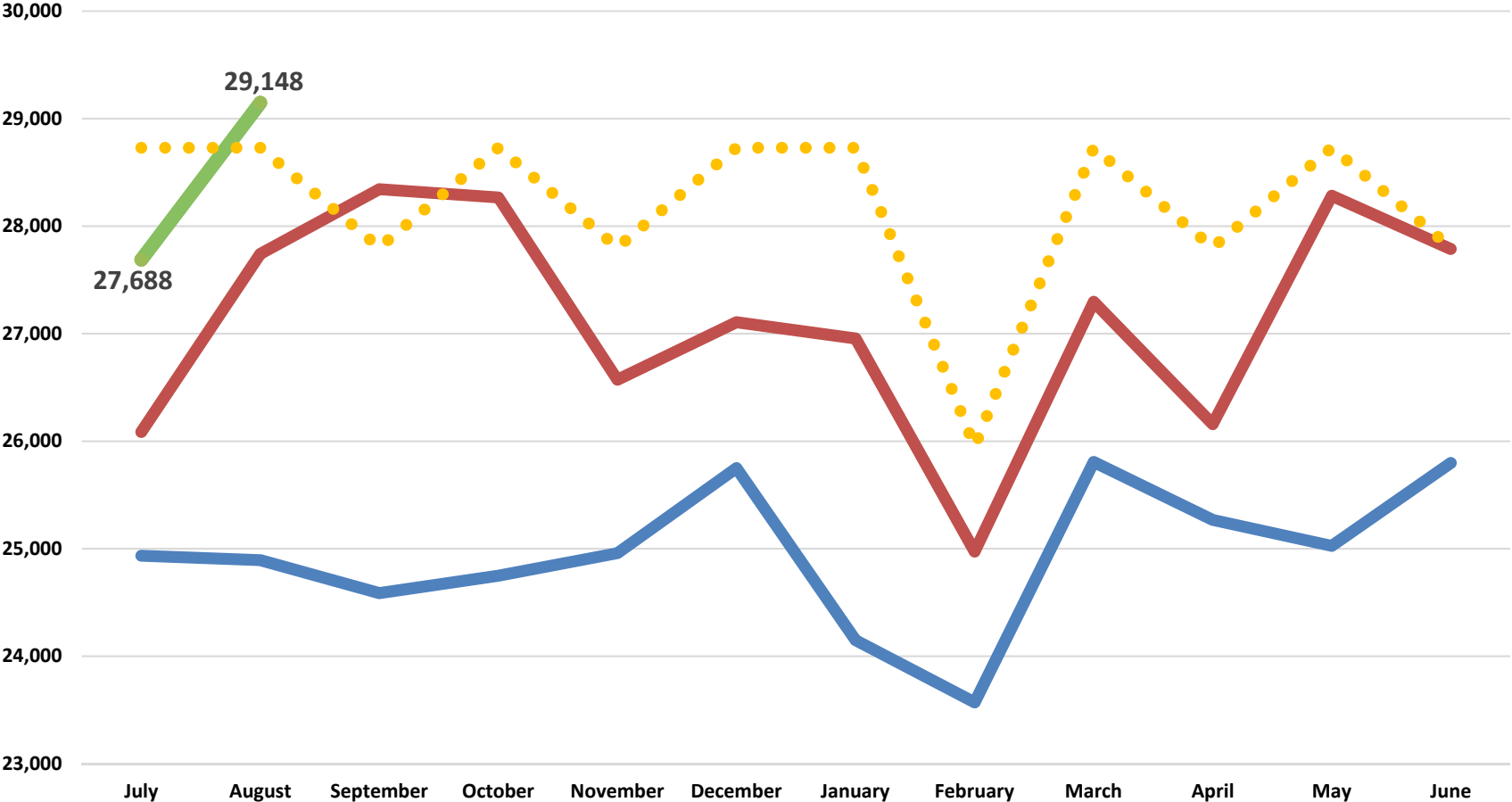
Medical Center – Avg. Patients Per Day



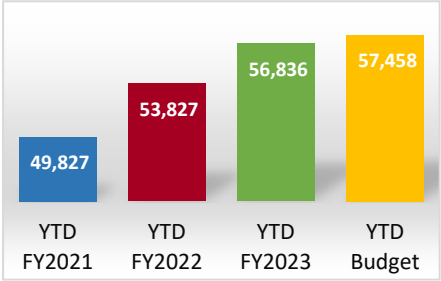
—●— **FY2021**
 —●— **FY2022**
 —●— **FY2023**
 ●●● **Budget**

284.6	312.2	299.7	314.0
YTD FY2021	YTD FY2022	YTD FY2023	YTD Budget

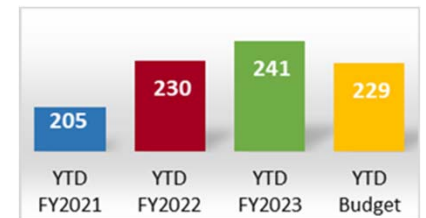
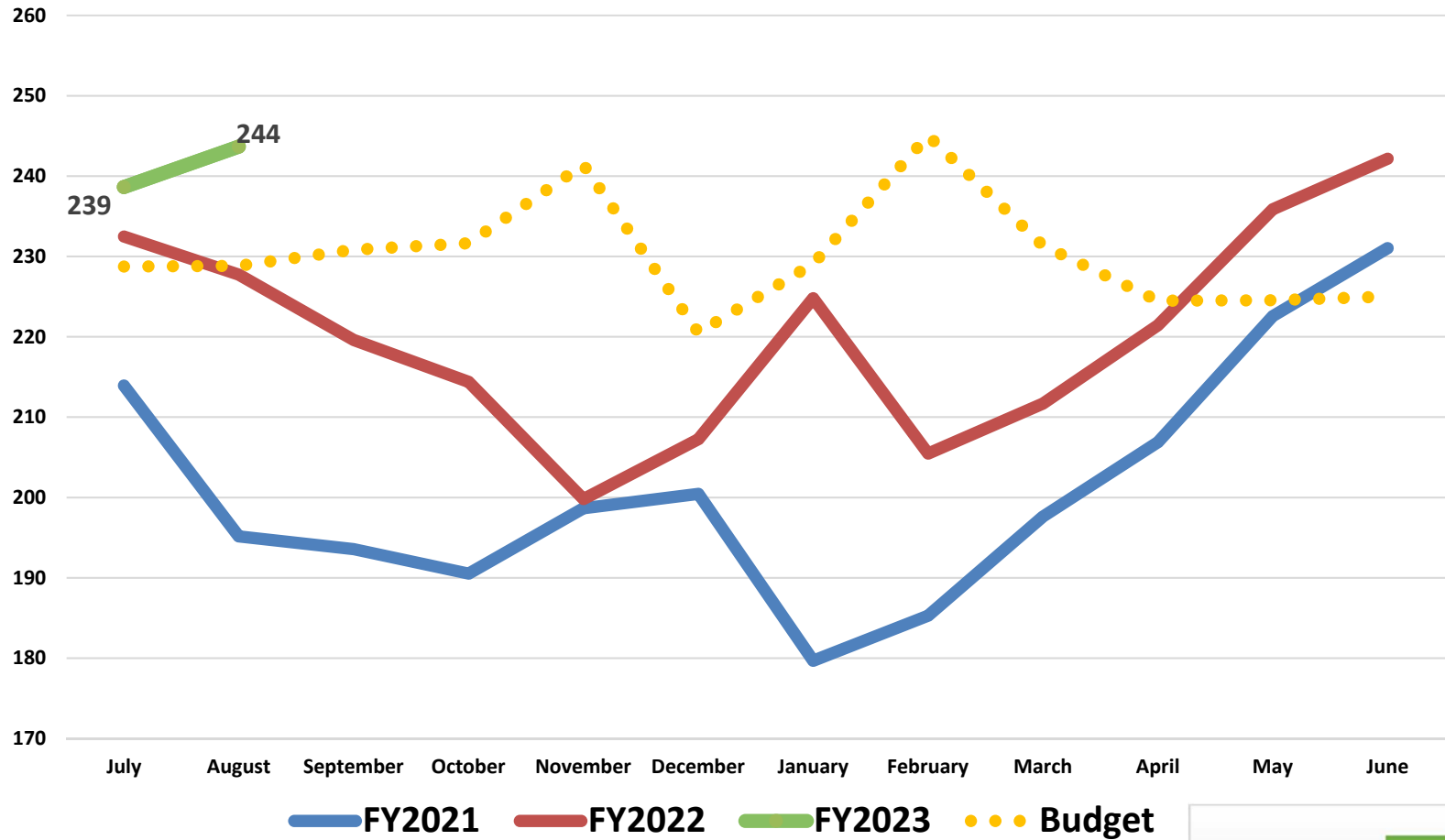
Adjusted Patient Days



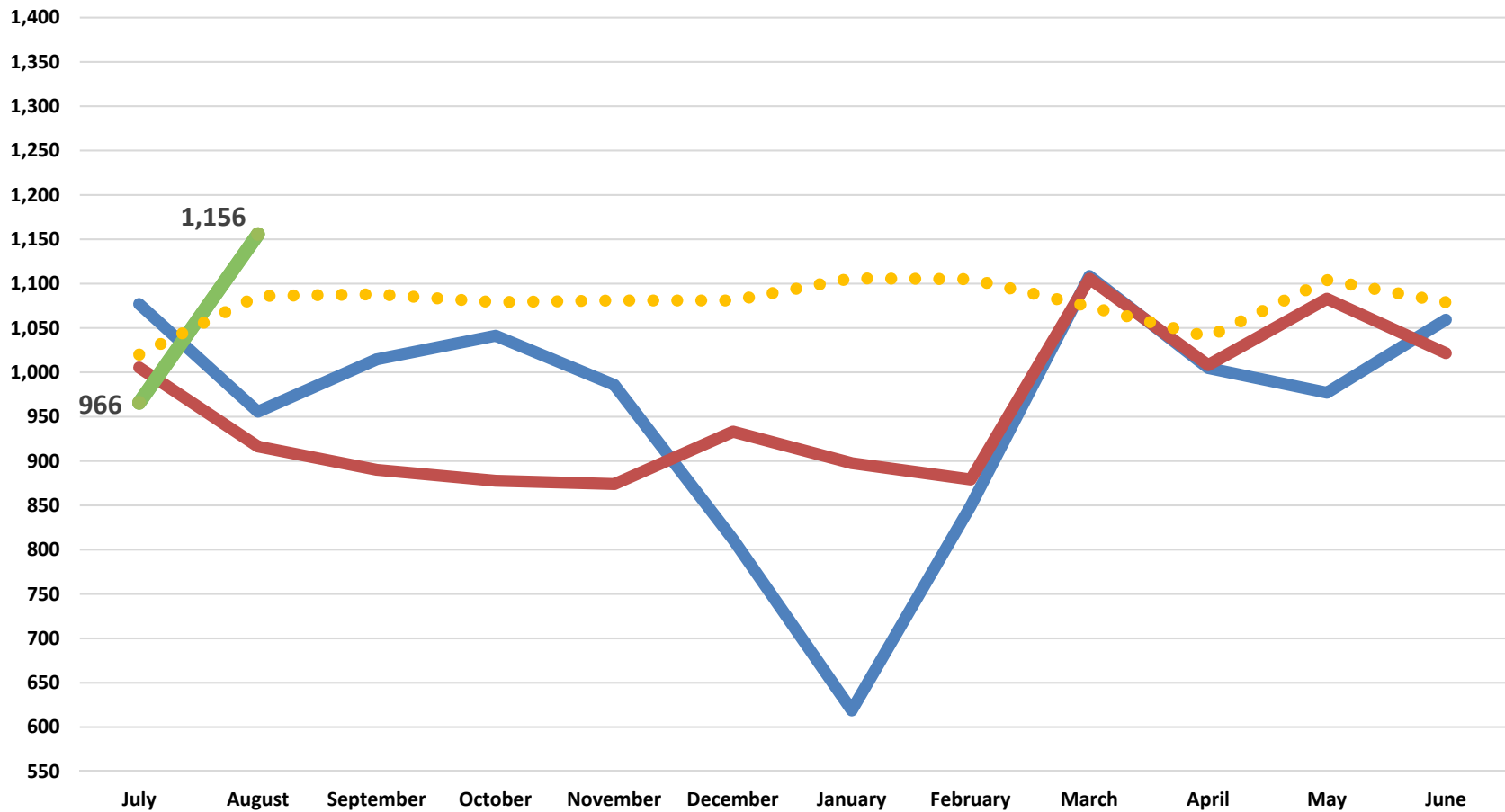
— FY2021
 — FY2022
 — FY2023
 ●●● Budget



Emergency Dept – Avg Treated Per Day



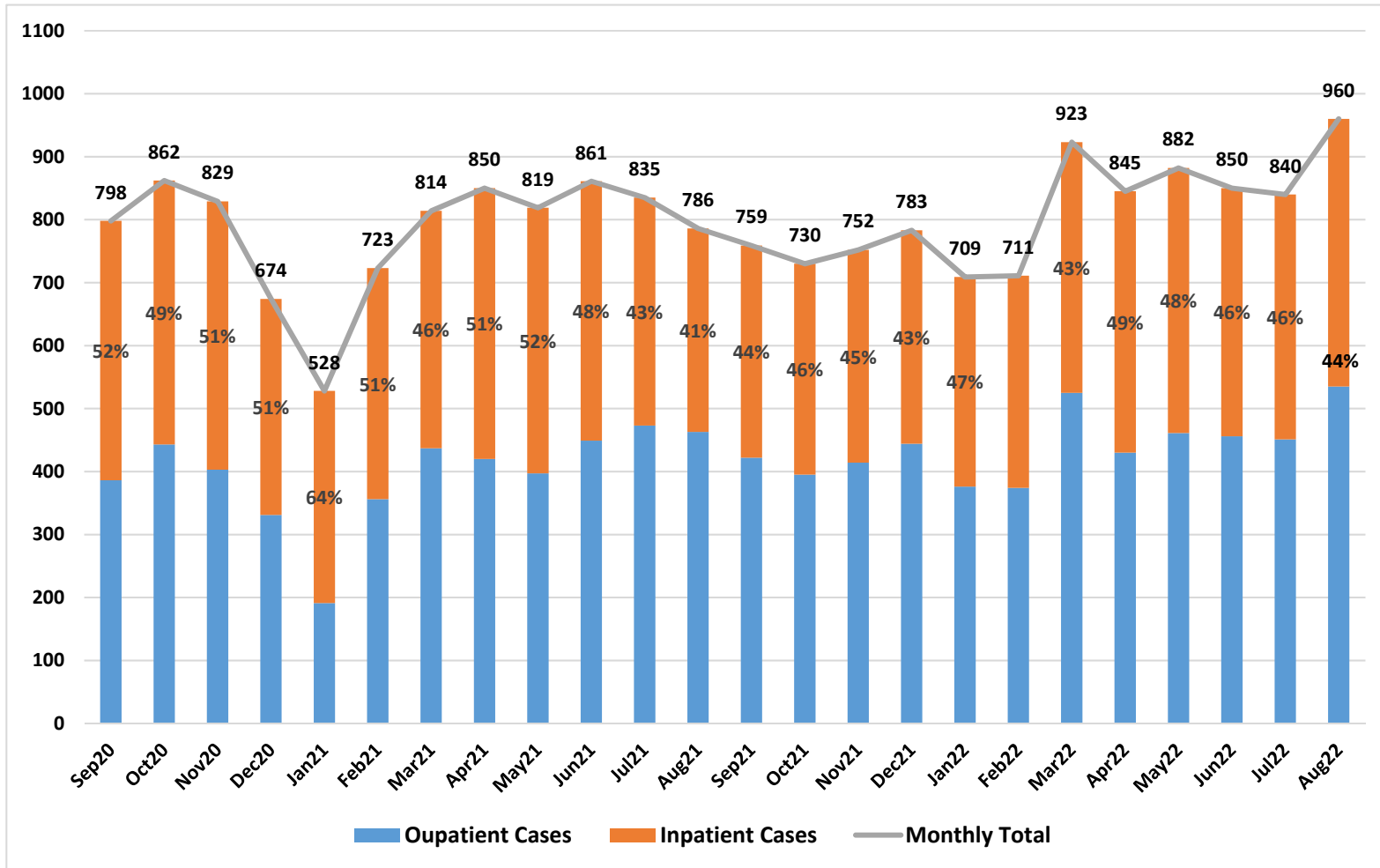
Surgery (IP & OP) – 100 Min Units



— FY2021
 — FY2022
 — FY2023
 ●●● Budget



Surgery Cases



Statistical Results – Fiscal Year Comparison (Aug)

	Actual Results			Budget	Budget Variance	
	Aug 2021	Aug 2022	% Change	Aug 2022	Change	% Change
Average Daily Census	465	447	(3.9%)	482	(34)	(7.1%)
KDHCD Patient Days:						
Medical Center	10,223	9,249	(9.5%)	9,929	(680)	(6.8%)
Acute I/P Psych	1,137	1,242	9.2%	1,530	(288)	(18.8%)
Sub-Acute	819	872	6.5%	817	55	6.7%
Rehab	467	567	21.4%	568	(1)	(0.2%)
TCS-Ortho	402	424	5.5%	419	5	1.2%
TCS	267	504	88.8%	520	(16)	(3.1%)
NICU	550	447	(18.7%)	530	(83)	(15.7%)
Nursery	556	560	0.7%	618	(58)	(9.4%)
Total KDHCD Patient Days	14,421	13,865	(3.9%)	14,931	(1,066)	(7.1%)
Total Outpatient Volume	49,817	50,468	1.3%	48,146	2,322	4.8%

Statistical Results – Fiscal Year Comparison (Jul-Aug)

	Actual Results			Budget	Budget Variance	
	FYTD 2022	FYTD 2023	% Change	FYTD 2023	Change	% Change
Average Daily Census	449	448	(0.1%)	476	(28)	(5.9%)
KDHCD Patient Days:						
Medical Center	19,354	18,580	(4.0%)	19,468	(888)	(4.6%)
Acute I/P Psych	2,200	2,467	12.1%	3,151	(684)	(21.7%)
Sub-Acute	1,648	1,771	7.5%	1,646	125	7.6%
Rehab	1,000	1,132	13.2%	1,146	(14)	(1.2%)
TCS-Ortho	786	792	0.8%	832	(40)	(4.8%)
TCS	676	1,008	49.1%	1,034	(26)	(2.5%)
NICU	1,083	929	(14.2%)	1,030	(101)	(9.8%)
Nursery	1,062	1,096	3.2%	1,218	(122)	(10.0%)
Total KDHCD Patient Days	27,809	27,775	(0.1%)	29,525	(1,750)	(5.9%)
Total Outpatient Volume	94,519	92,659	(2.0%)	96,293	(3,634)	(3.8%)

Other Statistical Results – Fiscal Year Comparison (Aug)

	Actual Results				Budget	Budget Variance	
	Aug 2021	Aug 2022	Change	% Change	Aug 2022	Change	% Change
Adjusted Patient Days	27,742	29,148	1,406	5.1%	28,265	883	3.1%
Outpatient Visits	49,817	50,468	651	1.3%	48,146	2,322	4.8%
Surgery Minutes-General & Robotic (I/P & O/P)	956	1,215	259	27.1%	1,125	90	8.0%
Endoscopy Procedures (I/P & O/P)	479	558	79	16.5%	631	(73)	(11.6%)
Physical & Other Therapy Units	17,344	18,875	1,531	8.8%	19,181	(306)	(1.6%)
ED Total Registered	7,224	7,702	478	6.6%	7,094	608	8.6%
Radiation Oncology Treatments (I/P & O/P)	2,205	2,339	134	6.1%	2,334	5	0.2%
Home Health Visits	2,921	3,078	157	5.4%	3,012	66	2.2%
Cath Lab Minutes (IP & OP)	303	310	7	2.3%	406	(96)	(23.6%)
Radiology/CT/US/MRI Proc (I/P & O/P)	16,900	17,247	347	2.1%	16,318	929	5.7%
RHC Registrations	10,691	10,890	199	1.9%	11,060	(170)	(1.5%)
O/P Rehab Units	20,561	20,139	(422)	(2.1%)	21,182	(1,043)	(4.9%)
KHMG RVU	36,380	34,986	(1,394)	(3.8%)	34,246	740	2.2%
OB Deliveries	438	419	(19)	(4.3%)	432	(13)	(3.0%)
Dialysis Treatments	1,645	1,560	(85)	(5.2%)	1,541	19	1.2%
Hospice Days	4,257	3,970	(287)	(6.7%)	4,283	(313)	(7.3%)
GME Clinic visits	1,251	1,111	(140)	(11.2%)	1,200	(89)	(7.4%)
Urgent Care - Demaree	4,092	3,226	(866)	(21.2%)	2,400	826	34.4%
Infusion Center	456	336	(120)	(26.3%)	456	(120)	(26.3%)
Urgent Care - Court	7,327	4,928	(2,399)	(32.7%)	3,650	1,278	35.0%

Other Statistical Results – Fiscal Year Comparison (Jul-Aug)

	Actual Results				Budget	Budget Variance	
	FY 2022	FY 2023	Change	% Change	FY 2023	Change	% Change
Adjusted Patient Days	53,835	56,858	3,022	5.6%	56,389	469	0.8%
Outpatient Visits	94,519	92,659	(1,860)	(2.0%)	96,293	(3,634)	(3.8%)
Surgery Minutes-General & Robotic (I/P & O/P)	2,025	2,229	204	10.1%	2,209	20	0.9%
Endoscopy Procedures (I/P & O/P)	1,017	1,068	51	5.0%	1,228	(160)	(13.0%)
ED Total Registered	14,531	15,195	664	4.6%	14,185	1,010	7.1%
Physical & Other Therapy Units	36,215	37,222	1,007	2.8%	38,362	(1,140)	(3.0%)
OB Deliveries	819	815	(4)	(0.5%)	823	(8)	(1.0%)
Radiology/CT/US/MRI Proc (I/P & O/P)	33,823	33,211	(612)	(1.8%)	33,088	123	0.4%
Home Health Visits	5,786	5,599	(187)	(3.2%)	6,018	(419)	(7.0%)
RHC Registrations	19,801	19,061	(740)	(3.7%)	20,950	(1,889)	(9.0%)
KHMG RVU	65,703	62,543	(3,160)	(4.8%)	66,670	(4,127)	(6.2%)
Radiation Oncology Treatments (I/P & O/P)	4,215	3,976	(239)	(5.7%)	4,801	(825)	(17.2%)
Cath Lab Minutes (IP & OP)	670	623	(47)	(7.0%)	797	(174)	(21.8%)
O/P Rehab Units	39,959	36,416	(3,543)	(8.9%)	40,626	(4,210)	(10.4%)
Hospice Days	8,565	7,796	(769)	(9.0%)	8,566	(770)	(9.0%)
Dialysis Treatments	3,338	3,024	(314)	(9.4%)	3,082	(58)	(1.9%)
Urgent Care - Demaree	7,242	6,193	(1,049)	(14.5%)	4,600	1,593	34.6%
GME Clinic visits	2,454	1,982	(472)	(19.2%)	2,400	(418)	(17.4%)
Urgent Care - Court	13,010	9,751	(3,259)	(25.0%)	6,900	2,851	41.3%
Infusion Center	889	625	(264)	(29.7%)	889	(264)	(29.7%)

Aug Financial Comparison (000's)

	Actual Results		Budget	Budget Variance	
	Aug 2021	Aug 2022	Aug 2022	Change	% Change
Operating Revenue					
Net Patient Service Revenue	\$49,714	\$54,965	\$57,189	(\$2,224)	(3.9%)
Other Operating Revenue	16,462	17,672	18,456	(784)	(4.2%)
Total Operating Revenue	66,175	72,637	75,645	(3,008)	(4.0%)
Operating Expenses					
Employment Expense	33,434	42,122	38,842	3,280	8.4%
Other Operating Expense	36,945	39,139	37,974	1,164	3.1%
Total Operating Expenses	70,379	81,261	76,816	4,445	5.8%
Operating Margin	(\$4,204)	(\$8,623)	(\$1,171)	(\$7,453)	
Stimulus Funds	0	0	255	(255)	
Operating Margin after Stimulus	(\$4,204)	(\$8,223)	(\$916)	(\$7,708)	
Non Operating Revenue (Loss)	552	326	371	(45)	
Excess Margin	(\$3,651)	(\$8,297)	(\$545)	(\$7,752)	
Operating Margin %	(6.4%)	(11.9%)	(1.5%)		
OM after Stimulus%	(6.4%)	(11.9%)	(1.2%)		
Excess Margin %	(5.5%)	(11.4%)	(0.7%)		
Operating Cash Flow Margin %	(1.4%)	(7.4%)	3.0%		

YTD (July-August) Financial Comparison (000's)

	Actual Results FYTD Jul-Aug		Budget FYTD	Budget Variance	FYTD
	FYTD2022	FYTD2023	FYTD2023	Change	% Change
Operating Revenue					
Net Patient Service Revenue	\$101,216	\$107,333	\$112,379	(\$5,046)	(4.5%)
Other Operating Revenue	31,496	35,785	36,906	(1,122)	(3.0%)
Total Operating Revenue	132,712	143,118	149,285	(6,167)	(4.1%)
Operating Expenses					
Employment Expense	66,112	83,441	76,735	6,707	8.7%
Other Operating Expense	69,680	76,226	75,061	1,165	1.6%
Total Operating Expenses	135,792	159,667	151,796	7,871	5.2%
Operating Margin	(\$3,080)	(\$16,549)	(\$2,511)	(\$14,038)	
Stimulus Funds	0	97	510	(413)	
Operating Margin after Stimulus	(\$3,080)	(\$16,452)	(\$2,001)	(\$14,451)	
Nonoperating Revenue (Loss)	1,134	781	742	39	
Excess Margin	(\$1,946)	(\$15,671)	(\$1,258)	(\$14,413)	

Operating Margin %	(2.3%)	(11.6%)	(1.7%)
OM after Stimulus%	(2.3%)	(11.5%)	(1.3%)
Excess Margin %	(1.5%)	(10.9%)	(0.8%)
Operating Cash Flow Margin %	2.6%	(7.0%)	2.9%

Aug Financial Comparison (000's)

	Actual Results			Budget	Budget Variance	
	Aug 2021	Aug 2022	% Change	Aug 2022	Change	% Change
Operating Revenue						
Net Patient Service Revenue	\$49,714	\$54,965	10.6%	\$57,189	(\$2,224)	(3.9%)
Supplemental Gov't Programs	4,286	5,042	17.6%	5,257	(216)	(4.1%)
Prime/QIP Program	667	743	11.4%	757	(14)	(1.9%)
Premium Revenue	5,425	5,927	9.2%	6,459	(533)	(8.2%)
Management Services Revenue	3,298	3,797	15.1%	3,478	319	9.2%
Other Revenue	2,786	2,164	(22.3%)	2,505	(341)	(13.6%)
Other Operating Revenue	16,462	17,672	7.4%	18,456	(784)	(4.2%)
Total Operating Revenue	66,175	72,637	9.8%	75,645	(3,008)	(4.0%)
Operating Expenses						
Salaries & Wages	28,198	29,435	4.4%	30,204	(769)	(2.5%)
Contract Labor	1,358	7,124	424.4%	2,448	4,676	191.0%
Employee Benefits	3,878	5,563	43.5%	6,189	(626)	(10.1%)
Total Employment Expenses	33,434	42,122	26.0%	38,842	3,280	8.4%
Medical & Other Supplies	13,004	11,666	(10.3%)	10,970	695	6.3%
Physician Fees	8,527	9,585	12.4%	9,012	572	6.4%
Purchased Services	399	1,120	180.8%	1,678	(558)	(33.3%)
Repairs & Maintenance	2,425	2,486	2.5%	2,560	(74)	(2.9%)
Utilities	740	999	35.1%	908	92	10.1%
Rents & Leases	519	540	4.2%	576	(36)	(6.2%)
Depreciation & Amortization	2,632	2,650	0.7%	2,834	(183)	(6.5%)
Interest Expense	646	589	(8.9%)	611	(22)	(3.5%)
Other Expense	1,466	2,013	37.3%	2,160	(147)	(6.8%)
Humana Cap Plan Expenses	3,472	3,831	10.3%	3,230	601	18.6%
Management Services Expense	3,115	3,660	17.5%	3,436	223	6.5%
Total Other Expenses	36,945	39,139	5.9%	37,974	1,164	3.1%
Total Operating Expenses	70,379	81,261	15.5%	76,816	4,445	5.8%
Operating Margin	(\$4,204)	(\$8,623)	105.1%	(\$1,171)	(\$7,453)	636.5%
Stimulus Funds	0	0	0.0%	255	(255)	(100%)
Operating Margin after Stimulus	(\$4,204)	(\$8,623)	105.1%	(\$916)	(\$7,708)	841.6%
Nonoperating Income						
Nonoperating Revenue (Loss)	552	326	(40.9%)	371	(45)	(12.1%)
Excess Margin	(\$3,651)	(\$8,297)	127.2%	(\$545)	(\$7,752)	1424%

Operating Margin %	(6.4%)	(11.9%)		(1.5%)
OM after Stimulus%	(6.4%)	(11.9%)		(1.2%)
Excess Margin %	(5.5%)	(11.4%)		(0.7%)
Operating Cash Flow Margin %	(1.4%)	(7.4%)		3.0%

YTD Financial Comparison (000's)

	Actual Results FYTD Jul-Aug			Budget FYTD	Budget Variance	FYTD
	FYTD2022	FYTD2023	% Change	FYTD2023	Change	% Change
Operating Revenue						
Net Patient Service Revenue	\$101,216	\$107,333	6.0%	\$112,379	(\$5,046)	(4.5%)
Supplemental Gov't Programs	8,574	10,084	17.6%	10,515	(431)	(4.1%)
Prime/QIP Program	1,333	1,485	11.4%	1,514	(28)	(1.9%)
Premium Revenue	10,327	11,828	14.5%	12,918	(1,090)	(8.4%)
Management Services Revenue	6,469	6,729	4.0%	6,956	(227)	(3.3%)
Other Revenue	4,793	5,659	18.1%	5,004	655	13.1%
Other Operating Revenue	31,496	35,785	13.6%	36,906	(1,122)	(3.0%)
Total Operating Revenue	132,712	143,118	7.8%	149,285	(6,167)	(4.1%)
Operating Expenses						
Salaries & Wages	55,673	58,611	5.3%	59,688	(1,077)	(1.8%)
Contract Labor	2,475	12,988	424.8%	4,722	8,266	175.0%
Employee Benefits	7,965	11,842	48.7%	12,324	(482)	(3.9%)
Total Employment Expenses	66,112	83,441	26.2%	76,735	6,707	8.7%
Medical & Other Supplies	22,600	21,259	(5.9%)	21,283	(24)	(0.1%)
Physician Fees	16,449	18,477	12.3%	18,009	468	2.6%
Purchased Services	4,971	4,057	(18.4%)	3,350	707	21.1%
Repairs & Maintenance	4,499	4,723	5.0%	5,120	(397)	(7.8%)
Utilities	1,428	1,714	20.0%	1,630	85	5.2%
Rents & Leases	993	1,051	5.8%	1,155	(104)	(9.0%)
Depreciation & Amortization	5,267	5,307	0.8%	5,667	(360)	(6.4%)
Interest Expense	1,201	1,178	(1.9%)	1,221	(44)	(3.6%)
Other Expense	2,916	3,644	24.9%	4,320	(676)	(15.6%)
Humana Cap Plan Expenses	3,472	8,235	137.2%	6,435	1,800	28.0%
Management Services Expense	5,883	6,581	11.9%	6,872	(291)	(4.2%)
Total Other Expenses	69,680	76,226	9.4%	75,061	1,165	1.6%
Total Operating Expenses	135,792	159,667	17.6%	151,796	7,871	5.2%
Operating Margin	(\$3,080)	(\$16,549)	437.3%	(\$2,511)	(\$14,038)	559%
Stimulus Funds	0	97	100.0%	510	(413)	(81.0%)
Operating Margin after Stimulus	(\$3,080)	(\$16,452)	434.2%	(\$2,001)	(\$14,451)	722%
Nonoperating Income						
Nonoperating Revenue (Loss)	1,134	781	(31.1%)	742	39	5.2%
Excess Margin	(\$1,946)	(\$15,671)	705.4%	(\$1,258)	(\$14,413)	1146%

Operating Margin %	(2.3%)	(11.6%)		(1.7%)
OM after Stimulus%	(2.3%)	(11.5%)		(1.3%)
Excess Margin %	(1.5%)	(10.9%)		(0.8%)

Kaweah Health Medical Group

Fiscal Year Financial Comparison (000's)

	Actual Results FYTD July - Aug			Budget FYTD	Budget Variance	FYTD
	Aug 2021	Aug 2022	% Change	Aug 2022	Change	% Change
Operating Revenue						
Net Patient Service Revenue	\$7,267	\$7,588	4.4%	\$8,185	(\$597)	(7.3%)
Other Revenue	159	123	(22.3%)	201	(78)	(38.6%)
Other Operating Revenue	159	123	(22.3%)	201	(78)	(38.6%)
Total Operating Revenue	7,425	7,711	3.8%	8,386	(675)	(8.0%)
Operating Expenses						
Salaries & Wages	1,949	2,000	2.6%	2,138	(138)	(6.5%)
Employee Benefits	332	396	19.2%	438	(42)	(9.6%)
Total Employment Expenses	2,281	2,396	5.0%	2,576	(180)	(7.0%)
Medical & Other Supplies	1,153	1,464	27.0%	1,159	305	26.4%
Physician Fees	4,620	4,622	0.0%	4,821	(199)	(4.1%)
Purchased Services	160	137	(14.6%)	179	(42)	(23.7%)
Repairs & Maintenance	346	486	40.5%	466	20	4.3%
Utilities	82	113	37.1%	110	3	2.7%
Rents & Leases	417	431	3.2%	443	(13)	(2.9%)
Depreciation & Amortization	134	114	(15.0%)	129	(15)	(11.6%)
Interest Expense	0	0	(100.0%)	0	0	0%
Other Expense	181	203	12.2%	309	(106)	(34.3%)
Total Other Expenses	7,093	7,569	6.7%	7,616	(47)	(0.6%)
Total Operating Expenses	9,375	9,965	6.3%	10,192	(227)	(2.2%)
Stimulus Funds	0	0	0.0%	0	0	0.0%
Excess Margin	(\$1,949)	(\$2,254)	(15.6%)	(\$1,806)	(\$448)	(24.8%)
Excess Margin %	(26.3%)	(29.2%)		(21.5%)		

Month of August - Budget Variances

- **Net Patient Revenues:** Net patient revenue was under budget by \$2.2M (3.9%) in August. This decrease was mainly due to the lower than anticipated volume in inpatient services which was partially offset by 4.8% increase in our outpatient visits. There was also a decrease in the acuity of the inpatients resulting in 5.4% lower case mix than prior year.
- **Salaries and Contract Labor:** The \$3.9M unfavorable variance is primarily due to the increase in the amount of contract labor utilized during the month (\$4.7M) and shift bonuses (\$706K) paid in August. We also paid \$506.1K of unbudgeted COVID supplemental sick pay in August. While costs are up, the productivity ratios are favorable in terms of worked hours per volume.
- **Medical and Other Supplies:** In August, surgery volume was up 8% over budget which impacted related supplies. In addition, there was \$380K related to COVID supplies.
- **Physician Expense:** The primary reason for the increase in physician fees over budget is due to the need for locums as well as some areas of lower collections than anticipated in Anesthesiology, Adult Hospitalist and Intensivist.
- **Humana Cap Plan expenses:** Third party claims for our Humana Medicare Advantage lives were \$601K higher than expected in August.

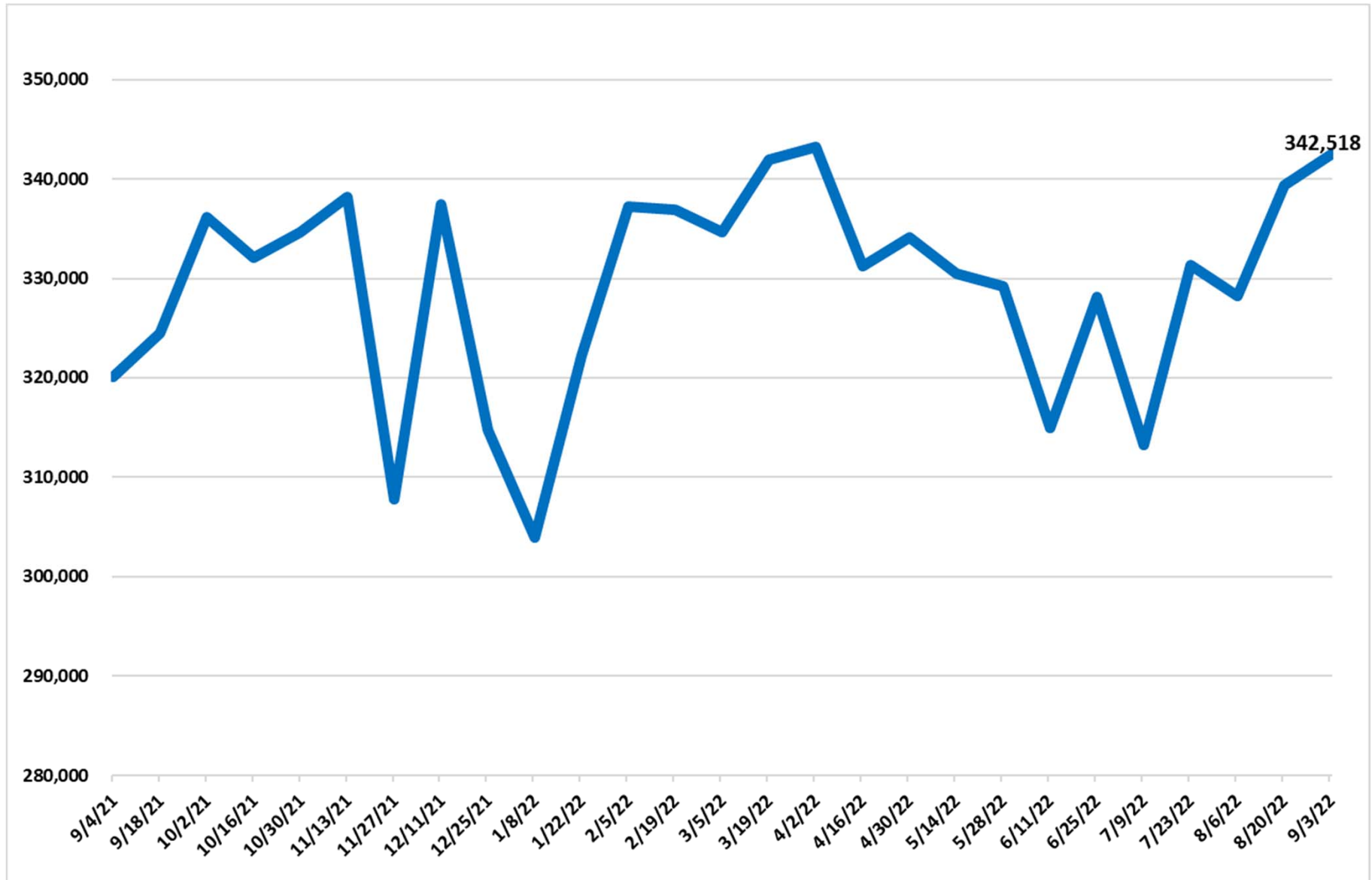
Trended Financial Comparison (000's)

Kaweah Delta Health Care District

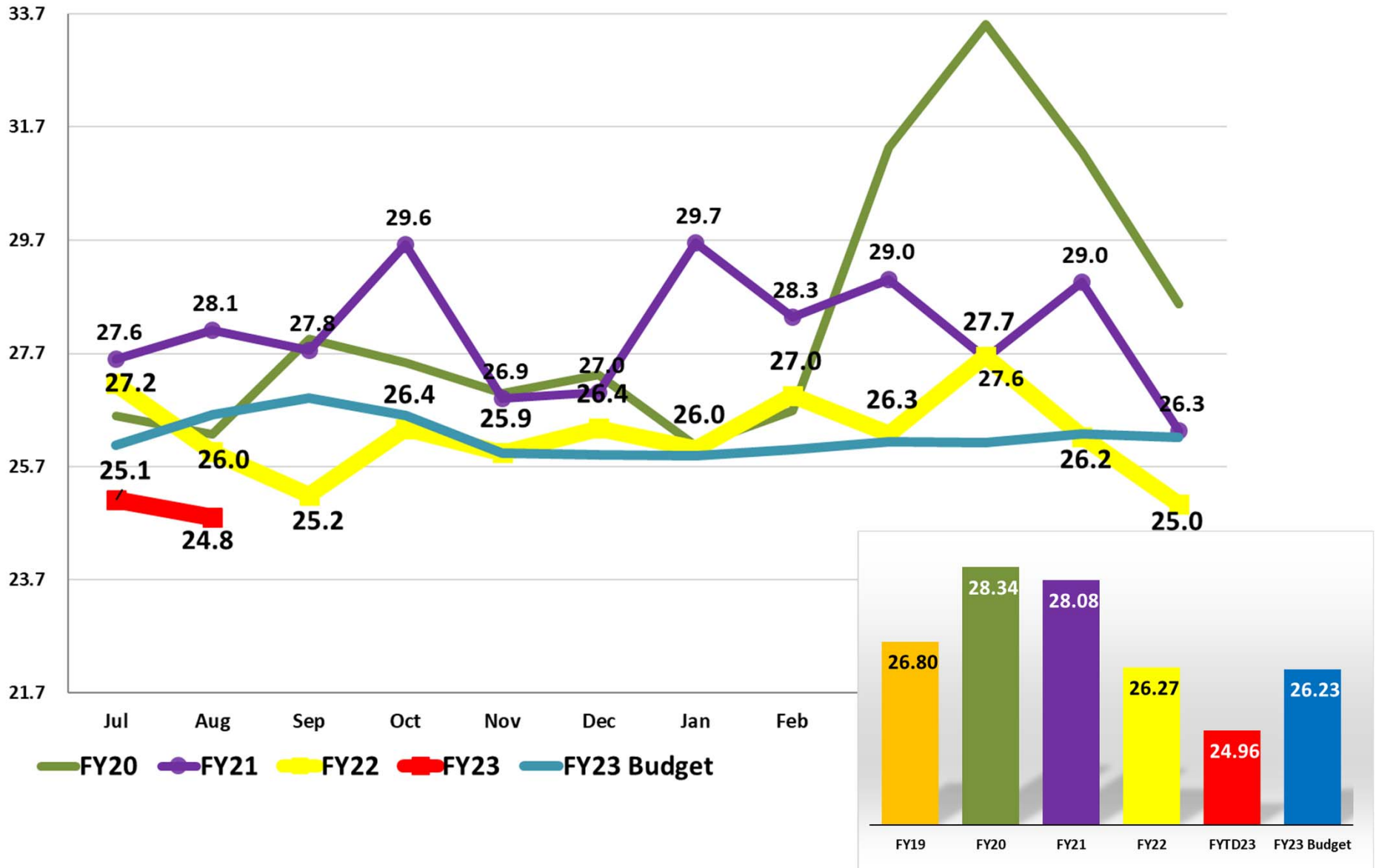
Trended Income Statement (000's)

	Adjusted Patient Days												
	27,742	28,344	28,267	26,571	27,106	26,955	24,973	27,296	26,159	28,283	27,788	27,688	29,148
	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22
Operating Revenue													
Net Patient Service Revenue	\$49,714	\$57,879	\$55,674	\$54,846	\$51,115	\$56,862	\$47,933	\$52,555	\$49,729	\$56,673	\$50,790	\$52,368	\$54,965
Supplemental Gov't Programs	4,286	4,286	4,383	11,778	10,297	4,383	5,579	5,192	6,983	4,383	8,334	5,042	5,042
Prime Program	667	667	667	667	667	3,285	667	667	667	3,282	3,282	743	743
Premium Revenue	5,425	5,163	5,156	5,054	5,173	5,272	6,574	5,772	9,112	5,948	5,943	5,901	5,927
Management Services Revenue	3,298	3,523	3,137	2,690	2,921	2,536	2,910	2,988	2,885	2,813	3,188	2,932	3,797
Other Revenue	2,348	1,873	2,250	1,974	2,300	1,993	1,796	1,990	3,789	2,126	2,743	3,495	2,164
Other Operating Revenue	16,024	15,513	15,592	22,162	21,358	17,469	17,526	16,609	23,436	18,552	23,490	18,113	17,672
Total Operating Revenue	65,737	73,391	71,266	77,008	72,473	74,331	65,459	69,164	73,165	75,225	74,280	70,480	72,637
Operating Expenses													
Salaries & Wages	28,198	31,872	30,538	28,408	29,967	29,407	27,297	30,503	28,987	28,998	27,936	29,176	29,435
Contract Labor	1,358	1,721	1,872	1,745	3,238	4,958	3,882	1,299	5,784	7,813	6,650	5,864	7,124
Employee Benefits	3,878	4,728	4,217	3,481	4,161	4,566	4,923	6,119	6,057	3,229	16,653	6,279	5,563
Total Employment Expenses	33,434	38,321	36,627	33,634	37,366	38,931	36,102	37,920	40,828	40,040	51,239	41,319	42,122
Medical & Other Supplies	13,004	11,942	11,714	10,623	10,687	10,913	10,406	11,180	10,685	11,914	7,187	9,593	11,666
Physician Fees	8,527	7,736	9,674	10,261	9,479	9,210	8,812	9,045	8,829	9,329	9,538	8,892	9,585
Purchased Services	1,368	1,680	1,683	1,565	1,745	1,261	1,511	1,304	1,914	2,038	1,758	2,937	1,120
Repairs & Maintenance	2,425	2,425	2,702	2,330	2,331	2,324	2,588	2,251	2,204	2,380	2,358	2,237	2,486
Utilities	740	696	860	760	654	753	736	723	753	794	822	715	999
Rents & Leases	519	487	474	522	505	528	525	515	519	585	517	510	540
Depreciation & Amortization	2,632	2,636	2,634	2,636	2,631	2,614	2,634	2,583	2,649	2,610	3,460	2,657	2,650
Interest Expense	646	499	501	500	498	655	671	671	671	826	700	589	589
Other Expense	1,466	1,641	1,563	1,557	1,804	2,110	1,731	2,019	1,907	2,812	2,528	1,631	2,013
Humana Cap Plan Expenses	2,503	3,642	3,982	3,130	2,902	2,327	2,617	5,196	3,413	2,850	2,407	4,404	3,831
Management Services Expense	3,115	3,734	2,988	2,628	2,462	2,570	2,835	3,003	3,380	2,268	3,227	2,921	3,660
Total Other Expenses	36,945	37,116	38,774	36,512	35,698	35,266	35,066	38,491	36,924	38,405	34,502	37,087	39,139
Total Operating Expenses	70,379	75,437	75,402	70,146	73,064	74,197	71,168	76,412	77,752	78,445	85,742	78,406	81,261
Operating Margin	(\$4,642)	(\$2,046)	(\$4,136)	\$6,862	(\$591)	\$134	(\$5,709)	(\$7,247)	(\$4,588)	(\$3,220)	(\$11,461)	(\$7,926)	(\$8,623)
Stimulus Funds	\$438	\$0	\$137	\$6,542	\$0	\$0	\$93	\$9,345	\$0	\$0	\$3,028	\$97	\$0
Operating Margin after Stimulus	(\$4,204)	(\$2,046)	(\$3,999)	\$13,404	(\$591)	\$134	(\$5,616)	\$2,098	(\$4,588)	(\$3,220)	(\$8,433)	(\$7,829)	(\$8,623)
Nonoperating Revenue (Loss)	552	(388)	595	587	2,495	568	693	(9,815)	(568)	(436)	(3,356)	455	326
Excess Margin	(\$3,651)	(\$2,434)	(\$3,404)	\$13,991	\$1,904	\$702	(\$4,924)	(\$7,718)	(\$5,156)	(\$3,656)	(\$11,789)	(\$7,374)	(\$8,297)

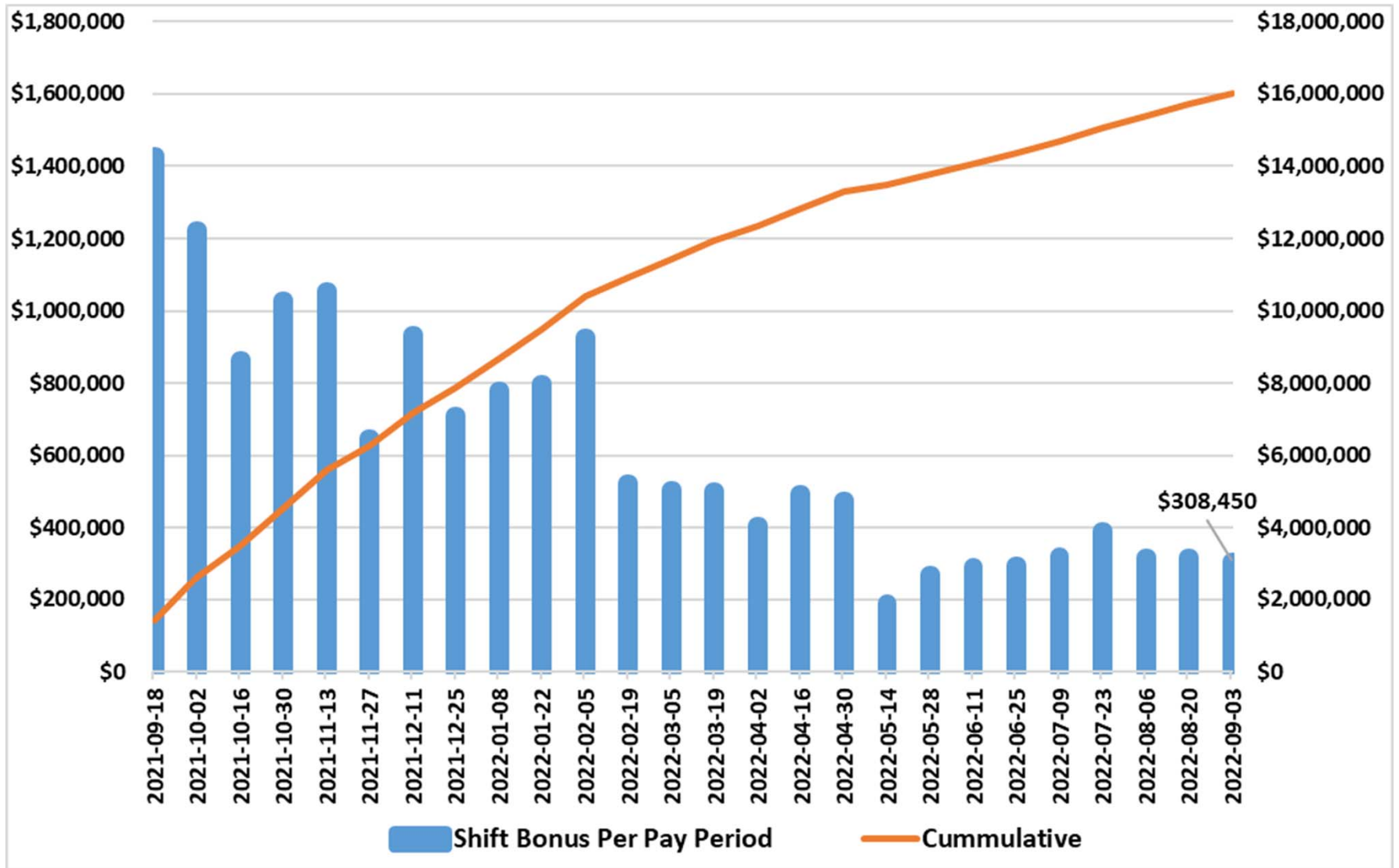
Productive Hours



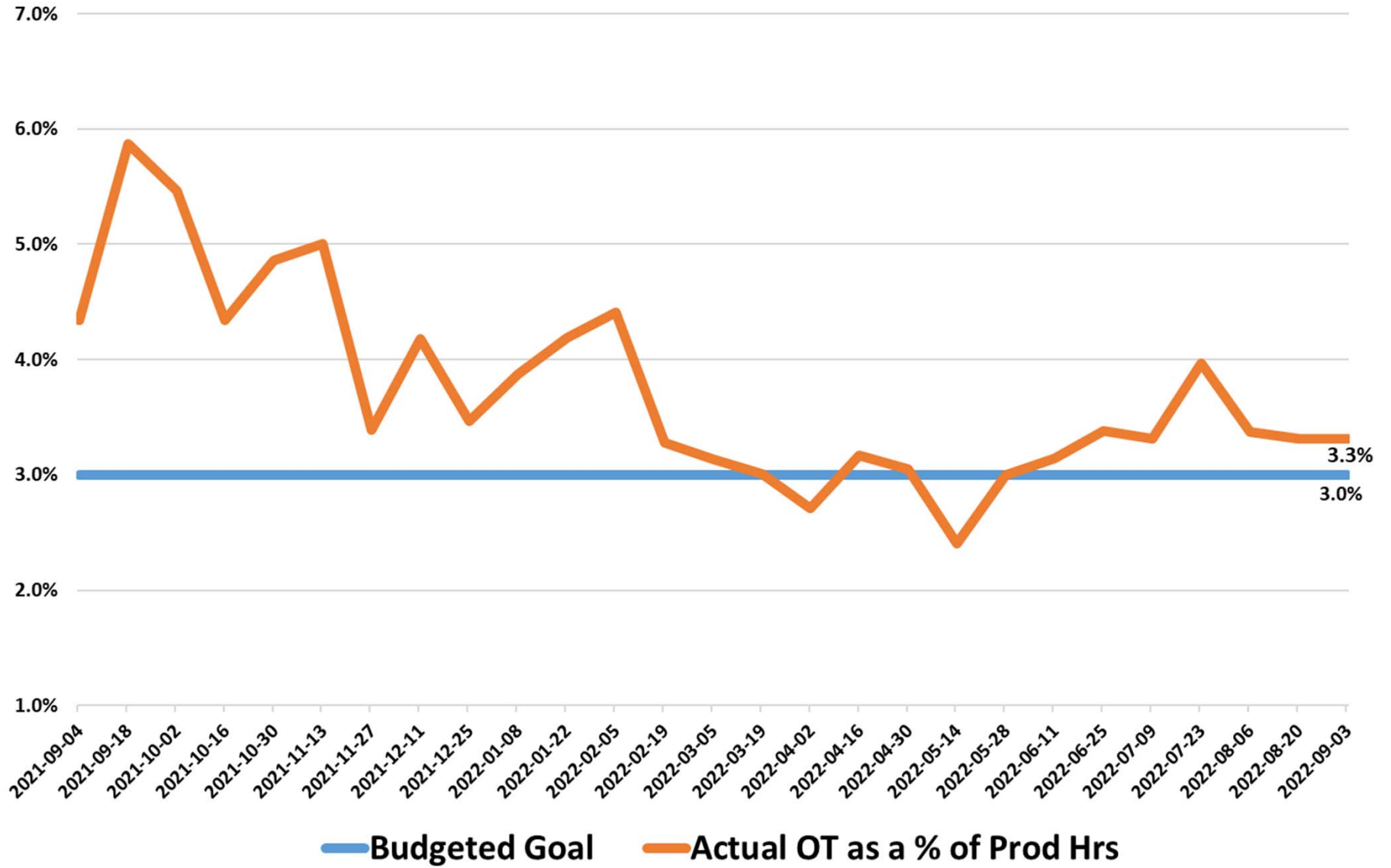
Productivity: Worked Hours/Adjusted Patient Days



