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: February 20, 2026

NOTICE

Date: Wednesday, February 25, 2026
Location: City of Visalia – City Council Chambers
Address: 707 W. Acequia Avenue, Visalia, California

Please join my meeting from your computer, tablet or smartphone.
https://meet.goto.com/KelsieD/kaweahdeltahealthcaredistrictboardofdirectorsmeeti
You can also dial in using your phone.
Access Code: 460-561-181
United States: +1 (646) 749-3122

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**

This agenda is posted in compliance with the Ralph M. Brown Act, including amendments enacted under Senate Bill 707.

KAWEAH DELTA HEALTH CARE DISTRICT BOARD OF DIRECTORS MEETING

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

Wednesday February 25, 2026 {Regular Meeting}

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OPEN SESSION (LIMITED PURPOSE – CONVENING ONLY) – 4:00 PM

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1. **CALL TO ORDER**
2. **PUBLIC COMMENT ON CLOSED SESSION ITEMS ONLY –** 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 TO CLOSED SESSION**

CLOSED SESSION – 4:01 PM

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1. **CALL TO ORDER**

2. **CONFERENCE WITH LEGAL COUNSEL – ANTICIPATED LITIGATION / QUARTERLY COMPLIANCE REPORT –** Conference with legal counsel regarding potential exposure to

litigation pursuant to Government Code 54956.9(d)(2); Matters involve compliance, risk management review, and related quality assurance issues.

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))

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

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.)

   Possible reportable action

5. **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.

   Possible reportable action

6. **MEDICAL STAFF QUALITY ASSURANCE/PEER REVIEW** 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 & Evid. Code 1157.

7. **APPROVAL OF THE CLOSED MEETING MINUTES** – January 2026.
   Possible reportable action
8. **ADJOURN CLOSED SESSION**

OPEN SESSION – 4:45 PM (OR IMMEDIATELY FOLLOWING CLOSED SESSION)

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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 (5) 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 2281 to Maggie Teran in recognition as the Kaweah Health World Class Employee of the month – February 2026.
   - **6.2.** World Class Team of the Month – Emergency Department Night Shift Team
   - **6.3.** Presentation of Resolution 2282 to Doug Niederreiter in recognition of his years of service and retirement after 31 years.
7. **INTRODUCTIONS**
   - **7.1.** Samantha Mcadams, Director of Home Health and Home Care Services
   - **7.2.** Teresa Boyce, Director of Medical Staff Services
   - **7.3.** Lynne Perkins, Director of Critical Care Services
   - **7.4.** Kevin Morrison, Vice President of Support Services
8. **CHIEF OF STAFF REPORT**
   Report relative to current Medical Staff events and issues.

9. 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 February 25, 2026, Consent Calendar.

[Consent Calendar Items 9.1 – 9.5 as presented]

Section	Item	Description	Type
9.1. REPORTS	A	Physician Recruitment	Receive and File
	B	Overall Strategic Plan	Receive and File
	C	Hospice	Receive and File
	D	Urology	Receive and File
	E	Quarterly Compliance Program Activity Report	Receive and File
	F	Length of Stay	Receive and File
9.2. MINUTES	A	Patient Experience- January 14, 2026	Approve Minutes
	B	Finance Property Services Acquisition Committee- January 21, 2026	Approve Minutes
	C	Quality Council Committee – January 15, 2026	Approve Minutes
	D	Regular Open Board Meeting – January 28, 2026	Approve Minutes
9.3. POLICIES	**A**	**Administrative Policies**	
	1	AP 126 Physician Recruitment Policy	Approve Revisions
	2	AP 41 Quality Improvement Plan	Approve Revisions
	3	AP175 Patient Safety Plan	Approve Revisions
	B	**Environment of Care**	
	1	EOC 1019 Equipment Cleaning and Low/Intermediate Level Disinfection	Approve Revisions
	2	EOC 1047 Alternate Equipment Maintenance Program	New
	3	EOC 8000 Heat and Illness Prevention Program	Approve Revisions
9.4. MEC		None	
9.5. DISTRICT	1	Semi Annual Investment Report December 31, 2025	Approve and File
	2	Pension Plan Financial Audit – Plan Year Ending June 30, 2025	Approve and File

Section	Item	Description	Type
	3	District Privacy Manual	Approve and File
	4	Code of Conduct	Approve and File

10. **CARDIAC SERVICE LINE REPORT**
Overview of initiatives, outcomes, and emerging priorities related to cardiac surgery service line and inclusive practices.

11. **STRATEGIC PLANNING INITAITIVE – PATIENT AND COMMUNITY EXPERIENCE**
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 SESSION – IMMEDIATELY FOLLOWING OPEN SESSION

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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**

Kaweah Delta Health Care District
Board of Directors Meeting

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Wednesday Febraury 25, 2026

Agenda item intentionally omitted

2281

RESOLUTION 2281

Board Resolution Honoring
Maggie Teran as World Class Employee of the Month of February

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

WHEREAS, Maggie Teran, of the Rehabilitation 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 February 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, Maggie'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 Maggie as **World Class Employee of the Month** for February 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 Maggie Teran as a token of recognition and gratitude.

PASSED AND ADOPTED this 25th of February, 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

2282

RESOLUTION 2282

RESOLUTION HONORING DOUG NIEDERREITER ON THE OCCASION OF THEIR YEARS OF SERVICE AND RETIREMENT

WHEREAS, Doug has faithfully and diligently served Kaweah Health for 31 years; and

WHEREAS, throughout their tenure, Doug has demonstrated exceptional dedication, professionalism, and leadership in his role as Inpatient Pharmacy Manager; and

WHEREAS, he has made significant contributions to Pharmacy; and

WHEREAS, Doug 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 Doug leaves behind;

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

PASSED AND ADOPTED this 25th of February 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

Separator Page

Overall Strategic Plan

FY 2026 Strategic Plan

Monthly Performance Report
February 25, 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.

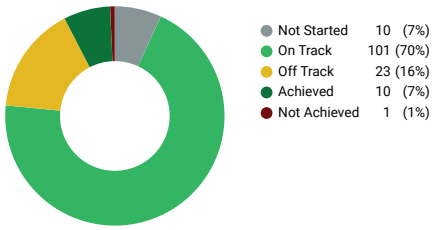
Our Pillars

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

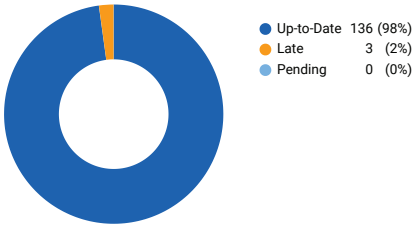
Our Five Strategic Plan Initiatives

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

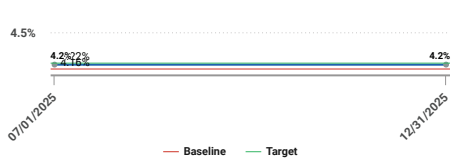
Champions: Dianne Cox and Hannah Mitchell

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

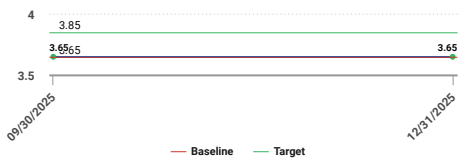
FY2026 Strategic Plan - Ideal Environment Strategies

#	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. 5 Employees just started at Carrington (Formerly SJVC)

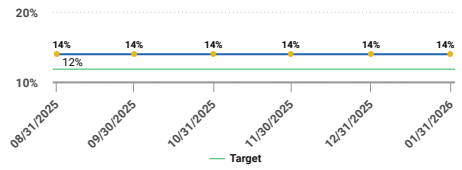
Employee Engagement Survey Score Greater Than 4.22%



Physician and APP Engagement Survey Score Greater Than 3.85%



Decrease Overall Turnover Rate



Strategic Growth and Innovation

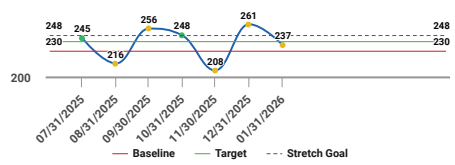
Champions: Marc Mertz and Kevin Bartel

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****.*

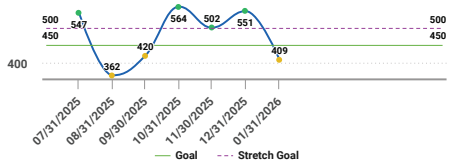
FY2026 Strategic Plan - Strategic Growth and Innovation Strategies

#	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.	Off Track	Kevin Bartel	Volume for CTS Impella procedures has exceeded FY26 target goal. January volumes for orthopedics and Endoscopy were below target.
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	Still progressing toward adding additional outpatient procedure spaces.
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 full rollout into OP clinics planned to be completed by end of 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.
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.

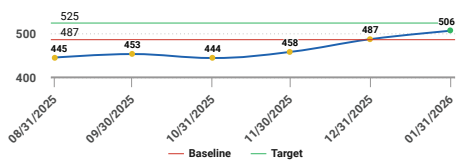
Perform 241 Orthopedic Surgery Cases Per Month



Perform 450 Endoscopy Cases Per Month



Increase Enrollment to 640 Lives in Enhanced Care Management



Outstanding Health Outcomes

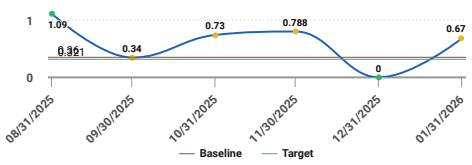
Champions: Dr. Paul Stefanacci

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

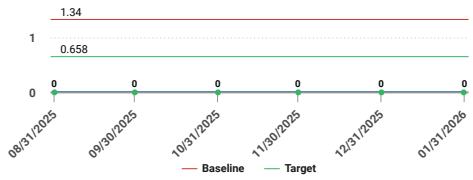
FY2026 Strategic Plan - Outstanding Health Outcomes Strategies

#	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 calculated and reported monthly in order to establish a baseline Serious Safety Event Rate (SSER). Will need 9-12 months of data for this baseline 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	There was low attendance at the HAI Quality Focus Team meetings for the latter part of CY2025. Initiatives to reduce HAI were discussed but not implemented. A new committee was created, the CAUTI - CLABSI committee, taking the place of the HAI Quality Focus Team. The initial meeting of the committee occurred on 2/10/2026. The attendees of the committee are very aware of the current state of CLABSI and CAUTI. They are familiar with where the HAI Quality Focus Team left off and what needs to be done to reduce CAUTI and CLABSI events. Immediate attention is being given to these organizational initiatives.
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.	On Track	Chris Patty	Date range represented October 1 - December 31, 2025. Once past the very high September data point (3.526) measure back below goal.

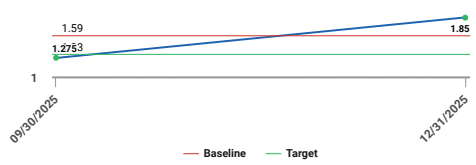
Decrease Standardized Infection Ratio (SIR) CAUTI to less than or equal to .321



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

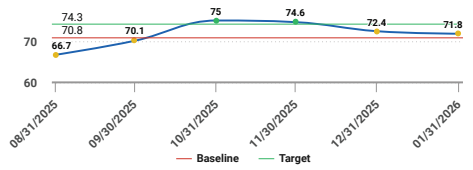
Champions: Marc Mertz and Deborah Volosin

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

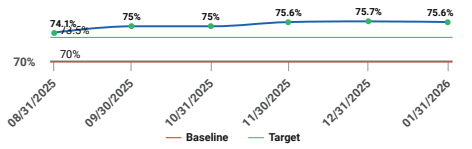
FY2026 Strategic Plan - Patient Experience and Community Engagement Strategies

#	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	Continuing the 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, Clinical Education training (LNRP), and Leadership meeting. Rolled out WMTY on 3M, 3S
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 PX rounding to ensure our environments are warm and welcoming.
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. Multiple Chamber Ambassador meetings, service club participation.
4.5	Adopting a Patient-Centered Approach to the Entire Healthcare Experience		On Track	Deborah Volosin	We continue to educate at the patient's experience at Orientation and staff meetings.

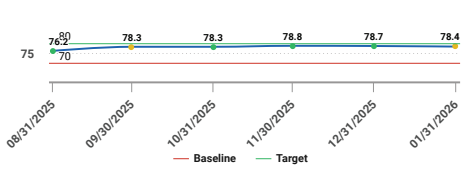
Achieve a score of 74.3 in HCAHPS Overall Rating



Achieve an Organizational-wide score of 73.5 in Human Understanding



Achieve a score of 80 in "Cleanliness of Clinic"



Physician Alignment

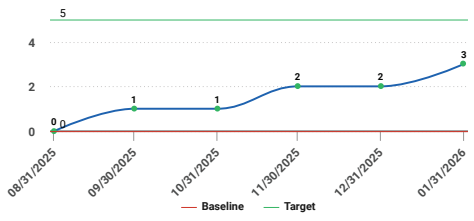
Champions: Marc Mertz and JC Palermo

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

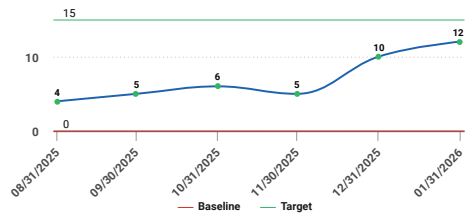
FY2026 Strategic Plan -Physician Alignment - Strategies

#	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	We continue to see increasing volumes of EBUS and ION cases with our pulmonologists. We're in the process of designing new space in the old OB suites on the 2nd floor to help accommodate this growth. The MitraClip program is tentatively targeted to launch in the April/May timeframe. We're also continuing to evaluate utilization of robotic surgery cases. Our new cardiothoracic surgeon will be using the robot downstairs, and we'll assess the potential need for a second robot over the next year or so. In addition, we're closely reviewing block utilization and overall OR efficiency. We've launched a new monthly meeting with providers and the Surgery Director to strengthen alignment around incentives and improve overall OR practices.
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	Kaweah is working with SIH on potential new payor arrangements, the possibility of a Healing at Home program, and seeking new ways to improve performance under current Medicare Advantage plans.

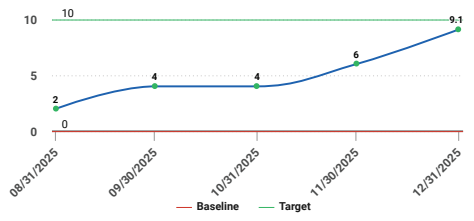
Recruit 5 Primary Care Physicians



Recruit 15 Specialty Providers



Recruit 10 Advanced Practice Providers



Hospice

KAWEAH HEALTH ANNUAL BOARD REPORT

Hospice Services - Summary

FY2026 Annualized

KEY METRICS - FY 2026 - The Annualized Six Months Ended December 31, 2025

UNIT OF SERVICE (Hospice Days)	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
51,488	12,682,578	8,212,514	4,470,064	2,376,492
▲ 15%	▲ 22%	▲ 16%	▲ 35%	▲ 92%

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

METRICS BY SERVICE LINE - FY 2026

SERVICE LINE	UNIT OF SERVICE (Hospice Days)	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
Hospice	50,222	$12,173,512	$7,703,448	$4,470,064	$2,861,446
Open Arms	1,266	$509,066	$509,066	$0	($596,144)
NonCerner Total	51,488	$12,682,578	$8,212,514	$4,470,064	$2,265,302

METRICS SUMMARY - 4 YEAR TREND

METRIC	FY2023	FY2024	FY2025	Annualized FY2026	%CHANGE FROM PRIOR YR	4 YR TREND
UNIT OF SERVICE (Hospice Days)	44,843	43,572	44,826	51,488	▲ 15%	
Net Revenue	8,938,605	9,321,547	$10,395,572	$12,682,578	▲ 22%	
Direct Cost	6,332,601	$6,518,457	$7,075,446	$8,212,514	▲ 16%	
Contribution Margin	2,606,005	$2,803,090	$3,320,126	$4,470,064	▲ 35%	
Indirect Cost	1,847,031	$1,832,254	$2,141,119	$2,204,762	▲ 3%	
Net Income	758,974	$970,836	$1,179,007	$2,265,302	▲ 92%	
Net Revenue Per UOS	$199	$214	$232	$246	▲ 6%	
Direct Cost Per UOS	$141	$150	$158	$160	▲ 1%	
Contrb Margin Per UOS	$58	$64	$74	$87	▲ 17%	

GRAPHS

Notes:
Source: Non-Cerner Service Line Reports
Criteria: Hospice and Open Arms

KAWEAH HEALTH ANNUAL BOARD REPORT

Hospice Services

FY2026 Annualized

KEY METRICS - FY 2026 - The Annualized Six Months Ended December 31, 2025

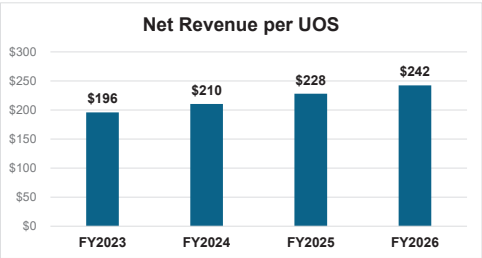
UNIT OF SERVICE (Hospice Days)	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
50,222	$12,173,512	$7,703,448	$4,470,064	$2,861,446
▲ 16%	▲ 23%	▲ 17%	▲ 35%	▲ 59%

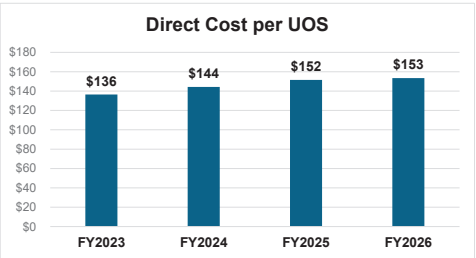
*Note: Arrows represent the change from prior year and the lines represent the 4-year trend

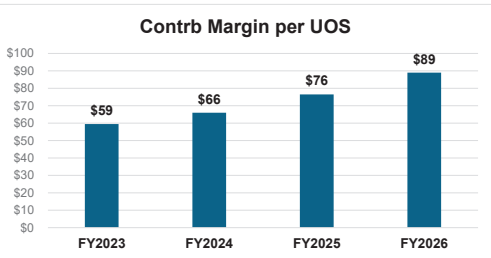
METRICS SUMMARY - 4 YEAR TREND

METRIC	FY2023	FY2024	FY2025	Annualized FY2026	%CHANGE FROM PRIOR YR	4 YR TREND
Unit of Service (Hospice Days)	43,805	42,460	43,419	50,222	▲ 16%	
Net Revenue	$8,582,828	$8,930,495	$9,901,490	$12,173,512	▲ 23%	
Direct Cost	$5,977,050	$6,128,682	$6,581,363	$7,703,448	▲ 17%	
Contribution Margin	$2,605,778	$2,801,813	$3,320,126	$4,470,064	▲ 35%	
Indirect Cost	$1,225,079	$1,235,807	$1,523,470	$1,608,618	▲ 6%	
Net Income	$1,380,699	$1,566,006	$1,796,656	$2,861,446	▲ 59%	
Net Revenue per UOS	$196	$210	$228	$242	▲ 6%	
Direct Cost per UOS	$136	$144	$152	$153	▲ 1%	
Contrb Margin per UOS	$59	$66	$76	$89	▲ 16%	

PER CASE TRENDED GRAPHS

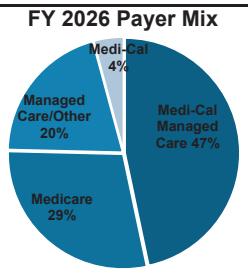




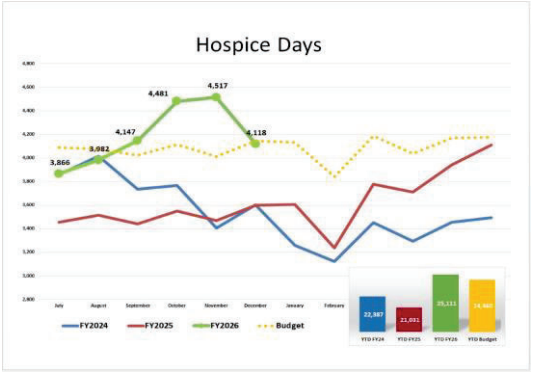


PAYER MIX - 4 YEAR TREND (Gross Charges)

PAYER	FY2023	FY2024	FY2025	FY2026
Medi-Cal Managed Care	39%	39%	39%	47%
Medicare	28%	25%	23%	29%
Managed Care/Other	23%	22%	19%	20%
Medi-Cal	9%	14%	19%	4%
Medi-Cal MC/Medi-Cal Comb	49%	53%	58%	51%



UNIT OF SERVICE GRAPH - HOSPICE DAYS TRENDED



Notes:
Source: Non-Cerner Service Line Reports
Criteria: Hospice

KAWEAH HEALTH ANNUAL BOARD REPORT

FY2026 Annualized

Hospice Services
Open Arms House

KEY METRICS - FY 2026 - The Annualized Six Months Ended December 31, 2025

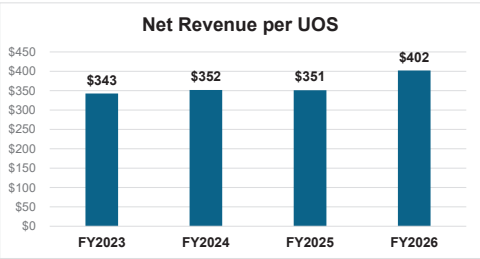
UNIT OF SERVICE (Hospice Days)	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
1,266	$509,066	$509,066	$0	($596,144)
▼ -10%	▲ 3%	▲ 3%	▶ 0%	▲ 3%

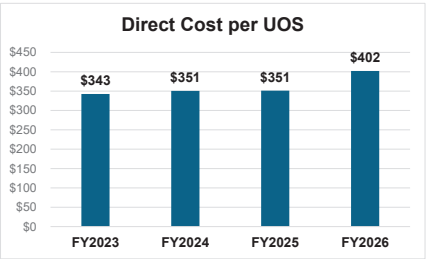
*Note: Arrows represent the change from prior year and the lines represent the 4-year trend

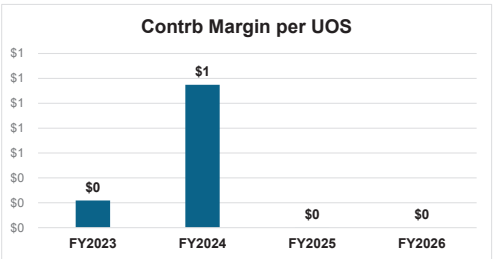
METRICS SUMMARY - 4 YEAR TREND

METRIC	FY2023	FY2024	FY2025	Annualized FY2026	%CHANGE FROM PRIOR YR	4 YR TREND
Unit of Service (Hospice Days)	1,038	1,112	1,407	1,266	▼ -10%	
Net Revenue	$355,777	$391,052	$494,082	$509,066	▲ 3%	
Direct Cost	$355,550	$389,775	$494,082	$509,066	▲ 3%	
Contribution Margin	$227	$1,277	$0	$0	▶ 0%	
Indirect Cost	$621,952	$596,447	$617,649	$596,144	▼ -3%	
Net Income	($621,725)	($595,170)	($617,649)	($596,144)	▲ 3%	
Net Revenue per UOS	$343	$352	$351	$402	▲ 15%	
Direct Cost per UOS	$343	$351	$351	$402	▲ 15%	
Contrb Margin per UOS	$0	$1	$0	$0	▶ 0%	

PER CASE TRENDED GRAPHS

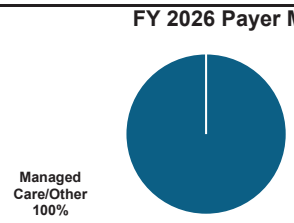




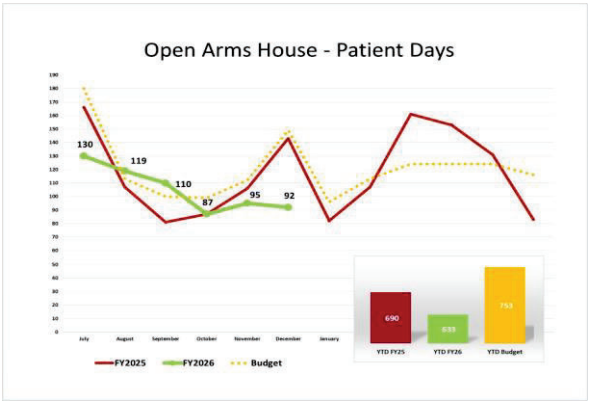


PAYER MIX - 4 YEAR TREND (Gross Charges)

PAYER	FY2023	FY2024	FY2025	FY2026
Managed Care/Other	100%	100%	100%	100%



UNIT OF SERVICE GRAPH - HOSPICE DAYS TRENDED



Notes:
Source: Non-Cerner Service Line Reports
Criteria: Open Arms House

Urology

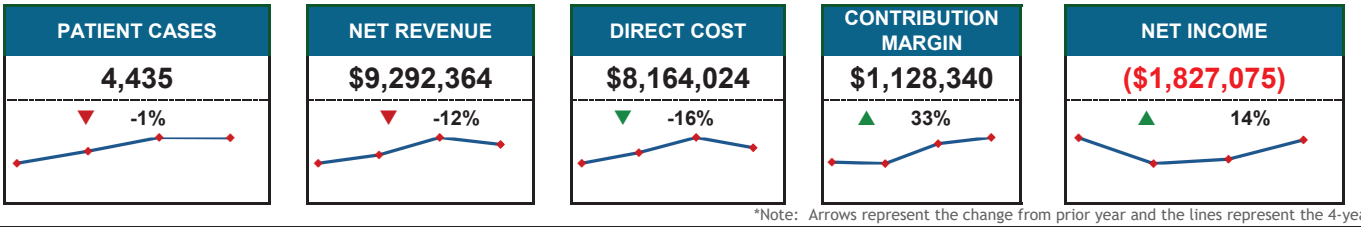
KAWEAH HEALTH ANNUAL BOARD REPORT

Urology Services - Summary

FY2025

KEY METRICS - FY 2025 - Twelve Months Ended June 30, 2025

PATIENT CASES	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
4,435	$9,292,364	$8,164,024	$1,128,340	($1,827,075)
▼ -1%	▼ -12%	▼ -16%	▲ 33%	▲ 14%



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

METRICS BY SERVICE LINE - FY 2025

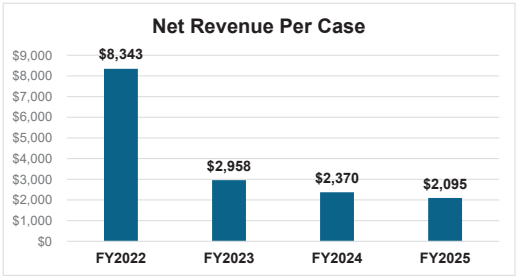
SERVICE LINE	PATIENT CASES	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
Urology Inpatient Surgery	159	$2,713,791	$2,157,032	$556,759	($143,793)
Urology Outpatient Clinic	3,551	$1,228,095	$880,252	$347,843	($405,051)
Urology Outpatient da Vinci Surgery	111	$1,130,641	$837,507	$293,134	$7,721
Urology Inpatient da Vinci Surgery	34	$720,281	$464,535	$255,746	$85,206
Urology Medical Inpatient	40	$476,077	$467,124	$8,953	($144,450)
Urology Outpatient Surgery	540	$3,023,479	$3,357,574	($334,095)	($1,226,708)
Urology Total	4,435	$9,292,364	$8,164,024	$1,128,340	($1,827,075)

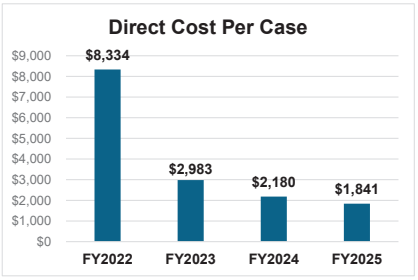
METRICS SUMMARY - 4 YEAR TREND

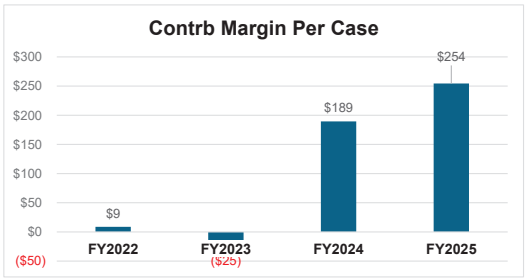
Clinic opened

METRIC	FY2022	FY2023	FY2024	FY2025	%CHANGE FROM PRIOR YR	4 YR TREND
PATIENT CASES	689	2,479	4,481	4,435 ▼	-1%	
Net Revenue	$5,748,320	$7,332,670	$10,619,506	$9,292,364 ▼	-12%	
Direct Cost	$5,742,329	$7,393,837	$9,770,490	$8,164,024 ▼	-16%	
Additional Reimbursement	$6,874	$483,422	$549,109	$578,357 ▲	5%	
Contribution Margin	$5,991	($61,167)	$849,016	$1,128,340 ▲	33%	
Indirect Cost	$1,797,937	$2,132,407	$2,973,877	$2,955,415 ▼	-1%	
Net Income	($1,791,947)	($2,193,574)	($2,124,861)	($1,827,075) ▲	14%	
Net Revenue Per Case	$8,343	$2,958	$2,370	$2,095 ▼	-12%	
Direct Cost Per Case	$8,334	$2,983	$2,180	$1,841 ▼	-16%	
Contrb Margin Per Case	$9	($25)	$189	$254 ▲	34%	

GRAPHS







Source: Inpatient and Outpatient Service Line Reports
Criteria: Surgeon Specialty = Urology, Surgery Flag/DaVinci Flag valued at "1", meaning patient had a charge out of department 7420/7421.
IP SLR = "Urology" and Med Vs Surg = "M" for Medical & OP Service Line = Urology Clinic

KAWEAH HEALTH ANNUAL BOARD REPORT

FY2025

Urology Services - IP Summary

KEY METRICS - FY 2025 - Twelve Months Ended June 30, 2025

PATIENT CASES	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
233	$3,910,149	$3,088,691	$821,458	($203,037)
▼ -15%	▼ -21%	▼ -13%	▼ -42%	▼ -167%

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

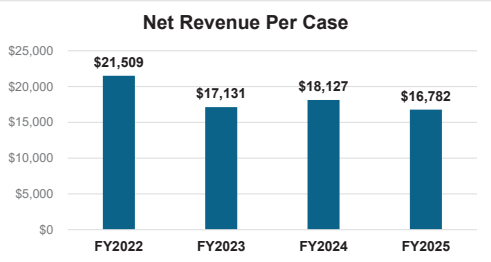
METRICS BY SERVICE LINE - FY 2025

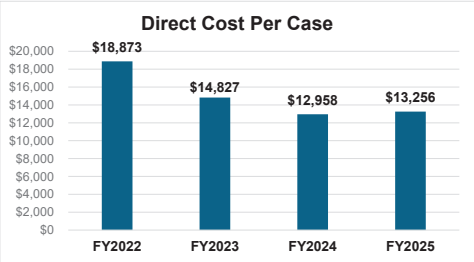
SERVICE LINE	PATIENT CASES	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
Urology Inpatient Surgery	159	$2,713,791	$2,157,032	$556,759	($143,793)
Urology Inpatient da Vinci Surgery	34	$720,281	$464,535	$255,746	$85,206
Urology Medical Inpatient	40	$476,077	$467,124	$8,953	($144,450)
Inpatient Urology Total	233	$3,910,149	$3,088,691	$821,458	($203,037)

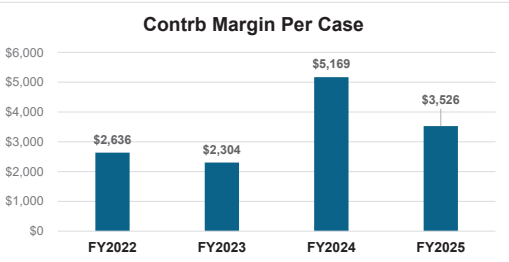
METRICS SUMMARY - 4 YEAR TREND

METRIC	FY2022	FY2023	FY2024	FY2025	%CHANGE FROM PRIOR YR	4 YR TREND
PATIENT CASES	139	225	274	233 ▼	-15%	
Net Revenue	$2,989,755	$3,854,483	$4,966,671	$3,910,149 ▼	-21%	
Direct Cost	$2,623,384	$3,336,177	$3,550,401	$3,088,691 ▼	-13%	
Additional Reimbursement	$6,874	$472,407	$525,428	$512,085 ▼	-3%	
Contribution Margin	$366,371	$518,306	$1,416,270	$821,458 ▼	-42%	
Indirect Cost	$844,599	$1,125,220	$1,111,040	$1,024,495 ▼	-8%	
Net Income	($478,229)	($606,913)	$305,230	($203,037) ▼	-167%	
Net Revenue Per Case	$21,509	$17,131	$18,127	$16,782 ▼	-7%	
Direct Cost Per Case	$18,873	$14,827	$12,958	$13,256 ▲	2%	
Contrb Margin Per Case	$2,636	$2,304	$5,169	$3,526 ▼	-32%	

GRAPHS







Source: Inpatient Service Line Reports
Criteria: Surgeon Specialty = Urology, Surgery Flag/DaVinci Flag valued at "1", meaning patient had a charge out of department 7420/7421.
IP SLR = "Urology" and Med Vs Surg = "M" for Medical

KAWEAH HEALTH ANNUAL BOARD REPORT

FY2025

Urology Services - OP Summary

KEY METRICS - FY 2025 - Twelve Months Ended June 30, 2025

PATIENT CASES	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
4,202	$5,382,215	$5,075,333	$306,882	($1,624,038)
▶ 0%	▼ -5%	▼ -18%	▲ 154%	▲ 33%

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

METRICS BY SERVICE LINE - FY 2025

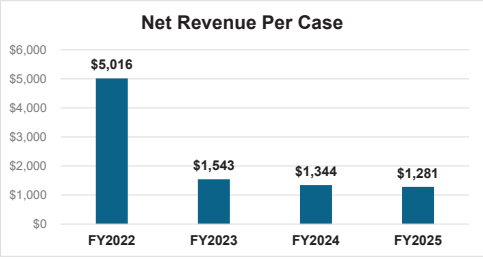
SERVICE LINE	PATIENT CASES	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
Urology Outpatient Clinic	3,551	$1,228,095	$880,252	$347,843	($405,051)
Urology Outpatient da Vinci Surgery	111	$1,130,641	$837,507	$293,134	$7,721
Urology Outpatient Surgery	540	$3,023,479	$3,357,574	($334,095)	($1,226,708)
Outpatient Urology Total	4,202	$5,382,215	$5,075,333	$306,882	($1,624,038)

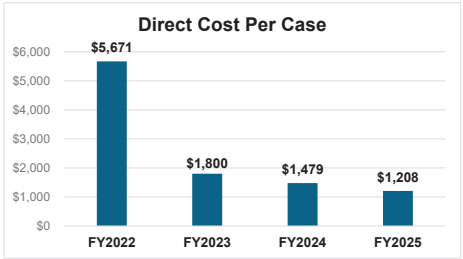
METRICS SUMMARY - 4 YEAR TREND

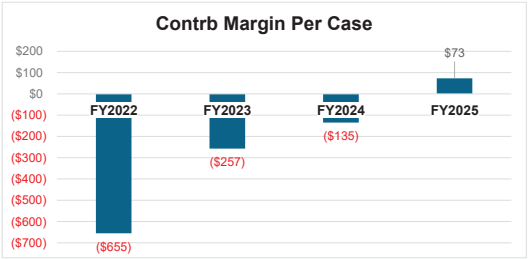
CLINIC OPENED

METRIC	FY2022	FY2023	FY2024	FY2025	%CHANGE FROM PRIOR YR	4 YR TREND
PATIENT CASES	550	2,254	4,207	4,202	0%	
Net Revenue	$2,758,565	$3,478,187	$5,652,835	$5,382,215	-5%	
Direct Cost	$3,118,945	$4,057,660	$6,220,089	$5,075,333	-18%	
Additional Reimbursement	$0	$11,015	$23,681	$66,272	180%	
Contribution Margin	($360,380)	($579,473)	($567,254)	$306,882	154%	
Indirect Cost	$953,338	$1,007,187	$1,862,837	$1,930,920	4%	
Net Income	($1,313,718)	($1,586,660)	($2,430,091)	($1,624,038)	33%	
Net Revenue Per Case	$5,016	$1,543	$1,344	$1,281	-5%	
Direct Cost Per Case	$5,671	$1,800	$1,479	$1,208	-18%	
Contrb Margin Per Case	($655)	($257)	($135)	$73	154%	

GRAPHS







Source: Outpatient Service Line Reports
Criteria: Surgeon Specialty = Urology, Surgery Flag/DaVinci Flag valued at "1", meaning patient had a charge out of department 7420/7421.
& Service Line = Urology Clinic

KAWEAH HEALTH ANNUAL BOARD REPORT

Urology Services - Inpatient Urologist Surgeries

FY2025

Surgery Flag = ALL, Da Vinci Flag =0

KEY METRICS - FY 2025 - Twelve Months Ended June 30, 2025

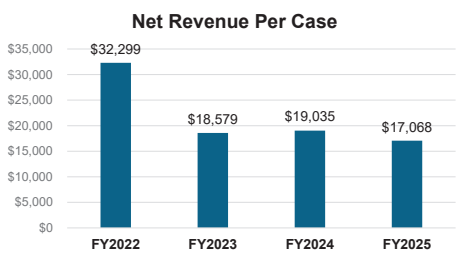
PATIENT CASES	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
159	$2,713,791	$2,157,032	$556,759	($143,793)
▼ -4%	▼ -14%	▼ -11%	▼ -23%	▼ -453%

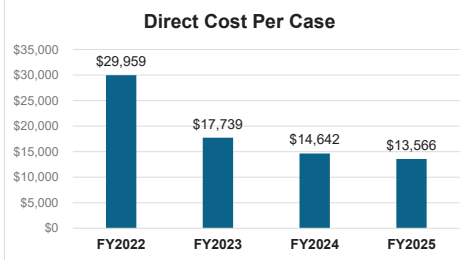
*Note: Arrows represent the change from prior year and the lines represent the 4-year trend

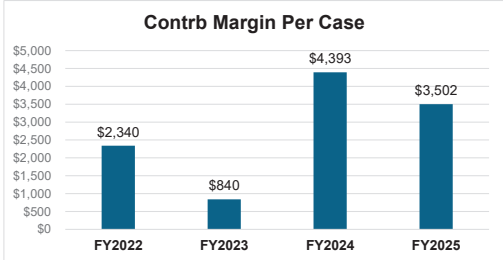
METRICS SUMMARY - 4 YEAR TREND

METRIC	FY2022	FY2023	FY2024	FY2025	%CHANGE FROM PRIOR YR	4 YR TREND
Patient Cases	47	129	165	159 ▼	-4%	
Patient Days	435	917	871	632 ▼	-27%	
ALOS	9.3	7.1	5.3	4.0 ▼	-25%	
GM LOS	5.6	3.9	3.7	3.5 ▼	-5%	
Net Revenue	$1,518,035	$2,396,729	$3,140,812	$2,713,791 ▼	-14%	
Direct Cost	$1,408,054	$2,288,311	$2,415,921	$2,157,032 ▼	-11%	
Additional Reimbursemen	$1,775	$361,612	$457,845	$403,010 ▼	-12%	
Contribution Margin	$109,981	$108,418	$724,891	$556,759 ▼	-23%	
Indirect Cost	$399,618	$744,230	$750,874	$700,552 ▼	-7%	
Net Income	($289,637)	($635,812)	($25,983)	($143,793) ▼	-453%	
Net Revenue Per Case	$32,299	$18,579	$19,035	$17,068 ▼	-10%	
Direct Cost Per Case	$29,959	$17,739	$14,642	$13,566 ▼	-7%	
Contrb Margin Per Case	$2,340	$840	$4,393	$3,502 ▼	-20%	
ALOS Opportunity	3.7	3.2	1.6	0.5 ▼	-69%	

PER CASE TRENDED GRAPHS

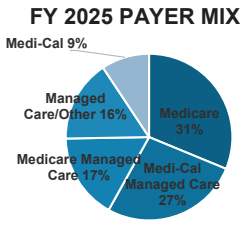






PAYER MIX - 4 YEAR TREND - (based on charges)

PAYER	FY2022	FY2023	FY2024	FY2025
Medicare	28%	30%	28%	31%
Medi-Cal Managed Care	6%	25%	32%	27%
Medicare Managed Care	50%	15%	13%	17%
Managed Care/Other	11%	20%	19%	16%
Medi-Cal	0%	9%	7%	9%



Notes:
Source: Inpatient Service Line Reports
Criteria: Surgeon Specialty = Urology, Surgery Flag = All and DaVinci Flag valued at "0".

KAWEAH HEALTH ANNUAL BOARD REPORT

Urology Services - Inpatient Urology Specialty daVinci Cases

FY2025

Surgery Flag = 0, Da Vinci Flag =1

KEY METRICS - FY 2025 - Twelve Months Ended June 30, 2025

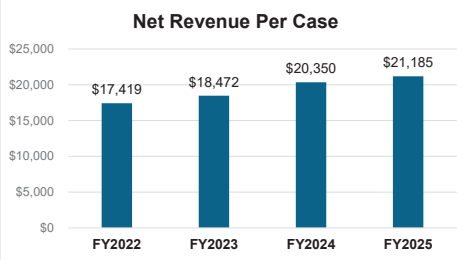
PATIENT CASES	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
34	$720,281	$464,535	$255,746	$85,206
▼ -41%	▼ -39%	▼ -39%	▼ -39%	▼ -52%

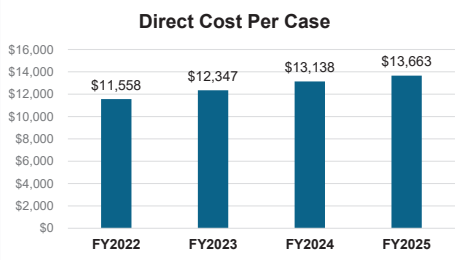
*Note: Arrows represent the change from prior year and the lines represent the 4-year trend

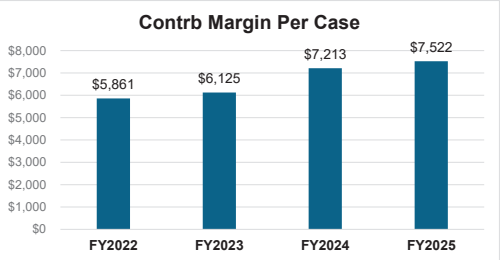
METRICS SUMMARY - 4 YEAR TREND

METRIC	FY2022	FY2023	FY2024	FY2025	%CHANGE FROM PRIOR YR	4 YR TREND
Patient Cases	71	62	58	34 ▼	-41%	
Patient Days	194	185	206	112 ▼	-46%	
ALOS	2.7	3.0	3.6	3.3 ▼	-7%	
GM LOS	3.1	3.1	2.7	3.2 ▲	17%	
Net Revenue	$1,236,744	$1,145,255	$1,180,327	$720,281 ▼	-39%	
Direct Cost	$820,588	$765,522	$761,991	$464,535 ▼	-39%	
Additional Reimbursement	($33,512)	$63,085	($11,655)	$31,223 ▲	368%	
Contribution Margin	$416,156	$379,733	$418,336	$255,746 ▼	-39%	
Indirect Cost	$340,388	$289,421	$242,387	$170,540 ▼	-30%	
Net Income	$75,768	$90,312	$175,949	$85,206 ▼	-52%	
Net Revenue Per Case	$17,419	$18,472	$20,350	$21,185 ▲	4%	
Direct Cost Per Case	$11,558	$12,347	$13,138	$13,663 ▲	4%	
Contrb Margin Per Case	$5,861	$6,125	$7,213	$7,522 ▲	4%	
ALOS Opportunity	(0.4)	(0.1)	0.8	0.1 ▼	-87%	

PER CASE TRENDED GRAPHS

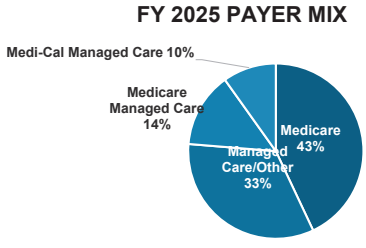






PAYER MIX - 4 YEAR TREND - (based on charges)

PAYER	FY2022	FY2023	FY2024	FY2025
Medicare	51%	56%	42%	43%
Managed Care/Other	20%	24%	25%	33%
Medicare Managed Care	29%	14%	31%	14%
Medi-Cal Managed Care	0%	3%	2%	10%



Notes:
Source: Inpatient Service Line Reports
Criteria: Surgeon Specialty = Urology, Surgery Flag = 0 and DaVinci Flag valued at "1".

