NOTICE

The Board of Directors of the Kaweah Delta Health Care District will meet in the City of Visalia City Council Chambers {707 W. Acequia, Visalia, CA} on Thursday December 21, 2023:

- 4:00PM Open meeting to approve the Closed agenda
- 4:01PM Closed meeting pursuant to Government Code 54956.9(d)(2), Health and Safety Code 1461, 32155, and 32106 and;
- 4:30PM Open Meeting

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.

All Kaweah Delta Health Care District regular board meeting and committee meeting notices and agendas are posted 72 hours prior to meetings (special meetings are posted 24 hours prior to meetings) in the Kaweah Health Medical Center, Mineral King Wing near the Mineral King entrance.

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

KAWEAH DELTA HEALTH CARE DISTRICT
Mike Olmos, Secretary/Treasurer

Cindy Moccio
Board Clerk / Executive Assistant to CEO

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

400 West Mineral King Avenue · Visalia, CA · (559) 624 2000 · www.kaweahhealth.org
OPEN MEETING AGENDA {4:00PM}

1. CALL TO ORDER

2. APPROVAL OF AGENDA

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

4. APPROVAL OF THE CLOSED AGENDA – 4:01PM

4.1. Conference with Legal Counsel – Anticipated Litigation – Significant exposure to litigation pursuant to Government Code 54956.9(d)(2) – 2 Cases – Rachele Berglund, Legal Counsel and Lindsay Johnson, Risk Management Specialist

4.2. Credentialing - Medical Executive Committee (MEC) requests that the appointment, reappointment and other credentialing activity regarding clinical privileges and staff membership recommended by the respective department chiefs, the credentials committee and the MEC be reviewed for approval pursuant to Health and Safety Code 1461 and 32155 – Daniel Hightower, MD, Chief of Staff

4.3. Quality Assurance pursuant to Health and Safety Code 32155 and 1461, report of quality assurance committee – Daniel Hightower, MD, Chief of Staff

4.4. Approval of the closed meeting minutes – November 16, 2023.

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

Action Requested – Approval of the December 21, 2023 closed meeting agenda.

5. ADJOURN
CLOSED MEETING AGENDA {4:01PM}

CALL TO ORDER

1. **CONFERENCE WITH LEGAL COUNSEL – ANTICIPATED LITIGATION** – Significant exposure to litigation pursuant to Government Code 54956.9(d)(2) – 2 Cases.
   
   *Rachele Berglund, Legal Counsel and Lindsay Johnson, Risk Management Specialist*

2. **CREDENTIALING** - Medical Executive Committee (MEC) requests that the appointment, reappointment and other credentialing activity regarding clinical privileges and staff membership recommended by the respective department chiefs, the credentials committee and the MEC be reviewed for approval pursuant to Health and Safety Code 1461 and 32155.
   
   *Daniel Hightower, MD, Chief of Staff*

   
   *Daniel Hightower, MD, Chief of Staff*

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

   *Action Requested – Approval of the closed meeting minutes – November 16, 2023.*

ADJOURN

OPEN MEETING AGENDA {4:30PM}

1. **CALL TO ORDER**

2. **APPROVAL OF AGENDA**

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

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

5. **OPEN MINUTES** – Request approval of the *November 16, 2023* open minutes.
   
   **Public Participation** – Members of the public may comment on agenda items before action is taken and after the item has been discussed by the Board.

   *Action Requested – Approval of the November 16, 2023 open meeting minutes.*
6. RECOGNITIONS

6.1. Presentation of Resolution 2208 to Ody DaSilva, in recognition as the Kaweah Health World Class Employee of the month – November 2023 – Director Gipson

6.2. Presentation of Resolution 2209 to Armando Gonzalez Zambrano, in recognition as the Kaweah Health World Class Employee of the month – December 2023 – Director Gipson

6.3. Presentation of Resolution 2210 to Brenda Isaac, RN in recognition of her retirement from Kaweah Health – 35 years of service – Director Havard Mirviss

6.4. Presentation of Resolution 2215 to Helene Oliver, RN, in recognition of her retirement from Kaweah Health – 41 years of service – Director Havard Mirviss

6.5. Presentation of Resolution 2213 to Melinda Blankenship, in recognition of her retirement from Kaweah Health – 42 years of service – Director Francis

6.6. Presentation of Resolution 2214 to Garth Gipson in recognition of his service to the Board 2020-2023 – Director Francis

6.7. Recognition of the Cardiovascular Data Team – Tracy Salsa & Keri Noeske

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

Daniel Hightower, MD, Chief of Staff

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

Action Requested – Approval of the December 2023 medical staff credentials report.

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

Daniel Hightower, MD, Chief of Staff

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

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

Action Requested – Approval of the December 21, 2023 Consent Calendar

9.1. REPORTS
   A. Physician Recruitment
   B. Strategic Plan
   C. Environment of Care
   D. Cardiovascular Services
   E. Compliance
   F. Throughput
9.2. POLICIES – ADMINISTRATIVE
A. AP71 – District Facsimile (FAX) and Email communications - Revised
B. AP181 – Property Acquisition, Sales, and Leasing - Revised
C. AP148 – Grants – Revised
D. AP27 – Use of District name and/or stationery – Revised
E. AP57 – Access to Legal Counsel – Revised
F. AP72 – Litigation, Handling Medical Records - Revised
G. AP119 – Visiting Regulations for Kaweah Delta Health Care District – Revised
H. AP41 - Quality Improvement Plan - Revised

9.3. POLICIES – HUMAN RESOURCES – As reviewed and supported for submission to the Board for review and consideration for approval.
A. HR184 – Attendance & Punctuality – Revised
B. HR234 – Paid Time Off (PTO), Extended Illness Bank (EIB) and Healthy Workplace, Healthy Families Act of 2014 – Revised

9.4. POLICIES – EMERGENCY MANAGEMENT
A. DM2210 – Code Orange Hazardous Material Spill Release - Revised

9.5. POLICIES – ENVIRONMENT OF CARE
A. EOC 1015 - Wireless Duress System - Revised
B. EOC 1096 - Electrical Safety Distribution System - Reviewed
C. EOC 4012 - Disposal of Radioactive Material - Reviewed
D. EOC 7305 - Utilities Management Inventory - Reviewed

9.6. Approval of Resolution 2216 - Janelle Wynn retiring from Kaweah Health (17 years).
9.7. Approval of Resolution 2217 Carla Hernandez retiring from Kaweah Health (12 years).
9.8. Approval of the Kaweah Delta Health Care District dba Kaweah Health Graduate Medical Education diplomas certifying that the Kaweah Delta Health Care District duties for each residency has been fulfilled – Mick Kastner – Emergency Medicine
9.9. Approval of amendment to the Board Bylaws incorporating changes on page 11 (Patient Experience), page 23 (Removal of 202 W. Willow – Board of Owners from the list of Independent Committees that have Board participation) and page 16 and 17 (Due to the approval of Resolution 2207 at the November Board meeting this section needed a major revision to match what is required in the Board resolution).
9.10. Approval of Resolution 2211 amending the employee’s salary deferral plan and Resolution 2212 amending the 457(b) deferred compensation plan.
9.11. Medical Executive Committee – December 2023
A. Privilege Forms – Anesthesiology – Revised
B. Privilege Forms – CRNA – Revised
C. Privilege Forms - Critical Care & Pulmonary Medicine – Revised
D. Medical Staff Policy – MS54 – COVID19 Testing and Isolation Guidelines (Revised)
9.13. Approval of rejection of claim of Mary Byers vs. Kaweah Delta Health Care District.

   *Amy Baker, MSN, RN, Director of Renal Services*

11. **STRATEGIC PLANNING – Strategic Growth and Innovation** - Detailed review of Strategic Plan Initiative.

   *Ryan Gates, Chief Population Health Officer and J.C. Palermo, Director Physician Recruitment and Relations*

12. **PROVIDER NEEDS ASSESSMENT** – Board action requested relative to the Kaweah Health physician recruitment annual physician recruitment plan – based on the Provider Needs Assessment for Kaweah Health Medical Center.

   *Marc Mertz, VP & Chief Strategy Officer and J.C. Palermo, Director Physician Recruitment and Relations*

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

   *Recommended Action: Having reviewed and analyzed the Provider Needs Assessment conducted by Zephyr Healthcare Advisors in 2023, which includes a specific list of the needed physician specialties for 2023 and 2024 in communities served by the District “Needed Physician Specialties,” the Board hereby finds that it will be in the best interests of the public health of the communities served by the District to have the District provide appropriate assistance in order to obtain licensed physicians and surgeons in the Needed Physician Specialties to practice in the communities served by the District. Therefore, the Board authorizes the District to provide the types of assistance authorized by Cal. Health & Safety Code §32121.3, to obtain licensed physicians and surgeons in the Needed Physician Specialties to practice in the communities served by the District.*

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

   *Malinda Tupper – Chief Financial Officer*


   *Malinda Tupper – Chief Financial Officer*

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


15. **KAWEAH DELTA BOARD OF DIRECTORS – ZONE III** – Discussion relative to letters of interest received for the Zone III Kaweah Delta Health Care District Board seat.

   *Board of Directors & Legal Counsel*
16. **ELECTION OF OFFICERS** - Kaweah Delta Health Care District – The offices of President, Vice President, and Secretary/Treasurer shall be selected at the first regular meeting in December of a non-election year of the District. To hold the office of President, a Board member must have at least one year of service on the Board of Directors. These officers shall hold office for a period of two (2) years or until the successors have been duly elected (or in the case of an unfulfilled term, appointed) and qualified. The officer positions shall be by election of the Board itself.

*Rachele Berglund, Legal Counsel*

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

*Action Requested*  
*Election of Kaweah Delta Health Care District Board of Directors Officers.*

17. **REPORTS**

17.1. **Chief Executive Officer Report** - Report on current events and issues.  
*Gary Herbst, Chief Executive Officer*

17.2. **Board President** - Report on current events and issues.  
*David Francis, Board President*

18. **APPROVAL OF THE CLOSED AGENDA**

18.1. **Conference with Legal Counsel – Anticipated Litigation** – Significant exposure to litigation pursuant to Government Code 54956.9(d)(2) – 1 Case – *Rachele Berglund, Legal Counsel* and *Gary Herbst, Chief Executive Officer*

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

*Action Requested:*  
*Approval of the closed session agenda.*

19. **ADJOURN**

**CLOSED MEETING AGENDA**

1. **CALL TO ORDER**

2. **CONFERENCE WITH LEGAL COUNSEL – ANTICIPATED LITIGATION** – Significant exposure to litigation pursuant to Government Code 54956.9(d)(2) – 1 Case – *Rachele Berglund, Legal Counsel* and *Gary Herbst, Chief Executive Officer*

3. **ADJOURN**

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KAWEAH DELTA HEALTH CARE DISTRICT
BOARD OF DIRECTORS MEETING
THURSDAY DECEMBER 21, 2023

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 8-31
MINUTES OF THE OPEN MEETING OF THE KAWEAH DELTA HEALTH CARE DISTRICT BOARD OF DIRECTORS HELD THURSDAY NOVEMBER 16, 2023 AT 4:00PM, IN THE CITY OF VISALIA CITY COUNCIL CHAMBERS – 707 W. ACEQUIA, VISALIA, CA.

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

The meeting was called to order at 4:02PM by Director Francis.

Director Francis entertained a motion to approve the agenda. 

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

PUBLIC PARTICIPATION – None

APPROVAL OF THE CLOSED AGENDA – 4:01PM

- Conference with Legal Counsel – Anticipated Litigation – Significant exposure to litigation pursuant to Government Code 54956.9(d)(2) – 1 Case – Rachele Berglund, Legal Counsel and Evelyn McEntire, Director of Risk Management
- Credentialing - Medical Executive Committee (MEC) requests that the appointment, reappointment and other credentialing activity regarding clinical privileges and staff membership recommended by the respective department chiefs, the credentials committee and the MEC be reviewed for approval pursuant to Health and Safety Code 1461 and 32155 – Daniel Hightower, MD, Chief of Staff
- Quality Assurance pursuant to Health and Safety Code 32155 and 1461, report of quality assurance committee – Daniel Hightower, MD, Chief of Staff
- Report involving trade secrets (Health and Safety Code 32106) – Discussion will concern a proposed new services/programs – estimated date of disclosure is December 2023 – Marc Mertz, Chief Strategy Officer, Ryan Gates, Chief Population Health Officer, and Gary Herbst, Chief Executive Officer
- Approval of the closed meeting minutes – October 25, 2023.

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

MMSC (Olmos/Havard Mirviss) to approve the November 16, 2023 closed agenda. This was supported unanimously by those present. Vote: Yes – Olmos, Havard Mirviss, Rodriguez, Gipson, and Francis

ADJOURN - Meeting was adjourned at 4:02PM

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

ATTEST:

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

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

The meeting was called to order at 4:46PM by Director Francis.

Director Francis asked for approval of the agenda.

**MMSC (Havard Mirviss/Gipson) to approve the open agenda with the removal of the Provider Needs Assessment to return to the Board in December 2023. This was supported unanimously by those present. Vote: Yes – Olmos, Havard Mirviss, Rodriguez, Gipson, and Francis**

**PUBLIC PARTICIPATION**

- Jack Balsley – Mr. Balsley shared with the Board concerns about the care that his family has received from the medical center. The Board instructed staff to reach out to Mr. Balsley to resolve the concerns he shared at the Board meeting this evening.

**CLOSED SESSION ACTION TAKEN:** Approval the closed minutes from October 25, 2023.

**OPEN MINUTES** – Request approval of the open meeting minutes from October 25, 2023.

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

**MMSC (Havard Mirviss/Olmos) to approve the open minutes from October 25, 2023. This was supported unanimously by those present. Vote: Yes – Olmos, Havard Mirviss, Rodriguez, Gipson, and Francis**

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

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

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

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

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

- No Report.

CONSENT CALENDAR – Director Francis entertained a motion to approve the November 16, 2023 consent calendar.

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

MMSC (Havard Mirviss/Olmos) to approve the November 16, 2023 consent calendar (copy attached to the original of these minutes and considered a part thereof). This was supported unanimously by those present. Vote: Yes – Olmos, Havard Mirviss, Rodriguez, Gipson, and Francis

QUALITY – Diabetes Committee Report – A review of key quality measures and action plans related to the care of in-patients with diabetes (copy attached to the original of these minutes and considered a part thereof) - Cody Ericsson, RN – Advanced Practice Nurse

KAWEAH HEALTH BOARD OF DIRECTORS – ZONE III – Discussion relative to options for filling the Zone 3 Kaweah Delta Health Care District Board seat (copy attached to the original of these minutes and considered a part thereof) - Board of Directors & Legal Counsel

MMSC (Havard Mirviss/Rodriguez) For the Board to proceed with the process to appoint a person to fill the vacancy in Zone 3 within 60 days of the vacancy – December 31, 2023. The deadline for submission of a letter of interest to fill Zone 3 will be December 20, 2023 with the option to extend the deadline at the discretion of the Board. Vote: Yes – Olmos, Havard Mirviss, Rodriguez, and Francis Abstained – Gipson

Director Rodriguez left the meeting.

STRATEGIC PLANNING – Empower Through Education - Detailed review of Strategic Plan Initiative (copy attached to the original of these minutes and considered a part thereof) - Lori Winston, MD, Chief Medical Education Officer and Hannah Mitchell, Director of Organizational Development.

WAYFINDING SURVEY – Report relative to a community engagement wayfinding survey (copy attached to the original of these minutes and considered a part thereof) - Marc Mertz, Chief Strategy Officer and Deborah Volosin, Director of Community Engagement

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 – Chief Financial Officer

REPORTS

Chief Executive Officer Report - Report relative to current events and issues – Gary Herbst, CEO

- Recognized Lori Winston - $300,000 of Cal Med Force funds for the District.
This week Mr. Herbst interviewed two CMO/CQO candidates – one will be invited for panel interviews at the end of November.

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

- No Report.

APPROVAL OF THE CLOSED AGENDA

Conference with Legal Counsel – Anticipated Litigation – Significant exposure to litigation pursuant to Government Code 54956.9(d)(2) – 1 Case – Rachele Berglund, Legal Counsel and Gary Herbst, Chief Executive Officer

MMSC (Gipson/Havard Mirviss) to approve the closed agenda (copy attached to the original of these minutes and considered a part thereof). This was supported unanimously by those present. Vote: Yes – Olmos, Havard Mirviss, Gipson, and Francis  Absent - Rodriguez

ADJOURN - Meeting was adjourned at 6:35PM.

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

ATTEST:

Mike Olmos, Secretary/Treasurer
Kaweah Delta Health Care District Board of Directors
RESOLUTION 2208

WHEREAS, the Department Heads of the KAWEAH DELTA HEALTH CARE DISTRICT dba KAWEAH HEALTH are recognizing Ody DaSilva with the World Class Service Excellence Award for the Month of November 2023, for consistent outstanding performance, and,

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

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

PASSED AND APPROVED this 21ST day of December 2023 by a unanimous vote of those present.

President, Kaweah Delta Health Care District

ATTEST:

Secretary/Treasurer, Kaweah Delta Health Care District
and of the Board of Directors, thereof
I want to nominate Ody DaSilva as Employee of the Month. Please let me explain how Ody emulates our Mission, Vision and Pillars:

Ody is one of the worker bees in the Medical Staff Services Department! Let me share a little more about her!

Health is our passion: Ody is passionate about her role in advocating for our patients, employees, community, and practitioners. She is the first person to bring any compliments or complaints regarding an experience to our attention and get a resolution. I admire her communication skills; she goes above and beyond in every interaction to provide excellent service and outstanding community health.

Excellence is our Focus: Ody has processed 240 reappointment applications for the practitioners to continue working at Kaweah Health and Sequoia Surgery Center in the calendar year of 2023. Her work contributes to our successful accreditation surveys and ensures that our practitioners continue to meet the privilege criteria approved by the Board of Directors. Ody independently processes and bills Sequoia Surgery for our services as their CVO to ensure that our providers working at this facility also meet our World-Class requirements and ensure our Financial Strength.

Compassion is our promise: Ody actively engages our Medical Staff and Advanced Practice Providers to provide them with an Ideal work Environment. Most gather around a water cooler; since we do not have one in the physician lounge, you can find a practitioner needing guidance or help next to Ody’s office, conveniently located near the Coffee Machine. Ody provides a compassionate ear and strives to empower our practitioners by educating them on new services or providing helpful guidance and assistance on completing reappointment applications.

I am honored to work on a team with Ody. She is consistently helpful to our team and others. She is always cheerful and the first to say, “How can I help?”. I’m grateful she chose Kaweah Health because we would not be the same without her!

Multiple physicians have shared with me regarding Ody's performance:

- I would rate Ody's performance as exceptional. I have seen her behave consistently with Kaweah's standards during my interactions. She deserves special recognition as she is pleasant, friendly, helpful, and knowledgeable. She is a great resource!
- She has excellent performance, communication, and professionalism. I feel her overall skill in her position and communication deserves special recognition. She is a great person to work with, and our team appreciates her. She does exceptional work with a high standard of care; she is very professional, prompt, and always available.

Nominated by: April McKee
RESOLUTION 2209

WHEREAS, the Department Heads of the KAWEAH DELTA HEALTH CARE DISTRICT dba KAWEAH HEALTH are recognizing TO BE ADDED with the World Class Service Excellence Award for the Month of December 2023, for consistent outstanding performance, and,

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

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

PASSED AND APPROVED this 21ST day of December 2023 by a unanimous vote of those present.

President, Kaweah Delta Health Care District

ATTEST:

Secretary/Treasurer, Kaweah Delta Health Care District
and of the Board of Directors, thereof
Employee of the Month Nomination - Armando Gonzalez Zambrano

1. He always has a smile on his face, never complains, never gives push back. He always comes when needed! I really appreciate having him in the department. He never fails to make the department clean and patients happy!  
   Nominated by: Georgianna Reyes

2. Any time I ask him for help he always tried his best to help out. He never shows any distaste towards my asking. Whenever he sees me, he always give me his extension even if he is not in my zone. He truly cares for his work and how it is done. BEST EVS EMPLOYEE EVER.  
   Nominated by: Brisa Torres Ramirez

3. Armando is always willing to help no matter how busy it gets. He always has a great attitude while working.  
   Nominated by: Nereida Corona-Arteaga

4. Armando is the best in the ED. He goes above and beyond for everyone in the department.  
   Nominated by: Hailey Scott

5. Armando is the most hard working EVS in the emergency room. He always goes above and beyond when you ask for him to do something. He always has a good attitude every day and is a great team member. 😊  
   Nominated by: Rebecca Killinger

6. Even though I have only worked a short time at Kaweah, Armando has really stuck out as not only an exceptional EVS employee, but also a very kind and thoughtful coworker. Armando is always friendly and consistently is a great team-player and helps the ED Tech and Nurses to clean rooms and keep the department looks clean and organized. Armando has also made me feel very welcome as a new employee.  
   Nominated by: Katie Wightman
7. Armando is a wonderful first-class employee. Even though we work different departments, we are coworkers. He works so hard to keep the ED clean. He is always friendly and so helpful. It’s nice to see him come into work. You know it’s going to be clean for patients and staff. Armando really deserves to be employee of the month.  
**Nominated by: Bertie Sadler-Hahn**

8. Armando always goes above and beyond when it comes to getting help cleaning anything. Very sweet and always leaves his information with us and is also so efficient.  
**Nominated by: Kassandra Contreras**

9. He always goes above and beyond! Thank you for all of your service!  
**Nominated by: Jessica Nasemento**

10. Armando goes above and beyond when it comes to helping us clean rooms, he gives us his extension just in case we need anything. Armando is very appreciate in the ED!  
**Nominated by: Danaly Bedolla**

11. Armando is a very hard worker, he is very respectful and is always on task. He comes into work giving it his all with a great big smile and a positive attitude. He is someone the team can rely on, he is a great team player. He primarily works in the ED department, which is an area where is very fast pace. He is beloved by EVS and ED staff. He is recognized frequently for his great attitude and work ethics. Just this year he received EVS employee of the month for March and he also received a Good Catch Award on May of this year. He is overall a World Class Kaweah Health employee.  
**Nominated by: Jesus Castro Beltran**
WHEREAS, Brenda Isaac, RN, is retiring from duty at Kaweah Delta Health Care District dba Kaweah Health after 35 years of service; and,

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

WHEREAS, the Board of Directors of the Kaweah Delta Health Care District is aware of her excellence in caring and service,

NOW, THEREFORE, BE IT RESOLVED that the Board of Directors of the Kaweah Delta Health Care District, on behalf of themselves, the hospital staff, and the community they represent, hereby extend their appreciation to Brenda Isaac, RN for 35 years of faithful service and, in recognition thereof, have caused this resolution to be spread upon the minutes of this meeting.

PASSED AND APPROVED this 21st day of December 2023 by a unanimous vote of those present.

President, Kaweah Delta Health Care District

Secretary/Treasurer
Kaweah Delta Health Care District
RESOLUTION 2215

WHEREAS, Helene Oliver, RN, is retiring from duty at Kaweah Delta Health Care District dba Kaweah Health after 41 years of service; and,

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

WHEREAS, the Board of Directors of the Kaweah Delta Health Care District is aware of her excellence in caring and service,

NOW, THEREFORE, BE IT RESOLVED that the Board of Directors of the Kaweah Delta Health Care District, on behalf of themselves, the hospital staff, and the community they represent, hereby extend their appreciation to Helene Oliver, RN for 41 years of faithful service and, in recognition thereof, have caused this resolution to be spread upon the minutes of this meeting.

PASSED AND APPROVED this 21st day of December 2023 by a unanimous vote of those present.

President, Kaweah Delta Health Care District

Secretary/Treasurer
Kaweah Delta Health Care District
RESOLUTION 2213

WHEREAS, Melinda Blankenship, is retiring from duty at Kaweah Delta Health Care District dba Kaweah Health after 42 years of service; and,

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

WHEREAS, the Board of Directors of the Kaweah Delta Health Care District is aware of her excellence in caring and service,

NOW, THEREFORE, BE IT RESOLVED that the Board of Directors of the Kaweah Delta Health Care District, on behalf of themselves, the hospital staff, and the community they represent, hereby extend their appreciation to Melinda Blankenship for 42 years of faithful service and, in recognition thereof, have caused this resolution to be spread upon the minutes of this meeting.

PASSED AND APPROVED this 21st day of December 2023 by a unanimous vote of those present.

President, Kaweah Delta Health Care District

Secretary/Treasurer
Kaweah Delta Health Care District
KAWEAH DELTA HEALTH CARE DISTRICT
BOARD OF DIRECTORS MEETING
THURSDAY DECEMBER 21, 2023

HOLDING SPOT FOR RESOLUTION 2214
## Physician Recruitment and Relations

**Medical Staff Recruitment Report - December 2023**

Prepared by: JC Palermo, Director Physician Recruitment - jpalermo@kaweahhealth.org - (559) 624-5456

*Date prepared: 12/7/2023*

### Valley Children's Health Care
- **Maternal Fetal Medicine**: TBD 12/4/2023 (Currently under review)
- **Neurology**: TBD 12/4/2023 (Currently under review)
- **Pediatric Cardiology**: TBD 12/4/2023 (Currently under review)
- **Pediatric Hematology/Oncology**: TBD 12/4/2023 (Currently under review)

### Delta Doctors Inc.
- **Family Medicine**: TBD 12/4/2023 (Currently under review)
- **OB/GYN**: TBD 12/4/2023 (Currently under review)
- **Adult Psychiatry**: TBD 12/4/2023 (Currently under review)

### Key Medical Associates
- **Cardiology**: TBD 12/4/2023 (Currently under review)
- **Family Medicine/Internal Medicine**: TBD 12/4/2023 (Currently under review)
- **Gastroenterology**: TBD 12/4/2023 (Currently under review)
- **Pediatrics**: TBD 12/4/2023 (Currently under review)
- **Pulmonology**: TBD 12/4/2023 (Currently under review)
- **Rheumatology**: TBD 12/4/2023 (Currently under review)

### Sequoia Oncology Medical Associates Inc.
- **Hematology/Oncology**: TBD 12/4/2023 (Currently under review)

### Orthopaedic Associates Medical Clinic, Inc.
- **Orthopedic Surgery (General)**: TBD 12/4/2023 (Currently under review)
- **Orthopedic Surgery (Hand)**: TBD 12/4/2023 (Currently under review)
- **Orthopedic Surgery (Trauma)**: TBD 12/4/2023 (Currently under review)

### Stanford Health Care
- **Cardiothoracic Surgery**: TBD 12/4/2023 (Currently under review)

### Sequoia Cardiology Medical Group
- **EP Cardiology**: TBD 12/4/2023 (Currently under review)

### Oak Creek Anesthesia
- **Anesthesia - General/Medical Director**: TBD 12/4/2023 (Currently under review)
- **Anesthesia - Obstetrics**: TBD 12/4/2023 (Currently under review)
- **Anesthesia - Regional Pain**: TBD 12/4/2023 (Currently under review)

### USC Urology
- **Urology**: TBD 12/4/2023 (Currently under review)

### Valley Hospitalist Medical Group
- **GI Hospitalist**: TBD 12/4/2023 (Currently under review)

### Other Recruitment/Group TBD
- **Dermatology**: TBD 12/4/2023 (Currently under review)
- **Family Medicine**: TBD 12/4/2023 (Currently under review)
- **Gastroenterology**: TBD 12/4/2023 (Currently under review)
- ** Hospice & Palliative Medicine**: TBD 12/4/2023 (Currently under review)
- **Neurology - Outpatient**: TBD 12/4/2023 (Currently under review)
- **Otolaryngology**: TBD 12/4/2023 (Currently under review)
- **Pediatrics**: TBD 12/4/2023 (Currently under review)
- **Pulmonology - Outpatient**: TBD 12/4/2023 (Currently under review)
- **Interventional Cardiology**: TBD 12/4/2023 (Currently under review)
- **General Cardiologist**: TBD 12/4/2023 (Currently under review)

### Candidate Activity

<table>
<thead>
<tr>
<th>#</th>
<th>Specialty</th>
<th>Group</th>
<th>Date Added</th>
<th>Current Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>OB/GYN</td>
<td>TBD</td>
<td>12/4/2023</td>
<td>Currently under review</td>
</tr>
<tr>
<td>2</td>
<td>OB/GYN</td>
<td>TBD</td>
<td>11/4/2023</td>
<td>Currently under review</td>
</tr>
<tr>
<td>3</td>
<td>ENT</td>
<td>TBD</td>
<td>11/1/2023</td>
<td>Currently under review</td>
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<tr>
<td>4</td>
<td>General Cardiology</td>
<td>TBD</td>
<td>11/1/2023</td>
<td>Currently under review</td>
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<tr>
<td>5</td>
<td>Cardiothoracic Surgery</td>
<td>Stanford</td>
<td>10/18/2023</td>
<td>Site Visit: 12/11/23</td>
</tr>
<tr>
<td>6</td>
<td>Pulmonology</td>
<td>TBD</td>
<td>10/15/2023</td>
<td>Site Visit: 12/7/23</td>
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<tr>
<td>7</td>
<td>Radiation Oncology</td>
<td>TBD</td>
<td>10/12/2023</td>
<td>Site Visit: 11/29/23</td>
</tr>
<tr>
<td>8</td>
<td>Radiation Oncology</td>
<td>TBD</td>
<td>10/12/2023</td>
<td>Site Visit: 12/8/23</td>
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<tr>
<td>9</td>
<td>Orthopedic Sports/Gen</td>
<td>Orthopaedic Associates Medical Clinic, inc</td>
<td>10/9/2023</td>
<td>Site Visit: 12/15/23</td>
</tr>
<tr>
<td>10</td>
<td>Gastroenterology</td>
<td>TBD</td>
<td>9/25/2023</td>
<td>Currently under review - Not available until 2025</td>
</tr>
<tr>
<td>11</td>
<td>Family Medicine</td>
<td>TBD</td>
<td>9/22/2023</td>
<td>Site Visit: 10/23/23</td>
</tr>
<tr>
<td>12</td>
<td>EP</td>
<td>TBD</td>
<td>9/11/2023</td>
<td>Currently under review</td>
</tr>
<tr>
<td>13</td>
<td>Neurology</td>
<td>Kaweah Delta Neurology</td>
<td>8/11/2023</td>
<td>Preparing Offer</td>
</tr>
<tr>
<td>14</td>
<td>Pediatric Hospitalist</td>
<td>Valley Children’s</td>
<td>8/1/2023</td>
<td>Site Visit: 10/2023</td>
</tr>
<tr>
<td>15</td>
<td>Intensivist</td>
<td>Central Valley Critical Care Medicine</td>
<td>7/17/2023</td>
<td>Currently under review</td>
</tr>
<tr>
<td>16</td>
<td>Hospitalist</td>
<td>Central Valley Critical Care Medicine</td>
<td>7/17/2023</td>
<td>Currently under review</td>
</tr>
<tr>
<td>17</td>
<td>Hospitalist</td>
<td>Central Valley Critical Care Medicine</td>
<td>7/17/2023</td>
<td>Currently under review</td>
</tr>
<tr>
<td>18</td>
<td>Gastroenterology</td>
<td>TBD</td>
<td>6/21/2023</td>
<td>Currently under review</td>
</tr>
<tr>
<td>19</td>
<td>Adult Psychiatry</td>
<td>Key Medical</td>
<td>6/21/2023</td>
<td>Pending offer</td>
</tr>
<tr>
<td>20</td>
<td>Family Medicine</td>
<td>TBD</td>
<td>6/21/2023</td>
<td>Currently under review</td>
</tr>
<tr>
<td>21</td>
<td>Family Medicine</td>
<td>TBD</td>
<td>6/21/2023</td>
<td>Currently under review</td>
</tr>
<tr>
<td>22</td>
<td>Orthopedic Trauma</td>
<td>Orthopaedic Associates Medical Clinic, inc</td>
<td>8/18/2023</td>
<td>Currently under review</td>
</tr>
</tbody>
</table>

Prepared by: JC Palermo, Director Physician Recruitment - jpalermo@kaweahhealth.org - (559) 624-5456

Date prepared: 12/7/2023

*Prepared by: JC Palermo, Director Physician Recruitment - jpalermo@kaweahhealth.org - (559) 624-5456*

Date prepared: 12/7/2023
Our Mission
Health is our passion.
Excellence is our focus.
Compassion is our promise.

Our Vision
To be your world-class healthcare choice, for life.

Our Pillars
Achieve outstanding community health.
Deliver excellent service.
Provide an ideal work environment.
Empower through education.
Maintain financial strength.

Our Six Initiatives
Empower Through Education
Ideal Work Environment
Strategic Growth and Innovation
Organizational Efficiency and Effectiveness
Outstanding Health Outcomes
Patient Experience and Community Engagement
Empower Through Education

Champions: Dr. Lori Winston and Hannah Mitchell

Objective: Implement initiatives to develop the healthcare team and attract and retain the very best talent in support of our mission.

## FY2024 Strategic Plan - Empower Through Education Strategies

<table>
<thead>
<tr>
<th>#</th>
<th>Name</th>
<th>Description</th>
<th>Status</th>
<th>Assigned To</th>
<th>Last Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1</td>
<td>Expand Online Learning Opportunities and Participation</td>
<td>Increase and optimize existing and new educational opportunities and platforms to support online and computer based learning.</td>
<td>On Track</td>
<td>Hannah Mitchell</td>
<td>While work is underway, the metrics related to this initiative are reporting on a quarterly basis.</td>
</tr>
<tr>
<td>1.2</td>
<td>Increase the Use of and Exposure to Simulation in Education</td>
<td>Develop and implement strategies to expand exposure to the SIM Lab and simulation concepts in training and education.</td>
<td>On Track</td>
<td>Kimberly Sokol</td>
<td>While work is underway, the metrics related to this initiative are reporting on a quarterly basis.</td>
</tr>
<tr>
<td>1.3</td>
<td>Expand Educational Opportunities for External Learners</td>
<td>Include external learners in existing and new training and educational opportunities.</td>
<td>Achieved</td>
<td>Kimberly Sokol</td>
<td>While work is underway, the metrics related to this initiative are reporting on a quarterly basis.</td>
</tr>
<tr>
<td>1.4</td>
<td>Improve Leadership Development and Education</td>
<td>Develop new and enhance existing educational and training opportunities for existing and emerging Kaweah Health and Medical Staff leaders.</td>
<td>On Track</td>
<td>Hannah Mitchell</td>
<td>While work is underway, the metrics related to this initiative are reporting on a quarterly basis.</td>
</tr>
</tbody>
</table>

## Objectives and Outcomes

- **On Track:** 3 (75%)
- **Achieved:** 1 (25%)
Ideal Work Environment

Champions: Dianne Cox and Raleen Larez

Objective: Foster and support healthy and desirable working environments for our Kaweah Health Teams

FY2024 Strategic Plan - Ideal Work Environment Strategies

<table>
<thead>
<tr>
<th>#</th>
<th>Name</th>
<th>Description</th>
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<th>Assigned To</th>
<th>Last Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.2</td>
<td>Ideal Practice Environment</td>
<td>Ensure a practice environment that is friendly and engaging for providers, free of practice barriers.</td>
<td>On Track</td>
<td>Lori Winston</td>
<td>Ongoing effort with the support of the Medical Staff Office.</td>
</tr>
<tr>
<td>2.5</td>
<td>Growth in Nursing School Partnerships</td>
<td>Increase the pool of local RN candidates with the local schools to increase RN cohort seats.</td>
<td>On Track</td>
<td>Dianne Cox</td>
<td>Data will be available January</td>
</tr>
<tr>
<td>2.1</td>
<td>Employee Retention and Resiliency</td>
<td>Kaweah Health is facing the same challenges as many employers in the labor market and must make retention a top priority.</td>
<td>On Track</td>
<td>Dianne Cox</td>
<td>Data will be available January</td>
</tr>
<tr>
<td>2.3</td>
<td>Kaweah Care Culture</td>
<td>Recreate Kaweah Care culture into the various aspects of the organization.</td>
<td>On Track</td>
<td>Dianne Cox</td>
<td>1. Employee Engagement and Experience (To be presented to HR Committee of the Board 12/13/2023). 2. Ideal Practice Environment/Physician Engagement and Experience (To be presented at the February 2024 HR Committee of the Board). 3. Patient Experience (Keri presents to the respective Board).</td>
</tr>
</tbody>
</table>

Objectives and Outcomes

- On Track 5 (100%)

Increase to 460 Volunteers (by 6/30/24)

- Baseline
- Target

Decrease Overall KH Turnover Rate (< 15%)

- Baseline
- Target

Decrease Nursing Turnover Rate (< 17%)

- Baseline
- Target
Objectives and Outcomes

**Objective: Grow intelligently** by expanding existing services, adding new services, and serving new communities. Find new ways to do things to improve efficiency and effectiveness.

### FY2024 Strategic Plan - Strategic Growth and Innovation Strategies

<table>
<thead>
<tr>
<th>#</th>
<th>Name</th>
<th>Description</th>
<th>Status</th>
<th>Assigned To</th>
<th>Last Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1</td>
<td>Recruit and Retain Providers</td>
<td>Develop a recruitment strategy around top physician needs to recruit and retain physicians and providers to address unmet community needs and to support Kaweah Health's growth.</td>
<td>On Track</td>
<td>JC Palermo</td>
<td>Along with the completion of a new Physician Needs Assessment report, the prioritization of specialty recruitments is being guided by the projects outlined by the Strategic Growth Committee.</td>
</tr>
<tr>
<td>3.2</td>
<td>Grow Targeted Inpatient and Surgery Volumes</td>
<td>Grow our inpatient volumes, particularly the surgical cases, with an emphasis on key service lines such as Cardiac and Urology.</td>
<td>Off Track</td>
<td>Kevin Bartel</td>
<td>Elective CABG case volumes are below established goal and impacted due to the holiday in November. Urology case volumes are close to expected goal, however IP case volumes are impacted by limited Urology call coverage.</td>
</tr>
<tr>
<td>3.3</td>
<td>Grow Targeted Outpatient Volumes</td>
<td>Increase access to outpatient care in locations that are convenient to our community.</td>
<td>Off Track</td>
<td>Ivan Jara</td>
<td>While the Industrial Park Clinic has opened and the Youth Crisis Stabilization Unit is on track, the 202 Willow Clinic has been delayed in opening until the first quarter of calendar year 2024. While endoscopy case volume is above goal, 67.9% of cases are completed by VMC providers.</td>
</tr>
<tr>
<td>3.4</td>
<td>Innovation</td>
<td>Implement and optimize new tools and applications to improve the patient experience, patient communication and patient outcomes.</td>
<td>Off Track</td>
<td>Jacob Kennedy</td>
<td>Call volumes are up, but due to three open positions and sick calls our metrics related to Average Patient Hold Time and Call Abandonment Rate are not at goal. In addition, integration of referral tools leads to progress.</td>
</tr>
</tbody>
</table>

### Objectives and Outcomes

- **Increase the Percentage of Coronary Artery Bypass Graph Surgery Cases that are Elective**
- **Increase Number of Urology Surgery Cases**
- **Increase Monthly Endoscopy Case Volume**
Organizational Efficiency and Effectiveness

Champions: Jag Batth and Rebekah Foster

Objective: Increase the efficiency and effectiveness of the Organization to reduce costs, lower length of stay and improve processes.

FY2024 Strategic Plan - Organization Efficiency and Effectiveness Strategies

<table>
<thead>
<tr>
<th>#</th>
<th>Name</th>
<th>Description</th>
<th>Status</th>
<th>Assigned To</th>
<th>Last Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.1</td>
<td>Patient Throughput and Length of Stay</td>
<td>Implement patient flow processes that are effective and efficient to improve patient throughput and lower the overall Length of Stay.</td>
<td>Off Track</td>
<td></td>
<td>November length of stay data is not available at the time of this report. These comments reflect October 2023 status. While we have not achieved our goals, work continues on this important initiative. For this month, both inpatient and emergency department length of stay numbers are trending downward. Although observation length of stay increased, there were three observation patients with long lengths of stay discharged in this month.</td>
</tr>
<tr>
<td>4.2</td>
<td>Increase Main and Cardiac Operating Room Efficiency/Capacity</td>
<td>Improve Operating Room Efficiency, Capacity and Utilization to meet surgery volume needs.</td>
<td>On Track</td>
<td>Lori Mulliniks</td>
<td>Three of our five metrics are on track and the remaining two are not at goal, but are trending toward goal.</td>
</tr>
<tr>
<td>4.3</td>
<td>Create a Process to Monitor Use of Tests and Treatments</td>
<td>Create and initiate a workgroup to identify areas of focus and establish benchmarks related to the use of tests and treatments.</td>
<td>On Track</td>
<td>Suzy Plummer</td>
<td>Team is meeting regularly to discuss focus areas, benchmarks and measures of success. Tracking will begin in January 2024.</td>
</tr>
<tr>
<td>4.4</td>
<td>Optimize Revenue Cycle Efforts</td>
<td>Focus efforts on key revenue cycle metrics to increase collections and reduce denials.</td>
<td>At Risk</td>
<td>Frances Carrera</td>
<td>The Patient Accounting team is down 7-9 FTEs and combined with regulatory billing changes, days in accounts receivable is increasing instead of decreasing. Our point of care efforts are improving, but we are still not meeting our...</td>
</tr>
</tbody>
</table>

Objectives and Outcomes

- On Track 2 (50%)
- Off Track 1 (25%)
- At Risk 1 (25%)

Decrease Inpatient Observed to Expected Length of Stay

Improve Elective Case Main Operating Room Utilization

Increase Front End Collections

This plan item was deleted.
### FY2024 Strategic Plan - Outstanding Health Outcomes Strategies

<table>
<thead>
<tr>
<th>#</th>
<th>Name</th>
<th>Description</th>
<th>Status</th>
<th>Assigned To</th>
<th>Last Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.1</td>
<td>Standardized Infection Ratio (SIR)</td>
<td>Reduce the Hospital Acquired Infections (HAIs) to the national 70th percentile in FYTD24 as reported by the Centers for Medicare and Medicaid Services</td>
<td>On Track</td>
<td>Sandy Volchko</td>
<td>Will be modifying the metric targets.</td>
</tr>
<tr>
<td>5.2</td>
<td>Sepsis Bundle Compliance (SEP-1)</td>
<td>Increase SEP-1 bundle compliance to overall 85% compliance rate for FY24 through innovative improvement strategies based on root causes.</td>
<td>On Track</td>
<td>Sandy Volchko</td>
<td>SEPSIS O/E Metric data is for June. Performance data not available. Will be modifying the metric/target.</td>
</tr>
<tr>
<td>5.3</td>
<td>Mortality and Readmissions</td>
<td>Reduce observed/expected mortality through the application of standardized best practices.</td>
<td>On Track</td>
<td>Sandy Volchko</td>
<td>Will be modifying metric targets.</td>
</tr>
<tr>
<td>5.4</td>
<td>Quality Improvement Program (QIP) Reporting</td>
<td>Achieve performance on the Quality Incentive Pool measures to demonstrate high quality care delivery in the primary care space.</td>
<td>At Risk</td>
<td>Sonia Duran-Aguilar</td>
<td>Proxy Performance out of Cozeva Population Health Tool shows Kaweah Health is meeting 4 Quality Measures out of 10; performance at 30%. A lot of QI efforts in the RHCs to finish strong by the end of the year.</td>
</tr>
<tr>
<td>5.6</td>
<td>Inpatient Diabetes Management</td>
<td>Optimize inpatient glycemic management using evidence-based practices to improve patient's glycemic control and reduce hypoglycemic events.</td>
<td>On Track</td>
<td>Sonia Duran-Aguilar</td>
<td>SHM performance data reports twice a year. Current performance data is from 5/2023. Next report will be in Fall 2023.</td>
</tr>
</tbody>
</table>

---

### Objective: To consistently deliver high quality care across the health care continuum.

**SEPSIS Mortality O/E**

<table>
<thead>
<tr>
<th>Date</th>
<th>O/E</th>
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<tbody>
<tr>
<td>07/30/2023</td>
<td>0.78%</td>
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**Meet 10 QIP Performance Measures**

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<th>Baseline</th>
<th>Target</th>
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<tbody>
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<td>6</td>
</tr>
<tr>
<td>07/30/2023</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>08/31/2023</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>09/30/2023</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>10/31/2023</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>11/30/2023</td>
<td>6</td>
<td>6</td>
</tr>
</tbody>
</table>

---

**Hypoglycemia in Critical Care Patients (< 4.3%)**

<table>
<thead>
<tr>
<th>Date</th>
<th>Baseline</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>07/30/2023</td>
<td>4.8%</td>
<td>2.4%</td>
</tr>
<tr>
<td>08/31/2023</td>
<td>4.5%</td>
<td>2.4%</td>
</tr>
<tr>
<td>09/30/2023</td>
<td>4.5%</td>
<td>2.4%</td>
</tr>
</tbody>
</table>

---

**Champions: Dr. LaMar Mack and Sandy Volchko**
Objectives and Outcomes

FY2024 Strategic Plan - Patient and Community Experience Strategies

<table>
<thead>
<tr>
<th>#</th>
<th>Name</th>
<th>Description</th>
<th>Status</th>
<th>Assigned To</th>
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</tr>
</thead>
<tbody>
<tr>
<td>6.1</td>
<td>Highlight World-Class Service/Outcomes (Hospitality Focus)</td>
<td>Develop strategies that provide our health care team the tools they need to deliver a world-class health care experience.</td>
<td>On Track</td>
<td>Keri Noeske</td>
<td>HCAHPS Data: For FY24 will be 30 days behind d/t HCAHPS surveying timelines. Data for July 2023 will be updated in September 2023. ED Score: Value below baseline. ED Operations team to assess feedback and recommend an action plan to Patient Experience Committee to address decrease.</td>
</tr>
<tr>
<td>6.2</td>
<td>Increase Compassionate Communication</td>
<td>To reach the 50th percentile in physician and nursing communication and responsiveness of staff on the HCAHPS survey.</td>
<td>On Track</td>
<td>Keri Noeske</td>
<td></td>
</tr>
<tr>
<td>6.3</td>
<td>Enhancement of Systems and Environment</td>
<td>To create a secure, warm and welcoming environment for patients and the community.</td>
<td>On Track</td>
<td>Keri Noeske</td>
<td>Two of seven lost belongings were located and returned to owners in July 2023. Investigations still pending on two items. Monitor departments for lost belongings trends and mandate action plans reported into patient care committee as needed.</td>
</tr>
<tr>
<td>6.4</td>
<td>Community Engagement</td>
<td>To provide an environment where community members and patients are able to assist staff in co-designing safe, high quality, and world-class care and services.</td>
<td>On Track</td>
<td>Deborah Volosin</td>
<td></td>
</tr>
</tbody>
</table>

Objective: Develop and implement strategies that provide our health care team the tools they need to deliver a world-class health care experience.
Environment of Care
3rd Quarter Report
July 1, 2023 through September 30, 2023
Presented by
Maribel Aguilar, Safety Officer
maquila@kaweahhealth.org
559-624-2381
**EOC**


### Plan for Improvement:
- Focus on Strains/Sprains and sharps exposures which are the most common type of injury.
- Assure that employees/managers are aware of proper training/instruction and noting any trends per employee and/or injuries.
- Same day on-site incident investigation with employee. Follow-up with manager for prevention opportunities and/or process changes and policy review. Investigation/ follow-up may include photos, video and interview of witnesses/ manager.
- Increase Sharps education in General Orientation by Infection Prevention and Manager orientation by EHS. Demo correct sharps activation in new hire physicals with all employees handling sharps.
- Utilize PTA in Employee Health for Ergo evaluations, evaluate for proper body mechanics to prevent injury, stretching exercises and equipment recommendations to ensure safety with our jobs.
- Continue to work with Infection Prevention to track exposures/outbreaks amongst Health Care Workers in 2023. As of 6/30/23 only 8 positive employees on LOA for COVID (new cases).

