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.

DATE POSTED: January 23, 2026

NOTICE

Date: Wednesday, January 28, 2026
Location: City of Visalia – City Council Chambers
Address: 707 W. Acequia Avenue, Visalia, California

SCHEDULE:

- **4:00 PM** – Open Session (to approve the Closed Session agenda)
- **4:01 PM** – Closed Session
  Pursuant to:
  - Government Code §54956.9(d)(1) (Existing Litigation)
  - Government Code §54956.9(d)(2) (Anticipated Litigation – Significant Exposure)
  - Health & Safety Code §§1461 and 32155 (Confidential Quality Assurance/Medical Staff Matters)
- **4:45 PM** – Open Session

AMERICANS WITH DISABILITIES ACT (ADA) NOTICE:
In compliance with the Americans with Disabilities Act, if you need special assistance to participate in this meeting, please contact the Board Clerk at (559) 624-2330. Notification at least 48 hours prior to the meeting will enable the District to make reasonable arrangements to ensure accessibility to the meeting.

POSTING NOTICE:
All Kaweah Delta Health Care District regular Board and committee meeting notices and agendas are posted at least **72 hours** prior to the meeting (and **24 hours** prior to special meetings) in the Kaweah Health Medical Center, Mineral King Wing, near the Mineral King entrance, in accordance with Government Code §54954.2(a)(1).

PUBLIC RECORDS:
Disclosable public records related to this agenda are available for public inspection at:
Kaweah Health Medical Center – Acequia Wing, Executive Offices (1st Floor)
400 West Mineral King Avenue, Visalia, CA 93291

You may also request records by contacting the Board Clerk at (559) 624-2330 or **kedavis@kaweahhealth.org**, or by visiting the District's website at **www.kaweahhealth.org**.

KAWEAH DELTA HEALTH CARE DISTRICT
David Francis, Secretary/Treasurer

Prepared by:

Kelsie K. Davis
Board Clerk / Executive Assistant to the 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 January 28, 2026 {Regular Meeting}

OPEN MEETING AGENDA {4:00PM}

1. **CALL TO ORDER**
2. **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.
3. **ADJOURN**

CLOSED MEETING AGENDA {4:01PM}

1. **CALL TO ORDER**

2. **CONFERENCE WITH LEGAL COUNSEL – EXISTING LITIGATION AND QUARTERLY RISK MANAGEMENT** –Discussion with legal counsel regarding ongoing litigation matters involving risk management, patient safety, or related claims. (Pursuant to Government Code 54956.9(d)(1))

A. BURNS-NUNEZ V KDHCD	I. GOODES V. KDHCD
B. M. VASQUEZ V. KDHCD	J. MARTINEZ-LUNA V. KDHCD
C. RHODES V. KDHCD	K. VIZCAINO V KDHCD
D. LARUMBLE-TORRES V KDHCD	L. MORENO V KDHCD
E. SMITHSON V KDHCD	M. RICHARDSON V KDHCD
F. RAMIREZ V. KDHCD	N. TINOCO V KDHCD
G. MEDINA V KDHCD	O. MACKEY V KDHCD
H. BURGER V KDHCD	P. ISQUIERDO V KDHCD

3. **CONFERENCE WITH LEGAL COUNSEL – EXISTING LITIGATION AND RISK MANAGEMENT** – *Discussion with legal counsel regarding ongoing litigation matters involving risk management, patient safety, or related claims. (Pursuant to Government Code 54956.9(d)(1))*

   Lucile Salter Packard Children's Hospital at Stanford v. Kaweah Delta Health Care District et al.

   Action Requested

4. **CONFERENCE WITH LEGAL COUNSEL – ANTICIPATED LITIGATION / QUALITY OF CARE RISK EXPOSURE –** Conference with legal counsel regarding potential exposure to litigation involving adverse patient outcomes, risk management review, and related quality assurance matters. Pursuant to Government Code 54956.9(d)(2); (2 cases.)

   Action Requested

5. **EXPOSURE TO LITIGATION AND QUALITY ASSURANCE REVIEW –** Quarterly Conference with legal counsel and risk management regarding a specific adverse event with potential legal exposure, including internal quality review and risk mitigation steps. (Government code 54956.9(d)(2) and Evid. Code 1157.)

6. MEDICAL STAFF CREDENTIALING AND PRIVILEGING - 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 Government Code 54957.

   Action Requested

7. MEDICAL STAFF QUALITY ASSURANCE discussion and evaluation of medical staff quality assurance matters, including peer review findings, performance assessments, and related compliance activities. This session is closed pursuant to Government Code 54957.

8. **APPROVAL OF THE CLOSED MEETING MINUTES** – December 17, 2025.
   Action Requested

9. **ADJOURN**

Kaweah Delta Health Care District
Board of Directors Meeting

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Kaweah Health
MORE THAN MEDICINE. LIFE.

OPEN MEETING AGENDA {4:45PM}

1. **CALL TO ORDER**
2. **ROLL CALL**
3. **FLAG SALUTE**
4. **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.
5. **CLOSED SESSION ACTION TAKEN** – Report on action(s) taken in closed session.
6. **RECOGNITIONS**
   - **6.1.** Presentation of Resolution 2279 to Donna Barker in recognition as the Kaweah Health World Class Employee of the month – January 2026.
   - **6.2.** World Class Team of the Month – Hospice Pediatrics Team
   - **6.3.** Presentation of Resolution 2280 to Glenn Byrd in recognition of his years of service and retirement after 21 years.
7. **CHIEF OF STAFF REPORT** – Report relative to current Medical Staff events and issues.
8. **CONSENT CALENDAR -** All items listed under the Consent Calendar are considered routine and non-controversial by District staff and will be approved by one motion, unless a Board member, staff, or member of the public requests that an items be removed for separate discussion and action.
   Public Participation – Members of the public may comment on agenda item before action is taken and after the item has been discussed by the Board.
   Action Requested – Approval of all items on the January 28, 2026, Consent Calendar.

Section	Item	Description	Type
8.1. REPORTS	A	Physician Recruitment	Receive and File
	B	Overall Strategic Plan	Receive and File
	C	Long Term Care	Receive and File
	D	Center for Mental Wellness	Receive and File

Section	Item	Description	Type
	E	Mental Health Hospital	Receive and File
	F	Quarterly Risk Management Report	Receive and File
8.2. MINUTES	A	Marketing and Community Relations- December 3, 2025	Approve Minutes
	B	Human Resource Committee- December 10, 2025	Approve Minutes
	C	Quality Council Committee – December 11, 2025	Approve Minutes
	D	Regular Open Board Meeting – December 17, 2025	Approve Minutes
8.3. POLICIES	**A**	**Board Policies**	
	1	BOD 10 Executive Employment Agreement Policy	New
	2	BOD 11 Severance and Compensation Limitation Policy	New
	3	BOD 12 CEO Performance Evaluation Policy	New
	4	BOD 13 Board Oversight and Accountability Policy	New
	5	BOD 14 Public Transparency and Disclosure Policy	New
	6	BOD 15 Closed Session and Labor Negotiations Policy	New
	7	BOD 16 Board Meeting Transparency and Remote Access Policy	New
	8	BOD 17 Language Access for Public Meeting Notices and Agenda Policy	New
	B	**Administrative Policies**	
	1	AP 07 Consent	Approve Revisions
	2	AP 91 Unannounced Regulatory Survey Plan for Response	Approve Revisions
	3	AP141 Credit and Collection Policy	Approve Revisions
	C	**Environment of Care**	
	1	DM 2227 Request to Operate Under CMS 1135 Waiver	Reviewed
	2	EOC 1033 Water Management Program	Approve Revisions
	3	EOC 3000 Security Management Plan	Approve Revisions
8.4. MEC	1	None	
8.5. DISTRICT	1	Resolution 2277– Board Transparency for SB707	Approve and File
	2	Resolution 2278– In Support of American College of Surgeons Level III Trauma Center Verification	Approve and File
	3.	Operational Compliance Committee Charter	New
	4.	Policy and Procedure Committee Charter	New
	5.	Resolution 2276- Authorizing Investment of Monies in the Local Agency Investment Fund	Approve and File

9. **EQUITY, INCLUSION & COMMUNITY HEALTH REPORT**- Overview of initiatives, outcomes, and emerging priorities related to health equity, inclusive practices, and community health needs across the district.
10. **ORTHOPEDIC QUALITY REPORT**- A review of key quality measures and actions focused on the care of the orthopedic patient population.
11. **STRATEGIC PLANNING INITAITIVE – STRATEGIC GROWTH AND INNOVATION**- presentation and discussion regarding the strategic growth and innovation initiative, including strategic objectives, implementation framework and anticipated outcomes.
12. **PATIENT EXPERIENCE AND SATISFACTION UPDATE** – Staff presentation and discussion regarding aggregated and de-identified patient experience data, including trends, themes, and opportunities for improvement. No individual patient information will be disclosed.
13. **FINANCIALS** – Presentation and discussion of current financial statements, budget performance, revenue, and expense trends, and year-to-date comparisons for the District.
14. **REPORTS**
    - **14.1.** Chief Executive Officer Report - Report on current events and issues.
    - **14.2.** Board President - Report on current events and issues.

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).
3. **ADJOURN**

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Agenda item intentionally omitted

Resolution 2279

RESOLUTION 2279

Board Resolution Honoring
Donna Barker as World Class Employee of the Month of January

WHEREAS, Kaweah Health recognizes outstanding performance, dedication, and excellence among its staff through the Employee of the Month program;

WHEREAS, Donna Barker, of the Revenue Integrity Department, has consistently demonstrated exceptional commitment to their responsibilities, a strong work ethic, and a positive attitude that uplifts their team;

WHEREAS, She has made significant contributions during the month of January 2026, including but not limited to providing seamless support and maintaining unshakable professionalism while juggling the chaos that only an exemplary employee can make;

WHEREAS, Donna's professionalism, integrity, and enthusiasm embody the core values of Kaweah Health, setting a high standard for colleagues and exemplifying what it means to go above and beyond in the workplace;

NOW, THEREFORE, BE IT RESOLVED, that the Board of Directors formally recognizes and congratulates Donna Barker as **World Class Employee of the Month** for January 2026, and expresses its sincere appreciation for her outstanding contributions;

BE IT FURTHER RESOLVED, that this resolution be entered into the official records of Kaweah Health and that a copy be presented to Donna Barker as a token of recognition and gratitude.

PASSED AND ADOPTED this 28th of January, 2026, by the Board of Directors of Kaweah Health.

David Francis
President
Kaweah Health Board of Directors

Dean Levitan
Secretary/Treasurer
Kaweah Health Board of Directors

Resolution 2280

RESOLUTION 2280

RESOLUTION HONORING GLENN BYRD ON THE OCCASION OF THEIR YEARS OF SERVICE AND RETIREMENT

WHEREAS, Glenn Byrd has faithfully and diligently served Kaweah Health for 21 years; and

WHEREAS, throughout their tenure, Glynn has demonstrated exceptional dedication, professionalism, and leadership in their role as Biomedical Technician; and

WHEREAS, he has made significant contributions to Clinical Engineering; and

WHEREAS, Glynn has earned the respect, admiration, and gratitude of colleagues, staff, and the community through their commitment to excellence and their positive influence on workplace culture; and

WHEREAS, the Kaweah Health Board of Directors recognizes the lasting legacy and enduring impact Glynn leaves behind;

NOW, THEREFORE, BE IT RESOLVED, that the Kaweah Health Board of Directors formally commends and thanks Glynn Byrd for his outstanding service, and extends sincere best wishes for a fulfilling, healthy, and well-deserved retirement.

PASSED AND ADOPTED this 28th of January 2026.

PASSED AND ADOPTED this 28th of January 2026, by the Board of Directors of Kaweah Health.

Dave Francis
President
Kaweah Health Board of Directors

Dean Levitan
Secretary/Treasurer
Kaweah Health Board of Directors

Physician Recruitment

Physician Recruitment Board Report - Physician Group Targets
January 2026

Key Medical Associates
Gastroenterology x1
Pediatrics x1
Pulmonology x1
Rheumatology x1

Orthopaedics Associates
Orthopedic Surgery (General) x1

Sequoia Cardiology
EP Cardiology x1

Other Recruitment/Group TBD
CT Surgery x1
Family Medicine x5
Gastroenterology x2
General Cardiology x1
Neurology IP/OP x2
OB/GYN x4
Pediatrics x1
Adult Psychiatry x1
Pulmonology OP x1
Urology x3

Oak Creek Anesthesia
Anesthesia - Cardiac x1
Anesthesia - General x1
Anesthesia - Regional x1
Anesthesia - GME Program Dir

Valley ENT
Audiology x1
Otolaryngology x1

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

January Board Report Narrative:

During the month of January, the Physician Recruitment Team continued to advance multiple priority hires while maintaining a strong focus on pipeline development and physician access.

A former Kaweah Health Family Medicine resident has accepted an offer to join Kaweah Delta Faculty Medical Group in a full-time capacity, and the parties are currently working through the contracting phase. Additionally, a Central Valley-based orthopedic spine surgeon has accepted an offer to join a Kaweah clinic and is also progressing through contracting.

Offers have also been extended to an OB/GYN physician, two Electrophysiology Cardiologists, and a Urologist with discussions ongoing. The team continues to prioritize engagement with Kaweah Health residents and strengthen connections with other local residency programs throughout the Central Valley to support long-term recruitment efforts.

The recruitment of additional OB/GYN, Family Medicine, Urology, and Gastroenterology physicians remains a top priority for the Kaweah Health Physician Recruitment team.

Board Report - Physician Recruitment - Jan 2026

	Specialty	Group	Phase	Expected Start Date
1	General Surgery	TBD	Site Visit	
2	Cardiothoracic Surgery	TBD	Site Visit	
3	PM&R	TBD	Site Visit	
4	Family Medicine	TBD	Site Visit	
5	General Surgery Program Director	TBD	Site Visit	
6	Vascular Surgery	South Valley Vasc	Site Visit	
7	Cardiology (EP)	TBD	Site Visit	
8	General Surgery	SAMGI	Site Visit	
9	Pulmonology	TBD	Site Visit	
10	General Surgery	SAMGI	Site Visit	
11	Orth Surgeon (Hand)	Orthopedic Assoc	Site Visit	
12	Interventional Radiology	Mineral King Radiology	Site Visit	
13	General Surgery	TBD	Site Visit	
14	Psychiatry	TBD	Screening	
15	Gastroenterology	TBD	Screening	
16	Pulmonology	TBD	Screening	
17	Radiology	TBD	Screening	
18	Family Medicine	TBD	Screening	
19	Family Medicine	TBD	Screening	
20	Family Medicine	TBD	Screening	
21	Cardiac Anesthesia	Oak Creek	Screening	
22	Orth Surgeon (Hand)	Orthopedic Assoc	Screening	
23	Pulmonology	Key Medical Associates	Screening	
24	General Surgery	SAMGI	Offer Extended	
25	General Surgery	SAMGI	Offer Extended	
26	General Surgery	SAMGI	Offer Extended	
27	Cardiology (EP)	TBD	Offer Extended	
28	Family Medicine	TBD	Offer Extended	
29	Urology	1099 - KH Direct	Offer Extended	
30	Pediatrics	TBD	Offer Extended	
31	ENT	Valley ENT	Offer Extended	
32	OBGYN	TBD	Offer Extended	
33	General Surgery	SAMGI	Offer Accepted	02/27/26
34	General Surgery	SAMGI	Offer Accepted	02/27/26
35	General Surgery	SAMGI	Offer Accepted	02/27/26
36	General Surgery	SAMGI	Offer Accepted	08/03/26
37	Family Medicine	TBD	Offer Accepted	
38	Adult Hospitalist	Valley Hospitalist Group	Offer Accepted	
39	Cardiothoracic Surgery	TBD	Offer Accepted	
40	Family Medicine	1099 - KH Direct	Offer Accepted	
41	Endocrinology	1099 - KH Direct	Offer Accepted	TBD
42	Neurology	1099 - KH Direct	Offer Accepted	TBD
43	Neonatology	Valley Childrens	Offer Accepted	11/03/25
44	Neonatology	Valley Childrens	Offer Accepted	07/28/25
45	Ortho - Spine	1099 - KH Direct	Offer Accepted	
46	Family Medicine	TBD	Leadership Call	
47	Sleep and Obesity	TBD	Leadership Call	
48	Family Medicine	TBD	Leadership Call	

	Specialty	Group	Phase	Expected Start Date
49	Neurology	TBD	Leadership Call	
50	Cardiology (EP)	TBD	Leadership Call	
51	General Surgery	TBD	Leadership Call	
52	Psychiatry	Oak Stone Medical Group	Leadership Call	
53	Family Medicine	TBD	Applied	
54	Psychiatry	Oak Stone Medical Group	Applied	
55	Family Medicine	TBD	Applied	
56	Hospitalist	TBD	Applied	
57	Urogynecology	TBD	Applied	

Overall Strategic Plan

FY 2026 Strategic Plan

Monthly Performance Report
January 28, 2026

Kaweah Health Strategic Plan: Fiscal Year 2026

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.

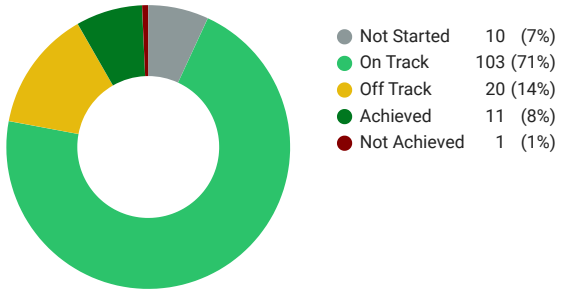
Our Pillars

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

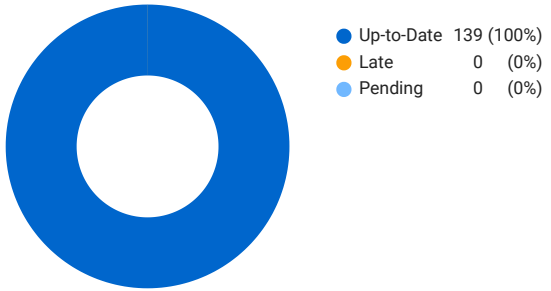
Our Five Strategic Plan Initiatives

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

Kaweah Health Strategic Plan FY2026 Overview: Status



Kaweah Health Strategic Plan FY2026 Overview: Updates



Ideal Environment

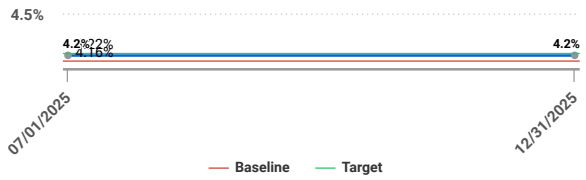
Champions: Dianne Cox and Hannah Mitchell

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

FY2026 Strategic Plan - Ideal Environment Strategies

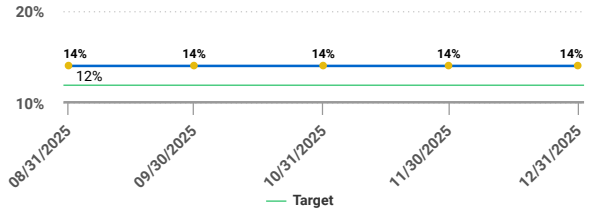
#	Name	Description	Status	Assigned To	Last Comment
1.1	Integrate Kaweah Care Culture	Integrate Kaweah Care culture into the various aspects of the organization.	On Track	Hannah Mitchell	The Executive Team and Directors of Organizational Development, Patient and Community Experience, Marketing, Medical Staff and GME meet on a monthly basis to further projects and initiatives surrounding the culture. Details are presented at the Board sub-committees for Patient Experience and Human Resources. The outcomes will be measured by the performance of our Employee and Physician engagement surveys in June 2026.
1.2	Ideal Practice Environment	Ensure a practice environment that is friendly and engaging for providers, free of practice barriers.	On Track	Shannon Vinson	Pending medical staff review and approval of proposed KPIs. Anticipated approval date: 1/20/26.
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	Kelly Pierce	25 Employees just started the Unitek Spring 2025 Cohort. Pending how many LVN-RN accepted into COS and Carrington (SJVC).

Employee Engagement Survey Score Greater Than 4.22%



Physician and APP Engagement Survey Score Greater Than 3.85%

Decrease Overall Turnover Rate



Strategic Growth and Innovation

Champions: Marc Mertz and Kevin Bartel

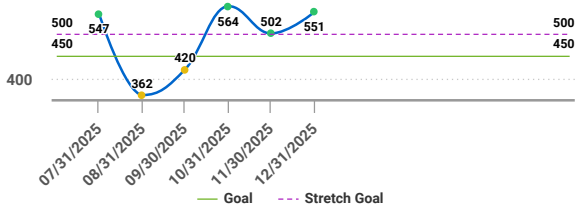
Objective: Grow intelligently *by expanding existing services, adding new services, and serving new communities. Find new ways to do things to* ***improve efficiency and effectiveness****.*

FY2026 Strategic Plan - Strategic Growth and Innovation Strategies

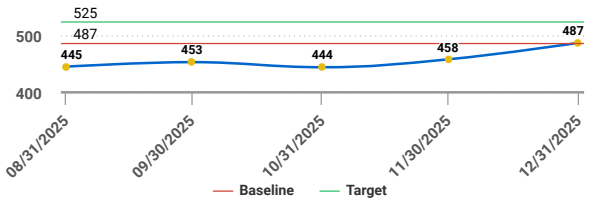
#	Name	Description	Status	Assigned To	Last Comment
2.1	Grow Targeted Service Line Volumes	Grow volumes in key service lines, including Orthopedics, Endoscopy, Urology and Cardio Thoracic services.	On Track	Kevin Bartel	For the month of December, surgery volume exceeded the target and stretch goals in place for orthopedics, CTS Impella cases and Endoscopy.
2.2	Enhance Medical Center Capacity and Efficiency	Enhance existing spaces to grow capacity for additional and expanded services and focus on operational efficiency within the surgery areas.	On Track	Kevin Morrison	New surgery director is still analyzing and assessing opportunities for improving operational efficiency within the surgery areas. No further projects planned yet for this FY26.
2.3	Expand access for patients though Clinic Network Development	Strategically expand and enhance the existing ambulatory network to increase access at convenient locations for the community.	On Track	Ivan Jara	Outpatient clinic access continues to grow through the development of new locations, new specialties, and the expansion of current services. Current efforts include physician recruitment (Primary and Specialty Care), advanced practice provider recruitment, new clinic locations (Specialty, Rural, and Commercial), and federal/state programs and grants.
2.4	Innovation	Implement and optimize new tools and applications to improve the patient experience, communication, and outcomes.	On Track	Kevin Bartel	Progress continues towards AI ambient listening implementation, with the pilot project being completed and full rollout into OP clinics planned to be completed by early February 2026.. Testing to implement a new call center platform, Webex, with the ability to scale to various service lines is taking place. WellApp (platform supporting enhancement for patient scheduling, registration and billing) is fully implemented throughout the clinics, with additional AI scheduling platforms being explored to improve the overall patient experience. Ongoing meetings with consultants scheduled for early December to engage key stakeholders in the enhanced care at home project, updates on progress to come.
2.5	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	No changes to status or work. Monthly meetings take place with Medi-Cal Managed Care Health Plans (Anthem BC and HealthNet) to foster strong working relationships that result in revenue generating programs and grant funding. Collaboration with these plans span across several projects to include CalAIM Enhanced Care Management (ECM), CalAIM Community Supports (CS), Equity Practice Transformation (EPT) and MOVES grant (funded by Centene Foundation). Currently updating contracts for CalAIM to add Population of Focus for Children and Youth ages 18-22. Exploring Community Health Worker (CHW) benefit and reimbursement for providing services with both Anthem BC and HealthNet.

Perform 241 Orthopedic Surgery Cases Per Month

Perform 450 Endoscopy Cases Per Month



Increase Enrollment to 640 Lives in Enhanced Care Management



Outstanding Health Outcomes

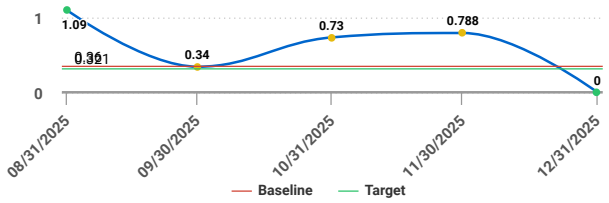
Champions: Dr. Paul Stefanacci

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

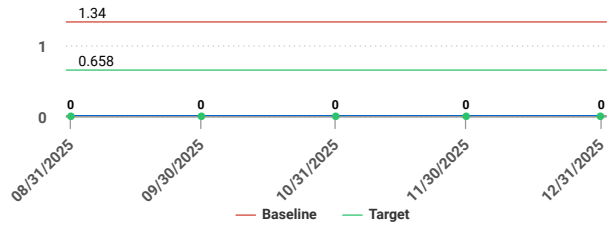
FY2026 Strategic Plan - Outstanding Health Outcomes Strategies

#	Name	Description	Status	Assigned To	Last Comment
3.1	Safety Program Enhancement	Improve the Patient Safety Program through enhanced proactive evidence based strategies.	On Track	Cindy Vander Schuur	Data currently being collected and reported to establish a baseline SSER. Will need several months of data for this calculation. No barriers
3.2	Reduce Hospital Acquired Infections (HAI)	Reduce the Hospital Acquired Infections (HAIs) to the selected national percentile in FY26 as reported by the Centers for Medicare and Medicaid Services.	Off Track	Shawn Elkin	Certain types of HAI (e.g., CAUTI, MRSA BSI) have demonstrated consistently low rates of infection. However, CLABSI events have increased over the past several months. Of note, central line utilization has achieved goal. Whereas, indwelling urinary catheter utilization has not met goal.
3.3	Reduce Surgical Complications	Reduce the Patient Safety Indicator (PSI) 90 composite rate to the selected national percentile in FY26 as reported by the Centers for Medicare and Medicaid Services.	Off Track	Chris Patty	Focused efforts continue in this area, however there have been limits on progress due to transitions of quality and patient safety resources to accreditation activities.

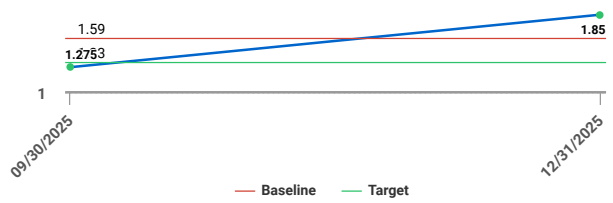
Decrease Standardized Infection Ratio (SIR) CAUTI to less than or equal to .321



SIR MRSA FYTD </=.0658



Decrease the CMS composite score consisting of 9 weighted individual PSIs definted by CMS to 1.33



Patient Experience and Community Engagement

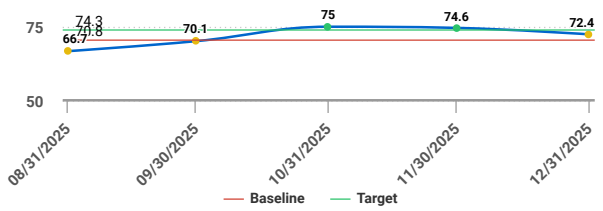
Champions: Marc Mertz and Deborah Volosin

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

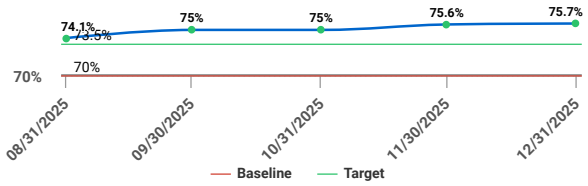
FY2026 Strategic Plan - Patient Experience and Community Engagement Strategies

#	Name	Description	Status	Assigned To	Last Comment
4.1	Empowering Leaders to Enhance Patient Experience	To improve patient experience, it is essential to cultivate a leadership culture that prioritizes patient-centered care. This strategy focuses on equipping leaders at all levels with the necessary skills, tools, and authority to drive meaningful improvements in patient interactions, service delivery, and overall satisfaction.	On Track	Deborah Volosin	Currently doing quarterly meetings with clinical Directors, Managers, and Assistant Managers
4.2	Fostering a Culture of Empathy and Human Understanding	Creating a culture of empathy and human-centered care is essential for enhancing patient experience and community trust.	On Track	Deborah Volosin	Education around Human Understanding and Empathy was shared this month at New Employee Orientations and Clinical Education training
4.3	Transforming the Patient Environment for a Better Experience	A well-designed and patient-friendly physical environment plays a critical role in patient experience and overall well-being. This strategy focuses on improving the hospital's physical spaces to promote comfort, accessibility, and a sense of healing	On Track	Deborah Volosin	Facilities, EVS, and Patient Access round with the CEO to ensure our environments are warm and welcoming. This includes identifying mismatched and worn out furniture and submitting requests for replacement.
4.4	Strengthening Community Engagement	Building strong relationships with the community is essential for fostering trust, improving health outcomes, and increasing access to care. This strategy focuses on actively engaging with community members through outreach programs, partnerships, and educational initiatives.	On Track	Deborah Volosin	Community Advisory Councils continue to meet monthly.
4.5	Adopting a Patient-Centered Approach to the Entire Healthcare Experience		On Track	Deborah Volosin	I continue to speak about the patient's experience across the continuum of care. (New Employee Orientation, Staff Meetings. Rolling out WMTY

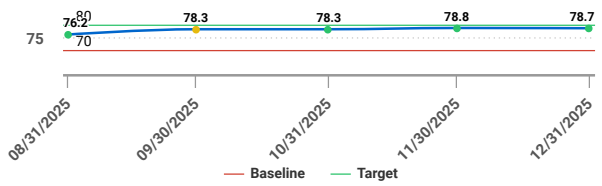
Achieve a score of 74.3 in HCAHPS Overall Rating



Achieve an Organizational-wide score of 73.5 in Human Understanding



Achieve a score of 80 in "Cleanliness of Clinic"



Physician Alignment

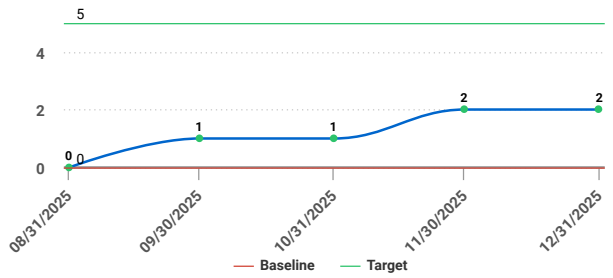
Champions: Marc Mertz and JC Palermo

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

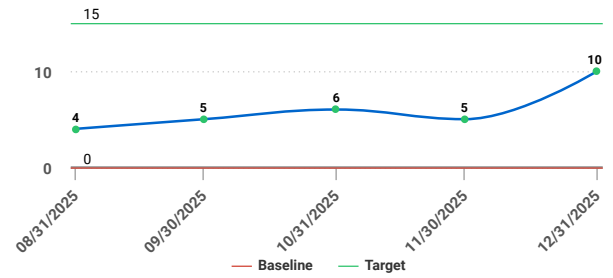
FY2026 Strategic Plan -Physician Alignment - Strategies

#	Name	Description	Status	Assigned To	Last Comment
5.1	Recruit Physicians and Advanced Practice Providers	Refine and execute recruitment strategy and employment options for physicians and advanced practice providers 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 continues to meet to discuss the most pressing community needs and how Kaweah Health can best deploy resources.
5.2	Develop and Provide Practice Support for Physicians	Continue to develop services and opportunities that improve alignment with and support for contracted and affiliated physician practices.	On Track	Jag Batth	Since the start of the program, we have completed close to 20 ION cases. We continue to build out a formal, comprehensive colorectal program and are also actively working on developing a mitral clip program. In parallel, OR upgrades are ongoing to support more complex procedures, including updated perfusion equipment for our cardiovascular cases.
5.3	Physician Alignment through Integrated Delivery Network (i.e. Sequoia Integrated Health)	With our physician community partners, continue to develop and strengthen relationships with health plans through Sequoia Integrated Health.	On Track	Marc Mertz	We continue to work closely with SIH on improving quality scores and outcomes as well as evaluating new payer arrangements.

