Kaweah Delta
MORE THAN MEDICINE. LIFE.

March 19, 2021

NOTICE

The Board of Directors of the Kaweah Delta Health Care District will meet in the Kaweah Delta Support Services Building - 520 West Mineral King – GME Conf. Room (5th floor) on Monday March 22, 2021 beginning at 3:30PM. Due to the maximum capacity allowed in this room per CDC social distancing guidelines, members of the public are requested to attend the meeting via GoTo meeting - https://www.gotomeet.me/CindyMoccio/kaweahdeltaopenregularboardmeetings or you can also dial in 669-224-3412 Access Code: 468-246-165.

The Board of Directors of the Kaweah Delta Health Care District will meet in an Open Board of Directors at 3:30PM (location and GoTo information above).

The Board of Directors of the Kaweah Delta Health Care District will meet in a Closed Board of Directors meeting at 3:31PM pursuant to Health and Safety Code 1461 and 32155, Government Code 54956.9(d)(1).

The Board of Directors of the Kaweah Delta Health Care District will meet in an Open Board of Directors meeting at 4:00PM (location and GoTo information above).

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 Delta Medical Center, Mineral King Wing entry corridor between the Mineral King lobby and the Emergency Department waiting room.

Due to COVID 19 visitor restrictions to the Medical Center - the disclosable public records related to agendas can be obtained by contacting the Board Clerk at Kaweah Delta 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@kdhcd.org, or on the Kaweah Delta Health Care District web page http://www.kaweahdelta.org.

KAWEAH DELTA HEALTH CARE DISTRICT
Garth Gipson, Secretary/Treasurer

Cindy Moccio

Cindy Moccio
Board Clerk / Executive Assistant to CEO

DISTRIBUTION:
Governing Board
Legal Counsel
Executive Team
Chief of Staff
www.kaweahdelta.org

KAWEAH DELTA HEALTH CARE DISTRICT - BOARD OF DIRECTORS MEETING

Kaweah Delta Medical Center / Support Services Building
520 West Mineral King – GME Conference Rooms (5th floor)

Join from your computer, tablet or smartphone
https://www.gotomeet.me/CindyMoccio/kaweahdeltaopenregularboardmeetings
or Dial In: 669-224-3412 / Access Code: 468-246-165

Monday March 22, 2021

OPEN MEETING AGENDA {3:30PM}

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 subject matter jurisdictions of the Board are requested to identify themselves at this time.
4. **APPROVAL OF THE CLOSED AGENDA – 3:31PM**
   - 4.1. **Approval of closed meeting minutes** – February 22, 2021.
   - *4.2.* **Conference with Legal Counsel** – Existing Litigation - Pursuant to Government Code 54956.9(d)(1) – Valdovinos v. Kaweah Delta Health Care District / Tulare County Superior Court Case VCU279423 – *Richard Salinas, Legal Counsel and Alexandra Bennett, Director of Risk Management*
   - 4.3. **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 Vice Chief of Staff*
   - 4.4. **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461, report of quality assurance committee –– *Monica Manga, MD Vice Chief of Staff*

   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 March 22, 2021 closed meeting agenda.
5. **ADJOURN**

CLOSED MEETING AGENDA {3:31PM}

1. **CALL TO ORDER**
2. **APPROVAL OF CLOSED MEETING MINUTES** – February 22, 2021.

   Recommended Action: Approval of the closed meeting minutes from February 22, 2001.
3. **CONFERENCE WITH LEGAL COUNSEL – EXISTING LITIGATION** - Pursuant to Government Code 54956.9(d)(1) – Valdovinos v. Kaweah Delta Health Care District / Tulare County Superior Court Case VCU279423

   Richard Salinas, Legal Counsel and Alexandra Bennett, Director of Risk Management
4. **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 Vice Chief of Staff
5. **QUALITY ASSURANCE** - Pursuant to Health and Safety Code 32155 and 1461, report of quality assurance committee.

   Monica Manga, MD Vice Chief of Staff
6. **ADJOURN**

OPEN MEETING AGENDA {4:00PM}

Join from your computer, tablet or smartphone

https://www.gotomeet.me/CindyMoccio/kaweahdeltaopenregularboardmeetings

or Dial In: 669-224-3412 / Access Code: 468-246-165

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 Board discussion. 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 subject matter jurisdictions of the Board are requested to identify themselves at this time.
4. **CLOSED SESSION ACTION TAKEN** – Report on action(s) taken in closed session.

5. **OPEN MINUTES** – Request approval of the February 22, 2021.

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 – February 22, 2021 open board of directors meeting minutes.

6. **RECOGNITIONS** – *Lynn Havard Mirviss*
   - **6.1.** Presentation of Resolution 2123 to Robert E. Pierce, in recognition of as the Service Excellence recipient – March 2021.
   - **6.2.** Presentation of Resolution 2124 to Nancy Allain, retiring from Kaweah Delta after 19 years of service.
   - **6.3.** Presentation of Resolution 2125 to Frank Orique, RN, retiring from Kaweah Delta after 31 years of service.
   - **6.4.** Presentation of Resolution 2126 to Rebecca Wright, ACR Compliance Coordinator, retiring from Kaweah Delta after 31 years of service.

7. **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.

Monica Manga, 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 provision al 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 provision al 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.

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

Monica Manga, MD, Vice Chief of Staff

9. **REVISED KAWEAH DELTA ANNUAL PHYSICIAN RECRUITMENT PLAN** – Review and discussion of the proposed revision to the Kaweah Delta Physician Recruitment Plan approved by the Board of Directors on September 28, 2020 - revised to include outpatient pulmonology.

Marc Mertz, VP & Chief Strategy Officer and Brittany Taylor – Director of Physician Recruitment & Relations

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: Having reviewed and analyzed the Provider Needs Assessment conducted by Sg2 in 2020, which includes a specific list of the needed physician specialties for 2020 and 2021 in communities served by the District "Needed Physician Specialties," the Board hereby finds that it will be in the best interests of the public health of the communities served by the District to have the District provide appropriate assistance in order to obtain licensed physicians and surgeons in the Needed Physician Specialties to practice in the communities served by the District. Therefore, the Board authorizes the District to provide the types of assistance authorized by Cal. Health & Safety Code §32121.3, to obtain licensed physicians and surgeons in the Needed Physician Specialties to practice in the communities served by the District.

10. **QUALITY – RAPID RESPONSE / CODE BLUE QUALITY COMMITTEE REPORT** - A review of key quality measures, analysis and actions associated with patients with rapid response team initiation and code blue response.

Kassie Waters, RN, MPH, Director of Cardiovascular Critical Care.

11. **STRATGIC PLANNING – HIGH PERFORMING OUT PATIENT (OP) NETWORK –** Review of the Kaweah Delta strategic plan initiative – High Performing OP Network including a review of the metrics and strategies/tactics.

Ryan Gates, Vice President of Population Health and Jessica Rodriguez, Director of Outpatient Clinic Network

12. **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 March 22, 2021 Consent Calendar.

12.1. REPORTS

A. Physician Recruitment
B. Hospice Services
C. Skilled Nursing Facility (SNF), Transitional Care Services (TCS South and West Campus) and Subacute Care Services
D. Environment of Care

12.2. **POLICIES** – Emergency Management

A. Code Shelter in Place - DM 2209 **Revised**
B. Code Gray Activation Plan - DM 2203 **Revised**
C. Code Triage Activation Plan - DM 2201 **Revised**
D. Code Orange Hazardous Material Spill/Release - DM 2210 **Revised**
E. Volunteer Practitioners in the event of a disaster - DM 2410 **Revised**
F. Code Blue/Code White Activation - DM 2202 **Revised**
G. Application for FEMA Financial Aid - DM 2119 **Reviewed**
H. Internal Flood-Activation Plan - DM 2215 **Reviewed**

12.3. **POLICIES** – Environment of Care

A. Fire Prevention Management Plan - EOC 5000 **Revised**
B. Utilities Management Emergency Power - EOC 7402 **Revised**
C. Hospital Electrical Safety Policy for Personal Items - EOC 6015 **Revised**
D. Facility Fire Response Plan - EOC 5001 **Reviewed**
E. Storage and Warming of Blankets in Warming Cabinets - EOC 6007 **Reviewed**
F. Utility Failures and Repair - EOC 1031 **Reviewed**
G. Safe Medical Device Act/Medical Device Tracking and Reporting- EOC 6009 **Reviewed**
H. Injury/Illness Prevention Program - EOC 1066 **Reviewed**

12.4. Recommendations from the Medical Executive Committee (March 2021)

A. Privileges
   1) Critical Care, Pulmonary & Sleep Medicine

B. Medical Staff Services Manual
   1) MS 02 Medical Staff Well Being Committee (**Revised**)
   2) MS 33 Reporting Guidelines (**Revised**)
   3) MS 40 Impaired Practitioner Policy (**Revised**)
   4) MS 44 Ongoing Professional Practice Evaluation (OPPE) / Focused Professional Practice Evaluation (FPPE) (**Revised**)
   5) MS 47 Code of Conduct for Medical Staff & Advanced Practice Providers (**Revised**)
   6) MS 51 Medical Staff and Advanced Practice Providers Notification (**Revised**)
   7) MS 52 Use of Outside Proctors (**Revised**)
   8) MS 16 Medical Staff Organization Financial Assistance for Fit-For-Duty Evaluations (**Reviewed**)
   9) MS 24 Trauma Peer Review and Trauma Performance Improvement (TPIP) (**Reviewed**)
   10) MS 25 Rescinded or Lapsed Membership and/or Privileges (**Reviewed**)
   11) MS.101 Red Rules (**Reviewed**)

13. **ORGANIZATIONAL REBRANDING INITIATIVE** – Review and discussion of rebranding initiative as reviewed by the Marketing and Community Relations Committee on November 17, 2020 and approved by the Board November 23, 2020.

Gary Herbst, CEO and Marc Mertz, Vice President and Chief Strategy 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.

Recommended Action: Authorize management to proceed with the immediate implementation of an organizational rebranding initiative.

- *The legal name of the organization will remain as **Kaweah Delta Health Care District**.*
- *The core brand name ("Doing Business As") will be **Kaweah Health**, to be applied consistently throughout the organization.*
- *The **Kaweah Health** naming convention to be applied to individual facilities.*
- *The facility name, as reflected on the California Department of Public Health (CDPH) Consolidated General Acute Care Hospital License, will be changed from Kaweah Delta Medical Center to **Kaweah Health Medical Center** effective May 1, 2021.*

14. REPORTS

14.1. Chief Executive Officer Report - Report relative to current events and issues.
Gary Herbst, Chief Executive Officer

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

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.

KAWEAH DELTA HEALTH CARE DISTRICT

BOARD OF DIRECTORS MEETING

MONDAY MARCH 22, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

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KDHCD - BOARD OF DIRECTORS MEETING

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KAWEAH DELTA HEALTH CARE DISTRICT

BOARD OF DIRECTORS MEETING

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KDHCD - BOARD OF DIRECTORS MEETING

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KDHCD - BOARD OF DIRECTORS MEETING

MONDAY MARCH 22, 2021

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MINUTES OF THE OPEN MEETING OF THE KAWEAH DELTA HEALTH CARE DISTRICT BOARD OF DIRECTORS HELD MONDAY FEBRUARY 22, 2021, AT 4:00PM, IN SUPPORT SERVICES BUILDING 5TH FLOOR GRADUATE MEDICAL EDUCATION CONFERENCE ROOM (CALL IN OPTION DUE TO STAY IN PLACE ORDER BY GOVENOR OF CALIFORNIA), DAVID FRANCIS PRESIDING

PRESENT: Directors Francis, Gipson, Havard Mirviss, Olmos & Rodriguez; G. Herbst, CEO; K. Noeske, VP & CNO; M. Tupper, VP & CFO; D. Cox, VP Chief Human Resources Officer; M. Mertz, VP & Chief Strategy Officer; D. Leeper, VP & CIO; R. Gates, VP Population Health; A. Banerjee, VP & Chief Quality Officer; D. Allain, VP Cardiac & Surgical Services; J. Batth, VP of Rehabilitation & Post-Acute Care Services; R. Berglund, Legal Counsel; and Cindy Moccio, recording

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

Director Francis entertained a motion to approve the agenda.

MMSC (Havard Mirviss/Olmos) 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 AGENDA – 4:01PM

Approval of closed meeting minutes – January 25 and February 17, 2021.
Conference with Legal Counsel – Anticipated Litigation – Significant exposure to litigation pursuant to Government Code 54956.9(d)(2) – 10 Cases **–** *Ben Cripps, Chief Compliance Officer and Rachele Berglund, Legal Counsel*
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 – *Byron Mendenhall, MD Chief of Staff*
Quality Assurance pursuant to Health and Safety Code 32155 and 1461, report of quality assurance committee –– *Byron Mendenhall, MD Chief of Staff*

MMSC (Havard Mirviss/Rodriguez) to approve the closed agenda. This was supported unanimously by those present. Vote: Yes – Havard Mirviss, 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:

Garth Gipson, 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 MONDAY FEBRUARY 22, 2021, AT 4:30PM, IN SUPPORT SERVICES BUILDING 5TH FLOOR GRADUATE MEDICAL EDUCATION CONFERENCE ROOM (CALL IN OPTION DUE TO STAY IN PLACE ORDER BY GOVENOR OF CALIFORNIA), DAVID FRANCIS PRESIDING

PRESENT: Directors Francis, Gipson, Havard Mirviss, Olmos & Rodriguez; G. Herbst, CEO; B. Mendenhall, MD, Chief of Staff; K. Noeske, VP & CNO; M. Tupper, VP & CFO; D. Cox, VP Chief Human Resources Officer; M. Mertz, VP & Chief Strategy Officer; D. Leeper, VP & CIO; R. Gates, VP Population Health; A. Banerjee, VP & Chief Quality Officer; D. Allain, VP Cardiac & Surgical Services; J. Batth, VP of Rehabilitation & Post-Acute Care Services; R. Berglund, Legal Counsel; and Cindy Moccio, recording

The meeting was called to order at 4:33PM by Director Francis.

Director Francis asked for approval of the agenda.

MMSC (Gipson/Havard Mirviss) 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 of closed minutes from January 25 and February 17, 2021.

OPEN MINUTES – Request approval of the meeting minutes January 25, January 26, and February 17, 2021.

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/Rodriguez) Approval of the open meeting minutes January 25, January 26, and February 17, 2021. This was supported unanimously by those present. Vote: Yes – Havard Mirviss, Olmos, Rodriguez, Gipson, and Francis

RECOGNITIONS – Director David Francis

- Presentation of Resolution 2120 to Monica Bolton, Occupational Therapist III, in recognition as the Service Excellence recipient – February 2021.
- Presentation of Resolution 2121 to Gloria Simonetti, Employee Health Manager, retiring from Kaweah Delta after 16 years of service.
- Presentation of Resolution 2122 to Laura Goddard, Director of Organizational Development, retiring from Kaweah Delta after 20 years of service.

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 {copy attached to the original of these minutes and considered a part thereof}.

MMSC (Havard Mirviss/Gipson) 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

CHIEF OF STAFF REPORT – Report from Byron Mendenhall, MD – Chief of Staff

- At the next Medical Staff meeting they will be selecting an incoming Secretary/Treasurer.

QUALITY – Value Based Purchasing Report – A review of quality indicators and improvement actions included in the Centers for Medicare and Medicaid Services quality incentive program (copy attached to the original of these minutes and considered a part thereof) - Anu Banerjee, Vice President – Chief Quality Officer, Sandra Volchko, RN, DNP, Director of Quality and Patient Safety, Evelyn McEntire, Quality Improvement Manager

STRATGIC PLANNING – FY21 Performance – Review of the performance of the FY21 Strategic Plan through the first two quarters. (copy attached to the original of these minutes and considered a part thereof) - *Marc Mertz, Vice President & Chief Strategy Officer*

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). Mr. Herbst requested the removal of item 11.2B {Administrative Policy AP.141 Credit and Collections}, and Director Olmos requested the removal of item 11.1D {Radiation Oncology Services & Medical-Oncology, 3South}.

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 approve the consent calendar with the removal of items 11.2B {Administrative Policy AP.141 Credit and Collections}, and Director Olmos requested the removal of item 11.1D {Radiation Oncology Services & Medical-Oncology, 3South}. This was supported unanimously by those present. Vote: Yes – Havard Mirviss, Olmos, Rodriguez, Gipson, and Francis

11.1D - Radiation Oncology Services & Medical-Oncology, 3South – Director Olmos commented and noted his support relative to the concept of a nurse navigator to help guide patients who are trying to negotiate cancer patient care.

MMSC (Olmos/Rodriguez) to approve 11.1D {Radiation Oncology Services & Medical-Oncology, 3South}. This was supported unanimously by those present. Vote: Yes – Havard Mirviss, Olmos, Rodriguez, Gipson, and Francis

CALL TO VOTE FOR THE INDEPENDENT SPECIAL DISTRICT REPRESENATIVE TO THE COUNTYWIDE RDA OVERSIGHT BOARD – Designation of a Kaweah Delta Board member to complete the ballot for the independent special district representative voting ballot to appoint an independent special district representative to the countywide RDA oversight Board. Representative Nominees include:

David Francis – Kaweah Delta Health Care District
George Ouzounian – Visalia Public Cemetery District
Stephen Presant – Tulare Public Cemetery District

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 (Gipson/Olmos) Vote for David Francis of the Kaweah Delta Health Care District Board of Directors as the representative nominee to serve as the independent special district representative to the countywide RDA oversight board. This was supported unanimously by those present. Vote: Yes – Havard Mirviss, Olmos, Rodriguez, Gipson, and Francis

CHIEF EXECUTIVE OFFICER REPORT – Report relative to current events and issues - Gary Herbst, Chief Executive Officer

- Our COVID numbers continue to move in a positive direction with only 61 COVID patient in house at this time.
- Summary relative to a recent meeting with representative from OSHPD relative to SB1953 requirements.

BOARD PRESIDENT REPORT – Report from David Francis, Board President

- No report.

ADJOURN - Meeting was adjourned at 6:54PM

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

ATTEST:

Garth Gipson, Secretary/Treasurer
Kaweah Delta Health Care District Board of Directors

Kaweah Delta
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RESOLUTION 2123

WHEREAS, KAWEAH DELTA HEALTH CARE DISTRICT recognizes Robert E. Pierce, with the World Class Service Excellence Award – March 2021 for consistent outstanding performance and,

WHEREAS, Robert embodies the Mission of Kaweah Delta; *Health is our passion, Excellence is our focus, Compassion is our promise* and,

WHEREAS, Robert embraces the Pillar of Kaweah Delta - *Deliver Excellent Service* and,

WHEREAS, the Board of Directors of the KAWEAH DELTA HEALTH CARE DISTRICT is aware of his 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 Kaweah Delta staff, and the community they represent, hereby extend their congratulations to Robert for this honor and in recognition thereof, have caused this resolution to be spread upon the minutes of the meeting.

PASSED AND APPROVED this 22nd day of March 2021 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

This nomination is for Robert E. (Bob) Pierce, not his son, Robert B. (Blake) Pierce (who is also fantastic). Blake is the only one listed in the directory below. 5T was fortunate to acquire Bob after an extended tenure as a bedside nurse on 2N. Bob came to 5T in January of 2020, a few months before the opening of our new unit. He came with ICCU experience but little to no charge nurse experience in his previous roles. While Bob had many uncertainties regarding this big jump, I did not have the same concerns. In fact, I had none. Bob jumped into this role with both feet- in the face of extreme adversity: a global pandemic, new leadership, new nurses, new cnas, understaffing and a wide variety of diagnoses that many of our staff had very little experience with. Fast forward a few months to May 12th and Bob was the Charge Nurse on 5T on the day we opened our unit for the very first patient. He has brought his very best, and more, with him every day since. Bob is a leader in so many ways, many of which he doesn't even realize. Bob's extremely kind and intentional demeanor speaks volumes about his character and his desire to make everyone feel welcomed, appreciated, valued and LOVED! Bob loves with his whole heart: he loves his patients, his coworkers, his team. Every interaction that Bob has is intentional. Did I mentioned that he's intentional? He is a man of many words and every word speaks power and love into the lives of those around him. He is encouraging, honest, and uplifting. He uses humor (usually making fun of himself) to diffuse stressful situations and he extends empathy and compassion that eases the hurt when sadness would otherwise prevail. Bob is well-known for his outstanding Ultrasound IV skills, his terrific people skills, the Starbucks card that's always in his scrub pocket waiting to be given to the person who works the hardest or goes above and beyond in the best way, and for his generosity in building up, encouraging and supporting those around us who can benefit from an act of kindness. Bob is a good human and there just aren't many of those around. Additionally, Bob is never afraid to speak up when things aren't right. He knows the importance of providing safe patient care and he finds meaningful alternatives and uses a solution-oriented approach to make positive changes in our area. At times, and often when I don't even realize I need it, Bob counsels me and teaches me how to handle situations that would otherwise frustrate or discourage me. He is a support system for so many of us- he is a pillar on 5T. It has been an absolute pleasure to have Bob lead this team and I can't imagine doing this job without him on this team. Bob, a simple thank you seems so insignificant but I hope it never loses its' meaning. THANK YOU!

Kaweah Delta
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RESOLUTION 2124

WHEREAS, Nancy Allain, is retiring from duty at Kaweah Delta Health Care District after 19 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;

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 appreciation to Nancy Allain for 19 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 22nd day of March 2021 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

Kaweah Delta
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RESOLUTION 2125

WHEREAS, Frank Orique, 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 his loyal service and devotion to duty;

WHEREAS, the Board of Directors of the KAWEAH DELTA HEALTH CARE DISTRICT is aware of his 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 appreciation to Frank Orique 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 22nd day of March 2021 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

Kaweah Delta
MORE THAN MEDICINE. LIFE.

RESOLUTION 2126

WHEREAS, Rebecca Wright, 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;

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 appreciation to Rebecca Wright 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 22nd day of March 2021 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

Physician Recruitment Annual Physician Recruitment Plan - 2021

As supported by the Provider Needs Assessment conducted by Sg2 in 2020, below is a list of the specialties included in our 2021 physician recruitment plan.

- Adult Hospitalist
- Anesthesiology
- Colorectal Surgery
- Dermatology
- Diagnostic Radiology
- EP Cardiology
- Family Medicine
- Family Medicine Associate Program Director
- Family Medicine Core Faculty
- Gastroenterology
- General Surgery
- Gynecology
- Intensivist
- Internal Medicine
- Maternal Fetal Medicine
- Neonatology
- Neurology
- OB/GYN
- Orthopedic Surgery_Hand
- Orthopedic Surgery_Trauma
- Otolaryngology
- Palliative Medicine
- Psychiatry
- Pulmonology *(Added)*
- Rheumatology
- Urology

**Attachments – Provider Needs Assessment for Kaweah Delta Medical Center*

Date Prepared: November 13, 2020
Revised: March 5, 2021
Prepared by: Brittany Taylor, Director of Physician Recruitment and Relations | btaylor@kdhcd.org | (559)624-2899

Kaweah Delta
MORE THAN MEDICINE. LIFE.

SG2
health care intelligence

Provider Needs Assessment for Kaweah Delta Medical Center

Final Report: October 1, 2020

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Purpose and Objectives

- Sg2 Consulting, a healthcare consulting firm headquartered in Chicago with regional offices in Los Angeles and Denver was retained by Kaweah Delta Medical Center ("KDMC" or "the Hospital") under the Central Valley Health Care Alliance[1] to complete a provider needs planning analysis.

Objectives

1. **Assess & Quantify** current physician/provider supply and demand for selected market-based specialties/subspecialties for seven service areas. The first three service areas include the Counties of Tulare and Kings, and the Counties combined. Three additional service area definitions were provided by the Hospital, which include the Primary Service Area, Total Service Area, and Facility Planning Service Area. The last service area is defined by KDMC's inpatient discharges which conforms to regulatory guidelines for CMS's and IRS's community physician needs service area definition. This is referred to as "GASH" (Geographic Area Served By Hospital). Refer to Appendix C pg 65 for legal definition.

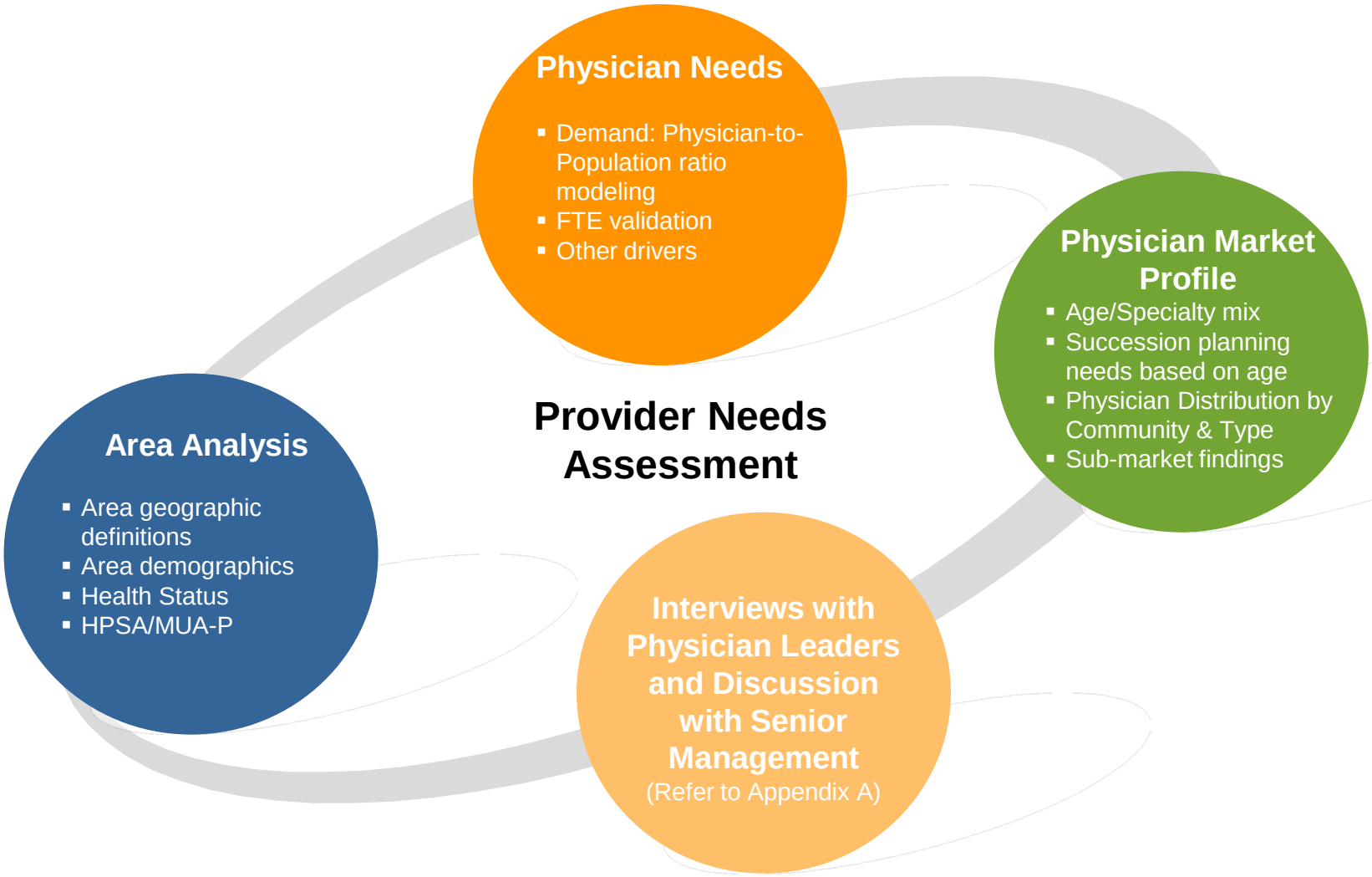
2. **Profile the physician market** to highlight market indicators that include but are not limited to depth and breadth of specialty coverage, age mix, potential succession planning needs, and other relevant areas of need going forward.

3. **Interview and obtain qualitative feedback** from physician leaders and senior leadership management regarding physician/provider manpower needs, strategic recruitment/development objectives, current environmental impacts, and other relevant issues at KDMC.

4. **Create an objective, empirically-based, and legally supportable physician recruitment platform** for the Hospital to use over the next 24 to 36 months.

[1] Joint Powers Agreement formed between Sierra View Medical Center & Kaweah Delta Medical Center

Methodology



Methodology – cont'd

- Sg2's analysis incorporated a quantitative and qualitative approach and is as follows:
  - Assess and quantify physician/provider needs in the defined service areas
    - Evaluate net needs for physicians within the Hospital's service areas listed below using physician-to-population ratio (demand) and applying against current supply using KDMC's service areas' population. (Hospital-based physicians such as anesthesiology, emergency medicine, radiology, intensivists, & hospitalists were excluded)
      1. Tulare County
      2. Kings County
      3. Tulare & Kings County combined
      4. KDMC PSA
      5. KDMC TSA
      6. KDMC FPSA
      7. Community physician needs service area. The service area is referred to as "GASH" (Geographic Area Served By Hospital).
    - A review of nationally published physician-to-population ratios such as GMENAC (Graduate Medical Education National Advisory Committee), Hicks and Glenn, Merritt Hawkins, Sg2's proprietary dataset, and other available data.
    - Determination of appropriate ratios by specialty based on market-specific factors, including managed care penetration, age/sex distribution, and regional physician practice patterns.
    - Identification of current practicing physicians within the geographic service area(s) (supply). We have estimated clinical full-time equivalent status of physicians by specialty based on knowledge of the market, feedback/information from researching and calling physician groups and individual offices, and input from KDMC's administrative staff and staff physicians during our interviews. APPs were included in primary care at 0.80 FTE for this analysis, and excluded in medical and surgical specialties.

Methodology – cont'd

- Profile physician market
  - Assessment of physician market to identify
    - Depth and breadth of specialty coverage;
    - Specialty/coverage gaps; and
    - Succession planning needs.
  - Profile physician market age by specialty.
  - Comparison of physician needs by sub-market.
  - Physician distribution by community.
- Interview and obtain qualitative feedback
  - Individual interviews were conducted with community physician leaders and senior leadership management. Refer to Appendix A on pg 58.
  - Highlight needs identified by interviewees.
- Create a medical staff development plan
  - Provide an objective recruitment plan for KDMC based on a review of pertinent internal and external planning information, relevant market information including demographics, health status, and health professional shortage area designations.

Physician Needs Indicators

The following indicators were evaluated in conjunction with assessing community ambulatory physician needs:

- Macro-level modeling: physician-to-population ratios were used for the defined service areas.
- Health Professional Shortage Area (HPSA) and Medically Underserved Area/Population (MUA/P) designations.
- Extent to which needs are indicated (through discussion) based on:
  - Availability/waiting time for consumers/patients to access physician practices (primary care and across specialties) indicated through interviews.
    - Extent to which practices are closed (completely or to certain payers).
  - Clinical gaps or desire to broaden out a subspecialty.
  - Other considerations.
- Physicians slowing practices/retiring/leaving area (succession planning).
- Service line gaps/development initiatives/market share growth opportunities (ie., curbing outmigration).

Executive Summary

- KDMC's total service area has an estimated population of approximately 600,000. The sub-markets being evaluated range in population size from 388K to 600K residents.
- This area is designated as both a HPSA and MUA and is a fast-growing, young region with a high indigent population.
  - The percentage of Medi-Cal patients in the area ranges from 40% to 55% of the population.
  - The health status of the region is not favorable compared to California as a whole. Cancer and heart-related diseases are high.
- The area is surrounded by smaller acute care providers, which include Adventist Health and Sierra View Medical Center, with Kaweah being the preferred destination for care within this region.
- The physician operating landscape is a composite of several operating vehicles, providing flexibility and choice for physicians to operate under – Key Medical Associates, Visalia Medical Clinic (1206(l) medical foundation), and FQHC/RHC clinic models.
- On a geographic basis, the PSA has the highest per capita physician supply. As the geographic footprint expands, physician per capita continues to decrease at a higher rate. Care is heavily concentrated around the Hospital.

Executive Summary – cont'd

- Given the challenging market landscape (payer mix, location, etc), there are deficiencies in terms of manpower in many of the specialties in this analysis. Recruitment and retention has also been of concern and continues to be a challenge.
  - Many providers (Primary Care APPs) leave after fulfilling the requirements of their student loan forgiveness programs (typically 2-3 years).
- Aging of the physician workforce/succession planning vulnerability is a key theme for this region. While physicians in this market continue to provide care beyond the age of 65, there are anecdotes of older physicians expressing the desire to retire sooner than anticipated in response to COVID-19. The aging workforce and associated wave of potential retirements could leave the area with gaps in care.
- Specialties with particular vulnerabilities (aging workforce, supply challenges) include the following:

- Primary Care	- Oncology/Hematology	- Orthopedic Surgery
- Gastroenterology	- Urology	- ENT

Executive Summary – cont'd

- Due to low reimbursement rates, many specialists in the region are not accepting Medi-Cal beneficiaries. This has been challenging for the residents in the community and also for hospital inpatient coverage.
- Physician recruitment in the area is challenging based on national shortages of (and competition for) physicians in several specialties, financial/economic realities, and lifestyle issues.
  - When evaluating physician needs, it is important to consider whether there is enough volume to support additional physicians given the large Medi-Cal population to which private practices are closed and the financial challenges that arise in operating practices that are largely skewed toward government payors.
  - As a way to ameliorate shortages and retain physicians in the area, KDMC continues to build out residency programs. Currently, there are five programs and a transitional year program. There are anecdotal reports of success in residents (about half) staying in the community upon completion of training.
- The area is saturated with FQHCs who cater to Medi-Cal patients and care continuity has been a growing challenge. The model is very volume driven. APPs for primary care are heavily utilized under this model.

Physician Landscape Scorecard

Physician Landscape			
Indicator	**Metric**	**Rating**	**Comments**
Physician age mix assessment	➢ Average age (53-55)		➢ 30% of physician workforce is over the age of 60 ➢ Some specialties are heavily skewed towards a more senior workforce
Physician supply/availability	➢ Need indicators		➢ There are many community shortages in the area
Succession planning/high risk for departures	➢ Key specialties present with above retirement age physicians		➢ Succession planning vulnerability present within the region ➢ Many high-producing providers are operating beyond retirement age (65)
Use of APPs	➢ Extent to use of APPs		➢ PCP APPs are heavily utilized in this area ➢ 1:1 Physician to APP ➢ Medical and surgical specialties have not fully adopted the use of APPs
Physician availability to all payor type/mix	➢ Physicians/providers available to provide coverage to the population		➢ Coverage in primary care is not restricted regardless of payor type (FQHC and RHC establishments) ➢ Many community-based/private physicians do not accept Medi-Cal

Physician Landscape Scorecard – cont'd

Physician Landscape			
Indicator	**Metric**	**Rating**	**Comments**
Physician use of telemedicine	➢ Extent of use of telemedicine to provide care		➢ Telemedicine has been actively used during COVID.
Physician growth (net new providers)	➢ Recruitment ➢ Retention		➢ Recruitment – physician recruitment is challenging (location and payor mix). ➢ Retention of primary care providers has been difficult. PCP APPs are leaving after completing their student loan forgiveness obligation.
Presence of Value-based care	➢ Fee for value vs fee for service behavior ➢ Managed care coverage (Capitation/risk arrangements)		➢ Sequoia Integrated Healthcare – Medicare Advantage 15K full risk. ➢ Additional value-based delivery models are being discussed/contemplated (bundle payments, Medi-Cal cap).

Hospital Landscape Scorecard

Hospital Landscape			
Indicator	**Metric**	**Rating**	**Comments**
Hospital capacity and availability of services	➢ Occupancy rate ➢ Diversion ➢ Operating room capacity		➢ Critical care issues and OR capacity issues ➢ No diversion (emergency department volume)
Population health	➢ PCMH – primary care/disease management focus ➢ Telemedicine – both o/p and i/p ➢ Managed care ➢ Risk arrangements ➢ Clinically integrated network		➢ Kaweah application to form an FQHC integrated delivery medical home – to comprise of PCP, medical, and surgical specialist coverage ➢ SIQ – managed care full risk ➢ Moderate clinical alignment – 1206 (l) Visalia Medical Clinic fully clinically aligned (40+ providers), Key Medical Associates (growing)
Hospital and Physician Alignment/Relationship	➢ Relationship between physicians and hospital (positive/negative) ➢ Degree of physician/hospital alignment (fragmentation-silo'd/integrated)		➢ Relationship between the Hospital and the physicians has been positive. Kaweah has been flexible creating different vehicles to support physicians in the area and tightening the relationship- Delta Doctors, Key Medical Associates, Visalia Medical Clinic (employed-like), and SIQ risk arrangement ➢ The market is a hybrid - slightly more fragmented than integrated – but has made positive and progressive strides

Hospital Landscape Scorecard – cont'd

Hospital Landscape			
Indicator	**Metric**	**Rating**	**Comments**
Hospital competition	➢ Degree of competition present in the area (low/high)		➢ Low degree of competition ➢ Kaweah is the preferred hospital destination within Tulare County
Quality of care	➢ HCAHPs ➢ Timely Effective Care ➢ VBC		➢ Patient experience: 2 out of 5 stars ➢ Timely effective care: 2 out of 5 stars ➢ VBC: 2 out of 5 stars
Clinically Integrated Delivery Network	➢ Physician/Hospital Leadership ➢ Clinical Guidelines/Measurements ➢ Synchronized Data Technology ➢ Lateral or Vertical Alignment		➢ Sequoia Integrated Healthcare (Humana contract 10-15K senior lives)

Patient Population Landscape Scorecard

Patient Population Landscape			
Indicator	**Metric**	**Rating**	**Comments**
Health status	➢ Overall health of the population		➢ The health of Tulare and Kings Counties residents is not favorable. A majority of the health status metrics fall below that of State levels.
Payor mix	➢ Degree of commercial payors vs government assisted payors		➢ The area has an unfavorable payor mix and is expected to possibly worsen due to the current economic challenges our nation is facing.
Consumer accessibility to care PCP	➢ Waiting period		➢ The proliferation of FQHCs/RHCs has made primary care services more accessible to this region.
Consumer accessibility to care Medical/Surgical specialties	➢ Waiting period ➢ Network Exclusion ➢ Outmigration		➢ Access to care for commercial and Medicare patients is not of an issue. ➢ A majority of independents do not provide coverage for the Medi-Cal population.
Demographics	➢ Senior population – aging, growth ➢ Median age ➢ Population growth		➢ The area is expected to grow 3-4% within the next five years. ➢ Median age is 33.9 vs 38.1 for CA ➢ Senior cohort will experience the highest growth.
HPSA/MUA	➢ Medically underserved ➢ Health professional shortage		➢ Most of the region is HPSA/MUA designated.

Purpose, Methodology, and Background

Executive Summary

Service Area Definitions & Demographics

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Physician Market Profile

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Appendices

Service Area Definitions Being Evaluated

- There are seven service areas being evaluated and are defined as the following:
  1. **Tulare County** area
  2. **Kings County** area
  3. **Tulare County & Kings County** combined
  4. **KDMC Strategic Service Areas (3) -** Service area definitions provided by the Hospital
     1. KDMC Primary Service Area (PSA)
     2. KDMC Total Service Area (PSA & SSA combined)
     3. KDMC Facility Planning Service Area (FPSA)
  5. **KDMC GASH (Community Provider Needs) -** Geographic Area Served By Hospital (GASH). 75% of KDMC inpatient discharges and is consistent with CMS's and IRS's legal requirement for defining community physician needs area definition. Should a hospital elect to provide income support (income guarantees, relocation payment, recruitment payment, etc.) and a need is present, monetary support is applicable.
- The following page displays the service area definitions for all sub-markets being evaluated.

KDMC Service Area Definitions

KDMC Total Service Area		
Zip Code	Community	Strategic Service Area
93603	Badger	PSA
93615	Cutler	PSA
93221	Exeter	PSA
93223	Farmersville	PSA
93227	Goshen	PSA
93235	Ivanhoe	PSA
93237	Kaweah*	PSA
93244	Lemon Cove	PSA
93646	Orange Cove	PSA
93647	Orosi	PSA
93271	Three Rivers	PSA
93277	Visalia	PSA
93290	Visalia	PSA
93291	Visalia	PSA
93292	Visalia	PSA
93278	Visalia*	PSA
93279	Visalia*	PSA
93286	Woodlake	PSA
93670	Yettem*	PSA

KDMC Total Service Area		
Zip Code	Community	Strategic Service Area
93201	Alpaugh	SSA
93202	Armona	SSA
93212	Corcoran	SSA
93618	Dinuba	SSA
93230	Hanford	SSA
93232	Hanford*	SSA
93631	Kingsburg	SSA
93242	Laton	SSA
93247	Lindsay	SSA
93628	Miramonte	SSA
93633	Miramonte	SSA
93641	Miramonte	SSA
93648	Parlier	SSA
93256	Pixley	SSA
93257	Porterville	SSA
93258	Porterville*	SSA
93675	Squaw Valley	SSA
93267	Strathmore	SSA
93666	Sultana	SSA
93270	Terra Bella	SSA
93272	Tipton	SSA
93673	Traver	SSA
93274	Tulare	SSA
93275	Tulare*	SSA
93282	Waukena	SSA

Source: KDMC 2020
*Per US Postal Service, these ZIP Codes are for Post Office

Note: TSA = PSA + SSA

KDMC Facility Planning Service Area	
Zip Code	Community
93615	Cutler
93618	Dinuba
93219	Earlimart
93221	Exeter
93223	Farmersville
93227	Goshen
93235	Ivanhoe
93247	Lindsay
93647	Orosi
93256	Pixley
93257	Porterville
93267	Strathmore
93271	Three Rivers
93272	Tipton
93673	Traver
93274	Tulare
93282	Waukena
93277	Visalia
93291	Visalia
93292	Visalia
93286	Woodlake

Source: KDMC 2020

KDMC GASH	
ZIP Code	Community
93277	Visalia
93291	Visalia
93274	Tulare
93292	Visalia
93257	Porterville
93221	Exeter
93618	Dinuba
93223	Farmersville
93247	Lindsay

Source: KDMC CY 2019

Service Area(s) Demographics Summary

- KDMC has defined three strategic service areas ranging in population size from 230K to 600K residents.
  - PSA: 229K
  - TSA: 597K
  - FPSA: 451K
- In addition, other service areas being evaluated have the following number of residents:
  - GASH: 388K
  - Tulare County: 464K
  - Kings County: 151K
- The area is predominantly Hispanic (60%-70%) followed by White (25%-30%).
- The median age of Tulare County is 33.9, compared to 38.1 for California as a whole.
- The proportion of females age 15-44 is higher in Tulare County than the State (21% vs 18%).
  - Within this subset of the female population, the median age in Tulare County is 28.8 vs 29.6 in California as a whole.
- The communities in the service areas have high-growth rates.
  - Communities anticipated to have the most growth (between 5% to 6%) include the City of Visalia (est. 60K residents) and Parlier (est.18K residents) while many of the remaining communities are projected to have a 3% to 4% growth range.
- While each service area has an estimated 50% of residents under age 44, the senior population (age 65+) is projected to increase the most within the next five years.
- See Appendix C pg 60-69 for sub-market demographics and regulatory GASH definition.

Tulare County & Kings County: Health Insights

- Compared to California, residents of Tulare County and Kings County have a **lower life expectancy** and a **higher premature age-adjusted mortality.**

- Compared to California, both Counties have higher rates of:
  - Infant mortality
  - Frequent mental and physical distress
  - Food insecurity
  - Limited access to healthy foods
  - Uninsured adults

Health Indicator	Tulare County	Kings County	California
Life expectancy	**78.5**	79.7	81.6
Premature age-adjusted mortality	**360**	340	270
Infant mortality (per 1,00 live births)	**6**	5	4
Frequent physical distress	**15%**	13%	11%
Frequent mental distress	**15%**	13%	11%
Diabetes prevalence	9%	**10%**	9%
Food insecurity	13%	13%	11%
Limited access to healthy foods	**8%**	5%	3%
Uninsured adults	12%	12%	10%

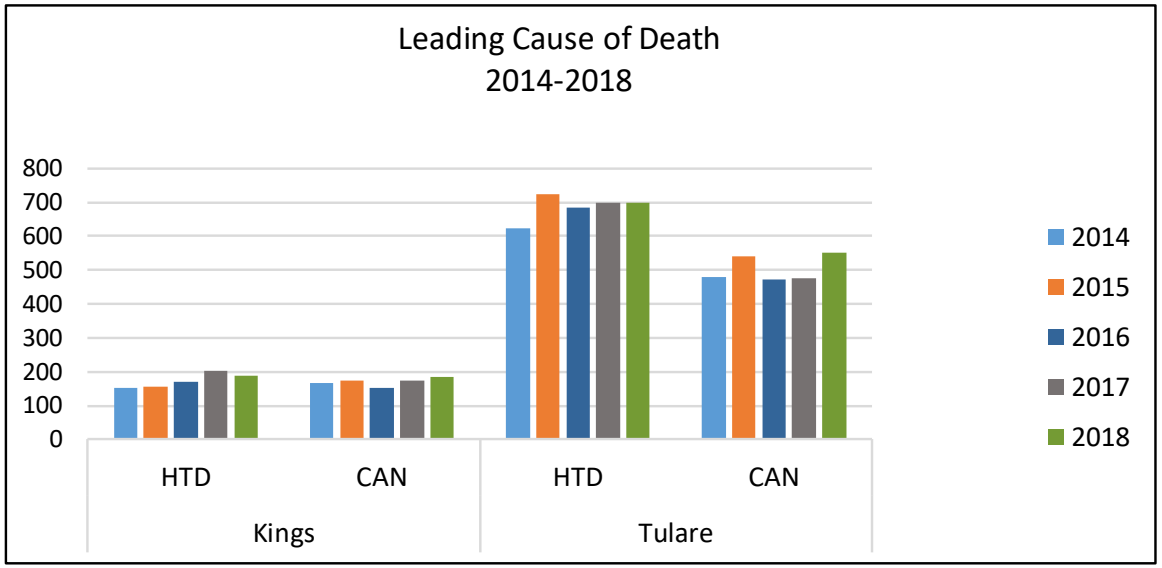
Source: County Health Rankings and Roadmaps accessed May 2020

Red text indicates below state levels; Green text indicates above state levels

Bold red indicates less desirable health indicator between Kings and Tulare County

Tulare County & Kings County: Health Insights – cont'd

The top two leading causes of death in both Counties include **heart-related diseases** and **cancer,** and are continuing to rise.



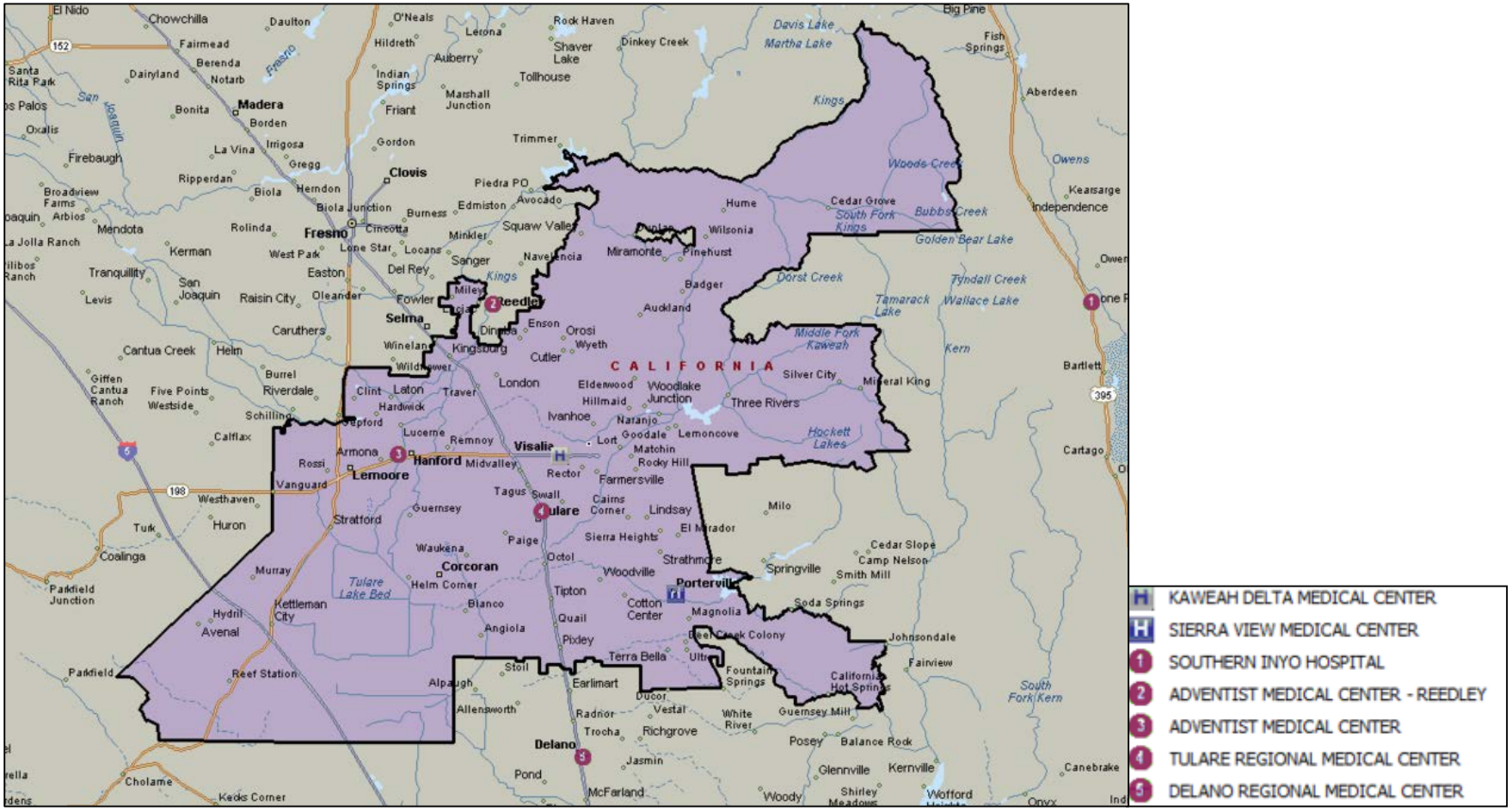
Source: California Health and Human Services Open Data Portal accessed May 2020

HTD: Disease of the Heart

CAN: Malignant Neoplasms (Cancers)

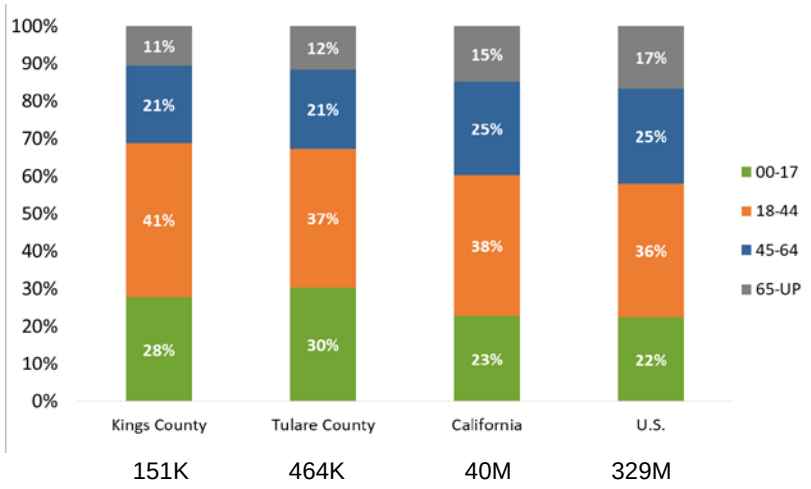
Notes: Cause-of-death between 1999 to present were coded using the Tenth Revision of the International Classification of Diseases codes (ICD-10). Counts that are less than 11 have bee excluded.

Tulare County & Kings County Area Depiction

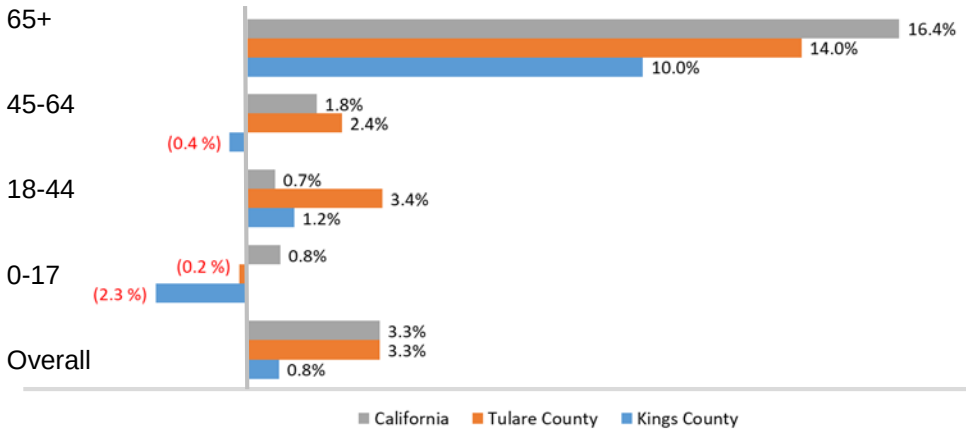


Age Profile – Tulare County & Kings County

Population by Age Cohort



% Change in Population by Age Cohort 2020 - 2025

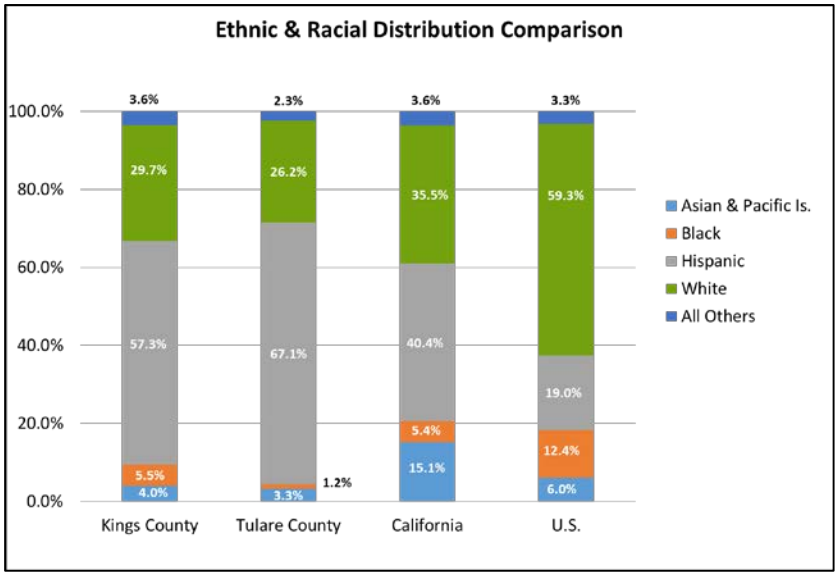


- Residents in both Tulare and Kings County are proportionally younger when compared to the State.
- Tulare County is anticipated to grow by 3% while Kings County is projected to have minimal growth (0.8%) in the next five years.
- While the age 65+ cohort comprises a small percentage of both Tulare and Kings County residents when compared to the State and Nation, this group is projected to have to highest growth (14% and 10% respectively).