### Evaluation:
- 75 OSHA recordable injuries in Qtr 2-2023, plus 117 Covid 19 claims
- Covid 19 vaccination began 12/18/20, boosters began Oct 2021
- Provided ergo evaluations
- 2023 Sharps Exposure- Quarter 2 - 18 total
- Influenza vaccination rate 2022-2023 82%

### Type of Injury

<table>
<thead>
<tr>
<th>Type of Injury</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Incidents</td>
<td>94</td>
<td>163</td>
<td>131</td>
<td>388</td>
</tr>
<tr>
<td>Covid 19+ OSHA recordable</td>
<td>276</td>
<td>117</td>
<td>319</td>
<td>712</td>
</tr>
<tr>
<td>Lost time cases</td>
<td>49</td>
<td>38</td>
<td>49</td>
<td>136</td>
</tr>
<tr>
<td>Strain/sprain</td>
<td>35</td>
<td>18</td>
<td>29</td>
<td>82</td>
</tr>
<tr>
<td>Sharps Exp # EE end of QTR</td>
<td>24</td>
<td>18</td>
<td>15</td>
<td>57</td>
</tr>
</tbody>
</table>

### OSHA recordable injuries and illnesses are as follows:
- Fatalities (reportable)
- Hospitalizations (reportable)
- Claim with lost work day, or modified work with restrictions (reportable)
- Medical treatment other than First Aid (recordable)

**Total Incidents** include First Aid and Report Only, 55/266
Kaweah Health Environment-of-Care Hazard Rounds 3rd Quarter 2023

To better depict the extent to which Kaweah Health performs audits to ensure a safe patient ready environment, findings from all entities that generate observations during EOC Hazard Rounds have been collated and analyzed.

<table>
<thead>
<tr>
<th>Quarter</th>
<th>% Returned in 14 days</th>
<th>% Returned &gt;14 days</th>
<th>% Not Returned</th>
<th># Returned in 14 days</th>
<th># Returned &gt;14 days</th>
<th># Not Returned</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st QTR</td>
<td>71%</td>
<td>29%</td>
<td>0%</td>
<td>17</td>
<td>7</td>
<td>0</td>
</tr>
<tr>
<td>2nd QTR</td>
<td>58%</td>
<td>38%</td>
<td>4%</td>
<td>28</td>
<td>18</td>
<td>2</td>
</tr>
<tr>
<td>3rd QTR</td>
<td>55%</td>
<td>36%</td>
<td>5%</td>
<td>13</td>
<td>8</td>
<td>1</td>
</tr>
</tbody>
</table>

**Goal:** Ensure a safe patient ready environment.

**Start Date:** July 1, 2023  
**End Date:** September 30, 2023

**Champion:** Keri Noeske

**Team:** Maribel Aguilar, Christine Madera, Miguel Morales, Edward Cordeiro Jr., Paul Gatley, Matt Howard, Shawn Elkin, Jaynell Tipton, Joetta Denney, Kerry Sommers, Josue Rodriguez, Damon Rolfo, Tendai Zinyemba, Cecelia Cantu, Cherise Mosqueda, Steve Gloeckler, Eric Davidson, Tyler Plumlee, David Valdez, Rebecca Leal

**Measure:** Audits are performed to review the environment of care from the following perspectives, using observations:

<table>
<thead>
<tr>
<th>Category</th>
<th>Observations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safety</td>
<td>Fire Life Safety, Medical Gases, Chemicals, Waste Stream</td>
</tr>
<tr>
<td>Security</td>
<td>Potential risk of harm to others and self</td>
</tr>
<tr>
<td>Clinical Engineering</td>
<td>Medical equipment</td>
</tr>
<tr>
<td>Infection Prevention</td>
<td>Hand hygiene, Isolation/PPE, Airflow, Storage</td>
</tr>
<tr>
<td>Environmental Services</td>
<td>Cleanliness of surfaces</td>
</tr>
<tr>
<td>Facilities</td>
<td>Intact surfaces, HVAC, Electrical, Water</td>
</tr>
<tr>
<td>Laundry</td>
<td>Linens</td>
</tr>
<tr>
<td>Accreditation</td>
<td>Oversight of regulatory/accreditation standards</td>
</tr>
<tr>
<td>Risk Management</td>
<td>Potential risk associated with the patient care environment</td>
</tr>
</tbody>
</table>

**Background:** A total of 22 locations were audited. There were 181 fallouts with approximately 1,200 items surveyed over a 3-month timeframe.

**Summary:**

The CVICU and CVICCU presented the greatest number of fallouts observed during this time period. The bulk (80%) of findings include: storage of items (15), cleanliness (25), doors propped open inappropriately (12), stained ceiling tiles (21), obstacles blocking egresses (9), and waste materials improperly discarded (9). A total of 41 work orders to correct findings were created. Some observations were addressed during the audit phase.
## Detailed Plan for Improvement (2023):

1. Leaders will continue to encourage staff to enter incident reports for workplace violence on Midas.
2. Traveler nurses will receive a CPI physical skills training upon hire. Those travel nurses will also receive a de-escalation tutorial and access to our code grey and code green information sheets.
3. WPV cases will be reviewed by the WPV case review team, and results to those case studies will be sent out to leadership to review for their units.
4. Safety specialist will assist mental health leadership in conducting WPV case reviews at the MH facility monthly. The safety specialist will continue rounding at MH on Mondays. MH will conduct a code grey drill monthly.
5. CPI training will include use of the new 3rd edition from the Crisis Prevention Institute. Refresher courses will focus on the latest in CPI instruction.
6. We will add a new CPI instructor in November from our EVS staff.

<table>
<thead>
<tr>
<th>Kaweah Health location</th>
<th>Quarter</th>
<th>WPV events reported by security (2023)</th>
<th>WPV events entered into MIDAS reporting system (2023)</th>
<th>WPV events reviewed by WPV case review team (2023)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Department</td>
<td>Q1 ’23</td>
<td>22</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Q2 ’23</td>
<td>31</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Q3 ’23</td>
<td>23</td>
<td>7</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Q4 ’23</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Health (WPV case review completed in-house at MH)</td>
<td>Q1 ’23</td>
<td>18</td>
<td>26</td>
<td>*</td>
</tr>
<tr>
<td></td>
<td>Q2 ’23</td>
<td>23</td>
<td>20</td>
<td>*</td>
</tr>
<tr>
<td></td>
<td>Q3 ’23</td>
<td>65</td>
<td>65</td>
<td>*</td>
</tr>
<tr>
<td></td>
<td>Q4 ’23</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Center</td>
<td>Q1 ’23</td>
<td>15</td>
<td>13</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>Q2 ’23</td>
<td>20</td>
<td>15</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>Q3 ’23</td>
<td>15</td>
<td>13</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>Q4 ’23</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Off-Campus facilities</td>
<td>Q1 ’23</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Q2 ’23</td>
<td>1</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Q3 ’23</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Q4 ’23</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Evaluation: Workplace violence reporting on MIDAS is continuing to improve. *WPV cases are being reviewed monthly for Mental Health. Because of the high amount of incidents, they are only reviewing those that there are recordings of that were exceptionally difficult situations.
Evaluation:
There was a 33% increase in WPV incidents district-wide in the 3rd quarter of 2023. In an event there may be multiple incidents i.e., if a patient strikes an RN and a tech that is one event but 2 incidents.

WPV EVENTS PARETO 3\textsuperscript{RD} QUARTER 2023

Evaluation:
There was a 225% increase in WPV events at Mental Health (20 to 65). There was a 35% decrease in WPV events in the ED (34 to 22). There was a 25% decrease in WPV events in the Medical Center (20 to 15). There was a 100% decrease in WPV events in off-campus areas (3 to 0). 59/266
Evaluation: There was an increase in WPV events per 1000 patient days for Mental Health (4.57 TO 16.4). There was a decrease in WPV events per 1000 patient days for the Medical Center (.79 TO .55). There was a decrease in WPV events per 1000 patient visits for the ED (1.43 TO .92).

Evaluation: Of the 7 WPV events reviewed by the WPV case review team, the most prominent root cause of WPV events were based on human factors, with a lack of critical thinking being the most prevalent.
EMERGENCY PREPAREDNESS

Third Quarter 2023

Performance Standard: Employees able to provide correct responses related to Code Green Response.
Goal: 100% Compliance (all employees surveyed answered correctly)
Status: Goal met for 3rd Quarter 2023

Evaluation:
Thirty-three departments were surveyed in the 3rd quarter. In all departments surveyed staff were able to verbalize Code Green response, which resulted in a 100% compliance rate.

95% minimum performance level was met for this quarter.

Detailed Plan for Improvement:
In each department visited there was knowledge of Code Green response.
UTILITIES MANAGEMENT
Second Quarter 2023

Performance Standard: High Risk, Low Risk, Infection Control Preventive Maintenance to be completed on time
Goal: 100% Compliance (no missed PM’s)
Status: Goal met for 3rd Quarter 2023

Evaluation:
2427 of 2427 preventative maintenance work orders were completed on time.

For 2023 2427 of 2427 preventative maintenance work orders completed on time.

<table>
<thead>
<tr>
<th></th>
<th>PM Completion %</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Non-High Risk</td>
</tr>
<tr>
<td>July</td>
<td>100.00%</td>
</tr>
<tr>
<td>August</td>
<td>100.00%</td>
</tr>
<tr>
<td>September</td>
<td>100.00%</td>
</tr>
<tr>
<td>Q3 Summary</td>
<td>100.00%</td>
</tr>
</tbody>
</table>
**SECURITY**

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

**Goal**: 100% compliance rate

**Minimum Performance Level**: <2.75 events per Quarter

---

**LIFE SAFETY**

**Third Quarter 2023**

**Performance Standard**: Employees able to demonstrate the correct response to RACE, specifically Contain- Was the Fire contained, were the fire doors closed, were the patient room doors closed, If evacuation needed did they know the process of marking door with tape.

**Goal**: 100% Compliance

**Status**: Goal met for 3rd Qtr. 2023

---

**Detailed Plan for Improvement:**

All departments surveyed in the 3rd Quarter were knowledgeable of R.A.C.E (Rescue, Alarm, Contain and Extinguish) response.
**EOC Component:** Medical Equipment Preventive Maintenance (PM) Compliance

**Performance Standard:** Maintain a 100% compliance rate on non-high risk and high risk Medical Equipment

**Performance Standard:** <1% Total of High Risk Devices to be Missing for Preventative Maintenance

---

### Evaluation:

For the reporting quarter, CY 2023, Q3 (Jul-Sep), Medical Device count available to receive Preventive Maintenance is 2035 and all of those devices received Preventive Maintenance. All Medical Devices this Quarter received PM or were marked as In Use or Missing in Action (MIA) as defined by TJC.

PM Compliance for Non-High Risk Devices is 100% and meets the 100% Compliance Goal.
PM Compliance for High Risk Including Life Support Devices is 100% and meets the 100% Compliance Goal.

**Performance Improvement Goal:** Total High Risk Devices MIA count is 21 for the Quarter. Total HRiLS MIA devices as % of total HRiLS inventory is 0.45%. Goal met.

---

### Calendar Year 2023

<table>
<thead>
<tr>
<th>Category</th>
<th>Jul-23</th>
<th>Aug-23</th>
<th>Sep-23</th>
<th>CY23, Q3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total PMs Opened</td>
<td>973</td>
<td>225</td>
<td>1076</td>
<td>2274</td>
</tr>
<tr>
<td>Total Administrative Closures</td>
<td>10</td>
<td>5</td>
<td>27</td>
<td>42</td>
</tr>
<tr>
<td>Total Devices Continuously in Use</td>
<td>0</td>
<td>1</td>
<td>10</td>
<td>11</td>
</tr>
<tr>
<td>Total Non-High Risk Devices MIA</td>
<td>84</td>
<td>0</td>
<td>81</td>
<td>165</td>
</tr>
<tr>
<td>Total High Risk including Life Support Devices MIA</td>
<td>10</td>
<td>4</td>
<td>7</td>
<td>21</td>
</tr>
<tr>
<td>Total Achievable PMs</td>
<td>869</td>
<td>215</td>
<td>951</td>
<td>2035</td>
</tr>
<tr>
<td>Total PMs Completed</td>
<td>869</td>
<td>215</td>
<td>951</td>
<td>2035</td>
</tr>
<tr>
<td>Total PMs Not Completed</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total PM Compliance</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
</tr>
<tr>
<td>Non-High Risk PM Compliance</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
</tr>
<tr>
<td>High Risk including Life Support PM Compliance</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
</tr>
</tbody>
</table>

**Plan for Improvement:** Clinical Engineering notifies department managers monthly about medical devices assigned to their areas that could not be located in the prior month and are also rounding monthly in departments with missing equipment. With these tactics, there has been a 30% recovery rate of MIA devices in Q1 and Q2 of CY23. The third quarter of 2023 MIA % was within target range at 0.45%. Clinical Engineering will search for these devices over the next quarter and report on devices found. Another consideration for additional improvement would be to acquire RFID trackers to assist in locating devices.
Cardiology Center, Diagnostic Center and Non-invasive Cardiology

Tracy M. Salsa RN BSN MBA
Director of Cardiovascular Service Line & Cardiology Co-Management Program
624-4919

Dec 2023

Summary Issue/Service Considered

Please note this fiscal narrative combines the Cardiology Center (7088), Diagnostic Center (7561), Noninvasive Cardiology (7560) and Nuclear Medicine (7652).

Board report changes/highlights

- Clinic volumes are up 8% over FY22
- Combined Contribution Margin (CM) at $2.6 million, up significantly from previous years (partly related to combining financials for these various cost centers due to shared expenses such as leases, administration and physician fees to follow billing for testing and services)
- Net Revenue per visit trending upward, currently at $306/visit
- Direct Costs per visit down by 3%, gaining efficiencies from higher volumes; this resulted in the positive CM/visit which is at its highest in the last four years at $86/visit
- Payor mix shows Medicare top payor with 38% with a stable trend; managed care is second top payor at 25% (slight increase by 1% from FY22) with stable payment trend; Medi-cal managed care is next top payor, decreasing by 17% from prior year (termination of La Salle contract in Jan 2023 contributed to this decrease)
- Added Dr. LaMar Mack, vascular surgeon, to this service line in Aug 2022; this addition is reflected in Cardiology Clinic and Diagnostic Center volume; added volume has improved efficiencies thus improved financials
- Cheryl Clark (Manager) continues to work with the Cleveland Clinic on our Intersocietal Accreditation Committee (IAC) Certification of our Non-Invasive Cardiology Lab (includes Diagnostic Center)
  - Our monthly Quality and Education Conference with Continuing Education Units (CEU) has been reinstated
- We have solidified Nurse Practitioner support for IP testing for the following:
  - Stress Testing
  - Bubble Studies
  - Image enhancement (Definity) studies
  - Chemical Stress Testing
  - Tilt Table Exams
This has allowed us to improve throughput for these exams, improve quality of imaging, and potentially assist with decreasing LOS.
We continue our collaboration with Valley Children’s Hospital to enhance our care of our neonatal and pediatric populations here at Kaweah Health.

**Quality/Performance Improvement Data**

Clinic/Diagnostic Center/Non-invasive Cardiology has implemented:

1. Addition of treadmill and echocardiogram room for stress testing – results for this increase is testing will be seen in FY24 financials; addition of this testing room improves patient throughput and timely testing needed for diagnosing and treatment.
2. Registered echo technicians administering Definity (image enhancer) – this results in improved patient throughput, better quality of images/tests, less labor costs, increase in number of tests performed, and prevents patients from repeat testing due to poor image quality thus reducing costs.
3. No show rate for Cardiology Center = 8.5%, down from 12% from FY22. This remains a high priority focus of clinic staff. Text messaging platform that reminds the patient of appointment implemented; bi-directional communication ability which has helped with fast response time to reschedule patient to prevent No Show. Patient Experience data shows a positive trend upward; this clinic is one of the highest ranked among KH entities.

Cardiology Center No Show rate data:

<table>
<thead>
<tr>
<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Canceled</td>
<td>11.00%</td>
<td>13.00%</td>
<td>15.00%</td>
<td>14.00%</td>
<td>13.00%</td>
<td>15.00%</td>
<td>29.00%</td>
<td>17.00%</td>
<td>15.00%</td>
<td>11.00%</td>
<td>16.00%</td>
<td>14.00%</td>
<td>14.50%</td>
</tr>
<tr>
<td>No Show</td>
<td>9.00%</td>
<td>8.00%</td>
<td>9.00%</td>
<td>10.00%</td>
<td>9.90%</td>
<td>7.00%</td>
<td>8.00%</td>
<td>8.00%</td>
<td>9.00%</td>
<td>9.00%</td>
<td>8.00%</td>
<td>8.00%</td>
<td>8.50%</td>
</tr>
</tbody>
</table>

Cardiology Center Patient Experience data:

5. Diagnostic Center No Show rate = 11% which is significantly down from FY22 at 21%. Process implemented last year (utilizing sonographers to make day before appointment reminder calls) remains in place. Sonographers that have a No Show during the day utilize this time slot to make appointment reminder calls for the next day’s scheduled patients. If patient needs to reschedule, the sonographer is able to reschedule the patient while on that phone call. Also implemented one sonographer as a Lead which has several added responsibilities; working the schedule to ensure no open slots is a primary responsibility. Patient Experience data shows a positive trend upward; this service line is one of the highest ranked among KH entities.

Diagnostic Center No Show rate data:

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>Canceled</td>
<td>12.00%</td>
<td>13.00%</td>
<td>13.00%</td>
<td>14.00%</td>
<td>16.00%</td>
<td>20.00%</td>
<td>17.00%</td>
<td>15.00%</td>
<td>14.00%</td>
<td>13.00%</td>
<td>13.00%</td>
<td>13.00%</td>
<td>14.42%</td>
</tr>
<tr>
<td>No Show</td>
<td>12.00%</td>
<td>11.00%</td>
<td>10.00%</td>
<td>10.00%</td>
<td>11.00%</td>
<td>15.00%</td>
<td>11.00%</td>
<td>10.00%</td>
<td>9.00%</td>
<td>13.00%</td>
<td>12.00%</td>
<td>13.00%</td>
<td>11.42%</td>
</tr>
</tbody>
</table>
Diagnostic Center Patient Experience data:

6. Nuclear Medicine (7652) provides SPECT imaging for cardiac patients. This testing is available three days a week (due to sharing a nuclear technician with PET CT). Ideally should have this service available five days a week but recruitment for a nuc tech has been difficult. Contracted labor has been used while recruiting for a nuclear technician. While the No Show averaged 2%, the Cancellation rate is at 9% - that coupled with the limited days during the week to provide this testing has resulted in longer wait times for a SPECT test. A minimum of 24 hours prep time is needed for a patient to undergo a SPECT test so filling open appointment slots on the day of is not an option. New workflow to address cancellations (to turn into a rescheduled testing date) is in place but this workflow is labor intensive. Continue to monitor this and make adjustments as necessary. Patient Experience data shows a steady trend upward; this service line is one of the highest ranked among KH entities.

Nuclear Medicine No Show data:

<table>
<thead>
<tr>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Canceled</td>
<td>9.00%</td>
<td>11.00%</td>
<td>9.00%</td>
<td>6.00%</td>
<td>10.00%</td>
<td>8.00%</td>
<td>9.00%</td>
<td>12.00%</td>
<td>8.00%</td>
<td>11.00%</td>
<td>8.00%</td>
<td>9.00%</td>
<td>9.17%</td>
</tr>
<tr>
<td>No show</td>
<td>6.00%</td>
<td>2.00%</td>
<td>1.00%</td>
<td>1.00%</td>
<td>3.00%</td>
<td>2.00%</td>
<td>1.00%</td>
<td>2.00%</td>
<td>1.00%</td>
<td>1.00%</td>
<td>3.00%</td>
<td>1.00%</td>
<td>2.00%</td>
</tr>
</tbody>
</table>

Nuclear Medicine Patient Experience data:

Policy, Strategic or Tactical Issues

Focus remains on growing our market share for cardiology services. This includes noninvasive testing (i.e. stress testing, echocardiograms), vascular studies, and stress testing. Also continued focus on growing our nuclear medicine program (SPECT and PET). Our sonographer team at the Diagnostic Center are all registered which has been a goal for a few years. We continue our affiliation with Cleveland Clinic, incorporating evidence-based care, maximizing our purchasing relationships to decrease costs, and shape clinical policies and workflows centered on world-class service to our patients. Non-invasive Cardiology/Diagnostic Center remains focused on obtaining accreditation through the Intersocietal Accreditation Commission (IAC). All sonographers must achieve certification in echocardiography prior to application submission for
this accreditation. This remains in progress – three staff at this time need certification and are working towards taking and passing the registry exam in order for KH to apply for this accreditation. In addition to this requirement, unanimous engagement/support from all interpreting cardiologists in achieving IAC quality measures and maintenance equates to 15 echocardiogram-related CMEs every three years (IAC required).

**Recommendations/Next Steps**

Several focused areas:

- Increase productivity by reducing check-in time (time study to be completed to assess inefficiencies and redundancies)
- Increase patient satisfaction – patients now receiving automated call requesting completion of an over-the-telephone survey regarding their last visit; data breakdown providing insight where attention should be which has resulted in increased patient satisfaction scores; portal also provides close to “real time” ability to follow-up on any negative patient experience feedback
- Decrease errors in information collected at front desk during check-in (results in clean claims)
- Increase upfront cash collections for all services
- Decrease no show rate for all areas
- Continue efforts for adding nuclear medicine services to the schedule (adding 2 days per week so 5 days week offer SPECT imaging)
- Utilize Clarify to help identify trends in market share/referral patterns
- Successful acquisition of Intersocietal Accreditation Committee (IAC) Certification
- Continue retrospective review of echocardiograms for report variability, report timeliness, completeness, ejection fraction (EF) and/or regurgitation/stenosis correlation with other modalities (requirement for IAC certification)
- Continue to increase the volume of echocardiography for quality review; Cleveland Clinic recommendation is to review approximately 2% of all completed echocardiograms with feedback given to sonographers as well as interpreting cardiologist

**Approvals/Conclusions**

The Cardiology Center, Diagnostic Center, Noninvasive Cardiology and Nuclear Medicine provides needed cardiology services to our community. We continue to assess innovative methods to deliver high quality and cost effective care. Adding Dr. LaMar Mack (vascular surgeon) added to our growing team and increasing our Cardiovascular Service Line visibility. Kaweah Health Cardiology Clinic continues offering world-class cardiology services in one location and remains committed to the delivery of the highest quality of care with service excellence at the core of what we do.
Cardiothoracic Surgery Clinic (7424)

Tracy M. Salsa RN BSN MBA
Director of Cardiovascular Service Line & Cardiology Co-Management Program
624-4919

Dec 2023

Summary Issue/Service Considered

Kaweah Health opened this newly added outpatient clinic January 17, 2022. Prior to this date, Kaweah Health cardiothoracic surgery patients received professional services from previously contracted physician group, which operated independently. Expenses for newly opened KH CTS Clinic are now separated from physician fees. Prior to Jan 2022, expenses for this service line were transferred to 7423. Due to our continued need to use locums for this service line, costs have increased for physician fees. We continue working with Stanford to recruit fulltime CT surgeons to eliminate the need to use locums. FY23 showed an increase in CTS cases, up by 31% from FY22 which indicates our upward trajectory for this service line. CM down due to direct cost per case up by 6% and a 4% decline in net revenue per case. Payor mix remains stable. Added cost of cardiac surgery coordinator FTE attributed to this cost center however positive impact on decreasing LOS due to the added position.

Quality/Performance Improvement Date

Quality is our top priority. Our team at this clinic is new to KH. The team has been orientated to KH processes, workflows and policies. Main focus at current time is turnaround time for referrals. Our goal is within 7 days for a new referral. We are meeting this goal 97% of the time. Patient experience remains a focus; working with NRC to have breakout data for this clinic.

Policy, Strategic or Tactical Issues

With the operations at the clinic up and running, following are focused areas:

- Recruitment of CT surgeons – contract signed with Stanford Health Aug 2022; recruitment efforts remain a priority; one Stanford hired CT surgeon started at KH on Oct 16, 2023
- Marketing plan for CT Surgery – CV Service Line Steering Committee and various workgroups developed to focus on growth opportunities, market, and community need
- Monitor & analyze Clarify data for market share, leakage, and opportunities
- Coding & billing for CTS claims for professional fees done by third party vendor; change to KH billing Aug 2023 and using different third party vendor for coding (for professional fees); increases visibility to claims, denials, AR, reversals, etc.
- Elective surgeries averaged approximately 22% during FY23; goal is to increase elective surgeries (cardiac as well as thoracic surgeries)
- Clinic No Show rate is very low (<2%)
**Recommendations/Next Steps**

As this service line grows as a KH entity, we have the ability to quickly pivot to ensure the above focus/metrics are met and even exceeded. CT surgeon recruitment is key as well as increasing referral volume. Elective CT surgery referrals are integral to growing this service line. Continue monitoring Clarify data will assist in target marketing efforts.

**Approvals/Conclusions**

The CT Surgery service line has experienced a change in CT surgeons. Quality of care and outcomes have remained unchanged despite these changes. Our focus remains on providing world class care to our CT surgery patients, a personal touch in the clinic for consultative, pre-operative and post-operative care.
Inpatient Cardiothoracic Surgeries

Christine Aleman, MSN, RN – Director of Cardiovascular Operations and Surgical Services (559) 624-2696

December 21, 2023

Summary Issue/Service Considered

The year 2023 has been a significant challenges for the health care, and our Cardiothoracic (CT) Surgery department at Kaweah Medical Center has not been exempt. Despite these hurdles, strategic initiatives and collaborations have been put in place to decrease the impact and pave the way for improvement. CT Surgery saw a 4% decline in net revenue per case, coupled with a 6% increase in direct cost which can be attributed to physician fees. As a result of the decreased revenue and increased cost we saw a net contribution margin loss of $9030 per case. On a positive note we have entered into a partnership with Stanford Medical Group to decrease our reliance on contract physician labor (LOCUMS). Dr. Michael McLean, Stanford faculty CTS, started here at Kaweah in mid-October 2023. This collaboration marks a pivotal step towards reducing dependence on external resources and ensuring consistent, high-quality care within our institution. We will continue to work on recruiting efforts to add highly specialized and efficient CT Surgeons for our Open Heart program.

Quality/Performance Improvement Data

- 6th Consecutive year – Healthgrades 50 Best Hospital for Cardiac Surgery
- Two Star overall rating for Coronary Artery Bypass Graft (CABG)
- Two Star overall rating for Aortic Valve Replacement

Policy, Strategic or Tactical Issues

- With collaboration with Cardiac Surgeons, the average length of stay (LOS) has decreased 12%. There is still an opportunity to decrease LOS by 2 days.
- Continue to work with CT Surgeons to streamline supply usage and expenses.
- Efforts will remain in our recruitment endeavors aimed at acquiring highly specialized and efficient CT Surgeons. Our focus remains for our Open Heart program is ensuring that it not only meets but exceeds the expectations of our patients and the wider community.
Recommendations/Next Steps

- Case volumes continue to be a key indicator for the program’s success
  - Continue to build relationships with the cardiologist who refer patient outside of the community.
- Opportunity to further decrease LOS

Approvals/Conclusions

- While 2023 presented challenges for our Cardiothoracic Surgery department, our proactive steps, including the partnership with Stanford Medical Group and ongoing recruitment efforts, position us well for the future. Continuous strategic planning will remain pivotal in navigating the evolving landscape of healthcare delivery.
Outpatient Cardiac Cath Lab

Christine Aleman, MSN, RN – Director of Cardiovascular Operations and Surgical Services (559) 624-2696
December 21, 2023

Summary Issue/Service Considered

FY23 brought a return to normalcy in the Outpatient Cardiac Cath Lab.
  • Patient volumes increased 5%
  • Net revenue decreased 4% due to a decrease in Medicare and Managed Care reimbursement
  • Direct costs decreased 3%
  • Positive Contribution Margin of $6.3 million
  • Staff Retention remains stable with no reliance on contract labor

Quality/Performance Improvement Data

  • Below the 25% percentile to 90% percentage in reduction of acute kidney injury
  • Radial usage increased to over 50% of all cases
  • Same Day Discharge continues to above national goal

Policy, Strategic or Tactical Issues

  • Continued expansion of structural heart program to include Left Arterial Occlusion with procedures like TAVR and Watchman.

Recommendations/Next Steps

  • Support a collaborative environment between cardiologist and staff focusing on patient outcomes
  • Continue to use utilize our affiliation with Cleveland Clinic to improve efficiencies in the Cath Lab

Approvals/Conclusions

Overall the Cath Lab has remained strong and viable. The Cath Lab continues to function as a high performing team providing necessary services for our community. We have made strides to improve processes in ways that not only contribute to increased efficiencies but also notably positive patient outcomes.
Inpatient Cardiology

Christine Aleman, MSN, RN – Director of Cardiovascular Operations and Surgical Services (559) 624-2696
December 21, 2023

Summary Issue/Service Considered

Inpatient cardiology which consists of inpatient Cardiac Cath Lab (35%), heart failure, acute myocardial infarction (AMI), and cardiac arrhythmia, has a positive contribution margin of $9.9 million. The 15% decrease in contribution margin from 2022 can be attributed to increasing direct costs, specifically in the area of room and board. Overall contribution margin of $9.9 million

Quality/Performance Improvement Data

- Addition of a Cardiac Care Coordinator for cardiac surgery patients
- Best Practice teams for Heart Failure and Acute Myocardial Infarction (MI)

Policy, Strategic or Tactical Issues

- Decrease overall length of stay
- Additional services – Inari clot removal systems

Recommendations/Next Steps

- Develop a Pulmonary Embolism Response Team (PERT)
- Implementation of a cardiogenic shock protocol

Approvals/Conclusions

Cardiovascular Services continues to perform well. FY 23 contribution margin of $16 million. This is the highest growth of cardiovascular contribution margin for outpatient services.
KAWEAH HEALTH ANNUAL BOARD REPORT
Cardiovascular Services - Inpatient Summary

KEY METRICS - FY2023 Twelve Months Ended June 30, 2023

<table>
<thead>
<tr>
<th>METRICS</th>
<th>FY2023 NET REVENUE</th>
<th>FY2023 DIRECT COST</th>
<th>FY2023 CONTRIBUTION MARGIN</th>
<th>FY2023 NET INCOME</th>
</tr>
</thead>
<tbody>
<tr>
<td>PATIENT CASES</td>
<td>$69,876,243</td>
<td>$62,790,136</td>
<td>$7,086,108</td>
<td>($8,604,857)</td>
</tr>
<tr>
<td>NET REVENUE</td>
<td>▲ 9%</td>
<td>▲ 20%</td>
<td>▲ 37%</td>
<td>▲ 301%</td>
</tr>
<tr>
<td>DIRECT COST</td>
<td>▲ 5%</td>
<td>▲ 20%</td>
<td>▲ 37%</td>
<td>▲ 301%</td>
</tr>
<tr>
<td>CONTRIBUTION MARGIN</td>
<td>▲ 37%</td>
<td>▲ 37%</td>
<td>▲ 37%</td>
<td>▲ 37%</td>
</tr>
<tr>
<td>NET INCOME</td>
<td>▲ 301%</td>
<td>▲ 301%</td>
<td>▲ 301%</td>
<td>▲ 301%</td>
</tr>
</tbody>
</table>

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

METRICS BY SERVICE LINE - FY2023

<table>
<thead>
<tr>
<th>SERVICE LINE</th>
<th>PATIENT CASES</th>
<th>NET REVENUE</th>
<th>DIRECT COST</th>
<th>CONTRIBUTION MARGIN</th>
<th>NET INCOME</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Cardiology</td>
<td>2,615</td>
<td>$48,362,021</td>
<td>$38,423,476</td>
<td>$9,039,545</td>
<td>($524,422)</td>
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<tr>
<td>Inpatient Cardiothoracic Surgeries</td>
<td>316</td>
<td>$21,513,322</td>
<td>$24,366,660</td>
<td>($2,853,338)</td>
<td>($8,080,434)</td>
</tr>
<tr>
<td>Inpatient Cardiovascular Services Total</td>
<td>2,931</td>
<td>$69,876,243</td>
<td>$62,790,136</td>
<td>$7,086,108</td>
<td>($8,604,857)</td>
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</tbody>
</table>

METRICS SUMMARY - 4 YEAR TREND

<table>
<thead>
<tr>
<th>METRIC</th>
<th>FY2020</th>
<th>FY2021</th>
<th>FY2022</th>
<th>FY2023</th>
<th>%CHANGE FROM PRIOR YR</th>
<th>4 YR TREND</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Cases</td>
<td>3,358</td>
<td>2,995</td>
<td>2,790</td>
<td>2,931</td>
<td>▲ 5%</td>
<td>▲</td>
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<tr>
<td>Patient Days</td>
<td>16,843</td>
<td>15,827</td>
<td>15,261</td>
<td>15,630</td>
<td>▲ 2%</td>
<td>▲</td>
</tr>
<tr>
<td>ALOS</td>
<td>5.62</td>
<td>5.28</td>
<td>5.47</td>
<td>5.33</td>
<td>▼ -3%</td>
<td>▼</td>
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<tr>
<td>Net Revenue</td>
<td>$75,522,792</td>
<td>$69,097,844</td>
<td>$63,816,698</td>
<td>$69,076,243</td>
<td>▲ 5%</td>
<td>▲</td>
</tr>
<tr>
<td>Direct Cost</td>
<td>$55,392,763</td>
<td>$52,655,449</td>
<td>$52,518,257</td>
<td>$62,790,136</td>
<td>▲ 20%</td>
<td>▲</td>
</tr>
<tr>
<td>Contribution Margin</td>
<td>$16,130,020</td>
<td>$16,442,406</td>
<td>$11,297,841</td>
<td>$7,086,108</td>
<td>▼ -37%</td>
<td>▼</td>
</tr>
<tr>
<td>Indirect Cost</td>
<td>$17,027,961</td>
<td>$14,100,882</td>
<td>$13,443,310</td>
<td>$15,000,964</td>
<td>▲ 17%</td>
<td>▲</td>
</tr>
<tr>
<td>Net Income</td>
<td>($897,032)</td>
<td>($2,341,604)</td>
<td>($2,145,478)</td>
<td>($8,084,957)</td>
<td>▼ -301%</td>
<td>▼</td>
</tr>
<tr>
<td>Net Revenue Per Case</td>
<td>$22,490</td>
<td>$23,071</td>
<td>$22,873</td>
<td>$23,840</td>
<td>▲ 4%</td>
<td>▲</td>
</tr>
<tr>
<td>Direct Cost Per Case</td>
<td>$17,687</td>
<td>$17,581</td>
<td>$18,824</td>
<td>$21,423</td>
<td>▲ 14%</td>
<td>▲</td>
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<tr>
<td>Contrib Margin Per Case</td>
<td>$4,803</td>
<td>$5,490</td>
<td>$4,049</td>
<td>$2,418</td>
<td>▼ -40%</td>
<td>▼</td>
</tr>
</tbody>
</table>

Source: Inpatient Service Line Reports
Criteria: Inpatient Cardiothoracic Surgeries and Cardiology Service Line

GRAPHS

Net Revenue Per Case

Direct Cost Per Case

Contrib Margin Per Case

$0  $5,000  $10,000  $15,000  $20,000  $25,000  $30,000  $35,000  $40,000  $45,000  $50,000

Source: Inpatient Service Line Reports
Criteria: Inpatient Cardiothoracic Surgeries and Cardiology Service Line
KAWEAH HEALTH ANNUAL BOARD REPORT
Cardiovascular Services - Inpatient Summary

KEY METRICS - FY 2023 Twelve Months Ended June 30, 2023

<table>
<thead>
<tr>
<th>METRIC</th>
<th>FY2023</th>
<th>FY2022</th>
<th>FY2021</th>
<th>FY2020</th>
<th>% CHANGE FROM PRIOR YR</th>
<th>4 YR TREND</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Cases</td>
<td>32,694</td>
<td>30,902</td>
<td>30,002</td>
<td>28,892</td>
<td>▲ 6%</td>
<td>▲ 1%</td>
</tr>
<tr>
<td>Net Revenue</td>
<td>$29,344,644</td>
<td>$29,344,644</td>
<td>$29,344,644</td>
<td>$28,100,783</td>
<td>▲ 1%</td>
<td>▲ 1%</td>
</tr>
<tr>
<td>Direct Cost</td>
<td>$20,451,570</td>
<td>$13,651,731</td>
<td>$13,651,731</td>
<td>$13,651,731</td>
<td>▲ 1%</td>
<td>▲ 1%</td>
</tr>
<tr>
<td>Contribution Margin</td>
<td>$8,893,074</td>
<td>$8,893,074</td>
<td>$8,893,074</td>
<td>$8,893,074</td>
<td>▲ 4%</td>
<td>▲ 4%</td>
</tr>
<tr>
<td>Net Income</td>
<td>$4,316,004</td>
<td>$4,316,004</td>
<td>$4,316,004</td>
<td>$4,316,004</td>
<td>▲ 6%</td>
<td>▲ 6%</td>
</tr>
</tbody>
</table>

Source: Outpatient Service Line Reports
Criteria: Outpatient Service Line (Cardiac Cath Lab, Cardiology Clinic and Non-Invasive Cardiology)
### Key Metrics - FY 2023

**Twelve Months Ended June 30, 2023**

<table>
<thead>
<tr>
<th>Metric</th>
<th>FY 2020</th>
<th>FY 2021</th>
<th>FY 2022</th>
<th>FY 2023</th>
<th>% Change from Prior Year</th>
<th>4Y Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Cases</td>
<td>340</td>
<td>293</td>
<td>242</td>
<td>316</td>
<td>▲ 31%</td>
<td>▲ 12%</td>
</tr>
<tr>
<td>Patient Days</td>
<td>3,779</td>
<td>3,654</td>
<td>3,091</td>
<td>3,454</td>
<td>▲ 12%</td>
<td>▲ 12%</td>
</tr>
<tr>
<td>ALOS</td>
<td>11.11</td>
<td>12.47</td>
<td>12.47</td>
<td>10.93</td>
<td>▼ -12%</td>
<td>▼ -12%</td>
</tr>
<tr>
<td>GM LOS</td>
<td>9.36</td>
<td>9.30</td>
<td>8.82</td>
<td>8.39</td>
<td>▼ -5%</td>
<td>▼ -5%</td>
</tr>
<tr>
<td>Opportunity Days</td>
<td>1.75</td>
<td>3.17</td>
<td>3.65</td>
<td>2.54</td>
<td>▼ -30%</td>
<td>▼ -30%</td>
</tr>
<tr>
<td>Net Revenue</td>
<td>$23,320,563</td>
<td>$21,011,260</td>
<td>$17,180,332</td>
<td>$21,513,322</td>
<td>▲ 25%</td>
<td>▲ 25%</td>
</tr>
<tr>
<td>Direct Cost</td>
<td>$22,207,298</td>
<td>$20,263,744</td>
<td>$17,663,012</td>
<td>$24,366,660</td>
<td>▲ 30%</td>
<td>▲ 30%</td>
</tr>
<tr>
<td>Contribution Margin</td>
<td>$1,122,265</td>
<td>$747,516</td>
<td>($413,680)</td>
<td>($2,853,338)</td>
<td>▼ -590%</td>
<td>▼ -590%</td>
</tr>
<tr>
<td>Indirect Cost</td>
<td>$5,877,766</td>
<td>$5,046,905</td>
<td>$4,562,303</td>
<td>$5,227,097</td>
<td>▲ 10%</td>
<td>▲ 10%</td>
</tr>
<tr>
<td>Net Income</td>
<td>($4,755,501)</td>
<td>($4,209,389)</td>
<td>($4,915,083)</td>
<td>($8,080,434)</td>
<td>▼ -64%</td>
<td>▼ -64%</td>
</tr>
<tr>
<td>Net Revenue Per Case</td>
<td>$68,616</td>
<td>$71,711</td>
<td>$71,030</td>
<td>$60,080</td>
<td>▼ -4%</td>
<td>▼ -4%</td>
</tr>
<tr>
<td>Direct Cost Per Case</td>
<td>$65,316</td>
<td>$69,160</td>
<td>$72,740</td>
<td>$77,110</td>
<td>▲ 6%</td>
<td>▲ 6%</td>
</tr>
<tr>
<td>Contrib Margin Per Case</td>
<td>$3,301</td>
<td>$2,551</td>
<td>($1,709)</td>
<td>($9,030)</td>
<td>▼ -428%</td>
<td>▼ -428%</td>
</tr>
</tbody>
</table>

### Payer Mix - 4 Year Trend (Gross Revenue)

<table>
<thead>
<tr>
<th>Payer</th>
<th>FY 2020</th>
<th>FY 2021</th>
<th>FY 2022</th>
<th>FY 2023</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare</td>
<td>35%</td>
<td>43%</td>
<td>38%</td>
<td>36%</td>
</tr>
<tr>
<td>Managed Care/Other</td>
<td>22%</td>
<td>18%</td>
<td>19%</td>
<td>25%</td>
</tr>
<tr>
<td>Medicare Managed Care</td>
<td>17%</td>
<td>18%</td>
<td>20%</td>
<td>21%</td>
</tr>
<tr>
<td>Medi-Cal Managed Care</td>
<td>14%</td>
<td>15%</td>
<td>17%</td>
<td>13%</td>
</tr>
<tr>
<td>Medi-Cal</td>
<td>7%</td>
<td>5%</td>
<td>5%</td>
<td>5%</td>
</tr>
</tbody>
</table>

### FY 2023 Payer Mix

- Medicare: 30%
- Managed Care: 25%
- Medi-Cal: 5%
- Other: 15%
KAWEAH HEALTH ANNUAL BOARD REPORT

Cardiovascular Services - Inpatient Cardiology Service Line

KEY METRICS - FY 2023 Twelve Months Ended June 30, 2023

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Medi-Cal</td>
<td>1,180</td>
<td>$16,222</td>
<td>$13,238</td>
<td>$2,983</td>
<td>43.6%</td>
<td>3,033</td>
<td>$19,342</td>
<td>$12,181</td>
<td>$7,161</td>
<td>41.7%</td>
<td>2,996</td>
<td>$15,950</td>
<td>$14,895</td>
<td>$9,093</td>
<td>41.7%</td>
<td>---</td>
</tr>
<tr>
<td>Medi-Cal Managed Care</td>
<td>523</td>
<td>$10,277</td>
<td>$11,200</td>
<td>$7,075</td>
<td>42.2%</td>
<td>3,033</td>
<td>$19,252</td>
<td>$12,181</td>
<td>$7,071</td>
<td>41.7%</td>
<td>2,996</td>
<td>$15,259</td>
<td>$12,181</td>
<td>$7,071</td>
<td>41.7%</td>
<td>---</td>
</tr>
<tr>
<td>Medicare</td>
<td>457</td>
<td>$18,079</td>
<td>$11,919</td>
<td>$6,160</td>
<td>53.7%</td>
<td>3,033</td>
<td>$18,078</td>
<td>$11,919</td>
<td>$6,160</td>
<td>53.7%</td>
<td>2,996</td>
<td>$16,601</td>
<td>$11,919</td>
<td>$6,160</td>
<td>53.7%</td>
<td>---</td>
</tr>
<tr>
<td>Mgd. Care/Other</td>
<td>347</td>
<td>$18,333</td>
<td>$10,300</td>
<td>$8,033</td>
<td>52.6%</td>
<td>3,033</td>
<td>$18,452</td>
<td>$12,406</td>
<td>$6,046</td>
<td>52.6%</td>
<td>2,996</td>
<td>$20,473</td>
<td>$12,269</td>
<td>$8,205</td>
<td>52.6%</td>
<td>---</td>
</tr>
<tr>
<td>MEDI-CAL</td>
<td>141</td>
<td>$31,414</td>
<td>$10,052</td>
<td>$11,353</td>
<td>44.4%</td>
<td>1,422</td>
<td>$30,094</td>
<td>$10,942</td>
<td>$19,152</td>
<td>50.6%</td>
<td>783</td>
<td>$31,031</td>
<td>$12,837</td>
<td>$18,194</td>
<td>50.6%</td>
<td>---</td>
</tr>
<tr>
<td>Cash Pay</td>
<td>18</td>
<td>$1,040</td>
<td>$11,837 ($10,797)</td>
<td>$613</td>
<td>0.6%</td>
<td>14</td>
<td>$832</td>
<td>$7,090 ($6,427)</td>
<td>0.3%</td>
<td>23</td>
<td>$928</td>
<td>$11,874 ($10,747)</td>
<td>0.8%</td>
<td>23</td>
<td>0.3%</td>
<td>---</td>
</tr>
<tr>
<td>Combine</td>
<td>2,792</td>
<td>$27,797</td>
<td>$23,992</td>
<td>$5,805</td>
<td>100.0%</td>
<td>2,792</td>
<td>$28,295</td>
<td>$23,470</td>
<td>$4,825</td>
<td>100.0%</td>
<td>2,792</td>
<td>$28,994</td>
<td>$23,470</td>
<td>$4,825</td>
<td>100.0%</td>
<td>---</td>
</tr>
</tbody>
</table>