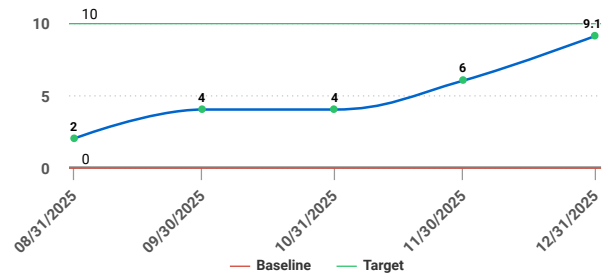
Recruit 5 Primary Care Physicians



Recruit 15 Specialty Providers



Recruit 10 Advanced Practice Providers



Long Term Care

REPORT TO THE BOARD OF DIRECTORS

Transitional and Subacute Care Services

Kari Moreno, Director of Post Acute Nursing
January 2026

Summary Issue/Service Considered

1. Sustain high-quality, patient-centered skilled nursing care while ensuring regulatory compliance, fiscal responsibility, and workforce stability.
2. Support Kaweah Health's strategic objective to deliver a coordinated continuum of post-acute services that meets community needs and maintains the organization's role as a District Center of Excellence.

Overall Analysis of financial/statistical data:

The overall contribution margin for both Skilled Nursing units: Subacute (SA) at Court Street campus and Short Stay (SS) at Akers campus, is slightly over 3.1 million. This is a increase from FY2025 associated with an increase in net revenue and increases in additional reimbursements by the Directed Payments program. Net revenue per day increased by 7% from $997 to $1,069 with an upward trend due to higher patient days while expenses remained static.

Subacute (SA) at Court Street financial/statistical data (32 bed unit):

Subacute contribution margin increased by 16% in FY25 ending at $3.4 million largely due to an increase in reimbursements provided by the Directed Payments program which increased from FY24 by 79%. Patient days have decreased 3% due to patient discharges which is atypical for this unit but collaborative efforts with the case management department are being made to stabilize the census for FY26. Net revenue per day increased 8% from $1,118 to $1,213. Direct cost per day increased 5% in FY25 due to increases in nurse staffing.

Short Stay (SS) at Akers Campus financial/statistical data (16 bed unit):

Financial and Statistical Performance
Short Stay Transitional services had a contribution margin loss at $287k, showing substantial improvement from FY24 and the prior two years. Patient days increased by 4% from FY24, with continued improvement demonstrated in early FY26. Net revenue per day is trending upward 10% over FY24, while direct cost per day remained static. Increased patient days and expenses remaining static contribute to a decreased loss of (37%) in contribution margin per day. Payer Mix is strongly Medicare and Medicare Managed, accounting for 80% of the business however both have a contribution margin per day loss of ($134) and ($116).

Quality/Performance Improvement Data

- Kaweah Health Skilled Nursing programs maintained a 4-Star CMS Nursing Home Compare rating, reflecting strong performance in quality measures, staffing, and regulatory compliance.
- Quality outcomes remained favorable, including low rates of falls with major injury, urinary tract infections, and hospital readmissions.
- Continued compliance with Biovigil hand hygiene monitoring, with Short Stay's overall compliance percentage for FY25 at 95.5% and Subacute's overall compliance percentage at 96.5%, surpassing the goal of 95%. We continue our efforts on Biovigil compliance showing continued improvement in FY26 with Subacute's compliance percentage at 97.3% YTD and Short Stay remains stable at 95.0%.
- Ongoing collaboration with Infection Prevention and Pharmacy teams to support antibiotic stewardship and reduce preventable infections and antibiotic usage.
- We have recently established a partnership with the Polaris Group, a remote MDS service company to optimize skilled nursing reimbursements and improve our nurse documentation systems.
- In early FY26, significant efforts were made to decrease labor costs in skilled nursing which included reducing the amount of high cost Registered Nurse utilization in both units, and a reduction of a nurse manager, streamlining the leadership structure. We continue to make efforts to reduce labor costs while maintaining quality and ensuring safe nursing practice is maintained.

Policy, Strategic or Tactical Issues

- Expansion of Subacute beds into the former Transitional Care Services unit has been initiated starting with the completion of our flooring remodel and the submission of our application to convert the skilled nursing beds to Subacute. The project continues with the submission of plans to update our call light system to HCAI and refurbishing the patient rooms in preparation for CDPH and DHCS inspections.
- We continue to focus on our documentation and reimbursement under the Patient Driven Payment Model. The goal is to ensure we are accurately capture the complexity of our patient population by optimizing clinician documentation, nurse documentation, and the MDS reporting system.
- Our partnership with the Polaris group, will provide additional MDS coverage as well as consulting services to improve documentation accuracy and optimization under the Patient Driven Payment Model (PDPM) to ensure appropriate reimbursement reflective of patient acuity.
- Restructure of LVN to resident ratio- increasing from 8:1 to 16:1 using phased approach. The LVN to resident ratio has transitioned to 1:16 on night shift and will

transition to day shift once medication administration efficiency efforts are completed.
- March 2025 we underwent our annual CMS recertification survey. We had a successful survey resulting in 12 findings all of which were addressed and demonstrated 100% compliance in subsequent audits.
-

Recommendations/Next Steps

- Continue to refine referral and admission workflows to ensure appropriate utilization and alignment with service line capacity.
- Maintain focused review of acute care transfers and post-discharge readmissions to identify opportunities for clinical and operational improvement.
- Improve the facility's 4-Star CMS rating to 5-stars, through proactive monitoring of evolving long-stay and short-stay quality measures and implementing recommendations from Polaris group.
- Continue optimization of Cerner documentation and MDS processes to support data integrity, compliance, and reimbursement accuracy.
- Strengthen collaboration with pharmacy, clinical education, and our providers through the Kaweah Health Skilled Nursing Antimicrobial Stewardship Program.
- Continued focus on infection prevention surveillance in partnership with Infection Prevention to ensure a proactive approach to Hospital Acquired Infections.

Approvals/Conclusions

- Assure continued compliance with all regulatory and licensure requirements.
- Support sustained financial performance through disciplined cost management, appropriate volume growth, and reimbursement optimization.
- Continue advancing clinical practice standards, documentation accuracy, and quality outcomes in alignment with Kaweah Health strategic priorities.

KAWEAH HEALTH ANNUAL BOARD REPORT

FY2025

Subacute and Transitional Care Services

Note: Includes patients at the Subacute and TCS Short Stay Unit at West Campus (older years include TCS).

KEY METRICS -- FY 2025

PATIENT DAYS	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
15,170	$16,213,211	$13,091,322	$3,121,889	($2,972,336)
▼ -1%	▲ 6%	▲ 3%	▲ 25%	▲ 5%

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

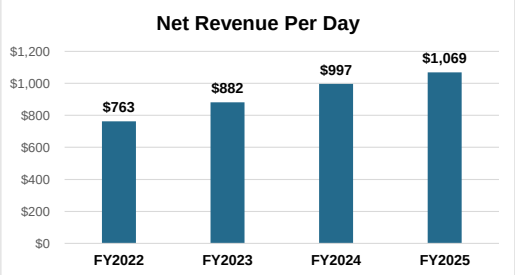
METRICS BY SERVICE LINE - FY 2025

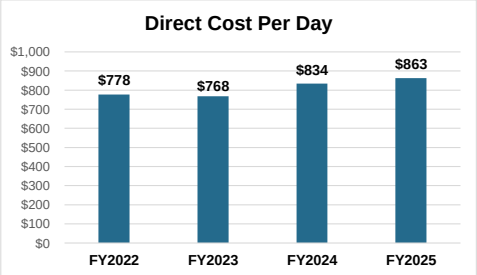
SERVICE LINE	PATIENT DAYS	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
Inpatient Subacute	10,850	$13,156,912	$9,748,121	$3,408,791	($714,216)
Transitional Care Ortho	4,320	$3,056,299	$3,343,201	($286,902)	($2,258,120)
Long Term Care Totals	15,170	$16,213,211	$13,091,322	$3,121,889	($2,972,336)

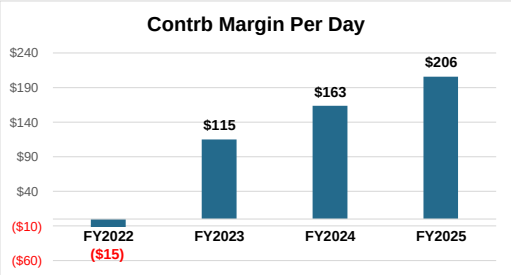
METRICS SUMMARY - 4 YEAR TREND

METRIC	FY2022	FY2023	FY2024	FY2025	%CHANGE FROM PRIOR YR	4 YR TREND
Patient Days	19,782	18,134	15,310	15,170	▼ -1%	
Net Revenue	$15,089,006	$16,002,808	$15,263,829	$16,213,211	▲ 6%	
Direct Cost	$15,380,928	$13,919,538	$12,761,174	$13,091,322	▲ 3%	
Additional Reimbursement	$0	$656,307	$1,500,965	$2,686,228	▲ 79%	
Contribution Margin	($291,922)	$2,083,270	$2,502,655	$3,121,889	▲ 25%	
Indirect Cost	$6,570,405	$6,020,600	$5,635,509	$6,094,225	▲ 8%	
Net Income	($6,862,327)	($3,937,330)	($3,132,854)	($2,972,336)	▲ 5%	
Net Revenue Per Day	$763	$882	$997	$1,069	▲ 7%	
Direct Cost Per Day	$778	$768	$834	$863	▲ 4%	
Contrb Margin Per Day	($15)	$115	$163	$206	▲ 26%	

GRAPHS







Notes:
Source: Inpatient Service Line Reports

KAWEAH HEALTH ANNUAL BOARD REPORT

FY2025

Subacute Services - South Campus

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

KEY METRICS -- FY 2025

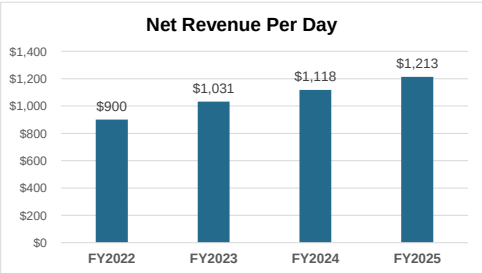
PATIENT DAYS	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
10,850	$13,156,912	$9,748,121	$3,408,791	($714,216)
▼ -3%	▲ 5%	▲ 2%	▲ 16%	▲ 1%

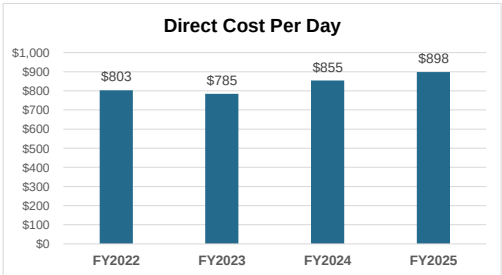
*Note: Arrows represent the change from prior year and the lines represent the 4-year trend

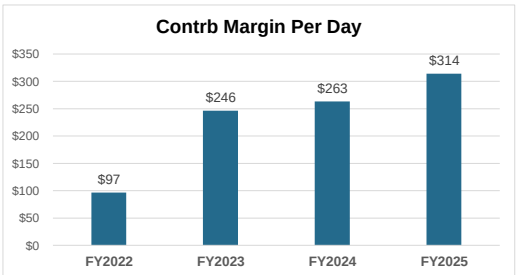
METRICS SUMMARY - 4 YEAR TREND

METRIC	FY2022	FY2023	FY2024	FY2025	%CHANGE FROM PRIOR YR	4 YR TREND
Patient Days	10,281	11,198	11,176	10,850	▼ -3%	
Net Revenue	$9,255,012	$11,547,822	$12,492,546	$13,156,912	▲ 5%	
Direct Cost	$8,260,716	$8,789,359	$9,552,196	$9,748,121	▲ 2%	
Additional Reimbursement	$0	$642,145	$1,470,105	$2,636,540	▲ 79%	
Contribution Margin	$994,296	$2,758,463	$2,940,350	$3,408,791	▲ 16%	
Indirect Cost	$3,253,827	$3,438,010	$3,665,118	$4,123,007	▲ 12%	
Net Income	($2,259,531)	($679,547)	($724,768)	($714,216)	▲ 1%	
Net Revenue Per Day	$900	$1,031	$1,118	$1,213	▲ 8%	
Direct Cost Per Day	$803	$785	$855	$898	▲ 5%	
Contrb Margin Per Day	$97	$246	$263	$314	▲ 19%	

PER CASE TRENDED GRAPHS

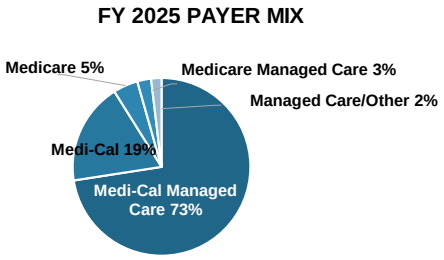






PAYER MIX - 4 YEAR TREND (GROSS REVENUE)

PAYER	FY2022	FY2023	FY2024	FY2025
Medi-Cal Managed Care	8%	32%	62%	73%
Medi-Cal	71%	51%	31%	19%
Medicare	10%	9%	4%	5%
Medicare Managed Care	2%	0%	1%	3%
Managed Care/Other	8%	8%	3%	2%



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

KAWEAH HEALTH ANNUAL BOARD REPORT

FY2025

Transitional Care Services Orthopedics - West Campus

Note: All patients at the Transitional Care Services West Campus location.

KEY METRICS -- FY 2025

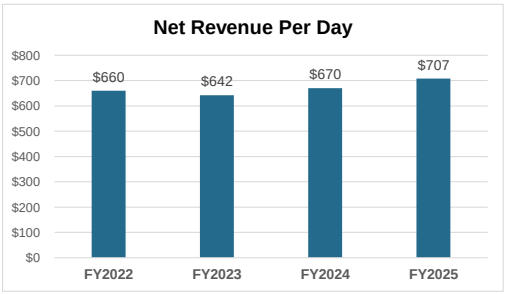
PATIENT DAYS	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
4,320	$3,056,299	$3,343,201	($286,902)	($2,258,120)
▲ 4%	▲ 10%	▲ 4%	▲ 34%	▲ 6%

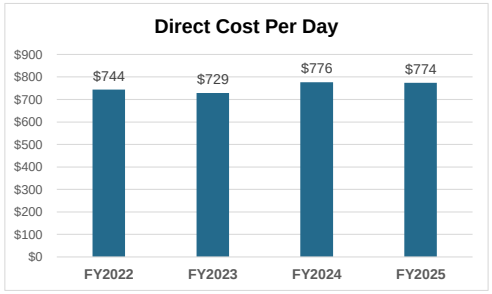
*Note: Arrows represent the change from prior year and the lines represent the 4-year trend

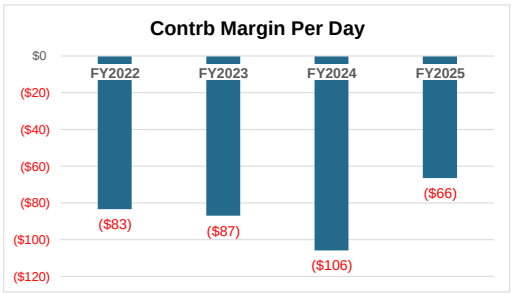
METRICS SUMMARY - 4 YEAR TREND

METRIC	FY2022	FY2023	FY2024	FY2025	%CHANGE FROM PRIOR YR	4 YR TREND
Patient Days	4,997	4,907	4,134	4,320	▲ 4%	
Net Revenue	$3,299,203	$3,150,591	$2,771,283	$3,056,299	▲ 10%	
Direct Cost	$3,716,299	$3,577,431	$3,208,978	$3,343,201	▲ 4%	
Additional Reimbursement	$0	$14,162	$30,860	$49,688	▲ 61%	
Contribution Margin	($417,096)	($426,840)	($437,695)	($286,902)	▲ 34%	
Indirect Cost	$2,002,148	$1,877,946	$1,970,391	$1,971,218	▶ 0%	
Net Income	($2,419,244)	($2,304,786)	($2,408,086)	($2,258,120)	▲ 6%	
Net Revenue Per Day	$660	$642	$670	$707	▲ 6%	
Direct Cost Per Day	$744	$729	$776	$774	▶ 0%	
Contrb Margin Per Day	($83)	($87)	($106)	($66)	▲ 37%	

PER CASE TRENDED GRAPHS

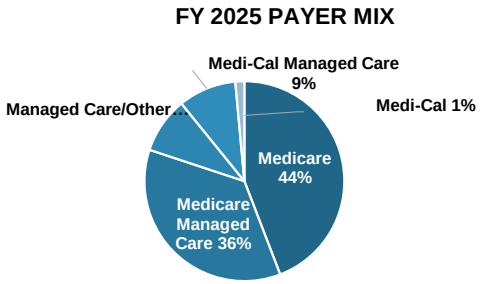






PAYER MIX - 4 YEAR TREND (GROSS REVENUE)

PAYER	FY2022	FY2023	FY2024	FY2025
Medicare	46%	46%	45%	44%
Medicare Managed Care	27%	36%	33%	36%
Managed Care/Other	9%	9%	11%	9%
Medi-Cal Managed Care	8%	6%	11%	9%
Medi-Cal	9%	2%	1%	1%



Source: Inpatient Service Line Report, Sub-Acute -Avg Patients Per Day slide

Selection criteria: EntyID = KHSA - Kaweah Health Subacute facility, excluding Exeter Rural Health Clinic visits.

Center for Mental Wellness

REPORT TO THE BOARD OF DIRECTORS

Center for Mental Wellness

Marc Mertz, Chief Executive Officer, 559-624-2511
Diana Saechao, Director of Medical Clinics and Urgent Cares, 559-624-5990

Date: January 28, 2026

Summary Issue/Service Considered

Kaweah Health operates the Center for Mental Wellness, located in central Visalia. The clinic opened in March 2023 to provide comprehensive behavioral health therapy services designed to enhance the mental and emotional well-being of the community. Services include individual, family, couples, and children's therapy, as well as specialized treatment for anxiety, depression, trauma, and other mental health conditions. Telehealth options are also available to increase access to care. The clinic is open Monday through Friday from 8:00 a.m. to 6:00 p.m. to better serve community needs.

The Center for Mental Wellness serves individuals of all ages, including children, adolescents, adults, and seniors. The clinic primarily serves patients with commercial/private insurance, Medicare, and self-pay options. During the current fiscal year, payer mix is 68% Commercial, 24% Kaweah Health employees, 6% Medicare, and 2% other payers.

The clinic addresses a critical gap in behavioral health therapy services in Tulare County, particularly for individuals covered by commercial insurance. Its primary goal is to provide accessible, high-quality mental health care that meets the emotional and psychological needs of the community. In addition, the clinic promotes mental health awareness and supports the development of a healthier, more resilient population.

Financial Performance Data

In FY25, the Center for Mental Wellness recorded 3,634 patient visits, reflecting a 16% increase over the prior fiscal year and demonstrating continued strong community demand for accessible mental and behavioral health services.

The clinic experienced modest turnover within the therapy team during the year. To support service growth and maintain access to care, additional therapists are scheduled to be onboarded in the current fiscal year.

For FY25, the Center for Mental Wellness reported a contribution loss of $94,000, inclusive of proxy reimbursement for Kaweah Health employees. This result was in line with expectations and primarily driven by staffing turnover and elevated no-show and cancellation rates. In response, the clinic implemented a revised attendance policy aimed at reducing missed appointments.

Despite the contribution loss, financial performance continues to improve. Net revenue per case increased by 1% to $137 in FY25 compared to FY24, and the contribution margin improved from –$33 per case to –$26 per case.

Employee Engagement Data

In the 2025 Employee Engagement Survey, three of the five employees from the clinic participated. Overall results indicated that staff consistently strive to deliver safe, error-free care and reported increased leadership presence.

In response to the feedback, leadership has re-established regular staff meetings, as well as multidisciplinary outpatient behavioral health and psychiatry collaboration meetings. These forums are intended to strengthen communication, ensure the therapy team feels supported, and provide opportunities for staff to contribute to internal processes and policy development in support of high-quality patient care.

Workgroup	2025 Survey Averages	2024 Survey Averages	Increase/ Decrease from 2024	Respondents	Response Rate
Center for Mental Wellness	4.16	4.50	-0.34	3	60%

Patient Experience

Patient feedback remains a key component of Kaweah Health's quality improvement efforts. In FY25, the Center for Mental Wellness demonstrated strong performance in patient experience, achieving a Net Promoter Score (NPS) of 90, placing the clinic in the 85th percentile.

The clinic's goal is to reach the 90th percentile by the end of FY26. This benchmark was exceeded ahead of schedule, with performance reaching the 92nd percentile in November 2025, reflecting continued improvements in patient satisfaction and service quality.

Strategic or Tactical Issues

Access to mental health services remains limited in Visalia and throughout the Central Valley. In response to the growing demand, Kaweah Health is actively re-evaluating current workflows and care delivery processes to improve access and expand service availability for the community.

Recommendations/Next Steps

The Center for Mental Wellness is focused on expanding access to care while improving appointment adherence to ensure efficient use of clinical capacity. To support these goals, the clinic will implement the following process improvements:

- No-Show Fee: The clinic will introduce a no-show fee to encourage appointment adherence and reduce missed visits. This measure is intended to promote accountability, improve schedule reliability, and minimize lost clinical time, allowing greater access for patients actively seeking care.
- Updated No-Show and Cancellation Rescheduling Process: The clinic will revise its no-show and late-cancellation policies to establish clear expectations for patients regarding timely appointment changes. The updated process will include standardized communication, limits on repeated missed appointments, and defined steps for rescheduling or returning patients to the waitlist.

Approvals/Conclusions

No additional approvals needed at this time.

KAWEAH HEALTH ANNUAL BOARD REPORT

FY2025

Center for Mental Wellness Clinic - Outpatient Service Line

KEY METRICS - FY 2025 TWELVE MONTHS ENDED JUNE 30, 2025

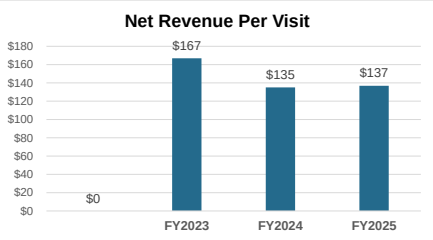
PATIENT VISITS	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
3,634	$497,111	$591,023	($93,912)	($386,566)
▲ 16%	▲ 18%	▲ 13%	▲ 8%	▲ 10%

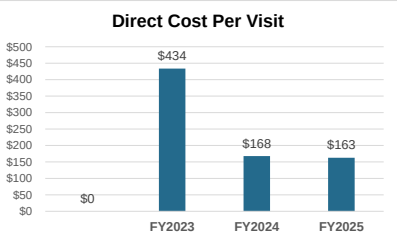
*Note: Arrows represent the change from prior year and the lines represent the 4-year trend

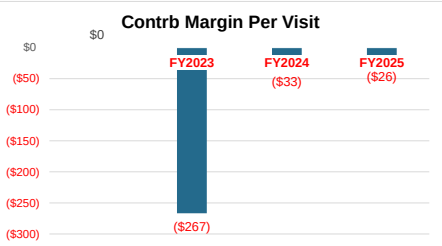
METRICS SUMMARY - 4 YEAR TREND

METRIC	FY2023	FY2024	FY2025	%CHANGE FROM PRIOR YR	4 YR TREND
Patient Visits	478	3,122	3,634	▲ 16%	
Net Revenue	$79,783	$421,794	$497,111	▲ 18%	
Direct Cost	$207,250	$523,900	$591,023	▲ 13%	
Contribution Margin	($127,467)	($102,106)	($93,912)	▲ 8%	
Indirect Cost	$0	$329,036	$292,654	▼ -11%	
Net Income	($127,467)	($431,142)	($386,566)	▲ 10%	
Net Revenue Per Visit	$167	$135	$137	▲ 1%	
Direct Cost Per Visit	$434	$168	$163	▼ -3%	
Contrb Margin Per Visit	($267)	($33)	($26)	▲ 21%	

PER CASE TRENDED GRAPHS

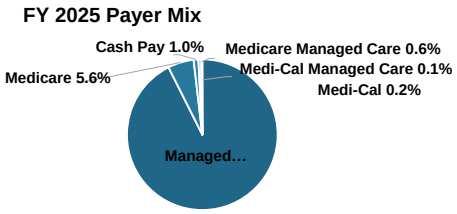






PAYER MIX - 4 YEAR TREND (PATIENT VISITS)

PAYER	FY2023	FY2024	FY2025
Managed Care/Other	99.2%	98.5%	92.6%
Medicare	0.0%	0.2%	5.6%
Cash Pay	0.8%	1.0%	1.0%
Medicare Managed Care	0.0%	0.2%	0.6%
Medi-Cal	0.0%	0.0%	0.2%
Medi-Cal Managed Care	0.0%	0.1%	0.1%

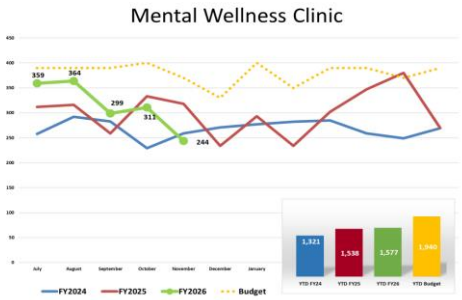


KAWEAH HEALTH ANNUAL BOARD REPORT

FY2025

Center for Mental Wellness Clinic - Outpatient Service Line

KEY METRICS - FY 2025 TWELVE MONTHS ENDED JUNE 30, 2025



Notes:
Source: Outpatient Service Line Reports
Criteria: Service Line 1 = Psychotherapy Clinic
*Added Proxy for KH Employee visits.

Quarterly Risk Management Report

BOD Risk Management Report – Open
4th Quarter 2025

Evelyn McEntire, Director of Risk Management
559-624-5297/emcentir@kaweahhealth.org

Risk Management Goals

1. Promote a safety culture as a proactive risk reduction strategy.

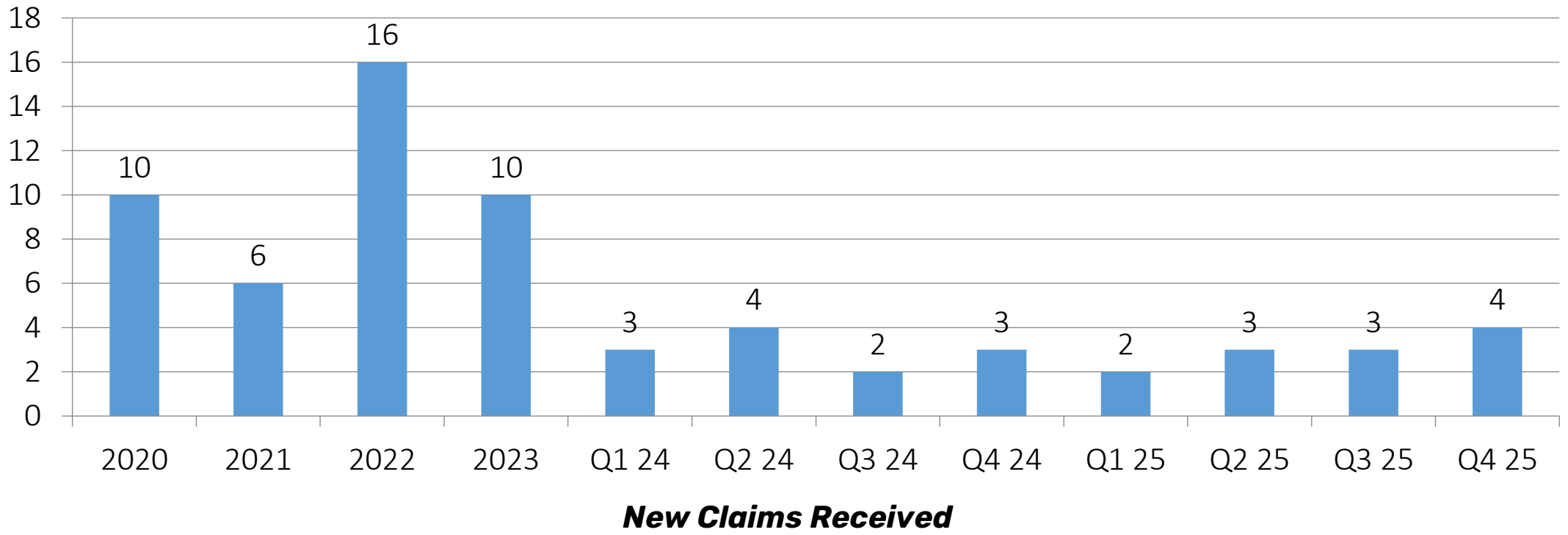
2. Reduce frequency and severity of harm (patient and non-patient).
    - Zero incidents of “never events”

3. Reduce frequency and severity of claims.

Kaweah Health
MORE THAN MEDICINE. LIFE.

Claims

2020 - 2025



New Claims Received

**Total cases closed in 4th Quarter 2025 – (1)*

December 3, 2025

Kaweah Delta Health Care District
Board of Directors Committee
Meeting Minutes

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

Marketing & Community Relations Committee – OPEN MEETING
Wednesday December 3, 2025
Sequoia Regional Cancer Center – Pauline & Maynard Faught Conference Room

Present: Directors: Armando Murrieta; Gary Herbst, Chief Executive Officer; Marc Mertz, Chief Strategy Officer; Karen Cocagne, Director of Marketing & Media Relations; Deborah Volosin, Director of Patient & Community Experience; Gary Rogers, Communications Manager; Samantha Torres, Social Media Specialist; Amee Longbottom, Sr. Communications Specialist; Jaclyn Bunting, Sr. Digital Strategist; and Lisette Mariscal, Recording

CALL TO ORDER – This meeting was called to order at 4:01 PM by Armando Murrieta.

PUBLIC/MEDICAL PARTICIPATION – There was no public or medical participation.

MINUTES- The open meeting minutes from October 1, 2025, were reviewed.

COMMUNITY EXPERIENCE –

2.1. Discussion on agenda item deferred.
2.2. Deborah presented the brand dashboard. (see Attachment 2.2. of the agenda)

MARKETING & MEDIA RELATIONS –

3.1.1. – Amee provided a verbal update on items scheduled for inclusion in the February issue of Vital Signs.
3.1.2. – 3.1.3. – Jaclyn presented performance data related to current digital campaigns.
3.1.4 – Rating information to be presented at a later meeting.
3.1.5. – A draft version of the new Cardiothoracic Surgery TV commercials was played.
3.1.6. – New signage will be installed at an existing location.
3.1.7. – Marketing efforts for the new Akers clinic have commenced.
3.2. – A report on recent marketing performance and engagement metrics was shared. (see attachment 3.2. of the agenda.

Kaweah Delta Health Care District
Board of Directors Committee
Meeting Minutes

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

Adjourned at 4:49 PM

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.

December 10, 2025

KAWEAH DELTA HEALTH CARE DISTRICT BOARD OF DIRECTORS HUMAN RESOURCES COMMITTEE MINUTES

Wednesday, December 11, 2024
Kaweah Health Medical Center
305 Acequia Avenue, Executive Office Conference Room (1st Floor)

PRESENT: Directors: Lynn Havard Mirviss (chair) & Armando Murrieta; Gary Herbst, CEO; Dianne Cox, Chief Human Resources Officer; Brittany Taylor, Director of Human Resources; Raleen Larez, Director of Employee Relations; Hannah Mitchell, Director of Organizational Development; JC Palermo, Director of Physician Recruitment; Paul Stefanacci, M.D., Chief Medical & Quality Officer; Kelsie Davis, recording

CALLED TO ORDER – at 4:01pm by Director Havard Mirviss

PUBLIC PARTICIPATION –None.

MINUTES- Reviewed.

PHYSICIAN RECRUITMENT – JC gave an updated overview and discussion of the monthly physician recruitment report.

IDEAL ENVIRONMENT STRATEGIC PLAN – Dianne, Hannah and Paul Stefanacci, MD, reviewed and discuss Kaweah Care Ideal Work Environment, Ideal Practices Environment, Physician Engagement and updates relative to current and proposed Initiatives which is attached hereto the minutes.