KAWEAH HEALTH ANNUAL BOARD REPORT

Urology Services - Inpatient Urology Medical

FY2025

KEY METRICS - FY 2025 - Twelve Months Ended June 30, 2025

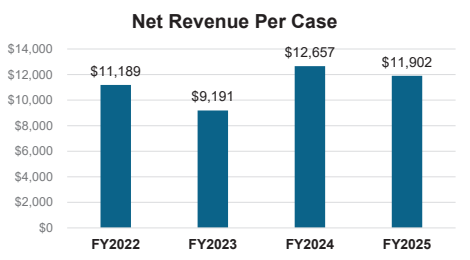
PATIENT CASES	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
40	$476,077	$467,124	$8,953	($144,450)
▼ -22%	▼ -26%	▲ 25%	▼ -97%	▼ -193%

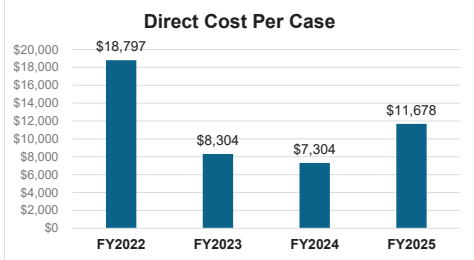
*Note: Arrows represent the change from prior year and the lines represent the 4-year trend

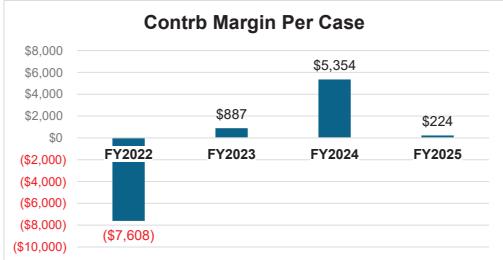
METRICS SUMMARY - 4 YEAR TREND

METRIC	FY2022	FY2023	FY2024	FY2025	%CHANGE FROM PRIOR YR	4 YR TREND
Patient Cases	21	34	51	40 ▼	-22%	
Patient Days	212	147	184	225 ▲	22%	
ALOS	10.1	4.3	3.6	5.6 ▲	56%	
GM LOS	3.1	2.6	2.7	3.0 ▲	13%	
Net Revenue	$234,976	$312,499	$645,532	$476,077 ▼	-26%	
Direct Cost	$394,742	$282,344	$372,489	$467,124 ▲	25%	
Additional Reimbursemen	$38,611	$47,710	$79,238	$77,852 ▼	-2%	
Contribution Margin	($159,767)	$30,155	$273,043	$8,953 ▼	-97%	
Indirect Cost	$104,593	$91,569	$117,779	$153,403 ▲	30%	
Net Income	($264,360)	($61,413)	$155,264	($144,450) ▼	-193%	
Net Revenue Per Case	$11,189	$9,191	$12,657	$11,902 ▼	-6%	
Direct Cost Per Case	$18,797	$8,304	$7,304	$11,678 ▲	60%	
Contrb Margin Per Case	($7,608)	$887	$5,354	$224 ▼	-96%	
ALOS Opportunity	7.0	1.7	0.9	2.6 ▲	181%	

PER CASE TRENDED GRAPHS

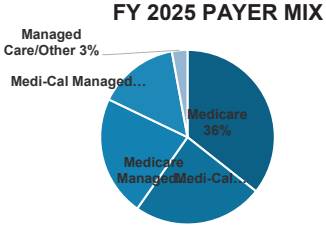






PAYER MIX - 4 YEAR TREND - (based on charges)

PAYER	FY2022	FY2023	FY2024	FY2025
Medicare	81%	28%	30%	36%
Medi-Cal	10%	1%	3%	24%
Medicare Managed Care	0%	27%	7%	22%
Medi-Cal Managed Care	5%	31%	24%	15%
Managed Care/Other	4%	14%	33%	3%



Notes:
Source: Inpatient Service Line Reports
Criteria: ServiceLine1Mne = Urology and EncTypeMne= IP and Surg Vs Medical = M for Medical with encounters in the Main Hospital (Kaweah Health Medical Center)

KAWEAH HEALTH ANNUAL BOARD REPORT

Urology Services - Outpatient Urology Surgical Cases

FY2025

Surgery Flag = 1, Da Vinci Flag =0

KEY METRICS - FY 2025 - Twelve Months Ended June 30, 2025

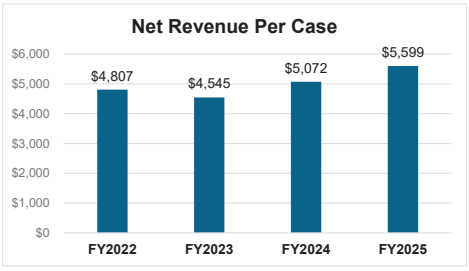
PATIENT CASES	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
540	$3,023,479	$3,357,574	($334,095)	($1,226,708)
▼ -20%	▼ -12%	▼ -20%	▲ 56%	▲ 31%

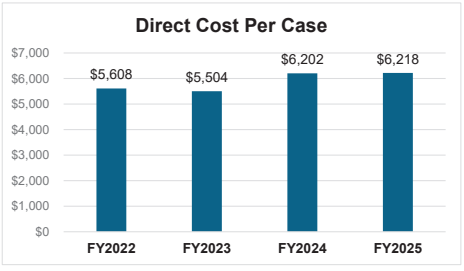
*Note: Arrows represent the change from prior year and the lines represent the 4-year trend

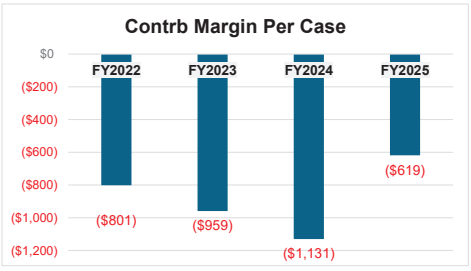
METRICS SUMMARY - 4 YEAR TREND

METRIC	FY2022	FY2023	FY2024	FY2025	%CHANGE FROM PRIOR YR	4 YR TREND
Patient Cases	487	527	678	540 ▼	-20%	
Net Revenue	$2,341,033	$2,395,012	$3,438,532	$3,023,479 ▼	-12%	
Direct Cost	$2,731,273	$2,900,455	$4,205,022	$3,357,574 ▼	-20%	
Additional Reimbursemen	$0	$1,885	$8,506	$5,253 ▼	-38%	
Contribution Margin	($390,240)	($505,443)	($766,490)	($334,095) ▲	56%	
Indirect Cost	$762,203	$785,379	$999,065	$892,613 ▼	-11%	
Net Income	($1,152,443)	($1,290,822)	($1,765,555)	($1,226,708) ▲	31%	
Net Revenue Per Case	$4,807	$4,545	$5,072	$5,599 ▲	10%	
Direct Cost Per Case	$5,608	$5,504	$6,202	$6,218 ▶	0%	
Contrb Margin Per Case	($801)	($959)	($1,131)	($619) ▲	45%	

PER CASE TRENDED GRAPHS

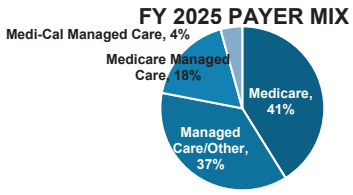






PAYER MIX - 4 YEAR TREND - (Based on Volume)

PAYER	FY2022	FY2023	FY2024	FY2025
Medicare	42%	40%	37%	41%
Managed Care/Other	39%	38%	39%	37%
Medicare Managed Care	19%	17%	17%	18%
Medi-Cal Managed Care	0%	3%	5%	4%



Notes:
Source: Outpatient Service Line Reports
Criteria: Surgeon Specialty = Urology, Surgery Flag = All and DaVinci Flag valued at "0".

KAWEAH HEALTH ANNUAL BOARD REPORT

Urology Services - Outpatient Urology daVinci Cases

FY2025

Surgery Flag = 0, Da Vinci Flag =1

KEY METRICS - FY 2025 - Twelve Months Ended June 30, 2025

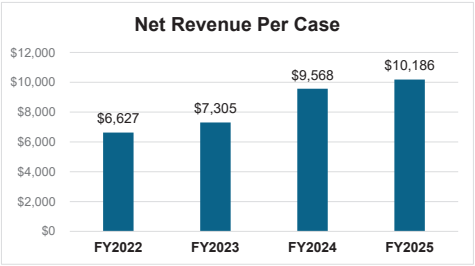
PATIENT CASES	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
111	$1,130,641	$837,507	$293,134	$7,721
▲ 4%	▲ 10%	▲ 7%	▲ 20%	▲ 18%

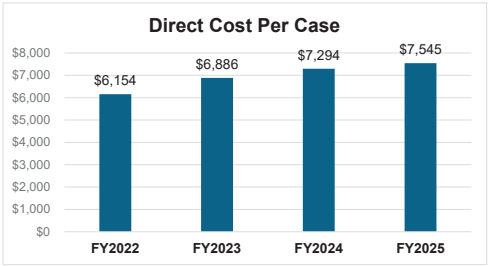
*Note: Arrows represent the change from prior year and the lines represent the 4-year trend

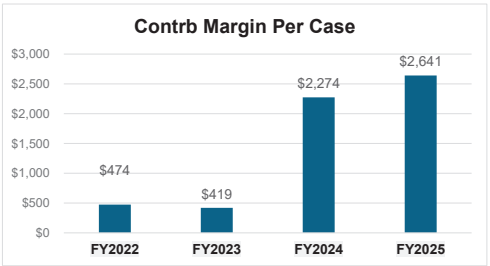
METRICS SUMMARY - 4 YEAR TREND

METRIC	FY2022	FY2023	FY2024	FY2025	%CHANGE FROM PRIOR YR	4 YR TREND
Patient Cases	63	81	107	111	▲ 4%	
Net Revenue	$417,532	$591,722	$1,023,775	$1,130,641	▲ 10%	
Direct Cost	$387,672	$557,763	$780,490	$837,507	▲ 7%	
Contribution Margin	$29,860	$33,959	$243,285	$293,134	▲ 20%	
Indirect Cost	$191,135	$217,255	$236,762	$285,413	▲ 21%	
Net Income	($161,275)	($183,296)	$6,523	$7,721	▲ 18%	
Net Revenue Per Case	$6,627	$7,305	$9,568	$10,186	▲ 6%	
Direct Cost Per Case	$6,154	$6,886	$7,294	$7,545	▲ 3%	
Contrb Margin Per Case	$474	$419	$2,274	$2,641	▲ 16%	

PER CASE TRENDED GRAPHS

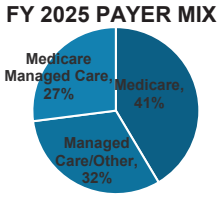






PAYER MIX - 4 YEAR TREND - (based on charges)

PAYER	FY2022	FY2023	FY2024	FY2025
Medicare	29%	48%	34%	41%
Managed Care/Other	40%	31%	37%	32%
Medicare Managed Care	32%	21%	28%	27%



Notes:
Source: Outpatient Service Line Reports
Criteria: Surgeon Specialty = Urology, Surgery Flag = 0 and DaVinci Flag valued at "1".

KAWEAH HEALTH ANNUAL BOARD REPORT

Urology Services - Outpatient Urology Clinic

FY2025

KEY METRICS - FY 2025 - Twelve Months Ended June 30, 2025

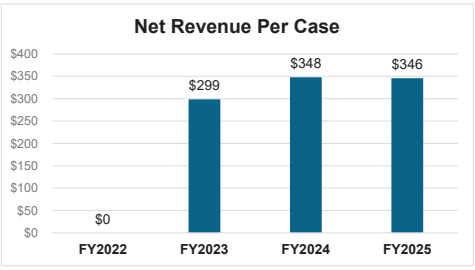
PATIENT CASES	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
3,551	$1,228,095	$880,252	$347,843	($405,051)
▲ 4%	▲ 3%	▼ -29%	▲ 890%	▲ 40%

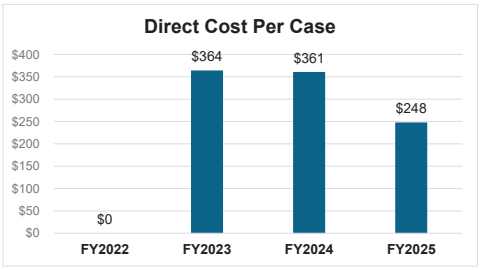
*Note: Arrows represent the change from prior year and the lines represent the 4-year trend

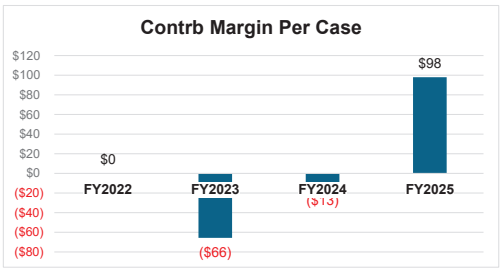
METRICS SUMMARY - 4 YEAR TREND

METRIC	FY2022	FY2023	FY2024	FY2025	%CHANGE FROM PRIOR YR	4 YR TREND
Patient Cases	0	1,646	3,422	3,551	▲ 4%	
Net Revenue	$0	$491,453	$1,190,528	$1,228,095	▲ 3%	
Direct Cost	$0	$599,442	$1,234,577	$880,252	▼ -29%	
Additional Reimbursemen	$0	$9,130	$15,175	$61,019	▲ 302%	
Contribution Margin	$0	($107,989)	($44,049)	$347,843	▲ 890%	
Indirect Cost	$0	$4,553	$627,010	$752,894	▲ 20%	
Net Income	$0	($112,542)	($671,059)	($405,051)	▲ 40%	
Net Revenue Per Case	$0	$299	$348	$346	▼ -1%	
Direct Cost Per Case	$0	$364	$361	$248	▼ -31%	
Contrb Margin Per Case	$0	($66)	($13)	$98	▲ 861%	

PER CASE TRENDED GRAPHS

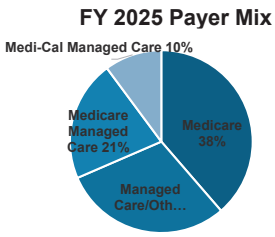






PAYER MIX - 4 YEAR TREND - (based on volume)

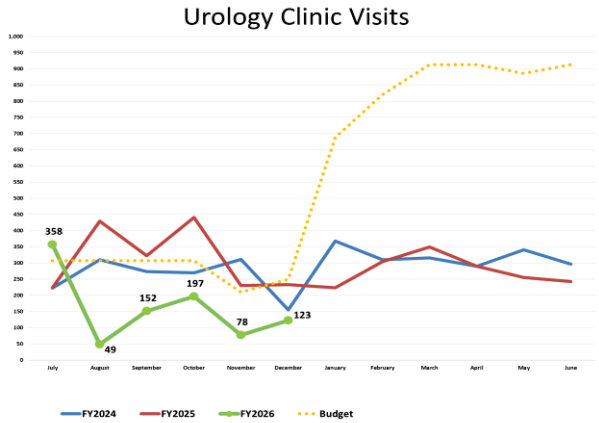
PAYER	FY2022	FY2023	FY2024	FY2025
Medicare	0%	31%	37%	38%
Managed Care/Other	0%	38%	33%	30%
Medicare Managed Care	0%	15%	21%	21%
Medi-Cal Managed Care	0%	14%	8%	10%



KAWEAH HEALTH ANNUAL BOARD REPORT

FY2025

Urology Services - Outpatient Urology Clinic



Notes:
Source: Outpatient Service Line Reports
Selection Criteria: Service Line1 = Urology Clinic

Quarterly Compliance Program Activity Report

Compliance Program Activity Report – Open Session

November 2025 through December 2025

Ben Cripps, Chief Compliance & Risk Officer

Education

Live Presentations

- Compliance and Patient Privacy – New Hire Orientation
- Compliance and Patient Privacy – Management Orientation
- PolicyTech System – Various Policy Reviewers, Approvers, and Owners
- Preventive Compliance Process – Various Department Leaders

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

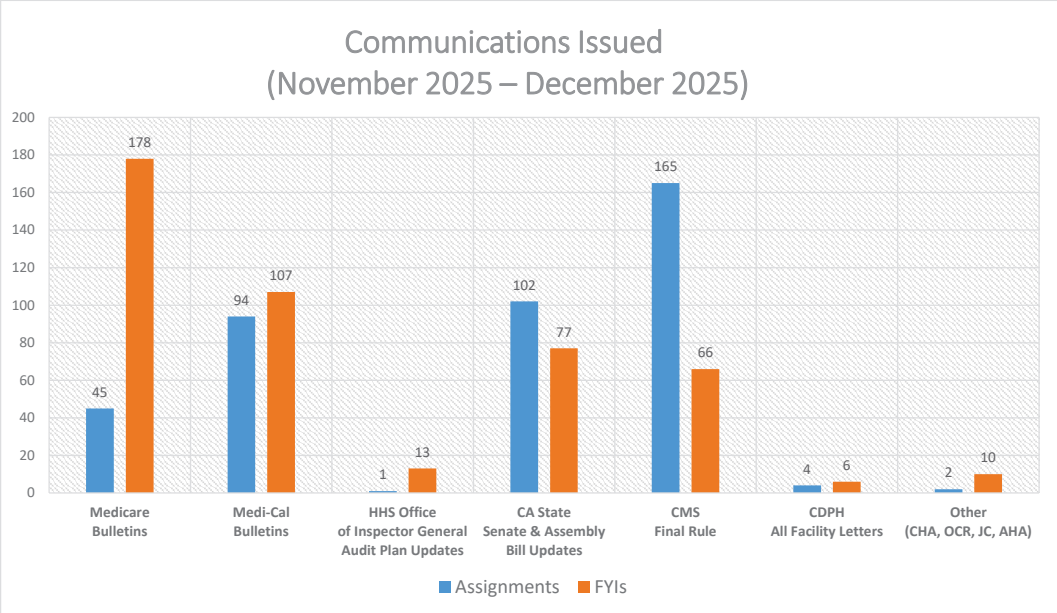
- Compliance Matters – Preventive Compliance Process

Prevention & Detection

- Review, Track, and Distribute Relevant Information Related to Regulatory Updates to Stakeholder Across the District
  - California Department of Public Health (CDPH) All Facility Letters (AFL)
  - Medicare Monthly Bulletins
  - Medi-Cal Monthly Bulletin
  - US HHS Office of Inspector General (OIG) Monthly Audit Plan Updates
  - California State Senate and Assembly Bill Updates
  - US HHS Office of Civil Rights Activities and Focus Areas
  - California Hospital Association Communications
  - American Hospital Association Communications
  - Joint Commission Communications

- Centers for Medicare and Medicaid Services (CMS) Final Rule – Review and distribution of the 2026 CMS Final Rules for Inpatient Prospective Payment System (IPPS), Outpatient Prospective Payment System (OPPS), Inpatient Psychiatric Facility (IPF), Inpatient Rehabilitation Facility (IRF), Skilled Nursing Facility (SNF) Prospective Payment System, Home Health Prospective Payment System, Hospice Wage Index and Payment Rate Update and Quality Reporting Program Requirements, Physician Fee Schedule (PFS), and End Stage Renal Disease (ESRD) Prospective Payment System.

Prevention & Detection - Issuance



Total Assignments: 413

Total FYIs: 457

Oversight

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

- Licensing Applications and Medicare/Medi-Cal Facility Enrollment – Forms preparation and submission of licensing applications to the California Department of Public Health (CDPH) and enrollment applications for Medicare or Medi-Cal. Ongoing communications and follow-up regarding status of pending applications.
  - Eleven (11) applications related to licensure were submitted.
  - Thirteen (13) applications for government payor enrollment and/or information were submitted.

- DHCS Documentation Audit and Onsite Visit for Medi-Cal Enrollment
  - SRCC Hanford Medical Oncology – Successful documentation audit and site visit, enrollment pending

Oversight

- Medicare Recovery Audit Contractor (RAC) Activity – Records preparation, tracking appeal timelines, and reporting
  - The following RAC Audit Activity took place between November 2025 – December 2025:
    - New Requests: Sixty-three (63) new RAC record requests were received.
    - Previously Open/Ongoing Requests:
      - Twelve (12) were reviewed and closed with no recovery after review of the medical records submitted
      - Twenty (20) were denied and are pending a decision from Care Management
      - Thirty-three (33) have had records submitted and are pending review by the RAC
      - Two (2) are pending a decision from Coding on whether to appeal to Level 1 with Noridian
      - Three (3) are closed and pending demand letter by the RAC
      - Two (2) are pending a response by the RAC on Kaweah's discussion request.

Policies and Procedures and Program Related Processes:

- Compliance and Privacy Related Document Reviews and Revisions:
  - Code of Conduct Revision
    - Revise the CEO's message on Page 4 to remove Gary Herbst's information and replace with Marc Mertz's information.
    - Replace Kaweah Delta with Kaweah Health throughout document.
  - District Privacy Manual Development
    - Compliance Department to create a District Privacy Manual in policy and procedure system and move privacy-related policies from the AP Manual to the newly created District Privacy Manual.

(*See attached request for Recommendation of Board action*)

Auditing and Monitoring

- Electronic Medical Record (EMR) User Access Privacy Audits – Daily monitoring of EMR user access through the use of FairWarning electronic monitoring technology which analyzes user and patient data to detect potential privacy violations
  - Average of one hundred and forty (140) daily alerts received and reviewed between November 1, 2025 – December 31, 2025.
  - Types of Alerts Reviewed:
    - Same Last Name: 75.5%
    - Co-Worker: 22.5%
    - VIP: 1.4%
    - Self-Access: 0.1%
    - Same Household: 0.5%

- Office of Inspector General (OIG) Exclusion Report Verification – Quarterly monitoring of OIG exclusion reports and attestations.
  - Medical Staff and Advanced Practice Providers – Review of reports and certification by Medical Staff Office that screening was completed and no Excluded Individuals or Entities were identified.
  - Suppliers – Review of reports and certification by the Finance Department that screening was completed and no Excluded Individuals or Entities were identified.
  - Two (2) non-credentialed providers were identified on the Medicare Opt-Out list from November – December 2025. Findings were tracked and logged into the system. No additional action was required as providers were only referring and not treating.

The pursuit of healthiness

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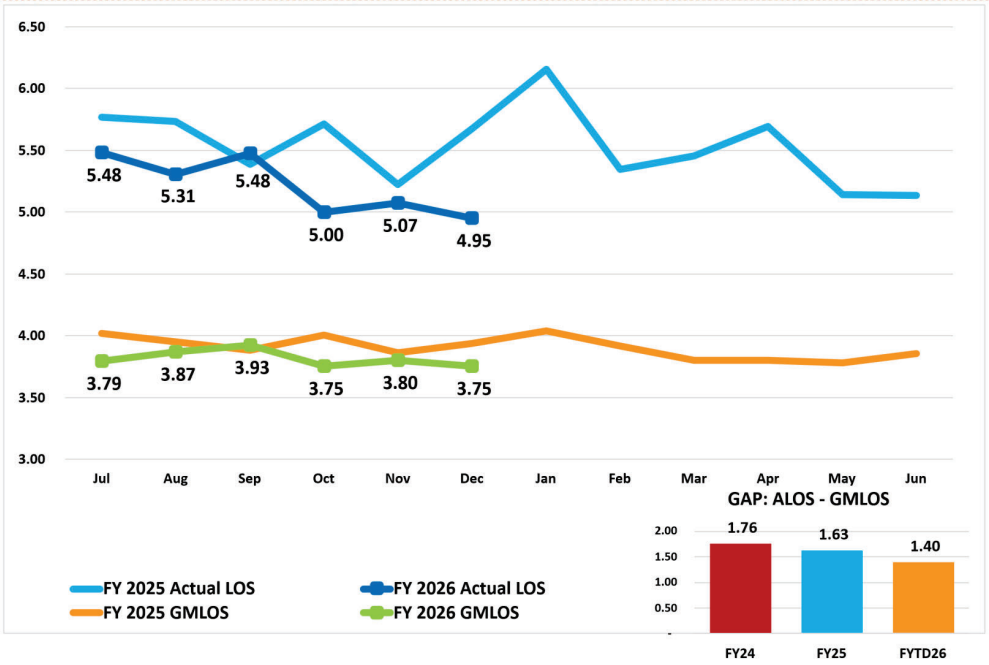
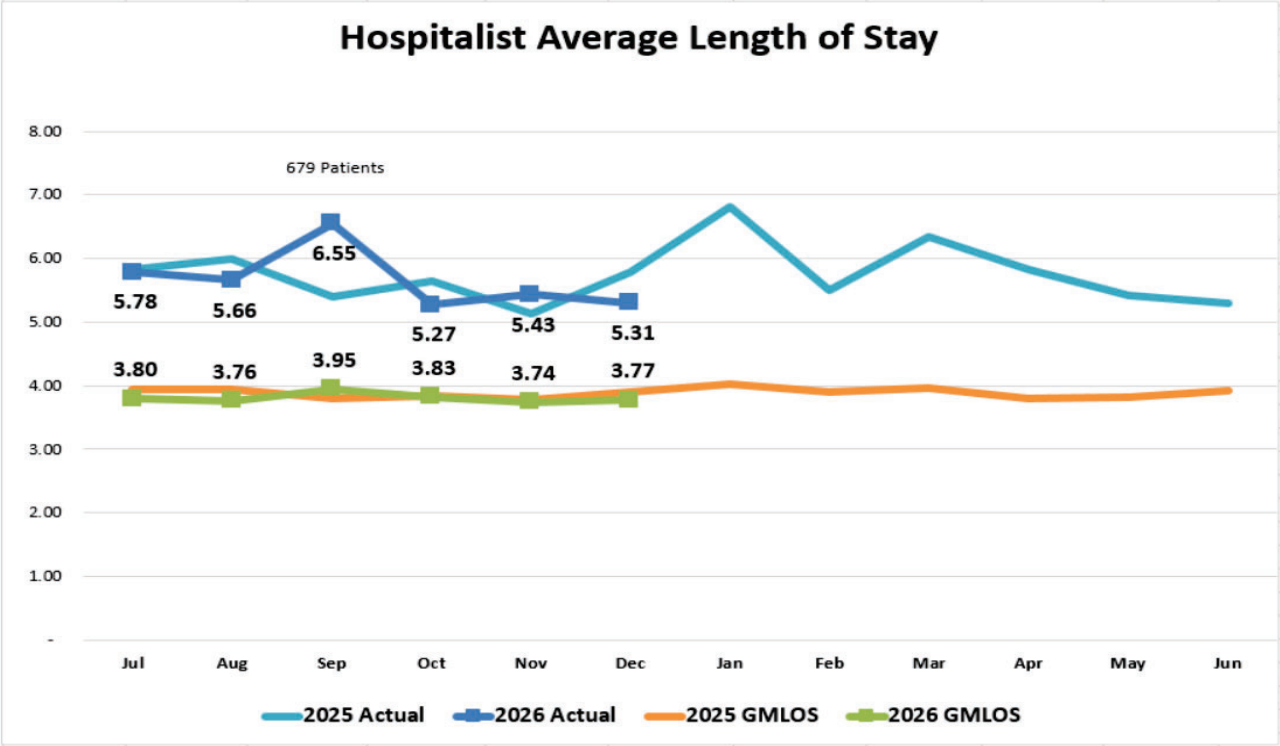
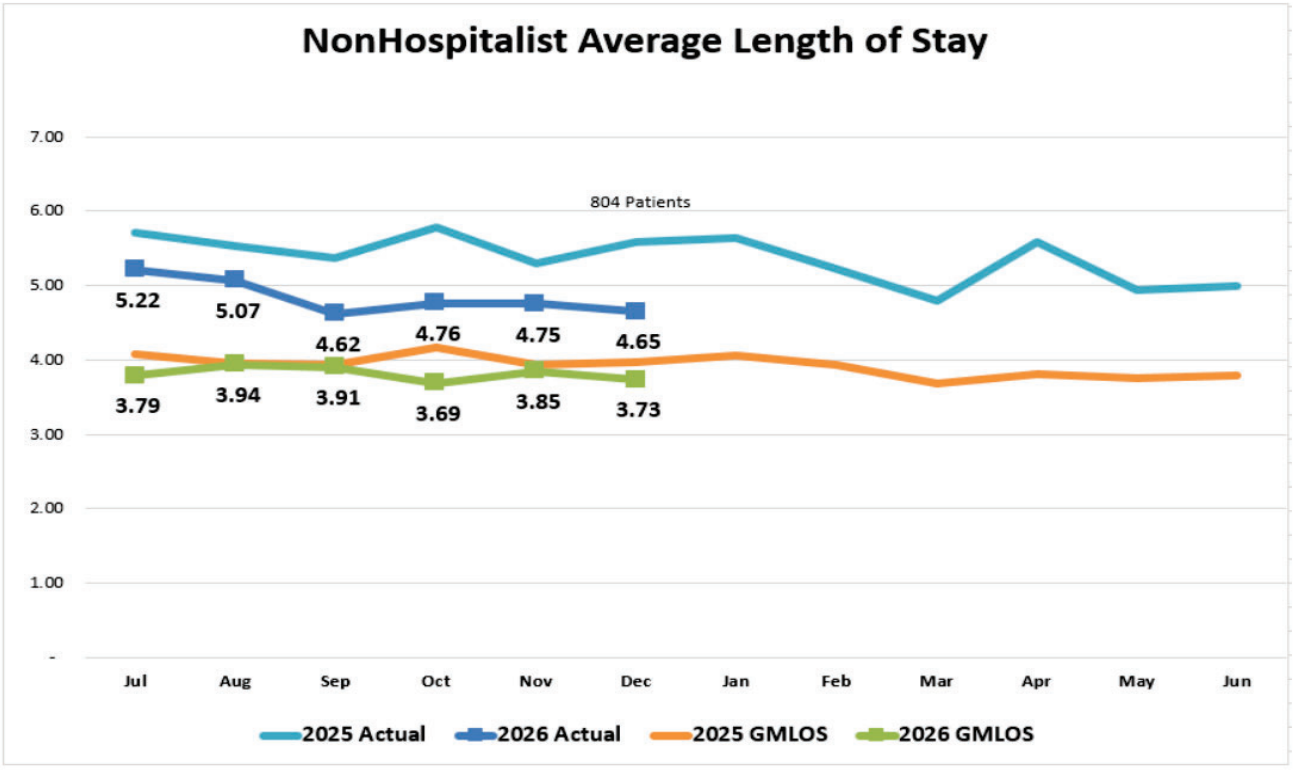
Length of Stay

Average Length of Stay versus National Average (GMLOS)




Hospitalist Average Length of Stay
8.00
7.00
6.00
5.00
4.00
3.00
2.00
1.00
-
679 Patients
5.78
5.66
6.55
5.27
5.43
5.31
3.80
3.76
3.95
3.83
3.74
3.77
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun
2025 Actual
2026 Actual
2025 GMLOS
2026 GMLOS


NonHospitalist Average Length of Stay
804 Patients
7.00
6.00
5.00
4.00
3.00
2.00
1.00
-
5.22
5.07
4.62
4.76
4.75
4.65
3.79
3.94
3.91
3.69
3.85
3.73
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun
2025 Actual
2026 Actual
2025 GMLOS
2026 GMLOS

Future Standing Reports starting February 2026

- Patient Transportation-Cameron Beatty
- Non-CM driven discharge processes-Emma Mozier
- OBS LOS 2S-Bre Mercer
- ED to Inpatient-Cameron Beatty
- Physician Rounding Per Diem-Dr Said
- EVS Per Diem-Denice and/or Rebecca Ceballos
- Discharge Processes-Amandeep Kaur
- Key Medical Throughput-Lorraine Simms
- SAMG LOS--TBD

January 14, 2026

Kaweah Delta Health Care District
Board of Directors Committee
Meeting Minutes

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

Patient Experience Committee – OPEN MEETING
Wednesday, January 14, 2026
Kaweah Health Medical Center – Executive Office Conference Room

Present: Director: Armando Murrieta; Marc Mertz, Chief Executive Officer; Deborah Volosin, Director of Patient & Community Experience; Sintayehu Yirgu, Patient Experience Advocate; Teresa Bobadilla, Patient Experience Data Analyst; Marlo Montejano, Patient Experience Liaison; and Lisette Mariscal, Recording

CALL TO ORDER – This meeting was called to order at 4:00 PM by Armando Murrieta.

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

MINUTES – The minutes from the November 2025 meeting were reviewed.

PATIENT EXPERIENCE –

1.1. Deborah Volosin provided a report on the current phases of the Patient Experience initiative. (see Attachment 1.1. of the agenda)

1.2. Teresa Bobadilla shared year-to-date HCAHPS trends across various areas of the organization. (see Attachment 1.2. of the agenda)

1.3. Teresa Bobadilla reviewed the inpatient unit percentile performance. (see Attachment 1.3. of the agenda)

1.4.– 1.7. Sintayehu Yirgu and Marlo Montejano reported on patient experience rounding, MIDAS, lost belongings, and service alerts metrics for the month of December. (see Attachment 1.4. – 1.7 of the agenda)

1.8. The Patient Experience team presented findings and data collected through the *What Matters to You* initiative. (see Attachment 1.8. of the agenda)

1.9. Discussion on this item was deferred.

Adjourned at 4:50 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.

January 21, 2026

Kaweah Delta Health Care District
Board of Directors Committee Meeting

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KAWEAH DELTA HEALTH CARE DISTRICT BOARD OF DIRECTORS FINANCE, PROPERTY, SERVICES & ACQUISITION COMMITTEE MINUTES

Kaweah Health Medical Center
305 W. Acequia Avenue, Executive Office Conference Room (1st Floor)

Wednesday January 21, 2025

Present: Directors: David Francis (Chair) & Dean Levitan; Marc Mertz, Chief Executive Officer. Malinda Tupper, Chief Financial Officer; Jennifer Stockton, Director of Finance, Jag Batth, Chief Operating Officer; Kelsie Davis, Board Clerk Recording

OPEN MEETING – Called to order at 10:04AM

PUBLIC PARTICIPATION –None

MINUTES- reviewed and forward to the Board for approval.

FINANCIALS- Review of the most current fiscal year financial results and budget.

ADJOURN – 10:35am *David Francis, Board Secretary/Treasurer*

January 15, 2026

OPEN Quality Council Committee
Thursday, January 15, 2026
The Executive Office Conference Room

Attending: Board Members: Mike Olmos, (Chair); Dr. Dean Levitan, Board Member; Marc Mertz, CEO; Jag Batth, Chief Operation Officer; Dr. Paul Stefanacci, Chief Medical Officer; Evelyn McEntire, Director of Risk Management; Scott Baker, Interim Chief Nursing Officer; Dr. Michael Tedaldi, MD, Vice Chief of Staff; Dr. Julianne Randolph, DO, Chief of Staff; Shawn Elkin; Infection Prevention Manager; Chris Patty; Clinical Practice Guidelines Program Manager; Kevin Bartel, Director of Orthopedics; Malinda Tupper; Director of Financial Officer; Megan Stuart, RN Clinical Care QA; Martha Cardenas, RN Clinical Care QA; 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 December Quality Council Open Session Minutes –** Dr. Dean Levitan, Board Member; Mike Olmos, Chair.
    - Reviewed and acknowledged the December 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. **Maternal Child Health Quality Report**
    b. **Health Equity Quality Report**

6. **Rapid Response Team Code Blue Quality Report –** A review of key process and outcomes measures related to rapid response a code blue processes. Scott Baker, DNP, MBA, MSN, RN, NEA-BC, CEN, CNL, Interim Chief Nursing Officer. Report reviewed and attached in minutes. Committee requested to bring back report to revisit when the next scheduled reporting calendar.

7. **Kaweah Health Chronic Dialysis Report -** A review of key quality measures and actions focused on the care of orthopedic patient population. Kevin Bartel*, Director of Surgical Services Lines.* 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 – *Mike Olmos, Chair*
Mike Olmos adjourned the meeting at 9:10AM.

January 28, 2026

MINUTES OF THE OPEN MEETING OF THE KAWEAH DELTA HEALTH CARE DISTRICT BOARD OF DIRECTORS HELD WEDNESDAY JANUARY 28, 2026, AT 4:00PM IN THE CITY OF VISALIA CITY COUNCIL CHAMBERS – 707 W. ACEQUIA, VISALIA, CA.

PRESENT: Directors Olmos, Francis, Levitan, & Murrieta; Marc Mertz, CEO; J. Randolph, Chief of Staff; M. Tupper, CFO; D. Cox, Chief Human Resource Officer; B. Cripps, CCO; D. Leeper, CIO; P. Stefanacci, CMO; R. Berglund, Legal Counsel; and K. Davis, recording

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

PUBLIC PARTICIPATION –None.

ADJOURN - Meeting was adjourned at 4:00PM

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

ATTEST:

Dean Levitan, MD, Secretary/Treasurer
Kaweah Delta Health Care District Board of Directors

MINUTES OF THE OPEN MEETING OF THE KAWEAH DELTA HEALTH CARE DISTRICT BOARD OF DIRECTORS HELD WEDNESDAY JANUARY 28, 2026, AT 4:45PM IN THE CITY OF VISALIA CITY COUNCIL CHAMBERS – 707 W. ACEQUIA, VISALIA, CA.

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

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

ROLL CALL- Directors Olmos, Levitan, Francis and Murrieta were present. Zone II Seat was Vacant.

FLAG SALUTE- Director Francis 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 January 2026, Approve settlement funds, the closed meeting minutes of December 17, 2025. There was also action taken by the Board to reject two claims on its merits pursuant to Government Code Section 54956.9.

RECOGNITIONS- Resolution 2279, 2280.

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

- Save the date- Doctors Day.
- Working on a mentoring program.

CONSENT CALENDAR – Director Francis entertained a motion to approve the January 28, 2026, consent calendar without 8.3.B.1.

PUBLIC PARTICIPATION – None.

MMSC (Olmos/Levitan) to approve the January 28, 2026, consent calendar without 8.3.B.1. This was supported unanimously by those present. Vote: Yes – Olmos, Levitan, Murrieta and Francis.

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. – Sonia Duran Aguilar delivered their yearly report for reporting requirements but is also part of the board educational plan.

ORTHOPEDIC QUALITY REPORT – A review of quality measures and actions focused on the care of the orthopedic patient population. – Kevin Bartel and Dr. Dean gave a presentation that was presented at Quality Council as well.

STRATEGIC PLANNIGN INITIATIVE – STRATEGIC GROWTH AND INNOVATION – Presented by Kevin Bartel regarding the strategic growth and innovation initiative, including strategic objectives, implementation framework and anticipated outcomes.

PATIENT EXPERIENCE AND SATISFACTION UPDATE- Deborah Volosin presented and had a meaningful discussion regarding aggregated and de-identified patient experience data, including trends, themes, and opportunities for improvement.

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 – Recruiting for Chief Ambulatory Officer and Chief Strategy Officer. Unitek Graduation. – *Marc Mertz, CEO*
Board President- Zone II Applications are due February 5, 2026. SB707 will be in full effect come February. – *David Francis, Board President*

ADJOURN - Meeting was adjourned at 6:32PM

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

ATTEST:

Dean Levitan, MD, Secretary/Treasurer
Kaweah Delta Health Care District Board of Directors

AP 126 Physician Recruitment Policy

Policy Number: AP126	Date Created: 06/24/2019
Document Owner: Kelsie Davis (Board Clerk/Executive Assistant to CEO)	Date Approved: Not Set
Approvers: Board of Directors (Administration)	

Physician Recruitment Policy

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

PURPOSE: The purposes of this Policy are: (1) to assure that all members (including Medicare and Medi-Cal beneficiaries) of the communities served by Kaweah Delta Health Care District herein after referred to as "Kaweah Health have adequate access to high quality primary care physicians, specialists and sub-specialists in the Kaweah Health service area; and (2) that assistance provided by Kaweah Health to recruited physicians is based upon identified community need and is in compliance with all applicable laws and regulations (including Section 32121.3 of the Local Healthcare District Law and the "physician recruitment" exception to the Stark Law (42 CFR 411.357(e).

Kaweah Health provides a wide array of health care. Kaweah Health is the primary provider of inpatient and other health care services in its primary market (Visalia and immediate surrounding communities). Further, Kaweah Health is the regional healthcare center for many subspecialty services for those communities south of Fresno and north of Bakersfield.

Local Health Care District law permits Kaweah Health to provide financial assistance throughout the physician recruitment process when the use of such funds provides a public benefit. Income guarantees and other assistance to recruited physicians may be offered if 1) Kaweah Health determines the community need, and 2) Kaweah Health verifies that any financial assistance is "commercially reasonable" to induce a recruited physician to relocate his or her medical practice to the service area.

POLICY: Recruitment of physicians to practice in the geographic area served by Kaweah Health affiliated facilities is appropriate in certain circumstances to:

A. Add physicians in an under-served geographic location (as defined below); or

B. Increase coverage where there is a shortage.

The Stark exception for Recruitment Agreements allows a hospital to offer remuneration to an eligible physician to induce the physician to relocate to the geographic area served by the hospital. Therefore, the

hospital must have a direct relationship with the potential recruit to meet the exception. The hospital cannot rely on a relationship with an existing group and the potential recruit.

Note: A recruitment arrangement is valid when the minimum necessary is offered to induce a physician to relocate his/her medical practice to the geographic area serviced by the facility in order to join the hospital's medical staff (along with meeting the other requirements of this policy).

Physician recruitment agreements are not appropriate to:

1. Retain a physician currently on the medical staff (*i.e.*, retention agreements); or
2. Provide additional compensation to existing medical staff members.

Under no circumstances are recruiting agreements to be tied expressly, by implication, or by "private understanding" to hospital utilization; according, the analysis and/or materials generated and factors considered in connection with the recruitment of a physician should not include estimated or projected hospital or other referrals.

I. **Documentation of Community Need:**

A. Kaweah Health is the only provider of inpatient services in Visalia and nearby surrounding communities and is a regional provider of numerous subspecialty services. Kaweah Health will focus the resources that are available for physician recruitment as deemed necessary for meeting our community's most compelling needs. Objective measures of community need include: population to physician ratios, outside consultant recommendations, and the need for 24/7/365 emergency on-call services.

B. Where the communities served by Kaweah Health have need for physicians other than inpatient primary care, specialty and subspecialty services, Kaweah Health may collaborate in recruiting with other healthcare providers in the region.

II. **Conditions for Assistance:**

A. The Kaweah Health Board of Directors finds it in the best interest of the public health of the communities served by the District to recruit licensed physicians and/or surgeons to practice in the communities served by Kaweah Health. On at least a quarterly basis, the Physician Recruitment Strategy Team updates, reviews, and approves the Physician Recruitment Plan based on the Provider Needs Assessment, trending access to care, and newly added services. The Board of Directors reviews and approves the physician recruitment plan, annually. (HSC 32121.3)

B. Kaweah Health recognizes that there is a need to utilize its public

resources to attract the physician(s) needed (e.g., the community's need for these particular services) is determined based on:

i. Demand for a particular medical service in the community coupled with a documented lack of availability of the service or long waiting periods for the service, if the physician is being recruited to increase availability of that service;

ii. Designation of the community (or that portion of the community that the physician is serving) at the time the recruitment agreement is executed as a Health Professional Shortage Area (HPSA) as defined in 42 CFR 5.1-5.4;

iii. A demonstrated reluctance of physicians to relocate to the hospital due to the hospital's physical location (this criterion is intended to refer to a hospital located in a rural or economically-disadvantaged area);

iv. A reasonably expected reduction in the number of physicians of that specialty serving the hospital's service area due to the anticipated retirement within the next three-year period of physicians presently in the community;

v. A documented lack of physicians serving indigent or Medi-Cal patients within the hospital's service are, provided that newly recruited physicians commit to serving a substantial number of Medi-Cal and indigent patients; or

vi. The need for ensuring on-call emergency coverage for the Emergency Department and other services.

C. A recruited physician must agree to establish (if new in practice) or relocate his or her existing practice to Kaweah Health's service area, and maintain a practice, as defined in the recruitment agreement, to ensure the community obtains the necessary benefit from the physician's presence in the community.

D. A recruited physician must obtain and maintain appropriate staff privileges on the Medical Staff of Kaweah Health's facilities throughout the term of the recruitment agreement.

E. A recruited physician must be willing to provide full disclosure of necessary information and allow reasonable review of patient and financial records that may be necessary to audit compliance with the terms of the recruitment agreement.

F. A recruited physician must maintain a current California state medical license, current DEA license, professional liability insurance and eligibility or certification in his/her respective specialty as required by the Medical Staff Bylaws or by regulation.

G. A recruited physician may be required to participate in Medicare, Medi-Cal and other third-party payor programs, and make good faith efforts to apply in a timely manner for credentialing with health plans that serve the communities of Kaweah Health. Except as otherwise

approved by Kaweah Health, the recruited physician must contract with Kaweah Health to assist in the payor credentialing process and to aid in setting up the processes for the timely billing and collection of professional services when necessary.

H. A recruited physician must participate in the hospital's specialty on-call panel if applicable.

I. Physician is relocating his or her medical practice from outside to inside the Geographic Service Area (GSA) of the hospital, consistent with the requirements below; and

J. Physician is not currently a member of the facility's medical staff and will become a member of the medical staff after the recruitment agreement is executed.

III. Relocation

One of the following conditions must be met in order for a physician to meet the relocation requirement:

A. A physician's medical practice was located outside the geographic area served by the hospital and either of the following is true:

i. The physician moves his or her previous medical practice, which was outside the hospital's GSA, more than 25 miles and into the hospital's GSA, or

ii. The physician moves his or her medical practice less than 25 miles from outside the hospital's GSA into the hospital's GSA, and the physician's new medical practice derives at least 75% of its revenues from patients not seen or treated by the physician at his or her prior medical practice site during the preceding three (3) years, measured on an annual basis (fiscal or calendar year); for the initial "start up" year of a recruited physician's practice, the 75% test will be satisfied if there is a reasonable expectation that the recruited physician's practice for the year will derive at least 75% of its revenues from professional services furnished to patients not seen or treated by the physician at his or her prior medical practice site during the preceding three (3) years. If the hospital is relying on this subsection, then the hospital must document the basis for its conclusion that the recruited physician is reasonable expected to derive at least 75% of his or her revenues from new patients.

B. The recruited physician will not be subject to the relocation requirement of 2.a. above if the physician establishes his or her medical practice in the geographic services area served by the recruiting hospital, and

i. The physician is (or will be upon the commencement of the recruitment agreement) in his or her first year of practice, including residents and post-resident fellows; or

ii. The physician has been employed full-time for at least the immediately previous two years with no independent practice outside of that employment by any one of the following:

- A Federal or State bureau of prisons or similar operating correctional facility to serve exclusively a prison population;
- The Department of Defense or Department of Veterans Affairs to serve active or veteran military personnel or their families; or
- Facilities of the Indian Health Service who serve patients who receive medical care exclusively through the Indian Health Service.

If a physician is sought after but does not meet the conditions for recruitment under this Policy, you may consider utilizing a different arrangement with the physician, such as an employment relationship. Please refer to the applicable policies.

IV. Geographic Area Served by the Hospital

The recruited physician must establish his or her medical practice within the area composed of the lowest number of contiguous zip codes from which the hospital draws at least 75 percent of its inpatients. Contiguous zip codes touch at least one other zip code in which inpatients reside. The hospital may include one or more zip codes from which the hospital draws no inpatients, provided such zip codes are entirely surrounded by contiguous zip codes in the GSA. If, on the effective date of the recruiting agreement, there is more than one configuration of the lowest number of contiguous zip codes that draw 75 percent of the facility's inpatients, the hospital may select the configuration that it wishes to apply.

V. Assistance:

A. Physician Recruitment Agreements must comply with applicable laws and regulations. In consideration of the foregoing, it is the policy of the Kaweah Health Board of Directors that Kaweah Health may provide the following types of physician recruitment assistance, each of which are outlined in this Paragraph III:

- Loans for payment of income guarantees, benefit expense allowance, and malpractice allowance;
- Loans for payment of a signing bonus, which include payment of a resident retention bonus;
- Loans for repayment of medical student loans;
- Loans for payment of a stipend for a fellowship program.