Notes:
Source: Inpatient Service Line Report
Selection Criteria: Inpatient Service Line - Cardiology
KAWEAH HEALTH ANNUAL BOARD REPORT
Cardiovascular Services - OP Cardiac Cath Lab

KEY METRICS - FY2023 Twelve Months Ended June 30, 2023

<table>
<thead>
<tr>
<th>METRIC</th>
<th>FY2020</th>
<th>FY2021</th>
<th>FY2022</th>
<th>FY2023</th>
<th>% CHANGE FROM PRIOR YEAR</th>
<th>4 YR TREND</th>
</tr>
</thead>
<tbody>
<tr>
<td>PATIENT CASES</td>
<td>2,819</td>
<td>2,862</td>
<td>2,572</td>
<td>2,692</td>
<td>▲ 5%</td>
<td></td>
</tr>
<tr>
<td>NET REVENUE</td>
<td>$20,370,666</td>
<td>$22,400,571</td>
<td>$21,099,494</td>
<td>$20,168,703</td>
<td>▼ .4%</td>
<td></td>
</tr>
<tr>
<td>DIRECT COST</td>
<td>$13,384,048</td>
<td>$12,721,510</td>
<td>$14,250,276</td>
<td>$13,851,731</td>
<td>▼ -3%</td>
<td></td>
</tr>
<tr>
<td>CONTRIBUTION MARGIN</td>
<td>$6,986,618</td>
<td>$9,679,062</td>
<td>$6,849,218</td>
<td>$6,316,972</td>
<td>▼ -3%</td>
<td></td>
</tr>
<tr>
<td>INDIRECT COST</td>
<td>$3,304,600</td>
<td>$3,279,617</td>
<td>$3,264,030</td>
<td>$3,163,809</td>
<td>▼ -3%</td>
<td></td>
</tr>
<tr>
<td>NET INCOME</td>
<td>$3,682,018</td>
<td>$6,399,445</td>
<td>$3,585,167</td>
<td>$3,153,163</td>
<td>▼ -12%</td>
<td></td>
</tr>
</tbody>
</table>

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

PER CASE TRENDED GRAPHS

PAYER MIX - 4 YEAR TREND (Patient Visits)

<table>
<thead>
<tr>
<th>PAYER</th>
<th>FY2020</th>
<th>FY2021</th>
<th>FY2022</th>
<th>FY2023</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare</td>
<td>46%</td>
<td>45%</td>
<td>45%</td>
<td>44%</td>
</tr>
<tr>
<td>Managed Care/Other</td>
<td>23%</td>
<td>23%</td>
<td>23%</td>
<td>23%</td>
</tr>
<tr>
<td>Medicare Managed Care</td>
<td>17%</td>
<td>19%</td>
<td>19%</td>
<td>19%</td>
</tr>
<tr>
<td>Medi-Cal Managed Care</td>
<td>13%</td>
<td>12%</td>
<td>12%</td>
<td>13%</td>
</tr>
<tr>
<td>Medi-Cal</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
</tr>
</tbody>
</table>

FY 2023 Payer Mix

Medicare Managed Care 19%
Managed Care Other 11%
Medicare 44%
KAWEAH HEALTH ANNUAL BOARD REPORT
Cardiovascular Services - OP Cardiac Cath Lab

KEY METRICS - FY 2023 Twelve Months Ended June 30, 2023

<table>
<thead>
<tr>
<th>Metric</th>
<th>FY2020</th>
<th>FY2021</th>
<th>FY2022</th>
<th>FY2023</th>
<th>% Change from Prior Yr</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Cases</td>
<td>23,164</td>
<td>25,664</td>
<td>27,745</td>
<td>30,002</td>
<td>▲ 8%</td>
</tr>
<tr>
<td>Net Revenue</td>
<td>$6,393,213</td>
<td>$7,462,760</td>
<td>$7,396,282</td>
<td>$9,175,941</td>
<td>▲ 15%</td>
</tr>
<tr>
<td>Direct Cost</td>
<td>$5,591,035</td>
<td>$5,977,780</td>
<td>$6,311,281</td>
<td>$6,598,839</td>
<td>▲ 5%</td>
</tr>
<tr>
<td>Contribution Margin</td>
<td>$802,179</td>
<td>$1,484,981</td>
<td>$1,585,001</td>
<td>$2,576,102</td>
<td>▲ 53%</td>
</tr>
<tr>
<td>Indirect Cost</td>
<td>$1,333,832</td>
<td>$1,180,332</td>
<td>$1,201,606</td>
<td>$1,413,261</td>
<td>▲ 18%</td>
</tr>
<tr>
<td>Net Income</td>
<td>($324,484)</td>
<td>$483,395</td>
<td>$1,162,840</td>
<td>▲ 141%</td>
<td></td>
</tr>
<tr>
<td>Net Revenue Per Case</td>
<td>$276</td>
<td>$280</td>
<td>$288</td>
<td>$306</td>
<td>▲ 6%</td>
</tr>
<tr>
<td>Direct Cost Per Case</td>
<td>$241</td>
<td>$224</td>
<td>$227</td>
<td>$220</td>
<td>▼ 3%</td>
</tr>
<tr>
<td>Contrib Margin Per Case</td>
<td>$35</td>
<td>$56</td>
<td>$61</td>
<td>$86</td>
<td>▲ 41%</td>
</tr>
</tbody>
</table>

PER CASE TRENDED GRAPHS

PAYER MIX - 4 YEAR TREND (Patient Visits)

<table>
<thead>
<tr>
<th>Payer</th>
<th>FY2020</th>
<th>FY2021</th>
<th>FY2022</th>
<th>FY2023</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare</td>
<td>40%</td>
<td>37%</td>
<td>37%</td>
<td>38%</td>
</tr>
<tr>
<td>Managed Care/Other</td>
<td>22%</td>
<td>23%</td>
<td>24%</td>
<td>25%</td>
</tr>
<tr>
<td>Medi-Cal Managed</td>
<td>22%</td>
<td>24%</td>
<td>21%</td>
<td>17%</td>
</tr>
<tr>
<td>Medicare Managed</td>
<td>11%</td>
<td>12%</td>
<td>14%</td>
<td>17%</td>
</tr>
<tr>
<td>Medi-Cal</td>
<td>3%</td>
<td>2%</td>
<td>2%</td>
<td>2%</td>
</tr>
<tr>
<td>Work Comp</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
</tr>
</tbody>
</table>

FY 2023 Payer Mix

Note: Arrows represent the change from prior year and the lines represent the 4-year trend.
### Outpatient Service Line Report
#### Payer Mix (Volume) by Location

**FY 2021 - FY 2023 (July 2020 - June 2023)**

<table>
<thead>
<tr>
<th>EncTypeMne</th>
<th>ServicesLineMne</th>
<th>OP (Multiple Items)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>2021</th>
<th></th>
<th></th>
<th>2022</th>
<th></th>
<th></th>
<th>2023</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Volume</td>
<td>Rev Per</td>
<td>Cost</td>
<td>Marg Per</td>
<td>Case</td>
<td>Per</td>
<td>%</td>
<td>Volume</td>
<td>Rev Per</td>
</tr>
<tr>
<td>Medicare</td>
<td>9,829</td>
<td>$262</td>
<td>$228</td>
<td>$34</td>
<td>36.9%</td>
<td>10,177</td>
<td>$222</td>
<td>$50</td>
<td>36.7%</td>
</tr>
<tr>
<td>Med. Care/Other</td>
<td>4,118</td>
<td>$413</td>
<td>$310</td>
<td>$301</td>
<td>22.3%</td>
<td>6,487</td>
<td>$447</td>
<td>$232</td>
<td>34.1%</td>
</tr>
<tr>
<td>Medicare Managed Care</td>
<td>3,331</td>
<td>$260</td>
<td>$227</td>
<td>$34</td>
<td>12.5%</td>
<td>3,864</td>
<td>$262</td>
<td>$49</td>
<td>14.0%</td>
</tr>
<tr>
<td>Med-Cal Managed Care</td>
<td>6,342</td>
<td>$166</td>
<td>$239</td>
<td>($74)</td>
<td>23.8%</td>
<td>5,959</td>
<td>$134</td>
<td>$262</td>
<td>($128)</td>
</tr>
<tr>
<td>Medi-Cal</td>
<td>618</td>
<td>$614</td>
<td>$173</td>
<td>$441</td>
<td>2.3%</td>
<td>591</td>
<td>$589</td>
<td>$197</td>
<td>2.1%</td>
</tr>
<tr>
<td>Work Comp</td>
<td>285</td>
<td>$152</td>
<td>$191</td>
<td>$1</td>
<td>1.1%</td>
<td>307</td>
<td>$147</td>
<td>$131</td>
<td>1.1%</td>
</tr>
<tr>
<td>Cash Pay</td>
<td>142</td>
<td>$181</td>
<td>$187</td>
<td>$4</td>
<td>0.5%</td>
<td>140</td>
<td>$146</td>
<td>$190</td>
<td>0.5%</td>
</tr>
<tr>
<td>Tulare County</td>
<td>1</td>
<td>$0</td>
<td>$155</td>
<td>($155)</td>
<td>0.0%</td>
<td>1</td>
<td>$0</td>
<td>$155</td>
<td>0.0%</td>
</tr>
<tr>
<td>Grand Total</td>
<td>26,664</td>
<td>$280</td>
<td>$224</td>
<td>$54</td>
<td>100.0%</td>
<td>27,745</td>
<td>$288</td>
<td>$61</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

**Notes:**
- Source: Outpatient Service Line Reports
- Criteria: Outpatient Service Lines: Non-Invasive Cardiology & Sequoia Cardiology Clinic
Compliance Program Activity Report – Open Session
August 2023 through October 2023

Ben Cripps, Chief Compliance & Risk Officer
Education

Live Presentations
• Compliance and Patient Privacy
  o Urgent Care
  o Lindsay Rural Health Clinic
  o Mental Health Hospital
  o Exeter Rural Health Clinic
  o Patient and Family Services
  o Radiology
  o Tulare Rural Health Clinic
  o GME New Resident Orientation
• Access To Kaweah health Electronic Records
  o Physician Office Staff

Written Communications – Bulletin Board / Area Compliance Experts (ACE) / All Staff
• False Claims Act
• Code of Conduct
Prevention & Detection

• Californian Department of Public Health (CDPF) All Facility Letters (AFL) – Review and distribute AFLs to areas potentially affected by regulatory changes; department responses reviewed and tracked to address the regulatory change and identify potential current/future risk.

• Medicare and Medi-Cal Monthly Bulletins – Review and distribute bulletins to areas potentially affected by the regulatory change; department responses reviewed and tracked to address the regulatory change and identify potential/current risk.

• Office of Inspector General (OIG) Monthly Audit Plan Updates – Review and distribute OIG Audit Plan issues to areas potentially affected by audit issue; department responses reviewed and tracked to identify potential current/future risk.

• California State Senate and Assembly Bill Updates – Review and distribute legislative updates to areas potentially affected by new or changed bill; department responses reviewed and tracked to address regulatory change and identify potential current/future risk.
Prevention & Detection

- **User Access Privacy Audits** – Fairwarning daily monitoring of user access to identify potential privacy violations.
  - Kaweah Health Employees
  - Non-employee users

- **Office of Inspector General (OIG) Exclusion Attestations** – Quarterly monitoring of department OIG exclusion list review and attestations.

- **Medicare PEPPER Report Analysis** – Quarterly review of Medicare Inpatient PEPPER statistical reports to identify outlier and/or areas of risk; evaluate with Kaweah Health leadership quarterly at PEPPER Review meeting; Distribution of Rehabilitation, Hospice, Home Health, and Mental Health PEPPER Reports to leadership for evaluation.
Oversight, Research & Consultation

New

**Dialysis Alteplase Billable Units** – Research and consultation to determine why Clarity was not sending the correct billable unit amounts for Alteplase. It was determined there was an oversight on the units and all claims have been reviewed for corrections. A clinical review of the eighteen (18) accounts impacted was completed. The review indicated the claim errors resulting in an underpayment to Kaweah Health. Charges have been corrected and the claims rebilled. Findings were shared with Dialysis, Revenue Integrity and Pharmacy Leadership.

**340B Audit Ceftazidime** – Research to determine why the Dialysis drug Ceftazidime did not contain a purchase history for the correct Charge Description Master (CDM). It was determined there were seven (7) separate charges reflecting the incorrect CDM resulting in underpayments. The charges have been corrected and rebilled to reflect the proper billing units. Findings were shared with Dialysis, Revenue Integrity and Pharmacy Leadership.

**Calcitriol and Sensipar Dialysis Medication** – Research to determine why discrepancies exist between the KHHIP (Kaweah Health Home Infusion Pharmacy) dispensed amount and Clarity billing for two Dialysis drugs. It was determined that the report being used by Dialysis to manually charge Sensipar is reporting the wrong quantities, while Calcitriol is being billed for only one dose, regardless of the volume dispensed. Calcitriol is a statistical charge and not on the claim, thus does not have a financial impact. Sensipar is an accumulator requiring the bills to be corrected. A three (3) year look back is being completed and a report is being generated to verify that the correct data interfaced and that manual charges are correct. A review is being conducted to determine if there is an underpayment or overpayment for Sensipar, the financial impact is not yet known. All claims are being held until resolved.
Oversight, Research & Consultation

New

**Billing Nitroglycerin in the Cath Lab** – Consultative oversight to ensure appropriate billing for Nitroglycerin in the Cath Lab due to pharmacy making small batches to conserve product in response to supply chain issue. It was determined that the accumulation mapping for Nitroglycerin needs to be adjusted anytime the National Drug Code (NDC) associated with Nitroglycerin is used to prevent overbilling. A charge report was generated indicating all charges posted as statistical charges as planned. Findings were shared with Revenue Integrity and Pharmacy Leadership.

**Duplicate IV Drip Charge** – Research to determine why duplicate charges for certain IV-drip medications were occurring. It was determined that nursing was selecting “Begin Bag Event” each time the titration of an IV drip bag was adjusted, instead of “Rate Change” thus resulting in duplicate charges that were identified and corrected. Nursing leadership will educate nurses in all departments with a heavy focus in ICU and Critical Care. Pharmacy will review data through weekly audits. A follow up meeting is scheduled in December to gauge improvements.

**Physician Orders by Text, including Secure Messaging** – Research on whether a physician can place orders via secure messaging or text messaging. It was confirmed CMS does not permit the texting of patient orders by physicians or other health care providers, regardless of the platform used. Findings were shared with Hospice Leadership.
Oversight, Research & Consultation

Ongoing

**Fair Market Value (FMV) Oversight** – Ongoing oversight and administration of physician payment rate setting and contracting activities including Physician Recruitment, Medical Directors, Call Contracts, and Exclusive and Non-Exclusive Provider Contracts.
Licensing & Enrollment

New

**Licensing Applications** – Forms preparation and submission of licensing application to the California Department of Public Health (CDPH); ongoing communication and follow-up regarding status of pending applications.

- *Acute Hospital License Renewal*
- *Home Health License Renewal*
- *Hospice Move – CDPH Notification*

**Enrollment** – Forms preparation and submission of licensing application to CDPH, as well as Medicare and Medi-Cal Facility Payor Enrollment; ongoing communication and follow-up regarding status of pending applications.

- *PECOS Enrollment – Hospice Move*
- *PECOS Enrollment Kaweah Health Medical Clinic-Plaza*
Situation: The Compliance Department conducted a charge billing review for Outpatient Services due to The Office of Inspector General’s (OIG) increased focus on claims accuracy and Medicare Recovery Auditors, as well as the implementation of Sorian Financial electronic medical record system.

Assessment: An internal audit of thirty (30) randomly selected encounters for dates of service January 1, 2023 – March 31, 2023 was completed. The electronic health record was used to review and assess whether the charge was supported by a physician order, the appropriateness of the billing modifier (as necessary), if the billing units noted on the order match the billing units submitted on the claim, if the service ordered by the physician match the service billed on the claim, and if Kaweah Health was reimbursed for the charges billed. The financial impact compliance rate was 99%. The results of the review have been shared with appropriate leadership.

Recommendation: Based on the findings, no further assessment is required at this time. The Compliance Department will continue to reassess the risk associated with the charge audits and determine if a reaudit will be required in the future.
Auditing & Monitoring

New

Urology Clinic Service Line

Situation: The Urology Clinic is a new service line that opened at Kaweah Health in 2022. A review was initiated to determine whether Kaweah Health is submitting claims in compliance with several elements: CMS documentation and billing guidelines, Article Number, diagnosis requirements, authorization, consent requirements for the procedure (when required), drug administration services for beneficiaries of Medicare Advantage and Commercial plans, compliance with documenting non-billable drugs in the Medicare Administration Record (MAR) and that the progress notes and services provided were captured on the billing statement.

Assessment: An internal audit of thirty (30) randomly selected encounters with dates of service from October 2022 – March 2023 was completed. The financial impact compliance rate totaled 99%. The results of the review have been shared with Urology and Health Information Management Leadership.

Recommendation: Based on the findings, no further assessment is required at this time.
Auditing & Monitoring
Update

Noridian Targeted Probe and Educate (TPE) Kaweah Health Medical Group (KHMG)

**Situation:** On February 22, 2023, Noridian notified Kaweah Health Medical Group of its intent to complete a prepayment review of pelvic ultrasound services billed with Current Procedural Terminology (CPT) code 76857 as a Kaweah Health Medical Group (VMC) provider was identified in the top 15% of dollars paid for the CPT in question compared to their peers.

**Assessment:** Noridian completed a review of thirty-four (34) randomly selected claims for dates of service February 22, 2023 – August 16, 2023. The review noted a 100% compliance rate for appropriate billing of pelvic ultrasound services.

**Recommendation:** The review has been closed by Noridian.
Projects
Update

Compliance Program Effectiveness Tool

**Situation:** In 2017, compliance professionals from the Department of Health and Human Services (HHS) and Office of Inspector General (OIG) published the results of a roundtable discussion surrounding effective methods for measuring the effectiveness of the seven (7) elements of compliance programs. A resource document was made public and is now widely used as an annual assessment conducted by healthcare organizations to measure the effectiveness of the organization’s compliance program.

**Assessment:** The effectiveness tool is used to identify potential gaps and risks within a compliance program. The Compliance Program Effectiveness Assessment has been completed.

**Outcome:** The results of the Effectiveness Assessment were used to develop actionable items to enhance the Compliance Program. A prioritization matrix was developed to identify which of the findings were deemed to have the greatest impact on the compliance program from lowest to highest risk, and lowest to highest effort. To date, items identified as having high-risk and requiring low-effort have been the primary focus with much work being accomplished.
The pursuit of healthiness
Throughput Steering Committee
# Performance Scorecard

## Leading Performance Metrics – Inpatient & Observation

<table>
<thead>
<tr>
<th>Metric</th>
<th>Patient Type</th>
<th>Definition</th>
<th>Goal</th>
<th>Baseline**</th>
<th>6/1/2023</th>
<th>Jul 2023</th>
<th>Aug 2023</th>
<th>Sep 2023</th>
<th>Oct 2023</th>
</tr>
</thead>
<tbody>
<tr>
<td>Observation Average Length of Stay (Obs ALOS)</td>
<td>Overall</td>
<td>Average length of stay (hours) for observation patients</td>
<td>36</td>
<td>46.35</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Average Length of Stay (IP ALOS)</td>
<td>Overall</td>
<td>Average length of stay (days) for inpatient discharges</td>
<td>5.64</td>
<td>5.53</td>
<td>5.47</td>
<td>5.53</td>
<td>5.33</td>
<td>5.51</td>
<td>6.08</td>
</tr>
<tr>
<td>Inpatient Observed-to-Expected Length of Stay</td>
<td>Overall</td>
<td>Observed LOS / geometric mean length of stay for inpatient discharges</td>
<td>1.32</td>
<td>1.45</td>
<td>1.41</td>
<td>1.48</td>
<td>1.41</td>
<td>1.45</td>
<td>1.58</td>
</tr>
<tr>
<td>Discharges*</td>
<td>Inpatient</td>
<td>Count of inpatient discharges</td>
<td>N/A</td>
<td>1,255</td>
<td>1,279</td>
<td>1,262</td>
<td>1,283</td>
<td>1,196</td>
<td>1,246</td>
</tr>
<tr>
<td>Observation</td>
<td>Count of observation discharges</td>
<td>N/A</td>
<td>450</td>
<td>450</td>
<td>452</td>
<td>467</td>
<td>431</td>
<td>430</td>
<td></td>
</tr>
<tr>
<td>Overall</td>
<td>Count of inpatient and observation discharges</td>
<td>N/A</td>
<td>1,704</td>
<td>1,729</td>
<td>1,714</td>
<td>1,750</td>
<td>1,627</td>
<td>1,676</td>
<td></td>
</tr>
</tbody>
</table>

*All metrics above exclude Mother/Baby, Behavioral Health, and Pediatrics encounter data

*O/E LOS to be updated to include cases with missing DRG when available

**Baseline calculation: Previous 6-month rolling median or average based on the metric’s calculation
# Performance Scorecard

## Leading Performance Metrics - Emergency Department

<table>
<thead>
<tr>
<th>Metric</th>
<th>Patient Type</th>
<th>Definition</th>
<th>Goal</th>
<th>Baseline**</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ED Boarding Time</strong></td>
<td>Inpatient</td>
<td>Median time (minutes) for admission order written to check out for admitted patients</td>
<td>259</td>
<td>147</td>
</tr>
<tr>
<td>(Lower is better)*</td>
<td>Observation</td>
<td>Median time (minutes) for admission order written to check out for observation patients</td>
<td>287</td>
<td>145</td>
</tr>
<tr>
<td></td>
<td><strong>Overall</strong></td>
<td>Median time (minutes) for admission order written to check out for inpatient and observation patients</td>
<td>286</td>
<td>147</td>
</tr>
<tr>
<td><strong>ED Admit Hold Volume</strong></td>
<td><strong>Overall &gt;4 Hours</strong></td>
<td>Count of patients (volume) with ED boarding time $\geq$ 4 hours</td>
<td>N/A</td>
<td>265</td>
</tr>
<tr>
<td>(Lower is better)*</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>ED Length of Stay (ED LOS)</strong></td>
<td>Discharged</td>
<td>Median ED length of stay (minutes) for discharged patients</td>
<td>214</td>
<td>291</td>
</tr>
<tr>
<td>(Lower is better)*</td>
<td>Inpatient</td>
<td>Median ED length of stay (minutes) for admitted patients</td>
<td>612</td>
<td>531</td>
</tr>
<tr>
<td></td>
<td>Observation</td>
<td>Median ED length of stay (minutes) for observation patients</td>
<td>577</td>
<td>525</td>
</tr>
<tr>
<td></td>
<td><strong>Overall</strong></td>
<td>Median ED length of stay (minutes) for admitted and discharged patients</td>
<td>N/A</td>
<td>338</td>
</tr>
<tr>
<td><strong>ED Visits</strong></td>
<td>Discharged</td>
<td>Count of ED visits for discharged patients</td>
<td>N/A</td>
<td>5,098</td>
</tr>
<tr>
<td>*</td>
<td>Inpatient</td>
<td>Count of ED Visits for admitted patients</td>
<td>N/A</td>
<td>1,119</td>
</tr>
<tr>
<td></td>
<td>Observation</td>
<td>Count of ED Visits for observation patients</td>
<td>N/A</td>
<td>449</td>
</tr>
<tr>
<td></td>
<td><strong>Overall</strong></td>
<td>Count of ED visits</td>
<td>N/A</td>
<td>6,665</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Check In Date and Time</th>
<th>Jun 2023</th>
<th>Jul 2023</th>
<th>Aug 2023</th>
<th>Sep 2023</th>
<th>Oct 2023</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ED Boarding Time</strong></td>
<td>125</td>
<td>141</td>
<td>158</td>
<td>184</td>
<td>165</td>
</tr>
<tr>
<td>(Lower is better)*</td>
<td>119</td>
<td>144</td>
<td>161</td>
<td>256</td>
<td>147</td>
</tr>
<tr>
<td><strong>Overall</strong></td>
<td>124</td>
<td>141</td>
<td>158</td>
<td>185</td>
<td>165</td>
</tr>
<tr>
<td><strong>ED Admit Hold Volume</strong></td>
<td>160</td>
<td>236</td>
<td>301</td>
<td>351</td>
<td>309</td>
</tr>
<tr>
<td>(Lower is better)*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>ED Length of Stay (ED LOS)</strong></td>
<td>287</td>
<td>294</td>
<td>297</td>
<td>298</td>
<td>285</td>
</tr>
<tr>
<td>(Lower is better)*</td>
<td>499</td>
<td>506</td>
<td>556</td>
<td>590</td>
<td>558</td>
</tr>
<tr>
<td><strong>Overall</strong></td>
<td>332</td>
<td>337</td>
<td>347</td>
<td>352</td>
<td>335</td>
</tr>
<tr>
<td><strong>ED Visits</strong></td>
<td>4,880</td>
<td>5,142</td>
<td>5,444</td>
<td>5,033</td>
<td>5,010</td>
</tr>
<tr>
<td>*</td>
<td>1,122</td>
<td>1,139</td>
<td>1,156</td>
<td>1,073</td>
<td>1,095</td>
</tr>
<tr>
<td></td>
<td>472</td>
<td>444</td>
<td>463</td>
<td>450</td>
<td>415</td>
</tr>
<tr>
<td><strong>Overall</strong></td>
<td>6,474</td>
<td>6,725</td>
<td>7,063</td>
<td>6,556</td>
<td>6,520</td>
</tr>
</tbody>
</table>

*All metrics above exclude Mother/Baby, Behavioral Health, and Pediatrics encounter data.*

**Baseline calculation: Previous 6-month rolling median or average based on the metric's calculation.*
October – 4 long LOS discharges, remove from the GMLOS and gap is 1.5, consistent with previous months. Minimal change in LOS gap metric this fiscal year.
Average Length of Stay Distribution

Overall

FY24 Overall LOS Distribution

<table>
<thead>
<tr>
<th></th>
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<th></th>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>53%</td>
<td>51%</td>
<td>49%</td>
<td>53%</td>
<td>50%</td>
<td>48%</td>
<td>49%</td>
<td>47%</td>
<td>50%</td>
<td>54%</td>
<td>52%</td>
<td>51%</td>
<td>52%</td>
<td>51%</td>
<td>51%</td>
<td>53%</td>
<td></td>
</tr>
</tbody>
</table>

Legend:
- **at GMLOS or Better**: 53% 51% 49% 53% 50% 48% 49% 47% 50% 54% 52% 51% 52% 51% 51% 53%
- **1-2 days over GMLOS**: 20% 22% 20% 20% 24% 24% 21% 21% 24% 23% 21% 24% 23% 23% 22% 22%
- **2-6 days over GMLOS**: 15% 16% 16% 15% 14% 16% 17% 19% 16% 15% 16% 15% 16% 16% 15% 15%
- **6-10 days over GMLOS**: 5% 5% 7% 5% 6% 5% 5% 5% 4% 6% 5% 5% 6% 5% 5% 5%
- **10-30 days over GMLOS**: 6% 5% 6% 6% 5% 6% 7% 6% 5% 3% 4% 5% 4% 4% 5% 5%
- **30+ days over GMLOS**: 1.2% 1.2% 1.7% 1.0% 1.2% 1.1% 1.6% 1.9% 0.5% 1.2% 0.5% 0.8% 0.9% 0.7% 0.6% 1.2%
<table>
<thead>
<tr>
<th>Update</th>
<th>Next Steps</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient Progression:</strong></td>
<td><strong>Next Steps</strong></td>
</tr>
<tr>
<td>Discharge lounge opened on 10/16/2023 with LVN discharge nurse and case management assistant</td>
<td>Need to hire one more case manager assistant to complete the staffing for the discharge lounge</td>
</tr>
<tr>
<td>Stable Case management staff, training new case management staff in coming weeks</td>
<td>Develop preferred provider network for skilled nursing facilities.</td>
</tr>
<tr>
<td>Established routine meetings and collaborations with community SNFs to improve discharge availability.</td>
<td>Working on staffing with 6 case managers on the weekends</td>
</tr>
<tr>
<td>Success measures for discharge lounge – discharge by noon and shorter ED boarding times.</td>
<td></td>
</tr>
</tbody>
</table>

| **ED to Inpatient Admission Process:** | **Patient Progression:** |
| HealthAnalytics data availability – Cerner developed access to the data, dashboard complete, validating data and creating access for leaders. | Established routine meetings and collaborations with community SNFs to improve discharge availability. |
| ED and Throughput leaders will analyse and monitor data for gaps in the process from admit order to physical placement in inpatient bed. | Stability measures for discharge lounge – discharge by noon and shorter ED boarding times. |
| Michelle/Rebekah to create subgroup to determine order sets and track the long term patients that are “holding ” in the ED for mental health or SNF placement or social admits | |
| Working on staffing with 6 case managers on the weekends | Identify and action plan opportunities when data available- due October/November 2023 based on data analysis and committee decisions for project plans. |

| **Transfer Center Operations:** | **Next Steps** |
| Repatriation of patients underway. | Data access – reconfiguration of the transfer center software underway, available in September. |
| Developed routine script and delivered education to eliminate variability in transfer decision making. | Use data to assess opportunities in transfers and develop action plans – due October 2023. |
| Completed negotiation transport rate with ambulance company for returns from Bay area health center partners. | |

| **Long Stay Committee:** | **Next Steps** |
| Committee is monitoring, tracking, and trending major barriers | Develop action plans to address barriers based on the data collected in the last 6 months. |
| is stable, making good progress and keeping volume of patients over 30 days down consistently. Throughput steering committee continuing to monitor patient volumes and movement. | IR continues to area with delay. Meeting scheduled with IR leadership to determine next steps to improve responsiveness. |
| Current 15 patients over 30 days (all time high was 70 patients), 5 patients with 100+ days | Initiate new project based on barrier analysis from long stay committee data. |
| | October – review recommendations from Long Stay Committee on new project to remove major/complex barriers from long stay patient discharges. |

| **Observation Program:** | **Next Steps** |
| Dashboard for observation patients in HealtheAnalytics completed | Going Live with Power plans with diagnosis specific pathways on 11/28 |
| New Manager started on unit to actively participate in rounds and set staff expectations | Working on cohorting observations patients on 2S, dashboard will track patient location by unit |
| Observation patients are primarily placed in 2S. Slight increase LOS from prior months, one pt with a 78 day stay impacted the overall numbers | Nuclear Med studies scheduling process completed, Completing outpatient EEG and stress testing process. |
| | Managed Care team (Kim) working on blanked pre-authorization process for Humana and other plans managed by Key Medical for obs pts |
| | Follow up with PT, recommendations for SNF vs HH due to patients not meeting criteria for SNF placement due to not having an inpatient 3 day stay |

102/266
POLICY: Kaweah Delta Health staff will utilize appropriate administrative, technical and physical safeguards to ensure the integrity and confidentiality of patient protected health information (PHI) and the business records of Kaweah Delta Health when using fax and email communications.

Sending PHI via fax transmission should be limited to urgent patient care requests. When possible, requests unrelated to patient care should be sent via mail. Routine disclosure to insurance companies, attorneys, or legitimate users should be made through U.S. Postal Service mail or other means. Emails sent outside Kaweah Delta Health should not contain PHI unless properly encrypted.

PROCEDURE:

I. Receiving Fax Documents, the following steps shall be observed:
   A. When possible, facsimile machines should be located in secure areas with limited public access.
   B. Request the sender to notify Kaweah Delta Health employee staff prior to sending the fax allowing them to present to receive the fax.
   C. Employees should not allow PHI to remain on a fax machine unattended. Faxes must be appropriately filed or disposed of immediately.
   D. If a department receives a misdirected fax, the receiver must contact the sender of the information to advise them of the incident and contact the Compliance Department.

II. Sending Fax Documents, the following steps shall be observed:
   A. Before sending a fax, employees shall verify the fax number by reciting it back to the receiver. Once verified, the employee shall input, review, and confirm the fax number on the fax machine display before sending the fax.
   B. If the fax contains PHI, the employee must confirm appropriate delivery via telephone with the intended receiver.
   C. A "test" fax sheet shall be utilized when sending PHI to a new or unfamiliar requestor.
   D. The employee shall review the printed confirmation sheet to confirm the
transmission delivery to the intended fax number.

E. When possible, departments should pre-program fax numbers and review and update these numbers periodically to eliminate transmission errors.

F. The cover page accompanying the facsimile transmission must include a Confidentiality Notice that indicates the information is confidential and that its use is limited (see Section V. below regarding appropriate use of facsimile cover page).

G. When possible, the employee must notify the recipient before sending PHI to be sure that someone is there to receive it. PHI should not be faxed if the employee believes there are not appropriate safeguards by the receiving party. Appropriate safeguards include, but are not limited to, having someone present to receive the fax, the receiving fax machine is in a secured location, the information is sent to an e-fax.

H. If notification is received that an error in transmission is made, the employee should immediately contact the incorrect recipient and request the return or destruction of the fax. If the misdirected fax contains PHI, the ISS Security Coordinator or the District Kaweah Delta Health Compliance Department must be notified. The District Kaweah Delta Health Compliance Department will investigate the incident and evaluate potential reporting obligations.

III. Request for Medical Records sent by Fax

A. The Medical Records Department Health Information Management (HIM) staff will fax pertinent medical record documents to physician offices and other appropriately sanctioned parties under emergency/urgent circumstances. Emergency/urgent is defined as a situation in which the records are needed immediately in order to provide medical care to the patient. Prior to faxing or mailing patient information, care must be taken to verify that the documents requested are for the right patient intended for the right party.

B. If records are not needed for an “emergency/urgent” situation, the request will be processed as general correspondence.

C. Physician orders may be received by District Kaweah Delta Health employees via fax transmission. Physician orders submitted via fax do not require a countersignature by the prescribing practitioner at a later date. Physician orders transmitted via facsimile may reduce the possibility of error inherent in the translation of verbal (telephone) orders, and thus contribute to improved patient care.

D. Except as required by law, a properly completed and signed authorization must be obtained prior to the release of patient information.

IV. Medical Record information received by Fax

A. Medical Record information received via fax does not need to be copied and will become part of the permanent medical record as “faxed”.

V. Fax Cover Sheet and Verbiage Requirement

A. The use of a fax coversheet which includes verbiage to safeguard the confidentiality of District business records and patient PHI is required. (see Exhibit A) The person sending the fax shall provide their name
and call back phone number on the fax cover sheet so they may be contacted if a question arises. This section of the cover sheet should never be left blank.

VI. E-mail communication

A. E-mails sent outside of Kaweah Delta Health containing protected health information shall be encrypted at the minimum standard set forth in the Health Insurance Portability and Accountability Act (HIPAA) Security Rule.

B. Email communications sent internally or externally should include the following disclaimer attached:

“DISCLAIMER: The information contained in this email transmission is confidential and intended for the addressee only. If the reader of this message is not the addressee or addressee’s agent, you are hereby advised that any dissemination, distribution or copying of the information is strictly prohibited.

The information contained in this email transmission may be protected under the Attorney/Client Privilege and protected from disclosure under California Evidence Code Section 1157. If protected by the attorney/client privilege or by California Evidence Code Section 1157, the information contained in this email transmission shall continue to be protected and will not be negated by virtue of sending the information via this email.

If you receive this email in error, please call the ISS Security Coordinator, Kaweah Delta Health Compliance Department at (559) 624-6462 or the District Chief Compliance and Risk Officer at (559) 624-5006 (collect if necessary) immediately upon receipt. Thank you for your cooperation.”
CONFIDENTIALITY NOTICE:

The information contained in this facsimile transmission is confidential and intended for the addressee only. If the reader of this message is not the addressee or addressee’s agent, you are hereby advised that any dissemination, distribution or copying of the information is strictly prohibited.

The information contained in this facsimile transmission may be protected under the Attorney/Client Privilege and protected from disclosure under California Evidence Code section 1157. If protected by the attorney/client privilege or by California Evidence Code Section 1157, the information contained in this facsimile transmission shall continue to be protected and will not be negated by virtue of sending the information via this facsimile.

If you receive this fax in error, please call the ISS Security Coordinator Kaweah Delta Health Compliance Department at (559) 624-5455 (collect if necessary) or the District Chief Compliance and Privacy and Risk Officer at (559) 624-5006 immediately upon receipt and return the facsimile documents to us by first class mail to the address above. Your postage will be reimbursed. Thank You for your cooperation.

*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
District Facsimile (FAX) and Email communications

represent a breach of a medical standard of care. New knowledge, new techniques, clinical or research data, clinical experience, or clinical or bio-ethical circumstances may provide sound reasons for alternative approaches, even though they are not described in the document.
Policy:
This policy provides guidelines for the purchase, sale, and leasing of real property, which is essential to Kaweah Delta Health carrying out its mission of providing high quality, customer-oriented, and financially strong healthcare services.

Parties Involved:
The Vice President/Chief Strategy Officer of Strategic Planning and Development of Strategic Planning shall work with the Director of Community Engagement on property acquisitions, sales, and leases. The Chief Compliance Officer will be involved with real estate contracts that involve physicians, and the Director of Facilities and Director of Facilities Planning will be consulted to determine the need and feasibility of property acquisitions.

Procedure:
I. For Kaweah Delta Health Property Acquisitions
   a. Kaweah Delta Health identifies potential property and notifies the Strategic Planning and Development Department.
   b. A Kaweah Delta Health representative, currently the Director of Community Engagement, conducts background investigation of property, including preliminary appraisals, fair market value, and feasibility studies.
   c. If property meets the mission of the organization, the representative will present the property to the Executive Team and/or Capital Committee for further review, order an appraisal, and request a Finance, Property, Services and Acquisitions Board Sub-Committee meeting to review the potential property with the committee. If the committee agrees to move forward with the purchase of the property, the property acquisition recommendation will then move forward for approval by the Board of Directors. (ref. EOC Policy 1008)
   d. Once the appraisal, prepared by a licensed appraiser, is received, it can be used to negotiate the sales price and for the purpose of preparing an official written offer.
   e. The Kaweah Delta Health representative can officially make a written offer, and, with final approval of terms by the Board of Directors,
management can enter into a purchase/sale agreement to acquire the property.

f. Shortly before property purchase is complete, the Facilities Department and Risk Management Department will be notified of the close of escrow date as the property will need to be added to the Kaweah Delta Health insurance policy, maintenance contracts, and security rounds. (Fill out utility transfer and insurance forms)

For bare land purchases consider:
Soil study for hazardous material
Drainage study/flood zone documentation

For building purchases consider:
| HVAC assessment | OSHPD 3 compliance assessment |
| Plumbing assessment- fiber optic scope | Exterior lighting assessment |
| all drain lines | Landscaping/irrigation assessment |
| Electric assessment- panel condition & capacity | Asbestos assessment |
| Foundation assessment/structural assessment | Lead paint assessment |
| Exterior finish assessment *(paint, stucco, brick, etc.)* | Hazardous materials assessment |
| Parking assessment | Exterior lighting assessment |
| Pests/termites/vermin assessment | Landscaping/irrigation assessment |
| Roof assessment | Structural assessment |
| Gutter assessment | Appliance assessment |
| Windows assessment | Life Safety assessment *(sprinklers, smoke detectors, etc)* |

II. Procedures for Kaweah Delta Health Property Sales:

a. Kaweah Delta Health identifies potential property that needs to be sold and notifies the Strategic Planning and Development Department.

b. A Kaweah Delta Health representative, currently the Director of Community Engagement, conducts background investigation of property, including preliminary appraisals, fair market value, and feasibility studies.

c. A Kaweah Delta Health representative will request a Finance, Property, Services and Acquisitions Board Sub-Committee meeting to review the potential property sale with the committee. If the committee agrees to move forward with the sale of the property, the property acquisition recommendation will then move forward for approval by the Board of Directors.
d. Once the appraisal, prepared by a licensed appraiser, is received, it can be used to list the property with a licensed agent or to negotiate the sales price with a potential buyer.

e. Once an offer is received from a potential buyer, the Kaweah Delta Health representative will take the offer to the Finance, Property, Services, and Acquisitions Board Sub-Committee for review. If the committee agrees to the terms of the sale, they will forward their recommendation to the Board of Directors for final approval.

f. Shortly before property sale is complete, the Facilities Department and Risk Management Department will be notified of close of escrow date as the property will need to be removed from the Kaweah Delta Health insurance policy, maintenance contracts, and security rounds. (Fill out utility transfer and insurance forms)

III. Procedures for Kaweah Delta Health Property Leases:

a. Kaweah Delta Health identifies a department or clinic that needs space and notifies the Strategic Planning and Business Development Department.

b. A Kaweah Delta Health representative, currently the Director of Community Engagement, will work with the department looking for space and will conduct a background investigation of available property for lease to determine feasibility and fair market value. Once fair market value is determined, the Kaweah Delta Health representative will consult with Kaweah Delta’s Health’s legal counsel and can begin negotiating the lease directly with the property owner. If the lease is not budgeted, the representative will take it to the Capital Committee and/or Executive Team for approval before engaging with legal counsel.

c. If the owner of the property is a physician, the Kaweah Delta Health Chief Compliance Officer and Kaweah Delta’s Health’s legal counsel must review the terms of the lease to ensure all legalities are met.

d. The Kaweah Delta Health representative will negotiate terms of the lease and facilitate ratification of contract with all contracts being approved and signed by the Vice President/Chief Strategy Officer of Strategic Planning and Business Development.

e. Once the lease is ratified and approved, the Finance Department will add the lease to their contract software and notify the Kaweah Delta Health representative 90 days prior to any deadline associated with the lease. (Cancellation, renewal, modification, etc.)

f. Shortly before property lease is complete, the Facilities Department and Risk Management Department will be notified of the contract commencement date as the property will need to be added to the Kaweah
Delta Health insurance policy, maintenance contracts, and security rounds. (*Fill out utility transfer and insurance forms*)
Grants

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

PURPOSE: To ensure that the appropriate guidelines and procedures are followed when applying for, administering and closing grants, regardless of which Kaweah Delta Health Care District (dba Kaweah Health) department manages the grants.

POLICY: All grant requests will be prepared and submitted under the auspices of the Development Department/Kaweah Health Foundation following the procedures outlined in this policy.

Kaweah Delta Health Care District and Kaweah Delta Hospital/Health Foundation by written agreement state that all grant funds awarded to the Foundation will be held by the Foundation and that the District/Kaweah Health will implement the grant programs. The Foundation will reimburse the District/Kaweah Health for appropriate grant expenditures after they are incurred.

DEFINITION: A “grant” is defined as: A funding commitment or contract that is received upon approval of the submitted “Application”, “Request for Proposal” (RFP), “Request for Application” (RFA), inquiry letter or other such request that includes, at a minimum, a reason for the request, how the funds will be used and the amount of funds requested.

A “match” is defined as a requirement on the part of the District and/or grant partners to provide in-kind services and/or dollars matching the requested grant amount or a portion of it.

PROCEDURE:

All grants, at a minimum, must be approved by the Vice President/Chief of the requesting Department and the Vice President/Director of the Development Department Foundation.

Process for grants under $50,000

For a grant under $50,000, the Vice President/Director of Development/the Kaweah Health Foundation has the authority to approve the grant request and submit it to the granting agency. The requesting department’s vice president/executive team member must approve the request and have the Grants Development Grants Manager/Coordinator review/edit/assist in the completion of the application.

Process for grants over $50,000
For grants over $50,000, the Executive Team, at the recommendation of the Vice President/Director of Development, must approve the grant request. Minutes of the Executive Team meeting where approval is given are filed in the grant file maintained at the Development Department. A summary of the grant program and a proposed budget range, including any match requirements, is presented to the Executive Team by the Vice President/Chief of the department requesting submission of the grant.

Preparation and submission of grant applications for all District departments

Upon receipt of the appropriate approvals as outlined above, the vice president/Chief of the requesting department will assign a staff person to work with the Grants Development Grants Manager/Coordinator to complete the application, which may include the development of the proposed project, collection of data, development of the budget contract policy compliance, financial requirements and any other requirements of the granting agency.

The Grants Development Grants Manager/Coordinator will complete the grant application in collaboration with the vice president/Chief and/or designated department staff. In some instances additional planning meetings may occur. Department Strategic Planning staff will be responsible for coordinating these strategic planning sessions and including other staff and/or agencies. Completion of the proposal will be reviewed by the Grants Development Manager/Coordinator and department staff. The Vice President/Director of Development will review the final application prior to submission.

The Grants Development Grants Manager/Coordinator is responsible for submitting the grant application to the potential funder on time, with all pertinent and required information including a budget in a format established by the funder. The vice president/Chief and/or designee of the department submitting the proposed program for funding will receive a copy of the final grant application. The official version of the submitted grant application will be maintained in the grant file residing in the Development Department.

Drafts of grant application sections assigned to the departments and collaborating (outside) partners are due no later than 10 days prior to grant submission due date. If the draft is not provided by that time it may not be possible to submit the grant or the partner may not be included in the final grant application.

Grant acceptances / denials and grant contracts

All notifications from the grantors of grant proposal acceptances or denials will be received by the Development Department. The Grants Development Grants Manager/Coordinator will notify the department personnel, finance department staff and department Vice President/Chief of the grantor’s decision.

