



November 22, 2019

**NOTICE**

The Board of Directors of the Kaweah Delta Health Care District (KDHCDC) will meet in an open Board of Directors meeting at 4:00PM on Monday, November 25, 2019 in the Kaweah Delta Medical Center (KDMC) Blue Room {Mineral King Wing (MKW) – 400 West Mineral King Avenue}.

The Board of Directors of the KDHCDC will meet in a closed Board of Directors meeting at 5:31PM on Monday, November 25, 2019 in the KDMC Blue Room pursuant to Health and Safety Code 32155, 1461, 32106 and Government Code 54956.9(d)(2).

The Board of Directors of the KDHCDC will meet in an open Board of Directors meeting at 6:00PM on Monday, November 25, 2019 in the KDMC Blue Room.

The Board of Directors of the KDHCDC will meet in a closed Board of Directors meeting immediately following the 6:00PM on Monday, November 25, 2019 in the KDMC Blue Room {MKW – 400 West Mineral King Ave} pursuant to Government Code 54957(b)(1).

The Board of Directors of the KDHCDC will meet in an open Board of Directors meeting immediately following the second closed session on Monday, November 25, 2019 in the Kaweah Delta Medical Center Blue Room {Mineral King Wing – 400 West Mineral King Avenue}.

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.

The disclosable public records related to agendas are available for public inspection at the Kaweah Delta Medical Center – Acequia Wing, Executive Offices (Administration Department) {1st floor}, 400 West Mineral King Avenue, Visalia, CA and on the Kaweah Delta Health Care District web page <http://www.kaweahdelta.org>.

KAWEAH DELTA HEALTH CARE DISTRICT  
Nevin House, Secretary/Treasurer

A handwritten signature in black ink that reads 'Cindy Moccio'.

Cindy Moccio - Board Clerk / Executive Assistant to CEO

DISTRIBUTION:  
Governing Board  
Legal Counsel  
Executive Team

Chief of Staff  
[www.kaweahdelta.org](http://www.kaweahdelta.org)



# KAWEAH DELTA HEALTH CARE DISTRICT BOARD OF DIRECTORS MEETING

Kaweah Delta Medical Center {Blue Room}  
400 West Mineral King Avenue, Visalia  
[www.KaweahDelta.org](http://www.KaweahDelta.org)

**Monday November 25, 2019**

## OPEN MEETING AGENDA {4:00PM}

1. **CALL TO ORDER**
2. **APPROVAL OF AGENDA**
3. **PUBLIC PARTICIPATION** – Members of the public may comment on agenda items before action is taken and after the item has been 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. **MASTER PLANNING** – Review and discussion of master planning process and options for Kaweah Delta Health Care District.  
*Joe Balbona, President and Kevin Boots, Senior Vice President – RBB Architects, Inc.*
5. **APPROVAL OF THE CLOSED AGENDA – 5:31PM**
  - 5.1. **Approval of closed meeting minutes** – September 23, 2019 and October 28, 2019.
  - 5.2. **Report involving trade secrets {Health and Safety Code 32106}** – Proposed new services/programs – estimated date of disclosure - March 2020 – *Gary Herbst, Chief Executive Officer*
  - 5.3. **Conference with Legal Counsel – Anticipated Litigation** – Significant exposure to litigation pursuant to Government Code 54956.9(d)(2) – 1 Case – *Dennis Lynch, Legal Counsel*
  - 5.4. **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461, report of quality assurance committee – *Byron Mendenhall, MD, Chief of Staff*
  - 5.5. **Credentialing** - Medical Executive Committee (October 2019) 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 pursuant to Health and Safety Code 1461 and 32155 – *Byron Mendenhall, MD, Chief of Staff*

## ADJOURN

### CLOSED MEETING AGENDA {5:31PM}

#### CALL TO ORDER

1. **APPROVAL OF CLOSED MEETING MINUTES – [SEPTEMBER 23, 2019](#) AND [OCTOBER 28, 2019](#)**

*Action Requested – Approval of the closed meeting minutes – September 23, 2019 and October 28, 2019*

2. **REPORT INVOLVING TRADE SECRETS {Health and Safety Code 32106}** – Discussion of proposed new services/programs – estimated date of disclosure - March 2020

*Gary Herbst, Chief Executive Officer*

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

*Dennis Lynch, Legal Counsel*

4. **[QUALITY ASSURANCE](#)** pursuant to Health and Safety Code 32155 and 1461, report of quality assurance committee – *Byron Mendenhall, MD, Chief of Staff*

5. **[CREDENTIALING](#)** - Medical Executive Committee (September 2019) 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 pursuant to Health and Safety Code 1461 and 32155

*Byron Mendenhall, MD, Chief of Staff*

## ADJOURN

### OPEN MEETING AGENDA {6:00PM}

1. **CALL TO ORDER**
2. **APPROVAL OF AGENDA**
3. **PUBLIC PARTICIPATION** – Members of the public may comment on agenda items before action is taken and after the item has been 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. **CLOSED SESSION ACTION TAKEN** – Report on action(s) taken in closed session.
5. **OPEN MINUTES** – Request approval of the [September 23, 2019](#) and [October 28, 2019](#) open board of directors meeting minutes.  
*Action Requested – Approval of the open meeting minutes – September 23, 2019 and October 28, 2019 open board of directors meeting minutes.*
6. **RECOGNITION** – Presentation of Resolution 2058 to [Kristin Braswell](#) - Service Excellence Award – November 2019 – *David Francis*
7. **CONSENT CALENDAR** - *All matters under the Consent Calendar will be approved by one motion, unless a Board member request separate action on a specific item.*

#### 7.1. REPORTS

- A. [Medical Staff Recruitment](#)
- B. [Renal Services](#)
- C. [Medical Critical Care](#)
- D. [Orthopedic Services](#)
- E. [Home Health](#)
- F. [202 West Willow, LLC](#)

#### 7.2. POLICIES

##### A. [ADMINISTRATIVE](#)

- |  |        |         |
|--|--------|---------|
| 1) Use of Guide Dogs name changed to: <a href="#">Accommodating Persons with Service Animals</a> | AP.73  | Revised |
| 2) <a href="#">Patient Privacy Use &amp; Disclosure of Patient Information</a>                   | AP.107 | Revised |
| 3) <a href="#">Patient Elopement Critical Incident Response – Code Green</a>                     | AP.133 | Revised |
| 4) <a href="#">Animal Assisted Activities / Therapy (AAA/AAT)</a>                                | AP.104 | Revised |
| 5) <a href="#">Foreign language forms, signs, etc.</a>   | AP.18  | Revised |
| 6) <a href="#">Interpreter Services</a>  | AP.122 | Revised |
| 7) <a href="#">Bioethics Committee</a>   | AP.97  | Revised |
| 8) Proper Addressing of Interoffice Mail   | AP.95  | Delete  |

##### B. [ENVIRONMENT OF CARE](#)

- |  |          |         |
|--|----------|---------|
| 1) <a href="#">Wireless Duress System</a>      | EOC 1015 | Revised |
| 2) <a href="#">Facility Fire Response Plan</a> | EOC 5001 | Revised |

#### 7.3. Recommendation from the Medical Executive Committee (NOVEMBER 2019)

- A. Medical Staff Policy
  - 1) MS.50 Late Career Policy (Deleted)

- 7.4. Approval of [Resolution 2055](#) rejecting the claim on behalf of Thomas Roy Cisneros vs. Kaweah Delta Health Care District.

*Recommended Action: Approve the November 25, 2019 Consent Calendar.*

8. **QUALITY – SURGICAL SERVICES QUALITY REPORT** - A review of performance on the key quality measures in the National Surgical Quality Improvement Program (NSQIP) as administered by the American College of Surgeons.

*Lamar Mack, MD, Physician Champion NSQIP*

9. **CLEVELAND CLINIC** – Status of implementation plans and opportunities relative to the Kaweah Delta affiliation with Cleveland Clinic Heart and Vascular Institute.

*Regina Sawyer, RN, Vice President and Chief Nursing Officer, Barry Royce, Director of Cardiovascular Service Line and Cardiovascular Co-Management Program*

10. **KAWEAH DELTA BOARD OF DIRECTORS – ZONE III** – Discussion of appointment process for filling the Zone III Kaweah Delta Health Care District Board seat.

*Dennis Lynch, Legal Counsel & Gary Herbst, Chief Executive Officer*

11. **FINANCIALS** – Review of the most current fiscal year 2020 financial results.

*Malinda Tupper, VP & Chief Financial Officer*

12. **STRATEGIC PLAN GROWTH AND DEVELOPMENT** – Update and discussion relative to growth and development.

*Marc Mertz, Vice President of Strategic Planning and Business Development*

13. **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.

*Byron Mendenhall, MD, Chief of Staff*

Recommended Action: Whereas a thorough review of all required information and supporting documentation necessary for the consideration of initial applications, reappointments, request for additional privileges, advance from provisional status and release from proctoring and resignations (pursuant to the Medical Staff bylaws) has been completed by the Directors of the clinical services, the Credentials Committee, and the 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 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.

#### 14. REPORTS

14.1. Chief of Staff – Report relative to current Medical Staff events and issues.  
*Byron Mendenhall, MD, Chief of Staff*

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

- District Hospital Leadership Forum
- Federally Qualified Health Center
- Alta Board Meeting – Boundaries

14.3. Board President - Report relative to current events and issues.  
*Lynn Havard Mirviss, Board President*

15. **APPROVAL OF CLOSED AGENDA AS FOLLOWS:** Closed Meeting Agenda – Kaweah Delta Medical Center Blue Room – Immediately following the open session

- **CEO Evaluation** – Discussion of with the Board and the Chief Executive Officer relative to the evaluation of the Chief Executive Officer pursuant to Government Code 54957(b)(1) – *Dennis Lynch, Legal Counsel & Board of Directors*

#### ADJOURN

### CLOSED MEETING AGENDA

1. **CALL TO ORDER**

2. **CEO EVALUATION** – Board and the Chief Executive Officer relative to the evaluation of the Chief Executive Officer pursuant to Government Code 54957(b)(1)

*Dennis Lynch, Legal Counsel & Board of Directors*

3. **ADJOURN**

### OPEN MEETING AGENDA

**Call to order**

**Approve agenda**

**Public / Medical Staff participation** – Members of the public or the medical staff may comment on agenda items before action is taken and after the item has been 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.

**1. CHIEF EXECUTIVE OFFICER CONTRACT** – Compensation review and adjustment / review and approval of Chief Executive Officer Contract.

*Dennis Lynch, Legal Counsel*

**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 MEDICAL CENTER REPLACEMENT HOSPITAL MASTER PLANNING SERVICES

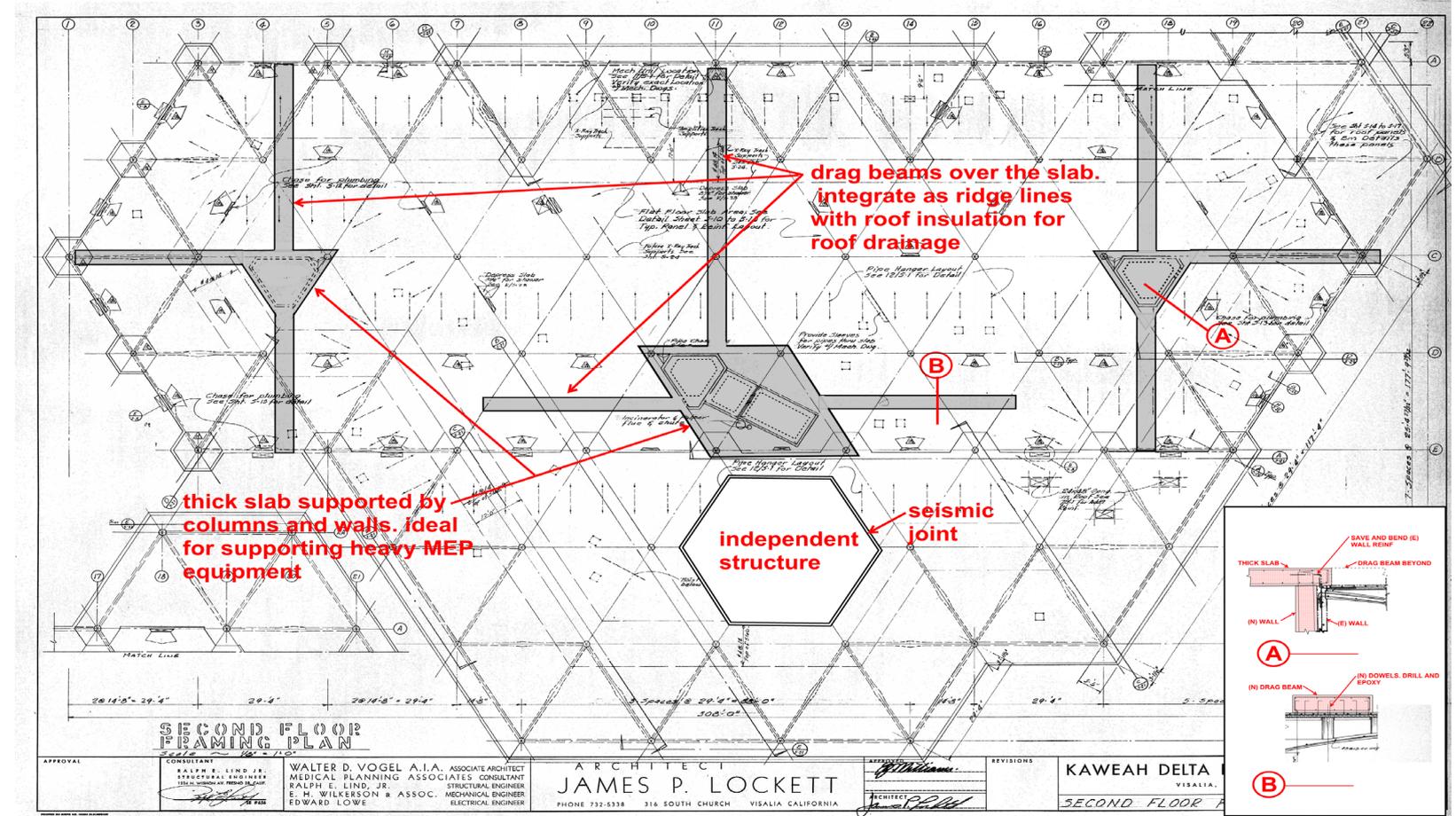
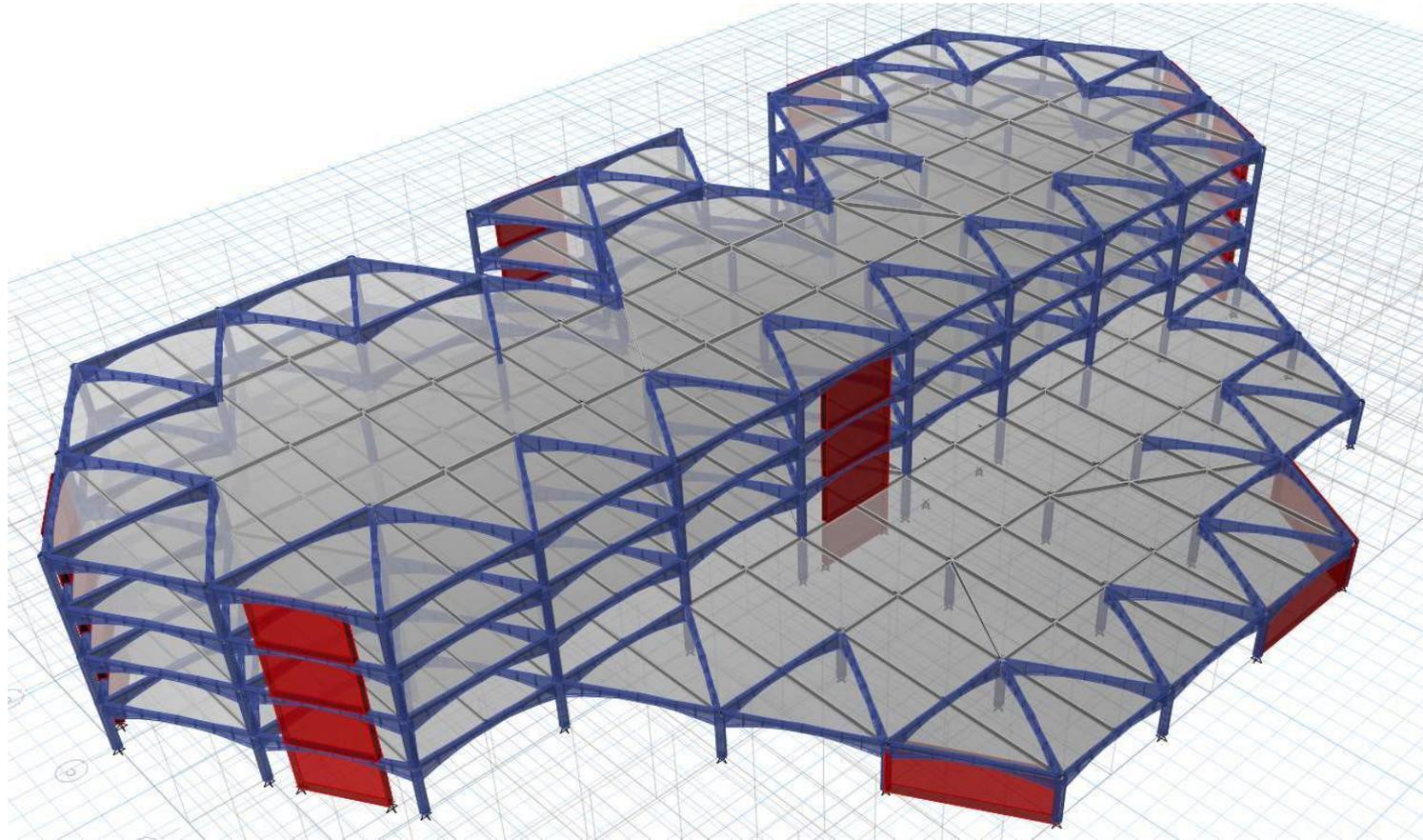
November 25, 2019

# SPC STRUCTURAL OPTIONS UPDATE

## STRUCTURAL PERFORMANCE CATEGORY



# MINERAL KING STRUCTURAL ANALYSIS – FLOOR REMOVAL: STATUS UPDATE



Keep All Floors: Conventional Shear Wall Retrofit

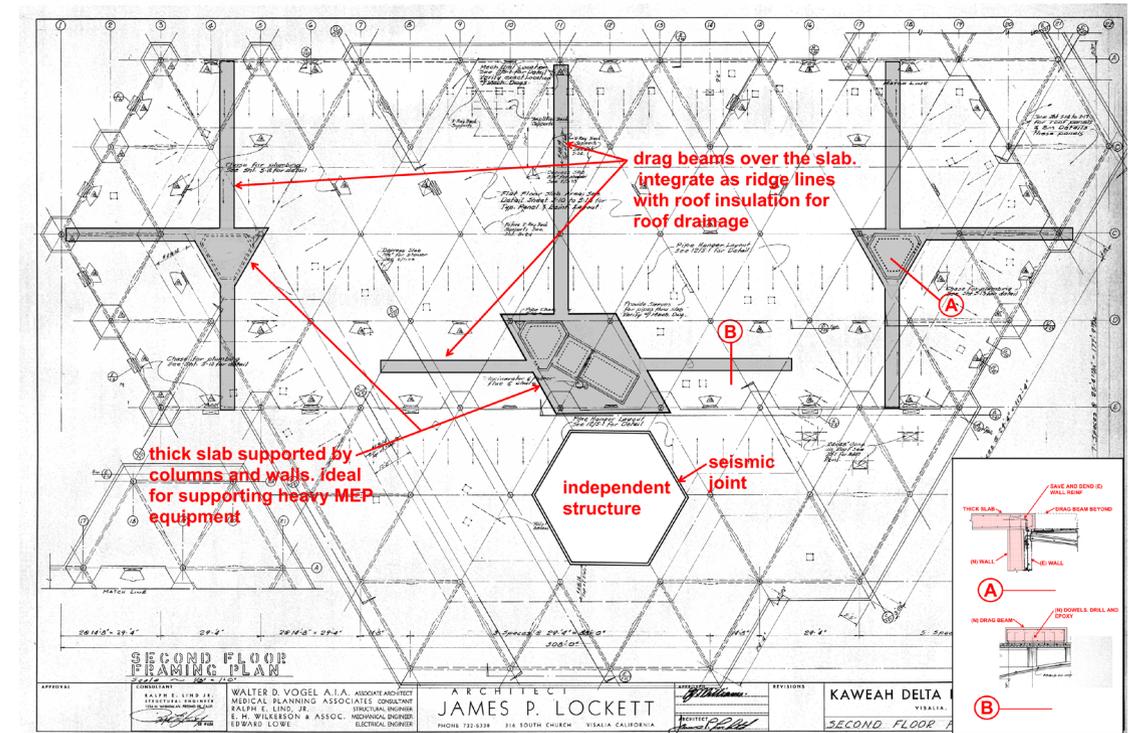
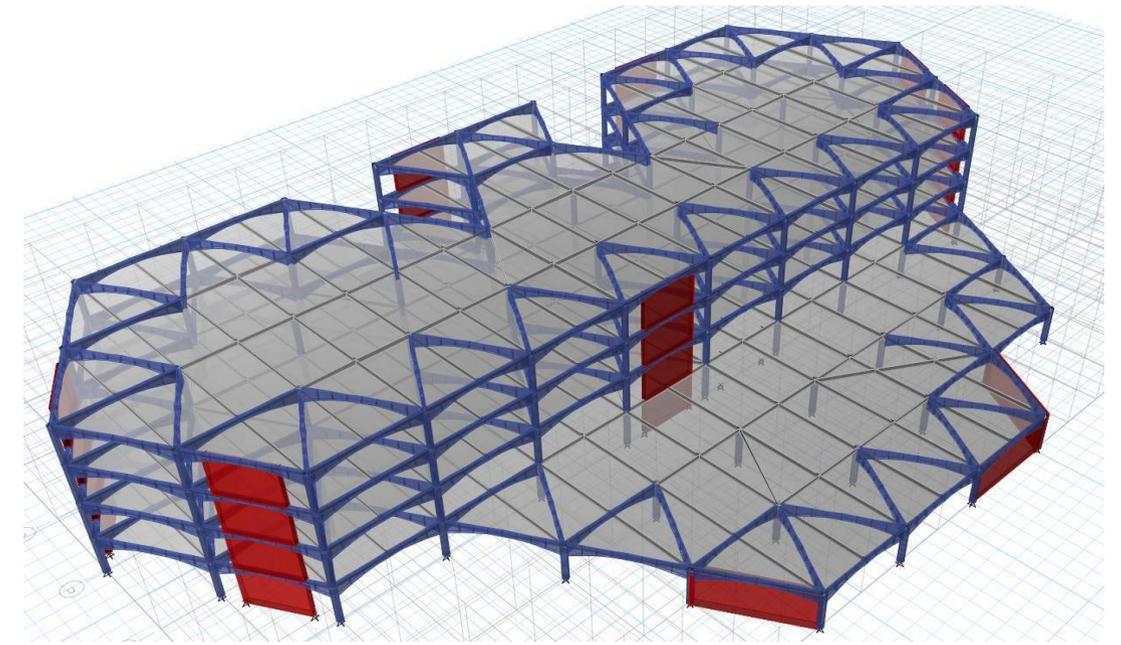
Remove All Floors: Conventional Shear Wall Retrofit

KAWEAH DELTA STRUCTURAL UPDATE

# MINERAL KING STRUCTURAL ANALYSIS – FLOOR REMOVAL: STATUS UPDATE

## FINDINGS:

- VERY CHALLENGING TO ACHIEVE FLOOR REMOVAL WITHOUT CLOSING MK BUILDING
  - PATIENT/STAFF SAFETY
  - INFECTION CONTROL CHALLENGES
  - LONG DURATION AND HIGH COST OF COMPLEXITY
- TECHNICALLY FEASIBLE ONLY IF MATERIAL AND MODELING ASSUMPTIONS ARE VALIDATED/ACCEPTED BY OSHPD



# MATERIAL TESTING: STATUS UPDATE

**OSHPD** Office of Statewide Health Planning and Development

Facilities Development Division  
2020 West El Camino Avenue, Suite 800  
Sacramento, CA 95833  
(916) 440-8300  
(916) 324-9188 Fax  
www.



## BLD-01031 - Original Building

This letter constitutes a written approval of the MTCAP as proposed and revised. Our approval does not authorize or approve any omission or deviation from applicable regulations nor does it address fire life safety issues. Should conditions develop that are not covered by the approved documents, a change order detailing and specifying the required work must be submitted for our review and approval.

Subject: Kaweah Delta Medical Center - #12601  
400 West Mineral King - Visalia, CA 93291  
Application #SER-2018-00134 – SPC 4D MTCAP

We have reviewed the Material Testing and Condition Assessment Program (MTCAP) revision dated April 30, 2019 as partial satisfaction of the SPC-4D requirements of SB 1953 for the following building:

### BLD-01031 - Original Building

This letter constitutes a written approval of the MTCAP as proposed and revised. Our approval does not authorize or approve any omission or deviation from applicable regulations nor does it address fire life safety issues. Should conditions develop that are not covered by the approved documents, a change order detailing and specifying the required work must be submitted for our review and approval.

If you need further information regarding SB1953, you may visit our web site at [www.oshpd.ca.gov/fdd](http://www.oshpd.ca.gov/fdd), or you can contact me at [Alireza.Asgari@oshpd.ca.gov](mailto:Alireza.Asgari@oshpd.ca.gov), or by phone at (916) 440-8473.

Sincerely,

Alireza Asgari, Ph.D., S.E.  
Senior Structural Engineer  
Seismic Compliance Unit

cc: Julieta Moncada - Kaweah Delta Health Care District  
File

- OSHPD APPROVAL OF BOTH MATERIAL TESTING AND CONDITION ASSESSMENT
  - FROM SEISMIC COMPLIANCE UNIT

- NEXT STEPS:
  1. OBTAIN APPROVAL FROM OSHPD TO OBTAIN AND TEST CORE SAMPLES (REVIEW IN PROGRESS)
  2. TAKE CONCRETE CORE SAMPLES (MAX OF 10) IN JAN 2020
  3. REVIEW TEST RESULTS
    - IF ACCETABLE, CONTINUE.
    - IF UNACCEPTABLE, STOP.

# MATERIAL TESTING: STATUS UPDATE

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If you need further information regarding SB1953, you may visit our web site at [www.oshpd.ca.gov/fdd](http://www.oshpd.ca.gov/fdd), or you can contact me at [Alireza.Asgari@oshpd.ca.gov](mailto:Alireza.Asgari@oshpd.ca.gov), or by phone at (916) 440-8473.

Sincerely,

Alireza Asgari, Ph.D., S.E.  
Senior Structural Engineer  
Seismic Compliance Unit

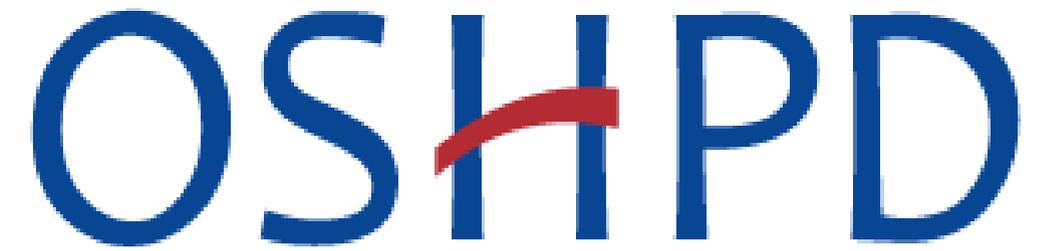
cc: Julieta Moncada - Kaweah Delta Health Care District  
File

- BIG PICTURE
  - IN DEPTH ANALYTICAL MODELING AND SCALE COMPENENT TESTING HAS NOT STARTED.
    - TESTING WILL NOT COMMENCE IF CORE SAMPLES AND CONDITION ASSESSMENTS ARE NOT FAVORABLE
    - RISK OF NON-SUCCESSFUL TESTING AND OUTCOME IS STILL PRESENT
- THIS PROGRAM IS BEING EXECUTED INCREMENTALLY
  - PROGRAM CAN STOP AT ANY TIME

# NPC STRUCTURAL UPDATE

## NON - STRUCTURAL PERFORMANCE CATEGORY

# NPC 2030 COMPLIANCE



Office of Statewide Health  
Planning and Development

- NPC – 2 REQUIRED FOR ALL BUILDINGS BY JAN 1, 2020:  
DONE!
- NPC-4D OSHPD ACCEPTED: STARTS JAN 1, 2020 WITH 2019  
CBC
  - NPC-3 STILL HAS TO HAPPEN BY 2030, PLUS MIN LEVEL 1  
COMPLIANCE
  - MORE TIME TO DO NPC UPGRADES, FOCUS ON CRITICAL  
AREAS FIRST
    - NEED EMERGENCY PREPAREDNESS PLAN AND SHOW  
PROGRESS OVER TIME

# NPC 2030 COMPLIANCE

CO-GEN

SPC - 3

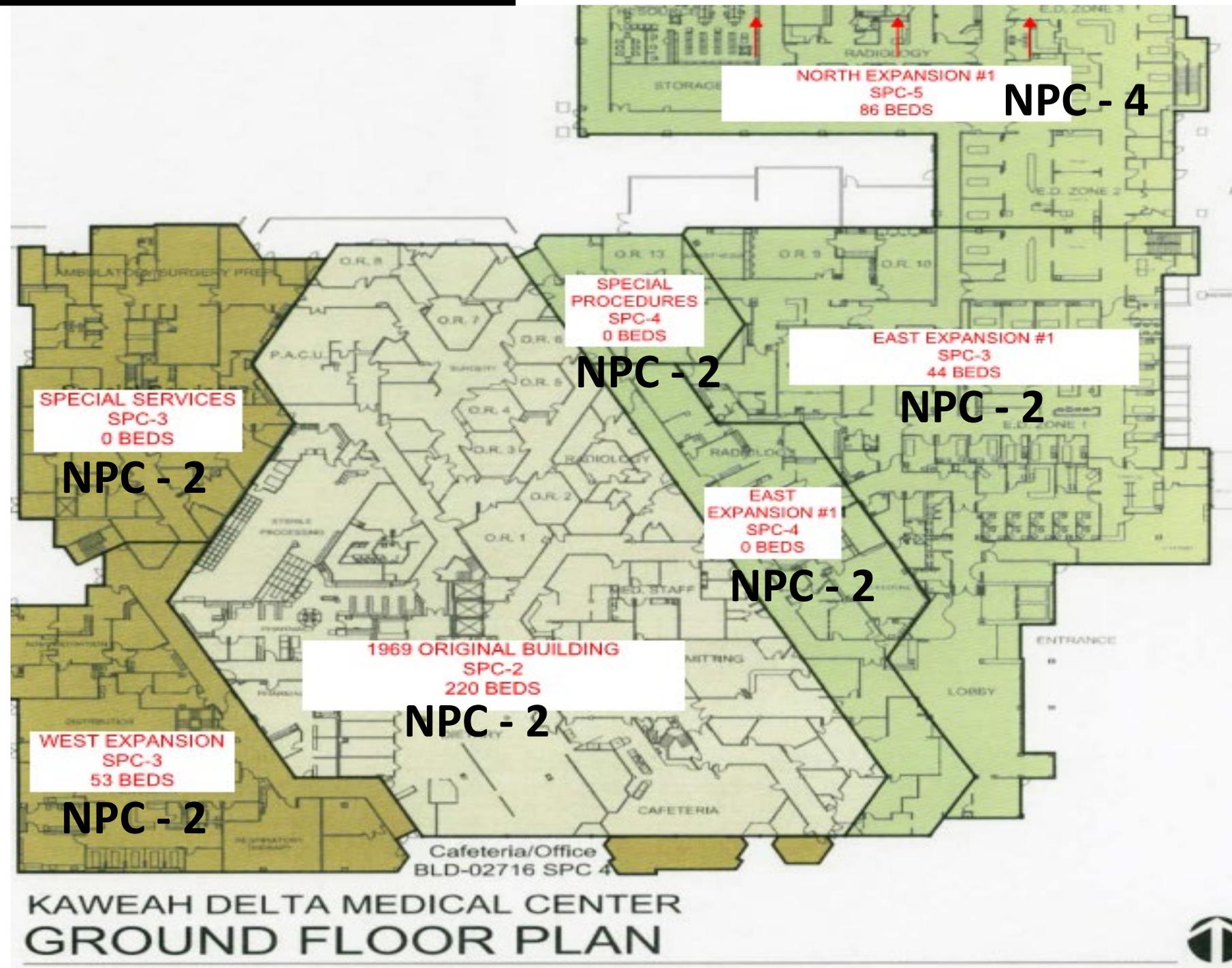
NPC - 2

DIETARY ADD.

NPC-4s

ED ADD.

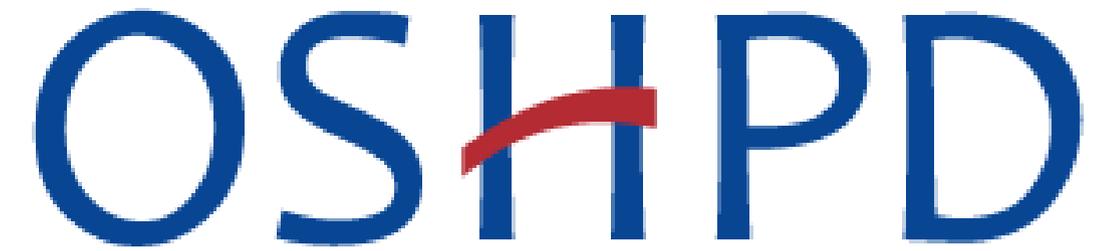
NPC-4s



RESULT:

**All BUILDING W/ THE EXCEPTION OF NORTH EXPANSION, DIETARY ADDITION AND ED ADDITION REQUIRE NPC UPGRADES BY 2030**

# NPC COMPLIANCE



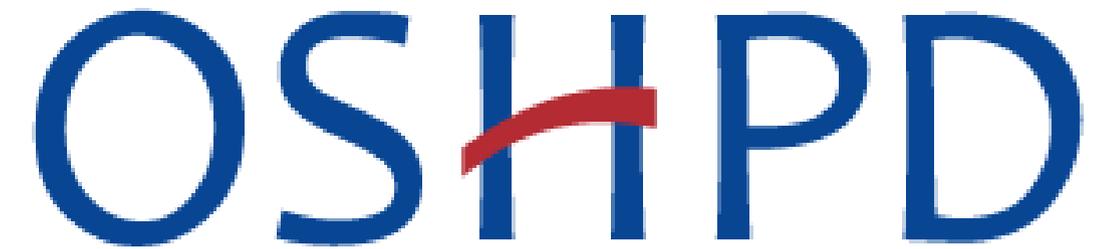
Updates from Paul Coleman/OSHPD Oct. 1, 2018

## **NPC Deadlines**

- By **January 1, 2024**, the hospital owner shall submit to the Office a **complete nonstructural evaluation** up to NPC 4 or 4D and NPC 5, for each building to remain in acute care service beyond January 1, 2030
- By **January 1, 2026**, the hospital owner shall submit to the Office **construction documents** for NPC 4 or 4D or NPC 5 compliance, that are deemed ready for review by the Office, for each building to remain in acute care service beyond January 1, 2030

# NPC COMPLIANCE

Updates from Paul Coleman/OSHDPD Oct. 1, 2018

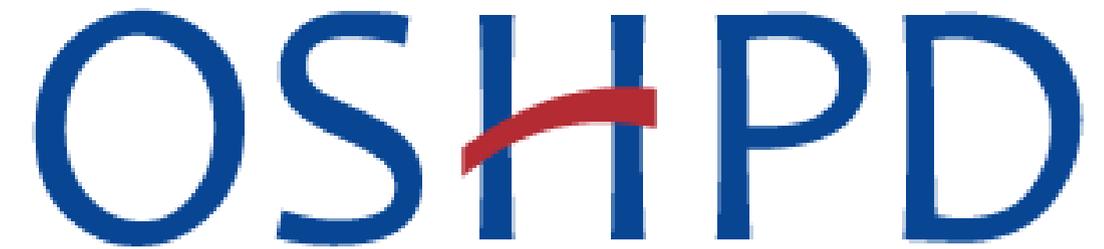


## **NPC Deadlines**

- By **January 1, 2028**, the hospital owner shall obtain a **building permit** to begin construction for NPC-4 or NPC-4D and NPC-5 for each building to remain in acute care service beyond January 1, 2030. Hospitals not meeting this deadline shall not be issued a building permit except for:
  - Seismic compliance
  - Maintenance
  - Emergency repairs
- Hospitals must be NPC 4D or NPC 4 **and** NPC 5 **by 2030**

# NPC COMPLIANCE

Updates from Paul Coleman/OSHPD Oct. 1, 2018



Office of Statewide Health  
Planning and Development

## **NPC work to be included in remodels/renovations**

- After **January 1, 2028**, buildings with NPC rating less than 4, all remodels/renovations, or other construction work, shall include anchorage and/or bracing of all equipment and services within the boundary of the scope of work that is not in compliance with NPC 4

# SPC Structural Options for Mineral King

- **Retrofit – SPC-4D assumes legislative extension**
  - Requires New Construction in Phase 1 for beds
  - Cant be started until Phase 1 is complete to avoid losing beds
  - Pros – Continued use of MK after retrofit
  - Cons outlined in 2016 KPFF Report
- **Removal of Floors – SPC-4D assumes legislative extension**
  - Requires New Construction of beds in Phase 1
  - Cant be started until Phase 1 is complete
  - Pros – Continued use of 1<sup>st</sup> floor Ancillary
  - Cons – major disruption to occupied portions
- **Re-Purpose – OSHPD1R (non Acute Care) assumes legislative extension**
  - Requires New Construction of beds and Ancillary in Phase 1 & 2
  - Cant be started until Phase 2 is complete
  - Pros – Continued use of refurbished building. Does not require structural retrofit
  - Cons – May not be cost effective, requires code upgrades

# Master Plan Strategy

# PROJECT SCENARIOS – PHASE 1

## SCENARIO 1

- \* 240 beds ( 240 beds possible)
- \* 8 floors + 1 ground floor (non beds)
- \* 21730 SF x 9 floors = 195,570 BGSF x \$1,700 = \$332,469,000
- \* 500 Car Parking Structure = \$15,000,000
- \* \$347,512,091 Total Project Cost (2019 \$)
- \* **Total Project Cost Escalated of \$457,238,989**

## SCENARIO 1A

- \* 120 beds ( 240 beds possible)
- \* 4 floors + 1 ground floor (non beds) + 4 shell bed floors
- \* 21,730 SF x 5 floors = 108,650 BGSF x \$1,700 = \$184,705,000
- \* 21,730 SF x 4 shell floors = 86,920 BGSF x \$980 = \$85,181,600
- \* 500 Car Parking Structure = \$15,000,000
- \* \$284,929,691 Total Project Cost (2019 \$)
- \* **Total Project Cost Escalated of \$374,896,204**

## SCENARIO 2

- \* 210 beds ( 210 beds possible)
- \* 7 floors + 1 ground floor (non beds)
- \* 21,730 SF x 8 floors = 173,840 BGSF x \$1,700 = \$295,528,000
- \* 500 Car Parking Structure = \$15,000,000
- \* \$310,571,091 Total Project Cost (2019 \$)
- \* **Total Project Cost Escalated of \$408,633,873**

## SCENARIO 3

- \* 180 beds ( 180 beds possible)
- \* 6 floors + 1 ground floor (non beds)
- \* 21,730 SF x 7 floors = 152,110 BGSF x \$1,700 = \$258,587,000
- \* 500 Car Parking Structure = \$15,000,000
- \* \$273,630,091 Total Project Cost (2019 \$)
- \* **Total Project Cost Escalated of \$360,028,757**

## SCENARIO 4

- \* 150 beds ( 150 beds possible)
- \* 5 floors + 1 ground floor (non beds)
- \* 21,730 SF x 6 floors = 130,380 BGSF x \$1,700 = \$221,646,000
- \* 500 Car Parking Structure = \$15,000,000
- \* \$236,689,091 Total Project Cost (2019 \$)
- \* **Total Project Cost Escalated of \$300,892,407**

## SCENARIO 4A

- \* 90 beds ( 150 beds possible)
- \* 3 floors + 1 ground floor (non beds) + 2 shell bed floors
- \* 21,730 SF x 4 floors = 86,920 BGSF x \$1,700 = \$147,764,000
- \* 21,730 SF x 2 shell floors = 43,460 BGSF x \$980 = \$42,590,800
- \* 500 Car Parking Structure = \$15,000,000
- \* \$205,397,891 Total Project Cost (2019 \$)
- \* **Total Project Cost Escalated of \$261,113,284**

# PROJECT SCENARIOS – PHASE 1

## SCENARIO 5

- \* 150 beds ( 150 beds possible)
- \* 5 floors + 0 ground floor (non beds)
- \* 21,730 SF x 5 floors = 108,650 BGSF x \$1,700 = \$184,705,000
- \* 21,730 SF x 0 shell floors = - BGSF x \$980 = \$0
- \* 435 Car Parking Structure = \$13,050,000
- \* \$197,755,435 Total Project Cost (2019 \$)
- \* **Total Project Cost Escalated of \$251,397,767**

## SCENARIO 5A

- \* 90 beds ( 120 beds possible)
- \* 3 floors + 1 ground floor (non beds) + 1 shell bed floors
- \* 21,730 SF x 4 floors = 86,920 BGSF x \$1,700 = \$147,764,000
- \* 21,730 SF x 1 shell floors = 21,730 BGSF x \$980 = \$21,295,400
- \* 435 Car Parking Structure = \$13,050,000
- \* \$182,152,426 Total Project Cost (2019 \$)
- \* **Total Project Cost Escalated of \$231,562,349**

## SCENARIO 6

- \* 90 beds ( 90 beds possible)
- \* 3 floors + 1 ground floor (non beds)
- \* 21,730 SF x 4 floors = 86,920 BGSF x \$1,700 = \$147,764,000
- \* 21,730 SF x 0 shell floors = - BGSF x \$980 = \$0
- \* 348 Car Parking Structure = \$10,440,000
- \* \$158,246,939 Total Project Cost (2019 \$)
- \* **Total Project Cost Escalated of \$201,172,357**

## SCENARIO 6A

- \* 60 beds ( 120 beds possible)
- \* 2 floors + 0 ground floor (non beds) + 2 shell bed floors
- \* 21,730 SF x 2 floors = 43,460 BGSF x \$1,700 = \$73,882,000
- \* 21,730 SF x 2 floors = 43,460 BGSF x \$980 = \$42,590,800
- \* 348 Car Parking Structure = \$10,440,000
- \* \$126,913,148 Total Project Cost (2019 \$)
- \* **Total Project Cost Escalated of \$161,339,090**

## SCENARIO 7

- \* 60 beds ( 60 beds possible)
- \* 2 floors + 1 ground floor (non beds)
- \* 21,730 SF x 3 floors = 65,190 BGSF x \$1,700 = \$110,823,000
- \* 21,730 SF x 0 shell floors = - BGSF x \$980 = \$0
- \* 261 Car Parking Structure = \$7,830,000
- \* \$118,695,852 Total Project Cost (2019 \$)
- \* **Total Project Cost Escalated of \$145,790,149**

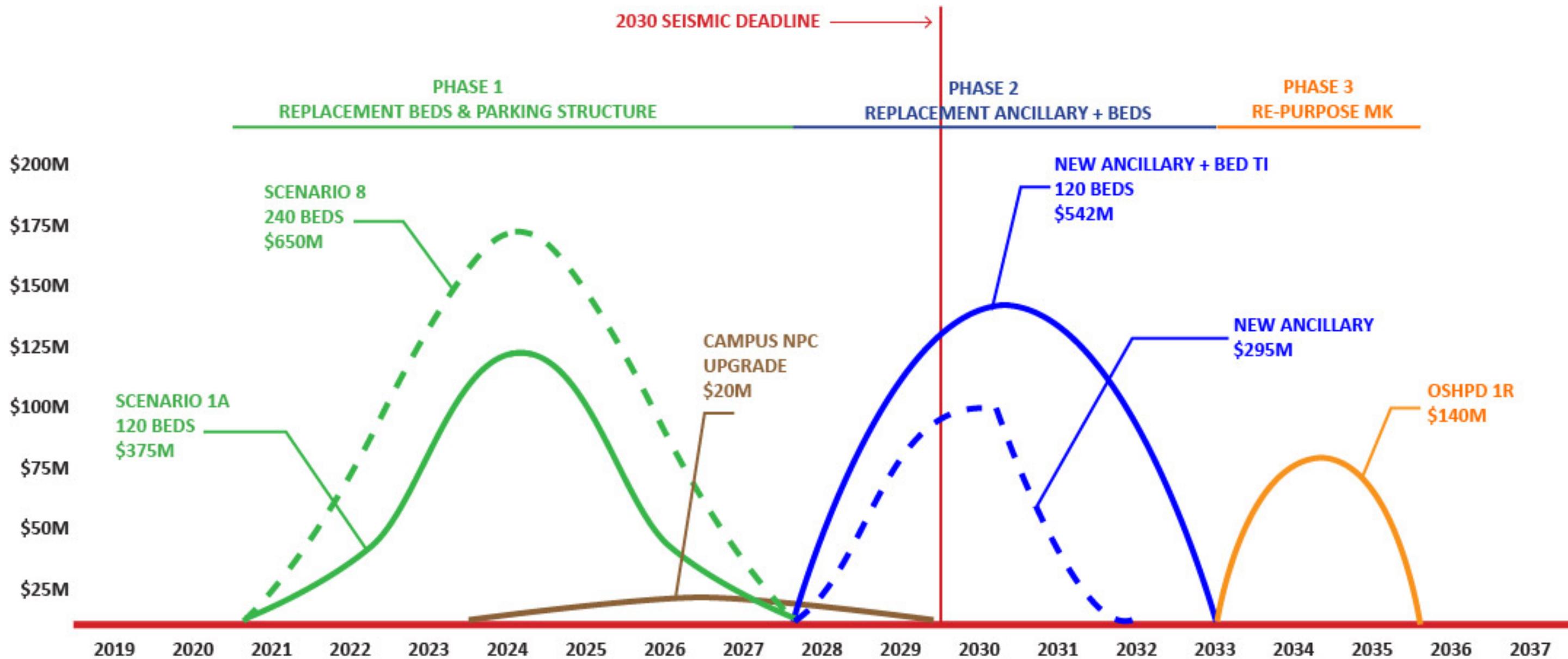
# PROJECT SCENARIOS – PHASE 1

## SCENARIO 8

- \* 240 beds ( 240 beds possible)
- \* 8 floors + 0 ground floor (non beds)
- \* 21,730 SF x 8 floors = 173,840 BGSF x \$1,700 = \$295,528,000
- \* 21,730 SF x 0 shell floors = - BGSF x \$980 = \$0
- \* 36,724 SF x 2 D&T floors = 73,447 BGSF x \$2,400 = \$176,273,760
- \* 500 Car Parking Structure = \$15,000,000
- \* \$486,946,217 Total Project Cost (2019 \$)
- \* **Total Project Cost Escalated of \$640,699,423**

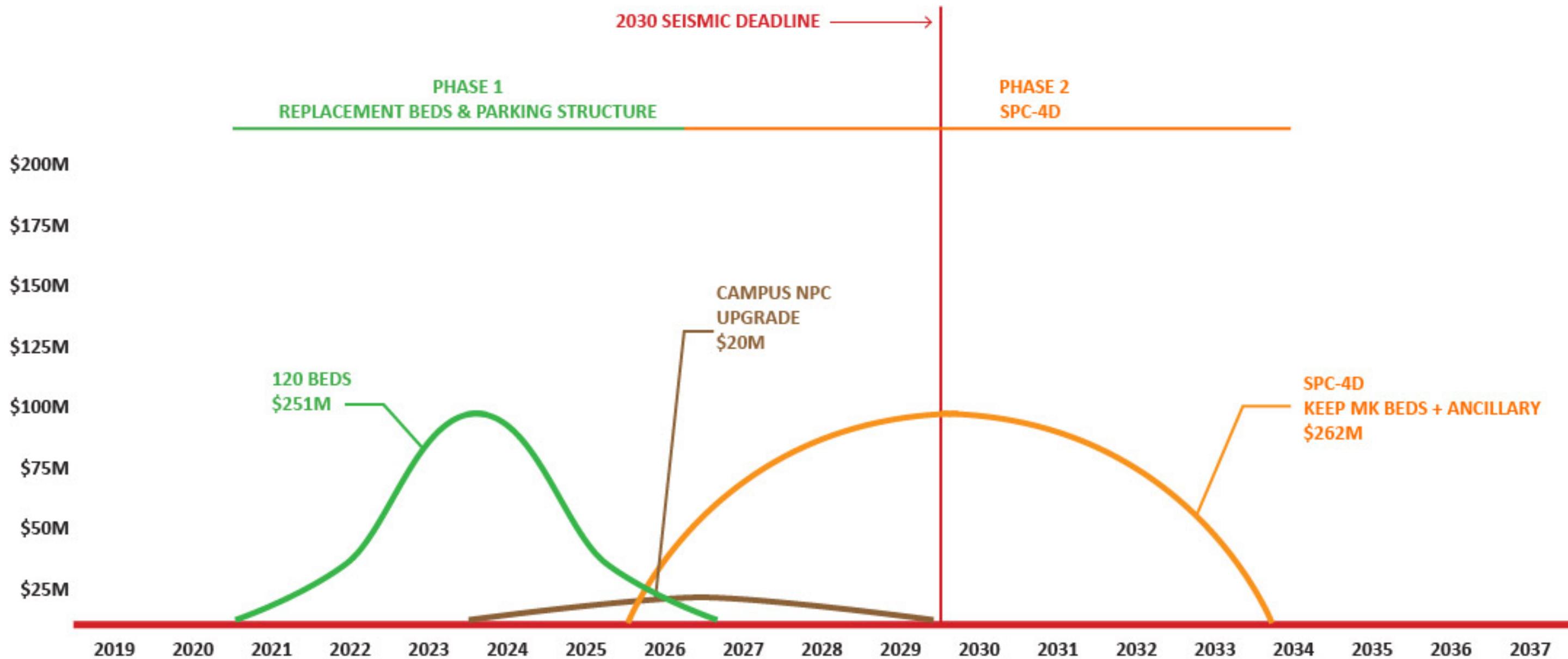
## SCENARIO 8A

- \* 60 beds ( 240 beds possible)
- \* 2 floors + 0 ground floor (non beds) + 6 shell bed floors
- \* 21,730 SF x 2 floors = 43,460 BGSF x \$1,700 = \$73,882,000
- \* 21,730 SF x 6 shell floors = 130,380 BGSF x \$980 = \$127,772,400
- \* 36,724 SF x 0 D&T floors = - BGSF x \$2,400 = \$0
- \* 36,724 SF x 2 D&T shell = 73,447 BGSF x \$1,120 = \$82,261,088
- \* 500 Car Parking Structure = \$15,000,000
- \* \$299,059,945 Total Project Cost (2019 \$)
- \* **Total Project Cost Escalated of \$393,488,084**



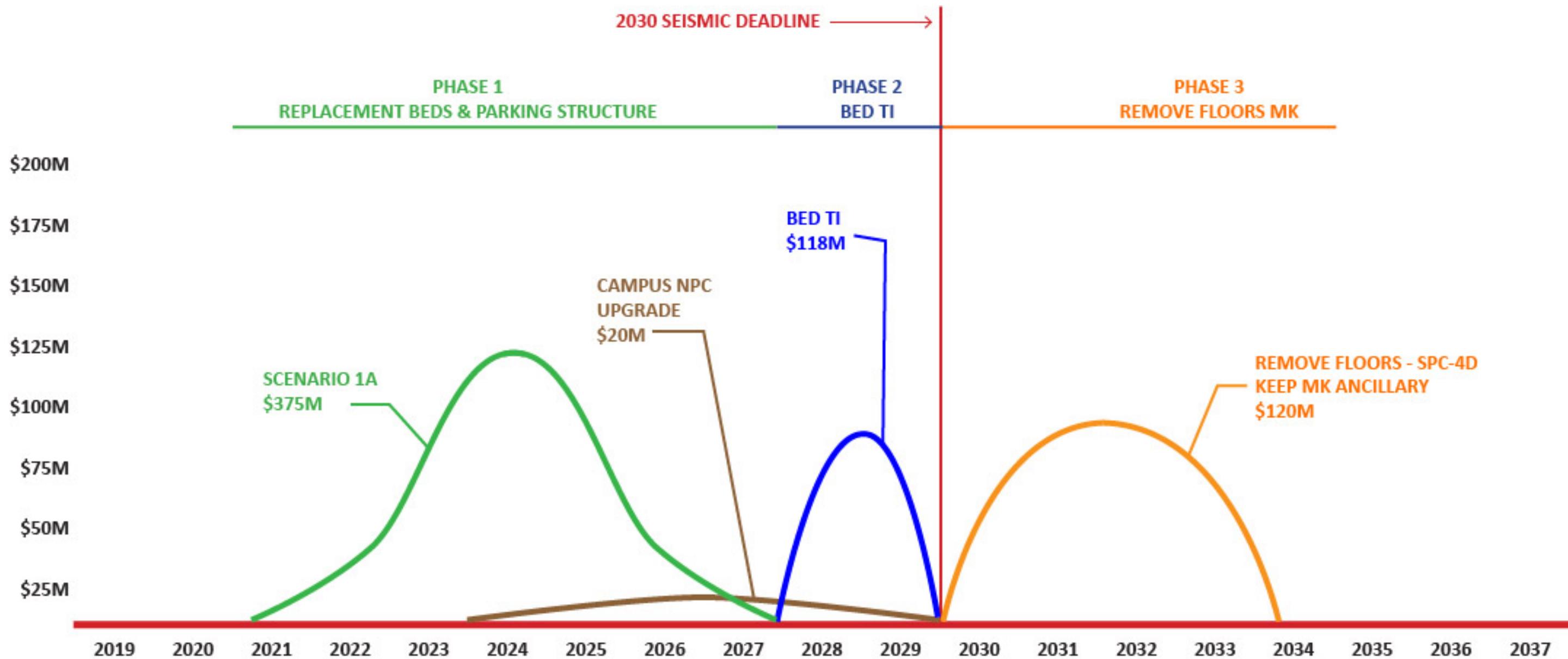
COMPLIANCE STRATEGY 1 - TOTAL PROJECT COST IN EXCESS OF \$1B - COMPLIANCE BY 2032-33

ALL ESTIMATED VALUES AND SCHEDULE DATES REQUIRE FURTHER VALIDATION



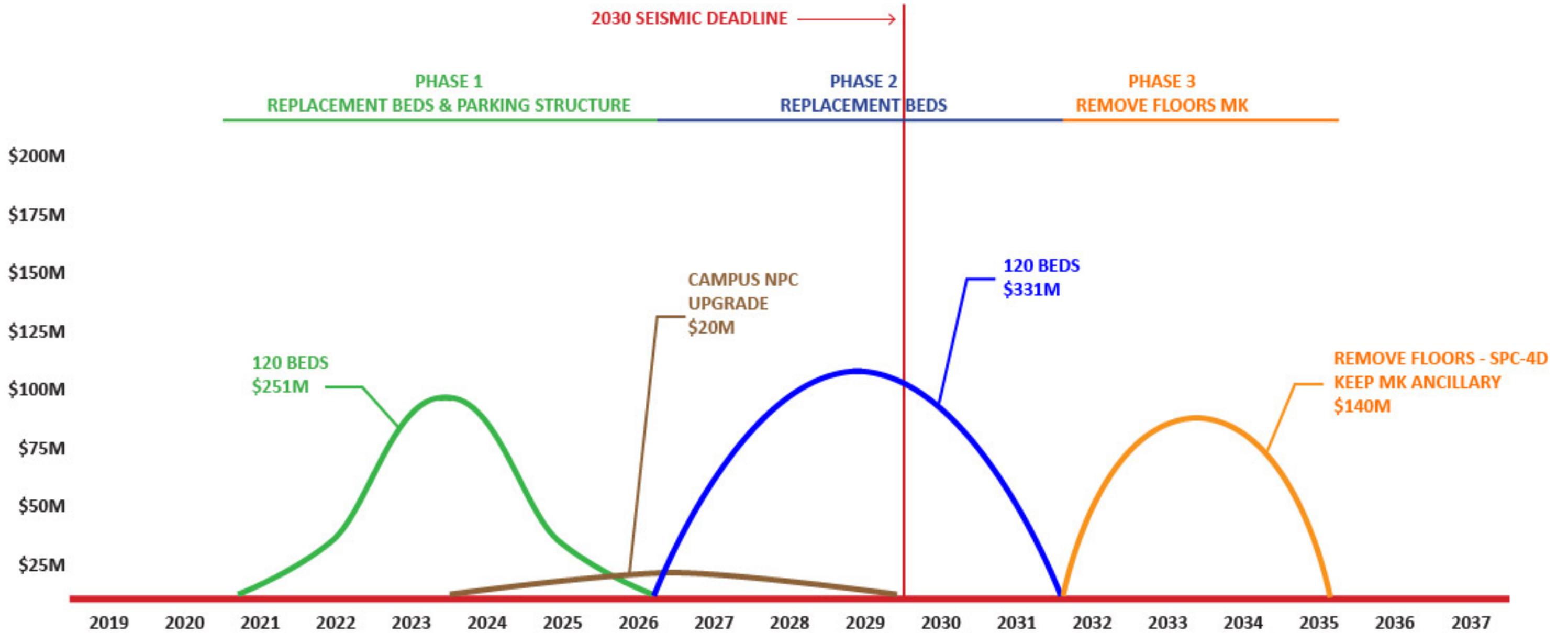
**COMPLIANCE STRATEGY 2 - TOTAL PROJECT COST IN EXCESS OF \$533M - COMPLIANCE BY 2034**

**ALL ESTIMATED VALUES AND SCHEDULE DATES REQUIRE FURTHER VALIDATION**



COMPLIANCE STRATEGY 3 - TOTAL PROJECT COST IN EXCESS OF \$633M - COMPLIANCE BY 2034

ALL ESTIMATED VALUES AND SCHEDULE DATES REQUIRE FURTHER VALIDATION



**COMPLIANCE STRATEGY 4 - TOTAL PROJECT COST IN EXCESS OF \$742M - COMPLIANCE BY 2036**

**ALL ESTIMATED VALUES AND SCHEDULE DATES REQUIRE FURTHER VALIDATION**

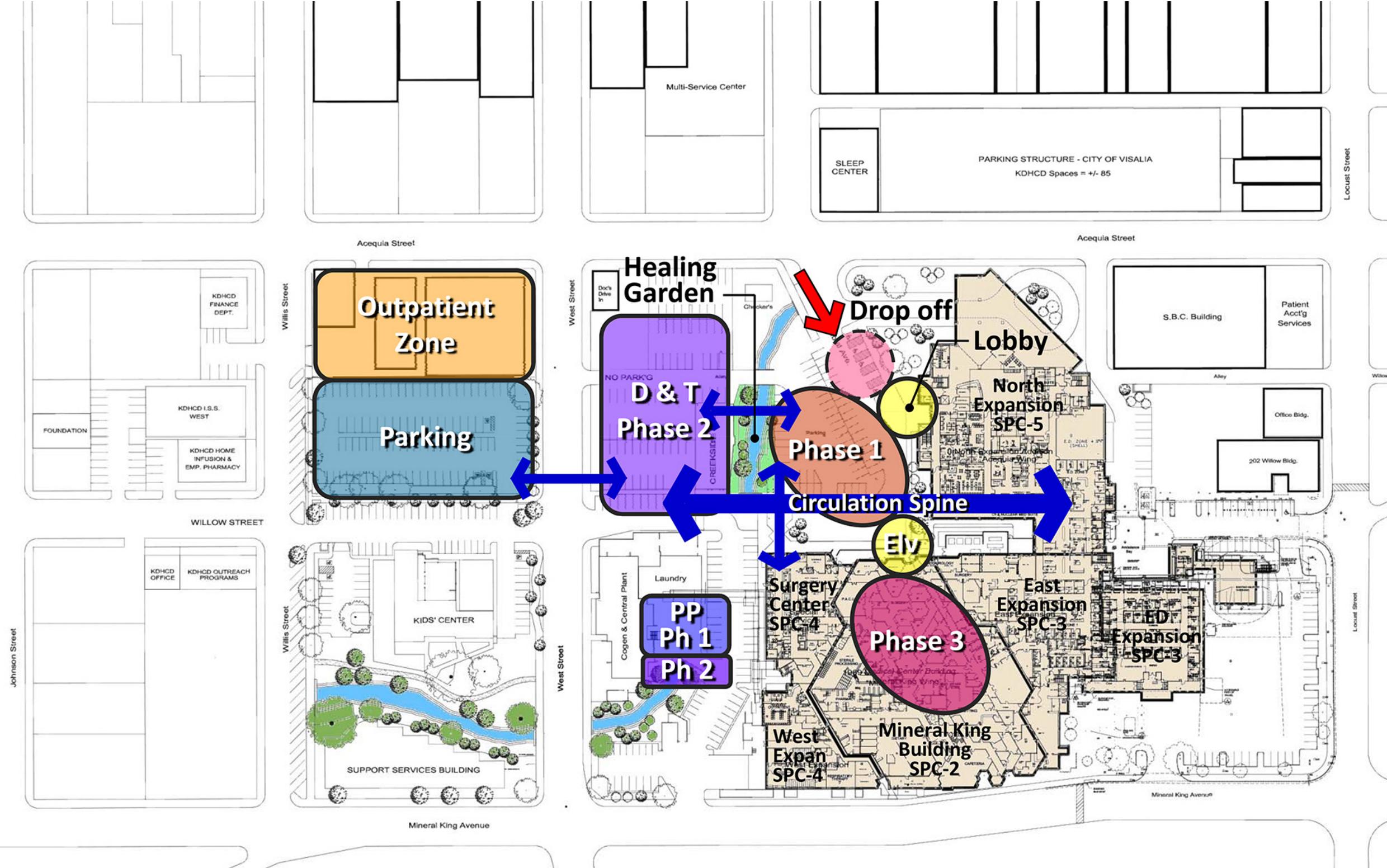
# Phased Master Plan Implementation

|                        | COMPLIANCE STRATEGY 1                   | COMPLIANCE STRATEGY 2                       | COMPLIANCE STRATEGY 3                      | COMPLIANCE STRATEGY 4                  |
|------------------------|---|---|--|--|
| <b>PHASE 1</b>         | REPLACEMENT BEDS & PARKING              | REPLACEMENT BEDS & PARKING                  | REPLACEMENT BEDS AND SHELL SPACE & PARKING | REPLACEMENT BEDS & PARKING             |
| <b>PHASE 2</b>         | ADDITIONAL REPLACEMENT BEDS & ANCILLARY | SPC-4D MK<br>(KEEP ANCILLARIES & SOME BEDS) | BED TI OF SHELLED SPACE                    | REPLACEMENT BEDS                       |
| <b>PHASE 3</b>         | RE-PURPOSE MK FOR NON ACUTE CARE        |   | REMOVE FLOORS MK<br>(KEEP ANCILLARIES)     | REMOVE FLOORS MK<br>(KEEP ANCILLARIES) |
| <b>FULL COMPLIANCE</b> | 2032 - 2033                             | 2034  | 2034                                       | 2036                                   |

**NOTE: ALL STRATEGIES REQUIRE LEGISLATIVE EXTENSION OF 2030 DEADLINE. LIKELY WITH PRE-CONDITIONS**



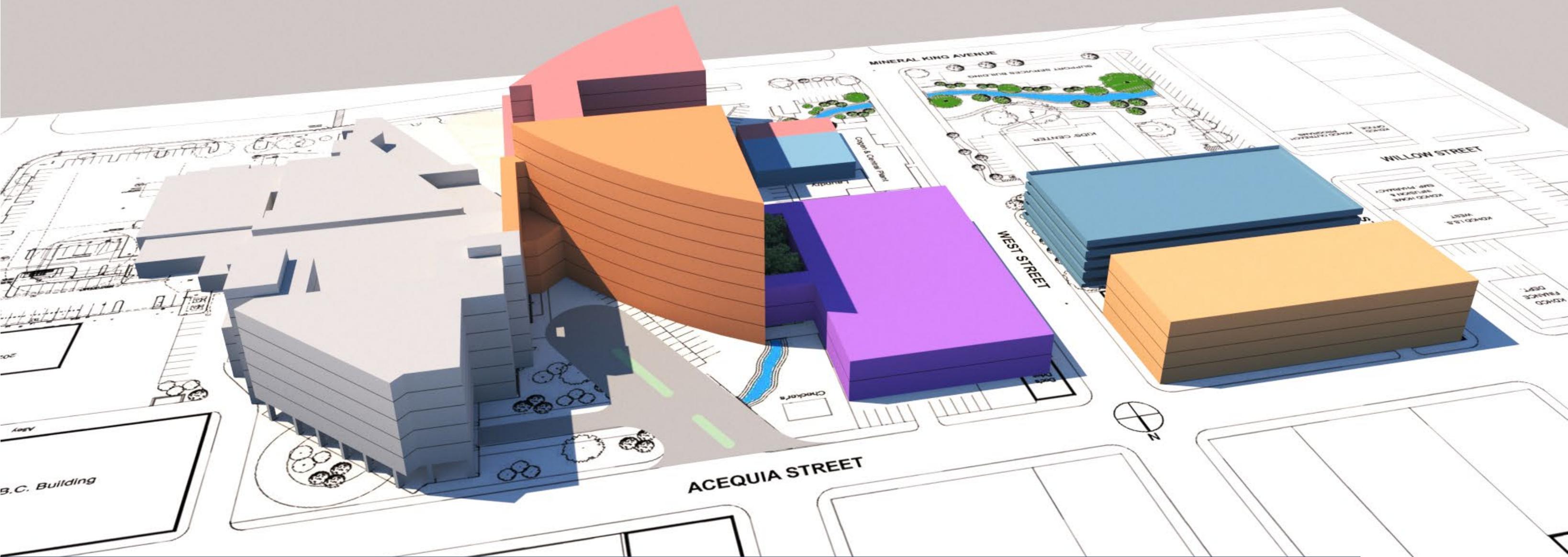
**KAWEAH DELTA MEDICAL CENTER REPLACEMENT HOSPITAL  
MASTER PLANNING SERVICES**



# KAWEAH DELTA SITE ANALYSIS



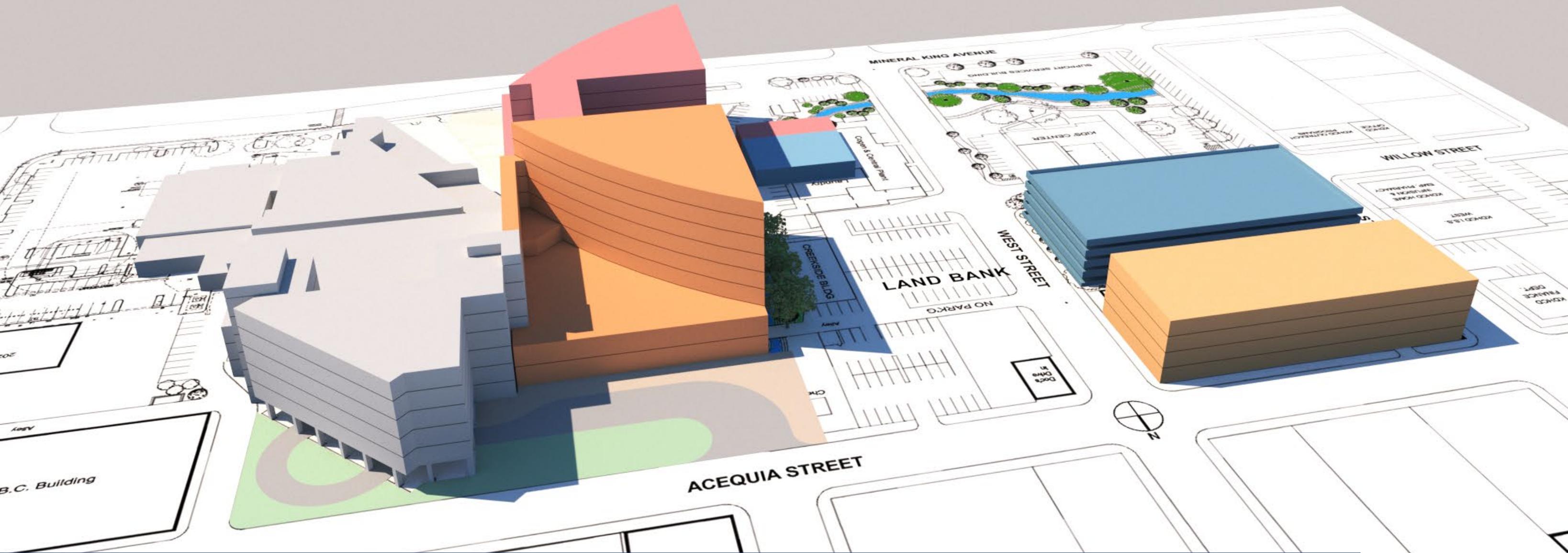
# SITE ANALYSIS – OPTION 1



# KAWEAH DELTA SITE ANALYSIS – OPTION 1



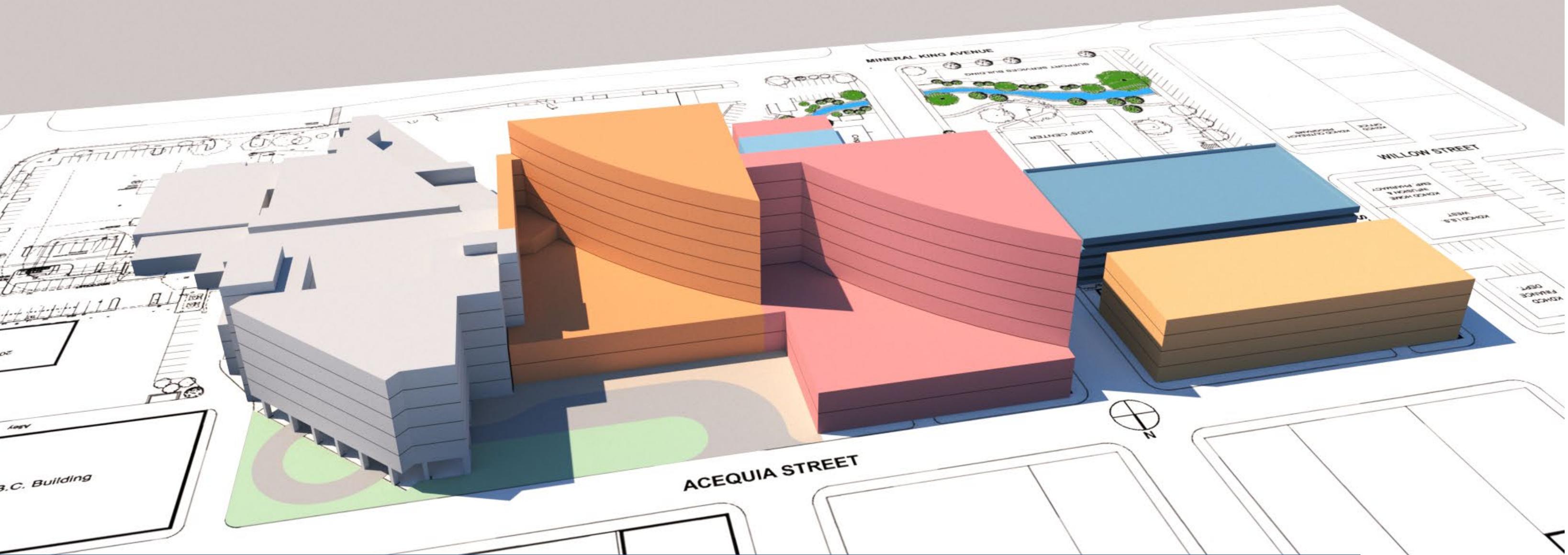
# SITE ANALYSIS – OPTION 2



# KAWEAH DELTA SITE ANALYSIS – OPTION 2



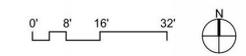
# SITE ANALYSIS – OPTION 3



## SITE ANALYSIS – OPTION 3



# SITE PLAN – PHASE 1 & EXISTING



# 3RD FLOOR PLAN - 30 PRIVATE BED UNIT

**BOARD OF DIRECTORS MEETING – CLOSED SESSION**

**KAWEAH DELTA HEALTH CARE DISTRICT**

**BOARD OF DIRECTORS MEETING**

**MONDAY NOVEMBER 25, 2019**

**CLOSED MEETING SUPPORTING DOCUMENTS**

**PAGES 41-63**

**BOARD OF DIRECTORS MEETING – CLOSED SESSION**

**KDHCD - BOARD OF DIRECTORS MEETING**

**MONDAY NOVEMBER 25, 2019**

**CLOSED MEETING SUPPORTING DOCUMENTS**

**PAGES 41-63**

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**KDHCD - BOARD OF DIRECTORS MEETING**

**MONDAY NOVEMBER 25, 2019**

**CLOSED MEETING SUPPORTING DOCUMENTS**

**PAGES 41-63**

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**CLOSED MEETING SUPPORTING DOCUMENTS**

**PAGES 41-63**

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**CLOSED MEETING SUPPORTING DOCUMENTS**

**PAGES 41-63**

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**KAWEAH DELTA HEALTH CARE DISTRICT**

**BOARD OF DIRECTORS MEETING**

**MONDAY NOVEMBER 25, 2019**

**CLOSED MEETING SUPPORTING DOCUMENTS**

**PAGES 41-63**

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**MONDAY NOVEMBER 25, 2019**

**CLOSED MEETING SUPPORTING DOCUMENTS**

**PAGES 41-63**

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**MONDAY NOVEMBER 25, 2019**

**CLOSED MEETING SUPPORTING DOCUMENTS**

**PAGES 41-63**

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**KAWEAH DELTA HEALTH CARE DISTRICT**

**BOARD OF DIRECTORS MEETING**

**MONDAY NOVEMBER 25, 2019**

**CLOSED MEETING SUPPORTING DOCUMENTS**

**PAGES 41-63**

**BOARD OF DIRECTORS MEETING – CLOSED SESSION**

**KDHCD - BOARD OF DIRECTORS MEETING**

**MONDAY NOVEMBER 25, 2019**

**CLOSED MEETING SUPPORTING DOCUMENTS**

**PAGES 41-63**

**BOARD OF DIRECTORS MEETING – CLOSED SESSION**

**KDHCD - BOARD OF DIRECTORS MEETING**

**MONDAY NOVEMBER 25, 2019**

**CLOSED MEETING SUPPORTING DOCUMENTS**

**PAGES 41-63**

**BOARD OF DIRECTORS MEETING – CLOSED SESSION**

**KDHCD - BOARD OF DIRECTORS MEETING**

**MONDAY NOVEMBER 25, 2019**

**CLOSED MEETING SUPPORTING DOCUMENTS**

**PAGES 41-63**

**BOARD OF DIRECTORS MEETING – CLOSED SESSION**

**KDHCD - BOARD OF DIRECTORS MEETING**

**MONDAY NOVEMBER 25, 2019**

**CLOSED MEETING SUPPORTING DOCUMENTS**

**PAGES 41-63**

**BOARD OF DIRECTORS MEETING – CLOSED SESSION**

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**MONDAY NOVEMBER 25, 2019**

**CLOSED MEETING SUPPORTING DOCUMENTS**

**PAGES 41-63**

**BOARD OF DIRECTORS MEETING – CLOSED SESSION**

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**MONDAY NOVEMBER 25, 2019**

**CLOSED MEETING SUPPORTING DOCUMENTS**

**PAGES 41-63**

**BOARD OF DIRECTORS MEETING – CLOSED SESSION**

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**CLOSED MEETING SUPPORTING DOCUMENTS**

**PAGES 41-63**

**BOARD OF DIRECTORS MEETING – CLOSED SESSION**

**KDHCD - BOARD OF DIRECTORS MEETING**

**MONDAY NOVEMBER 25, 2019**

**CLOSED MEETING SUPPORTING DOCUMENTS**

**PAGES 41-63**

**BOARD OF DIRECTORS MEETING – CLOSED SESSION**

**KDHCD - BOARD OF DIRECTORS MEETING**

**MONDAY NOVEMBER 25, 2019**

**CLOSED MEETING SUPPORTING DOCUMENTS**

**PAGES 41-63**

**BOARD OF DIRECTORS MEETING – CLOSED SESSION**

**KDHCD - BOARD OF DIRECTORS MEETING**

**MONDAY NOVEMBER 25, 2019**

**CLOSED MEETING SUPPORTING DOCUMENTS**

**PAGES 41-63**

**BOARD OF DIRECTORS MEETING – CLOSED SESSION**

**KDHCD - BOARD OF DIRECTORS MEETING**

**MONDAY NOVEMBER 25, 2019**

**CLOSED MEETING SUPPORTING DOCUMENTS**

**PAGES 41-63**

**BOARD OF DIRECTORS MEETING – CLOSED SESSION**

**KAWEAH DELTA HEALTH CARE DISTRICT**

**BOARD OF DIRECTORS MEETING**

**MONDAY NOVEMBER 25, 2019**

**CLOSED MEETING SUPPORTING DOCUMENTS**

**PAGES 41-63**

**BOARD OF DIRECTORS MEETING – CLOSED SESSION**

**KDHCD - BOARD OF DIRECTORS MEETING**

**MONDAY NOVEMBER 25, 2019**

**CLOSED MEETING SUPPORTING DOCUMENTS**

**PAGES 41-63**

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**KDHCD - BOARD OF DIRECTORS MEETING**

**MONDAY NOVEMBER 25, 2019**

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**PAGES 41-63**

MINUTES OF THE OPEN MEETING OF THE KAWEAH DELTA HEALTH CARE DISTRICT BOARD OF DIRECTORS HELD MONDAY SEPTEMBER 23, 2019 6:00PM, IN THE KAWEAH DELTA MEDICAL CENTER MINERAL KING WING BLUE ROOM, LYNN HAVARD MIRVISS PRESIDING

PRESENT: Directors Havard Mirviss, Hawkins Hipskind, House, & Francis; B. Mendenhall, MD, Chief of Staff; G. Herbst, CEO; R. Sawyer, VP & CNO, M. Tupper, VP & CFO; D. Cox, VP of Human Resources, M. Mertz, VP of Strategic Planning and Business Development, D. Leeper, VP & CIO; D. Lynch, Legal Counsel, K. Davis, Recording

The meeting was called to order at 6:04PM by Director Havard Mirviss.

Director Havard Mirviss entertained a motion to approve the agenda.

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

**PUBLIC/MEDICAL STAFF PARTICIPATION**

- None.

**CLOSED SESSION ACTION TAKEN:**

- Approval of closed minutes from August 26, 2019.
- Closed meeting action from July 22<sup>nd</sup> meeting;
  - Board ratification of the action by the Finance, Property, Services, and Acquisition Committee on 7/18/19 to approve management to move forward in the execution of a letter of intent relative to APN 172-010-034.
- Closed meeting action from August 26<sup>th</sup> meeting;
  - Approve Resolution 2046 to approve the purchase of the properties located at 1000 North Mooney Boulevard, Tulare, County of Tulare, California {APN's 172-010-034 and 172-010-026} for the total amount not to exceed \$1,590,000.

**OPEN MINUTES** – Request for approval of the August 26, 2019 open board of directors meeting minutes.

*MMSC (Hawkins/Hipskind) to approve of the open minutes – August 26, 2019. This was supported unanimously by those present. Vote: Yes – Havard Mirviss, Hawkins, House, Hipskind, and Francis*

**RECOGNITIONS** – Nevin House

- Presentation of Resolution 2047 to Chris Stafford, Health Unit Coordinator, Oncology 3S - Service Excellence Award – September 2019 (copy attached to the original of these minutes and considered a part thereof).

**CONSENT CALENDAR** – Director Havard Mirviss entertained a motion to approve the consent calendar. Director House requested the removal of the following items: {7.1C, 7.1D}

*MMSC (Hawkins/Hipskind) to approve the consent calendar with the removal of items: 7.1C {Report – Neurosciences Center} 7.1D {Report – Rural Health Clinics}. This was supported unanimously by those present. Vote: Yes – Havard Mirviss, Hawkins, House, Hipskind, and Francis*

- Further review of 7.1C {Report – Neurosciences Center} Discussion of the reduction in net revenue despite an increase in volume. Mr. Leal advised that efforts are underway to attract more patients with private insurance and to avoid out-migration, which will make the program more profitable. Mr. Mertz advised that additional marketing to support the program is already planned and will be forthcoming.
- Further review of 7.1D {Report – Rural Health Clinics} Mr. Garrett offered information on clinic volumes, the factors impacting them and the expectations during the upcoming months.

Director Havard Mirviss entertained a motion to approve the remainder of the consent calendar as presented.

*MMSC (Francis/Hawkins) to approve the the remainder of consent calendar as presented. This was supported unanimously by those present. Vote: Yes – Havard Mirviss, Hawkins, House, Hipskind, and Francis*

#### 7.1. REPORTS

- A. Medical Staff Recruitment
- B. Environment of Care
- C. Neurosciences Center
- D. Rural Health Clinics
- E. Quail Park

#### 7.2. POLICIES

- A. ADMINISTRATIVE
  - 1. Census Saturation Plan AP.114 Revised
  - 2. Disruption of services or unusual occurrences AP.30 Revised
- B. BOARD OF DIRECTORS
  - 1. Presentation of claims and service process BOD7 Reviewed
- C. EMERGENCY MANAGEMENT
  - 1. Request to operate under CMS 1135 waiver DM2227 New

7.3. Approval of Resolution 2048 to Debbie Murray, Coding Manager, retiring from duty at Kaweah Delta after thirty (30) years of service.

7.4. Recommendation from the Medical Executive Committee (SEPTEMBER 2019)

- A. Administrative Policy
  - 1. AP.171 Medically Ineffective Care (reviewed)
- B. Privilege Form – Nurse Practitioner / Physician Assistant

**QUALITY - QUALITY FOCUS TEAM REPORT** – Reducing Workplace Violence (copy attached to the original of these minutes and considered a part thereof) - Maribel Aguilar, Life Safety Manager and Todd Noeske, Safety Specialist

**STRATEGIC PLAN – OPERATIONAL EFFICIENCY** – Review of the strategic initiative charter (copy attached to the original of these minutes and considered a part thereof) - Regina Sawyer, Vice President & Chief Nursing Officer & Keri Noeske, Director of Care Management

- Keri Noeske presented on this subject utilizing the attached materials. There was focused discussion on throughput and length of stay.

**COMMUNITY ENGAGEMENT** - Report on the Kaweah Delta Community Engagement Initiative groups (copy attached to the original of these minutes and considered a part thereof) - Deborah Volosin, Director of Community Engagement

- Deborah Volosin presented on this subject utilizing the attached materials. She provided committee updates and responded to a Board inquiry relative to which of the committees are still accepting applications.

**CLEVELAND CLINIC** – Status of implementation plans and opportunities relative to the Kaweah Delta affiliation with Cleveland Clinic Heart and Vascular Institute (copy attached to the original of these minutes and considered a part thereof) - Regina Sawyer, RN, Vice President and Chief Nursing Officer, Barry Royce, Director of Cardiovascular Service Line and Cardiovascular Co-Management Program

- Barry Royce presented on this subject utilizing the attached materials. There was discussion of the status of implementation plans for the program and opportunities through its further development.

**GOLDEN STATE CARDIAC & THORACIC SURGERY, INC CONTRACT** – Review and requested approval of agreement effective October 1, 2019 between Kaweah Delta Health Care District and Golden State Cardiac & Thoracic Surgery Inc. (copy attached to the original of these minutes and considered a part thereof) - Ben Cripps, Compliance and Privacy Officer, Dennis Lynch, Legal Counsel

- Mr. Herbst presented on this matter, advising the Board that the negotiations for the contract terms have been completed, as reflected in the agreement. Arrangements for physician staffing are in the process of being finalized.

*MMSC to approve the agreement between Kaweah Delta Health Care District and Golden State Cardiac & Thoracic Surgery, Inc., as presented, subject to the CEO in his discretion determining that satisfactory arrangements for physician staffing to support the program have been completed. This was supported unanimously by those present. Vote: Yes – Havard Mirviss, Hawkins, House, Hipskind, and Francis*

**REBRANDING** – Presentation and discussion relative to the Kaweah rebranding initiative as reviewed by the Board Marketing and Public Affairs Committee (copy attached to the original of these minutes and considered a part thereof) - Marc Mertz, Vice President of Strategic Planning and Business Development, Dru Quesnoy, Director of Marketing and Communications, and Jennifer Manduffie, Sr. Graphic Designer

- Marc Mertz, Jennifer Manduffie and Dru Quesnoy provided an update on the current status of this matter. No action was requested at this time. The issue will come back to the Board at a subsequent meeting.

**CENTRAL VALLEY HEALTHCARE ALLIANCE** – Progress report on the Central Valley Healthcare Alliance activities (copy attached to the original of these minutes and considered a part thereof) - David Francis, Chair & Marc Mertz, Secretary – Central Valley Healthcare Alliance

- Director Francis and Marc Mertz provided an update on the current activities of the JPA, utilizing the attached materials and reporting that the collaboration among the parties involved is very positive and encouraging relative to additional future projects.

**FINANCIALS** – Review of the most current fiscal year 2020 financial results (copy attached to the original of these minutes and considered a part thereof) - Malinda Tupper, VP & Chief Financial Officer

- Malinda Tupper led the discussion on the financials. Director House requested that a footnote be added when the District has made a large payment (e.g., IGT) which impacts the financials because the corresponding reimbursement payment has not yet come back so the Board can be aware of the purpose of the payment and when the reimbursement payment can be expected.

**CREDENTIALING** – Byron Mendenhall, MD –Chief of Staff - Medical Executive Committee request 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.

Director Havard Mirviss requested a motion for the approval of the credentials report excluding the Emergency Medicine providers highlighted on Exhibit A {copy attached to the original of these minutes and considered a part thereof}.

MMSC (Hipskind/Francis) 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. Vote: Director Havard Mirviss, House, Hawkins, Francis & Hipskind – Yes.

Director John Hipskind, MD left the room for the vote on the credentials, for the Emergency Medicine providers as highlighted on Exhibit A {copy attached to the original of these minutes and considered a part thereof}.

Director Havard Mirviss requested a motion for the approval of the credentials report for the Emergency Medicine providers highlighted on Exhibit A {copy attached to the original of these minutes and considered a part thereof}.

MMSC (House/Francis) 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 Emergency Medicine providers 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 Emergency Medicine providers 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. Vote: Director Havard Mirviss, House, Francis & Hawkins – Yes. Director Hipkind – Absent

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

- None.

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

- The Joint Commission survey is underway. Brief discussion of the new matrix being utilized by TJC.
- District Hospital Leadership Forum – discussion of current legislation regarding nurse staffing ratios
- CMS proposed action to lower DSH payments. Congressional action may delay implementation
- Federally Qualified Health Center status update.

**BOARD PRESIDENT REPORT** – Report from Lynn Havard Mirviss, Board President:

- None.

**Adjourn** - Meeting adjourned at 8:45PM

Lynn Havard Mirviss, Board President  
Kaweah Delta Health Care District and the Board of Directors  
Thereof

ATTEST:

Nevin House, 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 OCTOBER 28, 2019 5:00PM, IN THE KAWEAH DELTA MEDICAL CENTER MINERAL KING WING BLUE ROOM, LYNN HAVARD MIRVISS PRESIDING

PRESENT: Directors Havard Mirviss, Hawkins & Francis; M. Manga, Vice Chief of Staff; G. Herbst, CEO; T. Rayner, SVP & COO; R. Sawyer, VP & CNO, M. Tupper, VP & CFO; D. Cox, VP of Human Resources, M. Mertz, VP of Strategic Planning and Business Development, D. Leeper, VP & CIO; D. Allain, J. Batth, J. Moncada, M. Williams, D. Volosin, C. Vawter, D. Lynch, Legal Counsel, C. Moccio, Recording.

ABSENT: Director House & Hipskind

The meeting was called to order at 5:02PM by Director Havard Mirviss.

Director Havard Mirviss asked for approval of the agenda.

*MMSC (Francis/Hawkins) to approve the open agenda. This was supported unanimously by those present. Vote: Yes – Havard Mirviss, Hawkins, and Francis Absent - House & Hipskind*

**PUBLIC PARTICIPATION** – none

Director Havard Mirviss called for the approval of the closed agenda.

**APPROVAL OF THE CLOSED AGENDA – 5:01PM**

**1. CALL TO ORDER**

**2. Conference with Legal Counsel – Existing Litigation** – Pursuant **to** Government Code 54956.9(d)(1) – Richard Salinas, *Legal Counsel & Evelyn McEntire, Director of Risk Management*

- A. Edison v Barcenas v KDHCD (Case # 265419)
- B. Saiz vs KDHCD (Case # 276364)
- C. Tapia v KDHCD (Case # 276467)
- D. Minton v KDHCD (Case # 277205)
- E. Ibarra v KDHCD (Case # 278288)
- F. Martinez (Santillan) v KDHCD (Case # VCU279163)
- G. Arroyo v KDHCD (Case # 278184)
- H. Holguin v KDHCD (Case # 278896)
- I. Doe v KDHCD (Case # 16-16650)
- J. Cowan v KDHCD (Case # VCU274052)
- K. McIntyre v KDHCD (Case # VCU272545)
- L. Adams v KDHCD (Case # 278006)
- M. Sansom v KDHCD (Case # 278743)
- N. Rascon v KDHCD (Case # 272009)
- O. Rivas v KDHCD (Case # VCU272084)
- P. Rocha v KDHCD (Case # 273862)
- Q. Lynch v KDHCD (Case # VCU277292)
- R. Borges v KDHCD (Case # 278212)
- S. Moran v KDHCD (Case # 279550)
- T. Shirk v KDHCD (Case # 280558)

U. Santillian v KDHCD (Case # VCU279163)

3. **Conference with Legal Counsel – Anticipated Litigation** – Significant exposure to litigation pursuant to Government Code 54956.9(d)(2) – 15 Cases - *Evelyn McEntire, Director of Risk Management & Richard Salinas, Legal Counsel*
4. **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461, report of quality assurance committee – *Evelyn McEntire, Director of Risk Management*
5. **Report involving trade secrets {Health and Safety Code 32106}** – Discussion will concern a proposed new services/programs – estimated date of disclosure is December 2019 – *Marc Mertz, Vice President of Strategic Planning and Business Development*
6. **Credentialing** - Medical Executive Committee (October 2019) 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 pursuant to Health and Safety Code 1461 and 32155 – *Monica Manga, MD, Vice Chief of Staff*
7. **Approval of closed meeting minutes – September 23, 2019**  
*Action Requested – Approval of the closed meeting minutes – September 23, 2019.*

*MMSC (Hawkins/Francis) to approve the closed agenda. This was supported unanimously by those present. Vote: Yes – Havard Mirviss, Hawkins, and Francis Absent – House & Hipkind*

**ADJOURN** - Meeting was adjourned at 5:03PM

Lynn Havard Mirviss, President  
Kaweah Delta Health Care District and the Board of Directors

ATTEST:

Nevin House, 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 OCTOBER 28, 2019 6:00PM, IN THE KAWEAH DELTA MEDICAL CENTER MINERAL KING WING BLUE ROOM, LYNN HAVARD MIRVISS PRESIDING

PRESENT: Directors Havard Mirviss, Hawkins, House, and Francis; M. Manga, MD, Vice Chief of Staff; G. Herbst, CEO; T. Rayner, SVP & COO; R. Sawyer, VP & CNO, M. Tupper, VP & CFO; D. Cox, VP of Human Resources, M. Mertz, VP of Strategic Planning and Business Development, D. Leeper, VP & CIO; D. Lynch, Legal Counsel, C. Moccio, Recording

ABSENT: Director Hipkind

The meeting was called to order at 6:00PM by Director Havard Mirviss.

Director Havard Mirviss entertained a motion to approve the agenda.

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

**PUBLIC/MEDICAL STAFF PARTICIPATION**

- None.

**CLOSED SESSION ACTION TAKEN:** Approval of the closed meeting minutes – September 23, 2019.

Authorized management to enter into the necessary agreements and take all necessary steps for the development of a new multi-specialty clinic at 1000 N. Mooney Blvd. in Tulare at or below the estimated budget of \$5,200,000.

**RECOGNITIONS** – Lynn Havard Mirviss

- Presentation of Resolution 2049 to Joyce Bergshoeff, RN, ICCU-3W - Service Excellence Award – October 2019 (copy attached to the original of these minutes and considered a part thereof).

**OPEN MINUTES** – Request for approval of the September 23, 2019 open board of directors meeting minutes.

- Deferred until the next Board meeting.

**CONSENT CALENDAR** – Director Havard Mirviss entertained a motion to approve the consent calendar. Director House requested the removal of the following items; 7.1B and 7.1E.

*MMSC (Hawkins/Francis) to approve the consent calendar with the removal of items; 7.1B {Reports: Risk Management} and 7.1E {Reports: Semi Annual Investment Report}. This was supported unanimously by those present. Vote: Yes – Havard Mirviss, Hawkins, House, and Francis*

- 7.1. REPORTS
  - A. Medical Staff Recruitment
  - B. Risk Management
  - C. Medical-Surgical – 2S Clinical Decision Unit-CDU, 2N, Tele, 3S Oncology
  - D. Post Surgical Care – 4S, 3N, Broderick Pavilion
  - E. Semi Annual Investment Report
- 7.2. POLICIES
  - A. HUMAN RESOURCES
 

|     |  |        |         |
|-----|--|--------|---------|
| 1.  | Just Culture                                       | HR.00  | New     |
| 2.  | Recruitment and Selection of Staff Members         | HR.28  | Revised |
| 3.  | New Hire Processing                                | HR.36  | Revised |
| 4.  | Status Classification of Employees/Concurrent Jobs | HR.61  | Revised |
| 5.  | Timekeeping  | HR.63  | Revised |
| 6.  | Overtime   | HR.71  | Revised |
| 7.  | Salary Administration                              | HR.78  | Revised |
| 8.  | Docking  | HR.80  | Revised |
| 9.  | Non-Employees                                      | HR.233 | Revised |
| 10. | Per Diem Staff                                     | HR.29  | Deleted |
| 11. | Working at Two or More Kaweah Delta Health         |        |         |
| 12. | Care District Job                                  | HR.32  | Deleted |
| 13. | Supplemental Staffing                              | HR.35  | Deleted |
- 7.3. Approve Resolution 2050 returning the claim for Luis Alfonso Garcia Viscarra vs. Kaweah Delta Health Care District.
- 7.4. Recommendation from the Medical Executive Committee (OCTOBER 2019)
  - A. Medical Staff Policy
    - 1. MS.43 Informed Consent for Surgical, Diagnostic, or Therapeutic Procedure
  - B. Medical Staff Bylaws and Rules and Regulations revisions
- 7.5. Request for appointment to the Kaweah Delta Health Care, Inc. Board effective November 1, 2019: 11/01/19 – 10/31/22; John Hipskind, MD, Marc Mertz, and Darrin Smith, MD.
- 7.6. Approval of Resolution 2052 in recognition of Betty Sumwalt, RN, Employee Health Services retiring from duty at Kaweah Delta Health Care District – 38 years of services.
- 7.7. Approval of Resolutions restating the Kaweah Delta Health Care District Employee Salary Deferral Plan as reviewed and supported by the Human Resources Committee on October 22, 2019.
  - A. Approval of Resolution 2053 restating the Kaweah Delta Health Care District Employee Salary Deferral Plan in Section 15.01 of the Plan’s Base Plan document effective January 5, 2003.

- B. Approval of Resolution 2054 restating the Kaweah Delta Health Care District Employee Salary Deferral Plan in Section 15.2 of the Plan's Base Plan document effective July 1, 2009.
- C. Approval of Resolution 2055 restating the Kaweah Delta Health Care District Employee Salary Deferral Plan in Section 7.1 of the Plan's Base Plan document effective July 1, 2012.
- D. Approval of Resolution 2056 restating the Kaweah Delta Health Care District Employee Salary Deferral Plan in Section 14.01 of the Plan's Base Plan document effective January 1, 2020.
- E. Approval of Resolution 2057 amending the 457(b) deferred compensation plan in section 14.01 of the Plan's Base Plan document effective July 1, 2017 as reviewed and supported by the Human Resources Committee on October 22, 2019.

**7.1B {Reports – Risk Management}**

- Inquiry relative to increased number of MIDAS reports related to patient issues. It was noted that this change is due to the form being easier to complete and the ability to report anonymously.

**7.1E {Reports – Semi Annual Investment Report}**

- Director House noted his concern relative to our daily expenses growing faster than our surplus funds. Inquired if there is a way to increase our surplus funds or cut the daily expenses. Management noted that we are working to do both.

*MMSC {House/Francis} to approve 7.1B {Reports: Risk Management} and 7.1E {Reports: Semi Annual Investment Report}. This was supported unanimously by those present.*

*Vote: Yes – Havard Mirviss, Hawkins, House, and Francis*

**ANNUAL AUDITED FINANCIAL STATEMENT** – Report to Board from Moss Adams relative to the annual audited financial statement for fiscal year 2018/2019 (copy attached to the original of these minutes and considered a part thereof) - *Kaweah Delta; Malinda Tupper, VP & Chief Financial Officer, Jennifer Stockton, Director of Finance, Moss Adams; Brian Conner, Partner*

*MMSC {House/Hawkins} to approve the 2018/2019 Annual Audited Financial Statement. This was supported unanimously by those present. Vote: Yes – Havard Mirviss, Hawkins, House, and Francis*

**QUALITY – CARDIOLOGY SERVICES** - A review of key quality indicators and actions through the American College of Cardiology quality program (copy attached to the original of these minutes and considered a part thereof) - Verma, MD, Director of Cardiac Cath Lab

**PRELIMINARY RESOLUTION FOR THE REFINANCING OF THE 2012 REVENUE BONDS** - Review of Resolution 2051, as reviewed and recommend for approval by the Finance, Property, Services, and Acquisition Committee (10/24/19) authorizing certain officers of

the District to take steps necessary for the potential issuance of revenue bonds (copy attached to the original of these minutes and considered a part thereof) - Kaweah Delta; Malinda Tupper, VP & Chief Financial Officer, Jennifer Stockton, Director of Finance

*MMSC (House/Francis) to approve Resolution 2051, a resolution of the Board of Directors of Kaweah Delta Health Care District authorizing consideration for the issuance of revenue bonds pursuant to the California Health and Safety Code and the California Government Code and a declaration of official intent to reimburse expenditures from the proceeds of tax-exempt bonds. This was supported unanimously by those present. Vote: Yes – Havard Mirviss, Hawkins, House, and Francis*

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

**REBRANDING** – Presentation and discussion relative to the Kaweah rebranding initiative as reviewed by the Board Marketing and Public Affairs Committee (copy attached to the original of these minutes and considered a part thereof) - Marc Mertz, Vice President of Strategic Planning and Business Development, Dru Quesnoy, Director of Marketing and Communications, and Jennifer Manduffie, Sr. Graphic Designer

**CREDENTIALING** – Monica Manga, MD - Vice Chief of Staff - Medical Executive Committee request 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.