Ethnic Profile – Tulare County & Kings County

Ethnic & Racial Distribution Comparison										
	Kings County			Tulare County			California			U.S.
Ethnicity/Race	2020 % of Total	2025 % of Total	Population % Change '20-'25	2020 % of Total	2025 % of Total	Population % Change '20-'25	2020 % of Total	2025 % of Total	Population % Change '20-'25	National 2020 % of Total
Asian & Pacific Is.	4.0%	4.2%	5.3%	3.3%	3.2%	2.3%	15.1%	16.1%	10.2%	6.0%
Black	5.5%	4.8%	(11.3 %)	1.2%	1.1%	(0.3 %)	5.4%	5.2%	(0.7 %)	12.4%
Hispanic	57.3%	60.5%	6.5%	67.1%	70.5%	8.6%	40.4%	41.9%	7.1%	19.0%
White	29.7%	26.9%	(8.5 %)	26.2%	22.8%	(9.9 %)	35.5%	33.0%	(3.7 %)	59.3%
All Others	3.6%	3.6%	1.4%	2.3%	2.3%	3.6%	3.6%	3.8%	8.0%	3.3%
Total	151,233	152,464	0.8%	463,814	479,324	3.3%	39,886,390	41,212,916	3.3%	100.0%

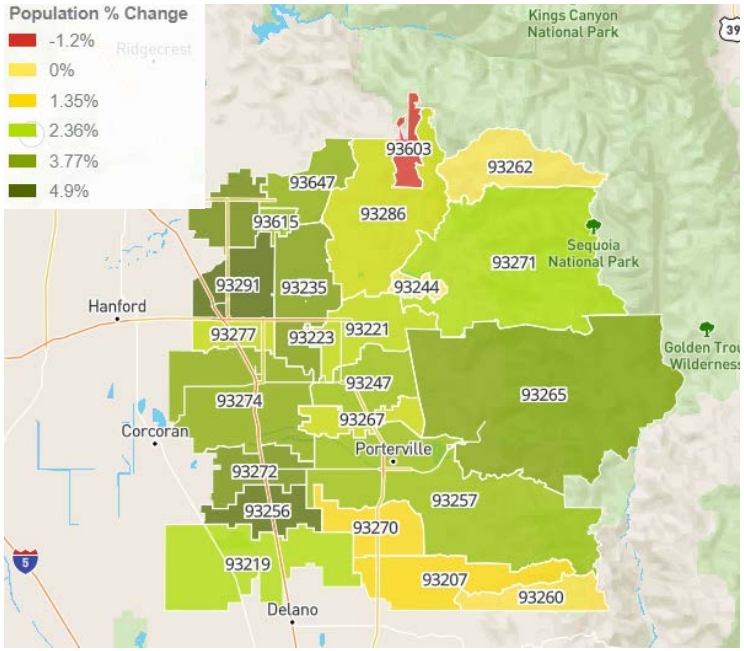
Source: Sg2 Market Demographics



- Tulare and Kings County are predominantly Hispanic (60%-70%) and White (~30%).
- Compared to California, the Hispanic population is proportionally higher in both Counties.
- The Hispanic population is projected to have the most growth in Tulare County (9%) and Kings County (7%).

Projected Growth: Tulare County

5-Year Population Growth Projected by ZIP Code



Population Growth by Age Cohort 2020 - 2025

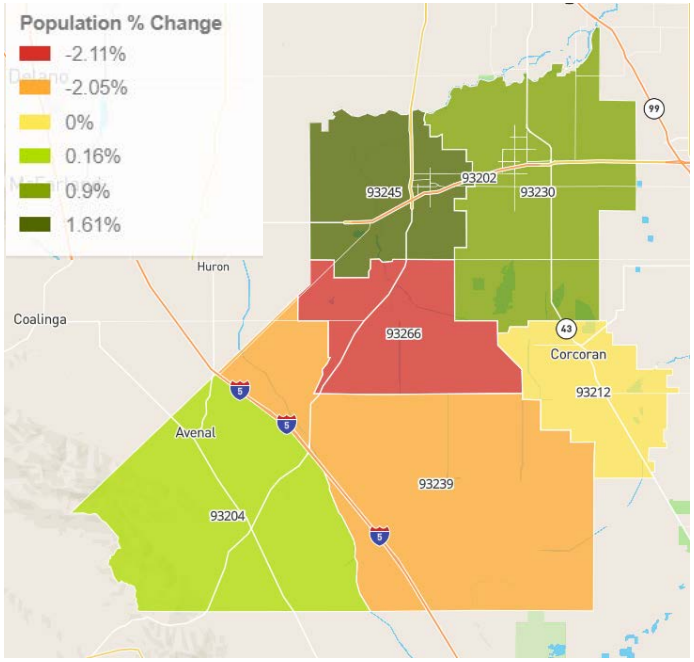
	Current Population		Population 5-Year % Change	
Age Group	Tulare County	Percent of Population	Market Growth Rates	California
0-17	140,206	30%	0%	1%
18-44	172,111	37%	3%	1%
45-64	96,891	21%	2%	2%
65-UP	54,606	12%	14%	16%
Overall	463,814	100%	3%	3%

Sg2 Market Demographics

- Tulare County is a fast-growing area.
- The City of Visalia, with estimated 60K residents, is projected to grow by 5%.
- While the 65+ age cohort reflects a small segment of the population, this age cohort is projected to grow the most (14%) in the next five years.

Projected Growth: Kings County

5-Year Population Growth Projected by ZIP Code



Population Growth by Age Cohort 2020 - 2025

	Current Population		Population 5-Year % Change	
Age Group	Kings County	Percent of Population	Market Growth Rates	California
0-17	41,859	28%	-2%	1%
18-44	62,105	41%	1%	1%
45-64	31,205	21%	0%	2%
65-UP	16,064	11%	10%	16%
Overall	151,233	100%	1%	3%

Sg2 Market Demographics

- Kings County is projected to have limited growth.
- The City of Lemoore, with estimated 39K residents, is projected to grow the most- by 2%.
- While the 65+ age cohort represents a small percent of the population, this age cohort is projected to grow the most (10%) in the next five years.

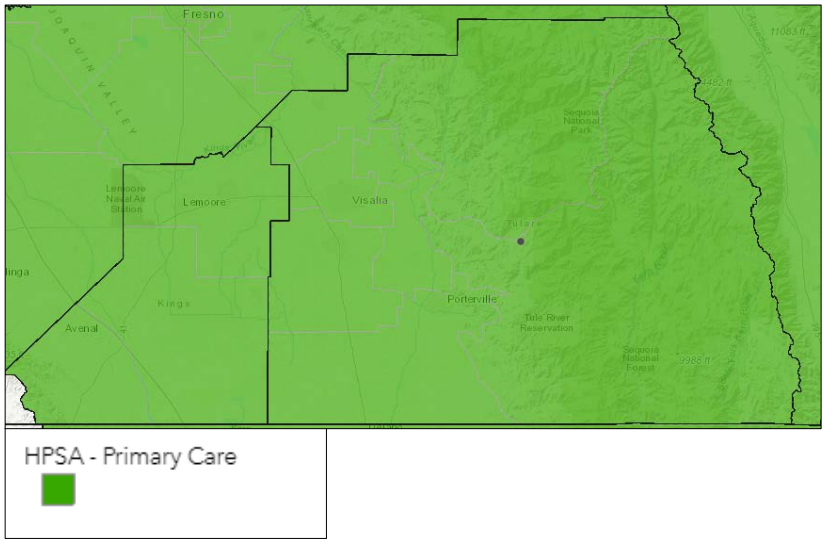
HPSA and MUA/P Designation

- Health Professional Shortage Areas (HPSAs) are designated by HRSA as having shortages of primary medical care providers and may be geographic, demographic, or institutional.
  - The benefits of being designated a Primary HPSA region include state and federal programs providing recruitment assistance and financial incentives to providers that practice in a HPSA area.
- Designated by HRSA, Medically Underserved Areas (MUAs) are designated by HRSA as areas in which residents have a shortage of personal health services. Medically Underserved Populations (MUPs) may include groups of persons who face economic, cultural, or linguistic barriers to healthcare.
  - The benefits of receiving a MUA/MUP designation include the eligibility to develop Community Health Centers, Migrant Health Centers, Federally Qualified Health Centers, and Rural Health Clinics, along with enhanced federal grant eligibility and a higher Medicare cap.
- Most of the communities within Kings and Tulare County, detailed on the following page, are both a HPSA-designated area and MUA/p-designated areas.

Service Area: HPSA and MUA/P Designation – cont'd

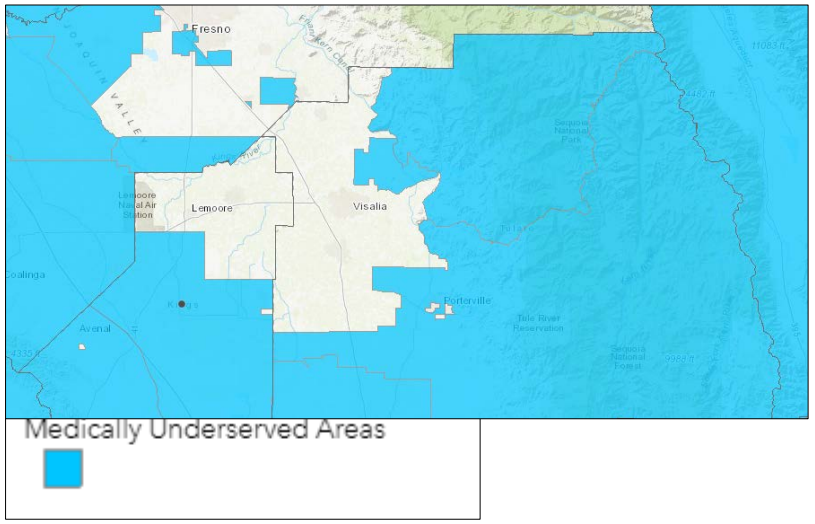
HPSA

- All of Tulare County and Kings County are HPSA-designated areas.



MUA/p

- Within Tulare County, most of the communities except for the Western region are MUA/p designated areas while most of Kings County, except for the Northeast area is a MUA/p-designated area.



Physician Needs – Summary

- The tables on the following pages illustrate physician needs by specialty for the seven service areas being evaluated.
- The following specialties present a large need across all the service areas being evaluated:
  - Cardiology
  - Dermatology
  - Endocrinology
  - ENT
  - General surgery
  - GI
  - Ob/Gyn
  - Oncology/Hematology
  - Ophthalmology
  - Orthopedics
  - Primary care
  - Psychiatry
  - Urology
- Refer to Appendix D pg 70-71 which represents physician needs excluding the Medi-Cal population.

Comparison of Physician Needs by Service Area

Specialty	Population to Support One Physician	KDMC GASH Net Need (Surplus)	Tulare County Net Need (Surplus)	Kings County Net Need (Surplus)	Tulare County & Kings County Net Need (Surplus)	KDMC PSA Net Need (Surplus)	KDMC TSA Net Need (Surplus)	KDMC FPSA Net Need (Surplus)
Primary Care								
Adult Primary Care (FM & IM)*	2,000	4.3	24.9	22.9	47.9	(44.5)	55.7	18.7
Pediatrics (General)	8,000	0.2	8.3	8.3	16.6	(1.8)	15.4	6.7
Medical								
Allergy & Immunology	75,000	(0.1)	0.9	1.7	2.7	(1.6)	2.5	0.7
Cardiology	22,000	3.4	6.9	4.7	11.5	(0.8)	10.7	6.3
- Electrophysiology	220,000	1.3	1.6	0.7	2.3	0.5	2.2	1.6
- Interventional/Invasive	63,000	0.2	1.4	1.2	2.6	(1.4)	2.3	1.2
- Medical/Non-Invasive	40,000	2.0	3.9	2.8	6.7	0.0	6.2	3.6
Dermatology	40,000	5.4	7.3	3.1	10.4	1.7	9.9	7.0
Endocrinology	60,000	3.6	4.8	2.3	7.2	1.9	6.9	4.6
Gastroenterology	40,000	3.9	5.8	2.7	8.5	0.7	8.0	5.5
Infectious Diseases	90,000	2.8	3.7	1.7	5.3	1.0	5.1	3.5
Nephrology	85,000	(9.3)	(8.4)	1.7	(6.8)	(9.1)	(7.0)	(8.6)
Neurology	44,000	1.0	2.7	2.9	5.7	(1.6)	5.3	2.5
Obstetrics/Gynecology	10,000	11.1	17.8	5.6	23.4	6.7	21.9	16.3
Oncology/Hematology	36,000	5.6	7.7	3.9	11.6	3.4	11.1	7.3
Gynecology Oncology	100,000	3.9	4.6	1.5	6.2	2.3	6.0	4.5
Physical Medicine & Rehabilitation	85,000	(0.9)	0.0	1.8	1.7	(2.6)	1.5	(0.2)
Psychiatry	20,000	7.6	11.4	1.8	13.2	(0.4)	12.3	10.8
Pulmonary Medicine	85,000	1.9	2.8	1.7	4.4	1.0	4.2	2.6
Radiation Oncology	95,000	1.3	2.1	1.6	3.7	0.6	3.5	2.0
Rheumatology	100,000	2.3	3.0	0.5	3.6	0.7	3.4	2.9
Surgical								
Surgery								
- Cardiothoracic/vascular Surgery	150,000	0.6	1.1	1.0	2.1	(0.5)	2.0	1.0
- Bariatric Surgery	100,000	3.4	4.1	1.5	5.7	1.8	5.5	4.0
- Colon & Rectal Surgery	200,000	1.9	2.3	0.8	3.1	1.1	3.0	2.3
- General Surgery	20,000	4.8	8.6	5.6	14.2	1.6	13.3	8.0
- Vascular Surgery	125,000	(0.2)	0.4	0.7	1.1	(1.1)	1.0	0.3
Neurosurgery	85,000	0.6	1.5	1.8	3.2	(1.3)	3.0	1.3
Ophthalmology	34,000	1.8	4.0	3.9	8.0	(1.5)	7.5	3.7
Orthopedic Surgery								
- General/Sports Medicine	26,000	6.6	9.5	4.3	13.9	2.5	13.2	9.1
- Foot/Ankle	295,000	1.3	1.6	0.5	2.1	0.8	2.0	1.5
- Hand Surgery	225,000	1.7	2.1	0.7	2.7	1.0	2.7	2.0
- Total Joint Reconstructive Surgery	175,000	1.5	2.0	0.9	2.8	0.6	2.7	1.9
- Trauma	160,000	2.1	2.6	0.9	3.5	1.1	3.4	2.5
Otorhinolaryngology	37,000	7.1	9.1	2.4	11.5	3.9	11.0	8.8
Plastic/Reconstructive Surgery	90,000	2.3	3.2	1.7	4.8	0.5	4.6	3.0
Spine Surgery	175,000	0.9	1.4	0.3	1.6	0.0	1.5	1.3
Urology	32,000	8.7	11.1	2.7	13.8	5.4	13.3	10.7
Service Area Population	Need	**388,430**	**463,814**	**151,233**	**615,047**	**228,808**	**597,438**	**451,460**
	Adequate Supply							

Note: Ratios rounded

*Primary Care Physician Supply includes APPs. APPs allocated 0.80 FTE

Tulare County Physician Needs Model

Specialty	Population to Support One Physician	Tulare County: Gross Physician Need	Tulare County: FTE Physician Supply	Tulare County: Net Need (Surplus)	Tulare County: Current Supply % of Need
Primary Care					
Adult Primary Care (FM & IM)*	2,000	231.9	207.0	24.9	89.2%
Pediatrics (General)	8,000	58.0	49.7	8.3	85.7%
Medical					
Allergy & Immunology	75,000	6.2	5.3	0.9	84.9%
Cardiology	22,000	21.1	14.2	6.9	67.4%
- Electrophysiology	220,000	2.1	0.5	1.6	23.7%
- Interventional/Invasive	63,000	7.4	6.0	1.4	81.5%
- Medical/Non-Invasive	40,000	11.6	7.7	3.9	66.4%
Dermatology	40,000	11.6	4.3	7.3	37.1%
Endocrinology	60,000	7.7	2.9	4.8	37.5%
Gastroenterology	40,000	11.6	5.8	5.8	50.3%
Infectious Diseases	90,000	5.2	1.5	3.7	28.1%
Nephrology	85,000	5.5	13.9	(8.4)	254.7%
Neurology	44,000	10.5	7.8	2.7	74.0%
Obstetrics/Gynecology	10,000	46.4	28.6	17.8	61.7%
Oncology/Hematology	36,000	12.9	5.2	7.7	40.4%
Gynecology Oncology	100,000	4.6	0.0	4.6	0.0%
Physical Medicine & Rehabilitation	85,000	5.5	5.5	0.0	100.8%
Psychiatry	20,000	23.2	11.8	11.4	50.9%
Pulmonary Medicine	85,000	5.5	2.7	2.8	49.5%
Radiation Oncology	95,000	4.9	2.8	2.1	57.4%
Rheumatology	100,000	4.6	1.6	3.0	34.5%
Surgical					
Surgery					
- Cardiothoracic/vascular Surgery	150,000	3.1	2.0	1.1	64.7%
- Bariatric Surgery	100,000	4.6	0.5	4.1	10.8%
- Colon & Rectal Surgery	200,000	2.3	0.0	2.3	0.0%
- General Surgery	20,000	23.2	14.6	8.6	62.7%
- Vascular Surgery	125,000	3.7	3.3	0.4	88.9%
Neurosurgery	85,000	5.5	4.0	1.5	73.3%
Ophthalmology	34,000	13.6	9.6	4.0	70.4%
Orthopedic Surgery					
- General/Sports Medicine	26,000	17.8	8.3	9.5	46.5%
- Foot/Ankle	295,000	1.6	0.0	1.6	0.0%
- Hand Surgery	225,000	2.1	0.0	2.1	0.0%
- Total Joint Reconstructive Surgery	175,000	2.7	0.7	2.0	26.4%
- Trauma	160,000	2.9	0.3	2.6	10.3%
Otorhinolaryngology	37,000	12.5	3.4	9.1	27.1%
Plastic/Reconstructive Surgery	90,000	5.2	2.0	3.2	38.8%
Spine Surgery	175,000	2.7	1.3	1.4	49.0%
Urology	32,000	14.5	3.4	11.1	23.1%
Service Area Population		**463,814**			Need
					Adequate Supply

Note: Ratios rounded.

*Primary Care Physician Supply includes APPs. APPs allocated 0.80 FTE

Kings County Physician Needs Model

Specialty	Population to Support One Physician	Kings County Gross Physician Need	Kings County FTE Physician Supply	Kings County Net Need (Surplus)	Kings County Current Supply % of Need
Primary Care					
Adult Primary Care (FM & IM)*	2,000	75.6	52.7	22.9	69.6%
Pediatrics (General)	8,000	18.9	10.6	8.3	56.1%
Medical					
Allergy & Immunology	75,000	2.0	0.3	1.7	12.4%
Cardiology	22,000	6.9	2.2	4.7	32.0%
- Electrophysiology	220,000	0.7	0.0	0.7	0.0%
- Interventional/Invasive	63,000	2.4	1.2	1.2	50.0%
- Medical/Non-Invasive	40,000	3.8	1.0	2.8	26.4%
Dermatology	40,000	3.8	0.7	3.1	18.5%
Endocrinology	60,000	2.5	0.2	2.3	7.9%
Gastroenterology	40,000	3.8	1.1	2.7	29.1%
Infectious Diseases	90,000	1.7	0.0	1.7	0.0%
Nephrology	85,000	1.8	0.1	1.7	5.6%
Neurology	44,000	3.4	0.5	2.9	14.5%
Obstetrics/Gynecology	10,000	15.1	9.5	5.6	62.8%
Oncology/Hematology	36,000	4.2	0.3	3.9	7.1%
Gynecology Oncology	100,000	1.5	0.0	1.5	0.0%
Physical Medicine & Rehabilitation	85,000	1.8	0.0	1.8	0.0%
Psychiatry	20,000	7.6	5.8	1.8	76.7%
Pulmonary Medicine	85,000	1.8	0.1	1.7	5.6%
Radiation Oncology	95,000	1.6	0.0	1.6	0.0%
Rheumatology	100,000	1.5	1.0	0.5	66.1%
Surgical					
Surgery					
- Cardiothoracic/vascular Surgery	150,000	1.0	0.0	1.0	0.0%
- Bariatric Surgery	100,000	1.5	0.0	1.5	0.0%
- Colon & Rectal Surgery	200,000	0.8	0.0	0.8	0.0%
- General Surgery	20,000	7.6	2.0	5.6	26.4%
- Vascular Surgery	125,000	1.2	0.5	0.7	37.2%
Neurosurgery	85,000	1.8	0.0	1.8	0.0%
Ophthalmology	34,000	4.4	0.5	3.9	11.2%
Orthopedic Surgery					
- General/Sports Medicine	26,000	5.8	1.5	4.3	25.8%
- Foot/Ankle	295,000	0.5	0.0	0.5	0.0%
- Hand Surgery	225,000	0.7	0.0	0.7	0.0%
- Total Joint Reconstructive Surgery	175,000	0.9	0.0	0.9	0.0%
- Trauma	160,000	0.9	0.0	0.9	0.0%
Otorhinolaryngology	37,000	4.1	1.7	2.4	41.6%
Plastic/Reconstructive Surgery	90,000	1.7	0.0	1.7	0.0%
Spine Surgery	175,000	0.9	0.6	0.3	69.4%
Urology	32,000	4.7	2.0	2.7	42.3%
Service Area Population		**151,233**			Need
					Adequate Supply

Note: Ratios rounded.

*Primary Care Physician Supply includes APPs. APPs allocated 0.80 FTE

Tulare County & Kings County Physician Needs Model

Specialty	Population to Support One Physician	Tulare County & Kings County: Gross Physician Need	FTE Physician Supply	Net Need (Surplus)	Current Supply % of Need
Primary Care					
Adult Primary Care (FM & IM)*	2,000	307.5	259.6	47.9	84.4%
Pediatrics (General)	8,000	76.9	60.3	16.6	78.4%
Medical					
Allergy & Immunology	75,000	8.2	5.5	2.7	67.1%
Cardiology	22,000	27.9	16.4	11.5	58.7%
- Electrophysiology	220,000	2.8	0.5	2.3	17.9%
- Interventional/Invasive	63,000	9.8	7.2	2.6	73.8%
- Medical/Non-Invasive	40,000	15.4	8.7	6.7	56.6%
Dermatology	40,000	15.4	5.0	10.4	32.5%
Endocrinology	60,000	10.3	3.1	7.2	30.2%
Gastroenterology	40,000	15.4	6.9	8.5	45.1%
Infectious Diseases	90,000	6.8	1.5	5.3	21.2%
Nephrology	85,000	7.2	14.0	(6.8)	193.5%
Neurology	44,000	14.0	8.3	5.7	59.4%
Obstetrics/Gynecology	10,000	61.5	38.1	23.4	61.9%
Oncology/Hematology	36,000	17.1	5.5	11.6	32.2%
Gynecology Oncology	100,000	6.2	0.0	6.2	0.0%
Physical Medicine & Rehabilitation	85,000	7.2	5.5	1.7	76.0%
Psychiatry	20,000	30.8	17.6	13.2	57.2%
Pulmonary Medicine	85,000	7.2	2.8	4.4	38.7%
Radiation Oncology	95,000	6.5	2.8	3.7	43.2%
Rheumatology	100,000	6.2	2.6	3.6	42.3%
Surgical					
Surgery					
- Cardiothoracic/vascular Surgery	150,000	4.1	2.0	2.1	48.8%
- Bariatric Surgery	100,000	6.2	0.5	5.7	8.1%
- Colon & Rectal Surgery	200,000	3.1	0.0	3.1	0.0%
- General Surgery	20,000	30.8	16.6	14.2	53.8%
- Vascular Surgery	125,000	4.9	3.8	1.1	76.2%
Neurosurgery	85,000	7.2	4.0	3.2	55.3%
Ophthalmology	34,000	18.1	10.1	8.0	55.8%
Orthopedic Surgery					
- General/Sports Medicine	26,000	23.7	9.8	13.9	41.4%
- Foot/Ankle	295,000	2.1	0.0	2.1	0.0%
- Hand Surgery	225,000	2.7	0.0	2.7	0.0%
- Total Joint Reconstructive Surgery	175,000	3.5	0.7	2.8	19.9%
- Trauma	160,000	3.8	0.3	3.5	7.8%
Otorhinolaryngology	37,000	16.6	5.1	11.5	30.7%
Plastic/Reconstructive Surgery	90,000	6.8	2.0	4.8	29.3%
Spine Surgery	175,000	3.5	1.9	1.6	54.1%
Urology	32,000	19.2	5.4	13.8	27.8%
Service Area Population		**615,047**			Need
					Adequate Supply

Note: Ratios rounded.

*Primary Care Physician Supply includes APPs. APPs allocated 0.80 FTE

PSA Physician Needs Model

Specialty	Population to Support One Physician	KDMC PSA Gross Physician Need	KDMC PSA FTE Physician Supply	KDMC PSA Net Need (Surplus)	KDMC PSA Current Supply % of Need
Primary Care					
Adult Primary Care (FM & IM)*	2,000	114.4	158.9	(44.5)	138.9%
Pediatrics (General)	8,000	28.6	30.4	(1.8)	106.3%
Medical					
Allergy & Immunology	75,000	3.1	4.7	(1.6)	152.4%
Cardiology	22,000	10.4	11.2	(0.8)	107.8%
- Electrophysiology	220,000	1.0	0.5	0.5	48.1%
- Interventional/Invasive	63,000	3.6	5.0	(1.4)	137.7%
- Medical/Non-Invasive	40,000	5.7	5.7	0.0	99.6%
Dermatology	40,000	5.7	4.0	1.7	69.9%
Endocrinology	60,000	3.8	1.9	1.9	49.8%
Gastroenterology	40,000	5.7	5.0	0.7	87.9%
Infectious Diseases	90,000	2.5	1.5	1.0	57.0%
Nephrology	85,000	2.7	11.8	(9.1)	438.4%
Neurology	44,000	5.2	6.8	(1.6)	130.8%
Obstetrics/Gynecology	10,000	22.9	16.2	6.7	70.8%
Oncology/Hematology	36,000	6.4	3.0	3.4	47.2%
Gynecology Oncology	100,000	2.3	0.0	2.3	0.0%
Physical Medicine & Rehabilitation	85,000	2.7	5.3	(2.6)	196.9%
Psychiatry	20,000	11.4	11.8	(0.4)	103.1%
Pulmonary Medicine	85,000	2.7	1.7	1.0	63.2%
Radiation Oncology	95,000	2.4	1.8	0.6	74.7%
Rheumatology	100,000	2.3	1.6	0.7	69.9%
Surgical					
Surgery					
- Cardiothoracic/vascular Surgery	150,000	1.5	2.0	(0.5)	131.1%
- Bariatric Surgery	100,000	2.3	0.5	1.8	21.9%
- Colon & Rectal Surgery	200,000	1.1	0.0	1.1	0.0%
- General Surgery	20,000	11.4	9.8	1.6	85.7%
- Vascular Surgery	125,000	1.8	2.9	(1.1)	158.4%
Neurosurgery	85,000	2.7	4.0	(1.3)	148.6%
Ophthalmology	34,000	6.7	8.2	(1.5)	121.8%
Orthopedic Surgery					
- General/Sports Medicine	26,000	8.8	6.3	2.5	71.6%
- Foot/Ankle	295,000	0.8	0.0	0.8	0.0%
- Hand Surgery	225,000	1.0	0.0	1.0	0.0%
- Total Joint Reconstructive Surgery	175,000	1.3	0.7	0.6	53.5%
- Trauma	160,000	1.4	0.3	1.1	21.0%
Otorhinolaryngology	37,000	6.2	2.3	3.9	37.2%
Plastic/Reconstructive Surgery	90,000	2.5	2.0	0.5	78.7%
Spine Surgery	175,000	1.3	1.3	0.0	99.4%
Urology	32,000	7.2	1.8	5.4	24.5%
Service Area Population		**228,808**			Need
					Adequate Supply

Note: Ratios rounded.

*Primary Care Physician Supply includes APPs. APPs allocated 0.80 FTE

TSA Physician Needs Model

Specialty	Population to Support One Physician	KDMC TSA Gross Physician Need	KDMC TSA FTE Physician Supply	KDMC TSA Net Need (Surplus)	KDMC TSA Current Supply % of Need
Primary Care					
Adult Primary Care (FM & IM)*	2,000	298.7	243.0	55.7	81.3%
Pediatrics (General)	8,000	74.7	59.3	15.4	79.4%
Medical					
Allergy & Immunology	75,000	8.0	5.5	2.5	69.0%
Cardiology	22,000	27.1	16.4	10.7	60.4%
- Electrophysiology	220,000	2.7	0.5	2.2	18.4%
- Interventional/Invasive	63,000	9.5	7.2	2.3	75.9%
- Medical/Non-Invasive	40,000	14.9	8.7	6.2	58.2%
Dermatology	40,000	14.9	5.0	9.9	33.5%
Endocrinology	60,000	10.0	3.1	6.9	31.1%
Gastroenterology	40,000	14.9	6.9	8.0	46.4%
Infectious Diseases	90,000	6.6	1.5	5.1	21.8%
Nephrology	85,000	7.0	14.0	(7.0)	199.2%
Neurology	44,000	13.6	8.3	5.3	61.1%
Obstetrics/Gynecology	10,000	59.7	37.8	21.9	63.3%
Oncology/Hematology	36,000	16.6	5.5	11.1	33.1%
Gynecology Oncology	100,000	6.0	0.0	6.0	0.0%
Physical Medicine & Rehabilitation	85,000	7.0	5.5	1.5	78.3%
Psychiatry	20,000	29.9	17.6	12.3	58.9%
Pulmonary Medicine	85,000	7.0	2.8	4.2	39.8%
Radiation Oncology	95,000	6.3	2.8	3.5	44.5%
Rheumatology	100,000	6.0	2.6	3.4	43.5%
Surgical					
Surgery					
- Cardiothoracic/vascular Surgery	150,000	4.0	2.0	2.0	50.2%
- Bariatric Surgery	100,000	6.0	0.5	5.5	8.4%
- Colon & Rectal Surgery	200,000	3.0	0.0	3.0	0.0%
- General Surgery	20,000	29.9	16.6	13.3	55.4%
- Vascular Surgery	125,000	4.8	3.8	1.0	78.5%
Neurosurgery	85,000	7.0	4.0	3.0	56.9%
Ophthalmology	34,000	17.6	10.1	7.5	57.5%
Orthopedic Surgery					
- General/Sports Medicine	26,000	23.0	9.8	13.2	42.6%
- Foot/Ankle	295,000	2.0	0.0	2.0	0.0%
- Hand Surgery	225,000	2.7	0.0	2.7	0.0%
- Total Joint Reconstructive Surgery	175,000	3.4	0.7	2.7	20.5%
- Trauma	160,000	3.7	0.3	3.4	8.0%
Otorhinolaryngology	37,000	16.1	5.1	11.0	31.6%
Plastic/Reconstructive Surgery	90,000	6.6	2.0	4.6	30.1%
Spine Surgery	175,000	3.4	1.9	1.5	55.7%
Urology	32,000	18.7	5.4	13.3	28.7%
Service Area Population		**597,438**			Need
					Adequate Supply

Note: Ratios rounded.

*Primary Care Physician Supply includes APPs. APPs allocated 0.80 FTE

FPSA Physician Needs Model

Specialty	Population to Support One Physician	KDMC FPSA Gross Physician Need	KDMC FPSA FTE Physician Supply	KDMC FPSA Net Need (Surplus)	KDMC FPSA Current Supply % of Need
Primary Care					
Adult Primary Care (FM & IM)*	2,000	225.7	207.0	18.7	91.7%
Pediatrics (General)	8,000	56.4	49.7	6.7	88.1%
Medical					
Allergy & Immunology	75,000	6.0	5.3	0.7	87.2%
Cardiology	22,000	20.5	14.2	6.3	69.3%
- Electrophysiology	220,000	2.1	0.5	1.6	24.4%
- Interventional/Invasive	63,000	7.2	6.0	1.2	83.7%
- Medical/Non-Invasive	40,000	11.3	7.7	3.6	68.2%
Dermatology	40,000	11.3	4.3	7.0	38.1%
Endocrinology	60,000	7.5	2.9	4.6	38.5%
Gastroenterology	40,000	11.3	5.8	5.5	51.7%
Infectious Diseases	90,000	5.0	1.5	3.5	28.9%
Nephrology	85,000	5.3	13.9	(8.6)	261.7%
Neurology	44,000	10.3	7.8	2.5	76.0%
Obstetrics/Gynecology	10,000	45.1	28.8	16.3	63.8%
Oncology/Hematology	36,000	12.5	5.2	7.3	41.5%
Gynecology Oncology	100,000	4.5	0.0	4.5	0.0%
Physical Medicine & Rehabilitation	85,000	5.3	5.5	(0.2)	103.6%
Psychiatry	20,000	22.6	11.8	10.8	52.3%
Pulmonary Medicine	85,000	5.3	2.7	2.6	50.8%
Radiation Oncology	95,000	4.8	2.8	2.0	58.9%
Rheumatology	100,000	4.5	1.6	2.9	35.4%
Surgical					
Surgery					
- Cardiothoracic/vascular Surgery	150,000	3.0	2.0	1.0	66.5%
- Bariatric Surgery	100,000	4.5	0.5	4.0	11.1%
- Colon & Rectal Surgery	200,000	2.3	0.0	2.3	0.0%
- General Surgery	20,000	22.6	14.6	8.0	64.5%
- Vascular Surgery	125,000	3.6	3.3	0.3	91.4%
Neurosurgery	85,000	5.3	4.0	1.3	75.3%
Ophthalmology	34,000	13.3	9.6	3.7	72.3%
Orthopedic Surgery					
- General/Sports Medicine	26,000	17.4	8.3	9.1	47.8%
- Foot/Ankle	295,000	1.5	0.0	1.5	0.0%
- Hand Surgery	225,000	2.0	0.0	2.0	0.0%
- Total Joint Reconstructive Surgery	175,000	2.6	0.7	1.9	27.1%
- Trauma	160,000	2.8	0.3	2.5	10.6%
Otorhinolaryngology	37,000	12.2	3.4	8.8	27.9%
Plastic/Reconstructive Surgery	90,000	5.0	2.0	3.0	39.9%
Spine Surgery	175,000	2.6	1.3	1.3	50.4%
Urology	32,000	14.1	3.4	10.7	23.7%
Service Area Population		**451,460**			Need
					Adequate Supply

Note: Ratios rounded.

*Primary Care Physician Supply includes APPs. APPs allocated 0.80 FTE

GASH Community Physician Needs Model

Specialty	Population to Support One Physician	KDMC GASH Gross Physician Need	KDMC GASH FTE Physician Supply	KDMC GASH Net Need (Surplus)	KDMC GASH Current Supply % of Need
Primary Care					
Adult Primary Care (FM & IM)*	2,000	194.2	189.9	4.3	97.8%
Pediatrics (General)	8,000	48.6	48.4	0.2	99.7%
Medical					
Allergy & Immunology	75,000	5.2	5.3	(0.1)	101.4%
Cardiology	22,000	17.6	14.2	3.4	80.5%
- Electrophysiology	220,000	1.8	0.5	1.3	28.3%
- Interventional/Invasive	63,000	6.2	6.0	0.2	97.3%
- Medical/Non-Invasive	40,000	9.7	7.7	2.0	79.3%
Dermatology	40,000	9.7	4.3	5.4	44.3%
Endocrinology	60,000	6.5	2.9	3.6	44.8%
Gastroenterology	40,000	9.7	5.8	3.9	60.0%
Infectious Diseases	90,000	4.3	1.5	2.8	33.6%
Nephrology	85,000	4.6	13.9	(9.3)	304.2%
Neurology	44,000	8.8	7.8	1.0	88.4%
Obstetrics/Gynecology	10,000	38.8	27.7	11.1	71.3%
Oncology/Hematology	36,000	10.8	5.2	5.6	48.2%
Gynecology Oncology	100,000	3.9	0.0	3.9	0.0%
Palliative Medicine (based on senior population)	20,000	2.3	1.0	1.3	43.4%
Physical Medicine & Rehabilitation	85,000	4.6	5.5	(0.9)	120.4%
Psychiatry	20,000	19.4	11.8	7.6	60.8%
Pulmonary Medicine	85,000	4.6	2.7	1.9	59.1%
Radiation Oncology	95,000	4.1	2.8	1.3	68.5%
Rheumatology	100,000	3.9	1.6	2.3	41.2%
Surgical					
Surgery					
- Cardiothoracic/vascular Surgery	150,000	2.6	2.0	0.6	77.2%
- Bariatric Surgery	100,000	3.9	0.5	3.4	12.9%
- Colon & Rectal Surgery	200,000	1.9	0.0	1.9	0.0%
- General Surgery	20,000	19.4	14.6	4.8	74.9%
- Vascular Surgery	125,000	3.1	3.3	(0.2)	106.2%
Neurosurgery	85,000	4.6	4.0	0.6	87.5%
Ophthalmology	34,000	11.4	9.6	1.8	84.0%
Orthopedic Surgery					
- General/Sports Medicine	26,000	14.9	8.3	6.6	55.6%
- Foot/Ankle	295,000	1.3	0.0	1.3	0.0%
- Hand Surgery	225,000	1.7	0.0	1.7	0.0%
- Total Joint Reconstructive Surgery	175,000	2.2	0.7	1.5	31.5%
- Trauma	160,000	2.4	0.3	2.1	12.4%
Otorhinolaryngology	37,000	10.5	3.4	7.1	32.4%
Plastic/Reconstructive Surgery	90,000	4.3	2.0	2.3	46.3%
Spine Surgery	175,000	2.2	1.3	0.9	58.6%
Urology	32,000	12.1	3.4	8.7	27.6%
Service Area Population		**388,430**			Need / Adequate Supply

Note: Ratios rounded.

*Primary Care Physician Supply includes APPs. APPs allocated 0.80 FTE

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Physician Market Summary

Physician Market Age Profile

The TSA has approximately 500 physicians of which an estimated 30% are over the age of 60 and the average age is 52.8. Certain specialties are vulnerable from a succession planning standpoint.

Physician Market by Type

While physician by type (PCP/medical/surgical/) are well represented, the area continues to have retention issues e.g. departures of APPs after fulfilling requirements of student loan forgiveness programs (est. 2-3 years).

Physician Distribution by Community

Physicians in the TSA are predominantly located in the Cities of Visalia, Hanford, Porterville, and Tulare.

Sub-market Physician Supply Comparison

The TSA is the most underserved service area overall while the PSA has the highest per capita physician supply.

Physician by Type

Primary Care	Medical Specialists	Surgical Specialists
210	180	90
43.8% of market	**37.5% of market**	**18.8% of market**

Physician Market Profile: Age by Specialty

Kaweah Delta Medical Center TSA
Physician Market Age Profile

Specialty	Total Physician	Average Age	Physician Age <40	41-50	51-60	61-70	71 +	Senior Workforce % Age 61+
Primary Care								
Family Practice/General Practice	98	53.7	21	22	23	20	12	33%
Internal Medicine	43	52.7	11	6	15	9	2	26%
Pediatrics	69	49.4	22	16	17	12	2	20%
Subtotal	210		54	44	55	41	16	1
Medical Specialties								
Allergy & Immunology	9	55.2	0	3	4	2	0	22%
Cardiology	20	58.5	1	4	4	10	1	55%
Dermatology	9	57.3	0	3	2	3	1	44%
Endocrinology	4	46.7	1	2	1	0	0	0%
Gastroenterology	9	59.3	1	0	1	7	0	78%
Infectious Diseases	2	54.0	0	1	1	0	0	0%
Nephrology	22	50.4	5	9	3	3	2	23%
Neurology	10	52.2	2	2	5	1	0	10%
Obstetrics/Gynecology	44	55.0	9	8	12	7	8	34%
Oncology/Hematology	7	64.6	0	0	1	5	1	86%
Physical Medicine & Rehab	10	48.3	3	2	4	1	0	10%
Psychiatry	20	49.9	4	10	2	2	2	20%
Pulmonary Medicine	7	52.1	1	2	2	2	0	29%
Radiation Oncology / Radiation Therapy	4	60.0	1	0	0	2	1	75%
Rheumatology	3	62.0	0	0	1	2	0	67%
Subtotal	180		28	46	43	47	16	35%
Surgical Specialties								
Surgery								
Cardiothoracic/vascular Surgery	2	48.5	0	2	0	0	0	0%
Bariatric Surgery	1	37.0	1	0	0	0	0	0%
General Surgery	20	49.6	3	9	3	4	1	25%
Vascular Surgery	7	45.3	3	2	2	0	0	0%
Neurosurgery	12	52.1	1	6	2	2	1	25%
Ophthalmology	15	48.5	6	3	3	2	1	20%
Orthopedic Surgery	15	52.8	4	5	1	2	3	33%
Otorhinolaryngology	8	59.9	1	1	1	4	1	63%
Plastic Surgery	3	59.3	0	1	1	0	1	33%
Urology	7	61.5	1	0	1	3	2	71%
Subtotal	90		20	29	14	17	10	30%
Physician Market Total	**480**	**52.8**	**102**	**119**	**112**	**105**	**42**	**31%**

- Specialties with an aging workforce include:
  - Primary Care
  - Cardiology
  - Dermatology
  - GI
  - OB/Gyn
  - Oncology/Hematology
  - Radiation Oncology
  - Rheumatology
  - Orthopedic Surgery
  - ENT
  - Urology

Physician Supply Service Area Comparison

Sub-market Physician Supply Comparison	KDMC					
	GASH	PSA	TSA	FPSA	Tulare County	Kings County
Population (2020)	388,430	228,808	597,438	451,460	463,814	151,233
% Pediatrics (0-17)	29.9%	29.0%	29.8%	30.3%	30.2%	27.7%
% Seniors (65+)	11.9%	12.4%	11.7%	11.6%	11.8%	10.6%
Adult PCP[(1)]						
Total FTEs	238.3	189.3	302.3	256.7	256.7	63.3
1 PCP per X Population	1,630	1,209	1,977	1,759	1,807	2,391
Medical Specialists						
Total FTEs (Current supply)	112.9	88.2	135.3	114.0	113.8	21.8
1 Medical Specialist per X Population	3,440	2,593	4,416	3,959	4,075	6,953
Surgical Specialists						
Total FTEs (Current supply)	53.3	42.1	62.1	53.3	53.3	8.8
1 Surgical Specialist per X Population	7,288	5,441	9,628	8,470	8,702	17,284

Note: Specialist counts are for specialties evaluated in this analysis versus all specialties. For example, podiatry is not

[(1)] Includes APPs

- The PSA has the highest per capita physician supply (primary care, medical specialties, and surgical specialties).
- The GASH has the second-highest per capita physician supply across primary care, medical, and surgical care.
- KDMC's TSA is the most underserved service area overall.

Comparison of Physician Needs by Service Area

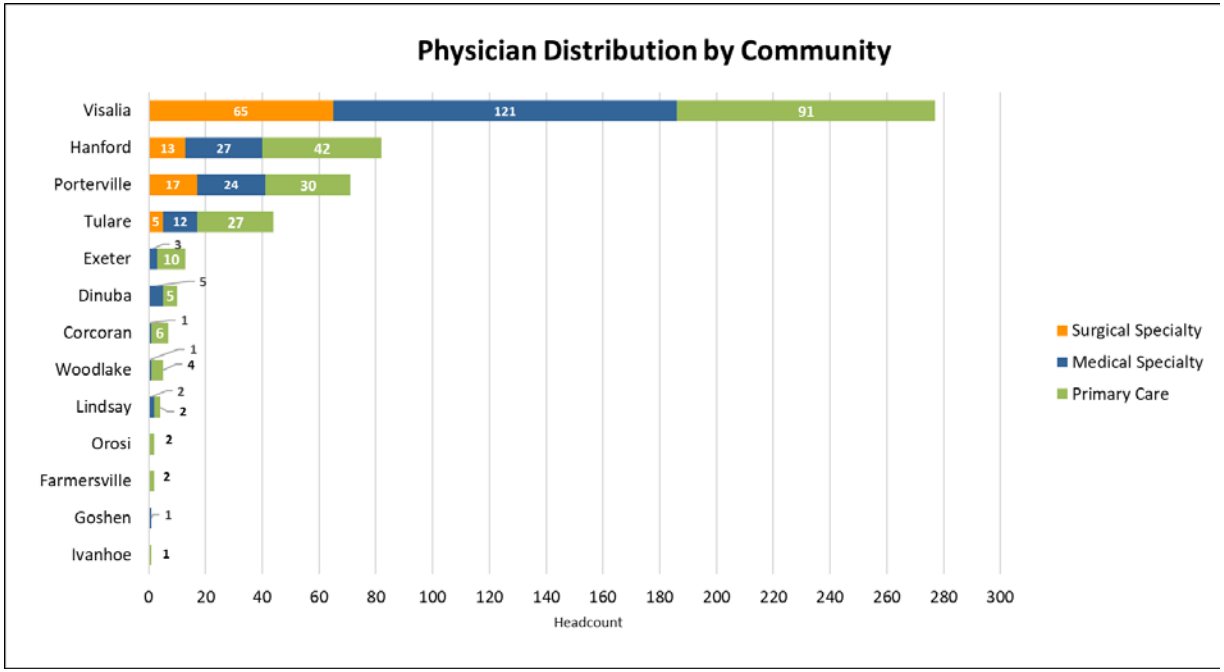
Specialty	Population to Support One Physician	KDMC GASH Net Need (Surplus)	Tulare County Net Need (Surplus)	Kings County Net Need (Surplus)	Tulare County & Kings County Net Need (Surplus)	KDMC PSA Net Need (Surplus)	KDMC TSA Net Need (Surplus)	KDMC FPSA Net Need (Surplus)
Primary Care								
Adult Primary Care (FM & IM)*	2,000	4.3	24.9	22.9	47.9	(44.5)	55.7	18.7
Pediatrics (General)	8,000	0.2	8.3	8.3	16.6	(1.8)	15.4	6.7
Medical								
Allergy & Immunology	75,000	(0.1)	0.9	1.7	2.7	(1.6)	2.5	0.7
Cardiology	22,000	3.4	6.9	4.7	11.5	(0.8)	10.7	6.3
- Electrophysiology	220,000	1.3	1.6	0.7	2.3	0.5	2.2	1.6
- Interventional/Invasive	63,000	0.2	1.4	1.2	2.6	(1.4)	2.3	1.2
- Medical/Non-Invasive	40,000	2.0	3.9	2.8	6.7	0.0	6.2	3.6
Dermatology	40,000	5.4	7.3	3.1	10.4	1.7	9.9	7.0
Endocrinology	60,000	3.6	4.8	2.3	7.2	1.9	6.9	4.6
Gastroenterology	40,000	3.9	5.8	2.7	8.5	0.7	8.0	5.5
Infectious Diseases	90,000	2.8	3.7	1.7	5.3	1.0	5.1	3.5
Nephrology	85,000	(9.3)	(8.4)	1.7	(6.8)	(9.1)	(7.0)	(8.6)
Neurology	44,000	1.0	2.7	2.9	5.7	(1.6)	5.3	2.5
Obstetrics/Gynecology	10,000	11.1	17.8	5.6	23.4	6.7	21.9	16.3
Oncology/Hematology	36,000	5.6	7.7	3.9	11.6	3.4	11.1	7.3
Gynecology Oncology	100,000	3.9	4.6	1.5	6.2	2.3	6.0	4.5
Physical Medicine & Rehabilitation	85,000	(0.9)	0.0	1.8	1.7	(2.6)	1.5	(0.2)
Psychiatry	20,000	7.6	11.4	1.8	13.2	(0.4)	12.3	10.8
Pulmonary Medicine	85,000	1.9	2.8	1.7	4.4	1.0	4.2	2.6
Radiation Oncology	95,000	1.3	2.1	1.6	3.7	0.6	3.5	2.0
Rheumatology	100,000	2.3	3.0	0.5	3.6	0.7	3.4	2.9
Surgical								
Surgery								
- Cardiothoracic/vascular Surgery	150,000	0.6	1.1	1.0	2.1	(0.5)	2.0	1.0
- Bariatric Surgery	100,000	3.4	4.1	1.5	5.7	1.8	5.5	4.0
- Colon & Rectal Surgery	200,000	1.9	2.3	0.8	3.1	1.1	3.0	2.3
- General Surgery	20,000	4.8	8.6	5.6	14.2	1.6	13.3	8.0
- Vascular Surgery	125,000	(0.2)	0.4	0.7	1.1	(1.1)	1.0	0.3
Neurosurgery	85,000	0.6	1.5	1.8	3.2	(1.3)	3.0	1.3
Ophthalmology	34,000	1.8	4.0	3.9	8.0	(1.5)	7.5	3.7
Orthopedic Surgery								
- General/Sports Medicine	26,000	6.6	9.5	4.3	13.9	2.5	13.2	9.1
- Foot/Ankle	295,000	1.3	1.6	0.5	2.1	0.8	2.0	1.5
- Hand Surgery	225,000	1.7	2.1	0.7	2.7	1.0	2.7	2.0
- Total Joint Reconstructive Surgery	175,000	1.5	2.0	0.9	2.8	0.6	2.7	1.9
- Trauma	160,000	2.1	2.6	0.9	3.5	1.1	3.4	2.5
Otorhinolaryngology	37,000	7.1	9.1	2.4	11.5	3.9	11.0	8.8
Plastic/Reconstructive Surgery	90,000	2.3	3.2	1.7	4.8	0.5	4.6	3.0
Spine Surgery	175,000	0.9	1.4	0.3	1.6	0.0	1.5	1.3
Urology	32,000	8.7	11.1	2.7	13.8	5.4	13.3	10.7
Service Area Population	Need	**388,430**	**463,814**	**151,233**	**615,047**	**228,808**	**597,438**	**451,460**
	Adequate Supply							

Note: Ratios rounded

*Primary Care Physician Supply includes APPs. APPs allocated 0.80 FTE

*Same table as pg 20

Physician Distribution by Community



- Physicians are predominantly located within the Cities of Visalia, Hanford, Porterville, and Tulare.
- The City of Visalia has high representation of medical specialties and low representation of primary care physicians.

Physician Workforce Vulnerability Analysis

- The table on the following page highlights specialty vulnerability within the TSA based on key factors including:
  - Current need
  - Succession planning
  - Aging workforce
- The most vulnerable specialties include:
  - Primary Care
  - Gastroenterology
  - Oncology/Hematology
  - Urology
  - Orthopedic Surgery
  - ENT

Physician Workforce Vulnerability Analysis – cont'd

KDMC TSA	Total Physicians	Market Indicators			Succession Planning		
Specialty	Headcount	Current Supply % of Need	FTEs Needed*	Expressed Need through Interviews	% of Physicians Age 60+	Departure/ Retirement Expressed	Risk Level
Adult Primary Care (FM & IM)	141	81%	55.7	Yes	33%	Yes	High
Gastroenterology	9	46%	8.0	Yes	78%	Yes	High
Oncology/Hematology	7	33%	11.1	Yes	86%	Yes	High
Urology	7	29%	13.3	Yes	71%	Yes	High
Orthopedic Surgery	13	69%	24.0	Yes	38%	Yes	High
Otorhinolaryngology	8	32%	11.0	Yes	63%	Yes	High
Cardiology	20	60%	10.7	No	55%	Yes	Moderate
General Surgery[(1)]	21	56%	21.8	Yes	24%	Yes	Moderate
Radiation Oncology	4	45%	3.5	No	75%	Yes	Moderate
Dermatology	9	33%	9.9	Yes	33%	Yes	Moderate
Obstetrics/Gynecology	44	63%	21.9	Yes	27%	Yes	Moderate
Rheumatology	3	44%	3.4	Yes	67%	No	Moderate
Endocrinology	4	31%	6.9	Yes	n/a	Yes	Moderate
Psychiatry	20	59%	12.3	Yes	15%	No	Moderate
Infectious Diseases	2	22%	5.1	No	n/a	No	Moderate
Allergy & Immunology	9	69%	2.5	No	33%	Yes	Moderate
Cardiothoracic/vascular Surgery	2	50%	2.0	No	n/a	No	Low
Vascular Surgery	7	78%	1.0	No	14%	No	Low
Neurosurgery	9	57%	3.0	No	33%	Yes	Low
Pulmonary Medicine	7	40%	4.2	No	29%	No	Low
Neurology	10	61%	5.3	Yes	10%	No	Low
Ophthalmology	15	57%	7.5	No	20%	No	Low
Pediatrics (General)	69	79%	15.4	No	23%	No	Low
Physical Medicine & Rehabilitation	10	78%	1.5	No	10%	No	Low
Plastic/Reconstructive Surgery	3	30%	4.6	No	33%	Yes	Low
Nephrology	22	199%	(7.0)	No	23%	No	Low

* () indicates adequate supply
[(1)]General Surgery incudes bariatric surgery and colorectal surgery
Note: Ages for all physcians not available. The above metrics are best estiamtes with current data.

Physician Market Profile: Identified Succession Planning

- Using 65 years of age as a benchmark for retirement/practice slowdown, the following physicians should be monitored for succession planning.