Once the grant contract is received by the Development Department, it will be reviewed by the Grants Development Grants Manager/Coordinator, the Vice President/Director of Development, the department vice president/Chief, a finance department representative, and the grant program director. The Grants Development Grants Manager/Coordinator will coordinate any questions or proposed edits (if allowed) to the grant contracts with the grantor. The final contract will be signed by the Vice President/Director of Development on behalf of the Foundation.
and Awards Management may be included in compliance policies for HRSA grants.

**Education and training requirements for program managers**

Upon receipt of the grant, an orientation session will be provided by the Grants Development Manager and the Grants Coordinator. This session will review the grant contractual agreement, scope of work, budget, implementation process, necessary programmatic and fiscal documentation, subcontract process, if appropriate, and any other issue pertinent to the implementation of the particular grant.

**Acquisition, management and disposal of equipment acquired with grant funds**

Unless a grant agreement states otherwise, all equipment acquired by the District for use in grant programs for which the Foundation reimburses the District is the property of the District.

**Grant management and changes**

The responsibility of the implementation and management of a grant-funded project lies with the vice president of the department in which the program resides. At the discretion of the vice presidentChief, this responsibility can be delegated to a director, coordinator or a position specific to the grant.

All proposed budget or program changes must be approved by the vice presidentChief of the department where the grant is being implemented and the Grants Development Manager, Grants Analyst, or Director of Development. Once this internal approval is given and documented, the request for changes can be submitted to the funding agency by the director in charge of program implementation.

All progress and final grant reports (both programmatic and budgetary) are to be prepared by in conjunction with both Foundation staff and grant program personnel. Reports must be reviewed by the Vice PresidentChief of that department, the Grants Development Manager and the Development Grant Coordinator as evidenced by the signatures of these parties on the draft and/or final copies of the reports. All reports are expected to be submitted in accordance with the grantor's requirements.

A quarterly review of all District and Foundation grants is completed by the District's Grants Review Committee, comprised of the Chief Operating Officer, Vice President of Development, Chief Nursing Officer, Grants Development Manager, and Development Coordinator. The Foundation Grants CommitteeExecutive Team. The Committee will meet quarterly to review the report in person or via email as well. If the meeting is held via email, it will be documented by a return email of a majority of committee members. Departmental personnel responsible for the grants may be called upon to present information and/or answer questions about their grants at these quarterly meetings of the Grants ReviewCommittee.

**Grant Expenditure Review and Payment Process (Responsibility of Development Coordinator)**
The reimbursement of all grant expenditures will comply with District reimbursement policies (see Administrative Policy Manual, AP 19) and any grant specific guidelines stated in the grant contract. All grant expenditures must have appropriate backup such as an invoice, receipt, etc. and any purchases from inventory will not be reimbursed. In the event of HRSA grants, Bridge Policy AP XX is included in the expenditure review and payment process.

A review of all grant expenses by the department director, Director of the Foundation, Development Coordinator, Grant Analyst, and Grants Development Manager is completed prior to submission to the District for reimbursement is required.

Proper expenditure of grant funds is the ultimate responsibility of the vice-Chief president of the department implementing the grant. At their discretion they may delegate a staff person (program coordinator or department director) in the department implementing the grant.

Employee Salaries and Benefits Reimbursed by Grants

If a grant limits the dollar amount of total payroll reimbursement and a grant employee's full salary is not able to be reimbursed under the grant without a modification to the benefit percentage, the reason for modification should be clearly documented within the grant file.

District employee benefit percentages are established each year by the Director of Strategic Planning/Finance Department. When the grant budgets are being created, this percentage will be used. It will be clear what the grant will pay for, determined by the grant guidelines, and any match that KD Kaweah Health is responsible to cover.

Grant Salary Information

District personnel salary information is used both for grant writing and reporting purposes. Salary and benefits information is made available to personnel who are directly responsible for the management of grant activity and also to those who are responsible for the preparation of grant reporting. The Director of Development—the Foundation ensures that all personnel who handle salary information are informed that they are expected to keep this information in the strictest confidence and are not to use this information for any other purpose other than grant-related business. The Vice-President of Development—the Foundation has access to everyone’s salary in the District in PeopleSoft reports. If Executive Team salary information is needed, either the appropriate vice president/Chief or the Vice-President/Chief of Human Resources will provide this information.

Bioterrorism Grant Processes

The funds for Bioterrorism grants are distributed through the Tulare County Health and Human Services Agency and are paid out to the grantees either through expense reimbursement or by the County making the purchases on behalf of the grantees. The policies and procedures outlined herein shall be followed in the case of Bioterrorism Grant funds with the following exceptions:

A. Receive letter or e-mail from the County verifying the amount of grant funds.
B. Complete non-stocks of order and have signed by Supervisor, Vice PresidentChief of the department and submit to Development Departmentthe Foundation. Include all equipment costs, including shipping and tax. Must be signed that Development Departmentthe Foundation will reimburse by (1) Development Coordinator, and (2) Vice PresidentDirector of Developmentthe Foundation.

C. Order from vendor through purchasing.

D. Development DepartmentThe Foundation will bill the county based upon the non-stocks submitted.

E. Development CoordinatorGrant analyst will reimburse the District once the items are received. This is tracked by approval of each item on the General Ledger report on the monthly performance report and then submitted to the Development CoordinatorGrant analyst.

F. Copy the Development Coordinator or Development Grant ManagerCoordinator on correspondence.

Grant Close-Out Processes

Grants Development ManagerAnalyst will contact all grantor agencies during the process of closing grants if any fund balances remain to determine what should be done with these balances, unless already specified in the agreement with the grantor agency. All correspondence with the grantor agencies should be documented and kept in the grant files. If contact with any of the grantor agencies is made by telephone, a request should be made to the contact person at such agencies to document via letter or email the agreement that was reached related to the remaining funds. If grantor gives permission to use the remaining funds, efforts should be made to use the funds as soon as possible for the uses the grantor specifies. If the grantor requests return of unused funds, the Grants AnalystDevelopment Manager will forward the request including all appropriate backup for the request, to the Development Coordinatorfinance department so that refund check can be processed.

The Finance Department will post monthly interest to those grants requiring it. The Finance Department will be notified by the Development CoordinatorGrant analyst when grant funds are exhausted and/or a grant is closed to help avoid the continued accrual of interest.

At the conclusion of each grant the Grants Development ManagerAnalyst will insure that a grant completion report containing a cost/benefit analysis is prepared within 30 days of grant completion utilizing the approved grant completion form. The Grant Analyst will compile all audit necessary paperwork including but not limited to payroll records, expense reports and equipment reimbursement records. The Grants Development ManagerAnalyst will submit the grant completion report to the Vice PresidentDirector of Developmentthe Foundation who will review it for completeness and then present it to the Kaweah Delta-Health Executive Team.

HIPAA Compliance in Grant Reporting
The Vice President/Director of Development/the Foundation and Grants Coordinator/Development Manager will review each grant before application is made to ensure that U.S. Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations are followed. All Development staff members must inform the Director/Vice President of Development/the Foundation of "informal" grant reporting requirements as well as formal grant reporting requirement.
Grants

Grant ideas/priorities are provided to the Development team by the Exec. Team, Directors and Managers for research.

Grant opportunities are researched by the Grants Coordinator/Development Manager.

Initial overview of grant requirements is developed, including:
- Grant source
- Program requirements
- District matching obligation
- Necessary resources

Is grant for more than $50,000?
- No
  - Grant is presented to the Director of Development and Chief and staff of the Department that would support the grant. A determination is then made as to whether the Grants Coordinator/Development Manager needs to be involved.
- Yes
  - Grant is presented to the Director of Development and Chief and staff of the Department that would support the grant. If they decide to proceed, it is presented to the Exec. Team for approval to proceed.

Is a grant application filed?
- No
  - Grants Coordinator/Development Manager will continue to research grant opportunities that align with strategic goals.
- Yes
  - Application is completed with joint efforts from applicable areas and Grants Coordinator/Development Manager.

A grant file is prepared in Development by the Grants Coordinator/Development Manager with the application and other supporting documents.

Was the grant awarded?
- No
  - The Quarterly Grant Report is updated to reflect denial of grant application.
- Yes
  - The Quarterly Grant Report is updated to reflect award of grant.

Go to Grant Management Processes Flowchart
Kaweah Health Hospital Foundation
Grant Management Processes

Continued from the
Grant Approval
and Application
Process Flowchart

The Grant Document
outlining the program and
financial specifications is
signed

Documentation is
updated in the Grant
File and shared drive

Upon awarding of grant
the Foundation
Coordinator notifies
Finance so that a Fund
Number can be set up in
the General Ledger

Grant money is
received from the
granting agency

Money is placed into the bank by the
Foundation Coordinator. Note that there
might be specific guidelines in the grant as
to how the grant funds must be invested

Grant instruction takes place between the
Foundation staff, Finance staff, and the
Program Coordinator for the grant. Clear
instruction is given by the Grants Analyst
related to:

- Program Goals
- Financial Issues
- Reporting Requirements

Work and programs
related to the Grant
began and expenses
are incurred

NOTICE: All financial and program
reports must be submitted to the
Grant Analyst for inclusion in the
Grant File and Share Drive

Go to Grant
Financial Processing
and Reporting
Flowchart
Use of district name, logo and/or stationery

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

**POLICY:** Use of Kaweah Delta Health Care District’s name, logo and stationery is restricted for official District business.

Use of business names for Kaweah Delta Health Care District (doing business as Kaweah Health) divisions and programs is limited to the list approved by the District board on July 14, 2008 and those subsequently approved by the Executive Team. The complete list including logos, required taglines, and logo use requirements is attached to this document (Exhibit A).

**PROCEDURE:**

I. **Use of Name**
   
   A. **Unless specifically authorized to do so,** staff members are not to publicly or privately present a point of view as being that of Kaweah Health.
   
   B. **Unless specifically authorized to do so,** staff members are not to speak with members of the media holding themselves out to be representatives of or speakers for the Health Care District. **Any media requests should be forwarded to Kaweah Delta Health’s Media Relations Department.**
   
   C. Requests to create a social media account using a business name for a Kaweah Delta program or division requires prior approval by the Kaweah Delta Media Relations/Health Marketing and Media Relations Department. The approval process is:
      
      1. Submit a request to the Marketing and Media Relations Department
      2. Meet all of the stated Marketing and Media Relations Department’s requirements for establishment of the social media account
      3. Agree to an annual audit to ensure that all social media accounts are in compliance with requirements

   **Unless specifically authorized to do so,** staff members are not to speak with members of the media holding themselves out to be...
representatives of or speakers for Kaweah Health. Any media requests should be forwarded to Kaweah Health’s Marketing and Media Relations Department.

**D.E.** Requests to create a social media account using a business name for a Kaweah Health program or division requires prior approval by the Kaweah Health Marketing and Media Relations Department. The approval process is:

1. Submit a request to the Marketing and Media Relations Department
2. Meet all of the stated Marketing and Media Relations Department’s requirements for establishment of the social media account
3. Agree to an annual audit to ensure that all social media accounts in are in compliance with requirements

**E.F.** Any and all websites that use a Kaweah Health business name must be coordinated through the Marketing and Communications Media Relations Department.

**E.G.** Requests to use any name other than those on the approved list will follow this procedure:

1. Submit the proposed name to the Marketing and Communications Media Relations Department for approval.
2. If approved, Marketing and Media Relations will submit the proposed name to the Chief Strategy Officer of Development.
3. If approved, the Vice President/Chief Strategy Officer of Development will take the proposal to the Executive Team for consideration.
4. If approved by the Executive Team, the requested name may be used in Marketing and internal materials with the approved logo and required tagline(s).

**USE OF KAWEAH HEALTH BRANDING/LOGO, DEPARTMENT AND SERVICE LINE LOGOS, AND USE OF STATIONERY**

**Use of Logo**

One of Kaweah Health’s primary strengths is its orchestrated approach to meeting the health care needs of our communities. While we are a structurally complex
organization with many departments, service lines and locations, all entities are united by a common mission, a shared vision, and the same five pillars.

It is important that we:
- Guide the public perception that we are a unified body working in harmony for their benefit.
- Maintain a readily recognized brand.

Having various logomarks, symbols, fonts, logotypes, naming, and divergent graphic styles for various entities undermine these objectives. This is true for any organization. The most basic principles of branding teach us that consistency is the foundation of a solid brand, and that individual preferences are cracks in that foundation. The Journey to World Class demands that we, at the very least, follow the most basic tenets of professional branding.

Kaweah Health not permit departments and/or service lines to have their own unique logomarks or wordmarks.

**The Solution**
While Kaweah Health does not allow hospital departments and service lines to represent themselves with their own unique logomarks or wordmarks, the Kaweah Health logo may be combined with the name of a secondary entity (as shown in the examples below) for specific uses.

These logo-plus-entity name treatments are only allowed on:
- Signage
- Promotional merchandise
- Apparel, such as pens, bags, jackets, non-workwear polo shirts, T-shirts and other giveaway items.

**Important**
Creation of these logo/name lockups is to be handled through the Kaweah Health Marketing and Media Relations Department. Generating identities from within individual departments is strictly prohibited.

For more information or additional samples, please go to KaweahHealthBrand.org/other resources
Stationery

II. Use of Stationery

A. Use of Kaweah Health stationery by any staff member is limited to purposes of official business within the scope of the duties and responsibilities of that individual.

B. All correspondence addressed to government officials, particularly which indicates a point of view for or against legislation, rules, or regulation, must be approved by the Chief Executive Officer prior to mailing.

C. No materials including, letterhead, flyers, promotional items, etc. should be sent to print without approval from the chain of command listed above.

There is only one approved version of the Kaweah Health letterhead and envelope. Stationery systems do not use service line lockups. Instead, these applications use the service line designation in text, as shown in the sample below.
PROCEDURE:

I. Use of Name
   A. Unless specifically authorized to do so, staff members are not to publicly or
      privately present a point of view as being that of the Health Care District.
   B. Unless specifically authorized to do so, staff members are not to speak with
      members of the media holding themselves out to be representatives of or
      speakers for the Health Care District. Any media requests should be
      forwarded to Kaweah DeltaHealth’s Marketing and Media Relations
      Department.
   C. Requests to create a social media account using a business name for a
      Kaweah DeltaHealth program or division requires prior approval by the
      Kaweah DeltaHealth Marketing and Media Relations Department. The
      approval process is:
      1. Submit a request to the Marketing and Media Relations Department
      2. Meet all of the stated Marketing and Media Relations Department’s
         requirements for establishment of the social media account
3. **Agree to an annual audit to ensure that all social media accounts are in compliance with requirements**

**B-D** Any and all websites that use a Kaweah Delta Health business name must be coordinated through the Marketing and Communications Media Relations Department.

**C-E** Requests to use any name other than those on the approved list will follow this procedure:

1. Submit the proposed name to the Marketing and Communications Media Relations Department for approval.
2. If approved Marketing and Media Relations will submit the proposed name to the Vice President/Chief Strategy Officer of Development.
3. If approved the Vice President/Chief Strategy Officer of Development will take the proposal to the Executive Team for consideration.
4. If approved by the Executive Team the requested name may be used in Marketing and internal materials with the approved logo and required tagline(s).

When using the name of a Kaweah Delta program (i.e. Worksite Wellness) on any marketing materials, the program must contain the tagline “A program offered by Kaweah Delta Health Care District” rather than the tagline “A division of Kaweah Delta Health Care District”. “A division of Kaweah Delta Health Care District” will apply to all service lines (i.e. Kaweah Delta Hospice, a division of Kaweah Delta Health Care District).

If you are unsure of the proper use of a tagline, contact the Marketing and Communications Media Relations Department for assistance.

II. **Use of Stationery**

A. Use of District stationery by any staff member is limited to purposes of official business within the scope of the duties and responsibilities of that individual.

B. All correspondence addressed to government officials, particularly which indicates a point of view for or against legislation, rules, or regulation, must be approved by the Chief Executive Officer prior to mailing.

C. No materials including, letter heads, flyers, promotional items, etc. should be sent to print without approval from the chain of command listed above.

*These guidelines, procedures, or policies herein do not represent the only medically or legally acceptable approach, but rather are presented with the recognition that acceptable approaches exist. Deviations under appropriate circumstances do not represent a breach of a medical standard of care. New knowledge, new techniques, clinical or research data, clinical experience, or clinical or bio-
ethical circumstances may provide sound reasons for alternative approaches, even though they are not described in the document."
POLICY: In order to control the costs of legal fees, and to streamline the dissemination of legal advice, direct access to legal counsel is limited to certain specific individuals.

Individuals authorized for direct and immediate access to District Administrative legal counsel are limited to:

A. any member of the District Kaweah DeltaHealth Board of Directors;
B. the Chief Executive Officer (CEO);
C. the District Executive Assistant to Board/to CEO & Board Clerk;
D. any individual with the title of Kaweah DeltaHealth Health Care District Senior Vice President/Executive Team Member; Vice President or Division Director;
E. the Director of Risk Management;
F. the District Chief Compliance & Risk Privacy Officer;
G. the Director of Internal Audit Leadership;
H. the Chief of Medical Staff;
I. the Chair of the Medical Staff Credentials Committee;
J. the Director of Patient Accounting Services or Credit Manager.

Directors or other staff members may be authorized for direct and immediate access to District legal counsel provided they are acting at the specific request or direction of an individual occupying any of the positions indicated above.

Individuals authorized for direct and immediate access to Medical Staff legal counsel are limited to:

A. any member of the District Board of Directors;
B. the Chief Executive Officer;
C. any Medical Staff Officer;
D. the Chair of the Medical Staff Credentials Committee;
E. Director of Medical Staff Services
Other staff members may be authorized for direct and immediate access to Medical Staff legal counsel provided they are acting at the specific request or direction of an individual occupying any of the positions indicated above.

*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 bioethical circumstances may provide sound reasons for alternative approaches, even though they are not described in the document.*
POLICY:

I. Risk Management (RM) will maintain an ongoing database of records in active litigation.

II. Receipt of Subpoena for Medical Records will trigger Health Information Management (HIM) staff to record original medical records to retain a master copy of records for ongoing litigation needs. A log shall be kept by the Health Information Management (HIM) clerk recording original medical records that have been released. Medical records maintained in computerized media shall be “locked”.

III. For any medical record where access has been limited, the electronic medical record shall indicate “Global Circulation File”, “This shall be considered a Locked File”. See Attachment A.

IV. Electronic Medical Records of litigation cases shall be “locked” by Medical Records personnel and shall not be released and/or recreated without authorization of the Director of Risk Management (RM) or the RM Coordinator, or in his/her absence, the Director of HIM.

V. Access for review of a medical record identified as a “litigation medical record” shall be limited to documented caregivers. Physician access to the medical record is never limited.

VI. The Director/Manager of RM or the RM Coordinator shall be notified of all requests for information from litigated medical records.

VII. Risk Management will use this same medical record security procedure for cases that are not litigated but in which there is a claim or other issue requiring increased medical record security. The length of retention on these cases will be determined on a case-by-case basis.

PROCEDURE:

I. Risk Management receives lawsuit.
II. **Risk Management Coordinator or Administrative Assistant, Manager, or Director (or designee)** will notify HIM Manager, Lead, and designated Tech by email including patient name and medical record number within one business day.

III. HIM will complete archiving of the records for response to subpoena within three business days.

IV. **Risk Management Coordinator, Manager, and Director** will be notified by HIM of any records requests for the held record. To review any locked medical record:

Call the Risk Management Department (extension 5284) for an appointment. Appointments to review locked files will be made between the hours of 8:00 a.m. and 4:00 p.m.

Caller must provide Director of Health Information Management or Risk Management with the authority as caregiver to access the medical record for any reason other than direct patient care.

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**GLOBAL CIRCULATING FILE**

**PLEASE NOTIFY THE RISK MANAGEMENT COORDINATOR IN RISK MANAGEMENT AT KAWEAH DELTA HEALTH CARE DISTRICT AT 624-5284 PRIOR TO RELEASE OF ANY MEDICAL RECORDS ON THIS PATIENT.**

**THIS IS A LOCKED FILE.**

**THE ORIGINAL MEDICAL RECORD IS LOCATED IN THE KDHCD HEALTH INFORMATION DEPARTMENT.**
PLEASE NOTE: IF ADDITIONAL RECORDS ARE ADDED AFTER THE DATE BELOW, PLEASE GIVE THE ORIGINAL TO THE RISK MANAGEMENT DEPARTMENT.

SIGNATURE

DATE

“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.”
Visiting Regulations for Kaweah Delta Health Care District

PURPOSE:
Visitor access guidelines balance the needs of all patients for privacy and rest, the environment needed by the medical staff and hospital staff to carry out their work, and everyone's need for safety and security with the presence of family or friends with the patient during the health care admission. In extenuating circumstances, exceptions to this policy may be considered by the Nurse Manager, House Supervisor or designee.

POLICY:

I. These regulations apply to all acute care areas of Kaweah Health Medical Center. Skilled Nursing (SNF V.2), Mental Health Hospital (MH.154) and Acute Rehabilitation (PR.04) have policies which are specific to those respective clinical areas.

II. General visiting hours are 9:00a.m. to 9:00p.m. Critical Care and Intermediate Critical Care department visiting hours are 10:00am-5:00pm and 7:00pm-9:00pm. All visitors must enter via designated locations and receive a visitor sticker each day.

III. Visitor Expectations

A. Generally patients are not permitted overnight visitors unless exceptions granted but the Unit Manager, House Supervisor, or designee. This may include situations but not limited to: support for a cognitive/mental disorder, end of life, change in level of care, deteriorating condition, and major surgery with high risk of death. 
   1. If a sleeping chair is available, it will be provided for the approved overnight visitor(s).

B. An interpreter designated by family may stay at the bedside of patients, if necessary for continuity of care.

C. Patients can request “no visitors” at any time. A sign will be posted on the door of the patient’s room to that effect. (AP.49 No Information No Presence in Facility Patient Status)
D. It is suggested that no more than two (2) visitors be in a patient’s room at one time as a limiting guideline. The nurse has the ability to allow more or less if it is in the patient’s best interest, or at the request of a patient or physician.

1. Other visitors must go to public lobby areas by the visitor elevator, in the main lobby, or in the cafeteria to wait. An adult must accompany children (15 and younger) at all times and the child or children are allowed in the main 1st floor lobby or the cafeteria if not approved for visitation.

E. Staff may request that visitors leave the room while they provide patient care or if visitors are interfering with the treatment or rest of any patient. Nursing staff may also ask any visitor to leave the patient care area if the visitor is being loud or disruptive in anyway.

F. Children under 12 years of age are not allowed to visit unless cleared by the Unit Leader, House Supervisor or designee.

1. For the health of all patients and staff, once authorized, the visit should be as brief as possible and the visitor should be directed to stay in the patient room.

G. Cell phones are prohibited in posted areas (such as but not limited to Emergency Room, Mental Health Hospital, during deliver of a newborn) and during patient care. Where allowed, cell phones and pagers are to be on vibrate/silent mode. For full details on use of cell phones, photography, video recording reference policy AP163 “Photography and Video Recording of Patients and Staff”.

H. Eating is allowed only in the public dining areas and, with the patient’s permission, in the patient’s room.

IV. Patients in Neonatal Intensive Care Unit, Post-partum, Pediatrics and Labor Delivery are allowed overnight visitors – details by location below. If the patient or guardian desires, this can be different people and different times. Those authorized to remain will be issued a visitor sticker which must be visibly displayed. **No minors allowed for visitation in NICU or Pediatrics.**

**Seasonal Restrictions:** Seasonal or disease specific visitor restrictions may be recommended by Infection Prevention as indicated by public health authority. Annual visitor restrictions for flu and seasonal respiratory disease begins October 1st and ends March 31st unless otherwise advised by Infection Prevention.

A. For pediatric patients, **two (2) banded guardian(s) per stay. 9am – 9pm visitors are allowed when accompanied by a banded guardian, max of two (2) persons in the room at any given time. the parents and/or**
primary care takers will be issued two orange wristbands for twenty-four (24) hour access.

B. For Labor and Delivery two visitors will be issued pink arm bands for (24) hour access.

C. For Post-partum patients, one support person will be issued a yellow armband for 24 hour access. Visiting hours for up to four (4) visitors or siblings (to the new baby) at one time are designated from 9:00am – 11:00am and 4:00pm-6:00pm daily.

D. For Neonatal Intensive Care Unit patients, two (2) banded guardian(s) per stay. An additional 4 visits per day allowed when accompanied by a banded guardian, max of two (2) persons in the room at any given time. Two parents and/or primary caretakers will be issued green armbands for (24) hour access.

"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 bioethical circumstances may provide sound reasons for alternative approaches, even though they are not described in the document."
Quality Improvement Plan

I. Purpose

The purpose of Kaweah Delta Health Care District's (KDHCD) Quality Improvement Plan is to have an effective, data-driven Quality Assessment Performance Improvement program that delivers high-quality, excellent clinical services and enhances patient safety.

II. Scope

All Kaweah Delta Health Care District facilities, departments, patient care delivery units and/or service areas fall within the scope of the quality improvement plan requirements.

III. Structure and Accountability

Accountability

III. Board of Directors

The Board of Directors retain overall responsibility for the quality of patient care. The Board approves the annual Quality Improvement Plan and assures that appropriate allocation of resources is available to carry out that plan.

The Board receives reports from the Medical Staff and Quality Council. The Board shall act as appropriate on the recommendations of these bodies and assure that efforts undertaken are effective and appropriately prioritized.

Quality Council

The Quality Council is responsible for establishing and maintaining the organization’s Quality Improvement Plan and is chaired by a Board member. The Quality Council shall consist of the Chief Executive Officer, representatives of the Medical Staff and other key hospital leaders. It shall hold primary responsibility for the functioning of the Quality Assessment and Performance Improvement program. Because District quality improvement activities may involve both the Medical Staff and other representatives of the...
District, membership is multidisciplinary. The Quality Council requires the Medical Staff and the organization’s staff to implement and report on the activities for identifying and evaluating opportunities to improve patient care and services throughout the organization. The effectiveness of the quality
improvement and patient safety activities will be evaluated and reported to the Quality Council.

**Medical Staff**

The Medical Staff, in accordance with currently approved medical staff bylaws, shall be accountable for the quality of patient care. The Board delegates authority and responsibility for the monitoring, evaluation and improvement of medical care to the Professional Staff Quality Committee “Prostaff,” chaired by the Vice Chief of Staff. The Chief of Staff delegates accountability for monitoring individual performance to the Clinical Department Chiefs. Prostaff shall receive reports from and assure the appropriate functioning of the Medical Staff committees. “Prostaff” provides oversight for medical staff quality functions including peer review.

**Quality Improvement Committee (“QComm”IC)**

In accordance with currently approved medical staff bylaws, shall be accountable for the quality of patient care. The Board delegates authority and responsibility for the monitoring, evaluation and improvement of medical care to the Quality Committee “QComm”, chaired by the Vice Chief of Staff and co-chaired by the CMO/CQO (or designee). The Chief of Staff delegates accountability for monitoring individual performance to the Clinical Department Chiefs. QComm shall receive reports from and assure the appropriate functioning of the Medical Staff committees. QComm provides oversight for medical staff quality functions including peer review.

QCommIC has responsibility for oversight of organizational performance improvement. Membership includes key medical staff and organizational leaders including the Chief of Staff, Medical Director of Quality and Patient Safety, or Chief Quality Officer, Secretary-Treasurer, Immediate Past Chief of Staff, Chief Executive Officer, Chief Operating Officer, Chief Nursing Officer, Chief Informatics Officer, Chief Human Resources Officer, Chief Financial Officer, Chief Compliance and Risk Management Officer, Chief Strategy Officer, Assistant Chief Nursing Officer, Directors of Quality and Patient Safety, Nursing Practice, Pharmacy, Health System, Accreditation, and Risk Management; Manager of Quality and Patient Safety, and Manager of Infection Prevention and Environmental Safety Officer. This committee reports to Medical Executive Committee, Prostaff, and the Quality Council.

The QCommIC shall have primary responsibility for the following functions:

1. **Health Outcomes**: The QCommIC shall assure that there is measureable improvement in indicators with a demonstrated link to improved health outcomes. Such indicators include but are not limited to measures reported to the Centers for Medicare and Medicaid Services (CMS) and The Joint Commission (TJC), and other quality indicators, as appropriate.

2. **Quality Indicators**:
   a. The QCommIC shall oversee measurement, and shall analyze
and track quality indicators and other aspects of performance. These indicators shall measure the effectiveness and safety of services and quality of care.

b. The QCommIC shall approve the specific indicators used for these purposes along with the frequency and detail of data collection.

c. The Board shall ratify the indicators and the frequency and detail of data collection used by the program.

c. **Prioritization:** The QCommIC shall prioritize quality improvement activities to assure that they are focused on high-risk, high-volume, or problem-prone areas. It shall focus on issues of known frequency, prevalence or severity and shall give precedence to issues that affect health.
outcomes, quality of care and patient safety. The QCommIC is responsible to establish organizational Quality Focus Teams who:

da. Are focused on enterprise-wide high priority, high risk, problem prone QI issues
db. May require elevation, escalation and focus from senior leadership
dc. Have an executive team sponsor
dd. Are chaired by a Director or Vice President
de. May have higher frequency of meetings as necessary to focus work and create sense of urgency.
df. Report quarterly into the QAPI program

3.4. Improvement: The QCommIC shall use the analysis of the data to identify opportunities for improvement and changes that will lead to improvement. The QCommIC will also oversee implementation of actions aimed at improving performance.

4.5. Follow-Up: The QCommIC shall assure that steps are taken to improve performance and enhance safety are appropriately implemented, measured and tracked to determine that the steps have achieved and sustained the intended effect.

5.6. Performance Improvement Projects: The QCommIC shall oversee quality improvement projects, the number and scope of which shall be proportional to the scope and complexity of the hospital’s services and operations. The QCommIC must also ensure there is documentation of what quality improvement projects are being conducted, the reasons for conducting those projects, and the measurable progress achieved on the projects.

Medical Executive Committee

The Medical Executive Committee (MEC) receives, analyzes and acts on performance improvement and patient safety findings from committees and is accountable to the Board of Directors for the overall quality of care.

Nursing Practice Improvement Council

The Nursing Practice Improvement Council is designed to ensure quality assessment and continuous quality improvement and to oversee the quality of patient care (with focus on systems improvements related to nursing practices and care outcomes).

The Nursing Practice Improvement Council is chaired by the Director of Nursing Practice and facilitated by a member of the Quality and Patient Safety department. This Council has staff nurse representation from a broad scope of inpatient and out-patient nursing units, and procedural nursing units. The Council will report to Patient Care Leadership, Professional Practice Council (PPC) and the Professional Staff Quality Committee.
IV. Graduate Medical Education

Graduate Medical Education (Designated Institutional Official (DIO), faculty and residents, are involved in achieving quality and patient safety goals and improving patient care through several venues including but not limited to:

a) Collaboration between Quality and Patient Safety Department, Risk Management, and GME Quality Subcommittee
b) GME participation in Quality Improvement Committee and Patient Safety Committee
c) GME participation in KDHCD quality committees and root cause analysis (including organizational dissemination of lessons learned)

V. Methodologies:

Quality improvement (QI) models present a systematic, formal framework for establishing QI processes within an organization. QI models used include the following:

- **Model for Improvement (FOCUS Plan-Do-Study-Act [PDSA] cycles)**
- **Six Sigma**: Six Sigma is a method of improvement that strives to decrease variation and defects with the use of the DMAIC roadmap.
- **Lean**: is an approach that drives out waste and improves efficiency in work processes so that all work adds value with the use of the DMAIC roadmap.

1. The **FOCUS-Plan, Do, Check, Act (PDCA)** methodology is utilized to plan, design, measure, assess and improve functions and processes related to patient care and safety throughout the organization.

   - **F**—Find a process to improve
   - **O**—Organize effort to work on improvement
   - **C**—Clarify knowledge of current process
   - **U**—Understand process variation
   - **S**—Select improvement

   **Plan:**

   - Objective and statistically valid performance measures are identified for monitoring and assessing processes and outcomes of care including those affecting a large percentage of patients, and/or place patients at serious risk if not performed well, or performed when not indicated, or not performed when indicated; and/or have been or likely to be problem prone.

   - Performance measures are based on current knowledge and clinical experience and are structured to represent cross-departmental, interdisciplinary processes, as appropriate.

   **Do:**
Data is collected to determine:

- Whether design specifications for new processes were met
- The level of performance and stability of existing processes
- Priorities for possible improvement of existing processes

Check:

- Assess care when benchmarks or thresholds are reached in order to identify opportunities to improve performance or resolve problem areas

Act:

- Take actions to correct identified problem areas or improve performance
- Evaluate the effectiveness of the actions taken and document the improvement in care
- Communicate the results of the monitoring, assessment and evaluation process to relevant individuals, departments or services

3. DMAIC (Lean Six Sigma): DMAIC is an acronym that stands for Define, Measure, Analyze, Improve, and Control. It represents the five phases that make up the road map for Lean Six Sigma QI initiatives.

Define the problem, improvement activity, opportunity for improvement, the project goals, and customer (internal and external) requirements. QI tools that may be used in this step include:

- Project charter to define the focus, scope, direction, and motivation for the improvement team
- Process mapping to provide an overview of an entire process, starting and finishing at the customer, and analyzing what is required to meet customer needs

Measure process performance:

- Run/trend charts, histograms, control charts
- Pareto chart to analyze the frequency of problems or causes

Analyze the process to determine root causes of variation and poor performance (defects):

- Root cause analysis (RCA) to uncover causes
- Failure mode and effects analysis (FMEA) for identifying possible product, service, and process failures

Improve process performance by addressing and eliminating the root causes:

- Pilot improvements and small tests of change to solve problems from complex processes or systems where there are many factors influencing the outcome
Kaizen event to introduce rapid change by focusing on a narrow project and using the ideas and motivation of the people who do the work

Control the improved process and future process performance.
- Quality control plan to document what is needed to keep an improved process at its current level. Statistical process control (SPC) for monitoring process behavior
- Mistake proofing (poka-yoke) to make errors impossible or immediately detectable

VI. Confidentiality

All quality assurance and performance improvement activities and data are protected under the Health Care Quality Improvement Act of 1986, as stated in the Bylaws, Rules and Regulations of the Medical Staff, and protected from discovery pursuant to California Evidence Code §1157.

VII. Annual Evaluation

Organization and Medical Staff leaders shall review the effectiveness of the Quality Improvement Plan at least annually to insure that the collective effort is comprehensive and improving patient care and patient safety. An annual evaluation is completed to identify components of the plan that require development, revision or deletion. Organization and Medical Staff leaders also evaluate annually their contributions to the Quality Improvement Program and to the efforts in improving patient safety.

VIII. Attachments

Components of the Quality Improvement and Patient Safety Plan:
- Attachment 1: Quality Improvement Committee Structure
- Attachment 2: Kaweah HealthDHCD-Prostaff Reporting Documents
- Attachment 3: Quality and Patient Safety Priorities, Outstanding Health Outcomes Strategic Plan

*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.*
Do:

- Data is collected to determine:
  - Whether design specifications for new processes were met
  - The level of performance and stability of existing processes
  - Priorities for possible improvement of existing processes

Check:

- Assess care when benchmarks or thresholds are reached in order to identify opportunities to improve performance or resolve problem areas

Act:

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  - Process mapping to provide an overview of an entire process, starting and finishing at the customer, and analyzing what is required to meet customer needs

Measure
- Measure process performance.
  - Run/trend charts, histograms, control charts
  - Pareto chart to analyze the frequency of problems or causes

Analyze
- Analyze the process to determine root causes of variation and poor performance (defects).
  - Root cause analysis (RCA) to uncover causes
  - Failure mode and effects analysis (FMEA) for identifying possible...
Quality Improvement Plan

Product, service, and process failures
- Improve process performance by addressing and eliminating the root causes.
- Pilot improvements and small tests of change to solve problems from complex processes or systems where there are many factors influencing the outcome.
- Kaizen event to introduce rapid change by focusing on a narrow project and using the ideas and motivation of the people who do the work.

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Attachment 1

Kaweah Health
Quality Reporting Structure

Communication on Quality Issues

Board of Directors

Quality Council (BOD Quality Subcommittee)

Medical Executive Committee

Quality Committee “QComm”

All three groups have membership representation

Issues Involving the Medical Staff Peer Review Findings

QAPI Monitoring and Improvements

Medical Staff Services/Committees

Kaweah Health Operational Departments

Committees

QAPI Activities
Quality Committee "QComm" Reporting Depts/Services/Committees

Departments within Kaweah Health participate in the Quality Improvement plan by prioritizing performance improvement activities based on high-risk, high-volume, or problem-prone areas. Department level indicators shall focus on issues of known frequency, prevalence or severity and shall give precedence to issues that affect health outcomes, quality of care and patient safety. Departments include, but are not limited to:

<table>
<thead>
<tr>
<th>Professional &amp; Patient Care Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Laboratory</td>
</tr>
<tr>
<td>Blood Utilization</td>
</tr>
<tr>
<td>Dept of Radiology/imaging Services (including Radiation Safety Report)</td>
</tr>
<tr>
<td>Dept of Emergency Medicine</td>
</tr>
<tr>
<td>Dept of Pathology (Annual)</td>
</tr>
<tr>
<td>EOC (Security, Facilities, Clinical Engineering, EVS, Employee Health, WPV; WPV annual report)</td>
</tr>
<tr>
<td>Peer Review (Semi-Annual)</td>
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<tr>
<td>CME Report</td>
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<tr>
<td>Patient Access</td>
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<tr>
<td>Population Health</td>
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<tr>
<td>Nutrition Services</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Staffing Analysis and Adverse Events</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality Incentives Program (previously PRIME), includes all Rural Health Clinics (Exeter, Lindsay, Woodlake, Dinuba, Tulare)</td>
</tr>
<tr>
<td>ISS Services</td>
</tr>
<tr>
<td>ISS - Clinical Informatics</td>
</tr>
<tr>
<td>ISS - Application Services</td>
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<tr>
<td>ISS - Technical Services</td>
</tr>
<tr>
<td>CPOE MUE (eCQMs)</td>
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<tr>
<td>Pharmacy</td>
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<tr>
<td>Inpatient Pharmacy</td>
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<tr>
<td>Med Safety &amp; ADE (Quarterly)</td>
</tr>
<tr>
<td>MERP Annual Review</td>
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<tr>
<td>Chemo Annual Review</td>
</tr>
<tr>
<td>Infection Prevention Services</td>
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<tr>
<td>Infection Prevention Quarterly Report</td>
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<tr>
<td>Hand Hygiene</td>
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<table>
<thead>
<tr>
<th>Risk Management</th>
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<tbody>
<tr>
<td>Risk Management (RCA and Focus Review Summary)</td>
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<tr>
<td>Grievances</td>
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<thead>
<tr>
<th>Mental Health Services</th>
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<tbody>
<tr>
<td>Dept of Psychiatry, MHH</td>
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<tr>
<td>Behavioral Health Committee</td>
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<thead>
<tr>
<th>Maternal Child Health/ Dept of OB/GYN &amp; Peds</th>
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<tbody>
<tr>
<td>Labor &amp; Delivery</td>
</tr>
<tr>
<td>Mother Baby</td>
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<tr>
<td>Neonatal Intensive Care Unit</td>
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<tr>
<td>Pediatrics</td>
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<tr>
<th>Respiratory Services</th>
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<tbody>
<tr>
<td>Sleep Lab and EEG</td>
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<tr>
<td>Respiratory Therapy and Pulmonary Function Test</td>
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<tr>
<th>Care Management</th>
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<tbody>
<tr>
<td>Patient &amp; Family Services</td>
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<tr>
<td>Case Management</td>
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<tr>
<td>Interpreter Services</td>
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<tr>
<td>Palliative Care Committee Minutes</td>
</tr>
<tr>
<td><strong>Episodic Care</strong></td>
</tr>
<tr>
<td>Emergency Dept. Quality Report</td>
</tr>
<tr>
<td>(Including Conscious Sedation, Dashboard..)</td>
</tr>
<tr>
<td>Trauma Service</td>
</tr>
<tr>
<td>Urgent Cares</td>
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<tr>
<td><strong>Cardiovascular Services</strong></td>
</tr>
<tr>
<td>Dept of Cardiovascular Services (ACC, STS)</td>
</tr>
<tr>
<td>Cath lab, IR, CVCU and Cardiac Surgery</td>
</tr>
<tr>
<td>CVICU</td>
</tr>
<tr>
<td>2 North</td>
</tr>
<tr>
<td>4 Tower</td>
</tr>
<tr>
<td>Telemonitoring Report</td>
</tr>
<tr>
<td>Non Invasive Inpatient Services</td>
</tr>
<tr>
<td><strong>Critical Care Services</strong></td>
</tr>
<tr>
<td>Intensive Care Unit, CVICU (non-cardiac)</td>
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<tr>
<td>3 West</td>
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<tr>
<td>5 Tower</td>
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<tr>
<td>Organ Donation (Annual)</td>
</tr>
<tr>
<td><strong>Rehabilitation Services</strong></td>
</tr>
<tr>
<td>Rehabilitation</td>
</tr>
<tr>
<td>Inpatient Therapies (KDMC, Rehab, South Campus)</td>
</tr>
<tr>
<td>Outpatient Therapies: Medical Office Building Akers (MOB), Exeter, Sunnyside, Dinuba, Lovers Lane, Therapy Specialists at Rehab/Neuro</td>
</tr>
<tr>
<td>Outpatient Wound Clinic at Rehab (included in Rehab report)</td>
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<tr>
<td><strong>Post Acute Services</strong></td>
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<tr>
<td>KH Home Infusion Pharmacy (KHHIP)</td>
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<tr>
<td>Hospice</td>
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<tr>
<td>Home Care Services (Home Health)</td>
</tr>
<tr>
<td>Short-Stay Rehab</td>
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<tr>
<td>Skilled Nursing Services (subacute and short-stay)</td>
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<tr>
<td><strong>Surgical Services</strong></td>
</tr>
<tr>
<td>SQIP - Surgical Quality Improvement Committee</td>
</tr>
<tr>
<td>Ambulatory Surgery Center/PACU/KATS</td>
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<tr>
<td>Operating Room</td>
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<tr>
<td>Sterile Processing Department</td>
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<tr>
<td>Broderick Pavilion</td>
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<tr>
<td>3 North</td>
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<tr>
<td>4 South</td>
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<tr>
<td>Anesthesia Services</td>
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<tr>
<td>Orthopedics</td>
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<tr>
<td>Endoscopy</td>
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<tr>
<td><strong>Renal Services/ Dept of Renal Services</strong></td>
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<tr>
<td>4 North</td>
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<tr>
<td>KH Visalia Dialysis</td>
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<tr>
<td><strong>Med/Surg</strong></td>
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<tr>
<td>2 South</td>
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<tr>
<td>3 South</td>
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<tr>
<td><strong>Publically Reported Measures</strong></td>
</tr>
<tr>
<td>Quality Monthly Dashboard:</td>
</tr>
<tr>
<td>I.P., PSIs, HACs, Mortality, HCAHPS, Core Measures</td>
</tr>
<tr>
<td>Committees</td>
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<tr>
<td>Disparities in care</td>
</tr>
<tr>
<td>Falls Committee</td>
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<tr>
<td>RRT/Code Blue</td>
</tr>
<tr>
<td>Pain Management</td>
</tr>
<tr>
<td>HAPI Committee (includes inpatient wound care)</td>
</tr>
<tr>
<td>Sepsis Quality Focus Team</td>
</tr>
<tr>
<td>CAUTI Committee</td>
</tr>
<tr>
<td>CLABSI Quality Focus Team</td>
</tr>
<tr>
<td>Stroke Committee Report</td>
</tr>
<tr>
<td>Diabetes Committee Report</td>
</tr>
<tr>
<td>Handoff Communication Quality Focus Team</td>
</tr>
<tr>
<td>Accreditation Regulatory Committee Minutes &amp; Audit Summary</td>
</tr>
<tr>
<td>Workplace Violence Committee</td>
</tr>
<tr>
<td>(annual report required by Cal-OSHA)</td>
</tr>
<tr>
<td>Diversion Prevention Committee</td>
</tr>
<tr>
<td>Bioethics Committee</td>
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<tr>
<td>MRSA Quality Focus Team</td>
</tr>
<tr>
<td>Throughput Project Report</td>
</tr>
<tr>
<td>Mortality Committee</td>
</tr>
<tr>
<td>Patient Safety Committee Minutes</td>
</tr>
<tr>
<td>HIM - HIM Committee Minutes and Suspensions</td>
</tr>
<tr>
<td>Professional Practice Committee (PPC) Minutes</td>
</tr>
</tbody>
</table>
**Objective:** Reduce the Hospital Acquired Infections (HAIs) to the national 70th percentile in FYTD24 as reported by the Centers for Medicare and Medicaid Services

<table>
<thead>
<tr>
<th>#</th>
<th>Level</th>
<th>Name</th>
<th>Start Date</th>
<th>Due Date</th>
<th>Assigned To</th>
<th>Status</th>
<th>Last Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.1</td>
<td>Objective</td>
<td>CAUTI, CLABSI, MRSA Quality Focus Teams</td>
<td>07/01/2023</td>
<td>06/30/2024</td>
<td>Sandy Volchko</td>
<td>Not Started</td>
<td></td>
</tr>
<tr>
<td>5.1.2</td>
<td>Objective</td>
<td>Daily catheter and central line Gemba rounds</td>
<td>07/01/2023</td>
<td>06/30/2024</td>
<td>Sandy Volchko</td>
<td>Not Started</td>
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<tr>
<td>5.1.3</td>
<td>Objective</td>
<td>Bio-Vigil</td>
<td>07/01/2023</td>
<td>06/30/2024</td>
<td>Sandy Volchko</td>
<td>Not Started</td>
<td></td>
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<tr>
<td>5.1.4</td>
<td>Objective</td>
<td>MRSA Decolonization</td>
<td>07/01/2023</td>
<td>06/30/2024</td>
<td>Sandy Volchko</td>
<td>Not Started</td>
<td></td>
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<tr>
<td>5.1.5</td>
<td>Outcome</td>
<td>Standardized Infection Ratio (SIR) CAUTI (CMS data FYTD)</td>
<td>07/01/2023</td>
<td>06/30/2024</td>
<td>Sandy Volchko</td>
<td>Not Started</td>
<td>FY24 Goal .48 (70th Percentile) Baseline FYTD .55 (June 2023) FY23 Goal .65 (national mean)</td>
</tr>
<tr>
<td>5.1.6</td>
<td>Outcome</td>
<td>Standardized Infection Ratio (SIR) CLABSI (CMS data FYTD)</td>
<td>07/01/2023</td>
<td>06/30/2024</td>
<td>Sandy Volchko</td>
<td>Not Started</td>
<td>FY24 Goal .39 (70th Percentile) Baseline FYTD .93 (June 2023) FY23 Goal .589 (national mean)</td>
</tr>
<tr>
<td>5.1.7</td>
<td>Outcome</td>
<td>Standardized Infection Ratio (SIR) MRSA (CMS data FYTD)</td>
<td>07/01/2023</td>
<td>06/30/2024</td>
<td>Sandy Volchko</td>
<td>Not Started</td>
<td>FY24 Goal .55 (70th Percentile) Baseline FYTD .63 (June 2023) FY23 Goal .726 (national mean)</td>
</tr>
</tbody>
</table>

**SIR CAUTI FYTD (< 0.48%)**
- **Target:** 0%
- **Actual:** 0.55% (08/07/2023)

**Decrease Utilization Rates for Foley Catheters - CAUTI FYTD (< 0.7%)**
- **Target:** 0%
- **Actual:** 0.7% (08/07/2023)

**SIR CLABSI FYTD (< 0.39%)**
- **Target:** 0%
- **Actual:** 0.93% (08/07/2023)

**Decrease Utilization Rates for Central Lines - CLABSI FYTD (< 0.68%)**
- **Target:** 0%
- **Actual:** 0% (08/07/2023)

**SIR MRSA FYTD (< 0.55%)**
- **Target:** 0%
- **Actual:** 0.63% (08/07/2023)
**Objective:** Increase SEP-1 bundle compliance to overall 85% compliance rate for FY24 through innovative improvement strategies based on root causes.

