Kaweah Delta Health Care District
Board of Directors Meeting

***Health** is our Passion. **Excellence** is our Focus. **Compassion** is our Promise.*

Kaweah Health
MORE THAN MEDICINE. LIFE.

February 21, 2025

NOTICE

The Board of Directors of the Kaweah Delta Health Care District will meet in the City of Visalia City Council Chambers {707 W. Acequia, Visalia, CA} on Wednesday, February 26, 2025:

- 4:00PM Open meeting to approve the closed agenda.
- 4:01PM Closed meeting pursuant to Government Code 54956.8, Government Code 54956.9(d)(1), Government Code 54956.9(d)(2), Health and Safety Code 1461 and 32155.
- 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: kedavis@kaweahhealth.org, or on the Kaweah Delta Health Care District web page http://www.kaweahhealth.org.

KAWEAH DELTA HEALTH CARE DISTRICT
David Francis, Secretary/Treasurer

Kelsie Davis
Board Clerk / Executive Assistant to CEO

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

KAWEAH DELTA HEALTH CARE DISTRICT
BOARD OF DIRECTORS MEETING

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

Wednesday February 26, 2025 {Regular Meeting}

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.
4. **APPROVAL OF THE CLOSED AGENDA – 4:01PM**
   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 February 26, 2025, closed meeting agenda.
5. **ADJOURN**

CLOSED MEETING AGENDA {4:01PM}

1. **CALL TO ORDER**
2. **CONFERENCE WITH LEGAL COUNSEL – ANTICIPATED LITIGATION –** Significant exposure to litigation pursuant to Government Code 54956.9(d)(2). 9 Cases
   Ben Cripps, Chief Compliance Officer and Rachele Berglund, Legal Counsel

3. **CONFERENCE WITH LEGAL COUNSEL – EXISTING LITIGATION –** Pursuant to Government Code 54956.9(d)(1).
   A. Martinez (Santillian) v KDHCD Case # VCU279163
   B. Franks v KDHCD Case #VCU290542
   C. Burns-Nunez v KDHCD Case # VCU293107
   D. Oney v KDHCD Case # VCU293813
   E. Parnell v Kaweah Health Case # VCU292139
   F. Newport v KDHCD Case # 1:23-CV-01752-NODJ-SAB
   G. M. Vasquez v KDHCD Case # VCU297964
   H. Apkarian-Souza v KDHCD Case # VCU303650
   I. Pendleton v KDHCD Case #VCU305571
   J. Rhodes v KDHCD Case # VCU306460
   K. Negrete v KDHCD Case #VCU309437
   L. LaRumbe-Torres v KDHCD Case #VCU313564
   M. Smithson v KDHCD Case #VCU313258
   N. Maxey v KDHCD Case #VCU314996
   O. Medina v KDHCD Case #VCU316413
   P. Richardson v KDHCD Case #VCU311369
   Q. Burger v. KDHCD Case #VCU312863
   R. Andrade v. KDHCD Case #VCU317338

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

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

5. 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

6. **QUALITY ASSURANCE** pursuant to Health and Safety Code 32155 and 1461, report of quality assurance committee.
Daniel Hightower, MD Chief of Staff
7. **APPROVAL OF THE CLOSED MEETING MINUTES** – January 22, 2025, closed meeting minutes.
8. **ADJOURN**

OPEN MEETING AGENDA {4:30PM}

1. **CALL TO ORDER**
2. **ROLL CALL**
3. **FLAG SALUTE- DIRECTOR LEVITAN**
4. **APPROVAL OF AGENDA**
5. **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.
6. **CLOSED SESSION ACTION TAKEN** – Report on action(s) taken in closed session.
7. **OPEN MINUTES** – Request approval of the January 22, 2025, 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 January 22, 2025, open minutes.

8. RECOGNITIONS

8.1. Presentation of Resolution 2250 to Angel Pena in recognition as the Kaweah Health World Class Employee of the month – February 2025 – *Director Levitan*

8.2. Presentation of Resolution 2251 to Margaret Galvin in recognition of her service and retirement at Kaweah Health. – *Director Levitan*

8.3. Presentation of Resolution 2252 to Leslie Kline in recognition of her service and retirement at Kaweah Health. – *Director Levitan*

8.4. Team of the Month –Staffing Facilitator Team

9. INTRODUCTIONS

9.1. New Director – Rhonda Quinones

9.2. New Interim Chief - Schlene Peet

10. 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 February 26, 2025, medical staff credentials report.

11. CHIEF OF STAFF REPORT – Report relative to current Medical Staff events and issues.
Daniel Hightower, MD, Chief of Staff

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

Public Participation – Members of the public may comment on agenda items before action is taken and after the item has been discussed by the Board.
Action Requested – Approval of the February 26, 2025, Consent Calendar.

12.1. REPORTS

A. Physician Recruitment
B. Strategic Plan
C. Throughput
D. Compliance Quarterly Report
E. Hospice/Open Arms House

12.2. POLICIES

A. Administrative Policies

A.1. AP41- Quality Improvement Plan- Reviewed
A.2. AP175- Patient Safety Plan- Reviewed

B. Environment of Care

B.1. EOC 3000- Security Management Plan - Revised
B.2. EOC 4007- Compressed Gas and Oxygen Use – Revised
B.3. EOC 6001- Medical Equipment Management Policy – Revised
B.4. EOC 6003- Medical Equipment Health Care Device Modification Policy- Reviewed
B.5. EOC 6015- Hospital Electrical Safety Policy for Personal Use – Revised
B.6. EOC 7001- Utilities Management Plan- Revised
B.7. EOC 7401- Utilities Management Program- Revised
B.8. DM 2225- Lockdown Security of Entry Doors- Revised

12.3. LEGAL

A. Priscilla Wilson Claim for Damages – rejection of Claim on its merits

13. STRATEGIC PLANNING INITATIVE – Physician Alignment – Detailed review of Strategic Plan Initiative.
Ryan Gates, Chief Ambulatory Officer & JC Palermo, Director of Physician Recruitment

14. FINANCIALS – Review of the most current fiscal year financial results.
Malinda Tupper – Chief Financial Officer

Kaweah Delta Health Care District
Board of Directors Meeting

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15. REPORTS

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

15.2. Board President - Report on current events and issues.
Mike Olmos, Board President

CLOSED MEETING AGENDA
IMMEDIATELY FOLLOWING THE OPEN SESSION

1. CALL TO ORDER

2. CEO EVALUATION – Discussion with the Board and the Chief Executive Officer relative to the evaluation of the Chief Executive Officer pursuant to Government Code 54957(b)(1).
Gary Herbst, Chief Executive Officer and Rachele Berglund, Legal Counsel

3. ADJOURN

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Agenda item intentionally omitted

1.22.2025 OPEN Minutes

MINUTES OF THE OPEN MEETING OF THE KAWEAH DELTA HEALTH CARE DISTRICT BOARD OF DIRECTORS HELD WEDNESDAY JANUARY 22, 2025, AT 4:00PM IN THE CITY OF VISALIA CITY COUNCIL CHAMBERS – 707 W. ACEQUIA, VISALIA, CA.

PRESENT: Directors Olmos, Francis, Levitan, Havard Mirviss & Murrieta; G. Herbst, CEO; D. Hightower, Chief of Staff; M. Tupper, CFO; J. Batth, Chief Operating Officer; B. Cripps, Chief Compliance Officer; D. Cox, Chief Human Resource Officer; P. Stefanacci, Chief Medical & Quality Officer; R. Gates; Chief Population Health Officer; M. Mertz, Chief Strategy Officer; R. Berglund, Legal Counsel; and K. Davis, recording

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

Director Olmos asked for approval of the agenda.

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

PUBLIC PARTICIPATION –None.

MMSC (Havard Mirviss/Armando) to approve the closed agenda. This was supported unanimously by those present. Vote: Yes - Havard Mirviss, Murrieta, Levitan, Olmos and Francis

ADJOURN - Meeting was adjourned at 4:00PM

Mike Olmos, President
Kaweah Delta Health Care District and the Board of Directors

ATTEST:

David Francis, Secretary/Treasurer
Kaweah Delta Health Care District Board of Directors

MINUTES OF THE OPEN MEETING OF THE KAWEAH DELTA HEALTH CARE DISTRICT BOARD OF DIRECTORS HELD WEDNESDAY JANUARY 22, 2025, AT 4:45PM IN THE CITY OF VISALIA CITY COUNCIL CHAMBERS – 707 W. ACEQUIA, VISALIA, CA.

PRESENT: Directors Olmos, Francis, Havard Mirviss, Murrieta & Levitan; G. Herbst, CEO; D. Hightower, Chief of Staff; M. Tupper, CFO; J. Batth, Chief Operating Officer; B. Cripps, Chief Compliance Officer; D. Cox, Chief Human Resource Officer; P. Stefanacci, Chief Medical & Quality Officer; R. Gates; Chief Population Health Officer; M. Mertz, Chief Strategy Officer; K. Noeske, Chief Nursing Officer; R. Berglund, Legal Counsel; and K. Davis, recording

The meeting was called to order at 4:45 PM by Director Olmos.

ROLL CALL- Director Olmos, Havard Mirviss, Levitan, Francis, and Murrieta were all present and accounted for.

FLAG SALUTE- Director Olmos lead the flag salute.

Director Olmos asked for approval of the agenda.

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

PUBLIC PARTICIPATION – None.

CLOSED SESSION ACTION TAKEN: approval of the closed meeting minutes from December 18, 2024.

OPEN MINUTES – Requested approval of the open meeting minutes from December 18, 2024.

PUBLIC PARTICIPATION – None.

MMSC (Havard Mirviss/Francis) to approve the open minutes from December 18, 2024.

This was supported unanimously by those present. Vote: Yes – Olmos, Havard Mirviss, Francis, Levitan and Murrieta.

RECOGNITIONS- Resolution 2246, 2248, and 2249. New Directors, Melany Gambini and Brooke Carmen. Team of the Month: Outpatient Behavioral Therapist Team.

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.

CHIEF OF STAFF REPORT – Report relative to current Medical Staff events and issues – *Daniel Hightower, Chief of Staff*

- No report.

Public Participation – None.

Director Olmos requested a motion for the approval of the January 22, 2025, Medical executive committee report as presented.

MMSC (Havard Mirviss/Murrieta) 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, 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, Levitan, Murrieta and Francis

CONSENT CALENDAR – Director Olmos entertained a motion to approve the January 22, 2025, consent calendar.

PUBLIC PARTICIPATION – None.

MMSC (Francis/Havard Mirviss) to approve the January 22, 2025, consent calendar. This was supported unanimously by those present. Vote: Yes – Olmos, Havard Mirviss, Levitan, Murrieta and Francis.

STRATEGIC PLAN- OUTSTANDING HEALTH OUTCOMES – A detailed review of strategic plan initiative. Copy attached to the original of the minutes and to be considered a part thereof.

FINANCIALS – Review of the most current fiscal year financial results. Copy attached to the original of these minutes and considered a part thereof.

REPORTS

Chief Executive Officer Report – None – *Gary Herbst, CEO*
Board President- None – *Mike Olmos, Board President*

ADJOURN - Meeting was adjourned at 7:00PM

Mike Olmos, President
Kaweah Delta Health Care District and the Board of Directors

ATTEST:

David Francis, Secretary/Treasurer
Kaweah Delta Health Care District Board of Directors

R2250 EOM Angel Pena

RESOLUTION 2250

WHEREAS, the Department Heads of the KAWEAH DELTA HEALTH CARE DISTRICT dba KAWEAH HEALTH are recognizing Angel Pena with the World Class Service Excellence Award for the Month of February 2025, 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 Angel Pena for this honor and in recognition thereof, have caused this resolution to be spread upon the minutes of the meeting.

PASSED AND APPROVED this 26th day of February 2025 by a unanimous vote of those present.

President, Kaweah Delta Health Care District

Secretary/Treasurer
Kaweah Delta Health Care District

R2251 Retirement Margaret Galvin

RESOLUTION 2251

WHEREAS, Margaret Galvin, 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 Margaret Galvin 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 26th day of February 2025 by a unanimous vote of those present.

President, Kaweah Delta Health Care District

Secretary/Treasurer
Kaweah Delta Health Care District

R2252 Retirement Leslie Kline

RESOLUTION 2252

WHEREAS, Leslie Kline, is retiring from duty at Kaweah Delta Health Care District dba Kaweah Health after 24 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 Leslie Kline for 24 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 26th day of February 2025 by a unanimous vote of those present.

President, Kaweah Delta Health Care District

Secretary/Treasurer
Kaweah Delta Health Care District

Physician Recruitment Report - February 2025

Physician Recruitment Board Report - Physician Group Targets
February 2025

Delta Doctors
Adult Psychiatry x1 Family Medicine x2

Key Medical Associates
Gastroenterology x1 Pediatrics x1 Pulmonology x1 Rheumatology x1

Orthopaedics Associates
Orthopedic Surgery (General) x1 Orthopedic Surgery (Hand) x1

Sequoia Cardiology
EP Cardiology x1

Oak Creek Anesthesia
Anesthesia - Cardiac x1 Anesthesia - General x2 Anesthesia - Regional x1

Valley ENT
Audiology x1 Otolaryngology x1

Valley Children's
Maternal Fetal Medicine x2 Neonatology x1 Pediatric Cardiology x1 Pediatric Hospitalist x1

Other Recruitment/Group TBD
CT Surgery x2 Family Medicine x3 Gastroenterology x2 General Cardiology x1 Neurology IP/OP x2 OB/GYN x2 Pediatrics x1 Pulmonology OP x1 Urology x3

February Board Report Narrative:

Over the last month we have added a number of names to the Cardiothoracic candidate pool bringing the total to 14. We are working with Dr. Bansal to screen and interview candidates as we begin to build out the Golden Valley Cardiothoracic Institute.

The Physician Recruitment team will be meeting with the Kaweah Health Psychiatry Residents and Sierra View Internal Medicine residents, mid-March.

OB/GYN and Family Medicine recruitment remain top priority recruitment focuses for the Kaweah Health Physician Recruitment team.

Board Report - Physician Recruitment - Feb 2025

	Specialty	Group	Phase	Expected Start Date
1	Occ Med	TBD	Site Visit	
2	Neurology	1099 - KH Direct	Site Visit	
3	ENT	Valley ENT	Site Visit	
4	PM&R	TBD	Site Visit	
5	Hand Surgeon	Orthopedic Assoc	Site Visit	
6	Family Medicine NP	TBD	Screening	
7	OBGYN	1099 - KH Direct	Screening	
8	OBGYN	1099 - KH Direct	Screening	
9	Family Medicine	TBD	Screening	
10	Cardiothoracic Surgery	TBD	Screening	
11	Cardiothoracic Surgery	TBD	Screening	
12	Psychiatry	TBD	Screening	
13	Dermatology	TBD	Screening	
14	Cardiothoracic Surgery	TBD	Screening	
15	Family Medicine	TBD	Screening	
16	OBGYN	TBD	Screening	
17	Cardiothoracic Surgery	TBD	Screening	
18	Anesthesia (Regional)	Oak Creek	Screening	04/01/25
19	Family Medicine	TBD	Resident	
20	Family Medicine	TBD	Resident	
21	Family Medicine	TBD	Offer Extended	
22	Anesthesia (Regional)	Oak Creek	Offer Extended	
23	Psychiatry	Precision Psych	Offer Extended	
24	Psychiatry	Precision Psych	Offer Extended	
25	Internal Medicine	TBD	Offer Extended	
26	Family Medicine	KH Faculty MG	Offer Extended	
27	Rheumatology	TBD	Offer Extended	
28	Family Medicine NP	CFC	Offer Extended	
29	General Surgery	TBD	Offer Accepted	08/01/25
30	Anesthesia (CRNA)	Oak Creek	Offer Accepted	04/01/25
31	Anesthesia (CRNA)	Oak Creek	Offer Accepted	04/01/25
32	Cardiothoracic Surgery	1099 - KH Direct	Offer Accepted	01/05/25
33	Dermatology	1099 - KH Direct	Offer Accepted	02/01/25
34	General Surgery	TBD	Offer Accepted	10/20/25
35	Ped Hospitalist	Valley Childrens	Offer Accepted	10/14/24
36	Pulmonology	1099 - KH Direct	Offer Accepted	05/01/25
37	Urology	1099 - KH Direct	Offer Accepted	03/01/25
38	Neonatology	Valley Childrens	Offer Accepted	
39	Endocrinology	1099 - KH Direct	Offer Accepted	
40	Pulmonology	TBD	Leadership Call	
41	Internal Medicine	TBD	Leadership Call	
42	Neurology	TBD	Leadership Call	
43	Neurology	TBD	Leadership Call	
44	Family Medicine	TBD	Leadership Call	
45	Pulmonology	TBD	Leadership Call	
46	Cardiothoracic Surgery	TBD	Applied	
47	Cardiothoracic Surgery	TBD	Applied	
48	Cardiothoracic Surgery	TBD	Applied	

	Specialty	Group	Phase	Expected Start Date
49	Cardiothoracic Surgery	TBD	Applied	
50	Rheumatology	TBD	Applied	
51	Rheumatology	TBD	Applied	
52	Cardiothoracic Surgery	TBD	Applied	
53	Cardiothoracic Surgery	TBD	Applied	
54	Cardiothoracic Surgery	TBD	Applied	
55	Cardiothoracic Surgery	TBD	Applied	
56	Cardiothoracic Surgery	TBD	Applied	
57	Cardiothoracic Surgery	TBD	Applied	
58	Anesthesia General	Oak Creek	Applied	
59	Gastroenterology	TBD	Applied	

FY25 Strategic Plan Overview Feb Final

FY 2025 Strategic Plan

Monthly Performance Report
Feb 26, 2025

Kaweah Health Strategic Plan: Fiscal Year 2025

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.

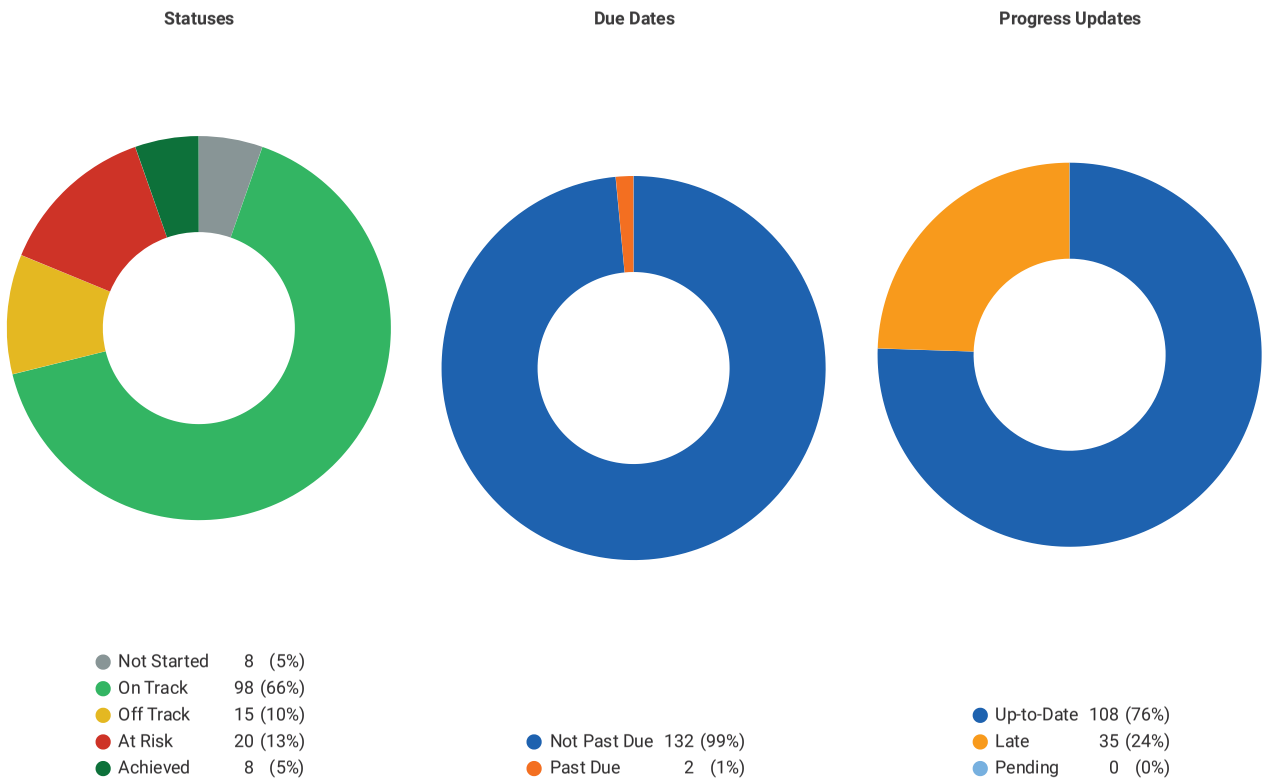
Our Pillars

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

Our Five Initiatives

Ideal Environment
Strategic Growth and Innovation
Outstanding Health Outcomes
Patient Experience and Community Engagement
Physician Alignment

Kaweah Health Strategic Plan FY2025 Overview



Ideal Environment

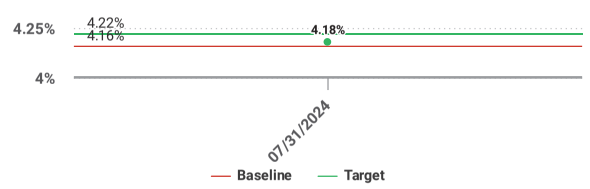
Champions: Dianne Cox and Hannah Mitchell

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

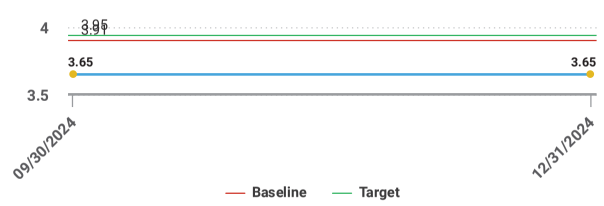
FY2025 Strategic Plan - Ideal Environment Strategies

#	Name	Description	Status	Assigned To	Last Comment
1.1	Integrate Kaweah Care Culture	Integrate Kaweah Care culture into the various aspects of the organization.	On Track	Dianne Cox	The Kaweah Care Steering Committee and its subcommittees are dedicated to embedding the Kaweah Care culture throughout the organization. Employee Engagement and Experience: We have planned a year-round calendar of exciting events to boost employee engagement and synergy, along with recognizing achievements through Starlight awards and Team Pyramid awards. Ideal Practice Environment Committee: Our focus is on enhancing the provider experience by improving the environment, systems, and overall culture. Patient Engagement and Experience Committee: We work on service recovery, patient navigation, managing lost belongings, improving customer service, enhancing the environment, and ensuring timely communication and transitions.
1.2	Ideal Practice Environment	Ensure a practice environment that is friendly and engaging for providers, free of practice barriers.	On Track	Dianne Cox	We have initiated several efforts aimed at enhancing provider experience: Team Rounding: Brief team rounding (60-90 seconds per room) involving a physician, RN, and case manager to streamline communication and improve patient care. Dedicated Workspaces: Will be establishing workstations in key locations including 5T, the library, and various hospital areas. Restoration/remodeling of the Medical Staff lounge, female locker room, and surgery spaces to better support provider needs.
1.3	Growth in Nursing School Partnerships	Increase the pool of local RN candidates with the local schools to increase RN cohort seats and increase growth and development opportunities for Kaweah Health Employees	On Track	Dianne Cox	We have formed partnerships with local high schools for the Career Technical Education program, including Visalia Unified, Cutler, Orosi, Hanford West, Tulare Joint Union, and Lindsay. Additionally, we are rolling out several initiatives: a Leadership Academy, an Emerging Leaders Program, Charge Nurse Development, and Mentorship and Succession Planning. A comprehensive calendar has been created to support and schedule all upcoming learning events.

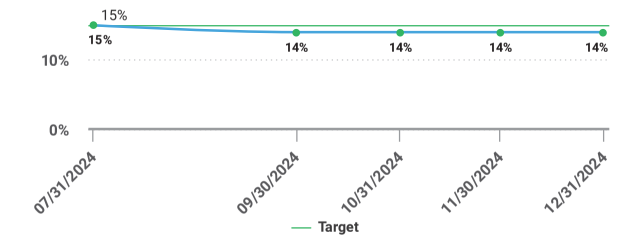
Employee Engagement Survey Score Greater Than 4.2%



Physician and APP Engagement Survey Score Greater Than 3.95%



Decrease Overall Turnover Rate (< 15%)



Strategic Growth and Innovation

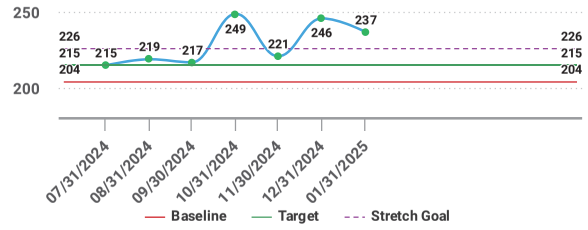
Champions: Jag Batth and Kevin Bartel

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****.*

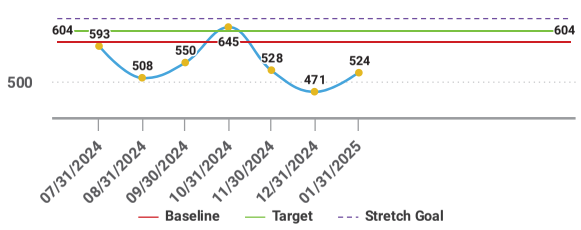
FY2025 Strategic Plan - Strategic Growth and Innovation Strategies

#	Name	Description	Status	Assigned To	Last Comment
2.1	Grow Targeted Surgery/Procedure Volumes	Grow volumes in key service lines, including Orthopedics, Endoscopy, Urology and Cardio Thoracic services.	Off Track	Kevin Bartel	Only 1 of the 4 surgical volume goals (orthopedic) was met for January 2025. All others were off track due for varying reasons. Urology is still limited primarily by lack of consistent USC subspecialist presence (one subspecialist case performed in January), provider PRO in January (limited total call coverage and elective cases) and continued limited on-call coverage overall for the service. Cardiothoracic surgeries continue to see a dramatic decrease in elective volume primarily driven by service line decisions to change affiliated partnerships, with recruitment ongoing to backfill for CTS surgeons.
2.2	Expand Clinic Network	Strategically expand and enhance the existing clinic network to increase access at convenient locations for the community.	On Track	Ivan Jara	We continue to evaluate and pursue growth opportunities through recruitment, acquisitions, new locations, quality initiatives, state/federal programs, and a team-based care model. All areas currently have active projects supporting the expansion of the clinic network.
2.3	Innovation	Implement and optimize new tools and applications to improve the patient experience, communication, and outcomes.	On Track	Jag Batth	Key initiatives include optimizing telehealth services (inpatient-Neurology focus), integrating referral and authorization software, and developing online scheduling tools (clinical lab), all on track. We continue to explore an advanced care at-home program with Key Medical Group. The centralized navigation service strategy will involve key stakeholders to help determine next steps.
2.4	Enhance Health Plan Programs	Improve relationships with health plans and community partners and participate in local/state/federal programs and funding opportunities to improve overall outcomes for the community.	On Track	Sonia Duran-Aguilar	Monthly meetings with MCPs to discuss CalAIM and quality remain underway. Additionally Sonia Duran-Aguilar has been asked to speak and present on CalAIM at Statewide Collaborative and Provider Forums to share experience with CalAIM and PATH CITED Round 2 and 3 funding awards. Work underway to complete PATH CITED Round 4 application due May 7th 2025 and working closely with MCPs to ensure our application aligns with gaps noted in Tulare County CalAIM programs and Populations of Focus. .
2.5	Explore Organizational Affiliations and Partnerships	Pursue organizational affiliations and partnerships.	On Track	Marc Mertz	We continue to evaluate existing and new partnerships as a way to improve the delivery of high quality care.

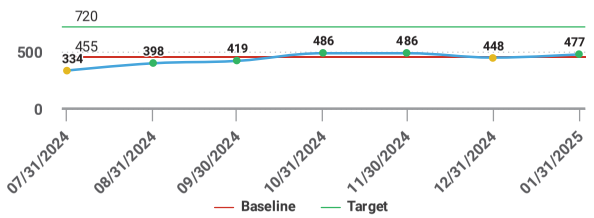
Perform 215 Orthopedic Surgery Cases Per Month



Perform 636 Endoscopy Cases Per Month



Increase Enrollment to 720 Lives in Enhanced Care Management



Outstanding Health Outcomes

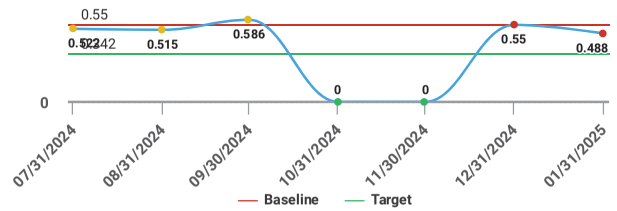
Champions: Dr. Paul Stefanacci and Sandy Volchko

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

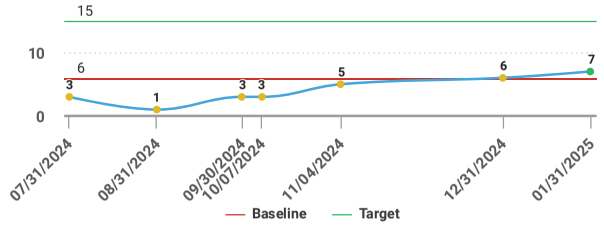
FY2025 Strategic Plan - Outstanding Health Outcomes Strategies

#	Name	Description	Status	Assigned To	Last Comment
3.1	Standardized Infection Ratio (SIR)	Reduce the Hospital Acquired Infections (HAIs) to the national 70th percentile in FYTD24 as reported by the Centers for Medicare and Medicaid Services	At Risk	Sandy Volchko	Key Actions: - Reduce line utilization; less lines less opportunity for infections to occur - Improve environmental cleaning effectiveness for high risk areas - MRSA nasal and skin decolonization for patient with lines - Improve hand hygiene
3.2	Sepsis Bundle Compliance (SEP-1)	Increase SEP-1 bundle compliance to overall 85% compliance rate for FY24 through innovative improvement strategies based on root causes.	At Risk	Sandy Volchko	Next Steps – enhanced engagement with GME through Sepsis Coordinator (ongoing education, order set utilization). Future State: Code Sepsis in ED
3.3	Mortality and Readmissions	Reduce observed/expected mortality through the application of standardized best practices.	At Risk	Sandy Volchko	Key Actions: - Provide guideline directed medical therapy at discharge - Provide guideline directed medical therapy during hospitalization
3.4	Quality Improvement Program (QIP) Reporting	Achieve performance on the Quality Incentive Pool measures to demonstrate high quality care delivery in the primary care space.	On Track	Sonia Duran-Aguilar	QIP reporting for Performance Year 7 (CY 2024) currently underway with Population Health Data Team and BI Development team collaborating on updating all QIP reports to reflect the Measure Specifications as outlined in the QIP Reporting Manual. Kaweah will report on 15 QIP measures for CY 2024.
3.5	Health Equity	Identify health disparities that improve affordable access to care by enhancing care coordination and more effective treatment through healthy living.	On Track	Sonia Duran-Aguilar	3 of 4 Program Elements Achieved Monthly Health Equity Committee Meeting in place. Identification of disparities for Population of Focus (Pregnant Persons), farmworkers remains underway. Discussion of focus on Maternal/Child Outcomes disparities. We have enrolled 16 patients into the HRSA Care Coordination Project with 7 of them being farmworkers.
3.6	Inpatient Diabetes Management	Optimize inpatient glycemic management using evidence-based practices to improve patient's glycemic control and reduce hypoglycemic events.	Off Track	Sandy Volchko	An inpatient diabetes management team has been established to focus on optimizing diabetes care for patients using Glucommander (GM), aiming to reduce hypoglycemia rates to or below SHM benchmarks for both critical and non-critical patients, and to minimize recurrent hypoglycemia in these settings to meet or fall below SHM benchmarks

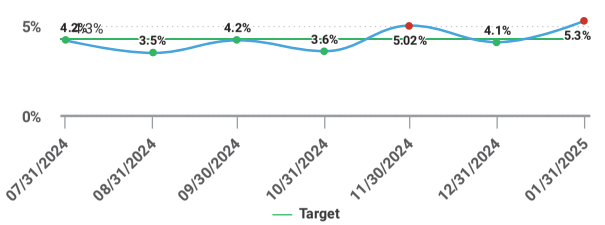
Decrease Standardized Infection Ratio (SIR) CAUTI to < 0.401



Meet or exceed 15 QIP measures in 2024



Hypoglycemia in Critical Care Patients (< 4.3%)



Patient Experience and Community Engagement

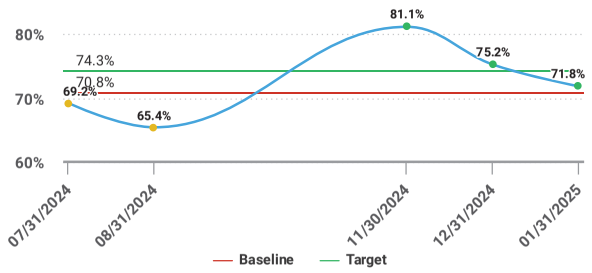
Champions: Keri Noeske and Deborah Volosin

Objective: Develop and implement strategies *that provide our health care team the tools they need to* ***deliver a world-class health care experience.***

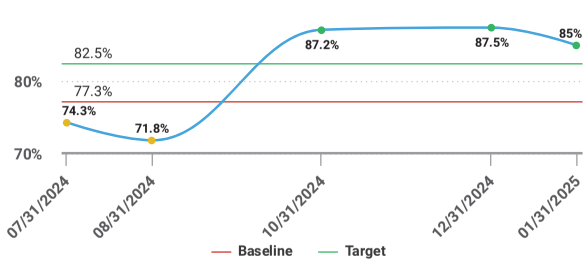
FY2025 Strategic Plan - Patient Experience and Community Engagement Strategies

#	Name	Description	Status	Assigned To	Last Comment
4.1	Highlight World-Class Service/Outcomes (Hospitality Focus)	Develop strategies that give our health care team the tools they need to deliver a world-class health care experience. We aim to be in the 90th percentile over the next three years.	On Track	Keri Noeske	Paper maps have been updated and given to the patient access teams at the front desks of both hospital entrances. There is new signage throughout the main hospital and new signage will be going up in parking lots in Winter/Spring of 2025. The community group will be coming back on campus in January and will re-evaluate patient wayfinding. We exceeded our goal for Best Image/Reputation in July (28.7), August (28.7), September (29.8), and October (31.1) of 2024.
4.2	Increase Compassionate Communication	To reach the 50th percentile in physician and nursing communication and responsiveness of staff on the HCAHPS survey.	On Track	Keri Noeske	Compassionate Communication modules were rolled out to clinical staff in Fall of 2024. We will continue to look for opportunities to make compassionate communication top of mind as we prioritize the patient experience initiative.
4.3	Enhancement of Systems and Environment	To create a secure, warm and welcoming environment for patients and the community.	On Track	Keri Noeske	Patient Access teams are working on customer service initiatives to ensure that all family members guests of patients feel welcomed when they enter our facilities.
4.4	Community Engagement	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.	On Track	Deborah Volosin	The Community Advisory Councils continue to meet and provide feedback and work on projects and initiatives. (Health Equity Survey review, QR Code for ED waiting room and patient rooms, Lost & Found initiatives, etc.)

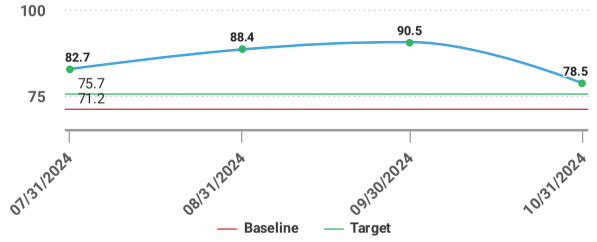
Achieve a score of 74.3 in HCAHPS Overall Rating



Achieve a 82.5 in Nursing Communication Inpatient Score



Achieve a score of 75.7 in the Cleanliness of Clinic Environment



Physician Alignment

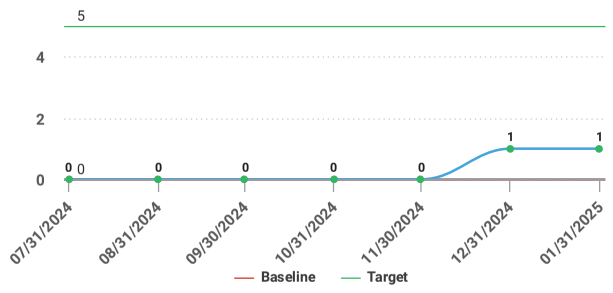
Champions: Ryan Gates and JC Palermo

Objective: Develop services and opportunities *that improve alignment with and support for contracted and affiliated* ***physician practices.***

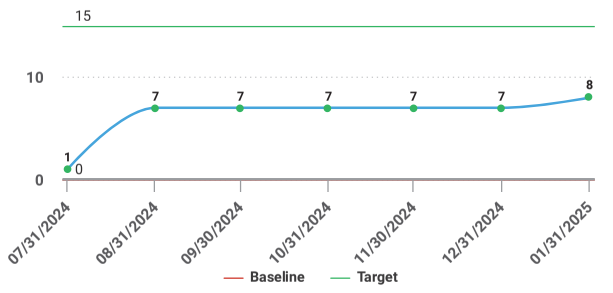
FY2025 Strategic Plan -Physician Alignment - Strategies

#	Name	Description	Status	Assigned To	Last Comment
5.1	Recruit Providers	Develop a recruitment strategy and employment options for physicians that will assist with recruitment of providers to support community needs and Kaweah Health's growth.	On Track	JC Palermo	The Physician Recruitment Strategy Committee has been meeting twice a month. We have established new processes, guidelines, and are having regular strategy discussions about practice locations. The team will continue to meet to ensure we are utilizing our resources as strategically as possible.
5.2	Physician Alignment and Practice Support	Develop services and opportunities that improve alignment with and support for contracted and affiliated physician practices.	On Track	Ryan Gates	Legal counsel and executives from Kaweah and Friendly PC met on 2/13/15 and reviewed and approved agreement terms with minor follow-ups to be ironed out by legal counsel. Legal counsel and executives from Kaweah and MSO met on 1/10/2025 and reviewed and approved agreement terms with minor follow-ups to be ironed out by legal counsel. Expecting execution of agreement with Friendly PC and MSO by 3/1/2025. W-2 compensation and benefit models for various specialties are being drafted in consultation with MSO and Friendly PC.

Recruit 5 Primary Care Physicians



Recruit 15 Specialty Providers

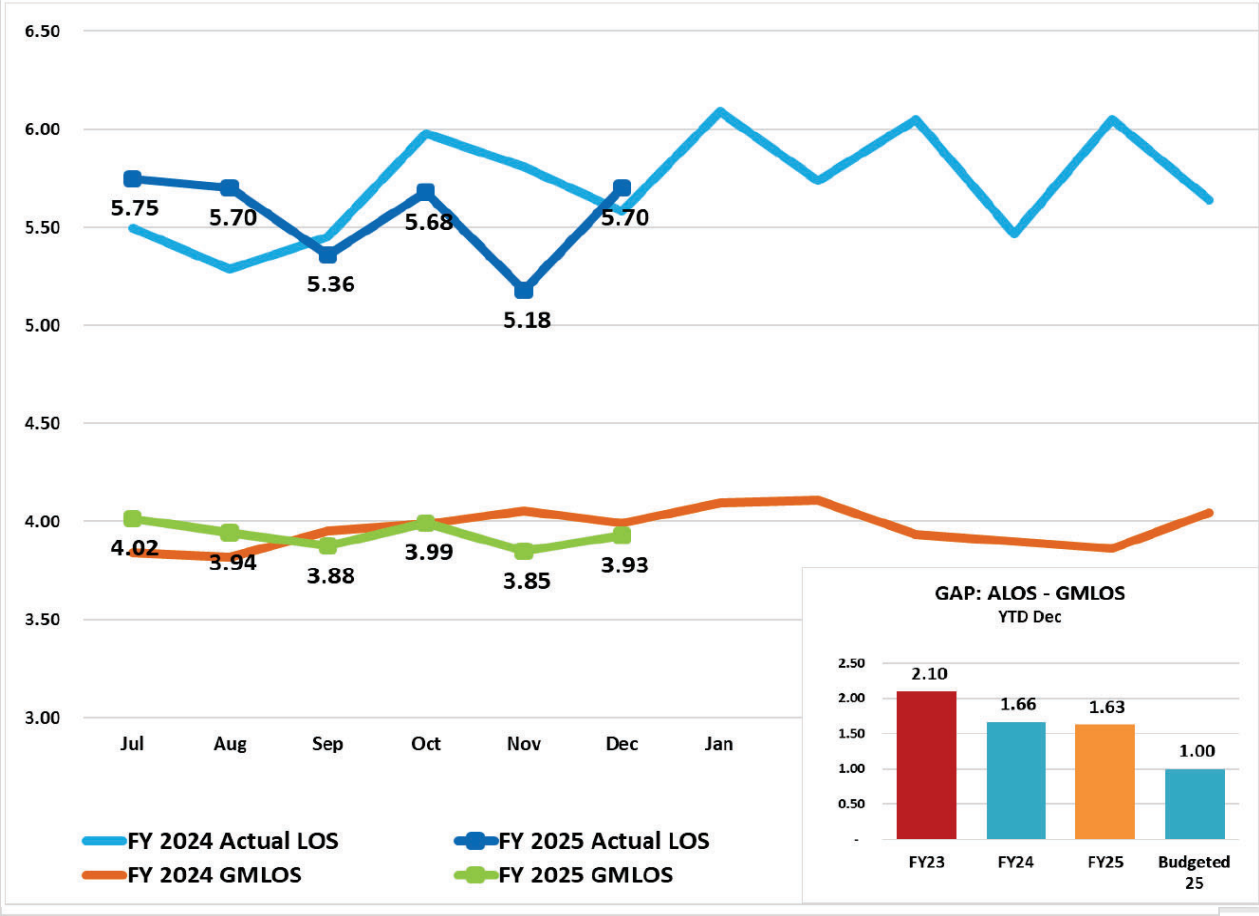


Pt Throughput Committee 1.22.25

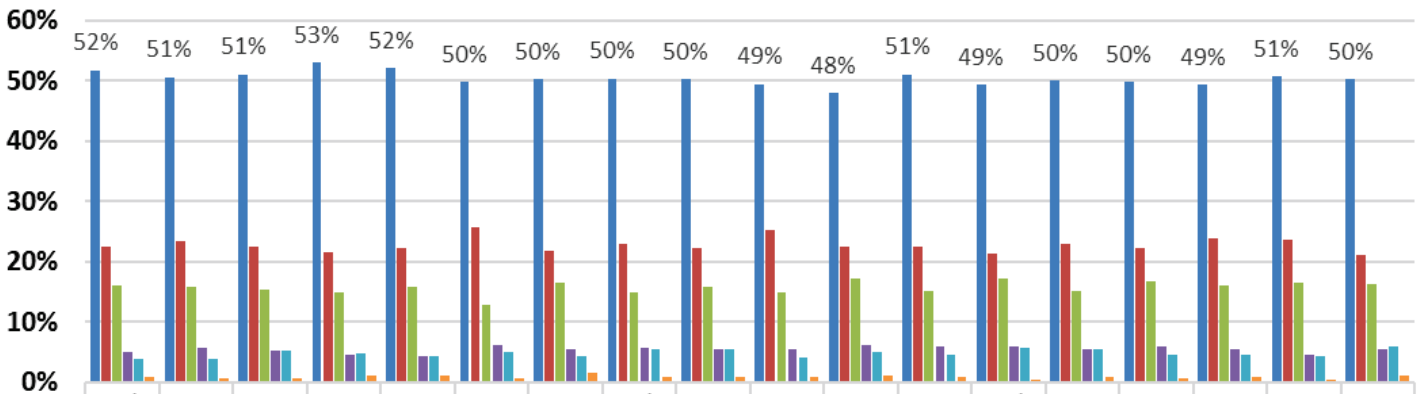
Patient Throughput Committee

January 22, 2025

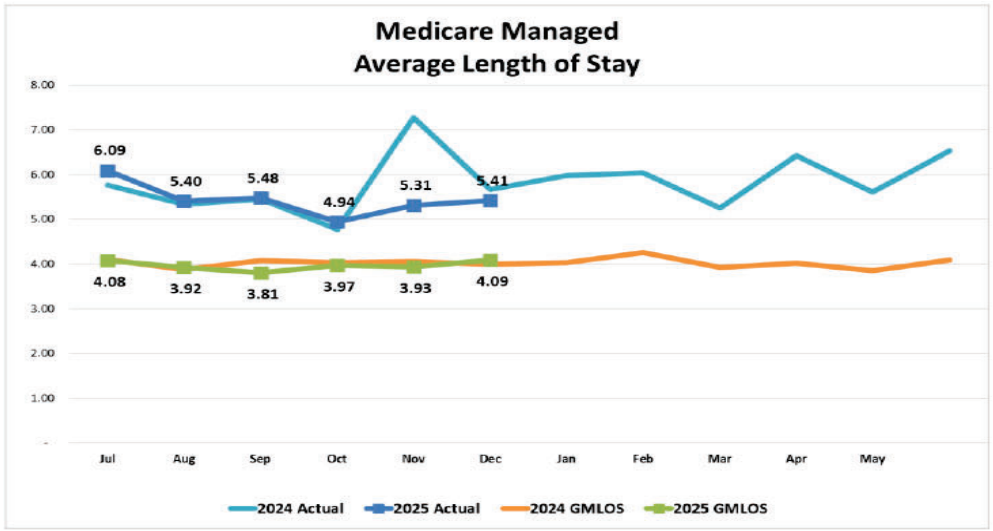
Average Length of Stay versus National Average (GMLOS)

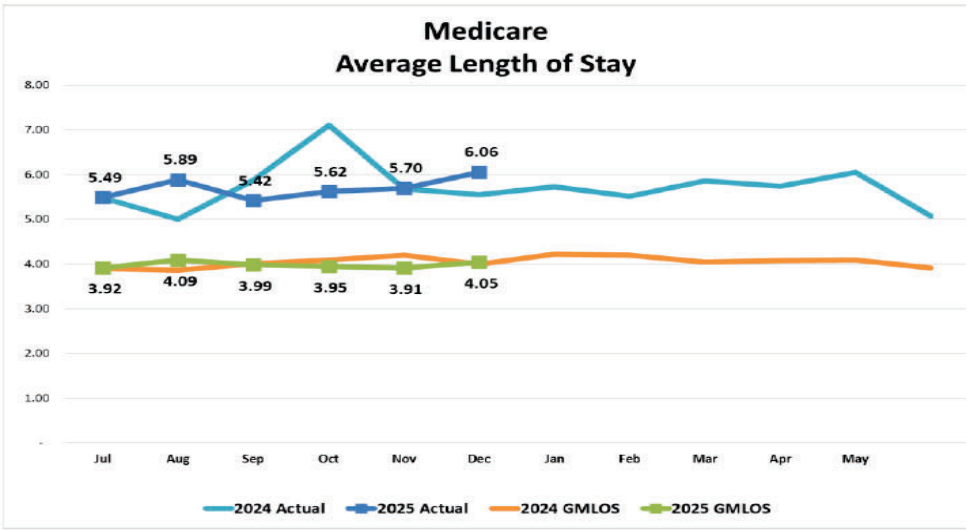


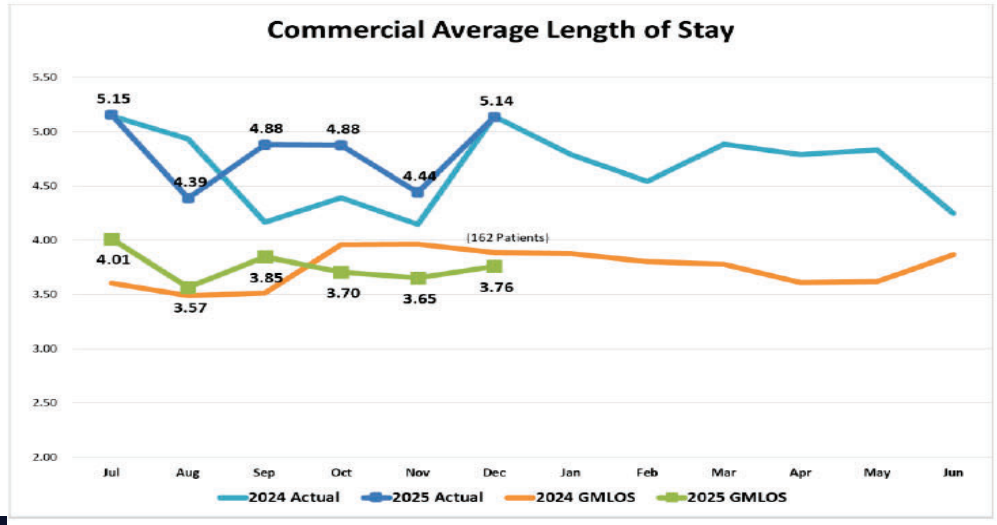
Average Length of Stay Distribution

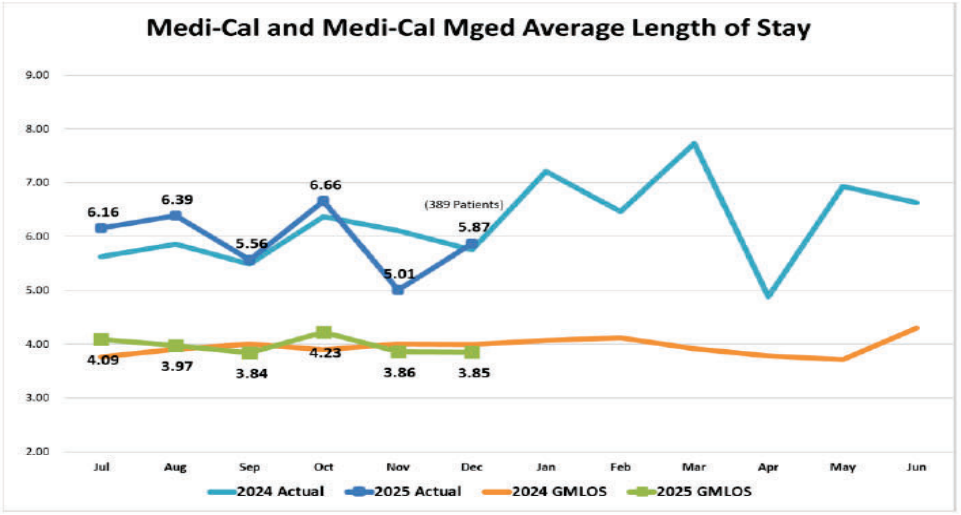


	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	2024												2025					
at GMLOS or Better	52%	51%	51%	53%	52%	50%	50%	50%	50%	49%	48%	51%	49%	50%	50%	49%	51%	50%
1-2 days over GMLOS	23%	23%	23%	21%	22%	26%	22%	23%	22%	25%	23%	22%	21%	23%	22%	24%	24%	21%
2-6 days over GMLOS	16%	16%	15%	15%	16%	13%	16%	15%	16%	15%	17%	15%	17%	15%	17%	16%	16%	16%
6-10 days over GMLOS	5%	6%	5%	5%	4%	6%	6%	6%	5%	5%	6%	6%	6%	6%	6%	5%	5%	6%
10-30 days over GMLOS	4%	4%	5%	5%	4%	5%	4%	5%	5%	4%	5%	5%	6%	6%	5%	5%	4%	6%
30+ days over GMLOS	0.9%	0.8%	0.6%	1.1%	1.2%	0.7%	1.5%	1.0%	0.9%	0.9%	1.2%	0.8%	0.5%	0.8%	0.6%	0.9%	0.3%	1.0%

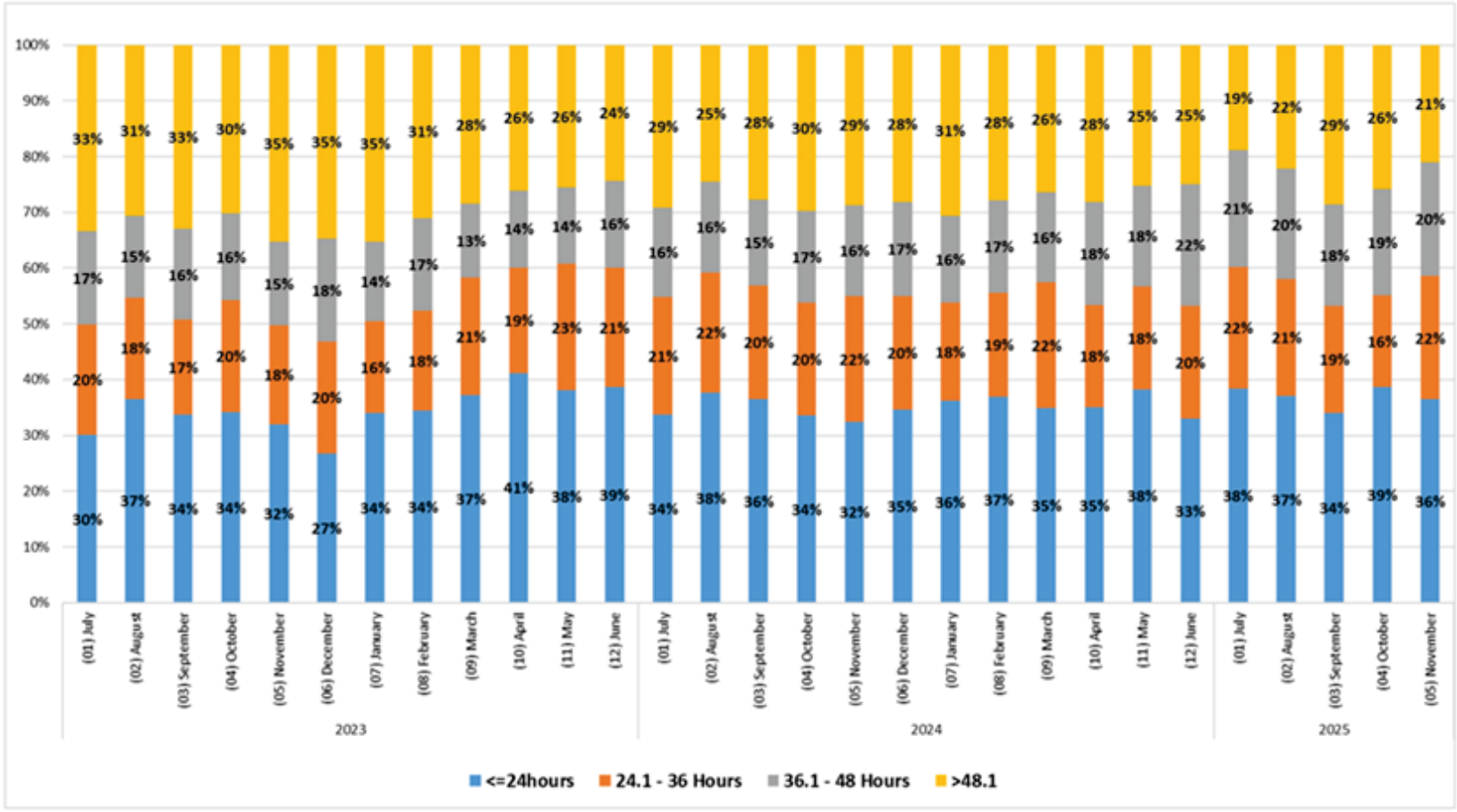

Medicare Managed
Average Length of Stay
8.00
7.00
6.00
5.00
4.00
3.00
2.00
1.00
-
6.09
5.40
5.48
4.94
5.31
5.41
4.08
3.92
3.81
3.97
3.93
4.09
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
2024 Actual
2025 Actual
2024 GMLOS
2025 GMLOS

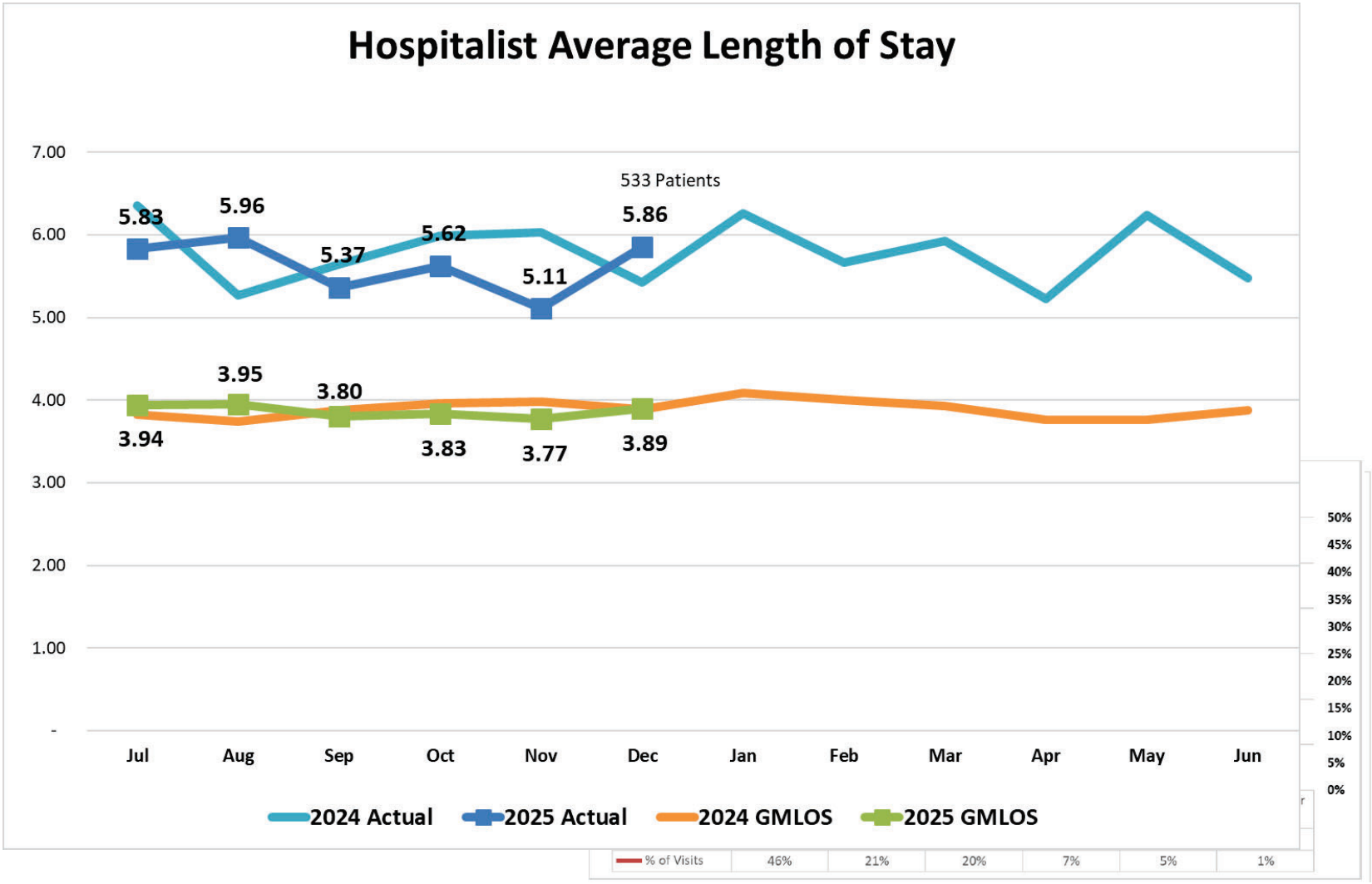

Medicare
Average Length of Stay
8.00
7.00
6.00
5.00
4.00
3.00
2.00
1.00
-
5.49
5.89
5.42
5.62
5.70
6.06
3.92
4.09
3.99
3.95
3.91
4.05
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
2024 Actual
2025 Actual
2024 GMLOS
2025 GMLOS


Commercial Average Length of Stay
5.50
5.00
4.50
4.00
3.50
3.00
2.50
2.00
5.15
4.39
4.88
4.88
4.44
5.14
4.01
3.57
3.85
3.70
3.65
3.76
(162 Patients)
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun
2024 Actual
2025 Actual
2024 GMLOS
2025 GMLOS

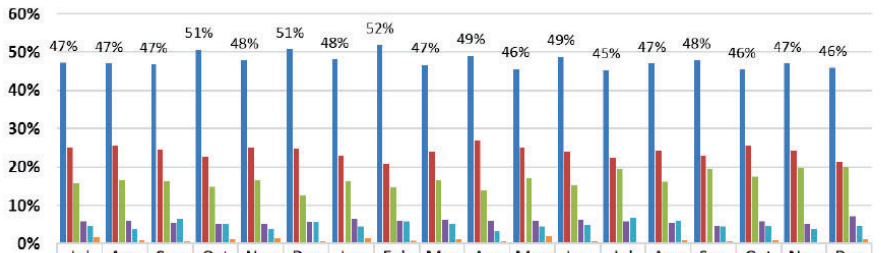

Medi-Cal and Medi-Cal Mged Average Length of Stay
9.00
8.00
7.00
6.00
5.00
4.00
3.00
2.00
6.16
6.39
5.56
6.66
5.01
5.87
4.09
3.97
3.84
4.23
3.86
3.85
(389 Patients)
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun
2024 Actual
2025 Actual
2024 GMLOS
2025 GMLOS

Monthly Discharges of Observation Patients by their Length of Stay



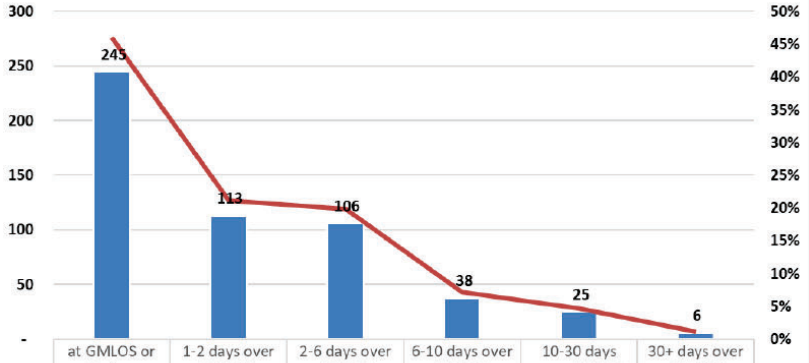

Hospitalist Average Length of Stay
533 Patients
7.00
6.00
5.00
4.00
3.00
2.00
1.00
-
5.83
5.96
5.37
5.62
5.11
5.86
3.94
3.95
3.80
3.83
3.77
3.89
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun
2024 Actual
2025 Actual
2024 GMLOS
2025 GMLOS
50%
45%
40%
35%
30%
25%
20%
15%
10%
5%
0%
% of Visits
46%
21%
20%
7%
5%
1%

FY25 Hospitalist LOS Distribution



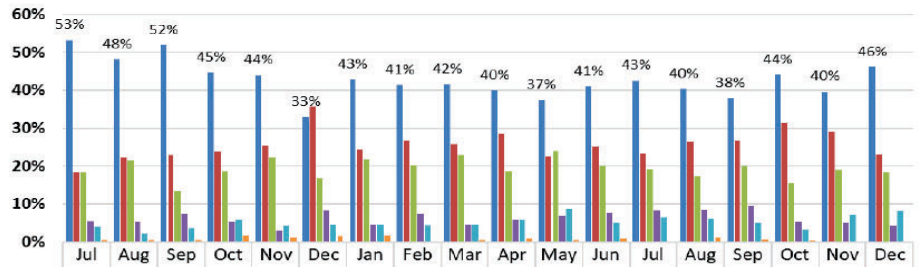
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	2024												2025					
at GMLOS or Better	47%	47%	47%	51%	48%	51%	48%	52%	47%	49%	46%	49%	45%	47%	48%	46%	47%	46%
1-2 days over GMLOS	25%	26%	25%	23%	25%	25%	23%	21%	24%	27%	25%	24%	22%	24%	23%	26%	24%	21%
2-6 days over GMLOS	16%	17%	16%	15%	17%	13%	16%	15%	17%	14%	17%	15%	20%	16%	19%	17%	20%	20%
6-10 days over GMLOS	6%	6%	5%	5%	5%	6%	6%	6%	6%	6%	6%	6%	6%	5%	5%	6%	5%	7%
10-30 days over GMLOS	5%	4%	6%	5%	4%	6%	5%	6%	5%	3%	4%	5%	7%	6%	4%	5%	4%	5%
30+ days over GMLOS	2%	1%	0%	1%	1%	0%	1%	1%	1%	1%	2%	1%	0%	1%	0%	1%	0%	1%

Dec FY25 Hospitalist LOS Distribution



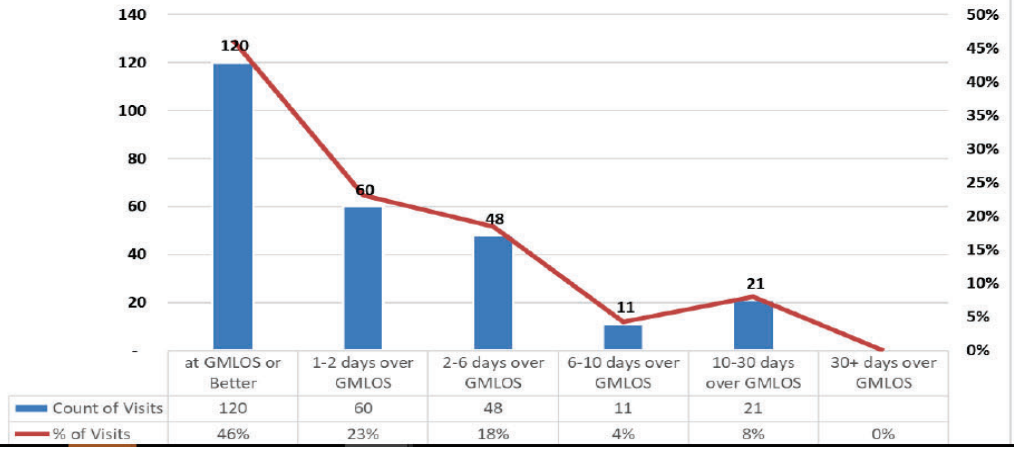
	at GMLOS or Better	1-2 days over GMLOS	2-6 days over GMLOS	6-10 days over GMLOS	10-30 days over GMLOS	30+ days over GMLOS
Count of Visits	245	113	106	38	25	6
% of Visits	46%	21%	20%	7%	5%	1%

FY25 FHCN LOS Distribution



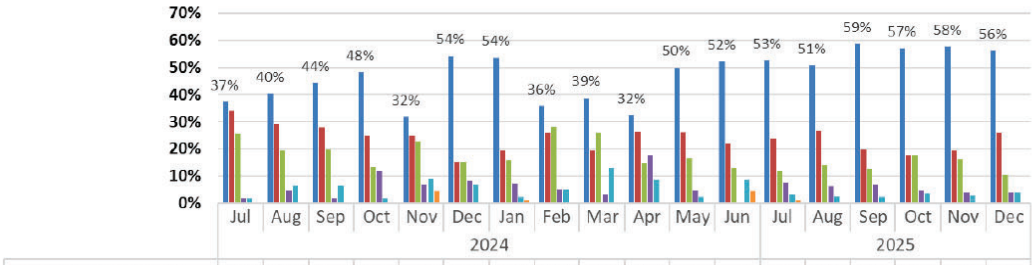
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	2024												2025					
at GMLOS or Better	53%	48%	52%	45%	44%	33%	43%	41%	42%	40%	37%	41%	43%	40%	38%	44%	40%	46%
1-2 days over GMLOS	18%	22%	23%	24%	25%	36%	24%	27%	26%	29%	23%	25%	23%	26%	27%	31%	29%	23%
2-6 days over GMLOS	18%	21%	14%	19%	22%	17%	22%	20%	23%	19%	24%	20%	19%	17%	20%	16%	19%	18%
6-10 days over GMLOS	5%	5%	7%	5%	3%	8%	5%	7%	5%	6%	7%	8%	8%	9%	10%	5%	5%	4%
10-30 days over GMLOS	4%	2%	4%	6%	4%	5%	5%	4%	5%	6%	9%	5%	7%	6%	5%	3%	7%	8%
30+ days over GMLOS	0%	0%	1%	2%	1%	2%	2%	0%	1%	1%	0%	1%	0%	1%	1%	0%	0%	0%

Dec FY25 FHCN LOS Distribution



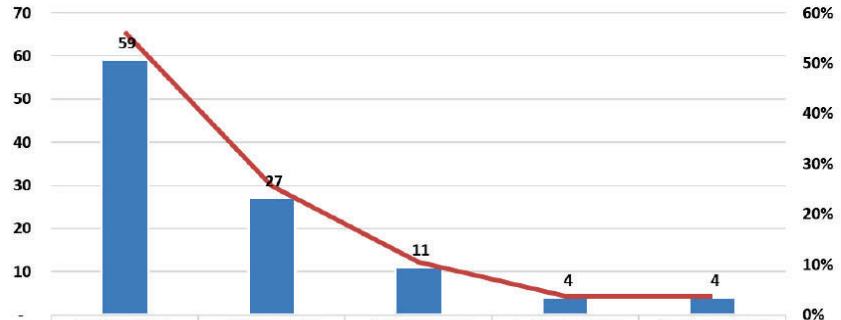
	at GMLOS or Better	1-2 days over GMLOS	2-6 days over GMLOS	6-10 days over GMLOS	10-30 days over GMLOS	30+ days over GMLOS
Count of Visits	120	60	48	11	21	
% of Visits	46%	23%	18%	4%	8%	0%

FY25 Humana-Key Medical LOS Distribution



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	2024												2025					
at GMLOS or Better	37%	40%	44%	48%	32%	54%	54%	36%	39%	32%	50%	52%	53%	51%	59%	57%	58%	56%
1-2 days over GMLOS	34%	29%	28%	25%	25%	15%	20%	26%	19%	26%	26%	22%	24%	27%	20%	17%	19%	26%
2-6 days over GMLOS	25%	19%	20%	13%	23%	15%	16%	28%	26%	15%	17%	13%	12%	14%	13%	17%	16%	10%
6-10 days over GMLOS	2%	5%	2%	12%	7%	8%	7%	5%	3%	18%	5%	0%	8%	6%	7%	5%	4%	4%
10-30 days over GMLOS	2%	6%	7%	2%	9%	7%	2%	5%	13%	9%	2%	9%	3%	3%	2%	3%	3%	4%
30+ days over GMLOS	0%	0%	0%	0%	5%	0%	1%	0%	0%	0%	0%	4%	1%	0%	0%	0%	0%	0%

Dec FY25 Humana-Key Medical LOS Distribution



	at GMLOS or Better	1-2 days over GMLOS	2-6 days over GMLOS	6-10 days over GMLOS	10-30 days over GMLOS
Count of Visits	59	27	11	4	4
% of Visits	56%	26%	10%	4%	4%

Performance Scorecard

Leading Performance Metrics – Inpatient & Observation

Age Group: (All) | Behavioral Health: (All)

Discharge Date: 8/1/2024 – 12/31/2024

Metric	Patient Type	Definition	Goal	Baseline**	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024
Observation Average Length of Stay (Obs ALOS) *(Lower is better)**	**Overall**	Average length of stay (hours) for observation patients	36	**38.24**	35.96	40.66	38.09	36.42	39.91
Inpatient Average Length of Stay (IP ALOS) *(Lower is better)**	**Overall**	Average length of stay (days) for inpatient discharges	5.64	5.59	5.73	5.35	5.68	5.24	5.74
Inpatient Observed-to-Expected Length of Stay *(Lower is better)***	**Overall**	Observed LOS / geometric mean length of stay for inpatient discharges	1.32	1.43	1.46	1.39	1.43	1.35	1.46
Discharges*	Inpatient	Count of inpatient discharges	N/A	1,331	1,382	1,298	1,355	1,229	1,267
	Observation	Count of observation discharges	N/A	762	750	749	770	753	806
	Overall	Count of inpatient and observation discharges	N/A	2,093	2,132	2,047	2,125	1,982	2,073

***All metrics above exclude Mother/Baby 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

Age Group: (All) | Behavioral Health: (All)

Check In Date and Time: 8/1/2024 12:00:00 AM – 12/31/2024 11:59:59 PM

Metric	Patient Type	Definition	Goal	Baseline**	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024
ED Boarding Time *(Lower is better)**	Inpatient	Median time (minutes) for admission order written to check out for admitted patients	**150**	200	198	199	164	153	201
	Observation	Median time (minutes) for admission order written to check out for observation patients	**150**	232	328	193	219	131	255
	Overall	Median time (minutes) for admission order written to check out for inpatient and observation patients	**150**	200	201	198	166	153	204
ED Admit Hold Volume *(Lower is better)**	**Overall >4 Hours**	Count of patients (volume) with ED boarding time ≥ 4 hours	**N/A**	417	434	411	281	247	404
ED Length of Stay (ED LOS) *(Lower is better)**	Discharged	Median ED length of stay (minutes) for discharged patients	**214**	287	290	296	295	261	265
	Inpatient	Median ED length of stay (minutes) for admitted patients	**500**	643	632	666	589	541	607
	Observation	Median ED length of stay (minutes) for observation patients	**500**	631	660	645	583	523	609
	Overall	Median ED length of stay (minutes) for admitted and discharged patients	**N/A**	330	329	341	338	302	305
ED Visits*	Discharged	Count of ED visits for discharged patients	**N/A**	6,348	6,454	6,272	6,251	5,890	6,656
	Inpatient	Count of ED Visits for admitted patients	**N/A**	1,179	1,215	1,146	1,179	1,121	1,131
	Observation	Count of ED Visits for observation patients	**N/A**	402	378	378	407	429	434
	Overall	Count of ED visits	**N/A**	7,929	8,047	7,796	7,837	7,440	8,221

***All metrics above exclude Mother/Baby encounter data.**

**Baseline calculation: Previous 6-month rolling median or average based on the metric's calculation

Observed-to-Expected Length of Stay

Unit Group	Loc Nurse Unit	Month of Discharge Date												
		Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24
Med/Surg	KHMC 1E Emergency Room ..	0.36	0.34	0.46	0.33	0.36	0.28	0.31	0.37	0.29	0.30	0.32	0.31	0.30
	KHMC 2N Medical Surgical	1.35	1.52	1.53	1.54	1.62	1.78	1.37	1.56	1.59	1.58	1.49	1.41	1.53
	KHMC 2S Medical Surgical	0.98	1.16	0.95	0.85	0.87	0.82	0.69	0.88	0.95	0.87	0.83	0.86	0.84
	KHMC 3N Medical Surgical	1.44	1.70	1.55	1.56	1.66	1.44	1.80	1.44	1.47	1.43	1.30	1.21	1.43
	KHMC 3S Medical Surgical	1.69	1.40	1.59	1.80	1.69	1.81	1.69	1.61	1.72	1.53	1.77	1.42	1.85
	KHMC 4N Medical Surgical	1.42	1.94	1.36	1.62	1.23	1.70	1.42	1.51	1.52	1.34	1.32	1.61	1.35
	KHMC 4S Medical Surgical	1.91	1.58	1.54	1.83	1.35	2.06	1.80	2.17	1.56	1.80	1.83	1.60	1.73
	KHMC 14 Medical Surgical	1.34	1.75	1.43	1.50	1.55	1.38	1.32	1.51	1.78	1.46	1.39	1.42	1.49
	KHMC BP Broderick Pavilion	0.82	1.00	0.71	0.74	0.65	0.76	0.84	0.80	1.42	0.96	0.97	0.69	0.79
	KHMC PE Pediatrics	0.73	1.01	0.96	0.65	0.78	0.76	0.60	0.77	0.66	0.81	0.73	0.63	0.92
ICU	KHMC 3W ICCU	1.56	1.32	2.14	1.18	0.99	1.85	1.73	1.61	1.18	1.53	1.59	1.73	1.28
	KHMC 1S ICCU	0.98	1.27	1.37	3.13	1.17	1.33	0.95	1.35	1.02	1.03	1.20	1.07	1.36
	KHMC CV Intensive Care	1.00	1.23	0.61	1.09	1.40	1.08	1.40	0.83	0.73	1.17	0.84	0.88	0.94
	KHMC IC Intensive Care	0.97	1.23	1.05	1.01	1.03	2.23	1.00	0.75	1.34	0.73	1.07	1.14	1.98
Grand Total		1.40	1.50	1.40	1.55	1.41	1.58	1.41	1.45	1.46	1.39	1.43	1.35	1.46

Observed-to-Expected Length of Stay by Calendary Year

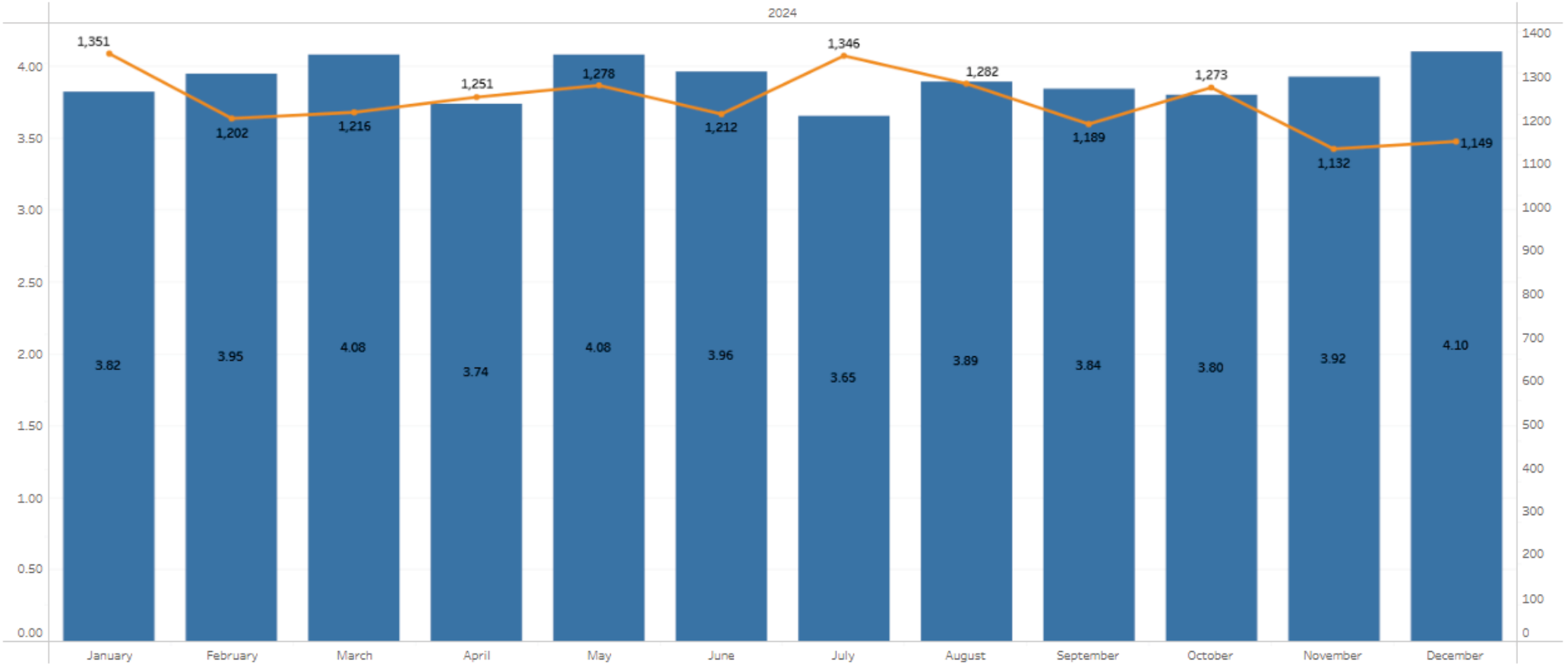
Unit Group	Loc Nurse Unit	Disch Dt Tm	
		2023	2024
Med/Surg	KHMC 1E Emergency Room Overflow	0.36	0.34
	KHMC 2N Medical Surgical	1.35	1.55
	KHMC 2S Medical Surgical	0.98	0.88
	KHMC 3N Medical Surgical	1.44	1.50
	KHMC 3S Medical Surgical	1.69	1.65
	KHMC 4N Medical Surgical	1.42	1.50
	KHMC 4S Medical Surgical	1.91	1.73
	KHMC 14 Medical Surgical	1.34	1.50
	KHMC BP Broderick Pavilion	0.82	0.87
	KHMC PE Pediatrics	0.73	0.80
ICU	KHMC 3W ICCU	1.56	1.50
	KHMC 1S ICCU	0.98	1.37
	KHMC CV Intensive Care	1.00	1.04
	KHMC IC Intensive Care	0.97	1.21

Average Length-of-Stay (hours) for Observation Patients

Unit Group	Loc Nurse Unit	Month of Discharge Date												
		Dec 2023	Jan 2024	Feb 2024	Mar 2024	Apr 2024	May 2024	Jun 2024	Jul 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024
Med/Surg	KHMC 1E Emergency Room Overflow	11.22	14.33	14.38	13.34	13.28	14.03	16.22	14.70	13.88	08.80	07.51	08.94	11.27
	KHMC 2N Medical Surgical	39.14	51.32	39.75	35.84	39.87	112.29	42.53	66.14	42.48	43.40	51.41	35.18	46.27
	KHMC 2S Medical Surgical	44.65	49.80	41.95	40.11	46.28	39.53	43.15	42.68	38.32	43.06	36.46	38.67	40.15
	KHMC 3N Medical Surgical	52.06	32.57	54.71	48.41	49.72	52.66	70.00	35.64	33.80	45.99	39.91	44.41	50.80
	KHMC 3S Medical Surgical	45.76	64.47	75.11	44.16	149.79	45.75	50.86	47.08	43.62	49.36	49.85	50.76	49.35
	KHMC 4N Medical Surgical	48.67	99.47	67.24	58.81	63.68	60.43	46.97	37.32	39.63	56.66	51.28	30.25	55.37
	KHMC 4S Medical Surgical	63.30	79.60	29.08	76.31	39.51	44.32	65.02	88.55	44.27	36.20	45.83	41.43	63.51
	KHMC 14 Medical Surgical	44.47	61.53	53.62	70.96	59.48	36.00	44.01	31.14	29.65	53.78	48.12	34.85	41.38
	KHMC BP Broderick Pavilion	27.37	29.18	30.51	31.10	28.28	30.09	26.62	27.97	26.44	31.71	28.70	25.14	26.66
	KHMC PE Pediatrics	27.07	18.69	20.20	19.92	21.64	21.32	28.46	19.36	22.69	22.14	21.67	19.44	19.30
ICU	KHMC 3W ICCU	69.45	63.10				67.77							11.92
	KHMC 1S ICCU	19.38						28.75	30.30		54.27			
	KHMC CV Intensive Care	70.57	117.40	01.65		34.85		38.97	31.95	26.94	38.48	28.85	20.37	23.08

Inpatient Average Discharge Order to Discharge Time (Hours)

*Exclusions: Patients with discharge order to discharge time > 24 hours.



Observation Program

Emma Mozier

Problem / Goals & Objectives / Metrics

Problem Statement: Observation patient length of stay has increased. Observation patients are not co-horted to support a streamlined workflow for this population for quick turn around.

Goals and Objectives: Improve efficiency of care in order to reduce overall observation patient length of stay.

Metrics: Observation hours, creating list of other metrics to monitor (ex: time of admit to order, readmission rate, etc)

Critical Issues / Barriers

Critical Issues (e.g. Barriers): None at this time

Deliverables:

Overall Obs LOS: July 38.28, Aug 35.96, Sept. 40.66, Oct. 38.09, Nov. 36.42, Dec. 39.91

2S Obs LOS: July 42.68, Aug. 38.32, Sept. 43.06, Oct. 36.46, Nov. 38.67, Dec. 40.15

Plan

(brief desciption of tasks, consider feedback loop, measures for success & communication plan)

#	Milestones	Start Date	Due Date	Who	Status R/Y/G
1	Meeting with key healthcare plans to evaluate if prior authorization if required can be changed to not required. Key Medical Group is very interested so far, taking to their Board for final decision May/June.	11/23	Ongoing	Kim F./Suzy/Emma	●
2	Evaluate and implement a second discharge/throughput round on 2S, continue to work on moving long obs and inpts off the unit (even through high census times)	7/24	Ongoing	Bre/Emma	●
3	Optimization and utilization review of observation power plan with key stakeholder physicians *Need: Provider specific LOS data	7/24	Ongoing	Emma/Stakeholder Physicians	●

On target / not yet started (not due); delay/slight concern; off target/serious concerns

Accomplishments / Next Steps

Accomplishments:

- Observation dashboard ready for use 10/2023. September power plan usage 47.45% (highest since go live 12/2023)
- PCP follow up process and resources finalized
- Medical observation patients are prioritized for placement on 2S
- Observation Powerplan updates went live 11/28/23: education to providers sent 11/27, Emma presented at Valley Hospitalist meeting 11/21, attended Department of Critical Care, Pulmonary Medicine & Adult Hospitalist meeting 12/18 to educate as well
- Outpatient appointment (NM Lexi, Treadmill, Holter, PCP) process implemented 6/3/24, 1st patient completed NM LexiScan on 7/12 (discharged 7/10)

Next Steps:

- Outpatient appointment process optimization: consider expanding the providers that are included
- Collaborate with radiology on MRI/CT delays
- Evaluate EEG outpatient appointment process
- Evaluate a targeted afternoon discharge round huddle on 2S
- Ongoing optimization of observation dashboard

Patient Progression

Denice Cabeje

Problem / Goals & Objectives / Metrics

Problem Statement: between January 1 – August 31, 2021, observed-to-expected length of stay (O/E LOS) was 1.44 and discharges before noon were well below the organizational goal of 25%, which led to higher than optimal occupancy rates, a large volume of ED holds (census of upwards to 20-40 per day) and limited bed availability for elective surgical cases or external transfers

Goals and Objectives: clarify care team roles and responsibilities; streamline and standardized multidisciplinary huddles to support advanced discharge planning and discharge before noon goal

Metrics: Questionable, may change. % of inpatients with discharge orders before 10 am and accuracy of predicted discharges and discharges before noon

Critical Issues / Barriers

Critical Issues (e.g. Barriers): staffing challenges; alignment of staff incentives and organizational goals

Deliverables:

- Clarify / update job descriptions and streamline corresponding workflows to allow Case Managers to operate at top of license
- Interdisciplinary structure standard for daily care facilitation, discharge planning and corresponding training tools
- Transparent anticipated discharge date for all care team and ancillary team members

Plan

(brief desciption of tasks, consider feedback loop, measures for success & communication plan)

#	Milestones	Start Date	Due Date	Who	Status R/Y/G
1	Phone Rounding with Hospitalists to identify DCP and date	12/30/24	01/27/25	Denice/Dr Said	
2	CM utilizing Delay of Care tabs and TS using work list from tab	01/27/25	02/24/25	Denice/TS	

On target / not yet started (not due); delay/slight concern; off target/serious concerns

Accomplishments / Next Steps

Accomplishments:

- Discharge Lounge second Care Coordinator will be back on 1/1/25
- Hiring for second FTE Throughput Supervisor and will have a PD also. Have worked through a SOP for staff fulfilling this role.
- Have CM staff starting to use Delays tab.

Next Steps:

- Identify staffing needs, several nurses in the RN programs going to half time. New staff is being interviewed to cover for the three nursing students, they need training time to get up to speed.
- Working on CM and CMA barriers to DC. Longest DC times are for Post Acute needs.
- Working with Molly and her team to identify streamlined processes. We now have scheduled time to work through processes.
- Conferring with payers on auth processes for DC to PACPs, we now have a dedicated staff member to work on auths and SNF placements.
- Working with PACPs on accepting and reason for not, timely auth submittal. This is also being worked through with our new dedicated Auth Nurse.

Next Meeting:

Wednesday, February 26, 2024
2:00p-3:30p
Granite Room

FINAL Q4 2024 Quarterly Compliance Report - Open Session

COMPLIANCE PROGRAM ACTIVITY REPORT – Open Meeting
Ben Cripps, Chief Compliance and Risk Officer
November 2024 through January 2025

EDUCATION

Live Presentations

- Compliance and Patient Privacy – New Hire Orientation
- Compliance and Patient Privacy – Management Orientation
- Compliance and Patient Privacy – Emergency Medicine PGY3 Administration Rotation
- Compliance and Patient Privacy – HIM Annual Education
- Compliance and Patient Privacy – Patient Accounting Annual Education
- Compliance and Patient Privacy – Case Management Annual Education
- Patient Privacy – Charge Nurse Curriculum

Written Communications – Bulletin Board / Area Compliance Experts (ACE) / All Staff / Leadership

- Importance of the Conditions of Admission
- Identity Theft
- Think Before You Act – Fairwarning
- Federal Stark Law: Physician Gifts/Non-Monetary Compensation Limit 2025

PREVENTION AND DETECTION

- **California Department of Public Health (CDPH) 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
    - Six (6) AFL's distributed and tracked between November 2024 – January 2025

- **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/future risk
    - Four hundred and fifty-three (453) bulletins distributed as assignments to department leaders and tracked between November 2024 – January 2025
        - Eighty-five percent (85%) compliance rate with assignment responses submitted within 15 days per policy. Fallouts are tracked and escalated as appropriate.

- **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
    - Twenty (20) OIG audit plan issues distributed and tracked between November 2024 – January 2025

- **California State Senate and Assembly Bill Updates** – Review and distribute legislative updates to areas potentially affected by new or changed bills; department responses reviewed and tracked to address regulatory change and identify potential current or future risk

- Thirteen (13) newly approved Assembly Bills distributed and tracked between November 2024 – January 2025
- Three (3) newly approved Senate Bills distributed and tracked between November 2024 – January 2025

- **Centers for Medicare and Medicaid Services (CMS) Final Rule** – Review and distribution of the 2025 CMS Final Rule for Inpatient Prospective Payment System (IPPS), Outpatient Prospective Payment System (OPPS), Inpatient Psychiatric Facility (IPF), Inpatient Rehabilitation Facility (IRF), End-Stage Renal Disease (ESRD), Skilled Nursing Facility (SNF), Home Health, Hospice, and Physician Fee Schedule (PFS) Prospective Payment System policy and payment updates; department responses reviewed and tracked to address the regulatory change and identify potential current/future risk
  - Two hundred and ten (210) topics distributed as assignments to department leaders

- **Patient Privacy Walkthrough** – Quarterly observations of privacy practices and privacy-related regulatory requirements including signage throughout Kaweah Health's inpatient and outpatient facilities; issues identified communicated to area Management for follow-up and education
  - Findings of the quarterly privacy walkthroughs performed between November 2024 – January 2025 noted:
    - Distribution and confirmation of new Discrimination signage

- **Electronic Medical Record (EMR) User Access Privacy Audits** – Daily monitoring of EMR user access through the use of FairWarning electronic monitoring technology which analyzes user and patient data to detect potential privacy violations
  - Average of one hundred and thirty-eight (138) daily alerts reviewed and investigated between November 2024 – January 2025

- **Office of Inspector General (OIG) Exclusion Attestations** – Quarterly monitoring of OIG Exclusion List review and attestations. Monthly screening and review of OIG Exclusion List for non-credentialed providers who have ordered ancillary services for patients presenting at the medical center
  - Nine (9) non-credentialed providers identified on the Medicare Opt-Out list between November 2024 – January 2025, findings tracked and logged in the system. No additional action required as the patients for whom services were ordered did not have Medicare coverage

OVERSIGHT

- **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

- **Medicare Recovery Audit Contractor (RAC) and Medicare Probe Audit Activity** – Records preparation, tracking, appeal timelines, and reporting
  - The following RAC Audit Activity took place between November 2024 – January 2025:
    - Eighty-eight (88) new RAC audit requests received, tracked and processed
    - Seven (7) RAC audit request appeals approved

- Six (6) RAC audit request appeals denied
- Seventy-seven (77) RAC audit request responses pending in review status

- **Licensing Applications and Medi-Cal/Medicare Facility Enrollment** – Forms preparation and submission of licensing applications to the California Department of Public Health (CDPH); ongoing communication and follow-up regarding status of pending applications. The following applications for licensure and/or enrollment were completed between November 2024 – January 2025:
    - Sequoia Regional Cancer Center Facility Medicare enrollment
    - Skilled Nursing Facility Medicare revalidation enrollment
    - Willow Suites 2nd & 5th Floors On-Campus Provider Designation Medicare enrollment updates
    - Kaweah Health Cardiology Center - Tulare Medi-Cal enrollment

- **KD Hub Non–Employee User Access** – Oversight and administration of non-employee user onboarding, privacy education, and user profile tracking; evaluate, document, and respond to requests for additional system access; on-going management of non-employee KD Hub users
    - Ninety-nine (99) system access applications were received and processed
    - A new user access application and tracking system was developed and implemented to replace the previous vendor, resulting in cost savings

RESEARCH, CONSULTATION AND OVERSIGHT

- **Conditions of Admission (COA) and Overall Registration Policy Process –** Consultation and oversight; Compliance was engaged to evaluate the Conditions of Admission (COA) process, specifically to establish a standardized protocol outlining the required frequency for the completion of COAs for individual patient visits as well as treatment series encounters, in which a patient is receiving repetitive outpatient treatments ordered by a practitioner for the treatment of a specific medical condition or diagnosis for a defined period of time. Workgroups reviewed regulations, policies, processes and current workflows, which identified gaps surrounding consistent application and formal definition of treatment series encounters. Policies and workflows were established to standardize the definition of treatment series encounters across all outpatient departments to ensure consistent COA requirements.

- **Inpatient Rehabilitation Facility (IRF) Preadmission Screening Clinical Scope –** Research and Consultation; Compliance was engaged to assess the scope of clinical personnel within the Inpatient Rehabilitation Facility (IRF) to conduct the preadmission screening process for admission to the IRF; specifically if Licensed Vocational Nurses (LVNs) were qualified to perform the screening according to regulatory requirements. The Medicare Benefit Policy Manual was reviewed and determined that qualified, licensed or certified clinical staff, including LVNs, may perform the preadmission screening as determined by IRF physicians. Findings were shared with IRF leadership.

- **Reporting of County Mental Health Patients SB 929** – Research and Consultation; Compliance was engaged by Patient and Family Services (PFS) to review and determine the appropriateness and extent of mental health 5150-designated patient data to be reported to Tulare County in accordance with Senate Bill 929 (SB929). SB929 was reviewed along with

state and federal privacy laws. Guidance outlining the appropriate data elements to include within SB929 required reporting was provided to PFS leadership.

- **Speech Language Pathologist (SLP) Certification Billing –** Research and Consultation; Compliance was engaged to evaluate the impact on billing for services for Speech Language Pathologists (SLPs) who obtain a national Certificate of Clinical Competence in Audiology and Speech-Language Pathology. Research into the chargemaster and SLP Medicare billable codes was conducted and determined that there is only one code used for billing SLP services, regardless of additional certification. Findings were shared with Rehabilitation Leadership.

- **Nasal Swab Scope of Practice in the Emergency Department** – Research and Consultation; Compliance was engaged to evaluate the scope of practice to perform nasal swabs for three of the clinical roles in the Emergency Department (ED). The scope of practice for Emergency Department Technicians (ED Techs), Medical Assistants (MAs), and Certified Nursing Assistants (CNAs) were reviewed, in addition to Title 22 regulatory guidance outlining requirements in a hospital setting. It was determined that ED Techs and MAs are allowed to perform nasal swabs, however CNAs are not. Findings were shared with ED Leadership.

- **Retacrit (Epotin) Charging Issue** – Consultation and Oversight; The Compliance Department was notified of a charge issue for inpatient Dialysis pharmaceutical drug, Retacrit. During a routine charge audit, it was identified that multiple accounts were holding for Retacrit due to charges exceeding the allowable billable units for the drug's associated revenue code. Through a review of the issue, it was discovered that the charge was inadvertently built for a single-dose vial, however, the drug was being dispensed as a multi-dose vial. Due to this discrepancy, the total charges and dose quantities were incorrect. After review of the 340B CDMs/NDCs and accumulations associated, it was noted that the accumulations matched the product which was appropriate. A charge audit was completed and determined that due to the accumulations being accurate and having no financial impact, there was no need to process corrected claims. An audit conducted in December 2024 confirmed effective corrective measures.

AUDITING AND MONITORING

- **High Cost DRG, Inpatient Amputations & Outpatient Watchman Coding Audit** – As a part of Kaweah Health's auditing and monitoring processes, high-cost procedures and services, as well as new procedures, are evaluated as potential risk areas for accurate coding and billing. Through the risk assessment process, an audit was initiated to evaluate the accuracy of high-cost and amputation inpatient Diagnosis-Related Group (DRG) coding assignments and outpatient watchman procedure coding. An external audit agency was engaged to conduct a facility review of fifty-six (56) randomly selected Medicare patient encounters, twenty-four (24) of which were inpatient encounters with high-cost DRG assignments, thirty-one (31) of which were inpatient amputation encounters, and one (1) of which was an outpatient watchman procedure with dates of service between July 1- August 31, 2024. Clinical coding and billing documentation was reviewed to evaluate accuracy and compliance in accordance with Medicare guidelines. The review noted a ninety-two percent (92%) DRG accuracy rate, resulting in four (4) total DRG changes, of which three (3) were underpayments totaling $46,330 and one (1) overpayment totaling $1,111. The review noted a virtually untraceable net financial error rate of 0.08%. The results of the outpatient watchman procedure resulted in a

100% procedure code accuracy and a net financial error rate of 0%. The findings of the review have been communicated with the coding leadership team. Risks associated with inpatient DRG, inpatient amputation and outpatient watchman procedure coding will be monitored to determine if a reaudit will be required in the future.