Director Havard Mirviss requested a motion for the approval of the credentials report {copy attached to the original of these minutes and considered a part thereof}.

MMSC (Hawkins/House) 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. Vote: Director Havard Mirviss, House, Hawkins & Francis – Yes.

**CHIEF OF STAFF REPORT** – Report from Monica Manga, MD – Vice Chief of Staff

- No report.

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

- District Hospital Leadership Forum annual meeting.
  - Split roll bill property taxes and Prop 13 on assess value not market value. Assessed value can only go up 2% per year. The proposed bill will split the tax roll into residential and commercial. New commercial assessed value will be based on the market value to be taxed. Concern about how that will impact the ability to get a bond measure approved. CHA is coming out in support and requested DHLF to support.
  - SB227 additional penalty for non 100% compliance for nursing ratios. We are waiting to find out how they will implement it. We are working on ways to mitigate it.
- Ryan Gates and Federally Qualified Health Clinic (FQHC) team are making progress. We are on target to submit our application in January 2020.

**BOARD PRESIDENT REPORT** – Report from Lynn Havard Mirviss, Board President:

- No report

**Adjourn** - Meeting adjourned at 8:12PM

Lynn Havard Mirviss, Board President  
Kaweah Delta Health Care District and the Board of Directors  
Thereof

ATTEST:

Nevin House, Secretary/Treasurer  
Kaweah Delta Health Care District Board of Directors

# Service Excellence November 2019

## Kristin Braswell, RN – Clinical Documentation

**1. Nominated By:** Christine Thomas

**BEHAVIORAL STANDARDS OF PERFORMANCE:**

**Respect:** Kristin is intelligent and holds a vast amount of knowledge that she is willing to share with her co-workers. She is approachable and friendly, often stopping her work to answer the questions of others.

**Communication:** Kristin communicates the needs of the department and is often a spokesperson for the other employees in our department when there is a problem with the computer program, etc.

**Personal Ownership:** She takes her role in the CDI department seriously. Puts a lot of effort into making sure her quality of work in her patient chart reviews is accurate to reflect the best DRG for reimbursement.

**Professional Image:** Kristin presents herself in a classy way. She always is neat, tidy and reflects a professional image.

**Commitment to Colleagues:** I feel Kristin shows her commitment to her colleagues because she has stepped forward and has tackled a difficult job duty in our department that requires a lot of tedious evaluation and time. She is exceptionally good at what she does and has improved the quality of our outcomes for our department. She does this job without complaining.

**COMMENTS:** Kristin is always available to her co-workers and stops what she is doing to assist them. She is great resource person and often helps problem solve. Kristin is intelligent, hardworking and carries a lot of responsibility in our department that has reflected a positive change in our productive outcomes. She is a pleasure to work with and her quiet humor is priceless.

**2. Nominated By:** Rebekah Foster

**Comments:** Kristin has done an amazing job the last 6 months when asked to help with a second level review process back in February to assist with quality documentation and coding, she jumped at the opportunity and has consistently found errors that she has worked diligently to correct with both the physicians and the coders to ensure that the documentation for each case she reviews is correct and accurately shows the course of treatment and correct diagnoses the patient had. she has tirelessly worked hard dealing with difficult physicians and contract coders to ensure that each record is accurate and has gone above and beyond her normal scope of practice in ensuring this new process is successful. She has found multiple instances of errors each month that she was able to correct which has directly affected billing and reimbursement for the hospital. She has done an amazing job at stepping up and taking on this difficult task and is always willing to help her coworkers. She is a huge asset to our department.

**3. Nominated By:** Elizabeth Hupp

**Comments:** Kristin goes above and beyond in her CDI duties. She was given the task of doing second level reviews on patients' charts and has been doing an EXCELLENT job! She is very thorough in her reviews, and is very helpful in advising her CDI team co-workers when we have questions with chart reviews. Kristin is very knowledgeable and always has a great attitude!! I don't know what we'd do without her!!

**4. Nominated By:** Rosie Alavezos

BEHAVIORALSTANDARDSOFPERFORMANCE:

Compassionate Service: Helps everyone without asking

Respect: sweet and patient to all

Commitment to Colleagues: always willing to help coworkers when approached.

**COMMENTS:** I would like to nominate Kristin because she is an amazing human, friend and co-worker, which I have the pleasure to work with. I know that if I struggle with question or anything at all she is always willing and open to help anytime, any day even in her days off. For that and much more I believe that Kristin deserve the employee of the month award. Thank you

## Kaweah Delta Physician Recruitment Open Position Snapshot - November 2019

Prepared by: Brittany Taylor, Senior Physician Recruiter btaylor@kdhcd.org - (559)624-2899

Date prepared: 11/20/2019

| <b>Central Valley Critical Care Medicine</b> |   |
|--|---|
| Hospitalist                                  | 4 |
| Intensivist                                  | 4 |

| <b>Delta Doctors Inc.</b> |   |
|---------------------------|---|
| Adult Primary Care        | 1 |
| OB/Gyn                    | 2 |
| Laborist                  | 1 |

| <b>Key Medical Associates</b> |   |
|-------------------------------|---|
| Adult Primary Care            | 1 |
| Gastroenterology              | 1 |
| Hospitalist                   | 1 |
| Pediatrics                    | 1 |

| <b>Orthopedics</b>        |   |
|---------------------------|---|
| Orthopedic Surgery - Hand | 1 |

| <b>Sequoia Radiation Oncology Medical Associates</b> |   |
|--|---|
| Radiation Oncology                                   | 1 |

| <b>Somnia</b>                       |   |
|-------------------------------------|---|
| Anesthesiology - Cardiac & Vascular | 1 |

| <b>Valley Children's Health Care</b> |   |
|--------------------------------------|---|
| Maternal Fetal Medicine              | 2 |

| <b>Valley Hospitalist Medical Group</b> |   |
|---|---|
| Nocturnist                              | 1 |
| GI Hospitalist                          | 1 |

| <b>Visalia Medical Clinic (Kaweah Delta Medical Foundation)</b> |   |
|---|---|
| Dermatology   | 2 |
| Gastroenterology  | 2 |
| Internal Medicine   | 1 |
| OB/GYN  | 3 |
| Orthopedic Surgery  | 1 |
| Otolaryngology  | 1 |
| Pediatrics  | 2 |
| Psychiatry  | 2 |
| Radiology - Diagnostic  | 1 |
| Rheumatology  | 1 |
| Urology   | 1 |
| Palliative Medicine   | 2 |

| <b>Kaweah Delta Faculty Medical Group</b>  |   |
|--|---|
| Family Medicine Associate Program Director | 1 |
| Family Medicine Core Faculty               | 1 |
| Family Medicine Medical Director           | 1 |
| Family Medicine Program Director           | 1 |

**Candidate Activity**

| Specialty/Position  | Group  | Last Name             | First Name | Availability | Board Certification                            | CA Licensed | Referral Source   | Current Status   |
|---|--|-----------------------|------------|--------------|--|-------------|---|--|
| Anesthesiology - Pain   | Somnia   | Sandhu, M.D.          | Navpark    | 05/19        | American Board of Anesthesiology, Certified    | Active      | Somnia  | Offer accepted; Start Date: 12/1/19  |
| Cardiothoracic Surgery  | Golden State Cardiac & Thoracic Surgery                  | Carrizo, M.D.         | Gonzalo    | 10/19        | American Board of Thoracic Surgery, Certified  | Active      | Cleveland Clinic Foundation affiliate job posting - 7/27/18 | Locum Start Date: 12/7/19  |
| Endocrinology   | Key Medical Associates                                   | Chahal, M.D.          | Rajinder   | 11/19        | American Board of Internal Medicine, Certified | Active      | Internal Referral   | Site Visit: 7/2/19; Offer accepted; Group Start date: 11/4/2019; KD start date pending privileges. |
| Family Medicine   | Visalia Medical Clinic (Kaweah Delta Medical Foundation) | Bland, D.O.           | Scott      | 08/21        | American Board of Family Medicine, Eligible    | None        | Direct - 9/15/19  | Pending site visit in early 2020   |
| Family Medicine   | Key Medical Associates                                   | Jones, M.D.           | Nicholas   | 08/20        | American Board of Family Medicine, Eligible    | None        | Carson Kolb   | Site Visit: 9/14/19; Offer extended  |
| Family Medicine   | Delta Doctors, Inc.                                      | Macias, M.D.          | Lea        | 08/20        | TBD  | Active      | Current KDH Resident  | Site Visit: 11/25/19   |
| Family Medicine   | Visalia Medical Clinic (Kaweah Delta Medical Foundation) | Singh, M.D.           | Sholin     | 08/20        | TBD  | Active      | Direct - UCSF Fresno Career Fair                            | Site visit pending dates   |
| Family Medicine Core Faculty                                  | Kaweah Delta Faculty Medical Group                       | Arellano-Banoni, M.D. | Gisela     | 10/19        | American Board of Family Medicine, Certified   | Active      | Internal Referral   | Site Visit: 9/25/19; Offer extended  |
| Family Medicine - Program Director/Associate Program Director | Kaweah Delta Faculty Medical Group                       | Martinez, M.D.        | Mario      | TBD          | American Board of Family Medicine, Certified   | Active      | Internal Referral   | Site Visit: 11/22/19   |
| Family Medicine   | Key Medical Associates                                   | Janvelian, M.D.       | Vladimir   | 09/20        | American Board of Family Medicine, Eligible    | None        | Carson Kolb - 11/28/18                                      | Site Visit: 2/15/19; Offer accepted; Start date pending  |
| Family Medicine   | Visalia Medical Clinic (Kaweah Delta Medical Foundation) | Patty, M.D.           | Christina  | 08/20        | American Board of Family Medicine, Eligible    | Active      | Direct - Local Candidate                                    | Site Visit: 2/5/19; Offer accepted; Start Date: 8/31/20  |
| Gastroenterology  | Key Medical Associates                                   | Jaafar, M.D.          | Imad       | 08/20        | American Board of Internal Medicine, Certified | In progress | 2019 Digestive Disease Week Career Fair                     | Site Visit: 7/27/19; Offer extended; 2nd visit: 11/9/19  |

### Candidate Activity

| Specialty/Position   | Group                                 | Last Name        | First Name | Availability | Board Certification                            | CA Licensed | Referral Source              | Current Status  |
|----------------------|---------------------------------------|------------------|------------|--------------|--|-------------|------------------------------|---|
| Hospitalist - Nights | Valley Hospitalist Medical Group      | Gadhia, M.D.     | Shardul    | TBD          | American Board of Internal Medicine, Certified | None        | Direct Candidate             | Site Visit: 10/25/19  |
| Hospitalist          | Central Valley Critical Care Medicine | Destia, M.D.     | Edomias    | 08/20        | TBD  | None        | Referral - Dr. Sukhvir Singh | Site Visit: 11/22/19  |
| Hospitalist          | Central Valley Critical Care Medicine | Diramerian, M.D. | Liza       | 08/20        | TBD  | None        | Referral - Dr. Umer Hayyat   | Site Visit: 12/18/19  |
| Hospitalist          | Central Valley Critical Care Medicine | Li, M.D., Ph.D.  | Yuehua     | 08/20        | American Board of Internal Medicine, Eligible  | Active      | Vista Staffing - 11/5/2019   | Site visit pending dates  |
| Hospitalist          | Central Valley Critical Care Medicine | Mavli, M.D.      | Zakiamad   | TBD          | American Board of Family Medicine, Certified   | Active      | Direct Candidate             | Site Visit: 9/10/19   |
| Hospitalist          | Central Valley Critical Care Medicine | Singh, M.D.      | Gurpreet   | 07/20        | American Board of Internal Medicine, Eligible  | None        | PracticeLink - 10/9/19       | Currently under review  |
| Hospitalist          | Central Valley Critical Care Medicine | Singh, M.D.      | Sukhvir    | 07/20        | American Board of Internal Medicine, Eligible  | Pending     | Vista Staffing - 8/12/2019   | Site Visit: 9/23/19   |
| Hospitalist          | Central Valley Critical Care Medicine | Tran, M.D.       | Michelle   | TBD          | American Board of Internal Medicine, Certified | Active      | Mdstaffers - 10/9/19         | Currently under review  |
| Hospitalist          | Central Valley Critical Care Medicine | Wang, M.D.       | Yanning    | 07/20        | TBD  | Active      | Vista Staffing - 11/18/19    | Currently under review  |
| Hospitalist          | Central Valley Critical Care Medicine | Youssef, M.D.    | Mina       | 07/20        | American Board of Internal Medicine, Eligible  | None        | Vista Staffing - 10/1/19     | Currently under review  |
| Hospitalist          | Central Valley Critical Care Medicine | Zhang, M.D.      | Yixi       | ASAP         | American Board of Internal Medicine, Certified | Pending     | Vista Staffing - 10/11/19    | Site visit pending dates  |
| Hospitalist          | Central Valley Critical Care Medicine | Hayyat, M.D.     | Umer       | 08/20        | American Board of Internal Medicine, Eligible  | In progress | Practice Link                | Site Visit: 8/14/19; Offer accepted                                   |
| Hospitalist          | Central Valley Critical Care Medicine | Milani, M.D.     | Kasra      | 11/19        | American Board of Internal Medicine, Certified | Active      | Vista Staffing - 8/12/2019   | Site Visit: 8/22/19; Offer accepted; Start date pending credentialing |
| Hospitalist          | Central Valley Critical Care Medicine | Upton, M.D.      | Tracy      | 08/20        | American Board of Internal Medicine, Eligible  | Active      | Vista Staffing - 9/12/19     | Site Visit: 10/17/19; Offer accepted                                  |

| Candidate Activity      |  |                    |            |              |   |             |                                   |   |
|-------------------------|--|--------------------|------------|--------------|---|-------------|-----------------------------------|---|
| Specialty/Position      | Group  | Last Name          | First Name | Availability | Board Certification   | CA Licensed | Referral Source                   | Current Status  |
| Intensivist             | Central Valley Critical Care Medicine/Valley Hospitalist | Emami, M.D.        | Nader      | 07/20        | American Board of Internal Medicine, Certified; Critical Care Medicine, Eligible                            | None        | Comp Health 10/1/19               | Site visit pending dates  |
| Intensivist             | Central Valley Critical Care Medicine/Valley Hospitalist | Greer, M.D.        | Robert     | 08/20        | TBD   | Active      | Vista Staffing - 11/18/19         | Currently under review  |
| Intensivist             | Central Valley Critical Care Medicine                    | John, D.O.         | Avinaj     | 08/21        | TBD   | None        | Vista Staffing - 10/25/19         | Site Visit: 12/13/19  |
| Intensivist             | Central Valley Critical Care Medicine                    | Kelker, M.D.       | Tariq      | TBD          | American Board of Surgery - General, Certified; American Board of Critical Care, Eligible - results pending | Active      | MDstaffers - 10/11/19             | Site visit pending dates  |
| Intensivist             | Central Valley Critical Care Medicine                    | Rubinchikova, M.D. | Yelena     | 12/19        | American Board of Internal Medicine, Eligible   | None        | Fidelis Partners - 8/14/19        | Site Visit: 10/21/19; offer pending   |
| Internal Medicine       | Visalia Medical Clinic (Kaweah Delta Medical Foundation) | Malik, M.D.        | Sara       | 08/21        | American Board of Internal Medicine, Eligible   | None        | Direct - Dr. Umer Hayyat's spouse | Pending site visit in early 2020  |
| Maternal Fetal Medicine | Valley Children's Hospital                               | Acosta, M.D.       | Reinaldo   | TBD          | American Board of OB/GYN, Certified; American Board of OB/GYN - Maternal Fetal Medicine - Certified         | Active      | Valley Children's - 7/11/2019     | Site Visit: 7/30/19; Possible locums to permanent                           |
| Neonatology             | Valley Children's Hospital                               | Ibonia, M.D.       | Katrina    | 12/19        | American Board of Pediatrics; Neonatal-Perinatal, Certified   | None        | Valley Children's - 8/1/2019      | Site Visit: 8/27/19; Offer accepted; Start date: 3/9/20                     |
| Neonatology             | Valley Children's Hospital                               | Gerard, M.D.       | Kimberley  | 01/20        | American Board of Pediatrics, Eligible (Exam 10/2019)   | Active      | Valley Children's - 11/28/18      | Site Visit: 1/11/19; Tentative start date: 1/6/20; Assigned to KD full-time |
| OB/GYN                  | Delta Doctors, Inc.                                      | Hayes, M.D.        | Carl       | TBD          | TBD   | Active      | Physician Empire - 10/29/19       | Site Visit: 12/10/19  |

**Candidate Activity**

| Specialty/Position         | Group  | Last Name        | First Name | Availability | Board Certification  | CA Licensed | Referral Source              | Current Status   |
|----------------------------|--|------------------|------------|--------------|--|-------------|------------------------------|--|
| OB/GYN                     | Delta Doctors, Inc.                                      | Saleh, M.D.      | Gamal      | 01/20        | American Board of Obstetrics & Gynecology, Certified               | None        | Mdstaffers - 9/6/19          | Site visit pending                                       |
| Otolaryngology             | Visalia Medical Clinic (Kaweah Delta Medical Foundation) | Badran, M.D.     | Karam      | 08/20        | American Board of Otolaryngology – Head and Neck Surgery, Eligible | Active      | Fidelis Partners - 8/8/2019  | Site Visit: 10/14/19; Offer extended                     |
| Otolaryngology             | Visalia Medical Clinic (Kaweah Delta Medical Foundation) | Neel, M.D.       | Gregory    | 08/20        | American Board of Otolaryngology – Head and Neck Surgery, Eligible | None        | AAO-HNS Job Posting          | Site visit pending dates                                 |
| Orthopedic Surgery - Spine | Orthopaedic Associates                                   | Daniels, M.D.    | Mathias    | TBD          | American Board of Orthopedic Surgery, Certified                    | Active      | Fidelis Partners - 3/28/19   | Site visit: 6/27/19; Offer accepted; Start date: 12/2/19 |
| Palliative Medicine        | Visalia Medical Clinic (Kaweah Delta Medical Foundation) | Mylavarapu, M.D. | Alexander  | 08/20        | American Board of Hospice & Palliative Medicine, Eligible          | None        | Fidelis Partners - 9/30/19   | Site visit: 11/5/19; Offer pending                       |
| Pediatrics                 | Visalia Medical Clinic (Kaweah Delta Medical Foundation) | Currie, D.O.     | Kristen    | 03/20        | American Board of Pediatrics, Certified                            | In progress | Practice Match - 9/17/19     | Site Visit: 10/28/19                                     |
| Pediatrics                 | Visalia Medical Clinic (Kaweah Delta Medical Foundation) | Wendt, M.D.      | Allen      | 12/19        | American Board of Pediatrics, Certified                            | Active      | Pacific Companies - 10/25/19 | Site Visit: 11/6/19; Offer pending                       |
| Radiation Oncology         | Sequoia Radiation Oncology Medical Associates            | Chang, D.O.      | Tangel     | 01/20        | American Board of Radiology - Radiation Oncology, Certified        | Active      | ASTRO Conference 2017        | Site Visit: 10/7/19; 2nd visit: 10/28/19; Offer pending  |

# Kaweah Delta Health Care District Annual Report to the Board of Directors, 11/2019

## Renal Services (Inpatient 4North and Dialysis Clinics)

Amy Baker, MSN, CMSRN Director Renal Services 559-624-5423

Jon Knudsen, MSN, FNP-C Director Critical Care Services, 559-624-2503

### Summary Issue/Service Considered

- Continually working to recruit open positions, reduce contract labor, and retain our high quality staff.
- Active surveillance of all quality measures including and focused improvements in fall prevention, Hospital Acquired Pressure Injuries (HAPI), and falls with injury.
- Continued optimization efforts regarding KDHUB for the areas on both the main campus as well as the outpatient clinics and acute dialysis
- Nursing remains focused on charge nurse and staff development to further improve the patient experience; each unit has focused goals in the form of “Operation Always” plans of action which includes meeting with the patient experience director monthly to review satisfaction scores and performance of individual questions.
- Collaborating with the violence in the workplace taskforce to better identify escalation in our mental health patients being treated on 4 North
- Continuous Ambulatory Peritoneal Dialysis (CAPD) clinic has increased census from 30 to 35 patients

### Quality/Performance Improvement Data

- Overall patient satisfaction reached 70.7% through October for Fiscal Year '20 on 4 North. We continue to work with the Patient Experience Director to identify best practices specific to the patient populations for maximum impact to increase scores and number of surveys completed.
- The dialysis clinic continues to rank in the top 5% for all California outpatient clinics in patient satisfaction.

4N monitors the following nurse sensitive quality indicators:

| CLINICAL QUALITY  | 4 North |      |      |      |
|---|---------|------|------|------|
|   | 3Q18    | 4Q18 | 1Q19 | 2Q19 |
| Central line associated blood stream infection (CLABSI) | 0.00    | 0.00 | 1.00 | 1.00 |
| NHSN Mean   | 1.50    | 1.50 | 1.50 | 1.50 |
| Catheter associated urinary tract infection (CAUTI)     | 0.00    | 0.00 | 1.00 | 1.00 |
| NHSN Mean   | 1.50    | 1.50 | 1.50 | 1.50 |
| Falls/1000 pt days                                      | 2.75    | 0.78 | 1.22 | 3.73 |
| NDNQI Mean  | 3.06    | 3.28 | 2.98 | 2.98 |
| Injury Falls/1000 pt days                               | 0.39    | 0.39 | 0.00 | 0.41 |
| NDNQI Mean  | 0.66    | 0.63 | 0.62 | 0.62 |
| % pts. Stage 2+HAPI - 1 Day PREVALENCE                  | 0.00    | 0.00 | 0.00 | 0.00 |
| *Hospital Acquired Pressure Injury                      | 1.36    | 1.08 | 1.31 | 1.20 |
| Hypoglycemia (% Patient Days < 70)                      | 4.80    | 5.70 | 5.80 | 5.90 |
| KDHCD Mean  | 3.30    | 3.20 | 3.20 | 3.50 |

## Policy, Strategic or Tactical Issues

- 4N performs weekly prevalence rounds evaluating skin and urinary/bloodstream catheters.
- The vast majority of patients on 4North are diabetics, many of which with complicated out-of-control blood sugars; resulting in difficult to maintain optimal blood sugars; and therefore have the highest population above the mean for normal blood sugar levels.
- 4N continues to work with the post-surgical departments for Post-Surgical Acute Kidney Injury (AKI) reduction.
- Dialysis clinic continues to engage in efforts to increase fistula rates and decrease central lines.
- Plans for reduction in length of stay for newly diagnosed kidney failure and sepsis patients.
- 4N performs daily discharge rounds and participates in discharge management/throughput committees on a bimonthly basis.
- Coordinated the addition of a patient risk for violence assessment for inpatient/outpatient areas.
- Coordinated the transition of new workflow for Restraint documentation and monitoring.
- Coordinating the workflow of patients that present to the emergency department with a dialysis related/access issue; with efforts to keep them from needing to be admitted for outpatient-related care.

## Recommendations/Next Steps

- Focused efforts on reduction in length of stay for sepsis, AKI and vascular access patients.
- Continued focused efforts on improving the patient experience and inspiring a culture of excellence within our staff.
- Collaboration with human resources on staff satisfaction survey action plans through the recent employee engagement survey.
- Continued KDHub optimization related to documentation, policies and medication administration safety.
- Maintain sustained improvements CAUTI, CLABSI, HAPI and falls and falls with injury reduction.
- Focused efforts on improving compliance with Heparin and blood administration.
- Continue focused partnership with the Clinical Education team and Advanced Practice Nurses to shore up the on-boarding and orientation process for new staff on all units.
- Continue to promote active engagement of our physician partners.
- Finance is working on a way to report the outpatient service line revenue separating hemodialysis (blood) from peritoneal dialysis (abdomen).

## Approvals/Conclusions

- Strive for overall quality outcomes and set goals to continue to improve.
- Overall increase in outpatient CAPD patient care volumes:
  - CAPD clinic increased by nearly 20% (5-6 patients)
- Collaboration with finance, patient accounting and insurance contracts to find ways to become a more profitable service line. Currently evaluating and revenue collection.

# KDHCD ANNUAL BOARD REPORT

## OUTPATIENT DIALYSIS SERVICES - *Summary*

FY2019

### KEY METRICS - FY 2019



\*Note: Arrows represent the change from prior year and the lines represent the 3-year trend

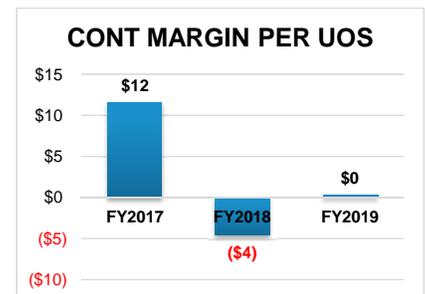
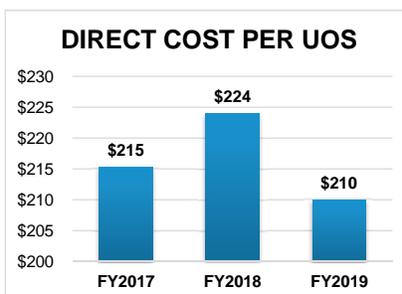
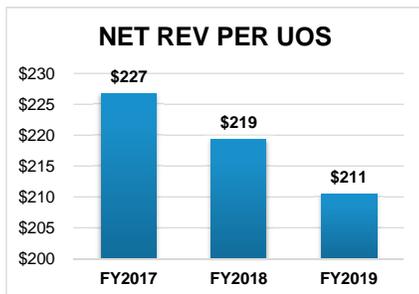
### FY 2019 METRICS

| SERVICE LINE        | STATISTIC | NET REVENUE | NET REV PER UOS | CONTRIBUTION MARGIN |
|---------------------|-----------|-------------|-----------------|---------------------|
| OUTPT DIALYSIS SVCS | 32,445    | \$6,831,754 | \$211           | \$10,006            |

### DIALYSIS TOTALS - 3 YEAR TREND

| METRIC               | FY2017        | FY2018        | FY2019        | %Change from Prior Yr | 3 YR Trend |
|----------------------|---------------|---------------|---------------|-----------------------|------------|
| STATISTIC            | 29,304        | 30,012        | 32,445        | ↑ 8%                  |            |
| NET REVENUE          | \$6,646,400   | \$6,584,431   | \$6,831,754   | ↑ 4%                  |            |
| DIRECT COST          | \$6,308,447   | \$6,718,971   | \$6,821,748   | ↑ 2%                  |            |
| CONTRIBUTION MARGIN  | \$337,953     | (\$134,539)   | \$10,006      | ↑ 107%                |            |
| INDIRECT COST        | \$2,359,665   | \$2,464,959   | \$2,294,012   | ↓ -7%                 |            |
| NET INCOME           | (\$2,021,711) | (\$2,599,498) | (\$2,284,006) | ↑ 12%                 |            |
| NET REV PER UOS      | \$227         | \$219         | \$211         | ↓ -4%                 |            |
| DIRECT COST PER UOS  | \$215         | \$224         | \$210         | ↓ -6%                 |            |
| CONTR MARGIN PER UOS | \$12          | (\$4)         | \$0           | ↑ 107%                |            |

### GRAPHS



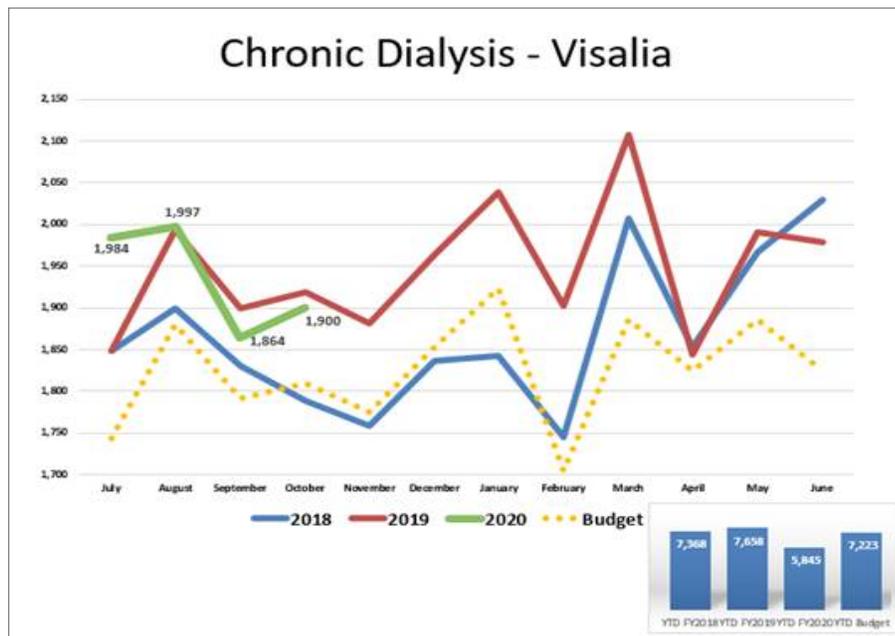
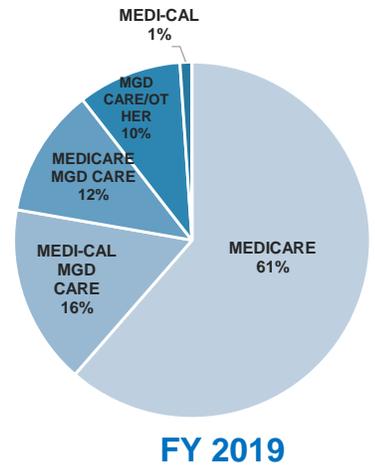
# KDHCD ANNUAL BOARD REPORT

## OUTPATIENT DIALYSIS SERVICES - *Summary*

FY2019

### PAYER MIX - 3 YEAR TREND

| PAYER             | FY2017 | FY2018 | FY2019 |
|-------------------|--------|--------|--------|
| MEDICARE          | 68%    | 63%    | 61%    |
| MEDI-CAL MGD CARE | 12%    | 15%    | 16%    |
| MEDICARE MGD CARE | 11%    | 12%    | 12%    |
| MGD CARE/OTHER    | 8%     | 8%     | 9%     |
| MEDI-CAL          | 2%     | 1%     | 1%     |
| CASH PAY          | 0%     | 0%     | 0%     |



# Kaweah Delta Health Care District Annual Report to the Board of Directors, 11/2019

## Medical ICU (2W) and Step Down ICU (3W)

Jon Knudsen, MSN, FNP-C  
Director Critical Care Services  
559-624-2503

### Summary Issue/Service Considered

- Proactively working with the cardiovascular critical care director and educators in developing our ongoing critical care nurse internship (CCNI) program.
- Continually working to recruit open positions, reduce contract labor, and retain our high quality staff.
- Active surveillance of all quality measures including and focused improvements in Hospital Acquired Pressure Injuries (HAPI), and Central Line Associated Bloodstream Infections (CLABSI); with the greatest focus currently on HAPIs with managers and educators performing weekly rounds.
- Continued optimization efforts regarding KDHub specific to critical care for both staff and physicians; namely medication administration.
- Collaborating with the Intensivist physician group to facilitate effective daily patient rounds in the ICU; and hospitalist group on 3West, enhancing both resident and nursing learning.
- We have continued growth of our Neurosurgical patients, led by Dr. Joe Chen. They have consulted and intervened with four-fold the number of patients we originally projected.

### Quality/Performance Improvement Data

- ICU and 3W continue to work with the Patient Experience Director to identify best practices to maximum impact to increase scores on inpatient units; as patients are rarely discharged from these 2 units.

2W and 3W monitor the following nurse sensitive quality indicators:

| CLINICAL QUALITY  | 2 West (ICU) |       |      |      | 3 West (ICCU) |      |      |      |
|---|--------------|-------|------|------|---------------|------|------|------|
|   | 3Q18         | 4Q18  | 1Q19 | 2Q19 | 3Q18          | 4Q18 | 1Q19 | 2Q19 |
| Central line associated blood stream infection (CLABSI) | 4.20         | 4.00  | 1.00 | 1.00 | 9.20          | 9.20 | 0.00 | 1.00 |
| NHSN Mean   | 0.80         | 0.80  | 0.80 | 0.80 | 0.90          | 0.90 | 0.90 | 0.90 |
| Catheter associated urinary tract infection (CAUTI)     | 2.20         | 2.20  | 1.00 | 0.00 | 3.20          | 1.70 | 0.00 | 1.00 |
| NHSN Mean   | 1.70         | 1.70  | 1.70 | 1.70 | 1.70          | 1.70 | 1.70 | 1.70 |
| Falls/1000 pt days                                      | 0.00         | 0.00  | 0.00 | 0.71 | 0.42          | 0.82 | 0.00 | 0.00 |
| NDNQI Mean  | 0.97         | 1.05  | 0.94 | 1.06 | 2.50          | 2.60 | 2.58 | 2.65 |
| Injury Falls/1000 pt days                               | 0.00         | 0.00  | 0.00 | 0.00 | 0.42          | 0.41 | 0.00 | 0.00 |
| NDNQI Mean  | 0.15         | 0.14  | 0.17 | 0.19 | 0.52          | 0.49 | 0.59 | 0.53 |
| % pts. Stage 2+HAPI - 1 Day PREVALENCE                  | 0.00         | 10.53 | 7.69 | 6.67 | 3.57          | 8.82 | 7.69 | 3.33 |
| *Hospital Acquired Pressure Injury NDNQI Mean           | 4.27         | 4.43  | 5.38 | 5.01 | 2.29          | 1.68 | 2.37 | 2.11 |
| Hypoglycemia (% Patient Days < 70)                      | 5.10         | 6.40  | 3.10 | 5.80 | 5.40          | 5.50 | 1.80 | 4.70 |
| KDHCD Mean  | 3.90         | 3.60  | 3.60 | 4.00 | 3.90          | 3.60 | 3.60 | 4.00 |

## Policy, Strategic or Tactical Issues

- Managers and assistant managers round daily focusing on central line necessity; which is part of the action plan for improvement on being higher than the mean.
- Patients receiving end of life care are more susceptible to skin breakdown and count in the quarterly prevalence studies, giving these areas a higher than preferred prevalence of skin issues.
- Sepsis reduction work has resulted in decreased mortality as well as a financial savings of more than one million dollars fiscal year ending 2019.
- ICU and 3W have active participation in the National Surgery and Quality Improvement Program (NSQIP), initiative Ventilator Associated Pneumonia (VAP) and Sepsis reduction.
- Both ICU and 3W perform daily interdisciplinary discharge rounds and participate in discharge management/throughput committees.
- Coordinated the transition to an electronic flowsheet for Heparin drip monitoring for all medical-surgical units, as it has been successful on ICU and 3W.
- Coordinated the transition of new workflow for Restraint documentation and monitoring through the efforts of the quality/performance improvement med surg/critical care nurse; including end of shift attestations as recommended by the Joint Commission.
- Collaborated with the environmental services director to streamline linen delivery, cleanup and utilization..

## Recommendations/Next Steps

- Work with the executive team to trial an automatic hand hygiene compliance tool; with the goal of reducing hospital acquired infections (HAI); will be implementing December 2019 for a 5 month trial in the ICU and 4 North (renal services).
- Continued efforts on reduction in length of stay for sepsis.
- Anticipating a full ICU refurbishment projected to begin in late Spring 2020.
- Continued focused efforts on improving the patient and family experience and inspiring a culture of excellence within our staff.
- Continued focus on staff satisfaction survey action plans from our recent employee engagement survey.
- Continued KDHub optimization related to documentation, policies and medication administration safety by working with the medication safety committee and the newly formed Nursing medication safety committee.
- Focused efforts on improving compliance with Heparin infusions and patients in restraints and compliant documentation.
- Continue focused partnership with the Clinical Education team and Advanced Practice Nurses to shore up the on-boarding and orientation process for new staff within the critical care floors.
- Continue to promote active engagement of our physician partners by attending their department meetings and by inviting them to the unit specific meetings like the comprehensive unit safety team meetings (CUSP).

## Approvals/Conclusions

- Strive for overall quality outcomes and set goals to continue to improve beyond the mean.

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

## Orthopedic Service Line

Jag Batth, Director  
Contact number: 559-624-3794  
November 7, 2019

### Summary Issue/Service Considered

1. Providing exceptional comprehensive orthopedic care through quality outcomes, efficiency, and cost effective care.
2. Ensuring that Orthopedics Services continues to provide the full continuum of services to the community.

### Analysis of financial/statistical data:

The orthopedic service line had a contribution margin of \$11,635,588 this fiscal year, compared to \$7,464,895 last year. The orthopedic service line experienced a 56% increase in contribution margin compared to the previous year. The increase in contribution margin is related to the decrease in direct cost by reducing the LOS, decrease with implant cost, and increase with overall inpatient surgical cases. There was an overall 9% increase in volume from 3,840 cases to 4,172 cases.

The inpatient surgical orthopedic volume increased by 13% compared to the previous year. The contribution margin per case improved by \$1190 (23%), and the direct cost per case declined by \$1764 (-12%) per case. The inpatient orthopedic service had a substantial contribution margin of \$9,914,903, an overall increase of 39% compared to last year. The orthopedic net income ended the year with \$4,642,117 compared to the previous year, \$2,170,923.

The inpatient medical orthopedic volume increased by 13% compared to the previous year. The contribution margin per case improved by \$16 (1%), and the direct cost per case declined by \$658 (-10%) per case. The inpatient medical orthopedic service line contribution margin ended the year with \$1,372,737 compared to the previous year, \$1,211,437.

The outpatient orthopedic volume increased by 5% compared to the previous year. For the first time in three years, the outpatient orthopedic surgery service line had a positive contribution margin of \$347,948. In FY 2018, it was a negative contribution of -\$882,773 and FY 2017 was a negative contribution of -\$112,360. The increase in the contribution is related to both decreasing the direct cost per case to \$3,707 (-11%) and increase the net revenue per case to \$3,868 (4%). The payer mix remained stable with the outpatient orthopedic surgical volume.

## Quality/Performance Improvement Data

Actively working with the marketing department to provide educational events in the community lead by the orthopedic surgeons. Orthopedic surgeons are directly collaborating with local primary care physicians to build long-term referral relationships. Able to increase orthopedic primary market share by .5% (60.7% overall) and the secondary market by 5.6% (27.6% overall) compared to the previous year.

According to the National Surgical Quality Improvement Program (NSQIP), Kaweah Delta continues to outperform the national benchmark related to orthopedic surgical complications in the following areas: urinary tract infections, pneumonia, VTE (venous thromboembolism prophylaxis), and surgical site infections.

Orthopedics continues to work closely with the trauma department to track the orthopedic trauma transfers. Cases are reviewed on a quarterly basis. We are working closely with the orthopedic traumatologist to provide additional call coverage and currently establishing a fair market case rate with the compliance department.

Patient satisfaction with the orthopedic physicians continues to average in the 68th percentile compared to their peer group.

The average length of stay for elective joint replacement patients is 1.53 days compared nationally to 1.97 days.

Performance and trends are carefully monitored for implant cost per case, joint camp attendance, infection rates, re-admission rates, complication rates, and functional assessments. Case reviews are completed with surgeons regarding infection, re-admission, and complications.

Orthopedics continues to be designated as Blue Distinction Center for the spine, knee, and hip replacement. To earn this distinction, we have a full range of patient support services with multidisciplinary teams to coordinate and streamline care, including shared decision making and preoperative patient education.

## Policy, Strategic or Tactical Issues

1. The orthopedic co-management arrangement was implemented approximately six years ago. Currently working on renewing the contract for an additional two years with substantially less incentive compensation. Over the past six years, this arrangement has resulted in assisting with the growth of the orthopedic service line, improved safety and quality in direct patient care, as well as overall efficiency and profitability.
2. The incentive compensation with the new contract will focus on standardizing supply, implant, and drug costs with each surgical case. The sub-committees will continue to focus efforts around outreach/marketing, and operational performance and efficiency.
3. Working closely with media relations, marketing, and internal key leaders to create a comprehensive and robust orthopedic program that will be known in the community as the Kaweah Delta Joint Replacement Institute.
4. Closely monitoring referral leakage and outmigration numbers. Focusing on both community members and primary care physicians to increase the market share. Emphasizing the importance of using local surgeons.

5. Working closely with Human Resources to recruit additional orthopedic surgeons as the orthopedic demands continue to grow in the region. Successfully hired a fellowship-training orthopedic surgeon specializing in joint replacements and an orthopedic spine surgeon who will be here by the end of the year.
6. Nurse Practitioner has been working with the orthopedic service for 1.5 years to assist with throughput and better coordination of care and efficiency with the entire continuum of care for orthopedics.

## Recommendations/Next Steps

1. The co-management agreement will continue to promote alignment of both parties' interests in improving quality, outcomes, and efficiency. Also, it prepares both groups for the changing healthcare delivery models.
2. Carefully watching the orthopedic surgical market shifting more and more into the outpatient surgical arena. Orthopedic surgeries that were traditionally performed as an inpatient are changing to outpatient. Working with the outpatient surgery staff and contracting department to provide orthopedic procedures safely and efficiently in the outpatient surgery areas. Currently evaluating same-day outpatient joint replacement surgeries.
3. Continuing to work on patient flow, improving efficiency in the surgery department, and clinical quality with the entire orthopedic service line with the primary focus on hip fractures and joint replacement patients.
4. Focus efforts in reducing the overall length of stay with orthopedic surgical cases to the geometric length of stay (GMLOS).
5. Continue with the physician partnership development, as well as referral relations, and marketing/community health outreach in orthopedics.
6. Support recruitment efforts for Board Certified Orthopedic Surgeons that specialize in the latest treatment in the area hands and trauma.
7. Continue to respond to Medicare initiatives related to Orthopedics at the State and National level.

## Approvals/Conclusions

Orthopedic services will focus in the coming year on:

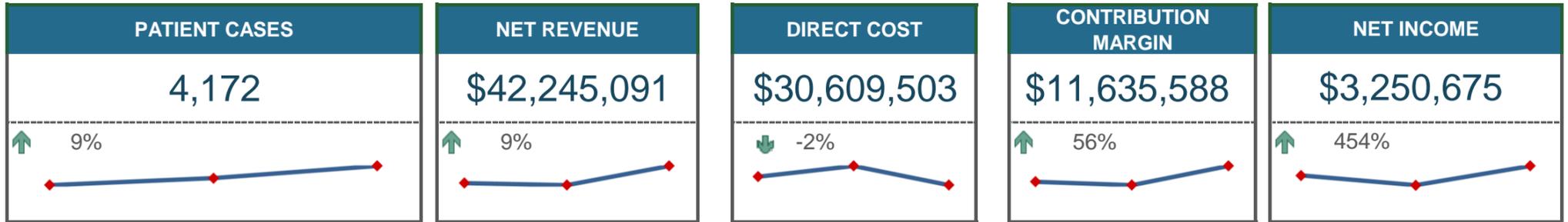
1. Work with the entire continuum of care from pre-surgery to post-surgery (rehabilitation physicians) to provide quality and comprehensive orthopedic services.
2. Continue to review profitability, contribution margin to identify opportunities for volume, growth, cost containment, customer satisfaction, and clinical excellence.

# KDHCD ANNUAL BOARD REPORT

FY2019

## Orthopedic Services - Summary

### KEY METRICS - FY 2019



Note: Arrows represent the change from prior year and the lines represent the 3-year trend.

### FY 2019 METRICS

| SERVICE LINE                            | PATIENT CASES | NET REVENUE         | NET REV PER CASE | CONTRIBUTION MARGIN |
|---|---------------|---------------------|------------------|---------------------|
| Inpatient Orthopedic -Surgical Services | 1,555         | \$29,883,471        | \$19,218         | \$9,914,903         |
| Inpatient Orthopedic - Medical Services | 462           | \$4,026,015         | \$8,714          | \$1,372,737         |
| Outpatient Orthopedic Surgeries         | 2,155         | \$8,335,605         | \$3,868          | \$347,948           |
| <b>Orthopedic Surgery Total</b>         | <b>4,172</b>  | <b>\$42,245,091</b> | <b>\$10,126</b>  | <b>\$11,635,588</b> |

### Orthopedic Services TOTALS - 3 YEAR TREND

| METRIC              | FY2017     | FY2018     | FY2019     | % Change from Prior Year | 3 YR Trend |
|---------------------|------------|------------|------------|--------------------------|------------|
| PATIENT CASES       | 3,650      | 3,840      | 4,172      | 9%                       | ↑          |
| NET REVENUE         | 39,072,087 | 38,694,025 | 42,245,091 | 9%                       | ↑          |
| DIRECT COST         | 30,878,697 | 31,229,130 | 30,609,503 | -2%                      | ↓          |
| CONTRIBUTION MARGIN | 8,193,390  | 7,464,895  | 11,635,588 | 56%                      | ↑          |
| INDIRECT COST       | 7,017,547  | 8,384,156  | 8,384,913  | 0%                       | ↑          |
| NET INCOME          | 1,175,843  | (919,261)  | 3,250,675  | 454%                     | ↑          |

Notes:

Source: Inpatient and outpatient Service Line Reports.

Selection Criteria for Orthopedic Services: Inpatient: Hospital #: KDHS; Service Line 1: Orthopedics, Surgical Services

Selection Criteria for OP Orthopedic Surgeries: Service Line 1= O/P Surgery, EncTypeMne = OP

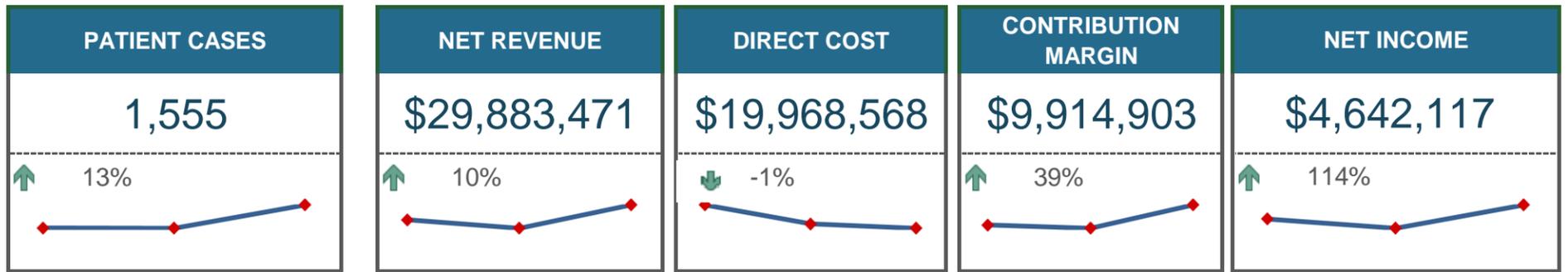
and Surgeon Specialty = Neurological Surgery, Podiatrist, Sugery - Surgery of the Hand & Orthopaedic Surgery

# KDHCD ANNUAL BOARD REPORT

## Inpatient Orthopedic Surgery -Surgical Services

FY2019

### KEY METRICS - FY 2019



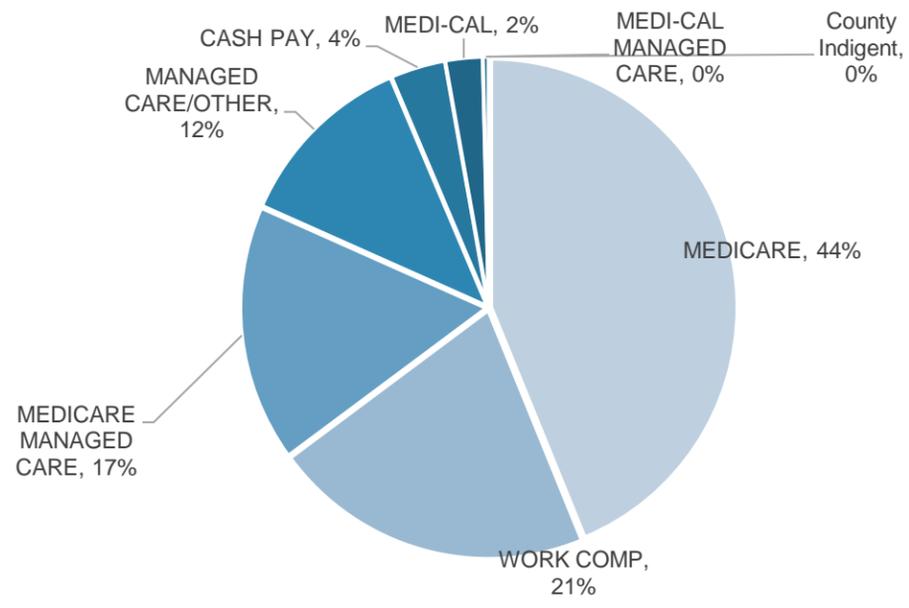
Note: Arrows represent the change from prior year and the lines represent the 3-year trend.

### ALL METRICS - 3 YEAR TREND

| METRIC                 | FY2017       | FY2018       | FY2019       | % Change from Prior Year | 3 YR Trend |
|------------------------|--------------|--------------|--------------|--------------------------|------------|
| PATIENT CASES          | 1,378        | 1,376        | 1,555        | 13%                      |            |
| PATIENT DAYS           | 5,806        | 5,121        | 5,560        | 9%                       |            |
| NET REVENUE            | \$28,176,086 | \$27,233,728 | \$29,883,471 | 10%                      |            |
| DIRECT COST            | \$20,664,612 | \$20,097,497 | \$19,968,568 | -1%                      |            |
| CONTRIBUTION MARGIN    | \$7,511,474  | \$7,136,231  | \$9,914,903  | 39%                      |            |
| INDIRECT COST          | \$4,355,326  | \$4,965,308  | \$5,272,786  | 6%                       |            |
| NET INCOME             | \$3,156,148  | \$2,170,923  | \$4,642,117  | 114%                     |            |
| NET REV PER CASE       | \$20,447     | \$19,792     | \$19,218     | -3%                      |            |
| DIRECT COST PER CASE   | \$14,996     | \$14,606     | \$12,842     | -12%                     |            |
| CONTRB MARGIN PER CASE | \$5,451      | \$5,186      | \$6,376      | 23%                      |            |
| ALOS                   | 4.2          | 3.7          | 3.6          | -4%                      |            |
| ALOS OPPORTUNITY       | 0.7          | 0.4          | 0.5          | 14%                      |            |

### PAYER MIX - 3 YEAR TREND

| PAYER                 | FY2017 | FY2018 | FY2019 |
|-----------------------|--------|--------|--------|
| MEDICARE              | 47%    | 50%    | 44%    |
| WORK COMP             | 23%    | 21%    | 21%    |
| MEDICARE MANAGED CARE | 11%    | 13%    | 17%    |
| MANAGED CARE/OTHER    | 10%    | 9%     | 12%    |
| CASH PAY              | 3%     | 3%     | 4%     |
| MEDI-CAL              | 4%     | 3%     | 2%     |
| MEDI-CAL MANAGED CARE | 1%     | 0%     | 0%     |
| County Indigent       | 0%     | 0%     | 0%     |



Notes:

Source: Inpatient Service Line Reports.

Selection Criteria: Hospital #: KDHS; Service Line 1: Orthopedics, Surgical Services

# KDHCD ANNUAL BOARD REPORT

## Inpatient Orthopedic Surgery - Medical Services

FY2019

### KEY METRICS - FY 2019



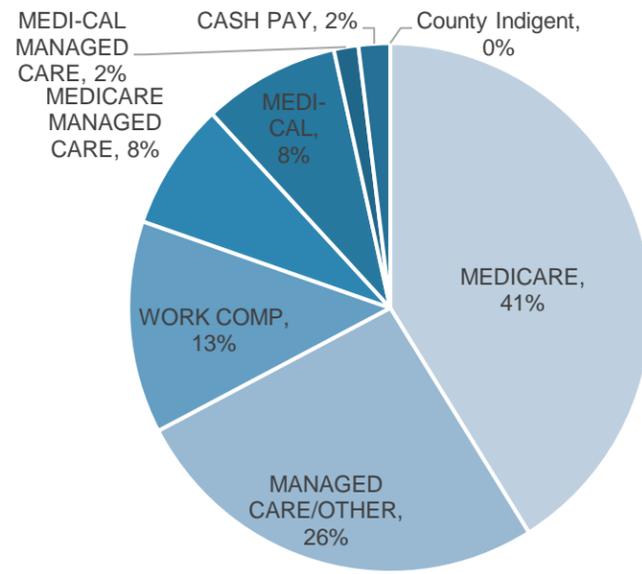
Note: Arrows represent the change from prior year and the lines represent the 3-year trend.

### ALL METRICS - 3 YEAR TREND

| METRIC                 | FY2017      | FY2018      | FY2019      | % Change from Prior Year | 3 YR Trend |
|------------------------|-------------|-------------|-------------|--------------------------|------------|
| PATIENT CASES          | 328         | 410         | 462         | ↑ 13%                    |            |
| PATIENT DAYS           | 1,663       | 1,825       | 1,846       | ↑ 1%                     |            |
| NET REVENUE            | \$3,188,782 | \$3,835,907 | \$4,026,015 | ↑ 5%                     |            |
| DIRECT COST            | \$2,394,506 | \$2,624,470 | \$2,653,278 | ↑ 1%                     |            |
| CONTRIBUTION MARGIN    | \$794,276   | \$1,211,437 | \$1,372,737 | ↑ 13%                    |            |
| INDIRECT COST          | \$735,359   | \$1,007,566 | \$999,517   | ↓ -1%                    |            |
| NET INCOME             | \$58,917    | \$203,871   | \$373,220   | ↑ 45%                    |            |
| NET REV PER CASE       | \$9,722     | \$9,356     | \$8,714     | ↓ -7%                    |            |
| DIRECT COST PER CASE   | \$7,300     | \$6,401     | \$5,743     | ↓ -10%                   |            |
| CONTRB MARGIN PER CASE | \$2,422     | \$2,955     | \$2,971     | ↑ 1%                     |            |
| ALOS                   | 5.1         | 4.5         | 4.0         | ↓ -10%                   |            |
| ALOS OPPORTUNITY       | 1.6         | 1.0         | 0.6         | ↓ -37%                   |            |

### PAYER MIX - FY2019

| PAYER                 | FY2017 | FY2018 | FY2019 |
|-----------------------|--------|--------|--------|
| MEDICARE              | 45%    | 46%    | 41%    |
| MANAGED CARE/OTHER    | 20%    | 22%    | 26%    |
| WORK COMP             | 17%    | 13%    | 13%    |
| MEDICARE MANAGED CARE | 9%     | 7%     | 8%     |
| MEDI-CAL              | 8%     | 9%     | 8%     |
| MEDI-CAL MANAGED CARE | 1%     | 1%     | 2%     |
| CASH PAY              | 1%     | 1%     | 2%     |
| County Indigent       | 0%     | 1%     | 0%     |



Notes:

Source: Inpatient Service Line Reports.

Selection Criteria: Hospital #: KDHS; Service Line 1: Orthopedics, Medical Services

# KDHCD ANNUAL BOARD REPORT

## Orthopedic Services - Outpatient Surgery Service Line

FY2019

### KEY METRICS - FY 2019



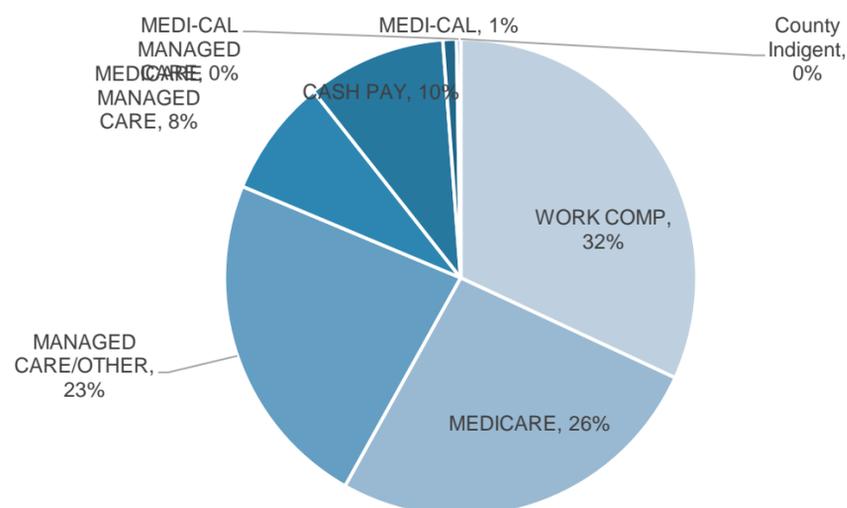
Note: Arrows represent the change from prior year and the lines represent the 3-year trend.

### ALL METRICS - 3 YEAR TREND

| Metric                 | FY2017        | FY2018        | FY2019        | % Change from Prior Year | 3 YR Trend |
|------------------------|---------------|---------------|---------------|--------------------------|------------|
| PATIENT CASES          | 1,944         | 2,054         | 2,155         | ↑ 5%                     | ↑          |
| NET REVENUE            | \$7,707,219   | \$7,624,390   | \$8,335,605   | ↑ 9%                     | ↑          |
| DIRECT COST            | \$7,819,579   | \$8,507,163   | \$7,987,657   | ↓ -6%                    | ↓          |
| CONTRIBUTION MARGIN    | (\$112,360)   | (\$882,773)   | \$347,948     | ↑ -139%                  | ↑          |
| INDIRECT COST          | \$1,926,862   | \$2,411,282   | \$2,112,610   | ↓ -12%                   | ↓          |
| NET INCOME             | (\$2,039,222) | (\$3,294,055) | (\$1,764,662) | ↑ -655%                  | ↑          |
| NET REV PER CASE       | \$3,965       | \$3,712       | \$3,868       | ↑ 4%                     | ↑          |
| DIRECT COST PER CASE   | \$4,022       | \$4,142       | \$3,707       | ↓ -11%                   | ↓          |
| CONTRB MARGIN PER CASE | (\$58)        | (\$430)       | \$161         | ↑ -159%                  | ↑          |

### PAYER MIX - FY2019

| PAYER                 | FY2017 | FY2018 | FY2019 |
|-----------------------|--------|--------|--------|
| WORK COMP             | 34%    | 32%    | 32%    |
| MEDICARE              | 29%    | 30%    | 26%    |
| MANAGED CARE/OTHER    | 21%    | 19%    | 23%    |
| MEDICARE MANAGED CARE | 7%     | 8%     | 8%     |
| CASH PAY              | 7%     | 9%     | 10%    |
| MEDI-CAL              | 1%     | 1%     | 1%     |
| MEDI-CAL MANAGED CARE | 1%     | 1%     | 0%     |
| County Indigent       | 0%     | 0%     | 0%     |



Notes:

Source: Outpatient Service Line Reports.

Selection Criteria: Service Line 1= O/P Surgery, EncTypeMne = OP; Surgeon Specialty = Neurological Surgery, Podiatrist, Sugery - Surgery of the Hand & Orthopaedic Surgery

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

## Home Health Agency, Private/Specialty Home Care, and Lifeline

Jag Batth, Director  
Contact number: 559-624-3794  
November 6, 2019

### Summary Issue/Service Considered

1. Achieving optimum balance of program priorities to address quality of care, compliance, profitability, and quality of work environment.
2. Ensuring that Home Health Services continues to provide the full continuum of services to the community.

### Analysis of financial/statistical data:

Home Health Agency, Home Care Services, and Lifeline experienced an increase in contribution margin. The three programs had a contribution margin of \$1,404,551 this fiscal year, compared to \$381,259 last fiscal year.

Home Health Agency The program had a 5% increase in total visits compared to last year. The average direct cost per visit decreased by \$18 (-10%), averaging \$161 per visit, and net revenue per visit also increased by \$9 (5%), averaging \$180 per visit. Overall, home health experienced a contribution margin of \$604,493. Payor mix stayed stable, with approximately 72% Medicare/Medicare Managed Care.

Home Care Services The program had a decrease in the number of hours/visits by 8,835 (-6%) for 144,019 hours/visits. The decrease is mostly related to not having enough staff to provide the visits. Kaweah Delta is working on recruiting additional staff to meet the overall demands of the program. The average cost per visit slightly increased, averaging \$20 per visit vs. \$19 per visit the prior year. However, the net revenue per visit increased from \$23 per visit to \$26 per visit. The net revenue increase was mostly related to the specialty home program increase in reimbursement under the Medical waiver program. Overall, the private home care services experienced a contribution margin of \$779,292 compared to \$613,135 the prior year.

Lifeline experienced a decrease in the number of cases by 159 (-9%) for 1592 cases. The average cost per case increased, averaging \$37 per case vs. \$36 per case the prior year. Overall, Lifeline experienced a contribution margin of \$20,668 FY 2019 compared to \$22,057 the previous year.

### Quality/Performance Improvement Data

1. Home Health Agency (HHA): Overall, patient quality of care exceeds national benchmarks. Currently, the home health compare website notes overall quality performance at a 4-star rating (1 through 5 rating scale). The agency has made excellent

gains with a number of quality care initiatives. Out-performing the national average with timely initiation of care, management of medications, improvement with transfers, improvement with bathing, improvement with breathing, and preventing re-hospitalizations. Performance and trends are carefully monitored and appropriate action plans are developed for any area that is below the national average. Overall, patient satisfaction is averaging 87% compared to the California average of 80% and the National average of 84%. The HHA patient satisfaction is at a 4-star rating on the publically reported website-home health compare.

2. Admissions to home health increased by 25 per month compared to the prior year. The average census also increased by 20 per month compared to the preceding year.
3. Home Health Agency had an excellent Joint Commission survey, resulting in a full 3-year accreditation. After an in-depth review, the Joint Commission noted excellent patient safety and care delivery processes. Joint Commission also indicated that the home health agency demonstrates enhanced patient outcomes, high-quality care, and ultimately that the HHA complies with Joint Commission standards of care.
4. Private Home Care Services: Client satisfaction scores are measured twice a year and the results continue to indicate a high degree of satisfaction. For 2019 the overall impression and likelihood of recommending to their family and friends was 100%. The overall courtesy of the staff was at 98%, and the admission process was at 91%. Employee engagement and satisfaction has increased to 93% compared to 92% the previous year.

## Policy, Strategic or Tactical Issues

1. The Home Health Agency will undergo a significant change in the structure of payment for Medicare patients. The new reimbursement model, Patient-Driven Groups Model (PDGM), is focused on patient characteristics, including diagnoses, comorbid conditions and therapy needs. This model will rebalance the payment system so that medically complex patients are reimbursed more consistently with their cost. This is expected to improve overall home health reimbursement for hospital-based home health programs.
2. Closely working with revenue cycle, finance, the managed care team to ensure proper billings and collections, negotiations of insurance rates, and the overall cost of providing the care is being managed well.
3. The Home Care division meetings continue quarterly and include Hospice, Home Infusion Pharmacy, Private Home Care, and Home Health on a quarterly basis. It is an excellent collaboration among the various groups to discuss overall quality, regulatory changes, concerns, etc that may affect all of us in the home care division.
4. Working closely with case management and the post-acute partners (Skilled Nursing & Acute Rehabilitation) to streamline the referral process to the post-acute settings.
5. There have been two publicly reported measures in Home Health that result in a star rating available to the public in regards to quality and overall patient satisfaction. Both ratings are at a 4-star on the home health compare website.
6. The Program for Evaluating Payment Patterns Electronic Report (PEPPER) is a comparative report that evaluates specific Medicare statistics against national benchmarks to evaluate charges that are vulnerable to improper payment. We monitor the report closely to ensure any outliers are addressed. Currently, there are no outliers to report.
7. Retention and recruitment of clinical staff and leaders. We are working closely with Human Resources to remain competitive with benefits, salaries, and employee engagement.
8. There is an extremely competitive market in the region, so we are continuing to market services as well as develop competitive billing practices.

9. Monitoring State license requirements for specialty home care, specifically in the area of ventilators and nursing competency requirements and adjust accordingly.
10. Working closely with the District Palliative Care program to offer palliative services in the home health setting.
11. The lifeline contract ends in Dec 2020. Evaluating the feasibility of continuing the program for an additional two years.
12. Strategizing the implementation of electronic visit verification by 2023 for all Medicaid personal care service and home health services.

## Recommendations/Next Steps

1. Maintain positive productivity in support of improved or sustained positive financial performance for all programs.
2. Monitor all publicly reported quality measures to achieve or sustain performance that exceeds national benchmarks. This will include the following:
  - i. ongoing audits of both start of care and discharge documentation
  - ii. timeliness completion and staff education in regards to documentation
  - iii. Continue to work closely with Patient Billing to ensure all revenues issues are being addressed promptly. This will include the following:
    - in-depth analysis of revenue, payments, and denials
    - monthly review of financial reports with the patient billing department
    - electronic billing implementation with payers
  - iv. initial certification documentation is complete (face-to-face requirements)
3. Participate in outreach programs and opportunities such as community forums and health fairs to market to consumers, physicians, and the overall community.
4. Working closely with Family HealthCare Network (FHCN) to improve communication with the FHCN Providers and home health clinical and office staff
5. Develop and implement a plan to address employee satisfaction using the Press Ganey results.

## Approvals/Conclusions

### **In the coming year, Home Health Services will focus on:**

1. Implementation of goals related to District cornerstones for Home Health, Private Home Care, and Lifeline to enhance program development, the satisfaction of all stakeholders, program marketing, and clinical quality of services.
2. Work with the entire continuum of care from the Acute Care Hospital to the post-acute care providers to meet patient needs and timely placement in the Home Health Care services.
3. Continue to review profitability, contribution margin to identify opportunities for volume, growth cost containment, customer satisfaction, and clinical excellence.

# KDHCD ANNUAL BOARD REPORT

## HOME HEALTH SERVICES - Summary

FY2019

### KEY METRICS - FY 2019



\*Note: Arrows represent the change from prior year and the lines represent the 3-year trend

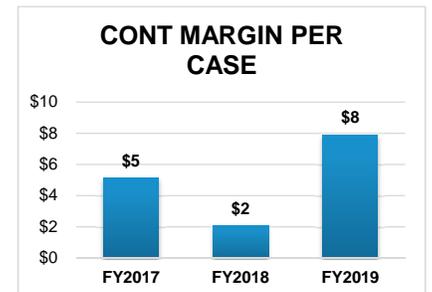
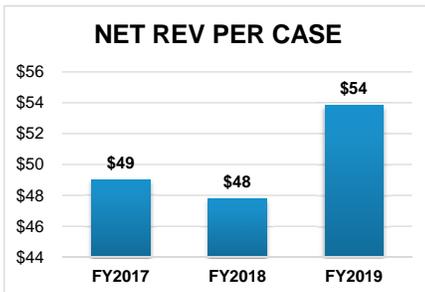
### FY 2019 METRICS

| SERVICE LINE       | VISITS  | NET REVENUE | NET REV PER CASE | CONTRIBUTION MARGIN |
|--------------------|---------|-------------|------------------|---------------------|
| HOME HEALTH AGENCY | 32,091  | \$5,766,927 | \$180            | \$604,593           |
| LIFELINE           | 1,592   | \$78,847    | \$50             | \$20,666            |
| HOME CARE          | 144,019 | \$3,717,520 | \$26             | \$779,292           |

### HOME HEALTH TOTALS - 3 YEAR TREND

| METRIC                | FY2017      | FY2018        | FY2019      | %Change from Prior Yr | 3 YR Trend |
|-----------------------|-------------|---------------|-------------|-----------------------|------------|
| VISITS                | 203,430     | 185,118       | 177,702     | ↓ -4%                 |            |
| NET REVENUE           | \$9,965,693 | \$8,843,173   | \$9,563,294 | ↑ 8%                  |            |
| DIRECT COST           | \$8,919,151 | \$8,461,914   | \$8,158,743 | ↓ -4%                 |            |
| CONTRIBUTION MARGIN   | \$1,046,542 | \$381,259     | \$1,404,551 | ↑ 268%                |            |
| INDIRECT COST         | \$1,692,810 | \$2,084,089   | \$1,843,016 | ↓ -12%                |            |
| NET INCOME            | (\$646,268) | (\$1,702,830) | (\$438,465) | ↑ 74%                 |            |
| NET REV PER CASE      | \$49        | \$48          | \$54        | ↑ 13%                 |            |
| DIRECT COST PER CASE  | \$44        | \$46          | \$46        | → 0%                  |            |
| CONTR MARGIN PER CASE | \$5         | \$2           | \$8         | ↑ 284%                |            |

### GRAPHS



# KDHCD ANNUAL BOARD REPORT

## HOME HEALTH - Home Health Agency

FY2019

### KEY METRICS - FY 2019



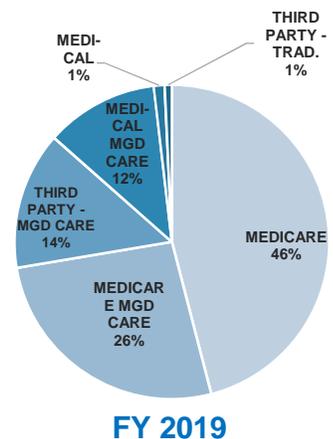
\*Note: Arrows represent the change from prior year and the lines represent the 3-year trend

### ALL METRICS - 3 YEAR TREND

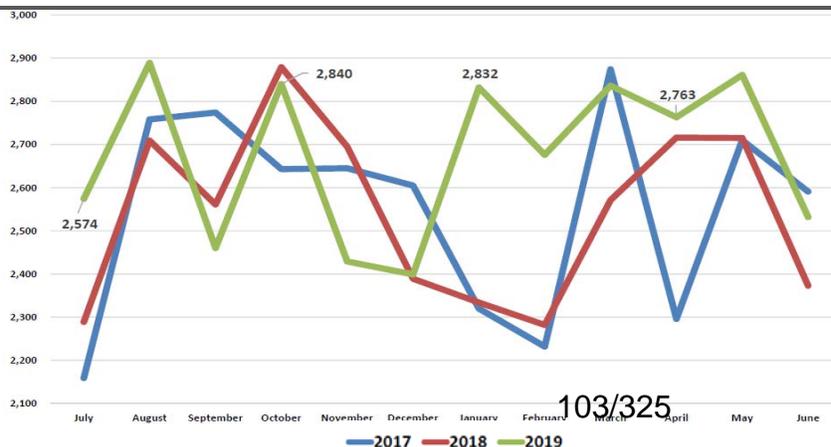
| METRIC                | FY2017      | FY2018        | FY2019      | %Change from Prior Yr | 3 YR Trend |
|-----------------------|-------------|---------------|-------------|-----------------------|------------|
| VISITS                | 30,607      | 30,513        | 32,091      | ↑ 5%                  |            |
| NET REVENUE           | \$6,067,644 | \$5,214,446   | \$5,766,927 | ↑ 11%                 |            |
| DIRECT COST           | \$5,677,058 | \$5,468,379   | \$5,162,334 | ↓ -5.6%               |            |
| CONTRIBUTION MARGIN   | \$390,586   | (\$253,933)   | \$604,593   | ↑ 338%                |            |
| INDIRECT COST         | \$920,629   | \$1,156,906   | \$1,130,015 | ↓ -2%                 |            |
| NET INCOME            | (\$530,043) | (\$1,410,839) | (\$525,422) | ↑ 63%                 |            |
| NET REV PER CASE      | \$198       | \$171         | \$180       | ↑ 5%                  |            |
| DIRECT COST PER CASE  | \$185       | \$179         | \$161       | ↓ -10%                |            |
| CONTR MARGIN PER CASE | \$13        | (\$8)         | \$19        | ↑ 336%                |            |

### PAYOR MIX - 3 YEAR TREND

| PAYOR                   | FY2017 | FY2018 | FY2019 |
|-------------------------|--------|--------|--------|
| MEDICARE                | 62%    | 48%    | 46%    |
| MEDICARE MGD CARE       | 14%    | 23%    | 26%    |
| THIRD PARTY - MGD CARE  | 8%     | 13%    | 14%    |
| MEDI-CAL MGD CARE       | 8%     | 12%    | 12%    |
| MEDI-CAL                | 5%     | 2%     | 1%     |
| THIRD PARTY - TRAD.     | 2%     | 1%     | 1%     |
| SELF PAY                | 0%     | 0%     | 0%     |
| THIRD PARTY - CAPITATED | 0%     | 0%     | 0%     |
| CHARITY                 | 0%     | 0%     | 0%     |



### HOME HEALTH VISITS - GRAPH OF 3 YEAR TREND



# KDHCD ANNUAL BOARD REPORT

## HOME HEALTH - Lifeline

FY2019

### KEY METRICS - FY 2019



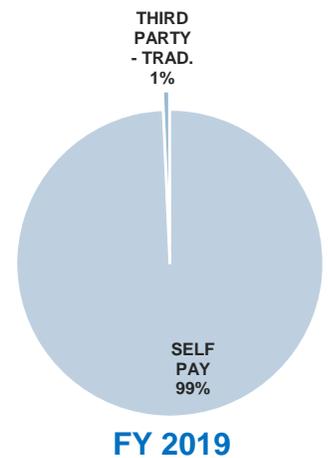
\*Note: Arrows represent the change from prior year and the lines represent the 3-year trend

### ALL METRICS - 3 YEAR TREND

| METRIC                | FY2017   | FY2018   | FY2019   | %Change from Prior Yr | 3 YR Trend |
|-----------------------|----------|----------|----------|-----------------------|------------|
| VISITS                | 1,916    | 1,751    | 1,592    | ↓ -9%                 |            |
| NET REVENUE           | \$89,748 | \$84,312 | \$78,847 | ↓ -6%                 |            |
| DIRECT COST           | \$75,759 | \$62,255 | \$58,181 | ↓ -7%                 |            |
| CONTRIBUTION MARGIN   | \$13,989 | \$22,057 | \$20,666 | ↓ -6%                 |            |
| INDIRECT COST         | \$12,586 | \$12,257 | \$11,144 | ↓ -9%                 |            |
| NET INCOME            | \$1,403  | \$9,800  | \$9,522  | ↓ -3%                 |            |
| NET REV PER CASE      | \$47     | \$48     | \$50     | ↑ 3%                  |            |
| DIRECT COST PER CASE  | \$40     | \$36     | \$37     | ↑ 2%                  |            |
| CONTR MARGIN PER CASE | \$7      | \$13     | \$13     | ↓ 0%                  |            |

### PAYOR MIX - FY2019

| PAYOR                   | FY2017 | FY2018 | FY2019 |
|-------------------------|--------|--------|--------|
| SELF PAY                | 92%    | 99%    | 99%    |
| THIRD PARTY - TRAD.     | 8%     | 1%     | 1%     |
| THIRD PARTY - MGD CARE  | 0%     | 0%     | 0%     |
| MEDICARE                | 0%     | 0%     | 0%     |
| MEDICARE MGD CARE       | 0%     | 0%     | 0%     |
| MEDI-CAL MGD CARE       | 0%     | 0%     | 0%     |
| MEDI-CAL                | 0%     | 0%     | 0%     |
| THIRD PARTY - CAPITATED | 0%     | 0%     | 0%     |
| CHARITY                 | 0%     | 0%     | 0%     |



# KDHCD ANNUAL BOARD REPORT

## HOME HEALTH - Home Care

FY2019

### KEY METRICS - FY 2019



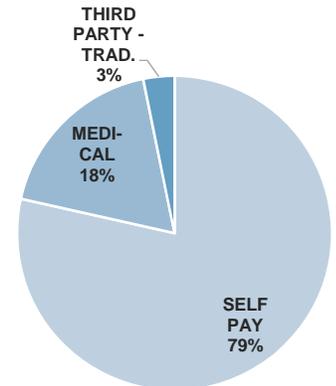
\*Note: Arrows represent the change from prior year and the lines represent the 3-year trend

### ALL METRICS - 3 YEAR TREND

| METRIC                | FY2017      | FY2018      | FY2019      | %Change from Prior Yr | 3 YR Trend |
|-----------------------|-------------|-------------|-------------|-----------------------|------------|
| VISITS                | 170,907     | 152,854     | 144,019     | -6%                   |            |
| NET REVENUE           | \$3,808,301 | \$3,544,415 | \$3,717,520 | 5%                    |            |
| DIRECT COST           | \$3,166,334 | \$2,931,280 | \$2,938,228 | 0%                    |            |
| CONTRIBUTION MARGIN   | \$641,967   | \$613,135   | \$779,292   | 27%                   |            |
| INDIRECT COST         | \$759,595   | \$914,926   | \$701,857   | -23%                  |            |
| NET INCOME            | (\$117,628) | (\$301,791) | \$77,435    | 126%                  |            |
| NET REV PER CASE      | \$22        | \$23        | \$26        | 12%                   |            |
| DIRECT COST PER CASE  | \$19        | \$19        | \$20        | 7%                    |            |
| CONTR MARGIN PER CASE | \$4         | \$4         | \$5         | 35%                   |            |

### PAYOR MIX - FY2019

| PAYOR                   | FY2017 | FY2018 | FY2019 |
|-------------------------|--------|--------|--------|
| SELF PAY                | 78%    | 78%    | 79%    |
| MEDI-CAL                | 18%    | 19%    | 18%    |
| THIRD PARTY - TRAD.     | 3%     | 3%     | 3%     |
| THIRD PARTY - MGD CARE  | 0%     | 0%     | 0%     |
| MEDICARE                | 0%     | 0%     | 0%     |
| MEDICARE MGD CARE       | 0%     | 0%     | 0%     |
| MEDI-CAL MGD CARE       | 1%     | 0%     | 0%     |
| THIRD PARTY - CAPITATED | 0%     | 0%     | 0%     |
| CHARITY                 | 0%     | 0%     | 0%     |



FY 2019

## FINANCIAL DATA - Do Not Re-sort (some are formulas)

| CLINIC NAME | METRIC NAME           | KEY                                 | FY2017       | FY2018        | FY2019       |
|-------------|-----------------------|-------------------------------------|--------------|---------------|--------------|
|             |                       | 1                                   | 2            | 3             | 4            |
| HOME HEALTH | VISITS                | HOME HEALTH AGENCYVISITS            | 30,607       | 30,513        | 32,091       |
| HOME HEALTH | TOTAL CHARGE          | HOME HEALTH AGENCYTOTAL CHARGE      | \$6,969,838  | \$6,765,498   | \$6,646,616  |
| HOME HEALTH | NET REVENUE           | HOME HEALTH AGENCYNET REVENUE       | \$6,067,644  | \$5,214,446   | \$5,766,927  |
| HOME HEALTH | DIRECT COST           | HOME HEALTH AGENCYDIRECT COST       | \$5,677,058  | \$5,468,379   | \$5,162,334  |
| HOME HEALTH | CONTRIBUTION MARGIN   | HOME HEALTH AGENCYCONTRIBUTION MA   | \$390,586    | (\$253,933)   | \$604,593    |
| HOME HEALTH | INDIRECT COST         | HOME HEALTH AGENCYINDIRECT COST     | \$920,629    | \$1,156,906   | \$1,130,015  |
| HOME HEALTH | NET INCOME            | HOME HEALTH AGENCYNET INCOME        | (\$530,043)  | (\$1,410,839) | (\$525,422)  |
| HOME HEALTH | NET REV PER CASE      | HOME HEALTH AGENCYNET REV PER CASE  | \$198        | \$171         | \$180        |
| HOME HEALTH | DIRECT COST PER CASE  | HOME HEALTH AGENCYDIRECT COST PER C | \$185        | \$179         | \$161        |
| HOME HEALTH | CONTR MARGIN PER CASE | HOME HEALTH AGENCYCONTR MARGIN PE   | \$13         | (\$8)         | \$19         |
| HOME HEALTH | REIMB/TOTAL CHARGE    | HOME HEALTH AGENCYREIMB/TOTAL CHA   | 87%          | 77%           | 87%          |
| HOME HEALTH | DFR%                  | HOME HEALTH AGENCYDFR%              | 13%          | 23%           | 13%          |
| LIFELINE    | VISITS                | LIFELINEVISITS                      | 1,916        | 1,751         | 1,592        |
| LIFELINE    | TOTAL CHARGE          | LIFELINETOTAL CHARGE                | \$90,419     | \$86,255      | \$79,211     |
| LIFELINE    | NET REVENUE           | LIFELINETOTAL CHARGE                | \$89,748     | \$84,312      | \$78,847     |
| LIFELINE    | DIRECT COST           | LIFELINEDIRECT COST                 | \$75,759     | \$62,255      | \$58,181     |
| LIFELINE    | CONTRIBUTION MARGIN   | LIFELINECONTRIBUTION MARGIN         | \$13,989     | \$22,057      | \$20,666     |
| LIFELINE    | INDIRECT COST         | LIFELINEINDIRECT COST               | \$12,586     | \$12,257      | \$11,144     |
| LIFELINE    | NET INCOME            | LIFELINETOTAL CHARGE                | \$1,403      | \$9,800       | \$9,522      |
| LIFELINE    | NET REV PER CASE      | LIFELINETOTAL CHARGE                | \$47         | \$48          | \$50         |
| LIFELINE    | DIRECT COST PER CASE  | LIFELINEDIRECT COST PER CASE        | \$40         | \$36          | \$37         |
| LIFELINE    | CONTR MARGIN PER CASE | LIFELINECONTR MARGIN PER CASE       | \$7          | \$13          | \$13         |
| LIFELINE    | REIMB/TOTAL CHARGE    | LIFELINEREIMB/TOTAL CHARGE          | 99%          | 98%           | 100%         |
| LIFELINE    | DFR%                  | LIFELINEDFR%                        | 1%           | 2%            | 1%           |
| HOME CARE   | VISITS                | HOME CAREVISITS                     | 170,907      | 152,854       | 144,019      |
| HOME CARE   | TOTAL CHARGE          | HOME CARETOTAL CHARGE               | \$3,836,784  | \$3,626,079   | \$3,734,065  |
| HOME CARE   | NET REVENUE           | HOME CARENET REVENUE                | \$3,808,301  | \$3,544,415   | \$3,717,520  |
| HOME CARE   | DIRECT COST           | HOME CAREDIRECT COST                | \$3,166,334  | \$2,931,280   | \$2,938,228  |
| HOME CARE   | CONTRIBUTION MARGIN   | HOME CARECONTRIBUTION MARGIN        | \$641,967    | \$613,135     | \$779,292    |
| HOME CARE   | INDIRECT COST         | HOME CAREINDIRECT COST              | \$759,595    | \$914,926     | \$701,857    |
| HOME CARE   | NET INCOME            | HOME CARENET INCOME                 | (\$117,628)  | (\$301,791)   | \$77,435     |
| HOME CARE   | NET REV PER CASE      | HOME CARENET REV PER CASE           | \$22         | \$23          | \$26         |
| HOME CARE   | DIRECT COST PER CASE  | HOME CAREDIRECT COST PER CASE       | \$19         | \$19          | \$20         |
| HOME CARE   | CONTR MARGIN PER CASE | HOME CARECONTR MARGIN PER CASE      | \$4          | \$4           | \$5          |
| HOME CARE   | REIMB/TOTAL CHARGE    | HOME CAREREIMB/TOTAL CHARGE         | 99%          | 98%           | 100%         |
| HOME CARE   | DFR%                  | HOME CAREDFR%                       | 1%           | 2%            | 0%           |
| SUMMARY     | VISITS                | SUMMARYVISITS                       | 203,430      | 185,118       | 177,702      |
| SUMMARY     | TOTAL CHARGE          | SUMMARYTOTAL CHARGE                 | \$10,897,041 | \$10,477,832  | \$10,459,892 |
| SUMMARY     | NET REVENUE           | SUMMARYNET REVENUE                  | \$9,965,693  | \$8,843,173   | \$9,563,294  |
| SUMMARY     | DIRECT COST           | SUMMARYDIRECT COST                  | \$8,919,151  | \$8,461,914   | \$8,158,743  |
| SUMMARY     | CONTRIBUTION MARGIN   | SUMMARYCONTRIBUTION MARGIN          | \$1,046,542  | \$381,259     | \$1,404,551  |
| SUMMARY     | INDIRECT COST         | SUMMARYINDIRECT COST                | \$1,692,810  | \$2,084,089   | \$1,843,016  |
| SUMMARY     | NET INCOME            | SUMMARYNET INCOME                   | (\$646,268)  | (\$1,702,830) | (\$438,465)  |
| SUMMARY     | NET REV PER CASE      | SUMMARYNET REV PER CASE             |              |               |              |
| SUMMARY     | DIRECT COST PER CASE  | SUMMARYDIRECT COST PER CASE         |              |               |              |
| SUMMARY     | CONTR MARGIN PER CASE | SUMMARYCONTR MARGIN PER CASE        |              |               |              |
| SUMMARY     | REIMB/TOTAL CHARGE    | SUMMARYREIMB/TOTAL CHARGE           |              |               |              |
| SUMMARY     | DFR%                  | SUMMARYDFR%                         |              |               |              |

M O R E T H A N M E D I C I N E . L I F E .

202 W. Willow, LLC  
November 21, 2019



# 202 W. Willow, LLC.

- The Malli Family gifted 30%, or 3,000 shares, ownership of 202 W. Willow, LLC dated October 31, 2017 - recorded at capital account balance of \$858,026.
- The LLC owns and rents a 32,293 square foot medical building located at 202 W. Willow. The District currently rents five suites in this building.
- Other owners include the Malli Family Trust (37%), Johnson Family Revocable Trust (15%), Kneeland Family Revocable Trust (10%), Spade Family Revocable Trust (5%) and May Family Revocable Trust (3%).

# Financial Report – 202 W. Willow, LLC

## October 31, 2019

|  |    |                 |
|--|----|-----------------|
| Initial Gift - October 2017                        | \$ | 858,026         |
| Income Allocation (30%) - 11/1/2017 to 9/30/2019   |    | 82,055          |
| Income Distribution (30%) - 11/1/2017 to 9/30/2019 |    | <u>(48,000)</u> |
| Investment Balance - October 31, 2019              | \$ | 892,081         |



|   |                                 |
|---|---------------------------------|
| Policy Number: AP73   | Date Created: No Date Set       |
| Document Owner: Cindy Moccio (Board Clerk/Exec Assist-CEO)                            | Date Approved: Not Approved Yet |
| Approvers: Board of Directors (Administration)  |                                 |
| <b><u>Accommodating Persons with Service Animals</u> <del>Use of Guide Dogs</del></b> |                                 |

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

**POLICY:** ~~Many people with disabilities use a service animal in order to fully participate in everyday life.~~ Kaweah Delta Health Care District (“Kaweah Delta”), in conformance with Federal and State Americans with Disabilities Act (ADA) requirements, will allow any visitor or patient the use of service animals~~guide dogs~~ as auxiliary aids. The ADA definition of service animals is any “dog individually trained to do work or perform tasks directly related to the partner’s disability, including, but not an limited to, guiding individuals with impaired vision, alerting individuals who are hearing impaired to intruders or sounds, providing non-violent protection or rescue work, pulling a wheelchair, fetching dropped items, assisting an ~~individua~~ individual during a seizure, alerting individuals to the presence of allergens, or helping persons with psychiatric and neurological disabilities by preventing or interrupting ~~impulsice~~ or destructive behaviors.” If an animal meets this definition, it is consideration a service animal regardless of whether it has been licensed or certified by a state or local government or a training program.

The service animals~~dogs~~ may be used in all situations except where it can clearly be shown that the presence or use of the animal would pose a significant health risk; in sterile areas such as the operating room, and newborn nursery; in the intensive care unit; or where the animal's~~dog's~~ behavior is disruptive to the environment.

**PROCEDURE:**

- I. Visitors - Unless specifically excluded above, visitors shall be allowed the use of a service animal~~guide dog~~ in accordance with the District Kaweah Delta's visitation ~~visiting~~ policy. For clarifications or questions, contact the House Supervisor for determination.
- II. Patients
  - A. Outpatient Settings - ~~Service Animals~~Guide dogs will be allowed in the outpatient setting.
  - B. Inpatient Settings - When a patient who is dependent upon a service animal~~guide dog~~ is hospitalized on bed rest and unable to care for

~~him/herself the service animal, the dog will not be permitted to remain at the District facility. the patient can make arrangements for a family member or friend to come to the hospital to provide these services or to keep the dog during the hospitalization. -~~

When the hospitalized patient is able to ambulate ~~ambulatory~~ or may benefit clinically from having the service animal ~~guide dog~~ present, the animal ~~dog~~ will be permitted to remain with the patient. The patient, family member, and/or designee will be responsible for grooming, feeding, and toileting the service animal ~~dog~~.

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| Policy Number: AP107   | Date Created: No Date Set       |
| Document Owner: Cindy Moccio (Board Clerk/Exec Assist-CEO)       | Date Approved: Not Approved Yet |
| Approvers: Board of Directors (Administration)                   |                                 |
| <b>Patient Privacy Use and Disclosure of Patient Information</b> |                                 |

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

**PurposePURPOSE:** This policy outlines how ~~KDHCD~~ Kaweah Delta Health Care District (Kaweah Delta) complies with the patient privacy requirements and the use and disclosure of Protected Health Information (patient informationPHI) in accordance with the Federal Health Insurance Portability and Accountability Act and the requirements of State of California privacy-related laws and regulations.

**PolicyPOLICY:** ~~KDHCD~~ Kaweah Delta complies with all Federal and State of California laws and regulations with regards to protecting patient privacy and using or disclosing patient information. When PHI is used, disclosed, or requested, Kaweah Delta will take reasonable efforts to limit the PHI that is used, disclosed, or requested to the minimum amount necessary to accomplish the purpose of the use, disclosure, or request.

**DEFINITIONS:**

**“Limited Data Set”** is protected health information that excludes direct identifiers of patients, including: (a) names, (b) address information, other than town or city, State, and zip code (5-number zip code), (c) telephone numbers, (d) fax numbers, (e) electronic mail addresses, (f) social security numbers, (g) medical record numbers, (h) health plan beneficiary numbers, (i) account numbers, (j) certificate/license numbers, (k) vehicle identifiers and serial numbers, including license plate numbers, (l) device identifiers and serial numbers, (m) web universal resource locators (URLs), (n) Internet Protocol (IP) address numbers, (o) biometric identifiers, including finger and voice prints; ~~and~~ (p) full face photographic images and any comparable images; and (q) any other unique identifying number, characteristic or code.

+

**“Organized Health Care Arrangement”** means a clinically integrated care setting in which individuals typically receive health care from more than one health care provider or an organized system of health care where more than one covered entity participates and where the participating covered entities and the providers hold themselves out to the public as participating in a joint arrangement. For ~~KDHCD~~ Kaweah Delta, the District, including all of its

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facilities and services, credentialed medical staff, and allied health professionals, is in an organized health care arrangement.

~~“Protected Health Information (PHI)” Individually identifiable health information that is transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. May also be referred to as electronic protected health information (ePHI).~~

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means A any information in any form or medium that is created or received by Kaweah Delta that relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual. (See AP.53 Patients’ Rights and Responsibilities for a more comprehensive definition)

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Information (i) that is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse about a patient and (ii) including demographic information that may identify a patient that relates to the patient’s past, present, or future physical or mental health or condition, related health care services, or payment for health care services.

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III. ~~“Protected Health Information” (“PHI”) means individually identifiable health and demographic information created by KDHC DKaweah Delta and relating to the physical or mental health or the provision of care to an individual which identifies the individual; or with respect to which there is a reasonable basis to believe the information can be used to identify the individual. It includes verbal, written or electronically maintained information.~~

**PROCESS:**

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I. ~~Uses of PHI~~

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~~I. KDHC DKaweah Delta may use or disclose PHI for treatment of patients, request payment for services, and for health care operations activities. KDHC DKaweah Delta discloses PHI to other health care providers and/or business associates for these same activities to ensure continuity of care.~~

II. Disclosures of PHI –

A. For disclosures of PHI except as permitted or required by this policy, ~~KDHC DKaweah Delta~~ shall obtain a valid authorization from the patient or their personal representative. ~~(See policy AP.04, Patient Access to and Release of Health Information)~~ ~~Access and Release of Protected Health Information)~~

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1. The authorization shall become a part of the patient's medical record. A copy of the signed authorization must be provided to the individual.
  2. An individual may revoke an authorization in writing.
    - a) The revocation does not apply to actions KDHCDKaweah Delta has taken in reliance on the authorization.
    - b) The written revocation shall become a part of the individual's medical record.
- B. KDHCDKaweah Delta may use or disclose an individual's PHI provided that the individual is informed in advance of the use or disclosure and the individual has the opportunity to agree, prohibit, or restrict the use or disclosure. KDHCDKaweah Delta may verbally inform the individual of and obtain the individual's verbal agreement or objection to a use or disclosure permitted by this section.
1. KDHCDKaweah Delta may use the following PHI to maintain a directory of individuals in its facility: (a) the individual's name, (b) the individual's location in KDHCDKaweah Delta's facility, (c) the individual's condition described in general terms that does not communicate specific medical information about the individual, and (d) the individual's religious affiliation.
  2. Disclosures for involvement in the patient's care and notification purposes:
    - a) KDHCDKaweah Delta may disclose to a family member, other relative, or a close personal friend of the individual, or any other person identified by the individual, the PHI directly relevant to such person's involvement with the individual's care or payment related to the individual's health care.
    - b) KDHCDKaweah Delta may use or disclose PHI or assist in the notification of (including identifying or locating), a family member, a personal representative of the individual, or another person responsible for the care of the individual of the individual's location, general condition-, or death.
    - c) If the individual is present for, or otherwise available prior to, a use or disclosure permitted as described in a) or b) above, and has the capacity to make health care decisions, KDHCDKaweah Delta may use or disclose the PHI if KDHCDKaweah Delta obtains the individual's agreement, provides the individual with the opportunity to

object to the disclosure, and the individual does not express an objection; or reasonably infers from the circumstances that the individual does not object to the disclosure.

- d) If the individual is not present, or the opportunity to agree or object to the use or disclosure cannot practicably be provided because of the individual's incapacity or an emergency circumstance, ~~KDHCD~~Kaweah Delta may determine whether the disclosure is in the best interests of the individual and, if so, disclose only the PHI that is directly relevant to the person's involvement with the individual's health care.
- e) ~~KDHCD~~Kaweah Delta may disclose PHI to a public or private entity available to assist in disaster relief efforts.

C. In certain situations, ~~KDHCD~~Kaweah Delta shall disclose PHI without an authorization or verbal agreement from the individual.

- 1. ~~KDHCD~~Kaweah Delta shall disclose PHI to public health authorities or law enforcement agencies to the extent the disclosure is required by law. The disclosure shall be limited to the relevant requirements of such law and will be made in accordance with AP.04 Access and Release of Protected Health Information (PHI); AP.66 Suspected Child and/or Dependent Adult Abuse Reporting; DC.05 Child Abuse/Sexual Abuse Reporting Requirements; AS.03 Suspected Elder/Dependant Adult Abuse Reporting; AS.05 Domestic Violence; AS.02 Suspected Child Abuse Reporting; and the following Emergency Department policies: ED.1004 Deadly Weapons or Criminal Act Injuries Report; ED.#1006 Examination/Testing for the Collection of Evidence; #IP 1.7 Reporting Infection/Communicable Disease, ED.4013 Overdose or Poisoning: Management and Referral; and ED.#3002 Patients Who Present to ED with Complaint of Suspected Sexual Assault~~Sexual Assault Triage Protocol.~~
- 2. ~~KDHCD~~Kaweah Delta shall disclose PHI as necessary, and as allowable under state and federal laws, to avert a threat to health or safety.
- 3. ~~KDHCD~~Kaweah Delta shall disclose PHI for specialized government functions including:
  - a) Disclosure to military command authorities regarding armed forces personnel.

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b) Disclosures to authorized federal officials for intelligence and national security activities.

4. ~~KDHCD~~Kaweah Delta shall disclose PHI regarding an inmate to a correctional institution or a law enforcement official.

5. ~~KDHCD~~Kaweah Delta shall disclose PHI to the extent necessary to comply with laws regarding workers' compensation or other similar programs.

III. Other requirements regarding the use and disclosure of PHI include:

A. ~~KDHCD~~Kaweah Delta may use or disclose health information which has been **de-identified** by: removing the following identifiers:

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- Names
- Geographic subdivisions smaller than State, i.e. address, city, county, precinct, zip code
- All elements of dates except year for birth dates & all elements, including year, for all ages over 89
- Telephone number
- Fax number
- E-mail address
- Social security number
- Medical record numbers
- Health plan beneficiary numbers
- Account numbers
- Certificate/license numbers
- Vehicle ID & serial numbers; license plate numbers
- Device identifiers and serial numbers
- URLs or Internet Protocol address numbers
- Biometric identifiers including finger & voice prints
- Full face photographic images or comparable images
- Any other unique identifying number, characteristic or code

B. ~~KDHCD~~Kaweah Delta shall limit the PHI used and/or disclosed on a routine basis to the **minimum amount necessary**.

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1. Use of PHI shall be limited to only the information needed for an employee or volunteer to do their job.

2. Disclosure of PHI shall be limited to only the information necessary to accomplish the purpose for which the disclosure is made.

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3. Unless the circumstances are unreasonable, Kaweah Delta staff may rely on a request from one of the requestors listed below as establishing the minimum necessary PHI that may be disclosed to:

a) Public officials that are requesting PHI in accordance with the requirements of 45 CFR § 164.512 for the performance of public health functions, health oversight functions, law enforcement functions, and specialized government functions, if the public official demonstrates that the information requested is the minimum amount necessary to perform the function.

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i. Staff will verify the identity of public officials by:

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a. Looking at the agency identification badge, official credentials or other proof of government status for requests made in person.

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b. Noting that the request is on appropriate government letterhead for requests made in writing.

ii. Staff will verify the authority of public officials by:

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a. Receiving a written statement of legal authority or documenting an oral statement of such authority.