Last Name	First Name	Age	Specialty
Aminian	A	70	Allergy & Immunology
Baz	Malik	69	Allergy & Immunology
Meyer	Barry	75	Cardiology
Behl	Ashok	69	Cardiology
Gupta	Vinod	69	Cardiology
Cislowski	David	68	Cardiology
Johnson	Dennis	68	Cardiology
Verma	Ashok	68	Cardiology
Lively	Harry	65	Cardiology
Whitaker	Duane	73	Dermatology
Pearson	Earl	70	Dermatology
Villard	Christopher	68	Dermatology
Garcia	Raynado	82	Family Practice/General Practice
Marconi	Ronald	77	Family Practice/General Practice
Weisenberger	John	77	Family Practice/General Practice
Castillo	Fausto	75	Family Practice/General Practice
Kumar	Ravi	75	Family Practice/General Practice
Mimura	Gary	73	Family Practice/General Practice
Pentschev	Stefan	73	Family Practice/General Practice
Evans	Thomas	72	Family Practice/General Practice
Molina	Arthur	71	Family Practice/General Practice
Nguyen	Chi	71	Family Practice/General Practice
Roach	William	71	Family Practice/General Practice
Velasco	Oscar	71	Family Practice/General Practice
Sorensen	Eric	70	Family Practice/General Practice
Krishna	Vijay	69	Family Practice/General Practice
Sidhu	Jasvir	69	Family Practice/General Practice
Espinosa	Andrea	67	Family Practice/General Practice
Metts	Julius	67	Family Practice/General Practice
Cruz	Danilo	66	Family Practice/General Practice
Kamboj	Pradeep	66	Family Practice/General Practice
Miyakawa	Jon	66	Family Practice/General Practice
Soloniuk-Tays	Gaylene	66	Family Practice/General Practice
Welden	Arnold	66	Family Practice/General Practice
Booker	John	65	Family Practice/General Practice
Perez	Raul	65	Family Practice/General Practice
Princeton	Harvard	65	Family Practice/General Practice
Shah	Harish	65	Family Practice/General Practice
Zweifler	John	65	Family Practice/General Practice

Last Name	First Name	Age	Specialty
Au	Alvin	65	Gastroenterology
Seralathan	Ramasamy	71	General Surgery
Chiu	Ching	77	Internal Medicine
Reddy	Ravindranath	76	Internal Medicine
Venkatesan	Kalpathy	69	Internal Medicine
Buttan	Vinay	68	Internal Medicine
Jindal	Rakesh	67	Internal Medicine
Woods	Robert	67	Internal Medicine
Nava	Adolph	66	Internal Medicine
Chen	Wei-Tzuoh	77	Nephrology
Heaney	David	73	Nephrology
Haley	Roger	70	Nephrology
Smith	Stephen	70	Nephrology
Thomas	Mohsen	66	Nephrology
Chahil	Boota	65	Neurology
Madsen III	Parley	72	Neurosurgery
Hoyt	Thomas	68	Neurosurgery
Acosta	Luis	77	Obstetrics/Gynecology
Salas	Jose	76	Obstetrics/Gynecology
Saljoughy	Togrol	75	Obstetrics/Gynecology
Nelson	David	72	Obstetrics/Gynecology
Pang	Kin	72	Obstetrics/Gynecology
Siddiqi	Naeem	72	Obstetrics/Gynecology
Khademi	Talaksoon	71	Obstetrics/Gynecology
Taksa	Charles	71	Obstetrics/Gynecology
Enloe	Thomas	70	Obstetrics/Gynecology
Ellsworth	Richard	69	Obstetrics/Gynecology
Hibbert	Morton	69	Obstetrics/Gynecology
Cryns	David	68	Obstetrics/Gynecology
Overton	Katherine	67	Obstetrics/Gynecology
Bryson	David	71	Oncology/Hematology
Baloch	Anwer	68	Oncology/Hematology
Havard	Robert	65	Oncology/Hematology
Kuo	Samuel	65	Oncology/Hematology
Ruda Jr	Joseph	75	Ophthalmology
Beard	Bradley	65	Ophthalmology
Ganti	Shashi	65	Ophthalmology

Last Name	First Name	Age	Specialty
Allyn	Donald	77	Orthopedic Surgery
Redd	Burton	76	Orthopedic Surgery
Tindall	Mark	72	Orthopedic Surgery
Srivastava	Pramod	66	Orthopedic Surgery
Wong	Ronald	72	Otorhinolaryngology
Stillwater	Lyle	69	Otorhinolaryngology
Calloway	Craig	68	Otorhinolaryngology
Nagrani	Kishu	77	Pediatrics
Sidharaju	Rajeswari	75	Pediatrics
Kamboj	Prem	70	Pediatrics
Zorn	Elinor	70	Pediatrics
Haack	Susan	68	Pediatrics
Sobieralski	Theodore	67	Pediatrics
Hall	Kathryn	66	Pediatrics
Hwang	A. Grace	66	Pediatrics
Resa	Ramon	66	Pediatrics
Sidhom	Niazi	66	Pediatrics
Buttan	Poonam	65	Pediatrics
Mitts	Thomas	73	Plastic Surgery
Velosa	Luis	78	Psychiatry
Castillo-Armas	Edgar	67	Psychiatry
Warner	Gregory	69	Pulmonary Medicine
Ramsinghani	Veena	73	Radiation Oncology / Radiation Therapy
Hanalla	Youssef	65	Radiation Oncology / Radiation Therapy
Kim	Owen	65	Radiation Oncology / Radiation Therapy
Boniske	Charles	68	Rheumatology
Bhardwaj	Virinder	72	Urology
Dwivedi	Rajendra	71	Urology
Hong	Tu-Hi	69	Urology

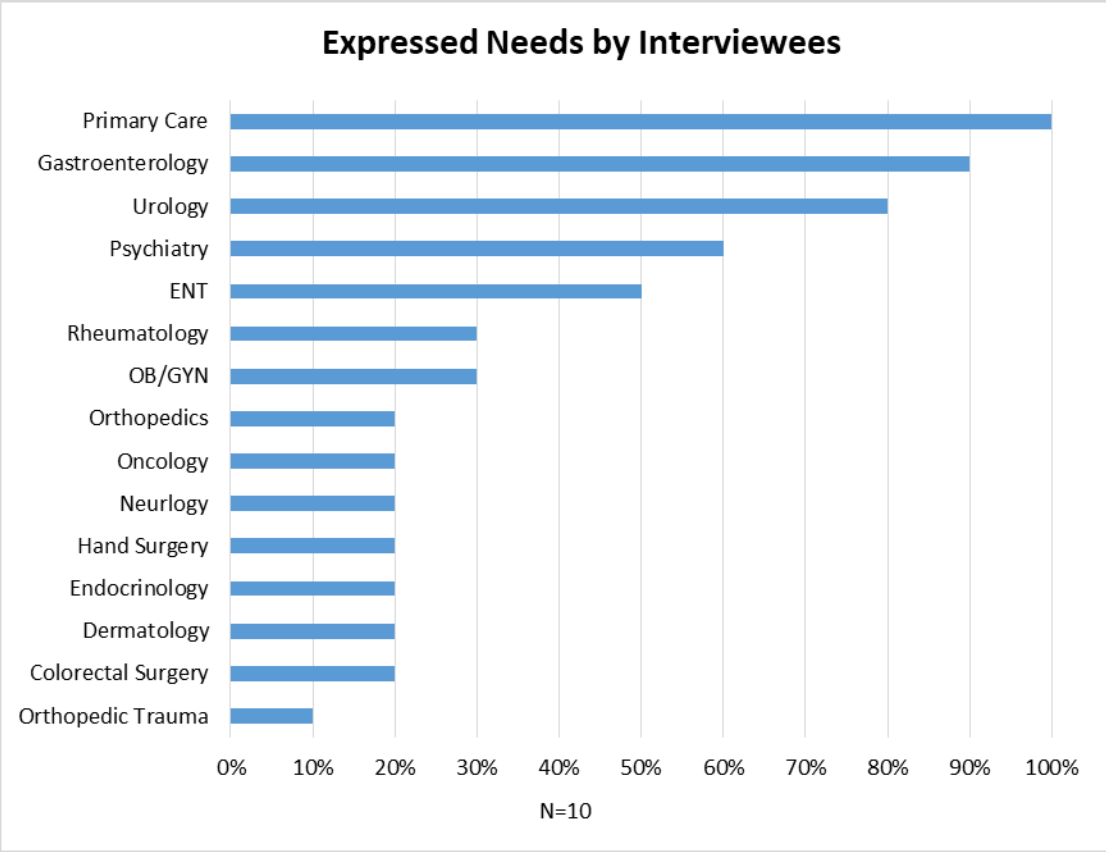
Key Findings/Reflections from Interviews

- KDMC has been and continues to pursue efforts to better meet the needs of the community.
  - The Hospital continues to build new residency programs to help alleviate the physician shortage and improve retention of physicians within the area.
    - Anecdotal reports indicate about half the residents remain in the area post-residency.
    - Residency programs have been geared towards specialties that are difficult to recruit for- e.g. behavioral health, emergency medicine, primary care, and surgery.
  - Kaweah has been flexible in creating different vehicles to support physicians and physician recruitment in the area e.g. Delta Doctors, Key Medical Associates, Visalia Medical Clinic (employed-like).
  - Despite that the area is largely FFS, KDMC has been progressive in its efforts to shift to FFV. The Hospital has created Sequoia Integrated Health to improve care quality/reduce costs under a risk-based model.
  - KDMC is exploring opportunities to build additional capacity to better accommodate growth, enhance access to care, and reduce potential leakage.

Key Findings/Reflections from Interviews – cont'd

- Many have expressed that the health of the Medi-Cal population seeking care in the FQHCs via APPs could be better managed with enhanced care continuity and potentially reduce avoidable emergency department visits.
  - Given the size of the Medi-Cal population in the area and the shift from FFS to FFV, KDMC's efforts to enter into the FQHC space will be important.
    - KDMC has applied for FQHC privilege and is exploring the ability to create a medical home – an integrated delivery model to monitor its patients throughout their continuum of care.
- Interviewees have expressed the following specialties as significant needs due to long wait and/or access issues in the following specialties:
  - Adult primary care
  - GI
  - Urology
  - Psychiatry (adult and pediatric)
  - ENT

Expressed Needs by Interviewees



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Community Physician Needs

Physician Market Profile

Recruitment Recommendations

Appendices

Recommendation: Physician/Provider Recruitment and Development Targets

- Based on qualitative and quantitative analysis of the service area(s) and feedback from interviews, suggested physician/provider needs by specialty are detailed on the following pages.

Recommendation: Physician/Provider Recruitment and Development Targets – cont'd

Specialty	Minimum FTEs Needed	Indicated Need Through Interviews	Potential Succession Planning Needed	Community Need for Physicians	Comments
FM/IM	3-4	✓	✓	✓	➢ Access issues ➢ Practice slow down
Dermatology	1-2	✓	✓	✓	➢ Practice slowdown
Endocrinology	1	✓	✓	✓	➢ Anticipated retirement
Gastroenterology	2-3	✓	✓	✓	➢ Access issues ➢ Anticipated retirement ➢ ED call and I/P coverage issues ➢ Medi-Cal population not being seen
OB/GYN	1-2	✓	✓	✓	➢ Need for OB/Gyns for Medi-Cal population
Palliative Medicine	1	✗	✗	✓	➢ Growing community demand ➢ Only one physician present
Psychiatry	1-2	✓	✗	✓	➢ Access issues ➢ Need for pediatric psychiatrist(s)
Rheumatology	1	✓	✓	✓	➢ Access issues ➢ Leakage

Recommendation: Physician/Provider Recruitment and Development Targets – cont'd

Specialty	Minimum FTEs Needed	Indicated Need Through Interviews	Potential Succession Planning Needed	Community Need for Physicians	Comments
Colon & Rectal Surgery	1	✓	✗	✓	➢ No physician currently present in the area
General Surgery	1-2	✓	✓	✓	➢ Access issues ➢ Growth
Orthopedic Surgery	1	✓	✓	✓	➢ Need for general and subspecialized surgeons ➢ Community leakage
ENT	1-2	✓	✓	✓	➢ Aging workforce ➢ Access and ED call issues
Urology	2-3	✓	✓	✓	➢ Aging workforce ➢ Access issues ➢ ED call and I/P coverage issues ➢ Community leakage
Neurology	1	✓	✗	✓	➢ I/P coverage issues
Cardiology: Electrophysiology	1	✗	✗	✓	➢ Additional depth and breath needed in service line

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Appendix A: Interviewees

KDMC Interviewees	
Name	**Clinical Area/Administration**
Gary Herbst	CEO - Kaweah Delta
Dr. Bruce Hall	Internist/CMO of Kaweah Delta Medical Foundation
Marc Mertz	VP Chief of Strategy
Ryan Gates	VP of Population Health Management
Brent Boyd	CEO of Foundation for Medical Care of Tulare & Kings Counties, Inc.
Dr. Mandeep Bagga	Psychiatry
Dr. Seth Criner	Orthopedic Surgery/Trauma
Dr. Monica Manga	Internal Medicine, Vice Chief of Staff
Dr. Onsy Said	Adult Hospitalist
Dr. Lori Winston	EM/Designated Institution Officer

Appendix B: Physician Market Inventory List

- Attached separately

Appendix C: Service Area Definitions and Demographics

- The following pages provide the below details:
  - KDMC Service Area maps by sub-market (PSA, TSA & FPSA)
  - KDMC Service Area demographics by sub-market (PSA, TSA & FPSA)
  - KDMC GASH
    - Legal definition
    - Area map and area definition
    - Demographics

Appendix C: KDMC Service Area Definitions & Area Depictions

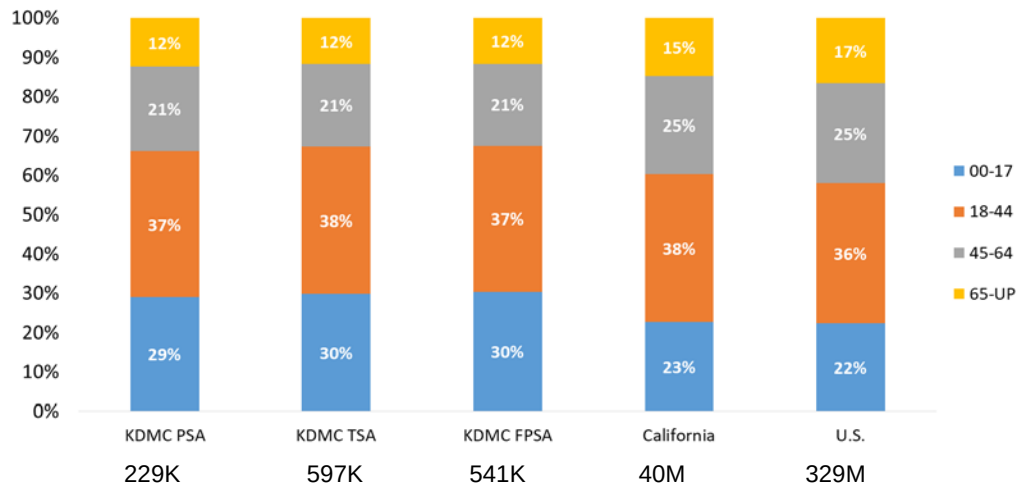
TSA

TSA = PSA + SSA

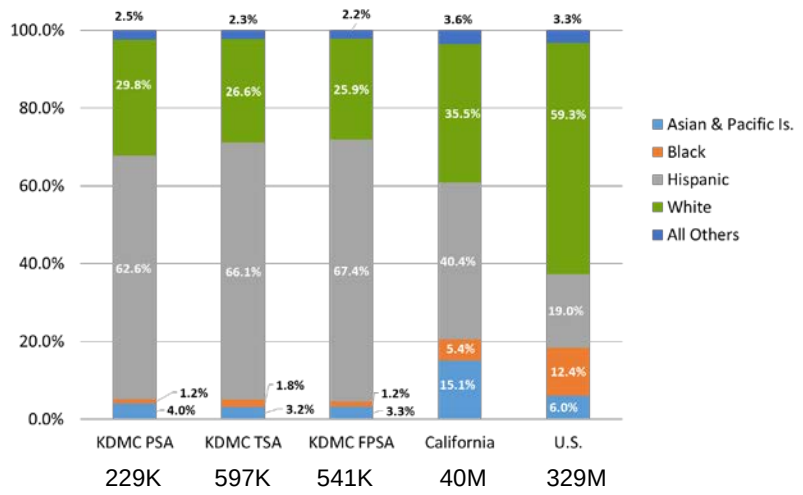
FPSA

Appendix C: Demographic Profile – KDMC Service Area(s)

Population by Age Cohort



Ethnic & Racial Distribution Comparison

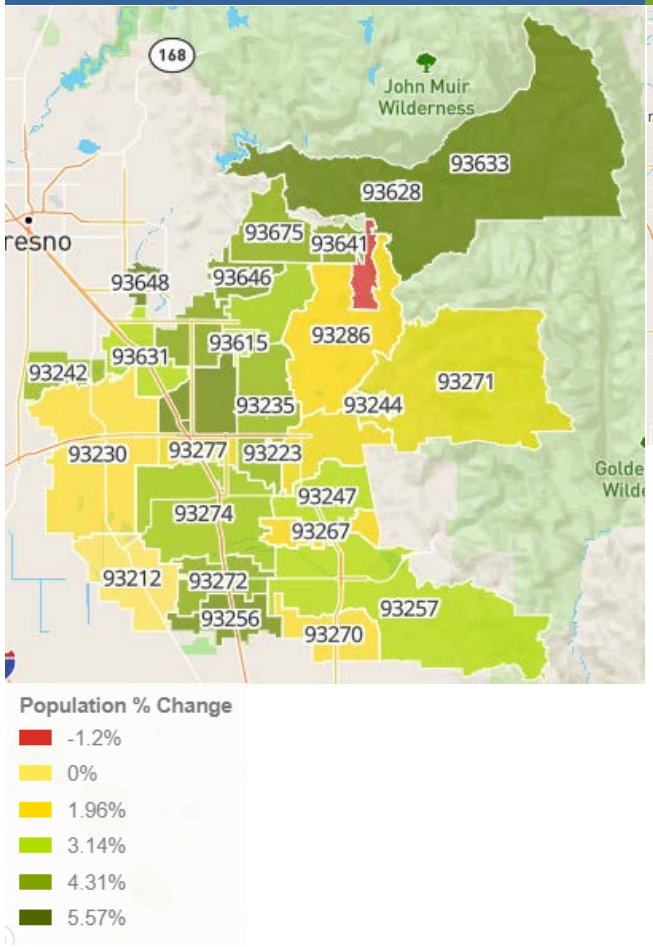


- The strategic service areas have younger populations when compared to California as a whole, and a correspondingly small segment of the senior population (65+).
- The pediatric population (age 00-17) is proportionally higher (30%) when compared to the State (23%).
- The service areas are largely Hispanic and White. Compared to the State, the Hispanic population is proportionally higher (60% to 70% vs 40%).

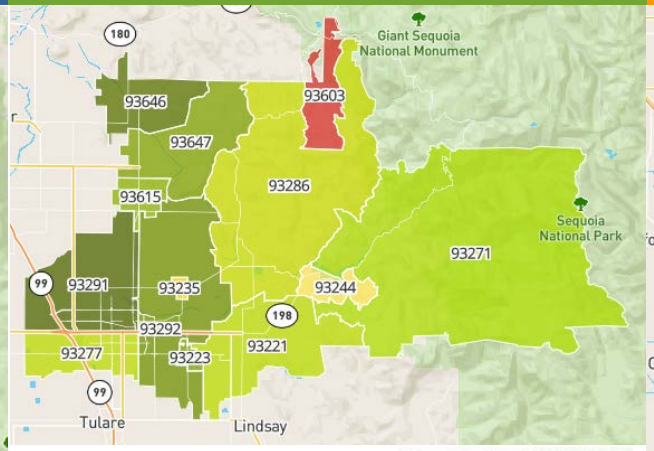
Appendix C: Projected Growth – KDMC Service Area(s)

5-Year Population Growth Projected by ZIP Code

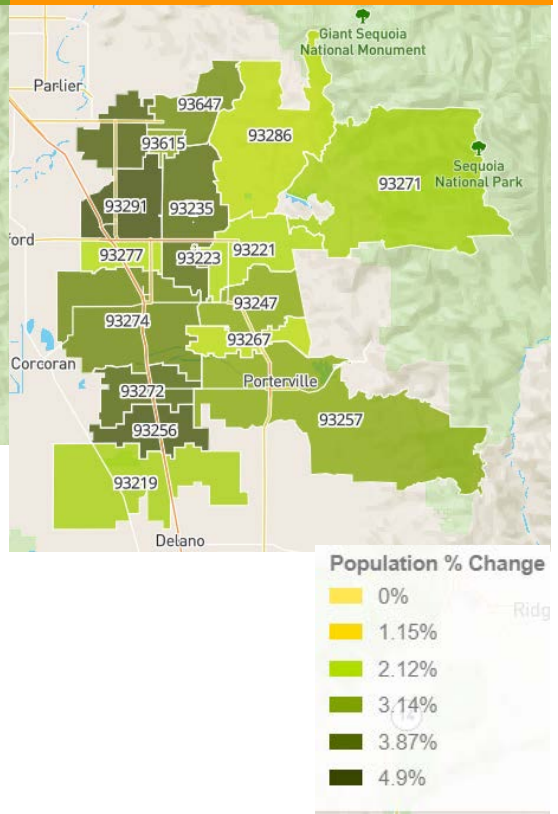
TSA



PSA



FPSA

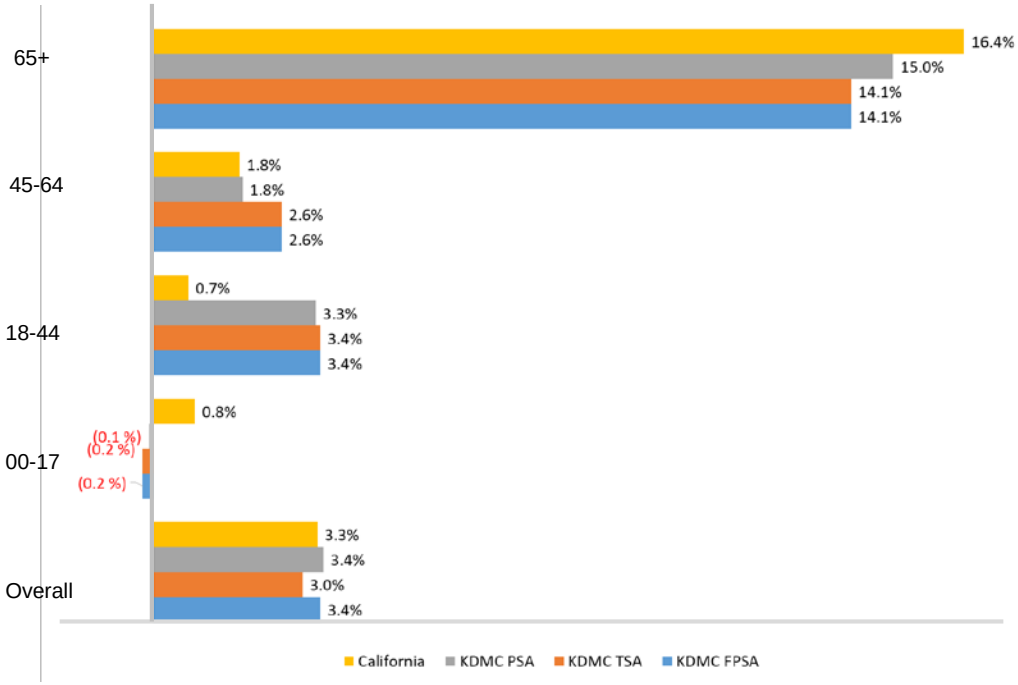


Appendix C: Projected Growth – KDMC Service Area(s) – cont'd

	Current Population		Population 5-Year % Change	
Age Group	Service Area	Percent of Population	Market Growth Rates	California
PSA				
0-17	66,411	29.0%	0%	1%
18-44	84,931	37.1%	3%	1%
45-64	49,171	21.5%	2%	2%
65-UP	28,295	12.4%	15%	16%
Overall	**228,808**	**100%**	**3%**	**3%**
TSA				
0-17	177,999	29.8%	0%	1%
18-44	224,357	37.6%	3%	1%
45-64	125,104	20.9%	2%	2%
65-UP	69,978	11.7%	13%	16%
Overall	**597,438**	**100%**	**3%**	**3%**
FPSA				
0-17	136,926	30.3%	0%	1%
18-44	168,104	37.2%	3%	1%
45-64	94,032	20.8%	3%	2%
65-UP	52,398	11.6%	14%	16%
Overall	**451,460**	**100%**	**3%**	**3%**

Sg2 Market Demographics

Population by Age Cohort
2020 - 2025

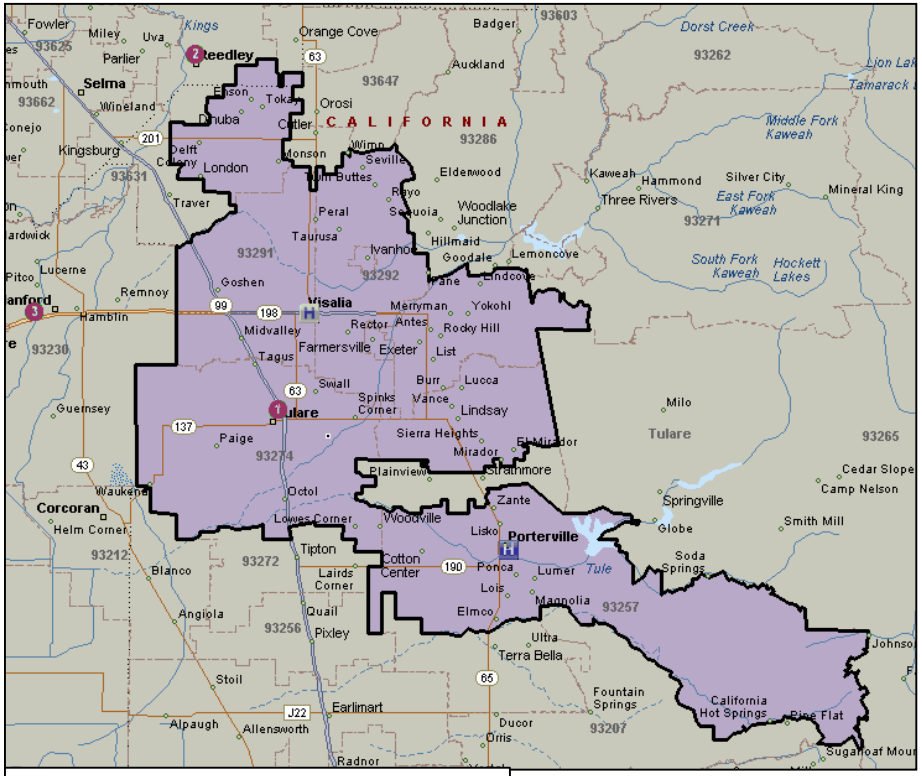


- Overall, the strategic service areas growth trends are similar to that of the State with the exception that the age 18-44 cohort and the age 45-64 cohort will grow at a more rapid rate compared to California.
- Despite the service areas being a younger population, it is the senior population that will have the biggest growth.

Appendix C: GASH Definition

- Geographic Area Served by the Hospital (GASH):
  - The Centers for Medicare & Medicaid Services' Stark Regulations (42 CFR §411.357) states:
    - (2)(i) The ‘‘geographic area served by the hospital’’ is the area composed of the lowest number of contiguous ZIP Codes from which the hospital draws at least 75 percent of its inpatients. The geographic area served by the hospital may include one or more ZIP Codes from which the hospital draws no inpatients, provided that such ZIP Codes are entirely surrounded by ZIP Codes in the geographic area described above from which the hospital draws at least 75 percent of its inpatients.
    - (2)(iii) Special optional rule for rural hospitals. In the case of a hospital located in a rural area (as defined at §411.351), the ‘‘geographic area served by the hospital’’ may also be the area composed of the lowest number of contiguous ZIP Codes from which the hospital draws at least 90 percent of its inpatients. If the hospital draws fewer than 90 percent of its inpatients from all of the contiguous ZIP Codes from which it draws inpatients, the ‘‘geographic area served by the hospital’’ may include noncontiguous ZIP Codes, beginning with the noncontiguous ZIP Code in which the highest percentage of the hospital's inpatients resides, and continuing to add noncontiguous ZIP Codes in decreasing order of percentage of inpatients.

Appendix C: KDMC GASH Definition & Area Depiction



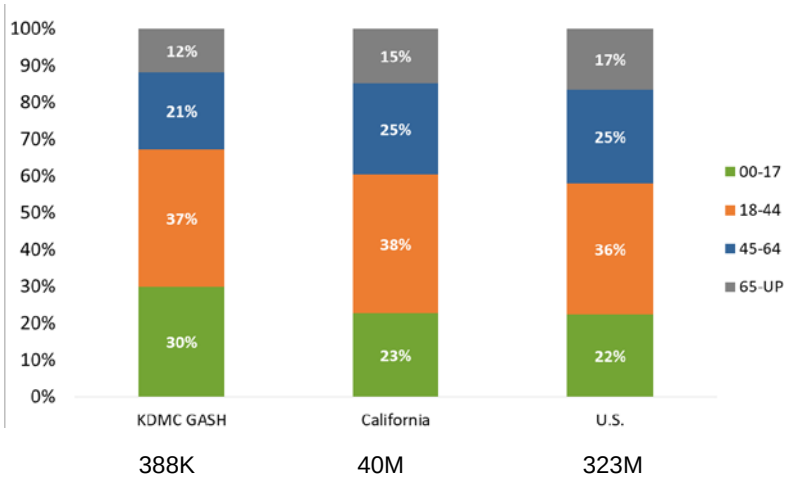
Kaweah Delta Medical Center
Patient Origin

		Inpatient Discharges		
ZIP Code	Community	Total	%	Cumulative %
93277	Visalia	4,377	15.7%	15.7%
93291	Visalia	4,362	15.7%	31.4%
93274	Tulare	4,267	15.3%	46.7%
93292	Visalia	3,177	11.4%	58.1%
93257	Porterville	1,191	4.3%	62.4%
93221	Exeter	1,138	4.1%	66.5%
93618	Dinuba	853	3.1%	69.5%
93223	Farmersville	851	3.1%	72.6%
93247	Lindsay	777	2.8%	75.4%
Subtotal		20,993	75.4%	
Other ZIPs		6,860	24.6%	
Total		**27,853**	**100.0%**	

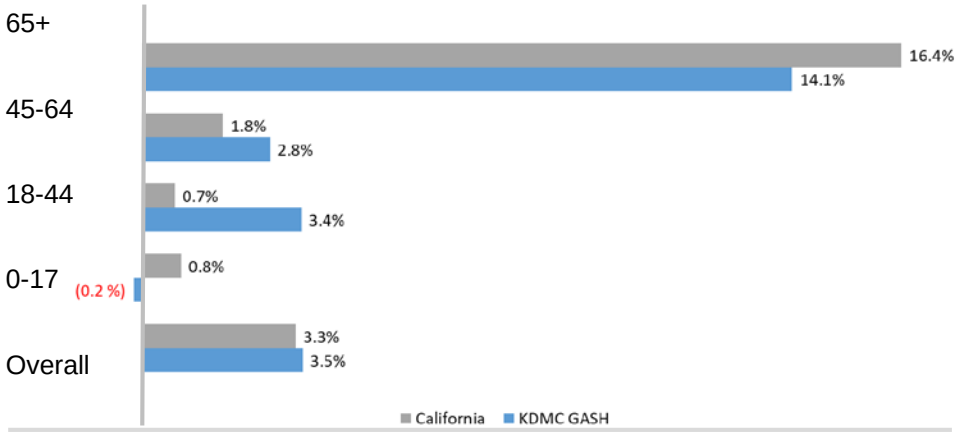
Note: Excludes normal newborns
Source: KDMC CY 2019

Appendix C: Age Profile – KDMC GASH

Population by Age Cohort



% Change in Population by Age Cohort 2020 - 2025

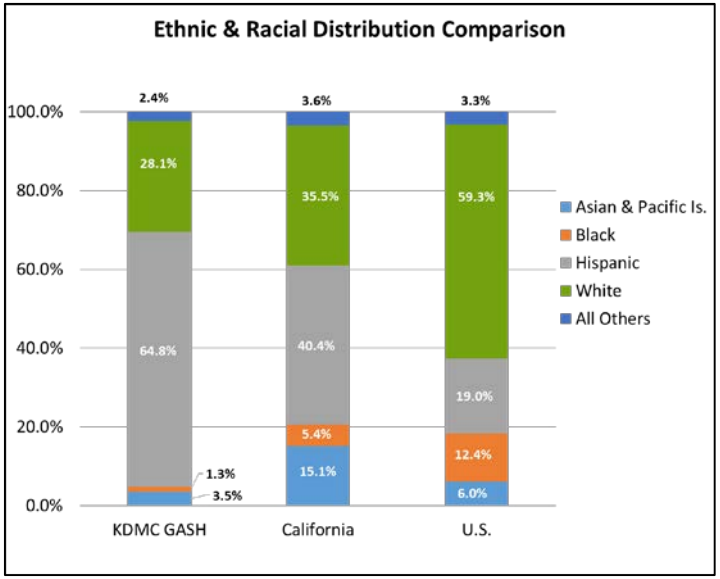


- Residents in the GASH are younger when compared to California as a whole.
- The population between the age of 18 and 64 is expected to grow at a more rapid rate compared to California.
- The senior population (age 65+) is expected to grow at a similar pace to California. However, this segment of the population comprises a small percentage of the GASH population.

Appendix C: Ethnic Profile – KDMC GASH

Ethnic & Racial Distribution Comparison							
	KDMC GASH			California			U.S.
Ethnicity/Race	2020 % of Total	2025 % of Total	Population % Change '20-'25	2020 % of Total	2025 % of Total	Population % Change '20-'25	National 2020 % of Total
Asian & Pacific Is.	3.5%	3.5%	3.3%	15.1%	16.1%	10.2%	6.0%
Black	1.3%	1.3%	0.2%	5.4%	5.2%	(0.7 %)	12.4%
Hispanic	64.8%	68.5%	9.4%	40.4%	41.9%	7.1%	19.0%
White	28.1%	24.4%	(10.1 %)	35.5%	33.0%	(3.7 %)	59.3%
All Others	2.4%	2.4%	4.0%	3.6%	3.8%	8.0%	3.3%
Total	388,430	401,921	3.5%	39,886,390	41,212,916	3.3%	100.0%

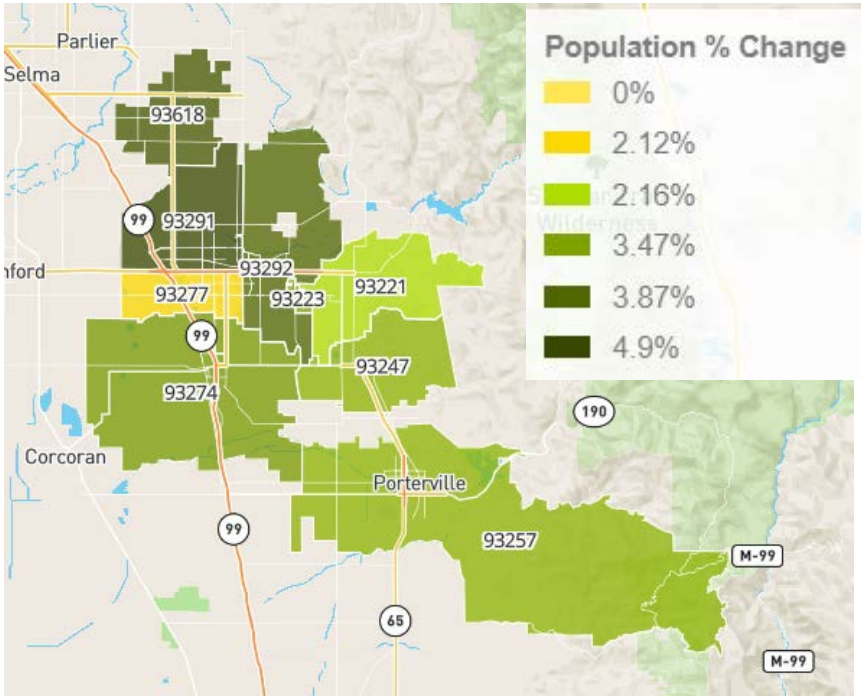
Source: Sg2 Market Demographics



- The GASH is predominantly Hispanic and White.
- The Hispanic population is proportionally higher when compared to California as a whole and will continue to grow.

Appendix C: Projected Growth – KDMC GASH

5-Year Population Growth Projected by ZIP Code



Population Growth by Age Cohort 2020 - 2025

	Current Population		Population 5-Year % Change	
Age Group	KDMC GASH	Percent of Population	Market Growth Rates	California
0-17	116,254	30%	0%	1%
18-44	144,358	37%	3%	1%
45-64	81,704	21%	3%	2%
65-UP	46,114	12%	14%	16%
Overall	388,430	100%	3%	3%

Sg2 Market Demographics

- The GASH population is young, and the area itself is rapidly growing.
- The City of Visalia, with estimated 60K residents, is projected to grow the most- by 5%.
- Despite being a young population, the senior cohort (65+) is expected to grow at almost five times the rate of the non-senior population.

Appendix D: Physician Needs Model excluding Medi-Cal

- Given that a large segment of the population is insured through Medi-Cal and not all practices accept Medi-Cal, the following pages highlight physician needs based on the exclusion of this population.
- KDMC provided the percentage of the population that is insured through Medi-Cal. As such, the needs model is reflective of this segmentation.
  - Tulare County: excludes 55% of the estimated 463K residents
  - PSA: excludes 39% of the estimated 228K residents
  - TSA: excludes 39% of the estimated 597K residents
- A majority of the specialties being evaluated are at or near adequate supply with the exception of
  - Dermatology
  - Oncology/hematology
  - General surgery
  - Orthopedics
  - ENT
  - Urology

Appendix D: Physician Needs Model excluding Medi-Cal – cont'd

		Tulare County				KDMC PSA				KDMC TSA			
Specialty	Population to Support One Physician	Gross Physician Need	FTE Physician Supply	Net Need (Surplus)	Current Supply % of Need	Gross Physician Need	FTE Physician Supply	Net Need (Surplus)	Current Supply % of Need	Gross Physician Need	FTE Physician Supply	Net Need (Surplus)	Current Supply % of Need
Adult Primary Care (FM & IM)*	2,000	104.4	207.0	(102.6)	198.3%	69.8	158.9	(89.1)	227.6%	182.2	243.0	(60.8)	133.3%
Pediatrics (General)	8,000	26.1	49.7	(23.6)	190.5%	17.4	30.4	(13.0)	174.2%	45.6	59.3	(13.7)	130.2%
Medical													
Allergy & Immunology	75,000	2.8	5.3	(2.5)	188.7%	1.9	4.7	(2.8)	249.9%	4.9	5.5	(0.6)	113.2%
Cardiology	22,000	9.5	14.2	(4.7)	149.8%	6.3	11.2	(4.9)	176.7%	16.6	16.4	0.2	99.1%
- Electrophysiology	220,000	0.9	0.5	0.4	52.7%	0.6	0.5	0.1	78.8%	1.7	0.5	1.2	30.2%
- Interventional/Invasive	63,000	3.3	6.0	(2.7)	181.1%	2.2	5.0	(2.8)	225.7%	5.8	7.2	(1.4)	124.5%
- Medical/Non-Invasive	40,000	5.2	7.7	(2.5)	147.6%	3.5	5.7	(2.2)	163.4%	9.1	8.7	0.4	95.5%
Dermatology	40,000	5.2	4.3	0.9	82.4%	3.5	4.0	(0.5)	114.6%	9.1	5.0	4.1	54.9%
Endocrinology	60,000	3.5	2.9	0.6	83.4%	2.3	1.9	0.4	81.7%	6.1	3.1	3.0	51.0%
Gastroenterology	40,000	5.2	5.8	(0.6)	111.7%	3.5	5.0	(1.5)	144.2%	9.1	6.9	2.2	76.1%
Infectious Diseases	90,000	2.3	1.5	0.8	62.5%	1.6	1.5	0.1	93.5%	4.0	1.5	2.5	35.8%
Nephrology	85,000	2.5	13.9	(11.4)	566.1%	1.6	11.8	(10.2)	718.6%	4.3	14.0	(9.7)	326.5%
Neurology	44,000	4.7	7.8	(3.1)	164.4%	3.2	6.8	(3.6)	214.4%	8.3	8.3	0.0	100.2%
Obstetrics/Gynecology	10,000	20.9	28.6	(7.7)	137.0%	14.0	16.2	(2.2)	116.1%	36.4	37.8	(1.4)	103.7%
Oncology/Hematology	36,000	5.8	5.2	0.6	89.7%	3.9	3.0	0.9	77.4%	10.1	5.5	4.6	54.3%
Gynecology Oncology	100,000	2.1	0.0	2.1	0.0%	1.4	0.0	1.4	0.0%	3.6	0.0	3.6	0.0%
Physical Medicine & Rehabilitation	85,000	2.5	5.5	(3.0)	224.0%	1.6	5.3	(3.7)	322.8%	4.3	5.5	(1.2)	128.3%
Psychiatry	20,000	10.4	11.8	(1.4)	113.1%	7.0	11.8	(4.8)	169.1%	18.2	17.6	0.6	96.6%
Pulmonary Medicine	85,000	2.5	2.7	(0.2)	110.0%	1.6	1.7	(0.1)	103.5%	4.3	2.8	1.5	65.3%
Radiation Oncology	95,000	2.2	2.8	(0.6)	127.4%	1.5	1.8	(0.3)	122.5%	3.8	2.8	1.0	73.0%
Rheumatology	100,000	2.1	1.6	0.5	76.7%	1.4	1.6	(0.2)	114.6%	3.6	2.6	1.0	71.3%
Surgical													
Surgery													
- Cardiothoracic/vascular Surgery	150,000	1.4	2.0	(0.6)	143.7%	0.9	2.0	(1.1)	214.9%	2.4	2.0	0.4	82.3%
- Bariatric Surgery	100,000	2.1	0.5	1.6	24.0%	1.4	0.5	0.9	35.8%	3.6	0.5	3.1	13.7%
- Colon & Rectal Surgery	200,000	1.0	0.0	1.0	0.0%	0.7	0.0	0.7	0.0%	1.8	0.0	1.8	0.0%
- General Surgery	20,000	10.4	14.6	(4.2)	139.4%	7.0	9.8	(2.8)	140.4%	18.2	16.6	1.6	90.8%
- Vascular Surgery	125,000	1.7	3.3	(1.6)	197.6%	1.1	2.9	(1.8)	259.7%	2.9	3.8	(0.9)	128.6%
Neurosurgery	85,000	2.5	4.0	(1.5)	162.9%	1.6	4.0	(2.4)	243.6%	4.3	4.0	0.3	93.3%
Ophthalmology	34,000	6.1	9.6	(3.5)	156.4%	4.1	8.2	(4.1)	199.8%	10.7	10.1	0.6	94.2%
Orthopedic Surgery													
- General/Sports Medicine	26,000	8.0	8.3	(0.3)	103.4%	5.4	6.3	(0.9)	117.4%	14.0	9.8	4.2	69.9%
- Foot/Ankle	295,000	0.7	0.0	0.7	0.0%	0.5	0.0	0.5	0.0%	1.2	0.0	1.2	0.0%
- Hand Surgery	225,000	0.9	0.0	0.9	0.0%	0.6	0.0	0.6	0.0%	1.6	0.0	1.6	0.0%
- Total Joint Reconstructive Surgery	175,000	1.2	0.7	0.5	58.7%	0.8	0.7	0.1	87.8%	2.1	0.7	1.4	33.6%
- Trauma	160,000	1.3	0.3	1.0	23.0%	0.9	0.3	0.6	34.4%	2.3	0.3	2.0	13.2%
Otorhinolaryngology	37,000	5.6	3.4	2.2	60.3%	3.8	2.3	1.5	61.0%	9.8	5.1	4.7	51.8%
Plastic/Reconstructive Surgery	90,000	2.3	2.0	0.3	86.2%	1.6	2.0	(0.4)	129.0%	4.0	2.0	2.0	49.4%
Spine Surgery	175,000	1.2	1.3	(0.1)	109.0%	0.8	1.3	(0.5)	163.0%	2.1	1.9	0.2	91.2%
Urology	32,000	6.5	3.4	3.1	51.4%	4.4	1.8	2.6	40.1%	11.4	5.4	6.0	47.0%
Service Area Population		**208,716**			Need	**139,573**			Need	**364,437**			Need
excluding Medi-Cal population					Adequate Supply				Adequate Supply				Adequate Supply

Note: Ratios rounded.

*Primary Care Physician Supply includes APPs. APPs allocated 0.80 FTE

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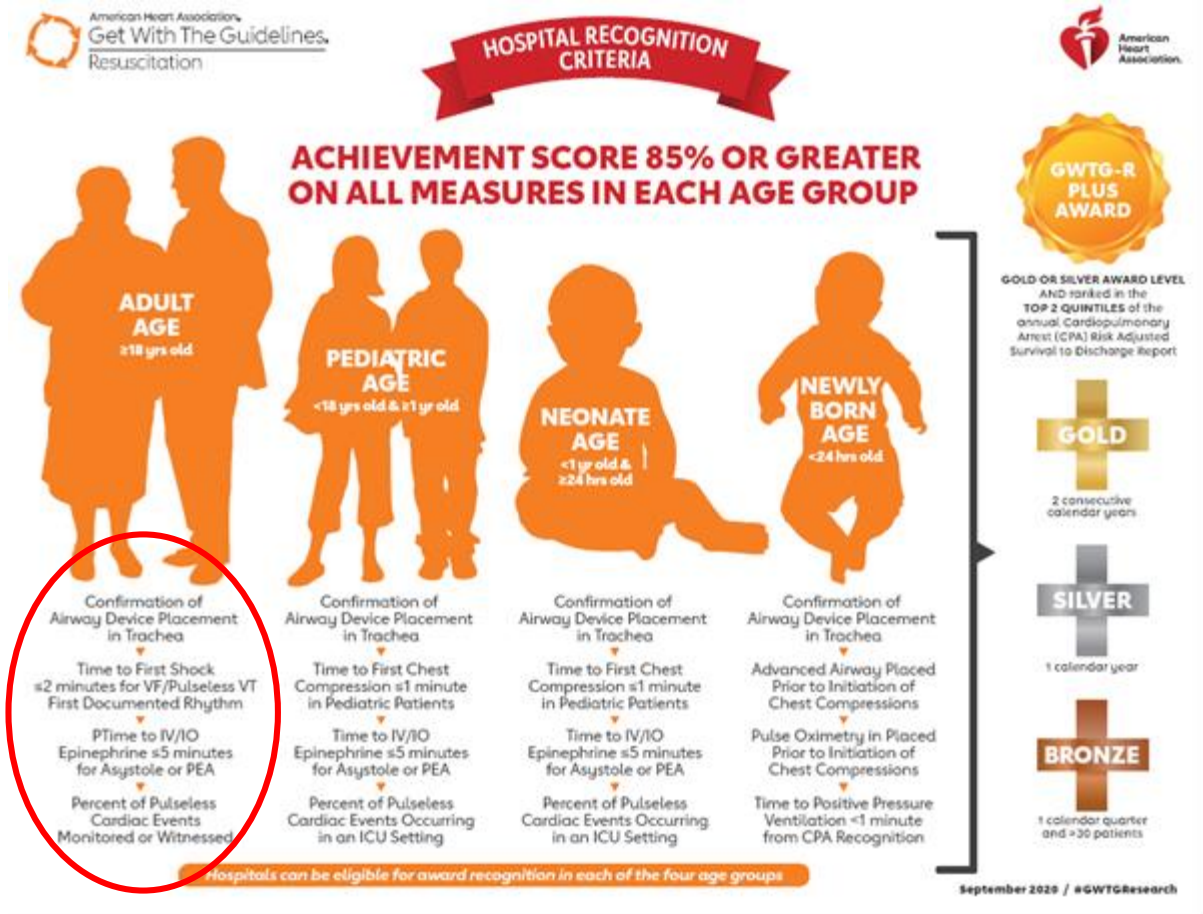
RRT/Code Blue ProStaff Report – 2021

Dr. Tang, Kassie Waters, Linde Swanson, Jeanette Callison, and Eileen Paul

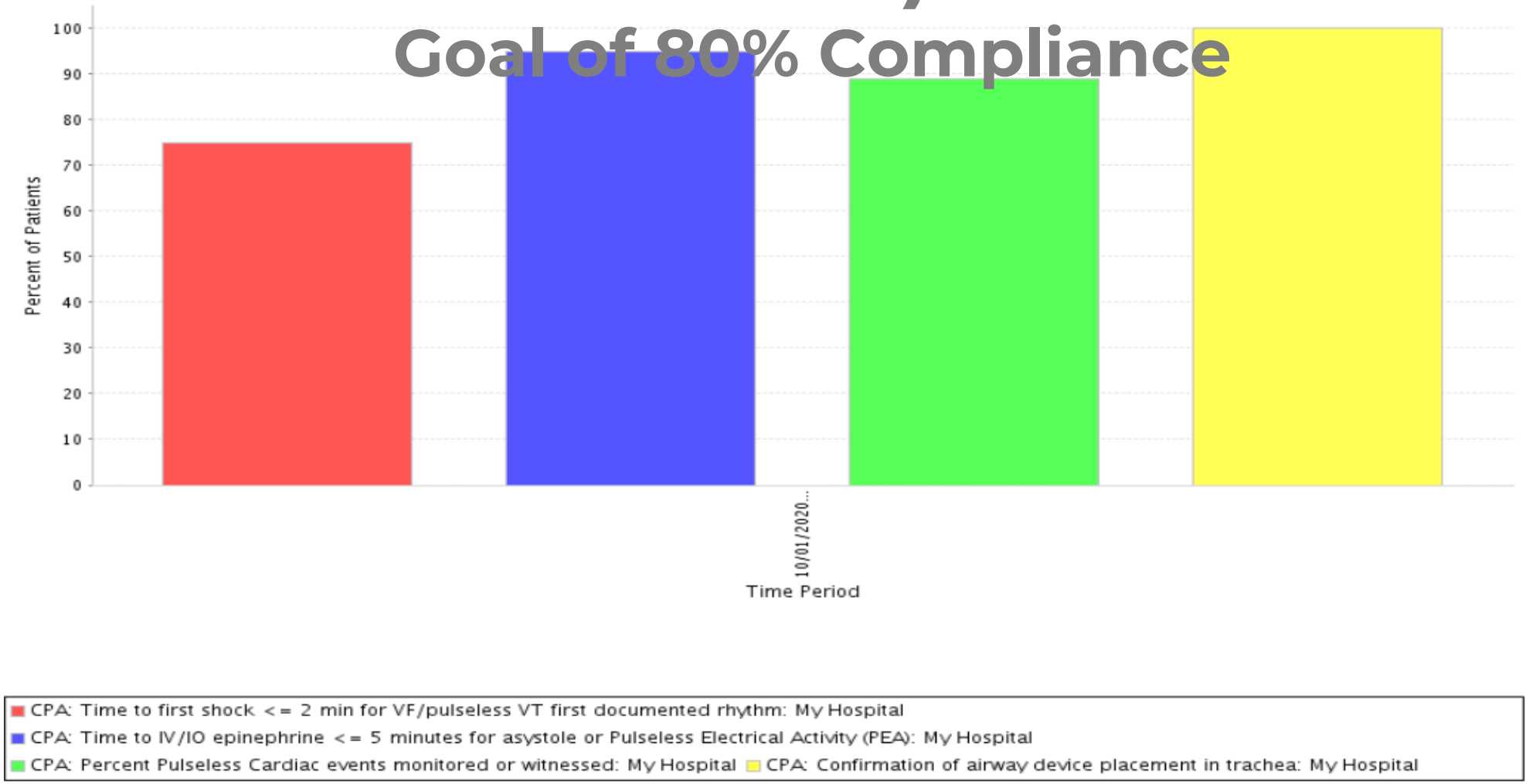
GWTG Resuscitation

- The RRT/Code Blue Committee has joined Get with the Guidelines (GWTG) Resuscitation AHA national registry to have access to national and state benchmarks for code blue and RRT measures.
- This information has been used to create a new RRT and Resuscitation Scorecard.
- The RRT/Code Blue Committee will also begin measuring GWTG hospital recognition criteria benchmarks as well. These will improve the quality of our codes and qualify us for awards.
    1. Confirmation of airway device placement
    2. Time to first shock
    3. Time to IV epinephrine
    4. Percent of Pulseless Events monitored or witnessed



GWTG Recognition Measures (Oct-Dec 2020)

Goal of 80% Compliance

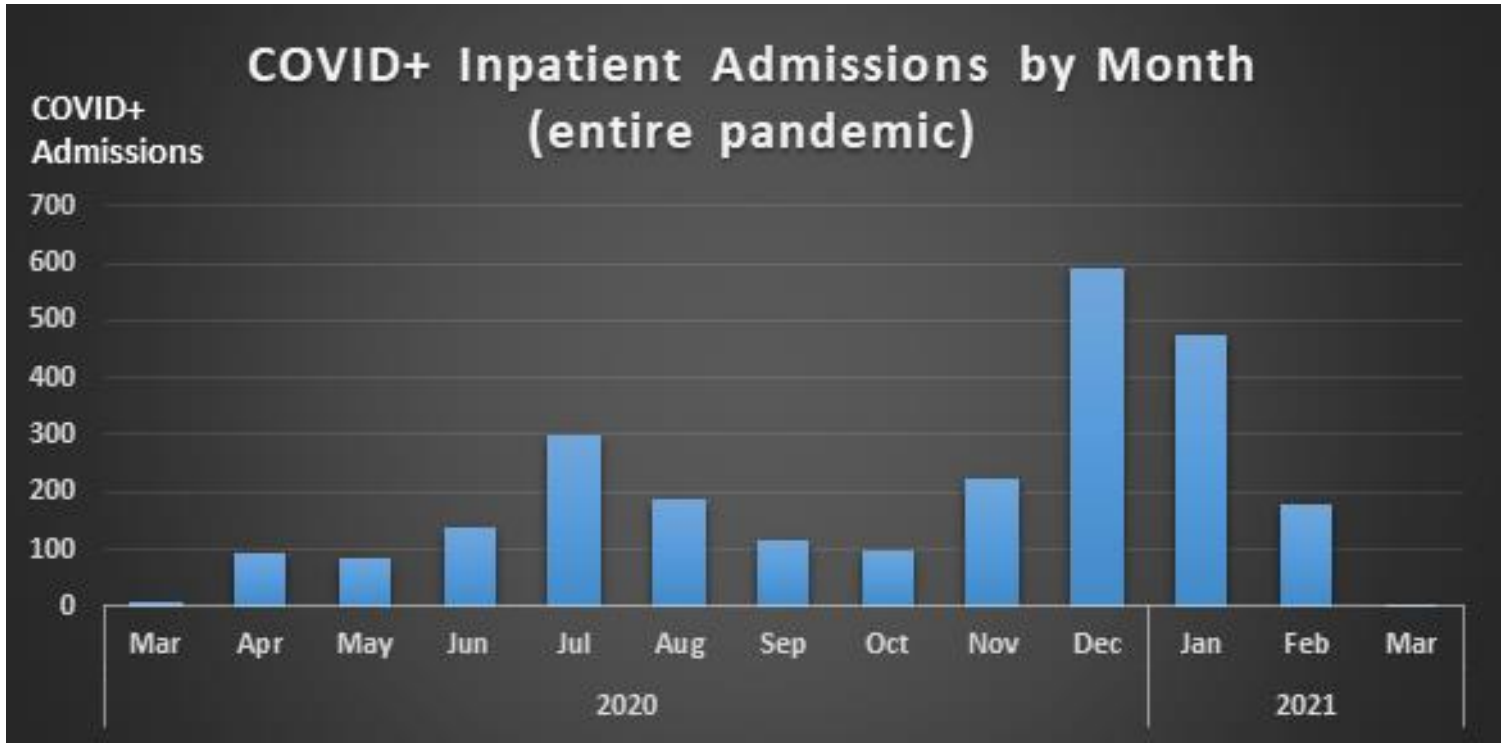


RRT and Resuscitation-Quality Scorecard

Measure Description	California Hospitals External Benchmark	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	YTD 2020
Code Blue Data														
Total Code Blues		12	11	18	7	16	13	32	23	15	16	16	32	18
Total COVID-19 Positive Code Blues		N/A	N/A	N/A	N/A	3	5	14	10	2	5	2	20	8
Code Blues per 1000 Discharges Med Surg		3	3	4	3	5	5	10	7	5	6	8	15	6
Code Blues per 1000 Discharges Critical Care		4.1	2.8	6.7	4.0	7.9	3.9	12.8	8.7	6.3	6.2	3.8	9.2	6.4
Percent of Codes in Critical Care	73%	50%	36%	50%	57%	56%	38%	56%	52%	53%	50%	31%	38%	47%
Code Blue: Survival to Discharge	22%	50%	45%	39%	29%	31%	38%	28%	9%	33%	31%	25%	9%	31%
Deaths from Cardiac Arrest		6	6	9	5	11	9	13	11	5	10	12	29	11
Overall Hospital Mortality per 1000 Patients		3.032	2.976	2.482	3.778	2.95	2.86	3.783	3.614	2.92	2.76	3.546	6.265	3.41
RRT Data														
Total RRTs		126	111	108	119	112	139	150	139	117	123	113	191	129
RRTs per 1000 patient discharge days		86	77	81	120	98	109	107	101	92	96	87	147	99
RRT mortality (percentage)	21%	23% n-29	15% n-17	16% n-17	31% n-37	25% n-28	21% n-29	27% n-40	22% n-30	27% n-32	22% n-27	30% n-34	36% n-68	25%
RRTs within 24 hours of Admit from ED (percentage)	18%	29% n-37	31% n-34	27% n-29	23% n-27	22% n-25	23% n-32	24% n-36	26% n-36	21% n-24	21% n-26	24% n-27	22% n-42	24%

Green	Better than Target
Yellow	Within 10% of Target
Red	Does not meet Target

The Year of Covid
Covid Volumes and Code Blues



- July and December had the highest number of code blues in critical are and in medical surgical areas per 1000 patient days & highest covid patient pan-demic volume months.