RETIREMENT PLAN AMENDMENTS – Dianne and Brittany Taylor reviewed and discuss the calendar year 2025
401(K) and 457b retirement plan amendments which are attached hereto the minutes.

HUMAN RESOURCES POLICIES – Dianne and her team reviewed the following Human Resources policies as reviewed and recommended to be presented to the Board for approval:

a. HR.13 Anti-Harassment and Abusive Conduct
b. HR.80 Docking Staff
c. HR.12 Equal Employment Opportunity
d. HR.70 Meal Periods, Rest Breaks and Breastfeeding and/or Lactation Accommodation
e. HR.14 Non-English/Limited English Speaking and/or Hearing Impaired Individuals – Non Discrimination (three-year renewal; no update) – No Changes

f. HR.46 Orientation of Kaweah Health Personnel – Revised
g. HR.234 Paid Time Off (PTO), Extended Illness Bank (EIB) and Healthy Workforce, Health Families Act of 2014
h. HR.47 Professional Licensure and Certification
i. HR.216 Progressive Discipline
j. HR.72 Standby and Callback
k. EH.06 Work Related Injury and Illness and Workers' Compensation

ADJOURN – *at 5:09pm by Director Havard Mirviss*

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.

December 11, 2025

OPEN Quality Council Committee
Thursday, December 11, 21025
The Executive Office Conference Room

Attending: Board Members: Dr. Dean Levitan (Standing Committee Chair), Dave Francis (Board Member); Gary Herbst, CEO; Marc Mertz, Chief Strategy Officer; Jag Batth, Chief Operation Officer; Amy Baker, MSN, RN, Director of Specialty Clinics; Connie Green, Nurse Manager, Chronic Dialysis; Chris Patty; Clinical Practice Guidelines Program Manager; Shawn Elkin, Infection Prevention Manager; Dr. Paul Stefanacci, Chief Medical Officer; Chris Patty, Clinical Practice Guidelines Program Manager; Kyndra Licon – Recording.

Dr. Dean Levitan called to order at 7:45 AM.

Review of Closed Session Agenda: Dr. Dean Levitan made a motion to approve the closed agenda, there were no objections.

Dr. Dean Levitan adjourned the meeting at 7:46 AM.

Public Participation – None.
Dr. Dean Levitan called to order at 8:00 AM.

4. **Review of November Quality Council Open Session Minutes –** Dr. Dean Levitan, Standing Committee Chair; Dave Francis, Board Member.
    - Reviewed and acknowledged the November Quality Council Open Session Minutes by Dr. Dean Levitan and Mike Olmos. No further actions.

5. **Written Quality Reports –** a review of key quality metrics and actions associated with the following improvement initiatives: Reports reviewed and attached in minutes. No action taken.
    a. **HAPI Quality Report**
    b. **Hand Hygiene Dashboard**
    c. **Subacute Quality Report**
    d. **Diabetes Committee Report**

6. **Emergency Department Quality Report –** A review of current performance and actions focused on the clinical goals for Emergency Department. Scott Baker, RN, Director of Emergency and Trauma Services. Report reviewed and attached in minutes. No action taken.

7. **Kaweah Health Chronic Dialysis Report -** A review of key performance indicators and actin associate with care of dialysis patient population. *Amy Baker, MSN, RN, Director of Specialty Clinic; Connie Green, Nurse Manager, Chronic Dialysis.* Report reviewed and attached in minutes. No action taken.

8. **Clinical Quality Goals Update**- A review of current performance and actions focused on the clinical quality goals for Healthcare Acquired Infections and Patient Safety Indicator (PSI) 90 Composite. *Shawn Elkin, Infection Prevention Manager; Chris Patty, Clinical Practice Guidelines Program Manager.* Reports reviewed and attached to minutes. No action taken.

Adjourn Open Meeting – *Dr. Dean Levitan,* Standing *Committee Chair*

Dr. Dean Levitan adjourned the meeting at 9:17 AM.

MINUTES OF THE OPEN MEETING OF THE KAWEAH DELTA HEALTH CARE DISTRICT BOARD OF DIRECTORS HELD WEDNESDAY DECEMBER 17, 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; J. Randolph, Chief of Staff; M. Tupper, CFO; D. Cox, Chief Human Resource Officer; M. Mertz, Chief Strategy Officer; D. Leeper, Chief Information Officer; P. Stefanacci, Chief Medical Officer; R. Berglund, Legal Counsel; and K. Davis, recording

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

PUBLIC PARTICIPATION –None.

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 DECEMBER 17, 2025, AT 4:30PM IN THE CITY OF VISALIA CITY COUNCIL CHAMBERS – 707 W. ACEQUIA, VISALIA, CA.

PRESENT: Directors Olmos, Francis, Murrieta, & Levitan; G. Herbst, CEO; J. Randolph, Chief of Staff; M. Tupper, CFO; D. Cox, Chief Human Resource Officer; M. Mertz, Chief Strategy Officer; D. Leeper, Chief Information Officer; P. Stefanacci, Chief Medical Officer; R. Berglund, Legal Counsel; and K. Davis, recording

The meeting was called to order at 4:30 PM by Director Olmos.

ROLL CALL- Directors Olmos, Levitan, Francis and Murrieta were present. Director Havard Mirviss was absent.

FLAG SALUTE- Director Olmos lead the flag salute.

PUBLIC PARTICIPATION – None.

CLOSED SESSION ACTION TAKEN: In closed session the board approved the Medical Executive Committee's credentialing recommendations for December 2025. The board also approved the closed meeting minutes of November 4, 7, 11, 13, 19, 2025. There was also action taken by the Board to reject the claim on its merits pursuant to Government Code Section 54956.9.

RECOGNITIONS- Resolution 2274, 2275.

CHIEF OF STAFF REPORT – Report relative to current Medical Staff events and issues – Julianne Randolph, DO, *Chief of Staff*

- No report.

CONSENT CALENDAR – Director Olmos entertained a motion to approve the December 17, 2025, consent calendar.

PUBLIC PARTICIPATION – None.

MMSC (Levitan/Murrieta) to approve the December 17, 2025, consent calendar. This was supported unanimously by those present. Vote: Yes – Olmos, Levitan, Murrieta and Francis.

ELECTION OF OFFICERS– The Board will consider and take action to elect Board Officers for the upcoming term, including President, Vice President, and Secretary.

Francis – President
Murrieta- Vice President
Levitan- Secretary/Treasurer

Rachele Berglund, Esq., entertained a motion to approve the new slate of Board Officers.

MMSC (Francis/Olmos) to approve the new two year term of board officers. This was supported unanimously by those present. Vote: Yes – Olmos, Levitan, Murrieta and Francis.

PATIENT EXPERIENCE AND SATISFACTION UDPATE – A staff presentation and discussion of regarding aggregated and de-identified patient experience data, including trends, themes, and opportunities for improvement. Presented by Deborah Volosin. Copy attached to the original of the minutes and to be considered a part thereof.

FINANCIALS – A presentation and discussion of current financial statements, budget performance, revenue, and expense trends, and year-to-date comparisons for the District. Presented by Malinda Tupper.
Copy attached to the original of the minutes and to be 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 6:34PM

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

BOD 10

Policy Number: BOD10	**Date Created: 01/01/2026**
Document Owner: Kelsie Davis (Board Clerk/Executive Assistant to CEO)	**Date Approved: TBD**
Approvers: Board of Directors (Administration)	

Executive Employment Agreement Policy

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

PURPOSE: This policy is adopted to ensure compliance with California Senate Bill 707 (Health and Safety Code §§ 32121–32121.9), promote transparency, strengthen Board oversight, and ensure responsible executive compensation and governance practices.

POLICY: This policy applies to the Chief Executive Officer (CEO), as defined in Article VI of the Board Bylaws, and any executive officer with equivalent authority over District operations or finances. Consistent with Article VI, Sections 1-5 of the Board Bylaws, the Board of Directors retains authority to appoint, evaluate, and dismiss the Chief Executive Officer.

Requirements

1. All executive employment agreements must be:
    - Approved by the Board of Directors in open session
    - Documented in official Board minutes
    - Publicly disclosed in accordance with District transparency policies
    - Limited to a maximum term of five (5) years
2. Agreements shall include:
    - Duties and responsibilities consistent with Article VI of the Bylaws
    - Compensation structure approved by the Board
    - Performance objectives aligned with District strategic goals
    - Termination provisions compliant with SB 707
    - Severance limitations as outlined in Policy 2
3. No agreement may auto-renew beyond the five-year statutory limit.

Implementation and Review

- These policies shall be reviewed at least every two (2) years.
- Board members and executives shall receive training on SB 707 requirements.

BOD 11

Policy Number: BOD11	Date Created: 01/01/2026
Document Owner: Kelsie Davis (Board Clerk/Executive Assistant to CEO)	Date Approved: TBD
Approvers: Board of Directors (Administration)	

Severance and Compensation Limitation Policy

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

PURPOSE: This policy is adopted to ensure compliance with California Senate Bill 707 (Health and Safety Code §§ 32121–32121.9), promote transparency, strengthen Board oversight, and ensure responsible executive compensation and governance practices.

POLICY: This policy applies to the Chief Executive Officer (CEO), as defined in Article VI of the Board Bylaws, and any executive officer with equivalent authority over District operations or finances. Consistent with Article VI, Sections 1-5 of the Board Bylaws, the Board of Directors retains authority to appoint, evaluate, and dismiss the Chief Executive Officer.

Severance Restrictions

1. Severance compensation shall not exceed:
    - The remaining term of the contract, or
    - One (1) year of base compensation for annually renewed contracts
2. Severance is strictly prohibited if termination is for cause, including but not limited to:
    - Fraud
    - Misconduct
    - Gross negligence
    - Malfeasance
3. Side letters, amendments, or informal agreements providing additional compensation are prohibited.

Compensation Changes

- All executive compensation adjustments must be approved by the Board in open session.

Implementation and Review

- These policies shall be reviewed at least every two (2) years.
- Board members and executives shall receive training on SB 707 requirements.

OD 12

Policy Number: BOD12	**Date Created: 01/01/2026**
Document Owner: Kelsie Davis (Board Clerk/Executive Assistant to CEO)	**Date Approved: TBD**
Approvers: Board of Directors (Administration)	

CEO Performance Evaluation Policy

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

PURPOSE: This policy is adopted to ensure compliance with California Senate Bill 707 (Health and Safety Code §§ 32121–32121.9), promote transparency, strengthen Board oversight, and ensure responsible executive compensation and governance practices.

POLICY: This policy applies to the Chief Executive Officer (CEO), as defined in Article VI of the Board Bylaws, and any executive officer with equivalent authority over District operations or finances. Consistent with Article VI, Sections 1-5 of the Board Bylaws, the Board of Directors retains authority to appoint, evaluate, and dismiss the Chief Executive Officer.

1. In alignment with **Article VI, Section 5** of the Board Bylaws, the Board shall meet annually in executive session to monitor and evaluate the performance of the Chief Executive Officer.

2. The evaluation shall:
    - Be conducted annually
    - Be based on goals and objectives agreed upon at the beginning of the evaluation cycle, consistent with **Board performance responsibilities outlined in Article II**
    - Include both qualitative and quantitative performance measures

3. Conclusions and recommendations from the evaluation shall be documented and transmitted to the CEO by the Board President, consistent with **Article III duties of the President**.

4. Results of the evaluation shall inform compensation decisions, which must be approved in open session.

Implementation and Review

- These policies shall be reviewed at least every two (2) years.
- Board members and executives shall receive training on SB 707 requirements.

BOD 13

Policy Number: BOD13	Date Created: 01/01/2026
Document Owner: Kelsie Davis (Board Clerk/Executive Assistant to CEO)	Date Approved: TBD
Approvers: Board of Directors (Administration)	

Board Oversight and Accountability Policy

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

PURPOSE: This policy is adopted to ensure compliance with California Senate Bill 707 (Health and Safety Code §§ 32121–32121.9), promote transparency, strengthen Board oversight, and ensure responsible executive compensation and governance practices.

POLICY: Consistent with Article II (Duties and Responsibilities of the Governing Body) of the Board Bylaws, the Board of Directors retains exclusive authority to:

- Hire, evaluate, and terminate the Chief Executive Officer
- Approve executive compensation and employment agreements
- Monitor organizational, financial, and management performance
- Ensure compliance with all applicable governance laws, including SB 707

The Board shall act collectively, exercise independent judgment, and maintain accountability to the community served by the District.

Implementation and Review

- These policies shall be reviewed at least every two (2) years.
- Board members and executives shall receive training on SB 707 requirements.

BOD 14

Policy Number: BOD14	Date Created: 01/01/2026
Document Owner: Kelsie Davis (Board Clerk/Executive Assistant to CEO)	Date Approved: TBD
Approvers: Board of Directors (Administration)	

Public Transparency and Disclosure Policy

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

PURPOSE: This policy is adopted to ensure compliance with California Senate Bill 707 (Health and Safety Code §§ 32121–32121.9), promote transparency, strengthen Board oversight, and ensure responsible executive compensation and governance practices.

POLICY: Consistent with Article II (Duties and Responsibilities of the Governing Body) of the Board Bylaws, the Board of Directors retains exclusive authority to:

1. Executive employment agreements, amendments, and renewals shall be posted on the District website within seventy-two (72) hours of Board approval.
2. The District shall comply with the Brown Act and Public Records Act.
3. Redactions shall be limited to legally protected information only.

The Board shall act collectively, exercise independent judgment, and maintain accountability to the community served by the District.

Implementation and Review

- These policies shall be reviewed at least every two (2) years.
- Board members and executives shall receive training on SB 707 requirements.

BOD 15

Policy Number: BOD15	Date Created: 01/01/2026
Document Owner: Kelsie Davis (Board Clerk/Executive Assistant to CEO)	Date Approved: TBD
Approvers: Board of Directors (Administration)	

Closed Session and Labor Negotiations Policy

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

PURPOSE: This policy is adopted to ensure compliance with California Senate Bill 707 (Health and Safety Code §§ 32121–32121.9), promote transparency, strengthen Board oversight, and ensure responsible executive compensation and governance practices.

POLICY: Consistent with Article II (Duties and Responsibilities of the Governing Body) of the Board Bylaws, the Board of Directors retains exclusive authority to:

1. Closed session discussions related to executive employment, evaluation, or discipline shall be conducted in accordance with the Brown Act and **Article II and Article VI of the Board Bylaws**.
2. While the Board may deliberate in closed session, final actions regarding:
    - Executive employment agreements
    - Compensation adjustments
    - Contract approvals or amendments must be reported out and approved in open session.
3. The Board President, consistent with **Article III responsibilities**, shall ensure accurate reporting of closed session actions.

Implementation and Review

- These policies shall be reviewed at least every two (2) years.
- Board members and executives shall receive training on SB 707 requirements.

BOD 16

Policy Number: BOD16	Date Created: 01/01/2026
Document Owner: Kelsie Davis (Board Clerk/Executive Assistant to CEO)	Date Approved: TBD
Approvers: Board of Directors (Administration)	

Board Meeting Transparency and Remote Access Policy

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

PURPOSE: This policy is adopted to ensure compliance with California Senate Bill 707 (Health and Safety Code §§ 32121–32121.9), and applicable provisions of the Brown Act, including public access and participation.

General Transparency Requirements

1. All regular and special meetings of the Board of Directors shall be conducted openly and publicly, except as permitted for closed session by law.
2. Meeting agendas shall be posted in accordance with the Brown Act and include sufficient detail to inform the public of the business to be transacted.
3. Agenda materials related to executive compensation, contracts, or performance shall be made publicly available, except for limited legally protected information.

Remote Public Access

1. The District shall provide **remote public access** to all regular and special Board meetings through a publicly accessible teleconference or internet-based platform.
2. Remote access information (e.g., call-in number or webcast link) shall be clearly identified on the posted agenda.
3. Members of the public shall be afforded the opportunity to:
    - Observe the meeting remotely
    - Provide public comment remotely, consistent with Brown Act requirements

Board Member Participation

1. Board members may participate remotely only as authorized by the Brown Act and District policy.
2. When remote participation by Board members is permitted:
    - Voting shall be conducted transparently
    - The public shall be able to hear all discussion

Meeting Disruptions

If technical difficulties prevent the public from accessing the meeting remotely, the Board shall recess or adjourn the meeting until access is restored, unless doing so would create an unreasonable disruption.

Responsibility

The Board President and District administration shall ensure implementation of this policy and ongoing compliance with state law.

Implementation and Review

- These policies shall be reviewed at least every two (2) years.
- Board members and executives shall receive training on SB 707 requirements.

BOD 17

Policy Number: BOD17	Date Created: 01/01/2026
Document Owner: Kelsie Davis (Board Clerk/Executive Assistant to CEO)	Date Approved: TBD
Approvers: Board of Directors (Administration)	

Language Access for Public Meeting Notices and Agendas Policy

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

PURPOSE: This policy is adopted to ensure meaningful access to Board meetings consistent with Government Code §54954.2, AB 361 / AB 2449 implementation guidance, SB 707 transparency principles, and Title VI language access obligations.

Language Posting Requirements

1. Board agendas and meeting notices shall be posted in English, which is the official language required by the Brown Act.
2. The District shall provide translated agenda summaries or notices in additional languages when:
    - A substantial portion of the District's service population has limited English proficiency, or
    - Language access is required to ensure meaningful public participation.
3. Full agenda translation is not required by law, unless specifically mandated by another statute or settlement agreement.

Standard District Practice

1. The District shall post:
    - The full agenda in English
    - A clear Language Access Notice in additional commonly spoken languages within the District (e.g., Spanish, other threshold languages)
2. The Language Access Notice shall:
    - Inform the public that translation or interpretation assistance is available
    - Provide contact information and reasonable advance notice instructions

Interpretation Services

When requested with reasonable notice, the District shall make good-faith efforts to provide:

- Oral interpretation for public comment
- Translated summaries of agenda items upon request

Responsibility

District administration, in coordination with the Board Secretary, shall determine threshold languages based on community demographics and periodically reassess language needs.

Implementation and Review

- These policies shall be reviewed at least every two (2) years.
- Board members and executives shall receive training on SB 707 requirements.

AP 91

Subcategories of Department Manuals not selected.

Policy Number: AP91	**Date Created: No Date Set**
Document Owner: Kelsie Davis (Board Clerk/Executive Assistant to CEO)	**Date Approved: Not Approved Yet**
Approvers: Board of Directors (Administration)	

Unannounced Regulatory Survey Plan for Response

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

PURPOSE: To ensure that the appropriate Kaweah Health personnel respond in a coordinated and timely manner upon notification that surveyors and/or an outside regulatory agency have arrived for an unannounced visit to Kaweah Delta Health Care District dba Kaweah Health.

POLICY: All unannounced regulatory visits to Kaweah Health will be handled in a coordinated and timely manner.

A. Surveyors will be provided immediate access to medical records. A Kaweah Health staff person will access the medical record as requested by and on behalf of the surveyor.

B. A District staff person will be available to accompany a surveyor during his/her visit.

C. If a surveyor requests to interview a Kaweah Health employee during the visit, Kaweah Health staff have the right to request another Kaweah Health staff member, the Director of Risk Management or the Chief Compliance & Risk Officer be present during the interview, as appropriate. Additionally, employees or employee representative's have the right to discuss possible regulatory violations or patient safety concerns with the California Department of Public Health's inspector privately during the course of an investigation or inspection by the Department.

D. In order to ensure compliance with HIPAA, state and federal privacy laws, Kaweah Health employees should validate surveyor credentials and purpose for the visit through on-campus interviews. Off-site phone interviews disallow this process and are, therefore, strongly discouraged.

PROCEDURE:

I. Upon arrival to any campus of Kaweah Health, Administration at Kaweah Health Medical Center will be notified (624-2221) and the regulatory surveyors will be escorted to the following location based on the Kaweah Health campus where they arrive at which time credentials will be verified.

If the surveyors are from Joint Commission go directly to item II

CAMPUS	*OFFICE TO TAKE SURVEYORS*	*STAFF TO VERIFY CREDENTIALS*
Kaweah Health Medical Center	Administration	Administration
Kaweah Health Skilled Nursing	Director of SNF	Director of SNF
Kaweah Health Rehabilitation Hospital	Director of Rehabilitation Hospital	Director of Rehabilitation Hospital
Kaweah Health Mental Health Hospital	Director of Mental Health Hospital	Director of Mental Health Hospital
Kaweah Health Dialysis - Visalia	Manager of Visalia Dialysis	Manager of Visalia Dialysis
Kaweah Health Rural Health Clinics	Director of Kaweah Health Rural Health Clinics {Exeter, Woodlake, Dinuba & Lindsay}	Director of Kaweah Health Rural Health Clinics

A. Upon arrival to the appropriate location as indicated in the preceding chart, the staff member assisting the surveyors will provide each surveyor with the appropriate surveyor identification badge.

Surveyor identification badges must be worn at all times while on Kaweah Health premises. Surveyor identification badges will be displayed above the waist so as to be fully visible to Kaweah Health personnel and Security staff. At the conclusion of each visit, surveyors will immediately return the vendor identification badge and check out of the facility.

B. The following individuals shall be notified by e-mail and by phone of their arrival.

~~Title~~	~~Phone~~	~~Cell~~
~~Chief Executive Officer~~	~~624-2330~~	~~740-2496~~
~~Applicable Chief:~~		
~~Chief Compliance & Risk Officer~~	~~624-5006~~	~~559-280-3105~~
~~Chief Operating Officer (COO)~~	~~624-2221~~	~~917-0490~~
~~Chief Financial Officer (CFO)~~	~~624-4065~~	
~~Chief of Human Resources~~	~~624-2362~~	~~559-300-1742~~
~~Chief Nursing Officer (CNO)~~	~~624-2221~~	~~269-569-0118~~
~~Chief Information & Cybersecurity Officer~~	~~624-5410~~	~~909-633-5278~~
~~Chief Strategy Officer~~	~~624-2359~~	~~310-227-6357~~
~~Risk Manager~~	~~624-2511~~	
~~Director of Quality and Patient Safety~~	~~624-2169~~	~~707-7086~~

Title	Phone	Cell
Chief Executive Officer	624-2330	
Chief Compliance & Risk Officer	624-5006	559-280-3105
Chief Medical and Quality Officer	624-2250	559-515-3779
Chief Operating Officer	624-3794	559-917-0490

Chief Financial Officer	624-4065	
Chief of Human Resources Officer	624-2362	
Chief Nursing Officer	624-2250	408-781-7358
Chief Information & Cybersecurity Officer	624-2254	
Chief Strategy Officer	Vacant	Vacant
Director of Risk Management	624-5297	559-786-6908
Director of Quality and Patient Safety	Vacant	Vacant

C. An e-mail will be sent to "Unannounced Survey Alert" including what outside regulatory agency is here, why they are here (if that information is provided), who is escorting them, and to what area they will be going.

D. A notification log shall be prepared by Administration and maintained in Administration documenting that the appropriate personnel were notified of the visit from the outside regulatory agency. This log will reflect the following data:

1. Date of the visit
2. What agency is making the visit and the name of the representative from that agency
3. Case # (if available)
4. Patient(s) the visit is concerning (if applicable)
5. Follow up report receipt date

E. Upon conclusion of the surveyor's visit, the Kaweah Health staff member who assisted/accompanied the surveyor shall notify (via phone, email or in-person) the CEO of the key issues/conclusions of the surveyor's findings.

F. Room designation for surveyors

G. Reserve a meeting Room as the daily meeting room for the surveyors and escorts. This room will also serve as the secure location for storage of requested survey documents to be delivered by various Kaweah Health personnel and the secure location for storage of surveyor's personal items (handbags, laptop computers, etc.).
1.

H. Arrange daily food service for surveyors if requested. Typical needs are for breakfast, lunch and afternoon snack, beverage service and bottled water available all day.

I. Reserve a room for the Exit Conference on the final day of the survey from 1200-1700.

II. Items III-V pertain specifically to unannounced surveys by the Joint Commission.

III. The Director of Quality and Patient Safety or designee will monitor the Joint Commission's secure Extranet website for impending survey information. Posting of survey announcement and surveyor biographies to the Extranet indicates possible impending survey. If survey is imminent, the following action is taken immediately:

A. Notify CEO, COO, CNO and CMO

B. Print surveyor biographies to facilitate positive identification on arrival.

IV. Regardless of location, upon arrival to Kaweah Health, the Joint Commission surveyor(s) should be greeted, Administration notified (624-2221) **and the surveyors will then be escorted to Administration at Kaweah Delta Medical Center where positive identification can be verified**. Immediate notification to the Director of Quality and Patient Safety or designee is required. Identification will be verified by comparing the surveyor(s) documentation with the biographies printed from the Extranet. If a discrepancy exists, security will be notified immediately. Additional notification will be made to local law enforcement and to the Joint Commission. If the credentials of the JOINT COMMISSION survey team are verified, the following actions will be taken immediately:

A. Upon arrival to Administration the surveyors will obtain the appropriate surveyor identification badge. Surveyor identification badges must be worn at all times while on Kaweah Health premises. Surveyor identification badges will be displayed above the waist so as to be fully visible to Kaweah Health personnel and Security staff. At the conclusion of the Joint Commission survey, surveyors will immediately return the vendor identification badge to the Administration or the Director of Quality and Patient Safety.

B. One of the executive assistants in Administration will call the PBX operator and direct them to immediately announce by overhead page “Attention all staff. Kaweah Health welcomes the Joint Commission surveyors with us today”. The announcement will be repeated three times in one-minute intervals.

C. One of the executive assistants in Administration will notify all KDHCD Executive Team Support members and email out the “Readiness Checklist” to the Leadership Team to be completed immediately by Director’s or designee upon notification of survey (and daily by 8 am). Each Executive Team Support member or their designee will contact their Executive Team member’s Director’s by phone of the unannounced survey.

D. One of the executive assistants in Administration will send an email to “Everyone” with high importance (red ! symbol) using the following text “An unannounced Joint Commission survey is in progress. See your area manager for additional information and instructions.”

V. Additional Responsibilities by Service Area

A. One of the executive assistants in Administration

1. Reserve a Conference Room as the daily meeting room for the surveyors and escorts. This room will also serve as the secure location for storage of requested survey documents to be delivered by various KDHCD personnel and the secure location for storage of surveyor’s personal items (handbags, laptop computers, etc.). One of the Executive Assistants in Administration shall have a portable copy machine delivered to this Room on day 1 of the survey. Also see page

4 wherein Facilities Department is to deliver a locking cabinet for secure storage to -the designated meeting room upon survey arrival.

2. Arrange daily food service for surveyors. Typical needs are for breakfast, lunch and afternoon snack, beverage service and bottled water available all day.

3. Reserve a meeting room for the Exit Conference on the final day of the survey, 1400-1700 hours.

B. Director of Quality and Patient Safety or Designee

1. If not already accomplished, print surveyor biographies from the Joint Commission website and deliver 15 copies to Administration on morning of unannounced survey.

2. Prepare/deliver opening conference presentation.

3. Arrange for temporary surveyor badges.

4. Arrange for survey escorts

5. E-mail survey schedule to leadership/communication group as soon as possible.

C. Patient Access

1. Prepare printed copy of patient census and deliver to Administration as soon as possible day 1 of survey and by 8 am each of survey thereafter. Census at minimum to include patient name, account number, medical record number, age, unit/room number, diagnosis and admit date. Include each campus census:

a) Kaweah Health Medical Center

b) Kaweah Health Skilled Nursing (Subacute and Transitional Care)

c) Kaweah Health Rehabilitation Hospital and Kaweah Delta Mental Health Hospital

2. Prepare printed copy of surgical/procedural schedules and deliver to Administration as soon as possible day 1 of survey and by 8 am each of survey thereafter. Include the following:

a) Inpatient and outpatient surgical schedule

b) Endoscopy lab schedule

c) Cardiac Cath lab schedule

d) Interventional radiology/Special Procedures schedule

D. Medical Staff Manager or Designee

1. Notify Medical Executive Committee membership of survey ASAP

2. Notify credentials committee chair of requested attendance at credentials session.

3. Notify P&T chair of requested attendance at medication management session.

E. Director of Facilities Operations or Designee

1. Deliver required Environment of Care (EOC) documents to Administration.

2. Deliver a locking cabinet to the designated meeting room for use of secure storage of surveyor belongings (with enough keys for each survey escort)

3. Deploy all facilities staff to

a) Remove clutter and obstructions throughout hospital

b) Ensure cleanliness of facility beginning with areas surrounding Administration

F. Director of Health Information or Designee

1. Deliver medical record statistic form to Administration

2. Review electronic physician orders for signatures, dates and times – if not, call physician to come and sign

G. Director of Clinical Education or Designee

1. Alert educators for potential need for competency review.

H. Director of Food & Nutrition Services or Designee

1. Deploy food services staff to check refrigerators for expired food

2. Direct staff to make rounds on patient care units and remove dirty trays, carts, etc.

I. Nursing Units: **Daily** during survey week (Nursing Director or designee accountable)

1. Utilize “Day of Survey Checklist” (Attachment A)

2. Identify three charts daily for surveyors to use of patients who have been in various units in the hospital and have been in the hospital at least 3 days or may be ready for discharge. Ensure these charts are complete (complete initial assessment, good daily notes, care-planning, etc)

3. Review all restraint patients and ensure current order and documentation up to date

J. Other Clinical Service areas

1. Utilize “Day of Survey Checklist” **daily** (Attachment A)

2. Management/Staff to ensure

a) No food in patient care areas, drinks are sequestered (ie in cupboard)
b) Areas clean and free of clutter
c) No supplies stored on floors
d) Confidential information out of public view

K. Information Systems

1. Chief Clinical Information Officer or designee to notify appropriate staff of need to assist with online chart reviews throughout survey

L. Human Resources (HR)

1. Be on alert for need to review HR files. KDHCD staff escorting surveyors will notify HR as files are requested.

Attachment A

Day of Survey Checklist	CHECK IF COMPLIANT
1. Halls clear, no equipment blocking medical gas shut off valve or fire pull stations.	
2 Unit/department clean (including drawers and cabinets).	
3 Garbage/Biohazard not overflowing, lids are closed.	
4 No outside shipping cardboard in patient care areas, or where patient supplies stored (check under sinks and counters).	
5 Sharps containers no more than ¾ full.	
2. Nothing stored on floors or 18 inches from ceiling and/or fire sprinklers.	
3. Doors are not propped open	
4. performance improvement activities posted in unit/department (include safety culture if applicable)	
5. All refrigerator log(s) complete.	
6. Patient refrigerator clean, patient food labeled with date and not expired	
7. Laundry bins in hallways are at least 8' apart, or 1 per pod (in MK units)	
8. Crash cart log up to date, with no gaps. Defibrillator plugged in, tamper-resident seals in place on crash carts.	
9. Isolation patient rooms - Isolation door caddy's are stocked, appropriate isolation precaution sign is posted on door.	
10. Hand Hygiene supplies are stocked (ie. soap and sanitizer)	
11. Cleaning supplies are stocked and ready to use	
12. Supplies current (<u>no</u> expired lab tubes, supplies, etc) (<u>check all supply places, drawers, etc)</u>	
13. Ice machines clean (no scale in bin, etc.).	
14. Oxygen tanks stored properly (in carts/caddy's/holder)	
15. Medication area clean and locked.	
8. Medications stored properly, no expired medications.	
9. Medications are not prepared within 1' of water (ie beside a sink with no barrier)	
10. Patient's own medications properly stored per policy	
11. Open multi-use vials dated, not expired and label does not cover up medication bottle label?	

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

I. Purpose

Kaweah Delta Health Care District (Kaweah Health) provides high quality health care services to our patients. It is the policy of Kaweah Health to bill patients and applicable third-party payers accurately, timely, and consistent with applicable laws and regulations, including without limitation California Health and Safety Code section 127400 *et seq*. Kaweah Health operates a non-profit hospital and, therefore, Kaweah Health must also comply with 26 U.S.C. § 501(r) and its implementing regulations, 26 C.F.R. § 1.501(r) *et seq*. This policy is intended to meet all such legal obligations.