---

### Plan

<table>
<thead>
<tr>
<th>#</th>
<th>Level</th>
<th>Name</th>
<th>Start Date</th>
<th>Due Date</th>
<th>Assigned To</th>
<th>Status</th>
<th>Last Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.2.1</td>
<td>Objective</td>
<td>Utilize SEPSIS Coordinators to identify and monitor patients</td>
<td>07/01/2023</td>
<td>06/30/2024</td>
<td>Sandy Volchko</td>
<td>Not Started</td>
<td>FY24 Goal .85 (no percentile) Baseline FY end .73 (June 2023) FY23 Goal .77</td>
</tr>
<tr>
<td>5.2.2</td>
<td>Objective</td>
<td>SEPSIS Alerts-Required MD notifications</td>
<td>07/01/2023</td>
<td>06/30/2024</td>
<td>Sandy Volchko</td>
<td>Not Started</td>
<td>FY24 Goal .78 (no percentile) Baseline FY end 1.12 (June 2023) FY23 Goal - N/A (new metric)</td>
</tr>
<tr>
<td>5.2.3</td>
<td>Objective</td>
<td>Quality Focus Team-RCAs/Fall out review</td>
<td>07/01/2023</td>
<td>06/30/2024</td>
<td>Sandy Volchko</td>
<td>Not Started</td>
<td>FY24 Goal .78 (no percentile) Baseline FY end 1.12 (June 2023) FY23 Goal - N/A (new metric)</td>
</tr>
<tr>
<td>5.2.4</td>
<td>Outcome</td>
<td>SEPSIS Bundle Compliance (SEP-1) % FYTD</td>
<td>07/01/2023</td>
<td>06/30/2024</td>
<td>Sandy Volchko</td>
<td>Not Started</td>
<td>FY24 Goal .78 (no percentile) Baseline FY end 1.12 (June 2023) FY23 Goal - N/A (new metric)</td>
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<tr>
<td>5.2.4.1</td>
<td>Outcome</td>
<td>SEPSIS Mortality O/E</td>
<td>07/01/2023</td>
<td>06/30/2024</td>
<td>Sandy Volchko</td>
<td>Not Started</td>
<td>FY24 Goal .78 (no percentile) Baseline FY end 1.12 (June 2023) FY23 Goal - N/A (new metric)</td>
</tr>
</tbody>
</table>

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**SEPSIS Bundle Compliance (SEP-1) %**

- Baseline: 76%
- Target: 85%
- FY24 Goal: 85% (no percentile)
- Baseline FY end: 73% (June 2023)
- FY23 Goal: 77%

**SEPSIS Mortality O/E**

- Baseline: 1.12%
- Target: 0.78%
- FY24 Goal: 0.78% (no percentile)
- Baseline FY end: 1.12% (June 2023)
- FY23 Goal: N/A (new metric)
**Mortality and Readmissions**

**Champions: Sandy Volchko**

**Objective:** Reduce observed/expected mortality through the application of standardized best practices.

### Objective:

- **5.3.1** Objective: Enhanced diagnosis specific workgroups/committees
  - Start Date: 07/01/2023
  - Due Date: 06/30/2024
  - Assigned To: Sandy Volchko
  - Status: Not Started

- **5.3.2** Objective: Standardized care based on evidence
  - Start Date: 07/01/2023
  - Due Date: 06/30/2024
  - Assigned To: Sandy Volchko
  - Status: Not Started

- **5.3.3** Outcome: Hospital Readmissions % AMI (CMS data FYTD)
  - Start Date: 07/01/2023
  - Due Date: 06/30/2024
  - Assigned To: Sandy Volchko
  - Status: Not Started
  - Goal: 80th Percentile / Baseline FYTD (March 2023)

- **5.3.4** Outcome: Hospital Readmissions % COPD (CMS data FYTD)
  - Start Date: 07/01/2023
  - Due Date: 06/30/2024
  - Assigned To: Sandy Volchko
  - Status: Not Started
  - Goal: 80th Percentile / Baseline FYTD (March 2023)

- **5.3.5** Outcome: Hospital Readmissions % HF (CMS data FYTD)
  - Start Date: 07/01/2023
  - Due Date: 06/30/2024
  - Assigned To: Sandy Volchko
  - Status: Not Started
  - Goal: 75th Percentile / Baseline FYTD (March 2023)

- **5.3.6** Outcome: Hospital Readmissions % PN Viral/Bacterial (CMS data FYTD)
  - Start Date: 07/01/2023
  - Due Date: 06/30/2024
  - Assigned To: Sandy Volchko
  - Status: Not Started
  - Goal: 70th Percentile / Baseline FYTD (March 2023)

- **5.3.7** Outcome: Decrease Mortality Rates AMI FYTD
  - Start Date: 07/01/2023
  - Due Date: 06/30/2024
  - Assigned To: Sandy Volchko
  - Status: Not Started
  - Goal: 90th Percentile / Baseline FYTD (March 2023)

- **5.3.8** Outcome: Decrease Mortality Rates COPD FYTD
  - Start Date: 07/01/2023
  - Due Date: 06/30/2024
  - Assigned To: Sandy Volchko
  - Status: Not Started
  - Goal: 60th Percentile / Baseline FYTD (March 2023)

- **5.3.9** Outcome: Decrease Mortality Rates HF FYTD
  - Start Date: 07/01/2023
  - Due Date: 06/30/2024
  - Assigned To: Sandy Volchko
  - Status: Not Started
  - Goal: 90th Percentile / Baseline FYTD (March 2023)

- **5.3.10** Outcome: Decrease Mortality Rates PN Bacterial FYTD
  - Start Date: 07/01/2023
  - Due Date: 06/30/2024
  - Assigned To: Sandy Volchko
  - Status: Not Started
  - Goal: 90th Percentile / Baseline FYTD (March 2023)

- **5.3.11** Outcome: Decrease Mortality Rates PN Viral FYTD
  - Start Date: 07/01/2023
  - Due Date: 06/30/2024
  - Assigned To: Sandy Volchko
  - Status: Not Started
  - Goal: Percentile TBD (specifics unavailable) / Baseline FYTD (March 2023)

- **5.3.12** Outcome: Percutaneous Coronary Intervention (PCI) In Hospital Mortality Rate - STEMI
  - Start Date: 07/01/2023
  - Due Date: 06/30/2024
  - Assigned To: Sandy Volchko
  - Status: Not Started
  - Goal: 50th Percentile / Baseline Rolling 4 quarters (10/1/21 - 9/30/22)

- **5.3.12.1** Outcome: Door to Balloon Time PCI for STEMI (< 50 mins)
  - Start Date: 07/01/2023
  - Due Date: 06/30/2024
  - Assigned To: Sandy Volchko
  - Status: Not Started
  - Goal: 90th Percentile / Baseline of 63 - Rolling 4 quarters (10/1/21 - 9/30/22)

- **5.3.13** Outcome: Acute Kidney Injury Post PCI
  - Start Date: 07/01/2023
  - Due Date: 06/30/2024
  - Assigned To: Sandy Volchko
  - Status: Not Started
  - Goal: 90th Percentile / Baseline Rolling 4 quarters (10/1/21 - 9/30/22)

- **5.3.14** Outcome: Risk Standardized Bleeding Rate
  - Start Date: 07/01/2023
  - Due Date: 06/30/2024
  - Assigned To: Sandy Volchko
  - Status: Not Started
  - Goal: 75th Percentile / Baseline Rolling 4 quarters (10/1/21 - 9/30/22)

### Acute Kidney Injury Post PCI (< 3.6%) - Target: 2%

- 0% - 2%

### PCI In-Hospital Mortality Rate - STEMI (< 2.5%) - Target: 0%

- 0% - 2%

### Risk Standardized Bleeding Rate (< 1.5%) - Target: 1%

- 0% - 1%
FY2024 Outstanding Health Outcomes

Mortality and Readmissions

Champions: Sandy Volchko

Hospital Readmissions % AMI FYTD (< 6.15%)

- Current: 6.15%
- Target: 6.12%
- Goal: 0%

Hospital Readmissions % COPD FYTD (< 9%)

- Current: 9%
- Target: 8.82%
- Goal: 0%

Hospital Readmissions % HF FYTD (< 11.72%)

- Current: 11.72%
- Target: 13.13%
- Goal: 0%

Hospital Readmissions % PN Viral/Bacterial FYTD (< 9%)

- Current: 9%
- Target: 4.46%
- Goal: 0%

Decrease Mortality Rates AMI FYTD (< 0.7)

- Current: 0.7
- Target: 0.5
- Goal: 0

Decrease Mortality Rates COPD FYTD (< 0.7)

- Current: 0.81
- Target: 0.5
- Goal: 0

Decrease Mortality Rates HF FYTD (< 0.52)

- Current: 0.84
- Target: 0.5
- Goal: 0

Decrease Mortality Rates PN Bacterial FYTD (< 0.53)

- Current: 0.53
- Target: 0.25
- Goal: 0

Decrease Mortality Rates PN Viral FYTD (<0.65)

- Current: 0.65
- Target: 0.25
- Goal: 0

Target:

- AMI: 0%
- COPD: 0%
- HF: 0%
- PN Viral/Bacterial: 0%
- PN Bacterial: 0.25
- PN Viral: 0.25
## FY2024 Outstanding Health Outcomes

### Health Equity

**Champions:** Ryan Gates and Sonia Duran-Aguilar

**Objective:** Identify health disparities that improve affordable access to care by enhancing care coordination and more effective treatment through healthy living.

---

### Plan

<table>
<thead>
<tr>
<th>#</th>
<th>Level</th>
<th>Name</th>
<th>Start Date</th>
<th>Due Date</th>
<th>Assigned To</th>
<th>Status</th>
<th>Last Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.5.1</td>
<td>Objective</td>
<td>Identify an individual to lead activities to improve Health Care Equity</td>
<td>07/01/2023</td>
<td>06/30/2024</td>
<td>Sonia Duran-Aguilar</td>
<td>Achieved</td>
<td>Chief Of Population Health Ryan Gates leading Health Equity Committee along with Sonia Duran-Aguilar Director of Population Health and Dr. Omar Guzman.</td>
</tr>
<tr>
<td>5.5.2</td>
<td>Objective</td>
<td>Develop Organizational Multi-Year Health Equity Plan/Road Map</td>
<td>07/01/2023</td>
<td>06/30/2024</td>
<td>Sonia Duran-Aguilar</td>
<td>Not Started</td>
<td></td>
</tr>
<tr>
<td>5.5.3</td>
<td>Objective</td>
<td>Review and Select Toolkit to be used, and identify gaps and develop plans to resolve</td>
<td>07/01/2023</td>
<td>06/30/2024</td>
<td>Sonia Duran-Aguilar</td>
<td>Not Started</td>
<td></td>
</tr>
<tr>
<td>5.5.4</td>
<td>Objective</td>
<td>Select Social Screening Data Collection Tool by 7/1/23</td>
<td>07/01/2023</td>
<td>06/30/2024</td>
<td>Sonia Duran-Aguilar</td>
<td>Achieved</td>
<td>PRAPARE Tool Selected and to be built out end of December 2023.</td>
</tr>
<tr>
<td>5.5.4.1</td>
<td>Objective</td>
<td>Build out tool in Cerner</td>
<td>07/01/2023</td>
<td>06/30/2024</td>
<td>Sonia Duran-Aguilar</td>
<td>Not Started</td>
<td></td>
</tr>
<tr>
<td>5.5.4.2</td>
<td>Objective</td>
<td>Develop training materials for front line staff and complete training</td>
<td>07/01/2023</td>
<td>06/30/2024</td>
<td>Sonia Duran-Aguilar</td>
<td>Not Started</td>
<td></td>
</tr>
<tr>
<td>5.5.4.3</td>
<td>Objective</td>
<td>Evaluate reporting capabilities/dashboards</td>
<td>07/01/2023</td>
<td>06/30/2024</td>
<td>Sonia Duran-Aguilar</td>
<td>Not Started</td>
<td></td>
</tr>
<tr>
<td>5.5.4.4</td>
<td>Objective</td>
<td>Implement new screening tool and monitor and reinforce progress using available reports</td>
<td>07/01/2023</td>
<td>06/30/2024</td>
<td>Sonia Duran-Aguilar</td>
<td>Not Started</td>
<td></td>
</tr>
<tr>
<td>5.5.5</td>
<td>Objective</td>
<td>Identify Disparities in data collected by 3/30/2024</td>
<td>07/01/2023</td>
<td>06/30/2024</td>
<td>Sonia Duran-Aguilar</td>
<td>Not Started</td>
<td></td>
</tr>
</tbody>
</table>
Objective: Achieve performance on the Quality Incentive Pool measures to demonstrate high quality care delivery in the primary care space.

<table>
<thead>
<tr>
<th>#</th>
<th>Level</th>
<th>Name</th>
<th>Start Date</th>
<th>Due Date</th>
<th>Assigned To</th>
<th>Status</th>
<th>Last Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.4.1</td>
<td>Objective</td>
<td>Improve Frontline staff (Clinic Primary Care/Internal Medicine/clinical staff) awareness of QIP performance and thereby ensure engagement and buy in QI efforts</td>
<td>07/01/2023</td>
<td>06/30/2024</td>
<td>Sonia Duran-Aguilar</td>
<td>Not Started</td>
<td></td>
</tr>
<tr>
<td>5.4.2</td>
<td>Objective</td>
<td>Optimize workflows to drive and hardwire best practices for clinical care (registration, MA intake, provider documentation)</td>
<td>07/01/2023</td>
<td>06/30/2024</td>
<td>Sonia Duran-Aguilar</td>
<td>Not Started</td>
<td></td>
</tr>
<tr>
<td>5.4.3</td>
<td>Objective</td>
<td>Continue with Monthly workgroups (MCPs, Revenue Integrity, Population Health/Clinic Teams) to track progress</td>
<td>07/01/2023</td>
<td>06/30/2024</td>
<td>Sonia Duran-Aguilar</td>
<td>Not Started</td>
<td></td>
</tr>
<tr>
<td>5.4.4</td>
<td>Objective</td>
<td>Continue to monitor Quality Data Code documentation and impact on QIP measure performance</td>
<td>07/01/2023</td>
<td>06/30/2024</td>
<td>Sonia Duran-Aguilar</td>
<td>Not Started</td>
<td></td>
</tr>
<tr>
<td>5.4.5</td>
<td>Objective</td>
<td>Optimize Patient Advisories/Health Maintenance that align with QIP measures</td>
<td>07/01/2023</td>
<td>06/30/2024</td>
<td>Sonia Duran-Aguilar</td>
<td>Not Started</td>
<td></td>
</tr>
<tr>
<td>5.4.6</td>
<td>Objective</td>
<td>Develop HealtheAnalytics Performance Dashboards-25 measures</td>
<td>07/01/2023</td>
<td>06/30/2024</td>
<td>Sonia Duran-Aguilar</td>
<td>Not Started</td>
<td></td>
</tr>
<tr>
<td>5.4.7</td>
<td>Objective</td>
<td>Completion of HealtheAnalytics Fall Out Worklists for QIP Measures-completed 18 FY23/ongoing for new and remaining measures (7 additional)</td>
<td>07/01/2023</td>
<td>06/30/2024</td>
<td>Sonia Duran-Aguilar</td>
<td>Not Started</td>
<td></td>
</tr>
<tr>
<td>5.4.8</td>
<td>Objective</td>
<td>Explore within Cerner, tools that improve automated coding (ICD/Quality Data Codes) per clinical documentation (long term strategy)</td>
<td>07/01/2023</td>
<td>06/30/2024</td>
<td>Sonia Duran-Aguilar</td>
<td>Not Started</td>
<td></td>
</tr>
<tr>
<td>5.4.9</td>
<td>Outcome</td>
<td>Meet 10 QIP measure performance</td>
<td>07/01/2023</td>
<td>06/30/2024</td>
<td>Sonia Duran-Aguilar</td>
<td>At Risk</td>
<td>Proxy performance out of Cozeva Population Health Platform shows performance at 30%</td>
</tr>
</tbody>
</table>

Meet 10 QIP Measure Performance

- Baseline
- Target
**Objective:** Optimize inpatient glycemic management using evidence-based practices to improve patient’s glycemic control and reduce hypoglycemic events.

### Plan

<table>
<thead>
<tr>
<th>#</th>
<th>Level</th>
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<th>Assigned To</th>
<th>Status</th>
<th>Last Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.6.1</td>
<td>Outcome</td>
<td>Achieve benchmark performance for hypoglycemia in Critical Care (CC) patient population, defined as percent patient days with blood glucose (BG) &lt;70</td>
<td>07/01/2023</td>
<td>06/30/2024</td>
<td>Sandy Volchko</td>
<td>On Track</td>
<td>For May 2023. Will get next reporting in Fall of 2023. Monthly monitoring is done using gluco metrics.</td>
</tr>
<tr>
<td>5.6.2</td>
<td>Outcome</td>
<td>Achieve benchmark performance for hypoglycemia in Non-Critical Care (NCC) patient population, defined as percent patient days with blood glucose (BG) &lt;70</td>
<td>07/01/2023</td>
<td>06/30/2024</td>
<td>Sandy Volchko</td>
<td>Not Started</td>
<td></td>
</tr>
<tr>
<td>5.6.3</td>
<td>Outcome</td>
<td>Achieve benchmark performance for percent of patients with hypoglycemia with at least one recurrent hypoglycemic day for Critical Care (CC)</td>
<td>07/01/2023</td>
<td>06/30/2024</td>
<td>Sandy Volchko</td>
<td>Not Started</td>
<td></td>
</tr>
<tr>
<td>5.6.4</td>
<td>Outcome</td>
<td>Achieve benchmark performance for percent of patients with hypoglycemia with at least one recurrent hypoglycemic day for Non Critical Care (NCC)</td>
<td>07/01/2023</td>
<td>06/30/2024</td>
<td>Sandy Volchko</td>
<td>Not Started</td>
<td></td>
</tr>
</tbody>
</table>

### Hypoglycemia in Critical Care Patients (< 4.3%)

**Baseline:** 4.8%  
**Target:** 2.4%

### Hypoglycemia in Non-Critical Care Patients (< 3.4%)

**Baseline:** 3.4%  
**Target:** 2%

### Recurrent Hypoglycemia in Critical Care Patients (< 26.8%)

**No data exists for the selected time range**

### Recurrent Hypoglycemia in Non-Critical Care Patients (< 29.6%)

**No data exists for the selected time range**
POLICY:

Attendance and punctuality is important to Kaweah Health’s mission to deliver high quality service to our patients and the community. It is each employee’s responsibility to maintain a good attendance record. Regular attendance and promptness are considered part of an employee's essential job functions. Employees with excessive absenteeism may be subject to Progressive Discipline.

Employees with disabilities may be granted reasonable accommodation to assist them in meeting essential functions under any provision in this policy. In cases of disability, appropriate documentation from a healthcare provider is required. A Leave of Absence may be considered as a reasonable accommodation. Please refer to Leave of Absence and the Reasonable Accommodation Policy for more information.

All absences will be recorded on an attendance record (utilizing specific comments in the timekeeping system), which will be used to identify acceptable or unacceptable attendance patterns. The focus of this policy is on the frequency of absences and is to ensure reliability of employees to their work schedule and/or work requirements.

Employees are also expected to report to work punctually at the beginning of the scheduled shift and when returning from meals and breaks.

An employee who misrepresents any reason for taking time off may be subject to disciplinary action up to and including termination of employment. See HR.216 Progressive Discipline.

PROCEDURE:

Absenteism is not being at work or failing to attending a Kaweah Health paid workshop when scheduled unless the absence is protected by law.

The following number of occurrences, including full shift absences, tardies and leaving early, will be considered excessive and will be grounds for counseling and disciplinary action up to and including termination. During the new hire introductory period (see HR.37 Introductory Period), unacceptable attendance may result in the employee being placed in an advanced step of disciplinary action up to and including termination of employment.
Occurrence (full days, consecutive days, tardies, and leaving work early):

- An occurrence is defined as a time off that was not pre-approved. This could include a full day or three (3) consecutive calendar days of unscheduled, unapproved, unprotected time off. If makeup time is authorized on the same day or within the week of the occurrence, the absence is still counted as an occurrence. (Information regarding Paid Sick Leave, please see policy HR.234, PTO)

- For the purpose of this policy, a "tardy" results when an employee fails to report to their work area ready for work at the start of their shift or fails to return from lunch or break at the appropriate time.

- Two tardies or leaving early that have not been pre-approved count as one occurrence. One tardy and one time leaving early can also count as one occurrence, as well as two unscheduled events of leaving early will count as one occurrence.

- An employee is expected required to call in absences two hours prior to the start of their scheduled shift.

- Please note that attendance and punctuality is considered an important factor of overall performance and employees will be subject to Progressive Discipline considered in performance. As such, if an employee has or is to receive disciplinary actions other than attendance, the Levels as noted below will escalate. The entire performance of an employee is considered when establishing Levels and Kaweah Health may apply any Level or immediate termination if warranted due to the circumstance as determined by Kaweah Health Leadership.

Number of Occurrences in a Rolling 12-Month Period

<table>
<thead>
<tr>
<th>Counseling</th>
<th>Occurrences</th>
<th>Introductory Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Verbal Warning</td>
<td>2,4</td>
<td>24</td>
</tr>
<tr>
<td>Level I Written Warning</td>
<td>3,5</td>
<td>NA</td>
</tr>
<tr>
<td>Level II Written Warning</td>
<td>4,5</td>
<td></td>
</tr>
<tr>
<td>Level III Written Warning</td>
<td>5,7</td>
<td></td>
</tr>
<tr>
<td>Termination</td>
<td>6,8</td>
<td>35</td>
</tr>
</tbody>
</table>

Pattern Absenteeism:

Employees will be considered to have a pattern of unscheduled absences if their absences tend to occur immediately before or after scheduled days off, before or after holidays or weekends, occur at regular intervals or on consistent days, occur immediately following disciplinary action, or occur on days that the employee requested off but were denied such request. Patterned absences will be considered misconduct and will be grounds for Progressive Discipline.

Absences not to be considered under this policy are noted below. Reasonable notice of these absences is requested and in some cases required. Progressive Discipline
may apply where reasonable notice or requested proof of time off documentation is not provided.

a. Work-related accident/illness.

b. Pre-scheduled Paid Time Off (PTO).

c. Pre-scheduled personal time.

d. Time off to vote or for duty as an election official. This provision will be limited to federal and statewide elections exclusively and shall not be extended to include local, city or county elections. Employees requesting time off to vote will submit the request in writing. The request should state specifically why the employee is not able to vote during non-working hours. Unless otherwise agreed, this time must be taken at the beginning or ending of the employee's shift to minimize the time away from work.

e. Time off for adult literacy programs.

f. Time off if a victim of a crime, or if a family member is the victim of a crime, when they take time off following the crime. Protections are for an employee who is a victim of domestic violence, sexual assault, or stalking for taking time off from work for any specified purpose, including seeking medical attention, for injuries caused by the domestic violence, assault, or stalking and appearing in court pursuant to a subpoena. In addition, protections include taking time off from work to obtain or attempt to obtain any relief. Relief includes, but is not limited to, a temporary restraining order, restraining order, obtaining psychological counseling, engaging in safety planning, seeking other injunctive relief, and to help ensure the health, safety or welfare of the victim or their child. Furthermore, protections include if the employee provides certification that they were receiving services for injuries relating to the crime or abuse or if the employee was a victim advocate.

g. Time off to attend judicial proceedings as a victim of a crime, the family member, registered domestic partner or child of a registered domestic partner who is a victim of a crime. Victim means any person who suffers direct or threatened physical, psychological, or financial harm as a result of the commission or attempted commission of specified crime or their spouse, parent, child, sibling, or guardian.

h. Employees who enter uniformed military service of the Armed Forces of the United States for active duty or training.

i. Eligible employees with a spouse, son, daughter, or parent on active duty or call to active duty status in the National Guard or Reserves in support of a contingency operation.

j. Time off of up to fourteen (14) days per calendar year for volunteer
Attendance & Punctuality

firefighter, reserve peace officer, or emergency rescue personnel training or duties.

k. Time off to attend school or child care activities for their children, grandchildren or guardians (limited to 40 hours per year not exceeding eight hours in any calendar month). Applies to children in grades 1 through 12 or in a licensed child care facility. Additional protections apply for required appearances after suspension of a child from school. Effective January 1, 2016, employees may take time off from work to find a school or a licensed child care provider and to enroll or re-enroll a child, and time off to address child care provider or school emergencies.

l. Bereavement time related to Policy.

m. Jury Duty or Witness Duty.

n. Leaves pursuant to legislative requirements Family and Medical Leave Act of 1993 (FMLA); California Family Rights Act of 1991 (CFRA); Pregnancy Disability Leave (PDL); Organ and Bone Marrow Donation Leave; and Workers’ Compensation (WC).

o. Kin Care: Kin Care authorizes eligible employees to use up to one-half (½) of the Extended Illness Bank (EIB) that they accrue annually, in a calendar year, to take time off to care for a sick family member. Employees who accrue EIB are eligible for Kin Care. Employees who are not eligible for EIB are not eligible for Kin Care. No more than one-half of an employee’s EIB accrual in a calendar year period can be counted as Kin Care. For example, for full-time employees this would mean no more than 24 hours can be utilized as Kin Care in a calendar year period. An employee must have EIB available to use on the day of the absence for that absence to be covered under Kin Care. An employee who has exhausted his/her EIB and then is absent to care for a sick family member cannot claim that absence under Kin Care. Kin Care can be used to care for a sick family member, to include a spouse or registered domestic partner, child of an employee, parents, parents-in-law, siblings, grandchildren and grandparents. A Leave of Absence form does not need to be submitted unless the employee will be absent and use sick leave for more than three continuous workdays. In addition, an employee taking Kin Care does not need to submit a doctor’s note or medical certification. However, in instances when an employee has been issued Disciplinary Action and directed to provide a doctor’s note for all sick days, then an employee may need to submit a doctor’s note.

Absence for Religious Observation

Kaweah Health will attempt to accommodate employees requesting absence for religious observation, however, in certain circumstances accommodation may not be possible or reasonable.
Attendance & Punctuality

**Notification of Late Arrival**

An employee is required to call in absences two hours prior to the start of their scheduled shift.

**Workers’ Rights in Emergencies**

Kaweah Health is compliant with California SB1044 and prohibits taking adverse action against an employee for refusing to report to or leaving work during an emergency condition. Prohibits from preventing an employee from accessing a mobile device during that time. This is specified as:

- Conditions of disaster or extreme peril to the safety of persons or property at the workplace or worksite caused by natural forces or a criminal act.
- An order to evacuate a workplace, a worksite, a worker’s home, or the school of a worker’s child due to natural disaster or a criminal act.

This paragraph does not apply to the following:

An employee or contractor of a health care facility who provides direct patient care, provides services supporting patient care operations during an emergency, or is required by law or policy to participate in emergency response or evacuation.

When feasible, an employee shall notify the employer of the emergency condition requiring the employee to leave or refuse to report to the workplace or worksite prior to leaving or refusing to report.

**Schedules**

- Employees are scheduled to work during specified hours. Unless approved by management, those hours may not be adjusted to accommodate early or late arrival or departure.

- Employees who arrive for work early may not leave before the end of their scheduled work period unless authorized to do so by their management. Employees may be subject to discipline for incurring unauthorized overtime by reporting to work prior to their scheduled start time. Employees who arrive for work late may not remain on duty beyond the regular scheduled work time to make up the lost time unless authorized to do so by their management. Employees who are absent without approval but are allowed to makeup time will continue to be subject to disciplinary action for lack of reliability.

- Employees are only paid for actual hours worked.

- Employees may not shorten the normal workday by not taking or by combining full meal periods and rest break periods and may not leave before the end of their scheduled shift without the authorization of a supervisor.

- Any employee who leaves Kaweah Health premises during work hours must notify and obtain approval from management and/or their designee prior to departure. Employees must clock out and in for their absence.
Attendance & Punctuality

f. Employees are to give advanced notice for cancellation of any class or program in which they are enrolled, whether voluntary or mandatory. Advanced notice for cancellation defined as the following:

1. If class is on Tuesday through Friday, cancel the day before by 8:00am. EXAMPLE: Class is Wednesday at noon- must cancel before Tuesday 8:00 am.
2. If class is on Monday, cancel prior to 23:59 on Saturday
3. Classes need to be cancelled through our Learning Management System (LMS)
4. If the employee cannot cancel in our LMS or they are past the defined time for advanced notice, the employee must contact their manager via phone or email letting them know they cannot attend.

5. Employees must be on time.

6. Failure to give advance notice may count as an occurrence under the Attendance Policy HR.184. Refer to Progressive Discipline policy HR 216.

i. Employees who are absent from work for three days and have not contacted their department manager or supervisor will be assumed to have voluntarily terminated their employment. Employees who are absent from work without authorization and without providing proper notification to management may be considered to have abandoned their job and will be terminated from employment.

j. Weekend Makeup Policy – Employees who call in on weekends may be required to make up weekend shifts missed. Weekend shift starts Fridays at 1800 and ends Mondays at 0600. Weekend shifts will be scheduled for makeup on a successive schedule at the discretion of the scheduling coordinator/supervisor per staffing needs.

k. Holiday Makeup Policy – Employees who call in on a holiday which is from 1800 the day before the holiday and ends 0600 the morning after the holiday, will be required to work another holiday or an extra weekend shift at the discretion of the scheduling coordinator/supervisor per staffing needs.

Holidays

Kaweah Health observes 72 holiday hours each year. Eligible employees may be scheduled a day off and will be paid provided adequate accrual exists within their PTO bank account for each observed holiday. Time off for the observance of holidays will always be in accordance Kaweah Health needs.

1. New Year’s Day (January 1st)
2. President’s Day (Third Monday in February)
3. Memorial Day (Last Monday in May)
4. Independence Day (July 4th)
5. Labor Day (First Monday in September)
6. Thanksgiving Day (Fourth Thursday in November)
Attendance & Punctuality

7. Day after Thanksgiving Day (Friday following Thanksgiving)
8. Christmas Day (December 25th)
9. Personal Day

Loitering
Kaweah Health employees may not arrive to work greater than thirty (30) minutes prior to the start of their shift and may not remain within Kaweah Health facilities greater than thirty (30) minutes beyond the end of their shift without specific purpose and/or authorization to do so.

Clocking
Employees should may not clock in, may not begin work before the start of their scheduled shift and must discontinue work and clock out at the conclusion of their scheduled shift, unless instructed otherwise by their management. Employees may not work off-the-clock, including use of electronic communication.

Further information regarding this policy is available through your department manager or the Human Resources Department
Attendance & Punctuality

Weekend shift starts Fridays at 1800 and ends Mondays at 0600.
*Holiday is from 1800 the day before the holiday and ends 0600 the morning after the holiday.*

“Responsibility for the review and revision of this Policy is assigned to the Chief Human Resources Officer. In some cases, such as Employee Benefits Policies, Summary Plan Descriptions and Plan Documents prevail over a policy. In all cases, Kaweah Health will follow Federal and State Law, as applicable, as well as Regulatory requirements. Policies are subject to change as approved by the Governing Board and will be communicated as approved after each Board Meeting. It is the employee’s responsibility to review and understand all Kaweah Health Policies and Procedures.”
Printed copies are for reference only. Please refer to the electronic copy for the latest version.

**POLICY:**

Paid Time Off (PTO), Extended Illness Bank (EIB) and Healthy Workplace, Healthy Families Act of 2014—Paid Sick Leave (PSL) benefits are offered to all employees as defined in this policy. PTO is offered to full-time and part-time benefit eligible employees for leisure, celebration of holidays, short-term illness and other personal needs. EIB is offered to full-time and part-time benefit eligible employees for extended illness and Kin Care. Private Home Care staff, temporary staff/interims and Per Diem staff are not eligible for PTO or EIB but are eligible for Paid Sick Leave (PSL) as defined in this policy. Excessive occurrences of unapproved time off may result in disciplinary action. See Policy HR.184 Attendance and Punctuality.

This policy does not apply to Graduate Medical Education

**PROCEDURE:**

**Eligibility and Accrual for PTO and EIB**

Full-time and part-time benefited employees are eligible to receive PTO and EIB as of the first pay period of eligibility (date of hire or transfer). If an eligible employee is changed to a non-eligible status, the PTO and EIB time accrual will cease. The employee will receive a lump-sum payment for all accrued PTO paid at 100% of their hourly rate of pay prior to the status change. During the non-eligible status, the employee will accrue PSL.

If a non-eligible employee is changed to an eligible status, the employee begins accruing PTO and EIB as of the first pay period in which the status change became effective; PSL accrual will cease. At no time will an employee accrue PTO and EIB as well as PSL. An employee accrues either PTO and EIB or PSL.

EIB accrual will be reinstated for employees who leave Kaweah Health and are rehired as follows:

a. If left as non-benefited and rehired as a non-benefited, we will reinstate the ending available EIB balance into a reserve bucket. These hours are available for use.

b. If terminated as a benefited and rehired as benefited, we will reinstate the
ending EIB balance.
c. If terminated as non-benefited and rehired as benefited, we will reinstate the ending available EIB balance from the reserved EIB balance (if any).
d. If terminated as a benefited and rehired as non-benefited, we will reinstate the ending available EIB balance up to the 80.48-hour maximum, placing the excess EIB balance into a reserve bucket. These hours are not available for use.

The rate of PTO and EIB accrual received is based on years of service. Employees receive accruals on up to 80 eligible hours, per pay period. The bi-weekly pay period starts at 12 AM on a Sunday, and ends at 11:59 PM on the last Saturday of the pay period. Qualified service hours which count towards a year of service for the accrual rate include the following: regular hours worked (non-overtime), Flex Time Off, PTO FMLA, PTO unscheduled, PTO/PSL, PTO Sick/Pregnancy, PTO/Workers Compensation, Sitter Pay, Sleep Pay, PTO hours, bereavement hours, jury duty hours, training/workshop hours, orientation hours, and mandatory dock hours. Neither EIB nor PTO accruals will be earned while employees are being paid EIB hours.

Eligibility and Accrual for PSL

PSL eligible employees include Per-Diem, Private Home Care, and Part-Time non-benefit eligible employees. PSL eligible employees will accrue at the rate of one hour per every 30 hours worked (.033333 per hour); accrual begins as of the first pay period. A new employee is entitled to use PSL beginning on the first day of employment. Employees are limited to 40.24 hours of use of accrued time in each calendar year. PSL will carry over to the following calendar year not to exceed 8048 hours of accrual in any calendar year.

Maximum Accruals

The maximum PTO accrual allowed is 400 hours. The accrual will cease once the maximum accrual is reached until PTO hours are used or cashed out. The maximum EIB accrual is 2000 hours; the maximum PSL accrual is 8048 hours in a calendar year. No payment is made for accrued EIB or PSL time when employment with Kaweah Health ends for any reason.

Requesting, Scheduling, and Access to PTO, EIB and PSL

Employees are required to use accrued PTO for time off for illness or unexpected absence occurrences.
Routine unpaid time off is not allowed. Any requests for unpaid time should be considered only on a case-by-case basis taking into consideration the need for additional staffing to replace the employee and other departmental impacts. It is the responsibility of management to monitor compliance. Employees should be aware that unpaid time off could potentially affect their eligibility for benefits.

Any planned request for PTO time, whether for traditional holiday, for vacation time or otherwise must be approved in advance by management. Management will consider the employee’s request as well as the needs of the department. In unusual circumstances, management may need to change the PTO requests of employees based upon the business and operational needs of Kaweah Health. In such situations, Kaweah Health is not responsible for costs employees may incur as a result of a change in their scheduled PTO time.

**AB 1522 Healthy Workplace Healthy Families Act of 2014**

An employee may utilize up to 4024 hours of PTO or PSL in a calendar year (January-December) period for the following purposes:

a) Diagnosis, care, or treatment of an existing health condition, or preventative care for an employee or an employee’s designated person, family member, as defined as employee’s parent, child, spouse, registered domestic partner, grandparent, grandchild, and siblings.

b) “Family Member” means any of the following:
   i. A child, which for purposes of this policy means a biological, adopted or foster child, stepchild, legal ward, or a child to whom the employee stands in loco parentis; this definition of child is applicable regardless of age or dependency status.
   ii. A biological, adoptive, or foster parent, stepparent, or legal guardian of an employee or the employee’s spouse or registered domestic partner, or a person who stood in loco parentis when the employee was a minor child.
   iii. Spouse
   iv. Registered domestic partner
   v. Grandparent
   vi. Grandchild
   vii. Sibling

c) Designated Person means the following:
   i. Under the California Family Rights Act (CFRA) and California Healthy Workplaces Health Families Act (HWHFA) an employee will be able to identify a designated person for whom they want to use leave when they request unpaid CFRA or paid HWHFA.

d) For an employee who is a victim of domestic violence, sexual assault or stalking, as specified.

There is no cash out provision for the PSL accrual, including upon termination of employment or with a status change to a benefit eligible position. However, if an
employee separates from Kaweah Health and is rehired within one year, previously accrued and unused PSL will be reinstated.

PSL and PTO time shall be utilized at a minimum of 1-hour increments and no more than the length of the employee’s shift.

PTO and PSL time taken under this section is not subject to the Progressive Discipline Policy HR.216.

**Time Off Due To Extended Illness**

Employees who are absent due to illness for more than three (3) consecutive work days should notify their manager and contact the Human Resources Department to determine if they are eligible for a leave of absence. Accrued EIB can be utilized for an approved continuous leave of absence beyond 24 hours and if admitted to a hospital or have a medical procedure under anesthesia. However, in instances when an employee has been issued Disciplinary Action and directed to provide a doctor’s note for all sick days, then an employee may need to submit a doctor’s note.

Employees who are absent due to illness for more than seven (7) consecutive days should file a claim for California State Disability Insurance. Claim forms are available in Human Resources. State Disability payments will be supplemented with any accrued EIB time by the Payroll Department and PTO at the employee’s request.

Employees who are absent with an Intermittent Leave under FMLA/CFRA are required to use accrued PTO for their absences, at no less than one hour and no more than the regular length of the shift.

**Time Off Due to Kin Care**

Kin Care allows eligible employees to use up to one-half (1/2) of the Extended Illness Bank (EIB) that they accrue annually in a calendar year to take time off to care for a sick family member. Only employees who accrue EIB are eligible for Kin Care. No more than one-half of an employee’s EIB accrual in a calendar year period can be counted as Kin Care. An employee who has exhausted their EIB and then is absent to care for a sick family member cannot claim that absence under Kin Care.

Kin Care can be used to care for a sick family member, to include a spouse or registered domestic partner, child of an employee, “child” means a biological, foster, or adopted child, a stepchild, a legal ward, a child of a domestic partner, or a child or a person standing in loco parentis, parents, parents- in-law, siblings, grandchildren and grandparents.

EIB time taken under this section to care for an immediate family member is not subject to the Progressive Discipline Policy HR.216.

**Holidays**
Kaweah Health observes 72 holiday hours each year. Eligible employees may be scheduled a day off and will be paid provided adequate accrual exists within their PTO bank account for each observed holiday. Time off for the observance of holidays will always be in accordance Kaweah Health needs.

1. New Year’s Day (January 1st)
2. President’s Day (Third Monday in February)
3. Memorial Day (Last Monday in May)
4. Independence Day (July 4th)
5. Labor Day (First Monday in September)
6. Thanksgiving Day (Fourth Thursday in November)
7. Day after Thanksgiving Day (Friday following Thanksgiving)
8. Christmas Day (December 25th)
9. Personal Day

Business departments and/or non-patient care areas will typically be closed in observance of the noted holidays. Where this is the case, employees assigned to and working in these departments will be scheduled for a day off on the day the department is closed. Employees affected by department closures for holidays should maintain an adequate number of hours within their PTO banks to ensure that time off is with pay.

In business departments and/or non-patient care areas, holidays, which fall on Saturday, will typically be observed on the Friday preceding the actual holiday and holidays, which fall on Sunday, will be observed on the Monday following the actual holiday.

Employees who work hours on some of these holidays may be eligible for holiday differential. For more information of eligibility, see policy HR.75 Differential Pay - Shift, Holiday, and Weekend.

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I. Policy

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

II. Procedure

In the event of a hazardous material release:

A. Response

See attached checklist and flowchart.

B. Definitions

1. Minor Spill

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

<table>
<thead>
<tr>
<th>CHEMICAL</th>
<th>SMALL SPILL AMOUNT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acid</td>
<td>½ cup or less</td>
</tr>
<tr>
<td>Base/Caustic</td>
<td>½ gallon or less</td>
</tr>
<tr>
<td>Bleach</td>
<td>½ gallon or less</td>
</tr>
<tr>
<td>Flammable liquids</td>
<td>½ gallon or less</td>
</tr>
<tr>
<td>Formaldehyde (10% Formalin or 3.7% Formaldehyde)</td>
<td>¾ cup or less</td>
</tr>
<tr>
<td>Glutaraldehyde (Cidex®, Wavicide)</td>
<td>½ gallon or less</td>
</tr>
<tr>
<td>Ortho-phthalaldehyde (Cidex® OPA)</td>
<td>1 gallon or less</td>
</tr>
<tr>
<td>All other chemicals (including chemotherapy drugs)</td>
<td>½ gallon or less</td>
</tr>
</tbody>
</table>

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

2. Major Spill

A major spill has occurred under the following conditions:

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

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

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

Background: Departments with significant hazardous materials are to develop a Disaster-Specific Plan to support this plan. (Consult Safety Officer if unsure.) Respond in accordance with this procedure and those developed by your department. A large-scale incident may develop into a Code Triage.

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

STAFF RESPONSE CHECKLIST

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

- If spill is MINOR: - The basic response will be ICIC.
  - Isolate the areas and deny access to others.
  - Contain the spill (reduce or eliminate spread)
  - Identify (Chemical name) Obtain and read Safety Data Sheet (SDS) for precautions. Binders are located in each specific department. Department head/managers should know the location of updated SDS document.
  - Clean-up (follow SDS). Use spill kit to clean up spill, if trained to do so.
  - Notify supervisor or Department Manager, who will notify Hospital Safety Officer
  - Complete Occurrence Report on Kaweah Compass.

- If spill is MAJOR:
  - Evacuate area.
  - Call PBX at Ext. 44 and inform them of a "Code Orange" and report:
    - Spill location
    - Chemicals involved
    - Approximate quantity of material spilled
    - Number of people exposed and/or injured
    - Your extension
  - Obtain SDS from MAXCOM.
  - Notify supervisor or Department Manager.
  - Contain spill only if trained, equipped, and safe to do so. Complete Occurrence Report on Kaweah Compass.

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

- If a chemical has splashed into someone’s eyes, direct that person to the nearest water source/eyewash station, begin immediate rinsing of their eyes with tap water for at least 15 minutes. Avoid direct contact with the contaminated person.

- If a person has chemicals on their skin, direct them to rinse affected area with soap and water for at least 15 minutes, in a shower, if available, otherwise in a sink. Removal of clothes is necessary to complete a thorough dermal decontamination. All clothes are to be placed in a plastic bag. After rinsing, direct person to remain in area until cleared by the Safety Officer. Label plastic bag "hazmat."

- If contaminated person(s) unable to self-decontaminate, wait for trained personnel with Personal Protective Equipment (PPE) to perform decontamination.
Decontamination as follows:

- **Removing your clothing:**
  - Quickly take off clothing that has a chemical on it. Any clothing that has to be pulled over your head should be cut off instead of being pulled over your head.
  - If you are helping other people remove their clothing, try to avoid touching any contaminated areas, and remove the clothing as quickly as possible.

- **Washing yourself:**
  - As quickly as possible, wash any chemicals from your skin with large amounts of soap and water. Washing with soap and water will help protect you from any chemicals on your body.
  - If your eyes are burning or your vision is blurred, rinse your eyes with plain water for 10 to 15 minutes. If you wear contacts, remove them and put them with the contaminated clothing. Do not put the contacts back in your eyes (even if they are not disposable contacts). If you wear eyeglasses, wash them with soap and water. You can put your eyeglasses back on after you wash them.