Code Blues and RRTs 2020

Code Blue Summary

- Code blues in critical care setting are below the California benchmark (higher is better). The committee's goal is for code blues to occur in critical care where there are resources , monitoring, and an intensivist on the unit.
- Code blue survival to discharge benchmark not met in August and December due to high volume of code blue patients with covid (special cause).
- Time to first shock below benchmark (higher is better).
    - Need to revise code blue sheet to capture time of first shock.
    - All other code blue process measures are above goal.

Rapid Response Team Summary

December:

- Highest amount of RRTs per 1000 patient discharge days: 147
- Highest mortality percentage: 36%

- Average year to date RRT mortality (25%) is above the California hospital average (21%).
- Average 2020 RRTs with 24 hours of Admit from ED are 24% compared to the California hospital average of 18%

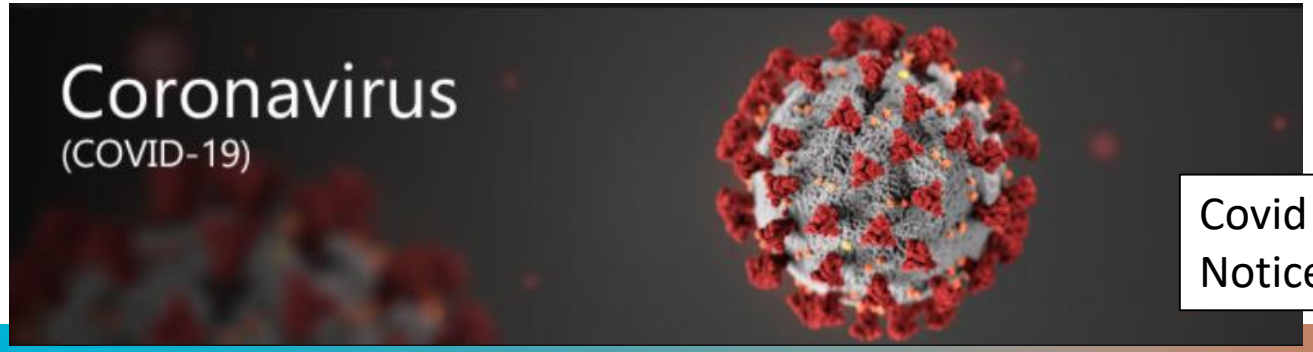
Analysis

- Observed a direct correlation in number of covid patients and increase volume of code blues, RRTs, and mortality.
- Covid patients required increase oxygen support and high flow oxygen delivery systems were maximized in acute care areas. Patients with low oxygen situation in low 90s became the new normal.
- Critical care patients extended to overflow area on 3 west and intermediate critical care patients to overflow area on 2 north, thus supporting code blues occurring outside critical care unit.
- At times, RRTs are called and palliative discussion occurs leading to comfort care and a contributing factor to the percent of RRT mortalities.
- Concern of appropriate admitting location due to higher percentage of RRT within 24 hours of admit from ED.

Greatest good for the greatest number of patients

Next Steps

- Revise code blue form to easily capture all code blue process elements to meet Get With The Guideline standards. In-Progress
- Assess teaching hospital Get With The Guideline benchmarks vs. California benchmarks. In-Progress
- RRT collaborating with operating room (OR) team and outlining processes to assist the OR team when a patient deteriorates. DONE
- Formalization of processes and role definition of each member of the RRT team. Developing checklists to ensure consistency with practice. In-Progress
- Formalization of RRT handoff after a rapid response and utilizing a physician communication handoff tool. In-Progress
- Formalization of non-licensed staff and family activated of RRT process. Pending
- Review data of time zero of RRT to time of code blues to assess missed opportunities. Pending.
- Reach out to Get With The Guidelines on best practices/improvements to lower RRT within 24 hours of Admit from ED.
    - Share data and feedback with hospitalist and ED physician groups. Pending.



Covid – Special Cause Factor.
Notice volume of covid patients are decreasing in March

Next Steps: Education

- The RRT nurses are working to educate staff during the event and to circle back with staff after the event to discuss quality of care.
- RRT nurse will be working to form partnerships with specific units to “champion” and be a go to person to help with education and reinforce utilizing RRT.
- Educate Staff about the importance of ETCO2 monitoring during codes to assess quality of chest compressions and airway device placement.
- Asses Cardiac Advanced Resuscitation Education for staff & providers caring for Open Heart Patients.
    - Cardiac Surgery Advanced Life Support (CALS) should be used on open heart patients vs the Advance Cardiovascular Life Support (ACLS). Standardize training is needed.

Questions

Kaweah Delta
FY 2021 Strategic Plan

High Performing OP Network

Strategic Initiative Summary: High Performing OP Delivery Network

Objective

Develop, maintain and grow a high-performing OP delivery network

Chair

Jessica Rodriguez
Sonia Duran-Aguilar

ET Sponsor

Ryan Gates

High Priority Performance Measures and the Pillars they Support	Baseline	FY-21 YTD	FY21 Goal	FY22 Goal	FY23 Goal
People – Provide an ideal work environment					
Employee Engagement Score	4.12	TBD	65th percentile (4.19)	70th percentile (TBD)	75th percentile (TBD)
Physician Engagement Score	3.55	TBD	50th percentile (3.68)	60th percentile (TBD)	75th percentile (TBD)
Service –Deliver excellent service					
Outpatient Patient Satisfaction Score (CG-CAHPS-Overall Doctor Rating)	81.3%	84.5%	50th percentile (85%)	60th percentile (TBD)	75th percentile (TBD)
Population Health – Achieve outstanding community health					
Outpatient Patient Outcome Measures	Multiple	Met	Achieve 100% of goals	Achieve 100% of goals	Achieve 100% of goals
Overall risk adjustment factor (RAF) score	0.9	TBD	1.2	TBD	TBD
Growth – Maintain financial strength					
Clinic Visits	112,439	**1% over**	100% to budget	100% to budget	100% to budget
Finance – Maintain financial strength					
Labor Productivity *(productive hours/unit of service)* RHC-SHWC / Urgent Cares	1.76	**18% under budget**	1.33	100% to budget	100% to budget
Maintain Positive Contribution Margin		**$1,724,902**	100% to budget	100% to budget	100% to budget
Provider deficiencies	0.2%	**0.2%**	0% variance	0% variance	0% variance

Strategies (Tactics)	Value Proposition / Net Annual Impact ($)
People: Leadership rounding with staff and physicians	Staff and Provider Retention
Service: Leadership and management rounding with patients	Patient attraction/retention – PRIME revenue
Population Health: Improve documentation/coding/billing processes for clinical documentation ** Close quality and hierarchical condition category gaps for SIH plan ** Focused committee efforts around clinical quality measurement improvement	Increase at-risk revenue by improved quality scores (Humana, PRIME, QIP, BHI, etc.) Increased at-risk revenue through improved RAF
Growth: Develop existing provider productivity/opportunity reports & identify new primary/specialty opportunities to add	Increase visits able to be captured by low volume & new providers
Finance: Monthly accountability meetings/reports around operational measures ** Including financial targets of visit volume, provider productivity, labor productivity, expenses and completion of provider deficiencies	% of last year budget gap to this year budget actual

Team Members

Marc Mertz
Dr. Monica Manga
Dr. Mario Martinez
Ed Largoza
Luke Schneider
Lacy Jensen
Leslie Bodoh
Clint Brown
Gail Robinson
Ivan Jara
Anthony Olivares
Tracy Salsa

Service Lines:

- RHC's *(Exeter, Dinuba, Woodlake, Lindsay)*
- Urgent Care's *(Court, Demaree)*
- CDMC
- Neurosciences
- Sequoia Cardiology
- Sequoia Health and Wellness Centers

Strategy Summary for: People – Provide an Ideal Work Environment

Strategic Initiative: High Performing OP Delivery Network

Objective

Develop, maintain and grow a high-performing OP delivery network

Key Components

1. Use SAQ and Employee Engagement results to identify areas for improvement and ensure management and staff work together with leadership to resolve
2. Use Physician Survey results to identify areas for improvement and ensure management and staff work together with physicians and leadership to resolve
3. Leadership and Executive Team rounding with staff and physicians
4. Incorporate into monthly dashboard rolled up overall and drilled down to clinic/provider level coupled with monthly accountability meetings around operational measures

Goals	FY21 - YTD	FY21	FY22	FY23
Employee Engagement Score	TBD	50th percentile (4.19)	60th percentile	75th percentile
Physician Engagement Score	TBD	50th percentile (3.68)	60th percentile	75th percentile

Team Members

Ryan Gates, Jessica Rodriguez, Ivan Jara, Anthony Olivares

Strategy Charter for: Service – Deliver Excellent Service

Strategic Initiative: High Performing OP Delivery Network

Objective

Develop, maintain and grow a high-performing OP delivery network

Key Components

1. Incorporation of "Connection to Mission" stories at the beginning of each department meeting
2. Monitoring of Outpatient Patient Satisfaction Scores (CG-CAHPS-Overall Doctor Rating) and develop opportunities for improvements based on scores and specific patient feedback
3. Monthly monitoring of MIDAS reports of patient grievances and patient safety/adverse events and develop corrective action plans when applicable
4. Review results and comments at monthly meetings to provide oversite and guidance in ensuring the delivery of excellent service:
   - Continuous Quality Improvement Committee (CQI)
   - Population Health Steering Committee
   - Staff, Provider and Clinic Network Medical Director Meetings
5. Incorporate into monthly dashboard rolled up overall and drilled down to clinic/provider level coupled with monthly accountability meetings around operational measures

Goals	FY21 - YTD	FY21	FY22	FY23
Outpatient patient satisfaction scores (CG-CAHPS) - Overall Doctor Rating - Office Staff Quality - Provider Communication - Access	**84.5%**	50th percentile (85%)	60th percentile (TBD)	75th percentile (TBD)

Team Members

Ryan Gates, Jessica Rodriguez, Ivan Jara, Anthony Olivares

Strategy Charter for: Population Health – Achieve Outstanding Community Health

Strategic Initiative: High Performing OP Delivery Network

Objective

Develop, maintain and grow a high-performing OP delivery network

Key Components

1. Participate in many of population health programs where we report on over 80 metrics but focus on in specific metrics in a prioritized fashion to ensure impact *(i.e. PRIME, Health Homes, QIP, BHI, health plan incentives, etc.)*
2. As metrics are met, they are retired and replaced with other prioritized metrics.
3. Opportunities for improvement are continuously discovered and addressed *(i.e. Cerner enhancements, clinic workflows, care coordination, patient outreach, provider documentation, etc.)*
4. LVN care coordinators, community care coordinators, providers and clinic teams use COZEVA, Cerner Health Advisories and HCC module to identify and close quality and HCC gaps
5. Incorporate into monthly dashboard rolled up overall and drilled down to clinic/provider level coupled with monthly accountability meetings around operational measures

Goals	FY21- YTD	FY21	FY22	FY23
A1c <9%	32.99%	36%	TBD	TBD
High Blood Pressure	67%	67%	TBD	TBD
Depression Screening	76%	76%	TBD	TBD
Flu Vaccinations	43.5%	50%	TBD	TBD
RAF Score Improvement	>1.167	1.2	TBD	117/271

Team Members

Sonia Duran-Aguilar, Ryan Gates, Jessica Rodriguez, Ivan Jara

Strategy Charter for: Growth – Maintain Financial Strength

Strategic Initiative: High Performing OP Delivery Network

Objective

Develop, maintain and grow a high-performing OP delivery network

Key Components

1. Clinic visit volume remains the strongest objective link to financial strength
2. Develop existing provider productivity/opportunity reports
3. Identify new primary/specialty opportunities to increase access and improve productivity
4. Incorporate into monthly dashboard rolled up overall and drilled down to clinic/provider level coupled with monthly accountability meetings around operational measures
5. Implement and optimize use of telehealth technologies
6. Improve marketing strategies to community and targeted physician recruitment

Goals	FY21 - YTD	FY21	FY22	FY23
Clinic Visits	1% over budget	100% to budget	100% to budget	100% to budget

Team Members

Ryan Gates, Jessica Rodriguez, Ivan Jara, Anthony Olivares

Strategy Charter for: Finance – Maintain Financial Strength

Strategic Initiative: High Performing OP Delivery Network

Objective

Develop, maintain and grow a high-performing OP delivery network

Key Components

1. Incorporate into monthly dashboard rolled up overall and drilled down to clinic/provider level coupled with monthly accountability meetings around operational measures
2. Localize clinic management to provide real time management of staffing and productivity
3. Add additional locations and services in line with community needs and strategic plan
4. Convert strategic clinics to FQHC for PPS rate reimbursement to improve financial performance and sustainability

Goals	FY21 - YTD	FY21	FY22	FY23
Labor Productivity	18% Under Budget	100% to budget	100% to budget	100% to budget
Provider Deficiencies	0.2%	0% variance	0% variance	0% variance

Team Members

Malinda Tupper, Ryan Gates, Jessica Rodriguez

Kaweah Delta Physician Recruitment and Relations
Medical Staff Recruitment Report - March 2021

Prepared by: Brittany Taylor, Director of Physician Recruitment and Relations - btaylor@kdhcd.org - (559)624-2899

Date prepared: 3/18/2021

Central Valley Critical Care Medicine	
Intensivist	1

Delta Doctors Inc.	
OB/Gyn	1

Kaweah Delta Faculty Medical Group	
Family Medicine Associate Program Director	1
Family Medicine Core Faculty	2

Key Medical Associates	
Internal Medicine/Family Medicine	2

Oak Creek Anesthesia	
General Anesthesia	3
Certified Registered Nurse Anesthetist	3

Other Recruitment	
Neurology	1
Orthopedic Surgery (Trauma)	1

Valley Children's Health Care	
Maternal Fetal Medicine	2

Visalia Medical Clinic (Kaweah Delta Medical Foundation)	
Dermatology	2
Family Medicine	4
Internal Medicine	1
Gastroenterology	2
Orthopedic Surgery (Hand)	1
Otolaryngology	2
Radiology - Diagnostic	1
Rheumatology	1
Urology	3
Urology - Advanced Practice Provider	1

Candidate Activity						
Specialty/Position	**Group**	**Last Name**	**First Name**	**Availability**	**Referral Source**	**Current Status**
Colorectal Surgery	Visalia Medical Clinic (Kaweah Delta Medical Foundation)	Ota, M.D.	Kyle	08/21	Current KD General Surgery resident	Offer accepted; Start Date: 8/2/2021
Diagnostic Radiology	Visalia Medical Clinic (Kaweah Delta Medical Foundation)	Bombard, M.D.	Tatyana	TBD	Curative -3/8/21	Currently under review
Diagnostic Radiology	Visalia Medical Clinic (Kaweah Delta Medical Foundation)	Dalle, D.O.	John	TBD	Merritt Hawkins - 2/26/21	Site Visit: 4/1/21
Diagnostic Radiology	Visalia Medical Clinic (Kaweah Delta Medical Foundation)	Murillo, M.D.	Horacio	TBD	Merritt Hawkins - 3/4/21	Currently under review
Dermatology	Visalia Medical Clinic (Kaweah Delta Medical Foundation)	Chu, M.D.	Thomas	08/21	Curative - 2/24/21	Site visit pending dates
Family Medicine	Visalia Medical Clinic (Kaweah Delta Medical Foundation)	Hsueh, D.O.	Marion	09/21	Direct referral	Site Visit: 3/23/21
Family Medicine	Key Medical Associates	Fernandez, M.D.	Rogelio	04/21	Direct referral	Offer accepted; Start Date: 4/2021
Family Medicine	Visalia Family Practice	Suleymanova, M.D.	Violetta	TBD	Direct -4/21/20 UCSF Fresno Career Fair	Offer accepted; Start Date: 4/19/21
Family Medicine - Associate Program Director	Kaweah Delta Faculty Medical Group	Ramirez, M.D.	Magda	ASAP	Current Core Faculty with Kaweah Delta Faculty Medical Group	Interview: 2/25/21
Family Medicine Core Faculty	Kaweah Delta Faculty Medical Group	Bassali, M.D.	Mariam	08/21	Referred by Dr. Martinez - 10/14/20	Site Visit: 3/10/21
Family Medicine Core Faculty	Kaweah Delta Faculty Medical Group	Demirchyan, M.D.	Daniel	08/21	MDStaffers - 1/29/20	Currently under review
Family Medicine Core Faculty	Kaweah Delta Faculty Medical Group	Mora-Roman Jr., MD	Ruben	08/21	Direct Referral - Dr. Rafael Martinez	Site Visit: 2/17/21

Candidate Activity						
Specialty/Position	**Group**	**Last Name**	**First Name**	**Availability**	**Referral Source**	**Current Status**
Gastroenterology	Visalia Medical Clinic (Kaweah Delta Medical Foundation)	Qaseem, M.D.	Tahir	09/21	Curative - 1/22/21	2nd Virtual meeting pending
Hospitalist	Central Valley Critical Care Medicine	Malik, M.D.	Sara	08/21	Direct - Dr. Umer Hayyat's spouse	Site Visit: 10/7/20; Offer accepted
Hospitalist	Central Valley Critical Care Medicine	Reed, M.D.	Jennifer	08/21	Vista Staffing - 1/18/21	Offer accepted
Intensivist	Central Valley Critical Care Medicine	John, D.O.	Avinaj	08/21	Vista Staffing - 10/25/19	Site visit: 12/13/19; Offer accepted
Intensivist	Central Valley Critical Care Medicine	Akinjero, M.D.	Akintunde	08/21	Vista Staffing - 10/20/20	Virtual Interview: 11/30/20 Offer accepted
Intensivist	Central Valley Critical Care Medicine	Chand, M.D.	Sudham	TBD	PracticeMatch - 2/5/21	Site visit pending dates
Intensivist	Central Valley Critical Care Medicine	Hansen, M.D.	Diana	TBD	Vista Staffing - 2/25/21	Offer extended
Intensivist	Central Valley Critical Care Medicine	Jenkins, M.D.	Eric	06/21	PracticeLink - 2/5/21	Currently under review
Intensivist	Central Valley Critical Care Medicine	Moore, M.D.	Justin	08/21	Vista Staffing - 2/18/21	Currently under review
Orthopedic Surgery - Hand	Visalia Medical Clinic (Kaweah Delta Medical Foundation)	Tomooka, D.O.	Beren	08/21	Direct referral	Phone Interview: 12/2/20; Site Visit: 3/12/21; Offer pending
Otolaryngology	Visalia Medical Clinic (Kaweah Delta Medical Foundation)	Nguyen, D.O.	Cang	07/22	Curative - 3/15/21	Currently under review
Palliative Medicine	Independent	Grandhe, M.D.	Sundeep	08/21	Direct -12/7/20	Virtual Interview: 12/28/20; Offer accepted; Start Date: 9/1/21
Rheumatology	Key Medical Associates	Alkhairi, MBBS	Baker	08/22	Enterprise Medical Recruiting - 2/12/21	Currently under review
Urology APP	Visalia Medical Clinic (Kaweah Delta Medical Foundation)	Dhanora	Kirat	06/21	Direct	Virtual Interview: 3/17/21; Offer pending
Urology	Visalia Medical Clinic (Kaweah Delta Medical Foundation)	Patel, M.D.	Neil	06/21	Los Angeles Career MD Fair 9/14/19	Site Visit: 9/25/20; Part-Time; Tentative Start Date: 6/01/2021

Kaweah Delta Health Care District
Annual Report to the Board of Directors

Hospice Services

Tiffany Bullock, BSN, RN
Director of Hospice Services. Contact number: 559-624-6447
March 22, 2021

Summary Issue/Service Considered

- Hospice's mission is to deliver optimal end-of-care to pediatric and adult populations in Kings and Tulare counties via the hospice and concurrent care program. The mission of Kaweah Delta Hospice is to provide physical, emotional, social and spiritual support to terminally ill patients as well as their families to live with dignity and comfort as they cope with end-of-life issues.
- Achieve optimal program outcomes with a priority on quality of care, compliance, profitability and quality of work environment.
- Hospice: A team approach for end-of-care care with the goal to improve quality of life and comfort through symptom management.
- Concurrent Care: A team approach for children with life-limiting diseases. The goal of pediatric concurrent care is to provide care that will optimize health, maximize function, and prevent hospitalizations.
- Hospice and concurrent care services provide nursing, physical and occupational therapy, spiritual counselors, social work services and home health aides to assist with personal care. Prior to COVID, volunteers were utilized to provide much needed services to patients that could not be provided otherwise. Unfortunately, due to the public health emergency, the use of volunteers had to be halted and has been unable to be resumed.
- With the adoption of a single director over both Home Health and Hospice that took place this year, this allows the two service lines to become more integrated and financially streamlined. Aspects of each department that have proven to be very successful, such as productivity, are more easily adopted to the other under this model.
- Kaweah Delta Hospice continues to see an increase in children seeking concurrent care. Total Patient Days/Average Daily Census (ADC) has increased by 8% over the past 2 years.
- Patient census has grown. The period from January 2020 to December 2020 saw an increase in the average daily census from 111 to 145. Hospice utilizes Kaweah Delta Home Infusion Pharmacy for medications needed for patients and works closely with them in coordinating services.
- Through positive staffing changes and productivity, Hospice has drastically decreased the number of patients that must be referred to outside hospice agencies.
- Due to the strong financial position for FY2021, Hospice has been able to provide care to more indigent patients who do not have insurance or means to pay for services.
- Dr. Ryan Howard assumed the role of Palliative Care and Hospice Medical Director on April 30 2020. Projections were correct in that this resulted in a significant increase in the number of referrals from the acute hospice.

Financial/statistical Analysis

- Hospice days for FY2021 are annualized to be 51,816. This is an increase of 21% from prior year and is the highest of the last 4 years
- Hospice has a FY2021 annualized contribution margin of $3.1 million, the highest of the last four years and an increase of 137%.
- Expenses have declined by 6% in FY2021.
- As compared to pre-COVID estimate, actual volumes ended higher by approximately 1,300 days.

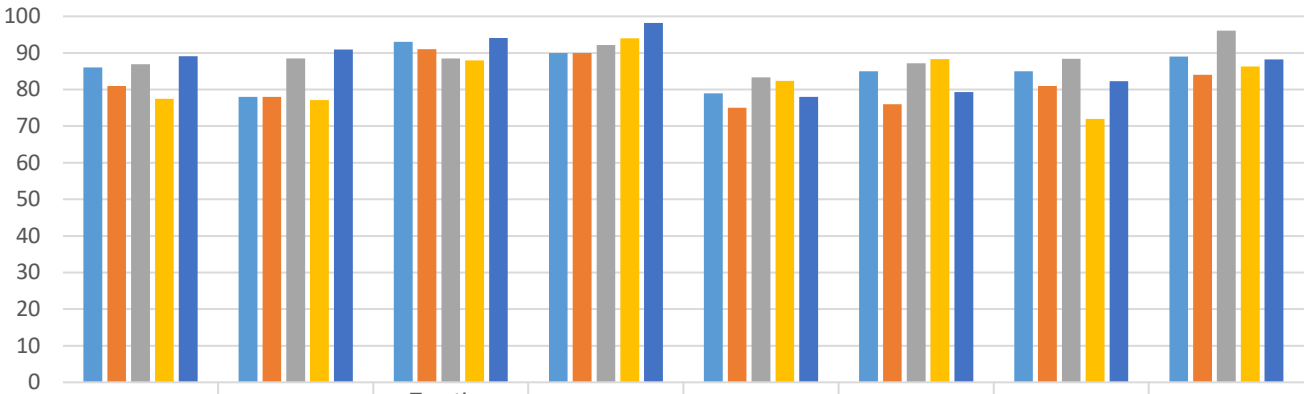
Quality/Performance Improvement Data

Quality reporting

- Hospice Item Set (HIS) data – Mandated reporting of data collected and reported to Medicare (CMS) on admission and at time of death or discharge. Reporting time frames have been met. We exceed the national benchmark in all elements.
- Hospice CAHPS survey – This is a CMS mandated survey that measures caregiver experience as well as quality measure information received from submissions on the Hospice Item Set. We exceed the national percentage in all elements in both categories of family caregiver experience as well as quality of patient care.

PI measures

As is noted from the graph below and mentioned above, Hospice meets or exceeds the national in all categories. Measures were recently submitted to the District Quality Committee via the ProStaff that will be the focus over the next year. These measures were chosen either due to recent decreases or as matter of importance to the overall quality of care. The initiatives will be “Treating Family Member with Respect”, Getting Help for Pain or Symptoms” and “Overall Rating of Hospice”. Action plans to stabilize and/or increase percentages in these measures are currently being implemented.



	Hospice Team Communication	Getting Timely Help	Treating Family Member with Respect	Providing Emotional Support	Getting Help for Pain or symptoms	Training Family in Care	Overall Rating of Hospice	Would you recommend this hospice?
KDH 2019 HOSPICE COMPARE	86	78	93	90	79	85	85	89
NATIONAL AVERAGE	81	78	91	90	75	76	81	84
1st Qrt 2020 Percy & Company	86.9	88.5	88.5	92.2	83.3	87.2	88.4	96.1
2st Qrt 2020 Percy & Company	77.5	77.1	88	94	82.4	88.3	72	86.3
3rd Qrt 2020 Percy & Company	89.1	90.9	94.1	98.2	78	79.3	82.3	88.2

Policy, Strategic or Tactical Issues

- Marketing efforts are underway to attempt to capture a greater market share of community hospice referrals from physicians and skilled nursing and assisted living facilities. Dr. Ryan Howard, one of two Hospice medical directors will be hosting virtual CME webinars targeting community physicians to provide education on palliative care and hospice. Additionally “lunch and learns” are being planned in the future. Kaweah Delta Marketing Department works with Hospice leadership to strategize best practices to cement relationships with local facilities. The Kaweah Delta Hospice Foundation has committed to providing financial support for marketing campaigns that will include radio and television ads.
- In line with the marketing strategy, the goal will be to increase referrals from the community which typically are early referrals to hospice. These early referrals should help increase lengths of stay on hospice increasing the benefits to patients and their families. This should also translate to a financial benefit.
- Productivity expectations were put into place in mid-2020 to ensure all staff were working at full capacity. This has resulted in being able to accept more referrals with the same amount of staff. Staffing will be monitored closely and positions added as needed to support acceptance of all referrals to hospice. Being able to accept all referrals from the acute center greatly decreases length of stay in the acute setting and frees up beds and assists with the financial impact to the District overall.
- Hospice leadership staff has begun working with leadership from Transitional Care Services to explore using beds in that facility for higher acuity hospice patients who

cannot be cared for at home by family. While this is the right thing to do for patients, it should also translate to filling empty beds at other sites in the District and provide financial gains.

- Hospice Director continues to meet with Patient Accounting Services on a bi-weekly basis to ensure we are decreasing unnecessary loss of income and optimize collection.

Recommendations/Next Steps

- Continue to increase referral sources through marketing campaigns and education provided to community physicians by Hospice Medical Director and efforts of Kaweah Delta Marketing Department.
- Ongoing pre and post billing monitoring to ensure regulatory requirements are met and no revenue is lost.
- Continued improvement and stabilization of financial performance.
- Ongoing exploration regarding implementation of General In-Patient (GIP) program. This will involve working closely with Hospice Medical Director and key leaders within the District.
- Once results of Safety Attitudes Questionnaire are received, as well as Employee Engagement survey scheduled to be administered in May 2021, develop action plans specific to results to improve staff satisfaction and decrease turnover.

baApprovals/Conclusions

In the coming year, hospice will focus on:

1. Working with key district people to explore implementation of GIP level of care.
2. Cement relationships with skilled nursing/assisted living facilities and community physicians to become the preferred hospice provider.
3. Continued review of profitability, look for means to maintain contribution margins and cost of care, increase patient satisfaction, increase staff satisfaction and achieve clinical excellence.
4. When deemed safe, re-implement the hospice volunteer program.

KDHCD ANNUAL BOARD REPORT

Hospice Services

FY2021 Annualized

*FY 2021 ANNUALIZED ON THE SEVEN MONTHS ENDED JANUARY 31, 2021

KEY METRICS - FY 2021 ANNUALIZED*

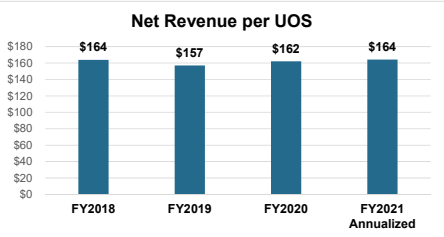
UNIT OF SERVICE (Hospice Days)	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
51,816	$8,517,951	$5,404,995	$3,112,956	$1,597,360
▲ 21%	▲ 23%	▼ -4%	▲ 137%	▲ 8291%

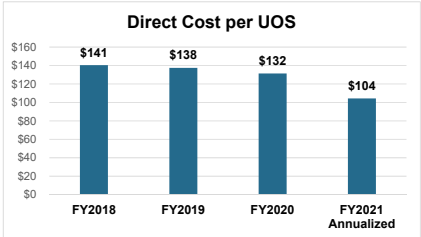
*Note: Arrows represent the change from prior year and the lines represent the 4-year trend

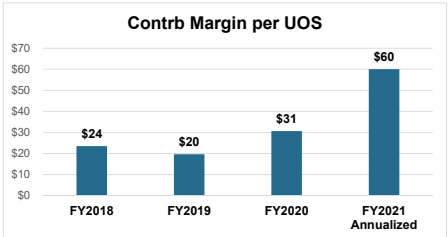
METRICS SUMMARY - 4 YEAR TREND

METRIC	FY2018	FY2019	FY2020	FY2021 Annualized	%CHANGE FROM PRIOR YR	4 YR TREND	Pre-Covid Ann. Jul. 19-Feb.20
Unit of Service (Hospice Days)	40,878	39,947	42,821	51,816	▲ 21%		41,511
Net Revenue	$6,705,086	$6,279,499	$6,943,542	$8,517,951	▲ 23%		$6,792,450
Direct Cost	$5,743,789	$5,495,420	$5,632,518	$5,404,995	▼ -4%		$5,524,061
Contribution Margin	$961,297	$784,079	$1,311,024	$3,112,956	▲ 137%		$1,268,390
Indirect Cost	$1,102,684	$1,132,602	$1,330,526	$1,515,596	▲ 14%		$1,059,197
Net Income	($141,387)	($348,523)	($19,502)	$1,597,360	▲ 8291%		$209,193
Net Revenue per UOS	$164	$157	$162	$164	▲ 1%		$164
Direct Cost per UOS	$141	$138	$132	$104	▼ -21%		$133
Contrb Margin per UOS	$24	$20	$31	$60	▲ 96%		$31

PER CASE TRENDED GRAPHS

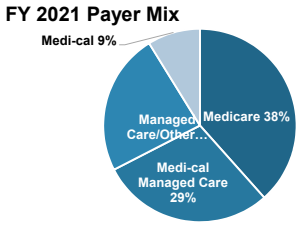




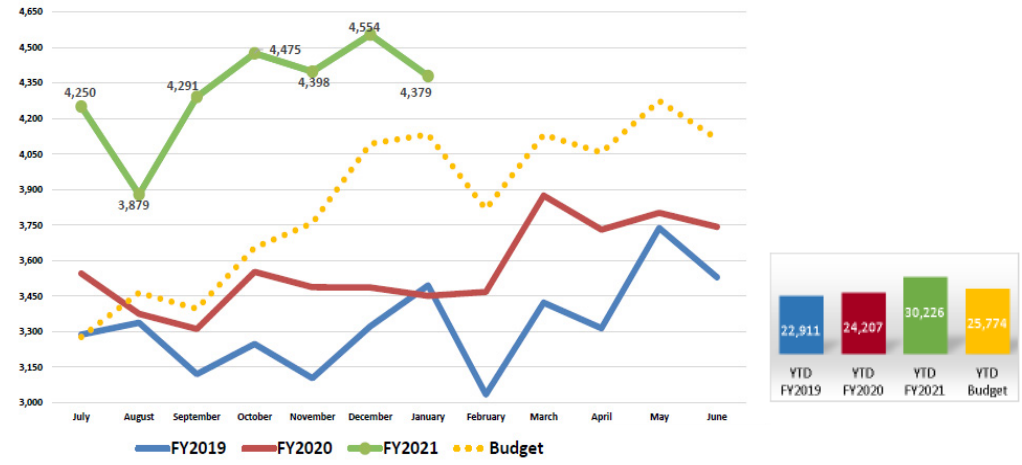


PAYER MIX - 4 YEAR TREND (Gross Charges)

PAYER	FY2018	FY2019	FY2020	FY2021 Annualized
Medicare	34%	30%	31%	38%
Medi-cal Managed Care	0%	0%	17%	29%
Managed Care/Other	30%	33%	28%	24%
Medi-cal	35%	37%	24%	9%
Tulare County	1%	1%	0%	0%



UNIT OF SERVICE GRAPH - HOSPICE DAYS TRENDED



Note regarding FY 2020: Write-offs in the amount of $532,000 taken in FY 2020 were related to prior periods. This report has been adjusted to recognize the write-offs in the correct fiscal year.
Note: The DFR rate is higher in FY 19 due to prior period adjustments in the amount of the $573,450.

Kaweah Delta Health Care District
Annual Report to the Board of Directors

Skilled Nursing Facility (SNF): Transitional Care Services (TCS South and West Campus) and Subacute Care Services: Fiscal Year 2021

Lisa Harrold, Administrator (559) 624-3854
Elisa Venegas, Director of Nursing (559) 624-6014
March 3, 2021

Summary Issue/Service Considered

Financial Performance:

- **Overall performance**
  - The three skilled nursing units have their highest overall contribution margin of the past four years, $460,000.
  - The payment model for Medicare, Patient Driven Payment Model (PDPM), in effect since October 2019 has had a significant positive impact on reimbursement for this program
  - The COVID pandemic has significantly impacted both census and reimbursement. Patient volume was significantly lower due to factors such as patient reluctance to remain in a hospital setting, visitor restrictions, surgery cancellations, and inability to accept COVID positive patients at the south campus due to space constraints preventing establishment of a designated isolation area for those patients. Medi-Cal payments were increased by 10% effective March 2020 due to the pandemic, which positively impacted both TCS and Subacute.

- **TCS South Campus (22 bed unit):**
  - Average daily census was 13, compared to 16 the prior fiscal year. Pre-COVID the unit was on track for an average census of 16.
  - Net revenue per day has increased to $598 from $579 the prior year, an increase of 3%.
  - Payer mix is fairly stable, with some increase noted in Medi-Cal and a decrease in Medicare managed care.
  - The overall contribution margin remained negative, though improved from prior year by approximately 48% Direct expense per day decreased from $742 to $696, a 6% decrease.

- **Short Stay (SS)Ortho West Campus (16 bed unit):**
  - Average daily census of 12, a decrease from 14 prior year. The unit was on track for an average census of 14 prior to the pandemic.
  - Net revenue increased from $575 to $597 per day.
  - Direct costs per day increased from $635 to $766. Non allocated direct costs were very stable between fiscal year 2020 and fiscal year 2021, but were spread across fewer patient days due to the pandemic. This accounts for 30% of the increase per patient day. In addition, allocated direct expenses increased by $232,000 from the prior year, 41% of the increase. These allocated direct expenses are based on budgeted census. The fiscal 21 budget projected an average census of 20, because there were plans to expand unit capacity to 23. This project was put on hold due to

unanticipated expectations from CDPH and OSHPD requiring formal site review and plans, despite the fact that the proposed additional rooms are identical to the existing skilled nursing beds in the same building. The final significant factor in the increase was a 25% increase in therapy cost per patient day.
    - As a result, contribution margin was markedly lower than prior years. Another contributing factor to this was uncompensated care, 3% of patient days, worth $65,000 in direct cost and 14% of patient days paid at the lower Humana Medicare rate, a $50,000 negative impact to the program.

- **Sub acute (32 bed unit):**
    - Average daily census year to date is 30.65, an increase from 29.8 the prior year.
    - Payer mix has remained fairly stable, with Medi-Cal remaining the dominant payer but with increases noted in commercial managed care.
    - Net revenue per day of $854 is a 3% increase from prior year.
    - Direct cost per day decreased to $706 from $744 prior year, a 5% decrease.
    - Contribution margin of $1.7 million is the strongest of the last 4 years.

Quality/Performance Improvement Data

- For the second year in a row, U.S. News and World Report recognized Kaweah Delta's short term skilled nursing program as a top nursing home in the country, placing the facility in the top 19% of facilities nationwide. This award is based on a comprehensive review of quality data, outcomes and evidence of a patient centered approach to care.
- The overall rating of District skilled nursing programs in the Centers for Medicare/Medicaid Services (CMS) 5 star Nursing Home Compare rating program is currently 5 stars. The program continues to average 5 out of 5 stars. Highlights of these results include no long term residents with falls with major injury or urinary tract infections in the last 5 quarters. In the top 1% of facilities for total falls. No short term residents with new or worsened pressure ulcers. Higher return to home percentages and lower readmissions and emergency room visits for short term residents.
- A team collaboration effort with a dedicated Infection Prevention representative and Pharmacy brings a continued focus on reduction of urinary tract infection together with antibiotic stewardship to ensure that antibiotics are used only when indicated and that the appropriate antibiotic is used. The infection preventionist is based in the skilled nursing arena, and is working closely with staff and leadership to monitor practice, provide education, analyze data and recommend improvement strategies.
- Skilled Nursing Value Based Purchasing involves one measure, all cause readmissions. Kaweah Delta's program again achieved the highest attainable program rank, resulting in bonus payments of 3% on all Medicare fee for service claims submitted between Oct 1, 2020 –Sept 30 2021. Clinical leadership and medical directors are conducting ongoing monitoring of all readmissions to evaluate and correct preventable causes of readmissions.
- In March 2020 efforts to mitigate COVID-19 began. The leadership team in collaboration with our designated infection preventionist, educator, and support from the command center developed and carried out the COVID-19 mitigation plan that was approved by CDPH. All staff went through education on changes needed to comply with the mitigation plan. Additionally, a wing at the West Campus Rehab facility was converted to a COVID-19 unit.

Policy, Strategic or Tactical Issues

- Efforts to expand the skilled nursing beds at the rehabilitation hospital by converting 7 acute rehab beds to skilled nursing were paused due to OSHPD requirements and associated fees. We will continue to evaluate the feasibility of this initiative given the cost.
- We have engaged our internal consulting team to assist in a review of our documentation and reimbursement under the Patient Driven Payment Model that went into effect October 2019. The goal of this engagement is to ensure we are accurately capturing patient diagnoses and clinical conditions in order to obtain the desired reimbursement.
- The 2020 annual CDPH survey did not occur. In place CDPH implemented COVID-19 mitigation visits every 6-8 weeks. Since April of 2020 CDPH began surveying all SNF units with a focus on infection prevention to reduce the risk of COVID-19. The visits have were successful, with a total of 2 findings All identified deficiencies were addressed and demonstrated 100% compliance in subsequent audits.
- We continue our engagement with California Hospital Association Center for Post-Acute Care through involvement with advisory board and participation in the skilled nursing monthly forum for members.
- The SNF leadership team is working with the Palliative Care program and Hospice to improve utilization of the Transitional Care Services comfort care/end of life program. The goals of this are to expand these services to a broader patient population as well as to collaborate effectively and integrate the treatment approach of Dr Howard, medical director of the Palliative Care program.

Recommendations/Next Steps

- Continue our work to monitor transfers to acute care during skilled nursing stay as well as acute care re-admissions after discharge to community. Work together with our medical directors to identify any trends, and develop action plans to minimize re-admissions.
- Maintain 5 star rating for the facility.
- Optimize effectiveness of new Cerner product by ensuring accuracy of data entry, and coaching team with best charting practices, particularly in documentation that will impact the MDS Assessment submissions and billing.
- Continue close partnership with LTC pharmacist and KD antimicrobial stewardship program.
- Continue to support and grow our unit based safety (CUSP) team on South Campus; develop a CUSP team for West Campus. Continue to work on safety issues identified by CUSP teams, as well as by annual Safety Attitudes Questionnaire

Approvals/Conclusions

- Assure compliance with all regulatory requirements
- Work to improve contribution margin by optimizing reimbursement while controlling costs.
- Continue to develop clinical practice and documentation and achieve increased ratings on quality measures.

KDHCD ANNUAL BOARD REPORT

Subacute and Transitional Care Services

FY2021 Annualized

Note: Includes patients at the Subacute and Transitional Care Services South Campus locations and TCS-Ortho Unit at West Campus.

KEY METRICS -- FY 2021 ANNUALIZED ON THE SEVEN MONTHS ENDED JANUARY 31, 2021

PATIENT DAYS	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
20,199	$14,940,117	$14,479,934	$460,183	($6,485,736)
▼ -11%	▶ 0%	▼ -5%	▲ 258%	▲ 3%

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

METRICS BY SERVICE LINE - FY 2021 ANNUALIZED

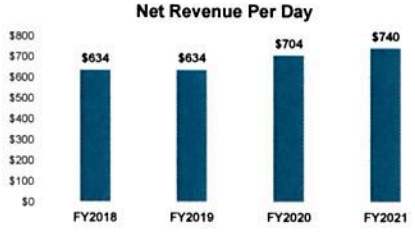
SERVICE LINE	PATIENT DAYS	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
Inpatient Subacute	11,189	$9,554,330	$7,904,453	$1,649,877	($1,583,323)
Tansitional Care Services	4,707	$2,814,941	$3,277,483	($462,542)	($1,944,543)
Tansitional Care Ortho	4,303	$2,570,846	$3,297,998	($727,152)	($2,957,870)
Long Term Care Totals	20,199	$14,940,117	$14,479,934	$460,183	($6,485,736)

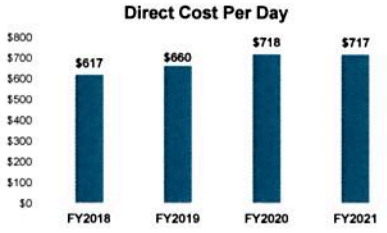
METRICS SUMMARY - 4 YEAR TREND

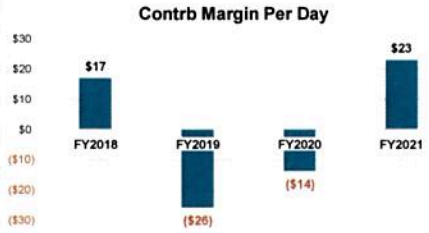
*Annualized

METRIC	FY2018	FY2019	FY2020	FY2021	%CHANGE FROM PRIOR YR	4 YR TREND	Pre-COVID Ann. Jul. 19 - Feb. 20
Patient Days	21,559	21,526	21,227	20,199	▼ -5%		21,959
Net Revenue	$13,657,789	$13,650,925	$14,953,726	$14,940,117	▶ 0%		$14,713,269
Direct Cost	$13,297,078	$14,205,852	$15,245,876	$14,479,934	▼ -5%		$15,778,719
Contribution Margin	$360,711	($554,927)	($292,150)	$460,183	▲ 258%		($1,065,450)
Indirect Cost	$6,414,835	$6,327,399	$6,405,925	$6,945,919	▲ 8%		$6,641,424
Net Income	($6,054,124)	($6,882,326)	($6,698,075)	($6,485,736)	▲ 3%		($7,706,874)
Net Revenue Per Day	$634	$634	$704	$740	▲ 5%		$670
Direct Cost Per Day	$617	$660	$718	$717	▶ 0%		$719
Contrb Margin Per Day	$17	($26)	($14)	$23	▲ 266%		($49)

GRAPHS







Notes:
Source: Inpatient Service Line Reports
Criteria: Inpatient Miscellaneous Medical Services
Criteria: Service Name Kaweah Delta Medical Center

KDHCD ANNUAL BOARD REPORT

FY2021 Annualized

Subacute Services - South Campus

Note: Includes all patients at the Subacute South Campus location.

KEY METRICS -- FY 2021 ANNUALIZED ON THE SEVEN MONTHS ENDED JANUARY 31, 2021

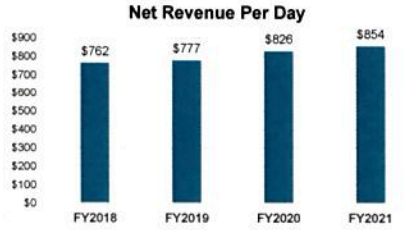
PATIENT DAYS	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
11,189	$9,554,330	$7,904,453	$1,649,877	($1,583,323)
▶ 0%	▲ 7%	▼ -2%	▲ 85%	▲ 31%

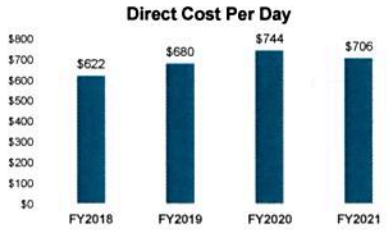
*Note: Arrows represent the change from prior year and the lines represent the 4-year trend

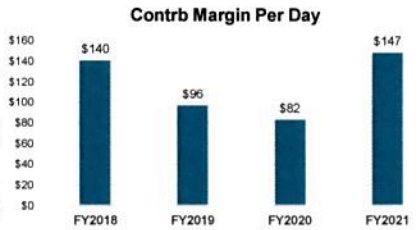
METRICS SUMMARY - 4 YEAR TREND

METRIC	FY2018	FY2019	FY2020	*Annualized FY2021	%CHANGE FROM PRIOR YR	4 YR TREND	Pre-COVID Ann. Jul. 19 - Feb. 20
Patient Days	11,324	11,337	10,858	11,189	▲ 3%		10,817
Net Revenue	$8,627,240	$8,803,935	$8,970,112	$9,554,330	▲ 7%		$8,571,333
Direct Cost	$7,040,924	$7,713,728	$8,076,312	$7,904,453	▼ -2%		$8,117,151
Contribution Margin	$1,586,316	$1,090,207	$893,800	$1,649,877	▲ 85%		$454,182
Indirect Cost	$3,156,949	$3,257,014	$3,186,710	$3,233,199	▲ 1%		$3,200,745
Net Income	($1,570,633)	($2,166,807)	($2,292,910)	($1,583,323)	▲ 31%		($2,746,563)
Net Revenue Per Day	$762	$777	$826	$854	▲ 3%		$792
Direct Cost Per Day	$622	$680	$744	$706	▼ -5%		$750
Contrb Margin Per Day	$140	$96	$82	$147	▲ 79%		$42

PER CASE TRENDED GRAPHS

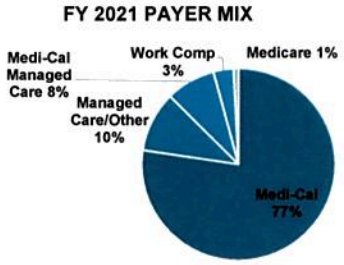






PAYER MIX - 4 YEAR TREND (GROSS REVENUE)

PAYER	FY2018	FY2019	FY2020	*Annualized FY2021
Medi-Cal	81%	84%	77%	77%
Managed Care/Other	7%	6%	7%	10%
Medi-Cal Managed Care	1%	7%	11%	8%
Work Comp	0%	1%	0%	3%
Medicare	9%	2%	3%	1%



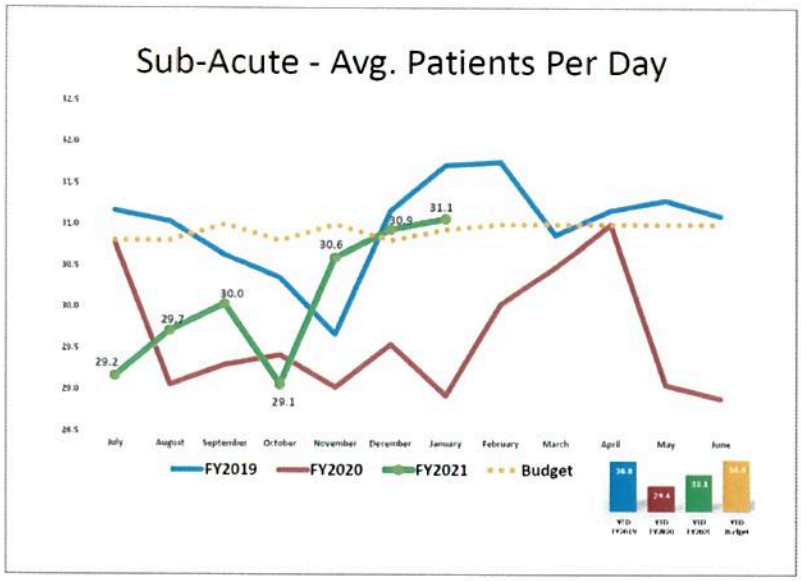
KDHCD ANNUAL BOARD REPORT

FY2021 Annualized

Subacute Services - South Campus

Note: Includes all patients at the Subacute South Campus location

KEY METRICS -- FY 2021 ANNUALIZED ON THE SEVEN MONTHS ENDED JANUARY 31, 2021



Source: Inpatient Service Line Report, Sub-Acute -Avg Patients Per Day slide
Selection criteria: EntyID = KDSA - Kaweah Delta Subacute facility, excluding Exeter Rural Health Clinic visits.

KDHCD ANNUAL BOARD REPORT

FY2021 Annualized

Transitional Care Services - South Campus

Note: All patients at the Transitional Care Services South Campus location. This excludes cases at TCS-Ortho West Campus location.

KEY METRICS -- FY 2021 ANNUALIZED ON THE SEVEN MONTHS ENDED JANUARY 31, 2021

PATIENT DAYS	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
4,707	$2,814,941	$3,277,483	($462,542)	($1,944,543)
▼ -21%	▼ -11%	▼ -19%	▲ 48%	▲ 20%

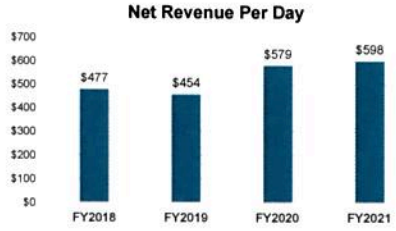
*Note: Arrows represent the change from prior year and the lines represent the 4-year trend

METRICS SUMMARY - 4 YEAR TREND

*Annualized

METRIC	FY2018	FY2019	FY2020	FY2021	%CHANGE FROM PRIOR YR	4 YR TREND	Pre-COVID Ann. Jul. 19 - Feb. 20
Patient Days	5,744	5,412	5,450	4,707	▼ -14%		5,913
Net Revenue	$2,737,195	$2,457,162	$3,152,922	$2,814,941	▼ -11%		$3,170,360
Direct Cost	$3,812,338	$3,872,310	$4,044,379	$3,277,483	▼ -19%		$4,320,578
Contribution Margin	($1,075,143)	($1,415,148)	($891,457)	($462,542)	▲ 48%		($1,150,218)
Indirect Cost	$1,802,623	$1,593,166	$1,549,950	$1,482,002	▼ -4%		$1,664,076
Net Income	($2,877,766)	($3,008,314)	($2,441,407)	($1,944,543)	▲ 20%		($2,814,294)
Net Revenue Per Day	$477	$454	$579	$598	▲ 3%		$536
Direct Cost Per Day	$664	$716	$742	$696	▼ -6%		$731
Contrb Margin Per Day	($187)	($261)	($164)	($98)	▲ 40%		($195)

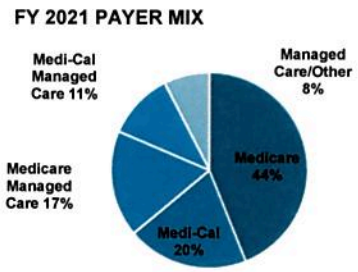
PER CASE TRENDED GRAPHS



PAYER MIX - 4 YEAR TREND (GROSS REVENUE)

*Annualized

PAYER	FY2018	FY2019	FY2020	FY2021
Medicare	49%	44%	42%	44%
Medi-Cal	15%	16%	12%	20%
Medicare Managed Care	15%	22%	24%	17%
Medi-Cal Managed Care	12%	12%	13%	11%
Managed Care/Other	8%	5%	8%	8%



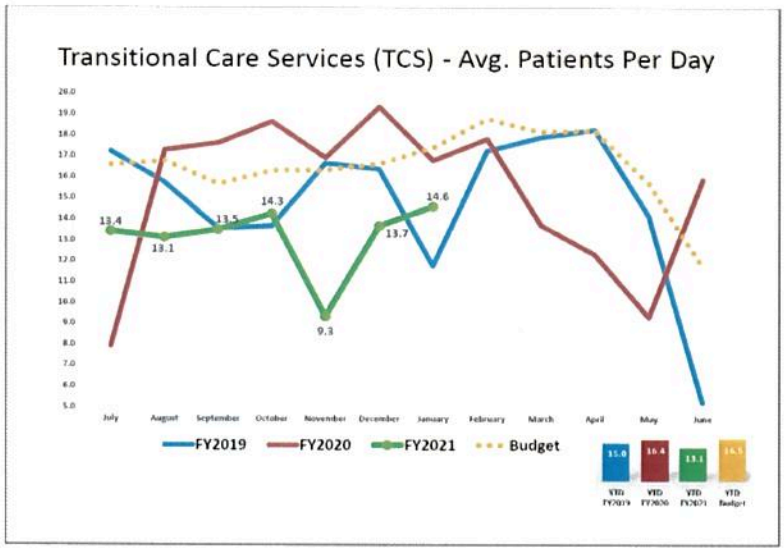
KDHCD ANNUAL BOARD REPORT

FY2021 Annualized

Transitional Care Services - South Campus

Note: All patients at the Transitional Care Services South Campus location. This excludes cases at TCS-Ortho West Campus location.

KEY METRICS -- FY 2021 ANNUALIZED ON THE SEVEN MONTHS ENDED JANUARY 31, 2021



Note: FY 2021 is annualized in graphs and throughout the analysis
Source: Inpatient Service Line Report, Transitional Care Services - Avg Patients Per Day stats slide
Selection criteria: EntyID = KDSN - Kaweah Delta Skilled Nursing/Transitional Care Services, patients having a room charge in department 6581.

KDHCD ANNUAL BOARD REPORT

FY2021 Annualized

Transitional Care Services Orthopedics - West Campus

Note: All patients at the Transitional Care Services West Campus location. This excludes cases at Transitional Care Services South Campus location.