B. Kaweah Health may recruit a physician(s) and guarantee his or her income and practice expenses, and provide for a benefit allowance:

i. The maximum assistance for an income guarantee is two years.

ii. The income guarantee advances must be structured as repayable loans subject to forgiveness if the physician maintains his or her practice in the community for a predetermined period of time, provides on-call coverage for the Emergency Department (if applicable) and renders health care services to all segments of the community, including Medi-Cal and indigent patients and (all of which have been agreed upon in order to ensure the economic benefit to the recruited physician relative to the value of community benefit).

C. **Approving Authority**.

The Executive Fair Market Value Committee (Chief Executive Officer, Chief Compliance and Risk Officer, and Board Chair) shall meet at least annually to review and approve the Fair Market Value (FMV) Guidelines for Recruitment Assistance.

The FMV Guidelines shall also be reviewed and approved by the District's third-party Fair Market Value consultant at least annually. Kaweah Health may consider other types of permitted assistance to a physician in exchange for consideration. In all cases, other permitted assistance shall be approved by the Executive FMV Committee and the Districts third party FMV firm.

The total financial compensation offered to any individual physician should not exceed the minimum amount required to induce the physician to relocate their practice to the GSA served by the hospital and to join the hospital's medical staff after consideration of all relevant variables. Relevant variables include but are not limited to the facility's location and community, the physician's demonstrated skills and the physician's personal interest in the location.

D. **Types of Assistance.**

1. Payment of a Signing Bonus in exchange for the execution of the recruitment agreement. The Signing Bonus may be paid in one or more payments, including a payment concurrent with the recruited physician's commencement of practice in Kaweah Health's service area. The Signing Bonus will be subject to repayment under a promissory note. The amount and forgiveness period shall be determined by the Executive FMV Committee.
2. Payment of a Resident Retention Bonus in exchange for the execution of the recruitment agreement. The Resident Retention Bonus may be paid in one or more payments, including a payment concurrent with the recruited physician's commencement of practice in Kaweah Health's service area. The Resident Retention Bonus will be subject to repayment under a promissory note. The amount and forgiveness period shall be determined by the Executive FMV Committee.
3. Payment of a stipend to a recruited physician who will participate in a

specialty fellowship program prior to commencing his/her practice in Kaweah Health's service area. The stipend may be paid in one or more payments during the term of the fellowship program. Fellowship Assistance will be subject to repayment under a promissory note. The amount and forgiveness period shall be determined by the Executive FMV Committee.

4. Payment to a recruited physician to assist in the repayment of his/her medical school student loans.

   i. Student loan assistance is subject to verification of the outstanding indebtedness.

   ii. All payments will be made to the recruited physician.

   iii. The recruitment agreement will stipulate that Kaweah Health is not responsible, in any manner, for making payments to any lender(s) holding the student loans.

   iv. The recruited physician will certify at the end of each year that he/she has used the payments towards repayment of his/her student loans and provide supporting documentation of the payments.

   v. The student loan assistance will be subject to repayment under a promissory note. The amount and forgiveness period shall be determined by the Executive FMV Committee.

5. Payment to a recruited physician to reimburse the cost of relocation. The relocation assistance will be subject to repayment under a promissory note. The amount and forgiveness period shall be determined by the Executive FMV Committee.

6. The contract will provide for the forgiveness of the Obligation over the predetermined period (see table above) if the physician remains in the community, agrees to continue emergency room coverage and maintains medical staff privileges at the hospital. Forgiveness shall be on the basis of a straight amortization of the Obligation for each month where all conditions are fulfilled. The Obligation forgiveness feature should be used consistently by a hospital for similar situations and under no circumstances should it be based upon the volume or value of any referrals by the referring physician.

7. If a recruited physician fails to meet the terms of the recruitment agreement, Kaweah Health may suspend assistance for non-compliance until the default is corrected. However, if the default is not cured in a timely manner, the amounts loan balances remaining due shall be due and payable generally within a period not exceeding thirty (30) days. However, balances may be due and payable within a period greater than thirty (30) days, not to exceed ninety (90) days provided requisite approval is obtained by the Chief Executive Officer or Executive Team member.

8. In the event of death or permanent disability of the physician, the agreement may include provisions to forgive all or a portion of any

remaining amounts due.

9. Each agreement will have a designated maximum amount of assistance authorized for a particular physician-recruit.
10. A recruited physician shall agree to the right of Kaweah Health to inspect and audit his or her practice in order to verify compliance with the recruitment agreement.
11. A recruited physician agrees to retain his/her records of billings, collections, and expenses for at least five (5) years.
12. Recruitment loans shall be evidenced by a promissory note with a market-rate of interest approved by the Executive FMV Committee and secured by the account receivables of the recruited physician.
13. In extraordinary circumstances, Kaweah Health's Chief Executive Officer may authorize, as an additional incentive (within the meaning of §32121.3(a)(4) of the District Law) IV.

VI. Other Conditions:

A. Kaweah Health may share risk for recruitment costs and income guarantee payments with a physician or physician group who wish to jointly recruit with Kaweah Health a new physician to the service area.

B. Kaweah Health shall establish an annual or multi-year plan and budget for this program based on identified needs.

C. Agreements will be standardized, but terms may vary according to the specific request and situation.

D. Kaweah Health, at its discretion, may obtain a life or disability insurance policy on a physician under a physician recruitment contract.

E. In accordance with District law, no recruitment agreement shall do any of the following:

1. Impose as a condition any requirement that the recruited physician's patients or a quota of the physician's patients, be admitted or referred to a specified hospital;
2. Restrict the recruited physician from establishing staff privileges at, referring patients to, or generating business for another entity; or
3. Provide payment or other consideration to the recruited physician for the physician's referral of patients to any Kaweah Health facility or affiliated organizations.

F. Agreements will be subject to ongoing compliance with this policy which is intended to comply with all applicable laws and regulations and which may be amended from time to time as the applicable laws and regulations change, and /or as the interpretations of the laws and regulations change.

VII. Other Recruitment

A. Physician Recruitment Strategy Committee reviews requests for recruitment assistance based on community needs. A formal Community Needs Assessment (CNA) shall be conducted every regularly utilizing a third party company. If the specialty is not included in the approved annual recruitment plan, additional Board of Director approval may be required.

B. Physician Recruitment Strategy Committee members are Chief Strategy Officer, Chief Compliance and Risk Officer, Chief Executive Officer, Chief of Service Line, Service Line Directors and Director of Physician Recruitment and Relations.

C. All recruitment agreements shall be approved by legal counsel as to form and compliance with applicable laws pursuit to.

D. Kaweah Health Board of Directors shall reserve the right to make the final decision, considering, among other things, Kaweah Health's budget and the needs of the communities served.

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AP 41 Quality Improvement Plan

Policy Number: AP41	Date Created: Not Set
Document Owner: Kelsie Davis (Board Clerk/Exec Assist-CEO)	Date Approved: 02/26/2025
Approvers: Board of Directors (Administration)	

Quality Improvement Plan

I. Purpose

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

II. Scope

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

III. Structure and Accountability

Board of Directors

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

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

Quality Council

The Quality Council is responsible for establishing and maintaining the organization's Quality Improvement Plan and is chaired by a Board member. The Quality Council shall consist of the Chief Executive Officer, representatives of the Medical Staff and other key hospital leaders. It shall hold primary responsibility for the functioning of the Quality Assessment and Performance Improvement program. Because District quality improvement activities may involve both the Medical Staff and other representatives of the District, membership is multidisciplinary. The Quality Council requires the Medical Staff and the organization's staff to implement and report on the

activities for identifying and evaluating opportunities to improve patient care and services throughout the organization. The effectiveness of the quality

improvement and patient safety activities will be evaluated and reported to the Quality Council.

Quality Committee ("QComm")

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

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

The QComm shall have primary responsibility for the following functions:

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

2. **Quality Indicators:**
   a. The QComm shall oversee measurement, and shall analyze and track quality indicators and other aspects of performance. These indicators shall measure the effectiveness and safety of services and quality of care.
   b. The QComm shall approve the specific indicators used for these purposes along with the frequency and detail of data collection.
   c. The Board shall ratify the indicators and the frequency and detail of data collection used by the program.

3. **Prioritization:** The QComm shall prioritize quality improvement activities toassure that they are focused on high- risk, high-volume, or problem- prone areas. It shall focus on issues of known frequency, prevalence or severity and shall give

precedence to issues that affect health

outcomes, quality of care and patient safety. The QComm is responsible to establish organizational Quality Focus Teams who:

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

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

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

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

Medical Executive Committee

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

IV. Graduate Medical Education

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

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

V. Methodologies:

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

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

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

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

    - **Plan:**

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

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

    - **Do:**

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

    - **Check:**

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

- **Act:**

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

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

    - **Define** the problem, improvement activity, opportunity for improvement, the project goals, and customer (internal and external) requirements. QI tools that may be used in this step include:
        - Project charter to define the focus, scope, direction, and motivation for the improvement team
        - Process mapping to provide an overview of an entire process, starting and finishing at the customer, and analyzing what is required to meet customer needs
    - **Measure** process performance.
        - Run/trend charts, histograms, control charts
        - Pareto chart to analyze the frequency of problems or causes
    - **Analyze** the process to determine root causes of variation and poor performance (defects).
        - Root cause analysis (RCA) to uncover causes
        - Failure mode and effects analysis (FMEA) for identifying possible product, service, and process failures

    Improve process performance by addressing and eliminating the root causes.
        - Pilot improvements and small tests of change to solve problems from complex processes or systems where there are many factors influencing the outcome
        - Kaizen event to introduce rapid change by focusing on a narrow project and using the ideas and motivation of the people who do the work
    - **Control** the improved process and future process performance.
        - Quality control plan to document what is needed to keep an improved process at its current level. Statistical process control (SPC) for monitoring process behavior
        - Mistake proofing (poka-yoke) to make errors impossible or immediately detectable

VI. Confidentiality

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

§1157.

VII. Annual Evaluation

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

VIII. Attachments (Click on “links & attachments” at the top right to open/view the documents.)

Components of the Quality Improvement and Patient Safety Plan:

Attachment 1: Quality Improvement Committee StructureAttachment 2: Kaweah Health Reporting Documents
Attachment 3: Quality and Patient Safety Priorities, Outstanding Health Outcomes Strategic Plan

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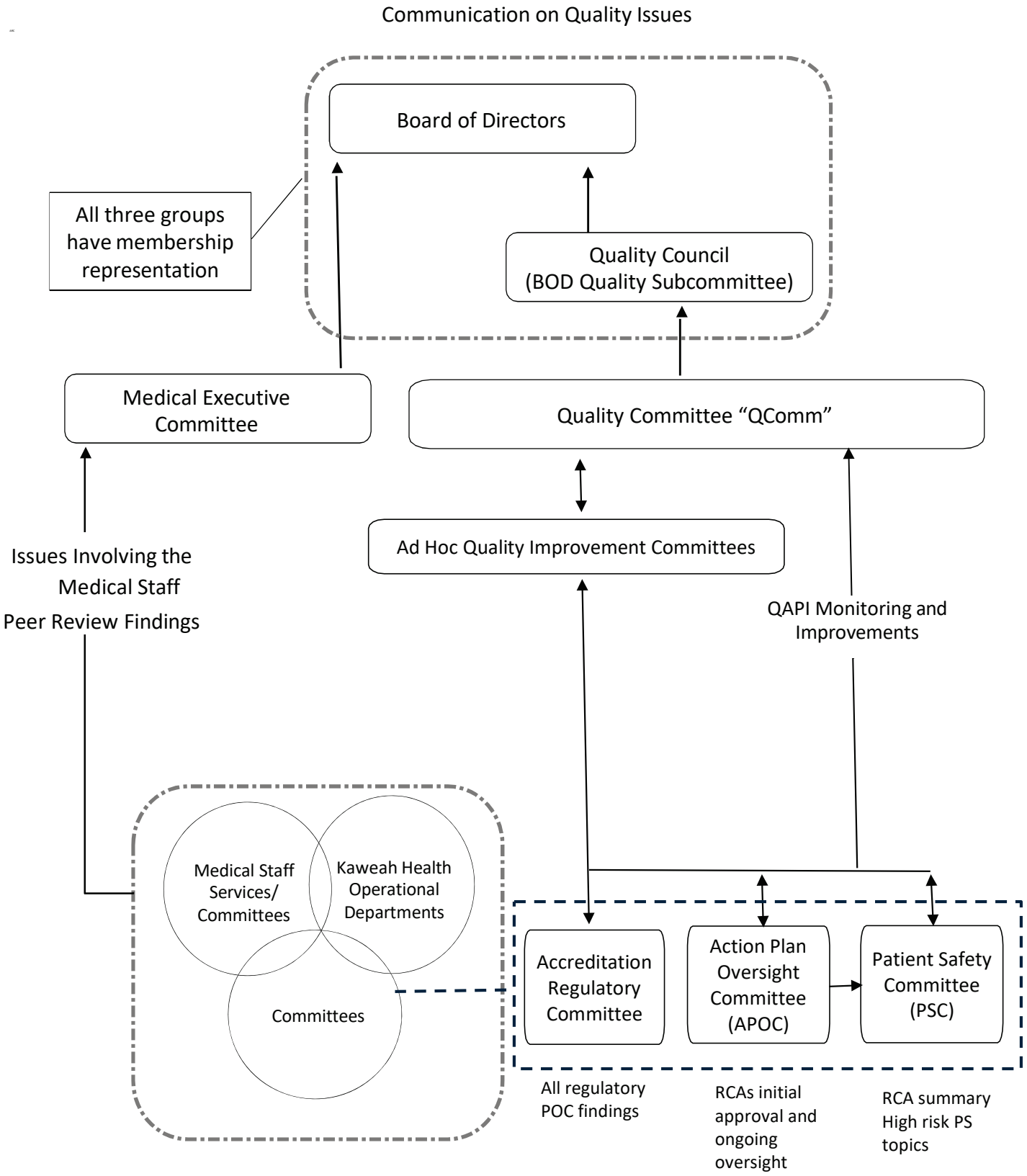
Attachment 1

Kaweah Health

QAPI Reporting Structure



Quality Committee "QComm" Participating Depts/Services/Committees

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

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

Cardiovascular Services
Dept of Cardiovascular Services (ACC, STS); Cath lab, IR, CVCU, 4T and Cardiac Surgery
Telemonitoring Report
Non Invasive Inpatient Services
Critical Care Services
Intensive Care Unit, CVICU (non-cardiac), 3W, 5T
Organ Donation
Rehabilitation Services
Rehabilitation
Inpatient Therapies (KDMC, Rehab, South Campus)
Outpatient Therapies: Medical Office Building Akers (MOB), Exeter, Sunnyside, Dinuba, Lovers Lane, Therapy Specialists at Rehab/Neuro
Outpatient Wound Clinic at Rehab (included in Rehab report)
Post Acute Services
KH Home Infusion Pharmacy (KHHIP)
Hospice
Home Care Services (Home Health)
Short-Stay Rehab
Skilled Nursing Services (subacute and short-stay)
Surgical Services
SQIP - Surgical Quality Improvement Committee
Ambulatory Surgery Center/PACU/KATS
Operating Room
Sterile Processing Department
Inpatient units: Broderick Pavilion, 3N, 4S
Anesthesia Services
Orthopedics
Endoscopy
Renal Services/ Dept of Renal Services
KH Visalia Dialysis
Publically Reported Measures
Value Based Purchasing Report
Healthgrades
Leapfrog Hospital Safety Score
Committees
Health Equity
Falls Committee
RRT/Code Blue
HAPI Committee (includes inpatient wound care)
Sepsis Quality Focus Team
Healthcare Acquired Infection Committee (CAUTI, CLABSI, MRSA, Hand Hygiene)
Stroke Committee Report
Diabetes Committee Report
Accreditation Regulatory Committee Minutes & Audit Summary
Workplace Violence Committee
Throughput Committee
Mortality Committee
Patient Safety Committee
HIM - HIM Committee

Policy Number: AP175	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), Kelsie Davis (Board Clerk/Executive Assistant to CEO)	

Patient Safety Plan

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

I. Purpose

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

II. Scope

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

III. Structure and Accountability

A. Board of Directors

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

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

B. Quality Council

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

C. Patient Safety Committee

The Patient Safety Team is a standing interdisciplinary group that manages the organization's Patient Safety Program through a systematic, coordinated, continuous approach. The Team will meet monthly to assure the maintenance and improvement of

Patient Safety in establishment of plans, processes and mechanisms involved in the provision of the patient care.

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

1. The Patient Safety Officer is the Chief Quality Officer.
2. The Patient Safety Committee is chaired by the Patient Safety Officer or designee.
3. The responsibilities of the Patient Safety Officer include institutional compliance with patient safety standards and initiatives, reinforcement of the expectations of the Patient Safety Plan, and acceptance of accountability for measurably improving safety and reducing errors. These duties may include listening to employee and patient concerns, interviews with staff to determine what is being done to safeguard against occurrences, and immediate response to reports concerning workplace conditions.
4. The Risk Management department is responsible for the identification, analysis, and stratification of reported patient safety events by specified sociodemographic factors to identify disparities as defined by 2025 CA Assembly Bill 3161. The Patient Safety Committee has oversight of this work to ensure interventions are developed to remedy known disparities.
5. Team membership includes services involved in providing patient care, such as: Pharmacy, Surgical Services, Risk Management, Infection Prevention, and Nursing. The medical staff representative on the team will be the Medical Director of Quality & Patient Safety.

D. Medication Safety Quality Focus Team

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

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

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

IV. Organization and Function

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

1. Reporting of potential or actual occurrences through the Occurrence Reporting Process Policy (AP10) by any employee or member of the medical staff. Examples of potential or actual occurrences include pressure ulcers, falls, adverse drug events, and misconnecting of: intravenous lines, enteral feeding tubes and epidural lines.

2. Reporting of potential or actual concerns in a daily leadership safety huddle which involves issues which occurred within the last 24 hours, a review the steps taken to resolve those matters when applicable, and anticipate challenges or safety issues in the next 24 hours. The daily safety huddle occurs Monday to Friday with the exception of holidays and includes directors and vice presidents that represent areas throughout the organization. The purpose of the daily safety huddle is immediate organizational awareness and action when warranted. Examples of issues brought forth in the Daily Safety Huddle include, patients at risk for elopement, violence, or suicide, and also can include potential diversion events, patient fall events, and medication related events.
3. Communication between the Patient Safety Officer and the Chief Operating Officer to assure a comprehensive knowledge of not only clinical, but also environmental factors involved in providing an overall safe environment.
4. Reporting of patient safety and operational safety measurements/activity to the performance improvement oversight committee, Quality Committee "Qcomm". QComm is a multidisciplinary medical staff committee composed of various key organizational leaders including: Medical Staff Officers, Chief Executive Officer, Chief Operating Officer, Chief Medical Officer/Chief Quality Officer, Chief Nursing Officer, and Directors of Nursing, Quality Improvement & Patient Safety, Risk Management, Safety Officer and Pharmacy.
5. Graduate Medical Education
    i. Graduate Medical Education (Designated Institutional Official (DIO), faculty and residents, are involved in achieving quality and patient safety goals and improving patient care through several venues including but not limited to:
        1. Collaboration between Quality and Patient Safety Department, Risk Management, and GME Quality Subcommittee
        2. GME participation in Quality Improvement Committee and Patient Safety Committee
        3. GME participation in Kaweah Health quality committees and root cause analysis (including organizational dissemination of lessons learned)

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

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

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

D. As a member of an integrated healthcare system and in cooperation with system initiatives, the focus of Patient Safety activities include processes that are high risk, high volume or problem prone, and may include:
1. Adverse Drug Events
2. Nosocomial Infections
3. Decubitus Ulcers
4. Blood Reactions
5. Slips and Falls

6. Restraint Use
7. Serious Event Reports
8. DVT/PE

E. A proactive component of the program includes the selection at least every 18 months of a high risk or error prone process for proactive risk assessment such as a Failure Modes Effects Analysis (FMEA), ongoing measurement and periodic analysis. The selected process and approach to be taken will be approved by the Patient Safety Committee, QComm and Quality Council.

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

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

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

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

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

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

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

V. Evaluation and Approval

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

VI. Confidentiality

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

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

References:

AP10 Occurrence Reporting Process
AP87 Sentinel Event and Adverse Event Response and Reporting
CA Assembly Bill 3161, Approved September 27, 2024

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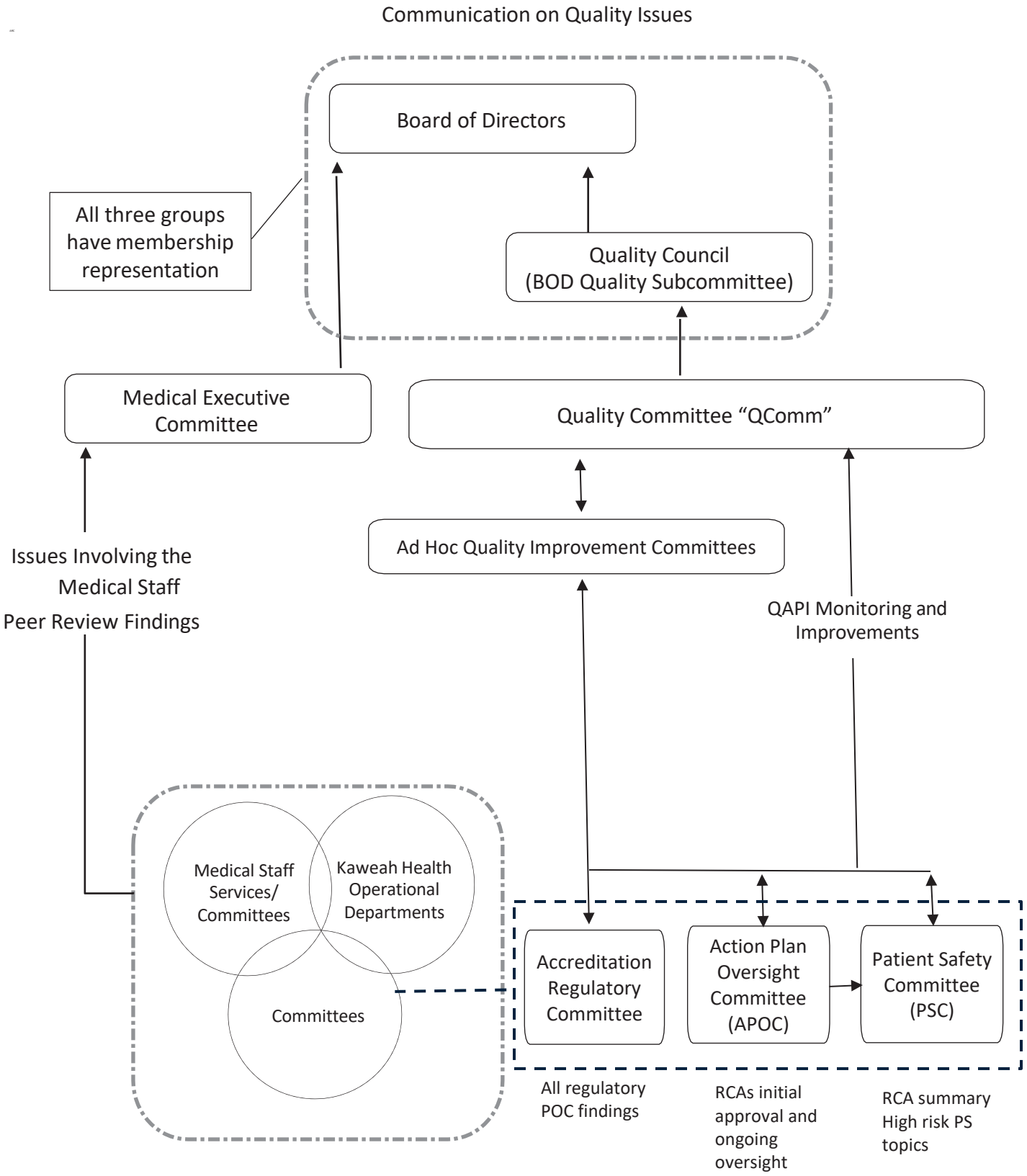
Attachment 1

Kaweah Health

QAPI Reporting Structure



Annual Review of Quality (AP.41) and Patient Safety Plan (AP.175)
Year End 2025 Quality and Patient Safety Initiatives & Quality Focus Team (QFT) Review

Quality Initiative	Type	Priority Category	Key Considerations	Measures of Success	Assigned Leader(s)
Quality Council (QC)	QAPI Oversight Committee - Board of Directors (BOD) Quality & Patient Safety Sub-Committee (per AP.41)	☒ High Risk ☒ Problem Prone ☒ High Volume	• Responsible for success of QAPI and Patient Safety Plans • Oversight committee where governance, medical staff leadership and hospital leadership oversee QAPI • QAPI reporting topics cover scope of services provided	• As determined by each QAPI program topic or service line report	Chaired by BOD Member
Quality Committee ("QComm")	QAPI Oversight Committee (Medical Staff) (per AP.41)	☒ High Risk ☒ Problem Prone ☒ High Volume	• Delegated responsibility for success of QAPI and Patient Safety Plans • Oversight committee where medical staff leadership and hospital leadership oversee QAPI • QAPI reporting topics cover scope of services provided	• As determined by each QAPI program topic or service line report	Chaired by the Vice-Chief of Staff
Patient Safety Committee (PSC)	Org Oversight Committee (per AP.175)	☒ High Risk ☒ Problem Prone ☒ High Volume	• Responsible per AP.175 Patient Safety Plan • Oversees Midas Event Triage and Ranking Committee (METER) and Quality-Risk Committee (QRC) • Oversees all action plans related to Root Cause Analysis and Focus Review teams • Oversees safety culture improvement action plan including Just Culture • Oversees patient safety priority QI work (ie. HAPI, Fall Prevention, National Patient Safety Goals).	• As determined by individual action plans • Reportable never events • Priority measures such as 2 identifier events, critical findings, and topic specific reported by committee listed below	Director of Quality and Patient Safety
Incident Management (IMM)	Patient Safety Committee	☒ High Risk ☒ Problem Prone ☒ High Volume	• (per AP.87) A multidisciplinary team including members from the organization and Medical Staff which reviews occurrence reports daily to rank and triage events so immediate notification of high-risk or unusual events can be made to hospital and Medical Staff leadership.	• Ranking task contributes to overall Serious Safety Event Rate reporting to QComm	• Director of Risk Management

Annual Review of Quality (AP.41) and Patient Safety Plan (AP.175)
Year End 2025 Quality and Patient Safety Initiatives & Quality Focus Team (QFT) Review

Just Culture Committee	Org Committee	☒ High Risk ☒ Problem Prone ☒ High Volume	• Key strategy in organization safety culture improvement action plan • National Quality Forum (NQF) safe practice included in Leapfrog Safety Grade	• Just Culture measures included in the Safety Culture Survey	Director of Organizational Development
Medication Safety	Org Oversight Committee	☒ High Risk ☒ Problem Prone ☒ High Volume	• Oversees the Medication Error Reduction Program (MERP) per CA state requirements • Through analysis of medication management data, identifies actual or potential medication safety risk and takes actions to improve the organizational medication use process. Supports strategic goals established to advance the culture of safety, promote multidisciplinary oversight and accountability in improving the medication use process, and optimize the use of high leverage strategies and technology to reduce medication errors across the organization. • Collaborative partnership with Patient Safety Committee on medication elements of high risk processes such as anticoagulation, medication reconciliation and procedural sedation safety which are Joint Commission National Patient Safety Goals. • Utilizes externally reported medication events and best practice recommendations to evaluate potential risk in organizational process and procedures to evaluate risk and recommend improvements to improve medication use systems • Oversees Adverse Drug Event Committee review of all reported medication events and reviews high or potential high severity reported events	• Several measures monitored as determined annually by the committee through the MERP and Adverse Drug Event (ADE) committee work. • Examples of monthly trended data includes utilization reversal medications, BCMA utilization, smartpump metrics, rates of reported events, ADC overrides. • Home medication list review for high risk patients within 24 hours of hospital admission metrics include: number of medication histories completed, total admission discrepancies and total admission discrepancies per patient	Director of Pharmacy and Medication Safety Coordinator

Annual Review of Quality (AP.41) and Patient Safety Plan (AP.175)
Year End 2025 Quality and Patient Safety Initiatives & Quality Focus Team (QFT) Review

Adverse Drug Event (ADE) Committee	Org Sub-Committee Medication Safety	☒ High Risk ☒ Problem Prone ☒ High Volume	• Reviews, tracks and trends and makes recommendations for process improvements in response to adverse drug event Midas reports • Uses the Just Culture framework to identify organizations process and systems that contributed the medication event and make QI recommendations to improve medication safety • Make recommendations for Root Cause Analysis or Focused Review as determined necessary	• ADE volume and tracked trends as reported to Medication Safety Committee • Aggregated trends analysis annually to Medication Safety	Medication Safety Coordinator
Patient Care Medication Safety Committee	Org Sub-Committee Medication Safety	☒ High Risk ☒ Problem Prone ☒ High Volume	• Multidisciplinary team that develops, plans and implements QI strategies to improve medication safety related issues relative to nursing practice identified by ADE or Medication Safety Committee	• Metrics determined by topics identified, examples include BCMA utilization, diversion prevention measures.	Medication Safety Specialist
Sepsis QFT	OHO Strategic Initiative Quality Focus Team (QFT)	☒ High Risk ☒ Problem Prone ☒ High Volume	• Established QFT since 2016 • High volume diagnosis, high mortality rates nationally (problem prone) • Centers for Medicare and Medicaid Services (CMS) SEP-1 bundle compliance publically reported on CMS care compare website	• SEP-1 Bundle compliance • Mortality	Medical Director of Quality & Patient Safety; Manager of Quality and Patient Safety
Hospital Acquired Pressure Injury (HAPI) QFT 2026 – replace with "Harm Committee"	Quality Focus Team (QFT); reports to PSC	☒ High Risk ☒ Problem Prone ☐ High Volume	• PSI3 (HAPI) is a component of Leapfrog Safety Score & CMS public report • Mandated reporting to California Department of Public Health (CDPH)	• Percent of patients with stage 2+ • Proportion of HAPIs that are device related • PSI3 (>Stage 2+)	Director of Nursing Practice
Healthcare Associated Infections (HAI) QFT	OHO Strategic Initiative, QFT	☒ High Risk ☒ Problem Prone ☐ High Volume	• CMS Value-Based Purchasing (VBP) and star rating Measure • Leapfrog safety grade metric • TJC National Patient Safety Goal (hand hygiene)	• Standardized Infection Ratio (SIR) for Central Line Associated Blood Stream Infection (CLABSI), Catheter Associated Urinary Tract Infection (CAUTI),	Medical Director Quality & Patient Safety, Manager of Infection Prevention, Directors of: Quality & Patient Safety, Post

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				and Methicillin-Resistant Staphylococcus Aureus (MRSA) • Standardized Utilization Ratios (SUR) for central lines and urinary catheter • HAI Bundle compliance measures • Hand Hygiene compliance	Acute Nursing, Renal Services and Environmental Services
Best Practice Team (HF, PN, COPD)	Org Committee	☒ High Risk ☒ Problem Prone ☒ High Volume	• CMS VBP and star rating Measure • High volume medical diagnosis (PN & HF) • CMS Readmission Reduction Program population	• Observed/expected (o/e) mortality and risk adjusted readmission rates • examples of key performance indicators (KPI) include discharge medications, inpatient medication management, order set utilization	Director of Respiratory Services; Medical Director of Best Practice Teams
Fall Prevention Committee 2026 – replace with "Harm Committee"	Org Committee, reports to PSC	☒ High Risk ☒ Proble m Prone ☐ High Volume	• Nursing sensitive quality indicator • Case reviews of fall events and collection an dissemination of contribution factors data	• Total falls and injury falls; contributing factors	Director of Nursing Practice
Falls University 2026 – replace with "Harm Committee"	Sub-Committee of Fall Prevention Committee	☒ High Risk ☒ Problem Prone ☐ High Volume	• Case reviews of fall events and collection and dissemination of contribution factors data • Reports to Fall Prevention Committee	• Contributing factors to falls	Director of Nursing Practice
Diabetes	Org Committee	☒ High Risk ☒ Problem Prone ☒ High Volume	• High volume, high risk volume patient population	• Hypo and Hyperglycemia rates	Director of Nursing Practice, Medical Director of Quality & Patient Safety
Trauma Quality Program	Org Committee	☒ High Risk ☒ Problem Prone ☒ High Volume	• Trauma program oversight and QI work related to ACS trauma designation	• Various measures through data registry including documentation of assessment findings, airway management, timeliness of diagnostic studies, timeliness of surgical intervention, mortality rates	Manager of Trauma Program, Medical Director of Trauma

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Stroke Quality Program	Org Committee	☒ High Risk ☒ Problem Prone ☒ High Volume	• The Joint Commission (TJC) certified program • High risk population • Oversees work of the ED Stroke Alert sub task force	• Various process measures through American Heart/Stroke Association including medication management, discharge indicators, timeliness of diagnostics studies and assessments	Manager of Stroke Program and Medical Director of Stroke Program
Health Equity	Org Committee	☒ High Risk ☒ Problem Prone ☒ High Volume	• TJC Sentinel Event issued January 2022 • New TJC Leadership standard 2023 • New TJC National Patient Safety Goal for 2024 • National and ACGME initiative	• Measures to identify disparities in care in key population; • 2024 Social Determinates of Health (SDOH). • Measures related to the effectiveness of demographic (REaL) collection (ie. Rate of "unknown" responses in a REaL field in the patients EMR)	Chief Population Health Officer, Director of Population Health
Patient Safety Indicator (PSI) Committee	Org Committee	☒ High Risk ☒ Problem Prone ☐ High Volume	• Review of coded complications of the surgical population • Reported on CMS Care Compare website • Component of CMS star rating, VBP program	• PSI rates	Medical Director of Surgical Quality, Director of Quality and Patient Safety
Surgical Quality Committee (SQIP)	Org Committee	☒ High Risk ☒ Problem Prone ☒ High Volume	• Oversees PSI (coded complications of care) • Oversees implementation of Enhanced Recovery After Surgery (ERAS) program (evidenced based care targeted at the surgical population	• ERAS measures • PSI measures • Surgical Site Infection measures	Director of Surgical Services, Medical Director of Surgical Quality
Population Health Steering Committee	Org Oversight Committee	☒ High Risk ☒ Problem Prone ☒ High Volume	• Quality Incentives Program (QIP) previously Public Hospital Redesign & Incentives Program (PRIME) • Oversees Population Health Quality Committee work	• In Calendar Year 2025 we will report on 8 quality measures to DHCS and 3 informational measures	Director of Population Health
Rapid Response/Code Blue	Org Committee	☒ High Risk ☒ Problem Prone ☒ High Volume	• TJC data monitoring requirements for accredited hospitals	• Several measures as submitted to American Heart Association registry including volume, location and outcome	Chief Nursing Officer, Director of Critical Care Services

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Mortality	Org Committee	☒ High Risk ☒ Problem Prone ☐ High Volume	• Review of unexpected deaths for follow up with quality of care concerns, coding or documentation	• Rates of cases with quality of care concerns, coding or documentation	Medical Director of Quality and Patient Safety, Manager of Quality Improvement
Infection Prevention Committee	Org Oversight Committee	☒ High Risk ☒ Problem Prone ☐ High Volume	• Oversees the Infection Prevention Plan • Oversees Surgical Site Infection task force • Oversees regulatory compliance with IP standards	• Several measures monitored through quarterly dashboard including surgical site infection rates, ventilator associated events, line infection rates, MRSA.	Manager of Infection Prevention, Medical Director of Infection Prevention
Accreditation Regulatory Committee	Org Oversight Committee	☒ High Risk ☒ Problem Prone ☒ High Volume	• Oversees compliance with regulatory standards and plans of correction	• Various measures determined by plans of correction • Regular tracer data for compliance with regulatory standards	Director of Quality & Patient Safety
Environment of Care Committee	Org Oversight Committee	☒ High Risk ☒ Problem Prone ☒ High Volume	• Oversees the EOC Plan and Workplace Violence Program (CA state mandate) • Oversees compliance with EOC regulatory standards per annual plan	• Various measures determined by annual plan; can include preventive maintenance completion rates, workplace violence, and employee injury rates.	Safety Officer
Emergency Management	Sub Committee of EOC	☒ High Risk ☒ Problem Prone ☐ High Volume	• Oversees the Emergency Operations Plan • Oversees compliance with EOP and Emergency Management regulatory standards.	• Various measured determined by annual plan and district wide exercises.	Safety Officer
Patient Throughput	Org Committee	☒ High Risk ☒ Problem Prone ☒ High Volume	• Committee that oversees various projects related to throughput including: work of 5 sub-groups: o Patient progression (includes discharge (d/c) management) o ED to inpatient admission process (includes RN to RN handoff, ED launch point enhancements)	• Various throughput measures including average length of stay (LOS) (obs and admitted patients) • ED throughput measures including ED boarding times, admit hold volume, ED LOS, visit volume. time to provider, time from door to admit, time from admit to arrival on unit.	CNO & COO

			○ Observation program (includes power plan enhancements, PCP and outpatient appointment processes) ○ Tests and treatments (ie. turnaround time)		

*All committees report to Quality Committee “QComm” per AP.41

AP175 Patient Safety Plan

Policy Number: AP175	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), Kelsie Davis (Board Clerk/Executive Assistant to CEO)	

Patient Safety Plan

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

I. Purpose

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

II. Scope

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

III. Structure and Accountability

A. Board of Directors

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

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

B. Quality Council

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

C. Patient Safety Committee

The Patient Safety Team is a standing interdisciplinary group that manages the organization's Patient Safety Program through a systematic, coordinated, continuous approach. The Team will meet monthly to assure the maintenance and improvement of

Patient Safety in establishment of plans, processes and mechanisms involved in the provision of the patient care.

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

1. The Patient Safety Officer is the Chief Quality Officer.
2. The Patient Safety Committee is chaired by the Patient Safety Officer or designee.
3. The responsibilities of the Patient Safety Officer include institutional compliance with patient safety standards and initiatives, reinforcement of the expectations of the Patient Safety Plan, and acceptance of accountability for measurably improving safety and reducing errors. These duties may include listening to employee and patient concerns, interviews with staff to determine what is being done to safeguard against occurrences, and immediate response to reports concerning workplace conditions.
4. The Risk Management department is responsible for the identification, analysis, and stratification of reported patient safety events by specified sociodemographic factors to identify disparities as defined by 2025 CA Assembly Bill 3161. The Patient Safety Committee has oversight of this work to ensure interventions are developed to remedy known disparities.
5. Team membership includes services involved in providing patient care, such as: Pharmacy, Surgical Services, Risk Management, Infection Prevention, and Nursing. The medical staff representative on the team will be the Medical Director of Quality & Patient Safety.

D. Medication Safety Quality Focus Team

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

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

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

IV. Organization and Function

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

1. Reporting of potential or actual occurrences through the Occurrence Reporting Process Policy (AP10) by any employee or member of the medical staff. Examples of potential or actual occurrences include pressure ulcers, falls, adverse drug events, and misconnecting of: intravenous lines, enteral feeding tubes and epidural lines.

2. Reporting of potential or actual concerns in a daily leadership safety huddle which involves issues which occurred within the last 24 hours, a review the steps taken to resolve those matters when applicable, and anticipate challenges or safety issues in the next 24 hours. The daily safety huddle occurs Monday to Friday with the exception of holidays and includes directors and vice presidents that represent areas throughout the organization. The purpose of the daily safety huddle is immediate organizational awareness and action when warranted. Examples of issues brought forth in the Daily Safety Huddle include, patients at risk for elopement, violence, or suicide, and also can include potential diversion events, patient fall events, and medication related events.
3. Communication between the Patient Safety Officer and the Chief Operating Officer to assure a comprehensive knowledge of not only clinical, but also environmental factors involved in providing an overall safe environment.
4. Reporting of patient safety and operational safety measurements/activity to the performance improvement oversight committee, Quality Committee "Qcomm". QComm is a multidisciplinary medical staff committee composed of various key organizational leaders including: Medical Staff Officers, Chief Executive Officer, Chief Operating Officer, Chief Medical Officer/Chief Quality Officer, Chief Nursing Officer, and Directors of Nursing, Quality Improvement & Patient Safety, Risk Management, Safety Officer and Pharmacy.
5. Graduate Medical Education
    i. Graduate Medical Education (Designated Institutional Official (DIO), faculty and residents, are involved in achieving quality and patient safety goals and improving patient care through several venues including but not limited to:
        1. Collaboration between Quality and Patient Safety Department, Risk Management, and GME Quality Subcommittee
        2. GME participation in Quality Improvement Committee and Patient Safety Committee
        3. GME participation in Kaweah Health quality committees and root cause analysis (including organizational dissemination of lessons learned)

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

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

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

D. As a member of an integrated healthcare system and in cooperation with system initiatives, the focus of Patient Safety activities include processes that are high risk, high volume or problem prone, and may include:
1. Adverse Drug Events
2. Nosocomial Infections
3. Decubitus Ulcers
4. Blood Reactions
5. Slips and Falls

6. Restraint Use
7. Serious Event Reports
8. DVT/PE

E. A proactive component of the program includes the selection at least every 18 months of a high risk or error prone process for proactive risk assessment such as a Failure Modes Effects Analysis (FMEA), ongoing measurement and periodic analysis. The selected process and approach to be taken will be approved by the Patient Safety Committee, QComm and Quality Council.

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

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

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

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

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

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

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

V. Evaluation and Approval

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

VI. Confidentiality

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

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

References:

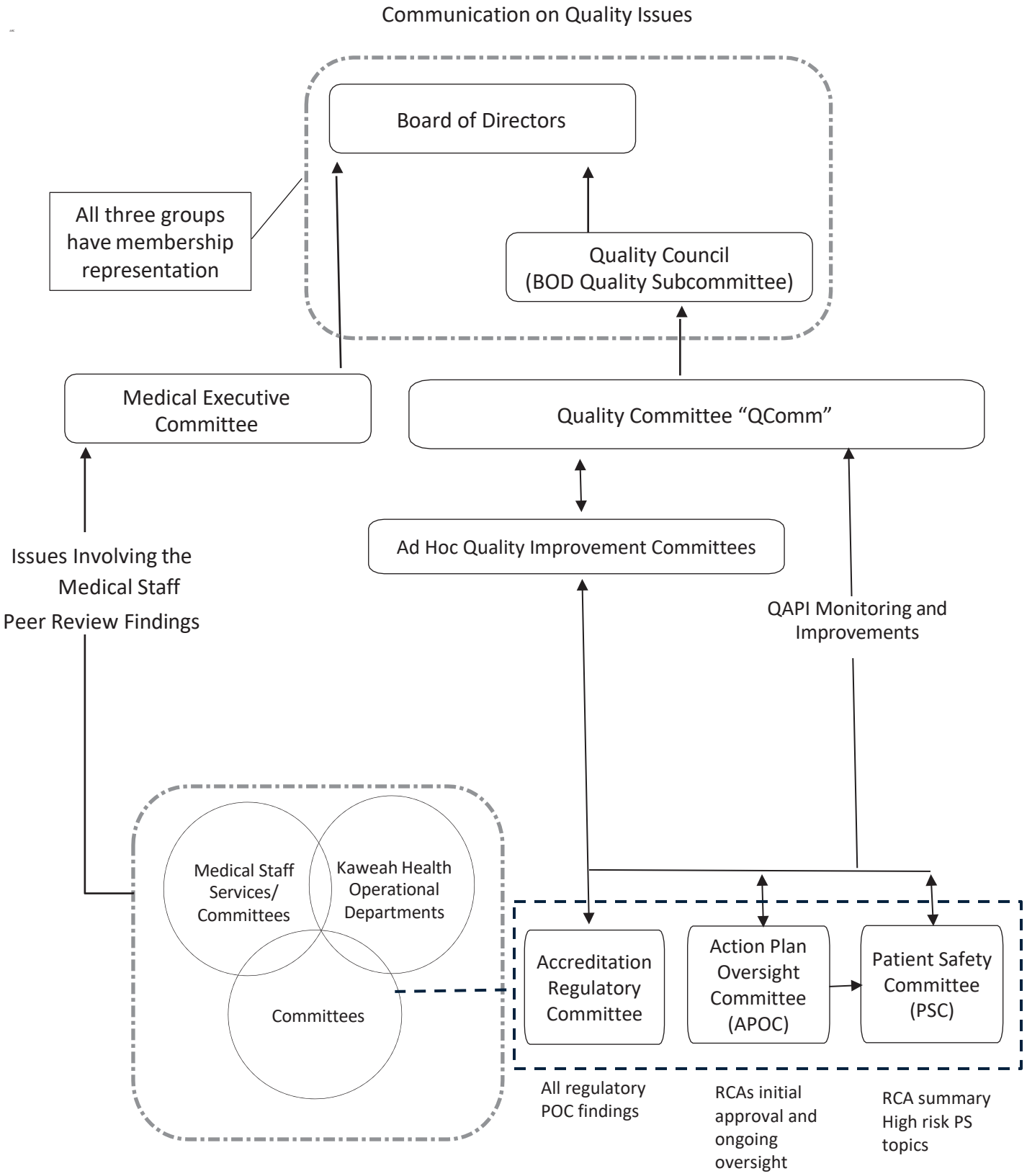
AP10 Occurrence Reporting Process
AP87 Sentinel Event and Adverse Event Response and Reporting
CA Assembly Bill 3161, Approved September 27, 2024

"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."

Attachment 1

Kaweah Health

QAPI Reporting Structure



EOC 1019 Equipment Cleaning and Low/Intermediate Level Disinfection

Policy Number: EOC1019	Date Created: No Date Set
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), Infection Prevention Committee	

Equipment Cleaning and Low/Intermediate Level Disinfection

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

I. Purpose

To list the indications and products that are approved for cleaning and low-level disinfection of environmental surfaces and non-critical reusable medical devices at Kaweah Health.) Note: The methods of high-level disinfection and sterilization are not addressed in this policy.

II. Policy

All common areas and common equipment will be cleaned appropriately according to standards provided by accrediting bodies, relevant associations, and the manufacturer's instructions for use (MIFU).

A. Environmental surfaces and reusable non-critical patient care devices must be cleaned and disinfected or sanitized in accordance with evidence-based guidance and MIFU to minimize the risk of healthcare-associated infections resulting from device contamination and provide safe patient care.
B. Applies to all Kaweah Health providers, staff and volunteers who perform cleaning, low-level disinfection, or sanitizing of environmental surfaces or reusable non-critical patient care devices.
C. Agents for cleaning and disinfection at Kaweah Health will be reviewed by Infection Prevention (IP) for appropriateness and approved by the Infection Prevention Committee.
    1. For approved agents in specialized areas (e.g., pharmacy, laboratory, respiratory, imaging, SPD, and endoscopy), please refer to the department specific policies for additional information.
D. All sanitizing and disinfectant products (including disposable wipes) must be used in accordance with the product's MIFU including specifications regarding dilution, storage, shelf-life, and contact time and the non-critical patient care device MIFU.