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b. Accepting a civil, judicial or administrative warrant, subpoena, order or other legal process.

b) Another healthcare provider

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c) A business associate (as established by way of written agreement or contract)

2. A professional that is a member Kaweah Delta staff, or a business associate of Kaweah Delta that is requesting the information to provide professional services to Kaweah Delta, provided that the professional demonstrates that the information requested is the minimum necessary required for the purpose requested.

d) \_\_\_\_\_

3. A researcher that is requesting PHI for research purposes and that provides an authorization from an individual, a waiver of authorization from an instructional review board (IRB), a data use agreement, assurance regarding use preparatory to research, or an assurance regarding the use of decedents' PHI.

~~e) \_\_\_\_\_~~

- C. ~~KDHCDKaweah Delta~~ will sometimes disclose information to a contracted business associate in a limited data set for the purposes of research, public health or health care operations. In these cases, the business associate contract shall be amended to include a data use agreement. The Privacy Officer shall ensure that data use agreements comply with the content requirements of the HIPAA Privacy regulation.
- D. ~~KDHCDKaweah Delta~~ may share demographic information and dates of health care provided to a patient with the ~~KDHCDKaweah Delta~~ Foundation. Any fundraising materials sent out shall include a description of how the individual may opt out of receiving any further fundraising communications.
- E. **Prior** to disclosing patient information, ~~KDHCDKaweah Delta~~ staff shall verify the identity of the person requesting the information **and** the authority of that person to access the information.

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- ~~1. Staff will verify the identity of public officials by:~~
  - ~~a) Looking at the agency identification badge, official credentials or other proof of government status for requests made in person.~~
  - ~~b) Noting that the request is on appropriate government letterhead for requests made in writing.~~
- ~~2. Staff will verify the authority of public officials by:~~
  - ~~a) Receiving a written statement of legal authority or documenting an oral statement of such authority.~~
  - ~~b) Accepting a civil, judicial or administrative warrant, subpoena, order or other legal process.~~

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| Policy Number: AP133   | Date Created: No Date Set       |
| Document Owner: Cindy Moccio (Board Clerk/Exec Assist-CEO)       | Date Approved: Not Approved Yet |
| Approvers: Board of Directors (Administration)                   |                                 |
| <b>Patient Elopement Critical Incident Response - Code Green</b> |                                 |

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

**POLICY:** Kaweah Delta Health Care District (KDHCD) is committed to the safety and security of all patients. All physicians and staff are responsible for responding quickly and appropriately in the event of the elopement of a cognitively impaired patient who may be at risk for harm, including patients on a voluntary or involuntary psychiatric hold who leave the hospital without notification of KDHCD staff. Unit personnel will respond immediately when a patient is identified as missing. This policy excludes competent patients leaving against medical advice (AMA).

**PROCEDURE:**

When a cognitively impaired patient, or a patient who is on an ~~voluntary -or~~ involuntary psychiatric hold such as a W&I 5150 or 5250, or a medical hold pending a psychiatric evaluation such as a H&S1799.111 is believed to be missing from -our facilities, or is observed ~~to leave~~ leaving a facility, the following process will be followed in response to the elopement: :

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- I. Call "44" to activate the overhead paging and announce a "Code Green", giving exact location to alert all staff a patient is missing or in the process of elopement. Hospital Security and all available staff will respond immediately to the location.

If patient is combative and leaving, the staff member noting the elopement will stay with the patient and alert the next nearest staff member to initiate a "Code Green". The staff member monitoring the patient will take all reasonable precautions to ensure the safety of the patient, without placing him or herself in harm's way.

The Visalia Police Department will be notified by a "9-911" call, if the patient leaves the facility.

- II. The Nurse Manager, (or Charge Nurse/Team Lead) will respond to the code alert and gather the following information:

- A. Patient name, room number, gender, approximate height and weight, hair color, race, photograph if available, and any other identifying information (e.g. using a wheelchair).
  - B. Time patient was last seen and description of what patient was wearing.
  - C. If the missing patient had any visitors in the last 24 hours, i.e. who visited the patient and when.
  - D. The area the patient left from and what direction they were going.
  - E. Notification of the patient's family.
- III. On weekends or when an administrator is not on campus, the nurse in charge of the patient will notify the House Supervisor. If the patient is not located, the House Supervisor will notify the administrator on-call and Risk Management.
- IV. If the elopement was not observed and a patient is found to be missing, all available personnel will search all rooms within the unit and initiate a "Code Green". If the patient is not found, the staff will follow the protocol listed in numbers I and II above.
- V. If staff are unable to find the patient within the building, KDHC staff will search the immediate grounds outside of KDHC's buildings and campus.
- VI. If the patient is not found, nursing staff will call the family and notify them of the patient's absence. Patient and Family Services should be notified to assist with calling the family or guardian of the patient.
- VII. If the patient is not found, the Nurse Manager, Charge Nurse or Team Lead will notify the Visalia Police Department with a "9-911" call to initiate an area search.
- VIII. Documentation of the patient's return to the facility will include:
- A. Time of return.
  - B. Patient's reason for leaving (if known), and where they went while AWOL.
  - C. Assessment of patient, including current vital signs (BP, T, P, R).
  - D. Interventions implemented (i.e.: sitter, TAB monitor).
  - E. Individuals notified of patient's return (Administration, Physician, and Family).
  - F. Completion of ~~an NOE~~ an occurrence -Midas R-report.

**PROCEDURE REFERENCES:**

[California Welfare & Institution Code Section 5150 and 5250](#)  
[California Health & Safety Code Section 1799.111](#)

Patient Elopement Critical Incident Response - Code Green  
3

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| Policy Number: AP104                                       | Date Created: No Date Set       |
| Document Owner: Cindy Moccio (Board Clerk/Exec Assist-CEO) | Date Approved: Not Approved Yet |
| Approvers: Board of Directors (Administration)             |                                 |
| <b>Animal Assisted Activities / Therapy (AAA/AAT)</b>      |                                 |

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

~~**PURPOSE:** To govern safe, conscientious, and professional involvement of animals in Animal Assisted Activities/Therapy within Kaweah Delta Health Care District.~~

**POLICY:** The Recreation Therapist and Activity Coordinators ~~located at the West campus~~ will coordinate and supervise the AAA/AAT program assuring that all participants are in compliance. Animal-Assisted Activities (AAA) provide opportunities for motivational, educational, recreational, and/or therapeutic benefits to enhance quality of life. Specially trained professionals, para-professionals, or volunteers in association with animals that meet specific criteria deliver AAA.

Animal-Assisted Therapy (AAT) is a goal-directed intervention in which an animal that meets specific criteria is an integral part of the patient's treatment process. AAT is directed and or delivered by a health or human service professional with specialized expertise and within the scope of practice of his or her profession. AAT is designed to promote improvement in human physical, social, emotional, and/or cognitive functioning. AAT may be group or individual in nature. ~~The process is documented and evaluated.~~

**PROCEDURE:**

- I. Any employee/authorized volunteer wishing to be involved in AAA/AAT must be registered with an AAA/AAT organization such as the Delta Society, Therapy Dogs International, etc. ~~The AAA/AAT coordinator is available to evaluate for registration.~~ AAA/AAT is currently limited to dogs.
- II. A yearly health/vaccination certificate will must be kept on file in with the ~~Kaweah Delta Rehabilitation Hospital~~ Recreation Therapist or Activity Coordinatory office.
- III. Handlers will evaluate the animal's health prior to each visit and will not bring an animal whose general well being is compromised or who has external parasites.
- IV. Animals found to have external parasites or who demonstrate illness during a visit will be immediately removed from the premises.
- V. Animals will be effectively controlled by leash (six foot maximum)

- VI. Animals will be bathed/groomed prior to visit.
- VII. Animals are not allowed in areas where medications are prepared or where food is being served.
- VIII. All persons coming in contact with animals shall utilize proper and frequent hand washing. Animals are not to be fed by patients during the visit.
- IX. The rights of patients, visitors, and staff not wishing to have contact with an animal will be respected.
- X. The rights of the animals for access to water, exercise areas, safety and freedom from undue stress will be respected.
- XI. The presence of animals in the hospital shall not lessen the standard of housekeeping or contribute to an objectionable odor.
- XII. Animals are to be toileted prior to visit. If toileting need arises during the visit, outdoor grass areas may be used. It is the responsibility of the handler to properly dispose of waste. Should an "accident" occur, the handler should seek assistance from staff/housekeeping for appropriate clean up.
- XIII. Should an incident occur (scratch, bite, severe adverse or allergic response, etc.) standard hospital injury protocol will be implemented.
- XIV. Incidents will be reviewed by the AAA/T coordinator, rehabilitation director, and handler. The animal may be placed on probation or asked to retire.
- XV. Female animals shall either be spayed or determined not to be in estrus while visiting.
- XVI. Human-animal volunteer teams may have their privilege for participation in the program suspended or revoked if any of the following occur:
  - A. The handler is unable to demonstrate adequate control of an animal.
  - B. The animal's temperament, behavior, or health is not appropriate (either on one visit or consistently over time).
  - C. The handler does not maintain standards of personal appearance for self or the animal.
  - D. Confidentiality is breached.
  - E. Volunteer misses three consecutive visits.

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| Policy Number: AP18  | Date Created: 06/01/1998        |
| Document Owner: Cindy Moccio (Board Clerk/Exec Assist-CEO) | Date Approved: Not Approved Yet |
| Approvers: Board of Directors (Administration)             |                                 |
| <b>Foreign Language Forms, Signs, Etc.</b>                 |                                 |

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

**POLICY:** To ensure quality of translation, all forms, signs, pamphlets, brochures, etc., produced for display on or distribution by Kaweah Delta Health Care District, in a language other than English, will be coordinated through the Marketing and Interpreter Services Departments. ~~to provide proper content and structure meeting District standards.~~

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| Policy Number: AP122                                       | Date Created: No Date Set       |
| Document Owner: Cindy Moccio (Board Clerk/Exec Assist-CEO) | Date Approved: Not Approved Yet |
| Approvers: Board of Directors (Administration)             |                                 |
| <b>Interpreter Services</b>                                |                                 |

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**PURPOSE:**

- A. To define the communication system that is used for patients who are Limited English Proficient (LEP) or who are deaf or hard of hearing (hearing impaired). Such a system will include appropriate “auxiliary aids” and/or language interpretation services to ensure effective communication between patients and staff during critical health services or treatment situations.
- B. To provide guidelines for coordinating timely response to meeting the assessed special language needs of individual patients, their designated representative, guardian or next of kin.
- C. To comply with the Americans with Disabilities Act (ADA), Title VI of the Civil Rights Act of 1964 and Health and Safety Code of California

Health and Safety Code of California requires licensed general acute care hospitals to provide language assistance services to patients with language or communication barriers.

Title VI of the Civil Rights Act of 1964 requires federal fund recipients to ensure the eligible Limited English Proficiency (LEP) persons have “meaningful access” to health services.

ADA Title II requires that public accommodations provide “auxiliary” aids when necessary to enable a person with disabilities to benefit from their services.

**POLICY:** It is the policy of Kaweah Delta Health Care District (KDHCD) to provide, to the extent possible, the use of qualified interpreters or assistive devices whenever a language or communication barrier exists. For patients that are minors or incapacitated, the preferred language of the patient’s parent(s) guardian, or surrogate decision-maker will also be determined. The Bill of Rights for People with Limited English Skills will be provided orally or in a written format. The patient will be informed of the availability of free ~~interpretive~~ interpreter services. If the patient still

chooses to use a family member or friend who volunteers to interpret, then a Waiver of Interpreter Services will be initiated and entered into the patient ~~file~~medical record.

- A. KDHCDC recognizes that individuals and Health Care Providers must be able to communicate effectively. When language barriers exist between providers and patients, the quality of information is diminished and the outcome of the patient encounter may be unsatisfactory. This may lead to decreased patient compliance and increased potential for medical errors and misdiagnosis.

In emergency situations, treatment will be provided in accordance with standard medical practice. Interpreters will be sought promptly; but treatment will not be delayed pending the arrival of an interpreter.

- B. It is the policy of KDHCDC to provide equal access to and equal participation in healthcare activities for persons who are visually impaired, deaf or hard-of-hearing as well as for persons with Limited English Proficiency (LEP). KDHCDC provides communication aids and services at no cost to the patient during their course of care. It is the policy of KDHCDC to use qualified interpreters (certified, certificated or trained~~or certificated~~) during critical health services or treatment situations. Qualified Sign Language interpreters are also available.
- C. Effective communication is important in every area of hospital communication, but KDHCDC prioritizes the most careful attention to effective communication in the provision of medical, nursing and ancillary services, where patient safety, medical error, and ability to understand treatment options are affected. The following types of encounters and procedures which are performed by providers who do not speak the primary language spoken by the patient/surrogate decision-maker, and which require the use of healthcare interpreter services, including, but not limited to:
- a. Providing clinic and emergency medical services;
  - b. Obtaining medical histories;
  - c. Explaining any diagnosis and plan for medical treatment;
  - d. Discussing any mental health issues or concerns;
  - e. Explaining any change in regimen or condition;
  - f. Explaining any medical procedures, tests or surgical interventions;
  - g. Explaining patient rights and responsibilities;
  - h. Explaining the use of seclusion or restraints;
  - i. Obtaining informed consent;
  - j. Providing medication instructions and explanation of potential side effects;
  - k. Explaining discharge plans;
  - l. Discussing issues at patient and family care conferences and/or health education sessions;

- m. Discussing Advanced Directives;
  - n. Discussing end of life decisions; and,
  - o. Obtaining financial and insurance information.
  
- D. Interpreter Services are available 24 hours a day, 7 days a week and are free of charge to the patient. Interpreter Services can be made available in a variety of ways, depending on the specific needs of the patient. (See "Procedure" for additional information.)
- E. All employees shall be instructed about interpretation services during their orientation program and on an ongoing basis as appropriate.
- F. The patient's preferred language is to be noted in the patient's medical record and plan of care. This will be determined by asking, "In what language do you prefer to discuss your health care?" This is regardless of whether the patient speaks English fluently or uses another language to communicate.
- G. The policy of KDHCD shall be to provide all patients and surrogate decision-makers requiring language assistance with medical care information in their preferred language. LEP patients/surrogate decision-makers shall be advised of their right to have interpreter services provided within a reasonable time, at no charge to them.
- H. A patient is not required or expected to use friends or family members as interpreters because the use of such individuals may result in breach of confidentiality and reluctance from the patient to reveal personal information critical to the services to be provided. Should an LEP patient/patient representative insist upon the use of a friend or family member to be her/his interpreter, KDHCD needs to first ensure that the patient understands that interpreter services are legally guaranteed and free of charge. The Office of Civil Rights (OCR) Policy Guidance states that the hospital may proceed, provided that the use of such a person does not compromise the effectiveness or confidentiality of the patient, and provided that the offer and the patient's wishes are documented in the patient's file. KDHCD personnel shall ensure that the patient signs the "Waiver of Interpreter Services" showing they have refused a hospital-provided interpreter (see attached form).
- I. Patient/families are to be made aware of the bilingual resources available in the following ways:
  - a. Signage/postings
    - i. Multilingual notices are to be placed in conspicuous locations informing patients of available bilingual services and how to access them. These notices shall also contain the telephone number where patients can file complaints about interpretation services.  
Each notice shall also include a TTY number for the hearing impaired. (See attached notices in English/Spanish.)

- ii. Notices shall be posted in conspicuous areas around the facility including, but not limited to, the emergency room and major entrances, admitting areas and lobbies.
  - iii. Educational and vital documents and materials shall also be translated to Spanish and be made available to Spanish only speaking patients, as this population comprises at least 5% of KDHC patient population.
  
- J. It will be the policy of KDHC to translate and make available all Vital Documents in Threshold Languages. The translation of other hospital written materials in Frequently Encountered or other languages shall be at the discretion of the issuing staff. Vital Documents that are not produced in a written translation shall be verbally translated to the patient or surrogate decision-maker. The provision of oral translation of all Vital Documents to patients shall be documented and documentation shall become a part of the medical record.
  - a. Prior to the assignment of work to a translator, the Interpreter Services Department will provide a Materials Review process for all materials that are to be translated into Spanish to ensure:
    - i. Appropriate reading level for the target population;
    - ii. Plain language will be used. The language is simple and clear;
    - iii. Messages and illustrations are culturally appropriate;
    - iv. Document prints clearly in black and white if it will be posted on the internet for public download
  - b. The KDHC Interpreter Services Department will translate all Spanish translations, unless they are unable to meet indicated timelines. All requests for translations in any language will be routed through the Interpreter Services Department. Approved agencies may be used by the Interpreter Services Department to provide translation of patient information or education.
  - c. The Interpreter Services Department will review all translations returned by approved translation agencies before translations are returned to the department for duplication and/or distribution.
  - d. The Interpreter Services Department will assist the Marketing Department with the Spanish translation of forms, signs, pamphlets, etc. for display or distribution by KDHC. (See Policy #: AP.18)

**PROCEDURE**

- I. Notification of Interpreter Services
  - a. Notices in the form of Language ID Posters ~~and Language Easels~~ are posted in the main hallway of each facility, Emergency Dept. and outpatient areas advising patients and their families about the availability of free interpretation services, a list of available languages, and how to access an interpreter.
  
- II. Patient Identification
  - a. The first access point in which a patient acquires services

(emergency room registration, admissions, etc.) shall incorporate the determination of language needs into intake procedure.

- i. Do you speak a language other than English at home?
    - ii. In what language do you prefer to receive your medical services?
  - b. If the patient does not understand, use the Language Determination Cards/Posters to help patients identify their language.
  - c. If the patient is unable to use the Language Determination Card, and hospital staff cannot determine the appropriate language, dial 8989 for assistance with the identification of their language.
  - d. Note the patient's preferred language in the Patient's medical record, on their face sheet and the Assessment Data Base Record.
- III. Inform Patients of their Right to Have Interpreter Services
  - a. If the patient speaks a language other than English at home, the statement informing patients of their rights to interpreter services will also be provided to patients in written form in their primary language.
  - b. This statement will be translated into all Threshold Languages.
- IV. Patient Wristbands
  - a. The wristband is light blue with the message: i. DIAL EXT. 8989 FOR INTERPRETER...
  - b. In order to ensure that the preferred communication preferences follow the patient from department/facility to department/facility, a light blue wristband will be placed on the patient's wrist (dominant arm) and secured in order to identify and visually communicate to all staff that the patient has requested interpreter service be provided during his/her stay.
  - c. If the patient's condition prohibits the application of the wristband to the wrist, then the ankle may be used.
  - d. This procedure is applicable to all staff that initially register/admit the patient, as well as staff who provide patient care.
- V. The Health Care Interpreter Network (HCIN)
  - a. Simply dial 8989.
  - b. Available 24 hours a day to assist with video and phone Interpretation via any KDHCD telephone, mobile phone or video phone.
  - ~~c. Procedures are outlined on KDCentral under Department/Interpreter Services/Health Care Interpreter Network.~~
  - ~~d.c.~~ If you are asked for your ~~Access Code~~Client ID, it is 841263.
- VI. Requesting an Interpreter
  - a. Staff must utilize the appropriate interpreter for explanations of tests/procedures, surgery, to obtain informed consent, and to give critical instructions.
  - b. If the staff person determines that an "in person" interpreter is required, he/she may contact the Interpreter Services Department

- at Ext. 2501, 5981, 5902);
  - c. A Language Resource Assistant (LRA) may also be called and is listed under KNet/Directories/Interpreter Directory.
  - d. Necessary emergency care will not be withheld pending the arrival of interpreter services.
  - e. All necessary contact numbers and ~~access codes~~ client IDs for the direct contact of contracted interpreter services shall be available to Emergency Room staff and in KDCentral.
  
- VII. Hearing Impaired Patients
  - a. American Sign Language Services are available by using the HCIN video phones located throughout the hospital and outlying facilities.
  - b. Call the Interpreter Services Department at Ext. 5981, 5902, or 2501 for assistance.
  - c. TTY Machines are available through PBX or the Information Desk as well as facilities throughout the District. Please follow the operating instructions.
    - i. Plug the AC adapter into the nearest electrical outlet, connect to phone line and turn the power on.
    - ii. Pick up the headset of the telephone and dial 1-800-735-2929 or 9-711.
    - iii. Place the headset onto the TTY machine
    - iv. Patient may begin using the keyboard.
  
- VIII. Documentation:
  - a. The Staff person utilizing the qualified provider of healthcare interpreting or device will document the encounter in the patient's medical record.
    - 1. Method (Face-to-face, Telephone, Video)
    - 2. Date and time
  - b. Documentation will be maintained in the Interpreter Services Department for:
    - i. All interpretation encounters performed by KDHCD Interpreter Services Staff.
    - ii. All services provided by contracted language interpretation services, including telephonic and videophone services.
  
- IX. Waiver of Interpreter Services
  - a. If after a patient has been informed of their right to receive free interpreter services, the patient insists upon the use of a friend or family member, then the Waiver of Interpreter Services will be completed and signed by the patient.
  
- X. Qualified Providers of Healthcare Interpreting
  - a. Certified Medical Interpreters:

i. These English/Spanish speaking interpreters are obtained from the KDHCDC Interpreter Services Department. These interpreters have achieved either a CHI credential from the Certification Commission for Healthcare Interpreters or a CMI credential from the National Board of Certification for Medical Interpreters.

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a-b. Certified Medical Interpreters:

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i. These English/Spanish speaking interpreters are obtained from the KDHCDC Interpreter Services Department and have been trained as interpreters.

b-c. Language Resource Assistants:

i. A list of staff is available on the KNet service system under Directories/ Interpreter Directory.

ii. These bilingual staff members have indicated a willingness to interpret and have been tested and qualified for their ability to do so at the general or clinical/advanced level. (See Policy # HR.17).

~~iii. Currently, only English/Spanish and English/Lahu bilingual staff is listed. They are classified at the general or clinical level. (See Policy # HR.17).~~

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c. Contracted Interpreter Services

XI. VIDATAK EZ Board

- a. Available through the Interpreter Services Department as well as Patient Family Services and House Supervisor.
- b. Initially designed for mechanically ventilated patients, they also work well for patients who display communication barriers but read in their own language and need to communicate basic needs and pain levels to their care providers from their bedside.
- c. They are available in English and pictures as well as:

|         |         |            |            |            |
|---------|---------|------------|------------|------------|
| Spanish | Chinese | Vietnamese | Korean     | Indonesian |
| Russian | Tagalog | Hindi      | Japanese   | Arabic     |
| Polish  | French  | German     | Portuguese | Italian    |
| Farsi   |         |            |            |            |

## Definition of Terms

### Non-English or Limited English Proficiency (LEP)

Those individuals whose native language is other than English and who cannot speak, read, write, or understand the English language at a level that permits them to interact effectively with healthcare providers.

### Communication Barrier

Applies to a person who is deaf/hearing impaired, intubated or has neurological deficits or speaks another language hindering communication.

### Deaf

This term is generally used to describe individuals with a severe to profound hearing loss, with little or no residual hearing. Some deaf people use sign language, such as America Sign Language (ASL) or Langue des Signes Quebecoise (LSQ) to communicate using their residual hearing and hearing aids, technical devices or cochlear implants, and/or speech reading.

### Hard of Hearing “person with hearing loss”, Hearing Impaired

This term is generally used to describe individuals who use spoken language (their residual hearing and speech) to communicate. Most hard of hearing people can understand some speech sounds with or without hearing aids and often supplement their residual hearing with speech reading, hearing aids and technical devices.

### Qualified Sign Language (ASL – American Sign Language) Interpreter:

A person who is fluent in sign language and is trained and proficient in the skill and ethics of interpreting and who is knowledgeable about the specialized terms and concepts that need to be interpreted for purposes of ensuring effective communication.

### Healthcare Interpreter

One who has been trained in healthcare interpreting, adheres to the professional code of ethics and protocols of healthcare interpreters, is knowledgeable about medical terminology, and can accurately and completely render communication from one language to another.

Bilingual staff may provide patient instructions only if they had their competency tested and qualified to do so.

### Translator

One who converts written text into a written text in a second language corresponding to and equivalent in meaning to the text in the first language.

### Language Resource Assistant (LRA)

Kaweah Delta Health Care District staff member who is bilingual and who is willing to provide language interpretation. This person's language competency has been

tested and is classified as general or clinical/advanced. They are identified by either an Orange LRA pin for General or a Dark Blue LRA pin for Clinical/Advanced that must be worn on their badge. Based on the designated level of language competency, the LRA will receive additional compensation to their current salary:

General - \$ ~~2.50-00~~ (~~fifty cents~~ two dollars) for each 15 minute increment  
Clinical/Advanced - \$ ~~14.00~~ (~~one dollar~~ four dollars) for each 15 minute increment

Compensation will be provided only for actual time of interpretation if such staff member is pulled outside of their line of work or work area. If being bilingual was an initial requirement of the job or staff member interprets within the course of their own work, additional compensation will not be awarded. A log of encounters will be submitted to the Interpreter Services Department on a bi-weekly basis. LRA compensation does not apply to the KDHC Residency program.

#### Auxiliary Aids

Dual handset telephone for foreign language interpretation; qualified interpreters; telephones with volume control, Vidatak boards, patient needs communication cards; exchange of written notes.

#### Contracted Services

A designated service that provides 24-hour foreign language interpretation services either in-person or via telephone through which KDHC has contractual agreements that define expectations and response time.

#### Attachments:

Waiver of Interpreter Services  
Availability of Interpreter/Para Obtenir un Intérprete  
Available Languages from contracted services

See Administrative Policy AP.18

### Kaweah Delta Health Care District

400 W. Mineral King • Visalia, CA 93277-6263 • 559 624 2000

#### WAIVER OF INTERPRETER SERVICES

I, \_\_\_\_\_ (Patient’s name) have been informed of my right to receive free interpreter services from Kaweah Delta Health Care District. I understand that I am entitled to these services at no cost to me or my family.

I am choosing to provide my own interpreter at this time. To the best of my knowledge, this person is 18 years old or over. This person will act as my interpreter from \_\_\_/\_\_\_/\_\_\_ to \_\_\_/\_\_\_/\_\_\_. The name of my interpreter is:

NAME:

ADDRESS:

PHONE:

RELATIONSHIP TO PATIENT:

I understand I can withdraw this waiver at any time and request the services of an interpreter at no cost. I also understand that this waiver does not give permission for any interpreter to act as my Authorized Representative.

*This form was translated to me orally in \_\_\_\_\_ and I understand it.*

Yo, \_\_\_\_\_ (nombre del paciente) he sido informado de mi derecho a recibir los servicios gratuitos de tener interprete de Kaweah Delta Health Care District. Entiendo que tengo derecho a que se presten servicios gratuitos de interpretación para mí o mis familiares.

He decidido proveer mi propio intérprete en este momento. A mi mejor saber y entender, esta persona es mayor de 18 años. Esta persona me brindará servicios desde el \_\_\_\_\_ (fecha inicial) hasta el \_\_\_\_\_ (fecha final). El nombre de mi intérprete es:

NOMBRE:

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DOMICILIO:

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TELÉFONO:

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RELACIÓN AL PACIENTE:

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Entiendo que podré revocar esta renuncia en cualquier momento y solicitar los servicios de un intérprete sin cargo alguno.

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También entiendo que esta renuncia no autoriza a ningún intérprete a actuar como mi representante autorizado.

*Este formulario fue traducido para mí y entiendo su contenido.*

Signature / Firma del paciente

Date / Fecha

|  |              |
|--|--------------|
| Signature of Interpreter / Firma del intérprete              | Date / Fecha |
| Signature of Staff Person / Firma del proveedor de servicios | Date / Fecha |

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WAIVER OF INTERPRETER SERVICES

Page 1 of 2

CVBF #934 Rev. 11/07



**Kaweah Delta Health Care District**

400 W. Mineral King • Visalia, CA 93277-6263 • 559 624 2000

**WAIVER OF INTERPRETER SERVICES**

**Bill of Rights for People with Limited English Skills**

*Even if you do not speak English well, you have the right:*

- To get help from an interpreter who can translate English into your language. This service is free to you and your family;
- To be treated with courtesy and respect;
- To be treated in a way that is sensitive to your ethnic and cultural needs;
- To obtain services without facing discrimination, abuse or harassment;
- To get information about health care services in your language;
- To be part of the process of assessing your health and putting together a plan for your health services;
- To be told in your language what could happen if you accept services or refuse them;
- To raise concerns you have about the services you receive;
- To be told in your language about how to make a complaint about healthcare providers; To be told in your language about your rights and responsibilities when using services;
- To be told in your language about laws and policies a health-care provider must follow;
- To have your health care records kept confidential.

**Declaración de derechos para personas con conocimiento limitado del idioma inglés**

*Aunque no hable bien el idioma inglés, usted tiene derecho a:*

- Recibir ayuda de un intérprete que pueda traducir del inglés a su idioma. Este servicio es gratuito para usted y su familia;
- Ser tratado con cortesía y respeto;
- Ser tratado de manera sensible a sus necesidades étnicas y culturales;
- Recibir servicios sin enfrentar discriminación, abuso ni hostigamiento;
- Recibir información sobre servicios de atención de la salud en su idioma;
- Participar en el proceso de evaluación de su salud y en el desarrollo de un plan para sus servicios de salud;
- Recibir información, en su idioma, sobre lo que podría pasar si usted acepta servicios o los rechaza;

- Expresar sus preocupaciones sobre los servicios que recibe;
- Recibir información, en su idioma, sobre la forma de presentar quejas sobre proveedores de atención de la salud;
- Recibir información, en su idioma, sobre sus derechos y responsabilidades al utilizar servicios;
- Recibir información, en su idioma, sobre las leyes y normas que deben respetar los proveedores de atención de la salud;
- Que sus registros de atención de la salud se mantengan en privado.

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WAIVER OF INTERPRETER SERVICES

Page 2 of 2

CVBF #934 Rev. 11/07

### AVAILABILITY OF INTERPRETERS

Patients/surrogate decision-makers of Kaweah Delta Health Care District, who are Limited English Proficient (LEP), shall have services provided to them in their primary language or have interpreter services provided to them during the delivery of all significant healthcare services. Interpreter services shall be available within a reasonable time, at no cost to patients.

This establishment subscribes to 24 hour interpretation services provided by:  
The Health Care Interpreter Network

To obtain an interpreter for further assistance, please notify:  
Interpreter Services Department  
624-5902 or 624-5981

TTY phones for Deaf & Hearing Impaired patients will be provided when needed or requested. Please contact the Operator. A qualified American Sign Language (ASL) Interpreter may be called by contacting the Interpreter Services Department. Service provided by:  
The Health Care Interpreter Network

To file a complaint with the District regarding interpreter services provided, contact the District's Interpreter Services Manager at (559) 624-5902 or the:  
Office of Civil Rights

US Department of Health and Human Services  
90 7<sup>th</sup> Street, Suite 4-100  
San Francisco, CA 94103  
(415) 437-8310: (415) 437-8311 TDD  
Fax (415) 437-8329

You will not be penalized for filing a complaint.

## DISPONIBILIDAD DEL SERVICIO DE INTÉRPRETES

Los pacientes o personas que toman decisiones al estar bajo la atención del Kaweah Delta Health Care District, quienes cuentan con un Dominio Limitado del Inglés (LEP, por sus siglas en Inglés), recibirán servicios en su propio idioma o tendrán los servicios provistos por un intérprete al estar recibiendo atención de salud clínicamente relevante. Los servicios del Departamento de Intérpretes se proporcionarán dentro de un espacio de tiempo razonable, sin costo alguno para el paciente.

Este centro está suscrito al servicio de interpretación las 24 horas del día, y será provisto por:

**The Health Care Interpreter Network**

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Para más ayuda y conseguir un intérprete, por favor llame  
a: Interpreter Services Department  
624-5981 ó 624-5902

Los Teléfonos TTY para los pacientes Sordos e Impedidos de la Audición serán provistos cuando se necesiten o se soliciten. Por favor, comuníquese con la Operadora. Un intérprete capacitado en Lenguaje en Señas Americano (ASL, por sus siglas en Inglés) podrá ser llamado al comunicarse con el Interpreter Services Department. Dicho servicio será provistos por:

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**The Health Care Interpreter Network**

Para presentar una queja frente al Distrito respecto a los servicios de interpretación provistos, comuníquese con la Gerencia del Interpreter Services Department al (559) 624-5902 ó a:

Office of Civil Rights (Oficina de Derechos Civiles)  
US Department of Health and Human Services  
90 7th Street, Suite 4-100  
San Francisco, CA 94103  
(415) 437 – 8310, (415) 437- 8311 TDD  
Fax (415) 437-8329

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No se le penalizará por presentar una queja.

## Supported Languages and Dialects by Language

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|  |  |  |
|--|--|--|
| <b>Acholi</b> – Uganda, Sudan                                      | <b>Haitian Creole</b> – Haiti                          | <b>Nepalese</b> – Nepal, India                               |
| <b>Afrikaans</b> – South Africa, Namibia                           | <b>Haka Burmese</b> – Myanmar (former Burma)           | <b>Nuer</b> – Sudan  |
| <b>Akan</b> – Ghana, Ivory Coast                                   | <b>Hakka</b> – China                                   | <b>Oromo</b> – Ethiopia                                      |
| <b>Akateko</b> – Guatemala   | <b>Hausa</b> – Niger, Nigeria                          | <b>Palestinian Arabic</b> – Israel, Jordan                   |
| <b>Albanian</b> – Albania  | <b>Hebrew</b> – Israel                                 | <b>Pangasinan</b> – Philippines                              |
| <b>Algerian Arabic</b> – Algeria                                   | <b>Hindi</b> – India                                   | <b>Papiamentu</b> – Netherlands Antilles                     |
| <b>Amharic</b> – Ethiopia  | <b>Hmong</b> – China, Vietnam, Laos                    | <b>Pashto (Pushto)</b> – Pakistan, Afghanistan               |
| <b>Arabic</b> – Widely Distributed                                 | <b>Hungarian</b> – Hungary                             | <b>Persian (Farsi)</b> – Afghanistan, Iran, Iraq, Pakistan   |
| <b>Armenian</b> – Armenia  | <b>Ibo (Igbo)</b> – Nigeria                            | <b>Polish</b> – Poland                                       |
| <b>Ashanti (Asante Twi)</b> – Ghana                                | <b>Ilocano</b> – Philippines                           | <b>Portuguese</b> – Portugal, Brazil, et al.                 |
| <b>Assyrian</b> – Iraq   | <b>Indonesian (Bahasa Indonesia)</b> – Indonesia       | <b>Portuguese Creole (Cape Verdean)</b> – Cape Verde         |
| <b>Azerbaijani</b> – Azerbaijan                                    | <b>Iraqi Arabic</b> – Iraq                             | <b>Pulaar</b> – Senegal                                      |
| <b>Azorean Portuguese</b> – Azores Islands                         | <b>Italian</b> – Italy                                 | <b>Punjabi (Panjabi)</b> – Pakistan, India                   |
| <b>Bahnar</b> – Vietnam  | <b>Japanese</b> – Japan                                | <b>Quechua</b> – Argentina, Bolivia, Colombia, Ecuador, Peru |
| <b>Bahasa Indonesia (Indonesian)</b> – Indonesia                   | <b>Jarai</b> – Vietnam                                 | <b>Quiche (K'iche)</b> – Guatemala                           |
| <b>Bambara</b> – Mali  | <b>Javanese</b> – Indonesia                            | <b>Rade</b> – Vietnam  |
| <b>Belarusan</b> – Belarus   | <b>Jordanian Arabic</b> – Jordan                       | <b>Romanian</b> – Romania                                    |
| <b>Bengali</b> – Bangladesh, India                                 | <b>Juba Arabic</b> – Sudan                             | <b>Russian</b> – Russia                                      |
| <b>Bosnian</b> – Bosnia & Herzegovina                              | <b>Kanjolab (Q'anjob'al)</b> – Guatemala               | <b>Samoa</b> – Samoa   |
| <b>Brazilian Portuguese</b> – Brazil                               | <b>Kannada</b> – India                                 | <b>San Miguel</b> – Mexico                                   |
| <b>Bulgarian</b> – Bulgaria  | <b>Kapampangan</b> – Philippines                       | <b>Santa Eulalia</b> – Guatemala                             |
| <b>Burmese</b> – Myanmar (former Burma)                            | <b>Karen (Pa'o, S'gaw)</b> – Myanmar (former Burma)    | <b>Saraiki</b> – Pakistan, India                             |
| <b>Cambodian (Khmer)</b> – Cambodia                                | <b>Kayah</b> – Myanmar (former Burma)                  | <b>Serbian</b> – Serbia, Montenegro                          |
| <b>Cantonese</b> – China   | <b>Khmer (Cambodian)</b> – Cambodia                    | <b>Serbo-Croatian</b> – Balkans                              |
| <b>Cape Verdean (Portuguese Creole)</b> – Cape Verde               | <b>Kinyarwanda</b> – Rwanda                            | <b>Shanghai</b> – China                                      |
| <b>Catalan</b> – Andorra, Spain                                    | <b>Kirundi</b> – Burundi                               | <b>Sichuan (Szechuan)</b> – China                            |
| <b>Cebuano</b> – Philippines                                       | <b>Koho</b> – Vietnam                                  | <b>Sinhalese</b> – Sri Lanka                                 |
| <b>Chaldean</b> – Iraq   | <b>Korean</b> – Korea                                  | <b>Slovak</b> – Slovakia                                     |
| <b>Chamorro</b> – Guam   | <b>Kpele</b> – Guinea, Liberia                         | <b>Somali</b> – Somalia                                      |
| <b>Chaozhou (Teochew)</b> – China                                  | <b>Krahn</b> – Liberia, Ivory Coast                    | <b>Soninke (Serahule)</b> – Mali                             |
| <b>Chin</b> – Myanmar (former Burma)                               | <b>Krio</b> – Sierra Leone                             | <b>Sorani (Central Kurdish)</b> – Iraq                       |
| <b>Chinese (var. languages/dialects)</b> – China                   | <b>Kunama</b> – Eritrea                                | <b>Spanish</b> – Spain, Latin America, et al.                |
| <b>Chuukese (Trukese)</b> – Micronesia                             | <b>Kurdish [Kurmanji, Sorani]</b> – Iraq, Turkey, Iran | <b>Sudanese Arabic</b> – Sudan                               |
| <b>Croatian</b> – Croatia  | <b>Kurmanji (Northern Kurdish)</b> – Turkey            | <b>Susu</b> – Guinea   |
| <b>Czech</b> – Czech Republic                                      | <b>Kuwaiti Arabic</b> – Kuwait                         | <b>Swahili</b> – Kenya, Somalia, Tanzania, et al.            |
| <b>Danish</b> – Denmark  | <b>Lao</b> – Laos                                      | <b>Swedish</b> – Sweden                                      |
| <b>Dari (Afgan Farsi)</b> – Afghanistan                            | <b>Latvian</b> – Latvia                                | <b>Syrian Arabic</b> – Syria                                 |
| <b>Dene</b> – Canada   | <b>Lebanese Arabic</b> – Lebanon                       | <b>Tagalog (Filippino)</b> – Philippines                     |
| <b>Dewoin</b> – Liberia  | <b>Lingala</b> – Congo, Republic of the                | <b>Tai Dam</b> – Vietnam                                     |
| <b>Dinka</b> – Sudan   | <b>Lithuanian</b> – Lithuania                          | <b>Taiwanese</b> – Taiwan                                    |
| <b>Duala</b> – Cameroon  | <b>Luganda</b> – Uganda                                | <b>Tamil</b> – India   |
| <b>Dutch</b> – Netherlands   | <b>Luo</b> – Kenya                                     | <b>Telugu</b> – India  |
| <b>Egyptian Arabic</b> – Egypt                                     | <b>Maay (Af Maay, Rahanween, Bantu)</b> – Somalia      | <b>Teochew (Chaozhou)</b> – China                            |
| <b>Estonian</b> – Estonia  | <b>Macedonian</b> – Macedonia                          | <b>Thai</b> – Thailand                                       |
| <b>Ewe</b> – Ghana   | <b>Malay</b> – Malaysia                                | <b>Tibetan</b> – China                                       |
| <b>Fante</b> – Ghana   | <b>Malayalam</b> – India                               | <b>Tigrigna (Tigrinya)</b> – Ethiopia, Eritrea               |
| <b>Farsi (Persian)</b> – Afghanistan, Iran, Iraq, Pakistan         | <b>Malinke</b> – Senegal                               | <b>Toishanese</b> – China                                    |
| <b>Fijian</b> – Fiji   | <b>Mam</b> – Guatemala                                 | <b>Tongan</b> – Tonga  |
| <b>Filipino (Tagalog)</b> – Philippines                            | <b>Mandarin</b> – China                                | <b>Trukese (Chuukese)</b> – Micronesia                       |
| <b>Finnish</b> – Finland   | <b>Mandinka (Mandingo)</b> – Senegal                   | <b>Tunisian Arabic</b> – Tunisia                             |
| <b>Flemish</b> – Belgium   | <b>Marathi</b> – India                                 | <b>Turkish</b> – Turkey                                      |
| <b>French</b> – Africa, Canada, France, Tunisia, et al.            | <b>Marshallese</b> – Marshall Islands                  | <b>Twí</b> – Ghana   |
| <b>French Creole</b> – Caribbean                                   | <b>Mayan [Akateko, Kanjobal]</b> – Guatemala, Mexico   | <b>Tzotzil</b> – Mexico                                      |
| <b>Fukienese</b> – China   | <b>Mien</b> – China, Laos, Thailand                    | <b>Ukrainian</b> – Ukraine                                   |
| <b>Fulani (Fulfulde, Fula)</b> – Cameroon, Niger, Nigeria, Senegal | <b>Mina (Gen)</b> – Togo, Benin                        | <b>Urdu</b> – Pakistan, India                                |
| <b>Fuzhou</b> – China  | <b>Minangkabau</b> – Indonesia                         | <b>Vietnamese</b> – Vietnam                                  |
| <b>Ga</b> – Ghana  | <b>Mixteco Alto</b> – Mexico                           | <b>Wolof</b> – Senegal                                       |
| <b>Gen (Mina)</b> – Togo, Benin                                    | <b>Mixteco Bajo</b> – Mexico                           | <b>Xhosa</b> – South Africa                                  |
| <b>German</b> – Germany  | <b>Mnong</b> – Vietnam                                 | <b>Yemeni Arabic</b> – Yemen                                 |
| <b>Gokana (Khana)</b> – Nigeria                                    | <b>Mongolian</b> – Mongolia                            | <b>Yiddish</b> – Israel                                      |
| <b>Greek</b> – Greece  | <b>Moroccan Arabic</b> – Morocco                       | <b>Yoruba</b> – Nigeria                                      |
| <b>Gujarati</b> – India  | <b>Nahuatl</b> – Mexico                                | <b>Yup'ik</b> – U.S.A (Alaska)                               |
|  | <b>Navajo</b> – U.S.A. (Southwest)                     | <b>Zulu</b> – South Africa                                   |
|  |  | <b>Zarma</b> – Niger   |

|                  |                 |                 |                |              |
|------------------|-----------------|-----------------|----------------|--------------|
| Afghani          | Croatian        | Hmong           | Maltese        | Shona        |
| Afrikaans        | Czech           | Hokkien         | Mandarin       | Sicilian     |
| Akan             | Danish          | Huizhou         | Mandingo       | Sindhi       |
| Albanian         | Dari            | Hungarian       | Marathi        | Sinhala      |
| Amharic          | Dene            | Icelandic       | Mien           | Slovakian    |
| Arabic           | Dinka           | Igbo/Ibo        | Micif          | Slovenian    |
| Aramaic          | Dogrib          | Ilocano         | Min Nan        | Somali       |
| Armenian         | Dutch           | Indonesian      | Moldavian      | South Slavey |
| Assyrian         | Eritrean        | Inuinaktun      | Mongolian      | Spanish      |
| Azərbayjani      | Estonian        | Inuktitut       | Ndebele        | Susu         |
| Azari/Azeri      | Fante           | Italian         | Nepali         | Swahili      |
| Belorussian      | Farsi           | Japanese        | North Slavey   | Swedish      |
| Bengali          | Fijian          | Kakwa           | Norwegian      | Tagalog      |
| Berber           | Finnish         | Karen           | Nuer           | Taiwanese    |
| Bosnian          | Flemish         | Khmer/Cambodian | Nyanja         | Tamil        |
| Bulgarian        | Formosan        | Kinyarwanda     | Nzema          | Telegu       |
| Burmese          | French          | Kirundi         | Ojibway        | Thai         |
| Cantonese        | French-Canadian | Kiswahili       | Ojicree        | Tibetan      |
| Cebuano          | Frisian         | Korean          | Oromo          | Tigrinya     |
| Chaldean         | Fuchownese      | Kurdish         | Polish         | Toisan       |
| Chao Chow        | Fur             | Kutchi          | Portuguese     | Tongan       |
| Chilcotin        | Ga              | Lao             | Punjabi        | Turkish      |
| Chipewyan        | German          | Latin           | Pushto         | Turkmen      |
| Cree             | Greek           | Lingala         | Romanian       | Twi/Asante   |
| Cree-James Bay   | Gujarati        | Lithuanian      | Russian        | Ukrainian    |
| Cree-Plains      | Gwichin         | Low German      | Salish         | Urdu         |
| Cree-Swampy Cree | Hakka           | Lugbara         | Sanskrit       | Uyghur       |
| Cree-Swampy      | Hausa           | Ma Di           | Saulteaux      | Veneto       |
| Cree-Woodlands   | Harari          | Macedonian      | Serbian        | Vietnamese   |
| Creole           | Hebrew          | Malay           | Serbo-Croatian | Yiddish      |
| Creole-Haitian   | Hindi           | Malayalam       | Shanghainese   | Zulu         |

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| Policy Number: AP97  | Date Created: No Date Set       |
| Document Owner: Cindy Moccio (Board Clerk/Exec Assist-CEO)       | Date Approved: Not Approved Yet |
| Approvers: Board of Directors (Administration), Executive Team A |                                 |
| <b>Bioethics Committee</b>                                       |                                 |

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

**Purpose:** In recognition of the complexity of modern medical practice and the multiple ethical issues which may arise in the provision of patient care, Kaweah Delta Medical Center will establish and maintain a Bioethics Committee to assist patients, families, hospital and medical staff in effectively addressing bioethical issues.

**Policy:** The Bioethics Committee (hereinafter referred to as “the committee”) shall ~~exist as a committee of the Medical Staff and~~ fulfill the following functions:

1. Provide education for patients, families, hospital and medical staff regarding relevant bioethics issues.
2. Provide the institution assistance with the analysis and development of policies and procedures regarding bioethics issues.
3. Provide Bioethics Consultation Services to assist patients, families, hospital and medical staff in addressing bioethics issues arising in the provision of patient care. This is an advisory function, only.

**Procedure:**

- I. Education: In cooperation with the hospital/medical staff, the committee will assist in identifying educational needs and develop (or assist others in the development of) appropriate educational resources to meet these needs. These resources can include presentations, CME courses, etc. The goal will be to provide participants with language, concepts and a body of knowledge to assist in addressing complex ethical issues arising in hospital practice.
  1. Identified educational needs will be reviewed at the next available committee meeting or by the Chair or Vice Chair between meetings if the need is urgent.
  2. Committee members will establish contact with a point person for the educational need and will work with this individual to develop a plan for addressing the need.
  3. A summary of educational service provided will be reviewed at next available meeting of the committee.

4. Materials used in the educational service will be archived in the Bioethics Committee Chair and/or Vice Chair ~~Medical Staff~~ Office for possible use in future educational services.
  5. Committee member providing educational service will obtain feedback from the “customer” regarding effectiveness of service provided and include this in summary presentation to the committee
- II. Policy Review & Development: The committee will assist the institution and its professional staff in the analysis of current policies and the development of new policies and procedures regarding bioethical issues.
1. Hospital and Medical staff members who identify possible need for policy review/development will contact the Bioethics Committee Chair or Vice Chair ~~Medical Staff Office~~ to request placement of policy on committee meeting agenda. Chair or Vice Chair will provide immediate review and consult with h appropriate hospital/medical staff h the Chief Medical Officer and/or Risk Manager as appropriate, if the need is urgent.
  2. Policy/procedure will be reviewed at committee meeting and committee member will be assigned to assist staff in further analysis and review as needed.
  3. Results of analysis and review and committee recommendations will be discussed and documented in the minutes of the next committee meeting.
- III. Bioethics Consultation Service: The committee will provide both informal and formal consultation services at the request of medical staff, hospital staff, patients, family members and/or surrogate decision makers which arise in the course of patient care provision.
1. Requests for bioethics consultation will be submitted by contacting the Bioethics Committee Chair or Vice Chair ~~Medical Staff Office~~ and will be responded to within 24 hours or by the next business day.
  2. Depending on the issue, a committee member will be identified as “Team Lead” who will provide initial review and will consult with committee chair to determine appropriate level of consultation.
  3. If **Informal Consultation** services are indicated:
    - a. Team Lead facilitates contact between requestor and appropriate committee member.
    - b. Committee member provides consultation services and provides a summary of same at next scheduled committee meeting.
  4. If **Formal Consultation** Services are indicated:
    - a. Team Lead will obtain the following information: Review of Medical Record noting patient’s diagnosis/prognosis/treatment plan; formulate bioethical issues/questions; establish decision makers (i.e., patient, family, surrogate).

- b. Team Lead will consult with Chair to establish plan for physician contact and consultation process/structure.
  - c. Team Lead will contact all appropriate parties and schedule Bioethics Consultation meeting (s) as appropriate.
  - d. Team Lead will ensure that all parties are advised of recommendations provided through the consultation process and that these recommendations are documented.
  - e. If, following Formal Consultation, the bioethics issues remain unresolved, Bioethics Chair will consult with appropriate hospital/medical staff ~~Chief of Staff or designee~~ to determine appropriate plan of action.
  - f. Summary of Formal Consultation will be provided by Team Lead at next committee meeting.
- IV. Appointment and Membership: The committee shall be a multidisciplinary body including representatives from the following disciplines: medical staff, nursing, social work, pastoral care, risk management, board members and community members.
1. New members will be recommended by the committee and appointed by the Bioethics Committee Chair or Vice Chair. ~~Chief of Staff~~.
  2. The Chair of the committee will be appointed by the Chief of Staff.
  3. The Vice Chair of the committee will be chosen by the membership of the committee.
  4. Membership shall be for a period of two (2) years with staggered terms to assure continuity. Committee Members can serve beyond the 2 year period by mutual agreement of the Chair/Vice Chair and the committee member.
  5. Each hospital (employee) member will designate a temporary replacement who will attend meetings in the event that a committee member is unable to fulfill committee responsibility.
- V. Meetings: The Bioethics Committee shall meet quarterly ~~bimonthly~~, with additional meets scheduled as appropriate to address urgent matters.
1. Meeting agenda will be developed by the Chair and distributed one week prior to the meeting.
  2. For business purposes, two members shall constitute a quorum.
  3. Actions of the committee will be taken by the vote of a majority of the members attending the meeting.
  4. Each member will be required to attend at least three (3) of the committee's regularly scheduled meetings each year. Failure to do so will be considered voluntary resignation and the vacancy will be filled by appointment of a new member.

- VI. Record Keeping: The committee will maintain minutes of all meetings which will include summaries of all case reviews and recommendations.
1. Minutes will be submitted to the Chair for approval by the committee.
  2. Minutes will not include identifying information about specific patient, family members, individual requesting consultation or professional staff participating in the case review process.
  3. Records of the committee meetings and functions will be maintained in accordance with ~~Medical Staff Bylaws and~~ applicable laws governing the confidentiality of records and medical review committees.
  4. When appropriate, actions and recommendations of the committee will be documented in the patient record.
- VII. Liability: Kaweah Delta Medical Center will provide liability protection for the committee members who do not have such protection by virtue of their status as members of the professional staff.
- VIII. Adoption and Approval of Policies and Procedures: Policies and procedures of the committee will be reviewed as appropriate by the membership of the committee.
1. Proposed modifications of approved policies and procedures will be submitted to the committee in writing at least four (4) weeks in advance of a regularly scheduled meeting.
  2. Following recommendation by the committee, policies/procedures will be forwarded to the appropriate committee for subsequent action.

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| Policy Number: AP73   | Date Created: No Date Set       |
| Document Owner: Cindy Moccio (Board Clerk/Exec Assist-CEO)                            | Date Approved: Not Approved Yet |
| Approvers: Board of Directors (Administration)  |                                 |
| <b><u>Accommodating Persons with Service Animals</u> <del>Use of Guide Dogs</del></b> |                                 |

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**POLICY:** ~~Many people with disabilities use a service animal in order to fully participate in everyday life.~~ Kaweah Delta Health Care District (“Kaweah Delta”), in conformance with Federal and State Americans with Disabilities Act (ADA) requirements, will allow any visitor or patient the use of service animals~~guide dogs~~ as auxiliary aids. The ADA definition of service animals is any “dog individually trained to do work or perform tasks directly related to the partner’s disability, including, but not an limited to, guiding individuals with impaired vision, alerting individuals who are hearing impaired to intruders or sounds, providing non-violent protection or rescue work, pulling a wheelchair, fetching dropped items, assisting an ~~individua~~ individual during a seizure, alerting individuals to the presence of allergens, or helping persons with psychiatric and neurological disabilities by preventing or interrupting ~~impulsice~~ or destructive behaviors.” If an animal meets this definition, it is consideration a service animal regardless of whether it has been licensed or certified by a state or local government or a training program.

The service animals~~dogs~~ may be used in all situations except where it can clearly be shown that the presence or use of the animal would pose a significant health risk; in sterile areas such as the operating room, and newborn nursery; in the intensive care unit; or where the animal's~~dog's~~ behavior is disruptive to the environment.

**PROCEDURE:**

- I. Visitors - Unless specifically excluded above, visitors shall be allowed the use of a service animal~~guide dog~~ in accordance with the District Kaweah Delta's visitation ~~visiting~~ policy. For clarifications or questions, contact the House Supervisor for determination.
- II. Patients
  - A. Outpatient Settings -- Service Animals~~Guide~~ dogs will be allowed in the outpatient setting.
  - B. Inpatient Settings - When a patient who is dependent upon a service animal~~guide dog~~ is hospitalized on bed rest and unable to care for

~~him/herself the service animal, the dog will not be permitted to remain at the District facility. the patient can make arrangements for a family member or friend to come to the hospital to provide these services or to keep the dog during the hospitalization. -~~

When the hospitalized patient is able to ambulate ~~ambulatory~~ or may benefit clinically from having the service animal~~guide dog~~ present, the animal~~dog~~ will be permitted to remain with the patient. The patient, family member, and/or designee will be responsible for grooming, feeding, and toileting the service animal~~dog~~.

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| Policy Number: AP107   | Date Created: No Date Set       |
| Document Owner: Cindy Moccio (Board Clerk/Exec Assist-CEO)       | Date Approved: Not Approved Yet |
| Approvers: Board of Directors (Administration)                   |                                 |
| <b>Patient Privacy Use and Disclosure of Patient Information</b> |                                 |

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**PurposePURPOSE:** This policy outlines how ~~KDHCD~~ Kaweah Delta Health Care District (Kaweah Delta) complies with the patient privacy requirements and the use and disclosure of Protected Health Information (patient informationPHI) in accordance with the Federal Health Insurance Portability and Accountability Act and the requirements of State of California privacy-related laws and regulations.

**PolicyPOLICY:** ~~KDHCD~~ Kaweah Delta complies with all Federal and State of California laws and regulations with regards to protecting patient privacy and using or disclosing patient information. When PHI is used, disclosed, or requested, Kaweah Delta will take reasonable efforts to limit the PHI that is used, disclosed, or requested to the minimum amount necessary to accomplish the purpose of the use, disclosure, or request.

**DEFINITIONS:**

**“Limited Data Set”** is protected health information that excludes direct identifiers of patients, including: (a) names, (b) address information, other than town or city, State, and zip code (5-number zip code), (c) telephone numbers, (d) fax numbers, (e) electronic mail addresses, (f) social security numbers, (g) medical record numbers, (h) health plan beneficiary numbers, (i) account numbers, (j) certificate/license numbers, (k) vehicle identifiers and serial numbers, including license plate numbers, (l) device identifiers and serial numbers, (m) web universal resource locators (URLs), (n) Internet Protocol (IP) address numbers, (o) biometric identifiers, including finger and voice prints; ~~and~~ (p) full face photographic images and any comparable images; and (q) any other unique identifying number, characteristic or code.

+

**“Organized Health Care Arrangement”** means a clinically integrated care setting in which individuals typically receive health care from more than one health care provider or an organized system of health care where more than one covered entity participates and where the participating covered entities and the providers hold themselves out to the public as participating in a joint arrangement. For ~~KDHCD~~ Kaweah Delta, the District, including all of its

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facilities and services, credentialed medical staff, and allied health professionals, is in an organized health care arrangement.

~~“Protected Health Information (PHI)” Individually identifiable health information that is transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. May also be referred to as electronic protected health information (ePHI).~~

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~~of~~  
means A any information in any form or medium that is created or received by Kaweah Delta that relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual. (See AP.53 Patients’ Rights and Responsibilities for a more comprehensive definition)

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~~of~~  
Information (i) that is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse about a patient and (ii) including demographic information that may identify a patient that relates to the patient’s past, present, or future physical or mental health or condition, related health care services, or payment for health care services.

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III. ~~“Protected Health Information” (“PHI”) means individually identifiable health and demographic information created by KDHCD Kaweah Delta and relating to the physical or mental health or the provision of care to an individual which identifies the individual; or with respect to which there is a reasonable basis to believe the information can be used to identify the individual. It includes verbal, written or electronically maintained information.~~

**PROCESS:**

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I. ~~Uses of PHI~~

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~~I. KDHCD Kaweah Delta may use or disclose PHI for treatment of patients, request payment for services, and for health care operations activities. KDHCD Kaweah Delta discloses PHI to other health care providers and/or business associates for these same activities to ensure continuity of care.~~

II. Disclosures of PHI –

A. For disclosures of PHI except as permitted or required by this policy, ~~KDHCD Kaweah Delta~~ shall obtain a valid authorization from the patient or their personal representative. ~~(See policy AP.04, Patient Access to and Release of Health Information)~~ ~~Access and Release of Protected Health Information)~~

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1. The authorization shall become a part of the patient's medical record. A copy of the signed authorization must be provided to the individual.
  2. An individual may revoke an authorization in writing.
    - a) The revocation does not apply to actions KDHCDKaweah Delta has taken in reliance on the authorization.
    - b) The written revocation shall become a part of the individual's medical record.
- B. KDHCDKaweah Delta may use or disclose an individual's PHI provided that the individual is informed in advance of the use or disclosure and the individual has the opportunity to agree, prohibit, or restrict the use or disclosure. KDHCDKaweah Delta may verbally inform the individual of and obtain the individual's verbal agreement or objection to a use or disclosure permitted by this section.
1. KDHCDKaweah Delta may use the following PHI to maintain a directory of individuals in its facility: (a) the individual's name, (b) the individual's location in KDHCDKaweah Delta's facility, (c) the individual's condition described in general terms that does not communicate specific medical information about the individual, and (d) the individual's religious affiliation.
  2. Disclosures for involvement in the patient's care and notification purposes:
    - a) KDHCDKaweah Delta may disclose to a family member, other relative, or a close personal friend of the individual, or any other person identified by the individual, the PHI directly relevant to such person's involvement with the individual's care or payment related to the individual's health care.
    - b) KDHCDKaweah Delta may use or disclose PHI or assist in the notification of (including identifying or locating), a family member, a personal representative of the individual, or another person responsible for the care of the individual of the individual's location, general condition-, or death.
    - c) If the individual is present for, or otherwise available prior to, a use or disclosure permitted as described in a) or b) above, and has the capacity to make health care decisions, KDHCDKaweah Delta may use or disclose the PHI if KDHCDKaweah Delta obtains the individual's agreement, provides the individual with the opportunity to

object to the disclosure, and the individual does not express an objection; or reasonably infers from the circumstances that the individual does not object to the disclosure.

- d) If the individual is not present, or the opportunity to agree or object to the use or disclosure cannot practicably be provided because of the individual's incapacity or an emergency circumstance, ~~KDHCD~~Kaweah Delta may determine whether the disclosure is in the best interests of the individual and, if so, disclose only the PHI that is directly relevant to the person's involvement with the individual's health care.
- e) ~~KDHCD~~Kaweah Delta may disclose PHI to a public or private entity available to assist in disaster relief efforts.

C. In certain situations, ~~KDHCD~~Kaweah Delta shall disclose PHI without an authorization or verbal agreement from the individual.

- 1. ~~KDHCD~~Kaweah Delta shall disclose PHI to public health authorities or law enforcement agencies to the extent the disclosure is required by law. The disclosure shall be limited to the relevant requirements of such law and will be made in accordance with AP.04 Access and Release of Protected Health Information (PHI); AP.66 Suspected Child and/or Dependent Adult Abuse Reporting; DC.05 Child Abuse/Sexual Abuse Reporting Requirements; AS.03 Suspected Elder/Dependant Adult Abuse Reporting; AS.05 Domestic Violence; AS.02 Suspected Child Abuse Reporting; and the following Emergency Department policies: ED.1004 Deadly Weapons or Criminal Act Injuries Report; ED.#1006 Examination/Testing for the Collection of Evidence; #IP 1.7 Reporting Infection/Communicable Disease, ED.4013 Overdose or Poisoning: Management and Referral; and ED.#3002 Patients Who Present to ED with Complaint of Suspected Sexual Assault~~Sexual Assault Triage Protocol.~~
- 2. ~~KDHCD~~Kaweah Delta shall disclose PHI as necessary, and as allowable under state and federal laws, to avert a threat to health or safety.
- 3. ~~KDHCD~~Kaweah Delta shall disclose PHI for specialized government functions including:
  - a) Disclosure to military command authorities regarding armed forces personnel.

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b) Disclosures to authorized federal officials for intelligence and national security activities.

4. ~~KDHCD~~Kaweah Delta shall disclose PHI regarding an inmate to a correctional institution or a law enforcement official.

5. ~~KDHCD~~Kaweah Delta shall disclose PHI to the extent necessary to comply with laws regarding workers' compensation or other similar programs.

III. Other requirements regarding the use and disclosure of PHI include:

A. ~~KDHCD~~Kaweah Delta may use or disclose health information which has been **de-identified** by: removing the following identifiers:

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- Names
- Geographic subdivisions smaller than State, i.e. address, city, county, precinct, zip code
- All elements of dates except year for birth dates & all elements, including year, for all ages over 89
- Telephone number
- Fax number
- E-mail address
- Social security number
- Medical record numbers
- Health plan beneficiary numbers
- Account numbers
- Certificate/license numbers
- Vehicle ID & serial numbers; license plate numbers
- Device identifiers and serial numbers
- URLs or Internet Protocol address numbers
- Biometric identifiers including finger & voice prints
- Full face photographic images or comparable images
- Any other unique identifying number, characteristic or code

B. ~~KDHCD~~Kaweah Delta shall limit the PHI used and/or disclosed on a routine basis to the **minimum amount necessary**.

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1. Use of PHI shall be limited to only the information needed for an employee or volunteer to do their job.

2. Disclosure of PHI shall be limited to only the information necessary to accomplish the purpose for which the disclosure is made.

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3. Unless the circumstances are unreasonable, Kaweah Delta staff may rely on a request from one of the requestors listed below as establishing the minimum necessary PHI that may be disclosed to:

a) Public officials that are requesting PHI in accordance with the requirements of 45 CFR § 164.512 for the performance of public health functions, health oversight functions, law enforcement functions, and specialized government functions, if the public official demonstrates that the information requested is the minimum amount necessary to perform the function.

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i. Staff will verify the identity of public officials by:

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a. Looking at the agency identification badge, official credentials or other proof of government status for requests made in person.

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b. Noting that the request is on appropriate government letterhead for requests made in writing.

ii. Staff will verify the authority of public officials by:

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a. Receiving a written statement of legal authority or documenting an oral statement of such authority.

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b. Accepting a civil, judicial or administrative warrant, subpoena, order or other legal process.

b) Another healthcare provider

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c) A business associate (as established by way of written agreement or contract)

2. A professional that is a member Kaweah Delta staff, or a business associate of Kaweah Delta that is requesting the information to provide professional services to Kaweah Delta, provided that the professional demonstrates that the information requested is the minimum necessary required for the purpose requested.

d) \_\_\_\_\_

3. A researcher that is requesting PHI for research purposes and that provides an authorization from an individual, a waiver of authorization from an instructional review board (IRB), a data use agreement, assurance regarding use preparatory to research, or an assurance regarding the use of decedents' PHI.

~~e) \_\_\_\_\_~~

- C. ~~KDHCDKaweah Delta~~ will sometimes disclose information to a contracted business associate in a limited data set for the purposes of research, public health or health care operations. In these cases, the business associate contract shall be amended to include a data use agreement. The Privacy Officer shall ensure that data use agreements comply with the content requirements of the HIPAA Privacy regulation.
- D. ~~KDHCDKaweah Delta~~ may share demographic information and dates of health care provided to a patient with the ~~KDHCDKaweah Delta~~ Foundation. Any fundraising materials sent out shall include a description of how the individual may opt out of receiving any further fundraising communications.
- E. **Prior** to disclosing patient information, ~~KDHCDKaweah Delta~~ staff shall verify the identity of the person requesting the information **and** the authority of that person to access the information.

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- ~~1. Staff will verify the identity of public officials by:~~
  - ~~a) Looking at the agency identification badge, official credentials or other proof of government status for requests made in person.~~
  - ~~b) Noting that the request is on appropriate government letterhead for requests made in writing.~~
- ~~2. Staff will verify the authority of public officials by:~~
  - ~~a) Receiving a written statement of legal authority or documenting an oral statement of such authority.~~
  - ~~b) Accepting a civil, judicial or administrative warrant, subpoena, order or other legal process.~~

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|  |                                 |
|--|---------------------------------|
| Policy Number: AP133   | Date Created: No Date Set       |
| Document Owner: Cindy Moccio (Board Clerk/Exec Assist-CEO)       | Date Approved: Not Approved Yet |
| Approvers: Board of Directors (Administration)                   |                                 |
| <b>Patient Elopement Critical Incident Response - Code Green</b> |                                 |

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

**POLICY:** Kaweah Delta Health Care District (KDHCD) is committed to the safety and security of all patients. All physicians and staff are responsible for responding quickly and appropriately in the event of the elopement of a cognitively impaired patient who may be at risk for harm, including patients on a voluntary or involuntary psychiatric hold who leave the hospital without notification of KDHCD staff. Unit personnel will respond immediately when a patient is identified as missing. This policy excludes competent patients leaving against medical advice (AMA).

**PROCEDURE:**

When a cognitively impaired patient, or a patient who is on an ~~voluntary -or~~ involuntary psychiatric hold such as a W&I 5150 or 5250, or a medical hold pending a psychiatric evaluation such as a H&S1799.111 is believed to be missing from -our facilities, or is observed ~~to leave~~ leaving a facility, the following process will be followed in response to the elopement: :

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- I. Call "44" to activate the overhead paging and announce a "Code Green", giving exact location to alert all staff a patient is missing or in the process of elopement. Hospital Security and all available staff will respond immediately to the location.

If patient is combative and leaving, the staff member noting the elopement will stay with the patient and alert the next nearest staff member to initiate a "Code Green". The staff member monitoring the patient will take all reasonable precautions to ensure the safety of the patient, without placing him or herself in harm's way.

The Visalia Police Department will be notified by a "9-911" call, if the patient leaves the facility.

- II. The Nurse Manager, (or Charge Nurse/Team Lead) will respond to the code alert and gather the following information:

- A. Patient name, room number, gender, approximate height and weight, hair color, race, photograph if available, and any other identifying information (e.g. using a wheelchair).
  - B. Time patient was last seen and description of what patient was wearing.
  - C. If the missing patient had any visitors in the last 24 hours, i.e. who visited the patient and when.
  - D. The area the patient left from and what direction they were going.
  - E. Notification of the patient's family.
- III. On weekends or when an administrator is not on campus, the nurse in charge of the patient will notify the House Supervisor. If the patient is not located, the House Supervisor will notify the administrator on-call and Risk Management.
- IV. If the elopement was not observed and a patient is found to be missing, all available personnel will search all rooms within the unit and initiate a "Code Green". If the patient is not found, the staff will follow the protocol listed in numbers I and II above.
- V. If staff are unable to find the patient within the building, KDHC staff will search the immediate grounds outside of KDHC's buildings and campus.
- VI. If the patient is not found, nursing staff will call the family and notify them of the patient's absence. Patient and Family Services should be notified to assist with calling the family or guardian of the patient.
- VII. If the patient is not found, the Nurse Manager, Charge Nurse or Team Lead will notify the Visalia Police Department with a "9-911" call to initiate an area search.
- VIII. Documentation of the patient's return to the facility will include:
- A. Time of return.
  - B. Patient's reason for leaving (if known), and where they went while AWOL.
  - C. Assessment of patient, including current vital signs (BP, T, P, R).
  - D. Interventions implemented (i.e.: sitter, TAB monitor).
  - E. Individuals notified of patient's return (Administration, Physician, and Family).
  - F. Completion of ~~an NOE~~ an occurrence -Midas R-report.

**PROCEDURE REFERENCES:**

[California Welfare & Institution Code Section 5150 and 5250](#)  
[California Health & Safety Code Section 1799.111](#)

Patient Elopement Critical Incident Response - Code Green  
3

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| Policy Number: AP104                                       | Date Created: No Date Set       |
| Document Owner: Cindy Moccio (Board Clerk/Exec Assist-CEO) | Date Approved: Not Approved Yet |
| Approvers: Board of Directors (Administration)             |                                 |
| <b>Animal Assisted Activities / Therapy (AAA/AAT)</b>      |                                 |

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

~~**PURPOSE:** To govern safe, conscientious, and professional involvement of animals in Animal Assisted Activities/Therapy within Kaweah Delta Health Care District.~~

**POLICY:** The Recreation Therapist and Activity Coordinators ~~located at the West campus~~ will coordinate and supervise the AAA/AAT program assuring that all participants are in compliance. Animal-Assisted Activities (AAA) provide opportunities for motivational, educational, recreational, and/or therapeutic benefits to enhance quality of life. Specially trained professionals, para-professionals, or volunteers in association with animals that meet specific criteria deliver AAA.

Animal-Assisted Therapy (AAT) is a goal-directed intervention in which an animal that meets specific criteria is an integral part of the patient's treatment process. AAT is directed and or delivered by a health or human service professional with specialized expertise and within the scope of practice of his or her profession. AAT is designed to promote improvement in human physical, social, emotional, and/or cognitive functioning. AAT may be group or individual in nature. ~~The process is documented and evaluated.~~

**PROCEDURE:**

- I. Any employee/authorized volunteer wishing to be involved in AAA/AAT must be registered with an AAA/AAT organization such as the Delta Society, Therapy Dogs International, etc. ~~The AAA/AAT coordinator is available to evaluate for registration.~~ AAA/AAT is currently limited to dogs.
- II. A yearly health/vaccination certificate will must be kept on file in with the ~~Kaweah Delta Rehabilitation Hospital~~ Recreation Therapist or Activity Coordinatory office.
- III. Handlers will evaluate the animal's health prior to each visit and will not bring an animal whose general well being is compromised or who has external parasites.
- IV. Animals found to have external parasites or who demonstrate illness during a visit will be immediately removed from the premises.
- V. Animals will be effectively controlled by leash (six foot maximum)

- VI. Animals will be bathed/groomed prior to visit.
- VII. Animals are not allowed in areas where medications are prepared or where food is being served.
- VIII. All persons coming in contact with animals shall utilize proper and frequent hand washing. Animals are not to be fed by patients during the visit.
- IX. The rights of patients, visitors, and staff not wishing to have contact with an animal will be respected.
- X. The rights of the animals for access to water, exercise areas, safety and freedom from undue stress will be respected.
- XI. The presence of animals in the hospital shall not lessen the standard of housekeeping or contribute to an objectionable odor.
- XII. Animals are to be toileted prior to visit. If toileting need arises during the visit, outdoor grass areas may be used. It is the responsibility of the handler to properly dispose of waste. Should an "accident" occur, the handler should seek assistance from staff/housekeeping for appropriate clean up.
- XIII. Should an incident occur (scratch, bite, severe adverse or allergic response, etc.) standard hospital injury protocol will be implemented.
- XIV. Incidents will be reviewed by the AAA/T coordinator, rehabilitation director, and handler. The animal may be placed on probation or asked to retire.
- XV. Female animals shall either be spayed or determined not to be in estrus while visiting.
- XVI. Human-animal volunteer teams may have their privilege for participation in the program suspended or revoked if any of the following occur:
  - A. The handler is unable to demonstrate adequate control of an animal.
  - B. The animal's temperament, behavior, or health is not appropriate (either on one visit or consistently over time).
  - C. The handler does not maintain standards of personal appearance for self or the animal.
  - D. Confidentiality is breached.
  - E. Volunteer misses three consecutive visits.

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| Policy Number: AP18  | Date Created: 06/01/1998        |
| Document Owner: Cindy Moccio (Board Clerk/Exec Assist-CEO) | Date Approved: Not Approved Yet |
| Approvers: Board of Directors (Administration)             |                                 |
| <b>Foreign Language Forms, Signs, Etc.</b>                 |                                 |

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

**POLICY:** To ensure quality of translation, all forms, signs, pamphlets, brochures, etc., produced for display on or distribution by Kaweah Delta Health Care District, in a language other than English, will be coordinated through the Marketing and Interpreter Services Departments. ~~to provide proper content and structure meeting District standards.~~

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| Policy Number: AP122                                       | Date Created: No Date Set       |
| Document Owner: Cindy Moccio (Board Clerk/Exec Assist-CEO) | Date Approved: Not Approved Yet |
| Approvers: Board of Directors (Administration)             |                                 |
| <b>Interpreter Services</b>                                |                                 |

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

**PURPOSE:**

- A. To define the communication system that is used for patients who are Limited English Proficient (LEP) or who are deaf or hard of hearing (hearing impaired). Such a system will include appropriate “auxiliary aids” and/or language interpretation services to ensure effective communication between patients and staff during critical health services or treatment situations.
- B. To provide guidelines for coordinating timely response to meeting the assessed special language needs of individual patients, their designated representative, guardian or next of kin.
- C. To comply with the Americans with Disabilities Act (ADA), Title VI of the Civil Rights Act of 1964 and Health and Safety Code of California

Health and Safety Code of California requires licensed general acute care hospitals to provide language assistance services to patients with language or communication barriers.

Title VI of the Civil Rights Act of 1964 requires federal fund recipients to ensure the eligible Limited English Proficiency (LEP) persons have “meaningful access” to health services.

ADA Title II requires that public accommodations provide “auxiliary” aids when necessary to enable a person with disabilities to benefit from their services.

**POLICY:** It is the policy of Kaweah Delta Health Care District (KDHCD) to provide, to the extent possible, the use of qualified interpreters or assistive devices whenever a language or communication barrier exists. For patients that are minors or incapacitated, the preferred language of the patient’s parent(s) guardian, or surrogate decision-maker will also be determined. The Bill of Rights for People with Limited English Skills will be provided orally or in a written format. The patient will be informed of the availability of free ~~interpretive~~ interpreter services. If the patient still

chooses to use a family member or friend who volunteers to interpret, then a Waiver of Interpreter Services will be initiated and entered into the patient ~~file~~medical record.

- A. KDHCD recognizes that individuals and Health Care Providers must be able to communicate effectively. When language barriers exist between providers and patients, the quality of information is diminished and the outcome of the patient encounter may be unsatisfactory. This may lead to decreased patient compliance and increased potential for medical errors and misdiagnosis.

In emergency situations, treatment will be provided in accordance with standard medical practice. Interpreters will be sought promptly; but treatment will not be delayed pending the arrival of an interpreter.

- B. It is the policy of KDHCD to provide equal access to and equal participation in healthcare activities for persons who are visually impaired, deaf or hard-of-hearing as well as for persons with Limited English Proficiency (LEP). KDHCD provides communication aids and services at no cost to the patient during their course of care. It is the policy of KDHCD to use qualified interpreters (certified, certificated or trained~~or certificated~~) during critical health services or treatment situations. Qualified Sign Language interpreters are also available.
- C. Effective communication is important in every area of hospital communication, but KDHCD prioritizes the most careful attention to effective communication in the provision of medical, nursing and ancillary services, where patient safety, medical error, and ability to understand treatment options are affected. The following types of encounters and procedures which are performed by providers who do not speak the primary language spoken by the patient/surrogate decision-maker, and which require the use of healthcare interpreter services, including, but not limited to:
- a. Providing clinic and emergency medical services;
  - b. Obtaining medical histories;
  - c. Explaining any diagnosis and plan for medical treatment;
  - d. Discussing any mental health issues or concerns;
  - e. Explaining any change in regimen or condition;
  - f. Explaining any medical procedures, tests or surgical interventions;
  - g. Explaining patient rights and responsibilities;
  - h. Explaining the use of seclusion or restraints;
  - i. Obtaining informed consent;
  - j. Providing medication instructions and explanation of potential side effects;
  - k. Explaining discharge plans;
  - l. Discussing issues at patient and family care conferences and/or health education sessions;

- m. Discussing Advanced Directives;
  - n. Discussing end of life decisions; and,
  - o. Obtaining financial and insurance information.
  
- D. Interpreter Services are available 24 hours a day, 7 days a week and are free of charge to the patient. Interpreter Services can be made available in a variety of ways, depending on the specific needs of the patient. (See "Procedure" for additional information.)
- E. All employees shall be instructed about interpretation services during their orientation program and on an ongoing basis as appropriate.
- F. The patient's preferred language is to be noted in the patient's medical record and plan of care. This will be determined by asking, "In what language do you prefer to discuss your health care?" This is regardless of whether the patient speaks English fluently or uses another language to communicate.
- G. The policy of KDHCDC shall be to provide all patients and surrogate decision-makers requiring language assistance with medical care information in their preferred language. LEP patients/surrogate decision-makers shall be advised of their right to have interpreter services provided within a reasonable time, at no charge to them.
- H. A patient is not required or expected to use friends or family members as interpreters because the use of such individuals may result in breach of confidentiality and reluctance from the patient to reveal personal information critical to the services to be provided. Should an LEP patient/patient representative insist upon the use of a friend or family member to be her/his interpreter, KDHCDC needs to first ensure that the patient understands that interpreter services are legally guaranteed and free of charge. The Office of Civil Rights (OCR) Policy Guidance states that the hospital may proceed, provided that the use of such a person does not compromise the effectiveness or confidentiality of the patient, and provided that the offer and the patient's wishes are documented in the patient's file. KDHCDC personnel shall ensure that the patient signs the "Waiver of Interpreter Services" showing they have refused a hospital-provided interpreter (see attached form).
- I. Patient/families are to be made aware of the bilingual resources available in the following ways:
  - a. Signage/postings
    - i. Multilingual notices are to be placed in conspicuous locations informing patients of available bilingual services and how to access them. These notices shall also contain the telephone number where patients can file complaints about interpretation services. Each notice shall also include a TTY number for the hearing impaired. (See attached notices in English/Spanish.)

- ii. Notices shall be posted in conspicuous areas around the facility including, but not limited to, the emergency room and major entrances, admitting areas and lobbies.
  - iii. Educational and vital documents and materials shall also be translated to Spanish and be made available to Spanish only speaking patients, as this population comprises at least 5% of KDHC patient population.
  
- J. It will be the policy of KDHC to translate and make available all Vital Documents in Threshold Languages. The translation of other hospital written materials in Frequently Encountered or other languages shall be at the discretion of the issuing staff. Vital Documents that are not produced in a written translation shall be verbally translated to the patient or surrogate decision-maker. The provision of oral translation of all Vital Documents to patients shall be documented and documentation shall become a part of the medical record.
  - a. Prior to the assignment of work to a translator, the Interpreter Services Department will provide a Materials Review process for all materials that are to be translated into Spanish to ensure:
    - i. Appropriate reading level for the target population;
    - ii. Plain language will be used. The language is simple and clear;
    - iii. Messages and illustrations are culturally appropriate;
    - iv. Document prints clearly in black and white if it will be posted on the internet for public download
  - b. The KDHC Interpreter Services Department will translate all Spanish translations, unless they are unable to meet indicated timelines. All requests for translations in any language will be routed through the Interpreter Services Department. Approved agencies may be used by the Interpreter Services Department to provide translation of patient information or education.
  - c. The Interpreter Services Department will review all translations returned by approved translation agencies before translations are returned to the department for duplication and/or distribution.
  - d. The Interpreter Services Department will assist the Marketing Department with the Spanish translation of forms, signs, pamphlets, etc. for display or distribution by KDHC. (See Policy #: AP.18)

**PROCEDURE**

- I. Notification of Interpreter Services
  - a. Notices in the form of Language ID Posters ~~and Language Easels~~ are posted in the main hallway of each facility, Emergency Dept. and outpatient areas advising patients and their families about the availability of free interpretation services, a list of available languages, and how to access an interpreter.
  
- II. Patient Identification
  - a. The first access point in which a patient acquires services

(emergency room registration, admissions, etc.) shall incorporate the determination of language needs into intake procedure.

- i. Do you speak a language other than English at home?
    - ii. In what language do you prefer to receive your medical services?
  - b. If the patient does not understand, use the Language Determination Cards/Posters to help patients identify their language.
  - c. If the patient is unable to use the Language Determination Card, and hospital staff cannot determine the appropriate language, dial 8989 for assistance with the identification of their language.
  - d. Note the patient's preferred language in the Patient's medical record, on their face sheet and the Assessment Data Base Record.
- III. Inform Patients of their Right to Have Interpreter Services
  - a. If the patient speaks a language other than English at home, the statement informing patients of their rights to interpreter services will also be provided to patients in written form in their primary language.
  - b. This statement will be translated into all Threshold Languages.
- IV. Patient Wristbands
  - a. The wristband is light blue with the message: i. DIAL EXT. 8989 FOR INTERPRETER...
  - b. In order to ensure that the preferred communication preferences follow the patient from department/facility to department/facility, a light blue wristband will be placed on the patient's wrist (dominant arm) and secured in order to identify and visually communicate to all staff that the patient has requested interpreter service be provided during his/her stay.
  - c. If the patient's condition prohibits the application of the wristband to the wrist, then the ankle may be used.
  - d. This procedure is applicable to all staff that initially register/admit the patient, as well as staff who provide patient care.
- V. The Health Care Interpreter Network (HCIN)
  - a. Simply dial 8989.
  - b. Available 24 hours a day to assist with video and phone Interpretation via any KDHC telephone, mobile phone or video phone.
  - ~~c. Procedures are outlined on KDCentral under Department/Interpreter Services/Health Care Interpreter Network.~~
  - ~~d.c.~~ If you are asked for your ~~Access Code~~Client ID, it is 841263.
- VI. Requesting an Interpreter
  - a. Staff must utilize the appropriate interpreter for explanations of tests/procedures, surgery, to obtain informed consent, and to give critical instructions.
  - b. If the staff person determines that an "in person" interpreter is required, he/she may contact the Interpreter Services Department

- at Ext. 2501, 5981, 5902);
  - c. A Language Resource Assistant (LRA) may also be called and is listed under KNet/Directories/Interpreter Directory.
  - d. Necessary emergency care will not be withheld pending the arrival of interpreter services.
  - e. All necessary contact numbers and ~~access codes-client IDs~~ for the direct contact of contracted interpreter services shall be available to Emergency Room staff and in KDCentral.
  
- VII. Hearing Impaired Patients
  - a. American Sign Language Services are available by using the HCIN video phones located throughout the hospital and outlying facilities.
  - b. Call the Interpreter Services Department at Ext. 5981, 5902, or 2501 for assistance.
  - c. TTY Machines are available through PBX or the Information Desk as well as facilities throughout the District. Please follow the operating instructions.
    - i. Plug the AC adapter into the nearest electrical outlet, connect to phone line and turn the power on.
    - ii. Pick up the headset of the telephone and dial 1-800-735-2929 or 9-711.
    - iii. Place the headset onto the TTY machine
    - iv. Patient may begin using the keyboard.
  
- VIII. Documentation:
  - a. The Staff person utilizing the qualified provider of healthcare interpreting or device will document the encounter in the patient's medical record.
    - 1. Method (Face-to-face, Telephone, Video)
    - 2. Date and time
  - b. Documentation will be maintained in the Interpreter Services Department for:
    - i. All interpretation encounters performed by KDHCD Interpreter Services Staff.
    - ii. All services provided by contracted language interpretation services, including telephonic and videophone services.
  
- IX. Waiver of Interpreter Services
  - a. If after a patient has been informed of their right to receive free interpreter services, the patient insists upon the use of a friend or family member, then the Waiver of Interpreter Services will be completed and signed by the patient.
  
- X. Qualified Providers of Healthcare Interpreting
  - a. Certified Medical Interpreters:

i. These English/Spanish speaking interpreters are obtained from the KDHCDC Interpreter Services Department. These interpreters have achieved either a CHI credential from the Certification Commission for Healthcare Interpreters or a CMI credential from the National Board of Certification for Medical Interpreters.

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a-b. **Certificated Medical Interpreters:**

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i. These English/Spanish speaking interpreters are obtained from the KDHCDC Interpreter Services Department and have been trained as interpreters.

b-c. Language Resource Assistants:

i. A list of staff is available on the KNet service system under Directories/ Interpreter Directory.

ii. These bilingual staff members have indicated a willingness to interpret and have been tested and qualified for their ability to do so at the general or clinical/advanced level. (See Policy # HR.17).

~~iii. Currently, only English/Spanish and English/Lahu bilingual staff is listed. They are classified at the general or clinical level. (See Policy # HR.17).~~

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c. Contracted Interpreter Services

XI. VIDATAK EZ Board

a. Available through the Interpreter Services Department as well as Patient Family Services and House Supervisor.

b. Initially designed for mechanically ventilated patients, they also work well for patients who display communication barriers but read in their own language and need to communicate basic needs and pain levels to their care providers from their bedside.

c. They are available in English and pictures as well as:

|         |         |            |            |            |
|---------|---------|------------|------------|------------|
| Spanish | Chinese | Vietnamese | Korean     | Indonesian |
| Russian | Tagalog | Hindi      | Japanese   | Arabic     |
| Polish  | French  | German     | Portuguese | Italian    |
| Farsi   |         |            |            |            |

## Definition of Terms

### Non-English or Limited English Proficiency (LEP)

Those individuals whose native language is other than English and who cannot speak, read, write, or understand the English language at a level that permits them to interact effectively with healthcare providers.

### Communication Barrier

Applies to a person who is deaf/hearing impaired, intubated or has neurological deficits or speaks another language hindering communication.

### Deaf

This term is generally used to describe individuals with a severe to profound hearing loss, with little or no residual hearing. Some deaf people use sign language, such as America Sign Language (ASL) or Langue des Signes Quebecoise (LSQ) to communicate using their residual hearing and hearing aids, technical devices or cochlear implants, and/or speech reading.

### Hard of Hearing “person with hearing loss”, Hearing Impaired

This term is generally used to describe individuals who use spoken language (their residual hearing and speech) to communicate. Most hard of hearing people can understand some speech sounds with or without hearing aids and often supplement their residual hearing with speech reading, hearing aids and technical devices.

### Qualified Sign Language (ASL – American Sign Language) Interpreter:

A person who is fluent in sign language and is trained and proficient in the skill and ethics of interpreting and who is knowledgeable about the specialized terms and concepts that need to be interpreted for purposes of ensuring effective communication.

### Healthcare Interpreter

One who has been trained in healthcare interpreting, adheres to the professional code of ethics and protocols of healthcare interpreters, is knowledgeable about medical terminology, and can accurately and completely render communication from one language to another.

Bilingual staff may provide patient instructions only if they had their competency tested and qualified to do so.

### Translator

One who converts written text into a written text in a second language corresponding to and equivalent in meaning to the text in the first language.

### Language Resource Assistant (LRA)

Kaweah Delta Health Care District staff member who is bilingual and who is willing to provide language interpretation. This person's language competency has been

tested and is classified as general or clinical/advanced. They are identified by either an Orange LRA pin for General or a Dark Blue LRA pin for Clinical/Advanced that must be worn on their badge. Based on the designated level of language competency, the LRA will receive additional compensation to their current salary:

General - \$ ~~2.50-00~~ (~~fifty cents~~ two dollars) for each 15 minute increment  
Clinical/Advanced - \$ ~~14.00~~ (~~one dollar~~ four dollars) for each 15 minute increment

Compensation will be provided only for actual time of interpretation if such staff member is pulled outside of their line of work or work area. If being bilingual was an initial requirement of the job or staff member interprets within the course of their own work, additional compensation will not be awarded. A log of encounters will be submitted to the Interpreter Services Department on a bi-weekly basis. LRA compensation does not apply to the KDHC Residency program.

#### Auxiliary Aids

Dual handset telephone for foreign language interpretation; qualified interpreters; telephones with volume control, Vidatak boards, patient needs communication cards; exchange of written notes.

#### Contracted Services

A designated service that provides 24-hour foreign language interpretation services either in-person or via telephone through which KDHC has contractual agreements that define expectations and response time.

#### Attachments:

Waiver of Interpreter Services  
Availability of Interpreter/Para Obtenir un Intérprete  
Available Languages from contracted services

See Administrative Policy AP.18

### Kaweah Delta Health Care District

400 W. Mineral King • Visalia, CA 93277-6263 • 559 624 2000

#### WAIVER OF INTERPRETER SERVICES

I, \_\_\_\_\_ (Patient’s name) have been informed of my right to receive free interpreter services from Kaweah Delta Health Care District. I understand that I am entitled to these services at no cost to me or my family.

I am choosing to provide my own interpreter at this time. To the best of my knowledge, this person is 18 years old or over. This person will act as my interpreter from \_\_\_/\_\_\_/\_\_\_ to \_\_\_/\_\_\_/\_\_\_. The name of my interpreter is:

NAME:

ADDRESS:

PHONE:

RELATIONSHIP TO PATIENT:

I understand I can withdraw this waiver at any time and request the services of an interpreter at no cost. I also understand that this waiver does not give permission for any interpreter to act as my Authorized Representative.

*This form was translated to me orally in \_\_\_\_\_ and I understand it.*

Yo, \_\_\_\_\_ (nombre del paciente) he sido informado de mi derecho a recibir los servicios gratuitos de tener interprete de Kaweah Delta Health Care District. Entiendo que tengo derecho a que se presten servicios gratuitos de interpretación para mí o mis familiares.

He decidido proveer mi propio intérprete en este momento. A mi mejor saber y entender, esta persona es mayor de 18 años. Esta persona me brindará servicios desde el \_\_\_\_\_ (fecha inicial) hasta el \_\_\_\_\_ (fecha final). El nombre de mi intérprete es:

NOMBRE:

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DOMICILIO:

Formatted: Spanish (Mexico)

TELÉFONO:

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RELACIÓN AL PACIENTE:

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Entiendo que podré revocar esta renuncia en cualquier momento y solicitar los servicios de un intérprete sin cargo alguno.

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También entiendo que esta renuncia no autoriza a ningún intérprete a actuar como mi representante autorizado.

*Este formulario fue traducido para mí y entiendo su contenido.*

Signature / Firma del paciente

Date / Fecha

|  |              |
|--|--------------|
| Signature of Interpreter / Firma del intérprete              | Date / Fecha |
| Signature of Staff Person / Firma del proveedor de servicios | Date / Fecha |

Label

WAIVER OF INTERPRETER SERVICES

Page 1 of 2

CVBF #934 Rev. 11/07



**Kaweah Delta Health Care District**

400 W. Mineral King • Visalia, CA 93277-6263 • 559 624 2000

**WAIVER OF INTERPRETER SERVICES**

**Bill of Rights for People with Limited English Skills**

*Even if you do not speak English well, you have the right:*

- To get help from an interpreter who can translate English into your language. This service is free to you and your family;
- To be treated with courtesy and respect;
- To be treated in a way that is sensitive to your ethnic and cultural needs;
- To obtain services without facing discrimination, abuse or harassment;
- To get information about health care services in your language;
- To be part of the process of assessing your health and putting together a plan for your health services;
- To be told in your language what could happen if you accept services or refuse them;
- To raise concerns you have about the services you receive;
- To be told in your language about how to make a complaint about healthcare providers; To be told in your language about your rights and responsibilities when using services;
- To be told in your language about laws and policies a health-care provider must follow;
- To have your health care records kept confidential.

**Declaración de derechos para personas con conocimiento limitado del idioma inglés**

*Aunque no hable bien el idioma inglés, usted tiene derecho a:*

- Recibir ayuda de un intérprete que pueda traducir del inglés a su idioma. Este servicio es gratuito para usted y su familia;
- Ser tratado con cortesía y respeto;
- Ser tratado de manera sensible a sus necesidades étnicas y culturales;
- Recibir servicios sin enfrentar discriminación, abuso ni hostigamiento;
- Recibir información sobre servicios de atención de la salud en su idioma;
- Participar en el proceso de evaluación de su salud y en el desarrollo de un plan para sus servicios de salud;
- Recibir información, en su idioma, sobre lo que podría pasar si usted acepta servicios o los rechaza;

- Expresar sus preocupaciones sobre los servicios que recibe;
- Recibir información, en su idioma, sobre la forma de presentar quejas sobre proveedores de atención de la salud;
- Recibir información, en su idioma, sobre sus derechos y responsabilidades al utilizar servicios;
- Recibir información, en su idioma, sobre las leyes y normas que deben respetar los proveedores de atención de la salud;
- Que sus registros de atención de la salud se mantengan en privado.

Label

WAIVER OF INTERPRETER SERVICES

Page 2 of 2

CVBF #934 Rev. 11/07

### **AVAILABILITY OF INTERPRETERS**

Patients/surrogate decision-makers of Kaweah Delta Health Care District, who are Limited English Proficient (LEP), shall have services provided to them in their primary language or have interpreter services provided to them during the delivery of all significant healthcare services. Interpreter services shall be available within a reasonable time, at no cost to patients.

This establishment subscribes to 24 hour interpretation services provided by:  
The Health Care Interpreter Network

To obtain an interpreter for further assistance, please notify:  
Interpreter Services Department  
624-5902 or 624-5981

TTY phones for Deaf & Hearing Impaired patients will be provided when needed or requested. Please contact the Operator. A qualified American Sign Language (ASL) Interpreter may be called by contacting the Interpreter Services Department. Service provided by:  
The Health Care Interpreter Network

To file a complaint with the District regarding interpreter services provided, contact the District's Interpreter Services Manager at (559) 624-5902 or the:

Office of Civil Rights  
US Department of Health and Human Services  
90 7<sup>th</sup> Street, Suite 4-100  
San Francisco, CA 94103  
(415) 437-8310: (415) 437-8311 TDD  
Fax (415) 437-8329

You will not be penalized for filing a complaint.

## DISPONIBILIDAD DEL SERVICIO DE INTÉRPRETES

Los pacientes o personas que toman decisiones al estar bajo la atención del Kaweah Delta Health Care District, quienes cuentan con un Dominio Limitado del Inglés (LEP, por sus siglas en Inglés), recibirán servicios en su propio idioma o tendrán los servicios provistos por un intérprete al estar recibiendo atención de salud clínicamente relevante. Los servicios del Departamento de Intérpretes se proporcionarán dentro de un espacio de tiempo razonable, sin costo alguno para el paciente.

Este centro está suscrito al servicio de interpretación las 24 horas del día, y será provisto por:

**The Health Care Interpreter Network**

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Para más ayuda y conseguir un intérprete, por favor llame  
a: Interpreter Services Department  
624-5981 ó 624-5902

Los Teléfonos TTY para los pacientes Sordos e Impedidos de la Audición serán provistos cuando se necesiten o se soliciten. Por favor, comuníquese con la Operadora. Un intérprete capacitado en Lenguaje en Señas Americano (ASL, por sus siglas en Inglés) podrá ser llamado al comunicarse con el Interpreter Services Department. Dicho servicio será provistos por:

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**The Health Care Interpreter Network**

Para presentar una queja frente al Distrito respecto a los servicios de interpretación provistos, comuníquese con la Gerencia del Interpreter Services Department al (559) 624-5902 ó a:

Office of Civil Rights (Oficina de Derechos Civiles)  
US Department of Health and Human Services  
90 7th Street, Suite 4-100  
San Francisco, CA 94103  
(415) 437 – 8310, (415) 437- 8311 TDD  
Fax (415) 437-8329

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No se le penalizará por presentar una queja.