Hospice Board report 2.2025

Kaweah Health Care District
Annual Report to the Board of Directors

Hospice Services

Tiffany Bullock, RN, BSN Contact number: 559-624-6447
Melany Gambini, RN Contact number: 559-624-8647
Director of Hospice Services
February 20, 2025

Summary Issue/Service Considered

- Kaweah Health Hospice's mission is to deliver optimal end-of-life care to pediatric and adult populations in Kings/Tulare. Southern Fresno counties via the hospice and concurrent care program. Hospice provides physical, emotional, social and spiritual support to terminally ill patients as well as their families using a team approach to help them live with dignity and comfort as they cope with end-of-life issues. The Ruth Wood Open Arms house complements hospice services by providing a home for end-of-life care for our community when patients have no other resources for care to be provided elsewhere.
- Hospice and concurrent care services provide nursing, physical and occupational therapy, spiritual counselors, social work services and home health aides to assist with personal care. In addition, Kaweah Health Hospice utilizes volunteers to provide much needed services to patients that could not be provided otherwise. This year a part time volunteer specialist was hired through a grant from the Kaweah Health Hospice Foundation to increase efforts to recruit and place volunteers for the benefit of our hospice patients. Additionally, this volunteer specialist will also utilize some volunteers to provide education to our local skilled nursing and assisted living facilities to increase awareness of the benefits and advantages of utilizing Kaweah Health Hospice.
- Of note is the fact that Kaweah Health Hospice continues to see children seeking concurrent care. For calendar year 2024 pediatric Average Daily Census (ADC) was 82.5, an increase of 5.5 from FY2023. In addition, in 2024, we began to service children in the Southern Fresno County area due to a need which was not being met by hospice agencies from Fresno County.
- Hospice utilizes Kaweah Health Home Infusion Pharmacy for medications needed for patients and works closely with them in coordinating services. The ability to receive medications for patients at the reduced cost lends to profitability.
- Hospice continues to be able to provide care to indigent patients who do not have insurance or means to pay for services with the support of the Kaweah Health Hospice Foundation. Additionally, while the Open Arms House does depend on residents and family members to help cover the cost of care to the best of their financial ability, if family is unable to cover the cost, we can offer a reduced rate based on the patient's income. The difference in cost will be covered through our partnership with Kaweah Health Hospice Foundation.

Financial/statistical Analysis

Hospice

- Average daily census for FY2024 was 120. There is no change in this from FY2023. There have been minimal changes to expenses with volumes projected to remain the same from the previous year.
- Hospice had a FY2023 contribution margin of $2.8 million, a slight increase from the previous fiscal year.
- Net revenue per unit of service was $214, up 7% from FY2023.

- Direct cost per unit of service increased by 5.5% from $141 to $150. This is primarily attributed to an increase in salaries due to pay for performance increases and market rate adjustments.
- Contribution margin has increased from $58 to $64 in FY2024. This is due to efforts to ensure we operating lean and also continue working with billing services to maximize collections.
- The average length of stay for 2024 was 17 days for adults. This is a notable decrease from previous years. Increased length of stay results in increased revenue as well as patients/families being able to receive the full benefit of the Hospice services. This is the result of the majority of referrals coming from the acute hospital where patients continue to seek treatment until the very end of life, leading to very short lengths of stay in Hospice.
- In 2024, billing services were outsourced to Simitree Healthcare. The goal was to increase collections and decrease avoidable adjustments. This began September 1, 2024. Evaluation continues taking place to determine the benefit of this, but at this time is looks optimistic.

Open Arms House

- FY2024 showed 1,112 patient days. This equates to an average daily census of 3 residents. This is a 6.6% increase from FY2023.
- FY2024 showed a 2.5% increase in expenses, due to market rate increases for staff. The Hospice Foundation, through monies received from donations and fund raising events, covers losses seen by the Open Arms House annually. Since opening the home in July 2022, the Hospice Foundation has made the District whole each fiscal year.

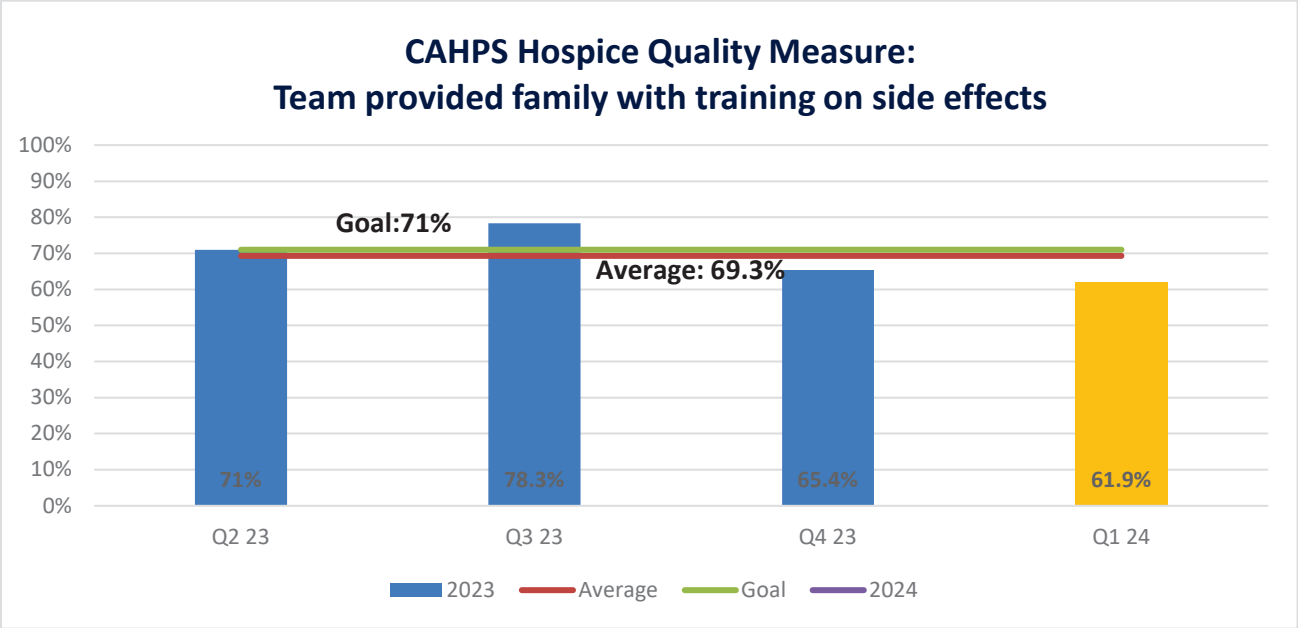
Quality/Performance Improvement Data

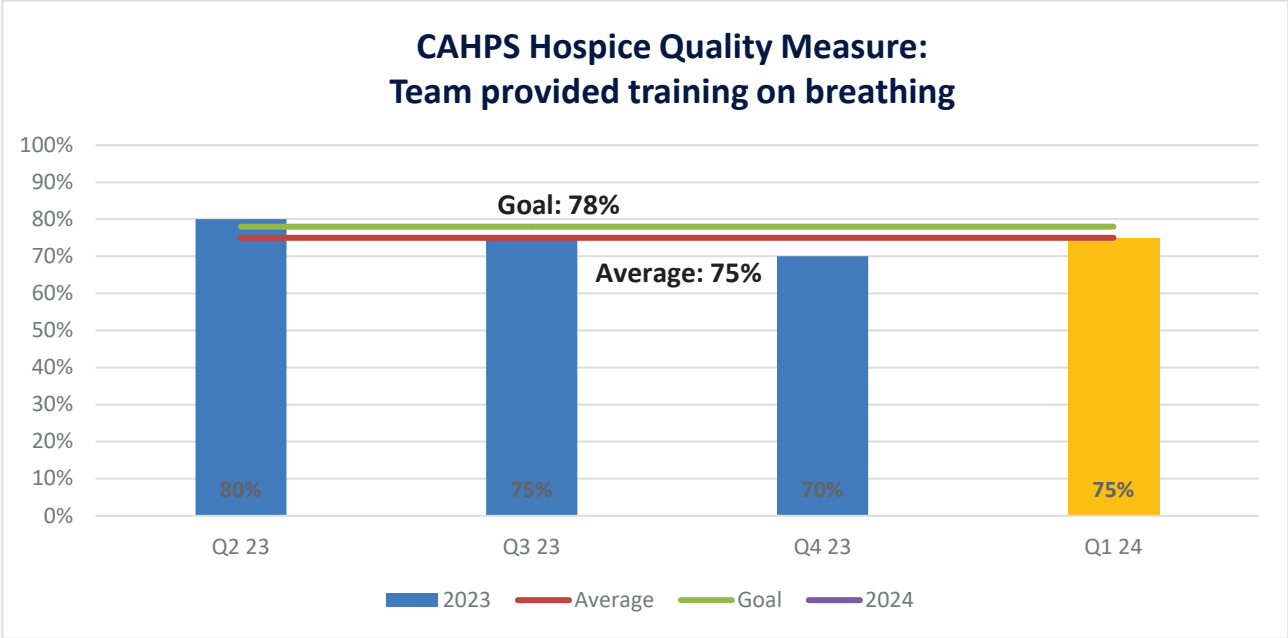
Quality reporting - Hospice

- Hospice Item Set (HIS) data - Mandated reporting of data collected and reported to Medicare (CMS) on admission and at time of death or discharge. Reporting time frames have been met. We exceed the national benchmark in all elements.
- Hospice Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey - This is a CMS mandated survey that measures caregiver experience as well as quality measure information received from submissions on the Hospice Item Set. We exceed the national percentage in all elements in both categories of family caregiver experience as well as quality of patient care. We currently have a 4-star rating for family caregiver survey summaries.
- In October 2025, CMS has scheduled to utilize the Hospice Outcomes and Patient Evaluation (HOPE) tool. This will be a new assessment tool for hospices which will replace the HIS as part of the Hospice Quality Reporting Program.

PI measures

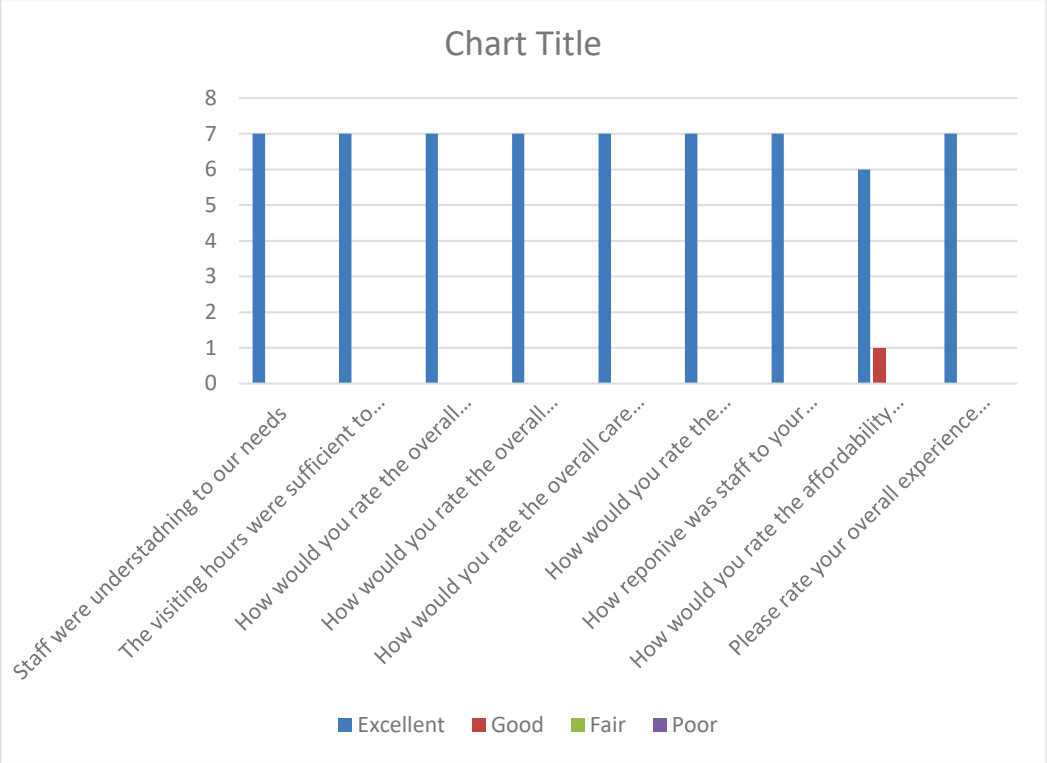
As is noted from the graphs below and mentioned above, Hospice meets or exceeds the national averages in all categories. Measures were recently submitted to the District Quality Committee via the ProStaff that will be the focus over the next year. These measures were chosen either due to recent decreases or as matter of importance to the overall quality of care. These measures include team provided training on breathing and team provided family with training on side effects. These statistics are obtained from NRC, an independent company we contract with the distribute the survey. These are used because they can provide more current, relevant and detailed data than that reported by CMS on Hospice Compare. This information from NRC will eventually be submitted to CMS and will be publicly reported. Action plans to stabilize and/or increase percentages in these measures have been implemented and are being monitored.


CAHPS Hospice Quality Measure:
Team provided family with training on side effects
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Goal:71%
Average: 69.3%
71%
78.3%
65.4%
61.9%
Q2 23
Q3 23
Q4 23
Q1 24
2023
Average
Goal
2024


CAHPS Hospice Quality Measure:
Team provided training on breathing
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Goal: 78%
Average: 75%
80%
75%
70%
75%
Q2 23
Q3 23
Q4 23
Q1 24
2023
Average
Goal
2024

Quality reporting – Open Arms House

In September 2024, satisfaction surveys began being sent to families after their loved one had expired at the Open Arms House. The goal is to obtain meaningful feedback for improvement and increase satisfaction. After the first round of results were received, it was noted 98% rated the home as “excellent” with one response noting it as “good”. These will continue to be sent and results shared with all interested parties.



Policy, Strategic or Tactical Issues

- Kaweah Health Hospice continues to see competition from the for-profit agencies in this area. These agencies have a strong emphasis on marketing to the community physicians and facilities and the finances to support these endeavors. In January 2025, a new Director was hired for Hospice with a revised job description. In addition to director responsibilities, this position has also been revised to include marketing and community relation efforts and a salary bonus paid for meeting or exceeding defined metrics. Focus will be on capturing more market share of referrals received from community skilled nursing and assisted living facilities.
- Kaweah Health Ruth Wood Open Arms continues to flourish in providing much needed assistance to our vulnerable Kaweah Health Hospice patients who do not have care available to them in their own home. All of these patients are serviced by Kaweah Health Hospice, which generates revenue for this department as well. Since opening, it has served nearly 250 residents.
- Hospice Director will continue weekly meetings with Simitree Healthcare to ensure billing is timely and collections are optimized.

Recommendations/Next Steps

- Continue to increase referral sources through marketing campaigns and efforts of Hospice Director and Kaweah Health Marketing Department, especially from community facilities.
- Ongoing pre- and post-billing monitoring to ensure regulatory requirements are met and no revenue is lost.
- Continued improvement and stabilization of financial performance.

- Increase the number of volunteers in Hospice.
- Provide an increased presence at community events and service club meetings.

Approvals/Conclusions

In the coming year, hospice will focus on:

1. Continue marketing campaigns/efforts to become the preferred hospice provider with the community and local facilities.
2. Continued review of profitability, look for means to maintain contribution margins and cost of care, increase patient satisfaction, increase staff satisfaction and achieve clinical excellence.
3. Grow the hospice volunteer program.
4. Continue to utilize the Open the Kaweah Health Ruth Wood Open Arms House for patients with the need.

KAWEAH HEALTH ANNUAL BOARD REPORT

FY2025

Hospice Services - Summary

KEY METRICS - FY 2025 - Six Months Annualized through December 31, 2024

UNIT OF SERVICE (Hospice Days)	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
43,442	9,949,606	6,672,216	3,277,390	2,376,492
▶ 0%	▲ 7%	▲ 2%	▲ 17%	▲ 35%

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

METRICS BY SERVICE LINE - FY 2025

SERVICE LINE	UNIT OF SERVICE (Hospice Days)	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
Hospice	42,062	$9,490,816	$6,213,426	$3,277,390	$2,053,166
Open Arms	1,380	$458,790	$458,790	$0	($740,196)
NonCerner Total	43,442	$9,949,606	$6,672,216	$3,277,390	$1,312,970

METRICS SUMMARY - 4 YEAR TREND

METRIC	FY2022	FY2023	FY2024	FY2025 Annualized	%CHANGE FROM PRIOR YR	4 YR TREND
NIT OF SERVICE (Hospice Days	50,259	44,843	43,572	43,442	▶ 0%	
Net Revenue	9,241,039	8,938,605	$9,321,547	$9,949,606	▲ 7%	
Direct Cost	5,986,228	$6,332,600	$6,518,457	$6,672,216	▲ 2%	
Contribution Margin	3,254,811	$2,606,005	$2,803,090	$3,277,390	▲ 17%	
Indirect Cost	1,224,926	$1,847,031	$1,832,254	$1,964,420	▲ 7%	
Net Income	2,029,885	$758,974	$970,836	$1,312,970	▲ 35%	
Net Revenue Per UOS	$184	$199	$214	$229	▲ 7%	
Direct Cost Per UOS	$119	$141	$150	$154	▲ 3%	
Contrb Margin Per UOS	$65	$58	$64	$75	▲ 17%	

KAWEAH HEALTH ANNUAL BOARD REPORT

FY2025

Hospice Services

KEY METRICS - FY 2025 - Six Months Annualized through December 31, 2024

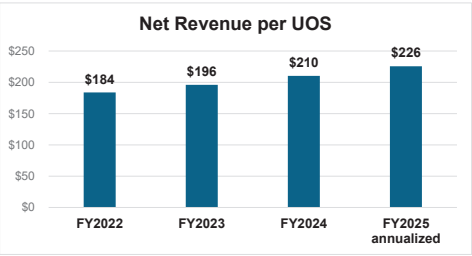
UNIT OF SERVICE (Hospice Days)	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
42,062	$9,490,816	$6,213,426	$3,277,390	$2,053,166
▼ -1%	▲ 6%	▲ 1%	▲ 17%	▲ 31%

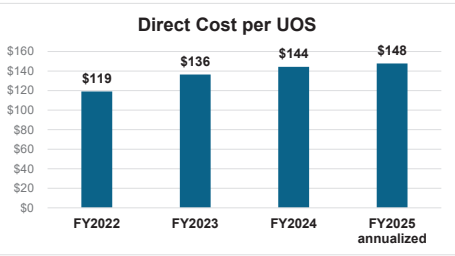
*Note: Arrows represent the change from prior year and the lines represent the 4-year trend

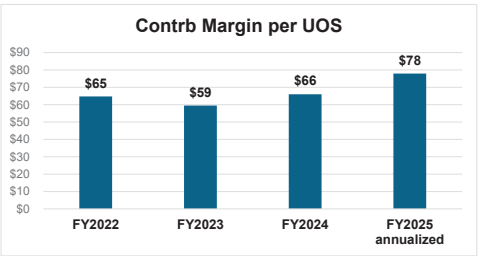
METRICS SUMMARY - 4 YEAR TREND

METRIC	FY2022	FY2023	FY2024	FY2025 annualized	%CHANGE FROM PRIOR YR	4 YR TREND
Unit of Service (Hospice Days)	50,259	43,805	42,460	42,062	▼ -1%	
Net Revenue	$9,241,039	$8,582,828	$8,930,495	$9,490,816	▲ 6%	
Direct Cost	$5,986,228	$5,977,050	$6,128,682	$6,213,426	▲ 1%	
Contribution Margin	$3,254,811	$2,605,778	$2,801,813	$3,277,390	▲ 17%	
Indirect Cost	$1,224,926	$1,225,079	$1,235,807	$1,224,224	▼ -1%	
Net Income	$2,029,885	$1,380,699	$1,566,006	$2,053,166	▲ 31%	
Net Revenue per UOS	$184	$196	$210	$226	▲ 7%	
Direct Cost per UOS	$119	$136	$144	$148	▲ 2%	
Contrb Margin per UOS	$65	$59	$66	$78	▲ 18%	

PER CASE TRENDED GRAPHS

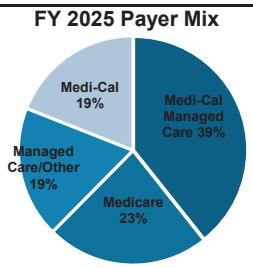




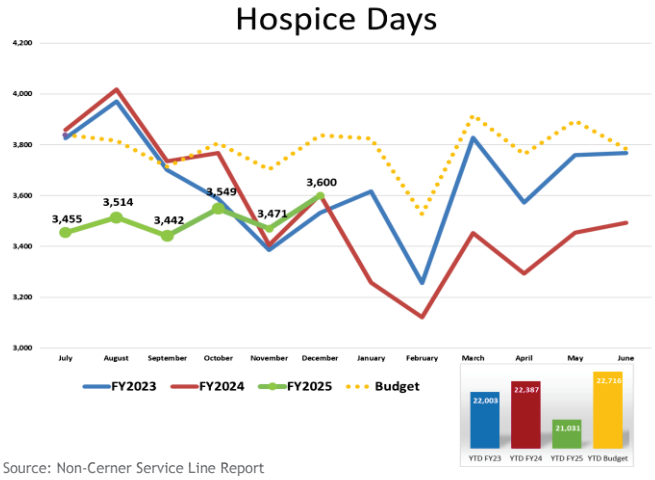


PAYER MIX - 4 YEAR TREND (Gross Charges)

PAYER	FY2022	FY2023	FY2024	FY2025	Reimb/ Hospice Day
Medi-Cal Managed Care	33%	39%	39%	39%	
Medicare	32%	28%	25%	23%	$211
Managed Care/Other	20%	23%	22%	19%	$218
Medi-Cal	14%	9%	14%	19%	
Medi-Cal MC/Medi-Cal Comb	48%	49%	53%	58%	$235



UNIT OF SERVICE GRAPH - HOSPICE DAYS TRENDED



Source: Non-Cerner Service Line Report
Note: Hospice Service Line

KAWEAH HEALTH ANNUAL BOARD REPORT

FY2025

Hospice Services
Open Arms House

KEY METRICS - FY 2025 - Six Months Annualized through December 31, 2024

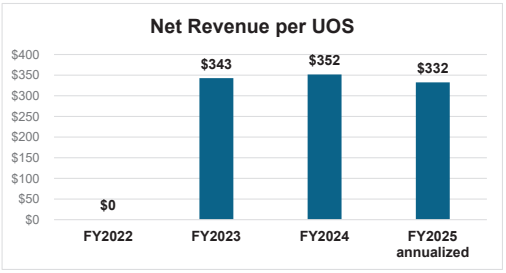
UNIT OF SERVICE (Hospice Days)	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
1,380	$458,790	$458,790	$0	($740,196)
▲ 24%	▲ 17%	▲ 18%	▼ -100%	▼ -24%

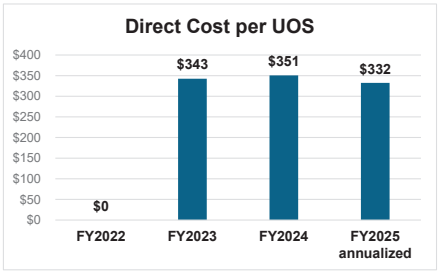
*Note: Arrows represent the change from prior year and the lines represent the 4-year trend

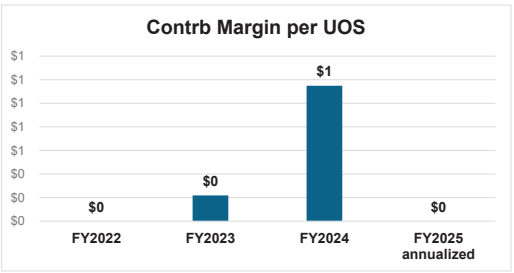
METRICS SUMMARY - 4 YEAR TREND

METRIC	FY2022	FY2023	FY2024	FY2025 annualized	%CHANGE FROM PRIOR YR	4 YR TREND
Unit of Service (Hospice Days)	0	1,038	1,112	1,380	▲ 24%	
Net Revenue	$0	$355,777	$391,052	$458,790	▲ 17%	
Direct Cost	$0	$355,550	$389,775	$458,790	▲ 18%	
Contribution Margin	$0	$227	$1,277	$0	▼ -100%	
Indirect Cost	$0	$621,952	$596,447	$740,196	▲ 24%	
Net Income	$0	($621,725)	($595,170)	($740,196)	▼ -24%	
Net Revenue per UOS	$0	$343	$352	$332	▼ -5%	
Direct Cost per UOS	$0	$343	$351	$332	▼ -5%	
Contrb Margin per UOS	$0	$0	$1	$0	▼ -100%	

PER CASE TRENDED GRAPHS

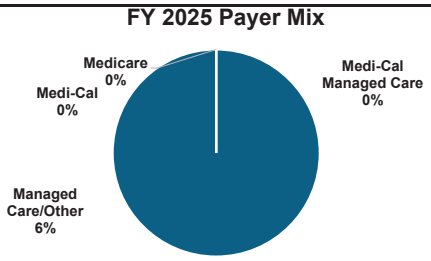




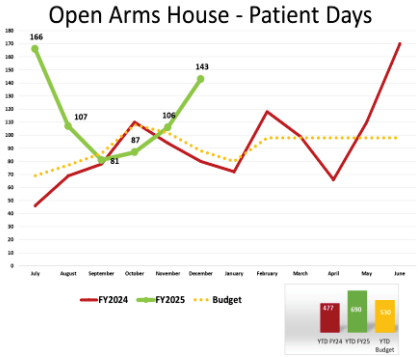


PAYER MIX - 4 YEAR TREND (Gross Charges)

PAYER	FY2022	FY2023	FY2024	FY2025
Managed Care/Other	0%	7%	6%	6%
Medicare	0%	0%	0%	0%
Medi-Cal Managed Care	0%	0%	0%	0%
Medi-Cal	0%	0%	0%	0%



UNIT OF SERVICE GRAPH - HOSPICE DAYS TRENDED



Source: Non-Cerner Service Line Report
Note: Open Arms House Service Line

AP41. Quality Improvement

Kaweah Delta Health Care District

Administrative Manual

Policy Number: AP41	**Date Created: Not Set**
Document Owner: Cindy Moccio (Board Clerk/Exec Assist-CEO)	**Date Approved: 01/26/2022**
Approvers: Board of Directors (Administration)	
Quality Improvement Plan	

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

I. Purpose

The purpose of Kaweah Health's Quality Improvement Plan is to have an effective, data-driven Quality AssessmentPerformance Improvement program that delivers high-quality, excellent clinical services and enhances patient safety.

II. Scope

All Kaweah Health facilities, departments, patient care delivery units and/or serviceareas fall within the scope of the quality improvement plan requirements.

III. Structure and Accountability

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.

Quality Committee (“QComm”)

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 providesoversight for medical staff quality functions including peer review.

QComm 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, 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, Directors of Quality and Patient Safety, Nursing Practice, Pharmacy, Accreditation, and Risk Management; Manager of Quality and Patient Safety, Manager of Infection Prevention and Environmental Safety Officer. This committee reports to Medical Executive Committee and the Quality Council.

The QComm shall have primary responsibility for the following functions:

1. **Health Outcomes:** The QComm shall assure that there is measureable improvement in indicators with a demonstrated link to improved healthoutcomes. 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 QComm 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 QComm 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.

3. **Prioritization:** The QComm shall prioritize quality improvement activities toassure 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 QComm is responsible toestablish organizational Quality Focus Teams who:

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

4. **Improvement:** The QComm shall use the analysis of the data to identifyopportunities for improvement and changes that will lead to improvement. The QComm will also oversee implementation of actions aimed at improving performance.

5. **Follow- Up:** The QComm 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.

6. **Performance Improvement Projects:** The QComm 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 QComm must also ensure there is documentation of what quality improvement projects are being conducted, the reasons for conducting those projects, and the measureable progress achieved onthe 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

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 Health 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."

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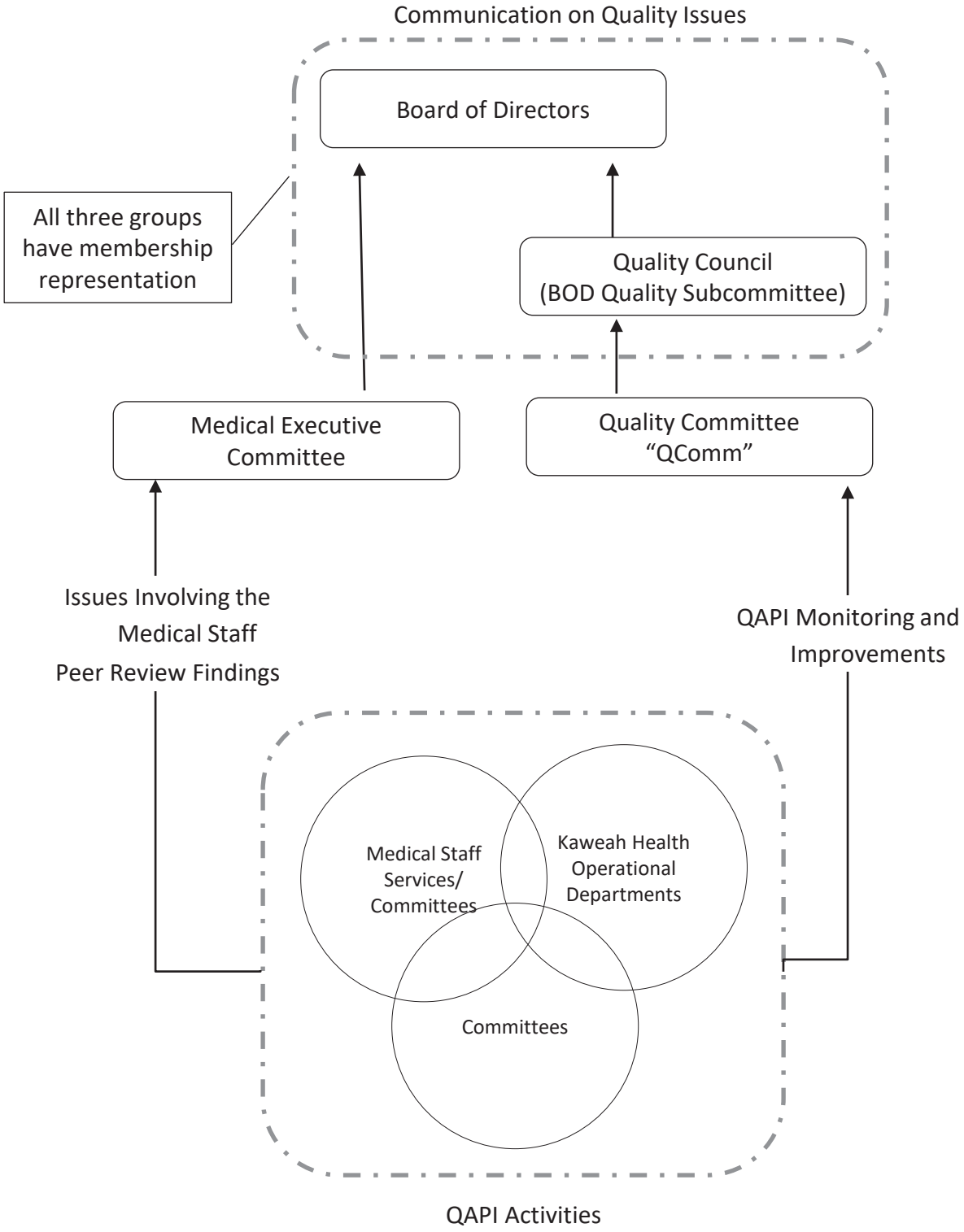
Attachment 1

Kaweah Health

Quality Reporting Structure



Quality Committee "QComm" Participating 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 and committees include, but are not limited to:

Professional & Patient Care Services
Laboratory
Blood Utilization
Dept of Radiology/imaging Services (including Radiation Safety Report)
Dept of Emergency Medicine
Dept of Pathology
EOC (Security, Facilities, Clinical Engineering, EVS, Employee Health, Workplace Violence)
Peer Review
Patient Access
Population Health
Nutrition Services
Quality Incentives Program (QIP), includes all Rural Health Clinics (Exeter, Lindsay, Woodlake, Dinuba, Tulare)
Pharmacy
Inpatient Pharmacy
Med Safety & ADE (Quarterly)
MERP Annual Review
Chemo Annual Review
Infection Prevention Services
Infection Prevention Committee
Healthcare Acquired Infection Prevention Committee & Hand Hygiene
Risk Management
Risk Management (RCA and Focus Review Summary)
Grievances
Mental Health Services
Dept of Psychiatry, Mental Health Hospital
Maternal Child Health/ Dept of OB/GYN & Peds
Labor & Delivery
Mother Baby
Neonatal Intensive Care Unit
Pediatrics
Respiratory Services
Sleep Lab and EEG
Respiratory Therapy and Pulmonary Function Test
Care Management
Patient & Family Services
Case Management
Interpreter Services
Palliative Care Committee
Episodic Care
Emergency Dept. Quality Report
Trauma Service
Urgent Cares
Cardiovascular Services

Dept of Cardiovascular Services (ACC, STS); Cath lab, IR, CVCU, 4T and Cardiac Surgery
Telemonitoring Report
Non Invasive Inpatient Services
Critical Care Services
Intensive Care Unit, CVICU (non-cardiac), 3W, 5T
Organ Donation
Rehabilitation Services
Rehabilitation
Inpatient Therapies (KDMC, Rehab, South Campus)
Outpatient Therapies: Medical Office Building Akers (MOB), Exeter, Sunnyside, Dinuba, Lovers Lane, Therapy Specialists at Rehab/Neuro
Outpatient Wound Clinic at Rehab (included in Rehab report)
Post Acute Services
KH Home Infusion Pharmacy (KHHIP)
Hospice
Home Care Services (Home Health)
Short-Stay Rehab
Skilled Nursing Services (subacute and short-stay)
Surgical Services
SQIP - Surgical Quality Improvement Committee
Ambulatory Surgery Center/PACU/KATS
Operating Room
Sterile Processing Department
Inpatient units: Broderick Pavilion, 3N, 4S
Anesthesia Services
Orthopedics
Endoscopy
Renal Services/ Dept of Renal Services
4 North
KH Visalia Dialysis
Publically Reported Measures

Value Based Purchasing Report
Healthgrades
Leapfrog Hospital Safety Score
Committees
Health Equity
Falls Committee
RRT/Code Blue
Patient Care Leadership (pain management)
HAPI Committee (includes inpatient wound care)
Sepsis Quality Focus Team
Healthcare Acquired Infection Committee (CAUTI, CLABSI, MRSA, Hand Hygiene)
Stroke Committee Report
Diabetes Committee Report
Accreditation Regulatory Committee Minutes & Audit Summary
Workplace Violence Committee
Bioethics Committee
Throughput Committee
Mortality Committee
Patient Safety Committee
HIM - HIM Committee

Attachment 3

Kaweah Health Outstanding Health Outcomes

FY2025 Strategic Plan Measures & Goals

Measure Name	Goal
Healthcare Acquired Infections	
Central Line Bloodstream Infection (CLABSI)	≤0.486 Standardized Infection Ratio
Central Line Utilization	≤0.6633 Standardized Utilization Ratio
Catheter-Associated Urinary Tract Infection (CAUTI)	≤0.342 Standardized Infection Ratio
Indwelling Urinary Catheter Utilization	≤0.6363 Standardized Utilization Ratio
Methicillin-Resistant Staphylococcus Aureus (MRSA)	≤0.435 Standardized Infection Ratio
Sepsis	
SEP-1 Bundle % Compliance (CMS Core Measure)	≥81%
Sepsis All Diagnosis Mortality Rate	≤0.61 Observed/Expected
Diabetes	
% Hypoglycemia in Critical Care (CC) Patients	< 4.3%
% Hypoglycemia with at least one recurrent hypoglycemic day CC Patients	<26.8%
% Hypoglycemia in Non-Critical Care (NCC) Patients	< 3.4%
% Hypoglycemia with at least one recurrent hypoglycemic day NCC Patients	<29.6%
Health Equity	
Achieved compliance on all Joint Commission HE National Patient Safety Goal Elements of Performance	4/4 elements compliant
Quality Incentive Pool (QIP)	
Number of QIP measures that achieve target	15/15 QIP Measures achieve goal
Mortality & Readmission	
Heart Failure (HF) Mortality	≤0.48 Observed/Expected
Chronic obstructive pulmonary disease (COPD) Mortality	≤0.70 Observed/Expected
Pneumonia (PN) Bacterial Mortality	≤0.57 Observed/Expected
Pneumonia (PN) Viral Mortality	≤0.44 Observed/Expected
HF Readmission	≤12.1%
COPD Readmission	≤9.09%
PN Readmission	≤8.24%
Cardiovascular Services	
PCI In-Hospital Risk-Adjusted Mortality Rate – STEMI	≤1.9%
Risk-Standardized Acute Kidney Injury Post PCI	≤ 5.6%
Risk Standardized Bleeding Rate	≤ 1.24%

AP175 Patient Safety

Policy Number: AP175	Date Created: Not Set
Document Owner: Kelsie Davis (Board Clerk/Executive Assistant to CEO)	Date Approved: 02/06/2024
Approvers: Board of Directors (Administration), Kelsie Davis (Board Clerk/Executive Assistant to CEO)	

Patient Safety Plan

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

I. Purpose

- Encourage organizational learning about medical/health care risk events and near misses
- Encourage recognition and reporting of medical/health events and risks to patient safety using just culture concepts
- Collect and analyze data, evaluate care processes for opportunities to reduce risk and initiate actions
- Report internally what has been found and the actions taken with a focus on processes and systems to reduce risk
- Support sharing of knowledge to effect behavioral changes in itself and within Kaweah Delta Healthcare District dba Kaweah Health (Kaweah Health)

II. Scope

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

III. Structure and Accountability

A. Board of Directors

The Board of Directors retains overall responsibility for the quality of patient care and patient safety. The Board approves annually the Patient Safety Plan and assures that appropriate allocation of resources is available to carry out that plan.

The Board receives reports from the Patient Safety Committee through the Professional Staff Quality Committee. The Board shall act as appropriate on the recommendations of these bodies and assure that efforts undertaken are effective and appropriately prioritized.

B. Quality Council

The Quality Council is responsible for establishing and maintaining the organization's Patient Safety 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 performance 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.

C. Patient Safety Committee

The Patient Safety Team is a standing interdisciplinary group that manages the organization's Patient Safety Program through a systematic, coordinated, continuous approach. The Team will meet monthly to assure the maintenance and improvement of Patient Safety in establishment of plans, processes and mechanisms involved in the provision of the patient care.

The scope of the Patient Safety Team includes medical/healthcare risk events involving the patient population of all ages, visitors, hospital/medical staff, students and volunteers. Aggregate data* from internal (IS data collection, incident reports, questionnaires,) and external resources (Sentinel Event Alerts, evidence based medicine, etc.) will be used for review and analysis in prioritization of improvement efforts, implementation of action steps and follow-up monitoring for effectiveness. The Patient Safety Committee has oversight of Kaweah Health activities related to the National Quality Forum's (NQF) Safe Practices (SP) Medication Safety, Section #4 Maternity Care, #5 ICU physician staffing, #6 A-D Culture of Safety Leadership Structures & System Documentation, Culture Measurement, Feedback & Intervention Documentation, Nursing workforce and Hand Hygiene, #7 Managing Serious Errors, and #8 Bard Code Medication Administration.

1. The Patient Safety Officer is the Chief Quality Officer
2. The Patient Safety Committee is chaired by the Patient Safety Officer or designee.
3. The responsibilities of the Patient Safety Officer include institutional compliance with patient safety standards and initiatives, reinforcement of the expectations of the Patient Safety Plan, and acceptance of accountability for measurably improving safety and reducing errors. These duties may include listening to employee and patient concerns, interviews with staff to determine what is being done to safeguard against occurrences, and immediate response to reports concerning workplace conditions.
4. Team membership includes services involved in providing patient care, such as: Pharmacy, Surgical Services, Risk Management, Infection Prevention, and Nursing. The medical staff representative on the team will be the Medical Director of Quality & Patient Safety.

D. Medication Safety Quality Focus Team

The Medication Safety Quality Focus Team (MSQFT) is an interdisciplinary group that manages the organizations Medication Safety Program including the District Medication Error Reduction Plan (MERP).

The purpose of the MSQFT is to direct system actions regarding reductions in errors attributable to medications promoting effective and safe use of medication throughout the organization. Decisions are made utilizing data review, approval of activities, resource allocation, and monitoring activities. Activities include processes that are high risk, high volume, or problem prone, some of which may be formally approved by the MSQFT as a District MERP goal (see Policy AP154 Medication Error Reduction Plan).

The MSQFT provides a monthly report to the Pharmacy and Therapeutics Committee and quarterly reports to the Professional Staff Quality Committee and directly to Quality Council. The MSQFT Chair is a member of the Patient Safety Committee. A quarterly report is presented at Patient Safety Committee in addition to active participation in patient safety activities related to medication use.

IV. Organization and Function

A. The mechanism to insure all components of the organization are integrated into the program is through a collaborative effort of multiple disciplines. This is accomplished by:

1. Reporting of potential or actual occurrences through the Occurrence Reporting Process Policy (AP10) by any employee or member of the medical staff. Examples of potential or actual occurrences include pressure ulcers, falls, adverse drug events, and misconnecting of: intravenous lines, enteral feeding tubes and epidural lines.
2. Reporting of potential or actual concerns in a daily leadership safety huddle which involves issues which occurred within the last 24 hours, a review the steps taken to resolve those matters when applicable, and anticipate challenges or safety issues in the next 24 hours. The daily safety huddle occurs Monday to Friday with the exception of holidays and includes directors and vice presidents that represent areas throughout the organization. The purpose of the daily safety huddle is immediate organizational awareness and action when warranted. Examples of issues brought forth in the Daily Safety Huddle include, patients at risk for elopement, violence, or suicide, and also can include potential diversion events, patient fall events, and medication related events.

3. Communication between the Patient Safety Officer and the Chief Operating Officer to assure a comprehensive knowledge of not only clinical, but also environmental factors involved in providing an overall safe environment.
4. Reporting of patient safety and operational safety measurements/activity to the performance improvement oversight committee, Quality Committee “Qcomm”. QComm is a multidisciplinary medical staff committee composed of various key organizational leaders including: Medical Staff Officers, Chief Executive Officer, Chief Operating Officer, Chief Medical Officer/Chief Quality Officer, Chief Nursing Officer, and Directors of Nursing, Quality Improvement & Patient Safety, Risk Management, Safety Officer and Pharmacy.
5. Graduate Medical Education
    i. 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:
        1. Collaboration between Quality and Patient Safety Department, Risk Management, and GME Quality Subcommittee
        2. GME participation in Quality Improvement Committee and Patient Safety Committee
        3. GME participation in Kaweah Health quality committees and root cause analysis (including organizational dissemination of lessons learned)

B. The mechanism for identification and reporting a Sentinel Event/other medical error will be as indicated in Organizational Policies AP87. Any root cause analysis of hospital processes conducted on either Sentinel Events or near misses will be submitted for review/recommendations to the Patient Safety Committee, Quality Committee and Quality Council.

C. As this organization supports the concept that events most often occur due to a breakdown in systems and processes, staff involved in an event with an adverse outcome will be supported by:

1. A non-punitive approach without fear of reprisal (just culture concepts).
2. Voluntary participation into the root cause analysis for educational purposes and prevention of further occurrences.
3. Resources such as Pastoral Care, Social Services, or EAP should the need exist to counsel the staff
4. Safety culture staff survey administered at least every 2 years to targeted staff and providers.

D. As a member of an integrated healthcare system and in cooperation with system initiatives, the focus of Patient Safety activities include processes that are high risk, high volume or problem prone, and may include:

1. Adverse Drug Events
2. Nosocomial Infections
3. Decubitus Ulcers
4. Blood Reactions
5. Slips and Falls
6. Restraint Use
7. Serious Event Reports
8. DVT/PE

E. A proactive component of the program includes the selection at least every 18 months of a high risk or error prone process for proactive risk assessment such as a Failure Modes Effects Analysis (FMEA), ongoing measurement and periodic analysis. The selected process

and approach to be taken will be approved by the Patient Safety Committee, QComm and Quality Council.

The selection may be based on information published by The Joint Commission (TJC) Sentinel Event Alerts, and/or other sources of information including risk management, performance improvement, quality assurance, infection prevention, research, patient/family suggestions/expectations or process outcomes.

F. Methods to assure ongoing inservices, education and training programs for maintenance and improvement of staff competence and support to an interdisciplinary approach to patient care is accomplished by:

1. Providing information and reporting mechanisms to new staff in the orientation training.
2. Providing ongoing education in organizational communications such as newsletters and educational bundles.
3. Obtaining a confidential assessment of staff's willingness to report medical errors at least once every two years.

G. Internal reporting – To provide a comprehensive view of both the clinical and operational safety activity of the organization:

1. The minutes/reports of the Patient Safety Committee, as well as minutes/reports from the Environment of Care Committee will be submitted through the Director of Quality Improvement and Patient Safety to the Quality Committee.
2. These monthly reports will include ongoing activities including data collection, analysis, and actions taken and monitoring for the effectiveness of actions.
3. Following review by Quality Committee, the reports will be forwarded to Quality Council.

H. The Patient Safety Officer or designee will submit an Annual Report to the Kaweah Health Board of Directors and will include:

1. Definition of the scope of occurrences including sentinel events, near misses and serious occurrences
2. Detail of activities that demonstrate the patient safety program has a proactive component by identifying the high-risk process selected
3. Results of the high-risk or error-prone processes selected for proactive risk assessment.
4. The results of the program that assesses and improves staff willingness to report medical/health care risk events
5. A description of the examples of ongoing in-service, and other education and training programs that are maintaining and improving staff competence and supporting an interdisciplinary approach to patient care.

V. Evaluation and Approval

The Patient Safety Plan will be evaluated at least annually or as significant changes occur, and revised as necessary at the direction of the Patient Safety Committee, Quality Committee, and/or Quality Council. Annual evaluation of the plan's effectiveness will be documented in a report to the Quality Council and the Kaweah Health Board of Directors.

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.

Attachments - Attachment 1: Quality Improvement/Patient Safety Committee Structure

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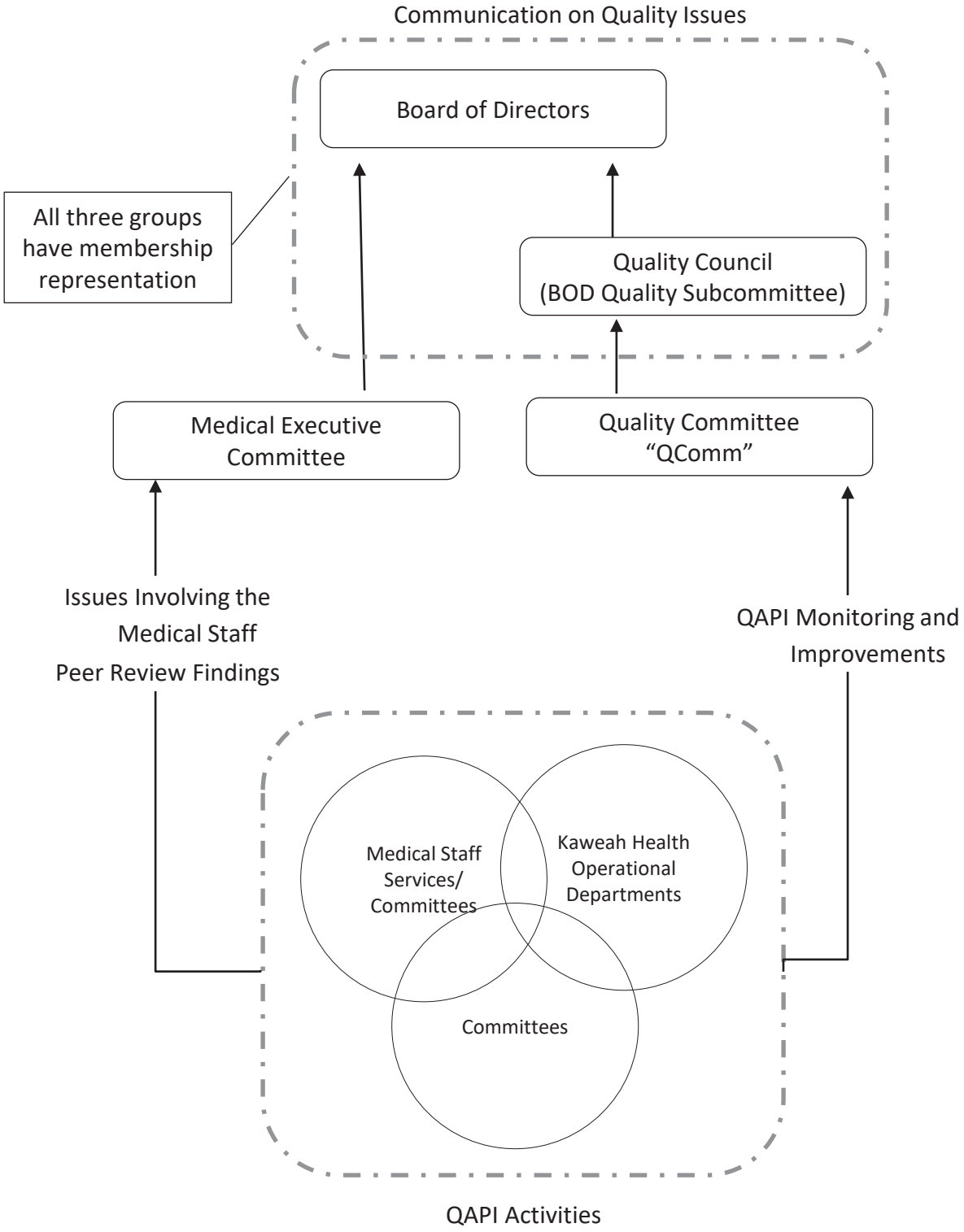
Attachment 1

Kaweah Health

Quality Reporting Structure



EOC 3000 Security_Management_Plan

Kaweah Health

Subcategories of Department Manuals not selected.

Policy Number: EOC 3000	**Date Created: 06/01/2009**
Document Owner: Maribel Aguilar (Safety Officer/Life Safety Manager)	**Date Approved: Not Approved Yet**
Approvers: Board of Directors (Administration), Board of Directors (EOC/Emergency Preparedness)	

Security Management Plan

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

I. OBJECTIVES

The objectives of the Management Plan for Security at Kaweah Health (KH) are to provide a safe environment wherein intentional risks for harm or loss can be minimized. The plan will identify risk mitigation strategies for both the grounds and District premises. The plan is an accreditation/ standards-based and regulatory driven program, which is assessed for effectiveness during the annual evaluation process.

II. SCOPE

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

Each off-site area is required to have a unit-specific Safety Plan that addresses the unique considerations of the built environment, including directions for reaching Security or law enforcement. Kaweah Health Medical Center personnel are to dial 44 for an immediate security response within the premises and grounds. Offsite areas are required to call the local police in the event an urgent security response is required.
All areas, including off-site areas are monitored for compliance with this plan during routine environmental surveillance by Environment of Care committee members. It is the responsibility of the Safety Officer to assess and document compliance with the Security Management Plan for all areas, including the offsite areas, using an environmental surveillance checklist.

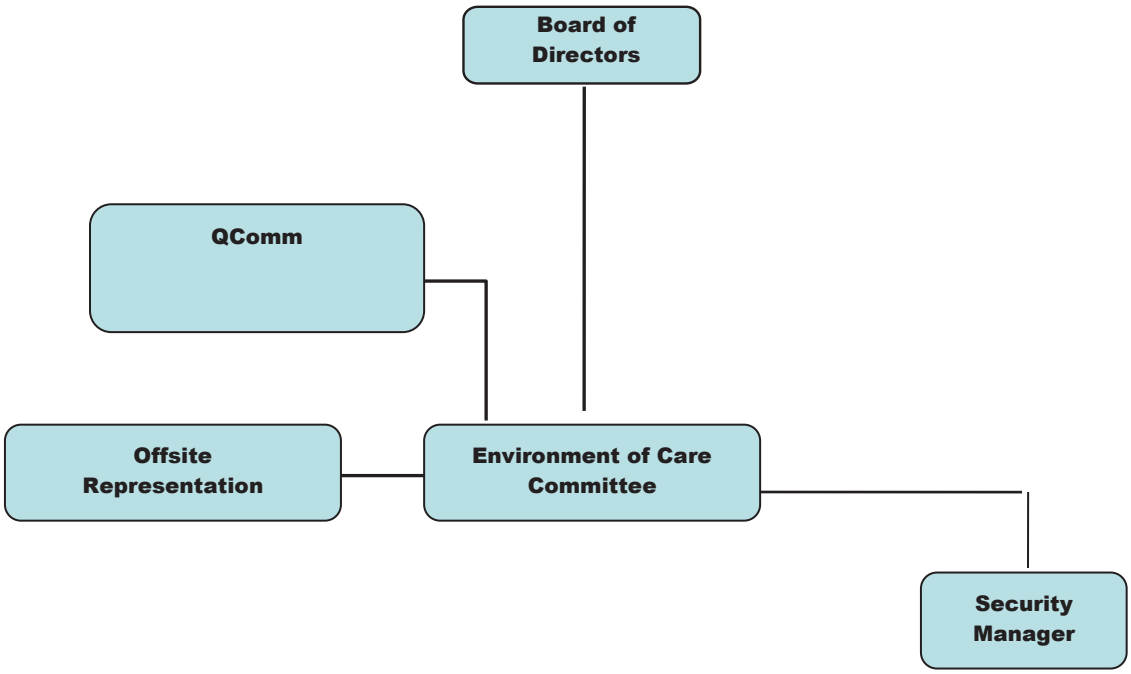
III. AUTHORITY

The authority for the Management Plan for Security is EC.01.01.01. The authority for overseeing and monitoring the Security Management Plan and program lies in the *Environment of Care* Committee, for the purpose of ensuring that security risks are identified, monitored and evaluated, and for ensuring that applicable regulatory activities are monitored and enforced as necessary.

IV. ORGANIZATION

The following represents the organization of security management at Kaweah Health .

Organization - Security Management



V. RESPONSIBILITIES

EC.01.01.01 EP 1

Leadership within Kaweah Health (KH) have varying levels of responsibility and work together in the management of risk and in the coordination of security risk reduction activities in the physical environment as follows:

Governing Board: The Board of Directors supports the Security Management Plan by:

- Review and feedback if applicable of the quarterly *Environment of Care* reports
- Endorsing budget support as applicable, which is needed to implement security improvements identified through the activities of the Security Management Program.

Quality Committee (QComm) : Reviews annual *Environment of Care* report from the *Environment of Care* Committee, and provides broad direction in the establishment of performance monitoring standards for security, and provides applicable feedback.

Administrative Staff: Administrative staff provides active representation on the *Environment of Care* Committee meetings and sets an expectation of accountability for compliance with the Security Management Program

Environment of Care Committee: Environment of Care Committee members review and approve the quarterly *Environment of Care* reports, which contain a Security Management component. Members also monitor and evaluate the Security Management Program **(EC.04.01.01-1)** and afford a multidisciplinary process for resolving *Environment of Care* issues relating to security. Committee members represent clinical, administrative and support services when applicable. The committee

addresses *Environment of Care* issues in a timely manner, and makes recommendations as appropriate for approval. *Environment of Care* issues are communicated to organizational leaders through quarterly and annual evaluation reports. At least annually, one Process Improvement activity is recommended to the Board of Directors, based upon the ongoing monitoring of *Environment of Care* management plans. *Environment of Care* issues are communicated to those responsible for managing the patient safety program as applicable when risks occur relating to Security that may have an impact on the safety of the patient.

Directors and Department Managers: These individuals support the Security Management Program by:

- Reviewing and correcting deficiencies identified through the hazard surveillance process that may pose a security risk.
- Communicating security recommendations from the *Environment of Care* Committee to applicable staff in a timely manner.
- Developing education programs within each department that ensure compliance with the policies of the Security Management Program (for example education or training relating to “Code Pink” or “Code Gray” response).
- Supporting all required employee security education and training by monitoring employee participation and setting clear expectations for employee participation to include a disciplinary policy for employees who fail to meet expectations.

Employees: Employees are required to participate in the Security Management Program by:

- Completing required security education.
- Calling Security, and notifying his/her manager if anything or anyone suspicious occurs in the department within which they are working.
- Participating in Code Pink/Purple drills.

Medical Staff: Medical Staff will support the Security Management Program by reporting any unusual or suspicious activity to Security staff.

Chief Compliance/Risk Officer: This individual has the ultimate authority over security personnel, and the Security Management Program.

MANAGEMENT OF SECURITY RISKS
EC.02-01-01 EP-1
The hospital identifies security risks associated with the environment of care. Risks are identified from internal sources such as ongoing monitoring of the environment, results of root-cause analyses, results of annual proactive risk assessments of high-risk processes, and from credible external sources such as Sentinel Event Alerts.

Risk Assessment: The management of organization security risks consists of the following processes:

1 **Policy/Plan/Program Development.** Inherent in risk assessment are the development of security policies, management plan for security, and program development for security through the structure of the *Environment of Care* Committee. Regulations, accreditation or industry standards (e.g., AB 508, Title 22) provide the structure for policy/plan and program development.

2 **Environmental Surveillance, Results of Root-Cause Analyses, Pro-active Risk Assessment of high-risk processes.** Included in risk assessment are findings during environmental surveillance that reflect risk identification, and findings from root-cause analyses that require follow-up and improvement actions. During the annual evaluation process, risk identification may occur from a retrospective analysis of performance monitoring of high-risk security processes, which will require a plan for improvement to minimize unfavorable outcomes from the possibility of consequential risks. Accountability for assessment and improvement activities is with the *Environment of Care* committee.

3 **External Sources: *Sentinel Event Alerts*, Regulatory and Insurer inspections, Audits, and Consultants. Security risk assessment may occur as a result of findings or recommendations generated from external sources, such as *Sentinel Event Alerts,* Regulatory and/or Insurer surveys, or audits conducted by recruited consultants.** Accountability for assessment and improvement activities is with the *Environment of Care* committee.

4 **Education:** Education is implemented to provide information, and thereby mitigate risk and includes, but is not limited to:
- New Hire Orientation
- Department Specific Education
- Education for patients, staff, physicians, volunteers, and students
- Education based upon a needs assessment for any specific population. Education based upon risk assessment or the results of surveys, inspections or audits.

5 **Drills – Planned Exercises:** Conducting drills such as infant security or disaster, constitute activities designed to inform, educate and thereby mitigate risk when areas of risk are identified during the debriefing and/or evaluation process.

6 **Reporting and Investigation of Incidents.** Complementary to risk assessment is proper reporting and investigation of security incidents. Internal processes and activities that support risk assessment include reporting and investigation mechanisms which may identify the opportunity to mitigate risk relating to property damage, thefts, vandalism, burglary, assault, battery and any violent incidents.

ACTIONS TO MINIMIZE OR ELIMINATE IDENTIFIED SECURITY RISKS
EC.02.01.01 EP-3
The hospital takes action to minimize or eliminate identified safety risks.

When risks are identified from the above processes, the *Environment of Care* Committee uses the risks identified to select and implement procedures and controls to achieve the lowest potential for adverse impact on the safety and security of patients, staff, and other persons throughout the organization. Moreover, the identified risks may serve as the basis for the selection of performance standards, with the criteria identified as follows:
- The performance standard represents a high-volume activity, thereby representing risk by virtue of ongoing occurrences.
- The performance standard could represent a sentinel event activity (e.g., infant abduction). These types of activities, though rare in occurrence, represent risk due to their seriousness.

- The performance standard represents an activity or finding that needs improvement due to the possibility of adverse outcomes.

Risk Reduction Strategies-Proactive

In-house Security Services are provided at KH. Coverage is provided twenty-four (24) hours per day, seven (7) days a week by uniformed facility security officers at the Main, South and the Acute Psych Hospital. Security provides routine patrols of the campus and parking lots, providing visual presence and identifying safety and security risk. Hospital entrance doors are secured by the security officer according to a set schedule with the exception of the Emergency Department public entrance. Employees are able to access the medical center with the use of an ID badge Key Card.

The Security Department is responsible for the following:

- Protection of persons/property
- Access control
- Parking and vehicle management
- Safety Escort service
- Loss prevention
- Patrol of buildings and grounds
- Maintaining daily activity logs
- Preparation of incident/crime reports

Additionally, the following mechanisms are in place to proactively minimize or eliminate security risks:

1. Committee Structure. The *Environment of Care* Committee is the structure through which security-related problems and issues can be identified and resolved. It should be noted that the *Environment of Care* Committee is closely integrated with patient safety functions. The purpose of the *Environment of Care* Committee with respect to the Patient Safety standards is to remain aware of sentinel event alert information from the Joint Commission and to assess organizational practices against current information relating to patient safety. Additionally, when recommendations are made for hospitals, each recommendation is critically reviewed, with a plan of action established. If sentinel events occur within the hospital that reflect security issues, the *Environment of Care* Committee will participate in improving outcomes relating to security risk management.

2. Reporting and Investigation Mechanisms. A reporting and investigation process is in place that is part of the responsibilities of security staff. Security incidents are reported on an electronic reporting system, which are completed by staff involved with the incident. Violent, assaultive and/or battery type incidents are reported to the local police with a written report generated within 72 hours. Security incidents are reported on a quarterly basis to the *Environment of Care* Committee, which provides members with the opportunity to observe for trends or patterns, and make the appropriate recommendations.

3. An Identification System. An identification system is in place to identify active employees, physician staff, volunteers and business associates; and to minimize the entry of unauthorized personnel onto the premises.

4. Access Control. Access Control is in place in sensitive areas, and protected by special systems which allows only authorized personnel to enter the areas.

5. Closed Circuit TV. Closed circuit TV is in place to monitor the security sensitive areas, public entrances, lobbies and corridors, and select parking lots.

6. Panic Buttons. Panic buttons are located in high-risk areas throughout the hospital. Alarms are installed and monitored internally, provided by a third party monitoring company or combination of both. When an alarm is activated, the PBX operator notifies Security and contacts the police for assistance. A burglar-panic alarm monitoring company will notify the hospital PBX in the event of activation so that hospital Security can respond. Panic Buttons are located in the following departments:
Administration, Admitting, Dietary, Emergency Department, Gift Shop, HIM, Human Resources, ICU, Kaweah Korner Employee Store, Labor and Delivery, Mother-Baby, NICU, Patient Accounting, Pediatrics, Foundation, Pharmacy, Rehabilitation Hospital, Risk Management, and the Surgery Waiting Room.

7. Policies. Security policies and procedures are in place, providing guidelines for the prevention of risk, e.g., “Code Pink” policy, Code Gray, Code Silver, Code Purple.

8. Education – for Newly-hired Staff and Ongoing (HR.01..05.03 EP 1; HR.01.04.01 EP 1, 3;). Education plan is in place to promote employee awareness of risk, and to provide the phone number to call in the event security assistance is needed.
    a. New hire Education. Education relating to general security processes is given during New hire orientation, and covers introductory information, which includes the phone number to call if security is needed, as well as hospital emergency codes information.
    b. Specific Job-Related Hazards. Education is provided to new security officers relating to specific job-related competencies, which is reviewed annually.

9. Loss Prevention strategies: Doors leading to departmental work areas are controlled by keys which are restricted to department members, facilities, security personnel and environmental services. The Admitting Office and the Security Department maintains a safe for patient valuables. Hospital property is tagged with a decal which lists the hospital’s property number. Property which is being removed from the premises must be accompanied by a signed property removal pass.

Risk Reduction Strategies – When Risks Have Been Identified
When proactive security risks have been assessed, risk reduction strategies will be the responsibility of security staff in coordination with the *Environment of Care* committee, unless the risk poses the potential for serious consequential events (i.e., death, serious injury or building threat). In this instance, the individual who has assessed the risk will notify the Safety Officer and Risk Management leadership who will then assume responsibility for reduction of the risk threat. Risk reduction strategies for the possibility of non-serious or non-imminent consequential events may be addressed through the *Sentinel Event Review* or *Intensive Assessment Processes,* or *Environment of Care*

Committee, based upon the severity and type of risk identified. Risk reduction strategies for identified risks include, but are not limited to the following:

1. Policies and Procedures. Policies and procedures may require development or revision, with applicable training completed for affected staff.
2. Education. New or reinforced education may be implemented to minimize the potential for future risk.
3. Equipment. The purchase of new equipment or the use of current equipment may require evaluation.
4. Administrative Controls. Administrative controls such as changes in staffing, or changes in staffing patterns may require evaluation and implementation.
5. Equipment Training. Training on equipment may be implemented or reinforced.
6. Repairs/ Upgrades on Equipment. Repairs and or upgrades/modifications on security equipment, such as cameras or hand-held radios may be required.
7. Elimination of the Risk. Elimination of the risk through removal of a hazard may occur.
8. Product or Equipment Change-out or Recall. Faulty or defective products or equipment may be recalled and replaced.

MAINTENANCE OF GROUNDS AND EQUIPMENT
EC. 02.01.01 EP 5

Kaweah Health manages risks associated with the grounds and equipment in order to minimize consequential events or adverse outcomes related to accidents.
Environmental surveys are done routinely by *Environment of Care* Committee personnel. Additionally, routine and varied security patrols are conducted wherein any security hazards are brought to the attention of the *Environment of Care* Committee. Building/grounds surveys with a contractor's representative are conducted when construction activities are occurring. In certain instances, Security staff may be requested to participate in a fire watch. Additionally, Risk Management reviews data from reported incidents that may identify patterns, trends and opportunities for improvements. The data involves all patient and visitor incidents related to accidents or other unusual events, which are not consistent with routine patient care and treatment. Incidents that involve patients or visitors, wherein some aspect of the building/grounds plays a consequential role, the Safety Officer will be notified so the hazard may be investigated and corrected as necessary. All of these activities contribute to an overall monitoring plan for the grounds and safety-related equipment.

EC.02-.01.01 EP 7
The hospital identifies individuals entering its facilities.
Identification methods used at the medical center include the following:

A. Photo Identification: All employees, members of the medical staff and volunteers are issued a photo identification badge to be worn while on hospital property.
B. Temporary Badges: Visitors are issued temporary badges in the Emergency Department, at all three main entrances (Mineral King Lobby, Surgery Center entrance and the Acequia Wing Lobby), and when visiting after hours. Vendors and Business Associates are issued temporary badges while working on the hospital campus.
C. Identification Bracelets: Patients are provided with identification bracelets.

EC.02.01.01 EP 8

The hospital controls access to and from areas it identifies as security sensitive.

Access Control: the following sensitive areas of the hospital are protected by special systems:

- CV-ICU – Badge Access
- Emergency Department – Combination Keypad, badge access and CCTV
- ICU/CCU – Combination Keypad and limited key access
- Information Systems – Limited key access, burglar alarm system and CCTV
- Labor & Delivery – Badge access, CCTV, Infant Abduction Prevention Security System, panic-duress alarms
- Materials Management – Limited key access
- Mother-Baby Unit – Badge access, Infant Abduction Prevention Security System, CCTV, and panic-duress alarms
- NICU – Badge access, HUGS Infant Security System, CCTV, and panic-duress alarms
- OB-Surgery – Badge access / CCTV / Infant Abduction Prevention Security System
- Operating Room –badge access
- Pediatrics Unit – Badge access, Infant Abduction Prevention Security System, CCTV, and panic-duress alarms
- Pharmacy: Dedicated key access, keypad and badge access
- Helipad – Badge access; key access for exterior staircase security fence

Vehicular Access and Traffic Control: Parking lot way finding signs assist Emergency vehicles, patients and visitors find their destination. The Emergency Department is clearly identified and when necessary, are assisted by a security officer for direction and/moving personal vehicles. Security provides traffic control in times of need with Facilities/Engineering's assistance.

EC.02.01.01 EP 9-10

The hospital has written procedures to follow in the event of a security incident, including an infant or pediatric abduction.

In the event of a security incident, staff is directed to Dial #44 (hospital emergency number) to contact Security via the Hospital Operator/PBX. The Hospital Emergency Code(s) help to communicate the type of emergency and response by Security and hospital staff. A back-up system is in place, which involves contracting with a local security guard services company that provides additional security staff when needed. If a system failure occurs, the Chief Compliance/Risk Officer has the authority to contact the appropriate vendors to initiate repairs or to request security guard services. The Director of Facilities will be notified immediately, in any event, when Security systems fail or when staffing plans cannot be met as scheduled.

Infant/Pediatric Security: The prevention of infant kidnapping is addressed by a "Code Pink" policy and procedure. All OB nursing personnel are in-serviced regarding the Code Pink policy. All parents, on admission, receive information on the prevention of infant kidnapping. At least twice a year, "Code Pink" drills are conducted to assess staff response to an infant abduction. Drills are evaluated for response plan effectiveness and reported to the *Environment of Care* Committee.

Handling of situations involving VIP's or the media: VIPs, patient family members and the media will be escorted by Security personnel to a designated area for waiting. The Director of Media Relations will be responsible for any information released to any entity. Security personnel will not give any information to any family member, VIP or the media. Security staff will take all precautions necessary to protect the individual. If the VIP has his/her own security protection, Security staff will work together with that security force to assure that the VIP is protected. This may include establishing special patrols or calling in additional officers.

02.01.01 EP 17
The hospital conducts and annual worksite analysis related to its workplace violence prevention program. The hospital takes actions to mitigate or resolve the workplace violence safety and security risks based upon finding from the analysis.

INFORMATION COLLECTION SYSTEM TO MONITOR CONDITIONS IN THE ENVIRONMENT
EC.04.01.01 EP's 1,3,5-6,
The hospital establishes a process(es) for continually monitoring, internally reporting, and investigating the following:

- Security incidents involving patients, staff or others within its facilities, including those related to Workplace Violence.

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

ANNUAL EVALUATION OF THE SECURITY MANAGEMENT PLAN
EC.04.01.01 EP-15
On an annual basis *Environment of Care* Committee members evaluate the Management Plan for Security, as part of a risk assessment process. Validation of the management plan occurs to ensure contents of the plan support ongoing activities within the medical center. Based upon findings, goals and objectives will be determined for the subsequent year. The annual evaluation will include a review of the following:

- The objectives: The objective of the Security Management Plan will be evaluated to determine continued relevance for the organization (i.e., the following questions will be asked: Was the objective completed? Did activities support the objective of the plan? If not, why not? What is the continuing plan? Will this objective be included in the following year? Will new objectives be identified? Will specific goals be developed to support the identified objective?).
- The scope. The following indicator will be used to evaluate the effectiveness of the scope of the Security Management Plan: the targeted population for the management plan will be evaluated (e.g., did the scope of the plan reach employee populations in the offsite areas, and throughout the organization? Was security managed appropriately for the offsite areas?)
- Performance Standards. Specific performance standards for the Security Management Plan will be evaluated, with plans for improvement identified. Performance standards will be monitored for achievement. Thresholds will be set for the performance standard identified. If a threshold is not met an analysis will occur to

determine the reasons, and actions will be identified to reach the identified threshold in the subsequent quarter.

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

THE DISTRICT ANALYZES IDENTIFIED *ENVIRONMENT OF CARE* ISSUES
EC.04.01.03 EP-2
Environment of care issues are identified and analyzed through the *Environment of Care* Committee with recommendations made for resolution. It is the responsibility of the *Environment of Care* Committee chairperson to establish an agenda, set the meetings, coordinate the meeting and ensure follow-up occurs where indicated. Topics that relate to overall security management are a standing agenda item for *Environment of Care* committee members to consider. Security issues are documented. Quarterly *Environment of Care* reports are communicated to Performance Improvement, the Medical Executive Committee and the Board of Directors.

PRIORITY IMPROVEMENT PROJECT
At least annually, priority Improvement activities are communicated by the *Environment of Care* Committee to the Governing Board. Each priority improvement activity is based upon ongoing performance monitoring and identified risk within the environment. The activity may be related to a security issue if the activity ranks high as a prioritized risk.

KAWEAH HEALTH TAKES ACTION ON IDENTIFIED OPPORTUNITIES TO RESOLVE ENVIRONMENTAL SAFETY ISSUES
EC.04.01.05 EP-1
Performance standards are identified, monitored and evaluated that measure effective outcomes in the area of security management. Performance standards are identified for Security, and they are approved and monitored by the *Environment of Care* Committee with appropriate actions and recommendations made. Whenever possible, the *environment of care* is changed in a positive direction by the ongoing monitoring, and changes in actions that promote an improved performance related to security.

Patient Safety
Periodically there may be an *environment of care* issue that has impact on the safety of our patients that results from a security issue. This may be determined from a *Sentinel Event*, security incident(s), environmental surveillance, patient safety standards or consequential actions identified through the risk management process. When a patient-safety issue emerges it is the responsibility of the Safety Officer or designee to bring forth the issue through the patient safety process.

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."

EOC 4007 Compressed_Gas_and_Oxygen_Use

Policy Number: EOC 4007	**Date Created: 04/01/2010**
Document Owner: Maribel Aguilar (Safety Officer/Life Safety Manager)	**Date Approved: Not Approved Yet**
Approvers: Board of Directors (Administration), Board of Directors (EOC/Emergency Preparedness)	

Compressed Gas and Oxygen Use

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

POLICY:

Personnel who use and transport compressed gas and/or oxygen shall be trained in the proper handling of cylinders, cylinder trucks, supports, and cylinder - valve protection caps. All cylinder storage areas shall be kept locked from access by unauthorized individuals.

COMPRESSED GAS USE:

PROCEDURE:

GENERAL STANDARDS:

1. Freestanding cylinders must be secured by two restraints or supported in a proper cylinder stand or cart in order to reduce the chance of falling.

2. Valve safety covers shall be left on until pressure regulators are attached.

3. Containers must be marked clearly with the name of the contents.

4. Large cylinders exceeding size E shall be transported on hand trucks. Do not roll or drag cylinders.

5. Tanks with wired-on tags or color code only shall not be accepted.

6. The use of oil, grease or lubricants on valves, regulators or fittings is prohibited.

7. Do not attempt to repair damaged cylinders or to force frozen cylinder valves.

PRESSURE REGULATORS AND NEEDLE VALVES:

Needle valves and regulators are designed specifically for different families of gases. Use only the properly designed fittings.

1. Throats and surfaces of tanks must be clean and tightly fitting. Do not lubricate.

2. Tighten regulators and valves firmly with the proper sized wrench. Do not use adjustable wrenches or pliers. Do not force tight fits.

3. Open valves slowly. Do not stand directly in front of gauges (the gauge face may blowout). Do not force valves that stick.

4. Check for leaks at connections. Do not attempt to force an improper fit. (It may only damage a previously undamaged connection and compound the problem).

5. Valve handles must be left attached to the cylinders.

6. The maximum rate of flow should be set by the high-pressure valve on the cylinder. Fine-tuning of flow should be regulated by the needle valve.

7. Shut off cylinder when not in use.

LEAK TESTING:

Cylinders and connections shall be tested by “snoop” or a soap solution. First test the cylinders before regulators are attached and test again after the regulators or gauges are attached.

SEGREGATION:

1. Full and empty containers should be physically segregated from each other in order to assist staff in selecting the proper cylinder.
2. All open and partially used containers should be placed in the empty rack.
3. Only full unopened cylinders will be placed in the full rack or area.

EMPTY CYLINDERS:

1. Must be marked empty.

2. Empty or unused cylinders must be returned promptly.

3. Replace valve safety caps.

OXYGEN USE:

Oxygen and other gases are potentially dangerous. Special safety precautions shall be followed at all times while using or storing oxygen.

PROCEDURE:

1. Kaweah Health is a designated “NO SMOKING" facility with signage strategically located in order to remind staffs and educate visitors and families. This designation prohibits smoking on District grounds at all times.

2. Be sure cylinders are secure on rack and never hang anything on cylinder.

3. Crack valves to clear them before bringing tank into patient's room.

4. Check oxygen supply regularly.

5. Store oxygen cylinders upright and secured.

"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."

EOC 6001

Medical_Equipment_Management_Policy_Clinical_Engineering_Management_Plan

Kaweah Health

Subcategories of Department Manuals not selected.

Policy Number: EOC 6001	**Date Created: 07/01/2009**
Document Owner: Maribel Aguilar (Safety Officer/Life Safety Manager)	**Date Approved: Not Approved Yet**
Approvers: Board of Directors (Administration), Board of Directors (EOC/Emergency Preparedness)	

Medical Equipment Management Policy

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

I. OBJECTIVES

EC 02.04.01 – The hospital manages medical equipment risks.

The objectives of the Medical Equipment Management Policy (MEMP) govern Kaweah Health to provide an environment that works to ensure medical equipment is safe, reliable, properly maintained and efficiently used in the delivery of patient care. Specific goals of the MEMP include but are not limited to the following:

- Inventory Management Program
- Preventive Maintenance Program
- Corrective Maintenance Program
- Performance Indicators Reports
- Annual Evaluation of the Medical Equipment Management Plan (ME Plan)
- Equipment Selection and Review Process
- Contract Review and Financial Oversight

The MEMP is inclusive of the below listed policies and others and is defined as the Medical Equipment Management Plan (ME Plan):

- EOC 6002 Medical Equipment Defective Repairs Policy
- EOC 6004 Medical Equipment / Hazardous Device Notification and Recall Policy
- EOC 6009 District Safe Medical Device / Device Tracking and Reporting
- EOC 6018 Retirement and Deletion of Medical Equipment
- AP.60 Technology Assessment Process (Administrative Policy Manual)
- AP41 Quality Improvement Plan

II. SCOPE

The scope of this ME Plan applies to the operation of Kaweah Delta Health Care District, DBA, Kaweah Health, any off-site locations included on its license, for all medical equipment used for the benefit of our patients, whether the device is owned, rented, leased or non-hospital owned.

Areas included are monitored bi-annually for compliance to the ME Plan through EOC Surveillance Rounding at Hospital and Off-Site Locations and is the responsibility of the Safety Officer to assess and document compliance with the ME Plan through the structure of the EOC Committee.

III. AUTHORITY

The authority for the Medical Equipment Management Plan (ME Plan) is EC 02.04.01. The authority for overseeing and monitoring the Medical Equipment Management Policy and ME Plan lies in the Environment of Care Committee (EOC), whose members will ensure activities relating to medical equipment management are identified, monitored, evaluated and ensure that regulatory activities are monitored and enforced as necessary.

IV. ORGANIZATION

The chart below represents the organization of the Management Equipment Management Plan (ME Plan) for Medical Equipment at Kaweah Health:

V. RESPONSIBILITIES

Leadership within Kaweah Health may have varying levels of responsibility and work together in the management of medical equipment as identified below:

Governing Board: The Board of Directors supports the MEMP and ME Plan by:

- Review and feedback if applicable of the quarterly and annual EOC report.
- Endorsing budget support as applicable to fund and empower implementation of the Medical Equipment Management Policy and the Medical Equipment Plan.

Medical Care Review Committee: Reviews annual EOC reports and provides feedback as applicable.

Quality Council: Reviews annual EOC report, provides direction in the establishment of performance monitoring standards relating to medical equipment risks.

Administrative Staff: Provide active representation at EOC meetings and set accountability expectations for compliance to the MEMP and its associated parts (ME Plan).

EOC Committee: Members review and approve the quarterly report and oversee any issues relating to the MEMP and its associated parts (ME Plan).

Directors and Department Managers: Support the MEMP and its associated parts (ME Plan) by:

- Reviewing and correcting deficiencies identified through EOC Surveillance Rounds.
- Communicating recommendations from the EOC to staff in a timely manner.
- Developing education plans for staff that ensure compliance with the MEMP and its associated parts (ME Plan).
- Supporting all required medical equipment education and training to include a disciplinary policy for employees who fail to meet the expectations.
- Serve as a resource for staff on matters of medical equipment usage.

Clinical Engineering Director: The Director of Clinical Engineering is responsible for the coordination, liaison, development and establishment of the overall organization and management of the MEMP and its associated parts (ME Plan).

- Submits completed reports to the EOC Quarterly or more frequently as requested. Reports are to include Compliance to TJC Standards, Departmental Process Improvement Goals, Identify MEMP and ME Plan compliance issues, safety risks and device recall information that will effect operation and safety of medical devices.
- Submits the Annual evaluation on the effectiveness of the MEMP and its associated parts (ME Plan) to the EOC Committee.
- Works Independently and collaboratively developing departmental and organizational equipment management policies and procedures.
- Ensures departmental clinical equipment management policies and procedures are consistent with Kaweah Health Safety, Infection Prevention, Risk Management and Facilities Management; reviews as needed but at least every three years.
- Ensures all medical equipment incidents are reported to the appropriate authorities/committees/departments/individuals (HH-L-4-012 Occurrence Reporting).
- Monitors Hemodialysis Department to ensure completion of infection prevention activities/preventive and corrective maintenance activities are completed, recorded and reported.

Employees: Employees of Kaweah Health are required to adhere to the MEMP and its associated parts (ME Plan) by:

- Completing applicable medical equipment training as assigned.
- Not using medical devices without ensuring a non-expired Clinical Engineering inspection sticker exists on the device in order to promote a safe environment.
- Will report medical equipment failures to their supervisors and Clinical Engineering per policy EOC 6002.
- Will report any observed or suspected unsafe conditions to their supervisor as soon as possible upon identifying a medical equipment risk.
- Will report any medical device with an expired PM Inspection sticker to their supervisors and Clinical Engineering per policy EOC 6002.

Medical Staff: Will support the MEMP and its associated parts (ME Plan) by:

- Will abide by hospital policies and procedures relating to the use, care and reporting of failures, safety concerns and incidents as are related to medical equipment.

EC 02.04.01 – EP 01: The hospital solicits input from individuals who operate and service equipment when it selects and acquires medical equipment.

Selection and acquisition of medical equipment that is new to the organization: Selection and acquisition of medical equipment is a combined effort of the Value Analysis Committee (VAC), Clinical Engineering, Materials Management, the department personnel using the device(s), Finance, Medical Staff, Vendors and Administration of the Hospital as is required.

- These devices must meet or exceed NFPA 2012 standards as is required.
- Meet NRTL (UL, TUV …), FDA, NFPA and other regulatory standards as apply.
- Must meet or exceed Manufacturer, Kaweah Health Electrical Safety or other regulatory standards as apply.
- Must be evaluated through VAC prior to purchase.
- Clinical Engineering will provide VAC with technical evaluations as requested to support the evaluation decision.

EC 02.04.01 – EP 02: The hospital maintains a written inventory of all medical equipment

Equipment Inventory: All owned, leased, rented, borrowed, loaned and non-facility owned medical devices will be evaluated for inclusion in the Medical Equipment Plan including all equipment at all sites on the hospital license.

All equipment will be evaluated and assigned to a department for management. These departments include; Clinical Engineering, Facilities Engineering, Information Systems Services, Clinical Laboratory, Pharmacy.

Medical Devices assigned to the Clinical Engineering department will be included in the ME Plan will be assigned a Biomedical ID# and entered into a Medical Equipment Database Inventory (MEDI). The devices shall include but are not limited to; any and all Electrical, Electronic, Mechanical, Electro-mechanical, Hydraulic medical devices that are used to Treat, Diagnose, Monitor and provide Analysis for the care of medical patients by any of the parties listed in the section (V. Responsibilities) of this policy.

All equipment that are recorded in the Medical Equipment Database Inventory (MEDI) will be:

- Subject to action by the EOC, RISK MANAGEMENT, MATERIALS MANAGEMENT, FDA, Manufacturer and State Regulators including recalls and hazard notices issued and tracked by the Risk Management Department.
- Monitored and addressed if subject to a medical incident. If a device is suspected in the death, serious injury or illness of an individual it is required per policy EOC 6009 to be reported immediately but not more than 24 hours to Risk and Clinical Engineering after the patient is no longer in danger of further risk or harm. (EOC 6009 Safe Medical Device Act Tracking and Reporting).

EC 02.04.01 – EP 03: The hospital identifies high-risk medical equipment on the inventory for which there is a risk of serious injury or death to a patient or staff member should the equipment fail. Note, high-risk equipment includes life-support equipment.

All selected equipment included in the MEDI shall be evaluated for risk and be assigned to either;

- EC 02.04.03 – EP 3 Non-High Risk (NHR)
- EC 02.04.03 – EP 2 High Risk including Life Support (HRiLS) classification of medical device.

All devices included in the MEDI will be assigned a risk number. The Risk number is assigned based on a formula applied to all devices. The formula will include will provide a weight based evaluation considering multiple factors that account for:

- Equipment Function
- Physical Risk
- Maintenance Requirements
- Equipment Service Experience
- Environment of Use

Medical Devices included in the MEDI with a Risk score equal to or greater than 13 are included in the High-Risk including Life-Support (HRiLS) Classification.

Medical Devices included in the MEDI with a Risk score equal to or below 12 are included in the Non-High-(NHR) Classification.

EC 02.04.01 – EP 04: The hospital identifies the activities and associated frequencies, in writing, for maintaining, inspecting, and testing all medical equipment on the inventory. These activities and associated frequencies are in

accordance with manufacturer's recommendations or with strategies of an alternative maintenance (AEM) program.

> **Note 1:** The strategies of an AEM program must not reduce the safety of equipment and must be based on accepted standards of practice, such as the American National Standards Institute (ANSI)/Association for the Advancement of Medical Instrumentation (AAMI) handbook ANSI/AAMI EQ56:2013, Recommended practice for a Medical Equipment Management Program.
>
> **Note 2:** Medical Equipment with activities and associated frequencies in accordance with manufacturer's recommendations must have a 100% completion rate.
>
> **Note 3:** Scheduled maintenance activities for both high-risk and non-high-risk medical equipment in an alternative equipment maintenance (AEM) program Inventory must have a 100% completion rate. AEM frequency is determined by the hospital's AEM program.

The Clinical Engineering Department is responsible, unless otherwise specified, for Initial Inspection, Scheduled Preventive Maintenance, Corrective Maintenance, Retirement Inspection/Status, and Incident Management through the recording of records in a Computerized Maintenance Management System or other record keeping system. This is by way of direct action or management of outside manufacturer, or third party contracted services.

The hospital does employ an AEM program.

Scheduled maintenance intervals shall reference the manufacturer's service guidelines or alternative sources to attain the maintenance guidelines (OneSource, Documentation Service). The inspection intervals can and shall be modified as the service history, use type, manufacturer recommendations change and are reviewed in coordination with the AEM program.

Devices that are Non-Hospital Owned including Rental, Leased and Consignment devices can be assigned to other departments for asset management but will still be subject to inclusion in the MEDI and are subject to all parts of the MEMP.

EC 02.04.01 – EP 5: The hospital's activities and frequencies for inspecting, testing, and maintaining the following items must be in accordance with manufacturers' recommendations:

- Equipment subject to federal or state law or Medicare Conditions of Participation in which, inspecting, testing, and maintaining must be in accordance with the manufacturers' recommendations, or otherwise establishes more stringent maintenance requirements.
- Medical laser devices
- Imaging and radiologic equipment (whether used for diagnostic or therapeutic purposes)
- New medical equipment with insufficient maintenance history to support the use of alternative maintenance strategies
    - NOTE: Maintenance history includes any of the following documented evidence:
        - Records provided by the hospital's contractors
        - Information made public by nationally recognized sources
        - Records of the hospital's experience over time

EC 02.04.01 – EP 6: A qualified individual(s) uses written criteria to support the determination whether it is safe to permit medical equipment to be maintained in an alternate manner that includes the following:

- How the equipment is used, including the seriousness and prevalence of harm during normal use
- Likely consequences of equipment failure or malfunction, including seriousness of and prevalence of harm
- Availability of alternative or backup equipment in the event the equipment fails or malfunctions
- Incident history of identical or similar equipment
- Maintenance requirements of the equipment
    - For more information on defining staff qualifications, refer to Standard HR.01.02.01

EC 02.04.01 – EP 7: The hospital identifies medical equipment on its inventory that is included in an alternative equipment maintenance program (AEM):

- Equipment Identified as included in the AEM will have been reviewed by the AEM Committee and be marked in the MEDI as AEM.

EC 02.01.04 – EP 9: The hospital has written procedures to follow when medical equipment fails, including using emergency clinical interventions and backup equipment.

- The hospital follows EOC 6002, Medical Equipment Defective Repairs Policy to remediate equipment failures. This includes Red Tagging the machine, notifying local management and Clinical Engineering. This includes ensuring the patients safety and quickest remediation measures possible.

EC 02.04.01 – EP 10: The hospital identifies quality control and maintenance activities to maintain the quality of the diagnostic computed tomography (CT), positron emission tomography (PET), magnetic resonance imaging (MRI), and nuclear medicine (NM) images produced. The hospital identifies how often these activities should be conducted.

- The Radiology Department manages the Radiography equipment and maintains contracts with Original Equipment Manufacturers, Third Party Service Providers and Contracted Physicists Services to maintain, certify and validate proper operation and functionality of the equipment. The Radiology department maintains the records to support these activities.

EC 02.04.01 – EP 11: The hospital monitors and reports all incidents in which medical equipment is suspected in or attributed to the death, serious injury, or serious illness of any individual, as required by the Safe Medical Device Act of 1990.

- The hospital follows Policy EOC 6009, Safe Medical Device Act/Device Tracking and Reporting Policy, in coordination with Department Management, Risk Management, Clinical Engineering and Leadership.

EC 02.04.03 – EP 1 Before initial use and after major repairs or upgrades of medical equipment on the Medical Equipment Database Inventory, the hospital performs safety, operational, and functional checks.

- Hospital Staff follow policy “EOC 6004 Initial Equipment” and “EOC 6002 Equipment Failure” to report new equipment to be used in the patient care vicinity.

EC 02.04.03 – EP 2 The hospital inspects, tests, and maintains all high-risk equipment. These activities are documented.

Note 1: High-risk equipment includes medical equipment for which there is a risk of serious injury or even death to a patient or staff member if it should fail, which includes life-support equipment

Note 2: Required activities and associated frequencies for maintaining, inspecting, and testing of medical equ8ipment completed in accordance with manufacturer’s recommendations must have a 100% completion rate.

Note 3: Scheduled maintenance activities for High-Risk medical equipment in an Alternative Equipment Maintenance (AEM) inventory must have a 100% completion rate. AEM frequency is determined by the hospital’s AEM program. (See also: PC 02.01.11,EP 2)

EC 02.04.03 – EP 3 The hospital inspects, tests, and maintains non-high-risk equipment identified on the medical equipment inventory. These activities are documented.

Note 1: Scheduled maintenance activities for non-high-risk medical equipment in an Alternative Equipment Maintenance (AEM) program inventory must have a 100% completion rate. AEM frequency is determined by the hospital’s AEM program.

EC 02.04.03 – EP 4 The hospital conducts performance testing and maintains all sterilizers. These activities are documented. (See Also IC.02.02.01, EP 2)

The Clinical Engineering department or contracted vendors maintain the sterilizers for manufacturer required preventive maintenance, cleaning and corrective maintenance activities. These activities are documented. Daily testing of the sterilizers is maintained by the Sterile Processing Department and activities are documented.

EC 02.04.03 – EP 5 The hospital performs equipment maintenance and chemical and biological testing of water used in Hemodialysis. These activities are documented.

The hospital’s Hemodialysis technicians perform equipment maintenance and chemical and biological testing of water used in Hemodialysis. These activities are documented and presented to the EOC committee quarterly.

EC 02.04.03 – EP 8 Equipment listed for use in oxygen-enriched atmospheres is clearly and permanently labeled (withstands cleaning/disinfecting) as follows:

- Oxygen-metering equipment, pressure-reducing regulators, humidifiers, and nebulizers are labeled with name of manufacturer or supplier.
- Oxygen-metering equipment and pressure reducing regulators are labeled “OXYGEN-USE NO OIL”
- Labels on flowmeters, pressure reducing regulators, and oxygen-dispensing apparatus designate the gasses for which they are intended.
- Cylinders and containers are labeled in accordance with Compressed Gas Association (CGA) C-7 (for full text, refer to NFPA 99-2012:11 5 3 1)
    - Note: Color coding is not utilized as the primary method of determining the cylinder or container contents.

EC 02.04.03 EP 10 – All occupancies containing hyperbaric facilities comply with construction, equipment, administration, and maintenance requirements of NFPA 99-2012: Chapter 14.

Maintenance of Hyperbaric Chambers is performed by the Manufacturer and a verification of services performed annually is recorded by the Clinical Engineering Department.

EC 02.04.03 EP 16 – Qualified hospital staff inspect, test, and calibrate Nuclear Medicine (NM) Equipment Annually. The results and completion dates are documented.

The Imaging Services Department manages the Imaging equipment and maintains contracts with Original Equipment Manufacturers, Third Party Service Providers and Contracted Medical Physicists Services to maintain, certify and validate proper operation and functionality of the equipment. The Imaging Services department maintains the records to support these activities.

EC 02.04.03 EP 18 – The hospital maintains the quality of the diagnostic computed tomography (CT), positron emission tomography (PET), magnetic resonance imaging (MRI), and nuclear medicine (NM) images produced.

The Imaging Services Department manages the Imaging equipment and maintains contracts with Original Equipment Manufacturers, Third Party Service Providers and Contracted Medical Physicists Services to maintain, certify and validate proper operation and functionality of the equipment. The Imaging Services department maintains the records to support these activities.

EC 02.04.03 EP 20 – For diagnostic Computed tomography (CT) services: at least annually, a diagnostic medical physicist does the following:

- Measures the radiation dose (in the form of volume computed tomography dose Index (CTDIvol) produced by each diagnostic CT system for the following for CT protocols: adult brain, adult abdomen, pediatric brain and pediatric abdomen. If one or more of these protocols is not used by the hospital, other commonly used CT protocols may be substituted.
- Verifies that the radiation dose (In the form of CTDIvol) produced and measured for each protocol for each measure tested is within 20 percent of the CTDIvol displayed on the CT console. The dates, results and verifications of these measurements are documented.
    - Note 1: This element of performance is only applicable for systems capable of calculating and displaying radiation doses
    - Note 2: This element of performance does not apply to dental cone beam CT radiographic imaging studies performed for diagnosis of conditions affecting the maxillofacial region or to obtain guidance for the treatment of such conditions.
    - Note 3: Medical physicists are accountable for these activities. They may be assisted with the testing and evaluation of equipment performance by individuals who have the required training and skills, as determined by the physicist. (For more information, refer to HR.01.02.01, EP 1; HR.01.02.07, EPs 1 and 2; HR.01.06.01, EP 1; LD.03.06.01, EP 4)

The Imaging Services Department manages the Imaging equipment and maintains contracts with Original Equipment Manufacturers, Third Party Service Providers and Contracted Medical Physicists Services to maintain, certify and validate proper operation and functionality of the equipment. The Imaging Services department maintains the records to support these activities.

EC 02.04.03 EP 21 – For diagnostic computed tomography (CT) services: At least annually, a diagnostic medical physicist conducts a performance evaluation of all CT Imaging equipment. The evaluation results along with recommendations for correcting any problems identified, are documented. The evaluation includes the use of phantoms to assess the following imaging matrix:

- Image uniformity
- Scout prescription accuracy
- Alignment light accuracy
- Table travel accuracy
- Radiation beam width
- High-contrast resolution
- Low-contrast detectability
- Geometric or distance accuracy
- Artifact evaluation
    - Note 1: This element of performance does not apply to dental cone beam CT radiographic imaging studies performed for diagnosis of conditions affecting the maxillofacial region or to obtain guidance for the treatment of such conditions.
    - Note 2: Medical physicists are accountable for these activities. They may be assisted with the testing and evaluation of equipment performance by individuals who have the required training and skills, as determined by the physicist. (For more information, refer to HR.01.02.01, EP 1; HR.01.02.07, EPs 1 and 2; HR.01.06.01, EP 1; LD.03.06.01, EP 4)

The Imaging Services Department manages the Imaging equipment and maintains contracts with Original Equipment Manufacturers, Third Party Service Providers and Contracted Physicists Services to maintain, certify and validate proper operation and functionality of the equipment. The Imaging Services department maintains the records to support these activities.

EC 02.04.03 EP 22 – At least annually, a diagnostic medical physicist or magnetic resonance imaging (MRI) scientist conducts a performance evaluation of all MRI imaging equipment. The evaluation results, along with recommendations for correcting any problems identified, are documented. The evaluation includes the use of phantoms to assess the following imaging matrix:

- Image uniformity for all radiofrequency (RF) coils used clinically
- Signal-to-noise ratio (SNR) for all coils used clinically
- Slice thickness accuracy
- Slice position accuracy
- Alignment light accuracy
- High-contrast resolution
- Low-contrast resolution (or contrast to noise ratio)
- Geometric or distance accuracy
- Magnetic field homogeneity
- Artifact evaluation
    - Note 2: Medical physicists are accountable for these activities. They may be assisted with the testing and evaluation of equipment performance by individuals who have the required training and skills, as determined by the medical physicist or MRI scientist. (For more information, refer to HR.01.02.01, EP 1; HR.01.02.07, EPs 1 and 2; HR.01.06.01, EP 1; LD.03.06.01, EP 4)

The Imaging Services Department manages the Imaging equipment and maintains contracts with Original Equipment Manufacturers, Third Party Service Providers and

Contracted Physicists Services to maintain, certify and validate proper operation and functionality of the equipment. The Imaging Services department maintains the records to support these activities.