III. Definitions

A. Cleaning: The removal of visible dirt, soil, and any other material. Thorough cleaning is needed for effective disinfection or sterilization.
B. Contact Time: The amount of time a disinfectant needs to sit on a surface, without being wiped away or disturbed, to effectively kill microorganisms as specified on the product label.
C. Low-Level Disinfection: A process that kills most vegetative bacteria, some viruses, and some fungi, but cannot be relied on to kill mycobacteria or bacterial spores.
D. Manufacturer's Instructions for Use (MIFUs): In compliance with the FDA's labeling requirements, manufacturers of medical devices provide specific instructions for cleaning and disinfection or sterilization. MIFUs include the steps required for cleaning, disinfection (including the level of disinfection) or sterilization, frequency of processing, the products that are compatible for use the device/instrument, and other device or instrument management requirements. Requirements may include updated practice recommendations issued through manufacturers' communications.
E. Non-critical Patient Care Item: Based on the Spaulding classification/categories of patient care items, these are reusable medical devices that encounter only intact skin. These items should be low-level disinfected between uses.
F. Sanitizing agent: A product that reduces the number of but does not necessarily eliminate bacteria on environmental surface.

IV. Procedure

A. See Table A for the table of agents approved sanitizing and low-level disinfection of environmental surfaces and reusable non-critical patient care devices; agents must be consistent with device MIFUs.

B. Cleaning and low-level disinfection:

1. Reusable non-critical medical devices (e.g., glucometers, oximeter probes) must be cleaned and disinfected according to MIFU after each use and when visibly soiled.

2. Use a hospital-approved low-level disinfectant that is consistent with the device's MIFU.

3. For equipment compatibility questions, utilize OneSource as a reference (Kaweah Compass > Other Applications > OneSource). If equipment is not listed in OneSource, contact Clinical Engineering.

4. If a hospital-approved disinfectant consistent with MIFU is not available, consultation with Infection Prevention is required.

5. Don gloves and clean surface to remove visible dirt, soil, and any other residue present.

6. Disinfect surface using friction and allow surface to remain undisturbed for the designated contact time.

7. Sanitizing and disinfectant products, including disposable wipes, must be used in accordance with the sanitizing or disinfectant product's specifications including appropriate dilution, storage, shelf-life, and contact time.

Table A: Table of Kaweah Health-approved agents for sanitizing and low-level disinfection.

Indication	Product	Active Ingredient	Use/Location	Contact Time
Low Level Disinfection	Preferred disinfectant, recommended for most equipment and environmental surfaces:			
	MicroKillTwo germicidal wipes	Quaternary Ammonium Compounds, isopropyl alcohol	Routine surface disinfection	2 minutes
	Alternative disinfectants, to be used only when the preferred disinfectant is not an option based on the device MIFU:			
	CaviWipes germicidal wipes	Quaternary Ammonium Compounds, isopropyl alcohol	Routine surface disinfection	3 minutes
	CaviWipes1™ germicidal wipes	Quaternary Ammonium Compounds, ethanol, isopropyl alcohol	Routine surface disinfection	1 minute
	Oxivir TB wipes	Hydrogen peroxide	Approved only in procedural areas	1 minute
	MicroKills AF2 wipes	Poly hexamethylene biguanide hydrochloride, Quaternary Ammonium Compounds	Routine surface disinfection	2 minutes
	Micro-Kill Bleach wipes*	Sodium hypochlorite	Approved only for use in dialysis and by trained EVS personnel	1 minute
	Vindicator	Quaternary Ammonium Compounds	Approved only for use by Environmental Services	1 minute
	Oxivir® Three 64	Advanced hydrogen peroxide	Approved only for use by Environmental Services	3 minutes
	QT3	Quaternary Ammonium Compounds	Approved only for use at Kaweah Kids Center	3 minutes
Sanitizing	Tersano ® Water	Ozone	Approved only for use at Kaweah Kids Center	5 minutes
	Gojo Purell® Foodservice Surface Sanitizing Wipes	Ethyl Alcohol, Isopropyl Alcohol	Approved only for food, breastmilk, and formula preparation areas	1 minute

Cleaning	Touchscreen wipes	Isopropyl alcohol	Approved only for cleaning. Not a disinfectant.	n/a

*Routine use of bleach products is restricted to dialysis. In the event of a Clostridium difficile outbreak, bleach may be used by trained EVS personnel for disinfection of surfaces as determined by Infection Prevention

Table B

Agents Approved for Cleaning and Low-level Disinfection of Environmental Surfaces and Non-Critical Devices

Preferred disinfectant, recommended for most equipment and environmental surfaces.

Micro-kill two Germicidal Wipes

Active Ingredient: Quaternary Ammonium Compounds, isopropyl alcohol
Use/Location: Routine Surface Disinfection
Dwell/wet time: 2 Minutes

⚠ **The most frequently used low-level disinfection products are listed in this table.**
Refer to Table A for a full list of approved low-level disinfection and sanitizing products.

Alternative Disinfectants - To be used only when the preferred disinfectant is not an option based on the device MIFU

CaviWipes Germicidal Wipes

Active Ingredient: Hydrogen Peroxide
Use/Location: Routine Surface Disinfection
Dwell/wet time: 3 Minutes

Micro-kill Af² Disinfecting Wipe

Active Ingredient: Quaternary Ammonium Compounds
Use/Location: Routine Surface Disinfection
Dwell/wet time: 2 Minutes

Oxivir TB Wipe

Active Ingredient: Hydrogen peroxide, isopropyl alcohol
Use/Location: Routine Surface Disinfection
Dwell/wet time: 1 minute for general disinfection 5 Minutes for TB

CaviWipes 1

Active Ingredient: Quaternary Ammonium Compounds, ethanol, isopropyl alcohol
Use/Location: Routine Surface Disinfection
Dwell/wet time: 1 Minutes

Micro-kill Bleach Wipe*

Active Ingredient: Sodium Hypochlorinate
Use/Location: Routine Surface Disinfection
Dwell/wet time: 3 Minutes

*Routine use of bleach products is restricted to dialysis. In the event of a Clostridium difficile outbreak, bleach may be used by trained EVS personnel for disinfection of surfaces as determined by Infection Prevention.

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Table C: Responsibilities for Cleaning and Low-Level Disinfection

Responsible Party	Scope of Cleaning / Disinfection	Examples of Surfaces/Equipment	Required Frequency
Environmental Services (EVS)	Routine cleaning and low-level disinfection of general environmental surfaces in clinical and non-clinical areas	Floors, walls, doors, windows, ledges, counters, furnishings, fixtures, public and staff restrooms, waiting areas, hallways, elevators, lobby areas, and high-touch environmental surfaces in patient rooms and common areas (e.g., bedside tables, over-bed tables, bed rails, handrails, light switches)	Daily and at routine intervals per EVS procedures • At patient discharge/transfer (terminal cleaning) • When visibly soiled or contaminated
Clinical Staff (Nursing and Other Direct Care Providers)	Cleaning and low-level disinfection of reusable non-critical patient care equipment used during delivery of patient care	Glucometers, pulse oximeter probes, thermometers, stethoscopes, blood pressure equipment, portable monitoring/therapy equipment, wheelchairs, stretchers (unless otherwise addressed in department policy)	• After each use • Between patients • When visibly soiled • Prior to storage' • As required by device MIFUs and department procedures
Departments Managing Specialty Equipment (e.g., Respiratory Therapy, Imaging, Endoscopy, SPD, procedural areas)	Cleaning and disinfection of department-owned reusable equipment	Department-specific reusable devices and equipment	As required by device MIFUs and department procedures
All Departments	Ensuring only clean equipment is stored and used for patient care	Reusable non-critical equipment and storage areas	Prior to storage and ongoing

Note: High-level disinfection and sterilization processes are addressed in separate policies and are not included in this table.

EOC 1047 Alternate Equipment Maintenance Program

Policy Number: EOC 1047	Date Created: 11/03/2025
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)	

Alternative Equipment Maintenance (AEM) Program- GFCI

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

Policy:

To establish a risk-based Alternative Equipment Maintenance (AEM) strategy for ground-fault circuit interrupter (GFCI) receptacles that replaces manufacturer-recommended monthly "TEST/RESET" checks with annual functional testing, while maintaining patient and staff safety and complying with CMS Conditions of Participation and accrediting-body expectations.

Procedure:

The organization implements an Alternative Equipment Maintenance (AEM) strategy for GFCI receptacles. Based on a documented risk assessment by qualified personnel and industry evidence indicating very low failure rates, the interval for routine GFCI functional testing is annually (12 months), replacing manufacturer-recommended monthly testing. This AEM does not alter other receptacle inspections/tests required by NFPA 99. GFCIs are tested upon installation, replacement, or servicing, and after any event suggesting damage or malfunction. Failed devices are removed from service until repaired or replaced. All GFCIs are noted in annual inspection logs, with records retained for survey review. This approach complies with CMS S&C 14-07 AEM provisions and is supported by ASHE/HFMM guidance and data demonstrating low failure rates and disproportionate burden of monthly testing.

This applies to all GFCI receptacles installed in the facility, including patient-care and non-patient-care areas, unless specifically excluded by regulation, code, or risk assessment (e.g., specialized systems where another authority requires a different interval). This AEM applies only to the GFCI functional trip test; it does not change other receptacle inspection requirements (visual condition, grounding continuity, polarity, retention force) governed by NFPA 99 practices.

Regulatory & Guidance Basis:

- CMS AEM allowance: Hospitals may deviate from manufacturer maintenance recommendations using a risk-based assessment by qualified personnel, with documentation and inventory controls identifying AEM-managed equipment.

- ASHE/HFMM evidence on GFCIs: ASHE-reported data (3-year member study) found extremely low failure rates of GFCIs with routine testing; HFMM cites <2% failures over three years at monthly testing in one large system and notes GFCIs as a "perfect candidate for an AEM." Another HFMM report on ASHE advocacy states no NFPA standard dictates test frequency and ASHE research shows an approximate 0.07% failure rate, making monthly testing excessive.

- NFPA 99/70 context: NFPA 99 prescribes testing triggers/intervals for hospital-grade vs. non-hospital-grade receptacles (e.g., certain non-hospital-grade outlets in specific patient locations at intervals not exceeding 12 months), but it does not mandate monthly GFCI testing; monthly originates from many manufacturers' instructions. This supports aligning to annual intervals under AEM when risk-justified.

Risk Assessment Summary:

- Method: Utility equipment AEM inclusion assessment per ASHE best practices (risk of failure, detectability, impact to patients/operations, maintenance history, redundancy, environment).
    i. Likelihood of failure: Very low based on ASHE member data; HFMM reports <2% failures across 3 years at monthly checks; advocacy article cites ~0.07% failure indication.
    ii. Severity if undetected: Potential for shock in wet/outdoor areas; however, GFCIs are inherently fail-safe (trip when fault detected) and are in addition to ground/bonding and general electrical protections; facility also performs routine receptacle inspections per NFPA 99.
    iii. Detectability/controls: Staff notice nuisance trips; work orders; annual documented test; targeted post-incident checks.
    iv. Redundancy/mitigation: Other safeguards (equipment ground, policies, staff education); ability to remove from service immediately upon test failure.
    Conclusion: With compensating controls and very low observed failure rates, shifting to annual GFCI testing maintains acceptable risk and meets CMS AEM criteria.

AEM Decision & Maintenance Strategy:

- Interval: Change routine GFCI functional testing from monthly to annually (12 months ± 30 days).
- Trigger-based tests (no change): Perform GFCI test after installation, replacement, or servicing; also after any incident of suspected electrical shock or water intrusion.
- Exclusions: Where an AHJ, project spec, or specific code section explicitly requires more frequent testing, that requirement governs; document any such locations.

Procedures – Inspection Process:

i. Identify: GFCIs by label and inventory ID. Inventory ID is based on the room location and number, outlets are then numbered sequentially clockwise starting on the left.
ii. Visual inspection: Damage, discoloration, moisture ingress, missing plates, and correct placement.
iii. Functional test: Press TEST to verify power interruption; press RESET to restore. Or test through use of standard testing device.
iv. Verify line/load wiring: If accessible, place Facilities Maintenance work order to correct if mis-wired.
v. Record results: (pass/fail), tech initials, date/time, asset ID.
i. If fail: Remove from service (tag out), open a work order, replace device, retest, and document corrective action.

Documentation & Evidence:

- Maintain:
  i. AEM risk assessment worksheet and EOC Committee approval through annual policy review.
  ii. Inventory list – As noted in the inspection logs.
  iii. Annual test logs and failure/corrective-action records.
  iv. Policy revision history stating deviation from manufacturer frequency under AEM.

Training & Qualifications:

- Technicians performing testing are qualified personnel (electricians or facilities techs knowledgeable on GFCI operation, hazards, and documentation).

Quality Assurance & Performance Indicators:

- Annual completion outlet testing
- Failure rate trend year over year; trigger RCA if a single facility failure rate exceeds 1% or if any shock event implicates a GFCI.
- Work order closure time for failed devices. Any failed device is blocked from use at the time identified, and not put back into use until repaired.

Communication Plan:

- Publish the policy; inform EOC committee of the new process. This does not change the current annual inspections being performed.
- For surveys, present: AEM policy, risk assessment, inspection logs, and recent annual results showing low failure rates consistent with ASHE evidence.

Cost/Risk Rationale (for EOC minutes)

- The District currently has over 2,000 GFCI outlets across the facilities. This equates to roughly 5 FTEs (or ±$445,000/year) needed to provide the monthly inspections currently recommended by manufactures. Annual outlet testing and inspections indicate a failure rate under 2%. Based on this the organization can justify implementing an AEM for this process in accordance with ASHE guidelines.

References:

CMS S&C 14-07-Hospital — permits AEM based on risk by qualified personnel, with inventory identification. CMS

HFMM/ASHE:

- Applying AEM in the real world — time/cost and low GFCI failure rate; AEM suitability. HFM Magazine
- ASHE advocacy plans — no NFPA test-frequency requirement; ASHE data ≈0.07% failure, monthly excessive. HFM Magazine
- Receptacle testing in patient areas — NFPA 99 testing intervals for certain receptacles (≤12 months) and test elements (visual, grounding, polarity, retention). HFM Magazine

ASHE AEM Risk-Assessment White Paper (Stymiest) — methodology for AEM inclusion and documentation acceptable to CMS/TJC. lashfm.org

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Appendices:

A) AEM Risk Assessment Worksheet:
   a. Asset Information
   b. Applicable Requirements
   c. Risk Assessment Factors
   d. Controls in Place
   e. Determination
   f. Follow-up Review

"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 8000 Heat and Illness Prevention Program

Kaweah Health

Subcategories of Department Manuals not selected.

Policy Number: EOC 8000	**Date Created: 07/01/2010**
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)	

Heat and Illness Prevention Program

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

PURPOSE

The purpose of Heat Illness Prevention Plan is to meet the requirements set forth in California Code of Regulations, Title 8, and also to serve as a supplement to the Kaweah Delta Health Care District , herin after referred to Kaweah Health (KH) Injury and Illness Prevention Program (IIPP). This information is intended and must be used in conjunction with the IIPP. The Heat Illness Prevention Plan establishes procedures and provides information, which is necessary to ensure that members of Kaweah Health are knowledgeable in the prevention and recognition of heat stress to ensure their own safety and the safety of others.

PROCEDURE

Heat Cramps

Description:
Heat cramps are the most common type of heat related injury and probably have been experienced by nearly everyone, at one time or another. Heat cramps are muscle spasms, which usually affect the arms, legs, or stomach. They do not usually occur until sometime later after work, at night, or when relaxing. Heat cramps are caused by heavy sweating, especially when water is not replaced quickly enough. Although heat cramps can be quite painful, they usually don't result in permanent damage.

Prevention/First Aid:
Call lead or supervisor immediately. Drink electrolyte solutions such as *Gatorade* or plenty of water during the day and try eating more fruits, such as bananas, to help keep your body hydrated during hot weather.

Heat Exhaustion

Description:
Heat exhaustion is more serious than heat cramps. It occurs when the body's internal temperature regulating system is overworked, but has not completely shut down. In heat exhaustion, the surface blood vessels and capillaries, which originally enlarged to cool the blood, collapse from loss of body fluids and necessary minerals. This happens when you do not drink enough fluids to replace what you are sweating away.

Symptoms Include:
Headache, heavy sweating, intense thirst, dizziness, fatigue, loss of coordination, nausea, impaired judgment, loss of appetite, hyperventilation, tingling in hands or feet, anxiety, cool moist skin, weak and rapid pulse (120-200), and low to normal blood pressure.

Prevention/First Aid:
Call Ext. 44 and ask for the House Supervisor, if the person becomes non-responsive, refuses water, vomits, or loses consciousness dial 911 or transport to Emergency Department. The employee suffering these symptoms should be moved to a cool location, such as a shaded area or air-conditioned building. Have them lie down with their feet slightly elevated. Loosen their clothing, apply cool, wet cloths or fan them. Have them drink water or electrolyte drinks. Try to cool them down, and have them checked by medical personnel. Victims of heat exhaustion should avoid strenuous activity for at least a day and they should continue to drink water to replace lost body fluids.
If employee is off-site they should call 911 directly to seek medical attention.

Heat Stroke

Description:
Heat stroke is a life threatening illness with a high death rate. It occurs when the body has depleted its supply of water and salt and the victim's core body temperature rises to deadly levels. A heat stroke victim may first suffer heat cramps and/or heat exhaustion before progressing into the heat stroke stage, but this is not always the case. It should be noted that, on the job, heat stroke is sometimes mistaken for a heart attack. It is therefore very important to be able to recognize the signs and symptoms of heat stroke - and to check for them anytime an employee collapses while working in a hot environment.

Symptoms Include:
A high body temperature (103 degrees F); a distinct absence of sweating (usually); hot red or flushed dry skin; rapid pulse; difficulty breathing; constricted pupils; any/all the signs or symptoms of heat exhaustion such as dizziness, headache, nausea, vomiting, or confusion, and possibly more severe systems including; bizarre behavior; and high blood pressure. Advance symptoms may be seizure or convulsions, collapse, loss of consciousness, and a body temperature of over 108 degrees F.

Prevention/First Aid:
Call Ext 44 and transport to Emergency Department immediately. It is vital to lower a heat stroke victim's body temperature. Quick actions can mean the difference between life and death. Pour water on them, fan them, or apply cold packs.
If employee is off-site they should call 911 directly to seek medical attention

PRECAUTIONS TO PREVENT HEAT ILLNESSES

Condition yourself for working in hot environments. Start slowly then build up to more physical work. Allow your body to adjust over a few days (acclimatization).

Drink plenty of liquids. Hydration is a continuous process. Don’t wait until you’re thirsty!
By then, there’s a good chance that you’re already on your way to being dehydrated.
Electrolyte drinks are good for replacing both water and minerals lost through sweating.
Never drink alcohol, and avoid caffeinated beverages like coffee and soda as these liquids can have the opposite effect and can actually increase the level of dehydration.

Take frequent breaks, especially if you notice you’re getting a headache or you start feeling overheated. Assure that adequate water and shade are available at the job site before work is to begin. Wear lightweight, light colored clothing when working out in the sun. You should immediately report all unsafe conditions and/or concerns to your supervisor or area manager.

Provisions of Water
Water is a key preventive measure to minimize the risk of heat related illnesses.
3395 (c) and 3396 (c) Employees shall have access to potable drinking water meeting the requirements of Sections 1524, 3363, and 3457, as applicable. Where the supply of water is not plumbed or otherwise continuously supplied, water shall be provided in sufficient quantity at the beginning of the work shift to provide one quart per employee per hour for drinking for the entire shift. Employers may begin the shift with smaller quantities of water if they have effective procedures for

replenishment during the shift as needed to allow employees to drink one quart or more per hour. The frequent drinking of water, as described in 3395 (e), shall be encouraged.

Access to Shade
Access to rest and shade or other cooling measures are important preventive steps to minimizing the risk of heat related illnesses. 3395 (d) Employees suffering from heat illness or believing a preventative recovery period is needed, shall be provided access to an area with shade that is either open to the air or provided with ventilation or cooling for a period of no less than five minutes. Such access to shade shall be permitted at all times.
3396 (d) Area must be provided and kept at a temperature below 82 degrees.

Training
Training is critical to help reduce the risk of heat related illnesses and to assist with obtaining emergency assistance without delay.

3395 (e) (1) and 3396 (h) Employee training: training in the following topics shall be provided to all supervisory and non-supervisory employees:

- The environmental and personal risk factors for heat illness;
- The employer's procedures for complying with the requirements of this standard;
- The importance of frequent consumption of small quantities of water, up to 4 cups per hour, when the work environment is hot and the employees are likely to be sweating more than usual in the performance of their duties.
- The importance of acclimatization;
- The different types of heat illness and the common signs and symptoms of heat illness;
- The importance to employees of immediately reporting to the employer, directly or through the employee's supervisor, symptoms or signs of heat illness in themselves, or in co-workers.
- The employer's procedures for responding to symptoms of possible heat illness, including how emergency medical services will be provided should they become necessary;
- The employer's procedures for contacting emergency medical services, and if necessary, for transporting employees to a point where they can be reached by an emergency medical service provider.
- The employer's procedures for ensuring that, in the event of an emergency, clear and precise directions to the work site can and will be provided as needed to emergency responders.

Note: T8 CCR 3203 (a)(3) requires that communication for employees shall be in a form readily understandable by all affected employee.

Departments with employees whose job duties require them to work in the outdoors or indoors during summer months in elevated heat conditions will take the following steps:.

- All employees, upon hire and annually thereafter, will receive training regarding Heat Illness Prevention Procedures. All newly hired workers will be assigned a buddy or experienced coworker to ensure that they understood the training and follow the company procedures.

- Water is available in the department at all times. There is a water fountain and cold water through the refrigerator.

- Fluids will be easily accessible for all employees and located in the employee break room.

- Frequent (hourly) waters breaks will be taken by all employees, when needed, and when the temperature exceeds 95 degrees F or indoor temperature above 82 degrees. An air-conditioned break room is available for this purpose.

- Shift leads will provide frequent reminders to employees to drink frequently, and more water breaks will be provided.

"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."

Semi Annual Investment Report December 31, 2025

KAWEAH DELTA HEALTH CARE DISTRICT
FINANCE DIVISION MEMORANDUM

TO: Finance Committee, Board of Directors, Chief Executive Officer and Executive Team

FROM: Jennifer Stockton, Director of Finance (ext. #5536) and Malinda Tupper, Chief Financial Officer (ext. #4065)

DATE: February 17, 2026

SUBJECT: **Semi-annual Investment Report – December 31, 2025**

Each month the Board of Directors receives an investment report depicting the specific investments held by the District including the nature, amount, maturity, yield, and investing institution. On a semi-annual basis, the District's Chief Financial Officer is required to review the District's investment policy with the Board, to discuss our compliance with that policy, to review the purpose of our various investment funds and to report on the performance, quality and risk profile of our current portfolio. At the Board's request, fulfillment of this requirement is hereby made by means of this written report and accompanying schedules.

The purpose of this report is to assure the Board that the following primary objectives have been satisfied with respect to its fiduciary responsibility for the sound and prudent management of the District's monetary assets:

1) The Board of Directors understands and approves of the District's investment policy and is confident that management has effectively complied with this policy.

2) Management has effectively established appropriate funds and managed investments in a manner that safeguards the District's assets, meets the ongoing liquidity needs of the District and provides necessary funds for the various projects and budgets approved and adopted by the Board.

3) Within the constraints of the investment policy and the funding needs of the District, management effectively maximizes its return on investments to meet the income expectations adopted by the Board as part of the annual budget.

4) The acceptance/approval of this report includes the semi-annual review and approval of the investment policy (and any changes proposed) as well as the delegation of authority contained within the policy. A redlined version of proposed changes is included in this report as part of this approval.

For the purpose of assessing performance relative to each of these objectives, this written report describes and evaluates each of the following documents accompanying this report and demonstrates achievement of the stated objectives.

General Deposit and Investment Policy

The District's current investment policy reflects strict compliance with the California Government Code (Code) sections 53600 through 53686 which govern the investment of surplus funds by governmental entities of the State of California, including political subdivisions thereof**. At December 31, 2025, the District's investment portfolio complies with all provisions of this policy**.

Statement of Purpose Guidelines District Funds

This document describes the various funds established by the District for the purpose of setting aside cash and investments for specific uses. The establishment of these funds (other than revenue or general obligation bond proceeds) is entirely at the discretion of the Board and are not mandated or controlled by any third-party or regulatory agency.

Summary of Investment Funds

This document depicts the carrying value, equal to cost, of investments held at December 31, 2025 in each of the various funds established by the District. As indicated in this report, the District's total adjusted surplus funds at December 31, 2025 were $245.5 million. The following table depicts the District's adjusted surplus funds over the past four years; the number of days cash on hand, a measure of liquidity; and the District's average daily operating expenses (excluding depreciation expense), the denominator used in the calculation of the liquidity measure; and the percent increase in each year over the prior year:

	December 31, 2025	December 31, 2024	December 31, 2023	December 31, 2022
Adjusted Surplus Funds	$254.544,000	$178,008,000	$183,602,000	$201,873,000
Days Cash on Hand	97.1	74.6	83.5	83.4
Average Daily Operating Expenses (excluding depreciation expense)	$2,529,000	$2,385,000	$2,199,000	$2,420,000
Percent Increase in Daily Expenses	6.0%	8.5%	-9.1%	7.6%
Days Cash on Hand Benchmarks:				
Moody's "A" Rated Hospitals	194.6 Days			
Revenue Bond Covenants	90 Days			

As illustrated in the above table, as of December 31, 2025 the District's liquidity ratio (days cash on hand) exceeded the covenant amount required by the District's revenue bond indentures, which is reported and measured for covenant compliance as of fiscal year end (June 30). Total surplus funds experienced a 21.6% increase from December 31, 2022 to December 31, 2025, and the number of days cash on hand increased 16.4% from 2022. The primary reasons for the increase in total surplus funds is the receipt of the Distressed Hospital loan in the amount of $21 million in March 2024, the receipt of

$47.7 million of FEMA funds in August 2025, and the transfer back of the bond reserve funds of $22 million in November 2025.

Given the District's current average daily operating expense total of $2.5 million, achievement of the Moody's "A"-rated hospitals' days cash on hand benchmark of 194.6 would require approximately $246.6 million of additional cash resources.

The District's surplus funds investment portfolio is separated into two different categories including short-term funds and long-term funds. The District's short-term funds included investment in the Local Agency Investment Fund (LAIF) and California Asset Management Program (CAMP). The annual yields for LAIF and CAMP were 4.2 % and 4.4%, respectively, for the year ended December 31, 2025. The District's long-term portfolio is managed by PFM Asset Management (PFM) and Allspring (formerly Wells Capital Management). The twelve-month total return of the portfolio managed by PFM was 6.0%, net of fees, while the twelve-month total return of the portfolio managed by Allspring was 5.6%, net of fees. The benchmark was 6.0% for the period. The benchmark for the managed portfolios is a custom index including 70% of the Merrill Lynch 1-5 year US Treasury Index and 30% of the Merrill Lynch 1-5 year A-AAA Corporate Index. The benchmark does include security types that the District is not allowed to purchase and that because of their nature tend to carry higher yields. These include foreign issuers and private placement securities. As of December 31, 2025, the District's investment portfolio had a weighted average prospective yield of 4.2%. The District's targeted rate of return of 4.2% was used to project interest income in the District's Annual Budget for the fiscal year. Both the budgeted yield and the prospective yield exclude market value fluctuations that are included in the total return figures noted above.

Investment Summary by Institution

This document depicts the amount of District investments held by various financial institutions as of December 31, 2025. In each case, the financial institution may be the issuer of an investment security, the custodian of securities, or the investment advisor managing the securities.

Investment Summary of Surplus Funds by Type

This document depicts the amount of District funds invested into the various categories of investments permitted by the District's investment policy and the Code, as well as the percentage of total surplus funds invested in each category and the corresponding limitation established by the Code for compliance measurement.

Investment Summary of Surplus Funds by Maturity

This document depicts the amount of District funds maturing each year over the five-year investment time horizon permitted by the District's investment policy. The measurement period for each year commences on January 1 and runs to December 31. The purpose of this schedule is to assess the overall liquidity of the District's portfolio, which has a weighted average maturity of 2.38 years at December 31, 2025.

Investment Summary of Surplus Fund's Unrealized Gains and Losses

All investment summaries referenced above include the cost of investments and do not reflect current market values. This document depicts the status of securities with respect to unrealized gains and losses at December 31, 2025. The District measures and records an adjustment to reflect the current fair market value of its total investment portfolio each quarter. The unrealized gain on the District's surplus fund portfolio at December 31, 2025 was $1,064,000.

Kaweah Delta Health Care District
General Deposit and Investment Policy

Scope

This policy sets forth the deposit and investment policy governing all District funds and related transactions and investment activity. This policy does not apply to the Employer Retirement Plan Trust. Bond proceeds shall be invested in securities permitted by the applicable bond documents. If the bond documents are silent as to the permitted investments, bond proceeds will be invested in the securities permitted by this Policy. Notwithstanding the other provisions of this Policy, the limitations (credit quality, percentage holdings, etc.) listed elsewhere in this Policy do not apply to bond proceeds. With the exception of permitted investment requirements, all other provisions of this policy will apply to the investment of bond proceeds to the degree they do not conflict with the requirements of the applicable bond documents.

Goals and Objectives

Legal Compliance: All District deposits and investments shall be in compliance with sections 53600 through 53686 of the California Government Code (Code) for local agencies. This policy sets forth certain additional restrictions which may exceed those imposed by the Code.

Prudence: The District Board of Directors (Board) and any persons authorized to make investment decisions on behalf of the District are trustees and therefore fiduciaries subject to the prudent investor standard. When managing District investment activities, a trustee shalt act with care, skill, prudence and diligence under the circumstances then prevailing, including, but not limited to, the general economic conditions and the anticipated ~~d~~ needs of the District, that a prudent person acting in a like capacity and familiarity with those matters would use in the conduct of funds of like character and with like aims, to safeguard the principal and maintain the liquidity needs of the District.

Goals: In order of priority, trustee goals shall be:

1) Safety - The principal of the portfolio will be preserved by investing in high quality securities and by maintaining diversification of securities to include various types, issuers and maturities. Investments will be limited to those allowed by the Code as outlined in the permitted investments section below. Due to the complexity of various investment options and the volatility of market conditions, the trustee may seek professional advice in making decisions in order to optimize investment selections.

The trustee will also monitor the ongoing credit rating of selected investments by reference to monthly investment statements and council with investment advisors.

2) Liquidity - The portfolio will be managed to ensure sufficient liquidity to meet routine and non-routine budgeted cash flow requirements as well as provide for unanticipated cash needs. Based upon these needs, investments with appropriate maturity dates will be selected. Generally, these investments will be held to maturity once purchased unless called by the issuer. Securities may be sold prior to maturity under the following circumstances: 1) A security with declining credit may be sold early to minimize loss of principal. 2) A security trade would improve the quality, yield, or target duration in the portfolio. 3) Liquidity needs of the portfolio require that the security be sold.

3) Rate of Return - The investment portfolio shall be designed with the objective of attaining a market rate of return throughout budgetary and economic cycles, taking into account the investment risk constraints and liquidity needs. Performance will be measured by the ability to meet the targeted rate of return, which will equal or exceed the average return earned on the District's investment in the State of California Local Agency Investment Funds.

Safekeeping

District investments not purchased directly from the issuer shall be purchased either from an institution licensed by the State as a broker-dealer or from a member of a federally-regulated securities exchange, a national or state-chartered bank, a federal or state association or from a brokerage firm designated as a primary government dealer by the Federal Reserve Bank. Investments purchased in a negotiable, bearer, registered or nonregistered format shall be delivered to the District by book entry, physical delivery or third party custodial agreement. The transfer of securities to the counterparty bank's customer book entry account may be used for book entry delivery. A counterparty bank's trust or separate safekeeping department may be used for the physical delivery of the security if the security is held in the District's name.

Authorized Financial Dealers and Institutions: If the District utilizes an external investment adviser, the adviser may be authorized to transact with its own Approved Broker/Dealer List on behalf of the District. In the event that the investment advisor utilizes its own Broker/Dealer List, the advisor will perform due diligence for the brokers/dealers on its Approved List.

Internal Controls: The Chief Financial Officer is responsible for establishing and maintaining an internal control structure designed to ensure that the assets of the District

are protected from loss, theft or misuse. The internal control structure shall be designed to provide reasonable assurance that these objectives are met. The concept of reasonable assurance recognizes that (1) the cost of a control should not exceed the benefits likely to be derived and (2) the valuation of costs and benefits requires estimates and judgments by management.

Delivery vs. Payment: All trades where applicable will be executed by delivery vs. payment (DVP) to ensure that securities are deposited in an eligible financial institution prior to the release of funds. Securities will be held by a third-party custodian as evidenced by safekeeping receipts.

Ethics and Conflicts of Interest

Officers and employees involved in the investment process shall refrain from personal business activity that could conflict with the proper execution and management of the investment program, or that could impair their ability to make impartial decisions. Employees and investment officials shall disclose any material interests in financial institutions with which they conduct business. They shall further disclose any personal financial/investment positions that could be related to the performance of the investment portfolio. Employees and officers shall refrain from undertaking personal investment transactions with the same individual with whom business is conducted on behalf of the District.

Delegation of Authority

1) The Board hereby delegates its authority to invest District funds, or to sell or exchange purchased securities, to the Treasurer for a one-year period, who shall thereafter assume full responsibility for those transactions until the delegation of authority is revoked or expires. The Board may renew the delegation of authority each year. The responsibility for day-to-day management (including the investment of funds, and selling or exchanging of purchases securities) of District investments is hereby delegated by the Board, and the Treasurer, to the Chief Financial Officer (CFO) and/or their designee subject to compliance with all reporting requirements and the prudent investor standard. The District may engage the services of one or more external investment managers to assist in the management of the investment portfolio in a manner consistent with the Districts' objectives. Such external managers will be granted the discretion to purchase and sell investment securities in accordance with the Investment Policy.

Reporting

The Treasurer or CFO shall annually submit a statement of investment policy to the Board summarizing the District's investment activities and demonstrating compliance with this

policy and the Code. The Treasurer or CFO shall submit monthly reports to the Board detailing each investment by amount, type, issuer, maturity date, and rate of return, and reporting any other information requested by the Board. The monthly reports shall also summarize all material non-routine investment transactions and demonstrate compliance of the portfolio with this policy and the Code, or delineate the manner in which the portfolio is not in compliance. Any concerns regarding the District's ability to maintain sufficient liquidity to meet current obligations shall be disclosed in the monthly reports.

Performance Standards: The investment portfolio will be managed in accordance with the parameters specified within this policy. The portfolio should obtain a market average rate of return during a market/economic environment of stable interest rates. A series of appropriate benchmarks shall be established against which portfolio performance shall be compared on a regular basis.

Deposits

All District deposits shall be maintained in banks having full-service operations in the State of California. Deposits are defined as working funds needed for immediate necessities of the District. Deposits in any depository bank shall not exceed the shareholders' equity of that bank. The Treasurer shall be responsible for the safekeeping of District funds and shall enter into a contract with any qualified depository making the depository responsible for securing the funds deposited. All District deposits shall be secured by eligible securities as defined by section 53651 of the Code and shall have a market value of at least 10 percent in excess of the total amount deposited. The Treasurer may waive security for the portion of any deposits insured pursuant to federal law and any interest which subsequently accrues on federally-insured deposits.

Permitted Investments

Sinking funds or surplus funds not required for immediate needs of the District shall be invested in authorized investments as defined in Code section 53601 and may be further limited by this policy. No investment shall be made in any security having a term remaining to maturity exceeding five years at the time of investment, which shall be measured from the settlement date to final maturity, unless the Board has granted express authority to make the investment no less than three months prior to the investment. The purchase of a security shall not have a forward settlement date exceeding 45 days from the time of investment. Certain investments are limited by the Code and this policy as to the percent of surplus funds which may be invested. Investments not expressly limited by the Code or this policy may be made in a manner which maintains reasonable balance between investments in the portfolio.

Authorized investments are limited to the following:

(a) Investment in the State of California Local Agency Investment Fund up to the maximum investment allowed by the State.

(b) United States Treasury notes, bonds, bills or certificates of indebtedness, or those for which the faith and credit of the United States are pledged for the payment of principal and interest.

(c) Registered State warrants or treasury notes or bonds of this State, including bonds payable solely out of the revenues from a revenue-producing property owned, controlled or operated by the State or a department, board, agency or authority of the State.

(d) Federal agency or United States government-sponsored enterprise obligations, participations, or other instruments, including those issued by or fully guaranteed as to principal and interest by federal agencies or United States government-sponsored enterprises.

(e) Bills of exchange or time drafts drawn on and accepted by a commercial bank, otherwise known as bankers' acceptances. Purchases of bankers' acceptances may not exceed 180 days maturity or 40 percent of surplus funds. However, no more than 30 percent of surplus funds may be invested in bankers' acceptances of any one commercial bank.

(f) Commercial paper of prime quality of the highest ranking or of the highest letter and numerical rating as provided for by a nationally recognized statistical rating organization (NRSRO). Eligible paper is further limited to issuing corporations organized and operating within the United States and having total assets exceeding five hundred million dollars ($500,000,000) and is rated in a rating category of ”A” or its equivalent or higher rating for the issuer's debt, other than commercial paper, if any, as provided for by an NRSRO. Purchases of eligible commercial paper may not exceed ~~270~~ 397 days maturity nor represent more than 10 percent of the outstanding paper of an issuing corporation. Purchases of commercial paper may not exceed 25 percent of surplus funds. This applicable limit on commercial paper may be 40 percent if the District’s investment assets under management exceed $100 million as permitted by Code with provisions. No more than 10 percent of surplus funds may be invested in the commercial paper and the medium-term notes of any single issuer.

(g) Negotiable certificates of deposit issued by a nationally or state-chartered bank, a savings association or a federal association, a state or federal credit union, or by a federally licensed or state-licensed branch of a foreign bank. For purposes of this section, negotiable certificates of deposit do not come within Article 2 (commencing with Section 53630), except that the amount so invested shall be subject to the limitations of Section 53638. The legislative body of a local agency and the treasurer or other official of the local agency having legal custody of the moneys are prohibited from investing local agency funds, or funds in the custody of the local agency, in negotiable certificates of deposit issued by a state or federal credit union if a member of the legislative body of the local agency, or a person with investment decision making authority in the administrative office manager's office, budget office, auditor-controller's office, or treasurer's office of the local agency also serves on the board of directors, or any committee appointed by the board of directors, or the credit committee or the supervisory committee of the state or federal credit union issuing the negotiable certificates of deposit. Purchases of all types of certificates of deposit may not exceed 30 percent of surplus funds.

(h) Investments in repurchase agreements or reverse repurchase agreements of any securities authorized by this policy when the term of the agreement does not exceed one year. The market value of securities underlying a repurchase agreement shall be valued at 102 percent or greater of the funds borrowed against those securities and the value shall be adjusted no less than quarterly. Reverse repurchase agreements shall meet all conditions and requirements set forth in Code section 53601.

(i) Medium-term notes, defined as all corporate and depository institution debt securities with a maximum of five years maturity, issued by corporations organized and operating within the United States or by depository institutions licensed by the United States or any state and operating within the United States. Notes eligible for investment shall be rated in a rating category of "A" or its equivalent or better by an NRSRO. Purchases of medium-term notes may not exceed 30 percent of surplus funds and no more than 10 percent of surplus funds may be invested in the medium-term notes and commercial paper of any single issuer.

(j) Any mortgage passthrough security, collateralized mortgage obligation, mortgage-backed or other pay-through bond, equipment lease-backed certificate, consumer receivable passthrough certificate, or consumer receivable-backed bond. ~~Securities eligible for investment under this subdivision shall be rated in a rating category of "AA" or its equivalent or better by an NRSRO and have a maximum~~

~~remaining maturity of five years or less. Purchases of collateralized mortgage obligations may not exceed 20 percent of surplus funds.~~

For securities eligible for investment under this subdivision not issued or guaranteed by an agency or issuer identified in subdivision (b) or (d) of this Policy section, the following limitations apply:

1. The security shall be rated in a rating category of "AA" or its equivalent or better by an NRSRO and have a maximum remaining maturity of five years or less.
2. Purchase of securities authorized by this paragraph shall not exceed 20 percent of surplus funds.

(k) Shares of beneficial interest issued by diversified management companies that invest in securities and obligations as authorized by section 53601 or that are money market funds registered with the Securities and Exchange Commission under the Investment Act of 1940, and that have attained the highest ranking or the highest letter and numerical rating provided by not less than two NRSROs. Purchases of shares of beneficial interest may not exceed 20 percent of surplus funds, and no more than 10 percent of surplus funds may be invested in shares of beneficial interest of any one mutual fund.

(I) Bonds issued by Kaweah Delta Health Care District, including bonds payable solely out of the revenues from a revenue-producing property owned, controlled, or operated by Kaweah Delta Health Care District.

(m) Bonds, notes. warrants, or other evidences of indebtedness of any local agency within this state, including bonds payable solely out of the revenues from a revenue- producing property owned, controlled, or operated by the local agency, or by a department, board, agency, or authority of the local agency.

(n) Registered treasury notes or bonds of any of the other forty-nine United States in addition to California, including bonds payable solely out of the revenues from a revenue-producing property owned, controlled, or operated by a state or by a department, board, agency, or authority of any of the other forty-nine United States, in addition to California.

(p) Shares of beneficial interest issued by a joint powers authority (JPA) organized pursuant to Section 6509.7 that invests in the securities and obligations authorized under California Government Code Section 53601 subdivisions (a) to (~~q~~r), inclusive. Each share shall represent an equal proportional interest in the underlying pool of securities owned by the JPA. The JPA issuing the shares shall

have retained an investment adviser registered or exempt from registration with the Securities and Exchange Commission, with not less than five years of experience investing in the in the securities and obligations authorized in California Government Code Section 53601 subdivisions (a) to (q), inclusive~~authorized securities~~, and having assets under management in excess of five hundred million dollars.

(q) United States dollar denominated senior unsecured unsubordinated obligations issued or unconditionally guaranteed by the International Bank for Reconstruction and Development, International Finance Corporation, or Inter-American Development Bank, with a maximum remaining maturity of five years or less, and eligible for purchase and sale within the United States. Investments under this subdivision shall be rated in a rating category of “AA” or its equivalent or better by an NRSRO and shall not exceed 30 percent of surplus funds.

Policy Considerations

This policy shall be reviewed on an annual basis. Any changes must be approved by the Chief Financial Officer and any other appropriate authority, as well as the individual(s) charged with maintaining internal controls.

Kaweah Delta Health Care District
STATEMENT OF PURPOSE GUIDELINES
DISTRICT FUNDS

Operating Accounts:
General operating funds to meet current and future operating obligations.

Self-Insurance Trust Fund:
Self-insurance fund established for potential settlement of general, professional and public liability claims. All earnings remain in the fund. Disbursements are allowed for payment of claims, legal fees, or by approval of the Board of Directors. Whenever possible, District operating funds or other funds will be used to meet such liabilities.

2015A Revenue Bond Fund:
The purpose of this fund is to hold and disburse the District's 2015A Revenue Bond principal and interest payments made by the District pending disbursement by the trustee bank.

2015B Revenue Bond Fund:
The purpose of this fund is to hold and disburse the District's 2015B Revenue Bond proceeds for various projects and to hold principal and interest payments made by the District pending disbursement by the trustee bank.

2017 C Revenue Bond Fund:
The purpose of this fund is to hold and disburse the District's 2017C Revenue Bond principal and interest payments made by the District pending disbursement by the trustee bank.

2020 Revenue Bond Fund:
The purpose of this fund is to hold and disburse the District's 2020 Revenue Bond proceeds for various projects and to hold principal and interest payments made by the District pending disbursement by the trustee bank.

2022 Revenue Bond Fund:
The purpose of this fund is to hold and disburse the District's 2022 Revenue Bond proceeds for various projects and to hold principal and interest payments made by the District pending disbursement by the trustee bank.

Master Debt Reserve Fund:
The purpose of this fund is to hold funds equal or greater than the amount of the District's maximum annual debt service. This fund was created due to the District's failure to meet the required MADS debt service requirement at December 31, 2022. The funds were transferred back to the Surplus Fund in 2025.

2014 General Obligation Bond Fund:
The purpose of this fund is to hold and disburse the District's 2014 General Obligation Bond principal and interest payments made by the District pending disbursement by the trustee bank.

Plant Fund:
The primary purpose of this fund is to retain investments for funded depreciation. In addition, funds for special capital projects and Board-designated projects which may include real property, unbudgeted capital equipment, etc. are retained in the fund. Disbursements are made for such special capital projects and for replacement capital items at the Board's discretion.

Cost Report Settlement Fund:
Account established to set aside sufficient funds to settle Federal and State cost reports due to the substantial nature of potential settlements.

Development Fund:
Accumulated reserves set aside from special projects, activities and memorials to be used as seed money for research, community service, or service development at the specific direction of the Board.

Workers' Compensation Liability Fund:
Funds available for possible settlement or payment of employee work-related medical claims, suits or judgments, or legal fees. Whenever possible, District operating funds or other funds will be used to meet such liabilities.

General Obligation Bond Reserve Fund:
The purpose of this fund is to hold funds set aside to establish a reserve account in the amount recommended by the County of Tulare.