II. Scope

The Credit and Collection Policy applies to all patients who receive services through any of the licensed hospital facilities operated by Kaweah Health. This policy also applies to any collection agency working on behalf of Kaweah Health, including entities to which Kaweah Health sells or refers a Patient's debt. Unless otherwise specified, this policy does not apply to physicians or other medical providers, including emergency room physicians (other than physician specialists on staff or with Kaweah Health hospital privileges who are called into the emergency department), anesthesiologists, radiologists, hospitalists, pathologists, etc., whose services are not included in a Kaweah Health bill.

This policy does not create an obligation for Kaweah Health to pay for such physicians' or other medical providers' services. In California, Health and Safety Code section 127450 *et seq*. requires an emergency physician who provides emergency services in a hospital to provide discounts to uninsured patients or patients with high medical costs who are at or below 350 percent of the federal poverty level.

III. Definitions

A. Collection Agency is any entity engaged by Kaweah Health to pursue or collect payment from Patients.

B. Extraordinary Collection Actions (ECAs) are any collection activities, as defined by the IRS, that healthcare organizations may take against an individual to obtain payment for care only after reasonable efforts have been made to determine whether the individual is eligible for financial assistance. ECAs include any of the following:

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i) Any action to obtain payment from a Patient that requires a legal or judicial process, including without limitation the filing of a lawsuit;

ii) Selling a Patient's debt to Kaweah Health to another party, including without limitation to a Collection Agency;

iii) Attaching or seizing a bank account or any other personal property[1];

iv) Causing a Patient's arrest or obtaining a writ of body attachment[2];

v) Wage garnishment;

vi) Delay or denial of medically necessary care based on the existence of an outstanding balance for prior service(s); or

vii) Obtaining an order for examination.

C. Financial Assistance Application means the information and documentation that a Patient submits to apply for financial assistance under Kaweah Health's Financial Assistance Policy. An application is complete after a Patient submits information and documentation sufficient for Kaweah Health to determine whether the individual is eligible for assistance. An application is incomplete if a Patient submits some, but not all, information and documentation needed to determine eligibility for assistance. Patients may submit required application information in writing and orally.

D. Financial Assistance refers to Charity Care and Discounted Care, as those terms are defined in the Finance Assistance Policy.

E. Financial Assistance Policy (FAP) is the Kaweah Health policy on Charity Care and Discounted Care Programs, which describes the Kaweah Health Financial Assistance Program. This includes the criteria Patients must meet in order to be eligible for financial assistance as well as the process by which Patients may apply for Financial Assistance.

F. Insured Patient means an individual whose hospital bill is fully or partially eligible for payment by a third-party payer.

G. Patient includes the individual who receives services at Kaweah Health. For purposes of this policy, Patient also includes any person financially responsible for their care, also referred to as Guarantor.

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H. Reasonable Efforts to Determine Eligibility are actions Kaweah Health must take to determine whether an individual is eligible for financial assistance under Kaweah Health's Financial Assistance Policy. These must include making a determination of presumptive eligibility as described in the FAP at Section III.A, and if the determination is less than Charity Care, providing adequate notice of an opportunity to apply for Charity Care and a reasonable period of time to do so.[3] For submitted applications, these efforts must include a reasonable opportunity to correct an incomplete application and Reasonable Efforts to Notify.[4]

I. Reasonable Efforts to Notify At a minimum, reasonable efforts include providing individuals with written and verbal notifications about the FAP and how to complete the FAP application, with reasonable opportunity to do so before initiating any ECA.[5]

J. Reasonable Payment Plan means monthly payments that are not more than 10 percent of a Patient's family income for a month, excluding deductions for essential living expenses. "Essential living expenses" means expenses for any of the following: rent or house payment and maintenance, food and household supplies, utilities and telephone, clothing, medical and dental payments, insurance, school or child care, child or spousal support, transportation and auto expenses, including insurance, gas, and repairs, installment payments, laundry and cleaning, and other extraordinary expenses.

K. Reasonable Time as used in this policy is a period of at least 30 days. That period may be extended for good cause. Situations that may merit an extension of time to act may include language access barriers, the need for disability accommodations, a Patient's or Patient's family member's continuing illness, or other obstacles specific to a Patient's circumstances.

L. Uninsured Patient or "Self-Pay Patient" means a Patient who does not have third party insurance, Medi-Cal, or Medicare, and who does not have a compensable injury for purposes of workers' compensation, automobile insurance, or other insurance as determined and documented by Kaweah Health.

IV. Policies and Procedures

After Kaweah Health Patients have received services, it is the policy of Kaweah Health to bill Patients and applicable payers accurately. During the billing and collections process, Kaweah Health staff, and any collection agency working on behalf of Kaweah Health, provide quality customer service and follow-up, and all unpaid accounts are handled in accordance with this Policy and applicable laws and regulations.

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A. Insurance Billing:

1. Obtaining Coverage Information: Kaweah Health makes reasonable efforts to obtain information from Patients about whether private or public health insurance or sponsorship may fully or partially cover the services rendered by Kaweah Health to the Patient. However, it is the Patient's responsibility to know their insurance benefits and coverage. With the exception of emergency care, all required referral(s) or authorizations must be secured prior to receiving services. If the Patient has questions regarding their financial responsibility or coverage of services at Kaweah Health, they can contact their insurance company in advance of services as appropriate.

2. Billing Third Party Payers: Kaweah Health shall diligently pursue all amounts due from third- party payers, including but not limited to contracted and non-contracted payers, indemnity payers, liability and auto insurers, and government program payers that may be financially responsible for a Patient's care. Kaweah Health bills all applicable third-party payers based on information provided by or verified by the Patient or their representative. Upon receiving proof of Qualified Medicare Beneficiary (QMB) or Medi- Cal eligibility (including but not limited to a copy of the Medi-Cal card or the Patient's date of birth and either a Medi-Cal ID number or Social Security number), Kaweah Health must bill exclusively to Medicare or Medi-Cal, and not the Patient, during periods of active QMB or Medi-Cal eligibility.[6]

3. Billing Medi-Cal Recipients: If the State Medi-Cal Eligibility System indicates a Patient with active Medi-Cal coverage also has other health coverage, and sufficient information is not available to bill that other health coverage, Kaweah Health will contact the patient in an attempt to get the necessary information. If the Patient indicates they do not in fact have other health coverage or cannot access necessary information, Kaweah Health will refer the Patient to their local Medi-Cal office or legal services office for further assistance. Except as authorized by law, KDHCD will not refer for collection an account with active Medi-Cal coverage at the time of service. This section shall not prevent Kaweah Health from billing a Medi-Cal patient for non-covered services, such as elective services, or from collecting the Medi-Cal Share of Cost after screening for eligibility for Financial Assistance.

4. Dispute Resolution with Third Party Payers: If a claim is denied or is not processed by a payer due to factors outside of Kaweah Health's control, Kaweah Health will follow up as appropriate to facilitate resolution of the claim. If resolution does not occur after reasonable follow-up efforts, Kaweah Health may

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bill the Patient or take other actions consistent with Kaweah Health's Financial Assistance Policy, current regulations, and industry standards. Balance billing Qualified Medicare Beneficiary (QMB) and Medi-Cal Patients for covered services is prohibited.

B. Patient Billing:

1. Billing Insured Patients: Kaweah Health bills Insured Patients for the Patient Responsibility amount as indicated in the third-party Explanation of Benefits (EOB) and as directed by the third-party payer.

2. Billing Uninsured or Self-Pay Patients: Kaweah Health bills Uninsured or Self-Pay Patients for items and services provided by Kaweah Health, using the amount Kaweah Health would receive for services under its contract with Blue Cross. All
Patients receive a statement as part of Kaweah Health's normal billing process that is compliant with and subject to Kaweah Health's Financial Assistance Policy. If a Patient has no health insurance coverage, it is Kaweah Health's responsibility to provide a written notice to a Patient that they may be eligible for public or private insurance, and an application for Medi-Cal or other state- or county-funded health coverage programs, no later than discharge for admitted Patients and as soon as possible for Patients receiving emergency or outpatient care.[7] Please refer to the Kaweah Health Financial Assistance Policy for more information.

3. Dispute Resolution with Patients/Guarantors: If a Patient/Guarantor disagrees with the account balance, the Patient/Guarantor may request the account balance be researched and verified prior to account assignment to a Collection Agency. The Patient/Guarantor may apply for Financial Assistance at any time. When a Patient/Guarantor has submitted an application for Financial Assistance, Kaweah Health will not assign an account to a Collection Agency before reaching a final eligibility determination. The referral of accounts for which an incomplete application for Financial Assistance has been received will be handled as outlined below.

C. Financial Assistance:

1. Kaweah Health notifies individuals that financial assistance is available to eligible individuals by doing the following:

   a. Kaweah Health posts notices in a visible manner in locations where there is a

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high volume of inpatient or outpatient admitting/registration, such as the emergency department, billing office, admitting office, and hospital outpatient service settings, consistent with all applicable federal and state laws and regulations, and Kaweah Health's FAP.

b. Kaweah Health makes its FAP, applications for assistance, and the plain language summary of its FAP, as well as other important information about the availability of financial assistance, easily available on the Kaweah Health website.

c. Kaweah Health makes paper copies of its FAP, the application for assistance under the FAP, and the plain language summary of the FAP available upon request and without charge, both by mail and in public locations in the hospital facility, including, at a minimum, in the emergency department, admissions area, and billing department.

d. Kaweah Health provides prominent Financial Assistance information on all Patient statements. The statement notifies and informs patients about the availability of financial assistance under the Kaweah Health FAP and includes the telephone number of the office or department which can provide information about the policy and application process, and the direct website address (or URL) where copies of this policy, the application form, and the plain language summary of this policy may be obtained. At the time of admission, discharge, and/or on at least one post-discharge written communication, Kaweah Health provides to every Patient a written, plain language summary of the Kaweah Health Financial Assistance Policy that contains information about the availability of Kaweah Health's Financial Assistance policy, eligibility criteria, and the contact information for a Kaweah Health employee or office where the Patient may apply for assistance or obtain further information about the policy.

D. Collection Practices:

1. Kaweah Health and its contracted Collection Agency(ies) undertake reasonable efforts to collect amounts due for services received by pursuing reimbursement from insurers and other sources. These efforts include assistance with applications for possible private and government program coverage. If any balance remains after payment by third-party payers, before considering any ECA, Kaweah Health will evaluate each Patient for Charity Care or Discounted Care consistent with its Financial Assistance Policy, for care received from Kaweah Health and incurred at any time during which the Patient was eligible for

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Financial Assistance under the FAP.

2. Kaweah Health pursues payment for debts owed for health care services provided by Kaweah Health according to Kaweah Health policies and procedures. All Kaweah Health procedures for assignment to collection/bad debt and application of a reasonable payment plan are applicable to all Kaweah Health Guarantors/Patients.[8] Kaweah Health complies with relevant federal and state laws and regulations in the assignment of bad debt. Kaweah Health is entitled to pursue reimbursement from third-party liability settlements or other legally responsible parties.

3. Prior to engaging in any ECA, and after normal collection efforts have not produced regular payments of a reasonable amount and the Patient has not completed a Financial Assistance application, complied with requests for documentation, or is otherwise nonresponsive to the application process, Kaweah Health or any Collection Agency acting on its behalf shall make reasonable efforts to presumptively determine whether a Patient is eligible for Financial Assistance based on prior eligibility for Financial Assistance or the use of third party data.[9]

4. Patient accounts may be referred to a Collection Agency only when:

   a. 180 or more days have passed since the first post-discharge billing statement was mailed to the Patient, or for billing statements that include any billing aggregation, at least 180 days have passed since the most recent episode of care[10]; and

   b. Kaweah Health is unaware of any pending appeals for insurance coverage of services[11]; and

   c. Kaweah Health has made attempts to collect payment using reasonable collection efforts, such as mailing billing statements or making telephone calls. Kaweah Health will mail four (4) Guarantor statements after the date of discharge from outpatient or inpatient care, with a final 30-day notice appearing on the fourth Guarantor statement, warning the account may be placed with a collection agency, and alerting the Guarantor that at least 180 days have passed since the first post-discharge billing statement for the most recent episode of care included in any billing aggregation[12]; and

   d. Kaweah Health has made reasonable efforts to presumptively determine

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whether a Patient is eligible for Financial Assistance based on prior eligibility for Financial Assistance or the use of third party data; and

e. Placement for collection has been approved by the Director of Revenue Cycle[13].

5. ECAs, including placement of an account with a collection agency, may not commence until 30 days after the final notice has been sent[14], and Kaweah Health has made reasonable efforts to determine whether the Patient is eligible for Financial Assistance.[15]

6. Accounts with a "Return Mail" status are eligible for collection assignment after good faith efforts have been documented and exhausted, including outbound phone calls and a reasonable search for a corrected address, and all other requirements of this section have been met.

7. Kaweah Health and any Collection Agency acting on its behalf will suspend ECAs when a completed Financial Assistance Application, including all required supporting documentation, is received and until such time as a determination regarding the Financial Assistance Application has been made. Prior to resuming collection efforts on accounts found ineligible for Charity Care, Kaweah Health will send the Patient: (i) written notification of the basis for the finding and the amount of assistance given if any, (ii) a billing statement showing any balance still owed by the Patient and the date payment is due, and (iii) if found eligible for only Discounted Care, instructions as to how the Patient may obtain information regarding the amounts generally billed (AGB) for their care. Collection efforts may then resume after the Patient has been given a reasonable time to pay the balance or enter into a reasonable payment plan.[16]
8. If any Patient account previously placed with a Collection Agency is subsequently found eligible for financial assistance, Kaweah Health and any Collection Agency acting on its behalf will pursue all reasonable measures to reverse prior collection efforts for debt that was
   1) incurred for care received from Kaweah Health during the previous 8 months; or 2) incurred at any time at which the patient was eligible for Financial Assistance under this policy.
   These reasonable measures include but are not limited to measures to vacate any judgment against the Patient, lift any levy or lien on the Patient's property, and remove from the Patient's credit report any adverse information previously reported to a consumer reporting agency or credit bureau.
9. If a Patient account previously placed with a Collection Agency is subsequently found eligible for Discounted Care with a remaining balance due, the account will be returned to Kaweah Health for payment or negotiation of an interest-free

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reasonable payment plan. The account will not be re-referred to any Collection Agency unless the Patient refuses to participate in a reasonable payment plan, or until a patient has failed to make payments under a reasonable payment plan for at least 90 days and Kaweah Health has made reasonable efforts to contact the patient by phone and in writing, giving notice that the extended payment plan may become inoperative.[17]

10. Kaweah Health and any Collection Agency acting on its behalf will suspend ECAs if an incomplete Financial Assistance Application is received and until a complete application has been submitted and a determination of eligibility is made, including resolution of any review or appeal of that determination,[18] or the Patient has failed to respond to requests for additional information and/or documentation within a reasonable period of time to respond to such requests. If a Patient submits an incomplete application, a written notice will be sent to the Patient that (i) describes the missing information/documentation required for a complete application, and (ii) includes contact information for a Kaweah Health employee or office where the Patient may obtain further information about the policy and assistance in applying.[19] Kaweah Health and any Collection Agency acting on its behalf must provide Patients with a reasonable timeframe (at least 30 days from notifying the Patient) to submit any missing information/documentation before resuming collection efforts.[20] If the Patient fails to provide the requested missing information/ documentation in a timely manner, Kaweah Health and any Collection Agency working on its behalf will make reasonable efforts to presumptively determine whether the Patient is eligible for Financial Assistance based on the information already provided, prior eligibility for Financial Assistance, or the use of third-party data.

11. Kaweah Health and any Collection Agency acting on its behalf does not base any FAP eligibility determination on any information obtained from Patients under duress or through the use of coercive practices, such as delaying or denying treatment until a Patient provides information.[21]

12. Kaweah Health and any Collection Agency acting on its behalf does not seek any Patient's waiver of their right to apply for Financial Assistance or to receive Financial Assistance application information.[22]

13. Kaweah Health and any Collection Agency acting on its behalf does not use in collection activities any information obtained from a Patient during the eligibility process for Financial Assistance.[23] Nothing in this section prohibits the use of information obtained by Kaweah Health or Collection Agency independently of the eligibility process for Financial Assistance.

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14. Patient accounts at a Collection Agency may be recalled and returned to Kaweah Health at the discretion of Kaweah Health and/or according to state or federal laws and regulations. Kaweah Health may choose to work the accounts to resolution with the Guarantor/Patient or third party as needed or place the account with another Collection Agency in full compliance with these requirements. An account that has been placed with an outside collection agency can be considered for charity care at any time in accordance with Kaweah Health's charity care policy. When, during the collection process, a patient asserts they cannot afford to pay the debt, has failed to make previously agreed upon extended payments, or is otherwise identified by the collection agency as meeting Kaweah Health's charity care eligibility criteria, the collection agency will refer the account back to Kaweah Health to screen for charity care eligibility. Kaweah Health will undertake reasonable efforts to gather eligibility information from the patient. If, after such reasonable efforts, the patient fails or refuses to provide required information, the account will be referred to the collection agency.

E. Collection Agencies:

Kaweah Health may refer Patient accounts to a Collection Agency subject to the following conditions:

1. The Collection Agency has a written agreement with Kaweah Health which provides that the Collection Agency's performance of its functions shall adhere to the terms of Kaweah Health's Financial Assistance Policy, this Credit and Collection Policy, the Hospital Fair Pricing Act (Health and Safety Code sections 127400 *et seq.*), and 26 U.S.C. § 501(r) and its implementing regulations, 26 C.F.R. § 1.501(r) *et seq.*, including the definition of "reasonable payment plan."

2. The Collection Agency has processes in place to identify Patients who may qualify for Financial Assistance, communicate the availability and details of the Financial Assistance Policy to these Patients, and refer Patients who are seeking Financial Assistance back to Kaweah Health Patient Financial Services. The Collection Agency shall suspend ECAs during any period after a completed Financial Assistance Application is pending, or an incomplete application is received and Kaweah Health has sent the required information described in IV.D.7 of this policy.[25]

3. All third-party payers have been properly billed, payment from a third-party payer is no longer pending, Kaweah Health is unaware of any pending insurance payment appeals, and the remaining debt is the financial responsibility of the

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Patient. A Collection Agency will not bill a Patient for any amount that a third-party payer is obligated to pay.

4. The Collection Agency sends every Patient a Notice of Rights, included as Attachment A, with each document sent indicating that the commencement of collection activities may occur.[26]

5. At least 180 days has passed since Kaweah Health sent the initial bill to the Patient on the account.

6. The Patient is not negotiating a reasonable payment plan, making payments under a reasonable payment plan as defined above, or making regular partial payments of a reasonable amount.[27]

F. Judicial Collection Actions:

In those situations where an account has been assigned for collection and the Collection Agency has information showing that the Patient has an income greater than 600% of the federal poverty level and would not qualify for Discounted Care, but has failed or refused to pay for the medical services, or, if a Patient is approved for Discounted Care and has failed or refused to make payments under a reasonable payment plan, the Collection Agency may be permitted to take legal action to collect the unpaid balance under the following conditions:

1. The Collection Agency shall assess a Patient or guarantor's ability to pay by reviewing, at a minimum, a current credit report for the Patient, if available, and reliable sources of publicly available information for Patients with little or no credit history, or a third party electronic review of Patient information.

2. When the Collection Agency has determined that legal action is appropriate and criteria for Extraordinary Collection Actions have been met, the Agency will forward a written request to the Director of Revenue Cycle, who must approve it prior to any legal action. The request must contain relevant particulars of the account, including:

    a. Documentation that the Collection Agency has complied with all applicable provisions of this policy, Kaweah Health's Financial Assistance Policy and all applicable laws and regulations; and

    b. A copy of the Collection Agency's documentation that led it to believe the

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Patient or guarantor has an income greater than 600% of the federal poverty level and would not qualify for Charity Care or Discounted Care, or, that the Patient was approved for Discounted Care and has failed or refused to make payments under a reasonable payment plan.

3. In cases where no Financial Assistance application is received by Kaweah Health, one additional attempt to inform the patient of Kaweah Health's Financial Assistance Policy and the opportunity to apply for assistance will be made before legal action is initiated. In addition to sending the patient a final correspondence, an additional attempt to contact the patient by phone will be made. If the Patient asks to apply for assistance, an application will be sent and no ECAs will be initiated until the application is received and processed, or an additional 30 days have passed without a complete or incomplete application being received.

4. The Director of Revenue Cycle will authorize each individual legal action in writing, after verifying that Kaweah Health and/or the Collection Agency working on its behalf has made legally sufficient reasonable efforts to determine the individual is eligible for Financial Assistance. This authority cannot be delegated to any other person. A copy of the signed authorization for legal action will be maintained in the Patient account file.

5. In no case will the Collection Agency be allowed to file a legal action as a last resort to motivate a Patient to pay when the Collection Agency has no information as to the Patient's income relative to the federal poverty level and eligibility for financial assistance.

6. If subsequent to a judgment being entered against any Patient for any unpaid balance, Kaweah Health or any Collection Agency working on its behalf receives information indicating the Patient would qualify for financial assistance under Kaweah Health's FAP, or, if the judgment is for a balance outstanding after Discounted Care is approved and the Patient has refused to make payments under a reasonable payment plan, the following shall apply:

   a. Neither Kaweah Health nor any assignee which is an affiliate or subsidiary of Kaweah Health shall use wage garnishments or liens on primary residences as a means of collecting unpaid hospital bills.[28]

   b. A Collection Agency which is not an affiliate or subsidiary of Kaweah Health may use the following measures to enforce judgment only under the following conditions:

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i. Wage Garnishment: The Collection Agency must file a noticed motion with the applicable Court, supported by a declaration identifying the basis for which the Agency believes that the Patient has the ability to make payments on the judgment under the wage garnishment, including, if available, information about probable future medical expenses based on the current condition of the Patient, and other financial obligations of the Patient.[29]

Citing:

[1] 26 C.F.R. § 1.501(r)-6(b)(iv)(C). [2] 26 C.F.R. § 1.501(r)-6(b)(iv)(F). [3] 26 C.F.R. § 1.501(r)-6(c)(2). [4] 26 C.F.R. § 1.501(r)-6(c)(3). [5] 26 C.F.R. § 1.501(r)-6(c)(3)-(c)(4). [6] 42 U.S.C. § 1396a(n)(3)(B); Welf. & Inst. Code § 14019.4. [7] Cal. Health & Safety Code § 127420(b). [8] Cal. Health & Safety Code § 127425(b). [9] 26 C.F.R. § 1.501(r)-6(c)(2). [10] Cal. Health & Safety Code § 127426(a). [11] Cal. Health & Safety Code § 127426(a). [12] 26 C.F.R. § 1.501(r)-6(c)(4)(ii). [13] Cal. Health & Safety Code § 127425(a), [14] 26 C.F.R. § 1.501(r)-6(c)(4). [15] 26 C.F.R. § 1.501(r)-6(a). [16] 26 C.F.R. § 1.501(r)-6(c)(8)(ii). [17] Cal. Health & Safety Code § 127425(g) [18] See FAP, Section VII.B. (p. 10) [19] 26 C.F.R. § 1.501(r)-6(c)(5). [20] 26 C.F.R. § 1.501(r)-6(c)(8)(ii). [21] 26 C.F.R. § 1.501(r)-6(c)(6)(ii) [22] 26 C.F.R. § 1.501(r)-6(c)(9). [23] Cal. Health & Safety Code § 127405(e)(3). [25] Cal. Health & Safety Code § 127425(d). [26] Cal. Health & Safety Code § 127430. [27] Cal. Health & Safety Code § 127425(e). [28] Cal. Health & Safety Code § 127425(f)(1). [29] Cal. Health & Safety Code § 127425(f)(2)(A).

Credit and Collection Policy
Attachment A

Policy Number: AP141	Date Created: No Date Set
Document Owner: Kelsie Davis (Board Clerk/Executive Assistant to CEO)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration)	
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KAWEAH HEALTH
NOTICE OF FINANCIAL RIGHTS

State and federal law requires hospitals to offer financial assistance to uninsured Patients and Patients with high medical debt who have low to moderate incomes. You may be eligible for free care or have your bill for medically necessary care reduced if you meet any of these criteria: (1) are receiving government benefits; (2) are uninsured; (3) have medical expenses in the past 12 months that exceed 10% of your Family income; (4) Your family's gross income (before deductions for taxes) must be less than 600% of the Federal Poverty Level for the calendar year. This information can be found at aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines; or (5) are in bankruptcy or have recently completed bankruptcy. To apply for financial assistance, you must request an application in one of the following ways:

- in person from the Acequia Lobby at the corner of Floral and Acequia, 305 West Acequia Avenue in Visalia, California 93291;
- over the phone by calling Patient Financial Services at (559) 470-0016 or (559) 624-4200 and selecting option 4; or
- by completing the online application at: KaweahHealth.org/charity

All patients have the right to apply for financial assistance under Kaweah Health's Financial Assistance policy which can be found by entering KaweahHealth/helppayingyourbill in your internet browser.

Hospital Bill Compliant Program

The Hospital Bill Complaint Program is a state program, which reviews hospital decisions about whether you qualify for help paying your hospital bill. If you believe you were wrongly denied financial assistance, you may file a complaint with the Hospital Bill Complaint Program. Go to HospitalBillComplaintProgram.hcai.ca.gov for more information and to file a complaint.

Help Paying Your bill

There are free consumer advocacy organizations that will help you understand the billing and payment process, as well as information regarding Covered California and Medi-Cal presumptive eligibility. You may call the Health Consumer Alliance at 888-804-3536 or go to healthconsumer.org for more information.

If you would like to access Kaweah Health's online estimation tool for shoppable services please visit us at KaweahHealth.org/shoppable

ATTENTION

If you need help in your language, please call 559-470-0016 or visit us at the Kaweah Health Medical Center, located at 305 West Acequia Avenue, in Visalia, California 93291 near the corner of Floral and Acequia. Go to the front desk in the Acequia Lobby and ask to speak with someone in Patient Financial Services. Our office is open Monday through Thursday from 8:00 AM – 5:00 PM and Friday from 8:00 AM – 12:00 PM.

Aids and services such as documents in braille, large print, audio, and other accessible

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electronic formats are available for people with disabilities. These services are free.

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Approvers: Board of Directors (Administration)	
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Free credit counseling services may be available from local nonprofit agencies.

ClearPoint Credit Counselling: 800-750-2227 /www.clearpoint.org

You may be eligible for FREE care if your income is below these amounts for your family size* (200% FPL)

Family Size*	Monthly	Annual
1	$2,~~608~~660	$31,~~300~~920
2	$3,~~525~~607	$4~~3,280~~2,~~300~~
3	$4,~~442~~553	$5~~3,300~~4,640
4	$5,~~358~~500	$6~~4,300~~6,000
5	$6,~~275~~447	$7~~5,300~~7,360
6	$7,~~192~~393	$8~~6,300~~8,720
7	$8,~~108~~340	$~~97,300~~100,080
8	$9,~~025~~287	$1~~08,300~~11,440

***For households larger than eight persons, please call for income limits.**

State and federal law requires debt collectors to treat you fairly and prohibits debt collectors from making false statements or threats of violence, using obscene or profane language, and making improper communications with third parties, including your employer. Except under unusual circumstances, debt collectors may not contact you before 8:00 am or after 9:00 pm. In general, a debt collector may not give information about your debt to another person, other than your attorney or spouse. A debt collector may contact another person to confirm your location or to enforce a judgment. For more information about debt collection activities, you may contact the Federal Trade Commission by telephone at 1-877-FTC-HELP (1-877- 382-4357) or online at www.ftc.gov.

You may be eligible for a DISCOUNT on your hospital bill if your income is below these amounts for your family size* (600% FPL)

Family Size*	Monthly	Annual
1	$7,~~825~~980	$9~~3,900~~5,760
2	$10,~~575~~820	$126,~~900~~840
3	$13,~~325~~660	$1~~59,900~~63,920
4	$16,~~075~~500	$19~~2,900~~8,000
5	$1~~89~~,~~825~~340	$2~~25,900~~32,080
6	$21,~~575~~180	$2~~58,900~~66,160
7	$2~~45,,325~~020	$~~291,900~~300,240
8	$27,~~075~~860	$3~~23~~4,~~903~~20

DM 2227

Policy Number: DM 2227	Date Created: 08/06/2019
Document Owner: Maribel Aguilar (Assistant Director of Environment of Care/Safety Officer)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration), Board of Directors (EOC/Emergency Preparedness), Kevin Morrison (Director of Facilities)	
Request to Operate Under CMS 1135 Waiver	

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

Policy:

Kaweah Delta Health Care District (KDHCD) herein after referred to as Kaweah Health (KH) is committed to providing all of our stakeholders with the safest environment possible. To help meet this commitment, KH has established a policy and procedure to ensure that sufficient health care items and services are available to meet the needs of individuals enrolled in Social Security Act programs in an emergency area during specific time periods and that providers who provide such services in good faith can be reimbursed and exempted from sanctions (absent any determination of fraud or abuse).

During an emergency, it may become necessary to waive certain CMS regulations. Once The U.S. President declares a disaster or emergency under the Stafford Act, the National Emergencies Act and The U.S. Department of Health and Human Services declares a public health emergency, CMS allows facilities to request a waiver of individual CMS Requirements of Participation. These waivers are allowed under Part 1135 of the Social Security Act and are referred to as an 1135 Waiver.

Procedure:

The Incident Commander will contact Compliance and instruct them to request a 1135 Waiver.

CMS is requiring that all 1135 Waiver requests be electronically submitted directly to CMS, and follow the process identified below:

1. The Compliance officer or designee will be responsible for requesting the 1135 Waiver and will provide to the Centers for Medicare and Medicaid Services (CMS) Regional Office (RO), at a minimum the following information, using this email address: rosfoso@cms.hhs.gov and copy the Bakersfield District Office, Attention: Camilla Guerra: camilla.guerra@cdph.ca.gov.
    - A letter delineating all specific, relevant federal laws or regulations for which a waiver is being sought.
    - Clear reasons and justifications for the request.

- *Example: Facility is sole community provider without reasonable transfer options at this point during the specified emergent event (e.g. flooding, tornado, fires, or flu outbreak). Facility needs a waiver to exceed its bed limit by X number of beds for Y days/weeks (be specific).*

- The State must have activated an emergency preparedness plan or pandemic preparedness plan in the area where the hospital is located, and
- The facility's Emergency Operations Plan (EOP) must have been activated for the specific waiver being requested.
- The type of relief the facility is seeking or the regulatory requirement(s)/reference(s) the facility is seeking to have waived

  Examples include:

  a. Requests by hospitals to provide screening/triage of patients at a location offsite from the hospital's campus;

  b. Hospitals housing patients in units not otherwise appropriate under the Medicare Conditions of Participation or for duration that exceeds regulatory requirements;

  c. Hospitals or nursing homes requesting increases in their certified bed capacity.

The 1135 waiver authority applies only to Federal requirements and does not apply to State requirements for licensure or conditions of participation.

"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 1033

Policy Number: EOC 1033	**Date Created: 11/04/2025**
Document Owner: Maribel Aguilar (Assistant Director of Environment of Care/Safety Officer)	**Date Approved: Not Approved Yet**
Approvers: Board of Directors (Administration), Board of Directors (EOC/Emergency Preparedness), Kelsie Davis (Board Clerk/Executive Assistant to CEO), Maribel Aguilar (Assistant Director of Environment of Care/Safety Officer)	

Water Management Program

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

Purpose:

To avoid risk of waterborne pathogens, specifically Legionella, causing patient/employee harm.

Policy:

A. The Water Management Program is managed and executed by representatives from Administration, Facilities, Environmental Services, Laboratory, and Infection Prevention. The ~~plan~~ program is reviewed annually and when any of the following events occur:
   1. New construction
   2. Changes in treatment products (e.g. disinfectants)
   3. Changes in water usage (e.g. restrictions due to drought)
   4. Changes in municipal water supply
   5. One or more cases of Legionella are identified
   6. Changes occur in applicable laws, regulations, standards, or guidelines

Procedure:

I. Maintenance

1. Routine Testing
   a. Water sample testing performed at least weekly on cooling towers for total dissolved solids, Biocide concentration, and scale.
   b. Logs kept are kept in Facilities.
   c. ~~Routine~~ A routine water testing program for the potable water system is implemented and performed at intervals as determined by a third-party consultant specialized in water management. If any positive samples occur, Director of Facilities, Safety Officer and Infection Prevention Manager are all notified and work with associated areas to limit access to potential sources. Applicable steps are taken to resolve the finding and source is retested and

put back into service upon negative test results. Steps are outlined further in Appendix A.