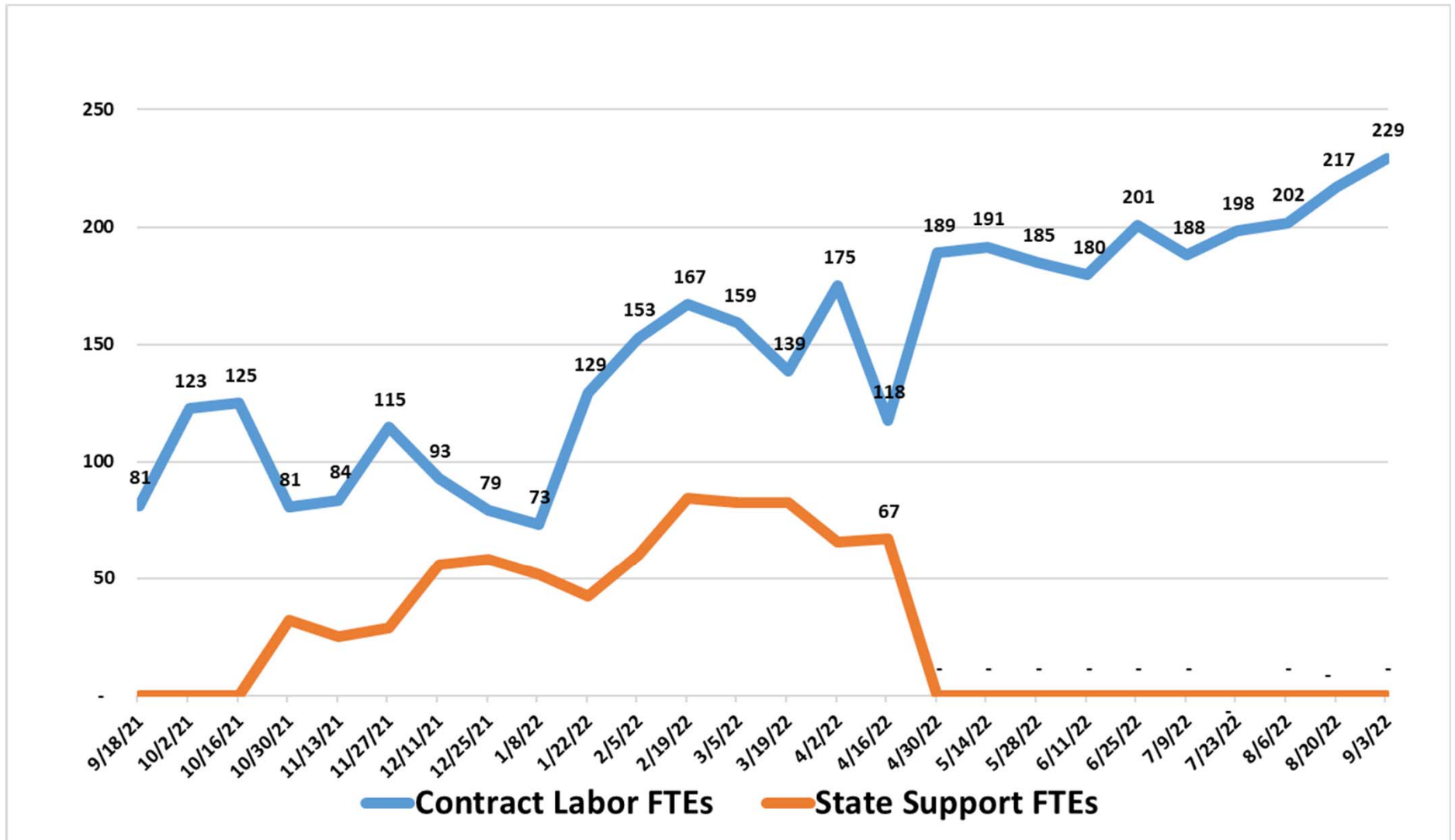
Shift Bonus



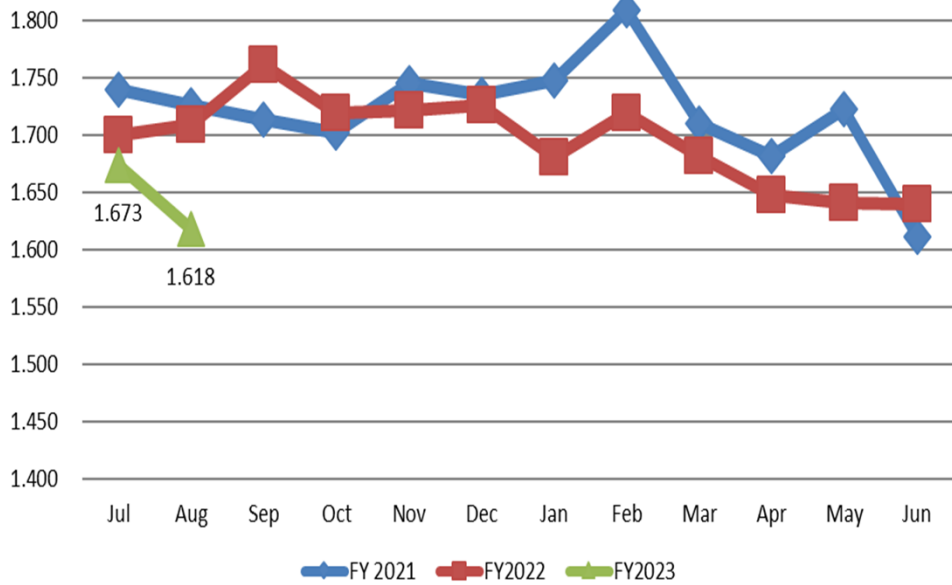
Overtime as a % of Productive Hours and \$



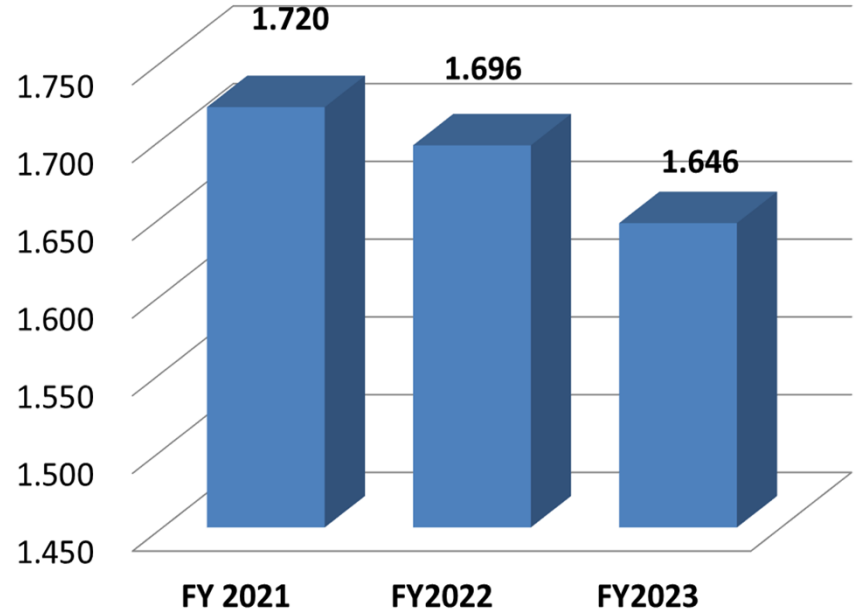
Contract Labor Full Time Equivalents (FTEs)



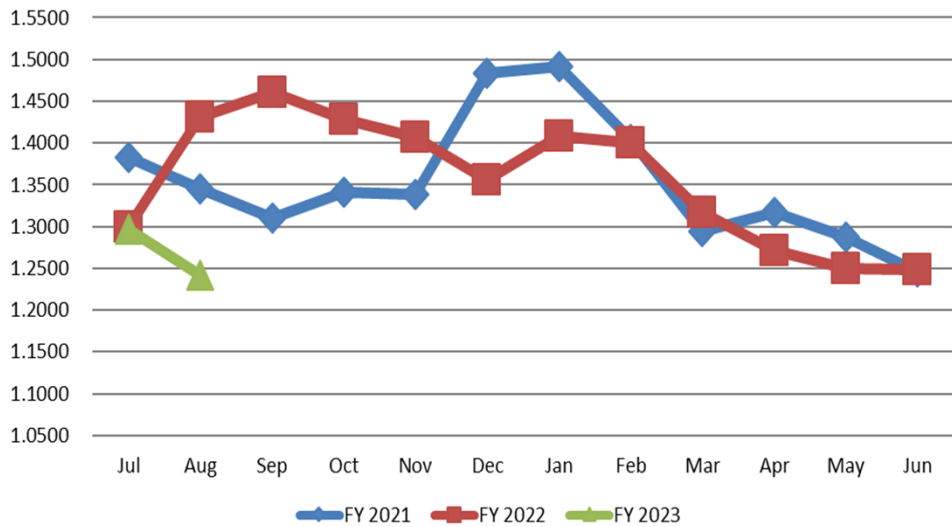
Case Mix Index w/o Normal Newborns



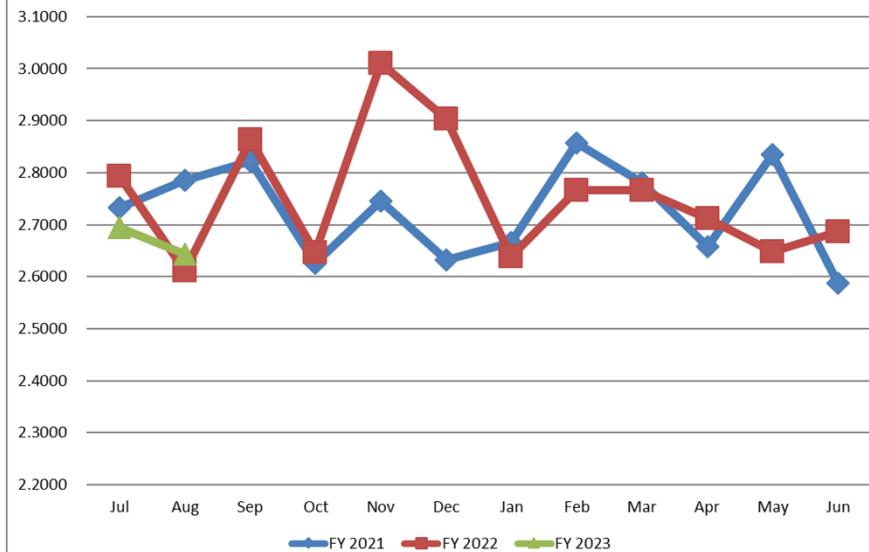
Case Mix Index w/o Normal Newborns - All



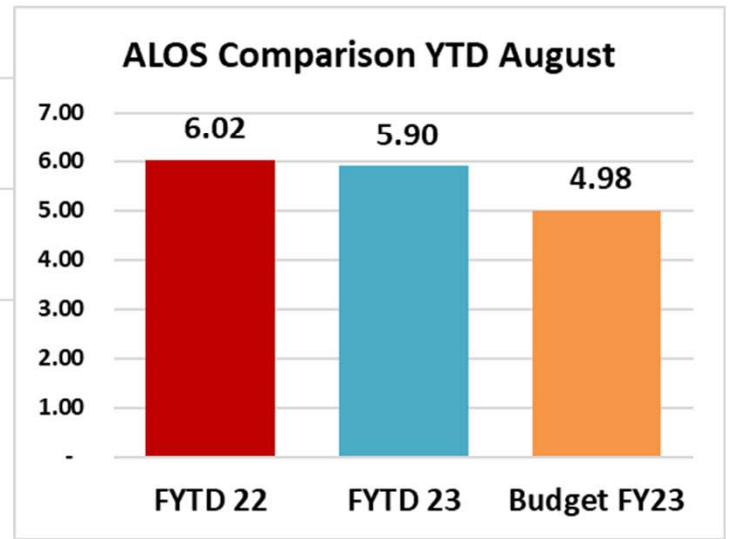
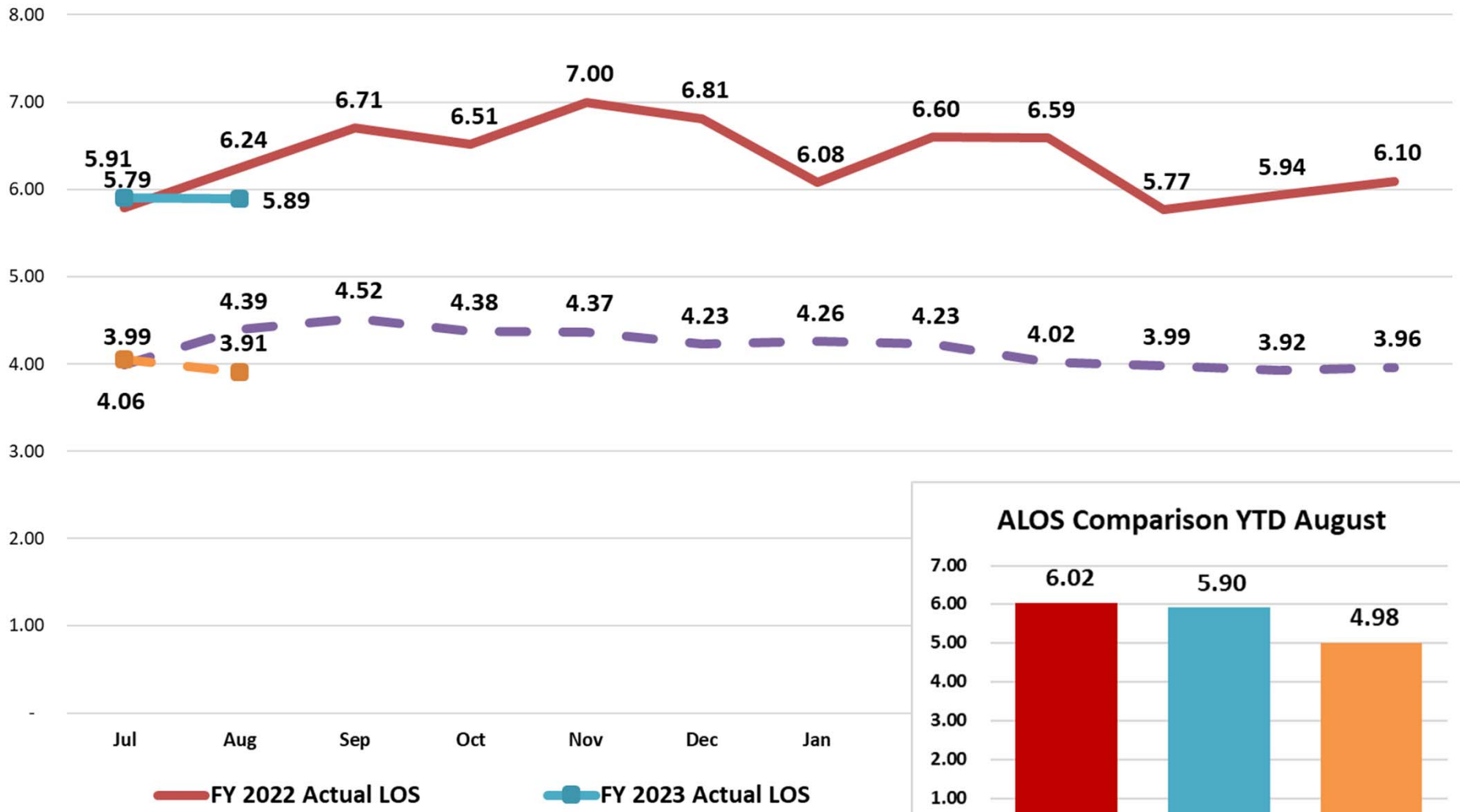
Case Mix **Medical w/o Normal Newborns**



Case Mix Index **Surgical w/o Normal Newborns**



Average Length of Stay versus National Average (GMLOS)



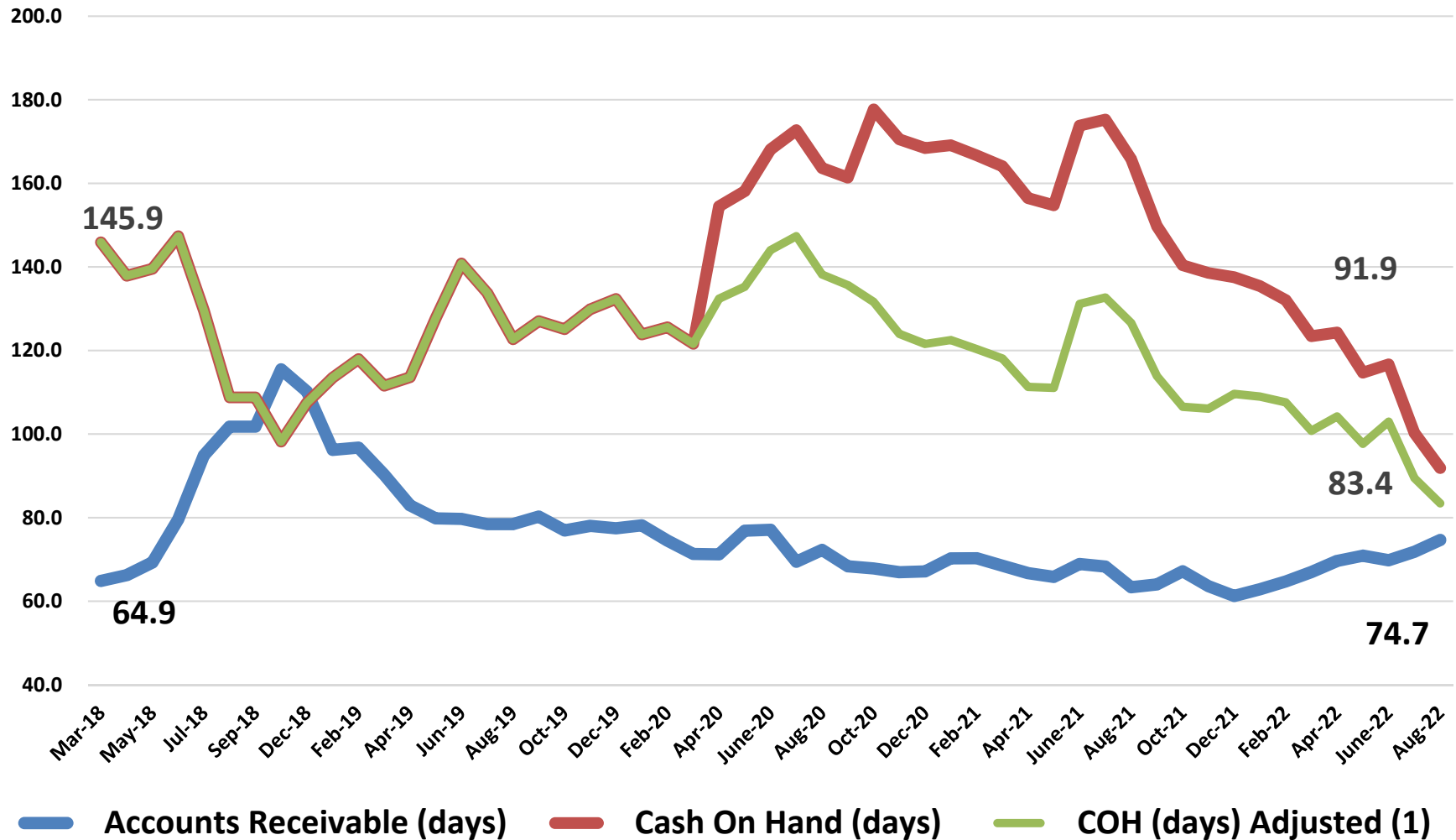
Average Length of Stay versus National Average (GMLOS)

	Including COVID Patients			Excluding COVID Patients		
	ALOS	GMLOS	GAP	ALOS	GMLOS	GAP
Mar-20	5.20	4.04	1.16	5.17	4.03	1.14
Apr-20	5.30	4.25	1.05	5.20	4.17	1.03
May-20	5.25	4.16	1.09	4.74	4.06	0.68
Jun-20	5.61	4.11	1.50	4.98	3.95	1.03
Jul-20	5.61	4.32	1.29	5.01	4.05	0.96
Aug-20	5.70	4.23	1.47	5.00	3.95	1.05
Sep-20	5.93	4.17	1.76	5.33	4.00	1.33
Oct-20	5.21	4.09	1.12	4.98	3.98	1.00
Nov-20	5.66	4.21	1.45	5.40	4.07	1.33
Dec-20	6.32	4.50	1.82	5.16	3.97	1.19
Jan-21	7.07	4.72	2.35	5.61	4.15	1.46
Feb-21	6.73	4.37	2.36	5.64	4.01	1.63
Mar-21	5.76	4.07	1.69	5.04	3.92	1.12
Apr-21	5.40	3.97	1.43	5.22	3.89	1.33
May-21	5.57	4.00	1.57	5.34	3.92	1.42
Jun-21	5.75	3.90	1.85	5.67	3.88	1.79
Jul-21	5.79	3.99	1.80	5.68	3.94	1.74
Aug-21	6.24	4.39	1.85	5.95	4.05	1.90
Sep-21	6.71	4.52	2.19	5.88	4.08	1.80
Oct-21	6.51	4.38	2.13	5.34	4.00	1.34
Nov-21	7.00	4.37	2.63	5.75	3.95	1.80
Dec-21	6.81	4.23	2.58	6.11	3.98	2.13
Jan-22	6.08	4.26	1.82	5.96	3.97	1.99
Feb-22	6.60	4.23	2.37	5.86	3.82	2.04
Mar-22	6.59	4.02	2.57	5.66	3.89	1.77
Apr-22	5.77	3.99	1.78	5.65	3.97	1.68
May-22	5.94	3.92	2.02	5.58	3.87	1.71
Jun-22	6.10	3.96	2.14	5.61	3.87	1.74
Jul-22	5.91	4.06	1.85	5.64	3.89	1.75
Aug-22	5.89	3.91	1.98	5.55	3.79	1.76
Average	6.00	4.18	1.82	5.46	3.97	1.49

Opportunity Cost of Reducing LOS to National Average - \$82M FY22



Trended Liquidity Ratios



(1) Adjusted for Medicare accelerated payments and the deferral of employer portion of FICA as allowed by the CARES act.

KAWEAH DELTA HEALTH CARE DISTRICT

RATIO ANALYSIS REPORT

AUGUST 31, 2022

	Current Month Value	Prior Month Value	June 30, 2022 Unaudited Value	2020 Moody's Median Benchmark		
				Aa	A	Baa
LIQUIDITY RATIOS						
Current Ratio (x)	2.3	2.3	1.9	1.5	1.7	1.8
Accounts Receivable (days)	74.7	71.8	69.4	47.2	46.3	45.9
Cash On Hand (days)	91.9	100.3	116.6	334.8	261.4	207.2
Cushion Ratio (x)	14.2	15.1	17.4	45.9	28.8	19
Average Payment Period (days)	49.5	49.9	63.0	100.5	89.4	95.2
CAPITAL STRUCTURE RATIOS						
Cash-to-Debt	107.4%	114.0%	128.2%	285.0%	200.8%	149.7%
Debt-To-Capitalization	31.9%	31.8%	31.3%	24.8%	31.7%	40.1%
Debt-to-Cash Flow (x)	(3.8)	(4.2)	8.5	2.4	3	3.9
Debt Service Coverage	(3.2)	(3.0)	1.4	7.5	5.2	3.7
Maximum Annual Debt Service Coverage (x)	(3.3)	(2.9)	1.4	6.6	4.4	3
Age Of Plant (years)	14.9	14.8	14.0	10.6	11.8	12.9
PROFITABILITY RATIOS						
Operating Margin	(11.5%)	(11.2%)	(4.2%)	2.2%	1.4%	0.6%
Excess Margin	(10.9%)	(10.4%)	(2.9%)	6.3%	4.8%	3.0%
Operating Cash Flow Margin	(6.9%)	(6.7%)	0.5%	7.4%	7.6%	6.2%
Return on Assets	(10.8%)	(10.0%)	(2.8%)	4.4%	3.8%	2.8%

KAWEAH DELTA HEALTH CARE DISTRICT

CONSOLIDATED INCOME STATEMENT (000's)

FISCAL YEAR 2022 & 2023

Fiscal Year	Operating Revenue			Operating Expenses				Operating Expenses Total	Operating Income	Non-Operating Income	Net Income	Operating Margin %	Excess Margin
	Net Patient Revenue	Other Operating Revenue	Operating Revenue Total	Personnel Expense	Physician Fees	Supplies Expense	Other Operating Expense						
2022													
Jul-21	51,502	15,035	66,537	32,678	7,922	9,596	15,217	65,413	1,124	582	1,706	1.7%	2.5%
Aug-21	49,714	16,024	65,737	33,434	8,527	13,004	15,414	70,379	(4,642)	990	(3,651)	(7.1%)	(5.5%)
Sep-21	57,879	15,513	73,391	38,332	7,736	11,942	17,438	75,448	(2,056)	(388)	(2,445)	(2.8%)	(3.3%)
Oct-21	55,674	15,592	71,266	36,627	9,674	11,714	17,386	75,402	(4,136)	732	(3,403)	(5.8%)	(4.7%)
Nov-21	54,846	22,162	77,008	33,634	10,261	10,623	15,629	70,146	6,862	7,129	13,991	8.9%	16.6%
Dec-21	51,115	21,796	72,911	37,366	9,479	10,687	15,532	73,064	(153)	2,057	1,904	(0.2%)	2.5%
Jan-22	56,862	17,469	74,331	38,931	9,210	10,913	15,143	74,197	134	568	702	0.2%	0.9%
Feb-22	47,933	17,525	65,458	36,102	8,812	10,406	15,848	71,168	(5,710)	787	(4,924)	(8.7%)	(7.4%)
Mar-22	52,555	16,609	69,164	37,920	9,045	11,180	18,266	76,412	(7,247)	(470)	(7,717)	(10.5%)	(11.2%)
Apr-22	49,729	23,436	73,165	40,828	8,829	10,685	17,410	77,752	(4,588)	(568)	(5,156)	(6.3%)	(7.1%)
May-22	56,673	18,552	75,225	40,040	9,329	11,914	17,162	78,445	(3,220)	(436)	(3,656)	(4.3%)	(4.9%)
Jun-22	50,790	24,505	75,295	51,319	9,413	8,179	19,029	87,941	(12,646)	126	(12,520)	(16.8%)	(16.6%)
2022 FY Total	\$ 635,270	\$ 224,218	\$ 859,488	\$ 457,212	\$ 108,238	\$ 130,842	\$ 199,474	\$ 895,766	\$ (36,278)	\$ 11,108	\$ (25,170)	(4.2%)	(2.9%)
2023													
Jul-22	52,368	18,113	70,480	41,319	8,892	9,593	18,601	78,406	(7,926)	552	(7,374)	(11.2%)	(10.4%)
Aug-22	54,965	17,672	72,637	42,122	9,585	11,666	17,888	81,261	(8,623)	326	(8,297)	(11.9%)	(11.4%)
2023 FY Total	\$ 107,333	\$ 35,785	\$ 143,118	\$ 83,441	\$ 18,477	\$ 21,259	\$ 36,490	\$ 159,667	\$ (16,549)	\$ 878	\$ (15,671)	(11.6%)	(10.9%)
FYTD Budget	112,379	37,416	149,795	76,735	18,009	21,283	35,769	151,796	(2,001)	742	(1,258)	(1.3%)	(0.8%)
Variance	\$ (5,046)	\$ (1,632)	\$ (6,677)	\$ 6,707	\$ 468	\$ (24)	\$ 720	\$ 7,871	\$ (14,548)	\$ 136	\$ (14,412)		
Current Month Analysis													
Aug-22	\$ 54,965	\$ 17,672	\$ 72,637	\$ 42,122	\$ 9,585	\$ 11,666	\$ 17,888	\$ 81,261	\$ (8,623)	\$ 326	\$ (8,297)	(11.9%)	(11.4%)
Budget	57,189	18,711	75,900	38,842	9,012	10,970	17,992	76,816	(916)	371	(545)	(1.2%)	(0.7%)
Variance	\$ (2,224)	\$ (1,039)	\$ (3,263)	\$ 3,280	\$ 572	\$ 695	\$ (103)	\$ 4,445	\$ (7,708)	\$ (45)	(7,752)		

KAWEAH DELTA HEALTH CARE DISTRICT

FISCAL YEAR 2022 & 2023

Fiscal Year	Patient Days	ADC	Adjusted	I/P Revenue %	DFR &	Net Patient	Personnel	Physician	Supply	Total	Personnel	Physician	Supply	Total
			Patient Days		Bad Debt %	Revenue/ Ajusted Patient Day	Expense/ Ajusted Patient Day	Fees/ Ajusted Patient Day	Expense/ Ajusted Patient Day	Expense/ Net Patient Revenue	Fees/ Net Patient Revenue	Expense/ Net Patient Revenue	Operating Expense/ Net Patient Revenue	
2022														
Jul-21	13,388	432	26,085	51.3%	76.2%	1,974	1,253	304	368	2,508	63.4%	15.4%	18.6%	127.0%
Aug-21	14,421	465	27,742	52.0%	77.3%	1,792	1,205	307	469	2,537	67.3%	17.2%	26.2%	141.6%
Sep-21	14,836	495	28,344	52.3%	75.0%	2,042	1,352	273	421	2,662	66.2%	13.4%	20.6%	130.4%
Oct-21	15,518	501	28,267	54.9%	75.8%	1,970	1,296	342	414	2,667	65.8%	17.4%	21.0%	135.4%
Nov-21	13,969	466	26,571	52.6%	74.8%	2,064	1,266	386	400	2,640	61.3%	18.7%	19.4%	127.9%
Dec-21	14,305	461	27,106	52.8%	76.4%	1,886	1,378	350	394	2,695	73.1%	18.5%	20.9%	142.9%
Jan-22	14,611	471	26,955	54.2%	74.3%	2,109	1,444	342	405	2,753	68.5%	16.2%	19.2%	130.5%
Feb-22	13,263	474	24,973	53.1%	75.8%	1,919	1,446	353	417	2,850	75.3%	18.4%	21.7%	148.5%
Mar-22	13,570	438	27,296	49.7%	76.7%	1,925	1,389	331	410	2,799	72.2%	17.2%	21.3%	145.4%
Apr-22	12,698	423	26,159	48.5%	77.0%	1,901	1,561	338	408	2,972	82.1%	17.8%	21.5%	156.4%
May-22	13,858	447	28,283	49.0%	74.6%	2,004	1,416	330	421	2,774	70.7%	16.5%	21.0%	138.4%
Jun-22	13,603	453	27,788	49.0%	77.7%	1,828	1,847	339	294	3,165	101.0%	18.5%	16.1%	173.1%
2022 FY Total	168,040	460	325,602	51.6%	75.9%	1,951	1,404	332	402	2,751	72.0%	17.0%	20.6%	141.0%
2023														
Jul-22	13,910	449	27,688	50.2%	75.6%	1,891	1,492	321	346	2,832	78.9%	17.0%	18.3%	149.7%
Aug-22	13,865	447	29,148	47.6%	76.4%	1,886	1,445	329	400	2,788	76.6%	17.4%	21.2%	147.8%
2023 FY Total	27,775	448	56,858	48.9%	76.0%	1,888	1,468	325	374	2,808	77.7%	17.2%	19.8%	148.8%
FYTD Budget	29,525	476	56,389	52.4%	75.1%	1,993	1,361	319	377	2,670	68.3%	16.0%	18.9%	135.1%
Variance	(1,750)	(28)	468	(3.5%)	0.9%	(105)	107	6	(4)	138	9.5%	1.2%	0.9%	13.7%
Current Month Analysis														
Aug-22	13,865	447	29,148	47.6%	76.4%	1,886	1,445	329	400	2,788	76.6%	17.4%	21.2%	147.8%
Budget	14,931	482	28,265	52.8%	75.1%	2,023	1,374	319	388	2,635	67.9%	15.8%	19.2%	134.3%
Variance	(1,066)	(34)	883	(5.3%)	1.2%	(138)	71	10	12	152	8.7%	1.7%	2.0%	13.5%

**KAWEAH DELTA HEALTH CARE DISTRICT
CONSOLIDATED STATEMENTS OF NET POSITION (000's)**

	Aug-22	Jul-22	Change	% Change	Jun-22 (Unaudited)
ASSETS AND DEFERRED OUTFLOWS					
CURRENT ASSETS					
Cash and cash equivalents	\$ 9,831	\$ 5,034	\$ 4,797	95.29%	\$ 21,693
Current Portion of Board designated and trusted assets	15,136	16,383	(1,247)	-7.61%	14,121
Accounts receivable:					
Net patient accounts	138,397	139,186	(789)	-0.57%	135,696
Other receivables	28,029	29,261	(1,232)	-4.21%	28,575
	166,426	168,448	(2,022)	-1.20%	164,271
Inventories	14,290	14,575	(286)	-1.96%	14,025
Medicare and Medi-Cal settlements	62,346	55,500	6,846	12.33%	57,965
Prepaid expenses	15,501	15,549	(48)	-0.31%	13,355
Total current assets	283,530	275,490	8,040	2.92%	285,430
NON-CURRENT CASH AND INVESTMENTS -					
less current portion					
Board designated cash and assets	231,356	252,342	(20,986)	-8.32%	266,042
Revenue bond assets held in trust	22	12	11	92.61%	8
Assets in self-insurance trust fund	1,042	1,042	0	0.04%	1,040
Total non-current cash and investments	232,421	253,396	(20,975)	-8.28%	267,091
CAPITAL ASSETS					
Land	17,542	17,542	-	0.00%	17,542
Buildings and improvements	425,551	425,542	9	0.00%	425,542
Equipment	325,116	325,209	(93)	-0.03%	325,209
Construction in progress	17,772	16,469	1,303	7.91%	15,620
	785,981	784,762	1,219	0.16%	783,912
Less accumulated depreciation	464,290	461,806	2,484	0.54%	459,223
	321,691	322,956	(1,265)	-0.39%	324,689
Property under capital leases -					
less accumulated amortization	(468)	(410)	(58)	14.04%	(353)
Total capital assets	321,223	322,545	(1,322)	-0.41%	324,337
OTHER ASSETS					
Property not used in operations	1,575	1,580	(4)	-0.27%	1,584
Health-related investments	4,311	4,508	(196)	-4.36%	4,620
Other	12,833	12,533	300	2.40%	12,511
Total other assets	18,720	18,621	100	0.53%	18,715
Total assets	855,894	870,051	(14,157)	-1.63%	895,573
DEFERRED OUTFLOWS	(35,284)	(35,247)	(37)	0.11%	(35,209)
Total assets and deferred outflows	\$ 820,610	\$ 834,805	\$ (14,194)	-1.70%	\$ 860,363

KAWEAH DELTA HEALTH CARE DISTRICT

CONSOLIDATED STATEMENTS OF NET POSITION (000's)

	Aug-22	Jul-22	Change	% Change	Jun-22
					(Unaudited)
LIABILITIES AND NET ASSETS					
CURRENT LIABILITIES					
Accounts payable and accrued expenses	\$ 49,926	\$ 54,648	\$ (4,721)	-8.64%	\$ 63,282
Accrued payroll and related liabilities	63,425	64,476	(1,051)	-1.63%	74,165
Long-term debt, current portion	9,901	2,903	6,998	241.10%	2,903
Total current liabilities	123,252	122,026	1,226	1.00%	140,349
LONG-TERM DEBT, less current portion					
Bonds payable	239,604	248,522	(8,918)	-3.59%	248,529
Capital leases	68	72	(4)	-5.95%	72
Notes payable	7,816	7,816	-	0.00%	7,816
Total long-term debt	247,488	256,410	(8,922)	-3.48%	256,417
NET PENSION LIABILITY	(32,374)	(32,264)	(110)	0.34%	(32,154)
OTHER LONG-TERM LIABILITIES	31,501	30,835	666	2.16%	30,622
Total liabilities	369,866	377,007	(7,140)		395,233
NET ASSETS					
Invested in capital assets, net of related debt	75,127	74,548	580	0.78%	76,362
Restricted	32,622	33,686	(1,064)	-3.16%	31,582
Unrestricted	342,995	349,564	(6,569)	-1.88%	357,186
Total net position	450,744	457,798	(7,054)	-1.54%	465,130
Total liabilities and net position	\$ 820,610	\$ 834,805	\$ (14,194)	-1.70%	\$ 860,363

OPERATION: BACK IN BLACK

\$47M	Revenue Cycle	Contracts/ Underpmts	Supplies/ Contracted Services	Through-put	Humana MA	Provider Related	Employee Related	
Impact	\$2.5M	\$8M	\$4M	\$8.6M	\$10M	\$1M	\$12.7M	
Director Owner	Frances Carrera	Kim Ferguson	Steve Bajari	Rebekah Foster / Kassie Waters	Lori Mulliniks /Sonia Duran- Aguilar	Assigned Physician Director	All Directors \$2.7M Efficiency/\$4M Contract	
Executive Owner	Malinda Tupper	Malinda Tupper	Malinda Tupper/Jag Batth	Jag Batth/Keri Noeske	Ryan Gates/Paul Scholfield	Ben Cripps/Exec Team	Malinda/Keri/Dianne	
BOD meeting #1	Oct	Aug	Jul	Monthly	Nov	Dec	Jan	
BOD meeting #2	Feb	Dec	Nov	Monthly	Mar	April	May	
How	Initiatives	Initiatives	Initiatives	Initiatives	Initiatives	Focus Contracts-Ben	Reduce Hours	
	Collections - focus	Contracts	Key Director Champions	Chartis Plan	KHMG Plan	Contractual Opportunities	- Productivity/monitoring	
	Appeal Accountability	Underpayments	Molly Niederreiter, Christine Aleman, James, McNulty, Lawrence Headley, Tendai Zinyemba John Leal, Tony Reyes, Jill Anderson Kaweah Shares			Performance/Collections	- Close Services	
	Denial prevention	IGT negotiations						- Reduce utilization
	Service line focus						Provider Documentation Committee: Dr. Boone	Reduce Rates
	Charge Capture						Gail Robinson, Keith Adams, Teresa Boyce,	Pay Practices- unsch OT..
	Self Pay Collections						Malinda/ Keri/Jag/Ryan	Reduce Contract Labor: *Retention efforts
							*Contract Invoice Recon	
							*Shift bonus -increase usage/lower rate	
							*Patient Assignments	
							*Reduction in Force	

**KAWEAH DELTA HEALTH CARE DISTRICT
SUMMARY OF FUNDS
Aug 31, 2022**

<u>Board designated funds</u>	<u>CUSIP</u>	<u>Maturity Date</u>	<u>Yield</u>	<u>Investment Type</u>	<u>G/L Account</u>	<u>Amount</u>	<u>Total</u>
LAIF			1.38	Various		7,330,368	
CAMP			2.37	CAMP		35,721,985	
PFM	31846V203		0.01	Money market		592,003	
Allspring	31846V203		0.01	Money market		139,127	
PFM	3136AEGQ4	27-Dec-22	2.28	U.S. Govt Agency	FNMA	168,583	
Torrey Pines Bank		5-Mar-23	0.35	CD	Torrey Pines Bank	3,059,808	
PFM	22552G3C2	17-Mar-23	0.59	CD	Credit Suisse Ag CD	665,000	
Allspring	345102NR4	8-Apr-23	0.30	Municipal	Foothill Ca	850,000	
PFM	459058JV6	20-Apr-23	0.13	Supra-National Agen	Intl Bk	620,000	
PFM	023135BQ8	3-Jun-23	0.80	MTN-C	Amazon Com Inc	445,000	
PFM	69371RQ82	8-Jun-23	0.80	MTN-C	Paccar Financial Mtn	140,000	
PFM	73358W4V3	1-Jul-23	1.09	Municipal	Port Auth NY	245,000	
PFM	24422EVH9	5-Jul-23	0.70	MTN-C	John Deere Mtn	230,000	
PFM	24422EVH9	5-Jul-23	0.70	MTN-C	John Deere Mtn	295,000	
PFM	3135G05G4	10-Jul-23	0.25	U.S. Govt Agency	FNMA	1,710,000	
PFM	3137FKK39	25-Jul-23	3.20	ABS	FHLMC	10,641	
PFM	157411TJ8	1-Aug-23	2.00	Municipal	Chaffey Ca	265,000	
PFM	797272QN4	1-Aug-23	2.00	Municipal	San Diego Ca Community	165,000	
PFM	874857KJ3	1-Aug-23	1.97	Municipal	Tamalpais Ca Union	370,000	
Allspring	14575TDX7	1-Aug-23	0.98	Municipal	Carson Ca Redev Ag	300,000	
Allspring	250433TX7	1-Aug-23	1.30	Municipal	Desert Sands Ca	315,000	
Allspring	697511FA6	1-Aug-23	0.58	Municipal	Palomar Ca	700,000	
Allspring	916544ES4	1-Aug-23	0.68	Municipal	Upper Santa Clara	1,100,000	
PFM	362569AC9	21-Aug-23	0.74	ABS	GM Fin Auto Lease	52,451	
PFM	798135H51	1-Sep-23	2.13	Municipal	San Jose Ca Ref	765,000	
PFM	89236TFN0	20-Sep-23	3.45	MTN-C	Toyota Motor	550,000	
PFM	02665WCQ2	10-Oct-23	3.63	MTN-C	American Honda Mtn	395,000	
PFM	65480EAD3	16-Oct-23	0.00	ABS	Nissann Auto Lease	101,061	
PFM	110122DT2	13-Nov-23	0.54	MTN-C	Bristol Myers Squibb	280,000	
PFM	14042WAC4	15-Nov-23	2.51	ABS	Capital One Prime	5,769	
PFM	91282CAW1	15-Nov-23	0.25	U.S. Govt Agency	US Treasury Bill	1,000,000	
PFM	91282CAW1	15-Nov-23	0.25	U.S. Govt Agency	US Treasury Bill	350,000	
PFM	459058JM6	24-Nov-23	0.25	Supra-National Agen	Intl Bk	1,265,000	
PFM	3137BTU25	25-Nov-23	3.06	U.S. Govt Agency	FHLMC	386,542	
PFM	3137EAF42	4-Dec-23	0.25	U.S. Govt Agency	FHLMC	595,000	
Allspring	650009R88	1-Jan-24	2.12	Municipal	New York ST	585,000	
PFM	91282CBE0	15-Jan-24	0.13	U.S. Govt Agency	US Treasury Bill	910,000	
PFM	693475AV7	23-Jan-24	3.50	MTN-C	PNC Financial	395,000	
PFM	05591RAC8	25-Jan-24	0.40	ABS	BMW Auto Leasing LLC	168,089	
PFM	6174468W2	25-Jan-24	0.53	MTN-C	Morgan Stanley	335,000	
Allspring	9128285Z9	31-Jan-24	2.50	U.S. Govt Agency	US Treasury Bill	775,000	
Allspring	69371RR24	2-Feb-24	0.35	MTN-C	Paccar Financial Mtn	1,000,000	
Allspring	6374HEU2	8-Feb-24	0.35	MTN-C	National Rural	1,400,000	
PFM	9128286G0	29-Feb-24	2.38	U.S. Govt Agency	US Treasury Bill	1,470,000	
PFM	58933YAU9	7-Mar-24	2.90	MTN-C	Merck Co Inc.	405,000	
PFM	904764BG1	7-Mar-24	3.25	MTN-C	Unilever Capital	200,000	
PFM	46647PBZ8	16-Mar-24	0.70	MTN-C	JP Morgan	215,000	
PFM	808513BN4	18-Mar-24	0.75	MTN-C	Schwab Charles	90,000	
Allspring	808513BN4	18-Mar-24	0.75	MTN-C	Schwab Charles	1,625,000	
Allspring	92343VGF5	22-Mar-24	0.75	MTN-C	Verizon	730,000	
PFM	3136AJB54	25-Mar-24	3.35	U.S. Govt Agency	FNMA	250,581	
PFM	61772BAA1	5-Apr-24	0.73	MTN-C	Morgan Stanley	230,000	
Allspring	61772BAA1	5-Apr-24	0.73	MTN-C	Morgan Stanley	700,000	
PFM	20030NCR0	15-Apr-24	3.70	MTN-C	Comcast Corp	395,000	
PFM	06406RAS6	26-Apr-24	0.50	MTN-C	Bank of Ny Mtn	170,000	
Allspring	06406RAS6	26-Apr-24	0.50	MTN-C	Bank of Ny Mtn	1,000,000	
PFM	912828X70	30-Apr-24	2.00	U.S. Govt Agency	US Treasury Bill	1,285,000	
Allspring	9128286R6	30-Apr-24	2.25	U.S. Govt Agency	US Treasury Bill	500,000	
Allspring	97705MUJ2	1-May-24	0.36	Municipal	Wisconsin ST	1,320,000	
Allspring	977100HH2	1-May-24	0.43	Municipal	Wisconsin ST	500,000	
PFM	023135BW5	12-May-24	0.45	MTN-C	Amazon Com Inc	250,000	
Allspring	023135BW5	12-May-24	0.45	MTN-C	Amazon Com Inc	875,000	
PFM	91324PEB4	15-May-24	0.55	MTN-C	JP Morgan	195,000	
PFM	912828WJ5	15-May-24	2.50	U.S. Govt Agency	US Treasury Bill	950,000	
PFM	912828WJ5	15-May-24	2.50	U.S. Govt Agency	US Treasury Bill	425,000	
Allspring	91412HKY8	15-May-24	0.58	Municipal	University Ca	1,000,000	
PFM	380144AC9	20-May-24	0.00	ABS	GM Fin Auto Lease	445,000	
PFM	40428HTA0	24-May-24	3.75	MTN-C	HSBC USA Inc	415,000	
PFM	04636NAC7	28-May-24	0.70	MTN-C	Astrazeneca LP	300,000	
Allspring	684100AC4	1-Jun-24	0.59	Municipal	Orange Ca	500,000	
Allspring	891371AT3	1-Jun-24	0.64	Municipal	Torrance Ca	1,450,000	
PFM	91282CCG4	15-Jun-24	0.25	U.S. Govt Agency	US Treasury Bill	865,000	
Allspring	546486BU4	15-Jun-24	0.52	Municipal	Louisiana ST	500,000	
Allspring	9128286Z8	30-Jun-24	1.75	U.S. Govt Agency	US Treasury Bill	1,000,000	
PFM	040654XU4	1-Jul-24	1.96	Municipal	Arizona ST	675,000	
PFM	20772KJW0	1-Jul-24	2.00	Municipal	Connecticut ST	150,000	
PFM	977123X60	1-Jul-24	0.62	Municipal	Wisconsin ST	470,000	
Allspring	284035AC6	1-Jul-24	0.63	Municipal	El Segundo Ca	510,000	
Allspring	544647BF6	1-Jul-24	5.00	Municipal	Los Angeles Calif Ca	1,500,000	
PFM	65479CAD0	15-Jul-24	0.00	MTN-C	Nissan Auto	67,795	
PFM	91159HFX1	30-Jul-24	2.40	MTN-C	US Bancorp	415,000	
PFM	574193TQ1	1-Aug-24	0.51	Municipal	Maryland ST	355,000	
PFM	797272QP9	1-Aug-24	2.05	Municipal	San Diego Ca Community	80,000	
PFM	798306WN2	1-Aug-24	0.70	Municipal	San Juan Ca	195,000	
PFM	874857KK0	1-Aug-24	2.02	Municipal	Tamalpais Ca Union	305,000	
PFM	02665WDY4	9-Aug-24	0.75	ABS	American Honda Mtn	190,000	

**KAWEAH DELTA HEALTH CARE DISTRICT
SUMMARY OF FUNDS
Aug 31, 2022**

PFM	05565EBU8	12-Aug-24	0.75	ABS	BMW US Cap LLC	120,000
PFM	05565EBU8	12-Aug-24	0.75	ABS	BMW US Cap LLC	220,000
PFM	904764BN6	12-Aug-24	0.63	MTN-C	Unilever Capital	100,000
PFM	438516BW5	15-Aug-24	2.30	MTN-C	Honeywell	330,000
PFM	69371RQ25	15-Aug-24	2.15	MTN-C	Paccar Financial Mtn	210,000
Allspring	30231GBC5	16-Aug-24	2.02	MTN-C	Exxon Mobil	1,320,000
PFM	254687FK7	30-Aug-24	1.75	MTN-C	Walt Disney Co	780,000
PFM	24422EVU0	10-Sep-24	0.63	MTN-C	Deere John Mtn	85,000
Allspring	14913R2P1	13-Sep-24	0.60	MTN-C	Caterpillar Finl Mtn	500,000
PFM	641062AU8	14-Sep-24	0.61	MTN-C	Nestle Holdings	640,000
PFM	4581X0DZ8	23-Sep-24	0.50	Supra-National Agen	Inter Amer Bk	870,000
PFM	912828YH7	30-Sep-24	1.50	U.S. Govt Agency	US Treasury Bill	425,000
PFM	89237VAB5	15-Oct-24	0.70	ABS	Toyota Auto Recvcs	180,702
PFM	43813KAC6	18-Oct-24	0.37	ABS	Honda Auto	268,863
PFM	06406RAL1	24-Oct-24	2.10	MTN-C	Bank of NY	150,000
PFM	09661RAD3	25-Oct-24	0.00	ABS	BMW Vehicle Owner	83,082
PFM	06406RAX5	25-Oct-24	0.85	MTN-C	Bank of Ny Mtn	390,000
PFM	172967MT5	30-Oct-24	0.78	MTN-C	Citigroup Inc	445,000
PFM	912828YM6	31-Oct-24	1.50	U.S. Govt Agency	US Treasury Bill	1,500,000
Allspring	912828YM6	31-Oct-24	1.50	U.S. Govt Agency	US Treasury Bill	650,000
PFM	605581MZ7	1-Nov-24	0.57	Municipal	Mississippi ST	300,000
PFM	14913Q3B3	8-Nov-24	2.15	MTN-C	Caterpillar Finl Mtn	850,000
Allspring	14913Q3B3	8-Nov-24	2.15	MTN-C	Caterpillar Finl Mtn	600,000
PFM	912828YV6	30-Nov-24	1.50	U.S. Govt Agency	US Treasury Bill	1,000,000
Allspring	912828YV6	30-Nov-24	1.50	U.S. Govt Agency	US Treasury Bill	175,000
Allspring	46647PAY2	5-Dec-24	4.02	MTN-C	JP Morgan	1,050,000
Allspring	07330NAT2	6-Dec-24	2.15	MTN-C	Branch Banking Trust	1,300,000
PFM	44933FAC0	15-Dec-24	0.00	ABS	Hyundai Auto	149,612
Allspring	91282CDN8	15-Dec-24	1.00	U.S. Govt Agency	US Treasury Bill	550,000
Allspring	912828YY0	31-Dec-24	1.75	U.S. Govt Agency	US Treasury Bill	1,000,000
PFM	3135G0X24	7-Jan-25	1.63	U.S. Govt Agency	FNMA	1,510,000
Allspring	24422EVC0	9-Jan-25	2.05	MTN-C	John Deere Mtn	500,000
PFM	21688AAS1	10-Jan-25	1.38	Supra-National Agen	Cooperatieve	440,000
Allspring	91282CDS7	15-Jan-25	1.13	U.S. Govt Agency	US Treasury Bill	3,300,000
Allspring	90331HPL1	21-Jan-25	2.05	MTN-C	US Bank NA	1,400,000
Allspring	38141GZH0	24-Jan-25	1.76	MTN-C	Goldman Sachs	725,000
PFM	3137FUZN7	25-Jan-25	0.53	U.S. Govt Agency	FHLMC	147,535
PFM	63743HFC1	7-Feb-25	1.88	MTN-C	National Rural Mtn	125,000
PFM	3137EAEPO	12-Feb-25	1.50	U.S. Govt Agency	FHLMC	1,000,000
PFM	89236TGT6	13-Feb-25	1.80	MTN-C	Toyota Motor	420,000
PFM	66989HAP3	14-Feb-25	1.75	MTN-C	Novartis Capital	425,000
PFM	92290BAA9	20-Feb-25	0.00	MTN-C	Verizon Owner	455,000
Allspring	24422EWB1	7-Mar-25	2.13	MTN-C	Deere John Mtn	550,000
PFM	771196BT8	10-Mar-25	2.13	MTN-C	Roche Holding Inc	730,000
PFM	14315FAD9	15-Mar-25	0.00	ABS	Carmax Auto Owner	159,231
PFM	369550BK3	1-Apr-25	3.25	MTN-C	General Dynamics	395,000
Allspring	072024XB3	1-Apr-25	0.88	Municipal	Bay Area Toll	250,000
Allspring	023135CE4	13-Apr-25	3.00	MTN-C	Amazon Com Inc	500,000
PFM	3130AJHU6	14-Apr-25	0.50	U.S. Govt Agency	FHLB	1,340,000
PFM	437076CM2	15-Apr-25	2.70	MTN-C	Home Depot Inc	65,000
PFM	3135G03U5	22-Apr-25	0.63	U.S. Govt Agency	FNMA	1,530,000
PFM	06406RBC0	25-Apr-25	3.50	MTN-C	Bank of NY	425,000
PFM	172967MX6	1-May-25	0.98	MTN-C	Citigroup Inc	440,000
Allspring	797412DM2	1-May-25	0.74	Municipal	San Diego County	300,000
PFM	037833DT4	11-May-25	1.13	MTN-C	Apple, Inc	655,000
PFM	91412HFM0	15-May-25	0.93	Municipal	University Calf Ca	185,000
Allspring	91282CEQ0	15-May-25	2.75	U.S. Govt Agency	US Treasury Bill	980,000
Allspring	45866FAT1	23-May-25	3.65	MTN-C	Intercontinental	725,000
PFM	3137BKRJ1	25-May-25	3.33	U.S. Govt Agency	FHLMC	855,000
PFM	438516CB0	1-Jun-25	1.35	MTN-C	Honeywell	220,000
PFM	291011BG8	1-Jun-25	3.15	MTN-C	Emerson Electric Co	265,000
PFM	438516CB0	1-Jun-25	1.35	MTN-C	Honeywell	180,000
PFM	46647PCH7	1-Jun-25	0.82	MTN-C	JP Morgan	725,000
PFM	46647PCH7	1-Jun-25	0.82	MTN-C	JP Morgan	275,000
Allspring	20772KNW5	1-Jun-25	0.92	Municipal	Connecticut ST	400,000
PFM	3135G04Z3	17-Jun-25	0.50	U.S. Govt Agency	FNMA	1,800,000
Allspring	3135G04Z3	17-Jun-25	0.50	U.S. Govt Agency	FNMA	2,000,000
Allspring	912828ZW3	30-Jun-25	0.25	U.S. Govt Agency	US Treasury Bill	350,000
PFM	241271AD6	1-Jul-25	1.26	Municipal	Florida ST	600,000
PFM	977123X78	1-Jul-25	0.77	Municipal	Wisconsin ST	440,000
PFM	32262XAD6	21-Jul-25	0.50	ABS	GM Financial	100,000
PFM	3137EAEU9	21-Jul-25	0.38	U.S. Govt Agency	FHLMC	520,000
Allspring	3137EAEU9	21-Jul-25	0.38	U.S. Govt Agency	FHLMC	1,500,000
PFM	91282CAB7	31-Jul-25	0.25	U.S. Govt Agency	US Treasury Bill	185,000
Allspring	91282CAB7	31-Jul-25	0.25	U.S. Govt Agency	US Treasury Bill	1,275,000
PFM	025816CY3	1-Aug-25	3.95	MTN-C	American Express Co	230,000
PFM	54438CYK2	1-Aug-25	0.77	Municipal	Los Angeles Ca	335,000
PFM	798306WP7	1-Aug-25	0.85	Municipal	San Juan Ca	190,000
Allspring	801747AD8	1-Aug-25	2.17	Municipal	Santa Cruz Ca	400,000
PFM	194162AM5	15-Aug-25	3.10	MTN-C	Colgate Palmolive	140,000
PFM	14316HAC6	15-Aug-25	0.78	ABS	Carmax Auto Owner	190,096
PFM	50117TAC5	15-Aug-25	0.62	ABS	Kubota Credit	195,000
Allspring	43811JAC1	15-Aug-25	0.00	ABS	Honda Auto Rec Own	1,350,000
Allspring	3135G05X7	25-Aug-25	0.38	U.S. Govt Agency	FNMA	1,500,000
Allspring	3130AK5E2	4-Sep-25	0.38	U.S. Govt Agency	FHLB	525,000