Kaweah Delta Health Care District
SUMMARY OF INVESTMENT FUNDS
12/31/25

	Investment Amount (Cost)		
		December 31, 2025	December 31, 2024
Trust Accounts			
Self-Insurance Trust Fund		$ 1,363,000	$ 1,715,000
2014 General Obligation Bond Fund		2,457,000	4,168,000
2015A Revenue Bond Fund		2,808,000	1,090,000
2015B Revenue Bond Fund		362,000	373,000
2017C Revenue Bond Fund		4,920,000	3,214,000
2020 Revenue Bond Fund		979,000	577,000
2022 Revenue Bond Fund		2,186,000	1,468,000
Master Debt Reserve Fund		-	22,811,000
Operating Accounts		9,214,000	14,016,000
Board Designated Funds			
Plant Fund			
Committed for Capital Expenditure	$19,513,000		
Uncommitted	163,512,000	183,025,000	120,715,000
General Obligation Bond Reserve		1,993,000	1,993,000
Cost Report Settlement Fund		3,448,000	3,448,000
Development Fund		104,000	104,000
Workers' Compensation Liability Fund		22,285,000	17,626,000
Total Board Designated Funds		210,855,000	143,886,000
Total Investments		**$ 235,144,000**	**$193,318,000**
Kaweah Health Hospital Foundation		**$20,910,000**	**$18,867,000**

Kaweah Delta Health Care District
SUMMARY OF INVESTMENT FUNDS
December 31, 2025

	December 31, 2025	December 31, 2024	December 31, 2023	December 31, 2022
Total Surplus Funds	**$220,069,000**	$157,902,000	$167,524,000	$189,125,000
Add: Kaweah Health Medical Group	**0**	0	242,000	2,011,000
Sequoia Regional Cancer Ctr.	**0**	0	5,000	2,000
KH Foundation	**20,910,000**	18,867,000	17,425,000	20,188,000
Adjustment to record fair market value (FMV)	**3,478,000**	549,000	(2,247,000)	(10,096,000)
Accrued Investment Earnings	**1,087,000**	690,000	653,000	643,000
Adjusted Surplus Funds	$245,544,000	$178,008,000	$183,602,000	$201,873,000
Daily Operating Expenses (excluding depreciation expense)	**$2,529,000**	$2,385,000	$2,199,000	$2,420,000
Percent Increase	**6.0%**	8.5%	-9.1%	7.6%
Days Cash on Hand (Actual - consolidated financial statements)	**97.1**	74.6	83.5	83.4
Benchmark:				
Moody's "A" Rated Hospitals (2024)	**194.6**			
Cash spread to "A" rating	**$246,556,000**			
Surplus portfolio return (includes FMV adjustment) :				
12-Months Ended :				
LAIF	**4.24%**	4.38%	3.93%	1.06%
CAMP	**4.36%**	5.31%	5.50%	1.80%
Total Return:				
Long-Term (PFM - net of fees)	**6.03%**	4.13%	5.16%	-4.99%
Long-Term (Allspring - net of fees)	**5.55%**	4.78%	4.25%	-5.13%
Benchmark (70% ML 1-5 Treasury, 30% ML US Corp A-AAA)	**6.00%**	3.83%	4.78%	-5.37%
Prospective Yield of Portfolio (No FMV)	**4.17%**	3.45%	2.65%	1.50%
Fiscal Year Budget (No FMV)	**4.22%**	2.82%	1.65%	0.92%

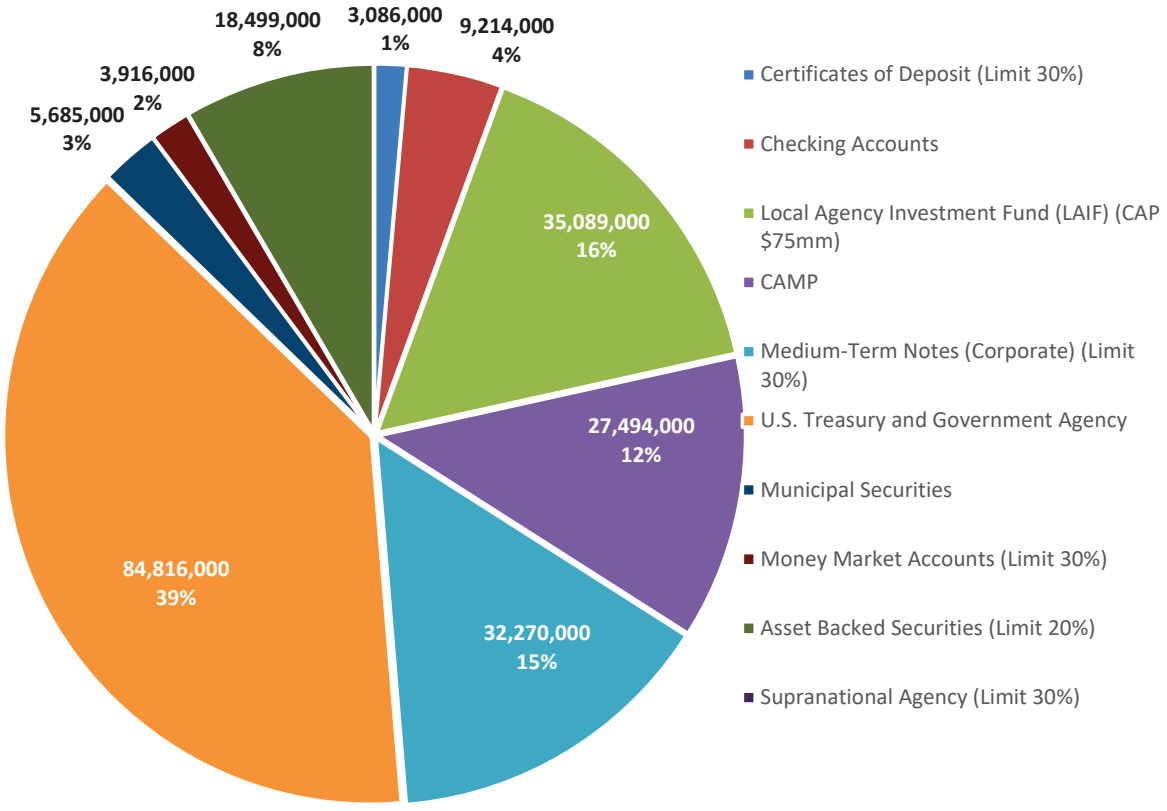
Note: All investment balances included in the attached investment summaries are stated at the cost value and do not reflect current fair market values. Please refer to the Investment Summary of Unrealized Gains and Losses for current market values.

Kaweah Delta Health Care District
INVESTMENT SUMMARY BY INSTITUTION
December 31, 2025

	Investment Amount (Cost)	
	December 31, 2025	December 31, 2024
US Bank (Bond Trustee)	$ 11,255,000	$ 29,533,000
Local Agency Investment Fund (LAIF)	35,089,000	9,773,000
PFM Asset Management (Manager) - US Bank Custodian	72,698,000	58,803,000
Allspring (Manager) - US Bank Custodian	70,993,000	57,459,000
Allspring (SITF)	1,363,000	1,715,000
CAMP (Managed by PFM)	29,951,000	17,303,000
Western Alliance (CD Placement GO Refinance)	3,217,000	3,000,000
Wells Fargo Bank (Operating accounts)	10,578,000	15,732,000
Total Investments	**235,144,000**	193,318,000
Less Trust Accounts	(15,075,000)	(35,416,000)
Total Surplus Funds	**$220,069,000**	$157,902,000
Kaweah Health Hospital Foundation		
Community West Bank	$505,000	$361,000
Various Short-Term and Long-Term Investments	20,405,000	18,506,000
	$20,910,000	**$18,867,000**

Kaweah Delta Health Care District
INVESTMENT SUMMARY OF SURPLUS FUNDS BY TYPE
December 31, 2025

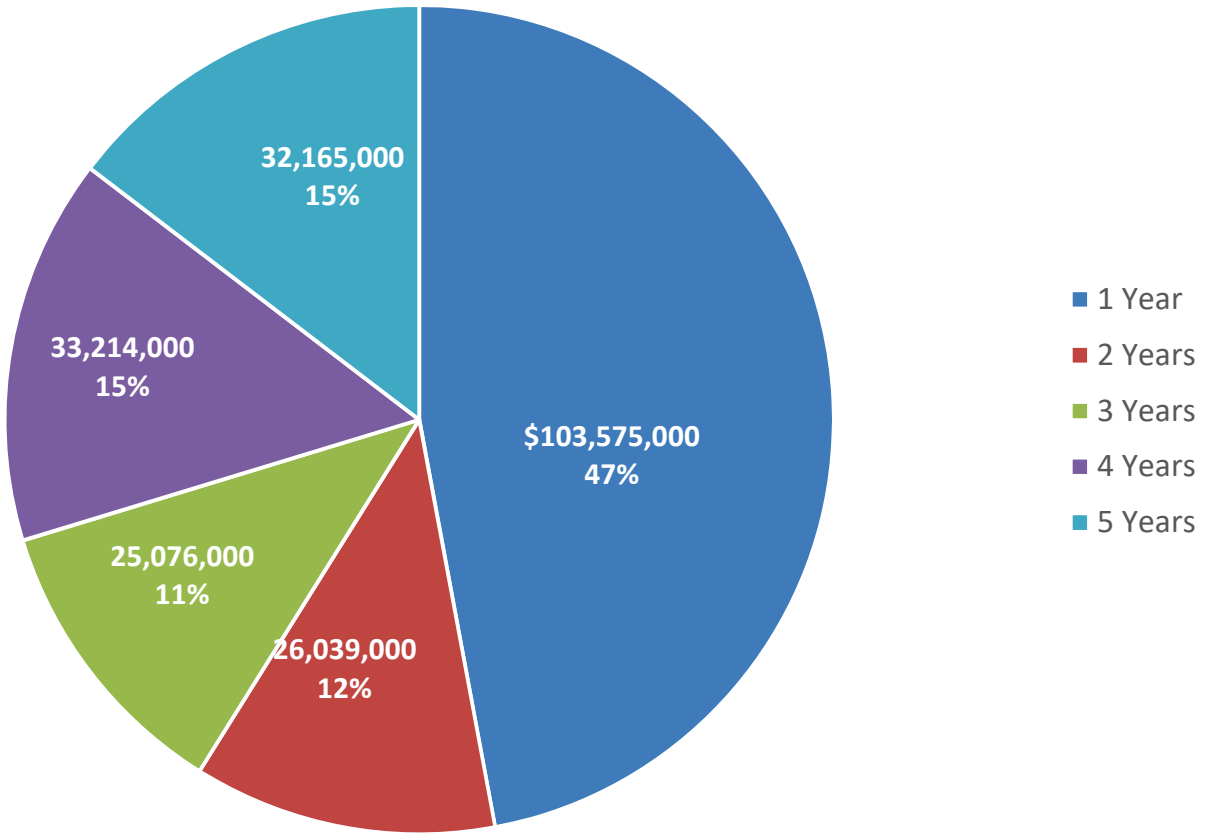
	Investment Amount (Cost)	%	$ or % Limit
Certificates of Deposit	$3,086,000	1.4%	30.0%
Checking Accounts	9,214,000	4.2%	
Local Agency Investment Fund (LAIF)	35,089,000	15.9%	$75 mm
CAMP	27,494,000	12.5%	
Medium-Term Notes (Corporate)	32,270,000	14.7%	30.0%
U.S. Treasury and Government Agency	84,816,000	38.5%	
Municipal Securities	5,685,000	2.6%	
Money Market Accounts	3,916,000	1.8%	20.0%
Commercial Paper	0	0.0%	25.0%
Asset Backed Securities (not issued or guaranteed by US government or agency)	18,499,000	8.4%	20.0%
Supranational Agency	0	0.0%	30.0%
Total Surplus Funds	**$220,069,000**	**100.0%**	



Kaweah Delta Health Care District
INVESTMENT SUMMARY OF SURPLUS FUNDS BY MATURITY
December 31, 2025

	Investment Amount (Cost)	%
1 Year	$103,575,000	47.1%
2 Years	26,039,000	11.8%
3 Years	25,076,000	11.3%
4 Years	33,214,000	15.1%
5 Years	32,165,000	14.6%
Total Surplus Fund Investments	**$ 220,069,000**	100.0%

Weighted Average Maturity	**2.38 Years**



Kaweah Delta Health Care District
INVESTMENT SUMMARY OF SURPLUS FUND'S UNREALIZED GAINS AND LOSSES
December 31, 2025

Description	Maturity	Par Value	Amort Cost	Market Value	Unrealized Gain (Loss)
Medium-Term Notes (Corporate):					
MORGAN STANLEY BK	04/21/2026	1,000,000	999,026	1,001,890	2,864
ASTRAZENECA L P	05/28/2026	265,000	265,031	262,289	(2,741)
TOYOTA MTR CR MTN	06/18/2026	1,400,000	1,399,700	1,383,004	(16,696)
AMERICAN HONDA MTN	07/07/2026	145,000	144,970	146,003	1,034
NATIXIS NY C D	09/18/2026	405,000	405,000	410,095	5,095
AMERICAN EXPRESS CO	11/04/2026	445,000	444,875	436,919	(7,956)
NATIONAL RURAL MTN	11/13/2026	160,000	159,985	162,166	2,181
CITIBANK N A SR NT	12/04/2026	1,000,000	1,002,420	1,013,210	10,790
TARGET CORP	01/15/2027	900,000	899,681	883,818	(15,863)
CISCO SYS INC	02/26/2027	260,000	259,876	262,915	3,039
STATE STR CORP SR	03/18/2027	335,000	335,000	339,486	4,486
HORMEL FOODS CORP	03/30/2027	115,000	114,956	116,236	1,280
HOME DEPOT INC SR NT	04/15/2027	220,000	217,673	216,460	(1,212)
PACCAR FIN MTN	05/13/2027	95,000	94,967	96,581	1,614
UNITEDHEALTH GROUP	05/15/2027	85,000	84,987	84,844	(144)
GOLDMAN SACHS BK	05/21/2027	1,100,000	1,103,003	1,105,764	2,761
GOLDMAN SACHS BK	05/21/2027	220,000	220,000	221,153	1,153
BLACKROCK FUNDING	07/26/2027	185,000	184,997	187,433	2,436
PACCAR FINANCIAL MTN	08/06/2027	900,000	898,607	910,395	11,788
BANK AMERICA CORP	09/15/2027	1,100,000	1,112,865	1,114,179	1,314
TOYOTA MTR MTN	10/08/2027	130,000	129,970	131,258	1,288
STATE STR CORP SR	10/22/2027	1,000,000	996,146	1,010,120	13,974
CATERPILLAR MTN	11/15/2027	1,000,000	999,464	1,016,330	16,866
BP CAP MKTS AMER INC	11/17/2027	310,000	310,000	316,129	6,129
MASTERCARD	01/15/2028	130,000	129,957	131,009	1,052
WELLS FARGO MTN	01/24/2028	145,000	145,000	146,221	1,221
BANK NY MELLON MTN	02/07/2028	300,000	294,997	298,545	3,548
ELI LILLY CO SR	02/12/2028	300,000	299,866	305,118	5,252
CISCO SYS INC	02/24/2028	70,000	69,946	71,138	1,191
HERSHEY CO	02/24/2028	80,000	79,961	81,258	1,297
CHEVRON USA INC	02/26/2028	340,000	340,000	345,287	5,287
JPMORGAN CHASE	04/22/2028	1,100,000	1,102,088	1,121,879	19,791
GOLDMAN SACHS	04/23/2028	155,000	155,000	156,770	1,770
CUMMINS INC	05/09/2028	20,000	19,989	20,156	167
MORGAN STANLEY	05/26/2028	280,000	280,162	285,586	5,424
TARGET CORP	06/15/2028	365,000	366,443	369,271	2,828
MORGAN STANLEY	07/06/2028	250,000	250,000	251,685	1,685
JOHN DEERE MTN	07/14/2028	700,000	708,102	718,851	10,749
JOHN DEERE MTN	07/14/2028	120,000	119,909	123,232	3,322
TRUIST BK SR NT MTN	07/24/2028	275,000	275,000	276,576	1,576
LOCKHEED MARTIN	08/15/2028	40,000	39,957	40,255	298
CITIBANK N A SR	09/29/2028	535,000	535,000	561,038	26,038
BANK NEW YORK MTN	10/25/2028	1,000,000	1,010,816	1,033,490	22,674
ALPHABET INC	11/15/2028	85,000	84,931	85,415	484
MORGAN STANLEY BK	01/12/2029	250,000	250,000	254,595	4,595
JPMORGAN CHASE CO	01/24/2029	140,000	140,000	142,603	2,603
PACCAR FINANCIAL MTN	01/31/2029	160,000	159,839	162,938	3,098
AIR PRODUCTS	02/08/2029	295,000	294,758	300,177	5,419
TEXAS INSTRS INC	02/08/2029	370,000	369,759	377,981	8,222
CUMMINS INC	02/20/2029	195,000	195,315	200,140	4,825
ASTRAZENECA FINANCE	02/26/2029	165,000	164,892	169,409	4,517
CISCO SYS INC	02/26/2029	225,000	224,951	230,942	5,991
BLACKROCK FUNDING	03/14/2029	270,000	270,017	275,999	5,983
ADOBE INC SR GLBL	04/04/2029	225,000	224,784	230,738	5,954
WELLS FARGO MTN	04/23/2029	205,000	205,000	208,815	3,815
AMERICAN EXPRESS CO	04/25/2029	245,000	245,000	248,758	3,758
BANK AMERICA MTN	05/09/2029	290,000	290,000	293,848	3,848
NATIONAL RURAL MTN	06/15/2029	850,000	858,587	879,070	20,483
HOME DEPOT INC	06/25/2029	500,000	497,772	512,620	14,848
HOME DEPOT INC	06/25/2029	95,000	94,577	97,398	2,821

Kaweah Delta Health Care District
INVESTMENT SUMMARY OF SURPLUS FUND'S UNREALIZED GAINS AND LOSSES
December 31, 2025

Description	Maturity	Par Value	Amort Cost	Market Value	Unrealized Gain (Loss)
PEPSICO INC SR	07/17/2029	280,000	279,695	285,482	5,788
TOYOTA MTR CR MTN	08/09/2029	195,000	194,894	198,167	3,272
ELI LILLY CO	08/14/2029	65,000	64,897	65,630	732
NOVARTIS CAPITAL	09/18/2029	365,000	364,341	363,204	(1,137)
ACCENTURE CAPITAL	10/04/2029	195,000	194,744	195,706	962
GOLDMAN SACHS	10/21/2029	580,000	580,000	579,872	(128)
ADOBE INC	01/17/2030	900,000	898,891	931,977	33,086
ADOBE INC	01/17/2030	285,000	284,649	295,126	10,477
WELLS FARGO CO MTN	01/23/2030	500,000	508,299	514,925	6,626
ELI LILLY CO SR	02/12/2030	600,000	616,630	616,968	338
CISCO SYS INC	02/24/2030	290,000	291,493	298,120	6,627
STATE STR CORP	04/24/2030	140,000	140,000	144,134	4,134
WALMART INC	04/28/2030	500,000	499,255	507,890	8,635
WALMART INC	04/28/2030	160,000	159,761	162,525	2,763
COLGATE PALMOLIVE CO	05/01/2030	180,000	179,918	181,228	1,310
TOYOTA MTR CORP MTN	05/15/2030	200,000	199,801	205,214	5,413
CITIBANK N A	05/29/2030	250,000	250,000	257,178	7,178
JOHN DEERE MTN	06/05/2030	285,000	284,866	289,768	4,902
ANALOG DEVICES INC	06/15/2030	435,000	434,660	440,903	6,243
GE AEROSPACE	07/29/2030	65,000	64,881	65,553	671
MERCK CO INC	09/15/2030	900,000	903,757	903,204	(553)
HOME DEPOT INC	09/15/2030	65,000	64,780	64,850	69
CHEVRON USA INC	10/15/2030	500,000	505,585	504,830	(755)
NOVARTIS CAPITAL	11/05/2030	540,000	538,431	539,422	991
SHELL FIN US INC	11/06/2030	130,000	129,516	129,983	467
NORTHERN TR CORP	11/19/2030	120,000	119,943	120,130	187
		$ 32,270,000	$ 32,329,260	$ 32,699,473	$ 370,213
Municipal Securities:					
ANAHEIM CA PUB	07/01/2026	1,000,000	999,806	990,150	(9,656)
LOS ANGELES CA	07/01/2026	270,000	270,000	267,157	(2,843)
CALIFORNIA ST UNIV	11/01/2026	125,000	125,000	126,154	1,154
MASSACHUSETTS ST	07/15/2027	1,000,000	1,000,000	1,000,270	270
ALAMEDA CNTY CA	08/01/2027	500,000	500,000	499,150	(850)
SAN JOSE CA REDEV	08/01/2027	400,000	394,637	396,480	1,843
SAN FRANCISCO CA	10/01/2027	1,000,000	1,000,000	1,015,400	15,400
LOS ANGELES CA	07/01/2028	140,000	140,000	142,635	2,635
SAN DIEGO CA	08/01/2028	1,000,000	1,028,569	1,052,050	23,481
LOS ANGELES CA	10/01/2029	250,000	250,000	254,790	4,790
		$ 5,685,000	$ 5,708,012	$ 5,744,235	$ 36,224

Kaweah Delta Health Care District
INVESTMENT SUMMARY OF SURPLUS FUND'S UNREALIZED GAINS AND LOSSES
December 31, 2025

Description	Maturity	Par Value	Amort Cost	Market Value	Unrealized Gain (Loss)
U.S. Treasury and Government Agency:					
U S TREASURY NT	03/31/2026	675,000	674,850	670,558.50	(4,291)
U S TREASURY NT	04/30/2026	5,225,000	5,205,587	5,177,086.75	(28,501)
U S TREASURY NT	04/30/2026	435,000	435,000	431,011.05	(3,989)
U S TREASURY NT	06/30/2026	1,850,000	1,851,448	1,825,931.50	(25,516)
U S TREASURY NT	09/30/2026	2,210,000	2,206,346	2,166,396.70	(39,950)
U S TREASURY NT	10/31/2026	800,000	799,212	783,904.00	(15,308)
U S TREASURY NT	11/15/2026	1,165,000	1,148,395	1,149,610.35	1,216
U S TREASURY NT	11/30/2026	2,000,000	1,999,526	1,959,060.00	(40,466)
U S TREASURY NT	11/30/2026	2,200,000	2,152,359	2,154,966.00	2,607
U S TREASURY NT	12/31/2026	2,000,000	1,955,999	1,955,700.00	(299)
U S TREASURY NT	01/31/2027	1,400,000	1,392,274	1,370,082.00	(22,192)
F H L M C MLTCL MT	03/25/2027	575,000	563,889	571,026.75	7,138
U S TREASURY NT	03/31/2027	3,330,000	3,307,831	3,288,774.60	(19,057)
U S TREASURY NT	04/30/2027	970,000	970,163	960,600.70	(9,562)
U S TREASURY NT	04/30/2027	250,000	242,531	240,380.00	(2,151)
U S TREASURY NT	04/30/2027	800,000	797,941	792,248.00	(5,693)
U S TREASURY NT	05/15/2027	925,000	918,729	911,051.00	(7,678)
U S TREASURY NT	07/31/2027	1,860,000	1,845,453	1,839,000.60	(6,452)
U S TREASURY NT	08/15/2027	190,000	184,805	186,304.50	1,499
U S TREASURY NT	08/31/2027	1,140,000	1,074,592	1,085,496.60	10,904
U S TREASURY NT	10/31/2027	1,500,000	1,393,040	1,421,310.00	28,270
U S TREASURY NT	12/31/2027	1,500,000	1,497,308	1,497,075.00	(233)
U S TREASURY NT	02/15/2028	80,000	81,286	81,221.60	(65)
U S TREASURY NT	02/29/2028	1,500,000	1,409,153	1,426,695.00	17,542
U S TREASURY NT	04/30/2028	600,000	562,277	570,000.00	7,723
U S TREASURY NT	04/30/2028	750,000	734,110	749,880.00	15,770
U S TREASURY NT	05/31/2028	730,000	712,481	731,912.60	19,431
F H L M C MLTCL	06/25/2028	530,000	532,661	540,684.80	8,023
F H L M C MLTCL MT	06/25/2028	430,091	430,086	433,862.93	3,777
U S TREASURY NT	06/30/2028	500,000	501,484	505,860.00	4,376
U S TREASURY NT	06/30/2028	1,300,000	1,285,929	1,315,236.00	29,307
F N M A GTD REMIC	07/25/2028	515,455	510,964	518,671.61	7,708
F H L M C MLTCL MTG	08/25/2028	545,000	540,686	554,134.20	13,449
F H L M C MLTCL	08/25/2028	545,000	538,476	556,330.55	17,855
F H L M C MLTCL	09/25/2028	535,000	531,501	546,261.75	14,761
F H L M C MLTCL	09/25/2028	410,000	402,716	420,127.00	17,411
U S TREASURY NT	09/30/2028	500,000	505,234	514,140.00	8,906
F H L M C MLTCL	10/25/2028	200,000	199,670	205,640.00	5,970
F H L M C MLTCL MTG	10/25/2028	300,000	299,503	307,170.00	7,667
U S TREASURY NT	10/31/2028	2,275,000	2,110,564	2,143,300.25	32,736
F H L M C MLTCL	11/25/2028	280,000	281,537	287,568.40	6,031
F H L M C MLTCL	12/25/2028	315,000	316,900	321,621.30	4,721
F H L M C MLTCL MTG	12/25/2028	325,000	326,986	330,512.00	3,526
U S TREASURY NT	12/31/2028	500,000	464,985	469,435.00	4,450
U S TREASURY NT	12/31/2028	1,200,000	1,198,364	1,206,792.00	8,428
U S TREASURY NT	02/28/2029	750,000	744,503	765,172.50	20,670
F H L M C MLTCL MTG	03/25/2029	315,000	315,842	326,264.40	10,422
U S TREASURY NT	03/31/2029	1,000,000	990,210	1,016,560.00	26,350
U S TREASURY NT	03/31/2029	225,000	223,207	228,726.00	5,519
U S TREASURY NT	04/30/2029	1,000,000	1,006,831	1,032,310.00	25,479
F H L M C MLTCL MTG	05/25/2029	460,000	461,985	470,414.40	8,430
U S TREASURY NT	05/31/2029	1,000,000	1,001,662	1,028,750.00	27,088
FHLMC REMIC SERIES	06/25/2029	200,000	202,907	203,380.00	473
U S TREASURY NT	06/30/2029	2,030,000	2,001,337	2,006,837.70	5,500
F H L M C MLTCL MTG	07/25/2029	515,000	518,472	524,100.05	5,628
F H L M C MLTCL MTG	07/25/2029	410,000	415,184	418,220.50	3,037
U S TREASURY NT	07/31/2029	500,000	505,523	506,465.00	942
U S TREASURY NT	07/31/2029	260,000	258,557	263,361.80	4,805
U S TREASURY NT	08/31/2029	750,000	737,425	749,880.00	12,455
F H L M C MLTCL MTG	09/25/2029	345,000	350,207	353,949.30	3,742
U S TREASURY NT	09/30/2029	950,000	932,336	945,582.50	13,246

Kaweah Delta Health Care District
INVESTMENT SUMMARY OF SURPLUS FUND'S UNREALIZED GAINS AND LOSSES
December 31, 2025

Description	Maturity	Par Value	Amort Cost	Market Value	Unrealized Gain (Loss)
U S TREASURY NT	10/31/2029	1,000,000	989,785	1,017,110.00	27,325
U S TREASURY NT	10/31/2029	1,000,000	990,985	1,017,110.00	26,125
U S TREASURY NT	11/30/2029	1,700,000	1,699,477	1,729,359.00	29,882
U S TREASURY NT	12/31/2029	2,000,000	1,993,706	2,053,440.00	59,734
FHLMC REMIC SERIES	01/25/2030	205,000	204,994	208,134.45	3,141
U S TREASURY NT	01/31/2030	800,000	796,040	795,408.00	(632)
U S TREASURY NT	01/31/2030	295,000	295,179	301,557.85	6,378
U S TREASURY NT	02/28/2030	160,000	160,000	162,036.80	2,037
U S TREASURY NT	03/31/2030	1,500,000	1,499,707	1,497,195.00	(2,512)
U S TREASURY NT	03/31/2030	700,000	702,605	708,911.00	6,306
U S TREASURY NT	04/30/2030	1,000,000	991,998	1,007,810.00	15,812
F H L M C MLTCL MTG	05/25/2030	575,000	574,982	581,687.25	6,706
F H L M C MLTCL	05/25/2030	375,000	380,275	379,335.00	(940)
U S TREASURY NT	05/31/2030	1,000,000	1,001,394	1,012,730.00	11,336
F H L M C MLTCL	06/25/2030	575,000	574,990	581,037.50	6,047
F H L M C MLTCL	06/25/2030	590,000	589,432	594,472.20	5,041
U S TREASURY NT	06/30/2030	2,000,000	1,998,675	2,015,080.00	16,405
U S TREASURY NT	06/30/2030	540,000	541,446	544,071.60	2,625
F H L M C MLTCL MTG	07/25/2030	460,000	459,395	463,928.40	4,533
U S TREASURY NT	07/31/2030	1,575,000	1,593,136	1,595,002.50	1,866
U S TREASURY NT	07/31/2030	500,000	501,849	503,690.00	1,841
U S TREASURY NT	07/31/2030	500,000	502,735	503,690.00	955
U S TREASURY NT	08/31/2030	800,000	797,755	797,160.00	(595)
U S TREASURY NT	08/31/2030	1,800,000	1,791,325	1,793,610.00	2,285
U S TREASURY NT	09/30/2030	1,000,000	995,852	996,130.00	278
U S TREASURY NT	10/31/2030	500,000	499,962	497,890.00	(2,072)
U S TREASURY NT	11/15/2030	465,000	405,734	406,493.70	760
F H L M C MLTCL 0.	11/25/2030	390,000	393,391	390,986.70	(2,404)
F H L M C MLTCL 0.	11/25/2030	335,000	334,988	334,805.70	(182)
U S TREASURY NT	11/30/2030	1,000,000	992,470	989,920.00	(2,550)
U S TREASURY NT	11/30/2030	900,000	893,250	890,928.00	(2,322)
		$ 84,815,546	$ 83,908,533	$ 84,385,326	$ 476,793

Kaweah Delta Health Care District
INVESTMENT SUMMARY OF SURPLUS FUND'S UNREALIZED GAINS AND LOSSES
December 31, 2025

Description	Maturity	Par Value	Amort Cost	Market Value	Unrealized Gain (Loss)
Asset-backed Securities:					
DAIMLER TRUCKS	03/15/2027	106,231	106,230	106,733	503
CARMAX AUTO OWNER	04/15/2027	50,486	50,486	50,485	(1)
CAPITAL ONE PRIME AT	05/17/2027	36,559	36,559	36,546	(13)
NISSAN AUTO LEASE	11/15/2027	500,000	499,999	504,920	4,921
MERCEDES BENZ AUTO	11/15/2027	51,100	51,098	51,185	88
MERCEDES BENZ AUTO	01/18/2028	1,000,000	999,935	1,009,720	9,785
GM FINL CONSUMER	02/16/2028	397,082	394,318	397,777	3,459
HONDA AUTO	02/18/2028	184,243	184,225	185,532	1,308
BMW VEH OWNER TR	02/25/2028	40,321	40,318	40,564	246
HYUNDAI AUTO	04/17/2028	60,368	60,367	60,792	425
ALLY AUTO RECV TR	05/15/2028	106,237	106,228	107,018	790
FORD CR AUTO OWNER	05/15/2028	91,059	91,059	91,648	589
GM FINL CON AUT RECV	06/16/2028	61,852	61,851	62,297	446
AMERICAN EXPRESS	09/15/2028	445,000	444,989	449,388	4,398
BANK OF AMERICA	11/15/2028	394,000	393,102	398,090	4,988
WELLS FARGO CARD	02/15/2029	560,000	559,904	567,414	7,510
BMW VEHICLE OWNER	02/26/2029	1,084,175	1,084,064	1,094,073	10,009
HYUNDAI AUTO REC	03/15/2029	1,000,000	999,896	1,011,180	11,284
JOHN DEERE OWNER	03/15/2029	1,000,000	999,868	1,014,250	14,382
FORD CR AUTO OWNER	04/15/2029	1,000,000	999,994	1,012,860	12,866
HYUNDAI AUTO REC	05/15/2029	195,000	194,989	196,537	1,547
VERIZON MASTER TRUST	06/20/2029	1,000,000	999,961	1,005,900	5,939
FORD CR AUTO OWNER	07/15/2029	360,000	359,998	361,112	1,114
AMERICAN EXPRESS	07/16/2029	1,025,000	1,024,967	1,039,032	14,065
TOYOTA AUTO	08/15/2029	260,000	259,992	262,782	2,790
GM FINL CON AUTO REC	08/16/2029	155,000	154,978	156,163	1,185
VOLKSWAGEN AUTO LN	08/20/2029	365,000	364,990	368,789	3,799
HONDA AUTO	09/21/2029	205,000	204,995	207,273	2,279
BMW VEHICLE	09/25/2029	140,000	139,989	141,408	1,420
FORD CREDIT AUTO	10/15/2029	445,000	444,964	449,414	4,450
HONDA AUTO	10/15/2029	125,000	124,988	125,765	777
TOYOTA AUTO	11/15/2029	220,000	219,989	221,727	1,738
GM FINL CONS AT	12/17/2029	500,000	504,982	505,135	153
NISSAN AUTO REC OWN	12/17/2029	500,000	499,917	506,540	6,623
MERCEDES BENZ	12/17/2029	255,000	254,956	258,690	3,734
VERIZON MASTER TRUST	03/20/2030	440,000	439,984	443,498	3,514
VOLKSWAGEN AUTO 3.	03/20/2030	215,000	214,965	215,531	566
AMERICAN EXPRESS	04/15/2030	410,000	409,994	414,678	4,685
GM FINANCIAL CONSUME	04/16/2030	95,000	94,988	95,720	732
BANK OF AMERICA	05/15/2030	265,000	264,999	268,185	3,186
WF CARD ISSUANCE	05/15/2030	515,000	514,992	521,834	6,842
FORD CREDIT AT OWNER	06/15/2030	235,000	234,964	235,625	661
CITIBANK CREDIT	06/21/2030	580,000	579,859	586,734	6,875
CHASE ISSUANCE	07/15/2030	1,000,000	999,982	1,009,720	9,738
AMERICAN EXPRESS	07/15/2030	330,000	329,957	334,280	4,323
CAPITAL ONE PRIME	07/15/2030	135,000	134,972	135,063	91
CAPITAL ONE MLT	09/16/2030	360,000	359,936	360,205	269
		$ 18,498,713	$ 18,498,734	$ 18,679,813	$ 181,079

Separator Page

Pension Plan Financial Audit – Plan Year Ending June 30, 2025

bakertilly

Kaweah Delta Health Care District Employees' Retirement Plan Audit Required Communications

2025 Audit Results

Agenda

1. Scope of Services
2. Executive Summary
3. Matters Required to be Communicated with Those Charged with Governance

Scope of Services

We have performed the following services for Kaweah Delta Health Care District

Annual Audit

Annual plan financial statements for the year ending June 30, 2025

Non-Attest Services

Assist management with drafting the plan financial statements for the year ending June 30, 2025

Executive Summary As Of And For The Years Ended June 30, 2025 and 2024

	6/30/2025	6/30/2024
	Employees Retirement Plan (in 000's)	Employees Retirement Plan (in 000's)
Audit Type	GAAS Audit	GAAS Audit
Opinion	Unmodified	Unmodified
Ending Net Assets	$293,542	$286,251
Net Investment Income	$25,551	$33,675
Employer Contributions	$2,321	$0
Benefits Paid and Expenses	$20,581	$19,778
Change in net assets	$7,291	$13,897
Net Pension Liability (NPL)	$16,169	$21,226
Change in NPL	($5,057)	($21,735)

Matters Required to be Communicated with Those Charged with Governance

Our responsibility with regard to the financial statement audit under U.S. auditing standards:

We are responsible for forming and expressing an opinion about whether the financial statements that have been prepared by management, with your oversight, are prepared, in all material respects, in accordance with *accounting principles generally accepted in the United States of America*. Our audit of the financial statements does not relieve you or management of your responsibilities.

Matters Required to be Communicated with Those Charged with Governance

Our responsibility with regard to the financial statement audit under U.S. auditing standards:

We conducted our audit in accordance with auditing standards generally accepted in the United States of America (U.S. GAAS). As part of an audit conducted in accordance with U.S. GAAS, we exercise professional judgment and maintain professional skepticism throughout the audit.

Matters Required to be Communicated with Those Charged with Governance

Our responsibility with regard to the financial statement audit under U.S. auditing standards:

Our audit of the financial statements included obtaining an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control or to identify deficiencies in the design or operation of internal control. Accordingly, we considered the entity's internal control solely for the purpose of determining our audit procedures and not to provide assurance concerning such internal control.

Matters Required to be Communicated with Those Charged with Governance

Our responsibility with regard to the financial statement audit under U.S. auditing standards:

We are also responsible for communicating significant matters related to the financial statement audit that are, in our professional judgment, relevant to your responsibilities in overseeing the financial reporting process. However, we are not required to design procedures for the purpose of identifying other matters to communicate to you.

Matters Required to be Communicated with Those Charged with Governance

Significant Accounting Practices:

Our views about qualitative aspects of the entity's significant accounting practices, including accounting policies, accounting estimates, and financial statement disclosures

The quality of the entity's accounting policies and underlying estimates are discussed throughout this presentation. There were no changes in the entity's approach to applying the critical accounting policies.

Matters Required to be Communicated with Those Charged with Governance

Significant Unusual Transactions:	No significant unusual transactions were identified during our audit of the entity's financial statements.

Matters Required to be Communicated with Those Charged with Governance

Significant Difficulties Encountered During the Audit:

We are to inform those charged with governance of any significant difficulties encountered in performing the audit. Examples of difficulties may include significant delays by management, an unreasonably brief time to complete the audit, unreasonable management restrictions encountered by the auditor or an unexpected extensive effort required to obtain sufficient appropriate audit evidence.

No significant difficulties were encountered during our audit of the entity's financial statements.

Matters Required to be Communicated with Those Charged with Governance

Disagreements With Management:

Disagreements with management, whether or not satisfactorily resolved, about matters that individually or in the aggregate could be significant to the entity's financial statements, or the auditor's report.

There were no disagreements with management.

Matters Required to be Communicated with Those Charged with Governance

Circumstances that affect the form and content of the auditor's report:	There were no circumstances that affected the form and content of the auditor’s report.

Matters Required to be Communicated with Those Charged with Governance

Uncorrected Misstatements:	There were no non-trivial misstatements detected as a result of audit procedures that were communicated to management.

Matters Required to be Communicated with Those Charged with Governance

Representations Requested of Management

We requested certain representations from management that are included in the management representation letter dated December 19, 2025.

See Exhibit 1

Matters Required to be Communicated with Those Charged with Governance

Management's Consultation with Other Accountants:

When we are aware that management has consulted with other accountants about significant auditing or accounting matters, we discuss with those charged with governance our views about the matters that were the subject of such consultation.

We are not aware of instances where management consulted with other accountants about significant auditing or accounting matters.

Matters Required to be Communicated with Those Charged with Governance

Significant issues arising from the audit that were discussed, or the subject of correspondence with management:	No significant issues arose during the audit that have not been addressed elsewhere in this presentation.

Matters Required to be Communicated with Those Charged with Governance

Other findings or issues arising from the audit that are, in the auditor's professional judgment, significant and relevant to those charged with governance regarding their oversight of the financial reporting process:	There are no items to report.

THANK YOU

District Privacy Manual

Requested Action: Audit and Compliance Committee make a recommendation to the Board of Directors for the Compliance Department to create a District Privacy Manual in policy and procedure system and move privacy-related policies currently located in the District Administrative Manual to the newly created District Privacy Manual.

Reason for Action:

- Having all privacy-related policies consolidated into one District Privacy Manual will allow end users to more easily identify and locate all Kaweah privacy policies when they are maintained in a single manual.
- Moving and consolidating the privacy-related policies into a District Privacy Manual will help to better align Kaweah's privacy-related policy management with Kaweah's Privacy Program activities.
- New and revised District Privacy Manual policies will be submitted to the Audit and Compliance Committee for review and approval in the same manner as Kaweah's Compliance Program policies.
- Maintaining the District Privacy Manual will be the responsibility of the Compliance Department in the same manner as Kaweah's Compliance Program policies.

Policies Proposed for Inclusion in District Privacy Manual:

- AP04 Access and Release of Protected Health Information (PHI)
- AP07 Communication with Law Enforcement Regarding Requests for Information and Requests to Interview Interrogate a Patient
- AP49 No information No presence in facility patient status
- AP53 Patient's Rights and Responsibilities, and Non-Discrimination
- AP64 Confidentiality Security and Integrity of Health Information
- AP103 Public Release of Patient Information
- AP107 Patient Privacy Use and Disclosure of Patient Information
- AP108 Patient Privacy Administration and Compliance Requirements
- AP150 Identity Theft Detection, Prevention, and Mitigation
- AP163 Photography and Video Recording of Patients and Staff
- AP71 District Facsimile (FAX) and Email Communications

Code of Conduct

Code of Conduct

Integrity, accountability, and excellence

Kaweah Health
MORE THAN MEDICINE. LIFE.

Table of Contents

Dear Kaweah Health Team Member:

We are proud to introduce you to our Code of Conduct for Kaweah Delta Health Care District (Kaweah Health). Our Code of Conduct reflects Kaweah Health's commitment to providing high-quality services to patients, and our commitment to ethical and legal business practices. These goals are vital to the ongoing success of Kaweah Health. This information booklet is an important and valuable expression of our commitment to integrity, accountability, and excellence – three of Kaweah Health's fundamental values. It has been designed to show each of us how our core values and standards go hand in hand.

Every person at Kaweah Health plays a role, directly or indirectly, in the patient experience and our reputation is based on how we conduct ourselves on a daily basis. Our reputation brings hope and confidence to patients who trust us to deliver high quality care and attracts people with the highest integrity to seek employment or affiliation with us.

The information in our Code of Conduct booklet will assist you in understanding the variety of legal, professional and ethical standards that regulate our work. Please make it a priority to become familiar with it. Much of what you see in the Code of Conduct booklet will not be new to you, but it will provide an accessible source of information when you have a question about a particular situation.

There may be times when you face a situation that is not specifically covered by the Code of Conduct. The complex challenges we face in the healthcare arena are not always easily categorized, and you may find that you need assistance in addressing a specific issue related to compliance. We encourage you to discuss the situation and initially seek guidance from your supervisor. If you are ever uncomfortable discussing the situation with your supervisor and would rather speak to our Compliance and Privacy Officer directly, you may do so by contacting the Compliance and Privacy Officer at 1-559-624-5006. If you prefer to report an issue or concern anonymously, you may call our Confidential Reporting Line at 1-800-998-8050. We will work diligently to ensure that questions and issues brought to our attention are addressed and resolved.

A commitment to ethical and legal business practices in caring for our patients and in our business dealings is crucial. Compliance means doing the right thing. I thank you for your personal commitment to compliance, our Code of Conduct and the part you play in making Kaweah Health an organization that we can all be proud of.

Sincerely,

Marc Mertz
Chief Executive Officer

Our Code of Conduct

PURPOSE OF THE CODE OF CONDUCT

Our Code of Conduct provides guidance to all Kaweah Delta Health Care District (Kaweah Health) employees and our care partners by creating and fostering an environment in which all stakeholders feel empowered and obligated to "do the right thing." The Code of Conduct assists us in carrying out our daily activities and working within appropriate ethical and legal standards. These obligations apply to our relationships with patients, affiliated physicians, third-party payers, subcontractors, independent contractors, vendors, volunteers, consultants and one another.

The Code of Conduct is a critical component of our Compliance Program. We have developed the Code of Conduct to ensure we all understand our ethical obligations and standards, administrative regulations, and medical staff bylaws comply with all applicable laws and regulations. Adherence to the Compliance Program is a condition of employment at Kaweah Health. Likewise, the granting of medical staff privileges and the offer of employment at Kaweah Health is contingent upon acceptance of and compliance with the Compliance Program.

The Code of Conduct is intended to be comprehensive and easily understood. However, in many cases, the subject matter discussed may have complexities that require additional guidance and direction. To provide additional guidance, we have developed comprehensive policies and procedures which may be accessed in Kaweah Health's Policy Tech system. The policies expand upon many of the principles communicated in our Code of Conduct. The standards set forth in the Code of Conduct are mandatory and must be followed.

KAWEAH HEALTH

Kaweah Delta Health Care District is a community venture, operating under the authority granted through the California Health and Safety Code as a health care district. As such, Kaweah Delta Health Care District is publicly owned and operates as a non-profit entity. Kaweah Health was established to provide quality health care within defined areas of expertise. Kaweah Health's intent is that no person shall be denied emergency admission or emergency treatment based on their ability to pay. Similarly, no person shall be denied access to treatment or admission to our facilities based upon race, color, national origin, ethnicity, disability, economic, religious or age status and/or on the basis of sexual preference. The medical welfare of the community and its particular health needs will be fulfilled, to the extent possible, based upon Kaweah Health's financial limitations.

OUR MISSION.
OUR VISION.
OUR PILLARS.

OUR MISSION STATEMENT

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

The mission articulates the reason Kaweah Health exists

OUR VISION

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

Our vision statement is what we aspire to be for our community and sets the future path and framework in our strategic planning.

OUR PILLARS

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

Like pillars that support a structure, these efforts are foundational to the success of Kaweah Health.

Kaweah Health Compliance Program

PROGRAM STRUCTURE AND STANDARDS

The Compliance Program was developed to provide oversite of administrative compliance efforts including:

1. establishing operating protocols and standards of conduct;
2. designating oversight responsibilities;
3. providing employee compliance training;
4. monitoring and auditing;
5. supporting and facilitating open lines of communication and reporting;
6. following through with enforcement and disciplinary procedures; and
7. establishing response and prevention plans.

The Compliance Program is intended to demonstrate in the clearest possible terms the absolute commitment of the organization to the highest standards of ethics and compliance. The elements of the program include setting standards (the Code of Conduct and Policies and Procedures), communicating the standards, providing a mechanism for reporting potential exceptions, monitoring and auditing, and maintaining an organizational structure that supports the continued growth of the program. Each of these elements is detailed below.

These elements are supported at all levels of the organization. Providing direction, guidance and oversight are the Audit and Compliance Committee of the Board of Directors and the Executive Team consisting of Senior Management.

The Compliance Officer shall have sufficient authority to fulfill the responsibilities of the position and shall have direct reporting responsibility to the CEO and the Board. The Compliance Officer shall administratively report to the CEO and provide an update to the Board annually, at a minimum, on the state of the Program.

The Compliance Officer is responsible for the day-to-day operation and oversight of Program activities. The Compliance Officer will oversee the implementation and maintenance of the Program and all Kaweah Health compliance policies, compliance education and training, auditing and monitoring activities, and resolution of compliance issues. The Compliance Officer shall have access to all documents and information related to compliance activities and may seek advice from Legal Counsel or retain consultants or experts, when necessary. The Compliance Officer may request additional staff, as deemed necessary, to assist in the performance of compliance activities.