- **Disposing of your clothes:**
  - After you have washed yourself, place your clothing inside a plastic bag. Avoid touching contaminated areas of the clothing. If you can’t avoid touching contaminated areas, or you aren’t sure where the contaminated areas are, wear rubber gloves or put the clothing in the bag using tongs, tool handles, sticks, or similar objects. Anything that touches the contaminated clothing should also be placed in the bag. If you wear contacts, put them in the plastic bag, too.
  - Seal the bag, and then seal that bag inside another plastic bag. Disposing of your clothing in this way will help protect you and other people from any chemicals that might be on your clothes.
  - When the local or state health department or emergency personnel arrive, tell them what you did with your clothes. The health department or emergency personnel will arrange for further disposal. Do not handle the plastic bags yourself.

- **If person was not splashed with chemicals on their skin or clothes, but is complaining of respiratory or systemic effects from breathing a hazardous material,** immediately escort person to the ED for treatment.

**Immediately upon hearing “Code Orange”:**

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

- **If outside alert area:**
  - Prepare to provide support as directed.

**PBX CHECKLIST**

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

- Page overhead “Attention, Code Orange” and location (2x) and then repeat 30 seconds later.
  - Call Environmental Services at ext. 2244.
  - Call Safety Officer

- Call House Supervisor (House supervisor will notify Administrator on Call (AOC)

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

**Note:** If the fire department is unable to respond, the Safety Officer will contact an outside contractor to clean up “major” spills.
SECURITY CHECKLIST

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

HAZARDOUS MATERIALS COORDINATOR (SAFETY OFFICER) CHECKLIST

☐ Report to scene of event and assess situation.
☐ Call Visalia Fire Department Hazardous Materials Unit for major spill cleanup.
☐ Call Engineering to ventilate/shut down recirculation system, if required
☐ Call Security to cordon off immediate area and expand the safety zone, as necessary, to prevent unauthorized exposure to hazardous conditions.
☐ Act as a liaison to Fire Department or spill clean-up contractor.
☐ Ensure safety of staff, visitors, and patients.
☐ Following the all-clear, ensure full documentation of event.
☐ Notify appropriate agencies.
Tulare County Environmental Health 559-624-7400
Cal EMA (California Emergency Management Agency) 1-800-852-7550

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

ALL CLEAR

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

Hazardous Material Spill occurs.

- Major Spill?
  - Yes: Evacuate area and deny entry.
  - Notify PDX at Ext. 44, tell them:
    - Activate “Code Orange”
    - Location
    - Quantity
    - Number exposed
    - Chemicals involved
    - Your extension
  - Isolate the area and deny entry.

- Minor Spill?
  - Yes: Can the spill be contained by a spill kit?
  - Yes: Trained to clean up spill?
    - Yes: Isolate the area and deny entry.
    - Notify supervisor of spill and clean up.
    - Notify Hazardous Materials Coordinator for disposal.
  - No: Locate someone trained to clean up spill. If no one is available, contact Hazardous Management Coordinator.
  - No: Evacuate area, call 911.

- Evacuate area.

- Assist those who may have been contaminated - only if your exposure is unlikely.

- Employee(s) exposed: Complete Employee Incident Report, Employee’s Claim for Workers’ Compensation Benefits.
- Department Manager: Complete the Employee Incident Report.
- Spill Discoverer: Complete Hazard Spill Release Reporting Form.

- Be prepared to respond to changing work hours and duty assignments as directed.
Wireless Duress System

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 Camera Room on E1 Unit (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:** ________________________________________________
RESOLUTION 2216

WHEREAS, Janelle Wynn, is retiring from duty at Kaweah Delta Health Care District dba Kaweah Health after 17 years of service; and,

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

WHEREAS, the Board of Directors of the Kaweah Delta Health Care District is aware of her excellence in caring and service,

NOW, THEREFORE, BE IT RESOLVED that the Board of Directors of the Kaweah Delta Health Care District, on behalf of themselves, the hospital staff, and the community they represent, hereby extend their appreciation to Janelle Wynn for 17 years of faithful service and, in recognition thereof, have caused this resolution to be spread upon the minutes of this meeting.

PASSED AND APPROVED this 21st day of December 2023 by a unanimous vote of those present.

President, Kaweah Delta Health Care District

Secretary/Treasurer
Kaweah Delta Health Care District
RESOLUTION 2216

WHEREAS, Carla Hernandez, is retiring from duty at Kaweah Delta Health Care District dba Kaweah Health after 12 years of service; and,

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

WHEREAS, the Board of Directors of the Kaweah Delta Health Care District is aware of her excellence in caring and service,

NOW, THEREFORE, BE IT RESOLVED that the Board of Directors of the Kaweah Delta Health Care District, on behalf of themselves, the hospital staff, and the community they represent, hereby extend their appreciation to Carla Hernandez for 12 years of faithful service and, in recognition thereof, have caused this resolution to be spread upon the minutes of this meeting.

PASSED AND APPROVED this 21st day of December 2023 by a unanimous vote of those present.

President, Kaweah Delta Health Care District

Secretary/Treasurer
Kaweah Delta Health Care District
Kaweah Delta Health Care District dba Kaweah Health
Bylaws

Article I  The District and Its Mission

Section 1  Kaweah Delta Health Care District dba Kaweah Health is a community venture, operating under the authority granted through the California Health and Safety Code as a health care district. (California Health and Safety Code – Division 23 – Sections 32000-32499.4) The purpose of the District is to provide quality health care within defined areas of expertise. It is the intent of the District that no person shall be denied emergency admission or emergency treatment based upon ability to pay. It is further the intent of the District that no person shall be denied admission or treatment based upon race, color, national origin, ethnic, economic, religious or age status or on the basis of sexual preference. The medical welfare of the community and its particular health needs will be fulfilled to the capacity of the District’s financial limitations.

Section 2  Kaweah Delta Health Care District operates under the authority of California Code for a health care district. As such, Kaweah Delta Health Care District is publicly owned and operates as a non-profit entity.

Section 3  As permitted by law, the District may, by resolution of the Board, conduct any election by all-mailed ballots pursuant to Division 4 (commencing with Section 4,000) of the California Elections Code.

Section 4  The Mission of Kaweah Delta Health Care District is; Health is our passion. Excellence is our focus. Compassion is our promise.

Section 5  The Vision of Kaweah Delta Health Care District is: To be your world-class healthcare choice, for life.

Section 6  The Pillars of Kaweah Delta Health Care District are:

1. Achieve outstanding community health
2. Deliver excellent service
3. Provide an ideal work environment
4. Empower through education
5. Maintain financial strength

Section 7  The mission, vision, and pillars of the District support the safety and quality of care, treatment, and service. {Joint Commission Standard LD.02.01.01}

Section 8  The Code of Conduct of Kaweah Delta Health Care District is a commitment to ethical and legal business practices, integrity, accountability, and excellence. The Code is a founding document of the Compliance Program, developed to express Kaweah Health’s understanding and obligation to comply with all applicable laws and regulations. {Joint Commission Standard LD.04.01.01}
Article II  The Governing Body

Section 1  The Governing Body of the Kaweah Delta Health Care District is a Board of Directors constituted by the five (5) publicly elected directors, who are elected by zone, each for four (4) year terms, with two (2) being elected on staggered terms and three (3) being elected two (2) years later on staggered terms. {California Health and Safety Code 32100} The election of the directors is to conform with the applicable California Code. Notwithstanding any other provision of law, a vacancy in any elective office on the governing board of a special district shall be filled as provided in Government Code 1780. This publicly elected Governing Body is responsible for the safety and quality of care, treatment, and services, establishes policy, promotes performance improvement, and provides for organizational management and planning (Joint Commission Standard LD.1.10).

Section 2  The Governing Body, every ten years, using new census data, shall redraw their district lines to reflect how local populations have changed. The Governing Body is required to engage the community in the redistricting process by holding public hearings and/or workshops and doing public outreach, including to non-English speaking communities {AB 849 - The Fair and Inclusive Redistricting for Municipalities and Political Subdivisions (FAIR MAPS) Act}.

Section 3  The Governing Body adopts the Bylaws of the organization. {California Health and Safety Code 32125}

Section 4  The principal office of Kaweah Delta Health Care District is located at Kaweah Health Medical Center - Acequia Wing, Executive Offices, 400 West Mineral King Avenue, Visalia, CA 93291. Correspondence to the Board should be addressed to the Board of Directors at this address. Kaweah Health also maintains a Web site at www.kaweahhealth.org. All noticed meeting agendas and supporting materials for Board meetings and Board committee meetings can be obtained at www.kaweahhealth.org/About-Us/Board-of-Directors.

Section 5  Duties and the Responsibilities of the Governing Body. As boards of directors have basic collective responsibilities, Board members are also entrusted with individual responsibilities as a part of Board membership. The obligations of Board service are considerable; they extend well beyond any basic expectations of attending meetings. Board members as individuals have no special privileges, prerogatives, or authority; they must meet in formal session to negotiate and make corporate decisions. The specific responsibilities of the Board are clustered into four areas: setting the direction for the district; establishing and supporting the structure of the district; holding the district accountable on behalf of the community; and serving as community leaders.

Considering the complexities of Board membership, a clear statement of individual Board member responsibilities adapted to the organization’s needs and circumstances can serve many purposes including clarifying expectation before candidate’s file for a seat that is up for election on the Kaweah Health Board of Directors.
PRIMARY RESPONSIBILITY - This Board’s primary responsibility is to develop and follow the organization’s mission statement, which leads to the development of specific policies in the four key areas of:

A. Quality Performance
B. Financial Performance
C. Planning Performance
D. Management Performance

The Board accomplishes the above by adopting specific outcome targets to measure the organization’s performance. To accomplish this, the Board must:

1) Establish policy guidelines and criteria for implementation of the mission. The Board also reviews the mission statements of any subsidiary units to ensure that they are consistent with the overall mission.

2) Evaluate proposals brought to the Board to ensure that they are consistent with the mission statement. Monitor programs and activities of the hospital and subsidiaries to ensure mission consistency.

3) Periodically review, discuss, and if necessary, amend the mission statement to ensure its relevance.

A. QUALITY PERFORMANCE RESPONSIBILITIES - This Board has the final moral, legal, and regulatory responsibility for everything that goes on in the organization, including the quality of services provided by all individuals who perform their duties in the organization’s facilities or under Board sponsorship. To exercise this quality oversight responsibility, the Board must:

1) Understand and accept responsibility for the actions of all physicians, nurses, and other individuals who perform their duties in the organization’s facilities.

2) Review and carefully discuss quality reports that provide comparative statistical data about services and set measurable policy targets to ensure continual improvement in quality performance.

3) Carefully review recommendations of the Medical Staff regarding new physicians who wish to practice in the organization and be familiar with the termination and fair hearing policies.

4) Reappoint individuals to the Medical Staff using comparative outcome data to evaluate how they have performed since their last appointment.

5) Appoint physicians to governing body committees and seek physician participation in the governance process to assist the Board in its patient quality-assessment responsibilities.

6) Fully understand the Board’s responsibilities and relationships with the Medical Staff and maintain effective mechanisms for communicating with them.
7) Regularly receive and discuss malpractice data reflecting the organization’s experience and the experience of individual physicians who have been appointed to the Medical Staff.

8) Adopt a Performance Improvement Plan and Risk Management Plan for the District and provide for resources and support systems to ensure that the plans can be carried out.

9) Regularly receive and discuss data about the Medical Staff to ensure that future staffing will be adequate in terms of ages, numbers, specialties, and other demographic characteristics.

10) Ensure that management reviews and assesses the attitudes and opinions of those who work in the organization to identify strengths, weaknesses, and opportunities for improvement.

11) Monitor programs and services to ensure that they comply with policies and standards relating to quality.

12) Take corrective action when appropriate and necessary to improve quality performance.

B. FINANCIAL PERFORMANCE RESPONSIBILITIES - This Board has the ultimate responsibility for the financial soundness of the organization. To accomplish this the Board must:

1) Annually review and approve the overall financial plans, budgets (Joint Commission Standard LD.04.01.03), and policies for implementation of those plans and budgets on a short and long-term basis. The plan must include and identify in detail the objective of, and the anticipated sources of financing for each anticipated capital expenditure:

2) Approve an annual audited financial statement prepared by a major accounting firm and presented directly to the Board of Directors. {Government Code Section 6061 & Health and Safety Code 32133}

3) Approve any specific capital expenditure in excess of $75,000, which is not included in the annual budget.

4) Authorize the Chief Executive Officer to settle a claim against Kaweah Delta Health Care District dba Kaweah Health not to exceed $75,000. Authorize the Chief Compliance & Risk Officer to settle a claim against Kaweah Delta Health Care District dba Kaweah Health not to exceed $25,000.

5) Approve financial policies, plans, programs, and standards to ensure preservation and enhancement of the organization’s assets and resources.

6) Exercising prudence with the Board in the control and transfer of funds.

7) Faithfully reading and understanding the organization’s financial statements and otherwise helping the Board fulfill its fiduciary responsibility.

8) Monitor actual performance against budget projections and review and adopt ethical financial policies and guidelines.
9) Review major capital plans proposed for the organization and its subsidiaries.

C. PLANNING PERFORMANCE RESPONSIBILITIES - The Board has the final responsibility for determining the future directions that the organization will take to meet the community’s health needs. To fulfill this responsibility, the Board must:

1) Review and approve a comprehensive strategic plan and supportive policy statements.
2) Develop long term capital expenditure plans as a part of its long range strategic planning.
3) Determine whether or not the strategic plan is consistent with the mission statement.
4) Assess the extent to which plans meet the strategic goals and objectives that have been previously approved.
5) Periodically review, discuss, and amend the strategic plan to ensure its relevance for the community.
6) Regularly review progress towards meeting goals in the plan to assess the degree to which the organization is meeting its mission.
7) Annually meet with the leaders of the Medical Staff to review and analyze the health care services provided by Kaweah Health and to discuss long range planning for Kaweah Health.

D. MANAGEMENT PERFORMANCE RESPONSIBILITIES - The Board is the final authority regarding oversight of management performance by our Chief Executive Officer (CEO). To exercise this authority, the Board must:

1) Oversee the recruitment, employment, and regular evaluations of the performance of the CEO.
2) Evaluate the performance of the CEO annually using goals and objectives agreed upon with the CEO at the beginning of the evaluation cycle.
3) Communicate regularly with the CEO regarding goals, expectations, and concerns.
4) Periodically survey CEO at comparable organizations to assure the reasonableness and competitiveness of our compensation package.
5) Periodically review management succession plans to ensure leadership continuity.
6) Ensure the establishment of specific performance policies which provide the CEO with a clear understanding of what the Board expects, and ensure the update of these policies based on changing conditions.

E. The Board is also responsible for managing its own governance affairs in an efficient and successful way. To fulfill this responsibility, the Board should:
1) Maintain written conflict-of-interest policies that include guidelines for the resolution of existing or apparent conflicts of interest. {Board of Directors policy BOD.05 – Conflict of Interest}

2) Members of the governing body are required to complete ethics training every two years, with the requirement that they take their first training no later than a year after they start their first day of service with the district. {AB 1234}

3) Members of the governing body are elected by the public and, accordingly, are judged on their individual performance by the electorate.

4) Participate both as a Board and individually in orientation programs and continuing education programs both within the organization and externally. As such, the District shall reimburse reasonable expenses for both in-state and out-of-state travel for such educational purposes. {Board Of Directors policy BOD.06 – Board Reimbursement for Travel and Service Clubs} {California Health and Safety Code 32103}

5) Periodically review Board structure to assess appropriateness of size, diversity, committees, tenure, and turnover of officers and chairpersons.

6) Assure that each Board member understands and agrees to maintain confidentiality with regard to information discussed by the Board and its committees.

7) Assure that each Board member understands and agrees to adhere to the Brown Act ensuring that Board actions be taken openly, as required, and that deliberations be conducted openly, as required.

8) Adopt, amend, and, if necessary, repeal the articles and bylaws of the organization.

9) Maintain an up-to-date Board policy manual, which includes specific policies covering oversight responsibilities in the area of quality performance, financial performance, strategic planning performance, and management performance.

Review Kaweah Health’s Mission, Vision & Pillar statements every two years.

Section 6 General Expectations of the Kaweah Health Board. Adhere to the duties and responsibilities of the Governing Body as outlined in Article II The Governing Body, Section 5 of the Kaweah Delta Health Care District Bylaws.

Knowing the organization’s mission, purpose, goals, policies, programs, services, strengths, and needs.

Performing the duties of Board membership responsibly and conforming to the level of competence expected from Board members as outlined in the duties of care, loyalty, and obedience as they apply to nonprofit Board members.

Serving in leadership positions and undertaking special assignments willingly and enthusiastically.
Avoiding prejudiced judgments on the basis of information received from individuals and urging those with grievances to follow established policies and procedures through their supervisors. (All matters of potential significance should be called to the attention of the executive and the Board’s elected leader as appropriate.)

Section 7  Relationship with Staff. Counseling the chief executive as appropriate and supporting them through often difficult relationships with groups or individuals.

Counseling the chief executive as appropriate and supporting them through often difficult relationships with groups or individuals.

Avoiding asking for special favors of the staff, including special requests for extensive information, without at least prior consultation with the chief executive, Board or appropriate committee chairperson.

Section 8  Avoiding Conflicts. Serving the organization as a whole rather than any special interest group or constituency. Regardless of whether or not the Board member was invited to fill a vacancy reserved for a certain constituency or organization, their first obligation is to avoid any preconception that they “represent” anything but the organization’s best interests.

Avoiding even the appearance of a conflict of interest that might embarrass the Board or the organization; disclosing any possible conflicts to the Board in a timely fashion. (Board of Directors policy - BOD5 – Conflict of Interest)

Maintaining independence and objectivity and doing what a sense of fairness, ethics, and personal integrity dictate, even though not necessarily being obliged to do so by law, regulation, or custom.

Never accepting (or offering) favors or gifts from (or to) anyone who does business with the organization.

The Board shall assess the adequacy of its conflict-of-interest/confidentiality policies and procedures at least every two years. (Political Reform Act (Government Code 8100 et seq.)

Section 9  Meetings. Preparing for and participating in Board and committee meetings, including appropriate organizational activities.

Asking timely and substantive questions at Board and committee meetings consistent with the Board member’s conscience and convictions, while at the same time supporting the majority decision on issues decided by the Board.

Maintaining confidentiality of the Board’s executive sessions and speaking for the Board or organization only when authorized to do so.

The Board of Directors of the Kaweah Delta Health Care District shall hold regular meetings at a meeting place within the jurisdiction of the Kaweah Delta Health Care District on the fourth Wednesday of each month, as determined by the Board of Directors each month. (California Health and Safety Code 32104)
The Board of Directors of the Kaweah Delta Health Care District may hold a special meeting of the Board of Directors as called by the President of the Board or in their absence the Vice President. In the absence of these officers of the Board a special meeting may be called by a majority of the members of the Board. A special meeting requires a 24-hour notice before the time of the meeting. {Government Code 54956}

Meetings of the Board of Directors shall be noticed and held in compliance with the applicable California Code for Health Care Districts. {The Ralph M. Brown Act - Government Code 54950}

Sections 32100.2 and 32106 of the California Health and Safety Code, as amended, indicate the attendance and quorum requirements for members of the Board of Directors of any health care district in the State of California. For general business the Board may operate under the rules of a small committee, however, upon the request of any member of the Governing Body immediate implementation of the Standard Code of Parliamentary Procedure (Roberts Rules of Order) shall be adopted for the procedure of that meeting.

The President of the Board of Directors shall appoint the committees of the Board and shall appoint the Chairperson and designate the term of office in a consistent and systematic approach. All committees of the Governing Body shall have no more than two (2) members of the Governing Body upon the committee and both Board members shall be present prior to the Board committee meeting being called to order. All committees of the Governing Body shall serve as extensions of the Governing Body and report back to the Governing Body for action.

The President of the Board of Directors may appoint, with concurrence of the Board of Directors, any special committees needed to perform special tasks and functions for the District.

Any special committee shall limit its activities to the task for which it was appointed, and shall have no power to act, except as specifically conferred by action of the Board of Directors.

The Chief of Staff shall be notified and shall facilitate Medical Staff participation in any Governing Board Committee that deliberates the discharge of Medical Staff responsibility.

The standing committees of the Governing Body are:

A. Academic Development

The members of this committee shall consist of two (2) Board members, Chief Executive Officer (CEO), Chief Medical Education Officer, Director of Graduate Medical Education, Director of Pharmacy, and any other members designated by the Board President.

This committee will provide Board direction and leadership for the Graduate Medical Education Program, the Pharmacy Residency Program, and achievement of Kaweah Health’s foundational Pillar “Empower through Education”.

April 26, 2023
B. **Audit and Compliance**

The members of this committee shall consist of two (2) Board members (Board President or Secretary/Treasurer shall be a standing member of this committee), CEO, Chief Financial Officer (CFO), Chief Compliance and Risk Officer, Internal Audit Manager, Compliance Manager, legal counsel, and any other members designated by the Board President. The Committee will engage an outside auditor, meet with them pre audit and post audit, and review the audit log of the Internal Audit Manager. The Committee will examine and report on the manner in which management ensures and monitors the adequacy of the nature, extent and effectiveness of compliance, accounting and internal control systems. The Committee shall oversee the work of those involved in the financial reporting process including the Internal Audit Manager and the outside auditors, to endorse the processes and safeguards employed by each. The Committee will encourage procedures and practices that promote accountability among management, ensuring that it properly develops and adheres to a compliant and sound system of internal controls, that the Internal Audit Manager objectively assesses management’s accounting practices and internal controls, and that the outside auditors, through their own review, assess management and the Internal Audit Manager’s practices. This committee shall supervise all of the compliance activities of the District, ensuring that Compliance and Internal Audit departments effectively facilitate the prevention, detection and correction of violations of law, regulations, and/or District policies. The Chief Compliance and Risk Officer will review and forward to the full Board a written Quarterly Compliance Report.

This committee, on behalf of the Board of Directors, shall be responsible for overseeing the recruitment, employment, evaluation and dismissal of the Chief Compliance and Risk Officer. These responsibilities shall be performed primarily by the CEO and/or the CEO’s designees, but final decisions on such matters shall rest with this committee, acting on behalf of the full Board.

C. **Community-Based Planning**

The members of this committee shall consist of two (2) Board members (Board President or Secretary/Treasurer shall be a standing member of this committee), CEO, Chief Strategy Officer, Facilities Planning Director and any other members designated by the Board President as they deem appropriate to the topic(s) being considered: community leaders including but not limited to City leadership, Visalia Unified School District (VUSD) leadership, College Of the Sequoias leadership, County Board of Supervisors, etc.

The membership of this committee shall meet with other community representatives to develop appropriate mechanisms to provide for efficient implementation of current and future planning of the organization’s facilities and services and to achieve mutual goals and objectives.
D. **Finance / Property, Services & Acquisitions**
The members of this committee shall consist of two (2) Board members - (Board President or Secretary/Treasurer will be a standing member of this committee), CEO, CFO, Chief Strategy Officer, Facilities Planning Director, and any other members designated by the Board President.

This committee will oversee the financial health of the District through careful planning, allocation and management of the District’s financial resources and performance. To oversee the construction, improvement, and maintenance of District property as well as the acquisition and sale of property which is essential for the Health Care District to carry out its mission of providing high-quality, customer-oriented, and financially-strong healthcare services.

E. **Governance & Legislative Affairs**
The members of this committee shall consist of two (2) Board members {Board President or the Board Secretary/Treasurer}, CEO and any other members designated by the Board President. Committee activities will include: reviewing Board committee structure, calendar, bylaws and, planning the bi-annual Board self-evaluation, and monitor conflict of interest. Legislative activities will include: establishing the legislative program scope & direction for the District, annually review appropriation request to be submitted by the District, effectively communicating and maintaining collegial relationships with local, state, and nationally elected officials.

F. **Human Resources**
The members of this committee shall consist of two (2) Board members, CEO, Chief Human Resources Officer, Chief Nursing Officer (CNO) and any other members designated by the Board President. This committee shall review and approve all personnel policies. This committee shall annually review and recommend changes to the Salary and Benefits Program, the Safety Program and the Workers’ Compensation Program. This committee will annually review the workers compensation report, competency report & organizational development report.

G. **Information Systems**
The members of this committee shall consist of two (2) Board members, CEO, CFO, CNO, Chief Information Officer (CIO), Medical Director of Informatics, and any other members designated by the Board President. This committee shall supervise the Information Systems projects of the District.

H. **Marketing and Community Relations**
The members of this committee shall consist of two (2) Board members and CEO, Chief Strategy Officer, Marketing Director, and any other members designated by the Board President.
This committee shall oversee marketing and community relations activities in the District in order to increase the community’s awareness of available services and to improve engagement with the population we serve. Additionally, create a brand that builds preference for Kaweah Health in the minds of consumers and creates a public image that instills trust, confidence, and is emblematic of Kaweah Health’s mission and our vision to become “world-class”. Further develops and fosters a positive perception that will attract the highest caliber of employees and medical staff.

I. Patient Experience
The members of this committee shall consist of two (2) Board members and the CEO, Chief Nursing Officer, CNO, Chief Human Resources Officer, Director of Emergency Services, Patient Experience Coordinator, Director of Community Engagement, and any other members designated by the Board President.

This committee will work with the patient experience team and leadership to develop a patient experience strategy to ensure that patient experiences are meeting the Mission and Vision of Kaweah Health and its foundational Pillar “Deliver excellent service”.

J. Quality Council
The members of this committee shall consist of two (2) Board members, CEO or designate, CNO, Chief Medical and Quality Officer (CMOQO), Chief of the Medical Staff, chair of the Professional Staff Quality Committee (Prostaff), Medical Directors of Quality and Patient Safety, Director of Quality and Patient Safety, Director of Risk Management, and members of the Medical Staff as designated by the Board.

This committee shall review and recommend approval of the annual Quality Improvement (QI) plan and Patient Safety plans to the Board of Directors, determine priorities for improvement, monitor key outcomes related to Quality Focus Team activities, evaluate clinical quality, patient safety, and patient satisfaction, monitor and review risk management activities and outcomes, evaluate the effectiveness of the performance improvement program, foster commitment and collaboration between the District and Medical Staff for continuous improvement, and review all relevant matters related to Quality within the institution, including Performance Improvement, Peer Review, Credentialing/Privileging and Risk Management.

K. Strategic Planning
The members of this committee shall consist of two (2) Board members, CEO, Chief Strategy Officer, all Executive Team members, Medical Staff Officers, Immediate past Chief of Staff along with other members of the Medical Staff as designated by the Board and the CEO.

This committee shall review the budget plan, review the strategic plan and organize objectives, review changes or additions to service lines.
The Strategic Planning Committee will provide oversight and forward to the full Board the following reports:
1. Review of the Strategic Plan Annually
2. Strategic Plan initiatives progress and follow-up bi-monthly to full Board.

L. **Independent Committees**
The following independent committees may have Board member participation.
1. Cypress Company, LLC
2. Graduate Medical Education Committee (GMEC)
3. Joint Conference
4. Kaweah Health Hospital Foundation
5. Quail Park {All entities}
6. Retirement Plans’ Investment Committee
7. Sequoia Integrated Health, LLC
8. Sequoia Surgery Center, LLC
9. Sequoia Regional Cancer Center – Medical & Radiation, LLC
10. Tulare Kings Cancer (TKC) Development, LLC
   • The Board President shall serve as General Manager for TKC Development, LLC.

11. 202 W. Willow – Board of Owners
12. 11 Central Valley Health Care Alliance - JPA

M. **Medical Affairs**
1) A member of the Board, as appointed by the President, shall also serve on the following Medical Staff Committees:
   a) Joint Conference Committee - This committee shall regularly meet to discuss current issues/concerns with Medical Staff, Board, and Administration.
   b) Credentials Committee - The Board shall participate in this committee to observe the Medical Staff process.

**Section 10** The Governing Body Bylaws:
The Governing Body Bylaws and any changes thereto may be adopted at any regular or special meeting by a legally constituted quorum of the Governing Body. All portions of Governing Body Bylaws must be in compliance with applicable California Code, which is the ruling authority.

Any member of the Governing Body may request a review for possible revision of the Bylaws of the organization.

The Chief Executive Officer and the Governing Body shall review the Bylaws and recommend appropriate changes annually.

**Section 11** Members of the Governing Body shall annually sign the Board Bylaws which outlines the duties and responsibilities of the Governing Body members including but not limited to adherence to the Board policies and the Brown Act.
Section 12 Members of the Governing Body are publicly elected. The members of the Governing Body are expected to participate actively in the functions of the Governing Body and its committees and to serve the constituency who elected them. Notwithstanding any other provision of law, the term of any member of the board of directors shall expire if he or she is absent from three consecutive regular meetings, or from three of any five consecutive meetings of the board and the board by resolution declares that a vacancy exists on the board. {California Health and Safety Code 32100.2}

Section 13 The Chief Executive Officer shall provide an orientation program to all newly elected members of the Governing Body. {Board of Directors policy – BOD1 – Orientation of a New Board Member} All members of the Board of Directors shall be provided with current copies of the District Bylaws and the Medical Staff Bylaws and any revisions of these Bylaws.

Article III Officers of the Board

Section 1 The offices of President, Vice President, and Secretary/Treasurer shall be selected at the first regular meeting in December of a non-election year of the District. To hold the office of President, Vice President, or Secretary/Treasurer, a Board member must have at least one year of service on the Board of Directors. These officers shall hold office for a period of two (2) years or until the successors have been duly selected (or in the case of an unfulfilled term, appointed) and qualified. The officer positions shall be by election of the Board itself.

Section 2 The duties and responsibilities of the Governing Body President are:

A. Adhere to the duties and responsibilities of the Governing Body as outlined in Article II – The Governing Body of the Kaweah Delta Health Care District Bylaws.

B. Keep the mission of the organization at the forefront and articulates it as the basis for all Board action.

C. Understand and communicate the roles and functions of the Board, committees, Medical Staff, and management.

D. Understand and communicate individual Board member, Board leader, and committee chair responsibilities and accountability.

E. Act as a liaison between the Board, management, and Medical Staff.

F. Plan agendas.

G. Preside over the meetings of the Board.

H. Preside over or attend other Board, Medical Staff, and other organization meetings.

I. Enforce Board and hospital bylaws, rules, and regulations (such as conflict of interest and confidentiality policies).
J. Appoint Board committee chairs and members in a consistent and systematic approach.

K. Act as a liaison between and among other Boards in the healthcare system.

L. Direct the committees of the Board, ensuring that the committee work plans flow from and support the hospital and Board goals, objectives, and work plans.

M. Provide orientation for new Board members and arrange continuing education for the Board.

N. Ensure effective Board self-evaluation.

O. Build cohesion among the leadership team of the Board President, CEO, and Medical Staff leaders.

P. Lead the CEO performance objective and evaluation process.

Section 3
The duties and responsibilities of the Governing Body Vice President are:

A. Adhere to the duties and responsibilities of the Governing Body as outlined in Article II - The Governing Body of the Kaweah Delta Health Care District Bylaws.

B. The Vice President shall act as President in the absence of the President or the Secretary/Treasurer in the absence of the Secretary/Treasurer, and so acting shall have all the responsibility and authority of that position.

Section 4
The Secretary/Treasurer shall act as the Secretary for the Board of Directors of Kaweah Delta Health Care District and in so doing shall:

A. Adhere to the duties and responsibilities of the Governing Body as outlined in Article II The Governing Body of the Kaweah Delta Health Care District Bylaws.

B. Maintain minutes of all meetings of the Board of Directors;

C. Be responsible for the custody of all records and for maintaining records of the meetings;

D. Be assured that an agenda is prepared for all meetings.

E. Will be custodian of all funds of Kaweah Delta Health Care District as well as the health care facilities operated by the District.

F. Will assure that administration is using proper accounting systems; that this is a true and accurate accounting of the transactions of the District; that these transactions are recorded and accurate reports are regularly reported to the Board of Directors.

G. In conjunction with the Board Audit and Compliance Committee shall see that a major accounting firm provides ongoing overview and scrutiny of the fiscal assets of the District, and shall further assure that an annual audit is
prepared by a major accounting firm and presented directly to the Board of Directors.

**Article IV  The Medical Staff**

**Section 1** The Governing Body shall appoint the Medical Staff composed of licensed physicians, surgeons, dentists, podiatrists, clinical psychologists, and all Allied Health Practitioners (including Physician Assistants, Nurse Practitioners and Nurse Midwives) duly licensed by the State of California. {California Health and Safety Code of the State of California, Section 32128} The Governing Body, upon consideration of the recommendations of the Medical Staff coming from the Medical Executive Committee, through the Credentials Committee, affirms or denies appointment and privileges to the Medical Staff of Kaweah Delta Health Care District in accordance with the procedure for appointment and reappointment of the medical staff as provided by the standards of the Joint Commission on Accreditation of Healthcare Organizations. {Joint Commission Standard MS.01.01.01} The Board of Directors shall reappoint members to the Medical Staff every two (2) years, as set forth in the Medical Staff Bylaws. The Governing Body requires that an organized Medical Staff is established within the District and that the Medical Staff submits their Bylaws, Rules and Regulations and any changes thereto, to the Governing Body for approval.

**Section 2** Members of the Medical Staff are eligible to run in the public election for membership on the Governing Body in the same manner as other individuals.

**Section 3** The Chief of Staff of Kaweah Delta Health Care District shall be notified and invited to each regular monthly meeting of the Governing Body and the Chief of Staff’s input shall be solicited with respect to matters affecting the Medical Staff.

**Section 4** The Chief of Staff of Kaweah Delta Health Care District shall be invited to all meetings of the Governing Body at which credentialing decisions are made concerning any member of the Medical Staff of Kaweah Health Medical Center or at which quality assurance reports are given concerning the provision of patient care at Kaweah Health Medical Center. Quality assurance reports shall be made to the Board periodically. Credentialing decisions shall be scheduled on an as-needed basis. The Chief of Staff shall be encouraged to advise the Board on the content and the quality of the presentations, and to make recommendations concerning policies and procedures, the improvement of patient care and/or the provision of new services by the District.

**Section 5** The District has an organized Medical Staff that is accountable to the Governing Body. {Joint Commission Standard LD.01.05.01} The organized Medical Staff Executive Committee shall make recommendations directly to the Governing Body for its approval. Such recommendations shall pertain to the following:

A. the structure of the Medical Staff;
B. the mechanism used to review credentials and delineate clinical privileges;
C. individual Medical Staff membership;
D. specific clinical privileges for each eligible individual;
E. the organization of the performance improvement activities of the Medical Staff as well as the mechanism used to conduct, evaluate, and revise such activities;
F. the mechanism by which membership on the Medical Staff may be terminated;
G. the mechanism for fair hearing procedures.

Section 6  The Governing Body shall act upon recommendations concerning Medical Staff appointments, re-appointments, termination of appointments, and the granting or revision of clinical privileges within 120 days following the regular monthly meeting of the Governing Body at which the recommendations are presented through the Executive Committee of the organized Medical Staff. The secretary of the board of directors or the hospital administrator shall mail notice of the action or decision to the affected applicant or medical staff member with the time specified in the applicable bylaw or rule (California Health & Safety Code 32151)

Section 7  The Governing Body requires that only a member of the organized Medical Staff with admitting privileges at Kaweah Health Medical Center may admit a patient to Kaweah Health Medical Center and that such individuals may practice only within the scope of the privileges granted by the Governing Body and that each patient's general medical condition is the responsibility of a qualified physician of the Medical Staff.

Section 8  The Governing Body requires, as outlined in Resolution 2207, that members of the organized Medical Staff, as a condition of appointment or reappointment and to maintain admitting and clinical privileges, and all Allied Health Practitioners (including Physician Assistants, Nurse Practitioners and Nurse Midwives) Advanced Practice Providers, as a condition of appointment or reappointment and to maintain clinical privileges, to obtain and maintain at all times, continuous coverage that meets or exceeds the standards set forth below:

Coverage Limits: At least $1 million per claim and at least $3 million annual aggregate, with a deductible or self-insured retention of not more than $100,000; and

Rating and Financial Strength: Maintains an A.M. Best Rating of at least A, and a Financial Strength Category (“FSC”) of at least VII ($50 million to $100 million); and;

Admitted Carriers: An insurance company on the List of Admitted Insurers published by the California Department of Insurance, which can be accessed here: https://interactive.web.insurance.ca.gov/apex_extprd/f?p=144:10:11467228532262::NO::; or

Non-Admitted/Surplus Line Insurers: An insurance company that meets the criteria identified in paragraphs 1 and 2, and is on the List of Approved Surplus Line Insurers (“LASLI”) published by the California Department of Insurance.
Section 9

The Governing Body holds the Medical Staff responsible for the development, adoption, and annual review of its own Medical Staff Bylaws, Rules and Regulations that are consistent with Kaweah Health policy, applicable codes, and other regulatory requirements. Neither the Medical Staff nor the Governing Body may make unilateral amendments to the Medical Staff Bylaws or the Medical Staff Rules and Regulations.

The Medical Staff Bylaws and the Rules and Regulations adopted by the Medical Staff, and any amendments thereto, are subject to, and effective upon, approval of the Governing Body, such approval not to be unreasonably withheld.

Section 10

The Medical Staff is responsible for establishing the mechanism for the selection of the Medical Staff Officers, Medical Staff Department Chairpersons, and Medical Staff Committee Chairpersons.

This mechanism will be included in the Medical Staff Bylaws.

Section 11

The Governing Body requires the Medical Staff and the Management to review and revise all department policies and procedures as often as needed. Such policies and procedures must be reviewed at least every three (3) years.

In adherence with Title 22, {70203} Policies relative to medical service {those preventative, diagnostic and therapeutic measures performed by or at the request of members of the organized medical staff} shall be approved by the governing body as recommended by the Medical Staff.

In adherence with Title 22, {70213} Nursing Service Policies for patient care shall be developed, maintained and implemented by nursing services; policies which involve the Medical Staff shall be reviewed and approved by the Medical Staff prior to implementation.

Section 12

Individuals who provide patient care services (other than District staff members), but who are not subject to the Medical Staff privilege delineation process, shall submit their credentials to the Interdisciplinary Practice Committee of the Medical Staff which shall, via the Executive Committee, transmit its recommendations to the Governing Body for approval or disapproval.

Section 13

The quality of patient care services provided by individuals who are not subject to Medical Staff privilege delineation process, shall be included as a portion of the District’s Performance Improvement program.
Section 14  The Governing Body specifies that under the privacy regulations of the Health Insurance Portability and Accountability Act (HIPAA), the Medical Staff and the District are in an Organized Health Care Arrangement (OHCA). The OHCA is a clinically integrated care setting in which individuals receive health care from more than one provider and the providers hold themselves out to the public as participating in a joint arrangement. The Medical Staff is in an OHCA with the District for care provided at District facilities. This joint arrangement is disclosed to the patients in the Notice of Privacy Practices given to patients when they access care at any of the District’s facilities.

Article V Joint Committees

Section 1  The President of the Governing Body or a member of the Board appointed by the President shall participate, along with the CEO, in the Joint Conference Committee, which is a committee of the Medical Staff. This committee shall serve as a systematic mechanism for communication between members of the Governing Body, Administration, and members of the Medical Staff. Specifically, issues which relate to quality of patient care shall be regularly addressed. Additionally, other matters of communication which are of importance to maintaining a sound working relationship between the Governing Body and the Medical Staff shall be discussed. The minutes, if any, shall be kept by the organized Medical Staff under the direction of its President. The proceedings and records of this committee are protected by Section 1157 of the evidence Code.

Article VI Chief Executive Officer

Section 1  The Governing Body shall be solely responsible for appointment or dismissal of the Chief Executive Officer. {Board of Directors policy – BOD2 – Chief Executive Officer (CEO) Transition}

Section 2  The Governing Body shall assure that the Chief Executive Officer is qualified for their responsibilities through education and/or experience. {Board of Directors policy – BOD3 – Chief Executive Officer (CEO) Criteria}

Section 3  The Chief Executive Officer shall act on behalf of the Governing Body in the overall management of the District.

Section 4  In the absence of the Chief Executive Officer, an Executive Team member designated by the Chief Executive Officer or by the President of the Governing Body shall assume the responsibilities of this position. The Governing Body retains final authority to name the person to act during the absence or incapacity of the Chief Executive Officer.

Section 5  Annually the Governing Body shall meet in Executive session to monitor the performance of the Chief Executive Officer. The conclusions and recommendations from this performance evaluation will be transmitted to the Chief Executive Officer by the Governing Body.
Section 6 The Chief Executive Officer shall select, employ, control, and have authority to discharge any employee of the District other than any individual with the title or equivalent function of a member of the Executive Team or Board Clerk. Employment of new personnel shall be subject to budget authorization granted by the Board of Directors.

Section 7 The Chief Executive Officer shall organize, and have the authority to reorganize the administrative structure of the District, below the level of CEO, subject to the limitations set forth in in Section 6 above. The District’s organizational chart shall reflect that the Chief Compliance and Risk Officer has direct, solid-line reporting relationships to the Board (functional) and to the CEO (administrative).

Section 8 The Chief Executive Officer shall report to the Board at regular and special meetings all significant items of business of Kaweah Delta Health Care District and make recommendations concerning the disposition thereof.

Section 9 The Chief Executive Officer shall submit regularly, in cooperation with the appropriate committee of the Board, periodic reports as required by the Board.

Section 10 The Chief Executive Officer shall attend all meetings of the Board when possible and shall attend meetings of the various committees of the Board when so requested by the committee chairperson.

Section 11 The Chief Executive Officer shall serve as a liaison between the Board and the Medical Staff. The Chief Executive Officer shall cooperate with the Medical Staff and secure like cooperation on the part of all concerned with rendering professional service to the end that patients may receive the best possible care.

Section 12 The Chief Executive Officer shall make recommendations concerning the purchase of equipment and supplies and the provision of services by the District, considering the existing and developing needs of the community and the availability of financial and medical resources.

Section 13 The Chief Executive Officer shall keep abreast and be informed of new developments in the medical and administrative areas of hospital administration.

Section 14 The Chief Executive Officer shall oversee the physical plants and ground and keep them in a good state of repair, conferring with the appropriate committee of the Board in major matters, but carrying out routine repairs and maintenance without such consultation.

Section 15 The Chief Executive Officer shall supervise all business affairs such as the records of financial transactions, collections of accounts and purchase and issuance of supplies, and be certain that all funds are collected and expended to the best possible advantage.

Section 16 The Chief Executive Officer shall supervise the preservation of the permanent medical records of the District and act as overall custodian of these records.

Section 17 The Chief Executive Officer shall keep abreast of changes in applicable laws and regulations and shall insure that a District compliance program, appropriate educational programs, and organizational memberships are in place to carry out this responsibility.
Section 18 The Chief Executive Officer shall be responsible for assuring the organization’s compliance with applicable licensure requirements, laws, rules, and regulations, and for promptly acting upon any reports and/or recommendations from authorized agencies, as applicable.

Section 19 The Chief Executive Officer will ensure that the business of the Health Care District is conducted openly and transparently, as required by law.

Section 20 The Chief Executive Officer will oversee the activities of the Health Care District’s community relations committees to ensure meaningful participation of community members and communication of the input and recommendation from the committee to the Board and to organization’s management.

Section 21 The Chief Executive Officer shall perform any special duties assigned or delegated to them by the Board.

Article VII The Health Care District Guild

Section 1 The Governing Body recognizes the Kaweah Delta Health Care District Guild in support of the staff and patients of the District.

Section 2 The Chief Executive Officer is charged with effecting proper integration of the Guild within the framework of the organization.

Article VIII Performance Improvement (PI)

Section 1 The Governing Body requires that the Medical Staff and the Health Care District staff implement and report on the activities and mechanisms for monitoring and evaluating the quality of patient care, for identifying and resolving problems, and for identifying opportunities to improve patient care within the District.

Section 2 The Governing Body, through the Chief Executive Officer, shall support these activities and mechanisms.

Section 3 The Governing Body shall adopt a Performance Improvement Plan and Risk Management Plan for the District and shall provide for resources and support systems to ensure that the plans can be carried out.

Section 4 The Governing Body requires that a complete and accurate medical record shall be prepared and maintained for each patient; that the medical record of the patient shall be the basis for the review and analysis of quality of care. The Governing Body holds the organized Medical Staff responsible for self-governance with respect to the professional work performed in the hospital and for periodic meetings of the Medical Staff to review and analyze at regular intervals their clinical experience. Results of such review will be reported to the Governing body at specific intervals defined by the Board.

Section 5 The quality assurance mechanisms within any of the District’s facilities shall provide for monitoring of patient care processes to assure that patients with the same health problem are receiving the same level of care within the District.
Article IX Conflict of Interest

Section 1 The Administration Policy Manual of Kaweah Delta Health Care District and the Board of Directors Policy Manual has a written Conflict of Interest Policy (Administrative Policy AP23 and Board of Directors Policy BOD5), which requires the completion and filing of a Conflict of Interest Statement disclosing financial interests that may be materially affected by official actions and provides that designated staff members must disqualify themselves from acting in their official capacity when necessary in order to avoid a conflict of interest. The requirements of this policy are additional to the provisions of Government Code § 87100 and other laws pertaining to conflict of interest; and nothing herein is intended to modify or abridge the provisions of the policies of Kaweah Delta Health Care District which apply to:

A. members of the Governing Body,
B. the executive staff,
C. employees who hold designated positions identified in Exhibit “A” of the District Conflict of Interest Code.

Section 2 Each member of the Governing Body, specified executives, and designated employees must file an annual Conflict of Interest Statement as required by California Government Code – Section 87300-87313.