**KAWEAH DELTA HEALTH CARE DISTRICT
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PFM	44933LAC7	15-Sep-25	0.00	ABS	Hyundai Auto	190,000
PFM	002824BM1	15-Sep-25	3.88	MTN-C	Abbott Laboratories	195,000
Allspring	47788UAC6	15-Sep-25	0.36	ABS	John Deere Owner	685,000
PFM	3137EAEX3	23-Sep-25	0.00	U.S. Govt Agency	FHLMC	835,000
Allspring	3137EAEX3	23-Sep-25	0.00	U.S. Govt Agency	FHLMC	750,000
Allspring	06051GJG5	25-Sep-25	0.98	MTN-C	Bk of America	1,300,000
Allspring	742718FL8	29-Oct-25	0.55	MTN-C	Procter Gamble Co	1,300,000
Allspring	91282CAT8	31-Oct-25	0.25	U.S. Govt Agency	US Treasury Bill	770,000
PFM	50117XAE2	17-Nov-25	0.56	ABS	Kubota Credit	165,000
Allspring	91282CAZ4	30-Nov-25	0.38	U.S. Govt Agency	US Treasury Bill	1,200,000
Allspring	91282CAZ4	30-Nov-25	0.38	U.S. Govt Agency	US Treasury Bill	1,350,000
PFM	14316NAC3	15-Dec-25	0.00	ABS	Carmax Auto Owner	131,311
PFM	91282CBC4	31-Dec-25	0.38	U.S. Govt Agency	US Treasury Bill	445,000
PFM	9128CBC4	31-Dec-25	0.38	U.S. Govt Agency	US Treasury Bill	950,000
PFM	9128285T3	31-Dec-25	2.63	U.S. Govt Agency	US Treasury Bill	2,000,000
PFM	9128CBH3	31-Jan-26	0.38	U.S. Govt Agency	US Treasury Bill	1,000,000
Allspring	857477BR3	6-Feb-26	1.75	MTN-C	State Street Corp	350,000
Allspring	857477BR3	6-Feb-26	1.75	MTN-C	State Street Corp	650,000
PFM	38141GXS8	12-Feb-26	0.86	MTN-C	Goldman Sachs	205,000
PFM	912828P46	15-Feb-26	1.63	U.S. Govt Agency	US Treasury Bill	1,000,000
PFM	14314QAC8	17-Feb-26	0.00	ABS	Carmax Auto Owner	285,000
PFM	91282CBQ3	28-Feb-26	0.50	U.S. Govt Agency	US Treasury Bill	1,500,000
PFM	857477BM4	30-Mar-26	2.90	MTN-C	State Street Corp	420,000
PFM	9128CBT7	31-Mar-26	0.38	U.S. Govt Agency	US Treasury Bill	1,000,000
Allspring	91282CBT7	31-Mar-26	0.75	U.S. Govt Agency	US Treasury Bill	675,000
PFM	06051GKM0	2-Apr-26	3.38	MTN-C	Bank of America	250,000
PFM	06051GFX2	19-Apr-26	3.50	MTN-C	Bank of America	295,000
Allspring	95000U2X0	25-Apr-26	3.91	MTN-C	Wells Fargo co	800,000
Allspring	46647PCZ7	26-Apr-26	4.08	MTN-C	JP Morgan	250,000
PFM	91282CBW0	30-Apr-26	0.75	U.S. Govt Agency	US Treasury Bill	1,000,000
PFM	91282CBW0	30-Apr-26	0.75	U.S. Govt Agency	US Treasury Bill	435,000
Allspring	91282CBW0	30-Apr-26	0.75	U.S. Govt Agency	US Treasury Bill	1,900,000
Allspring	91282CBW0	30-Apr-26	0.75	U.S. Govt Agency	US Treasury Bill	450,000
Allspring	91282CBW0	30-Apr-26	0.75	U.S. Govt Agency	US Treasury Bill	1,000,000
Allspring	91282CBW0	30-Apr-26	0.75	U.S. Govt Agency	US Treasury Bill	1,875,000
PFM	459200JZ5	15-May-26	3.30	MTN-C	IBM Corp	410,000
PFM	04636NAA1	28-May-26	1.20	MTN-C	Astrazeneca LP	265,000
PFM	91282CCF6	31-May-26	0.75	U.S. Govt Agency	US Treasury Bill	1,000,000
PFM	9128286X3	31-May-26	2.13	U.S. Govt Agency	US Treasury Bill	1,200,000
PFM	14317DAC4	15-Jun-26	0.00	ABS	Carmax Auto Owner	550,000
Allspring	14316HAD4	15-Jun-26	0.91	ABS	Carmax Auto Owner	1,750,000
Allspring	89236TJK2	18-Jun-26	1.13	MTN-C	Toyota Motor	1,400,000
PFM	91282CCJ8	30-Jun-26	0.88	U.S. Govt Agency	US Treasury Bill	750,000
PFM	91282CCJ8	30-Jun-26	0.88	U.S. Govt Agency	US Treasury Bill	240,000
Allspring	91282CCJ8	30-Jun-26	0.88	U.S. Govt Agency	US Treasury Bill	1,850,000
PFM	544647FC9	1-Jul-26	1.46	Municipal	Los Angeles Ca	270,000
Allspring	03255LKA6	1-Jul-26	1.89	Municipal	Anaheim Ca Pub	1,000,000
PFM	931142EM1	8-Jul-26	3.05	MTN-C	Walmart INC	205,000
PFM	43815PAC3	20-Jul-26	0.00	ABS	Honda Auto Rec Own	130,000
PFM	06406RBJ5	24-Jul-26	4.41	MTN-C	Bank of NY Mtn	55,000
PFM	89788MAH5	28-Jul-26	4.26	MTN-C	Truist Financial Mtn	275,000
PFM	91282CCP4	31-Jul-26	0.63	U.S. Govt Agency	US Treasury Bill	280,000
PFM	91282CCP4	31-Jul-26	0.63	U.S. Govt Agency	US Treasury Bill	600,000
Allspring	380130AF1	20-Aug-26	5.40	ABS	GM Fin Atmbl Lease	1,365,000
PFM	91282CCW9	31-Aug-26	0.75	U.S. Govt Agency	US Treasury Bill	1,000,000
PFM	14913R2Q9	14-Sep-26	1.15	MTN-C	Caterpillar Finl Mtn	220,000
Allspring	34528QHf4	15-Sep-26	2.44	MTN-C	Ford Credit	1,750,000
PFM	91282CCZ2	30-Sep-26	0.88	U.S. Govt Agency	US Treasury Bill	1,000,000
Allspring	91282CCZ2	30-Sep-26	0.88	U.S. Govt Agency	US Treasury Bill	1,210,000
Allspring	9128CCZ2	30-Sep-26	0.88	U.S. Govt Agency	US Treasury Bill	1,000,000
PFM	46625HRV4	1-Oct-26	2.95	MTN-C	JP Morgan	415,000
Allspring	91282CDG3	31-Oct-26	1.13	U.S. Govt Agency	US Treasury Bill	800,000
PFM	025816CM9	4-Nov-26	0.02	MTN-C	American Express Co	445,000
PFM	539830BH1	15-Nov-26	3.55	MTN-C	Lockheed Martin	203,000
PFM	14041NFY2	16-Nov-26	0.00	ABS	Capital One Multi	640,000
Allspring	02582JJR2	16-Nov-26	0.90	MTN-C	American Express Cr	1,750,000
PFM	91282CDK4	30-Nov-26	1.25	U.S. Govt Agency	US Treasury Bill	1,000,000
PFM	91282CDK4	30-Nov-26	1.25	U.S. Govt Agency	US Treasury Bill	200,000
PFM	91282CDK4	30-Nov-26	1.25	U.S. Govt Agency	US Treasury Bill	1,000,000
Allspring	91282CDK4	30-Nov-26	1.13	U.S. Govt Agency	US Treasury Bill	1,100,000
Allspring	91282CDK4	30-Nov-26	1.13	U.S. Govt Agency	US Treasury Bill	900,000
PFM	91282CDQ1	31-Dec-26	1.25	U.S. Govt Agency	US Treasury Bill	1,000,000
PFM	91282CDQ1	31-Dec-26	1.25	U.S. Govt Agency	US Treasury Bill	1,000,000
PFM	02665WDJ7	8-Jan-27	2.35	MTN-C	American Honda Mtn	220,000
PFM	24422EWA3	11-Jan-27	1.70	MTN-C	Deere John Mtn	220,000
PFM	87612EBM7	15-Jan-27	1.95	MTN-C	Target Corp	115,000
PFM	87612EBM7	15-Jan-27	1.95	MTN-C	Target Corp	215,000
Allspring	87612EBM7	15-Jan-27	1.95	MTN-C	Target Corp	900,000
Allspring	912828Z78	31-Jan-27	1.50	U.S. Govt Agency	US Treasury Bill	650,000
Allspring	912828Z78	31-Jan-27	1.50	U.S. Govt Agency	US Treasury Bill	750,000
PFM	00724PAC3	1-Feb-27	2.15	MTN-C	Adobe Inc	220,000
PFM	3130AKYH3	10-Feb-27	0.83	U.S. Govt Agency	FHLB	710,000

**KAWEAH DELTA HEALTH CARE DISTRICT
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PFM	654106AJ2	27-Mar-27	2.75	MTN-C	Nike Inc	215,000
Allspring	91282CEF4	31-Mar-27	2.50	U.S. Govt Agency	US Treasury Bill	1,280,000
Allspring	91282CEF4	31-Mar-27	2.50	U.S. Govt Agency	US Treasury Bill	550,000
Allspring	91282CEF4	31-Mar-27	2.38	U.S. Govt Agency	US Treasury Bill	1,500,000
PFM	14318MAD1	15-Apr-27	0.00	ABS	Carmax Auto Owner	600,000
PFM	437076CA8	15-Apr-27	2.50	MTN-C	Home Depot Inc	220,000
PFM	91282ZLN3	30-Apr-27	0.50	U.S. Govt Agency	US Treasury Bill	250,000
PFM	91282CEN7	30-Apr-27	2.88	U.S. Govt Agency	US Treasury Bill	800,000
Allspring	91282CEN7	30-Apr-27	2.88	U.S. Govt Agency	US Treasury Bill	970,000
PFM	665859AW4	10-May-27	4.00	MTN-C	Northern Tr Corp Sr	250,000
Allspring	665859AW4	10-May-27	4.00	MTN-C	Northern Tr Corp Sr	800,000
PFM	912828X88	15-May-27	2.38	U.S. Govt Agency	US Treasury Bill	925,000
PFM	459200KH3	15-May-27	1.70	MTN-C	IBM Corp	230,000
PFM	91324PEG3	15-May-27	3.70	MTN-C	Unitedhealth Group	85,000
Allspring	14041NGA3	15-May-27	7.10	ABS	Capital One Multi	1,750,000
PFM	14043GAD6	17-May-27	4.14	ABS	Capital One Prime	265,000
PFM	02582JJT8	17-May-27	2.39	MTN-C	American Express Co	655,000
PFM	254683CS2	17-May-27	0.00	MTN-C	Discover Card Exe	305,000
Allspring	254683CS2	17-May-27	3.32	MTN-C	Discover Card Exe	1,750,000
PFM	693475AT2	19-May-27	3.15	MTN-C	PNC Financial	215,000
PFM	89788MAC6	19-May-27	3.15	MTN-C	Truist Financial Mtn	240,000
Allspring	91282CET4	31-May-27	2.63	U.S. Govt Agency	US Treasury Bill	2,000,000
Allspring	91282CEW7	20-Jun-27	3.00	U.S. Govt Agency	US Treasury Bill	175,000
Allspring	576004HD0	15-Jul-27	3.68	Municipal	Massachusetts St	1,000,000
PFM	91282CFB2	31-Jul-27	2.75	U.S. Govt Agency	US Treasury Bill	1,675,000
Allspring	010878BF2	1-Aug-27	3.46	Municipal	Alameda Cnty Ca	500,000
PFM	458140BY5	5-Aug-27	3.75	MTN-C	Intel Corp	420,000
PFM	254683CP8	15-Sep-28	0.00	MTN-C	Discover Card Exe	495,000
PFM	89238EAC0	20-Jul-32	0.00	ABS	Toyota Lease Owner	235,000
PFM	91282CAZ4	1-Nov-25	0.38	U.S. Govt Agency	US Treasury Bill	500,000

\$ 227,273,233

**KAWEAH DELTA HEALTH CARE DISTRICT
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	Maturity Date	Yield	Investment Type	G/L Account	Amount	Total
<u>Self-insurance trust</u>						
Wells Fargo Bank			Money market	110900	1,312,186	
Wells Fargo Bank			Fixed income - L/T	152300	<u>1,132,214</u>	2,444,400
<u>2015A revenue bonds</u>						
US Bank			COI	152445	-	
US Bank			Principal/Interest payment fund	142115	<u>156,791</u>	156,791
<u>2015B revenue bonds</u>						
US Bank			Principal/Interest payment fund	142116	1,035,964	
US Bank			Project Fund	152442	<u>9,720</u>	
US Bank			COI	152443	<u>-</u>	1,045,684
<u>2017C revenue bonds</u>						
US Bank			Principal/Interest payment fund	142118	<u>2,447,103</u>	2,447,103
<u>2020 revenue bonds</u>						
Signature Bank			Project Fund	152446	4,600	
US Bank			Principal/Interest payment fund	142113	<u>300,322</u>	304,922
<u>2014 general obligation bonds</u>						
LAIF			Interest Payment fund	152440	<u>1,788,007</u>	1,788,007
<u>Operations</u>						
Wells Fargo Bank	(Checking)	0.16	Checking	100000	(1,698,311)	
Wells Fargo Bank	(Savings)	0.16	Checking	100500	<u>4,073,682</u>	
					2,375,371	
<u>Payroll</u>						
Wells Fargo Bank	(Checking)	0.16	Checking	100100	(121,645)	
Wells Fargo Bank	(Checking)	0.16	Checking	100201	775,823	
Wells Fargo Bank	(Checking)	0.16	Checking	100200	36,845	
Wells Fargo Bank			Checking	100205	927	
Bancorp	(Checking)		Checking	100202	<u>(36,249)</u>	
					655,701	3,031,072
Total investments					\$	<u>238,491,212</u>

**KAWEAH DELTA HEALTH CARE DISTRICT
SUMMARY OF FUNDS
Aug 31, 2022**

Kaweah Delta Medical Foundation

Wells Fargo Bank	Checking	100050		\$ 5,687,018
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Sequoia Regional Cancer Center

Wells Fargo Bank (Medical)	Checking	100535	792,782	\$ 792,782
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Kaweah Delta Hospital Foundation

VCB Checking	Investments	100501	432,533	
Various	S/T Investments	142200	8,615,367	
Various	L/T Investments	142300	11,139,635	
Various	Unrealized G/L	142400	30,990	
				\$ 20,218,525

Summary of board designated funds:

Plant fund:

Uncommitted plant funds	\$ 178,174,519		142100	
Committed for capital	16,627,388		142100	
		<u>194,801,907</u>		
GO Bond reserve - L/T	1,992,658		142100	
401k Matching	6,023,373		142100	
Cost report settlement - current	2,135,384		142104	
Cost report settlement - L/T	<u>1,312,727</u>		142100	
		3,448,111		
Development fund/Memorial fund	104,184		112300	
Workers compensation - current	5,625,000		112900	
Workers compensation - L/T	<u>15,278,000</u>		113900	
		20,903,000		
		<u>\$ 227,273,233</u>		

	Total Investments	%	Trust Accounts	Surplus Funds	%
<u>Investment summary by institution:</u>					
Bancorp	\$ (36,249)		0.0%	(36,249)	0.0%
CAMP	35,721,985		15.0%	35,721,985	15.5%
Local Agency Investment Fund (LAIF)	7,330,368		3.1%	7,330,368	3.2%
Local Agency Investment Fund (LAIF) - GOB Tax Rev	1,788,007		0.7%	-	0.0%
Allspring	92,304,127		38.7%	2,444,400	39.0%
PFM	88,856,946		37.3%	88,856,946	38.6%
Torrey Pines Bank	3,059,808		1.3%	3,059,808	1.3%
Wells Fargo Bank	5,511,721		2.3%	5,511,721	2.4%
Signature Bank	4,600		0.0%	4,600	0.0%
US Bank	3,949,900		1.7%	3,949,900	0.0%
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Total investments	\$ 238,491,212	100.0%	\$ 8,186,907	230,304,305	100.0%

**KAWEAH DELTA HEALTH CARE DISTRICT
SUMMARY OF FUNDS
Aug 31, 2022**

<u>Investment summary of surplus funds by type:</u>		<u>Investment Limitations</u>
Negotiable and other certificates of deposit	\$ 3,724,808	69,091,000 (30%)
Checking accounts	3,031,072	
Local Agency Investment Fund (LAIF)	7,330,368	75,000,000
Cal Trust	-	
CAMP	35,721,985	
Medium-term notes (corporate) (MTN-C)	54,240,795	69,091,000 (30%)
U.S. government agency	88,258,241	
Municipal securities	21,340,000	
Money market accounts	731,130	46,061,000 (20%)
Commercial paper	-	57,576,000 (25%)
Asset Backed Securities	12,730,907	46,061,000 (20%)
Supra-National Agency	3,195,000	69,091,000 (30%)
	<u>\$ 230,304,305</u>	

Return on investment:

Current month	<u><u>0.82%</u></u>
Year-to-date	<u><u>0.82%</u></u>
Prospective	<u><u>1.57%</u></u>
LAIF (year-to-date)	<u><u>1.18%</u></u>
Budget	<u><u>1.65%</u></u>

Fair market value disclosure for the quarter ended June 30, 2022 (District only):

	<u>Quarter-to-date</u>	<u>Year-to-date</u>
Difference between fair value of investments and amortized cost (balance sheet effect)	N/A	(8,344,119)
Change in unrealized gain (loss) on investments (income statement effect)	\$ (4,656,399)	(11,234,996)

**KAWEAH DELTA HEALTH CARE DISTRICT
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Investment summary of CDs:

Credit Suisse Ag CD	\$ 665,000
Dnb Bank Asa Ny CD	0
Torrey Pines Bank	3,059,808
	<u>\$ 3,724,808</u>

Investment summary of asset backed securities:

American Honda Mtn	\$ 190,000
BMW Vehicle Owner	83,082
BMW Auto Leasing LLC	168,089
BMW US Cap LLC	340,000
Capital One Multi	2,390,000
Capital One Prime	270,769
Carmax Auto Owner	3,665,638
FHLMC	10,641
GM Fin Atmbl Lease	1,365,000
Gm Fin Auto Lease	497,451
Gm Financial	100,000
Honda Auto	268,863
Honda Auto Rec Own	1,480,000
Hyundai Auto	339,612
John Deere Owner	685,000
Kubota Credit	360,000
Nissann Auto Lease	101,061
Toyota Auto Recvs	180,702
Toyota Lease Owner	235,000
	<u>\$ 12,730,907</u>

KAWEAH DELTA HEALTH CARE DISTRICT
SUMMARY OF FUNDS
Aug 31, 2022

Investment summary of medium-term notes (corporate):

Abbott Laboratories	\$	195,000
Adobe Inc	\$	220,000
Amazon Com Inc		2,070,000
American Express Co		1,330,000
American Express Cr		1,750,000
American Honda Mtn		615,000
Apple, Inc		655,000
Astrazeneca LP		565,000
Bank of America		545,000
Bank of NY		575,000
Bank of NY Mtn		1,615,000
Bk of America		1,300,000
Branch Banking Trust		1,300,000
Bristol Myers Squibb		280,000
Caterpillar Finl Mtn		2,170,000
Citigroup Inc		885,000
Colgate Palmolive		140,000
Comcast Corp		395,000
Deere John Mtn		855,000
Discover Card Exe		2,550,000
Emerson Electric Co		265,000
Exxon Mobil		1,320,000
Ford Credit		1,750,000
General Dynamics		395,000
Goldman Sachs		930,000
Home Depot Inc		285,000
Honeywell		730,000
HSBC USA Inc		415,000
IBM Corp		640,000
Intel corp		420,000
Intercontinental		725,000
John Deere Mtn		1,025,000
JP Morgan		3,125,000
Lockheed Martin		203,000
Merck Co Inc.		405,000
Morgan Stanley		1,265,000
National Rural		1,400,000
National Rural Mtn		125,000
Nestle Holdings		640,000
Nike Inc		215,000
Nissan Auto		67,795
Northern Tr Corp Sr		1,050,000
Novartis Capital		425,000
Paccar Financial Mtn		1,350,000
PNC Financial		610,000
Procter Gamble Co		1,300,000
Roche Holding Inc		730,000
Schwab Charles		1,715,000
State Street Corp		1,420,000
Target Corp		1,230,000
Toyota Motor		2,370,000
Truist Financial Mtn		515,000
Unilever Capital		300,000
Unitedhealth Group		85,000
US Bancorp		415,000
US Bank NA		1,400,000
Verizon		730,000
Verizon Owner		455,000
Walmart INC		205,000
Walt Disney Co		780,000
Wells Fargo co		800,000
	\$	<u>54,240,795</u>

Investment summary of U.S. government agency:

Federal National Mortgage Association (FNMA)	\$	10,469,165
Federal Home Loan Bank (FHLB)		2,575,000
Federal Home Loan Mortgage Corp (FHLMC)		6,589,077
US Treasury Bill		68,625,000
	\$	<u>88,258,241</u>

**KAWEAH DELTA HEALTH CARE DISTRICT
SUMMARY OF FUNDS
Aug 31, 2022**

Investment summary of municipal securities:

Arizona ST	\$	675,000
Alameda Cnty Ca	\$	500,000
Anaheim Ca Pub		1,000,000
Bay Area Toll		250,000
Carson Ca Redev Ag		300,000
Chaffey Ca		265,000
Connecticut ST		550,000
Desert Sands Ca		315,000
El Segundo Ca		510,000
Florida ST		600,000
Foothill Ca		850,000
Los Angeles Ca		605,000
Los Angeles Calif Ca		1,500,000
Louisiana ST		500,000
Maryland ST		355,000
Massachusetts St		1,000,000
Mississippi ST		300,000
New York ST		585,000
Orange Ca		500,000
Palomar Ca		700,000
Port Auth NY		245,000
San Diego Ca		-
San Diego Ca Community		245,000
San Diego County		300,000
San Francisco		-
San Jose Ca Ref		765,000
San Juan Ca		385,000
Santa Cruz Ca		400,000
Tamalpais Ca Union		675,000
Torrance Ca		1,450,000
University Ca		1,000,000
University Calif Ca		185,000
Upper Santa Clara		1,100,000
Wisconsin ST		2,730,000
		<u>\$ 21,340,000</u>

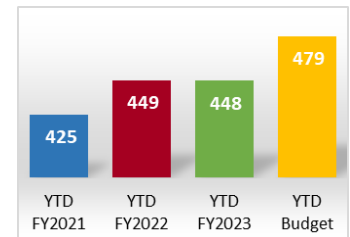
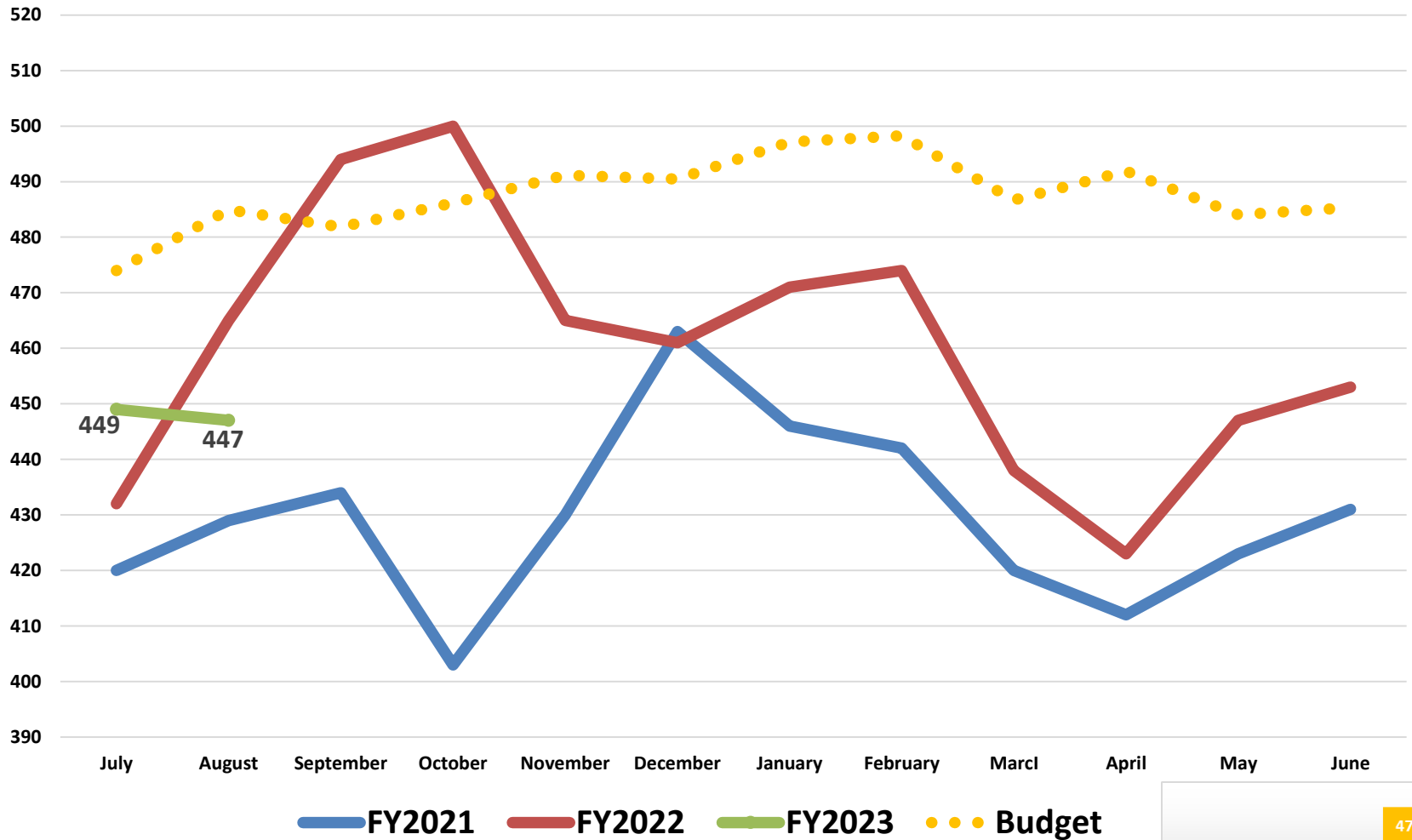
Investment summary of Supra-National Agency:

Cooperative	\$	440,000
Inter Amer Bk		870,000
Intl Bk		1,885,000
		<u>\$ 3,195,000</u>

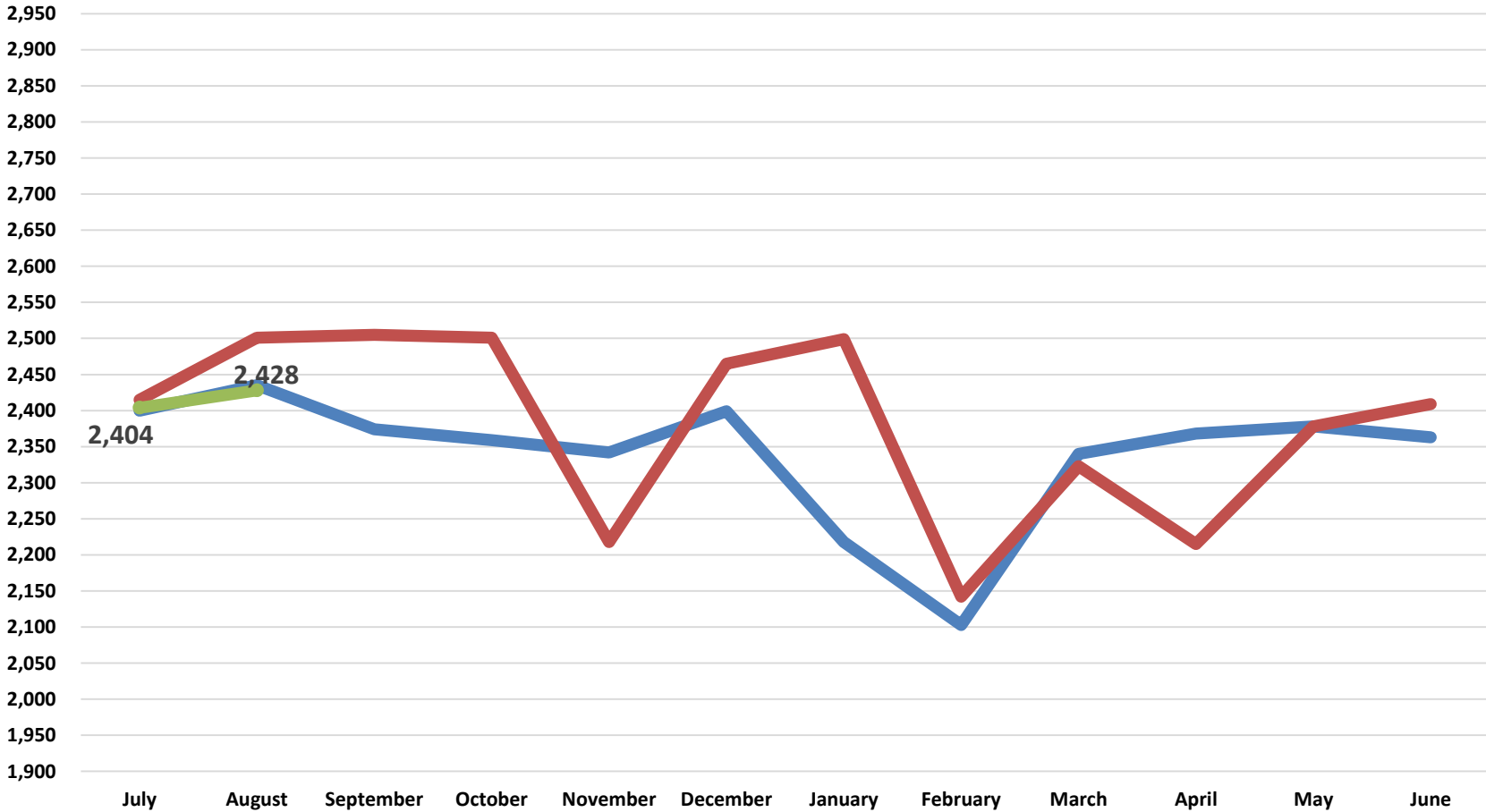
Statistical Report

September 2022

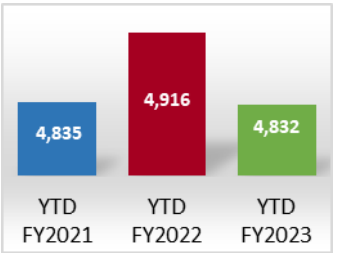
Average Daily Census



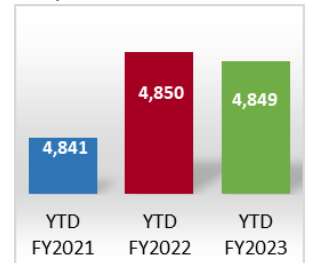
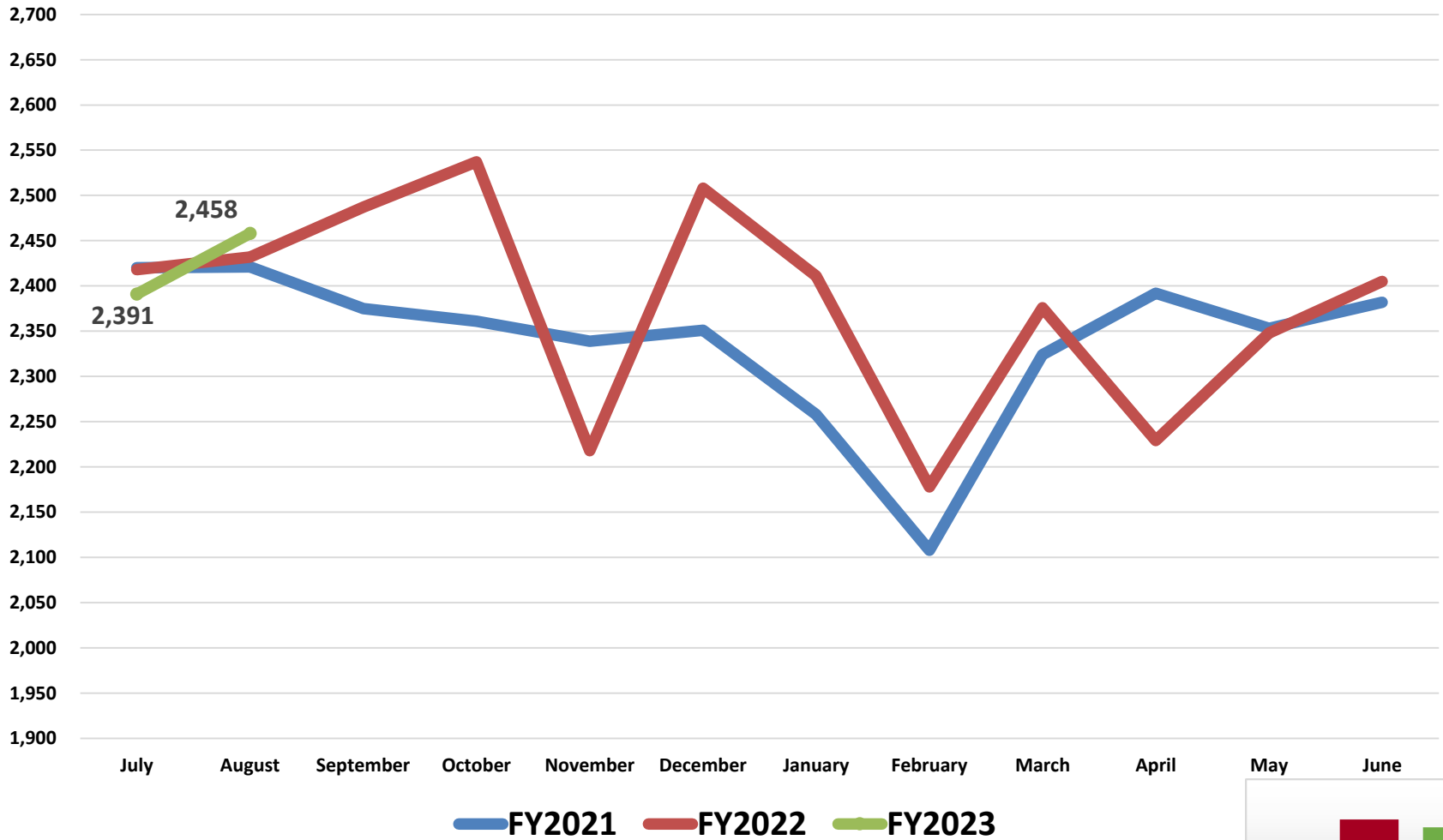
Admissions



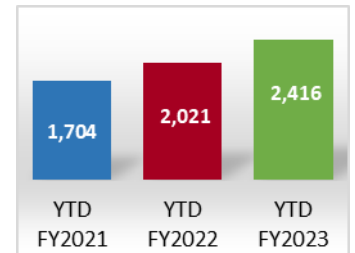
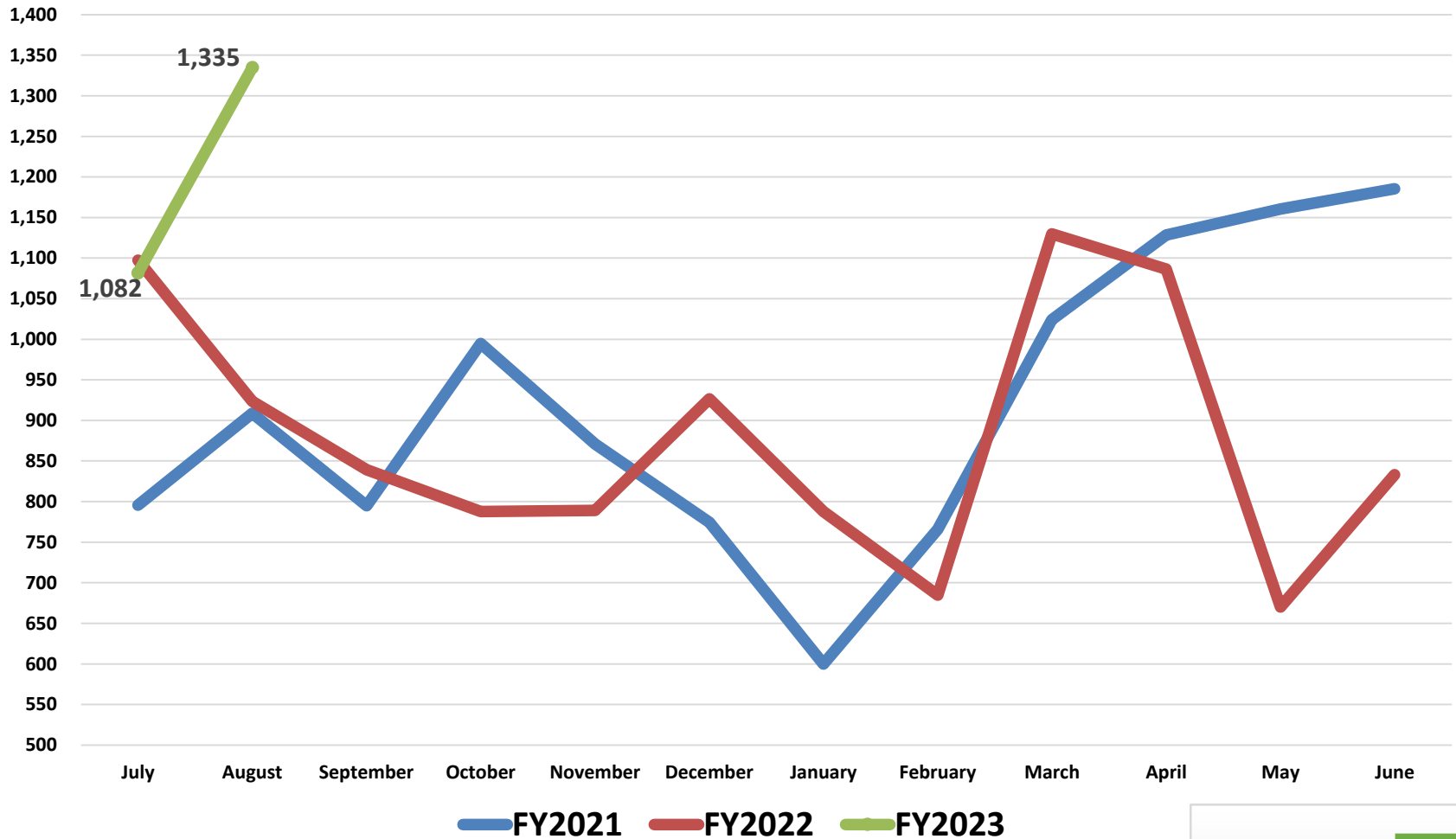
— FY2021 — FY2022 — FY2023



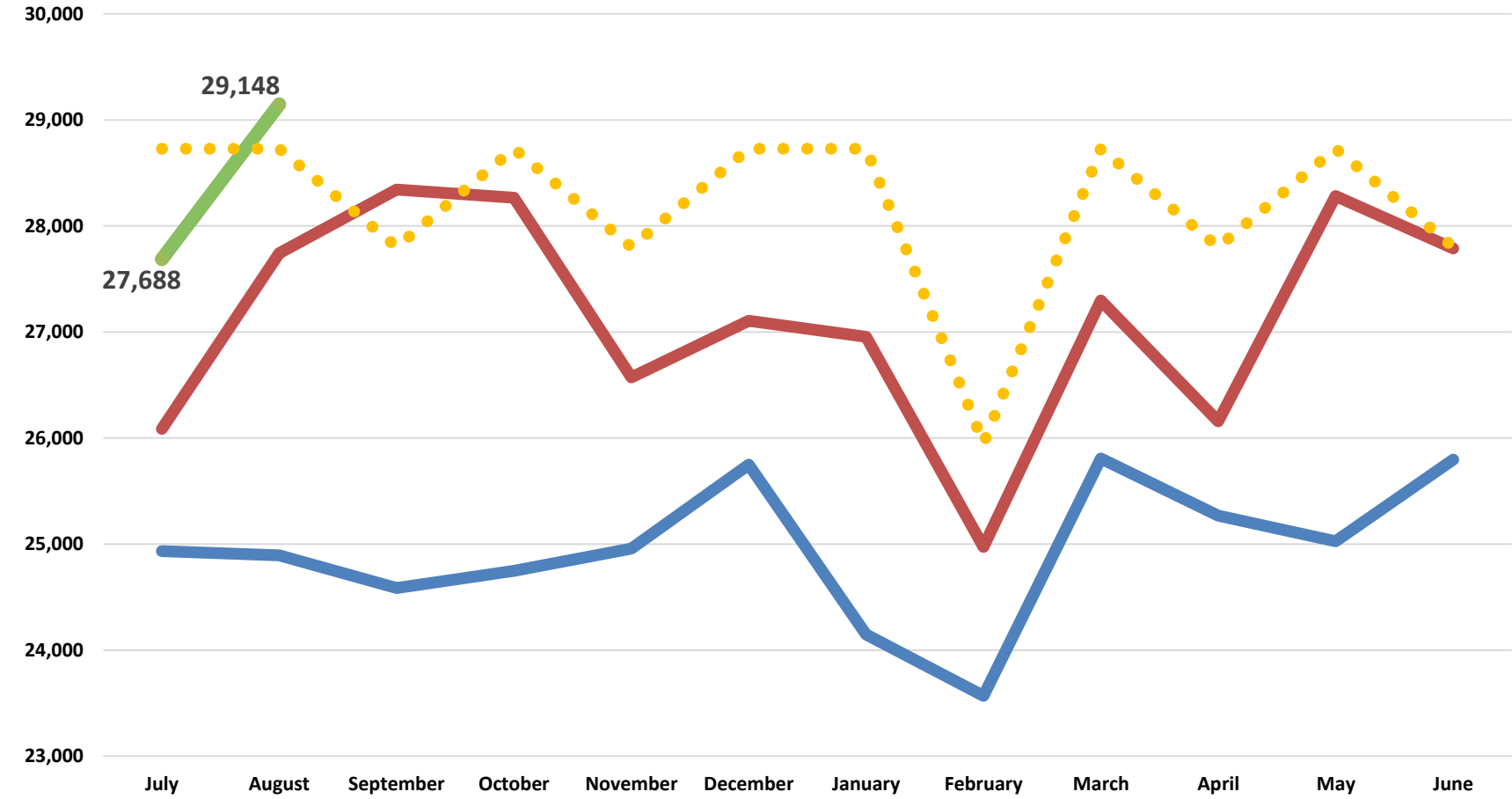
Discharges



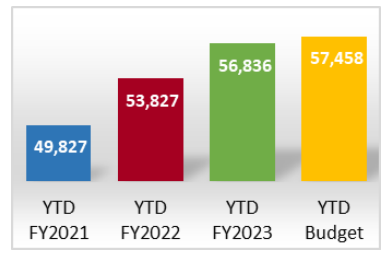
Observation Days



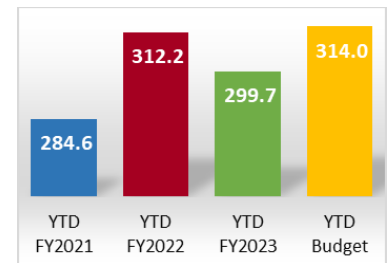
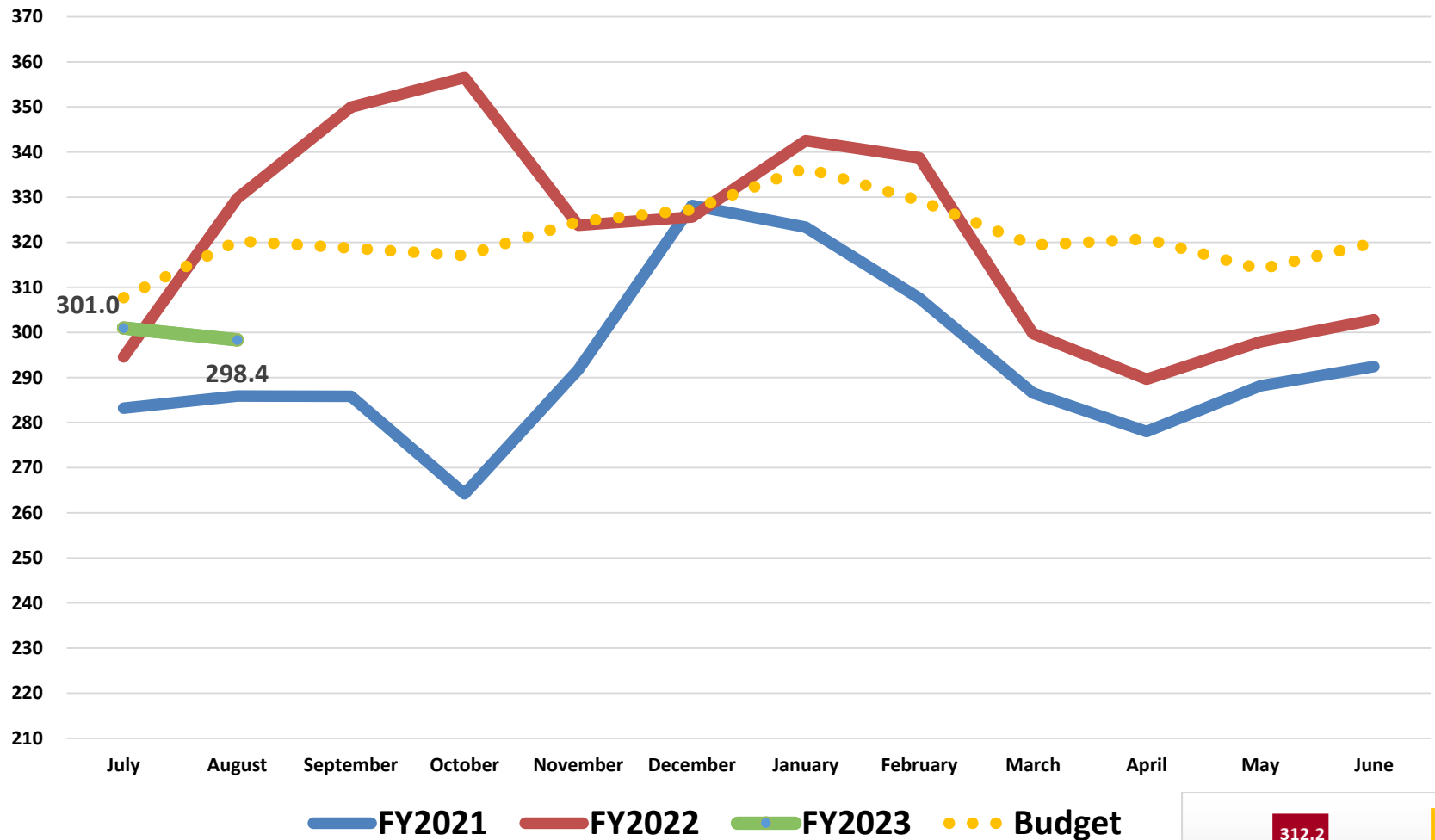
Adjusted Patient Days



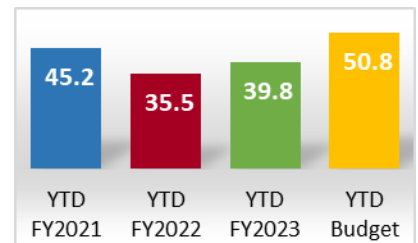
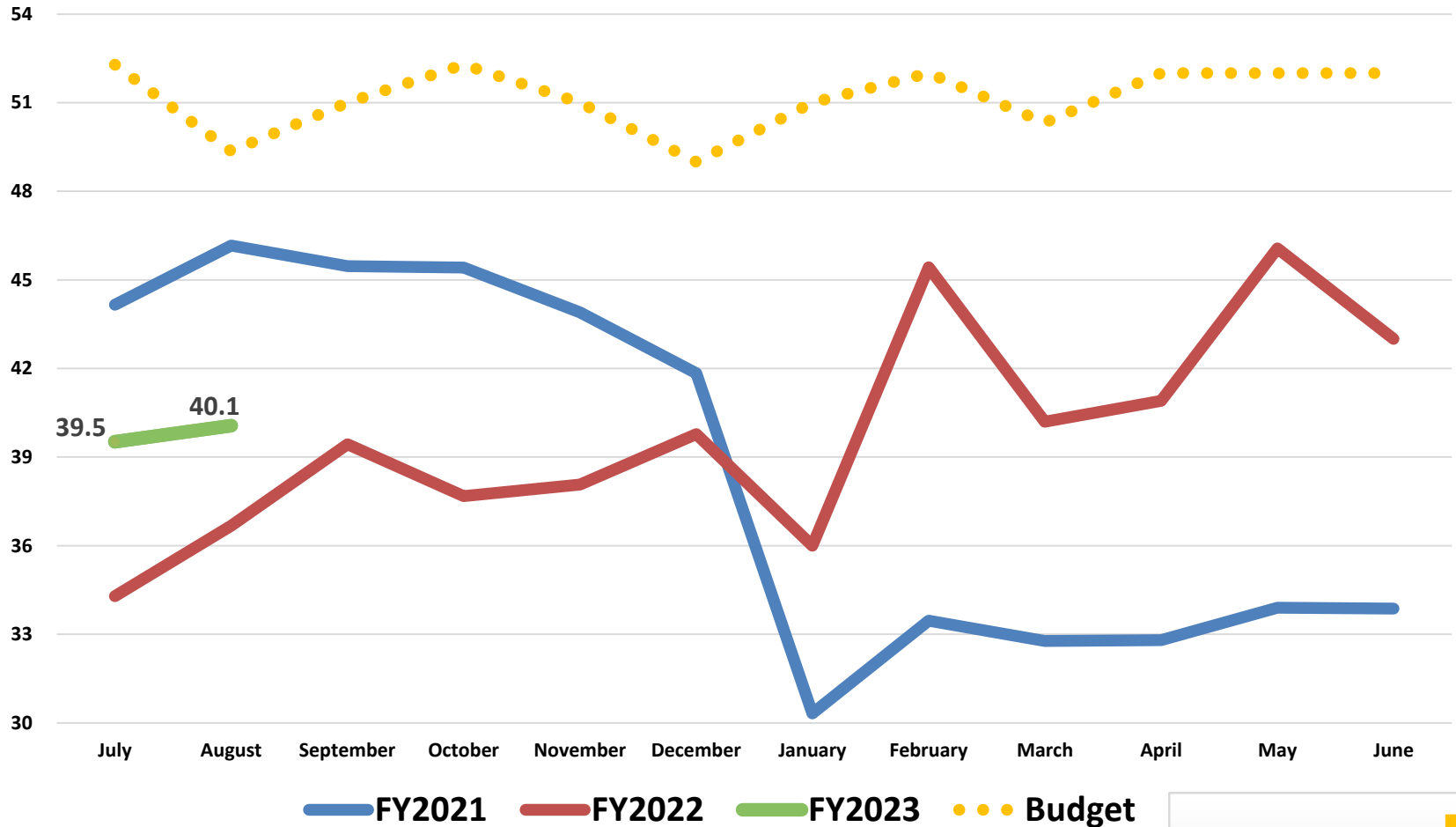
—●— **FY2021**
 —●— **FY2022**
 —●— **FY2023**
 ●●● **Budget**



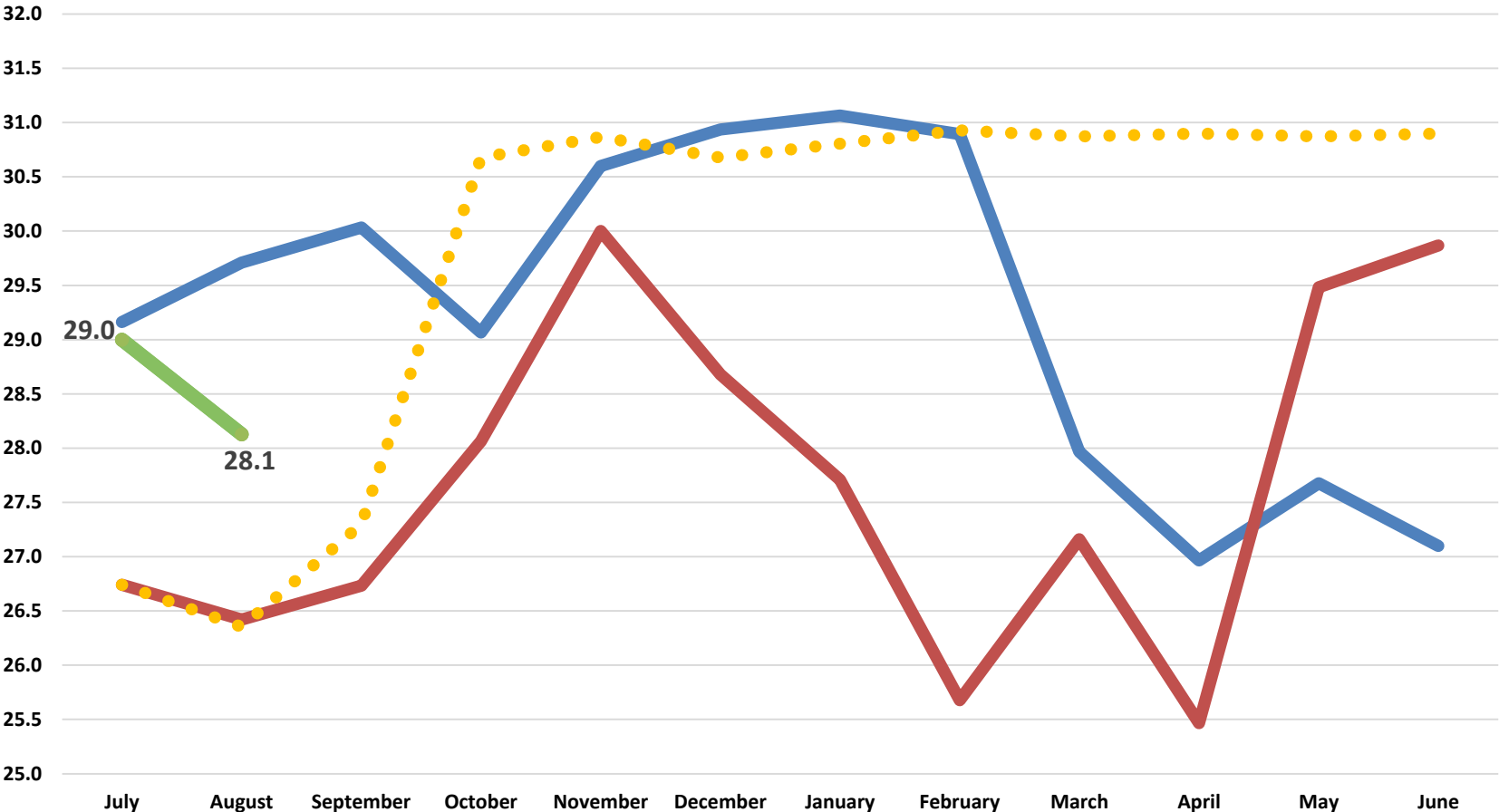
Medical Center – Avg. Patients Per Day



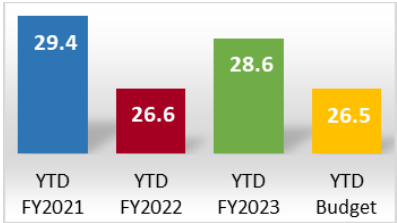
Acute I/P Psych - Avg. Patients Per Day



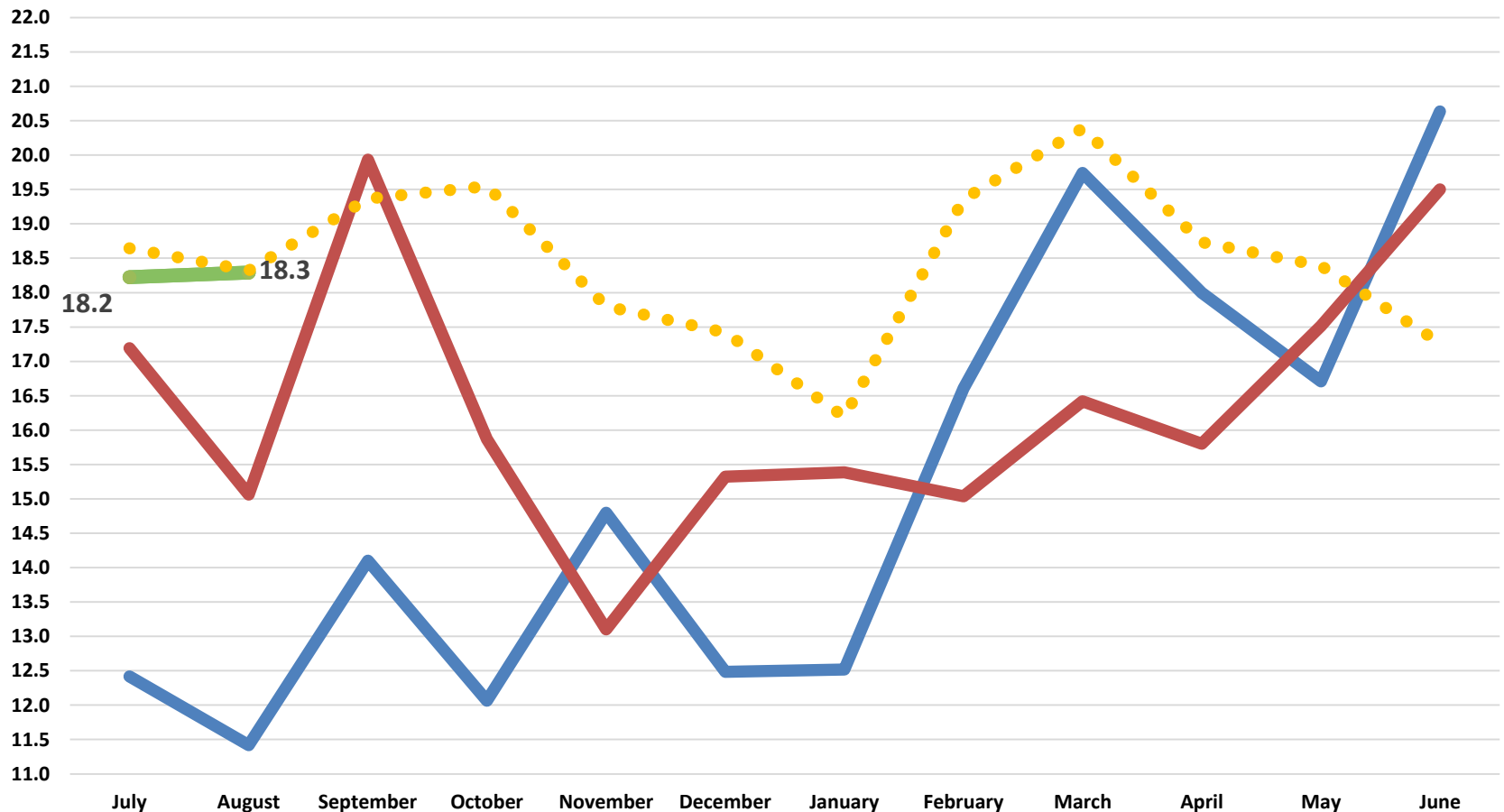
Sub-Acute - Avg. Patients Per Day



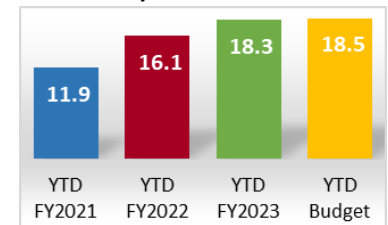
—●— **FY2021**
 —●— **FY2022**
 —●— **FY2023**
 ●●● **Budget**