The Compliance Team plays a key role in ensuring the successful implementation of our Compliance Program. They are responsible for distributing standards, ensuring training is conducted, conducting monitoring and responding to audits, investigating and resolving Confidential Reporting Line issues and otherwise administering the Compliance Program.

Another important resource to address issues related to this Code of Conduct is the Human Resources Department. Human Resources staff are highly knowledgeable about many of the compliance risk areas described in this Code of Conduct, particularly those that pertain to employment and the workplace. The Human Resources staff are responsible for ensuring compliance with various employment laws. If a concern relates to specific details of an individual's work situation, rather than larger issues of organizational ethics and compliance, the Human Resources Department is the most appropriate area to contact. In that we promote the concept of management autonomy, every effort should be made to resolve workplace conduct and employment practice issues through the individual's supervisor. However, the Human Resources Department is also available to provide support to employees and management.

RESOURCES FOR REPORTING A CONCERN

To obtain guidance on an ethical or compliance issue or to report a concern, individuals may choose from several options. We encourage the resolution of issues,

including human resources-related issues (e.g., payroll, fair treatment and disciplinary issues). It is an expected good practice, when one is comfortable with it and thinks it appropriate under the circumstances, to raise concerns first with one's supervisor. If it is uncomfortable or inappropriate, the individual may discuss the situation with the Compliance and Privacy Officer (559) 624-5006 or the Human Resources Department. If the issue is employee relations in nature, employees should contact the Human Resources Department for assistance and further guidance. Individuals are always free to contact the Confidential Reporting Line at 800-998-8050.

Kaweah Health makes every effort to maintain, within the limits of the law, the confidentiality of the identity of any individual who reports concerns or possible misconduct. There is no retribution or discipline for anyone who reports a concern in good faith.

Any employee who deliberately makes a false accusation with the purpose of harming or retaliating against another employee is subject to discipline.

PERSONAL OBLIGATION TO REPORT

We are committed to ethical and legal conduct that is compliant with all relevant laws and regulations and to correcting any wrongdoing whenever it may occur in the organization. Each employee has an individual responsibility for reporting any activity by any employee, physician, subcontractor, or vendor that appears to violate applicable laws, rules, regulations, accreditation standards, medical practice standards, Federal Healthcare Conditions of Participation or the Code of Conduct. If a matter posing serious compliance risk to the organization or involving a serious issue of medical necessity, clinical outcomes or patient safety is reported, and if the reporting individual doubts that the issue has been given sufficient or appropriate attention, the individual should report the matter to higher levels of management, the Director of Risk Management, the Compliance and Privacy Officer or the Confidential Reporting Line until satisfied that the full importance of the matter has been recognized.

QUESTIONS CONTACT:

Kaweah Health Compliance and Privacy Officer
(559) 624-5006

Kaweah Health Compliance Advocate/ Kaweah Health Legal Counsel
(559) 738-8100 or (559) 280-3075

Confidential Reporting Line
1 (800) 998-8050

INTERNAL INVESTIGATIONS

We are committed to investigating all reported concerns promptly and confidentially to the extent possible. The Compliance and Privacy Officer coordinates findings from investigations and immediately recommends corrective action or changes that need to be made. When an investigation is initiated based upon a report of a problem by an employee, the final resolution of the issue will be reported back to that employee. We expect all employees to cooperate with investigation efforts. Giving false or misleading information during an investigation may lead to disciplinary action, up to and including termination.

CORRECTIVE ACTION

Where an internal investigation substantiates a reported violation, it is the policy of the organization to initiate corrective action, including, as appropriate, making prompt restitution of any overpayment amounts, notifying the appropriate governmental agency, instituting disciplinary action as necessary and implementing systemic changes to prevent a similar violation from recurring in the future.

DISCIPLINE

All violators of the Code of Conduct will be subject to disciplinary action. The seriousness of the offense and frequency of the violation precise discipline utilized and frequency of the violation may result in any or all of the following disciplinary actions:

- Written Warning
- Written Reprimand
- Suspension
- Termination and/or
- Restitution

TRAINING AND EDUCATION

Training and education have been developed to ensure that employees throughout the organization are aware of the standards that apply to them. Code of Conduct training is conducted at the time an individual joins the organization and is communicated regularly to all employees. Compliance training in areas of specific compliance risk (e.g., billing, coding, cost reports) is required of certain individuals. Kaweah Health policies outline the training requirements.

All Staff and Board Members shall receive on-going education about relevant compliance topics including updates to the Compliance Program, Code of Conduct, new laws and regulations, or new Compliance and Privacy policies and procedures.

Many resources regarding our program are available to all Kaweah Health employees on our Intranet and to the general public on the Internet.

MEASURING PROGRAM EFFECTIVENESS

We are committed to assessing the effectiveness of our Compliance Program through various efforts. Our efforts are supported in part by the Internal Audit Department, which routinely conducts internal audits of issues that have regulatory or compliance implications. Responsible Executives and management routinely undertake monitoring efforts in support of policies and compliance in general. Departments conduct self-monitoring, and the Compliance Department conducts reviews designed to assess facility implementation of the Code of Conduct, policies and procedures, Confidential Reporting Line and related investigations, and monitoring efforts. Most of these methods of assessment result in reports of findings by the reviewers and corrective action plans by the departments that are reviewed. Through these reviews, we are continuously assessing the effectiveness of the Program and finding ways to improve it.

LEADERSHIP RESPONSIBILITIES

While all Kaweah Health employees are obligated to follow our Code of Conduct, we expect our leaders to set the example, and in every respect to be a model for others. We expect everyone at Kaweah Health with supervisory responsibilities to be kind, sensitive, honest, thoughtful and respectful. We expect all leaders to create an environment where each team member feels free to raise concerns and propose new ideas.

We also expect that leadership will provide their team members with sufficient information to comply with laws, regulations, policies and procedures, and will provide the resources to address and resolve ethical dilemmas. They must help to create and maintain a culture that promotes the highest standards of ethics and compliance. This culture must encourage everyone in the organization to share concerns when they arise. We must never sacrifice ethical and compliant behavior in the pursuit of business objectives.

Kaweah Health Leaders at all levels should use all available education and guidance to most effectively incorporate ethics and compliance into all aspects of Kaweah Health.

OUR FUNDAMENTAL COMMITMENT

We are committed to providing Personal, Professional, Compassionate Experiences, Every Person Every Time and specifically:

To our patients:
We are committed to providing safe, high quality care that is sensitive, compassionate, promptly delivered, and cost effective.

To our employees:
We are committed to a working environment which treats all employees with fairness, dignity and respect, and affords them an opportunity to grow and develop professionally, and to work in a team environment in which all ideas are considered.

To our affiliated physicians:
We are committed to providing a work environment which has excellent facilities, equipment and outstanding professional support.

To our third-party payers:
We are committed to working with our third-party payers in a manner that demonstrates our commitment to contractual obligations and reflects our shared concern for quality healthcare and bringing efficiency and cost effectiveness to healthcare. We encourage our payers to adopt their own set of ethical practices to recognize their obligations to patients and providers and the need for fairness and responsiveness.

To our regulators:
We are committed to maintaining an environment of compliance with rules, regulations, policies and sound business practices. We accept the responsibility to self-govern and monitor adherence to the requirements of the law and to our Code of Conduct.

To our joint venture partners:
We are committed to fully performing our responsibilities to support our jointly owned services in a manner that reflects the mission and values of each of our organizations.

To the communities we serve:
We are committed to understanding the needs of the communities we serve and to providing high quality, cost-effective healthcare. We realize that we have a responsibility to those in need. We proudly support charitable contributions and community events in an effort to promote goodwill, health and other good causes.

To our suppliers:
We are committed to fair competition among prospective suppliers and the sense of responsibility required of a good customer. We encourage our suppliers to adopt their own set of ethical principles.

To our volunteers:
We are committed to ensuring that our volunteers feel a sense of meaning from their work and receive recognition for their volunteer efforts. Volunteers assisting our patients and their families are an integral part of the fabric of healthcare. Our volunteers are an important part of the Kaweah Health team.

To our Foundation donors:
We are committed to ensuring that donations made to Kaweah Health are managed respectfully and responsibly to serve the needs of Kaweah Health and the patients and communities we serve.

OUR COMMITMENT TO OUR PATIENTS

Our Commitment To Our Patients

Patient Care and Rights

In the availability of services; the admission, transfer or discharge of patients; or in the care we provide, we make no inappropriate distinctions based on age, gender, disability, race, color, religion, sexual orientation, gender identity, medical condition, educational background, economic status, the source of payment for care or national origin.

Upon admission, we provide each patient with a written statement of Patient Rights and a Notice of Privacy Practices. These statements include the rights of the patient to make decisions regarding medical care and regarding his or her health information maintained by Kaweah Health. Such statements conform to all applicable state and federal laws, including but not limited to the Health Insurance Portability and Accountability Act of 1996 (hereinafter referred to as HIPAA).

We seek to involve patients in all aspects of their care, including giving consent for treatment and making other healthcare decisions, which may include managing pain effectively, foregoing or withdrawing treatments, and, as appropriate, end of life care. In the promotion and protection of patients' rights, each patient and his or her representatives are afforded appropriate confidentiality, privacy, security and protective services, opportunity for resolution of complaints, and pastoral or spiritual care.

Patients shall be treated in a manner that preserves their dignity, autonomy, self-esteem, civil rights, and involvement in their own care. Kaweah Health facilities maintain processes to support patient rights in a collaborative manner which involves Kaweah Health leaders and others. These processes are based on policies and procedures, which address both patient care and organizational ethics. These processes include informing each patient, or when appropriate, the patient's representative of the patient's rights in advance of furnishing or discontinuing care. Patients, and when appropriate, their families or caregivers are informed about the outcomes of care, including unanticipated outcomes. Additionally, patients are involved as clinically appropriate in resolving dilemmas about care decisions.
Kaweah Health maintains processes for prompt resolution of patient grievances which include informing patients of the grievance process which includes notification of the resolution. Patients and/or their families have a right to file a complaint or grievance regarding their care and may do so by contacting Kaweah Health's Risk Management Department, the Joint Commission, or California Department of Public Health.

Kaweah Health maintains an ongoing, proactive patient safety effort for the identification of risk to patient safety and the prevention, reporting and reduction of healthcare errors.

Kaweah Health has established patient safety and quality of care policies. It is the responsibility of each staff member to follow our standards and policies. It is important to report non-compliance, safety or quality concerns to management so the issues can be addressed. Kaweah Health is committed to investigating and responding to all reported concerns. An employee may also report safety or quality of care concerns to the Joint Commission (TJC) by accessing their website at www.jointcommission.org. Additionally, TJC can be contacted online at https://www.jointcommission.org/report_a_complaint.aspx or by fax at (630) 792-5636. Kaweah Health will take no disciplinary action against any employee because they report a safety or quality of care concern.

Interpretive Services

Fluency in English is required for all employees having patient contact. To facilitate communication with non-English speaking or hearing-impaired individuals, Kaweah Health has alternatives in place including a 24-hour Language Line of more than 100 languages. Employees may access the line directly. A procedure is in place explaining how to use the Language Line. Employees may also contact management or the Interpreter Services department for assistance.

Interpreting services are available for both verbal and sign languages. Contact the nursing staffing office for details or to obtain an interpreter. Kaweah Health employees who are able to communicate in a second language are encouraged to contact the Interpreter Services Department for information on the voluntary interpreter program.

Patient Information

We collect information about the patient's medical condition, history, medication, and family illnesses. We realize the sensitive nature of this information and are committed to maintaining its confidentiality.

Kaweah Health employees must never access, use or disclose confidential information in a manner that violates the privacy rights of our patients. In accordance with our appropriate access and privacy policies and procedures, which are consistent with state and federal privacy requirements, no Kaweah Health employee, affiliated physician or other healthcare partner has a right to any patient information other than what is necessary to perform his or her job duties.

Subject only to emergency exceptions, patients can expect their privacy will be protected. Patient-specific information will be released only to persons authorized by the patient to receive the information or those authorized by law to receive the information.

Abuse and/or Neglect Reporting

Kaweah Health is committed to promoting a healthcare environment free from threats, harassment, abuse (verbal, physical, mental, or sexual), neglect, corporal punishment, involuntary seclusion and misappropriation of property.

Following State and Federal laws and Kaweah Health policy, all employees are mandated reporters of suspected child or elder/dependent adult abuse and domestic violence injuries. Patient and Family Services staff are available to help assess patients and make appropriate telephone and written reports. Please call (559) 624-2257 for assistance. See Suspected child and or elder dependent adult abuse reporting/AP66 policy for additional information.

LEGAL AND REGULATORY COMPLIANCE

Legal And Regulatory Compliance

Legal and Regulatory Compliance

Kaweah Health provides a variety of healthcare services in the local area. These services are provided pursuant to appropriate federal, state, local laws and regulations and the Conditions of Participation for Federal Healthcare programs.

We have developed policies and procedures to address many legal and regulatory requirements. However, it is impractical to develop policies and procedures that encompass the full body of applicable law and regulation. Clearly, these laws and regulations not covered in organization policies and procedures must be followed. There are sources of expertise within the organization concerning these matters and these resources should be utilized for advice concerning human resources, legal, regulatory, and the Conditions of Participation requirements.

Witnessing Legal Documents

Employees must not act as a witness to a last will and testament, a promissory note, or other legal document not prepared by Kaweah Health, for a patient, a patient's family member, or another staff member.

Coding and Billing for Services

We have implemented policies, procedures and systems to facilitate accurate billing to government payers, commercial insurance payers and patients. These policies, procedures, and systems conform to pertinent federal and state laws and regulations. Kaweah Health prohibits its employees and agents from knowingly presenting or causing to be presented claims for payment or approval which are false or otherwise fraudulent.

In support of accurate billing, medical records must provide reliable documentation of the services rendered. It is important that all individuals who contribute to medical records provide complete and accurate information and do not destroy any information considered part of the official medical record.

Accurate and timely documentation also depends on the diligence and attention of physicians who treat patients in our facilities. We expect those physicians to provide us with complete and accurate documentation in a timely manner.

Any subcontractors engaged to perform billing, coding or collection services are expected to have the necessary skills, systems and appropriate quality control procedures to ensure all billings are accurate and complete. Kaweah Health requires the business associates to have their own ethics and compliance programs and a Code of Conduct or to adopt Kaweah Health's Code of Conduct as their own.

For coding questions, you can contact Health Information Management Services at (559) 624-2218. For billing questions, contact Patient Financial Services at (559) 624-4200. To report any suspected billing or coding misconduct, contact the Compliance and Privacy Officer at (559) 624-5006 or the Confidential Reporting Line at 1-800-998-8050.

False Claims Act and the Deficit Reduction Act of 2005

Both the Federal False Claims Act and the California State False Claims Act (FCA) protect the government from fraud involving any state or federally funded contract or program, including the Medicare and Medicaid (Medi-Cal) programs. Both acts establish liability for any person who knowingly presents or causes to be presented a false or fraudulent claim to the State or Federal government for payment. Any provider who violates the Federal and/or California FCA is liable to the state for three (3) times the amount of damages, Civil Monetary Penalties for each claim submitted, and possible exclusion from participation in federal and state healthcare programs.

Employee Protection – Qui Tam "Whistleblower" Provision

To encourage individuals to come forward and report misconduct involving false claims, both the Federal False Claims Act and the California False Claims Act include "qui tam" or whistleblower provisions. The "qui tam" or whistleblower provision allows a person who is the "original source" of knowledge of a past or present fraud to file a

qui tam action. The party bringing the action is known as the "relator." "Original source" is defined as direct and independent knowledge of the information on which the allegations are based by one who has voluntarily provided the information to the Government before filing a lawsuit on behalf of the U.S. Government or State of California. The purpose of a qui tam suit is to recover the funds received as a result of the false claims to the U.S. Government or State of California. If the suit is successful, the relator may receive a percentage of the funds recovered.

In addition to a possible financial award, the False Claims Act entitles whistleblowers to additional relief, including employment reinstatement, back pay, and any other compensation arising from retaliatory conduct against a whistleblower for filing an action under the False Claims Act or committing other lawful acts, such as investigating a false claim or providing testimony for, or assistance in, a False Claims Act action.

Cost Reports

We are required by federal and state laws and regulations to submit certain reports of our operating costs and statistics. We comply with federal and state laws, regulations, and guidelines relating to all cost reports. These laws, regulations, and guidelines define what costs are allowed and outline the appropriate methodologies to claim reimbursement for the cost of services provided to program beneficiaries.

Kaweah Health policies address cost report compliance and articulate our commitment to ensuring accurate development and submission. Finance Department personnel are educated regarding federal and state laws, regulations and guidelines, and corporate policies; maintain a standardized work paper package to provide consistency in the preparation, organization, presentation, and review of cost reports; apply a uniform cost report review process; identify and exclude non-allowable costs; adhere to documentation standards; and use transmittal letters to report protested items and report other appropriate disclosures. All issues related to the preparation, submission and settlement of cost reports must be performed by or coordinated with our Finance Department.

Financial Reporting and Records

We have established and maintain a high standard of complete accuracy in documenting, maintaining, and reporting financial information. This information serves as a basis for managing our business and is important in meeting our obligations to patients, employees, suppliers, and others. The financial records are also necessary for compliance with tax and financial reporting requirements.

All financial information must reflect actual transactions and conform to generally accepted accounting principles. All funds or assets must be properly recorded in the books and records of the organization. Kaweah Health maintains a system of internal controls to provide reasonable assurances that all transactions are executed in accordance with management's authorization and are recorded in a proper manner so as to maintain accountability of the organization's assets.

We diligently seek to comply with all applicable auditing, accounting and financial disclosure laws. Finance management receives training and guidance regarding auditing, accounting and financial disclosures relevant to their job responsibilities. They are also provided the opportunity to discuss issues of concern with the Board of Directors' Audit and Compliance Committee. Anyone having concerns regarding accounting or auditing matters should report such matters to the Director of Internal Audit, the Compliance and Privacy Officer or the Confidential Reporting Line.

Emergency Treatment-EMTALA

We adhere to the Emergency Medical Treatment and Active Labor Act ("EMTALA") and Kaweah Health policy in providing an emergency medical screening examination and necessary stabilization to all patients, regardless of ability to pay. Provided we have the capacity and capability, anyone who presents in the Emergency Department with an emergency medical condition or who is in labor is treated. In an emergency situation or if the patient is in labor, we will not delay the medical screening and necessary stabilizing treatment in order to seek financial and demographic information. We do not admit, discharge, or transfer

patients with emergency medical conditions simply based on their ability or inability to pay or any other inappropriate discriminatory factor.

Patients with emergency medical conditions are only transferred to another facility at the patient's request or if the patient's medical needs cannot be met at Kaweah Health Medical Center (e.g., we do not have the capacity or capability) once the patient has been stabilized, appropriate care is knowingly available at another facility and the receiving hospital has accepted the transfer. Patients are only transferred in strict compliance with state and federal EMTALA regulatory and statutory requirements.

Response to Government Inquiries

Various agencies may contact individuals associated with Kaweah Health to initiate a compliance-related inquiry. We will comply with lawful and reasonable requests or demands and we will provide truthful responses to government inquiries. At the same time, it is imperative that we protect the rights of Kaweah Health and its employees. Both Kaweah Health and its employees have the right to be represented by legal counsel during any compliance-related governmental inquiry. Kaweah Health employees have the right to have an attorney present during questioning by outside government agencies, whether that questioning occurs at work or away from work. Any individual who receives an inquiry, visit, subpoena or other legal document from a government agency, at work or at home regarding Kaweah Health business shall immediately notify his or her supervisor, the Compliance and Privacy Officer and/or the Director of Risk Management.

Your supervisor, Director of Risk Management and/or the Compliance and Privacy Officer will assist in verifying the credentials of the investigator and determining the legitimacy of the inquiry, and will follow proper procedures for cooperating with the request.

In some cases, government investigators, or persons presenting themselves as such, may contact employees outside of the workplace, during non-work hours, or at the employee's home. Do not feel pressured to talk with the person under such circumstances without first contacting the Compliance and Privacy Officer, the Director of Risk Management or the Compliance Advocate.

Accreditation and Federal/State Agencies

In preparation for, during and after surveys, Kaweah Health employees respond to all consultants and representatives of accrediting bodies in a direct, open and honest manner. No action should ever be taken when interacting with representatives of accrediting bodies that would mislead any member of a survey team.

COMPLIANCE ADVOCACY & PARTNERSHIPS

Compliance Advocacy & Partnerships

Risk Management

The Risk Management Department oversees the risk prevention and claims process. Each employee is considered an important component of Kaweah Health's risk prevention program. Every employee plays a key role in risk prevention by functioning within the scope of their job description and following Kaweah Health's policies, procedures and guidelines. Staff must alert their supervisors to unsafe situations. If something does not feel right or you suspect an undesired patient outcome, notify your immediate supervisor and complete an occurrence report. Any employee who has a concern about the safety or quality of care provided in Kaweah Health may report their concerns to Risk Management, Compliance or the Confidential Reporting Line.

Audit and Consulting Services

The Audit and Consulting Services Department (ACS) serves as an independent and objective auditing and consulting service for Kaweah Health, reporting to the Board of Directors and the Chief Executive Officer. The Internal Audit function within ACS seeks to gain an in-depth understanding of the business culture, systems, and processes in place at the organization and to provide assurance to the Board and Management that internal controls are in place, that they adequately mitigate risks and that they help Kaweah Health meet its organizational goals and objectives. While the Department assesses the internal controls throughout the organization, each Kaweah Health employee is a part of and is responsible for maintaining a proper control structure. This involves performing their roles as outlined in their job description, following all laws and regulations and adhering to Kaweah Health policies. Any employee that has a concern related to internal controls at Kaweah Health, adherence to Kaweah Health policies and procedures, or adherence to laws and regulations should notify their supervisor immediately. Concerns may also be reported to Internal Audit, Compliance, Risk Management or the Confidential Reporting Line. The Consulting Services function within ACS provides internal consulting support to the Organization. This includes Project Management, Data Analysis, Performance Improvement, and other services. The scope of the engagements varies and is determined in conjunction with Management requesting the service. Reporting for consulting projects is not typically at the Board level unless internal control, compliance or other significant issues are identified during the course of the project.

Quality and Patient Safety

Kaweah Health works to continuously improve its clinical and organizational functions. Each quality improvement activity is carried out in various formal and informal settings. Continuous quality improvement is achieved through the effective implementation and coordination of three distinct but overlapping processes:

- The systematic measurement and evaluation of outcomes, processes and services, especially as they relate to Kaweah Health's strategic plan defined annually.
- The analysis of these observations and measures.
- The design and implementation of quality improvement projects when desired or necessary.

BUSINESS RECORDS AND INFORMATION SYSTEMS

Business Records And Information Systems

Accuracy, Retention, and Disposal of Documents and Records

Each Kaweah Health employee is responsible for the integrity and accuracy of our organization's documents and records, not only to comply with regulatory and legal requirements but also to ensure records are available to support our business practices and actions. No one may alter or falsify information on any record or document. Records must never be destroyed in an effort to deny governmental authorities that which may be relevant to a government investigation.

Medical and business documents and records are retained in accordance with the law and our record retention policy. It is important to retain and destroy records only according to our policy. Kaweah Health employees must not tamper with records.

Electronic Media

All communications systems, including but not limited to electronic mail, Intranet, Internet access, telephones, and voice mail, are the property of Kaweah Health and are to be used primarily for business purposes in accordance with electronic communications policies and standards.

Users of computer and telephonic systems should presume no expectation of privacy in anything they create, store, send, or receive on the computer and telephonic systems. Kaweah Health reserves the right to monitor and/or access electronic media usage and content consistent with policies and procedures.

Employees may not use internal communication channels or access the Internet at work to post, store, transmit, download, or distribute any threatening materials; knowingly, recklessly, or maliciously false materials; obscene materials; or anything constituting or encouraging a criminal offense, giving rise to civil liability, or otherwise violating any laws.

Employee Privacy

Kaweah Health collects and maintains personal information that relates to your employment, including medical and benefit information. Access to personal information is restricted solely to people with a need to know this information. Personal information is released outside Kaweah Health or to its agents only with employee approval, except in response to appropriate investigatory or legal requirements, or in accordance with other applicable law. Employees who are responsible for maintaining personal information and those who are providing access to such information must ensure that the information is not disclosed in violation of Kaweah Health's policies and procedures.

Information Security and Confidentiality of Information

Confidential information about our organization's strategies and operations is a valuable asset. Although Kaweah Health employees may use confidential information to perform their jobs, it must not be shared with others unless the individual(s) and/or entities have a legitimate need to know the information in order to perform their specific job duties or carry out a contractual business relationship. In addition, these individuals and/or entities must have agreed to maintain the confidentiality of the information.

We exercise due care and diligence in maintaining the confidentiality, availability and integrity of information. Because so much of our clinical and business information is generated and contained within our computer systems, it is essential that each Kaweah Health employee protect our computer systems and the information contained in them by not sharing passwords and by reviewing and adhering to our information security policies and guidance.

It is Kaweah Health's policy to observe copyrights, trademarks, and/or licenses and safeguard the intellectual property of Kaweah Health and those with whom we do business.

WORKPLACE CONDUCT AND EMPLOYMENT PRACTICES

Workplace Conduct And Employment Practices

Diversity and Equal Employment Opportunity

It is the responsibility of Kaweah Health to create and maintain an equal opportunity work environment in which employees are treated with respect, diversity is valued, and opportunities are provided for development. Harassment or abuse is prohibited in the workplace.

Kaweah Health also prohibits discrimination in any work-related decision on the basis of race, creed, sexual orientation, gender identity, age, disability status, national origin, or any other illegal basis. We make reasonable accommodations to the known physical and mental limitations of otherwise qualified individuals with disabilities.

We comply with all laws, regulations, and policies related to non-discrimination in all of our personnel actions. Such actions include hiring, staff reductions, transfers, terminations, evaluations, recruiting, compensation, corrective action, discipline, and promotions.

If a Kaweah Health employee perceives that inequitable or unfair conduct is occurring in the workplace, the employee should contact the Human Resources Department. If the employee feels the matter was not resolved to his/her satisfaction, the employee may contact the Compliance and Privacy Officer or the Compliance Advocate or call the Confidential Reporting Line. See Equal Employment Opportunity/HR.12 policy for additional information.

Conflicts of Interest

A conflict of interest may occur if a Kaweah Health employee's outside activities, personal financial interests, or other personal interests influence or appear to influence his or her ability to make objective decisions in the course of the employee's job responsibilities. A conflict of interest may also exist if the demands of any outside activities hinder or distract an employee from the performance of his or her job or cause the individual to use Kaweah Health resources for other than Kaweah Health purposes. Situations of actual or potential conflict of interest are to be avoided by all employees, including personal, financial, or romantic involvement with a competitor, supplier, patient or employee of Kaweah Health which impairs the ability to exercise good judgment on behalf of Kaweah Health or creates an actual or potential conflict of interest. A good rule of thumb is that a conflict of interest may exist any time an objective observer of your actions might wonder if your actions are significantly influenced by your personal or financial activities or interests.

Kaweah Health employees are obligated to ensure they remain free of conflicts of interest in the performance of their responsibilities. If employees have any question about whether an outside activity or personal interest might constitute a conflict of interest, they must obtain the approval of their supervisor before pursuing the activity, or obtaining or retaining the interest. See Vendor Relationships and Conflict of Interest/AP.40 policy for additional information.

Gifts

Kaweah Health employees are prohibited from soliciting or receiving gifts, loans, entertainment or any other consideration of value from any individual or organization that does business or may wish to do business with Kaweah Health. If an employee receives any gift or favor, it must be returned, and the employee's supervisor must be notified. A Kaweah Health employee must not accept a personal gift of any consideration of value or any cash payment from a patient. In accordance with Kaweah Health policy, patients wishing to express appreciation to employees may do so in the form of flowers or candy addressed to and for the enjoyment of the entire department or by donating to the Foundation Guardian Angel recognition program in the employee's honor. For more information about the Guardian Angel Program, you can contact Kaweah Health Hospital Foundation at (559)624-2359. See Vendor Relationships and Conflict of Interest/AP.40 policy for additional information on gifts.

- ***Referral Sources.*** Any gifts or entertainment involving physicians or other persons in a position to refer patients are subject to federal laws, rules and regulations regarding these practices and must be undertaken with the utmost integrity and good judgment. Individuals uncertain about whether a particular event or function is appropriate should contact Human Resources or Compliance for direction.

Anti-Kickback and Stark Law

Federal and state laws and regulations govern the relationship between hospitals and physicians who may refer patients to the facilities. The applicable federal laws include the Anti-Kickback Law and the Stark Law. It is important that those employees who interact with physicians, particularly regarding making payments to physicians for services rendered, leasing space, recruiting physicians to the community, and arranging for physicians to serve in leadership positions in facilities, are aware of the requirements of the laws, regulations, and policies that address relationships between facilities and physicians.

If relationships with physicians are properly structured, but not diligently administered, failure to administer the arrangements as agreed may result in violations of the law. Any business arrangement with a physician must be structured to ensure compliance with legal requirements, our policies and procedures and with any operational guidance that has been issued. See Physician Contracts and Relationships/CP.03 policy for additional information.

Keeping in mind that it is essential to be familiar with the laws, regulations, and policies, there are two overarching principles that govern our interactions with physicians:

- ***We do not pay for referrals.*** We accept patient referrals and admissions based solely on the patient's medical needs and our ability to render the needed services. We do not pay or offer to pay anyone - employees, physicians, or other persons or entities - for referral of patients.

- ***We do not accept payments for referrals we make.*** No Kaweah Health employee or any other person acting on behalf of the organization is permitted to solicit or receive anything of value, directly or indirectly, in exchange for the referral of patients. Similarly, when making patient referrals to another healthcare provider, we do not take into account the volume or value of referrals that the provider has made (or may make) to us.

Relationships with Subcontractors and Suppliers

We must manage our subcontractor and supplier relationships in a fair and reasonable manner, free from conflicts of interest and consistent with all applicable laws and good business practices. We promote competitive purchasing to the maximum extent practicable. Our selection of subcontractors, suppliers, and vendors will be made on the basis of objective criteria including quality, technical excellence, price, delivery, adherence to schedules, service, and maintenance of adequate sources of supplies. Our purchasing decisions will be made on the supplier's ability to meet our needs, and not on personal relationships and friendships. We employ the highest ethical standards in business practices in source selection, negotiation, determination of contract awards, and the administration of all purchasing activities.

Research, Investigations and Clinical Trials

Participation in Human Subjects Research is governed by federal and state laws. Federal law requires all research involving human subjects to have prior approval from an Institutional Review Board, and the approval includes additional examination of the proposed research from both ethical and privacy protection perspectives. Kaweah Health's Institutional Review Board (IRB) is made up of several scientists, non-scientists and public members.

All persons invited to participate in a clinical investigation or human subjects research study are provided a full explanation of potential risks, expected benefits and alternatives. Additionally, no persons are ever required to participate in research, and may withdraw from a study at any time, and for any reason.

Sanctioned/Excluded Individuals and Entities

We do not contract with, employ, or bill for services rendered by an individual or entity that is excluded or ineligible to participate in Federal healthcare programs; suspended or debarred from Federal government contracts; or has been convicted of a criminal offense related to the provision of healthcare items or services and has not been reinstated in a Federal healthcare program after a period of exclusion, suspension, debarment, or ineligibility, provided that we are aware of such criminal offense. Pursuant to Kaweah Health's policy, we routinely search the Department of Health and Human Services' Office of Inspector General and General Services Administration's lists of such excluded and ineligible persons. Kaweah Health's policy addresses the procedures for timely and thorough review of such lists and appropriate enforcement actions.

Employees, vendors, and privileged practitioners at Kaweah Health facilities are required to report to us if they become excluded, debarred or ineligible to participate in Federal healthcare programs; or have been convicted of a criminal offense related to the provision of healthcare items or services. See Excluded Individuals/Entities/CP.07 policy for additional information.

Identification Badge Policy

All Kaweah Health employees, contracted non-employees, physicians, care providers, vendors and volunteers are required to wear an identification badge at all times while performing their work on Kaweah Health premises. Students, vendor and service representatives, temporary help, contractors and construction workers, and volunteers will wear identification badges as a condition of being on Kaweah Health property. Additionally, all employees should wear a badge attachment, which contains important safety information. Badges must be worn chest high or above, with the name and picture clearly visible to patients, visitors, co-workers, physicians, and volunteers. If an employee damages or loses their badge, a replacement must be purchased through the Human Resources Department. See Identification Badges/HR.183 policy for additional information.

Kaweah Health Property and Assets

Kaweah Health property is made available to Kaweah Health employees only for authorized business purposes and shall not be used for personal reasons. This applies to physical assets such as office equipment, computers, software, medical supplies, as well as other types of property such as company records, patient information and customer lists. Kaweah Health property must not be removed from the premises unless it is necessary to do so to perform your job. If property is removed from the premises, you must maintain it in your possession at all times and return the property as soon as it is no longer needed. See Security of Purchased Equipment and or Supplies/AP42 policy for additional information.

All Kaweah Health employees are expected to maintain and properly care for Kaweah Health property. We all have an obligation to treat Kaweah Health property and equipment with care and respect. This includes reporting any damage or malfunction of Kaweah Health property to appropriate personnel. If you are aware of anyone intentionally or negligently damaging Kaweah Health property or equipment, report your observations to your supervisor or other manager who will investigate the matter and take appropriate action. See Safe Medical Device Act/ Medical Device Tracking and Reporting/EOC 6009 policy for additional information.

Client lists are a valuable asset and should never be disclosed to anyone outside Kaweah Health without specific management approval. Ask your supervisor about any request you receive for such a client listing.

Controlled Substances

Some of our employees routinely have access to prescription drugs, controlled substances, and other medical supplies. Many of these substances are governed and monitored by specific regulatory organizations and must be administered by physician order only. Prescription and controlled medications and supplies must be handled properly and only by authorized individuals. If you become aware of inadequate security of drugs or controlled substances or the diversion of drugs from the organization,

the incident must be reported immediately. See Reporting Requirements for Drug Diversion Illegal Substance Abuse or Controlled Substance Abuse/AP110 policy for additional information.

Harassment and Workplace Violence

Each Kaweah Health employee has the right to work in an environment free of harassment, abusive, threatening, intimidating and disruptive behavior. We do not tolerate harassment by anyone based on the diverse characteristics or cultural backgrounds of those who work with us. Degrading or humiliating jokes, slurs, intimidation, or other harassing conduct is not acceptable in our workplace.

Sexual harassment is prohibited. This prohibition includes unwelcome sexual advances or requests for sexual favors in conjunction with employment decisions. Moreover, verbal or physical conduct of a sexual nature that interferes with an individual's work performance or creates an intimidating, hostile, or offensive work environment will not be tolerated at Kaweah Health.

Harassment also includes incidents of workplace violence. Workplace violence includes robbery and other commercial crimes, stalking, violence directed at the employer, terrorism, and hate crimes committed by current or former employees. Employees who observe or experience any form of harassment or violence should report the incident to their supervisor, the Human Resources Department, a member of Management, the Compliance and Privacy Officer or the Confidential Reporting Line. Retaliation for reporting is strictly prohibited by law and policy. See the Anti-Harassment and Abusive Conduct/HR.13 policy for additional information.

Health and Safety

Kaweah Health shall comply with all applicable workplace health, safety, and environmental laws and regulations. Kaweah Health employees handle hazardous chemicals, infectious agents, medical waste, and low-level radioactive material at various locations. All employees are expected to handle materials according to established control, storage and disposal procedures. If you do not know the correct procedure for handling or disposing of any material, promptly ask your supervisor or another Kaweah Health resource such as the Safety Officer at (559)624-2381 or Director of Risk Management at (559)624-2340 for assistance.

Most chemicals used in our facilities are not classified as hazardous waste. Information regarding the hazards, proper handling, and disposal of chemicals is contained within the Material Safety Data Sheets (MSDS) supplied to us by the manufacturer. The MSDS can be found on Kaweah Health's Intranet and in a binder available to departments where hazardous materials are used. If you are not sure, ask your supervisor or the Safety Officer before disposing of any chemical waste. Kaweah Health safety plans and manuals provide additional guidance.

Kaweah Health contracts with licensed disposal companies to remove and treat bio-hazardous waste to render it non-infectious. Bio-hazardous waste is placed in designated containers, either all red in color or having a fluorescent orange and black biohazard symbol.

Behaviors that Undermine a Culture of Safety

Intimidating and disruptive behaviors can cause medical errors, contribute to poor patient satisfaction, contribute to adverse outcomes, increase the cost of care, and cause qualified clinicians, administrators, and managers to seek new positions in more professional environments. Safety and quality of patient care is dependent on teamwork, communication, and a collaborative work environment. To assure quality and to promote a culture of safety, we endeavor to address behaviors that threaten the performance of the healthcare team.

Intimidating and disruptive behaviors include overt actions such as verbal outbursts, and physical threats, as well as passive activities such as refusing to perform assigned tasks or quietly exhibiting uncooperative attitudes during routine activities. Such behaviors include reluctance or refusal to answer questions, return phone calls or pages; condescending language or voice intonation; and impatience with questions. Overt and passive behaviors undermine team effectiveness and can compromise the safety of patients. All intimidating and disruptive behaviors are unprofessional and should not be tolerated.

License and Certification Renewals

Employees, individuals retained as independent contractors, and privileged practitioners in positions which require professional licenses, certifications, or other credentials are responsible for maintaining the current status of their credentials and shall comply at all times with federal and state requirements applicable to their respective disciplines. To assure compliance, Kaweah Health may require evidence of the individual having a current license or credential status.

Kaweah Health does not allow any employee, independent contractor or privileged practitioner to work in a position that requires a license or certification without valid, current licenses or credentials.

Substance Use and Mental Acuity

To protect the interests of our employees and patients, we are committed to an alcohol and drug-free work environment. All employees must report for work free of the influence of alcohol and illegal drugs. Reporting to work under the influence of any illegal drug or alcohol; having an illegal drug in an employee's system; or using, possessing, or selling illegal drugs while on Kaweah Health work time or property may result in immediate termination. We may use drug testing as a means of enforcing this policy.

It is also recognized that individuals may be taking prescription or over-the-counter drugs, which could impair judgment or other skills required in job performance. Employees with questions about the effect of such medication on their performance or who observe an individual who appears to be impaired in the performance of his or her job must immediately follow appropriate protocol for reporting. The reporting protocol may vary by department or by site. It is up to the employee to familiarize themselves with their proper reporting chain of command.

MARKETING, ADVERTISING AND FUNDRAISING PRACTICES

Marketing, Advertising And Fundraising Practices

Marketing and Advertising

Kaweah Health will advertise to inform the community of the availability and value of our services, to provide educational information about personal health, and to inform the public of Kaweah Health's views on public policy issues related to healthcare.

Kaweah Health is perceived as a reliable, authoritative source of information about medical care within the healthcare system. We shall remain mindful of the trust the public places in us to provide accurate, balanced information. Advertising will be honest and accurate and, when presenting views on issues, clearly distinguish opinion from factual data. Advertising shall not disparage or demean competitors, customers, or patients.

Antitrust - Compete Fairly

Antitrust laws are designed to create a level playing field in the marketplace and to promote fair competition. These laws could be violated by discussing Kaweah Health business with a competitor, such as how our prices are set, disclosing the terms of supplier relationships, allocating markets among competitors, or agreeing with a competitor to refuse to deal with a supplier. Our competitors are other health systems and facilities in markets where we operate.

At trade association meetings, employees must be alert to potential situations where it may not be appropriate to participate in discussions regarding prohibited subjects with competitors. Prohibited subjects include any aspect of pricing, our services in the market, key costs such as labor costs, and marketing plans. If a competitor raised a prohibited subject, employees must end the conversation immediately.

In general, employees should avoid discussing sensitive topics with competitors or suppliers. Employees also must not provide any information in response to an oral or written inquiry concerning an antitrust matter without first consulting their manager, responsible Executive Team member or the Compliance and Privacy Officer.

Kaweah Health Hospital Foundation

Kaweah Health Hospital Foundation is one of our oldest and strongest traditions. The members of the Foundation Board of Directors are volunteers from the community including Kaweah Health employees and doctors who believe in advancing local healthcare by being donors, fundraisers, and ambassadors for Kaweah Health. Since being established in 1980, the Foundation has raised monies to build new facilities, purchase medical technology, and advance patient care. The Foundation conducts fundraising activities throughout the year; it receives gifts from individuals, businesses, Kaweah Health employees and other foundations in the form of cash, securities and bequests.

Government Relations and Political Activities

Kaweah Health complies with all federal, state, and local laws governing participation in government relations and political activities. Additionally, Kaweah Health funds or resources may not be contributed directly to individual political campaigns, political parties, or other organizations which intend to use the funds primarily for political objectives. Organization resources include financial and non-financial donations such as using work time and telephones to solicit for a political cause or candidate or the loaning of Kaweah Health property for use in the political campaign. Kaweah Health engages in public policy debate only in a limited number of instances where it has special expertise that can inform the public about the public policy formulation process. When the organization is directly impacted by public policy decisions, it may provide relevant factual information about the impact of such decisions. In articulating positions, the organization only takes positions that it believes can be shown to be in the larger public interest. The organization encourages trade associations with which it is associated to do the same.

It is important to separate personal and corporate political activities in order to comply with the appropriate rules and regulations relating to lobbying or attempting to influence government officials.

No use of Kaweah Health resources, including e-mail, is appropriate for personally engaging in political activity. An employee may, of course, participate in the political process on his or her own time and at his or her own expense. While doing so, it is important that Kaweah Health employees not give the impression they are speaking on behalf of or representing Kaweah Health in these activities. Employees cannot seek to be reimbursed by Kaweah Health for any personal contributions for such purposes.

At times, Kaweah Health may ask employees to make personal contact with government officials or to write letters to present its position on specific issues. In addition, some members of Kaweah Health's Management Team may be required to interface on a regular basis with government officials.

Solicitation, Fundraising and Distribution of Material

In order to avoid disruption of healthcare operations or disturbance of patients, and to maintain appropriate order and discipline, solicitation and distribution of literature on Kaweah Health premises and among Kaweah Health staff and patients is prohibited.

Kaweah Health supports community organizations who engage in health-related charitable and fundraising activities/events that are consistent with or advance Kaweah Health's mission. Furthermore, Kaweah Health will consider support of certain health-related charitable activities/events that are held in the local communities. Formal approval is required by Kaweah Health policy for these types of charitable and fundraising activities. See Solicitation, Fundraising and Distribution of Materials/ AP158 policy for additional information.

Acknowledgment Process

Kaweah Health requires all employees to attest in an acknowledgment confirming they have received the Code of Conduct, understand it represents mandatory policies of Kaweah Health and agree to abide by it. New employees are required to sign an acknowledgment as a condition of employment. Adherence to and support of Kaweah Health's Code of Conduct and participation in related activities training is considered in decisions regarding hiring and promotion.

Notes

Code of Conduct

Integrity, accountability, and excellence

KaweahHealth.org

Kaweah Health
MORE THAN MEDICINE. LIFE.