EC 02.04.03 EP 23 – At least annually, a diagnostic medical physicist or nuclear medicine physicist conducts a performance evaluation of all nuclear medicine imaging equipment. The evaluation results, along with recommendations for correcting any problems identified, are documented. The evaluations are conducted for all of the image types produced clinically by each NM scanner (for example, planar and/or tomographic) and include the use of phantoms to assess the following imaging matrix:

- Image uniformity / system uniformity
- High-contrast resolution / system spatial resolution
- Sensitivity
- Energy resolution
- Count-rate performance
- Artifact evaluation
    - Note 1: The following test is recommended but not required: Low contrast resolution or detectability for non-planar acquisitions
      Note 2: The medical physicist or nuclear medicine physicist is accountable for these activities. They may be assisted with the testing and evaluation of equipment performance by individuals who have the required training and skills, as determined by the medical physicist or nuclear medicine physicist. (For more information, refer to HR.01.02.01, EP 1; Hr.01.02.07, EPs 1 and 2; HR.01.06.01, EP 1; LD 03.06.01, EP 4.)

The Imaging Services Department manages the Imaging equipment and maintains contracts with Original Equipment Manufacturers, Third Party Service Providers and Contracted Physicists Services to maintain, certify and validate proper operation and functionality of the equipment. The Imaging Services department maintains the records to support these activities.

EC 02.04.03 EP 24 – At least annually, a diagnostic medical physicist conducts a performance evaluation of all positron emission tomography (PET) imaging equipment. The evaluation results, along with recommendations for correcting any problems identified, are documented. The evaluations are conducted for all of the image types produced clinically by each PET scanner (for example, planar and/or tomographic) and include the use of phantoms to assess the following imaging metrics:

- Image uniformity / system uniformity
- High-contrast resolution / system spatial resolution
- Low-contrast resolution or detectability (not applicable for planar acquisitions)
- Artifact evaluation
    - Note 1: The following tests are recommended, but not required, for PET scanner testing: sensitivity, energy resolution and count rate performance.
      Note 2: Medical physicists are accountable for these activities. They may be assisted with the testing and evaluation of equipment performance by individuals who have the required training and skills, as determined by the medical physicist, (For more information, refer to HR.01.02.01, EP 1; HR.01.02.07, EPs 1 and 2; HR.01.06.01, EP 1; LD 03.06.01, EP 4.)

The Imaging Services Department manages the Imaging equipment and maintains contracts with Original Equipment Manufacturers, Third Party Service Providers and Contracted Physicists Services to maintain, certify and validate proper operation and

functionality of the equipment. The Imaging Services department maintains the records to support these activities.

EC 02.04.03 EP 25 – For computed tomography (CT) position emission tomography (PET), nuclear medicine (NM), or magnetic resonance imaging (MRI) services: the annual performance evaluation conducted by the diagnostic medical physicist or MRI scientist (for MRI only) includes testing of image acquisition display monitors for maximum and minimum luminance, luminance uniformity, resolution, and spatial accuracy.

- Note 1: This element of performance does not apply to dental cone beam CT radiographic imaging studies performed for diagnosis of conditions affecting the maxillofacial region or to obtain guidance for the treatment of such conditions.
  Note 2: Medical physicist or MRI scientists are accountable for these activities. They may be assisted with the testing and evaluation of equipment performance by individuals who have they required training and skills, as determined by the physicist or MRI scientist. (For more information, refer to HR.01.02.01, EP 1; HR.01.02.07, EPs 1 and 2; HR.01.06.01, EP 1; LD 03.06.01, EP 4.)

The Imaging Services Department manages the Imaging equipment and maintains contracts with Original Equipment Manufacturers, Third Party Service Providers and Contracted Physicists Services to maintain, certify and validate proper operation and functionality of the equipment. The Imaging Services department maintains the records to support these activities.

EC 02.04.03 EP 26 – The hospital performs equipment maintenance on anesthesia apparatus. The apparatus are tested at the final path to patient after any adjustment, modification, or repair. Before the apparatus is returned to service, each connection is checked to verify proper gas flow and an oxygen analyzer is used to verify oxygen concentration. Areas designated for servicing of oxygen equipment are clean and free of oil, grease, or other flammables. (For full test, refer to NFPA 99-2012: 11.4.1.3; 11.5.1.3; 11.6.2.5; 11.6.2.6)

The Clinical Engineering Department or contracted vendor performs equipment maintenance on anesthesia apparatus. Testing to the manufacturers' standards are completed throughout the service. Each connection is tested for proper gas flow and an oxygen analyzer is used to verify oxygen concentration. Areas used for servicing of oxygen equipment are clean and free of oil, grease or other flammables.

EC 02.04.03 EP 27 – The hospital meets NFPA 99-2012: Healthcare Facilities code requirements related to electrical equipment in the patient care vicinity. (For full text refer to NFPA 99-2012: Chapter 10)

Note: The hospital meets the applicable provisions of the Health Care Facilities Code Tentative Interim Amendment. (TIA) 12-5

EC 02.04.03 EP 34 – For hospitals that provide fluoroscopic services: At least annually, a diagnostic medical physicist conducts a performance evaluation of fluoroscopic imaging equipment. The evaluation results, along with recommendations for correcting any problems identified, are documented. The evaluation includes an assessment of the following:

- Beam alignment and collimation
- Tube potential/Kilovolt peak (kV/kVp) accuracy
- Beam filtration (half-value layer)
- High-contrast resolution
- Low-contrast detectability

- Maximum exposure rate in fluoroscopic mode
- Displayed air-kerma rate and cumulative-air kerma accuracy (when applicable)
    - Note 1: Medical physicist conducting performance evaluations may be assisted with the testing and evaluation of equipment performance by individuals who have the required training and skills, as determined by the physicist.
    - Note 2: This element of performance does not apply to fluoroscopy equipment used for therapeutic radiation treatment planning or delivery.

The Imaging Services Department manages the Imaging equipment and maintains contracts with Original Equipment Manufacturers, Third Party Service Providers and Contracted Medical Physicists Services to maintain, certify and validate proper operation and functionality of the equipment. The Radiology department maintains the records to support these activities.

"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."

EOC 6003 Medical_Equipment-_Health_Care_Device_Modification_Policy

Kaweah Health

Subcategories of Department Manuals not selected.

Policy Number: EOC 6003	**Date Created: 04/01/2010**
Document Owner: Maribel Aguilar (Safety Officer/Life Safety Manager)	**Date Approved: Not Approved Yet**
Approvers: Board of Directors (Administration), Board of Directors (EOC/Emergency Preparedness)	

Medical Equipment- Health Care Device Modification Policy

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

PURPOSE:
Given the nature of the environments that medical healthcare devices are subject to operate in, it can be readily assumed that not all devices will act in the necessary fashion to meet the needs of the Healthcare professional. There may be times and certain unforeseen circumstances that arise, which may require the modification of the device being used, to adapt to the end user's preferences. It is, therefore, necessary to have a standing policy that delineates the procedures that shall be followed, without exception.

STANDARD:
Every patient that visits Kaweah Health has the right to expect the finest quality healthcare that we can provide. These services include providing the most current, up-to-date medical technology that we can provide. They have the right to expect that the equipment used in any treatment they may receive shall be in proper operating condition, and be functioning exactly as the device manufacturer designed, and that the Healthcare Professional using the device, shall be properly trained and fully competent in its operation.

POLICY:
It shall be the policy of Kaweah Health, that NO MEDICAL HEALTHCARE DEVICE MODIFICATIONS SHALL BE CONSIDERED, ATTEMPTED, OR COMPLETED, WITHOUT PRIOR, WRITTEN APPROVAL OF THE DEVICE MANUFACTURER, AND THE FOOD AND DRUG ADMINISTRATION, (where applicable).

PROCEDURES:

1. All written requests for Healthcare Device Modifications shall be submitted to all positions listed below via e-mail.

   - ❑ Director of Medical Staff
   - ❑ Director of Nursing
   - ❑ Director of Materials Management
   - ❑ Chairperson of the Safety Committee
   - ❑ Director of Risk Management
   - ❑ Director of Clinical Engineering

2. The management of the Clinical Engineering Dept. shall review each request, and notify the Device Manufacturer, supplying all necessary information included on the initial request for modification.

3. Given the nature of each individual request, all requests shall be submitted at least 90 days prior to the expected time that the device is expected to be used in its modified state. This should provide the necessary time for each request to be routed to the Device Manufacturer, and the Food and Drug Administration, and a reply received.

4. Documentation of all received requests shall be maintained by the Clinical Engineering Department, with copies supplied to all individuals listed in item (1).

5. All APPROVED modifications shall be noted on the Device Maintenance History log in the Medical Equipment Database (MEDB), which is maintained by the Clinical Engineering Department, denoting exactly the modification made, the date completed, and the date returned to service.

"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."

EOC 6015

Hospital_Electrical_Safety_Policy_for_Personal_Items

Kaweah Health

Subcategories of Department Manuals not selected.

Policy Number: EOC 6015	**Date Created: 04/01/2010**
Document Owner: Maribel Aguilar (Safety Officer/Life Safety Manager)	**Date Approved: Not Approved Yet**
Approvers: Board of Directors (Administration), Board of Directors (EOC/Emergency Preparedness)	

Hospital Electrical Safety Policy for Personal Items

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

Policy:

Kaweah Delta Health Care District herein referred to as Kaweah Health (KH) is committed to providing a safe environment for our patients, visitors, and staff members. To this end, the following policy and procedure have been developed.

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

Definitions:

Pertinent 2012 NFPA 99 Definitions:

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

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

• "Patient care room" is defined in section 3.3.138 as any room of a health care facility wherein patients are intended to be examined or treated. Note that this term replaces the term "patient care area" used in the 1999 NFPA 99, but the definition has not changed.

• "Patient care vicinity" is defined in section 3.3.139 as a space, within a location intended for the examination and treatment of patients (i.e., patient care room) extending 6 ft. beyond the normal location of the bed, chair, table, treadmill, or other device that supports the patient during examination and treatment and extends vertically 7 ft. 6 in. above the floor.

Procedure:

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

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

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

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

All items shall meet the following criteria for approval:

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

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

The following conditions apply for use:

Personal Owned Medical Device:

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

Personal Use Electrical Device:

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

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

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

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

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

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

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

5. The following devices are generally permitted for use:

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

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

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

6. The following devices are prohibited from use:

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

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

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

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

EOC 7001 Utilities_Management_Plan

Subcategories of Department Manuals not selected.

Policy Number: EOC 7001	**Date Created: 07/01/2010**
Document Owner: Maribel Aguilar (Safety Officer/Life Safety Manager)	**Date Approved: Not Approved Yet**
Approvers: Board of Directors (Administration), Board of Directors (EOC/Emergency Preparedness)	

Utilities Management Plan

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

I. OBJECTIVES

The objectives of the Management Plan for Utility Equipment at Kaweah Delta Health Care District ,herein after referred to as Kaweah Health (KH)are to manage effective, safe, and reliable operations of utility equipment that provides a safe, controlled physical environment for the patients, employees, physicians, and visitors who enter the premises. Inherent in utility equipment processes are operational reliability of utility equipment, the development of a utility equipment inventory and program, and an inspection and maintenance program designed to minimize risks to our patients and the physical environment. Specific processes in place to support the objectives of the utility equipment management plan include the following:

- Preventive Maintenance
- Corrective Maintenance
- Annual maintenance on equipment/systems
- User/maintainer training
- Performance indicators

Annual Evaluation of the Utilities Management Plan

SCOPE

The scope of the Utility Management Plan applies to KH with the Director of Facilities Planning, overseeing the management of the utility systems, and with broad oversight by the *Environment of Care (EOC)* Committee. With respect to the offsite areas per KH license, the Facilities Planning Director has oversight responsibility for the utility system that provides services to the offsite areas. The facility manager, or managers if applicable, will have the responsibility of the day-to-day operations relating to utility services, which often means working in partnership with a lessor, or building owner if applicable. Utility failure plans are required for each offsite area, and are the responsibility of the offsite manager. Utility issues for the offsite areas may be brought to the attention of the *EOC* Committee.

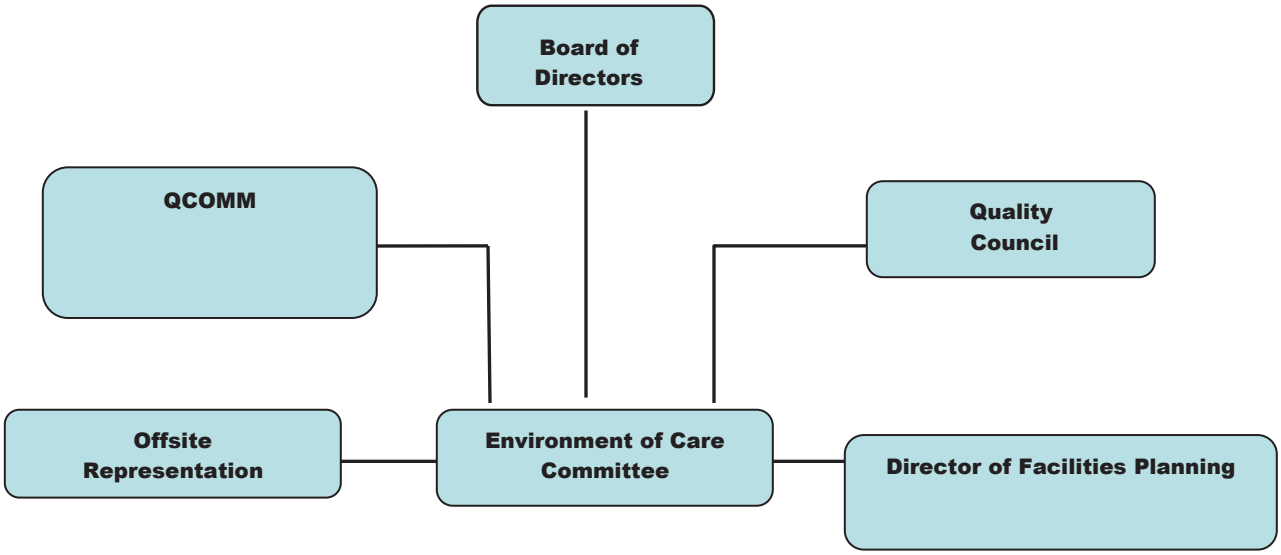
AUTHORITY

The authority for the Management Plan for Utility Equipment is EC. 02.05.01. The authority for overseeing and monitoring the utility equipment plan and program lies in the *EOC* Committee, whose members will ensure activities relating to utility equipment management are identified, monitored and evaluated, and for ensuring that regulatory activities are monitored and enforced as necessary.

ORGANIZATION

The following represents the organization of the Utilities Management Plan at KH:

Organization –Utilities Management Plan



RESPONSIBILITIES

Leadership within Kaweah Health have varying levels of responsibility and work together in the management of utility equipment as identified below:

Board of Directors: The Board of Directors supports the Utility Management Plan by:

- Review and feedback if applicable of the quarterly and annual *EOC* reports.
- Endorsing budget support as applicable for capital purchases relating to utility equipment.

Quality Council: Reviews annual *EOC* report from the *EOC* Committee, and provides broad direction in the establishment of performance monitoring standards relating to utility equipment risks.

Professional Staff Quality Committee or PROSTAFF: Reviews annual *EOC* report from the *EOC* Committee, providing feedback if applicable.

Administrative Staff: Administrative staff provides active representation on the *EOC* Committee meetings and sets an expectation of accountability for compliance with the Utility Equipment Program

***Environment of Care* Committee:** *EOC* Committee members review and approve the quarterly *EOC* reports, which contain a Utility Equipment component, and oversee any issues relating to the overall utility equipment program.

Directors and Department Managers: These individuals support the Utility Management Program by:

- Reviewing and correcting deficiencies identified through the hazard surveillance process that relate to utility equipment risks.
- Communicating recommendations from the *EOC* Committee to affected staff in a timely manner.
- Providing information/in-services to staff that insure compliance with applicable policies of the within the Utility Management program.
- Serving as a resource for staff on matters of utility equipment usage.

Employees: Employees of Kaweah Health are required to participate in the Utility Management program by:

- Completing applicable utility equipment training.
- Reporting utility equipment failures to their supervisor and to Facilities
- Reporting any observed or suspected unsafe conditions to his or her department manager as soon as possible after identification that may pose a utility equipment risk, which include, but are not

limited to: frayed electrical cords, use of extension cords, overuse of power adaptors, equipment brought in by patients, or any loss of utility power.

Medical Staff: Medical Staff will support the Utility Management Program by abiding by the Kaweah Health's policies and procedures relating to the use of utility equipment

The [organization] manages risks associated with its utility systems.
EC. 02.05.01-1
EC.02.06.05-1,2

When planning for new, altered or renovated space that will impact utility systems, KH uses one of the following design criteria:
-State rules and regulations, and
-*Guidelines for Design and Construction of Hospitals and Healthcare Facilities*, current edition, published by the American Institute of Architects.
When the above rules, regulations and guidelines do not meet specific design needs, other reputable standards and guidelines are used that provide equivalent design criteria. When planning for demolition, construction or renovation, a pre-construction risk assessment is used that addresses utility requirements that affect care, treatment and services. If any utility-related risks are identified during the pre-construction assessment, KH will take action to minimize the identified utility risks. After construction projects are completed, the Director Facilities Planning will ensure the acquisition of as-built drawings, and in addition will insure that other utility system maps and drawings are updated and current.

KH maintains a written inventory of all operating components of utility systems or maintains a written inventory of selected operating components of utility systems based on risk for infection, occupant needs, and systems critical to patient care (including all life support systems). Kaweah Health evaluates new types of utility components before initial use to determine whether they should be included in the inventory.
EC.02.05.01-3 through 7
EC.02.05.05, EPs 1through 6

Written Inventory
KH maintains a written inventory of utility systems, which includes (but not limited to) the following:

Water Supply System
Irrigation Water System
Domestic Hot Water System
Hot Water Heat Recovery System
Water Softening System
Patio Storm Drain System
Sewage System
Basement Sump Pump
Natural Gas System
Fuel Oil System
Steam Boilers and Distribution System
Condensate Return
Medical Air System
Medical Vacuum System
Medical Oxygen System
Heating, Ventilation and Air Conditioning System
Electrical System 7 Emergency Generators 7 Transfer Switch
Elevator System
Nurse Call System
Kitchen Fire Extinguishing System
Fire Sprinkler System
MRI Halon Fire Extinguisher System
Fire Alarm Monitoring System – API
Paging System
Telephone System and Telephones
Two-Way Radio System
Pagers

ICU/CCU Monitor System
Master Clock System
Sterilizers
ETO Abator System
Trash Compactor
Bailer

Any new utility equipment purchased for KH is evaluated for inclusion into the written inventory. The utility management program includes equipment that meets the following criteria:

- Equipment maintains the climatic environment in patient care areas.
- Equipment that constitutes a risk to patient life support upon failure.
- Equipment is a part of a building system, which is used for infection control.
- Equipment that is part of the communication system, which may affect the patient or the patient care environment.
- Equipment is an auxiliary or ancillary part of a system control or interface to patient care environment, life support, or infection control.

Inspection and Maintenance Activities

Documentation of inspection, testing and maintenance demonstrates systems and components performance within prescribed limits and adherence to established schedules. The minimum required documentation is exception reporting. This documentation lists all items tested and indicates pass or fail. Those items that fail have additional documentation of repair and subsequent testing indicating performance within standards. As part of utility system operational plans, planned or preventive maintenance is a key factor in assuring the ongoing performance and reliability of utility systems whereby each system is properly identified, operated, and maintained. A system is no more reliable than the individual pieces of equipment, or components, within it. Each component within a system is evaluated to determine the content and frequency of testing procedures, inspections, calibrations, and the servicing and replacement of parts. In the development of preventive maintenance programs, a review is made from various sources of information, such as manufacturers recommendations, codes, standards, and federal, state, and local laws and regulations. The basic sources of information are invaluable as start-up aids; however, over time it is essential that local operating experience be factored in to modify the program. Through this process, initial levels of risk are maintained or reduced.

Minimization of Pathogenic Biological Agents

The Utility Management plan includes processes for activities that will reduce the potential for hospital-acquired illnesses that could be transmitted through the Utility Systems. These include policies and or procedures relating to:

- **Cooling Towers/Open and Closed Water Systems:** Biological and/or chemical treatment(s) and testing or cultures are in place wherein the potential for hospital-acquired illness could occur within Kaweah Health's cooling and heating systems.
- **Domestic Hot and Cold Water Systems:** Periodic biological testing of the hot and cold water systems are in effect as part of the utility management program.
- **Equipment Maintenance - HVAC:** A filter change program is in effect to reduce the risks associated with air borne contaminants within the major air handling systems.
- **Air Pressure Monitoring/Maintenance:** A program is in place in Facilities that allows for the air pressure monitoring, maintenance, and balancing for the following critical areas: surgical operating rooms, critical care areas, including ICU, special procedure rooms, isolation rooms and the labor and delivery suites.
- **Construction.** Protocol and procedures are in place to coordinate Infection Control and construction activities that establishes how an area will be assessed before and during construction for the purpose of minimizing the risks associated with air-borne biological contaminants (e.g., aspergillosis).

The Facilities Planning Director/Safety Officer is responsible for the proper and safe functioning of all equipment within the facility and the general condition of the facility. Facilities management requires written procedures that are developed and specify the action to be taken during the failure of essential equipment and major utility services. The written procedures include a call system for summoning essential personnel and outside assistance when required. The following essential equipment and services are included: Major air conditioning equipment, air handling systems (ventilation, filtration, quantitative exchanges, humidity), boilers, electrical power services, fire alarm and extinguishing systems, water supply, all waste disposal systems, and medical gas and vacuum systems. Qualified engineering consultative advice is available as needed. In the event that the in-house personnel cannot correct the problem and restore the operation of the equipment, then

Administration, the Facilities Planning Director and Safety Officer, or their designated representative shall have full authorization to call in an outside resource to correct the situation.

Kaweah Health maps the distribution of its utility systems
EC.02.05.01-17
Layout maps or blueprints for utilities with complicated infrastructures are maintained to enhance troubleshooting effectiveness. Distribution maps are located in Facilities, and are for plumbing, medical gases and electrical.

Kaweah Health labels utility system controls to facilitate partial or complete emergency shutdowns.
EC.02.05.01-9
Controls for Utility Systems are labeled in an efficient manner. Most importantly, controls that are located remotely from related equipment are clearly labeled. The label explains the equipment that is controlled and the power source panel identification. Medical gas valves are clearly labeled as to what areas they isolate. Other plumbing valves are labeled in correspondence with a master valve list.

Kaweah Health has written procedures for responding to utility system disruptions
EC.02.05.01-10
Policies and procedures are in place in Facilities, which identify emergency procedures for utility system disruptions or failures. Systems are in place to mitigate the consequences of a utility failure, such as the emergency generators, battery operated equipment, staff interventions in the event equipment fails and the use of outside vendors for emergency assistance as may be needed.

Kaweah Health's procedures address shutting off the malfunctioning system and notifying staff in affected areas.
EC.02.05.01-11
Staff and employees are notified in affected areas when a partial or total system shutdown is necessary. When a utility system must be shutdown, notification is made to Administration, Nursing, and the Department Director(s)/managers of the affected department(s), and agencies having jurisdiction if applicable.

Kaweah Health's procedures address performing emergency clinical interventions during utility systems disruptions.
EC.02.05.01-12
In the event of a utility system disruption that impacts the flow of electrical-operated medical equipment, clinical interventions are to be provided based upon the scope of practice of the patient care provider, and may include such interventions as:

- Use of portable monitors and ventilators
- Manual bagging of a patient if the patient is on a ventilator that loses power and does not have a battery back-up
- Battery-operated equipment
- Manual intravenous administration in the event IV equipment fails, and does not have battery back-up

Kaweah Health has a reliable emergency electrical power source
EC.02.05.03-1-16
KH provides and maintains a reliable emergency power system that is adequately sized, designed and fueled as required by the LSC occupancy requirements and the services provided, and supplies emergency power to the following areas and systems:

i. Alarm Systems
ii. Egress illumination
iii. Elevator (1)
iv. Emergency Communication Systems
v. Exit Sign Illumination
vi. Blood, Bone and Tissue Storage Units
vii. Emergency Care Areas (Urgent Care)
viii. Intensive Care
ix. Medical Air Compressors
x. Medical/Surgical Vacuum Systems
xi. Newborn Nurseries

xii. OB Delivery Rooms
xiii. Operating Rooms
xiv. Recovery Rooms
xv. Special Care Units
xvi. Lighting at emergency generator locations
xvii. Emergency Rooms
xviii. Dispensing Cabinets
xix. Medication Carousels
xx. Central Medication Robots (if applicable)
xxi. Medication Refrigerators
xxii. Medication Freezers

Kaweah Health inspects, tests, and maintains utility systems.
Note: At times, maintenance is performed by an external service, and KH must have access to this documentation.
EC.02.05.05- 2and 4 through 6

On a regular and consistent basis, inspection, testing, and maintenance is part of a process to assure system and component performance. The initial inspection and test are part of the acceptance of new systems and components. Ongoing inspection, testing and maintenance increases reliability, systems and components life, and user confidence. The intervals for inspection, testing and maintenance are based on the needs of the systems and components. The intervals may be less than or more than one year. The exception is the required weekly testing of the emergency generators. If an interval greater than one year is selected, it must be approved by the *EOC* committee. The Facilities Planning Director will apply or obtain professional judgment to set intervals so known risks, hazards and maintenance needs are managed. In Facilities a computerized maintenance system is used to facilitate the scheduling, inspection, testing, maintenance, monitoring, and documentation of equipment for the utilities systems.

Equipment Currently in Inventory:

- Scheduled maintenance work orders are issued on a monthly basis to Facility's staff.
- Maintenance is performed in accordance with the instructions included in the work order. The assigned engineer documents the maintenance, including any pertinent observations, on the work order. When maintenance and documentation are completed, the engineer returns the work order to the Facility's department.
- If scheduled maintenance cannot be performed (i.e., parts not available), the reason is documented on the work order and returned to Facilities. There is a system of evaluation for equipment not serviced within the scheduled time frame.
- If systems' equipment must be removed from the user area for more than one day, the engineer prepares a corrective maintenance work order.
- If scheduled maintenance is to be performed by an outside vendor, the Facility Director or designee contacts the vendor and instructs the vendor to perform the maintenance as detailed in the work order, document the maintenance and any associated work done on the work order. A copy of this documentation is maintained in Facilities.

Incoming Equipment:

- Requests for new equipment are reviewed and approved by the Facilities Planning Director or designee for proper safety features, including electrical needs, drainage needs, ventilation needs and space consideration as required by manufacturer specifications.
- After receipt of new equipment, but prior to its installation, it must be inspected, with electrical and mechanical tests performed, and determined in conjunction with Clinical Engineering and Facilities that it meets all appropriate safety standards.
- If the equipment fails to pass the required tests and inspection, the engineer will return the equipment to Purchasing unless the deficiency is corrected. The equipment is not assigned an identification number until the equipment has passed all the requirements.
- After passing inspection, and if recommended by manufacturer, the new equipment will be entered on the Preventive Maintenance Database. At this time, the equipment is assigned an identification number, and the engineer performing the inspection will install the respective tag with the assigned equipment number, and then process the necessary data entry of the specific procedures and frequency to be followed during the preventive maintenance as recommended by the manufacturer.
- If the manufacturer does not recommend preventive maintenance to the equipment, i.e., microwave oven, addressograph, the responsible engineer performing the inspection will apply a tag with the date

the inspection was performed, and will place the equipment on the Non-Clinical Equipment Inspection Log, and will be subject to visual inspection once a year to verify proper operation.

- In the event that equipment not belonging to Kaweah Health is brought into KH for use, they must be inspected and determined to be safe by the Clinical Engineering Department. This would apply to any items brought by patients, visitors or employees (radios, televisions, coffee makers, etc.). The Facilities Planning Director or designee is authorized to remove any item, which is found to be unsafe for use in the District. This will include any demonstration equipment brought in by any vendor.

Documentation is maintained in the Facilities Department, and includes, but is not limited to the following:

- A current, accurate and separate inventory of utility components identified in this plan
- Performance and safety testing of each critical component before initial use.
  - Maintenance of critical components of High Risk Utility systems/equipment consistent with the maintenance strategies identified in this plan.
  - Maintenance of critical components of infection control utility systems/equipment for consistent with the maintenance strategies identified in this plan.
  - Maintenance of critical components of non-high risk utility systems/equipment on the inventory consistent with maintenance strategies identified in this plan.

Kaweah Health inspects, tests and maintains emergency power systems
EC.02.05.07- 1 through 10

1. At 30-day intervals, a functional test is performed of battery-powered lights required for egress for a minimum duration of 30 seconds. The completion date of the test is documented and maintained in Facilities.
2. Every 12 months, performs a functional test of battery-powered lights required for egress and exit signs for a duration of 1 ½ hours. The completion date of the tests or replacement is documented and maintained by the KH Safety Department.
3. SEPSS (Stored Electrical Energy Emergency and Standby Power Systems) testing: **Not applicable**.
4. At least weekly, the hospital inspects the emergency power supply system (EPSS), including all associated components and batteries. The results and completion dates of weekly inspections are documented-**Not applicable**.
5. The generators are tested monthly by Facilities for at least 30 continuous minutes. The completion date of the tests is documented and kept on file by the KH Safety Department.
6. The emergency generator tests are conducted with a dynamic load that is at least 30% of the nameplate rating of the generator or meets the manufacturer's recommended prime movers' exhaust gas temperature.
7. Monthly, the automatic transfer switches are tested, and the completion date of the tests is documented and maintained by the KH Safety Department.
8. At least annually, the hospital tests the fuel quality to ASTM standards. The test results and completion dates are documented.
9. At least once every 36 months, each emergency generator is tested for a minimum of 4 continuous hours. The completion date of the tests is documented and maintained by the KH Safety Department.
10. The 36-month emergency generator test uses a dynamic or static load that is at least 30% of the nameplate rating of the generator or meets the manufacturer's recommended prime movers' exhaust gas temperature.

    If the required emergency power system test fails, KH will implement measures to protect patients, visitors and staff until necessary repairs or corrections are completed. This is the responsibility of Facilities personnel. If a required emergency power system test fails, Facilities personnel will perform a retest after making the necessary repairs or corrections.

Kaweah Health inspects, tests and maintains medical gas and vacuum systems.
EC.02.05.09-1 through 14

Facilities inspects, tests, and maintains critical components of piped medical gas systems, including master signal panels, area alarms, automatic pressure switches, shutoff valves, flexile connectors, and outlets. The plan for inspecting, testing and maintaining medical gas and vacuum system includes, but is not limited to:

- Annual inspection of alarm panel
- Annual inspection of area alarms

A routine PM schedule is in place for automatic pressure switches, shutoff valves, flexible connectors and outlets (annual testing for patient-care areas, and annual for non-patient care areas).

When the systems are installed, modified, or repaired including cross-connections testing, piping purity testing and pressure testing, a qualified individual (e.g., a contractor/certified licensed technician) insures that the medical gas systems are installed/maintained/repaired. When the installation is completed, or when maintenance or repair work is done, the qualified individual ensures that cross connection testing, piping purity testing and pressure testing are included in the process, and that code requirements are met. The systems will be additionally tested (to ensure it is connected properly so that a sufficient volume is yielded at each outlet) following periods of construction or if there is evidence that the system has been breached.

KH maintains the main supply valve and area shut-off valves of piped medical gas and vacuum systems and ensure they are accessible and clearly labeled. To maintain safety in the event of an emergency, a current and complete set of documents indicating the distribution of the medical gas systems and control for partial or complete shutdown is maintained. The documents include "as-built" drawings, construction or design drawings, line or isometric drawings, shop drawings, or any combination of these if they reflect present conditions.

When the hospital has bulk oxygen systems above ground, they are in a locked enclosure (such as a fence) at least 10 feet from vehicles and sidewalks. There is permanent signage stating “OXYGEN – NO SMOKING – NO OPEN FLAMES.”
The hospital’s emergency oxygen supply connection is installed in a manner that allows a temporary auxiliary source to connect to it.

The hospital tests piped medical gas and vacuum systems for purity, correct gas, and proper pressure when these systems are installed, modified, or repaired. The test results and completion dates are documented.

The hospital makes main supply valves and area shutoff valves for piped medical gas and vacuum systems accessible and clearly identifies what the valves control.

Locations containing only oxygen or medical air have doors labeled "Medical Gases: NO Smoking or Open Flame." Locations containing other gases have doors labeled “Positive Pressure Gases: NO Smoking or Open Flame. Room May Have Insufficient Oxygen. Open Door and Allow Room to Ventilate Before Opening.”

Ongoing Education for Users and Maintainers
HR.01.05.03-1

The Facility’s Education Department and the department managers hold responsibility for coordinating and implementing the education and training of the utility equipment users jointly.
USER EDUCATION:
Employees will receive a general overview of the Utilities Management Plan at initial and annual orientation. Department Directors will provide department specific orientation and education to their employees to insure that utility equipment users will be able to describe and/or demonstrate the following items:

1. Basic operating and safety features for users to follow
2. Emergency procedures to follow when utility equipment fails.
3. KH’s process for reporting utility equipment management problems, failures and user errors (i.e., they are reported to Facilities, who in turn reports this information to the *EOC* Committee.

Maintainer Education
For the maintainers of utility equipment, thorough training about the capabilities and limitations of equipment is made by the manufacturer. Self-assessment can be used annually, through the competency process, to determine the need for additional training. Training may be provided by:

- Formal academic courses
- Seminars, in-service training
- On-the-job training
- Service schools

Information collection system to monitor conditions of the environment.

1. Kaweah Health establishes a process(es) for continually monitoring, internally reporting, and investigating the following:
    - Utility equipment management problems, failures and user errors

Through the *EOC* Committee structure, utility problems, failures and user errors are reported by Facilities, who investigate the issue, and provide corrective actions. Minutes and agendas are kept for each Environment of Care meeting and filed in Performance Improvement.

Annual Evaluation of the Utilities Management Plan.
EC.04.01.01-EP-15
On an annual basis *EOC* Committee members evaluate the Utilities Management Plan, as part of a risk assessment process. Validation of the management plan occurs to ensure contents of each plan support ongoing activities within KDHCD. Based upon findings, goals and objectives will be determined for the subsequent year. A report will be written and forwarded to the Governing Board. The annual evaluation will include a review of the following:

- The objectives: The objective of the Utilities Management plan will be evaluated to determine continued relevance for KH (i.e., the following questions will be asked; was the objective completed? Did activities support the objective of the plan? If not, why not? What is the continuing plan? Will this objective be included in the following year? Will new objective(s) be identified? Will specific goals be developed to support the identified objective?)
- The scope. The following indicator will be used to evaluate the effectiveness of the scope of the utilities management plan: the targeted population for the management plan will be evaluated (e.g., did the scope of the plan reach applicable employee populations in the off-site areas, and throughout KH?)
- Performance Standards. Specific performance standards for the Utilities Management plan will be evaluated, with plans for improvement identified. Performance standards will be monitored for achievement. Thresholds will be set for the performance standard identified. If a threshold is not met an analysis will occur to determine the reasons, and actions will be identified to reach the identified threshold in the subsequent quarter.
- Effectiveness. The overall effectiveness of the objectives, scope and performance standards will be evaluated with recommendations made to continue monitoring, add new indicators if applicable or take specific actions for ongoing review.

KDHCD analyzes identified *EOC* issues.
EC.04.01.03-EP-2
EOC issues relating to utility equipment are identified and analyzed through the *EOC* Committee with recommendations made for resolution. It is the responsibility of the *EOC* Committee chairperson to establish an agenda, set the meetings, coordinate the meeting and ensure follow-up occurs where indicated. Quarterly Environment of Care reports are communicated to Performance Improvement, the Medical Executive Committee and the Board of Directors.

KDHCD improves its *EOC*
EC.04.01.05-EP1
Performance standards are identified monitored and evaluated that measure effective outcomes in the area of utility equipment management. Performance standards are also identified for Safety, Security, Hazardous Materials, Emergency Management, Fire Prevention and Medical equipment management. The standards are approved and monitored by the *EOC* Committee with appropriate actions and recommendations made. Whenever possible, the *environment of care* is changed in a positive direction by the ongoing monitoring~~,~~ and changes in actions that promote an improved performance.

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

"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."

EOC 7401 Utilities_Management_Program

Kaweah Health

Subcategories of Department Manuals not selected.

Policy Number: EOC 7401	**Date Created: 04/01/2010**
Document Owner: Maribel Aguilar (Safety Officer/Life Safety Manager)	**Date Approved: Not Approved Yet**
Approvers: Board of Directors (Administration), Board of Directors (EOC/Emergency Preparedness)	

Utilities Management Program

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

POLICY:
Kaweah Health shall maintain a Utilities Management Program, effectively known as the Utilities Management Plan, designed to accurately plan, operate, assess and manage all activities with-in the utility systems environment.

The Utilities Management Program shall include equipment that meets the following criteria:

Maintains the climatic environment in Patient care areas.
Risk potential to Patient life support upon failure.
Building systems, which are involved with infection control.
Communication systems which may affect the Patient or the Patient care environment.
Auxiliary or ancillary part of a system control or interface to Patient care environment, life support, or infection control.

The following systems are included in the Utilities Management Program:

Electrical Distribution Panels
H.V.A.C. Equipment
Heating and Exhaust Equipment
Plumbing, Water Heating and Distribution Equipment
Boiler, Steam
Medical/Surgical Air and Vacuum Equipment
Domestic Water
Sewage Removal Systems
Alarm Systems

The following systems are included in the Utilities Management Program but due to complexity of maintenance, will be serviced by District Vendors:

Vertical Transport Systems
Medical Gas Delivery Equipment, Manifolds, Bulk Oxygen Storage, including Alarm Panels, Valves, Automatic Pressure Switches, Flexible Connectors and Outlets
Sterilization Equipment
Automatic Fire Extinguishing Systems
Emergency Power Equipment including Transfer Switches

"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."

DM 2225 Lockdown-Security_of_Entry_Doors

Policy Number: DM 2225	Date Created: 09/01/2011
Document Owner: Maribel Aguilar (Safety Officer/Life Safety Manager)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration), Board of Directors (EOC/Emergency Preparedness)	

Lockdown-Security of Entry Doors

POLICY:

A facility lockdown will be authorized as indicated for each facility by the Incident Commander. In the event an emergency situation requiring the need for facility lockdown, all entry doors to the facilities will be secured and monitored to isolate the hospital or any Kaweah Health facility from the outside public due to an emergency, either internal or external.
Staff from the labor pool will be assigned to each entry door in order to monitor entries and exits through those doors.

PROCEDURE:

Door Monitor Procedures:

To ensure that the hospital or other facility remains in lockdown, door monitors will be assigned toeach of the doors as listed below, or in the case of a labor pool shortage, one monitor will be assigned to high traffic doors, in order to ensure that no unauthorized access to the facility occurs.

When the labor pool has enough monitors for each door to be monitored, the door monitor is to stand on the inside of the door. Once the lockdown commences, no one will be allowed entry into the facility, except for the designated emergency entrance.

Persons may exit, but no one is allowed to enter.
When encountering someone seeking entry into the hospital, the door monitor will inform that person that the hospital is currently in lockdown and no one is allowed entry, except through the Emergency Room Entrance. If the person seeking entry is requesting medical attention, the person will be directed to the Emergency Department entrance where the person will be admitted for a Medical Screening Exam. Assistance will be provided when indicated to move patients who presented to an entrance other than the Emergency Department Entrance.

Within the hospital's capabilities at the time of the incident, the Emergency Department shall provide Medical Screening Exams (MSE) to all persons presenting for medical emergencies. In situations where the safety and security of the hospital

may be endangered, special consideration should be made to ensure the securing of all access points into and out of the Emergency Department. The MSE can be performed in appropriate sites other than the physical plant of the Emergency Department as directed by the Hospital Incident Commander should the Emergency Department facility become uninhabitable.
The lockdown will remain in effect until the Incident Commander through PBX announces “all clear”.

RESPONSIBLE PARTY	ACTION
Executive Officer or designee, Incident Commander Safety Officer, Security Officer, Nursing Administration	1. Order Lockdown procedures
Security Staff Staff Labor Pool	2. Execute lockdown procedures 3. Door monitoring assignments are made, employees report to assigned doors and monitor door access.

Door Numbers: (See attached map)
Downtown Campus
1) Mineral King Main Entrance Slider Doors
2) Ambrosia Patio Door
3) Ambrosia Kitchen Door
4) Nursing Staff Door (Mineral King)
5) Food & Nutrition Services Double Doors
6) Loading Dock Double Doors
7) Central Logistics ** Assigned to area staff
8) Surgery Waiting Room West Door ** Assigned to area staff
9) Surgery Sliding Doors
10) Ambulatory Surgery Exit Door
11) Acequia Tower – Southwest Employee Entrance Doors
12) Acequia Tower West Staircase
13) Acequia Tower West Employee Entrance Door / Staircase Exit Door
14) Acequia Main Entrance Slider Doors
15) Acequia Tower East Employee Entrance Door / Staircase Exit Door
16) Acequia Tower East Staircase Exit
17) Emergency Department Ambulance Entrance Doors
18) Emergency Department-Security Vestibule Entrance / Exit Doors*** - Assigned area staff
19) Emergency Department- Employee Entrance Door

South Campus:
1) Urgent Care main entrance 1633 South Court
2) Urgent Care south door
3) Urgent Care ambulance Bay
4) Urgent Care glass door
5) KATS Main Entrance sliding door
6) KATS employee entrance south door
7) TCU and Subacute visitor entrance TCU ambulance bay

8) Subacute north east door
9) Subacute north door
10) Storage entrance south door
11) Dietary south door

West Campus Door Numbers:
Mental Health:
1) West exterior (4 exit route) doors 2) North entrance Ambulance port doors
3) Food Services Dining Room (2) exterior doors
4) Dietary Patio (gate) door
5) Front (Patient Family Services) entrance door
6) Main entrance/Lobby door
7) South exterior (Distribution/Loading zone) door
8) East exterior(Exit route) door9) North exterior (Gate) door
Kaweah Dialysis Center
1) Main entrance/Lobby Automatic Doors
2) East exterior (Patio/Lounge) door
3) West entrance (Ambulance) door
4) North entrance (Employee) door
5) North Biohazard Door
6) North Supply Room Door
Rehabilitation Center:
1) South entrance (Ambulance port) door
2) Southeast exterior (exit route) double doors
3) East exterior (Exit route) door
4) Front entrance (Cousteau's Grill) double doors
5) East side exterior (Cousteau's Grill) single door
6) North entrance (Loading Zone door
7) North exterior (Employee) door
8) North Exterior (Exit route) door
9) Front entrance (Outpatient) automatic double doors
10) Main entrance/Lobby automatic double doors
Lifestyle Fitness Center
1) South exterior (Gymnasium) door
2) West entrance (2nd floor) door
3) West Entrance (1st floor) Outpatient Rehab doors
4) Main entrance/Lobby automatic double doors
5) East Entrance (Employee) door
6) East entrance (2nd floor) door
7) South exterior (Lap Pool) door
8) North Exterior (Hand Center) door
9) East (Lap Pool) door
10) East Entrance (Gym)
Kaweah Health Imaging and Breast Center
1) West exterior (Lab Draw) door
2) West entrance (Employee) door
3) South end exterior (exit route) door
4) Two South exterior (Exit routes) doors (back courtyard area)
5) Front Entrance/Main Lobby automatic double doors
6) North Door exterior (Employee) door Breast Center

Sequoia Regional Cancer Center

1) North exterior (Exit route) door
2) North exterior (Staff/Lounge Patio) door
3) Two north exterior (exit route) doors
4) Main entrance/Lobby automatic double doors
5) North entrance (Ambulance automatic double doors
6) East exterior (Exit route) door
7) East entrance (employee) side door
8) South exterior (exit route) door

02.26.2025 rejection of claim letter KKD .Priscilla Wilson

Kaweah Health

February 26, 2025

Matthew D. Owdom, Esq.
Owdom Law Firm
734 W. Oak Avenue
Visalia, California 93291

RE: Notice of Rejection of Claim, of Priscilla Wilson v. Kaweah Delta Health Care District

NOTICE IS HEREBY GIVEN, the Claim which you presented to Kaweah Delta Health Care District Board of Directors, received January 16, 2025, as it relates to damages occurring from approximately start of employment in 2018 to December 2024 was rejected on its merits by the Kaweah Delta Health Care District Board of Directors on February 26, 2025.

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 in a municipal or superior court of the State of California on this Claim. See Government Code section 945.6.

This time limitation applies only to causes of action arising under California law for which a Claim is mandated by the California Government Tort Claims Act, Government Code sections 900 *et seq*. Other causes of action, including those arising under federal law, may have shorter time limitations for filing.

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

Sincerely,

Dave Francis
Secretary, Kaweah Delta Health Care District Board of Directors

cc: Rachele Berglund, Attorney at Law

PA Initiative Final

FY 2025 Strategic Plan

Physician Alignment
Feb 26, 2025

Recruit Providers Champions: Ryan Gates and JC Palermo

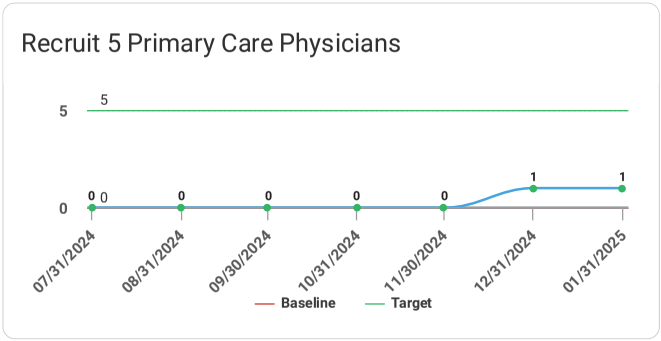
Description: *Develop a recruitment strategy and employment options for physicians that will assist with recruitment of providers to support community needs and Kaweah Health's growth.*

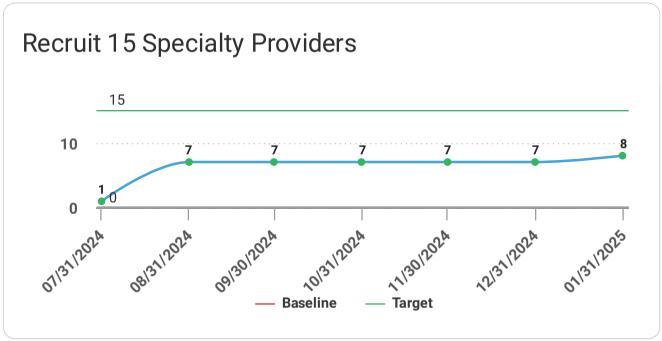
Work Plan (Tactics)

#	Name	Start Date	Due Date	Assigned To	Status	Last Comment
5.1.1	Develop Employment Options for Physicians.	07/01/2024	01/31/2025	Ryan Gates	Off Track	1/10/25 met with respective legal counsel teams and finalized a draft contract. Clarification on a few additional elements is underway and contract execution is expected by 3/1/25.
5.1.2	Beginning early in their residencies, build partnerships with and educate Kaweah Health residents related to practice opportunities and recruitment packages.	07/01/2024	06/30/2025	JC Palermo	On Track	The Kaweah Health Recruitment Team met with the Kaweah Health Family Medicine Residents 12/4, planning to meet with the Kaweah Health Psychiatry Residents 3/19, and the Sierra View Internal Medicine Residents 3/14. Outreach has started to residencies in Bakersfield and Fresno as well.
5.1.3	Support independent physician practices with succession planning and jointly explore options for long term practice sustainability and growth.	07/01/2024	06/30/2025	JC Palermo	On Track	We continue to meet with and discuss long and short-term strategies with our local physician population.
5.1.4	Continue to work directly with local physicians and medical groups to assist in recruitment and placement of new physicians in their practices.	07/01/2024	06/30/2025	JC Palermo	On Track	We are working with local primary care providers to recruit APPs and Physicians to provide expanded coverage to our community.

Performance Measure (Outcomes)

#	Name	Start Date	Due Date	Assigned To	Status	Last Comment
5.1.4.1	Recruit 5 Primary Care Physicians	07/01/2024	06/30/2025	JC Palermo	On Track	We have successfully recruited a local primary care physician to start working in a Kaweah Health Clinic. This transition will take place in the summer. We are also discussing opportunities with local residents, along with posting Kaweah Health practice opportunities nationwide.
5.1.4.2	Recruit 15 Specialty Providers	07/01/2024	06/30/2025	JC Palermo	On Track	Since July 1st we have signed: 2 Pediatric Hospitalists, 1 Psychiatrist, 1 Dermatologist, 1 Pulmonologist, 2 General Surgeons, and 1 Cardiothoracic Surgeon.





Physician Alignment and Practice Support Champions: Ryan Gates and JC Palermo

Description: *Develop services and opportunities that improve alignment with and support for contracted and affiliated physician practices.*

Work Plan (Tactics)

#	Name	Start Date	Due Date	Assigned To	Status	Last Comment
5.2.1	Engage local physician community to understand their medical practice objectives, challenges, opportunities and support needs.	07/01/2024	06/30/2025	Ryan Gates	On Track	Kaweah Health continues to meet and engage with local medical practices to understand opportunities and how best to support the needs of the community physicians.
5.2.2	Develop medical practice support models to ensure the success of local and regional physicians based upon identified needs and opportunities.	07/01/2024	06/30/2025	Ryan Gates	On Track	Meetings completed with two current providers to evaluate transitioning to a wRVU model. Conversations are happening with Family Medicine Faculty regarding solo practice opportunities. A family medicine provider has signed and will be using a wRVU compensation model. There are also conversations with other family medicine providers underway.
5.2.3	Explore opportunities for established and new physicians to invest in and practice at a new ambulatory surgery center and clinics.	07/01/2024	06/30/2025	Ryan Gates	On Track	We continue conversations with local physicians to refine our assumptions for volumes. Once this effort is complete, we will share the results with our local physician partners and come to agreements.
5.2.4	Continue to work with Key Medical Group in joint recruitment and support for physician practices in our community.	07/01/2024	06/30/2025	Ryan Gates	On Track	Kaweah Health continues to meet with and collaborate with Key Medical Group in joint recruitment efforts and support for physician practices in the community.
5.2.5	Promote Kaweah Health services and the physicians that support them.	07/01/2024	06/30/2025	Ryan Gates	On Track	Kaweah Health continues to promote Kaweah Health Services and supporting physicians.

CFO REPORT TO BOARD 2.26.2025

CFO Financial Report

Month Ending January 2025

kaweahhealth.org

Kaweah Health
MORE THAN MEDICINE. LIFE.

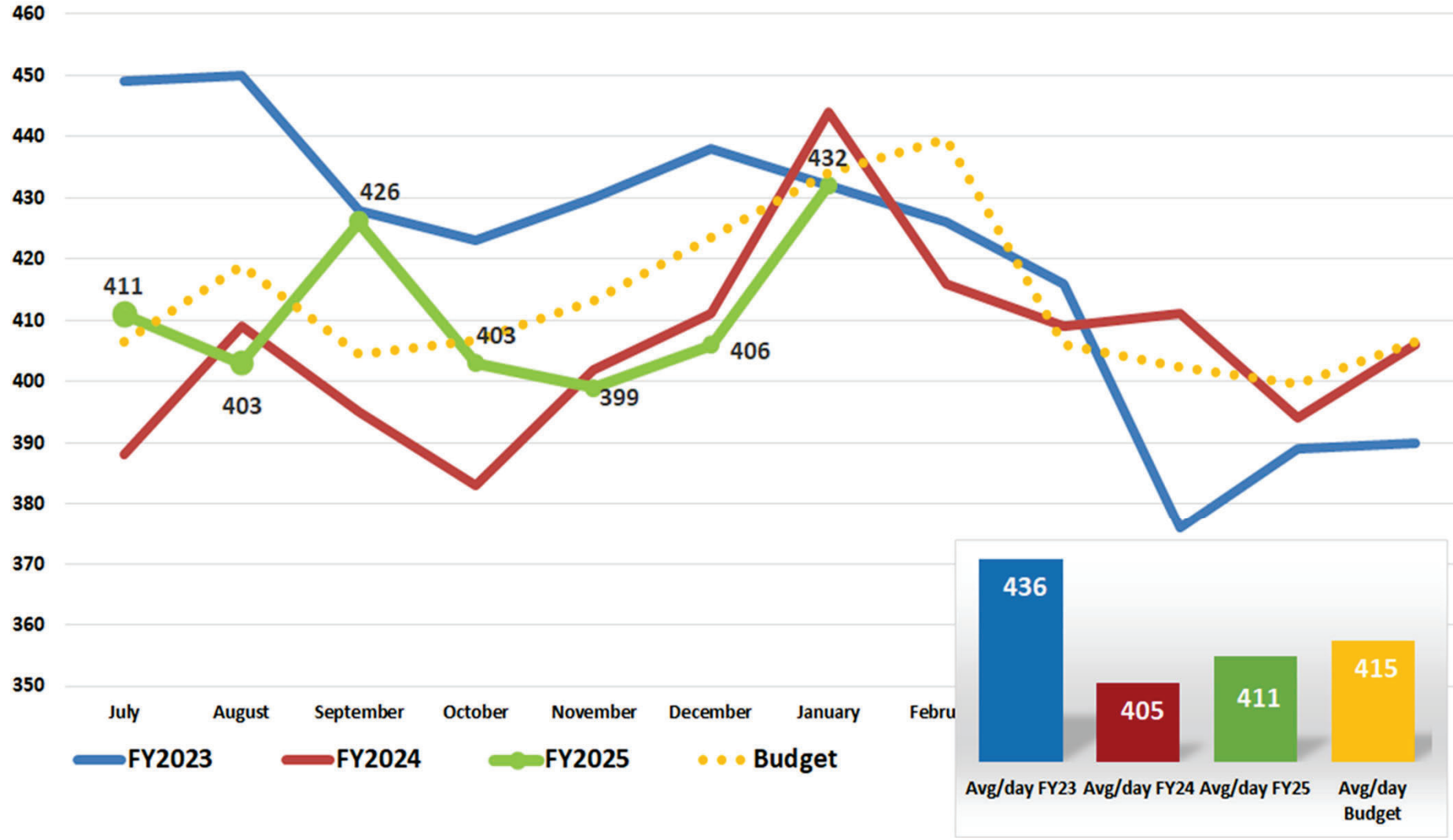
Summary Payer Volumes (FY25-through January 2025)

Patient Type	Payor Group	Patient Cases				Patient Cases %			
FISCAL YEARS		2022	2023	2024	2025	2022	2023	2024	2025
Inpatient	Medi-Cal Managed Care	**8,537**	**8,738**	**9,359**	**5,998**	**29.6%**	**31.6%**	**33.5%**	**35.2%**
	Commercial	**6,763**	**6,384**	**6,288**	**3,595**	**23.4%**	**23.1%**	**22.5%**	**21.1%**
	MEDICARE	**6,526**	**6,083**	**6,000**	**3,510**	**22.6%**	**22.0%**	**21.5%**	**20.6%**
	Medicare Managed Care	**2,990**	**3,021**	**3,459**	**2,204**	**10.4%**	**10.9%**	**12.4%**	**12.9%**
	MEDI-CAL	**3,672**	**3,053**	**2,454**	**1,472**	**12.7%**	**11.0%**	**8.8%**	**8.6%**
	Cash Pay	**217**	**209**	**247**	**200**	**0.8%**	**0.8%**	**0.9%**	**1.2%**
	Work Comp	**115**	**90**	**94**	**43**	**0.4%**	**0.3%**	**0.3%**	**0.3%**
	Tulare County	**49**	**58**	**37**	**33**	**0.2%**	**0.2%**	**0.1%**	**0.2%**
Inpatient Total		**28,869**	**27,636**	**27,938**	**17,055**	**4.9%**	**4.9%**	**4.9%**	**5.2%**
Outpatient	Commercial	**185,320**	**172,035**	**180,887**	**103,842**	**33.0%**	**32.3%**	**33.6%**	**33.1%**
	Medi-Cal Managed Care	**186,686**	**169,668**	**161,954**	**95,103**	**33.2%**	**31.8%**	**30.1%**	**30.3%**
	MEDICARE	**96,957**	**94,486**	**99,025**	**60,266**	**17.3%**	**17.7%**	**18.4%**	**19.2%**
	Medicare Managed Care	**51,185**	**60,067**	**66,989**	**39,820**	**9.1%**	**11.3%**	**12.4%**	**12.7%**
	MEDI-CAL	**23,905**	**22,960**	**14,837**	**6,401**	**4.3%**	**4.3%**	**2.8%**	**2.0%**
	Cash Pay	**14,528**	**9,788**	**8,763**	**4,777**	**2.6%**	**1.8%**	**1.6%**	**1.5%**
	Work Comp	**3,388**	**3,988**	**6,130**	**3,515**	**0.6%**	**0.7%**	**1.1%**	**1.1%**
Outpatient Total		**561,969**	**532,992**	**538,585**	**313,724**	**95.1%**	**95.1%**	**95.1%**	**94.8%**
Grand Total		**590,838**	**560,628**	**566,523**	**330,779**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

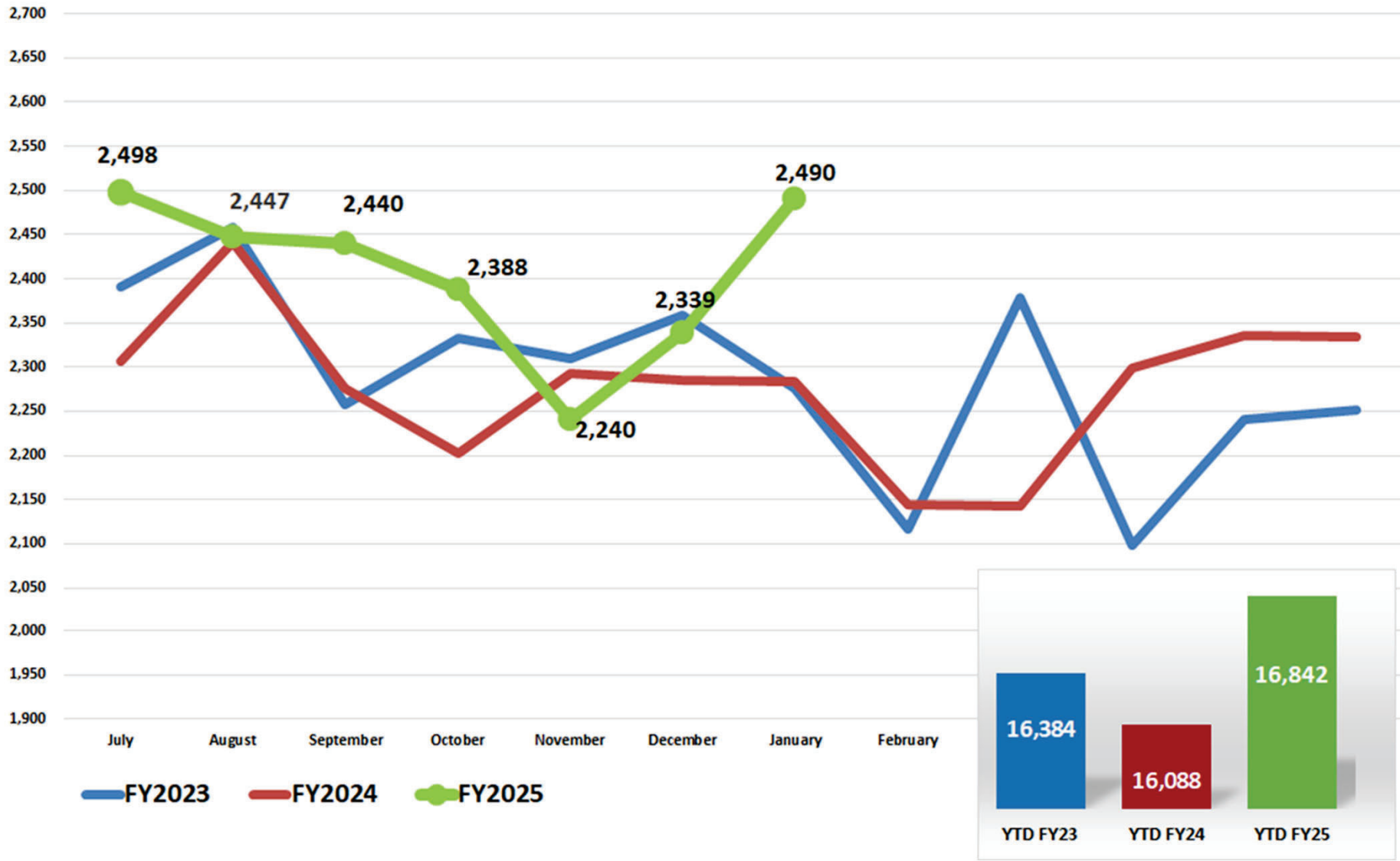
Patient Type Payer Volume Report (FY25-through January 2025)

	Patient Cases				Patient Cases %			
	2022	2023	2024	2025	2022	2023	2024	2025
Inpatient								
Medi-Cal	12,209	11,791	11,813	7,470	42.3%	42.7%	42.3%	43.8%
Medicare	9,516	9,104	9,459	5,714	33.0%	32.9%	33.9%	33.5%
	21,725	20,895	21,272	13,184	75.3%	75.6%	76.1%	77.3%
% of Total Inpatient	75%	76%	76%	77%				
Outpatient								
Medi-Cal	210,591	192,628	176,791	101,504	37.5%	36.1%	32.8%	32.4%
Medicare	148,142	154,553	166,014	100,086	26.4%	29.0%	30.8%	31.9%
	358,733	347,181	342,805	201,590	63.8%	65.1%	63.6%	64.3%
% of Total Outpatient	64%	65%	64%	64%				

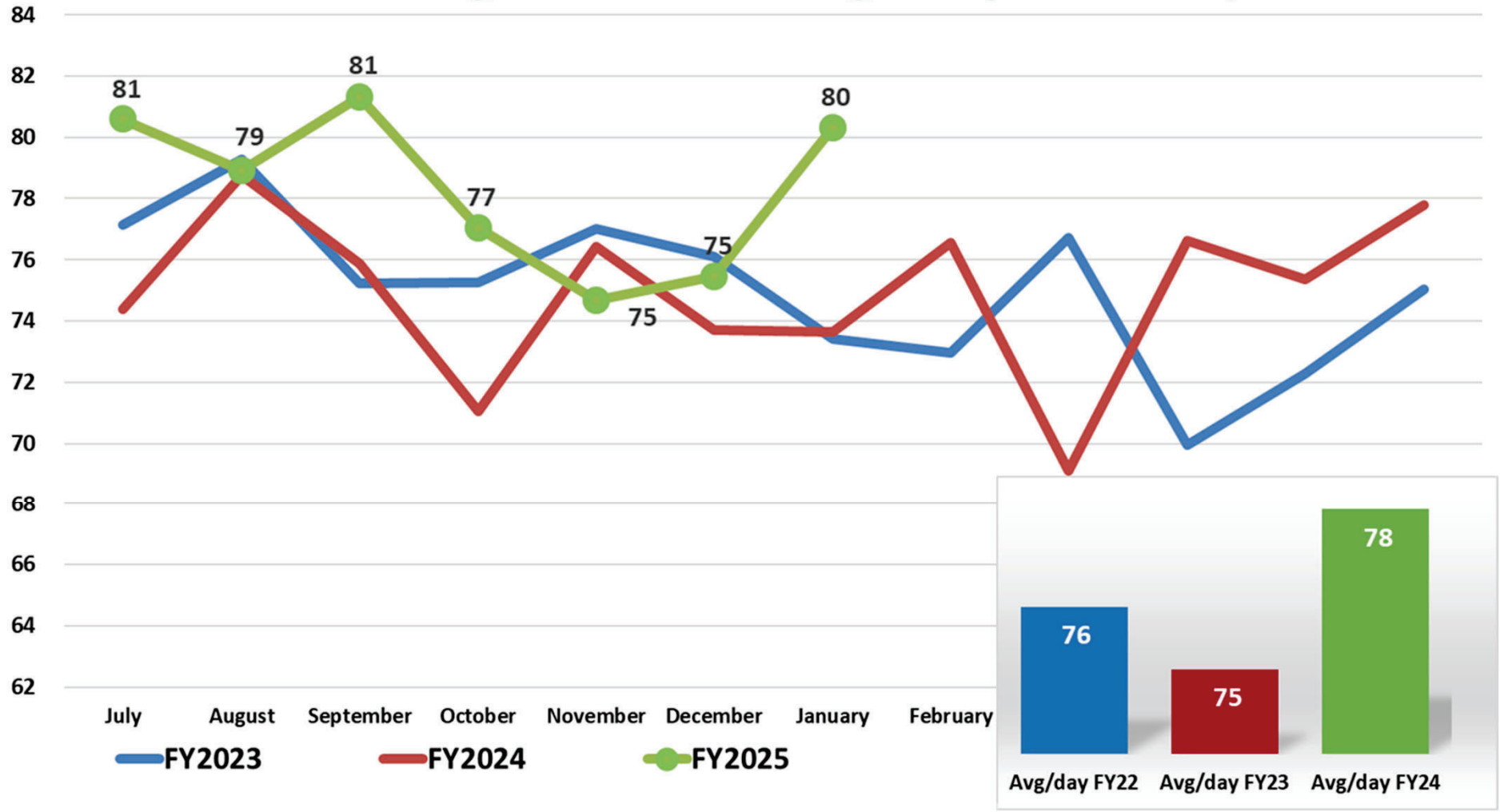
Average Daily Census



Discharges


2,700
2,650
2,600
2,550
2,500
2,450
2,400
2,350
2,300
2,250
2,200
2,150
2,100
2,050
2,000
1,950
1,900
2,498
2,447
2,440
2,388
2,240
2,339
2,490
July
August
September
October
November
December
January
February
FY2023
FY2024
FY2025
16,384
16,088
16,842
YTD FY23
YTD FY24
YTD FY25

Average Discharges per day

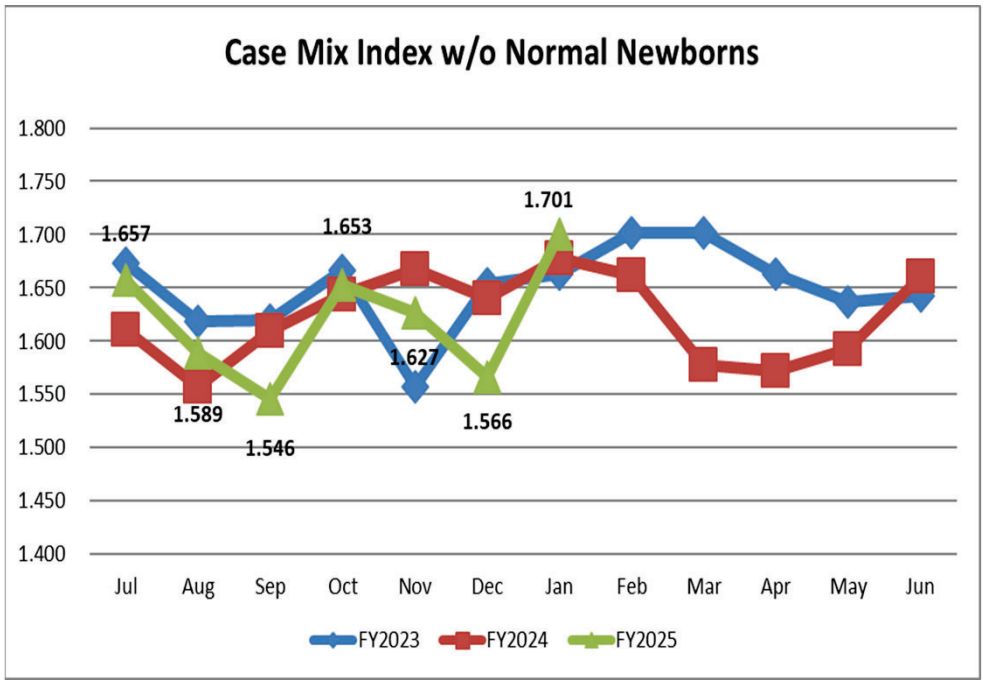


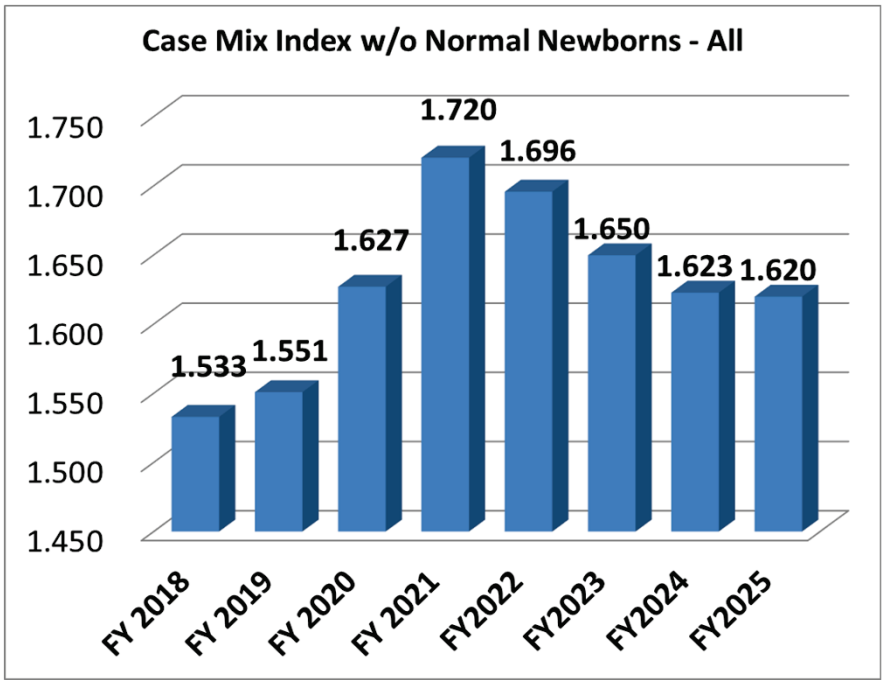
Statistical Results – Fiscal Year Comparison (Jan)

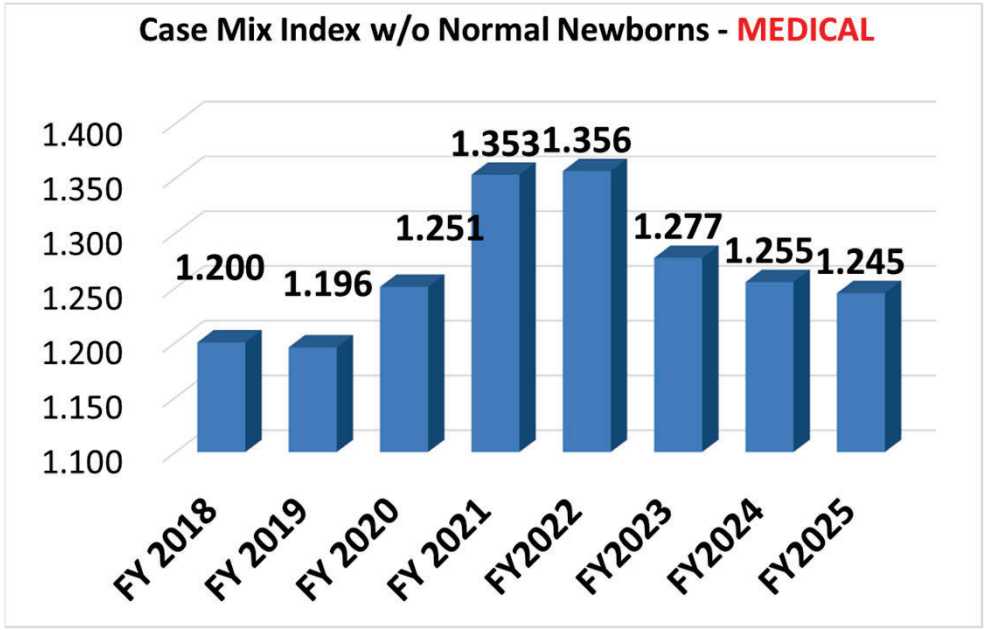
	Actual Results			Budget	Budget Variance	
	Jan 2024	Jan 2025	% Change	Jan 2025	Change	% Change
Average Daily Census	**444**	**432**	**(2.7%)**	**432**	**0**	**0.1%**
KDHCD Patient Days:						
Medical Center	9,650	9,397	(2.6%)	9,215	182	2.0%
Acute I/P Psych	1,340	1,073	(19.9%)	1,403	(330)	(23.5%)
Sub-Acute	945	941	(0.4%)	920	21	2.3%
Rehab	631	717	13.6%	545	172	31.6%
TCS-Ortho	313	363	16.0%	398	(35)	(8.8%)
NICU	373	346	(7.2%)	400	(54)	(13.5%)
Nursery	512	558	9.0%	500	58	11.6%
Total KDHCD Patient Days	**13,764**	**13,395**	**(2.7%)**	**13,381**	**14**	**0.1%**
Total Outpatient Volume	**61,318**	**62,713**	**2.3%**	**61,660**	**1,053**	**1.7%**

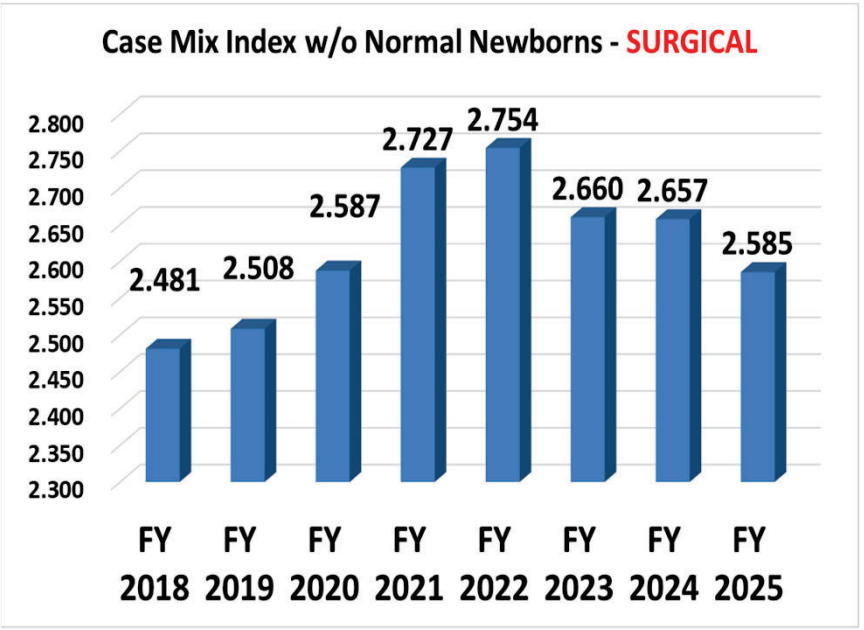
Statistical Results – Fiscal Year Comparison (Jul-Jan)

	Actual Results			Budget	Budget Variance	
	FYTD 2024	FYTD 2025	% Change	FYTD 2025	Change	% Change
Average Daily Census	**405**	**411**	**1.6%**	**416**	**(5)**	**(1.1%)**
KDHCD Patient Days:						
Medical Center	58,610	60,840	3.8%	60,145	695	1.2%
Acute I/P Psych	9,174	7,799	(15.0%)	9,729	(1,930)	(19.8%)
Sub-Acute	6,553	6,466	(1.3%)	6,470	(4)	(0.1%)
Rehab	3,771	4,193	11.2%	3,855	338	8.8%
TCS-Ortho	2,399	2,531	5.5%	2,703	(172)	(6.4%)
NICU	2,941	2,956	0.5%	3,020	(64)	(2.1%)
Nursery	3,568	3,667	2.8%	3,500	167	4.8%
Total KDHCD Patient Days	**87,016**	**88,452**	**1.7%**	**89,422**	**(970)**	**(1.1%)**
Total Outpatient Volume	**406,583**	**418,779**	**3.0%**	**427,644**	**(8,865)**	**(2.1%)**

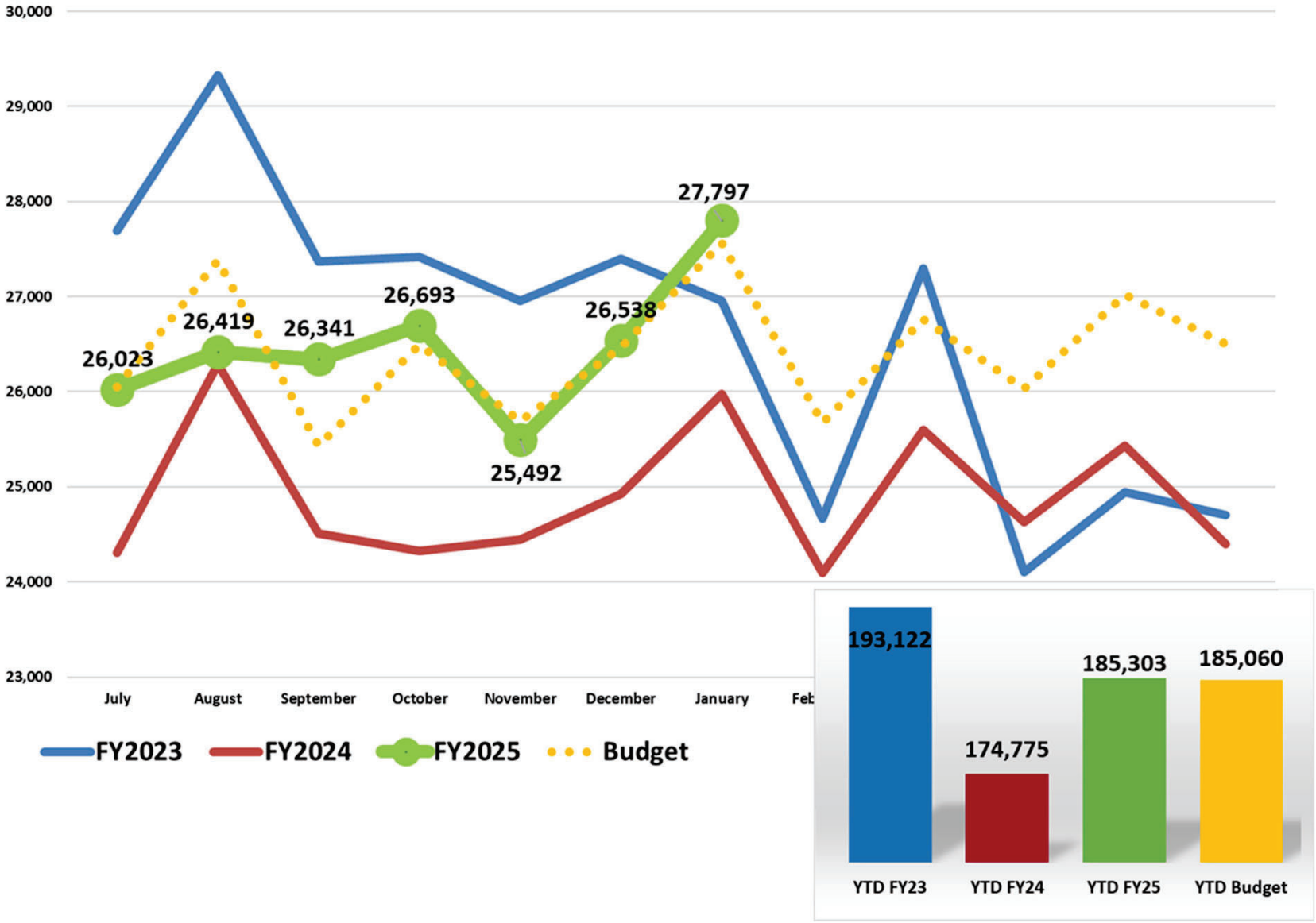

Case Mix Index w/o Normal Newborns
1.800
1.750
1.700
1.650
1.600
1.550
1.500
1.450
1.400
1.657
1.589
1.546
1.653
1.627
1.566
1.701
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun
FY2023
FY2024
FY2025


Case Mix Index w/o Normal Newborns - All
1.750
1.700
1.650
1.600
1.550
1.500
1.450
1.533
1.551
1.627
1.720
1.696
1.650
1.623
1.620
FY 2018
FY 2019
FY 2020
FY 2021
FY2022
FY2023
FY2024
FY2025

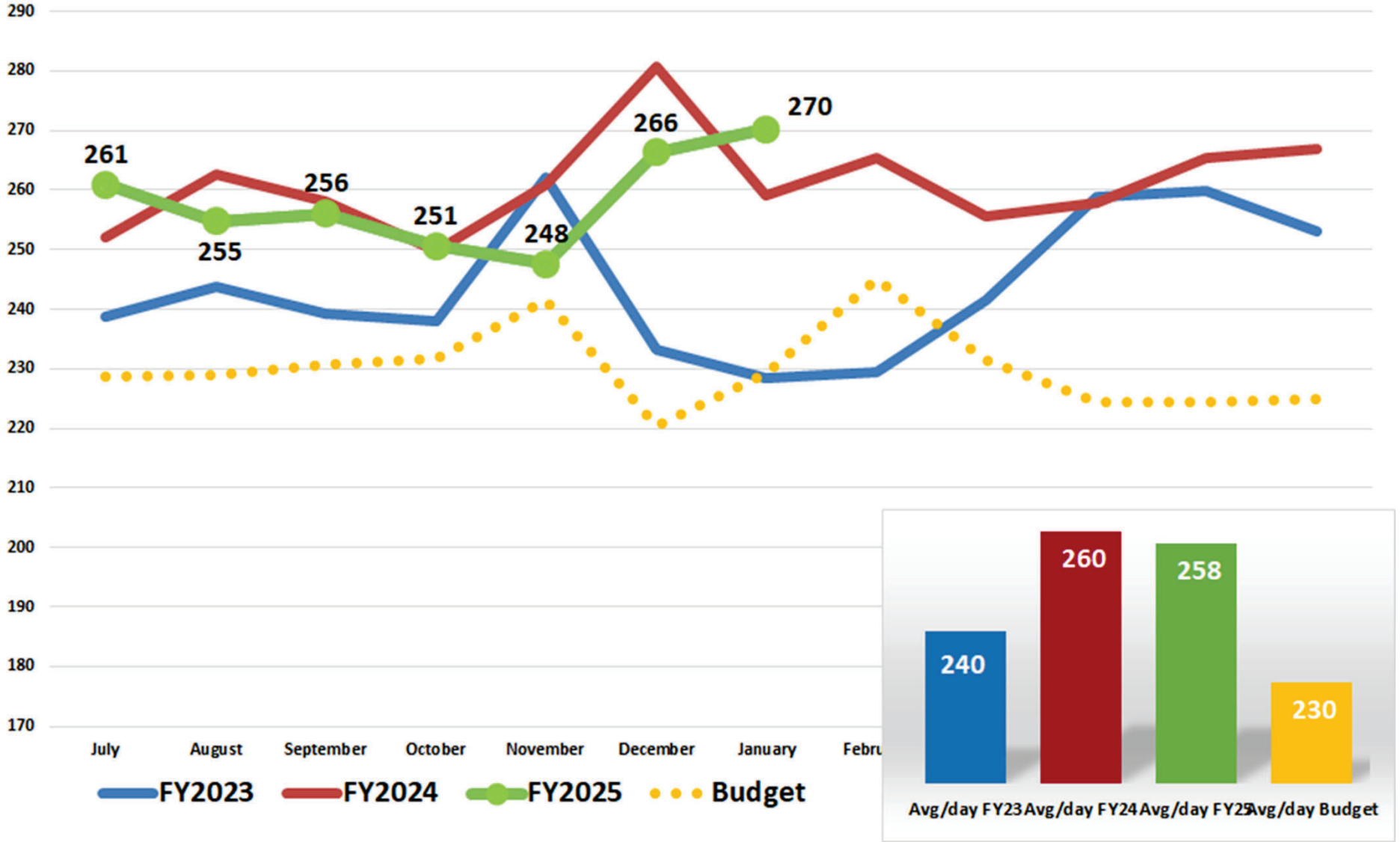

Case Mix Index w/o Normal Newborns - MEDICAL
1.400
1.350
1.300
1.250
1.200
1.150
1.100
1.200
1.196
1.251
1.353
1.356
1.277
1.255
1.245
FY 2018
FY 2019
FY 2020
FY 2021
FY2022
FY2023
FY2024
FY2025


Case Mix Index w/o Normal Newborns - SURGICAL
2.800
2.750
2.700
2.650
2.600
2.550
2.500
2.450
2.400
2.350
2.300
2.481
2.508
2.587
2.727
2.754
2.660
2.657
2.585
FY 2018
FY 2019
FY 2020
FY 2021
FY 2022
FY 2023
FY 2024
FY 2025

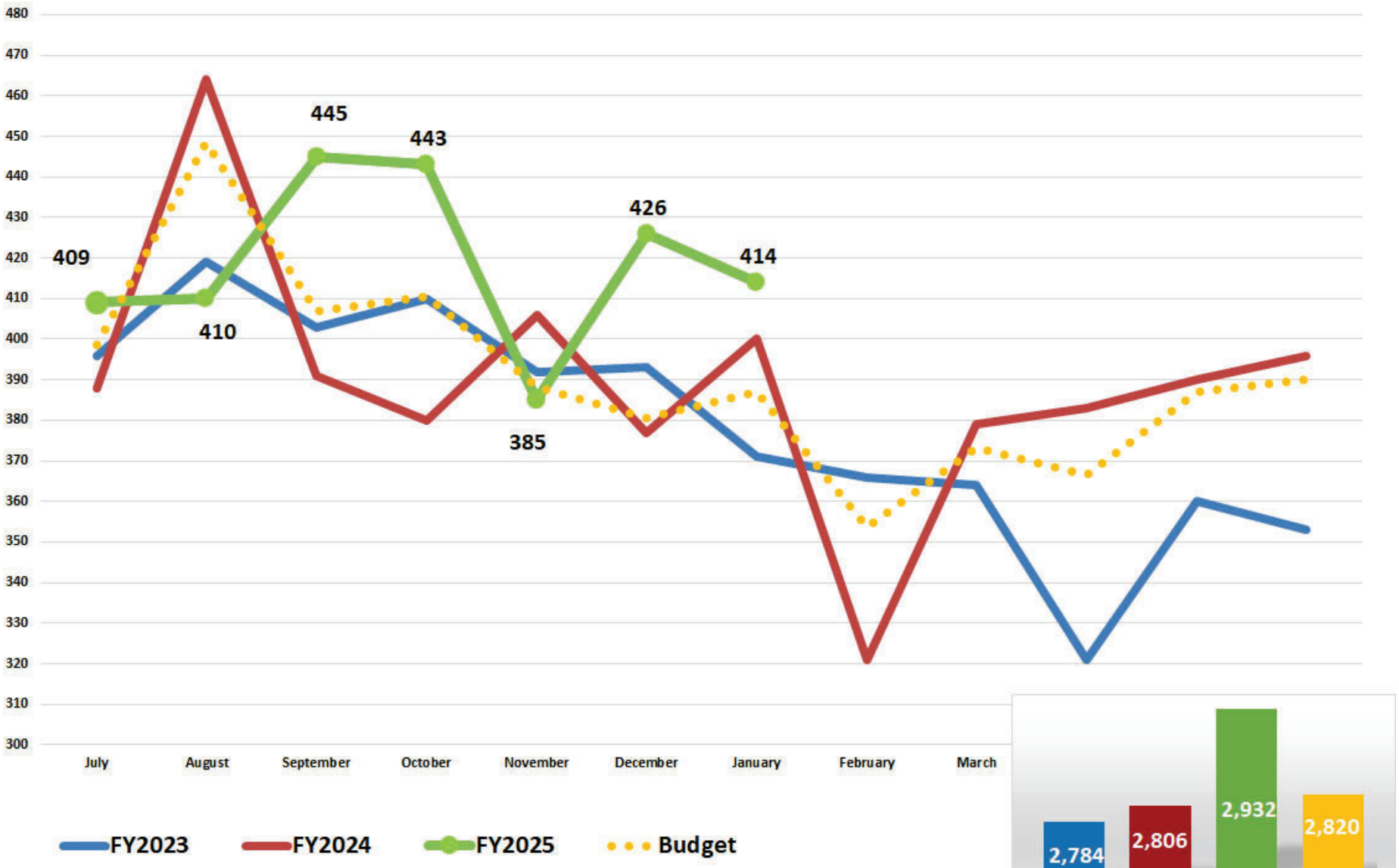
Adjusted Patient Days



ED - Avg Treated Per Day

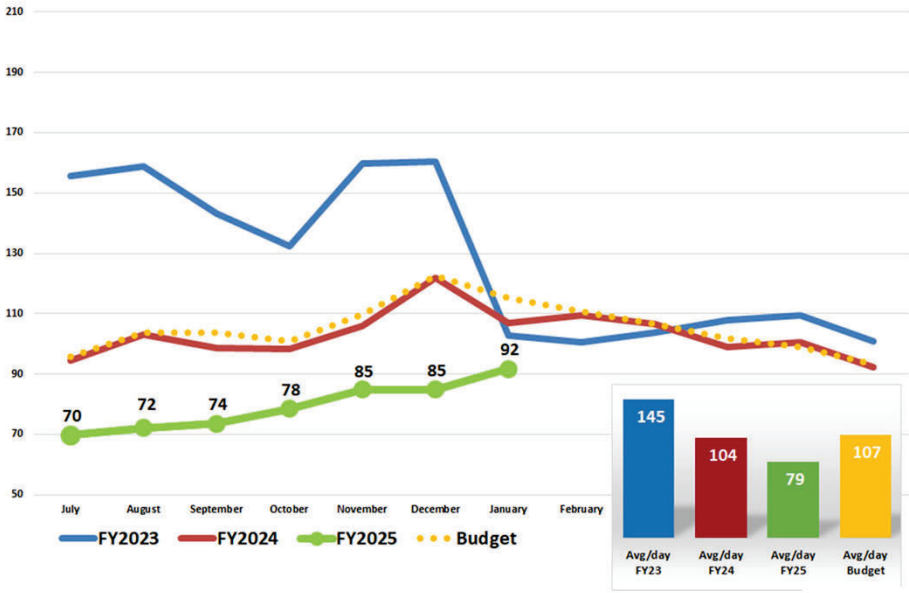


Deliveries

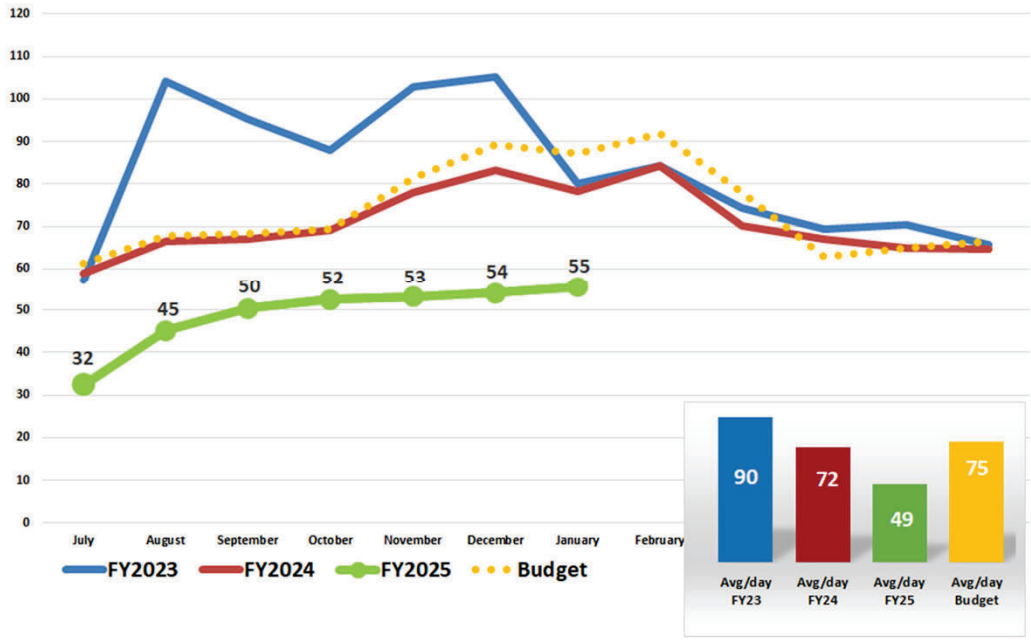

480
470
460
450
440
430
420
410
400
390
380
370
360
350
340
330
320
310
300
July
August
September
October
November
December
January
February
March
409
410
445
443
385
426
414
FY2023
FY2024
FY2025
Budget

2,784
2,806
2,932
2,820
YTD FY23
YTD FY24
YTD FY25
YTD Budget

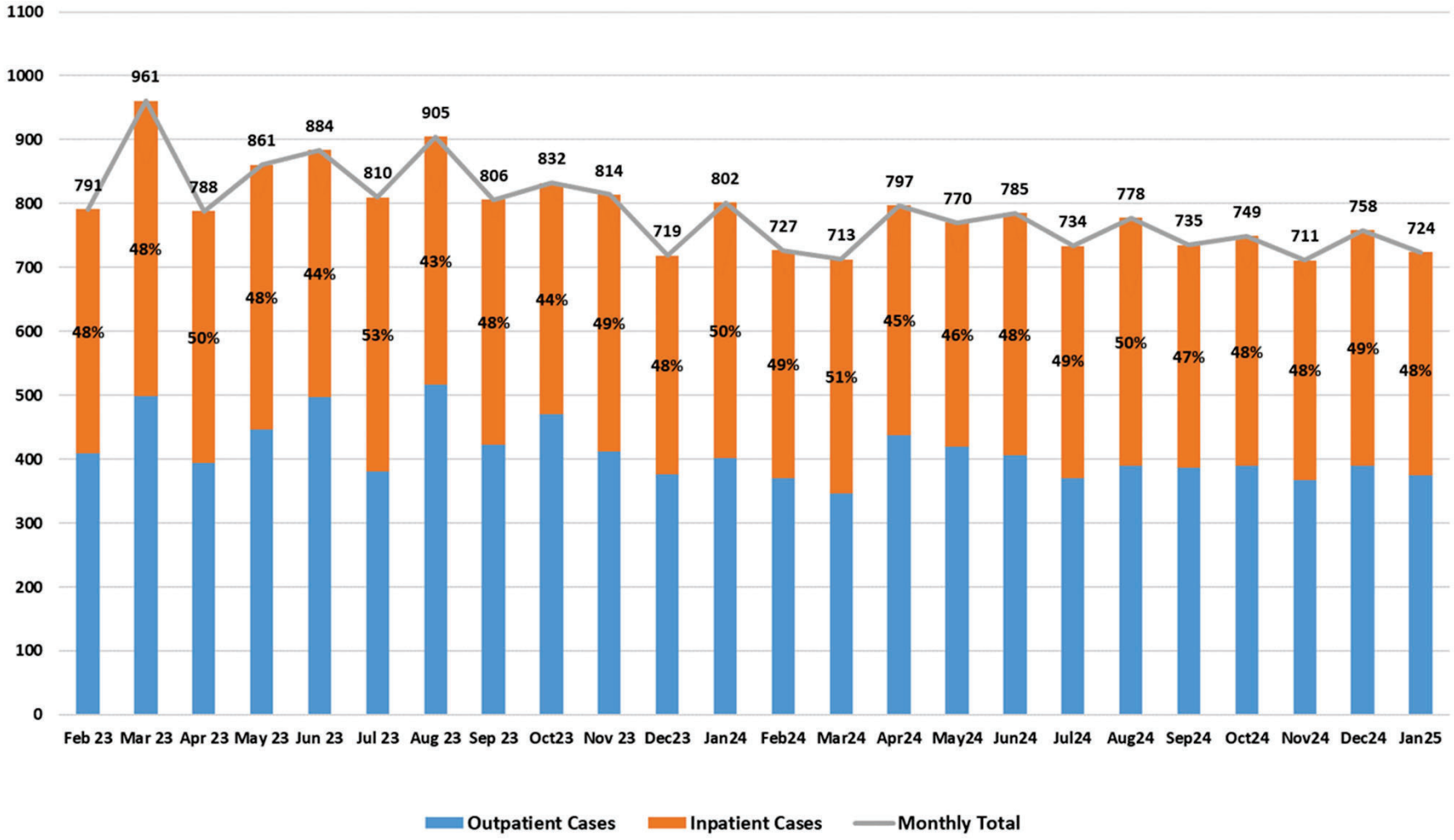
Urgent Care – Court Avg Visits Per Day



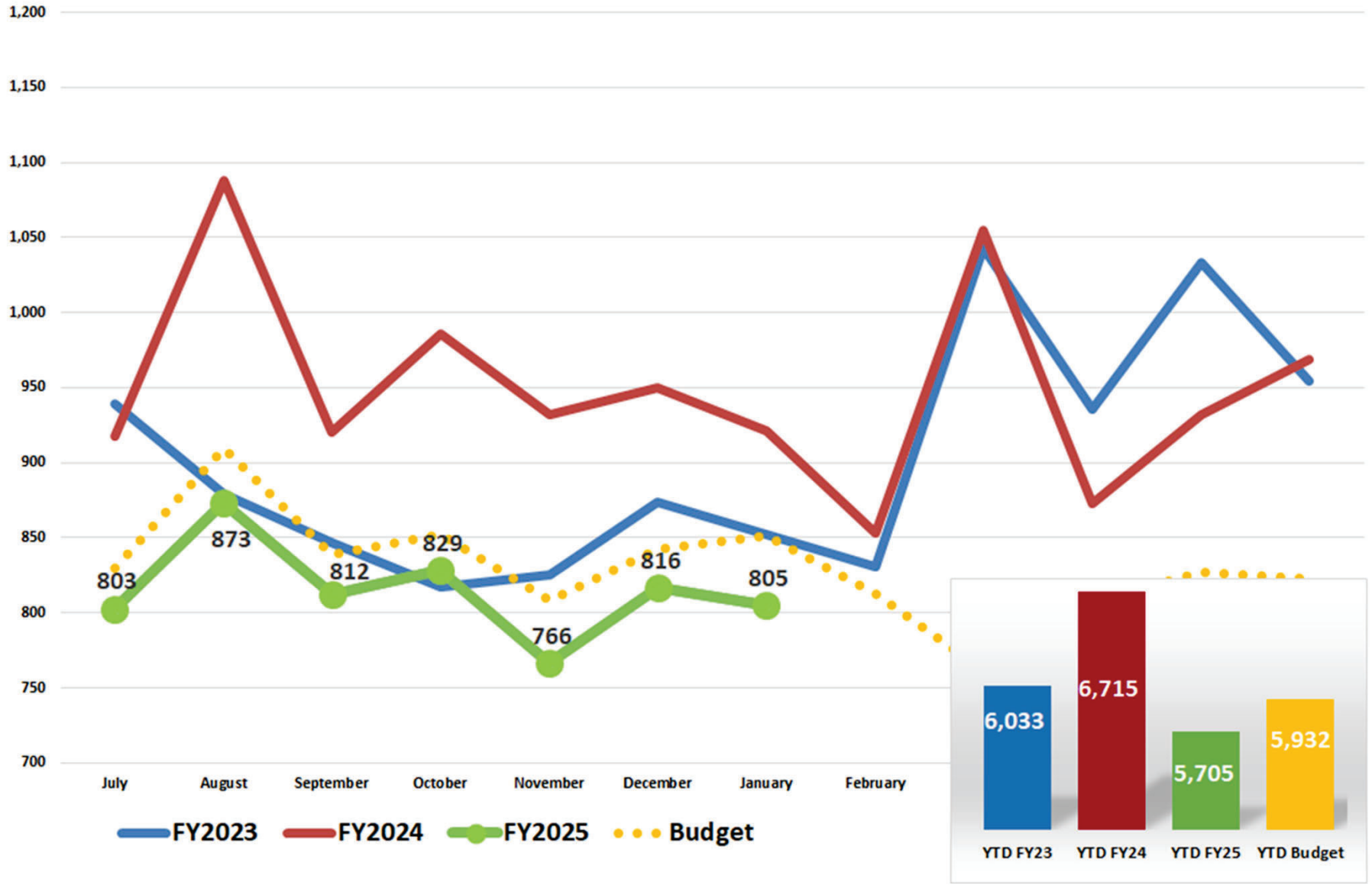
Urgent Care – Demaree Avg Visits Per Day