2. EVS routinely runs sinks and showers in patient rooms during daily cleaning and during the discharge cleaning process.
3. Water Flow System Diagrams with descriptions

II. Risks

A. Legionellosis is a waterborne disease. Man-made water supplies that aerosolize water, such as potable water systems (showers), air conditioning cooling towers, whirlpool spas, and decorative fountains, are the common sources for transmission. Conditions conducive to Legionella growth include warm water temperatures (20-45^{0}C), stagnation, scale and sediment, and low biocide levels.

B. There are more than 34 known species and more than 50 serogroups of Legionella. Many of the species have not been implicated in disease, but may have potential to. The Legionella pneumophilia serogroup 1 is most frequently implicated in disease and most frequently found in the environment.

C. The incubation period for Legionnaires Disease is 2 to ~~10~~ 14 days.
   1. Clinical description of Legionellosis is associated with two clinically and epidemiologically distinct illnesses:
      a. Legionnaires' disease, which is characterized by fever, myalgia, cough, and clinical or radiographic pneumonia; and
      b. Pontiac Fever, a milder illness without pneumonia

D. Legionella pneumophilia is ubiquitous in aquatic systems. Susceptible individuals, specifically those who are immunocompromised, have a greater risk of contracting Legionellosis. Individuals seeking medical care typically are in a state of weakened immunity. Therefore, patients and visitors at any Kaweah Health facility have a potentially compromised immune system and must be safeguarded against risk of infection cause by Legionella pneumophilia.

E. Legionella Risk Areas
   1. See Water Flow System Risk Area Diagrams

III. Legionella Outbreak Response:

A. Clinical Criteria for Reporting
   1. No clinical criteria alone are sufficient to generate a report to public health authorities.

B. Laboratory Criteria for Reporting

Legionnaire's Disease

1. Isolation of Legionella organism from lower respiratory secretions, lung tissue, or pleural fluid

2. Detection of any Legionella species from lower respiratory secretions, lung tissue, or pleural fluid by a validated nucleic acid amplification test
3. Detection of Legionella pneumophilia serogroup 1 antigen in urine using validated reagents
4. Fourfold or greater rise in antibody titer to specific species or serogroups of Legionella other than L. pneumophilia serogroup 1 (e.g., L. micdadei, L. pneumophilia serogroup 6)
5. Fourfold or greater rise in antibody titer to multiple species of Legionella using pooled antigens
6. Detection of specific Legionella antigen or staining of the organism in lower respiratory secretions, lung tissue, or pleural fluid by direct fluorescent antibody (DFA) staining, immunohistochemistry (IHC), or other similar method, using validated reagents

Pontiac Fever

1. Detection of Legionella pneumophilia serogroup 1 antigen in urine using validated reagents
2. Fourfold or greater rise in specific serum antibody titer to Legionella pneumophilia serogroup 1 using validated reagents
3. Fourfold or greater rise in antibody titer to specific species or serogroups of Legionella other than L. pneumophila serogroup 1 (e.g., L. micdadei, L. pneumophila serogroup 6)
4. Fourfold or greater rise in antibody titer to multiple species of Legionella using pooled antigens

Extrapulmonary Legionellosis

1. Isolation of Legionella organism from any extrapulmonary site
2. Detection of any Legionella species from any extrapulmonary site by a validated nucleic acid amplification test
3. Detection of specific Legionella antigen or staining of the organism from any extrapulmonary site by direct fluorescent antibody (DFA) staining, immunohistochemistry (IHC), or other similar method, using validated reagents

C. Epidemiologic Linkage Criteria for Reporting
   1. None required.

D. Vital Records Criteria for Reporting
   1. Report any person whose death certificate lists Legionnaire's disease, Legionellosis, Extrapulmonary Legionellosis, or Pontiac Fever anywhere on the death certificate.

E. Other Criteria Reporting
   1. Report any person whose healthcare/medical record contains a diagnosis Legionnaire's disease, Legionellosis, Extrapulmonary Legionellosis, or Pontiac Fever.

F. Disease-specific data elements to be included in the initial report
   1. Symptoms consistent with Legionnaire's disease, Pontiac fever, or extrapulmonary disease.

2. Exposure within the two weeks (14-days) prior to illness onset, the following data elements should be included in the initial report when known:
   (a) Travel or overnight stay somewhere other than usual residence – if yes, location and dates of travel
   (b) Visiting or working in any healthcare facility – if yes, location and dates
   (c) Any water exposures (e.g. hot tubs, respiratory therapy equipment, or other sources of aerosolized water) – if yes, location and dates

G. Upon identification of ≥1 case of presumptive healthcare-associated Legionnaires' disease at any time or ≥2 cases of possible healthcare-associated Legionnaires' disease within 12 months of each other:~~Upon identification of a potential Legionnaire's, Pontiac Fever, Extrapulmonary Legionellosis case~~:
   1. RN Field Infection Preventionist AND/OR RN IP Data Coordinator OR IP Data Analyst/CME Coordinator contacts:
      (a) Safety Officer
      (b) Microbiology AND/OR Serology Section Chief(s)
      (c) Facilities Manager AND/OR Director
      (d) Tulare County Health and Human Services Agency
      ~~(d)~~(e) Chief Nursing Officer (CNO)
   ~~2. Safety Officer contacts Chief Nursing Officer (CNO) to alert the CNO of a probable Legionnaire's case~~
   ~~3.~~ Microbiology and/or Serology Section Chief(s) will provide Infection Prevention with necessary laboratory information as it relates to the outbreak
   2.
   ~~4.~~3. Notify Facilities to implement Legionella Control Measures (see Legionella
   Control Measures Diagrams).Facilities Manager and/or Director will contact contracted vendor to collect environmental water samples for response testing related to outbreak.
   4. Infection Prevention will contact and submit information related to the Legionella Outbreak to Tulare County Health and Human Services Agency - Public Health Branch – Communicable Diseases Program
   5. Infection prevention will initiate prospective surveillance for legionella cases for 3 months after identification of most recent case or as recommended by Public Health if recommendations are received.

III. Mitigation

~~A. Continue to monitor for new Legionellosis cases.~~
~~B.~~A. ~~Consider methods to avoid future incidents.~~See appendix A

References:

CDC. *Developing a Water Management Program to Reduce Legionella Growth & Spread in Buildings – A Practical Guide to Implementing Industry Standards*. June 24, 2021 Version 1.1

Heyman, David, MD. Control of Communicable Diseases Manual – Legionellosis. American Public Health Association Press, 20th Edition. pg. 335.

State of California – Health and Human Services Agency. Legionellosis Case Report. CDPH 8588 (revised 7/14/)

"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."

Water Management
Response Testing Procedure

This procedure is to be used in conjunction with the Water Management Program for response testing associated with any positive samples resulting from validation testing, or positive patient results indicating presence of legionella on tests order by the provider including but not limited to urinary antigen test, etc.

This procedure can and will be modified as needed based on the environmental conditions and testing method of the positive sample, or samples taken. All actions taken as part of this response procedure will be documented by the Facilities Maintenance department and reviewed with the Infection Prevention department prior to response testing.

The sample method will be the standard ISO method performed during the validation testing, or as recommended by the third-party water management consultant, when applicable.

I General Response Testing Guidelines

Patient Rooms:
If a water sample should test positive for Legionella during routine validation testing restricted access and use of the plumbing fixtures (sink faucets, shower heads, etc.) in the room will be implemented, including possible closing of the room to patient occupancy and relocating patient(s) to an appropriate space until a clean fixture has been installed and post mitigation activities result in water samples returning without the presence of legionella.

Additional testing of the following areas will also be performed, unless tested during the same validation test.

- Sample from all remaining fixtures in the room,
- Sample from fixtures in the immediately adjacent rooms.
- Sample from fixtures at distal points on the unit/floor.
- Sample from the hot water system at the main return loop at the boiler.

**Should testing be performed as a result of a positive presumptive patient case then fixtures will be swabbed as part of the response testing.*

Ice Machines:
If an ice machine should test positive for legionella during routine validation testing the Facilities department will restrict access and use of the ice machine, and notification to applicable departments as outlined in the Water Management Plan will be made. The fixture will be removed and replaced with a new or sanitized fixture. Unit will be retested and cleared before being put back into service.

Additional testing of the following areas will also be performed, unless tested during the same validation test.

- Sample from all remaining ice machines on the unit,
- Sample from fixtures in the immediately adjacent rooms.
- Sample from fixtures at distal points on the unit/floor.

II Mandatory Facility Actions

All potential mitigation steps will be reviewed and aligned with guidance provided by CDC and ASHRAE and in consultation with a water management consultant. The following are considered thresholds for when specific mitigation measures should be considered:

- In the event of 10 possible healthcare-associated cases of legionella in a 12 month period consideration for low level chlorination will be made in consultation with water management consultant.
- In the event of 5 presumptive healthcare-associated legionella cases in 6 month period consideration for high level chlorination will be made in consultation with water management consultant.
- Point of use (POU) microbial filters in high-risk areas may be utilized when high-level disinfectant is determined to be necessary in consultation with water management consultant. Filters would be installed prior to disinfection process.
- Low level and High level chlorination efforts may also be taken in response to environmental validation test results as determined by third-party water management consultant.

**Note: Actions noted above are determined based on the CDC recommendation to "consider implementing immediate control measures in facilities with populations at increased risk if Legionella growth doesn't appear well controlled" as these thresholds would demonstrate a potential environment where legionella growth is not well controlled.*

EOC 3000

Kaweah Health

Subcategories of Department Manuals not selected.

Policy Number: EOC 3000	**Date Created: 06/01/2009**
Document Owner: Maribel Aguilar (Assistant Director of Environment of Care/Safety Officer)	**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~~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.

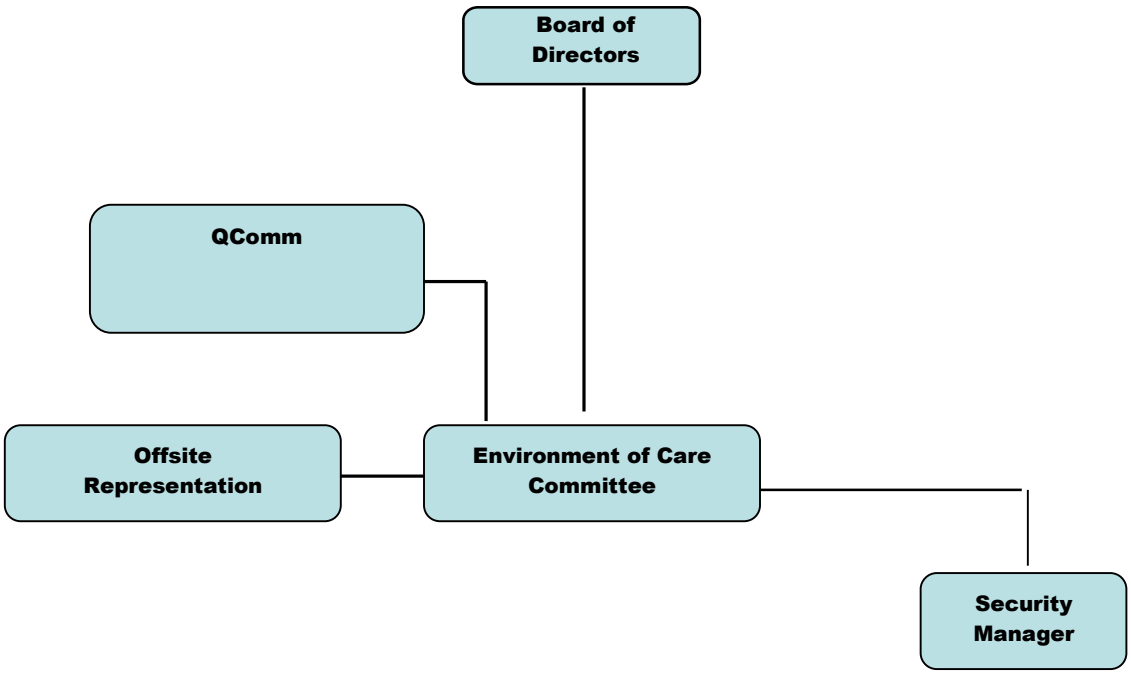
III. AUTHORITY

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). Education should cover access control procedures, including opening protocols, end-of-shift securing procedures, the location of panic alarms (if installed), and any special security measures.
-
- 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.~~
- If employees observe any suspicious activity or individuals in or around the hospital, immediately contact Security and notify your manager.
- When using access-controlled doors, do not allow unauthorized individuals to enter. Always ensure the door closes and secures properly.
- Challenge individuals within the facility who are not displaying a valid employee ID, contractor badge, or visitor pass. If uncomfortable doing so or need assistance, contact Security immediately.
- ~~o~~
- Participating in Code Pink/Purple alarm response and 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, ~~Crisi~~Crisis Stabilization Unit 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~~. Video Surveillance System (VSS). VSS ~~Closed circuit TV~~ is in place to monitor the security sensitive areas, public entrances, lobbies and corridors, and select parking lots.

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. The Security Services Department conducts monthly tests of panic alarms and maintains a list of their locations.

~~6. 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.~~6. 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.~~7. Education – for Newly-hired Staff and Ongoing (HR.01.~~05~~03.~~03~~ 01 EP 1; ~~HR.01.04.01 EP 1, 3~~NPG 12.05.01, EP1; NPG12.05.01,EP1;). 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.

NPG.11.01.01, EP 1~~EC.02.01.01 EP 8~~

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

Sensitive hospital areas are safeguarded through a layered security approach, tailored to the location and function of each unit. The following measures are implemented to ensure comprehensive protection:

- Video Surveillance Systems (VSS): Continuous recording of restricted zones to deter unauthorized access and provide investigative support.
- Controlled Access: Badge and key entry limited to authorized personnel, with electronic activity logs maintained for badge system for accountability.
- Security Fencing: Physical barriers installed around exterior sensitive sites to prevent unauthorized entry.
- Panic Alarms: Immediate alert systems in high-risk areas to enable rapid response by security staff and law enforcement.
- Specialized Alarm Systems: Advanced detection technologies in special areas.

The Security Services Department maintains a detailed inventory of all security measures for sensitive areas, documented in the *Sensitive Area Protection Inventory*.

~~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.

NPG.11.01.01, EP 2~~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.

NPG.02.04.01, EP 3~~02.01.01 EP 17~~
The hospital conducts ~~and~~an 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
NPSG.11.01.01 EP 3 ,
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.

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

Resolution 2277–

Board Resolution No. 2277

Resolution of the Board of Directors Adopting SB 707 Governance, Transparency, and Meeting Access Policies

WHEREAS, the Kaweah Delta Health Care District is a California health care district subject to the Ralph M. Brown Act and California Health & Safety Code §§ 32121–32121.9 (SB 707); and

WHEREAS, the Board of Directors is responsible for ensuring transparent governance, public accountability, and appropriate oversight of executive employment and compensation; and

WHEREAS, the Board desires to formalize policies governing executive employment, severance limitations, meeting transparency, remote public access, agenda posting, and language access;

NOW, THEREFORE, BE IT RESOLVED that the Board of Directors hereby adopts the SB 707 Governance & Transparency Compliance Policies, including all associated Administrative Standards, effective immediately;

BE IT FURTHER RESOLVED that District administration is directed to implement these policies, ensure staff training, and maintain ongoing compliance with applicable state law;

BE IT FURTHER RESOLVED that the Board shall periodically review these policies and make updates as necessary to reflect changes in law or best practices.

PASSED AND ADOPTED this 28th day of January, 2026.

Dave Francis
Board of Directors/ President

Dean Levitan, M.D.
Board Secretary/Treasurer

Resolution 2278–

RESOLUTION NO. 2278

A RESOLUTION OF THE BOARD OF DIRECTORS OF THE KAWEAH DELTA HEALTH CARE DISTRICT

IN SUPPORT OF AMERICAN COLLEGE OF SURGEONS LEVEL III TRAUMA CENTER VERIFICATION

WHEREAS, the Kaweah Delta Health Care District ("District") is committed to providing high-quality, timely, and comprehensive trauma care to the communities it serves; and

WHEREAS, the American College of Surgeons (ACS) Committee on Trauma establishes nationally recognized standards for trauma center verification to ensure optimal outcomes for trauma patients; and

WHEREAS, verification as a Level III Trauma Center by the American College of Surgeons demonstrates compliance with rigorous clinical, operational, and performance improvement standards; and

WHEREAS, the multidisciplinary Trauma Performance Improvement and Patient Safety (PIPS) Program plays a critical role in evaluating trauma care across disciplines, identifying opportunities for improvement, and implementing corrective actions to enhance patient outcomes; and

WHEREAS, the Board of Directors recognizes the importance of sustaining the organizational commitment, resources, and oversight necessary to maintain trauma verification standards throughout the verification cycle;

NOW, THEREFORE, BE IT RESOLVED that the Board of Directors of the Kaweah Delta Health Care District hereby:

1. Supports and approves verification by the American College of Surgeons as a Level III Trauma Center.
2. Affirms the District's commitment to maintaining the high standards required to provide optimal care for all trauma patients.
3. Authorizes and supports the multidisciplinary Trauma Performance Improvement and Patient Safety Program with authority to evaluate care, identify improvement opportunities, and implement corrective actions.
4. Commits to ongoing adherence to all standards required for Level III Trauma Center verification throughout the verification cycle.

5. Ensures necessary personnel, facilities, equipment, and resources are available to maintain compliance.

PASSED AND ADOPTED this 28th day of January, 2026, by the Board of Directors of the Kaweah Delta Health Care District.

Dave Francis,
Board President

Dean Levitan, M.D.
Secretary/Treasurer

Operational Compliance Committee Charter

Operational Compliance Committee Charter

Purpose: The Operational Compliance Committee ("OCC") is a multidisciplinary team consisting of organizational leaders established for the purpose of achieving organizational compliance and facilitating the operations of the Kaweah Compliance Program.

Duties and Responsibilities:

- Participate in the development and review of Kaweah policies, procedures and processes created to govern compliance.
- Support and advise the CCRO and Compliance Department concerning compliance program activities, including but not limited to gathering compliance data generated through internal monitoring and audits, conducting appropriate and timely risk assessments, developing and completing annual compliance work plans.
- Provide input and support needed to analyze and make recommendations regarding the legal and regulatory environment affecting Kaweah.
- Provide input on and help support compliance-related education for all Workforce Members.
- Provide input and recommendations on compliance-related auditing, monitoring, reporting, tracking, and trending.
- Assist in implementing action plans when deficiencies are identified.
- Serve as a "clearinghouse" and avenue for the sharing and distribution of information regarding Compliance.
- Support the evaluation and management of potential conflicts of interest that may affect Kaweah.
- Facilitate and coordinate Compliance activities and programs among and across all Kaweah departments, units, and locations.
- Promote a "culture of Compliance" across the organization.

Subcommittees, Workgroups, and Task Forces:

Certain responsibilities of the OCC, as appropriate, may be accomplished through the development of subcommittees, workgroups, and task forces designed to focus on specific compliance-related functions and goals.

In furtherance of this, the OCC may identify and select members throughout Kaweah that are best suited in relation to area oversight, job responsibilities and subject matter expertise to participate in the workgroups in order to accomplish the goals established by the OCC.

Some subcommittee, workgroup, and task force members and participants will be considered members of the OCC, as set out herein below. However, subcommittee, workgroup, task force members, and other Kaweah employees may be required to

attend, participate, and/or present information and data or respond to queries on assigned compliance-related projects as invited guests of the OCC; and such attendees shall not be considered members of the OCC.

Subcommittees, Workgroups, and Task Forces shall report their activities to the OCC, including tracking and trending data as assigned by and in a manner determined by the Chief Compliance and Risk Management Officer and Compliance Department.

Standing Subcommittees of the OCC shall include the following:

- Conflicts of Interest Subcommittee
- Policy and Procedure Subcommittee
- Privacy and Information Security Subcommittee

Standing Workgroups of the OCC shall include the following (any of which may be held in combination or separately):

- Care Management
- Clinical Documentation Improvement
- HIM
- Patient Access
- Patient Accounting and Revenue Integrity

Committees Reporting Information:

Kaweah has certain established committees that perform compliance-related functions in relation to their areas of expertise and oversight. Information sharing with the Operational Compliance Committee will help to ensure risks in these specialty areas is incorporated into the organization's overall compliance functions and shared with the Audit and Compliance Committee and Board, as necessary. Committees that should regularly report their compliance-related activities to the Operations Compliance Committee, include the following:

- HIM Committee
- 340B Committee

Structure and Composition:

The OCC shall be a standing committee comprised of members of Kaweah's leadership team and other individuals who (1) have significant responsibility for the administration of various aspects of Kaweah's Compliance Program, (2) manage or oversee compliance-related controls due to their assigned roles and responsibilities at Kaweah, or (3) are considered subject matter experts in areas with common compliance-related risks.

Chair: Chief Compliance and Risk Management Officer

Membership:

- Director of Corporate Compliance

- Compliance Manager
- Compliance Department Staff
- Director and Managers of Revenue Cycle and Patient Accounting
- Directors ISS (Technical and Applications)
- Director Finance
- Director Employee Relations
- Director Quality and Patient Safety
- Director HIM
- Director Care Management
- Director Nursing
- Director 340B Program

Chair Rights and Responsibilities:

- Develop a written charter.
- Establish an agenda for each meeting.
- Track and provide feedback on active participation of committee members.
- Facilitate committee discussions.
- Assist in identifying and triaging the priority of matters of the committee.
- Reporting OCC activities, subcommittee activities, and workgroup/task force activities to the Audit and Compliance Committee.

Agenda, Meeting Minutes, and Reports:

Meeting agendas will be prepared and distributed in advance of each meeting.

Meeting minutes will be prepared and distributed to the committee members for review and approval following each meeting.

Meeting minutes and reports will be submitted to the Audit and Compliance Committee to facilitate their oversight of compliance activities throughout Kaweah.

Meeting Cadence:

The OCC shall meet from time to time as needed or appropriate, but no less frequently than quarterly. The CCRO shall determine the frequency, date and time of meetings and give appropriate notice of such meetings to all members.

Policy and Procedure Committee Charter

Policy and Procedure Committee Charter

Purpose: The Policy and Procedure Committee is established for the purpose of providing strategic advice on organizational policies and related policy resources. The Committee will support the development and enhancement of the common platform for managing organization policies designed to promote consistency and accountability.

Duties and Responsibilities:

- Serve as core superusers for the policy and procedure system.
- Evaluating and assigning Roles.
- Evaluating and establishing and/or removing Groups and Group membership.
- Evaluating processes related to the implementation of policies and procedures.
- Tracking and reporting policy and procedure review delinquencies to the Operational Compliance Committee and Executive Team.
- Identifying and facilitating training and education on the policy and procedure system.
- Coordinating the review and retirement of duplicative policies.
- Obtaining feedback from organizational stakeholders on process improvements for policy and procedure management.
- Providing feedback on policy and procedure system processes across the organization.
- Providing guidance as subject-matter experts (SMEs) in their respective areas on opportunities to improve policy operations across the organization.
- Reviewing and revise organization policy on policies as needed.
- Reviewing Policy and Procedure Committee Charter at least annually and recommend changes to the Compliance Committee as needed.

Structure & Composition:

Chair: Director of Corporate Compliance: Jill Berry

Membership:

- Compliance Support: Lisa Wass, Amy Valero
- Quality and Accreditation Lead: Pending
- Nursing Lead: Kari Knuedsen (Veritta Henry & Chris McRae, Interim)
- Risk Management Lead: Laree Irving
- Maribel: Maribel Aguilar
- HR Lead: Raleen Larez
- Clinics: Ivan Jara
- Administrative Procedures: Kelsie Davis
- IT – Policy System Administrator and Project Support: Pending
- P&P Project Manager: Pending

Agenda, Meeting Minutes, and Reports: A meeting agenda will be prepared and distributed in advance of each meeting. The Committee Chair may invite relevant SMEs to attend meetings when deemed appropriate or necessary. Meeting minutes shall be prepared and distributed to the Committee members and to the Compliance Committee following each meeting.

Reporting to Compliance Committee: The Policy and Procedure Committee shall be a subcommittee of the Compliance Committee, and the minutes of each meeting shall be submitted to the Compliance Committee. The Compliance Committee will review and recommend actions related to policies and procedures as needed.

Meetings: The Committee shall meet as needed but no less than quarterly. Meeting times and dates will be communicated by the Chair in advance. A majority of the Committee constitutes a quorum, and any action taken during a meeting with a quorum present shall be an action of the Committee. The Chair will determine whether meetings will be held in-person or virtually.

Resolution 2276-

RESOLUTION NUMBER 2276

RESOLUTION OF KAWEAH DELTA HEALTH CARE DISTRICT

400 W. MINERAL KING, VISALIA CA, 93291 - (559) 624-2000

AUTHORIZING INVESTMENT OF MONIES IN THE LOCAL AGENCY INVESTMENT FUND

WHEREAS, The Local Agency Investment Fund is established in the State Treasury under Government Code section 16429.1 et. seq. for the deposit of money of a local agency for purposes of investment by the State Treasurer; and

WHEREAS, the Board of Directors hereby finds that the deposit and withdrawal of money in the Local Agency Investment Fund in accordance with Government Code section 16429.1 et. seq. for the purpose of investment as provided therein is in the best interests of the District.

NOW THEREFORE, BE IT RESOLVED, that the Board of Directors hereby authorizes the deposit and withdrawal of Kaweah Delta Health Care District monies in the Local Agency Investment Fund in the State Treasury in accordance with Government Code section 16429.1 et.seq. for the purpose of investment as provided therein.

BE IT FURTHER RESOLVED, as follows:
Section 1. The following District officers holding the title(s) specified herein below **or their successors in office** are each hereby authorized to order the deposit or withdrawal of monies in the Local Agency Investment Fund and may execute and deliver any and all documents necessary or advisable in order to effectuate the purposes of this resolution and the transactions contemplated hereby:

Marc Mertz Chief Executive Officer	Malinda Tupper Chief Financial Officer	Jennifer Stockton Director of Finance
_____ Signature	_____ Signature	_____ Signature

Section 2. This resolution shall remain in full force and effect until rescinded by the Board of Directors by resolution and a copy of the resolution rescinding this resolution is filed with the State Treasurer's Office.

PASSED AND ADOPTED, by the Board of Directors of Kaweah Delta Health Care District State of California on this 28th day of January, 2026.

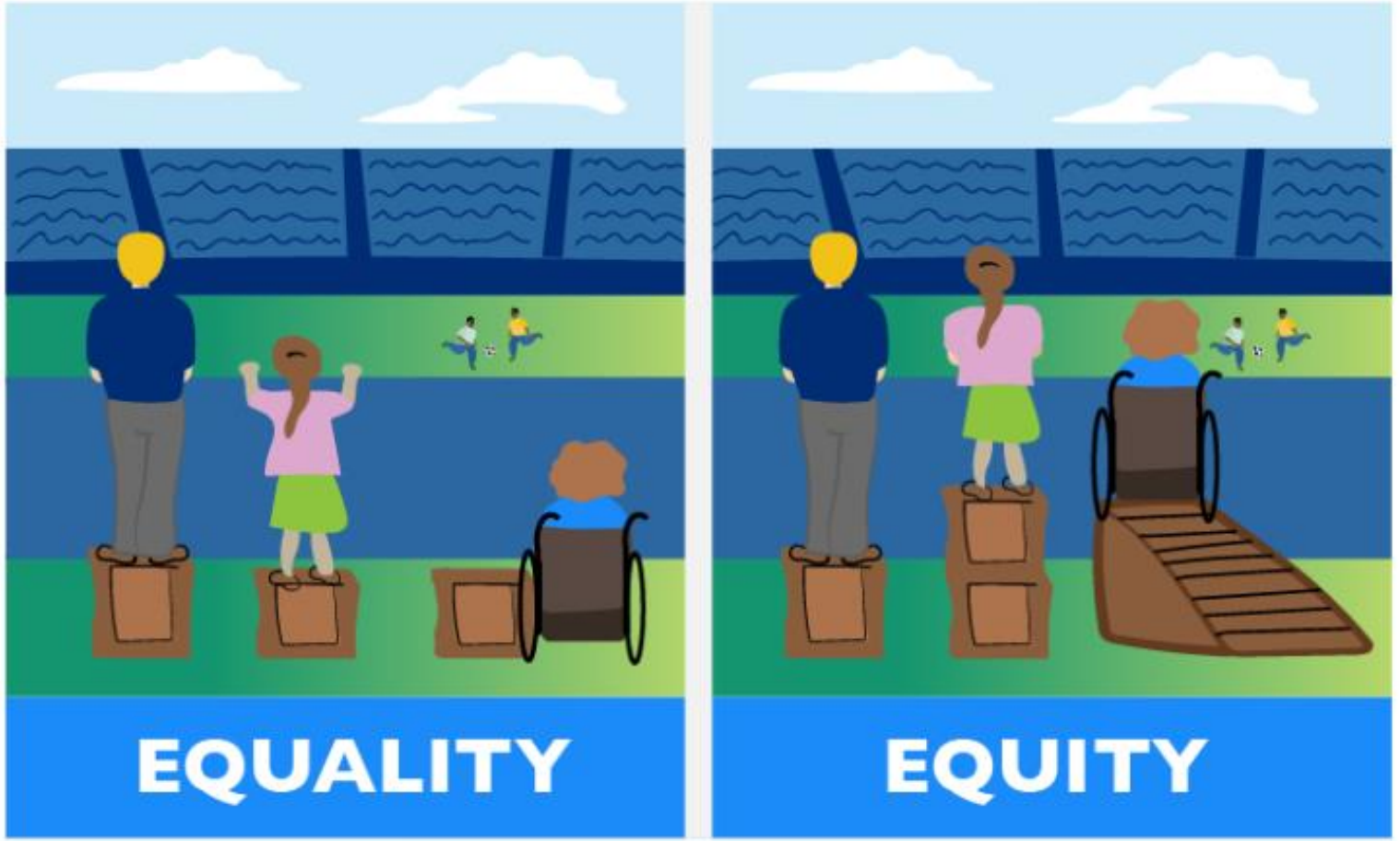
EQUITY, INCLUSION & COMMUNITY HEALTH REPORT-

Health Equity at Kaweah Health

January 28, 2026

What is Health Equity?

Health equity is the **state in which everyone has a fair and just opportunity to attain** their highest level of health



https://www.cdc.gov/healthequity/whatis/index.html

https://www.hopkinsacg.org/health-equity-equality-and-disparities/

Health Disparities are preventable differences in health outcomes that are experienced by distinct populations.

Identifying and addressing the root causes of disparities is the work of **Health Equity**.

https://www.cdc.gov/healthequity/whatis/index.html

Kaweah Health
MORE THAN MEDICINE. LIFE.

Regulatory Updates

CMS

- Health Equity →
- CMS Framework for Healthy Communities

JOINT COMMISSION

- National Patient Safety Goal (NPGs) →
- National Performance Goals (NPGs)

HCAI

- AB 1204 Hospital Equity Report Program
- AB 3161 Patient Safety & Antidiscrimination

https://www.cms.gov/files/document/cms-framework-health-equity-2022.pdf

CMS Updates

- **CMS Health Equity 2022-2023**
  - 5 priorities
  - Reporting completed for CY 2024 on May 15, 2025
  - Hospital Inpatient Quality Reporting (IQR) FY2026 IPPS/CY 2024 Reporting Year Changes which no longer affect payment determination
    - Removal of the following measures:
      - Hospital Commitment to Health Equity (HCHE)
      - Screening for Social Drivers of Health
      - Screen Positive Rate for Social Drivers of Health

CMS Framework for Healthy Communities

https://www.cms.gov/files/document/cms-framework-health-equity-2022.pdf

Joint Commission Updates

National Patient Safety Goals	National Performance Goals
Identify an individual to lead activities to improve health care equity	Who owns Health Equity?
Assess the **patient's health-related social needs**	
Analyze quality and safety data to identify disparities	What data was reviewed (REaL, etc.)? How do you identify disparities in your population?
Develop an action plan to improve health care equity	What inequity are you actively addressing?
Take action when the organization does not meet the goals in its action plan	
Inform key stakeholders about progress to improve health care equity	How does leadership track progress?