KEY METRICS -- FY 2021 ANNUALIZED ON THE SEVEN MONTHS ENDED JANUARY 31, 2021

PATIENT DAYS	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
4,303	$2,570,846	$3,297,998	($727,152)	($2,957,870)
▼ -10%	▼ -9%	▲ 6%	▼ -147%	▼ -51%

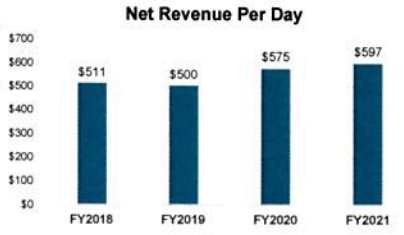
*Note: Arrows represent the change from prior year and the lines represent the 4-year trend

METRICS SUMMARY - 4 YEAR TREND

*Annualized

METRIC	FY2018	FY2019	FY2020	FY2021	%CHANGE FROM PRIOR YR	4 YR TREND	Pre-COVID Ann. Jul. 19 - Feb. 20
Patient Days	4,491	4,777	4,919	4,303	▼ -13%		5,229
Net Revenue	$2,293,354	$2,389,828	$2,830,692	$2,570,846	▼ -9%		$2,971,577
Direct Cost	$2,443,816	$2,619,814	$3,125,185	$3,297,998	▲ 6%		$3,340,991
Contribution Margin	($150,462)	($229,986)	($294,493)	($727,152)	▼ -147%		($369,414)
Indirect Cost	$1,455,263	$1,477,219	$1,669,265	$2,230,718	▲ 34%		$1,776,603
Net Income	($1,605,725)	($1,707,205)	($1,963,758)	($2,957,870)	▼ -51%		($2,146,017)
Net Revenue Per Day	$511	$500	$575	$597	▲ 4%		$568
Direct Cost Per Day	$544	$548	$635	$766	▲ 21%		$639
Contrb Margin Per Day	($34)	($48)	($60)	($169)	▼ -182%		($71)

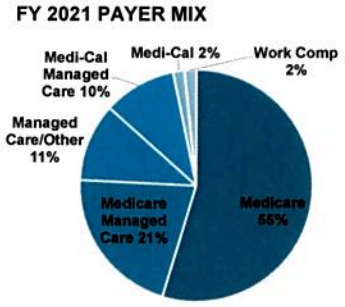
PER CASE TRENDED GRAPHS



PAYER MIX - 4 YEAR TREND (GROSS REVENUE)

*Annualized

PAYER	FY2018	FY2019	FY2020	FY2021
Medicare	61%	62%	62%	55%
Medicare Managed Care	24%	24%	21%	21%
Managed Care/Other	9%	8%	10%	11%
Medi-Cal Managed Care	4%	5%	7%	10%
Medi-Cal	1%	0%	0%	2%
Work Comp	0%	2%	1%	2%



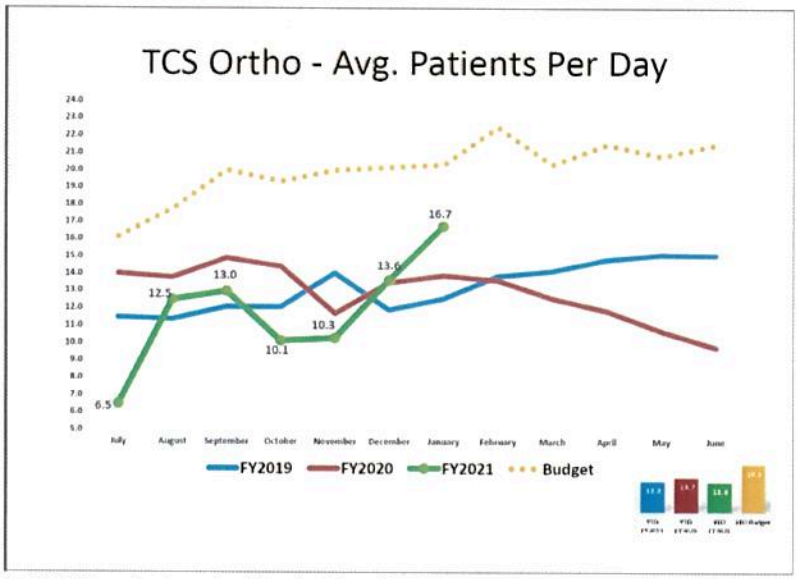
KDHCD ANNUAL BOARD REPORT

FY2021 Annualized

Transitional Care Services Orthopedics - West Campus

Note: All patients at the Transitional Care Services West Campus location. This excludes cases at Transitional Care Services South Campus location.

KEY METRICS -- FY 2021 ANNUALIZED ON THE SEVEN MONTHS ENDED JANUARY 31, 2021



Note: FY 2021 is annualized in graphs and throughout the analysis
Source: Inpatient Service Line Report, Transitional Care Services - Avg Patients Per Day stats slide
Selection criteria: EntyID = KDSN - Kaweah Delta Skilled Nursing/Transitional Care Services West patients having a room charge in department 6587.

Kaweah Delta
HEALTH CARE DISTRICT

Annual Evaluation of the Environment of Care 2020

Prepared by

Environment of Care Committee

Maribel Aguilar, Safety Officer

Please contact Maribel Aguilar with any questions (559) 624-2381.

March 2021

Evaluation of the *Objectives* of the Environment of Care Management Plans and the Emergency Operations Plan
Kaweah Delta Health Care District
2020

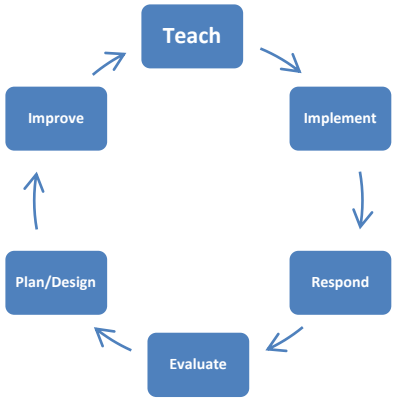
Introduction

The goal at Kaweah Delta Health Care District is to provide a safe *Environment of Care* for our patients, staff, physicians and visitors, so that quality is preserved and risks are minimized. The *Environment of Care* filters through every aspect of our District, from the first patient contact (i.e., clean hospital, comfortable place to sit, privacy), through the assessment, treatment, discharge and continuing care. It is an integral component of patient safety insofar as risks could negatively impact their patient experience, such as a medical equipment failure due to a power outage, a breach in infant or child security, or the untoward effects of a hazardous materials exposure.

Other important functions, such as Infection Prevention (as when pre-construction risk assessments are made or Infection Prevention permits are issued) overlap with the E*nvironment of Care*. There is also integration with Human Resources with respect to educational needs and competency assessments for our staff. To determine if elements of the *Environment of Care* and Emergency Operations are effective, there is linkage to Performance Improvement, i.e., in the establishment of performance standards to monitor if we are meeting established thresholds of performance. The objectives of the various *Environment of Care* Management plans and the Emergency Operations Plan have been to manage risk so that our patient occupants and visitors can safely receive care and our patient care providers can provide treatment in a safe environment. We continue to view the following dynamic processes as tools and constructs to support change and improvements within the *Environment of Care* and Emergency Operations within the District.

Teach: *Educating staff regarding their roles*

Improve*: Making decisions about our findings*



Implement*: Implementing design*

Plan/Design: *Strategic and ongoing master planning by the organizational leadership*

Respond: *Measuring standards that we have set for the environment of care and emergency management*

Evaluate*: Gathering information about our outcomes*

Our *Environment of Care* Management plans address six elements, and one chapter, Emergency Management, provides the framework for disaster planning and emergency operations. The six elements include Safety, Security, Hazardous Materials and Waste, Fire Prevention, Clinical Equipment and Utilities Management. There is much diversity in *Environment of Care* and Emergency Operations planning, however each have parallels with planning, teaching, implementing, responding, monitoring and improving. Our purpose with the *Environment of Care* is to ensure ongoing diminishment of risk (e.g., possible loss or injury) within our District. The Safety Officer and *Environment of Care* Committee members provide the leadership foundation for the management of risks, promoting a teamwork approach, and ongoing attention to programs, plans, and related activities that point toward risk reduction. Whenever possible, the *Environment of Care* and Emergency Management are integrated with regulatory requirements from Federal, State and local agencies having jurisdiction, enforcing standards that encourage continued improvement in the workplace.

Evaluation of Objectives – Safety Management Plan

Various risks are inherent in the environment because of the types of care provided and the types of equipment that may be used during patient care or office activities. The Safety Management plan is designed to provide a physical environment wherein risks may be proactively identified. Risks are managed proactively from multiple focus—environmental surveillance, insurer surveys, regulatory and or accreditation surveys, and sometimes in response to an incident or injury that has occurred. It is the responsibility of the Safety Officer and *Environment of Care* Committee members to coordinate and manage these risk assessment and reduction activities. Safety and Infection Prevention policies and procedures, staff training and continuing education provide structure and direction for our staff so that their attention to tasks at hand can be focused on doing the right thing and/or implementing the safest method involved in their day-to-day work activities. Taken together, these programs and activities have contributed to effective injury management and support the objective of the Safety Management plan to reduce risk. The objectives of the Safety Management Plan have been met.

Evaluation of the Objectives of the Hazardous Materials and Waste Management Plan

The objective of the Hazardous Materials and Waste Management plan is to minimize the risks associated with hazardous chemicals, radioactive materials, hazardous energy sources, hazardous medications and hazardous gases/vapors for all those who enter the District, as well as the surrounding community. Equally important is our effort to reduce waste and to use non-hazardous products whenever feasible. Our educational programs, completion of annual chemical inventories and monitoring of spills and radiation/laser issues in the District demonstrate our commitment to minimize the risks associated with the use and disposal of hazardous materials.
The objectives of the Hazardous Materials and Waste Management Plan have been met.

Evaluation of Objectives – Security Management Plan

The Security Management plan is designed to provide the highest quality of security for our patients, visitors, physicians and staff placing an emphasis on care and respect. Our objective is to create a safe place to work, in a peaceful environment, so that those who enter the premises feel at ease. Through security risk assessments, we are continually looking for processes and ways to improve our security systems and reduce risk. Global threats of terrorism keep our security staff at a heightened level of awareness which necessitates a strong partnership with local authorities. A training program is in place for our security staff, which includes skills building and assault training techniques that has also been extended to Emergency Department staff, Mental Health staff and other staff whose positions or departments may represent risk. Security hardware (e.g., camera surveillance and card readers) are designed to spot activity and/or deter an unfavorable activity from occurring. We carefully monitor our incidents to determine if there are any trends relating to violence. The District has a stance of zero tolerance for violence. These processes support the Security Management's plan objective to diminish risk within the premises. The objectives of the Security Management Plan have been met.

Evaluation of the Objectives of the *Emergency Operations Plan*

The objective of the *Emergency Operations Plan* is to minimize risks related to potential emergencies that fall on a continuum from disruptive to disastrous, and to ensure an effective staff response to disasters and emergent events that may effect our organization's ability to provide care. This plan is intended to identify risks and balance these risks against preparedness and mitigation strategies in place as well as to use information relating to these risks in the design of our disaster drills. Our *Emergency Operations Plan* addresses four phases of emergency management, which includes: mitigation, preparedness, response and recovery, and includes the testing of our plan through drill activities that require a practiced response from our staff. On March 13, 2020, Kaweah Delta activated the Hospital Incident Command System (HICS) in response to the COVID-19 pandemic. The role of HICS in a rapidly evolving complex incident is to help manage the information, logistics, and operational needs in a systematic manner, while providing scalability and business continuity to prevent interruptions to mission critical services. Since opening the Incident Command Center, Kaweah Delta has faced two significant surges of COVID patients requiring a large scale response and the use of surge beds to meet the communities Healthcare needs. Throughout the COVID response, Kaweah Delta has collaborated with local, state and federal partners, activated a labor pool, utilized alternate care sites, and maximized the use of technology to meet the medical demands of the community.

The use of the *HICS,* a standardized approach to disaster management, allows our management and staff to respond to all-hazard types of disasters. We have continued to actively partner with our community partners including The County of Tulare Office of Emergency Services, Tulare County Public Health Emergency Preparedness Program, Visalia Police Department and Visalia Fire Department. We have continued to train staff for in emergency response including decontamination and workplace violence prevention and we have a very active Emergency Management Subcommittee that has addressed multiple issues throughout the year, including, but not limited to, refining and augmenting our inventory of organizational assets and resources, planning for drills, and completing the hazard vulnerability analysis. The District has succeeded in meeting the objectives of the Emergency Operations Plan and have continued to strengthen our partnerships with other organizations, and agencies having jurisdiction (e.g., local law enforcement, fire departments, and the Tulare County Department of Health Services). The objectives of the Emergency Management Plan have been met.

Evaluation of the Objectives of the Fire Prevention Management Plan

We recognize that the risk of fire carries with it the most significant single threat to the environment of care as our patients are often unable to move safely by themselves. Staff must continually practice their fire response skills to extend protection to our patients in the event of a fire or the products of fire. The objective of the Fire Prevention Management Plan is to minimize the risk of fire, potential injury from fire and limit property damage. Our expectation and duty is to comply with the *Life Safety Code©* through a fire equipment testing and maintenance program as well as through ongoing fire drill, which test correct staff fire response. Through scheduled hazard surveillance, fire drills, a viable *Statement of Conditions*, fire equipment testing, inspection, maintenance and staff education, the objective of the Fire Prevention plan has been successfully met.

Evaluation of the Objectives of the Clinical Engineering Management Plan

The objective of the Clinical Engineering Management Plan includes the assurance that our medical equipment is operationally reliable, with the risk of a medical equipment failure minimized. In order to meet this objective multiple programs are in place which include, but are not limited to: (1) risk assessment of all incoming medical equipment, (2) preventive and corrective maintenance programs, (3) corrective maintenance program for equipment that needs repair, and (4) training for the users and maintainers to minimize human error. We monitor our preventive maintenance for life safety and non-life safety medical equipment to ensure we are meeting established thresholds, which promotes sound operational reliability for medical equipment used on our patients. We ensure that any type of medical equipment that enters the District is checked by Clinical Engineering staff before it is used on our patients. These programs and safeguards have been effective in allowing us to meet the objectives stated in our Clinical Engineering Management Plan.

Evaluation of the Objectives of the Utilities Management Plan

The objective of the Utilities Management Plan is to minimize the risks relating to utility disruptions and to ensure our utility equipment remains operationally reliable. Meeting these two objectives promotes a safe, controlled and comfortable environment for our patients, staff, visitors and physicians. To meet this objective, programs must be in place that include, but are not limited to, risk assessment of utility equipment, preventive and corrective maintenance programs, timely and efficient response to utility failures, and ongoing education for those who use and maintain utility equipment. The *Environment of Care* committee monitors preventive maintenance of utility equipment and utility failures to ensure established thresholds of performance are met. These efforts are for the purpose of promoting the highest level of operational reliability for utility equipment that supports our built environments. These programs are in place in all facilities within the District with ongoing monitoring and assessment demonstrating that our objectives for the Utility Management plan have been met.

EVALUATION - *SCOPE* of the ENVIRONMENT OF CARE

Evaluation of the Scope: Our management plans identify the scope of each plan which applies to all District staff and physicians. The scope of the management plans are intended to be broad-based to allow for a multitude of accomplishments to occur. Each contributes to overall risk reduction in the District. The activities that are identified below support a multi-faceted approach to reducing risks that may occur from different sources, internal and external, to the District. The scope, based upon these activities, is evaluated to be supportive of a safe physical environment within which we proactively risk-assess and take appropriate actions. The following key activities support a breadth and depth of the scope *of the Environment of Care (EOC) activities* and Emergency Management at Kaweah Delta Health Care District.

Safety Management:

- Environmental surveillance completed, with action items identified, and corrections made.
- Safety Education for employees include online learning modules.
- Sharp exposures, with an increase in sharp injuries. Syringe safety education provided.
- Employee injuries monitored, with 9.7 % decrease in OSHA reportable injuries (Without Covid+ claims). Worker's Compensation Administrator continues to implement the Risk Improvement Action Plan.
- Safe Patient Handling training complete for patient care staff.
- Infection Prevention monitored hand hygiene compliance.
- Environment of Care training modules distributed to physicians and volunteers.
- Dialysis water testing monitored.
- Product recalls monitored.
- *Environment of Care* Committee meetings regularly scheduled, reviewing district-wide issues, trends, reflecting a solid EOC program.
- Reviewed/revised Safety Management Plan with approval from Board of Directors.

Security Management:

- Security incidents reviewed with access granted to key areas for select staff members.
- CPI- Nonviolent Crisis Intervention training conducted for employees working in Mental Health, Security, Emergency Department, Float Pool, Rehab and South Campus. Additionally, Licensed Patient Family Services staff, Maintenance staff, Leadership staff, Unit Charge staff and Nursing Supervision staff also received CPI training. Over 800 staff trained.
- Security officer staffing was increased in the Emergency Department and the Acute Mental Health Facility to improve safety and security efforts.
- Security Risk Assessments completed for all campuses.
- Reviewed/revised Security Management Plan with approval from Board of Directors.

Hazardous Materials and Waste Management:

- Annual hazardous materials inventory complete. Annual chemical specific and safety data sheet training for all district employees.
- Radiation Safety Committee monitored radiation issues (i.e., badge reading, apron safety, license requirements, annual update of radiation safety plan, etc.).
- Hazardous gas monitoring and testing completed.
- Reviewed/revised Hazardous Materials Plan with approval from Board of Directors.
- Hazardous Materials Business Plan updated-submitted to Tulare County.

Emergency Operations:

- The Emergency Management Subcommittee involved with planning/design relating to: inventory of organizational assets, equipment purchases, drill design, implementation and follow-up relating to drills and actual events, and integrating community partnerships into planning activities.
- The *Hazardous Vulnerability Analysis* reviewed/revised with top risks identified, and mitigation, preparedness, response, recovery identified.
- Training was completed for the following: Decontamination, Emergency Preparedness, Anhydrous Ammonia Handing, Evacusled Evacuation, and new hire orientation.
- The *Emergency Operations Plan* reviewed/revised based on the evaluations of the emergency exercises with approval from Board of Directors.
- Reviewed/revised unit specific fire, safety and emergency plans.
- Participated in Tulare County disaster planning activities.

Life Safety Management:

- All fire drills were held per schedule, with no trends noted.
- Visalia Fire Department conducted annual Life Safety Inspection.
- The *Statement of Conditions* monitored routinely, and updated throughout 2020.
- Fire testing equipment completed per schedule.
- Reviewed/revised Life Safety Management Plan with approval from Board of Directors.

Clinical Engineering Management:

- Preventive maintenance for life support and non-life support medical equipment completed, with thresholds of performance met.
- Reviewed/revised Clinical Equipment Management Plan with approval from Board of Directors.

Utility Equipment Management:

- Preventive maintenance and utility reports reviewed quarterly, including utility failures, and actions taken.
- Indoor air quality monitored and issues identified with resolutions completed.
- Reviewed/revised Utility Management Plan with approval from Board of Directors.

EVALUATION: *PERFORMANCE STANDARDS*

OVERVIEW. Information to follow represents the evaluation of established performance standards. Performance Standards were chosen based upon the following criteria:

1. The performance standard represents a measurable area of one of the EOC components.
2. The performance standard indicates a key reflection of the scope of the component.
3. The performance standard represents a high volume activity, or low volume but high-risk consequences.
4. The performance standard reflects actual or potential risk to the organization.

2020 PERFORMANCE STANDARDS
Kaweah Delta Health Care District

SAFETY

•Objective is to reduce OSHA reportable work related injuries/illness in the year 2020.
Goal: Reduce OSHA reportable injuries by 10% or no more than 193 incidents.
Minimum Performance Level: Reduce OSHA Reportable Injuries by 10% or no more than 193 incidents.
Outcome: Goal not met. Due to Covid 19 related injuries.

•*Patient death or serious disability associated with a fall will be monitored.*
Goal: No patient death or serious disability while on the premises of a KDHCD facility.
Minimum Performance Level: No patient death or serious disability while on the premises of a KDHCD facility.
Outcome: Goal not met. One patient death or serious disability associated with a fall.

•Reporting of non-patient safety related injuries.
Goal: Increase reporting of non-patient safety related injuries within 7 days by 10%.
Minimum Performance Level: 100% compliance.
Outcome: Goal met.

•Infection Prevention - Compliance with environmental rounding on units.
Goal: 100% compliance.
Minimum Performance Level: 90% of observations will demonstrate the correct practice.
Outcome: *Goal not met. The plan is to continue comprehensive rounds in 2021 to increase awareness.*

UTILITIES MANAGEMENT

•Utility equipment will be preventively maintained on a quarterly basis.
Goal: 100% compliance.
Minimum Performance Level: 100% compliance.
Outcome: Goal not met. 2020 compliance at 89%. Compliance impacted by Covid.

SECURITY

•The Security department will track Code Grey response on events.
Goal: 90% compliance on response from Code Grey responders (CPI responders, identifying roles and debriefing).
Minimum Performance Level: 90% compliance.
Outcome: Goal met for code grey response effectiveness.
Goal not for code grey role identification.
Goal not met for code grey debriefing. 2020 compliance at 76%.

FIRE PREVENTION

•Storage of equipment and supplies will be monitored.
Goal: 100% Compliance.
Minimum Performance Level: 100% of equipment and supplies will be stored appropriately.
Outcome: Goal not met. Year end compliance 95%. Safety and Facilities will focus on storage compliance for 2021.

EMERGENCY MANAGEMENT

•Staff able to demonstrate the correct response related to use of fire extinguisher.
Goal: 100% Compliance.
Minimum Performance Level: 95% of staff will properly verbalize response to use of fire extinguisher.
Outcome: Goal met.

CLINICAL EQUIPMENT

- The Clinical Engineering Department will complete assigned preventive maintenance tasks as required per policy EOC 6001.

Goal: 100% Compliance

Minimum Performance Level: 100% Compliance is the minimum compliance requirement per TJC for both Non High Risk (NHR) and High Risk including Life Support (HRLS) devices.

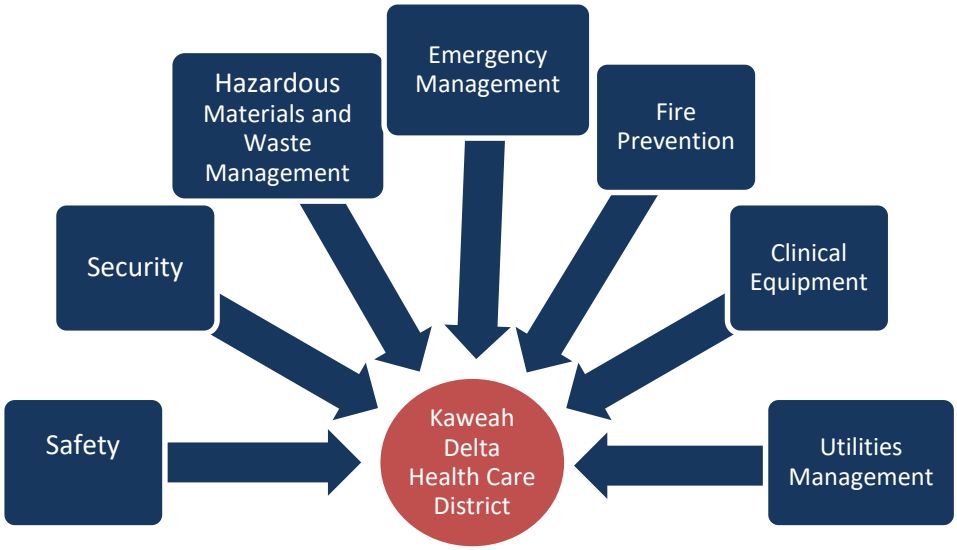
Outcome: Goal not met. 2020 compliance at 98%

•Continually improve completion of Preventive Maintenance for High Risk including Life Support (HRLS) devices

Goal: 100% Compliance.

Minimum Performance Level: Lower and keep the number of these devices recorded as Missing In Action (MIA) to less than 1% of the total HRLS inventory per quarter.

Outcome: Goal not met.2020 compliance at 1.1%.



EOC Component: SAFETY

Performance Standard: Employee Health: Reduce Occupational Safety & Health Administration (OSHA) recordable work related injury cases by 10% from 2019. No more than 193 workers compensation injuries in 2020.

Goal: Reduce OSHA recordable injuries by 10% in 2020.

Minimum Performance Level: Reduce OSHA recordable injuries by 10% in 2020.

Evaluation:
There were 186 OSHA recordable injuries during the 4th quarter 2020 including 133 Covid 19 claims, 467 total for 2020.

- Goal for Quarter 4 not met, goal for 2020 not met due to Covid 19 claims. Without Covid 19 claims OSHA recordable injuries were reduced by 9.7% for 2020.

Type of injury	Q1	Q2	Q3	Q4	Totals 2020	Annual % chg	Totals 2019	Per 1000 employees
Total Incidents	112	226	177	244	759	44.0%	527	47.33
OSHA recordable	43	117	121	186	467	117.2%	215	36.08
Lost time cases	20	99	96	163	378	164.3%	143	31.62
Strain/sprain	27	26	21	27	101	-5.6%	107	5.24
Bruise/ Contusion	6	5	2	3	16	-55.6%	36	0.58
Cum Trauma	1	1	0	1	3	-40.0%	5	0.19
Sharps Exp	21	13	22	20	76	-5.0%	80	3.88
Covid 19+ *	4	71	63	133	271	n/a	0	25.80
BBF Splash	5	0	4	3	12	-36.8%	19	0.58
# EE end of QTR	5037	5036	5125	5155				

Plan for Improvement:

- Continue to work with infection prevention to decrease Covid 19+ exposures/ claims by healthcare workers in 1st qtr. of 2021.
- Identify employees with ≥ 3 OSHA recordable injuries in last 2 years. Employee health (EH) 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 EH. Demo correct sharps activation in new hire physicals with all employees handling sharps.
- Utilize physical therapy 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.

EOC Component: SAFETY

Performance Standard:

Risk Management – No patient death or serious disability* associated with a fall while being cared for in a KDHCD facility.
Goal: 100% Compliance.
Minimum Performance Level: 100% Compliance

Evaluation:
There was one incident of patient death or serious disability associated with a fall while being cared for in a KDHCD facility during 2020.

The Minimum Performance Level was not met for this standard in 2020.

*Serious disability means physical or mental impairment that substantially limits one or more of the major life activities of an individual, or the loss of bodily function, if the impairment lasts more than seven (7) days or is still present at the time of discharge, or loss of a body part.

Plan for Improvement:
Hazardous Surveillance inspections of all KDHCD facilities will be conducted on a scheduled basis. Safety issues identified will be reported to Department Managers and action plans for correction generated.

Continue to monitor.

EOC Component: SAFETY

Performance Standard:

Risk Management – Reporting of non-patient safety related injuries within 7 days will increase by 10% by the end of 2020.

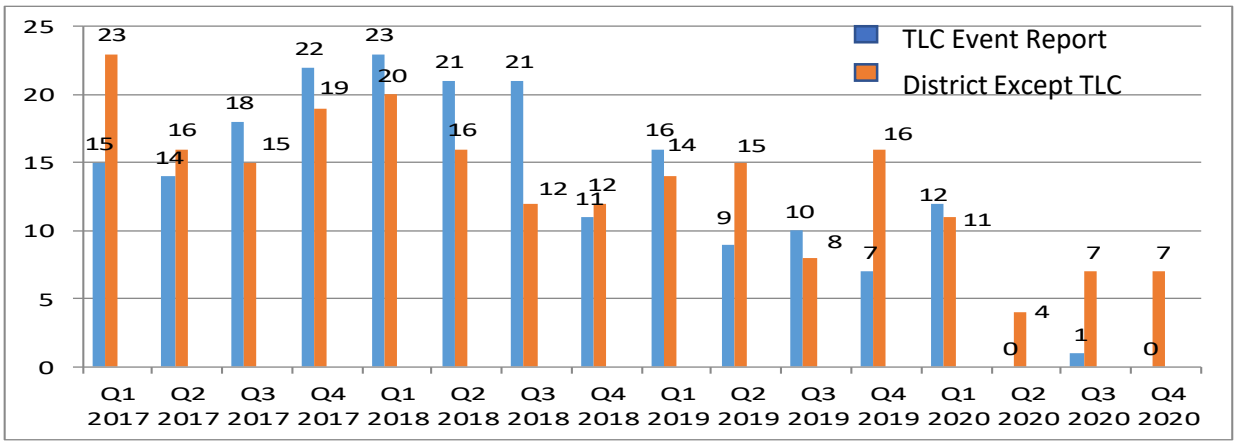
Goal: Increase non-patient safety related reporting on events by 10%
Minimum Performance Level: Increase non-patient safety related reporting by 10%.

Evaluation:
In 2020, there were a total of 29 reported visitor injuries reported, all within 7 days.

Non-patient related events were tracked by Risk Management. In 2020 we had a decrease of 69% from the 2019 reports of 95.
This could be a result of visitor changes throughout the organization

Minimum performance measure was met for 2020 at 100% compliance.

Non-Patient Related Injuries



Indicator	Quarter 1 2020	Quarter 2 2020	Quarter 3 2020	Quarter 4 2020	2020 YTD Totals	2019 YTD Totals
Non-patient Related Events within 7 days	11	4	7	7	29	95

*Injury is defined as physical or mental impairment that requires additional medical treatment or intervention.

Plan for Improvement:
Risk Management has conducted education to staff related to occurrence reporting and when and how to report any type of injury. For 2021 we will focus on non-patient safety related reported to risk management within 7 calendar days.

EOC Component: SAFETY

Performance Standard:

Infection Prevention: Improve hand hygiene awareness/compliance through rounding with patient care units twice yearly.

Goal: 100% compliance with hand hygiene performance and monitoring processes.
Minimum Performance Level: 90% compliance per The Joint Commission recommendations for improvement.

Evaluation:

In 2020 **General areas** the categories of Mechanical Equipment, Housekeeping, Linens and Patient Room/Environment were all at 100% compliance. The greatest amount of attention in these areas include Cleaning, Disinfection & Sterilization.

For Pharmacy, all categories except Hand Hygiene, Receiving, Packaging and Distribution were at 100% compliance. Areas of concern include Hand Hygiene, Receiving, packaging and Distribution.

For Food Services, all categories except quality control were at 100% compliance.

Overall goal for 2020 was not met.

Results Key
Green- 96%-100%
Yellow- 90%-95%
Red- less than 90%

General Areas	Key Performance Measure Results		
Mechanical Equipment	100%	0%	0%
Housekeeping	100%	0%	0%
Linens	100%	0%	0%
Patient room/environment	100%	0%	0%
Cleaning, Disinfection & Sterilization	0%	0%	100%
Hand Hygiene	0%	50%	50%
Staff Workspace	50%	0%	50%
Medication Room	50%	10%	40%

Pharmacy	Key Performance Measure Results		
Category	Green	Yellow	Red
Standard/Regulation	100%	0%	0%
USP 797 Sterile Compouding Room - ISO 7 Buffer Room (Anteroom)	100%	0%	0%
USP 797 Sterile Compouding Room - ISO 5 Compounding Hoods/Room	100%	0%	0%
USP 800 Negative Pressure Hazardous Medication Compounding Room - ISO 7 Buffer Room (Anteroom)	100%	0%	0%
USP 800 Negative Pressure Hazardous Medication Compounding Room - ISO 8 Negative Pressure Room	100%	0%	0%
Housekeeping	100%	0%	0%
Hand Hygiene	50%	0%	50%
Receiving	50%	0%	50%
Packaging and Distribution	81.3%	0%	18.8%

Food Services	Key Performance Measure Results		
Category	Green	Yellow	Red
Attire	100%	0%	0%
Hand Hygiene	100%	0%	0%
Food Storage and Safety	100%	0%	0%
Food Preparation	100%	0%	0%
Sanitation	100%	0%	0%
Quality Control	33.30%	0%	66.70%

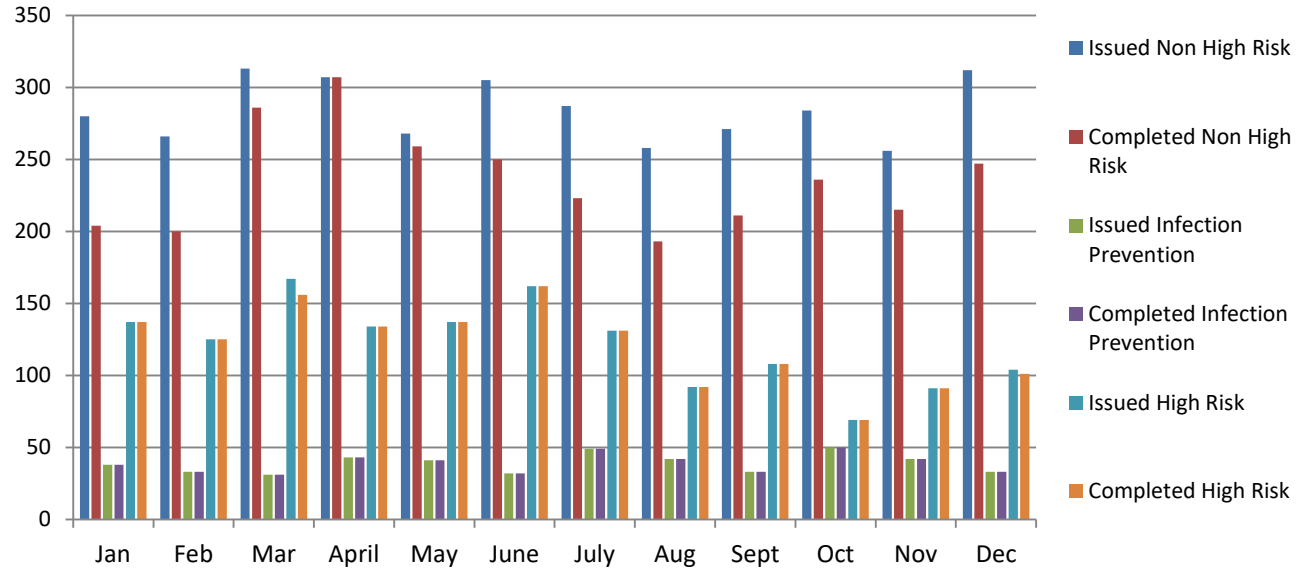
Plan for Improvement:.
Action plans from each area were requested for items out of compliance. Leaders of the areas are required to submit in writing their actions to correct the items out of compliance. Infection Prevention will follow up with manager or director as appropriate. We will continue this performance measure for 2021.

EOC Component: **UTILITIES MANAGMENT**

Performance Standard: **Utility Equipment–** Maintain a 100% completion rate on high risk, non-high risk and Infection Control preventative maintenance work orders throughout the District.
Goal: 100 % compliance rate
Minimum Performance Level: 100% completion rate.

Evaluation:
In 2020, there were a total of 3407 issued non-high risk work orders, of those 2831 were completed on time resulting in a 83% compliance rate. There were a total of 467 infection control work orders, all were completed on time, resulting in 100% compliance.
There were a total of 1457 high risk work orders of those 1443 were completed on time resulting in 99% compliance.

Annual performance measure was not met with 89% compliance.



Plan for Improvement:
Facilities Team and Nursing scheduled to meet to discuss ensuring room availability for regulatory compliance mandatory preventative & safety work orders. These rooms must have their PM work completed per the requirements or the rooms will need to be reviewed and possibly taken out of service until compliance is re-established.

EOC Component: SECURITY

Performance Standard:

In order to improve Code Gray event outcomes, the Security Department will track: 1, number of CPI responders arriving to a Code Gray event; 2, identify if roles/assignments are clearly stated; 3, debriefing taking place after every event.

Goal: 90% compliance with Code Grey event outcomes.

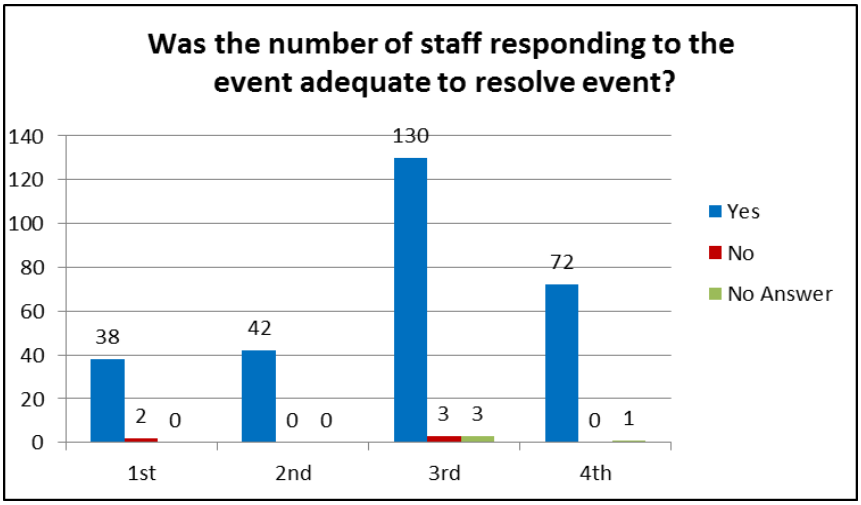
Evaluation:

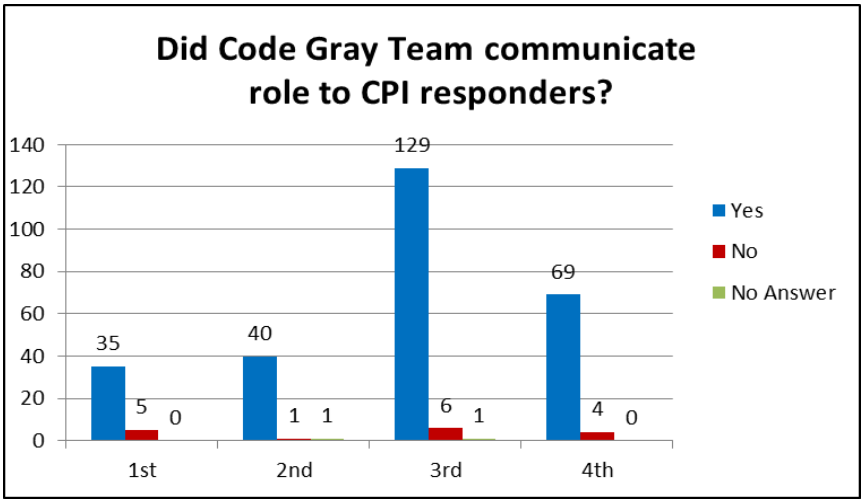
- Item 1: There were 73 recorded code gray events in the Medical Center in the Fourth Quarter. Out of 73 Code Gray events, 72 events had an appropriate staffing response. Goal for 4th quarter was met. Annual goal was met with 96% compliance .
- Item 2: Of the 73 reported Code Gray events, 90% of the events resulted in effective role delegation with responding CPI (Crisis Prevention Institute) trained personnel. Goal for 4th quarter was met. Annual goal was met with 93% compliance.
- Item 3: Of the 73 reported events, 90% of the events resulted in group debriefing after the event. Goal for 4th quarter was met. Annual goal was not met with 76% compliance.

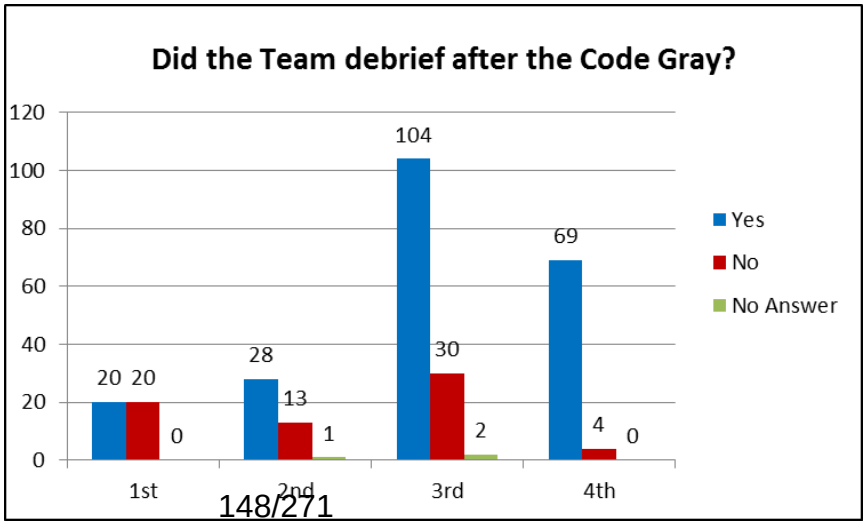
Plan for Improvement:

Security manager is working with CPI instructors to provide education on the expectations when responding to code greys.

Security personnel responding to Code Gray events will help prompt the patient care Nurse or event Team Leader to debrief with the team after the event has resolved.







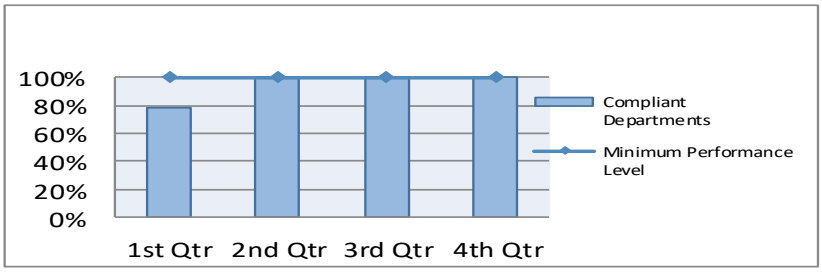
EOC Component: FIRE PREVENTION/LIFE SAFETY

Performance Standard:

Equipment and supply storage compliance will be monitored during hazardous surveillance inspections. Supplies are not to be stored on the floor. There also needs to be a clearance of 18" to the ceiling in sprinklered rooms and 24" in non-sprinkle red rooms per California Fire Code & The Joint Commission requirements.
Goal: 100% of departments inspected will be compliant.
Minimum Performance Level: 100% of department inspected will be compliant.

Evaluation:
There were 48 hazardous surveillance inspections conducted in 2020. The compliance rating regarding proper storage overall was 95%.
In the non-compliant departments supplies were found to be stored too close to the ceiling (18" clearance required).
Although significant improvement was made in storage compliance and 4th qtr. performance measure was met, the Minimum Performance Level set for 2020 was not met.

Storage Compliance 2020



Plan for Improvement:
We will continue to monitor storage compliance in 2021 and work to improve compliance with this standard. Unit managers will be required to round with the team.
Correction notices will be sent to the directors in all non-compliant departments and appropriate Vice President if departments are out of compliance on two separate occasions.

EOC Component: EMERGENCY MANAGEMENT

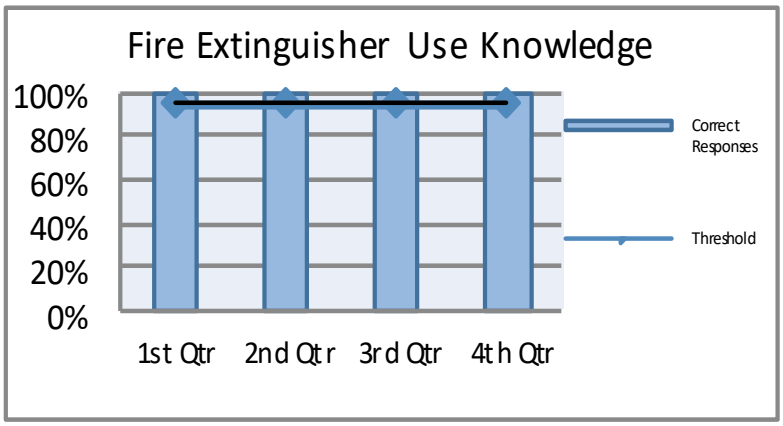
Performance Standard:

During routine hazard surveillance rounds employees will be queried on how proper use of a fire extinguisher
Goal: 100% Compliance.

Minimum Performance Level: Employees able to answer correctly 95% of the time.

Evaluation:
Twenty-six departments were surveyed in the 4th quarter. In all departments surveyed staff where able to verbalize proper use of the fire extinguisher, which resulted in a 100% compliance rate.

95% minimum performance level was met for 2020.



Plan for Improvement:
In each department visited there was knowledge of Fire Extinguisher Use.
Employees have been able to verbalize proper procedure when using a fire extinguisher.

We will continue to monitor through hazard surveillance rounding and during the quarterly mini drills.

EOC Component: Clinical Equipment

Performance Standard:

The Clinical Engineering Department will complete assigned preventive maintenance tasks as required per policy EOC 6001.

Goal: 100% Compliance is the minimum compliance requirement per TJC for both Non High Risk (NHR) and High Risk including Life Support (HRLS) devices.

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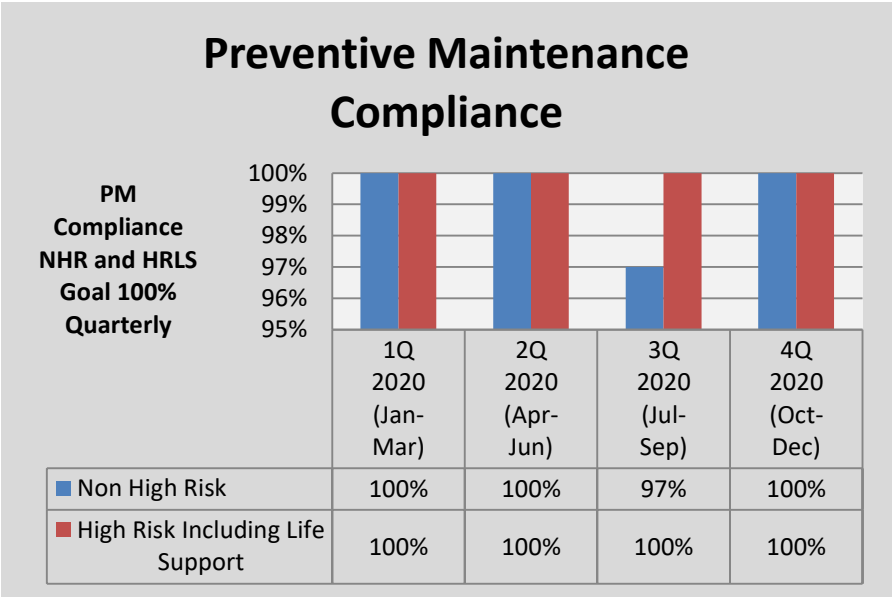
Evaluation:
In the 4th quarter the objective was met, reaching 100% compliance with Non High Risk and High Risk including Life Support devices preventative maintenance.

For the year 2020 performance measure of 100% was not met.



	1Q 2020 (Jan-Mar)	2Q 2020 (Apr-Jun)	3Q 2020 (Jul-Sep)	4Q 2020 (Oct-Dec)
Non High Risk	100%	100%	97%	100%
High Risk Including Life Support	100%	100%	100%	100%

EOC Component: Clinical Equipment

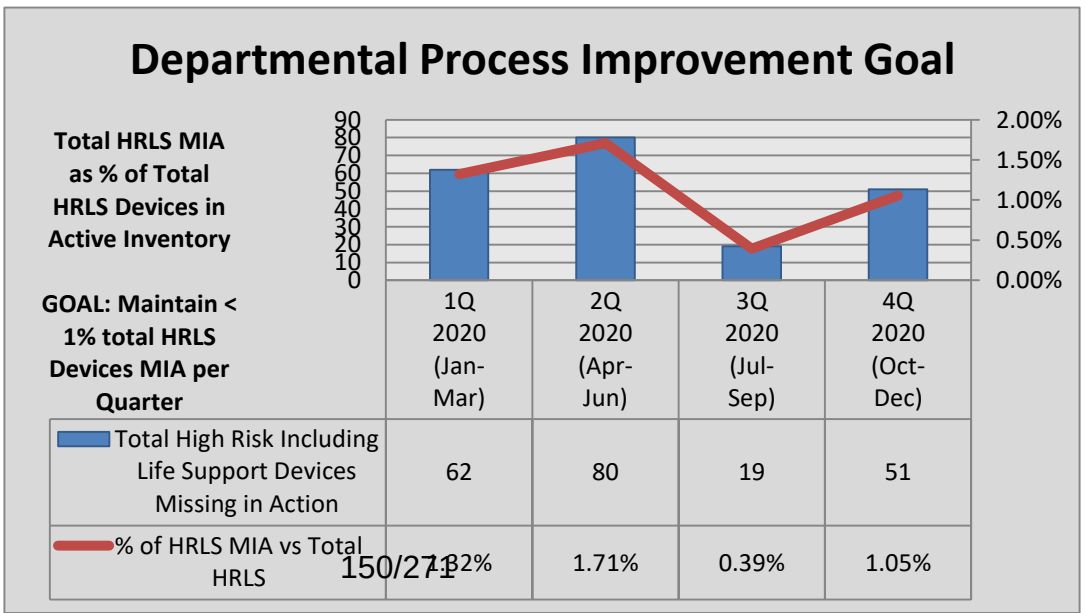
Performance Standard:

Continually improve completion of Preventive Maintenance for High Risk including Life Support (HRLS) devices.

Goal: Lower and keep the number of these devices recorded as Missing In Action (MIA) to less than 1% of the total HRLS inventory per quarter.

Evaluation:
In the 4th quarter the objective was not met with keeping the number of devices recorded as missing in action to less than 1% of total inventory.

For the year 2020 performance measure was not met.



	1Q 2020 (Jan-Mar)	2Q 2020 (Apr-Jun)	3Q 2020 (Jul-Sep)	4Q 2020 (Oct-Dec)
Total High Risk Including Life Support Devices Missing in Action	62	80	19	51
% of HRLS MIA vs Total HRLS	1.32%	1.71%	0.39%	1.05%

The KDHCD Emergency Preparedness Committee, a subcommittee of the Environment of Care Committee, met regularly throughout 2020 to address the preparedness needs within the District. Members from the Subcommittee ensured that leadership throughout the District were assigned positions in the *Hospital Incident Command System* (HICS), and that the organizational chart was kept current. The KDHCD Emergency Operations Plan was reviewed/revised during 2020.

Community Partners: Participated with Tulare County Public Health Emergency Preparedness Advisory Committee, Central California Emergency Medical Services Agency (CCEMSA), County of Tulare Evacuation Planning, and Visalia Fire Department.

Hazard Vulnerability Analysis: The Hazard Vulnerability Analysis (HVA) was re-evaluated and approved by the Environment of Care Committee. Input regarding the HVA was solicited from our executive team, medical staff and community partners. KDHCD also worked with CCEMSA hospitals in Fresno, Kings, Madera, and Tulare Counties to review the communitywide HVA.

Offsite Facilities: During 2020, the Emergency Planning Committee focused on the offsite facilities to ensure the specific risks of each facility were addressed during emergency exercises.

Disaster Exercises: On March 13, 2020, Kaweah Delta activated the Hospital Incident Command System (HICS) in response to the COVID-19 pandemic. The role of HICS in a rapidly evolving complex incident is to help manage the information, logistics, and operational needs in a systematic manner, while providing scalability and business continuity to prevent interruptions to mission critical services. Since opening the Incident Command Center, Kaweah Delta has faced two significant surges of COVID patients requiring a large scale response and the use of surge beds to meet the communities Healthcare needs. Throughout the COVID response, Kaweah Delta has collaborated with local, state and federal partners, activated a labor pool, utilized alternate care sites, and maximized the use of technology to meet the medical demands of the community.

Six critical elements were identified during the exercise, with staff performance exceeding the established threshold. The exercises/incidents were critiqued through a multidisciplinary process which included administration, clinical and support staff, and medical staff. After action improvement items were identified and will be presented to the Emergency Management Sub commitment. Objectives were evaluated relating to six critical areas: communications, resources and assets, safety and security of the patient, staff roles and responsibilities, the management of utilities and patient clinical and support activities.

EVALUATION – OVERALL *EFFECTIVENESS*
ENVIRONMENT OF CARE AND EMERGENCY OPERATIONS

Safety: Based upon the objectives, scope and performance standards, the risks within our Safety Management plan have been managed effectively. The Safety Education program for the District is highly effective, 100% of departments completed the Safety Training Modules. The Infection Prevention Department monitored infection control practices. Risk Management continued to monitor visitor injuries, with no trends identified. Based on the high level of commitment to education, surveillance and ongoing activities, the Management Plan for Safety is highly effective in promoting safety standards for the organization and in guiding the direction of safety-related activities. In 2021, we will improve safety outcomes by continuing with our monitoring activities and current programs, knowing they are effective in promoting safety standards for the organization and in guiding us towards continued risk reduction.

Security: The Management Plan for Security and the security program is effective at Kaweah Delta Health Care District as proven by the objectives to minimize security risks being met in 2020. The Workplace Violence Committee worked to monitor the Workplace Violence Program, implementing recommendations and responding to actual threats. Workplace violence awareness and crisis intervention training is provided to employees working in high risk areas and for support staff who also support patient care in those high risk patient care areas. Code Silver (active shooter) education is available for staff. Security risk assessments were completed for all facilities. Any identified deficiencies are reported and tracked until correction/improvement is made.

Hazardous Materials: We continue to minimize risks related to hazardous materials and wastes by monitoring spill activity and completing hazardous gas monitoring in areas with known chemical contaminants. An annual chemical inventory was completed and all employees were required to complete Hazardous Materials and chemical specific training. Other activities that support the effectiveness of our program include assessing the level of knowledge staff have relating to the Hazardous Materials program, specifically their role during a spill event. Our Radiation Safety Committee monitors radiation issues, such as badge readings, apron safety, annual review of the Radiation Safety Plan, and license amendments. Based upon the objectives, scope and performance standards, the Hazardous Materials Plan and program is rated to be highly effective.

Emergency Management: Based upon the objectives, scope and performance standards, the Emergency Operations Plan is effective in providing the framework for disaster response for our staff. The Emergency Management Subcommittee continued to meet to review and plan for multiple preparedness activities including, but not limited to, drill design and follow-up activities relating to COVID 19 pandemic. Training was completed for Decontamination Processes, Emergency Preparedness, Anhydrous Ammonia Handing and new hire orientation. The Hazard Vulnerability Analysis was reviewed and found to be an effective tool in prioritizing critical events and assessing the prioritization against the District's preparedness. KDHCD is actively involved with community-wide preparedness activities which strengthening ties with agencies having jurisdiction and the California Department of Health Services.

Fire Prevention Management: Based upon the objectives, scope and performance standards, the Fire Prevention Management plan is effective. Fire drills were completed for the District, with staff performing according to a pre-established checklist. Fire equipment inspection, maintenance and testing was completed, with ongoing monitoring of the *Statement of Conditions* in effect. Infection Prevention assessment continued to be integrated into construction activities along with any Interim Life Safety Measures assessments that were needed.

Clinical Equipment Management: Based upon the objectives, scope and performance standards, the Clinical Equipment Plan and program are effective. Preventive Maintenance was monitored quarterly for high risk including life support and non high risk medical equipment, with the thresholds of performance met. The separation of our inventory (i.e., high risk including life support medical equipment from non high risk medical equipment) places a higher focus on the safety of our patients and keeps the *Environment of Care* closely integrated with Patient Safety standards. The Clinical Equipment Plan and program are effective in promoting safe equipment usage for our patients.

Utility Equipment Management: Based upon our objective, to provide a comfortable, safe, environment for our patients and our staff, our goal for 2020 was not met. Performance monitoring focused on the completion of critical life support utility equipment . A skilled facilities staff, strong leadership, and the management of the automated preventive maintenance program has helped us in improving the objective to minimize the risks associated with utility failures.

Kaweah Delta Health Care District

Subcategories of Department Manuals not selected.

Policy Number: DM 2209	**Date Created: 07/01/2011**
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)	

Code Shelter-In-Place

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

I. Policy

Upon notification of a potentially hazardous airborne chemical/radiation cloud, smoke or other pollutants in the atmosphere surrounding a facility in the Kaweah Delta Health Care District, the District will activate its Toxic Cloud (Code Shelter-in-Place) procedure to protect the health of patients, employees and visitors.

"Shelter-in-Place" is a nationally accepted emergency code indicating the need to stay inside of a shelter or facility during periods of potential exposure to airborne hazards. County Communications may divert ambulance traffic to other facilities during a Shelter-in-Place incident.

II. Procedure

A. Plan Activation

Authority for activation of the Shelter-in-Place rests with Administration/Administrator On Duty/Nursing Supervisor following an alert from Tulare County Communications, as received in the Emergency Department via the ER communications system.

The Emergency Department staff receiving the alert will notify Emergency Department Manager or, after hours, the Nursing Supervisor who will then notify Administration. Administration will direct PBX to overhead page "Code Shelter-in-Place."

If the incident has potential to overwhelm normal hospital operations, Code Triage will also be activated. The Incident Commander will assume responsibility for emergency operations.

B. Notification of Staff

1. Activation – When advised to do so by the Incident Commander, PBX announces "Code Shelter-in-Place" (2x) and activates XMatters messaging system, CISCO phone display messaging..

2. Termination – When the incident is over, only the Incident Commander has the authority to terminate the Code Shelter-in-Place, and direct PBX to announce "Code Shelter-in-Place, All Clear" via overhead page. Areas not served by overhead page will be notified by a pre-established telephone tree initiated by PBX.

C. Code Shelter-in-Place Response

Please see attached Shelter in Place checklist and flowchart for detailed response guidelines.

CODE SHELTER-IN-PLACE

Purpose: To protect the health of all occupants within the facility in the event of potentially hazardous atmospheric contamination from chemicals, smoke, radiation or other pollutants.