## Supported Languages and Dialects by Language

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|  |  |  |
|--|--|--|
| <b>Acholi</b> – Uganda, Sudan                                      | <b>Haitian Creole</b> – Haiti                          | <b>Nepalese</b> – Nepal, India                               |
| <b>Afrikaans</b> – South Africa, Namibia                           | <b>Haka Burmese</b> – Myanmar (former Burma)           | <b>Nuer</b> – Sudan  |
| <b>Akan</b> – Ghana, Ivory Coast                                   | <b>Hakka</b> – China                                   | <b>Oromo</b> – Ethiopia                                      |
| <b>Akateko</b> – Guatemala   | <b>Hausa</b> – Niger, Nigeria                          | <b>Palestinian Arabic</b> – Israel, Jordan                   |
| <b>Albanian</b> – Albania  | <b>Hebrew</b> – Israel                                 | <b>Pangasinan</b> – Philippines                              |
| <b>Algerian Arabic</b> – Algeria                                   | <b>Hindi</b> – India                                   | <b>Papiamento</b> – Netherlands Antilles                     |
| <b>Amharic</b> – Ethiopia  | <b>Hmong</b> – China, Vietnam, Laos                    | <b>Pashto (Pushto)</b> – Pakistan, Afghanistan               |
| <b>Arabic</b> – Widely Distributed                                 | <b>Hungarian</b> – Hungary                             | <b>Persian (Farsi)</b> – Afghanistan, Iran, Iraq, Pakistan   |
| <b>Armenian</b> – Armenia  | <b>Ibo (Igbo)</b> – Nigeria                            | <b>Polish</b> – Poland                                       |
| <b>Ashanti (Asante Twi)</b> – Ghana                                | <b>Ilocano</b> – Philippines                           | <b>Portuguese</b> – Portugal, Brazil, et al.                 |
| <b>Assyrian</b> – Iraq   | <b>Indonesian (Bahasa Indonesia)</b> – Indonesia       | <b>Portuguese Creole (Cape Verdean)</b> – Cape Verde         |
| <b>Azerbaijani</b> – Azerbaijan                                    | <b>Iraqi Arabic</b> – Iraq                             | <b>Pulaar</b> – Senegal                                      |
| <b>Azorean Portuguese</b> – Azores Islands                         | <b>Italian</b> – Italy                                 | <b>Punjabi (Panjabi)</b> – Pakistan, India                   |
| <b>Bahnar</b> – Vietnam  | <b>Japanese</b> – Japan                                | <b>Quechua</b> – Argentina, Bolivia, Colombia, Ecuador, Peru |
| <b>Bahasa Indonesia (Indonesian)</b> – Indonesia                   | <b>Jarai</b> – Vietnam                                 | <b>Quiche (K'iche)</b> – Guatemala                           |
| <b>Bambara</b> – Mali  | <b>Javanese</b> – Indonesia                            | <b>Rade</b> – Vietnam  |
| <b>Belarusan</b> – Belarus   | <b>Jordanian Arabic</b> – Jordan                       | <b>Romanian</b> – Romania                                    |
| <b>Bengali</b> – Bangladesh, India                                 | <b>Juba Arabic</b> – Sudan                             | <b>Russian</b> – Russia                                      |
| <b>Bosnian</b> – Bosnia & Herzegovina                              | <b>Kanjobal (Q'anjob'al)</b> – Guatemala               | <b>Samoa</b> – Samoa   |
| <b>Brazilian Portuguese</b> – Brazil                               | <b>Kannada</b> – India                                 | <b>San Miguel</b> – Mexico                                   |
| <b>Bulgarian</b> – Bulgaria  | <b>Kapampangan</b> – Philippines                       | <b>Santa Eulalia</b> – Guatemala                             |
| <b>Burmese</b> – Myanmar (former Burma)                            | <b>Karen (Pa'o, S'gaw)</b> – Myanmar (former Burma)    | <b>Saraiki</b> – Pakistan, India                             |
| <b>Cambodian (Khmer)</b> – Cambodia                                | <b>Kayah</b> – Myanmar (former Burma)                  | <b>Serbian</b> – Serbia, Montenegro                          |
| <b>Cantonese</b> – China   | <b>Khmer (Cambodian)</b> – Cambodia                    | <b>Serbo-Croatian</b> – Balkans                              |
| <b>Cape Verdean (Portuguese Creole)</b> – Cape Verde               | <b>Kinyarwanda</b> – Rwanda                            | <b>Shanghai</b> – China                                      |
| <b>Catalan</b> – Andorra, Spain                                    | <b>Kirundi</b> – Burundi                               | <b>Sichuan (Szechuan)</b> – China                            |
| <b>Cebuano</b> – Philippines                                       | <b>Koho</b> – Vietnam                                  | <b>Sinhalese</b> – Sri Lanka                                 |
| <b>Chaldean</b> – Iraq   | <b>Korean</b> – Korea                                  | <b>Slovak</b> – Slovakia                                     |
| <b>Chamorro</b> – Guam   | <b>Kpele</b> – Guinea, Liberia                         | <b>Somali</b> – Somalia                                      |
| <b>Chaozhou (Teochew)</b> – China                                  | <b>Krahn</b> – Liberia, Ivory Coast                    | <b>Soninke (Serahule)</b> – Mali                             |
| <b>Chin</b> – Myanmar (former Burma)                               | <b>Krio</b> – Sierra Leone                             | <b>Sorani (Central Kurdish)</b> – Iraq                       |
| <b>Chinese (var. languages/dialects)</b> – China                   | <b>Kunama</b> – Eritrea                                | <b>Spanish</b> – Spain, Latin America, et al.                |
| <b>Chuukese (Trukese)</b> – Micronesia                             | <b>Kurdish [Kurmanji, Sorani]</b> – Iraq, Turkey, Iran | <b>Sudanese Arabic</b> – Sudan                               |
| <b>Croatian</b> – Croatia  | <b>Kurmanji (Northern Kurdish)</b> – Turkey            | <b>Susu</b> – Guinea   |
| <b>Czech</b> – Czech Republic                                      | <b>Kuwaiti Arabic</b> – Kuwait                         | <b>Swahili</b> – Kenya, Somalia, Tanzania, et al.            |
| <b>Danish</b> – Denmark  | <b>Lao</b> – Laos                                      | <b>Swedish</b> – Sweden                                      |
| <b>Dari (Afgan Farsi)</b> – Afghanistan                            | <b>Latvian</b> – Latvia                                | <b>Syrian Arabic</b> – Syria                                 |
| <b>Dene</b> – Canada   | <b>Lebanese Arabic</b> – Lebanon                       | <b>Tagalog (Filippino)</b> – Philippines                     |
| <b>Dewoin</b> – Liberia  | <b>Lingala</b> – Congo, Republic of the                | <b>Tai Dam</b> – Vietnam                                     |
| <b>Dinka</b> – Sudan   | <b>Lithuanian</b> – Lithuania                          | <b>Taiwanese</b> – Taiwan                                    |
| <b>Duala</b> – Cameroon  | <b>Luganda</b> – Uganda                                | <b>Tamil</b> – India   |
| <b>Dutch</b> – Netherlands   | <b>Luo</b> – Kenya                                     | <b>Telugu</b> – India  |
| <b>Egyptian Arabic</b> – Egypt                                     | <b>Maay (Af Maay, Rahanween, Bantu)</b> – Somalia      | <b>Teochew (Chaozhou)</b> – China                            |
| <b>Estonian</b> – Estonia  | <b>Macedonian</b> – Macedonia                          | <b>Thai</b> – Thailand                                       |
| <b>Ewe</b> – Ghana   | <b>Malay</b> – Malaysia                                | <b>Tibetan</b> – China                                       |
| <b>Fante</b> – Ghana   | <b>Malayalam</b> – India                               | <b>Tigrigna (Tigrinya)</b> – Ethiopia, Eritrea               |
| <b>Farsi (Persian)</b> – Afghanistan, Iran, Iraq, Pakistan         | <b>Malinke</b> – Senegal                               | <b>Toishanese</b> – China                                    |
| <b>Fijian</b> – Fiji   | <b>Mam</b> – Guatemala                                 | <b>Tongan</b> – Tonga  |
| <b>Filipino (Tagalog)</b> – Philippines                            | <b>Mandarin</b> – China                                | <b>Trukese (Chuukese)</b> – Micronesia                       |
| <b>Finnish</b> – Finland   | <b>Mandinka (Mandingo)</b> – Senegal                   | <b>Tunisian Arabic</b> – Tunisia                             |
| <b>Flemish</b> – Belgium   | <b>Marathi</b> – India                                 | <b>Turkish</b> – Turkey                                      |
| <b>French</b> – Africa, Canada, France, Tunisia, et al.            | <b>Marshallese</b> – Marshall Islands                  | <b>Twí</b> – Ghana   |
| <b>French Creole</b> – Caribbean                                   | <b>Mayan [Akateko, Kanjobal]</b> – Guatemala, Mexico   | <b>Tzotzil</b> – Mexico                                      |
| <b>Fukienese</b> – China   | <b>Mien</b> – China, Laos, Thailand                    | <b>Ukrainian</b> – Ukraine                                   |
| <b>Fulani (Fulfulde, Fula)</b> – Cameroon, Niger, Nigeria, Senegal | <b>Mina (Gen)</b> – Togo, Benin                        | <b>Urdu</b> – Pakistan, India                                |
| <b>Fuzhou</b> – China  | <b>Minangkabau</b> – Indonesia                         | <b>Vietnamese</b> – Vietnam                                  |
| <b>Ga</b> – Ghana  | <b>Mixteco Alto</b> – Mexico                           | <b>Wolof</b> – Senegal                                       |
| <b>Gen (Mina)</b> – Togo, Benin                                    | <b>Mixteco Bajo</b> – Mexico                           | <b>Xhosa</b> – South Africa                                  |
| <b>German</b> – Germany  | <b>Mnong</b> – Vietnam                                 | <b>Yemeni Arabic</b> – Yemen                                 |
| <b>Gokana (Khana)</b> – Nigeria                                    | <b>Mongolian</b> – Mongolia                            | <b>Yiddish</b> – Israel                                      |
| <b>Greek</b> – Greece  | <b>Moroccan Arabic</b> – Morocco                       | <b>Yoruba</b> – Nigeria                                      |
| <b>Gujarati</b> – India  | <b>Nahuatl</b> – Mexico                                | <b>Yup'ik</b> – U.S.A (Alaska)                               |
|  | <b>Navajo</b> – U.S.A.(Southwest)                      | <b>Zulu</b> – South Africa                                   |
|  |  | <b>Zarma</b> – Niger   |

|                  |                 |                 |                |              |
|------------------|-----------------|-----------------|----------------|--------------|
| Afghani          | Croatian        | Hmong           | Maltese        | Shona        |
| Afrikaans        | Czech           | Hokkien         | Mandarin       | Sicilian     |
| Akan             | Danish          | Huizhou         | Mandingo       | Sindhi       |
| Albanian         | Dari            | Hungarian       | Marathi        | Sinhala      |
| Amharic          | Dene            | Icelandic       | Mien           | Slovakian    |
| Arabic           | Dinka           | Igbo/Ibo        | Micif          | Slovenian    |
| Aramaic          | Dogrib          | Ilocano         | Min Nan        | Somali       |
| Armenian         | Dutch           | Indonesian      | Moldavian      | South Slavey |
| Assyrian         | Eritrean        | Inuinaktun      | Mongolian      | Spanish      |
| Azərbayjani      | Estonian        | Inuktitut       | Ndebele        | Susu         |
| Azari/Azeri      | Fante           | Italian         | Nepali         | Swahili      |
| Belorussian      | Farsi           | Japanese        | North Slavey   | Swedish      |
| Bengali          | Fijian          | Kakwa           | Norwegian      | Tagalog      |
| Berber           | Finnish         | Karen           | Nuer           | Taiwanese    |
| Bosnian          | Flemish         | Khmer/Cambodian | Nyanja         | Tamil        |
| Bulgarian        | Formosan        | Kinyarwanda     | Nzema          | Telegu       |
| Burmese          | French          | Kirundi         | Ojibway        | Thai         |
| Cantonese        | French-Canadian | Kiswahili       | Ojicree        | Tibetan      |
| Cebuano          | Frisian         | Korean          | Oromo          | Tigrinya     |
| Chaldean         | Fuchownese      | Kurdish         | Polish         | Toisan       |
| Chao Chow        | Fur             | Kutchi          | Portuguese     | Tongan       |
| Chilcotin        | Ga              | Lao             | Punjabi        | Turkish      |
| Chipewyan        | German          | Latin           | Pushto         | Turkmen      |
| Cree             | Greek           | Lingala         | Romanian       | Twi/Asante   |
| Cree-James Bay   | Gujarati        | Lithuanian      | Russian        | Ukrainian    |
| Cree-Plains      | Gwichin         | Low German      | Salish         | Urdu         |
| Cree-Swampy Cree | Hakka           | Lugbara         | Sanskrit       | Uyghur       |
| Cree-Swampy      | Hausa           | Ma Di           | Saulteaux      | Veneto       |
| Cree-Woodlands   | Harari          | Macedonian      | Serbian        | Vietnamese   |
| Creole           | Hebrew          | Malay           | Serbo-Croatian | Yiddish      |
| Creole-Haitian   | Hindi           | Malayalam       | Shanghainese   | Zulu         |

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|  |                                 |
|--|---------------------------------|
| Policy Number: AP97  | Date Created: No Date Set       |
| Document Owner: Cindy Moccio (Board Clerk/Exec Assist-CEO)       | Date Approved: Not Approved Yet |
| Approvers: Board of Directors (Administration), Executive Team A |                                 |
| <b>Bioethics Committee</b>                                       |                                 |

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

**Purpose:** In recognition of the complexity of modern medical practice and the multiple ethical issues which may arise in the provision of patient care, Kaweah Delta Medical Center will establish and maintain a Bioethics Committee to assist patients, families, hospital and medical staff in effectively addressing bioethical issues.

**Policy:** The Bioethics Committee (hereinafter referred to as “the committee”) shall ~~exist as a committee of the Medical Staff and~~ fulfill the following functions:

1. Provide education for patients, families, hospital and medical staff regarding relevant bioethics issues.
2. Provide the institution assistance with the analysis and development of policies and procedures regarding bioethics issues.
3. Provide Bioethics Consultation Services to assist patients, families, hospital and medical staff in addressing bioethics issues arising in the provision of patient care. This is an advisory function, only.

**Procedure:**

- I. Education: In cooperation with the hospital/medical staff, the committee will assist in identifying educational needs and develop (or assist others in the development of) appropriate educational resources to meet these needs. These resources can include presentations, CME courses, etc. The goal will be to provide participants with language, concepts and a body of knowledge to assist in addressing complex ethical issues arising in hospital practice.
  1. Identified educational needs will be reviewed at the next available committee meeting or by the Chair or Vice Chair between meetings if the need is urgent.
  2. Committee members will establish contact with a point person for the educational need and will work with this individual to develop a plan for addressing the need.
  3. A summary of educational service provided will be reviewed at next available meeting of the committee.

4. Materials used in the educational service will be archived in the Bioethics Committee Chair and/or Vice Chair ~~Medical Staff~~ Office for possible use in future educational services.
  5. Committee member providing educational service will obtain feedback from the “customer” regarding effectiveness of service provided and include this in summary presentation to the committee
- II. Policy Review & Development: The committee will assist the institution and its professional staff in the analysis of current policies and the development of new policies and procedures regarding bioethical issues.
1. Hospital and Medical staff members who identify possible need for policy review/development will contact the Bioethics Committee Chair or Vice Chair ~~Medical Staff Office~~ to request placement of policy on committee meeting agenda. Chair or Vice Chair will provide immediate review and consult with appropriate hospital/medical staff ~~h the Chief Medical Officer and/or Risk Manager as appropriate~~, if the need is urgent.
  2. Policy/procedure will be reviewed at committee meeting and committee member will be assigned to assist staff in further analysis and review as needed.
  3. Results of analysis and review and committee recommendations will be discussed and documented in the minutes of the next committee meeting.
- III. Bioethics Consultation Service: The committee will provide both informal and formal consultation services at the request of medical staff, hospital staff, patients, family members and/or surrogate decision makers which arise in the course of patient care provision.
1. Requests for bioethics consultation will be submitted by contacting the Bioethics Committee Chair or Vice Chair ~~Medical Staff Office~~ and will be responded to within 24 hours or by the next business day.
  2. Depending on the issue, a committee member will be identified as “Team Lead” who will provide initial review and will consult with committee chair to determine appropriate level of consultation.
  3. If **Informal Consultation** services are indicated:
    - a. Team Lead facilitates contact between requestor and appropriate committee member.
    - b. Committee member provides consultation services and provides a summary of same at next scheduled committee meeting.
  4. If **Formal Consultation** Services are indicated:
    - a. Team Lead will obtain the following information: Review of Medical Record noting patient’s diagnosis/prognosis/treatment plan; formulate bioethical issues/questions; establish decision makers (i.e., patient, family, surrogate).

- b. Team Lead will consult with Chair to establish plan for physician contact and consultation process/structure.
  - c. Team Lead will contact all appropriate parties and schedule Bioethics Consultation meeting (s) as appropriate.
  - d. Team Lead will ensure that all parties are advised of recommendations provided through the consultation process and that these recommendations are documented.
  - e. If, following Formal Consultation, the bioethics issues remain unresolved, Bioethics Chair will consult with appropriate hospital/medical staff ~~Chief of Staff or designee~~ to determine appropriate plan of action.
  - f. Summary of Formal Consultation will be provided by Team Lead at next committee meeting.
- IV. Appointment and Membership: The committee shall be a multidisciplinary body including representatives from the following disciplines: medical staff, nursing, social work, pastoral care, risk management, board members and community members.
1. New members will be recommended by the committee and appointed by the Bioethics Committee Chair or Vice Chair. ~~Chief of Staff~~.
  2. The Chair of the committee will be appointed by the Chief of Staff.
  3. The Vice Chair of the committee will be chosen by the membership of the committee.
  4. Membership shall be for a period of two (2) years with staggered terms to assure continuity. Committee Members can serve beyond the 2 year period by mutual agreement of the Chair/Vice Chair and the committee member.
  5. Each hospital (employee) member will designate a temporary replacement who will attend meetings in the event that a committee member is unable to fulfill committee responsibility.
- V. Meetings: The Bioethics Committee shall meet quarterly ~~bimonthly~~, with additional meets scheduled as appropriate to address urgent matters.
1. Meeting agenda will be developed by the Chair and distributed one week prior to the meeting.
  2. For business purposes, two members shall constitute a quorum.
  3. Actions of the committee will be taken by the vote of a majority of the members attending the meeting.
  4. Each member will be required to attend at least three (3) of the committee's regularly scheduled meetings each year. Failure to do so will be considered voluntary resignation and the vacancy will be filled by appointment of a new member.

- VI. Record Keeping: The committee will maintain minutes of all meetings which will include summaries of all case reviews and recommendations.
1. Minutes will be submitted to the Chair for approval by the committee.
  2. Minutes will not include identifying information about specific patient, family members, individual requesting consultation or professional staff participating in the case review process.
  3. Records of the committee meetings and functions will be maintained in accordance with ~~Medical Staff Bylaws and~~ applicable laws governing the confidentiality of records and medical review committees.
  4. When appropriate, actions and recommendations of the committee will be documented in the patient record.
- VII. Liability: Kaweah Delta Medical Center will provide liability protection for the committee members who do not have such protection by virtue of their status as members of the professional staff.
- VIII. Adoption and Approval of Policies and Procedures: Policies and procedures of the committee will be reviewed as appropriate by the membership of the committee.
1. Proposed modifications of approved policies and procedures will be submitted to the committee in writing at least four (4) weeks in advance of a regularly scheduled meeting.
  2. Following recommendation by the committee, policies/procedures will be forwarded to the appropriate committee for subsequent action.

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|  |                                 |
|--|---------------------------------|
| Policy Number: EOC 1015  | Date Created: 08/05/2019        |
| Document Owner: Maribel Aguilar (Safety Officer/Life Safety Mgr)   | Date Approved: Not Approved Yet |
| <b>Approvers: Board of Directors (Administration), Board of Directors (EOC/Emergency Preparedness), Cindy Moccio (Board Clerk/Exec Assist-CEO), Maribel Aguilar (Safety Officer/Life Safety Mgr)</b> |                                 |
| <b>Wireless Duress System</b>  |                                 |

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

**Policy:**

The wireless duress system in the Emergency Room and Mental Health Hospital consists of wireless transmitters that communicate to the wireless internet system and specific computers to allow staff to use a wireless transmitter to request assistance if they have safety concerns.

All Emergency Room (ER) staff, Mental Health (MH) staff, Patient and Family Services (PFS), and Graduate Medical Education Residents (GME) on rotations in the ER and/or MH are issued wireless duress transmitters upon hire/assignment and are required to wear the transmitters while on duty. ER and MH management maintain a supply of extra wireless transmitters to distribute as needed (lost, float staff, etc.)

ER and MH Providers are encouraged to wear/utilize the wireless transmitters and sign them out through ER or MH Administration.

**Procedure:**

I. Issuance:

1. HR distributes wireless transmitters programmed with staff names to all ER staff upon hire.
2. GME distributes wireless transmitters to Residents/Students upon assignment to ER and/or Mental Health.
3. ER Providers sign out transmitters from the ER at the start of each shift and return them at the end of their shift.
4. Mental Health manages assignment of transmitters for employees and Medical Staff working at Mental Health Hospital.
5. ER management maintains a supply of extra transmitters for float staff, Environmental Services Staff, Patient Family Services Staff, lost or broken transmitters, etc.
6. All transmitters are tested for functionality prior to issuance.
7. Lost transmitters- All Staff, Providers, Residents/Students may be charged \$80 replacement fee for lost transmitters. Each case will be dealt with on an individual basis and HR shall decide if the individual shall be charged this cost.

I. Monitoring:

1. ER Duress System Monitoring PC's are located:
  - a. PBX/Information Service Center (ER monitoring)
  - b. ER Security Desk (ER monitoring and programming)
  - c. ED Zone 1, 2 &3 (monitoring and programming)
  - d. Security office (monitoring and programming)
  - e. Human Resources administrative assistants (3) (ER monitoring and programming)
  - f. Graduate Medical Education (3) (programming only)
  - g. ER Nurse Manager (monitoring and programming)
2. Mental Health Duress System monitoring PCs are located:
  - a. East Wing Nurse Station (MH monitoring)
  - b. West Wing Nurse Station (MH monitoring)
  - c. MH Security (MH monitoring)
  - ~~d. MH Director (MH monitoring)~~
  - ~~e. MH Director of Nursing (MH monitoring/programming)~~
  - ~~f. MH Nurse Managersgr. (MH monitoring)~~
  - ~~g. MH Assistant Nurse Mgr. (MH monitoring)~~
3. Upon activation of the duress alarm all above PC's automatically indicate the individual in distress (if the badge is programmed, extra transmitters are not programmed) and their specific location. MH transmitters are not programmed with names, so the MH computers do not indicate this.
4. PBX/Information Service Center is responsible for paging overhead within the ER the specific location of the alarm (Duress Alarm, ER Zone 3 Room 28) and also paging this via the security radio system.
5. MH alarms are paged overhead at the MH Hospital by MH Staff.

## II. Response:

1. All available Security and ER staff respond to provide assistance to ER Duress Alarm.
2. All available Security and MH staff respond to provide assistance to MH Duress Alarm.

## III. Clearing/Resetting the system:

1. Upon response and resolution of the alarm, staff reset the alarm system by double clicking and holding the transmitter button for five seconds. Charge staff ensure that this takes place.

## IV. Maintenance of the system:

1. Transmitters are cleaned with an approved hospital germicide —wipe. Do not immerse them in water/disinfectant.
2. Transmitters that are damaged/non-functional are returned to Information Technology after a service call/help desk ticket is opened by 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."*

**Duress Transmitter Issuance Form**

*Employee/Provider Name:* \_\_\_\_\_

*Date:* \_\_\_\_\_

*Department:* \_\_\_\_\_

*Employer:* \_\_\_\_\_

*Duress Transmitter #:* \_\_\_\_\_

Lost badges- All Staff, Providers, Residents/Students are charged \$80 replacement fee for lost transmitters.

By signing below I agree to pay via payroll deduction the above referenced fee for my badge if I lose it.

*Signature:* \_\_\_\_\_



Subcategories of Department Manuals  
not selected.

|   |                                 |
|---|---------------------------------|
| Policy Number: EOC 5001   | Date Created: 10/01/2011        |
| Document Owner: Maribel Aguilar (Safety Officer/Life Safety Mgr)                                | Date Approved: Not Approved Yet |
| Approvers: Board of Directors (Administration), Board of Directors (EOC/Emergency Preparedness) |                                 |
| <b>Facility Fire Response Plan</b>  |                                 |

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

**Policy:** Kaweah Delta Health Care District will maintain a current Facility Fire Response Plan that addresses multiple features designed for the protection of life and property in the event of a fire.

**Purpose:** The purpose of the Kaweah Delta Health Care District's facility Fire Response Plan is to provide an environment conducive to the prevention of facility fires and the protection of life and property in the event of a fire.

**Scope:** The scope of the Kaweah Delta Health Care District (KDHCDC)-Facility Fire Response Plan pertains to all property, buildings, and grounds owned and operated by Kaweah Delta Health Care District.

**Authority and Responsibility:** It shall be the responsibility of the Director of Facilities Operations in conjunction with the Risk Manager, Safety Officer and administration to implement the content of the Kaweah Delta Health Care District Facility Fire Response Plan to ensure the protection of life and property in the event of a fire within the confines of Kaweah Delta Health Care District facilities

**Fire Safety Training:** All employees, Guild members, Licensed Independent Practitioners and other staff members will receive in-depth training on department-specific plans as well as the facility fire response in an effort to keep both plans at maximum effectiveness.

I. **FIRE PREVENTION:**

An unsafe act or unsafe conditions or both cause most fires. If each and every employee performed their duties in a safe manner and were alert to remove, correct and/or report unsafe conditions to their supervisor, most fires would be prevented.

A. **Fire Resistive Construction:**

1. It is the responsibility of the Kaweah Delta Health Care District Maintenance Department to maintain the initial standard of Type I fire resistive construction of Kaweah Delta Health Care District.
2. The Maintenance Department will monitor future construction changes and additions in such a manner as to protect the lives and ensure the physical safety of the patients, the employees, and the visitors to the hospital.
3. Whenever, for any reason, a smoke barrier wall or a fire wall is penetrated in order to run conduit, pipe or telephone cable, a Fire/Smoke Wall Penetration Permit will be issued and the Maintenance Department will check to see that the opening has been properly repaired.
4. No grills or windows will be cut in doors without the approval of the Maintenance Manager. No doors will be removed, or the designation of swing changed, without the Maintenance Managers permission. No hardware will be changed that might keep an automatic smoke control door from closing, that might disable panic hardware, or that might allow a fire door to stand open due to removal of a door closer.

5. Any partitions added to the building will be constructed of steel studs and fire resistant 5/8 inch sheet-rock.
6. All materials and fabrics will meet Class A requirements for all hospital settings.

**B. No Smoking Policy:**

1. Communication of the policy will be by signage at campus entrances, building entrances, parking areas and reminders from staff when necessary. Job applicants will be notified of the policy upon application and during orientation.
2. As the fifteen (15) minute employee break is a paid break, staff will not be permitted to use tobacco products during these times. Employees will be required to leave the campus if they choose to use tobacco products during their lunch break.
3. This policy applies to all persons while on KDHC property. Employees found to be in violation of this policy will be subject to corrective action up to and including termination.
4. All employees will be responsible for the enforcement of this policy. Should an employee be found using tobacco products on KDHC property, the incident should be reported to the department manager.
5. "Script" cards will be developed which can be given to employees, visitors or patient. If a family member chooses not to abide by the policy it is not the responsibility of the KDHC employee to force the family member to discontinue smoking.
6. Patients will not be permitted to smoke while under KDHC's care, even with a physician order.
7. KDHC will assist with compliance by sponsoring smoking cessation programs and providing smoking cessation education materials.
8. Persistent non-compliance with this policy should be directed to the following personnel:
  - Medical Staff – Vice President for Medical Affairs and Chief Medical Officer
  - KDHC Staff – Appropriate Director and Executive Team Member

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**C. Housekeeping Practices:**

1. EVS in conjunction with occupants of the respective areas must monitor all facilities to avoid the accumulation of empty boxes, trash, wet and/or oily rags or other flammables or combustibles.
2. Do not stack boxes within eighteen inches from the bottom of the sprinkler heads.
3. Fire doors may not be wedged open or blocked with equipment. If a fire door does not have a mechanical hold open device installed, it is to remain in the closed position.
4. Wheeled equipment is permitted to be left unattended in the corridor for more than 30 minutes provided:
  - The equipment does not reduce the clear unobstructed corridor width to less than 5 feet.
  - The wheeled equipment is limited to equipment that is in use, medical emergency equipment not in use, and patient lift and transport equipment. Beds are not considered transport equipment or emergency medical equipment, so they are not allowed in corridors.

**D. Electrical Hazard Prevention:**

Electrical devices with frayed cords or wires and defective switches or plugs should be taken out of use, tagged with the defect, and reported to the appropriate department, Clinical Engineering or Maintenance Department.

E. **Flame Spread Ratings:**

The responsibility of acquiring flame spread ratings and the acquisition of approved equipment will be vested in the Hospital Architect of record, Facilities Planning Director, Director of Facilities Operations and the Director of Materials Management.

1. Kaweah Delta Health Care District shall maintain on file ~~in the Safety Office~~ flame spread ratings on covering/finishing materials used within the facility.
2. These shall include, but not be limited to:
  - a. Carpet - flame retardant
  - b. Wall coverings - flame retardant
  - c. Drapes - flame retardant
  - d. Waste baskets - constructed of nonflammable material
  - e. Upholstery - flame retardant
  - f. Bedding - flame retardant
  - g. Decorations - flame retardant
3. Material will not be purchased if material flame spread rating data is not available

II. **FIRE IDENTIFICATION:**

Kaweah Delta Health Care District, Main Campus, is equipped with a Simplex 2120 Multiplex Fire and a Siemens Fire Finder XLS Alarm System. This system will identify, signal, and annunciate, upon activation of one of the initiation devices, any Code Red incidents. Employees will also be depended upon for quick, accurate detection and identification of fire.

A. **Initiation Devices:**

The Fire Alarm System provides the following means of initiating and identifying fire and smoke.

1. **Smoke Detectors** - There are smoke detectors located throughout the facility. Specific rooms and corridors are equipped with smoke detectors.
2. **Duct Detectors** - There are duct detectors installed on many of the District's air handlers. These are duct-mounted smoke detectors.
3. **Heat Detectors** - There are standard heat/thermo detectors located in the kitchen area, janitor closets and some mechanical areas. These detectors are combination rate of rise and set point operated.
4. **Flow Switches** - There are flow switches which annunciate fire sprinkler zones. Department-specific fire responses identify any sprinkler zone that serves that department.
5. **Pull Stations** - There are manual pull stations located throughout the facility. There will be a pull station located at all stair and ground floor exits and at various other locations. Department-specific fire responses note the pull station for that area.
6. Employees should report any odors of smoke or sighting of smoke to PBX Immediately by calling the code phone number 44 inside the main facility or 911 for all other locations.

B. **Alarm Signaling:**

Upon activation of any initiation device such as smoke detector or any device mentioned in "Fire Identification" section herein, an audible and visual alarm will activate.

1. Audible Alarms: There are chimes located throughout the facility. These will sound until an "All Clear" is called.
2. Visual: There are wall-mounted strobe lights located throughout the facility. These will remain lit until an "All Clear" is called.

C. **Communication:**

Upon identification of any Code Red incident, a series of communication events will take place. These events integrate mechanical and human responses.

1. Activation of any of our initial devices will be relayed to our outside monitoring company who will immediately contact Visalia fire dispatch for response of the initial firefighting units to the facility.
2. Simultaneously, this activation of the fire alarm system will display the zone and location at the main annunciator panels located in PBX.
3. The PBX operator will read the signal from the annunciator board and page "Code Red" three times. The location, device, and zone will be communicated via the public address system with the volume booster engaged. An "All Clear" will be announced by the PBX operator, three times, after notification of "All Clear" by the Maintenance Personnel director or supervisor, or fire department. This same procedure will be followed on all shifts.
4. Our telephone system will be used for identification of a Code Red incident by dialing 44 at the

hospital.

5. During a Code Red incident the telephone system should be limited to emergency calls only.
6. An alternate communication system will be used upon loss of the public address system, phones, or radio. Should the Code Red incident take place on the first floor and require evacuation of the PBX staff, the PBX manager will order transfer of communication operations to the ER.

**D. Fire Alarm Device Failure:**

To ensure staff knowledge and awareness in the event of pull station or any fire alarm system failure.

1. All employees, Guild members, or other staff that attempts to operate a manual fire alarm pull station should recognize that within seconds of pulling the handle on the pull station, audible and visual alarms will initiate.
2. Should the signaling devices (audible and visual) fail to initiate, the following protocol shall be used.
  - a. Alternate locations of fire alarm pull stations should be found. These alternate locations should be identified in the department-specific fire responses.
  - b. All exits have a fire alarm pull station
  - c. Communicate the exact location and any other incident specifics to PBX by dialing **44** at the nearest available phone after activating pull station.

**III. CODE RED TEAM AND INCIDENT COMMAND STRUCTURE:**

**A. Code Red Command Center:**

1. A Code Red command center will be set up in the Physician’s Lounge across from PBX. This center becomes the communication hub during a disaster and fire incident.
2. First shift command center staffing will consist of the Maintenance Personnel supervisor, and fire department designee. Need for an administrative representative will be evaluated as necessary.
3. The safety officer, when not at the fire location, will be stationed at the command center. All communication pertaining to extinguishment, evacuation or other emergency response will be transmitted from the command center to all necessary locations.
4. The second and third shift command center will be set up in the Physician’s Lounge with the arrival of the fire department, maintenance personnel, and safety officer.

**B. Management of Smoke Transmission:**

1. Kaweah Delta Health Care District will require a fire alarm system that will limit the transfer of smoke. The buildings are equipped with a Fire Alarm System that addresses and accomplishes compartmentization of smoke by automatic controls.
2. The Fire Alarm System provides for activation of smoke dampers upon initiation of all automatic device Priority I alarms.
3. Documentation of the fire/smoke damper system is evidenced by life safety and mechanical drawings kept on file in the Maintenance department.

**IV. CODE RED EMERGENCY RESPONSE:**

**A. First Responder Procedures in Fire Area:**

The specific plan for each department specifies the details of actions to be undertaken by employees in the event of a fire in your area. In general, the person discovering the fire (employees) must immediately:

**RACE**

1. **Rescue** - REMOVE any persons in immediate danger.
2. **Alarm** - Communicate the presence of fire by immediately activating the nearest fire alarm pull station.
3. Call, or designate someone to call the operator by dialing (Hospital Specific Number) to report the exact location and type of fire. If possible, have someone stay by the pull station to direct the Code Red responders to the site.
4. **Confine/Contain** – Close Doors, clear hallways. Equipment in hallways should be moved to inside unit/patient rooms with the door closed.
5. **Extinguish/Evacuate** - The fire should be extinguished if it is small and easily controllable by use of the fire extinguishers; however, all personnel in the fire area must evacuate the area as instructed in their fire response.

**B. Recommended Actions for All Personnel including During a Fire Alarm:**

1. Personnel should stay in the area in which they are at the time of the alarm. They should follow the instructions of the person in charge of that area at the time. Personnel should not be transiting

through the corridors unless they have specific fire-related duties.

2. All patient room doors are to be kept closed to aid in the evacuation; however, patient bathroom doors may be open. Any other door may ONLY be closed if it has been ascertained that NO PERSONS are in the room at the time of the alarm.
3. **DO NOT USE ELEVATORS.** Use stairways only. Elevators are to be utilized only by the fire department.
4. Personnel should attempt to reassure patients that the situation is under control and that they will be attended to throughout the event.
5. Visitors already in the hospital should remain with the patient in their room unless instructed otherwise by the person in charge of the area.
6. All visitors/vendors attempting to enter the hospital should be intercepted by an employee, and instructed to wait outside in the parking lot until the alarm is cleared.
7. Telephones should not be used during a Code Red. The paging system and any telephone conversation deemed essential should be limited to fire directives and emergencies only.
8. All nonessential electrical equipment should be turned off.
9. Guild members should remain in the area to which they are assigned and should follow the directions of the person in charge of that area.
10. All personnel should be prepared to follow their plan to evacuate their department upon orders from the person in charge as conditions warrant.

C. **Code Red Response Procedures:**

1. Code Red members will vary according to shift, will respond immediately to the announced location of the fire and will be in charge of the situation until the fire department arrives.
2. All available engineers, environmental service aides, security staff and nursing supervisor will report immediately to the fire location.
3. Maintenance personnel will determine the location and severity of the fire and smoke as well as assess the amount and spread of smoke, flame and area affected, spread patterns, and the extinguishing of the fire. This information will be continually transmitted to the command center.
4. Security staff will provide foot traffic control and maintain egress availability at stairway entrance. Environmental services staff will report to the department head or charge nurse to assist in evacuation preparation.
5. Code Red responders will serve as supplemental staff necessary for horizontal evacuation. Horizontal evacuation preparation is mandatory, in all zones, pending determination of fire and/or smoke severity. If a call for vertical evacuation is determined necessary, the Code Red responders will assist in the evacuation.

D. **Extinguishment of Fire:**

Kaweah Delta Health Care District is equipped with portable fire extinguishers, kitchen hood extinguishing systems, and specific areas covered with a fire sprinkler system.

1. Response to the Code Red includes use of portable fire extinguishers if the fire is containable as assessed by personnel on scene. All employees will be trained in use of portable extinguishers as part of their annual safety training.
2. Kitchen grill fires will be extinguished by an Ansul hood extinguishing system.
3. Kaweah Delta Health Care District has a fire pump that serves a stand pipe system with hose cabinets located at each end of each floor. The fire pumps also backs up the areas that are served by sprinklers.
4. The Visalia Fire Department, with back up from Tulare County units, serves as responders to this facility. The Visalia Fire Department has stations located within a two-mile radius of Kaweah Delta Health Care District. This provides us with a response time, which is normally five minutes, or less. Our policy is to allow professional fire fighters to extinguish any fire assessed above a minor category, which allows hospital staff to concentrate on an organized and timely evacuation.

E. **Disabling the Fire Alarm System:**

1. Kaweah Delta Health Care District will protect its buildings against unauthorized disabling of fire alarm system. Maintenance personnel or the fire alarm vendor shall not disable any portion of the fire alarm system without securing approval of the Facilities Director, notification of the house supervisor, and local fire department when the system will be off line for more than ¼ hour. California Department of Public Health will be notified if the failure exceeds 4 hours. In the event the Director of Maintenance is not present, the house supervisor may substitute.
2. Fire watch shall be instituted in all areas where system is inactive. Fire watch staffing as follows:
  - a. Security - All patient areas
  - b. Maintenance - All non-patient areas

Security will be responsible to conduct a fire-watch if the failure exceeds 4 hours. All areas will be monitored each hour. Security will maintain documentation of the fire-watch.

V. **EVACUATION PROCEDURES:**

Kaweah Delta Health Care District recognizes the necessity for a timely and organized evacuation in the event of a verified Code Red situation. Evaluation of the Code Red as to the need for calling an internal disaster will be made by the safety director or the highest level administrative representative in-house, giving access to a personnel pool will be established at the first floor conference room.

A. **Departmental Evacuation:**

1. All departments will evacuate following department-specific plans: first to horizontal zones, then vertical to east and west parking lot evacuation stations.
2. All zones effected will evacuate in accordance with a horizontal strategy and, if necessary, a vertical evacuation.
  - a. Horizontal strategy is moving from smoke compartment of incident to adjacent smoke compartment.
  - b. Vertical evacuation is complete evacuation of the smoke compartment of incident and alarm to a lower floor or to north or south parking lot stations if determined necessary by safety officer, nursing supervisor, administrative representative or ordered by the fire department.
3. Maintenance Personnel will use two way radios and cell phones for communication and coordination purposes.
4. All available ambulance companies will be notified by emergency room staff of the evacuation. The ambulances will be utilized for transporting patients to other area hospitals if determined necessary by administrative representative.

B. **Patient Evacuation:**

If the fire alarm sounds while transporting a patient from one department to another, the following procedures should be followed:

1. Evacuation while transporting patients via elevators
  - a. Fire announcement cannot be heard in elevators.
  - b. If the fire alarm is activated by a smoke detector located by elevator lobbies, all elevators will automatically go to the ground floor. If the fire is located on the ground floor, all elevators will automatically stop on the second floor.
  - c. When an elevator stops, the employee should exit with the patient and place the patient in the first safe area (room) available, close the door and remain with the patient until "All Clear" sounds or evacuation orders are given.
  - d. If any sensor other than those directly in front of the elevators activates the fire alarms, the elevator service will not be interrupted.
  - e. If employee exits, elevator and fire alarm is sounding, the employee should verify location of the fire, move the patient to the closest safe area (room) and remain with the patient until "All Clear" sounds or evacuation orders are given.
2. Evacuation of patients while transporting via hallways or other common areas:
  - a. If the fire alarm occurs while on the floor in transit, immediately move the patient to the closest safe area on that floor. The employee should remain with the patient until "All Clear" sounds or evacuation orders are given.
  - b. If the patient and the transporter have not left the floor and the fire alarm sounds, return the patient to their room. The transporter will remain on the patient floor until "All Clear" sounds. If evacuation is required, the employee will remain on the floor and get further instructions from the floor supervisor/manager.
3. Triaging Patients:
  - a. Emergency room physician will be in charge of the triage of patients.
  - b. All available physicians and interns will evacuate with the patients to the parking lot in order to assist with triage of patients.
  - c. Nurse managers/charge nurses from each nursing unit will assess their patients' condition and report any immediate need to the emergency room physician.
  - d. Personnel from each nursing unit will remain with their assigned unit.
  - e. Nurse managers/charge nurses will delegate patient care to their unit personnel and any additional non-nursing staff from other departments if necessary and available.

## VI. CODE RED TRAINING AND DRILLS:

### A. Code Red Training:

The Maintenance Department is responsible for conducting fire drills. The organization, training, equipping and supervision of hospital personnel in response to a fire alarm is the responsibility of the Safety Officer.

#### 1. Fire Drills:

- a. The hospital shall hold unannounced fire drills quarterly on each shift, which shall be treated as a true fire as much as possible.
- b. Department managers or their designee shall complete a fire drill critique form and submit a copy to the safety office within twenty-four hours of each drill.

#### 2. Hospital Personnel:

All hospital personnel will be trained and periodically in-serviced on their department-specific fire response as well as the hospital-wide fire response in accordance with the following schedule.

- a. Initial training at the time of hire
- b. Once annually
- c. Districtwide life safety training is conducted annually. The Safety Department distributes training materials including post tests to verify competency.
  - (1) Verification of initial and annual training will be evidenced by a completion of training form, which will be sent to the safety director in our electronic learning system.
  - (2) ~~Verification of monthly department review will be evidenced by inclusion in the monthly department minutes.~~

### B. Code Red Drills:

Kaweah Delta Health Care District will perform fire drills on a timely basis that educate and test all employees, Guild members, [Licensed Independent Practitioners](#) and other staff on proper Code Red response.

#### 1. Frequency of Drills:

A Code Red Drill shall be performed once per shift per quarter. The need for additional drills will be assessed by the Environment of Care Committee based on the effectiveness of previous drills and any life safety deficiencies identified and not corrected.

#### 2. Responsibility:

- a. The Director of Facilities Operations along with support and assistance from the Safety Officer, Environment of Care Committee, and Maintenance Department Manager will be responsible for performance of all Code Red Drills.
- b. All aspects of department plans will be followed but will not include actual evacuation, either horizontal or vertical.
- c. All department managers will complete or assign responsibility for completing a Code Red critique form. The Environment of Care Committee will critique the incident location and facility-wide response. Completed critique forms will follow the protocol ascribed to in the life safety plan.

#### 3. Fire Drill Procedures:

- a. Prior to initiating a Code Red Drill, notification of the impending drill will be made by the Maintenance staff, to PBX, monitoring company, and the Visalia Fire Department.
- b. The Code Red Drill will commence with a Maintenance staff mechanic either initiating an automatic fire alarm device or placing a red flashing beacon light, representing a fire, somewhere in the facility. All further actions taken will be subject to the Code Red critique policy.

#### 4. Code Red Critique:

- a. Kaweah Delta Health Care District requires that all Code Red Drills and incidents be monitored, and that staff response be evaluated for effectiveness of training.
- b. The Code Red critique form is divided into the following categories of evaluation.
  - (1) Notification
  - (2) Mechanical response
  - (3) Staff response
  - (4) Random sample (staff)
  - (5) Code Red response
  - (6) Overall evaluation and rating
- c. All questions must be answered.
- d. Corrective action must be taken and tracked for the Environment of Care Committee.
- e. Completed forms will be forwarded to the Safety Officer and Maintenance Manager.

- f. The Safety Officer will submit a quarterly report to the Environment of Care Committee on all Code Red critiques. The report will include required actions to be taken and any recommendations.
- g. When the need for additional training is identified by use of the Code Red critique, this training and education will become the responsibility of the department managers. Documentation of this additional training will be by:
  - (1) Department minutes
  - (2) Completed action plan
- h. The Environment of Care Committee will perform Monitoring and follow-up of actions taken for effectiveness.

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|  |                                 |
|--|---------------------------------|
| Policy Number: EOC 1015  | Date Created: 08/05/2019        |
| Document Owner: Maribel Aguilar (Safety Officer/Life Safety Mgr)   | Date Approved: Not Approved Yet |
| <b>Approvers: Board of Directors (Administration), Board of Directors (EOC/Emergency Preparedness), Cindy Moccio (Board Clerk/Exec Assist-CEO), Maribel Aguilar (Safety Officer/Life Safety Mgr)</b> |                                 |
| <b>Wireless Duress System</b>  |                                 |

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

**Policy:**

The wireless duress system in the Emergency Room and Mental Health Hospital consists of wireless transmitters that communicate to the wireless internet system and specific computers to allow staff to use a wireless transmitter to request assistance if they have safety concerns.

All Emergency Room (ER) staff, Mental Health (MH) staff, Patient and Family Services (PFS), and Graduate Medical Education Residents (GME) on rotations in the ER and/or MH are issued wireless duress transmitters upon hire/assignment and are required to wear the transmitters while on duty. ER and MH management maintain a supply of extra wireless transmitters to distribute as needed (lost, float staff, etc.)

ER and MH Providers are encouraged to wear/utilize the wireless transmitters and sign them out through ER or MH Administration.

**Procedure:**

I. Issuance:

1. HR distributes wireless transmitters programmed with staff names to all ER staff upon hire.
2. GME distributes wireless transmitters to Residents/Students upon assignment to ER and/or Mental Health.
3. ER Providers sign out transmitters from the ER at the start of each shift and return them at the end of their shift.
4. Mental Health manages assignment of transmitters for employees and Medical Staff working at Mental Health Hospital.
5. ER management maintains a supply of extra transmitters for float staff, Environmental Services Staff, Patient Family Services Staff, lost or broken transmitters, etc.
6. All transmitters are tested for functionality prior to issuance.
7. Lost transmitters- All Staff, Providers, Residents/Students may be charged \$80 replacement fee for lost transmitters. Each case will be dealt with on an individual basis and HR shall decide if the individual shall be charged this cost.

I. Monitoring:

1. ER Duress System Monitoring PC's are located:
  - a. PBX/Information Service Center (ER monitoring)
  - b. ER Security Desk (ER monitoring and programming)
  - c. ED Zone 1, 2 &3 (monitoring and programming)
  - d. Security office (monitoring and programming)
  - e. Human Resources administrative assistants (3) (ER monitoring and programming)
  - f. Graduate Medical Education (3) (programming only)
  - g. ER Nurse Manager (monitoring and programming)
2. Mental Health Duress System monitoring PCs are located:
  - a. East Wing Nurse Station (MH monitoring)
  - b. West Wing Nurse Station (MH monitoring)
  - c. MH Security (MH monitoring)
  - ~~d. MH Director (MH monitoring)~~
  - ~~e. MH Director of Nursing (MH monitoring/programming)~~
  - ~~f. MH Nurse Managersgr. (MH monitoring)~~
  - ~~g. MH Assistant Nurse Mgr. (MH monitoring)~~
3. Upon activation of the duress alarm all above PC's automatically indicate the individual in distress (if the badge is programmed, extra transmitters are not programmed) and their specific location. MH transmitters are not programmed with names, so the MH computers do not indicate this.
4. PBX/Information Service Center is responsible for paging overhead within the ER the specific location of the alarm (Duress Alarm, ER Zone 3 Room 28) and also paging this via the security radio system.
5. MH alarms are paged overhead at the MH Hospital by MH Staff.

## II. Response:

1. All available Security and ER staff respond to provide assistance to ER Duress Alarm.
2. All available Security and MH staff respond to provide assistance to MH Duress Alarm.

## III. Clearing/Resetting the system:

1. Upon response and resolution of the alarm, staff reset the alarm system by double clicking and holding the transmitter button for five seconds. Charge staff ensure that this takes place.

## IV. Maintenance of the system:

1. Transmitters are cleaned with an approved hospital germicide —wipe. Do not immerse them in water/disinfectant.
2. Transmitters that are damaged/non-functional are returned to Information Technology after a service call/help desk ticket is opened by staff.

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*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."*

**Duress Transmitter Issuance Form**

*Employee/Provider Name:* \_\_\_\_\_

*Date:* \_\_\_\_\_

*Department:* \_\_\_\_\_

*Employer:* \_\_\_\_\_

*Duress Transmitter #:* \_\_\_\_\_

Lost badges- All Staff, Providers, Residents/Students are charged \$80 replacement fee for lost transmitters.

By signing below I agree to pay via payroll deduction the above referenced fee for my badge if I lose it.

*Signature:* \_\_\_\_\_



Subcategories of Department Manuals  
not selected.

|   |                                 |
|---|---------------------------------|
| Policy Number: EOC 5001   | Date Created: 10/01/2011        |
| Document Owner: Maribel Aguilar (Safety Officer/Life Safety Mgr)                                | Date Approved: Not Approved Yet |
| Approvers: Board of Directors (Administration), Board of Directors (EOC/Emergency Preparedness) |                                 |
| <b>Facility Fire Response Plan</b>  |                                 |

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

**Policy:** Kaweah Delta Health Care District will maintain a current Facility Fire Response Plan that addresses multiple features designed for the protection of life and property in the event of a fire.

**Purpose:** The purpose of the Kaweah Delta Health Care District's facility Fire Response Plan is to provide an environment conducive to the prevention of facility fires and the protection of life and property in the event of a fire.

**Scope:** The scope of the Kaweah Delta Health Care District (KDHCDC)-Facility Fire Response Plan pertains to all property, buildings, and grounds owned and operated by Kaweah Delta Health Care District.

**Authority and Responsibility:** It shall be the responsibility of the Director of Facilities Operations in conjunction with the Risk Manager, Safety Officer and administration to implement the content of the Kaweah Delta Health Care District Facility Fire Response Plan to ensure the protection of life and property in the event of a fire within the confines of Kaweah Delta Health Care District facilities

**Fire Safety Training:** All employees, Guild members, Licensed Independent Practitioners and other staff members will receive in-depth training on department-specific plans as well as the facility fire response in an effort to keep both plans at maximum effectiveness.

I. **FIRE PREVENTION:**

An unsafe act or unsafe conditions or both cause most fires. If each and every employee performed their duties in a safe manner and were alert to remove, correct and/or report unsafe conditions to their supervisor, most fires would be prevented.

A. **Fire Resistive Construction:**

1. It is the responsibility of the Kaweah Delta Health Care District Maintenance Department to maintain the initial standard of Type I fire resistive construction of Kaweah Delta Health Care District.
2. The Maintenance Department will monitor future construction changes and additions in such a manner as to protect the lives and ensure the physical safety of the patients, the employees, and the visitors to the hospital.
3. Whenever, for any reason, a smoke barrier wall or a fire wall is penetrated in order to run conduit, pipe or telephone cable, a Fire/Smoke Wall Penetration Permit will be issued and the Maintenance Department will check to see that the opening has been properly repaired.
4. No grills or windows will be cut in doors without the approval of the Maintenance Manager. No doors will be removed, or the designation of swing changed, without the Maintenance Managers permission. No hardware will be changed that might keep an automatic smoke control door from closing, that might disable panic hardware, or that might allow a fire door to stand open due to removal of a door closer.

5. Any partitions added to the building will be constructed of steel studs and fire resistant 5/8 inch sheet-rock.
6. All materials and fabrics will meet Class A requirements for all hospital settings.

**B. No Smoking Policy:**

1. Communication of the policy will be by signage at campus entrances, building entrances, parking areas and reminders from staff when necessary. Job applicants will be notified of the policy upon application and during orientation.
2. As the fifteen (15) minute employee break is a paid break, staff will not be permitted to use tobacco products during these times. Employees will be required to leave the campus if they choose to use tobacco products during their lunch break.
3. This policy applies to all persons while on KDHC property. Employees found to be in violation of this policy will be subject to corrective action up to and including termination.
4. All employees will be responsible for the enforcement of this policy. Should an employee be found using tobacco products on KDHC property, the incident should be reported to the department manager.
5. "Script" cards will be developed which can be given to employees, visitors or patient. If a family member chooses not to abide by the policy it is not the responsibility of the KDHC employee to force the family member to discontinue smoking.
6. Patients will not be permitted to smoke while under KDHC's care, even with a physician order.
7. KDHC will assist with compliance by sponsoring smoking cessation programs and providing smoking cessation education materials.
8. Persistent non-compliance with this policy should be directed to the following personnel:
  - Medical Staff – Vice President for Medical Affairs and Chief Medical Officer
  - KDHC Staff – Appropriate Director and Executive Team Member

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**C. Housekeeping Practices:**

1. EVS in conjunction with occupants of the respective areas must monitor all facilities to avoid the accumulation of empty boxes, trash, wet and/or oily rags or other flammables or combustibles.
2. Do not stack boxes within eighteen inches from the bottom of the sprinkler heads.
3. Fire doors may not be wedged open or blocked with equipment. If a fire door does not have a mechanical hold open device installed, it is to remain in the closed position.
4. Wheeled equipment is permitted to be left unattended in the corridor for more than 30 minutes provided:
  - The equipment does not reduce the clear unobstructed corridor width to less than 5 feet.
  - The wheeled equipment is limited to equipment that is in use, medical emergency equipment not in use, and patient lift and transport equipment. Beds are not considered transport equipment or emergency medical equipment, so they are not allowed in corridors.

**D. Electrical Hazard Prevention:**

Electrical devices with frayed cords or wires and defective switches or plugs should be taken out of use, tagged with the defect, and reported to the appropriate department, Clinical Engineering or Maintenance Department.

E. **Flame Spread Ratings:**

The responsibility of acquiring flame spread ratings and the acquisition of approved equipment will be vested in the Hospital Architect of record, Facilities Planning Director, Director of Facilities Operations and the Director of Materials Management.

1. Kaweah Delta Health Care District shall maintain on file ~~in the Safety Office~~ flame spread ratings on covering/finishing materials used within the facility.
2. These shall include, but not be limited to:
  - a. Carpet - flame retardant
  - b. Wall coverings - flame retardant
  - c. Drapes - flame retardant
  - d. Waste baskets - constructed of nonflammable material
  - e. Upholstery - flame retardant
  - f. Bedding - flame retardant
  - g. Decorations - flame retardant
3. Material will not be purchased if material flame spread rating data is not available

II. **FIRE IDENTIFICATION:**

Kaweah Delta Health Care District, Main Campus, is equipped with a Simplex 2120 Multiplex Fire and a Siemens Fire Finder XLS Alarm System. This system will identify, signal, and annunciate, upon activation of one of the initiation devices, any Code Red incidents. Employees will also be depended upon for quick, accurate detection and identification of fire.

A. **Initiation Devices:**

The Fire Alarm System provides the following means of initiating and identifying fire and smoke.

1. **Smoke Detectors** - There are smoke detectors located throughout the facility. Specific rooms and corridors are equipped with smoke detectors.
2. **Duct Detectors** - There are duct detectors installed on many of the District's air handlers. These are duct-mounted smoke detectors.
3. **Heat Detectors** - There are standard heat/thermo detectors located in the kitchen area, janitor closets and some mechanical areas. These detectors are combination rate of rise and set point operated.
4. **Flow Switches** - There are flow switches which annunciate fire sprinkler zones. Department-specific fire responses identify any sprinkler zone that serves that department.
5. **Pull Stations** - There are manual pull stations located throughout the facility. There will be a pull station located at all stair and ground floor exits and at various other locations. Department-specific fire responses note the pull station for that area.
6. Employees should report any odors of smoke or sighting of smoke to PBX Immediately by calling the code phone number 44 inside the main facility or 911 for all other locations.

B. **Alarm Signaling:**

Upon activation of any initiation device such as smoke detector or any device mentioned in "Fire Identification" section herein, an audible and visual alarm will activate.

1. Audible Alarms: There are chimes located throughout the facility. These will sound until an "All Clear" is called.
2. Visual: There are wall-mounted strobe lights located throughout the facility. These will remain lit until an "All Clear" is called.

C. **Communication:**

Upon identification of any Code Red incident, a series of communication events will take place. These events integrate mechanical and human responses.

1. Activation of any of our initial devices will be relayed to our outside monitoring company who will immediately contact Visalia fire dispatch for response of the initial firefighting units to the facility.
2. Simultaneously, this activation of the fire alarm system will display the zone and location at the main annunciator panels located in PBX.
3. The PBX operator will read the signal from the annunciator board and page "Code Red" three times. The location, device, and zone will be communicated via the public address system with the volume booster engaged. An "All Clear" will be announced by the PBX operator, three times, after notification of "All Clear" by the Maintenance Personnel director or supervisor, or fire department. This same procedure will be followed on all shifts.
4. Our telephone system will be used for identification of a Code Red incident by dialing 44 at the

hospital.

5. During a Code Red incident the telephone system should be limited to emergency calls only.
6. An alternate communication system will be used upon loss of the public address system, phones, or radio. Should the Code Red incident take place on the first floor and require evacuation of the PBX staff, the PBX manager will order transfer of communication operations to the ER.

**D. Fire Alarm Device Failure:**

To ensure staff knowledge and awareness in the event of pull station or any fire alarm system failure.

1. All employees, Guild members, or other staff that attempts to operate a manual fire alarm pull station should recognize that within seconds of pulling the handle on the pull station, audible and visual alarms will initiate.
2. Should the signaling devices (audible and visual) fail to initiate, the following protocol shall be used.
  - a. Alternate locations of fire alarm pull stations should be found. These alternate locations should be identified in the department-specific fire responses.
  - b. All exits have a fire alarm pull station
  - c. Communicate the exact location and any other incident specifics to PBX by dialing **44** at the nearest available phone after activating pull station.

**III. CODE RED TEAM AND INCIDENT COMMAND STRUCTURE:**

**A. Code Red Command Center:**

1. A Code Red command center will be set up in the Physician’s Lounge across from PBX. This center becomes the communication hub during a disaster and fire incident.
2. First shift command center staffing will consist of the Maintenance Personnel supervisor, and fire department designee. Need for an administrative representative will be evaluated as necessary.
3. The safety officer, when not at the fire location, will be stationed at the command center. All communication pertaining to extinguishment, evacuation or other emergency response will be transmitted from the command center to all necessary locations.
4. The second and third shift command center will be set up in the Physician’s Lounge with the arrival of the fire department, maintenance personnel, and safety officer.

**B. Management of Smoke Transmission:**

1. Kaweah Delta Health Care District will require a fire alarm system that will limit the transfer of smoke. The buildings are equipped with a Fire Alarm System that addresses and accomplishes compartmentization of smoke by automatic controls.
2. The Fire Alarm System provides for activation of smoke dampers upon initiation of all automatic device Priority I alarms.
3. Documentation of the fire/smoke damper system is evidenced by life safety and mechanical drawings kept on file in the Maintenance department.

**IV. CODE RED EMERGENCY RESPONSE:**

**A. First Responder Procedures in Fire Area:**

The specific plan for each department specifies the details of actions to be undertaken by employees in the event of a fire in your area. In general, the person discovering the fire (employees) must immediately:

**RACE**

1. **Rescue** - REMOVE any persons in immediate danger.
2. **Alarm** - Communicate the presence of fire by immediately activating the nearest fire alarm pull station.
3. Call, or designate someone to call the operator by dialing (Hospital Specific Number) to report the exact location and type of fire. If possible, have someone stay by the pull station to direct the Code Red responders to the site.
4. **Confine/Contain** – Close Doors, clear hallways. Equipment in hallways should be moved to inside unit/patient rooms with the door closed.
5. **Extinguish/Evacuate** - The fire should be extinguished if it is small and easily controllable by use of the fire extinguishers; however, all personnel in the fire area must evacuate the area as instructed in their fire response.

**B. Recommended Actions for All Personnel including During a Fire Alarm:**

1. Personnel should stay in the area in which they are at the time of the alarm. They should follow the instructions of the person in charge of that area at the time. Personnel should not be transiting

through the corridors unless they have specific fire-related duties.

2. All patient room doors are to be kept closed to aid in the evacuation; however, patient bathroom doors may be open. Any other door may ONLY be closed if it has been ascertained that NO PERSONS are in the room at the time of the alarm.
3. **DO NOT USE ELEVATORS.** Use stairways only. Elevators are to be utilized only by the fire department.
4. Personnel should attempt to reassure patients that the situation is under control and that they will be attended to throughout the event.
5. Visitors already in the hospital should remain with the patient in their room unless instructed otherwise by the person in charge of the area.
6. All visitors/vendors attempting to enter the hospital should be intercepted by an employee, and instructed to wait outside in the parking lot until the alarm is cleared.
7. Telephones should not be used during a Code Red. The paging system and any telephone conversation deemed essential should be limited to fire directives and emergencies only.
8. All nonessential electrical equipment should be turned off.
9. Guild members should remain in the area to which they are assigned and should follow the directions of the person in charge of that area.
10. All personnel should be prepared to follow their plan to evacuate their department upon orders from the person in charge as conditions warrant.

C. **Code Red Response Procedures:**

1. Code Red members will vary according to shift, will respond immediately to the announced location of the fire and will be in charge of the situation until the fire department arrives.
2. All available engineers, environmental service aides, security staff and nursing supervisor will report immediately to the fire location.
3. Maintenance personnel will determine the location and severity of the fire and smoke as well as assess the amount and spread of smoke, flame and area affected, spread patterns, and the extinguishing of the fire. This information will be continually transmitted to the command center.
4. Security staff will provide foot traffic control and maintain egress availability at stairway entrance. Environmental services staff will report to the department head or charge nurse to assist in evacuation preparation.
5. Code Red responders will serve as supplemental staff necessary for horizontal evacuation. Horizontal evacuation preparation is mandatory, in all zones, pending determination of fire and/or smoke severity. If a call for vertical evacuation is determined necessary, the Code Red responders will assist in the evacuation.

D. **Extinguishment of Fire:**

Kaweah Delta Health Care District is equipped with portable fire extinguishers, kitchen hood extinguishing systems, and specific areas covered with a fire sprinkler system.

1. Response to the Code Red includes use of portable fire extinguishers if the fire is containable as assessed by personnel on scene. All employees will be trained in use of portable extinguishers as part of their annual safety training.
2. Kitchen grill fires will be extinguished by an Ansul hood extinguishing system.
3. Kaweah Delta Health Care District has a fire pump that serves a stand pipe system with hose cabinets located at each end of each floor. The fire pumps also backs up the areas that are served by sprinklers.
4. The Visalia Fire Department, with back up from Tulare County units, serves as responders to this facility. The Visalia Fire Department has stations located within a two-mile radius of Kaweah Delta Health Care District. This provides us with a response time, which is normally five minutes, or less. Our policy is to allow professional fire fighters to extinguish any fire assessed above a minor category, which allows hospital staff to concentrate on an organized and timely evacuation.

E. **Disabling the Fire Alarm System:**

1. Kaweah Delta Health Care District will protect its buildings against unauthorized disabling of fire alarm system. Maintenance personnel or the fire alarm vendor shall not disable any portion of the fire alarm system without securing approval of the Facilities Director, notification of the house supervisor, and local fire department when the system will be off line for more than ¼ hour. California Department of Public Health will be notified if the failure exceeds 4 hours. In the event the Director of Maintenance is not present, the house supervisor may substitute.
2. Fire watch shall be instituted in all areas where system is inactive. Fire watch staffing as follows:
  - a. Security - All patient areas
  - b. Maintenance - All non-patient areas

Security will be responsible to conduct a fire-watch if the failure exceeds 4 hours. All areas will be monitored each hour. Security will maintain documentation of the fire-watch.

V. **EVACUATION PROCEDURES:**

Kaweah Delta Health Care District recognizes the necessity for a timely and organized evacuation in the event of a verified Code Red situation. Evaluation of the Code Red as to the need for calling an internal disaster will be made by the safety director or the highest level administrative representative in-house, giving access to a personnel pool will be established at the first floor conference room.

A. **Departmental Evacuation:**

1. All departments will evacuate following department-specific plans: first to horizontal zones, then vertical to east and west parking lot evacuation stations.
2. All zones effected will evacuate in accordance with a horizontal strategy and, if necessary, a vertical evacuation.
  - a. Horizontal strategy is moving from smoke compartment of incident to adjacent smoke compartment.
  - b. Vertical evacuation is complete evacuation of the smoke compartment of incident and alarm to a lower floor or to north or south parking lot stations if determined necessary by safety officer, nursing supervisor, administrative representative or ordered by the fire department.
3. Maintenance Personnel will use two way radios and cell phones for communication and coordination purposes.
4. All available ambulance companies will be notified by emergency room staff of the evacuation. The ambulances will be utilized for transporting patients to other area hospitals if determined necessary by administrative representative.

B. **Patient Evacuation:**

If the fire alarm sounds while transporting a patient from one department to another, the following procedures should be followed:

1. Evacuation while transporting patients via elevators
  - a. Fire announcement cannot be heard in elevators.
  - b. If the fire alarm is activated by a smoke detector located by elevator lobbies, all elevators will automatically go to the ground floor. If the fire is located on the ground floor, all elevators will automatically stop on the second floor.
  - c. When an elevator stops, the employee should exit with the patient and place the patient in the first safe area (room) available, close the door and remain with the patient until "All Clear" sounds or evacuation orders are given.
  - d. If any sensor other than those directly in front of the elevators activates the fire alarms, the elevator service will not be interrupted.
  - e. If employee exits, elevator and fire alarm is sounding, the employee should verify location of the fire, move the patient to the closest safe area (room) and remain with the patient until "All Clear" sounds or evacuation orders are given.
2. Evacuation of patients while transporting via hallways or other common areas:
  - a. If the fire alarm occurs while on the floor in transit, immediately move the patient to the closest safe area on that floor. The employee should remain with the patient until "All Clear" sounds or evacuation orders are given.
  - b. If the patient and the transporter have not left the floor and the fire alarm sounds, return the patient to their room. The transporter will remain on the patient floor until "All Clear" sounds. If evacuation is required, the employee will remain on the floor and get further instructions from the floor supervisor/manager.
3. Triaging Patients:
  - a. Emergency room physician will be in charge of the triage of patients.
  - b. All available physicians and interns will evacuate with the patients to the parking lot in order to assist with triage of patients.
  - c. Nurse managers/charge nurses from each nursing unit will assess their patients' condition and report any immediate need to the emergency room physician.
  - d. Personnel from each nursing unit will remain with their assigned unit.
  - e. Nurse managers/charge nurses will delegate patient care to their unit personnel and any additional non-nursing staff from other departments if necessary and available.

## VI. CODE RED TRAINING AND DRILLS:

### A. Code Red Training:

The Maintenance Department is responsible for conducting fire drills. The organization, training, equipping and supervision of hospital personnel in response to a fire alarm is the responsibility of the Safety Officer.

#### 1. Fire Drills:

- a. The hospital shall hold unannounced fire drills quarterly on each shift, which shall be treated as a true fire as much as possible.
- b. Department managers or their designee shall complete a fire drill critique form and submit a copy to the safety office within twenty-four hours of each drill.

#### 2. Hospital Personnel:

All hospital personnel will be trained and periodically in-serviced on their department-specific fire response as well as the hospital-wide fire response in accordance with the following schedule.

- a. Initial training at the time of hire
- b. Once annually
- c. Districtwide life safety training is conducted annually. The Safety Department distributes training materials including post tests to verify competency.
  - (1) Verification of initial and annual training will be evidenced by a completion of training form, which will be sent to the safety director in our electronic learning system.
  - (2) ~~Verification of monthly department review will be evidenced by inclusion in the monthly department minutes.~~

### B. Code Red Drills:

Kaweah Delta Health Care District will perform fire drills on a timely basis that educate and test all employees, Guild members, [Licensed Independent Practitioners](#) and other staff on proper Code Red response.

#### 1. Frequency of Drills:

A Code Red Drill shall be performed once per shift per quarter. The need for additional drills will be assessed by the Environment of Care Committee based on the effectiveness of previous drills and any life safety deficiencies identified and not corrected.

#### 2. Responsibility:

- a. The Director of Facilities Operations along with support and assistance from the Safety Officer, Environment of Care Committee, and Maintenance Department Manager will be responsible for performance of all Code Red Drills.
- b. All aspects of department plans will be followed but will not include actual evacuation, either horizontal or vertical.
- c. All department managers will complete or assign responsibility for completing a Code Red critique form. The Environment of Care Committee will critique the incident location and facility-wide response. Completed critique forms will follow the protocol ascribed to in the life safety plan.

#### 3. Fire Drill Procedures:

- a. Prior to initiating a Code Red Drill, notification of the impending drill will be made by the Maintenance staff, to PBX, monitoring company, and the Visalia Fire Department.
- b. The Code Red Drill will commence with a Maintenance staff mechanic either initiating an automatic fire alarm device or placing a red flashing beacon light, representing a fire, somewhere in the facility. All further actions taken will be subject to the Code Red critique policy.

#### 4. Code Red Critique:

- a. Kaweah Delta Health Care District requires that all Code Red Drills and incidents be monitored, and that staff response be evaluated for effectiveness of training.
- b. The Code Red critique form is divided into the following categories of evaluation.
  - (1) Notification
  - (2) Mechanical response
  - (3) Staff response
  - (4) Random sample (staff)
  - (5) Code Red response
  - (6) Overall evaluation and rating
- c. All questions must be answered.
- d. Corrective action must be taken and tracked for the Environment of Care Committee.
- e. Completed forms will be forwarded to the Safety Officer and Maintenance Manager.

- f. The Safety Officer will submit a quarterly report to the Environment of Care Committee on all Code Red critiques. The report will include required actions to be taken and any recommendations.
- g. When the need for additional training is identified by use of the Code Red critique, this training and education will become the responsibility of the department managers. Documentation of this additional training will be by:
  - (1) Department minutes
  - (2) Completed action plan
- h. The Environment of Care Committee will perform Monitoring and follow-up of actions taken for effectiveness.

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

# RESOLUTION 2055

WHEREAS, a claim on behalf of Thomas Roy Cisneros has been presented on October 23, 2019 to the Board of Directors of the Kaweah Delta Health Care District,

IT IS HEREBY RESOLVED AS FOLLOWS:

1. The aforementioned claim is hereby rejected.
2. In accordance with Government Code Section 913, the Secretary of the Board of Directors is hereby directed to give notice of rejection of said claim to Glenda de Guzman Esq., The Dunnion Law Firm, in the following form:

"Notice is hereby given that the claim which you presented to the Board of Directors of the Kaweah Delta Health Care District on October 23, 2019, was rejected by the Board of Directors on November 25, 2019."

## **WARNING**

"Subject to certain exceptions, you have only six (6) months from the date this notice was personally delivered or deposited in the mail to file a court action on this claim. See Government Code Section 945.6.

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

PASSED AND ADOPTED by unanimous vote of those present at a regular meeting of the Board of Directors of the Kaweah Delta Health Care District on November 25, 2019.

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President, Kaweah Delta Health Care District

ATTEST:

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

/cm

November 25, 2019

**Sent via Certified Mail**  
**No. 7016034000002569166**  
**Return Receipt Required**

Glenda de Guzman Esq.  
THE DUNNION LAW FIRM  
2711 Garden Road  
Monterey, CA 93940

**RE: Notice of Rejection of Claim of Thomas Roy Cisneros vs. Kaweah Delta Health Care District**

Notice is hereby given that the claim, which you presented to the Board of Directors of the Kaweah Delta Health Care District on October 23, 2019, was rejected on its merits by the Board of Directors on November 25, 2019

**WARNING**

Subject to certain exceptions, you have only six (6) months from the date this notice was personally delivered or deposited in the mail to file a court action on this claim. See Government Code Section 945.6. You may seek the advice of an attorney of your choice in connection with this matter. If you desire to consult an attorney, you should do so immediately.

Sincerely,

Nevin House  
Secretary/Treasurer, Board of Directors

cc: Richard Salinas, Attorney at Law



**American College of Surgeons  
National Surgical Quality Improvement Program**

Dr. Mack – Surgeon Champion

Kassie Waters BSN MPA CPHQ– Quality Improvement Manager

Shaye Garrett – Data Analyst



AMERICAN COLLEGE OF SURGEONS

*Inspiring Quality:  
Highest Standards, Better Outcomes*

100+years

# PROGRAM OVERVIEW

- ACS NSQIP is a data-driven, risk-adjusted, outcomes-based program to measure and improve the quality of surgical care.
- Benefits of participation include:
  - Identifying quality improvement targets
  - Improving patient care and outcomes
  - Decreasing institutional healthcare costs

# NSQIP Semiannual Report Post Surgical Complications

04/01/2018 - 03/31/2019

ACS NSQIP Interim Semiannual Report: Site Summary

Kaweah Delta District Hospital

Site Number: 2258

## All Cases

|                                | Total Cases | Observed |       | Pred Obs Rate** | Expected Rate | Odds Ratio | 95% C.I. |       | Outlier | Decile | Adjusted Percentile | Adjusted Quartile | Assessment*       |
|--------------------------------|-------------|----------|-------|-----------------|---------------|------------|----------|-------|---------|--------|---------------------|-------------------|-------------------|
|                                |             | Events   | Rate  |                 |               |            | Lower    | Upper |         |        |                     |                   |                   |
| ALLCASES Mortality             | 1400        | 11       | 0.79% | 0.75%           | 0.72%         | 1.04       | 0.69     | 1.55  |         | 7      | 55                  | 3                 | As Expected       |
| ALLCASES Morbidity             | 1400        | 52       | 3.71% | 3.79%           | 4.20%         | 0.89       | 0.69     | 1.16  |         | 4      | 36                  | 2                 | As Expected       |
| ALLCASES Cardiac               | 1400        | 8        | 0.57% | 0.51%           | 0.42%         | 1.22       | 0.68     | 2.18  |         | 8      | 63                  | 3                 | As Expected       |
| ALLCASES Pneumonia             | 1398        | 2        | 0.14% | 0.31%           | 0.53%         | 0.58       | 0.30     | 1.13  |         | 1      | 17                  | 1                 | Exemplary         |
| ALLCASES Unplanned Intubation  | 1399        | 6        | 0.43% | 0.39%           | 0.36%         | 1.08       | 0.63     | 1.85  |         | 7      | 56                  | 3                 | As Expected       |
| ALLCASES Ventilator > 48 Hours | 1399        | 7        | 0.50% | 0.49%           | 0.46%         | 1.05       | 0.57     | 1.97  |         | 6      | 52                  | 3                 | As Expected       |
| ALLCASES VTE                   | 1400        | 5        | 0.36% | 0.47%           | 0.53%         | 0.89       | 0.57     | 1.38  |         | 3      | 37                  | 2                 | As Expected       |
| ALLCASES Renal Failure         | 1400        | 9        | 0.64% | 0.44%           | 0.29%         | 1.55       | 0.88     | 2.72  |         | 10     | 81                  | 4                 | Needs Improvement |
| ALLCASES UTI                   | 1399        | 7        | 0.50% | 0.62%           | 0.93%         | 0.67       | 0.39     | 1.16  |         | 2      | 23                  | 1                 | Exemplary         |
| ALLCASES SSI                   | 1395        | 20       | 1.43% | 1.45%           | 1.49%         | 0.97       | 0.66     | 1.43  |         | 5      | 46                  | 2                 | As Expected       |
| ALLCASES Sepsis                | 1370        | 7        | 0.51% | 0.51%           | 0.50%         | 1.01       | 0.57     | 1.81  |         | 6      | 50                  | 2                 | As Expected       |
| ALLCASES C.diff Colitis        | 1400        | 3        | 0.21% | 0.21%           | 0.21%         | 1.01       | 0.52     | 1.98  |         | 6      | 50                  | 2                 | As Expected       |
| ALLCASES ROR                   | 1400        | 27       | 1.93% | 1.76%           | 1.54%         | 1.15       | 0.84     | 1.57  |         | 8      | 68                  | 3                 | As Expected       |
| ALLCASES Readmission           | 1400        | 50       | 3.57% | 3.65%           | 3.90%         | 0.96       | 0.76     | 1.20  |         | 4      | 42                  | 2                 | As Expected       |

# NSQIP Semiannual Report Summary

## **Analysis:**

- Pneumonia and Urinary Tract Infection complications are low and performance was noted as “Exemplary”
- Renal Failure complications were higher than expected and performance was noted as “Needs Improvement”
- All other quality metrics were “As Expected”

## **Actions/Next Steps:**

- Urology reviewed all renal failure cases at last NSQIP committee and noted no correlations. Recommendation is to involve urology earlier in cases.

# Kaweah Medical Center

## Enhanced Recovery After Surgery

### Improving Surgical Care & Recovery Program Registry



AMERICAN COLLEGE OF SURGEONS  
*Inspiring Quality: Highest Standards, Better Outcomes*

#### Comprehensive Program

**Goal:** Improving perioperative care that includes the principles of enhance recovery but also incorporates best practices to reduce:

- SSI
- VTE
- UTI
- Opioid use
- LOS

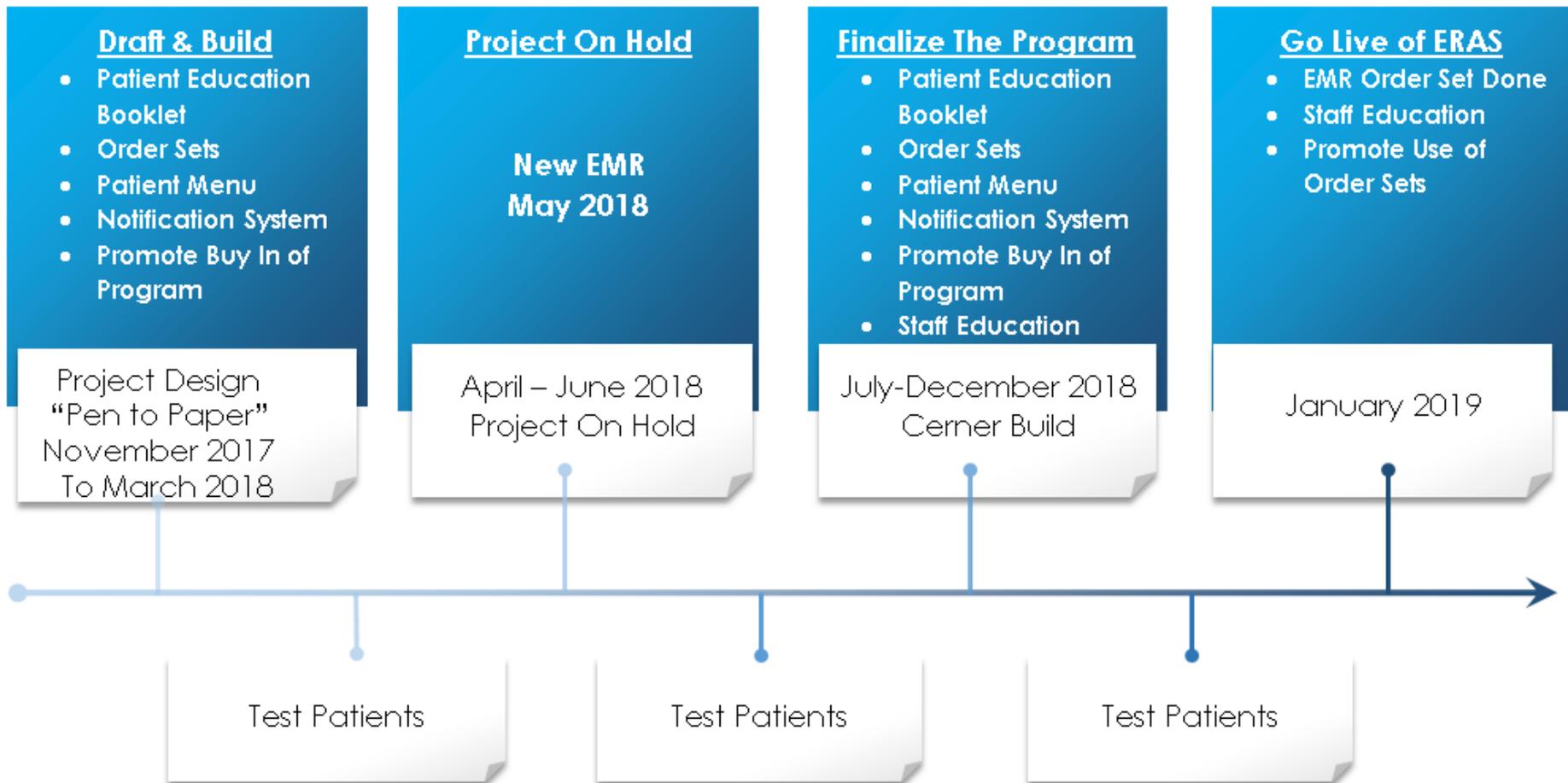
#### Team Members – ERAS Colorectal Program

- (1) ISCR project lead
- (2) Surgeon champion
- (3) Anesthesia champion
- (5) Senior executive
- (6) Unit champions  
3 North – Med/Surgical  
ACS/PACU  
Surgery  
Dietary

- (7) Pharmacist
- (8) Health information  
technology (IT) specialist

Kassie Waters, Quality Manager  
Dr. Mack & Dr. Potts  
Dr. Tang  
Regina Sawyer, CNO  
Brian Pearcey, Director of  
Surgical Services Kari Knudsen,  
Director of Post-Surgical  
Services, Andrea Hodgkins,  
Nurse Manager, Leticia Quinn,  
Nurse Manager, Amanda  
Tercero, Nurse Manager, Kris  
Daugherty, Nutrition Manager,  
Ryann Jung, Registered Dietitian  
Blake Bartlett, Pharmacist-IT, &  
Kelly Mendoza, Pharmacist  
Kurtis Stutsman, Clinical  
Content, IT

# Colorectal ERAS Project Timeline



# Johns Hopkins Site Visit October 8, 2019

## Enhanced Recovery After Surgery



AMERICAN COLLEGE OF SURGEONS  
*Inspiring Quality: Highest Standards, Better Outcomes*

Four Johns Hopkins representatives met with individual team members all day and reviewed:

- Current state of program
- Implementation successes and barriers
- Best practices seen at other hospitals

### **Findings:**

- Excellent teamwork and alignment
- High level of support of the program
- Timeline of implementation on track with other hospitals
- Great program outcomes

### **Suggested Next Steps:**

- Implement ERAS or program components into all surgical areas

## Enhanced Recovery after Surgery Dashboard January – August 2019 (Total 37 Elective Cases)

### Process Measures Done In 24 Hours Postop

Multi-modal Pain Management

35/37=94%

ISCR Group Performance=80%

Postop VTE Prophylaxis

26/37=70%

ISCR Group Performance=86%

Postop Intake Liquids

32/37=86%

ISCR Group Performance=80%

Postop Mobilization

28/37=75%

ISCR Group Performance=67%

Foley Removal

31/37=83%

ISCR Group Performance=95%

### Outcome Measures

UTI Postop 30 Days

0/37=0%

2018 Baseline=0%

ISCR Group Performance=1.87%

SSI Postop 30 Days

1/37=2.7%

2018 Baseline=10.53%

ISCR Group Performance=8.45%

VTE Postop 30 Days

0/37=0%

2018 Baseline=2.56%

ISCR Group Performance= 1.5%

Readmission Postop 30 Days

1/37=2.7%

2018 Baseline=15.38%

ISCR Group Performance=9.88

Average LOS

4.11

ISCR Group Performance= 6.23

Return of Bowel Function (days)

1.72

ISCR Group Performance =2.04

Key: Green=>80% Yellow=70-80% Red=<70%. Improving Surgical Care & Recovery (ISCR)Group Performance=NSQIP participating hospitals (elective cases)

# Enhanced Recovery After Surgery Dashboard

## Analysis:

- Postop VTE prophylaxis has the lowest compliance rate. Reasons for non-compliance include: patient refusal, held for procedure, ordered late, not ordered, and ordered but given on POD 2.
- Postop Mobilization was the second to the lowest compliance rate. Noted these patients were mobilized late in the afternoon on POD 1, but not within 24 hours of surgery stop time.
- All outcome measures are performing well compared to baseline and ISCR Group Performance.

## Actions/Next Steps:

- Postop VTE prophylaxis - Establish concurrent case reviews with providers when opportunities for improvement are identified. Also, meet with pharmacy and review cases when lovenox is canceled and if contraindications were noted.
- Postop Mobilization – Most fallouts were due to ambulating late in the evening on POD 1. Provide staff education and feedback.

# ERAS Projects

## **NSQIP Committee Oversight of ERAS Teams (meet quarterly)**

- Enhanced Recovery After Surgery Workgroup Teams (meet monthly)
  - Elective Colorectal – Project completed - Continue to monitor
  - In-Patient Colorectal – New team  
Team Lead: Surgical Resident project
  - Orthopedic – New Team  
Team Lead: Megan Goddard, Nurse Practitioner
  - GYN – New Team  
Team Lead: Dr. Sabogal



# Kaweah Delta Health Care District Cleveland Clinic Affiliation Report to the Board of Directors

## Executive Summary

November 25, 2019

**Barry Royce, MHA, RN 624-4919**  
**Regina Sawyer, DNP, RN 624-2836**

### Strategic Session:

- We completed our Strategic Planning Session on June 1<sup>st</sup>. We have finalized review of the Draft and have sent this back for the final version to be created.

### Quality:

- Cleveland Clinic (CC) reviews our data, which we submit to a National Data Base and compares it to their data and like CC Affiliates. This data can then be used to identify trends and areas for improvement.
- They additionally have meetings quarterly with Cardiovascular Operating Room (CVOR) and Cath Lab Medical Staff to discuss outcomes, data, and opportunities for improvement. To date we have had 2 meetings with the surgical group and one with the Cardiology group.
- At this time there is also review with physician leadership of items that are on the strategic plan to evaluate progress of monthly meetings.

### Program Development Initiatives:

- We requested staffing analysis, efficiency analysis, and financial review analysis. The financial analysis is still pending scheduling, but:
  - Cath Lab site review was completed in October
  - CVOR review will be completed on November 13<sup>th</sup>
  - Electro-physiology will be completed in January 2020

After these are completed we will look into the financial review to see if we are billing for everything we can.

- CC has been assisting us further with our desire to have a Same Day Discharge of patients who receive a Stent, Pacemaker, or Internal Cardiac Defibrillator (ICD). This has helped decrease our utilization of hospital beds for these patients and increased our capacity for other patients. This process went live on August 1<sup>st</sup>. Prior to go-live we had discharged 7 such patients in the previous 12 months.
  - We have had 25 patients discharged in the past 3 months since go-live. We have additional work to do, but feel we can get can likely double this number with additional focus. Each of these patients we discharge frees up a patient bed at a savings of (\$30/hour for Observation) and adds the potential opportunity to admit another patient or not hold that patient in the Emergency Department. These patients do not qualify for

Observation Status and as such there is no additional billing, beyond their procedure we can do. These patients occupy a bed for 16 – 20 hours.

- They have been assisting with establishing and implementing a process for us to change to Same Day Admit for our Cardiac Surgery cases. This will immediately decrease our Length of Stay (LOS) for these cases by (1) day. This process was set to go live in mid-October.
  - Process on hold until Dr. Carrizo arrives
- We have redesigned our Block Schedule to improve our inpatient Cath Lab access. This process has decreased our weekend call back and Length of Stay (LOS) of our Acute Myocardial Infarction (AMI) patients.
  - Our LOS has decreased by (0.66) days, since go-live, in the most recent quarter as compared to the previous 6 quarters. Annual admission volumes for this type of patient is 1200. This gives us a potential of 792 patients bed days, at a cost of \$4,340/day (per Finance for AMI patients).
  - Our call back, for Cath Lab staff has also decreased by (89) hours per pay period, at a rate of (\$67.5/hr.), for a savings of (\$6,007/pay period).
- New documentation tool has been implemented to improve documentation of device insertion criteria. This will help with compliance.
  - We have additional progress to be made, but we have improved from 19% to 52%
- Working on Cath Lab turn over time. There are three aspects to this: 1) End of procedure to time patient leaves the room; 2) Time once patient has left the room, to the time the room is cleaned and a new patient enters the room (Wheels out to Wheels in); 3) Time from patient entering the room until patient is ready for procedure to begin. The first component that staff will be working on is prep time of the patient once they have entered the room.

#### **Financials:**

- Completed contracts with vendors has potential expected savings of \$1.25 – \$1.5 million. Range is based upon the compliance we can achieve with Cardiologists.
  - Since implementation of renegotiated contract we have realized a savings of \$231,046 in FY20 Q1 – for annualized savings of \$924,184 annually
- Block Schedule Savings
  - LOS - \$4,340/day for 792 days - \$3,437,280 annually
  - Decreased Call Back hours - \$6,007/pay period or \$156,195 annually
- Same Day Discharge
- Currently at 25 patients/quarter at a savings of \$30/hour for an average of 18 hours is a saving of \$13,500/quarter – or \$54,000/year, with a potential to double this amount.

#### **Marketing:**

- Outcome booklet revisions are completed. Cleveland Clinic will be out in January to present this to the community Primary Care Providers (PCP) along with a Grand Rounds educational session with Dr. Soltesz.

#### **Second Opinions:**

- We continue to have access to second opinions from CC. Utilization of this varies.



Zone III Resignation  
December 31, 2019

NEXT  
STEPS



Decision by KDHC  
Board - next steps

# APPOINTMENT

- Appointment by KDHC Board within 60 days of the effective date of the vacancy **SATURDAY - FEBRUARY 29, 2020**
- Notice of the vacancy shall be posted in 3 or more conspicuous places in the district at least 15 days before the appointment is made.

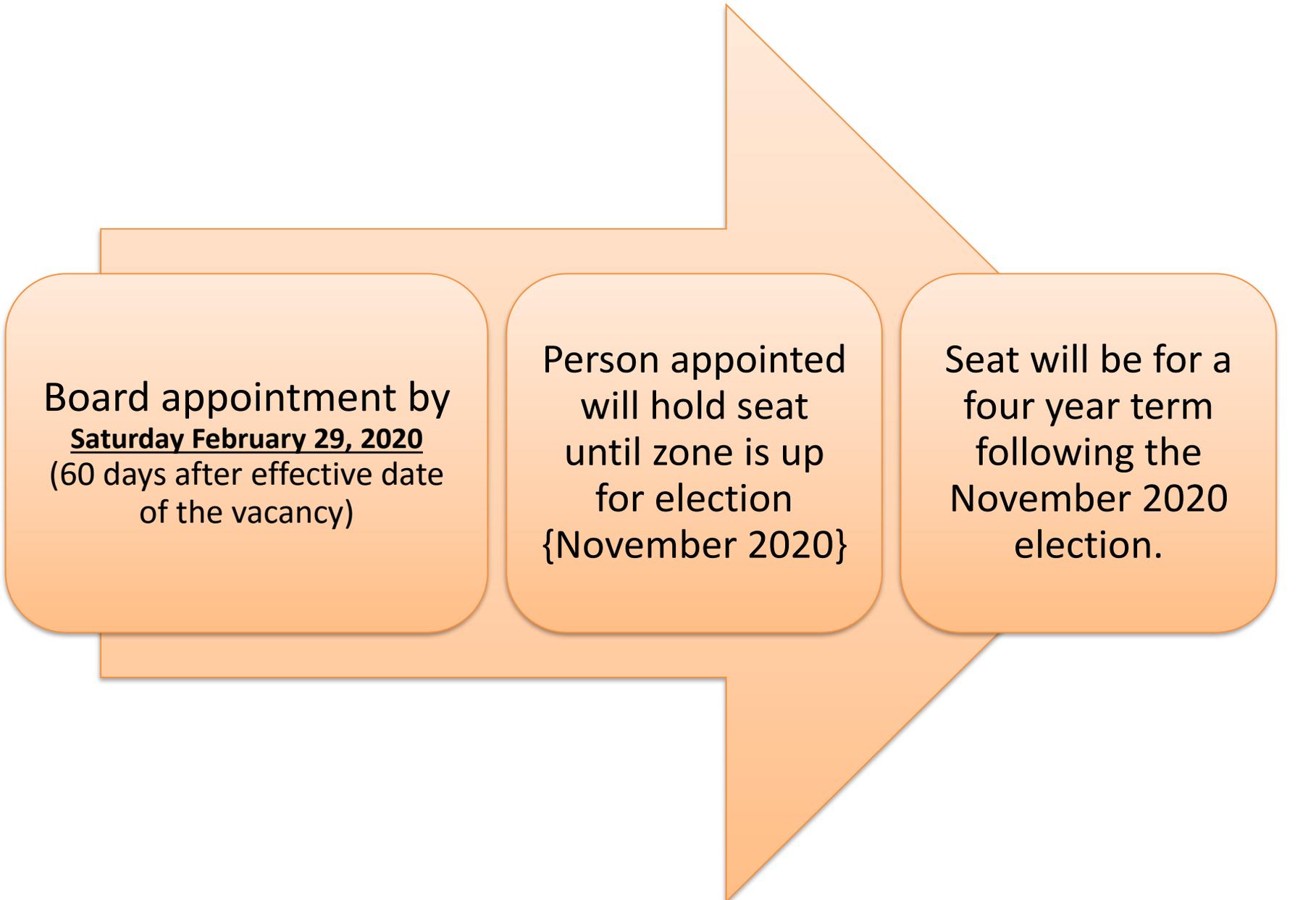
## Call an Election

- Call an election within 60 days of vacancy. {February 29, 2020}
- Election shall be held on the next established election date that is scheduled 130 or more days after the date the Board calls the election.

# CALL AN ELECTION

Election shall be held on the next established election date that is scheduled 130 or more days after the date the Board calls the election.

| Date election is called<br>{within 60 days of vacancy}   | Next election 130+ days after the<br>date the Board calls the election |
|--|--|
| 130 days or more after the date the district<br>board calls the election<br><b>Vacancy Date {12/31/19}</b> | November 3, 2020   |



Board appointment by  
Saturday February 29, 2020  
(60 days after effective date  
of the vacancy)

Person appointed  
will hold seat  
until zone is up  
for election  
{November 2020}

Seat will be for a  
four year term  
following the  
November 2020  
election.

If the vacancy is not filled or an election called by the KDHCD Board within 60 days:

- The Board of Supervisors may appoint a person to fill the vacancy within 90 days of the vacancy. {March 30, 2020}
- The Board of Supervisors may order the District to call an election to fill the vacancy.

M O R E T H A N M E D I C I N E . L I F E .