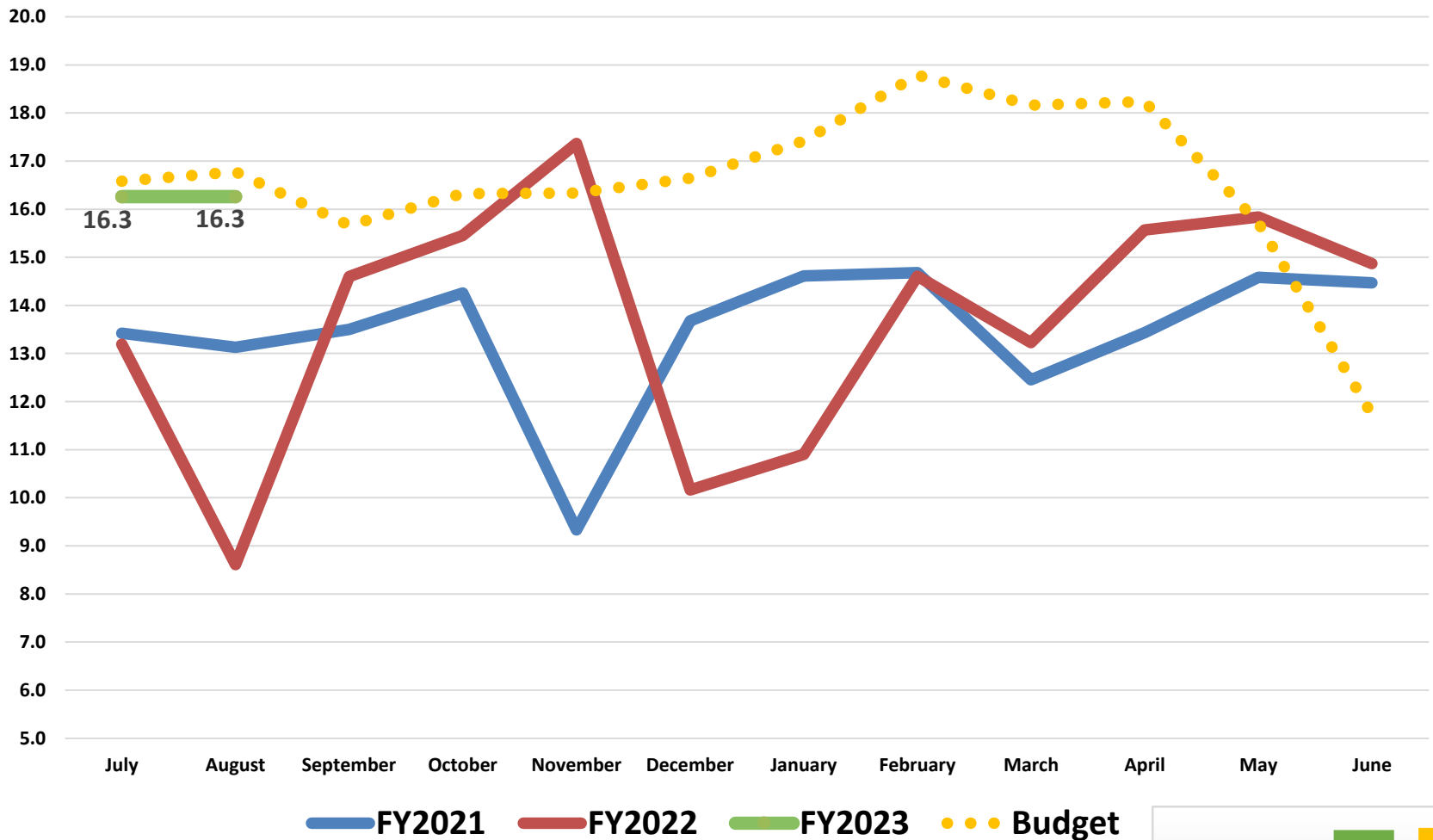
Rehabilitation Hospital - Avg. Patients Per Day



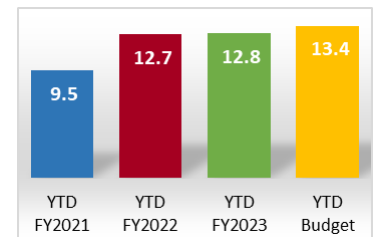
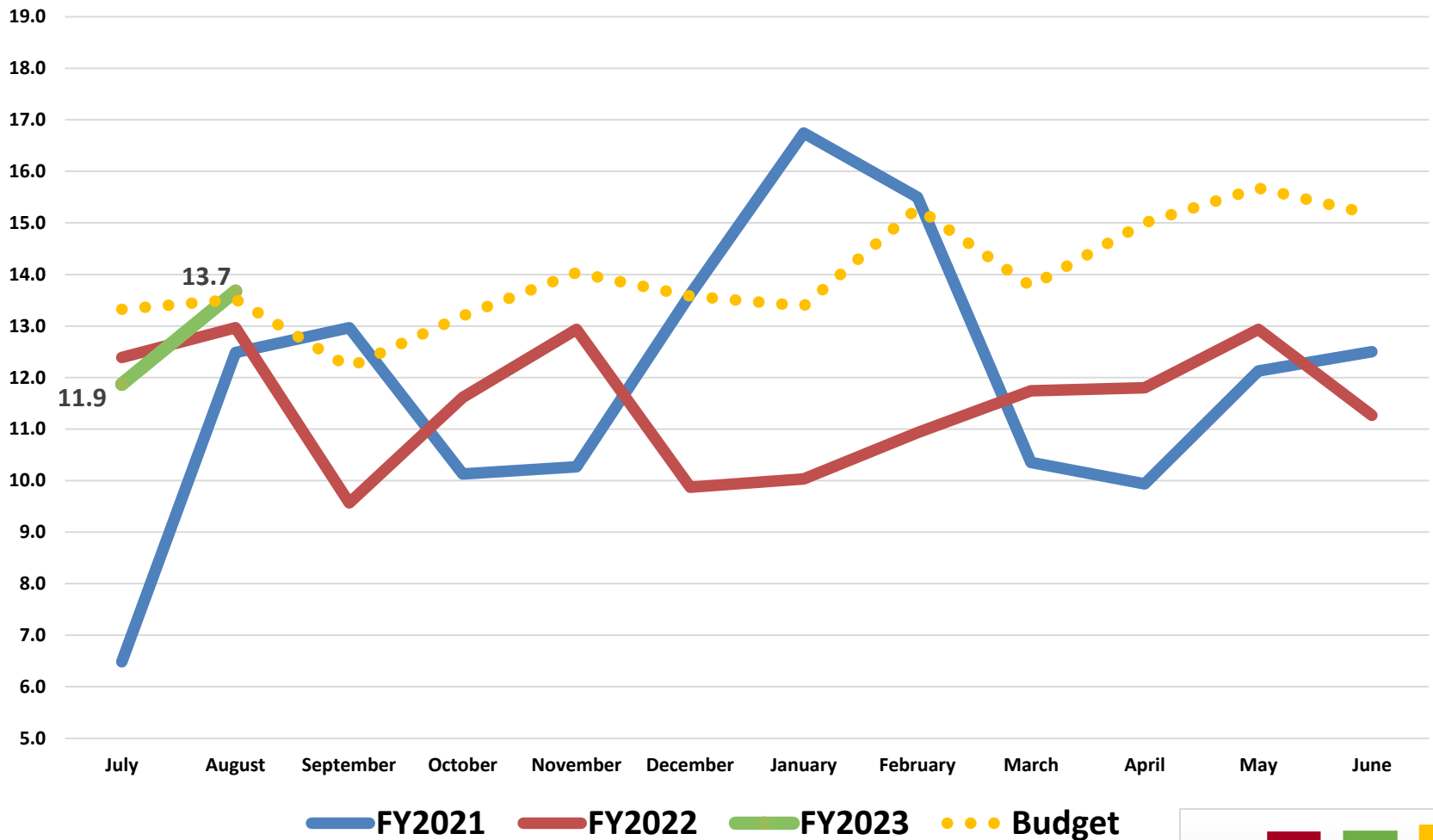
—●— **FY2021**
 —●— **FY2022**
 —●— **FY2023**
 ●●● **Budget**



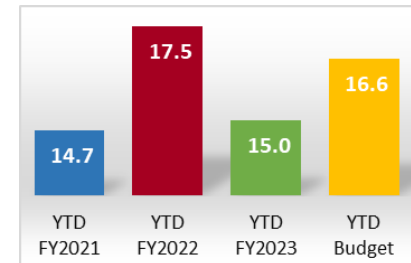
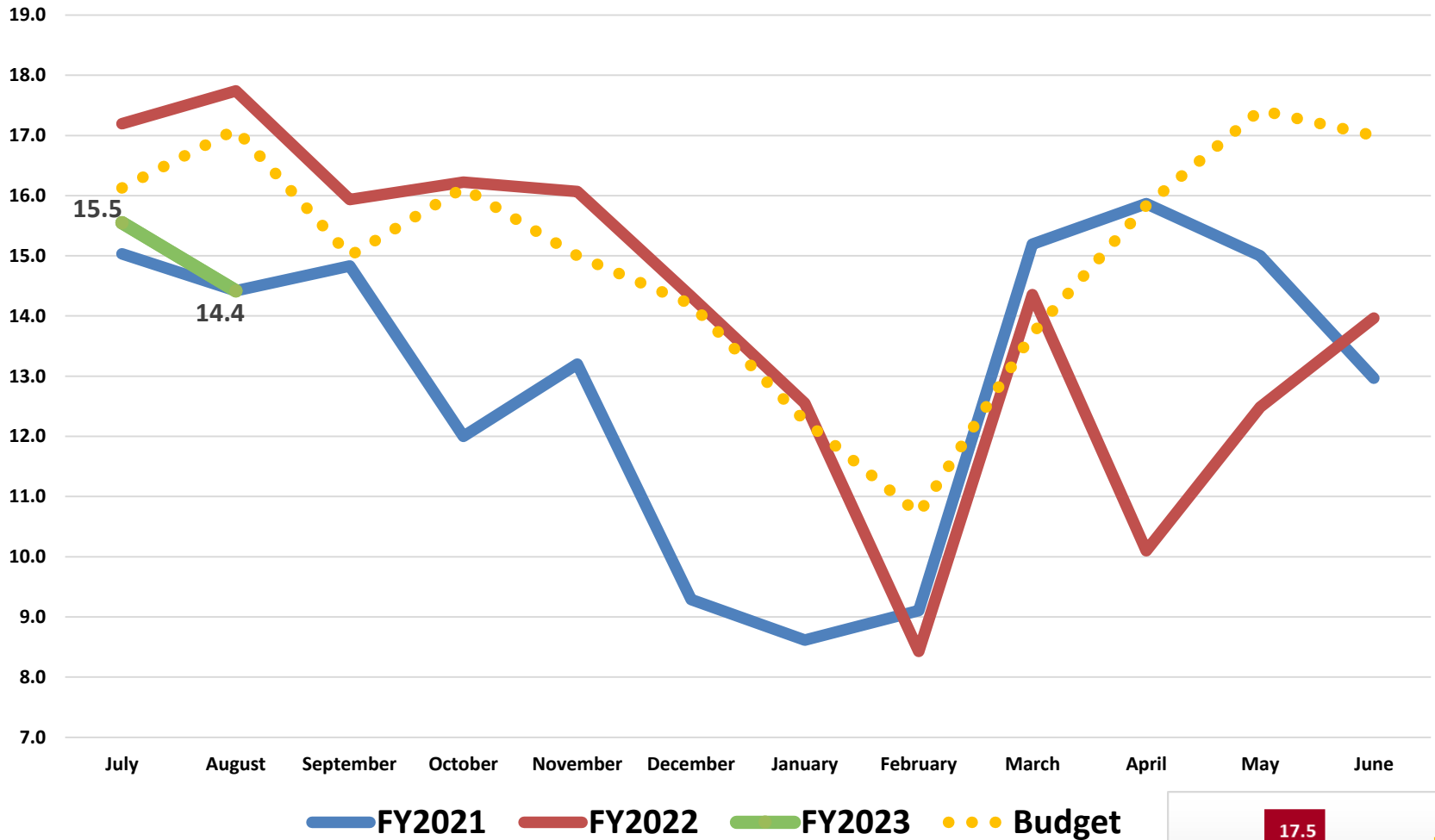
Transitional Care Services (TCS) - Avg. Patients Per Day



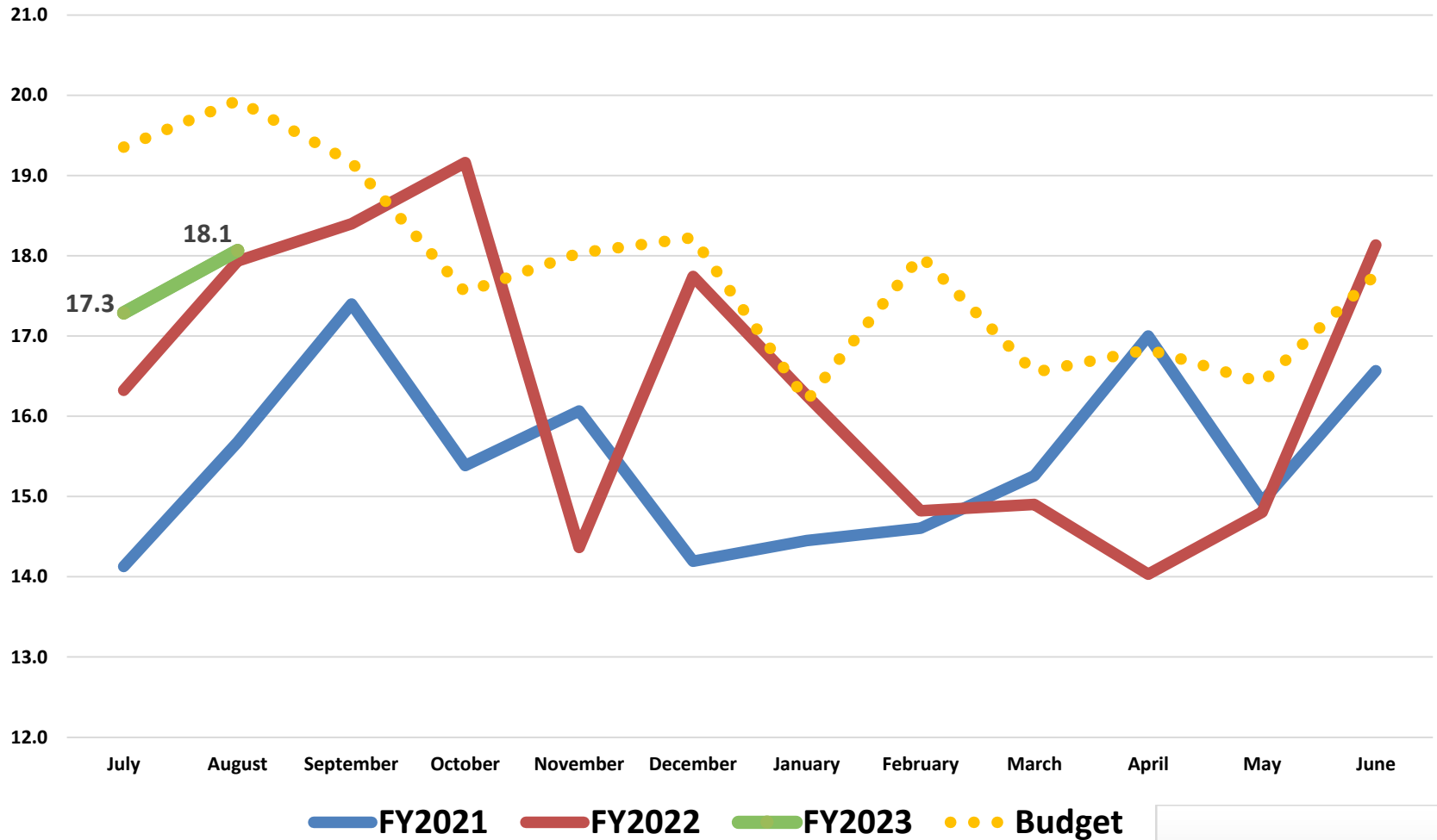
TCS Ortho - Avg. Patients Per Day



NICU - Avg. Patients Per Day

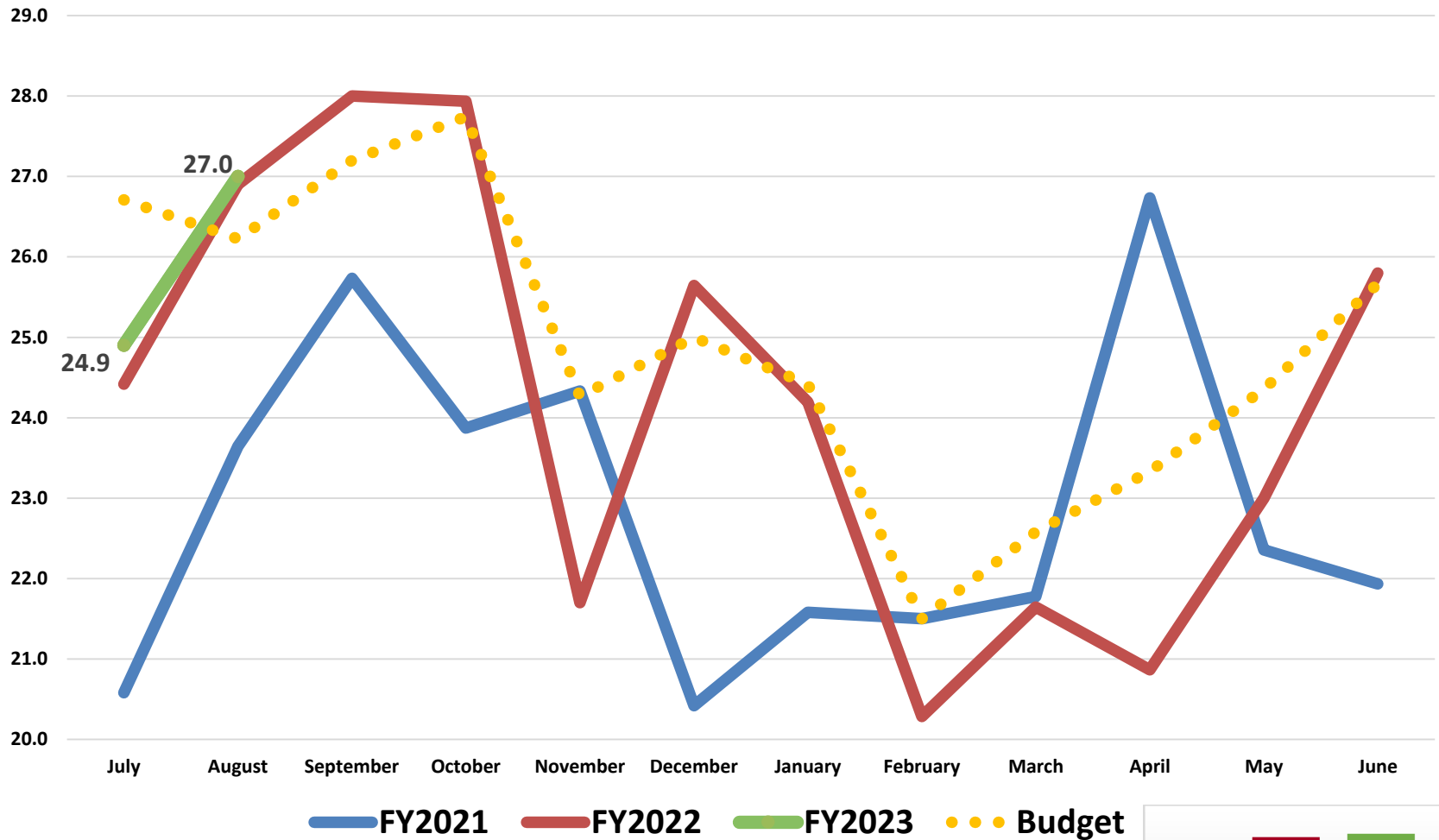


Nursery - Avg. Patients Per Day



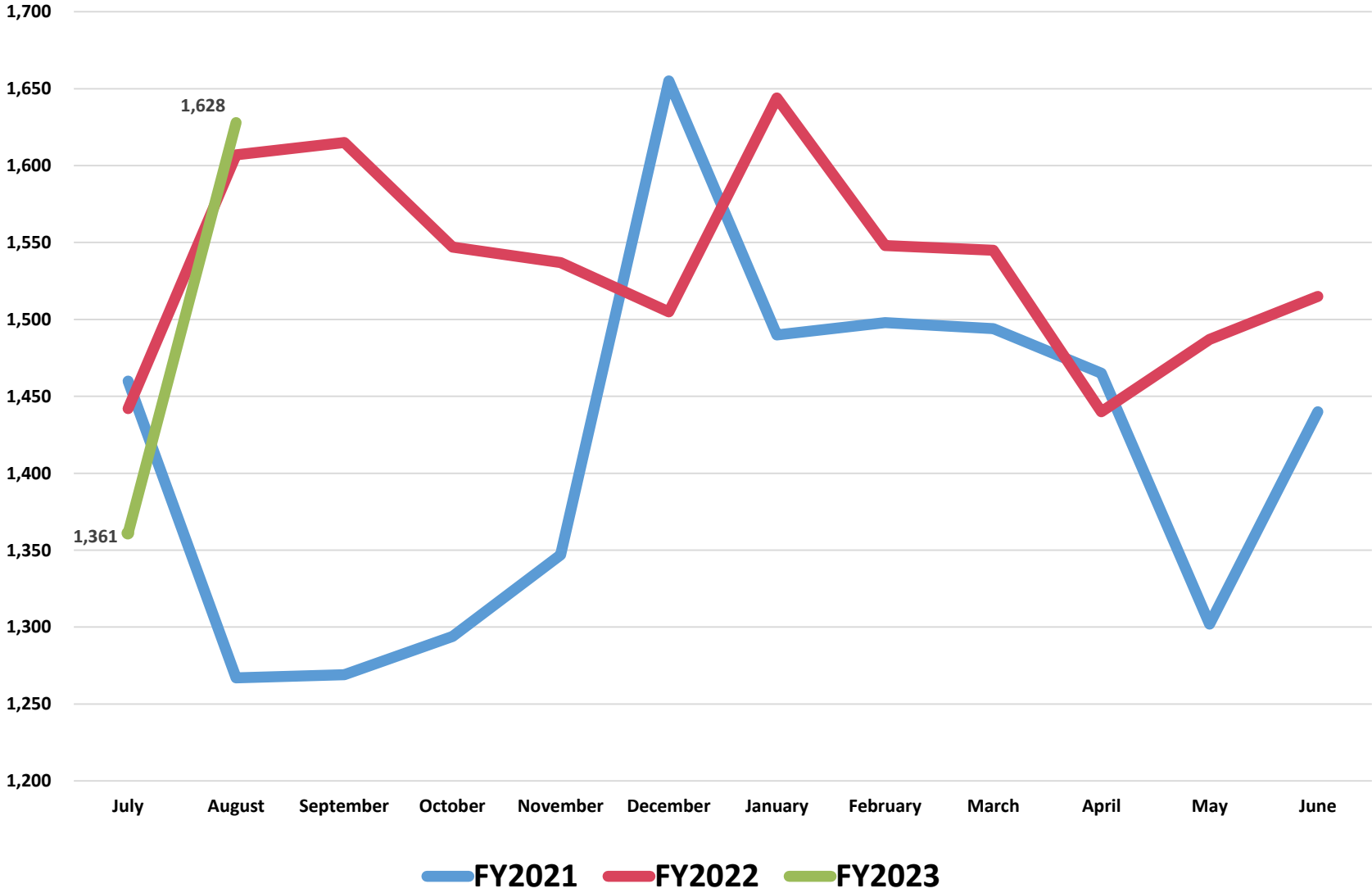
14.9	17.1	17.7	19.6
YTD FY2021	YTD FY2022	YTD FY2023	YTD Budget

Obstetrics - Avg. Patients Per Day

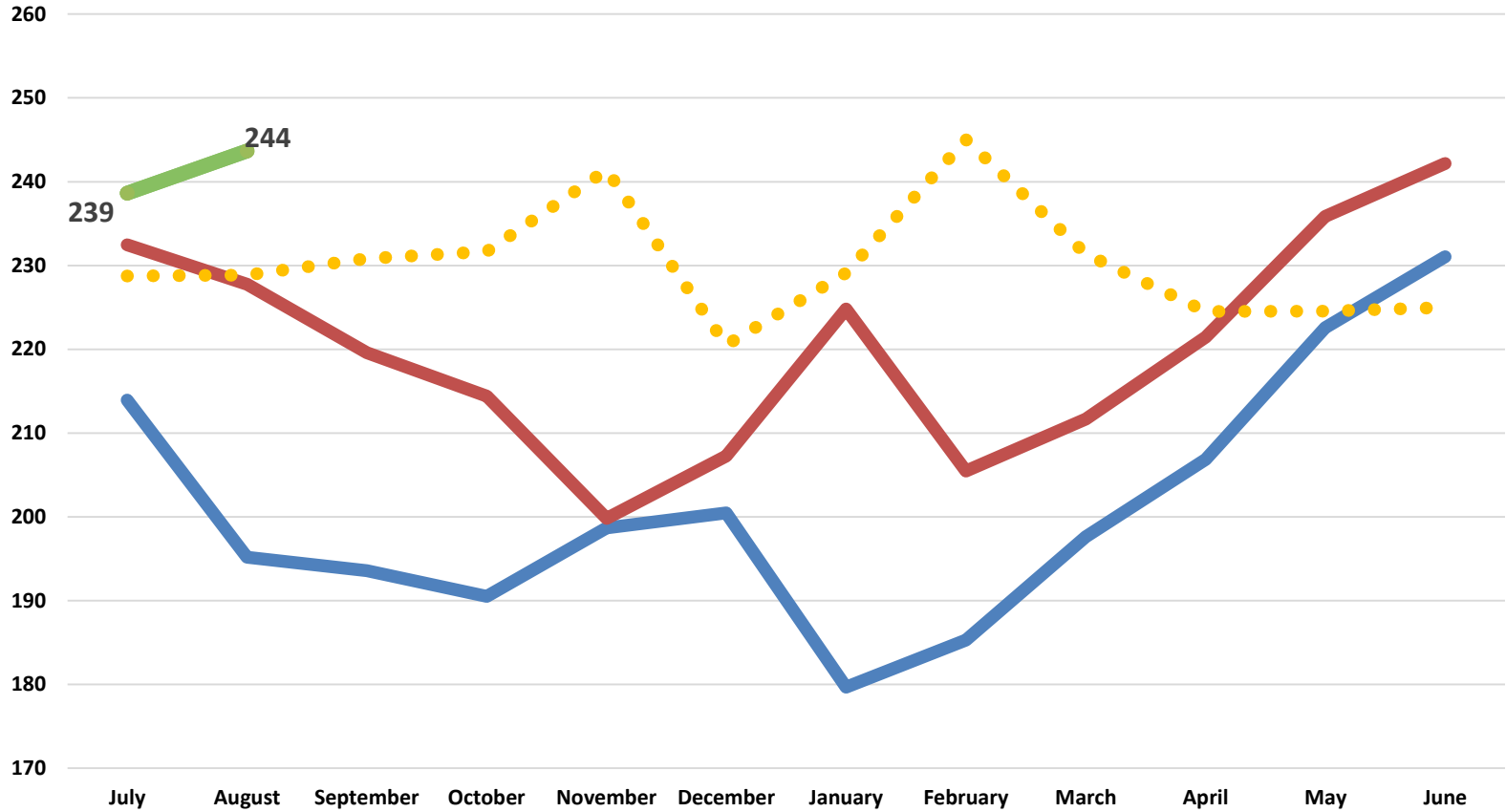


22.1	25.7	26.0	26.5
YTD FY2021	YTD FY2022	YTD FY2023	YTD Budget

Outpatient Registrations per Day



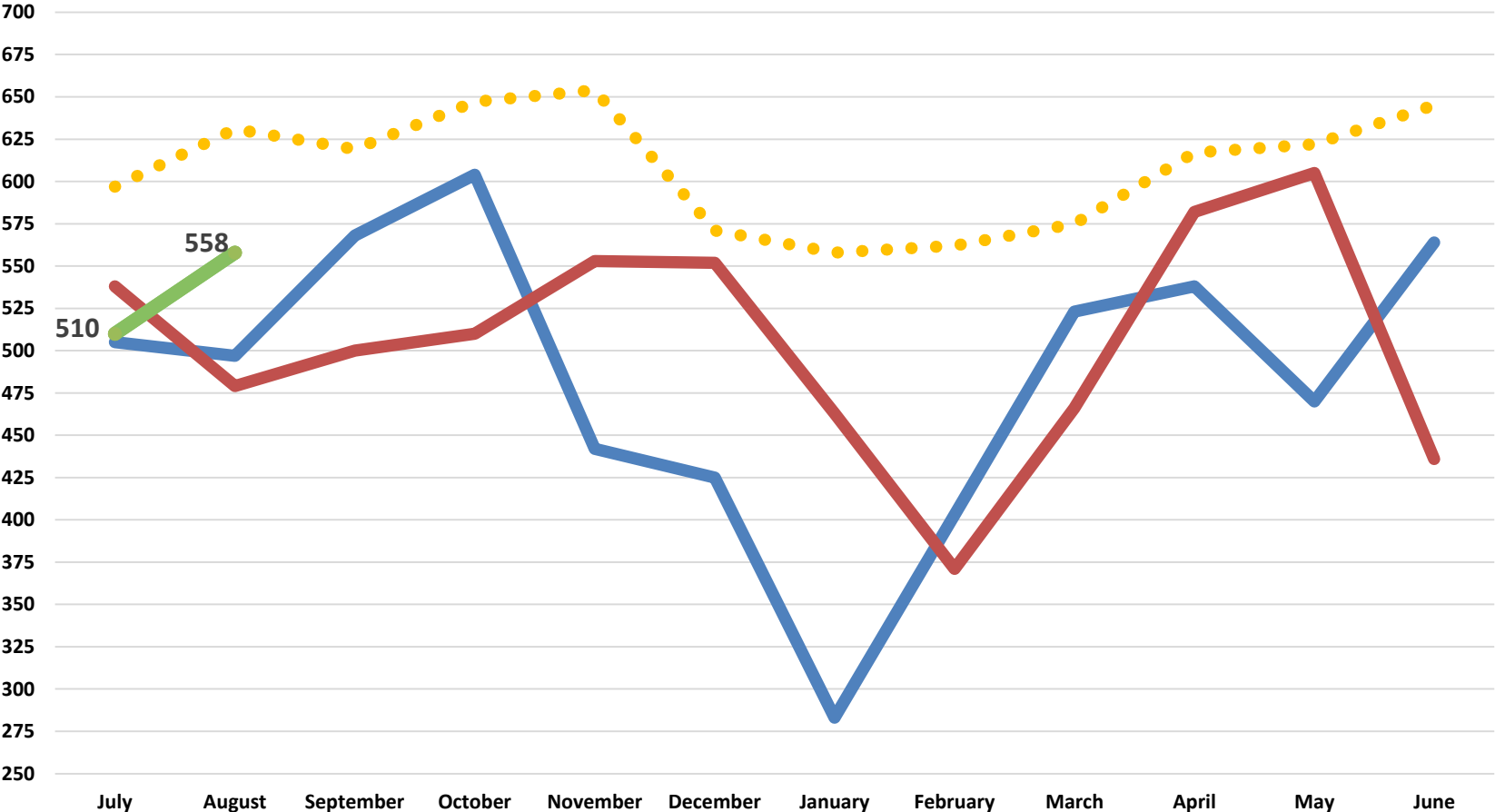
Emergency Dept – Avg Treated Per Day



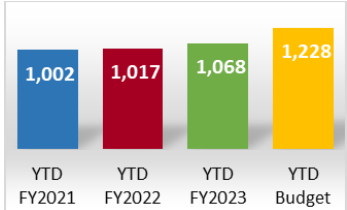
—●— **FY2021**
 —●— **FY2022**
 —●— **FY2023**
 ●●● **Budget**

205	230	241	229
YTD FY2021	YTD FY2022	YTD FY2023	YTD Budget

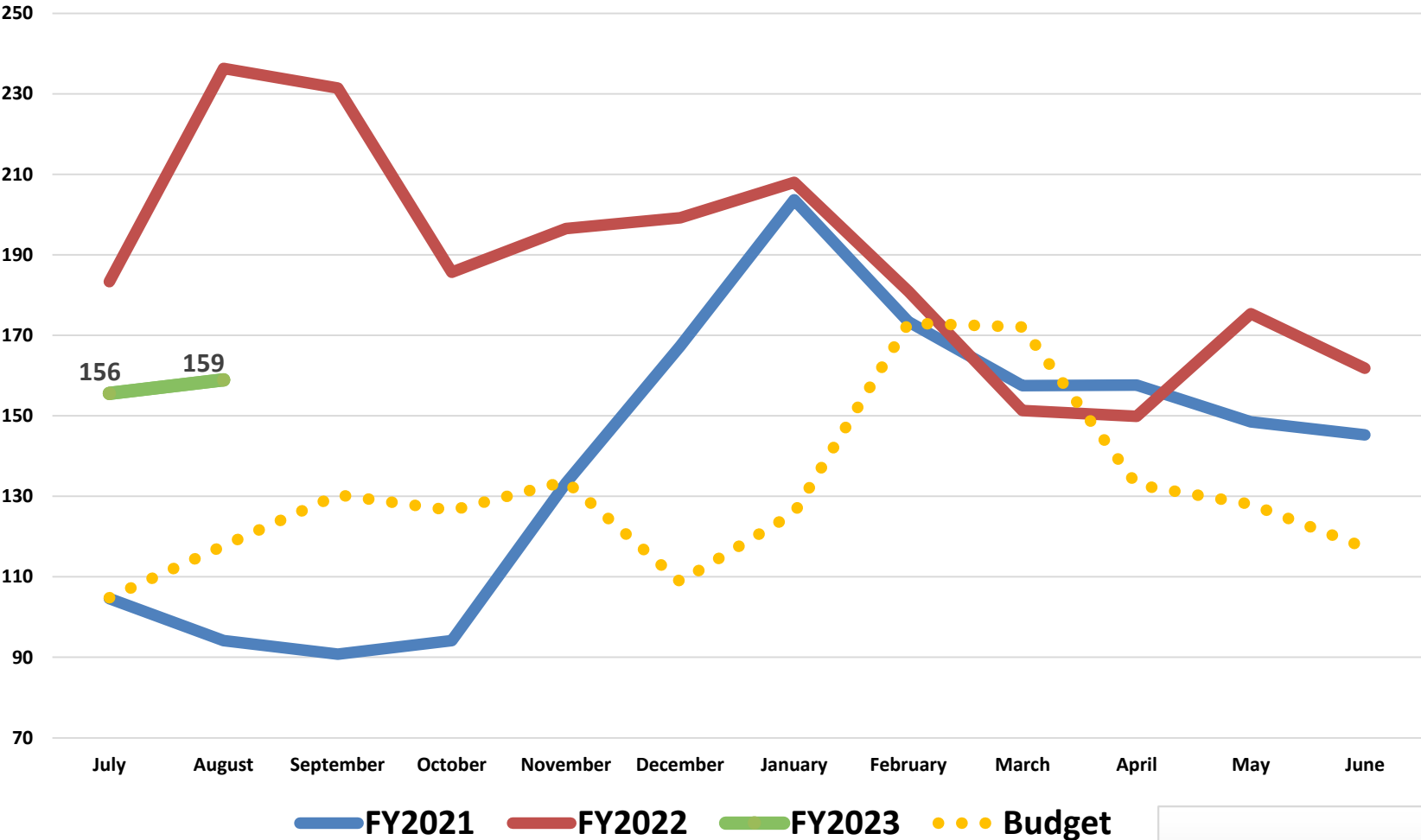
Endoscopy Procedures



—●— **FY2021**
 —●— **FY2022**
 —●— **FY2023**
 ●●● **Budget**

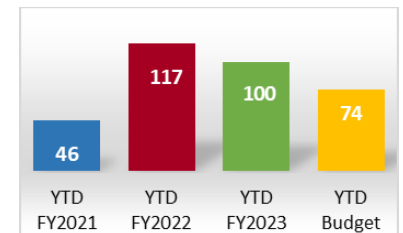
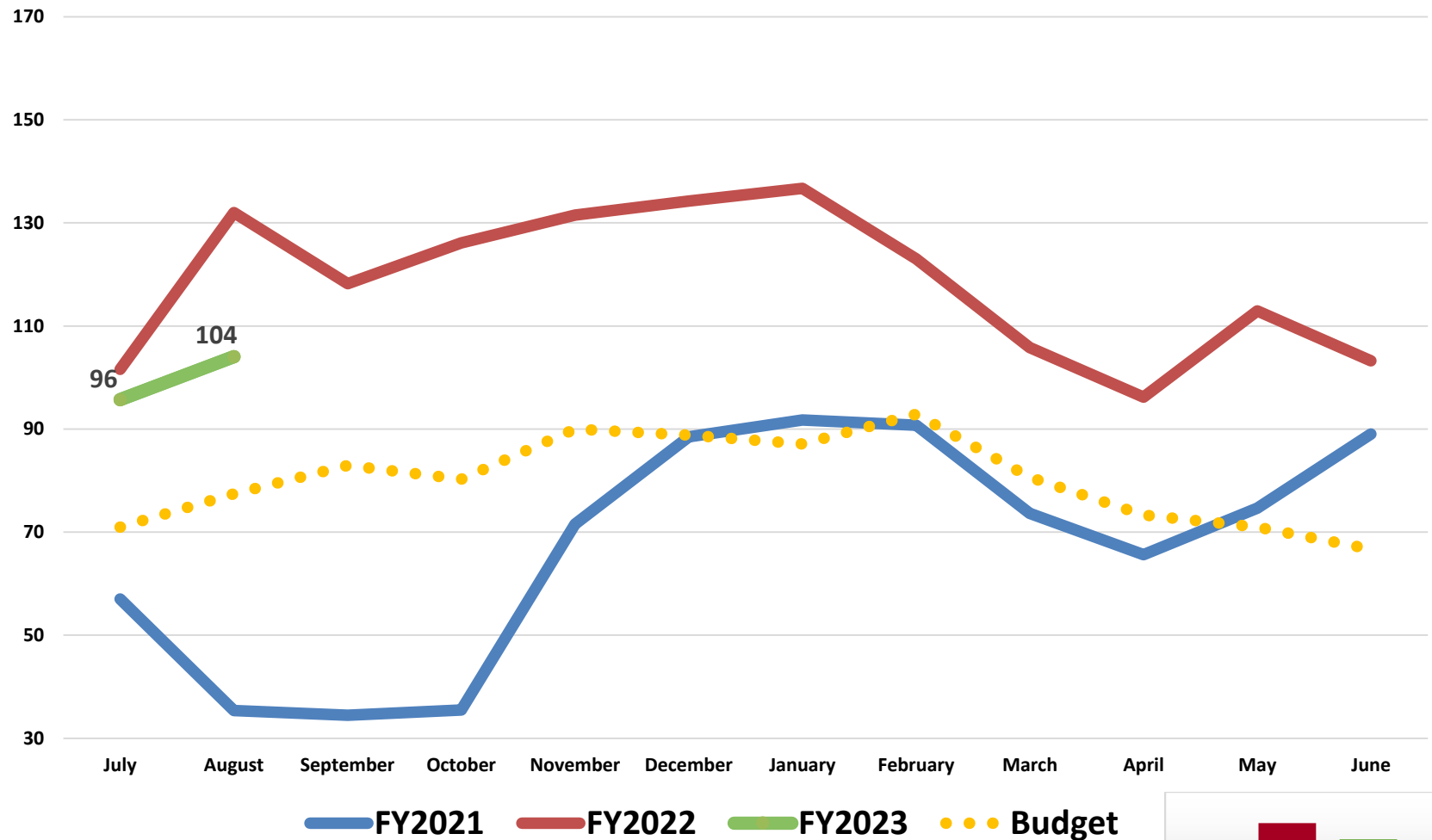


Urgent Care – Court Average Visits Per Day

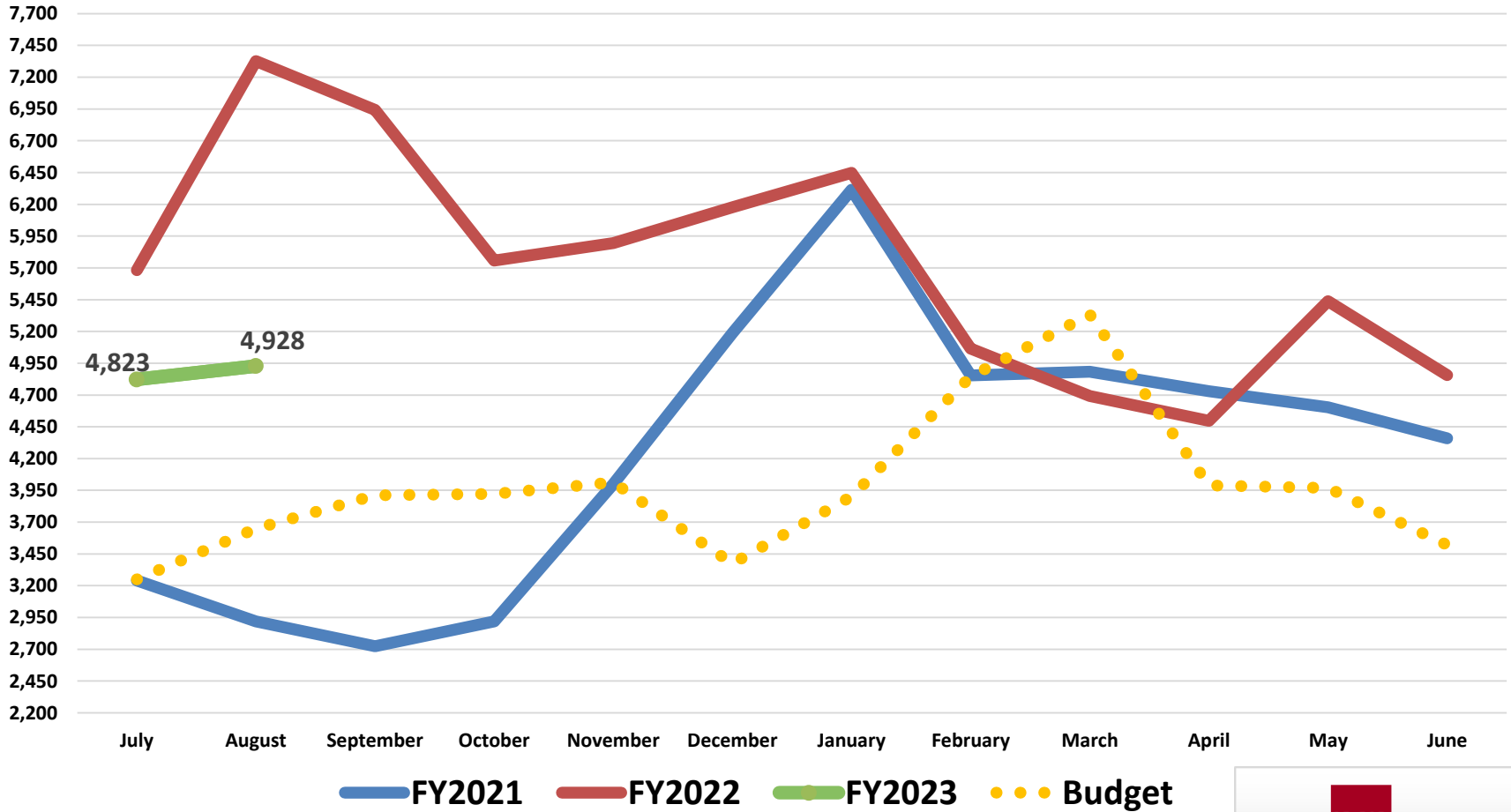


99	210	157	111
YTD FY2021	YTD FY2022	YTD FY2023	YTD Budget

Urgent Care – Demaree Average Visits Per Day

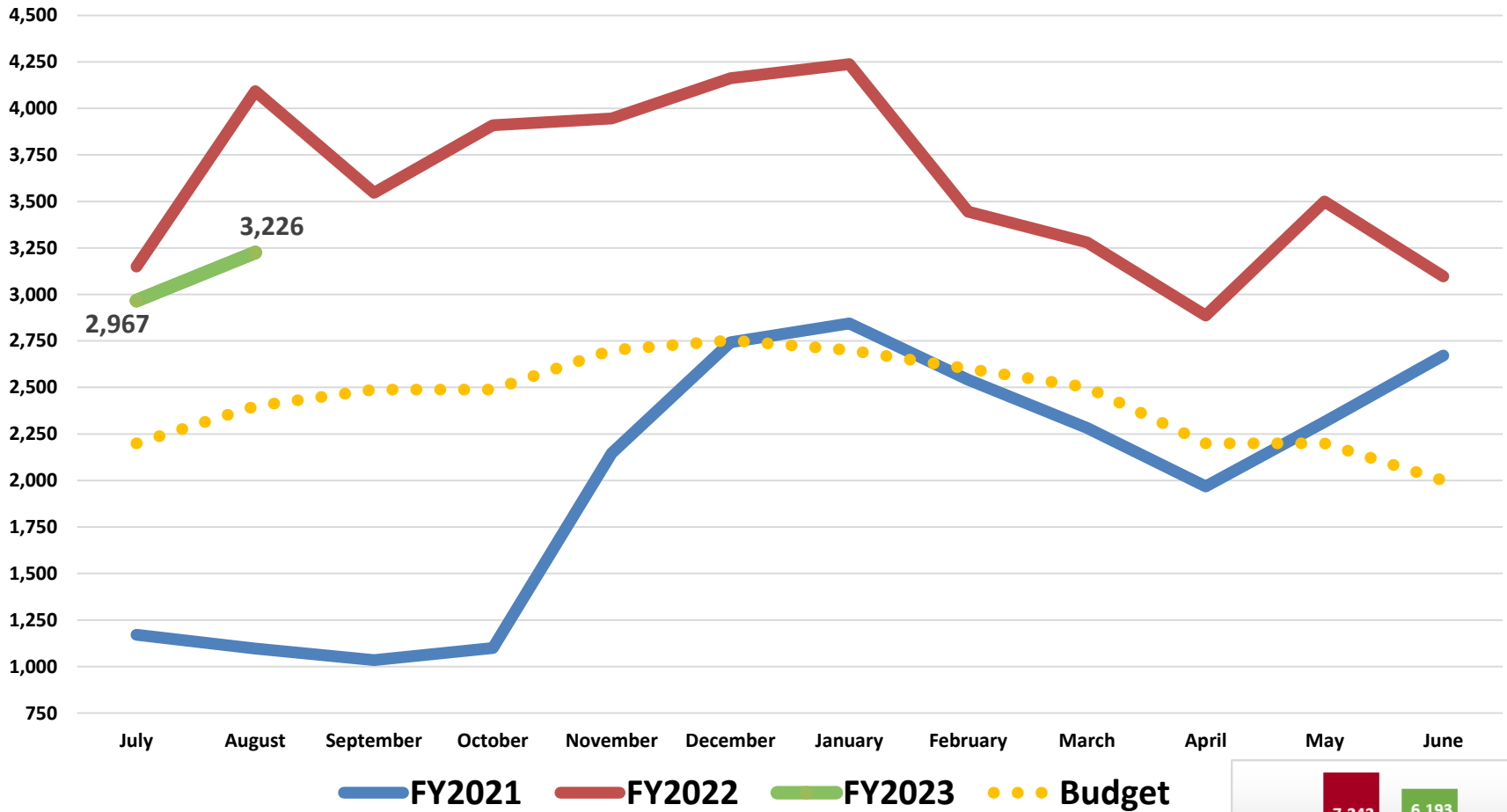


Urgent Care – Court Total Visits



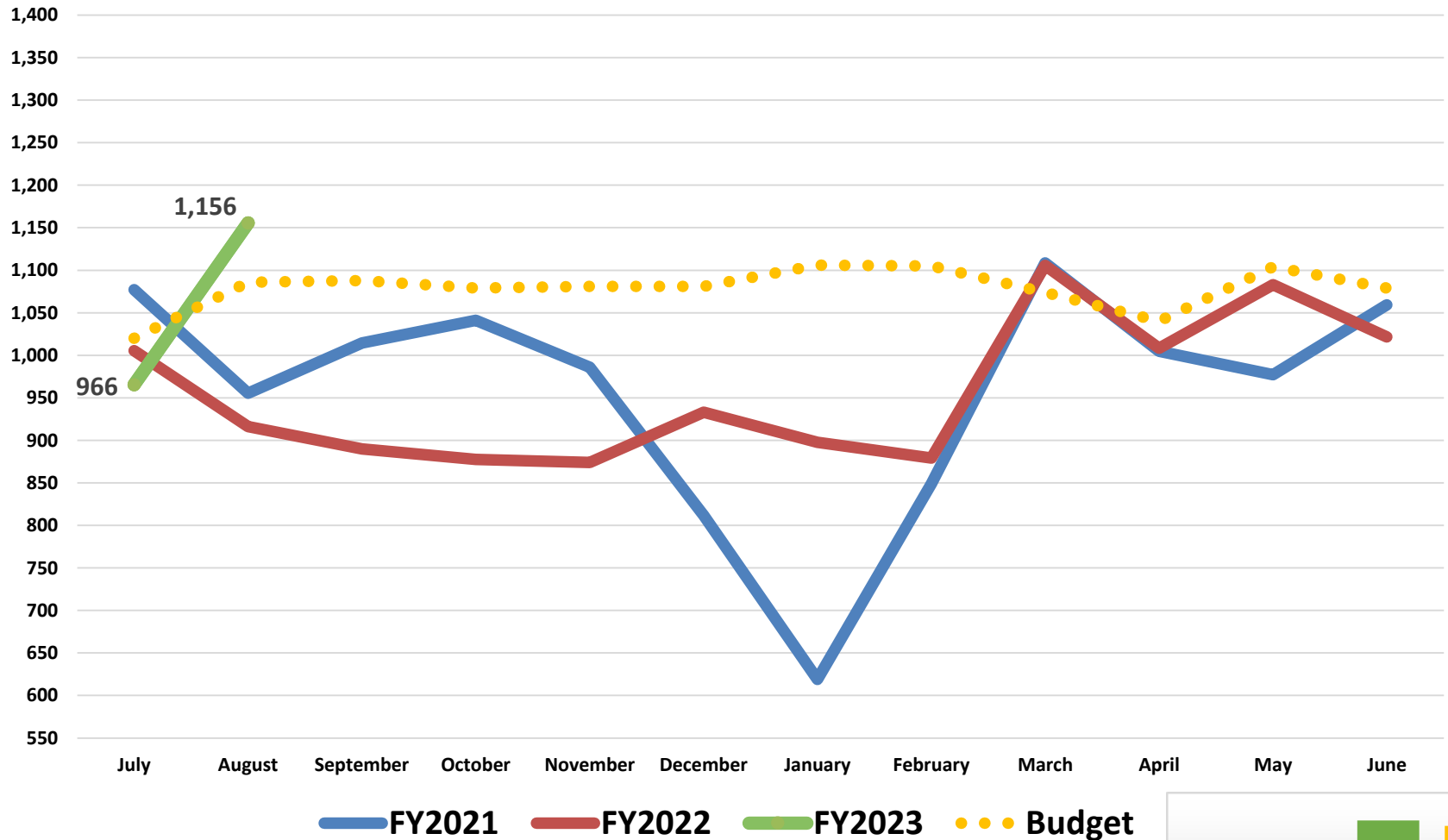
6,161	13,010	9,751	6,900
YTD FY2021	YTD FY2022	YTD FY2023	YTD Budget

Urgent Care – Demaree Total Visits



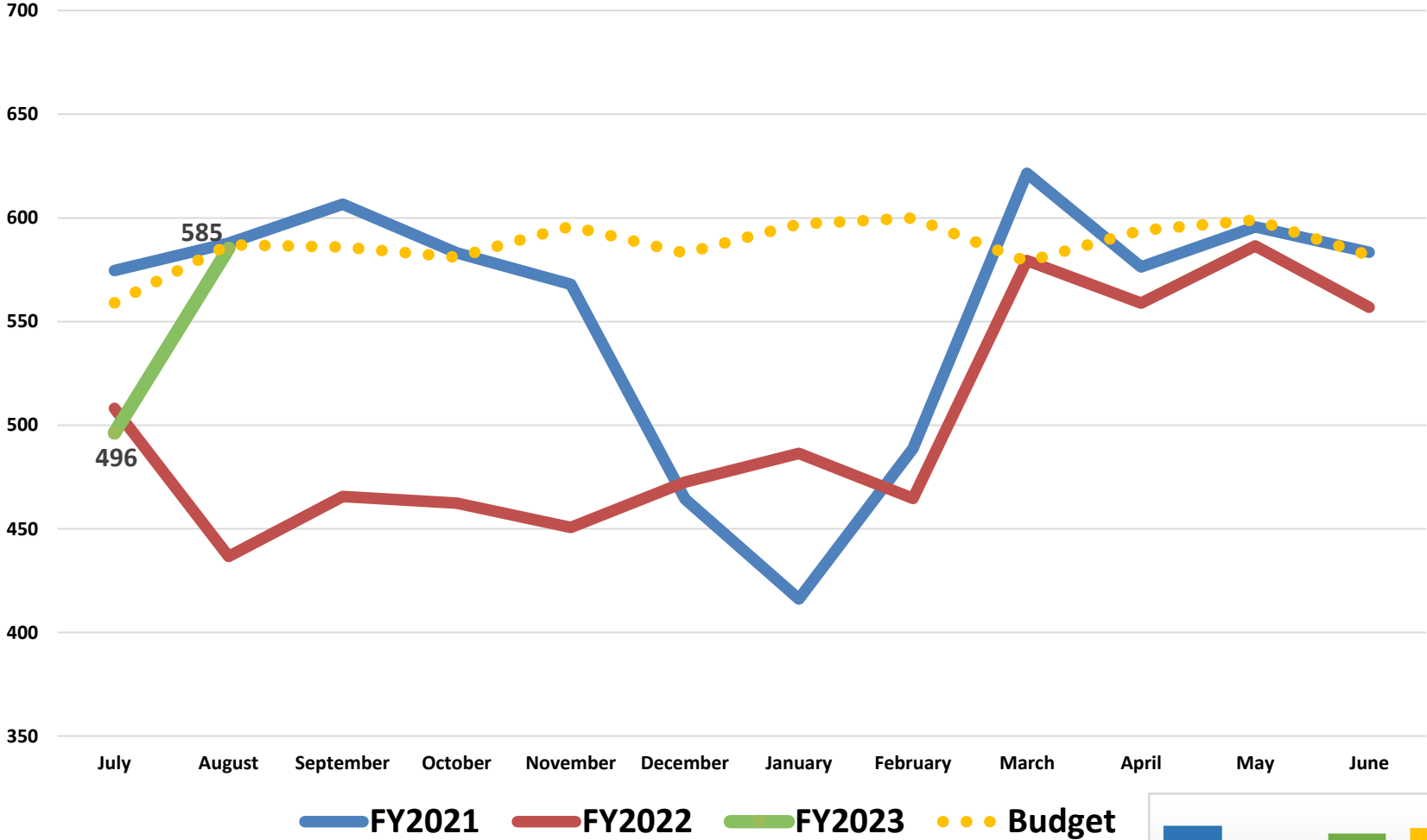
2,268	7,242	6,193	4,600
YTD FY2021	YTD FY2022	YTD FY2023	YTD Budget