HCAI Updates

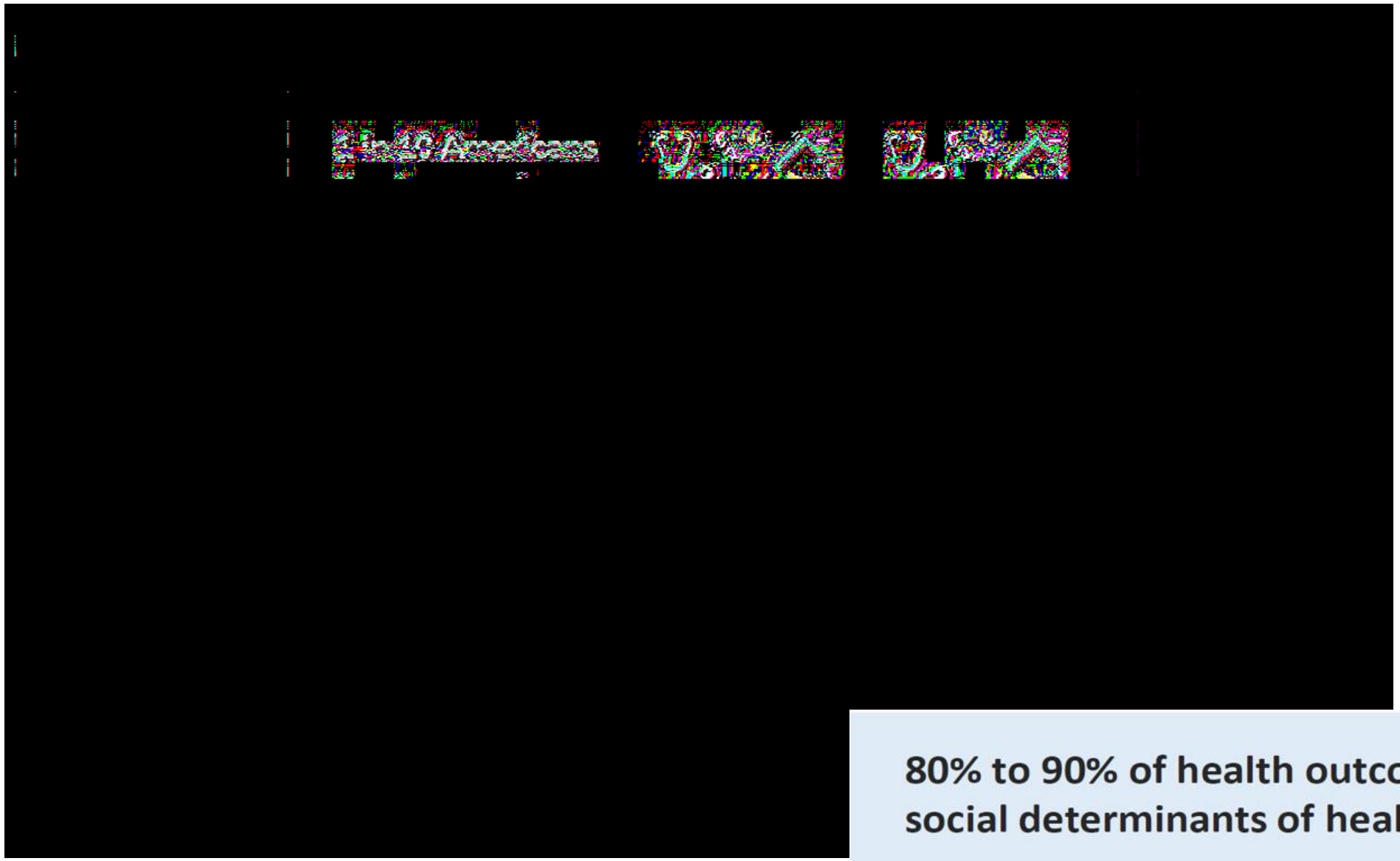
- **HCAI AB 1204 Hospital Equity Report Program**
  - Department of Health Care Access and Information (HCAI) to develop and administer a hospital equity report program to collect and post hospital equity reports
  - Acute Hospitals, Acute Psychiatric Hospitals and Children's Hospitals

- These annual reports are required to include measures on **patient access, quality, and outcomes by race, ethnicity, language, disability status, sexual orientation, gender identity, and payor** as recommended by the newly created Hospital Equity Measures Advisory Committee
  - Reporting deadline: September 30th, 2025 – Kaweah Health will pay the penalty

Updates

- **HCA AB 3161 Patient Safety and Antidiscrimination**
  - Adds to current requirements to include a process to identify and address racism and discrimination in our Patient Safety Plan
  - Requires analysis and stratification of patient safety events by sociodemographic factors specified by the State for reportable events
  - Identify disparities and require that the facility use prescribed stratification categories as specified by the State
  - Required demographic info: REaL, SOGI, disability status, payor, sex
  - Goes into effect 1/1/2026: Safety plan is submitted bi-annually
    - $5,000 fine for failure to adopt, update or submit patient safety plans

The Impact of Social Determinants of Health



80% to 90% of health outcome contributors are social determinants of health.

—National Academy of Medicine

Total Population

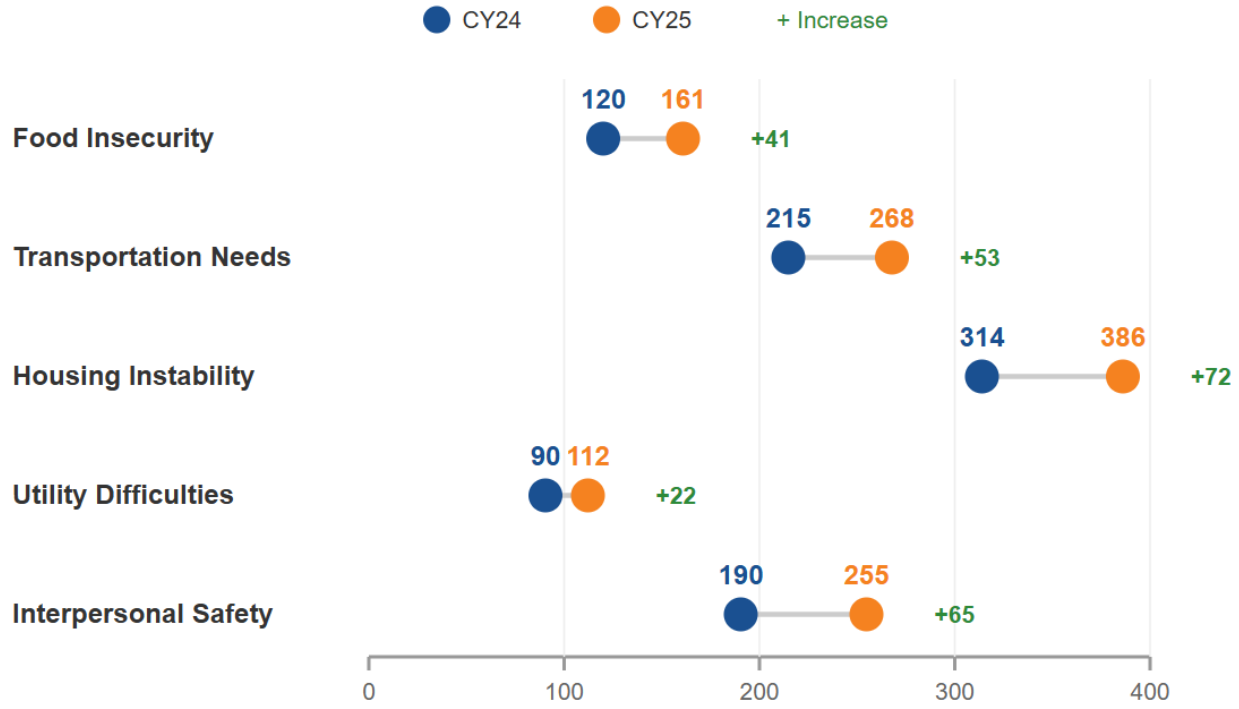
2024	2025
12,393	14,763

↑ 19.1% increase

Screening Rate

2024	2025
29%	31%
n: 3537	n: 4525

SDOH Categories: CY24 vs CY25



Positive Screening Rate

2024	2025
16%	17%

Unique Patients with 1 or More + SDOH

2024	2025
565	747

↑ 32.2% increase

Addressing Health Equity at Kaweah

CalAIM-Tulare County

- Enhanced Care Management – Familiar Faces (high utilizing), chronic co-morbid conditions, SMI/SUD
- Community Supports-Homeless Individuals

HRSA Care Coordination Grant-pregnant individuals in Lindsay

Equity Practice Transformation (EPT) Program-pregnant individuals

MOVES Grant-

- Behavioral Health-Children & Youth in Lindsay
- Community Outreach Health Promotion & Social Needs Screening-Tulare County

ORTHOPEDIC QUALITY REPORT-

Orthopedic Service Line

Quality Council Report

January 2026

Kevin Bartel, Director of Surgical Service Lines

Surgical Site Infection July 1, 2024 – June 30, 2025 (12 months)

Type of SSI	Total # of Procedures	Actual # of infections	Predicted # of Infections	Kaweah Health Standardized Infection Ratio	National benchmark* (lower is better)
KPRO (TKA)	167	0	1.277	0	10th percentile
HPRO (THA)	182	0	2.748	0	10th percentile
FUSN (Spinal fusion)	349	3	5.885	0.51	25th percentile
FX (hip fracture)	402	4	4.168	0.96	N/A
Total	1,100	7	14.078	0.498	

*CDC NHSN 2022 quartile data

Goal: measure the standardized infection ration (SIR) of these orthopedic procedure types for patients who experienced a surgical site infection within 90 days after surgery

Review/Analysis

- SIR for all four procedure types were below the predicted number of infections
- Total number of hip fracture cases increased 81% from prior year
- All three Spinal Fusion cases were elective with surgeon commonality, involving patients with known comorbidities that increased risk of poor tissue healing and reduced post-operative mobilization ability
- All four hip fracture cases were emergent with surgeon commonality

Surgical Site Infection July 1, 2024 – June 30, 2025 (12 months)

CURRENT IMPROVEMENT ACTIVITIES	EXPECTED COMPLETION DATE	BARRIERS/UPDATES
Retrospective SSI review- Review of identified SSIs in a timely manner by Director and Orthopedic Nurse Practitioners that support the service to identify trends in care provision/education that can be discussed both at SQIP and directly with the surgeon and surgery teams at the monthly orthopedic co-management meetings as appropriate.	Ongoing	IP team to send notification of SSI to Director to initiate review.
Review of SPD processes and workflows – Through review of the spinal fusion SSI cases identified during this reporting period, there was a determination that opportunity existed to audit our SPD workflows and processes to verify necessary equipment sterility and process adaptation. External company selected to perform SPD audit in November 2025.	November 2025	Surgery leadership team will collaborate with audit company to ensure any gaps identified from the audit are addressed

Complication Rate

July 1, 2024 – June 30, 2025 (12 months)

All Payers

Overall complication rate: **1.23%** (7 complications from 567 total cases)

Percentile: 28th percentile (lower is better)

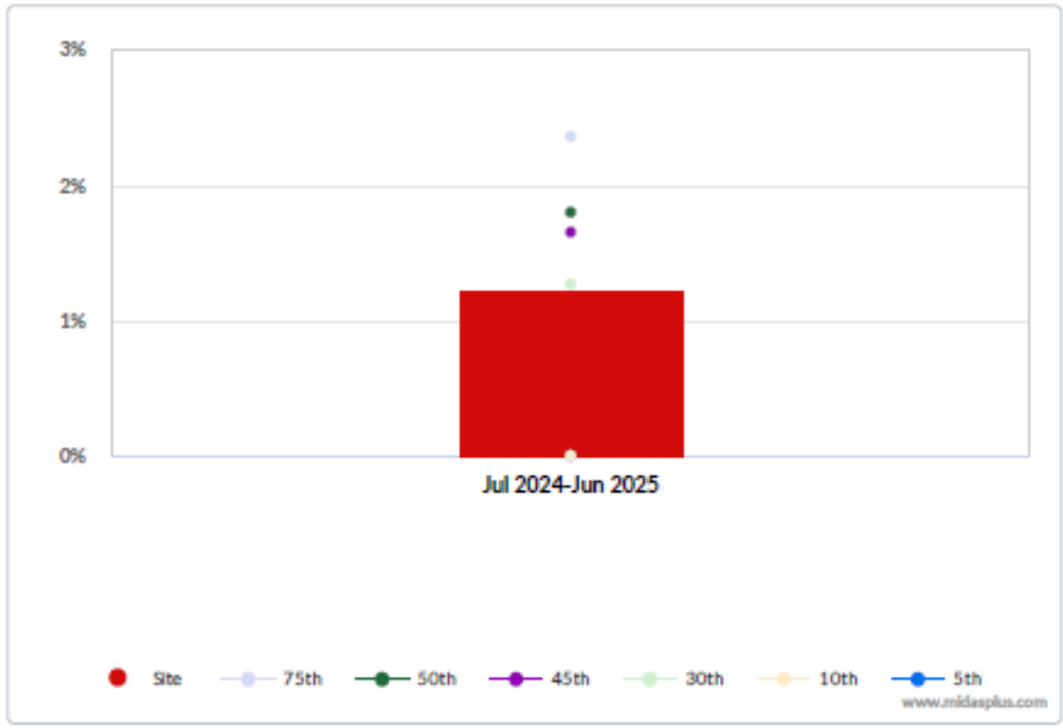
Kaweah goal: 30th percentile (1.27% complication rate)

GOAL MET

KAWEAH DELTA MEDICAL CENTER

CMS CJR Hip/Knee Arthroplasty - Complication Rate, Same Facility

Compared with 400+ beds



Period	Site Value	Site Percentile	Num	Den	Category	5th	10th	30th	45th	50th	75th	# Sites
Jul 2024-Jun 2025	1.23%	28th	7	567	400+ beds	0.00	0.00	1.27	1.66	1.80	2.36	82

Complication Rate

July 1, 2024 – June 30, 2025 (12 months)

Medicare only

Overall complication rate: **2.48%** (4 complications from 161 total cases)

Percentile: 68th percentile (lower is better)

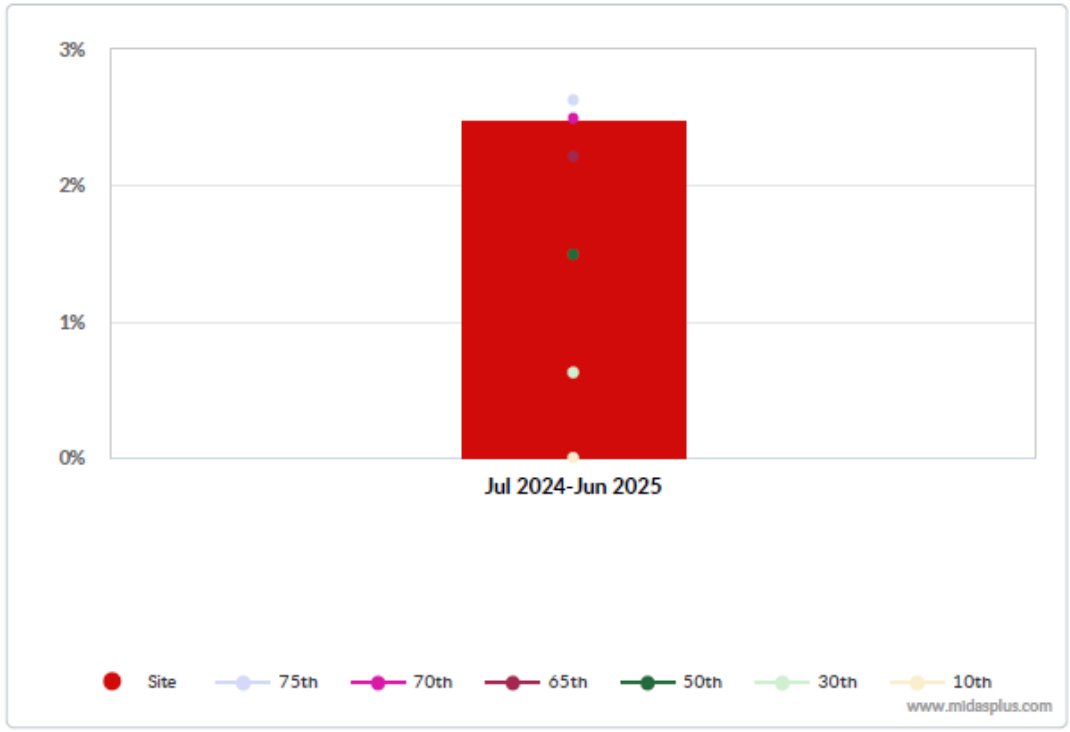
Kaweah goal: 45th percentile (1.22% complication rate)

GOAL NOT MET

KAWEAH DELTA MEDICAL CENTER

CMS CJR Hip/Knee Arthroplasty - Complication Rate, Same Facility, Medicare

Compared with 400+ beds



Period	Site Value	Site Percentile	Num	Den	Category	10th	30th	50th	65th	70th	75th	# Sites
Jul 2024-Jun 2025	2.48%	68th	4	161	400+ beds	0.00	0.63	1.49	2.21	2.50	2.63	80

Complication Rate

July 1, 2024 – June 30, 2025 (12 months)

	Primary Proc Type	Primary Proc Date	Complication Type
Q3 2024	THA	7/1/2024	mechanical complication
	TKA	7/11/2024	pneumonia
	TKA	7/22/2024	acute MI (NSTEMI)
	THA	7/23/2024	mechanical complication
Q4 2024	THA	10/1/2024	infection
	THA	10/28/2024	mechanical complication
Q1 2025			
Q2 2025	THA	5/15/2025	death within 30 days

Medicare

- 6 of the 7 total complications were discharged to home after their initial procedure with discharge orders for 2 week OP follow up with their surgeon and subsequent OP physical therapy.
- 1 of the 7 complications was discharged to Skilled Nursing Facility secondary to challenges with mobility following surgery.

Complication Rate

July 1, 2024 – June 30, 2025 (12 months)

CURRENT IMPROVEMENT ACTIVITIES	EXPECTED COMPLETION DATE	BARRIERS/UPDATES
Joint surgery patient education- Providing consistent and standardized education for our joint surgery patients is critical to optimize expectations and outcomes. KH Joint Surgery books are provided to local offices to disburse to patients pre-operatively, a joint surgery educational video on the KH website is promoted to scheduled surgery patients, and information from patients is gathered pre-operatively (functional and social status) by our orthopedic NPs to consider optimal discharge disposition in advance.	Ongoing	Relying on various local orthopedic offices to disperse joint surgery educational books and promote educational video is challenging, as their workflows vary.
Coordinated therapy pre/post op 86% of complications reported were discharged from hospital to home, with surgeon follow up approximately 2 weeks post-operatively, after which time OP therapy is referred to begin rehab efforts. There may be benefit with scheduling these patients with a session of therapy pre-operatively, and/or coordinating therapy to begin within a week of surgery, so that a licensed PT can play a role in wound inspection, inflammation reduction modalities, patient education on healing, and guiding light exercises.	4/30/26	Will initiate this workflow consideration with Dr. Kim in collaboration with therapy leadership
Optimize patient discharge disposition: Coordinated communication between our KH orthopedic NPs and KH case managers/post-acute liaisons to spotlight priority patients coordinate appropriate level of rehab/therapy indicated for their condition (i.e. transfer to inpatient rehab, short stay, SNF, home health as appropriate) in order to optimize patient access to recovery and education.	Ongoing	We continue to experience scenarios where patients have been told by their surgeon that they can go to rehab after their surgery, which isn't always allowed (per payer guidelines).

Thank you

Live with passion.

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

Kaweah Health

STRATEGIC GROWTH AND INNOVATION-

FY2026 Strategic Plan

Strategic Growth and Innovation

Marc Mertz, CEO
Kevin Bartel, Director of Surgical Service Lines

Strategic Growth & Innovation

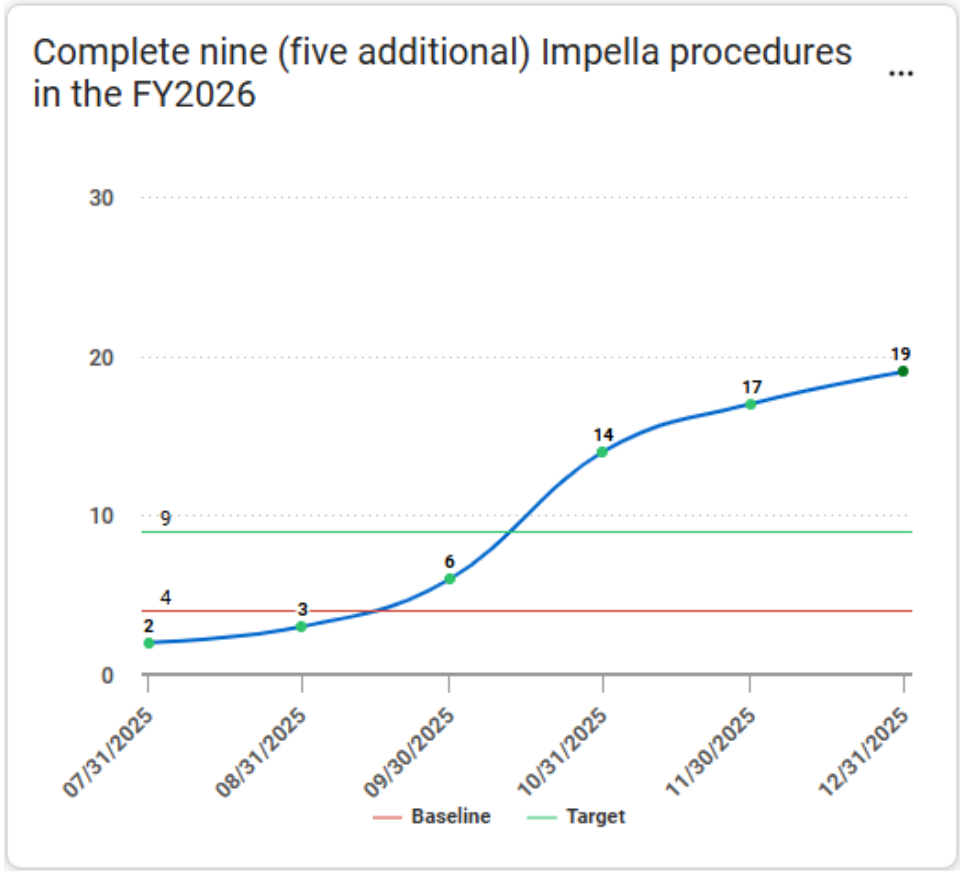
Broad scope of objectives

- Grow Targeted Service Line Volumes
- Enhance Medical Center Capacity & Efficiency
- Expand Access through Clinic Network Development
- Innovation
- Enhance Health Plan Programs

Grow Targeted Service Line Volumes

Kevin Bartel - Ivan Jara - Renee Lauck - Ayham Zoreikat - Kari Moreno - Lori Mulliniks

Orthopedics – Endoscopy – Cardiothoracic



ACHIEVED-it

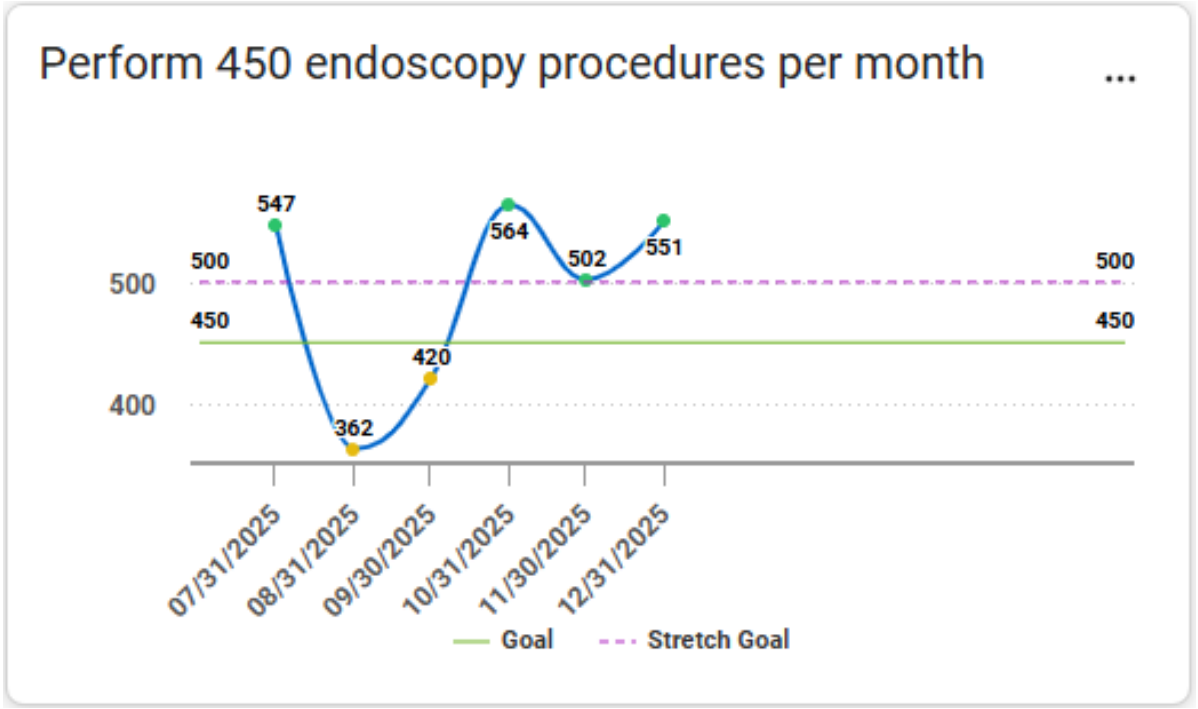
- Evaluate & secure orthopedic trauma future state
- Complete 9 total Impella procedures in FY2026
- Implement a lung cancer screening program

Grow Targeted Service Line Volumes

Orthopedics – Endoscopy – Cardiothoracic

ON TRACK

- Develop plan for comprehensive women's health center
- Execute the Cardiothoracic Strategic Plan
- Complete pro forma for the mitral clip program
- Establish an EP Cardiology Program
- Develop a strategy for Skilled Nursing Facility growth
- Perform 450 endoscopy procedures per month

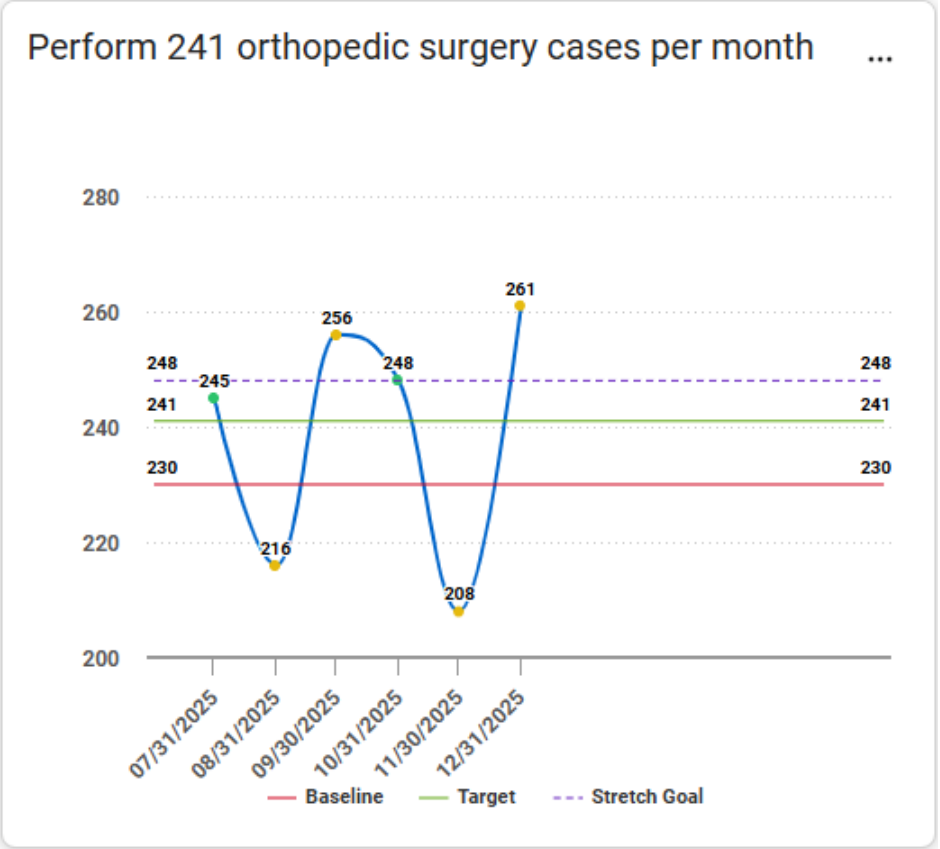


Grow Targeted Service Line Volumes

Orthopedics – Endoscopy – Cardiothoracic

OFF TRACK

- Perform 241 orthopedic surgery cases per month (239)



Enhance Medical Center Capacity and Efficiency

Kevin Morrison – Jeffery Cater – Lori Mulliniks

Enhance existing spaces to grow capacity for expanded & new services,
Focus on operational efficiency within the surgery areas

ACHIEVED-it

- Consistently operate a 6th Cath Lab

ON TRACK

- Complete expansion of the Cardiovascular Post Acute Care Unit (PACU)

Not Achieved

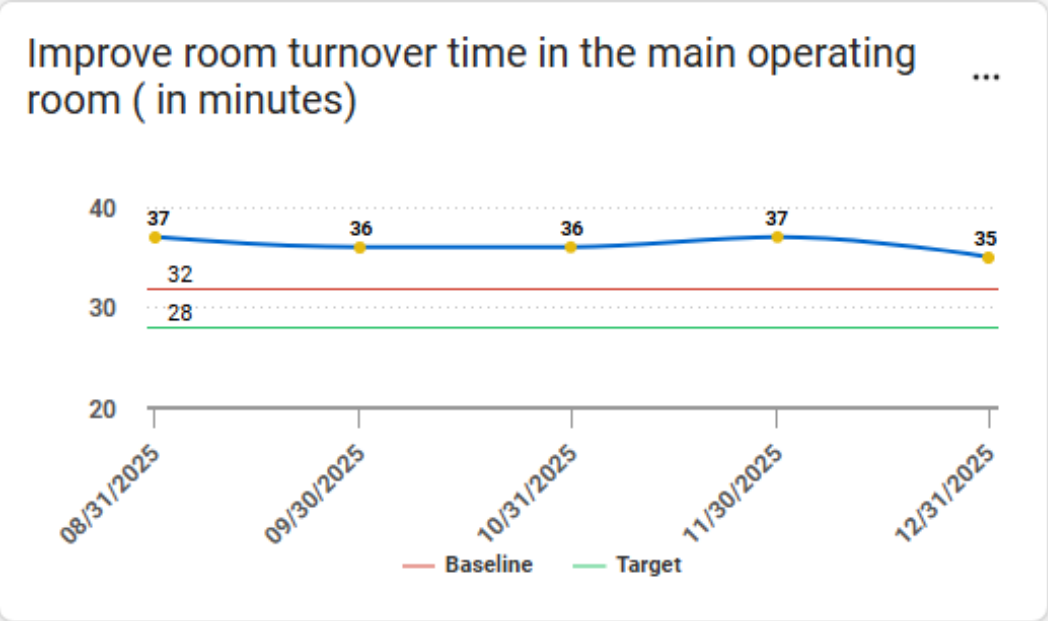
- Complete renovation and licensing of two outpatient procedure rooms