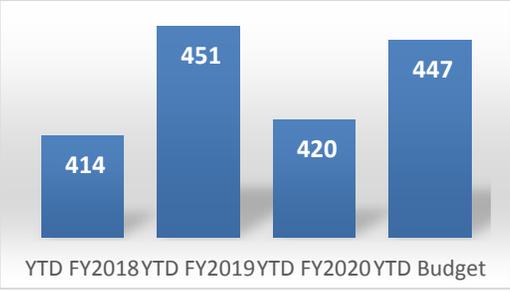
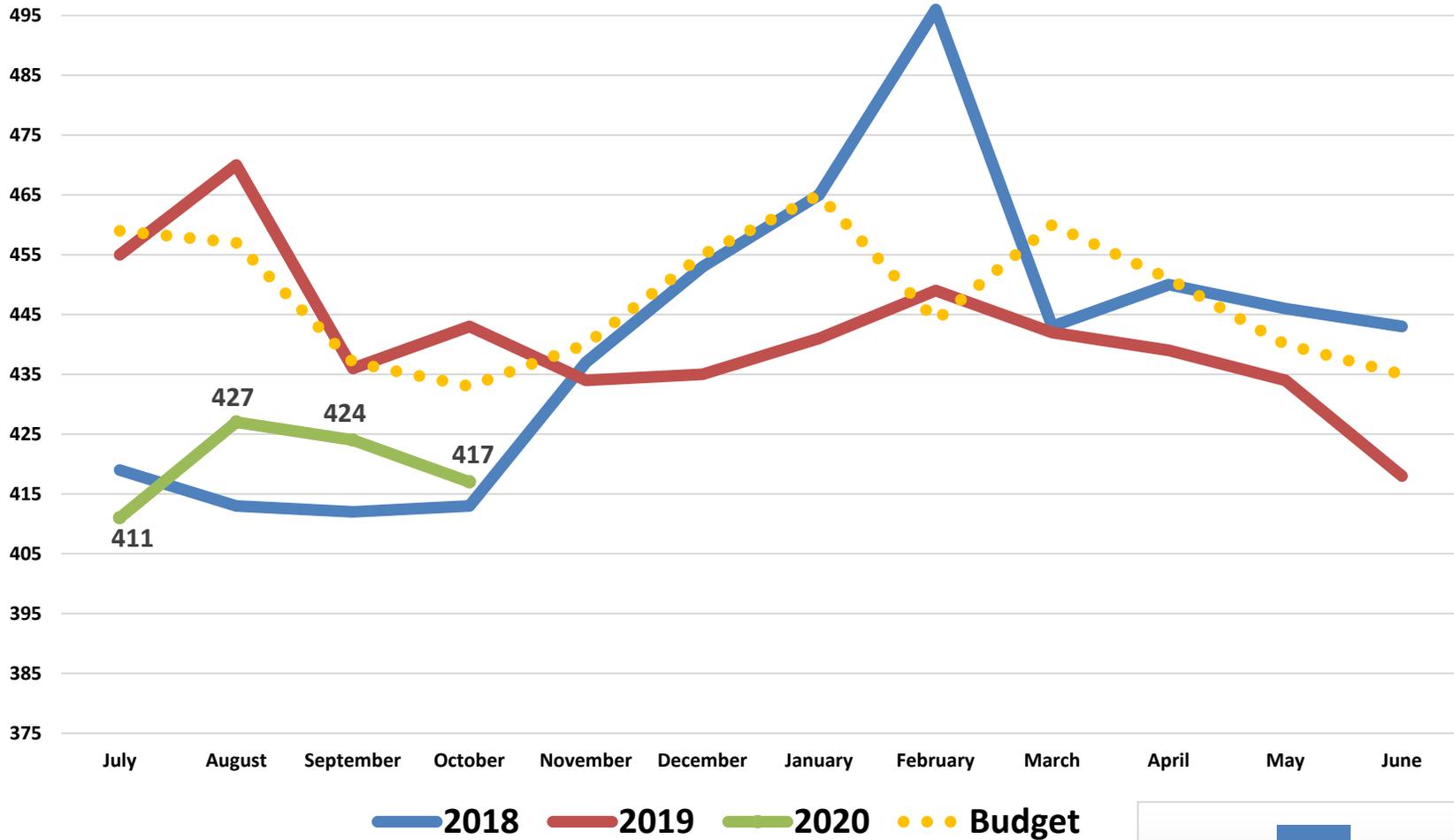
# CFO Financial Report

November 21, 2019

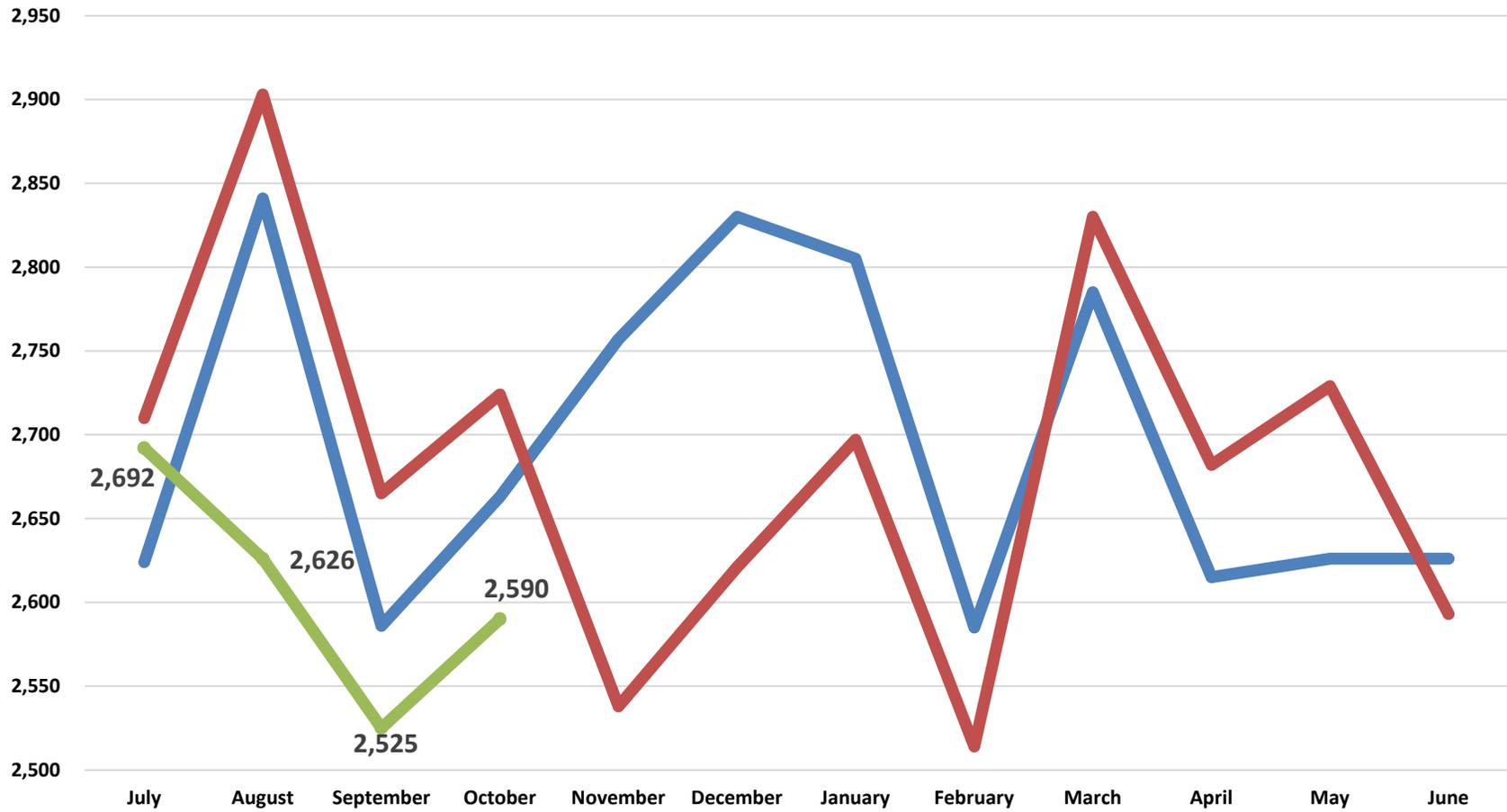


Kaweah Delta  
HEALTH CARE DISTRICT

# Average Daily Census



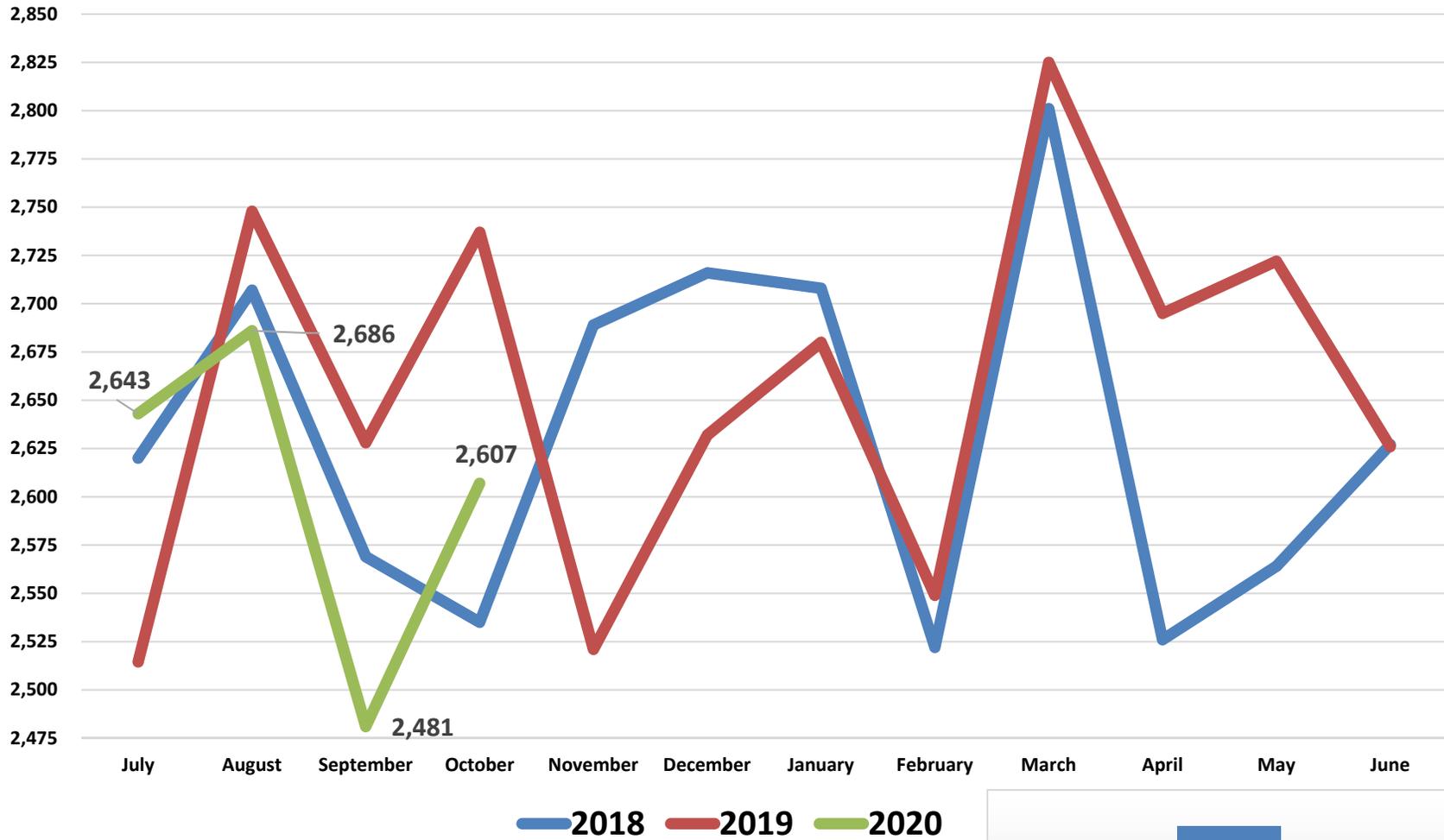
# Admissions



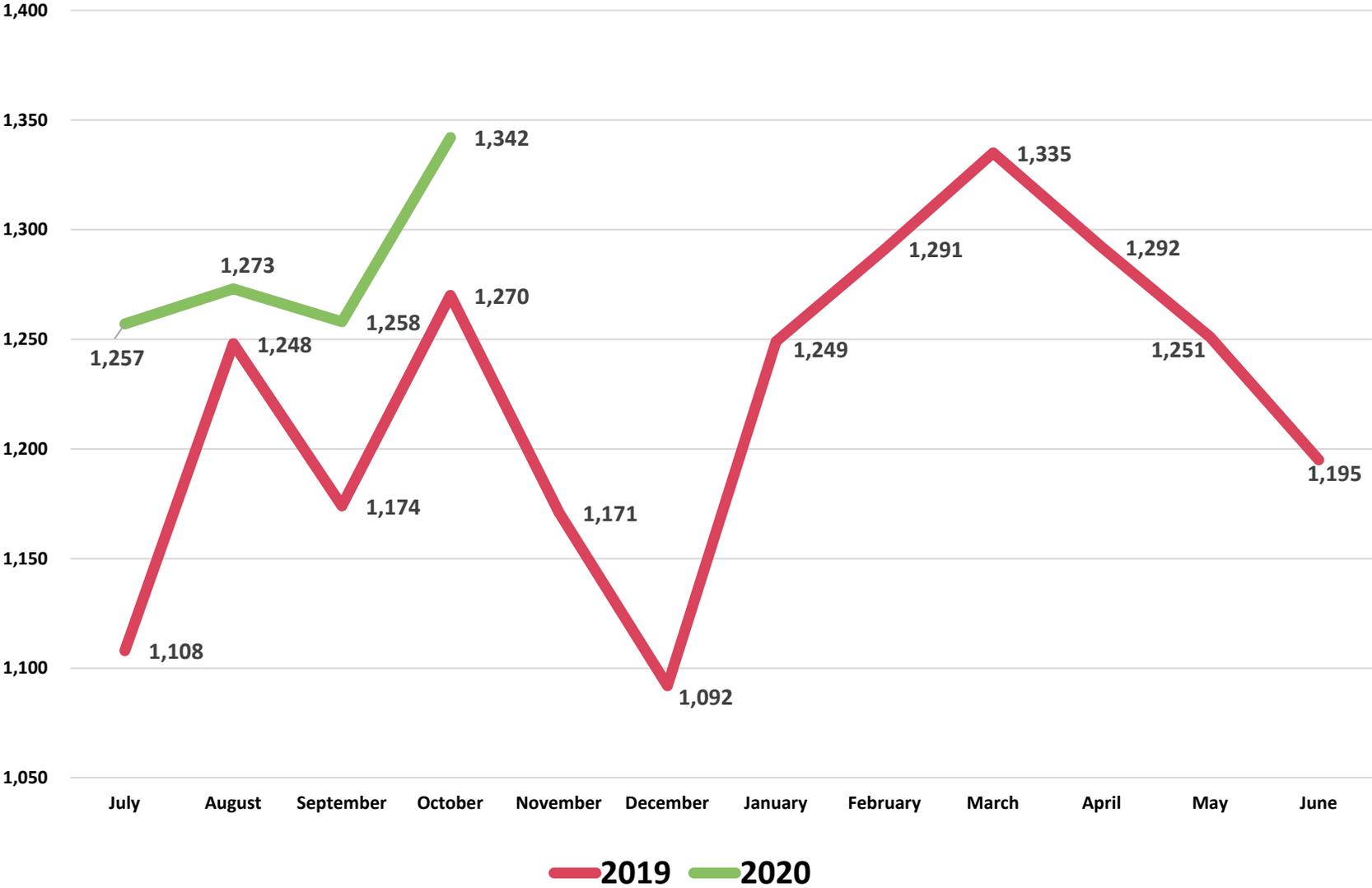
— 2018 — 2019 — 2020



# Discharges



# Outpatient Registrations per Day



## Statistical Results – Fiscal Year Comparison (October)

|                                 | Actual Results |               |               | Budget        | Budget Variance |               |
|---------------------------------|----------------|---------------|---------------|---------------|-----------------|---------------|
|                                 | Oct 2018       | Oct 2019      | % Change      | Oct 2019      | Change          | % Change      |
| <b>Average Daily Census</b>     | <b>443</b>     | <b>417</b>    | <b>(6.0%)</b> | <b>433</b>    | <b>(16)</b>     | <b>(3.8%)</b> |
| <b>KDHCD Patient Days:</b>      |                |               |               |               |                 |               |
| Medical Center                  | 8,864          | 8,080         | (8.8%)        | 8,356         | (276)           | (3.3%)        |
| Acute I/P Psych                 | 1,522          | 1,445         | (5.1%)        | 1,478         | (33)            | (2.2%)        |
| Sub-Acute                       | 941            | 912           | (3.1%)        | 955           | (43)            | (4.5%)        |
| Rehab                           | 549            | 550           | 0.2%          | 638           | (88)            | (13.8%)       |
| TCS-Ortho                       | 374            | 447           | 19.5%         | 402           | 45              | 11.2%         |
| TCS                             | 424            | 578           | 36.3%         | 525           | 53              | 10.1%         |
| NICU                            | 497            | 393           | (20.9%)       | 457           | (64)            | (14.0%)       |
| Nursery                         | 573            | 519           | (9.4%)        | 619           | (100)           | (16.2%)       |
| <b>Total KDHCD Patient Days</b> | <b>13,744</b>  | <b>12,924</b> | <b>(6.0%)</b> | <b>13,430</b> | <b>(506)</b>    | <b>(3.8%)</b> |
| <b>Total Outpatient Volume</b>  | <b>39,370</b>  | <b>41,602</b> | <b>5.7%</b>   | <b>41,772</b> | <b>(170)</b>    | <b>(0.4%)</b> |

# Statistical Results – Fiscal Year Comparison (Jul-Oct)

| Actual Results |           |          | Budget    | Budget Variance |          |
|----------------|-----------|----------|-----------|-----------------|----------|
| FYTD 2019      | FYTD 2020 | % Change | FYTD 2020 | Change          | % Change |

|                             |            |            |               |            |             |               |
|-----------------------------|------------|------------|---------------|------------|-------------|---------------|
| <b>Average Daily Census</b> | <b>451</b> | <b>420</b> | <b>(6.9%)</b> | <b>447</b> | <b>(27)</b> | <b>(6.1%)</b> |
|-----------------------------|------------|------------|---------------|------------|-------------|---------------|

**KDHCD Patient Days:**

|                 |        |        |         |        |         |         |
|-----------------|--------|--------|---------|--------|---------|---------|
| Medical Center  | 35,567 | 32,529 | (8.5%)  | 34,835 | (2,306) | (6.6%)  |
| Acute I/P Psych | 5,897  | 5,752  | (2.5%)  | 5,864  | (112)   | (1.9%)  |
| Sub-Acute       | 3,788  | 3,646  | (3.7%)  | 3,795  | (149)   | (3.9%)  |
| Rehab           | 2,396  | 2,071  | (13.6%) | 2,489  | (418)   | (16.8%) |
| TCS-Ortho       | 1,443  | 1,755  | 21.6%   | 1,603  | 152     | 9.5%    |
| TCS             | 1,853  | 1,889  | 1.9%    | 2,080  | (191)   | (9.2%)  |
| NICU            | 2,113  | 1,777  | (15.9%) | 1,824  | (47)    | (2.6%)  |
| Nursery         | 2,404  | 2,201  | (8.4%)  | 2,459  | (258)   | (10.5%) |

|                                 |               |               |               |               |                |               |
|---------------------------------|---------------|---------------|---------------|---------------|----------------|---------------|
| <b>Total KDHCD Patient Days</b> | <b>55,461</b> | <b>51,620</b> | <b>(6.9%)</b> | <b>54,949</b> | <b>(3,329)</b> | <b>(6.1%)</b> |
|---------------------------------|---------------|---------------|---------------|---------------|----------------|---------------|

|                                |                |                |             |                |              |             |
|--------------------------------|----------------|----------------|-------------|----------------|--------------|-------------|
| <b>Total Outpatient Volume</b> | <b>147,626</b> | <b>157,772</b> | <b>6.9%</b> | <b>156,631</b> | <b>1,141</b> | <b>0.7%</b> |
|--------------------------------|----------------|----------------|-------------|----------------|--------------|-------------|

# Other Statistical Results – Fiscal Year Comparison (October)

|   | Actual Results |               |              |             | Budget        | Budget Variance |               |
|---|----------------|---------------|--------------|-------------|---------------|-----------------|---------------|
|   | Oct 2018       | Oct 2019      | Change       | % Change    | Oct 2019      | Change          | % Change      |
| <b>Adjusted Patient Days</b>                    | <b>25,579</b>  | <b>26,070</b> | <b>491</b>   | <b>1.9%</b> | <b>26,311</b> | <b>(241)</b>    | <b>(0.9%)</b> |
| <b>Outpatient Visits</b>                        | <b>39,370</b>  | <b>41,602</b> | <b>2,232</b> | <b>5.7%</b> | <b>41,772</b> | <b>(170)</b>    | <b>(0.4%)</b> |
| Urgent Care - Demaree                           | 1,422          | 1,951         | 529          | 37.2%       | 1,744         | 207             | 10.6%         |
| Endoscopy Procedures (I/P & O/P)                | 544            | 722           | 178          | 32.7%       | 544           | 178             | 24.7%         |
| Home Health Visits                              | 2,548          | 2,900         | 352          | 13.8%       | 2,850         | 50              | 1.7%          |
| KDMF RVU  | 34,543         | 38,227        | 3,684        | 10.7%       | 37,008        | 1,219           | 3.2%          |
| Hospice Days                                    | 3,247          | 3,552         | 305          | 9.4%        | 3,328         | 224             | 6.3%          |
| Physical & Other Therapy Units                  | 17,537         | 18,557        | 1,020        | 5.8%        | 18,106        | 451             | 2.4%          |
| Radiation Oncology Treatments (I/P & O/P)       | 2,202          | 2,319         | 117          | 5.3%        | 2,035         | 284             | 12.2%         |
| Cath Lab Minutes (IP & OP)                      | 377            | 397           | 20           | 5.3%        | 394           | 3               | 0.8%          |
| ED Visit  | 6,776          | 7,117         | 341          | 5.0%        | 7,793         | (676)           | (9.5%)        |
| GME Clinic visits                               | 1,094          | 1,140         | 46           | 4.2%        | 1,240         | (100)           | (8.8%)        |
| Dialysis Treatments                             | 1,918          | 1,900         | (18)         | (0.9%)      | 1,809         | 91              | 4.8%          |
| Radiology/CT/US/MRI Proc (I/P & O/P)            | 15,690         | 15,451        | (239)        | (1.5%)      | 15,343        | 108             | 0.7%          |
| O/P Rehab Units                                 | 21,167         | 20,830        | (337)        | (1.6%)      | 22,868        | (2,038)         | (9.8%)        |
| Home Infusion Days                              | 11,853         | 11,633        | (220)        | (1.9%)      | 11,939        | (306)           | (2.6%)        |
| Surgery Minutes – General & Robotic (I/P & O/P) | 1,205          | 1,110         | (95)         | (7.9%)      | 1,253         | (143)           | (12.9%)       |
| OB Deliveries                                   | 431            | 385           | (46)         | (10.7%)     | 424           | (39)            | (10.1%)       |
| Urgent Care - Court                             | 4,096          | 3,529         | (567)        | (13.8%)     | 4,329         | (800)           | (22.7%)       |

# Other Statistical Results – Fiscal Year Comparison (Jul-Oct)

|   | Actual Results |                |                |               | Budget         | Budget Variance |               |
|---|----------------|----------------|----------------|---------------|----------------|-----------------|---------------|
|   | FY 2019        | FY 2020        | Change         | % Change      | FY 2020        | Change          | % Change      |
| <b>Adjusted Patient Days</b>                    | <b>104,254</b> | <b>103,166</b> | <b>(1,088)</b> | <b>(1.0%)</b> | <b>106,239</b> | <b>(3,073)</b>  | <b>(2.9%)</b> |
| <b>Outpatient Visits</b>                        | <b>147,626</b> | <b>157,772</b> | <b>10,146</b>  | <b>6.9%</b>   | <b>156,631</b> | <b>141</b>      | <b>0.7%</b>   |
| Urgent Care - Demaree                           | 3,384          | 7,150          | 3,766          | 111.3%        | 6,283          | 867             | 13.8%         |
| Cath Lab Minutes (IP & OP)                      | 1,082          | 1,493          | 411            | 38.0%         | 1,571          | (78)            | (5.0%)        |
| Endoscopy Procedures (I/P & O/P)                | 1,996          | 2,468          | 472            | 23.6%         | 1,996          | 472             | 23.6%         |
| Home Health Visits                              | 9,704          | 11,582         | 1,878          | 19.4%         | 10,441         | 1,141           | 10.9%         |
| KDMF RVU  | 117,025        | 132,588        | 15,563         | 13.3%         | 131,613        | 975             | 0.7%          |
| Radiation Oncology Treatments (I/P & O/P)       | 7,883          | 8,645          | 762            | 9.7%          | 8,140          | 505             | 6.2%          |
| Hospice Days                                    | 12,991         | 13,783         | 792            | 6.1%          | 13,315         | 468             | 3.5%          |
| GME Clinic visits                               | 4,069          | 4,267          | 198            | 4.9%          | 4,920          | (653)           | (13.3%)       |
| Surgery Minutes – General & Robotic (I/P & O/P) | 4,100          | 4,224          | 124            | 3.0%          | 4,759          | (535)           | (11.2%)       |
| Radiology/CT/US/MRI Proc (I/P & O/P)            | 60,071         | 61,575         | 1,504          | 2.5%          | 61,368         | 207             | 0.3%          |
| Physical & Other Therapy Units                  | 71,155         | 72,633         | 1,478          | 2.1%          | 73,758         | (1,125)         | (1.5%)        |
| ED Visit  | 29,090         | 29,610         | 520            | 1.8%          | 30,079         | (469)           | (1.6%)        |
| Dialysis Treatments                             | 7,658          | 7,745          | 87             | 1.1%          | 7,223          | 522             | 7.2%          |
| O/P Rehab Units                                 | 79,774         | 79,937         | 163            | 0.2%          | 85,124         | (5,187)         | (6.1%)        |
| Home Infusion Days                              | 46,052         | 43,897         | (2,155)        | (4.7%)        | 45,161         | (1,264)         | (2.8%)        |
| OB Deliveries                                   | 1,733          | 1,604          | (129)          | (7.4%)        | 1,696          | (92)            | (5.4%)        |
| Urgent Care - Court                             | 16,864         | 13,629         | (3,235)        | (19.2%)       | 15,850         | (2,221)         | (14.0%)       |

# October Financial Comparison (000's)

|                                  | Actual Results   |                |                | Budget         | Budget Variance  |                 | Explanation          |
|----------------------------------|------------------|----------------|----------------|----------------|------------------|-----------------|----------------------|
|                                  | Oct 2018         | Oct 2019       | % Change       | Oct 2019       | Change           | % Change        |                      |
| <b>Operating Revenue</b>         |                  |                |                |                |                  |                 |                      |
| Net Patient Service Revenue      | 48,768           | 52,165         | 7.0%           | 52,395         | (\$230)          | (0.4%)          |                      |
| Supplemental Gov't Programs      | 3,470            | 4,185          | 20.6%          | 4,319          | (134)            | (3.1%)          |                      |
| Prime Program                    | 997              | 905            | (9.2%)         | 905            | 0                | 0.0%            |                      |
| Premium Revenue                  | 2,899            | 3,649          | 25.9%          | 3,498          | 151              | 4.3%            |                      |
| Management Services Revenue      | 2,802            | 3,014          | 7.6%           | 2,818          | 196              | 7.0%            |                      |
| Other Revenue                    | 1,476            | 2,142          | 45.1%          | 1,831          | 311              | 17.0%           | See highlights slide |
| Other Operating Revenue          | 11,644           | 13,896         | 19.3%          | 13,372         | 524              | 3.9%            |                      |
| <b>Total Operating Revenue</b>   | <b>60,413</b>    | <b>66,061</b>  | <b>9.3%</b>    | <b>65,767</b>  | <b>294</b>       | <b>0.4%</b>     |                      |
| <b>Operating Expenses</b>        |                  |                |                |                |                  |                 |                      |
| Salaries & Wages                 | 24,578           | 25,747         | 4.8%           | 25,657         | 90               | 0.3%            |                      |
| Contract Labor                   | 1,580            | 1,044          | (33.9%)        | 303            | 741              | 244.8%          |                      |
| Employee Benefits                | 6,691            | 6,755          | 1.0%           | 6,172          | 583              | 9.5%            |                      |
| <b>Total Employment Expenses</b> | <b>32,849</b>    | <b>33,546</b>  | <b>2.1%</b>    | <b>32,132</b>  | <b>1,415</b>     | <b>4.4%</b>     |                      |
| Medical & Other Supplies         | 9,867            | 10,551         | 6.9%           | 9,584          | 967              | 10.1%           | See highlights slide |
| Physician Fees                   | 7,145            | 8,287          | 16.0%          | 7,926          | 361              | 4.6%            | See highlights slide |
| Purchased Services               | 2,448            | 3,467          | 41.7%          | 2,891          | 576              | 19.9%           | See highlights slide |
| Repairs & Maintenance            | 2,191            | 2,399          | 9.5%           | 2,242          | 157              | 7.0%            |                      |
| Utilities                        | 567              | 603            | 6.4%           | 508            | 95               | 18.7%           |                      |
| Rents & Leases                   | 424              | 464            | 9.5%           | 531            | (67)             | (12.7%)         |                      |
| Depreciation & Amortization      | 2,574            | 2,488          | (3.3%)         | 2,563          | (75)             | (2.9%)          |                      |
| Interest Expense                 | 463              | 440            | (4.9%)         | 524            | (83)             | (15.9%)         |                      |
| Other Expense                    | 1,574            | 1,609          | 2.2%           | 1,797          | (188)            | (10.5%)         |                      |
| Management Services Expense      | 2,825            | 3,006          | 6.4%           | 2,774          | 233              | 8.4%            |                      |
| <b>Total Operating Expenses</b>  | <b>62,927</b>    | <b>66,862</b>  | <b>6.3%</b>    | <b>63,471</b>  | <b>3,390</b>     | <b>5.3%</b>     |                      |
| <b>Operating Margin</b>          | <b>(\$2,514)</b> | <b>(\$801)</b> | <b>68.2%</b>   | <b>\$2,296</b> | <b>(\$3,097)</b> | <b>(134.9%)</b> |                      |
| Nonoperating Revenue (Loss)      | 345              | 774            | 124.3%         | 670            | 103              | 15.4%           |                      |
| <b>Excess Margin</b>             | <b>(\$2,169)</b> | <b>(\$27)</b>  | <b>(98.8%)</b> | <b>\$2,966</b> | <b>(\$2,994)</b> | <b>(100.9%)</b> |                      |
| <b>Operating Margin %</b>        | <b>(4.2%)</b>    | <b>(1.2%)</b>  |                | <b>3.5%</b>    |                  |                 |                      |
| <b>Excess Margin %</b>           | <b>(3.6%)</b>    | <b>(0.0%)</b>  |                | <b>4.5%</b>    |                  |                 |                      |

# YTD Financial Comparison (000's)

|                                  | Actual Results FYTD Jul-Oct |                |               | Budget FYTD    | Budget Variance FYTD |                |
|----------------------------------|-----------------------------|----------------|---------------|----------------|----------------------|----------------|
|                                  | FYTD2019                    | FYTD2020       | % Change      | FYTD2020       | Change               | % Change       |
| <b>Operating Revenue</b>         |                             |                |               |                |                      |                |
| Net Patient Service Revenue      | 196,650                     | 202,392        | 2.9%          | 204,098        | (\$1,706)            | (0.8%)         |
| Supplemental Gov't Programs      | 13,881                      | 17,009         | 22.5%         | 17,277         | (268)                | (1.5%)         |
| Prime Program                    | 3,988                       | 4,462          | 11.9%         | 3,621          | 841                  | 23.2%          |
| Premium Revenue                  | 12,042                      | 15,306         | 27.1%         | 13,992         | 1,315                | 9.4%           |
| Management Services Revenue      | 10,126                      | 11,160         | 10.2%         | 10,732         | 427                  | 4.0%           |
| Other Revenue                    | 6,095                       | 7,692          | 26.2%         | 7,190          | 502                  | 7.0%           |
| Other Operating Revenue          | 46,133                      | 55,629         | 20.6%         | 52,812         | 2,818                | 5.3%           |
| <b>Total Operating Revenue</b>   | <b>242,783</b>              | <b>258,021</b> | <b>6.3%</b>   | <b>256,910</b> | <b>1,111</b>         | <b>0.4%</b>    |
| <b>Operating Expenses</b>        |                             |                |               |                |                      |                |
| Salaries & Wages                 | 95,513                      | 101,001        | 5.7%          | 101,942        | (941)                | (0.9%)         |
| Contract Labor                   | 5,146                       | 4,143          | (19.5%)       | 1,234          | 2,909                | 235.7%         |
| Employee Benefits                | 23,775                      | 26,239         | 10.4%         | 24,494         | 1,745                | 7.1%           |
| <b>Total Employment Expenses</b> | <b>124,433</b>              | <b>131,384</b> | <b>5.6%</b>   | <b>127,670</b> | <b>3,713</b>         | <b>2.9%</b>    |
| Medical & Other Supplies         | 38,938                      | 37,792         | (2.9%)        | 37,348         | 444                  | 1.2%           |
| Physician Fees                   | 27,637                      | 30,323         | 9.7%          | 31,720         | (1,397)              | (4.4%)         |
| Purchased Services               | 10,922                      | 15,010         | 37.4%         | 11,464         | 3,546                | 30.9%          |
| Repairs & Maintenance            | 8,584                       | 8,465          | (1.4%)        | 8,958          | (492)                | (5.5%)         |
| Utilities                        | 2,260                       | 2,279          | 0.8%          | 2,016          | 263                  | 13.1%          |
| Rents & Leases                   | 2,073                       | 2,053          | (0.9%)        | 2,124          | (71)                 | (3.4%)         |
| Depreciation & Amortization      | 10,018                      | 10,011         | (0.1%)        | 9,899          | 112                  | 1.1%           |
| Interest Expense                 | 1,788                       | 1,771          | (0.9%)        | 2,095          | (324)                | (15.5%)        |
| Other Expense                    | 6,508                       | 6,328          | (2.8%)        | 7,130          | (802)                | (11.3%)        |
| Management Services Expense      | 9,956                       | 10,922         | 9.7%          | 10,562         | 361                  | 3.4%           |
| <b>Total Operating Expenses</b>  | <b>243,116</b>              | <b>256,338</b> | <b>5.4%</b>   | <b>250,986</b> | <b>5,352</b>         | <b>2.1%</b>    |
| <b>Operating Margin</b>          | <b>(\$333)</b>              | <b>\$1,683</b> | <b>605.6%</b> | <b>\$5,924</b> | <b>(\$4,241)</b>     | <b>(71.6%)</b> |
| Nonoperating Revenue (Loss)      | 2,173                       | 6,609          | 204.1%        | 2,663          | 3,946                | 148.2%         |
| <b>Excess Margin</b>             | <b>\$1,840</b>              | <b>\$8,292</b> | <b>350.6%</b> | <b>\$8,587</b> | <b>(\$295)</b>       | <b>(3.4%)</b>  |

|                    |        |      |      |
|--------------------|--------|------|------|
| Operating Margin % | (0.1%) | 0.7% | 2.3% |
| Excess Margin %    | 0.8%   | 3.1% | 3.3% |

# Kaweah Delta Medical Foundation

## Fiscal Year Financial Comparison (000's)

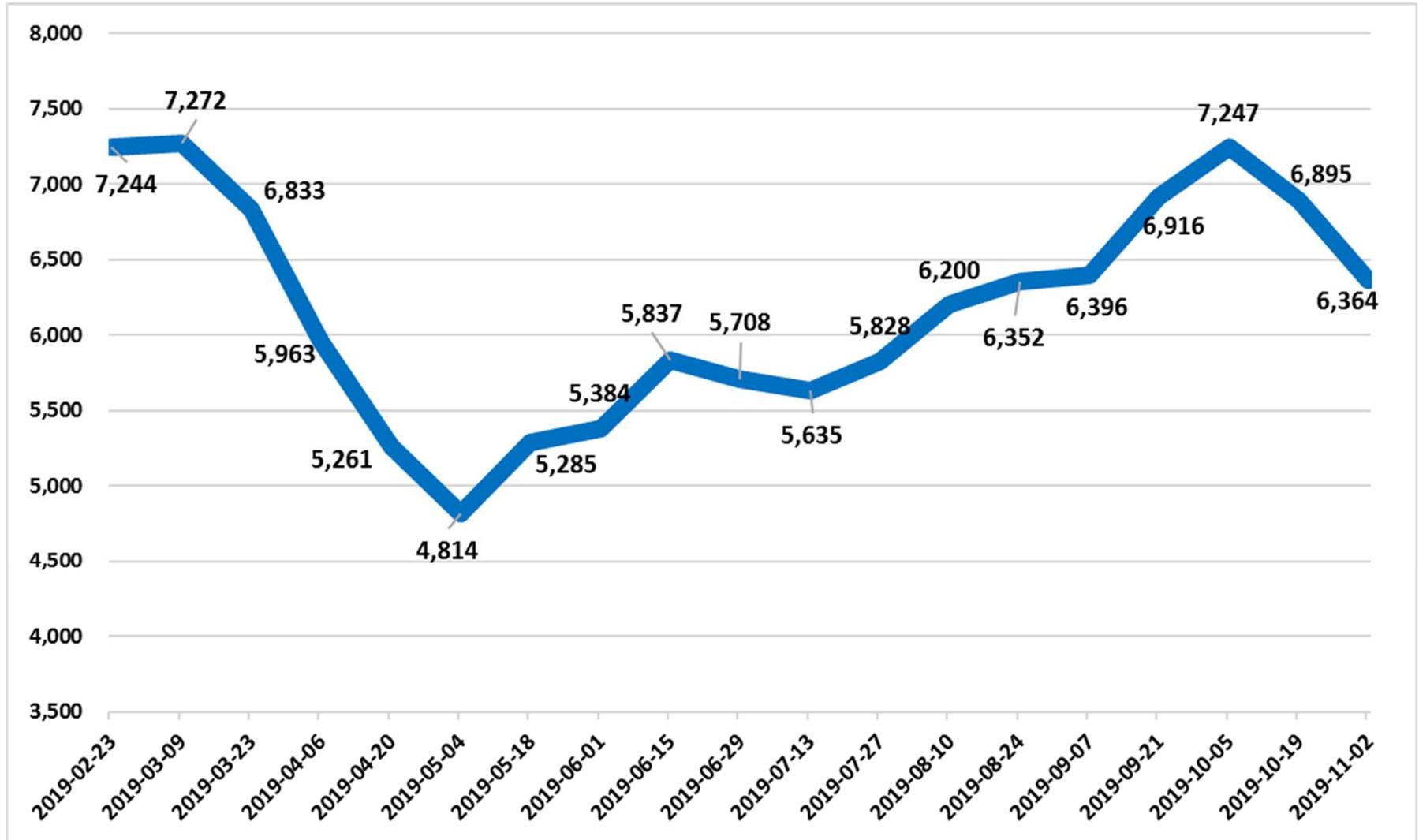
|                                  | Actual Results FYTD October |                  |                | Budget FYTD      | Budget Variance FYTD |               |
|----------------------------------|-----------------------------|------------------|----------------|------------------|----------------------|---------------|
|                                  | Jul - Oct 2018              | Jul - Oct 2019   | % Change       | Jul - Oct 2019   | Change               | % Change      |
| <b>Operating Revenue</b>         |                             |                  |                |                  |                      |               |
| Net Patient Service Revenue      | \$14,265                    | \$15,127         | 6.0%           | \$15,706         | (\$579)              | (3.7%)        |
| Other Operating Revenue          | 116                         | 70               | (39.6%)        | 212              | (142)                | (67.0%)       |
| <b>Total Operating Revenue</b>   | <b>14,381</b>               | <b>15,197</b>    | <b>5.7%</b>    | <b>15,918</b>    | <b>(721)</b>         | <b>(4.5%)</b> |
| <b>Operating Expenses</b>        |                             |                  |                |                  |                      |               |
| Salaries & Wages                 | 3,756                       | 3,869            | 3.0%           | 4,077            | (208)                | (5.1%)        |
| Contract Labor                   | 37                          | 37               | (0.5%)         | 0                | 37                   | 0.0%          |
| Employee Benefits                | 928                         | 1,028            | 10.8%          | 971              | 57                   | 5.9%          |
| <b>Total Employment Expenses</b> | <b>4,721</b>                | <b>4,933</b>     | <b>4.5%</b>    | <b>5,047</b>     | <b>(114)</b>         | <b>(2.3%)</b> |
| Medical & Other Supplies         | 1,986                       | 2,142            | 7.9%           | 2,074            | 68                   | 3.3%          |
| Physician Fees                   | 7,106                       | 8,143            | 14.6%          | 8,658            | (515)                | (5.9%)        |
| Purchased Services               | 391                         | 443              | 13.3%          | 217              | 226                  | 104.3%        |
| Repairs & Maintenance            | 659                         | 631              | (4.3%)         | 875              | (244)                | (27.9%)       |
| Utilities                        | 171                         | 143              | (16.2%)        | 141              | 2                    | 1.2%          |
| Rents & Leases                   | 904                         | 858              | (5.1%)         | 956              | (99)                 | (10.3%)       |
| Depreciation & Amortization      | 395                         | 422              | 6.9%           | 352              | 70                   | 20.0%         |
| Interest Expense                 | 9                           | 5                | (47.0%)        | 8                | (3)                  | (39.9%)       |
| Other Expense                    | 630                         | 580              | (8.0%)         | 615              | (35)                 | (5.7%)        |
| <b>Total Operating Expenses</b>  | <b>16,972</b>               | <b>18,300</b>    | <b>7.8%</b>    | <b>18,943</b>    | <b>(643)</b>         | <b>(3.4%)</b> |
| <b>Excess Margin</b>             | <b>(\$2,591)</b>            | <b>(\$3,103)</b> | <b>(19.8%)</b> | <b>(\$3,025)</b> | <b>(\$78)</b>        | <b>(2.6%)</b> |
| <b>Excess Margin %</b>           | <b>(18.0%)</b>              | <b>(20.4%)</b>   |                | <b>(19.0%)</b>   |                      |               |

# Highlights – Budget Variances

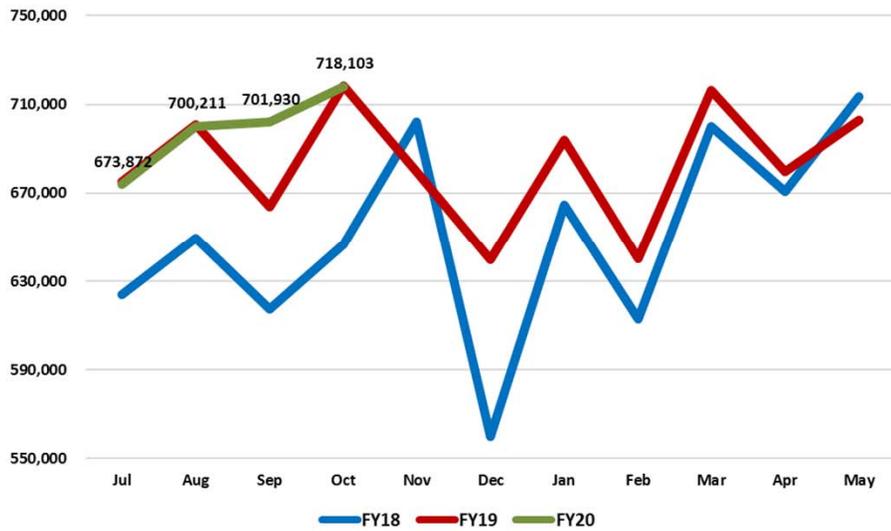
## October

1. Other Income, Quail Park distribution received and retail pharmacy exceeded budget
2. Operating Expenses, Medical and other supplies: Increase over budget due to
  - a. Purchases of flu vaccine - \$229K
  - b. Increase in COGS due to increase in surgical procedures and TAVR procedures -\$376K
3. Operating Expenses, Physician fees: Increase over budget by \$361K due to
  - a. Reconciliation of Pediatric Hospitalist contract – Year 2 - \$686K (Locums)
  - b. Offset by volume decreases, higher professional collections and contract changes
4. Operating Expenses, Purchased services: increase over budget due to
  - a. Collections fees -\$80K, IT services - \$170K, and HIM services - \$65K
  - b. Press Ganey and recruitment fees - \$73K
  - c. Humana third party expenses - \$131K over budget in Oct and over \$2.1M YTD.  
Premium revenue over budget \$1.3M YTD
5. Cash and Days Cash on Hand: \$6.5M sent to the State for PRIME IGT 10/23/19 – returned \$13.1M in November

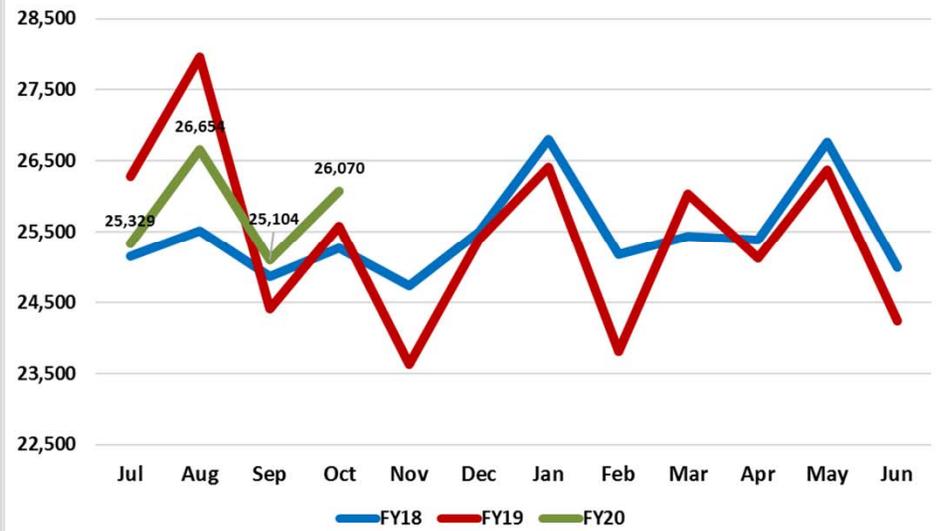
# Contract Labor Hours



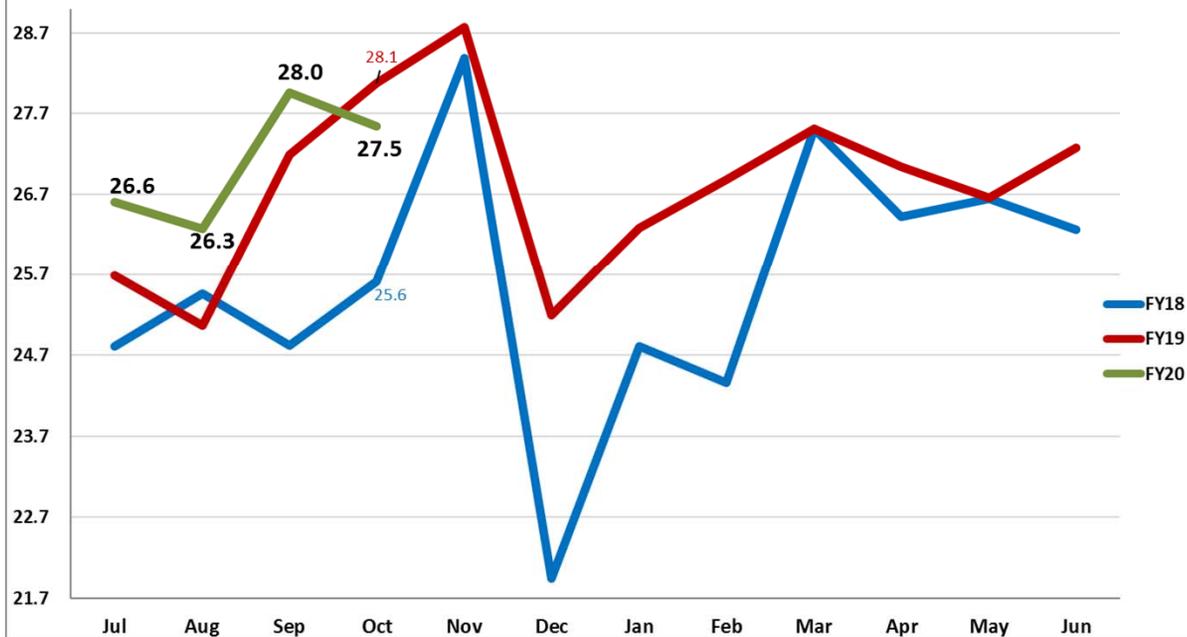
**Worked Hours including Contract Labor**



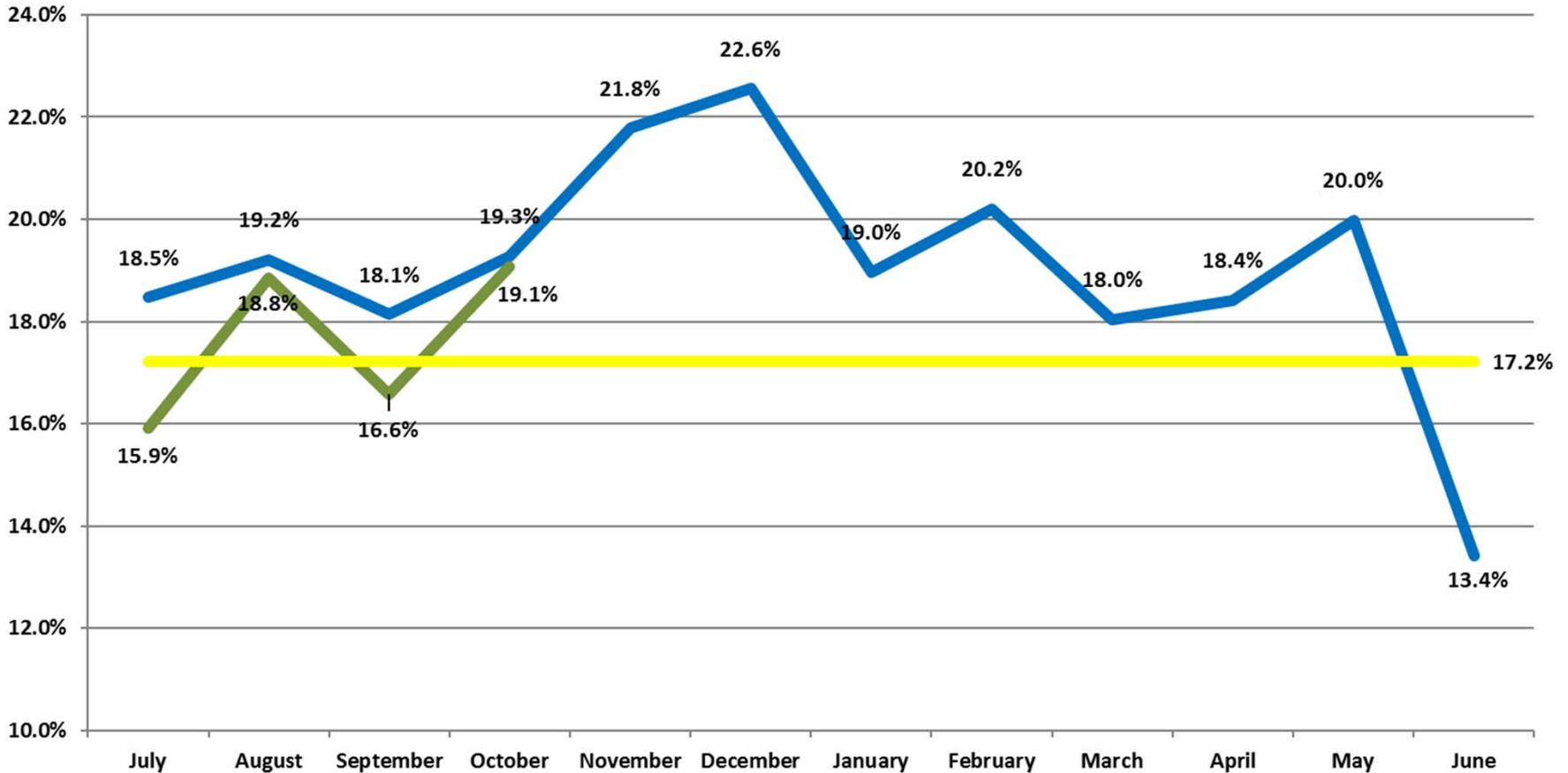
**Adjusted Patient Days**



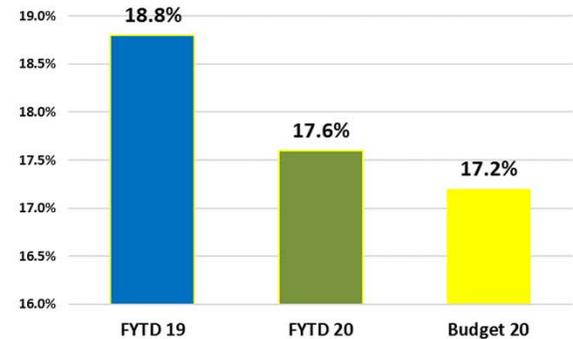
**Productivity Measure  
Worked Hours / Adjusted Patient Days**



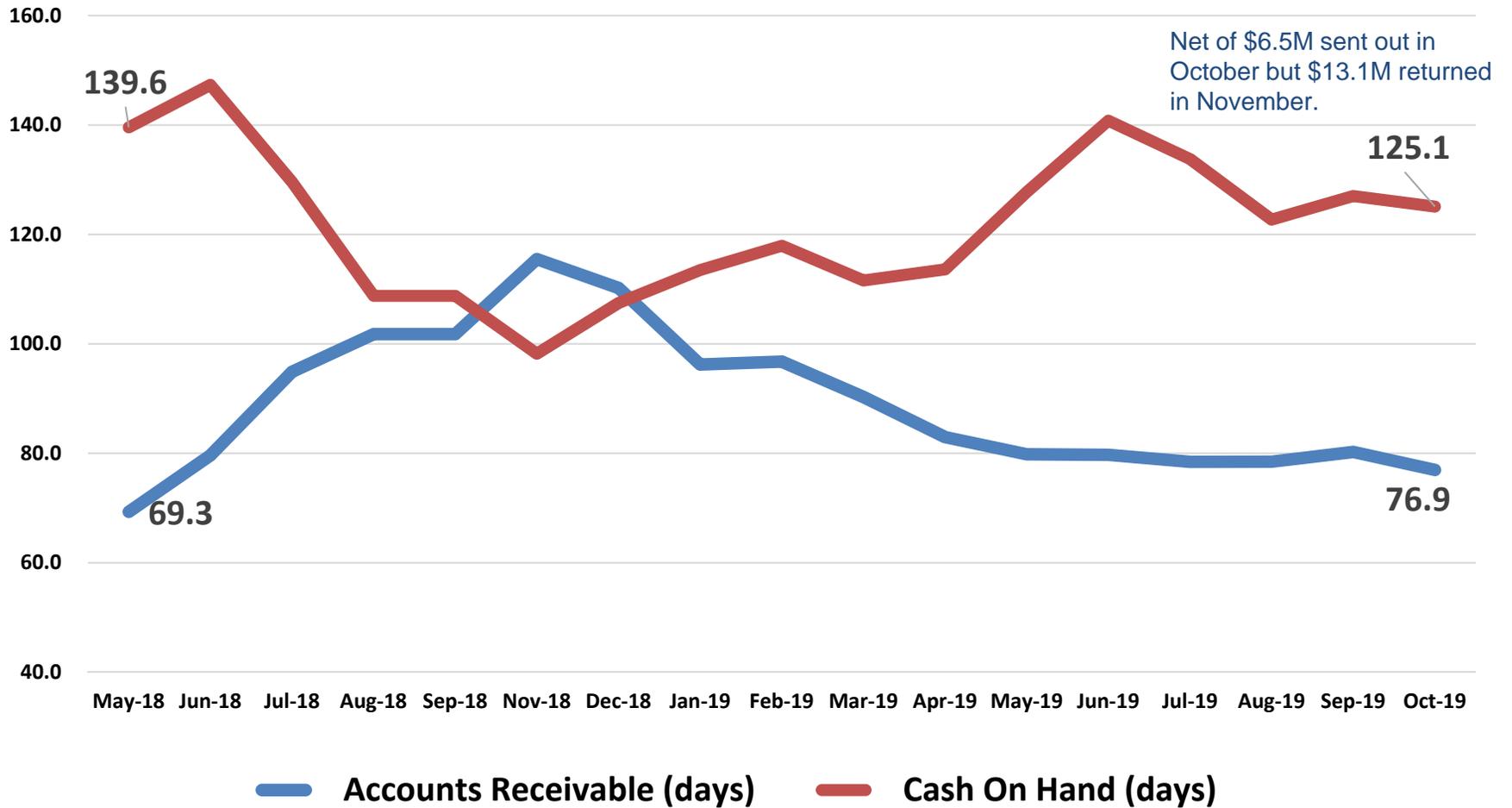
# Supply Expense as a % of Net Revenue



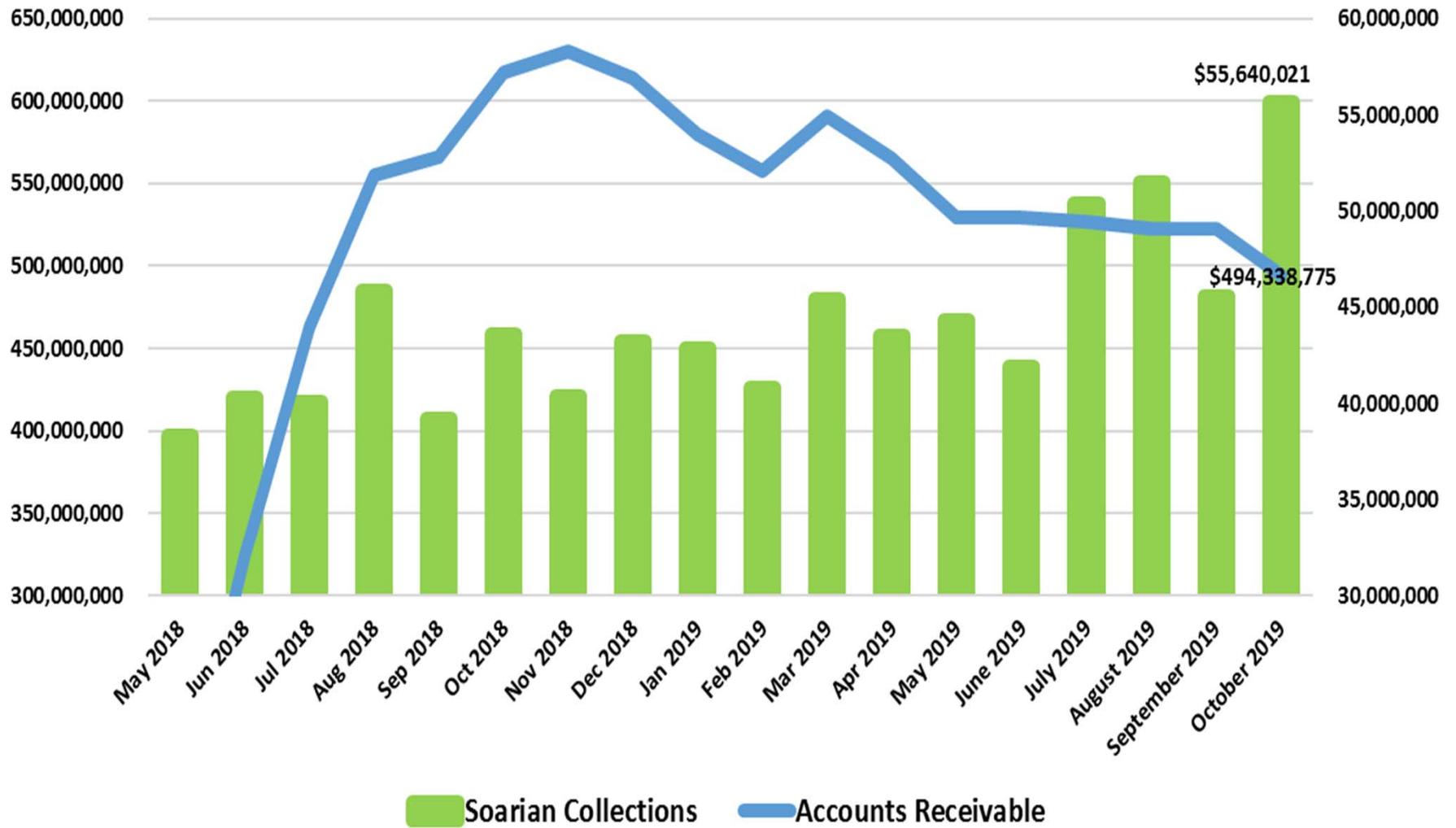
— FY19    
 — FY20    
 — Budget



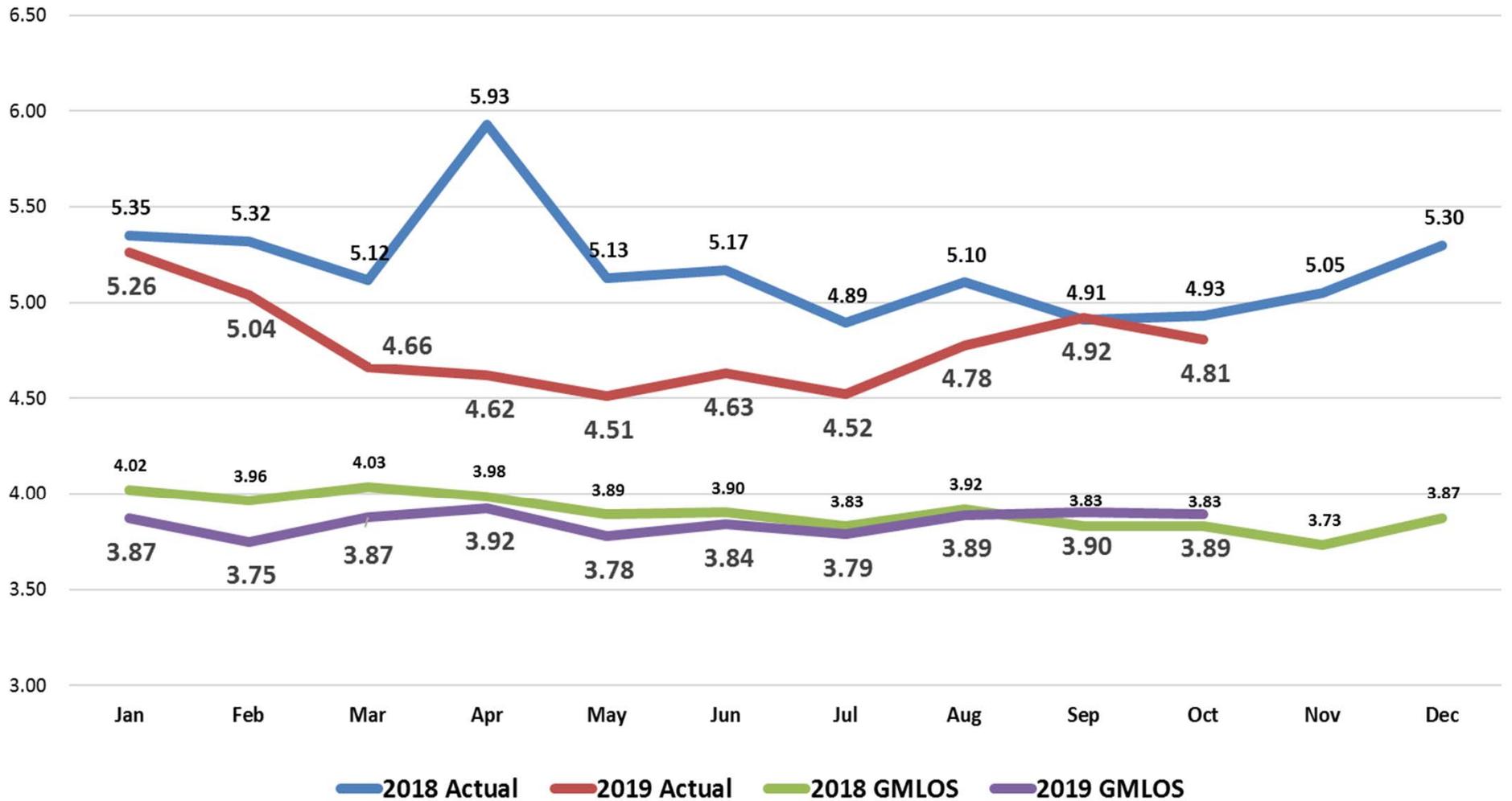
# Trended Liquidity Ratios



## Patients Accounts Receivable and Collections

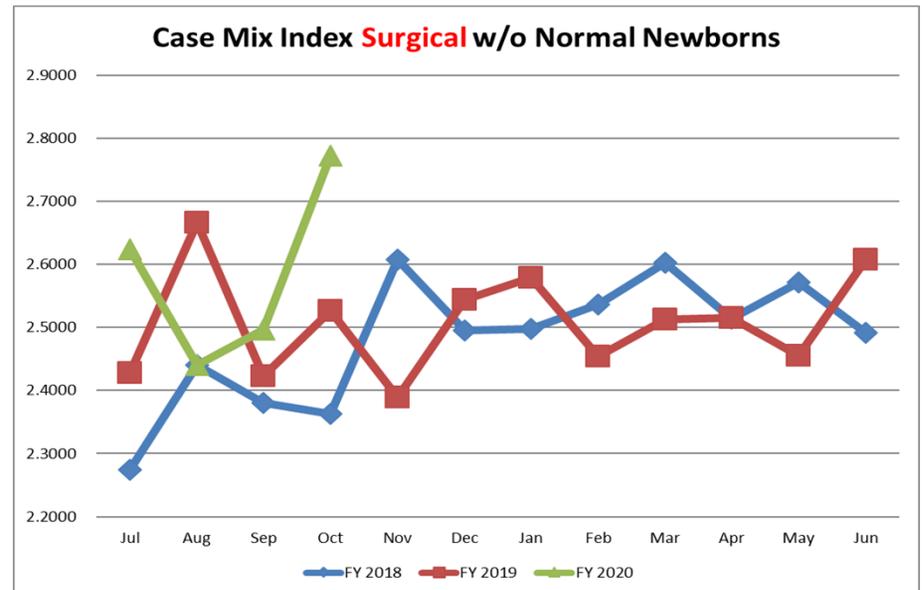
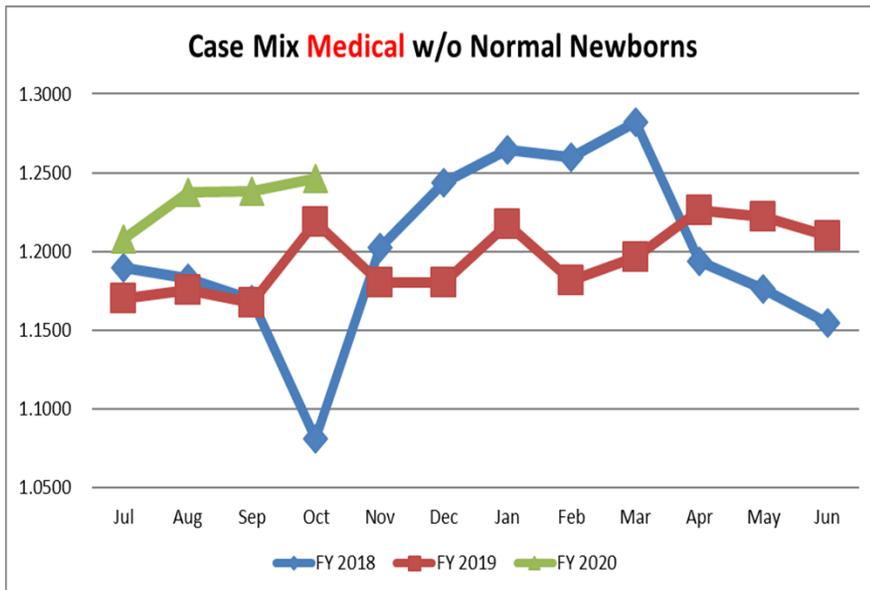
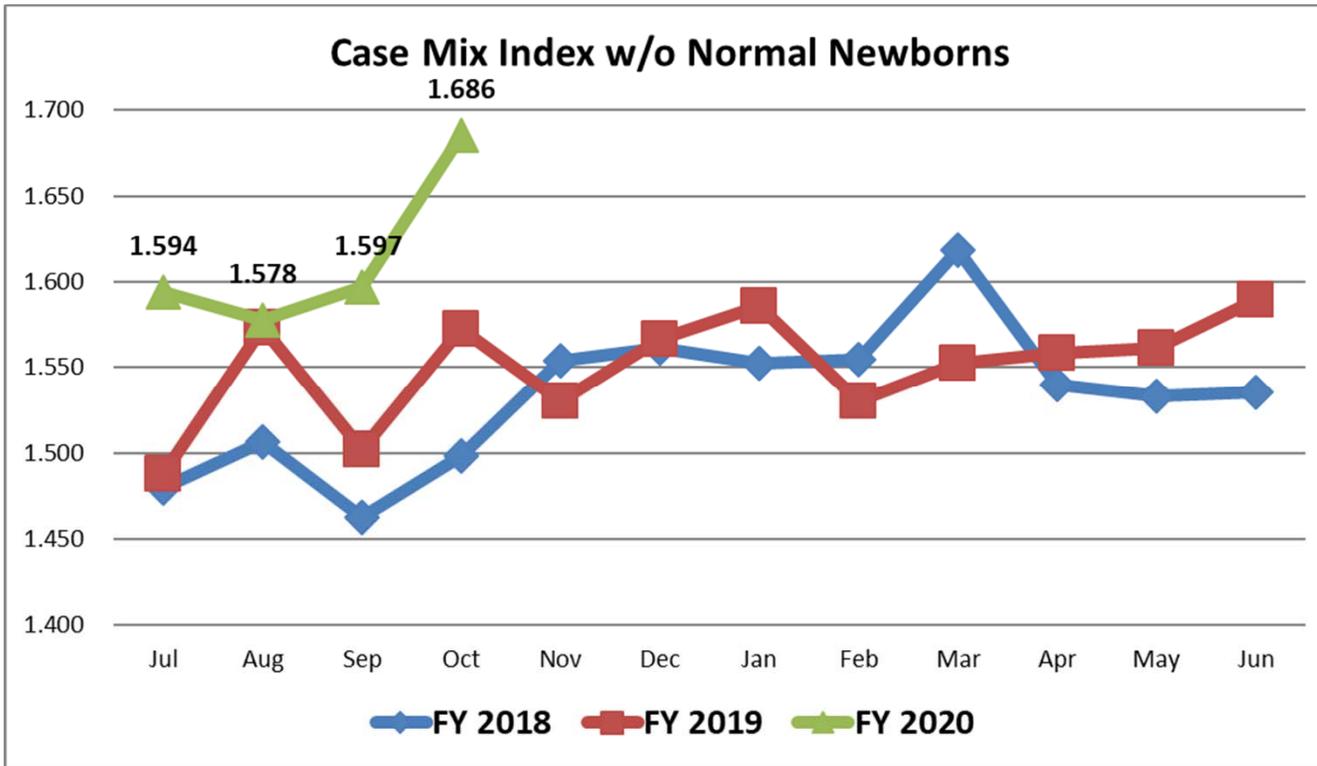


# Average Length of Stay versus National Average (GMLOS)



# Opportunity Cost for Reducing LOS to National Average (GMLOS)





**KAWEAH DELTA HEALTH CARE DISTRICT**  
**CONSOLIDATED INCOME STATEMENT (000's)**  
**FISCAL YEAR 2019 & 2020**

| Fiscal Year                   | Operating Revenue   |                         |                         | Operating Expenses |                   |                   |                         |                          |                   |                  | Operating Income  | Non-Operating Income | Net Income    | Operating Margin % | Excess Margin |
|-------------------------------|---------------------|-------------------------|-------------------------|--------------------|-------------------|-------------------|-------------------------|--------------------------|-------------------|------------------|-------------------|----------------------|---------------|--------------------|---------------|
|                               | Net Patient Revenue | Other Operating Revenue | Operating Revenue Total | Personnel Expense  | Physician Fees    | Supplies Expense  | Other Operating Expense | Operating Expenses Total |                   |                  |                   |                      |               |                    |               |
| <b>2019</b>                   |                     |                         |                         |                    |                   |                   |                         |                          |                   |                  |                   |                      |               |                    |               |
| Jul-18                        | 49,124              | 11,390                  | 60,514                  | 30,147             | 6,300             | 9,585             | 12,701                  | 58,733                   | 1,781             | 434              | 2,215             | 2.9%                 | 3.6%          |                    |               |
| Aug-18                        | 52,124              | 11,439                  | 63,563                  | 31,602             | 7,668             | 10,624            | 12,980                  | 62,874                   | 689               | 482              | 1,171             | 1.1%                 | 1.8%          |                    |               |
| Sep-18                        | 46,634              | 11,659                  | 58,293                  | 29,835             | 6,524             | 8,862             | 13,361                  | 58,582                   | (289)             | 912              | 624               | (0.5%)               | 1.1%          |                    |               |
| Oct-18                        | 48,769              | 11,644                  | 60,413                  | 32,849             | 7,145             | 9,867             | 13,066                  | 62,927                   | (2,514)           | 345              | (2,169)           | (4.2%)               | (3.6%)        |                    |               |
| Nov-18                        | 43,870              | 18,365                  | 62,235                  | 31,066             | 7,310             | 10,195            | 13,900                  | 62,470                   | (235)             | 449              | 214               | (0.4%)               | 0.3%          |                    |               |
| Dec-18                        | 43,717              | 14,732                  | 58,449                  | 31,115             | 7,023             | 10,329            | 12,736                  | 61,202                   | (2,754)           | 614              | (2,140)           | (4.7%)               | (3.6%)        |                    |               |
| Jan-19                        | 44,312              | 18,178                  | 62,489                  | 34,290             | 6,624             | 8,909             | 13,104                  | 62,927                   | (438)             | 460              | 22                | (0.7%)               | 0.0%          |                    |               |
| Feb-19                        | 45,261              | 15,334                  | 60,595                  | 30,249             | 6,989             | 9,473             | 13,280                  | 59,991                   | 604               | 565              | 1,169             | 1.0%                 | 1.9%          |                    |               |
| Mar-19                        | 48,012              | 18,073                  | 66,085                  | 32,229             | 6,775             | 9,219             | 13,606                  | 61,830                   | 4,255             | 3,325            | 7,580             | 6.4%                 | 10.9%         |                    |               |
| Apr-19                        | 45,828              | 17,318                  | 63,146                  | 31,272             | 7,105             | 9,209             | 15,748                  | 63,334                   | (188)             | 604              | 416               | (0.3%)               | 0.7%          |                    |               |
| May-19                        | 47,078              | 18,515                  | 65,594                  | 32,104             | 8,403             | 9,728             | 13,265                  | 63,501                   | 2,093             | 585              | 2,678             | 3.2%                 | 4.0%          |                    |               |
| Jun-19                        | 47,183              | 24,376                  | 71,558                  | 29,357             | 7,655             | 6,865             | 15,114                  | 58,992                   | 12,566            | 3,562            | 16,128            | 17.6%                | 21.5%         |                    |               |
| <b>2019 FY Total</b>          | <b>\$ 561,911</b>   | <b>\$ 191,023</b>       | <b>\$ 752,933</b>       | <b>\$ 376,115</b>  | <b>\$ 85,521</b>  | <b>\$ 112,866</b> | <b>\$ 162,861</b>       | <b>\$ 737,363</b>        | <b>\$ 15,570</b>  | <b>\$ 12,337</b> | <b>\$ 27,907</b>  | <b>2.1%</b>          | <b>3.6%</b>   |                    |               |
| <b>2020</b>                   |                     |                         |                         |                    |                   |                   |                         |                          |                   |                  |                   |                      |               |                    |               |
| Jul-19                        | 51,799              | 13,802                  | 65,601                  | 32,948             | 7,266             | 8,683             | 13,597                  | 62,494                   | 3,107             | 744              | 3,852             | 4.7%                 | 5.8%          |                    |               |
| Aug-19                        | 50,243              | 13,937                  | 64,181                  | 33,307             | 7,284             | 9,986             | 14,583                  | 65,160                   | (980)             | 662              | (318)             | (1.5%)               | (0.5%)        |                    |               |
| Sep-19                        | 48,185              | 13,994                  | 62,179                  | 31,582             | 7,486             | 8,571             | 14,182                  | 61,822                   | 356               | 4,429            | 4,785             | 0.6%                 | 7.2%          |                    |               |
| Oct-19                        | 52,165              | 13,896                  | 66,061                  | 33,546             | 8,287             | 10,551            | 14,477                  | 66,862                   | (801)             | 774              | (27)              | (1.2%)               | (0.0%)        |                    |               |
| <b>2020 FY Total</b>          | <b>\$ 202,392</b>   | <b>\$ 55,629</b>        | <b>\$ 258,021</b>       | <b>\$ 131,384</b>  | <b>\$ 30,323</b>  | <b>\$ 37,792</b>  | <b>\$ 56,839</b>        | <b>\$ 256,338</b>        | <b>\$ 1,683</b>   | <b>\$ 6,609</b>  | <b>\$ 8,292</b>   | <b>0.7%</b>          | <b>3.1%</b>   |                    |               |
| <b>FYTD Budget</b>            | <b>204,098</b>      | <b>52,812</b>           | <b>256,910</b>          | <b>127,670</b>     | <b>31,720</b>     | <b>37,348</b>     | <b>54,247</b>           | <b>250,986</b>           | <b>5,924</b>      | <b>2,663</b>     | <b>8,587</b>      | <b>2.3%</b>          | <b>3.3%</b>   |                    |               |
| <b>Variance</b>               | <b>\$ (1,706)</b>   | <b>\$ 2,818</b>         | <b>\$ 1,111</b>         | <b>\$ 3,713</b>    | <b>\$ (1,397)</b> | <b>\$ 444</b>     | <b>\$ 2,592</b>         | <b>\$ 5,352</b>          | <b>\$ (4,241)</b> | <b>\$ 3,946</b>  | <b>\$ (295)</b>   |                      |               |                    |               |
| <b>Current Month Analysis</b> |                     |                         |                         |                    |                   |                   |                         |                          |                   |                  |                   |                      |               |                    |               |
| <b>Oct-19</b>                 | <b>\$ 52,165</b>    | <b>\$ 13,896</b>        | <b>\$ 66,061</b>        | <b>\$ 33,546</b>   | <b>\$ 8,287</b>   | <b>\$ 10,551</b>  | <b>\$ 14,477</b>        | <b>\$ 66,862</b>         | <b>\$ (801)</b>   | <b>\$ 774</b>    | <b>\$ (27)</b>    | <b>(1.2%)</b>        | <b>(0.0%)</b> |                    |               |
| <b>Budget</b>                 | <b>52,395</b>       | <b>13,372</b>           | <b>65,767</b>           | <b>32,132</b>      | <b>7,926</b>      | <b>9,584</b>      | <b>13,830</b>           | <b>63,471</b>            | <b>2,296</b>      | <b>670</b>       | <b>2,966</b>      | <b>3.5%</b>          | <b>4.5%</b>   |                    |               |
| <b>Variance</b>               | <b>\$ (230)</b>     | <b>\$ 524</b>           | <b>\$ 294</b>           | <b>\$ 1,415</b>    | <b>\$ 361</b>     | <b>\$ 967</b>     | <b>\$ 647</b>           | <b>\$ 3,390</b>          | <b>\$ (3,097)</b> | <b>\$ 103</b>    | <b>\$ (2,994)</b> |                      |               |                    |               |

# KAWEAH DELTA HEALTH CARE DISTRICT

## FISCAL YEAR 2019 & 2020

| Fiscal Year                   | Patient Days   | ADC         | Adjusted       | I/P Revenue % | DFR &        | Net Patient                  | Personnel                    | Physician                 | Supply                       | Total                                  | Personnel                    | Physician                 | Supply                       | Total                                  |
|-------------------------------|----------------|-------------|----------------|---------------|--------------|------------------------------|------------------------------|---------------------------|------------------------------|--|------------------------------|---------------------------|------------------------------|--|
|                               |                |             | Patient Days   |               | Bad Debt %   | Revenue/ Ajusted Patient Day | Expense/ Ajusted Patient Day | Fees/ Ajusted Patient Day | Expense/ Ajusted Patient Day | Operating Expense/ Ajusted Patient Day | Expense/ Net Patient Revenue | Fees/ Net Patient Revenue | Expense/ Net Patient Revenue | Operating Expense/ Net Patient Revenue |
| <b>2019</b>                   |                |             |                |               |              |                              |                              |                           |                              |  |                              |                           |                              |  |
| Jul-18                        | 14,096         | 455         | 26,287         | 53.6%         | 72.4%        | 1,869                        | 1,147                        | 240                       | 365                          | 2,234                                  | 61.4%                        | 12.8%                     | 19.5%                        | 119.6%                                 |
| Aug-18                        | 14,569         | 470         | 28,016         | 52.0%         | 76.0%        | 1,861                        | 1,128                        | 274                       | 379                          | 2,244                                  | 60.6%                        | 14.7%                     | 20.4%                        | 120.6%                                 |
| Sep-18                        | 13,052         | 435         | 24,371         | 53.6%         | 73.5%        | 1,914                        | 1,224                        | 268                       | 364                          | 2,404                                  | 64.0%                        | 14.0%                     | 19.0%                        | 125.6%                                 |
| Oct-18                        | 13,744         | 443         | 25,579         | 53.7%         | 73.5%        | 1,907                        | 1,284                        | 279                       | 386                          | 2,460                                  | 67.4%                        | 14.7%                     | 20.2%                        | 129.0%                                 |
| Nov-18                        | 13,013         | 434         | 23,625         | 55.1%         | 74.9%        | 1,857                        | 1,315                        | 309                       | 432                          | 2,644                                  | 70.8%                        | 16.7%                     | 23.2%                        | 142.4%                                 |
| Dec-18                        | 13,497         | 435         | 25,399         | 53.1%         | 76.2%        | 1,721                        | 1,225                        | 277                       | 407                          | 2,410                                  | 71.2%                        | 16.1%                     | 23.6%                        | 140.0%                                 |
| Jan-19                        | 13,671         | 441         | 26,407         | 51.8%         | 76.9%        | 1,678                        | 1,299                        | 251                       | 337                          | 2,383                                  | 77.4%                        | 14.9%                     | 20.1%                        | 142.0%                                 |
| Feb-19                        | 12,584         | 449         | 23,811         | 52.8%         | 75.9%        | 1,901                        | 1,270                        | 294                       | 398                          | 2,519                                  | 66.8%                        | 15.4%                     | 20.9%                        | 132.5%                                 |
| Mar-19                        | 13,707         | 442         | 26,032         | 52.7%         | 76.9%        | 1,844                        | 1,238                        | 260                       | 354                          | 2,375                                  | 67.1%                        | 14.1%                     | 19.2%                        | 128.8%                                 |
| Apr-19                        | 13,162         | 439         | 25,125         | 52.4%         | 76.9%        | 1,824                        | 1,245                        | 283                       | 367                          | 2,521                                  | 68.2%                        | 15.5%                     | 20.1%                        | 138.2%                                 |
| May-19                        | 13,440         | 434         | 26,367         | 51.0%         | 75.3%        | 1,785                        | 1,218                        | 319                       | 369                          | 2,408                                  | 68.2%                        | 17.8%                     | 20.7%                        | 134.9%                                 |
| Jun-19                        | 12,547         | 418         | 24,234         | 51.8%         | 75.6%        | 1,947                        | 1,211                        | 316                       | 283                          | 2,434                                  | 62.2%                        | 16.2%                     | 14.6%                        | 125.0%                                 |
| <b>2019 FY Total</b>          | <b>161,082</b> | <b>441</b>  | <b>305,353</b> | <b>52.8%</b>  | <b>75.4%</b> | <b>1,840</b>                 | <b>1,232</b>                 | <b>280</b>                | <b>370</b>                   | <b>2,415</b>                           | <b>66.9%</b>                 | <b>15.2%</b>              | <b>20.1%</b>                 | <b>131.2%</b>                          |
| <b>2020</b>                   |                |             |                |               |              |                              |                              |                           |                              |  |                              |                           |                              |  |
| Jul-19                        | 12,744         | 411         | 25,329         | 50.3%         | 73.8%        | 2,045                        | 1,301                        | 287                       | 343                          | 2,467                                  | 63.6%                        | 14.0%                     | 16.8%                        | 120.6%                                 |
| Aug-19                        | 13,240         | 427         | 26,654         | 49.7%         | 74.8%        | 1,885                        | 1,250                        | 273                       | 375                          | 2,445                                  | 66.3%                        | 14.5%                     | 19.9%                        | 129.7%                                 |
| Sep-19                        | 12,712         | 424         | 25,104         | 50.6%         | 74.1%        | 1,919                        | 1,258                        | 298                       | 341                          | 2,463                                  | 65.5%                        | 15.5%                     | 17.8%                        | 128.3%                                 |
| Oct-19                        | 12,924         | 417         | 26,070         | 49.6%         | 74.6%        | 2,001                        | 1,287                        | 318                       | 405                          | 2,565                                  | 64.3%                        | 15.9%                     | 20.2%                        | 128.2%                                 |
| <b>2020 FY Total</b>          | <b>51,620</b>  | <b>420</b>  | <b>103,166</b> | <b>50.0%</b>  | <b>74.3%</b> | <b>1,962</b>                 | <b>1,274</b>                 | <b>294</b>                | <b>366</b>                   | <b>2,485</b>                           | <b>64.9%</b>                 | <b>15.0%</b>              | <b>18.7%</b>                 | <b>126.7%</b>                          |
| <b>FYTD Budget</b>            | <b>54,949</b>  | <b>447</b>  | <b>106,239</b> | <b>51.7%</b>  | <b>74.3%</b> | <b>1,921</b>                 | <b>1,202</b>                 | <b>299</b>                | <b>352</b>                   | <b>2,433</b>                           | <b>62.6%</b>                 | <b>15.5%</b>              | <b>18.3%</b>                 | <b>123.0%</b>                          |
| <b>Variance</b>               | <b>(3,329)</b> | <b>(27)</b> | <b>(3,073)</b> | <b>(1.7%)</b> | <b>0.0%</b>  | <b>41</b>                    | <b>72</b>                    | <b>(5)</b>                | <b>15</b>                    | <b>52</b>                              | <b>2.4%</b>                  | <b>(0.6%)</b>             | <b>0.4%</b>                  | <b>3.7%</b>                            |
| <b>Current Month Analysis</b> |                |             |                |               |              |                              |                              |                           |                              |  |                              |                           |                              |  |
| Oct-19                        | 12,924         | 417         | 26,070         | 49.6%         | 74.6%        | 2,001                        | 1,287                        | 318                       | 405                          | 2,565                                  | 64.3%                        | 15.9%                     | 20.2%                        | 128.2%                                 |
| <b>Budget</b>                 | <b>13,430</b>  | <b>433</b>  | <b>26,311</b>  | <b>51.0%</b>  | <b>74.1%</b> | <b>1,991</b>                 | <b>1,221</b>                 | <b>301</b>                | <b>364</b>                   | <b>2,435</b>                           | <b>61.3%</b>                 | <b>15.1%</b>              | <b>18.3%</b>                 | <b>121.1%</b>                          |
| <b>Variance</b>               | <b>(506)</b>   | <b>(16)</b> | <b>(241)</b>   | <b>(1.5%)</b> | <b>0.5%</b>  | <b>10</b>                    | <b>66</b>                    | <b>17</b>                 | <b>40</b>                    | <b>130</b>                             | <b>3.0%</b>                  | <b>0.8%</b>               | <b>1.9%</b>                  | <b>7.0%</b>                            |

**KAWEAH DELTA HEALTH CARE DISTRICT  
RATIO ANALYSIS REPORT  
OCTOBER 31, 2019**

|  | Current<br>Month<br>Value | Prior<br>Month<br>Value | June 30,<br>2019<br>Unaudited<br>Value | 2017 Moody's<br>Median Benchmark |               |        |
|--|---------------------------|-------------------------|--|----------------------------------|---------------|--------|
|  |                           |                         |  | Aa                               | A             | Baa    |
| <b>LIQUIDITY RATIOS</b>                          |                           |                         |  |                                  |               |        |
| Current Ratio (x)                                | 2.8                       | 2.8                     | 2.2                                    | 1.7                              | <b>1.9</b>    | 2.1    |
| Accounts Receivable (days)                       | 76.9                      | 80.2                    | 79.7                                   | 48.4                             | <b>48.4</b>   | 46.5   |
| Cash On Hand (days)— <i>see highlights slide</i> | 125.1                     | 127.0                   | 140.8                                  | 264.6                            | <b>226.5</b>  | 156.5  |
| Cushion Ratio (x)                                | 17.1                      | 17.2                    | 18.5                                   | 36.6                             | <b>23.9</b>   | 13.8   |
| Average Payment Period (days)                    | 41.6                      | 43.3                    | 51.0                                   | 75.0                             | <b>59.6</b>   | 59.6   |
| <b>CAPITAL STRUCTURE RATIOS</b>                  |                           |                         |  |                                  |               |        |
| Cash-to-Debt                                     | 111.2%                    | 111.4%                  | 120.5%                                 | 217.6%                           | <b>169.6%</b> | 111.7% |
| Debt-To-Capitalization                           | 31.3%                     | 31.3%                   | 31.5%                                  | 26.0%                            | <b>32.9%</b>  | 39.3%  |
| Debt-to-Cash Flow (x)                            | 3.9                       | 3.4                     | 3.6                                    | 2.2                              | <b>3.0</b>    | 4.5    |
| Debt Service Coverage                            | 3.7                       | 4.3                     | 4.0                                    | 7.1                              | <b>5.4</b>    | 3.0    |
| Maximum Annual Debt Service Coverage (x)         | 3.7                       | 4.3                     | 4.0                                    | 6.4                              | <b>4.7</b>    | 2.8    |
| Age Of Plant (years)                             | 12.8                      | 12.7                    | 12.1                                   | 10.1                             | <b>11.6</b>   | 12.1   |
| <b>PROFITABILITY RATIOS</b>                      |                           |                         |  |                                  |               |        |
| Operating Margin                                 | 0.7%                      | 1.3%                    | 2.0%                                   | 3.5%                             | <b>2.3%</b>   | (.4%)  |
| Excess Margin                                    | 3.1%                      | 4.2%                    | 3.6%                                   | 6.6%                             | <b>5.2%</b>   | 1.9%   |
| Operating Cash Flow Margin                       | 5.2%                      | 5.9%                    | 6.8%                                   | 9.2%                             | <b>8.6%</b>   | 6.0%   |
| Return on Assets                                 | 2.8%                      | 3.7%                    | 3.0%                                   | 5.3%                             | <b>4.0%</b>   | 1.7%   |

**KAWEAH DELTA HEALTH CARE DISTRICT**  
**CONSOLIDATED STATEMENTS OF NET POSITION (000's)**

|  | Oct-19     | Sep-19     | Change     | % Change | Jun-19<br>(Audited) |
|--|------------|------------|------------|----------|---------------------|
| <b>ASSETS AND DEFERRED OUTFLOWS</b>                    |            |            |            |          |                     |
| <b>CURRENT ASSETS</b>                                  |            |            |            |          |                     |
| Cash and cash equivalents                              | \$ 6,481   | \$ 9,536   | \$ (3,055) | -32.04%  | \$ 4,220            |
| Current Portion of Board designated and trusted assets | 15,542     | 14,403     | 1,139      | 7.91%    | 12,577              |
| Accounts receivable:                                   |            |            |            |          |                     |
| Net patient accounts                                   | 136,572    | 142,210    | (5,638)    | -3.96%   | 146,605             |
| Other receivables                                      | 23,231     | 14,973     | 8,258      | 55.15%   | 13,907              |
|  | 159,803    | 157,183    | 2,619      | 1.67%    | 160,512             |
| Inventories  | 10,552     | 10,854     | (302)      | -2.78%   | 10,479              |
| Medicare and Medi-Cal settlements                      | 40,237     | 44,521     | (4,284)    | -9.62%   | 30,759              |
| Prepaid expenses                                       | 11,378     | 12,428     | (1,050)    | -8.45%   | 11,510              |
| Total current assets                                   | 243,991    | 248,925    | (4,934)    | -1.98%   | 230,057             |
| <b>NON-CURRENT CASH AND INVESTMENTS -</b>              |            |            |            |          |                     |
| less current portion                                   |            |            |            |          |                     |
| Board designated cash and assets                       | 255,264    | 252,600    | 2,664      | 1.05%    | 278,883             |
| Revenue bond assets held in trust                      | 33,607     | 33,570     | 37         | 0.11%    | 33,569              |
| Assets in self-insurance trust fund                    | 4,241      | 4,233      | 8          | 0.19%    | 4,209               |
| Total non-current cash and investments                 | 293,112    | 290,403    | 2,709      | 0.93%    | 316,662             |
| <b>CAPITAL ASSETS</b>                                  |            |            |            |          |                     |
| Land   | 16,989     | 16,137     | 852        | 5.28%    | 16,137              |
| Buildings and improvements                             | 359,236    | 358,410    | 825        | 0.23%    | 356,887             |
| Equipment  | 274,724    | 275,184    | (460)      | -0.17%   | 275,513             |
| Construction in progress                               | 49,268     | 49,727     | (459)      | -0.92%   | 42,299              |
|  | 700,216    | 699,458    | 758        | 0.11%    | 690,836             |
| Less accumulated depreciation                          | 365,288    | 364,363    | 925        | 0.25%    | 357,681             |
|  | 334,928    | 335,095    | (167)      | -0.05%   | 333,155             |
| Property under capital leases -                        |            |            |            |          |                     |
| less accumulated amortization                          | 2,901      | 2,977      | (76)       | -2.54%   | 3,204               |
| Total capital assets                                   | 337,829    | 338,072    | (243)      | -0.07%   | 336,359             |
| <b>OTHER ASSETS</b>                                    |            |            |            |          |                     |
| Property not used in operations                        | 1,720      | 1,887      | (167)      | -8.84%   | 3,724               |
| Health-related investments                             | 7,513      | 7,487      | 26         | 0.35%    | 7,537               |
| Other  | 10,492     | 9,980      | 512        | 5.13%    | 9,706               |
| Total other assets                                     | 19,726     | 19,354     | 371        | 1.92%    | 20,967              |
| Total assets   | 894,658    | 896,755    | (2,096)    | -0.23%   | 904,045             |
| <b>DEFERRED OUTFLOWS</b>                               | (2,492)    | (2,454)    | (38)       | 1.55%    | (2,340)             |
| Total assets and deferred outflows                     | \$ 892,166 | \$ 894,300 | \$ (2,134) | -0.24%   | \$ 901,704          |

**KAWEAH DELTA HEALTH CARE DISTRICT  
CONSOLIDATED STATEMENTS OF NET POSITION (000's)**

|   | Oct-19     | Sep-19     | Change     | % Change | Jun-19     |
|---|------------|------------|------------|----------|------------|
|   |            |            |            |          | (Audited)  |
| <b>LIABILITIES AND NET ASSETS</b>               |            |            |            |          |            |
| <b>CURRENT LIABILITIES</b>                      |            |            |            |          |            |
| Accounts payable and accrued expenses           | \$ 28,397  | \$ 33,979  | \$ (5,582) | -16.43%  | \$ 35,319  |
| Accrued payroll and related liabilities         | 50,105     | 46,762     | 3,343      | 7.15%    | 59,163     |
| Long-term debt, current portion                 | 8,715      | 8,908      | (192)      | -2.16%   | 9,360      |
| Total current liabilities                       | 87,217     | 89,648     | (2,431)    | -2.71%   | 103,842    |
| <b>LONG-TERM DEBT, less current portion</b>     |            |            |            |          |            |
| Bonds payable                                   | 256,674    | 256,731    | (57)       | -0.02%   | 258,553    |
| Capital leases                                  | 89         | 110        | (21)       | -19.14%  | 174        |
| Total long-term debt                            | 256,763    | 256,841    | (78)       | -0.03%   | 258,727    |
| <b>NET PENSION LIABILITY</b>                    | 29,511     | 29,945     | (435)      | -1.45%   | 31,249     |
| <b>OTHER LONG-TERM LIABILITIES</b>              | 30,767     | 30,005     | 763        | 2.54%    | 28,647     |
| Total liabilities                               | 404,259    | 406,440    | (2,181)    | -0.54%   | 422,465    |
| <b>NET ASSETS</b>                               |            |            |            |          |            |
| Invested in capital assets, net of related debt | 109,409    | 109,378    | 31         | 0.03%    | 105,427    |
| Restricted                                      | 34,124     | 32,743     | 1,380      | 4.22%    | 30,090     |
| Unrestricted                                    | 344,374    | 345,738    | (1,365)    | -0.39%   | 343,722    |
| Total net position                              | 487,907    | 487,860    | 47         | 0.01%    | 479,239    |
| Total liabilities and net position              | \$ 892,166 | \$ 894,300 | \$ (2,134) | -0.24%   | \$ 901,704 |

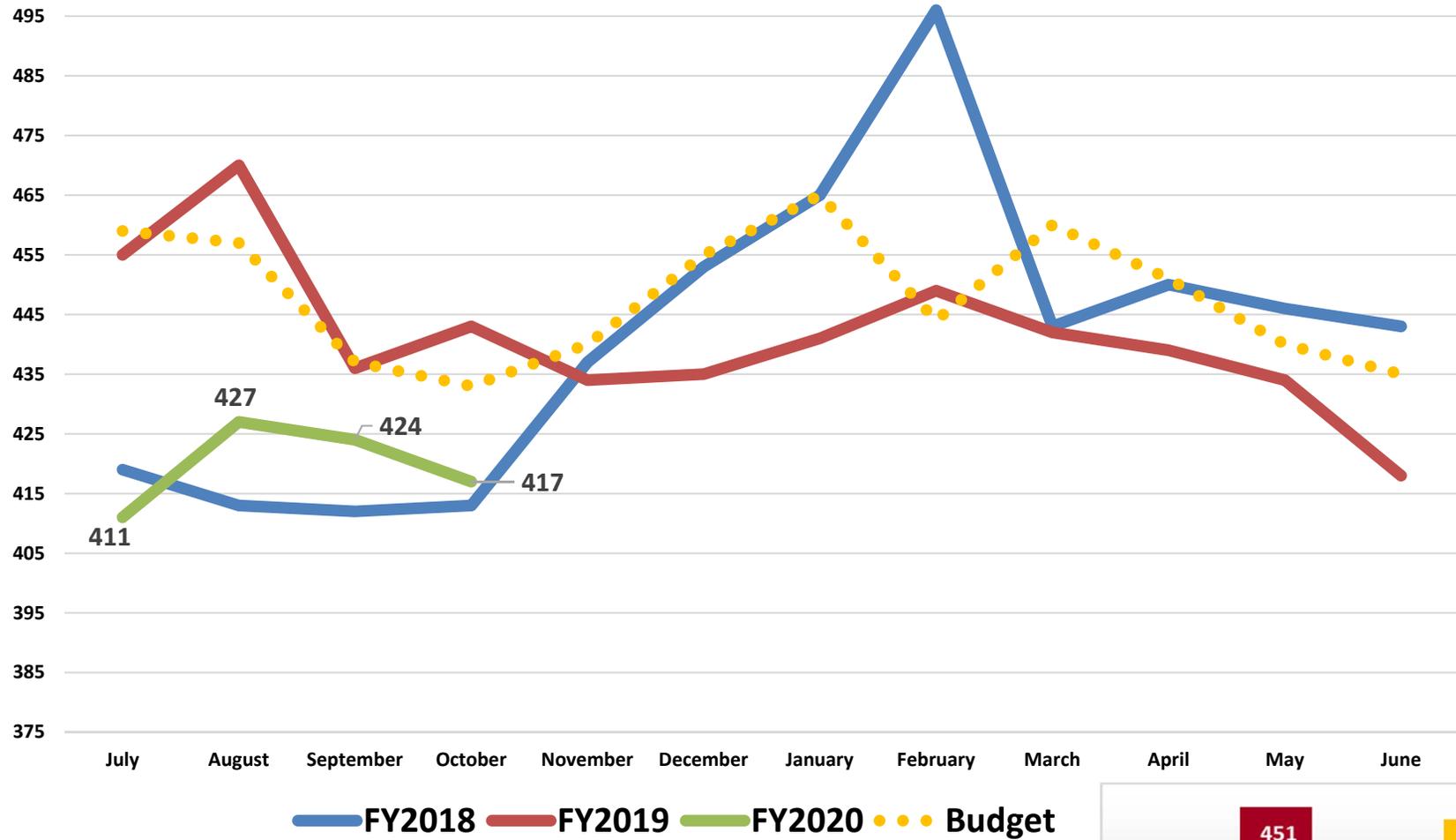
M O R E T H A N M E D I C I N E . L I F E .