Section 3 The Board shall assess the adequacy of its conflict-of-interest/confidentiality policies and procedures {Board of Directors Policy - BOD5 - and Administrative Policy 23 – Conflict of Interest} every even numbered year. {Political Reform Act – State Fair Political Practice Commission}

Article X Indemnification of Directors, Officers, and Employees

Section 1 Actions other than by the District. The District shall have the power to indemnify any person who was or is a party, or is threatened to be made a party, to any proceeding (other than an action by or in the right of the District to procure a judgment in its favor) by reason of the fact that such person is or was a director, officer or employee of the District, against expenses, judgments, fines, settlements, and other amounts actually and reasonably incurred in connection with such proceeding if that person acted in good faith and in a manner that the person reasonably believed to be in the best interest of the District and, in the case of a criminal proceeding, had no reasonable cause to believe the conduct of that person was unlawful. The termination by any proceeding by judgment, order, settlement, conviction or upon a plea of nolo contendere or its equivalent, shall not, of itself, create a presumption that the person did not act in good faith and in the manner that the person reasonably believed to be in the best interests of the District person’s conduct was unlawful.

Section 2 Actions by the District. The District shall have the power to indemnify any person who was or is a party, or is threatened to be made a party, to any threatened, pending, or completed action by or in the right of the District to procure a judgment in its favor by reason of the fact that such person is or was a
director, officer, or employee of the District, against expenses actually and reasonably incurred by such person in connection with the defense or settlement of that action, if such person acted in good faith, in a manner such person believed to be in the best interest of the District and with such care, including reasonable inquiry, as an ordinarily prudent person in a like position would use under a similar circumstance.

No indemnification shall be made under this Section:

A. with respect to any claim, issue or matter as to which such person has been adjudged to be liable to the District in their performance of such person's duty to the District, unless and only to the extent that the court in which that proceeding is or was pending shall determine upon application that, in view of all the circumstances of the case, such person is fairly and reasonably entitled to indemnity for the expenses which the court shall determine;

B. of amounts paid in settling or otherwise disposing of a threatened or pending action, with or without court approval;

C. of expenses incurred in defending a threatened or pending action that is settled or otherwise disposed of without court approval.

Section 3 Successful defense by director, officer, or employee. To the extent that a director, officer or employee of the District has been successful on the merits in defense of any proceeding referred to in Section 1 or Section 2 of this Article X, or in defense of any claim, issue or matter therein, the director, officer or employee shall be indemnified as against expenses actually and reasonably incurred by that person in connection therewith.

Section 4 Required approval. Except as provided in Section 3 of this Article, any indemnification under this Article shall be made by the District only if authorized in the specific case, upon a determination that indemnification of the officer, director or employee is proper in the circumstances because the person has met the applicable standard of conduct set forth in Sections 2 and 3 of this Article X, by one of the following:

A. a majority vote of a quorum consisting of directors who are not parties to the proceeding; or

B. the court in which the proceeding is or was pending, on application made by the District or the officer, director or employee, or the attorney or other person rendering services in connection with the defense, whether or not such other person is opposed by the District.

Section 5 Advance of expenses. Expenses incurred in defending any proceeding may be advanced by the District before the final disposition of the proceeding upon receipt of an undertaking by or on behalf of the officer, director or employee to repay the amount of the advance unless it shall be determined ultimately that the officer, director or employee is entitled to be indemnified as authorized in this Article.
Section 6 Other contractual rights. Nothing contained in this Article shall affect any right to indemnification to which persons other than directors and officers of this District may be entitled by contract or otherwise.

Section 7 Limitations. No indemnification or advance shall be made under this Article except as provided in Section 3 or Section 4, in any circumstance where it appears:

A. that it would be inconsistent with the provision of the Articles, a resolution of the Board, or an agreement in effect at the time of accrual of the alleged cause of action asserted in the proceeding in which the expenses were incurred or other amounts were paid, which prohibits or otherwise limits indemnification; or

B. that it would be inconsistent with any condition expressly imposed by a court in approving a settlement.

Section 8 Insurance. If so desired by the Board of Directors, the District may purchase and maintain insurance on behalf of any officer, director, employee or agent of the corporation, insuring against any liability asserted against or incurred by the director, officer, employee or agent in that capacity or arising out of the person's status as such, whether or not the District would have the power to indemnify the person against that liability under the provisions of this Article.

If any article, section, sub-section, paragraph, sentence, clause or phrase of these Bylaws is for any reason held to be in conflict with the provisions of the Health and Safety Code of the State of California, such conflict shall not affect the validity of the remaining portion of these Bylaws.

These Bylaws for Kaweah Delta Health Care District are adopted, as amended, this 26th-21st day of AprilDecember, 2023.

President Secretary/Treasurer
Kaweah Delta Health Care District Kaweah Delta Health Care District

Vice President Board Member
Kaweah Delta Health Care District Kaweah Delta Health Care District

Board Member
Kaweah Delta Health Care District

April 26December 21, 2023
To: Kaweah Delta Health Care District (KDHCD) Board of Directors
From: Human Resources
Date: December 4, 2023
Re: Plan Amendments – KDHCD 457(b) Deferred Compensation Plan

Amendments related to new Legislation.

The purpose of this Memorandum is to refresh the Board of Directors with background information on a provision under the Bipartisan American Miners Act of 2019 and a provision under the SECURE Act 1.0, which were signed into law by President Donald Trump on December 20, 2019. The formal amendment needs to be in place by December 31, 2025.

Amendment Overview

SECURE Act Qualified Birth or Adoption Distribution – A Qualified Birth or Adoption Distribution (‘QBAD’) is a distribution to an individual during the one-year period beginning on the child’s birthdate or on the date the legal adoption of an individual under the age of 18 is formalized. The 10% early withdrawal tax does not apply, and the QBAD may be repaid as a rollover contribution to the participant’s account within a 3-year period. The maximum aggregate amount for a QBAD by any individual is $5,000 per child.

The Bipartisan American Miners Act of 2019 In-Service Distribution - The bill lowers the age to take in-service distributions under a pension plan or governmental section 457(b) from age 70.5 to age 59.5.

These optional provisions were added to the plan effective 1/1/2022 and will be included in the Amendment to be completed by 12/31/25.

Suggested Action and Next Steps

Approve the amendment to add QBADs and lower the in-service distribution age to 59.5.
RESOLUTION 2211
OF THE BOARD OF DIRECTORS OF
KAWEAH DELTA HEALTH CARE DISTRICT
AMENDING THE KAWEAH HEALTH CARE DISTRICT 457(B) DEFERRED
COMPENSATION PLAN

WHEREAS the Board of Directors (the “Board”) of the Kaweah Delta Health Care District (the “District”) adopted the Kaweah Delta Health Care District 457(b) Deferred Compensation Plan as amended effective January 1, 2022 (the “Plan”); and

WHEREAS the District reserves the right to amend or restate the Plan in Section 10.01 of the Plan Document.

WHEREAS the District desires to amend the Plan document effective January 1, 2022, to reflect the following:

Qualified Birth and Adoption Distribution will amend the type of distributions allowed under the plan to include qualified birth and adoption distributions.

In-Service Distribution Age will amend the age required for in-service distributions to 59.5.

NOW, THEREFORE, BE IT RESOLVED, that an authorized officer be and hereby is directed and authorized to amend the plan which is attached hereto.

This Resolution is adopted by the Board of Directors of Kaweah Delta Health Care District at a duly constituted meeting held on the 21st day of December 2023.

KAWEAH DELTA HEALTH CARE DISTRICT

__________________________
President, Kaweah Delta Health Care District

ATTEST:

__________________________
Secretary/Treasurer
Kaweah Delta Health Care
District and of the Board of
Directors, thereof
To: Kaweah Delta Health Care District (KDHCD) Board of Directors  
From: Human Resources  
Date: December 4, 2023  
Re: Plan Amendments – Employees’ Salary Deferral Plan

Amendments Related to New Legislation

The purpose of this Memorandum is to refresh the Board of Directors with background information on an optional provision under SECURE Act 1.0, which was signed into law by President Donald Trump on December 20, 2019. The formal amendment needs to be in place by December 31, 2025.

Amendment Overview

- **Qualified Birth or Adoption Distribution** – A Qualified Birth or Adoption Distribution (‘QBAD’) is a distribution to an individual during the one-year period beginning on the child’s birthdate or on the date the legal adoption of an individual under the age of 18 is formalized. The 10% early withdrawal tax does not apply, and the QBAD may be repaid as a rollover contribution to the participant’s account within a 3-year period. The maximum aggregate amount for a QBAD by any individual is $5,000 per child.

This optional provision under SECURE 1.0 was added to the plan effective 1/1/2022 and included in the Interim Amendment signed 6/15/23.

- **Employer Match** – The Plan Document now defines Employer Matching Contributions as discretionary from year to year. This permits KDHCD the ability to define the Matching Contribution Formula each year to align with business strategies. Each year, the Board must approve the Matching Contribution for the Plan. The Matching Contribution for the January 1, 2023 – December 31, 2023 Plan Year will be 50%:

<table>
<thead>
<tr>
<th>Years of Service</th>
<th>Matching Contribution</th>
<th>Maximum Matching Salary Deferral or ROTH Deferral Contribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-2</td>
<td>50%</td>
<td>3% of Compensation</td>
</tr>
<tr>
<td>3-5</td>
<td>50%</td>
<td>4% of Compensation</td>
</tr>
<tr>
<td>6-10</td>
<td>50%</td>
<td>5% of Compensation</td>
</tr>
<tr>
<td>11 or more</td>
<td>50%</td>
<td>6% of Compensation</td>
</tr>
</tbody>
</table>

Suggested Action and Next Steps

Approve the QBAD amendment and match formula for participants of the Employees’ Salary Deferral Plan.
RESOLUTION 2212
OF THE BOARD OF DIRECTORS OF
KAWEAH DELTA HEALTH CARE DISTRICT
AMENDING THE EMPLOYEES’ SALARY DEFERRAL PLAN

WHEREAS the Board of Directors (the “Board”) of the Kaweah Delta Health Care District (the “District”) adopted the Kaweah Delta Heath Care District Employees’ Salary Deferral Plan, as amended and restated effective June 1, 2022 (the “Plan”); and

WHEREAS the District reserves the right to amend or restate the Plan in Section 14.01 of the Plan’s Base Plan Document.

WHEREAS the District desires to amend the Plan document effective January 1, 2022, to reflect the following:

Qualified Birth and Adoption Distribution will amend the type of distributions allowed under the plan to include qualified birth and adoption distributions.

WHEREAS the District desires to define the Rules for determining the Matching Contribution Formula for the January 1, 2023 – December 31, 2023 Plan Year to reflect the following:

- The Matching Contribution will be based on the number of Years of Service a Participant has per the definition of Years of Service for the purpose of the Matching Contribution and the formula for each Year of Service tier has a separate limit above which Salary Deferrals and ROTH Deferrals will not be matched. Matching Contributions are subject to a specific definition of Plan Compensation. Kaweah Delta Health Care District staff will need to check the definitions of the specific Plan Compensation applicable to Matching Contributions. The March Contribution Formula is outlined in the following table:

<table>
<thead>
<tr>
<th>Years of Service</th>
<th>Matching Contribution</th>
<th>Maximum Matching Salary Deferral or ROTH Deferral Contribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-2</td>
<td>50%</td>
<td>3% of Compensation</td>
</tr>
<tr>
<td>3-5</td>
<td>50%</td>
<td>4% of Compensation</td>
</tr>
<tr>
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<td>50%</td>
<td>5% of Compensation</td>
</tr>
<tr>
<td>11 or more</td>
<td>50%</td>
<td>6% of Compensation</td>
</tr>
</tbody>
</table>

NOW, THEREFORE, BE IT RESOLVED, that an authorized officer be and herby is directed and authorized to the Amend the plan which is attached hereto.

This Resolution is adopted by the Board of Directors of Kaweah Delta Health Care District at a duly constituted meeting held on the 21st day of December 2023.

KAWEAH DELTA HEALTH CARE DISTRICT

____________________________________
President, Kaweah Delta Health Care District

ATTEST:

_____________________________
Secretary/Treasurer
Kaweah Delta Health Care
District and of the Board of Directors, thereof
# Privileges in Anesthesiology

Name: ____________________________________________________________   Date: _________________

Please Print

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## ANESTHESIA PRIVILEGE CRITERIA

**Initial Criteria:** Successfully completed a post-graduate residency program in Anesthesiology approved by the Accreditation Council for Graduate Medical Education (ACGME) or the American Osteopathic Association (AOA); **AND** Documentation of provision of inpatient care to at least 250 anesthesia patients over the past 24 months; **AND** current certification or active participation in the examination process leading to certification in Anesthesiology by the ABA or the AOBA or active participation in the examination process leading to certification in 5 years. **Active enrollment in Maintenance of Certification in Anesthesiology (not required for those with lifetime certification)**

**Certification:** ACLS **AND** PALS

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## ADULT AND ADOLESCENT CORE PRIVILEGES

<table>
<thead>
<tr>
<th>Request</th>
<th>Procedure</th>
<th>Renewal Criteria</th>
<th>FPPE</th>
<th>Approve</th>
</tr>
</thead>
<tbody>
<tr>
<td>□</td>
<td>Patients 11 years of age and older:</td>
<td>Minimum of 250 cases required in the past two years <strong>AND</strong> Maintain current certification or active participation in the examination process leading to certification in Anesthesiology by the ABA or the AOBA <strong>AND</strong> Current PALS certification</td>
<td>6 retrospective or concurrent reviews with a Minimum of one direct observation</td>
<td></td>
</tr>
</tbody>
</table>

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## ADULT CARDIOTHORACIC CORE PRIVILEGES

<table>
<thead>
<tr>
<th>Request</th>
<th>Procedure</th>
<th>Initial Criteria</th>
<th>Renewal Criteria</th>
<th>FPPE</th>
<th>Approve</th>
</tr>
</thead>
<tbody>
<tr>
<td>□</td>
<td>Performance of H&amp;P (may include telehealth)</td>
<td>Initial Core Criteria <strong>AND</strong> Completion of Cardiac Anesthesia fellowship preferred. Documentation of a minimum of 24 months of clinical experience dedicated to the perioperative care of surgical patients with cardiovascular disease; <strong>AND</strong> Board Certification in Perioperative Echocardiography <strong>AND</strong> 50 TEE Procedures in the past 2 years</td>
<td>Minimum 50 open heart cases required in the past two years <strong>AND</strong> Maintenance of Perioperative Echocardiography Board Certification <strong>AND</strong> 50 TEE Procedures in the past 2 years</td>
<td>6 retrospective or concurrent reviews with a Minimum of one direct observation</td>
<td></td>
</tr>
<tr>
<td>Request</td>
<td>Procedure</td>
<td>Initial Criteria</td>
<td>Renewal Criteria</td>
<td>FPPE</td>
<td>Approve</td>
</tr>
<tr>
<td>---------</td>
<td>------------</td>
<td>-----------------</td>
<td>------------------</td>
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<td>---------</td>
</tr>
</tbody>
</table>
|         | • Performance of H&P; Consultation (may include telehealth) and management for pregnant patients requiring non-obstetric surgery  
• General anesthesia for cesarean deliver; Image-guided procedures  
• All types of neuraxial analgesia (including epidural, spinal and combined spinal) and different methods of maintaining analgesia such as bolus, continuous infusion, and patient-controlled epidural analgesia  
• Anesthetic management of both spontaneous and operative vaginal delivery, retained placenta, cervical dilation, and uterine curettage, as well as postpartum tubal ligation, cervical cerclage, and assisted reproductive endoclinology interventions  
• Interpretation of antepartum and intrapartum fetal surveillance tests | Initial Core Criteria AND a minimum of 3 labor epidurals AND 3 spinals in the past two years AND Completion of Kaweah Health Post Partum Hemorrhage & Hypertensive Disorder in Pregnancy Education Modules within 30 days of privilege granted | Minimum of 15 cases required in the past two years. AND Completion of Kaweah Health Post Partum Hemorrhage & Hypertensive Disorder in Pregnancy Education Modules within the last 24 months | Minimum of 3 labor epidurals AND 3 spinals with direct observation | None |

<table>
<thead>
<tr>
<th>Request</th>
<th>Procedure</th>
<th>Initial Criteria</th>
<th>Renewal Criteria</th>
<th>FPPE</th>
<th>Approve</th>
</tr>
</thead>
</table>
|         | Pediatric Core Privileges for patients under 5 years of age  
• Management of children requiring general anesthesia for elective and emergent surgery for a wide variety of surgical conditions, including neonatal surgical emergencies, and congenital disorders | Initial Core Criteria AND Pediatric subspecialty training or equivalent experience AND PALS certification AND at least 10 pediatric procedures in the last 24 month | Minimum of 10 pediatric cases required in the past two years AND Maintenance of PALS certification | Minimum of 10 pediatric cases required in the past two years AND Maintenance of PALS certification | None |

<table>
<thead>
<tr>
<th>Request</th>
<th>Procedure</th>
<th>Initial Criteria</th>
<th>Renewal Criteria</th>
<th>FPPE</th>
<th>Approve</th>
</tr>
</thead>
</table>
|         | Pediatric Core Privileges for patients 5 years and older  
• Management of children requiring general anesthesia for elective and emergent surgery for a wide variety of surgical conditions, including neonatal surgical emergencies, and congenital disorders | Initial Core Criteria AND PALS certification AND at least 10 pediatric procedures in the last 24 month | Minimum of 5 pediatric cases required in the past two years AND Maintenance of PALS certification | Minimum of 5 pediatric cases required in the past two years AND Maintenance of PALS certification | None |

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Initial Criteria</th>
<th>Renewal Criteria</th>
<th>FPPE</th>
<th>Approve</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supervision of a technologist using fluoroscopy equipment</td>
<td>Current and valid Fluoroscopy supervisor and Operator Permit or a Radiology Supervisor and Operator Permit</td>
<td>Maintenance of Fluoroscopy Permit</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Trans Thoracic Echo Cardiography (TTE)</td>
<td>1) Completion of an ACGME or AOA approved residency training program that included training specific to TTE; OR 2) Documentation of completion of a training course specific to point of care ultrasound that includes TTE. (Module must be a minimum of 8 hours and include the physics of ultrasound and hands on-training.) AND Documentation of a minimum of 20 TTEs IF training completed prior to the last 24 months</td>
<td>Minimum of 10 procedures in the past 24 months</td>
<td>Minimum of 10 procedures in the past 24 months</td>
<td>3 direct observation AND 5 over-reads</td>
</tr>
<tr>
<td>Trans Esophageal Echo Cardiography (TEE)</td>
<td>1) Completion of an ACGME or AOA approved residency training program that included training specific to TEE; OR 2) Documentation of completion of a training course specific to point of care ultrasound that includes TEE. (Module must be a minimum of 16 hours and include the physics of ultrasound and hands on-training.) AND Documentation of a minimum of 50 TEEs IF training completed prior to the last 24 months</td>
<td>Minimum of 50 procedures in the past 24 months</td>
<td>Minimum of 50 procedures in the past 24 months</td>
<td>5 direct observation AND 5 over-reads</td>
</tr>
</tbody>
</table>
Swan Ganz Catheters

1) Completion of an ACGME or AOA approved residency training program that included training specific to SGC. Document of a minimum of 12 SGC placements if training completed prior to the last 24 months; OR
2) Documentation of successful placement of 6 SGCs by direct concurrent observation of a member of the Medical Staff with SGC privileges.

- Minimum of 6 procedures in the past 24 months
- A minimum of 1 direct observation

Outpatient Services at a Kaweah Health Clinic identified below. Privileges include performance of core privileges/procedures as appropriate to an outpatient setting and may include telehealth:
- Dinuba
- Exeter
- Lindsay
- Tulare
- Woodlake
- KHMC – Willow
- Specialty Clinic
- Sequoia Cardiology Clinic

- Initial Core Criteria AND Contract for Outpatient Clinical services with Kaweah Delta Health Care District.
- Maintain initial criteria
- None

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

(a) In exercising any clinical privileges granted, I am constrained by any Hospital and Medical Staff policies and rules applicable generally and any applicable to the particular situation.
(b) I may participate in the Kaweah Health Street Medicine Program, as determined by Hospital policy and Volunteer Services guidelines. As a volunteer of the program, Medical Mal Practice Insurance coverage is my responsibility.
(c) Emergency Privileges – In case of an emergency, any member of the medical staff, to the degree permitted by his/her license and regardless of department, staff status, or privileges, shall be permitted to do everything reasonably possible to save the life of a patient from serious harm.

Name: ____________________________________________________

Print

Signature: ________________________________________________________________      __________________

Applicant      Date

Signature: ________________________________________________________________      __________________

Department of Anesthesia Chair      Date
CERTIFIED REGISTERED NURSE ANESTHETIST

Initial Criteria

Education: Master of Registered Nursing Degree. Current licensure as an Advanced Nurse Practitioner in the state of California.

Formal Training: Successful completion of a nurse anesthesia educational program accredited by the AANA, CANAEP; Certification by the CCNA or recertification by the Council on Recertification; Current active licensure to practice professional nursing or advanced practice nursing in the nurse anesthetist category by the State of California Board of Nursing.

Certifications: ACLS or equivalent certification AND PALS certification AND current certification by NBCRNA

Clinical Experience: Documentation of patient care for 250 patients in the past two years OR certification within the last 12 months

Renewal Criteria: Documentation of patient care for 250 patients in the past 24 months AND Maintenance of current certification by NBCRNA AND ACLS or equivalent certification AND current PALS certification

FPPE: A minimum of Six (6) cases representative of privileges requested (3- Direct Observation; 3- Retrospective Review)

ADULT AND ADOLESCENT CORE PRIVILEGES

Patients 11 years of age and older:
- Performance of H&P;
- Assessment of, consultation for (may include telehealth), and preparation of patients for anesthesia; Clinical management of cardio & pulmonary resuscitation;
- Evaluation of respiratory function and application of respiratory therapy;
- Monitoring and maintenance of normal physiology during the perioperative period;
- Relief and prevention of pain during and following surgical, obstetrical, therapeutic, and diagnostic procedures using sedation/analgnesia, general anesthesia, and regional anesthesia;
- Diagnosis and treatment of acute, chronic, and cancer-related pain;
- Ultrasound guided regional nerve blocks;
- Management of critically ill patients;
- Treatment of patients for pain management (excluding chronic pain management);
- Post anesthesia care and discharge;

OBSTETRIC CORE PRIVILEGES

Clinical Experience: A minimum of 3 labor epidurals AND 3 spinals in the past two years AND Completion of Kaweah Health Post Partum Hemorrhage & Hypertensive Disorder in Pregnancy Education Modules within 30 days of privilege granted.

Renewal Criteria: A Minimum of 15 obstetric cases required in the past two years. AND Completion of Kaweah Health Post Partum Hemorrhage & Hypertensive Disorder in Pregnancy Education Modules within the last 24 months.

FPPE: A Minimum of 3 labor epidurals AND 3 spinals with direct observation.

PEDIATRIC CORE PRIVILEGES

Patients under 5 years of age
- Performance of H&P;
- All types of neuraxial analgesia (including epidural, spinal, combined spinal, and epidural analgesia) and different methods of maintaining analgesia such as bolus, continuous infusion, and patient-controlled epidural analgesia;
- Anesthetic management of both spontaneous and operative vaginal delivery, retained placenta, cervical dilation, and uterine curettage, as well as postpartum tubal ligation, cervical cerclage, and assisted reproductive endocrinology interventions;
- Consultation (may include telehealth) and management for pregnant patients requiring non-obstetric surgery;
- General anesthesia for cesarean deliver;

FPPE: 2 retrospective or concurrent reviews with a minimum of one direct observation.
## Certified Registered Nurse Anesthetist

### Provider Name: ________________________________________________________ Date: _________________

Please Print

<table>
<thead>
<tr>
<th>Patient 5 years and older</th>
<th>PALS certification and at least 10 pediatric procedures in the last 2 years</th>
<th>A Minimum of 5 pediatric cases required in the past two years AND maintenance of PALS certification.</th>
<th>2 retrospective or concurrent reviews with a minimum of one direct observation</th>
</tr>
</thead>
</table>

### Acknowledgment of Practitioner:

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

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

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

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

---

**Advanced Practice Provider Signature** ____________________________ **Date** ____________________

**Department of Anesthesiology Chairman Signature** ____________________________ **Date** ____________________
Privileges in Critical Care, Pulmonary & Sleep Medicine

Please Print

CRITICAL CARE CORE PRIVILEGES

Education & Training: M.D. or D.O. and Successful completion of an ACGME or AOA accredited program in the relevant medical specialty AND Successful completion of an accredited fellowship in critical care medicine and/or current subspecialty certification or active participation in the examination process leading to subspecialty certification in critical care medicine by the ABMS or AOA Boards within the timeframe determined by the certifying board

Current Clinical Competence: Documentation of provision of inpatient care to at least fifty (50) patients in the CCU over the past 24 months or completion of residency or clinical fellowship within the past 12 months.

OR *CA licensed physicians involved in their 2nd or 3rd year Critical Care Fellowship Program

Renewal Criteria: Minimum 60 cases required in the past two years AND Maintain current certification or active participation in the examination process leading to certification in Critical Care Medicine by the ABMS or AOA Board.

FPPE Requirement: Minimum of 8 of the following cases reviewed concurrently or retrospectively, to include: 5 diverse admissions & 2 flexible therapeutic bronchoscopies.

<table>
<thead>
<tr>
<th>Request</th>
<th>Procedure</th>
<th>Initial Criteria</th>
<th>Renewal Criteria</th>
<th>FPPE</th>
<th>Approve</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Privileges include: Privileges to evaluate, diagnose, perform history and physical exam, provide treatment or consultation (may include telehealth) to patients 14 years of age and older, with multiple organ dysfunction and in need of critical care AND</td>
<td>Documentation of 5 procedures in the last 2 years.</td>
<td>5 procedures in the last 2 years.</td>
<td>Minimum of 3 cases concurrently</td>
<td></td>
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<tr>
<td></td>
<td>Airway management, including intubation</td>
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<tr>
<td></td>
<td>Airway management, including intubation</td>
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<tr>
<td></td>
<td>Arterial puncture and cannulation</td>
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<tr>
<td></td>
<td>Cardiopulmonary resuscitation</td>
<td></td>
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<tr>
<td></td>
<td>Cardioversion and defibrillation</td>
<td></td>
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<tr>
<td></td>
<td>Central venous and pulmonary artery catheter insertion</td>
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<tr>
<td></td>
<td>Flexible bronchoscopy (excluding biopsies) with established Airway (Endotracheal/Tracheostomy)</td>
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<tr>
<td></td>
<td>Lumbar puncture</td>
<td></td>
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<tr>
<td></td>
<td>Needle and tube thoracostomy</td>
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<td></td>
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<tr>
<td></td>
<td>Paracentesis</td>
<td></td>
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<tr>
<td></td>
<td>Thoracentesis</td>
<td></td>
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<tr>
<td></td>
<td>Tracheostomy/criocephalotomy, emergency</td>
<td></td>
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<td></td>
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<tr>
<td></td>
<td>Transthoracic Echocardiography</td>
<td></td>
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<tr>
<td></td>
<td>Swan Ganz Catheters</td>
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</tbody>
</table>

Admitting Privileges (Must request Active Staff Status)

ADVANCED PRIVILEGES

(Must meet the criteria for Critical Care Core Privileges)

<table>
<thead>
<tr>
<th>Request</th>
<th>Procedure</th>
<th>Initial Criteria</th>
<th>Renewal Criteria</th>
<th>FPPE</th>
<th>Approve</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Flexible bronchoscopy (excluding biopsies) without an established Airway (Endotracheal/Tracheostomy)</td>
<td>Documentation of 5 procedures in the last 2 years.</td>
<td>5 procedures in the last 2 years.</td>
<td>Minimum of 3 cases concurrently</td>
<td></td>
</tr>
</tbody>
</table>

TELEMEDICINE PRIVILEGE REQUEST

Tele-Intensivist Privileges Only

<table>
<thead>
<tr>
<th>Request</th>
<th>Procedure</th>
<th>Initial Criteria</th>
<th>Renewal Criteria</th>
<th>FPPE</th>
<th>Approve</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Privileges to evaluate, diagnose, perform history and physical exam, provide treatment or consultation to patients 18 years of age and older, with multiple organ dysfunction and in need of critical care</td>
<td>Same as Critical Care Core Privileges</td>
<td>Same as Critical Care Core Privileges</td>
<td>Minimum of 5 cases reviewed concurrently or retrospectively</td>
<td></td>
</tr>
</tbody>
</table>

PULMONARY CORE PRIVILEGES

Education & Training: M.D. or D.O. and Successful completion of an ACGME or AOA-accredited fellowship in pulmonary medicine. AND ACLS Certification unless boarded in Critical Care AND Current certification or active participation in the examination process leading to certification in Pulmonary Disease OR Critical Care by the American Board of Internal Medicine or the American Osteopathic Board of Internal Medicine within the timeframe determined by the certifying board

Current Clinical Competence: Documentation of provision of inpatient care to at least fifty (50) patients over the past 24 months or completion of residency or clinical fellowship within the past 12 months.

OR *CA licensed physicians involved in their 2nd or 3rd year Pulmonary Fellowship Program

Renewal Criteria: Minimum 50 cases required in the past two years AND Maintenance of certification or active participation in the examination process leading to certification in Pulmonary Disease OR Critical Care by the American Board of Internal Medicine or the American Osteopathic Board of Internal Medicine AND ACLS Certification unless boarded in Critical Care.

FPPE Requirements: Minimum of 5 diverse admissions concurrently or retrospectively (Critical Care Core can be counted)

<table>
<thead>
<tr>
<th>Request</th>
<th>Procedure</th>
<th>Approve</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Core Privileges include: Evaluate, diagnose, consult, perform history and physical exam, and provide treatment and consultation (may include telehealth) to patients with disorders chest or thorax AND</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Airway Management, including intubation</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Airway Management, including intubation</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Arterial puncture and cannulation</td>
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<tr>
<td></td>
<td>Central venous and pulmonary artery catheter insertion</td>
<td></td>
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<tr>
<td></td>
<td>Flexible diagnostic bronchoscopy with Transbronchial biopsies</td>
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<tr>
<td></td>
<td>Inhalation challenge studies</td>
<td></td>
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<tr>
<td></td>
<td>Pulmonary function testing interpretation</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Thoracentesis and related procedures</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Flexible diagnostic bronchoscopy with Endobronchial biopsies</td>
<td></td>
</tr>
</tbody>
</table>

Admitting Privileges (Must request Active Staff Status)
### Privileges in Critical Care, Pulmonary & Sleep Medicine

Name: _____________________________________________________________________________________

Please Print

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**SLEEP MEDICINE CORE PRIVILEGES**

- **Education & Training:** M.D. or D.O. and Successful completion of an ACGME or AOA-accredited fellowship in sleep medicine, AND ACLS Certification
- **Current Clinical Competence:** Documentation of provision of care to at least fifty (50) patients over the past 24 months or completion of residency or clinical fellowship within the past 12 months.
- **Renewal Criteria:** Minimum of 50 cases required in the past two years AND Maintenance of certification or active participation in the process leading to certification in Sleep Medicine OR completion of a CAQ by the relevant AOA board. Current certification by the AASM is acceptable for applicants who became certified prior to 2007.

**FPPE Requirements:** Minimum of 3 cases reviewed concurrently or retrospectively.

<table>
<thead>
<tr>
<th>Request</th>
<th>Core Privileges include:</th>
<th>Procedure</th>
<th>Initial Criteria</th>
<th>Renewal Criteria</th>
<th>FPPE</th>
<th>Approve</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Evaluate, diagnose, consult, perform history and physical exam, and provide treatment (may include telehealth) to patients presenting with conditions or sleep disorders AND</td>
<td></td>
<td>Documentation of 400 in the last 2 years.</td>
<td>400 in the last 2 years.</td>
<td>Minimum of 20 cases concurrently</td>
<td></td>
</tr>
</tbody>
</table>

**ADVANCED PRIVILEGES**

( Must meet the criteria for Sleep Medicine Core Privileges)

<table>
<thead>
<tr>
<th>Request</th>
<th>Procedure</th>
<th>Initial Criteria</th>
<th>Renewal Criteria</th>
<th>FPPE</th>
<th>Approve</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Polysomnography (including sleep stage scoring)</td>
<td>Documentation of 400 in the last 2 years.</td>
<td>400 in the last 2 years.</td>
<td>Minimum of 20 cases concurrently</td>
<td></td>
</tr>
</tbody>
</table>

**ADDITIONAL PRIVILEGES**

(Must also meet the Criteria Above)

<table>
<thead>
<tr>
<th>Request</th>
<th>Procedure</th>
<th>Initial Criteria</th>
<th>Renewal Criteria</th>
<th>FPPE</th>
<th>Approve</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Administration of Moderate Sedation</td>
<td>Successful completion of Kaweah Health sedation exam</td>
<td>Successful completion of Kaweah Health sedation exam</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Percutaneous tracheostomy</td>
<td>Documentation of training and 10 procedures in the last 2 years</td>
<td>Minimum of 5 cases required in last 2 years</td>
<td>5 direct observation</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Fluoroscopy Privileges</td>
<td>Current and valid CA Fluoroscopy supervisor and Operator Permit or a CA Radiology Supervisor and Operator Permit</td>
<td>Current and valid CA Fluoroscopy supervisor and Operator Permit or a CA Radiology Supervisor and Operator Permit</td>
<td>None</td>
<td></td>
</tr>
</tbody>
</table>

**Acknowledgment of Practitioner:**

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

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

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

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

Signature: ________________________________________________________________      _________________  
Applicant  
Date

Signature: ________________________________________________________________      _________________  
Department of Critical Care, Pulmonology, Adult Hospitalist Medicine Chairman  
Date
These guidelines are for practitioners ordering repeat tests for patients suspected to be or infected with the COVID-19 virus. Tests may be processed through Kaweah Health Medical Center Lab, the Tulare county Public Health Lab (TCPHL), or a Commercial lab. Supplies of testing kits will be continuously monitored.

Repeat testing parameters:

- Allowed for **symptomatic** patients only IF the first test is negative
- If a patient’s first test is negative but there is strong suspicion of COVID-19 based on clinical presentation or recent exposure, the patient should be placed in appropriate precautions and re-tested as close to the first test as possible. Recommend retesting with a non-rapid molecular test (example: PCR).
  - PCR test results will supersede any ID-Now results.
- If a second COVID test is negative, subsequent diagnostic testing should be done at least 3 and 5 days after the first negative test(s)**symptoms**. Patient to remain in isolation if there continues to be a strong suspicion of COVID-19 until ruled out.

Follow up Testing on Prior Positive Persons:

- If a patient does not have a COVID-19 positive test on file and is here receiving COVID-19 care or in quarantine for COVID-19, they should be retested.
  - If a patient is not here for COVID-19 care and is post quarantine but within 390 days of their last positive test, they do not need to be retested.
- Repeat testing to determine release from quarantine is not approved except for patients being discharged to or at the Kaweah Health Mental Health Hospital (KMHM)
  - If a patient is requiring admission to the KMHM, is asymptomatic for COVID-19 and 7 days post their COVID-19 positive date, they may be retested for COVID-19 on an antigen platform. If the test is negative, be removed from quarantine.
- In all other circumstances, no additional COVID-19 testing is required for 390 days post-infection. Instead, use Time-Based or Symptom-Based strategies to determine resolution of infection (see attached flowcharts)
**Practitioners and Employees:**
Employee Health will use the Centers for Disease Control (CDC) recommended non-test based strategies for return to work clearance: Time-Based for asymptomatic and Symptomatic-Based for symptomatic COVID-19 positive healthcare personnel.

**References:**


"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."
Discontinuation of Transmission-Based Precautions and Disposition of Patient with COVID-19 in Healthcare Settings

Patient tested positive COVID-19

Patient Immunocompromised?

No

Mild/Moderate/Severe illness

At least 10 days have passed since symptoms first appeared or if asymptomatic 10 days have passed since positive test result

AND

At least 24 hours have passed since last fever without the use of fever reducing medications

AND

Improvement in respiratory symptoms (e.g., cough, shortness of breath)

Discontinue Isolation

Yes

Severely immunocompromised

At least 20 days have passed since symptoms first appeared

AND

At least 24 hours have passed since last fever without the use of fever reducing medications

AND

Improvement in respiratory symptoms (e.g., cough, shortness of breath)

AND

Test based strategy performed:
- At least 2 consecutive respiratory specimens collected ≥24 hours apart using antigen or PCR test (2 negative results clears the patient from isolation).
- Retest if symptoms worsen or return after ending isolation.
- If patient is persistently positive by PCR for >30 days recommend Infectious Disease Consult.

Note: Criteria depicted above is not required for discharge to home.
Discontinuation of Transmission-Based Precautions and Disposition of Patient with COVID-19 in Healthcare Settings

Patient tested positive COVID-19 → Patient Immunocompromised?

- Yes
  - Severe Immuno-compromised
    - At least 20 days have passed since symptoms first appeared
    - AND
      - At least 24 hours have passed since last fever without the use of fever reducing medications.
      - AND
      - Improvement in respiratory symptoms (e.g., cough, shortness of breath)
    - AND
    - Test based strategy performed:
      - At least 2 consecutive respiratory specimens collected 24 hours apart using antigen or PCR test (2 negative results clear the patient from isolation).
      - Retest if symptoms worsen or return after ending isolation.
      - If patient is persistently positive by PCR for >40 days recommend Infectious Disease Consult.

- No
  - Moderate/Severe Immuno-compromised
    - At least 10 days have passed since symptoms first appeared OR if asymptomatic 10 days have passed since positive test result.
    - AND
    - At least 24 hours have passed since last fever without the use of fever reducing medications.
    - AND
    - Improvement in respiratory symptoms (e.g., cough, shortness of breath)
  - Discontinue Isolation

*Severely immuno-compromised conditions include:
- Active treatment for solid tumor and hematologic malignancies.
- Hematologic malignancies associated with poor response to COVID-19 vaccines regardless of current treatment (e.g., chronic lymphocytic leukemia, non-Hodgkin lymphoma, multiple myeloma, acute leukemia).
- Receipt of solid-organ transplant or an allogeneic transplant and taking immunosuppressive therapy.
- Receipt of chimeric antigen receptor (CAR)-T cell therapy or hematopoietic cell transplant (HCT) (within 2 years of transplantation or taking immunosuppressive therapy).
- Moderate or severe primary immunodeficiency (e.g., common variable immunodeficiency disease, severe combined immunodeficiency, DiGeorge syndrome, Wiskott-Aldrich syndrome).
- Advanced HIV Infection (people with HIV and CD4 cell counts less than 200/mm3, history of an AIDS-defining illness without immune reconstitution, or clinical manifestations of symptomatic HIV) or untreated HIV infection.
- Active treatment with high-dose corticosteroids (i.e., 20mg or more of prednisone or equivalent per day when administered for 2 or more weeks), alkylating agents, antimetabolites, transplant-related immunosuppressive drugs, or other biologic agents that are immunosuppressive or immunomodulatory (e.g., B-cell depleting agents).

Note: Criteria depicted above is not required for discharge home.
Role of Testing after Discontinuation of Isolation Precautions and Role of Serologic Testing

Patient with positive COVID-19 history

Patient with symptomatic COVID-19 who remain asymptomatic after recovery? 

History of a positive serologic (antibody) test?

Patient with history of symptomatic COVID-19 who now presents with new symptoms consistent with COVID-19 during the 3-months after initial symptoms onset?

Yes

Retesting is not recommended within 3-months after symptom onset for the initial COVID-19 infection.

Isolate patient and consider Infectious Disease Consult

Serologic testing should not be used to establish the presence or absence of COVID-19 or reinfection

The algorithm above will be regularly revised to stay in line with professional and regulatory guidance.
Role of Testing after Discontinuation of Isolation Precautions and Role of Serologic Testing

Patient With Positive COVID-19 History

Patient with symptomatic COVID-19 who remain asymptomatic after recovery?

No

Yes

Retesting is not recommended within 3-months after symptom onset for the initial COVID-19 infection.

Patient with history of symptomatic COVID-19 who now presents with new symptoms consistent with COVID-19 during the 3-months after initial symptoms onset?

No

Yes

Isolate patient and consider Infectious Disease Consult

History of a positive serologic (antibody) test?

No

Yes

Serologic testing should not be used to establish the presence or absence of COVID-19 or reinfection

The algorithm above will be regularly revised to stay in line with professional and regulatory guidance.
December 21, 2023

Robert D. Bassett, Esq.
Quinlan,Kershaw & Fanucchi
2125 Merced St.
Fresno, CA 93721

RE: Notice of Rejection of Claim of Billy Byers vs. Kaweah Delta Health Care District

Notice is hereby given that the claim, which you presented to the Board of Directors of Kaweah Health on December 1, 2023, was rejected on its merits by the Board of Directors on December 21, 2023.

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,

Mike Olmos
Secretary/Treasurer, Board of Directors

cc: Richard Salinas, Attorney at Law
December 21, 2023

Robert D. Bassett, Esq.
Quinlan, Kershaw & Fanucchi
2125 Merced St.
Fresno, CA 93721

RE: Notice of Rejection of Claim of Mary Byers vs. Kaweah Delta Health Care District

Notice is hereby given that the claim, which you presented to the Board of Directors of Kaweah Health on December 1, 2023, was rejected on its merits by the Board of Directors on December 21, 2023.

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,

Mike Olmos
Secretary/Treasurer, Board of Directors

cc: Richard Salinas, Attorney at Law
Renal Services

Kaweah Health Dialysis Clinic and Inpatient Acute Dialysis

**KAWEAH HEALTH DIALYSIS CLINIC**
- 131 Hemodialysis Patients
- 16 Peritoneal Dialysis Patients
- 4 Kidney Transplants in 2022
- 3 Kidney Transplants in 2023
- 18,119 Hemodialysis Treatments in 2022
- 16,427 Hemodialysis Treatments in 2023 and still counting!
- 29 Dialysis Machines onsite
- 24 reclining chair stations and 2 isolation rooms
- 4 hospital beds for patients to use if medically indicated
- 2 private Peritoneal Dialysis treatment Rooms

**INPATIENT ACUTE DIALYSIS**
- 6 rooms located on 4 North where acute hemodialysis treatments are performed on medical surgical level of care patients
- Acute Dialysis Registered Nurses travel to critical care to perform hemodialysis treatments or set up and assist in maintaining Sustained Low Efficiency Dialysis (SLED)
- 8,254 Hemodialysis Treatments in 2022
- 6,667 Hemodialysis Treatment in 2023 and still counting!
- 17 Dialysis and Reverse Osmosis Machines
Quality and Performance Data

Patient Satisfaction Scores

- 24 patients completed the Patient Satisfaction Survey in Spring 2023
- Staff scored higher than benchmark in “Staff behaved professionally and “Staffed cared”
- Out of 32 questions, 15 scored higher than benchmark
- Low scores were discussed during Unit Based Council (UBC)
- Plans were developed and implemented to address any low scores

<table>
<thead>
<tr>
<th>Question Text</th>
<th>Benchmark</th>
<th>Kaweah Health Dialysis Center</th>
</tr>
</thead>
<tbody>
<tr>
<td>Center was clean</td>
<td>78.7%</td>
<td>79.2%</td>
</tr>
<tr>
<td>Connected to machine within 15 min</td>
<td>46.4%</td>
<td>52.2%</td>
</tr>
<tr>
<td>Doctors cared</td>
<td>66.7%</td>
<td>83.3%</td>
</tr>
<tr>
<td>Doctors explained things understandably</td>
<td>63.9%</td>
<td>82.6%</td>
</tr>
<tr>
<td>Doctors listened carefully</td>
<td>65.8%</td>
<td>87.5%</td>
</tr>
<tr>
<td>Doctors showed respect</td>
<td>71.9%</td>
<td>91.7%</td>
</tr>
<tr>
<td>Doctors spent enough time</td>
<td>53.5%</td>
<td>73.9%</td>
</tr>
<tr>
<td>Doctors up to date about care from other doctors</td>
<td>88.5%</td>
<td>91.3%</td>
</tr>
<tr>
<td>Doctors/staff talked about peritoneal dialysis</td>
<td>65.8%</td>
<td>70.8%</td>
</tr>
<tr>
<td>Doctors/staff talked about what treatment was right</td>
<td>85.8%</td>
<td>91.7%</td>
</tr>
<tr>
<td>Felt comfortable asking about dialysis care</td>
<td>94.5%</td>
<td>95.8%</td>
</tr>
<tr>
<td>Involved as much as wanted in choosing treatment</td>
<td>88.3%</td>
<td>95.0%</td>
</tr>
<tr>
<td>Know how to take care of dialysis connection method</td>
<td>94.3%</td>
<td>95.0%</td>
</tr>
<tr>
<td>Rate center</td>
<td>78.4%</td>
<td>91.7%</td>
</tr>
<tr>
<td>Rate kidney doctors</td>
<td>65.5%</td>
<td>82.3%</td>
</tr>
<tr>
<td>Rate staff</td>
<td>77.6%</td>
<td>95.8%</td>
</tr>
<tr>
<td>Staff behaved professionally</td>
<td>75.7%</td>
<td>91.7%</td>
</tr>
<tr>
<td>Staff cared</td>
<td>70.5%</td>
<td>91.3%</td>
</tr>
<tr>
<td>Staff checked on patient as closely as wanted</td>
<td>67.4%</td>
<td>79.2%</td>
</tr>
<tr>
<td>Staff discussed diet</td>
<td>91.9%</td>
<td>91.7%</td>
</tr>
<tr>
<td>Staff explained blood test results understandably</td>
<td>66.7%</td>
<td>83.3%</td>
</tr>
<tr>
<td>Staff explained things understandably</td>
<td>68.2%</td>
<td>87.5%</td>
</tr>
<tr>
<td>Staff explained what to do if problems at home</td>
<td>86.2%</td>
<td>87.5%</td>
</tr>
</tbody>
</table>
Quality and Performance Data

KT/V Scores

<table>
<thead>
<tr>
<th></th>
<th>Goal 2021</th>
<th>Actual 2021</th>
<th>Goal 2022</th>
<th>Actual 2022</th>
<th>Goal 2023</th>
<th>Actual 2023</th>
</tr>
</thead>
<tbody>
<tr>
<td>%KT/V &gt; 1.2</td>
<td>97.61%</td>
<td>95.66%</td>
<td>97.61%</td>
<td>96.43%</td>
<td>97.61%</td>
<td>97.66%</td>
</tr>
</tbody>
</table>

- KT/V measures how well a patient is being dialyzed
- This is measured each month for each patient
- Our dialysis team monitor patients labs and work closely with nephrologists to adjust prescriptions to ensure treatments are adequate
- An interdisciplinary care team meets weekly to discuss patients who are not meeting their KT/V goals
- The interdisciplinary team consists of dietician, registered nurse and a social worker to ensure the best care is provided to our patients
Quality and Performance Data

Fistula and Catheter Rate

<table>
<thead>
<tr>
<th></th>
<th>Goal 2021</th>
<th>Actual 2021</th>
<th>Goal 2022</th>
<th>Actual 2022</th>
<th>Goal 2023</th>
<th>Actual 2023</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fistula Rate</td>
<td>62%</td>
<td>53.46%</td>
<td>62%</td>
<td>54.48%</td>
<td>62%</td>
<td>56.49%</td>
</tr>
<tr>
<td>Long term Catheter Rate (Greater than 90 days)</td>
<td>17%</td>
<td>24.39%</td>
<td>17%</td>
<td>23.83%</td>
<td>17%</td>
<td>22.32%</td>
</tr>
</tbody>
</table>

- We continue to struggle with meeting our fistula and long term catheter goals
- Reasons are
  - Vascular surgery availability
  - Patient preference
  - Nephrologist preference for patient
Quality and Performance Data

Bloodstream Infections

- Patients receiving dialysis are at a greater risk for blood stream infection than the general population
- To ensure our team is utilizing best practices the Nurse Manager completes audits each month
- The audits include observations of hand hygiene compliance, medication preparation and administration and central venous access site care
- Results are discussed during the monthly Quality Assessment and Performance Improvement (QAPI) meeting

<table>
<thead>
<tr>
<th>BSI Infection Ratio (SIR)</th>
<th>Goal 2021</th>
<th>Actual 2021</th>
<th>Goal 2022</th>
<th>Actual 2022</th>
<th>Goal 2023</th>
<th>Actual 2023</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0</td>
<td>2.679</td>
<td>0</td>
<td>2.340</td>
<td>0</td>
<td>1.334</td>
</tr>
</tbody>
</table>

235/266
The Dialysis Clinic has its own robust Quality Assessment and Performance Improvement (QAPI) Program
Meets monthly at Dialysis Clinic
90 different quality data indicators are discussed for Hemodialysis
50 different quality data indicators are discussed for Peritoneal Dialysis
If a goal is not met further evaluation is completed to see what needs to be done to correct the fall out.
Policy, Strategic or Tactical Issues

Working to Increase Patient Census

• Partnered with Physician Recruitment and Relation Team to make office visits at our local nephrologist office
• Created a Kaweah Health Dialysis Clinic Patient Referral Form
• Peritoneal Dialysis Nurses evaluate all hemodialysis patients to see if Peritoneal Dialysis would be an option
• Created a flyer with marketing to post on 4 North and add to welcome folder for all patients on 4 North
Policy, Strategic or Tactical Issues

Clarity- Electronic Medical Record

- Clarity does not interface well with Soarian Financials
- Charges are incorrect or missing when they interface from Clarity to Soarian Financials
- Currently we are performing manual audits and manually entering in missing or incorrect charges
- Work group created with dialysis clinic team, revenue cycle and finance team members collaborating on fallout opportunities
- Requesting new electronic medical record
Policy, Strategic or Tactical Issues

Employee Engagement and Retention

- Celebrate Nephrology Nurses Week in September
- Celebrate Certified Hemodialysis Technician Week in October
- Focus on top opportunities from last Employee Engagement Pulse Survey
- Improve Employee Communication by Weekly Updates and Daily Safety Huddles
Conclusion

Plan for future...