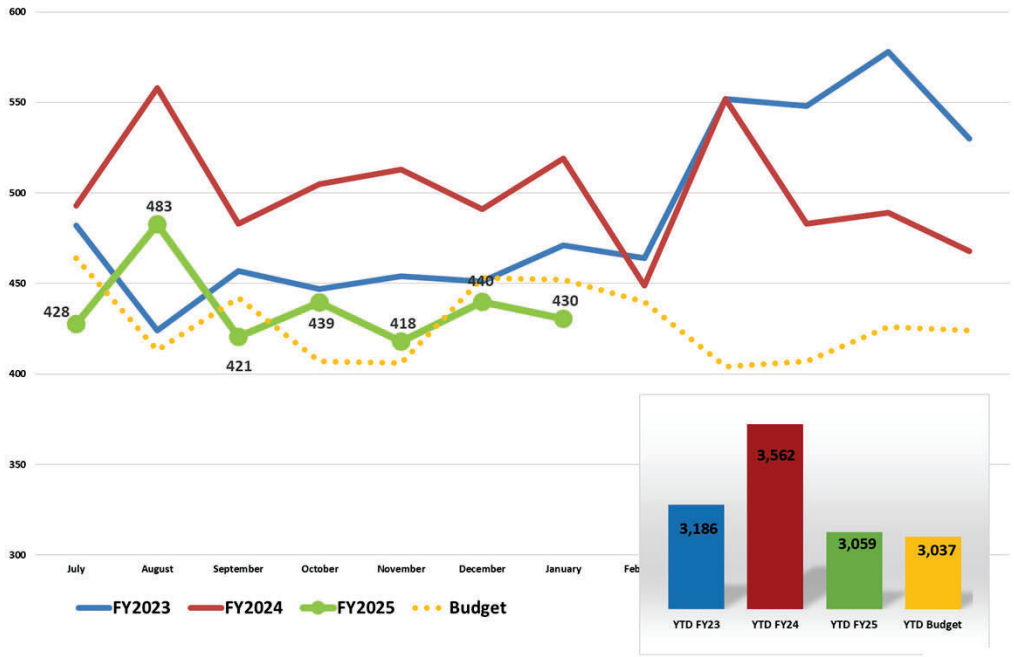
Surgery Cases (IP & OP)



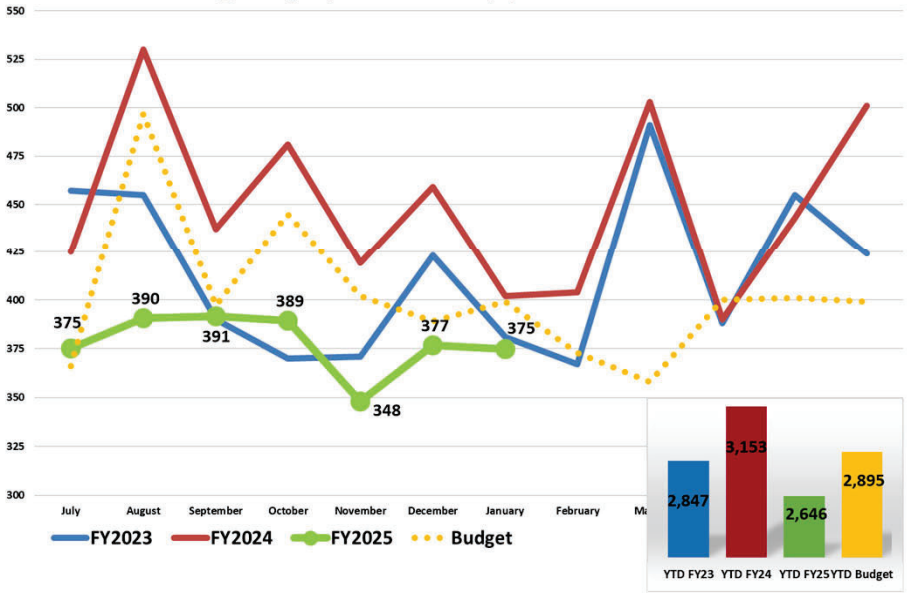
Surgery (IP & OP) – 100 Min Units



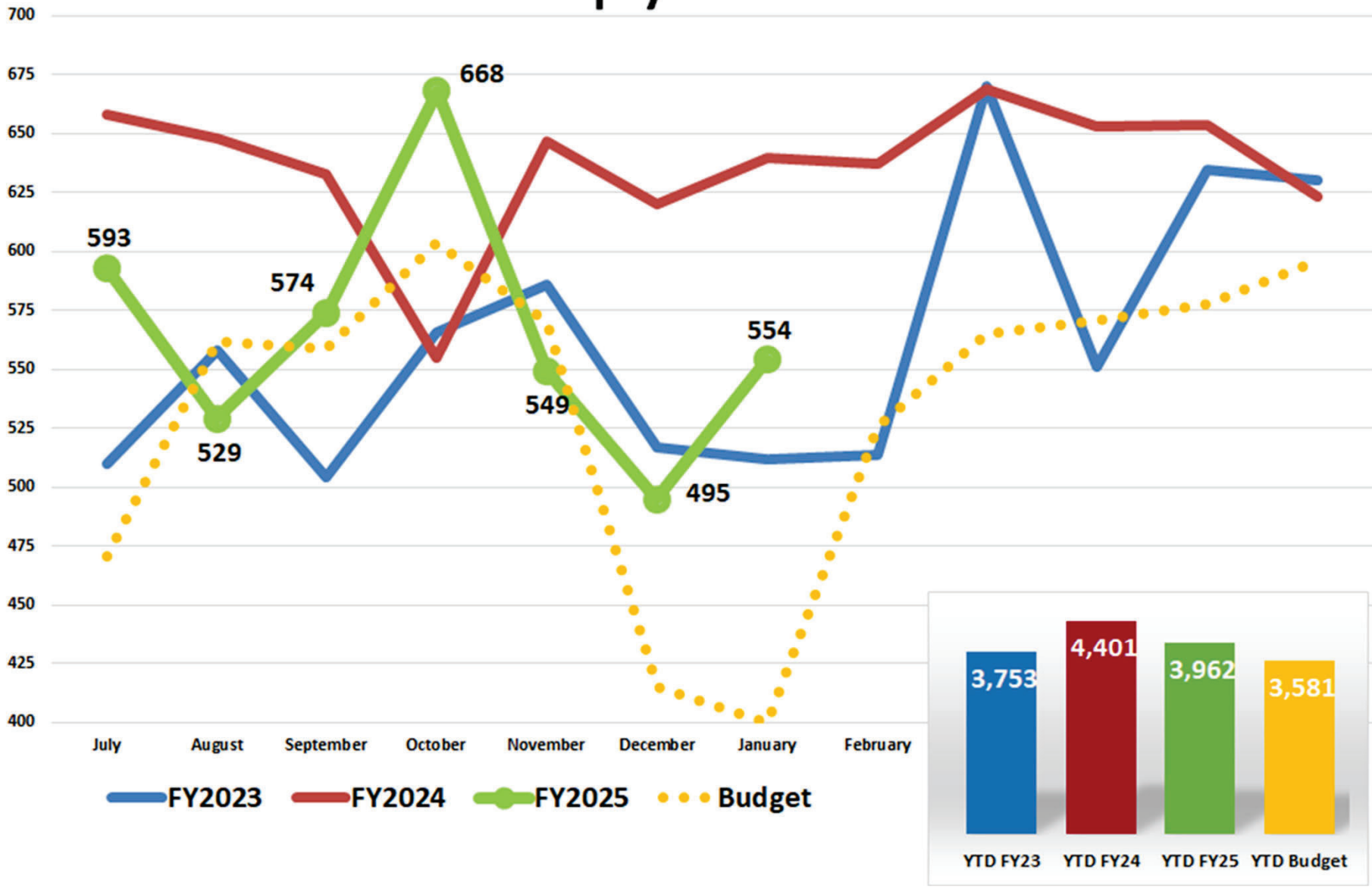
Surgery (IP Only) - 100 Min Unit



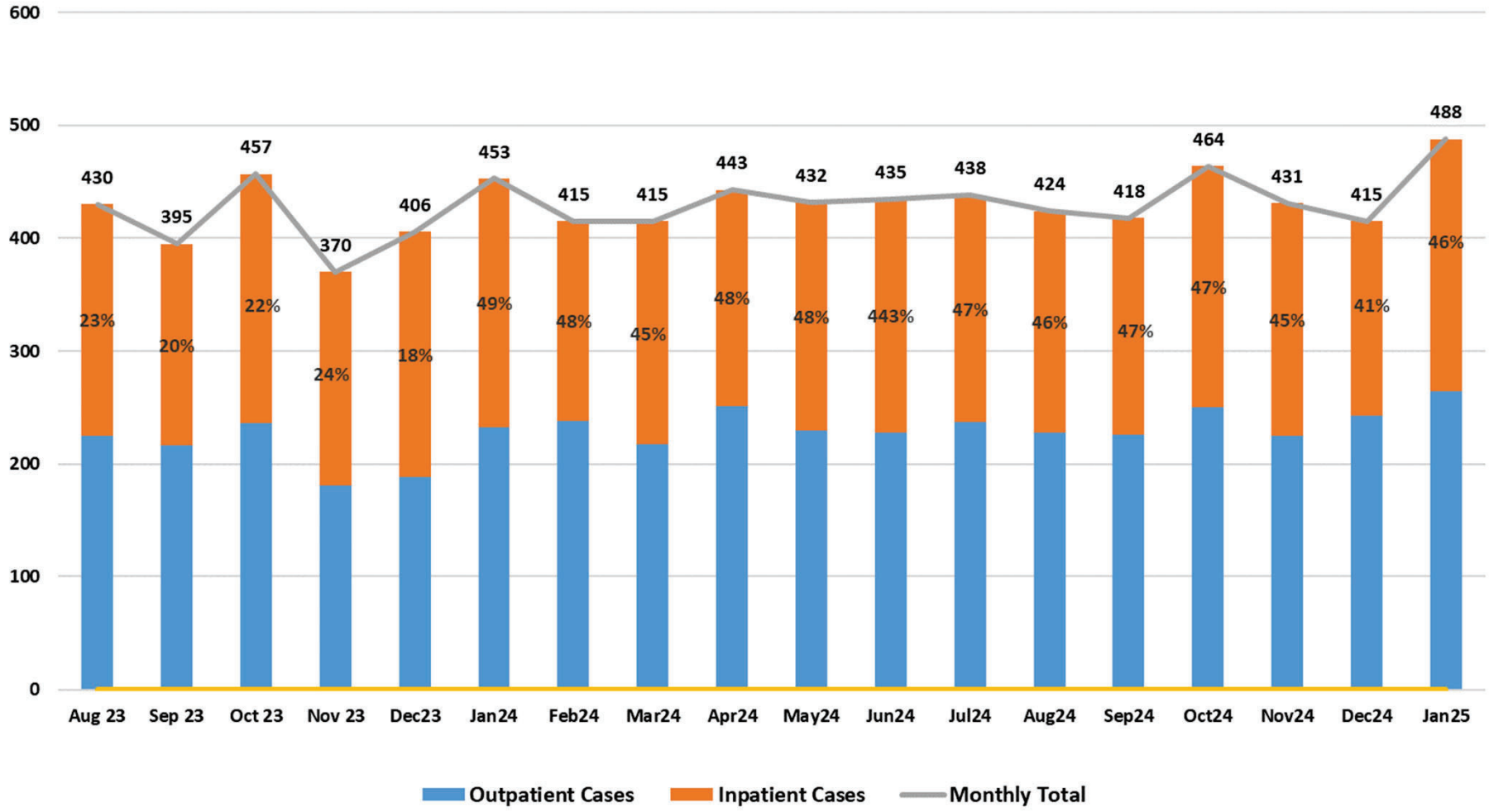
Surgery (OP Only) - 100 Min Units



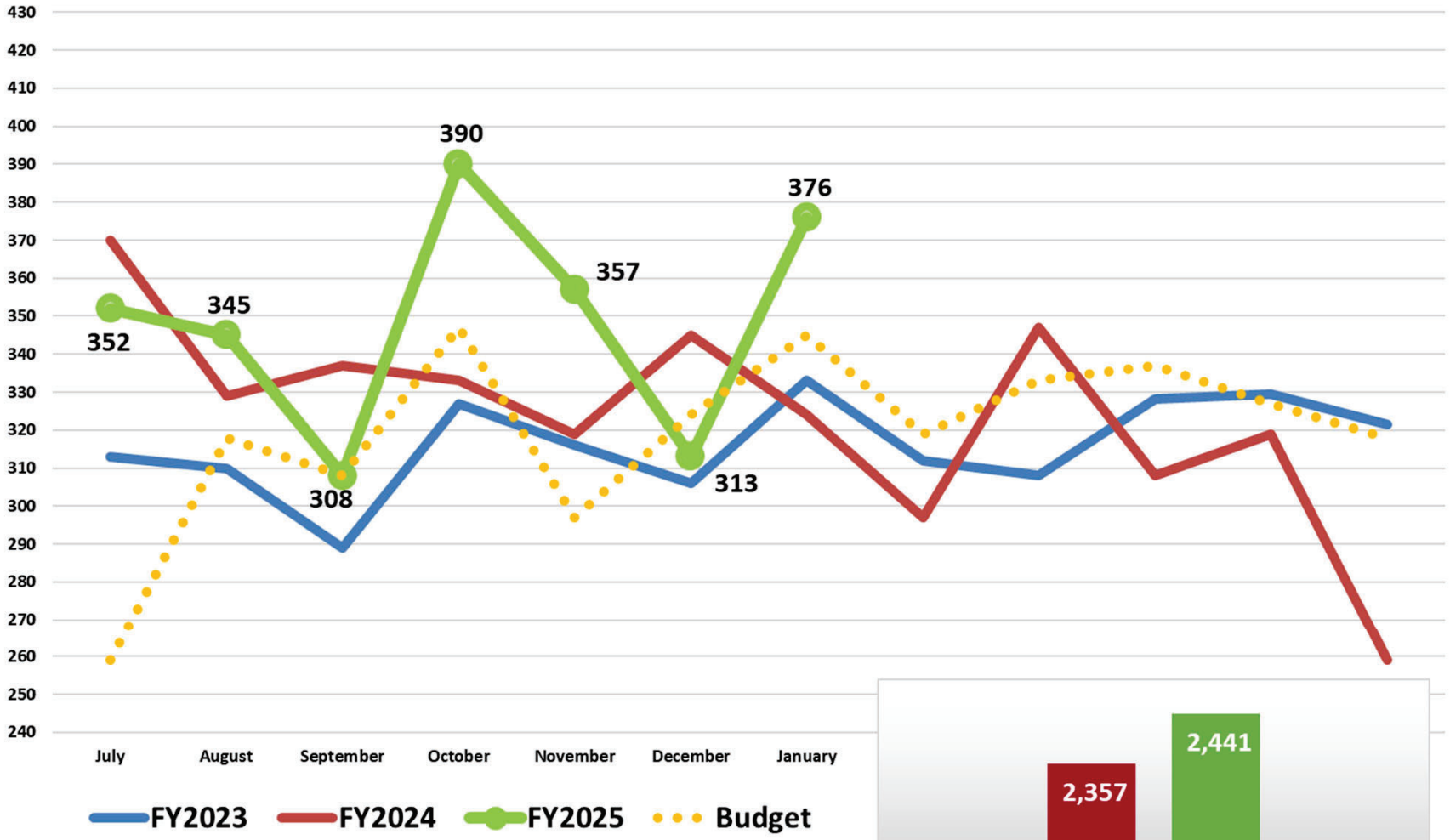
Endoscopy Procedures

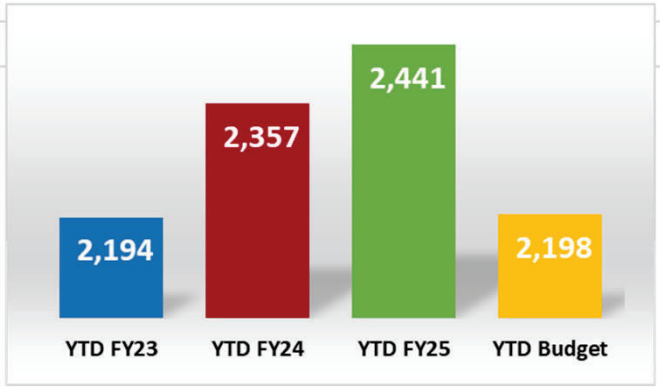


Cath Lab Patients (IP & OP)

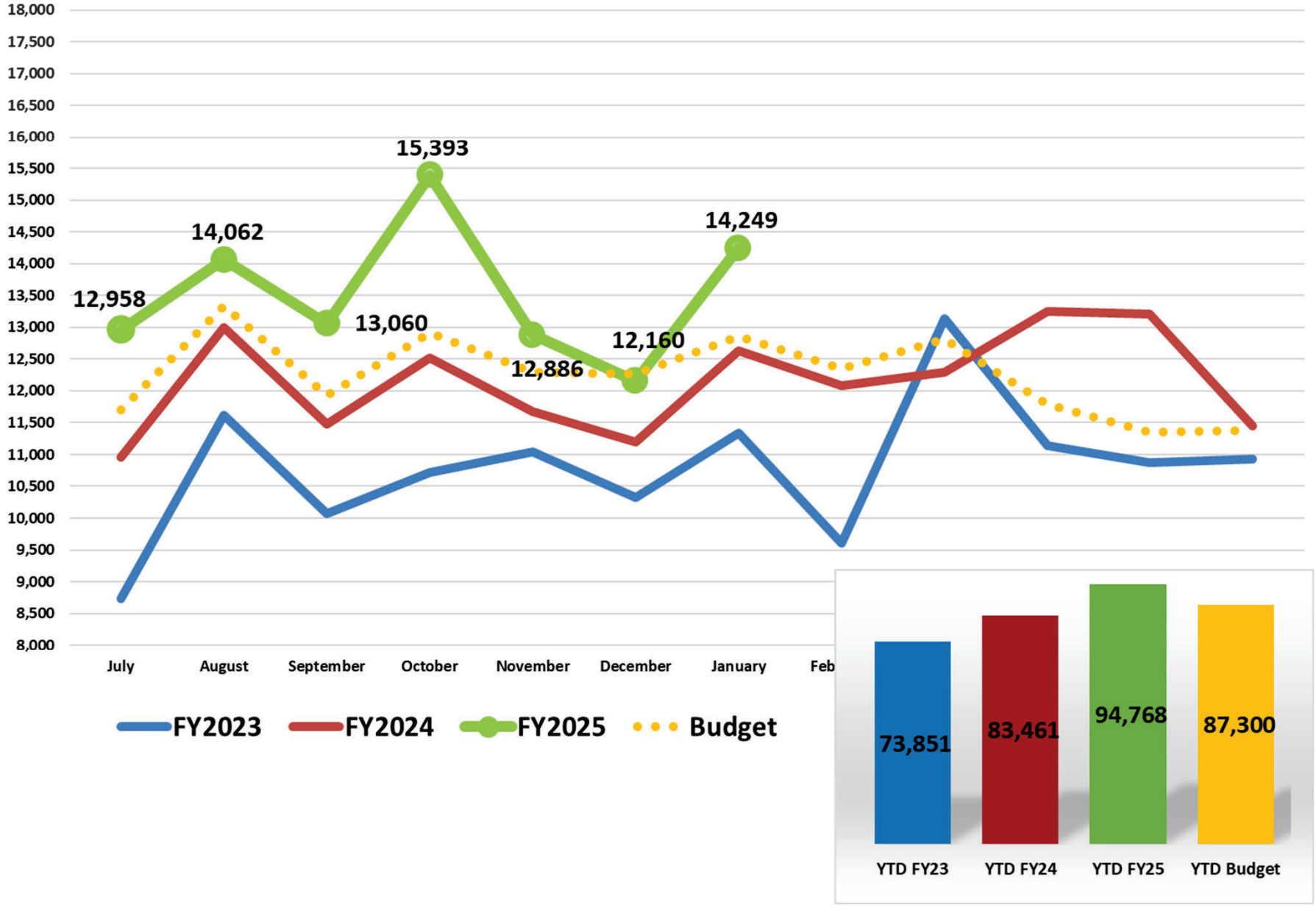


Cath Lab (IP & OP) – 100 Min Units

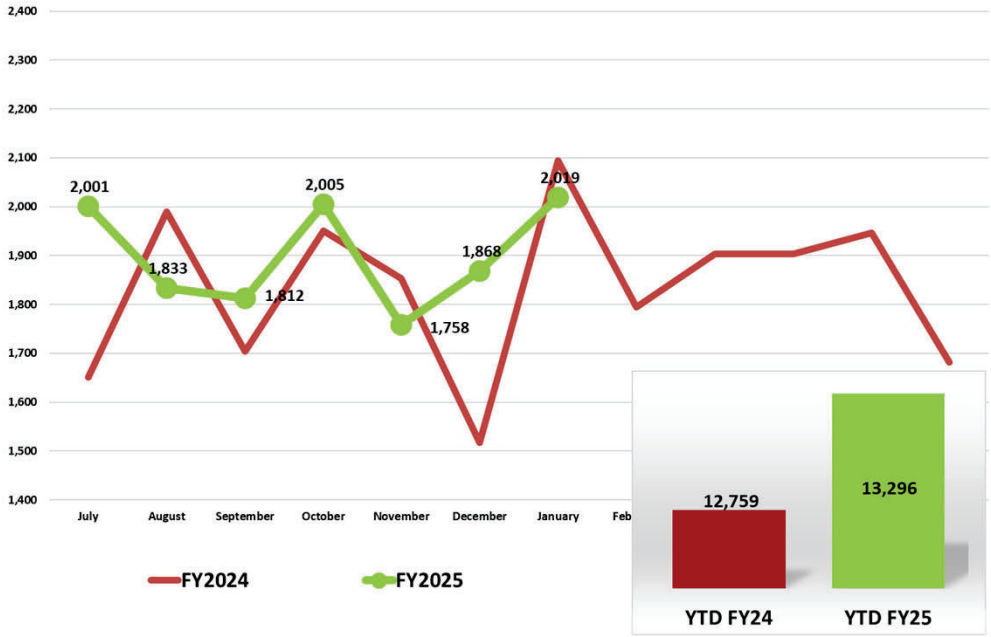




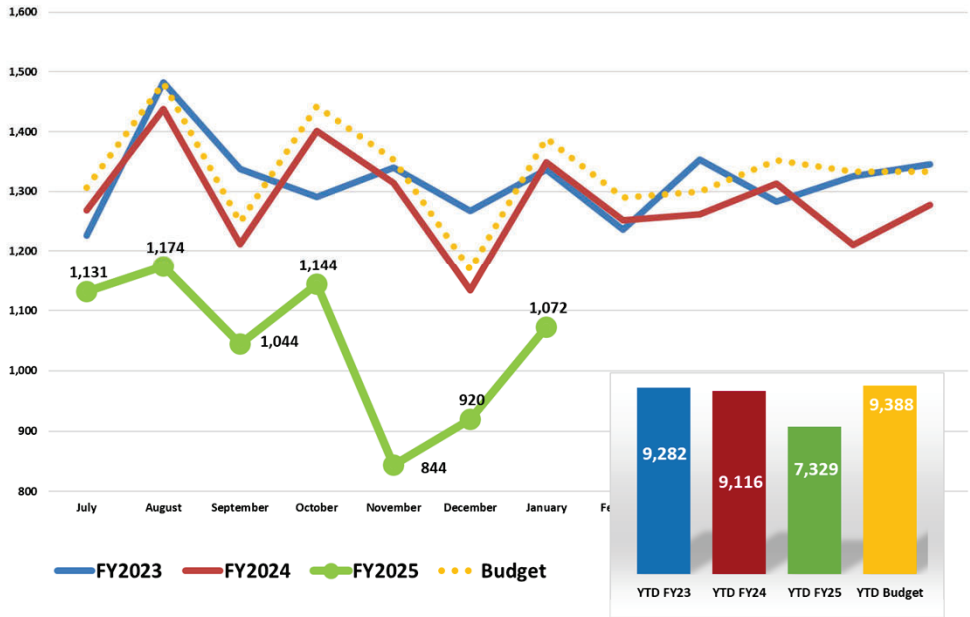
Rural Health Clinics Registrations



Medical Oncology Visits



Medical Oncology Treatments



Other Statistical Results – Fiscal Year Comparison (Jan)

	Actual Results				Budget	Budget Variance	
	Jan 24	Jan 25	Change	% Change	Jan 25	Change	% Change
Rural Health Clinics Registrations	12,611	14,233	1,622	12.9%	12,860	1,373	10.7%
RHC Exeter - Registrations	6,043	6,911	868	14.4%	6,506	405	6.2%
RHC Lindsay - Registrations	1,972	1,985	13	0.7%	2,153	(168)	(7.8%)
RHC Woodlake - Registrations	1,158	1,263	105	9.1%	550	713	129.6%
RHC Dinuba - Registrations	1,396	1,565	169	12.1%	1,551	14	0.9%
RHC Tulare - Registrations	2,042	2,509	467	22.9%	2,100	409	19.5%
Urgent Care – Court Total Visits	3,315	2,845	(470)	(14.2%)	3,569	(724)	(20.3%)
Urgent Care – Demaree Total Visits	2,428	1,719	(709)	(29.2%)	2,704	(985)	(36.4%)
KH Medical Clinic - Ben Maddox Visits	796	1,040	244	30.7%	1,350	(310)	(23.0%)
KH Medical Clinic - Plaza Visits	294	270	(24)	(8.2%)	629	(359)	(57.1%)
KH Medical Willow Clinic Visits	0	1,338	1,338	0.0%	666	672	101.0%
KH Cardiology Center Visalia Registrations	1,605	1,510	(95)	(5.9%)	1,588	(78)	(4.9%)
KH Mental Wellness Clinic Visits	277	293	16	5.8%	390	(97)	(24.9%)
Urology Clinic Visits	368	224	(144)	(39.1%)	570	(346)	(60.7%)
Wound Care Visits	952	1,129	177	18.6%	1,800	(671)	(37.3%)

Other Statistical Results – Fiscal Year Comparison (Jul-Jan)

	YTD Actual Results				Budget	Budget Variance	
	YTD Jan 24	YTD Jan 25	Change	% Change	YTD Jan 25	Change	% Change
Rural Health Clinics Registrations	83,324	94,631	11,307	13.6%	87,300	7,331	8.4%
RHC Exeter - Registrations	41,482	45,124	3,642	8.8%	43,743	1,381	3.2%
RHC Lindsay - Registrations	12,017	13,028	1,011	8.4%	12,595	433	3.4%
RHC Woodlake - Registrations	7,637	9,203	1,566	20.5%	7,527	1,676	22.3%
RHC Dinuba - Registrations	8,954	10,627	1,673	18.7%	9,836	791	8.0%
RHC Tulare - Registrations	13,234	16,649	3,415	25.8%	13,600	3,049	22.4%
Urgent Care – Court Total Visits	22,397	17,052	(5,345)	(23.9%)	23,088	(6,036)	(26.1%)
Urgent Care – Demaree Total Visits	15,389	10,523	(4,866)	(31.6%)	16,111	(5,588)	(34.7%)
KH Medical Clinic - Ben Maddox Visits	5,513	6,225	712	12.9%	8,100	(1,875)	(23.1%)
KH Medical Clinic - Plaza Visits	507	1,911	1,404	276.9%	4,073	(2,162)	(53.1%)
KH Medical Willow Clinic Visits	0	2,666	2,666	0.0%	3,588	(922)	(25.7%)
KH Cardiology Center Visalia Registrations	10,020	10,848	828	8.3%	10,607	241	2.3%
KH Mental Wellness Clinic Visits	1,869	2,065	196	10.5%	2,520	(455)	(18.1%)
Urology Clinic Visits	1,912	2,107	195	10.2%	3,799	(1,692)	(44.5%)
Wound Care Visits	7,103	5,994	(1,109)	(15.6%)	11,650	(5,656)	(48.6%)

Other Statistical Results – Fiscal Year Comparison (Jan)

	Actual Results				Budget	Budget Variance	
	Jan 24	Jan 25	Change	% Change	Jan 25	Change	% Change
All O/P Rehab Svcs Across District	19,945	20,760	815	4.1%	21,303	(543)	(2.6%)
Physical & Other Therapy Units (I/P & O/P)	18,590	18,971	381	2.0%	19,633	(662)	(3.4%)
Radiology - CT - All Areas	4,574	4,653	79	1.7%	4,559	94	2.1%
Radiology - MRI - All Areas	872	893	21	2.4%	864	29	3.4%
Radiology - Ultrasound - All Areas	2,696	3,077	381	14.1%	2,639	438	16.6%
Radiology - Diagnostic Radiology	10,498	10,116	(382)	(3.6%)	9,872	244	2.5%
Radiology – Main Campus	15,968	15,749	(219)	(1.4%)	15,337	412	2.7%
Radiology - Ultrasound - Main Campus	2,082	2,389	307	14.7%	2,025	364	18.0%
West Campus - Diagnostic Radiology	1,188	1,368	180	15.2%	1,134	234	20.6%
West Campus - CT Scan	468	507	39	8.3%	445	62	14.1%
West Campus - MRI	402	427	25	6.2%	404	23	5.7%
West Campus - Ultrasound	614	688	74	12.1%	614	74	12.1%
West Campus - Breast Center	1,738	1,535	(203)	(11.7%)	1,694	(159)	(9.4%)
Med Onc Visalia Treatments	1,349	1,072	(277)	(20.5%)	1,389	(317)	(22.8%)
Rad Onc Visalia Treatments	1,612	1,222	(390)	(24.2%)	1,982	(760)	(38.3%)
Rad Onc Hanford Treatments	268	176	(92)	(34.3%)	384	(208)	(54.2%)

Other Statistical Results – Fiscal Year Comparison (Jul-Jan)

	YTD Actual Results				Budget	Budget Variance	
	YTD Jan 24	YTD Jan 25	Change	% Change	YTD Jan 25	Change	% Change
All O/P Rehab Svcs Across District	137,538	143,901	6,363	4.6%	147,310	(3,409)	(2.3%)
Physical & Other Therapy Units (I/P & O/P)	119,938	129,426	9,488	7.9%	137,573	(8,147)	(5.9%)
Radiology - CT - All Areas	31,540	32,277	737	2.3%	31,743	534	1.7%
Radiology - MRI - All Areas	5,819	6,138	319	5.5%	6,045	93	1.5%
Radiology - Ultrasound - All Areas	18,247	21,186	2,939	16.1%	18,368	2,818	15.3%
Radiology - Diagnostic Radiology	67,004	67,247	243	0.4%	66,982	265	0.4%
Radiology – Main Campus	105,244	107,722	2,478	2.4%	105,353	2,369	2.2%
Radiology - Ultrasound - Main Campus	14,187	16,536	2,349	16.6%	14,249	2,287	16.0%
West Campus - Diagnostic Radiology	7,540	8,088	548	7.3%	7,575	513	6.8%
West Campus - CT Scan	3,224	3,393	169	5.2%	3,288	105	3.2%
West Campus - MRI	2,542	2,924	382	15.0%	2,804	120	4.3%
West Campus - Ultrasound	4,060	4,650	590	14.5%	4,119	531	12.9%
West Campus - Breast Center	11,898	11,764	(134)	(1.1%)	11,938	(174)	(1.5%)
Med Onc Visalia Treatments	9,116	7,329	(1,787)	(19.6%)	9,388	(2,059)	(21.9%)
Rad Onc Visalia Treatments	10,386	10,208	(178)	(1.7%)	13,582	(3,374)	(24.8%)
Rad Onc Hanford Treatments	1,733	1,696	(37)	(2.1%)	2,958	(1,262)	(42.7%)

Other Statistical Results – Fiscal Year Comparison (Jan)

	Actual Results				Budget	Budget Variance	
	Jan 24	Jan 25	Change	% Change	Jan 25	Change	% Change
ED - Avg Treated Per Day	259	270	11	4.2%	229	41	17.9%
Surgery (IP & OP) – 100 Min Units	921	805	(116)	(12.6%)	851	(46)	(5.4%)
Endoscopy Procedures	640	554	(86)	(13.4%)	400	154	38.5%
Cath Lab (IP & OP) - 100 Min Units	324	376	52	16.0%	345	31	9.0%
Cardiac Surgery Cases	28	37	9	32.1%	31	6	19.4%
Deliveries	400	414	14	3.5%	387	27	7.0%
Clinical Lab	260,135	271,849	11,714	4.5%	247,641	24,208	9.8%
Reference Lab	6,005	6,249	244	4.1%	5,544	705	12.7%
Dialysis Center - Visalia Visits	1,567	1,468	(99)	(6.3%)	1,757	(289)	(16.4%)
Infusion Center - Units of Service	425	385	(40)	(9.4%)	572	(187)	(32.7%)
Hospice Days	3,258	3,606	348	10.7%	3,824	(218)	(5.7%)
Home Health Visits	3,032	2,729	(303)	(10.0%)	3,215	(486)	(15.1%)
Home Infusion Days	20,760	20,159	(601)	(2.9%)	23,309	(3,150)	(13.5%)

Other Statistical Results – Fiscal Year Comparison (Jul-Jan)

	YTD Actual Results				Budget	Budget Variance	
	YTD Jan 24	YTD Jan 25	Change	% Change	YTD Jan 25	Change	% Change
ED - Avg Treated Per Day	260	258	(2)	(0.9%)	230	28	12.1%
Surgery (IP & OP) – 100 Min Units	6,715	5,705	(1,010)	(15.0%)	5,932	(227)	(3.8%)
Endoscopy Procedures	4,401	3,962	(439)	(10.0%)	3,581	381	10.6%
Cath Lab (IP & OP) - 100 Min Units	2,357	2,441	84	3.6%	2,198	243	11.1%
Cardiac Surgery Cases	200	192	(8)	(4.0%)	238	(46)	(19.3%)
Deliveries	2,806	2,932	126	4.5%	2,820	112	4.0%
Clinical Lab	1,660,112	1,735,963	75,851	4.6%	1,708,914	27,049	1.6%
Reference Lab	39,779	46,047	6,268	15.8%	39,913	6,134	15.4%
Dialysis Center - Visalia Visits	10,611	10,517	(94)	(0.9%)	12,299	(1,782)	(14.5%)
Infusion Center - Units of Service	2,719	3,016	297	10.9%	3,480	(464)	(13.3%)
Hospice Days	25,645	24,637	(1,008)	(3.9%)	26,540	(1,903)	(7.2%)
Home Health Visits	21,604	19,889	(1,715)	(7.9%)	22,474	(2,585)	(11.5%)
Home Infusion Days	158,192	153,464	(4,728)	(3.0%)	157,862	(4,398)	(2.8%)

January Financial Summary (000's)

	Comparison to Budget - Month of January			
	Budget Jan-2025	Actual Jan-2025	$ Change	% Change
Operating Revenue				
Net Patient Service Revenue	$55,057	$61,895	$6,838	11.0%
Other Operating Revenue	$20,486	$18,042	($2,443)	-13.5%
Total Operating Revenue	**$75,542**	**$79,938**	**$4,395**	**5.5%**
Operating Expenses				
Employment Expenses	$38,639	$39,859	$1,220	3.1%
Other Expenses	$36,304	$36,630	$326	0.9%
Total Operating Expenses	**$74,943**	**$76,489**	**$1,546**	**2.0%**
Operating Margin	**$599**	**$3,448**	**$2,849**	
Stimulus/FEMA	$0	$0	$0	
Operating Margin after Stimulus/FEMA	**$599**	**$3,448**	**$2,849**	
Nonoperating Revenue (Loss)	$658	$845	$188	
Excess Margin	**$1,257**	**$4,293**	**$3,037**	

Year to Date Financial Summary (000's)

	Comparison to Budget - YTD January			
	Budget YTD Jan-2025	Actual YTD Jan-2025	$ Change	% Change
Operating Revenue				
Net Patient Service Revenue	$372,451	$381,538	$9,088	2.4%
Other Operating Revenue	$141,616	$136,582	($5,034)	-3.7%
Total Operating Revenue	**$514,066**	**$518,120**	**$4,054**	**0.8%**
Operating Expenses				
Employment Expenses	$269,945	$280,616	$10,671	3.8%
Other Expenses	$261,945	$253,861	($8,084)	-3.2%
Total Operating Expenses	**$531,890**	**$534,477**	**$2,586**	**0.5%**
Operating Margin	**($17,824)**	**($16,357)**	**$1,468**	
Stimulus/FEMA	$0	$47,722	$47,722	
Operating Margin after Stimulus/FEMA	**($17,824)**	**$31,365**	**$49,190**	
Nonoperating Revenue (Loss)	$4,610	$9,826	$5,216	
Excess Margin	**($13,214)**	**$41,191**	**$54,406**	

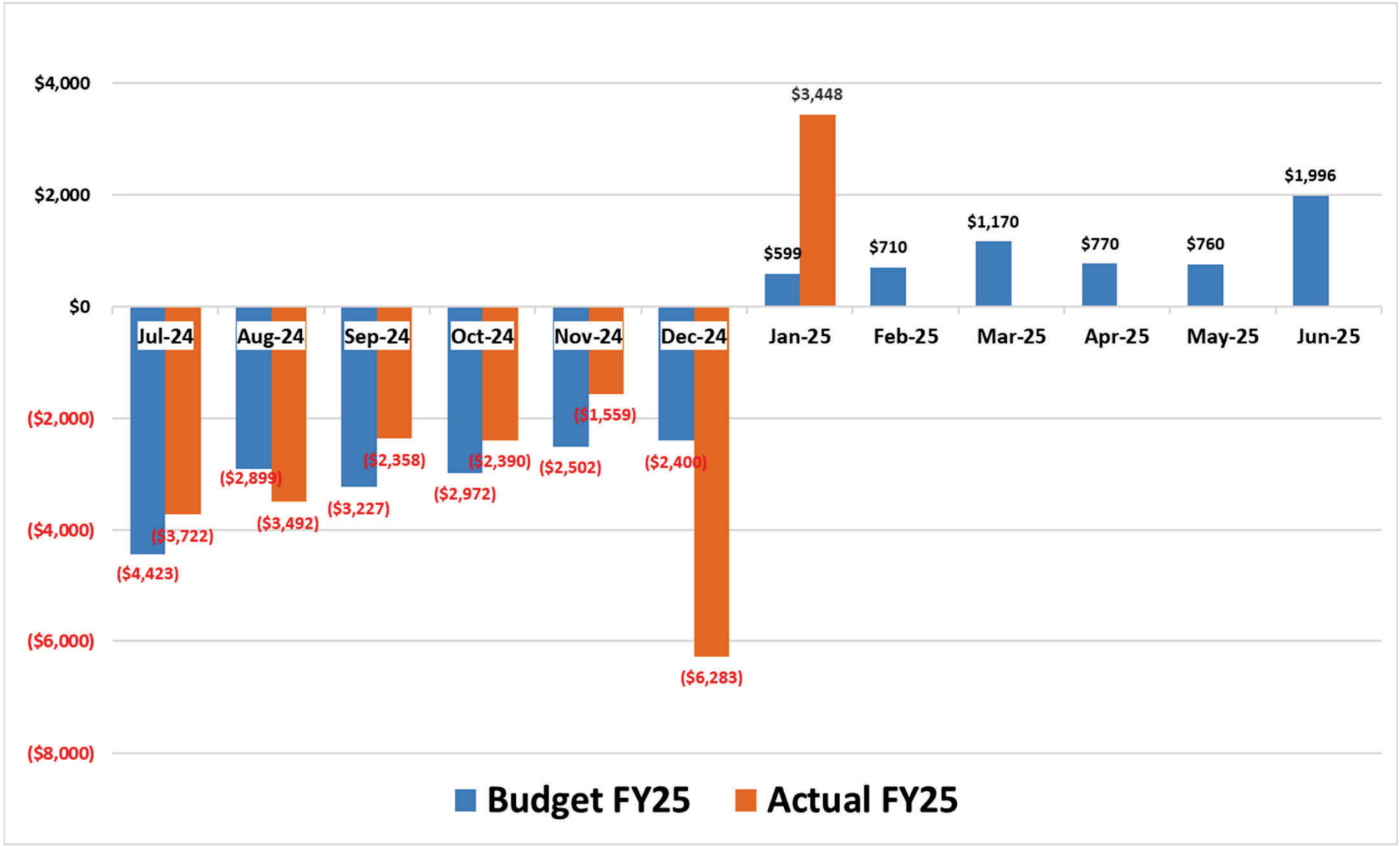
January Financial Comparison (000's)

	Comparison to Budget - Month of January				Comparison to Prior Year - Month of January			
	Budget Jan-2025	Actual Jan-2025	$ Change	% Change	Actual Jan-2024	Actual Jan-2025	$ Change	% Change
Operating Revenue								
Net Patient Service Revenue	**$55,057**	**$61,895**	**$6,838**	**11.0%**	**$49,472**	**$61,895**	**$12,423**	**20.1%**
Supplemental Gov't Programs	$7,744	$2,717	($5,027)	-185.0%	$8,780	$2,717	($6,062)	-223.1%
Prime Program	$792	$5,551	$4,759	85.7%	$2,459	$5,551	$3,092	55.7%
Premium Revenue	$7,547	$5,500	($2,047)	-37.2%	$6,754	$5,500	($1,254)	-22.8%
Management Services Revenue	$0	$0	$0	0.0%	$3,756	$0	($3,756)	0.0%
Other Revenue	$4,403	$4,274	($129)	-3.0%	$2,630	$4,274	$1,644	38.5%
Other Operating Revenue	$20,486	$18,042	($2,443)	-13.5%	$24,379	$18,042	($6,336)	-35.1%
Total Operating Revenue	**$75,542**	**$79,938**	**$4,395**	**5.5%**	**$73,851**	**$79,938**	**$6,086**	**7.6%**
Operating Expenses								
Salaries & Wages	$32,308	$32,478	$171	0.5%	$29,705	$32,478	$2,773	8.5%
Contract Labor	$1,202	$2,487	$1,286	51.7%	$1,780	$2,487	$707	28.4%
Employee Benefits	$5,130	$4,894	($236)	-4.8%	$6,160	$4,894	($1,266)	-25.9%
Total Employment Expenses	**$38,639**	**$39,859**	**$1,220**	**3.1%**	**$37,645**	**$39,859**	**$2,214**	**5.6%**
Medical & Other Supplies	$14,197	$14,325	$128	0.9%	$14,980	$14,325	($655)	-4.6%
Physician Fees	$7,253	$6,499	($754)	-11.6%	$7,558	$6,499	($1,059)	-16.3%
Purchased Services	$1,819	$1,789	($30)	-1.7%	$1,709	$1,789	$80	4.5%
Repairs & Maintenance	$2,081	$2,203	$122	5.5%	$2,964	$2,203	($762)	-34.6%
Utilities	$833	$1,099	$266	24.2%	$831	$1,099	$268	24.4%
Rents & Leases	$154	$163	$9	5.7%	$140	$163	$23	14.1%
Depreciation & Amortization	$3,302	$3,113	($189)	-6.1%	$2,890	$3,113	$223	7.2%
Interest Expense	$608	$646	$38	5.8%	$603	$646	$43	6.6%
Other Expense	$2,291	$2,037	($254)	-12.5%	$1,315	$2,037	$722	35.4%
Humana Cap Plan Expenses	$3,766	$4,756	$989	20.8%	$2,751	$4,756	$2,005	42.2%
Total Other Expenses	**$36,304**	**$36,630**	**$326**	**0.9%**	**$35,742**	**$36,630**	**$888**	**2.4%**
Total Operating Expenses	**$74,943**	**$76,489**	**$1,546**	**2.0%**	**$73,388**	**$76,489**	**$3,102**	**4.1%**
Operating Margin	**$599**	**$3,448**	**$2,849**		**$464**	**$3,448**	**$2,985**	
Stimulus/FEMA	**$0**	**$0**	**$0**		**$0**	**$0**	**$0**	
Operating Margin after Stimulus/FEMA	**$599**	**$3,448**	**$2,849**		**$464**	**$3,448**	**$2,985**	
Nonoperating Revenue (Loss)	$658	$845	$188		$969	$845	($124)	
Excess Margin	**$1,257**	**$4,293**	**$3,037**		**$1,432**	**$4,293**	**$2,861**	

Year to Date: July through January Financial Comparison (000's)

	Comparison to Budget - YTD January				Comparison to Prior Year - YTD January			
	Budget YTD Jan-2025	Actual YTD Jan-2025	$ Change	% Change	Actual YTD Jan-2024	Actual YTD Jan-2025	$ Change	% Change
Operating Revenue								
Net Patient Service Revenue	**$372,451**	**$381,538**	**$9,088**	**2.4%**	**$336,033**	**$381,538**	**$45,505**	**11.9%**
Supplemental Gov't Programs	$52,386	$48,572	($3,814)	-7.9%	$47,897	$48,572	$675	1.4%
Prime Program	$5,543	$10,302	$4,759	46.2%	$7,389	$10,302	$2,913	28.3%
Premium Revenue	$52,830	$49,021	($3,809)	-7.8%	$51,968	$49,021	($2,947)	-6.0%
Management Services Revenue	$0	$0	$0	0.0%	$23,113	$0	($23,113)	0.0%
Other Revenue	$30,856	$28,687	($2,170)	-7.6%	$22,837	$28,687	$5,849	20.4%
Other Operating Revenue	$141,616	$136,582	($5,034)	-3.7%	$153,205	$136,582	($16,623)	-12.2%
Total Operating Revenue	**$514,066**	**$518,120**	**$4,054**	**0.8%**	**$489,238**	**$518,120**	**$28,882**	**5.6%**
Operating Expenses								
Salaries & Wages	$221,384	$224,051	$2,667	1.2%	$199,631	$224,051	$24,419	10.9%
Contract Labor	$9,365	$11,198	$1,833	16.4%	$13,280	$11,198	($2,082)	-18.6%
Employee Benefits	$39,197	$45,367	$6,170	13.6%	$46,934	$45,367	($1,567)	-3.5%
Total Employment Expenses	**$269,945**	**$280,616**	**$10,671**	**3.8%**	**$259,846**	**$280,616**	**$20,770**	**7.4%**
Medical & Other Supplies	$107,326	$97,748	($9,578)	-9.8%	$92,407	$97,748	$5,341	5.5%
Physician Fees	$50,362	$50,376	$14	0.0%	$46,438	$50,376	$3,938	7.8%
Purchased Services	$12,602	$11,743	($858)	-7.3%	$11,213	$11,743	$530	4.5%
Repairs & Maintenance	$14,549	$14,913	$364	2.4%	$16,278	$14,913	($1,365)	-9.2%
Utilities	$6,752	$6,761	$9	0.1%	$6,294	$6,761	$467	6.9%
Rents & Leases	$1,076	$971	($105)	-10.8%	$1,061	$971	($90)	-9.3%
Depreciation & Amortization	$23,112	$22,214	($899)	-4.0%	$19,760	$22,214	$2,454	11.0%
Interest Expense	$4,219	$4,187	($32)	-0.8%	$4,209	$4,187	($21)	-0.5%
Other Expense	$15,826	$14,397	($1,429)	-9.9%	$13,301	$14,397	$1,096	7.6%
Humana Cap Plan Expenses	$26,121	$30,550	$4,429	14.5%	$24,108	$30,550	$6,443	21.1%
Total Other Expenses	**$261,945**	**$253,861**	**($8,084)**	**-3.2%**	**$235,068**	**$253,861**	**$18,793**	**7.4%**
Total Operating Expenses	**$531,890**	**$534,477**	**$2,586**	**0.5%**	**$494,914**	**$534,477**	**$39,563**	**7.4%**
Operating Margin	**($17,824)**	**($16,357)**	**$1,468**		**($5,675)**	**($16,357)**	**($10,681)**	
Stimulus/FEMA	**$0**	**$47,722**	**$47,722**		**$3,220**	**$47,722**	**$44,502**	
Operating Margin after Stimulus/FEMA	**($17,824)**	**$31,365**	**$49,190**		**($2,455)**	**$31,365**	**$33,821**	
Nonoperating Revenue (Loss)	$4,610	$9,826	$5,216		$9,115	$9,826	$711	
Excess Margin	**($13,214)**	**$41,191**	**$54,406**		**$6,659**	**$41,191**	**$34,532**	

Budget and Actual Fiscal Year 2025: Trended Operating Margin (000's)



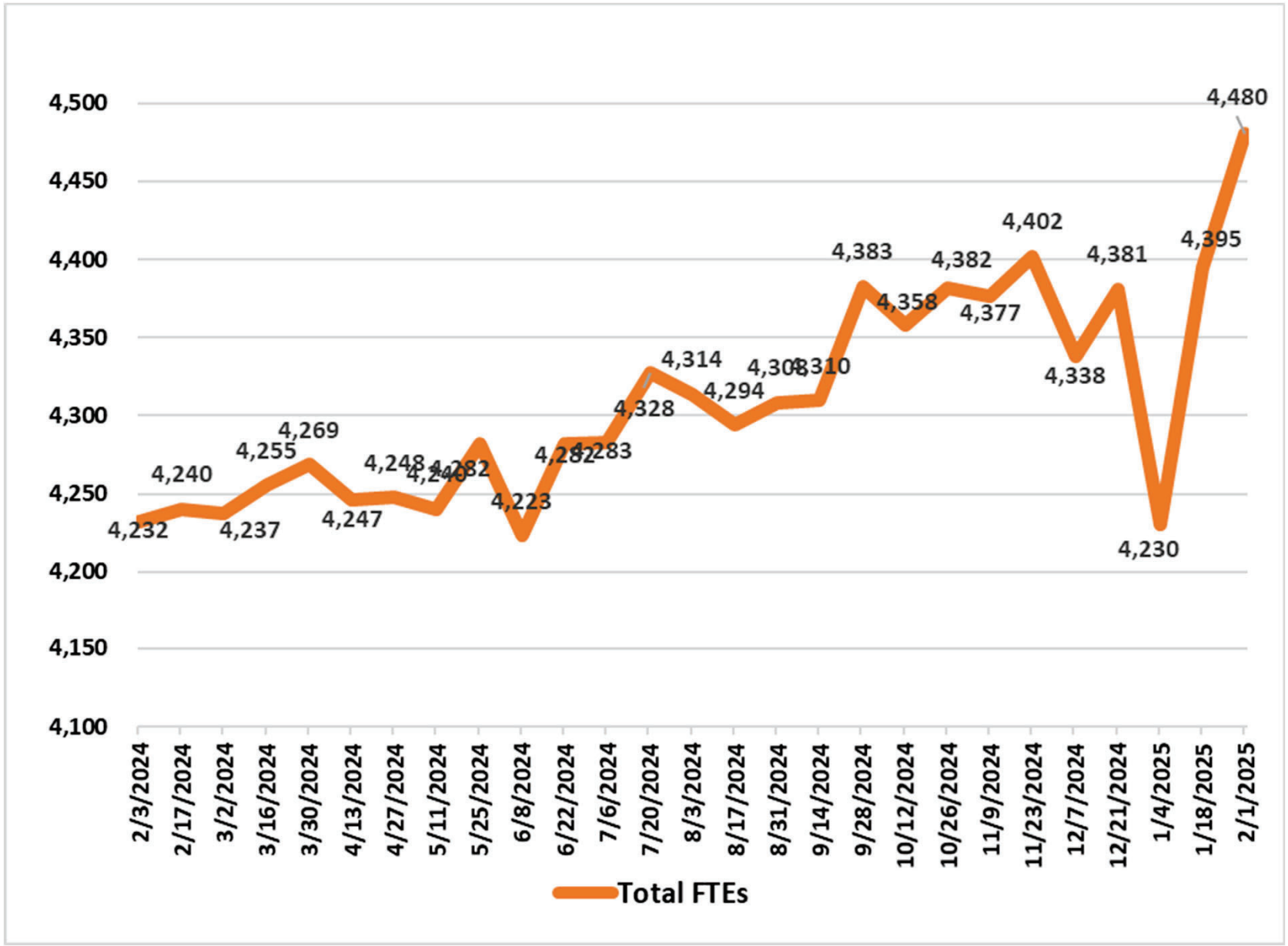
July 2024 – January 2025 : Trended Financial Information (000's)

	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	FY 2025
Patient Service Revenue	$50,866	$53,450	$51,648	$56,157	$54,496	$53,026	$61,895	$381,538
Other Revenue	$19,487	$20,024	$19,142	$20,242	$19,868	$19,778	$18,042	$136,582
Total Operating Revenue	$70,353	$73,474	$70,790	$76,398	$74,364	$72,804	$79,938	$518,120
Employee Expense	$38,264	$39,058	$37,671	$41,494	$41,051	$43,219	$39,859	$280,616
Other Operating Expense	$35,811	$37,908	$35,477	$37,294	$34,872	$35,868	$36,630	$253,861
Total Operating Expenses	$74,075	$76,965	$73,148	$78,788	$75,923	$79,087	$76,489	$534,477
Net Operating Margin	($3,722)	($3,492)	($2,358)	($2,390)	($1,559)	($6,283)	$3,448	($16,357)
Stimulus/FEMA	$0	$0	$0	$0	$0	$47,722	$0	$47,722
NonOperating Income	$1,190	$896	$4,720	$1,371	$905	($101)	$845	$9,826
Excess Margin	($2,533)	($2,596)	$2,362	($1,019)	($654)	$41,338	$4,293	$41,191
Profitability								
Operating Margin %	(5.3%)	(4.8%)	(3.3%)	(3.1%)	(2.1%)	(8.6%)	4.3%	(3.2%)
Operating Margin %excl. Int	(4.4%)	(4.0%)	(2.5%)	(2.4%)	(1.3%)	(7.8%)	5.1%	(2.3%)
Operating EBIDA	$46	$239	$1,457	$1,348	$2,293	($2,546)	$7,207	$10,045
Operating EBIDA Margin	0.1%	0.3%	2.1%	1.8%	3.1%	(3.5%)	9.0%	1.9%
Liquidity Indicators								
Day's Cash on Hand	97.4	89.8	91.9	88.4	78.9	74.6	78.3	78.3
Day's in Accounts Receiveable	64.0	68.5	71.0	68.3	66.9	65.8	72.5	72.5
Unrestricted Funds (000's)	$219,800	$209,641	$214,303	$207,507	$187,057	$177,933	$191,281	$191,281
Debt & Other Indicators								
Debt Service Coverage (MADS	0.70	0.50	1.40	1.80	1.50	3.20	3.70	3.70
Discharges (Monthly)	2,498	2,447	2,440	2,388	2,240	2,339	2,490	2,406
Adj Discharges (Case mix adj)	8,455	8,215	7,779	8,441	7,760	7,724	8,790	57,163
Adjusted patient Days (Mo.)	26,023	26,419	26,419	26,693	25,492	26,538	27,797	27,797
Cost/Adj Discharge	$8.8	$9.4	$9.4	$9.3	$9.8	$10.2	$8.7	$9.4
Compensation Ratio	75%	73%	73%	74%	75%	82%	64%	74%

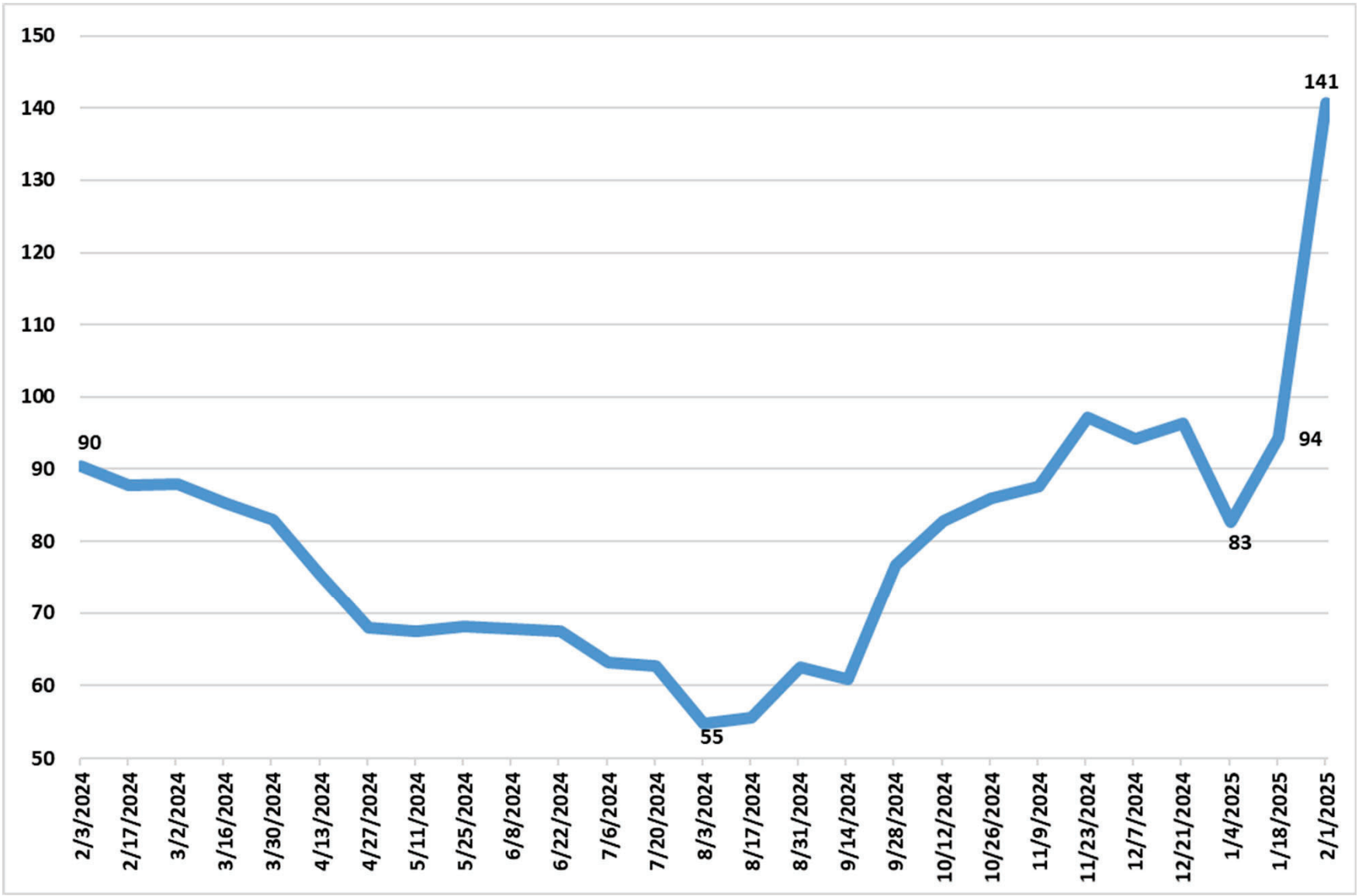
Month of January - Budget Variances

- **Net Patient Service Revenue:** The $6.8M favorable variance in January resulted from the mix and acuity of our patients.
- **Supplemental Gov't Programs:** The unfavorable variance of $4.0M is due to recording an additional reserve related to our Medi-Cal DSH funding**.**
- **Prime Program Revenue:** The Prime revenue was positively impacted by recording $4.8M of additional unexpected QIP revenue related to FY23.
- **Premium Revenue:** Due to a decrease in enrollment in our Medicare managed care plan in January, we experienced a $2.0M unfavorable variance.
- **Contract Labor**: The unfavorable variance of $1.3M is due to an unexpected increase in the need of contract labor primarily in ICCU and the ED.
- **Humana Cap Expenses:** The unfavorable variance of $989K is due to higher than anticipated third party expenses.

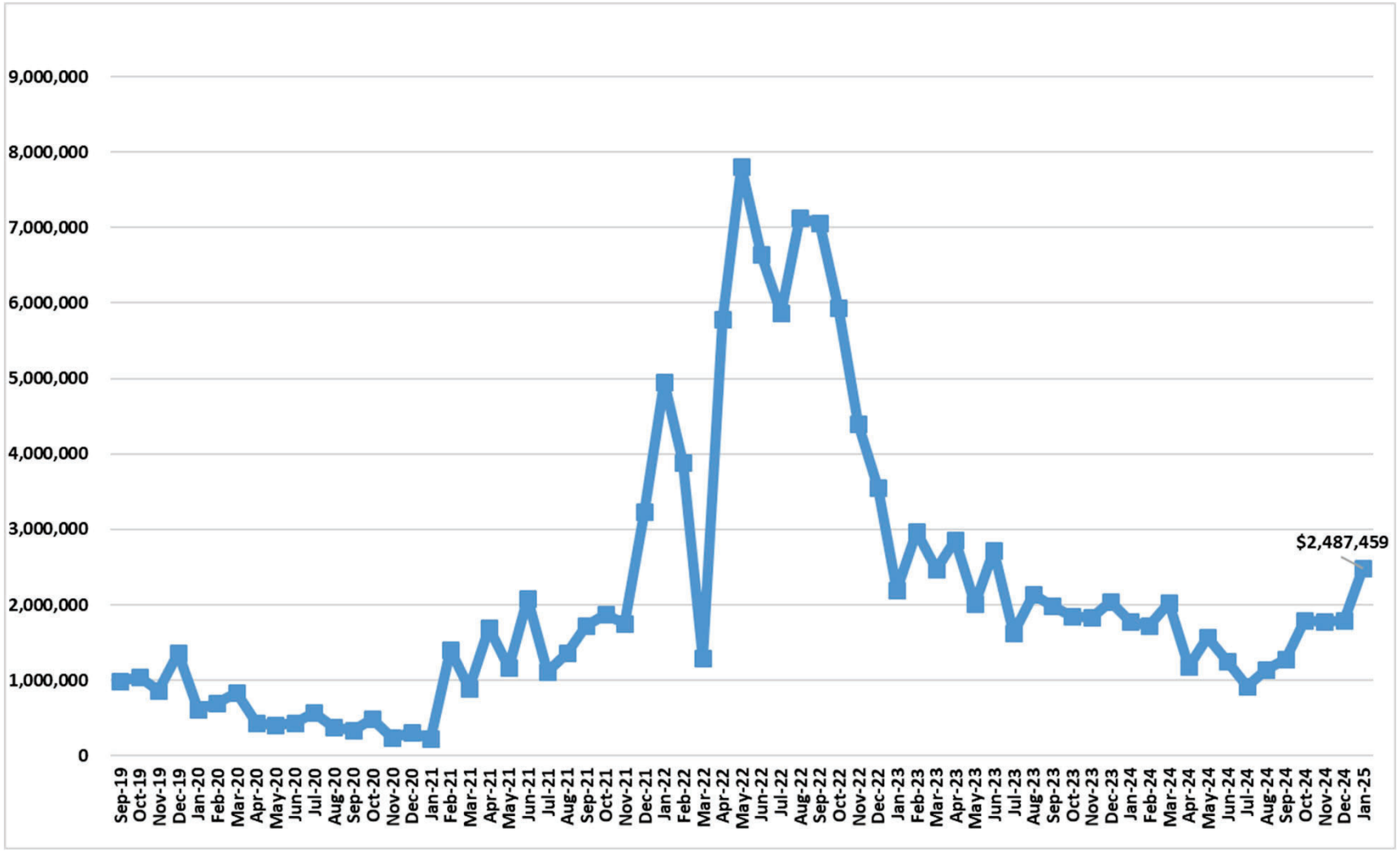
Total FTEs (includes Contract Labor)



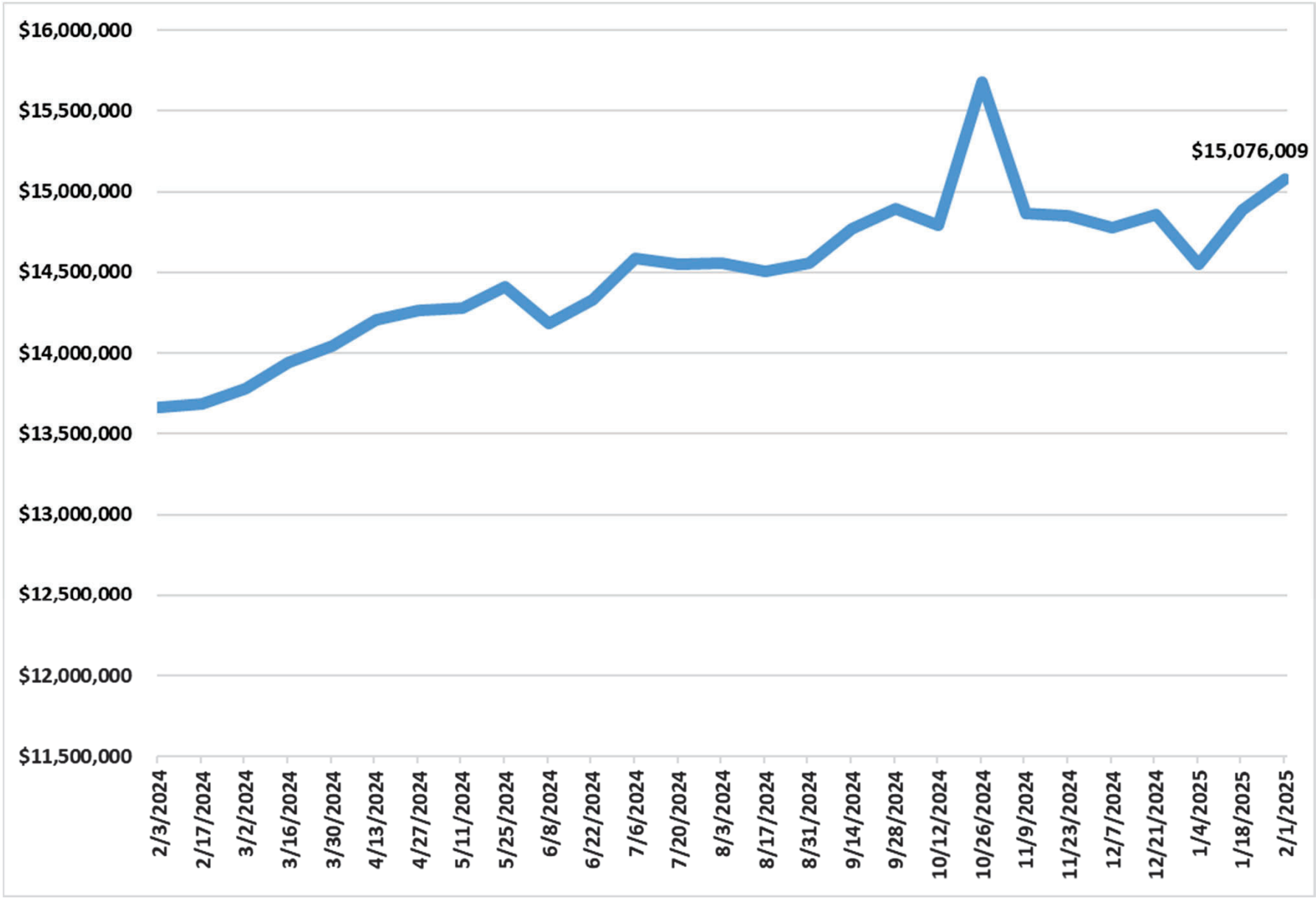
Contract Labor Full Time Equivalents (FTEs)



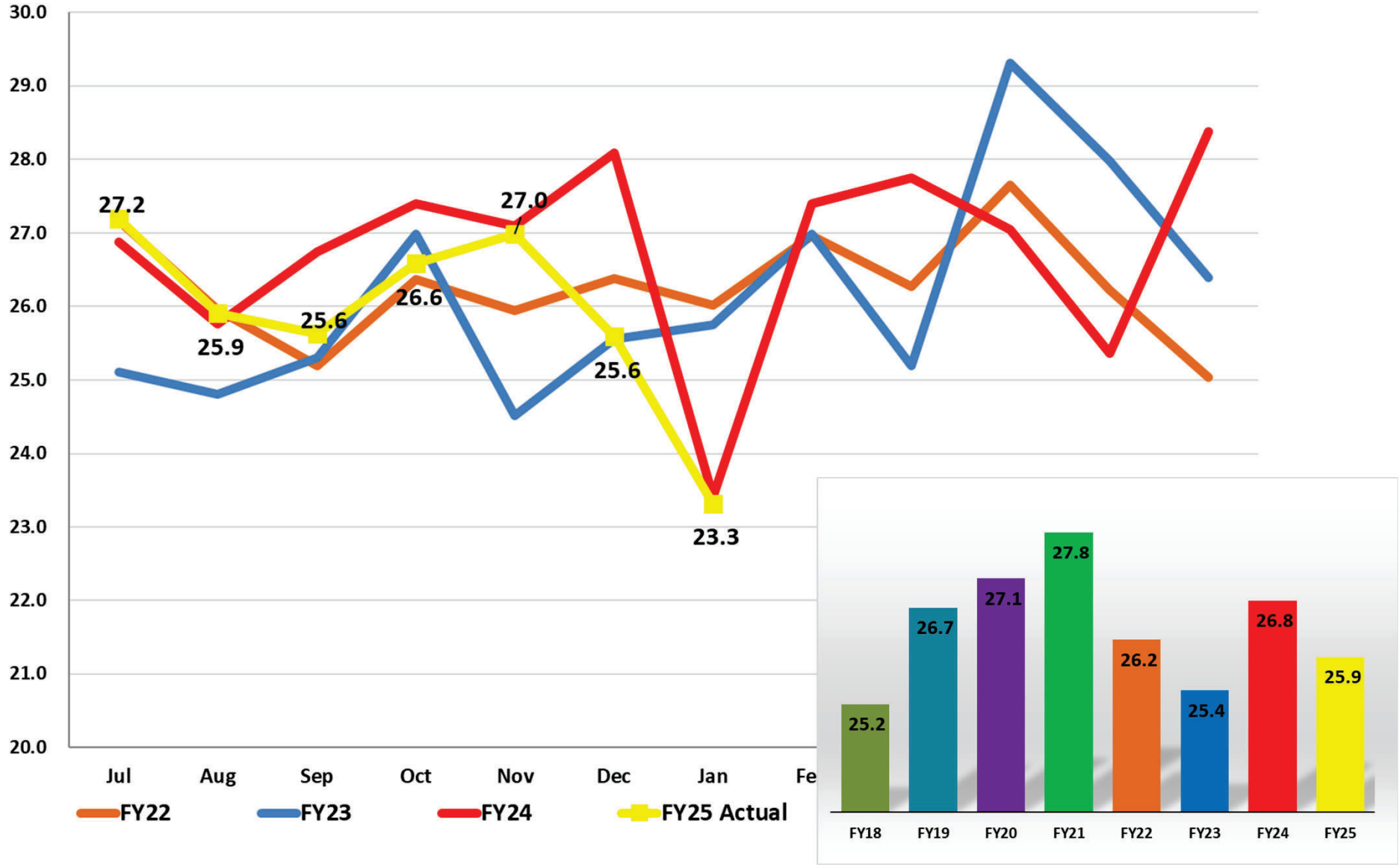
Contract Labor Expense



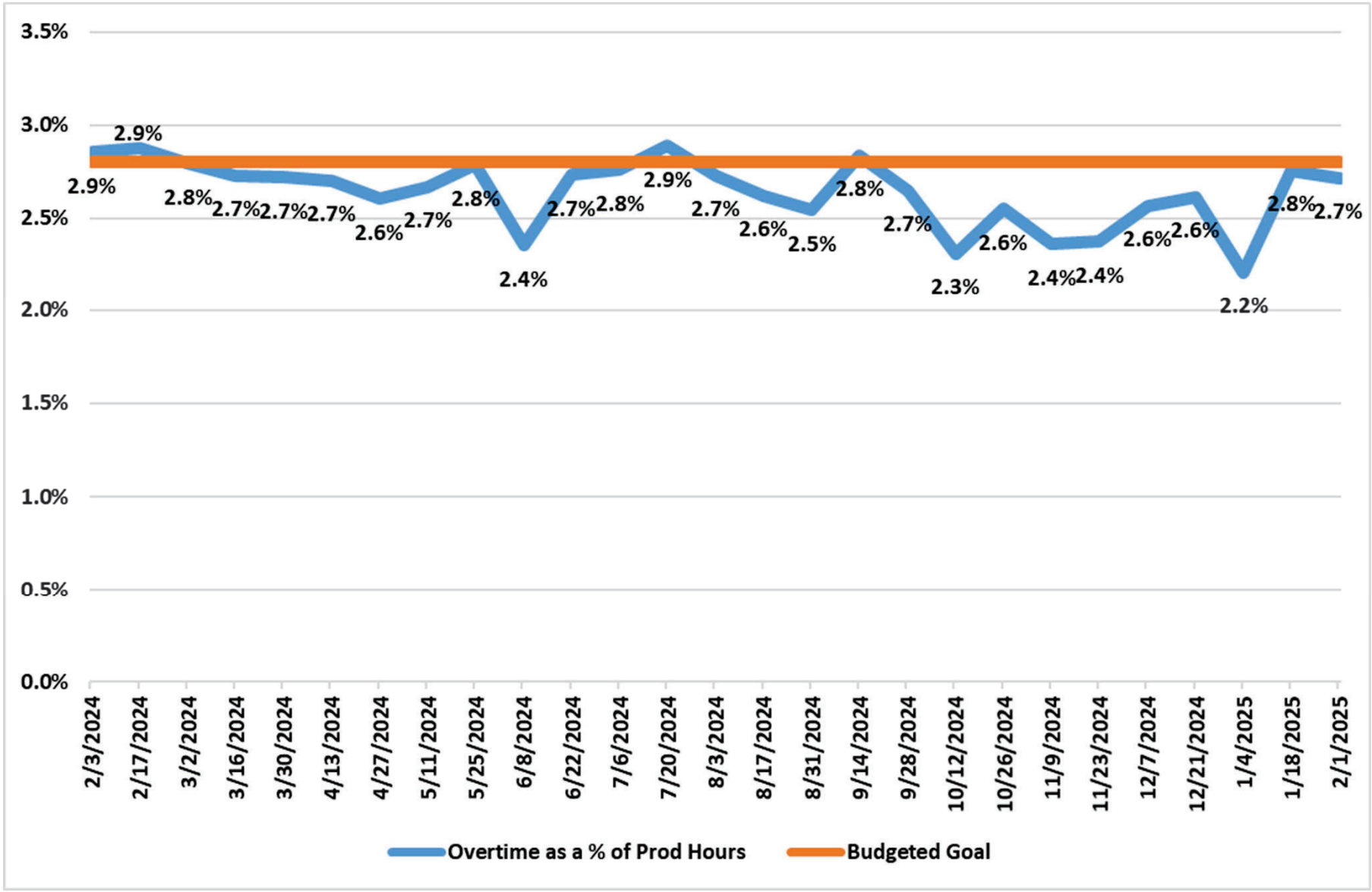
Total Payroll: excludes contract labor and PTO cash out



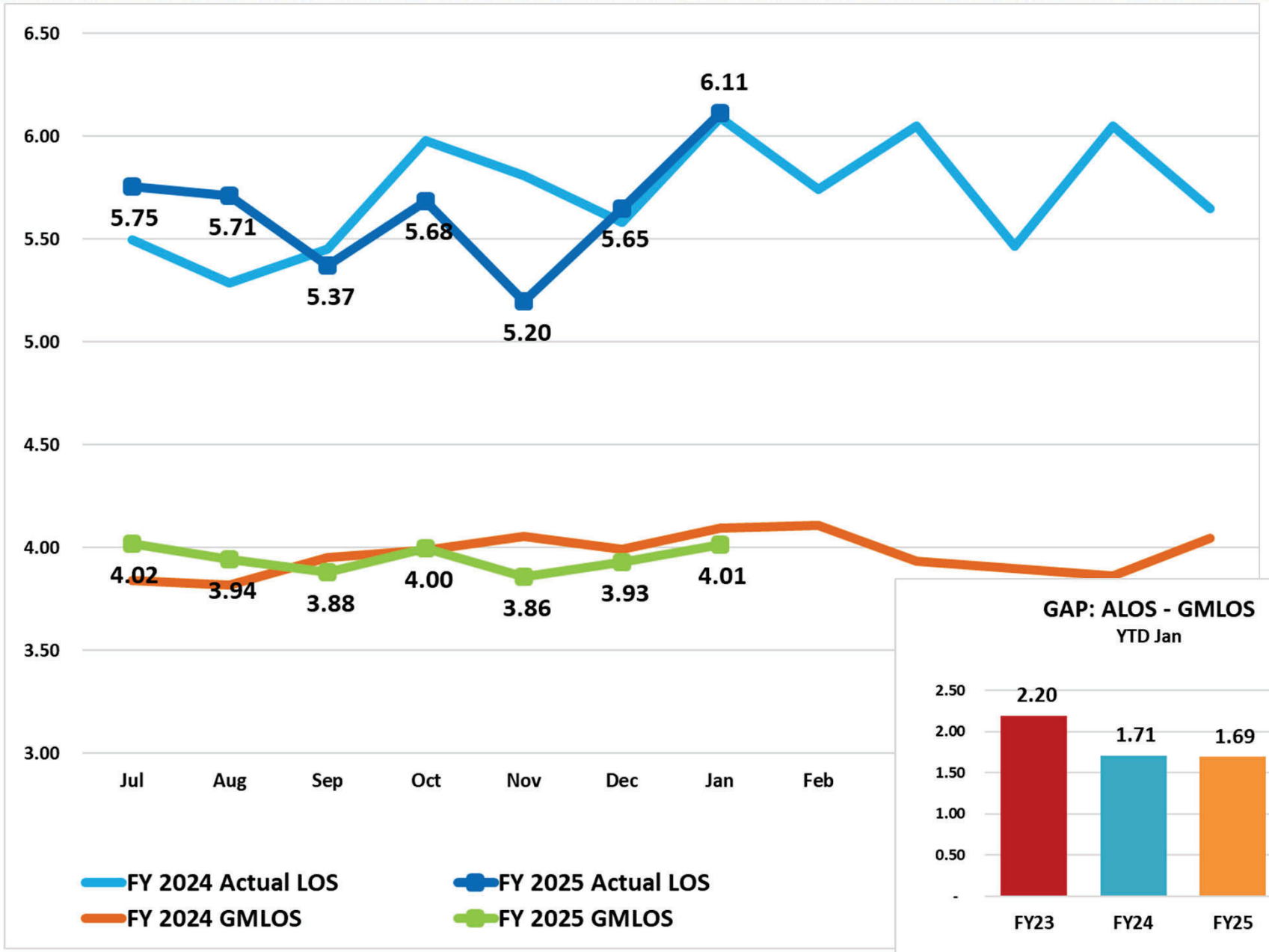
Productivity Measure : Worked Hours/ Adj. Patient Days



Overtime as a % of Productive Hours



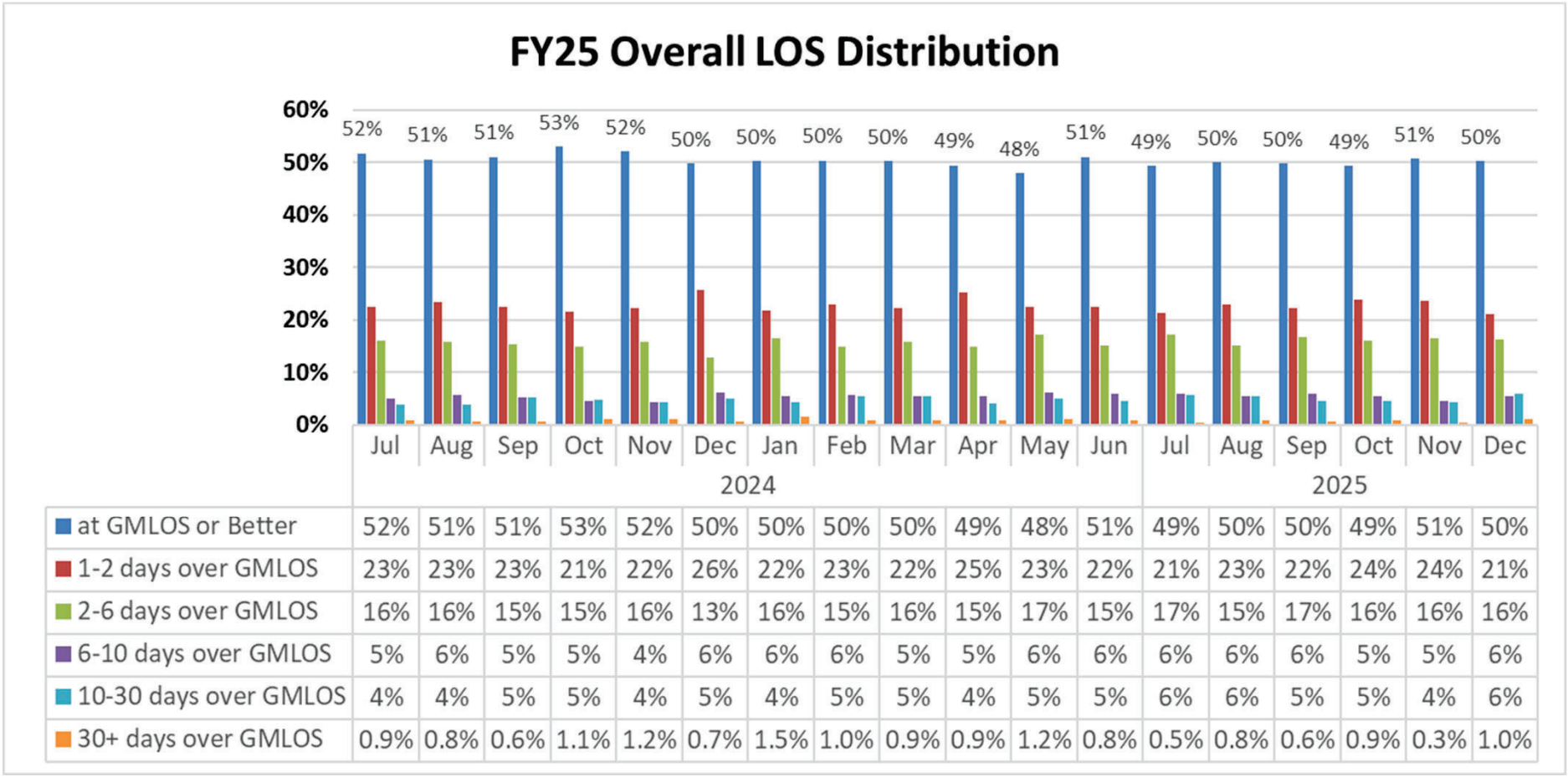
Average Length of Stay versus National Average (GMLOS)



Average Length of Stay versus National Average (GMLOS)

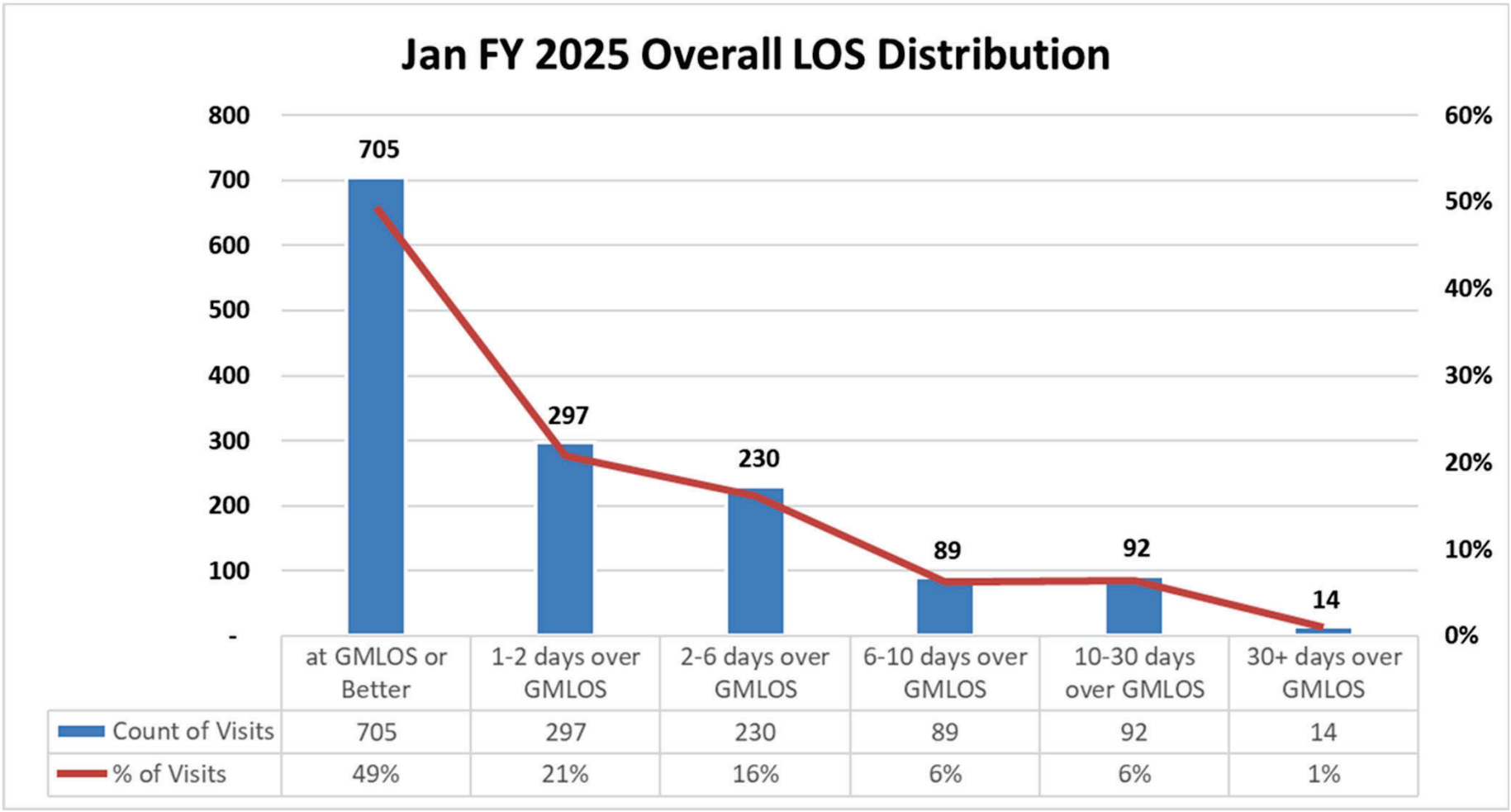
	Including COVID Patients		
	ALOS	GMLOS	GAP
Jan-23	6.82	4.02	2.80
Feb-23	6.56	4.06	2.50
Mar-23	5.69	4.09	1.60
Apr-23	5.35	3.99	1.36
May-23	5.37	3.99	1.38
Jun-23	5.39	3.94	1.45
Jul-23	5.50	3.90	1.60
Aug-23	5.29	3.84	1.45
Sep-23	5.45	3.82	1.64
Oct-23	5.98	3.95	2.03
Nov-23	5.81	3.99	1.82
Dec-23	5.58	4.05	1.53
Jan-24	6.09	3.99	2.10
Feb-24	5.74	4.10	1.64
Mar-24	6.05	4.11	1.94
Apr-24	5.47	3.94	1.53
May-24	6.05	3.90	2.15
Jun-24	5.63	3.86	1.76
Jul-24	5.75	4.02	1.74
Aug-24	5.71	3.94	1.77
Sep-24	5.37	3.88	1.49
Oct-24	5.68	4.00	1.69
Nov-24	5.20	3.86	1.34
Dec-24	5.65	3.93	1.72
Jan-25	6.11	4.01	2.10
	5.73	**3.97**	**1.76**

Average Length of Stay Distribution



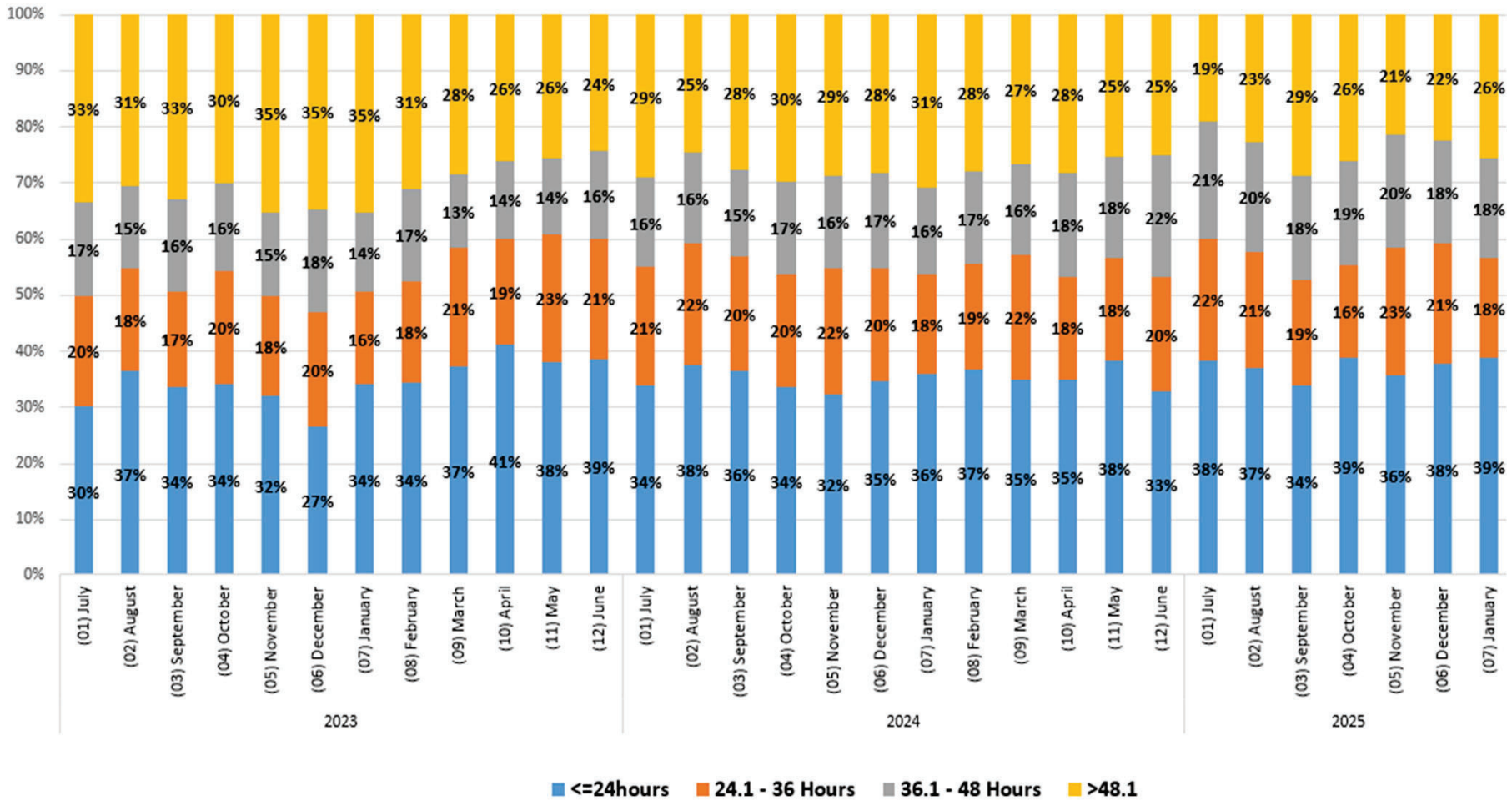
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
at GMLOS or Better	52%	51%	51%	53%	52%	50%	50%	50%	50%	49%	48%	51%	49%	50%	50%	49%	51%	50%
1-2 days over GMLOS	23%	23%	23%	21%	22%	26%	22%	23%	22%	25%	23%	22%	21%	23%	22%	24%	24%	21%
2-6 days over GMLOS	16%	16%	15%	15%	16%	13%	16%	15%	16%	15%	17%	15%	17%	15%	17%	16%	16%	16%
6-10 days over GMLOS	5%	6%	5%	5%	4%	6%	6%	6%	5%	5%	6%	6%	6%	6%	6%	5%	5%	6%
10-30 days over GMLOS	4%	4%	5%	5%	4%	5%	4%	5%	5%	4%	5%	5%	6%	6%	5%	5%	4%	6%
30+ days over GMLOS	0.9%	0.8%	0.6%	1.1%	1.2%	0.7%	1.5%	1.0%	0.9%	0.9%	1.2%	0.8%	0.5%	0.8%	0.6%	0.9%	0.3%	1.0%

Length of Stay Distribution

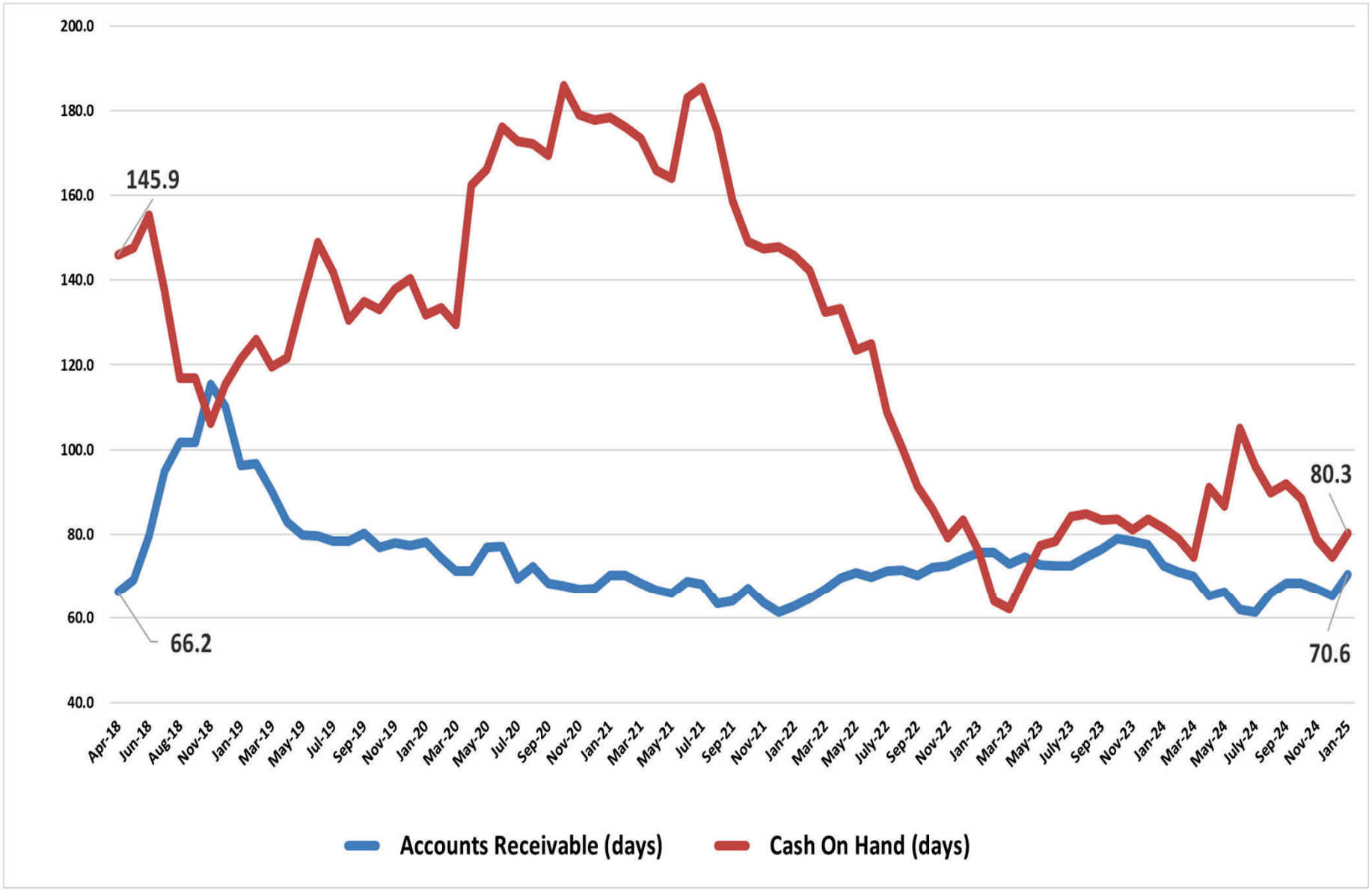


	at GMLOS or Better	1-2 days over GMLOS	2-6 days over GMLOS	6-10 days over GMLOS	10-30 days over GMLOS	30+ days over GMLOS
Count of Visits	705	297	230	89	92	14
% of Visits	49%	21%	16%	6%	6%	1%