Background:

- ☐ "Shelter-in-Place" is a nationally accepted term indicating the need to stay inside of a shelter or facility during periods of potential exposure to an airborne chemical, smoke, radiation or other contaminants. It is a process of "sheltering" individuals from these hazards by using prearranged measures including, but not limited to, entrance and exit limitations, securing outside air sources, communicating the danger of its occupants, and at the same time trying to maintain a normal business function. Upon notification from County Communications, EMS and/or the fire department, the Incident Commander will have PBX page "Code Shelter-in-Place" (2x). All outside persons wishing to enter the facility will be directed to the Main entrance. Engineering and Security will help secure the building.
- ☐ County Communications may divert ambulance traffic during a Shelter-in-Place incident.

INCIDENT COMMANDER CHECKLIST

- ☐ Notify, even if off-site, the Administrator on Call, Emergency Management Coordinator, and Public Information Officer.
- ☐ Notify PBX and request that they call Security and the Engineer On Duty.
- ☐ Order a facility lock down.
- ☐ Notify PBX, when appropriate, to request overhead page of "Code Shelter-in-Place."
- ☐ Document all communications.

STAFF RESPONSE CHECKLIST

Upon hearing Code Shelter-in-Place:

- ☐ Stay inside and notify visitors to also remain inside the hospital.
- ☐ Ensure all external windows and doors are closed and locked until the "All Clear" is announced.
- ☐ Use plastic sheeting and blue tape to seal any doors and windows with obvious air leaks.
- ☐ Discontinue using any devices that require an exhaust hood, and/or the replenishment of air from outside the hospital (i.e., lab or pharmacy equipment, dietary gas ovens and cook tops).
- ☐ Provide assistance as requested.
- ☐ County Communications will divert ambulance traffic during a Shelter-in-Place incident.

PBX CHECKLIST

- ☐ Upon direction from the Incident Commander, announce "Code Shelter-in-Place" (2x).
- ☐ Contact ISS Help Desk to send out Berbee message to all phones "Code Shelter in Place"
- ☐
- ☐ Upon direction from the Incident Commander, announce "Code Shelter-in-Place, All Clear" (2x).

EMERGENCY MANAGEMENT COORDINATOR CHECKLIST

- ☐ Assist the Incident Commander in managing the incident.
- ☐ Request status on toxic cloud from County Communications.
- ☐ Direct and inform staff based on information received from agencies managing the incident (FD, HazMat).

ENGINEERING CHECKLIST

Upon hearing the page, "Code Shelter-in-Place," Engineering will:

- ☐ Shut Down HVAC
- ☐ Lock down the Central Plant (doors are supposed to be locked at all times).
- ☐ Lock Down Facility
- ☐ Proceed to perform the Facility Lock Down.
  - ☐ Ensure all external windows and doors are closed (to minimize any outside air seeping into the hospital).

- ☐ Notify Security Officer via mobile radio that the lock down has been completed.
- ☐ Update the HCC when each of the preceding procedures has been completed.

If Main entrance is to be used, set up fans between the sets of double doors to blow air outside.

SECURITY CHECKLIST

Upon hearing the page, "Code Shelter-in-Place," Security will:

- ☐ Post signs on exterior doors directing people to authorized main entrance.
- ☐ Assist with crowd control.
- ☐ Post a monitor from the Labor Pool to redirect exiting people to remain in the Lobby until "All Clear" is announced.
- ☐ Immediately lock all entrances and the cafeteria patio door.
- ☐ Confirm that the ED and other entrances are locked. If not locked, proceed with "Facility Lock Down."
- ☐ Ensure the ED Ambulance door is in locked position.
- ☐ Notify Engineer on duty via radio that Facility Lock Down has been completed.
- ☐ Notify Director of Plant Operations and Security supervisor.
- ☐ Limit foot traffic into and out of the facility by alerting and discouraging anyone from leaving the facility during the Shelter-in-Place and funneling patients into a pre-assigned location/entrance thus keeping the outside air from entering the facility.
- ☐ Maintain radio contact with the HCC, ED, PBX and Engineering.
- ☐ Do not leave post unless instructed to do so by the Incident Commander, Director of Plant Operations or by the Security supervisor.

EMERGENCY DEPARTMENT STAFF CHECKLIST

Upon hearing the page, "Code Shelter-in-Place," Emergency Department Team Lead or designee will:

- ☐ Act as the communications liaison between the County and the ED Leadership or the Nursing Supervisor and the HCC.
- ☐ Notify the ED Director or the Nursing Supervisor of the alert, giving known details of the type and extent of the crisis.
- ☐ Notify visitors in the waiting room of the alert and explain that the doors will remain closed until after the "All Clear."
- ☐ Communicate regularly with the HCC.
- ☐ Notify the HCC of any updates from government agencies.
- ☐ Document all communications.

ALL CLEAR

When "Code Shelter-in-Place, All Clear" is announced, return to your normal work duties unless otherwise directed.

- ☐ When the danger has passed, Engineering will turn on supply fans first to pressurize building with filtered air and then turn on exhaust fans.
- ☐ Security will open doors, remove signs, and assist with crowd control.

"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: DM 2203	Date Created: 07/01/2011
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)	

Code Gray- Activation Plan

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

POLICY
Code Gray is designed to show a coordinated team response to protect our employees and others from any potential aggressor. The hospital has “zero tolerance” for violence.

In situations where hospital staff, physicians, or visitors are in a situation where they are not comfortable due to persons becoming aggressive, abusive, or threatening in any manner, a CODE GRAY may be called. This will initiate help, first from any personnel in the immediate area, and secondly from a follow-up team as described below. The intent of declaring a CODE GRAY will be to immediately have additional personnel show up, not necessarily to intervene directly, but to demonstrate a presence of other people in the area. The person calling the CODE GRAY will have the opportunity to request additional help or to dismiss staff responding.

Extremely violent situations will require a different approach. This area should be considered OFF LIMITS by initiating a Code Silver (See Policy #2204 Code Silver). Calling additional staff members to the scene puts additional people at risk. Calling an area OFF LIMITS will signal a STAT page to security and the Nursing Supervisor. The Visalia Police Department would be notified immediately when any person reports that an individual is threatening violence with a weapon.

Procedure
A. Response

See attached checklist and flowchart.

B. Supporting Information

1. Combative or abusive behavior can be displayed by anyone; a patient, a patient’s family member, staff, staff family members, or acquaintances of employees and patients. Combative or abusive behavior can escalate into a more violent episode. A comprehensive workplace violence prevention policy should include procedures and responsibilities to be taken in the event of a violent incident in the workplace

2. Recognize early warning signs. The following are examples of warning signs but are not all inclusive.

    a. Direct or verbal threats of harm.
    b. Intimidation of others by words and or actions.
    c. Refusing to follow policies.
    d. Hypersensitivity or extreme suspiciousness.
    e. Extreme moral righteousness.
    f. Inability to take criticism of job performance.
    g. Holding a grudge, especially against supervisor.
    h. Often verbalizing hope for something to happen to the other person against whom the individual has the grudge.
    i. Expression of extreme desperation over recent problems.
    j. Intentional disregard for the safety of others.
    k. Destruction of property.

Emergency Management Manual

CODE GRAY – ABUSIVE/ASSAULTIVE BEHAVIOR

Purpose: To provide a safe and secure healthcare environment for patients, visitors, volunteers, physicians and employees. Also, to assist employees in managing and/or de-escalating the situation by a show of force, to gain the cooperation of the abusive or assaultive person, or to subdue and restrain the individual if necessary.

Note: If the situation involves a weapon, immediately notify PBX of “Code Silver and location.”

The Hospital Incident Command System (HICS) is not activated for a Code Gray unless the incident disrupts day-to-day hospital operations.

STAFF RESPONSE CHECKLIST

In the event a situation with an angry, belligerent or threatening person has escalated or has the potential to escalate; or, in the event of imminent danger where there is a potential for a violent or criminal act to occur; or, when a violent or criminal act is in progress:
 Dial the District operator at Ext. 44. Provide the operator with the following:
 Where you are and where the incident is occurring
 Description and number of person(s) involved. Do not hang up until the operator has all your information.

Verbal Abuse:
 Use a calm voice and attempt to verbally de-escalate the situation.
 If verbal abuse continues, call a second person to assist you. Move patients away from the hostile person, if safe to do so.
 Step back from person and try to get a barrier between you and the person.
Direct others away from the area.

Physical Battery:
 Protect yourself and others from blows, attempt to get away from the person/area and defend
yourself as necessary for personal safety.
 Put distance and/or barrier between the parties involved – only when safe to do so. Do not attempt
to confront the person(s).
 Remove patients, staff and visitors from the immediate area. Remain calm and reassure those around you.
 Provide assistance and medical help for all injured persons when safe to do so.
Documentation to Complete:
 Per normal procedures, if employee is injured:
 Employee completes Incident Report and submits to supervisor, who completes, signs and forwards report to Risk Management

If you hear a “Code Gray” announcement for a distant location:
 Trained available personnel respond to the Code and take direction from Nursing Supervisor, charge staff or Security Officer.
 Stand by for further instructions.
 Provide assistance as requested.

If you are at an off campus site: In the event a situation has escalated and a violent or criminal act occurs call 9-911.

PBX CHECKLIST

 When notified of a violent or potentially violent situation, immediately overhead page "Code Gray and location" (2x).
 Notify Security via radio.

CHECKLIST-SOUTH CAMPUS

When notified of a violent or potentially violent situation, immediately overhead page to South Campus "Code Gray and location" (2x).
Send out a Berbee page and Berbee message to South Campus.
Notify Security via radio.
Notify Nursing Supervisor. (And notify police if instructed to do so by Nursing Supervisor by dialing 9-911.)

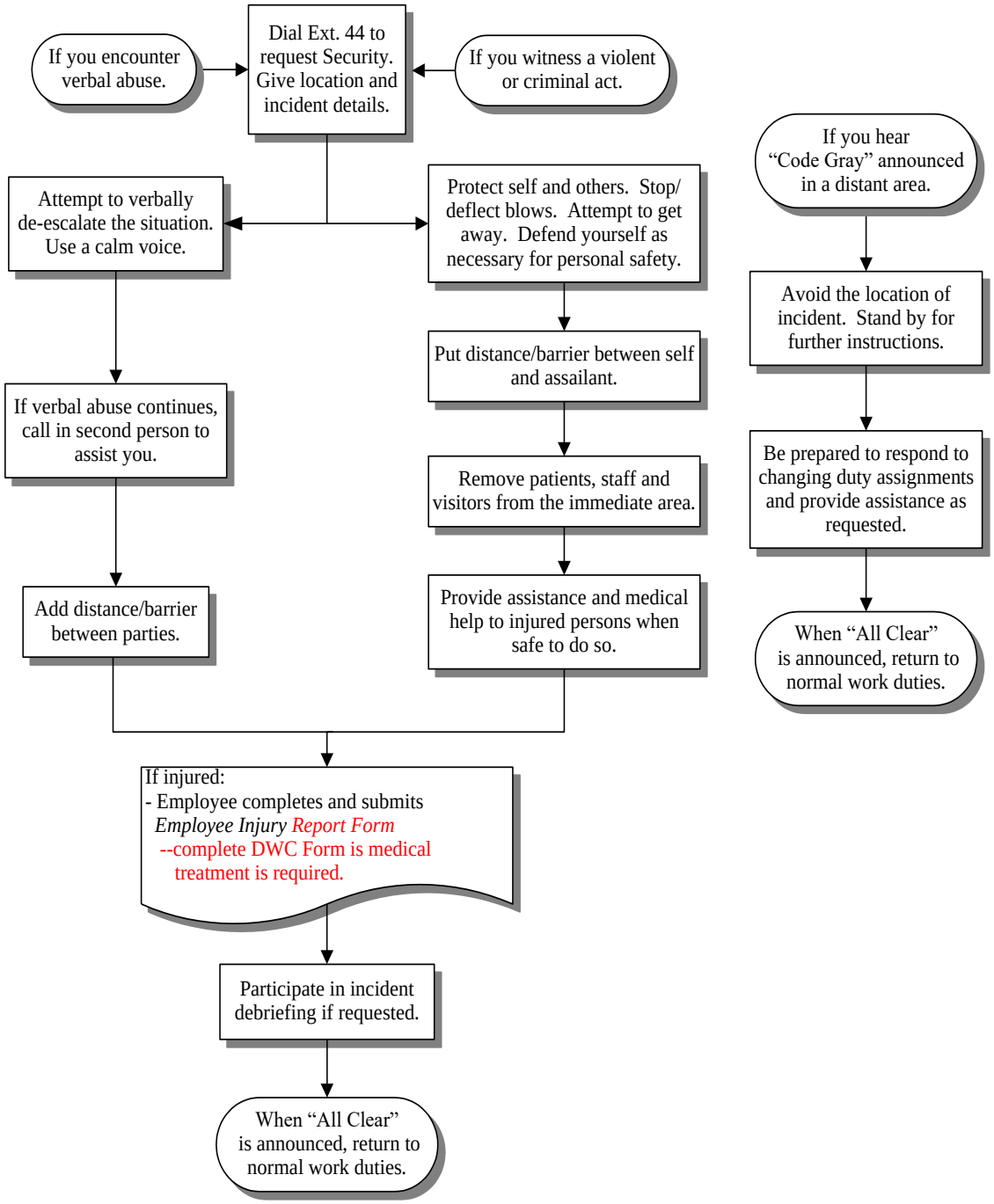
SECURITY CHECKLIST

Upon notification of the potential for or actual occurrence of a violent or criminal act:
Dispatch Security personnel to the location as appropriate.
 When responding to the scene and approach with caution. When using force, Security will use only the minimum amount of physical force necessary to restrain or protect the individual from self-injury and/or from injuring others.
If situation has potential to disrupt hospital operations:
 Notify Nursing Supervisor.
 Direct PBX to announce by overhead page "Code Gray, location."
 Monitor and coordinate incident per department procedures. Control crowds and provide direction at the scene.
 Request help from the police department if necessary or call in extra Security staff for long-term incidents.
 If warranted, the Security Officer will file an Incident Report. Officers will determine if a report should be filed with law enforcement.

Kaweah Delta Health Care District
Delivering excellence.

Emergency Management Manual

Code Gray - Abusive/Assaultive Behavior



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Kaweah Delta Health Care District

Subcategories of Department Manuals not selected.

Policy Number: DM 2201	**Date Created: 03/14/2008**
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)	

Code Triage- Activation Plan

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

I. Policy

In the event of an emergency incident that has the potential to overwhelm day-to-day operations, Kaweah Delta Health Care District will activate the Emergency Operations Plan. The decision to activate the plan will be made by the Incident Commander CEO, Administrator on Duty (until the CEO arrives), or Nursing Supervisor (until the CEO or Administrator on Duty arrives). The decision to terminate shall be made by the Incident Commander in coordination with the authority having jurisdiction and other civil or military authorities involved. The Emergency Operations Plan is flexible and can be customized to the needs of an emergency per the Hospital Incident Command System (HICS) model. The Incident Commander has ultimate responsibility and authority for decision making during Emergency Operations Plan activation.

Emergencies affecting the hospital may be:

A. Internal – Any occurrence within the District such as fire, explosion, bomb threat, hazardous materials spill/release, etc., which significantly impact normal practices and procedures and/or which overwhelm available resources. This could include injured patients and/or employees, loss of critical systems or services needed for patient care that would require partial or complete evacuation. Also, a large external disaster could overtax District resources to the point that it also becomes an internal disaster.

B. External – A major fire, flood, earthquake, explosion, air or ground vehicular accidents, hazardous materials spill/release, or any other major emergency outside of District facilities that produces multiple victims requiring timely treatment of mass casualties.

II. Procedures

A. Determining Need for Emergency Operations Plan Activation

1. Upon direction of the Incident Commander, the PBX Operator notifies the HICS team via paging system “Code Triage, Alert” (3x).

a. When an emergency or unusual event impacts the District, the primary leaders for the Hospital Command Center (HCC) report to the HCC for an early stage Code Triage.

b. Staff who report to the HCC include those who fill the following key roles in the **HICS model:**

1. Incident Commander:
2. Safety/Security Officer
3. Liaison Officer
4. Public Information Officer (PIO)
5. Logistics Chief
6. Planning Chief
7. Operations Chief
8. Finance Chief
9. Facility Unit Leader
10. Medical Staff Director

2. The HICS team will analyze the situation and determine the level of response.

B. Code Triage – Emergency Operations Plan Activation

1. The Incident Commander authorizes the PBX Operator to announce the Code Triage and implements HICS to the extent required.

2. Hospital-Wide Announcement
   a. Administrator On Call or Director On Call will determine if Code Triage needs to activated.
   b. PBX Operator makes the overhead announcement: “Code Triage” (2x). ISS Help Desk activates the Cisco phone digital display on all district phones and notifies leadership staff via X-Matters alert system.

C. Response Procedure
See attached Plan Activation Checklist and flowchart (Appendix B & C).

D. Functional Areas

See attached table, “Functional Areas during Activation of the Emergency Operations Plan.” (Appendix D)

E. Emergency Supplies, Disaster Kits and MOUs

Kaweah Delta Health Care District will maintain a minimum stockpile of emergency supplies and ensure immediate access to critical materials including pharmaceuticals, medical supplies, food, linen, industrial and potable (drinking) waters as needed. The hospital will maintain Memos of Understanding (MOUs) with vendors to receive priority shipment of critical supplies in the event of an emergency.
See attached table, “Emergency Supplies.” (Appendix E)

F. Termination of Code Triage

1. The decision to terminate the Code Triage will be made by the Incident Commander, in coordination with the authority having jurisdiction and other involved civil or military authorities.
2. When the Code Triage is terminated, the Incident Commander notifies the PBX Operator, who makes the overhead announcement, “Code Triage, All Clear” (3x).

Note: See Appendix for form:

Department Emergency Status Report

"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."

CODE TRIAGE – PLAN ACTIVATION

INCIDENT COMMANDER CHECK LIST

 Establish HCC.
 Assess situation and activate HICS to the extent necessary to manage the incident.
 Direct PBX Operator for all overhead emergency announcements.
 Brief managers and medical staff on anticipated impact and update them on the event's status.
 Provide leadership for HICS Command Team (see Incident Commander Job Action Sheet).
 Determine when the incident has been stabilized to the point where normal hospital operations may be resumed and deactivate HICS. Authorize PBX Operator to announce "All Clear."
 Conduct an incident debriefing as soon as possible following the deactivation of Code Triage.

Note: The Incident Commander has ultimate responsibility and authority for decision-making during Emergency Operations Plan activation.

PBX OPERATOR CHECKLIST

 As directed, PBX Operator implements "Code Triage, Alert" to summon key HICS staff to the HCC and activates the Cisco phone digital display on all district phones.
 Leadership staff will be notified via Xmatters alert system.
 If directed by the Incident Commander, the PBX Operator announces: "Code Triage" (2x).

DEPARTMENT MANAGERS CHECKLIST

 Implement hospital and department disaster-specific plan.
 Inventory personnel, supplies, equipment, victims and injuries on your *Emergency/Disaster Status Report* and send to HCC via runner.
 Report all needs and concerns via HICS Chain-of-Command.
 At Code Triage:
Complete Department Status Form and fax to Incident Command Center #713-2332.
Send surplus staff to Labor Pool.
Activate staff call backlists to summon off-duty staff if requested.
Report to Incident Command Center for assignment.
 Update HCC on department status as needed or requested. Stand by for further instructions from HCC.
 Participate in incident debriefing as requested.

STAFF RESPONSE CHECKLIST

If Off-Duty:

 Secure home and family (and pets), then
 If you have a pre-assigned emergency duty through HICS, report for work automatically and do not wait for contact from Kaweah Delta Health Care District.

Emergency Management Manual

 If you do not have a pre-assigned emergency duty, stay tuned to television news broadcasts or the following radio stations: KMJ 580.
 Be prepared to report for an emergency assignment.
 If the broadcast message indicates, or if you do not hear a broadcast message within two hours after a major event, call the Employee Emergency Phone Line: 559-624-2008 .
 The message will specify where and when to report.
 Leave a message on the phone line giving your status and the time you will be able to arrive at the assigned work location.
 If summoned, wear ID badge and bring appropriate license.

If On-Duty:

 Follow instructions in the Emergency Management Manual.
 All unassigned or available hospital staff must report to the Labor Pool.
 Remain at hospital and perform duties as assigned. Wear your ID badge at all times.
 If you are evacuated from a building, check in at your assigned Evacuation Assembly Area.

EMERGENCY DEPARTMENT CHECKLIST

 The ED Team Leader will report all incident-related messages from StatusNet Communications system or EMS Agency Duty Officer to the Incident Commander at HCC.
 When the emergency incident/disaster involves the potential for large numbers of victims arriving to the ED, the Operations Chief will appoint a HICS Medical Care Director/Treatment Areas Supervisor to direct the activation, emergency operations and assignment of HICS Unit Leaders for functional treatment areas required during activation of the Emergency Operations Plan. The HICS Unit Leader positions will be assigned on the basis of staff availability and experience.
 Call Central Logistic to request the ED Disaster Carts.
 ED Team Leader to refer to ED specific “Disaster Cheat Sheet” for more detailed actions.
 Directions for activation (HICS Job Action Sheets) of treatment areas will be distributed to the HICS Unit Leaders by the HICS Medical Care Director/Treatment Areas Supervisor.
 Supplies for the Triage and Treatment areas are located in the ED supply room and in pre-positioned MCI Supply trailers. ED Charge Nurse/Nursing Shift Supervisor has keys.
 Treatment Areas Unit Leaders communicate staff overload issues during a Code Triage to the Treatment Areas Supervisor, who will discuss with the Medical Care Director/Operations Chief.

ALL CLEAR

At the conclusion of a disaster, the Incident Commander will notify the PBX Operator to overhead page, “Code Triage, All Clear” (3x) and notify other medical facilities and government agencies as appropriate. Return to your normal work duties, unless otherwise directed.

Note: Following the emergency incident, the Department Manager(s) of the affected area(s) shall fax an *Emergency Occurrence/Drill Critique* to the Safety Office within 24 hours: 559-713-2204.

Functional Areas during Activation of the Emergency Management Plan

Appendix D

Functional Area	Location		Essential Activity	Responsible Person
	Primary	Secondary		
Clinical Admitting	Admitting	TBD	Complete admission paperwork and locate bed assignment	Bed Control in collaboration with the Nursing Unit Leader
Decontamination Area	Portable Shower Units outside Emergency Department	N/A	For chemical and radioactive decontamination	Decon Unit Leader
Delayed Treatment Area			Care of dying and those who may be treated when time and staff permit	Delayed Treatment Unit Leader
Dependent Care Area	Kaweah Kids		Care for staff dependents who have no alternative care arrangements	Dependent Care Unit Leader
Discharged Patients Holding Area	Acequia Wing Lobby		Hold discharged patients until trans-portation is available	Discharge Unit Leader
Employee/ Physician Entrance	Admin Entrance	Lobby Entrance	Controlled access to hospital	Medical Staff Labor Pool and Labor Pool Unit Leaders
Holding Area for Patients Waiting to be Admitted	Main Lobby		Waiting area for patients awaiting inpatient beds	Immediate Treatment Unit Leader
Hospital Command Center (HCC) (GSH)	Blue Room	Admin Conf Room	Command area	Incident Commander
Satellite HCC at West Campus	Rehab Charting Room		Command area	West Campus Incident Commander
Satellite HCC at South Campus	Subacute Station A			South Campus Incident Commander
Immediate Treatment Area	Emergency Department		Treatment of critical and serious patients	Immediate Treatment Unit Leader
Labor Pool – Main Campus	Cafeteria	MCS Auditorium	Organize and assign personnel	Labor Pool Unit Leader
Labor Pool – South Campus	Cafeteria	TBD	Organize and assign personnel	Labor Pool Unit Leader
Labor Pool – West Campus	Rehab Cafeteria	TBD	Organize and assign personnel	Labor Pool Unit Leader
Logistics Command Post	Blue Room	Maintenance Upstairs	Manage the provision of material/supply resources, nutritional resources and the safe environment	Logistics Chief

Functional Area	Location		Essential Activity	Responsible Person
	Primary	Secondary		
Media Area	Acequia Wing Lobby	SSB Emerald Room	Provide information to news media, coordinate all internal and external communication	Public Information Officer
Medical Staff Pool	Medical Staff Offices		Organize and assign medical staff	Medical Staff Unit Leader
Minor Treatment Area and Non-emergent First Aid	Acequia Wing Shell Space Future ED Zone 4 and 5.		Walking wounded and stable patients treated	Minor Treatment Unit Leader
Morgue	Morgue	Medical Waste Storage Area	Deceased victims	Morgue Unit Leader
Operations Command Post	Blue Room		Manage the medical mission of the hospital, including all nursing units and supportive and ancillary units	Operations Chief
Patient Information Area	Surgery Center Waiting Room		Victims' families receive information	Patient Information Officer
Relative Waiting Area	Surgery Center Waiting Room		Victims' families receive information	Patient Information Officer
Security Command Post	Security Offices	VP Operations' Office	Monitor security cameras, assign Security Officers, answer calls	Safety/Security Officer
Staff Rest/ Nutrition Area	4th Floor Infusion Center.	Cafeteria	Provision of a staff rest area, food and drink, information updates and psychological support	Staff Support Unit Leader
Triage Area	Outside Emergency Department		Patients triaged	Triage Unit Leader
Visitor/Relative's Entrance	Lobby Entrance	Main Entrance	Controlled access to hospital	Safety & Security Officer

1.	Communication equipment: • 800 MHz handheld radios • Emergency Cell phones • Laptops, Cellular Hot Spots	PBX / ISS	
2.	Decontamination Equipment, including • Personal protective equipment (PPE) • Plastic tarps, tents, frames • Shower curtains • Privacy screens • Showers • Liquid soaps and towelettes • Water supply • Fan • Trash/laundry receptacles and bags	Lab basement and Emergency Trailer located in Kaweah Kids Parking Lot	N/A
3.	Decontamination Unit (Portable)	Emergency Trailer	N/A
4.	Disaster Kits (recommended supplies) • Heavy work gloves • Crowbar • Flashlight and batteries • Waterless soap • Duct tape • Blue tape (for sealing windows) • Super Bar (to open jammed doors or cabinets, etc.)	Onsite Maintenance	N/A
5.	Evacuation Equipment • Stryker Evac Chairs • Evacusleds	Mineral King Floors 3rd and 4th floor. Mineral King Wing beds	N/A
6.	Evacuation Maps	Onsite	N/A
7.	First Aid Supplies		N/A
8.	Food Supplies	Kitchen/Creekside	N/A
9.	HICS vests	Hospital Command Center (HCC)	N/A
10.	Lighting • Portable emergency lighting • Extension cords • Flashlights	Plant Operations Emergency Trailer Departments	N/A
11.	Linen	Laundry	MOU
	• 1 Box 20 gauge IV Catheters • 1 Box 18 gauge IV Catheters • 1 Box 16 gauge IV Catheters • 10 boxes Exam Gloves small • 10 boxes Exam Gloves medium • 10 boxes Exam Gloves large • 2 boxes Exam Gloves extra large		
12.	Pharmaceuticals • Standard emergency medications • Other specific drugs as indicated by the incident	Contact Pharmacy Director or Emergency Management Coordinator for location of cache.	N/A
13.	Water (potable): Supplemental in-tank and bottled water (12-oz bottles)	•	In Progress

14.	Incident Command Cart Code Triage- Activation Plan	Hospital Command Center (HCC)	N/A 8
15.	Medical Supply Disaster Carts: 5 Adult Ambu-Bags (Bag-Valve Mask Device) 5 Pediatric Ambu-Bags (Bag-Valve Mask Device) 5 Anesthesia Bags (To provide ventilation to an infant or newborn) 10 Pediatric 02 Masks 10 Adult Non-Rebreather 02 Masks 20 Hand Held Nebulizers (for breathing treatments). Possibly stocked in Respiratory. 2 Box disposable tongue depressors. 2 IV Pumps • 20 Secondary IV Set (To hang IV Piggybacks) • 5 boxes alcohol preps • 5 Yankauer Suction Catheters • 5 Suction catheters 8 French • 5 Suction catheters 10 French • 5 Suction catheters 14 French • 5 Suction catheters 18 French • 5 Suction Connection Tubings • 5 Suction Canisters • 5 Stethoscopes • 5 Manual BP Cuffs Adult Size (Not the disposable cuffs that are designed for use on a machine) • 5 Manual BP Cuffs Pediatric Size • 40 bags IV Normal Saline 1000 mL • 10 bags IV Normal Saline 250 mL • 10 bags IV D5W/0.25% Normal Saline • 1 Box 24 gauge IV Catheters • 1 Box 22 gauge IV Catheters	Central Logistics – the three Disaster Carts would be delivered to the ED	N/A

Kaweah Delta Health Care District

Subcategories of Department Manuals not selected.

Policy Number: DM 2210	**Date Created: 07/01/2011**
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)	

Code Orange- Hazardous Material Spill/Release

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

I. Policy

In the event of a hazardous materials spill/release, Kaweah Delta Healthcare District will activate its Code Orange procedure to provide a coordinate and effective response.

II. Procedure

In the event of a hazardous material release:

A. Response

See attached checklist and flowchart.

B. Definitions

1. Minor Spill

The following is guidance for amounts to be considered as **small**

CHEMICAL	SMALL SPILL AMOUNT
Acid	½ cup or less (Except Hydrochloric acid = ¼ cup)
Base/Caustic	½ gallon or less (Except ammonium hydroxide = ¼ cup)
Bleach	½ gallon or less
Flammable liquids	½ gallon or less (Except methanol = ½ cup)
Formaldehyde (10% Formalin or 3.7% Formaldehyde)	¾ cup or less
Glutaraldehyde (Cidex®, Wavicide)	½ gallon or less
Ortho-phthalaldehyde (Cidex® OPA)	1 gallon or less
All other chemicals (including chemotherapy drugs)	½ gallon or less

a. Only minor spill cleanup will be done in-house by trained staff with appropriate spill kit and Personal Protective Equipment (PPE). User departments are responsible for ensuring their staff are properly trained and equipped to assess minor spills in their department.

2. Major Spill

A major spill has occurred under the following conditions:

- A life threatening condition exists, or there is an immediate danger posed to staff, patients or visitors.
- You are not able to manage the spill on your own, and the condition requires the assistance of emergency personnel
- The condition requires the immediate evacuation of all employees from the area or the building.
- The spill is of a large enough quantity that additional assistance is required (threshold quantities will vary based on the chemical and can be verified on Safe Use Guides or SDSs, but is generally greater than 2.0 liters).
- The contents of the spilled material is unknown.
- The spilled material is highly toxic
- You feel physical symptoms of exposure
- The chemical is bio-hazardous, radioactive or flammable.

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CODE ORANGE – HAZARDOUS MATERIALS SPILL/RELEASE

Purpose: To identify unsafe exposure conditions, safely evacuate area, and protect people from exposure, within the hospital or on its grounds, due to a hazardous material spill/release.

Background: Departments with significant hazardous materials are to develop a Disaster-Specific Plan to support this plan. (Consult Safety Officer if unsure.)

Respond in accordance with this procedure and those developed by your department. A large-scale incident may develop into a Code Triage.

Note: All District personnel who have been exposed and require treatment **must** report to the Emergency Department (ED). All others exposed who are asymptomatic, must also report to the Employee Health Nurse or the ED after hours.

STAFF RESPONSE CHECKLIST

Immediately upon discovering a hazardous materials spill/release, user department will:

- ☐ If spill is **MINOR**: - The basic response will be **ICIC.**
  - ☐ **I**solate the areas and deny access to others.
  - ☐ **C**ontain the spill (reduce or eliminate spread)
  - ☐ **I**dentify (Chemical name) Obtain and read Safety Data Sheet (SDS) for precautions. Binders are located in each specific department. Department head/managers should know the location of updated SDS document.
  - ☐ **C**lean-up (follow SDS). Use spill kit to clean up spill, if trained to do so.
  - ☐ Notify supervisor or Department Manager, who will notify Hospital Safety Officer
  - ☐ Complete Occurrence Report on KD Central.
- ☐ If spill is **MAJOR**:
  - ☐ Evacuate area.
  - ☐ Call PBX at Ext. 44 and inform them of a "Code Orange" and report:
    - ☐ Spill location
    - ☐ Chemicals involved
    - ☐ Approximate quantity of material spilled
    - ☐ Number of people exposed and/or injured
    - ☐ Your extension
  - ☐ Obtain SDS from MAXCOM.
  - ☐ Notify supervisor or Department Manager.
  - ☐ Contain spill only if trained, equipped, and safe to do so.
    Complete Occurrence Report on KD Central.

Assist those who may have been contaminated – *only if your exposure is unlikely*:

- ☐ **If a chemical has splashed into someone's eyes**, direct that person to the nearest water source/eyewash station, begin immediate rinsing of their eyes with tap water for at least 15 minutes. Avoid direct contact with the contaminated person.
- ☐ **If a person has chemicals on their skin**, direct them to rinse affected area with soap and water for at least 15 minutes, in a shower, if available, otherwise in a sink. Removal of clothes is necessary to complete a thorough dermal decontamination. All clothes are to be placed in a plastic bag. After rinsing, direct person to remain in area until cleared by the Safety Officer. Label plastic bag "hazmat."
- ☐ **If contaminated person(s) unable to self-decontaminate**, wait for trained personnel with Personal Protective Equipment (PPE) to perform decontamination.

Decontamination as follows:

- ☐ Removing your clothing:
  - ☐ Quickly take off clothing that has a chemical on it. Any clothing that has to be pulled over your head should be cut off instead of being pulled over your head.
  - ☐ If you are helping other people remove their clothing, try to avoid touching any contaminated areas, and remove the clothing as quickly as possible.
- ☐ Washing yourself:
  - ☐ As quickly as possible, wash any chemicals from your skin with large amounts of soap and water. Washing with soap and water will help protect you from any chemicals on your body.
  - ☐ If your eyes are burning or your vision is blurred, rinse your eyes with plain water for 10 to 15 minutes. If you wear contacts, remove them and put them with the contaminated clothing. Do not put the contacts back in your eyes (even if they are not disposable contacts). If you wear eyeglasses, wash them with soap and water. You can put your eyeglasses back on after you wash them.
- ☐ Disposing of your clothes:
  - ☐ After you have washed yourself, place your clothing inside a plastic bag. Avoid touching contaminated areas of the clothing. If you can't avoid touching contaminated areas, or you aren't sure where the contaminated areas are, wear rubber gloves or put the clothing in the bag using tongs, tool handles, sticks, or similar objects. Anything that touches the contaminated clothing should also be placed in the bag. If you wear contacts, put them in the plastic bag, too.
  - ☐ Seal the bag, and then seal that bag inside another plastic bag. Disposing of your clothing in this way will help protect you and other people from any chemicals that might be on your clothes.
  - ☐ When the local or state health department or emergency personnel arrive, tell them what you did with your clothes. The health department or emergency personnel will arrange for further disposal. Do not handle the plastic bags yourself.
- ☐ **If person was not splashed with chemicals on their skin or clothes, but is complaining of respiratory or systemic effects** from breathing a hazardous material, immediately escort person to the ED for treatment.

Immediately upon hearing "Code Orange":

If within alert area:

- ☐ Assist those contaminated (only if exposure is unlikely).
- ☐ Assist emergency responders.
- ☐ Secure area to prevent exposure to others.
- ☐ Return to work duties when safe.

If outside alert area:

- ☐ Prepare to provide support as directed.

PBX CHECKLIST

Upon receiving report of "Code Orange," and as directed by the Safety Officer (or AOD after hours), PBX will:

- ☐ Page overhead "Attention, Code Orange" and location (2x) and then repeat 30 seconds later.
  - ☐ Call Environmental Services at ext 2244.
  - ☐ Call Safety Officer
- ☐ Call House Supervisor (House supervisor will notify Administrator on Call (AOC)

.

- ☐
- ☐ Announce "Code Orange, All Clear" if authorized by the Safety Officer in coordination with the fire department.

Note: If the fire department is unable to respond, the Safety Officer will contact an outside contractor to clean up "major" spills.

SECURITY CHECKLIST

- ☐ Secure area from pedestrian traffic.

- ☐ Do not allow personnel other than the fire department to enter the isolated area.
- ☐ If the area involved is near an air conditioning intake, advise Maintenance to shut down air conditioning units in the immediate vicinity.

HAZARDOUS MATERIALS COORDINATOR (SAFETY OFFICER) CHECKLIST

Report to scene of event and assess situation.

- ☐ Call Visalia Fire Department Hazardous Materials Unit for major spill cleanup.
- ☐ Call Engineering to ventilate/shut down recirculation system, if required
- ☐ Call Security to cordon off immediate area and expand the safety zone, as necessary, to prevent unauthorized exposure to hazardous conditions.
- ☐ Act as a liaison to Fire Department or spill clean-up contractor.
- ☐ Ensure safety of staff, visitors, and patients.
- ☐ Following the all-clear, ensure full documentation of event.
- ☐ Notify appropriate agencies.

  Tulare County Environmental Health 559-624-7400
  Cal EMA (California Emergency Management Agency1-800-852-7550

- ☐ Follow up with spill department to evaluate and modify processes as necessary.

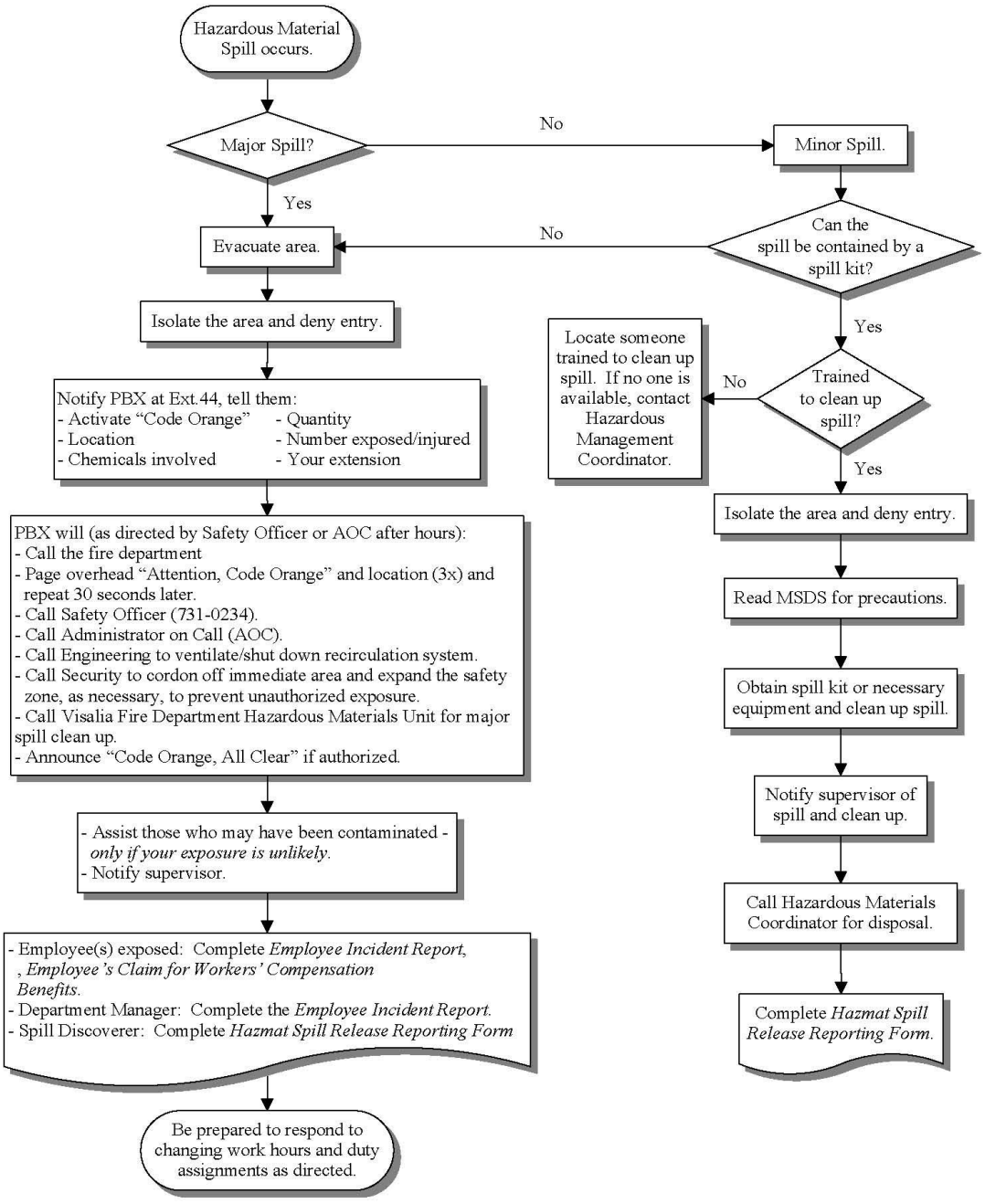
ALL CLEAR

After “Code Orange, All Clear” is announced (3x), return to your normal work duties, unless otherwise directed.

Kaweah Delta Health Care District
Delivering excellence.

Emergency Management Manual

Code Orange - Hazardous Materials Spill/Release
At Spill Site



Kaweah Delta Health Care District

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Approvers: Board of Directors (Administration), Board of Directors (EOC/Emergency Preparedness)	

Volunteer Practicioners in the Event of a Disaster

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

PURPOSE:

Individuals who are qualified to practice in a health care profession, e.g., M.D., D.O. D.P.M, P.A. or N.P., and who are not employees of Kaweah Delta Health Care District may be engaged in the provision of care and services at any district facility during an "emergency" (defined as any officially declared emergency, whether it is local, state, or national).

POLICY:

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 may assign disaster responsibilities. The responsible individual 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 (those that are required by law and regulation to have a license, certification, or registration to practice their profession). The credentialed Medical Staff oversee the professional performance of volunteer practitioners, either by direct observation, mentoring or clinical record review.

Once the immediate disaster situation is under control, the assignment of disaster responsibilities is terminated.

PROCEDURE:

1. The volunteer practitioner must:

   A. Complete the application form (attachment A). This form includes the applicant's statement that he/she has a current unrestricted license certification and training, knowledges and competency to practice in their 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, certification to practice
   - Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), or Medical Reserve Corps (MRC)

2. Assignment of volunteer practitioners to appropriate areas is accomplished by the CEO/designee in concert with the Chief of Staff (COS)/designee.

3. The application for volunteer practitioners shall be forwarded as soon as possible to the medical staff office to immediately verify as much information as possible, including verification of licensurecertification A record of this information will be retained by the Medical Staff Services Office and forwarded to Human Resources department, as appropriate. If not completed immediately, primary source verification of licensecertification 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.

4. The CEO/designee in concert with the COS/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 responsibilities initially assigned.

5. To ensure oversight of the professional performance of volunteer practitioners:

   If hospital staff is available, concurrent mentoring will occur; the volunteer will be paired with an appropriate medical staff, e.g., Physician with Physician. Medical Directors of the area the practitioner is assigned to will oversee appropriateness of care and competency of volunteer.

   a. -

   b. Any information gathered that is not consistent with that provided by the individual must be referred to the CEO/designee immediately, who will determine any additional necessary action. A volunteer practitioner's assignment 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.

   c. Each volunteer practitioner will be required to wear a hospital badge signifying that the volunteer is authorized.

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ATTACHMENT A

Kaweah Delta
HEALTH CARE DISTRICT
Medical Staff

Disaster Privileges Application

Name of Provider	
Email Address	

Primary Office Address			
Cell Phone			
Type of Licensure	☐ Physician ☐ Psychologist ☐ Nurse Anesthetist	☐ Nurse Practitioner ☐ Physician Assistant ☐ Other _____	
State of Licensure *		**License # ***	
NPI #			
Do you have a current DEA certificate?	☐ Yes If yes, please provide DEA #: ☐ No		
Practice Specialty			
Current Government Issued Photo ID (provide copy)	☐ State Driver's License ☐ Passport ☐ Other _____		
Past Work Experience Includes: (Check all that apply)	☐ ER ☐ ICU	☐ Hospitalists / Internal Medicine ☐ Outpatient Clinics	
Extended Experience Includes: (Check all that apply)	☐ Central Line Insertion ☐ Mechanic Ventilator Management ☐ Management of Hospital Patients	☐ Trauma ☐ Shock Resuscitation ☐ Intubation	

* *Information not required to be entered if copy of license is provided and attached*

I certify that the above information is correct and that I have no restrictions on my license to practice in the State listed above or any other State.

I also certify that I have the training, knowledge and competency to practice in my specialty and have no restrictions on clinical privileges at any hospital/facility where clinical privileges have been or are currently granted.

I volunteer to provide clinical services to Kaweah Delta Health Care District during this disaster and agree to practice as directed and under the supervision of an assigned practitioner. I agree to wear my Disaster Privileges ID Badge at all times when functioning under these disaster privileges to enable staff and patients to readily identify my status.

I agree to maintain confidentiality of patient information, per current HIPAA requirements related to the protection and confidential handling of protected health information.

I understand that I will be notified when the organization's emergency plan is no longer in effect and I understand that the disaster privileges at this organization will immediately terminate. I also agree that these privileges may be terminated at any time without cause or reason during the disaster and that I have no right to a hearing or review. Email completed form along with copy of current government issued photo ID to: medstaff@kdhcd.org.

_____ _____

Signature of Provider ***Date***

DISASTER PRIVILEGE VERIFICATION & RECOMMENDATION FORM

_____

Name

The information provided by the Provider has been reviewed and will be verified, as soon as possible, as outlined in the Medical Staff Bylaws and related policies and procedures. On this basis, this Provider is granted disaster privileges to treat patients as directed by his/her assigned Kaweah Delta provider during this emergency.

_____ _____

Chief of Staff, CEO or Designee ***Date***

Provider Assigned to Disaster Volunteer	

Review 72 hours after provider begins exercising disaster privileges:

☐ Continue disaster privileges as assigned based on no concerns identified.
Additional assignment areas:
_____

☐ Discontinue disaster privileges:
_____

Chief of Staff, CEO or Designee: _____ Date: _____

MEDICAL STAFF SERVICES OFFICE USE ONLY

Checklist (please obtain copies if possible and attach to this document):

☐ Government-Issued ID (Driver's License or Passport)

AND – ONE OF THE FOLLOWING

☐ Current picture ID from a healthcare organization
☐ Current license to practice
☐ DMAT (Disaster Medical Assistance Team)
☐ MRC (Medical Reserve Corps)

_____

Name Date

_____

Title

☐ State License Verified *	Current	☐ or Received	Photo Taken
☐ Entry	MD-Staff	☐ Requested	ID Badge
☐ Entry	HR Online	☐ Doc Master Changes	Email to ISS
☐ Financials Entry	Soarian	☐ Doctor Master File Changes	Email to
☐ Privileges After 72 Hour Review	Continue	☐ Privileges After 72 Hour Review	Discontinue

Out-of-state licenses need the approval of the EMS Authority.

Kaweah Delta Health Care District

Subcategories of Department Manuals not selected.

Policy Number: DM 2202	**Date Created: 03/14/2008**
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)	

Code Blue/Code White Activation

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

Policy

This policy is designed to provide a coordinated and effective response by a trained team of professionals to cardiopulmonary arrest.

Definitions:

Code Blue: Adult CPR Medical Emergency

Code White: Pediatric Medical Emergency

Procedure

A. Background

In the event of a cardiopulmonary arrest the assigned Code Blue Team members will respond to the location of the arrest. All other personnel are to stay out of the area unless assigned by the team leader. Please refer to PC.189 policy and procedure in the Patient Care Manual.

B. Response

See attached checklist and flowchart.

CODE BLUE/WHITE – Medical Emergency

Purpose: To provide assistance if you witness or become aware of a medical emergency involving a fellow employee, patient or visitor at the hospital.

STAFF RESPONSE CHECKLIST

When you are the first person to find a patient, visitor or employee who appears to be a victim of a medical emergency or to be in life threatening distress, immediately initiate the following:

If the victim is in an area of the hospital where <u>a physician or nurse is nearby</u>:

- ☐ Yell for help.
- ☐ The physician or nurse will assess the situation.
- ☐ If there is a cardiac/respiratory arrest or medical emergency the Physician or Nurse will direct staff to dial Ext. 44 to report a Code Blue/Code White with the location. Off site facilities will call 9-911.
- ☐ If trained in CPR, initiate.
- ☐ Await the arrival of the Code Blue Team.

If the victim is in an area of the hospital where <u>no physician or nurse is present but other people are present</u>:

- ☐ Yell for help – Direct responder to dial Ext. 44 to report situation and location.
- ☐ Remain with victim until the Code Blue Team arrives. Off site facilities will call 9-911.
- ☐ If trained in CPR, initiate. If not trained in CPR, attempt to arouse victim.

If the victim is in an area of the hospital where <u>no one else is present but you</u>:

- ☐ Go to the nearest phone and dial Ext. 44 to report situation and location.
- ☐ Return to the victim and initiate CPR, if trained, and await Code Blue Team arrival.

If the victim is in an area <u>on campus but not in the main hospital buildings</u>:

- ☐ Go to the nearest phone and dial 911.
- ☐ Return to the victim and initiate CPR, if trained, and await paramedics.

If the victim is in an outside facility - <u>not in the main hospital buildings</u>:

- ☐ Yell for help
- □ Go to the nearest phone and dial 9-911.
- ☐ Return to the victim and initiate CPR, if trained, and await paramedics.

PBX Checklist

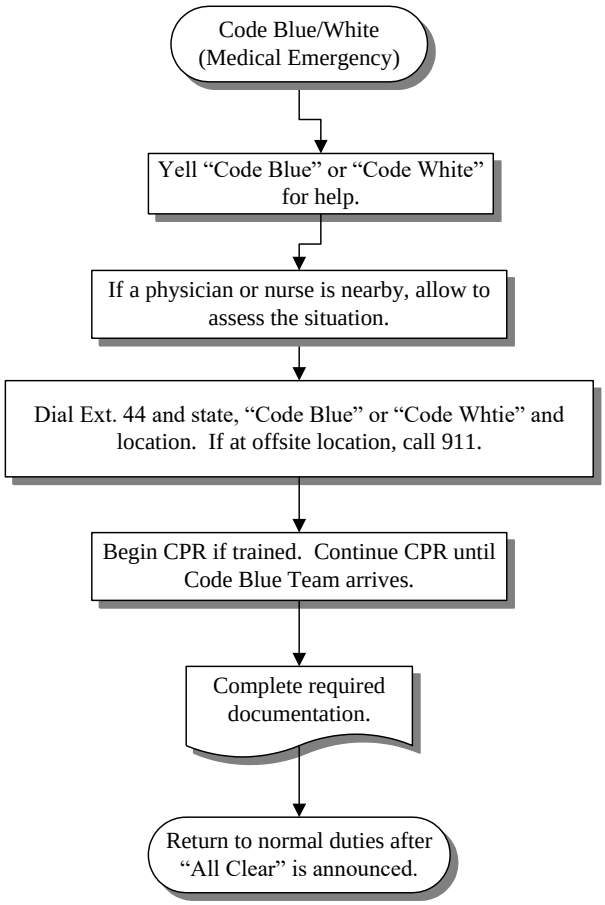
- ☐ Announce “Code Blue” or “Code White” (2x) and state the location over PA system.
- ☐ Immediately send out a page via paging system.

All Clear

After “Code Blue, All Clear” is announced (2x), return to your normal work duties, unless otherwise directed.

Emergency Management Manual

Code Blue /White - Medical Emergency



"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."

Kaweah Delta Health Care District

Subcategories of Department Manuals not selected.

Policy Number: EOC 5000	Date Created: 06/01/2009
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)	
Fire Prevention Management Plan	

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

I. OBJECTIVES

The objectives of the Management Plan for Fire Prevention Life Safety at Kaweah Delta Health Care District (KDHCD) are to provide an environment wherein patient care can be safely administered, to provide a fire safe *environment of care* to protect patients, personnel, visitors and property from fire and the products of combustion, and to provide for the safe construction and use of building and grounds in accordance with applicable codes and regulations for the State of California.

II. SCOPE

The scope of this management plan applies to **all buildings within KDHCD**

Each off site area is required to have a unit-specific fire plan that addresses the unique considerations of the environment, including, but not limited to, building evacuation requirements. Off-site areas are monitored for compliance with this plan during routine environmental surveillance by Environment of Care (EOC) committee members.

It is the responsibility of the Safety Officer to assess and document compliance with the Fire Prevention Plan for the off-site areas, using an environmental surveillance checklist.

III. AUTHORITY

The authority for overseeing and monitoring the fire prevention management plan and program lies with the *Environment of Care* Committee, whose members will ensure that fire prevention activities are identified, monitored and evaluated, and will also ensure that regulatory activities are monitored and enforced, as necessary.

IV. RESPONSIBILITIES

KDHCD Leadership have varying levels of responsibility and work together in the management of fire risks as identified below:

Board of Directors: The Board of Directors supports the Fire Prevention Management Plan through review and feedback, if applicable, of the quarterly and annual *Environment of Care* reports and endorsing budget support.

Professional Staff Quality Committee/PROSTAFF: Reviews the annual *Environment of Care* report from the *Environment of Care* Committee, providing feedback, if necessary.

Quality Council: Reviews annual *Environment of Care* report from the *Environment of Care* Committee and provides broad direction in the establishment of performance monitoring standards relating to fire prevention and fire risks.

Administrative Staff: Administrative staff provides active representation during the *Environment of Care* Committee meetings and sets an expectation of accountability for compliance with the Fire Prevention Program.

Environment of Care Committee: Environment of Care Committee members review and approve the quarterly *Environment of Care* reports, which contain a Fire Prevention component and oversee any issues relating to the overall fire prevention program.

Directors and Department Managers: Support the Fire Prevention Management Program by:

1. Reviewing and correcting deficiencies identified through the hazard surveillance process that relate to fire risks
2. Communicating recommendations from the Environment of Care Committee to affected staff in a timely manner.
3. Developing education programs within each department that ensure compliance with the policies of the Fire Prevention Management Program.
4. Supporting all required employee fire prevention education and training to include a disciplinary policy for employees who fail to meet the expectations.
5. Serving as a resource for staff on matters of fire prevention.

Employees: Employees of KDHCD are required to participate in the Fire Prevention Life Safety Management program by:

1. Completing required fire prevention education.
2. Participating in fire drills
3. Reporting any observed or suspected unsafe conditions to his or her department manager as soon as possible after identification that may pose a fire risk.

Medical Staff: Medical Staff will support the Fire Prevention Management Program by abiding by the District's policies and procedures relating to fire prevention and Life Safety.

V. MANAGEMENT OF FIRE RISKS

KDHCD has multiple processes in place that minimize the potential for harm from fire, smoke and other products of combustion, they include, but are not limited to:

1. This written plan serves to identify the overall components of the *Management Plan for Fire Prevention and Life Safety*.
2. Life Safety policies and procedures, which include an overall fire response plan for all staff
3. Fire Drills: Fire drills are performed per code to test staff response relating to the overall fire plan and to keep staff trained through rehearsal.
4. Procedures for testing, inspection and maintenance: Procedures are in place to ensure fire equipment testing and suppression equipment are properly tested, inspected and maintained.

5. Risk Assessment: Risk assessment for life safety includes ongoing hazard surveillance, *the Interim Life Safety Assessment* process, loss audits, regulatory, insurer and accreditation surveys.
6. Performance Standards: Performance standards are in place, based upon risk to the medical center, and monitored quarterly.
7. Education: Education and training of staff, physicians, temporary workers, students and volunteers is in place.
8. Testing, Inspection and maintenance: Testing, inspection and maintenance of fire extinguishing and suppression equipment, and fire alarm systems is in place.
9. *Statement of Conditions*: A Statement of Conditions is in place and is current. The deemed responsibility for the Statement of Conditions lies, jointly, with the Safety Office and the Facilities Director.