- Strive for overall quality outcomes and set goals to continue to improve
- Increase peritoneal dialysis and hemodialysis patient volumes
- Monitor patient to nurse assignments to ensure productive ratios are maintained
- Evaluate and request new electronic medical record for dialysis clinic with third party billing to eliminate interface with Soarian Financials
- Evaluate hemodialysis standards in care to make appropriate pharmaceutical decisions for patients and clinic
The pursuit of healthiness
FY 2024 Strategic Plan
Strategic Growth and Innovation
December 21, 2023
Objective: Develop and Implement Strategies and Practices to Recruit and Retain Providers.

Plan

<table>
<thead>
<tr>
<th>#</th>
<th>Level</th>
<th>Name</th>
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<th>Status</th>
<th>Last Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1.1</td>
<td>Objective</td>
<td>Develop New Recruitment Strategy for Top Physician Needs</td>
<td>07/01/2023</td>
<td>06/30/2024</td>
<td>JC Palermo</td>
<td>On Track</td>
<td>Along with the completion of a new Physician Needs Assessment report, the prioritization of specialty recruitments is being guided by the projects outlined by the Strategic Growth Committee.</td>
</tr>
<tr>
<td>3.1.1.1</td>
<td>Outcome</td>
<td>Recruit 5 Primary Care Physicians</td>
<td>07/01/2023</td>
<td>06/30/2024</td>
<td>JC Palermo</td>
<td>On Track</td>
<td>Dr. Rafael Martinez will be starting at the Ben Maddox clinic, full-time, starting 1/8/24. Offers are out to 3 Kaweah Health PGY3 Residents and recruitment efforts are underway.</td>
</tr>
<tr>
<td>3.1.1.2</td>
<td>Outcome</td>
<td>Recruit 15 Specialty Physicians</td>
<td>07/01/2023</td>
<td>06/30/2024</td>
<td>JC Palermo</td>
<td>On Track</td>
<td>Specialties physicians recruited to date include: Anesthesiologist, Neonatologist, Pediatric Hospitalist, Hospice/Palliative Care, and Cardiothoracic surgery. Offers are out to the following specialties: Neurologist x2, Endocrinologist, Pulmonologist.</td>
</tr>
</tbody>
</table>

Number of Primary Care Physicians Recruited

Number of Specialty Physicians Recruited
Objective: Increase Inpatient and Surgical Volumes in Targeted Areas.

<table>
<thead>
<tr>
<th>Plan</th>
<th>Level</th>
<th>Name</th>
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</tr>
</thead>
<tbody>
<tr>
<td>3.2.1.1</td>
<td>Outcome</td>
<td>Increase the Percentage of Coronary Artery Bypass Graph Surgery Cases that are Elective</td>
<td>07/01/2023</td>
<td>06/30/2024</td>
<td>Lori Mulliniks</td>
<td>Off Track</td>
<td>Dropped due to November holiday.</td>
</tr>
<tr>
<td>3.2.2.1</td>
<td>Outcome</td>
<td>Increase Number of Urology Surgery Cases</td>
<td>07/01/2023</td>
<td>06/30/2024</td>
<td>Kevin Bartel</td>
<td>Off Track</td>
<td>FYTD 2024 through October (4 months) has shown a 36% increase in IP Urology surgery volume compared with this same time frame in FYTD 2023. The primary barrier to additional IP surgeries continues to be limited on-call Urology coverage at Kaweah (40-50%) each month.</td>
</tr>
<tr>
<td>3.2.2.2</td>
<td>Outcome</td>
<td>Decrease Urology Cases Transferred out of Kaweah Health</td>
<td>07/01/2023</td>
<td>06/30/2024</td>
<td>Kevin Bartel</td>
<td>On Track</td>
<td>FYTD 2024 through November (5 months), there have been a total of 22 Urology cases that were transferred out of Kaweah Health due to the reason of &quot;Specialist not available&quot;, which is indicative of our lack of full-time Urology call coverage at Kaweah currently.</td>
</tr>
</tbody>
</table>

Increase the Percentage of Elective Coronary Artery Bypass Graph Surgeries

Increase Urology Surgery Cases by 20% from FY 2023 Volumes

Decrease the Number of Urology Cases Transferred out of Kaweah Health in FY 2024 by 40%
**Objective:** *Increase Outpatient Services and Volumes by Focusing on Targeted Areas for Expansion and Growth.*

### Plan

<table>
<thead>
<tr>
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<th>Due Date</th>
<th>Assigned To</th>
<th>Status</th>
<th>Last Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.3.1.1</td>
<td>Outcome</td>
<td>Open 202 Willow Clinic (Employee Clinic, Commercial, Walk In and Employee Wellness Programs)</td>
<td>05/01/2023</td>
<td>10/13/2023</td>
<td>Ivan Jara</td>
<td>Off Track</td>
<td>Recruitment in progress</td>
</tr>
<tr>
<td>3.3.1.2</td>
<td>Outcome</td>
<td>Open Industrial Park Clinic (Occupational Medicine)</td>
<td>10/31/2022</td>
<td>09/29/2023</td>
<td>Ivan Jara</td>
<td>Achieved</td>
<td>Clinic has opened.</td>
</tr>
<tr>
<td>3.3.1.3</td>
<td>Outcome</td>
<td>Open a Youth Crisis Stabilization Unit</td>
<td>07/01/2023</td>
<td>05/01/2024</td>
<td>Melissa Quinonez</td>
<td>On Track</td>
<td>We are finalizing the provider agreement and financial terms. We need to verify equipment and furniture costs. Need to review plans to determine if age groups can be separated due to grant covering youth up to age 21. Cannot treat minors in the same area as adults.</td>
</tr>
<tr>
<td>3.3.1.4</td>
<td>Outcome</td>
<td>Increase Monthly Endoscopy Case Volume</td>
<td>07/01/2023</td>
<td>06/30/2024</td>
<td>Lori Mulliniks</td>
<td>At Risk</td>
<td>Although we are above our goal of 350, we need to understand that 67.9% of that volume is performed by VMC providers, with 25.3% provided by Dr. Ota, 18.7% by Dr. Hsueh and 16.0% by Dr. Pua. A recruitment strategy needs to be implemented.</td>
</tr>
</tbody>
</table>

**Increase Monthly Endoscopy Case Volume**

![Graph showing the increase in monthly endoscopy case volume from July 2023 to November 2023.](image-url)
### Innovation  
**Champion: Jacob Kennedy**

**Objective: Implement and Optimize Innovative Technological Solutions.**

<table>
<thead>
<tr>
<th>#</th>
<th>Level</th>
<th>Name</th>
<th>Start Date</th>
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<th>Assigned To</th>
<th>Status</th>
<th>Last Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.4.1.1</td>
<td>Outcome</td>
<td>Increase Volume of Text Messages to Patients as a Percent of Total Call Volume</td>
<td>07/01/2023</td>
<td>06/30/2024</td>
<td>Jacob Kennedy</td>
<td>On Track</td>
<td>We saw a decrease in inbound text volume from October to November by 2200 text messages. Call Volumes increased slightly bringing the overall percentage down. We have our hold music updated now to state that patients can text as opposed to waiting on hold, and as more patients here this, we should see this percentage increase.</td>
</tr>
<tr>
<td>3.4.1.2</td>
<td>Outcome</td>
<td>Reduce the Patient Call Abandonment Rate</td>
<td>07/01/2023</td>
<td>06/30/2024</td>
<td>Jacob Kennedy</td>
<td>Off Track</td>
<td>We had an increase in call volume, primarily due to flu season. This has started to impact our team that is three FTEs short plus sick calls. We have started to use Patient Navigation Specialists who are cross trained on both referrals and call center scheduling, and this will help as the staff ramp up.</td>
</tr>
<tr>
<td>3.4.1.3</td>
<td>Outcome</td>
<td>Reduce the Average Hold Time for Patients (in seconds)</td>
<td>07/01/2023</td>
<td>06/30/2024</td>
<td>Jacob Kennedy</td>
<td>Off Track</td>
<td>As stated above, with increase call volume and reduced staffing levels, our hold times have increased. We are working on adding staff and ramping up our Patient Navigation Specialists to have more staff on the phones to decrease hold times.</td>
</tr>
<tr>
<td>3.4.1.4</td>
<td>Outcome</td>
<td>Reduce the Time to Receive Authorization Approval (in days)</td>
<td>11/01/2023</td>
<td>06/30/2024</td>
<td>Jacob Kennedy</td>
<td>Off Track</td>
<td>We are taking 4 days to process a new referral and send to the healthplan for authorization. The healthplans are taking roughly 5 days to reach a decision on authorizations. We have started to use the Valer (Referrals management software) platform to manage referrals, however are not fully integrated with this yet. We hope to have this completed by May 2024. In the meantime, we are performing a manual process which has not yet show the benefits of quicker response times for authorizations.</td>
</tr>
<tr>
<td>3.4.1.5</td>
<td>Outcome</td>
<td>Reduce the Time From Referral to Scheduled Appointment (in days)</td>
<td>11/01/2023</td>
<td>06/30/2024</td>
<td>Jacob Kennedy</td>
<td>Off Track</td>
<td>We are taking 4 days to process a new referral and send to the healthplan for authorization. The healthplans are taking roughly 5 days to reach a decision on authorizations. From there, the referral is forwarded to the specialist for scheduling. We have started to use the Valer (Referrals management software) platform to manage referrals, however are not fully integrated with this yet. We hope to have this completed by May 2024. In the meantime, we are performing a manual process which has not yet show the benefits of quicker scheduling times.</td>
</tr>
<tr>
<td>3.4.1.6</td>
<td>Outcome</td>
<td>Increase the Percent of Telehealth Visits vs Face to Face Visits</td>
<td>07/01/2023</td>
<td>06/30/2024</td>
<td>Jacob Kennedy</td>
<td>Off Track</td>
<td>We saw a slight increase in overall telehealth visits as a percentage of all visits. We continue to ramp up Exeter providers, providing access and training to Amwell. We next need to discuss how to further integrate telehealth visits into our normal patient care model moving forward. We have a plan to start a team in 2024 that will start to map this out.</td>
</tr>
</tbody>
</table>
Increase Volume of Text Messages to Patients as a Percent of Total Call Volume

Baseline | Target
--- | ---
0% | 0%
5% | 0%
12% | 12%
12.2% | 12.2%
12.4% | 12.4%
17% | 17%
20% | 20%

Reduce the Patient Call Abandonment Rate

Baseline | Target
--- | ---
21% | 10%
22% | 22%
22% | 22%
27% | 27%
27% | 27%
30.8% | 30.8%
30.8% | 30.8%
17.9% | 17.9%
17.9% | 17.9%
23.5% | 23.5%
23.5% | 23.5%

Reduce the Average Hold Time for Patients (in seconds)

Baseline | Target
--- | ---
245 | 120
229 | 229
229 | 229
306 | 306
306 | 306
325 | 325
154 | 154
211 | 211

Reduce the Time to Receive Authorization Approval (in days)

Baseline | Target
--- | ---
10 | 5
9 | 5

Reduce the Time From Referral to Scheduled Appointment (in days)

Baseline | Target
--- | ---
5 | 5

Increase the Percent of Telehealth Visits vs Face to Face Visits

Baseline | Target
--- | ---
12% | 22%
12.6% | 15.1%
12.2% | 13.1%
12.4% | 10.3%
17% | 11%
Health Plan & Community Partnerships  Champions: Marc Mertz and Sonia Duran Aguilar

Objective: Expand Existing and Develop New Partnerships with Community Partners and Healthplans.

<table>
<thead>
<tr>
<th>#</th>
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<th>Name</th>
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</tr>
</thead>
<tbody>
<tr>
<td>3.5.1.1</td>
<td>Outcome</td>
<td>Develop a Plan for Gateway Partnerships, Including Financial Projections and Approval by the Board</td>
<td>07/01/2023</td>
<td>06/30/2024</td>
<td>Marc Mertz</td>
<td>On Track</td>
<td>Financial feasibility study for an ambulatory surgery center is underway and should be completed in January.</td>
</tr>
<tr>
<td>3.5.1.2</td>
<td>Outcome</td>
<td>Cal AIM: Increase Enrollment in Enhanced Care Management</td>
<td>07/01/2023</td>
<td>06/30/2024</td>
<td>Sonia Duran-Aguilar</td>
<td>On Track</td>
<td>We continue to grow the program. Currently at Capacity with ECM given recent staff transitions. Will begin posting Community Care Coordinators funded through the PATH CITED Round 2 Funds ($1.2M). 9 Net new CCC will be added to the team in 2024 and enrollment goals will increase.</td>
</tr>
<tr>
<td>3.5.1.3</td>
<td>Outcome</td>
<td>Cal AIM: Increase Enrollment in Community Supports</td>
<td>07/01/2023</td>
<td>06/30/2024</td>
<td>Sonia Duran-Aguilar</td>
<td>On Track</td>
<td>We continue to grow the program. Currently at Capacity with CS. Will begin posting Community Care Coordinators funded through the PATH CITED Round 2 Funds ($1.2M). 2 Net new CCC will be added to the Community Supports team in 2024 and enrollment goals will increase.</td>
</tr>
</tbody>
</table>
KAWEAH DELTA HEALTH CARE DISTRICT
BOARD OF DIRECTORS MEETING
THURSDAY DECEMBER 21, 2023

HOLDING SPOT FOR PROVIDER NEEDS ASSESSMENT
KAWEAH DELTA HEALTH CARE DISTRICT
BOARD OF DIRECTORS MEETING
THURSDAY DECEMBER 21, 2023

HOLDING SPOT FOR FINANCIAL STATEMENT
December 11, 2023

David Jason, Vice President
US Bank Trust Company, National Association
One California Street, Suite 1000
San Francisco, CA 94111

Malinda Tupper, V.P. & Chief Financial
Kaweah Delta Health Care District
400 West Mineral King Avenue
Visalia, California 93291

Re: Independent Consultant Report

Dear Mr. Jason and Ms. Tupper,

We have been engaged to review and evaluate compliance by Kaweah Delta Health Care District (the “District”) concerning compliance with the Long-Term Debt Service Coverage Ratio (“DSCR”) and Days Cash on Hand (“DCOH”) covenants contained in its $19,361,000 Kaweah Delta Health Care District Revenue Refunding Bonds, Series 2015A, $98,425,000 Kaweah Delta Health Care District Revenue Bonds, Series 2015B, $59,511,000 Kaweah Delta Health Care District Revenue Refunding Bonds, Series 2017C, $6,800,000 Kaweah Delta Health Care District Revenue Bonds, Series 2020A, $8,200,000 Kaweah Delta Health Care District Revenue Bonds, Series 2020B, and $32,035,000 Kaweah Delta Health Care District Revenue Refunding Bonds, Series 2022 (collectively, the “Bonds”). Our review did not include an examination of any other covenants for the Bonds. We have completed a review and evaluation of the District’s unaudited financial report for the fiscal year ending June 30, 2023, internally prepared financial statements for the three months ended Sept 30, 2023, the District’s operating budget for the fiscal year ended June 30, 2024, and the resulting impact on its DSCR and DCOH covenants. Following is a summary of our review and evaluation process and a description of our recommendations that we believe will improve the District’s DSCR and DCOH ratios in an effort to meet its covenants in the future, as calculated pursuant to the District’s 1999 Indenture, the First Supplemental Indenture, the Second Supplemental Indenture, the Third Supplemental Indenture, the Fourth Supplement, the Fifth Supplemental Indenture, the Sixth Supplemental Indenture, the Seventh Supplemental Indenture, the Eighth Supplemental Indenture, the Ninth Supplemental Indenture, the Tenth Supplemental Indenture, the Eleventh Supplemental Indenture, the Twelfth Supplemental Indenture, and the Amendment to Indenture dated November 1, 2022 (collectively, the “Indenture”).

Overview:
This Independent Consultant’s Report is being prepared in compliance with Sections 6.03(b) and 6.09 of the 1999 Indenture relating to the Bonds as amended by Section 5.01 of the First Supplemental Indenture, by Section 6.01 of the Fifth Supplemental Indenture and by Section 3(vii) of the Amendment to Indenture dated November 1, 2022. The District failed to meet its DSCR and DCOH covenants for the fiscal year ended June 30, 2023 and as of June 30, 2023, respectively (actual DSCR of -.51 versus the target DSCR covenant of 1.10 and actual DCOH of 78.3 vs the target DCOH of 90). The DSCR covenant is defined in Section 6.03(b) of the 1999 Indenture as amended by Section 3(vii) of the Amendment to Indenture dated November 1, 2022, as follows:

Section 3(vii) of the Amendment to Indenture states that Section 6.03(b) of the Indenture is hereby amended and restated in its entirety as follows:

Within one hundred and fifty (150) days after the end of each Fiscal Year, the District shall compute, or cause to be computed, the Long-Term Debt Service Coverage Ratio for such Fiscal Year and promptly furnish to the Trustee a Certificate setting forth the results of such computation. The District further covenants and agrees that if in such Fiscal Year the Long-Term Debt Service Coverage Ratio shall have been less than 1.25:1.0 (or 1.10:1.0 so long as Days Cash on Hand as of the end of such Fiscal Year are at least seventy-five (75) days), it will promptly employ an Independent Consultant to make recommendations as to a revision of the rates, fees and charges or the methods of operations of the District which will result in producing Long-Term Debt Service Coverage Ratio at least equal to 1.25:1.0 (or 1.10:1.0, as the case may be) in the current Fiscal Year. Copies of the recommendations of the Independent Consultant shall be filed by the District with the Trustee and the initial underwriter of the Series 199A Bonds. The District shall, promptly upon its receipt of such recommendations, subject to applicable requirements or restrictions imposed by law, revise its rates, fees and charges or its methods of operation and shall take such other action as shall be in conformity with such recommendations; provided, that the District shall not be required to take any action if the District files with the Trustee and the initial underwriter of the Bonds a certified copy of a resolution of the District Board to the effect that the District Board has determined in good faith that such recommendations, in whole or in part, are not in the best interests of the District. In the event that the District shall fail to comply with the recommendations of the Independent Consultant, the District shall notify the Trustee and, subject to applicable requirements or restrictions imposed by law and the proviso of the preceding sentence, the Trustee may, in addition to the rights and remedies elsewhere set forth herein, institute and prosecute an action or proceeding in any court or before any board or commission having jurisdiction to compel the District to comply with the recommendations and requirements of this subsection (b). If the District complies and continues in all material respects with the recommendations of the Independent Consultant in respect to said rates, fees, charges and methods of operation and the Long-Term Debt Service Coverage Ratio (as projected by the Independent Consultant in its recommendations as to rates, fees and charges or the methods of operations of the District) is not less than 1.0:1.0 in any Fiscal Year the District will be deemed to have complied with the covenants contained in this Section for such Fiscal Year or Fiscal Years notwithstanding that the Long-Term Debt Service Coverage Ratio shall be less than 1.25:1.0 (or 1.10:1.0, as the case may be); provided that this sentence shall not be construed as in any way excusing the District from taking any action or performing any duty required under this Indenture or be construed as constituting a waiver of any other Event of Default.
The DCOH covenant is defined in Section 6.09 of the 1999 Indenture as amended by Section 6.01 of the Fifth Supplemental Indenture dated May 1, 2011, as follows:

Section 6.01 of the Fifth Supplemental Indenture states that Section 6.09 of the 1999 Indenture is hereby amended and effective immediately to read in its entirety which Section was further amended by the Amendment to Indenture as follows:

Within one hundred and fifty (150) days after the end of each Fiscal Year, the District will calculate Days Cash on Hand as of the end of such Fiscal Year and furnish to the Trustee a certificate setting forth the results of such computation. If Days Cash on Hand at the end of any Fiscal Year is less than ninety (90) days for such period, it will promptly employ an Independent Consultant to make recommendations as to a revision of the rates, fees and charges or the methods of operations of the District which will result in producing Days Cash on Hand at least equal to ninety (90) days for the then-current Fiscal Year. Copies of the recommendations of the Independent Consultant shall be filed by the District with the Trustee. The District shall, promptly upon its receipt of such recommendations, subject to applicable requirements or restrictions imposed by law, revise its rates, fees and charges or its methods of operations and shall take such action in conformity with such recommendations; provided, that the District shall not be required to take any such action if the District files with the Trustee a certified copy of a resolution of the District to the effect that the District has determined in good faith that such recommendations, in whole or in part, are not in the best interests of the District. In the event that the District shall fail to comply with the recommendations of the Independent Consultant, the District shall notify the Trustee, subject to the applicable requirements or restrictions imposed by law and the proviso of the preceding sentence, and the Trustee may, in addition to the rights and remedies elsewhere set forth herein, institute and prosecute an action or proceeding in any court or before any board or commission having jurisdiction to compel the District to comply with the recommendations and requirements of this section. If the District complies in all material respects with the recommendations of the Independent Consultant with respect to said rates, fees, charges and methods of operations, the District will be deemed to have complied with the covenants contained in this Section for such period notwithstanding that Days Cash on Hand shall be less than ninety (90) days; provided that this sentence shall not be construed in any way excusing the District from taking any action or performing any duty required under this Indenture or be construed as constituting a waiver of any other Event of Default.

Calculation of Days’ Cash on Hand for the District:

The District has covenanted to conduct its business such that is DCOH is not less than 90 days cash on hand. The DCOH as of June 30, 2023 is calculated as follows:
Calculation of Long-Term Debt Service Coverage Ratio

The result of the District’s DCOH being greater than 75 as of June 30, 2023, its covenant relating to Long-Term Debt Coverage Ratio is 1.10:1.0. The DSCR for the fiscal year ended June 30, 2023, is calculated as follows:

<table>
<thead>
<tr>
<th>6/30/2023</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Income before Capital Contributions</td>
<td>$ (47,218,000)</td>
</tr>
<tr>
<td>General Obligation Bond Tax Revenue</td>
<td>(3,515,000)</td>
</tr>
<tr>
<td>Depreciation and Amortization</td>
<td>32,649,500</td>
</tr>
<tr>
<td>Interest Expense</td>
<td>8,806,300</td>
</tr>
<tr>
<td>Income Available to Meet Debt Service</td>
<td>($9,277,200)</td>
</tr>
<tr>
<td>Maximum Annual Debt Service</td>
<td>$ 18,314,143</td>
</tr>
<tr>
<td>Debt Service Coverage Ratio</td>
<td>-0.51 x</td>
</tr>
</tbody>
</table>

As a result of the District not meeting its DCOH and DSCR covenants, it is required to hire an Independent Consultant to review operations and remedies to improve financial performance and restore the ability to meet set covenants. This report reflects the Independent Consultants review and contains both comments on the state of current operations, the mitigating measures taken to date and its recommendation of future initiatives to restore and maintain fiscal health for the District.

Review and Evaluation Process

- Reviewed relevant (DCOH and DSCR) covenants, historical compliance, and trended performance.
- Phone and on-site interviews with management team to gain understanding on recent downturn in financial performance and status of performance improvement plan (the “PIP”) which was initiated in late FY22.
• Evaluate the key PIP initiatives, measuring the level of achievement to date, ongoing efforts, affiliated costs, and timeline for achievement. Evaluation of the PIP included:
  o Labor/productivity – analysis of key metrics associated with labor initiatives, married to volume levels to make sure changes in expense are true gains vs right sizing with volume changes. Test sustainability of new staffing levels / use of contract labor. Consider the impact on outer years of nursing program investment of insure adequate pipeline of clinicians.
  o Closing/restructuring services: examined service line historical profit and loss of impacted services. Considered onetime costs verses ongoing cost reductions, impact on potential downstream revenue and perhaps benefit of backfilling space with new services.
  o Revenue cycle: tested the key metrics associated with the plan improvements and performed a sensitivity analysis on expected achievement levels.
  o Supplies/contracted services: reviewed the work plan and use analytics to test feasibility, level of achievement to date, and potential future improvements.
  o Analysis of District’s average length of stay vs. expected, quantify potential future financial benefit.
  o Review other growth initiatives to help develop service line growth over the next several years.
• Developed a basic baseline 5-year forecast prior to PIP initiatives, with the goal of being able to accurately quantify the prospects of meeting debt covenants over time. This was needed to help to sort out what recent changes were anomalies versus the new normal (impacts of COVID pandemic has made this a needed analysis).
• Reviewed current debt schedules.
• Reviewed multiyear capital expense schedule (routine + major items).

**Reasons for Failure to Meet the Long-Term Debt Service Coverage Ratio Target Covenants:**

<table>
<thead>
<tr>
<th>Year</th>
<th>Income before Capital Contributions</th>
<th>General Obligation Bond Tax Revenue</th>
<th>Depreciation and Amortization</th>
<th>Interest Expense</th>
<th>Income Available to Meet Debt Service</th>
<th>Maximum Annual Debt Service</th>
<th>Debt Service Coverage Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>2017</td>
<td>$18,767,021</td>
<td>(3,033,657)</td>
<td>23,508,988</td>
<td>7,005,759</td>
<td>$46,248,111</td>
<td>$16,076,913</td>
<td>2.9</td>
</tr>
<tr>
<td>2018</td>
<td>$27,352,911</td>
<td>(3,197,739)</td>
<td>25,680,969</td>
<td>6,374,753</td>
<td>$56,210,894</td>
<td>15,709,671</td>
<td>3.6</td>
</tr>
<tr>
<td>2020</td>
<td>($7,651,000)</td>
<td>(3,330,000)</td>
<td>30,678,000</td>
<td>7,411,000</td>
<td>$27,108,000</td>
<td>16,967,599</td>
<td>1.6</td>
</tr>
<tr>
<td>2021</td>
<td>$12,414,000</td>
<td>(3,430,000)</td>
<td>31,646,000</td>
<td>8,407,000</td>
<td>$49,037,000</td>
<td>16,967,599</td>
<td>2.9</td>
</tr>
<tr>
<td>2022</td>
<td>($14,332,000)</td>
<td>(3,703,000)</td>
<td>32,882,000</td>
<td>8,881,000</td>
<td>$23,728,000</td>
<td>17,559,131</td>
<td>1.35</td>
</tr>
<tr>
<td>2023</td>
<td>($47,218,000)</td>
<td>(3,515,000)</td>
<td>32,649,500</td>
<td>8,806,300</td>
<td>($9,277,200)</td>
<td>$ 18,314,143</td>
<td>-0.51 x</td>
</tr>
</tbody>
</table>

Prior to the COVID pandemic, the District was financially stable, and like most other businesses, COVID brought unique challenges to the District. The information above shows a $50M to $60M annual decline in net income for the years FY20-23. This loss includes stimulus/special supplemental funding from the Federal Government/HRSA for this same period.

The challenges presented by the pandemic affected most areas of the District’s business operations. Key challenges:

- Profitability was negatively impacted by new patient needs/volumes associated with COVID replacing the more historically profitable services (elective surgeries), and continued migration of services from inpatient to outpatient settings.
• Labor costs increased dramatically due to loss of key physicians, nurses, and other clinicians. More use of overtime, extended shifts and traveler/contract nurses and clinicians was used to meet the growing needs. Use of contract labor accounted for the largest area of increase, accounting for roughly a $35-40M increase in spending over historical levels in FY23.

• Supply costs/general inflation increases have risen faster than increases in revenue rates as disruptions in supply chain resulted in a rapid increase in costs FY21-23.

• Costs of all services rose faster than historical trend factors.

Below are trended annual financial statements for the District, which show the large increases in Contract Labor, Medical and Other Fees, and Other Expenses.

<table>
<thead>
<tr>
<th>Actual Results, in 000's</th>
<th>2019</th>
<th>2020</th>
<th>restated 2021</th>
<th>restated 2022</th>
<th>2023</th>
</tr>
</thead>
<tbody>
<tr>
<td>OPERATING REVENUE:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net patient service revenue</td>
<td>$638,382</td>
<td>$614,435</td>
<td>$652,256</td>
<td>$710,723</td>
<td>$693,157</td>
</tr>
<tr>
<td>Other revenue</td>
<td>113,191</td>
<td>119,913</td>
<td>124,062</td>
<td>146,591</td>
<td>157,022</td>
</tr>
<tr>
<td>Total operating revenue</td>
<td>751,573</td>
<td>734,348</td>
<td>776,318</td>
<td>857,314</td>
<td>850,179</td>
</tr>
<tr>
<td>OPERATING EXPENSES:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Salaries and wages</td>
<td>289,671</td>
<td>310,423</td>
<td>326,062</td>
<td>352,108</td>
<td>338,996</td>
</tr>
<tr>
<td>Contract Labor (1)</td>
<td>14,997</td>
<td>9,767</td>
<td>9,778</td>
<td>41,435</td>
<td>49,160</td>
</tr>
<tr>
<td>Employee benefits</td>
<td>73,618</td>
<td>74,552</td>
<td>56,356</td>
<td>64,895</td>
<td>76,349</td>
</tr>
<tr>
<td>Total employment expenses</td>
<td>378,286</td>
<td>394,742</td>
<td>392,196</td>
<td>458,438</td>
<td>464,505</td>
</tr>
<tr>
<td>Medical and other supplies</td>
<td>141,150</td>
<td>148,816</td>
<td>162,660</td>
<td>162,631</td>
<td>166,010</td>
</tr>
<tr>
<td>Medical and other fees (1)</td>
<td>89,814</td>
<td>97,632</td>
<td>103,440</td>
<td>114,783</td>
<td>109,917</td>
</tr>
<tr>
<td>Purchased services</td>
<td>40,781</td>
<td>44,088</td>
<td>54,533</td>
<td>58,208</td>
<td>62,356</td>
</tr>
<tr>
<td>Repairs and maintenance</td>
<td>25,901</td>
<td>25,516</td>
<td>26,155</td>
<td>26,936</td>
<td>25,824</td>
</tr>
<tr>
<td>Utilities</td>
<td>5,723</td>
<td>6,085</td>
<td>7,495</td>
<td>9,277</td>
<td>10,287</td>
</tr>
<tr>
<td>Rents and leases</td>
<td>6,119</td>
<td>6,373</td>
<td>1,960</td>
<td>1,688</td>
<td>1,818</td>
</tr>
<tr>
<td>Depreciation and amortization</td>
<td>30,851</td>
<td>30,678</td>
<td>36,009</td>
<td>38,905</td>
<td>40,031</td>
</tr>
<tr>
<td>Other</td>
<td>13,285</td>
<td>15,537</td>
<td>14,292</td>
<td>16,486</td>
<td>22,210</td>
</tr>
<tr>
<td>Total operating expenses</td>
<td>731,910</td>
<td>769,467</td>
<td>798,740</td>
<td>887,352</td>
<td>902,958</td>
</tr>
<tr>
<td>OPERATING INCOME (LOSS)</td>
<td>$19,663</td>
<td>$(35,119)</td>
<td>$(22,422)</td>
<td>$(30,038)</td>
<td>$(52,779)</td>
</tr>
</tbody>
</table>

(1) - Contract labor is included in Medical and other fees in the AFS, but is broken out here for illustrative purposes.

District’s Response: Performance Improvement Plan Developed and Implemented

In response to declining financial performance, the District developed a performance improvement plan (the “PIP”) and began implementation late FY22 – early FY23. This was a comprehensive plan that considered improvements throughout all of the District’s operations. Key components of the PIP:

- **Revenue cycle improvements** – improved front office collections, payer contract renegotiations for more favorable rates.
- **Labor costs** - reduction in workforce, reduction in both contract labor use and contract labor rates, change in employee benefits.
- **Service line closing / restructuring** – Terminate KHMG (medical foundation) agreement, various relocation, downsizing, or closure of various services.
- **Supply chain / contracted services** – renegotiate contracts system wide, including material management, HR, Information Technology, Clinical Engineering, Pharmacy, Lab, Radiology, and others.

**Overall view of PIP to date**: While the PIP plans were developed and implemented late FY22 – early FY23, many were still unfolding throughout FY23 and will be more mature in FY24 and beyond. This is especially true of the new contracts for payer/insurers and supply chain, as contracts are typically made in advance for 2 – 3-year periods. The same is true with changes of service line offerings, the implementation timeline is longer. The most immediately impactful initiatives were labor related, both with work force reductions and addressing the use and rate of contract labor (primarily traveling nurses).

**LABOR COSTS**
The District reduced its workforce by roughly 450 FTEs (including 200 FTEs associated with the KHMG termination). The reduction in workforce occurred primarily between October of 2022 and January of 2023, as seen in the graph below. The KHMG contract was terminated as of April 30, 2023. The graph below shows the reduction in employees. These reductions (non KHMG related) in work force will save $13M per year over the peak of higher labor costs during COVID.

Recruitment and retention of clinical employees, especially nurses, will continue to be an area that the District, like the health care industry overall, will continue to be challenged by. The District, in an effort to be able to train, recruit and retain nurses has invested and partnered with three separate nursing programs in its surrounding area (Unitek, COS, and SJVC). Over the next few years, an estimated additional 100 new nurses...
will be entering the workforce through these programs annually going forward. The benefit of having sufficient nurses in the local market will reduce / prevent the dependence on traveling nurses, which was nationally, and for the District, the primary financial stressor during the COVID pandemic. The tables below show the wave of contract labor FTEs and costs that peaked in FY23 for the District (in $000’s). Peaking at nearly 230 contracted FTEs, the number now is around 80, with the future budget to operate in the mid 60’s FTEs of contract labor.
The annual savings in contracted costs are roughly $30M going forward compared to FY23, which was its high point. While the contracted labor costs are anticipated to be higher than pre COVID, the shortage of available clinical staff is likely to take several years to correct, and it may be part of a new normal that needs to be managed going forward. Investment and partnering in local nursing programs are an important piece to ensure a sufficient pipeline of future nurses and other clinicians.

**SERVICE LINE CLOSING / RESTRUCTURING**

The annual savings for this group of initiatives are approximately $12M annually starting in FY24. Terminating the contract with Kaweah Health Medical Group (“KHMG”) on April 30, 2023, will save $8M annually going forward. Below is a trended history of KHMG.
In addition to the termination of the KHMG agreement, various other initiatives are estimated to improve financial performance $5M annually going forward, which will be partly achieved in FY24 and fully mature by FY25. Other key initiatives:

- Relocation of family medicine residency program. Will eliminate $1.4M annual loss and improve profitability at Tulare Rural Health Clinic, and free up vacated space for new clinical operations. With improved profitability, total annual improvement is $3.4M, in FY24.
- Close neuroscience clinic, diabetes clinic, and skilled nursing facility on Court Street., estimated 1.5M annual improvement beginning in FY24.

**REVENUE CYCLE**

The annual financial improvement for this group of initiatives is approximately $15M annually starting in FY24. Key areas of improvement for revenue cycle:

- Renegotiating majority of payer contracts during FY23; $11.3M annual improvement beginning in FY24, and improvements continuing through the new contract terms (through 2026).
- Improve upfront collections for surgery and outpatient clinics; $1.9M annual improvement beginning in FY24.
- Bringing outsourced accounts receivable back in house, will result in reduction of denials; $2.2M annual improvement beginning in FY24.

**SUPPLY CHAIN / CONTRACT SERVICES**
The annual savings for this group of initiatives are approximately $8.6M annually starting in FY24. Key areas of renegotiated contracts for supply chain / contract services:

<table>
<thead>
<tr>
<th>Completed Projects by grouped teams</th>
<th># Projects</th>
<th>FY23 Savings</th>
<th>FY24 Savings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Purchased Services</td>
<td>24</td>
<td>$1,800,000</td>
<td>$2,200,000</td>
</tr>
<tr>
<td>Clinics/Outpatient</td>
<td>17</td>
<td>100,000</td>
<td>100,000</td>
</tr>
<tr>
<td>Cath Lab/IR + Inpatient</td>
<td>35</td>
<td>1,300,000</td>
<td>1,900,000</td>
</tr>
<tr>
<td>Surgical Services</td>
<td>28</td>
<td>1,100,000</td>
<td>1,800,000</td>
</tr>
<tr>
<td>Laboratory, Pharmacy, + Radiology</td>
<td>18</td>
<td>1,900,000</td>
<td>1,900,000</td>
</tr>
<tr>
<td>EVS/Laundry/Patient Transport + Food &amp; Nutritional Svcs</td>
<td>6</td>
<td>500,000</td>
<td>700,000</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>128</strong></td>
<td><strong>$6,700,000</strong></td>
<td><strong>$8,600,000</strong></td>
</tr>
</tbody>
</table>

Many of the various projects were completed early in FY23 resulting in performance improvements in FY23 and FY24 represents a full year of new contracts in place. To the credit of the District, they had 8 different vice presidents champion areas of improvement and while many of the projects were fairly small, in aggregate they will yield over $8M in improvement annually.

**Performance Improvement Plan Results, District Financials by Quarter, FY22 - Q1, FY24**

Many of the PIP’s initiatives were implemented during FY23 and their impact is more apparent through trended quarterly financials. Below is the District’s income statement by quarter for FY23 and FY24, Q1:
The operating margin (loss) peaked in FY22 Q4 and FY23 Q1. Many of the PIP initiatives began in FY23 Q1-Q2, and the reduction in contract labor and physician fees are the largest immediate impact areas. FY24 Q1 represents a level of profitability that would result in the District meeting its DSCR for FY24. Below is a forecast for FY24 using Q1 actual and Q2-4 budget.
The forecasted DSCR, using Q1 actual and Q2-4 budgeted for FY24 is shown below.

<table>
<thead>
<tr>
<th>FY 2021</th>
<th>FY 2022</th>
<th>FY 2023</th>
<th>Forecasted FY 2024</th>
</tr>
</thead>
<tbody>
<tr>
<td>Net income (loss) w/o Stimulus</td>
<td>$(20,047,000)</td>
<td>$(33,074,000)</td>
<td>$(47,899,000)</td>
</tr>
<tr>
<td>Stimulus/Covid Supplemental</td>
<td>$32,461,000</td>
<td>$18,742,000</td>
<td>$681,000</td>
</tr>
<tr>
<td>Depreciation and amortization</td>
<td>$31,646,000</td>
<td>$32,882,000</td>
<td>$32,649,500</td>
</tr>
<tr>
<td>Interest</td>
<td>$8,407,000</td>
<td>$8,881,000</td>
<td>$8,806,300</td>
</tr>
<tr>
<td>GO Bond tax revenue</td>
<td>$(3,430,000)</td>
<td>$(3,703,000)</td>
<td>$(3,515,000)</td>
</tr>
<tr>
<td>Net income available for debt service</td>
<td>$49,037,000</td>
<td>$23,728,000</td>
<td>$(9,277,200)</td>
</tr>
<tr>
<td>Maximum annual debt service (without GO Bonds)</td>
<td>$16,967,599</td>
<td>$16,967,600</td>
<td>$18,314,143</td>
</tr>
<tr>
<td>Long-term debt service coverage ratio</td>
<td>2.9</td>
<td>1.4</td>
<td>(0.5)</td>
</tr>
</tbody>
</table>

FY24 DSCR ratio incorporates debt associated with a Distressed Hospital Loan Program loan that is anticipated to take effect in January of 2024.
The FY24 forecasted DSCR and DCOH shows considerable margin to meet the District’s covenants but note that it contains roughly $17M in stimulus / FEMA funding, which is likely to occur in FY24, but not guaranteed. In the event the stimulus / FEMA request is not approved, the District’s DSCR would be 1.4 for FY24, and represents a tighter range to make the DSCR covenant. Similarly, it would make it more likely that the DCOH would land between 85-90, if the stimulus/FEMA request was not approved. It is expected to be the last year of the special funding relief available to help hospitals associated with COVID. For the District, that will represent a challenge in the upcoming years to build back volumes and services and continue with strong fiscal management.

**Future Prospects and Recommendations Going Forward**

The District has made a very strong work plan to address the areas that lead to the financial decline, specifically addressing both the contract labor market immediately and investing in nursing programs that will mitigate a return to the labor market shortage for nurses locally. And it also attacked all of the usual areas associated with turnarounds in health care: Revenue cycle (business office improvements and new payer contracts), labor costs/productivity, supply chain and service line adjustments. And they are seeing great results early on, with continuing improvements that will be seen throughout FY24.

The challenge ahead is that the trend rate of revenue increases generally will not keep pace with cost increases. This margin compression will result in needing to find efficiencies or grow business annually. With this in mind (and also the loss of outside COVID relief funding), these are some areas recommended to address in the upcoming years. (The District is currently working on several of these).

- **Service line growth**: grow the service lines that share these two components. First, the service line is generally profitable, and second, represents a current need in the market. Cardiology, orthopedic and oncology are typically the service lines that rise to the top of potential opportunities. A third component for the District should be to consider what the service line growth will look like on a payer mix basis.

- **Plan for migration of services from inpatient to outpatient settings**: Key here is to invest in outpatient settings that will likely be the next up for services moving to outpatient settings, and to have a plan for your existing inpatient facility space which may become vacant over the next decade. This may include mental health or rehab hospital services for example.
Address excess length of stay: Based on an analysis of the District’s current average length of stay (the “ALOS”), the District has an annual opportunity of approximately $12M if its ALOS was closer to the average expected stay (adjusted for acuity). It will take some time to achieve this full amount, but partial gains should be achievable beginning in 2024.

Clinical documentation: On of the easiest ways to improve financial performance is to get fully paid for the services you are currently providing. The current initiative underway relating to Humana RAF score should be considered to be expanded to address other high acuity patients.

Manage the labor force pipeline / retention of current employees: The COVID pandemic resulting in many near retirement age opting for early retirement leaving a durable labor shortage, particularly for nurses. This combined with the new minimum wage requirement legislation for California hospitals introduces a potential twin area of challenge: higher wages and shortage of available employees. As referenced before, investment in local nursing programs is key, and doing whatever practical to be an employer of choice in the market will be critical. Additionally, assessing the benefit of outsourcing some functions may make sense where local labor supply cannot meet the District’s needs.

District’s DSCR and DCOH Covenant Prospects for Near Future

The District, based on its performance improvement plan, which is currently materially implemented, is expected to meet the DSCR and DCOH covenants for FY24. For FY25 going forward, it is also expected that it will continue to make the covenants due to the recurring nature of the improvements made and positive cash accumulation going forward. The District’s ability to maintain strong fiscal management and find areas of service line growth will help continue to improve its financial performance. Two of the key unknowns going forward will be how long the labor market challenges and high inflation numbers remain. These two represent challenges that the District will need to address / navigate through into the foreseeable future.

Best regards,

Harold Emahiser

Harold Emahiser, President
Optimum Financial Consultants, Inc.