Monthly Discharges of Observation Patients by their Length of Stay



Trended Liquidity Ratios



Ratio Analysis Report

	Current Month Value	Prior Month Value	June 30, 2024 Audited Value	2023 Moody's Median Benchmark		
				Aa	A	Baa
LIQUIDITY RATIOS						
Current Ratio (x)	3.0	3.3	2.3	1.7	**1.8**	1.7
Accounts Receivable (days)	70.6	65.3	61.9	47.8	**47.7**	47.8
Cash On Hand (days)	80.3	74.6	105.1	273.9	**188.4**	134.1
Cushion Ratio (x)	8.9	8.3	10.7	44.7	**24.2**	16.6
Average Payment Period (days)	50.4	48.0	58.6	70.9	**62.7**	64.0
CAPITAL STRUCTURE RATIOS						
Cash-to-Debt	89.7%	83.4%	106.3%	271.7%	**164.5%**	131.0%
Debt-To-Capitalization	31.9%	32.1%	34.5%	22.5%	**31.1%**	35.0%
Debt-to-Cash Flow (x)	2.7	3.1	3.4	2.4	**3.6**	6.9
Debt Service Coverage	4.7	4.1	3.7	6.7	**4.5**	2.1
Maximum Annual Debt Service Coverage (x)	3.7	3.2	2.9	6.8	**3.8**	1.9
Age Of Plant (years)	14.0	13.9	13.3	11.1	**12.8**	13.9
PROFITABILITY RATIOS						
Operating Margin	(3.2%)	(4.5%)	0.8%	2.1%	**0.5%**	(2.3%)
Excess Margin	7.2%	7.5%	2.4%	5.5%	**2.7%**	(.9%)
Operating Cash Flow Margin	1.9%	0.6%	6.1%	6.7%	**5.5%**	3.0%
Return on Assets	7.8%	8.2%	2.4%	3.9%	**2.4%**	(.7%)

Consolidated Statements of Net Position (000's)

	Jan-25	Jun-24 (Audited)
ASSETS AND DEFERRED OUTFLOWS		
CURRENT ASSETS		
Cash and cash equivalents	$ 4,674	$ 19,412
Current Portion of Board designated and trusted assets	20,139	14,944
Accounts receivable:		
Net patient accounts	144,092	133,806
Other receivables	86,834	25,023
	230,926	158,829
Inventories	14,086	13,738
Medicare and Medi-Cal settlements	86,446	82,755
Prepaid expenses	9,667	8,403
Total current assets	365,939	298,082
NON-CURRENT CASH AND INVESTMENTS - less current portion		
Board designated cash and assets	179,291	210,518
Revenue bond assets held in trust	22,848	19,326
Assets in self-insurance trust fund	706	827
Total non-current cash and investments	202,845	230,671
INTANGIBLE RIGHT TO USE LEASE, net of accumulated amortization	13,102	10,464
INTANGIBLE RIGHT TO USE SBITA, net of accumulated amortization	9,882	12,153
CAPITAL ASSETS		
Land	14,541	17,542
Buildings and improvements	428,894	428,209
Equipment	336,206	334,316
Construction in progress	25,020	22,757
	804,661	802,825
Less accumulated depreciation	528,086	512,148
	276,575	290,676
OTHER ASSETS		
Property not used in operations	8,173	4,487
Health-related investments	2,454	2,676
Other	17,366	17,120
Total other assets	27,994	24,283
Total assets	896,336	866,329
DEFERRED OUTFLOWS	14,510	15,283
Total assets and deferred outflows	**$ 910,847**	**$ 881,611**

Consolidated Statements of Net Position (000's)

	Jan-25	Jun-24
LIABILITIES AND NET ASSETS		
CURRENT LIABILITIES		
Accounts payable and accrued expenses	$ 32,509	$ 41,096
Accrued payroll and related liabilities	66,460	62,382
SBITA liability, current portion	3,539	4,146
Lease liabiilty, current portion	2,869	2,248
Bonds payable, current portion	12,754	12,585
Notes payable, current portion	1,921	9,850
Total current liabilities	120,052	132,306
LEASE LIABILITY, net of current portion	10,484	8,477
SBITA LIABILITY, net of current portion	4,448	5,846
LONG-TERM DEBT, less current portion		
Bonds payable	212,286	214,713
Notes payable	18,829	20,750
Total long-term debt	231,115	235,463
NET PENSION LIABILITY	21,534	21,226
OTHER LONG-TERM LIABILITIES	38,814	36,256
Total liabilities	426,448	439,574
NET ASSETS		
Invested in capital assets, net of related debt	59,156	66,112
Restricted	61,791	52,733
Unrestricted	359,536	323,192
Total net position	484,399	442,037
Total liabilities and net position	**$ 910,847**	**$ 881,611**

KAWEAH DELTA HEALTH CARE DISTRICT
SUMMARY OF FUNDS
January 31, 2025

Board designated funds	Maturity Date	Yield	Investment Type		G/L Account	Amount	Total
LAIF		4.37	Various			11,955,175	
CAMP		4.55	CAMP			33,691,604	
Allspring		3.99	Money market			377,832	
PFM		3.99	Money market			417,347	
Allspring	17-Jan-30	4.95	MTN-C	Adobe Inc		900,000	
PFM	17-Jan-30	4.95	MTN-C	Adobe Inc		285,000	
Allspring	7-Mar-25	2.13	MTN-C	Deere John Mtn		550,000	
American Business Bank	20-Mar-25	4.50	CD	American Business Bank		235,500	
CalPrivate Bank	20-Mar-25	4.50	CD	CalPrivate Bank		235,500	
Citizens National Bank of Texas	20-Mar-25	4.50	CD	Citizens National Bank of Texas		235,500	
Community Bank of the Day	20-Mar-25	4.50	CD	Community Bank of the Day		203,034	
East West Bank	20-Mar-25	4.50	CD	East West Bank		235,500	
Farmers Bank and Trust Compar	20-Mar-25	4.50	CD	Farmers Bank and Trust Company		235,500	
Frontier Bank of Texas	20-Mar-25	4.50	CD	Frontier Bank of Texas		235,500	
Optus Bank	20-Mar-25	4.50	CD	Optus Bank		198,863	
Poppy Bank	20-Mar-25	4.50	CD	Poppy Bank		235,500	
Republic Bank	20-Mar-25	4.50	CD	Republic Bank		206,240	
St. Louis Bank	20-Mar-25	4.50	CD	St. Louis Bank		235,500	
Willamette Valley Bank	20-Mar-25	4.50	CD	Willamette Valley Bank		235,500	
Optus Bank	27-Mar-25	4.50	CD	Optus Bank		22,383	
Western Alliance - CDARS	31-Mar-25	4.50	CD	Western Alliance		250,000	
Allspring	1-Apr-25	0.88	Municipal	Bay Area Toll		250,000	
Allspring	1-May-25	0.74	Municipal	San Diego County		300,000	
Allspring	15-May-25	2.75	U.S. Govt Agency	US Treasury Bill		980,000	
PFM	15-May-25	0.93	Municipal	University Calf Ca		185,000	
Allspring	1-Jun-25	0.92	Municipal	Connecticut ST		400,000	
Allspring	17-Jun-25	0.50	U.S. Govt Agency	FNMA		2,000,000	
Allspring	30-Jun-25	0.25	U.S. Govt Agency	US Treasury Bill		350,000	
Allspring	21-Jul-25	0.38	U.S. Govt Agency	FHLMC		1,500,000	
Allspring	1-Aug-25	2.17	Municipal	Santa Cruz Ca		400,000	
PFM	1-Aug-25	0.85	Municipal	San Juan Ca		190,000	
Allspring	25-Aug-25	0.38	U.S. Govt Agency	FNMA		1,500,000	
PFM	25-Aug-25	3.75	U.S. Govt Agency	FHLMC		259,680	
Allspring	4-Sep-25	0.38	U.S. Govt Agency	FHLB		525,000	
Allspring	23-Sep-25	0.38	U.S. Govt Agency	FHLMC		750,000	
Allspring	29-Oct-25	0.55	MTN-C	Procter Gamble Co		1,300,000	
Allspring	31-Oct-25	0.25	U.S. Govt Agency	US Treasury Bill		770,000	
Allspring	30-Nov-25	0.38	U.S. Govt Agency	US Treasury Bill		2,550,000	
Allspring	6-Feb-26	1.75	MTN-C	State Street Corp		1,000,000	
PFM	15-Feb-26	1.63	U.S. Govt Agency	US Treasury Bill		1,000,000	
PFM	28-Feb-26	0.50	U.S. Govt Agency	US Treasury Bill		1,500,000	
Allspring	31-Mar-26	0.75	U.S. Govt Agency	US Treasury Bill		675,000	
PFM	31-Mar-26	0.75	U.S. Govt Agency	US Treasury Bill		1,000,000	
PFM	2-Apr-26	3.38	MTN-C	Bank of America		250,000	
PFM	19-Apr-26	3.50	MTN-C	Bank of America		295,000	
Allspring	21-Apr-26	4.75	MTN-C	Morgan Stanley		1,000,000	
Allspring	25-Apr-26	3.91	MTN-C	Wells Fargo co		800,000	
PFM	30-Apr-26	0.75	U.S. Govt Agency	US Treasury Bill		1,000,000	
PFM	15-May-26	3.30	MTN-C	IBM Corp		410,000	
PFM	28-May-26	1.20	MTN-C	Astrazeneca LP		265,000	
PFM	31-May-26	0.75	U.S. Govt Agency	US Treasury Bill		1,000,000	
PFM	31-May-26	2.13	U.S. Govt Agency	US Treasury Bill		1,200,000	
PFM	15-Jun-26	0.55	ABS	Carmax Auto Owner		63,155	
Allspring	18-Jun-26	1.13	MTN-C	Toyota Motor		1,400,000	
Allspring	30-Jun-26	0.88	U.S. Govt Agency	US Treasury Bill		1,850,000	
PFM	30-Jun-26	0.88	U.S. Govt Agency	US Treasury Bill		990,000	
Allspring	1-Jul-26	1.89	Municipal	Anaheim Ca Pub		1,000,000	
PFM	1-Jul-26	1.46	Municipal	Los Angeles Ca		270,000	
PFM	7-Jul-26	5.25	ABS	American Honda Mtn		145,000	
PFM	8-Jul-26	3.05	MTN-C	Walmart INC		205,000	
PFM	17-Jul-26	5.08	MTN-C	Cooperatieve CD		400,000	
PFM	20-Jul-26	3.73	ABS	Honda Auto Rec Own		60,021	
PFM	31-Jul-26	0.63	U.S. Govt Agency	US Treasury Bill		880,000	
PFM	31-Aug-26	0.75	U.S. Govt Agency	US Treasury Bill		800,000	
PFM	14-Sep-26	1.15	MTN-C	Caterpillar Finl Mtn		220,000	
PFM	18-Sep-26	5.61	MTN-C	Natixis Ny		405,000	
Allspring	30-Sep-26	0.88	U.S. Govt Agency	US Treasury Bill		2,210,000	
PFM	30-Sep-26	0.88	U.S. Govt Agency	US Treasury Bill		1,000,000	
Allspring	31-Oct-26	1.13	U.S. Govt Agency	US Treasury Bill		800,000	
PFM	1-Nov-26	4.76	Municipal	California St Univ		125,000	
PFM	4-Nov-26	1.65	MTN-C	American Express Co		445,000	
PFM	13-Nov-26	5.60	MTN-C	National Rural Mtn		160,000	
Allspring	30-Nov-26	1.25	U.S. Govt Agency	US Treasury Bill		2,000,000	
Allspring	4-Dec-26	5.49	MTN-C	Citibank N A		1,000,000	
PFM	11-Jan-27	1.70	MTN-C	Deere John Mtn		220,000	
Allspring	15-Jan-27	1.95	MTN-C	Target Corp		900,000	
PFM	26-Feb-27	4.80	MTN-C	Cisco Sys		260,000	
PFM	15-Mar-27	5.90	MTN-C	Daimler Trucks		325,000	
PFM	18-Mar-27	4.99	MTN-C	State Street Corp		335,000	
PFM	25-Mar-27	3.22	U.S. Govt Agency	FHLMC		575,000	
PFM	30-Mar-27	5.39	MTN-C	Hormel Food Corp		115,000	
PFM	15-Apr-27	3.97	ABS	Carmax Auto Owner		338,054	
PFM	15-Apr-27	2.50	MTN-C	Home Depot Inc		220,000	
Allspring	30-Apr-27	2.75	U.S. Govt Agency	US Treasury Bill		970,000	
PFM	30-Apr-27	0.50	U.S. Govt Agency	US Treasury Bill		250,000	
PFM	30-Apr-27	2.75	U.S. Govt Agency	US Treasury Bill		800,000	
PFM	13-May-27	5.00	MTN-C	Paccar Financial Mtn		95,000	
PFM	15-May-27	2.38	U.S. Govt Agency	US Treasury Bill		925,000	
PFM	15-May-27	1.70	MTN-C	IBM Corp		230,000	
PFM	15-May-27	3.70	MTN-C	Unitedhealth Group		85,000	
PFM	17-May-27	3.66	ABS	Capital One Prime		168,161	
Allspring	21-May-27	5.41	MTN-C	Goldman Sachs		1,100,000	
Allspring	15-Jul-27	3.68	Municipal	Massachusetts St		1,000,000	
PFM	26-Jul-27	4.60	MTN-C	Blackrock Funding		185,000	
PFM	30-Jul-27	4.65	MTN-C	Honeywell		185,000	
Allspring	1-Aug-27	3.46	Municipal	Alameda Cnty Ca		500,000	
Allspring	6-Aug-27	4.45	MTN-C	Paccar Financial Mtn		900,000	
PFM	15-Aug-27	2.25	U.S. Govt Agency	US Treasury Bill		190,000	
PFM	31-Aug-27	0.50	U.S. Govt Agency	US Treasury Bill		1,140,000	
Allspring	15-Sep-27	5.93	MTN-C	Bank of America		1,100,000	
Allspring	1-Oct-27	4.66	Municipal	San Francisco Ca		1,000,000	
PFM	8-Oct-27	4.35	MTN-C	Toyota Motor		130,000	
PFM	31-Oct-27	0.50	U.S. Govt Agency	US Treasury Bill		1,500,000	
Allspring	15-Nov-27	4.60	MTN-C	Caterpillar Finl Mtn		1,000,000	

KAWEAH DELTA HEALTH CARE DISTRICT
SUMMARY OF FUNDS
January 31, 2025

Allspring	15-Nov-27	5.49	ABS	Nissan Auto Lease	500,000
PFM	15-Nov-27	4.51	ABS	Mercedes Benz Auto	151,079
PFM	17-Nov-27	5.02	MTN-C	Bp Cap Mkts Amer	310,000
PFM	15-Jan-28	4.10	MTN-C	Mastercard	130,000
Allspring	18-Jan-28	5.66	ABS	Mercedes Benz Auto	1,000,000
PFM	24-Jan-28	4.90	MTN-C	Wells Fargo MTN	145,000
PFM	7-Feb-28	3.44	MTN-C	Bank New York Mellon Mtn	300,000
Allspring	16-Feb-28	4.47	MTN-C	GM Finl Consumer	1,000,000
PFM	18-Feb-28	5.41	ABS	Honda Auto	350,000
PFM	25-Feb-28	5.47	ABS	BMW Vehicle Owner	95,000
PFM	29-Feb-28	1.13	U.S. Govt Agency	US Treasury Bill	1,500,000
PFM	17-Apr-28	5.48	ABS	Hyundai Auto	115,000
Allspring	22-Apr-28	5.57	MTN-C	JP Morgan	1,100,000
PFM	30-Apr-28	3.50	U.S. Govt Agency	US Treasury Bill	750,000
PFM	30-Apr-28	1.25	U.S. Govt Agency	US Treasury Bill	600,000
PFM	15-May-28	5.46	ABS	Ally Auto Rec	195,000
PFM	15-May-28	4.87	MTN-C	American Express Co	150,000
PFM	15-May-28	4.79	MTN-C	Bank of America	180,000
PFM	15-May-28	5.23	MTN-C	Ford CR Auto Owner	160,000
PFM	26-May-28	5.50	MTN-C	Morgan Stanley	280,000
PFM	31-May-28	3.63	U.S. Govt Agency	US Treasury Bill	1,500,000
PFM	16-Jun-28	5.45	ABS	GM Finl con Auto Rec	110,000
PFM	25-Jun-28	4.82	U.S. Govt Agency	FHLMC	530,000
PFM	25-Jun-28	4.78	U.S. Govt Agency	FHLMC	435,162
PFM	30-Jun-28	4.00	U.S. Govt Agency	US Treasury Bill	1,500,000
PFM	14-Jul-28	4.95	MTN-C	John Deere Mtn	120,000
PFM	25-Jul-28	4.18	U.S. Govt Agency	FNMA	515,817
Allspring	1-Aug-28	5.75	Municipal	San Diego County	1,000,000
PFM	15-Aug-28	5.69	MTN-C	Harley Davidson	500,000
PFM	15-Aug-28	5.53	ABS	Fifth Third Auto	385,000
PFM	25-Aug-28	4.74	U.S. Govt Agency	FHLMC	545,000
PFM	25-Aug-28	4.65	U.S. Govt Agency	FHLMC	545,000
PFM	15-Sep-28	5.23	MTN-C	American Express	445,000
PFM	15-Sep-28	5.16	MTN-C	Chase Issuance Trust	435,000
PFM	25-Sep-28	4.85	U.S. Govt Agency	FHLMC	410,000
PFM	25-Sep-28	4.80	U.S. Govt Agency	FHLMC	535,000
PFM	29-Sep-28	5.80	MTN-C	Citibank N A	535,000
PFM	30-Sep-28	4.63	U.S. Govt Agency	US Treasury Bill	500,000
Allspring	25-Oct-28	5.80	MTN-C	Bank New York Mtn	1,000,000
PFM	25-Oct-28	5.07	U.S. Govt Agency	FHLMC	200,000
PFM	25-Oct-28	4.86	U.S. Govt Agency	FHLMC	300,000
PFM	31-Oct-28	1.38	U.S. Govt Agency	US Treasury Bill	1,500,000
PFM	31-Oct-28	1.38	U.S. Govt Agency	US Treasury Bill	775,000
Allspring	15-Nov-28	4.98	MTN-C	Bank of America	394,000
PFM	25-Nov-28	5.00	U.S. Govt Agency	FHLMC	280,000
PFM	25-Dec-28	4.57	U.S. Govt Agency	FHLMC	325,000
PFM	25-Dec-28	4.72	U.S. Govt Agency	FHLMC	315,000
PFM	31-Dec-28	3.75	U.S. Govt Agency	US Treasury Bill	1,200,000
PFM	31-Dec-28	1.38	U.S. Govt Agency	US Treasury Bill	500,000
PFM	12-Jan-29	5.02	MTN-C	Morgan Stanley	250,000
PFM	16-Jan-29	4.60	MTN-C	Chase Issuance Trust	490,000
PFM	24-Jan-29	4.92	MTN-C	JP Morgan	140,000
PFM	31-Jan-29	4.60	MTN-C	Paccar Financial Mtn	160,000
PFM	8-Feb-29	4.60	MTN-C	Air products	295,000
PFM	8-Feb-29	4.60	MTN-C	Texas Instrs	370,000
PFM	15-Feb-29	4.94	MTN-C	Wells Fargo Card	560,000
PFM	20-Feb-29	4.90	MTN-C	Cummins INC	195,000
PFM	22-Feb-29	4.90	MTN-C	Bristol Myers Squibb	200,000
Allspring	26-Feb-29	5.18	ABS	BMW Vehicle Owner	1,100,000
PFM	26-Feb-29	4.85	MTN-C	Cisco Sys	225,000
PFM	26-Feb-29	4.85	MTN-C	Astrazeneca	165,000
PFM	28-Feb-29	4.25	U.S. Govt Agency	US Treasury Bill	750,000
PFM	14-Mar-29	4.70	MTN-C	Blackrock Funding	50,000
PFM	14-Mar-29	4.70	MTN-C	Blackrock Funding	220,000
Allspring	15-Mar-29	5.20	ABS	John Deere Owner	1,000,000
Allspring	15-Mar-29	5.38	ABS	Hyundai Auto Rec	1,000,000
PFM	25-Mar-29	5.18	U.S. Govt Agency	FHLMC	315,000
Allspring	31-Mar-29	4.13	U.S. Govt Agency	US Treasury Bill	1,000,000
PFM	31-Mar-29	4.13	U.S. Govt Agency	US Treasury Bill	225,000
PFM	4-Apr-29	4.80	MTN-C	Adobe Inc	225,000
Allspring	15-Apr-29	5.10	MTN-C	Ford CR Auto Owner	1,000,000
PFM	15-Apr-29	5.10	MTN-C	Ford CR Auto Owner	415,000
PFM	15-May-29	4.42	ABS	Hyundai Auto Rec	195,000
PFM	25-May-29	4.72	U.S. Govt Agency	FHLMC	460,000
Allspring	31-May-29	4.50	U.S. Govt Agency	US Treasury Bill	1,000,000
Allspring	15-Jun-29	5.15	MTN-C	National Rural Mtn	850,000
Allspring	20-Jun-29	5.98	MTN-C	Verizon Master Trust	1,000,000
Allspring	25-Jun-29	4.75	MTN-C	Home Depot Inc	500,000
PFM	25-Jun-29	4.64	U.S. Govt Agency	FHLMC	200,000
PFM	25-Jun-29	4.75	MTN-C	Home Depot Inc	95,000
PFM	30-Jun-29	3.25	U.S. Govt Agency	US Treasury Bill	2,030,000
PFM	15-Jul-29	4.76	MTN-C	Ford CR Auto Owner	360,000
Allspring	16-Jul-29	4.65	MTN-C	American Express	1,025,000
PFM	17-Jul-29	4.50	MTN-C	Pepsico inc	280,000
PFM	25-Jul-29	4.54	U.S. Govt Agency	FHLMC	515,000
PFM	25-Jul-29	4.62	U.S. Govt Agency	FHLMC	410,000
Allspring	31-Jul-29	4.00	U.S. Govt Agency	US Treasury Bill	500,000
PFM	31-Jul-29	4.00	U.S. Govt Agency	US Treasury Bill	750,000
PFM	6-Aug-29	4.84	MTN-C	Citibank N A	295,000
PFM	9-Aug-29	4.55	MTN-C	Toyota Motor	195,000
PFM	14-Aug-29	4.20	MTN-C	Eli Lilly Co	65,000
PFM	16-Aug-29	4.27	ABS	GM Finl con Auto Rec	155,000
PFM	18-Aug-29	4.64	MTN-C	Toyota Auto	260,000
PFM	31-Aug-29	3.63	U.S. Govt Agency	US Treasury Bill	750,000
PFM	18-Sep-29	3.80	MTN-C	Novartis Capital	365,000
PFM	25-Sep-29	4.79	U.S. Govt Agency	FHLMC	345,000
Allspring	30-Sep-29	3.50	U.S. Govt Agency	US Treasury Bill	950,000
PFM	4-Oct-29	4.05	MTN-C	Accenture Capital	195,000
Allspring	31-Oct-29	4.13	U.S. Govt Agency	US Treasury Bill	1,000,000
PFM	31-Oct-29	4.13	U.S. Govt Agency	US Treasury Bill	1,200,000
Allspring	30-Nov-29	4.13	U.S. Govt Agency	US Treasury Bill	1,700,000
PFM	17-Dec-29	4.78	ABS	Mercedes Benz Auto	255,000
Allspring	31-Dec-29	4.38	U.S. Govt Agency	US Treasury Bill	1,000,000
Allspring	31-Dec-29	4.38	U.S. Govt Agency	US Treasury Bill	1,000,000
PFM	1-May-27	5.41	MTN-C	Goldman Sachs	220,000
					$ 166,767,109

KAWEAH DELTA HEALTH CARE DISTRICT
SUMMARY OF FUNDS
January 31, 2025

	Maturity Date	Yield	Investment Type		G/L Account	Amount	Total
Self-insurance trust							
Wells Fargo Bank			Money market		110900	967,173	
Wells Fargo Bank			Fixed income - L/T		152300	748,756	
							1,715,929
2015A revenue bonds							
US Bank			Principal/Interest payment fund		142110	1,271,069	
							1,271,069
2015B revenue bonds							
US Bank			Principal/Interest payment fund		142110	715,156	
							715,156
2017C revenue bonds							
US Bank			Principal/Interest payment fund		142110	3,736,255	
							3,736,255
2020 revenue bonds							
US Bank			Principal/Interest payment fund		142110	676,907	
							676,907
2022 revenue bonds							
US Bank			Principal/Interest payment fund		142110	1,719,891	
							1,719,891
2014 general obligation bonds							
CAMP			Interest Payment fund		152440	3,737,382	
							3,737,382
Master Reserve fund							
US Bank					142102	(368,772)	
US Bank					142103	23,216,821	
							22,848,049
Operations							
Wells Fargo Bank		0.16	Checking	100100	100100	(3,304,706)	
Wells Fargo Bank		0.16	Checking	100500	100500	6,753,158	
						3,448,452	
Payroll							
Wells Fargo Bank		0.16	Checking		100200	(202,860)	
Wells Fargo Bank		0.16	Checking	Flexible Spending	100300	1,024,248	
Wells Fargo Bank		0.16	Checking	HSA	100300	15,905	
Wells Fargo Bank			Checking	Resident Fund	100300	-	
Bancorp			Checking	Bancorp	100300	-	
						837,293	
							4,285,745
					Total investments		**$ 207,473,492**

KAWEAH DELTA HEALTH CARE DISTRICT
SUMMARY OF FUNDS
January 31, 2025

Kaweah Delta Medical Foundation

Wells Fargo Bank	Checking	100100	$ 8,818

Sequoia Regional Cancer Center

Wells Fargo Bank	Checking	100500	(34,163)
			$ (34,163)

Kaweah Delta Hospital Foundation

Central Valley Community Checking	Investments	100100	312,752
Various	S/T Investments	142200	5,175,418
Various	L/T Investments	142300	13,330,559
Various	Unrealized G/L	142400	3,053,913
			$ 21,872,641

Summary of board designated funds:

Plant fund:

Uncommitted plant funds		$ 113,610,953	142100	
Committed for capital		18,991,533	142100	
		132,602,486		
GO Bond reserve - L/T		1,992,658	142100	
401k Matching		10,993,670	142100	
Cost report settlement - current	2,135,384		142104	
Cost report settlement - L/T	1,312,727		142100	
		3,448,111		
Development fund/Memorial fund		104,184	112300	
Workers compensation - current	5,180,000		112900	
Workers compensation - L/T	12,446,000		113900	
		17,626,000		
		$ 166,767,109		

Investment summary by institution:

	Total Investments	%	Trust Accounts	Surplus Funds	%
Bancorp	$ -	0.0%		-	0.0%
Cal Trust	-	0.0%		-	0.0%
CAMP	33,691,604	16.2%		33,691,604	19.7%
Local Agency Investment Fund (LAIF)	11,955,175	5.8%		11,955,175	7.0%
CAMP - GOB Tax Rev	3,737,382	1.8%	3,737,382	-	0.0%
Allspring	59,226,832	28.5%	1,715,929	57,510,903	33.6%
PFM	58,893,477	28.4%		58,893,477	34.4%
Western Alliance	250,000			250,000	0.1%
American Business Bank	235,500			235,500	0.1%
CalPrivate Bank	235,500			235,500	0.1%
Citizens National Bank of Texas	235,500			235,500	0.1%
Community Bank of the Day	203,034			203,034	0.1%
East West Bank	235,500			235,500	0.1%
Farmers Bank and Trust Company	235,500			235,500	0.1%
Frontier Bank of Texas	235,500			235,500	0.1%
Optus Bank	221,247			221,247	0.1%
Poppy Bank	235,500			235,500	0.1%
Republic Bank	206,240			206,240	0.1%
St. Louis Bank	235,500			235,500	0.1%
Willamette Valley Bank	235,500			235,500	0.1%
Wells Fargo Bank	6,001,674	2.9%		6,001,674	3.5%
Signature Bank	-	0.0%	-	-	0.0%
US Bank	30,967,327	14.9%	30,967,327	-	0.0%
Total investments	$ 207,473,492	100.0%	$ 36,420,638	171,052,854	100.0%

KAWEAH DELTA HEALTH CARE DISTRICT
SUMMARY OF FUNDS
January 31, 2025

Investment summary of surplus funds by type:			**Investment Limitations**	
Negotiable and other certificates of deposit	$	3,000,021	51,316,000	(30%)
Checking accounts		4,285,745		
Local Agency Investment Fund (LAIF)		11,955,175	75,000,000	
CAMP		33,691,604		
Medium-term notes (corporate) (MTN-C)		36,524,000	51,316,000	(30%)
U.S. government agency		66,800,659		
Municipal securities		6,620,000		
Money market accounts		795,179	34,211,000	(20%)
Commercial paper		-	42,763,000	(25%)
Asset Backed Securties		7,380,471	34,211,000	(20%)
Supra-National Agency		-	51,316,000	(30%)
	$	171,052,854		

Return on investment:

Current month	**4.25%**
Year-to-date	**3.73%**
Prospective	**3.45%**
LAIF (year-to-date)	**4.50%**
Budget	**2.82%**

Fair market value disclosure for the quarter ended Dec 31, 2024 (District only):	**Quarter-to-date**	**Year-to-date**
Difference between fair value of investments and amortized cost (balance sheet effect)	N/A	(1,578,431)
Change in unrealized gain (loss) on investments (income statement effect)	$ (686,000)	2,518,575

Investment summary of CDs:		
American Business Bank	$	235,500
CalPrivate Bank		235,500
Citizens National Bank of Texas		235,500
Community Bank of the Day		203,034
East West Bank		235,500
Farmers Bank and Trust Company		235,500
Frontier Bank of Texas		235,500
Poppy Bank		235,500
Republic Bank		206,240
St. Louis Bank		235,500
Willamette Valley Bank		235,500
Optus Bank		221,247
Western Alliance		250,000
	$	3,000,021

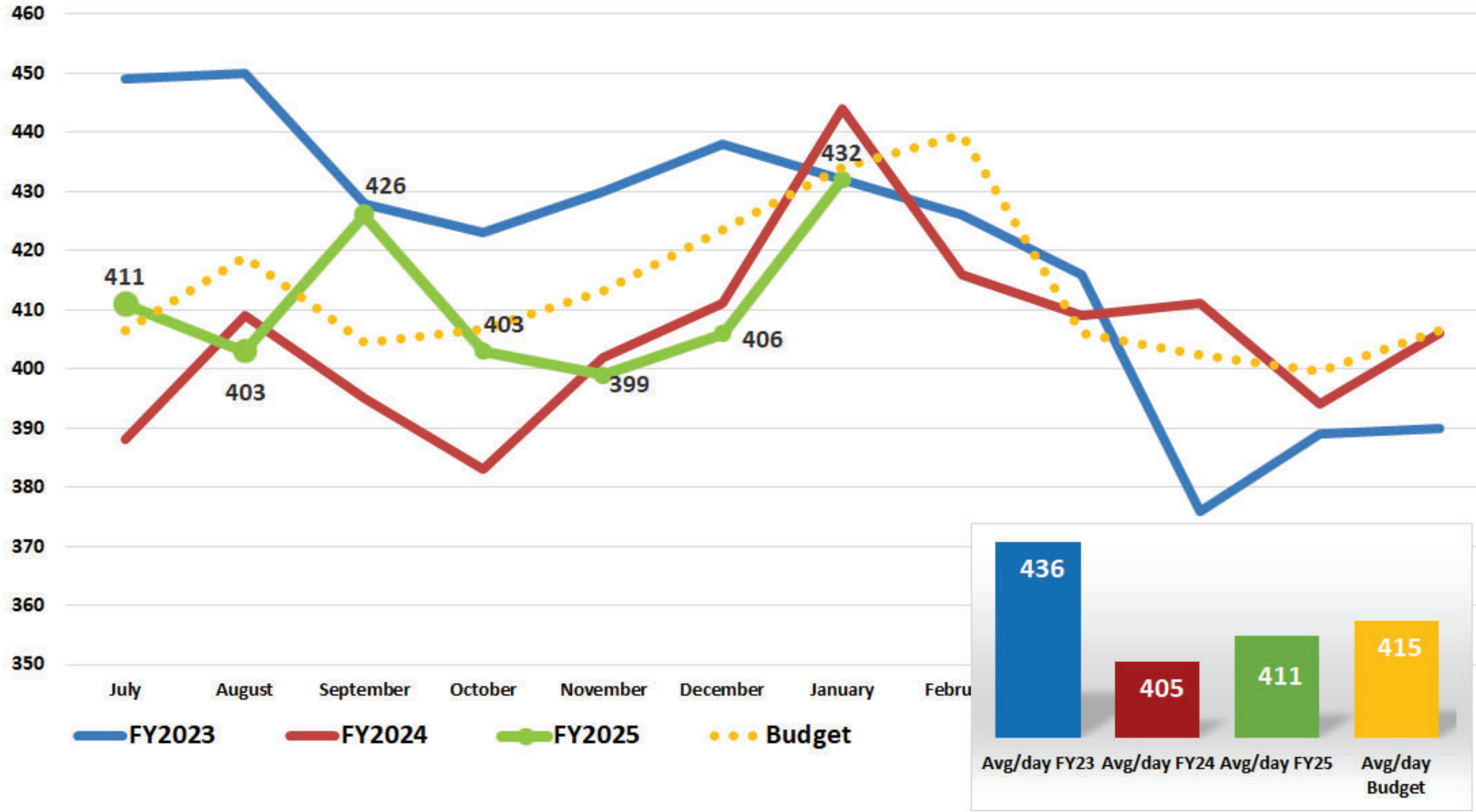
Investment summary of asset backed securities:		
Ally Auto Rec	$	195,000
American Honda Mtn		145,000
BMW Vehicle Owner		1,195,000
Fifth Third Auto		385,000
Capital One Prime		168,161
Carmax Auto Owner		401,209
GM Finl con Auto Rec		265,000
Honda Auto		350,000
Honda Auto Rec Own		60,021
Hyundai Auto		115,000
Hyundai Auto Rec		1,195,000
John Deere Owner		1,000,000
Mercedes Benz Auto		1,406,079
Nissan Auto Lease		500,000
	$	7,380,471

KAWEAH DELTA HEALTH CARE DISTRICT
SUMMARY OF FUNDS
January 31, 2025

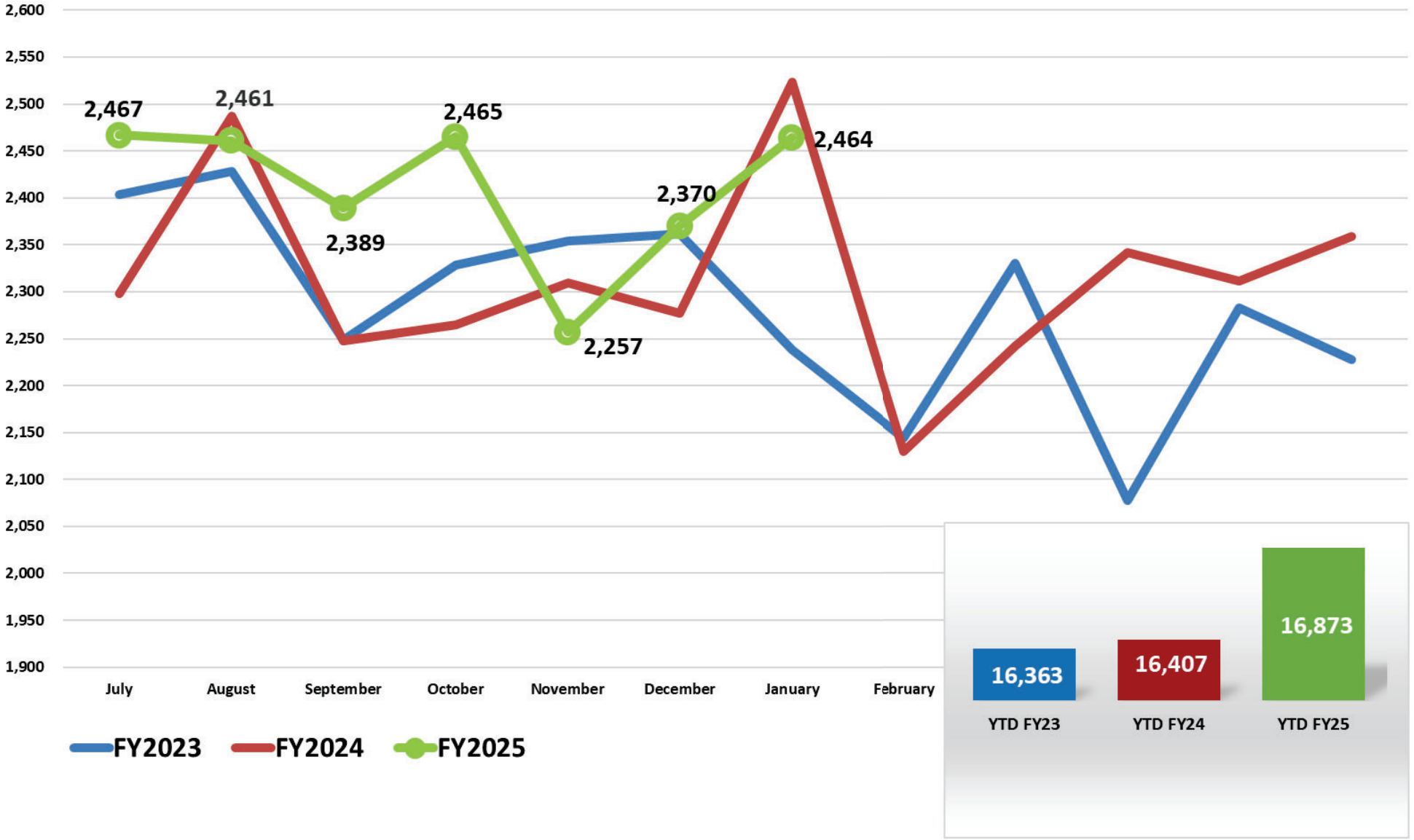
Investment summary of medium-term notes (corporate):		
Accenture Capital	$	195,000
Adobe Inc		1,410,000
American Express		1,470,000
American Express Co		595,000
Air products		295,000
Astrazeneca		165,000
Astrazeneca LP		265,000
Bank of America		2,219,000
Bank New York Mellon Mtn		300,000
Bank New York Mtn		1,000,000
Blackrock Funding		455,000
Bp Cap Mkts Amer		310,000
Bristol Myers Squibb		200,000
Chase Issuance Trust		925,000
Caterpillar Finl Mtn		1,220,000
Cisco Sys		485,000
Citibank N A		1,830,000
Cooperatieve CD		400,000
Cummins INC		195,000
Daimler Trucks		325,000
Deere John Mtn		770,000
Eli Lilly Co		65,000
Ford CR Auto Owner		1,935,000
GM Finl Consumer		1,000,000
Goldman Sachs		1,320,000
Harley Davidson		500,000
Home Depot Inc		815,000
Honeywell		185,000
Hormel Food Corp		115,000
IBM Corp		640,000
John Deere Mtn		120,000
JP Morgan		1,240,000
Mastercard		130,000
Morgan Stanley		1,530,000
National Rural Mtn		1,010,000
Natixis Ny		405,000
Novartis Capital		365,000
Paccar Financial Mtn		1,155,000
Pepsico inc		280,000
Procter Gamble Co		1,300,000
State Street Corp		1,335,000
Target Corp		900,000
Texas Instrs		370,000
Toyota Auto		260,000
Toyota Motor		1,725,000
Unitedhealth Group		85,000
Verizon Master Trust		1,000,000
Walmart INC		205,000
Wells Fargo Mtn		145,000
Wells Fargo Card		560,000
Wells Fargo co		800,000
	$	36,524,000
Investment summary of U.S. government agency:		
Federal National Mortgage Association (FNMA)	$	4,015,817
Federal Home Loan Bank (FHLB)		525,000
Federal Home Loan Mortgage Corp (FHLMC)		9,749,842
US Treasury Bill		52,510,000
	$	66,800,659
Investment summary of municipal securities:		
Alameda Cnty Ca	$	500,000
Anaheim Ca Pub		1,000,000
Bay Area Toll		250,000
California St Univ		125,000
Connecticut ST		400,000
Los Angeles Ca		270,000
Massachusetts St		1,000,000
San Diego County		1,300,000
San Francisco Ca		1,000,000
San Juan Ca		190,000
Santa Cruz Ca		400,000
University Calf Ca		185,000
	$	6,620,000

Statistical Report
January 2025

Average Daily Census



Admissions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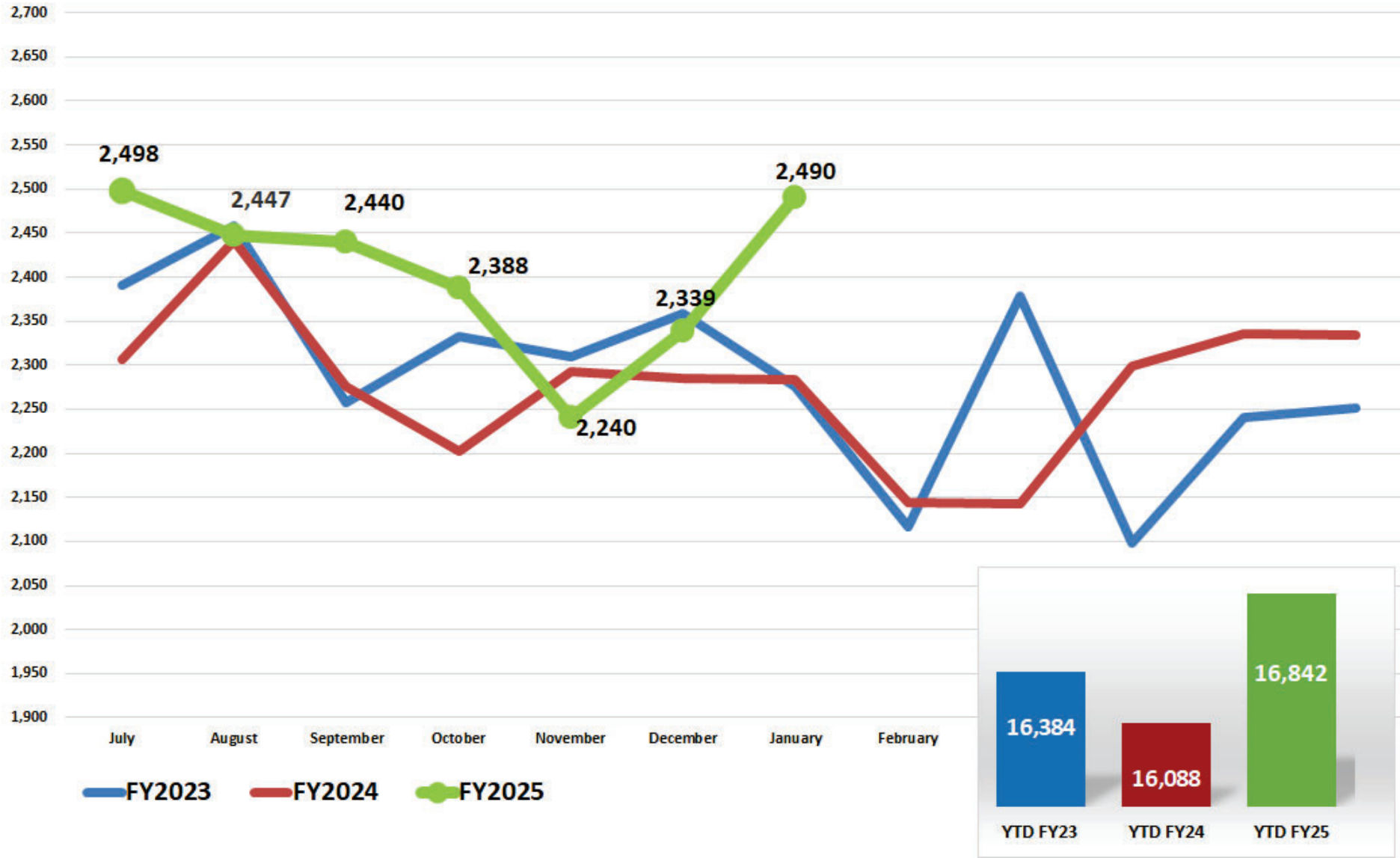
2,550
2,500
2,450
2,400
2,350
2,300
2,250
2,200
2,150
2,100
2,050
2,000
1,950
1,900
2,467
2,461
2,389
2,465
2,257
2,370
2,464
July
August
September
October
November
December
January
February
FY2023
FY2024
FY2025
16,363
16,407
16,873
YTD FY23
YTD FY24
YTD FY25

Discharges


2,700
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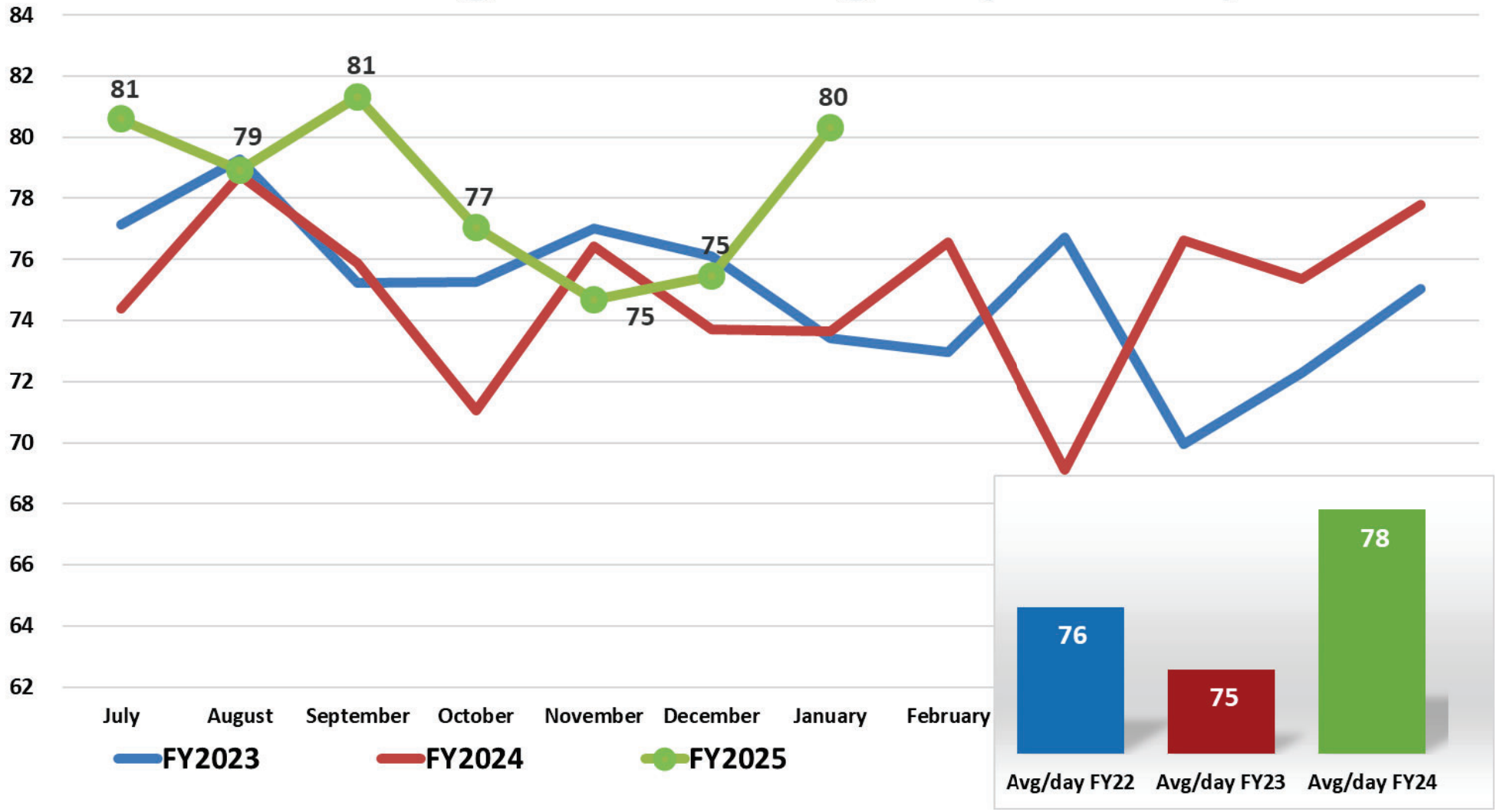
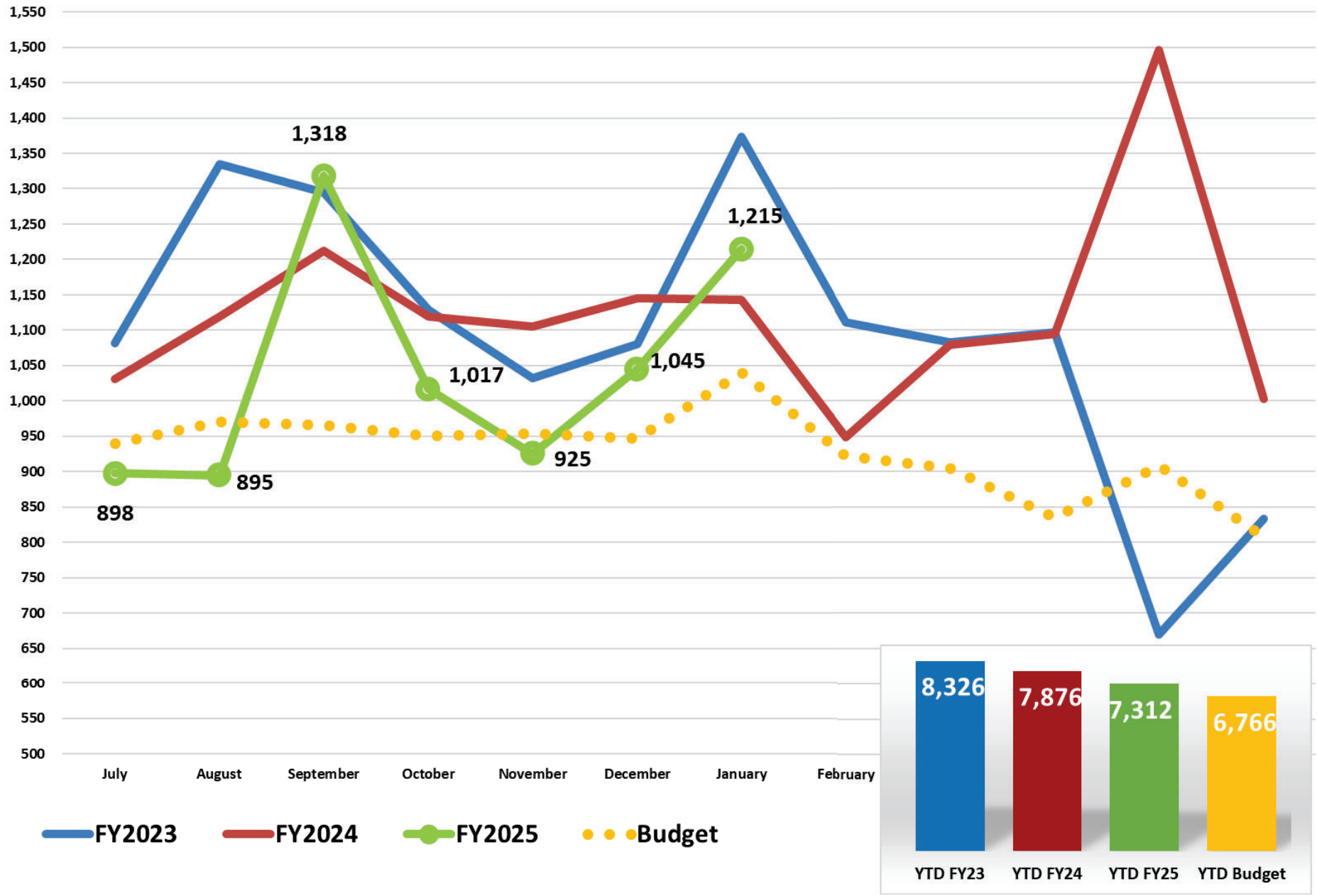
2,600
2,550
2,500
2,450
2,400
2,350
2,300
2,250
2,200
2,150
2,100
2,050
2,000
1,950
1,900
2,498
2,447
2,440
2,388
2,240
2,339
2,490
July
August
September
October
November
December
January
February
FY2023
FY2024
FY2025
16,384
16,088
16,842
YTD FY23
YTD FY24
YTD FY25

Average Discharges per day

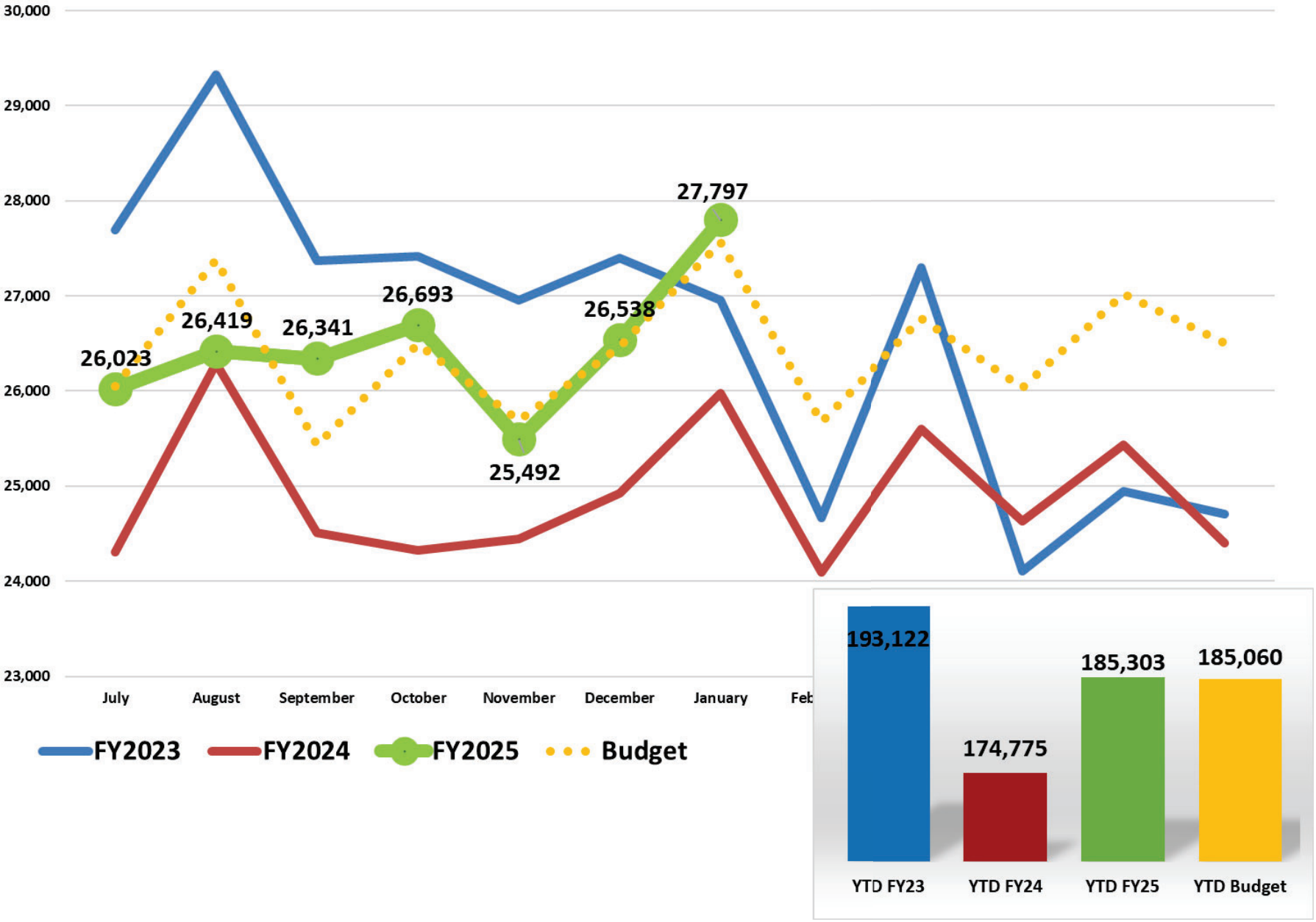


277/368

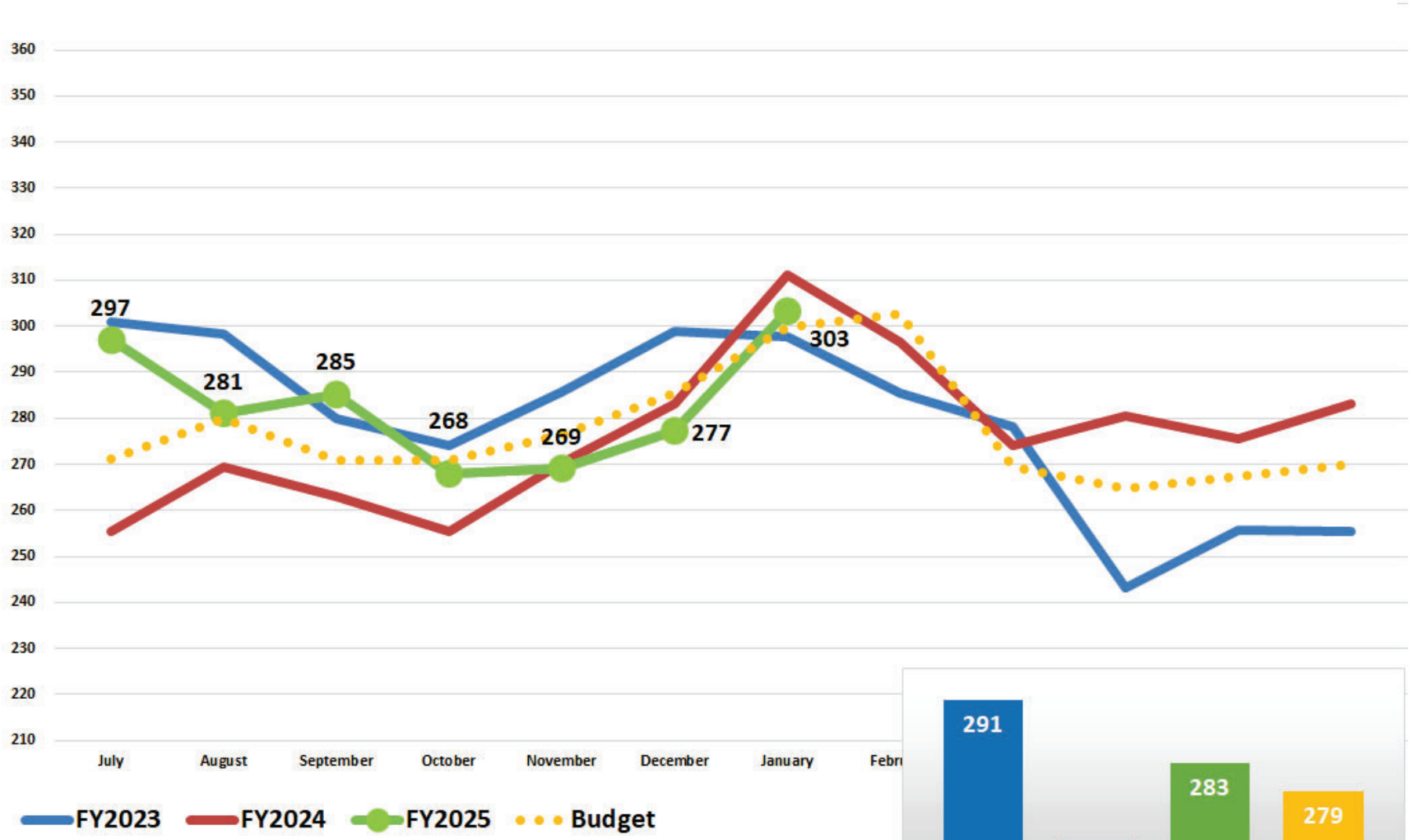
Observation Days



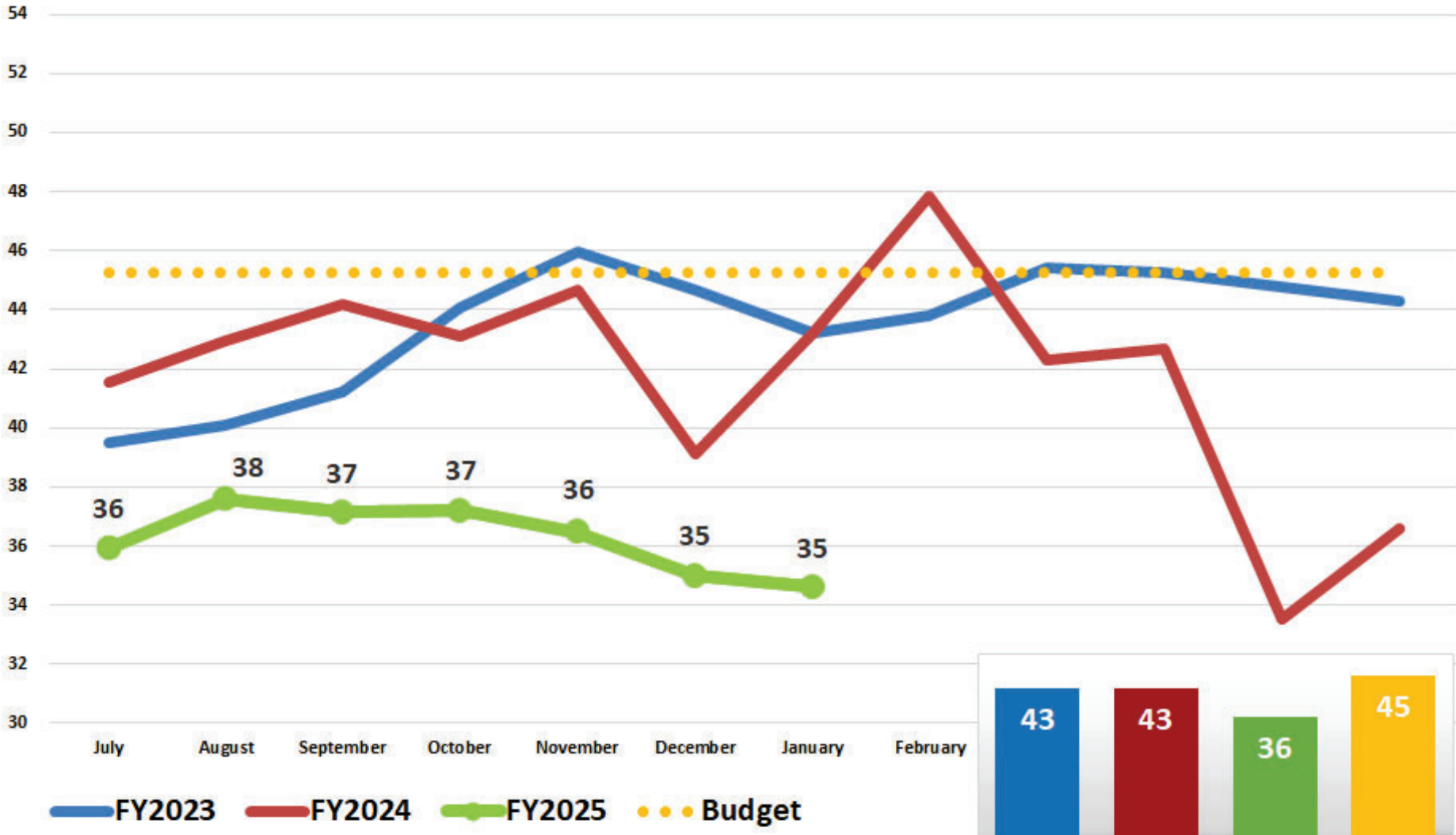
Adjusted Patient Days



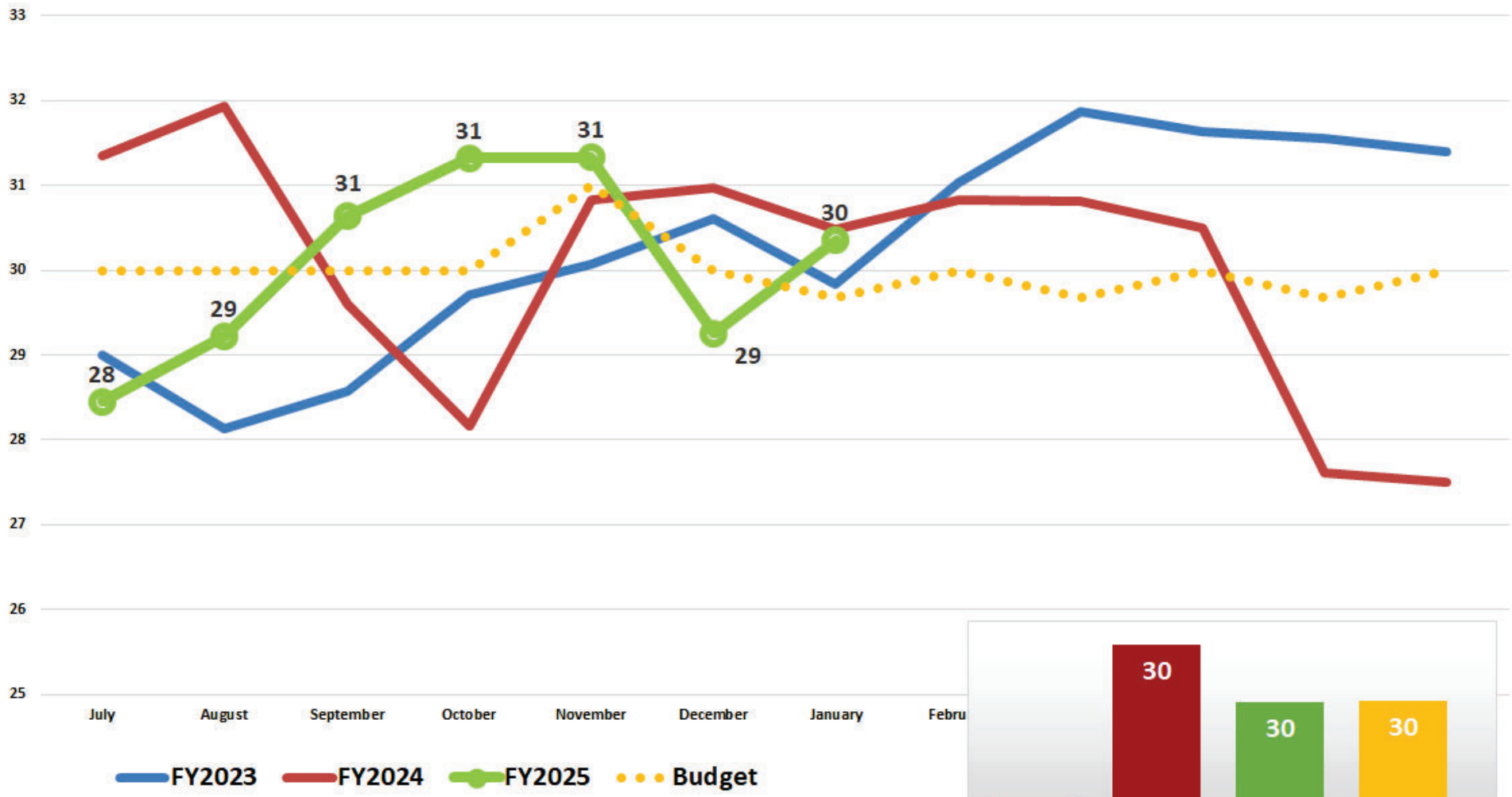
Medical Center (Avg Patients Per Day)



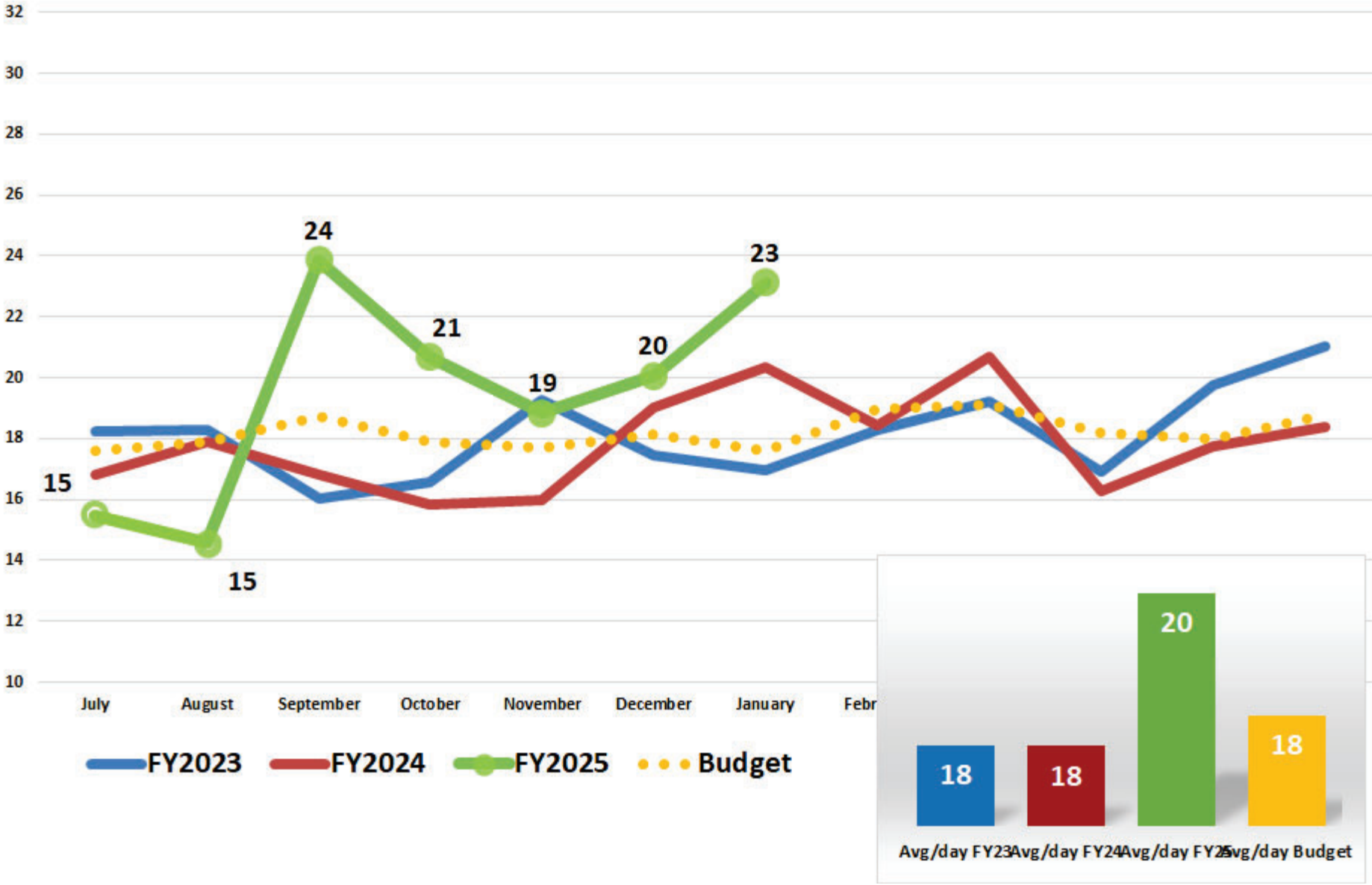
Acute I/P Psych (Avg Patients Per Day)



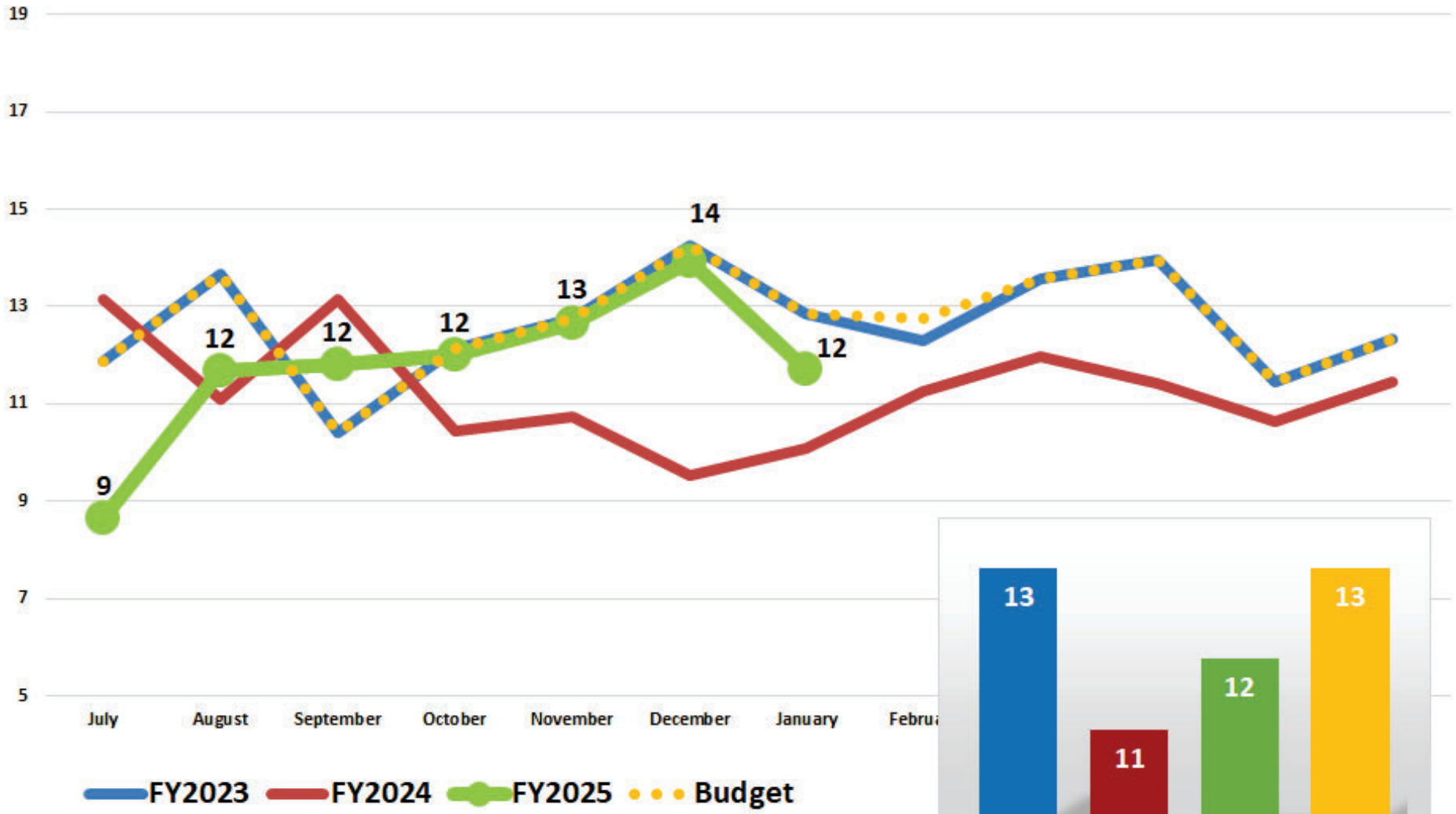
Sub-Acute - Avg Patients Per Day



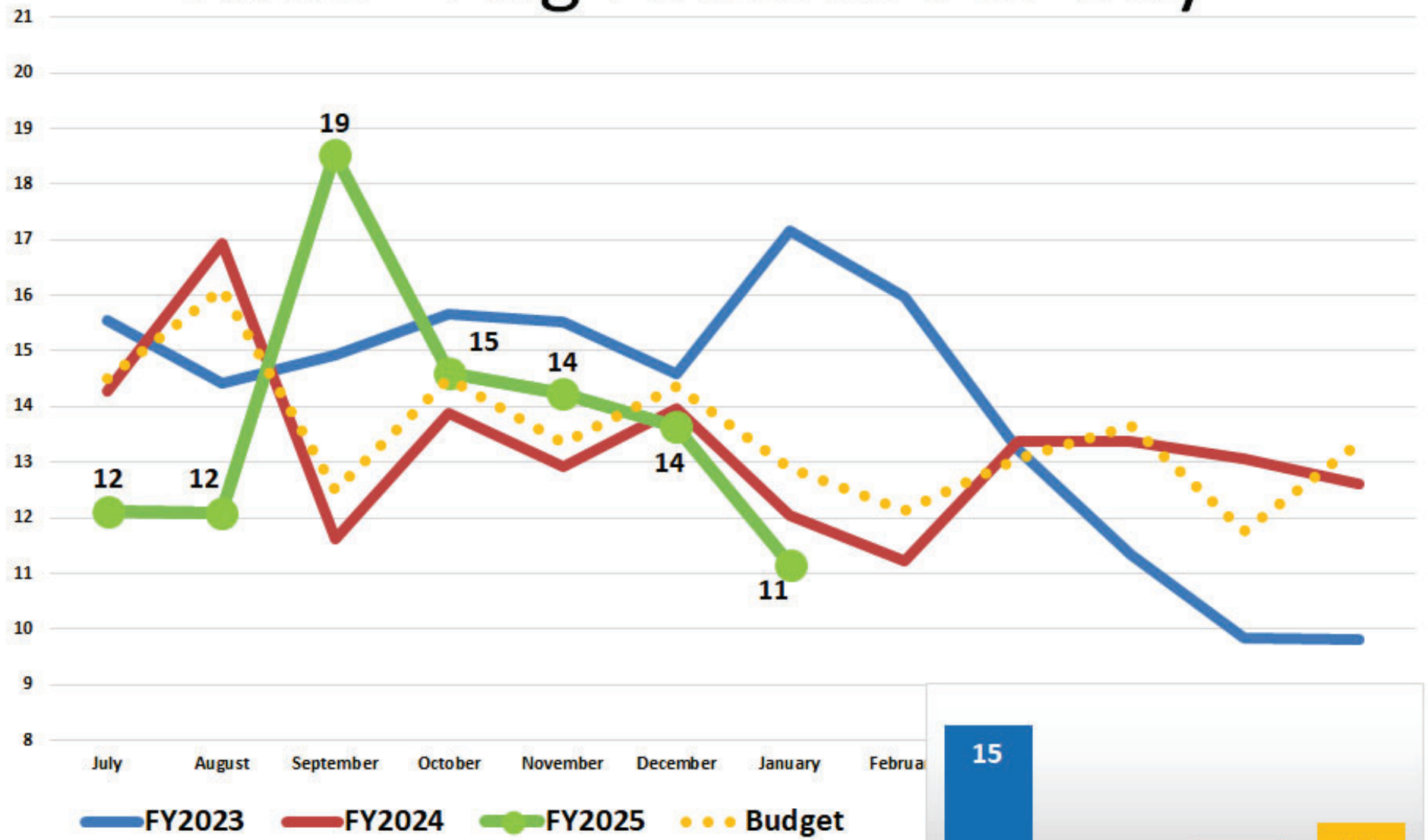
Rehabilitation Hospital - Avg Patients Per Day