Separator Page

CARDIAC SERVICE LINE REPORT

Cardiac Surgery Service Line

Quality Council Report

Q3 2023 → Q2 2025

Risk-Adjusted Data

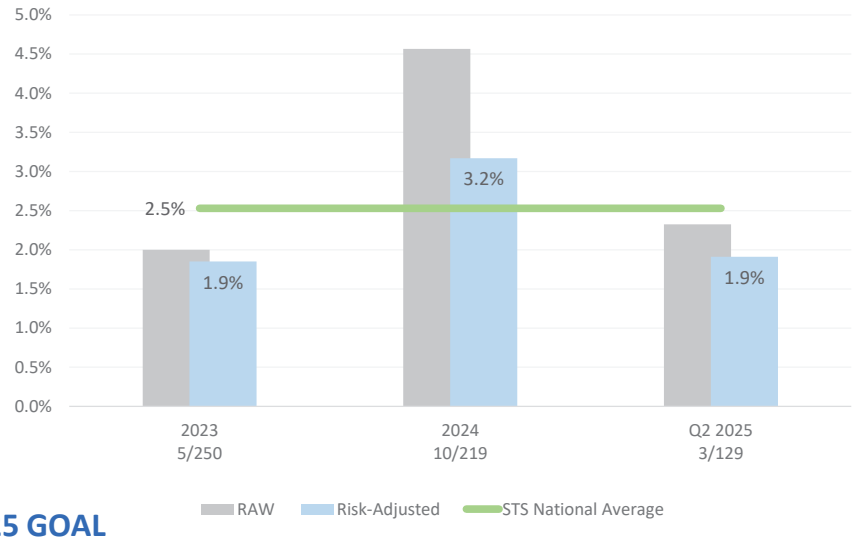
Blue = Risk-Adjusted data

Green = STS Average

Gray = Non-Risk Adjusted Value (for Reference only)

Data Analysis by the Society of Thoracic Surgeons National Adult Cardiac Surgery Database

Operative Mortality Reduction – Multiprocedural (All Analyzed Cardiac Surgery Procedures)



GOAL MET

FY25 GOAL

Decrease STS Operative Mortality to </= 2.5% (STS goal is national mean from Q2 2025)

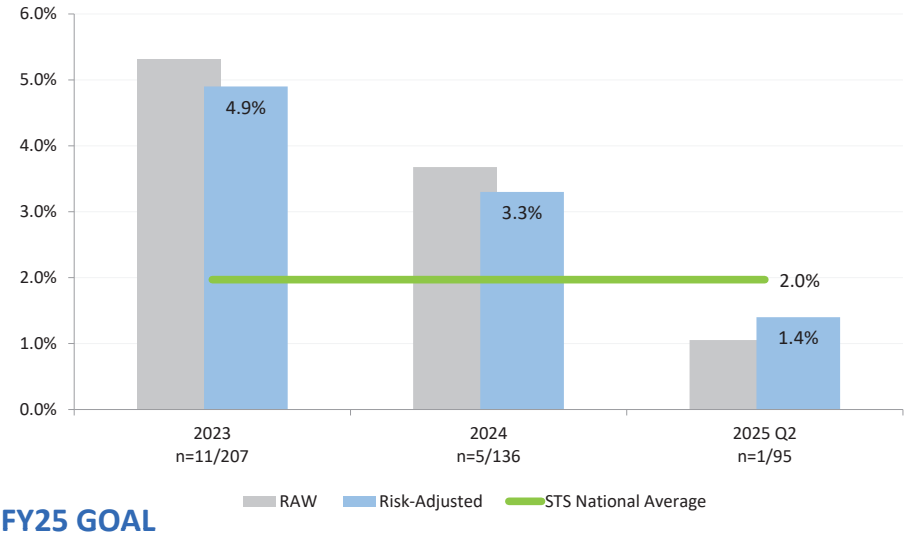
Operative Mortality Reduction – Multiprocedural (All Analyzed Cardiac Surgery Procedures)

The Targeted Opportunities

1. Further standardizing post-operative care
2. Setting expectations of post-op care immediately to staff
3. Educate nursing staff on emergent re-sternotomy procedures

CURRENT IMPROVEMENT ACTIVITIES	COMPLETION DATE	BARRIERS
Review mortalities with Cardiothoracic Surgeons	On-going	Manual chart review for possible care opportunities
Review mortalities in monthly CV M&M	On-going Monthly	Requires cardiothoracic and cardiologist participation
Recruiting new permanent cardiothoracic surgeons	06/30/2026	Recruiting CT surgeons to the area

Renal Failure Reduction - CABG patients



GOAL MET

FY25 GOAL

Decrease Risk-adjusted Renal Failure to ≤ 2.0% (STS goal is national average from Q2 2025)

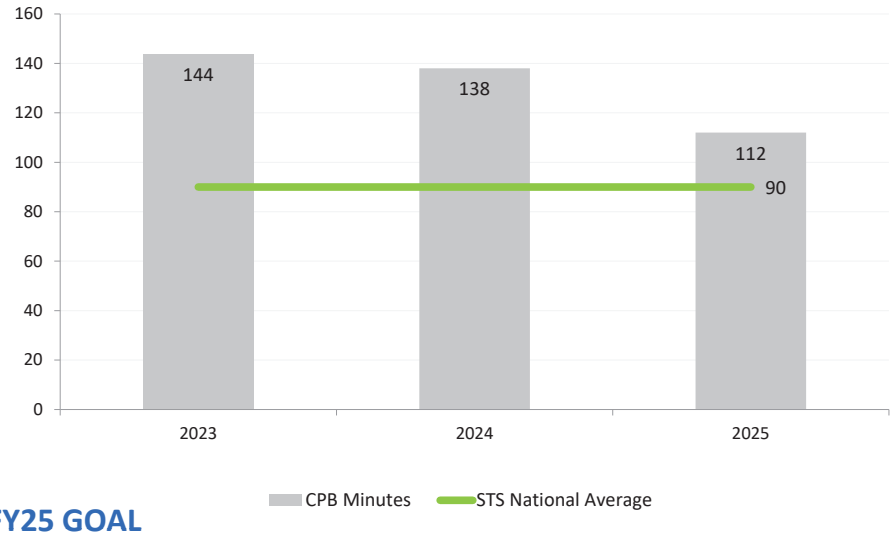
Renal Failure Reduction - CABG patients

Targeted Opportunities

1. Focus on the Pre-op care of chronic kidney disease patients
2. Fully optimize prior to surgery when time allows
3. Decrease time on pump
4. Lower hypotension events that require prolonged vasopressors

CURRENT IMPROVEMENT ACTIVITIES	COMPLETION DATE	BARRIERS
Review each fallout with cardiothoracic surgeon	On-going	NA
Involve nephrologist early and pre-operatively when necessary	On-going	NA
Pre-op medication reconciliation	On-going	Time for patient education in pre-op setting

Cardiopulmonary Bypass Time - CABG patients

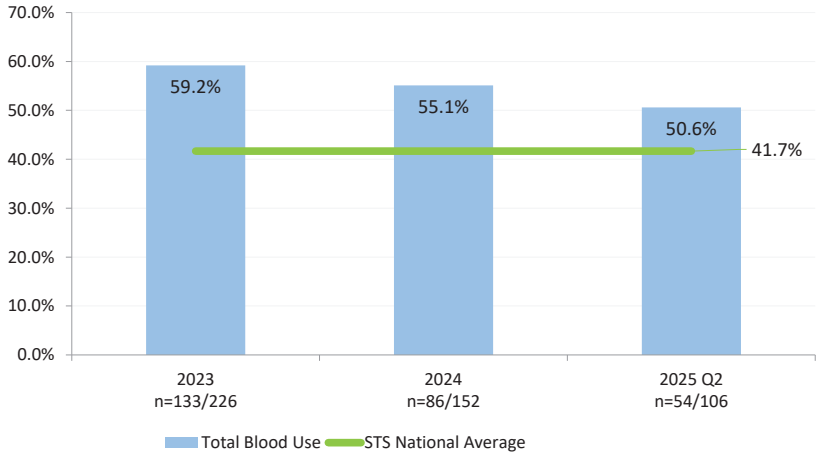


GOAL MET

FY25 GOAL

Decrease Risk-adjusted Renal Failure to ≤ 2.0% (STS goal is national average from Q2 2025)

Blood Use Reduction - CABG patients



IMPROVED

FY25 GOAL

Decrease Cardiac Surgery Blood Use Rate to </= 41.7% (STS goal is National Average from Q2 2025)

Blood Use Reduction - CABG patients

Targeted Opportunities

1. Decrease rate of patients that get a single unit packed red blood cell transfusion
2. Treat pre-operative anemia or transfusion as needed prior to the OR
3. Standardize post-op transfusion requirements
4. **Update Blood management system**

CURRENT IMPROVEMENT ACTIVITIES	COMPLETION DATE	BARRIERS
Optimize H&H prior to surgery	On-going	Epogen use inpatient vs outpatient
Audit of cases requiring a single unit of blood	On-going	Manual audit; resources to complete this
If trend identified with the above, develop plan to address (standardized Hgb cutoff for transfusion)	12/31/2025	NA

Thank you

Live with passion.

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

Kaweah Health

PATIENT AND COMMUNITY EXPERIENCE

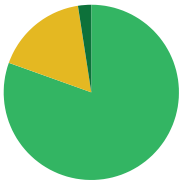
FY 2026 Strategic Plan

Patient Experience and Community Engagement

February 25, 2026

Patient Experience and Community Engagement - Marc Mertz and Deborah Volosin

All Items



- On Track 33 (80%)
- Off Track 7 (17%)
- Achieved 1 (2%)

Spotlight Items

Name	Aligns To	Status	Spotlight Comment
Achieve an organizational-wide score of 74 in HCAHPS "Overall Rating of Hospital"	Provide training on best practices to all areas of organization to focus on the both the HCAHPS and Real Time surveys and priorities set by NRC	Off Track	Our current scores are not at goal however; much work and effort are focused in this area. There is an increased focus on accountability and transparency involving the patient experience and related scores. Education and training have been provided to all leaders related to accessing and understanding real time patient experience data, with the expectation that they review, own and act upon the results. Patients are invited to attend Leadership meetings to share their patient experience stories, both good and bad. In addition, there are a number of initiatives that have been launched, including Wayfinding and What Matters to You that are intended to have a positive impact on overall patient experience.
Achieve an organizational-wide score of 73.8 in HCAHPS "Would Recommend Hospital".	Provide training on best practices to all areas of organization to focus on the both the HCAHPS and Real Time surveys and priorities set by NRC	Off Track	This is a very important CMS dimension as it is tied to value-based purchasing and reimbursements. This dimension has been trending down since November. We continue to educate our leaders on the scores and the dimensions that patients are surveyed on. Increased awareness and focus should lead to an increase in scores.
Achieve an organizational-wide score of 67.7 in Real Time Net Promoter Score (NPS)	Provide training on best practices to all areas of organization to focus on the both the HCAHPS and Real Time surveys and priorities set by NRC	On Track	We are seeing an improvement in the net promoter score. This score is based on Facility Would Recommend, which is the question "How likely would you be to recommend this facility to your family and friends?" This is an aggregate score that includes inpatient, ED, rural clinics, urgent cares, and specialty clinics. Every patient receives a real-time survey.
Add 10 New Community Advisory Council Members In FY26	Expand Engagement and Participation in Community Advisory Councils	Off Track	Patient Experience is working with the social media team to develop and deploy a solicitation post to attract potential new members. In addition, we have three new potential members currently pending acceptance to a CAC.

Empower ALL Team Members to Deliver Patient Centric Care Champion: Deborah Volosin and Marc Mertz

Description: *Focus on equipping team members at all levels with the necessary skills, tools, and authority to drive meaningful improvements in patient interactions, service delivery, and overall satisfaction.*

Work Plan (Tactics)

#	Name	Start Date	Due Date	Assigned To	Status	Last Comment
4.1.1	Ensure Unit Leaders Are Accessing Survey Data and Patient Experience Feedback and that they are sharing the information with their teams	07/01/2025	06/30/2026	Deborah Volosin	On Track	PX monitors leader activity in NRC system to ensure they are reviewing feedback and scores.
4.1.2	Provide training on best practices to all areas of organization to focus on the both the HCAHPS and Real Time surveys and priorities set by NRC	07/01/2025	06/30/2026	Deborah Volosin	On Track	Survey information is presented monthly at Board meetings, Leadership, and Kaweah Care. PX Director presents at New Employee Orientation.
4.1.3	Set PX goals in Spring 2025, provide training and education to drive improvement and accountability so that each area meets their PX goals	07/01/2025	06/30/2026	Deborah Volosin	On Track	The goals were set in Spring 2025 and will be monitored and evaluated in Spring 2026
4.1.4	Support Services Partnership and Coordination	07/01/2025	06/30/2026	Deborah Volosin	On Track	The Patient Experience Steering Committee meets monthly and is working on (1) Lost Belongings processes, (2) cleanliness and food services scores, (3) inpatient room television/music channels, (4) ED waiting room intercom, (5) Surgery waiting room enhancements, (6) Acequia Wing Lobby enhancements, (7) customer service trainings.

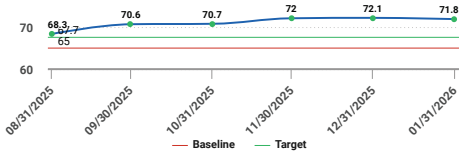
Performance Measure (Outcomes)

#	Name	Start Date	Due Date	Assigned To	Status	Last Comment
4.1.2.3	Achieve an organizational-wide score of 67.7 in Real Time Net Promoter Score (NPS)	07/01/2025	06/30/2026	Deborah Volosin	On Track	7/1/2025-12/31/2025
4.1.2.2	Achieve an organizational-wide score of 73.8 in HCAHPS "Would Recommend Hospital".	07/01/2025	06/30/2026	Deborah Volosin	Off Track	7/1/2025-12/31/2025
4.1.2.1	Achieve an organizational-wide score of 74 in HCAHPS "Overall Rating of Hospital"	07/01/2025	06/30/2026	Deborah Volosin	Off Track	7/1/2025-12/31/2025
4.1.1.1	Patient Experience to monitor user activity logs and provide monthly reports to Leadership, each unit manager, assistant manager, and clinical director	07/01/2025	06/30/2026	Deborah Volosin	On Track	Part of communication with clinical Directors, Manager, and Assistant Managers quarterly PX meetings
4.1.4.1	PX Steering Committee to act on feedback to improve all aspects of the patient journey	07/01/2025	06/30/2026	Deborah Volosin	On Track	Committee will be reviewing wayfinding results.

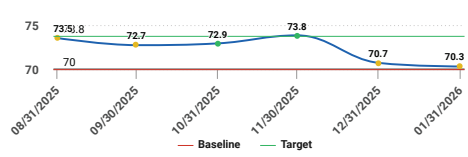
Empower ALL Team Members to Deliver Patient Centric Care Champion: Deborah Volosin and Marc Mertz

Description: *Focus on equipping team members at all levels with the necessary skills, tools, and authority to drive meaningful improvements in patient interactions, service delivery, and overall satisfaction.*

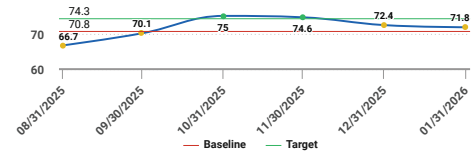
Achieve an organizational-wide score of 67.7 in Real Time Net Promoter Score (NPS)



Achieve an organizational-wide score of 73.8 in HCAHPS "Would Recommend Hospital".



Achieve an organizational-wide score of 74 in HCAHPS "Overall Rating of Hospital"



Foster a Culture of Human Understanding Champions: Deborah Volosin and Marc Mertz

Description: *Foster an environment where empathy, respect, and compassion are at the core of all interactions.*

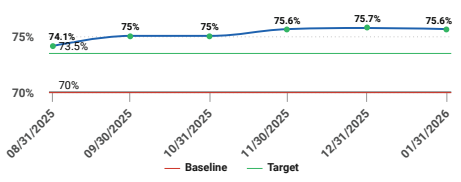
Work Plan (Tactics)

#	Name	Start Date	Due Date	Assigned To	Status	Last Comment
4.2.1	Provide Staff Education on Delivering Compassionate, Empathetic, and Individualized Patient Care	07/01/2025	06/30/2026	Deborah Volosin	On Track	PX Director presented at 4 unit staff meetings in September. Prepping units for WMTY Pilot
4.2.2	Implement a Comprehensive Customer Service Training Across All Areas of the Organization	07/01/2025	06/30/2026	Deborah Volosin	On Track	Patient Access has rolled this training out to all their staff. Leaders are performing audits and monitoring NRC feedback data.

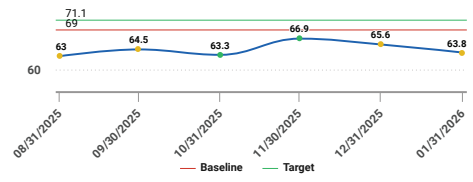
Performance Measure (Outcomes)

#	Name	Start Date	Due Date	Assigned To	Status	Last Comment
4.2.1.1	Achieve an Organizational-wide Score of 73.5 in Human Understanding	07/01/2025	06/30/2026	Deborah Volosin	On Track	7/1/2025-12/31/2025
4.2.2.1	Achieve an Organizational-wide Score of 71.1 in Responsiveness of Staff	07/01/2025	06/30/2026	Deborah Volosin	Off Track	7/1/2025-12/31/2025

Achieve an Organizational-wide Score of 73.5 in Human Understanding



Achieve an Organizational-wide Score of 71.1 in Responsiveness of Staff



Enhancement of Environment Champion: Deborah Volosin and Marc Mertz

Description: *Focus on improving the hospital's physical spaces to promote comfort, accessibility, and a sense of healing.*

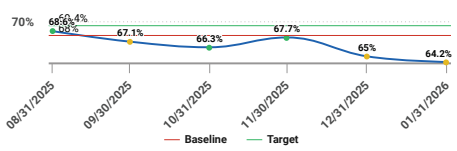
Work Plan (Tactics)

#	Name	Start Date	Due Date	Assigned To	Status	Last Comment
4.3.1	Conduct Executive Rounds with EVS, Facilities, Patient Experience to Identify and Address Cleanliness and Other Improvement Opportunities	07/01/2025	06/30/2026	Deborah Volosin	On Track	Monthly rounds are occuring
4.3.2	Incorporate Cleanliness Feedback into Patient Experience QR Code Surveys and relay information to EVS Leadership	07/01/2025	06/30/2026	Kevin Morrison	On Track	Have implemented QR codes for easier accessibility by visitors and patients to notify of issues. Will work with Deborah in updating the QR code surveys to include cleanliness information.
4.3.3	Implement Facility Upgrade and Refurbishment Projects to Enhance the Patient and Staff Environment	07/01/2025	06/30/2026	Kevin Morrison	On Track	Continuing to complete projects (i.e. flooring replacement, restroom upgrades, Ambrosia Cafe) that enhance the environment.

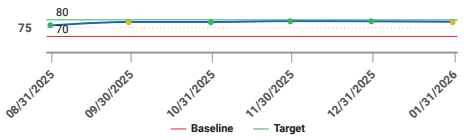
Performance Measure (Outcomes)

#	Name	Start Date	Due Date	Assigned To	Status	Last Comment
4.3.2.1	Achieve a Score of 69.4 in The HCAHPS Cleanliness Score	07/01/2025	06/30/2026	Deborah Volosin	Off Track	7/1/2025-12/31/2025
4.3.2.2	Achieve a Score of 80 in Real-Time "Clean Clinic" Score	07/01/2025	06/30/2026	Deborah Volosin	Off Track	7/1/2025-12/31/2025
4.3.3.1	Complete 5 Facility Upgrades and Refurbishment Projects	07/01/2025	06/30/2026	Kevin Morrison	On Track	3N flooring replacement is completed. The remaining projects, a new Acequia Wing Conference Room and update to Respiratory Therapy are on track for completion this fiscal year.

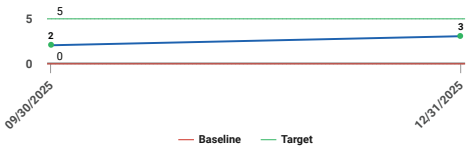
Achieve a Score of 69.4 in The HCAHPS Cleanliness Score



Achieve a score of 80 in "Cleanliness of Clinic" Score



Complete 5 Facility Upgrades and Refurbishment Projects



Community Engagement Champion: Deborah Volosin and Marc Mertz

Description: *Build strong relationships with the community to foster trust, improve health outcomes, and increase access to care.*

Work Plan (Tactics)

#	Name	Start Date	Due Date	Assigned To	Status	Last Comment
4.4.1	Foster a mindset toward a Patient and Community-Centered Culture at Kaweah Health by partnering community members with hospital leadership to co-design services and processes within the system. (CAC meetings, leadership presentations, Lost Belongings initiative, etc. Always include patients and community members on committees that involve patient care concerns)	07/01/2025	06/30/2026	Deborah Volosin	On Track	CAC meetings occur monthly.
4.4.2	Expand Engagement and Participation in Community Advisory Councils	07/01/2025	06/30/2026	Deborah Volosin	On Track	One new member has been added to the groups this fiscal year.
4.4.3	Encourage Greater Involvement of Kaweah Health Leaders in Service Clubs and Community Organizations	07/01/2025	06/30/2026	Deborah Volosin	On Track	Continue to share the importance of community involvement.
4.4.4	Expand Opportunities for KH Leaders to Participate in the Speakers Bureau	07/01/2025	06/30/2026	Deborah Volosin	On Track	7 speakers have gone out into the community this fiscal year

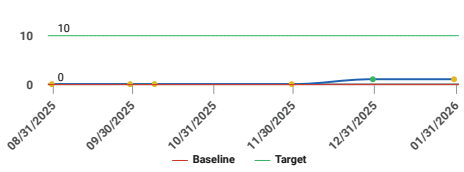
Performance Measure (Outcomes)

#	Name	Start Date	Due Date	Assigned To	Status	Last Comment
4.4.1.1	Restore Overnight Stay Privileges for Visitors to Enhance Patient Support and Experience	07/01/2025	06/30/2026	Deborah Volosin	Achieved	Visitor Policy approved by BOD in September. All patients can have one overnight visitor.
4.4.1.2	Revise Policies to Foster a More Welcoming and Supportive Environment for Patients and Families	07/01/2025	06/30/2026	Deborah Volosin	On Track	Visitor policy was updated and approved. Continuing to work on Lost Belongings Policy
4.4.2.1	Add 10 New Community Advisory Council Members In FY26	07/01/2025	06/30/2026	Deborah Volosin	Off Track	Social Media is working with CE to solicit new members in our groups.
4.4.3.1	Goal of 25 Leaders Participating in Service Clubs	07/01/2025	06/30/2026	Deborah Volosin	Off Track	24 leaders are involved with service clubs/community boards
4.4.4.1	Goal of 12 New Speaking Engagements for Leaders In The Community	07/01/2025	06/30/2026	Deborah Volosin	On Track	We have scheduled 12 speaking engagements so far this fiscal year.

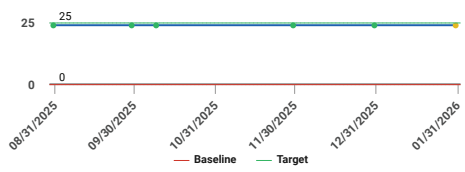
Community Engagement Champion: Deborah Volosin and Marc Mertz

Description: *Build strong relationships with the community to foster trust, improve health outcomes, and increase access to care.*

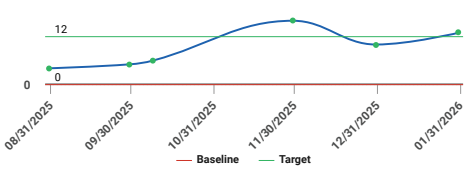
Gain 10 New Members In FY26



Goal of 25 Leaders Participating in Service Clubs



Gain 12 New Speaking Engagements for Leaders In The Community



Promote a Patient-Centric Culture Champion: Deborah Volosin and Marc Mertz

Description: *Focus on ensuring that every touchpoint in a patient's healthcare journey—from scheduling and admission to discharge and follow-up care—is designed with their needs, preferences, and well-being in mind.*

Work Plan (Tactics)

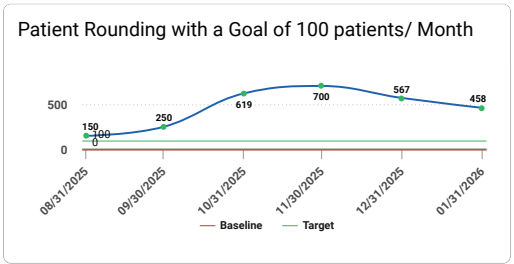
#	Name	Start Date	Due Date	Assigned To	Status	Last Comment
4.5.1	Executive Team to support the Patient Experience team by modeling patient-centered behaviors, reinforcing expectations with leaders, and using patient feedback to guide priorities and visibly champion key initiatives	07/01/2025	06/30/2026	Deborah Volosin	On Track	ET is rounding, we are sharing positive and negative patient stories in Leadership. Building a PX Champions group
4.5.2	Identify and Address Departmental Barriers to Delivering Excellent Customer Service by meeting with clinical unit leaders quarterly to review Patient Experience data	07/01/2025	06/30/2026	Deborah Volosin	On Track	I am currently meeting with leaders and discussing barriers they are encountering regarding the patient's experience.
4.5.3	Utilize Community Advisory Council (CAC) members to help conduct a Comprehensive Evaluation of the Patient Journey From First Engagement to the Receipt of Their Final Bill to Identify Improvement Opportunities	07/01/2025	06/30/2026	Deborah Volosin	On Track	Wayfinding exercise is completed. Will create additional initiatives for the CAC members to help identify opportunities.
4.5.4	Patient Rounding	07/01/2025	06/30/2026	Deborah Volosin	On Track	PX Department completed 450 patient rounds in the month of December 2025.

Performance Measure (Outcomes)

#	Name	Start Date	Due Date	Assigned To	Status	Last Comment
4.5.1.1	ET to highlight at least one patient-centered initiative, success story, or improvement opportunity each leadership meeting, demonstrating alignment with PX team priorities and patient feedback	07/01/2025	06/30/2026	Deborah Volosin	On Track	PX is sharing patient stories with CEO, inviting patients and families to tell their stories at Leadership
4.5.2.1	Director of Patient and Community Experience will report out on the unit specific barriers and successes at the Kaweah Care committee	07/01/2025	06/30/2026	Deborah Volosin	On Track	Director will summarize data from clinical leader meetings and report to Kaweah Care.
4.5.3.1	Community Advisory Council members will participate in a minimum of two structured evaluations of the patient journey, covering key milestones from initial engagement through final billing. Findings will be documented and shared with the Executive Team, with at least two improvement recommendations implemented as a result of their input	07/01/2025	06/30/2026	Deborah Volosin	On Track	Completed Wayfinding exercise. Will create more opportunities for their input
4.5.4.1	Patient Experience Team will interact with a minimum of 100 patients/families per month. (rounding, phone, email, social media, etc.). ET and Board Members will round one hour per month with the PX team with rounding numbers reported at the Kaweah Care Meetings	07/01/2025	06/30/2026	Deborah Volosin	On Track	ET + PX rounds

Promote a Patient-Centric Culture Champion: Deborah Volosin and Marc Mertz

Description: *Focus on ensuring that every touchpoint in a patient's healthcare journey—from scheduling and admission to discharge and follow-up care—is designed with their needs, preferences, and well-being in mind.*



Separator Page

PATIENT EXPERIENCE AND SATISFACTION UPDATE

Patient & Community Experience

February 2026

Patient Experience Matters

Opportunities and insights to increase patient satisfaction.

Kaweah Health
January 2026

Survey Scores

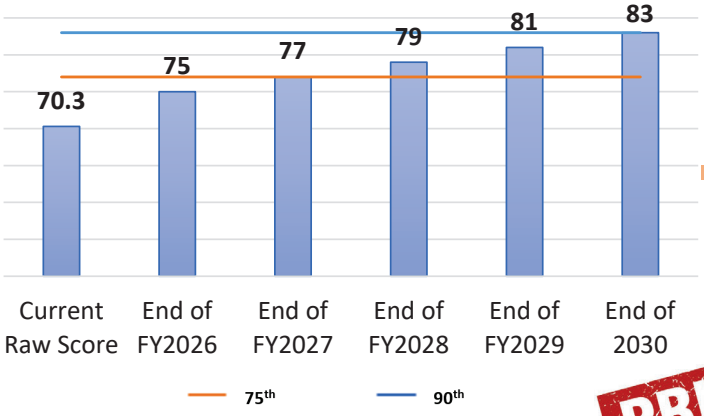
HCAHPS: 70.3
50th Percentile

Inpatient NPS: 60.3
30th Percentile

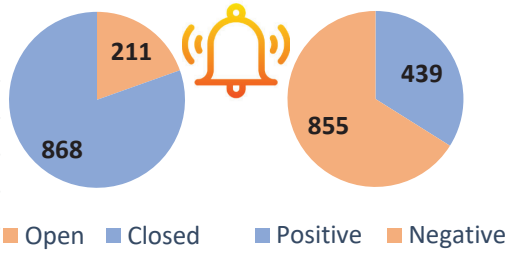
Medical Practice NPS: 78.0
12th Percentile

Fiscal Year Data
July 2025 - December 2025

5 Year HCAHPS Goal



Service Alerts



Human Understanding – 75.6
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

January 2026

- **Rounding** 300
- **MIDAS** 67 Opened
- **ED Rounding** 150

290/469

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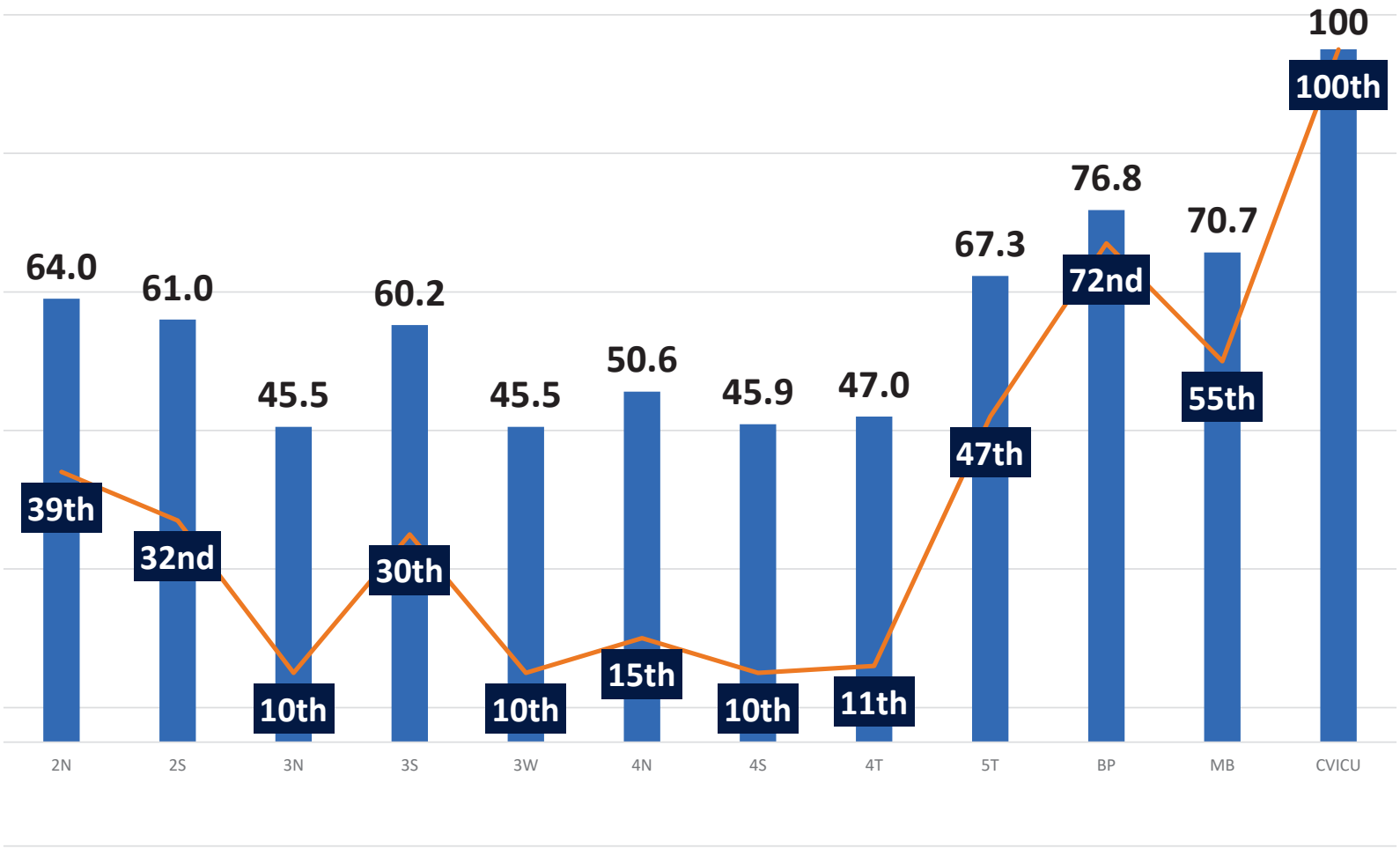
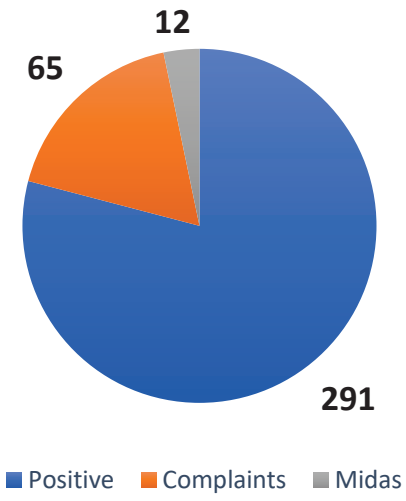
Inpatient Unit's NPS Score:
July 2025 – December 2025



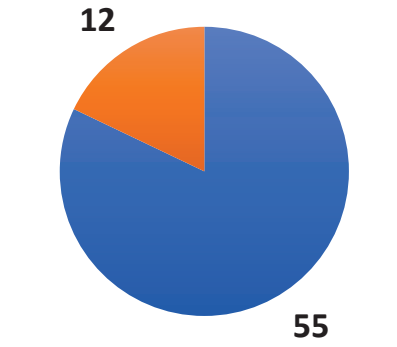
Rounding: January

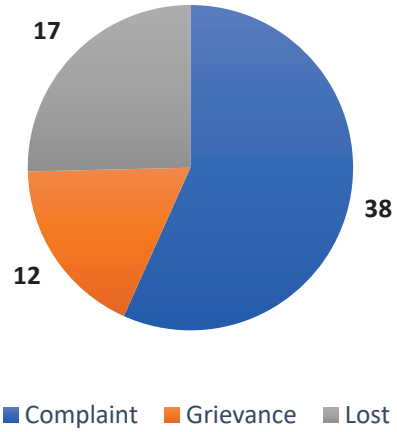
300 Rounds



MIDAS: January

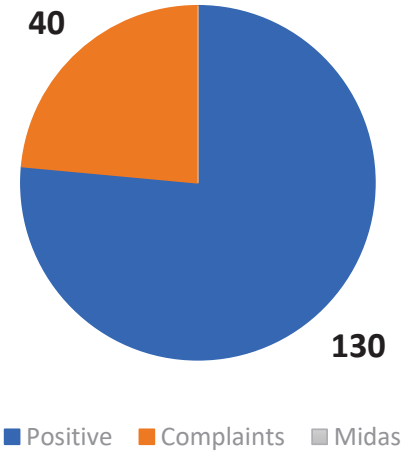
67 Opened





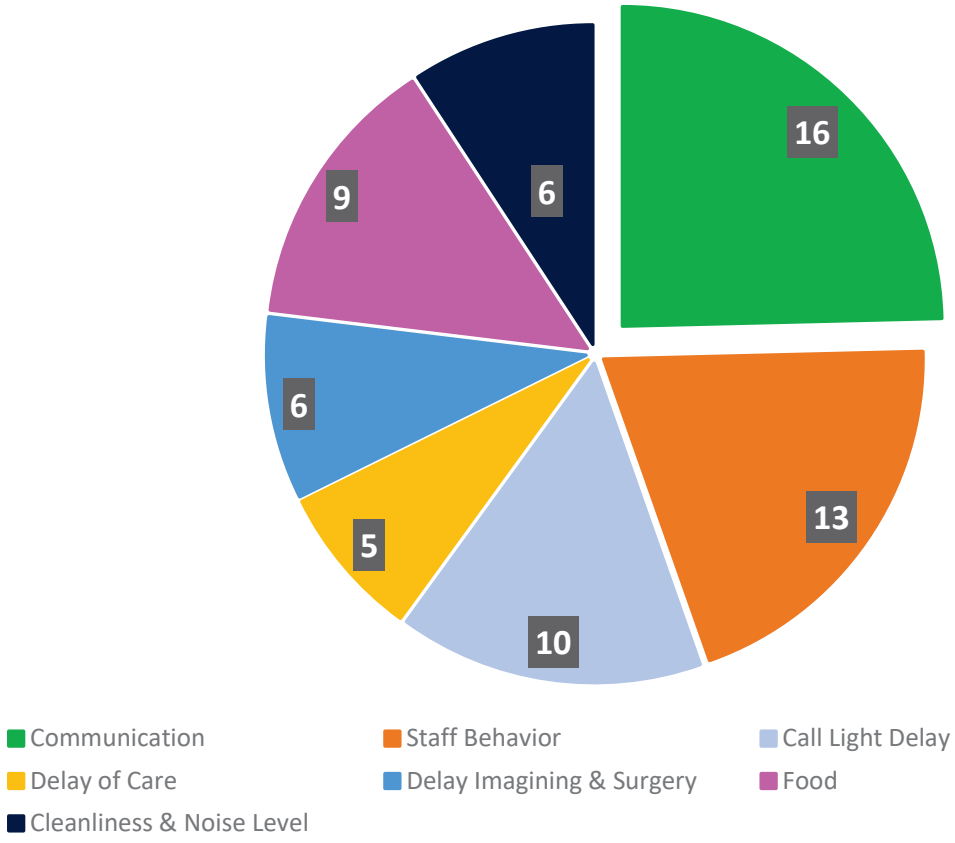
ED Rounding: January

150 Rounds



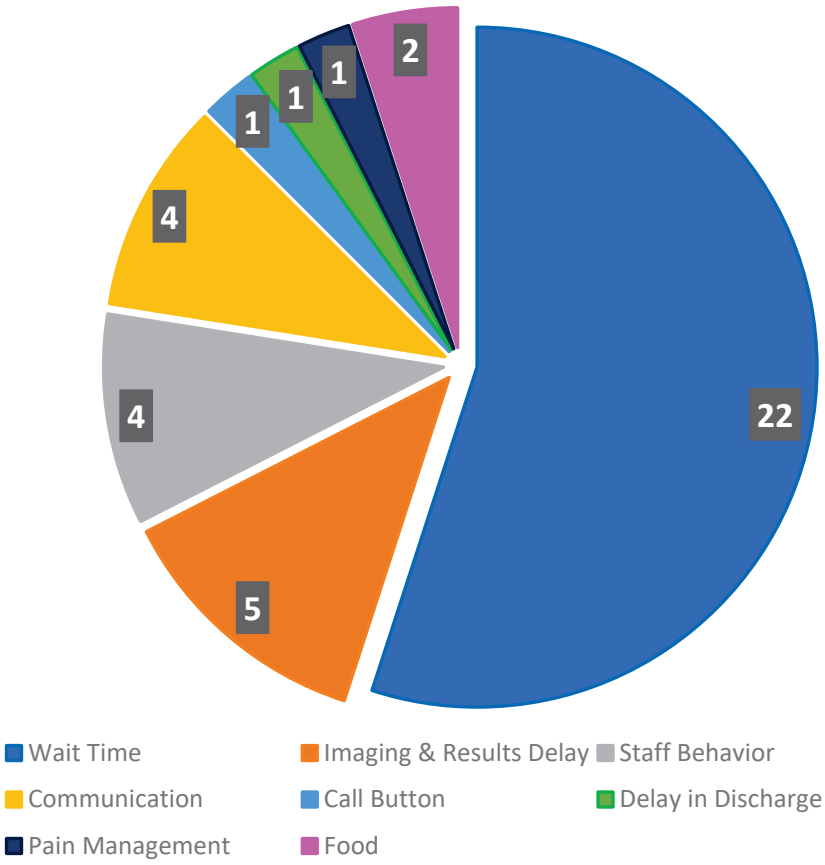
Patient Rounding Complaints Breakdown: January

65 complaints



ED Patient Rounding Complaints Breakdown: January

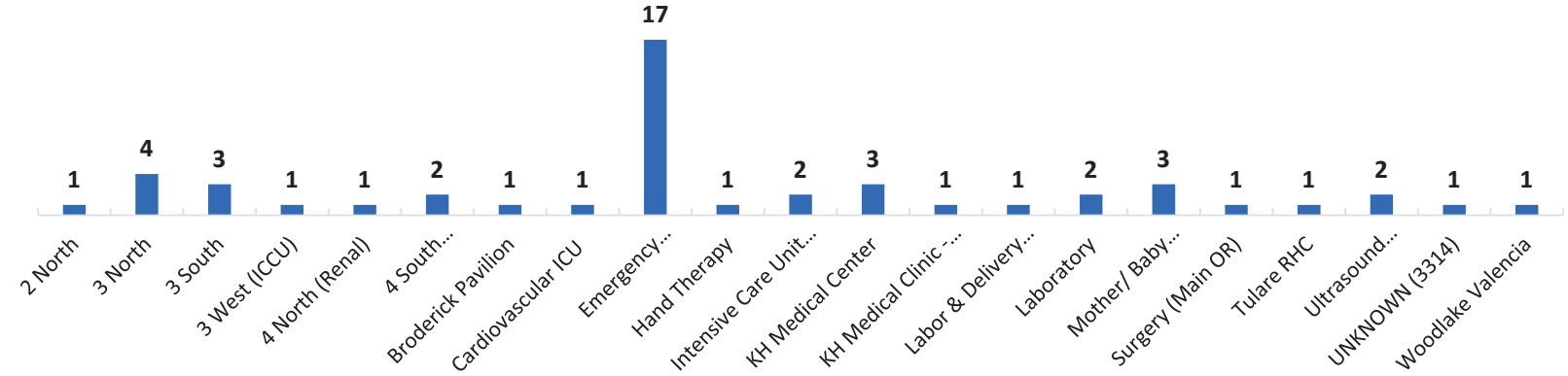
40 Complaints



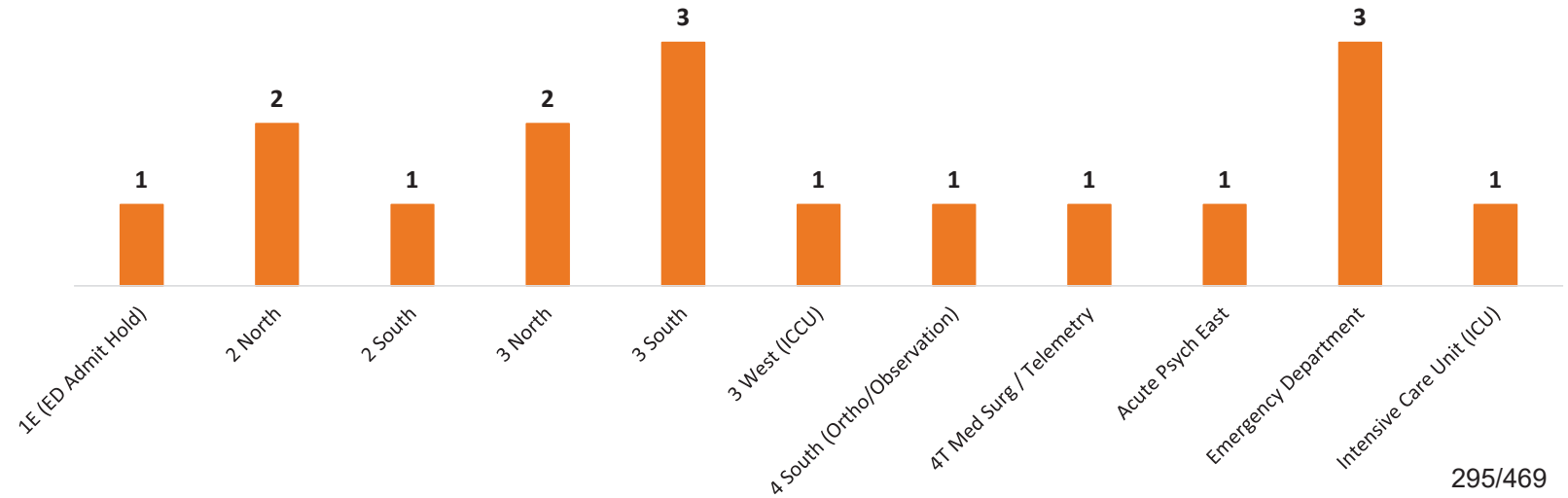
MIDAS: January

67 Opened

Complaints & Grievances



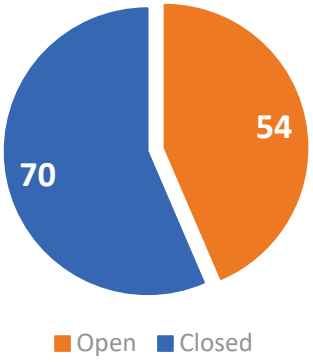
Lost Belongings



Lost Belongings

FY to Date: 124

7/1/25 - 1/31/26



Wayfinding Exercise
October 2025

Wayfinding Survey Results

21 Participants

Exercise Completed in October 2025

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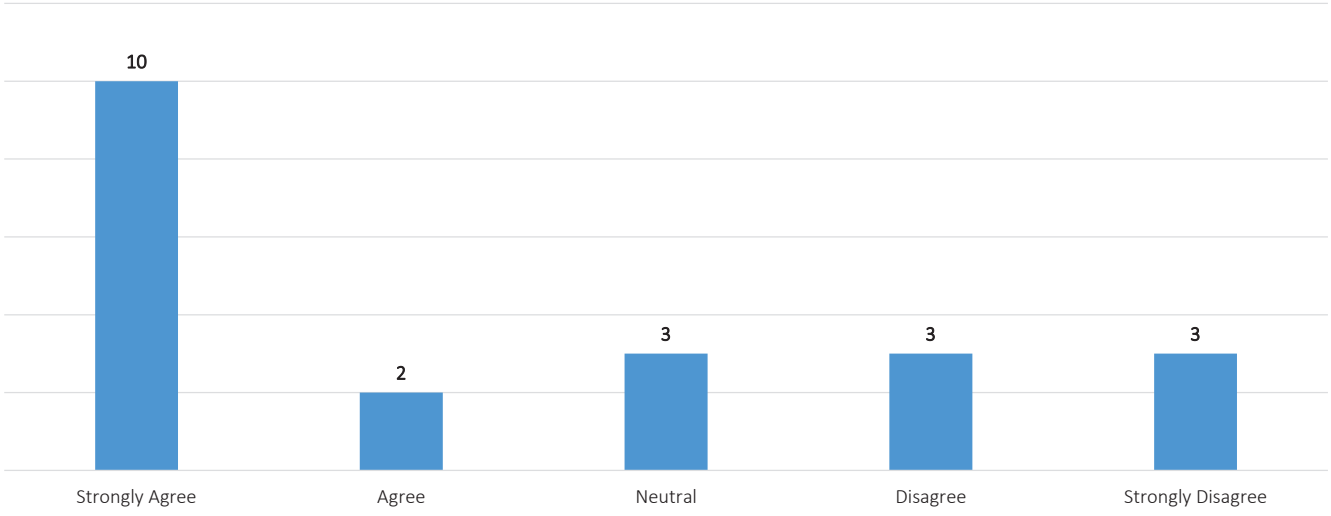
1. I went to Kaweah Health website and found the location before I came on campus.



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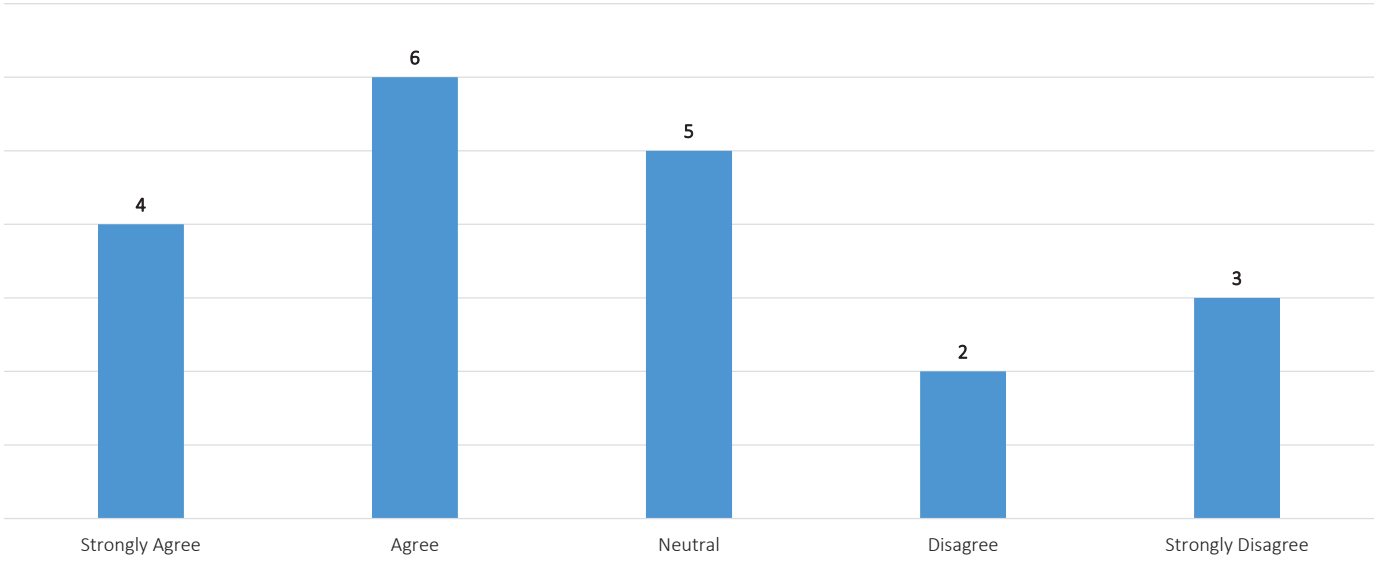
2. The website was very informative and gave me clear directions on the location I was attempting to find.