Surgery (IP & OP) – 100 Min Units



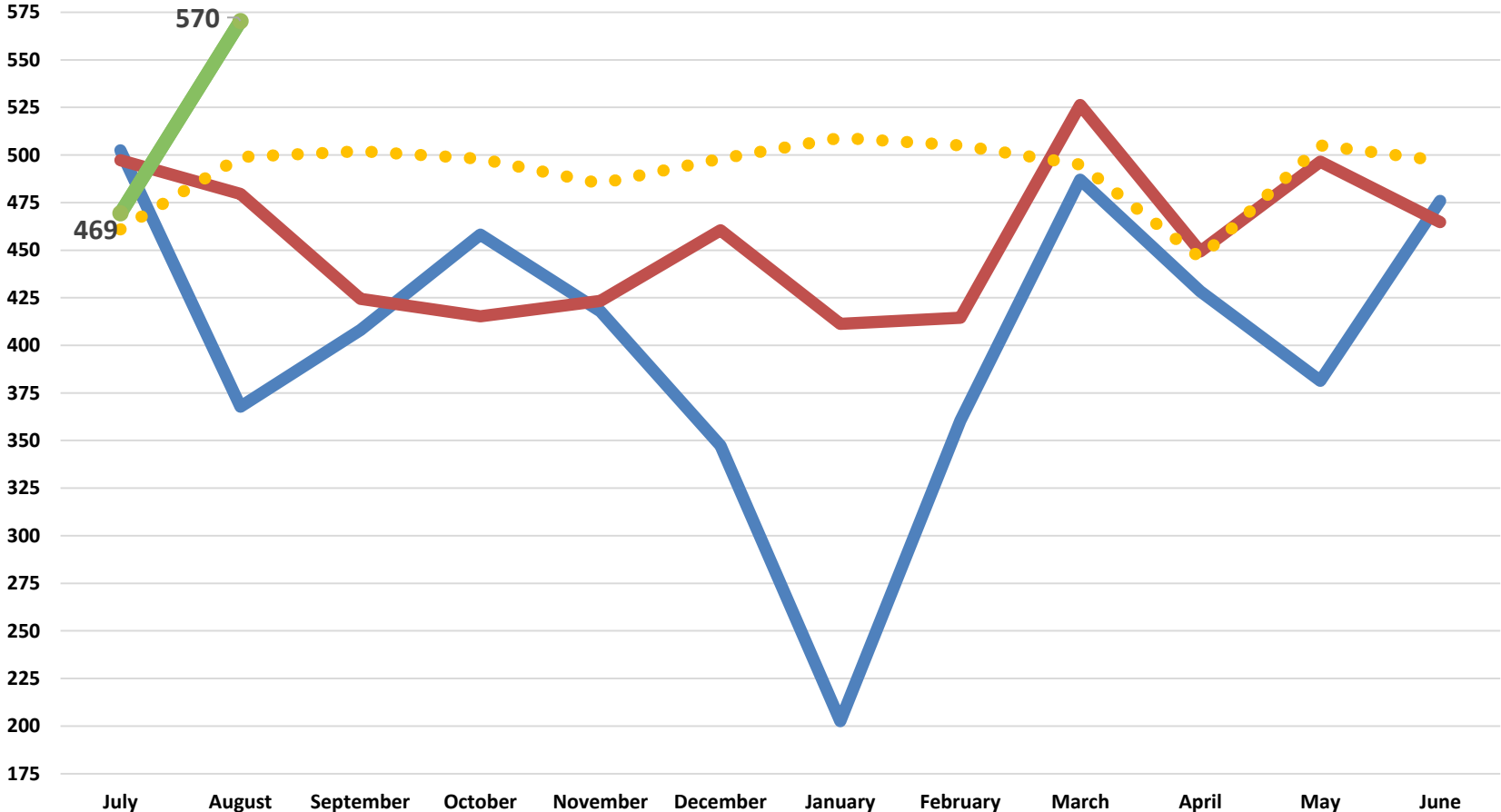
2,033	1,922	2,121	2,106
YTD FY2021	YTD FY2022	YTD FY2023	YTD Budget

Surgery (IP Only) – 100 Min Units



1,162	945	1,082	1,146
YTD FY2021	YTD FY2022	YTD FY2023	YTD Budget

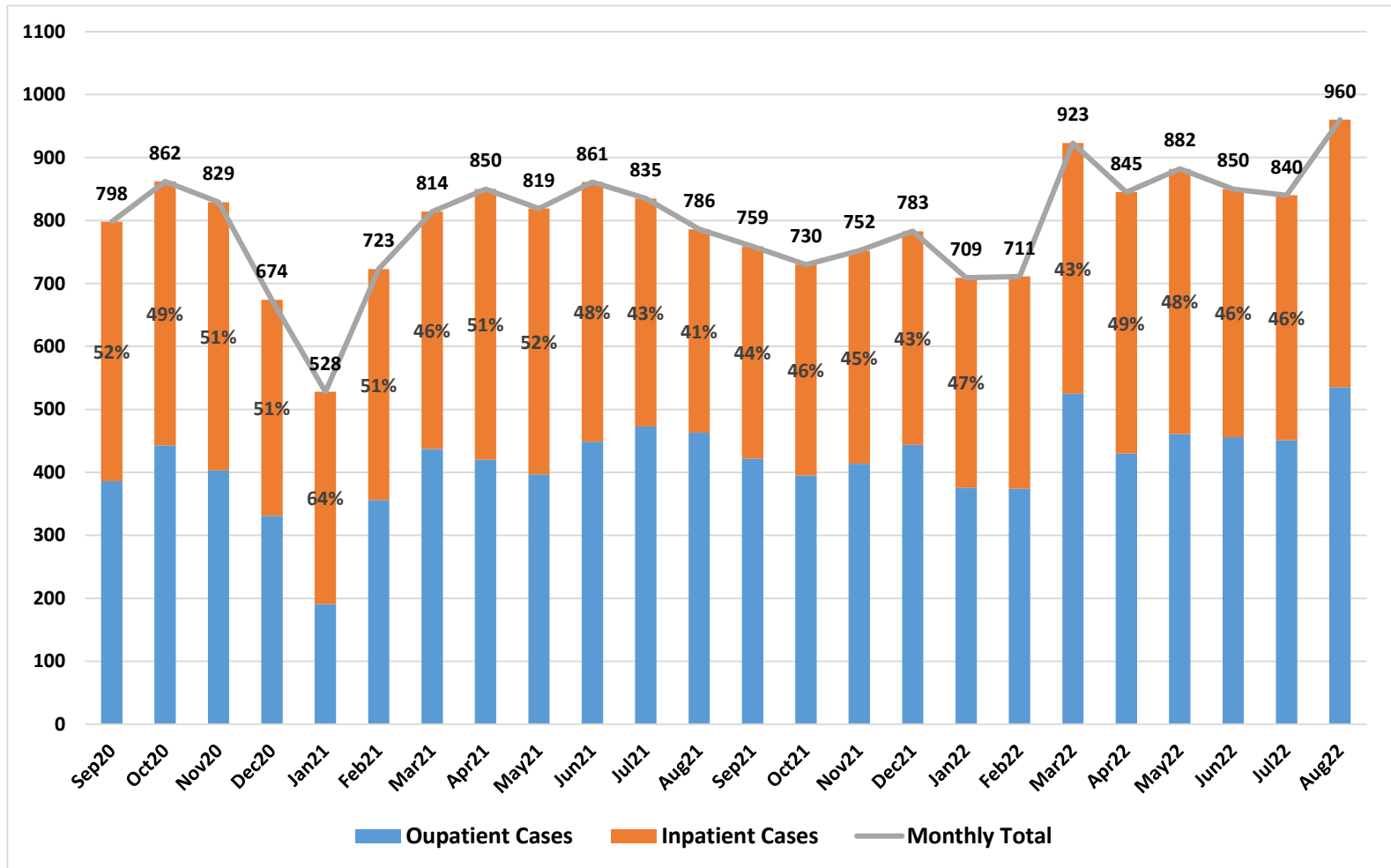
Surgery (OP Only) – 100 Min Units



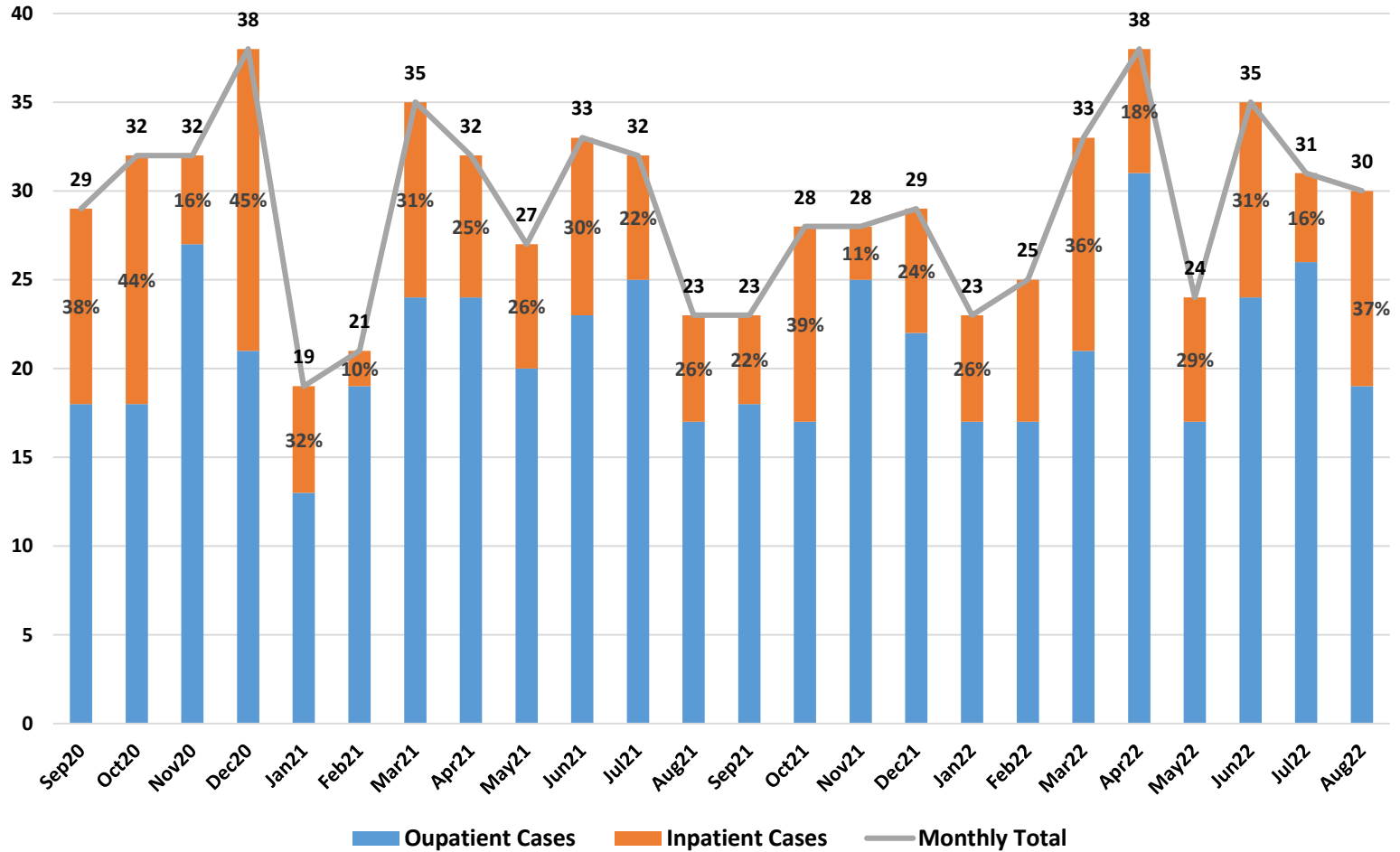
—●— FY2021
 —●— FY2022
 —●— FY2023
 ●●● Budget

870	977	1,040	960
YTD FY2021	YTD FY2022	YTD FY2023	YTD Budget

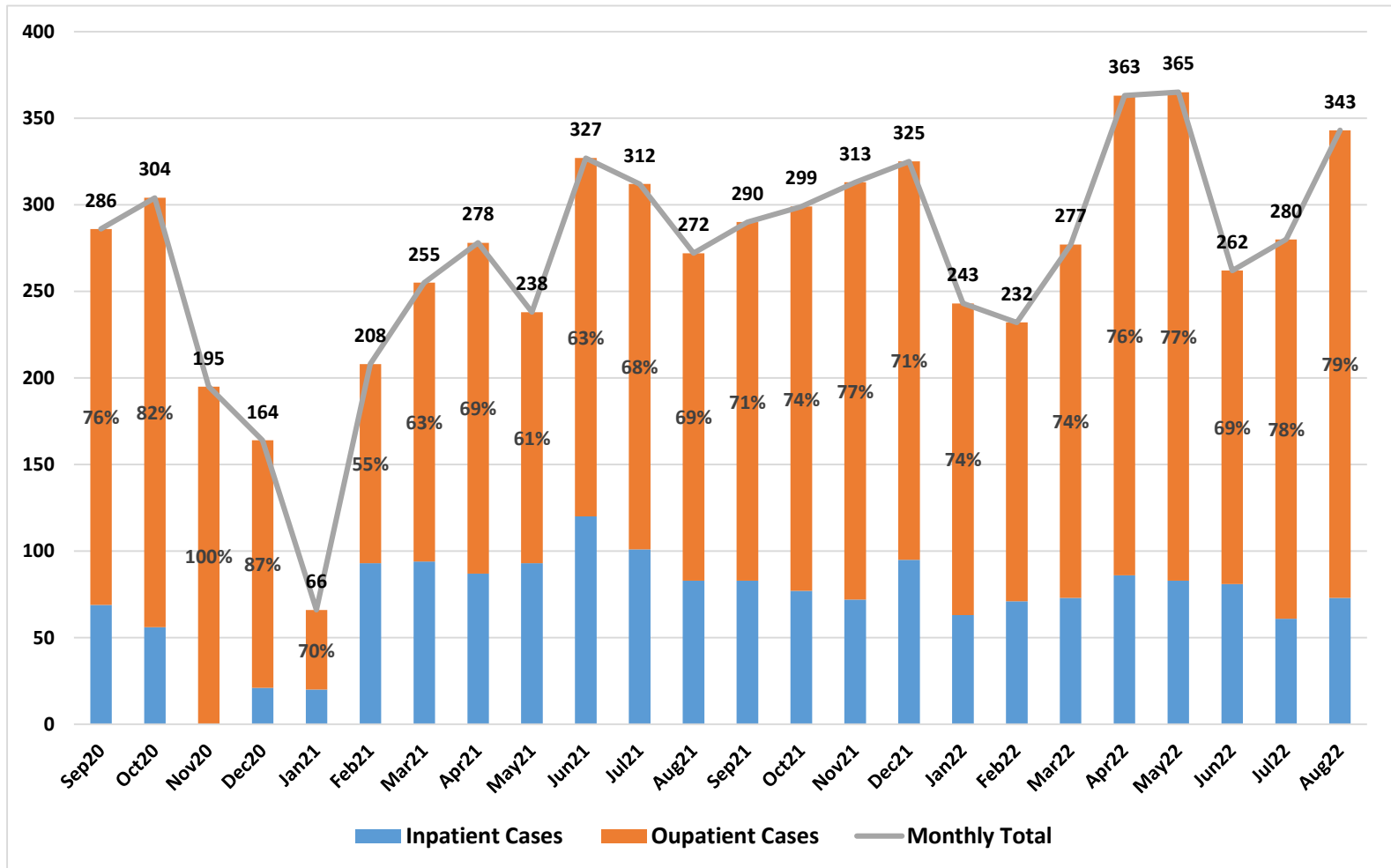
Surgery Cases



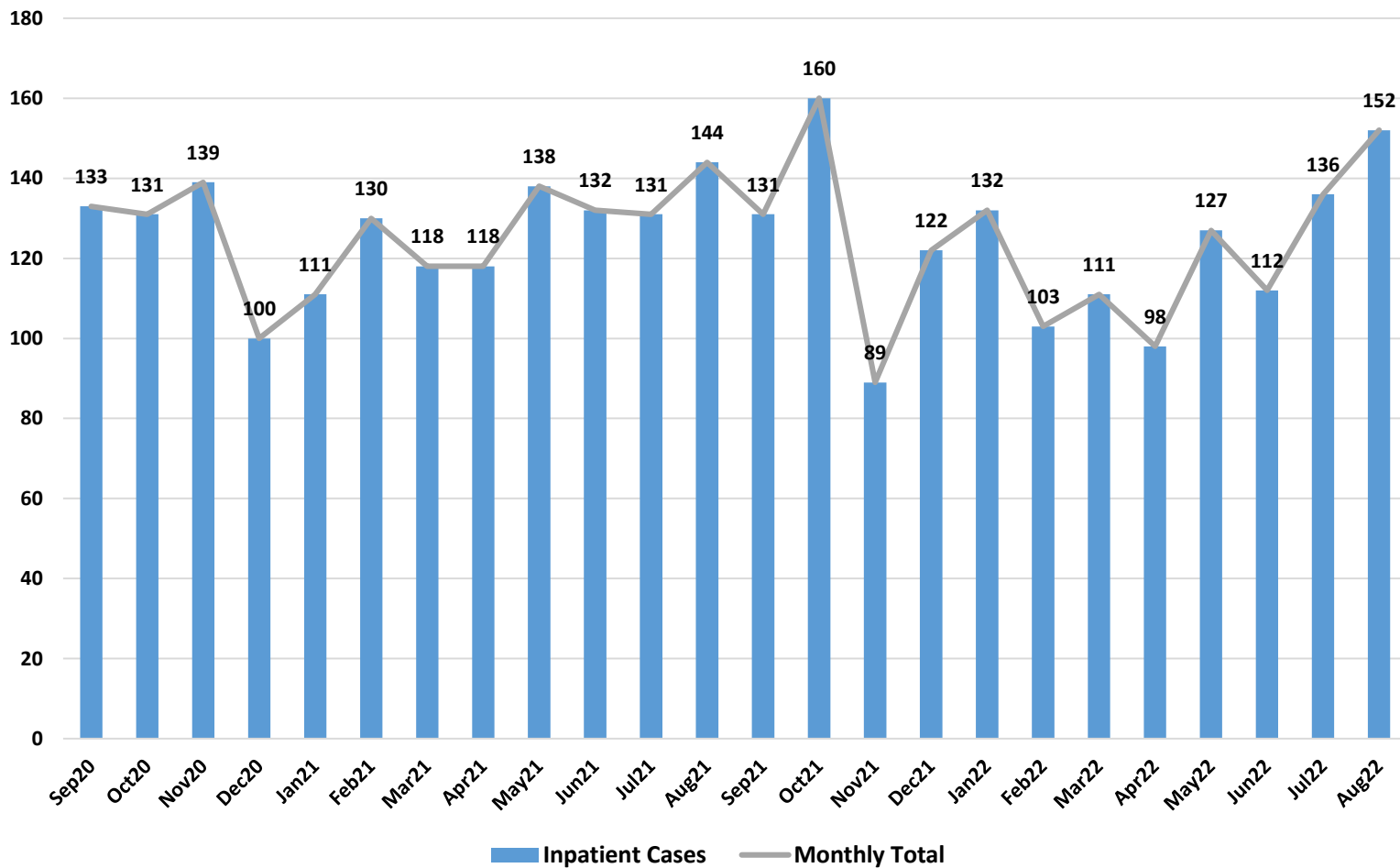
Robotic Cases



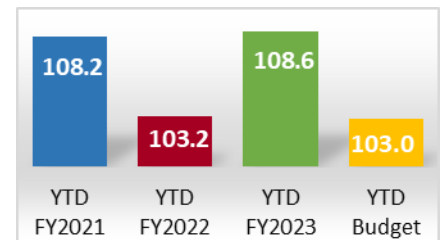
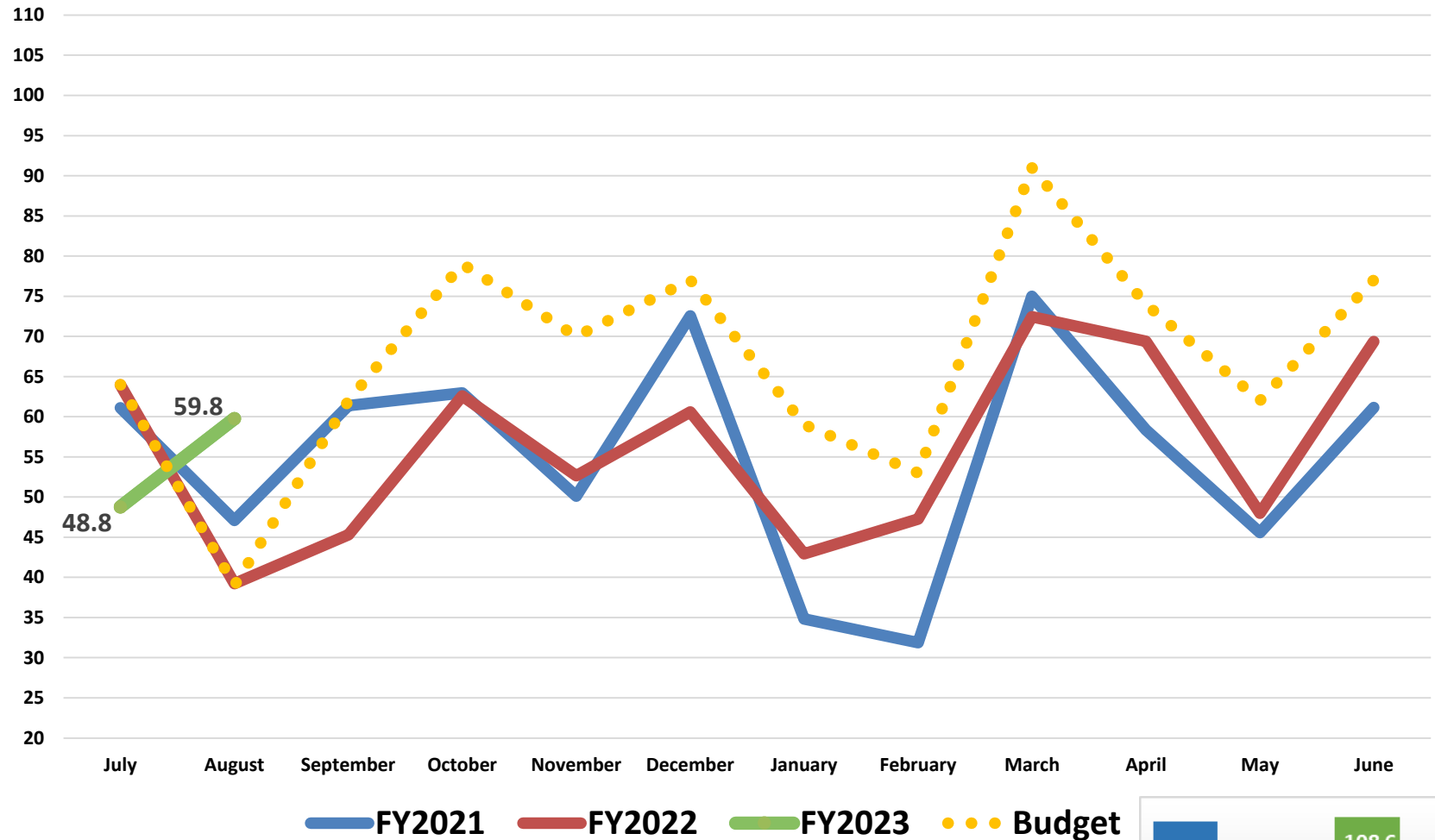
Endo Cases (Endo Suites)



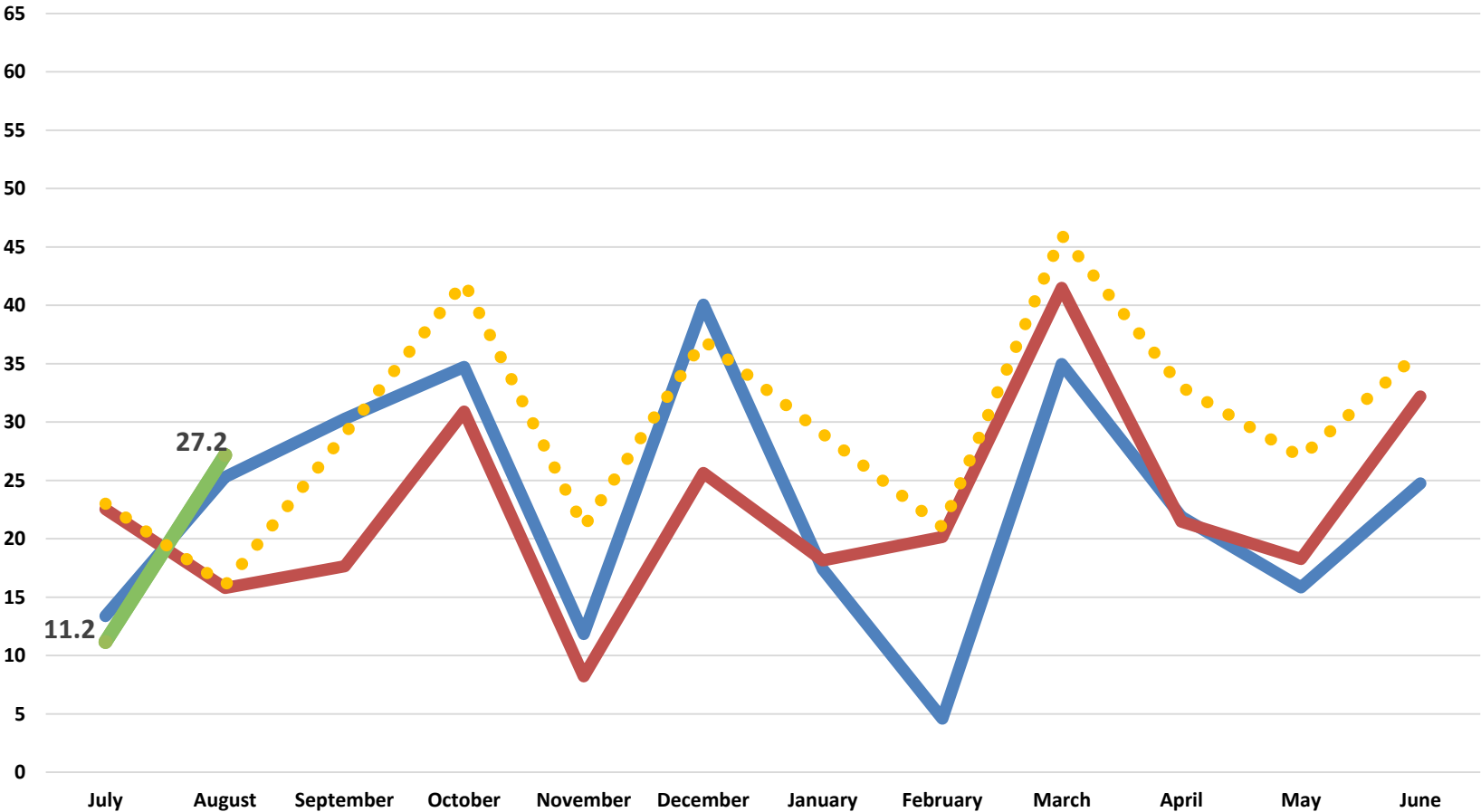
OB Cases



Robotic Surgery (IP & OP) – 100 Min Units



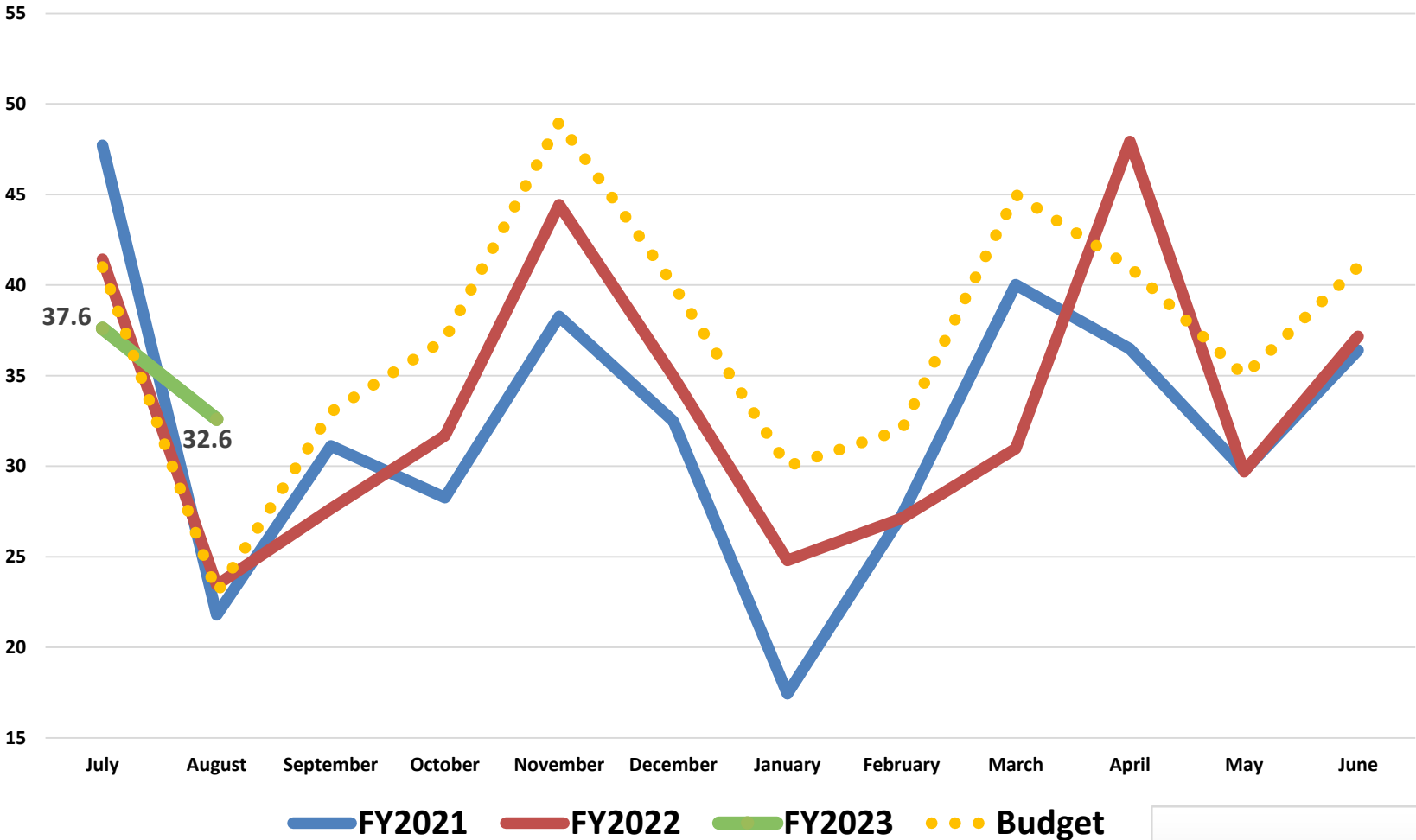
Robotic Surgery (IP Only) – 100 Min Units



— FY2021
 — FY2022
 — FY2023
 ••• Budget

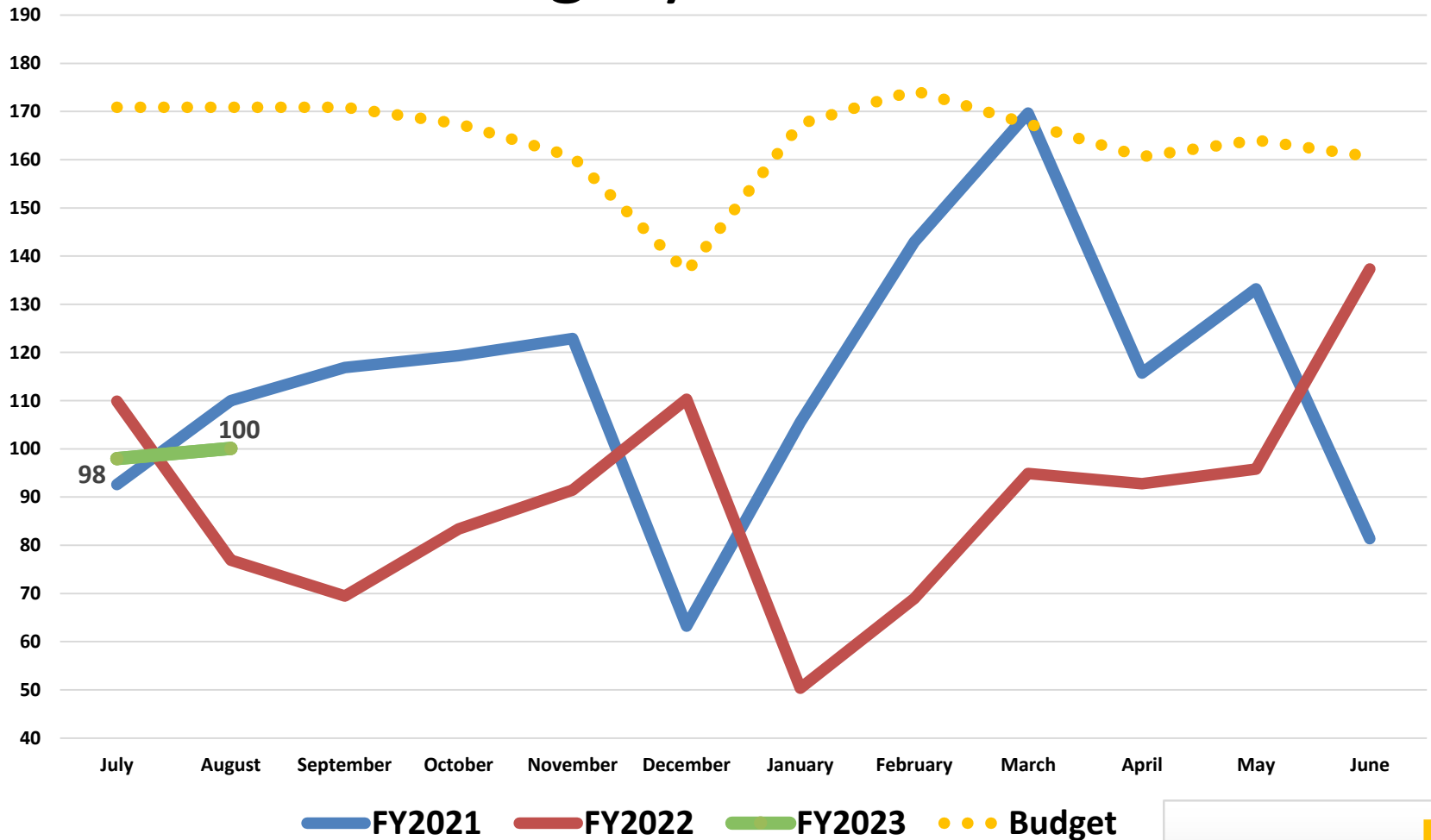
38.7	38.3	38.3	39.0
YTD FY2021	YTD FY2022	YTD FY2023	YTD Budget

Robotic Surgery (OP Only) – 100 Min Units



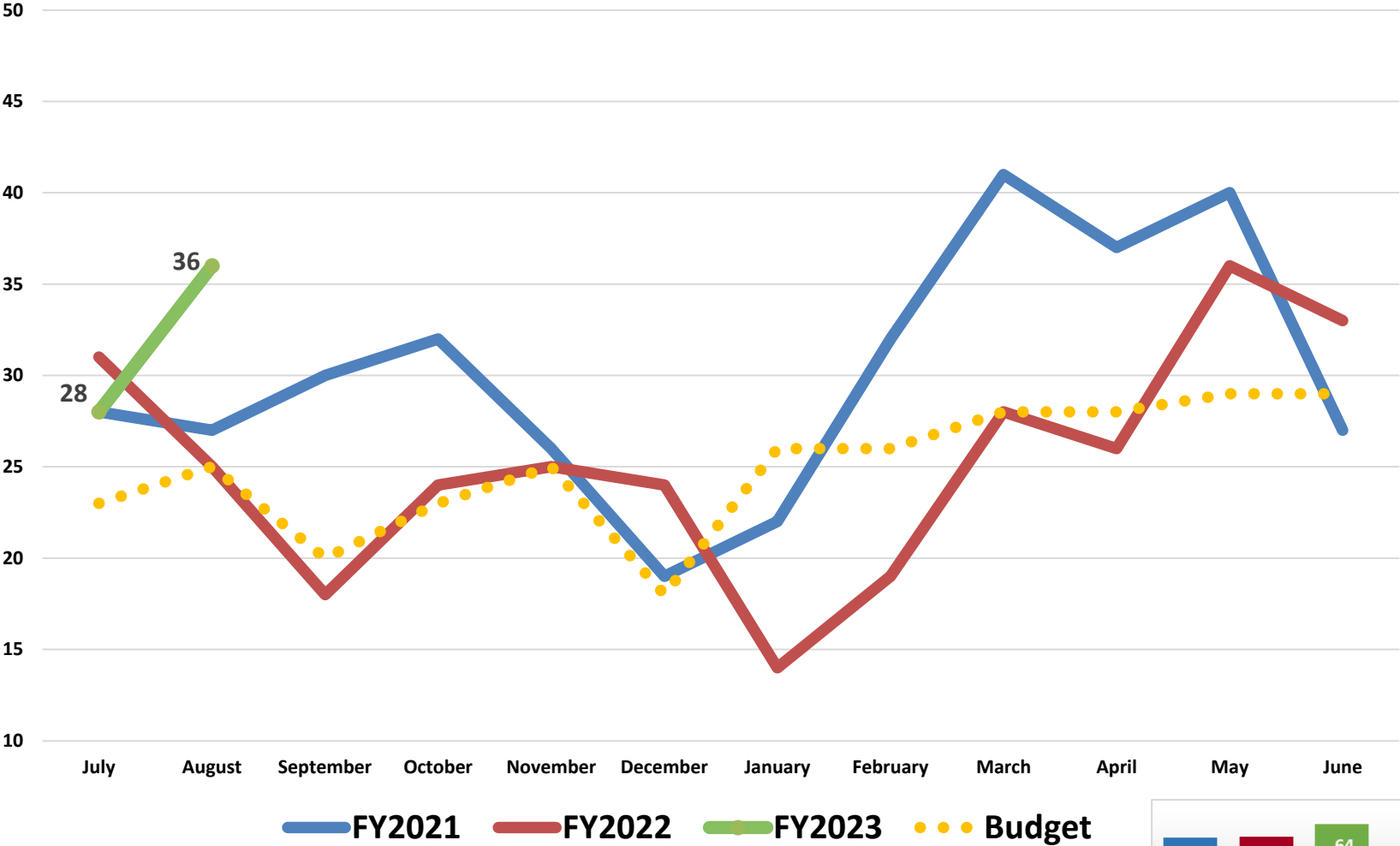
69.5	64.9	70.2	64.0
YTD FY2021	YTD FY2022	YTD FY2023	YTD Budget

Cardiac Surgery – 100 Min Units



203	187	198	342
YTD FY2021	YTD FY2022	YTD FY2023	YTD Budget

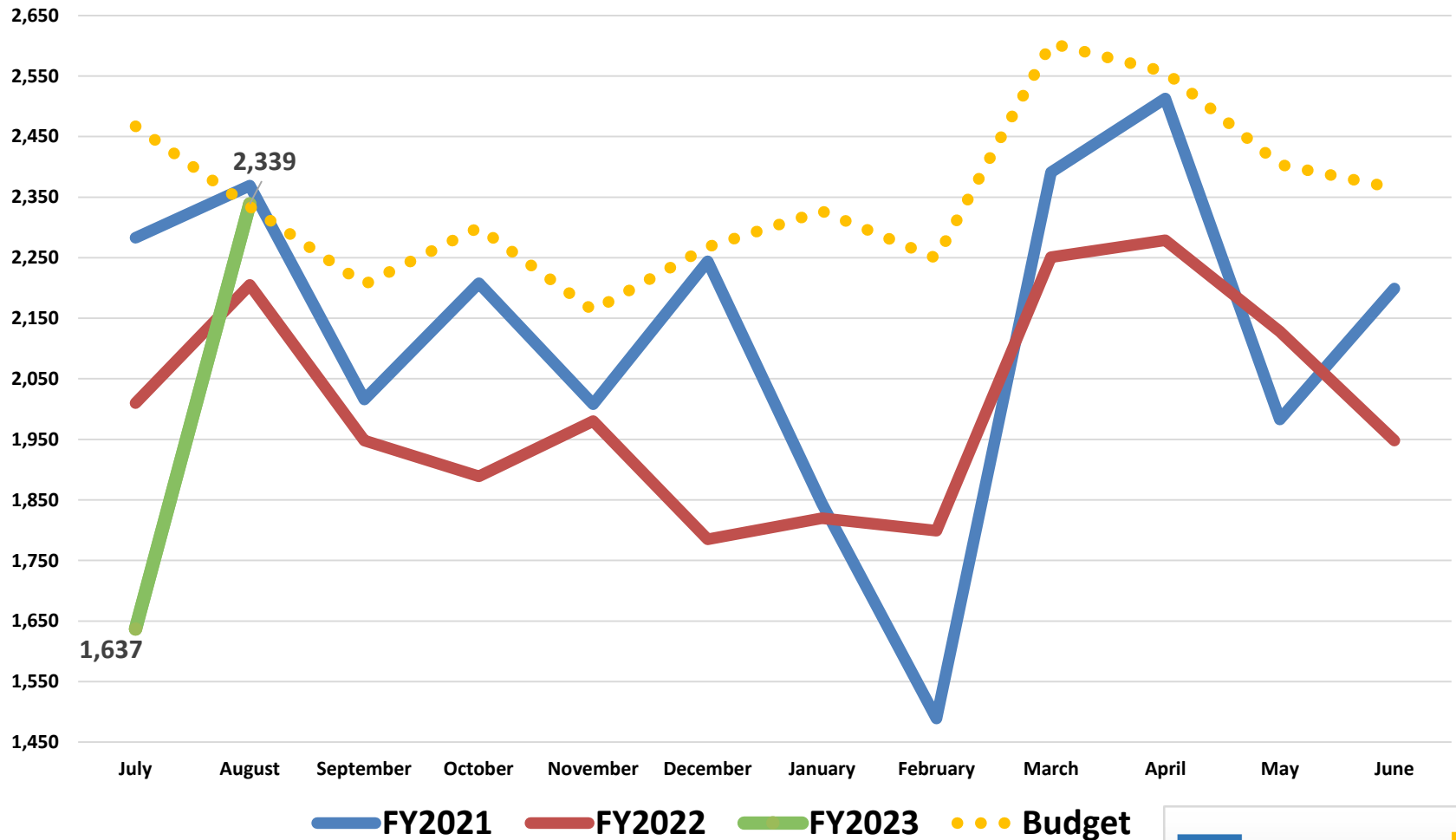
Cardiac Surgery – Cases



55	56	64	48
YTD FY2021	YTD FY2022	YTD FY2023	YTD Budget

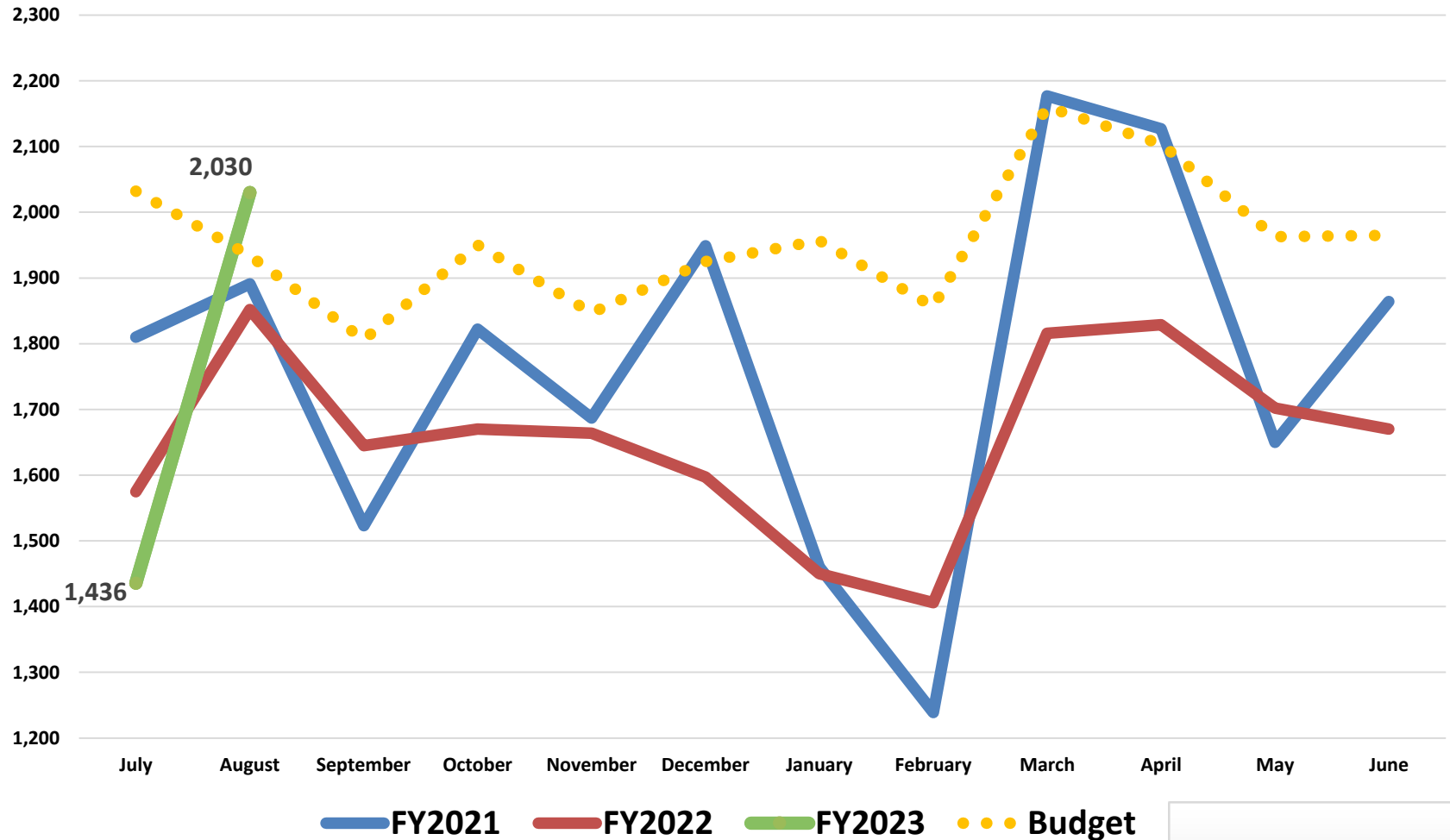
Radiation Oncology Treatments

Hanford and Visalia



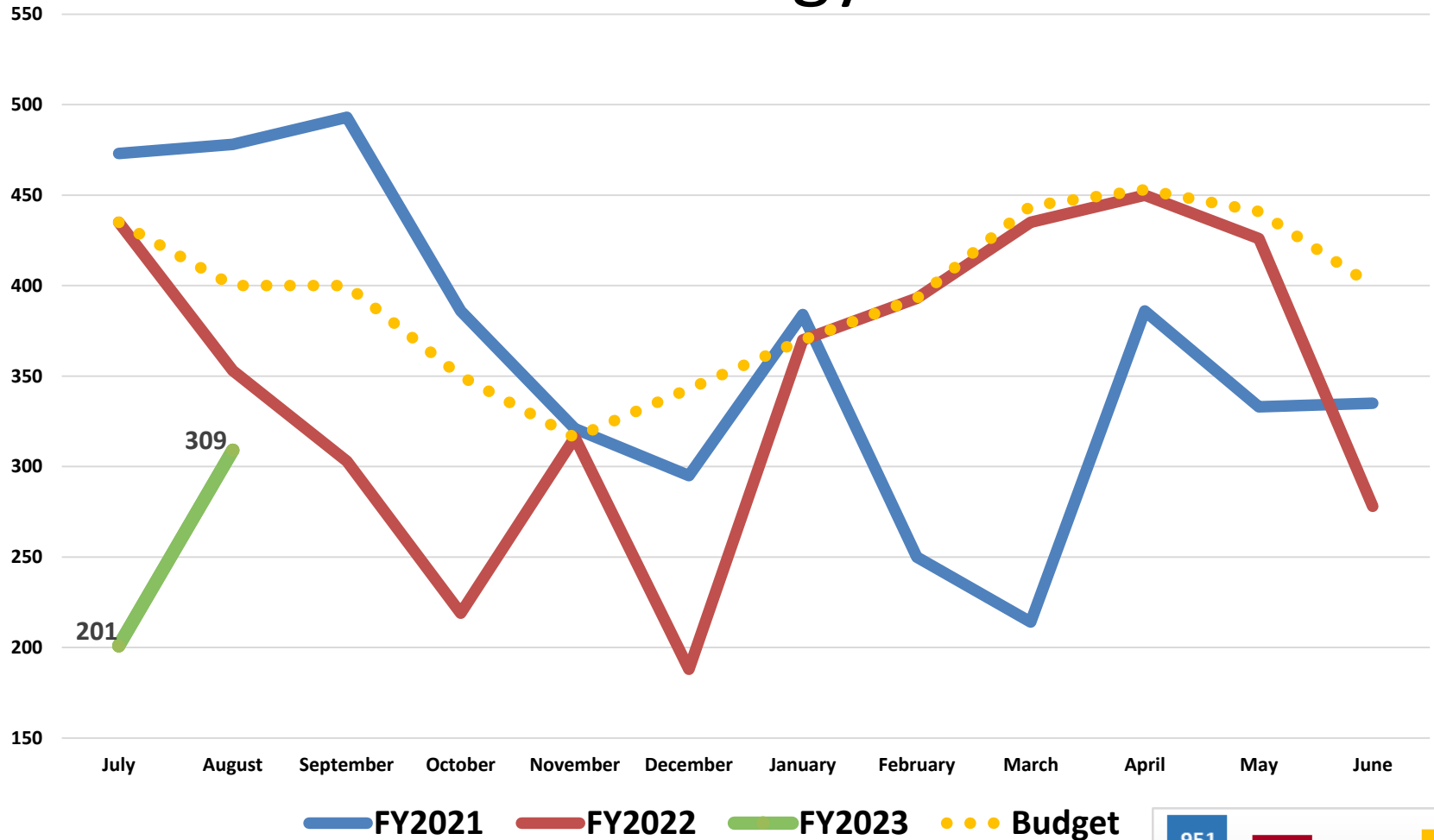
4,652	4,215	3,976	4,801
YTD FY2021	YTD FY2022	YTD FY2023	YTD Budget

Radiation Oncology - Visalia



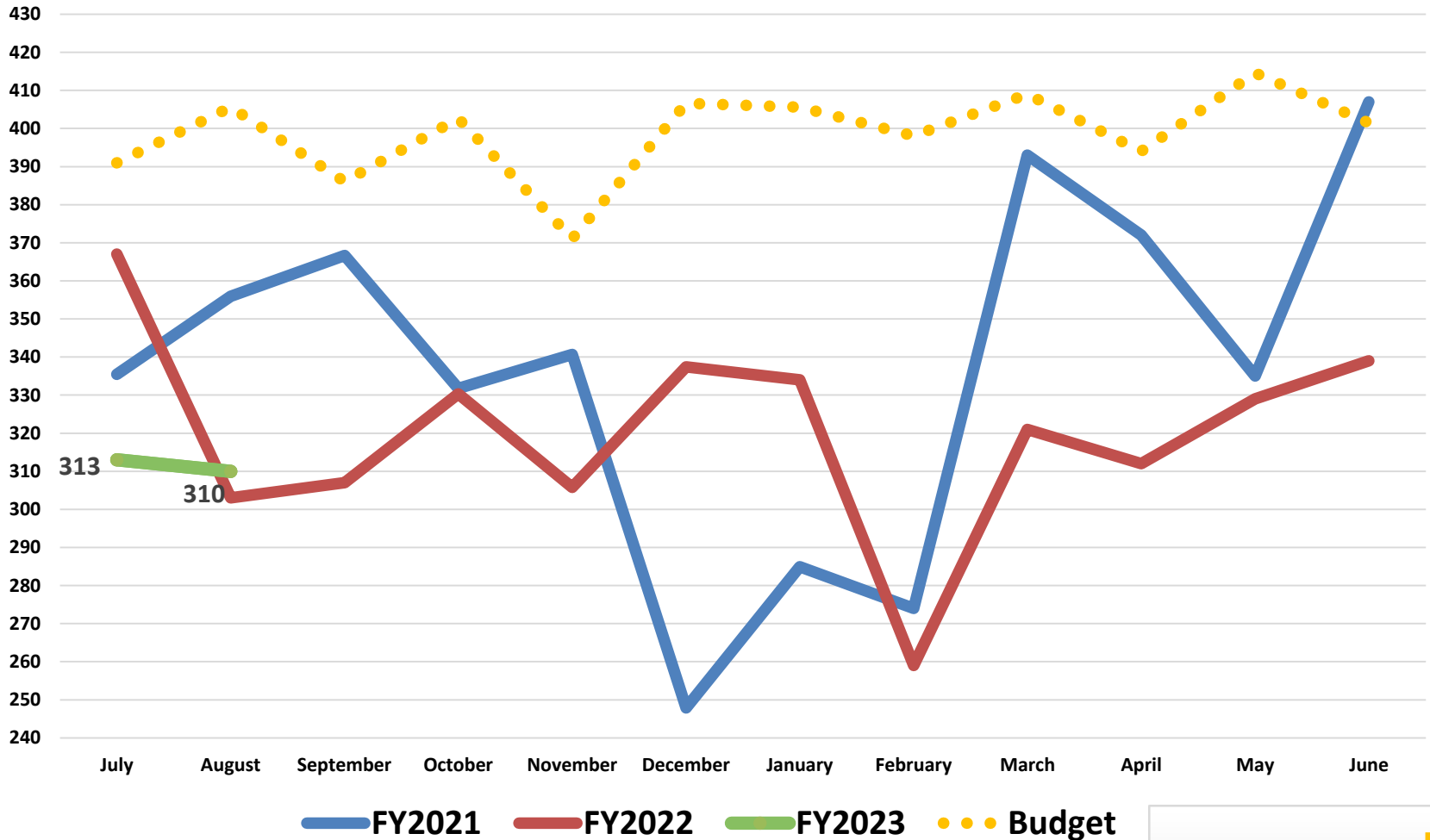
3,701	3,427	3,466	3,966
YTD FY2021	YTD FY2022	YTD FY2023	YTD Budget

Radiation Oncology - Hanford



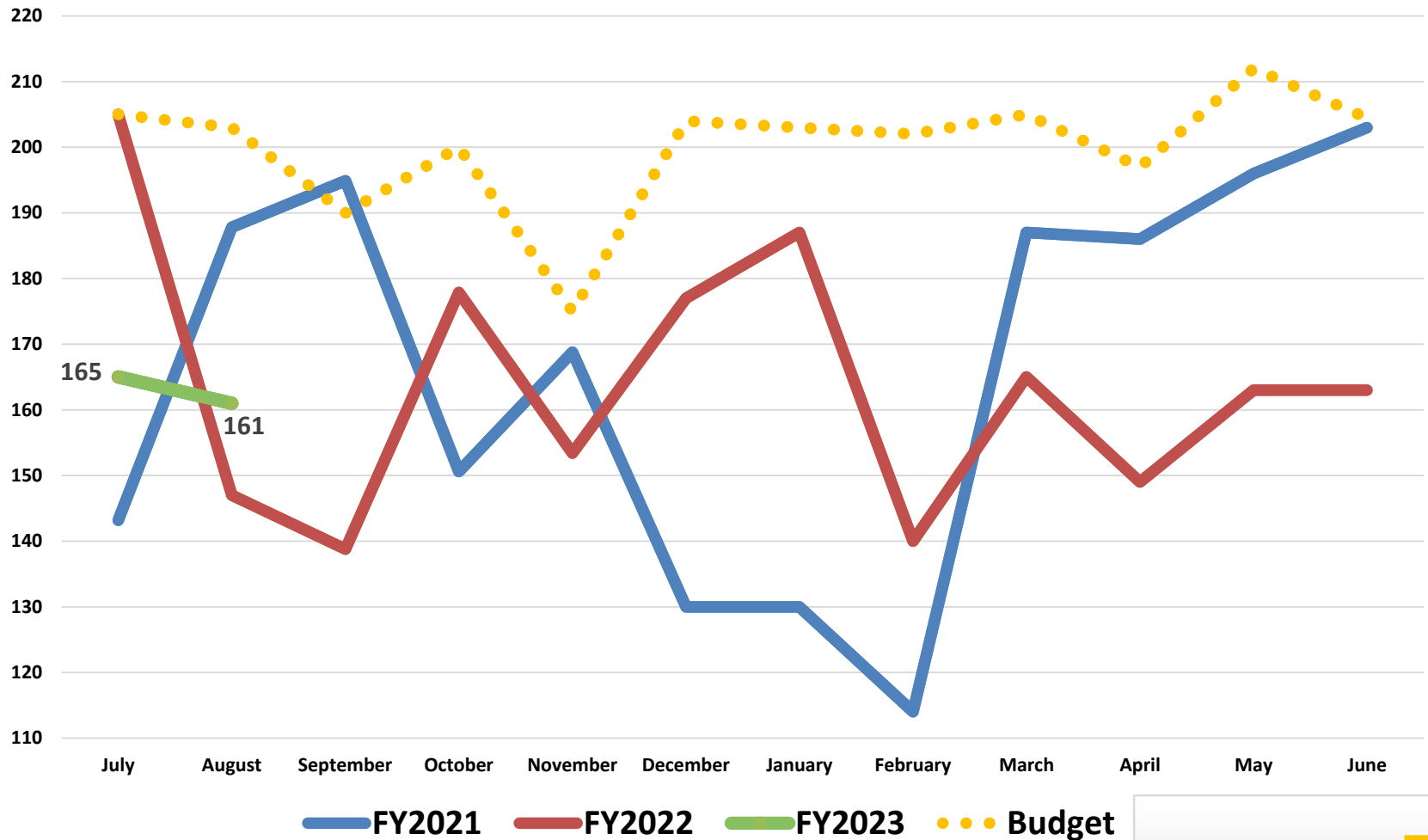
951	788	510	835
YTD FY2021	YTD FY2022	YTD FY2023	YTD Budget