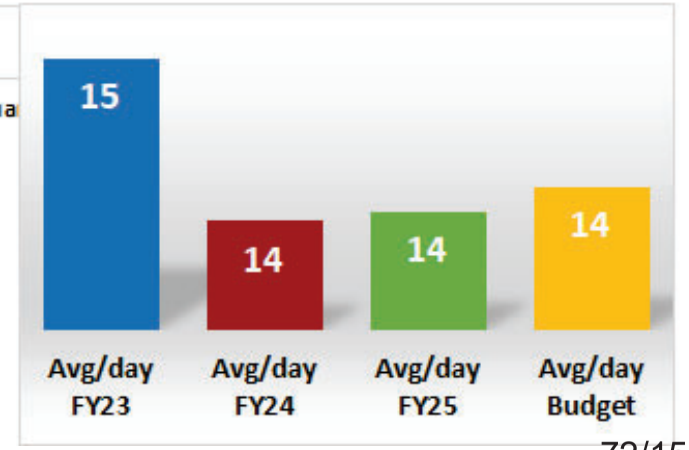


TCS Ortho - Avg Patients Per Day

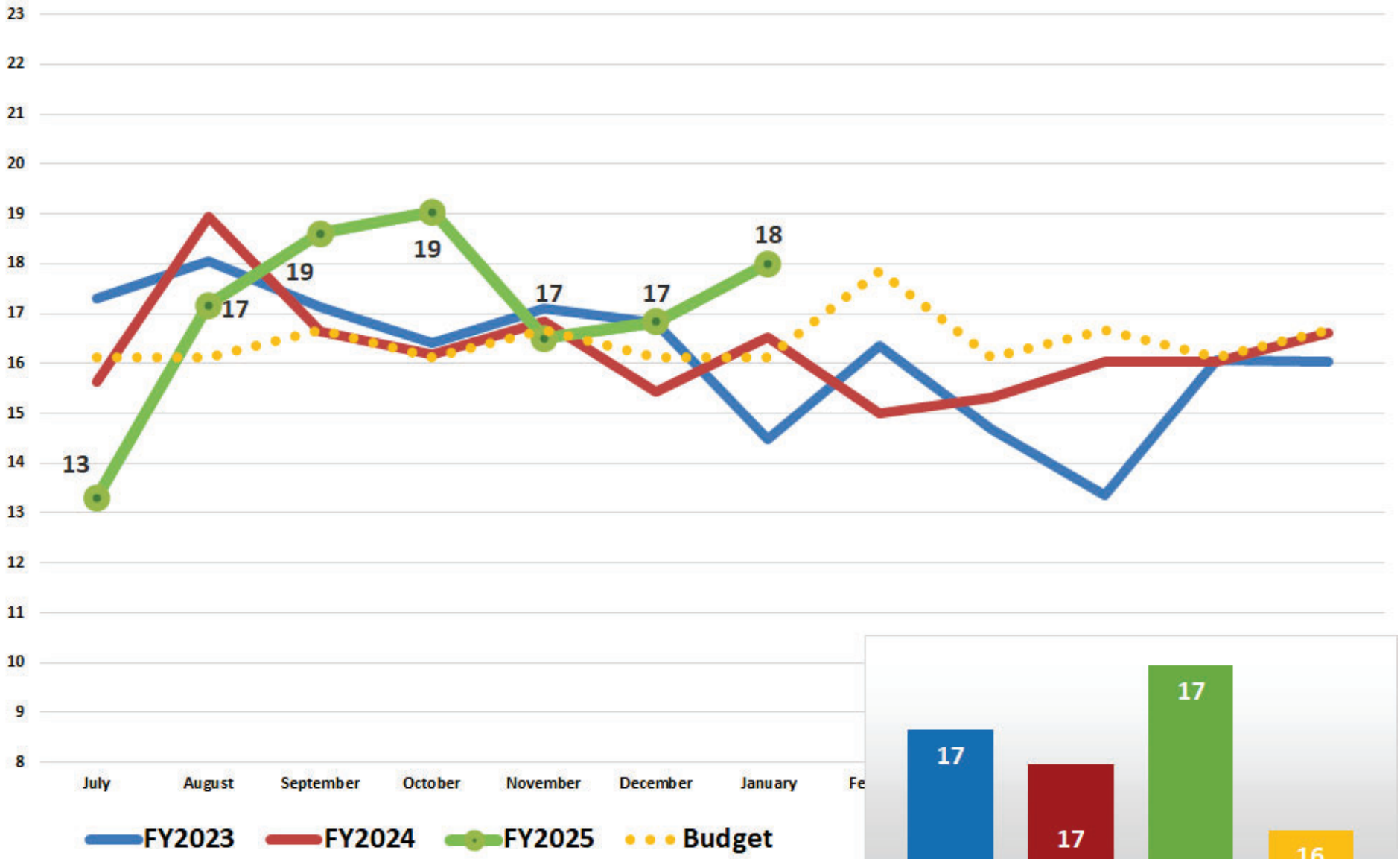


NICU - Avg Patients Per Day

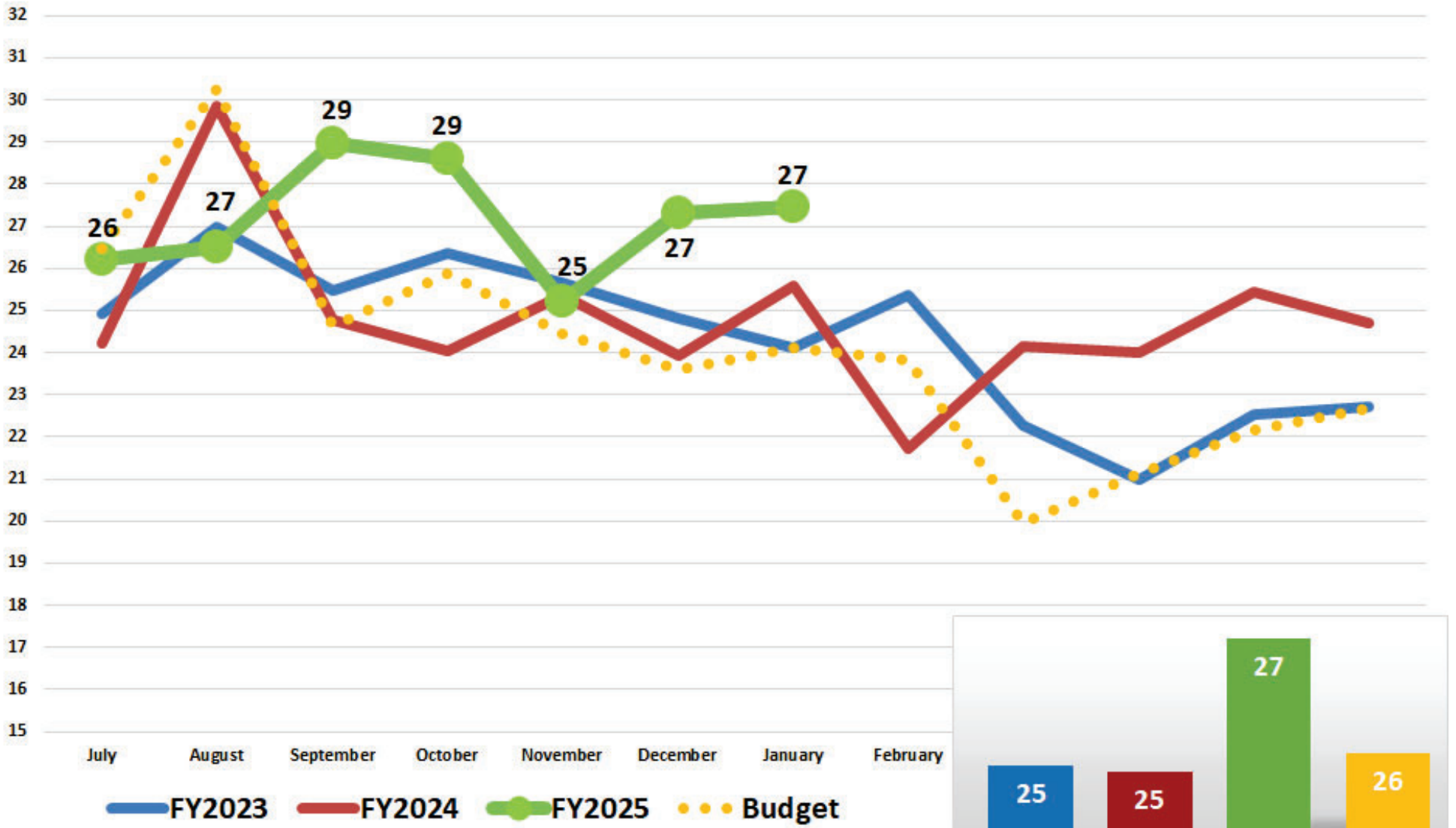




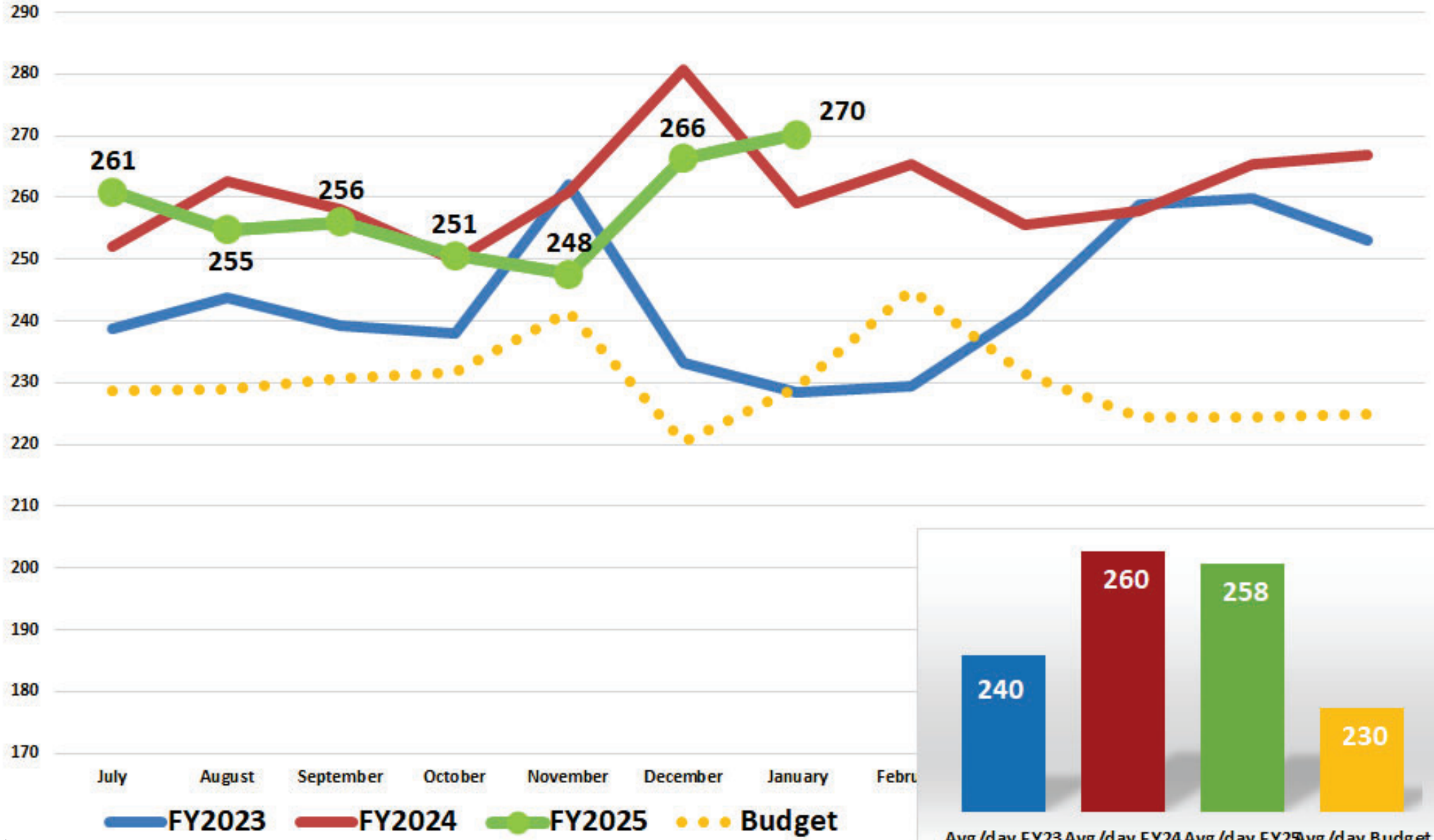
Nursery - Avg Patients Per Day



Obstetrics - Avg Patients Per Day

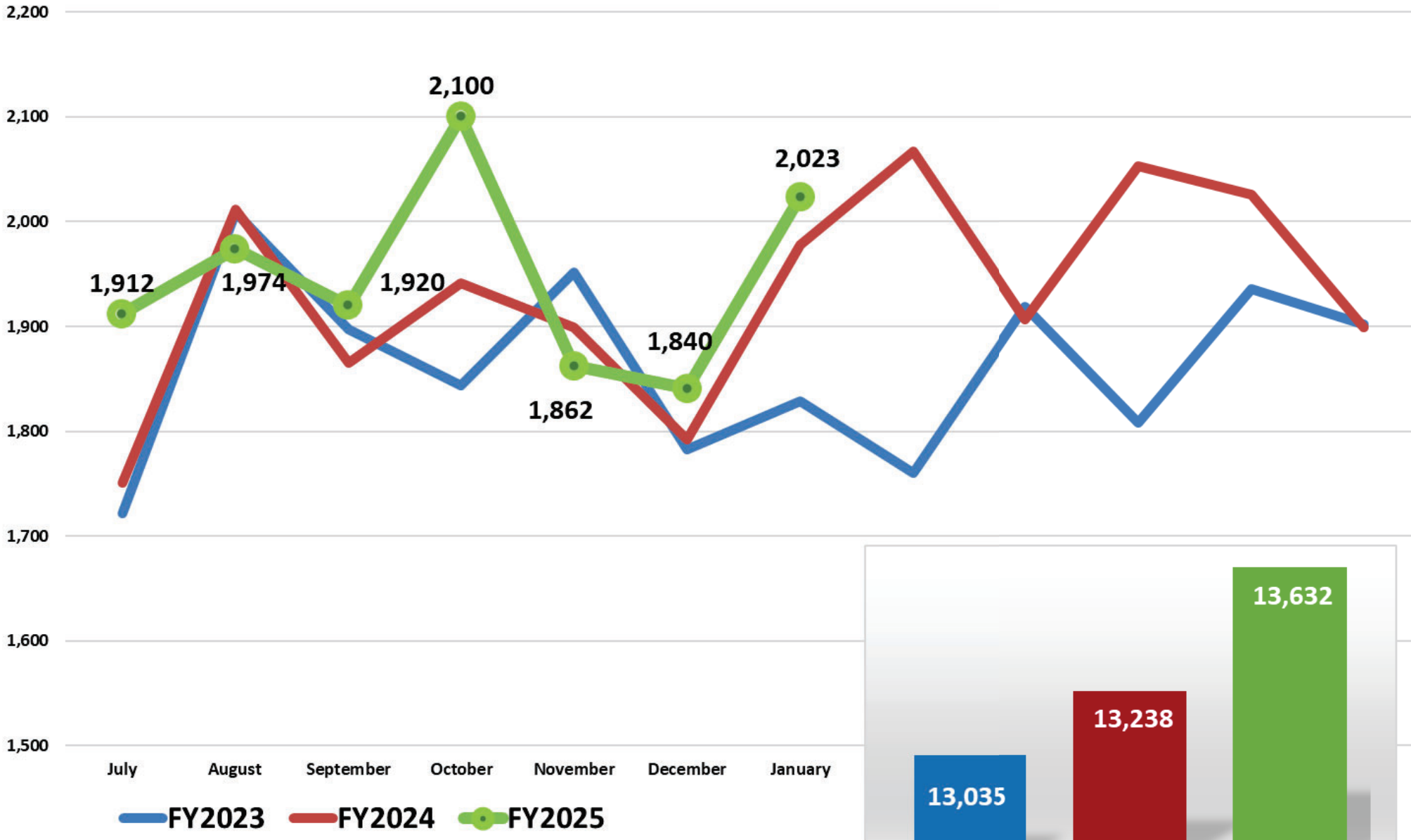


ED - Avg Treated Per Day

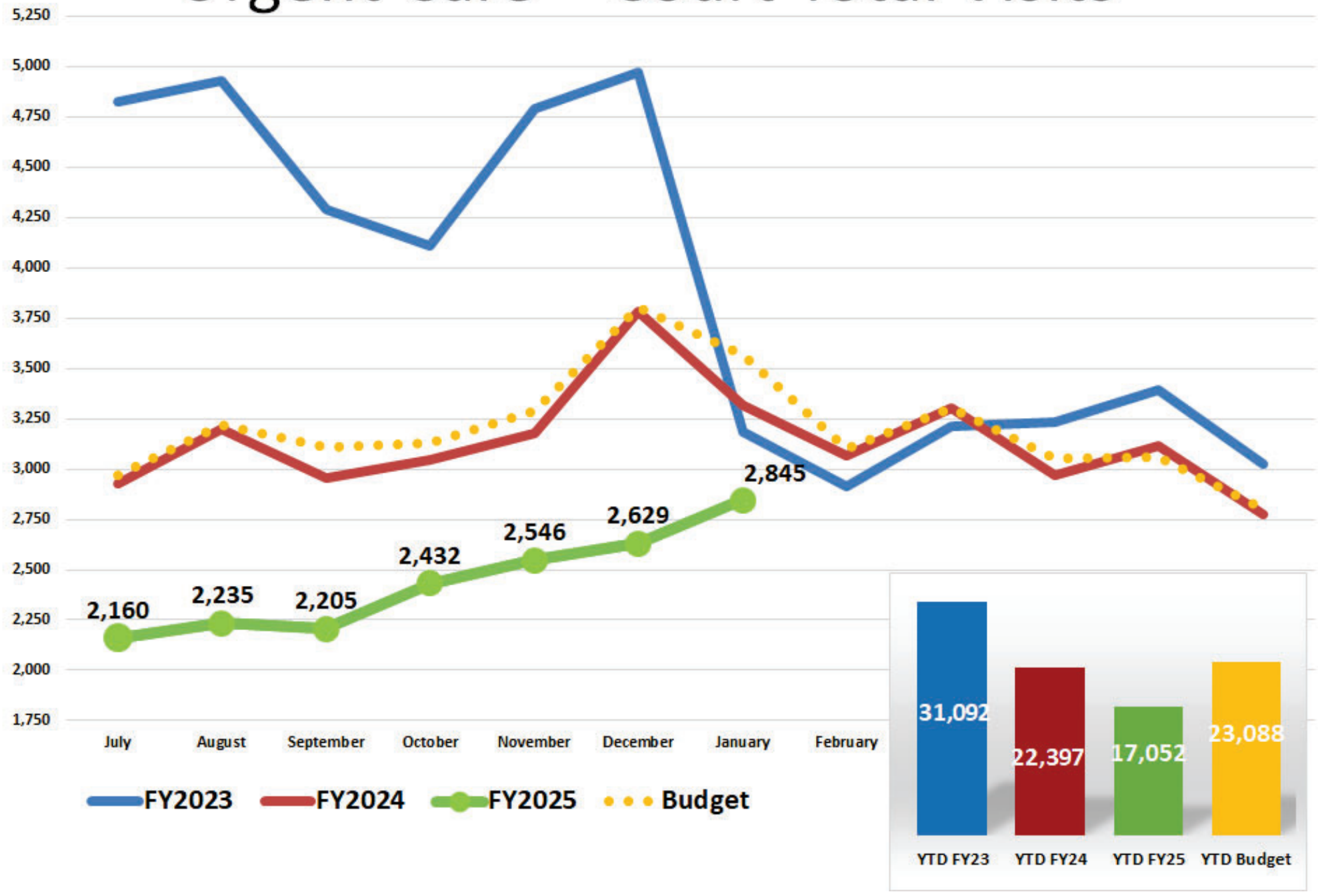


Outpatient Registrations

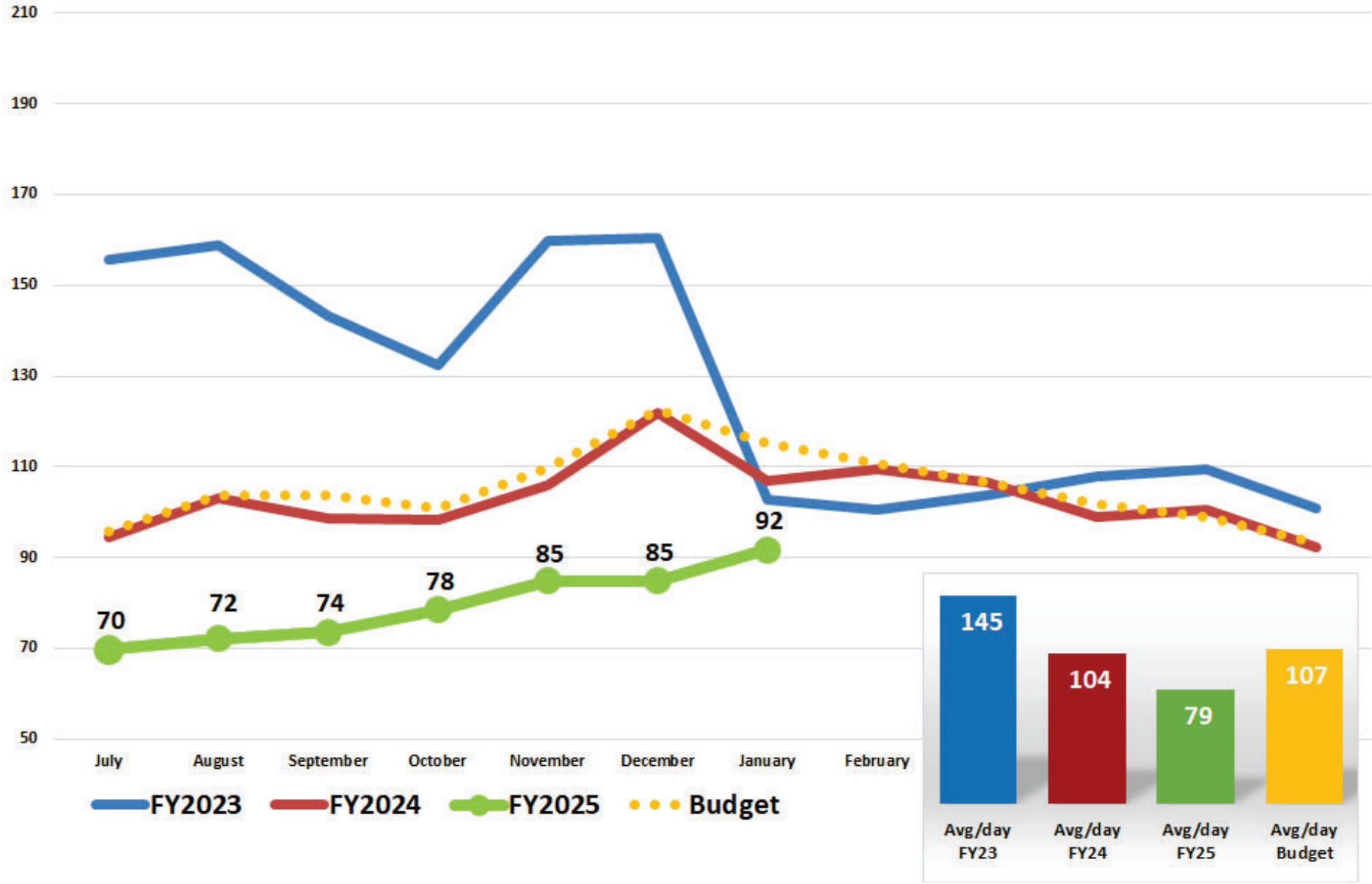
Outpatient Registrations Per Day



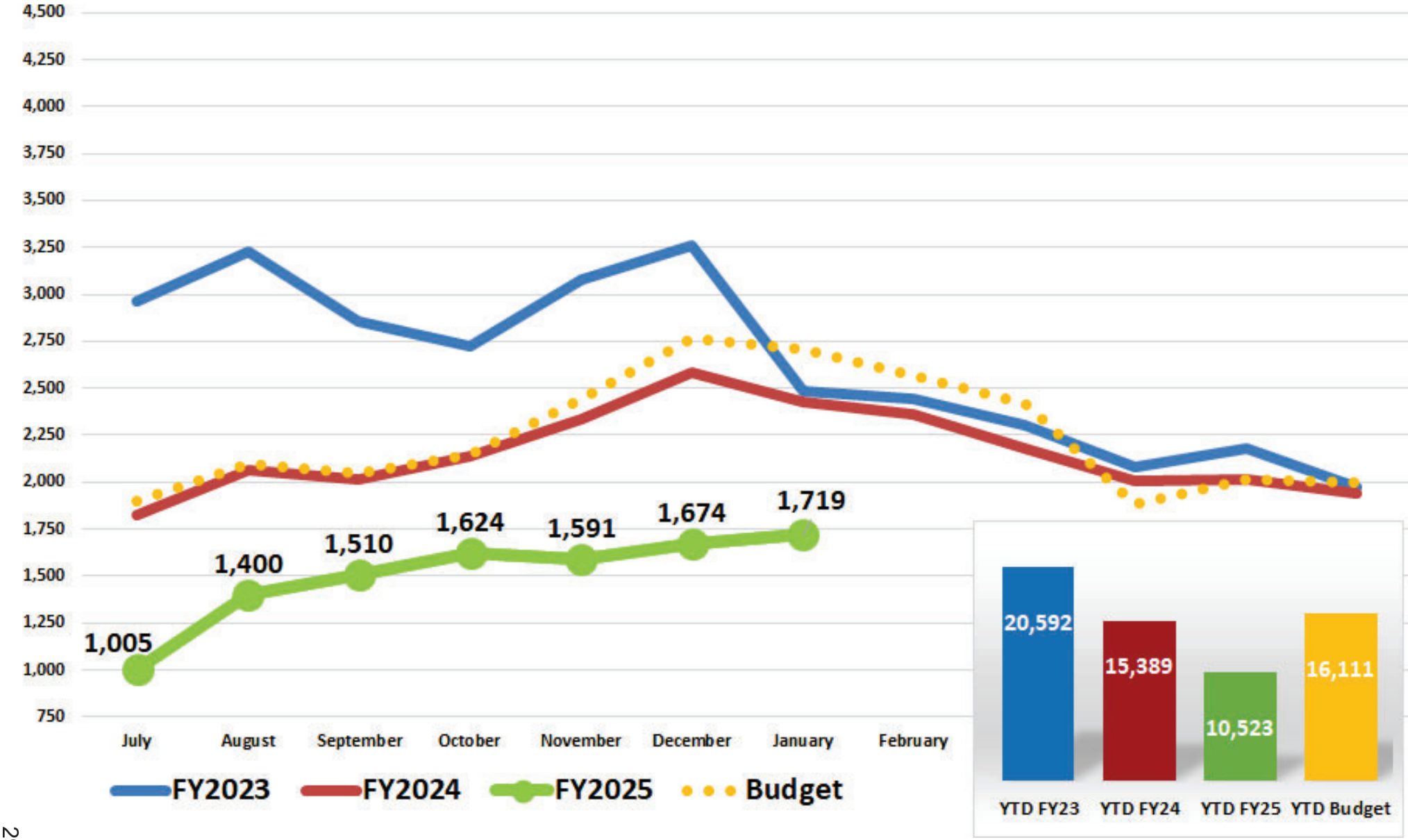
Urgent Care – Court Total Visits



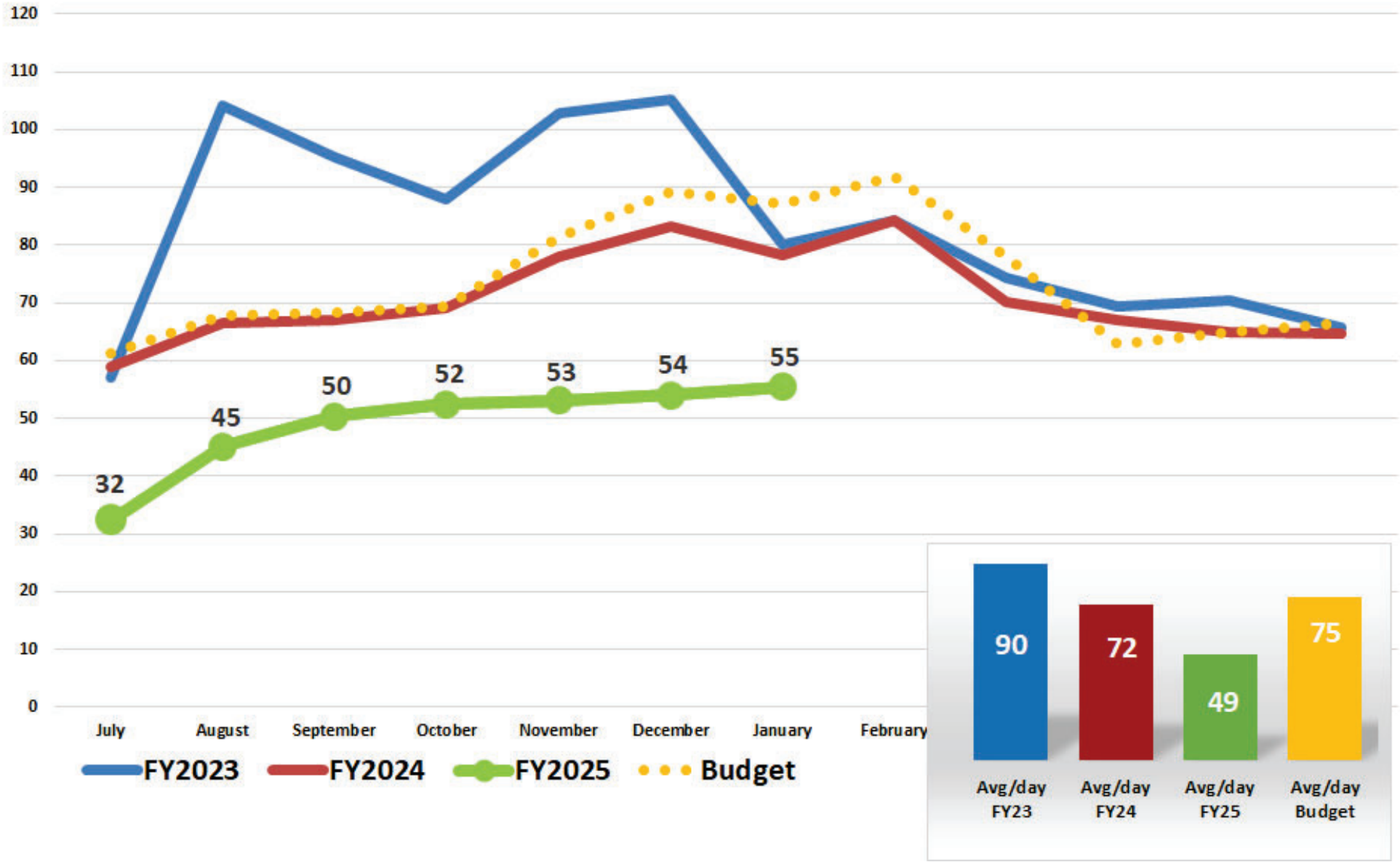
Urgent Care – Court Avg Visits Per Day



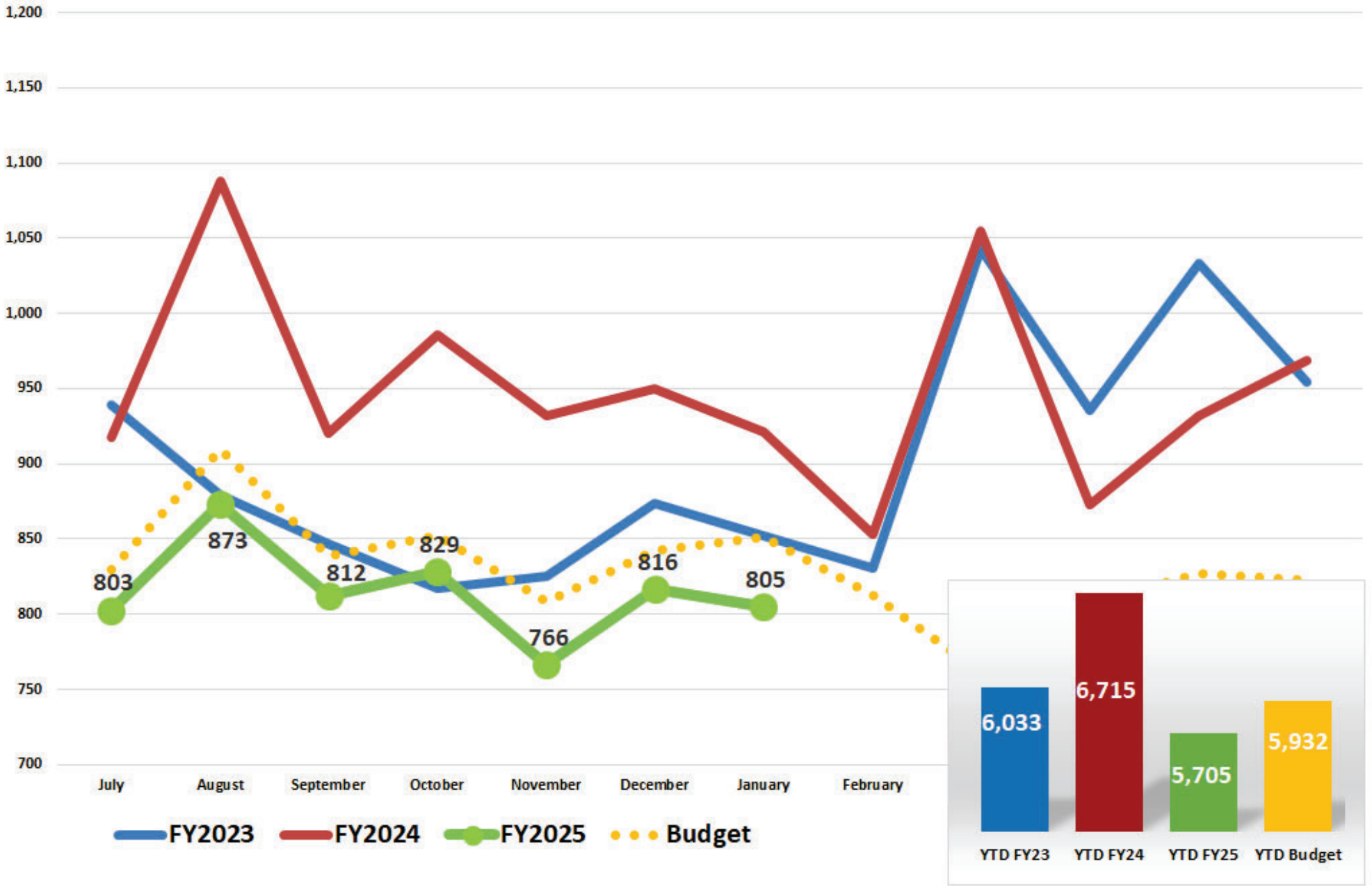
Urgent Care – Demaree Total Visits



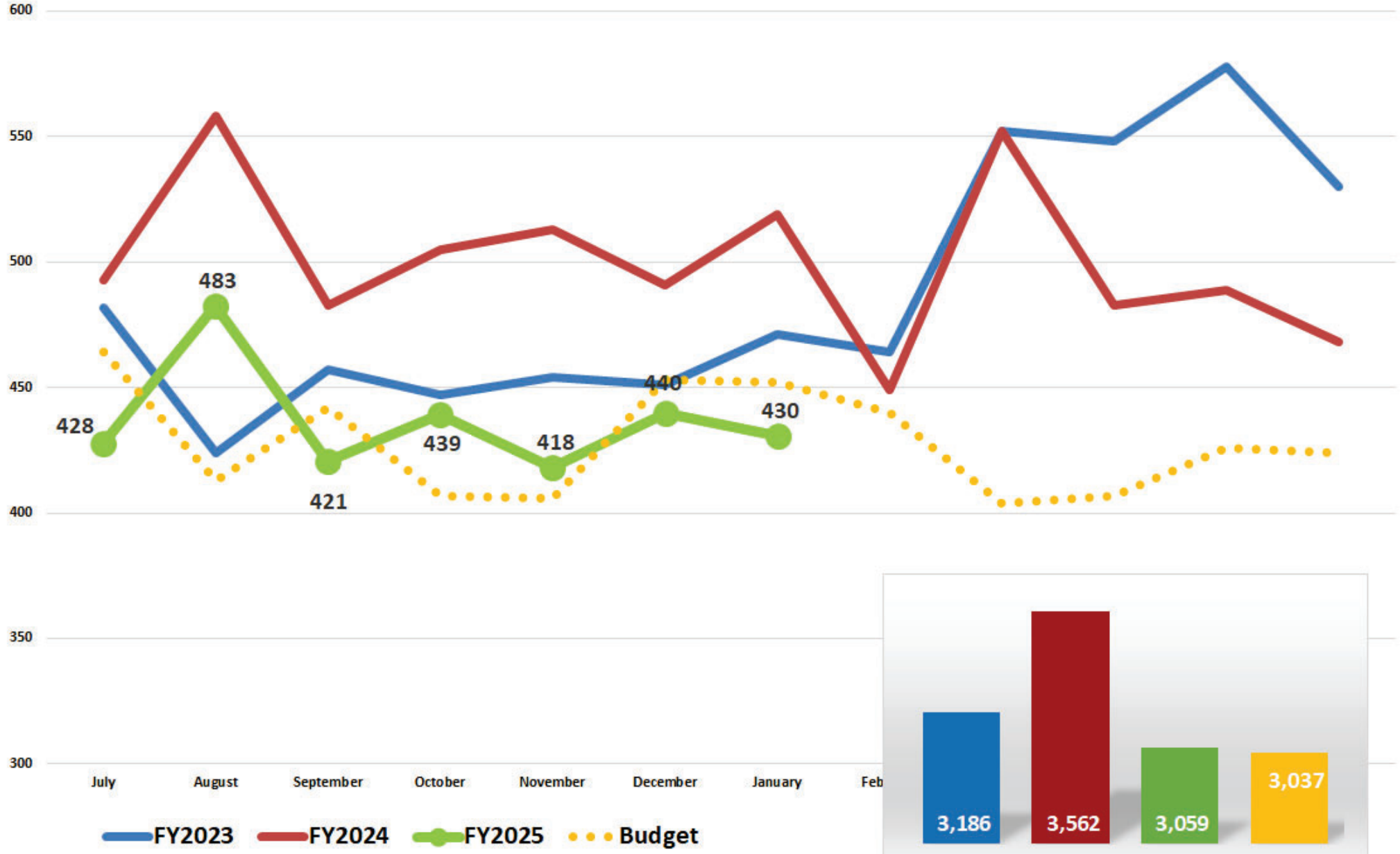
Urgent Care – Demaree Avg Visits Per Day



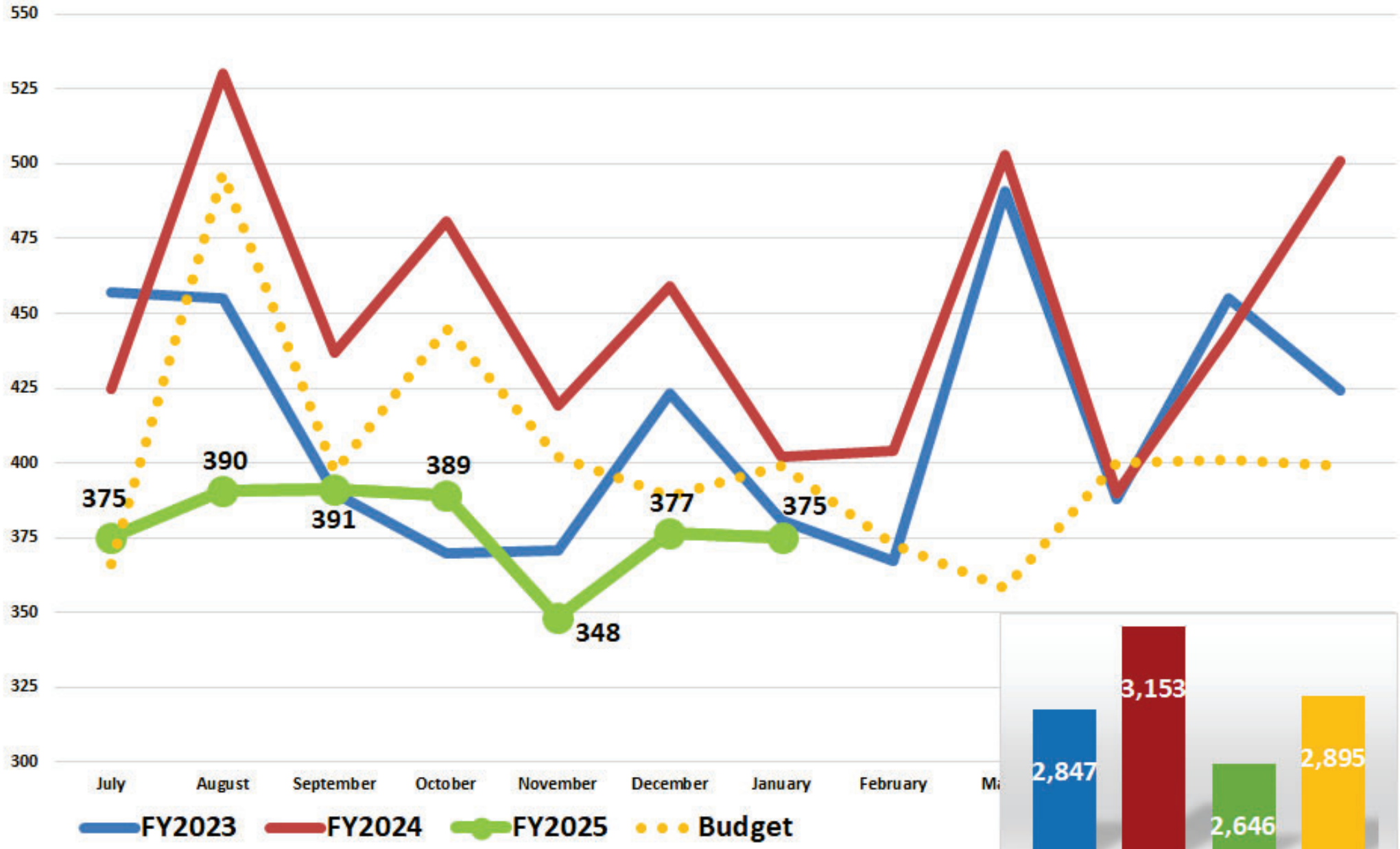
Surgery (IP & OP) – 100 Min Units



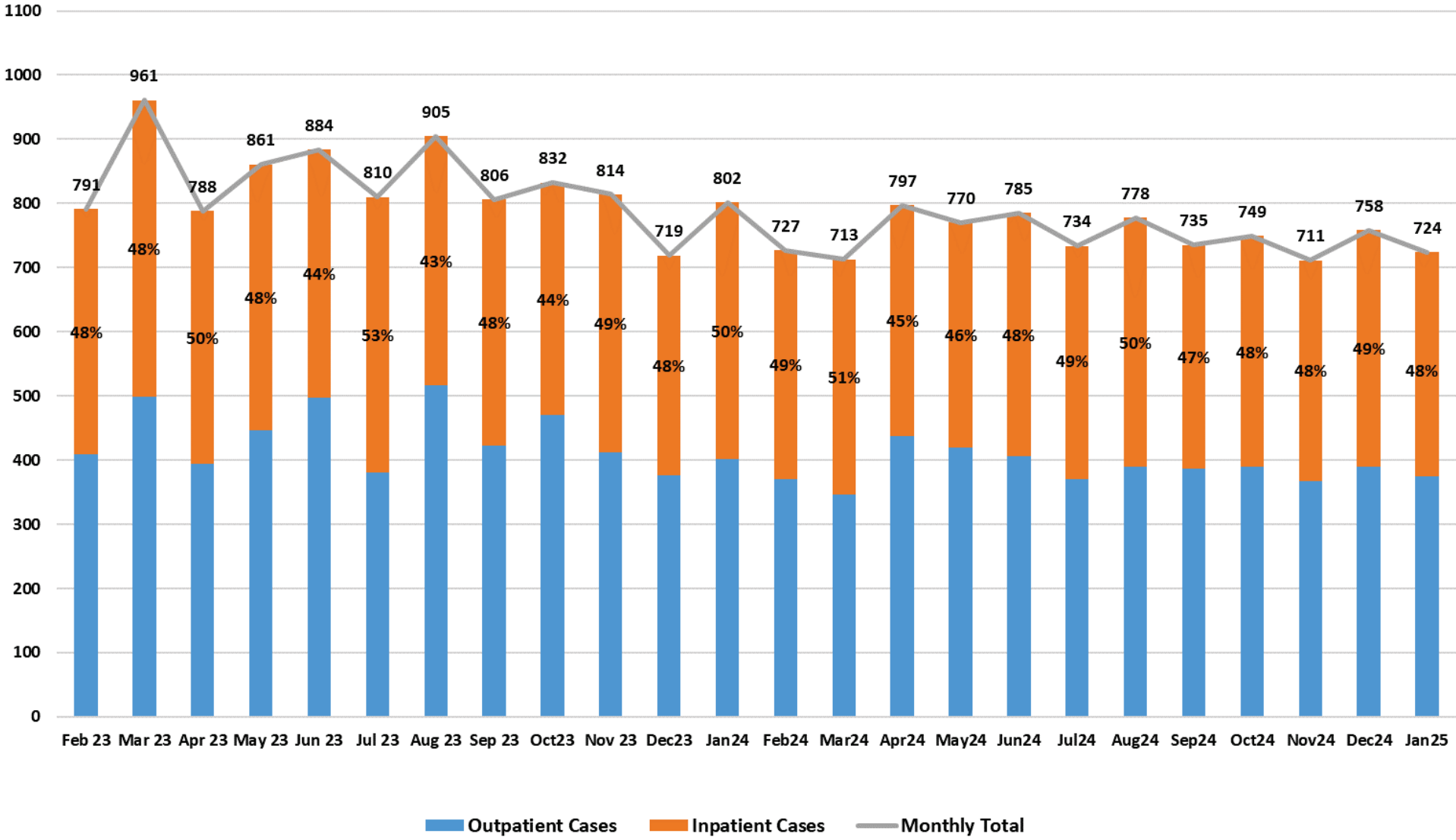
Surgery (IP Only) - 100 Min Unit



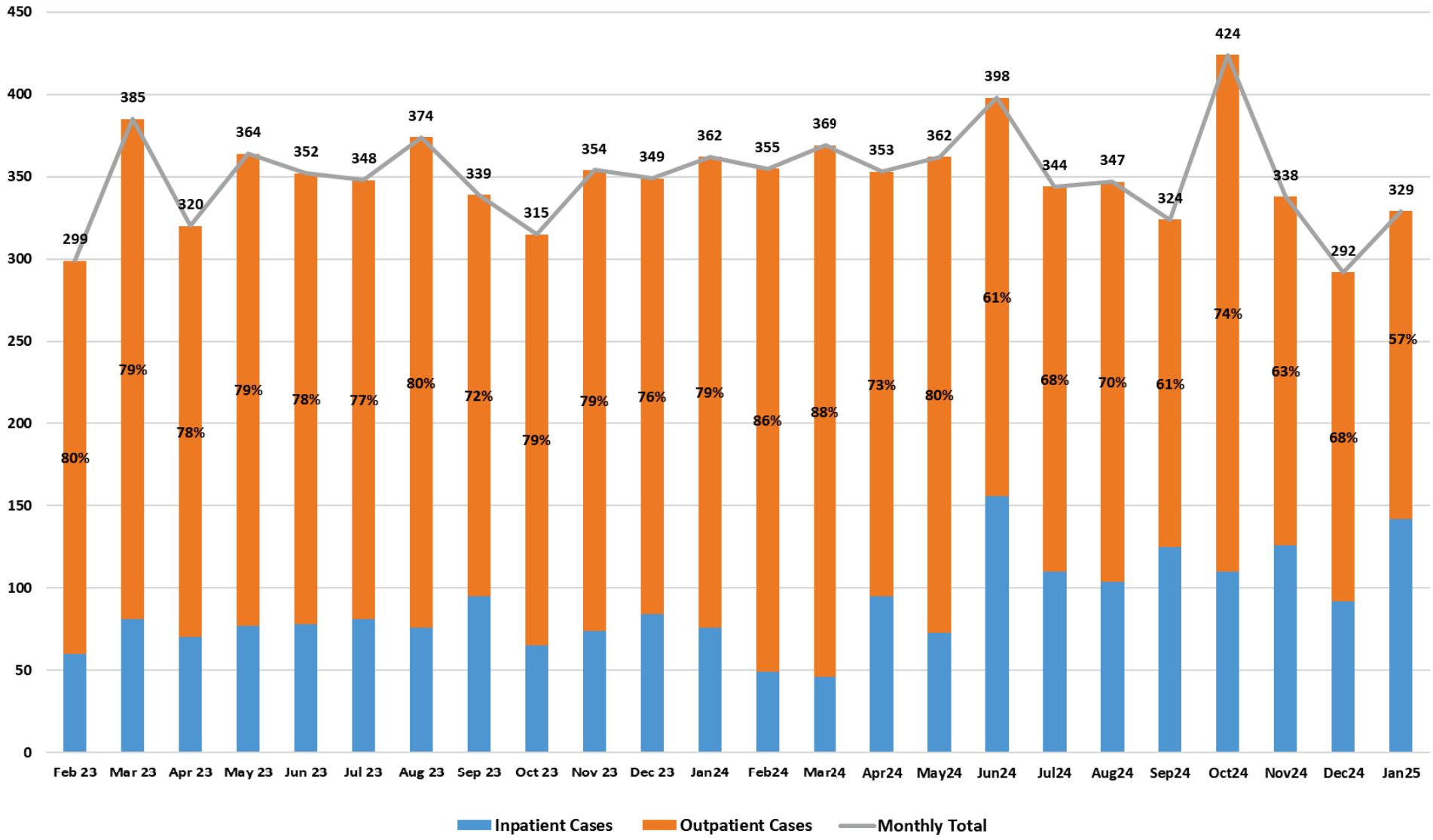
Surgery (OP Only) - 100 Min Units



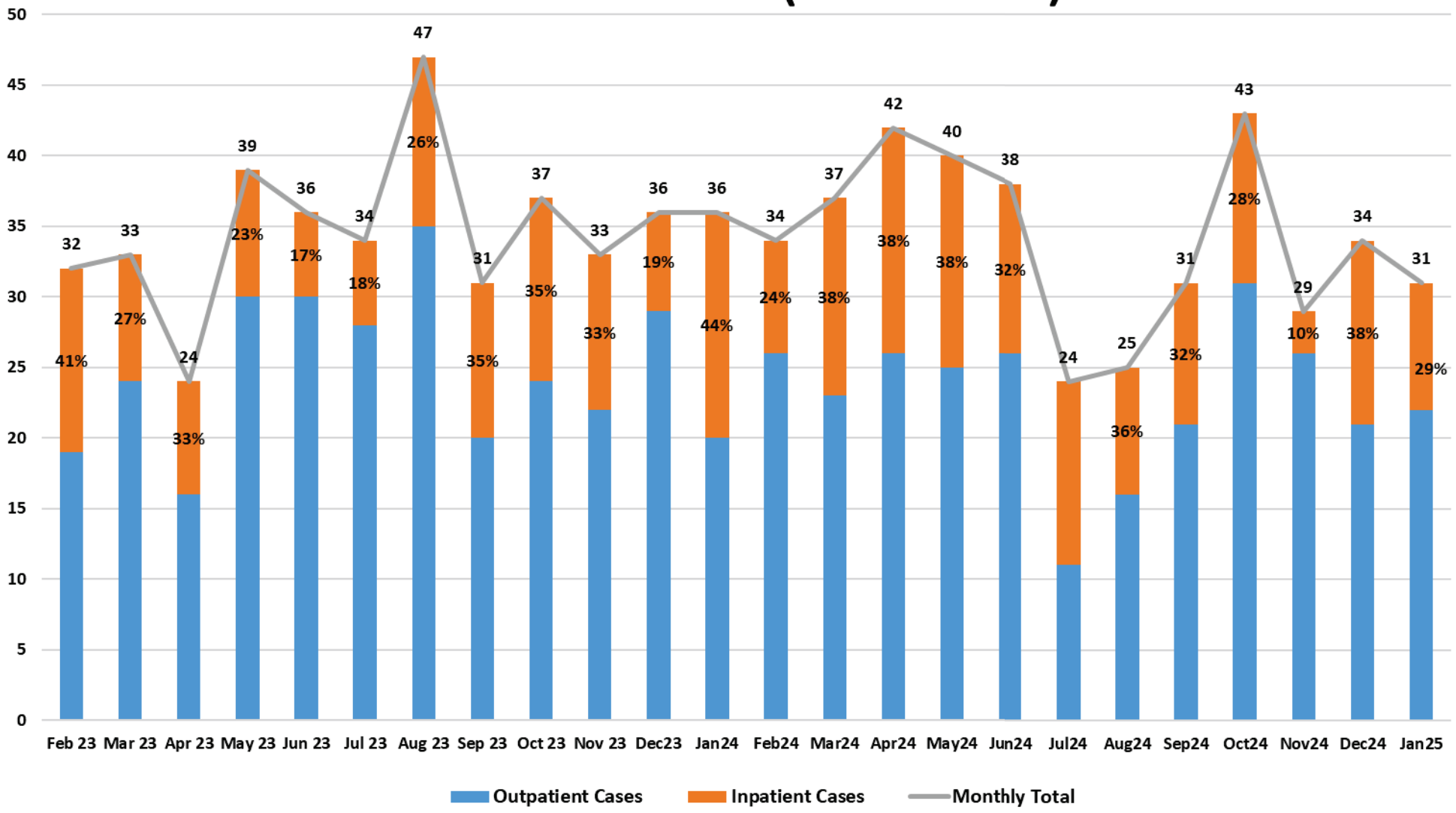
Surgery Cases (IP & OP)



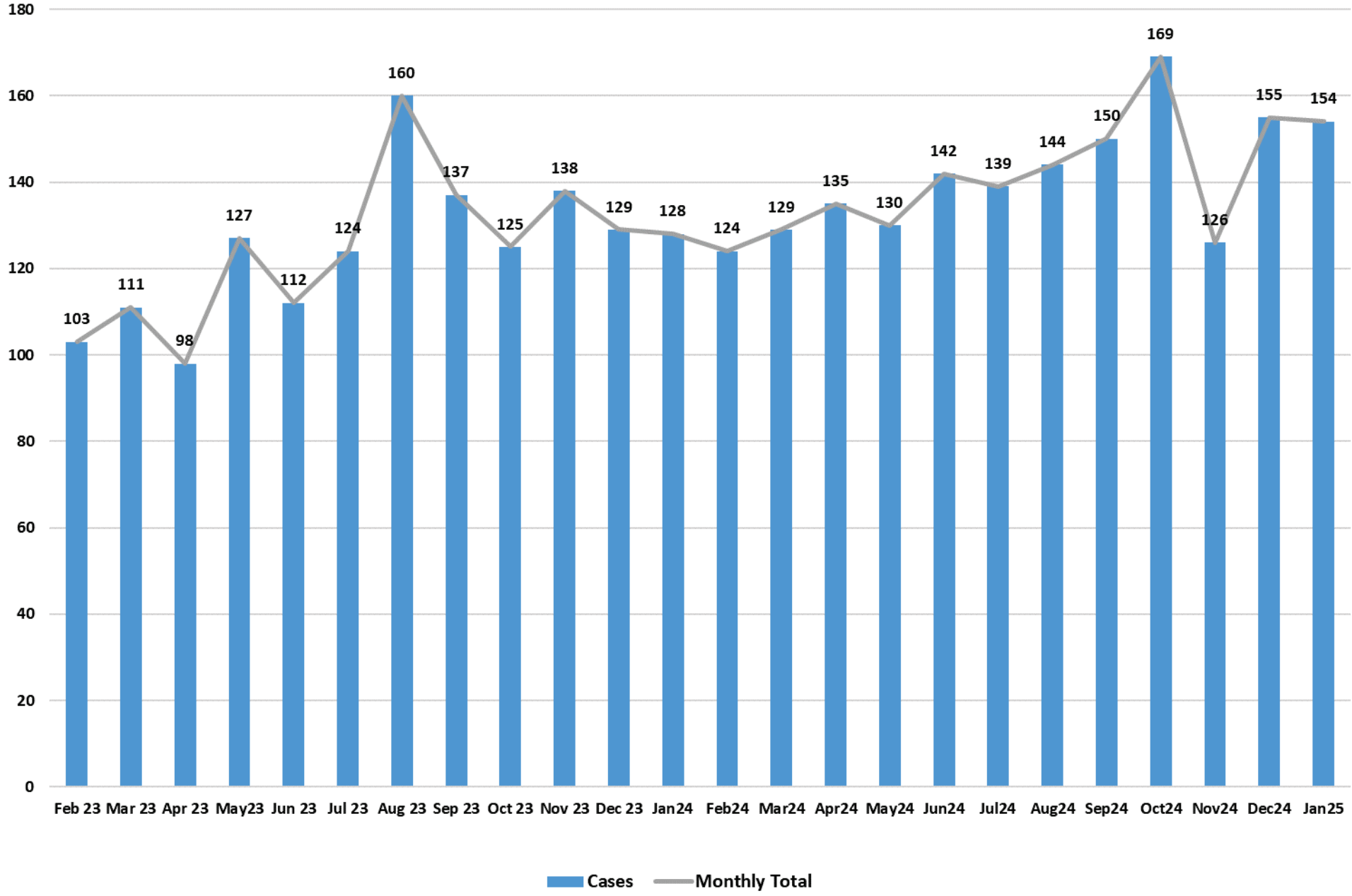
Endo Cases (Suites A & B and OR)



Robotic Cases (IP & OP)



OB Cases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Feb 23
Mar 23
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Jun 23
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Nov 23
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Jan24
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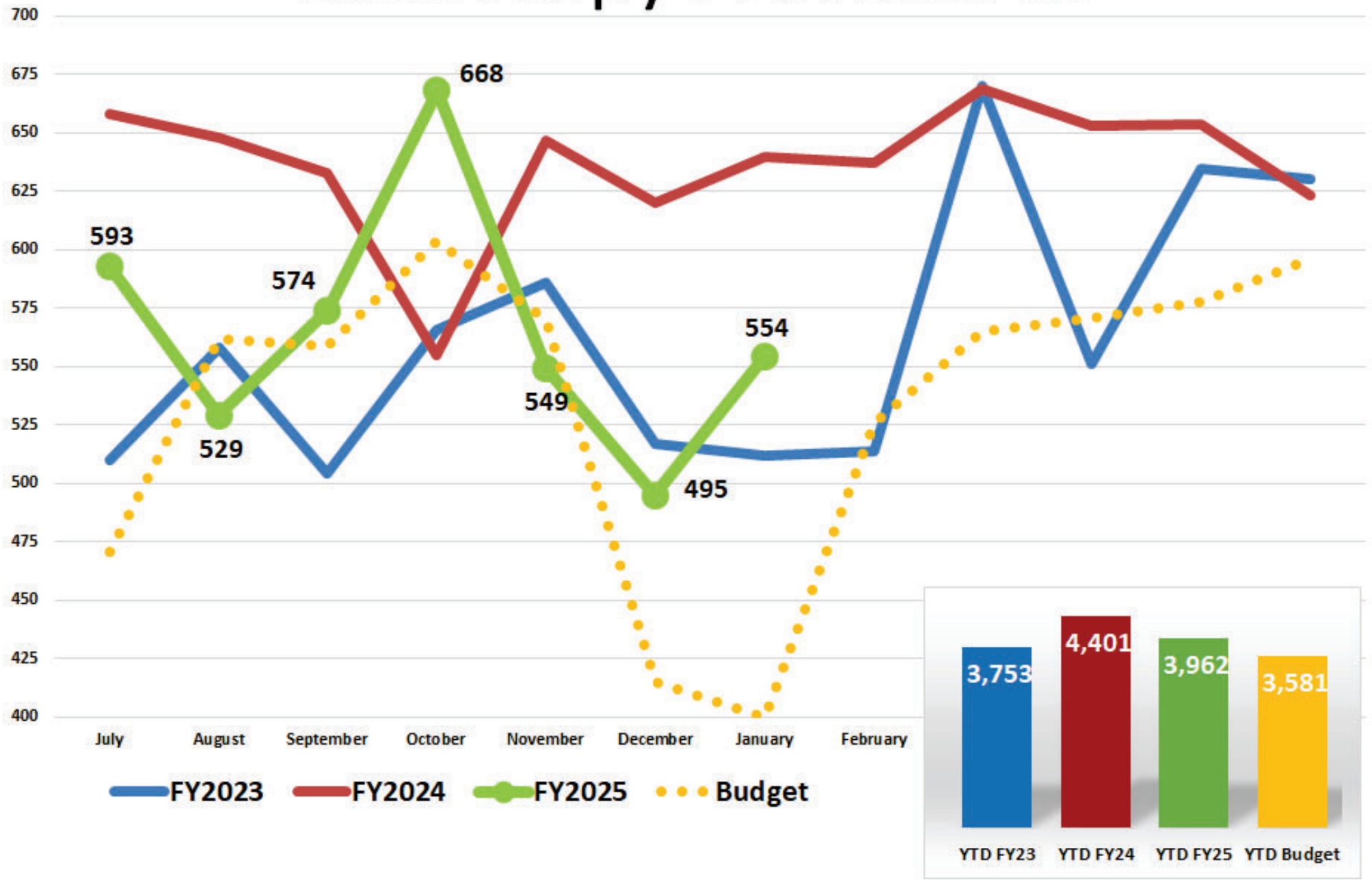
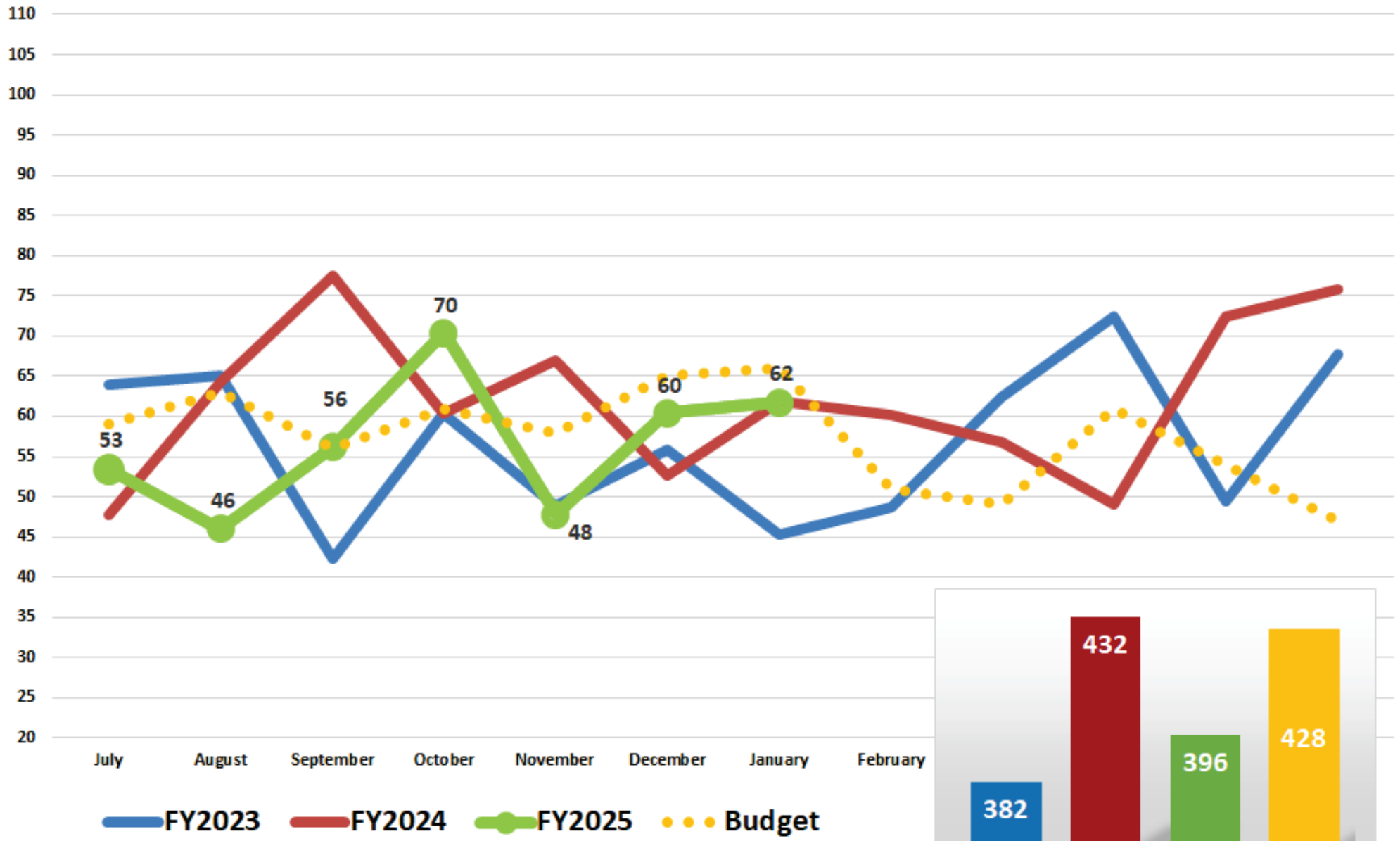
Dec24
Jan25
Cases
Monthly Total

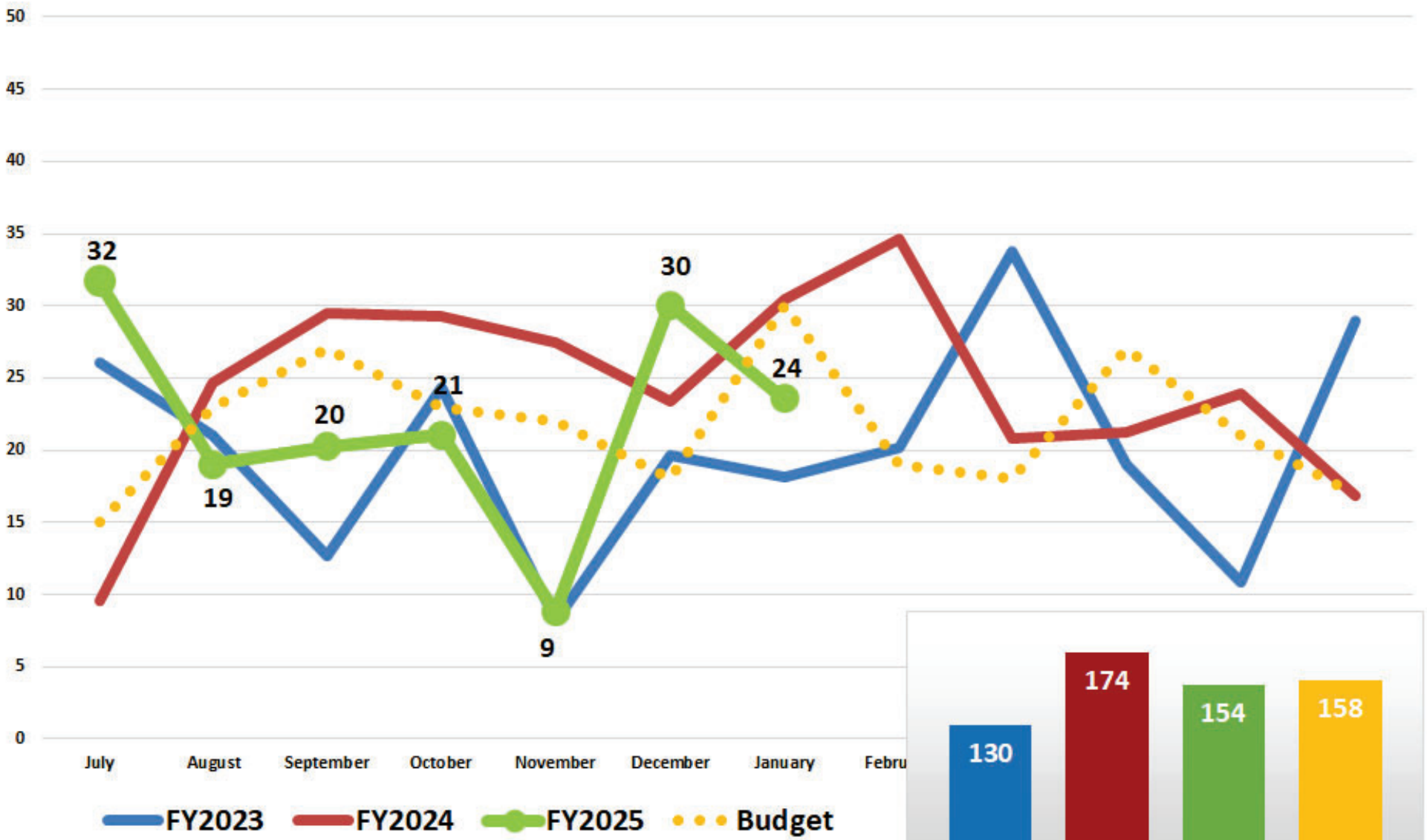
Endoscopy Procedures



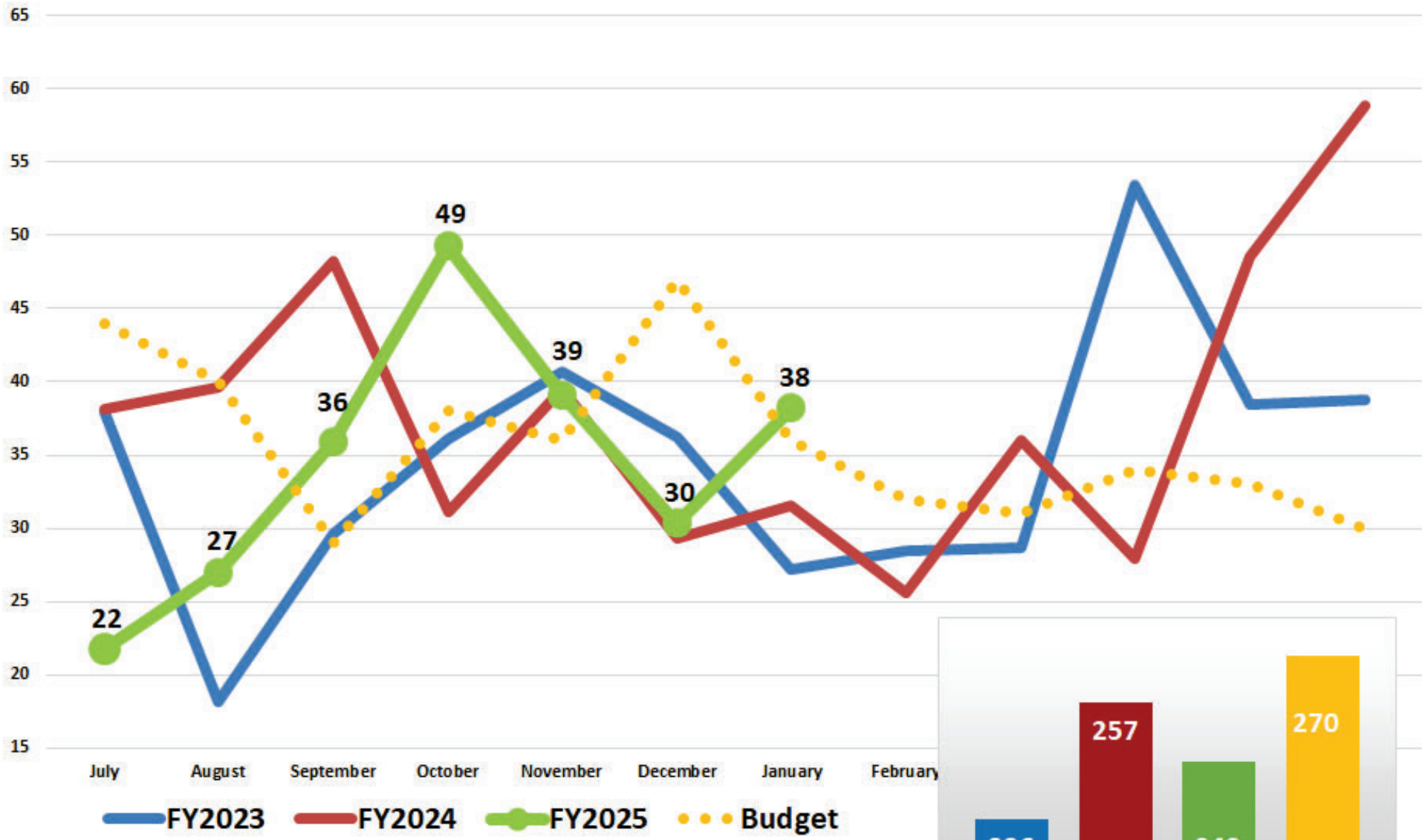
Robotic Surgery (IP & OP) - 100 Min Units



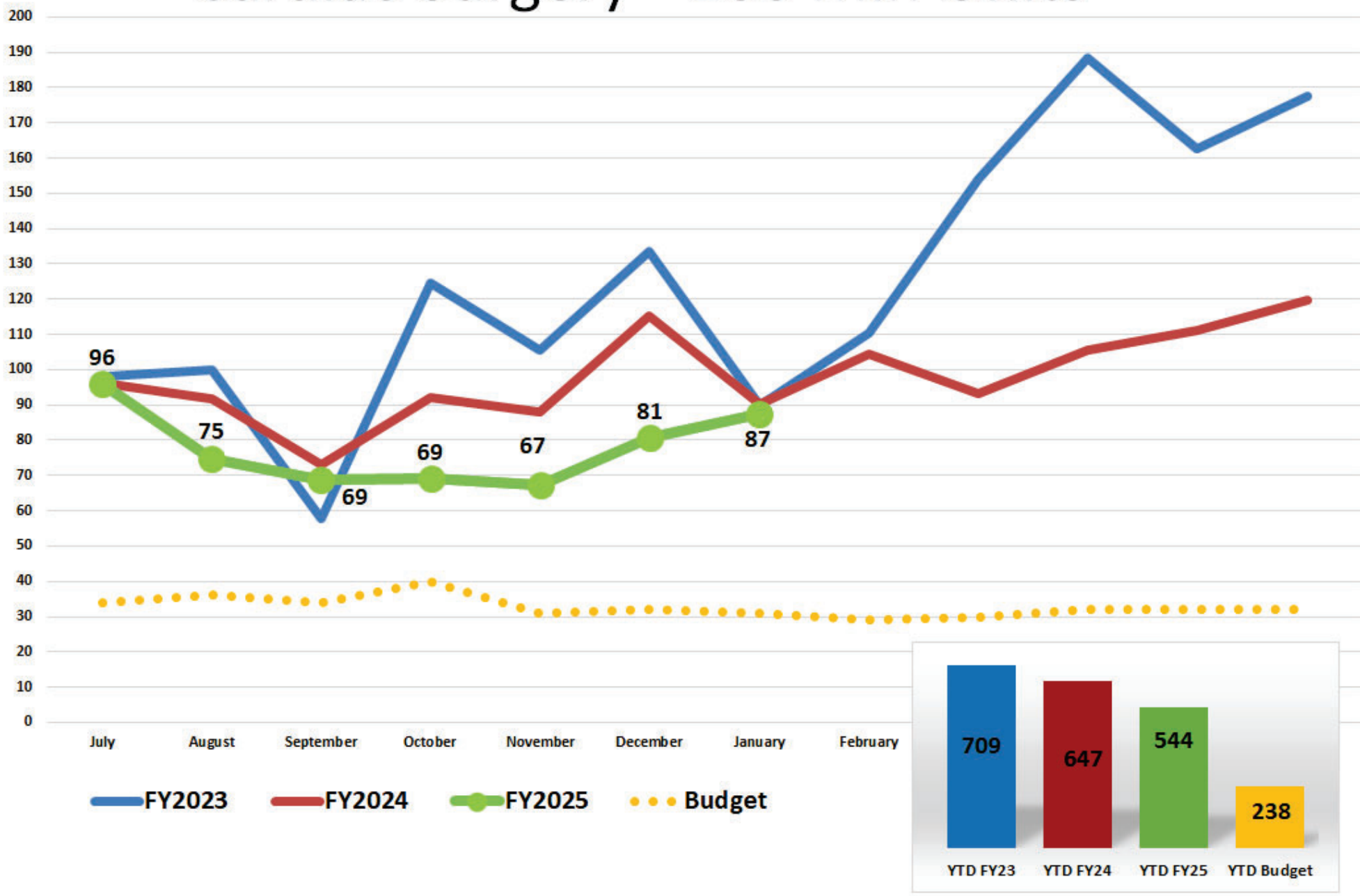
Robotic Surgery Minutes (IP Only)



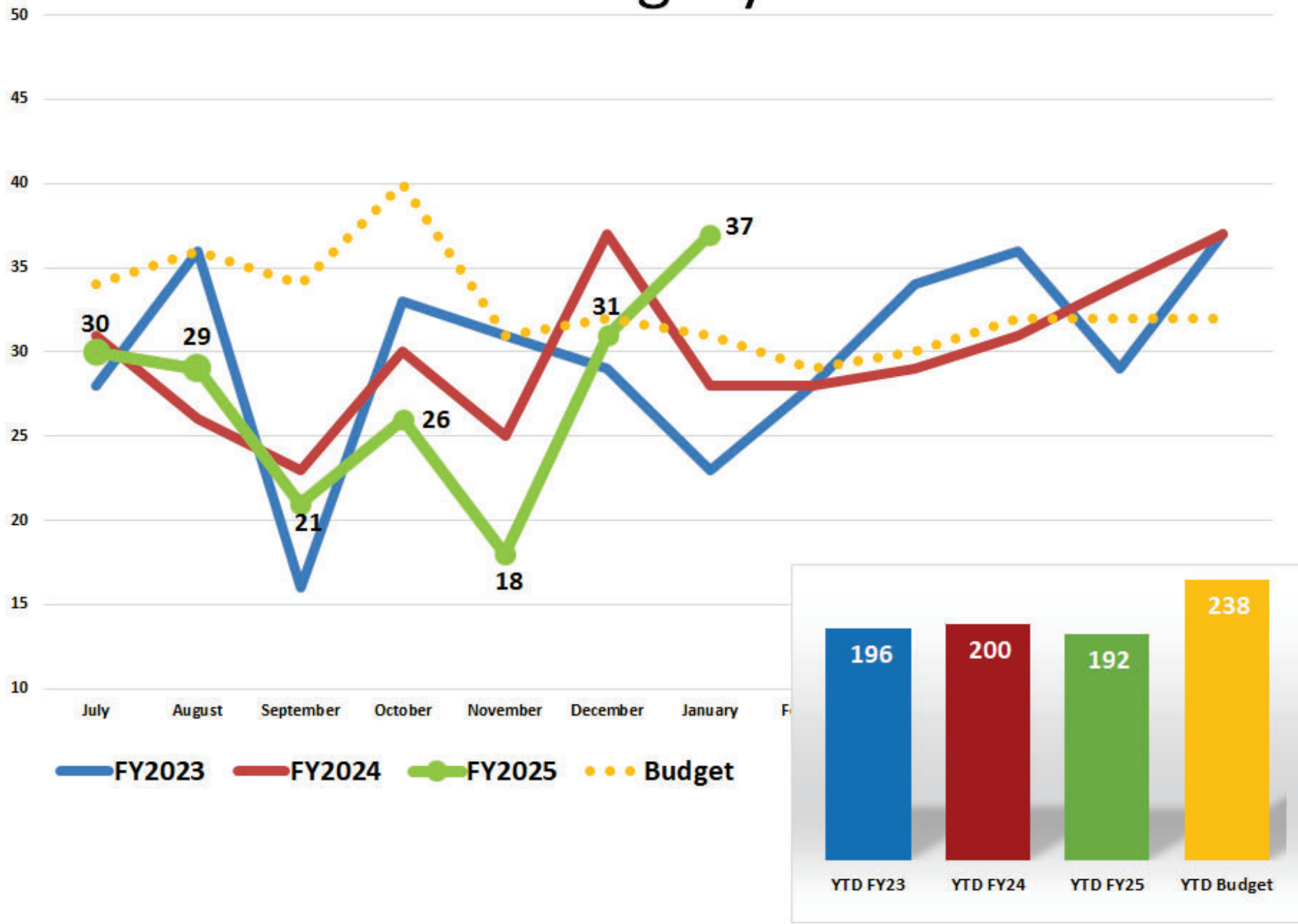
Robotic Surgery Minutes (OP Only)



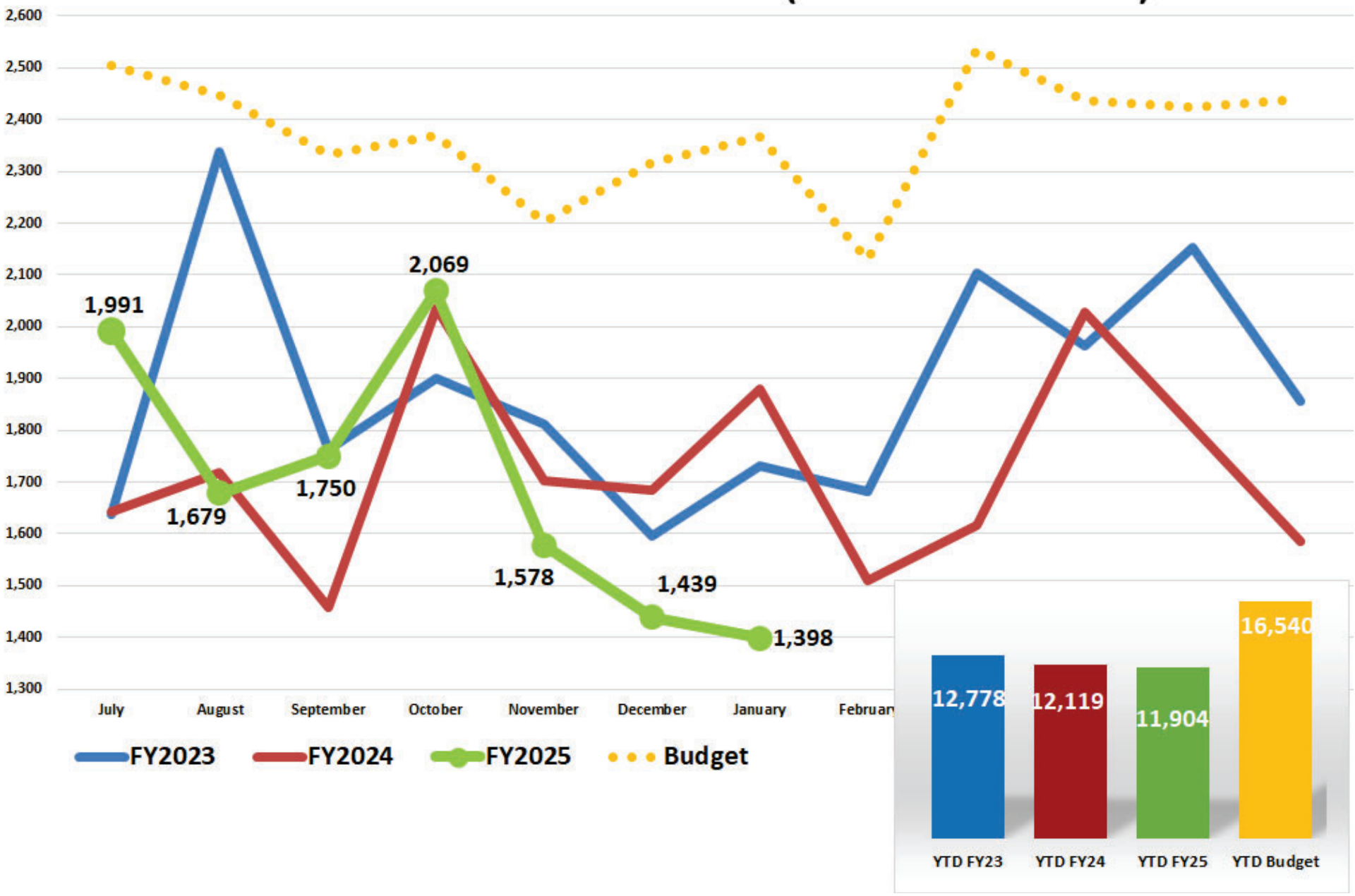
Cardiac Surgery - 100 Min Units



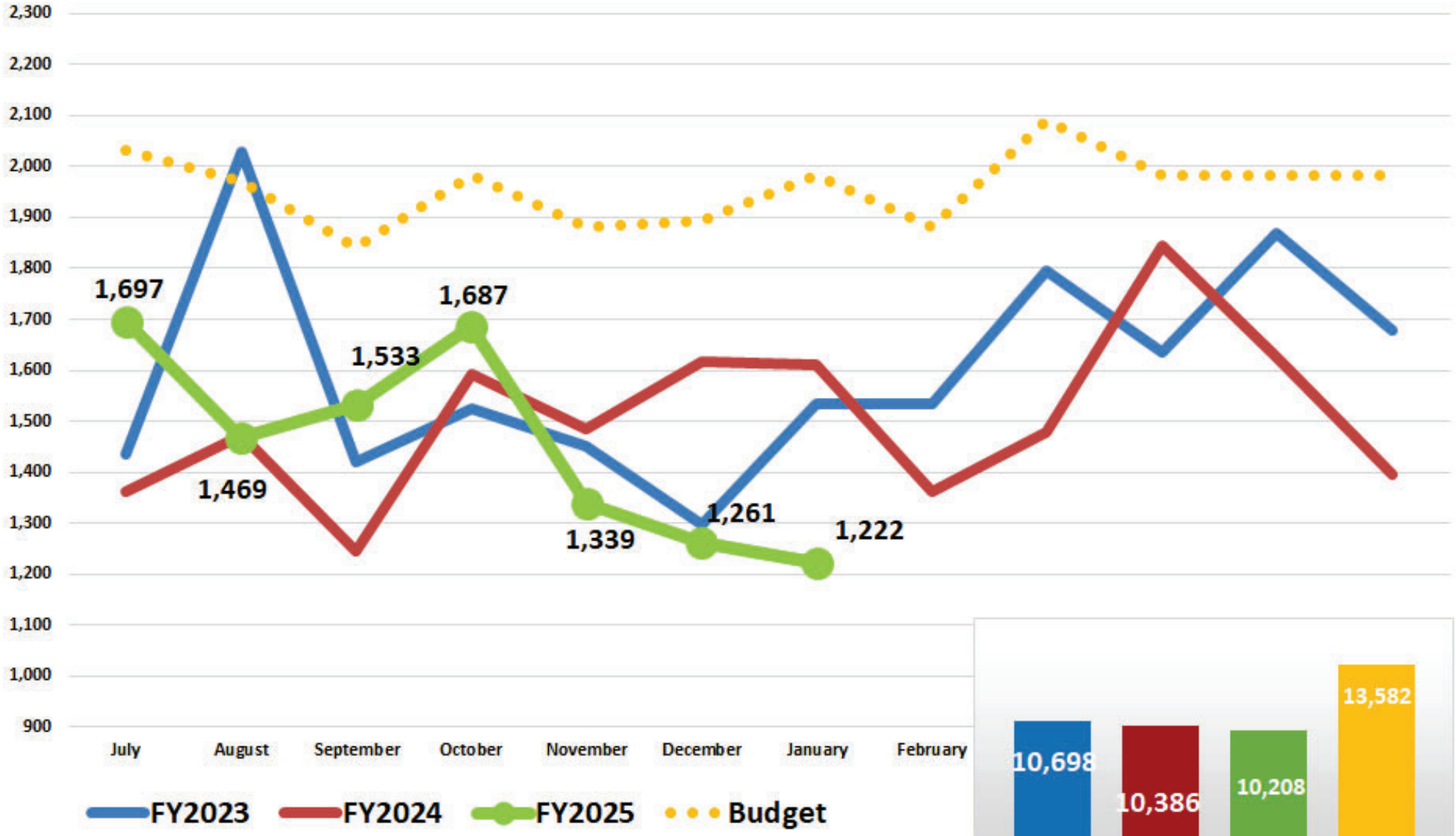
Cardiac Surgery Cases



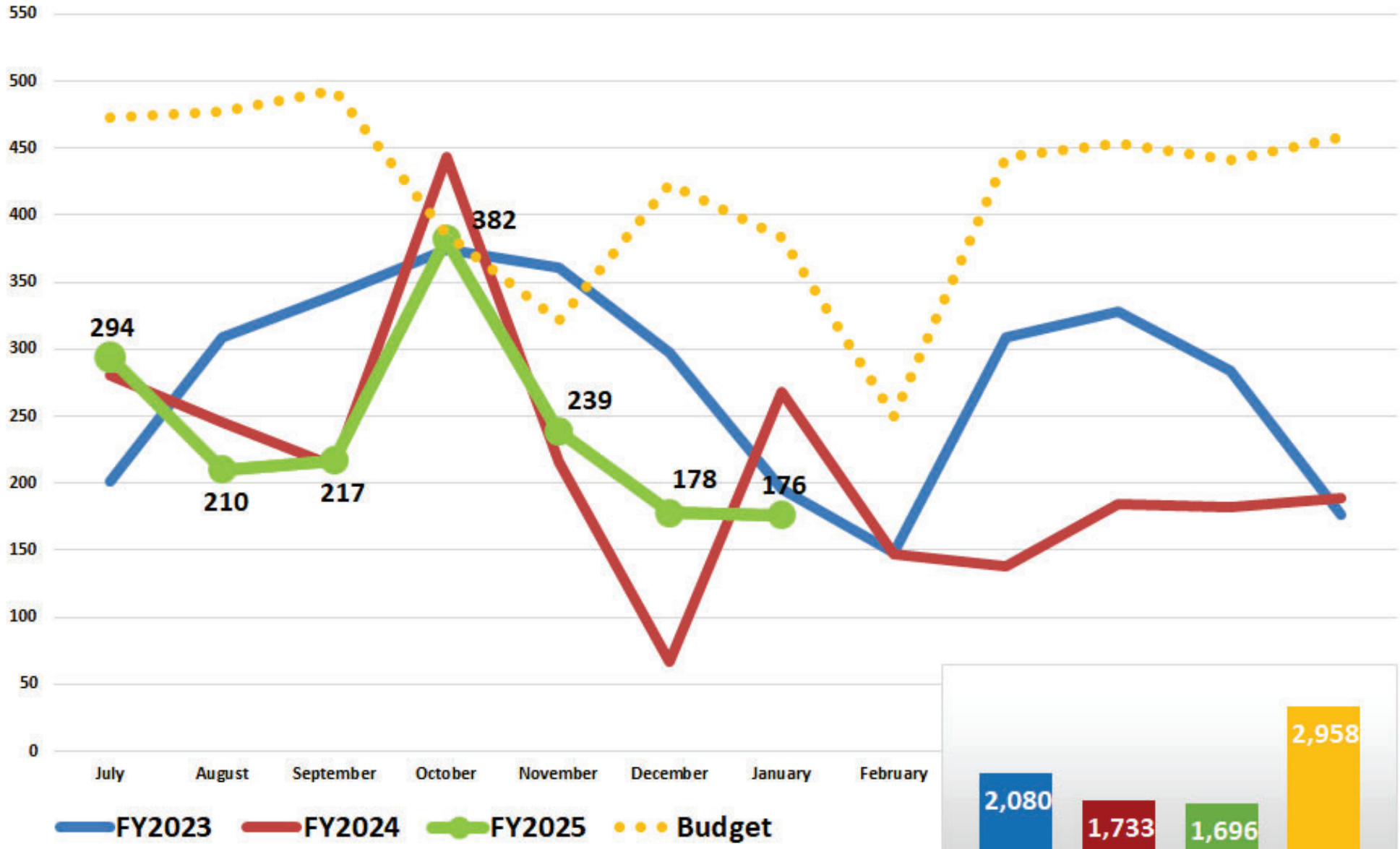
Rad Onc Treatments (Vis. & Hanf.)



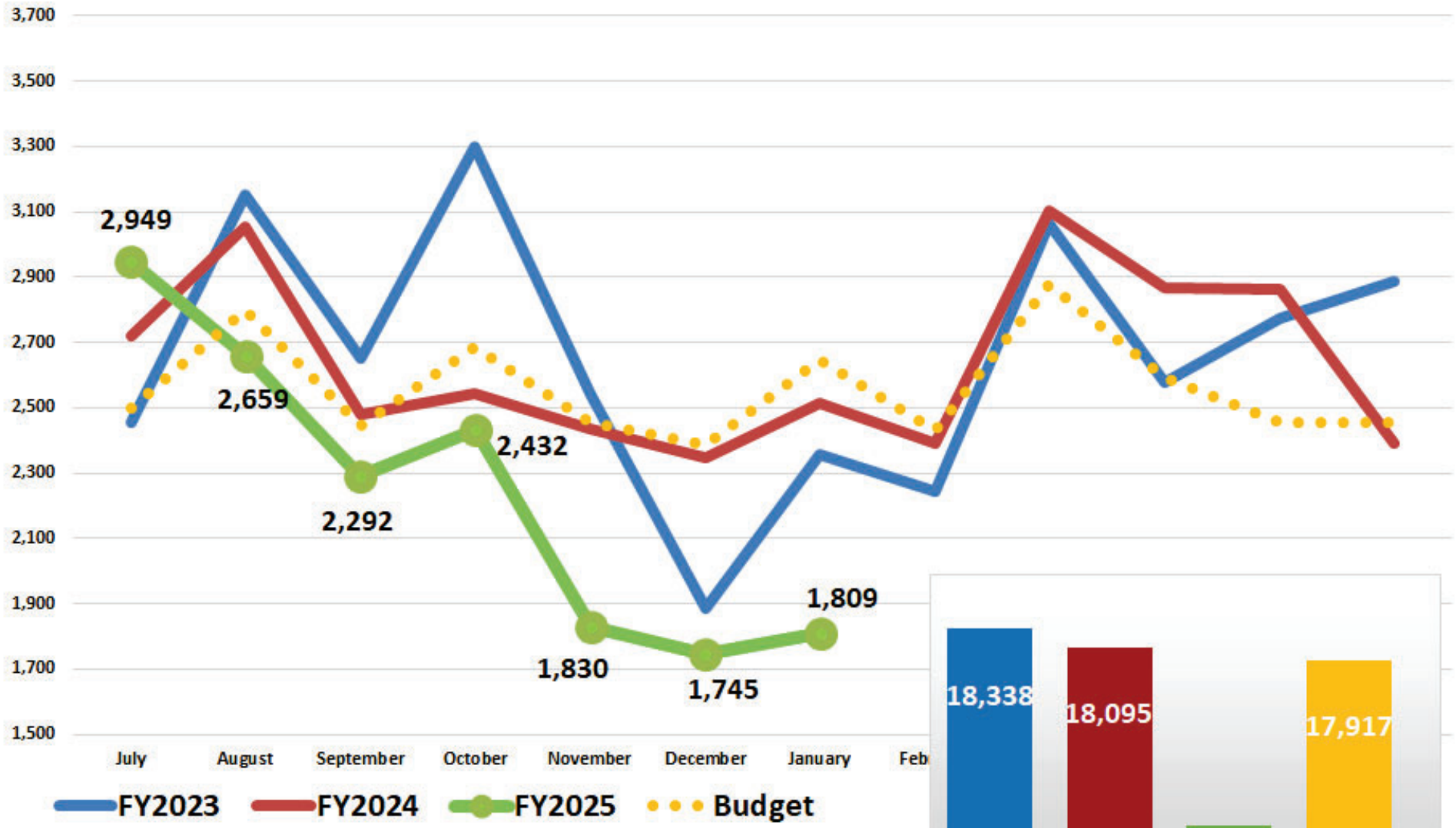
Rad Onc Visalia



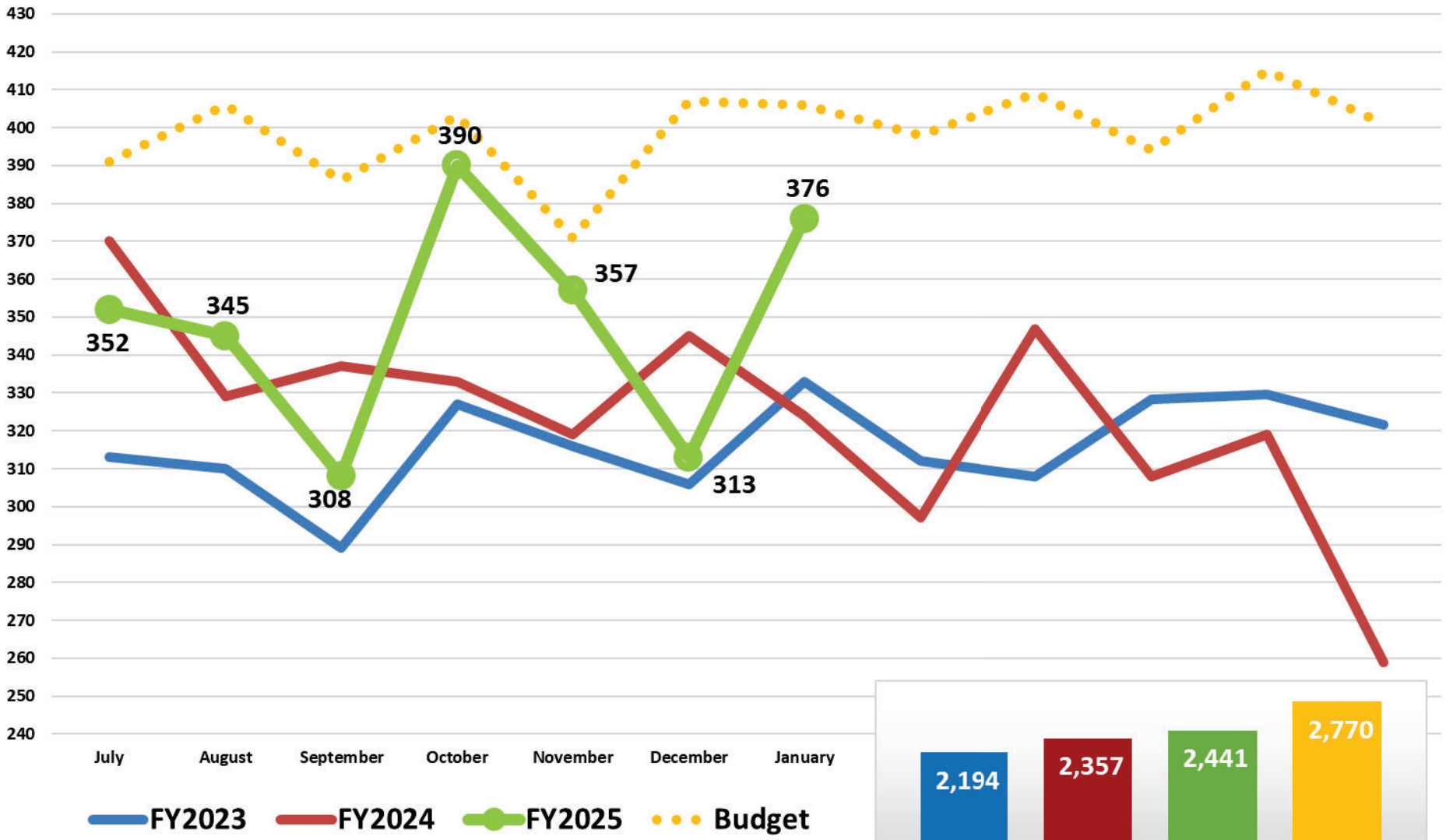
Rad Onc Hanford

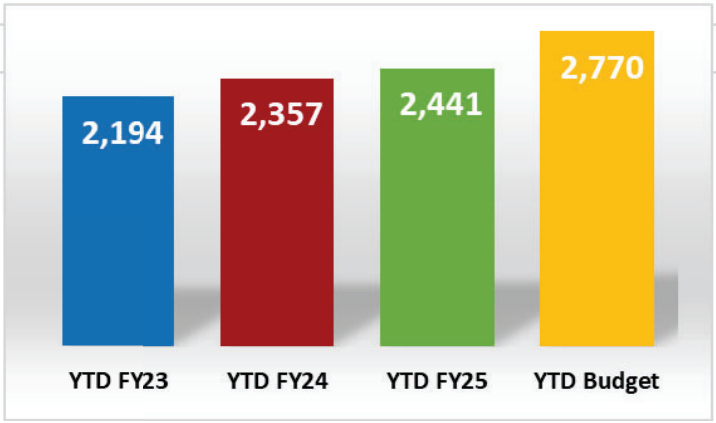


Therapy - Cypress Hand Center

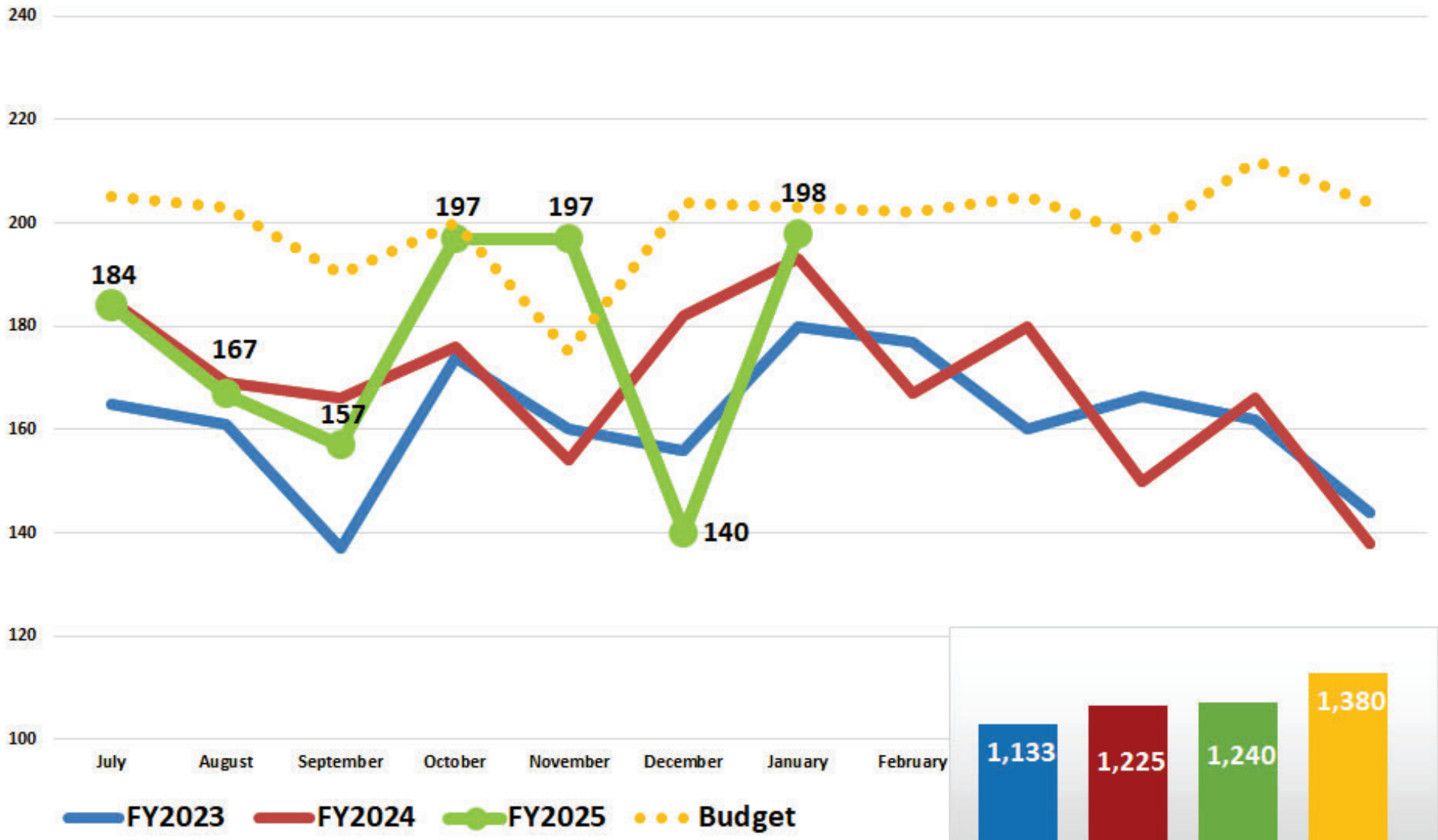


Cath Lab (IP & OP) – 100 Min Units

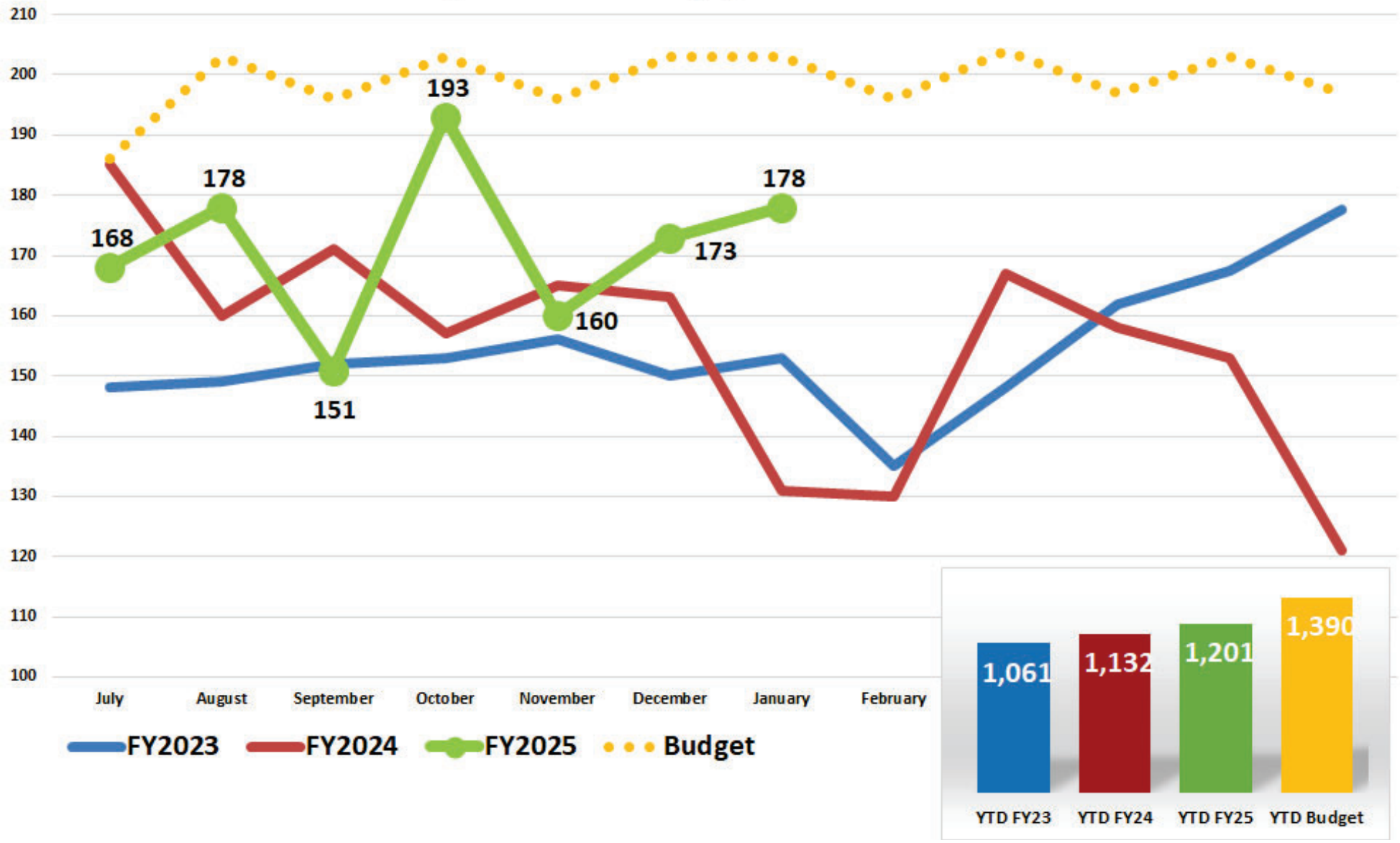




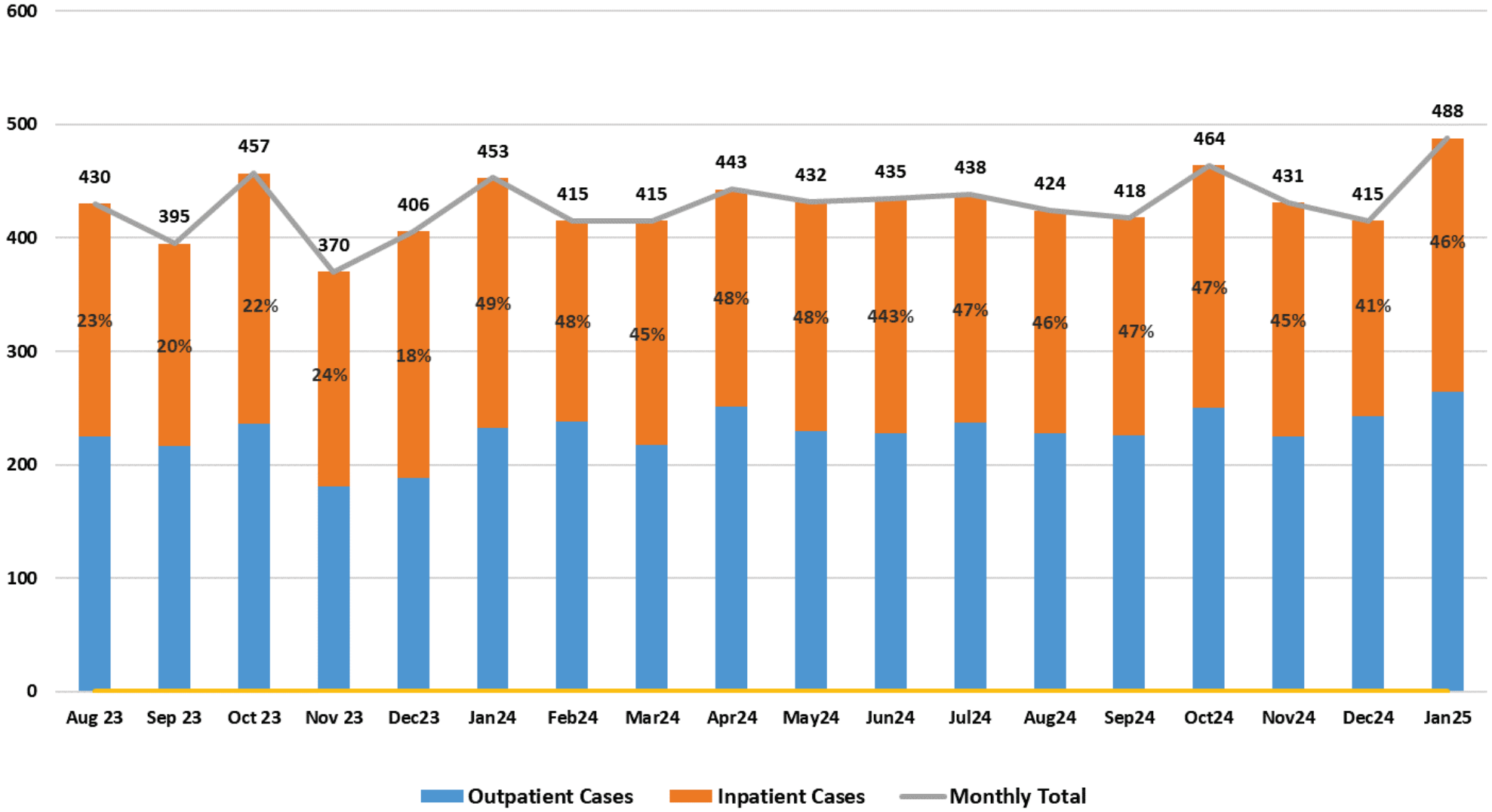
Cath Lab (IP Only) – 100 Min Units



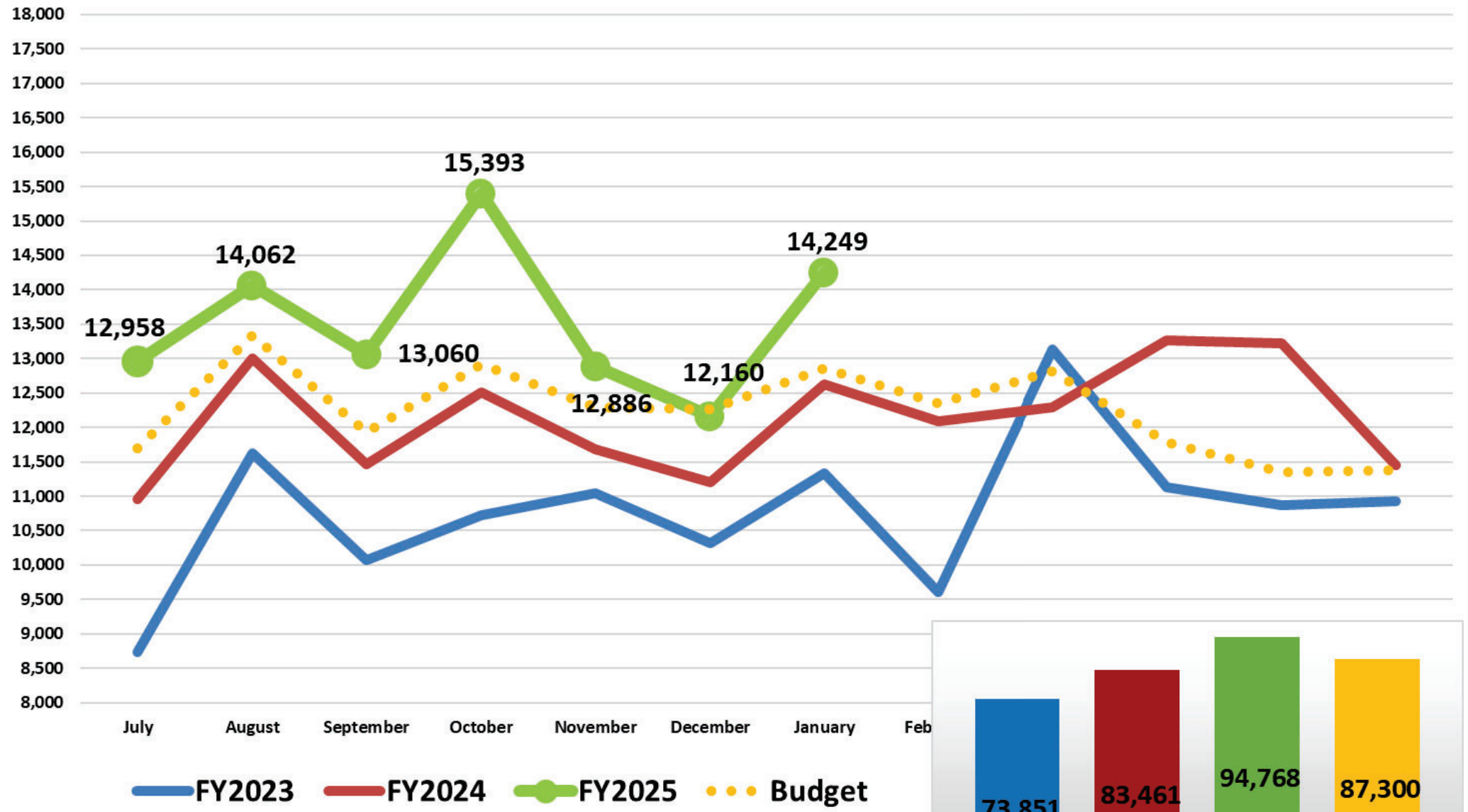
Cath Lab (OP Only) – 100 Min Units



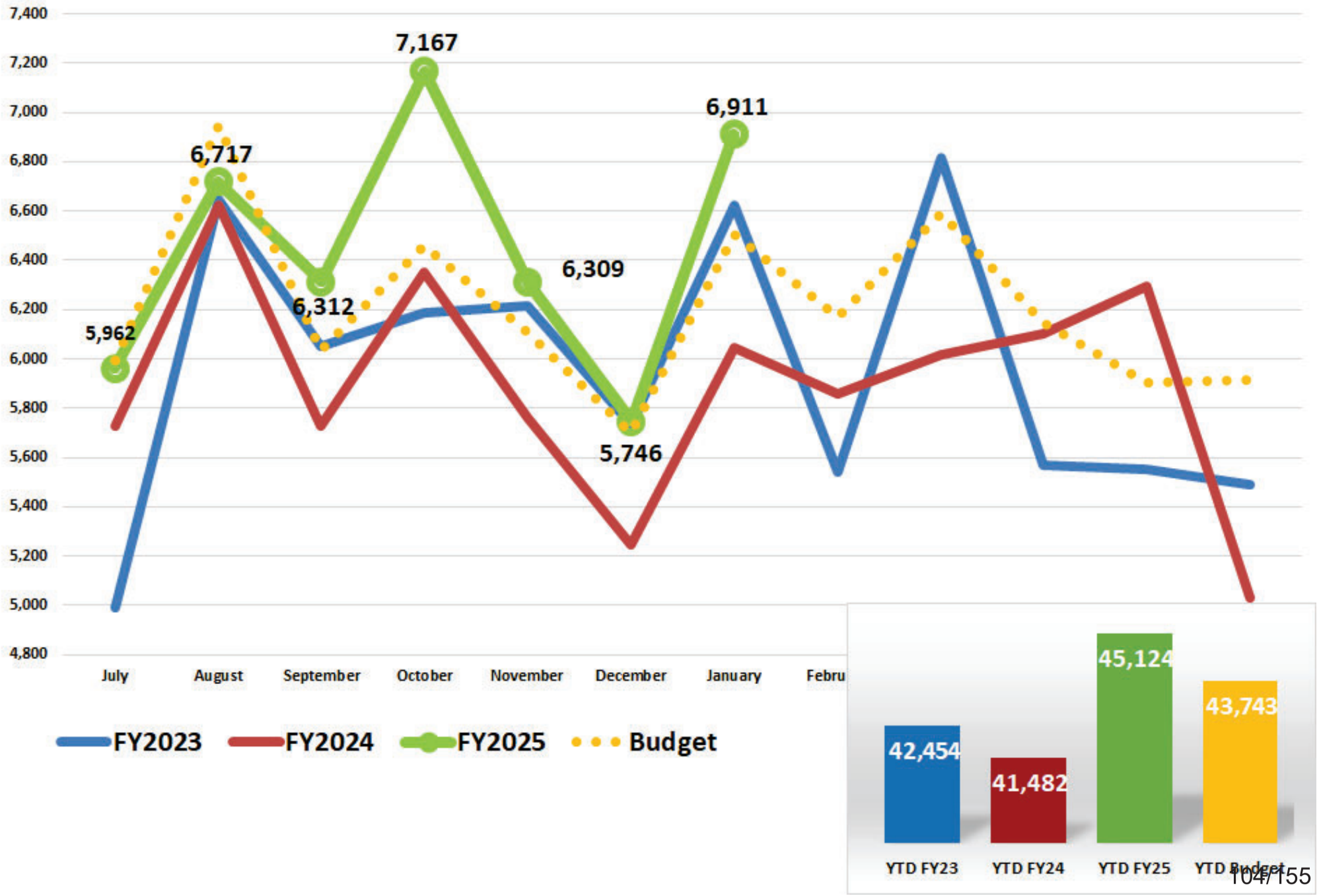
Cath Lab Patients (IP & OP)