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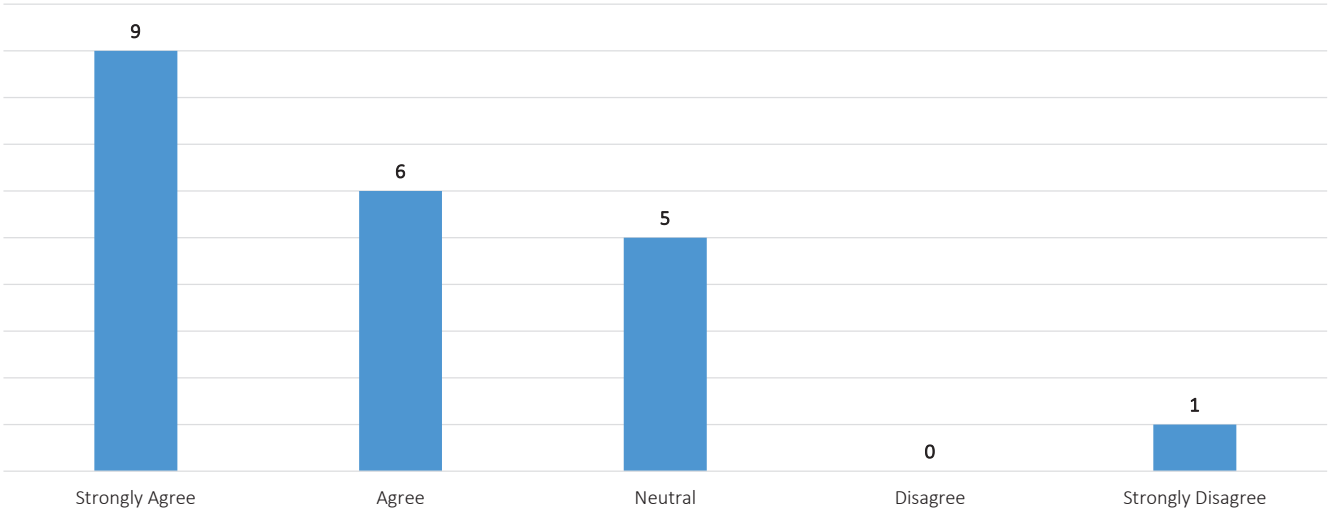
Feedback - Website

Positive:

Opportunities:

- While searching for ambulatory surgery on the website I noticed several images were very low resolution and made the site look cheap in those particular instances. I noticed it in several instances.
- The web site needs to be redone.
- On web-directional in 2nd paragraph, E/N etc., no map link or pic. COVID still a drop down.
- There is a lot of information, but shouldn't I be able to simply search Hospital? The locations tab doesn't get you to the interactive map. I google to get to it, then backtracked to find it through the home page. An added dropdown on the home page (under locations) OR at the bottom of the locations page would be great
- It was difficult to find a map showing where to mid 4S on the website. I tried the "Q" function asking for a map. The system could not find a "map". I tried "4S". No response. I finally saw a link called Visitor. The map came up.
- I tried to google ambulatory surgery at Kaweah Delta Hospital, but nothing came up. I went to the website and searched ambulatory surgery and nothing came up. I found the surgery section of the website that had an ambulatory section, but there was no information on where it was located or how to find it. I ended up calling the hospital and asking him where it was located and they told me it was at surgery on the east side of the hospital.
- I suspect if I was going there either to pick up a relative or have surgery, I would have clear instructions from the surgeon as to where to go and retrieve a parking pass from them. But just looking for that facility was not easy. When I arrived on the north side of the hospital, I asked where it was, and she directed me out the doors to the west and around the building to the surgery entrance. When I got there I asked where ambulatory surgery was, and she pointed out the exit doors and said go down the hall to the left to the doors labeled A
- The Wayfinder works quite well outside the hospital and the web site has a pretty cool set of maps for each floor. You put in your current location and your desired location and up pops a map, (after you hit go). The tracking of your progress on the route does not work very well, however I did arrive at Labor and Delivery with zero issues.

3. It was easy to find parking.



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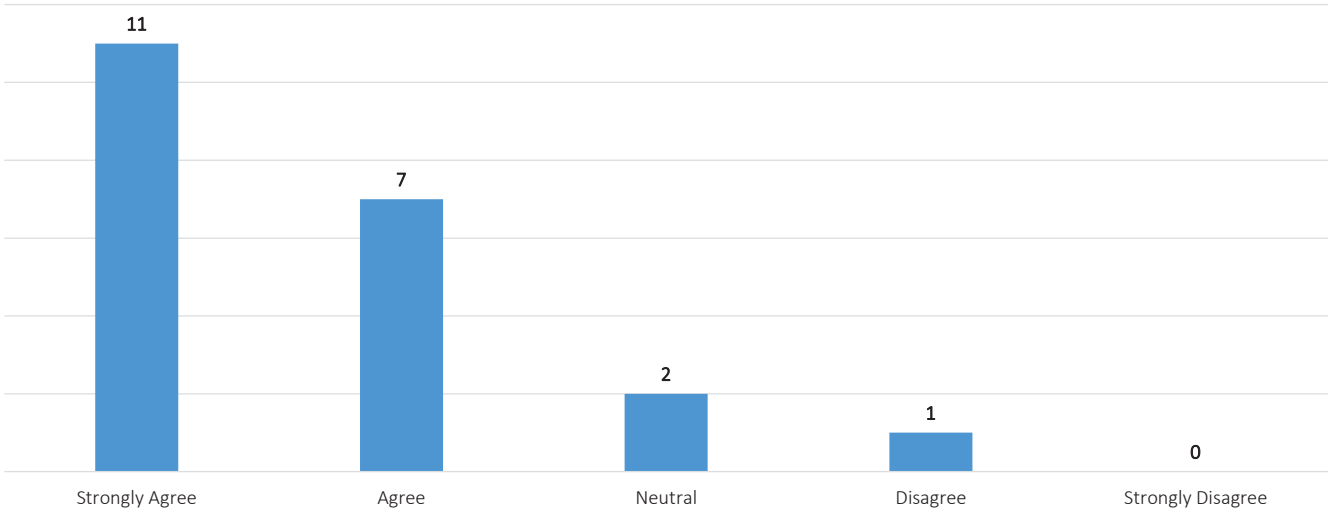
4. There was proper signage for parking.



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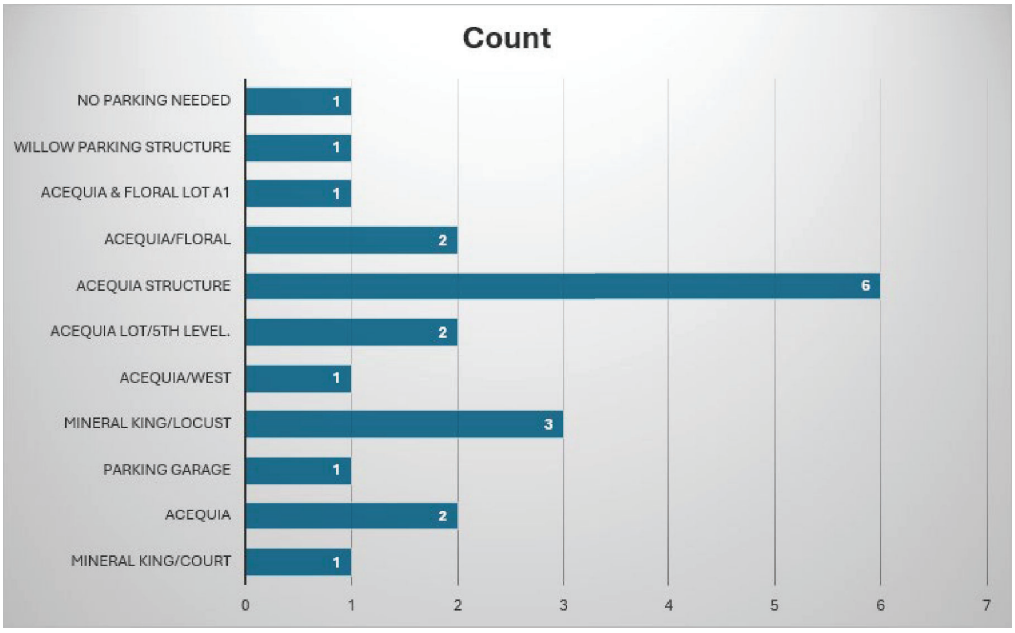
5. Which parking lot did you park in?



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Feedback - Parking

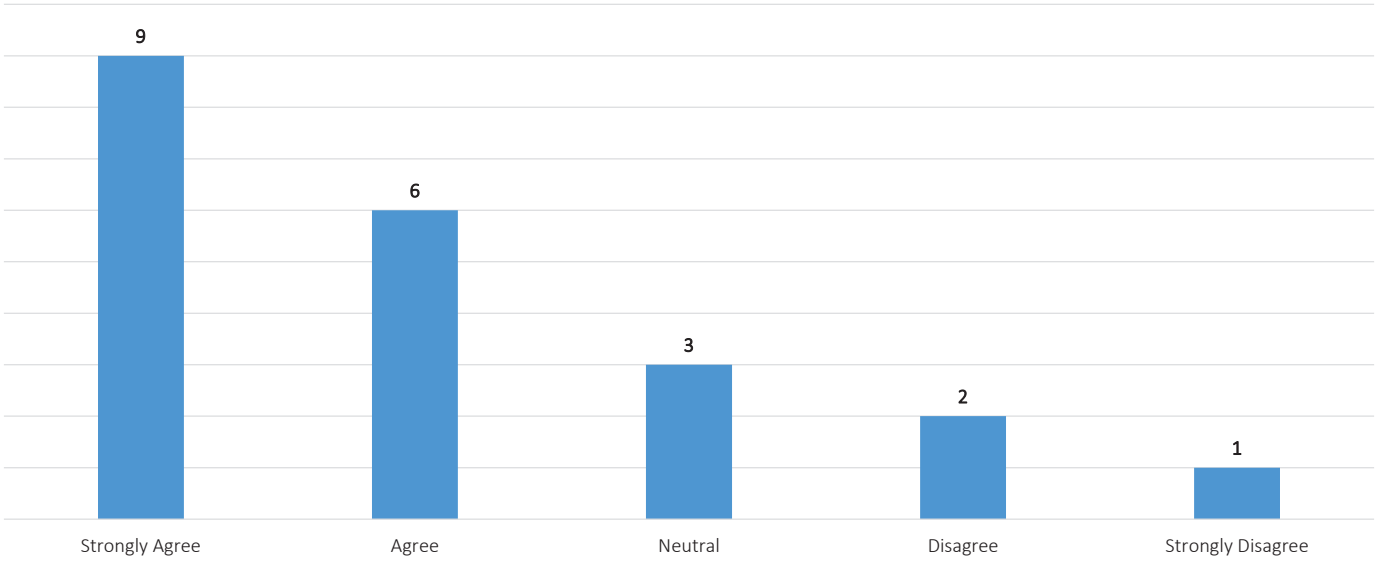
Positive:

- Easy to find parking, it was a long walk inside the building to get to the correct elevator to go to 2 West ICU.

Opportunities:

- Parking lot was full till 5th floor. The parking lot elevator was out of service, so I got extra steps in. But for some people this is could be problematic.
- “Dr. Only” signs unsure if parking for guests okay.
- North parking garage. Top floor was the only spot I could find to park there. Everything else looked to be reserved for I’m not sure who.
- The number of employees along with visitors that cut across Acequia and Mineral King worries me.

6. It was easy to find the correct entrance for my assigned location.



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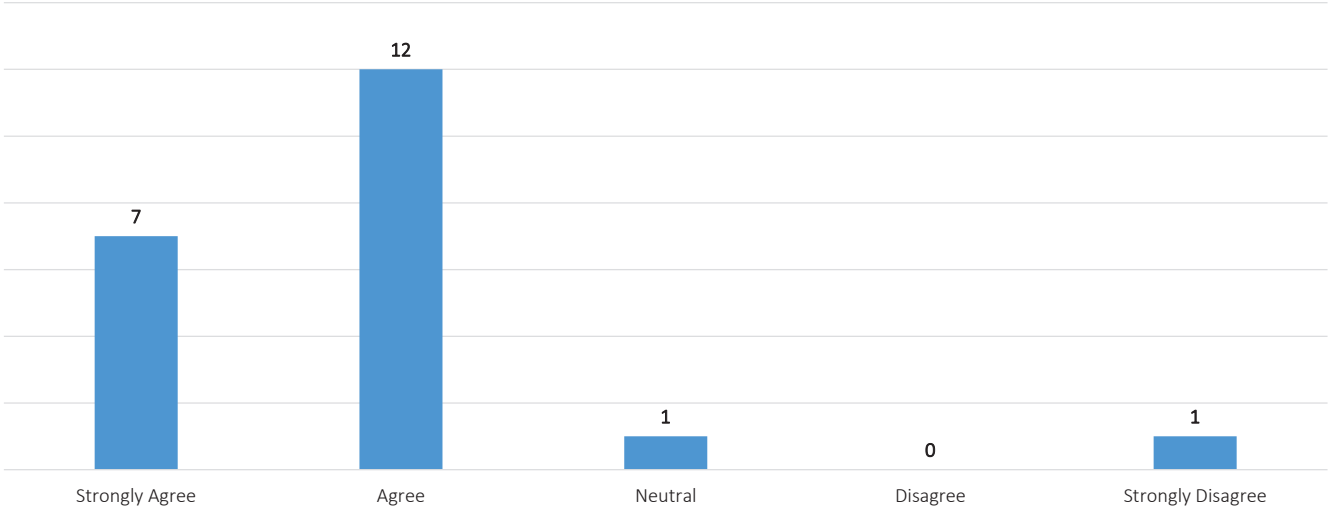
7. The internal signage was easy to follow.



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Feedback - Signage

Positive

- Signage was useful and told me exactly where to go. I went down a heap to fast at one point, but the signage corrected me and set me in the correct path. The location was clearly marked upon arrival.
- I thought the signage was pretty easy and clear to see/read. All of the staff were super friendly and helpful when asked and even when not and just looking around confused so that was nice. I will say none of the staff knew where the location was. The very last staff person I asked, said the acronym of this location and then she knew what I was asking to find, so I thought that was interesting. But overall great experience.
- I like the new signage in the hallway of Acequia wing when going to Mineral King side.
- Signage is good. It was wise to use the Kaweah interactive map first. Well done on that piece. Easy to find. I entered from Acequia entrance to see how difficult this might be. No problem.

Opportunities

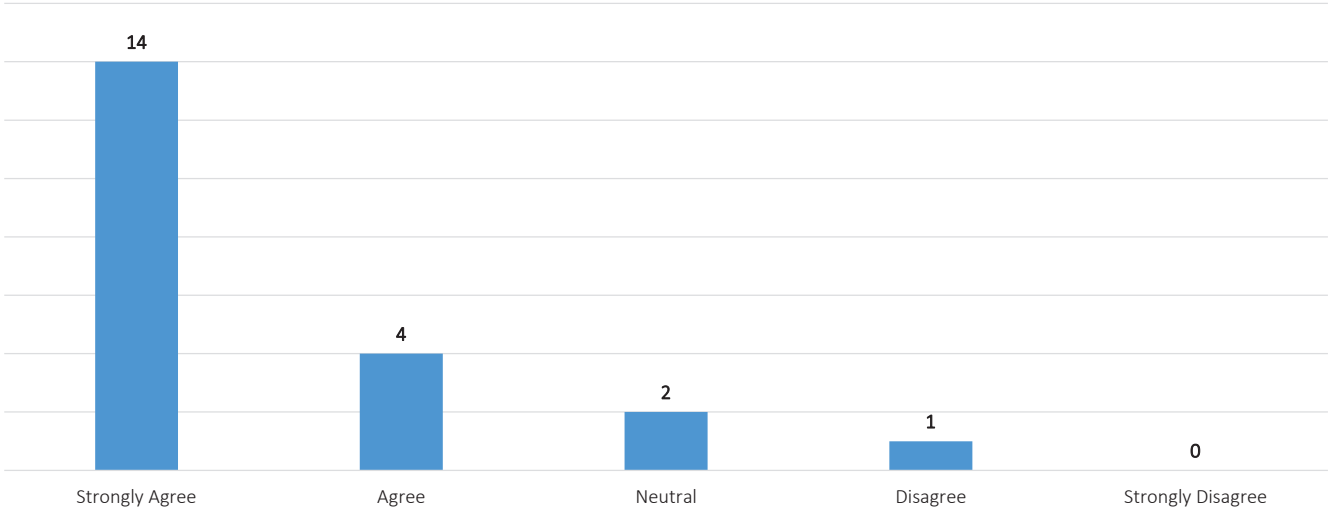
- I struggled locating restrooms- the signs are tiny. These could be made more modern, larger, and more easily visible.
- There was no signage indicating ambulatory surgery anywhere to be seen. When I arrived at the doors, they were obviously locked as it's a restricted area to patient and staff so I could not get in. I never saw the QR code which I had found last year when Completing this way finding exercise to a different location.
- I did have someone come up from behind when I was standing staring at the entrance of what I believed to be ambulatory surgery. I chatted with them for a minute, and even they were surprised there was no signage for ambulatory surgery when they thought there was.
- Lobby signage was too limited. Big sign for Mineral King wing not helpful unless you already knew 4S was in that wing.
- There was a blue line on the wall beginning in the Acequia lobby that was helpful but then it was gone. The staff member helping me told me to then look at the maroon strip. The transition into the Mineral King wing is poorly marked - probably confusing for first time visitors.
- More signs are needed. Please consider a wall or pedestal map in the Acequia lobby please add signage at the point a visitor transitions into the Mineral King wing. A well made 8x10 map that could be handed out to visitors would be helpful.
- I have been coming to this Hospital since 1969 and I know my way around but feel like for signage in the hallways would be beneficial.

Feedback – Signage (*cont'd*)

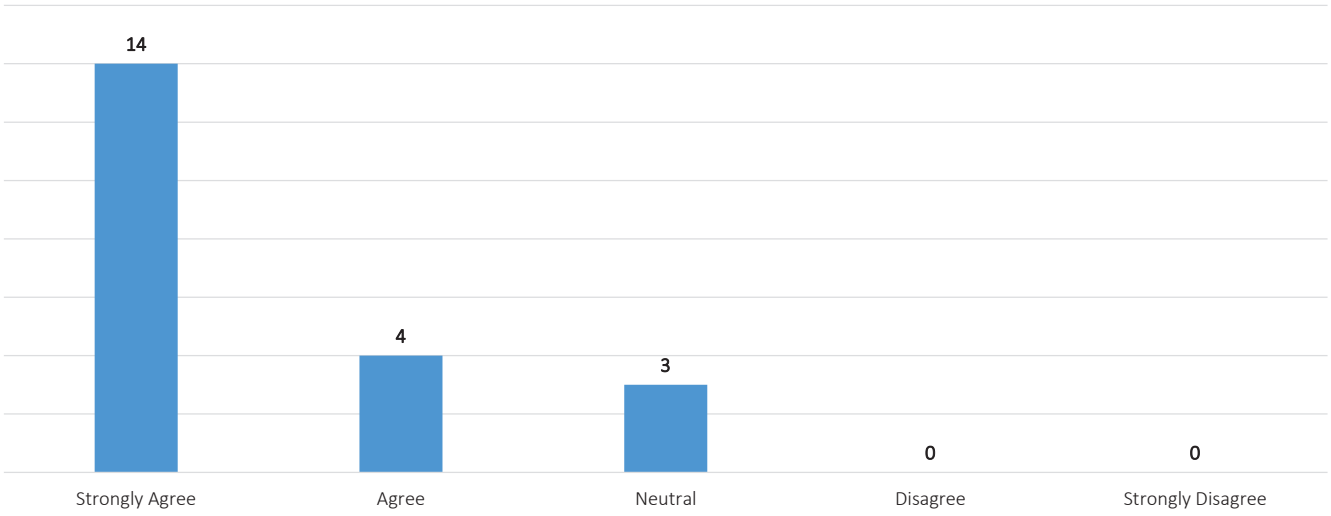
Opportunities:

- I did not see any QR codes posted. One elevator to patient floors was not working. Took 8 minutes to get an elevator. Saw a sign to take stairs, but did not find stairs. Entryway, halls, and trash cans were clean. Did not see hand sanitizers.
- I expected to see a directory in front of me in the lobby; elevators were to my right past reg desk. I had very brief interaction with reg desk who pointed out the elevator. Perhaps this is intentional so that visitors must stop there to check in.
- The blue line from the Acequia entrance leaves a bit to be desired as to how to get to the elevator for the south wing. Perhaps a few signs stating you are here with a map? I really appreciate being asked to provide feedback to the administration of Kaweah Health!

8. The area outside the facility was clean. (trash cans, windows, sidewalks, etc.)



9. The inside of the facility was clean. (trash cans, windows, hallways, floors, bathrooms, etc.)



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Feedback – Maintenance/Cleanliness

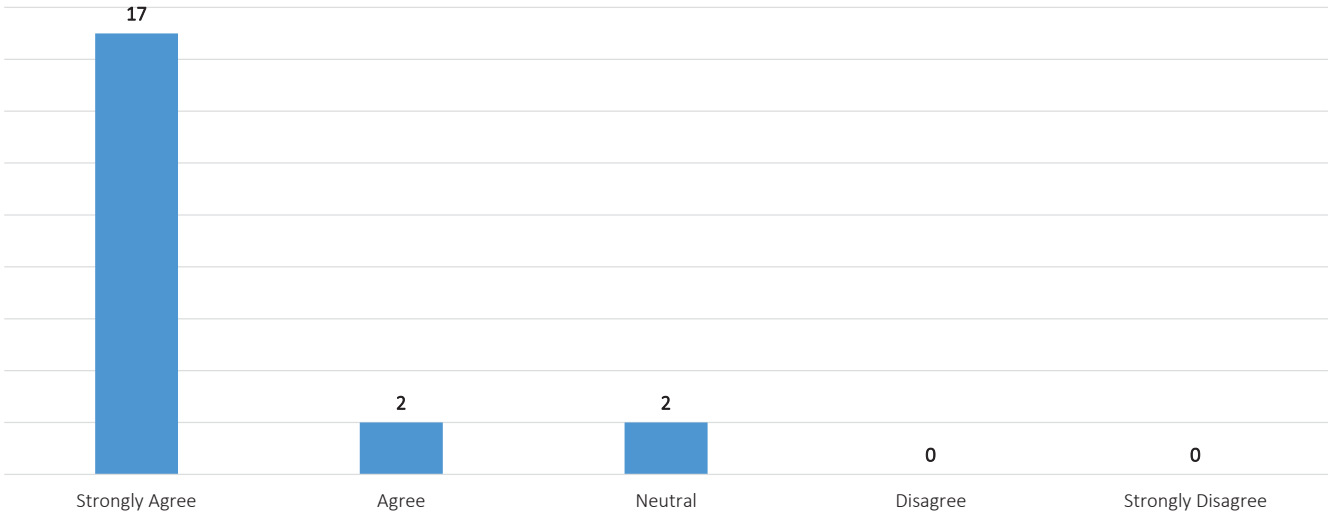
Positive: Despite the concerns noted, your director in charge of custodial services deserves recognition for a job well done in the public spaces.

- Cleanliness over all seemed good, much better than when I was a patient at Kaweah in 2023.
- In NICU facility was spotless and well organized.
- The patient room I saw was, I was told, awaiting cleaning but it looked good.
- The floors, walls, and bathroom fixtures were clean. The cabinets were free of dust on the inside. The metal threshold was mostly clean
- The new flooring on 4S looked shiny and clean . A brilliant replacement for the old, dirty looking, carpet tiles.
- Facility & parking lot were immaculate.

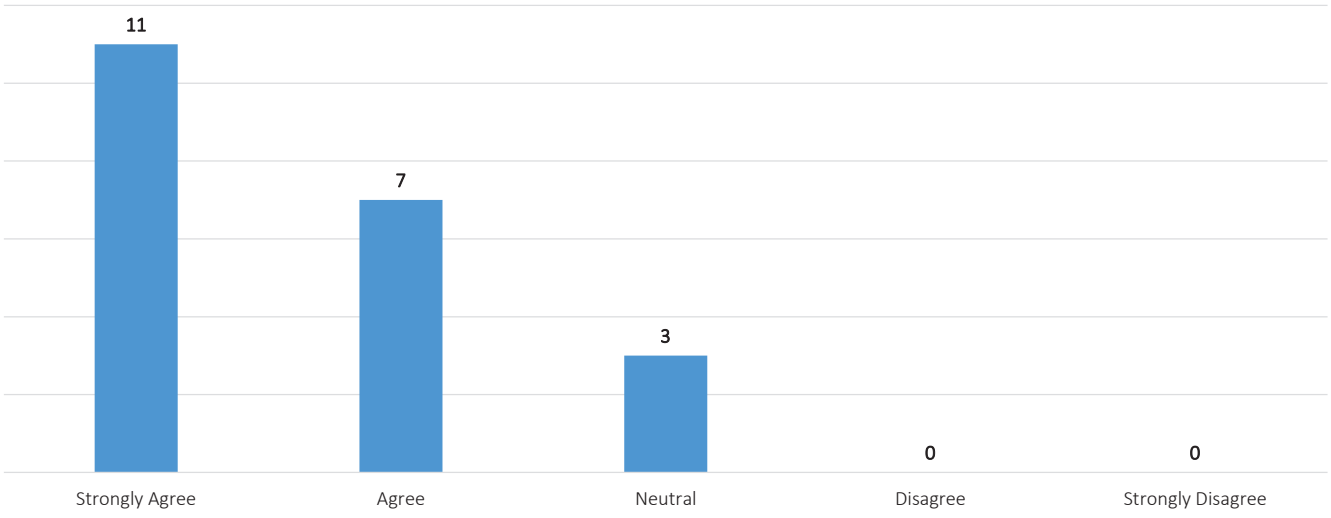
Opportunities:

- Facility: Very clean and lots of hand sanitizer available. A few elevators were broken, but still not difficult to maneuver to my location. I felt like there could be more painted bathroom directions (arrows) for those of us that get lost easily. I was asked for help on the way out more than on the way, but that could have been due to the lunchtime hour. I kept an eye out for QR codes in the waiting room and bathroom, but none were found.
- In several places the space where the floor covering and wall covering meet was black with dirt
- The metal door thresholds were generally dirty wherever I looked. I saw a floor cleaner machine being used.
- I am familiar with the equipment needed to clean institutional floors. The equipment I saw looked too small to do an effective, time efficient job.
- I encourage Kaweah to really scrub the concrete outside the Acequia entry and make and effort improve the feeling of the entry . Please consider more and friendlier lighting, many planted urns, and many security cameras in that outdoor space. Security cameras in the parking structure would help improve a sense of safety.
- The concrete area outside the Acequia wing is dirty and needs to be power washed.
- It appears the units in use are inadequate to clean the metal door thresholds.

10. The staff members were friendly, knowledgeable, and gave adequate directions and assistance.



11. The restrooms were easy to locate.



Feedback - Restrooms

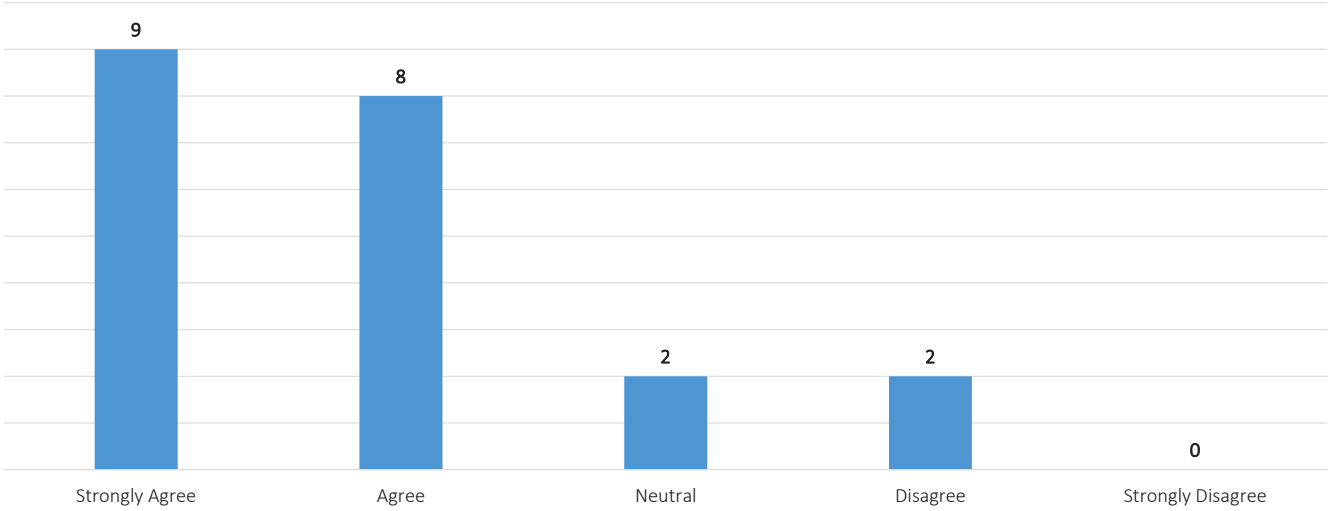
Positive:

- Restrooms at Acequia entrance were very clean and well stocked with the exception of 1 stall had no seat liners but otherwise great condition.

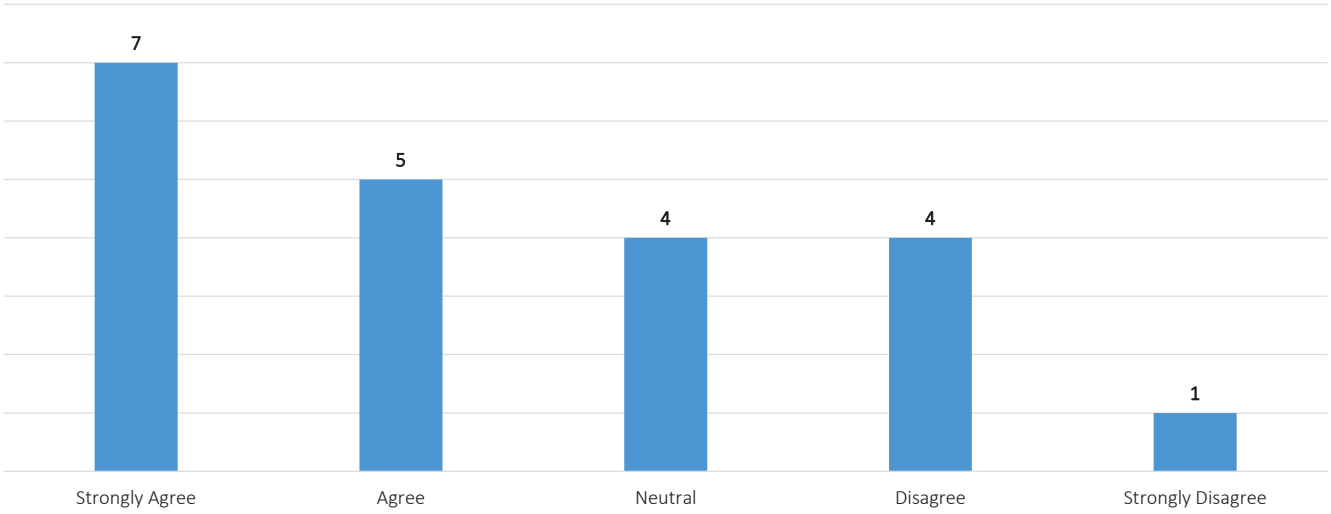
Opportunities:

- I looked in the men's bathroom in the Acequia lobby. The fixtures were clean and all seemed in good repair. I noted that the floor tile grout just inside the door was quite dirty. Otherwise the tile and grout lines were clean.
- The three restrooms I visited had trash on the floor and the one downstairs had a dirty rug.
- The trash on the floors could definitely be a timing issue.
- 1st floor unisex bathroom trash overflowing
- Restrooms did have some trash on floor but probably was recent.

12. The cafeteria was easy to locate.



13. In the cafeteria, food looks appetizing, staff was friendly, area was clean, etc.



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Feedback - Cafeteria

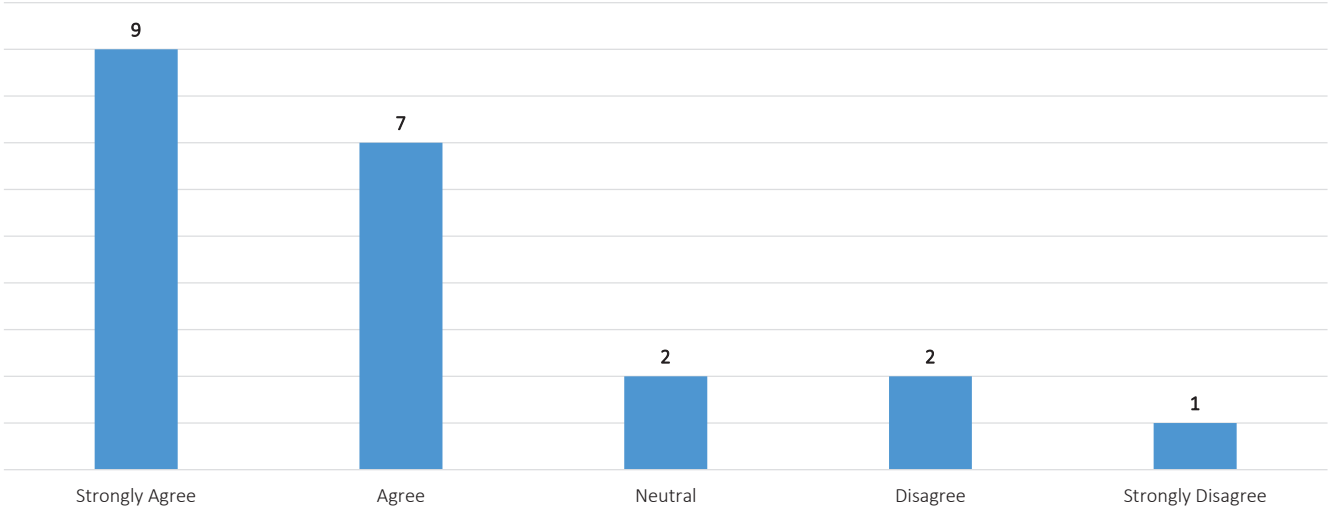
Positive:

- Well stocked with a multitude of options, some which my husband actually wanted to eat for dinner while we were there.
- I felt it was a good variety of choices in the prepackaged meals and snacks. The cafeteria style food clearly had some favored options. Two dishes were completely gone, but the meatballs were piled high. I did also tour the cafeteria and was very impressed with the murals, sanitation and food with one exception
- The North fork Cafe was clean, bright and well stocked. The sandwiches were identifiable as to "allergens" and all products were within code dates.

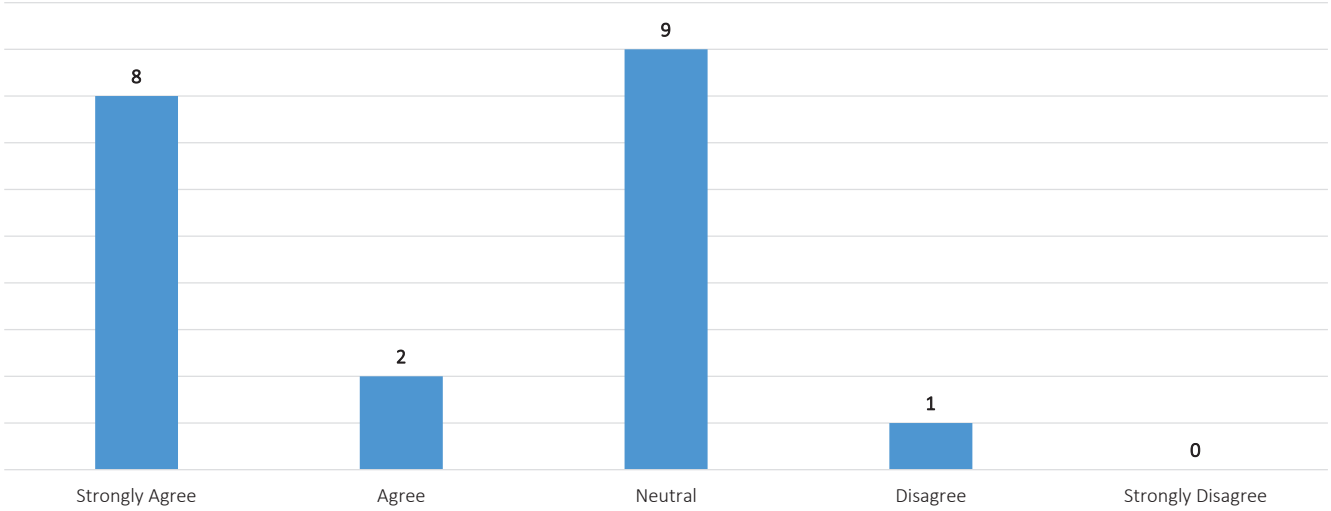
Opportunities:

- Cafeteria was fine and food looked good. I wish the entrance was more grand, I took a pic of it as it really doesn't look like a cafeteria entrance, under whelming. Cafeteria food was end of lunch and did not look appetizing. Some food for sale is in containers that are not see-through. This is not appealing, since I assume people open them to see what is inside and they might close them and return to shelf.
- The cafeteria is not ADA compliant. The staff member pushing my wheelchair found a door around the corner that was large enough to allow wheelchair access. It I were a first-time visitor I would never have found the accessible doors. The check out counters are too high. A wheelchair user cannot access them with the same ease as an ambulatory person. Not all food serving areas were accessible from my wheelchair. The cold drink cooler could be used only when I completely blocked the food service route
- I purchased a sandwich that had sourdough bread noted in the ingredient list. It actually was whole wheat bread, (please see photos). There was also a photograph on the wall in the cafeteria that noted food ingredients that might cause reactions if one has allergies, (see photos). The ingredient labels did not use any of the icons on photo of food allergies. Staff was friendly and helpful. I looked for hand sanitizers and could not easily find them. The cafeteria is clean and staff is friendly but the food is marginal. The cafeteria is cramped and uncomfortable. Please note I am comparing it against other hospitals and surgery centers. Lots of room for growth
- The food service line was not fully operational when I visited, the serving areas were dreary steel. I asked a hospital employee about the food. The response was the food was poor to adequate.
- Additionally, the cafeteria's appearance and food presentation did not meet expectations, appearing unappealing and potentially uninviting for patients or visitors relying on it for meals. I also found the signage for the cafeteria unclear, which caused confusion about the correct entrance.
- I had a little trouble finding the exit from the cafeteria; I first started backtracking through the food line.

14. Vending machines were easy to locate.



15. Vending machines were functioning properly.



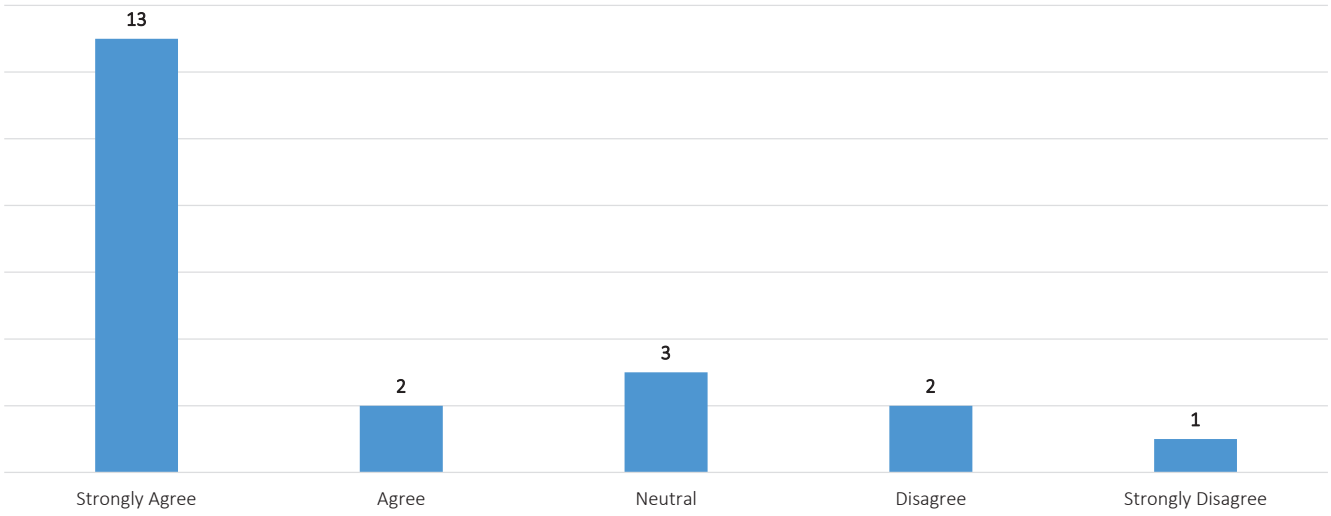
Feedback – Vending Machines

Positive:

Opportunities:

- I could only find vending machines in the Acequia Lobby. The vending machine area is poorly marked for a first-time visitor. One of the machines was not working.
- It would be helpful if the entrance to the vending machine area opened onto the Acequia wing entry if you wish visitors to know it is there
- We decided to purchase a coffee from the vending machine and struggled with payment. It rejected the tap methods several times and well as our cash. Once we swiped, we were good to go.
- Didn't see cafe or vending.
- I encountered some difficulty locating the vending machines, and while one staff member kindly provided directions, they noted that the machines were challenging to find—a sentiment I partially agree with. This individual, who mentioned working at the hospital for 10 years, expressed frustration, stating that their concerns and those of others were often overlooked by management despite repeated feedback. This was particularly disheartening to hear, as it contrasted with my initial perception of the hospital as a responsive and supportive institution.
- Vending machines were fine downstairs but only paper towels available, no utensils. The Vending machine in ICU was older.

16. The hand sanitizers were visible and available.



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Feedback - Elevators

Positive:

- The elevator floors were clean as were all the floors in 3 South, (excellent polish!).

Opportunities:

- I found the elevator fine but one was out of service. The elevator that I did use looked very old and tired. I was only going up one floor and would have taken the stairs but I didn't see signage for that.
- Upon entering the hospital, I observed that the ground floor, particularly the elevator area, was noticeably unclean, with dried vomit on the elevator door. I promptly informed the staff of this issue

Feedback - Miscellaneous

- Given it was Halloween and right before shift change, the hospital was impeccably clean and staff were super friendly and inviting. We were greeted outside of 2 North by an RN who inquired if we needed help and I explained who I was and he offered to give me a tour of his area. A patient's alarm was activated while we were in there and he promptly (and courteously) excused himself to go an assist the patient.
- The two staff members at the front desk were terrific. They smiled when I came up to the desk. They were helpful and kind. I requested a wheelchair. They had none I could use by myself. One of the staff members immediately asked if she could help and push the wheelchair. She took me to 4S, and, with the approval of an RN on the floor, took me into a room. The front desk person took me to the cafeteria.
- Thanks for the experience. I have not spent a lot of time in the hospital so was good for me to learn the layout.
- My experience was excellent. The bulletin boards were amazingly well done! There appears to be a significant pride reflected in the staff. Several years ago my spouse spent a considerable amount of time on this floor. I really appreciate the staff in this unit. The equipment was stored in a very organized manner! Please see my photos that I sent to the Director of community engagement.). I was. A bit hesitant to just walk in so I asked for a tour. A young lady, Ashley Conn, RN gave me a tour and was very friendly. I could hear heart beats of babies yet to be delivered. The bulletin boards were fantastic. Is it possible for me to nominate Ashley for a Daisy Award? I took several photographs of the bulletin boards which I will forward to Deborah Volosin. The spirits of the staff appeared quite good. Overall the hospital looks much, much better than the last time I was allowed to join a wayfinding activity. It is also a terrific improvement from what I saw as a patient in 2023.
- Staff were friendly. I was surprised no one stopped me along the way. The vendor pass badge was helpful. Things are clean.
- I spent 30 minutes there from arrival, to parking, to locked NICU door, to cafeteria and then exit to my car. Consider rendering the final optional question in Spanish.
- I suggest you look at the food serving area used by El Diamante High School or St Agnes.

Feedback – Miscellaneous (*cont'd*)

- I approached my recent visit to Kaweah health with high expectations, intending to provide a positive review based on my strong appreciation for the institution and its dedicated staff. I am deeply grateful for the presence of this hospital in our community. However, my experience during this visit led me to a different perspective, and I would like to share constructive feedback to support your commitment to excellence.
- In contrast, the floor I was assigned to evaluate was exceptionally clean, and the staff there appeared courteous. However, during my time exploring the hospital, no staff members proactively offered assistance as I navigated the facility. The receptionist at the front desk was an exception, providing clear directions with a warm and professional demeanor, which I greatly appreciated.
- As someone who has long admired Kaweah health this experience was eye-opening and, unfortunately, not in a positive way. I share this feedback in the hope that it will contribute to meaningful improvements. Thank you for your attention to these observations, and I remain supportive of your efforts to provide exceptional care to our community.
- The search I did directed me to the Acequia/ Floral parking garage so I assume that is the best place to go. The seating area was very full. Has a sign to call a nurse. Not sure if that is standard or just for ICU. Fairly impersonal and not very welcoming.
- Overall, we were impressed with our experience with how well the facilities looked and the response we received from staff. Thank you for inviting me to participate.
- I chose neutral on the website questions, as I did not want to locate anything beforehand. I wanted to enter the facility and be directed by staff to see how well directions were provided.
- The plants look good and are well maintained

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FINANCIALS

Agenda item intentionally omitted