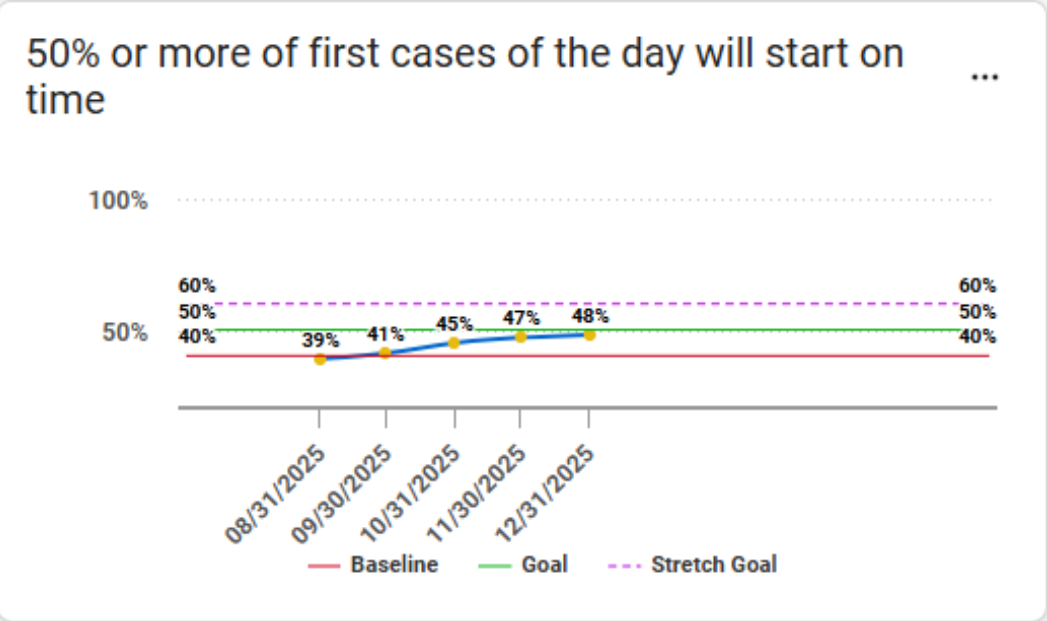
Enhance Medical Center Capacity and Efficiency

Kevin Morrison – Jeffery Cater – Lori Mulliniks

OFF TRACK

- Improve room turnover time in the main operating room (in minutes)
- 50% or more of first cases of the day will start on time
- Launch a Block Time Utilization Committee





Expand Access for Patients through Clinic Network Development

Marc Mertz – Jag Batth – Ivan Jara – Diana Saechao

Strategically expand & enhance the existing clinic network to increase access

ACHIEVED-it

- Opened the Youth Crisis Stabilization Unit (December 2025)

ON TRACK

- Open & evaluate further expansion of a multispecialty clinic on Akers (Phase I)
- Expand the rural health clinic network
- Launch occupational medicine at the Plaza clinic
- Assess the need for an expansion of SRCC-Medical Oncology services and space

OFF TRACK

- Finalize the plan for the ambulatory surgery center project

Innovation

Ivan Jara – Luke Schneider – Marc Mertz

Implement & optimize new tools, applications and services to improve the patient experience, communication and outcomes

ACHIEVED-it

- Pilot ambient listening technology in select clinics

ON TRACK

- Continue exploring opportunities to use technology and AI across KH
- Optimize new call system to support integrated access for patients
- Identify new strategies and tools related to scheduling, registration and billing to enhance the patient experience

OFF TRACK

- Complete feasibility study for enhance care at home and determine next steps

Enhance Health Programs

Sonia Duran-Aguilar

Enhance relationships with health plans & community partners, participate in programs & funding opportunities to improve overall outcomes for the community

ON TRACK

- Maintain Community Supports (CS) community care coordinators (CCC) staff at 5, with an assigned case load of 40 patients each

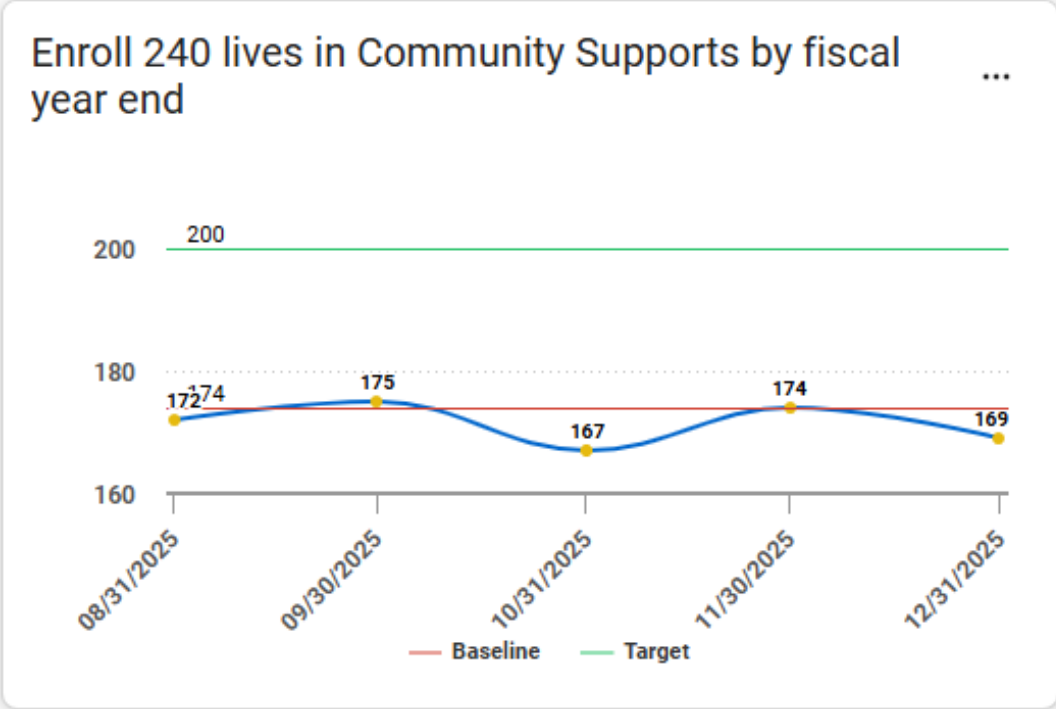
OFF TRACK

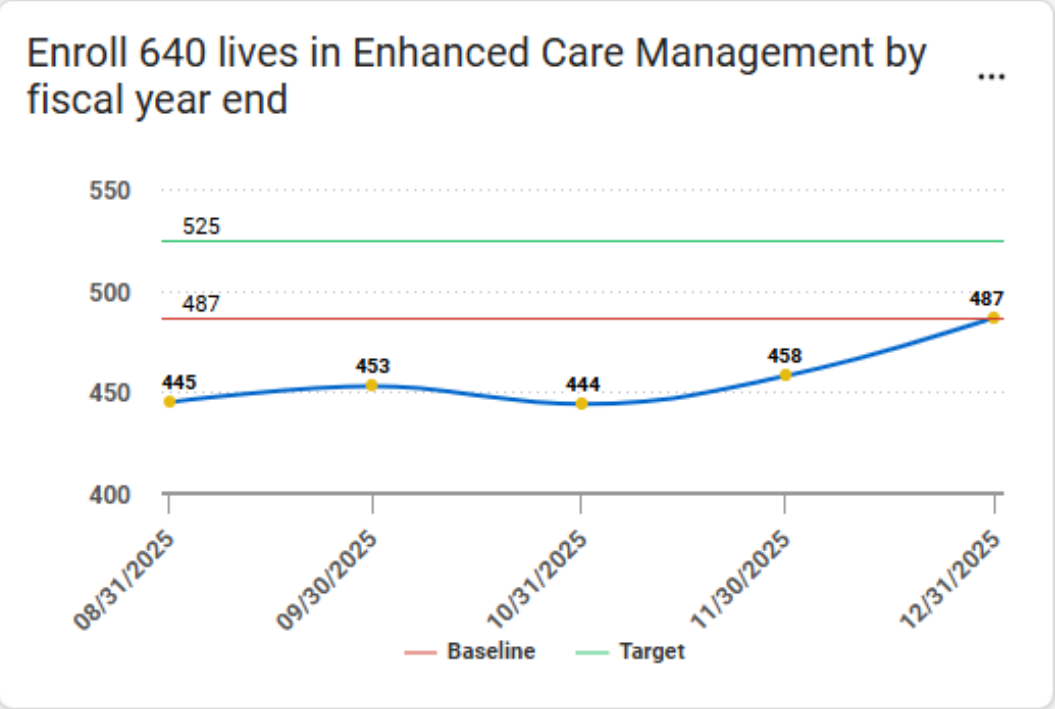
- Maintain Enhance Care Management (ECM) CCC staff at 15 with an assigned case load of 40 patients
- Increase enrollment to 525 lives in ECM by fiscal year end
- Increase enrollment to 200 lives in CS by fiscal year end

Enhance Health Programs

Sonia Duran-Aguilar

Enhance relationships with health plans & community partners, participate in programs & funding opportunities to improve overall outcomes for the community





The pursuit of healthiness

Kaweah Health
MORE THAN MEDICINE. LIFE.

PATIENT EXPERIENCE AND SATISFACTION UPDATE

Board of Directors

Patient & Community Experience

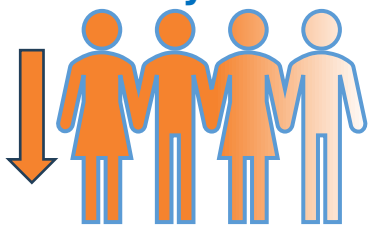
January 2026

Patient Experience Matters

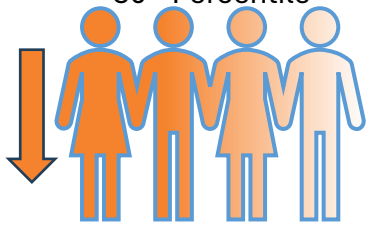
Opportunities and insights to increase patient satisfaction.

Kaweah Health December 2025

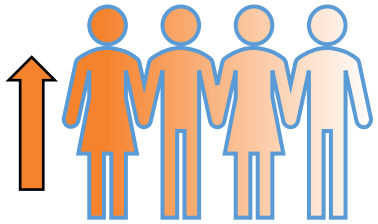
Survey Scores



HCAHPS: 70.5
50th Percentile



Inpatient NPS: 62.0
34th Percentile

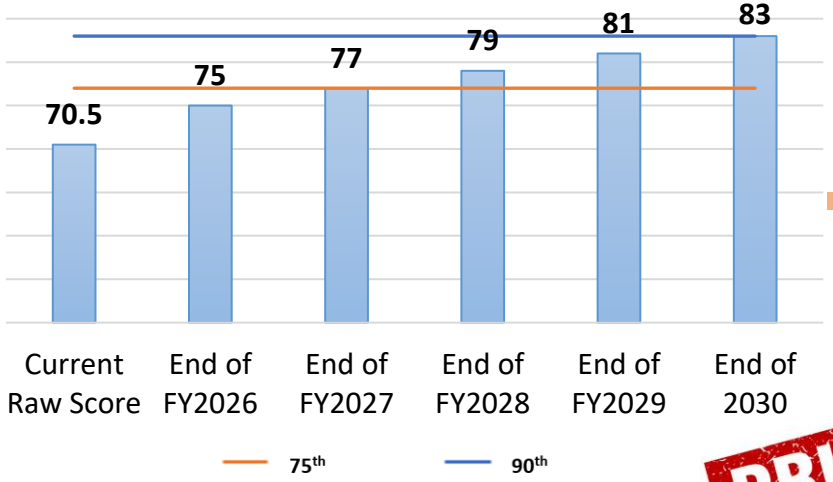


Medical Practice NPS: 77.9
12th Percentile

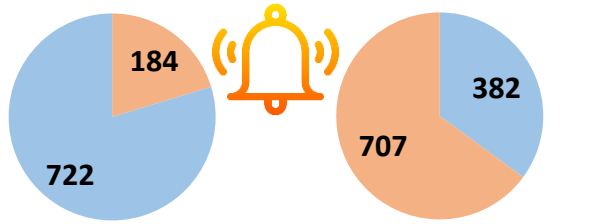
Fiscal Year Data

July 2025 - November 2025

5 Year HCAHPS Goal



Service Alerts



Human Understanding – 75.7
12th Percentile

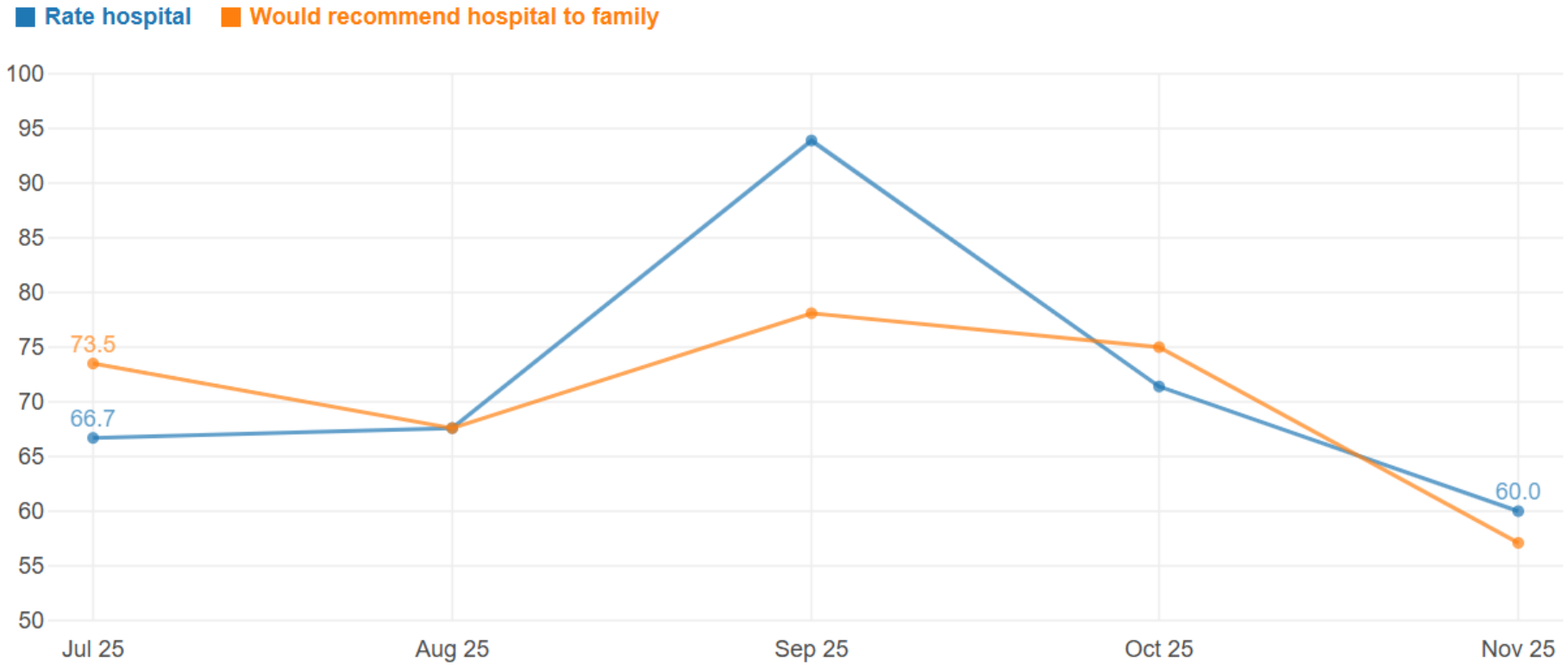
PRIORITY

- **Spending enough time with patient**
- **Providing consistent information**
- **Informed of delays**
- **Quiet rooms at night**
- **Providers knowing medical history**
- **Nurses explaining things understandably**

December 2025

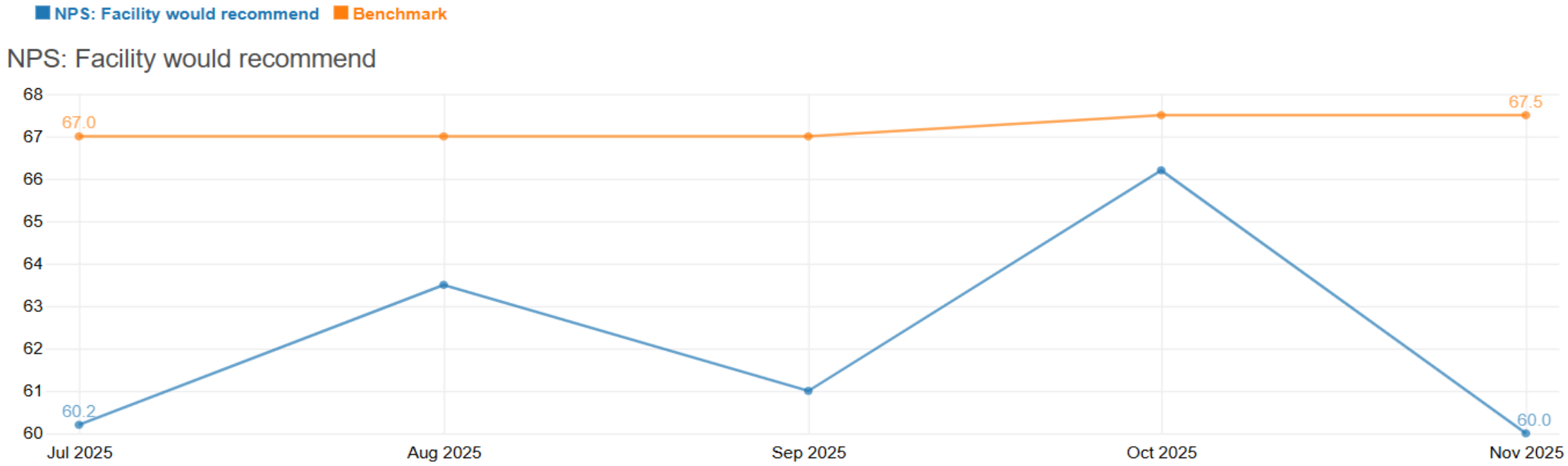
Rounding	MIDAS	ED Rounding
300	87 Opened	158

HCAHPS Trend
7/1/2025 – 11/30/2025



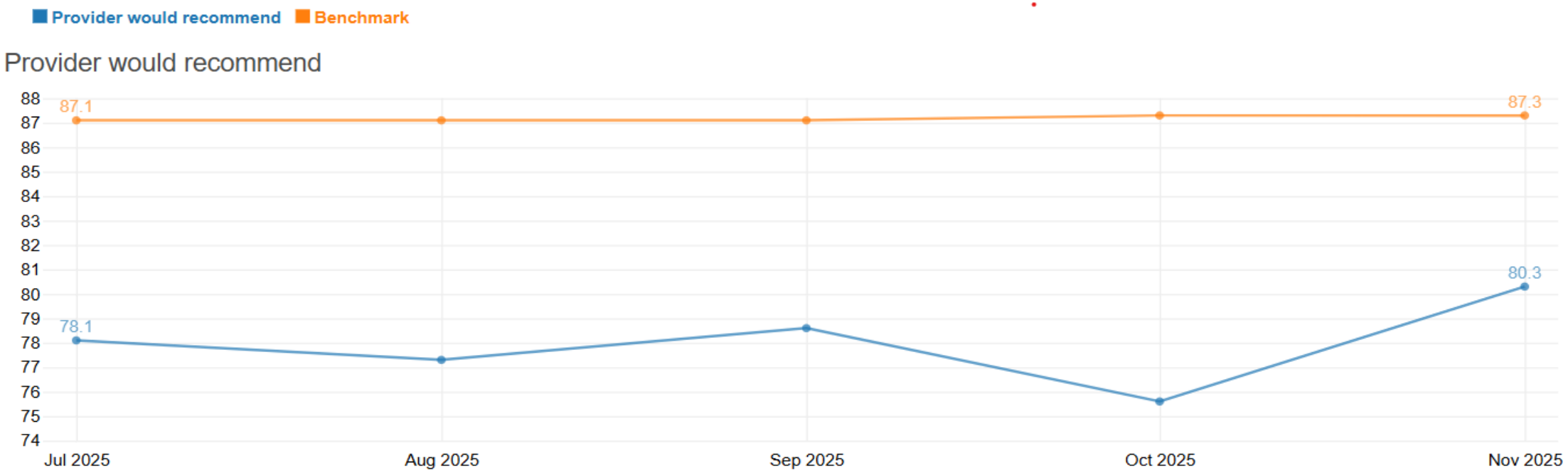
Question	Benchmark	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25
Rate hospital	71.4	66.7 n = 33	67.6 n = 34	93.9 n = 33	71.4 n = 28	60.0 n = 30
Would recommend hospital to family	72.6	73.5 n = 34	67.6 n = 34	78.1 n = 32	75.0 n = 28	57.1 n = 28

Inpatient Real Time Surveys (NPS) (7/1/2025-11/30/25)



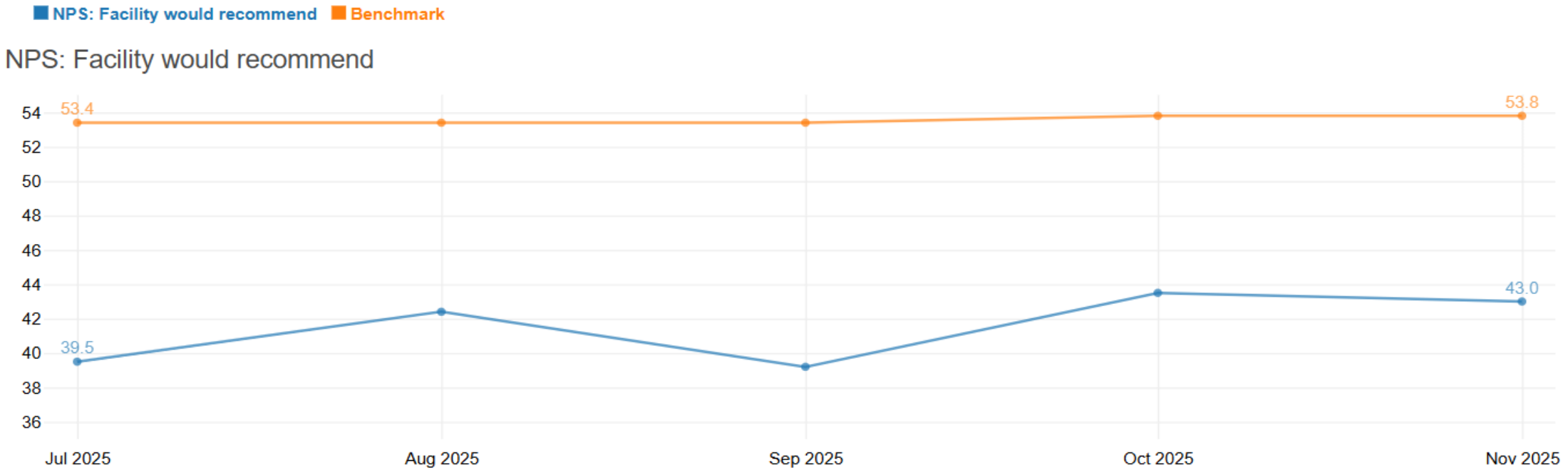
	Jul 2025	Aug 2025	Sep 2025	Oct 2025	Nov 2025
NPS: Facility would recommend	60.2 n = 259	63.5 n = 211	61.0 n = 187	66.2 n = 198	60.0 n = 220

Med Practice Real Time Surveys (NPS)
(7/1/2025 - 11/30/2025)



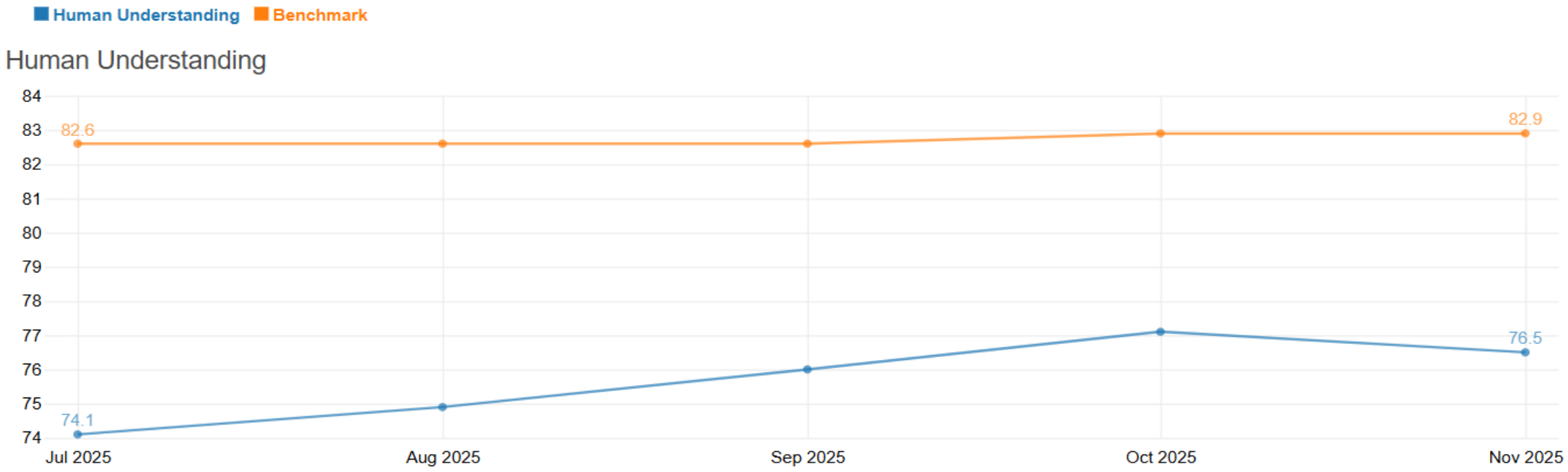
	Jul 2025	Aug 2025	Sep 2025	Oct 2025	Nov 2025
Provider would recommend	78.1 n = 770	77.3 n = 688	78.6 n = 695	75.6 n = 620	80.3 n = 529

Emergency Department Real Time Surveys (NPS)
(7/1/2025 - 11/30/25)



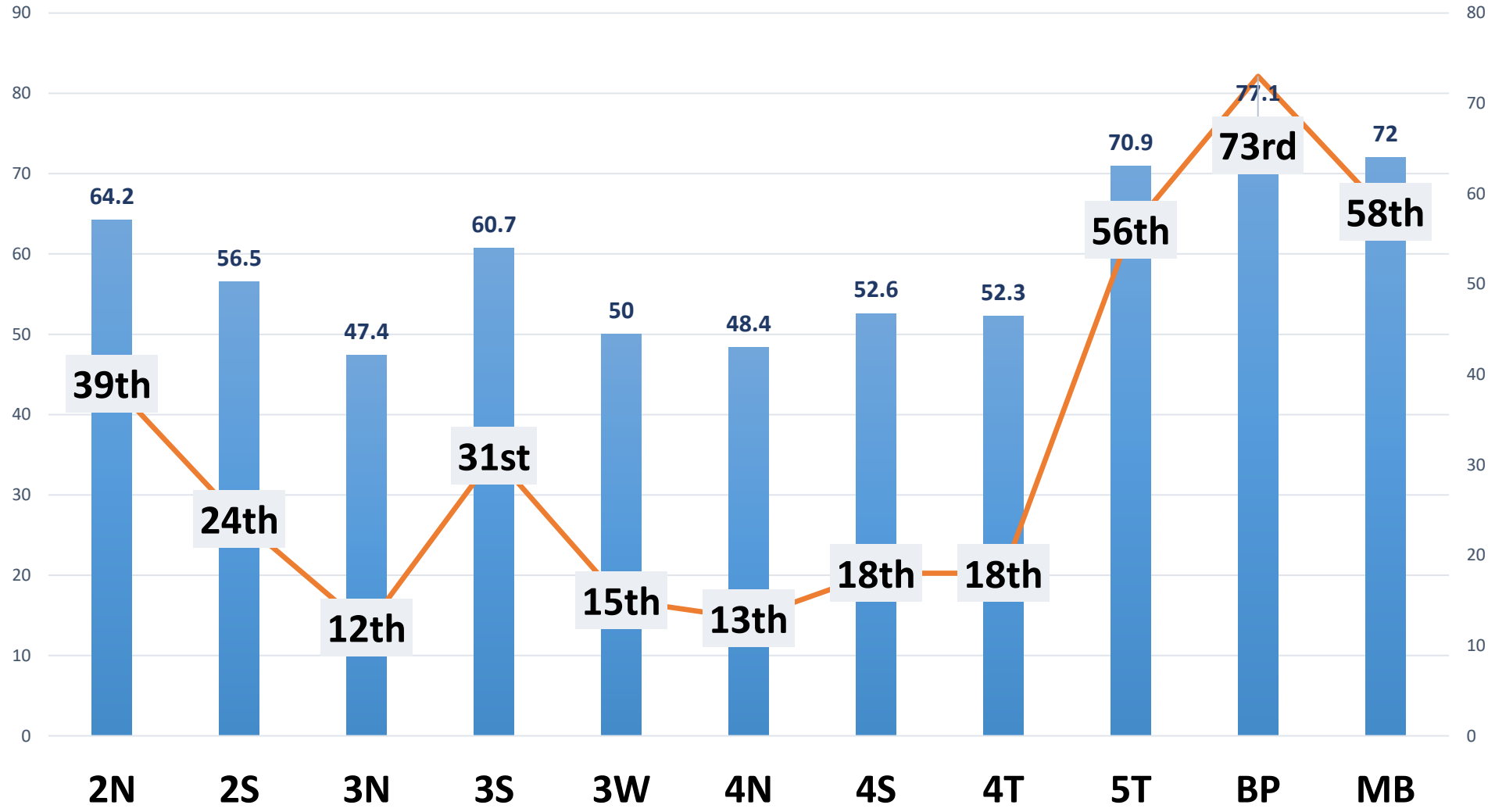
	Jul 2025	Aug 2025	Sep 2025	Oct 2025	Nov 2025
NPS: Facility would recommend	39.5 n = 845	42.4 n = 821	39.2 n = 793	43.5 n = 710	43.0 n = 698

Human Understanding- Real Time Surveys (7/1/2025 - 11/30/2025)



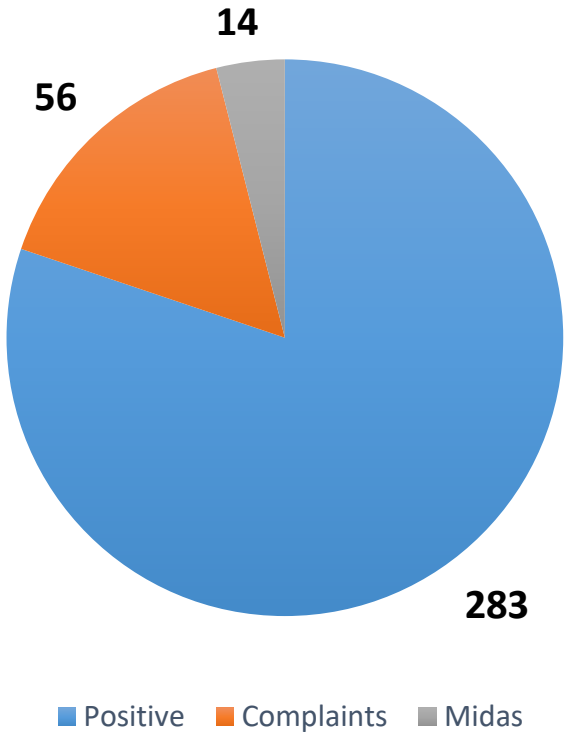
	Jul 2025	Aug 2025	Sep 2025	Oct 2025	Nov 2025
Human Understanding	74.1 n = 3,593	74.9 n = 3,510	76.0 n = 3,836	77.1 n = 3,949	76.5 n = 3,380