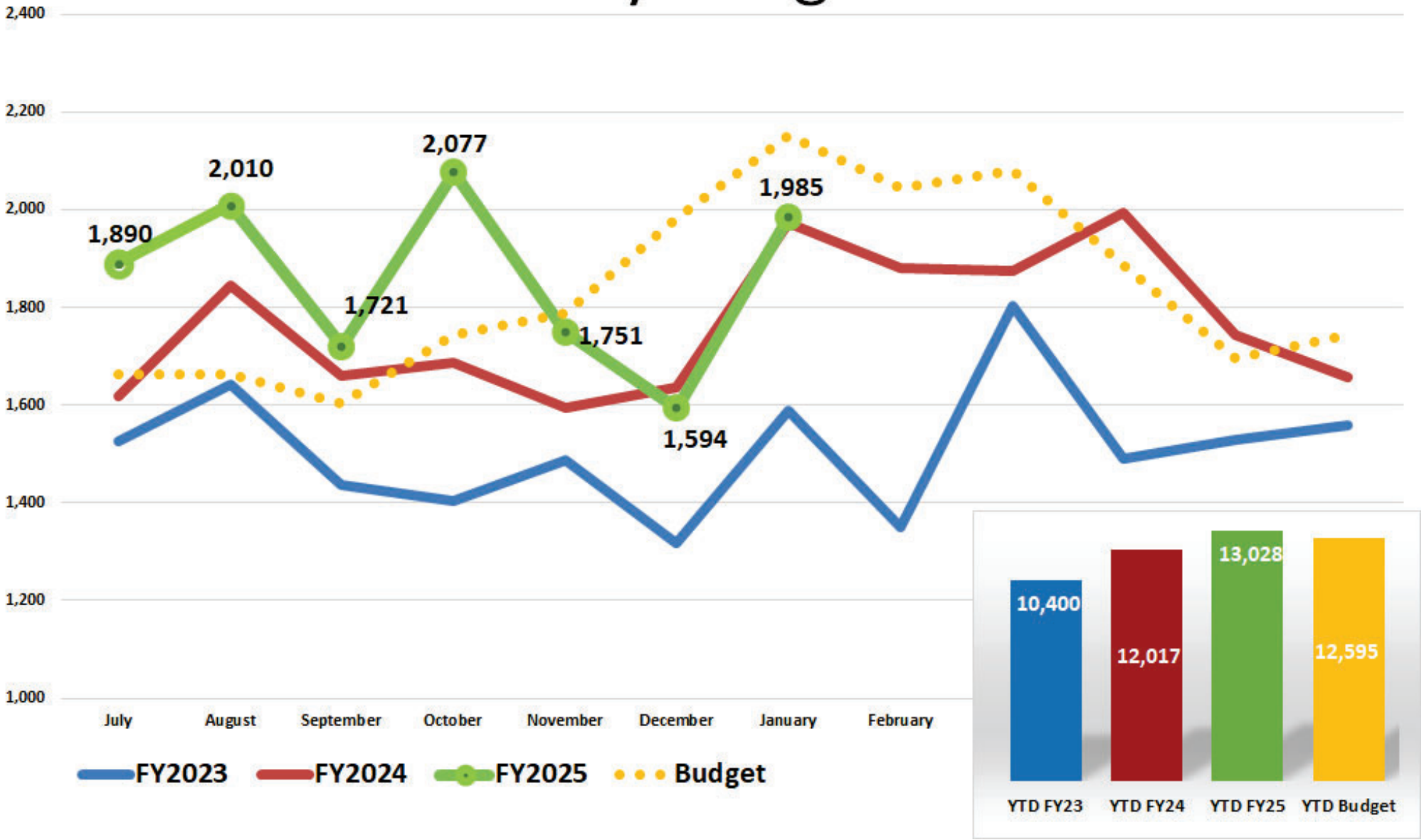
Rural Health Clinics Registrations



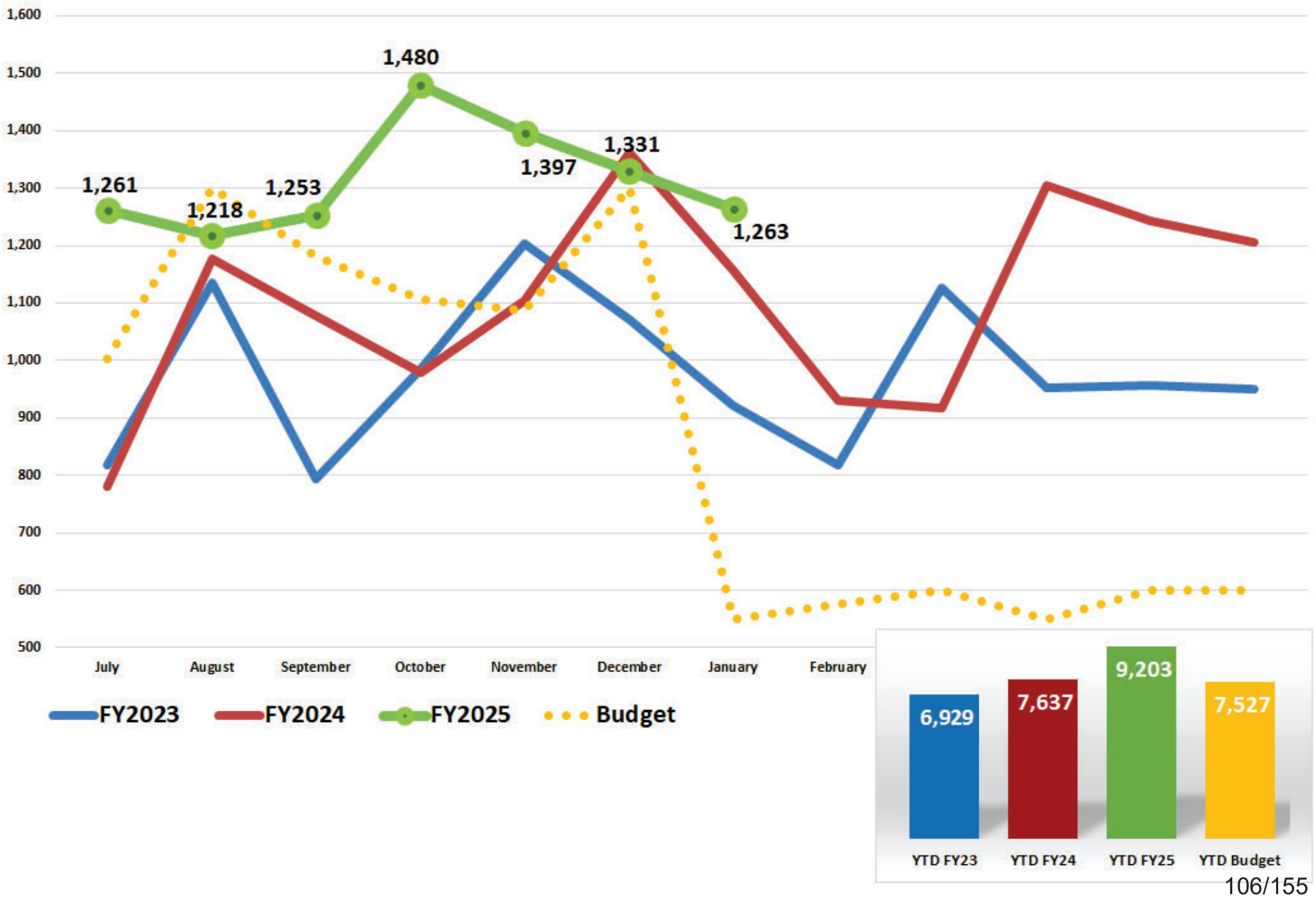
RHC Exeter - Registrations



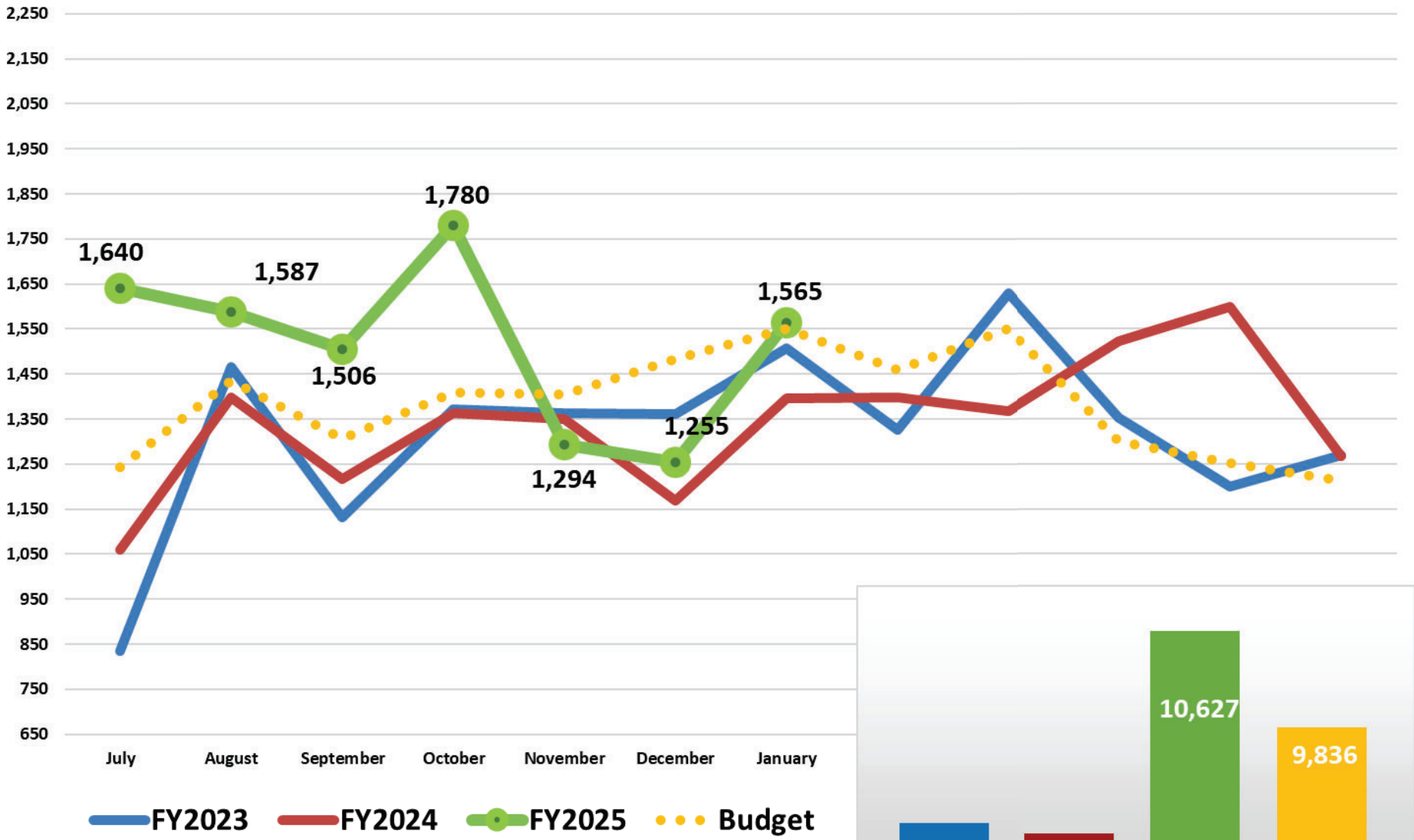
RHC Lindsay - Registrations



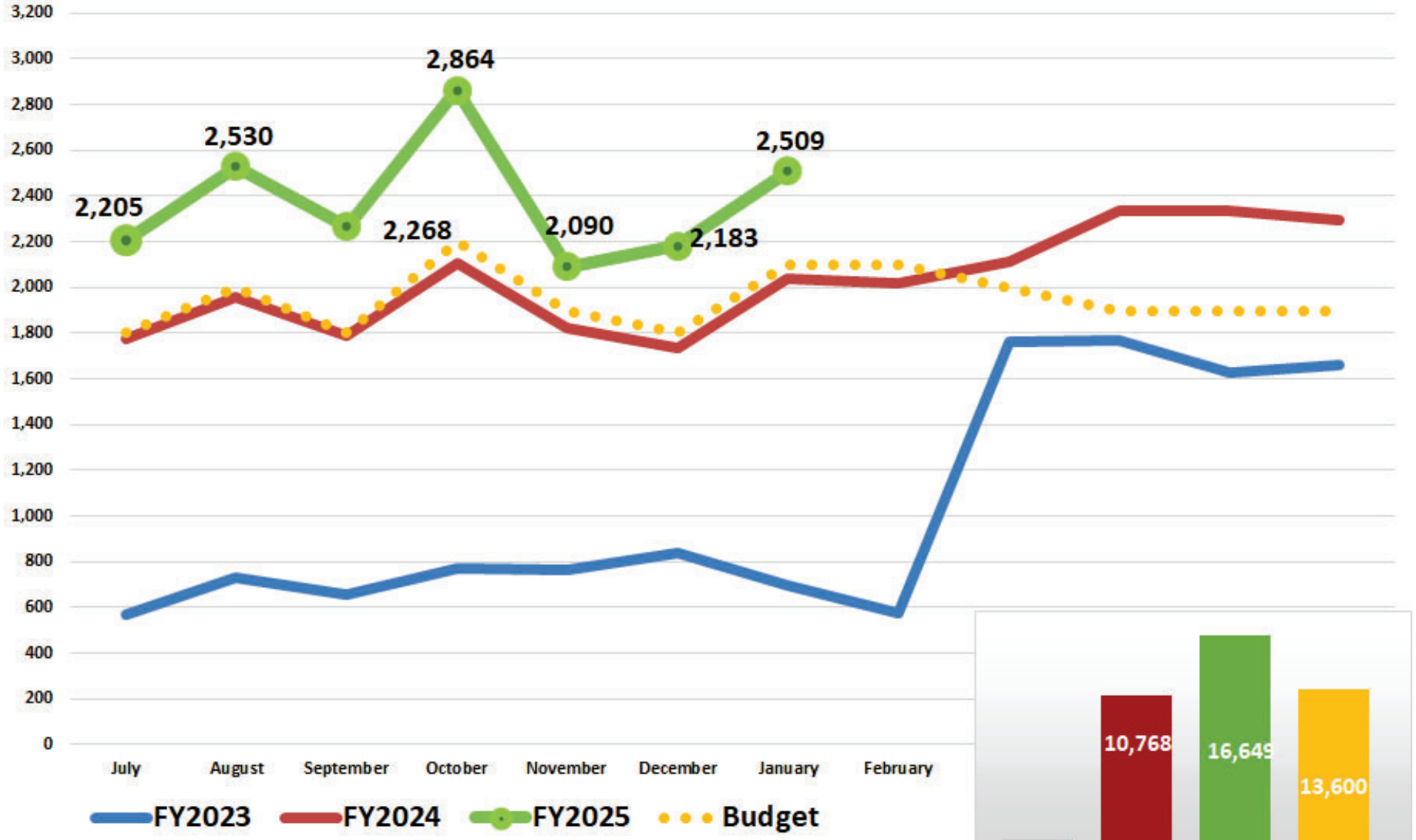
RHC Woodlake - Registrations



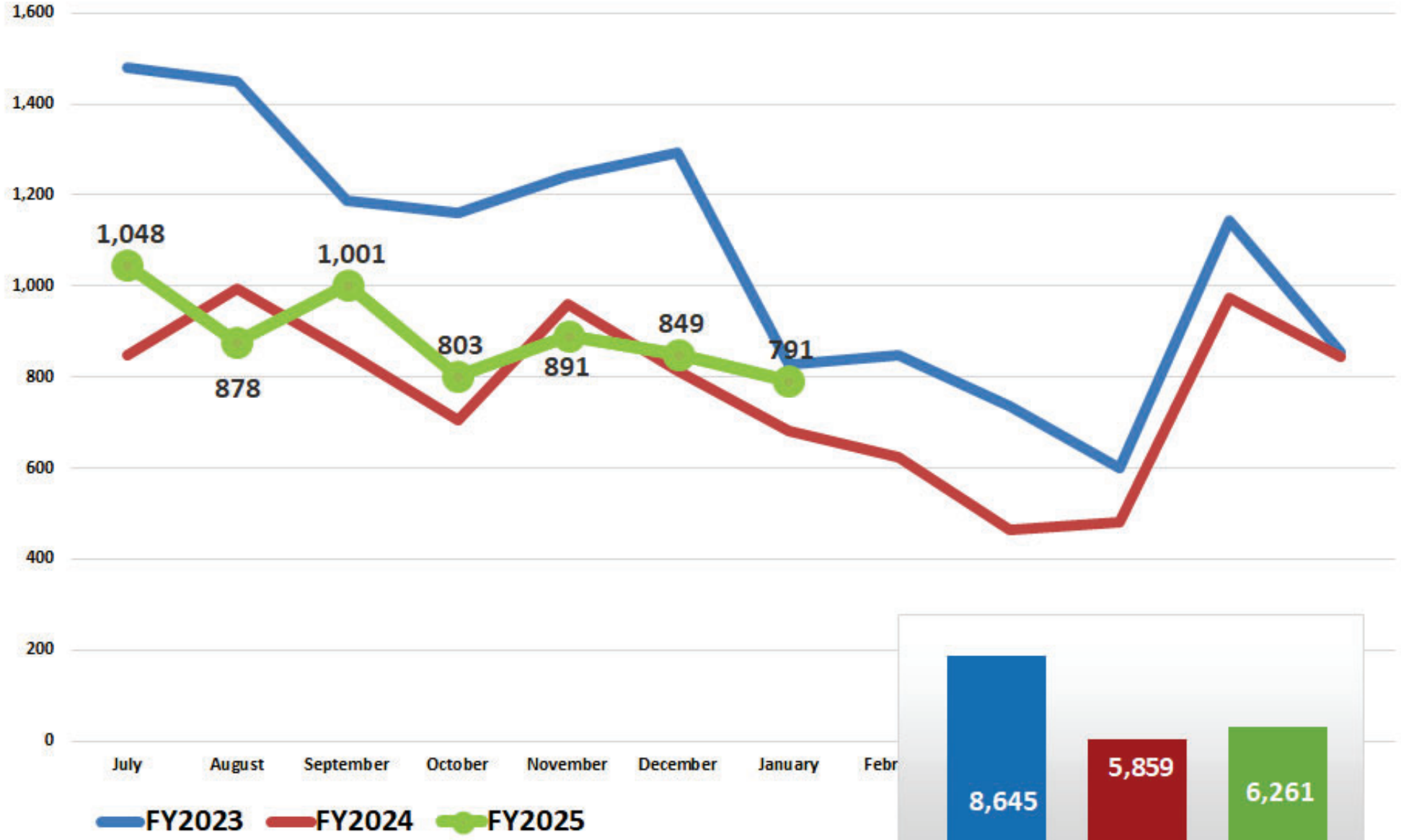
RHC Dinuba - Registrations



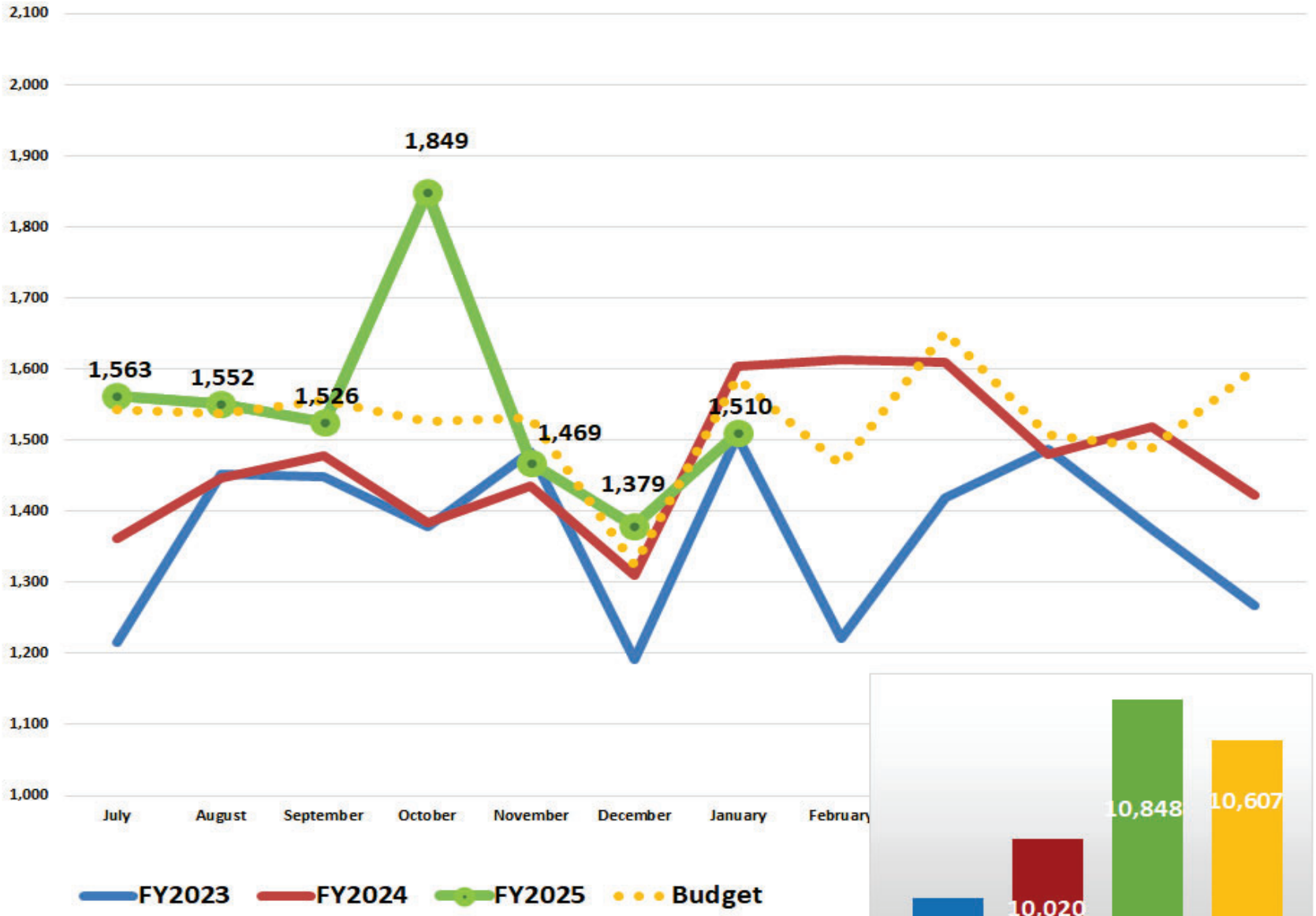
RHC Tulare - Registrations



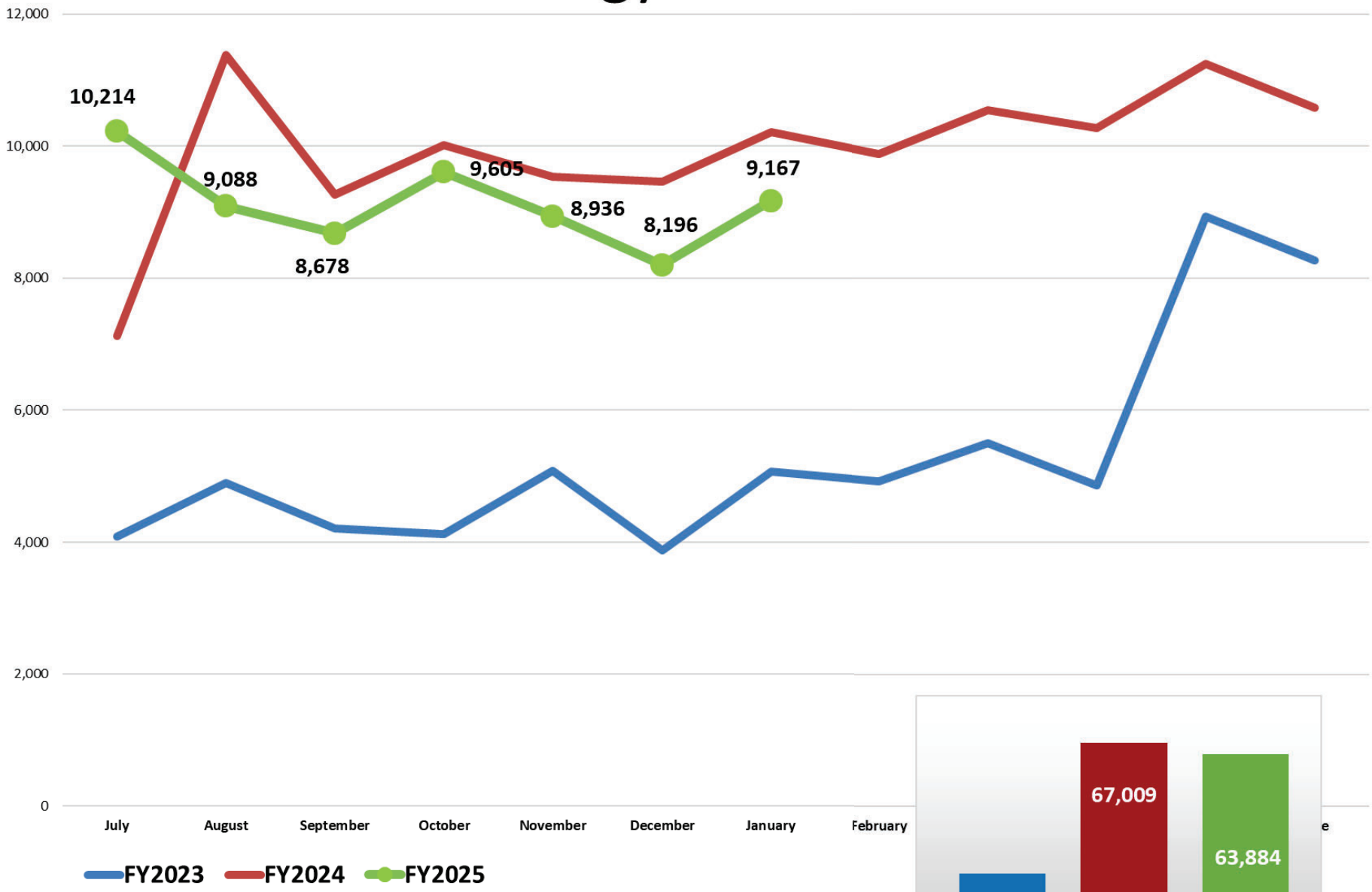
Neurosurgery Clinic - wRVU's



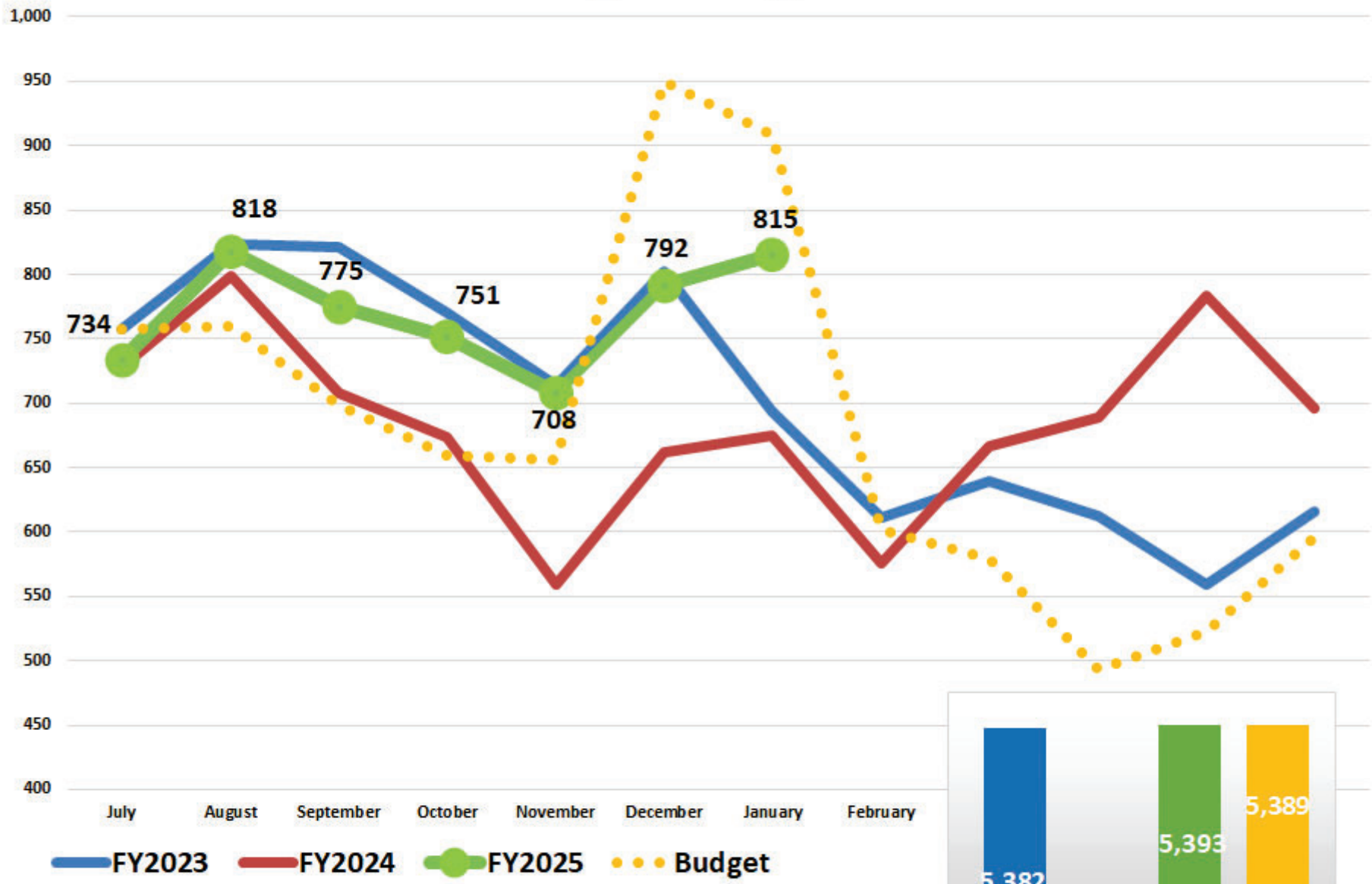
KH Cardiology Center Registrations



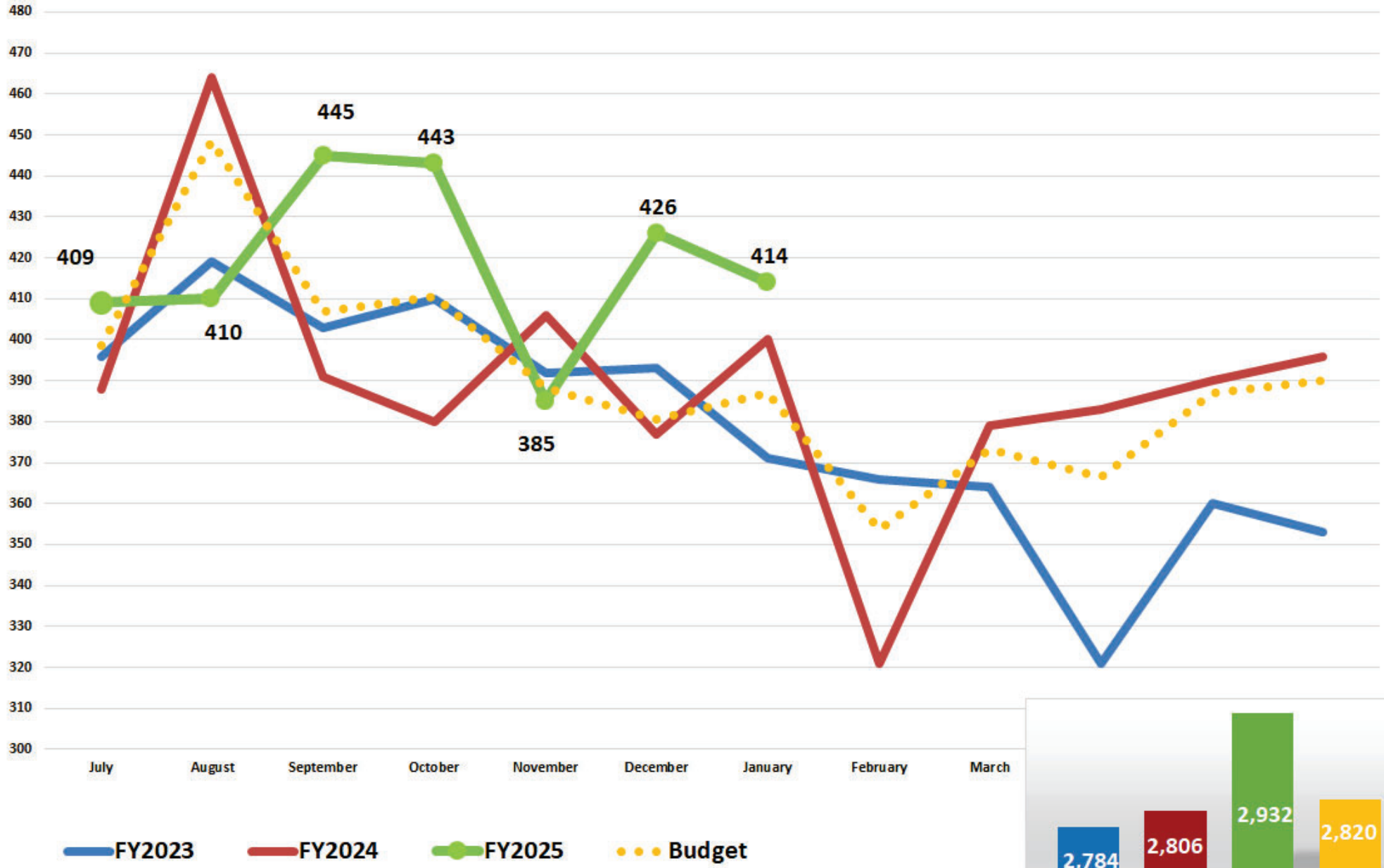
KH Cardiology Center - wRVU's



Labor Triage Registrations



Deliveries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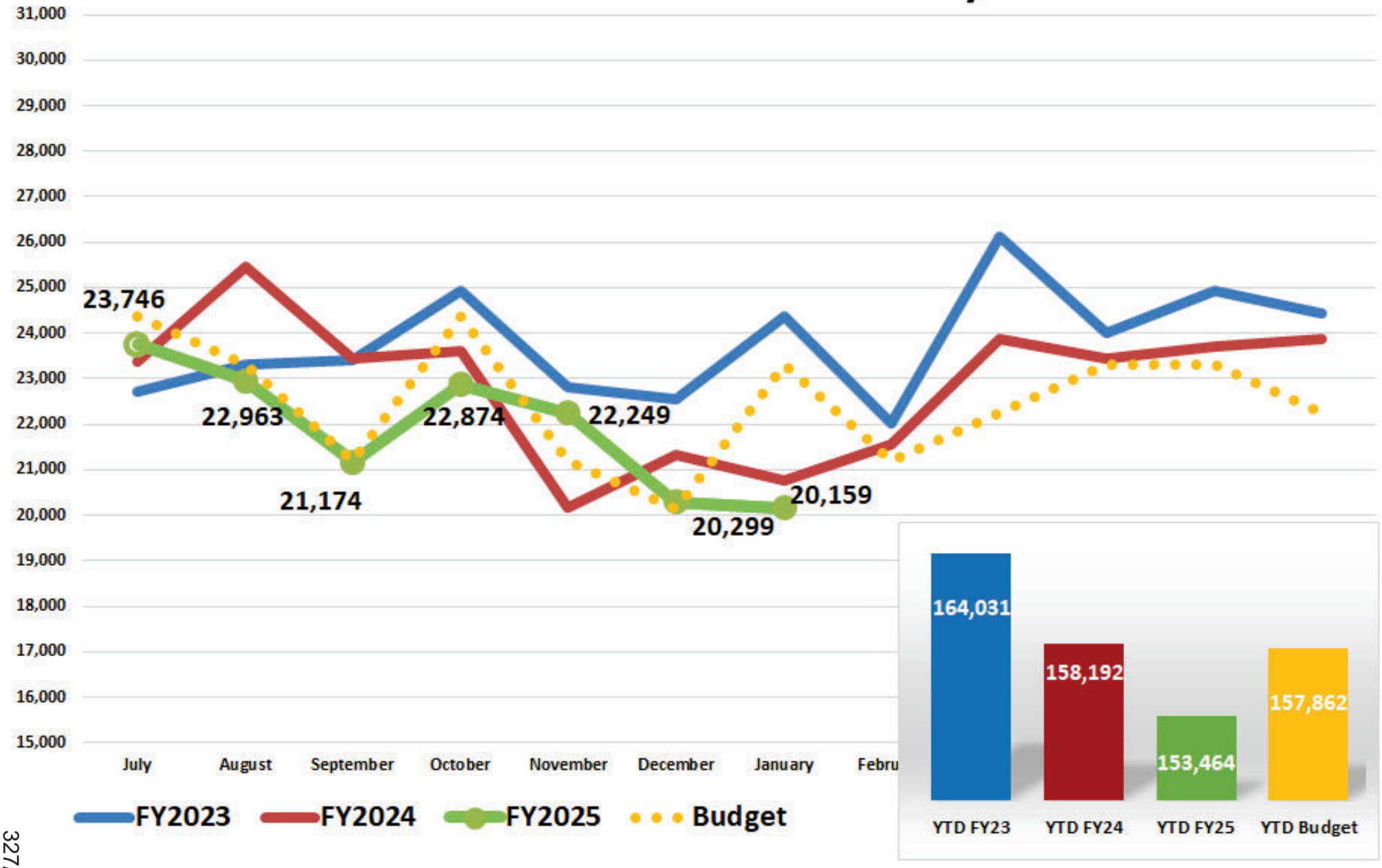
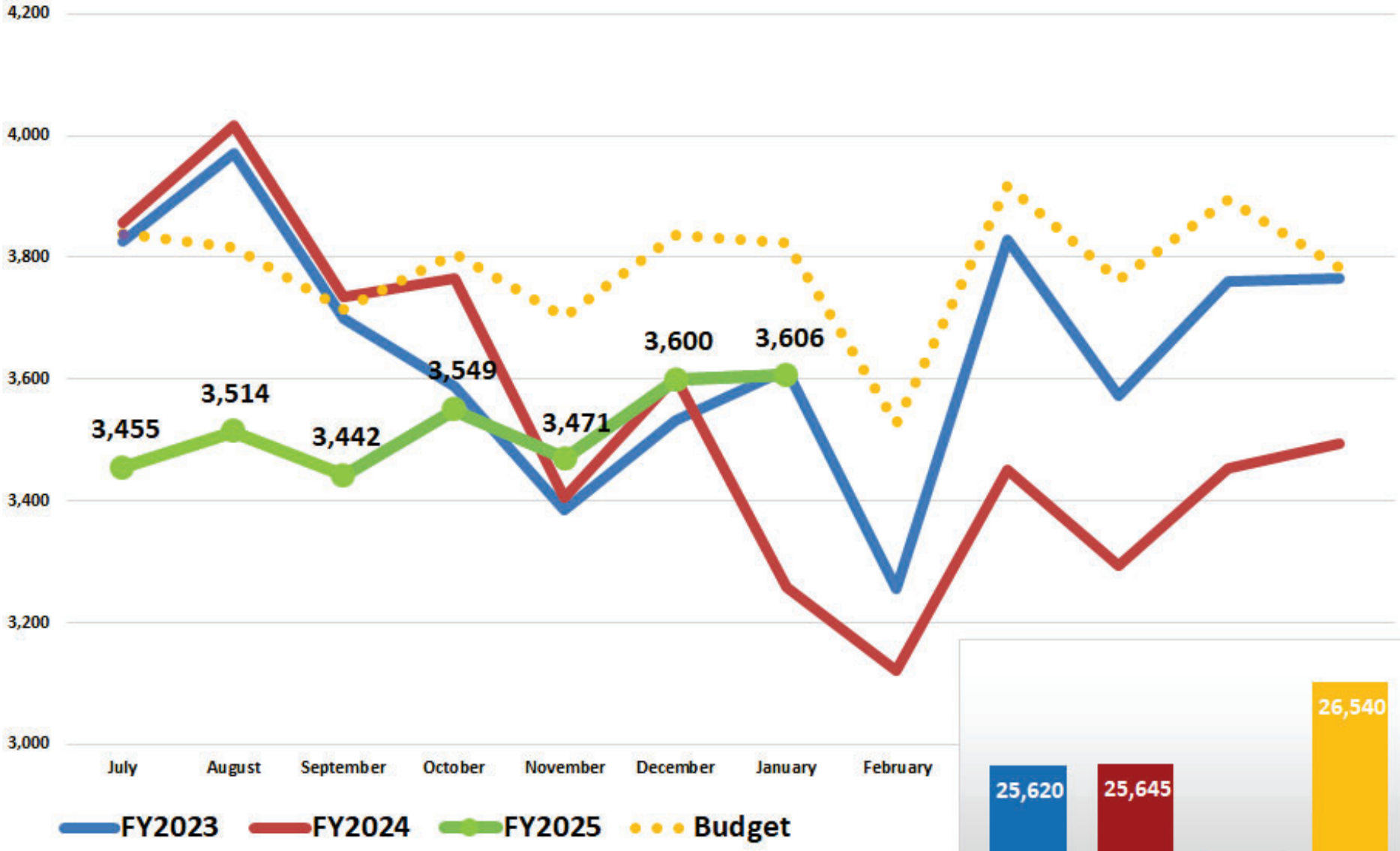
443
385
426
414
July
August
September
October
November
December
January
February
March
FY2023
FY2024
FY2025
Budget

2,784
2,806
2,932
2,820
YTD FY23
YTD FY24
YTD FY25
YTD Budget

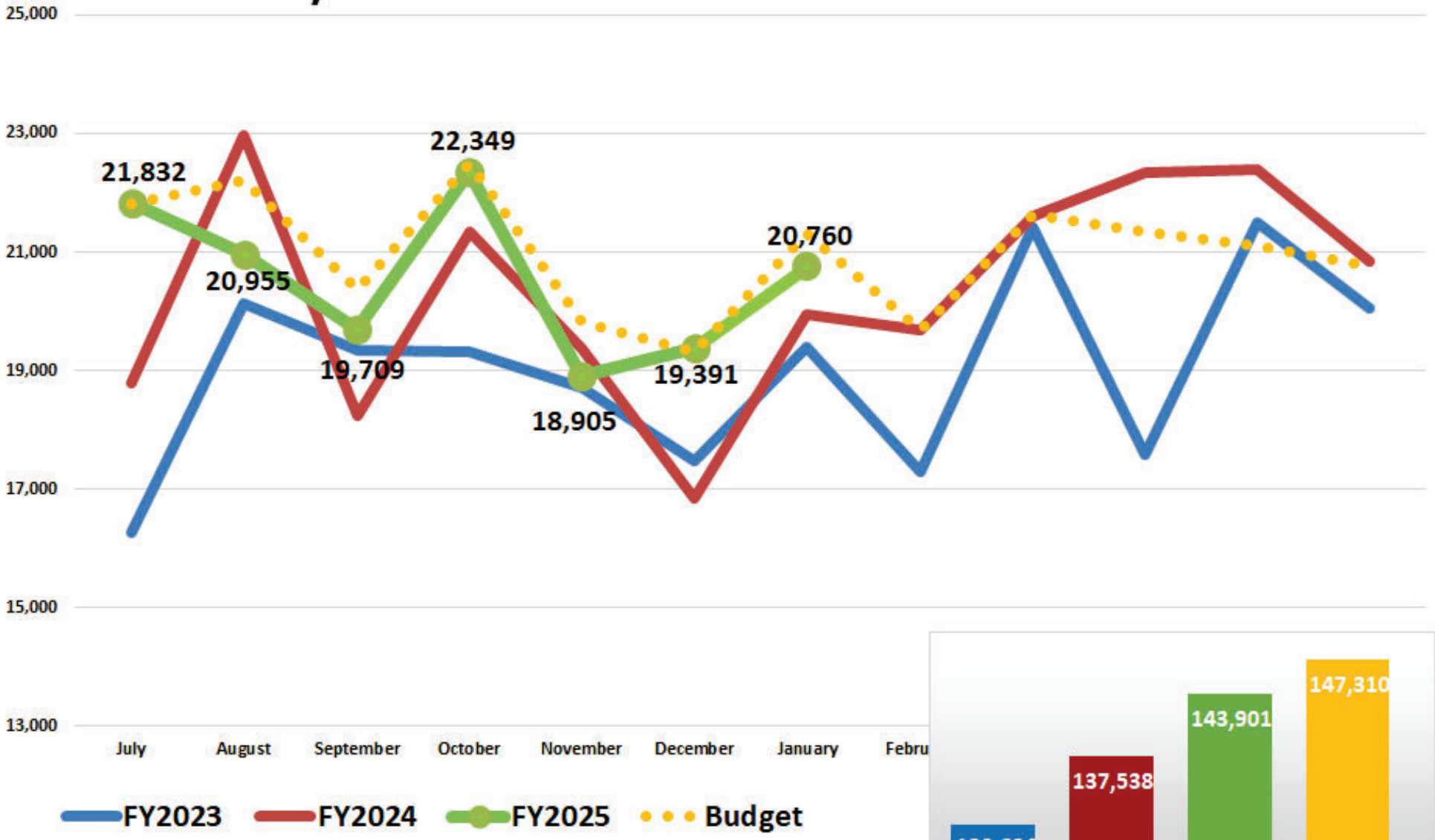
Home Infusion Days



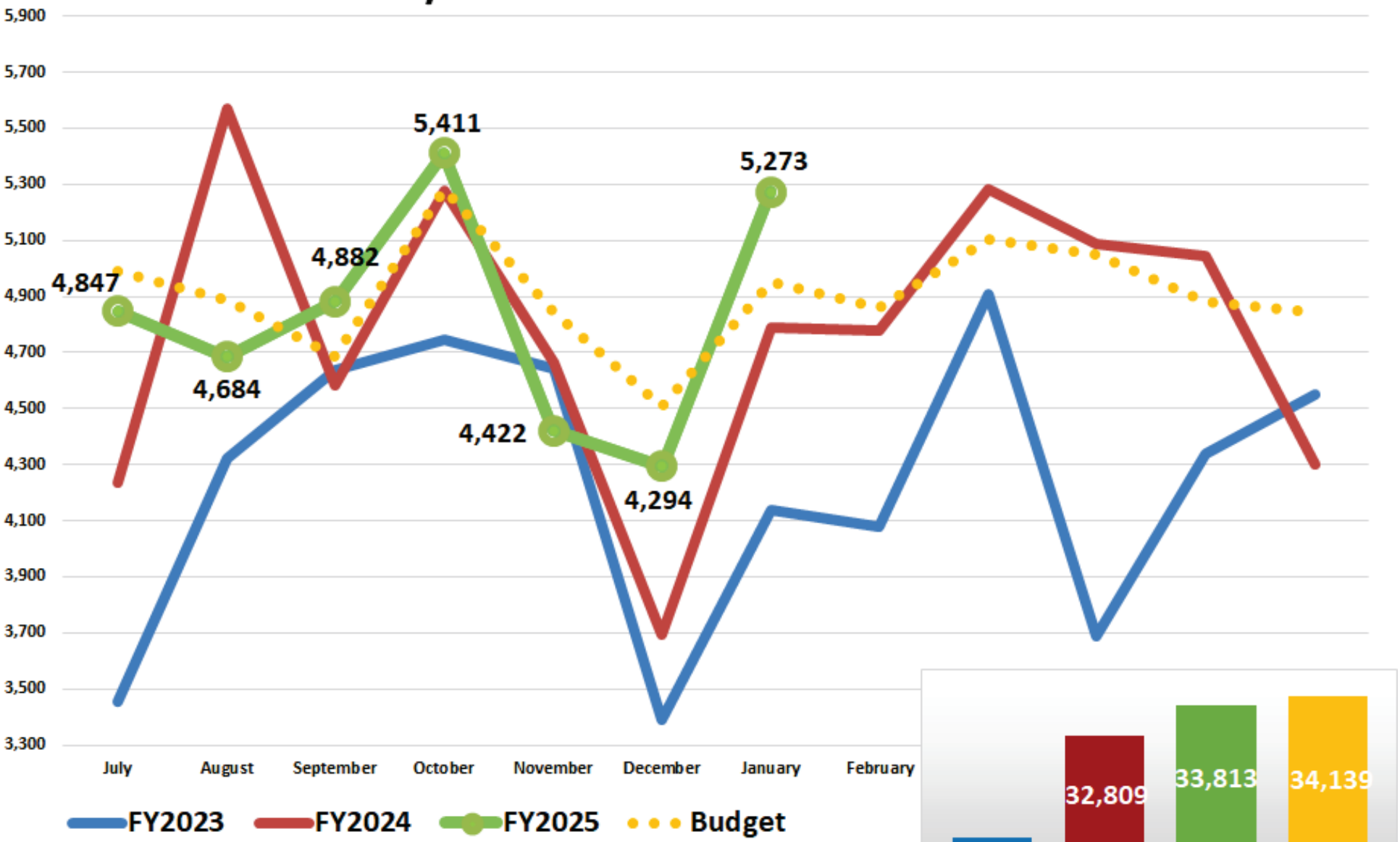
Hospice Days



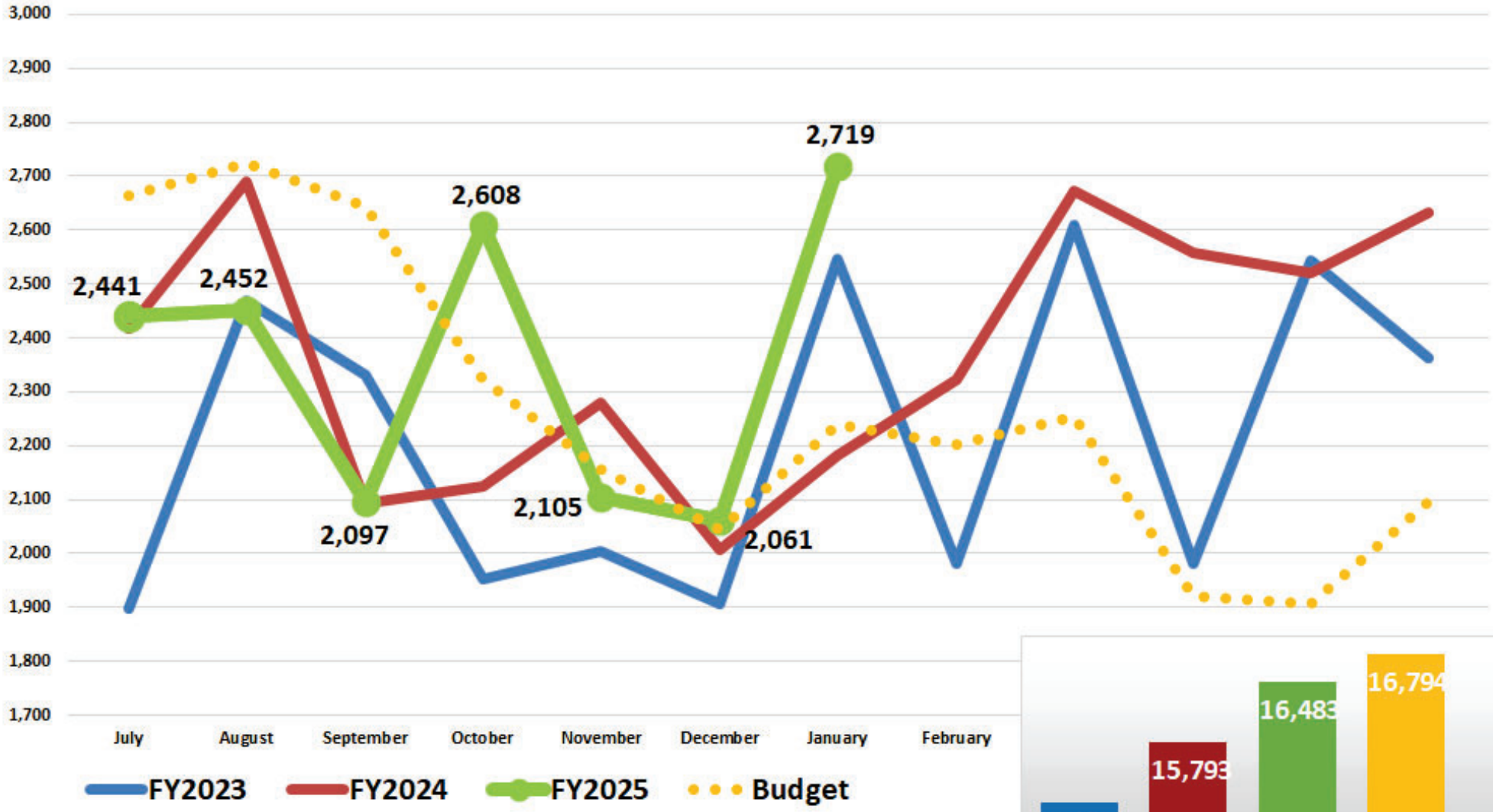
All O/P Rehab Svcs Across District



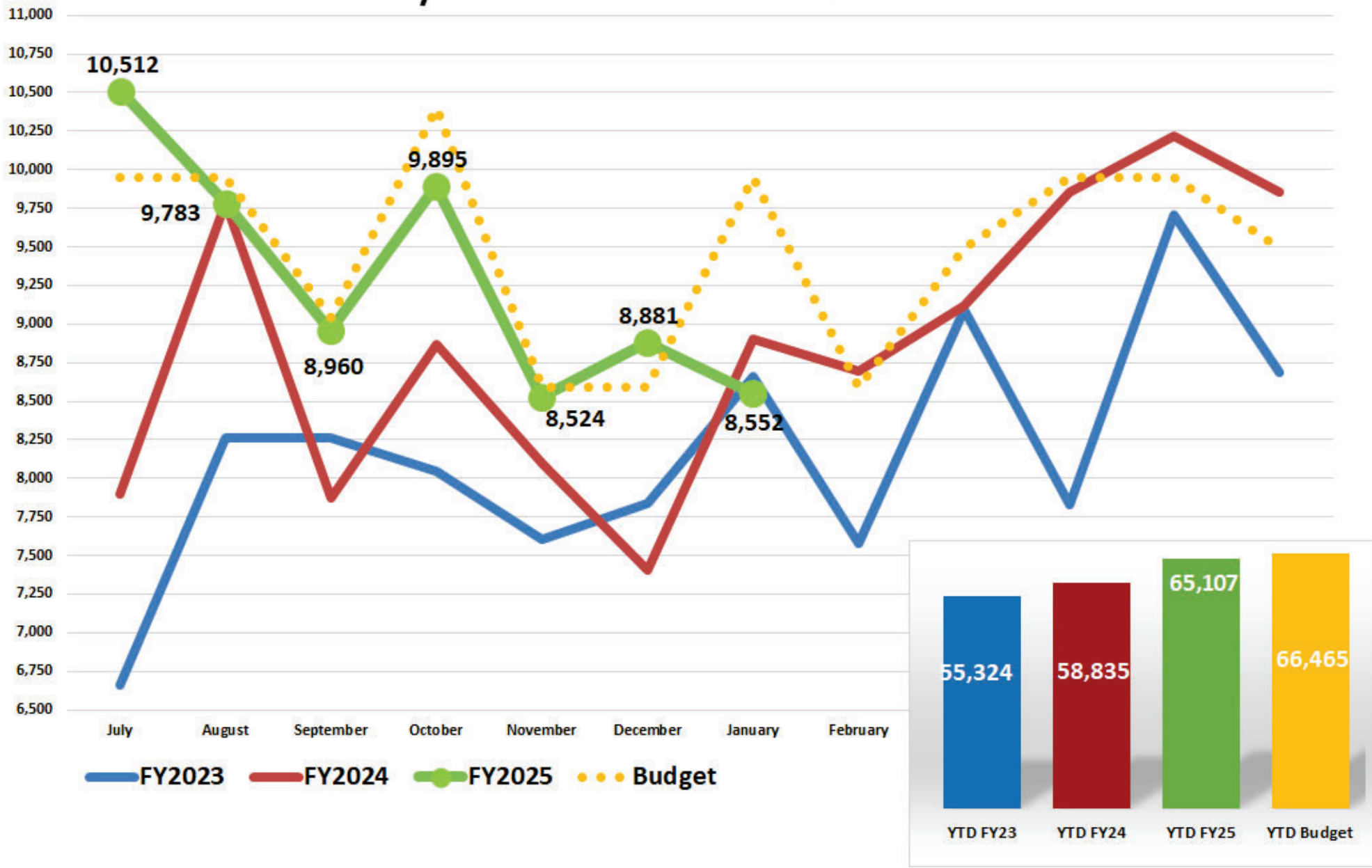
O/P Rehab Services



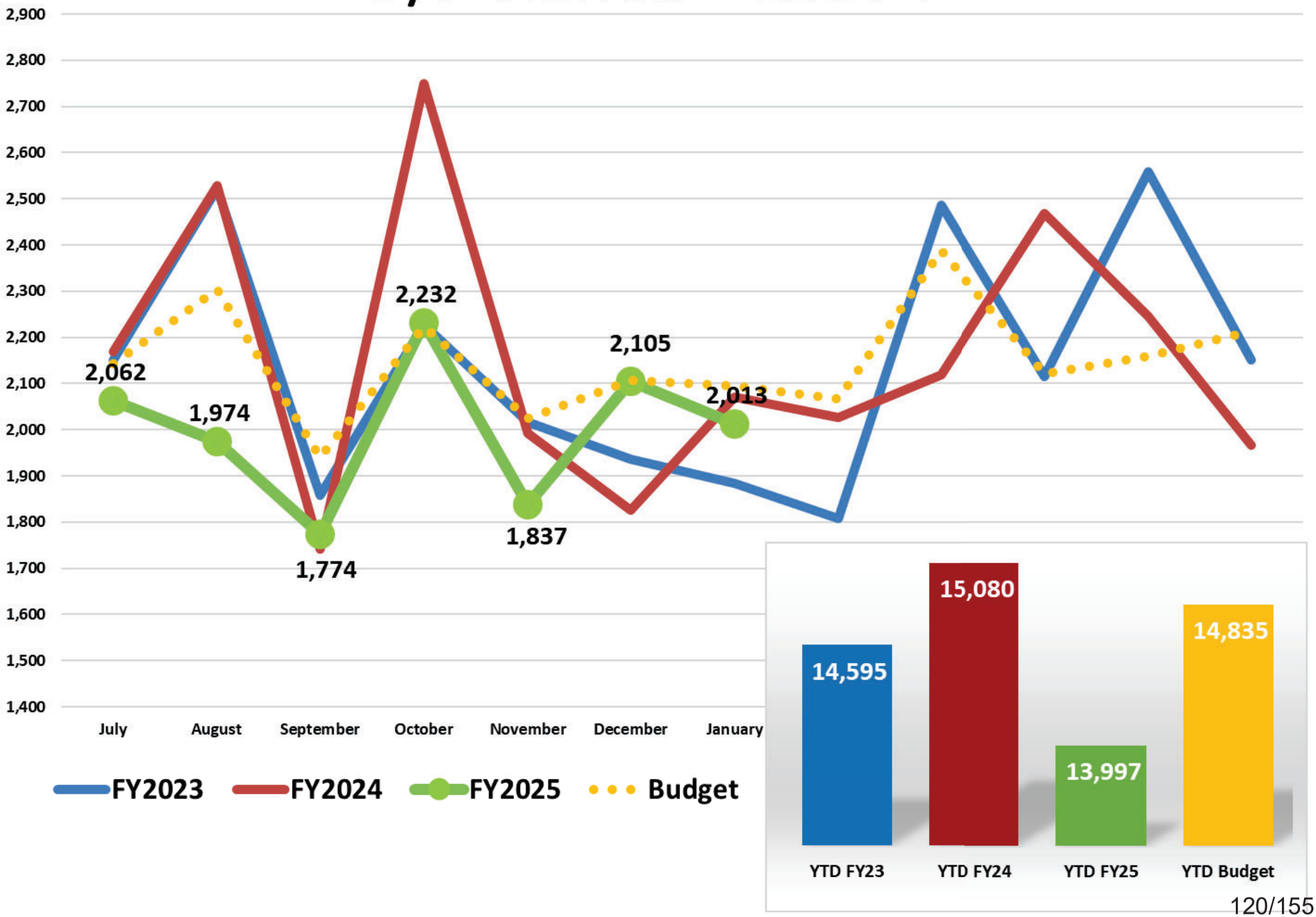
O/P Rehab - Exeter



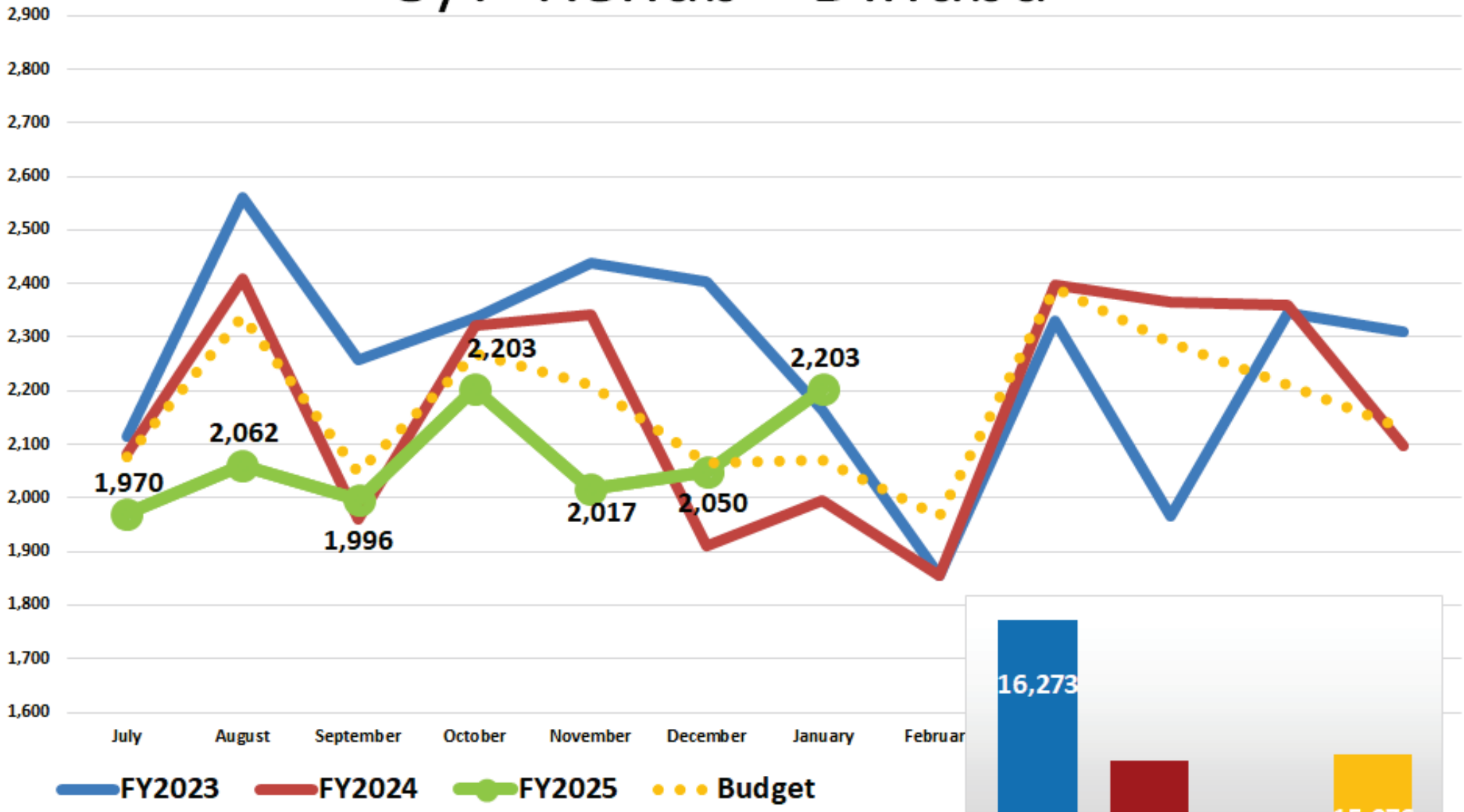
O/P Rehab - Akers



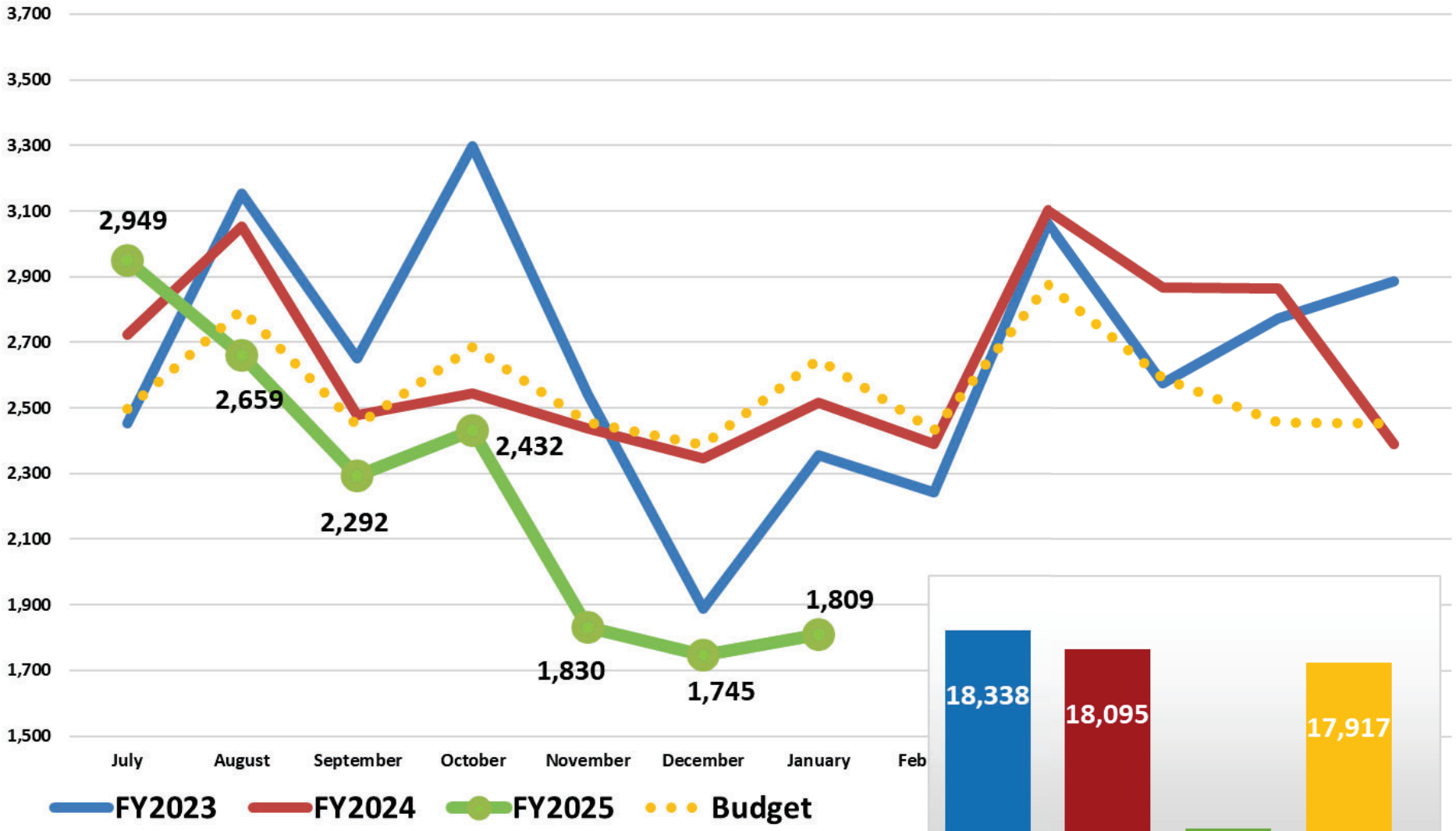
O/P Rehab - LLOPT



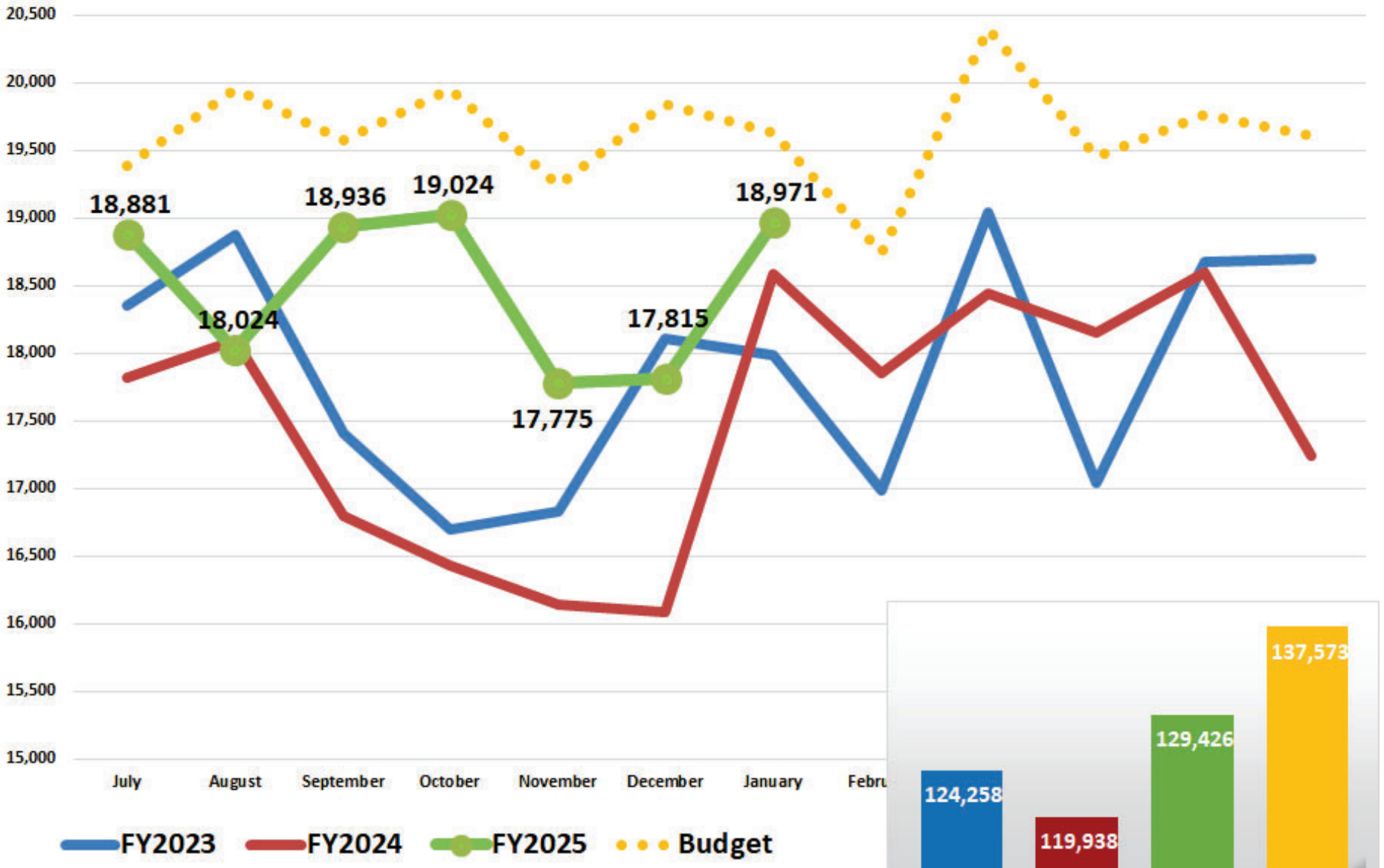
O/P Rehab - Dinuba



Therapy - Cypress Hand Center

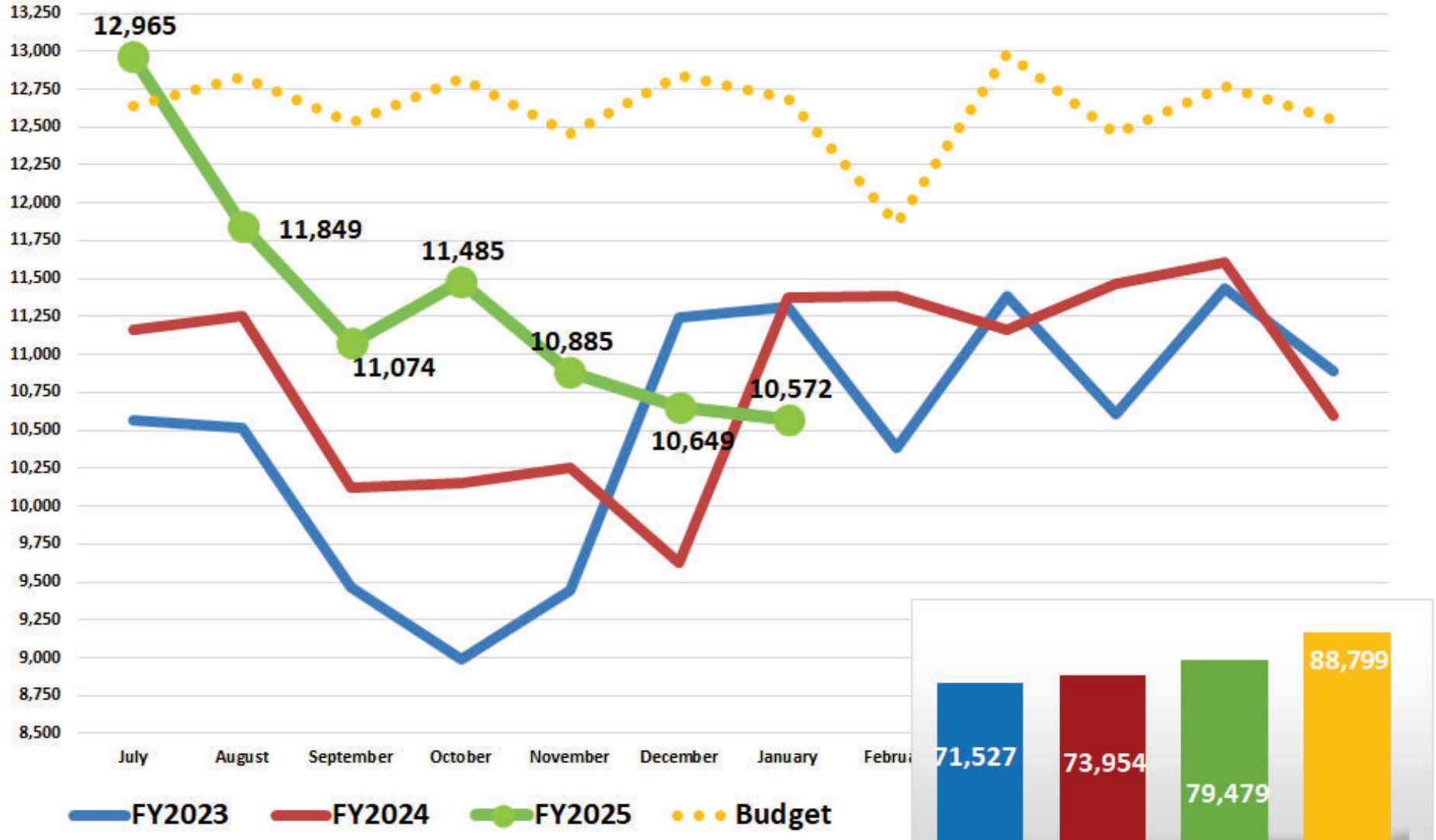


Physical & Other Therapy Units (I/P & O/P)