# Statistical Report

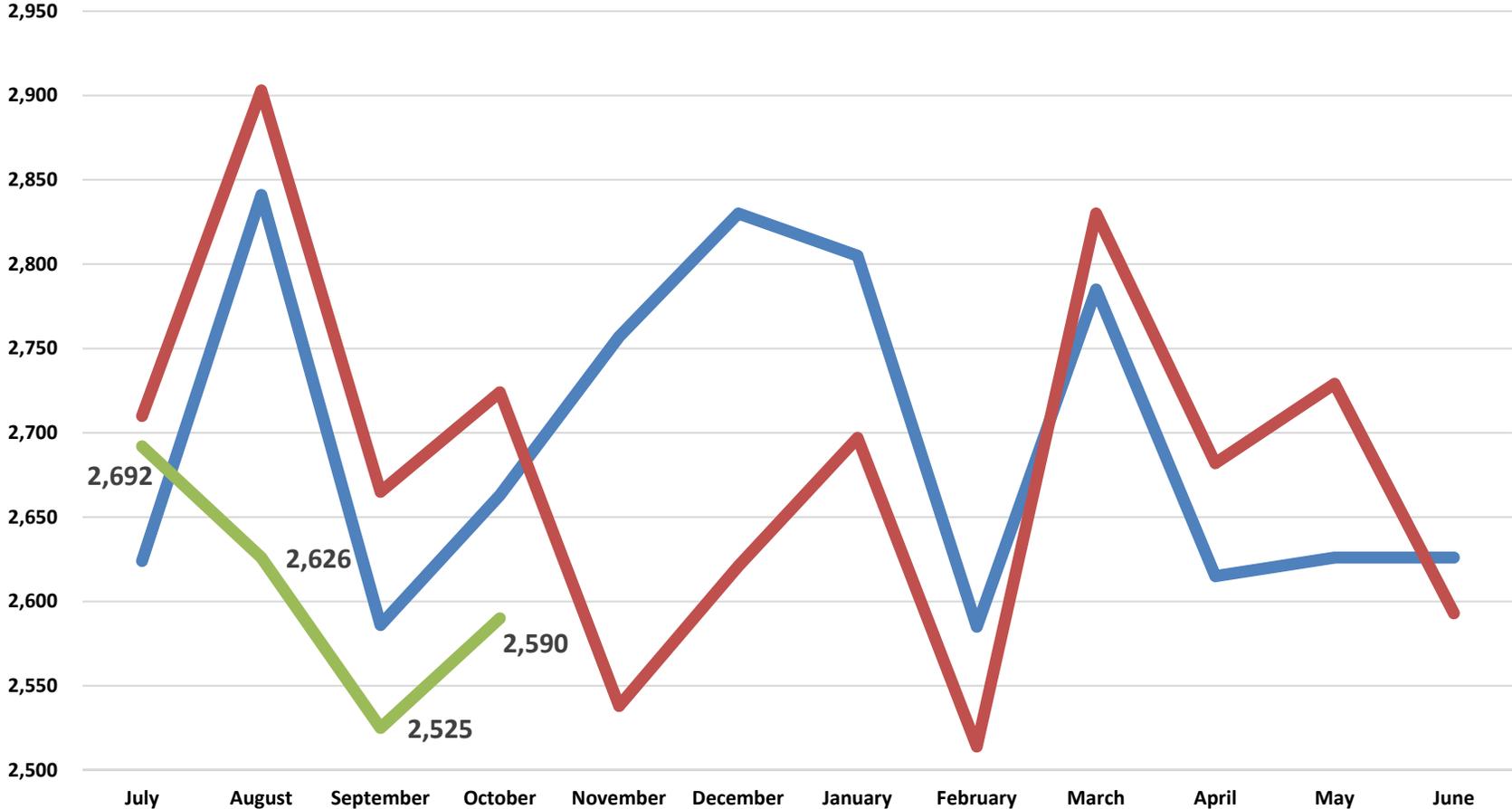
November 21, 2019



# Average Daily Census



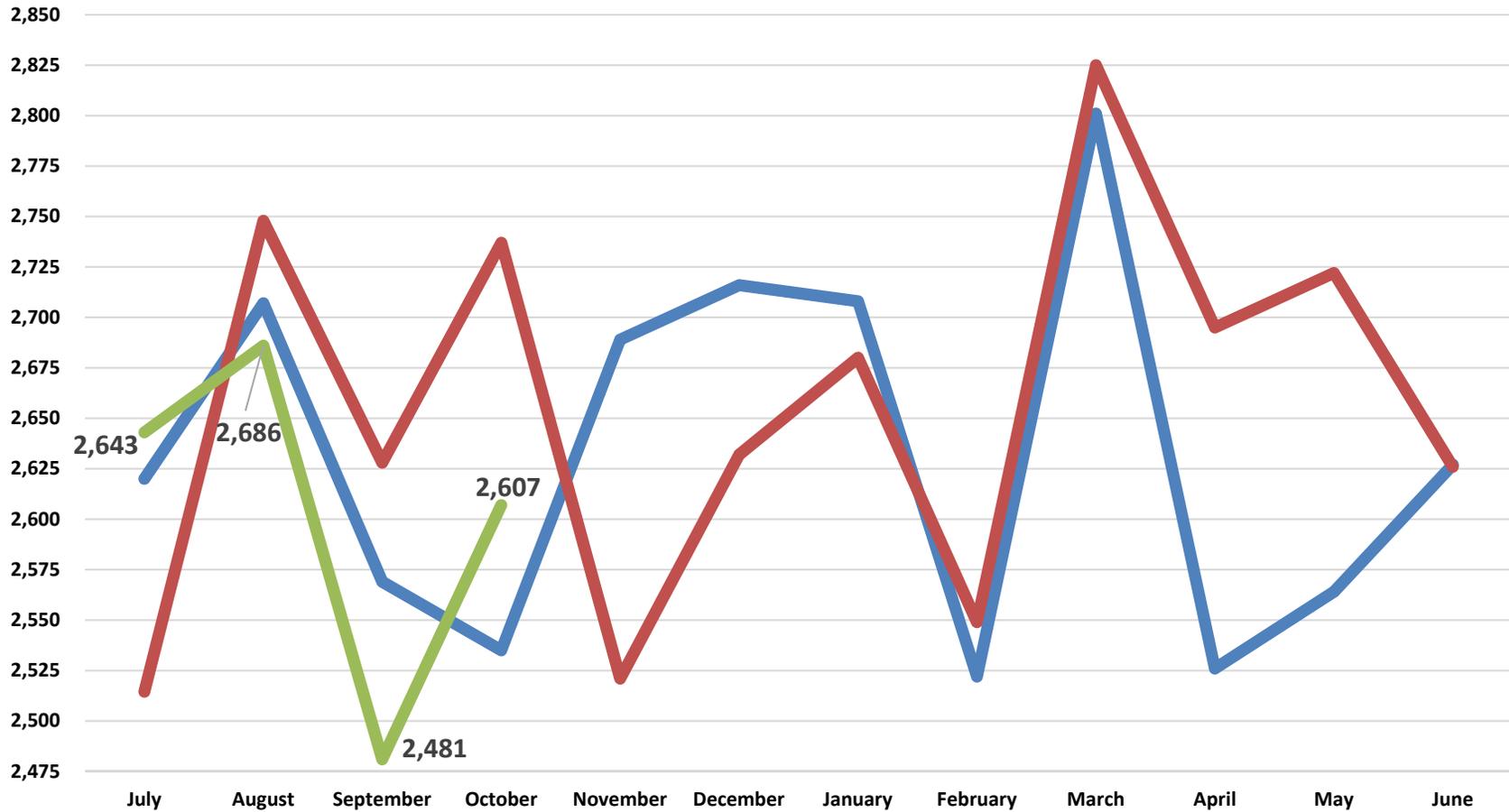
# Admissions



— FY2018 — FY2019 — FY2020



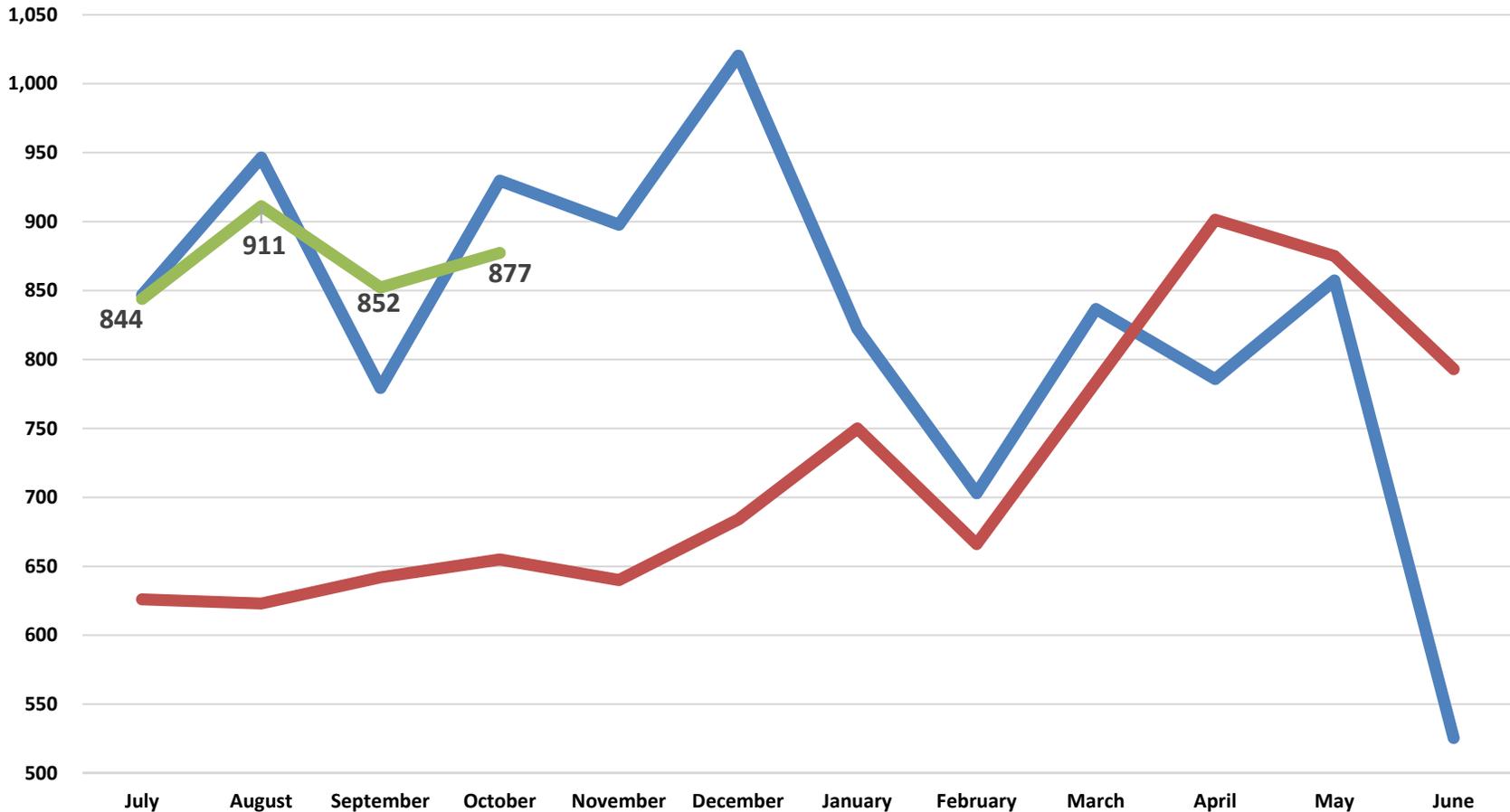
# Discharges



— FY2018 — FY2019 — FY2020



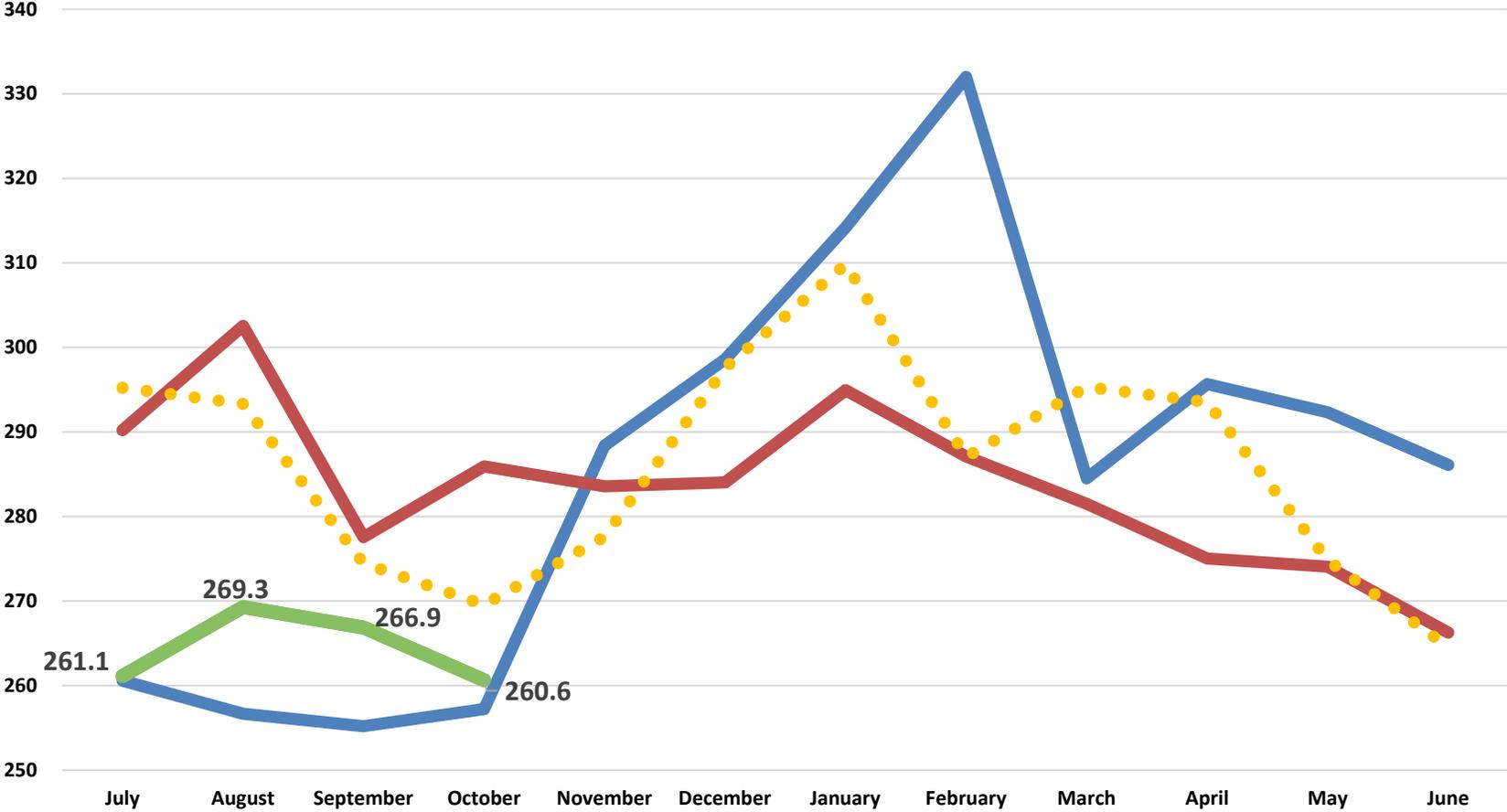
# Observation Days



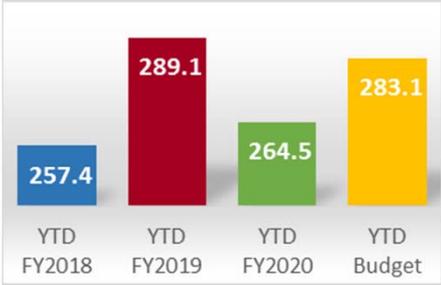
— FY2018 — FY2019 — FY2020



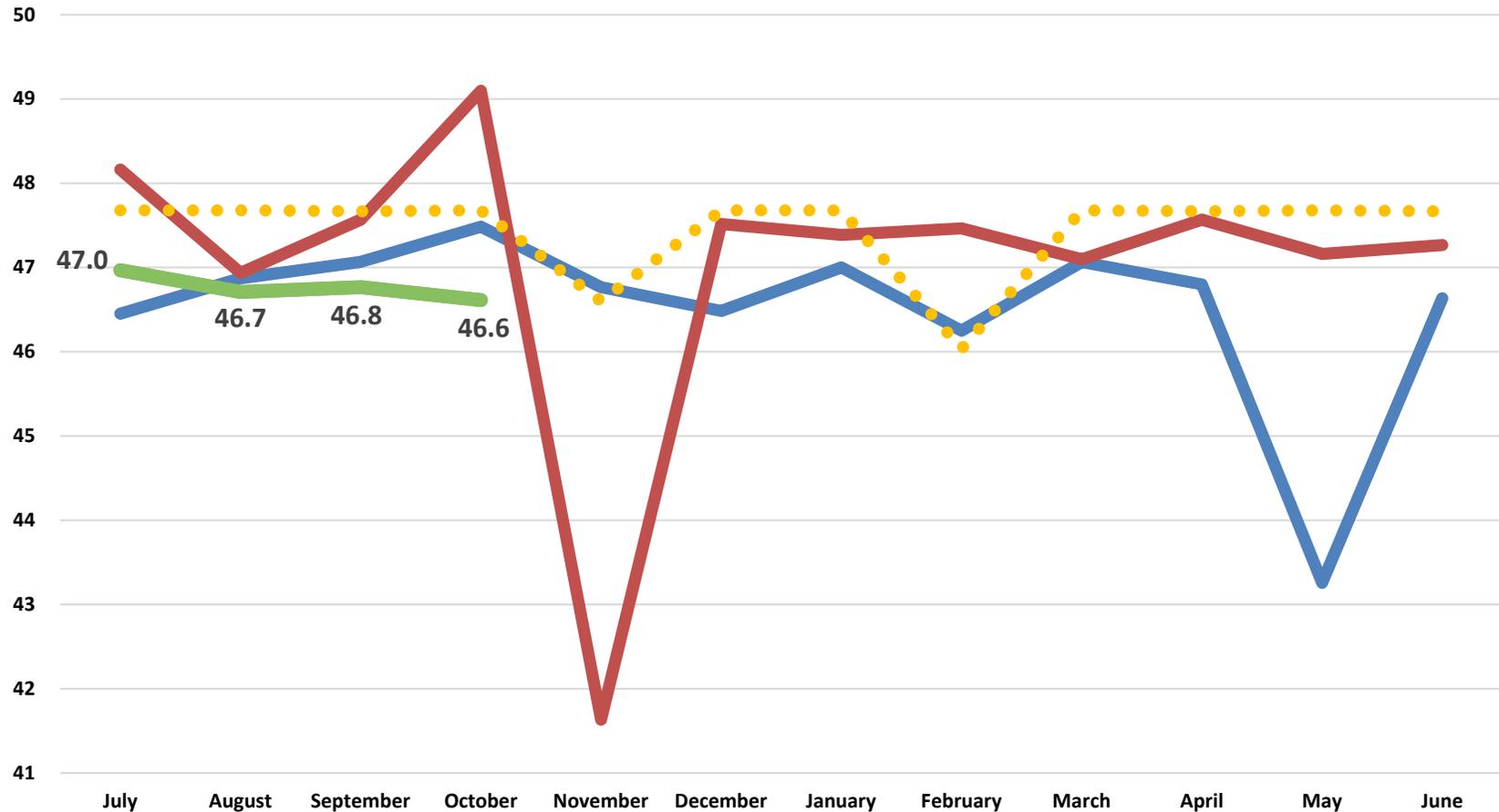
# Medical Center – Avg. Patients Per Day



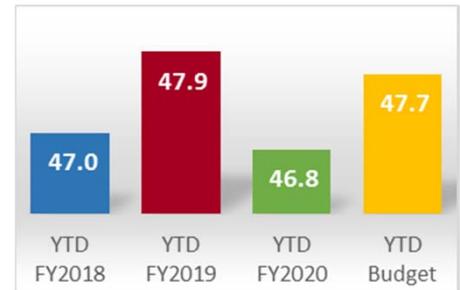
— **FY2018**
— **FY2019**
— **FY2020**
••• **Budget**



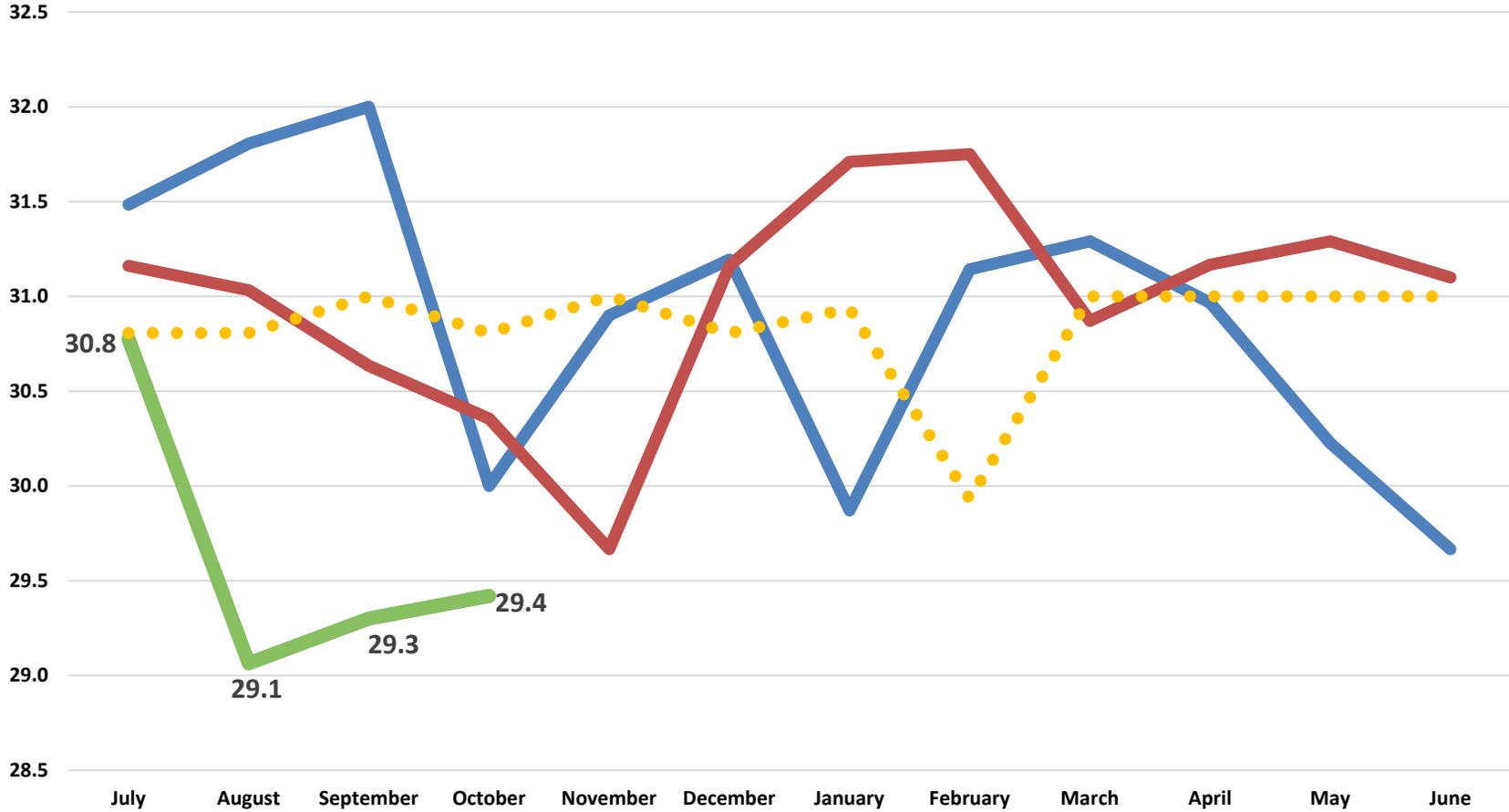
# Acute I/P Psych - Avg. Patients Per Day



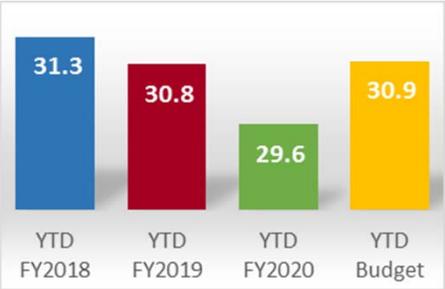
— FY2018 — FY2019 — FY2020 ••• Budget



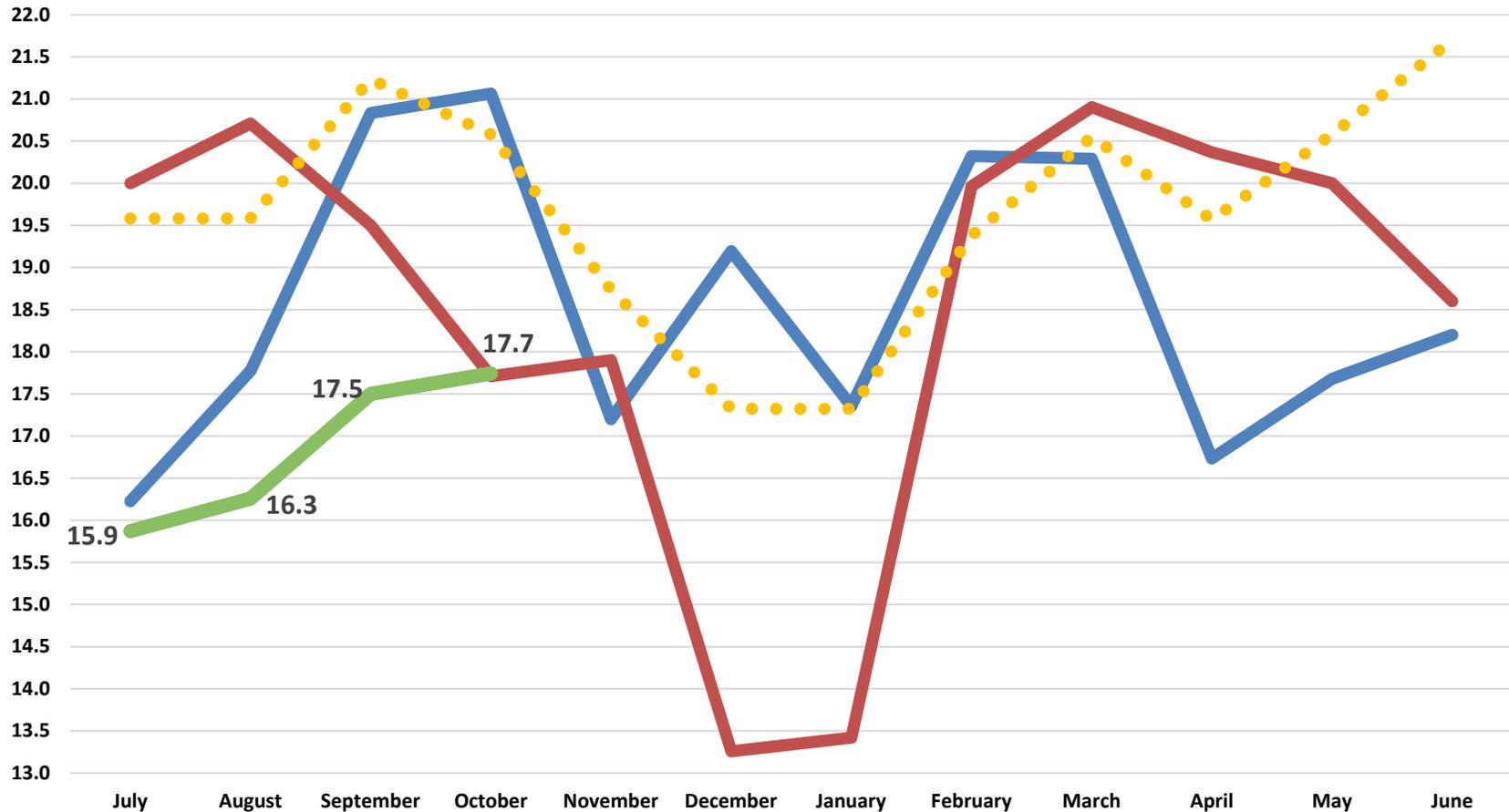
# Sub-Acute - Avg. Patients Per Day



— **FY2018**
— **FY2019**
— **FY2020**
●●● **Budget**



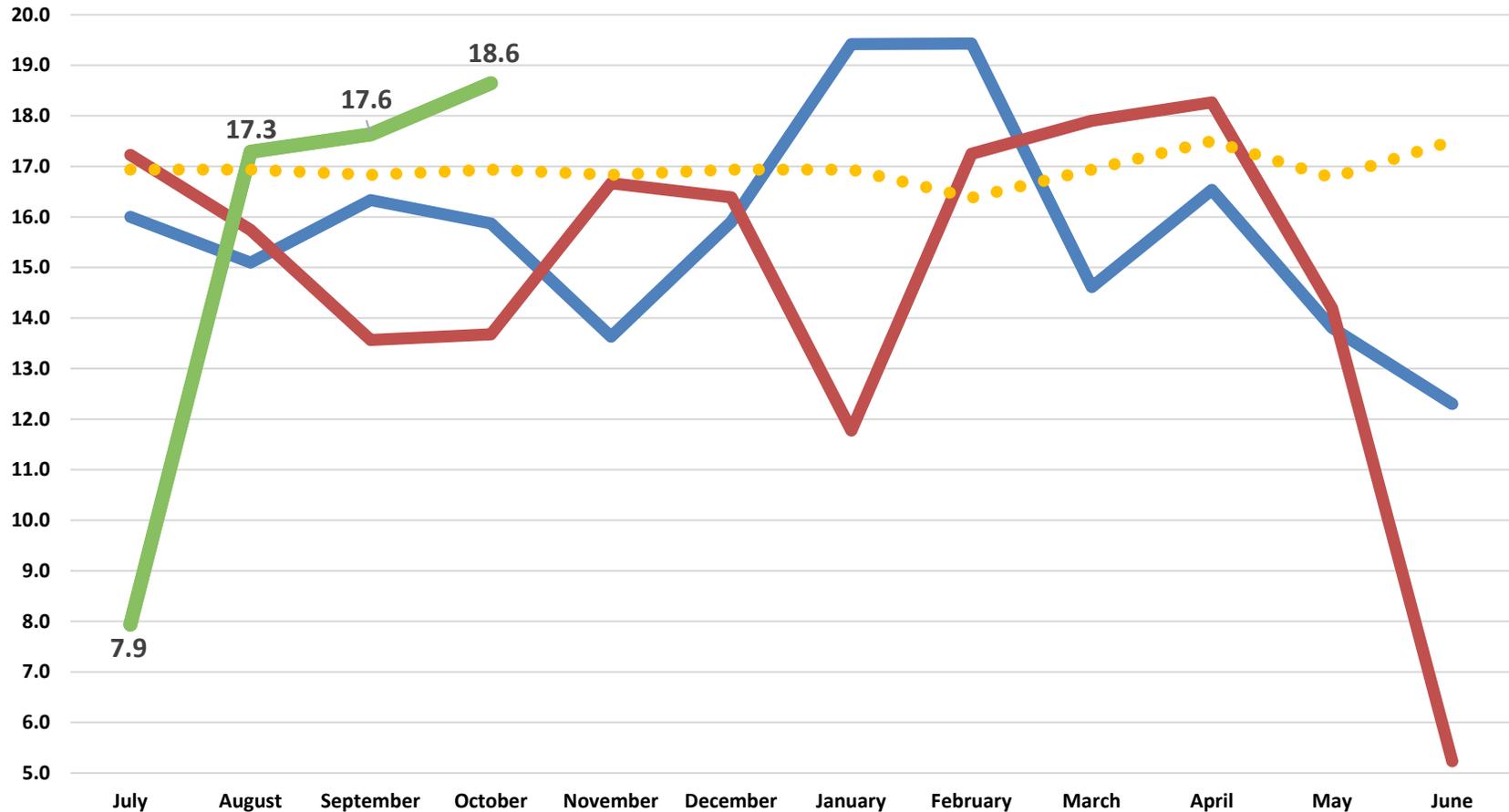
# Rehabilitation Hospital - Avg. Patients Per Day



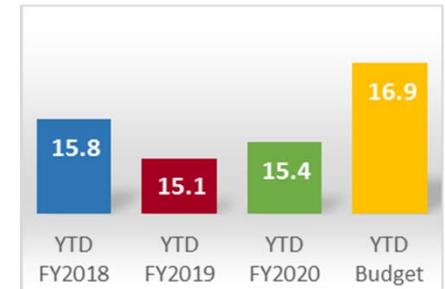
— FY2018 — FY2019 — FY2020 ●●● Budget



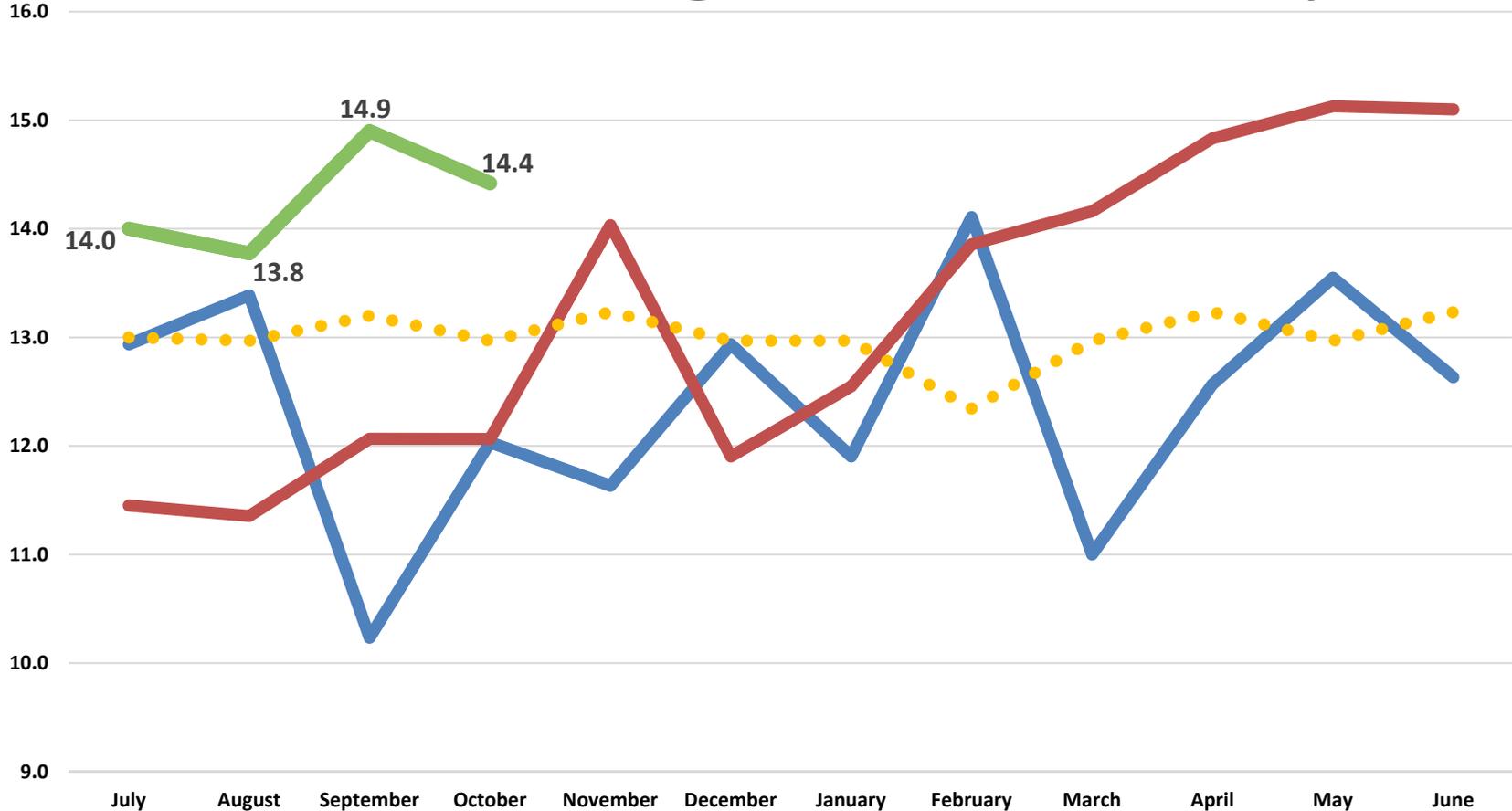
# Transitional Care Services (TCS) - Avg. Patients Per Day



— FY2018 
 — FY2019 
 — FY2020 
 ●●● Budget



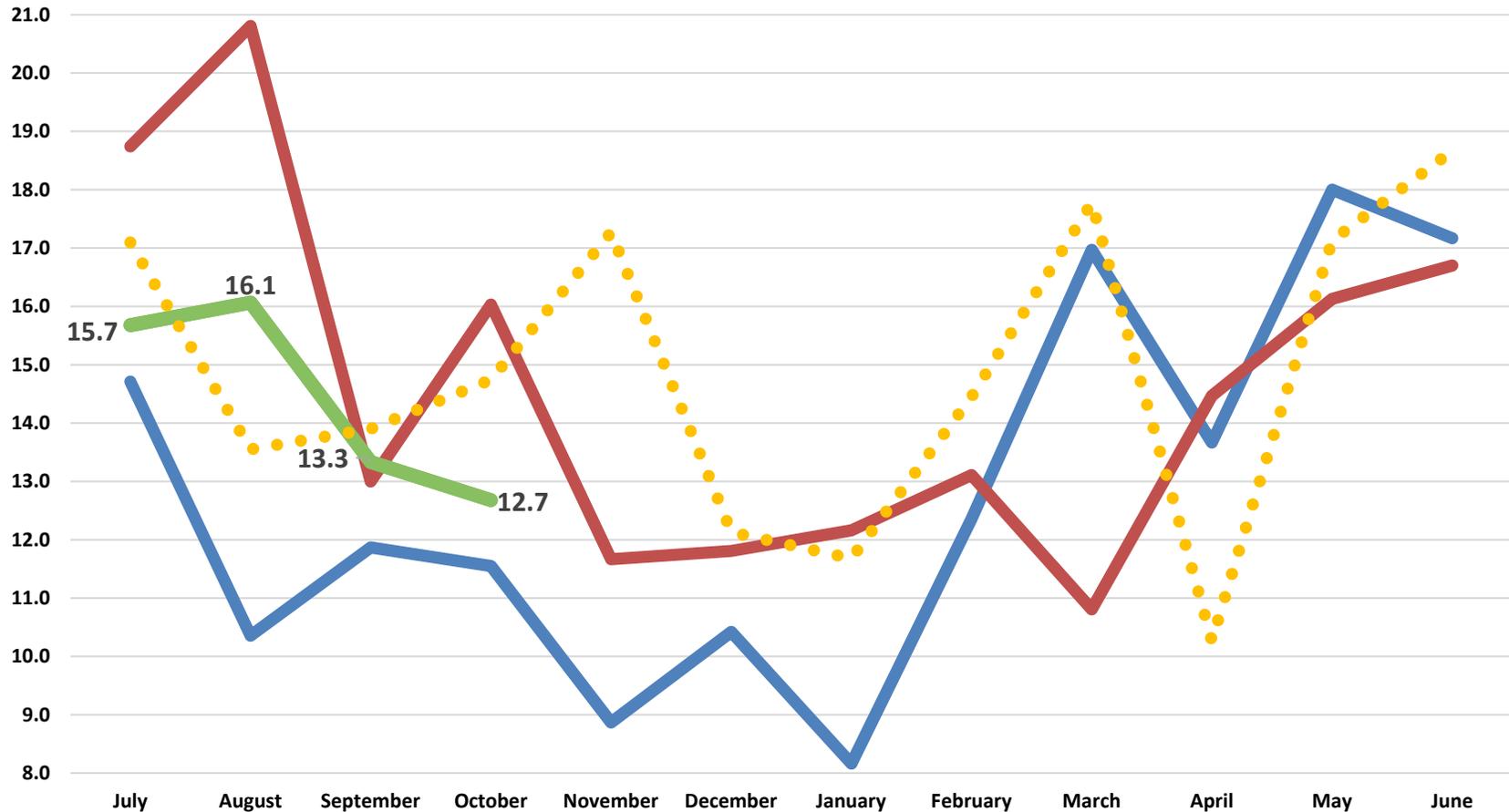
# TCS Ortho - Avg. Patients Per Day



— FY2018 
 — FY2019 
 — FY2020 
 ●●● Budget



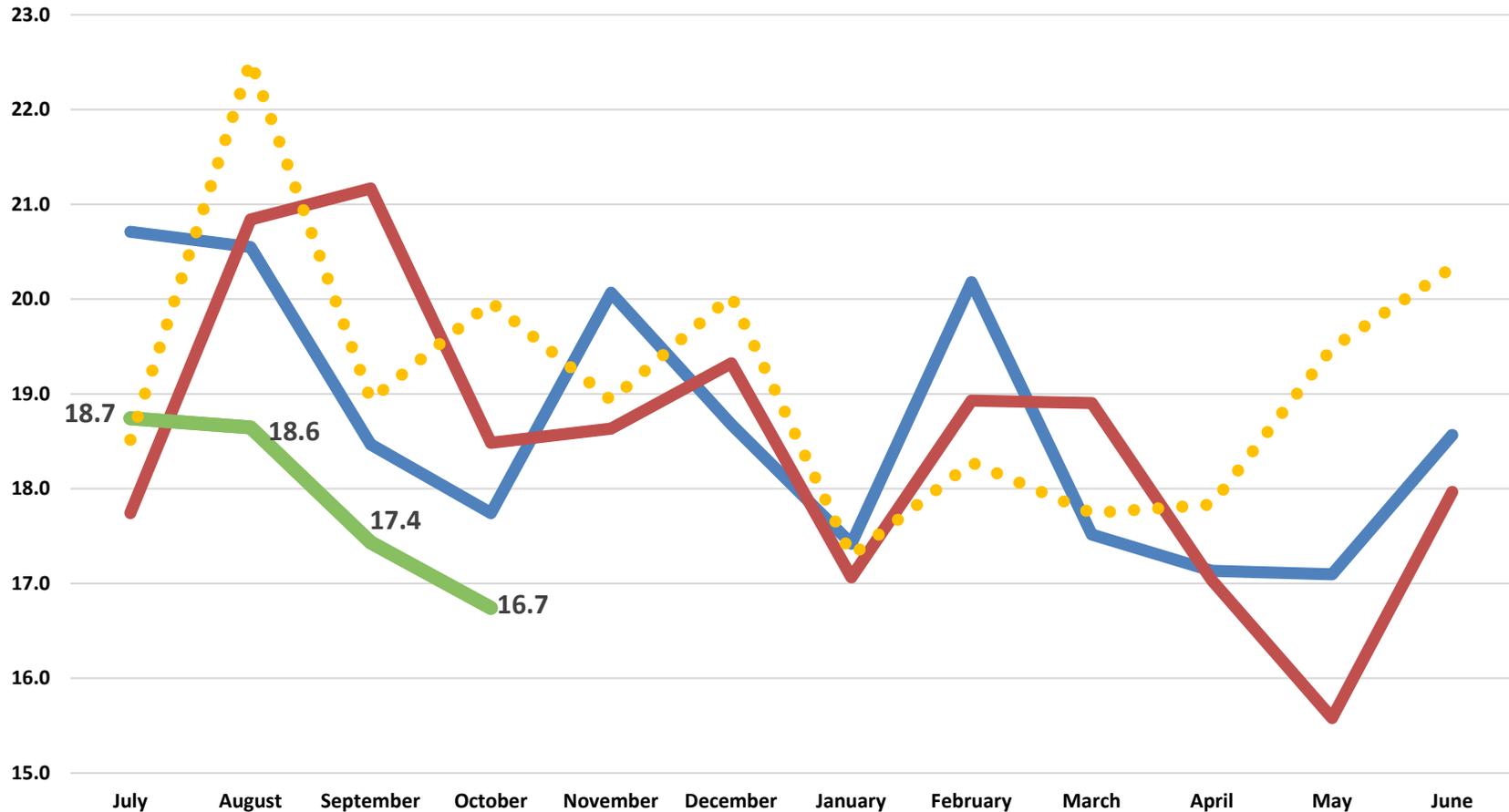
# NICU - Avg. Patients Per Day



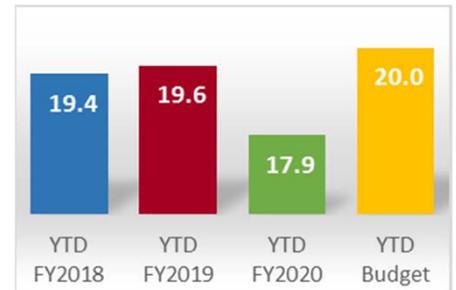
— FY2018 
 — FY2019 
 — FY2020 
 ••• Budget



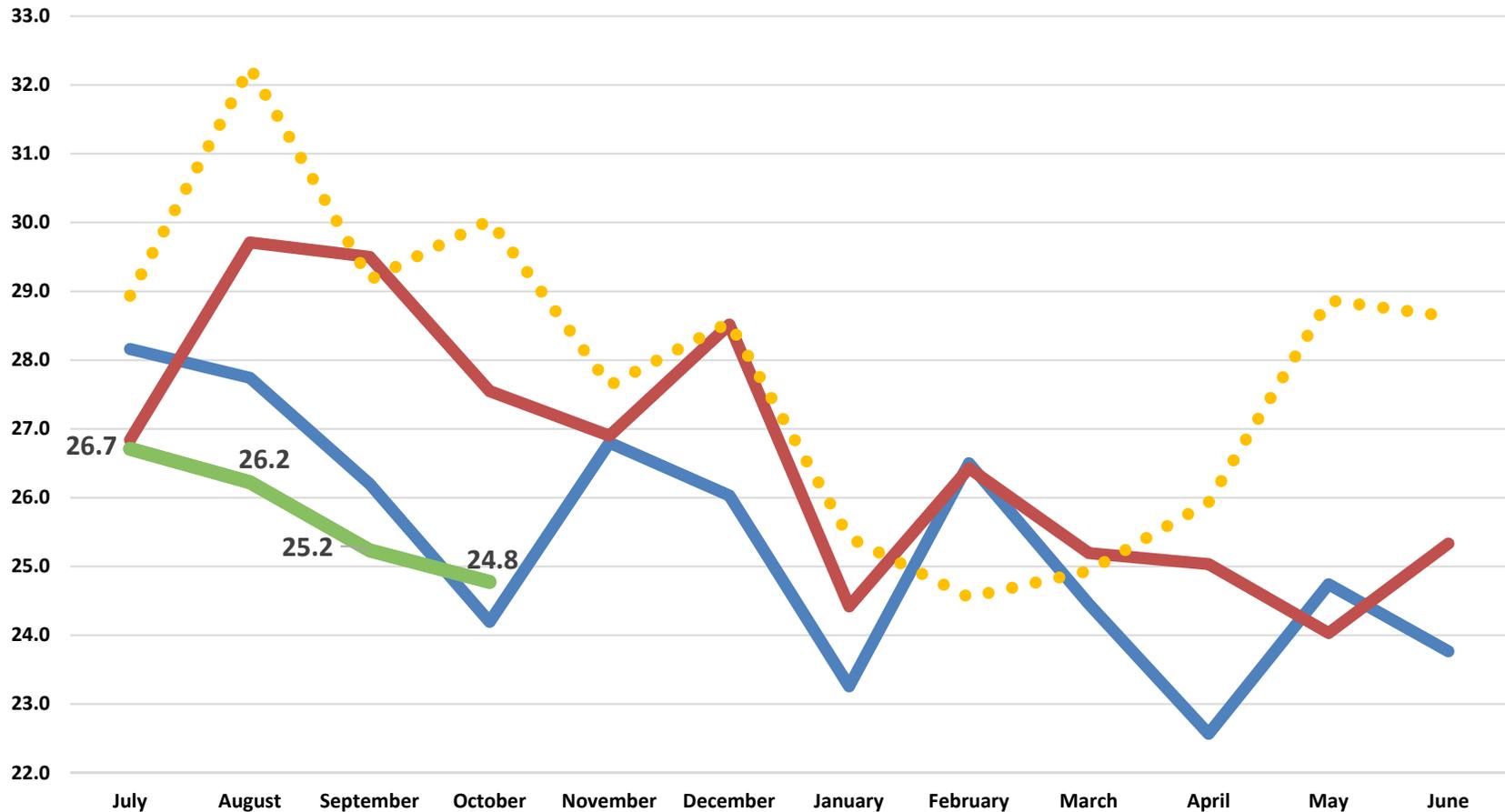
# Nursery - Avg. Patients Per Day



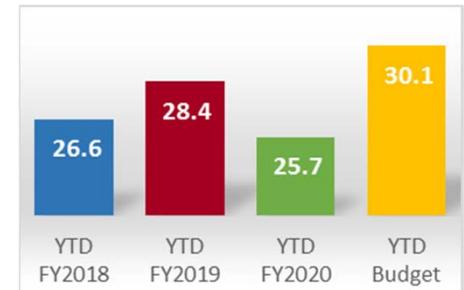
— FY2018 
 — FY2019 
 — FY2020 
 ••• Budget



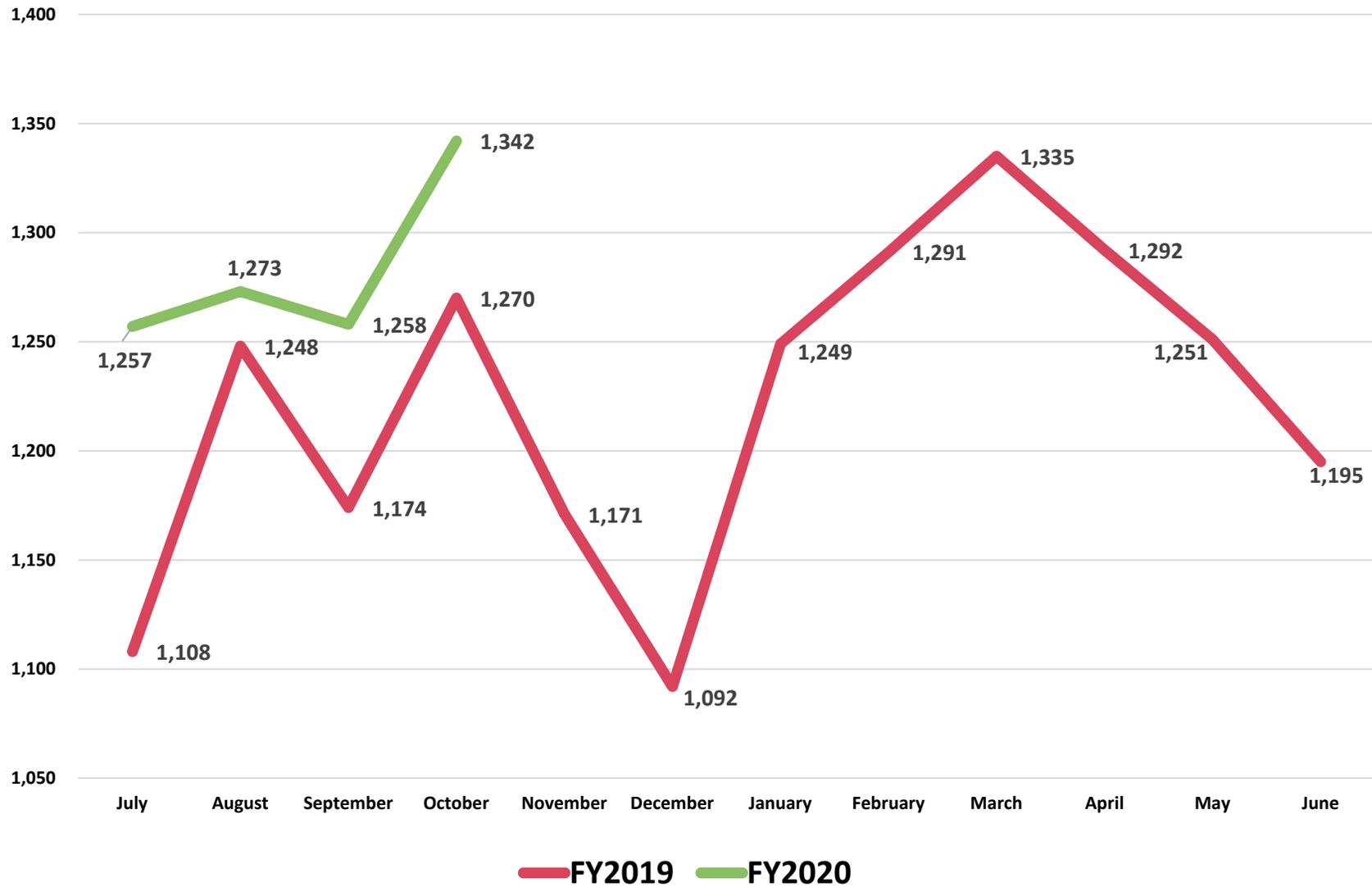
# Obstetrics - Avg. Patients Per Day



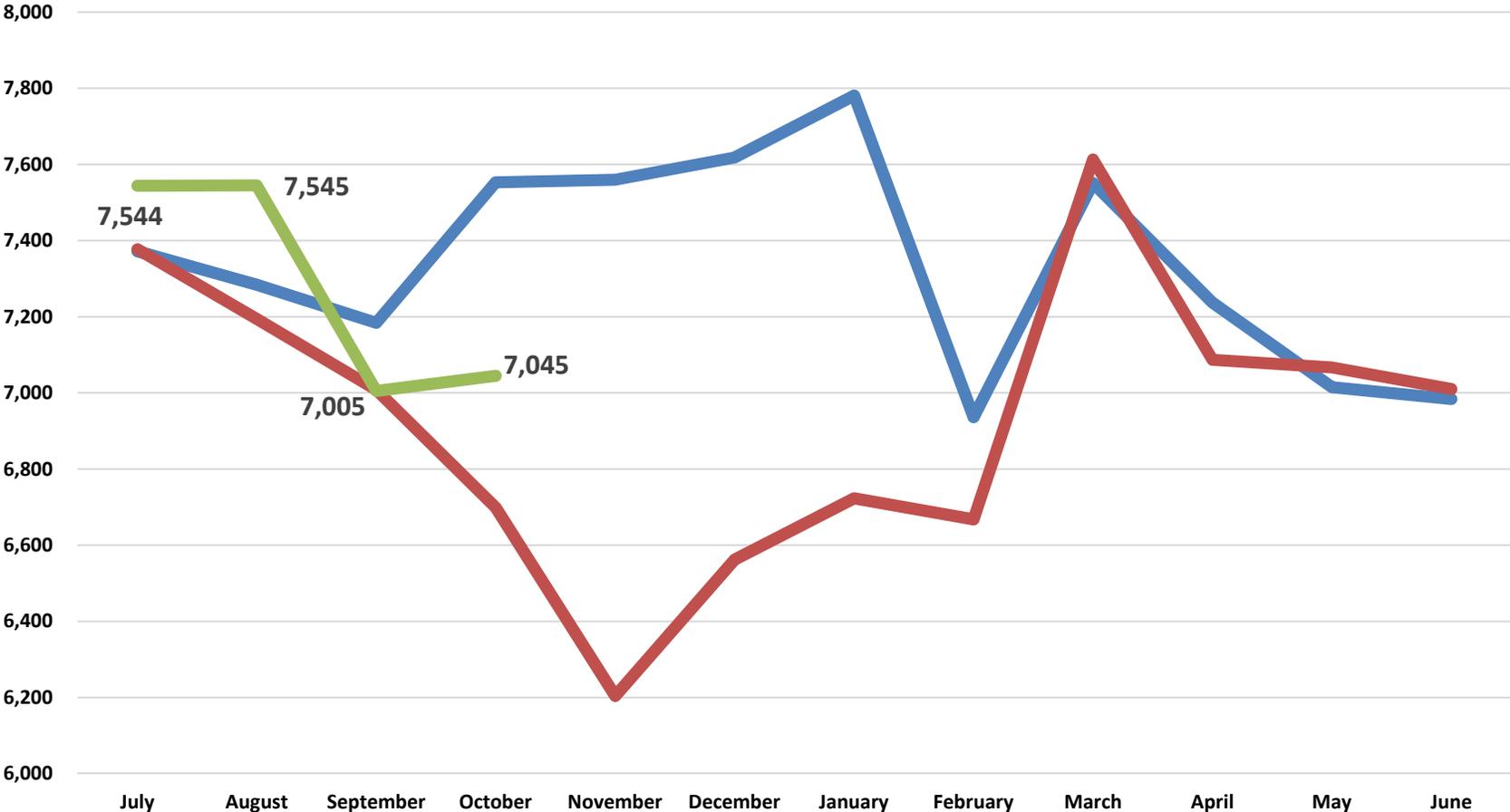
— FY2018 
 — FY2019 
 — FY2020 
 ••• Budget



# Outpatient Registrations per Day



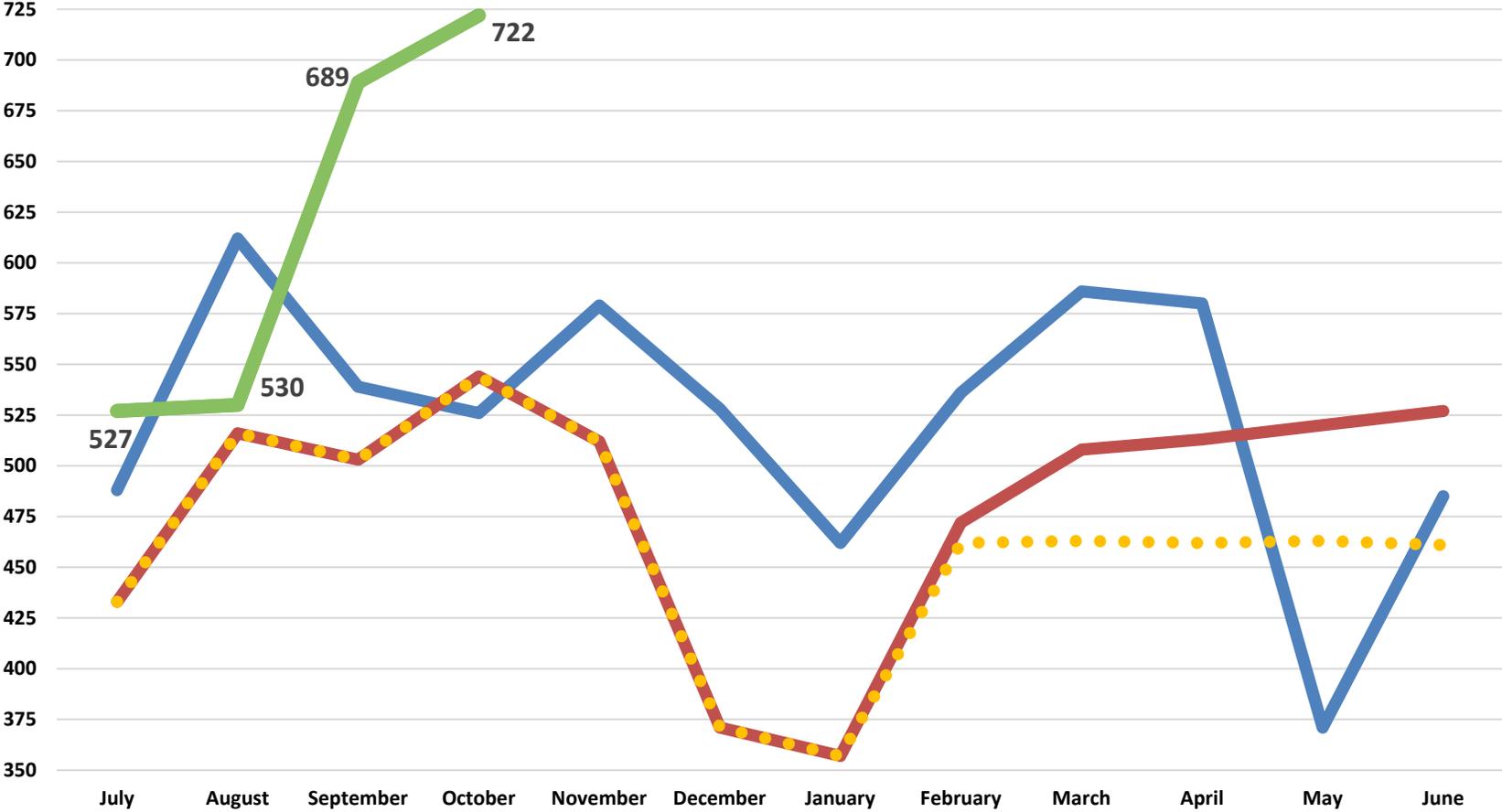
# Emergency Department – Total Treated



— FY2018 — FY2019 — FY2020



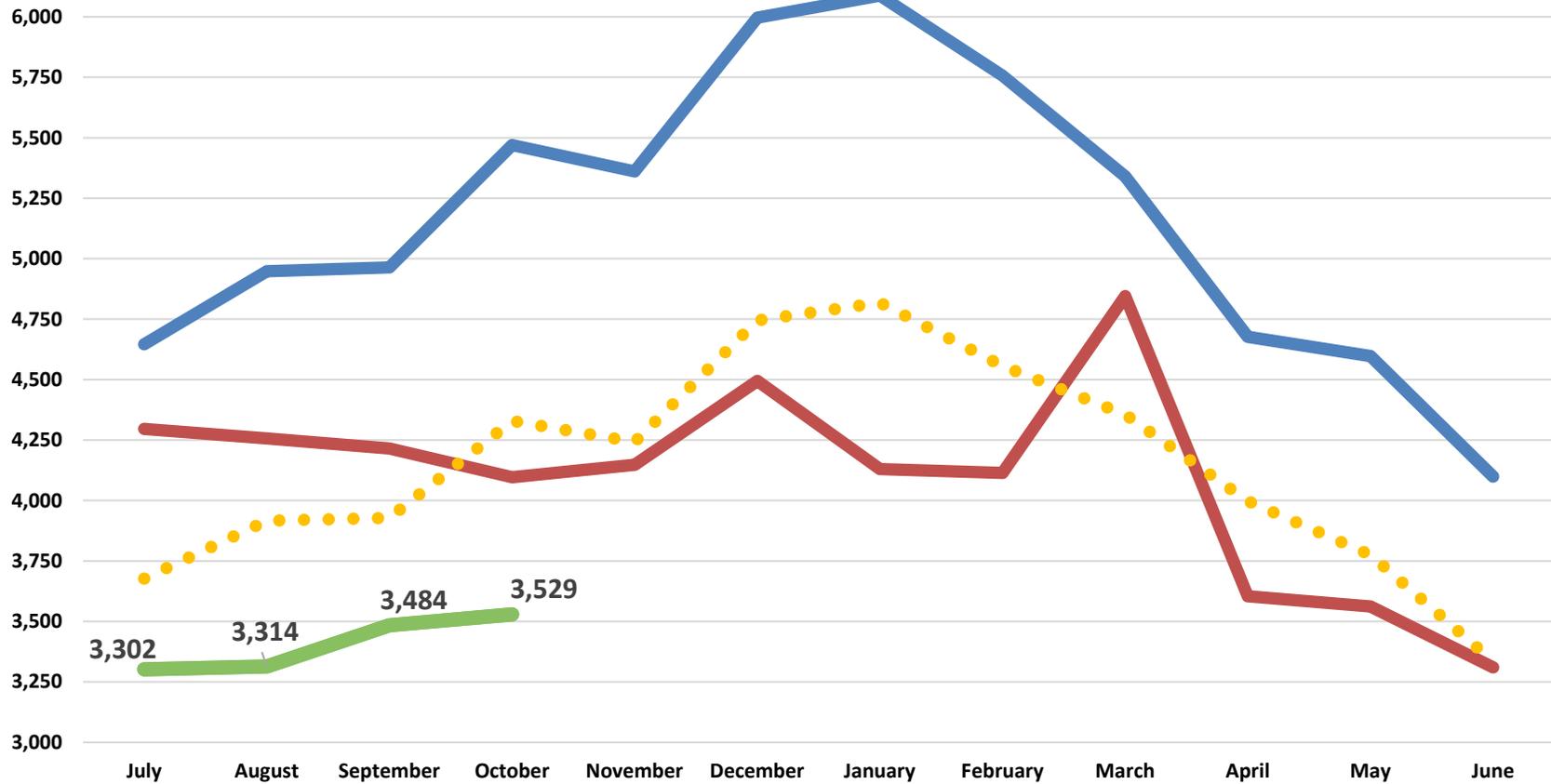
# Endoscopy Procedures



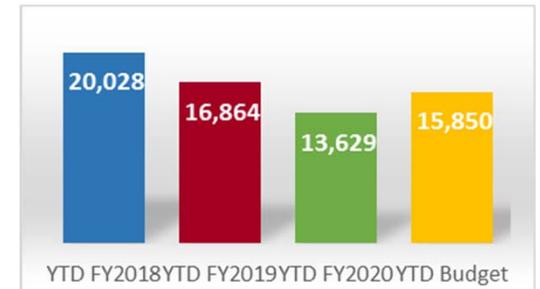
— FY2018 
 — FY2019 
 — FY2020 
 ●●●● Budget



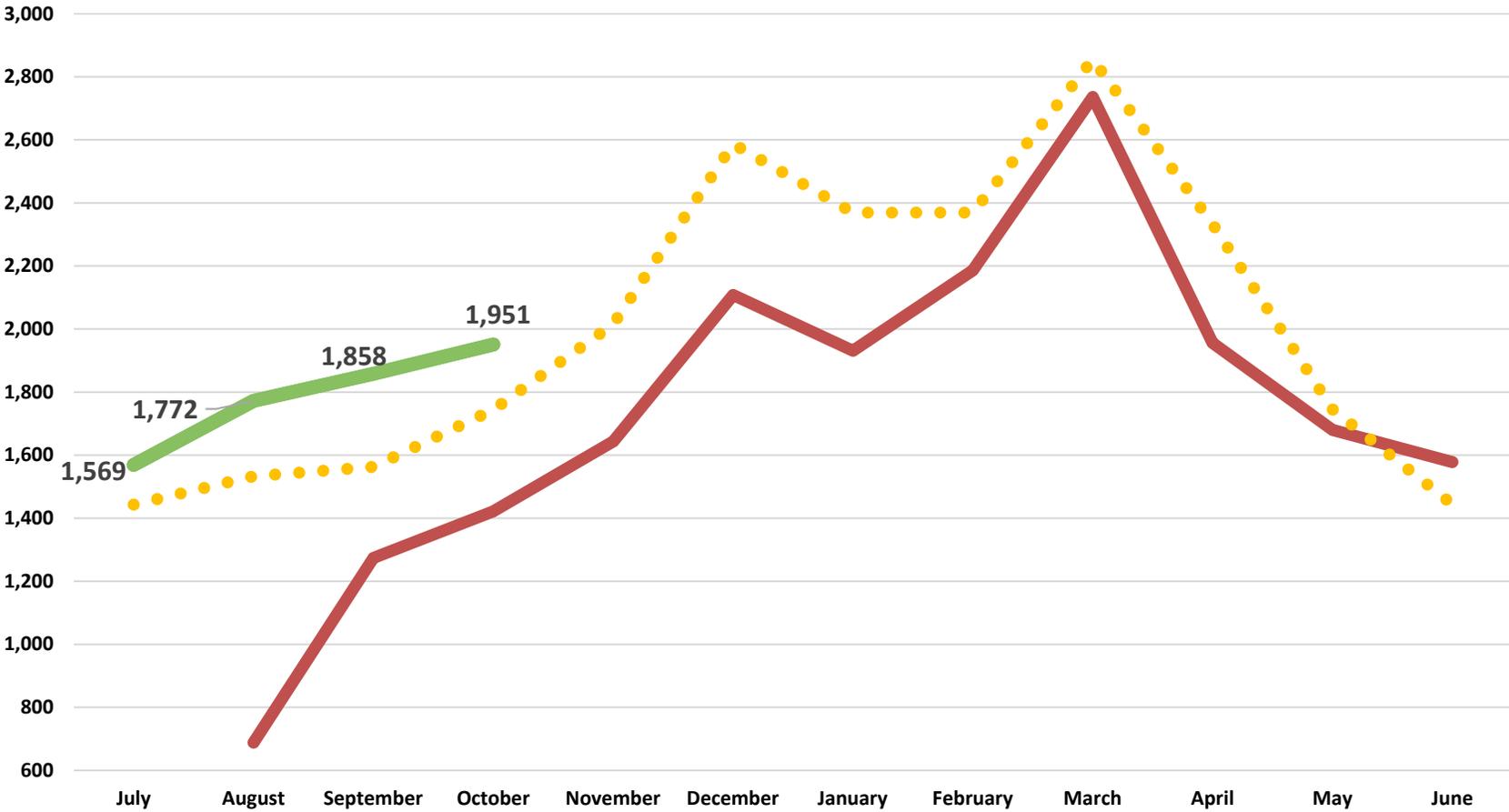
# Urgent Care – Court Visits



— **FY2018**
— **FY2019**
— **FY2020**
●●● **Budget**



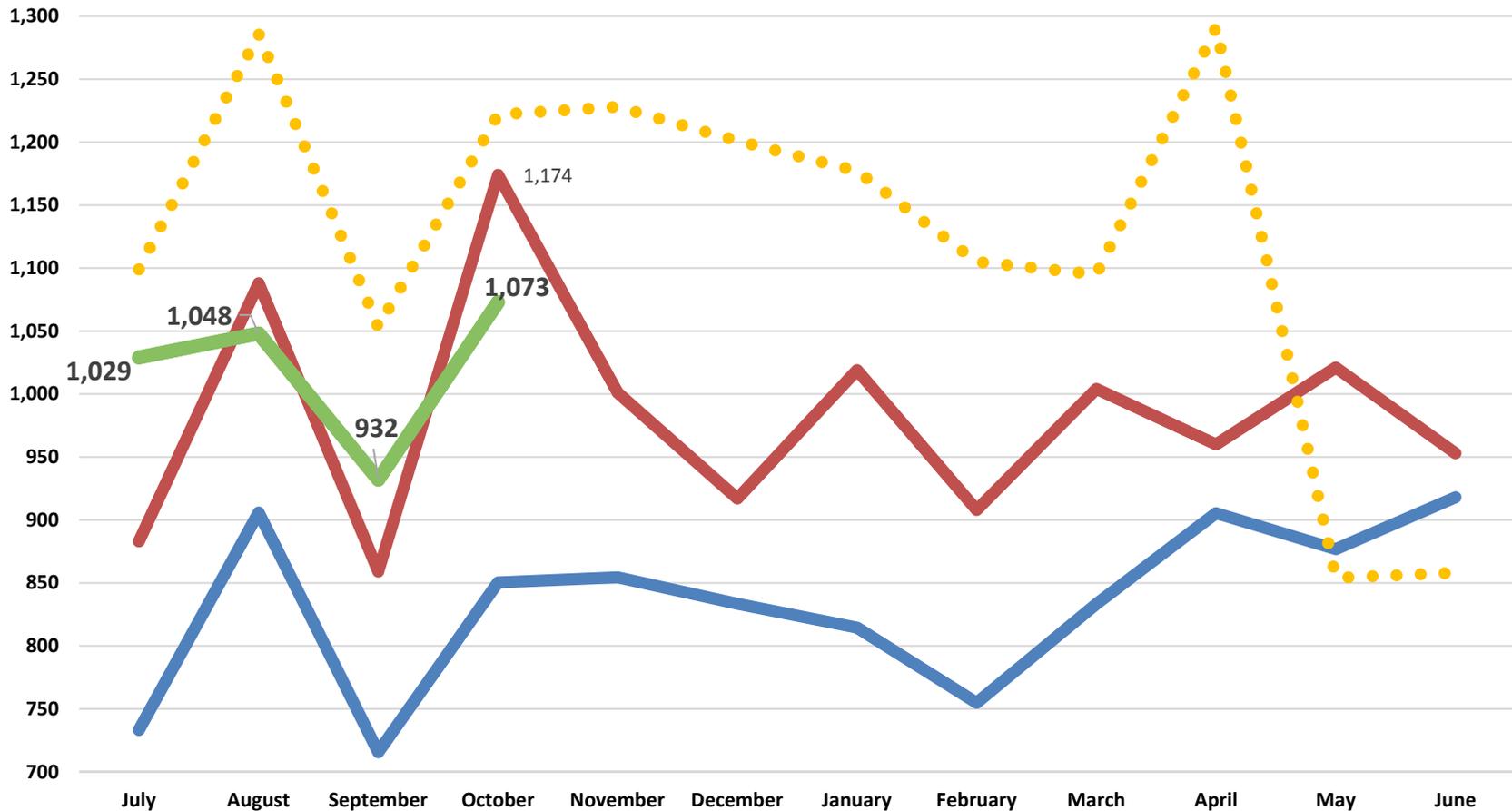
# Urgent Care – Demaree Visits



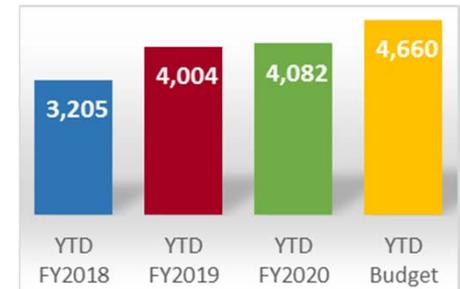
— **FY2018**  
 — **FY2019**  
 — **FY2020**  
 ●●● **Budget**



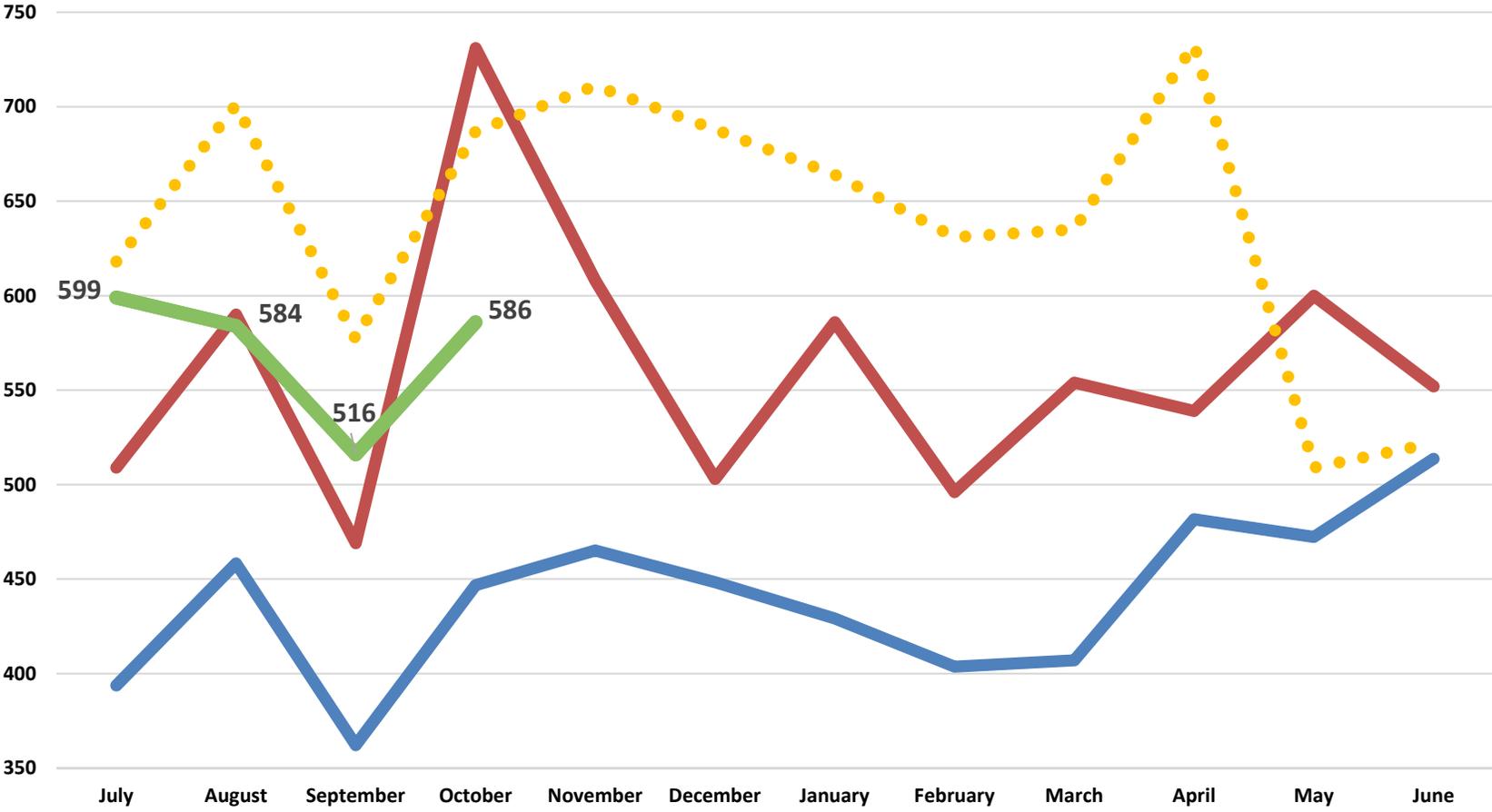
# Surgery (IP & OP) – 100 Min Units



— FY2018 — FY2019 — FY2020 ••• Budget



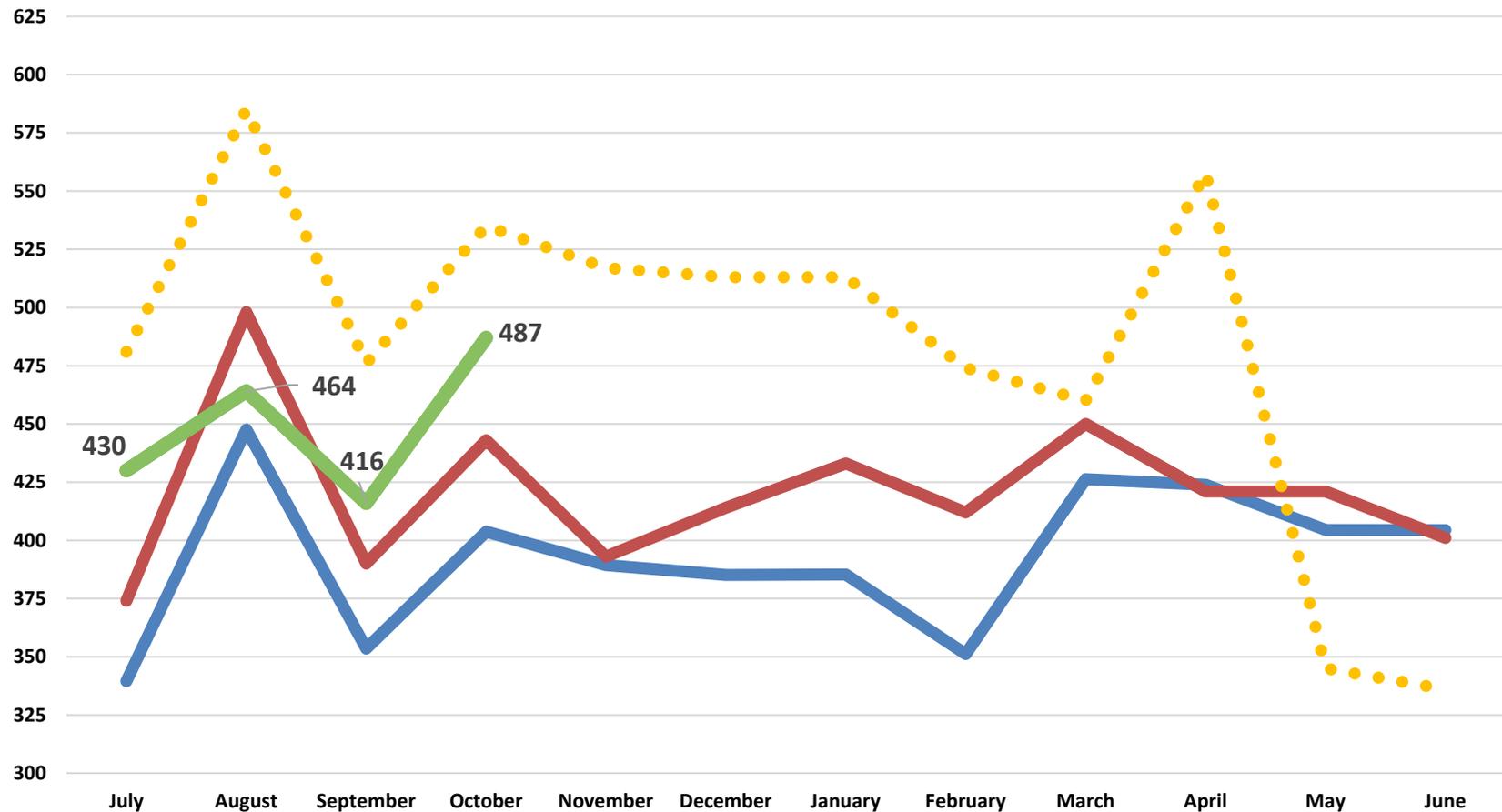
# Surgery (IP Only) – 100 Min Units



— FY2018 
 — FY2019 
 — FY2020 
 ●●● Budget



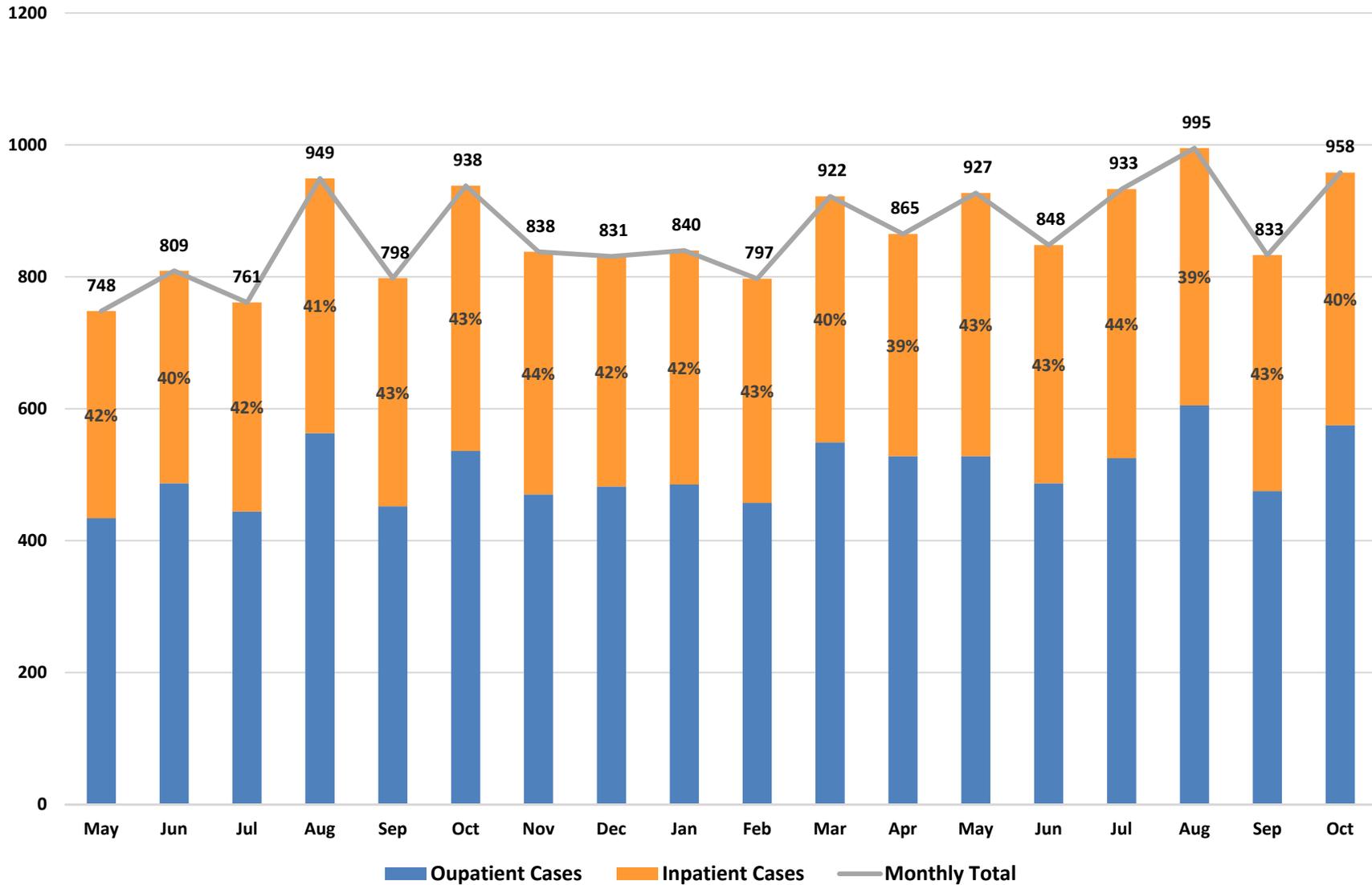
# Surgery (OP Only) – 100 Min Units



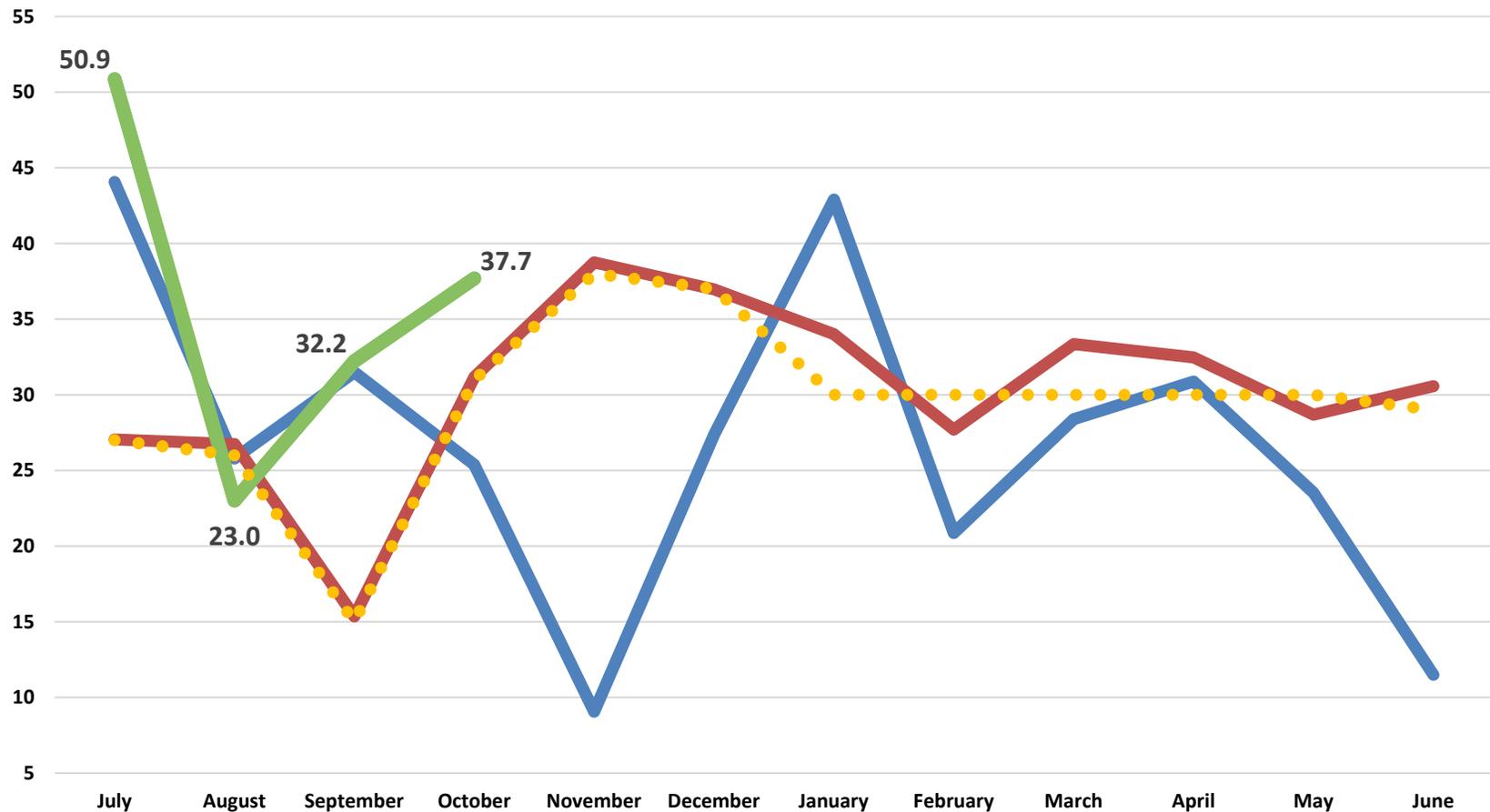
— FY2018 
 — FY2019 
 — FY2020 
 ●● Budget



# Surgery (IP & OP) - Cases



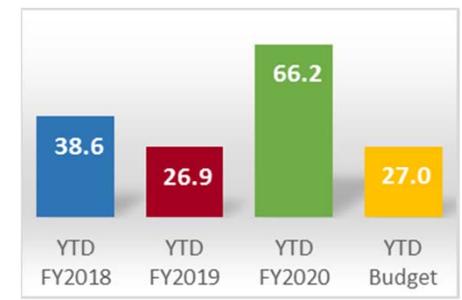
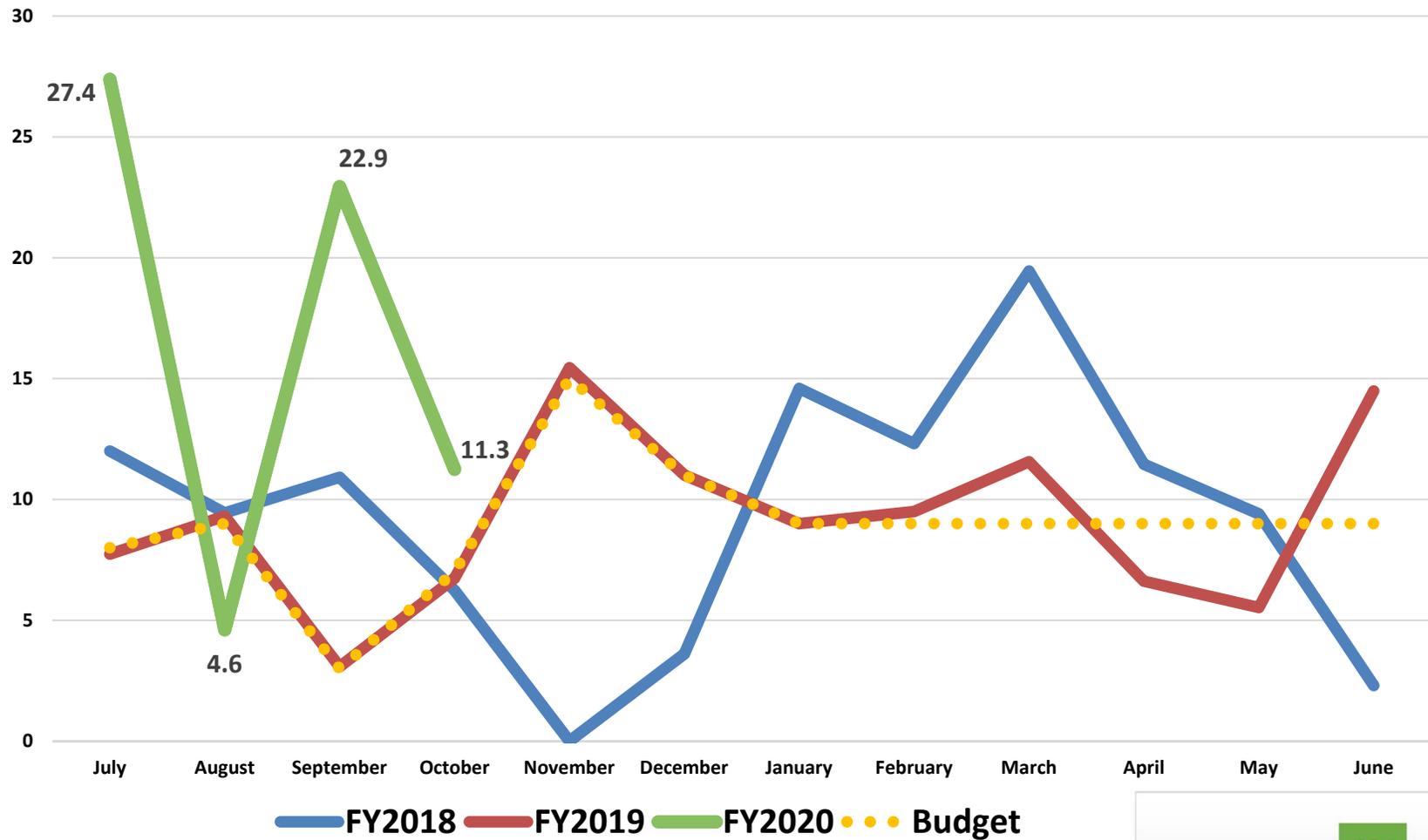
# Robotic Surgery (IP & OP) – 100 Min Units



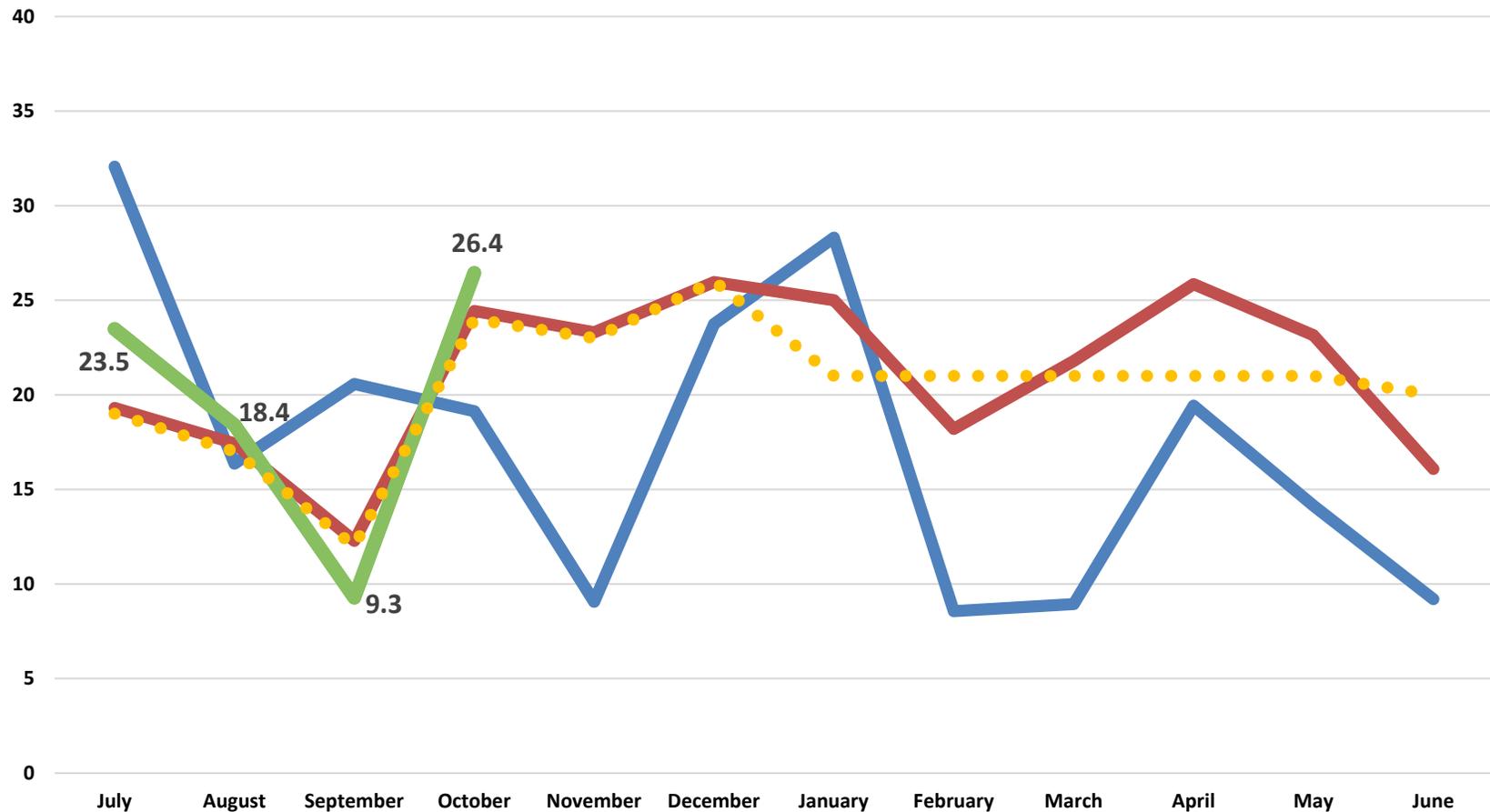
— FY2018 
 — FY2019 
 — FY2020 
 ●●● Budget



# Robotic Surgery (IP Only) – 100 Min Units



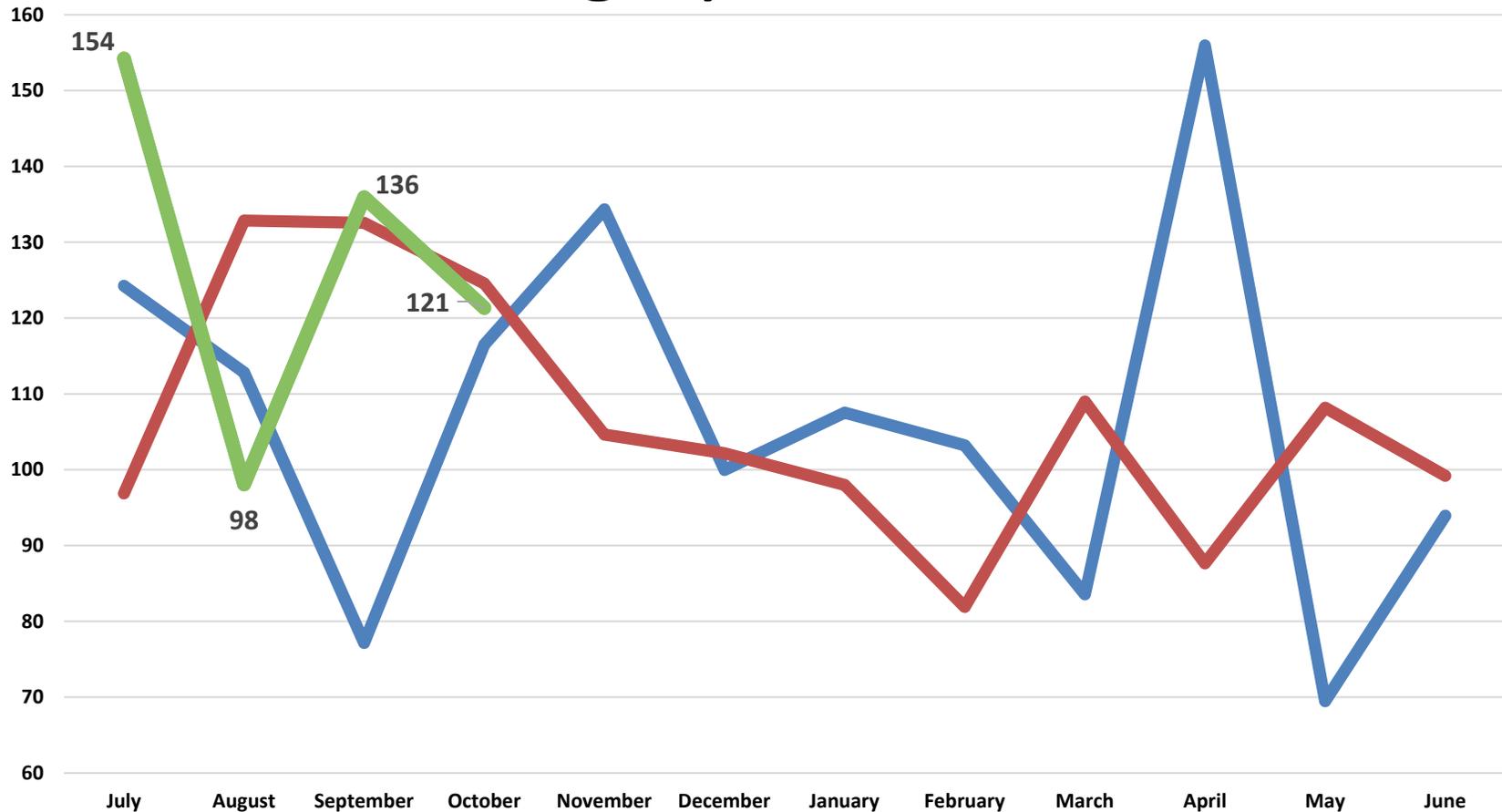
# Robotic Surgery (OP Only) – 100 Min Units