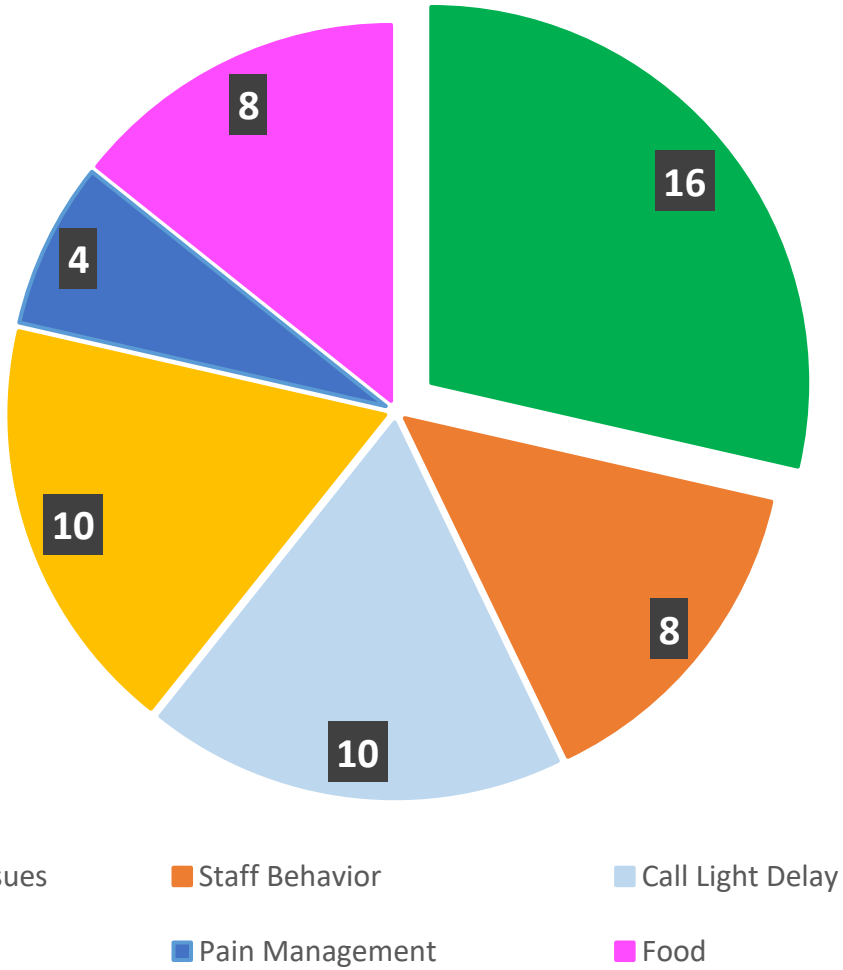
Inpatient Unit's NPS Score:
7/1/2025 – 11/30/2025



Inpatient Rounding: December

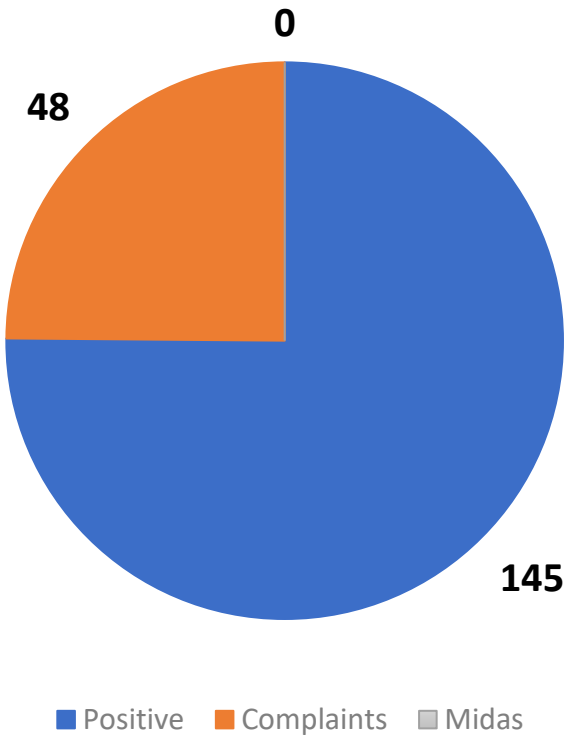
300 Rounds

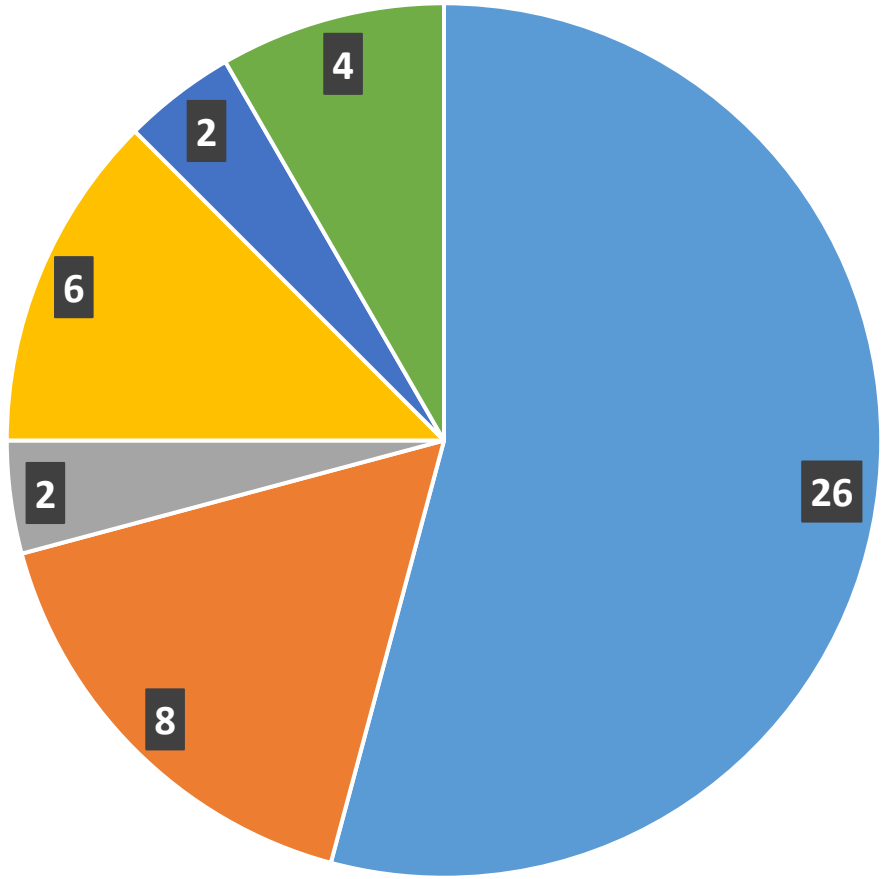




ED Rounding: December

158 Rounds

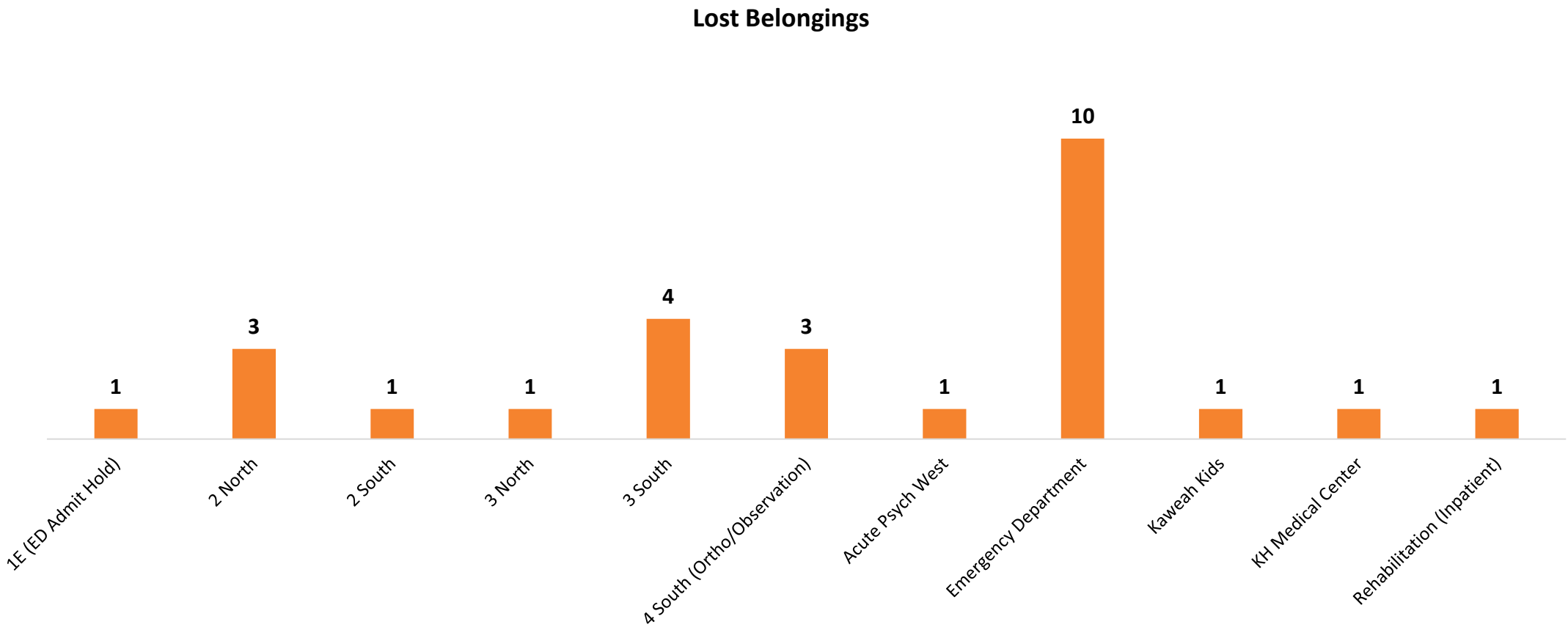




MIDAS: December

87 Opened

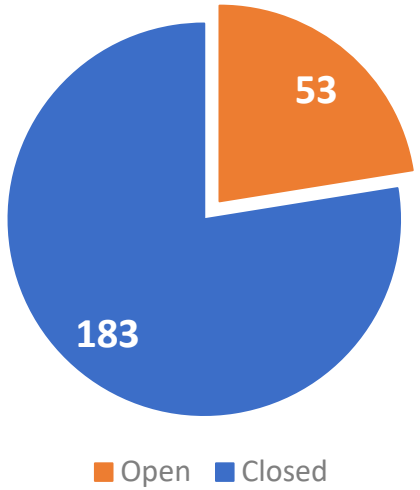
Lost Belongings: December



Lost Belongings

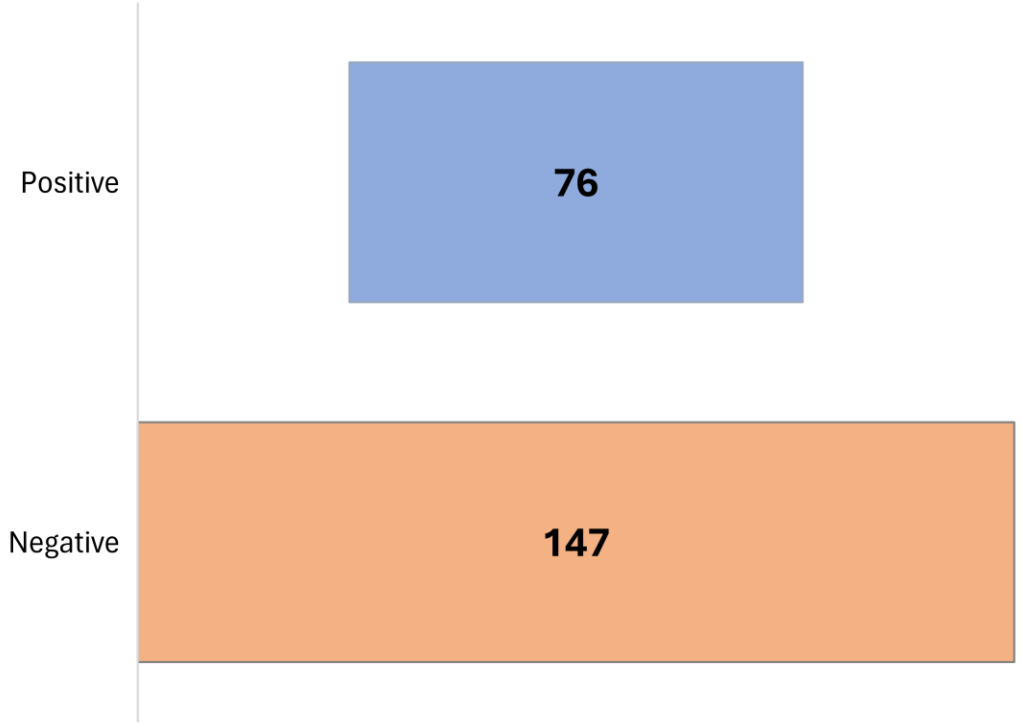
Year to Date Total: 236

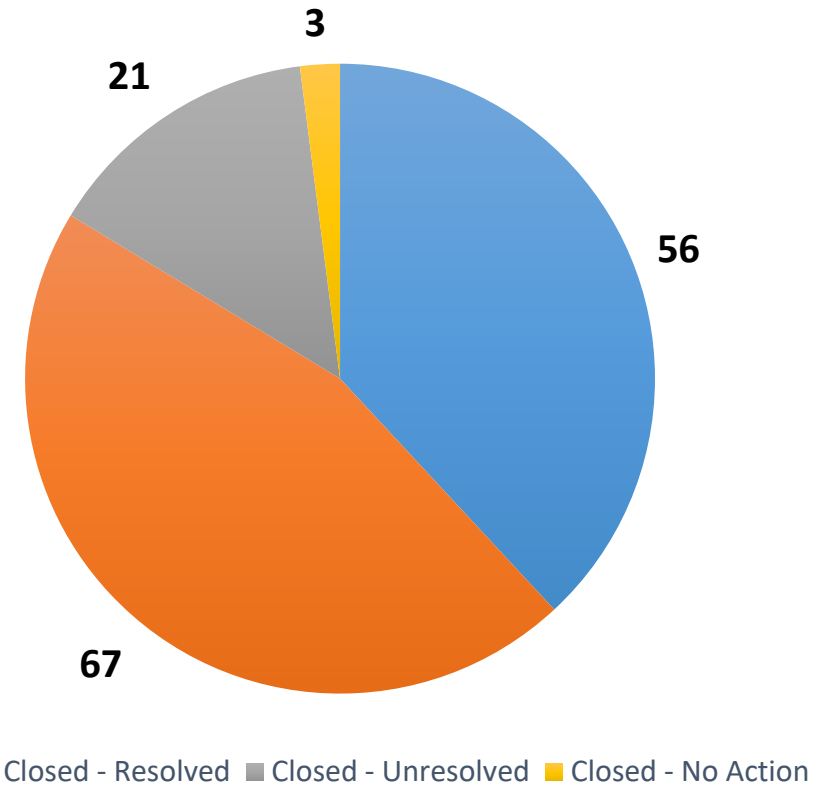
1/1/25 - 12/31/25



Service Alerts: November

184 Total



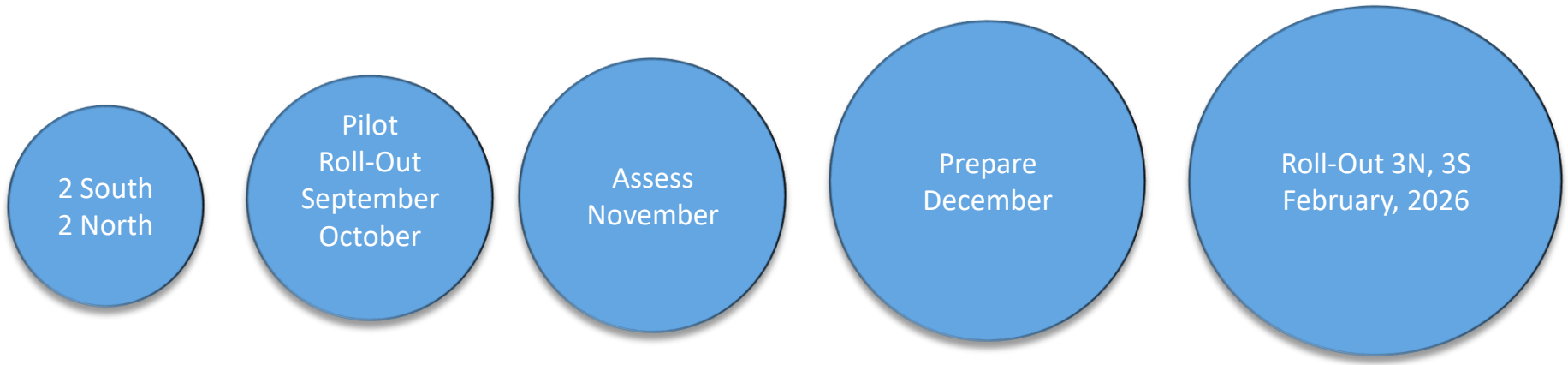


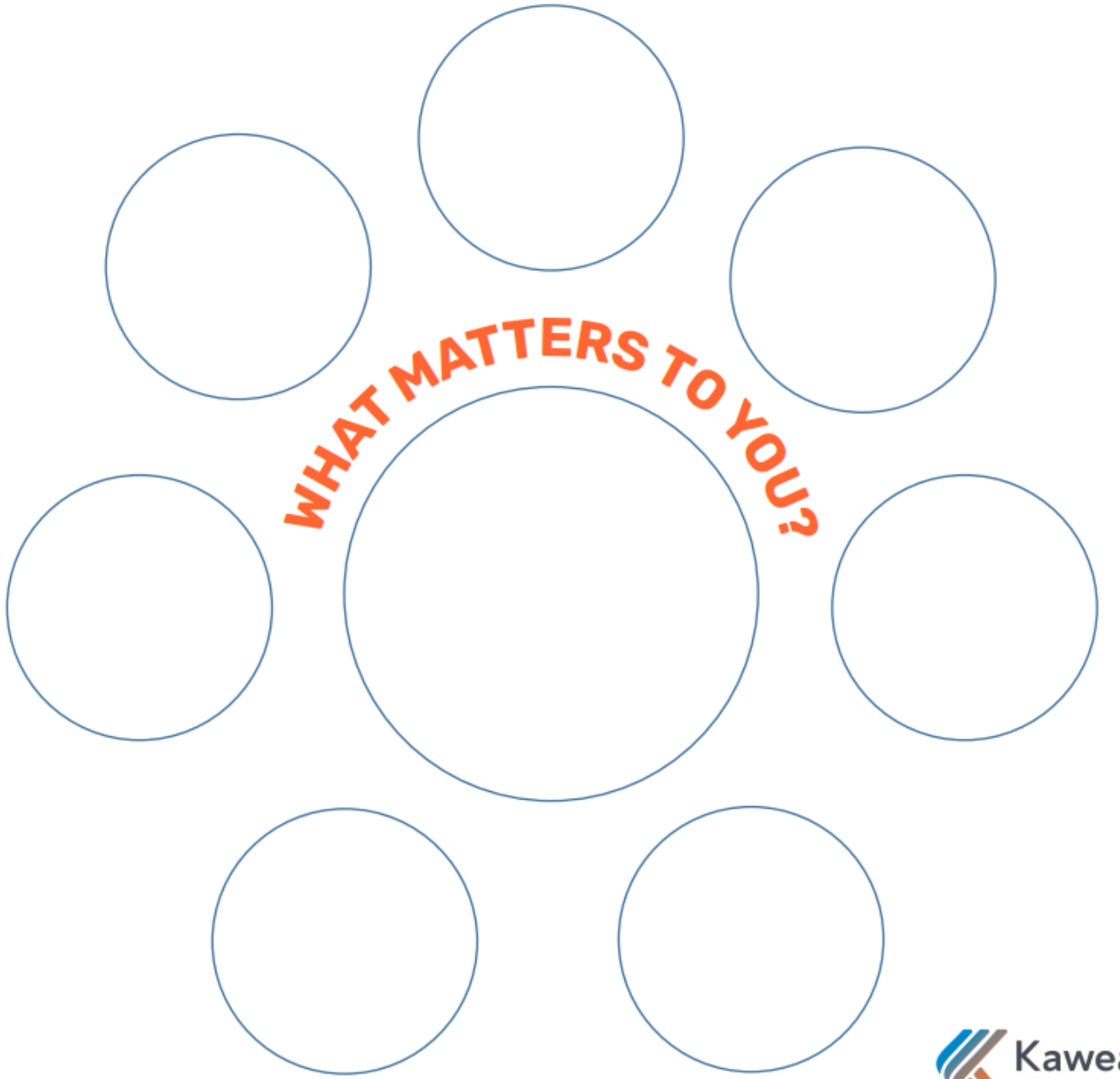
ROUNDING

November/December Executive Team Rounds = 14 executive rounds

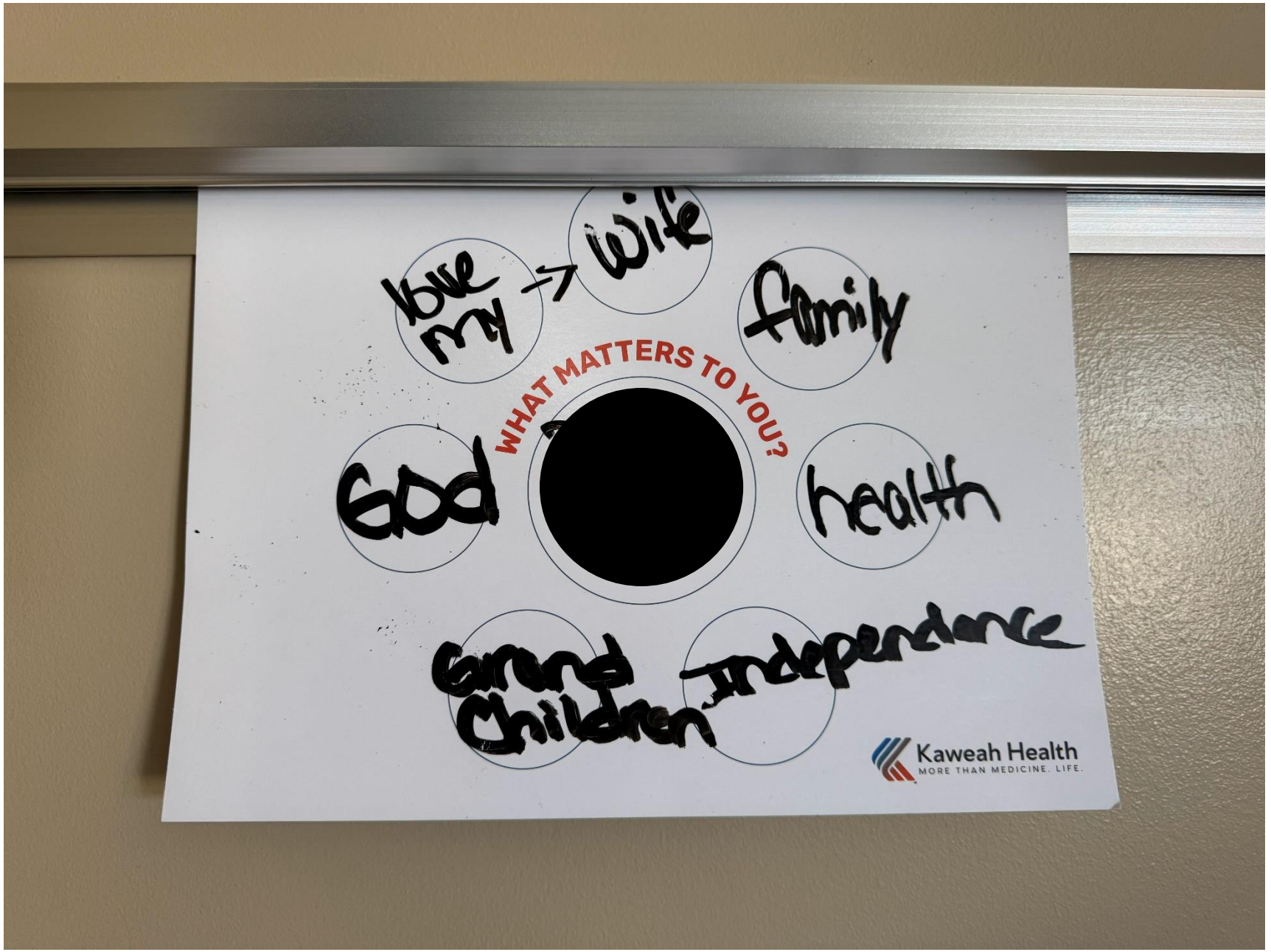
Executive	November	December
Gary H.	11/4	12/3
Marc M.	11/20	12/23
Jag B.	11/12	12/10
Malinda T.	11/17	12/22
Dianne C.	11/11	12/15
Schlene P.	11/24	
Ben C.	11/24	12/18
Ryan G.		
Paul S.		12/2
Doug L.		

WHAT MATTERS TO YOU PILOT

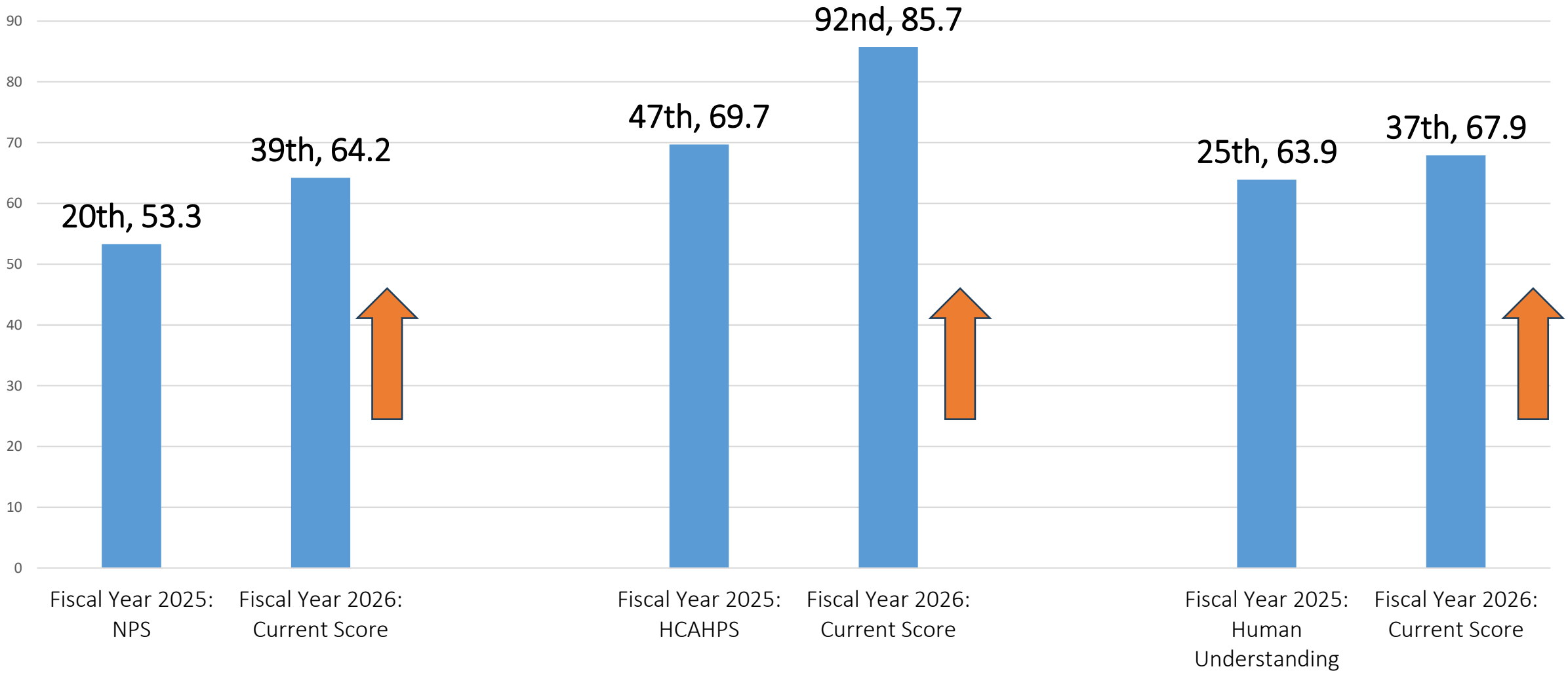




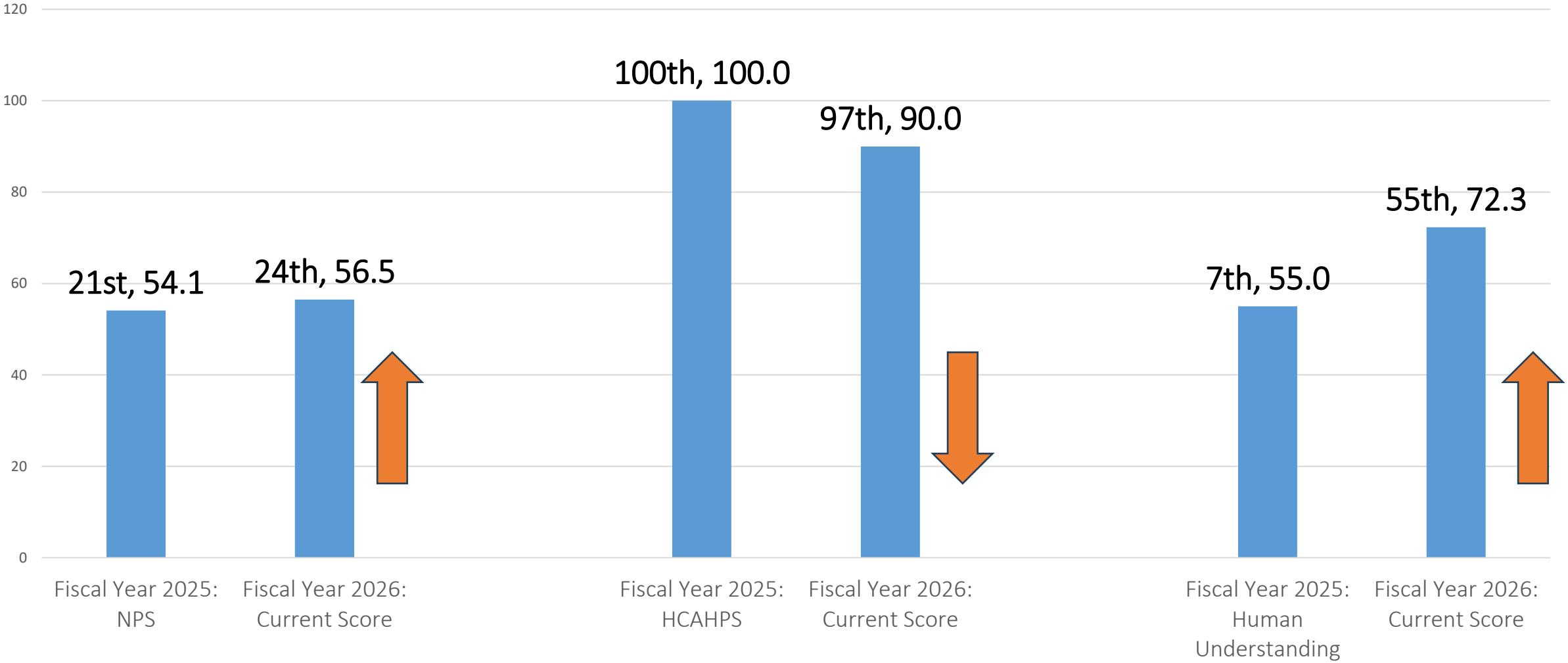
Kaweah Health
MORE THAN MEDICINE. LIFE.


love my → wife
family
WHAT MATTERS TO YOU?
God
health
Grand Children
Independance
Kaweah Health
MORE THAN MEDICINE. LIFE.

2 North


90
80
70
60
50
40
30
20
10
0
20th, 53.3
39th, 64.2
47th, 69.7
92nd, 85.7
25th, 63.9
37th, 67.9
Fiscal Year 2025: NPS
Fiscal Year 2026: Current Score
Fiscal Year 2025: HCAHPS
Fiscal Year 2026: Current Score
Fiscal Year 2025: Human Understanding
Fiscal Year 2026: Current Score

2 South


120
100
80
60
40
20
0
21st, 54.1
24th, 56.5
100th, 100.0
97th, 90.0
7th, 55.0
55th, 72.3
Fiscal Year 2025: NPS
Fiscal Year 2026: Current Score
Fiscal Year 2025: HCAHPS
Fiscal Year 2026: Current Score
Fiscal Year 2025: Human Understanding
Fiscal Year 2026: Current Score