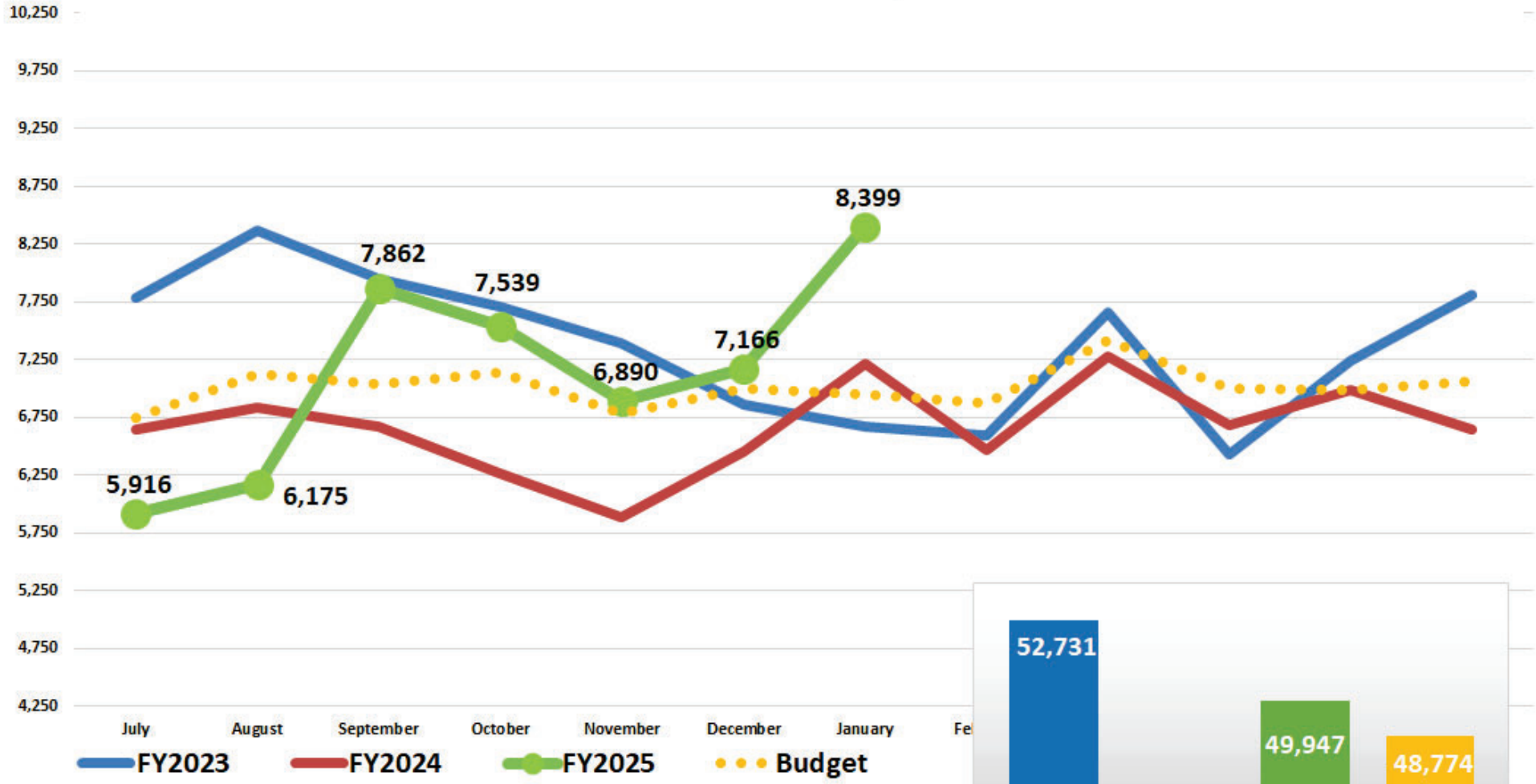


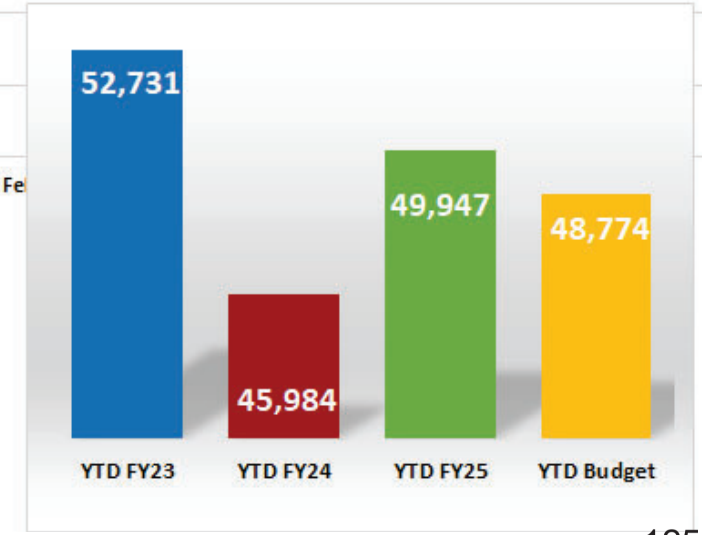
Physical & Other Therapy Units

(I/P & O/P)-Main Campus

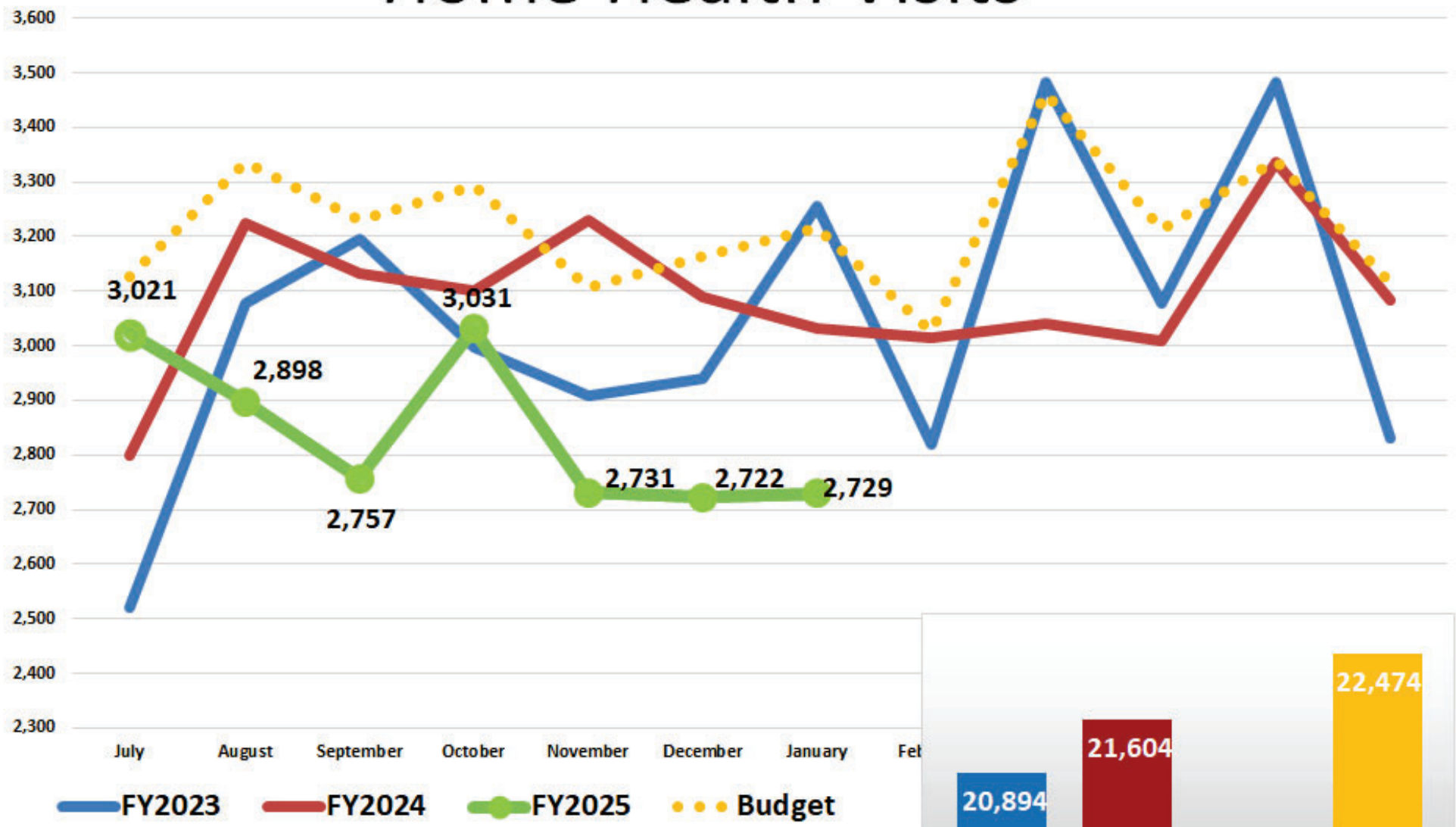


Physical & Other Therapy Units (I/P & O/P)-KDRH & South Campus

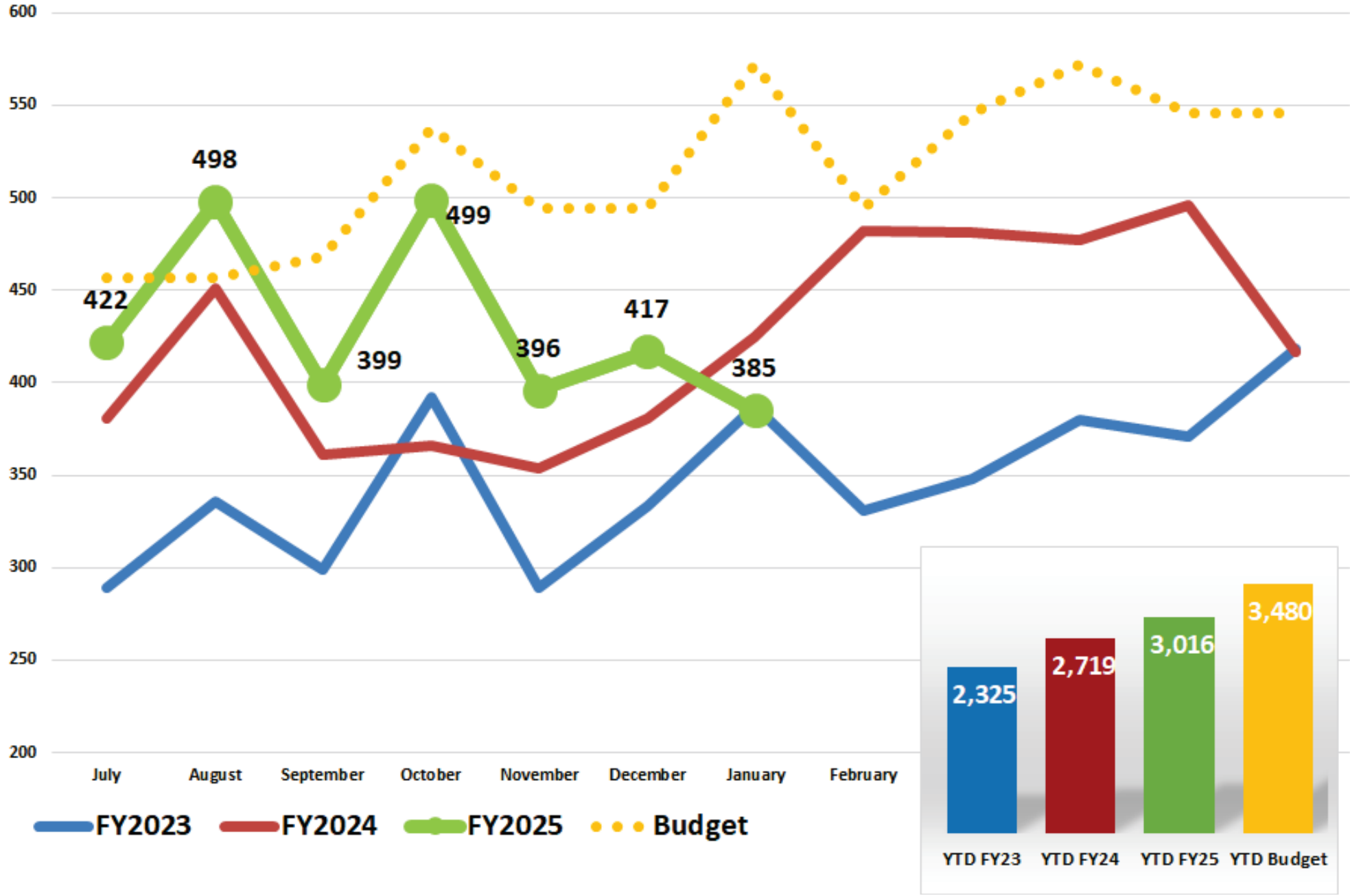




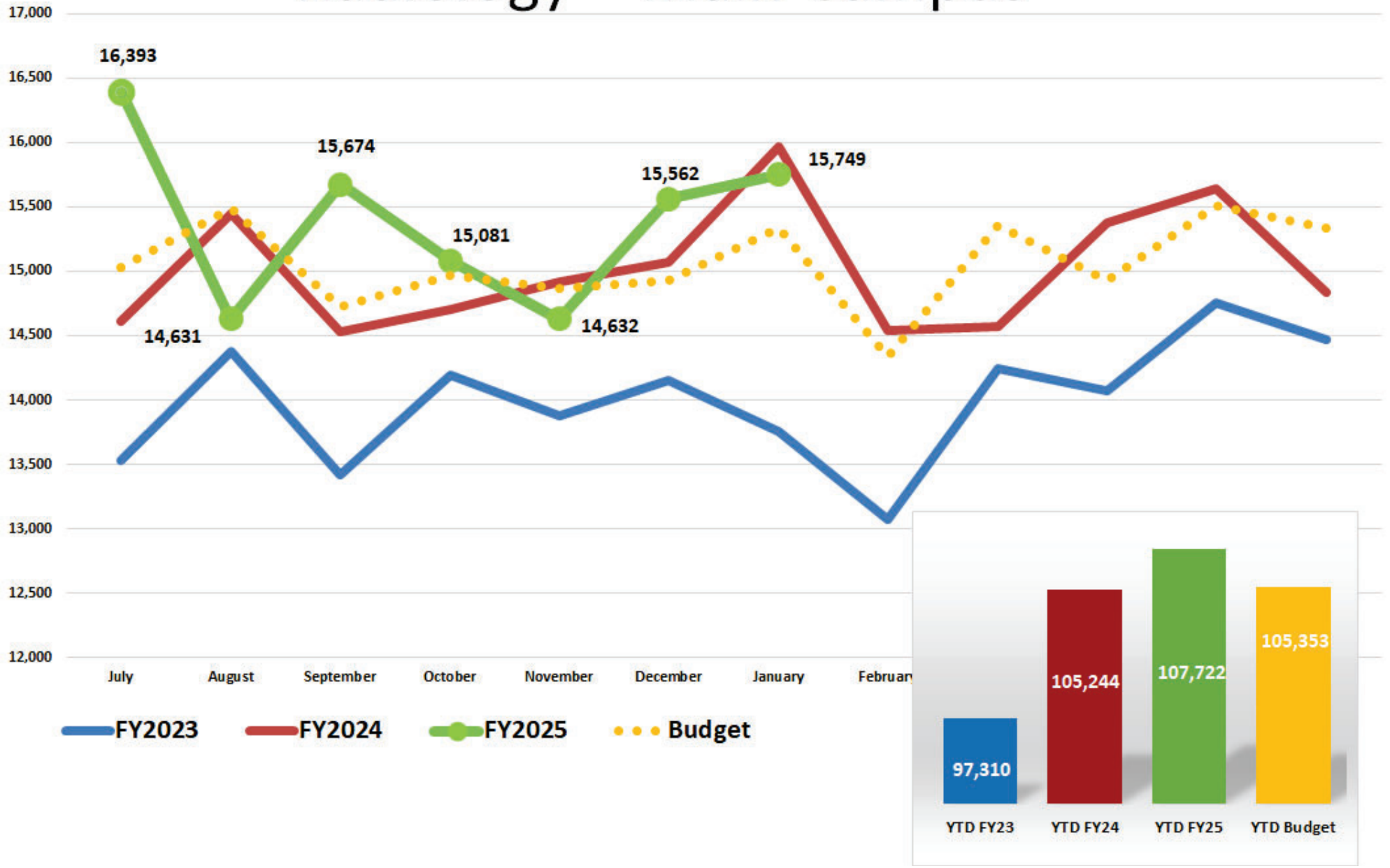
Home Health Visits



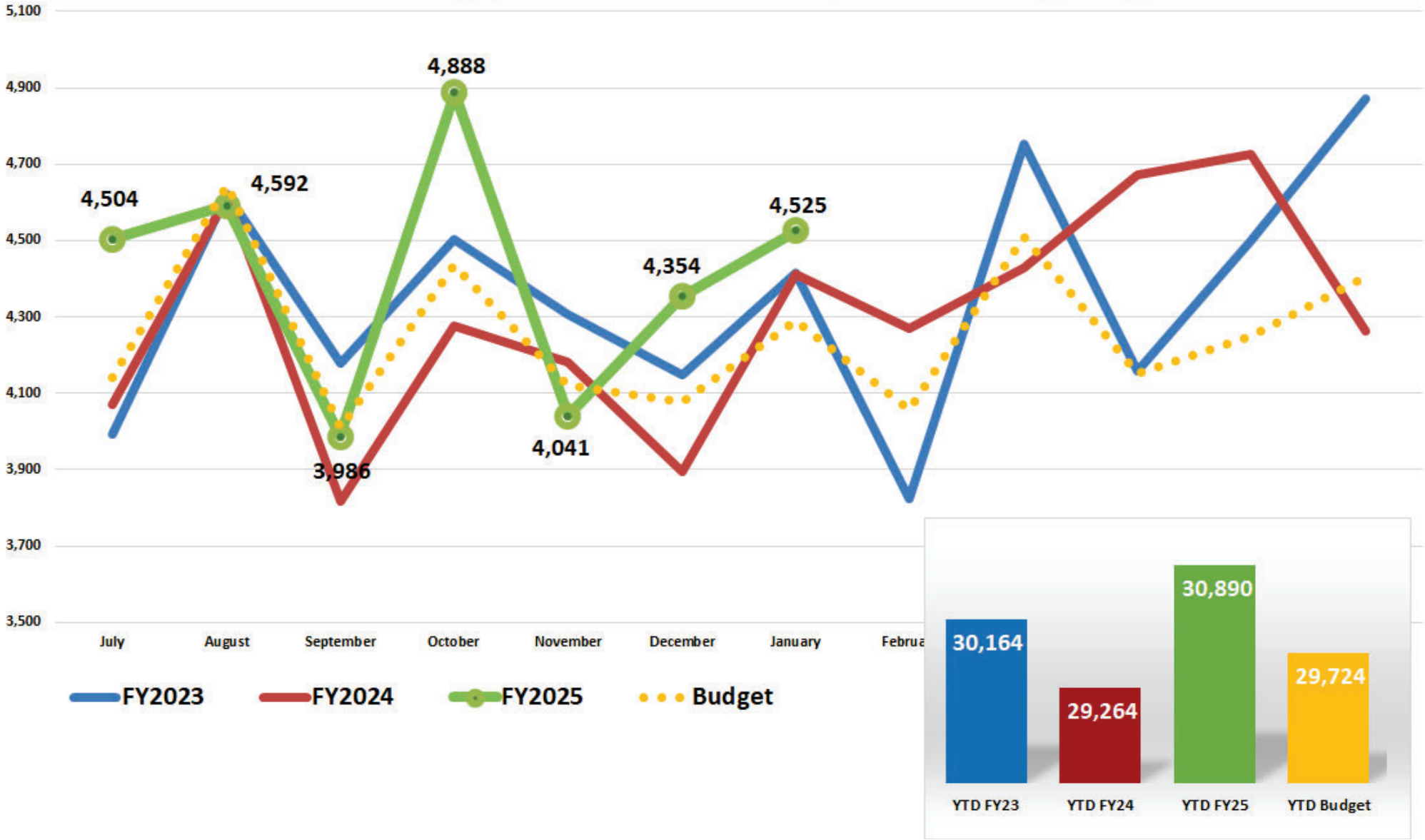
Infusion Center - Units of Service



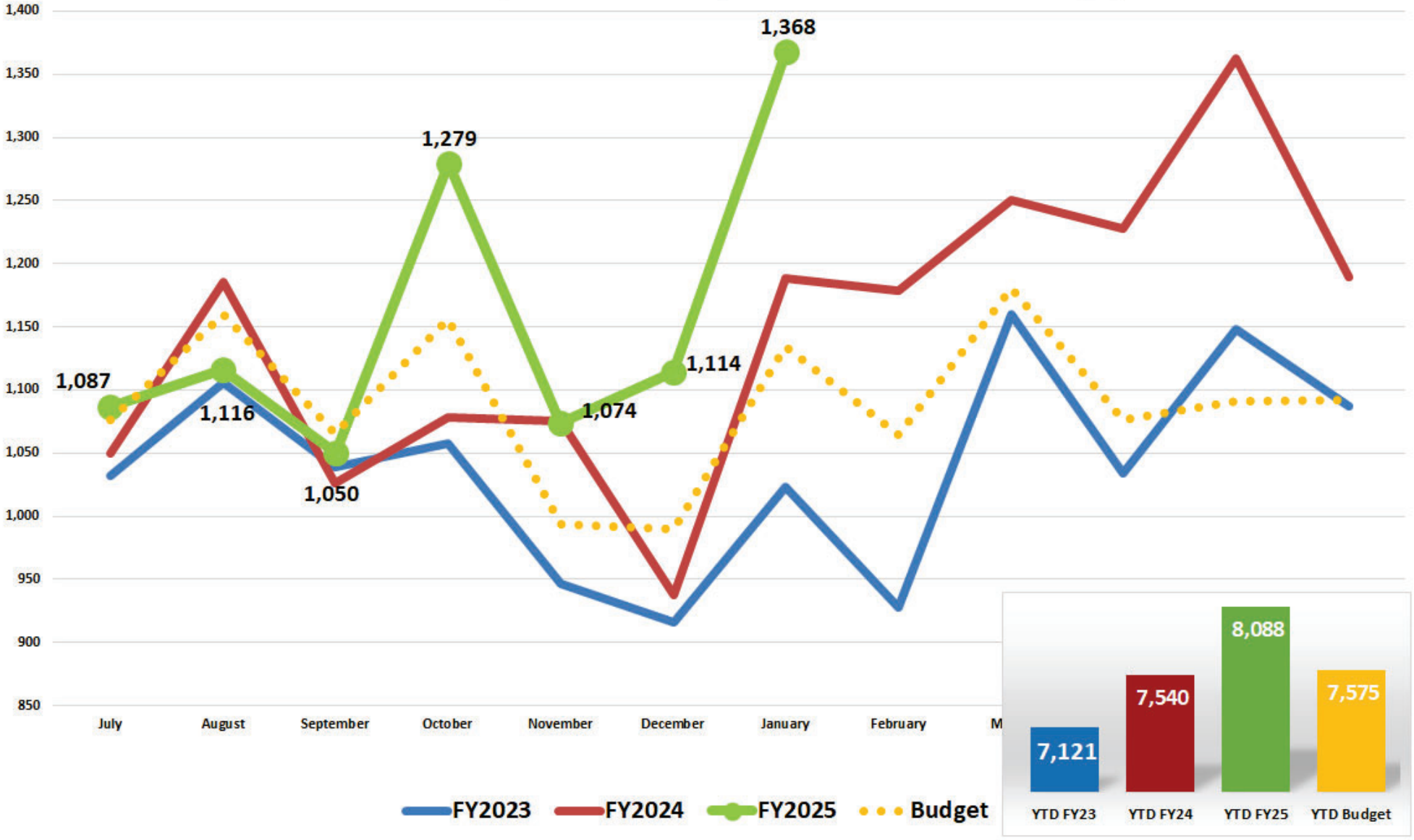
Radiology – Main Campus



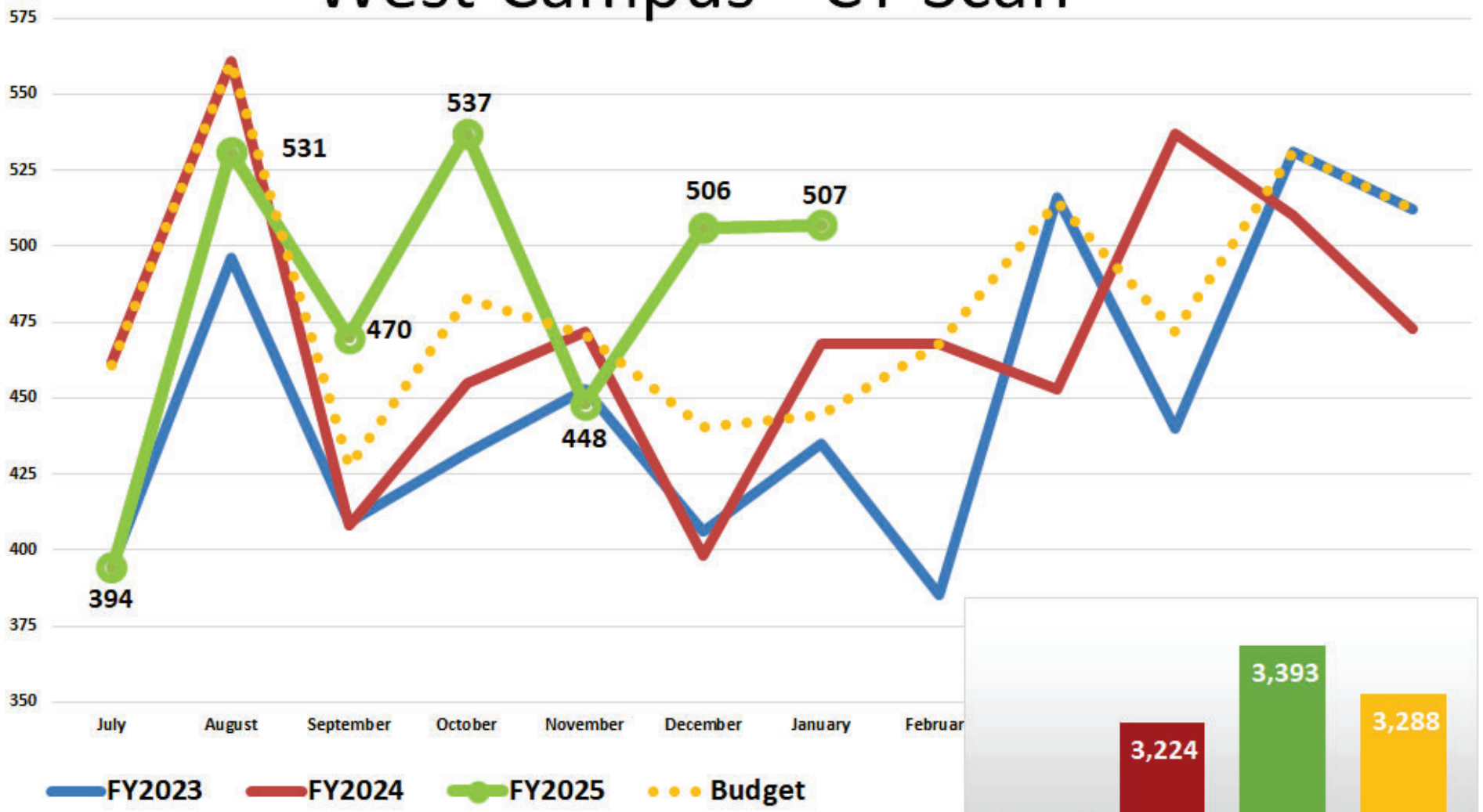
Radiology - West Campus Imaging



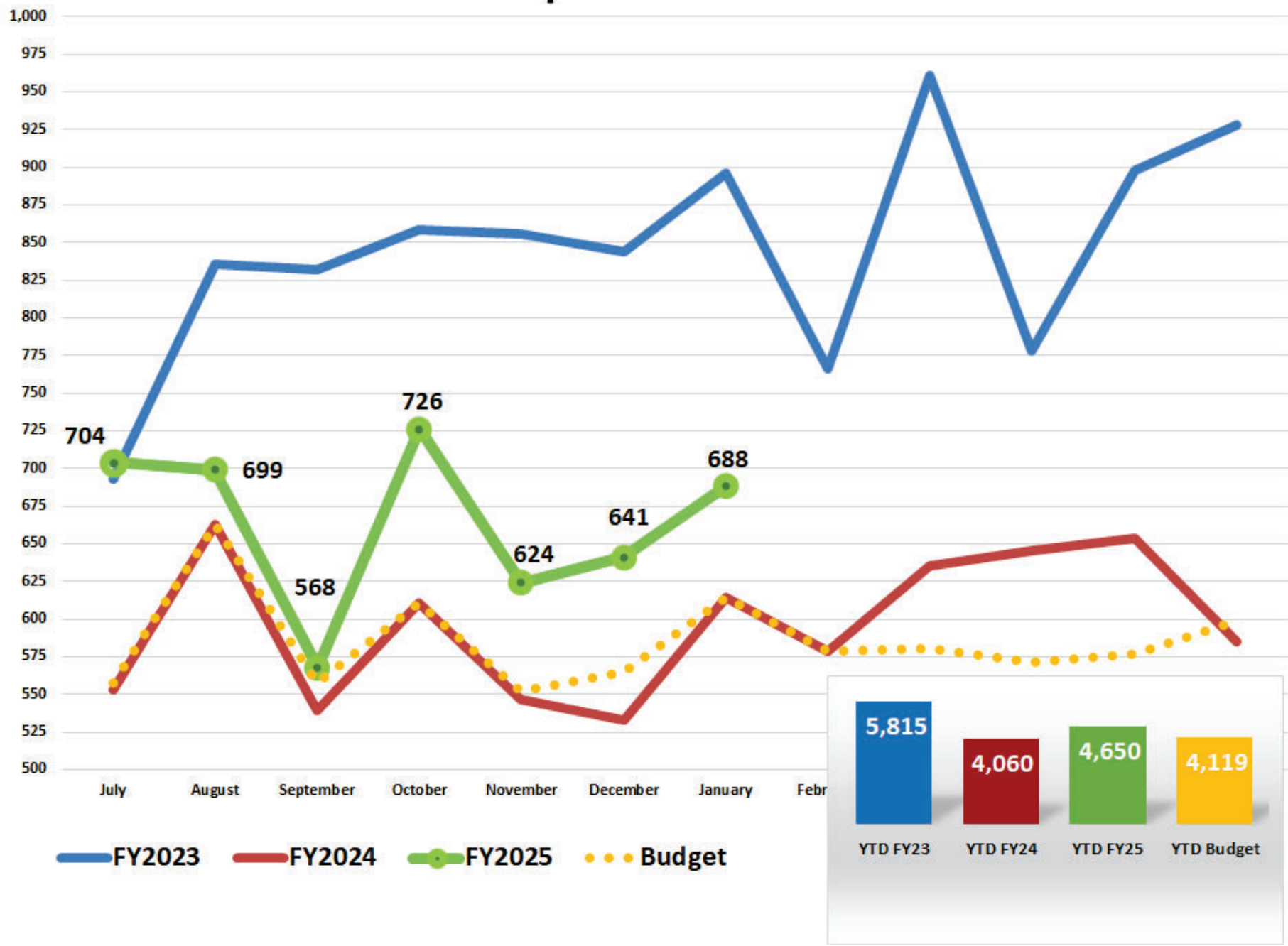
West Campus - Diagnostic Radiology



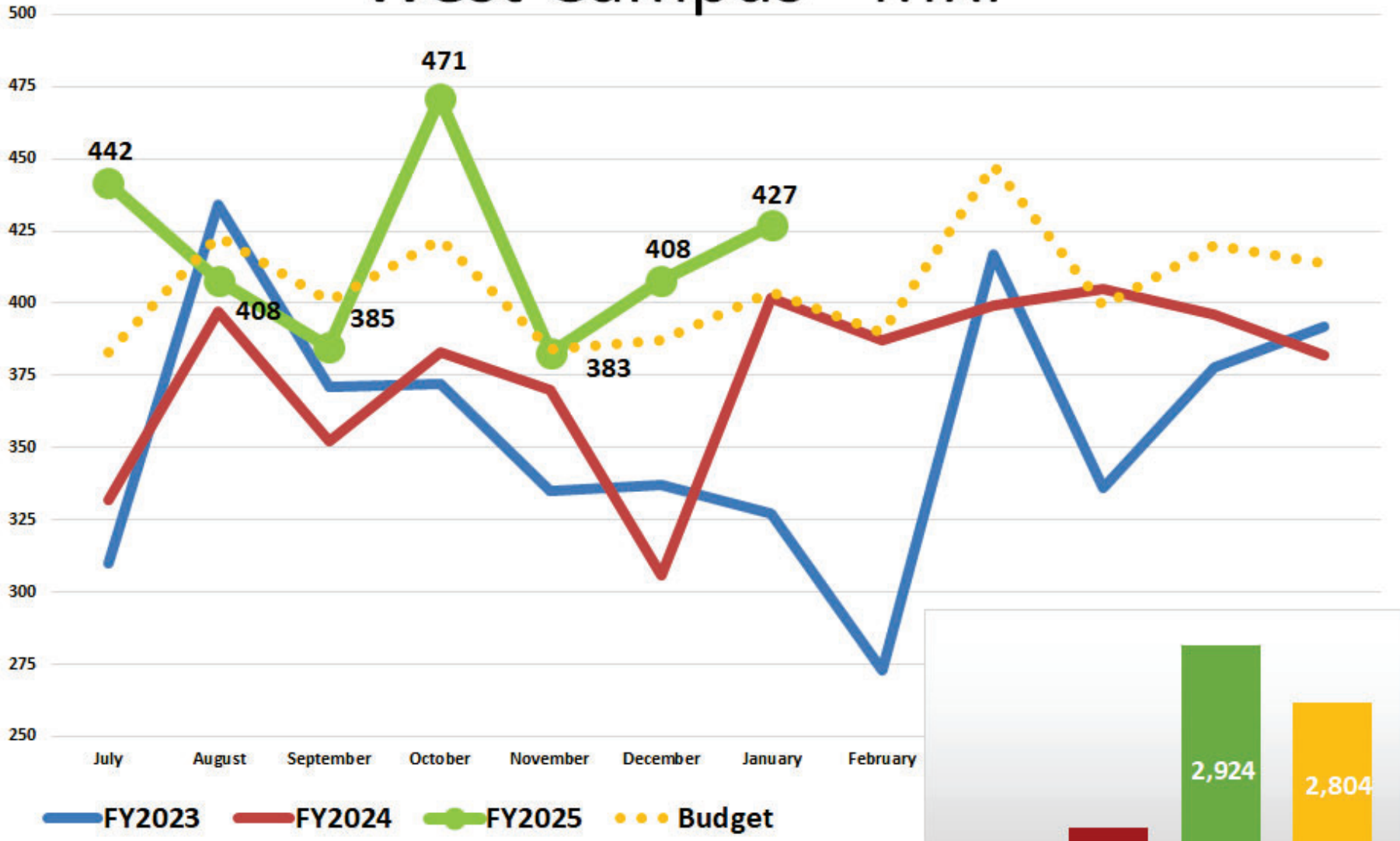
West Campus - CT Scan

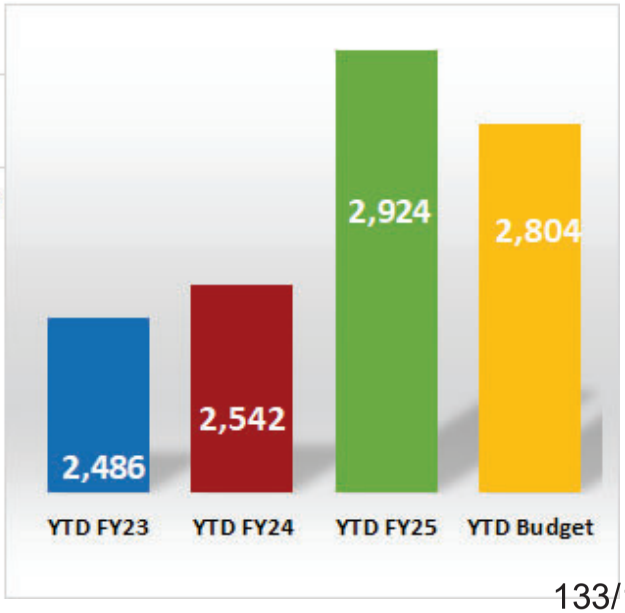


West Campus - Ultrasound

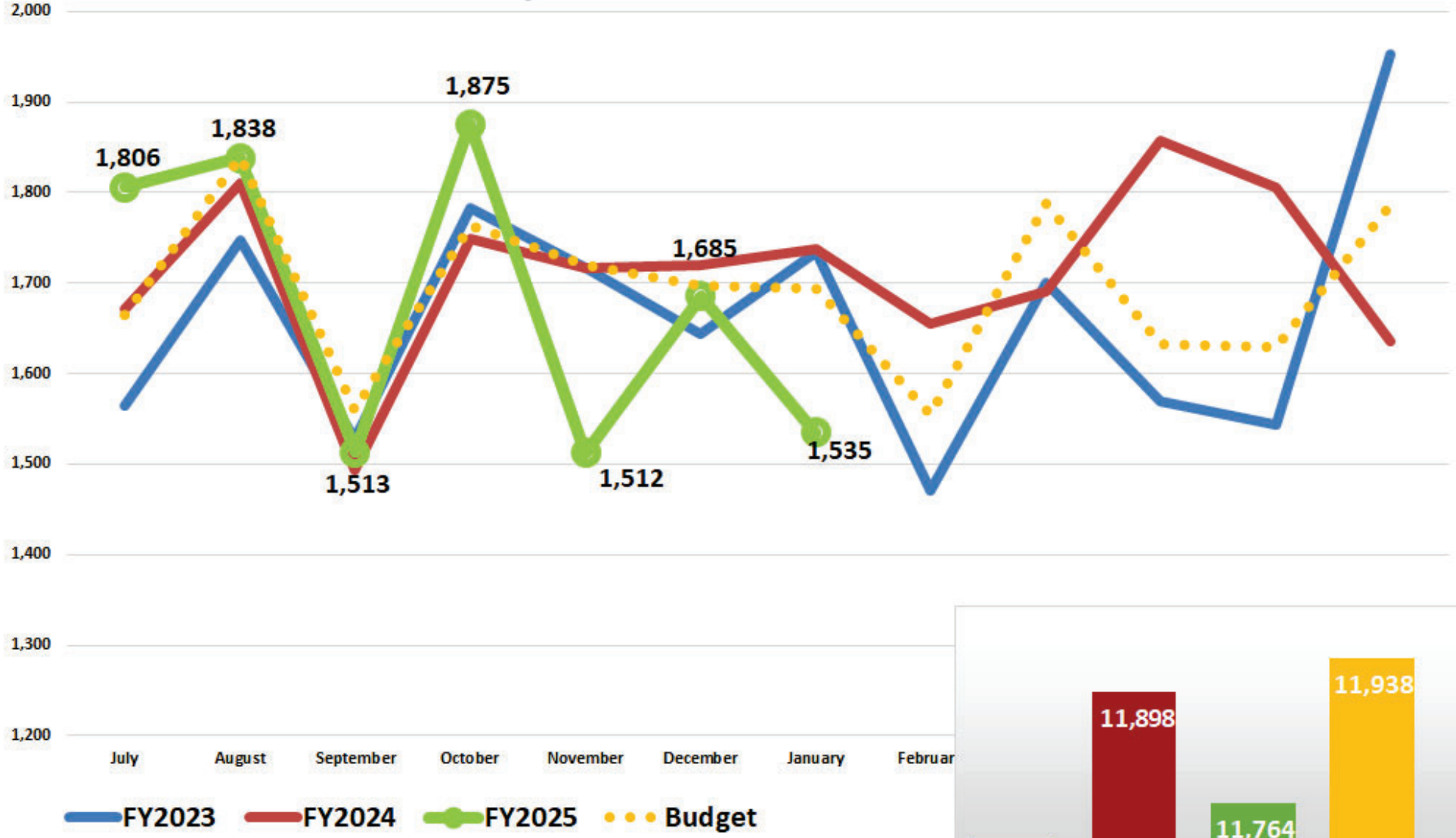


West Campus - MRI

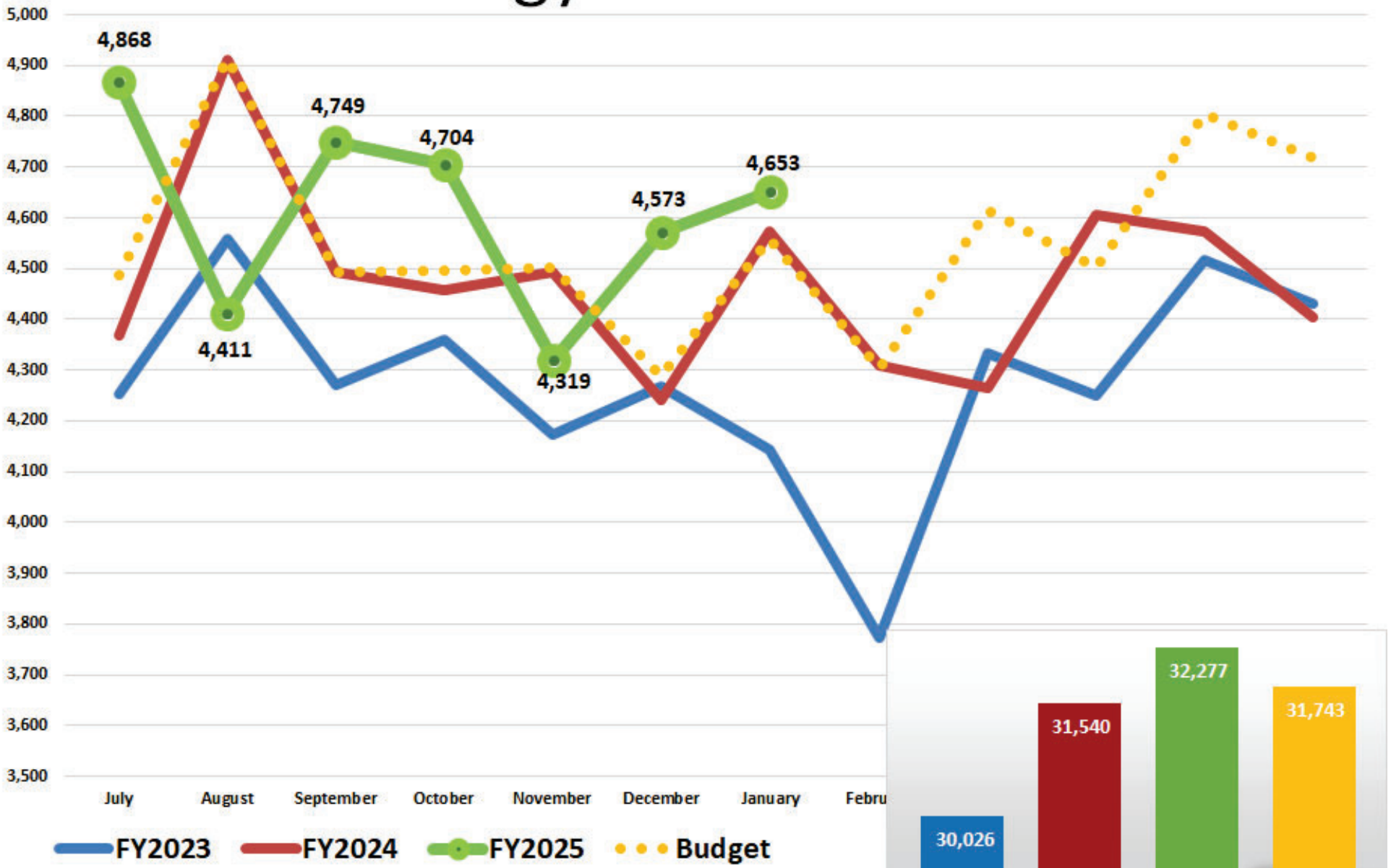




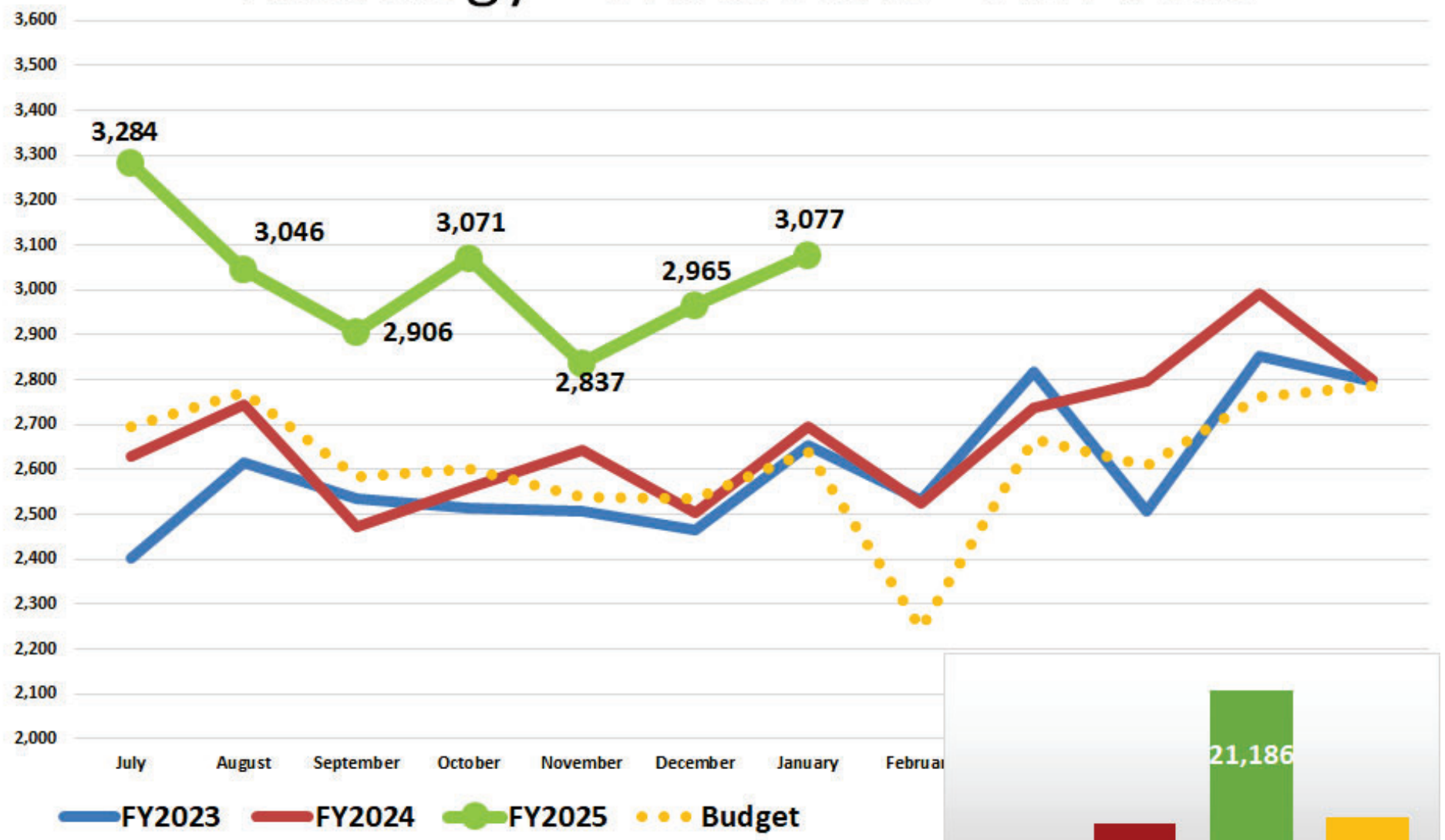
West Campus - Breast Center

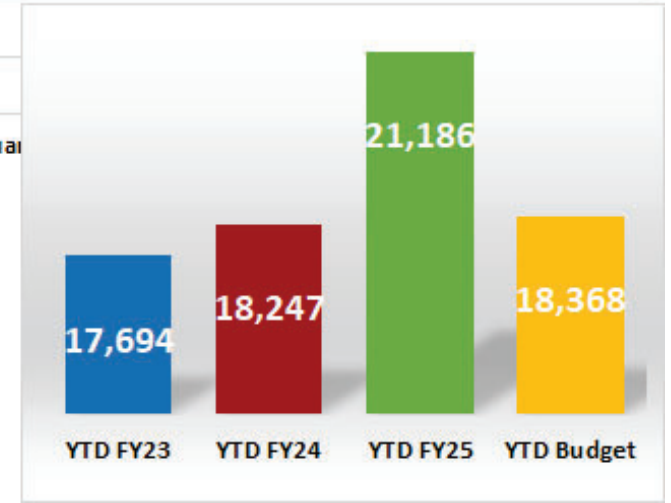


Radiology - CT - All Areas

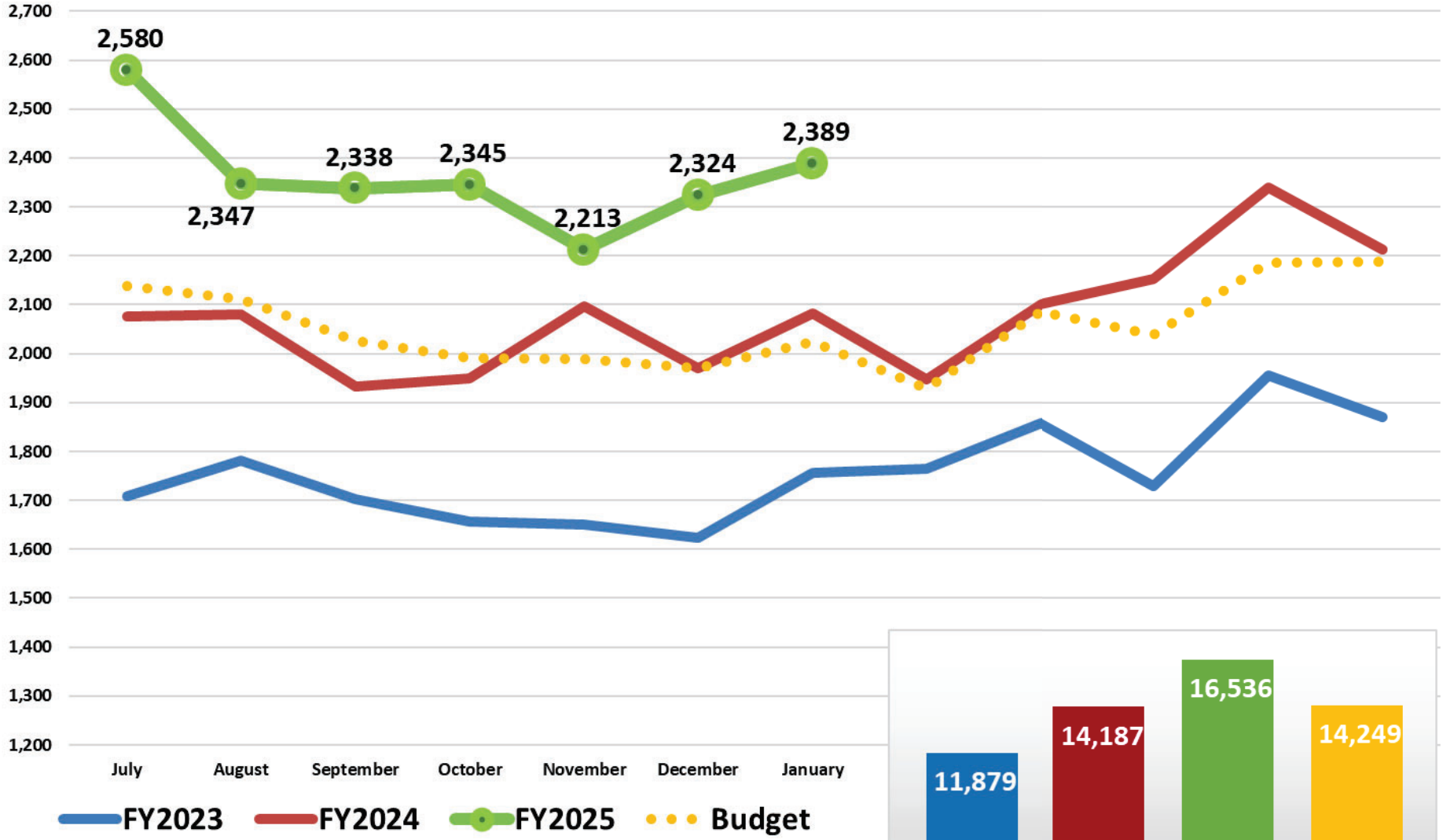


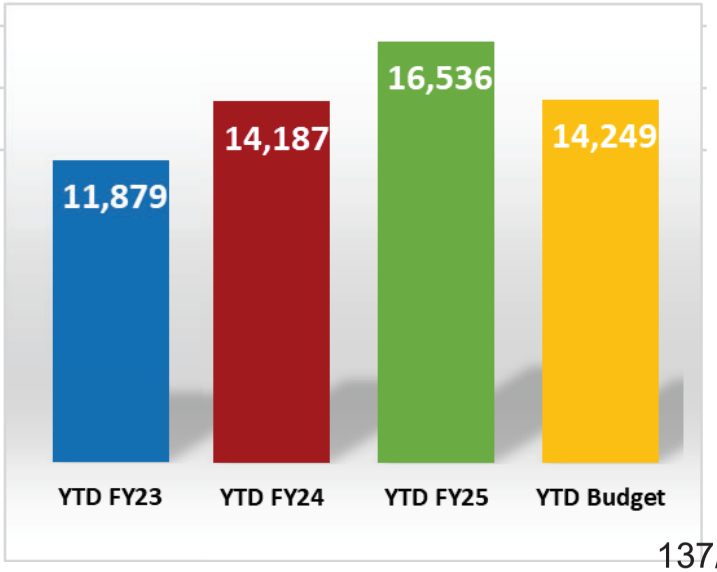
Radiology - Ultrasound - All Areas



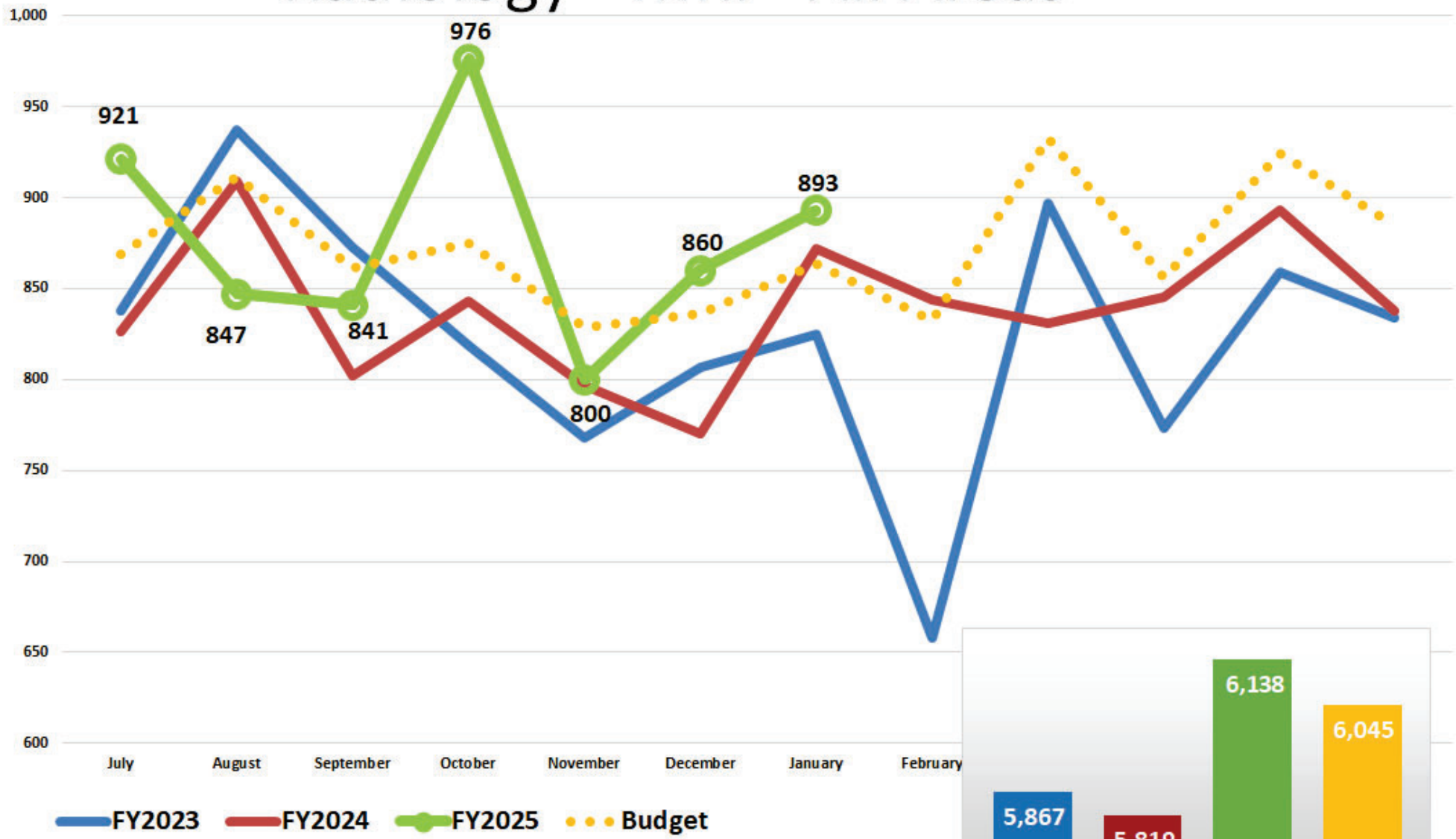


Radiology - Ultrasound - Main Campus

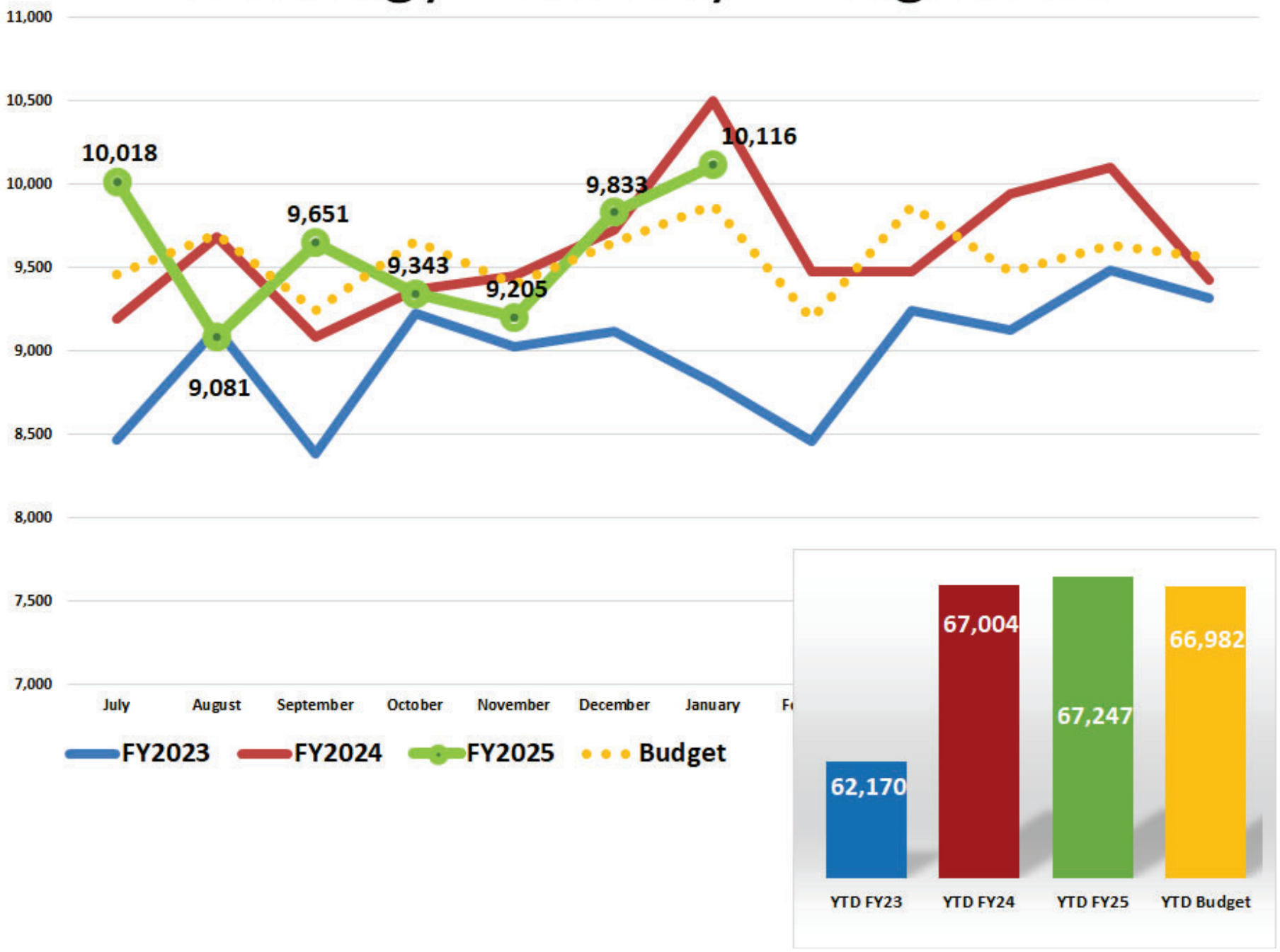




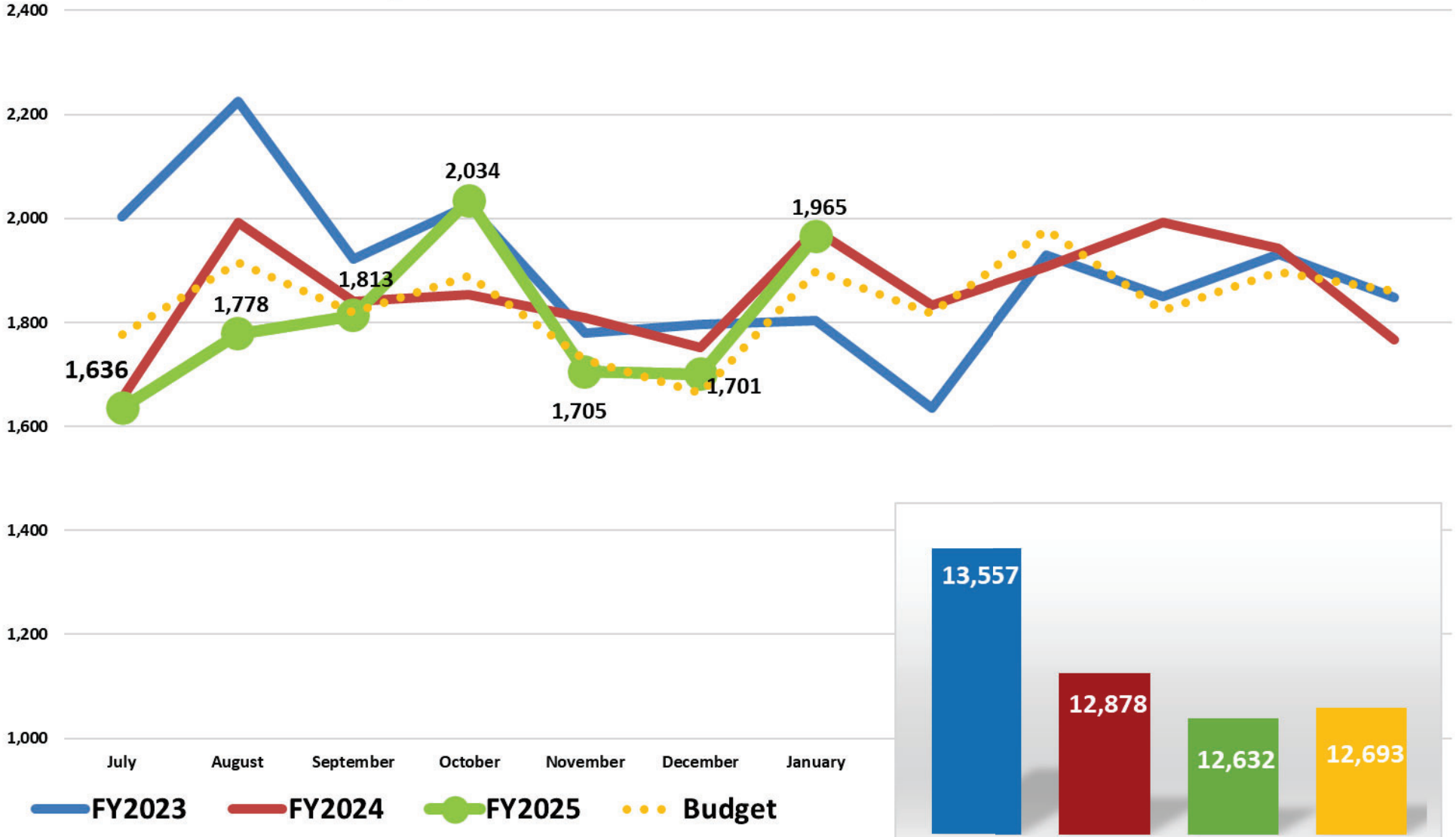
Radiology - MRI - All Areas



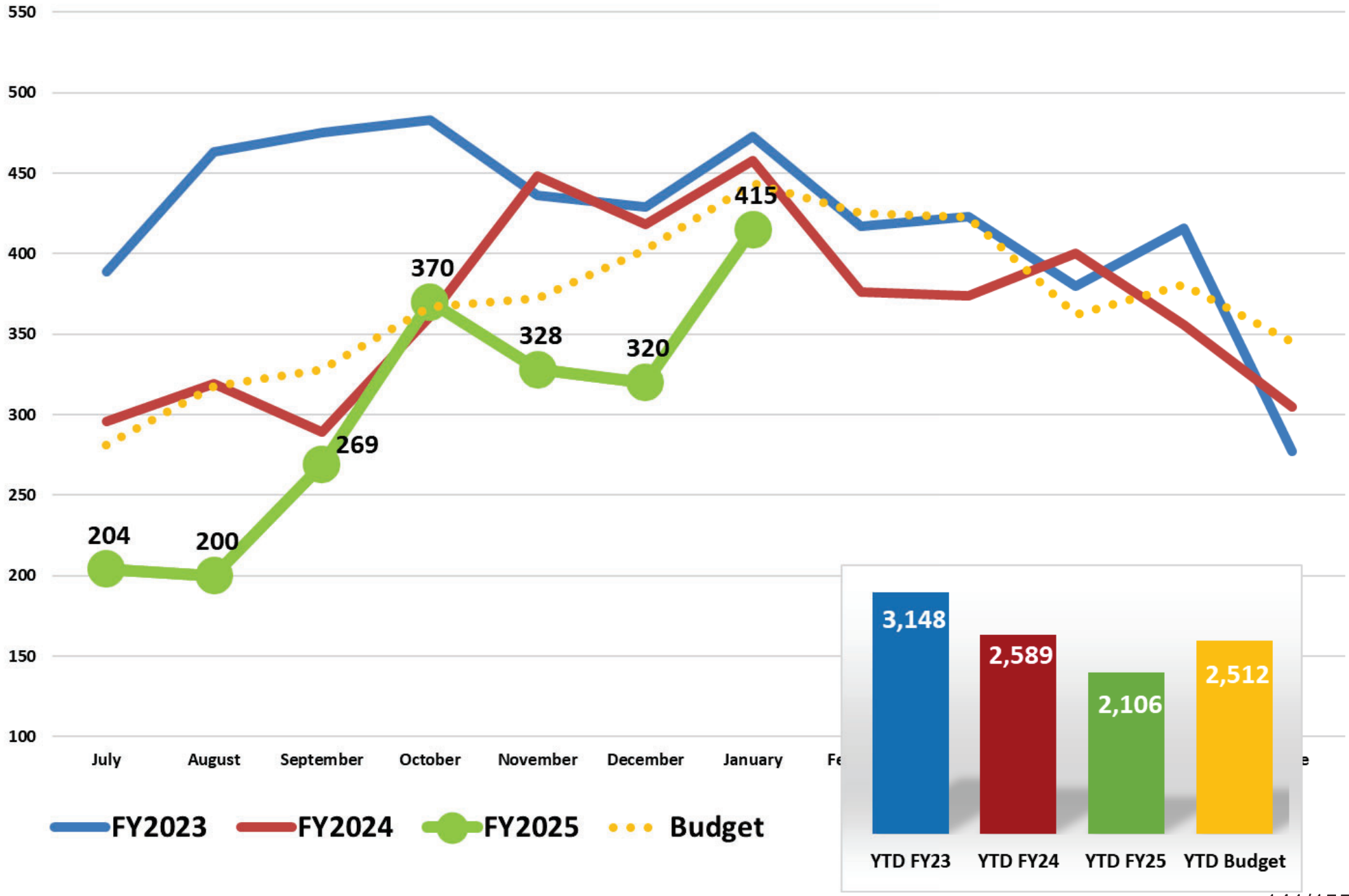
Radiology Modality - Diagnostic



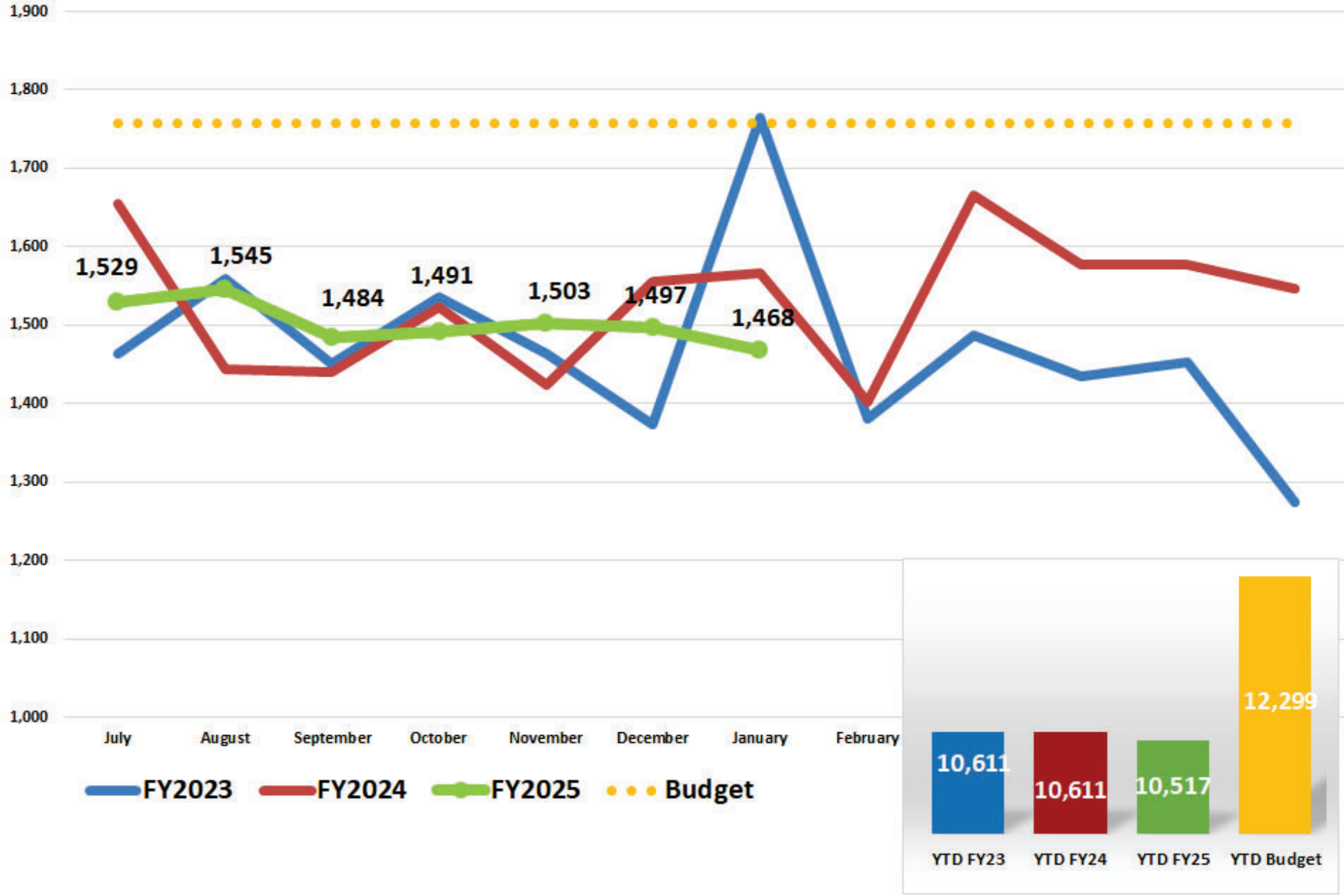
Radiology - UC Court/South Campus



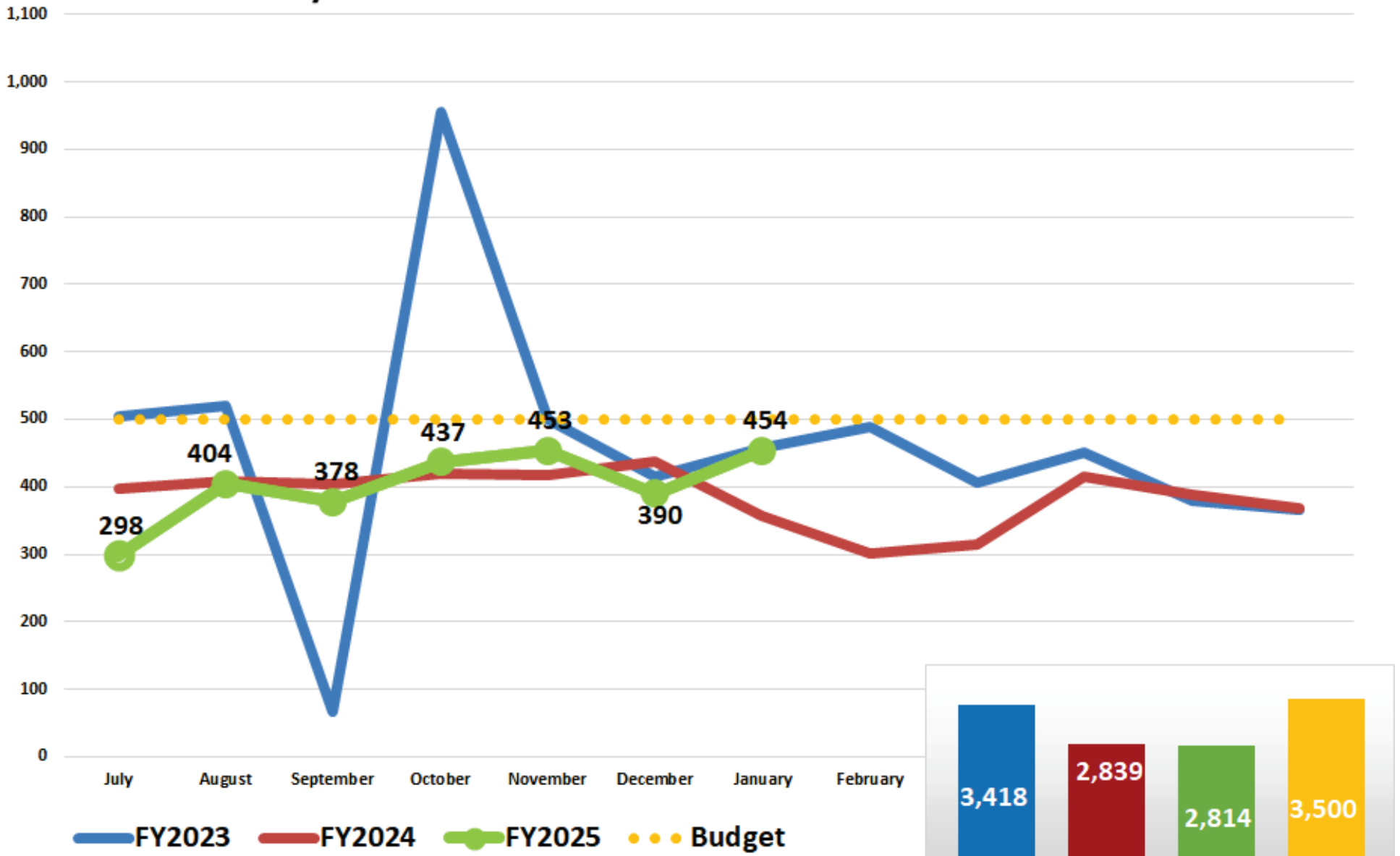
Radiology - UC Demaree/North Campus



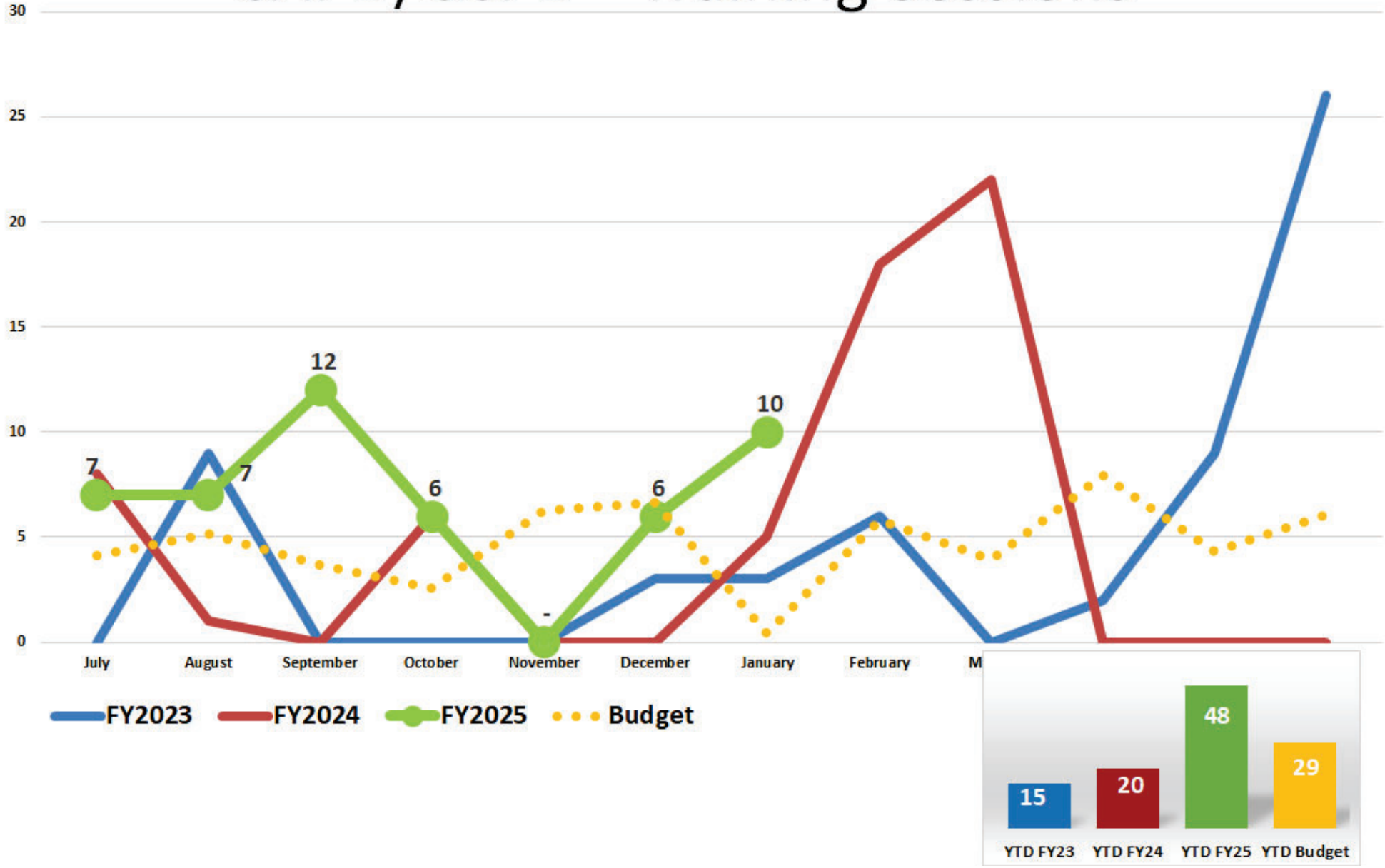
Chronic Dialysis - Visalia



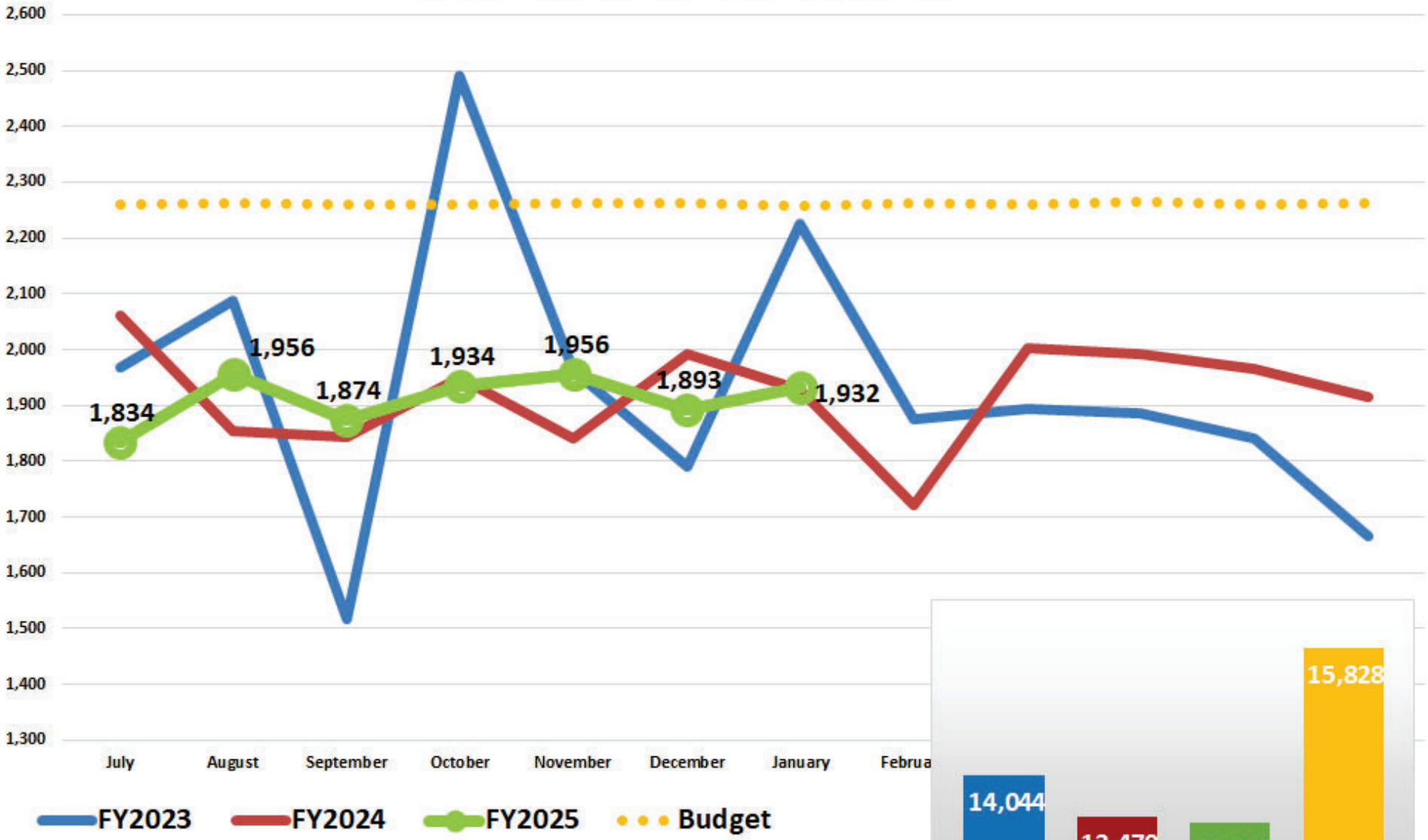
CAPD/CCPD - Maintenance Sessions



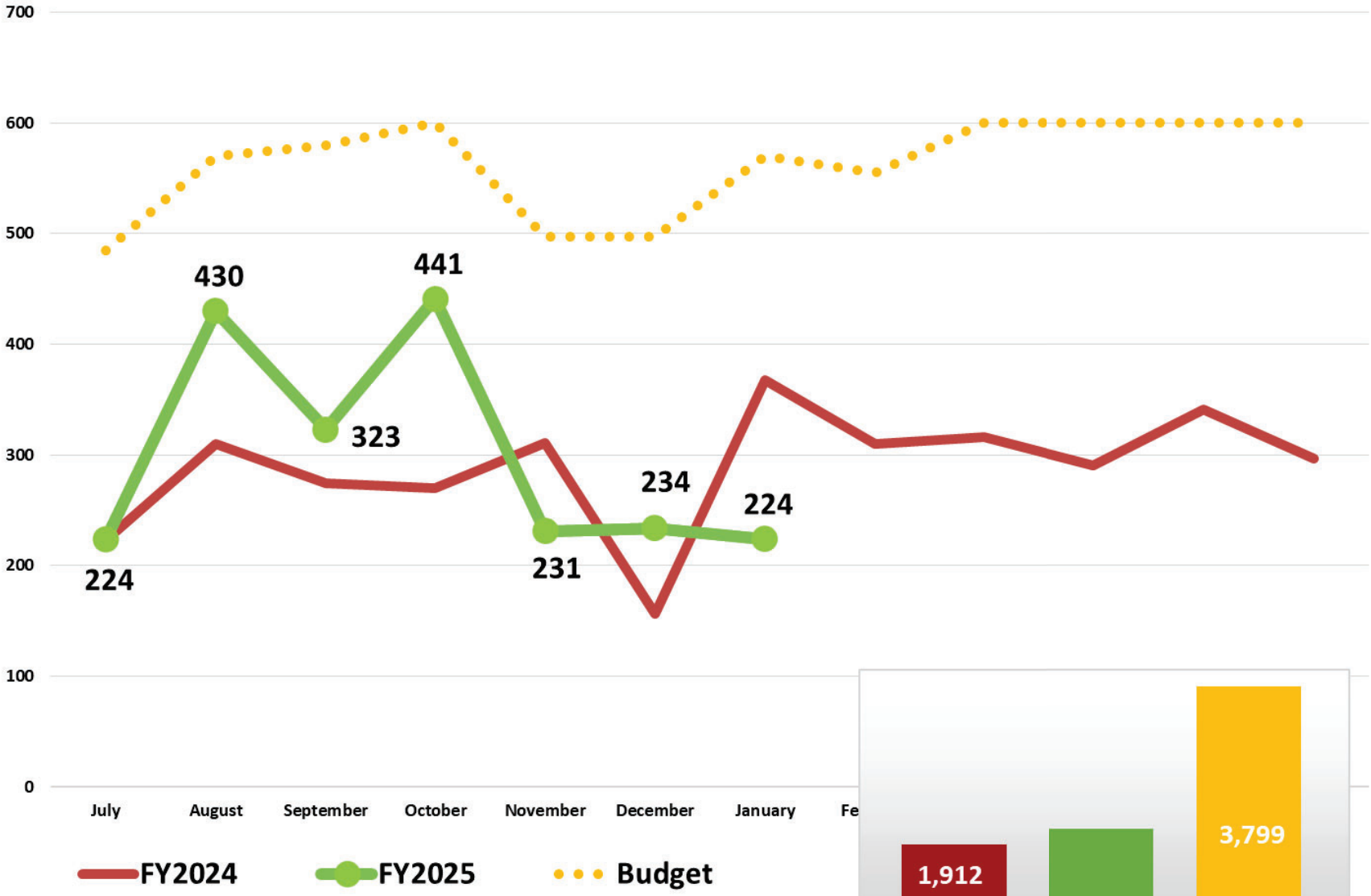
CAPD/CCPD - Training Sessions



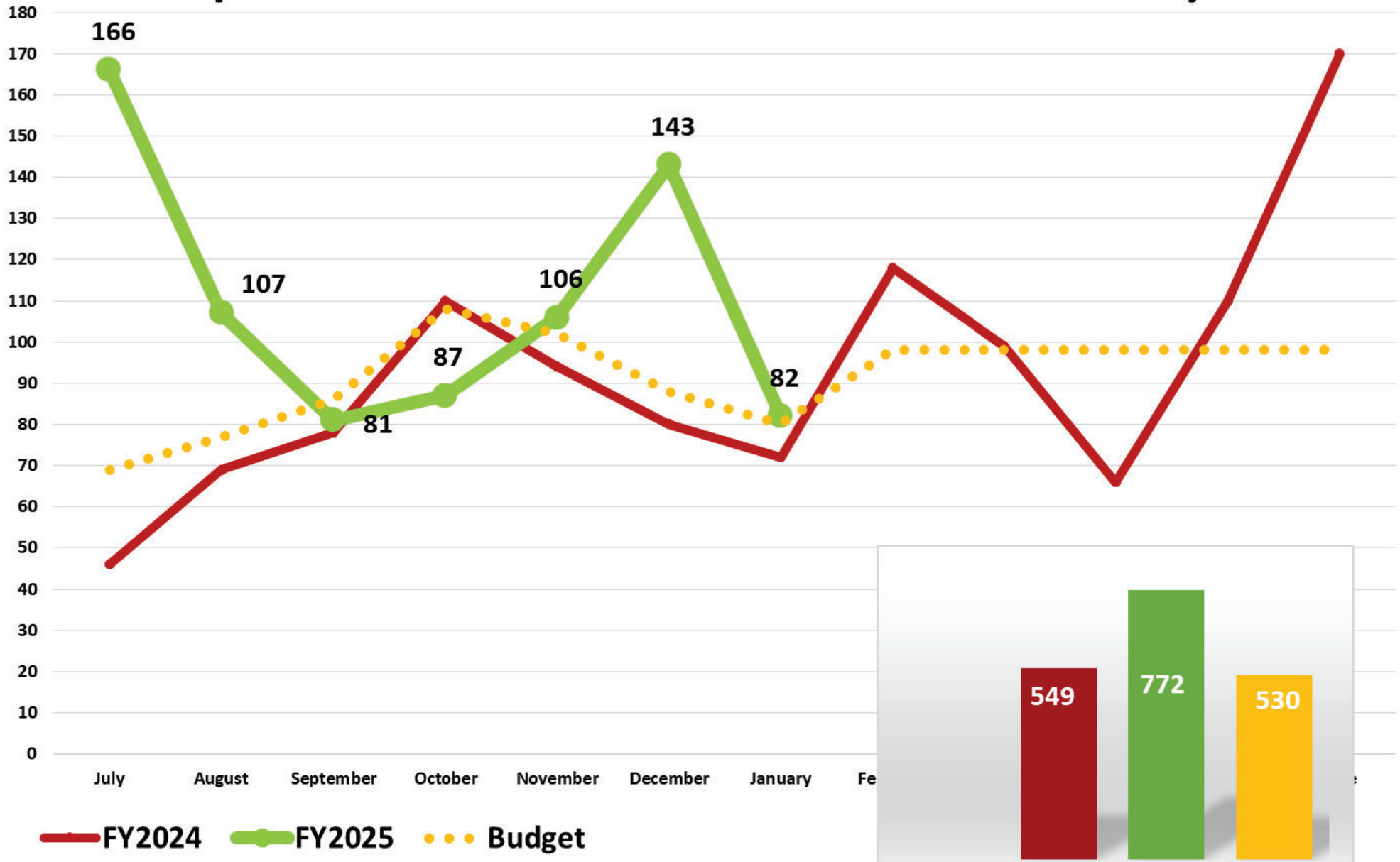
All CAPD & CCPD



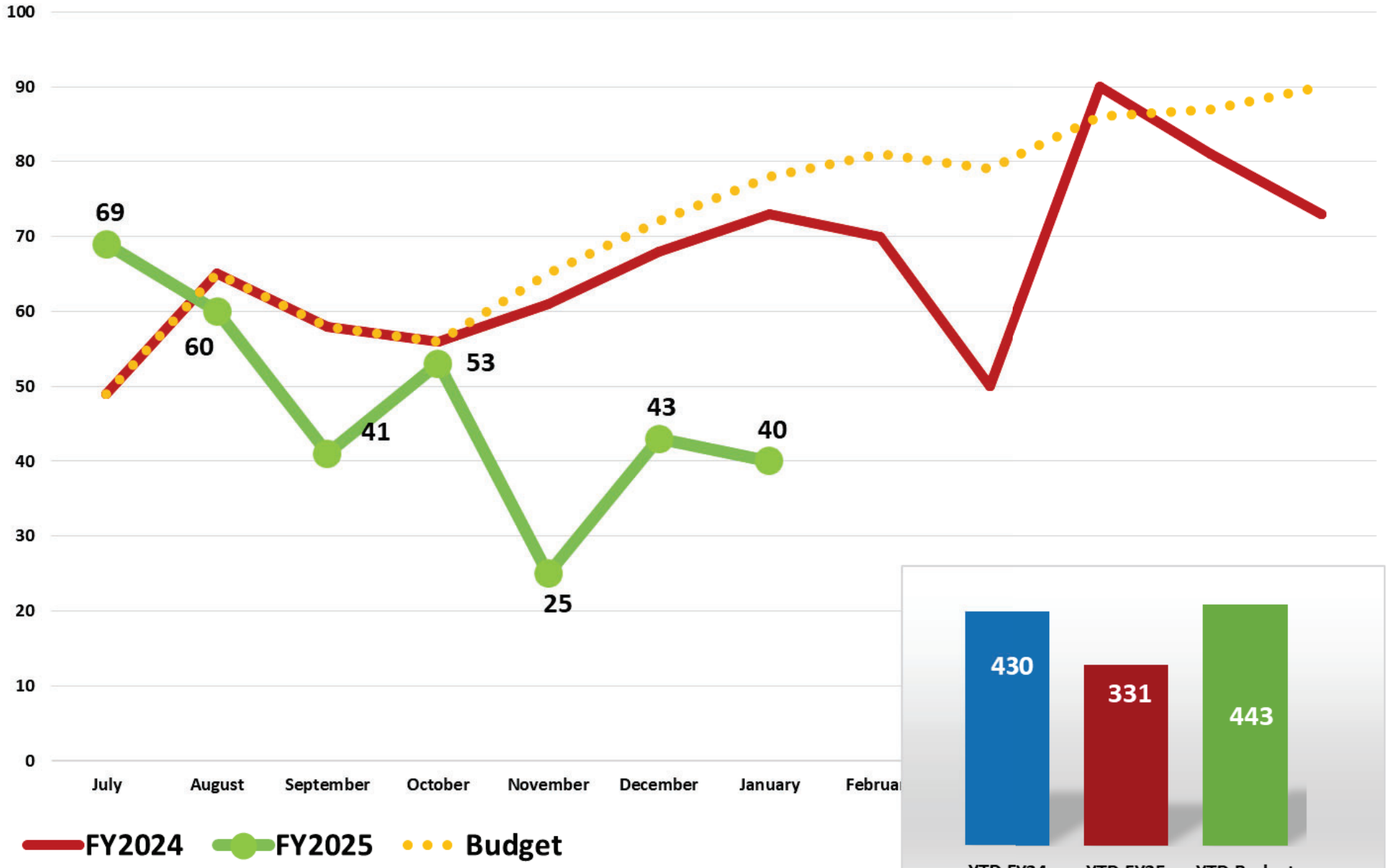
Urology Clinic Visits



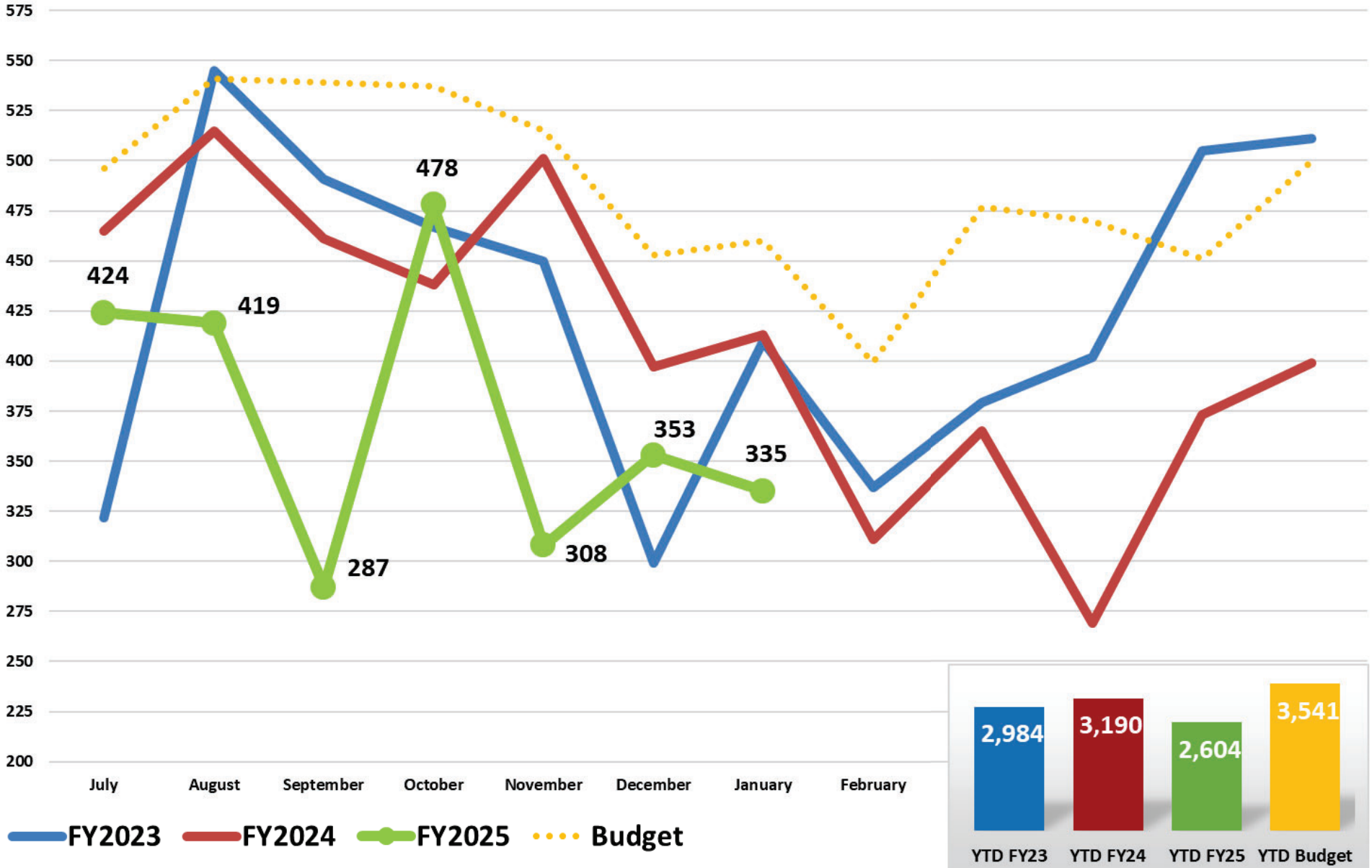
Open Arms House - Patient Days



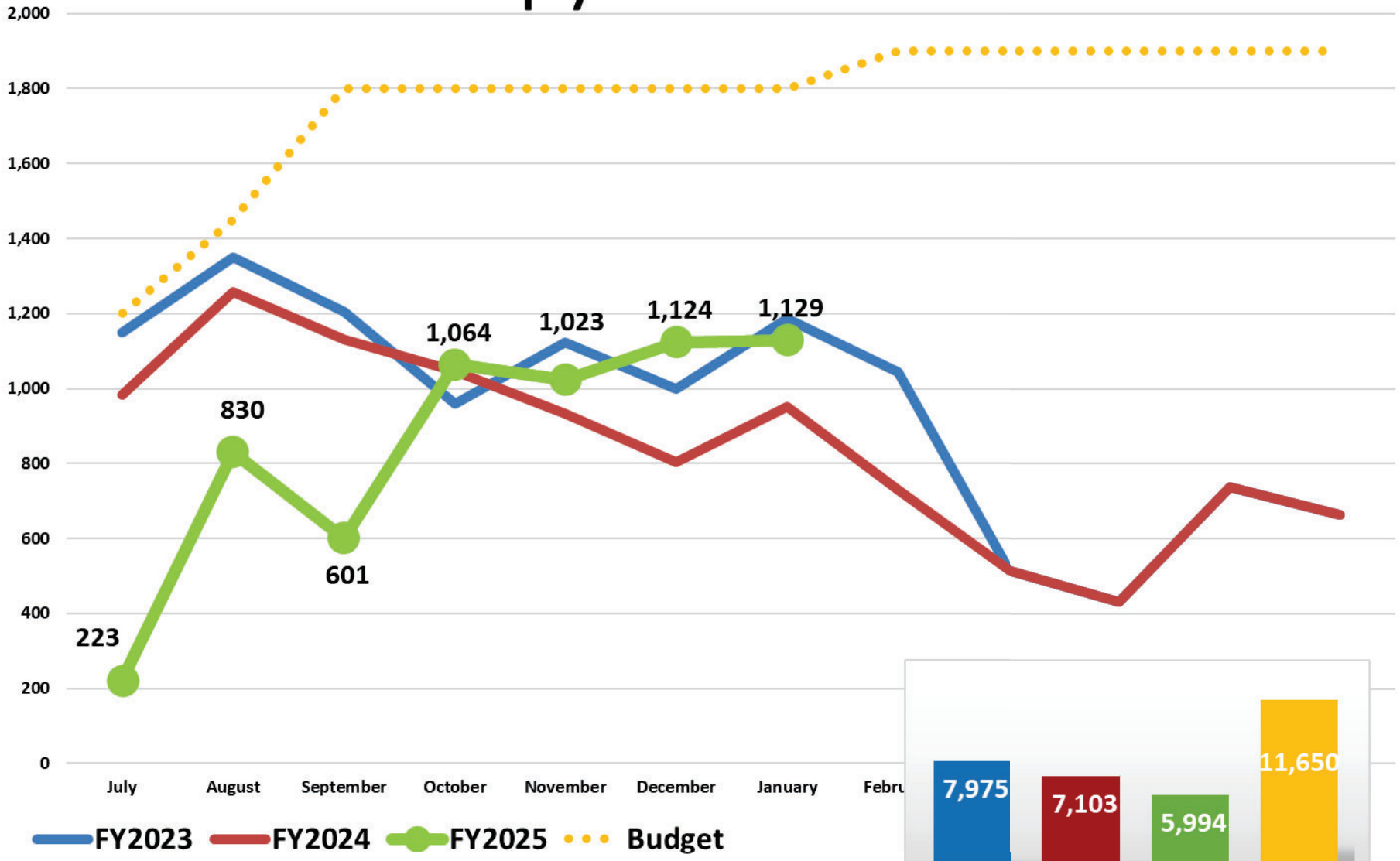
Cardiothoracic Surgery Clinic - Visits

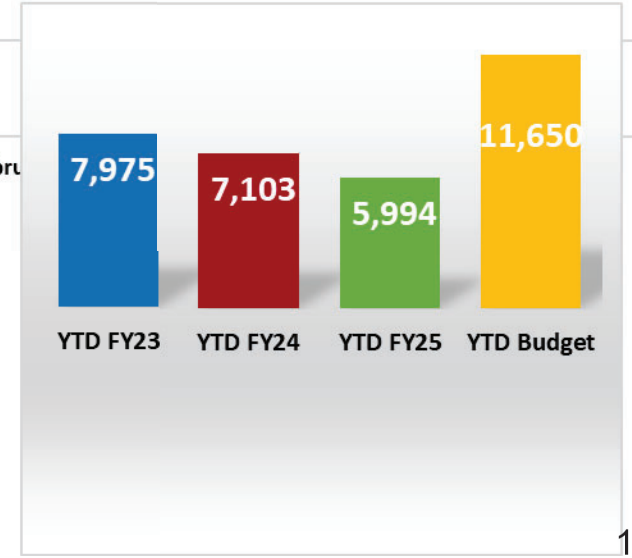


Cardiac Rehabilitation

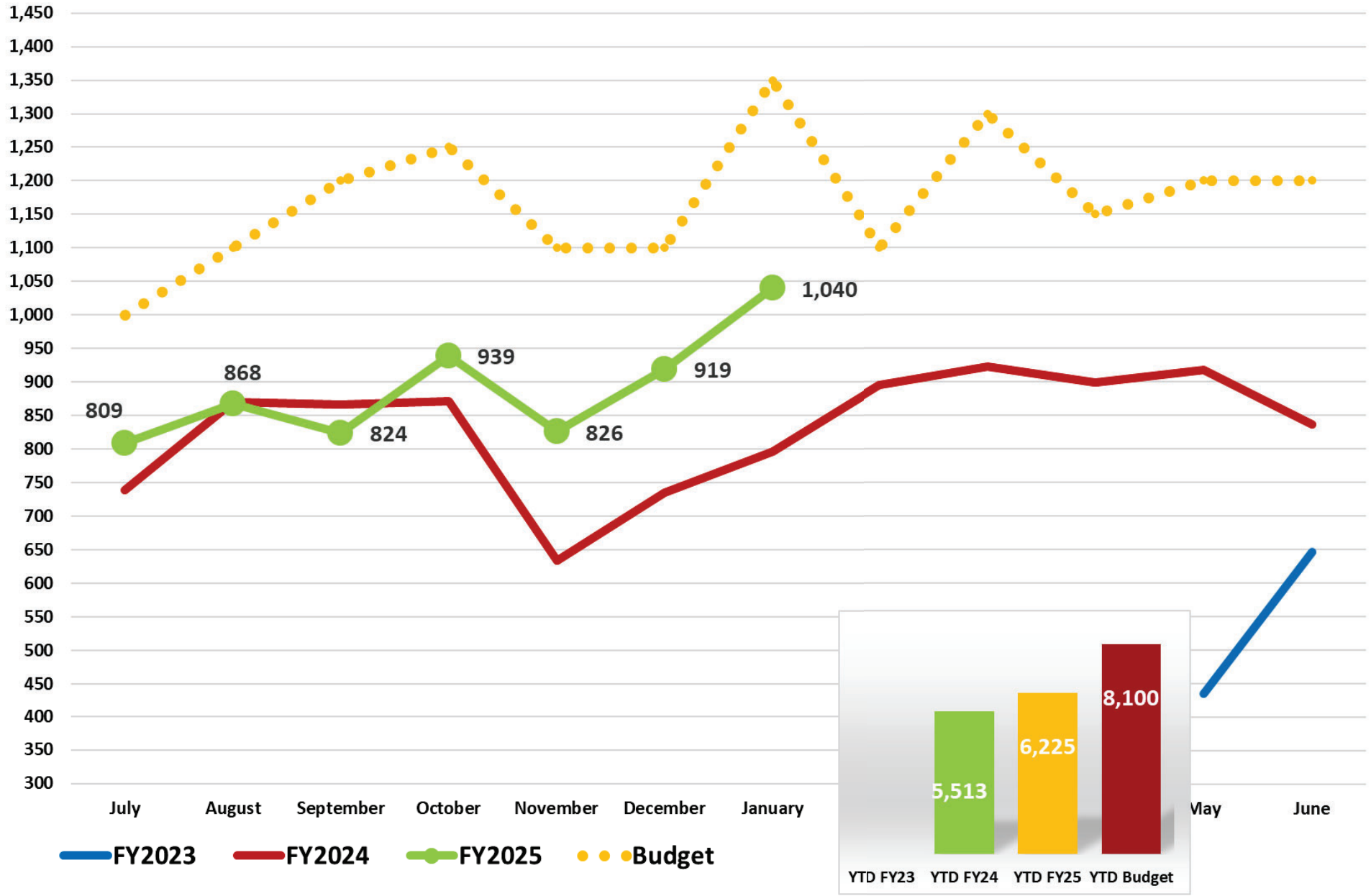


Therapy-Wound Care

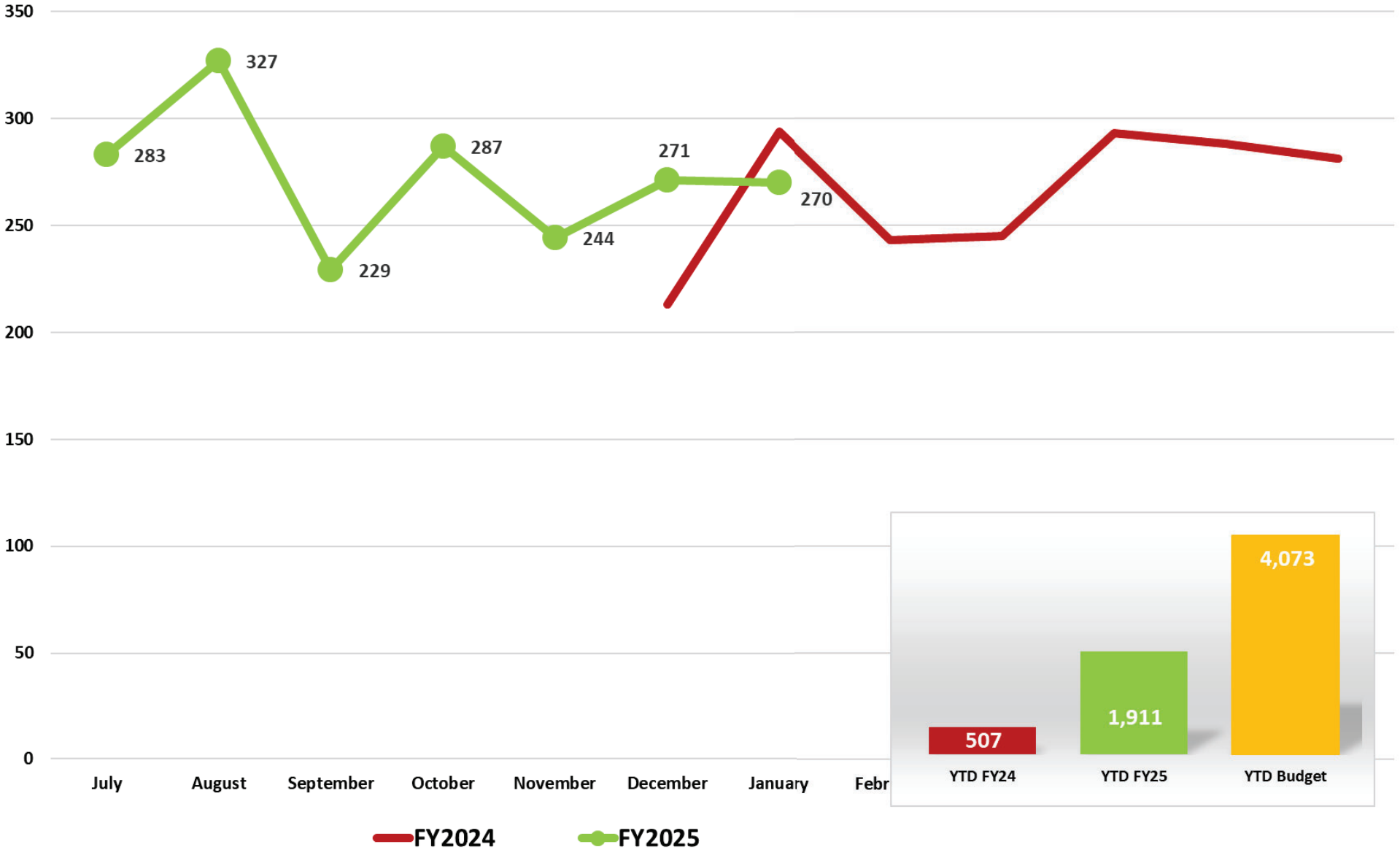




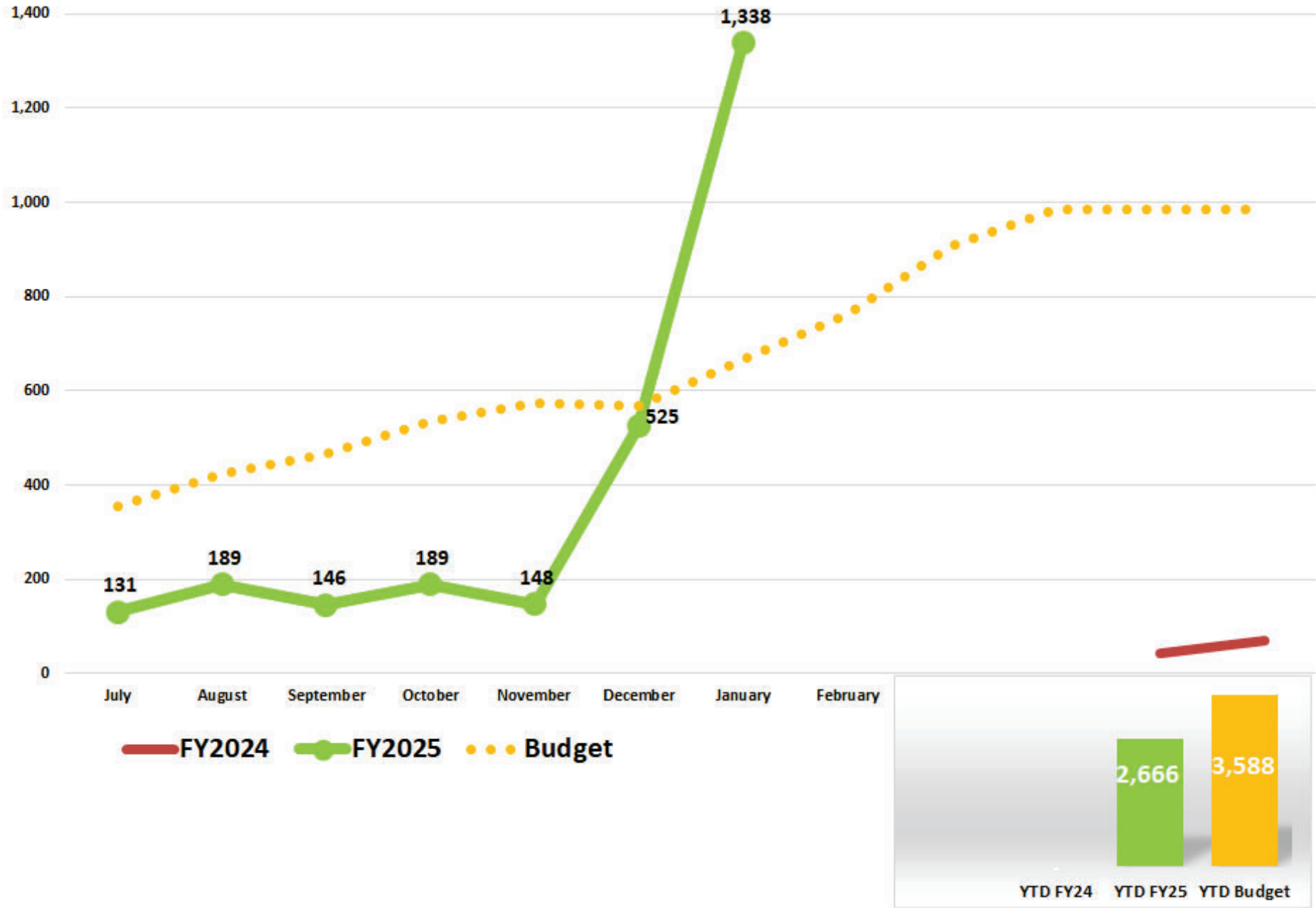
KH Medical Clinic - Ben Maddox



KH Medical Clinic - Plaza



KH Willow Clinic



Medical Oncology Treatments