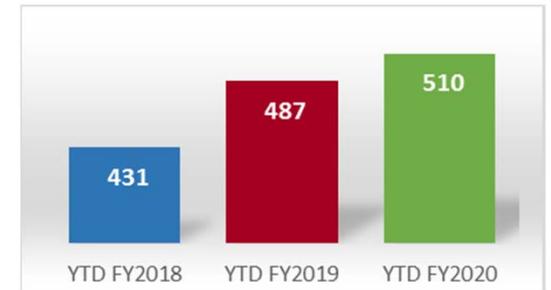
— FY2018 
 — FY2019 
 — FY2020 
 ●●● Budget



# Cardiac Surgery – 100 Min Units

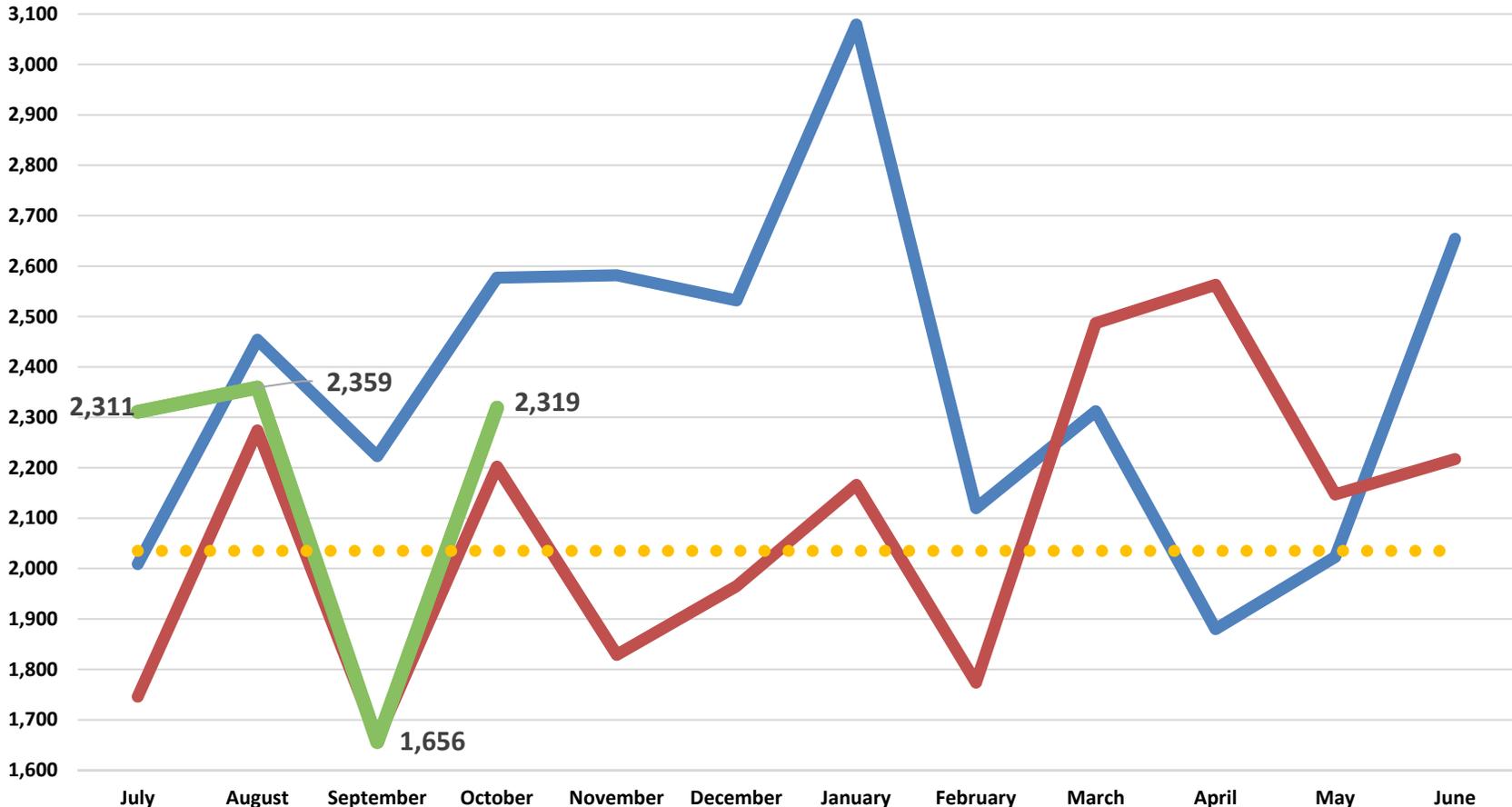


— FY2018 — FY2019 — FY2020

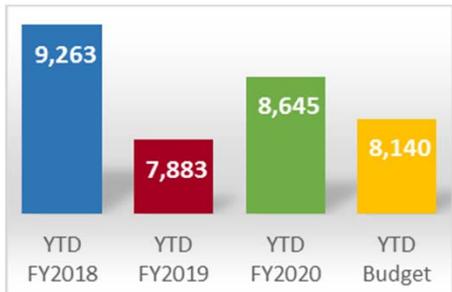


# Radiation Oncology Treatments

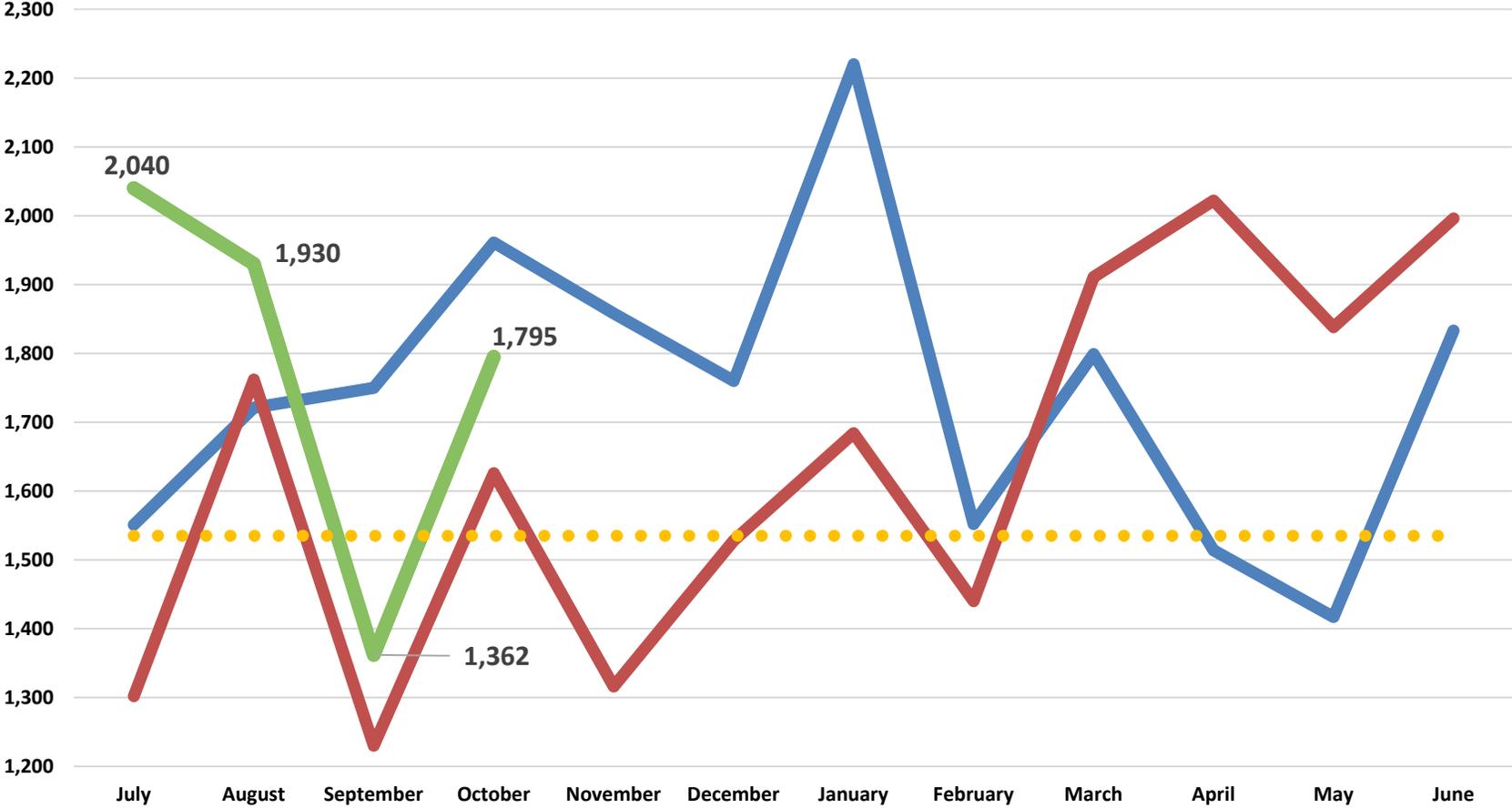
## Hanford and Visalia



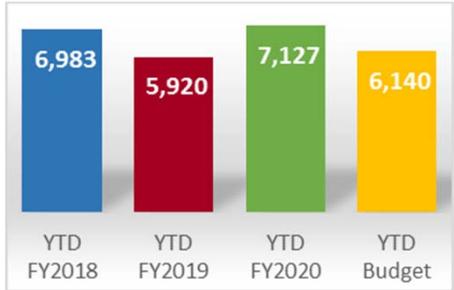
— FY2018 
 — FY2019 
 — FY2020 
 ●●● Budget



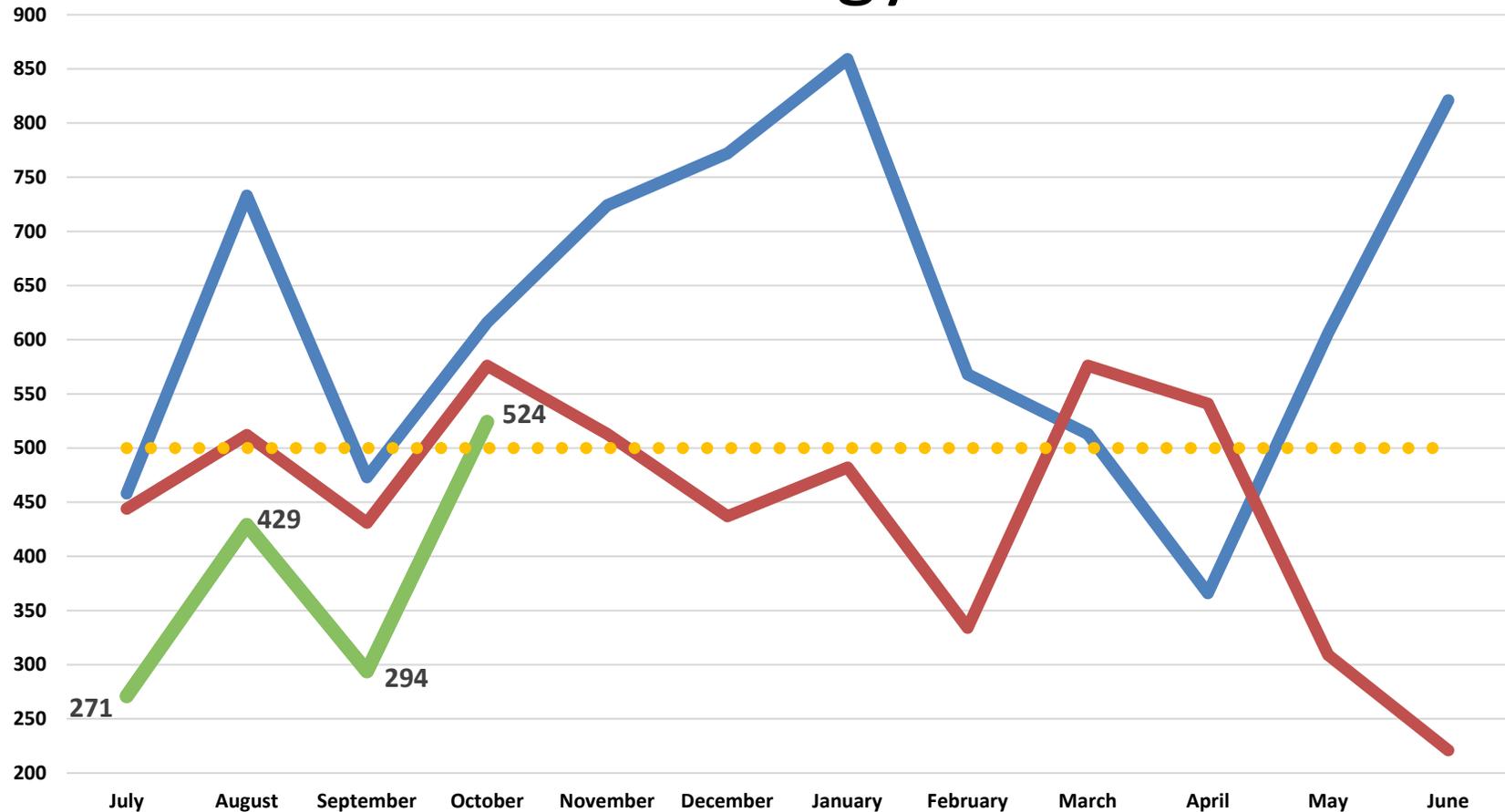
# Radiation Oncology - Visalia



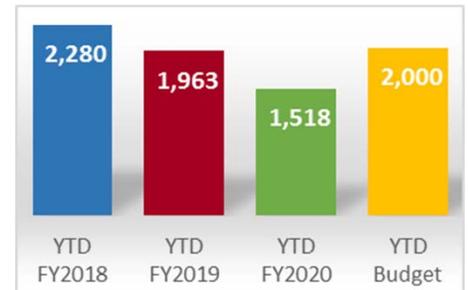
— FY2018 
 — FY2019 
 — FY2020 
 ●●● Budget



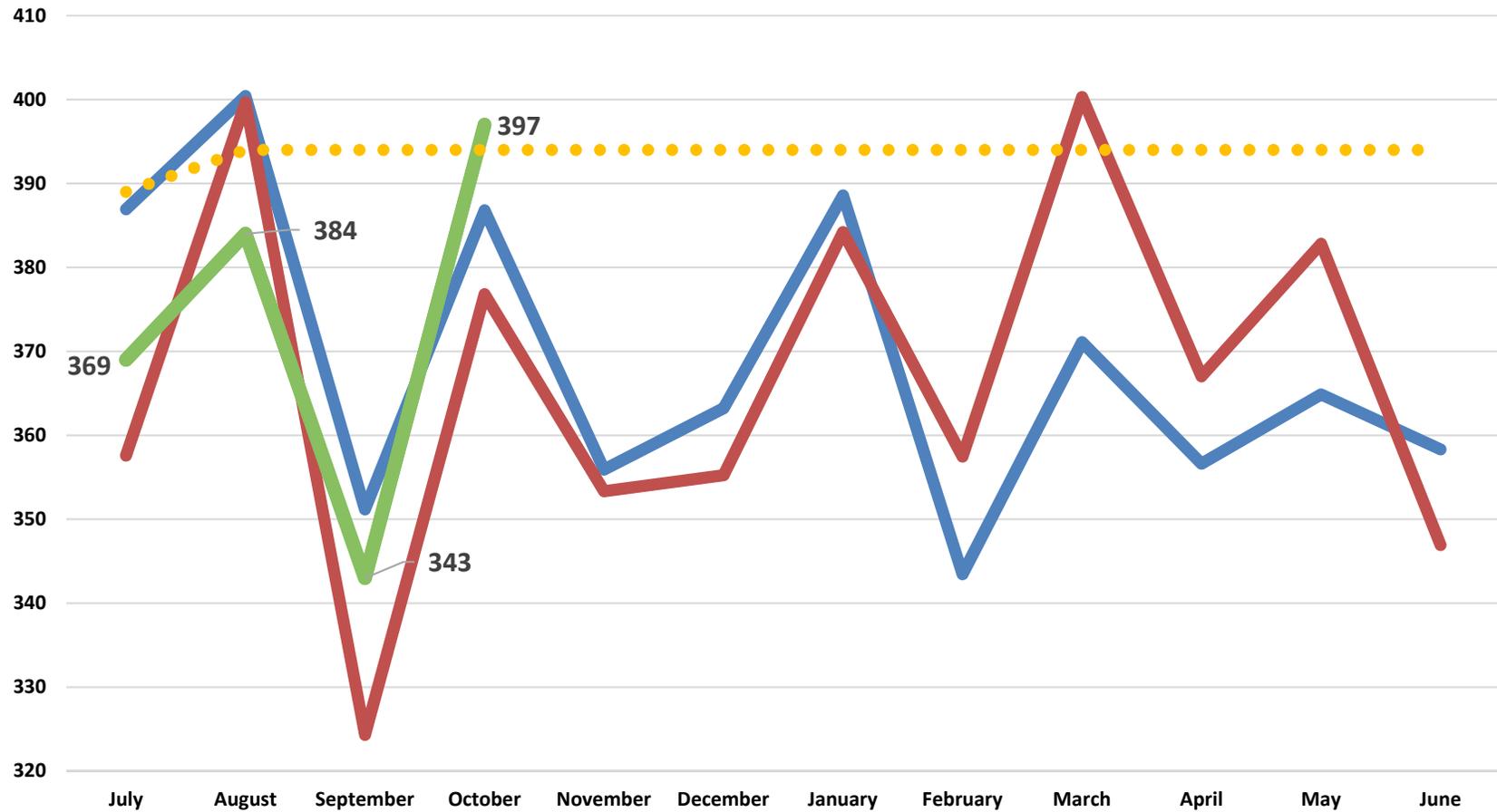
# Radiation Oncology - Hanford



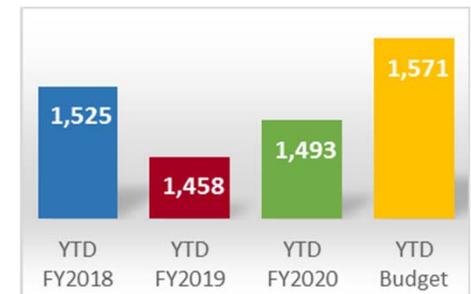
— FY2018 
 — FY2019 
 — FY2020 
 ●● Budget



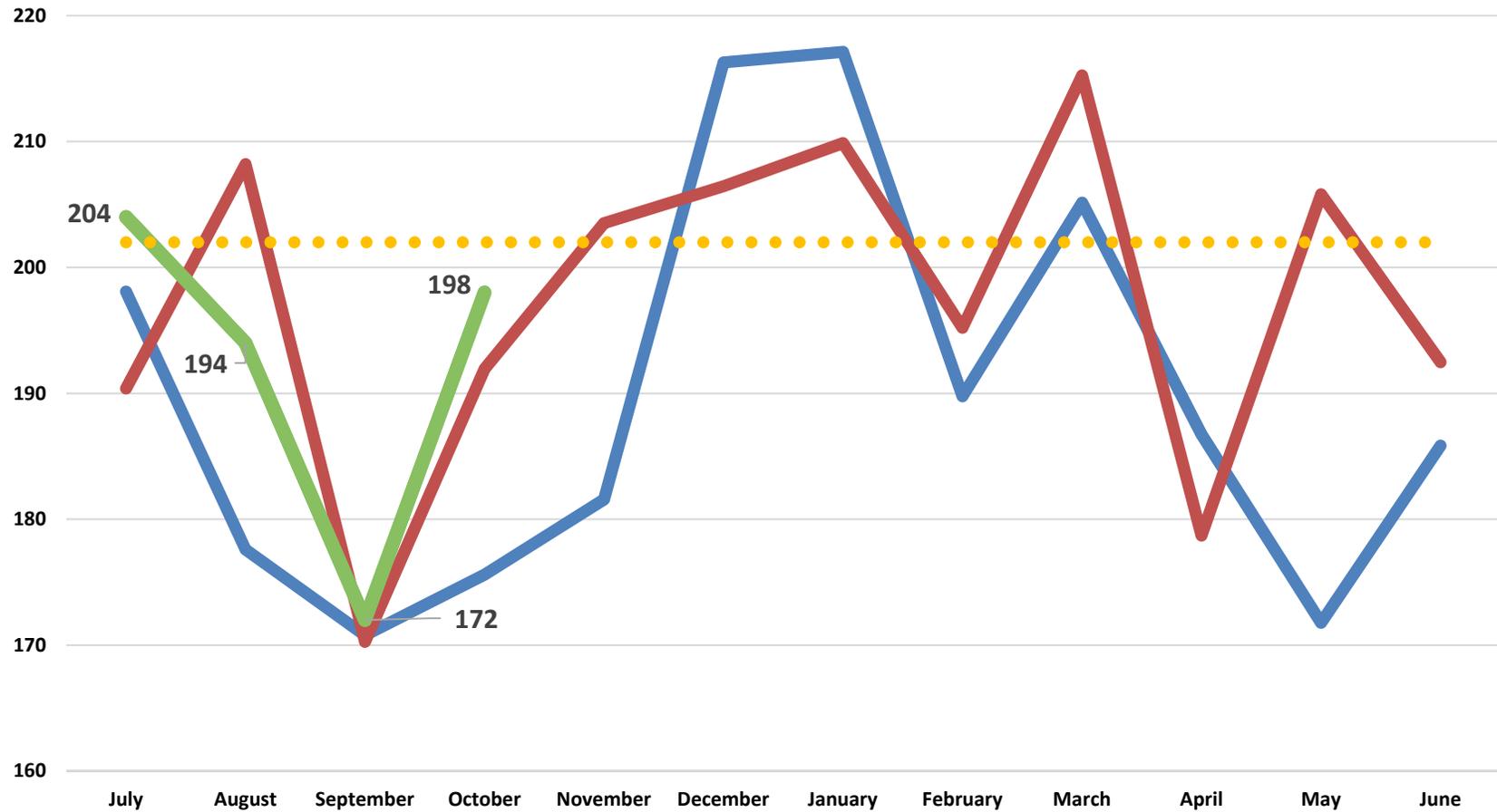
# Cath Lab (IP & OP) – 100 Min Units



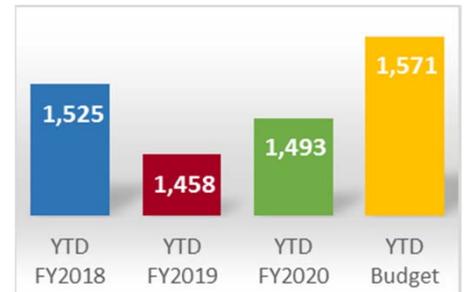
— FY2018 — FY2019 — FY2020 ●●● Budget



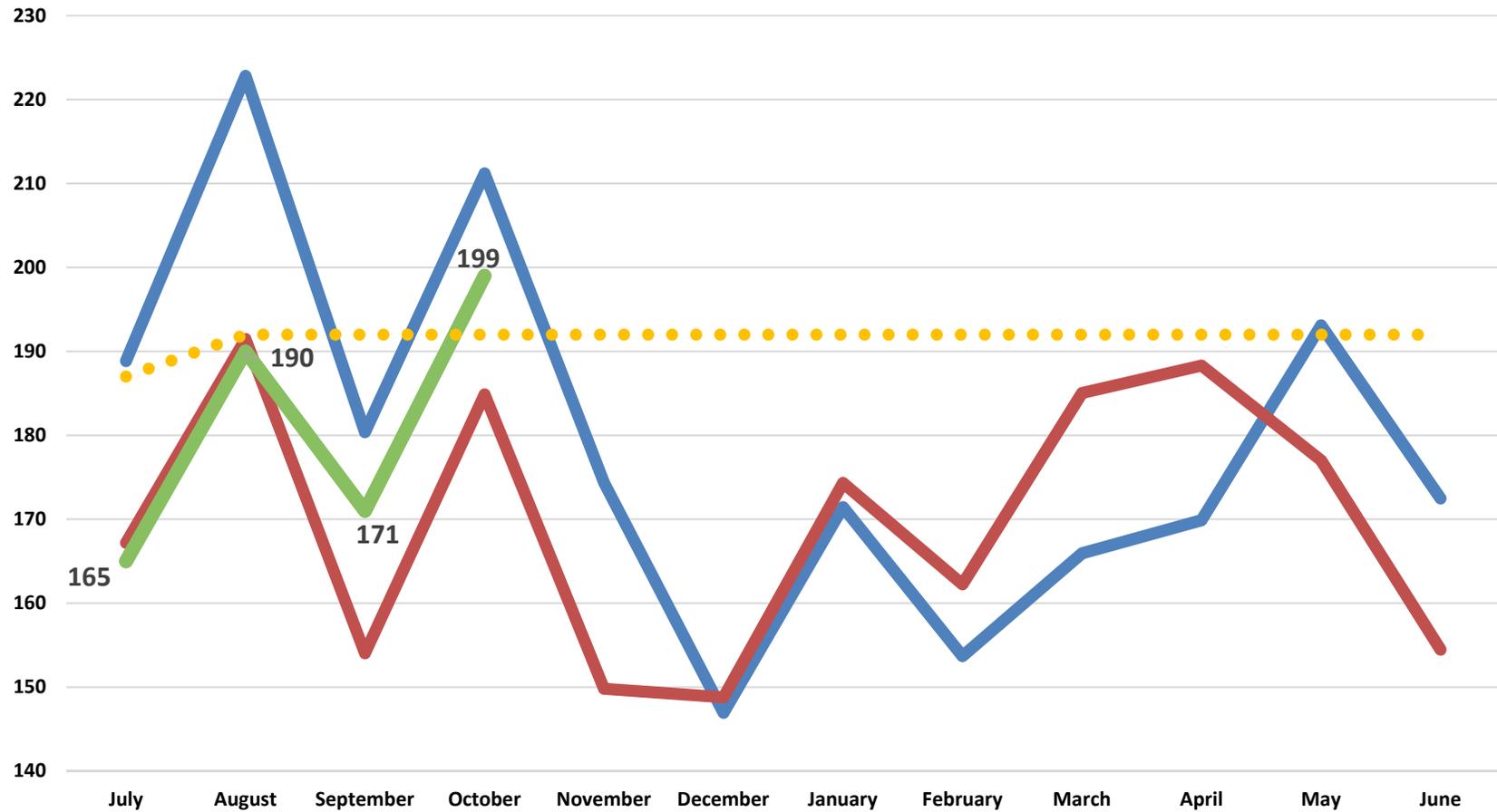
# Cath Lab (IP Only) – 100 Min Units



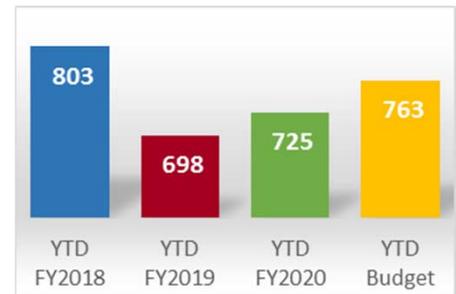
— FY2018 
 — FY2019 
 — FY2020 
 ●●● Budget



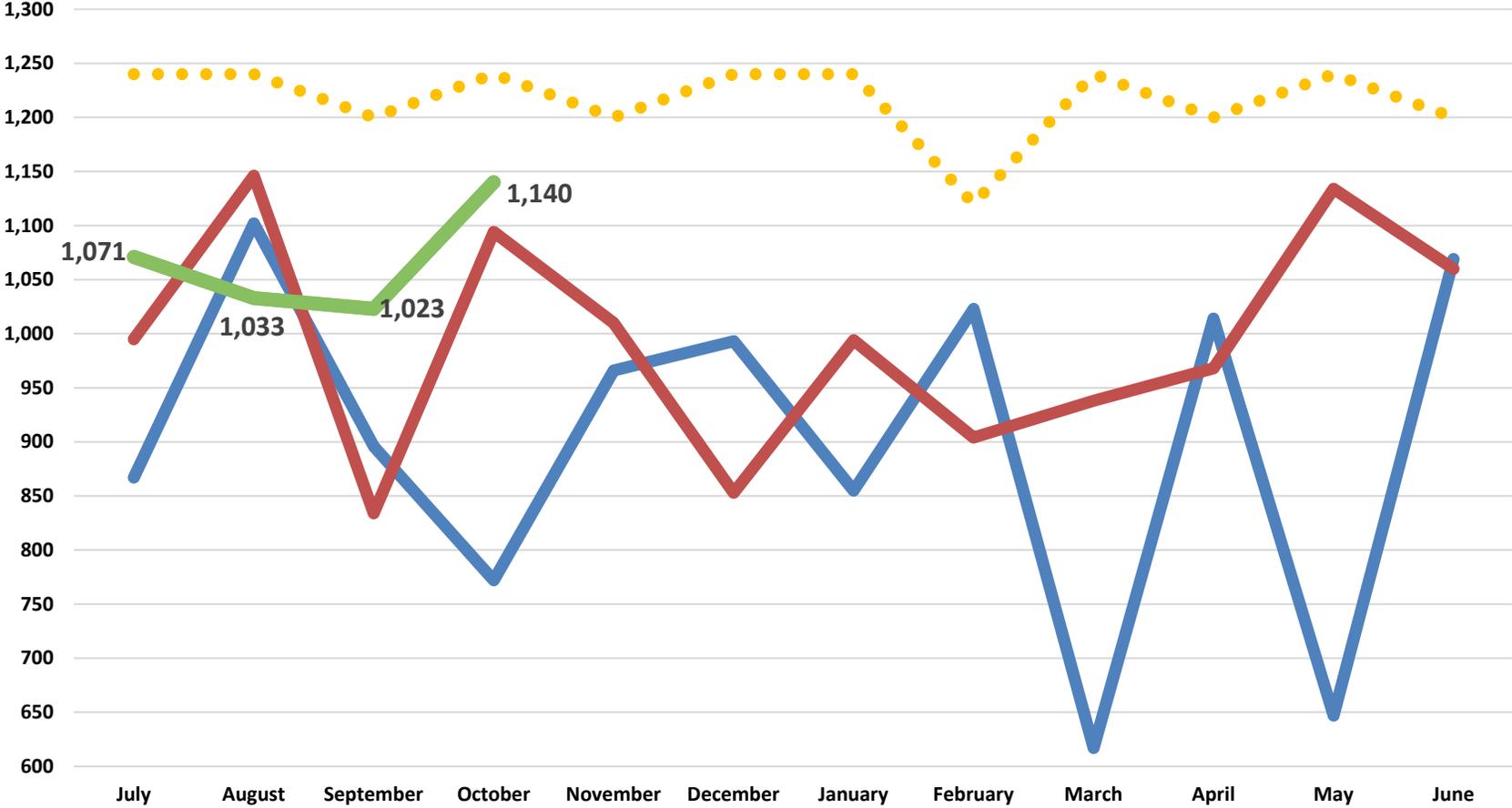
# Cath Lab (OP Only) – 100 Min Units



— FY2018 
 — FY2019 
 — FY2020 
 ●●● Budget



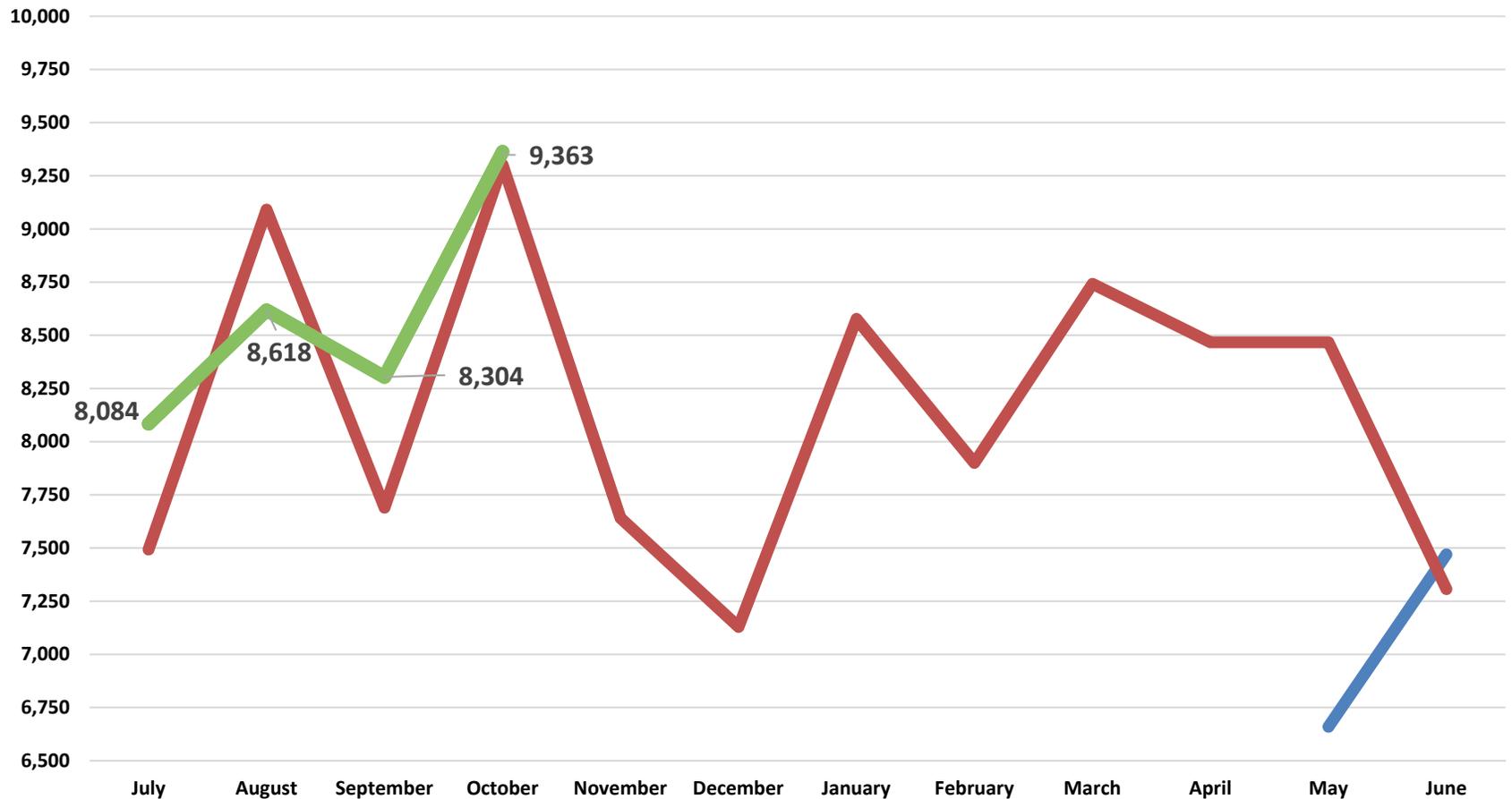
# GME Family Medicine Clinic Visits



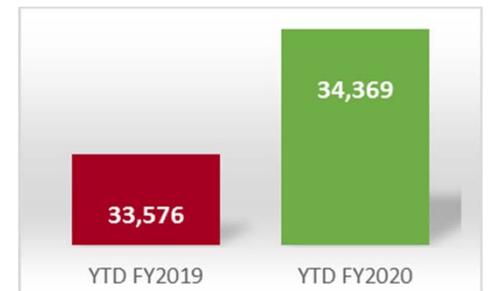
— FY2018 
 — FY2019 
 — FY2020 
 ●● Budget



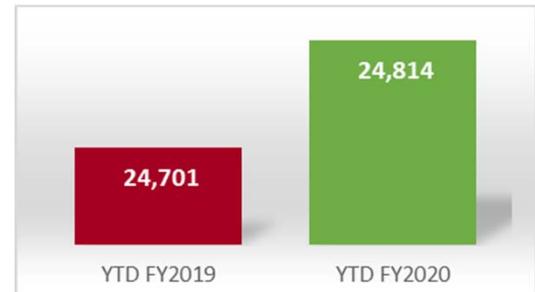
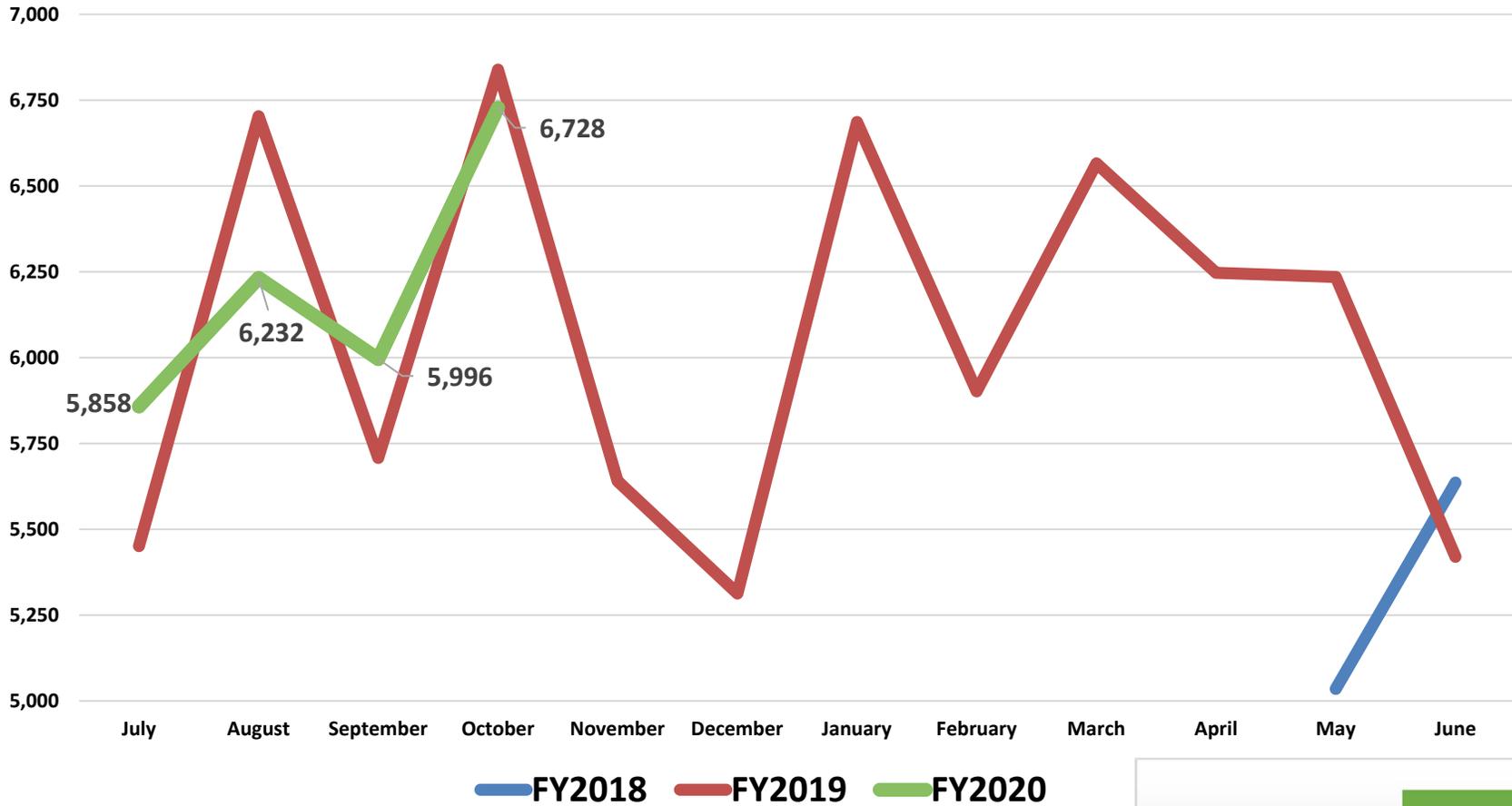
# Rural Health Clinic Registrations



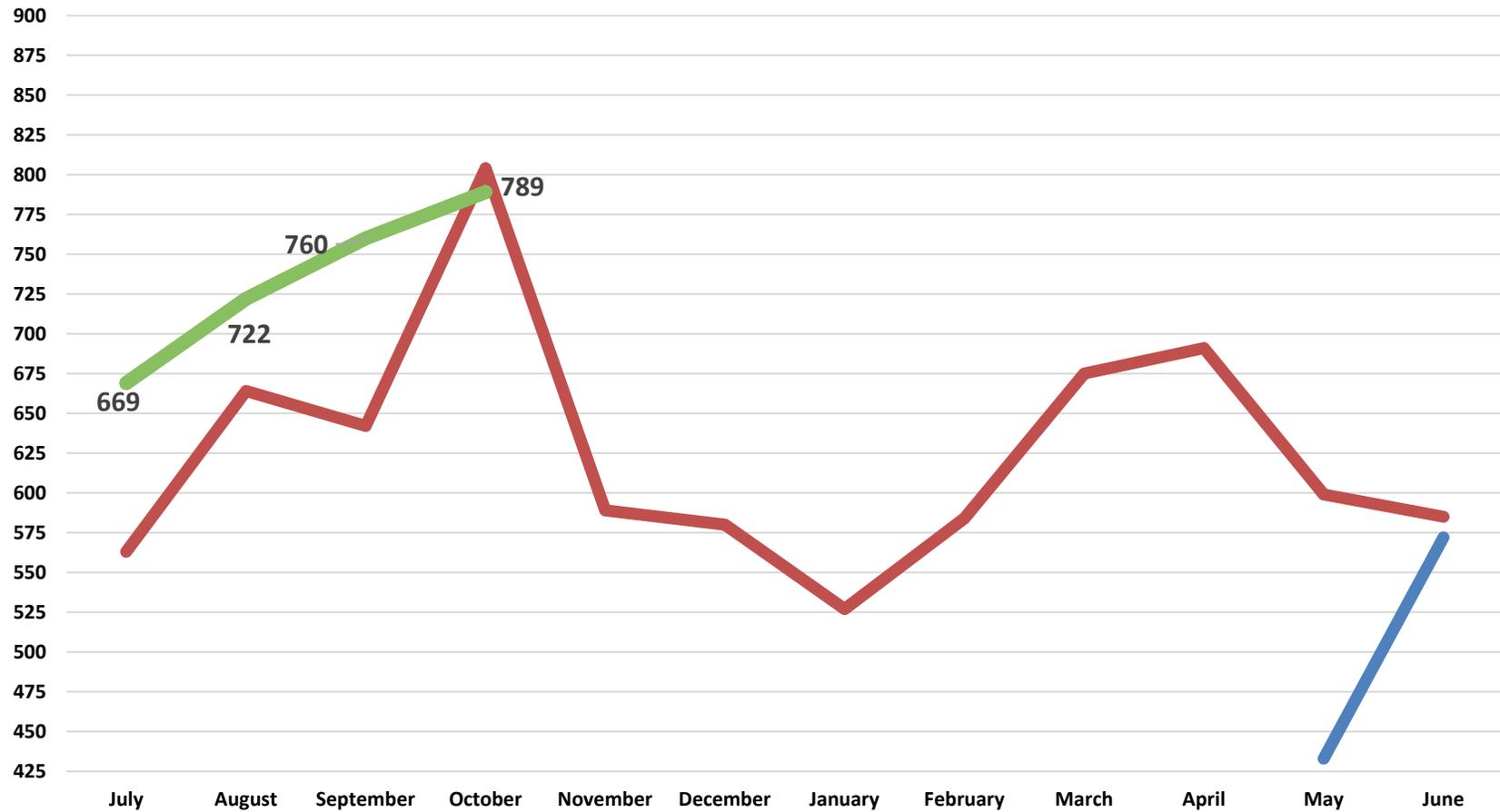
— FY2018 — FY2019 — FY2020



# Exeter RHC - Registrations



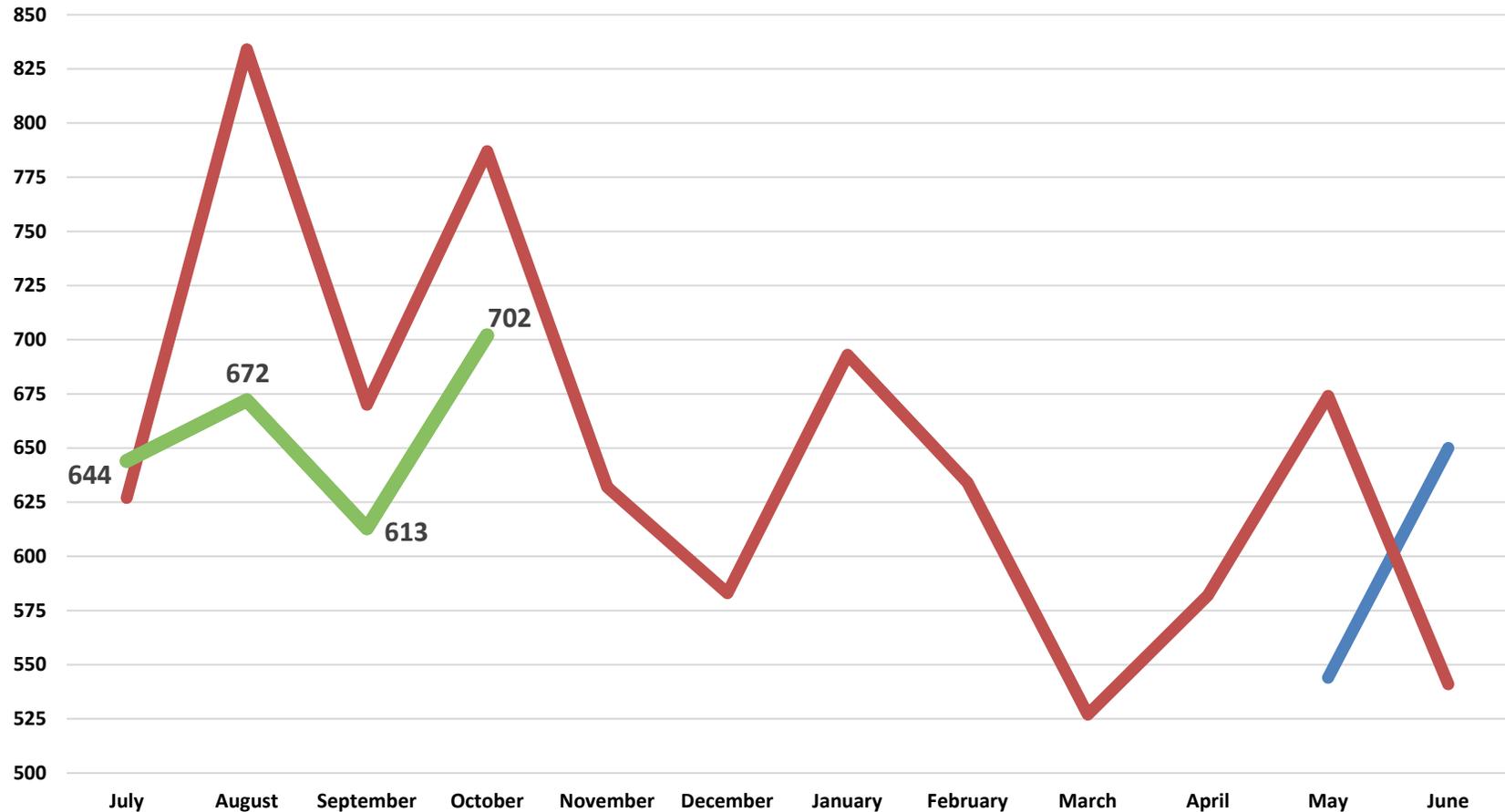
# Lindsay RHC - Registrations



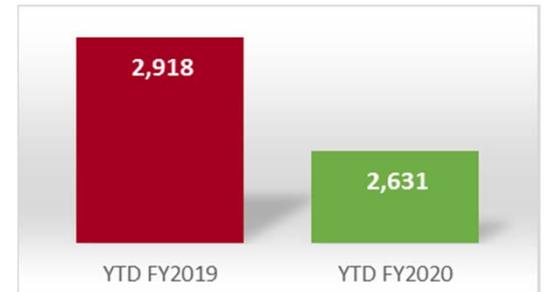
— FY2018 — FY2019 — FY2020



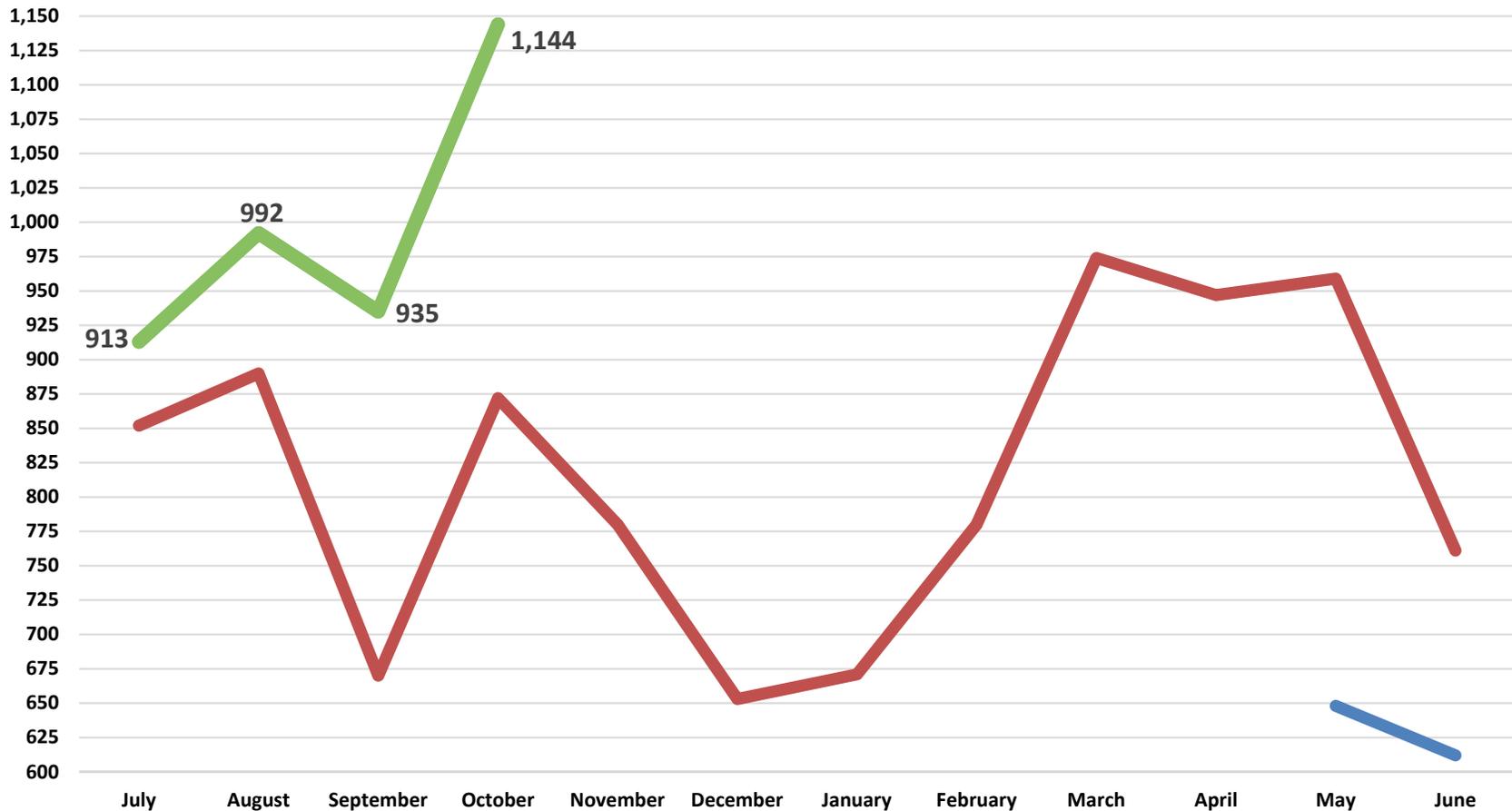
# Woodlake RHC - Registrations



— FY2018 — FY2019 — FY2020



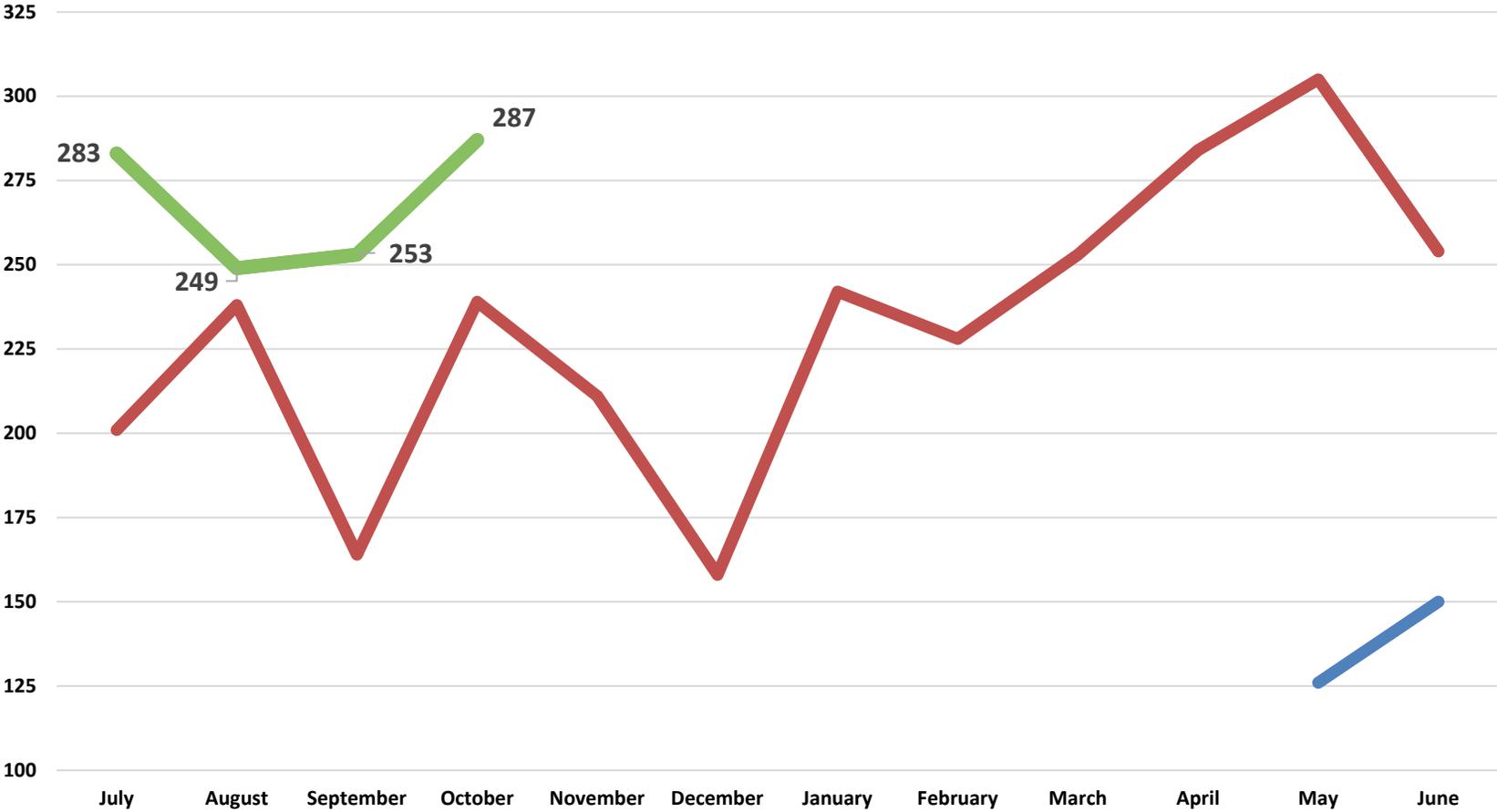
# Dinuba RHC - Registrations



— FY2018 — FY2019 — FY2020



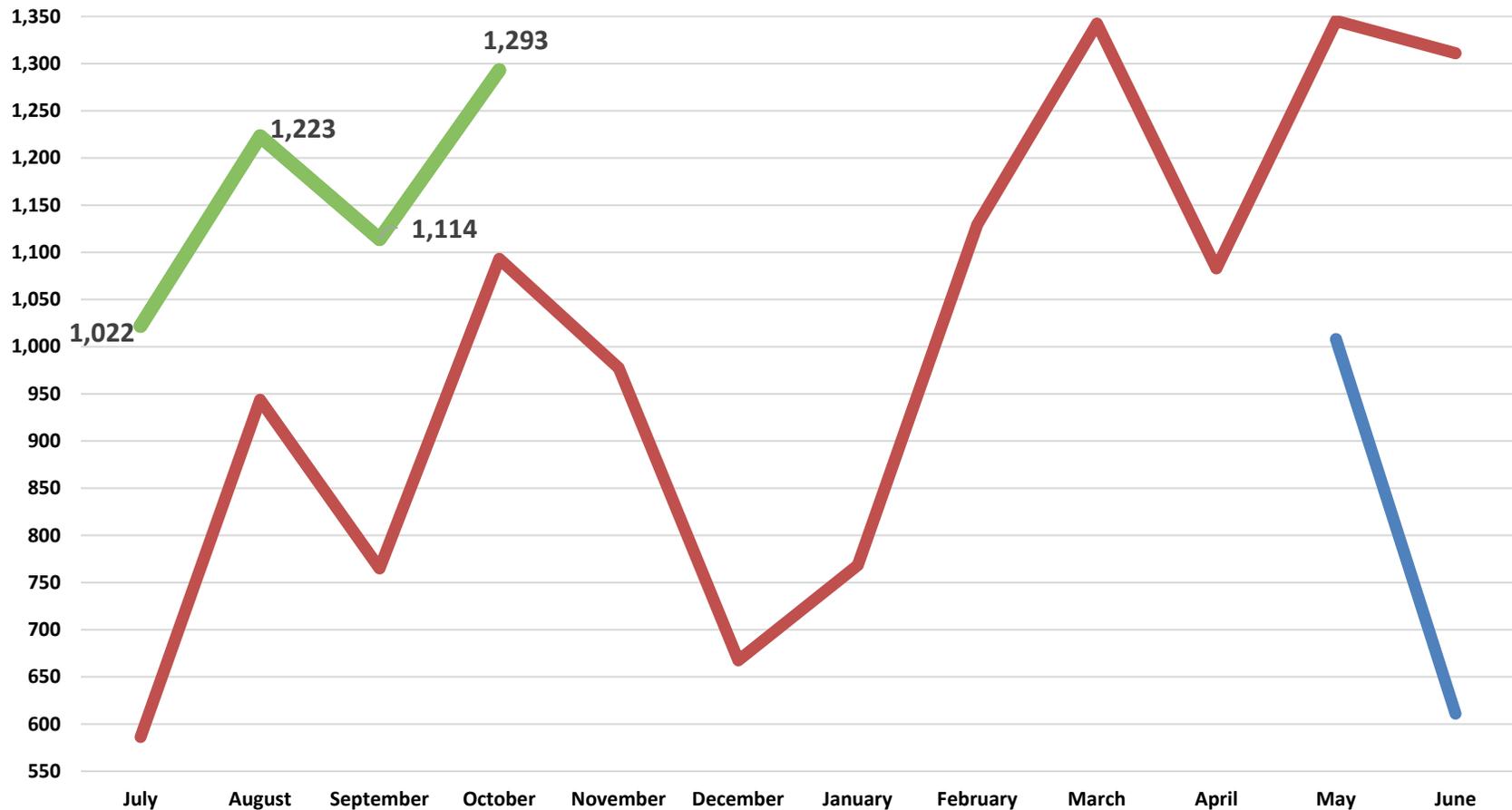
# Neurosurgery Clinic - Registrations



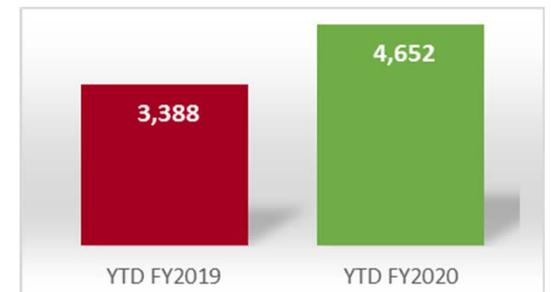
— FY2018 — FY2019 — FY2020



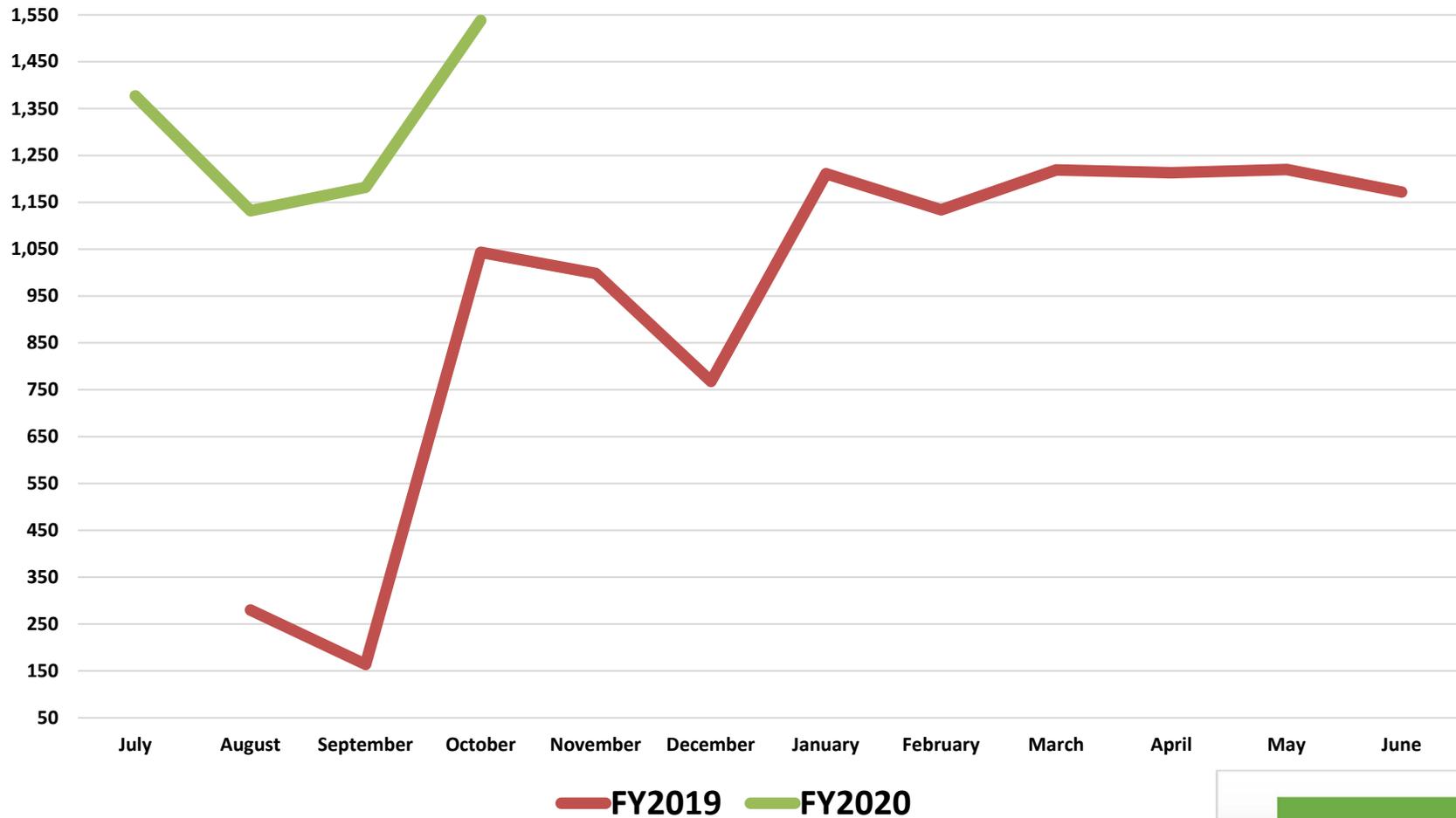
# Neurosurgery Clinic - wRVU's



— FY2018 — FY2019 — FY2020

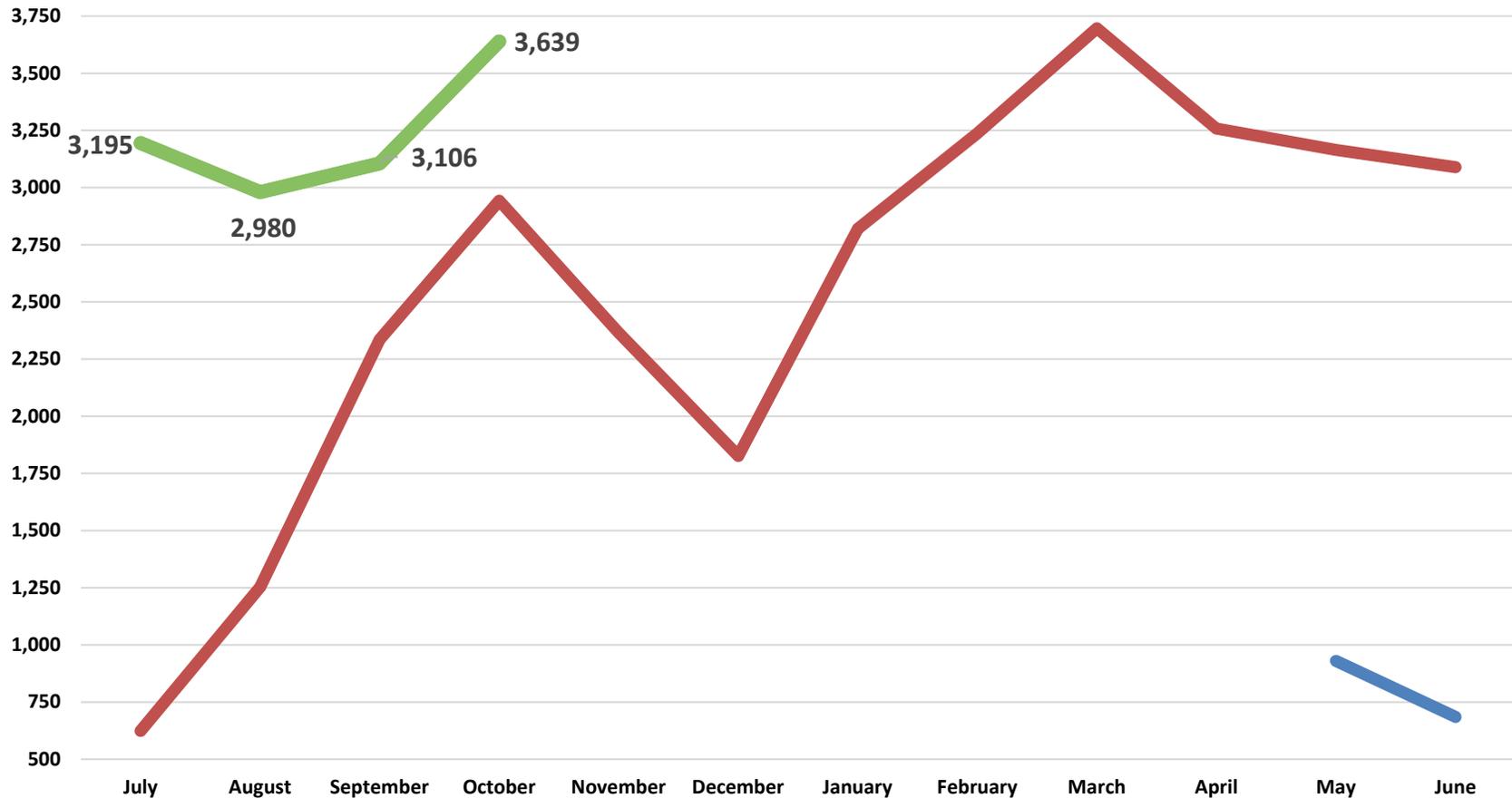


# Sequoia Cardiology - Registrations

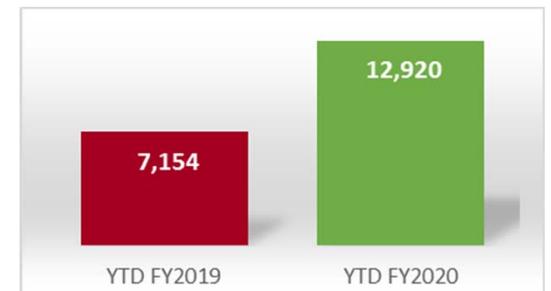


5,229  
YTD FY2020

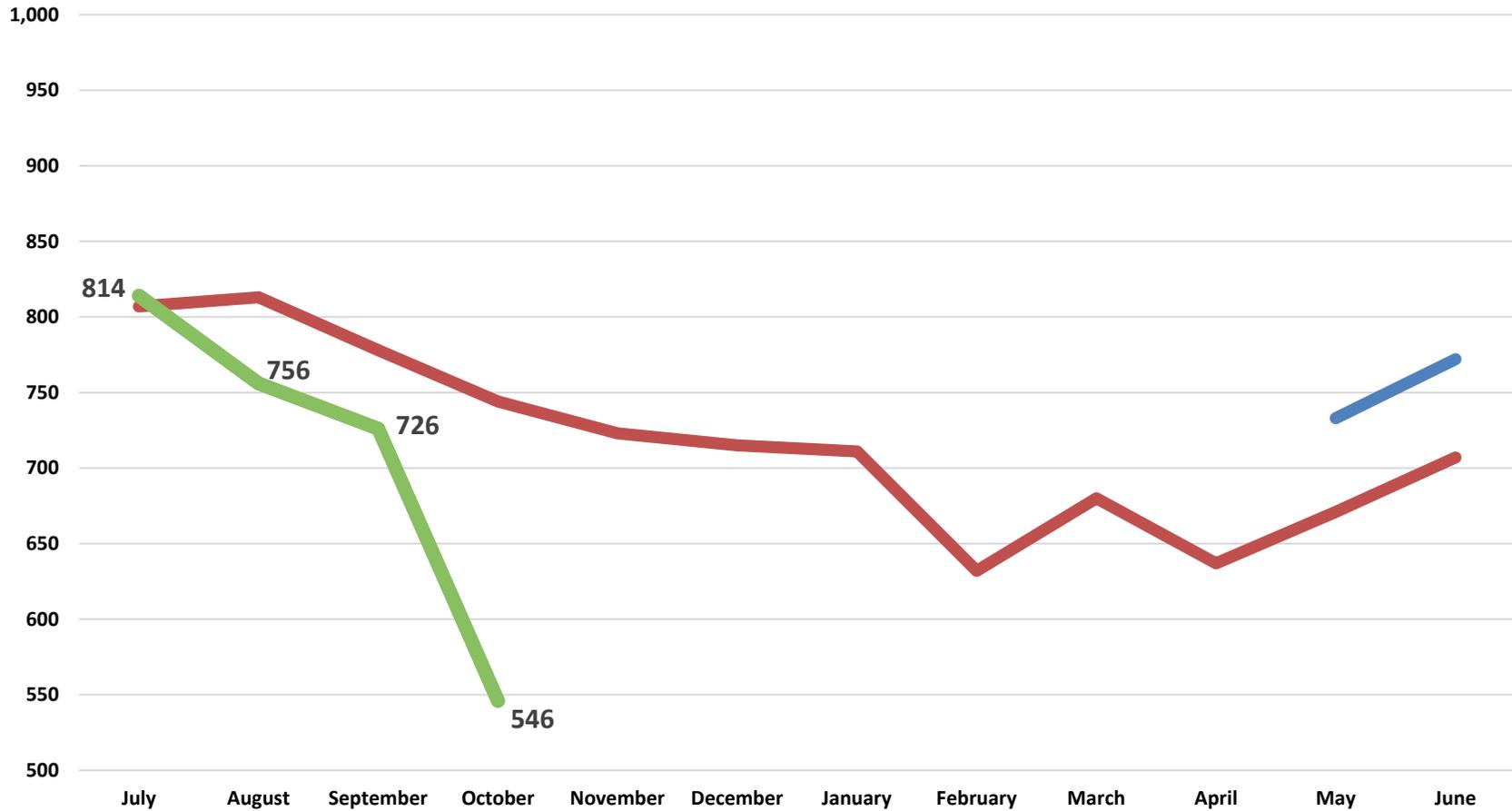
# Sequoia Cardiology – wRVU's



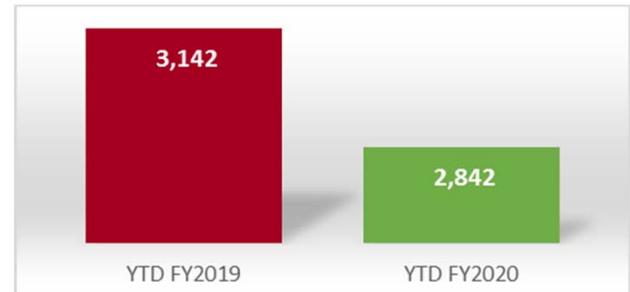
— FY2018 — FY2019 — FY2020



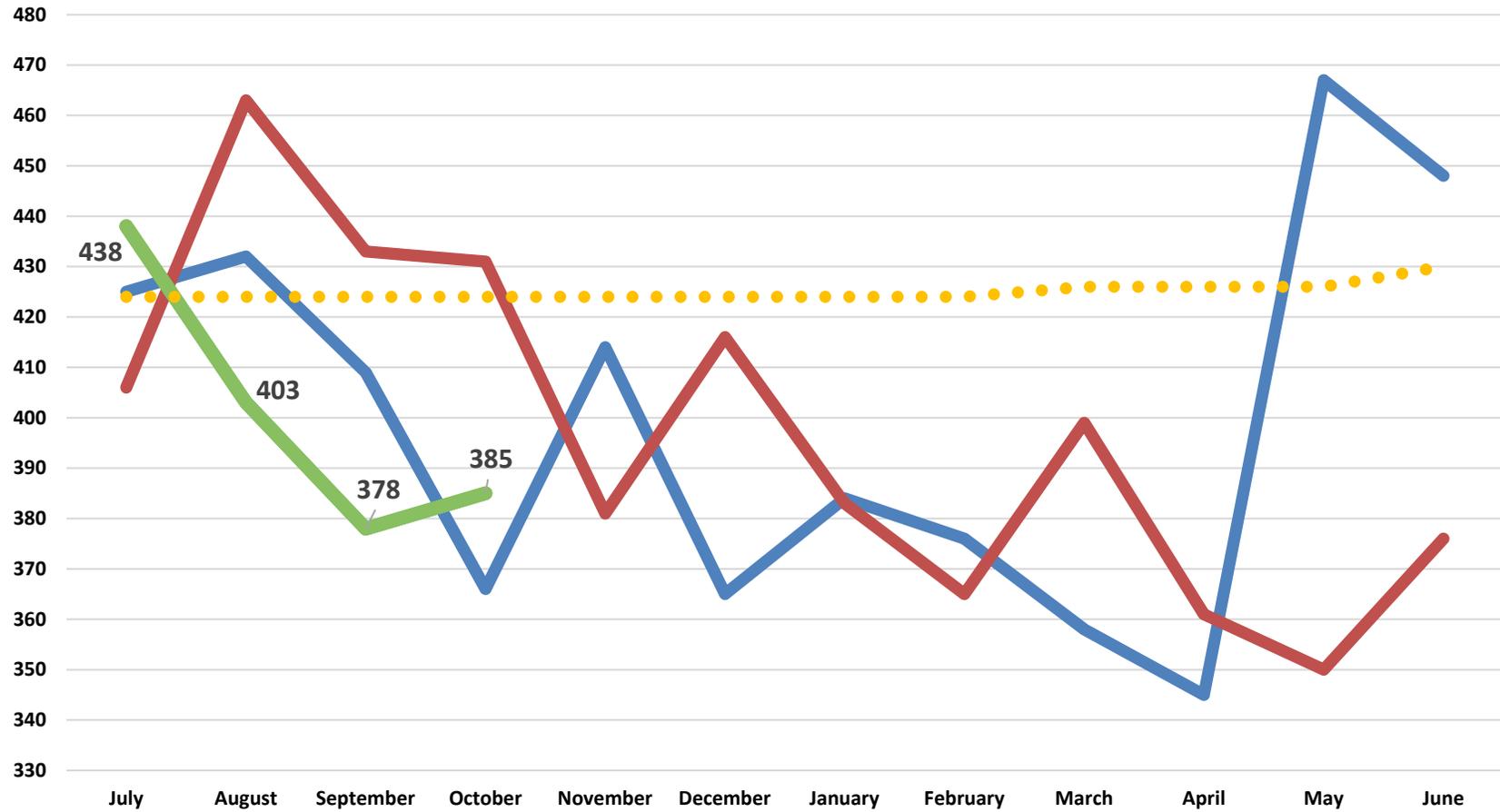
# Labor Triage Registrations



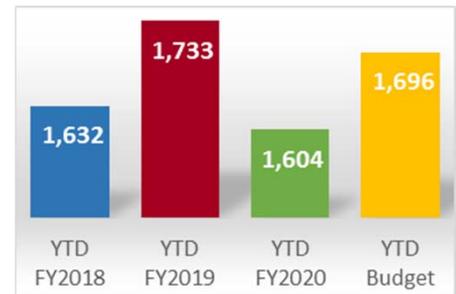
— FY2018 
 — FY2019 
 — FY2020



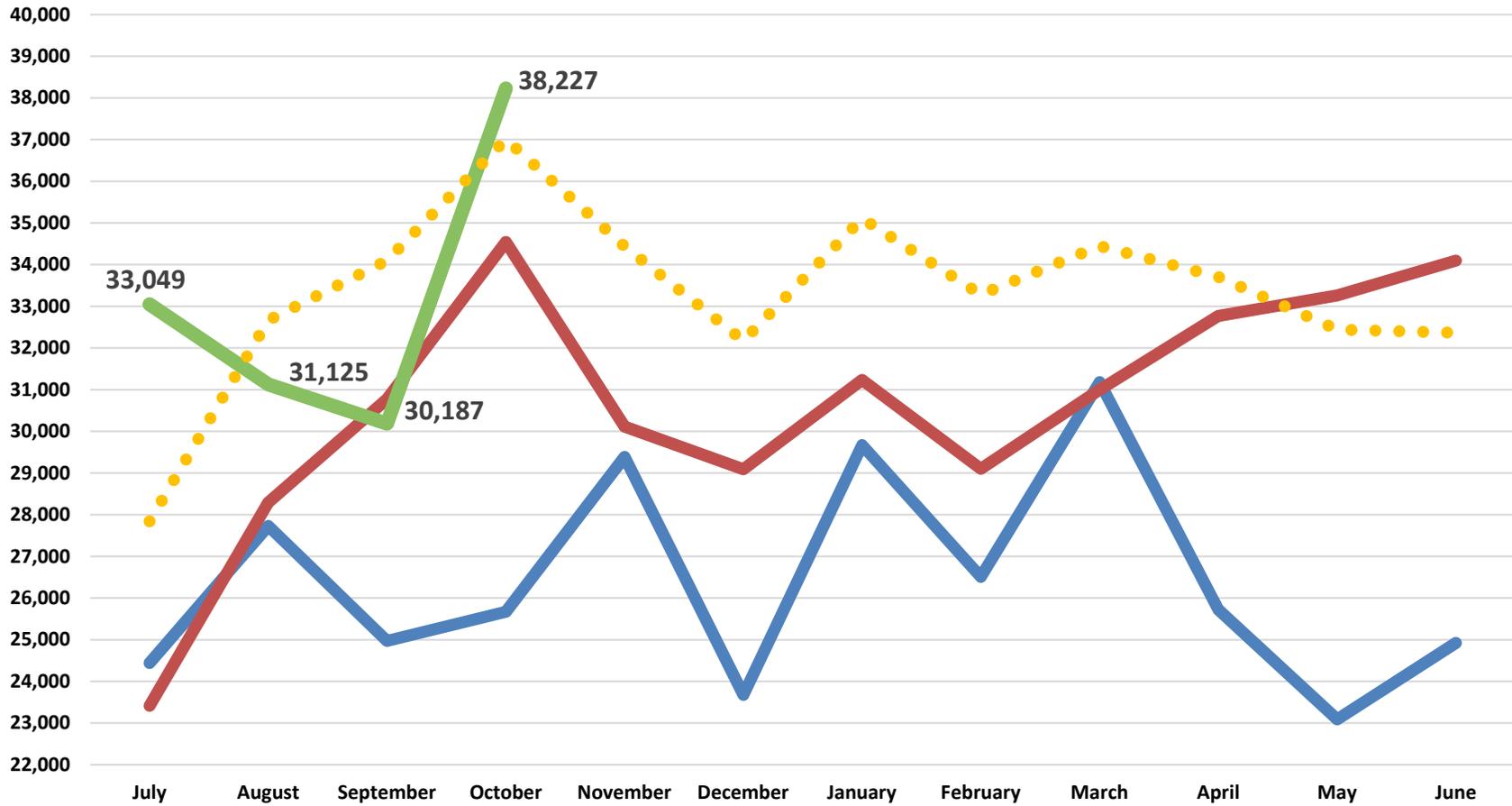
# Deliveries



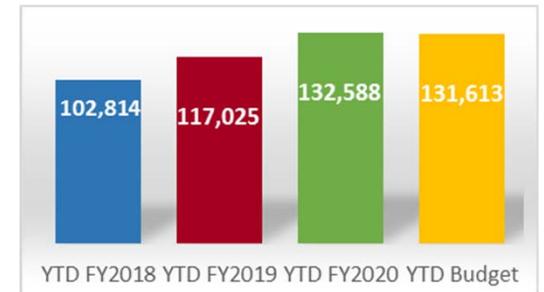
— FY2018 
 — FY2019 
 — FY2020 
 ●●● Budget



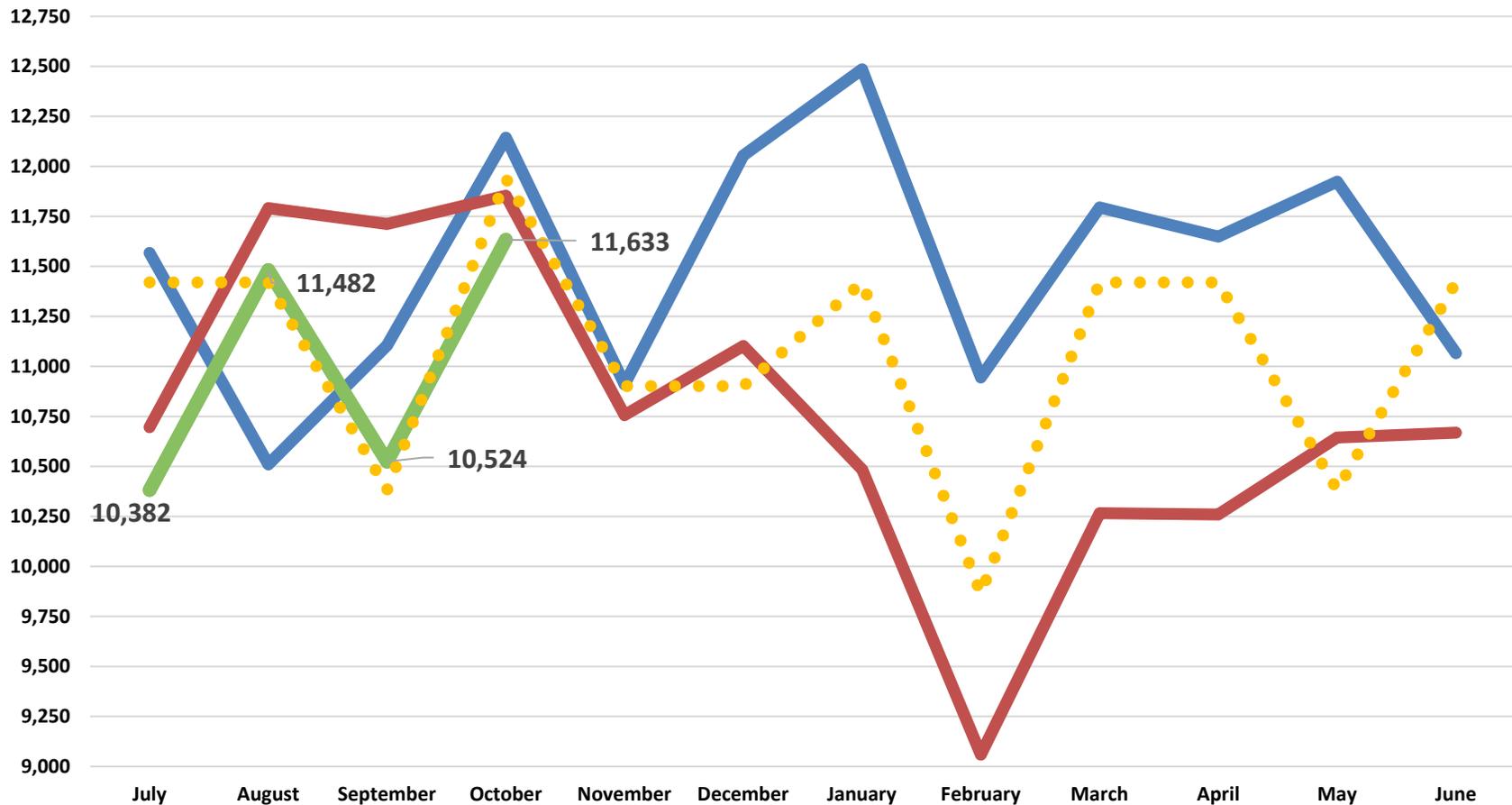
# KDMF RVU's



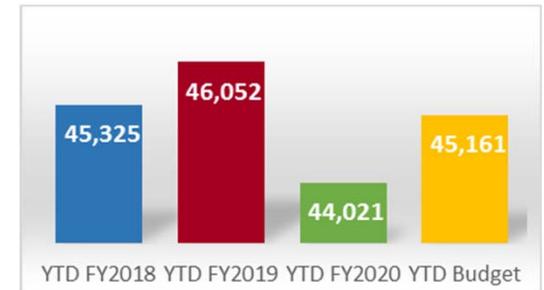
— FY2018 — FY2019 — FY2020 ••• Budget



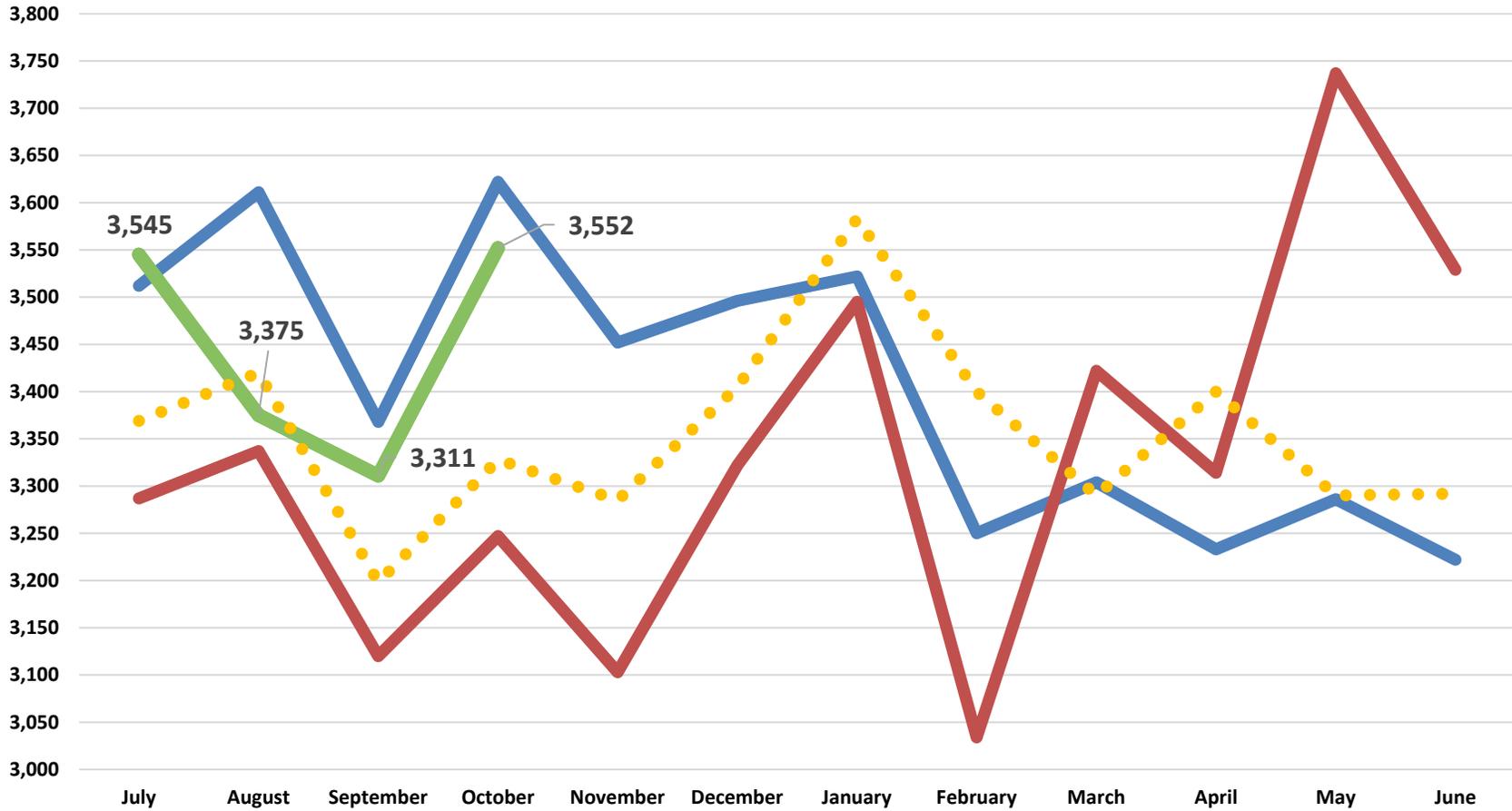
# Home Infusion Days



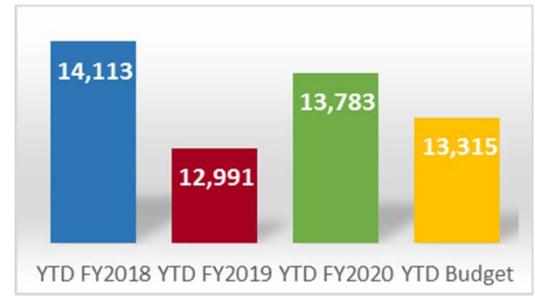
— FY2018 
 — FY2019 
 — FY2020 
 ••• Budget



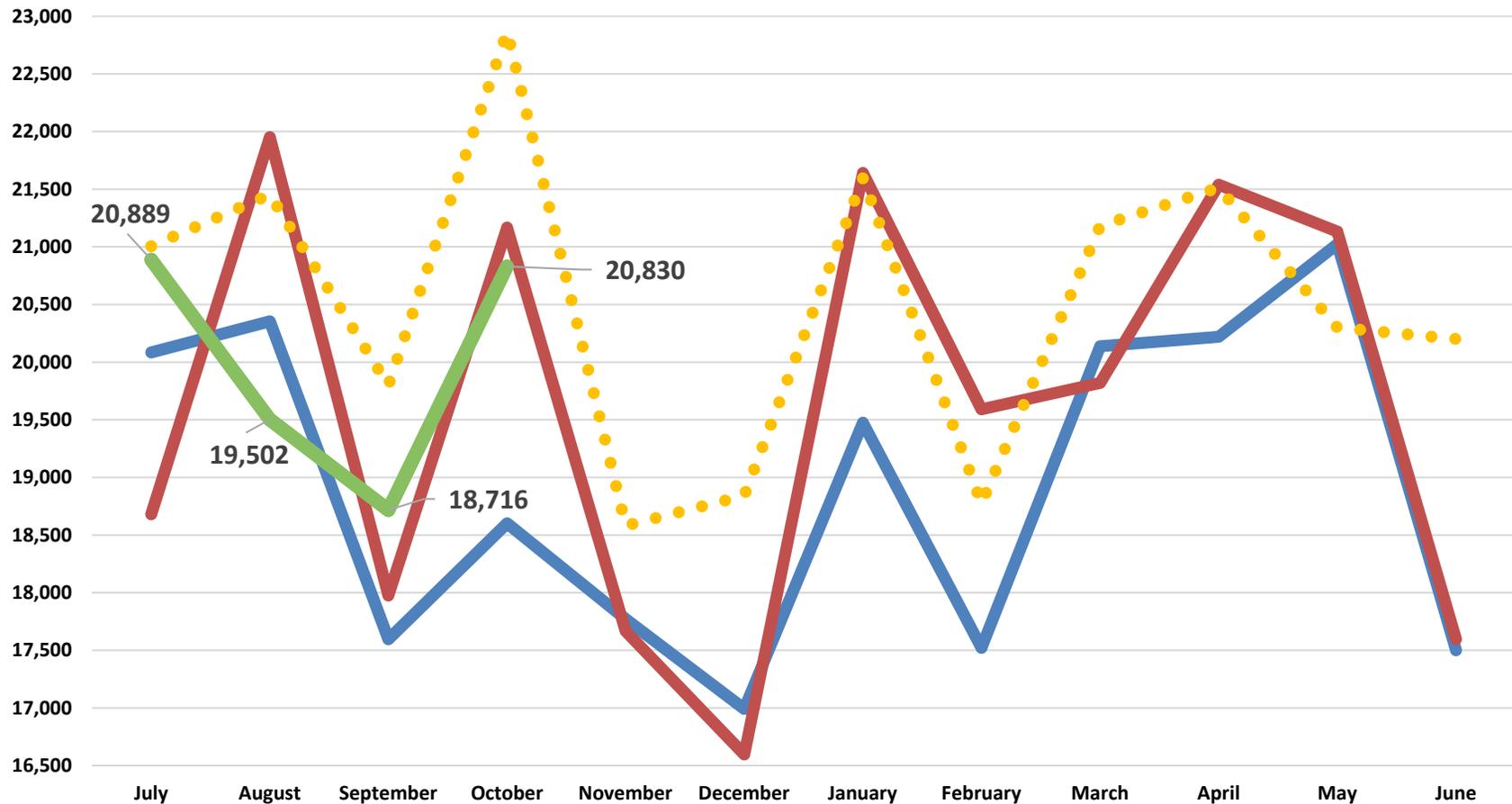
# Hospice Days



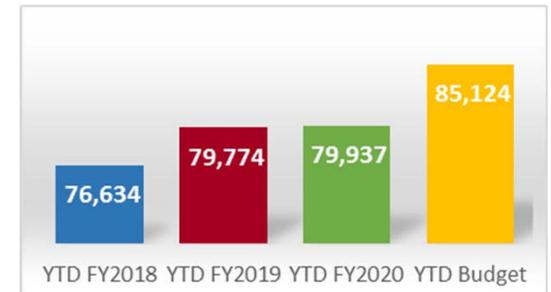
— FY2018 
 — FY2019 
 — FY2020 
 ●●● Budget



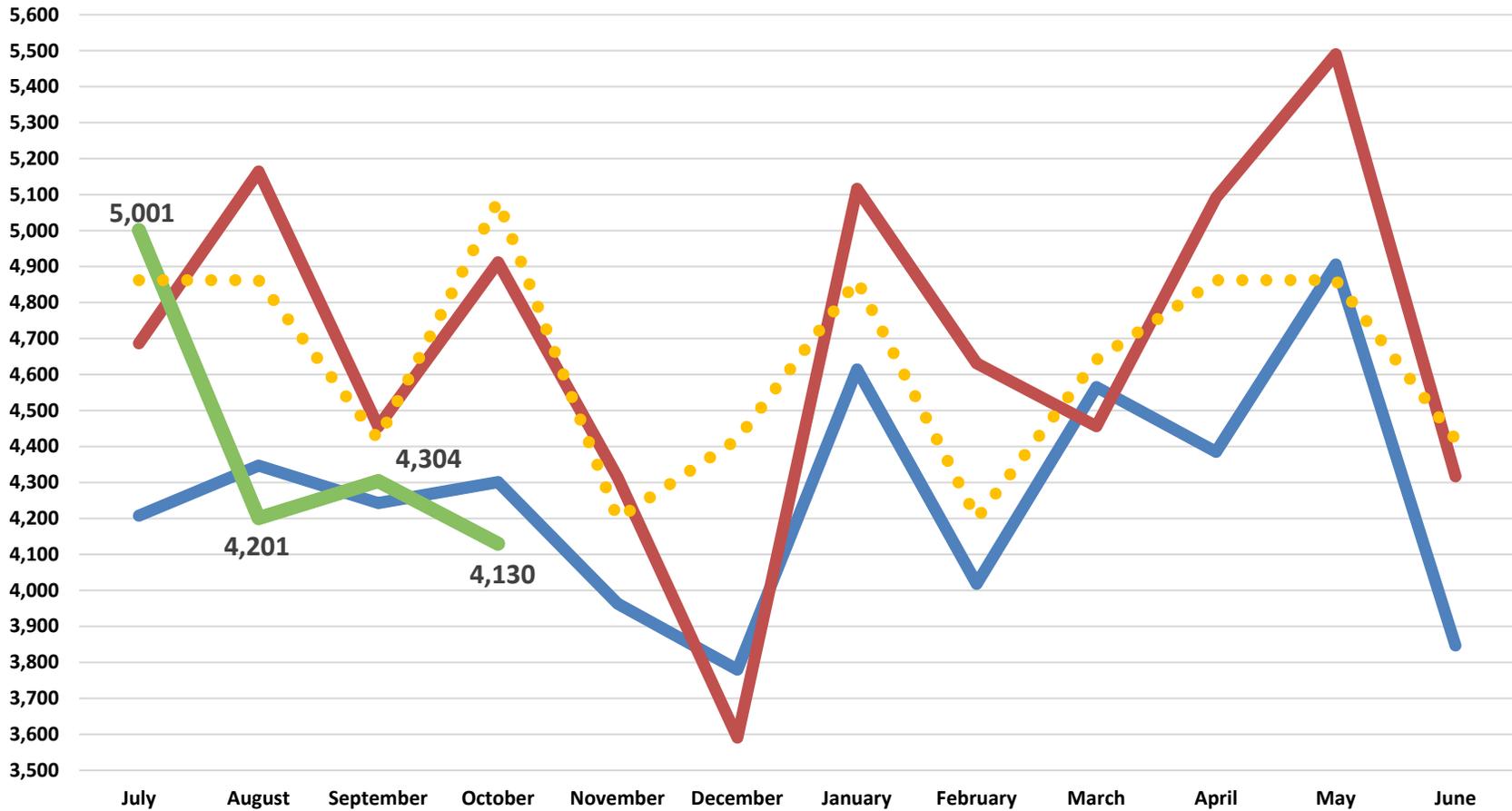
# All O/P Rehab Services Across District