Cath Lab (IP & OP) – 100 Min Units



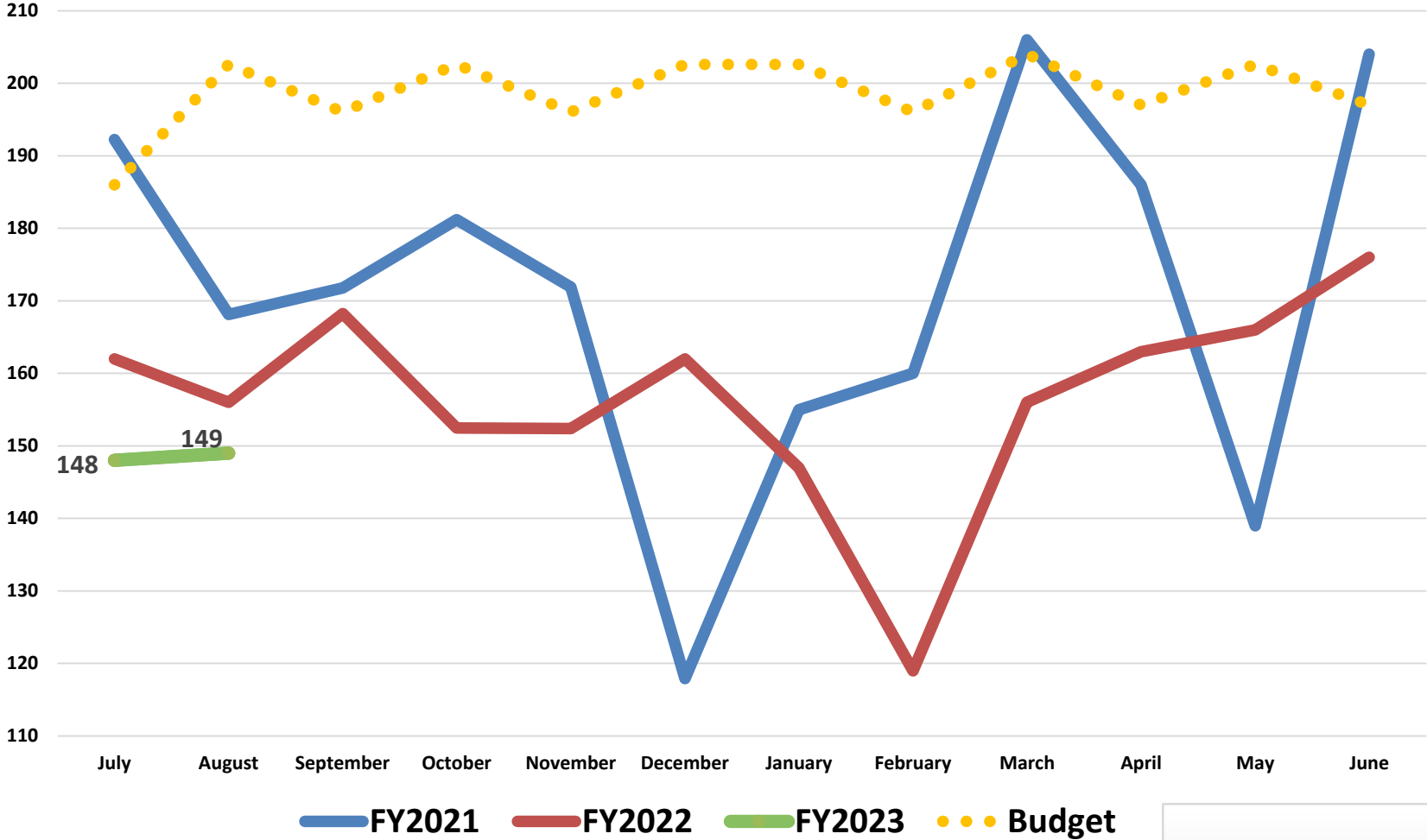
691	670	623	797
YTD FY2021	YTD FY2022	YTD FY2023	YTD Budget

Cath Lab (IP Only) – 100 Min Units



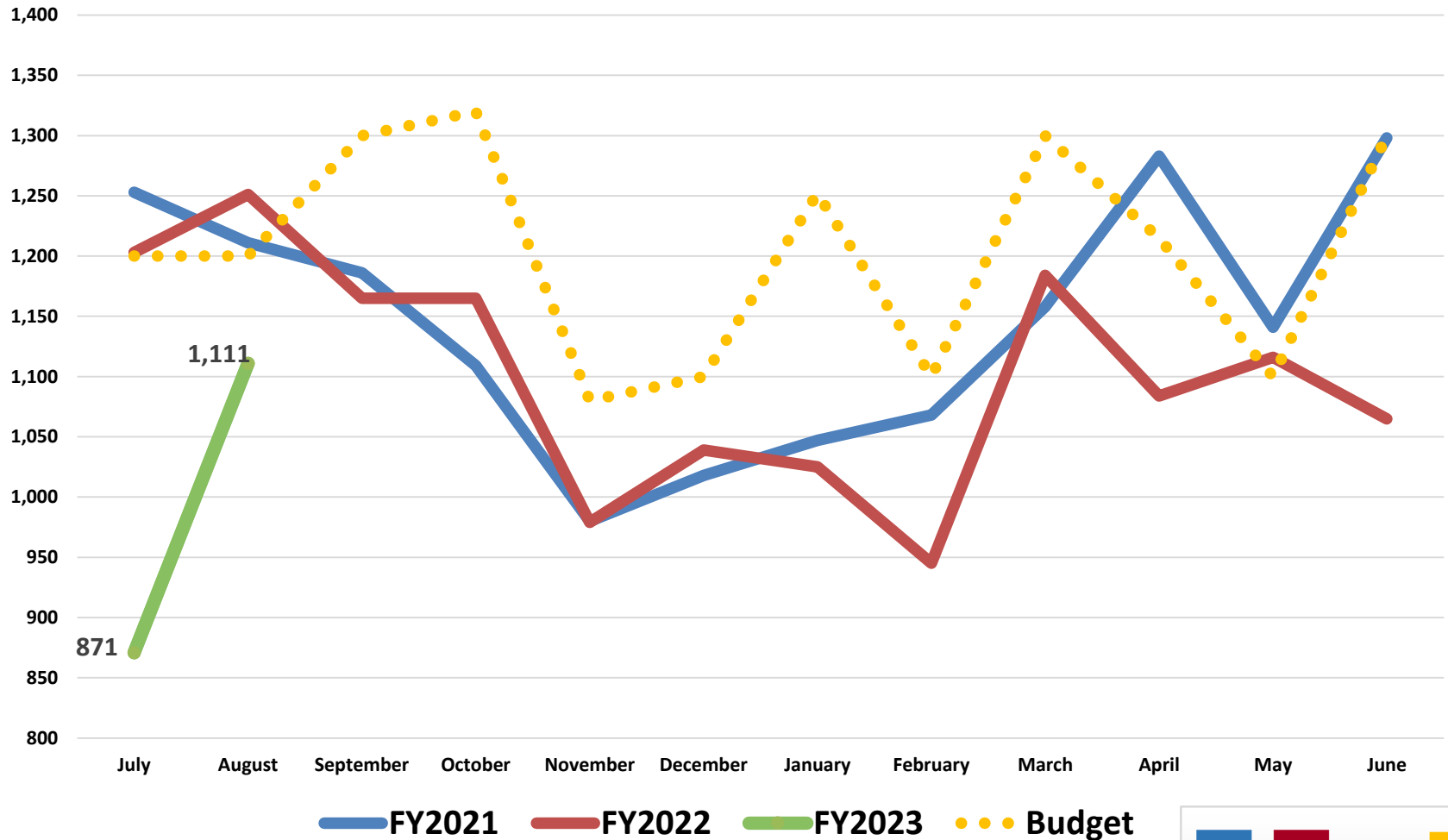
331	352	326	408
YTD FY2021	YTD FY2022	YTD FY2023	YTD Budget

Cath Lab (OP Only) – 100 Min Units



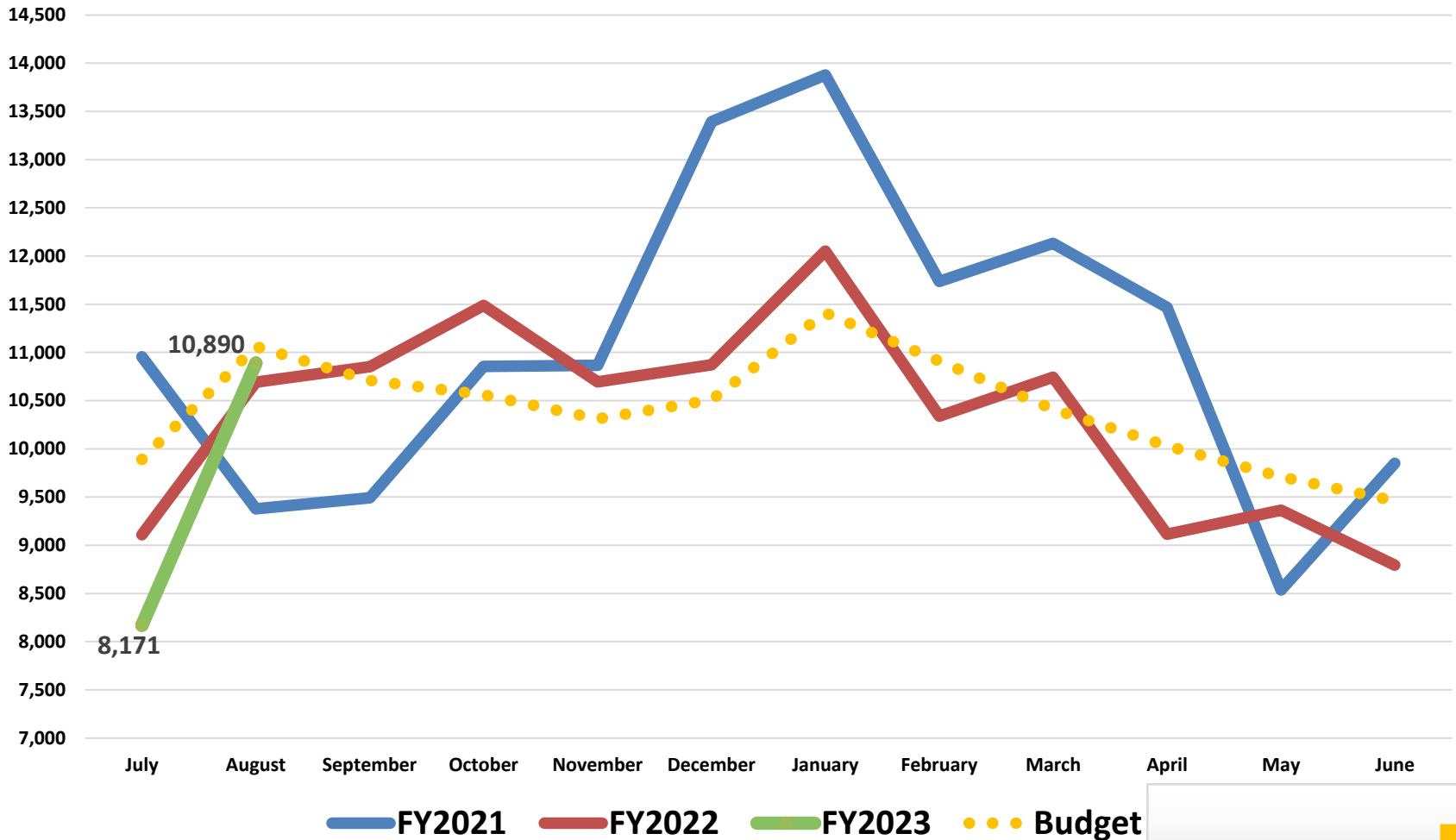
360	318	297	389
YTD FY2021	YTD FY2022	YTD FY2023	YTD Budget

GME Family Medicine Clinic Visits



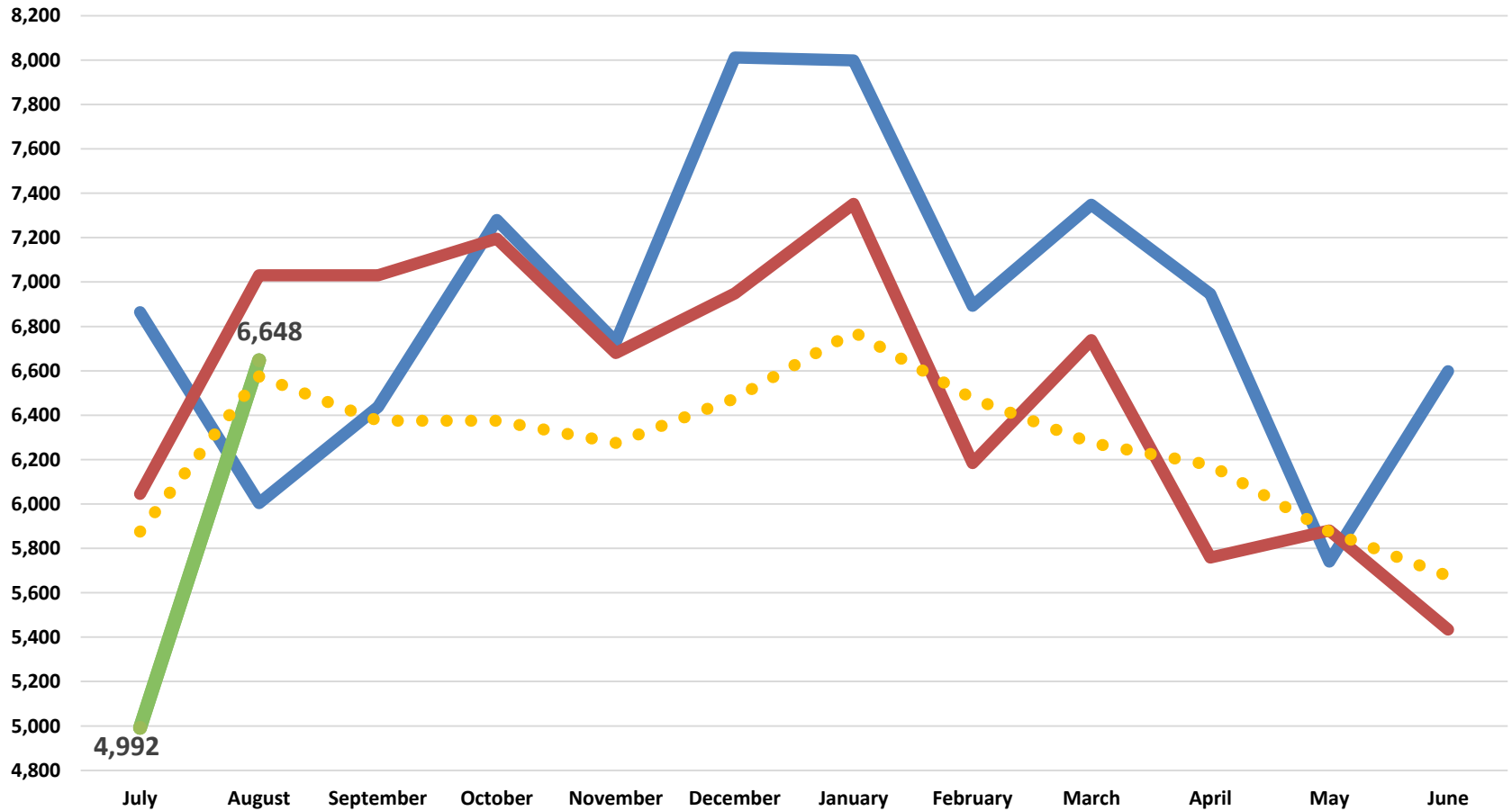
2,464	2,454	1,982	2,400
YTD FY2021	YTD FY2022	YTD FY2023	YTD Budget

Rural Health Clinic Registrations

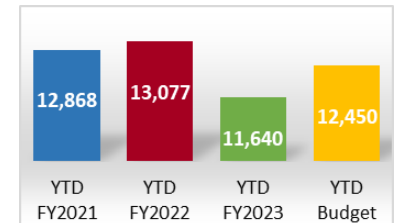


20,334	19,801	19,061	20,950
YTD FY2021	YTD FY2022	YTD FY2023	YTD Budget

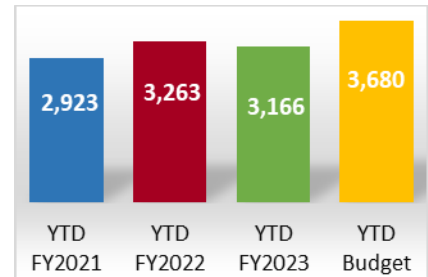
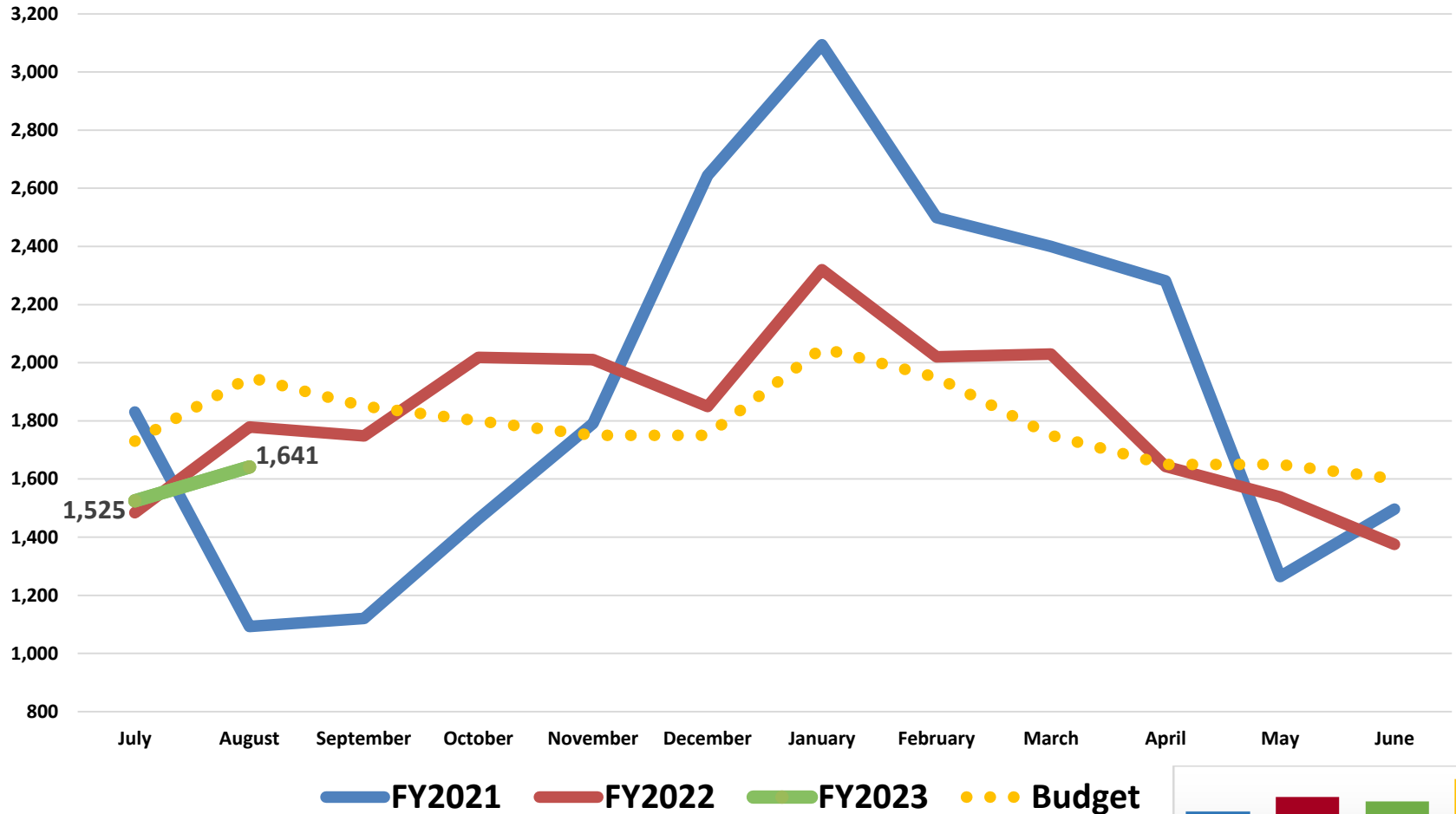
Exeter RHC - Registrations



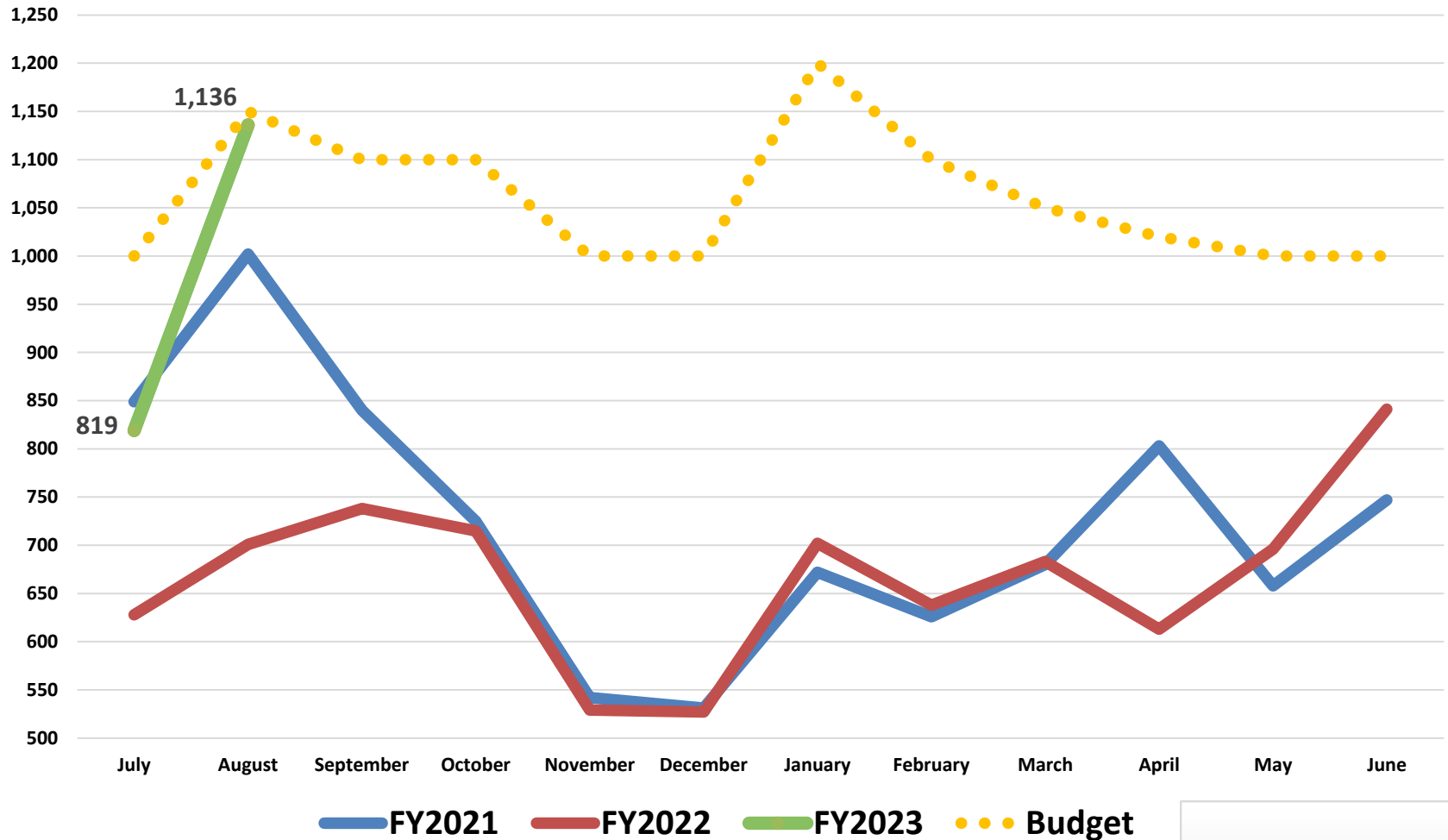
—●— FY2021
 —●— FY2022
 —●— FY2023
 ●●● Budget



Lindsay RHC - Registrations

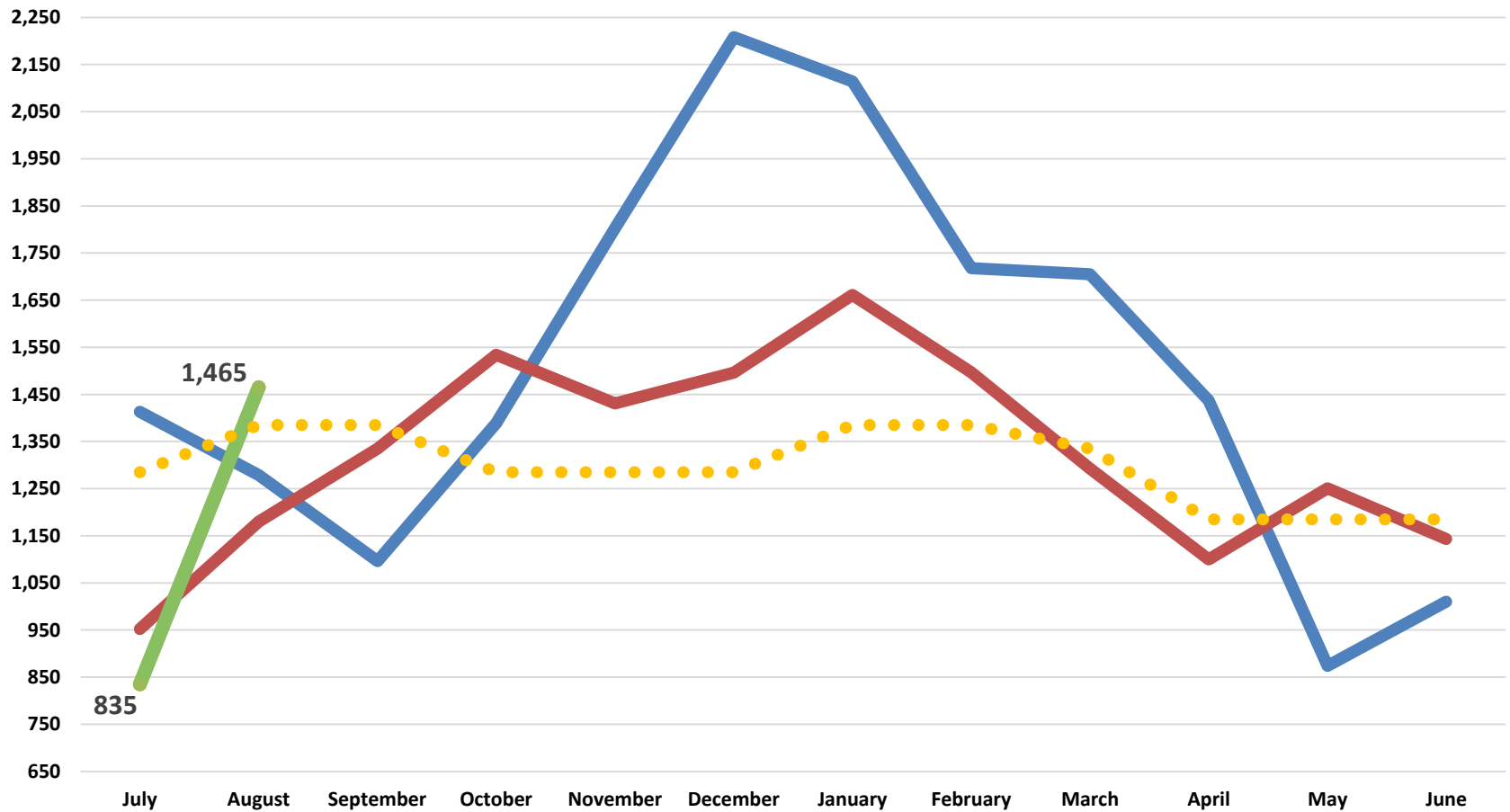


Woodlake RHC - Registrations

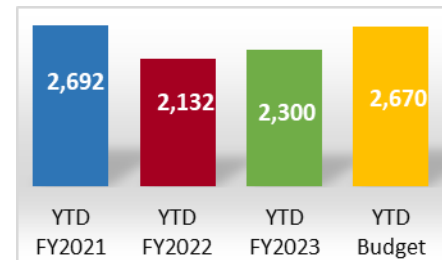


1,851	1,329	1,955	2,150
YTD FY2021	YTD FY2022	YTD FY2023	YTD Budget

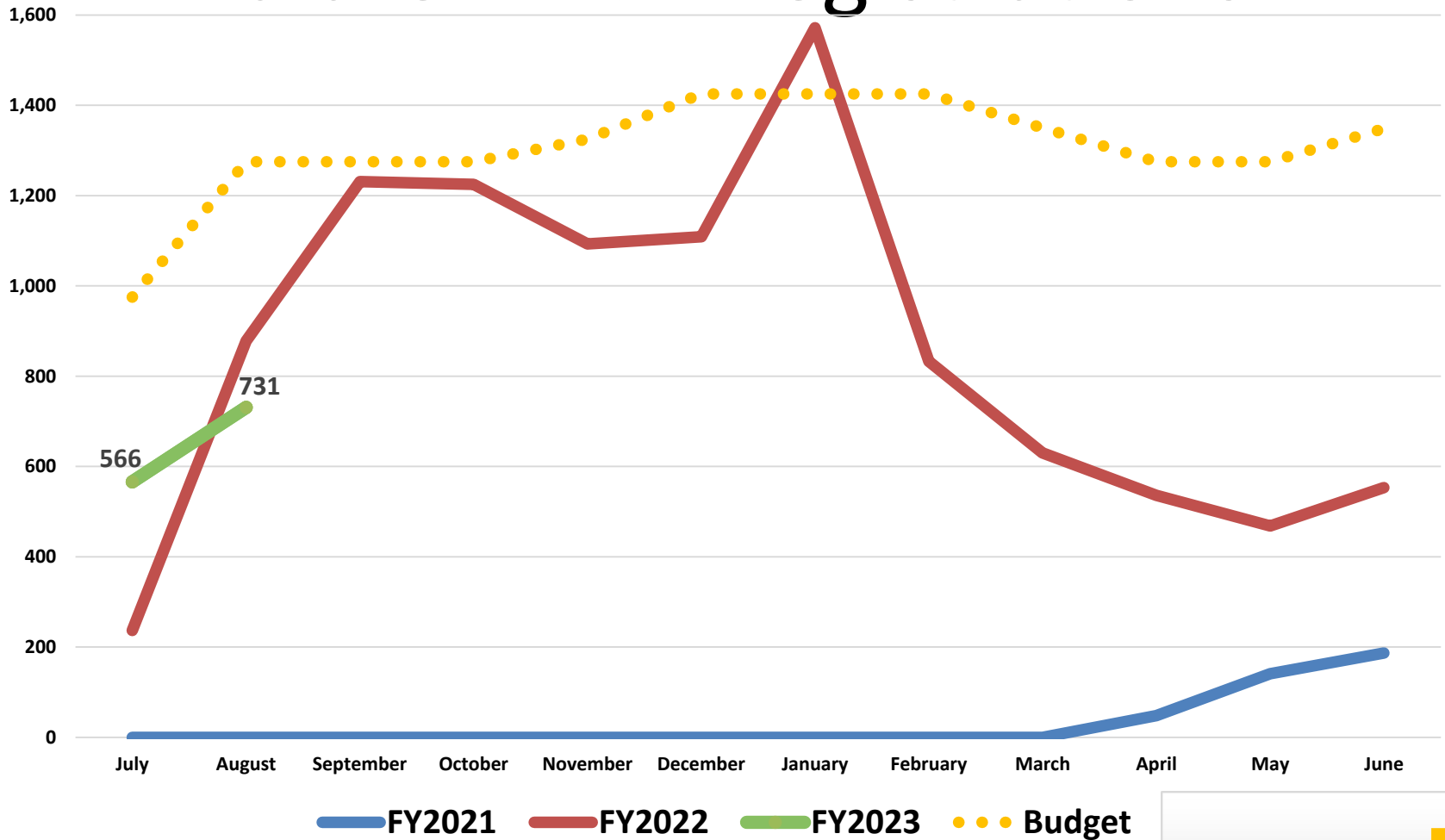
Dinuba RHC - Registrations



—●— **FY2021**
 —●— **FY2022**
 —●— **FY2023**
 ●●● **Budget**

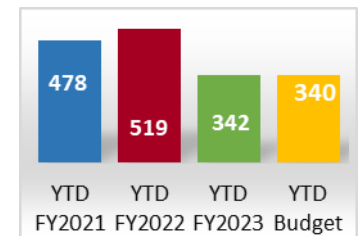
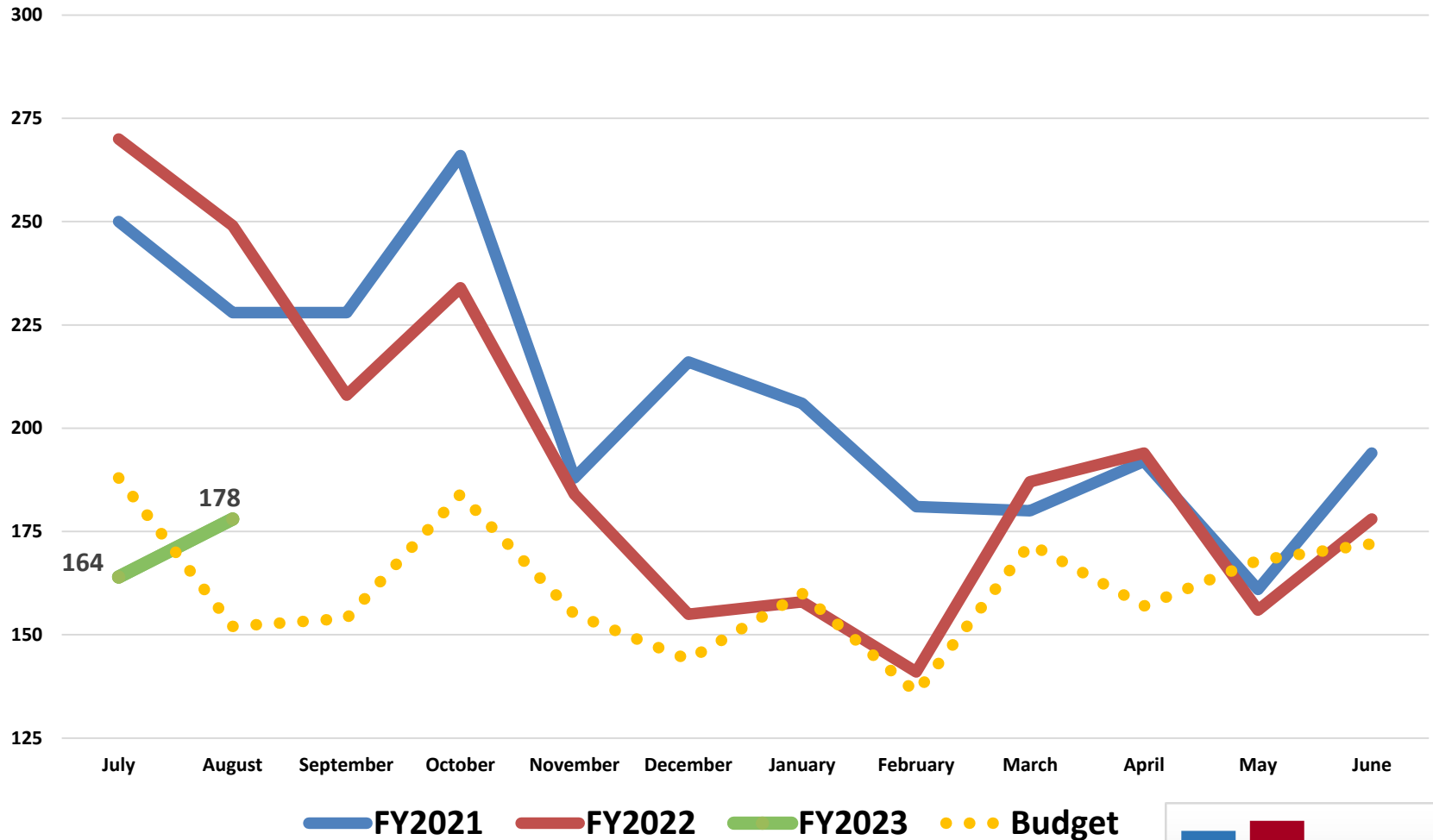


Tulare RHC - Registrations

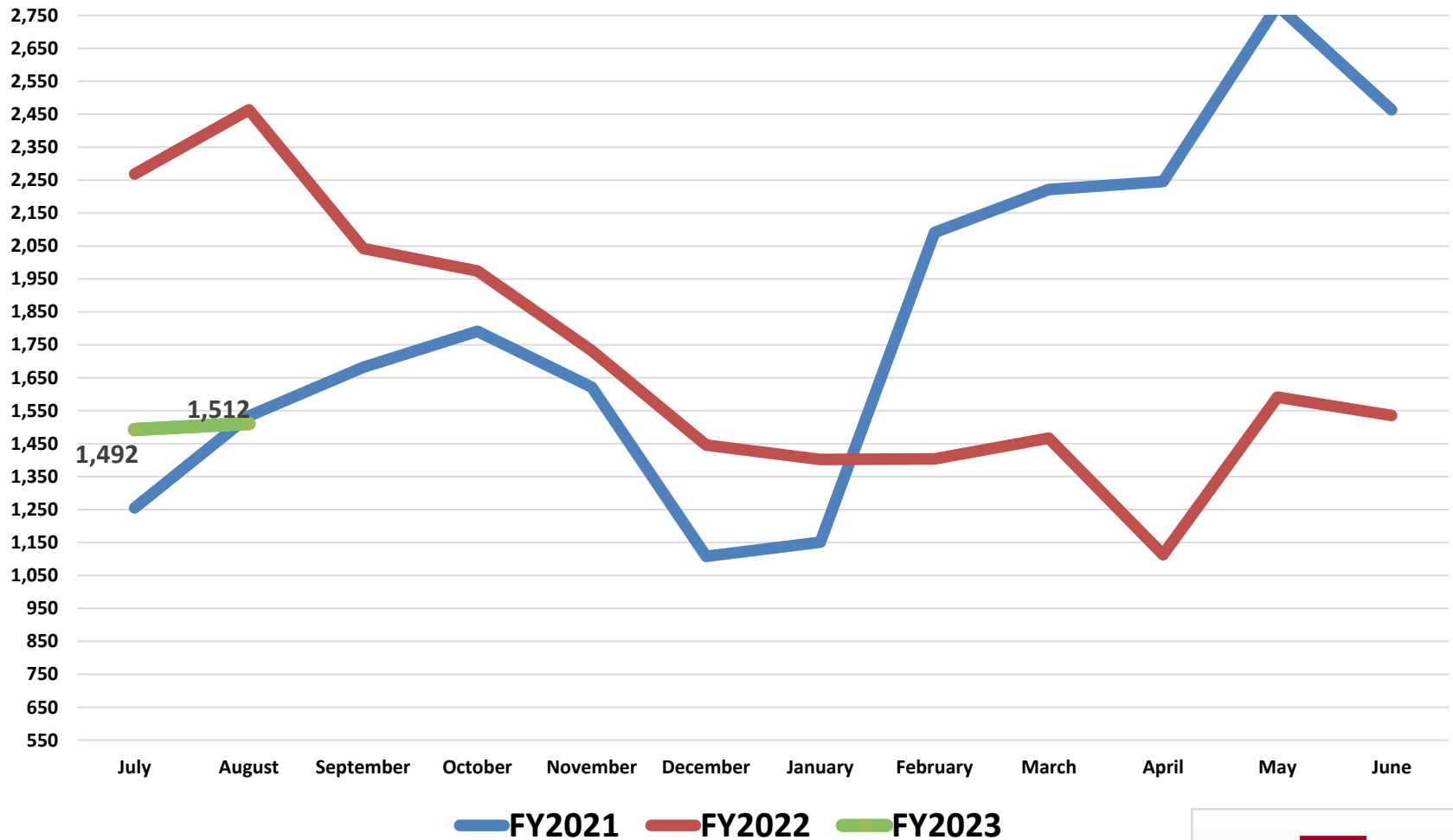


-	1,115	1,297	2,250
YTD FY2021	YTD FY2022	YTD FY2023	YTD Budget

Neurosurgery Clinic - Registrations

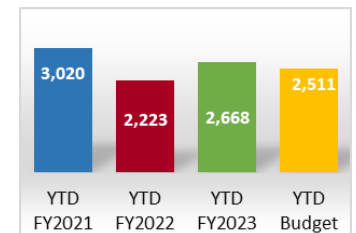
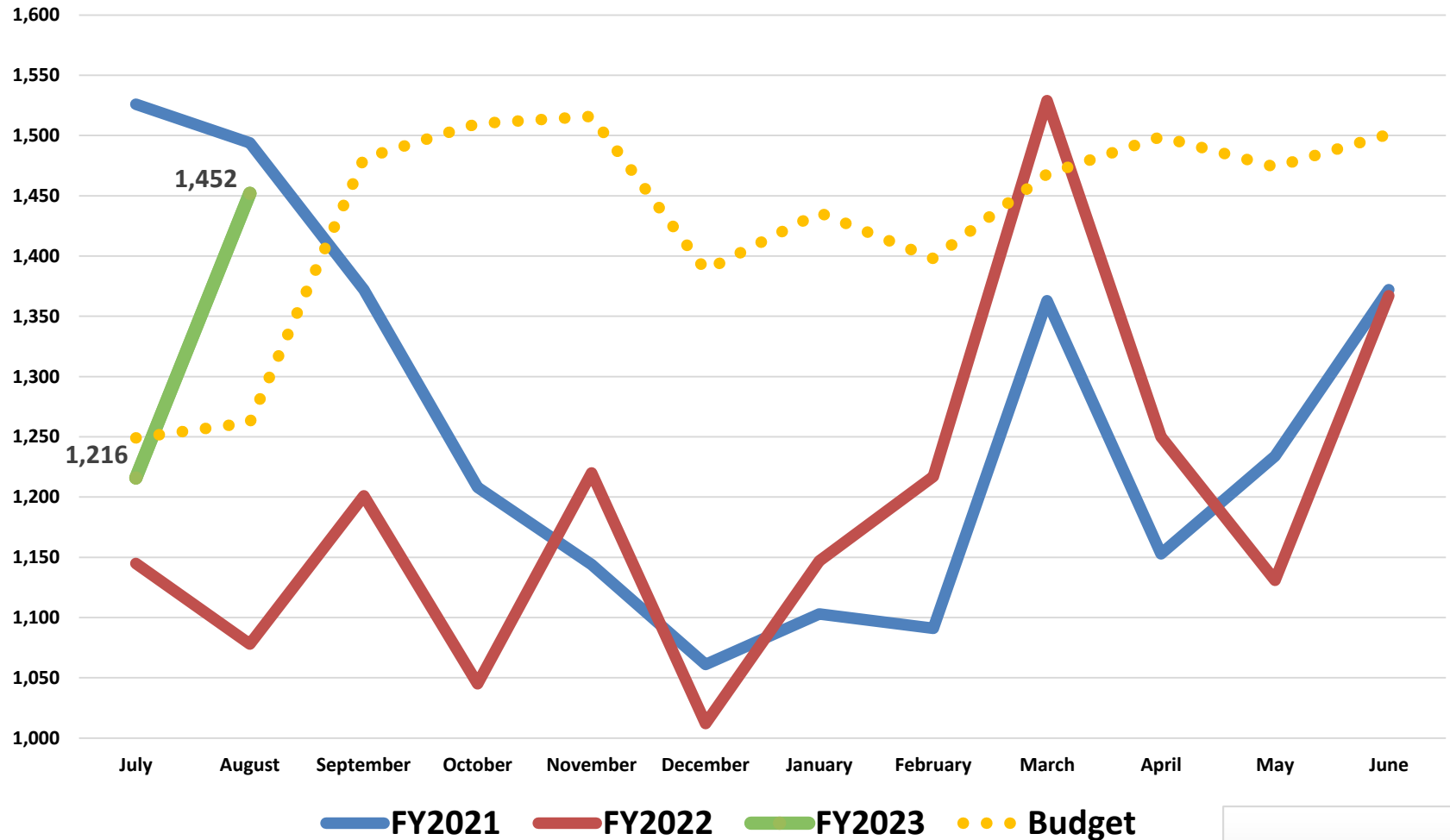


Neurosurgery Clinic - wRVU's

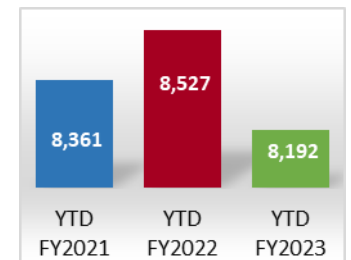
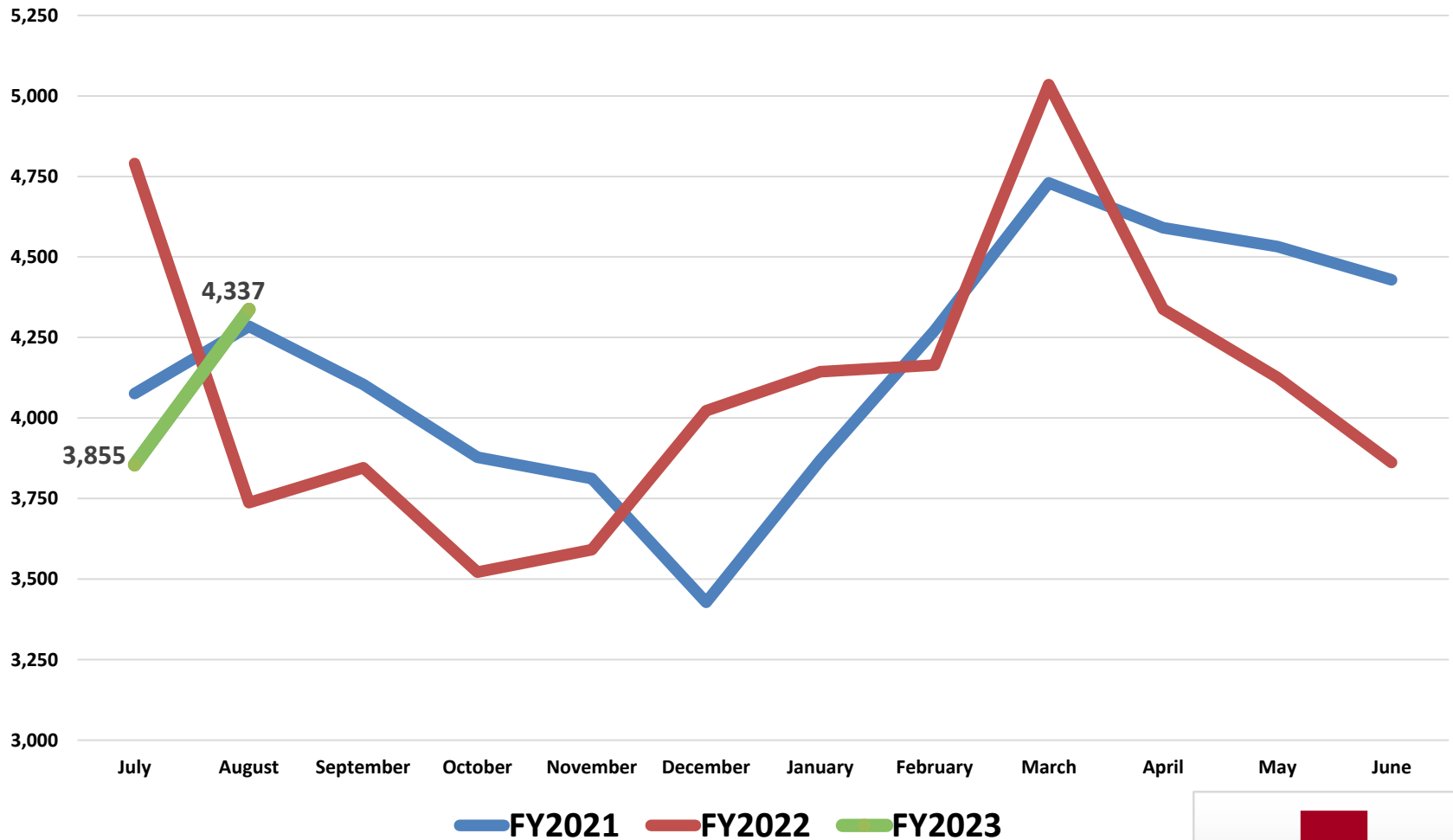


2,789	4,731	3,004
YTD FY2021	YTD FY2022	YTD FY2023

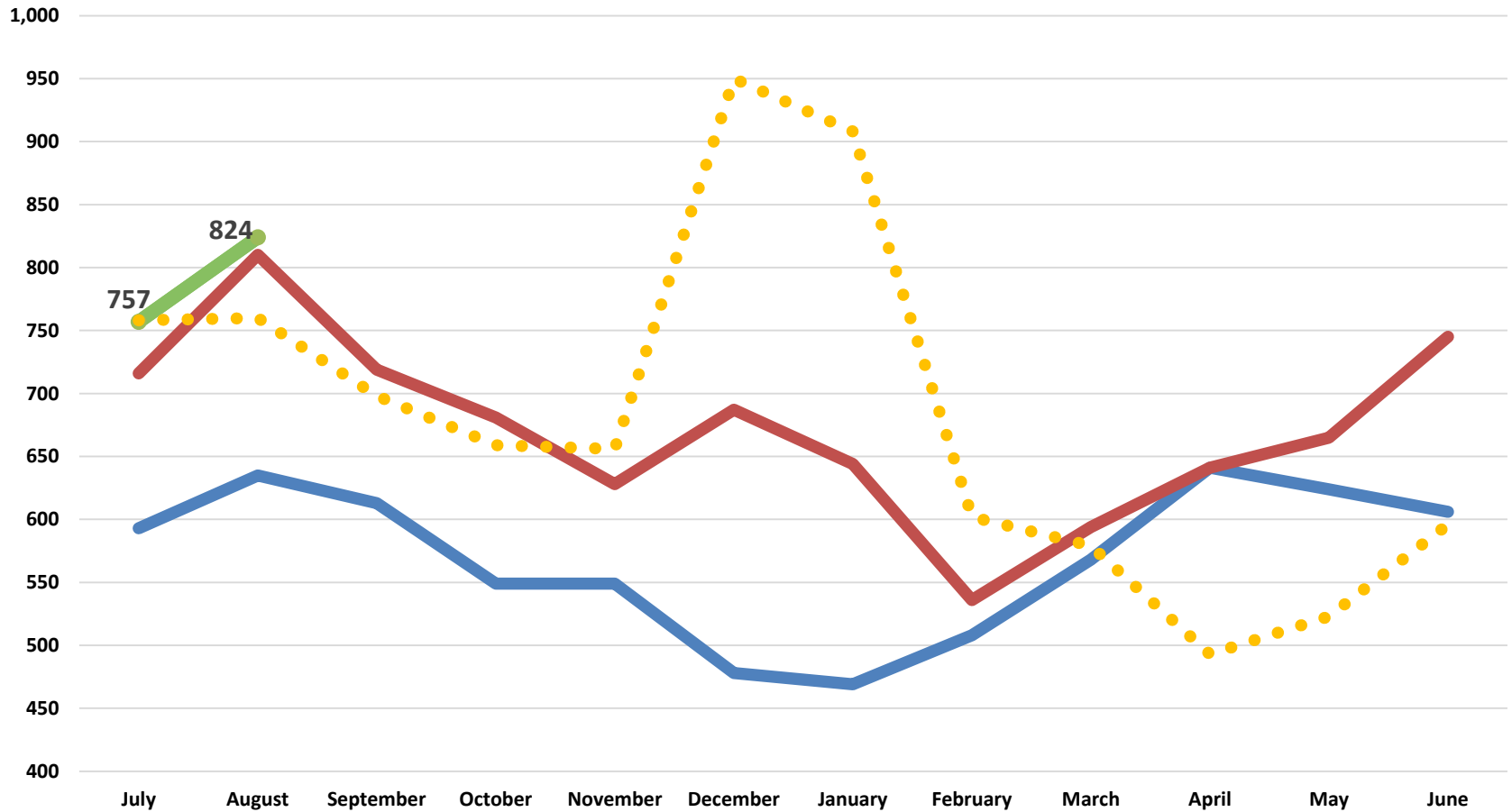
Sequoia Cardiology - Registrations



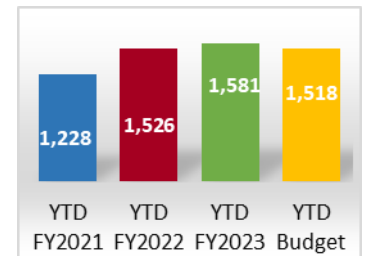
Sequoia Cardiology – wRVU's



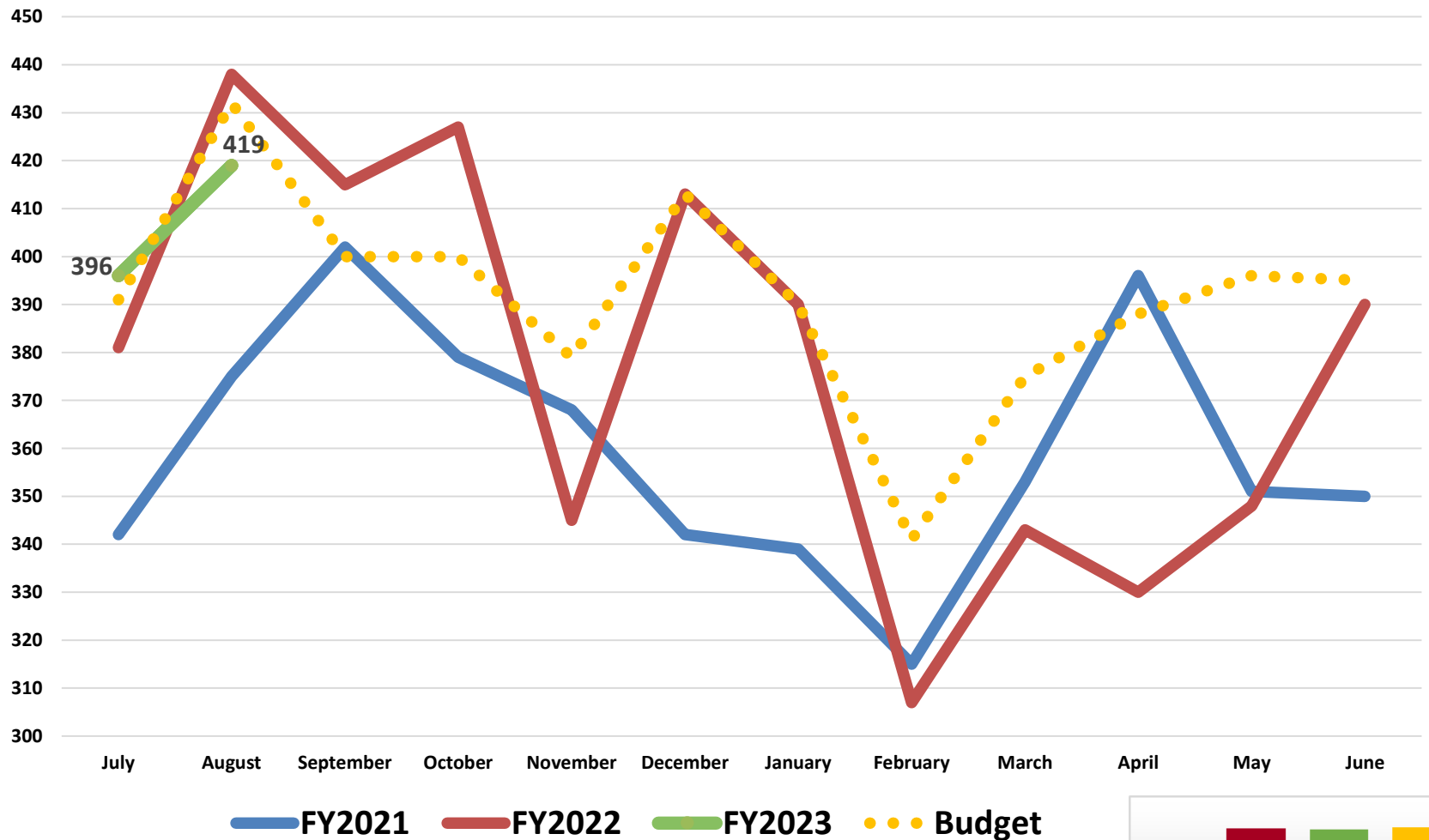
Labor Triage Registrations



—●— FY2021
 —●— FY2022
 —●— FY2023
 ●●● Budget

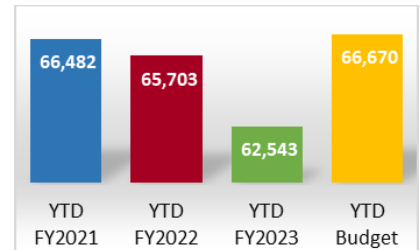


Deliveries

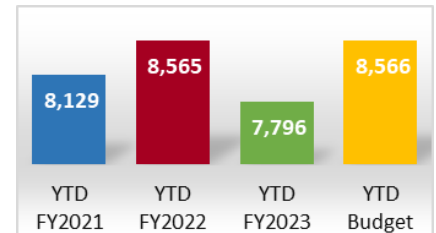
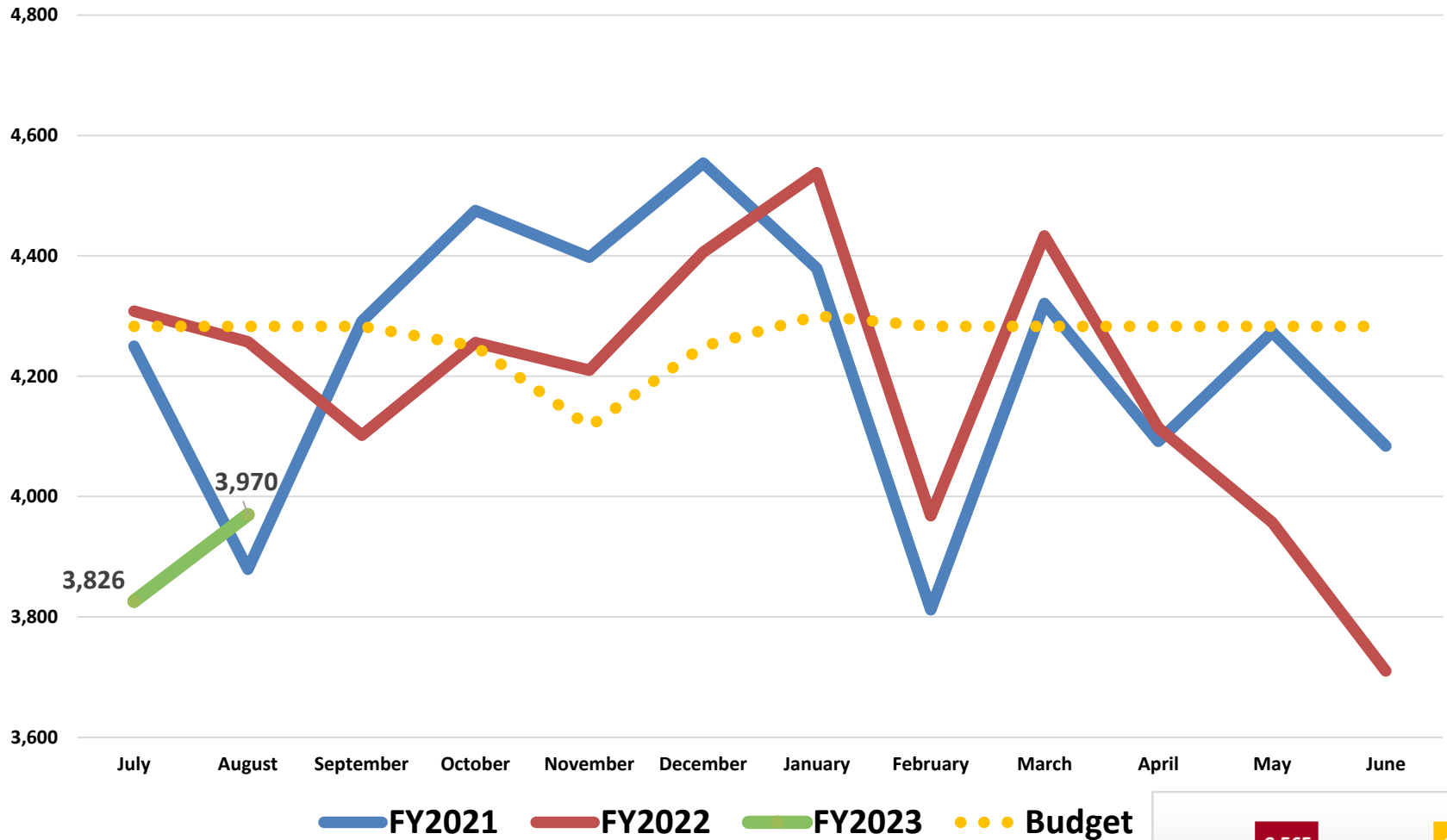