Reviewing Proposed Acquisitions:

To minimize the risks associated with flammable products brought into KDHCD, a process is in place for the review of proposed acquisitions of bedding, window draperies, furnishings, decorations, wastebaskets and other equipment and materials. KDHCD has all "requests for purchases" submitted to Facilities for review. The materials are acquired or approved through Facilities and Purchasing, and ensures:

1. Product(s) meets smoke and flame-resistant standards
2. Waste baskets are of noncombustible materials, or other approved material
3. Flame resistant coating and covering are maintained to retain their effectiveness
4. Attention is given to heat-generating combustible material and placement of equipment close to heat sources.

Staff will acquire samples and/or specification to assure that they have Class A rating (flame spread 0-25 and smoke development of 0-450) or rating such as Plenum, Fire rated per material. Staff will proceed with acquisition only when approved specifications are met, and are responsible for maintaining the specifications on file for each acquisition. Furniture purchased for the hospital meets state technical bulletin requirements, which requires a rating tag be attached to each article of furniture.

All materials within the hospital shall meet federal, state and local requirements for system construction, and treating and testing by approved testing agencies. Records of all materials shall be maintained on the hospital premises in the form of independent test laboratory reports, i.e., tags, or construction documentation.

These items include, but are not limited to:

Item	Verification
Finish materials	Independent Test Report
Low Voltage Wire	UL Smoke Rating/Independent Test
Construction Materials	Approved As-Builts
Furniture (State bulletins)	Test Report/Tags
Bedding/Curtains	Test report/Tags/Treat
Decorations	Test report/Tags/Treat
Holiday Trees	Office of State Fire Marshal Tag/Treat
Waste Baskets (similar items)	Location/Material/Approved

Contractors:

All contractors, before starting work at KDHCD, are responsible for adhering to the following criteria.

1. All equipment installed in the facility (high and low voltage) will be listed and approved by an independent testing lab (approved by the State of California).
2. All components will be hospital grade.
3. Modifications to existing equipment cannot be made without written approval of the KDHCD (re-certification may be required).
4. All finish material will be approved and meet code requirements.
5. All furniture will meet state bulletin requirements for sprinkled and non-sprinkled areas.
6. All construction will meet federal/state and local requirements.
7. Contractors will become familiar with KDHCD's Fire Procedures.
8. Contractors are to act in a professional manner, and to maintain proper identification and demonstrate respect for patient privacy and confidentiality.

Before initiation of a construction project, interim life safety measures (ILSM) will be assessed by the safety department, and an Infection Control permit will be issued. Ongoing ILSM's are the responsibility of the Safety Officer. A policy is in place that identifies in detail the ILSM process, including individuals who are responsible for implementation.

Newly constructed and existing environments of care are designed and maintained to comply with the *Life Safety Code.*

To minimize the potential for harm from fire, when newly constructed and existing environment of care are designed, only licensed architects are used, who oversee the process of subcontractors, who are independently licensed and bonded. Local, state and federal regulations are followed.

Exceptions to this are made on an case by case basis, by the Facilities Department, in conjunction with authorized personnel ensuring that all applicable regulations, codes and standards are followed.

Other Methods in Place to minimize the potential for harm from Fire, Smoke and other Products of Combustion include the following:

1. Fire/Smoke Doors: All doors are held open only by approved devices, i.e. electromagnetic or electromechanical. At NO TIME may doors be propped open with doorstops or other devices not connected to the fire alarm system.

2. General Environment: All areas of KDHCD are kept clean and orderly. Trash is removed regularly from designated holding areas.

3. Portable Electric Equipment: All plugs must be grounded. Extension cords must comply with the extension cord policy. Equipment must be in good operating condition.

4. Smoking: "No Smoking" regulations are strictly enforced, policy HR.193.

5. Ventilation Hoods: Ventilation hoods are cleaned on a regular basis, to code, to prevent buildup. The automatic fire extinguishing systems are properly charged and inspected and all nozzles securely fastened.

6. Storage Areas: Every attempt is made to arrange stock in an orderly fashion, with a minimum of eighteen (18) inches below the sprinkler heads and a minimum of twenty four (24) inches below the ceiling in non-sprinkled areas.

7. Aisles: Aisles between storage shelves are at least three feet apart. No storage is permitted within thirty-six (36) inches in front of electrical panels. Combustible materials shall not be stored in electrical rooms.

8. Space Heaters: Portable space heating devices shall be prohibited in all District areas, with the following exception: Approved portable space heating devices may be allowed in **non-patient care areas** as long as they conform to the following:
   - Heating elements of such devices do not exceed 212 degrees Fahrenheit (NFPA 101©, 2000 Edition, §19.7.8)
   - Required for medical or extreme necessity
   - Approval of the Director of Facilities, Clinical Engineering and Chief Operating Officer
   - The heating device must be equipped with a tip over shut off
   - The heater shall not be plugged into a surge protector or extension cord

9. Flammable Liquids: (Such as acetone, alcohol, benzene, and ether) limit the amount on hand to a minimum working supply. If possible, keep in metal container. Where safety cabinets or storage rooms are available, keep these materials in them and maintain the door to such storage in the closed position. No smoking, open flame or sparking device shall be allowed around flammable liquids or compressed gas. Oxygen and nitrous oxide shall not be stored with flammable gases, such as cyclopropane and ethylene, or with flammable liquids.

10. Electrical Hazards: Report promptly any frayed, broken or overheated extension cords or electrical equipment. Do not operate light switches, or connect or disconnect equipment where any part of your body is in contact with metal fixtures or is in water. Specially built equipment is in use in the operating and delivery rooms to eliminate electric sparks, and to control static electricity.

11. Acids: All concentrated or corrosive acids must be handled with extreme care. Avoid storing these materials on high shelves, or in locations where they are likely to be spilled or the containers broken. Organic acids and inorganic acids shall not be stored together. Any spillage shall be immediately diluted or neutralized and cleaned up.

Minimization of risk to patients who smoke:

See policy HR.193 “Tobacco Free Campus.”

Maintaining free and unobstructed access to all exits:

Surveillance activities allow *Environment of Care* Committee members to monitor compliance with *Life Safety Code* requirements, including maintaining free and unobstructed access to all exits. Should an exit need to be obstructed for some reason (i.e. construction, renovation, etc.) an ILSM assessment will be made before the exit path is impeded and Interim Life Safety Measures will be put into place.

The District has a written fire response plan:

See policy EOC.5002 “Fire Response Plan.”

Specific roles and responsibilities of Staff, Licensed Independent Practitioners (LIPs) and Volunteers in preparing for building evacuation:

Specific roles and responsibilities of staff, LIPs and volunteers in preparing for building evacuation are integrated into new-hire orientation and annual safety training, the information is also discussed during fire drills.

The District conducts fire drills:

1. Fire drills are conducted quarterly on all shifts in each building defined by the *Life Safety Code* as the following:
   - Ambulatory Health Care Occupancy
   - Health Care Occupancy

2. Fire drills are conducted annually in all free standing buildings classified as a business occupancy as defined by the *Life Safety Code*.

3. At least 50% of fire drills are unannounced at KDHCD facilities.

4. Staff who work in buildings where patients are housed or treated participate in fire drills

   Note: Staff participate in fire drills in all areas of the hospital, with the exception of those who cannot leave patient care during the time of a drill.

5. KDHCD critiques fire drills to evaluate fire safety equipment, fire safety-building features, and staff response to fire.
   - The evaluation is documented and reported to the *Environment of Care* on a quarterly basis.
   - Fire drills are critiqued post drill to identify deficiencies and opportunities for improvement.

The District maintains fire safety equipment and fire safety building features:
The following types of equipment or features exist within the District, with the following maintenance, testing and inspection requirements in place. All tests and/or inspections are documented and maintained in the Facilities Department.

1. At least quarterly, KDHCD tests supervisory signal devices (except valve tamper switches).
   a. Note: Supervisor signals include the following: control valves; pressure supervisor; pressure tank, pressure supervisory for a dry pipe, steam pressure; water level supervisor signal initiating device; water temperature supervisory; and room temperature supervisory.

2. Every six months, KDHCD tests valve tamper switches and water flow devices.

3. Every 12 months, KDHCD tests duct detectors, , heat detectors, manual fire alarm boxes and smoke detectors.

4. Every 12 months, KDHCD tests visual and audible fire alarms, including speakers and door releasing devices on the inventory.

5. Every quarter, KDHCD tests fire alarm equipment for notifying off-site fire responders.

6. Every week, KDHCD tests diesel fire pumps under no-flow conditions.

7. Every week, KDHCD inspects electric motor driven fire pumps under no-flow conditions.

8. Every month, KDHCD tests electric motor driven fire pumps under no-flow conditions.

9. Every 12 months KDHCD tests main drains at system low point or at all system risers.

10. Every quarter, KDHCD inspects all fire department water supply connections.

11. Every 12 months, KDHCD tests fire pumps under flow conditions.

12. Every 5 years, KDHCD conducts water-flow tests for standpipe systems.

13. Every 6 months, KDHCD inspects any automatic fire-extinguishing systems in a kitchen.

14. Every 12 months, KDHCD tests carbon dioxide and other gaseous automatic fire-extinguishing systems.

15. At least monthly, KDHCD inspects portable fire extinguishers.

16. Every 12 months, KDHCD performs maintenance on portable fire extinguishers.

17. KDHCD operates fire and smoke dampers one year after installation and then at least every 6 years to verify that they fully close.

18. Every 12 months, KDHCD tests automatic smoke-detection shutdown devices for air-handling equipment.

19. Every 12 months, KDHCD tests sliding and rolling fire doors for proper operation and full closure.

20. Every 12 months, KDHCD tests and inspects door assemblies.

21. Every month, KDHCD tests elevators with fire fighters' emergency operations..

22. Every month, KDHCD inspects fire sprinkler gauges and valve tamper switches.

Monitoring Conditions in the Environment:

The District establishes a process for continually monitoring, internally reporting, and investigating fire safety management problems, deficiencies and failures.

Through the *Environment of Care* Committee structure, the above elements are reported and investigated on a routine basis by managerial or administrative staff, with oversight by the committee. Minutes and agendas are kept for each *Environment of Care* meeting and filed in Performance Improvement.

Patient Safety: Periodically there may be an *Environment of Care* issue that has impact on the safety of our patients relating to life safety and or fire prevention. This may be determined from *Sentinel Event* surveillance, environmental surveillance, patient safety standards or consequential actions identified through the risk management process. When a patient-safety issue relating to life safety or fire prevention emerges, it is the responsibility of the Safety Officer or designee to bring forth the issue through the patient safety process.

Annual Evaluation of the Fire Prevention Management Plan:

On an annual basis *Environment of Care* Committee members evaluate the Fire Prevention Life Safety Management Plan, as part of a risk assessment process. Validation of the plan occurs to ensure contents of each plan support ongoing activities within the District.

Based upon findings, goals and objectives will be determined for the subsequent year.

A report will be written and forwarded to the Board of Directors.

The annual evaluation will include a review of the following:

1. Objectives: The objective of the Fire Prevention Management plan will be evaluated to determine continued relevance for the District (i.e., the following questions will be asked; was the objective completed? Did activities support the objective of the plan? If not, why not? What is the continuing plan? Will this objective be included in the following year? Will new objective(s) be identified? Will specific goals be developed to support the identified objective?)

2. The scope: The following indicator will be used to evaluate the effectiveness of the scope of the Fire Prevention Life Safety Management Plan: the targeted population for the management plan will be evaluated (e.g., did the scope of the plan reach employee populations in throughout the entire District?)

3. Performance Standards: Specific performance standards for the Fire Prevention Life Safety Management Plan will be evaluated, with plans for improvement identified.

   Performance standards will be monitored for achievement.

   Thresholds will be set for the performance standard identified. If a threshold is not met, an analysis will occur to determine the reasons and actions will be identified to reach the identified threshold in the subsequent quarter.

4. Effectiveness: The overall effectiveness of the objectives, scope and performance standards will be evaluated, with recommendations made to continue monitoring, add new indicators, if applicable, or take specific actions for ongoing review.

The District analyzes identified Environment Of Care issues:

EC.04.01.03-EP-1-2
Environment of care issues relating to Life Safety and/or fire prevention are identified and analyzed through the *Environment of Care* Committee with recommendations made for resolution.

It is the responsibility of the *Environment of Care* Committee chairperson to establish an agenda, set the meetings, coordinate the meeting and ensure follow-up occurs where indicated.

Quarterly *Environment of Care* reports are communicated to Performance Improvement, PROSTAFF and the Board of Directors.

Priority Improvement Project:

At least annually, a performance improvement project is selected by the Environment *of Care* Committee members. The priority improvement activity is based upon ongoing performance monitoring and identified risk within the environment. Based upon risk assessment, a priority improvement project may be related to Life Safety or Fire Prevention issues.

Improvement of the Environment of Care:

EC.04.01.05-EP1-3
Performance standards are identified monitored and evaluated that measure effective outcomes in the area of fire prevention management.

Performance standards are also identified for Safety, Security, Hazardous Materials, Emergency Management, Medical Equipment management and Utilities management.

The standards are approved and monitored by the *Environment of Care* Committee with appropriate actions and recommendations made. Whenever possible, the *environment of care* is changed in a positive direction by the ongoing monitoring and changes in actions that promote an improved performance.

Kaweah Delta Health Care District

Subcategories of Department Manuals not selected.

Policy Number: EOC 7402	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)	

Utilities Management Emergency Power

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

POLICY:

Kaweah Delta Health Care District shall provide and maintain a reliable, adequate emergency power system to provide electricity to designated areas during interruption of normal utility power.

Areas supplied by emergency power include, but are not limited to:
All Alarm Systems
Blood, Bone and Tissue Storage Units
Egress Illumination and Exit Signs
Elevator (at least one in patient care areas)
Communication Systems (PBX and Paging System)
Medical Air and Medical and Surgical Vacuum Systems
Operating Rooms and Recovery Room
Special Care Units - ICU, CCU, SNF, Emergency Department
Steam Delivery System (at least one boiler)
Delivery Rooms
Newborn Nurseries
Generator Locations

When operating on Emergency Power, the following status will occur:
1. White Electrical Plugs - OFF Red Electrical Plugs - ON
2. Main Phone Switch ON
3. Elevators *

Mineral King Wing

1. Otis Main Visitor OFF
2. Otis Main Visitor OFF
3. Otis Surgery ON
5. Schindler ON
6. Fresno Employee ON
7. Fresno Employee OFF
8. US East Expansion ON
9. US East Expansion ON

Acequia Wing

1. Thyssenkrupp Employee ON
2. Thyssenkrupp Employee OFF
3. Thyssenkrupp Visitor ON
4. Thyssenkrupp Visitor OFF
5. Thyssenkrupp Employee ON
6. Thyssenkrupp Employee OFF
7. Thyssenkrupp Surgery ON
8. Thyssenkrupp Surgery ON

4. Medical Air, Oxygen, Nitrous, Nitrogen Gases*	ON
5. Medical Vacuum*	ON
6. Water Pumps*	ON
7. Air Conditioning	OFF
8. Computers	ON – terminals on pending availability of Red Plugs.
9. Kronos	OFF
10.Dietary*	Cold Food Only
11. Tube System*	OFF

* If applicable to the campus

"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."

Kaweah Delta Health Care District

Subcategories of Department Manuals not selected.

Policy Number: EOC 6015	**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)	

Hospital Electrical Safety Policy for Personal Items

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

Policy:

Kaweah Delta Health Care District is committed to providing a safe environment for our patients, visitors, and staff members. To this end, the following policy and procedures have been developed.

Kaweah Delta Health Care District reserves the right to remove ANY personal electrical device that, in its opinion, presents a significant risk.

Definitions:

Pertinent 2012 NFPA 99 Definitions:

• "Patient bed location" is defined in section 3.3.136 as the location of a patient sleeping bed, or the bed or procedure table of a critical care area.

• "Patient-care-related electrical equipment" is defined in section 3.3.137 as electrical equipment that is intended to be used for diagnostic, therapeutic, or monitoring purposes in the patient care vicinity;

• "Patient care room" is defined in section 3.3.138 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 NFPA 99, but the definition has not changed.

• "Patient care vicinity" is defined in section 3.3.139 as a space, within a location intended for the examination and treatment of patients (i.e., patient care room) extending 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 7 ft. 6 in. above the floor.

Procedure:

1. All Privately Owned Medical Devices or Personal Electrical Items **MUST** be inspected by the Clinical Engineering Department, PRIOR to use, to ensure compliance with the existing Kaweah Delta Electrical Safety Policy, EOC 1085, when the patient is admitted to a Nursing Unit.

   The Clinical Engineering Deptartment On-Call Technician will be notified immediately upon arrival of any patient owned personal electrical item, or personal use medical device, (i.e., Cpap, BiPap, Portable Ventilator, etc.). The patient's Nurse, Unit Charge Nurse, or HUC, shall notify Clinical

Engineering by calling the Hospital PBX Operator and requesting that the Clinical Engineering On-Call Technician be notified of a Patient Owned incoming device inspection.

Incoming Patient Owned Medical Device requests shall be immediately responded to when notification is received by Clinical Engineering staff. Personal Electrical convenience or entertainment devices, such as Gameboy consoles, DVD Players, Radio's, etc., shall be responded to on the next Medical Device call in or within four (4) hours.

All items shall meet the following criteria for approval:

All line powered (AC) devices must have an Underwriter's Laboratories LISTED label or equivelant.

Line powered devices must be in safe condition, without evidence of wear, deterioration, or repair.

The following conditions apply for use:

Personal Owned Medical Device:

- Must be unplugged while not in use.
- May only be plugged into a wall outlet in the Patient Care Vicinity.
- May not be plugged into a power strip in the Patient Care Vicinity.

Personal Use Electrical Device:

- Must be unplugged when not in use.
- May not be plugged in to a power strip in the Patient Care Vicinity.
- May be plugged into a wall outlet or an approved power tap with UL1364 or 1364A rating in the Patient Care Room outside the patient care vicinity.

Power cords for such devices must be in good condition, with no exposed wires, cracked insulation, or broken, bent, or missing blades on the power plug.

2. Certain areas of the Hospital shall be restricted from any Personal Use Electrical Devices. These areas shall include, but not be limited to the following:

   Intensive Care Units - ICU, NICU, CVICU
   Surgical Rooms - OR, Delivery OR
   Cardiac Cath Lab
   PACU, Flex-Care
   Certain specific Exam/Treatment Rooms of ER
   Cardiology Treatment Areas
   Nuclear Medicine, MRI, Ultrasound and Radiology Treatment Rooms

3. In addition, patient clinical condition may prohibit the use of certain electrical items. Use of any device shall be restricted if, in the opinion of the Nurse, or Physician, the patient's ability to operate the device is compromised by medication, physical abilities, or care environment.

   Hair dryers, or any device that can produce a spark, shall not be used in areas where oxygen is being administered. Wall powered electric shavers shall not be used if the patient is attached to any medical device.

4. The Hospital reserves the right to remove, any personal electrical device that, presents or develops a significant risk to the patient, visitor, staff or equipment of Kaweah Delta Health Care District.

5. The following devices are generally permitted for use:

   Small battery-powered devices: Clocks, Radios, MP-3 & CD players**,** Cell phones and computer tablets. Use of head or earphones is encouraged with these devices.

   The above devices should be used in a manner that does not disturb other patients or visitors.

   Electric hair dryers or shavers. **(Hair dryers are NOT permitted for use in areas where oxygen is being administered.)**

   No portable communication devices or cellular telephone shall be permitted or used in any area which is considered electrically sensitive or where Intensive patient monitoring is being conducted.

6. The following devices are prohibited from use:

   Portable televisions, Extension cords, power strips, heating pads, space heaters, heating blankets, and any heating device with exposed heating surface. (Ie. Cooking ware, curling irons, hair irons, coffeepots, and coffee makers.)

   General Mobile Radio Service (GMRS) RF Transmitting Devices Ie. CB-Radios, Walkie-talkies, Amateur Radios, FRS Radios etc.

7. PLEASE NOTE: Kaweah Delta Health Care District reserves the right to refuse to treat a patient who, in the opinion of the Nursing Supervisor On-Duty at the time, and in consultation with, and concurrence of, the attending physician, presents a safety risk to a visitor, patient, or staff member, by refusing to comply with the above policy and procedures. Continued refusal to comply, and with concurrence of the attending physician, will result in notification of the patient's physician, for potential discharge of the patient for Safety Reasons.

"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."

Privileges in Critical Care, Pulmonary & Sleep Medicine

Name: _____

Please Print

CRITICAL CARE CORE PRIVILEGES

Education & Training: M.D. or D.O. and Successful completion of an ACGME or AOA accredited program in the relevant medical specialty **AND** Successful completion of an accredited fellowship in critical care medicine and/or current subspecialty certification or active participation in the examination process leading to subspecialty certification in critical care medicine by the ABMS or AOA Boards within the timeframe determined by the certifying board
Current Clinical Competence: Documentation of provision of inpatient care to at least fifty (50) patients in the CCU over the past 24 months or completion of residency or clinical fellowship within the past 12 months.
OR *CA licensed physicians involved in their 2nd or 3rd year Critical Care Fellowship Program

Renewal Criteria: Minimum 60 cases required in the past two years **AND** Maintain current certification or active participation in the examination process leading to certification in Critical Care Medicine by the ABMS or AOA Board.
FPPE Requirement: Minimum of 8 of the following cases reviewed concurrently or retrospectively, To include: 5 diverse admissions

Request	Procedure	Approve
☐	**Privileges include:** Privileges to evaluate, diagnose, perform history and physical exam, provide treatment or consultation (may include telehealth) to patients 14 years of age and older, with multiple organ dysfunction and in need of critical care **AND** • Airway management, including intubation • Arterial puncture and cannulation • Cardiopulmonary resuscitation • Cardioversion and defibrillation • Central venous and pulmonary artery catheter insertion • Lumbar puncture • Needle and tube thoracostomy • Paracentesis • Thoracentesis • Tracheostomy/cricothyroidotomy, emergency • Transthoracic Echocardiography • Swan Ganz Catheters	☐
☐	Admitting Privileges (Must request and maintain inpatient contact volume for Courtesy or Active Staff Status)	☐

ADVANCED PRIVILEGES
(Must meet the criteria for Critical Care Core Privileges)

Request	Procedure	Initial Criteria	Renewal Criteria	FPPE	Approve
☐	Flexible Therapeutic bronchoscopy	Documentation of 5 procedures in the last 2 years.	5 procedures in the last 2 years.	Minimum of 2 cases concurrently	☐
☐	~~Pericardiocentesis, emergency~~	~~Documentation of 5 procedures in the last 2 years.~~	~~5 procedures in the last 2 years.~~	~~Minimum of 2 cases concurrently~~	☐

PULMONARY CORE PRIVILEGES

Education & Training: M.D. or D.O. and Successful completion of an ACGME or AOA-accredited fellowship in pulmonary medicine. **AND** ACLS Certification unless boarded in Critical Care **AND** Current certification or active participation in the examination process leading to certification- in Pulmonary Disease OR Critical Care by the American Board of Internal Medicine or the American Osteopathic Board of Internal Medicine within the timeframe determined by the certifying board
Current Clinical Competence: Documentation of provision of inpatient care to at least fifty (50) patients over the past 24 months or completion of residency or clinical fellowship within the past 12 months.
OR *CA licensed physicians involved in their 2nd or 3rd year Pulmonary Fellowship Program

Renewal Criteria: Minimum 50 cases required in the past two years **AND** Maintenance of certification or active participation in the examination process leading to certification in Pulmonary Disease OR Critical Care by the American Board of Internal Medicine or the American Osteopathic Board of Internal Medicine **AND** ACLS Certification unless boarded in Critical Care.
FPPE Requirements: Minimum of 5 diverse admissions concurrently or retrospectively (Critical Care Core can be counted)

Request	Procedure	Approve
☐	**Core Privileges include:** Evaluate, diagnose, consult, perform history and physical exam, and provide treatment and consultation (may include telehealth) to patients with disorders chest or thorax **AND** • Airway Management, including intubation • Arterial puncture and cannulation • Central venous and pulmonary artery catheter insertion • Inhalation challenge studies • Pulmonary function testing interpretation • Thoracentesis and related procedures	☐
☐	Admitting Privileges (Must request and maintain inpatient contact volume for Courtesy or Active Staff Status)	☐

ADVANCED PRIVILEGES
(Must meet the criteria for Pulmonary Core Privileges)

Request	Procedure	Initial Criteria	Renewal Criteria	FPPE	Approve
☐	Flexible diagnostic bronchoscopy with Transbronchial biopsies	Documentation of 5 procedures in the last 2 years.	5 procedures in the last 2 years.	Minimum of 3 cases concurrently	☐
☐	Flexible diagnostic bronchoscopy with Endobronchial biopsies	Documentation of 5 procedures in the last 2 years.	5 procedures in the last 2 years.	Minimum of 3 cases concurrently	☐

SLEEP MEDICINE CORE PRIVILEGES

Education & Training: M.D. or D.O. and Successful completion of an ACGME or AOA-accredited fellowship in sleep medicine, **AND** ACLS Certification unless boarded in Critical Care **AND/OR** Current sub-specialty certification or active participation in the examination process leading to certification within the time frame determined by the certifying board in Sleep Medicine by the by the relevant ABMS board or completion of a CAQ by the relevant AOA board. Current certification by the AASM is acceptable for applicants who became certified prior to 2007.
Current Clinical Competence: Documentation of provision of care to at least fifty (50) patients over the past 24 months or completion of residency or clinical fellowship within the past 12 months.
Renewal Criteria: Minimum of 50 cases required in the past two years **AND** Maintenance of certification or active participation in the process leading to certification in Sleep Medicine **OR** completion of a CAQ by the relevant AOA board. Current certification by the AASM is acceptable for applicants who became certified prior to 2007 **AND** Documentation of 10 Cat I or II CME hours in sleep medicine.
FPPE Requirements: Minimum of 3 cases reviewed concurrently or retrospectively

Request	Procedure	Approve
☐	**Core Privileges include:** Evaluate, diagnose, consult, perform history and physical exam, and provide treatment (may include telehealth) to patients presenting with conditions or sleep disorders **AND** • Actigraphy • Home/ambulatory testing • Maintenance of wakefulness testing • Monitoring with interpretation of EKGs, electroencephalograms, electro-oculographs, electromyographs, flow, oxygen saturation, leg movements, thoracic and abdominal movement, and CPAP/BI-PAP tritration • Multiple sleep latency testing • Oximetry • Sleep log interpretation	☐
☐	Admitting Privileges (Must request and maintain inpatient contact volume for Courtesy or Active Staff Status)	☐

ADVANCED PRIVILEGES
(Must meet the criteria for Sleep Medicine Core Privileges)

Request	Procedure	Initial Criteria	Renewal Criteria	FPPE	Approve
☐	Polysomnography (including sleep stage scoring)	Documentation of 400 in the last 2 years.	400 in the last 2 years.	Minimum of 20 cases concurrently	☐

ADDITIONAL PRIVILEGES
(Must also meet the Criteria Above)

Request	Procedure	Initial Criteria	Renewal Criteria	FPPE	Approve
☐	Administration of Moderate Sedation	Successful completion of KDHCD sedation exam	Successful completion of KDHCD sedation exam	None	☐
☐	Percutaneous tracheostomy	Documentation of training and 10 procedures in the last 2 years	Minimum of 5 cases required in last 2 years	5 direct observation	☐
☐	Fluoroscopy Privileges	Current and valid CA Fluoroscopy supervisor and Operator Permit or a CA Radiology Supervisor and Operator Permit	Current and valid CA Fluoroscopy supervisor and Operator Permit or a CA Radiology Supervisor and Operator Permit	None	☐

Acknowledgment of Practitioner:

I have requested only those privileges for which by education, training, current experience and demonstrated performance I am qualified to perform and for which I wish to exercise and I understand that

(a) In exercising any clinical privileges granted, I am constrained by any Hospital and Medical Staff policies and rules applicable generally and any applicable to the particular situation.

(b) I may participate in the Kaweah Delta Street Medicine Program, as determined by Hospital policy and Volunteer Services guidelines. As a volunteer of the program, Medical Mal Practice Insurance coverage is my responsibility.

(c) **Emergency Privileges –** In case of an emergency, any member of the medical staff, to the degree permitted by his/her license and regardless of department, staff status, or privileges, shall be permitted to do everything reasonably possible to save the life of a patient from serious harm.

Signature: _____ _____
Applicant *Date*

Signature: _____ _____
Department of Critical Care, Pulmonology, Adult Hospitalist Medicine Chairman *Date*

Appendix D

Policy Submission Summary

Manual Name: Medical Staff Manual			**Date: 3.1.21**
Support Staff Name:			
Routed to:			**Approved By: (Name/Committee – Date)**
☐ **Department Director** ☐ **Medical Director** *(if applicable)* ☐ **Medical Staff Department** *(if applicable)* ☐ **Patient Care Policy** *(if applicable)* ☐ **Pharmacy & Therapeutics** *(if applicable)* ☐ **Interdisciplinary Practice Council** *(if applicable)* ☐ **Credentials Committee** *(if applicable)* ☐ **Executive Team** *(if applicable)* ☒ **Medical Executive Committee** *(if applicable)* ☒ **Board of Directors**			
Policy/Procedure Title	**#**	**Status** (New, Revised, Reviewed, Deleted)	**Name and Phone # of person who wrote the new policy or revised an existing policy**
MEDICAL STAFF WELL-BEING COMMITTEE	MS 02	Revised	Teresa Boyce x 2365
Reporting Guidelines	MS 33	Revised	Teresa Boyce x 2365
Impaired Practitioner Policy	MS 40	Revised	Teresa Boyce x 2365
Ongoing Professional Practice Evaluation (OPPE) / Focused Professional Practice Evaluation (FPPE)	MS 44	Revised	April McKee x 2344
Code of Conduct for Medical Staff & Advanced Practice Providers	MS 47	Revised	Teresa Boyce x 2365
Medical Staff and Advanced Practice Provider Notifications	MS 51	Revised	April McKee x2344
Use of Outside Proctors	MS 52	Revised	Debbie Roeben x2732
Medical Staff Organization Financial Assistance for Fit-For-Duty Evaluations	MS 16	Reviewed	
Trauma Peer Review and Trauma Performance Improvement (TPTIP)	MS 24	Reviewed	
RESCINDED OR LAPSED MEMBERSHIP AND/OR PRIVILEGES	MS 25	Reviewed	
Red Rules	MS. 101	Reviewed	

Policy Number: MS 02	Date Created: 02/01/2007
Document Owner: April McKee (Medical Staff Svcs Manager)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration), Medical Executive Committee	

MEDICAL STAFF WELL-BEING COMMITTEE

PURPOSE:

In order to maintain and improve the quality of care and assist staff members in the maintenance of appropriate standards of personal performance, the medical staff Well-Being Committee is responsible to take note of and to evaluate issues related to the health, ~~behavior~~, well being or impairment of medical staff/allied health members.

DEFINITION~~S~~:

1. Impaired practitioner: one who is unable to practice medicine with reasonable skill and safety to patients because of physical or mental illness, including deterioration through the aging process or loss of motor skill, or abuse or excessive use of drugs, including alcohol.

   Recognition of impairment of practitioners:
   a. Irritability: mood swings; negative attitude; argumentative; inappropriate anger; overreaction of criticism; altercations with staff, peers and patients; “personality change”
   b. Inaccessibility: frequent tardiness; frequent absence; “MIA” missing in action (frequent trips to bathroom, parking lot); prolonged lunch breaks; unavailable when on call; frequent beeper failure; frequent illness
   c. Cognitive impairment: lack of concentration; confusion; forgetfulness; difficulty thinking/speaking
   d. Physical impairment (resulting in the inability to provide optimal patient care): loss of motor skills; problems with balance; poor coordination and clumsiness
   e. Mental impairment: disruption in thinking, feeling, moods, and ability to relate to others
   f. Incidentals: disheveled appearance; tremors; “green tongue” from mints; bruises; needle tracks; heaving drinking at staff or social functions; off-duty intoxication; runny nose; raspy voice; alcohol on breath; red, yellow or black and blue eyes; dilated or constricted pupils; staff, patient or peer complaints; slurred speech; black outs; subject of hospital gossip (marital problems, DUI, financial problems, “party” reputation, etc.)

~~2. Inappropriate behavior: physical or verbal activity or any event that demeans a person, is disrespectful, causes unnecessary or unreasonable stress, or creates work disruption. Such behavior may include but are not limited to~~

~~displaying disruptive attitudes, yelling or swearing, bullying belittling or intimidating; harassment, including sexual harassment~~

~~3. Sexual Harassment: unwelcome verbal or physical conduct of a sexual nature which may include verbal harassment (such as epithets, derogatory comments or slurs), physical harassment (such as unwelcome touching, assault, or interference with movement or work), and visual harassment (such as the display of derogatory cartoons, drawings, or posters)~~

RESPONSIBILITIES:

The role of the Well-Being Committee is advisory in nature, and not a substitute for a personal physician or a disciplinary body. The Committee's focus should be the needs of the physician in question. It will report only to MEC and to the physician in question.

REFERRALS TO THE COMMITTEE:

1. Practitioners who develop a physical/mental impairment are required to "self report" to the chief of staff/designee. The practitioner agrees to notify the chief of staff/designee immediately in writing upon learning that he/she has developed substance abuse, mental or physical illness, or sustained any injury which could have an effect on the exercise of his/her clinical privileges.

2. Any person, practitioner or employee, suspecting a practitioner of being impaired must initiate a report to the Well-Being Committee. The individual making the report does not have to have proof of the impairment, but must state the facts leading to the suspicions, including dates, times, locations. The report will be forwarded to the chief of staff, via the medical staff office.

3. A charge of, or arrest for, driving while intoxicated/under the influence will automatically trigger a referral to the Well Being Committee.

~~4. Recurrent inappropriate behaviors that are not amenable to informal counseling and are documented in occurrence reports or confirmed by documented interviews by medical staff leaders (MEC) or medical staff officers.~~

The Committee:

1. Will be the identified point within the District where information and concerns about the health ~~and behavior~~ of an individual medical/allied health member can be delivered for consideration and evaluation.

2. May receive and assess reports related to the health, ~~behavior,~~ well-being or impairment of medical/allied health staff members; seek corroboration and additional information.

3. The referring source will be advised that follow-up action was taken.

4. Provide advice, recommendations and assistance to the ~~medical/allied health staff~~ Practitioner in question; provide recommendations for treatment and/or education; provide assistance in obtaining what is recommended.

5. Monitor ~~medical/allied health staff~~Practitioner for compliance with the terms of a monitoring agreement.

6. Assist ~~medical/allied health staff~~Practitioner with reinstatement issues.

7. Educate ~~the members of the medical/allied health staff~~Practitioners and other organization staff about physician health, ~~behavior,~~ well-being and impairment; about appropriate responses to different levels and kinds of distress and impairment; about treatment, recovery and monitoring; about the responsibilities of the medical staff in response to concerns about a ~~medical/allied health member~~Practitioner's health; and about appropriate resources for prevention, treatment, rehabilitation, monitoring and reinstatement.

8. When the medical staff receives a notification that a physician has entered ~~the Medical Board of California's Diversion Program (or similar program)~~a substance abuse recovery program, this communication should trigger the development of a monitoring agreement between the Well-Being Committee and the physician in diversion.

   a. Once practitioner has completed a program, the Well-Being Committee will establish a post-monitoring agreement whereby the practitioner agrees to provide an attestation at the time of reappointment. Attestation will address continued compliance regarding their particular issue.

9. Maintenance of confidentiality of the licensed independent practitioner seeking referral or referred for assistance is maintained by the Well-Being Committee, except as limited by applicable law, ethical obligation, or when the health and safety of a patient is threatened."

~~9.~~10. ~~All contacts with the committee shall be confidential to the degree protected by law.~~ In the event information received by the committee clearly demonstrates that the health or known impairment of a medical/allied health member poses an unreasonable risk of harm to patients or others in the hospital, that information shall be conveyed to ~~those individuals or committees within the medical staff responsible~~ the Chief of Staff for assuring that appropriate follow-up action is taken.

COMPOSITION:

A minimum of five (5) active members of the medical staff shall be appointed by the chief of staff, a majority of which, including the chair, shall be physicians. The membership shall include a psychiatrist and up to 5 immediate Past Chiefs of Staff who no longer serve on MEC> Except for initial appointments, each shall serve a term of two (2) years, and the terms shall be staggered. Insofar as possible,

members of the committee shall not serve as active participants on other peer review or quality improvement committees while serving on this committee.

Individuals who are not members of the medical staff may be appointed when such appointment will materially increase the effectiveness of the work of the committee.

Involvement of the following qualified physicians is desirable:

1. Physician recovering from alcoholism and/or other chemical dependence;
2. Psychiatrist or physician with mental health and/or addiction medicine training

RECORD KEEPING

Only those records should be kept which are appropriate to the charges given to the committee by the medical staff.

"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: MS 33	Date Created: 06/01/2011
Document Owner: April McKee (Medical Staff Svcs Manager)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration), Medical Executive Committee	

Reporting Guidelines ~~for 805.01 (CA Business Professional Code)~~

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

I. Policy

State and Federal Governments require specific disciplinary actions against Practitioners to be reported. This purpose of this policy is to provide guidance what must be reported and required timelines.

II. Procedure

State Report

~~An 805~~ California Business Professional Code 805 requires that disciplinary actions against physicians be reported to the California Medical Board and the California Osteopathic Medical Board~~d and the~~ . Kaweah Delta Medical Staff Office follows established guidelines for reporting found at the following sites:

https://www.mbc.ca.gov/Forms/Health_Facility_Reporting_FAQ.aspx
https://www.ombc.ca.gov/forms_pubs/

~~I.~~

~~In addition to reporting disciplinary actions under BP Section 805, certain final decisions or recommendations of the Medical Executive Committee, following formal investigation of practitioners, must be reported to the applicable licensing board – regardless of whether a hearing is held.~~

~~"Practitioners." This policy applies to physicians, dentists, podiatrists and psychologists, licensed midwifes and physician assistants.~~

~~"Formal Investigation" refers to a formal disciplinary investigation performed by or under the direction of the Medical Executive Committee, pursuant to the corrective action provisions of the bylaws or rules, in which the practitioner receives notice of the reasons for the proposed action or recommendation and has a reasonable opportunity to respond. This policy does not apply to investigations or reviews conducted by clinical departments, officers, or other committees which are not part of the Medical Executive Committee's formal disciplinary process.~~

~~Decisions or final recommendations covered by this policy must satisfy **each** of the following four elements:~~

1. Final decisions or recommended actions to deny, terminate or restrict (for a cumulative total of 30 days within a 12 month period) the clinical privileges of a practitioner;

1. Made by the Medical Executive Committee;

2. Following a formal investigation of the practitioner;

3. Based on the Medical Executive Committee's written determination that any of the following acts may have occurred:

   a. Incompetence, or gross or repeated deviation from the standard of care involving death or serious bodily injury to one or more patients, to the extent or in such manner as to be dangerous or injurious to any person or to the public – even if no summary suspension is required;
   b. The use of or prescribing for or administering to himself or herself, any controlled substance, or the use of any dangerous drug, or of alcoholic beverages, to the extent or in such manner as to be dangerous on injurious to the practitioner, any other person, or the public, or to the extent that such use impairs the ability of the licentiate to practice safely;
   c. Repeated acts of clearly excessive prescribing, furnishing, or administering of controlled substances or repeated acts of prescribing, dispensing or furnishing of controlled substances without a good faith effort prior examination of the patient and medical reason therefore – this does not apply to a prescribing, furnishing or administering controlled substances for intractable pain consistent with lawful prescribing;
   d. Sexual misconduct with one or more patients during a course of treatment or examination.

II. Procedure

1. Following a formal investigation the Medical Executive Committee shall vote to approve a final action or recommendation (i.e. termination, summary suspension or restriction of privileged) against a practitioner of due to actions contained in I.4 of this Policy.
2. The Medical Staff Services Director/designee shall promptly complete a facility report form required by the applicable licensing board.
3. The report form shall be signed by the Chief of Staff/designee and by the CEO/designee.
4. The report shall be transmitted within 15 days of the Medical Executive Committee's certification.
5. The Medical Staff Services Director/designee shall send the practitioner a copy of the report along with notice of the practitioner's right to submit a response by electronic or other means.

~~6. Applicable Medical Staff officers and support staff shall proceed to implement the decision or final recommendation in accordance with the bylaws, rules and policies of the Medical Staff.~~
~~7. Applicable Medical Staff officers and support staff shall assure that any additional reporting required by Section 805 or NPDB is timely made.~~

Federal Report

Reports for specific disciplinary actions against practitioners must be filed with the National Practitioner Data Base (NPDB). Kaweah Delta Medical Staff Office follows established guidelines for reporting to the NPDB found at the following site:~~ra~~

https://www.npdb.hrsa.gov/hcorg/whatYouMustReportToTheDataBank.jsp

"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: MS 40	Date Created: 03/01/2021
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	
Impaired Practitioner Policy	

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

I. **Purpose:** Substance abuse can adversely impact patient care and workplace safety. Use and abuse of alcohol or controlled substances may impair the ability of a medical staff member and advanced practice provider (collectively, Practitioner~~APP~~) to provide services and may endanger the individual, his or her co-workers, patients and the public. This policy is developed to provide for patient safety and to help eliminate the problem of workplace substance abuse.

II. **Policy:** It is the medical staff's policy to continuously strive toward preventing ~~practitioners~~ Practitioners from providing patient care services while impaired and toward maintaining a work environment free from illegal drug use and abuse of other substances. It is also the medical staff's policy that the integrity, well being, confidentiality, and professional activity~~/~~ and personal privacy of the ~~provider~~ Practitioner under review ~~being evaluated is~~be protected to the extent permitted by law.

III. **Applicability of Policy:** This policy applies to all ~~members of the medical staff and the APP staff.~~Practitioners holding membership or privileges at Kaweah Delta Health Care District (KDHCD).

IV. **Definitions:**

A. Controlled substance – Any and all chemical substances or drugs listed in any controlled substances acts or regulations applicable under any federal, state or local laws. Where these laws are conflicting (e.g. medical marijuana) legal counsel will render an opinion regarding the legality of use of such substances by practitioners.

B. Illegal drug – Any controlled substance the possession of which is illegal under any federal, state or local laws. Where these laws are conflicting (e.g.: medical marijuana) legal counsel will determine the legality of such substances.

C. Drug or alcohol test – Any test administered to determine the presence or absence of a chemical or drug in a person's urine or blood. ~~This~~ Testing should be done by a reputable laboratory with a definitive testing modality and NOT a screening test, which may be unreliable. When warranted by the circumstances, a Practitioner may be required to submit hair or nail samples for drug or alcohol testing.

D. Under the influence – A condition ~~which~~ that impairs or may ~~possibly~~ impair a~~ny person's~~ Practitioner's ability to provide medical services in a safe and productive manner and/or may adversely affect his or her safety or that of patients or other ~~medical/allied health staff members~~Practitioners. This must be shown to be reasonably present at the time of occurrence.

E. Screening Physical Exam – An immediate thorough exam that includes, as appropriate, bedside point-of-care (POC) testing [blood glucose, ethanol breathalyzer, EKG, etc] mini-mental status exam, neurological exam, GCS, and/or toxidrome evaluations.

F. Chief of Staff Designee or Designee – Any Officer of the Medical Staff: Vice Chief of Staff, Past Chief of Staff or Secretary/Treasurer; The Chief Medical Officer may be asked on a case by case basis to act as a ~~Designee of the~~ Chief of Staff Designee in the absence of all Officers of the Medical Staff.

V. Prohibited Actions:

The following are prohibited while engaging in activities related to patient care ~~providing medical services~~ at a ~~Kaweah Delta Healthcare District~~KDHCD facilities:

1. Possessing, consuming, or being under the influence of alcohol or illegal drugs.

2. Exhibiting physical or mental impairment likely to adversely affect patient care or workplace safety.

3. Distribution, sale, or purchase of ~~an~~ controlled substances or illegal drugs while ~~providing medical services~~on KDHCD property, even if the illegal drug itself is not actually possessed on ~~Kaweah Delta Health Care District~~ KDHCD premises.

4. Use or being under the influence of other substances that cause an altered psycho physiological state, where there is any possibility such use may impair the Practitioner's ability ~~of the medical staff member or APP~~ to safely provide medical services to patients or may adversely affect their safety or patient safety and care or the safety of other individuals.

~~4.~~5. **Diversion or theft of an medications, including controlled substances, from KDHCD.**

Procedure:

I. REPORTING OF SUSPECTED IMPAIRMENT

Evidence of possible impairment ~~shall~~ includes altered mental state, slurred speech, impaired balance, smell of alcohol, unsteady gait, lack of focus, shaking hands, vision impairment, problems communicating, observed possession ~~or~~ use, or diversion of alcohol ~~or drugs~~, controlled substances or illegal drugs, or failure to comply with protocols for documenting use of ~~narcotics~~ controlled substances or other drugs.

Whenever a hospital staff member observes evidence of possible impairment by a ~~member of the medical staff or APP~~Practitioner while on hospital premises, the staff member ~~shall~~ must immediately inform his or her supervisor who shall inform the CEO or ~~representative~~ Designee. The CEO or ~~representative~~ Designee shall immediately inform the Chief of Staff /~~designee~~Designee.

Whenever a ~~medical staff member or (APP)~~ Practitioner~~-~~ observes evidence of possible impairment of ~~a medical staff or APP~~another Practitioner, he or she ~~shall~~ must immediately inform the Chief of Staff or ~~designee~~Designee.

Whenever the Chief of Staff or ~~designee~~ Designee receives a report of possible impairment, ~~the Chief of Staff or designee shall~~ he or she must promptly conduct or supervise the administration of a Screening Physical Exam of the ~~practitioner~~Practitioner. The purpose of the preliminary evaluation is to determine whether ~~to ask the suspect practitioner to agree to~~ drug or alcohol ~~or other~~ testing is warranted.

II. SUBSTANCE ABUSE TESTING FOR REASONABLE CAUSE

A. Situations ~~in which~~ When Drug or Alcohol Testing ~~Shall Be~~is Required. A Practitioner is required to submit to ~~Drug~~ drug or alcohol testing ~~of a medical staff member or APP will~~

~~be required~~ under any of the following circumstances ~~(in accordance with the required clinical evaluation findings)~~:

1. When there is a reasonable suspicion that ~~a medical staff member or APP~~the Practitioner is under the influence of ~~any~~ alcohol, controlled substance or ~~alcohol~~ illegal drugs while ~~providing medical services~~ engaging in activities related to patient care at a KDHCD facilities~~y~~. "Reasonable suspicion" includes but is not limited to incidents in which the ~~individual~~ Practitioner:

    a. Is observed using alcohol, controlled substances, or illegal drugs while ~~providing medical services~~engaging in activities related to patient care at a KDHCD facilities~~y~~;

    b. Is in an apparent state of physical impairment as determined by an immediate Screening Exam.

    c. Is in an impaired mental state, as determined by ~~an~~ the immediate Screening Physical Exam.

    d. Exhibits marked changes in ~~personal~~ behavior that are not otherwise explainable, as determined by an immediate Screening Physical Exam.

    e. ~~Exhibits deteriorating~~Is involved in one or more incidents raising serious concerns about his or her work performance or delivery of patient care that is not ~~attributable to other factors determined by an~~explained by the immediate Screening Physical Exam.

    f. Any suspected or actual violation of this policy.

2. When a ~~medical staff member or APP~~Practitioner is suspected to be in possession of alcohol, a controlled substance or an illegal drug in violation of this policy, or when alcoholic beverages, controlled substances or illegal drugs are found ~~in a health district area controlled by the medical staff member or APP~~on KDHCD premises under the control of Practitioner (e.g., locker or desk)~~.~~;

3. When a ~~medical staff member or APP~~Practitioner has suspicious patterns or discrepancies in any medication and/or narcotic administration report;

4. As required by Well-Being Committee contract.

B. If testing for reasonable cause is indicated:

1. Both the person reporting the event ~~as well as the~~and Chief of Staff/~~designee~~ Designee will complete an Occurrence Report.

~~2. The sample of urine or blood, as determined by the substance of suspicion for testing, must be provided within two (2) hours.~~

~~3.~~2. If deemed warranted by the Screening Physical Exam, t~~T~~he Chief of Staff~~/designee~~ or Designee ~~shall~~ will escort the ~~medical/ staff member or APP~~Practitioner to the ~~medical~~ Medical ~~staff~~ Staff conference room to submit ~~a blood and/or urine specimen as determined by the substance of suspicion after the required Screening Physical Exam findings suggest the need for such testing.~~ to a POC test. In this situation, the Practitioner must submit to the POC test within two (2) hours.

3. The Chief of Staff or ~~designee~~ Designee will obtain from the ~~medical staff member or APP~~Practitioner the Consent for ~~Substance Use Testing~~Drug and/or Alcohol Testing (~~attachment~~ Attachment A), including an authorization for release of medical

information. Refusal to submit to ~~substance use~~drug or alcohol testing or to ~~authorize~~ execute the ~~release of the test results~~Consent form will be cause for summary suspension of clinical privileges. ~~from the medical staff(see Medical Staff Bylaws, Summary Suspension).~~

4. The Chief of Staff or ~~designee~~ Designee shall ask the ~~individual being tested~~Practitioner if he or she is taking any medication prescribed or recommended by a health care professional and ~~should~~ will note on the ~~consent~~ Consent form any prescribed medication ~~listed by the individual~~so specified. If the test reveals the presence of a ~~drug~~ medicationprescribed for the ~~individual~~Practitioner, he or she~~, the individual~~ will not be subject to discipline unless the levels of the ~~drug~~ medication show ~~purposeful~~ abuse. Even if the ~~individual~~ Practitioner is not abusing a prescribed ~~drug~~medication, the ~~drug~~ medication may make the individual unfit to attend to patients as determined by the Screening Physical Exam. If so, the ~~individual~~ Practitioner will not be disciplined, but ~~should no~~may be required to refrain from ~~t~~ attending to patients while under the influence of the~~se~~ medication~~s~~.

5. The Chief of Staff or ~~designee~~ Designee will contact the KDHCD house supervisor to obtain the phone number for Mineral King Lab mobile services, after which he or she will contact the service to come to a location designated by the Chief of Staff or ~~designee~~Designee, where a urine or blood sample will be obtained to test for the suspected substance following the chain of custody for specimens. The Chief of Staff or ~~designee~~ Designee will directly observe the collection of all samples.

6. A confidential number, as assigned by the ~~medical~~ Medical ~~staff~~ Staff ~~services~~ Services ~~director~~Director/designee, will be used for all samples and for reporting the results.

7. The ~~person~~ Practitioner submitting the specimen will validate the chain of custody process through signature on the chain of custody form (~~attachment~~ Attachment B) and initials on the sealed specimen.

8. The same specimen will then be transported by ~~Mineral King~~Adventist Health phlebotomist to the ~~Mineral King Lab~~Adventist Health Toxicology in Tulare, CA for testing, with the chain of custody being followed.

9. The Medical Staff Services Director shall maintain the confidential documentation of the incident for the Chief of Staff or ~~designee~~ Designee and CEO or ~~designee~~ Designee to review.

10. The original test results and the Reasonable Cause for testing form(s) ~~for medical staff members or APPs~~ will be forwarded to the Medical Staff Services Director for review by the Chief of Staff or ~~designee~~ Designee and the Well-Being Committee.

E. If the POC testing for substance use and/or the Screening Physical Exam indicate impairment at the time of providing care to patients, the ~~medical staff member's/APP's~~Practitioner's privileges will be summarily suspended pursuant to the Medical Staff Bylaws, pending the test results from ~~Mineral King Lab~~Adventist Health Toxicology. The responsibility for care of the ~~affected practitioner's~~ Practitioner's hospitalized patients will be assigned to another P~~p~~ractitioner with appropriate clinical privileges. The wishes of the patient shall be considered in the selection of a covering ~~practitioner~~Practitioner.

F. Arrangements for safe transportation home will be ~~provided to the medical staff member/APP.~~ made for the Practitioner.

G. If the testresults ~~for substance use testing~~ are negative, the ~~medical staff member/APP~~ Practitioner will be advised through the Well-Being Committee of the need for further

evaluation of other medical or mental health issues ~~such as, but not limited to, cognitive decline, mental or physical illness, disruptive behavior, emotional duress, etc.~~.

H. A positive ~~result fo~~r alcohol and/or drug test ~~or any illegal substance, or a~~ result indicating abuse of a prescribed medication may result in the continuation of ~~the~~ a summary suspension~~, per the Medical Staff Bylaws~~. The Medical Executive Committee will meet ~~regarding the~~to consider ~~continuation of~~continuing the summary suspension within the timelines specified ~~as required~~ in the Medical Staff bylaws.

The ~~medical staff member or APP~~Practitioner will be referred to the Well-Being Committee.

ATTACHMENT A

CONSENT TO ~~SUBMIT TO~~ DRUG AND/OR ALCOHOL TESTING AND

AUTHORIZATION FOR RELEASE OF ~~CONFIDENTIAL~~ MEDICAL INFORMATION

I voluntarily agree to submit to a comprehensive drug and alcohol testing and analysis to be administered by an outside, independent laboratory.

~~I acknowledge that the District and its Medical Staff are concerned about my ability to perform my privileges safely and that I have been requested to submit to drug and/or alcohol testing. I further acknowledge that I have been informed previously of the Impaired ProviderPolicy.~~

I understand that the testing is voluntary on my part, that I may refuse to submit to testing , and that such refusal may be grounds for disciplinary action, ~~up to and~~ including summary suspension of my clinical priileges.

~~I hereby consent to the requested drug and/or alcohol testing.~~

I hereby authorize the testing facility to disclose the results of the evaluation and tests, including and related analyses and/or reports of testing to the KDHCD Chief of Staff via the Medical Staff Services Director ~~for review by the Chief of Staff~~ for use in connection with the consideration of whether I am fit to practice and my continued qualification for Medical Staff membership and clinical privileges by the Chief of Staff and Medical Executive Committee. I authorize the Chief of Staff to release this information to the Medical Executive Committee and ny Ad Hoc Committee that may be formed in connection with this pupose. I also authorize the Chief of Staff to release this information to the Chair of KDHC Medical Staff ~~or designee and to the~~ Well-Being Committee ~~Chair or designee, and that the results may be used for counseling or intervention by the Well Being Committee or as grounds for disciplinary action in accordance with the Medical Staff bylaws if I do not cooperate with the Well-Being Committee or if the Well Being Committee determines that a referral to the Medical Executive Committee for disciplinary action is appropriate..~~…

I understand that the information obtained will be maintained confidentially and will not be released to anyone else or used for any other purpose unless required by law, governmental agencies, or subpoena.

My consent and authorization ~~for the release of the testing information~~ shall expire ~~at the end of two~~ oneyears from the date of this consent and authorization.

~~With full knowledge of the foregoing, I hereby agree to submit to drug and/or alcohol testing.~~I have signed this consent and authorization voluntarily, and I understand that I have a right to receive a copy upon my request.

_____ _____

Signature Date

_____
Printed Name

_____ _____
Witness' Signature Date

ATTACHMENT B

LABORATORY
LEGAL CHAIN OF CUSTODY FORM

Identification Band Verified: YES□ NO□
Specimen Type: □ Urine Blood□ Both□
Test Requested: Urine Drug Screen□ □ Blood Alcohol Other: Specify□□

Received By: _____ Time:_____ Date: _____
Signature

Taken To: _____ Time:_____ Date: _____
Location

Received By: _____ Time:_____ Date: _____
Signature

Taken To: _____ Time:_____ Date: _____
Location

Received By: _____ Time:_____ Date: _____
Signature

Taken To: _____ Time:_____ Date: _____
Location

Received By: _____ Time:_____ Date: _____
Signature

Taken To: _____ Time:_____ Date: _____
Location

Received By: _____ Time:_____ Date: _____
Signature

Taken To: _____ Time:_____ Date: _____
Location

Place a tamper proof evidence seal over the lid and down the sides of the specimen container.