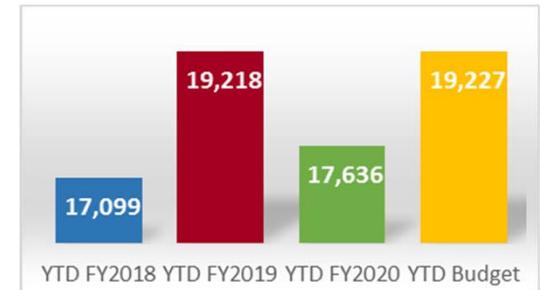
— FY2018 
 — FY2019 
 — FY2020 
 ●● Budget



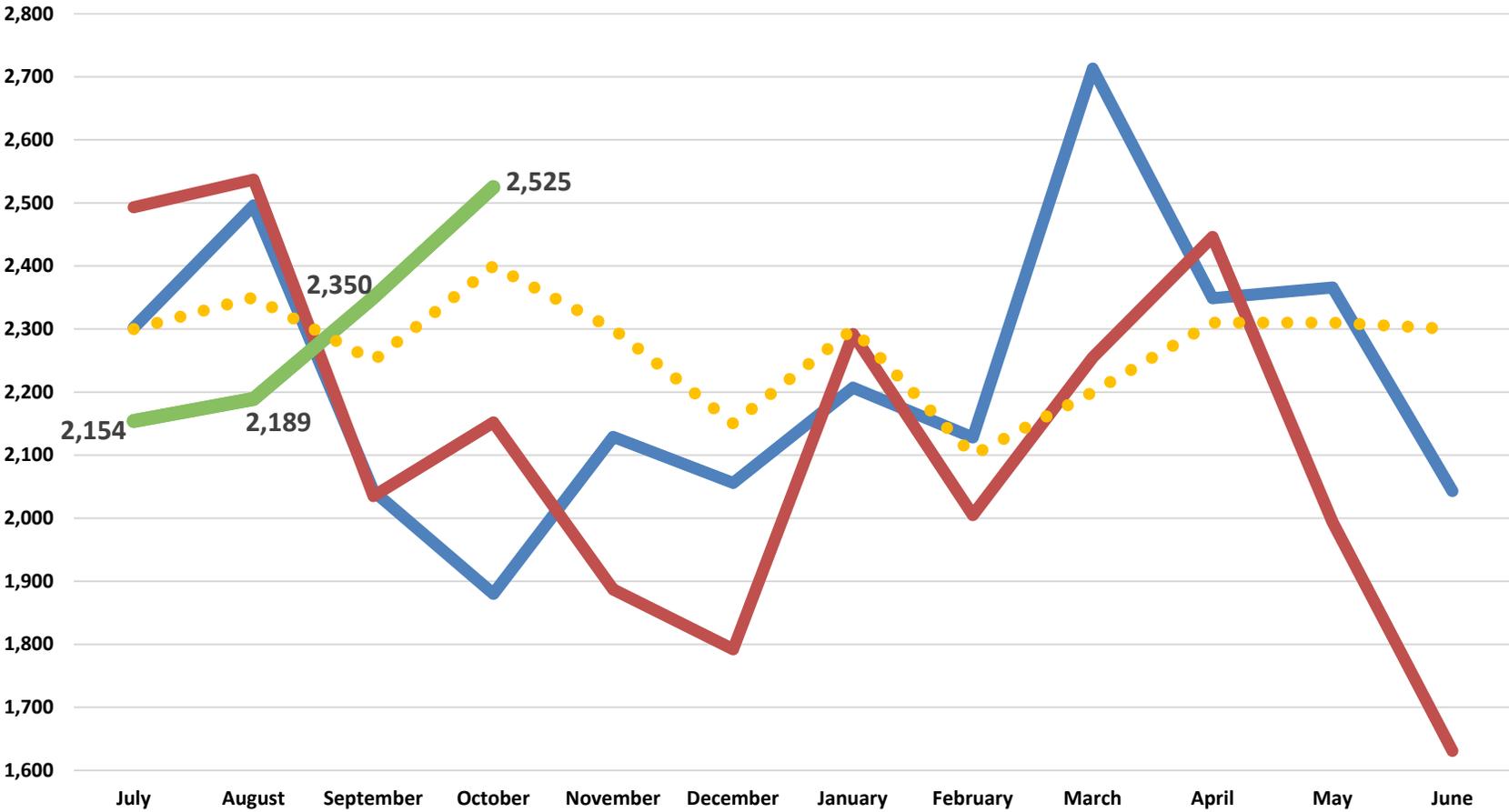
# O/P Rehab Services



— FY2018 — FY2019 — FY2020 ••• Budget



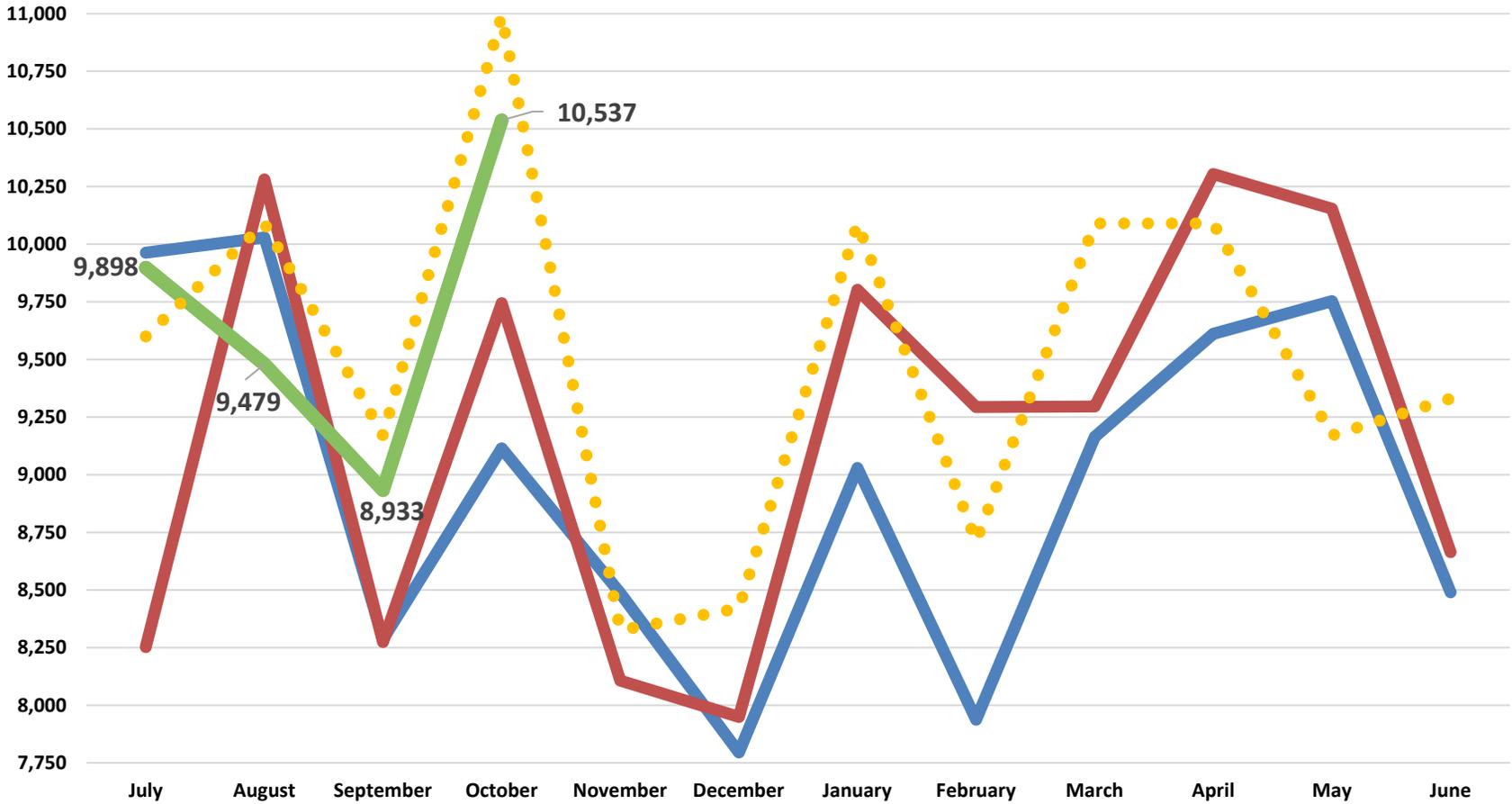
# O/P Rehab - Exeter



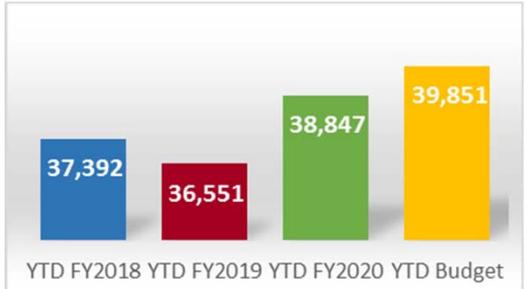
— FY2018 
 — FY2019 
 — FY2020 
 ••• Budget



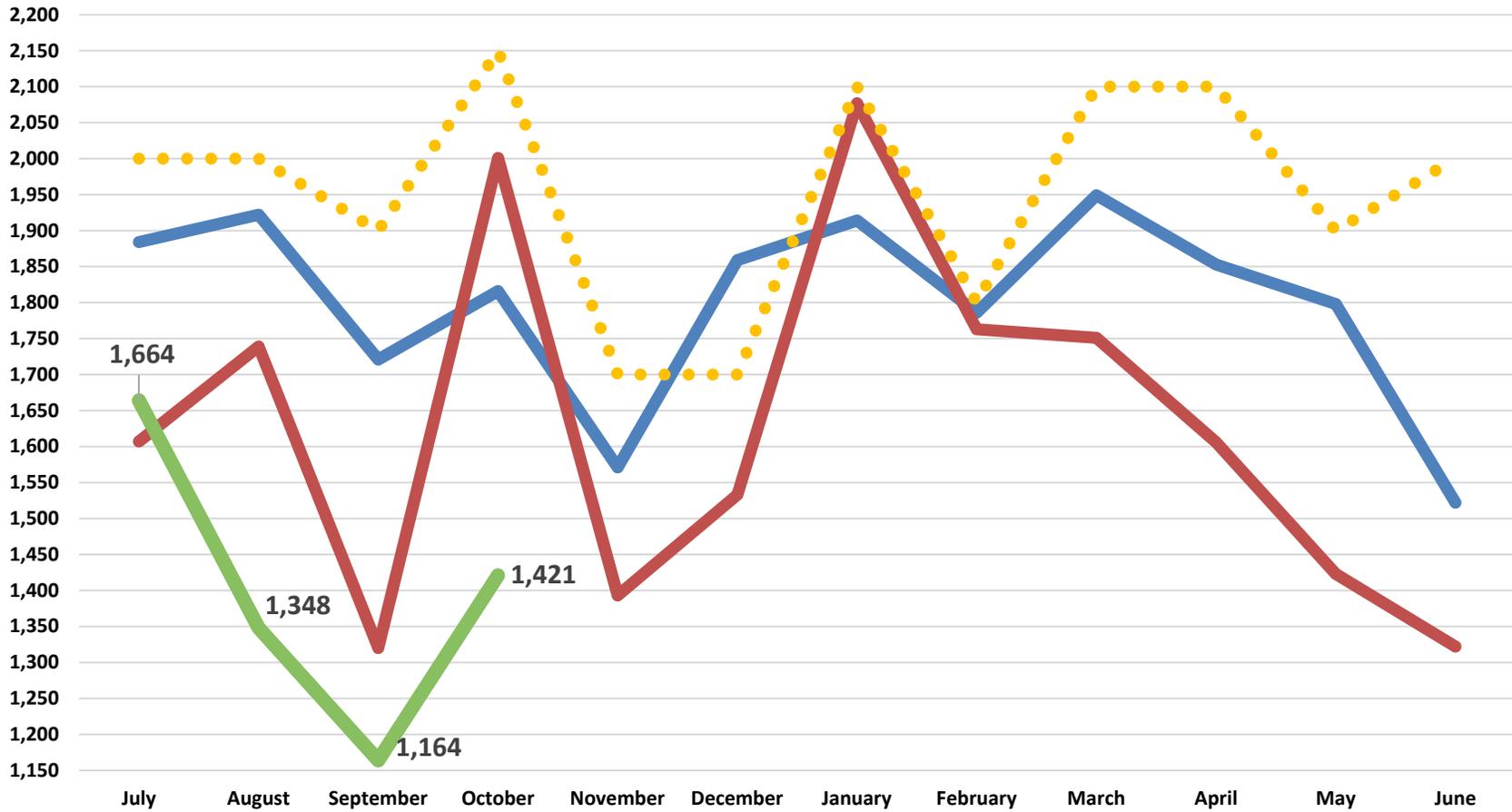
# O/P Rehab - Akers



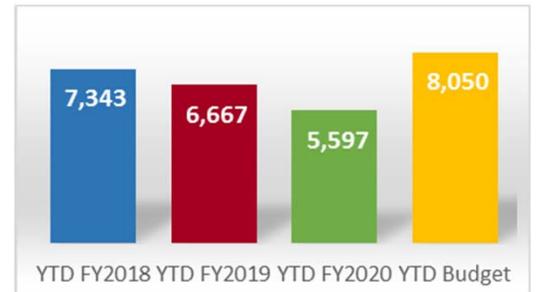
— FY2018 
 — FY2019 
 — FY2020 
 ●●● Budget



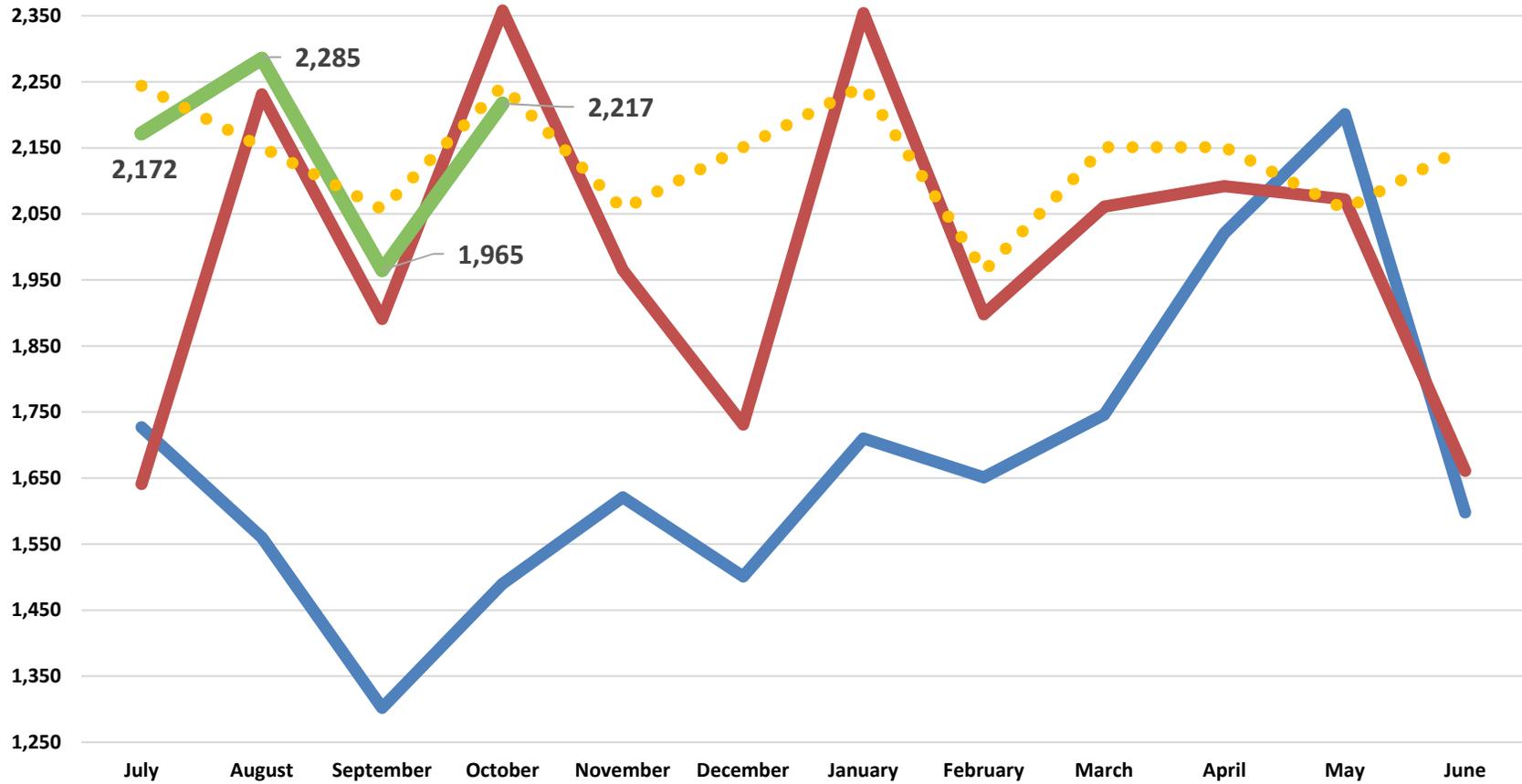
# O/P Rehab - LLOPT



— FY2018 
 — FY2019 
 — FY2020 
 ●● Budget



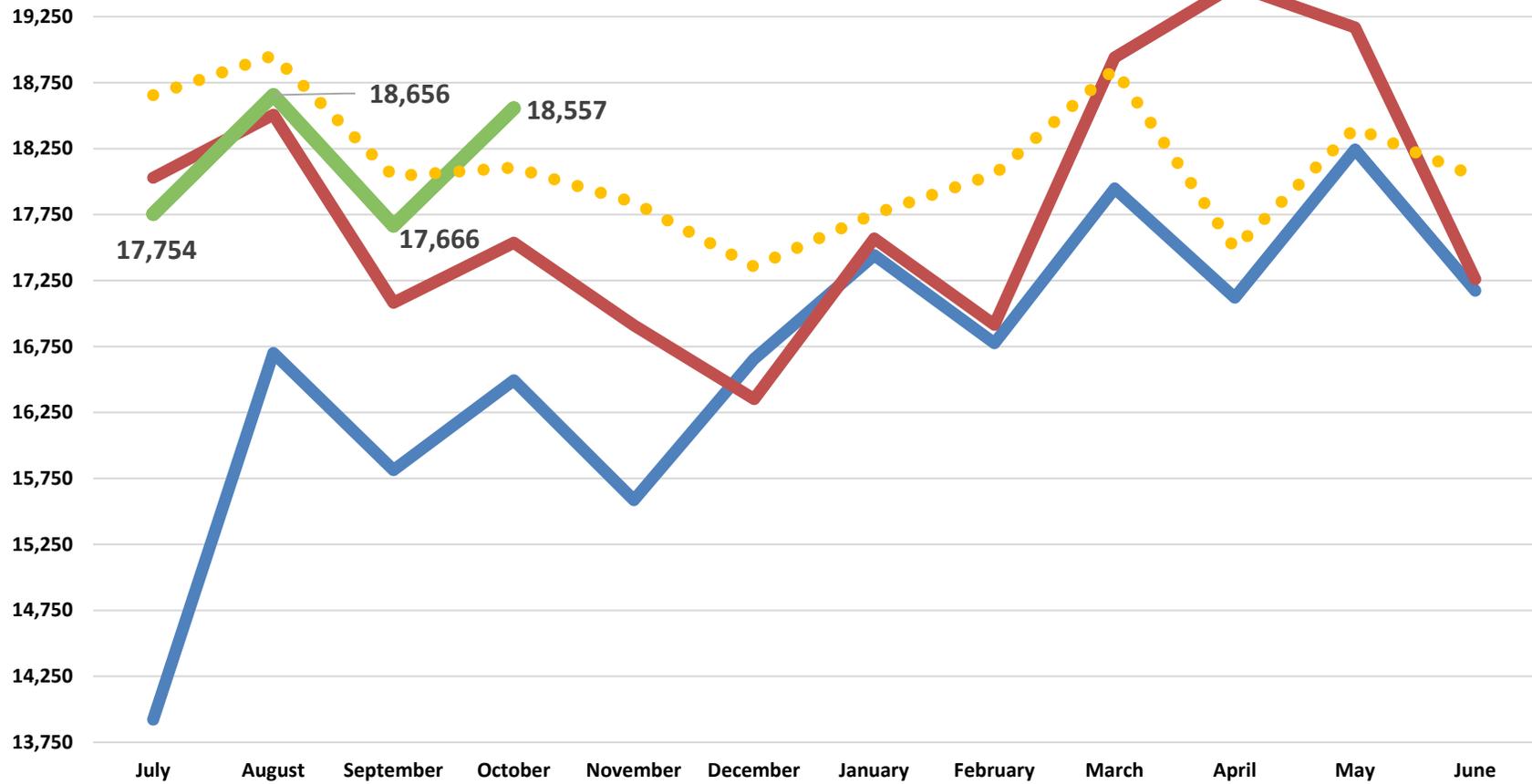
# O/P Rehab - Dinuba



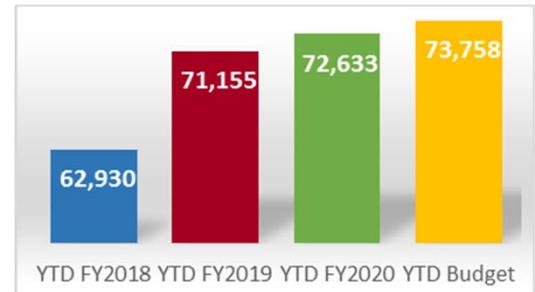
— FY2018 
 — FY2019 
 — FY2020 
 ●●● Budget



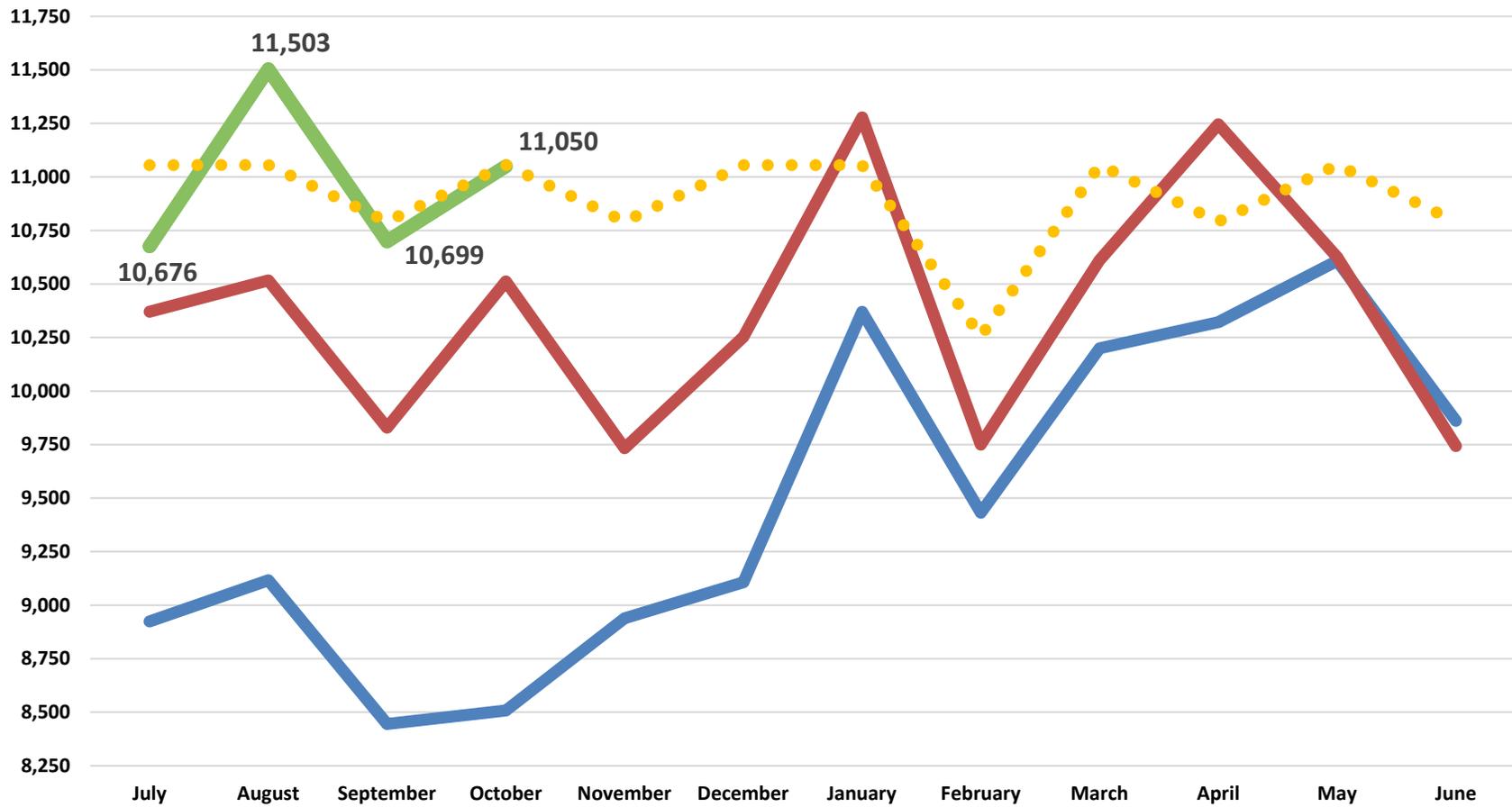
# Physical & Other Therapy Units (I/P & O/P)



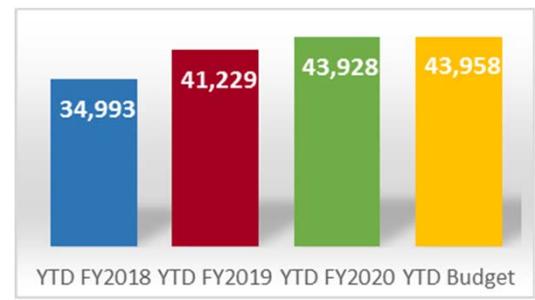
— FY2018 
 — FY2019 
 — FY2020 
 ●● Budget



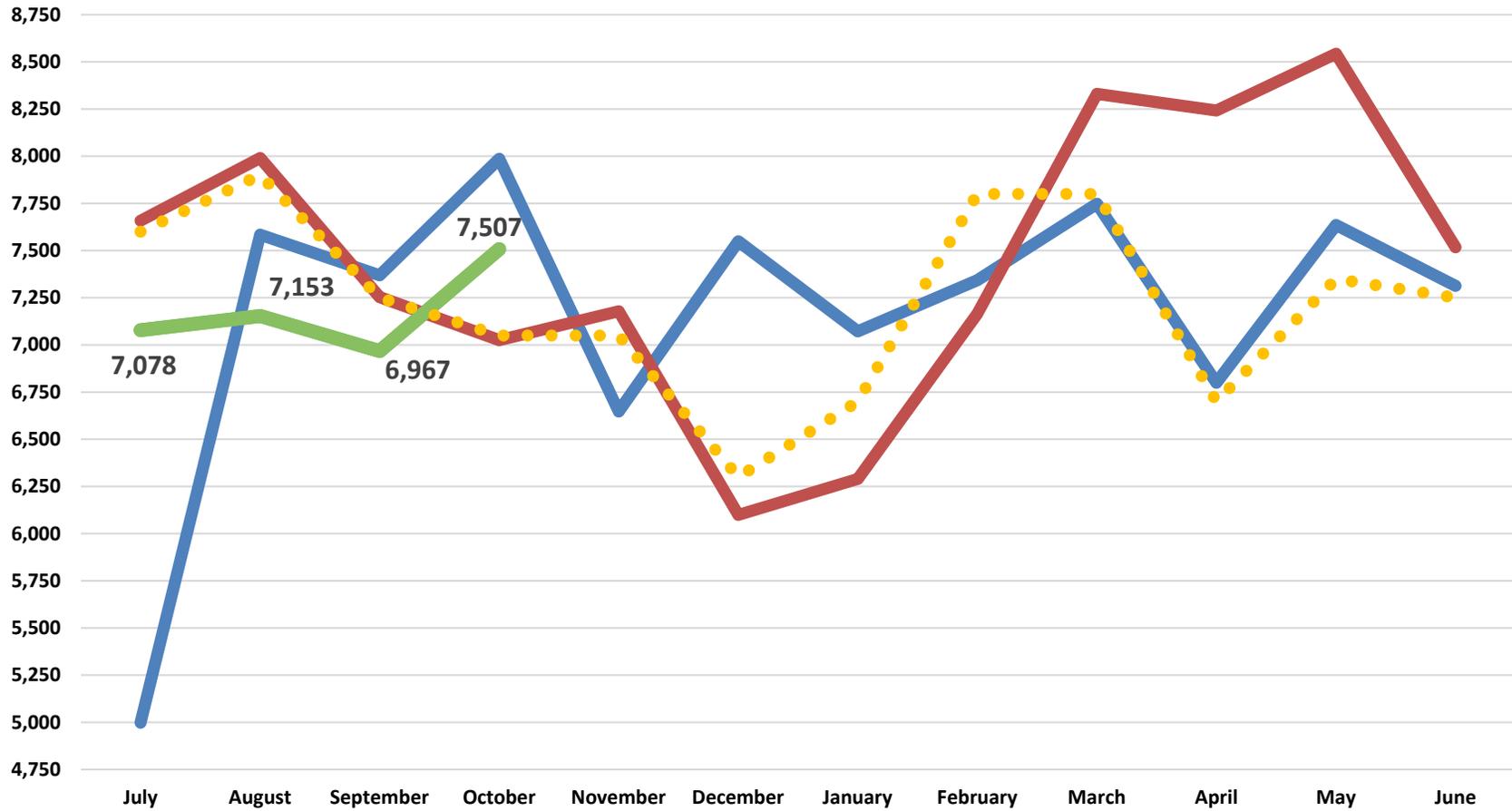
# Physical & Other Therapy Units (I/P & O/P)-Main Campus



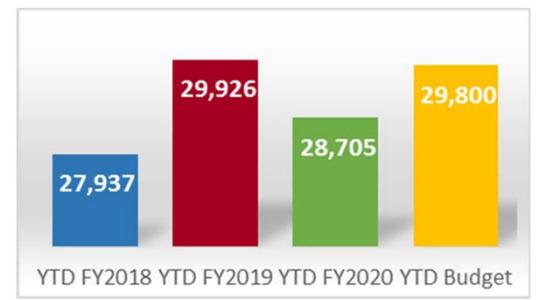
— FY2018 
 — FY2019 
 — FY2020 
 ●●● Budget



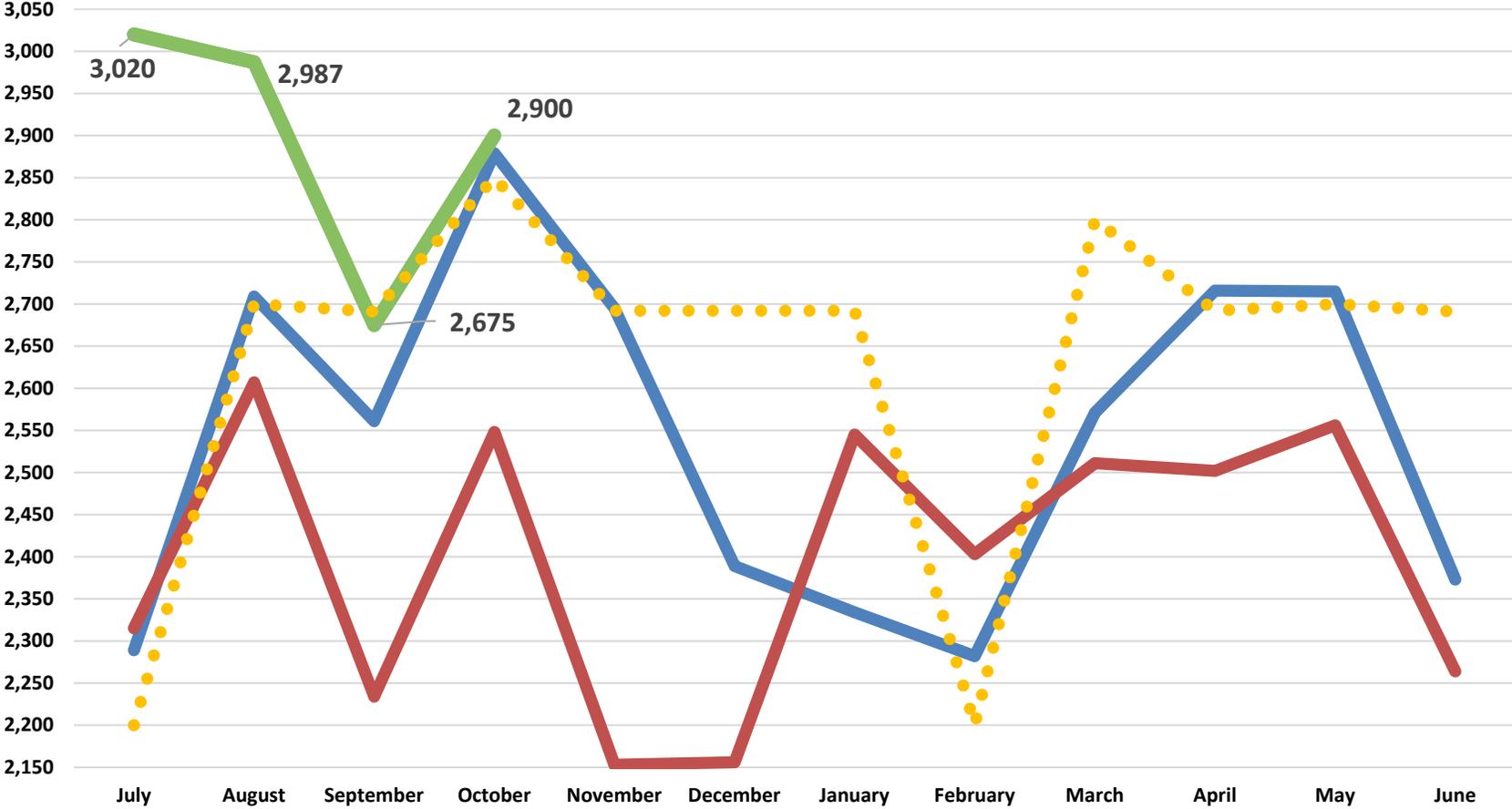
# Physical & Other Therapy Units (I/P & O/P)-KDRH & South Campus



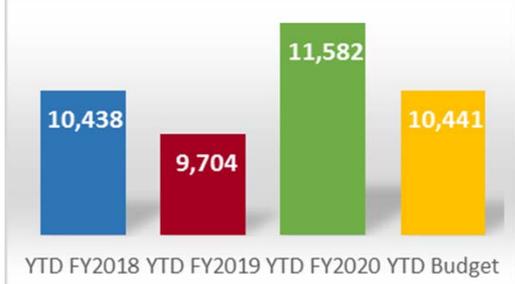
— FY2018 
 — FY2019 
 — FY2020 
 ●●● Budget



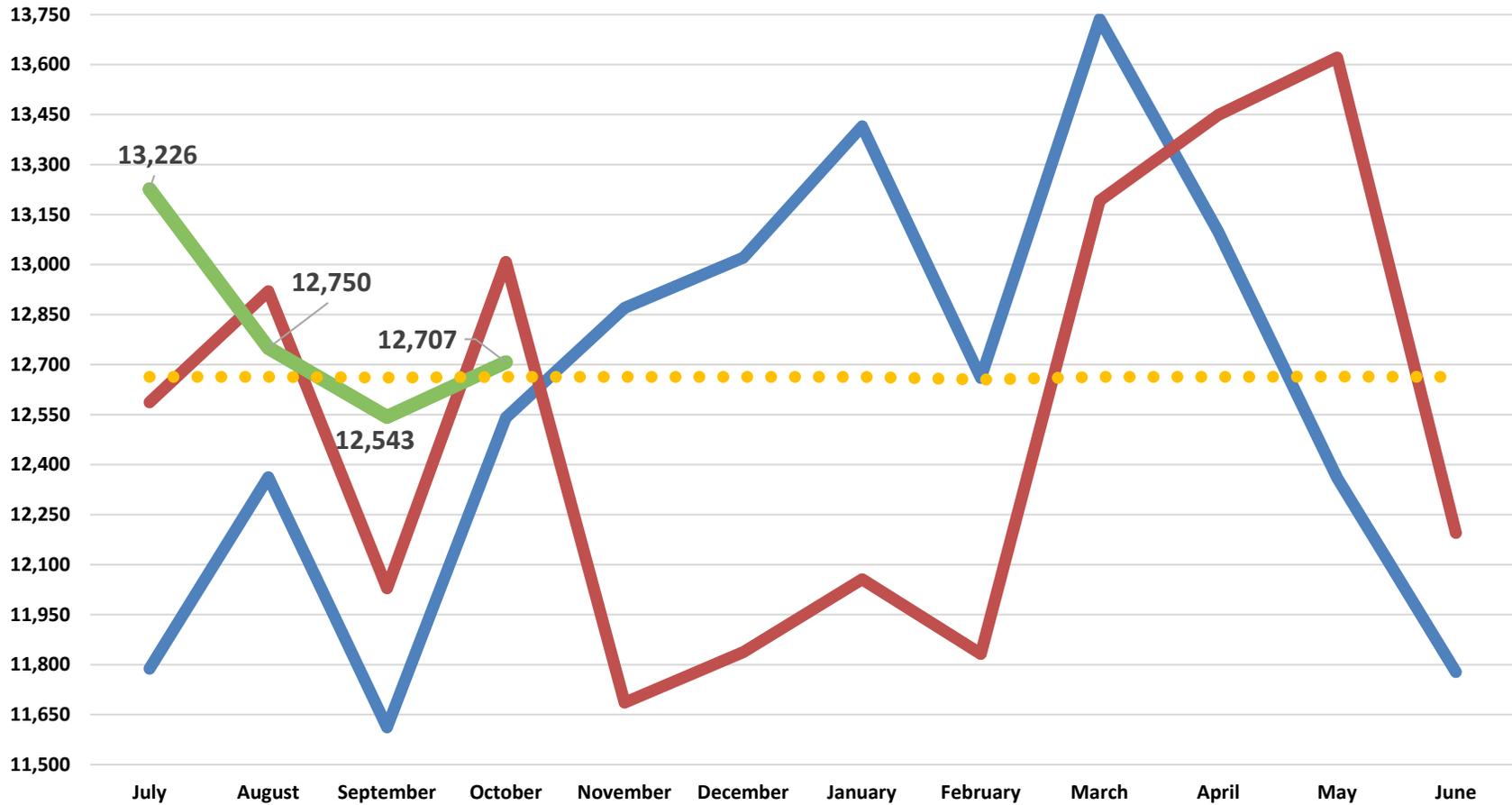
# Home Health Visits



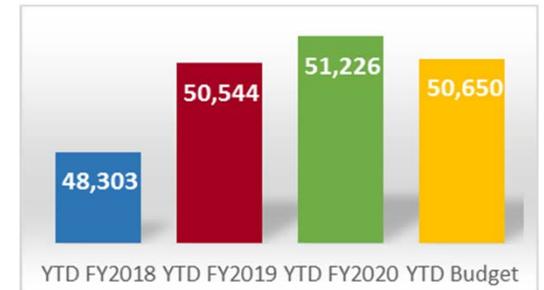
— FY2018 
 — FY2019 
 — FY2020 
 ●●● Budget



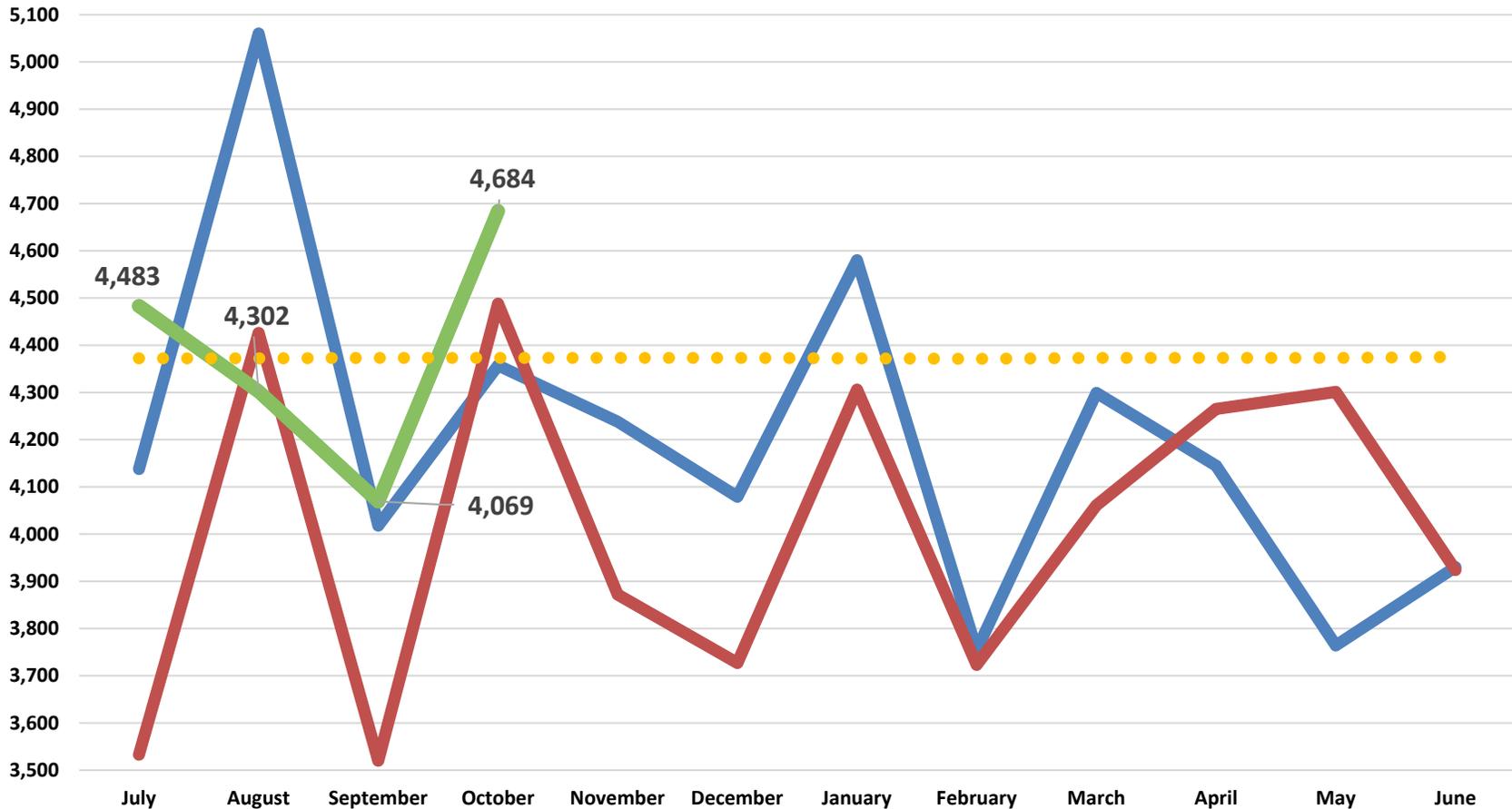
# Radiology – Main Campus



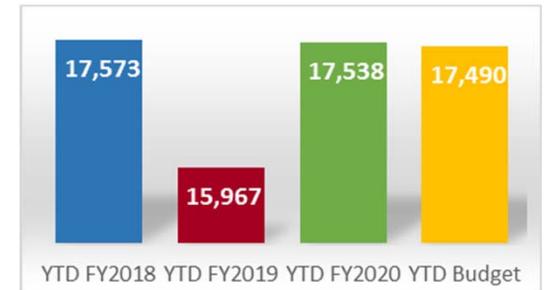
— FY2018 
 — FY2019 
 — FY2020 
 ••• Budget



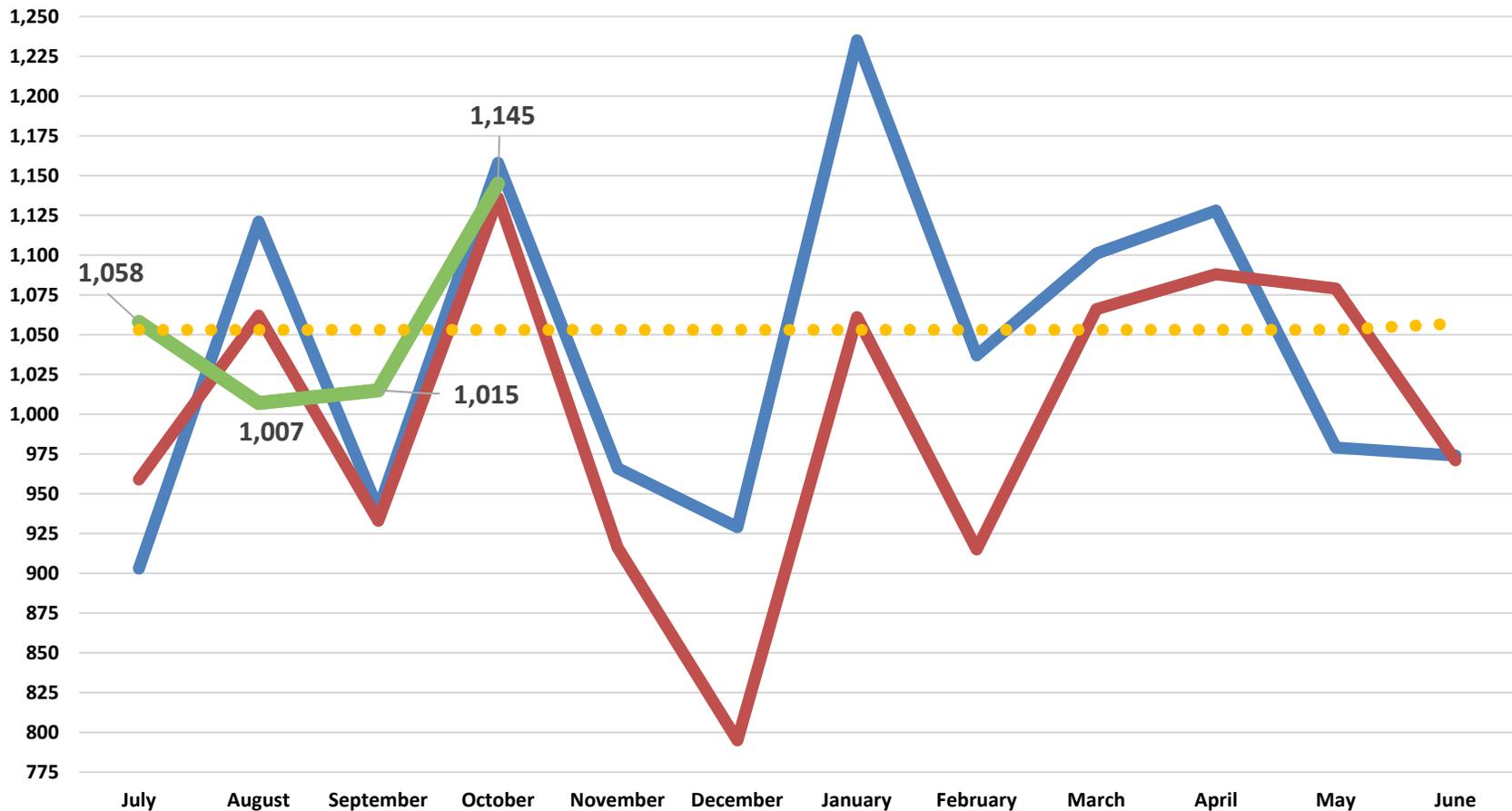
# Radiology – West Campus Imaging



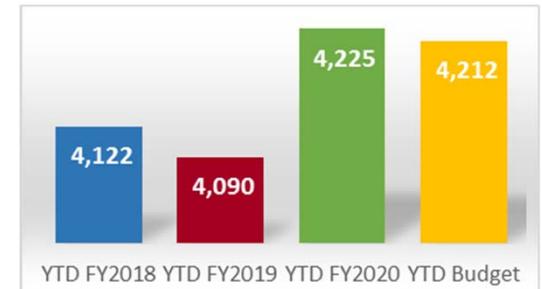
— FY2018 
 — FY2019 
 — FY2020 
 ●●● Budget



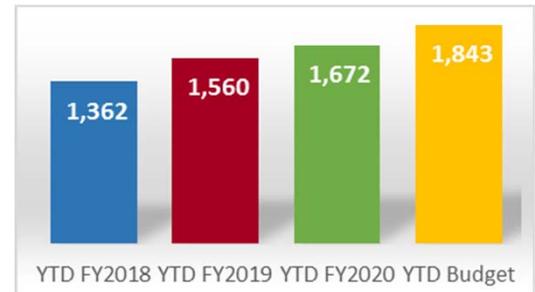
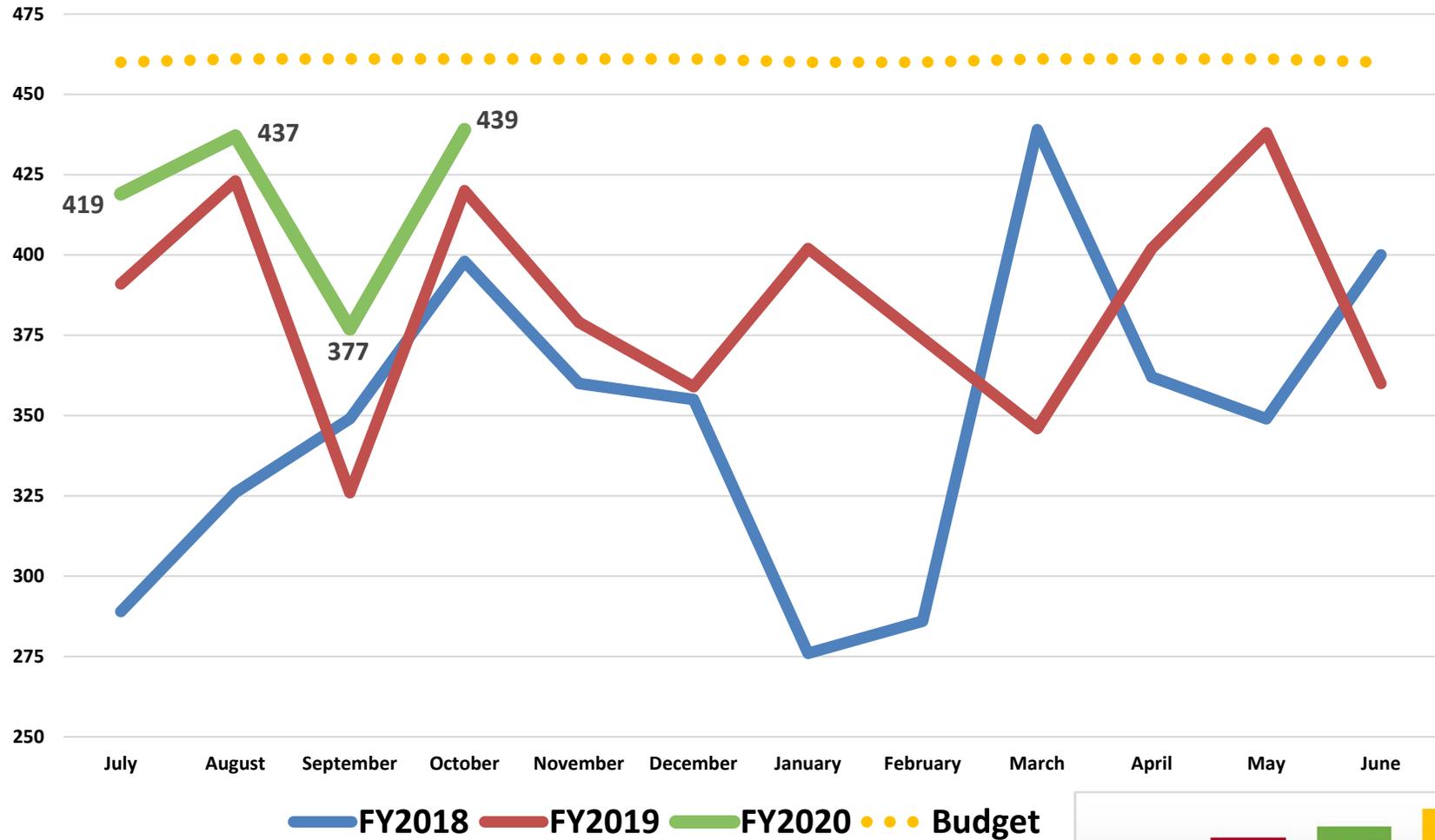
# West Campus – Diagnostic Radiology



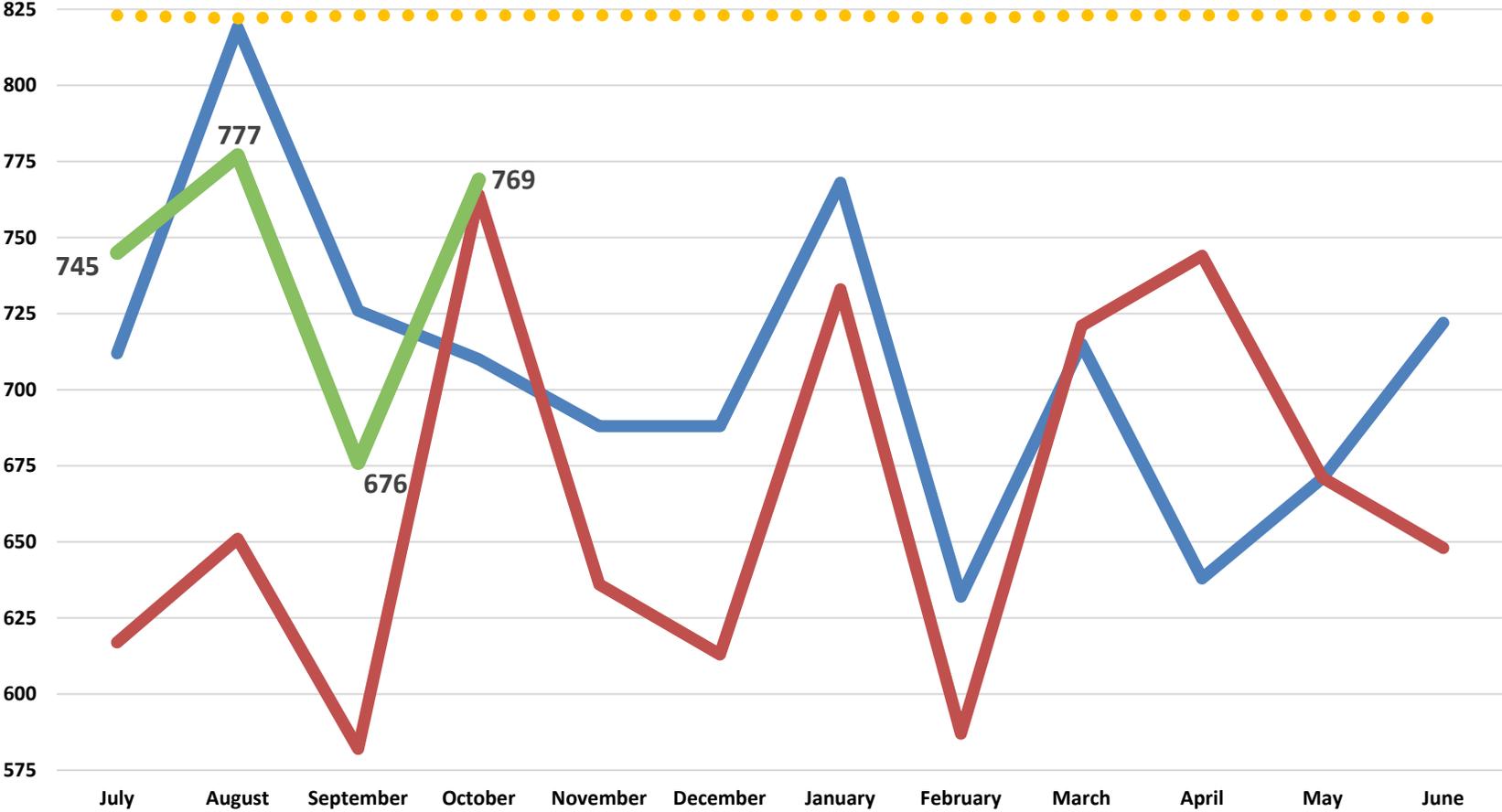
— FY2018 
 — FY2019 
 — FY2020 
 ●●● Budget



# West Campus – CT Scan



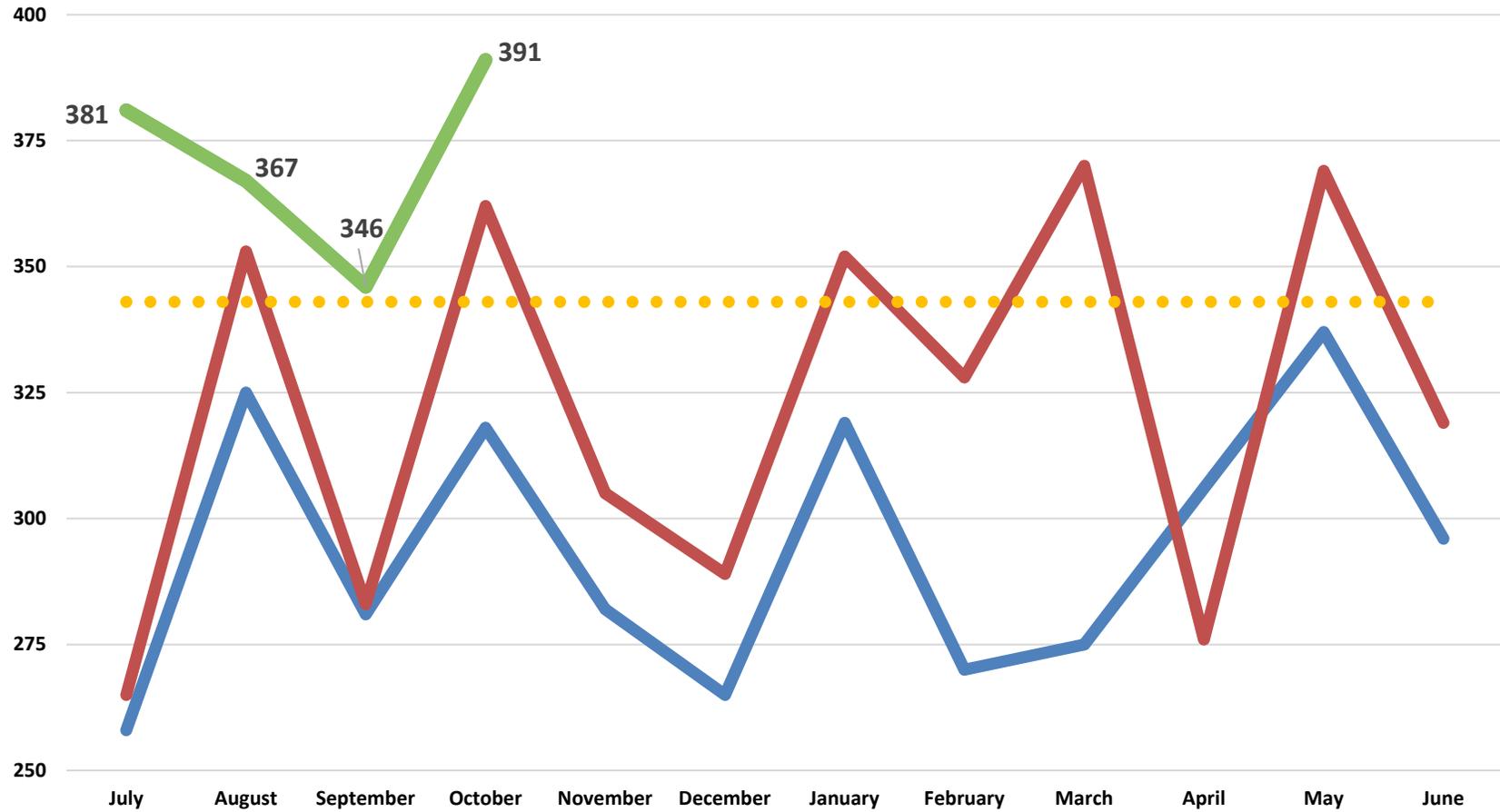
# West Campus - Ultrasound



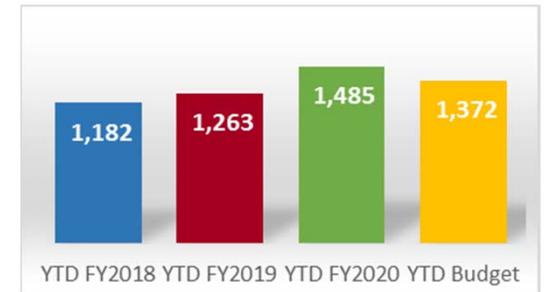
— FY2018 
 — FY2019 
 — FY2020 
 ●●● Budget



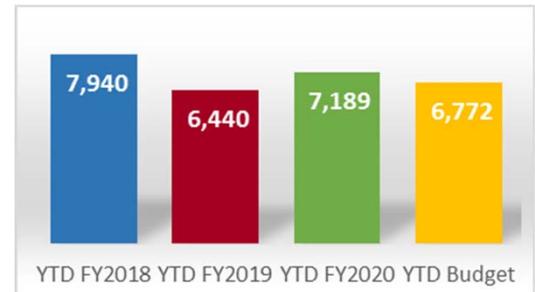
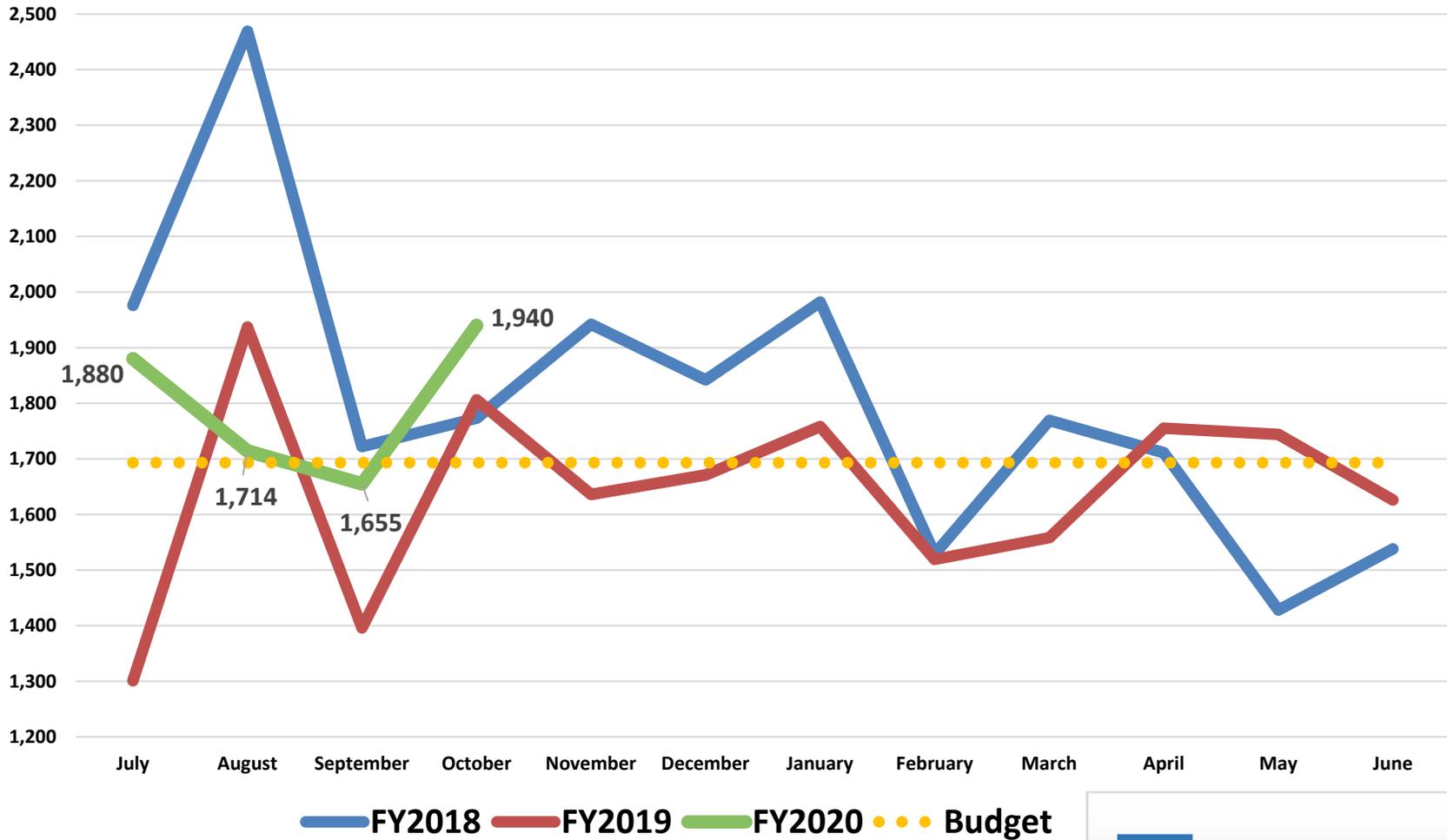
# West Campus - MRI



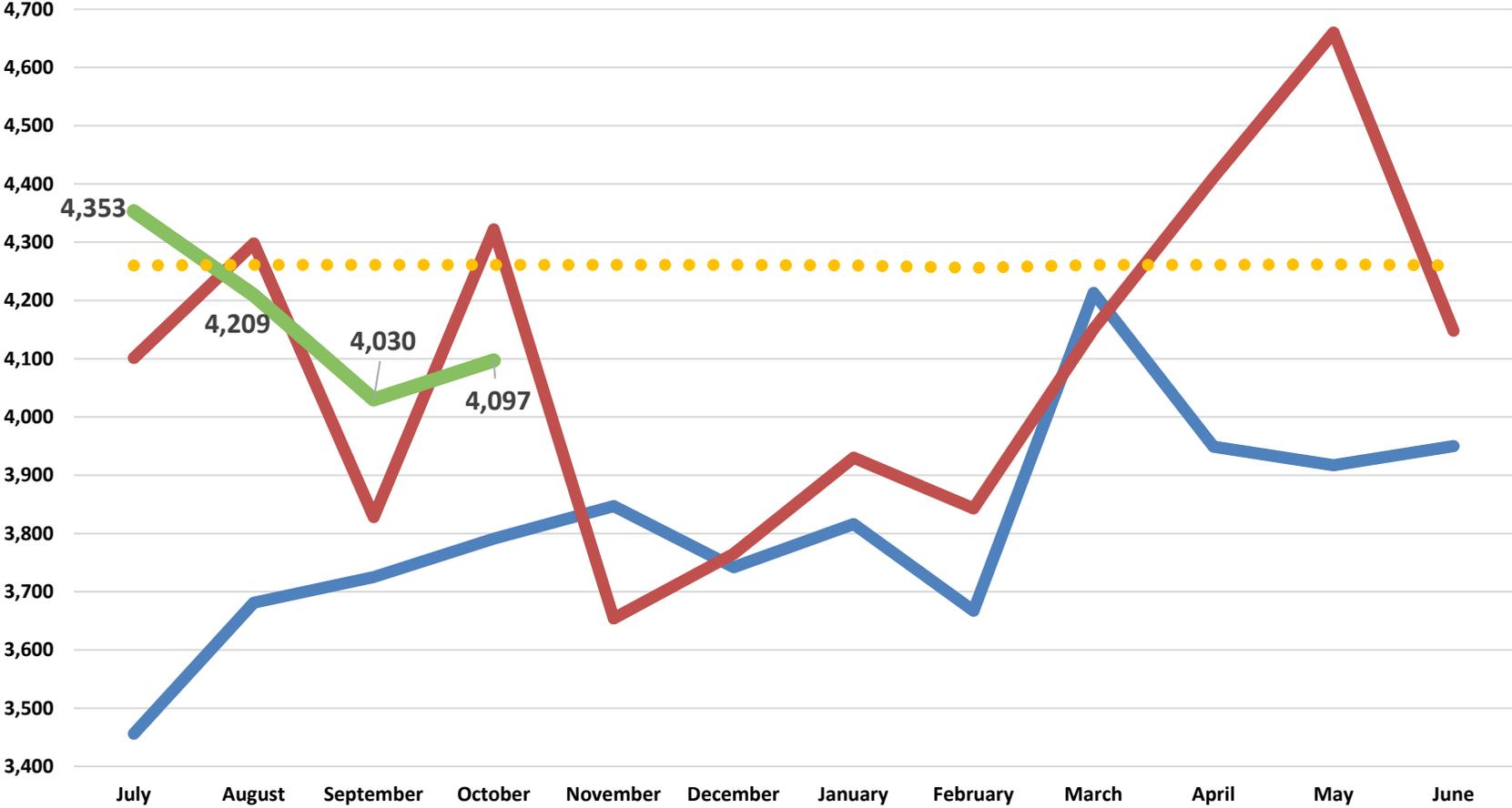
— FY2018 
 — FY2019 
 — FY2020 
 ••• Budget



# West Campus – Breast Center



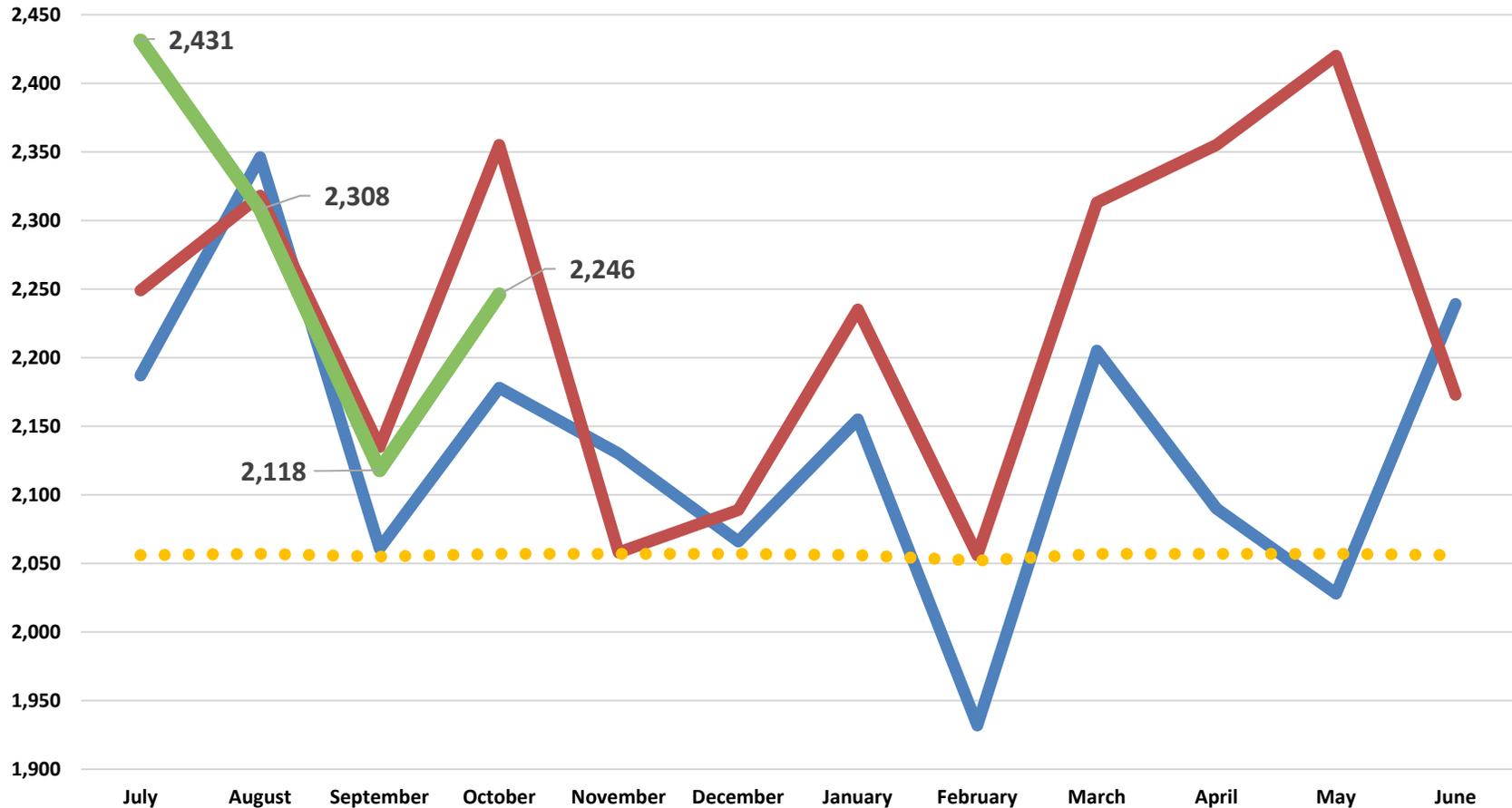
# Radiology all areas – CT



— FY2018 
 — FY2019 
 — FY2020 
 ●●● Budget



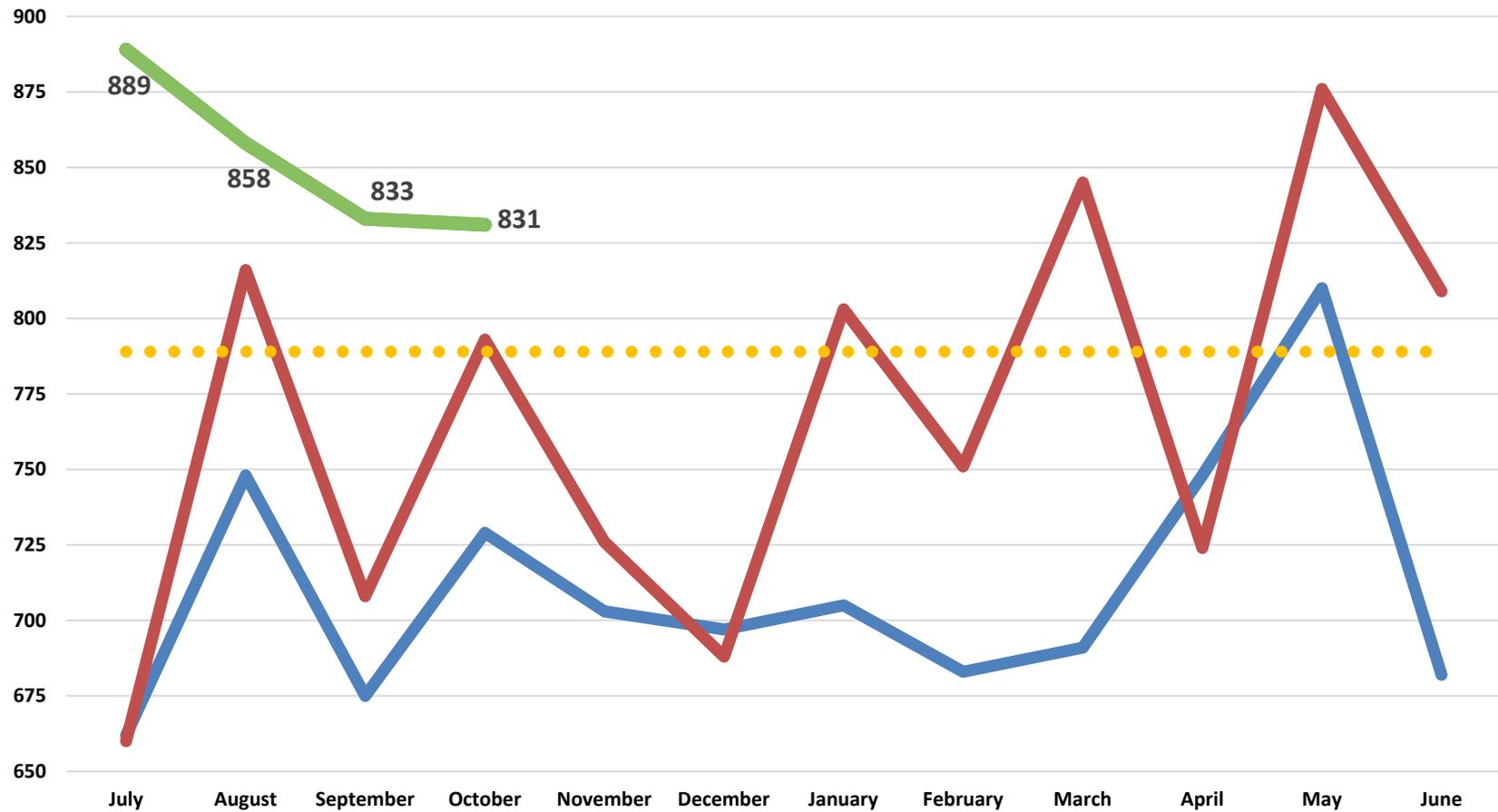
# Radiology all areas – Ultrasound



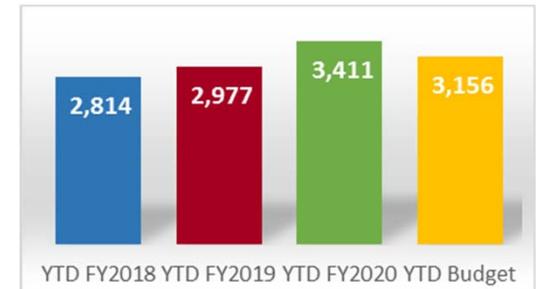
— FY2018 
 — FY2019 
 — FY2020 
 ●●● Budget



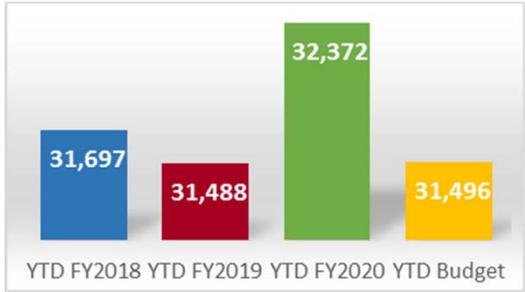
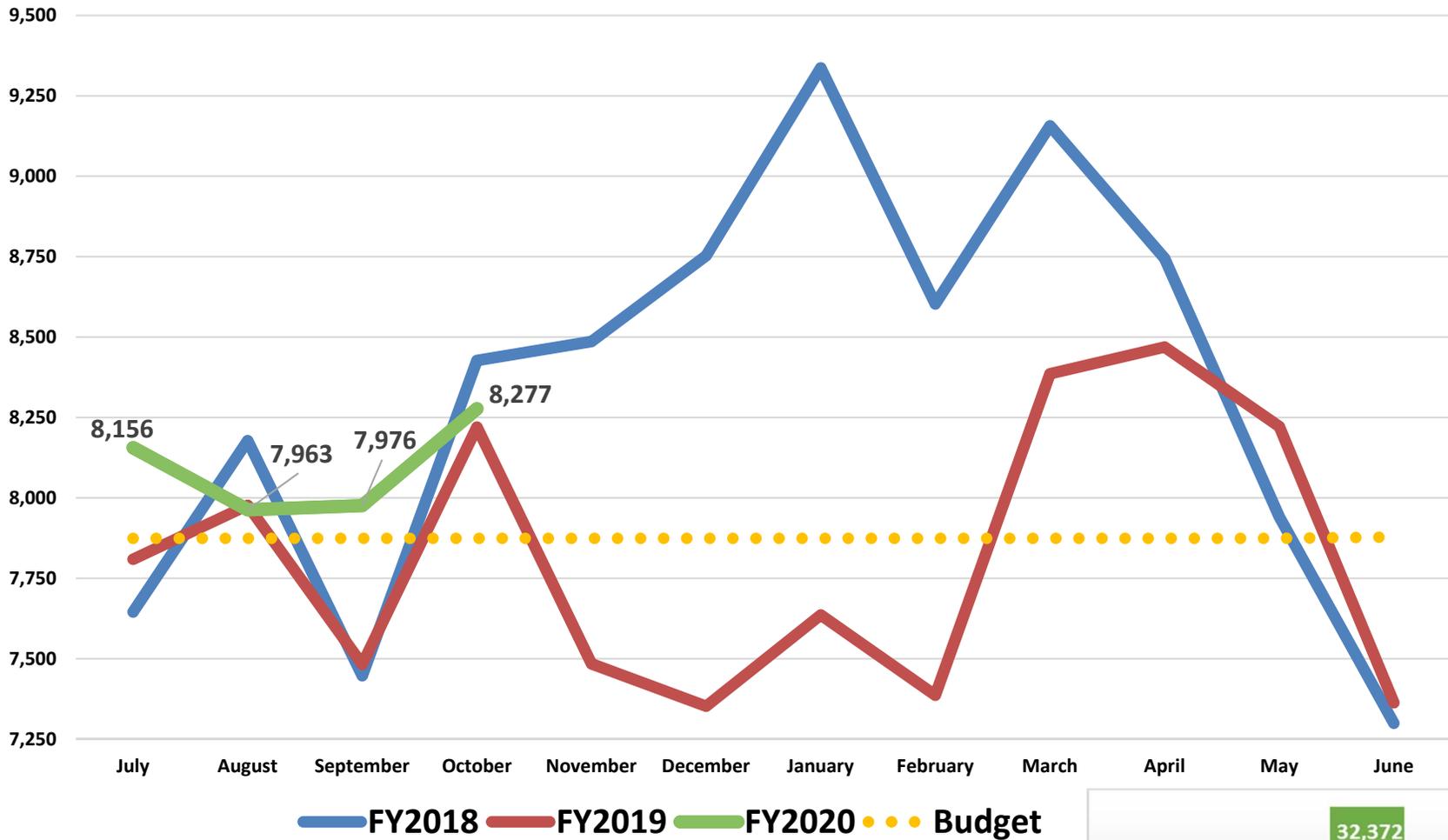
# Radiology all areas – MRI



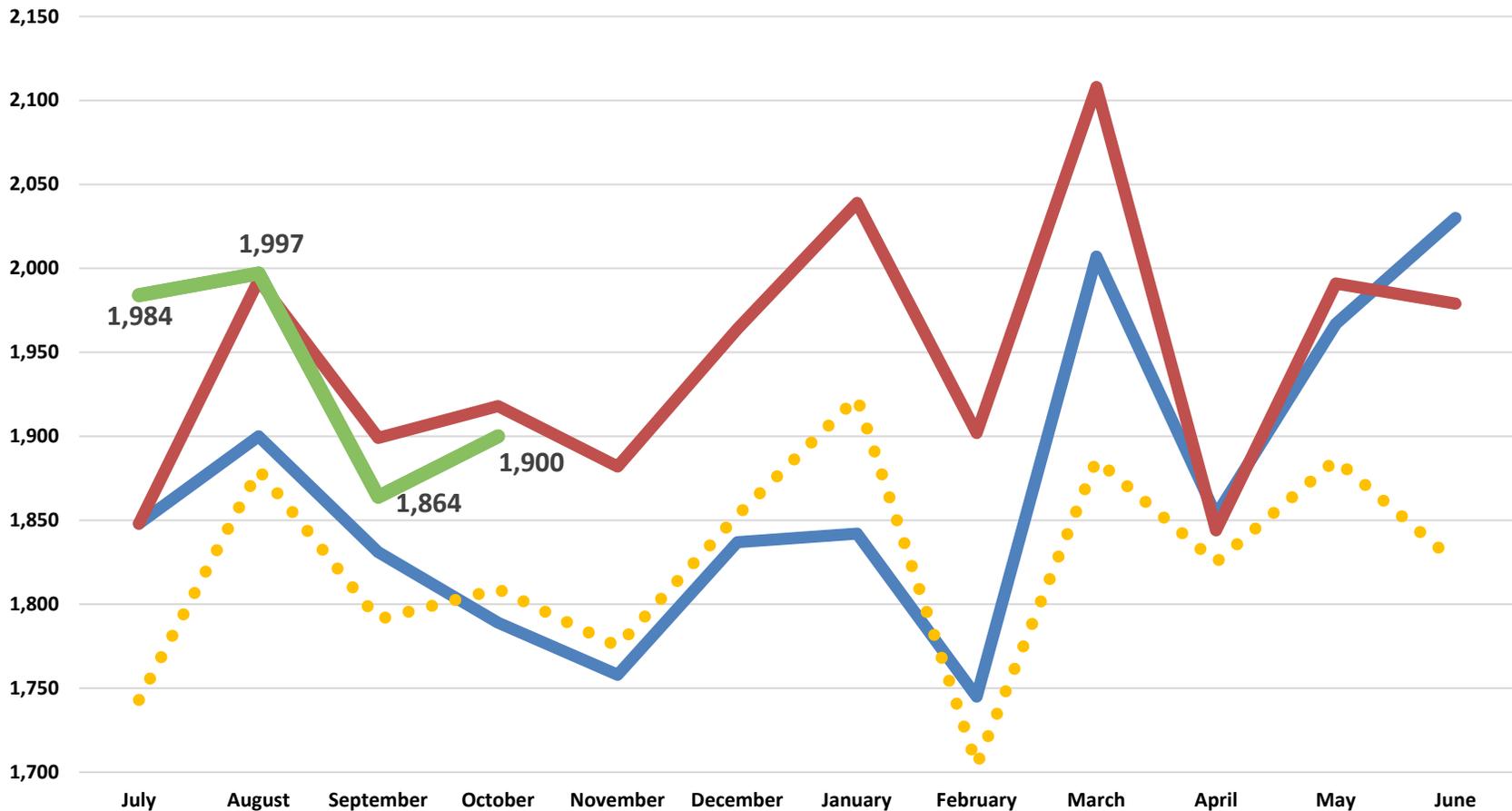
— FY2018 
 — FY2019 
 — FY2020 
 ●●● Budget



# Radiology Modality – Diagnostic Radiology



# Chronic Dialysis - Visalia

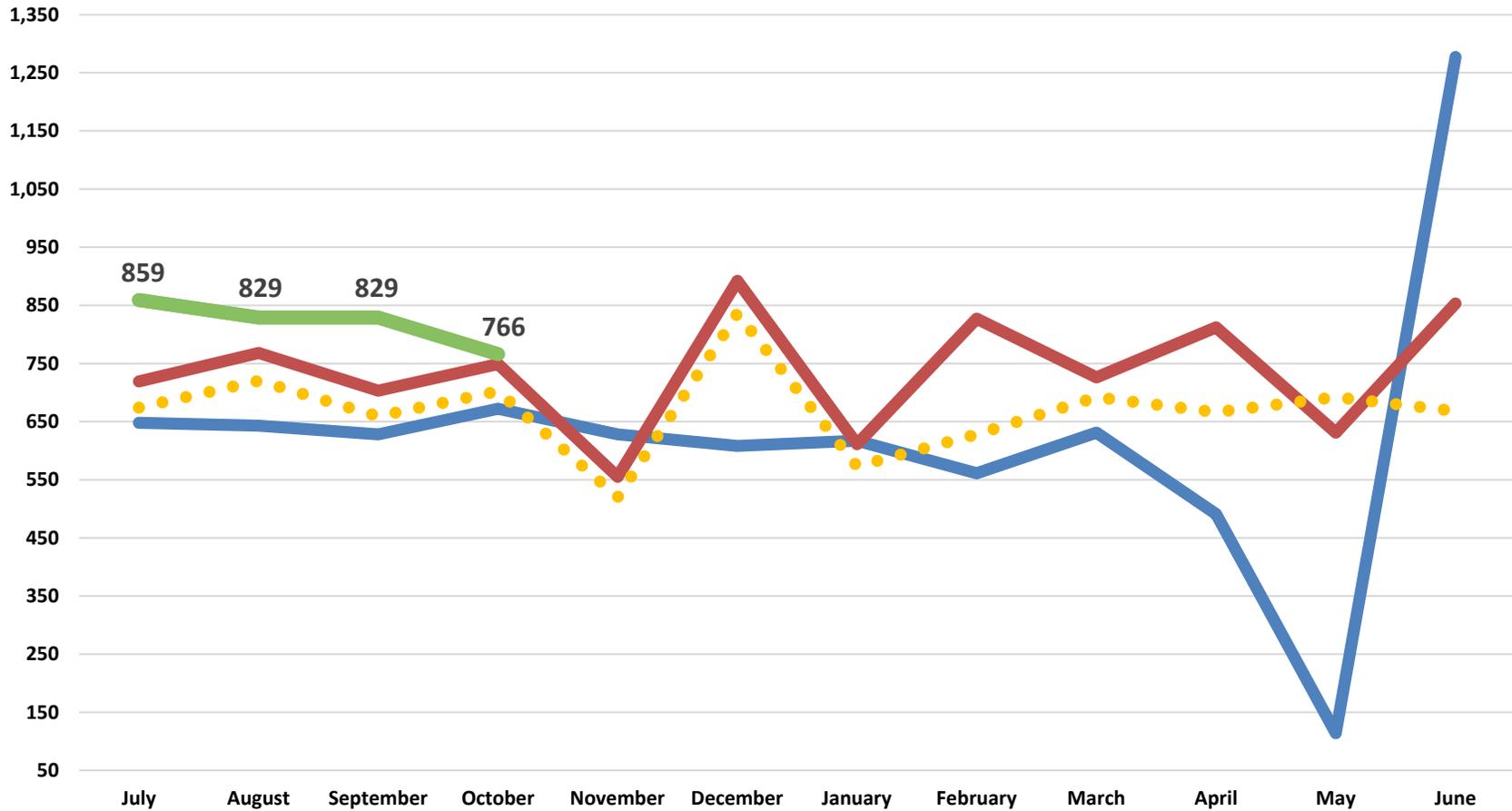


— FY2018 
 — FY2019 
 — FY2020 
 ••• Budget



# CAPD/CCPD – Maintenance Sessions

(Continuous peritoneal dialysis)

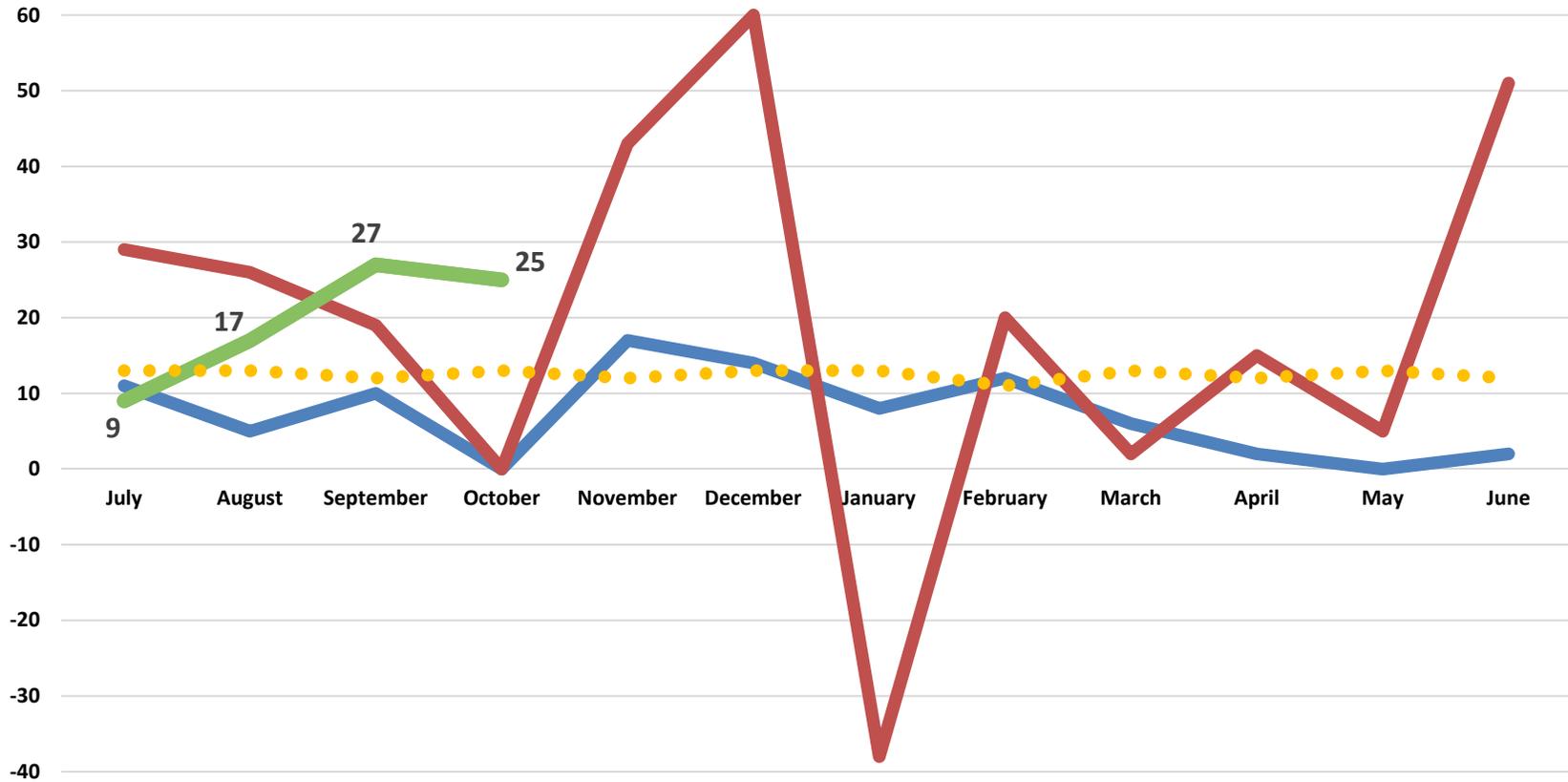


— FY2018 — FY2019 — FY2020 ●●● Budget

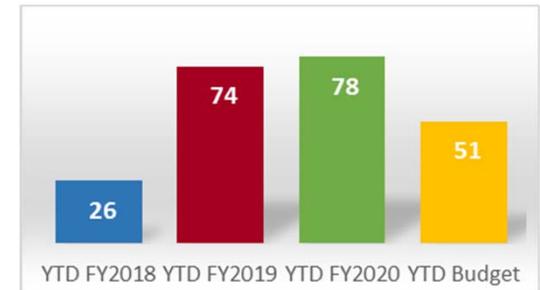


# CAPD/CCPD – Training Sessions

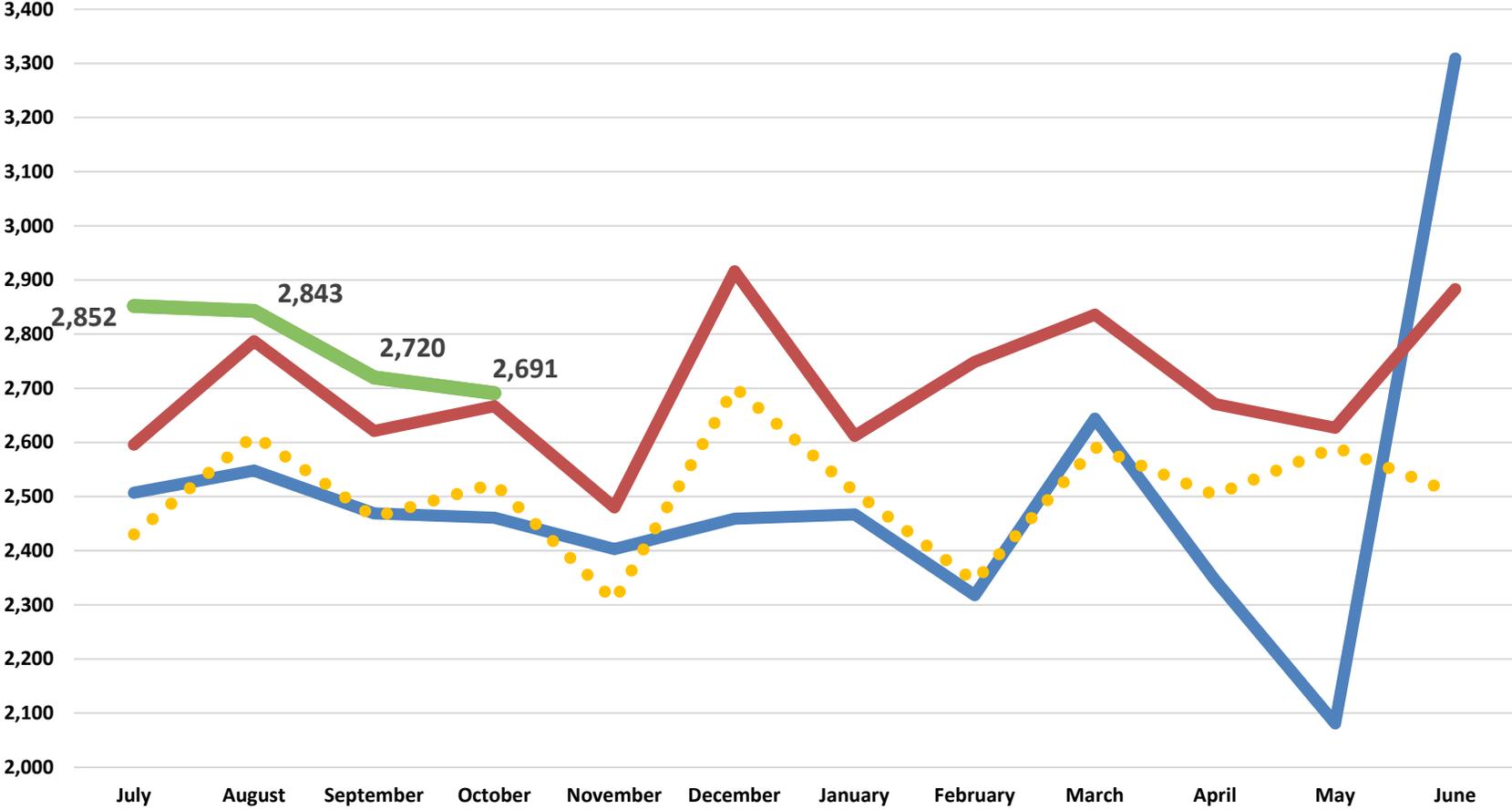
(Continuous peritoneal dialysis)



— FY2018 — FY2019 — FY2020 ••• Budget



# All CAPD & CCPD



— FY2018 
 — FY2019 
 — FY2020 
 ●● Budget