717	819	815	823
YTD FY2021	YTD FY2022	YTD FY2023	YTD Budget

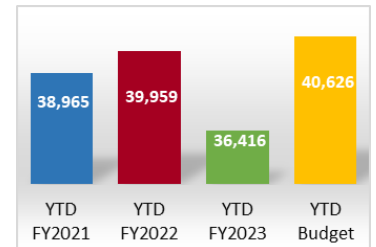
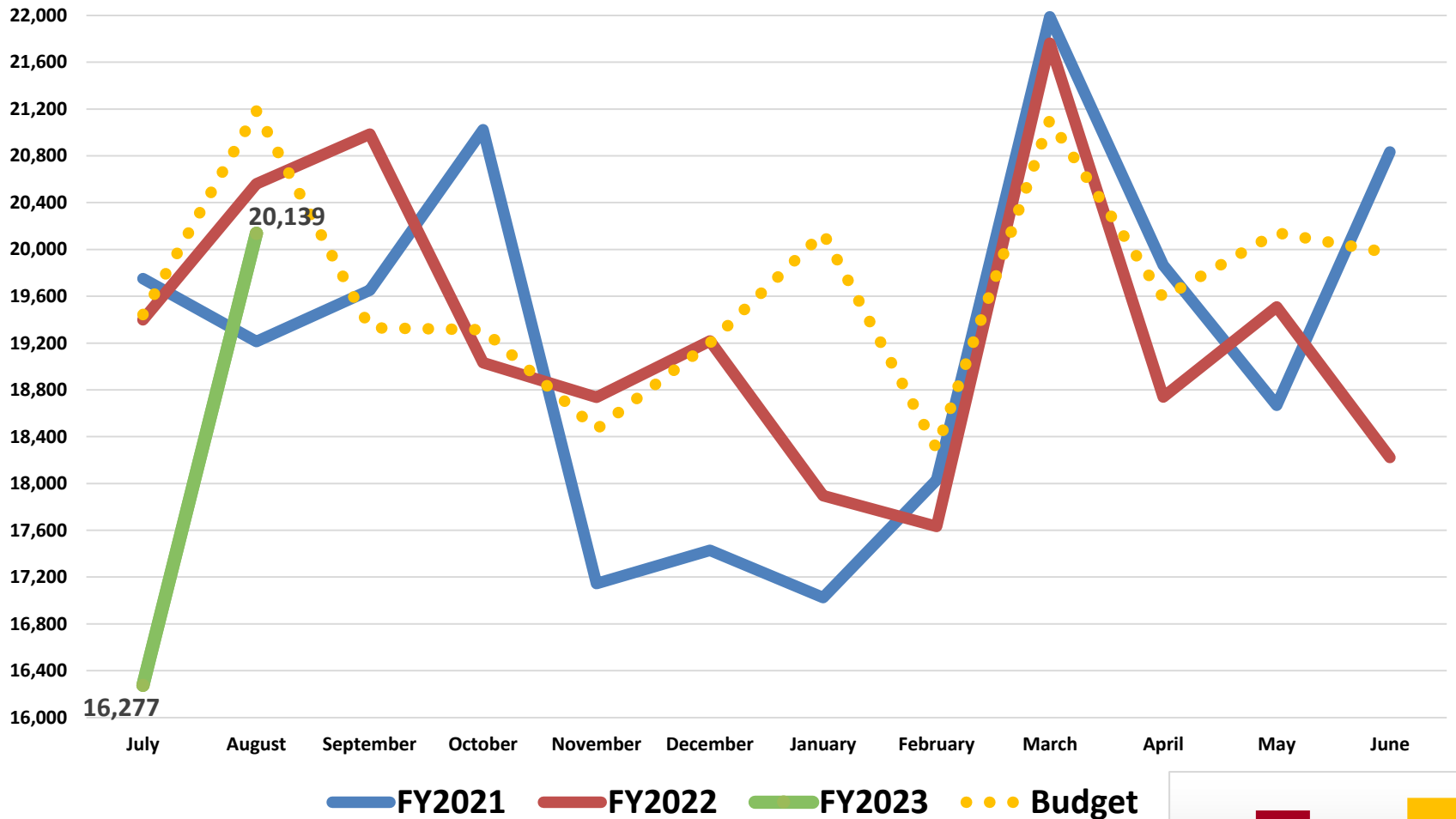
KHMG RVU's



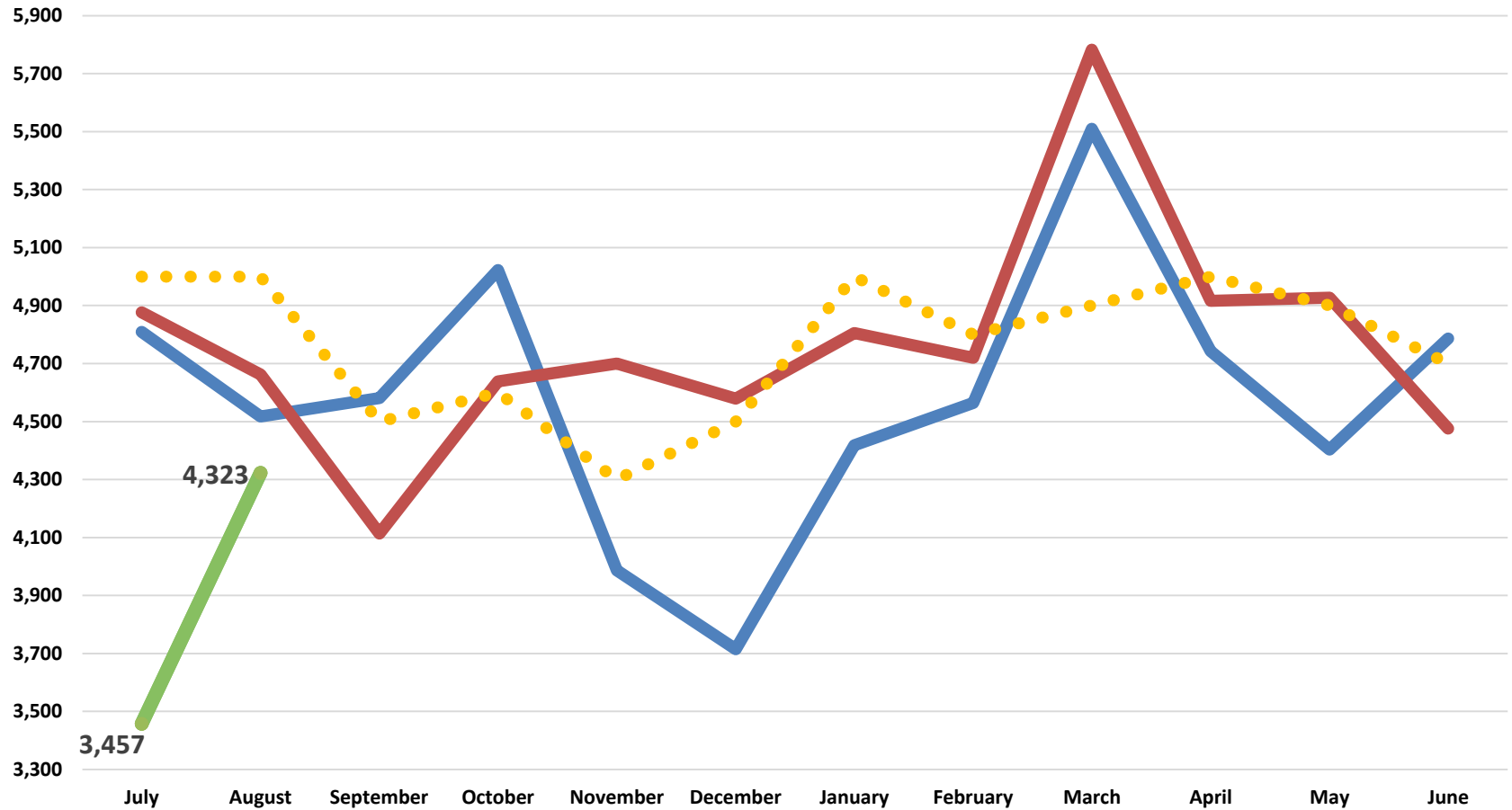
Hospice Days



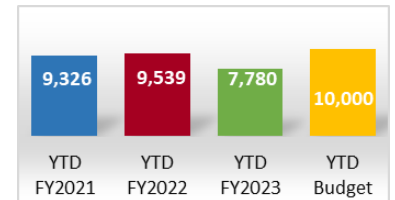
All O/P Rehab Services Across District



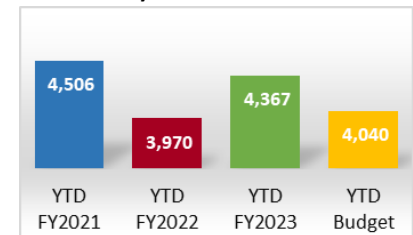
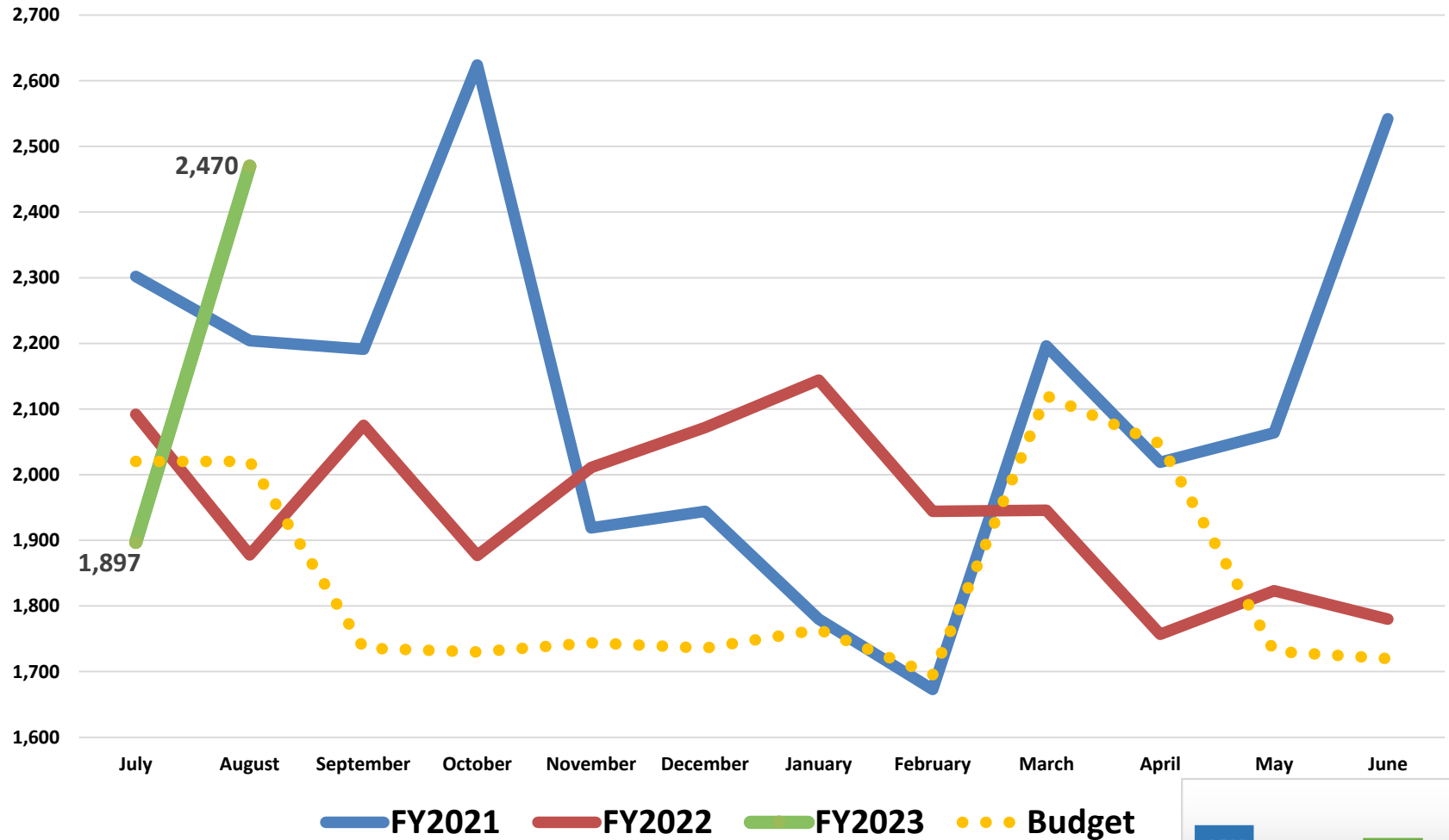
O/P Rehab Services



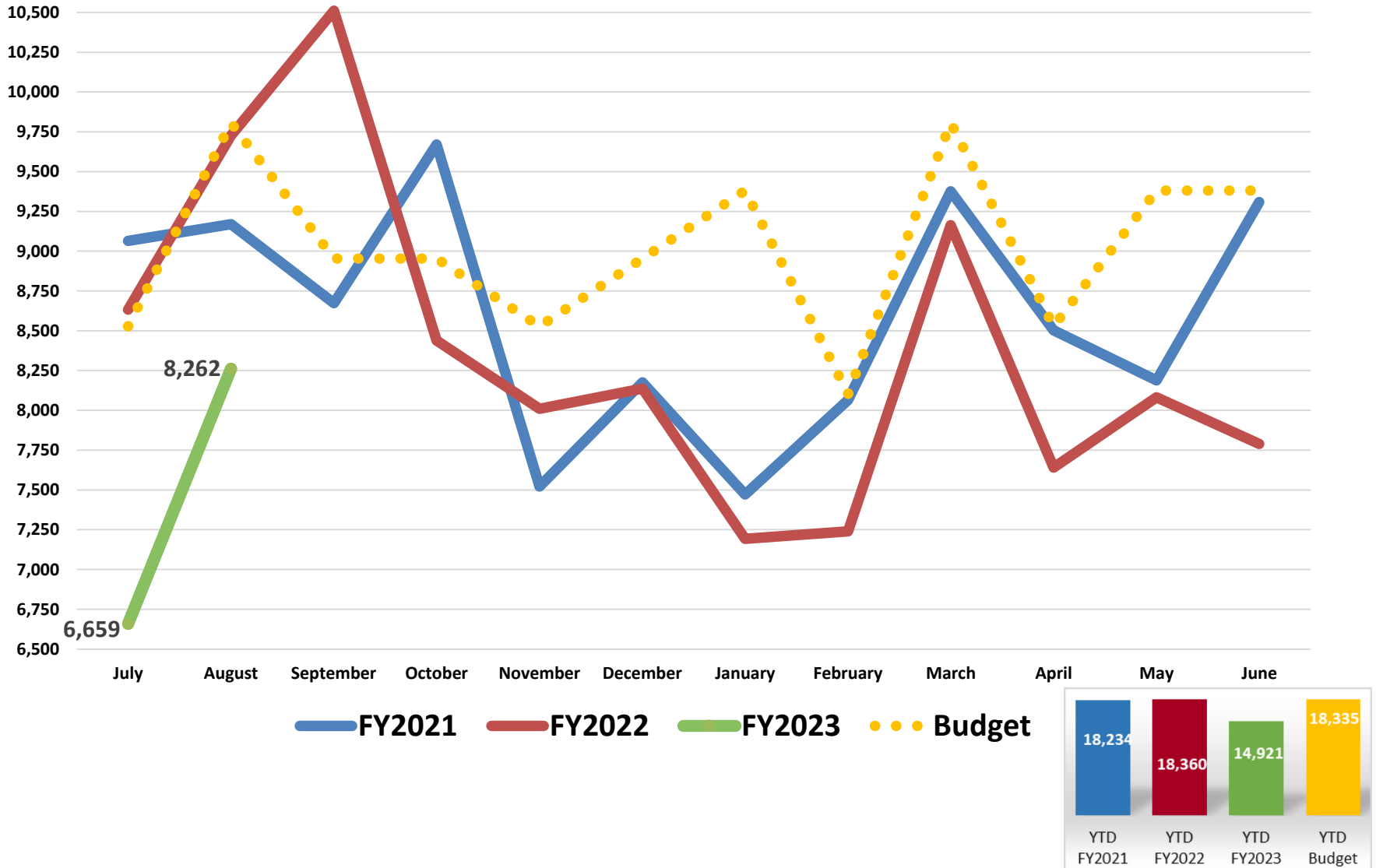
—●— **FY2021**
 —●— **FY2022**
 —●— **FY2023**
 ●●● **Budget**



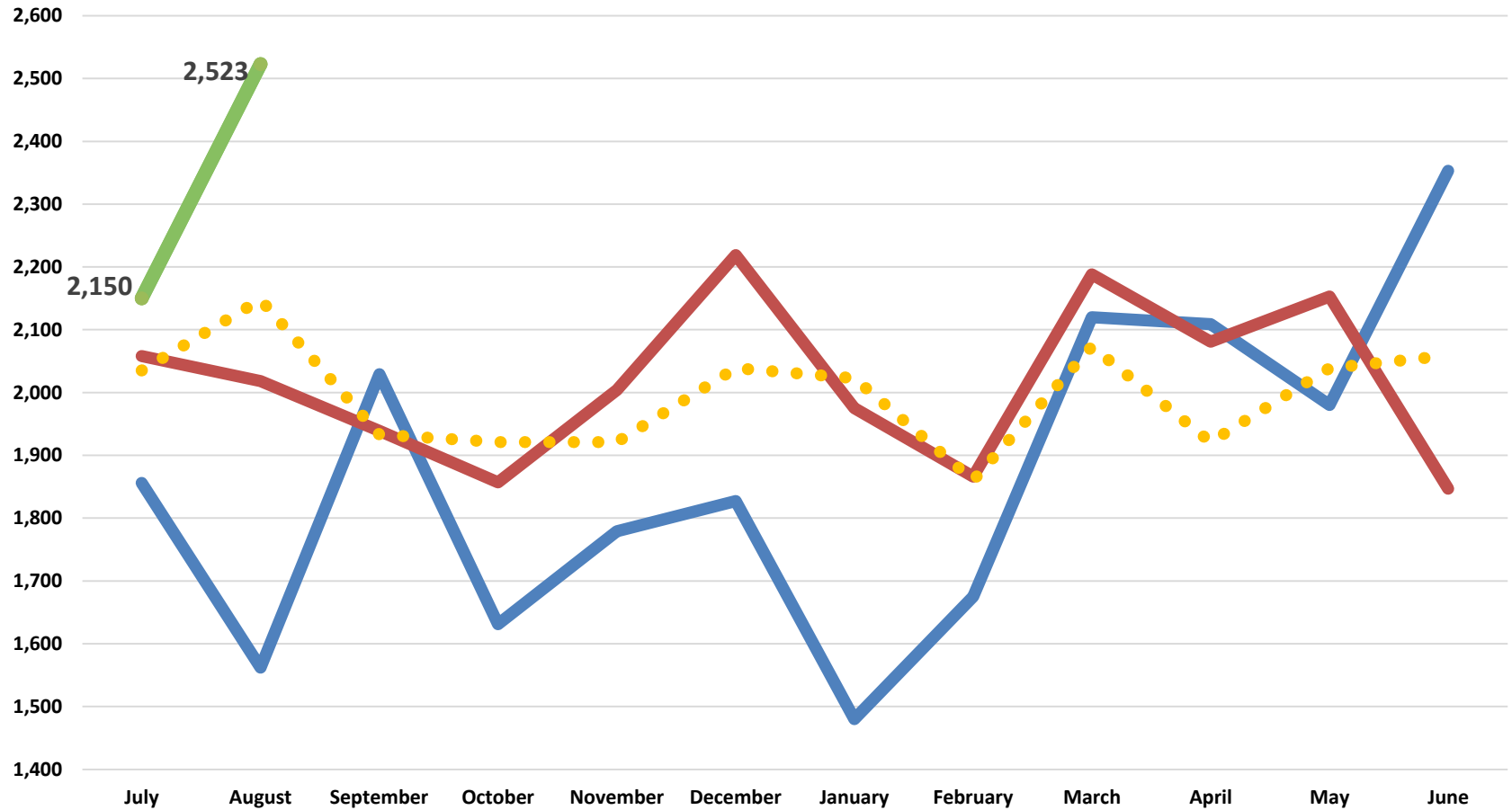
O/P Rehab - Exeter



O/P Rehab - Akers



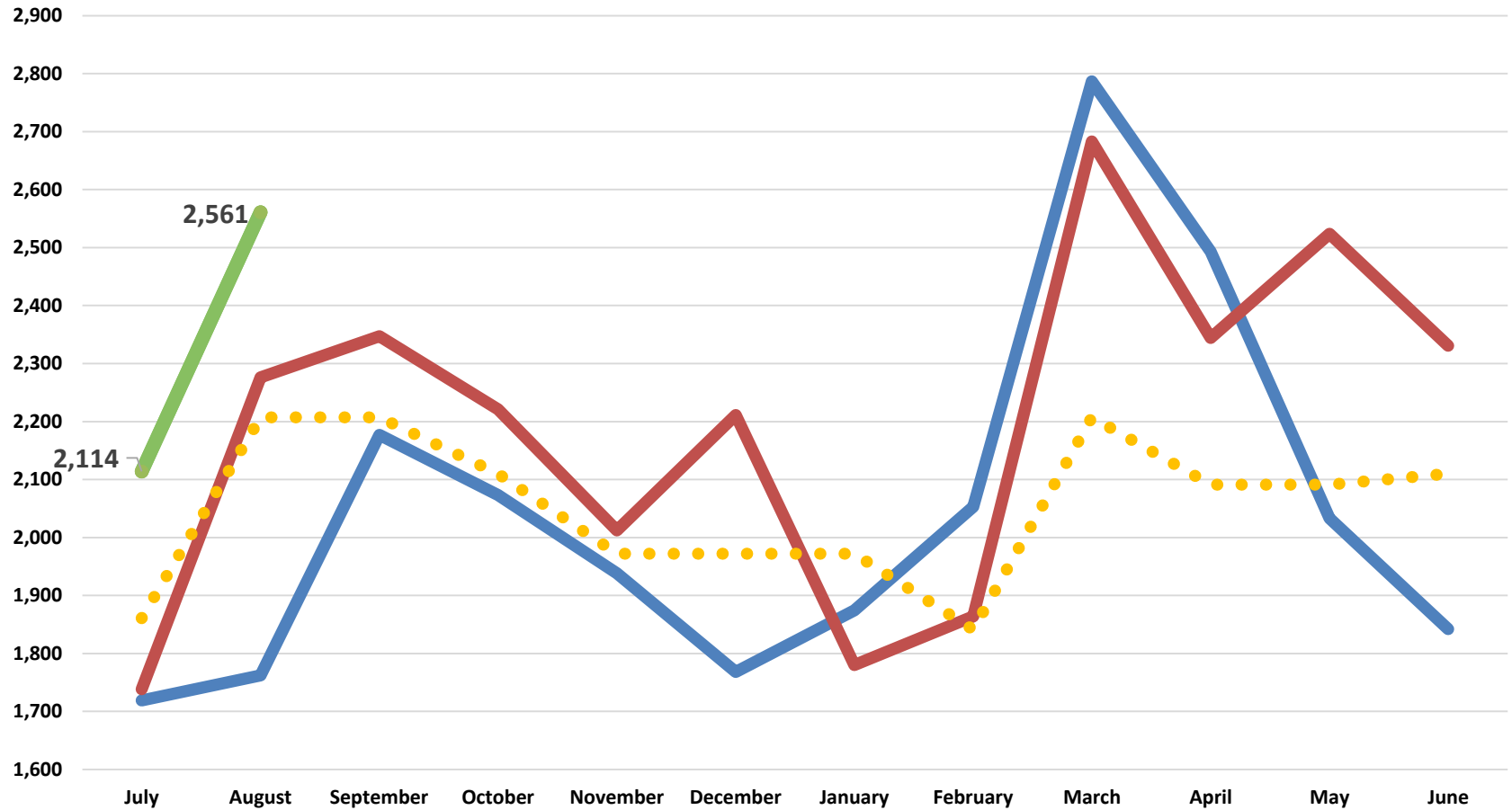
O/P Rehab - LLOPT



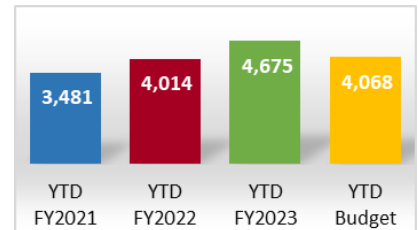
—●— **FY2021**
 —●— **FY2022**
 —●— **FY2023**
 ●●● **Budget**

3,418	4,076	4,673	4,183
YTD FY2021	YTD FY2022	YTD FY2023	YTD Budget

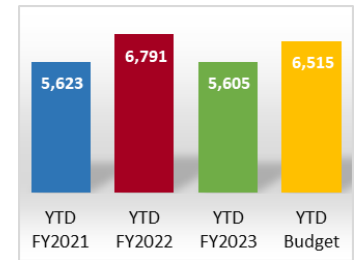
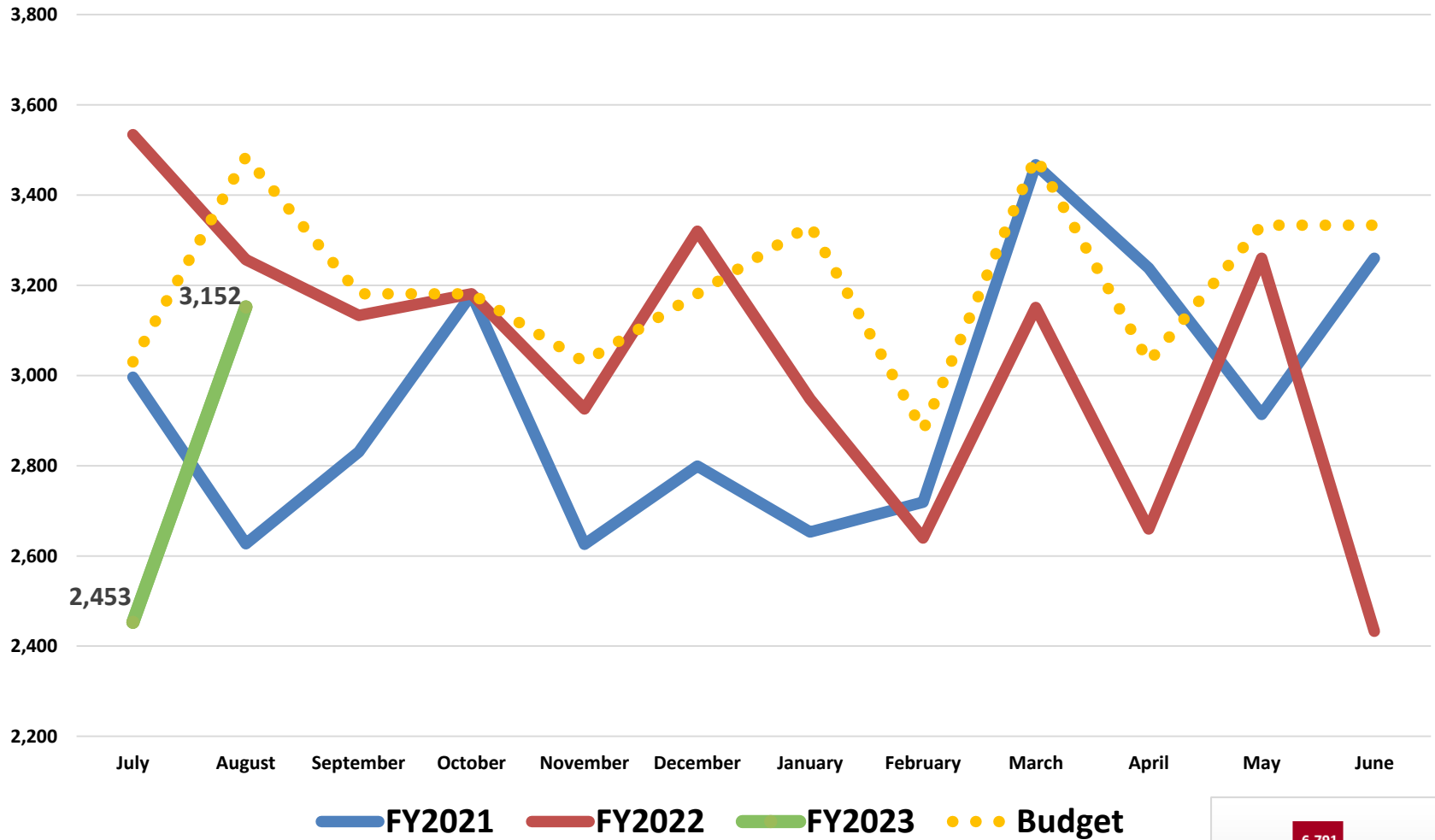
O/P Rehab - Dinuba



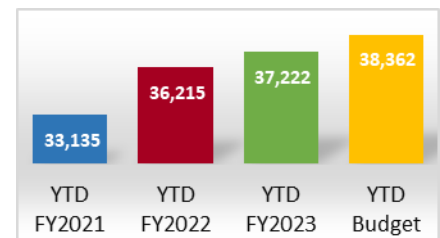
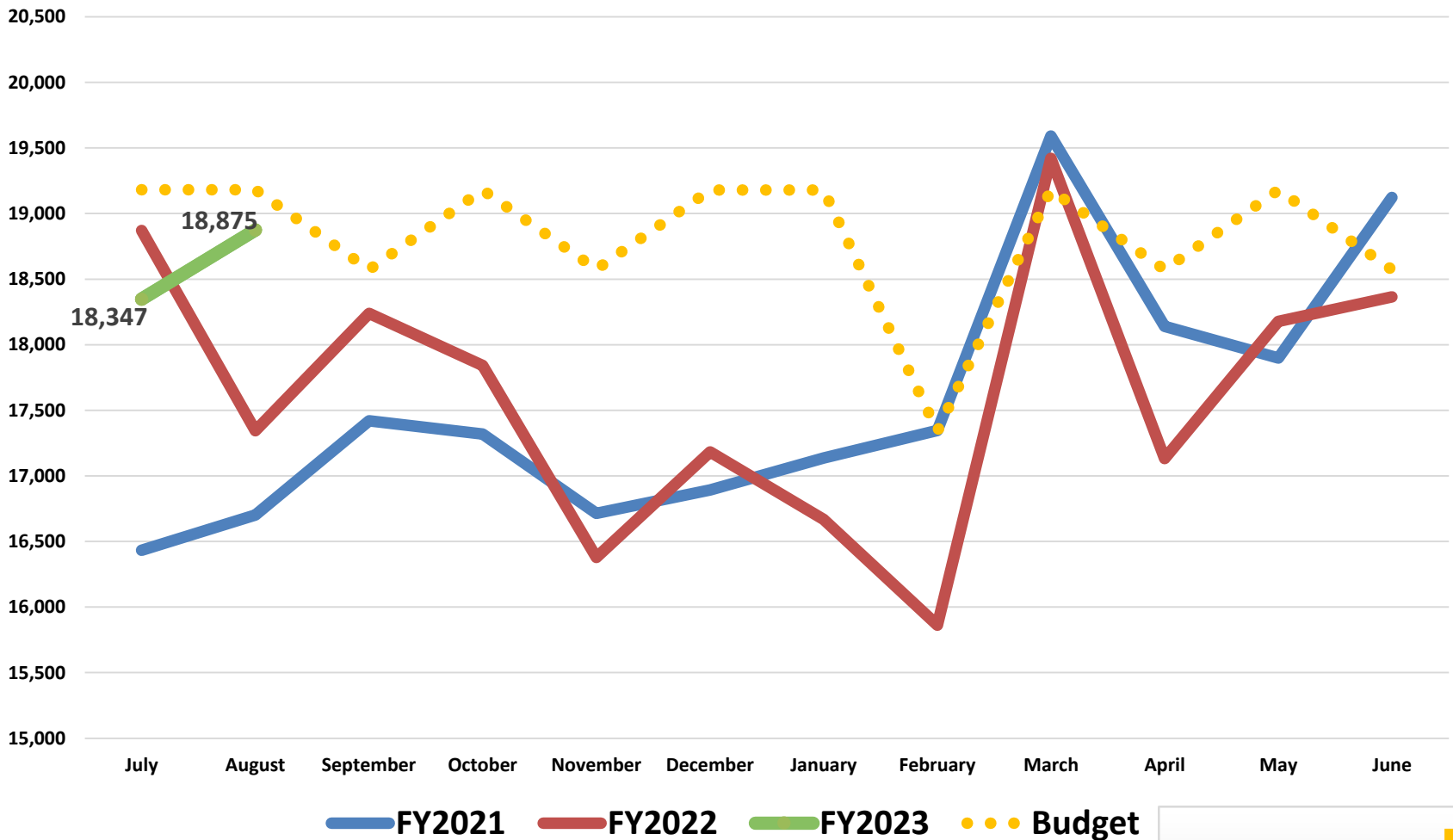
—●— FY2021
 —●— FY2022
 —●— FY2023
 ●●● Budget



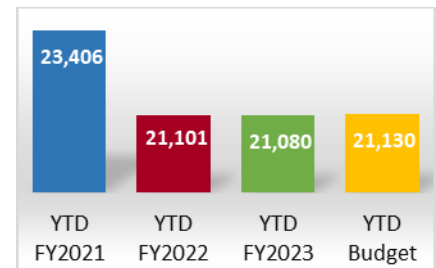
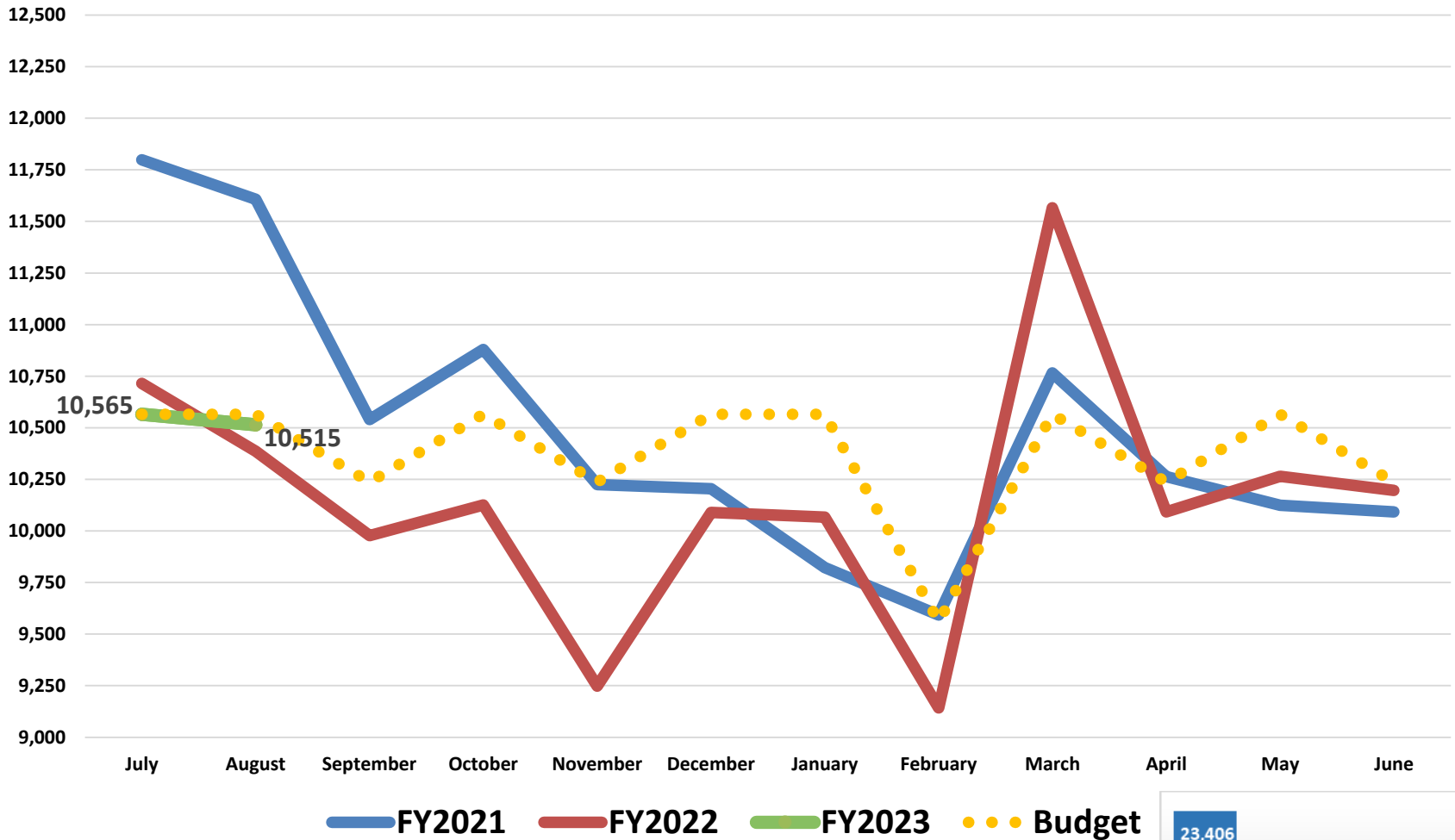
Therapy - Cypress Hand Center



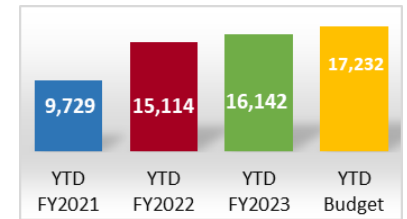
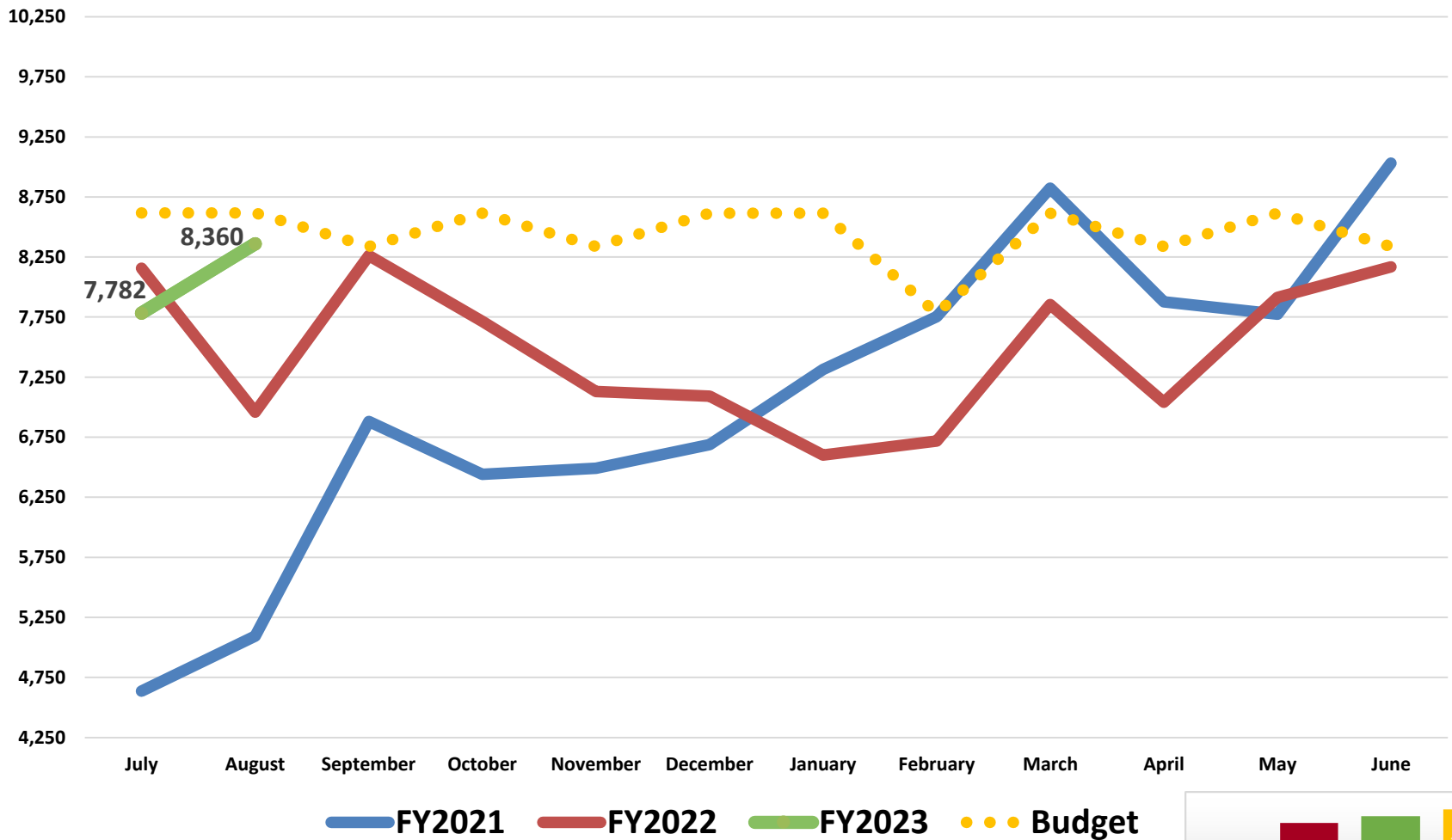
Physical & Other Therapy Units (I/P & O/P)



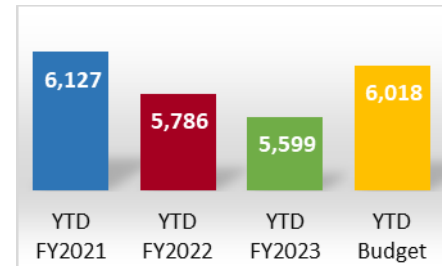
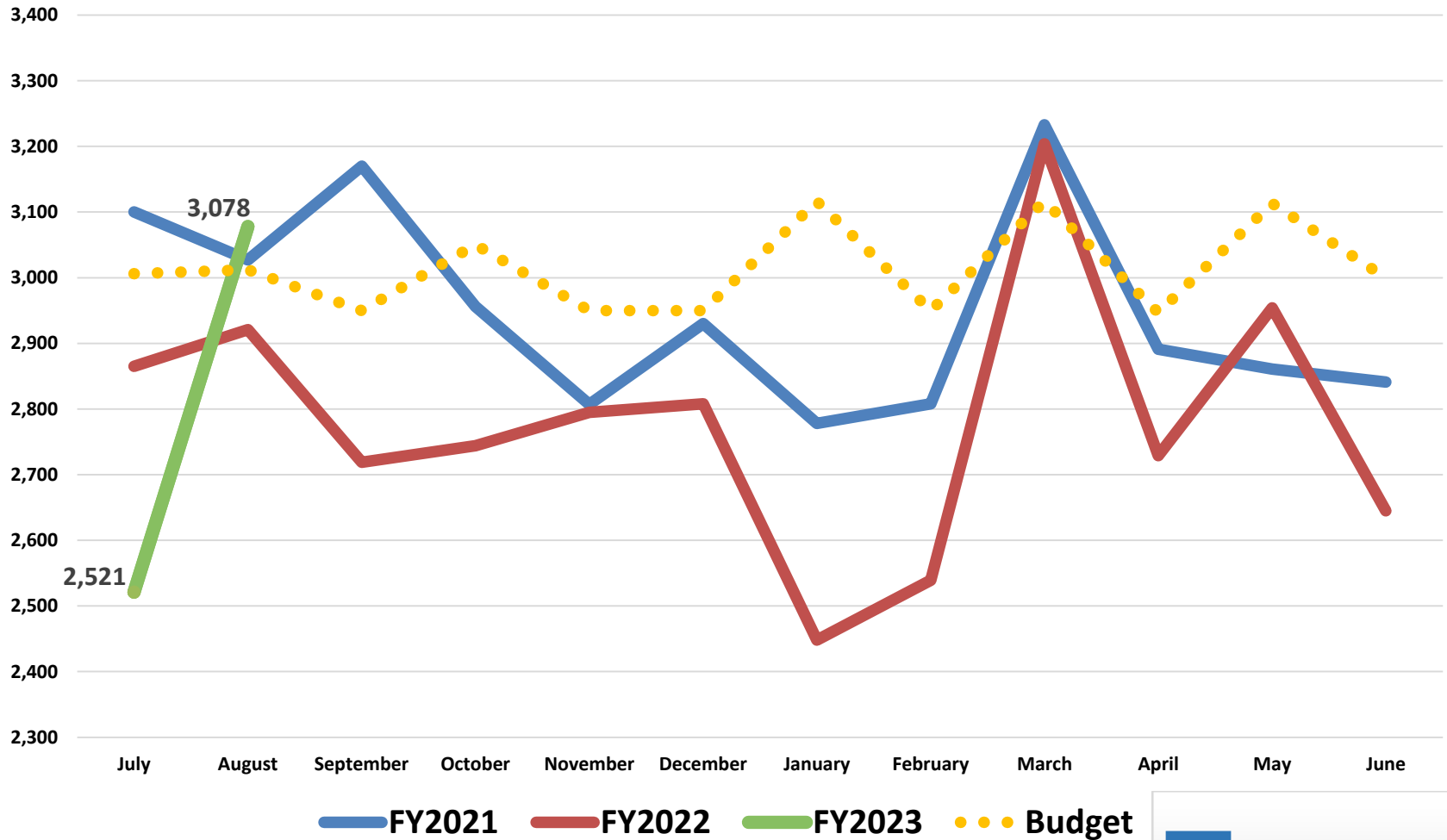
Physical & Other Therapy Units (I/P & O/P)-Main Campus



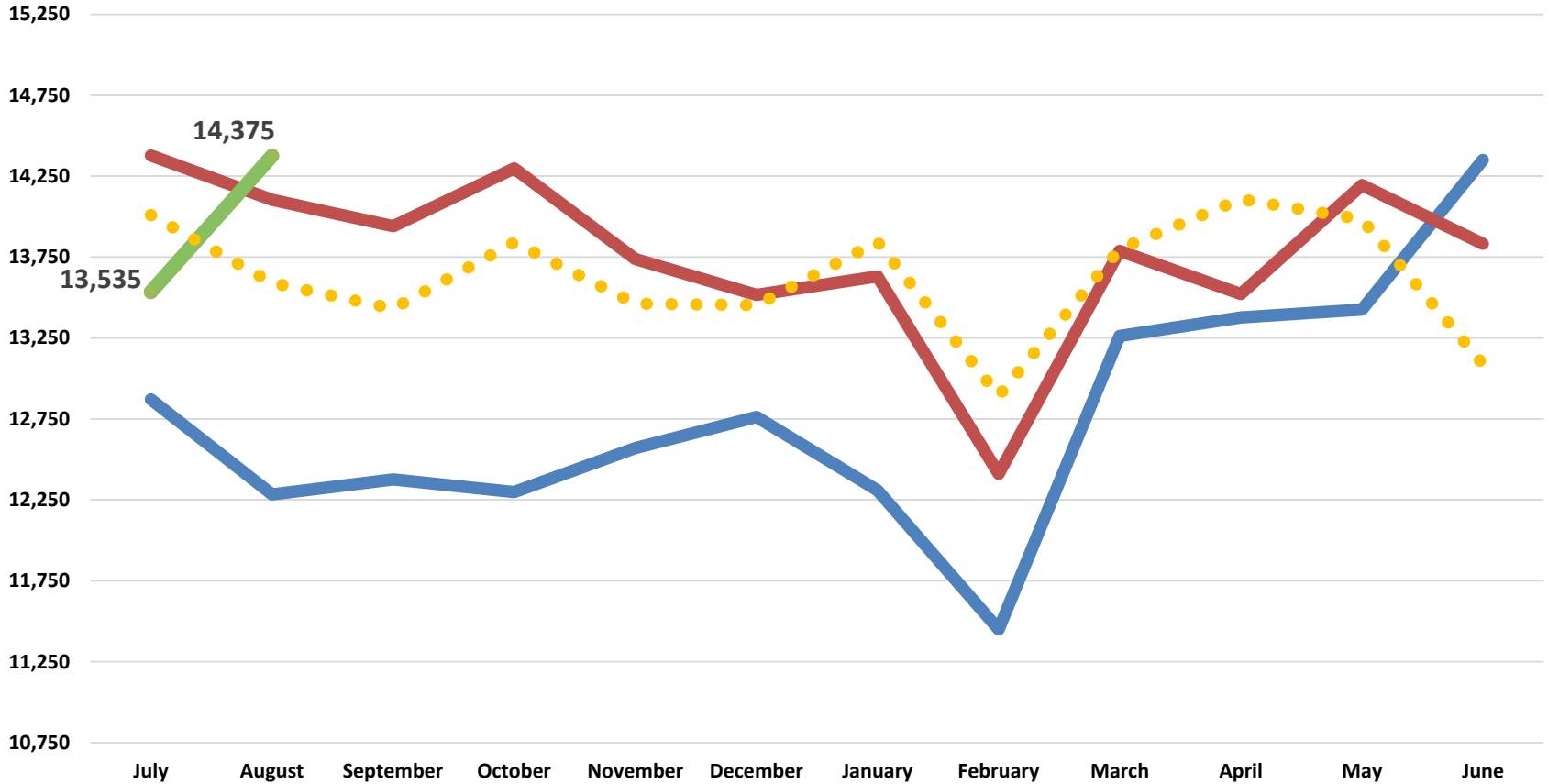
Physical & Other Therapy Units (I/P & O/P)-KDRH & South Campus



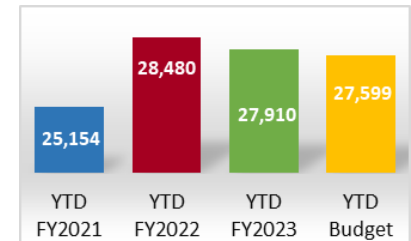
Home Health Visits



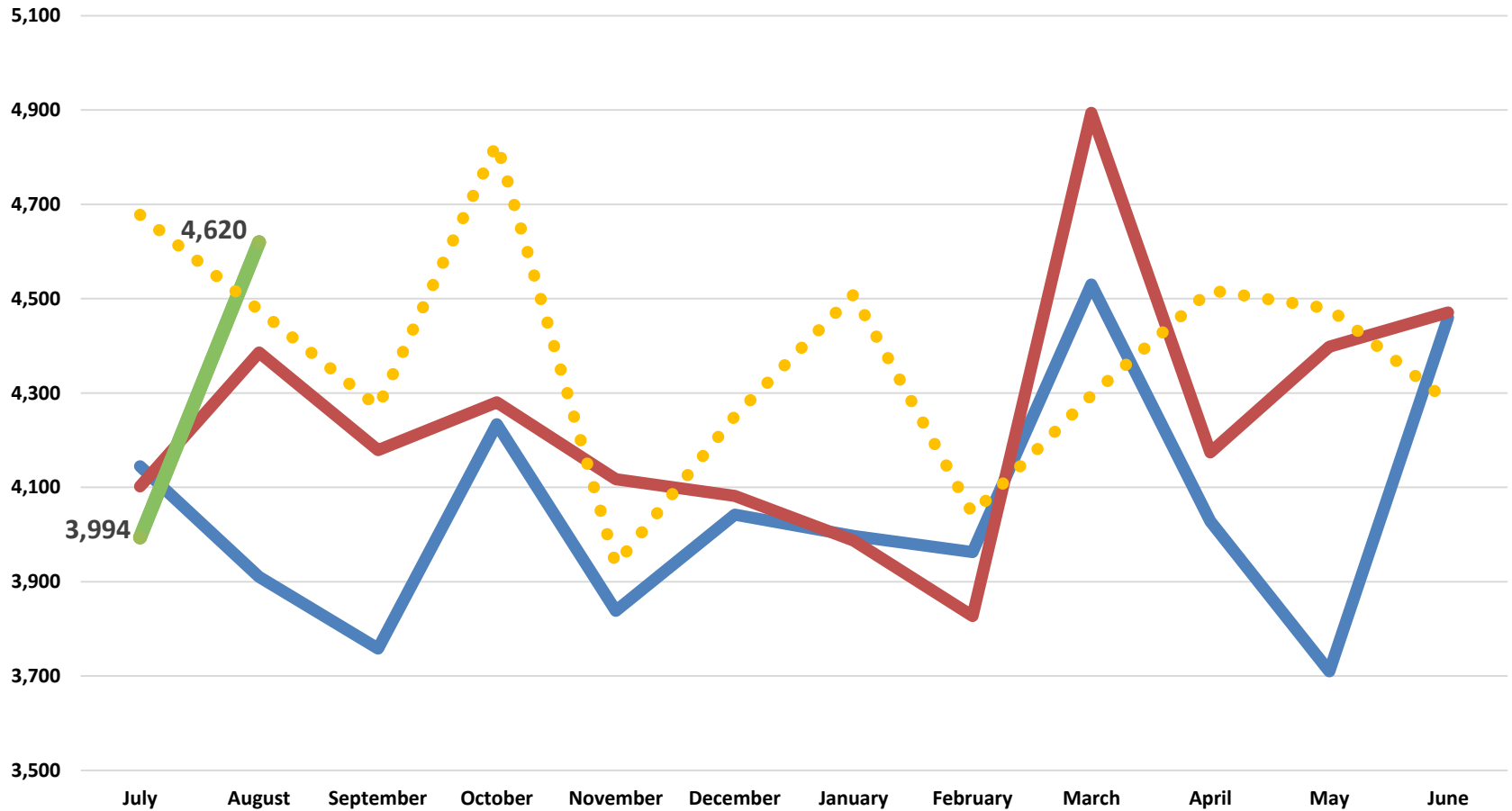
Radiology – Main Campus



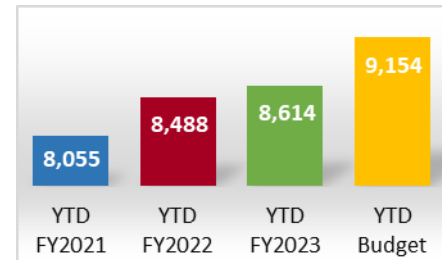
—●— **FY2021**
 —●— **FY2022**
 —●— **FY2023**
 ●●● **Budget**