Date and sign. Do all of the above in front of the practitioner.

Name:_____Date Collected:_____

Time Collected: _____

Collection Witnessed By:_____

Policy Number: MS 44	Date Created: 02/26/2021
Document Owner: April McKee (Medical Staff Svcs Manager)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration), Medical Executive Committee, April McKee (Medical Staff Svcs Manager), Cindy Moccio (Board Clerk/Exec Assist-CEO), Teresa Boyce (Director of Medical Staff Svcs)	

Ongoing Professional Practice Evaluation (OPPE) / Focused Professional Practice Evaluation (FPPE)

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

Purpose:

The purpose of Ongoing Professional Practice Evaluation (OPPE) and Focused Professional Practice Evaluation (FPPE) is to define, determine, maintain and evaluate the current competency and professional behavior of members of the Medical Staff and Allied Health Practitioners at Kaweah Delta Health Care District. Competency includes the ability to provide care, treatment and service in accordance with credentialing and privileging processes and requirements of the Medical Staff.

OPPE and FPPE are based on the Accreditation Council for Graduate Medical Education's (ACGME) and the American Board of Medical Specialties' (ABMS) six core competencies:

i. Patient care
ii. Medical knowledge
iii. Interpersonal skills
iv. Professionalism
v. Systems-based practice
vi. Practice-based learning

Goals:

I. To create an ongoing, systemic, data based process for the medical staff to evaluate practitioner performance and maintain accountabilities for addressing opportunities for improvement.

II. To identify areas of performance improvement needed, and assist the practitioner in achieving a successful resolution of those needs.

III. To create a positive peer case review culture by recognizing practitioner excellence as well as identifying improvement opportunities through a process that is clearly defined, fair, non-punitive and educational.

Scope:

I. This policy addresses the OPPE of practitioners who are currently exercising privileges under the evaluation of the medical staff. It also addresses the

initial as well as *triggered* FPPE of those practitioners which may arise from concerns identified through OPPE.

i. Behavioral and/or clinical trends are evaluated by the Department Chair who will determine through the completion of a Trend Analysis (Attachments A and B) if a *triggered* FPPE will be initiated.

II. During OPPE and FPPE processes the practitioner is NOT considered to be "under investigation" for the purposes of reporting requirements under the Healthcare Quality Improvement Act.

III. Should ambiguity, lack of internal expertise, or a conflict of interest exist in the performance of FPPE, a referral for external peer review may be made to the PRC Chair.

IV. OPPE and FPPE processes are quality assurance and peer review activities. As such, they are confidential and protected from discovery pursuant to California Evidence Code section 1157, and subject to the immunities afforded by state and federal law.

V. Should the Department Chair be the subject physician of the OPPE or FPPE, the Vice Chair will conduct the evaluation process. Should the Chief of Staff be the subject of the OPPE or FPPE, the Vice Chief of Staff will conduct the evaluation process.

Policy:

I. Each practitioner's performance is initially evaluated by way of conducting an *initial* FPPE. This is a time-limited period, not to exceed six (6) months unless granted an extension per MS.45 Focused Professional Practice Evaluation Guidelines for Initial Proctoring policy, during which the practitioner's professional performance is evaluated. Based upon the findings of the initial FPPE, the Department Chair shall determine whether:

i. The practitioner's performance is deemed satisfactory;

ii. The period of evaluation must be extended or modified;

iii. Action must be taken to improve performance; or

iv. The practitioner's privileges should be limited or revoked.

II. The performance of each practitioner who holds clinical privileges is continuously evaluated by way of OPPE. Every eight (8) months an evaluation of the previous eight (8) month period shall be performed. This routine allows potential problems with a practitioner's performance to be identified and resolved as soon as possible via institution of an FPPE, and fosters a more efficient, evidence-based privilege renewal process.

III. A practitioner may also be evaluated by way of conducting a *triggered* FPPE when questions arise regarding a practitioner's ability to provide safe, high quality patient care as referenced in the Medical Staff Trend Analysis Procedure. This is a time-limited period, not to exceed twelve (12) months, during which the practitioner's professional performance is evaluated. Based upon the findings of the triggered FPPE, the Department Chair shall determine whether:

i. The practitioner's performance is deemed satisfactory;

ii. The period of evaluation must be extended or modified;

iii. Action must be taken to improve performance; or

iv. The practitioner's privileges should be limited or revoked.

Procedure:

OPPE: Selection of Practitioner Performance Measures

I. Practitioner performance measures will be selected by medical staff departments that will address the Accreditation Council for Graduate Medical Education's (ACGME) and the American Board of Medical Specialties' (ABMS) six General Competencies, are appropriate to the practitioner's specialty, are reflective of practitioner performance, and are attributable to individual practitioners. These measures will utilize multiple sources of data. Whenever appropriate, the indicators should be linked to specific privileges or privilege groups.

OPPE: The Scorecard and Practitioner Performance Feedback

I. The best approach to improve practitioner performance is to provide practitioners their own data on the general competencies on a regular basis through the OPPE scorecard. The same scorecard will be used by medical staff leaders as the OPPE report for systematic measurement, evaluation, and follow-up.

II. Individual scorecards will be continually available to all practitioners with privileges on the medical staff and who also have significant clinical activity. The data will be confidential to the individual practitioner and appropriate medical staff leaders (i.e.: Department Chairs, Credentials Committee, Medical Staff Officers, and MEC).

III. Should one or more indicators become outlying data or below benchmark, the Department Chair may conduct a Trend Analysis as referenced in the Medical Staff Trend Analysis Procedure.

OPPE: Routine Scorecard Review and Follow-up

I. Department Chairs will review the OPPE scorecards within 45 days of distribution and with the practitioners communicate the findings including but not limited to:
    i. Any single indicator which is below target or benchmark
    ii. Any single indicator which is substantially lower than the Peer Score
    iii. Three or more general competencies which have an indicator in a single report period below target or benchmark
    iv. Unique circumstances requiring a discussion with the practitioner
    v. Positive outcomes and/or data

II. After follow-up, the Department Chair will *document* conclusions or the need for a Trend Analysis or FPPE for *each* indicator that was discussed with the practitioner.

FPPE: Initial

I. Direction and follow-up for initial FPPE will be facilitated by the medical staff office.

FPPE: Triggered

I. Triggers may include, but are not limited to:
    i. Specific questions of clinical competence, patient care and treatment, case management;
    ii. Inappropriate or disruptive behavior as referenced in the Disruptive Medical/Allied Health Staff Member policy;
    iii. Referrals from the Medical Staff Peer Review Committee (MSPRC) such as:
        a. a single case
        b. 3 or more peer review cases rated as Level 4 – Below Standard of Care
        c. 5 or more peer review cases rated as Level 3 – Opportunity for Improvement
    iv. Referrals by the Department Chair, Chief of Staff (COS), Chief Medical Officer (CMO), or the Medical Executive Committee (MEC).
    v. Violations of applicable ethical standards; the Medical Staff Bylaws, Rules & Regulations, or Policies & Procedures; or the Code of Ethical Conduct

II. If a *triggered* FPPE results from findings of the MSPRC as a result of an

individual case review or a series of case reviews. The following procedure shall be followed:

The Department Chair, will also be informed of any PRC Level 4 determinations set by the PRC, so that you can meet with the physician and discuss the case. Depending on the outcome of that discussion, your options as Department Chair are either to close the event by offering helpful input/suggestions to the physician, or, if appropriate, take further action to correct the situations.

i. The PRC Chair will communicate the potential practitioner improvement opportunities to the appropriate Department Chair.
ii. The Department Chair, with the assistance of the PRC Chair, and if requested, the COS or CMO, will determine if additional data is needed or will use the current data to perform a Trend Analysis. The Department Chair is responsible for notifying the practitioner that a Trend Analysis will be conducted.
iii. The Department Chair will then determine if a *triggered* FPPE is required. If indicated, the Triggered FPPE / Plan For Improvement Form (Attachment C) will be completed in conjunction with the practitioner and monitored according to the Trend Analysis Procedure.

III. If a triggered FPPE results by other information or events that are brought to the attention of the Department Chair, COS, or CMO, the following procedure shall be followed:

i. The Department Chair, and if requested, the COS or CMO, will determine if additional data is needed or will use the current data to perform a Trend Analysis (Attachments A and B). The Department Chair is responsible for notifying the practitioner that a Trend Analysis will be conducted.
ii. The Department Chair will then determine if a triggered FPPE is required. If indicated, the Plan For Improvement Form (Attachment B) will be completed and monitored in conjunction with the practitioner according to the Trend Analysis Procedure.

Use of OPPE and FPPE at Reappointment

I. At time of reappointment, the Department Chair will review the past two years of OPPE and, if any, FPPE data and document the interpretation and any improvement activities for each indicator and provide his/her recommendation for reappointment to the Credentials Committee.

References:

Medical Staff Credentials Policy 6.B
Medical Staff Disruptive Medical/Allied Health Staff Member Policy MS 11
Medical Staff Trend Analysis Procedure (Attachment A)
Medical Staff Trend Analysis Form (Attachment B)
Medical Staff Triggered FPPE / Plan for Improvement Form (Attachment C)

"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."

Medical Staff Office
Attachment A

Medical Staff Trend Analysis Procedure

Purpose:

To collect information regarding an individual practitioner's *ongoing* or *triggered* focused professional performance evaluation (OPPE or triggered FPPE) by the Department Chair or his/her designee to identify potential actionable trends. This may lead to the recommendation of a Plan For Improvement.

The need for a Trend Analysis is based on the Accreditation Council for Graduate Medical Education's (ACGME) and the American Board of Medical Specialties' (ABMS) six core competencies:

- Patient care
- Medical knowledge
- Interpersonal skills
- Professionalism
- Systems-based practice
- Practice-based learning

The Trend Analysis is a quality improvement and peer review activity. As such, it is confidential and protected from discovery pursuant to California Evidence Code section 1157, and subject to the immunities afforded by state and federal law.

Goals:

I. To create a positive peer case review culture by recognizing practitioner excellence as well as identifying improvement opportunities through a process that is clearly defined, fair, efficient and useful.

II. To make recommendations for quality improvement and education, if necessary, to improve practitioner care and help practitioners achieve those improvements.

Procedure:

I. A request for a Trend Analysis shall be made to the Department Chair based on at least one of the following circumstances and shall cite the perceived need:
   i. Specific questions of clinical competence, patient care and treatment, case management;
   ii. Inappropriate or disruptive behavior as referenced in the Disruptive Medical/Allied Health Staff Member policy;
   iii. Referrals from the Medical Staff Peer Review Committee (MSPRC) such as:
      a. a single case

b. 3 or more peer review cases rated as Level 4: Below Standard of Care
c. 5 or more peer review cases rated as Level 3: Opportunity For Improvement

iv. Referrals by the Department Chair, Chief of Staff (COS), Chief Medical Officer (CMO), or the Medical Executive Committee (MEC).

v. Violations of applicable ethical standards; the Medical Staff Bylaws, Rules & Regulations, or Policies & Procedures; or the Code of Ethical Conduct

II. If the request for a Trend Analysis is approved, the Department Chair will inform the practitioner and the PRC Chair that a trend analysis will be conducted and cite the circumstance(s).

i. If multiple cases will be reviewed, the Department Chair will determine which of the following case selection methods will be used:
- Single case
- 100% of cases
- Random sampling

ii. The Department Chair or his/her designee shall perform the Trend Analysis by completing the Trend Analysis Evaluation Form (Attachment A). The Department Chair will provide his/her recommendations on the Form and submit the Form to the PRC Chair within 45 days of the approval of the trend analysis.

iii. If the Department Chair's recommendations shall include an action plan, he/she shall complete the Plan For Improvement (PFI) Form (Attachment B) in conjunction with the practitioner and submit it to the PRC Chair concurrently with the Trend Analysis Evaluation Form. The PRC Chair will seek approval from the Peer Review Committee (PRC), then forward the PFI to the Medical Executive Committee (MEC) for approval. Upon approval from the MEC, the PFI will take effect immediately.

iv. It is the responsibility of the Department Chair to monitor and document progress throughout the duration, and upon completion, of the PFI. The Department Chair in conjunction with the practitioner will update the PFI Form to document the practitioner's progress and completion of the Plan. The Form shall be forwarded to the PRC Chair for approval. The PRC Chair will then forward the PFI to the MEC for its approval.

III. If the request for Trend Analysis is not approved, the Department Chair will inform the PRC Chair and cite the circumstance(s).

Medical Staff Office
Attachment B

Trend Analysis
Procedural/Surgical Practitioner Evaluation Form
CONFIDENTIAL PEER REVIEW DOCUMENT

Confidential for file of: _____

Department: _____

Reason for Trend Analysis: _____

Name of Reviewer:_____ **Title:** _____

Patient Account Number(s): _____

_____

Diagnosis(es): _____

_____

Procedure(s): _____

_____

Complications (if any): _____

_____

PLEASE ANSWER ALL OF THE FOLLOWING: If the answer to any of the questions is "no" or "unsatisfactory," please attach an explanation on a separate sheet.

Please Circle			
Yes	**No**	**N/A**	1. Was there pre-procedural justification for the procedure documented?
Yes	**No**	**N/A**	2. Was the practitioner's problem formulation (e.g., initial impressions, rules-outs, assessment, etc.) appropriate?
Yes	**No**	**N/A**	3. Was all necessary initial information (e.g., history & physical, progress notes, orders) recorded by the practitioner in a timely manner in the patient's medical record?
Yes	**No**	**N/A**	4. Did the pre-operative diagnosis coincide with intra-operative findings?
Yes	**No**	**N/A**	5. Was postoperative care adequate?
Yes	**No**	**N/A**	6. Did the practitioner make patient rounds at least daily?
Yes	**No**	**N/A**	7. Was handwritten information recorded legibly?
Yes	**No**	**N/A**	8. Were the practitioner's entries in the patient's record informative?
Yes	**No**	**N/A**	9. Were the practitioner's entries in the patient's record appropriate?
Yes	**No**	**N/A**	10. Was the practitioner's use of diagnostic services (e.g., lab, x-ray, and invasive diagnostic procedures) appropriate?

Yes	**No**	**N/A**	11. Was the practitioner's medication use appropriate?
Yes	**No**	**N/A**	12. Was the practitioner's use of blood and blood components appropriate?
Yes	**No**	**N/A**	13. Was the practitioner's use of ancillary services (physical therapy, respiratory therapy, social service, etc.) appropriate?
Yes	**No**	**N/A**	14. Were the practitioner's other orders appropriate?
Yes	**No**	**N/A**	15. Were any complications anticipated, recognized promptly, and dealt with appropriately?
Yes	**No**	**N/A**	16. Was the patient's length of stay appropriate?
Yes	**No**	**N/A**	17. Was the discharge plan appropriate?
No	**Yes**	**N/A**	18. Was there any evidence that the practitioner exhibited any disruptive or inappropriate behavior to the patient or other staff?
No	**Yes**	**N/A**	19. Was there any evidence of patient dissatisfaction with the practitioner?
No	**Yes**	**N/A**	20. Is there an opportunity for improvement not already identified?

Basic Assessment	**Satisfactory**	**Unsatisfactory**
1. Basic medical knowledge		
2. Clinical judgment/skill		
3. Communication skill		
4. Use of consultants		
5. Professional attitude/behavior		
6. Documentation		
7. Relationship to patient		

Generally, how would you describe this practitioner's skill and competence in managing this patient?

☐ Excellent ☐ Standard of care ☐ Opportunity for improvement ☐ Below Standard of care

Recommendations: _____

_____

_____

_____

☐ Check here if a Plan For Improvement will be initiated (Please attach Plan)

_____ _____

Reviewer's Signature (if other than Department Chair) **Date**

_____ _____

Department Chair's Signature **Date**

This document is confidential and protected from discovery pursuant to California Evidence Code section 1157.

Trend Analysis
General Competencies Practitioner Evaluation Form
CONFIDENTIAL PEER REVIEW DOCUMENT

Confidential for file of: _____

Department: _____

Reason for Trend Analysis: _____

Name of Reviewer:_____ **Title:** _____

Patient Account Number(s): _____

_____

Diagnosis(es): _____

_____

Procedure(s): _____

_____

Complications (if any): _____

_____

PLEASE ANSWER ALL OF THE FOLLOWING: If the answer to any of the questions is "no" or "unsatisfactory," please attach an explanation on a separate sheet.

Please Circle			
Yes	**No**	**N/A**	1. Was there adequate evidence to support the patient's admission?
Yes	**No**	**N/A**	2. Was the initial level of care appropriate?
Yes	**No**	**N/A**	3. Was the practitioner's problem formulation (e.g.: initial impressions, rule-outs, assessment, etc.) appropriate?
Yes	**No**	**N/A**	4. Was all necessary initial information (e.g.: history & physical, progress notes, orders) recorded by the practitioner in a timely manner in the patient's medical record?
Yes	**No**	**N/A**	5. Did the practitioner make patient rounds at least daily?
Yes	**No**	**N/A**	6. Was handwritten information recorded legibly?
Yes	**No**	**N/A**	7. Were the practitioner's entries in the patient's record informative?
Yes	**No**	**N/A**	8. Were the practitioner's entries in the patient's record appropriate?
Yes	**No**	**N/A**	9. Was the practitioner's use of diagnostic services (e.g., lab, x-ray, and invasive diagnostic procedures) appropriate?
Yes	**No**	**N/A**	10. Was the practitioner's medication use appropriate?

Yes	**No**	**N/A**	11. Was the practitioner's use of blood and blood components appropriate?
Yes	**No**	**N/A**	12. Was the practitioner's use of ancillary services (physical therapy, respiratory therapy, social service, etc.) appropriate?
Yes	**No**	**N/A**	13. Were the practitioner's other orders appropriate?
Yes	**No**	**N/A**	14. Were any complications anticipated, recognized promptly, and dealt with appropriately?
Yes	**No**	**N/A**	15. Was the patient's length of stay appropriate?
Yes	**No**	**N/A**	16. Was the discharge plan appropriate?
No	**Yes**	**N/A**	17. Was there any evidence that the practitioner exhibited any disruptive or inappropriate behavior to the patient or other staff?
No	**Yes**	**N/A**	18. Was there any evidence of patient dissatisfaction with the practitioner?
No	**Yes**	**N/A**	19. Is there an opportunity for improvement not already identified?

Basic Assessment	**Satisfactory**	**Unsatisfactory**
1. Basic medical knowledge		
2. Clinical judgment/skill		
3. Communication skill		
4. Use of consultants		
5. Professional attitude/behavior		
6. Documentation		
7. Relationship to patient		

Generally, how would you describe this practitioner's skill and competence in managing this patient?

☐ Excellent ☐ Standard of care ☐ Opportunity for improvement ☐ Below Standard of care

Recommendations: _____

_____

_____

_____

☐ Check here if a Plan For Improvement will be initiated (Please attach Plan)

_____ _____

Reviewer's Signature (if other than Department Chair) **Date**

_____ _____

Department Chair's Signature **Date**

This document is confidential and protected from discovery pursuant to California Evidence Code section 1157.

Medical Staff Office
Attachment C

Triggered FPPE / Plan for Improvement Form

CONFIDENTIAL PEER REVIEW DOCUMENT

Confidential for file of: _____

Department: _____

Department Chair/ Designee Name:

_____

Issue/concern was identified through:
☐ Event Report System ☐ Peer Review Committee ☐ Other: _____

Issue/concern is related to (check all that apply):
☐ Patient Care ☐ Clinical Knowledge ☐ Interpersonal/Communication skills ☐ Professionalism
☐ System-based practice ☐ Practice-based Learning

Description of Concern:
Improvement Action: What will the physician do differently based on the improvement opportunity defined by the data? ☐ Education ☐ Simulation ☐ Change in Practice ☐ Proctoring ☐ Other Description of details:

Timeframe for progress: Every _____ months (to be reported to the Practitioner and Peer Review Committee in writing) Timeframe for achieving goal(s): _____ months (to be reported to the Practitioner and Peer Review Committee in writing)
Method of monitoring: Is monitoring the OPPE scorecard data sufficient or will additional data collection specific to the improvement opportunity be needed to demonstrate improvement?
Additional Comments:

I acknowledge the concerns identified and have participated in developing the Plan For Improvement. I will comply with the arrangement as outlined above.

_____ _____

Physician's Signature **Date**

Department Chair's Signature **Date**

PROGRESS OF THIS PLAN

Department Chair's comments regarding the progress of this Plan:

I acknowledge the comments made by the Department Chair regarding my progress of this Plan For Improvement as outlined above.

_____ _____

Physician's Signature **Date**

_____ _____

Department Chair's Signature **Date**

FINAL RECOMMENDATIONS OF THIS PLAN

Department Chair's Final Recommendations upon completion of the Plan For Improvement:

I acknowledge the final recommendations of this Plan For Improvement. I will comply with the recommendations as outlined above.

_____ _____

Physician's Signature **Date**

_____ _____

Department Chair's Signature **Date**

This document is confidential and protected from discovery pursuant to California Evidence Code section 1157.

Kaweah Delta Health Care District

Medical Staff Services

Policy Number: MS 47	**Date Created: 02/25/2021**
Document Owner: April McKee (Medical Staff Svcs Manager)	**Date Approved: Not Approved Yet**
Approvers: Board of Directors (Administration), Medical Executive Committee, April McKee (Medical Staff Svcs Manager), Cindy Moccio (Board Clerk/Exec Assist-CEO), Teresa Boyce (Director of Medical Staff Svcs)	

Code of Conduct For Medical Staff & Advanced Practice Providers

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

Purpose:

The purpose of this policy is to encourage behavior that promotes a culture of safety, quality and respect.

A high standard of professional behavior, ethics and integrity are expected of individual ~~members of the~~ Medical Staff and Advanced Practice ~~(APP)~~ Staff (collectively, Practitioners) at Kaweah Delta Health Care District (KDHCD). The Code of Conduct is a statement of the ideals and guidelines for professional behavior of ~~the Medical Staff/APP~~Practitioners in all dealings with patients, their families, other health professionals, employees, students, vendors, government agencies, and others they may encounter.

Policy:

~~Medical Staff/APP~~Practitioners have a responsibility for the welfare of their patients, along with a responsibility to maintain their own professional and personal well-being. Each ~~member~~ Practitioner is expected to treat all fellow colleagues, hospital staff, students, patients and others with courtesy and respect.

When a practitioner is found to have fallen short of these expectations, the Medical Staff supports tiered, non-confrontational intervention strategies focused on restoring trust, placing accountability on, and rehabilitating the offending ~~Medical Staff/APP~~Practitioner. However, the safeguarding of patient care and safety is paramount, and the Medical Staff will enforce this policy with disciplinary measures whenever necessary.

I. DEFINITIONS

A. “Appropriate behavior” includes any reasonable conduct to advocate for patients, to recommend improvements in patient care, to participate in the operations, leadership or activities of the organized Medical Staff, or to engage in professional practice including practice that may be in competition with the hospital. Appropriate behavior is not subject to discipline under the bylaws.

B. “Inappropriate behavior” means conduct that is unwarranted and is reasonably interpreted to be demeaning or offensive. Persistent, repeated inappropriate behavior can become a form of harassment and thereby become disruptive, and subject to treatment as disruptive behavior.

C. “Disruptive behavior” means any abusive conduct including sexual or other forms of harassment, or other forms of verbal or non-verbal conduct that harms or intimidates others to the extent that quality of care or patient safety could be compromised.

D. “Harassment” means conduct toward others based on but not limited to their race, religious creed, color, national origin, physical or mental disability, marital status, sex, age, sexual orientation, or veteran status; which has the purpose or direct effect of unreasonably interfering with a person’s work performance or which creates an offensive, intimidating or otherwise hostile work environment.

E. “Sexual harassment” means unwelcome sexual advances, requests for sexual favors, or verbal or physical activity through which submission to sexual advances is made an explicit or implicit condition of employment or future employment-related decisions; unwelcome conduct of a sexual nature which has the purpose or effect of unreasonably interfering with a person’s work performance or which creates an offensive intimidating or otherwise hostile work environment.

F. “Practitioner” means physicians or advanced practice providers that have been granted membership and/or privileges at Kaweah Delta by the Board of Directors.

II. TYPES OF CONDUCT

A. Appropriate Behavior.
Examples of appropriate behavior include, but are not limited to the following:

- Criticism communicated in a reasonable manner and offered in good faith with the aim of improving patient care and safety;
- Encouraging clear communication;
- Expressions of concern about a patient’s care and safety;
- Expressions of dissatisfaction with policies through appropriate grievance channels or other civil non-personal means of communication;
- Use of cooperative approaches to problem resolution;
- Constructive criticism conveyed in a respectful and professional manner;
- Professional comments to any professional, managerial, supervisory, or administrative staff of members of the board of Directors about patient care or safety provided by others;
- Active participation in medical staff and hospital meetings.

B. Inappropriate Behavior

Inappropriate behavior by ~~Medical Staff members and Advanced Practice Providers~~Practitioners is ~~strongly discouraged.~~prohibited. Examples of inappropriate behavior include, but are not limited to the following:

- Belittling or berating statements;
- Name ~~calling'~~calling;
- Use of profanity or disrespectful language;
- Inappropriate comments written in the medical record;
- Blatant failure to respond to patient care needs or staff requests;
- Personal sarcasm or cynicism;
- Lack of cooperation without good cause;
- Refusal to return phone calls, pages, or other messages concerning patient care;
- Condescending language; and degrading or demeaning comments regarding patients and their families; nurses, physicians, hospital personnel and/or the hospital.

C. Disruptive Behavior

Disruptive behavior by ~~Medical Staff members~~Practitioners is prohibited. Examples of disruptive behavior include, but are not limited to the following:

- Physically threatening language directed an anyone in the hospital including physicians, nurses, other ~~Medical Staff members~~Practitioners or any hospital employee, administrator, or member of the Board of Directors, patients, their families, and visitors;
- Physical contact with another individual that is threatening, unwelcome, or intimidating;
- Throwing instruments, charts or other things;
- Threats of violence or retribution or retaliation;
- Sexual harassment; ~~and~~
- Other forms of harassment including, but not limited to, persistent inappropriate behavior and repeated threats of litigation;
- Behavior that disrupts patient care, hospital operations, and/or meetings of the Medical Staff, Medical Staff Committees, or hospital.
- ~~Repetitive inappropriate comments or disruptions in meetings~~

~~D. Interventions~~

~~Interventions should initially be non-adversarial in nature with the focus on restoring trust, placing accountability on and rehabilitating the offending practitioner and protecting patient care and safety.~~

III. PROCEDURE

A. Delegation by Chief of Staff

At the discretion of the Chief of Staff (or Vice Chief if the Chief of Staff is the subject of the complaint), the duties here assigned to the Chief of Staff can be delegated to a designee. Designees may be the Chief Medical Officer, other Medical Staff Officers, or Department Chairs/Vice Chairs.

B. Initiation of Complaints
Complaints about a ~~member of the Medical Staff or Advanced Practice Providers~~ Practitioner regarding allegedly inappropriate or disruptive behavior are encouraged to be entered into the event reporting system or conveyed to ~~contact~~ the Peer Review Coordinator (PRC). Information should include the following:

1. Date, time and location of the behavior;
2. A factual description of the behavior;
3. The circumstances which precipitated the incident;
4. The name and medical record number of any patient or other persons who were involved in or witnessed the incident;
5. The consequences, if any, of the inappropriate or disruptive behavior as it relates to patient care of safety, hospital personnel or operations; and
6. Any action taken to intervene in or remedy the incident, including names of those intervening.

The complainant will be provided a written acknowledgement of receipt of the complaint.

C. Processing Behavioral Event Reports
The process whereby the event report is processed is as follows (see attached flow chart):

1. Incident report is submitted through MIDAS or directly to the PRC. ~~Reports~~ Midas reports involving physicians are immediately routed to the Medical Staff PRC ~~and Chief Medical Officer (CMO)~~. (VP of HR is also notified on all Hostile Work Environment or Harassment incidents. If incident is an abuse allegation, Risk Management is also informed.).
2. The PRC does an initial screening and reports result of inquiry to ~~CMO~~Chief of Staff. ~~(CO.~~
3. Minor incidents are tracked and trended~~.~~, with follow up/educational call or email to physician, at the discretion of the Chief of Staff.
4. Significant incidents are sent to PRC for detailed Case Review. Results are reported to ~~CMO and~~ the Chief of Staff (COS). ~~(If incident is considered Hostile Work Environment of Harassment, VP of HR is also informed).~~ ~~If incident is an abuse allegation, Risk Management is also informed.~~ The following action may be taken as determined by the Chief of Staff:
    a. Prompt Collegial Intervention by COS, or Designee ~~and/or CMO~~;
    b. Forward to Department Chair for Collegial Intervention;
    c. Forward to Behavior Committee (which consists of COS, VCOS, PCOS, Secretary Treasurer ~~and CMO as an ex-officio member~~)
        i. Letter will be sent to practitioner containing a synopsis of the event, asking for practitioner's view of the event with a response expected within 30 days
        ii. Incident and response letter discussed at subsequent Behavior Committee

iii. Action may include:
1. Dismiss as unfounded or if unable to authenticate;
2. Track and Trend;
3. 1:1 conversation with practitioner and COS or other officer;
4. Request for additional information;
5. Educational letter to physician.

iv. Three (3) incidents in a rolling 12 months require action
1. Behavior Committee meets with and advises practitioner that recurring behavior must cease or corrective action will be initiated. This "final warning" shall be sent to the offending ~~medical staff member~~Practitioner in writing.
~~1.~~2. FPPE Developed by Department Chair

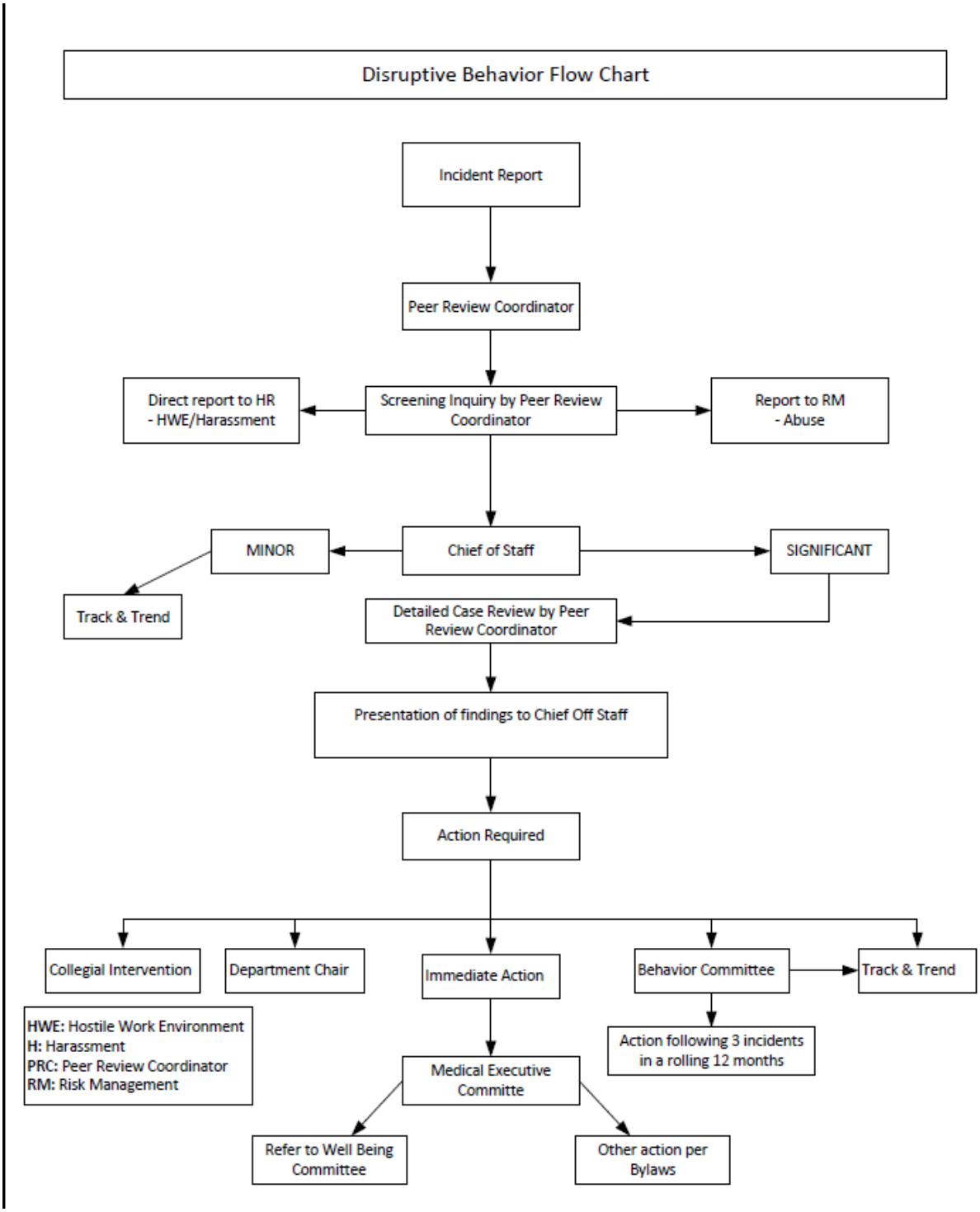
d. Track and Trend
e. Forward to MEC for further action per bylaws; Options include, but are not limited to ~~are~~:
~~i. FPPE developed by Department Chair~~
i. Referral to Well Being Committee
ii. Professional Conduct Agreement
iii. Requirement to attend continuing education course or program at practitioner's expense
iv. Initiate formal investigation
~~ii.~~ Formal corrective action, such as a summary suspension of clinical privilege if a single incident of disruptive behavior or repeated incidents of disruptive behavior constitute an imminent danger to the health of an individual or individuals, the offending practitioner may be summarily suspended, per the Medical Staff Bylaws. The medical staff member shall have all of the due process rights set forth in the medical staff bylaws.
~~i. Summary Suspension: If a single incident of disruptive behavior or repeated incidents of disruptive behavior constitute an imminent danger to the health of an individual or individuals, the offending practitioner may be summarily suspended, per the Medical Staff Bylaws. The medical staff member shall have all of the due process rights set forth in the medical staff bylaws.~~
~~ii. Initiate formal investigation~~

D. ~~Any~~ In the event of inconsistencies between this policy and the Medical Staff Bylaws, the Medical Staff Bylaws will prevail.

References:
Kaweah Delta Medical Staff Bylaws

"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."


Disruptive Behavior Flow Chart
Incident Report
Peer Review Coordinator
Direct report to HR - HWE/Harassment
Screening Inquiry by Peer Review Coordinator
Report to RM - Abuse
MINOR
Chief of Staff
SIGNIFICANT
Track & Trend
Detailed Case Review by Peer Review Coordinator
Presentation of findings to Chief Off Staff
Action Required
Collegial Intervention
Department Chair
Immediate Action
Behavior Committee
Track & Trend
HWE: Hostile Work Environment
H: Harassment
PRC: Peer Review Coordinator
RM: Risk Management
Action following 3 incidents in a rolling 12 months
Medical Executive Committe
Refer to Well Being Committee
Other action per Bylaws

Kaweah Delta Health Care District

Medical Staff Services

Policy Number: MS 51	**Date Created: 03/02/2021**
Document Owner: April McKee (Medical Staff Svcs Manager)	**Date Approved: Not Approved Yet**
Approvers: Board of Directors (Administration), Medical Executive Committee, April McKee (Medical Staff Svcs Manager), Cindy Moccio (Board Clerk/Exec Assist-CEO), Teresa Boyce (Director of Medical Staff Svcs)	

Medical Staff and Advanced Practice Provider Notifications

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

Policy:

To establish guidelines for notifications to Medical Staff and Advanced Practice Provider Staff (Collectively, Practitioner).

Procedure:

I. Notifications of upcoming expirations
- A. License, Certificates, and Insurance
  - i. Upcoming expiration notices are sent 45, 30, and ~~15~~ 10 days prior to expiration.
  - ii. Once suspended (day of expiration) the ~~practitioner~~ Practitioner is notified via certified mail.
- B. Health Requirements (PPD, TB affidavit)
  - i. Upcoming expiration notices are sent 45, 30, and ~~15~~ 10 days prior to the end of the month in which the ~~practitioners~~ Practitioners current health status expires.
  - ii. The first business day of the month after the ~~providers~~ Practitioner's health status has expired a final notice granting a two week extension is sent from the Chief of Staff.
  - iii. Once suspended (day after extension expires) the ~~practitioner~~ Practitioner is notified via certified mail.
- C. Proctoring
  - i. 1st notice is sent when privileges are granted
  - ii. Additional notices are sent 4-6 weeks and 3 months after the initial notification
  - iii. Notification of the Board has granted request for extension or privileges have expired is sent.
- D. Reappointments
  - i. Application (1st notice) is sent 4 months prior to expiration.
  - ii. Notices are sent 3 ½ months, 3 months, and 2 ½ months prior to expiration
  - iii. ~~Once suspended (day after expiration)~~ Final Notice: ~~practitioner~~ Practitioner is notified privileges will expire via certified mail, email, and text 2 months prior to expiration.

II. Notifications of Mandatory Education
    A. Notices are sent after initial/temporary appointment and 4 months prior to reappointment expiration.

III. Processing Application
    A. Once an initial application is received and accepted in the Medical Staff Services Office the ~~practitioner~~ Practitioner applying for privileges is notified of the status of their application every 10 days until the 4th and Final notice is sent.

IV. The Medical Staff Services office uses the following methods of communication:
    A. E-mail
    B. Fax
    C. Text
    D. Phone Calls
    E. Postal Mail
    F. Certified Mail

"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: MS 52	Date Created: 02/12/2021
Document Owner: April McKee (Medical Staff Svcs Manager)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration), Medical Executive Committee, April McKee (Medical Staff Svcs Manager), Cindy Moccio (Board Clerk/Exec Assist-CEO), Teresa Boyce (Director of Medical Staff Svcs)	

Use of Outside Proctors

Purpose: To provide guidelines for application and assessment to outside proctors.

Policy: Whenever a new procedure has been approved and an outside proctor is required, the outside proctor will be evaluated based upon current licensure (U.S.) and current membership of the Active medical staff at a Joint Commission accredited acute care hospital where he/she currently holds privileges for the procedure he/she is proctoring. Documentation of the applicant's current clinical activity performing the noted procedure is required and will be requested from the current hospital(s). The outside proctor is expected only to proctor (observe and report) and not to assist with patient care.

Procedure:

I. Outside Proctor Request

Individuals requesting to be an outside proctor or companies requesting an outside proctor to come in will be provided an application (see Attachment) which must be completed by the applicant and returned to the Credentialing Services office at least ~~five~~ ten (~~5~~10) working days prior to the date of procedure with a minimum of the following:

1. Completed Application (all information provided including fax numbers and signed Consent and Release)
2. Current Curriculum Vitae (CV)
3. Current Valid Photo ID (must be in color)
4. Copy of current PPD result (must be within the last 12 months)
5. If positive reactor to PPD, completion of TB Screening Affidavit Form is required which notes the date and result of most recent chest x-ray result
6. Copy of current Flu vaccination (if during influenza season)

~~3.~~

II. Processing the Application

When the application is returned, a review for completeness is performed by the Credentialing Services office. If the application is incomplete, it will be returned to the applicant.

If the application is complete, the Credentialing Services office will process as follows:

1. Current U.S. state medical license will be verified (license must be current and unrestricted)
2. Medicare/Medicaid Sanction verification (OIG)
3. Written or verbal verification from current hospital affiliation(s) where applicant is on the Active staff and holds privileges for the procedure to be proctored will be requested.
4. A clinical activity report will be requested to verify that the applicant is currently performing the procedure to be proctored here. Report will be requested for the last two (2) year period.

Information gathered on the application will be verified by the primary source. Primary source may include verbal verifications, which require a dated, signed note in the credentialing file, including the name of individual providing the information, date and time of verification.

III. Approval Process

1. Once all verifications and clinical activity report are received, the application and supportive documentation are made available to the Chief of Staff for review and approval.
2. If approved, the Chief of Staff will appoint the outside proctor as an ex-officio department member.
3. The Credentialing Services office will email notification of approval to the applicant and appropriate hospital personnel.
4. On the day of procedure(s), outside proctor is required to pick up Proctor badge and blank proctor forms from Medical Staff Services Office.

IV. Outside Proctor Responsibilities

1. The outside proctor is expected only to proctor (observe and report) and is not authorized to assist with patient care.
2. The outside proctor will directly observe and evaluate the procedure being performed via the proctor form.
3. It is the outside proctor's responsibility to report any poor or significantly substandard performances.
4. After procedure has been performed, a proctor form is completed by the outside proctor immediately following the procedure.
5. Prior to leaving the facility, the completed proctor form is returned to the Credentialing Services office at the time the Proctor badge is returned.

Rebranding
November 2020

Our Current Branding

Feedback from Focus Groups

- In the Fall of 2018, a series of focus groups were formed to review Kaweah Delta's Mission and Vision Statements and to update the annual strategic plan. Participants included staff, leaders, medical staff, Board members, and the community.
- In addition to providing input on our Mission, Vision, and Strategic Plan, the participants (unsolicited) urged us to consider changing our name and branding/logo.
- So we formed new focus groups to consider our branding
  - The focus groups came up with top three aspirational words they wanted to describe Kaweah Delta: **Innovative**, **Compassionate**, and **Renowned**
  - We then showed the groups our current name and logo, and the groups felt that they did not reflect these words
  - We tested three new logo/branding ideas, and the groups did not like those, either

Kaweah Delta

Design of the New Branding

- Our Marketing Department then worked with an outside firm, Creative Butter, to develop new branding ideas.
- For inspiration, the team considered the Native American origin of the word Kaweah. Patterns and colors used by the Yokuts were combined with modern design and colors to develop multiple logo and branding options.
- The inspiration for the new logos is not intended to be communicated to the public as an explanation for the design, it is simply the approach that we took to develop the logos.
- The options were shared with several focus groups and more than 115 people voted on the branding they liked the best.

Kaweah Delta

Results

- The results overwhelmingly favored one design, including the color and font.
- People suggested that the logo reflects warmth, diversity, and a modern feel.
- People see different things in the logo: a delta, our five pillars, three rivers, a mountain, grasped hands, etc. All are correct!

LOGO	COLOR	FONT	RUNNER UP
KAWEAH HEALTH MORE THAN MEDICINE. LIFE.	3	13	2	12
KAWEAH HEALTH MORE THAN MEDICINE. LIFE.	9	12	5	17
Kaweah Health MORE THAN MEDICINE. LIFE.	84	60	57	16
kaweah health MORE THAN MEDICINE. LIFE.	7	10	9	12
KAWEAH HEALTH MORE THAN MEDICINE. LIFE.	1	1	7	2
Kaweah Health MORE THAN MEDICINE. LIFE.	19	14	26	37

Examples

Kaweah Health™
Medical Center

Emblem

Service line name

Primary Brand

Kaweah Health™

Primary with service line
- building wayfinding

Kaweah Health
Medical Center

Primary with tagline

Kaweah Health™
More than medicine. Life.

Primary with descriptor

Kaweah Health™
Cardiology Center

Retail with independent trademark
system font and color guide

Lifestyle
FITNESS CENTER

FQHC with independent trademark
system font and color

Sequoia Health
& Wellness Centers

Partnership with independent trademark
system font anf color

Sequoia Regional
Cancer Center
Radiation Oncology - A division of Kaweah Health

Kaweah Delta

Why Now?

- Financially, it is a challenging time to commit to a rebranding.
- However, the current name and brand has been in use since the 1960s and is in need of modernization to better reflect the values of our organization.
- Kaweah Delta is not the same organization we were 50 years ago, or even 15 years ago. We offer a significantly broader scope of services and significantly higher quality of care and patient experience.
- Our current branding and naming is inconsistent and does not adequately convey our scope of services or locations to the community
- Many of our current signs are in need of replacement
- Improving our branding and the consistency of our naming will increase awareness and, most likely, volumes.
- Perhaps most importantly, in 2020 Kaweah Delta has demonstrated that it truly is dedicated to the health of our community. Health is our Passion. The name Kaweah Health better reflects who we are and what we aspire to be.

What are Others Doing?

Many other healthcare organizations are updating their name and logo. Many choose to incorporate “health” into their name, including CVS.

Signage Changes

- The most significant expense associated with the proposed rebranding is related to signage.
- Kaweah Delta has more than 50 buildings, most of which have Kaweah Delta signs. Many of these signs are quite old and in need of repair. The style of these signs is not consistent.
- Kaweah Delta's campuses can be confusing for visitors, and we lack adequate wayfinding signs for both vehicles and visitors in our facilities.
- Many prominent buildings have no signage, including the Support Services Building and the Willow building. Adding signs to these buildings will improve visibility from 198, and properly convey the scope of the Kaweah Delta campus.

Sign Examples

- The Marketing and Facilities Departments worked with A-Plus Signs to assess every one of our facilities and the signage. Together, we have developed recommendations for improved and additional signage.

Monument Wayfinding sign Example

Proposed
Monument Wayfinding Sign
Internally-illuminated
6' – 4" W x 5'-0" H

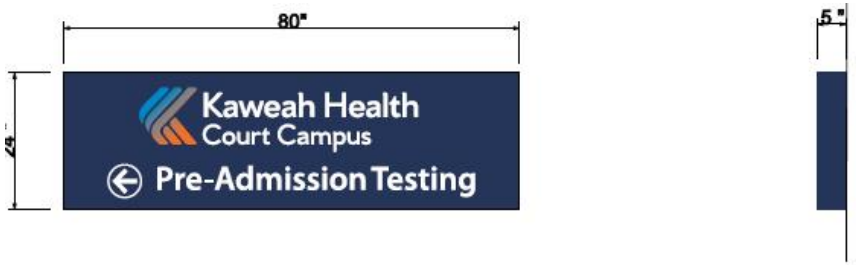
Existing

Example of Campus Monument Signs

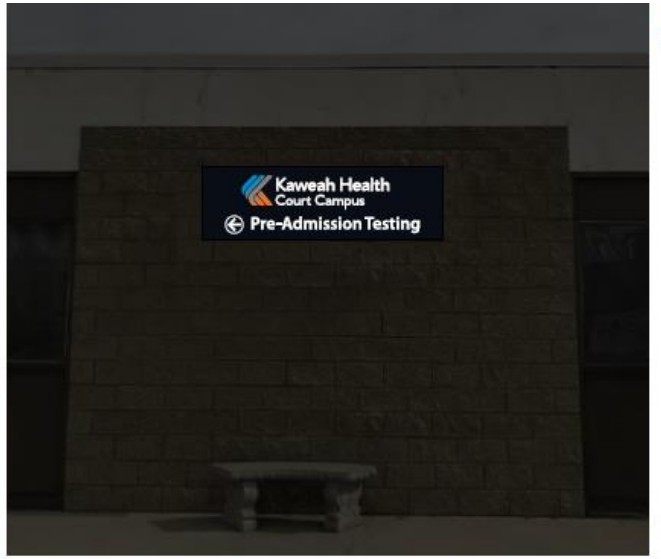
Proposed

Existing

Example of Campus Monument Signs



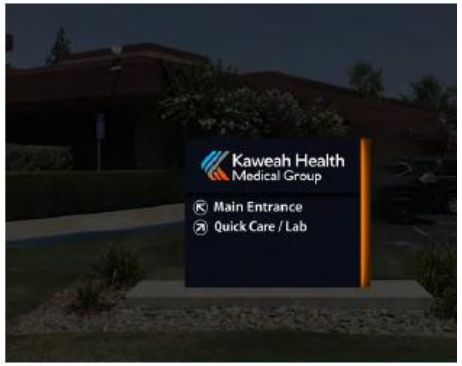
Proposed



Existing

KDMF becomes Kaweah Health Medical Group

Proposed



Existing

Proposed

Existing

Example of Urgent Care Signage

Proposed

Existing

Signage Changes

To lessen the financial impact on FY2021, we are recommending that signage be addressed in two phases:

Phase One	Phase Two
Replace current Kaweah Delta signs with consistently styled Kaweah Health signs	Add new signs on SSB, Willow, and other prominent locations
Update naming to increase consistency and public awareness (e.g. VMC becomes Kaweah Health Medical Group)	Install new monument signs to mark the boundaries of all of our campuses
Add one large sign on SSB facing highway 198	Replace old sign infrastructure
	Add wayfinding signage on all campuses
Estimated Cost: $575,000 ($463,000 is in the FY21 capital budget)	**Estimated Cost: $600,000**

All costs include signage, design, installation, OSHPD fees (when required), and contingency.

Operating Expenses

One-time Costs

- In addition to the capital costs for the signage, there will be operational expenses for communication (internal and external), advertising, supplies (e.g. forms, stationary, badges, etc.), tents, banners, uniforms, and other branded items.
  - Examples of internal and external communications are included in the appendix of this document.
- The Kaweah Delta FY2021 operational budget includes $164,779 for these items. In addition, due to COVID-19, the Marketing budget has additional funds available, if necessary.

Communication Plan

Internal Communication to Employees

- Messaging topics
  - We understand the concern about the timing- we would question it, too
  - Modernization is necessary and common in the healthcare industry
  - The new brand better reflects the great work we all do/ scope of services
  - New brand will help us grow public awareness and to increase volumes- which will improve our financial performance
  - The FY21 costs are approximately 4% of our annual capital budget and 0.02% of our annual operating budget
  - First comprehensive rebrand in our history- this one will last for decades
  - We solicited public donations and support to offset the expenses
- Examples of communications are provided in the Appendix

Communication Plan

External Communications The Public

- We will want to communicate with patients, the general public, physicians, other public entities, and the media
- Message topics include:
  - We are committed to the health of our community
  - We have greatly expanded and enhanced our services, and the new branding reflects our commitment to remaining modern
  - Our naming of services was inconsistent
  - The FY21 costs are approximately 4% of our annual capital budget and 0.02% of our annual operating budget
  - First comprehensive rebrand in our history- this one will last for decades

Potential Fundraising Campaign

Campaign Support for the Effort

- This campaign has not been presented to the Hospital Foundation Board for consideration and is shared only as an example of a potential campaign
- Campaign overview
  - As we approach a new year, KDHCD has survived a historic moment in time by handling the COVID-19 pandemic. While our resources were directed toward modifying our facility and treating our seriously ill pandemic patients, our district continues to deliver babies (4,500 per year), treat cardiac patients, and treat other illnesses on a daily basis in our large service area. As 2021 approaches, the pandemic will continue to impact our daily lives and strain healthcare resources across our nation. We must move toward the future to continue our quest for World-Class Healthcare. As such the Foundation is proposing a “modernization” themed capital campaign for the 2021 -2022 fiscal year.

“Enhancing Health: Excellence in Care”

Possible 1 Year Campaign vs. 2 Year Campaign

1 Year	2 Years
Halo Bassinet: A new bassinet system to replace our well-worn bassinets in the mother-baby unit. This will be a key talking point for the campaign.	
Ambrosia Remodel: The success of the Siren Grill during the remodel of the Emergency Department indicates there is a need for a full grill when the Ambrosia Café reopens in 2021. In addition, much of the equipment is in need of upgrade to serve the visitors and staff as volumes increase and we open the new Emergency Department.	
Signage: A portion of the campaign will be directed toward offsetting the cost of new signage throughout the organization. This will include signage for our Kaweah Health rebranding, and (if approved) a new donor recognition wall in the Acequia Wing and Emergency Department	
	Rosa Robotic System: Our orthopedic surgeons are using more and more robotic techniques to improve patient outcomes and speed recovery from routine orthopedic procedures
Potential additional equipment to be fully or partially funded by this campaign: Pediatric friendly furnishings and décor for the new emergency department, ventilators for subacute unit, upgrade our aging endoscopy ultrasound, replacement of walk-in refrigerator for food services, replacement of bladder scanners throughout the medical center	
Total Campaign Goal: $1,400,000	Total Campaign Goal: $2,400,000

Recommended Timeframe

- Construction of the ED expansion and the Tulare Clinic will both be completed in January. Both will likely open in March/April, depending on licensing
- OSHPD must approve any sign that is attached to the acute Medical Center or our licensed facilities on the Court Street and Akers campuses. Approval will likely require 30 to 45 days.
- Construction and installation of the new signs will require 3 to 4 months.
- If we want to proceed with the rebrand, the recommendation is to start the process as soon as possible to coincide the launch with the opening of the ED and Tulare Clinic.

Appendix

Examples of Communication Talking Points

Modernization is necessary and common in the healthcare industry

INTERNAL: People and communities evolve, and so must we. Kaweah Health brings us closer to the world-class healthcare organization we strive to be.
EXTERNAL: People and communities evolve, and so must we to meet the needs of you, your family, and our growing community. Kaweah Health brings us closer to the world-class healthcare organization we strive to be – your world-class healthcare choice, for life.

We understand the concern about the timing- we would question it, too

INTERNAL: No matter what time we're living in or situation we're facing, there will always be reasons to pause – but life only moves forward. Kaweah Health is our future, and there is no better time than the present to be all that we can be.
EXTERNAL: No matter what time we're living in or situation we're facing, there will always be reasons to pause – but life only moves forward. The pandemic has revived a passion for health in our world. Now is the time to breathe life into Kaweah Health – the future of healthcare in the Central Valley.

The new brand better reflects the great work we all do/ scope of services

INTERNAL: We are not the same organization we were 60, 30, or even 10 years ago. The new brand reflects who we are today and brings attention to the advances we've made along the way (Acequia Wing, ED Expansion, Cleveland Clinic and USC affiliations, SHWC, etc.)
EXTERNAL: We are not the same organization we were 60, 30, or even 10 years ago. Kaweah Health reflects who we are today and the strides we've made on our journey to providing you with the world-class care you deserve (Acequia Wing, ED Expansion, Cleveland Clinic and USC affiliations, SHWC, etc.).

Examples of Communication Talking Points

First rebrand in our history- this one will last for decades

INTERNAL: We have been a place of healing for nearly 60 years, caring for the entire community including you and the family and friends you love. Your history is written here. Kaweah Health is our next chapter and you get to be part of the story.
INTERNAL: We have been a place of healing for nearly 60 years, caring for the entire community including you and the family and friends you love. Your history is written here. Kaweah Health is the next chapter and generations of your family will be part of the story. This is your hospital, your health, your home. This is your story

New brand will help us grow public awareness and to increase volumes- which will improve our financial performance / The FY21 costs are approximately 4% of our annual capital budget and 0.02% of our annual operating budget

INTERNAL: Excellence is what we do, and experts is who we are. We are the Central Valley's most awarded hospital and it's time to shed our old identity and take a giant step closer to world-class care. What we spend on the new brand is less than the price we pay for poor memories of who we used to be. Investing in Kaweah Health is an investment in our future.
EXTERNAL: Excellence is what we do, and experts is who we are. We are the Central Valley's most awarded hospital, not the hospital of years long past. Investing in Kaweah Health is an investment in our community's future. The small percentage we spend on the new brand will help us take a giant step closer towards world-class care.

We solicited public donations and support to offset the expenses

INTERNAL: We are responsible stewards of the community's investment and have harnessed the power of the spirit of giving. Kaweah Health belongs to the community and we have invited them to join us on this journey.
EXTERNAL: We are responsible stewards of your investment and immensely grateful for your generous spirit of giving. Kaweah Health belongs to you, and your support on this history-making journey is priceless.