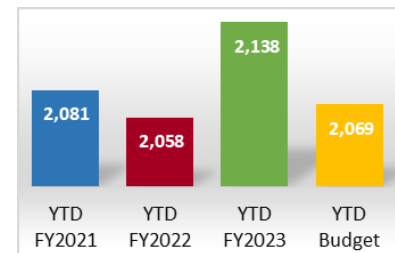
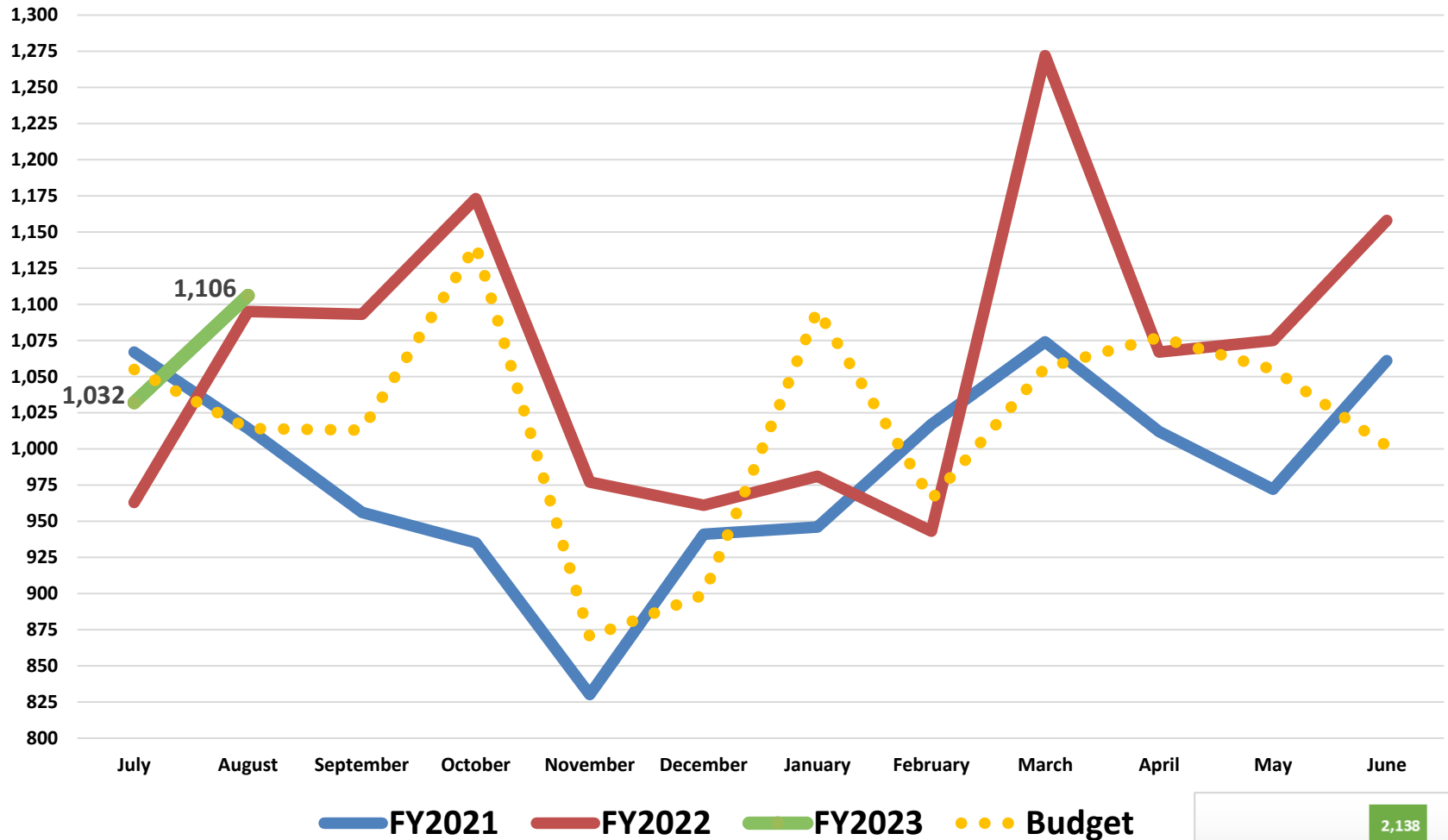
Radiology – West Campus Imaging



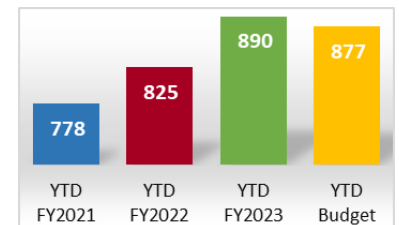
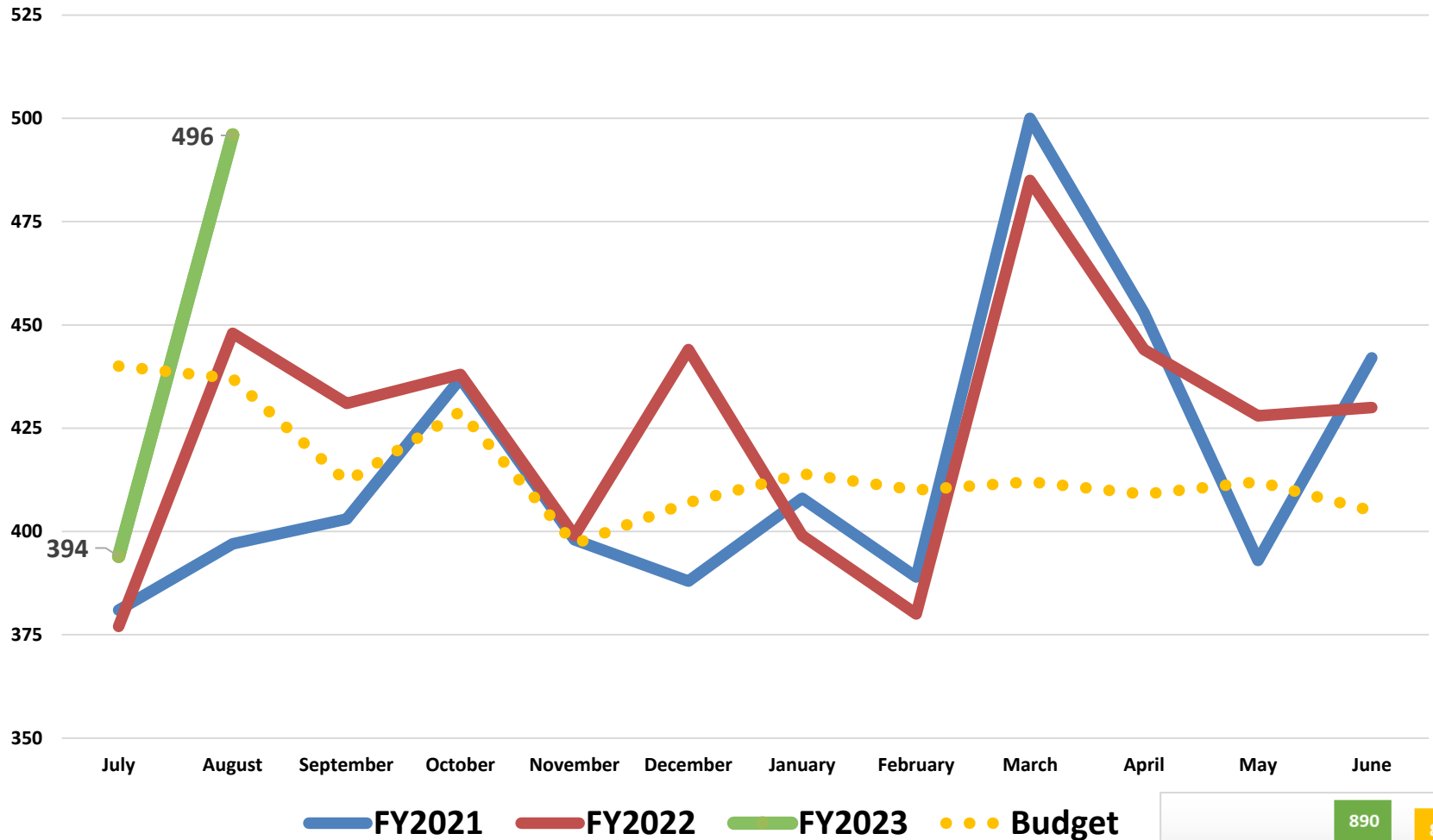
— **FY2021**
 — **FY2022**
 — **FY2023**
 ●●● **Budget**



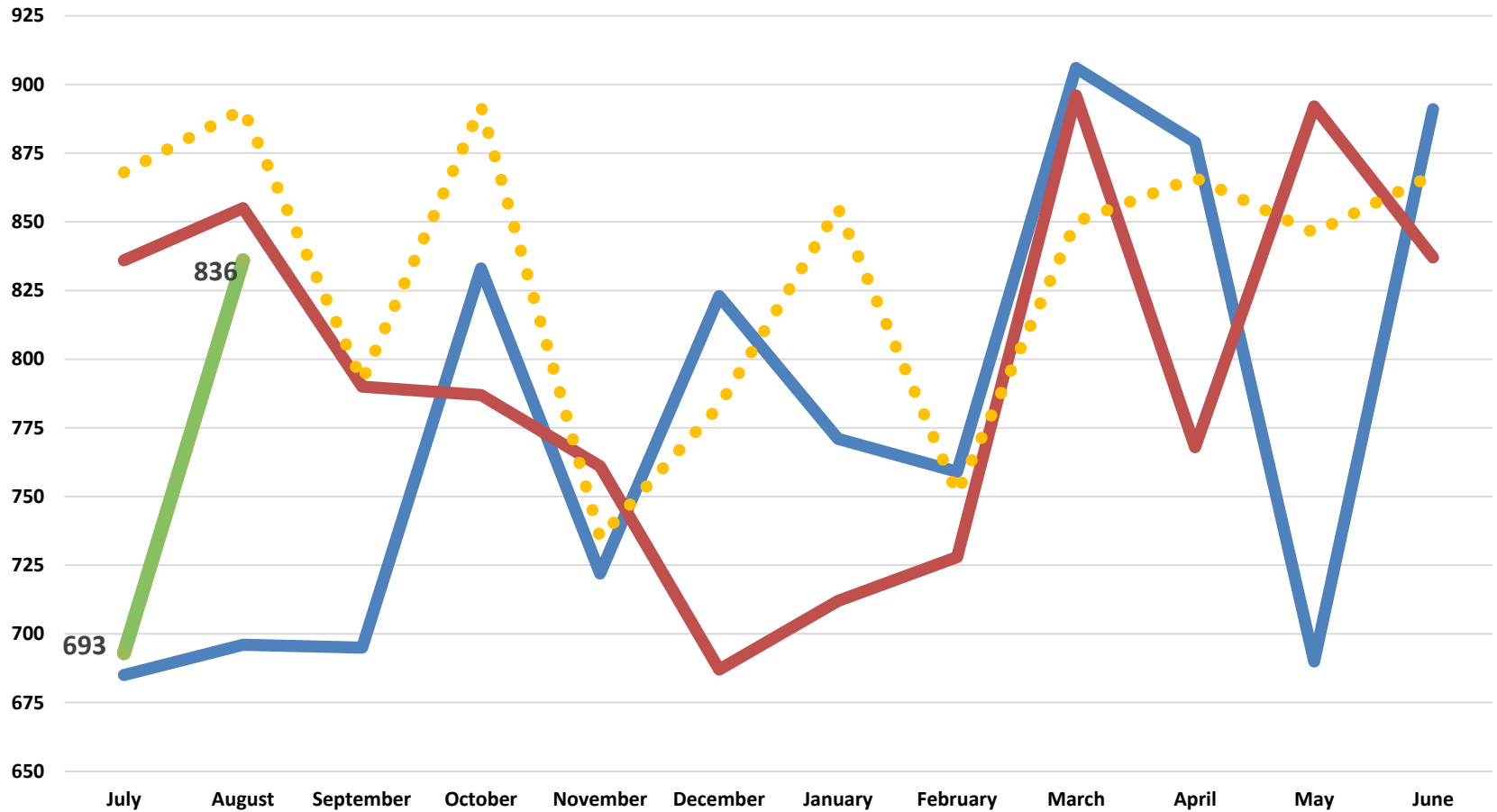
West Campus – Diagnostic Radiology



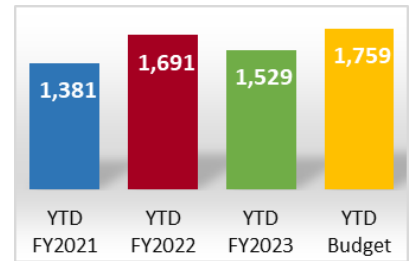
West Campus – CT Scan



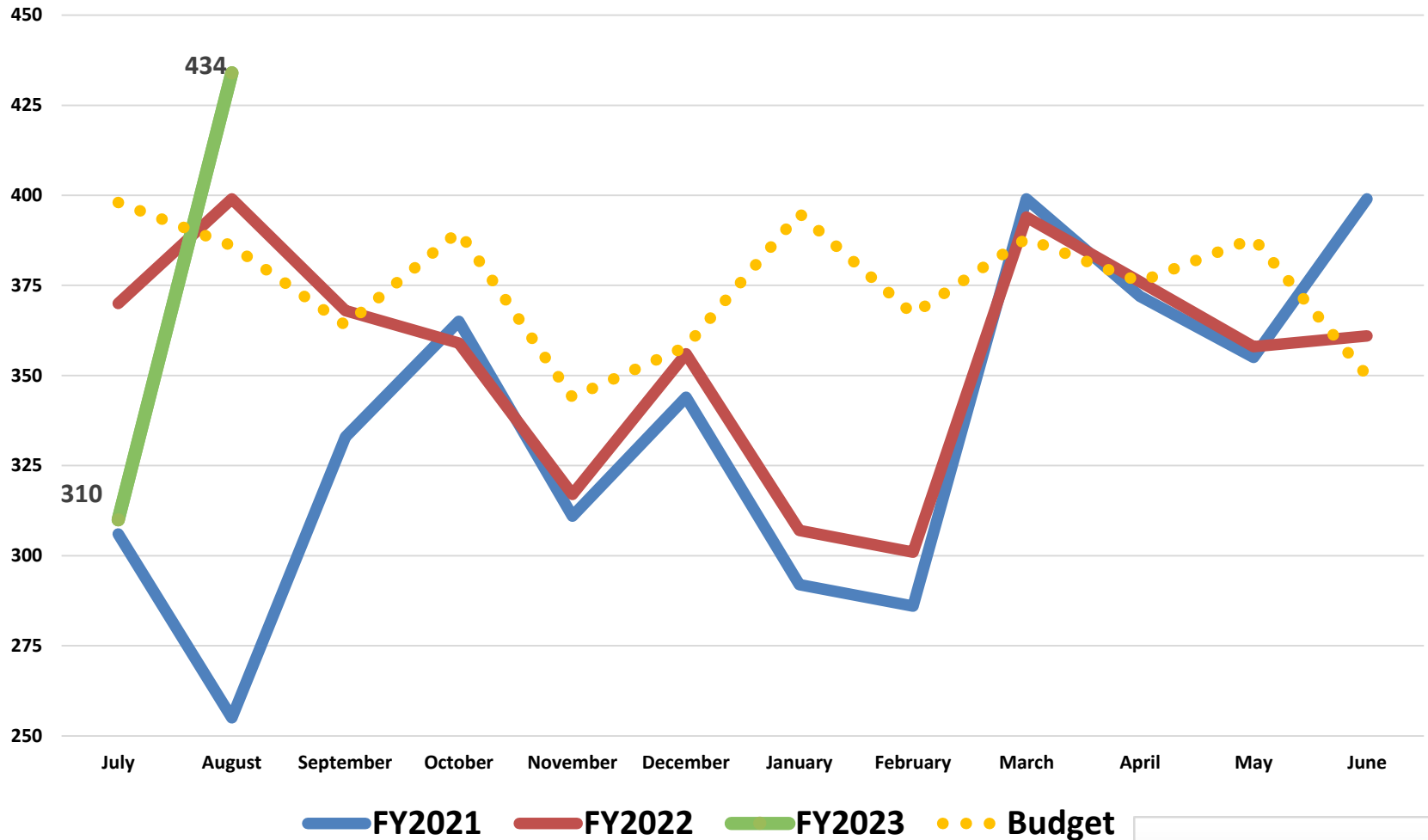
West Campus - Ultrasound



—●— FY2021
 —●— FY2022
 —●— FY2023
 ●●● Budget

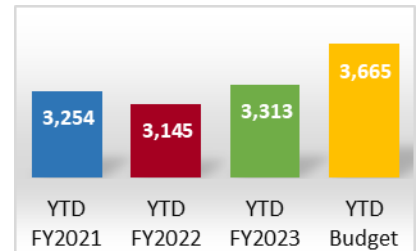
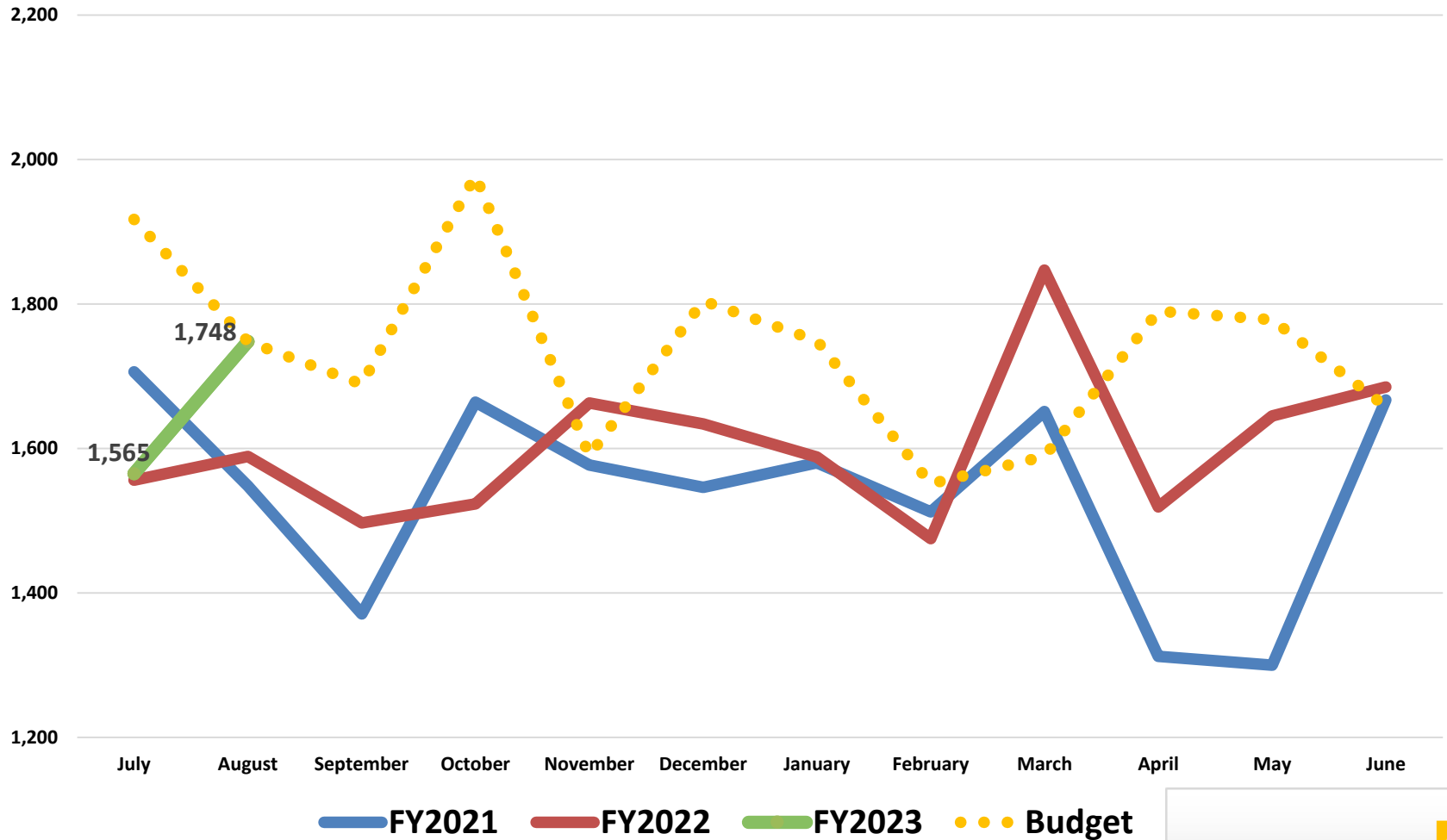


West Campus - MRI

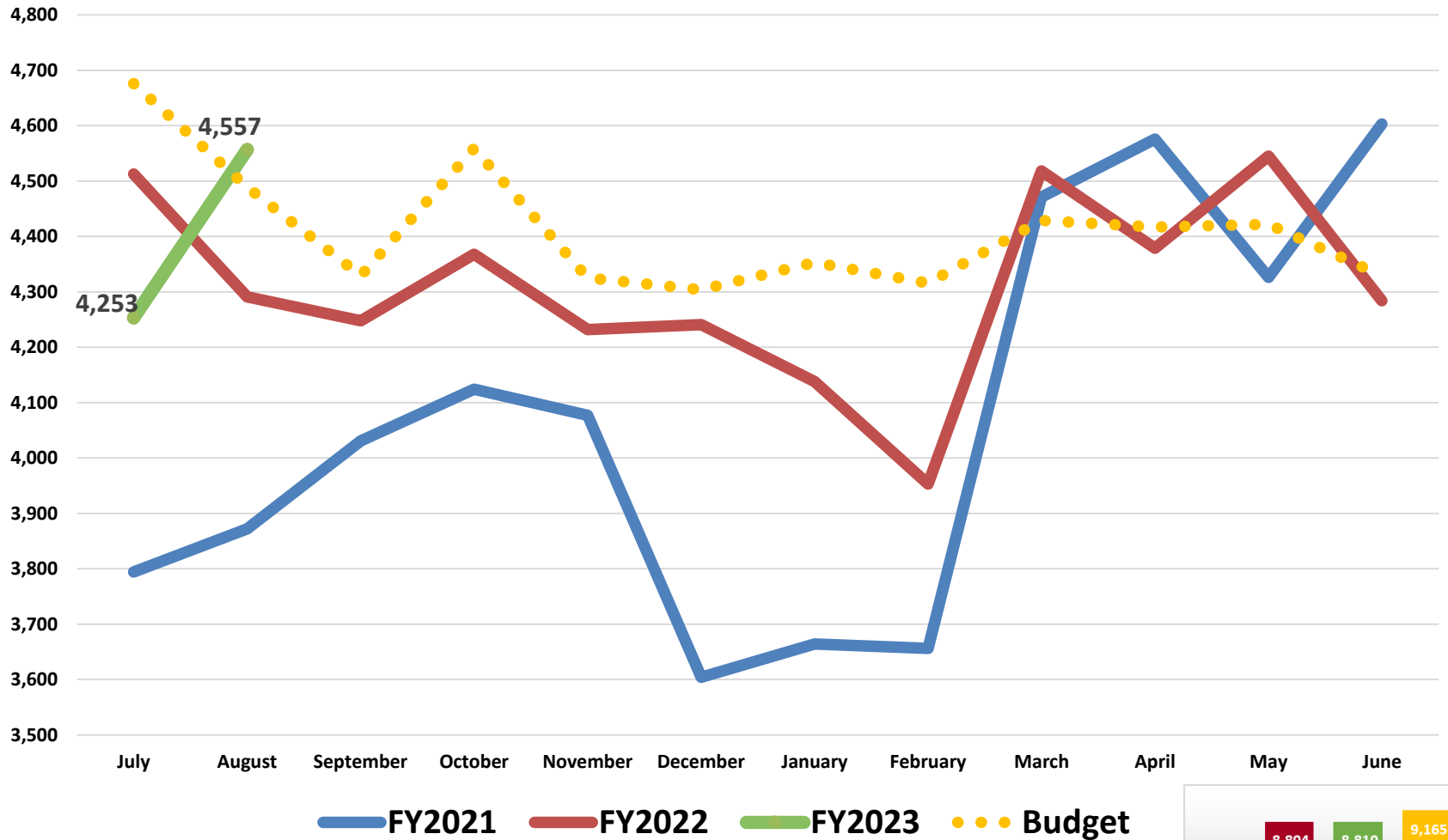


561	769	744	784
YTD FY2021	YTD FY2022	YTD FY2023	YTD Budget

West Campus – Breast Center

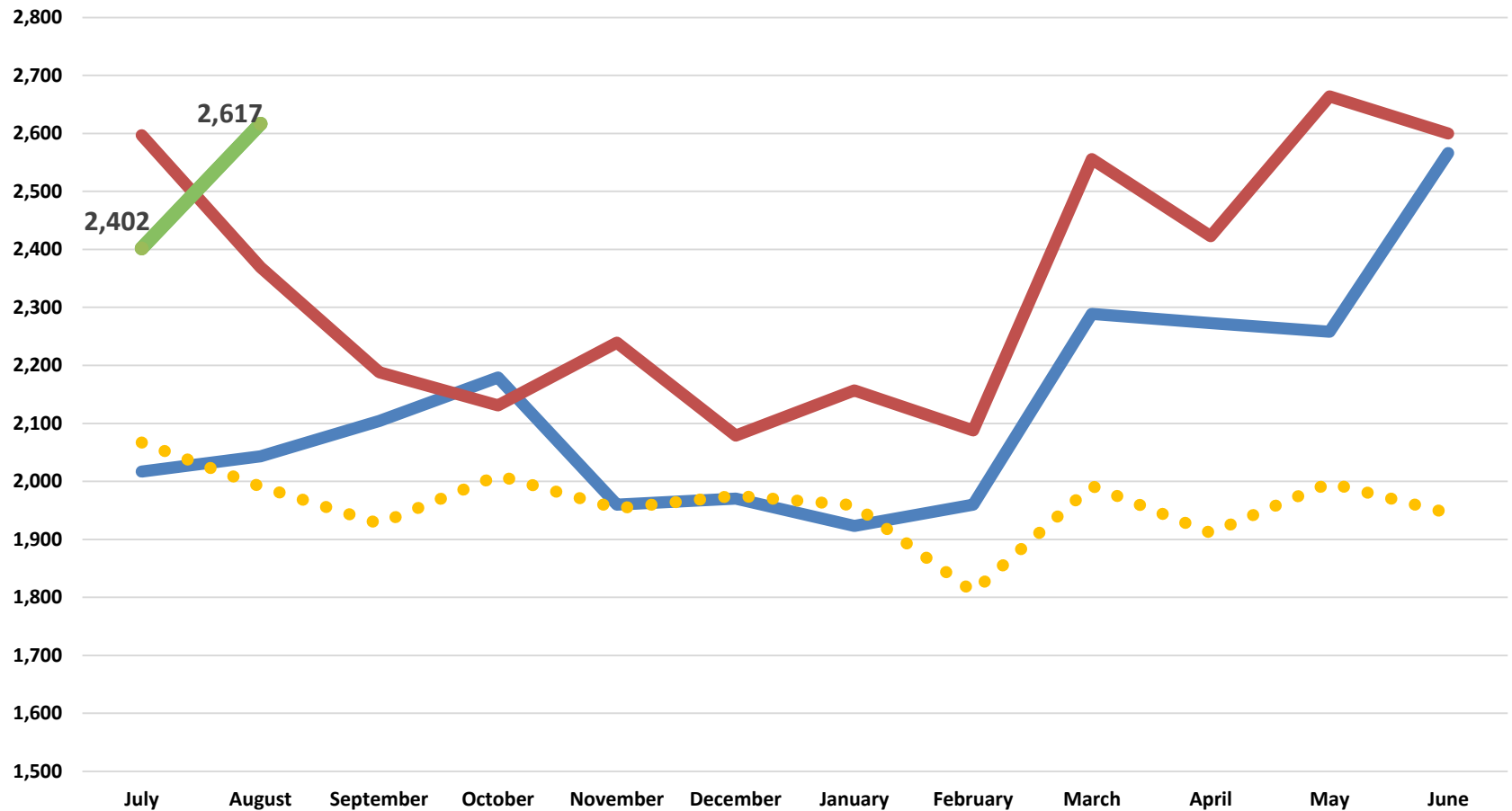


Radiology all areas – CT

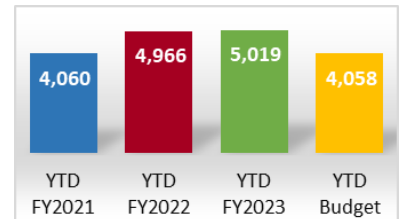


7,666	8,804	8,810	9,165
YTD FY2021	YTD FY2022	YTD FY2023	YTD Budget

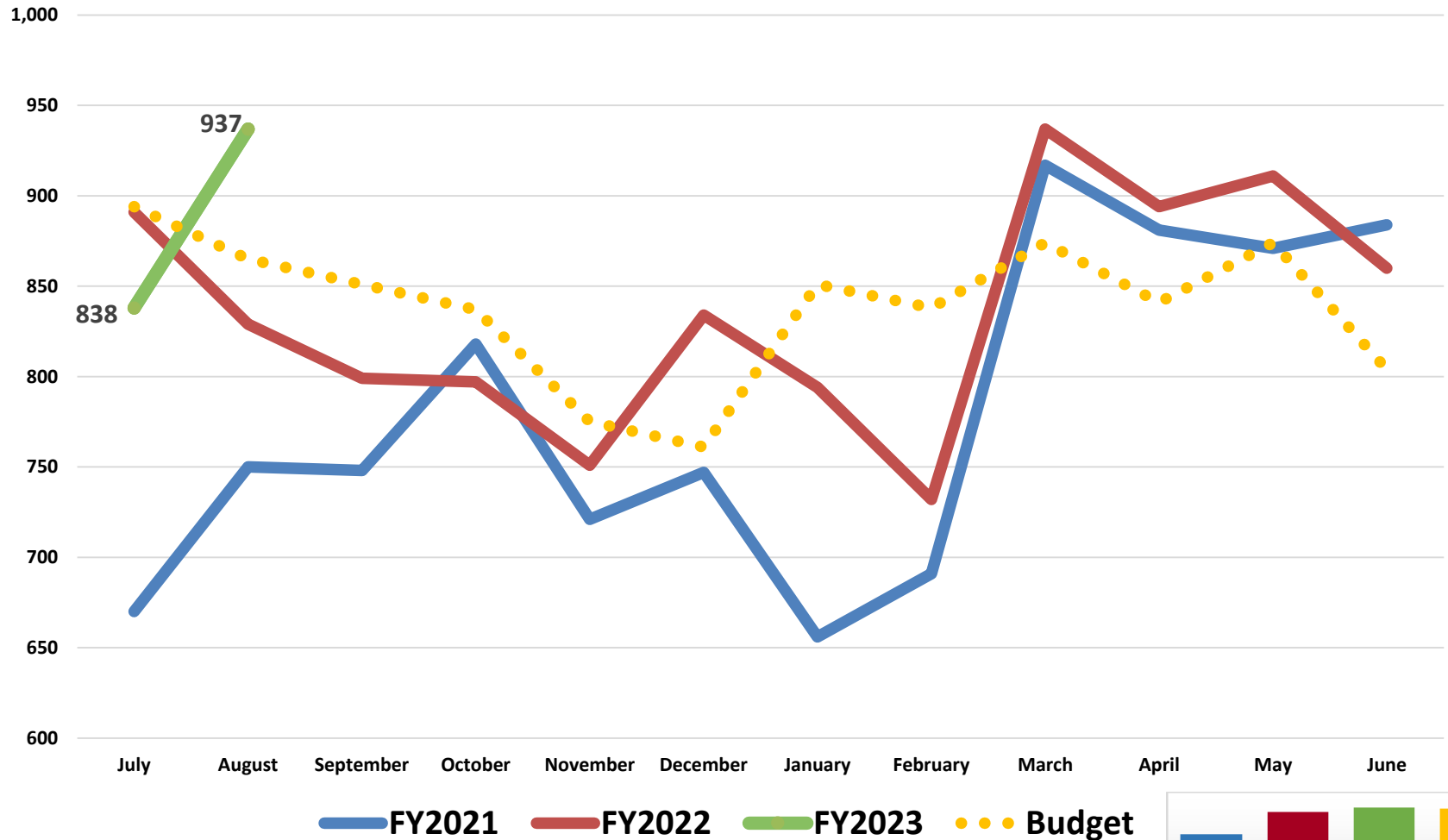
Radiology all areas – Ultrasound



—●— **FY2021**
 —●— **FY2022**
 —●— **FY2023**
 ●●● **Budget**

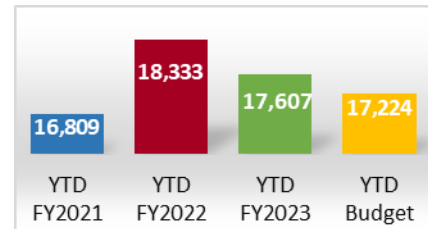
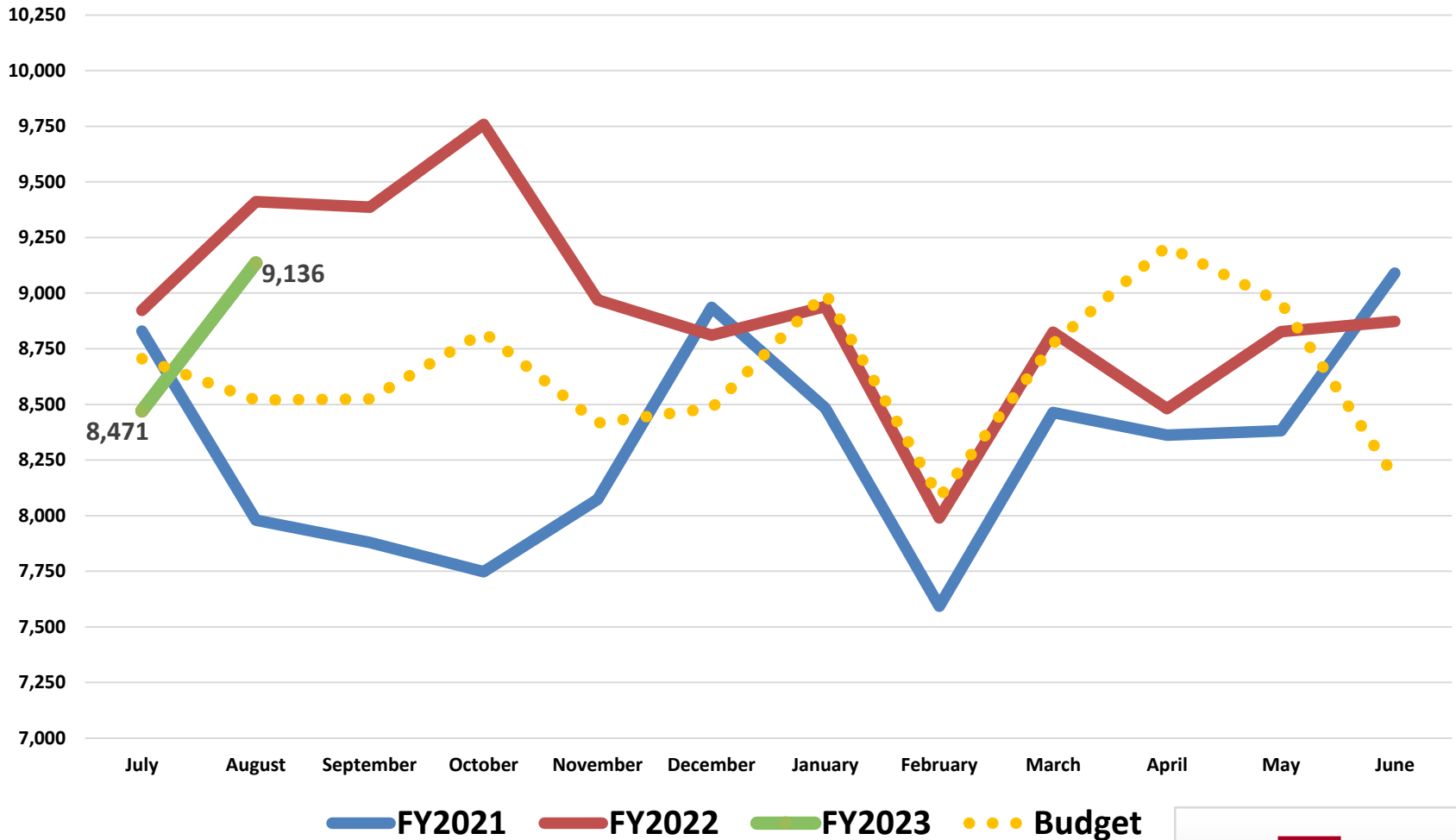


Radiology all areas – MRI

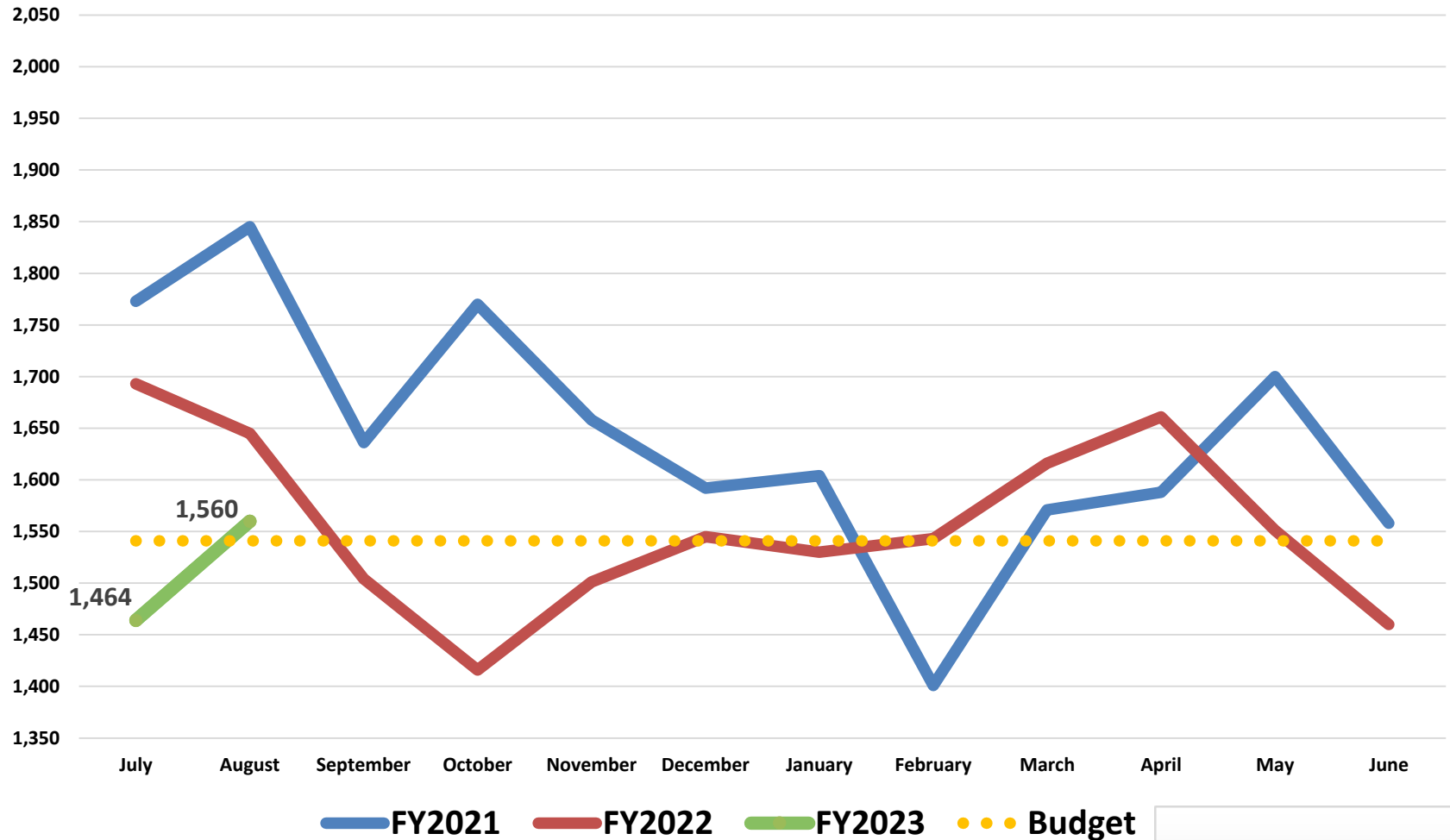


1,420	1,720	1,775	1,759
YTD FY2021	YTD FY2022	YTD FY2023	YTD Budget

Radiology Modality – Diagnostic Radiology



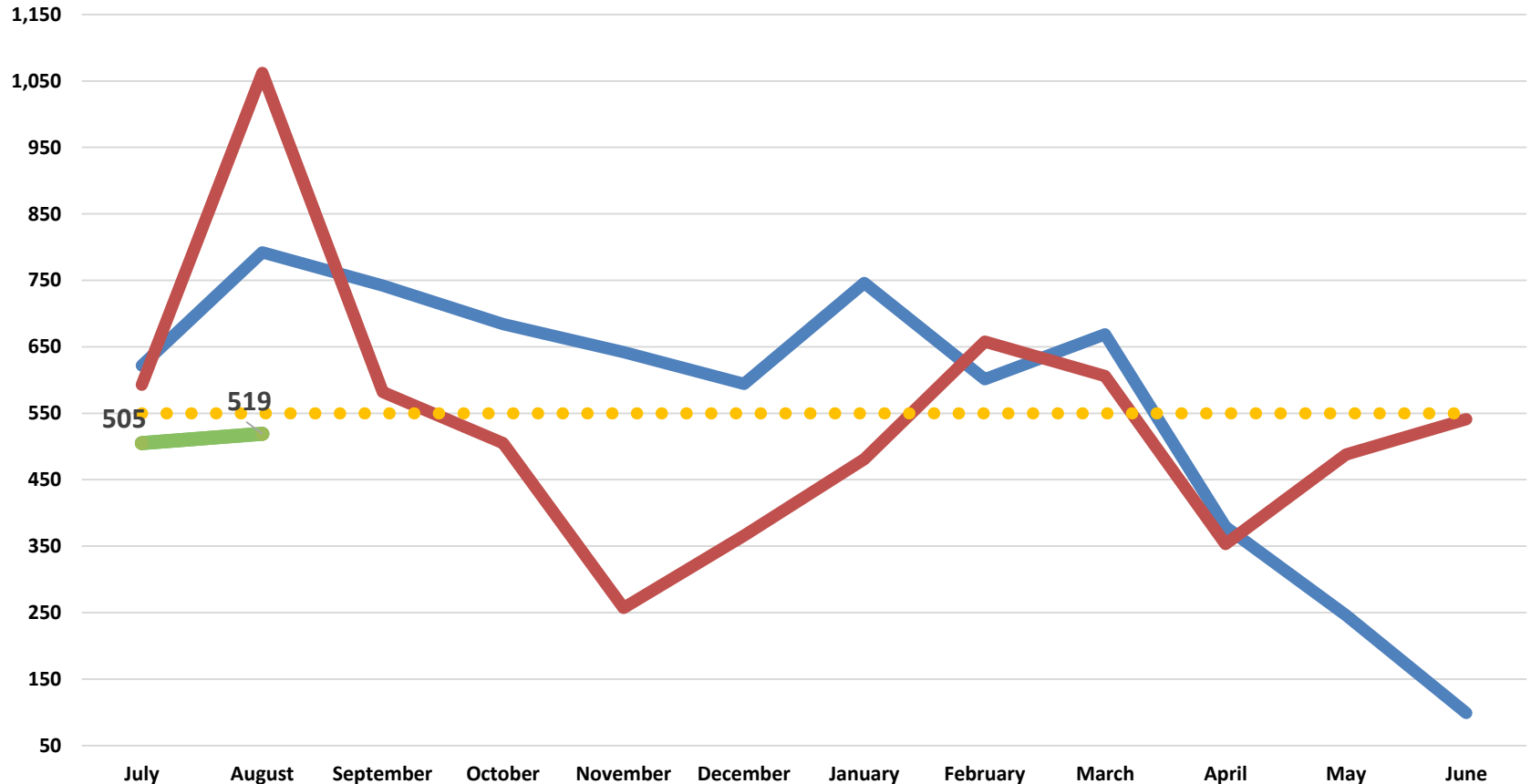
Chronic Dialysis - Visalia



3,618	3,338	3,024	3,082
YTD FY2021	YTD FY2022	YTD FY2023	YTD Budget

CAPD/CCPD – Maintenance Sessions

(Continuous peritoneal dialysis)

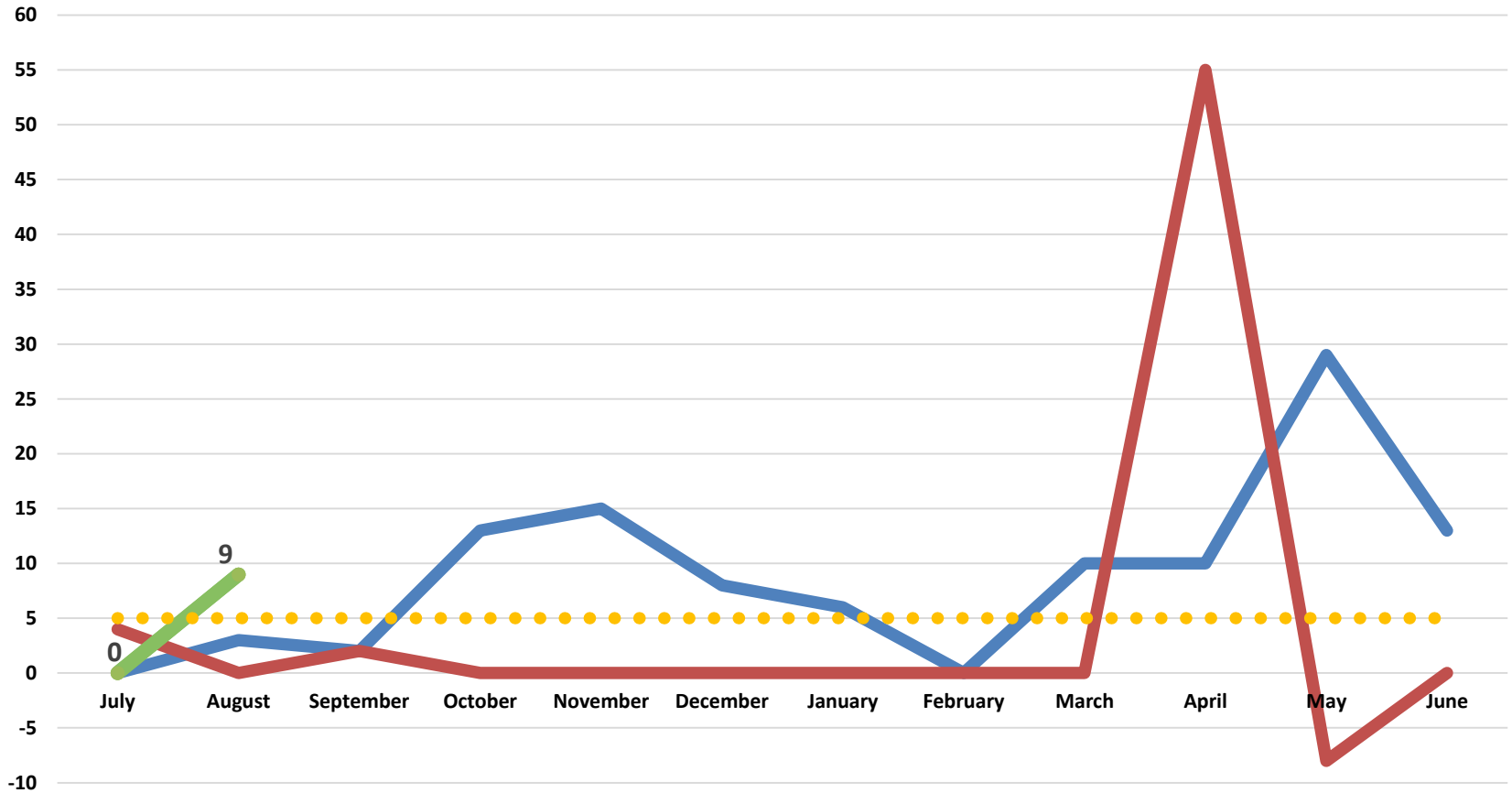


—●— FY2021
 —●— FY2022
 —●— FY2023
 ●●● Budget

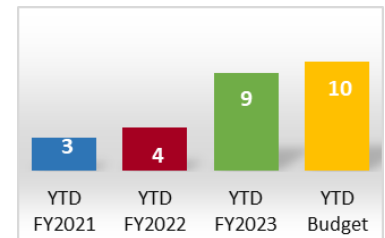


CAPD/CCPD – Training Sessions

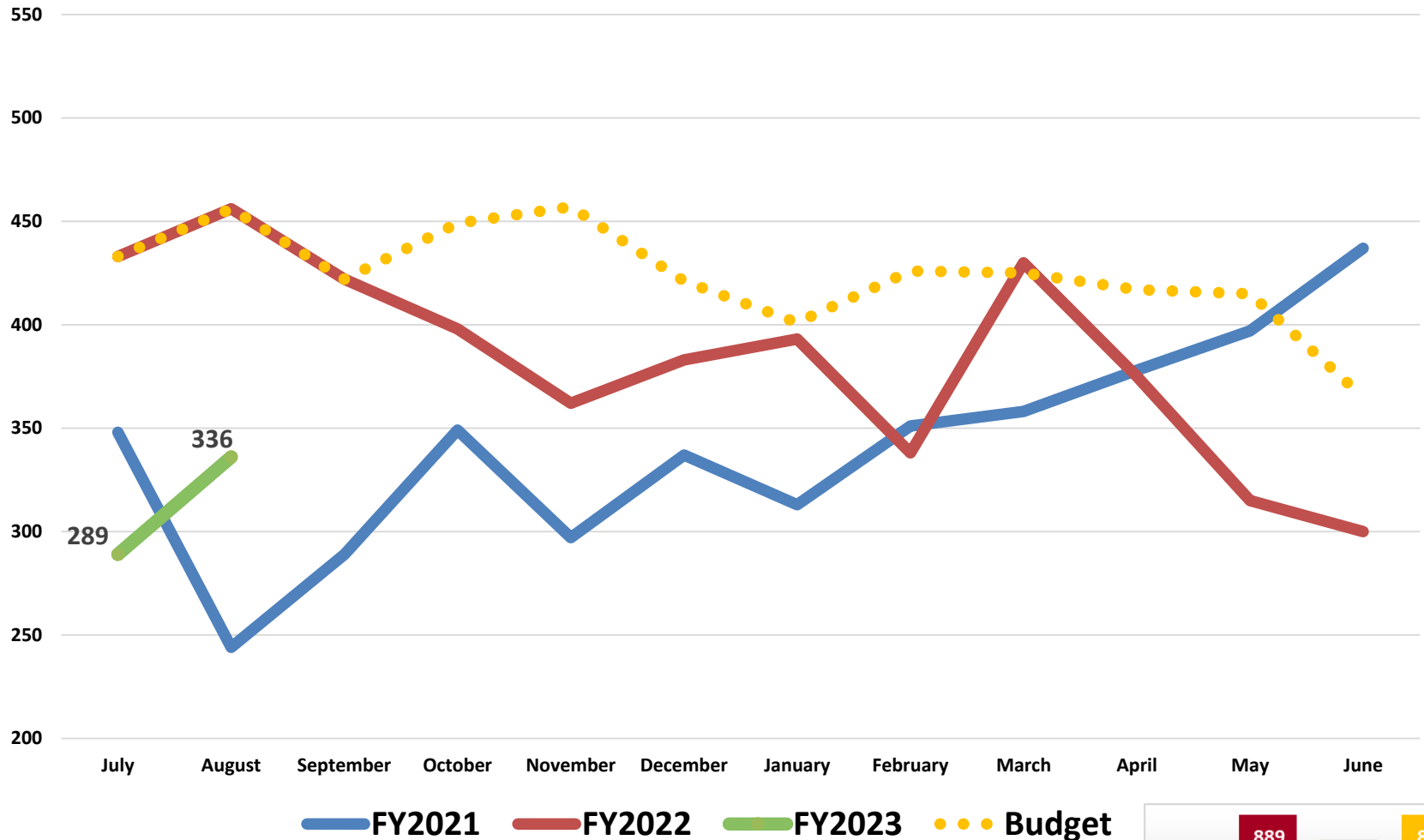
(Continuous peritoneal dialysis)



FY2021 FY2022 FY2023 Budget



Infusion Center – Outpatient Visits



592	889	625	889
YTD FY2021	YTD FY2022	YTD FY2023	YTD Budget

KAWEAH HEALTH
FINANCE DIVISION MEMORANDUM

TO: Finance Committee, Board of Directors, Chief Executive Officer and Executive Team

FROM: Malinda Tupper, Chief Financial Officer
Jennifer Stockton, Director of Finance

DATE: September 22, 2022

SUBJECT: California Health Facilities Financing Authority (“CHFFA”) Bridge Loan Program II

On September 28, 2022, Kaweah Health’s Board of Directors (the “Board”) will be asked to approve Resolution 2175 related to the third phase of the CHFFA Non-designated Public Hospital Bridge Loan Program. To offset the delay and assist with the cash flow issues caused by the change from PRIME to QIP, the legislature authorized CHFFA to provide low-cost working capital loans to eligible non-designated public hospitals to assist with their operations. Kaweah Health has received loans in phase one of the program totaling \$ 7.8 million.

Information regarding the CHFFA Bridge Loan is as follows:

	CHFFA Bridge Loan – Phase II
Guaranteed amount	\$3,993,950
Maximum amount	\$10,121,293
Interest Rate	0.0%
Loan Fee	1%
Loan Maturity	24 months from loan execution
Use of Funds	working capital
Type	Subordinate Indebtedness
Security	Medi-Cal payments.

Resolution 2175 -The resolution ratifies the submission of the loan application, authorized Malinda Tupper, Chief Financial Officer, to execute the loan documents, and approves the Loan and Security Agreement and the Promissory Note.

For any questions regarding the documents, please contact Malinda Tupper at 624-4065 or Jennifer Stockton at 624-5536.

RESOLUTION **2175** OF KAWEAH DELTA HEALTHCARE DISTRICT AUTHORIZING
EXECUTION AND DELIVERY OF A LOAN AND SECURITY AGREEMENT,
PROMISSORY NOTE, AND CERTAIN ACTIONS WITH THE CALIFORNIA HEALTH
FACILITIES FINANCING AUTHORITY
NONDESIGNATED PUBLIC HOSPITAL BRIDGE LOAN PROGRAM II

Nondesignated Public Hospital Bridge Loan Program II

WHEREAS, Kaweah Delta Healthcare District (the “Borrower”) is a nondesignated public hospital as defined in Welfare and Institutions Code section 14165.55, subdivision (I), excluding those affiliated with county health systems pursuant to Section 2.0, Chapter 43, Statutes of 2022; and

WHEREAS, Borrower has determined that it is in its best interest to borrow an aggregate amount not to exceed **\$10,121,293.00** from the California Health Facilities Financing Authority (the “Lender”), with that loan to be funded with the proceeds of the Lender's Nondesignated Public Hospital Bridge Loan Program II; and

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

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

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

Section 2. **Malinda Tupper, Chief Financial Officer**, an “Authorized Officer”) is hereby authorized and directed, for and on behalf of the Borrower, to do any and all things and to execute and deliver any and all documents that the Authorized Officer(s) deem(s) necessary or advisable to consummate the borrowing of moneys from the Lender and otherwise to effectuate the purposes of this Resolution and the transactions contemplated hereby.

Section 3. The proposed form of Loan and Security Agreement (the “Agreement”), which contains the terms of the loan, is hereby approved. The loan shall be in a principal amount not to exceed **\$10,121,293.00**, shall not bear interest, and shall mature 24 months from the date of the executed Loan and Security Agreement between the Borrower and the Lender. The {Each} Authorized Officer(s) is (are) hereby authorized and directed, for and on behalf of the Borrower, to execute the Agreement in substantially that form, which includes the redirection of up to 20% of Medi-Cal reimbursements (checkwrite payments) to Lender in the event of default, with those changes therein as the Authorized Officer(s) may require or approve, and the approval to be conclusively evidenced by the execution and delivery thereof.

Section 4. The proposed form of Promissory Note (the “Note”) as evidence of the Borrower's obligation to repay the loan is hereby approved. The Authorized Officer(s) is (are)

hereby authorized and directed, for and on behalf of the Borrower, to execute the Note in substantially that form, with those changes therein as the Authorized Officer(s) may require or approve and the approval to be conclusively evidenced by the execution and delivery thereof.

Date of Adoption: _____

SECRETARY'S CERTIFICATE

I, _____, Secretary of Kaweah Delta Healthcare District, hereby certify that the foregoing is a full, true and correct copy of a resolution duly adopted at a regular meeting of the Board of Directors of Kaweah Delta Healthcare District duly and regularly held at the regular meeting place thereof on the ____ day of _____, 20__, of which meeting all of the members of said Board of Directors had due notice and at which the required quorum was present and voting and the required majority approved the resolution by the following vote at said meeting:

Ayes:

Noes:

Absent:

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

Secretary

Date: _____